Excerpts from an interview with Donald Berwick, the former head of the Centers for Medicare & Medicaid Services, by Tinker Ready for HealthLeaders Media, 1/7/16 and 1/14/16:

HLM: “What are the most pressing quality issues facing hospitals today? Berwick: The cost of healthcare in America remains out of control and continues to erode other important agendas in public and private policy and action. I see, by far, the biggest opportunity for proper cost reduction to be through the continued improvement of care.”

“I deeply believe that better care is lower-cost care. I see that hospital leaders continue to have difficulty in making that link and centering improvement in the strategic agenda of the hospitals. They are still driven by revenue maximization, market share, and more traditional approaches to management of the top line instead of the actual quality of care.”

“The quality of hospital care is important in its own right. But there is also this immense opportunity to use the improvement of care to get costs to a reasonable level.”

“It’s important to recognize that we have not yet sufficiently changed the payment system to align with what needs to be done. So, hospitals remain in a difficult position with a payment system that encourages revenue maximization as a strategy.”

“If you look at what is happening in hospitals, we have tremendous areas of overuse of procedures, technology, and tests that cannot help people. They are being done for historic reasons.”

“We have a tremendous amount of paperwork and non-value added activity that staff are forced to engage in and that the patient pays the price for. We have continuing problems with coordination and continuing problems with safety.”

“If we were able to address each of those, focusing on overuse of ineffective care, focusing on administrative burdens, focusing on safety and reliability of care and really getting authentically focused on the needs of patients, costs would fall and not rise.”

HLM: “How do you see hospitals responding to the push for patient-centered care? Berwick: I think there is a new, more modern level of authenticity about that focus on [patient] needs that hospitals have found difficult to adopt, in which you really do regard the patient and family not as your guests, but as your hosts.”

“I’ve often said we need to act not like we are hosts in our organizations, but like we are guests in people’s lives. That’s a shift of power. We are asking the people...”
we serve more and more about how we are really doing, what they really need, what they want and what they don’t want and tuning in more to their real needs and desires instead of our habits.”

HLM: “You’ve also called for a more ‘moral’ approach to the delivery of care. Could you explain what that would entail? Berwick: If you think about the pursuit of health as the ultimate goal of the investment we are making, in our case about 18% of our gross domestic product, it would lead you to ask what creates health and what disturbs it.”

“The answers are pretty clear that among the great disrupters of health are injustice, inequity, racism, and a failure to regard healthcare as human right. These, to me, are moral issues. The commitment to a fair and just society, one in which equality is embraced, in which responsibility for each other is part of the fabric.”

“To me it sounds right. It matches my ethical frame. It also sounds smart because what you are interested in is people who can live lives at the highest level of function and be productive in society and enjoy their lives.”

“The relationships between poverty, injustice, racism and inequity on one hand, and health status, function, and longevity on the other hand, are very well described. I think health professionals need to be advocates for social justice. Hospitals need to inspect their processes of care to see that they are sensitive to issues of social determinants of health and social supports that people need in order to stay out of the hospital. That needs to be woven into the fabric of hospital care.”

“The wonderful work Rebecca Onie is doing at Health Leads is an example of equipping healthcare providers, in this case medical students, to reach out to patients and understand the full spectrum of their needs and not stop at the boundaries of job descriptions or the walls of the institution.”

“That’s why integrated health systems, in the end, will have a better shot at success than hospitals. This does demand that hospitals reach outside their walls to give people the support they need.”

HLM: “The IHI Leadership Alliance is made up of 40 organizations working to pursue the triple aim: better care, better health and lower costs. You’ve said another area they will target is ‘joy in work.’ Can you describe that effort? Berwick: You’ll see in the work of the IHI an increasing focus on joy and pride in work as an essential goal. I would say any sensible hospital leader has to realize that it is on the critical path to success.”

“There is growing evidence of problems of morale and burnout in the workforce, [among] doctors, nurses, administrators, and even executives. It is a signal of a problem that is very toxic to quality. In any service industry, let alone one that is dependent on compassion, the customer, the person you are helping, isn’t going to experience excellence in the hand of a demoralized staff.”

