Health Trends: Mixed Bag and Rural Lags

From the 2015 Wisconsin Health Trends by the University of Wisconsin Population Health Institute:

Background—“The 2020 Health Plan for Wisconsin established a goal for all state residents to live longer and better. Progress toward this goal can be measured by monitoring health outcomes—and the factors that contribute to those outcomes—for the state’s overall population, as well as by considering the health status of specific populations within the state. This fourth annual report assesses progress for 19 indicators of health outcomes and factors in Wisconsin by examining trends over the past 10 years and determining whether current rates are better or worse than expected.”

Our Approach—“Ten-year baseline trends for 19 leading health indicators were measured and compared to an improvement of one percent per year, the standard developed for the federal Healthy People 2020. To assess recent progress, the most current rate for each indicator was compared to the expected rate had the baseline trend continued. In addition, where data are available, we have analyzed 10 year trends on these leading health indicators broken out by gender, race and ethnicity, geography, and socioeconomic status. These detailed analyses are available online.”

Results—“When considering the overall population of the state, the 2015 report shows that the baseline mortality trends for all age groups in Wisconsin continue to improve, with the exception of the group of 25-64 year olds, for whom the mortality rate has remained stable. The greatest improvement in mortality is among children and young adults (ages 1-24). One health outcome, self-reported health, remains a cause for concern with an increasing percentage of adults reporting their health as fair or poor.”

“Within health behaviors, the rates of smoking, teen births, and excessive drinking continue to show improvement with decreasing trends while obesity rates continue to rise.”

“Although the most recent values for all socioeconomic factors were better than expected, the overall trends continue to worsen for all of these factors, including high school drop-outs, unemployment, children in poverty, and violent crime rate.”

“However, these patterns of improving health do not hold true for all of the subgroups that make up the state’s population, e.g.:”

“With friends near their end of life, neither invade or evade.” – Parker Palmer

RWHC Eye On Health, 3/13/16
The percentage of children in poverty is much higher for those living in urban counties compared with those living in rural, non-urban, and suburban counties.

African American infants are almost twice as likely to be born at a low birthweight compared with infants of other racial/ethnic subgroups.

Smoking rates are more than four times higher for those without a high school degree compared with those with a college degree.

Male death rates are higher than female death rates across all age groups.”

“Readers can find disparity graphs by gender, race/ethnicity, geography, or socioeconomic status at: http://ow.ly/ZdbPs.”

Summary—“Wisconsin continues to make progress toward the 2020 goal of residents living longer. However, not everyone in the state is living healthier. Many trends within the state, including increasing rates of people reporting their overall health to be fair or poor, adult obesity, and worsening social and economic factors, will lead to poorer health outcomes and more disparities if left unaddressed. Moreover, current trends in health outcomes and health factors are markedly different for various subgroups within the state’s population. Efforts to improve health in Wisconsin must consider the full array of factors that influence how long and how well we live and reevaluate the circumstances that may produce longer and healthier lives for some—but not all—of the state’s residents.”

The report is available at http://ow.ly/Zd9u3

Rural Youth More Likely to Abuse Opioids

From “Rural Opioid Abuse: Prevalence and User Characteristics” by Jennifer Lenardson, MHS; John Gale, MS; Erika Ziller, PhD, at the Maine Rural Health Research Center, 2/16:

“Opioid abuse is the fastest growing substance abuse problem in the nation and the primary cause of unintentional drug overdose deaths. In recent years, non-medical use of pain relievers has been higher in urban counties than rural, however, multiple studies document a higher prevalence rate among specific vulnerable rural populations, particularly among youth, women who are pregnant or experiencing partner violence, and persons with co-occurring disorders. Heroin use has also grown significantly in recent years, particularly among those reporting non-medical use of opioid pain relievers prior to initiating heroin.”

