From “Need a Hospitalist? Call a Nurse! Physicians learn to love a program that could provide a lifeline for hospitals struggling to find doctors” in Hospital & Health Networks, 4/10/17:

“Hospitalist programs, common in medium-sized and large hospitals for years, have been too costly for many smaller and rural hospitals to adopt. But a new model using nurse practitioners opens the door for small and critical access hospitals, in some cases with dramatic results for patient outcomes and patient satisfaction, as well as for physician retention rates. They could even be a key to the survival of some of America’s most challenged hospitals.”

“Nurse practitioners run the hospitalist program at Rusk County Memorial Hospital in Ladysmith, WI, overseen by an off-site collaborating physician. ‘Without the creation of our hospital medicine program, it is unlikely our hospital could have survived,’ says Charisse Oland, CEO of Rusk, a 25-bed hospital with a service area of about 18,000 people.”

“A few years ago, an independent medical group that had been providing much of the area’s primary care started having a difficult time attracting new physicians to replace those who left. On top of that, the physicians who remained increasingly referred patients to another hospital 45 minutes away.”

“Rusk employs advanced practice nurse prescribers as hospitalists, and Oland also reports improved customer service for patients. The APN hospitalists ‘really enjoy engaging with patients and their families,’ she says. ‘They’re available whenever the family needs them, rather than just morning or evenings, and spend more time than under the old model. Our climbing patient satisfaction scores are indicative of these improvements.’ ”

“Rusk took several steps to address the problem, including starting its own primary care clinic. But it was the adoption of a nurse practitioner hospitalist model pioneered at two other Wisconsin critical access hospitals—Eagle River Memorial Hospital and Aspirus Medford Hospital—that sparked an impressive turnaround.”

What’s happening at small hospitals—“Compared with larger community hospitals and tertiary and quaternary care centers, critical access hospitals have been slow to adopt hospitalist programs, primarily because of the cost. But as small-town physicians get older, they want to cut back on their inpatient responsibilities, and younger physicians are reluctant to take jobs that require call duty.”

“The use of NPs in hospitalist programs has been growing for nearly a decade, says Tracy Cardin, an acute care nurse practitioner and a hospitalist at the University of Chicago Medical Center. Nearly 65 percent of all adult hospital medicine programs—and 33 percent of pediatric programs—use either NPs or physi-
Traditionally, many hospital medicine programs have used advanced practice nurses in support roles that do not take full advantage of what they have to offer, Flores says. She sees that changing as the hospital medicine field matures. For example, the University of Chicago Medical Center has seven hospitalist teams. Of those, five comprise APNs and physicians; one has only physicians; and one has only APNs. ‘I work at the maximum scope of practice and rely on my physicians when I need higher-level medical decision-making,’ Cardin says.”

“In some hospitals, nurse hospitalists are responsible for admitting patients during evening or night shifts. In others, they are co-managing a specific patient population in conjunction with a physician hospitalist.”

“Cardin, who last year became the first NP elected to the SHM board of directors, believes that hospital medicine programs are heading toward significant change, and that NPs and PAs increasingly will become important. As hospital revenues decline in the emerging era of value-based reimbursement, hospitals will be unable to afford a hospitalist staff that is entirely or primarily composed of physicians.”

**Outcomes to date in Rusk County**—“In the first year of the program at Ladysmith, two primary care physicians moved into the community, which was key to Rusk’s turnaround. Eliminating inpatient rounds and call duty from the job description has made it easier for Rusk to attract physicians and two others have since joined the practice. In 2016, the hospital had 417 admissions, a 23 percent increase from 2014. ‘We believe admissions will grow even more because we just added another primary care physician in December,’ Oland says.”

“Another sign of success: Patient satisfaction survey results are climbing steadily and now exceed national averages. Last year, 85 percent of Rusk’s patients said they would definitely be willing to recommend Rusk, up from just 61 percent before the hospitalist program started.”

“Of course, the hospitalist program is a major new expense. During 2014, Rusk spent $410,000 on salary and benefits for three hospitalists and incurred $20,000 in recruitment costs. That expense was offset by $290,000 in revenue from hospitalist billings for services; thus, the total cost of the program to Rusk was $140,000.”

