A Non-Nurse on the Future of Nursing

Tim Size, RWHC Executive Director

“At 3.6 million strong, nurses are by far the largest sector of the health profession and also the profession the public most trusts year after year,” (The Future of Nursing: Campaign for Action.) In 2010, The National Academy of Medicine (NAM), then known as the Institute of Medicine, approved a groundbreaking report on the “Future of Nursing.” The central point was and is that we need nurses to have a leadership role in meeting the demands of our changing health-care system. NAM offered up an action-oriented blueprint, calling on nurses to serve a greater role in America’s increasingly complex health-care system in four key ways:

- Practice “to the full extent of their education and training.”

- Achieve “higher levels of education and training through an improved education system.”

- Be “full partners, with physicians and other health-care professionals, in redesigning health care.”

- Assure “better data collection infrastructure for effective workforce planning and policy.”

Where are we and where do we need to be?

Data and Workforce Planning–For our state of Wisconsin, this is a good news, bad news story. The Good: amongst all the health-care professions in Wisconsin, nursing has good workforce data collection and forecasting through a partnership of the Wisconsin Center of Nursing and the Wisconsin Department of Workforce Development. Also, we have seen that the RN workforce can grow—in WI by 10,000 from 2010 to 2016. The Bad: the most recent forecast shows Wisconsin will be nearly 17,000 Registered Nurses short by 2030, just as the “baby boomer” generation fully enters the retirement years and presents with a greater need for health care.

We also need nursing’s leadership to help us all focus on the forecast for family caregivers, 44 million nationwide, who offer critical support to nursing and other health-care professionals. According to AARP, “in 2010, the family caregiver support ratio was more than 7 potential caregivers for every person in the high-risk years of 80-plus. In 2030, the ratio is projected to decline sharply to 4 to 1. Rising demand and shrinking families to provide long term services and supports (LTSS) and support call for new solutions to the financing and delivery of LTSS.” Nursing can lead by expanding its focus on this rapidly diminishing resource.

Redesigning Health Care–As noted in the “Future of Nursing,” “efforts to cultivate and promote leaders within the nursing profession—from the front lines of care to the boardroom—will prepare nurses with the skills needed to help improve health care and advance their profession. As leaders, nurses must act as...
full partners in redesign efforts, be accountable for their own contributions to delivering high-quality care, and work collaboratively with leaders from other health professions.”

The Future of Nursing: Campaign for Action is sponsored by the Robert Wood Johnson Foundation, the country’s largest philanthropy devoted to health and AARP, the nation’s largest nonprofit, nonpartisan organization dedicated to empowering Americans 50 and older. As of July 2017, the campaign reports over 3,200 nurses serving on corporate boards. This represents a significant improvement but the holistic perspective a nurse leader brings is still underutilized by health-care and related sectors.

In these roles, nursing can significantly strengthen statewide and local efforts to address the determinants of health, including how and where we live, work and play. In Wisconsin, a significant new opportunity will soon be available through the Healthy Community Designation initiative sponsored by the University of Wisconsin Population Health Initiative <https://uwphi.pophealth.wisc.edu>. While I may be speaking from my own self-interest, all aspects of the impact of Wisconsin’s baby boomer demographic shift needs to be considered in the preparation and deployment of our nursing students; the unique health-care needs of our elders are no longer on the edge of the population served but at its core.

**Improved Education System**—In a soon to be released set of recommendations from Competitive Wisconsin <http://www.competitewi.com>, nursing needs to be part of a multi-sector collaborative effort to “define challenges and proposing outcome and cost-effective systemic proposals on how best to address Wisconsin’s short and long-term physician and nurse shortages.” Current efforts to expand enrollment and shorten the time in school without sacrificing quality must continue to be pursued. If schools of nursing and providers further partnered to improve nurse engagement and retention rates, we would reduce the need for additional graduates and the forecast nursing shortages. Developing a diverse workforce, in every sense of the word (including rural and inner city), must continue to be a priority.

