Review & Commentary on Health Policy Issues for a Rural Perspective – February 1st, 2015

Rural Health’s Twin Advantage

by Tim Size, RWHC Executive Director

The best of rural health care has long been place-based and patient-centered, values deeply embedded in rural communities. We do not need to turn rural into a small version or outpost of urban. We do need to build on rural’s natural strengths as we continue to seek the Triple Aim of driving quality of care up and costs down while improving the health of the whole community.

Hopefully, that sounds familiar, as it is from my last Commentary. I am not engaging in one of those all too frequent senior moment’s but acting out my belief that repetition for emphasis is important. Next in our conversation, I would like to touch briefly on two key opportunities we all have as we work for or live in rural communities: advocacy and collaboration.

For me advocacy means acting to have others share your vision. For rural health that often means confronting the multiple myths embedded not far below the surface of many opinions. Some of my “favorites” include: rural residents don’t care about local care; rural is naturally healthy, needs less; rural health should cost less than urban care or rural health care is inordinately expensive; rural quality is lower; urban is better; rural hospitals and clinics are just band-aid stations.

These stereotypes should make your blood boil, and that is good. Advocacy needs passion to fuel it over the long haul that is often needed to make a difference. Use that energy to work in your community and with others who have earned your respect for standing up for rural health.

There are many opportunities to advocate for rural health. Pick an issue you care about, commit to making a difference and seek partners with the same passion. In a similar way, we all have opportunities to collaborate in the work we do or lives we lead. Key opportunities for rural health can be seen as falling into three buckets:

- Providing local patient-centered care that is team-based and outcome-focused
- Collaborating regionally to emphasize the value of care over the volume of care
- Partnering locally and regionally to foster healthy local communities

When I started out with RWHC thirty-five years ago, in some ways it was easier to talk about collaboration. It was a rare enough of an idea to be almost exotic. If you found anyone talking about it, it was fairly safe to assume they were sincere. And if they didn’t have much experience (like me) they were willing to start learning.

“Sometimes it’s the people no one imagines anything of who do the things that no one can imagine.” The Imitation Game

RWHC Eye On Health, 1/13/15
Today the idea of “collaboration” has become fashionable; in many areas it has become a requirement for funding or moving an initiative forward. And that is good. But it also means we have to be even more deliberative in conversations or planning focused on this approach. Too many are using the word without much appreciation or commitment to what it means in terms of behaving differently.

Collaboration can coexist with competition and can be part of traditional organizational structures. But it is a way of working that is different and is not a way that many of us existing leaders were trained in or educated about. For my part, here are some of the characteristics I look for as signs of effective collaboration:

- There is an understanding that collaboration is not easy, as demonstrated by the current state of affairs in most State capitals and in particular Washington. To be clear, this state of affairs isn’t new, just recycled. One of my favorite quotes is by Mark Twain: “In the first place, God made idiots. That was for practice. Then he made your Party.”

- The work follows a mutually agreed to strategic plan not dominated by one entity.

- Strategies use both art and science to employ political, economic and social forces to a common end.

- Partners listen as allies—they work to understand before evaluating. I find myself strongly agreeing with an unexpected source, Newt Gingrich, a former Republican House Speaker. “Look to work with people willing to say ‘Yes, if …’ rather than ‘No, because…’”

We will achieve our vision for a healthy rural America if we use our passion to advocate for it and do the hard work of working together.

“Will You Be My Doctor?”

From “The Quality of Mercy: Will You Be My Doctor?” by Dr Timothy Daaleman in JAMA, 11/12/14:

“I have noticed a troubling phenomenon in patients who are new to my practice and have multiple comorbidities. Joan (not her real name) first came to see me several months ago with a recent medical history that included an aggressive breast cancer, resulting in a double mastectomy, as well as a wide surgical resection of a melanoma that was discovered a short time after her first diagnosis. And if these misfortunes were not enough, just a few months out from her cancer operations, Joan was a passenger in a car that was struck by another vehicle, which eventually led to a rotator cuff repair of her right shoulder. Joan was still in a shoulder immobilizer when we first met, and she recounted each of these adversities in a measured, almost rehearsed way. Yet her emotion broke the cadence of our visit when she voiced one unaddressed concern at the end of the encounter: ‘So will you be my doctor?’”

