Wisconsin Aces


“A growing body of research establishes that adverse childhood experiences (ACEs)—traumatic experiences in a person’s life occurring before the age of 18 that the person remembers as an adult—may negatively affect health and well-being throughout a person’s life span. The impact of ACEs, however, can be ameliorated by trauma-informed practices, including early childhood interventions that mitigate social and environmental risks for families and promote resilience.”

“There has been a promising surge in proposed policies that recognize the impact of ACEs and incorporate trauma-informed approaches. The increased focus on ACEs science has been described as ‘a non-partisan issue in politically challenging times,’ and advocates from all sides of the political spectrum have championed trauma-informed policy approaches. Some states have sought to integrate trauma-informed policy approaches throughout all levels of state government and decision-making.”

“Wisconsin has been a leader in integrating trauma-informed policy across its state government. Much of the impetus to integrate trauma-informed policy throughout the state has been due to the efforts of Wisconsin First Lady Tonette Walker. Since assuming her role as First Lady, Tonette Walker has adopted trauma-informed care as her platform issue. In 2011, she organized the Fostering Futures initiative to raise awareness about how ACEs shape people’s lives. The initiative has grown over time and has led the charge in training government employees across various state agencies on trauma-informed practices.”

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“In 2014, Wisconsin became the first state in the nation to pass a joint resolution addressing early childhood adversity and calling for state policy decisions to take into account ACEs science. Earlier, states such as Washington had employed state policy primarily to support local capacity-building to address the health effects of trauma.) The resolution provides that the ‘Wisconsin state legislature will acknowledge and take into account the principles of early childhood brain development and will, whenever possible, consider the concepts of toxic stress, early adversity, and buffering relationships, and note the role of early intervention and investment in early childhood years as important strategies to achieve a lasting foundation for a more prosperous and sustainable state through investing in human capital.’ While the resolution itself did not authorize new programs or mandates, it represented a critical legal tool for raising

“There cannot be a crisis next week. My schedule is already full.” Henry Kissinger

RWHC Eye On Health, 4/14/18
awareness and provided an important framework for state level decision-making.”

“In 2016, Governor Scott Walker directed seven state agencies to participate in a learning collaborative led by the Fostering Futures initiative to learn about ACEs and to implement trauma-informed practices for their departmental workforces. The agencies participating include the Department of Health Services Division of Public Health, the Department of Health Services Children’s Long-Term Supports, the Wisconsin Economic Development Corporation, the Department of Corrections, the Department of Children and Families, the Department of Veterans Affairs, and the Department of Workforce Development. Several of these agencies have already trained their entire staff on ACEs science and trauma-informed practice. The positive impacts of these initiatives are already being realized. For example, the Economic Development Corporation saw a drastic reduction in its voluntary employee attrition rate the first year these approaches were implemented.”

“Other state agencies have sought to adopt trauma-informed practices as well, including the Wisconsin Department of Justice and the State Public Defender’s Office. The Department of Justice has worked toward resolutions calling for state policy decisions to consider ACEs science. In 2014, California passed a resolution echoing the language of Wisconsin’s resolution and urging the Governor to recognize the roles of early intervention and investment in children as important strategies. In 2017, Utah passed a resolution encouraging state officials, agencies, and employees to promote trauma-informed interventions and practices. Virginia also passed a resolution last year commending the work of Trauma-Informed Community Networks at the local and regional level.”

“At the federal level, a bipartisan resolution on ‘Recognizing the Importance and Effectiveness of Trauma-informed Care’ was introduced in the House (H. Res. 443) and the Senate (S. Res. 346) this past year. If passed, this resolution would recognize the need for trauma-informed care among existing federal programs and agencies and encourage the use of trauma-informed care within the federal government.”

“The momentum toward integrating trauma-informed approaches throughout various levels of government is encouraging, and the Network plans to continue to monitor policy developments in this area. If you have questions about these issues and would benefit from legal technical assistance, please feel free to contact the Network.”

Brittney Crock Bauerly, J.D., is a Staff Attorney for the Network for Public Health Law–Northern Region. The Network provides information and technical assist-
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Nation’s First Rural OB-GYN Track

From “Portage part of history as doctor studies in
first rural track for OB-GYNs” by Noah Vernau in
the Portage Daily Register, 4/1/18:

“It’s hard to believe: Only 6 percent of all OB-GYNs
in the United States practice in rural environments. An
effort to boost that number
brought Dr. Laura McDowell to Portage. ‘We have to
start somewhere,’ the 27-year-old obstetrician-
gynecologist said of her participation in the University
of Wisconsin-Madison’s rural-residency program for
OB-GYNs—the first such program in the nation.”