The high average age of nursing faculty is a significant threat to meeting our long-term nursing shortage. Schools when hiring faculty should have additional flexibility to substitute experience for a terminal degree. We need new models to support community-based clinical instructors as downward cost pressure on providers means fewer potential student placements without remuneration.

We must retain two-year degree programs as a door into the profession. Many or most health-care facilities encourage, if not require, that the nurses they employ hold or complete a BSN. While the importance of nursing’s shift to focus on BS prepared practitioners is widely recognized, associate degree nurses are held in high respect and will continue to be needed, particularly in our rural communities.

**Practice Environment**—According to the American Association of Nurse Practitioners, the practice environment in 22 states is “full,” “reduced” in 16 states (including Wisconsin) and “restricted” in the remaining 12. Full is defined as “state practice and licensure law provides for all nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications.”

Substantial progress is needed for nurse practitioners in Wisconsin and many other states to practice “to the full extent of their education and training.” A truly collaborative team recognizes and respects the full contributions of what each member can do for the patient that expands on what anyone can do alone. We have
entered an era when the shortage of health-care professionals across the country is creating institutional and market forces in support of truly collaborative practice. **We accelerate the development of true team-based care when we spend more time talking and learning across our own disciplines’ boundaries.**

As noted by NAM, “The United States has the opportunity to transform its health-care system, and nurses can and should play a fundamental role in this transformation. Working together, with many diverse parties, nursing can help ensure that the health-care system provides seamless, affordable, quality care that is accessible to all and leads to improved health outcomes.”

“Epidemic of Despair in the Rural Heartland?”

*From “Is There an Epidemic of Despair in the Rural Heartland? New research shows rising premature death rates in rural less-educated whites.” by Rob Whitley in Psychology Today, 10/26:*

“Not all is well in the rural heartland. This is the underlying message of numerous research reports published this year, from respected institutions including the Centers for Disease Control and Prevention and the Brookings Institution. These reports indicate a sharp increase in premature death rates in rural areas from 1999 to 2015.”

“Recognizing the importance of this topic, the October 2017 issue of the *American Journal of Public Health* (AJPH) has a special focus on rural health. The issue contains sophisticated research papers and accompanying editorials documenting which rural Americans are most affected by the increase in premature death, as well as speculation on underlying causes. All these papers point to one clear conclusion.”

“Rural whites with a high-school education or less have seen the highest increase in premature death rates in the last 15 years. This stands in contrast to falling premature death rates in urban whites, as well as falling premature death rates in minorities (though blacks still have the highest premature death rates overall).”

“These findings are fleshed out in detail in the flagship paper from the AJPH special issue by Dr. Elizabeth Stein and colleagues at the University of Wisconsin, ominously subtitled ‘The Epidemic of Despair Among White Americans.’”

“So what is happening? Evidence from these research papers suggests that an increase in self-destructive behaviors is the largest contributor to the rise in death rates in rural whites. These include a significant increase in suicide (especially in rural men) from 1999 to the present. They also include an increase in drug abuse and overdoses, especially common where there is a local opioid crisis. Furthermore, liver disease and cirrhosis (often due to long-term alcohol abuse) account for a large proportion of these excess deaths.”

“Why this self-destruction? These statistics raise the question of why are so many less-educated white rural Americans engaging in self-destructive and risky behaviors that lead to premature death. Numerous explanations have been advanced.”

“Firstly, rural America has undergone a radical economic transition in the last 30 years. Family farms have decreased in number, and manufacturing jobs have been outsourced in a global economy. Indeed, rural areas were hit particularly hard by the 2008 recession, with a precipitous decline in manufacturing and manual labor. This led to high rates of unemployment and poverty among manual, rural and blue-collar workers, with the attendant hopelessness and despair.”

“Second, some research suggests rural residents are underserved vis-a-vis health and social services.
There are fewer community and voluntary clinics, given sparse population density. This can mean costly travel to specialist (e.g., addictions) services. Likewise, the informal safety net provided by charitable organizations, such as homeless missions or free clinics, may be smaller in rural areas as they tend to congregate in urban centers.”