“Understanding what generates pride and joy is crucial. Understanding what generates pride and joy is not easy and the theory and approach are still very much under development, especially in an era of austerity. But it is possible.”

“We will be making a big mistake if we continue on a trajectory of healthcare which continues to erode the energy and self-confidence and joy—that’s the right word—of the people who are doing the work of caring.”
Wisconsin Rural Health Leaders on the Hill

How many rural Wisconsin health care leaders can you fit in an elevator in the Longworth House Office Building? On February 3, a group of Wisconsin rural health care interests stormed Capitol Hill to meet with nine member offices in our Congressional Delegation. Our hardy group of fourteen was making these Hill visits in conjunction with the Nation Rural Health Association’s (NRHA’s) 27th annual Rural Health Policy Institute.

Our group’s size displayed the importance of our visit and the timing couldn’t have been better, missing Snowmageddon from the week before and having unseasonably good weather for our visits. We signaled our concerns on years of cuts on rural hospitals and how NRHA’s Save Rural Hospitals Act (H.R. 3225) can restore many of these cuts; four of Wisconsin’s House members have already signed on as sponsors. Additionally, the Save Rural Hospitals Act includes a couple of major regulatory fixes to issues that have long complicated rural health care.

Some of regulatory fixes seemed to be replaying the greatest hits on arbitrary CMS regulations, such as: the 96-hour admission hard cap for CAHs as a condition of payment and the push by CMS to increase the need for direct supervision by a physician for more outpatient services. Our rural hospital leaders rhetorically asked how many sessions we might have to continue to request these fixes, as both of these regulations do nothing to improve the level of care nor reduce the cost for the Medicare beneficiary.

Our meetings were also able to focus on workforce and the educational programs and investments that Wisconsin helps support. For a second year in a row, and hopefully to become the norm, our group was joined by a Wisconsin Academy of Rural Medicine (WARM) student, Zach Meyer from Reedsburg, whose experience in the educational pipeline, starting in the Area Health Education Center (AHEC) programs, led him to WARM and started him on his path.

At the NRHA’s Policy Institute, we were engaged by both Congressional leaders and members of the administration from the CMS and HRSA, and we learned about the establishment of a CMS Rural Health Council to work across the entire agency to oversee our work in three strategic priority areas. They will be: 1) improving access to care to all Americans in rural settings; 2) supporting the unique economics of providing health care in rural America; and 3) making sure the health care innovation agenda appropriately fits rural health care markets.

This announcement inspired one of our leaders to ask our Congressional Delegation to send a letter to CMS to use this new Council to review and explore the relatively new phenomenon of regional CMS offices reportedly revoking the provider-based status of hospital provider-based clinic operations because of hospital leasing arrangements with visiting specialists. Our rural Wisconsin health care leaders believe this shared space/mixed-use issue would be a prime issue for this Council’s review as it relates to both the access and the economics of providing health care to all Americans in rural settings.

Help Grow Next Generation of Rural Health Leaders

The National Rural Health Association Foundations needs your contribution to help develop the next generation of rural health leadership.

Go to www.ruralhealthweb.org/go/top/donate to learn more.
Nursing as an Alternative to Farming

From “Cooperative offers opportunities for men” in Agri-View, 1/14/16:

“A nursing workforce that is diverse and reflective of the population benefits the population it serves. In Wisconsin, the nursing population is only 6.9 percent male, which definitely does not represent the population served. It’s lower than the national figure of men in nursing, which is 9.6 percent.”

“Nurses play an important role in the health of communities and sufficient numbers of men contribute to this nursing resource. The need to encourage growth in a diverse nursing workforce is imperative, and key strategies are not only to encourage men to enter the profession, but to also support them in nursing practice.”

“A Robert Wood Johnson Foundation State Implementation Program grant was awarded to the Wisconsin Center for Nursing, Wisconsin Nursing LEADS the Partnerships in Action for Community Care. As a result, the Diversity Learning Collaborative teamed with Wisconsin Action Coalition co-lead, the Rural Wisconsin Health Cooperative, to create a new offering to support men in rural nursing practice. Following the well-established structure of the Rural Wisconsin Health Cooperative roundtables, which brings together affinity groups – obstetric nurses, pharmacists, emergency room nurses, lab, etc. – for learning and networking, the “Men in Nursing Roundtable” is building its own agenda. The program will work to advance the directive of the Institute of Medicine Report to increase gender diversity in the nursing workforce.”