“However, the hospital’s increase in patient volume translated into nearly $3,500 a day, Oland says, making the program a financial win. More fundamentally, Oland says, Rusk could not have survived without the hospitalist program because it would not be able to keep physicians in the community.”

A detailed case study of the Ladysmith experience, including the three scenarios hospital leaders considered in choosing and designing the hospitalist program, how the program works, and the lessons learned along the way is available at:

http://ow.ly/Imzh30aJqV8
Transforming Practice One Nurse at a Time

From “A Personal Journey: Transforming Practice One Nurse at a Time” by Cella Janisch-Hartline, RWHC Nursing Leadership Senior Manager, as published in Nursing Matters, March, 2017:

“Talk about a rough start in the profession of nursing. I remember my first two weeks as a graduate nurse like it was yesterday: the pain, the tears, the disbelief, the moments of questioning everything without supportive colleagues. Get the picture? If the answer is yes, no further comments are needed if not, let me explain. On numerous occasions in the first year or practice, I was thrown into situations with a sink or swim attitude by the experienced RNs. The phrase, ‘you are a RN, you should know that,’ still rings loudly in my ears to this day. Through the blood, sweat and tears in the early part of my career I remember thinking, is this what I worked so hard for... is this what it’s really like to be a RN? In those early moments of reflection and through much soul searching, I decided it was up to me to influence and change this profession one nurse at a time. With great conviction and a ton of courage, I marched into my boss’s office and said ‘I know I don’t have much experience, but I want to help new nurses when they come on board. I want to be the person that makes their transition easier and more supported.’ That was only the beginning of a profound, intense, evolutionary journey which continues today. ‘Making a difference one nurse at a time’ has been my motto in the profession for years now.”

“I was blessed to be an acute care rural nurse for nearly 24 years of my career. I worked across the continuum in a small critical access hospital. Rural nursing allowed me to become a very knowledgeable ‘generalist.’ What I mean is that I had to know something about a lot of things to be successful as a rural nurse. I never became an expert at any one thing. Much of my learning came through the school of ‘hard knocks.’ On any given shift, I could end up working in three or more units with limited resources available to me to help me or answer my questions. I learned much ‘on the fly,’ jumping into situations with both feet, hoping that I knew enough to prevent my patient from crashing and having a poor outcome. In those days, there was not even a doctor in the hospital on the night shift. Oh, the memories that led to my key learning experiences have been just priceless.”

“Today, my passion to help and support new nurses remains alive and well. I love being a rural healthcare nurse. Now, in my current role as the Nursing Leadership Senior Manager at the Rural Wisconsin Health Cooperative, I am blessed to have a large forum to impact new rural nurses as the coordinator/lead educator for the Wisconsin Nurse Residency Program. To date, I have touched, influenced and supported 677 rural nurses within their first couple years of nursing practice. Time and time again, I have witnessed their journeys unfold, like a flower blossoming one petal at a time, over the year that I get to spend with each of them. Throughout the program, each one of them is reminded regularly that each day, many times a day, they have to choose what kind of nurse they want to be. Not only do I get to impact them, the nurses I guide continue to transform me both personally and professionally. Their stories, their vulnerabilities, their willingness to allow me to be a part of their experiences, has moved my soul profoundly. Now I understand why I had a rough start in the nursing profession, because it was part of the preparation for my journey of impacting and transforming practice one nurse at a time.”
About RWHC’s Nurse Residency Program: “It is a structured one year program. Participants come to a central location from our member hospitals from across the state of WI once a month. The new nurse is highly engaged in an interactive, reflective and enriched learning environment. The sessions are designed around an effective standard curriculum for the nurse who is often isolated on the unit or in the organization with minimal resources. Networking with peers who are going through the same challenges is a powerful experience for the new nurse. The new rural nurse learns quickly that she/he is not alone. Besides the curriculum delivery, there are small group breakout sessions incorporated into each learning day and are facilitated with the action reflection model incorporating the accepted standards of care and practice along with a high level of professionalism. RWHC needs to run two sessions per month to accommodate the volume of participants involved each year at our location.”