“Third, rural less-educated whites remain a stigmatized population, written off by some more highly educated people as irredeemable ‘rednecks,’ ‘hillbillies,’ or ‘white trash.’ This rhetoric became particularly intense after the election of Donald Trump. These attitudes may contribute to a lack of empathy among decision-making elites, possibly contributing to patchy health and charitable service provision. Such stigma may also be internalized by rural, less educated whites, perhaps contributing to self-stigma, a known predictor of self-destructive behaviors.”

“I witnessed all of the above first-hand during a recently completed ethnographic study of people living in poverty in northern New England. Study participants often reported a sudden job loss, followed by unemployment and depletion of savings, leading to poverty and even homelessness. Many used drugs and alcohol to dull psychological and physical pain. While this study was local to northern New England, it is a familiar pattern repeated across America.”

“The authors of the research papers describing the rise in premature deaths among less-educated rural whites must be commended for raising awareness of this important disparity. So far, this issue has been worsening under the radar of society, but now it is emerging into public discourse. Hopefully, appropriate action will follow.”

Editor’s Note: Too many of us have no idea about the public health data noted in this article, or if we do, we don’t seem to care. We need more “bridge” people to help our country embrace a more inclusive view of persistent health disparities or equity across the rural-urban “divide” in both directions.

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**Health Care is a Wisconsin Advantage**

*From “Health care can be a state advantage” by Tom Still, President of the Wisconsin Technology Council in the Wisconsin State Journal, 11/5:*

“Every few years someone in state government laments, ‘We need a better brand for Wisconsin!’ Cabinet secretaries scurry about, agency communications directors scratch their heads over possible slogans, and marketing campaigns go largely unfunded. Here’s an idea: Let’s talk about Wisconsin's tangible business assets without making it all about tourism and cheese.”

“One such asset is quality health care, a commodity largely taken for granted inside Wisconsin and largely unknown to people and companies who may be thinking of moving or expanding here.”

“Much like an educated workforce, reliable public utilities and affordable business costs for land and talent are worth bragging about, so is quality health care. That’s the conclusion of a report issued this month by the Wisconsin Technology Council.”

“‘Taking the pulse: How quality health care builds a better bottom line’ examined leading indicators of health-care quality, based on public and private data. It also compared quality rankings to costs. Key findings were: Wisconsin is consistently one of the top states for quality health care, as measured by 200 metrics compiled by the federal Agency for Healthcare Research and Quality. It ranked No. 1 in the nation in 2017. In the seven-state region surrounding or within a day’s drive of Wisconsin, only two other states ranked in the top quartile. Wisconsin has ranked no lower than 7th nationally since 2006.”

“Wisconsin ranked just $3 above the national median ($4,666 versus $4,663) in the average employer share of single premium health insurance in 2015. That placed the state in the second-lowest cost quartile among the 50 states. Wis-
Wisconsin was $800 above the national median ($13,187 versus $12,387) in the average employer share of family premium health insurance for the same year, still outside the most expensive quartile.”

“Wisconsin health insurance premiums are growing slower than other states in the seven-state region and the nation, especially since 2010. For single coverage, the cost increase has averaged 2.2 percent per year versus 3.8 percent nationally. Wisconsin ranked second best in the nation in this category. For family coverage, the cost increase has averaged 4 percent versus 4.5 percent nationally. Wisconsin is tied for 10th nationally in controlling the growth in family coverage premiums since 2010.”

“Wisconsin also ranks favorably in national and regional comparisons of deaths that could have been avoided by proper health care, Medicare 30-day hospital readmissions, hospital length of stays, mean inpatient charges, the percentage of the total population covered by health insurance and use of electronic health records. All are rankings that speak to quality while controlling costs.”

“The logjam over Obamacare in Washington, DC, has upended the health insurance market as companies and workers come to grips with rising costs. That confusion is playing out this fall in Wisconsin and elsewhere as group health plan enrollments come due for employers and employees alike.”