“This study examined the rural-urban prevalence of non-medical use of pain relievers and heroin in the past year and the socio-economic characteristics associated with their use as well as treatment history and perceived need for treatment; perceived risk of using drugs; and other risky behavior. Rural opioid users were more likely to have socio-economic vulnerabilities that might put them at risk of adverse outcomes, including limited educational attainment, poor health status, being uninsured, and low-income. Rural heroin users, especially men and those in poor

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Overall, profitability of rural hospitals decreased while the profitability of urban hospitals increased since FY 2012. “The upward trend in profitability of urban hospitals compared to the downward trend of rural hospitals further widened the urban-rural gap in hospital financial performance. Causes of this gap may include declines in patient volume and cuts in reimbursements from Medicaid and Medicare among other factors that impact rural hospitals disproportionately than urban hospitals.”

RRCs and urban hospitals had the highest profitability compared to other hospitals. “RRCs are the largest among rural hospitals and more similar to urban hospitals. RRCs have on average, 140 acute beds, an acute average daily census of 57, and most are located in large urban areas. As such, RRCs can generate higher revenue and may be better able to manage fixed costs.”

R-PPS hospitals with 26-50 beds and MDHs had the lowest profitability compared to other hospitals. “Interestingly, the smallest R-PPS category (<26 beds) was not the most unprofitable: it may be that most hospitals in this group previously converted to a CAH and only the most financially viable hospitals remain. Among rural hospital types, MDHs are the smaller having a range of 25-50 acute beds and an acute care average daily census range of 3-13 patients. Most of these hospitals are located in more rural areas with a higher percentage of elderly.”

“ Compared to urban hospitals, rural hospitals serve older, poorer, and sicker communities where higher percentages of patients are covered through public insurance programs if they are covered at all. Additionally, because of their smaller size and lower patient volumes, rural hospitals are particularly vulnerable to shifts in the economy and demography of their markets as well as to state and federal policy changes. This puts rural hospitals at higher risk of financial distress, closure, or conversion to some other type of health care facility. All of these outcomes may have implications for the communities served by rural hospitals. For all these reasons, it is important for policy makers to monitor the financial performance of rural hospitals.”

The study is available at: http://ow.ly/ZggQr

Medicare Continues Anti-Rural Bias

From “2012-14 Profitability of Urban and Rural Hospitals by Medicare Payment Classification” by Sharita Thomas, MPP; Mark Holmes, PhD; George Pink, PhD, in a Findings Brief from the North Carolina Rural Health Research Program, March, 2016:

“More Americans are now aware of the financial challenges faced by rural hospitals. Media coverage of the 66 rural hospital closures between January 2010 and January 2016 has highlighted the health care access and economic challenges facing rural America. Rural hospital closures are not a new phenomenon–hundreds of rural hospitals closed in the 1980s and 1990s. Recognizing that many rural hospitals are the only health care facility in their community and that their survival is vital to ensure access to health care, federal policymakers created four classifications of rural hospitals that qualify for special payment provisions under Medicare: Critical Access Hospitals (CAHs), Medicare Dependent Hospitals (MDHs), Sole Community Hospitals (SCHs), and Rural Referral Centers (RRCs).”

“This study compares the fiscal years (FY) 2012-2014 profitability of urban hospitals to that of rural hospitals. Rural hospitals are further divided by ‘size’ of rural Prospective Payment System hospitals (R-PPS <26 beds, 26-50 beds, and >50 beds) and by the four rural Medicare payment classifications (CAH, MDH, SCH, and RRC) despite the urban location of some. Two financial ratios, total margin and operating margin, were used to compare the profitability of hospital groups. Below are the three principal findings.”

