The Business of Rural Health is Health


“Now is the time for Balanced Scorecard driven strategic planning to incorporate population health measures. The growing expectation of healthcare providers regarding health improvement and healthcare costs suggest that healthcare providers join with public health and other community leaders to ‘look upstream’ for opportunities to prevent illness and reduce future healthcare expenses. Community leadership must act, and hospitals are part of that leadership.”

“The Balanced Scorecard is a practical performance improvement tool that rural hospitals are increasingly integrating into their strategic planning and management processes. The goal of the Balanced Scorecard is to link strategy with action and to identify cause/effect relationships among short and long-term objectives. Robert Kaplan and David Norton helped to popularize Balanced Scorecard in the early 1990s and they organized key objectives into four domains: Financial, Customer, Internal Processes, and Learning and Growth. Since then, strategic planning consultants and hospital leaders have been adapting, applying, and evolving the tool for healthcare.”

“Many hospitals have long been involved in key community-wide interventions—this is not new. However, the concept of including population metrics in a hospital’s Balanced Scorecard is challenging because hospitals are not solely responsible for their communities’ health. As best expressed by a rural hospital CEO during a focus group discussion at the Rural Wisconsin Health Cooperative in early 2004, ‘when population health outcomes are everyone’s responsibility, it is, as a practical matter, no one’s responsibility.’ ”

“Although the disciplines of population health analysis and Balanced Scorecard-based management are well-established, the two have not previously been considered together. Rural hospitals may accept an implicit and informal role in its community health, but that role is easily subjugated by the more pressing demands of revenue-generating activity.”

“We need to emphasize that the issue is not whether or not hospitals should be in charge, but whether or not hospitals have a collaborative leadership role to play with the local public health agency, local businesses, clinicians, schools, employers, etc. In some communities, a hospital may play a facilitator or convener role, but in no communities should this be about the hospital ‘taking charge’ of the community’s health. Even if you could find a hospital that wanted that role, the nature of the work requires community-wide collaborations to get the job done. This is not a competition between individualism and a community focus, but creating a synergy between two important frames—personal health and population health.”
“The essence of Balanced Scorecards is that successful organizations focus on those objectives and related outcomes, that if achieved, go a long way to advancing the organization’s vision. If organizational success is directly affected by measures of population health, hospitals will engage. But hospitals don’t print money and few rural hospitals have separate foundations with substantial undesignated resources. The challenge is as it has always been, how do we pay for caring for today’s patients while finding the funds to become more proactive to reduce the future healthcare needed.”

“In the meantime, much can be done at the local level by rural hospitals to foster population health awareness and new collaborative interventions, such as:

- Devote a periodic Board meeting or a portion of every Board meeting to review available population health indicators.

- Add Board members with specific interest and/or expertise in population health measurement and improvement.

- Create a ‘population health’ subcommittee of the hospital board to explore opportunities for hospital partnerships with other community organizations to improve proactively population health.

- Consider hospital employees or employees of a proactive local employer as a ‘community’ and develop interventions to improve employee health. Then, expand the experience to the larger community.”

“Business schools cite railroads as a classic example of a failure to adapt to changing times; falling from tycoon status in the late 19th century to bankruptcy in the 20th. The railroads kept on doing what initially had been a successful strategy—selling access to rail cars and track. However, the railroads failed to adapt to a market that was redefining transportation as cars and airplanes, not trains.”

“Healthcare ‘markets’ are being redefined; shifting from purchasing service units to purchasing quality outcomes. Importantly, quality care is increasingly defined in both personal and population perspectives. This developing redefinition of healthcare markets needs to be reflected in hospital strategic planning. This is a great opportunity for rural hospitals and the communities they serve.”

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Physician Burnout & Local Leadership

From “Physician Burnout Heavily Influenced by Leadership Behaviors” by Alexandra Wilson Pecci, for HealthLeaders Media, 4/28/15:

“Researchers find a ‘very strong relationship between physician satisfaction and burnout and the leadership behaviors of physician ‘supervisors’ in large healthcare organizations. Physician burnout is prevalent throughout the U.S. healthcare system—experienced by nearly half (46%) of physicians, according to data published in JAMA last year. But effective leadership appears to alleviate it, according to new research from Mayo Clinic and published in the April issue of Mayo Clinic Proceedings.”