“One potential asset for Wisconsin is that it’s not a captive health insurance market. The report revealed that Wisconsin is one of only two states in which the three largest insurers control less than 60 percent of the market. Other states in the seven-state region showed “top three” insurance market shares ranging from 67 to 97 percent. The U.S. median is 90 percent. More choice may lead to more competition over time, even if Obamacare is dismantled.”

“Employers have a right to complain about health-care costs, but they aren’t powerless to control the rate of increase or the outcomes.”

“As the reported noted, individual companies, groups of companies or institutions have found ways to work with health systems. This is often accomplished through onsite clinics, incentive programs and prevention strategies that engage employees. Results include lower rates of absenteeism and fewer people showing up sick, avoiding procedure costs through preventive care, and lower costs of care due to better physical fitness and health habits.”

“Examples in this report include Colony Brands and Monroe Clinic; Ashley Furniture and Gundersen Health System; Hoffmaster and Thedacare; Organic Valley and Vernon Memorial Healthcare; Northeast Wisconsin Technical College and Bellin Health; several companies working with Columbus Community Hospital; and a mix of Chippewa Valley institutions working with Mayo Clinic.” Editor’s note: four of the seven examples are in rural communities.

“Quality health care is not only nice to have; it’s an asset in the state-to-state race to attract and retain companies and workers.”

“Let’s market one of the things Wisconsin does best.”

Common Ground at the Thompson Center

From a Guest Editorial “Center will search for Common ground” by Ryan Owens in the Wisconsin State Journal, 10/21:

“A recent Gallup poll revealed that only 19 percent of Americans trust government in Washington, DC, to do what is right. And no wonder. Many of our politicians refuse to work with each other to solve problems that affect real people. That culture must change.”

“We aim to change it at the Tommy G. Thompson Center on Public Leadership. If one thing defines the enduring spirit of Americans—and certainly us Wisconsinites—it is our
ability to solve problems by working together. We understand that when we listen to each other and cooperate, we can solve any problem.”

“It’s a simple idea that has worked well in the past: Identify a problem. Come together. Combine your knowledge. Solve the problem. Repeat.”

“These are the truths that characterize the Thompson Center, which was announced last spring and included in the state budget.”

“Our mission at the Thompson Center, on the UW-Madison campus, is to understand public leadership and apply leadership to contemporary problems. We will provide an environment to study, discuss and improve leadership objectively and professionally.”

“We must produce more effective public leaders today. And to produce them, we will identify and understand effective public leadership, teach leadership skills to future generations of leaders, and reach out to policymakers with the research we perform.”

“This fall, we will host a bipartisan conference dedicated to identifying leadership skills among public leaders in the legislative, executive and judicial branches of the state and federal government. Our goal will be to uncover useful leadership practices and inform our public leaders about them.”

“This spring, we will host a conference on criminal justice reform. Our question: How can we reform the criminal justice system in a way that improves justice for all, saves money and protects individual liberties? We will examine prosecutorial discretion, prisoner re-entry, and civil forfeiture reform.”

“Similarly, in the coming years, we will examine health care reform, transportation reform, tax reform, and other areas in need of improvement. At the Thompson Center, we are united in our desire to improve public leadership.”

“People want to see public leaders from both parties work together in a spirit of trust. We aim to help those leaders in doing so.”

“We are fortified with the knowledge that many public-spirited leaders are in Wisconsin now from both political parties. We are eager to work with them to accomplish great things and help move Wisconsin forward.”

Owens is a professor of political science at UW-Madison. For more information about the Tommy G. Thompson Center: https://thompsoncenter.wisc.edu.

Network Adequacy is a Central Rural Issue

“Regulating Network Adequacy for Rural Populations: Perspectives of Five States”–A research publication by Casey M, Henning-Smith C, Abraham J, Moscovice I at the University of Minnesota Rural Health Research Center:

“For the vast majority of health plans offered in the private market, the provider network—including the set of hospitals, physicians, and other providers who deliver care under the terms of the insurance contract—is a key coverage feature.”