“The new group will come together to plan strategies to address ways to meet the report’s recommendation, as well as to support members in their work as rural nurses who are male. The support will be in alignment with the framework provided by American Assembly of Men in Nursing chapters, to discuss specific factors that impact males in the profession. At the end of the first year of scheduled meetings, it will be determined if the group would like to continue as an ongoing roundtable and dovetail as an official American Assembly of Men in Nursing Wisconsin chapter, with a focus unique to men in rural nursing.”

“Results of the work of the group will be shared statewide through other Rural Wisconsin Health Cooperative clinical and administrative roundtables, and through members of the Wisconsin Action Coalition. The lead agency providing administrative support and infrastructure is the Rural Wisconsin Health Cooperative. This will include meeting space and logistics, email listserve, and confidential portal for document sharing. Co-facilitation will be provided by Robb Pastor, RN, CNO, FACHE, of Southwest Health Center in Platteville, Wisconsin, along with Jo Anne Preston, Rural Wisconsin Health Cooperative Workforce and Organizational Development senior manager. Preston also acts as the liaison to the Wisconsin Center for Nursing Partnerships in Action for Community Care grant initiative through the Diversity Learning Collaborative.”

“Meetings for the Men in Nursing Roundtable will be held at the Rural Wisconsin Health Cooperative on a quarterly basis from 2:00 to 3:30 p.m. on the fourth Friday of the month. Roundtable membership fees are waived for any nursing students wishing to join the group.”

“Meeting dates scheduled for 2016 are Jan. 22, April 22, July 22 and Oct. 28. Expected outcomes are to encourage participating nurses to grow professionally and to demonstrate the contributions being made by men in the nursing profession. Educational opportunities will be explored and offered as part of the group agenda. Potential projects could include outreach to
elementary through high school students to encourage young men to consider nursing careers.”

“Another related outcome will be to create a dialogue with elementary through high school counselors and key community stakeholders who will be encouraged to support men in nursing career choices, to help connect the dots between what men offer and opportunities to exhibit those talents in a nursing career. This is reflective of the true intent behind this effort, as not just a numbers game, but rather a focus on competencies and interests, versus exclusively gender. Additionally, the increasing awareness of the need for diversity, including men in nursing, is hoped to impact gender inclusion and balance in Wisconsin nursing-education programs. All nurses interested in these efforts are invited to participate in the roundtable. Contact Preston at jpreston@rwhc.com for more information.” Participation is in person or virtually through two-way voice and video.

“The Men in Nursing Roundtable represents a creative approach to provide a unique support network for men in the nursing profession. The Wisconsin Partnerships in Action for Community Care grant is also working throughout the state to increase the number of formal American Assembly of Men in Nursing chapters. Barbara Nichols is the diversity coordinator at the Wisconsin Center for Nursing and can be reached at nichols@wicenterfornursing.org for more information on creating a chapter and other diversity efforts.”

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**Virtual Visits & Monitoring: the New Normal**

From “3 Ways Telemedicine is Changing Healthcare” by Lena Weiner, for *HealthLeaders Media*, 1/21/16:

“From increasing access to influencing better patient outcomes, health systems are recognizing the benefits of virtual patient visits and remote monitoring—and finding ways to mitigate the costs. Once the realm of science fiction, telemedicine has become a reality of care—and an option for patients that might once have been difficult to reach, including rural patients, professionals with busy schedules, and patients unable or uncomfortable seeking care in person. But telemedicine is changing, and providers must be ready to exploit its possibilities.”

**Virtual Visit Volumes are on the Rise**—“Gone are the days when telemedicine was a rarity; appointments are going mainstream. ‘I can’t imagine seeing a primary care provider in the office for a sinus infection anymore,’ says Deborah Dahl, vice president of care innovation at Banner Health in Phoenix, AZ. She says many traditionally brick-and-mortar services, such as visits for routine acute care, follow up care, e-pharmacy, and counseling are poised to move online.”