“Since first meeting Joan, I have been asked this question enough times by other patients that it has pushed me to find out why they are thinking this way. It has also raised concern that new patient appointments are turning into auditions for primary care. Perhaps, I reasoned, a previous physician had retired or moved, or maybe there was an insurance issue, particularly around Medicare or Medicaid, that triggered the search for a new health professional. This assumption was put

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**Eye On Health** is the monthly newsletter of the Rural Wisconsin Health Cooperative. Begun in 1979, RWHC has as its **Mission** that rural Wisconsin communities will be the healthiest in America. Our **Vision** is that... RWHC is a strong and innovative cooperative of diversified rural hospitals... it is the “rural advocate of choice” for its Members... it develops and manages a variety of products and services... it assists Members to offer high quality, cost-effective healthcare... assists Members in partnerships to make their communities healthier... generates additional revenue by services to non-Members... ongoing use of strategic alliances in pursuit of its Vision. Tim Size, Editor, 880 Independence Lane, Sauk City, WI 53583

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aside when I found out that the percentage of physicians who report accepting new Medicare patients has actually been higher in recent years, when compared with those accepting patients with private insurance. More surprisingly, nonelderly Medicaid patients—typically those with a high number of medical and/or mental health comorbidities—have a usual source of care and a similar number of outpatient visits at rates that are comparable to patients with insurance.”

“These reports did not cast light on to what I was hearing in the examination room, so I queried several patients as to why they had asked my permission to be their doctor. All responded that their previous physician had pronounced them to be ‘too complex’—a term that they uniformly used—and that they needed to transfer their care to another doctor. This led me to speculate on some of the off-the-record diagnostic criteria that are used to mark the threshold of medically complicated patients as ‘too complex.’ For some physicians, patients may cross that border when the social and economic hurdles in their lives make simple health care tasks, such as getting transportation for a scheduled appointment, formidable. For others I believe it is the administrative waterboarding of prior authorizations, disability determinations, medical leave forms, and the like that pushes them over the edge. This may be part of the reason why access to care markedly drops off for patients who have a higher burden of disability and for those who are more limited in their economic resources. The dividing line for me lies somewhere between a persistent, low-level frustration of just trying to get by managing patients who rarely see meaningful improvement, and the long-term emotional hazards of caring for those whose lives are permanently disrupted by illness or non recoverable injury. I walk that line every week.”

“In my most exasperated clinical moments, I freely admit to wishing that several patients would magically find their way to one of my colleagues on follow-up. But when I get to that feeling state, I remind myself that mercy, which is a willingness to enter into the chaos of another, is part and parcel of what I signed onto as a physician. The image of chaos rouses the better angels of my nature by restoring a broader perspective of the patient in front of me as a person, beyond the suffering and despair that clouds my view and darkens my emotions.”

“A hallmark of mercy is hiddenness. Clinical works of mercy, such as unprompted phone calls to patients or social rounding on those who are hospitalized, are everyday events that are transparent but largely inconspicuous and do not translate into value or production-measured activities. In my early years as a physician, I would often stick to my biomedical guns with complex patients, and this allowed me to wall off and look over the human turmoil that would be in the examination room. There is a greater pull for me these days to enter into the chaos. I have discovered that the attraction is tied to a series of subtle, interior shifts—from helplessness to empowerment, from isolation to presence, from hard-heartedness to compassion—that inexplicably flows from walking the difficult road with patients. It is in practicing works of mercy that we become merciful.”

“The quality of mercy will be severely strained in coming years if Joan’s question to me is a harbinger of where value-driven health care is headed. I do not know where mercy fits into future value streams, but I do know that mercy remains a prerequisite for caring, an individual and organizational capacity that needs to be awakened, deepened, and sustained. In current or emerging care settings, it is still during clinical moments—when patients seek help from physicians—that the actions of the individual physician and the larger health care system converge. These clinical moments lay bare the normative and moral work of physicians, endeavors that have historically provided the foundation for sustained therapeutic activity between patients and physicians. They also reveal a larger truth that if the arc of medicine is to ultimately bend toward healing, mercy will be its fulcrum.”
Medical Schools Get the Results They Model

From “Why I’m Becoming a Primary-Care Doctor: The U.S. has a shortage of family physicians, but many med students avoid the specialty, stigmatizing it as uninteresting” by Mara Gordon from The Atlantic at www.theatlantic.com on 9/18/14:

“At my medical school, we spend 7 out of 48 weeks of the goal of becoming a primary-care doctor. But somewhere between orientation and Match Day, the high-pressure moment when medical school seniors find out where they will be training, the idealism wears off.”