“In 2013, nearly 3,000 physicians and scientists across Mayo Clinic’s three campuses in Arizona, Florida, and Minnesota responded to a survey about...
their wellbeing in the workplace. They were asked not only to rate themselves on burnout and satisfaction, but also to evaluate their immediate supervisors, who were physicians and scientists themselves, in 12 specific dimensions of leadership.”

“Not only did 40% of respondents report at least one symptom of burnout, but researchers were able to link burnout rates to how well the physicians rated their leaders. For every one-point improvement in the 60-point leadership score, there was a 3.3% decrease in likelihood of burnout and a 9% increase in satisfaction. Scores were adjusted for age, gender, length of employment, and specialty area.”

“‘There was this very strong relationship between satisfaction and burnout and the leadership behaviors of physician supervisors,’ says Tait Shanafelt, MD, professor of medicine at Mayo Clinic and first author of the study. ‘At a high level, the most important point is that leadership behaviors matter.’”

“Shanafelt says the specific leadership behaviors he and his team evaluated could be boiled down into how well the supervisors informed, engaged, and empowered those that they led. He points out that all of the leadership behaviors measured were actionable, ones that can be learned or developed. ‘Part of what this tells us is that healthcare organizations probably need to invest more thought and energy both into how they select and also how they develop and train effective physician leaders,’ he says.”

“Traditionally, physician leaders have been selected based on being good doctors or experts in their field, rather than whether they necessarily have the skills and qualities of effective leaders, Shanafelt says. ‘Those clinical qualities, while certainly admirable, may or may not set them up to succeed as a leader,’ he says. Rather, other qualities, such as being open to new ideas, consensus building, and bringing together diverse opinions, are ones that make good leaders who can bring about change.”

“Today physicians have less autonomy than ever before. Shanafelt says that 75% of physicians are now employed by large healthcare organizations, which is a profound change from the solo or small group practices of days gone by.”

“That change in practice structure has also brought a change in leadership needs. Shanafelt says effective leaders today should ask their physicians for their ideas, let the individuals that they’re leading identify and develop solutions to local problems, as well as giving them the tools to put those solutions into effect.”

“‘Physicians are inherently critical thinkers who want to solve problems,’ he says. ‘The good physician leaders recognize that and sort of engage and empower their physicians to develop their own solutions.’ Shanafelt acknowledges that physicians are not always easy to lead.”

“‘Physicians can be a challenging group of individuals to lead because they often bring this very deep understanding of medical practice, they often have developed a healthy degree of skepticism, which is part of the training process,’ he says. ‘They’re very attentive to detail, want evidence for decision-making, which can make it hard to build consensus. The rise in physicians working in large groups, combined with the perfect storm of burnout factors, makes it more important than ever for healthcare organizations to work on training and developing physicians who can lead in such a challenging environment.’”

Wisconsin Long-Term Care

From “The State of State Long-Term Care Policies” by Diane Farsetta in CARE Connections, the newsletter of the Center for Aging Research and Education at the University of Wisconsin–Madison School of Nursing, Spring 2015:

“How can state policymakers meet the increased demand for long-term services and support and ensure quality care for often vulnerable populations, while staying within tight budgets?”
“It’s not an easy task. For one thing, state policies aren’t the only factor shaping long-term care. There are federal policies, regulations, funding and initiatives; market, financial and workforce pressures; professional and educational trends; changing demographics, especially with regards to age, health and whether there are family members who can help; and healthcare system realities.”

“To further complicate the picture, the priorities for quality long-term care depend on who you ask. ‘Some would probably say that long-term care providers need more resources,’ explains University of Wisconsin-Madison School of Nursing Associate Dean Barb Bowers, PhD, RN, FAAN.”