24th Annual $2,500 Monato Essay Prize

A $2,500 Prize for the Best Rural Health Paper by a University of Wisconsin student or recent graduate. Write on a rural health topic for a class and submit by June 1st. Submission info available at www.RWHC.com

The brief is available at: http://ow.ly/Zh2y4
Doctors and Nurses Are Not Widgets

From “Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider” by Thomas Bodenheimer, MD, and Christine Sinsky, MD, in the Annals of Family Medicine, November/December, 2014:

Introduction—“Since Don Berwick and colleagues introduced the Triple Aim into the health care lexicon, this concept has spread to all corners of the health care system. The Triple Aim is an approach to optimizing health system performance, proposing that health care institutions simultaneously pursue 3 dimensions of performance: improving the health of populations, enhancing the patient experience of care, and reducing the per capita cost of health care. The primary Triple Aim goal is to improve the health of the population, with 2 secondary goals—improving patient experience and reducing costs—contributing to the achievement of the primary goal.”

“In visiting primary care practices around the country, the authors have repeatedly heard statements such as, ‘We have adopted the Triple Aim as our framework, but the stressful work life of our clinicians and staff impacts our ability to achieve the 3 aims.’ These sentiments made us wonder, might there be a fourth aim—improving the work life of health care clinicians and staff—that, like the patient experience and cost reduction aims, must be achieved in order to succeed in improving population health? Should the Triple Aim become the Quadruple Aim?”

Care Team Well-Being As A Prerequisite For The Triple Aim—“Burnout among the health care workforce threatens patient-centeredness and the Triple Aim. Dissatisfied physicians and nurses are associated with lower patient satisfaction. Physician and care team burnout may contribute to overuse of resources and thereby increased costs of care. Unhappy physicians are more likely to leave their practice; the cost of family physician turnover approaches $250,000 per physician. Dissatisfied physicians are more likely to prescribe inappropriate medications which can result in expensive complications.”

“Physician burnout is associated with reduced adherence to treatment plans, resulting in negatively affected clinical outcomes. Burnout also leads to lower levels of empathy, which is associated with worsened clinical outcomes for patients with diabetes. Patient safety is threatened by nurse dissatisfaction; many nurses report that their workload causes them to miss important changes in their patients’ condition. Dissatisfied physicians are 2 to 3 times more likely to leave practice, thereby exacerbating the growing shortage of primary care physicians and complicating the achievement of a healthy population.”

“Practices working toward the Triple Aim may increase physician burnout and thereby reduce their chances of success. Higher scores on a patient-centered medical home assessment may be associated with greater clinician burnout in safety-net clinics. More EHR functionalities—email with patients, physician order entry, alerts and reminders—intended to promote the Triple Aim are associated with more burnout and intent to leave practice.”

Addressing The Fourth Aim—“How can health care organizations work toward the fourth aim, improving the work life of clinicians and staff? For primary care physicians the following list suggests some practical steps:

- Implement team documentation: nurses, medical assistants, or other staff, present during the patient visit, entering some or all documentation into the EHR, assisting with order entry, prescription pro-
cessing, and charge capture. Team documentation has been associated with greater physician and staff satisfaction, improved revenues, and the capacity of the team to manage a larger panel of patients while going home earlier.

- Use pre-visit planning and pre-appointment laboratory testing to reduce time wasted on the review and follow-up of laboratory results.
- Expand roles allowing nurses and medical assistants to assume responsibility for preventive care and chronic care health coaching under physician-written standing orders.
- Standardize and synchronize workflows for prescription refills, an approach which can save physicians 5 hours per week while providing better care.
- Co-locate teams so that physicians work in the same space as their team members; this has been shown to increase efficiency and save 30 minutes of physician time per day.
- To avoid shifting burnout from physicians to practice staff, ensure that staff who assume new responsibilities are well-trained and understand that they are contributing to the health of their patients and that unnecessary work is reengineered out of the practice.”

“The negative impact on patient-centered care will be deep and long lasting. On the other hand, if an emphasis on the workforce comes at the expense of patients’ needs, this focus could have negative consequences.”

“Health care is a relationship between those who provide care and those who seek care, a relationship that can only thrive if it is symbiotic, benefiting both parties.”