“The size and composition of the provider network can influence an enrollee’s ability to access primary and specialty care in a timely fashion. There may also be financial implications related to the provider network since expenses associated with care received from a provider outside of the network may or may not be covered, depending on the plan type. Additionally, the set of providers within a plan’s network can vary in quality, which can affect patient outcomes.”
“Ensuring access to care is an ongoing challenge in rural America, where the health-care workforce supply is smaller and the health-care needs are greater. This causes challenges for insurers, consumers, and state regulatory agencies alike. One strategy that is used to help ensure access to care within insurance plans is network adequacy regulation, in which states define and enforce certain requirements for insurers’ provider networks. Often these come in the form of standards around maximum allowable travel times and distances to reach primary and specialty care. However, those standards do not always account for differences by rurality in provider supply, population health-care needs, and geographic complexities.”

“Health plans have increasingly adopted narrow provider networks as a cost-saving mechanism, and several studies have examined the implications of narrow networks for premiums and enrollees’ ability to access care. However, limited attention has been focused on rural-specific network adequacy issues.”

“This study reviewed the literature on network adequacy, analyzed state and federal network adequacy standards, and conducted structured interviews with representatives of state insurance departments in five states: California, Kentucky, Montana, Texas, and Wisconsin.”

We Need Rural Health Leaders
The National Rural Health Association Foundation needs your contributions to support the development of the next generation of rural health leaders.

www.ruralhealthweb.org/donationform

“The unknown can be a breeding ground for crippling fear: Where do we start to untangle the complex changes in payment systems, population health, the opioid crisis, etc.? Will our organization survive the next five years? Will my job be relevant when the dust settles, and if not, where will I land?”

“We need to build our resilience—our ability to bounce back from ongoing challenges. Don’t let fear take over; turn it on its head with some F.E.A.R. busting practices.”

F: Flexibility—“Becoming more flexible and adaptable allows us to weather the ‘high winds’ of change and is a fundamental leadership and life skill to develop. What situations make you dig in your heels, sensing immediate resistance in yourself? There are definitely times when your ‘no way’ response to a change is appropriate, but sometimes it is an overreaction to a perceived threat. Learn to recognize what your own resistance looks, feels or sounds like. When you sense a strong negative reaction to a change, stop and ask yourself:

- What is the worst thing that could happen and how would I know it was really starting to happen?
- What could potentially be positive if the change was in fact a good move?
- What is the need that I am afraid won’t be met? Is it to feel competent? Have the regard of others? Belong? Maintain control? Be free to act?
- How can I embrace the change AND get my needs met?”

E: Expectations—“Manage your expectations by paying attention to your thinking:

- Listen for your inner playlist of expecting the worst and replace it with, ‘I expect to learn, succeed, find an opportunity to grow in this challenge, find solutions.’

Leadership Insights: “F.E.A.R.”

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

“Peter Drucker, organizational change guru, said, ‘The best way to predict the future is to create it.’ Really, Mr. Drucker? If he was still alive today, we’d be asking him just how leaders can look ahead with power and fearlessness amidst all the uncertainty.”
Think of someone you know who has handled a change or challenge effectively. What actions did they take? How did they communicate effectively to improve the situation and get their needs met?

- Manage your ‘what ifs’ by focusing on the present moment and breaking down the big change into smaller pieces that you can achieve today.”

A: Act—“Make a list of your concerns. Next, list the things you can’t control about those concerns and STOP DWELLING ON THOSE! Tear up that list and throw it away. Make a new list to identify what you can influence related to those concerns. That is what you take action on.”

R: Relate—“I repeat, it’s all about relationships, the quality of which are a result of communication. Communication gaps are filled with rumors which breed mistrust. With your team:

- Proactively and regularly ask for the rumor list and address each one.

- **Practice empathy.** It’s human to struggle with change and empathy is how we survive. What this does NOT sound like: ‘I know it’s a stupid initiative, but senior leadership says we have to do it.’ Revise these undermining comments to authentic, professional relations, i.e., ‘I understand this is hard and that it has some down sides. We will monitor it for problems and benefits, and we can only really do that if we give it 100%. I need your best effort and I will do the same.’ ”

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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