“While Dahl’s sentiments may not yet be typical (telemedicine appointments are generally not reimbursed by the Centers for Medicare & Medicaid Services or most other payers), providers are paving the way for virtual visits to become the norm.”

“‘I think more urgent and follow-up care will shift to the virtual space in the near future,’ says Peter Rasmussen, MD, medical director of distance health at the Cleveland Clinic.”

“He foresees regular online patient visits with a care coordinator or nurse for health maintenance, and visits to a clinic or doctor’s office only for hands-on visits such as eye examinations, throat cultures, and comprehensive physical exam every year or two.”

“‘We are laying the groundwork for a full virtual healthcare system,’ he says. While Cleveland Clinic’s distance health program initially focused on uses such as providing care to rural areas, the ease of access for urbanites and busy professionals has become apparent, says Rasmussen.”

**Better Patient Monitoring Enables Faster Interventions**—“Being able to reach patients in their home environments has distinct advantages, Dahl says, such as enabling providers to intervene early and influence better outcomes.”

“Many patients with multiple chronic conditions take numerous medications that have not been checked for interaction, or even for necessity. To verify the necessity and safety of all medications, pharmacists at Banner Health interact remotely with patients via a camera on
a tablet or mobile phone and have them go through the medications they take regularly, says Dahl.”

“After discussing regular medications, they often ask the patient to go into their bathroom and go through their medicine cabinet with them.”

“They always have expired medications in their medicine cabinets,’ says Dahl. Not only is this an opportunity for the pharmacist to ask them to dispose of old medications, but this experience gives the pharmacist an idea what the patient may be taking on a supplementary basis.”

“A virtual house call is also an opportunity to look at the patient’s home environment and intervene before a situation becomes dangerous. Among the conditions visible are fall hazards, squalor, and elder abuse scenarios. ‘The kinds of things you see unintentionally are amazing,’ she says.”

“Another sort of remote technology enabling clinicians to monitor for potential danger is the kind that Suzanne Hinderliter, RN, vice president of telemedicine services at OSF Healthcare, in Peoria, IL, says that her organization has adopted.”

“OSF uses a telemonitoring application ‘that gathers data from EMRs and bedside monitoring systems.’ It allows clinicians to see subtle changes to the patient’s condition that otherwise might go unnoticed. Hinderliter says OSF has seen a 26% decrease in mortality and a 20% decrease in length of stay system-wide since they began using telemonitoring technology.”

**Partnerships Can Mitigate Costs**—“Going it alone is going out of fashion. Dignity Health has historically been hesitant to form partnerships in telemedicine, preferring to remain independent. But that’s a notion that is ‘evolving,’ says Shez Partovi, MD, chief medical information officer at Dignity Health.”

“We’re at a point where we’re looking at potentially partnering with other organizations,’ he says. During the program’s growth phase, Partovi and his colleagues wanted to have more control over the services offered and costs associated with the program. But now, they’re at a point in their growth where a partnership might be the next step to further growth.”

“Dignity Health is not alone. Its sentiments are echoed throughout the provider community—with so many different moving parts, it is becoming difficult, if not impossible, to go it alone in telemedicine.”

“[Partnering] is almost mandatory,’ says Cleveland Clinic’s Rasmussen, whose organization partners with American Well for technology infrastructure and supplemental clinician staffing. ‘The cost,’ he says, is ‘not an insignificant sum… [but] I don’t think we could do the same [in-house] for less.’”

“The greatest advantage of partnering she sees has been that the infrastructure has already been built, which decreases cost. ‘If we had to build completely in-house, it would have been a lot more.’ Even when paying clinicians the same hourly wage as an in-house employee, supplemental staffing through a partner is less expensive.”

**Rural Pharmacists Critical to Rural Health**

From the “Lemberger Report” recently completed by the University of Wisconsin School of Pharmacy:

“The Lemberger Report was initiated to provide information and insights related to pharmacy and public health in Wisconsin. With this second report in 2015, they build on findings from the first report in 2011 to contribute to the well-being of the State in keeping with the Wisconsin Idea. A key aspect of their approach has been to undertake systematic collection and
analysis of existing health services data with an eye toward ambulatory care pharmacy.”