Conclusion—“The Triple Aim has provided society with a compass, pointing the way forward for our health care system. The positive engagement, rather than the negative frustration, of the health care workforce is of paramount importance in achieving the primary goal of the Triple Aim—improving population health. Leaders and providers of health care should consider adding a fourth dimension—improving the work life of those who deliver care—to the compass points of better care, better health, and lower costs.”

The article is available at: http://ow.ly/ZgojA

APNP Hospitalists Help Rural Hospital

From “How an Advanced Nurse Practitioner Hospitalist Program Helped One Hospital” in a seven minute video in the H&HN Daily, 3/7/16:

“After the loss of several primary care providers, Rusk County Memorial Hospital, Ladysmith, Wis., found that call burden and lack of a hospitalist program are barriers to physician recruitment. By implementing an advanced nurse practitioner hospitalist program, this rural hospital was able to recruit more physicians, improve patient satisfaction scores, generate more revenue with outpatient testing, treat patients at a higher acuity level and earn a quality award. ‘We did not want to lose people in our community because they could not be served in the inpatient setting and we were able to do that because the nurse hospitalists were present,’ says Charisse Oland, CEO.”

The video is available at: http://ow.ly/ZgEtF
Physician Engagement Doesn’t Just Happen

From “Physician Engagement, a Primer for Healthcare Leaders” by Clint MacKinney, MD, MS, on the Rural Health Value Team at http://ow.ly/ZgKWx:

“The physician’s professional role often demands specialized knowledge and fast-paced decision making; physicians are trained and socialized to be autonomous, independent, and in control. These physician characteristics are indispensable in certain high-risk and/or time-sensitive clinical circumstances. Yet, traditional medical care and volume-based payments (e.g., fee-for-service) have been associated with suboptimal clinical quality, patient-insensitive care, and inefficient care delivery processes.”

“Now, old practices are being displaced by new demands for systems of care, economies of scale, and value-based payment. In response, new health care delivery strategies are expanding, including coordinated care, team-based care, shared decision making, continuous quality and safety improvement, data analysis, Lean and Six Sigma efficiencies, chronic disease management, and a community health focus.”

“These new strategies will require new physician skills. Nonetheless, active physician participation and creative physician leadership will remain imperative for effective healthcare model design, implementation, and operation; that is, physicians must be engaged. Physician engagement is proactive physician involvement and meaningful physician influence that move a healthcare organization toward a shared vision and a successful future.”

“Physician engagement is becoming increasingly important to healthcare organizations for two fundamental reasons. First, as society increasingly demands greater healthcare value (quality, service, and efficiency), physicians will be tasked to bring their clinical knowledge and experience to healthcare delivery that is transitioning from single-patient, visit-focused care to comprehensive and longitudinal care (e.g., care provided in clinically integrated networks). Healthcare systems that proactively engage physicians in the transition to new healthcare payment and delivery models will be most capable of delivering value-laden care, and getting paid for that care. Second, healthcare payment appears to be increasingly linked to primary care physicians. For example, the Medicare Shared Savings Program assigns beneficiaries to an accountable care organization through primary care services. Clinical quality, the performance on which Medicare shared savings is dependent, includes exclusively outpatient measures delivered by primary care physicians and their clinical teams. Since cost-control is fundamental to many new payment models, including shared savings programs, primary care management of referrals may relegate specialists and hospitals to vendor roles, each vying for patients based on the highest quality and lowest cost venue. Furthermore, the performance, brand, and positioning of the physician enterprise will likely rival or eclipse the reputation of the sponsoring hospital.’”

“But how do healthcare leaders engage autonomous, independent, and in-control professionals in common goals and a shared vision of success?”

See the full article at: http://ow.ly/ZgxMH

About Rural Health Value: Rural Health System Analysis and Technical Assistance is a cooperative agreement between the Office of Rural Health Policy, the RUPRI Center for Rural Health Policy Analysis (RUPRI Center), and Stratis Health. The Rural Health Value Team will analyze rural implications of changes in the organization, finance, and delivery of health care services and will assist rural communities and providers transition to a high performance rural health system.