“McDowell is the first participant, and Portage is her
first stop on her clinical rotations. She’ll train in hospi-
tals in Monroe, Watertown and Ripon, too, for a
total of eight rotations during her four-year residency, training in each location
twice. ‘The need has been there for so long,’
McDowell said of her goal to work in a rural envi-
nronment like Portage.”

“She’s very much aware of the shortage of rural
OB-GYNs, in part because she grew up in rural
Minnesota, in communities with populations as low
as 370, she said. Last year she graduated from med-
ical school at University of Minnesota-Duluth, where
the city’s population is less than 90,000 and where
the focus of the school was centered, naturally, on
rural medicine.”

“She’s learning at Divine Savior Healthcare in Portage
from Dr. Brenda Jenkin, who grew up on a pig farm
near Brandon, Wisconsin. ‘Population: 853,’ Jenkin
had memorized. Jenkin, the only OB-GYN practicing
in Portage, earned her medical degree from UW-
Madison in 1987 and completed her four-year residen-
cy in Philadelphia in 1991. She spent the majority of
her career working in urban settings—once part of the
94 percent of OB-GYNs who do so today—before she
left Madison for Portage about three years ago.”

“Nearly half of the counties in the U.S. do not have
an obstetrician/gynecologist, according to the Ameri-
can College of Nurse-Midwives. ‘What happens is
people need to travel long distances for care,’ Jenkin
said. ‘People don’t always have the means to travel
long distances for care. Everybody doesn’t have a
car, everybody doesn’t have a driver’s license,
there’s no public transporta-
tion and sometimes
they’re working two or
three jobs. So there are the
same barriers to health care
that you have in the inner
city, except you add on that
it’s an hour away.’ ”

The Genesis—“Rural Resi-
dency Program Manager
Jody Silva said it took the
university about three years
to develop the program for
OB-GYNs after receiving a
$375,000 grant from the
Wisconsin Rural Physicians
Residency Assistance Program. WRPRAP, itself
funded by the state budget and housed at UW-
Madison, launched in 2010 and each year helps fund
rural rotations for various Wisconsin medical schools
in fields like psychiatry, surgery and OB-GYN, pro-
gram coordinator Kimberly Bruksch-Meck explained.
‘It’s a pioneering effort,’ Bruksch-Meck said of
America’s first rural residency program for OB-
GYNs. ‘Women’s health in general is in high need in
rural Wisconsin, where there’s a large shortage of
physicians, even among family physicians.’ ”
“McDowell, who spent the first year of her training in Madison, is the only doctor in the rural-residency program, but the school expects to add a second doctor soon and will have four residents on a rural track by 2021. McDowell and the others who follow her will spend about 80 percent of their residencies in Madison, Silva said. Participants get picked for the program if they want to practice in rural areas; the university is also considering if they’re from rural settings and if they had rural experience during medical school. ‘Our ultimate goal would be to expand the program even more,’ Silva said. ‘What the program was built upon was providing a larger OB-GYN workforce in rural Wisconsin because it’s in great need right now, and we definitely don’t have any plans to stop (adding doctors and rural sites). We hope to increase our numbers as the demands increase.’”

**The demand**—“There will be between 6,000 and 8,800 fewer OB-GYNs than needed in the U.S. by the year 2020 and a shortage of 22,000 by the year 2050, according to the American Congress of Obstetricians and Gynecologists, the estimates noted by the university.”

‘Pregnant women driving an hour-plus to seek medical care, that can be dangerous for both the mom and baby,’ Silva said. ‘Another issue is maternal mortality: women dying after giving birth is on the rise, and so these two things have reached a critical point where pregnant women need easier access to doctors. ‘We expect the population to increase in rural locations while the doctors decrease, so it will only get that much worse.’

“Only about 19 percent of the U.S. population reside in what’s considered rural areas, or roughly 60 million people, according to the U.S. Census Bureau in 2016. This is despite the fact 97 percent of the nation’s land is considered rural. But the 94-6 ratio in favor of urban OB-GYNs is ‘very disproportionate,’ no matter how you analyze it, McDowell said. ‘In my experience, some people don’t even feel comfortable going to the bigger city, and so that’s another barrier,’ she said. ‘Some people choose not to seek care, in general, because their fear of being in the city is so much.’”

“Why did it take so long for the U.S. to get its first rural track for OB-GYNs? ‘The light bulb went on. Somebody just finally saw the need,’ said Jenkin, referring to doctors in Madison who helped develop the program. ‘There is a global track for people interested in international medicine, so maybe somebody thought, ‘Gee, if we’re sending people to Ethiopia, maybe we can send some people to rural locations.’”

“After young doctors complete their traditional residencies, they typically seek jobs that look similar to what their programs had offered them, Jenkin said. Their comfort levels will most often take them to urban settings, accordingly. Said McDowell: ‘This was the program I wanted to go into because I knew it’d give me that ‘rural reality,’ versus an academic-centered residency program that you can get everywhere. I thought having that dichotomy would be really beneficial for my understanding once I get out of residency and establish a practice then.’”