“The disparity in pharmacy and pharmacist distribution in Wisconsin suggests that more consideration of barriers and incentives affecting the education, recruitment, location, and retention of pharmacists in underserved areas is needed. How to stimulate supply and coverage of pharmacy/pharmacist resources to those areas is an important health professional workforce consideration.”

“It is not enough to train sufficient numbers of practicing pharmacists. The larger challenge may be attracting them to practice in some counties with the highest needs for their services. This is particularly true for the parts of Wisconsin already designated as Health Professional Shortage Areas (HPSAs) for primary care physicians.”

The Report is available at: http://ow.ly/YnxFs

Leadership Insights: “Crickets”

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

“Not the bugs, but that dearth of sound you dread hearing when you have a staff meeting and ask people for input or ideas. It is one of the reasons some leaders stop asking, because being met with silence can be uncomfortable and discouraging. You want people to be as engaged as you are in what is happening, and when they don’t speak up it can look like they are not. Don’t give up. Some simple facilitation techniques can help draw people out.”

First, clarify your question. “All skilled facilitation starts here. What do you really want to know? Consider the difference between the following two examples.”

| Version 1: “Are you getting through your performance reviews with staff?” A simple head nod or shake will do (or neither if someone wants to stay under the radar). Asking it this way also may imply that it is okay if the answer is no. Assuming you are asking because you have a concern, consider: |
| Version 2: ‘What kinds of barriers are you running into in completing performance reviews with your staff by the due date?’ Asking about barriers shows your willingness to help remove those barriers and make your priorities clear. Thoughtful open-ended questions are an opportunity to reinforce your expectations as well as avoid yes/no responses.’ |

Partner discussions. “This is my go-to standard practice. In a large group, people may think, ‘Someone else will answer. I don’t need to stick my neck out.’ When asked to talk with a partner though, there is no escaping participation. Sometimes you’ll want to mix it up so that people are talking with someone other than who they sit by. Simply count off, draw a number out of a bag or put letters to match up at each seat prior to starting. For example, if you are concerned that your question, such as the one above about barriers to performance reviews might be met with crickets, ask people to discuss with a partner for a few minutes, then regroup and ask for what kinds of issues came up in their partner discussions.”

Wait. “If you ask, it helps to give people a minute to think. Take a drink of water, write down a note, and take a couple of breaths. Someone will talk.”

Flip chart work. “In mixed groups again, ask people to go to flip charts on the wall and brainstorm their ideas/answers to your question or problem you are trying to solve. If you are trying to get different people to speak up than the usual, assign creatively, such as, ‘The spokesperson in each group will be the person who lives farthest away from work.’”

Post-it notes. “Give everyone a stack of Post-it notes and a Sharpie. Pose your clear question or problem. Ask them to write—one idea per Post-it—an idea or so-
olution. After a few minutes, ask them to post all the ideas on the wall randomly, then have small groups **silently** cluster together the notes into similar themes. Once everyone has had a chance to participate silently, open it up for discussion about what the themes reveal. This is a simple affinity process that allows people to see a problem and its solutions differently and it can reveal emerging consensus.”

**Don’t talk; write.** “Not everyone gets out of first gear by talking. Pose your question/issue and ask people to take a few minutes to write down their thoughts about it. They won’t have to show it to anyone, but the time spent thinking and writing gives them a way to start the discussion.”

**Paper pass.** “Each person writes at the top of their page a clear question about a challenge or problem they have that needs some ideas. Every one passes their sheet to the right, quickly reads it, and then writes down any idea that comes to mind for about a minute. Then pass again to the right, and repeat a few times.

Fresh eyes, and sometimes even crazy ideas, can spark discussion and new solutions.”

**Go arounds.** “Follow up a question with, ‘Let’s go around the table and everyone share one reaction, idea, your current status,’ etc. People do have a right to pass, but frequent passing is an individual coaching opportunity for you with that employee.”

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.

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