Wisconsin Rural Health Conference
June 29th-July 1st at the Osthoff Resort, Elkhart Lake
Leadership Insights: “Your Team Productive?”

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

“The New York Times (2/25/16) noted Google’s three-year research into the answer to what makes a highly productive team was followed by reader comments that were interesting, disturbing, sometimes obnoxious, affirming—quite a mix! Whatever one’s thoughts on all the emphasis on teamwork or Google’s efforts, what makes a team productive is confirmed in additional research on ‘collective intelligence’ (see http://ow.ly/Zer4t) it boils down to two things:

1. Everyone has a chance to have their say and be heard (a skill known as conversational turn-taking)
2. It is psychologically safe (the skill of empathy, having the sensitivity to read others)”

“Making even small improvements in these two communication strengths is worth considering.”

Conversational turn-taking—“Do you talk too much? Leaders often get ‘the floor’ more just because of their role, and it becomes easy to tilt this way. Set a task for yourself to ask what others think at specified intervals and use a timer if you need help to remind you. Try:

- I have shared my thoughts; what do others think?
- Poke some holes in my plan and tell me how you see it differently.
- I am curious if there might be something I am missing in my conclusions, I’d like everyone to throw out some alternate stances for us all to consider.”

“Once others are invited to give input, listen with interest. Not sure if you talk too much? Ask someone you trust, ‘Roughly what percentage of the speaking time am I using in this meeting?’ Or, ‘In this meeting, I’d like you to just track (make a tick mark) how many times I start talking when someone else is still talking.’ Feedback is your friend. Thank that person.”

“Do you allow someone else to talk too much? No matter who it is, a dominator shuts others down and your team productivity suffers. Address the behavior, for the good of the team and for that individual’s own success. Feedback is their friend too.”

Making it safe—“Strive to be good at reading others. How sensitive are you to what others say without saying a word? A very interesting and kind of fun way to explore this is to take the “Reading the Eyes in the Mind” test at http://ow.ly/Zd38G. Once you see where you score, make it a point to improve by paying more attention to cues and the way faces leak information. Don’t jump to conclusions, but instead:

1. Observe. Look up, consider facial expressions and contemplate if they match tone of voice.
2. Make a guess, then ask about what you notice. For example, ‘Your facial expression makes me wonder if you might be puzzled; is that right? Can you tell me more about that?’ ”

“Decide that safety matters. You have to believe it matters before you can work on it. It may be easy to dismiss psychological safety as ‘their problem, not mine.’ If the cost of speaking up is too high though, it becomes your problem. People will hold back on ideas, safety concerns and creativity for fear of being wrong or ridiculed. Start with the desire to create a culture where people can speak up, disagree without losing status, learn from mistakes, and laugh a little. Leaders, you go first.”
Next Time You Are Asked “Who is Rural?”

From “Wisconsin Divided Six Ways: A Review of Rural-Urban Classification Systems” by Penny Black for the Rural Health Data CANVAS, a program of the Wisconsin Office of Rural Health at the University of Wisconsin Madison, 2/16:

“The definition of rural used for policy and program decisions affects Wisconsin residents in very real and tangible ways. In addition to determining how much land and population are classified as rural, definitions affect how the demographic and economic makeup of Wisconsin communities are understood and handled in the context of policy and programmatic decision-making. In this report, rural Wisconsin is defined using six commonly used classification systems—maps, methodology descriptions, and demographic data illustrate the differences and similarities between systems and the implications for Wisconsin residents. Distinctions are made between metropolitan, micropolitan, and rural classes to illustrate that rural is more than just, ‘not metro.’ ”

The Wisconsin Office of Rural Health’s Data CANVAS compiles, analyzes, and visualizes rural health data for actionable insight. Visit CANVAS online at www.ruralhealthdata.org.

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