“At my medical school, 12 out of 162 students in this past year’s graduating class have started primary-care residency programs. Nationwide, about 12 percent of graduates in the 2014 Match entered residencies dedicated specifically to primary care (though graduates who do general internal medicine or pediatrics programs may still end up in primary care).”

“In the academic hospitals where American medical students complete most of their training, specialty care is the norm rather than the exception. Teams of specialist consultants visit hospitalized patients, asking lots of pointed questions about whatever organ they know best. We students follow along, as part of a whirlwind 12 months known as the ‘core clerkships.’ If a patient has a problem that doesn’t fall within the bounds of whatever specialty we happen to be rotating through, it’s not our responsibility—our advice to the patient is to follow up with his primary-care doctor.”

“At my medical school, we spend 7 out of 48 weeks of core clerkships in dedicated primary care settings. But more than half of doctors’ visits are made to primary-care offices, according to the Centers for Disease Control and Prevention’s National Ambulatory Medical Care Survey. The majority of medical care is taking place in outpatient settings, away from the type of care centers where we students learn the basics.”

“The lack of exposure to primary care sets the stage for my medical school’s hyper-specialized Match list. The role models we work with every day are specialists, and we start to imagine our future careers looking like theirs. As a classmate who is also going into family medicine said, ‘We don’t get to see the primary-care rockstars.’ ”

“But there’s something deeper at play, a widespread and nagging perception that primary care doctors just aren’t as smart as their specialist counterparts. When I spoke to Andrew Morris-Singer, a primary-care physician at Harvard, he recounted a story a medical student once told him. The student told a colleague about his plans to practice general medicine, and the doctor apparently responded: ‘A monkey could do this.’ ”

“Bias against primary care influences the way medical students think about their careers. A 2013 paper in the journal Academic Medicine interviewed more than 1,500 students, and authors found that students who attended schools where there was frequent badmouthing of primary care were, unsurprisingly, less likely to pursue a career in that field.”

“This stigma has certainly affected me and my classmates who are bound for primary care. Most of us have strongly considered other paths. When a hand surgeon told me I had excellent surgical technique, I had a 24-hour fantasy of going into orthopedics. I thought seriously about obstetrics and gynecology, a field with strong public-health implications, but more surgery than I really wanted to do. It’s been hard at times not to envision myself in a medical specialty, given that’s most of what I’ve seen in medical school.”

“Doctors love data, and there’s good data that more primary-care mentorship can encourage medical students to go into this field. Clese Erickson, the director of the American Association of Medical Colleges’ Center for Workforce Statistics and the lead author of the 2013 Academic Medicine study that examined primary-care stigma in medical schools, says strong role models—the ‘primary-care rockstars’ my classmate lamented not meeting—can really change the trajectory of students’ careers.”

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‘Their eyes would light up,’ she said, describing her interviews with students around the country who described these kinds of formative experiences. Students at schools with a positive ‘primary-care culture,’ she said, ‘are connected with primary-care physicians, and practices, and can see something that they would want to wake up every day and do.’ ”

“Sitting in a classroom and listening to a lecture on why primary care is cool won’t convince anyone. It’s seeing it in action that might.”

“When I spoke to Morris-Singer, he asked me where I saw myself in five years. For a moment, I forgot I was the one who had come with questions for him, and I felt like what I will become this fall: a medical student on a job interview.”

“I told him some of the things that make me excited about working in primary care. I’m eager to work across disciplines to help keep patients healthy, rather than reacting when they get sick; I want to get to know my patients over time. There will be painfully rushed office visits in my future. There will be red tape and frustrations. But like many of my smart peers headed into this field, I also feel motivated by the challenges of designing new systems that meet the needs of patients, not the needs of insurance companies.”

“As part of an advanced family-medicine elective this past spring, I worked in a free North Philadelphia clinic with a harm-reduction philosophy, trading heroin users packs of clean needles for their dirty ones in an effort to curb the spread of HIV and Hepatitis C. These patients did not always have complicated medical problems. But the ways the legal and healthcare systems had let them down were certainly complicated. It was thrilling to work with other doctors who saw this inequality as a call to action, not a problem outside of the scope of our medical practice. This kind of challenge is the reason I went to medical school.”

“Harnessing this sense of activism and opportunity, Morris-Singer said, is the key to more primary-care doctors, and not just primary-care doctors who feel subservient to an antiquated bureaucracy.”