“‘It’s the full gamut,’ Jenkin said, ‘which is really nice because in an academic setting you’re on labor and delivery for specific period of time, then on gynecologic surgery for period of time, and so on, whereas here it’s all integrated. McDowell is attracted to the more personal nature of the job and variety of work in rural hospitals, and she’s certain that she’ll choose to work in one after completing her residency, she said. ‘There’s no passing the hat, so to speak, to a partner, or at least not as much.’ ‘It takes the right person,’ Jenkin said. ‘It’s not for everybody, and it shouldn’t be.’”
What to Do About the VA?

From a Blog Post “The Discontinuity of Continuity” by Dr. Kevin Fickenscher at CREO Creative Solutions, 4/2/18:

“At the outset, let me say that this note is out-of-character for me. In fact, it’s a first! I don’t usually comment on people changing positions or moving from or to various roles. I view those types of changes as the inevitable outcome of what happens in modern day corporations. However, the decision by President Trump to fire US Veterans Affairs Secretary David Shulkin, MD, deserves some commentary.”

“There are a couple of items you should be aware of before reading my thoughts. First, I’ve known David for nearly 25 years. We ‘grew up’ together in the world of health care systems as Chief Medical Officers for various care delivery organizations. As part of that club, we got to see one another’s warts, scars and traumas as we all moved from working as clinicians to becoming administrators and then, working diligently to become leaders - a process that most of us continue to work on to this day.”

“Second, David is a person who is driven by facts and data. One of the reasons the VA has turned the corner in recent years is because of the measured philosophy he has brought to the agency. When push comes to shove, an approach to solving problems where ‘just the facts, Ma’am’ is the dominant model creates an environment of accountability—and, transparency—that is difficult to argue against.”

“Third, on a good day, taking on the challenge of remodeling the VA is a gargantuan task. On a bad day, it can seem impossible. Change is difficult but in an organization like the VA–it requires a degree of perseverance that is inestimable. Yet, David has slowly but surely moved the chess pieces forward in an effort to provide veterans with the health care they deserve.”

“Finally, any person looking at the capabilities of the VA and those of other health care systems would easily come to the conclusion that forming some type of alliance between this large, cumbersome bureaucracy and local health care delivery organizations would make sense. But, there is clearly not a cookie cutter model and anyone that goes down that road will likely be doomed to failure. The potential integration and/or collaboration with local providers is a move that requires the careful consideration of the types of services available locally to support not just the run-of-the-mill medical problems of veterans but also the unique veteran disabilities whether physical or mental. It also makes sense to have some defined proof points recognizing that the initial models will likely be variable and not deployed on a uniform basis across the entire nation. Such was the approach of Dr. Shulkin…”

“While Dr. Shulkin’s departure will no doubt be absorbed–just as the departure of most leaders in government or private industry–his methodical movement toward ‘solving the problem’ will likely result in a backward slide within the VA. It is unfortunate. When one considers the data, it’s obvious that progress was once again occurring within the VA after a 10+ year hiatus. Efforts were being made to enhance quality; initiatives, to enhance service; and, projects, to increase access. And, at the end of the day–increasing the quality/service/access triad is one of the important requirements for ‘making health care better.’ ”

“So, what should be done about the VA? Here are a couple of steps that require
serious consideration and which the next Secretary should put on the table as part of the requirement for taking the job. It’s probably not a complete list and—more importantly—is a list that is devised as an ‘observer’ of the VA rather than as ‘consultant’ or ‘employee’ or ‘advisor’ to the VA. These are purely my high-level thoughts in considering how our nation can best honor its commitments to veterans and also drive efficiency and effectiveness in a large, bureaucratic organization.

The thoughts include:

1. **Initiate a Revised Structure for the VA**—Congress should seriously consider re-establishing the VA as a separate ‘Public-Private Partnership’ (P3) corporation. One of the issues that Dr. Shulkin mentioned in his departure interviews was for Congress to address how the problem of the ‘revolving door of leaders’ at the VA can be resolved. Political appointees to leadership positions is the last thing that is needed to solve the problems. In a large organization that is complex and spans the entire nation—consistent, focused and reliable leadership is essential. It will require a strong, diverse team that moves in concert philosophically and managerially to solve problems. Large, diverse corporations require such leadership to be successful.