“The development of our nurse residency program was originally funded through a federal grant which was coordinated by Dr. Marilyn Meyer Bratt through Marquette University, Milwaukee, and now is fully supported by our members.”

For more information, contact Cella Janisch-Hartline at chartline@rwhc.com

A Rural Primer for Non-Rurals

From “Rural America broadens our economic, intellectual, cultural diversity” by Kenneth Johnson in Salon, 2/26/17:

“Rural people and issues generally receive little attention from the urban-centric media and policy elites. Yet, rural America makes unique contributions to the nation’s character and culture, as well as provides most of its food, raw materials, drinking water and clean air. The recent presidential election also reminds us that, though rural America may be ignored, it continues to influence the nation’s future.”

“‘Rural America’ is a deceptively simple term for a diverse collection of places. It includes nearly 72 percent of the land area of the United States and 46 million people. Farms, ranches, grain elevators and ethanol plants reflect the enduring importance of agriculture.”

“But, there is much more to rural America than agriculture. It includes manufacturing parks, warehouses and food processing plants strung along rural interstates; sprawling exurban expanses just beyond the outer edge of the nation’s largest metropolitan areas; regions where generations have labored to extract, process and ship coal, ore, oil and gas to customers near and far; timber and pulp mills deep in rural forests; industrial towns struggling to retain jobs in the face of intense global competition; and fast-growing recreational areas close to mountains, lakes and coastlines.”

Where is rural America?—“Clearly farms on the Great Plains are rural and Chicago is not, but where is the boundary between what is rural and what is urban? There is no simple answer. The U.S. Department of Agriculture, the federal agency with primary responsibility for rural America, has multiple definitions of what is rural. The Census Bureau has yet another.”

“I rely upon a widely used USDA definition in which ‘rural areas’ include everything that is outside a metropolitan area. These 1,976 counties were home to 46.2 million residents in 2015. ‘Metropolitan areas’ include counties with a city of 50,000 residents or more, together with adjacent counties—mostly suburban—closely linked to these urban cores. More than 275.3 million people live in these 1,167 urban counties.”

Demographic trends in rural America—“More than 90 percent of the U.S. population was rural in 1790. By 1920, that number had dwindled to just under 50 percent. Today, only 15 percent of the population resides in rural counties.”

“Growing economic and social opportunities in urban areas, coupled with mechanization and farm consolidation, caused millions of people to leave rural areas over the past century. The magnitude of the migration loss varied from decade to decade, but the pattern was consistent: More people left rural areas than arrived.”
“There were brief periods when the rural population rebounded in the 1970s and the 1990s. But generally the growth of the urban population throughout the 20th century has far exceeded that in rural areas. Between 2000 and 2015, the rural population grew by just 3.1 percent. Urban areas grew by 16.3 percent.”

“Recently, the Great Recession and its aftermath disrupted established rural demographic trends. Both immigration and internal migration diminished, as residents were ‘frozen in place’ by houses they couldn’t sell and by a national job market that provided fewer incentives to move. Fertility rates also dropped to record lows during the recession and have yet to recover.”

“Other changes are underway in rural America as well. The population is rapidly becoming more diverse. Minorities represent 21 percent of the rural population, but produced 83 percent of the growth between 2000 and 2010. Hispanics are particularly important to this growing rural diversity.”

“The rural population is also growing older. The median age in rural counties is 41.5. That’s already more than three years older than in urban counties. More than 16 percent of the rural population is over 65, compared to 12.5 percent of the urban population.”

**Rural and urban America are intertwined**—“Few people appreciate that the fates of rural and urban America are inextricably linked. Improving the opportunities, accessibility and viability of rural areas is critical—both to the 46 million people who live there and to the much larger urban population that depends on rural America’s contributions to their material, environmental and social well-being. A vibrant rural America broadens the nation’s economic, intellectual and cultural diversity.”

“Yet rural areas face unique demographic, economic and institutional challenges. Distances are greater and places are more isolated. The advantages derived from businesses and services clustering together are limited. As a result, programs to expand health insurance and reform education may affect rural people and communities differently than in the 50 largest metropolitan areas. Such challenges are frequently overlooked in a policy and media environment dominated by urban interests.”