“Frontline staff want better training, pay and benefits, with accountability for poor performers. Nurses want more staff and greater flexibility in scheduling. Families are most concerned that staff are familiar with and engage their loved one. The residents themselves want meaningful relationships with other residents and staff.’ ”

Still, state policies account for wide variations in the quality of long-term services and supports. ‘Where you live really matters,’ summarizes Raising Expectations, a comprehensive report released last year at http://ow.ly/Nf1UK by AARP, the Commonwealth Fund and SCAN Foundation. Wisconsin’s long-term care system compares favorably to that of most other states, ranked eighth nationally, based on composite measures of affordability and access, choice of setting and provider, quality of life and quality of care, support for family caregivers, and effective transitions.”

“The report identifies two factors directly impacted by state policies that are major drivers of long-term care quality overall: the percentage of long-term care funding that goes towards home and community-based services (HCBS), and how many low-to-moderate-income adults with disabilities access long-term care services through Medicaid. States ‘establish both functional and financial eligibility standards for Medicaid coverage’ and ‘directly affect access to HCBS and choice of services and providers.’ ”

“In Wisconsin, just over 46 percent of Medicaid and state long-term care funds go towards HCBS for older adults and adults with physical disabilities. That’s the tenth highest percentage nationally. New Mexico, which ranks first on this measure, directs 65 percent of its long-term care funds to HCBS.”

“Of the report’s composite measures of long-term care quality, Wisconsin ranks in the top ten nationally for choice of setting and provider, and for quality of life and quality of care. However, Wisconsin barely ranks in the top quarter of states for effective transitions, and falls to the second quarter on support for family caregivers and affordability and access.”

“In just over ten years, the baby boomers will start entering their 80s. By strengthening state long-term care policies now, we can help ensure their and their families’ well-being.”
Bad Science Still Fuels Anti-Vaccine Myth

From “Another study finds no link between MMR vaccine and autism” by Jethro Mullen, CNN, 4/22:

“The vaccine for measles, mumps and rubella doesn’t bring an increased risk of autism, according to a new study of more than 95,000 children. The study, published in the April 21\textsuperscript{st} issue of the \textit{Journal of the American Medical Association}, is the latest piece of research to debunk the myth associating the MMR vaccine with autism.”

\textbf{Vaccine-autism connection debunked again}—“Using a database from a large commercial health plan, the researchers paid particular attention to children who had older siblings with autism, or ASD, which puts them at a higher genetic risk of developing autism.”

“‘We found that there was no harmful association between the receipt of the MMR vaccine and the development of an autism spectrum disorder,’ said Anjali Jain, a pediatrician at the Lewin Group, a health care consulting firm in Virginia, who worked on the study.”

\textbf{Beliefs continue to persist}—“As dozens of measles cases began popping up in the United States in recent months, unfounded fears about a link between vaccines and autism resurfaced.”

“‘Although there is a lot of research suggesting that there is no link between the MMR vaccine and autism spectrum disorder, those beliefs continue to persist,’ said Jain. The study found that children who had an older sibling with autism were less likely to be vaccinated. ‘Their vaccination rates were about 10\% less than for kids with unaffected siblings,’ Jain said.”

“The myth about a link between vaccines and autism, propagated by a small but vocal group of anti-vaccine activists, grew out of a now discredited study from 1998 that was published in a British medical journal by a doctor who was later stripped of his license.”

“‘We’re not sure as a scientific community what causes autism, but vaccines do not,’ CNN’s Dr. Sanjay Gupta said last month.”

Eight Principles of Collaborative Leadership

“Rural Network Leadership” by Tim Size, RWHC Executive Director, was published on 4/30 by the National Rural Health Resource Center as technical assistance for grantees of the Federal Office of Rural Health at \url{http://ow.ly/N8xY0}:

“Leadership is the capacity to help transform a vision of the future into reality.”

“The significant challenges we face today in healthcare require a form of leadership that is less authoritative and more collaborative. Ronald Heifitz and colleagues at the Stanford Graduate School of Business say it very well. These ‘problems require innovation and learning among the interested parties, and, even when a solution is discovered, no single entity has the authority to impose it on the others. The stakeholders themselves must create and put the solution into effect since the problem is rooted in their attitudes, priorities, or behavior. And until the stakeholders change their outlook, a solution cannot emerge.’ It is important to not confuse being collaborative with endless stanzas of singing ‘Kum By Ya;’ collaboration frequently requires strong external catalytic action.”