2. **Establish a Functional Governance Model**—While the P3 model is a potential solution, the requirements for making it work—in my estimation—will never be met if Congress serves as the ‘Board of Directors.’ I don’t care whether it is a Democrat or Republican Board that is in control. Congressional governance will only continue to exacerbate the ongoing problems of the VA. Rather, appropriate ‘oversight’ should be put in place that represents true governance—like a large health care system. The delivery of quality, reliable, cost-effective health care for veterans is not a political process. It requires a governance oversight that can resolve the very significant problems faced in providing care to veterans. If I were a Czar and able to make the changes, the Board of Directors would be something like: 3 veterans, 3 health system leaders, 3 "open" positions; and, 3 Congressional appointees. The positions would be staggered and be for 6 - 9 years in duration. They would be required to provide a report to Congress every year. I’m sure there are other parameters but this is a good starter kit:

3. **Deploy Tele-Technology**—The VA has actually been one of the leaders in exploring the use of tele-technologies for enhancing the ability of the agency to delivery services. In particular, the use of VA systems has been shown to be very effective in delivering care to rural areas and to those veterans with mental health issues such as PTSD. What’s needed; however, is for Congress to support a national infrastructure plan for enhancing the digital capacity of all geographic areas across the USA on a ubiquitous basis. The fact of the matter is that many rural areas—which are large swaths of the nation—have inadequate digital capacity for supporting the types of communication required for effective telecare.

4. **Continue the Focus on Service**—One of the areas Dr. Shulkin emphasized was enhancing the service capability of the VA. This is a cultural phenomenon and does not simply occur because of declarations. The efforts that he initiated should be continued and expanded. And, in my experience, culture starts at the very top with leaders. So, continuing that focus from the Office of the Secretary will be crucial or it will hit the dustbin of talked about strategies that never become reality.
5. **Continue the Drive for Transparency**—When problems are hidden or covered over, they are unseen. Dr. Shulkin has really pushed the ‘transparency’ agenda which has been very good for the VA. The ideas and efforts need to be continued. Continued use of metrics and comparisons to private health care providers should also be expanded. Let’s hope that this effort does not slide into oblivion with the passing to a new leadership team...

**Dr. Fickenscher’s Blogs at CREO Creative Solutions are available at:** [http://ow.ly/NBSX30jodQq](http://ow.ly/NBSX30jodQq)

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**2018 Wipfli-RWHC Cost Champion Awards**

The purpose of the Wipfli-RWHC Cost Champion 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 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**—Greg Dempsey, Facilities Manager, at Fort HealthCare for “Identifying and Adjusting the Heating and Cooling Requirements of Certain Spaces of the Facility.” Seven construction projects over 70 years resulted in many spaces no longer in need of continuous heating and cooling. Air handlers for these spaces were identified and adjusted to provide conditioned air only as needed. Currently on a pace to save $180,000 to $250,000/year. Additional projects could bring total savings to $360,000/year.

**Honorable Mention**—Todd Lull, Director of IT, Southwest Health Center, Inc., for “Researching and Installing High Speed Network.” Southwest Health Center, Inc., needed high speed network connection to offsite facility. Quotes came in at $30,000+ one-time fee or $16,000 annually. IT researched other options and concluded point to point wireless connection between sites was feasible. Equipment delivering 1.4 Gbps purchased for $3,500 and installed by staff has been in operation for two months without any interruptions.

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 distributed by Wipfli to the nominating hospital for the nominated employee(s) as a cash award or in a manner consistent with hospital policy.

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**Rural Health’s 2018 Outstanding Educator**

The National Rural Health Association’s (NRHA) 2018 Outstanding Educator Award recipient is Wisconsin’s very own **Cella Janisch-Hartline**. Cella will be honored on May 11 at NRHA’s Annual Meeting in New Orleans, the nation’s largest gathering of rural health professionals.

As nursing leadership senior manager at the Rural Wisconsin Health Cooperative, Cella guides first-year nurses through the nurse residency program,
helping the co-operative to increase first-year nursing retention from 50 to 60 percent to more than 90 percent. She also helped develop a rural leadership residency, allowing new rural leaders to learn best practices, receive coaching, and use available tools and resources. She has also created and taught “boot camps” for rural OB nurses, ER nurses, certified nurse anesthetists, and nursing supervisors. A strong advocate of work-life balance, Cella is also an avid outdoor adventurer and photographer.

Jo Anne Has “Gone Fishing”

Leadership Insights will be back next month. In the meantime, back issues of the series by Jo Anne Preston, RWHC Workforce & Organizational Development Senior Manager, are always available online at www.RWHC.com.

For individual or group coaching contact Jo Anne Preston at jpreston@RWHC.com or 608-644-3261; Cella Janisch Hartline at chartline@rwhc.com or 608-644-3235 or for general info, Carrie Ballweg at cballweg@RWHC.com or 608-643-2343.

Upcoming RWHC Leadership Programs

May 16 - Peer Today, Boss Tomorrow
June 8 - Coaching for Performance
June 14 - Empowering vs. Enabling

Non-Members Welcome. Register & other events www.RWHC.com/Services.aspx

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