“Policymakers need to design comprehensive policies that can address the multifaceted challenges rural communities face. Fast-growing rural counties need programs capable of managing their growth and development. In contrast, rural areas with diminishing populations need policies to ameliorate the adverse impacts of this migration. Sustained population loss can affect the availability of critical services like health care, education and emergency services. Resources such as broadband, capital and expertise can facilitate new development.”

“In the wake of the election upset which hinged, in part, on rural voters, more media companies have dispatched correspondents to rural areas. They, and everyone else with a newfound interest in rural America, need to understand that the people, places and institutions in this vast area are far from monolithic. Rural America has been, and continues to be, buffeted by a complex mix of economic, social and demographic forces.”

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**The 2017 Wipfli-RWHC Cost Champions**

The purpose of the Wipfli-RWHC Cost Champions Awards is to encourage and share implemented cost saving ideas suggested by a team or individual employed by a RWHC-member rural hospital. A first-place award of $1,500 and two honorable mention awards of $500 each are made possible by the generous support of Wipfli LLP. Wipfli is helping rural hospitals to more effectively understand and manage their resources. This year’s award winners are as follows:

**First Place:** Jodi Lankey, Purchasing Agent, Mile Bluff Medical Center, for “Implementing a Transportation and Freight Management Process.” Previously,
shipment of goods was at the discretion of the supplier, without regard to cost. Mile Bluff has partnered with Triose Inc. to implement a transportation and freight management service. Triose provides vendors a shipping guide listing specific freight routing instructions to be used on all shipments to Mile Bluff.

Honorable Mention: Julie Stenbroten, Home Health Manager, Stoughton Hospital, for “Developing a Fleet Care Program.” Under prior practice, home health employees used their own vehicles and were reimbursed federal rate ($0.54/mile in 2016). Stoughton Hospital entered into an agreement with Enterprise to start a Fleet Care program with a total of eight vehicles. Four employees with highest mileage were permanently assigned vehicles and two assigned daily based on who will be driving the furthest. Two staff selected a personal use option that allows use for both work and personal needs. The personal use portion of the lease fees are deducted from the employee’s paycheck. Employees who choose to use their own vehicle rather than a fleet vehicle are reimbursed at $0.25/mile.

Honorable Mention: Lisa Michaelis-Alft, Regional Director of Lab Services, Ministry St. Mary’s Hospital, for “Combining Two Histology Locations to a Single Location.” Ascension Health providers, Howard Young Medical Center, Woodruff, and St. Marys, Rhinelander, both provided histology services independent of each other. Formed task force to evaluate benefits of combining histology at a single location. Established leadership and practices to allow consolidation of histology while maintaining acceptable service level for both locations.

By January 31 of each year, RWHC member CEOs are invited to make one nomination of a hospital team or employee’s cost saving idea implemented in the prior calendar year. The awards are made annually and sent directly by Wipfli to the nominating hospital for distribution to the nominated employee(s) as a cash award or in a manner consistent with hospital policy.

You Become What You Think

From “Turning Negative Thinkers Into Positive Ones” by Jane Brody in The New York Times, 4/3/17:

“More than a sudden bonanza of good fortune, repeated brief moments of positive feelings can provide a buffer against stress and depression and foster both physical and mental health.”

“Negative feelings activate a region of the brain called the amygdala, which is involved in processing fear and anxiety and other emotions. Dr. Richard J. Davidson, a neuroscientist and founder of the Center for Healthy Minds at the University of Wisconsin–Madison, has shown that people in whom the amygdala recovers slowly from a threat are at greater risk for a variety of health problems than those in whom it recovers quickly.”

“Dr. Barbara Fredrickson, a psychologist at the University of North Carolina, in her newest book, ‘Love 2.0,’ endorses the following to foster positive emotions:

Do good things for other people–In addition to making others happier, this enhances your own positive feelings. It can be something as simple as helping someone carry heavy packages or providing directions for a stranger.