“In \textit{Leadership Is an Art}, Max DePree offers a model for employer-to-employee relationships based on his experience that productivity is maximized by designing work to meet basic employee needs. His vision of the art of corporate leadership brought employees into the decision-making process. DePree’s experience is primarily within the world of the Fortune 500, but many have found him to offer a useful framework for non-profit and public sectors.”

“While DePree was a successful leader of a Fortune 500 Company, some may describe him as impractical, a common descriptor thrown by the ‘pragmatists’ at ‘collaborators.’ Robert Greenleaf offers a suggestion that may be helpful in thinking through this dilemma: ‘For optimal performance, a large institution needs administration for order and consistency, and leadership so as to mitigate the effects of administration on initiative and creativity and to build team effort to give these qualities extraordinary encouragement.’”
“As the executive director of a cooperative of rural hospitals for more than 35 years, it is easier for me than for many to see rural health through the lenses of collaboration, the opportunities it creates, and the threats it endures as a model for organization and community work. We have adopted and adapted DePree’s eight leadership principles as a guide for both our internal and external relationships.

1. There is Mutual Trust—“Develop relationships based primarily on mutual trust so that the cooperative goes beyond the minimum performance inherent in written agreements. While responding to a rapidly changing market in 1984, the implementation in six months, from scratch, of a rural-based health insurance company was only possible due to the prior existence of a basic level of trust among the key actors.”

2. Commitment Makes Sense—“Participants may join a cooperative to explore its potential; they remain only if they perceive that they are receiving a good return on their investment of time and money. RWHC offers a broad array of shared services from which hospitals pick and choose according to their individual needs; commitments are made because they have been structured in a way that attempts to maximize the ‘fit’ for each individual participant.”

3. Participants Needed—“Each organization must know that it is needed for the success of the cooperative. It is a major mistake to ever take for granted the participation or commitment of any member. The RWHC communication budget is ample testimony to the importance of early and frequent communication and consultation.”

4. All Involved in Planning—“The planning is interactive, with the plan for the Cooperative being the result of, and feeding into, the plans of the individual participants. One theatrical but powerful example of ignoring the need for local input and preferences involved RWHC within months of its incorporation in 1979. Two regional health planners were practically driven from the bare wood stage of Wisconsin’s historic Ringling Theater after their presentation of a unilaterally developed plan for consolidations and closures. The plan was not implemented and did not contribute to discussion of how rural healthcare in southern Wisconsin could be improved.”

5. Big Picture Understood—“Participants need to know where the organization is headed and where they are going within the organization. RWHC has a motto: ‘Say it early and keep saying it.’ A number of RWHC’s more significant initiatives, such as improving rural hospital access to capital, various quality improvement projects, and advocacy for major education reform within the University of Wisconsin’s health professional schools has been multiyear if not indefinitely long efforts.”

6. Participants Affect Their Own Future—“The desire for autonomy needs to be made to work for RWHC through the promotion of collaborative solutions that enhance self-interest. When RWHC began operations, many observers were highly skeptical about whether it would last, let alone make any real contribution that rural hospitals’ traditional needs for autonomy would prevent any meaningful joint activity. Some shared services have been undersubscribed as hospitals have chosen local options when, at least from the perspective of RWHC staff, a cooperative approach offers a better service at a lower cost.”

7. Accountability Up Front—“Participants must know up front what the rules are and what is expected of them. Discussions at RWHC board meetings are comparable to customer focus groups and equally valuable. Participation in all Cooperative shared services requires a signed contract, not so much as to permit legal enforcement, but to ensure that all parties in the partnership have thought through up-front the expectations of all the participants.”

8. Decisions Can Be Appealed—“A clear non-threatening appeal mechanism is needed to ensure individual rights against arbitrary actions. The use of
the cooperative strength of RWHC hospitals has been used to enforce an appeals process in a variety of circumstances, including a potential breach of contract by a large health insurer; individually, few could have justified the necessary prolonged legal challenge to enforce the contract but through concerted joint inquiry into the legal options available, further legal action became unnecessary.