‘The next generation is hungry,’ he told me. ‘They see the problems in the system.’ He went on to imitate a typical shocked medical student response to some of the absurd processes we find ourselves shackled to in American healthcare: ‘He’s faxing! Why is he faxing something?’ There’s something screwed up here.’ Instead, Morris-Singer wants medical students to think: ‘I can help fix this.’ ”

Binge Drinking: Learning When to Stop

by Dave Johnson, RWHC Director of Member Relations & Business Development

Wisconsin has a drinking problem. Or at the very least, we have a problem with binge drinking. Over the last 10 years, Wisconsin has consistently had the highest, or second highest percentage of adults who binge drink in the United States.

According to the Centers for Disease Control binge drinking is “four drinks consumed by a woman, or five drinks consumed by a man, in a two-hour period.”

Can binge drinkers in Wisconsin choose to consciously change their behavior? In an attempt to answer that question and hopefully drive change, RWHC and four member hospitals, with their community advisory teams, have launched a project to reduce the prevalence of binge drinking.

On average, one in four Wisconsin s binge drinks, five times per month, consuming 9 drinks per occurrence. Some may view this as a survival technique for Wisconsin winters. But the reality is that binge drinking is a negative
part of our culture that consumes valuable resources, and negatively impacts thousands of lives each year.

Most people in Wisconsin are aware that binge drinking in our state is a problem. During 2012 and 2013, Wisconsin hospitals participated in “community health needs assessments,” a process in which hospitals, their community partners, and local citizens take the pulse of the needs that are present in their respective communities. Access to care, diabetes, and obesity were all common themes impacting the health of local citizens in many of those CHNA reports.

However, alcohol was the most prevalent factor in many of those reports. Amongst RWHC member hospitals, 52% reported alcohol as a among the top three community concerns in their needs assessment. Despite this concern, change has been slow.

In January of 2014, representatives from Medical College of Wisconsin, RWHC, and the four participating hospitals launched a process to encourage adults to self report their drinking behavior and at the same time, inform them about the risks of binge drinking and educate them about local services that may be available.

Selecting from known best practices, the group selected a screening instrument that allowed anonymous self reporting of drinking behavior, identified and trained health educators at each participating site, and created a uniform process to screen and inform patients who choose to complete the survey.

During specified days and hours at each site, patients entering the clinic or urgent care setting are asked to complete a voluntary survey known as AUDIT (Alcohol Use Disorders Identification Test). AUDIT is a best practice survey recommended by the World Health Organization, and it has been used in many research projects across the Country.

If a patient screens positive for binge drinking behavior, they are asked if they would like to meet with a health educator to learn more about binge drinking, and how they may access resources to assist them in changing that behavior. In the event the patient would like to meet with a health educator and one is not currently available on site, a health educator from another hospital can meet with the patient through a secure tele-health connection to provide the patient with the necessary information.

The participants believe that this project will inform and educate rural Wisconsin citizens about binge drinking, and as a result they will change the way they view the culture of drinking and make choices that reduce risky drinking behavior. The screening and brief intervention process will continue through 2015, and the group hopes to expand the project to additional sites in the following year.

“A Collaborative Response to Reduce Binge Drinking in Rural Wisconsin Communities” is a grant project developed by Memorial Medical Center (Ashland), Gundersen Boscobel Area Hospital & Clinics (Boscobel), Moundview Memorial Hospital & Clinics (Friendship), Stoughton Hospital (Stoughton), RWHC and, academic partners at the Medical College of Wisconsin to inform and educate adults in those communities about binge drinking.

This project is funded in part by the Healthier Wisconsin Partnership Program, a component of the Advancing a Healthier Wisconsin endowment at the Medical College of Wisconsin.

Funding from the Federal Health Resources and Service Administration Flex Program through the Wisconsin Office of Rural Health allows RWHC to make four videos available to you at no charge at:

www.rwhc.com/Resources/PublicPresentations.aspx

RWHC partnered with Paul Frigoli (Ph.D., R.N., C.P.H.Q., C.S.S.B.B.) to create a series for managers and leaders in rural healthcare who are not directly involved in coordinating quality improvement, but whose collaboration is needed to make it happen.

Quality is everyone’s job, and this webinar series will help clarify the different roles that every health care
manager plays in creating the highest quality envi-
ronment possible.