Appreciate the world around you–It could be a bird, a tree, a beautiful sunrise or sunset or even an article of clothing someone is wearing. I met a man recently who was reveling in the architectural details of the 19th-century houses in my neighborhood.

Develop and bolster relationships–Building strong social connections with friends or family members enhances feelings of self-worth and, long-term studies have shown, is associated with better health and a longer life.
Establish goals that can be accomplished—Perhaps you want to improve your tennis or read more books. But be realistic; a goal that is impractical or too challenging can create unnecessary stress.

Learn something new—It can be a sport, a language, an instrument or a game that instills a sense of achievement, self-confidence and resilience. But here, too, be realistic about how long this may take and be sure you have the time needed.

Choose to accept yourself, flaws and all—Rather than imperfections and failures, focus on your positive attributes and achievements. The loveliest people I know have none of the external features of loveliness but shine with the internal beauty of caring, compassion and consideration of others.

Practice resilience—Rather than let loss, stress, failure or trauma overwhelm you, use them as learning experiences and steppingstones to a better future. Remember the expression: When life hands you a lemon, make lemonade.

Practice mindfulness—Ruminating on past problems or future difficulties drains mental resources and steals attention from current pleasures. Let go of things you can’t control and focus on the here-and-now. Consider taking a course in insight meditation.”

Leadership Insights: “Who Will Work?”

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

“As nice as it would be to leave this problem for the policy wonks to figure out, everyone working in healthcare—especially a leader—has a stake in creating an adequate, competent and diverse supply of health care professionals to meet the needs of the population. Disturbing trends foretell shortages in many health professions. We may be able to quickly turn out more entry level positions, but when the supply of those requiring years of training rapidly retires, it will be too late.”

“Rainer Strack in his TED talk, “The Workforce Crisis of 2030 and How to Start Solving it Now,’ shares ideas for immediate action. He urges the creation of a ‘people strategy’ that focuses on four critical efforts:

Choose great people. You will compete with everyone else for the best and brightest. Strack’s talk references a survey of 200,000 job seekers identifying the top four things they wanted in a job: (a) appreciation for their work, (b) good relationships with colleagues, (c) good work life balance and (d) good relationship with the boss.

Your Call to Action. Create a desirable work environment. Genuinely thank people for their contributions. Facilitate an interactive work space where people can have some fun and get to know each other. Model and encourage work life balance. Examine your written and unwritten policies about time off. Build positive relationships with your employees—there are MANY ways to do this!

Educate people. Education can be the first cut to tight budgets, but you don’t want to lose the people who see themselves as life-long learners!

Your Call to Action Always be looking for learning opportunities. Create informal opportunities to provide education like brown bag ‘lunch and learns’ if education budgets are tight. Create a learning culture. Regularly ask what people are interested in, what they enjoy and match new projects with their interests and talents.

Retain great people that you already have. Don’t lose your best people because you are allowing others to drive them away. When we don’t hold underperformers accountable, it alienates the high performers.
They want to be surrounded by others who are motivated, and may look elsewhere.

**Your Call to Action.** Continually re-recruit. We are not done ‘selling’ our organization at the time of hire. Other employers will try to sell themselves to your best people, you should too. Have conversations about their goals, what you value about them, what they want (and what you envision) for their future. Keep something interesting in their view of the future that involves staying with you.

**Forecast supply and demand.** For this we need good data. Thank you, Wisconsin nurses! Yet again, you are helping tremendously. Though slightly painful, those re-licensure surveys provide the data that helps plan for the future. Yes, we could already find out with just licensing numbers that there are 76,781 RNs in Wisconsin. But before the survey we could not have known if they were working full time, part time, or even working at all. That’s a huge difference in the capacity of the workforce. The WI Department of Workforce Development (in collaboration with the WI Center for Nursing and other partners) created a forecasting tool that uses workforce data to create future supply and demand scenarios that really help with planning. Nurses are the only health care profession to provide this *full* data through licensure surveys.

**Your Call to Action.** Let’s go beyond nursing! Contact YOUR networks (licensing boards and associations) to promote a similar licensure survey so your profession can also have a more accurate forecast of future supply and demand.”

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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