“In summary, leadership is the capacity to help transform a vision of the future into reality. Individuals who can and will exercise leadership are like a river’s current—a part past where we now stand, a part yet to come. We have an ongoing need to remember and to look toward the next ‘generation.’”

The full article from which the above is abstracted is available at http://ow.ly/N8wM7.

Leadership Insights: “Arrogance”

The Leadership Insights series is by Jo Anne Preston, RWHC Organizational Development Manager. Back issues are available at www.RWHC.com.

“Early in life I had to choose between honest arrogance and hypocritical humility. I chose the former and have seen no reason to change.”—Frank Lloyd Wright

“Wisconsin’s famous architect Frank Lloyd Wright had a very different work environment than we do today.”

“Arrogance in our world is a career derailer. Smart, talented and often right (they might believe always right), they have body language that scares some and invites a row with others. Nobody knows much about them personally because they don’t share and they don’t invite others to either. They interrupt, state conclusions, and shut down when disagreed with—behaviors that will stall team work—and ever increasingly, teams are how we get things done.”

“Two challenges to coaching for change:

1. Unlike Frank, the arrogant person may not see themselves as such.

2. The very nature of arrogant behaviors makes people shy away from helping them to see it.”

“Do you need to coach someone who may not even know or care that they are seen this way? Rather than trying to convince someone to accept a label of arrogance—a term that conjures up defensiveness in most people—focus on behavioral skills.”

Start with non-verbal awareness. “We are responsible for the visual cues we send out. Describe what you consistently see (frown, raised eyebrow when others speak, solid stare, pursed lips, lips curled up on one side that one might perceive as a smirk, covering their mouth with a finger when they are not talking, tapping fingers or feet, etc.). Describe what you would like to see instead (lean in, open facial expression, intermittent vs. solid or no eye contact, smile that is genuine and appropriate, etc.). If it is possible, record a meeting and watch the recording together to facilitate the discussion about their individual demeanor.”

Newly hired? Recently promoted? Looking to brush up on some management skills?

RWHC offers a series of leadership development workshops that focus on the critical areas of success for health care leaders. Topics include skills like coaching, conflict resolution, clear communication, leading change and many more.

Check out the full leadership catalog at http://ow.ly/O4sv4. Workshops are offered to attendees at RWHC in Sauk City and can also be custom designed to work with your leadership team in your community. This option has many advantages for your team as they learn together and it also saves you time and travel.

To learn more, contact:
Jo Anne Preston jpreston@rwhc.com
Carrie Ballweg cballweg@rwhc.com, or telephone 608-643-2343.

Who are they comfortable with? “Chances are good that they loosen up with certain people. Perhaps they laugh a little, or share some things they are interested in outside of work. Ask them to describe how they look and act different in those environments and assume those postures when they are with others.”

Teach them to start reading others. “If you can record a meeting, are there people who look like they are verbally or even physically ‘backing up’
from them? They might interact with others in the group but not respond to the arrogant person. Discuss the reactions of others in the group as a learning discussion, not a finger-pointing exercise. Share your observations about who ‘battles’ with them and who looks scared of them. Encourage them to use more of an inquiry approach with people who tend to back off from them (‘I’d be interested in your point of view; what are your ideas?’). Suggest that in meetings they intentionally check in on the group pulse, for example, ‘Can we pause here and just check in? I want to make sure that I am not dominating the discussion and that everyone is getting a chance to weigh in and address the issues most important to all of us.’ ”

Five second rule. “Ask them when in a discussion or debate to allow five seconds after the other person is done speaking before they respond. It will seem like forever, but it is a way to heighten the awareness of their interrupting, ‘conclusion stating’ behavior.”

They ARE smart. “Remind them that people really do value their knowledge, but when they feel dismissed by the arrogant person, they likely will dismiss in return, and no one wins. Smart is not enough when collaboration is the working model.”

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

Upcoming RWHC Leadership Programs

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