**Broadly, the topics covered include:**

- Defining quality and evidence based practice
- Data gathering: where you get it, why it matters, and how it is used once it is gathered
- The why, what, how and when of documentation
- Understanding core measures and the implications of improving them
- Overview of basic process initiatives and practice
- Understanding everyone’s role in improving patient outcomes
- Why quality matters to everyone, not just the quality manager, and how YOU can help improve it at your organization

Visit the **RWHC Leadership Series web pages** at [www.RWHC.com](http://www.RWHC.com) to view all our class offerings. If you would like more information about the *RWHC Leadership Series*, please email **Education Coordinator, Carrie Ballweg** at CBallweg@rwhc.com or call 608-643-2343.

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**Leadership Insights: “Who’s in Charge Here?”**

The *Leadership Insights* series is by Jo Anne Preston, RWHC Organizational Development Manager. Back issues available at [www.RWHC.com](http://www.RWHC.com).

“Put me in charge, I am good with that. Or tell me you are in charge and I am happy to follow. But not knowing which role to execute can create anxiety, misunderstandings and a poor outcome.”

“This is not about the question, ‘Should I delegate or not?’ This is about those times when you are interested in sharing leadership in a project and you don’t want anyone to end up saying:

- ‘Oh, I thought someone else was taking care of that; I didn’t realize I was responsible for it!’
- ‘I already did this and so did you—looks like we duplicated our efforts here.’
- ‘I’m upset because I thought you would do this and now it is not done.’
- ‘I’m frustrated because I thought this was my area, but you have taken it over.’ ”

“Leave your conversations clear about what role each person is to play. Look at great teams: they know who is in charge, and everyone knows their part. There are many reasons why people leave a discussion with a murky view of who is to take the lead which can end up with no one taking it. If you are the one who is to lead, take steps to reduce needless uncertainty. **Watch out for the following traps:**

1. **You feel like it is stating the obvious, and that seems superfluous.** It’s not only ok to state the obvious, but it makes things more clear if you say things like, ‘I will have the final say in the project/meeting/event. As you progress on your part, check in with me once a week about where your contribution fits into the overall plan.’

2. **You assume they just know.** You are the manager, so it’s likely they will assume you will take the lead, but your conversations may leave some ambiguity. Recap after those conversations who will be doing what.

3. **You can’t make up your mind.** Are you secretly hoping they will either offer to take on more responsibility, or tell you straight out they are not ready for it? Like with most things, it’s more helpful to be open about this. For example, ‘Typically I would take the lead in this kind of project, but I am considering asking you to take on part or even all of the leadership of it. If this was your project, how would you go about achieving it?’

4. **Project Management (PM) isn’t your strong suit.** Too often leaders approach projects with the ‘jump in and start doing’ method. Sometimes that
works, but if we take the time on the front end to create a project plan with key milestones and deliverables, we reduce the likelihood of important tasks falling through the cracks.

“Project management is really people management. You don’t have to approach it with the complex software required to build a skyscraper. Keep it simple. Just take the time to list and share key milestones toward your end goal, and write in the person responsible for each of the tasks for those milestones.”

“Another simple PM tool is the RACI chart. RACI is an acronym for Responsible, Accountable, Consulted and Informed, and answers these questions next to each deliverable in your project:

- **R**–Who is Responsible for completing the actual work?
- **A**–Who is Accountable for saying the task is complete and can sign off on it?
- **C**–Who needs to be Consulted before any major decisions or changes are made?
- **I**–Who needs to be kept Informed when an action has been taken?”

“www.ProjectManagementDocs.com is a great resource for free PM tools that you can adapt and simplify to meet your needs.”

Contact Jo Anne Preston for individual or group coaching at jpreston@RWHC.com or 608-644-3261. For Info re the RWHC Leadership Series 2015 go to www.RWHC.com and click on “Services” or contact Carrie Ballweg at cballweg@RWHC.com or 608-643-2343.

<table>
<thead>
<tr>
<th>Upcoming RWHC Leadership Programs</th>
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<tbody>
<tr>
<td>2/26: Conflict: Building Trust through Skillful Conversations</td>
</tr>
<tr>
<td>3/12: Monkey Management (Based on The One Minute Manager)</td>
</tr>
<tr>
<td>4/9: Lateral Violence: Empowering Staff to Stop Bad Behaviors</td>
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<tr>
<td>Open to Non-Members. To register or see other events, go to: <a href="http://www.RWHC.com/Services.aspx">www.RWHC.com/Services.aspx</a></td>
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