Thank You, Family Caregivers

From “The Heroes Among Us” by Bob Roth for the Phoenix Jewish News, 10/31:

“There are so many months dedicated to raising awareness about important health issues that it is hard to keep track of all of them. Every year there seems to be a new health issue that is being added to a specific month. While there are many important health issues that are worthy of a monthly dedication, in my mind there is no more important health observation/awareness month than National Family Caregivers Month, which is celebrated every year during November. Celebration is a good description of what we, as a community and nation, should be doing for these selfless individuals that give up their lives to assist their loved ones to be able to stay at home.”

“So why does it stand out for me? It’s because it affects so many of us, and there are so many that live among us that don’t see themselves as a caregiver. The statistics are overwhelming. According to estimates from the National Alliance for Caregiving, during the past year, 65.7 million Americans (or 29% of the adult U.S. adult population, involving 31% of all U.S. households) served as family caregivers for an ill or disabled relative.”

“The backbone of our country’s long-term, home-based and community-based care systems is the family caregiver. Since 1994, the month of November is recognized as National Family Caregivers Month. In 1997, President Clinton signed the first proclamation recognizing November as National Family Caregivers Month; this has been proclaimed by an American president annually ever since. The purpose of recognizing family caregivers is to draw attention to the many challenges facing family caregivers, advocate for stronger public policy to address family caregiving issues and raise awareness about community programs that support family caregivers.”

“These unsung heroes are giving of themselves and are providing billions of dollars’ worth of caregiving services each year. They are dramatically reducing the demands that are placed on our long-term care system and they contribute to improving the quality of life of their loved ones.”

“According to AARP, the average family caregiver is 50+, and most are female (60%). The majority (86%) of 50+ caregivers provide care for a relative, while 47% care for a parent or parent-in-law. One in 10 cares for a spouse. One in four caregivers of someone 50+ is providing care to the oldest-old, which are those who are ages 85 or older. On average, 50+ caregivers’ recipients are 74.7 years old.”

“Being a caregiver can be both physically and emotionally exhausting. If you are taking care of a loved one, it is important to remember to recharge your batteries. Caregiving can also lead to additional pressures, such as financial strain, family conflict and so-

“In a politically diverse nation, only by finding common ground can we achieve results for the common good.” - Olympia Snowe

RWHC Eye On Health, 11/11/19
cial withdrawal. Over time, caregiver stress can lead to burnout.”

“So, this Thanksgiving, join us in recognizing family caregivers nationally for keeping the promise to be there for their aging family members and friends. Make sure that this Thanksgiving, if you see a friend, a loved one or a neighbor in the role of being a family caregiver, offer to ‘share the care.’ By offering to share the care with the family caregiver you will enable the caregiver to get ‘respite’ rest so that they can be a better caregiver to their loved one. At the very least, take the opportunity to reach out to a family caregiver by sending a card of appreciation or a bouquet of flowers to brighten up their day. While November may be the official month to recognize an individual’s act as a family caregiver, every month and every day is one in which they make a difference.”

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**Time to Get Real About Workforce Shortages**

By Tim Size, RWHC Executive Director

We know rural and urban Wisconsin employers have begun to experience the retirement of baby boomers in record numbers. What is particularly true in the healthcare sector is that an aging population not only reduces the supply of workforce but also increases demand, as the need for healthcare really takes off as we move into our senior years.

While it is important to note the longstanding challenge for rural Wisconsin communities to recruit health care practitioners, the current supply of health professionals is at best, OK for our urban communities. In any event, the available forecasts show that both urban and rural will soon face major shortages.

Before looking at the forecasts, here are a few examples of the impact of current healthcare workforce shortages:

Current healthcare professional shortages in our rural communities can mean patients wait longer for treatment, get less treatment than is optimal, or receive no treatment. Or it means they leave their community to get needed care, taking revenue out of the local community, weakening the local hospital and clinic.

It often takes over a half year, at best, for a rural hospital to recruit a physician. One RWHC Member, in a very attractive location, has been recruiting a practitioner for their behavioral health program for over a year with no results. Unfilled positions lead to more pressure on existing staff, more burnout and more early retirements or loss of staff to urban communities currently without these challenges.

When a rural clinic loses a physician, they don’t just lose the direct patient care and financial support to the community, they almost always lose a teacher. It is not uncommon for one physician to annually train several medical students, resident physicians, and physician’s assistants. Without this training, these learners are not exposed to the benefits of a rural practice and are less likely to consider working in a rural community.

*Continued on page 5.*
10 TIPS FOR FAMILY CAREGIVERS

1. Seek support from other caregivers. You are not alone!
2. Take care of your own health so that you can be strong enough to take care of your loved one.
3. Accept offers of help and suggest specific things people can do to help you.
4. Learn how to communicate effectively with doctors.
5. Caregiving is hard work so take respite breaks often.
6. Watch out for signs of depression and don’t delay getting professional help when you need it.
7. Be open to new technologies that can help you care for your loved one.
8. Organize medical information so it’s up to date and easy to find.
9. Make sure legal documents are in order.
10. Give yourself credit for doing the best you can in one of the toughest jobs there is!

CaregiverAction.org
“Conversation Starters re Urban-Rural Language Differences and Other Stumbling Blocks to Understanding Our Working Together” by Tim Size, RWHC Executive Director, 11/11/19

The suggestions, in no order, are from multiple conversations with staff and colleagues; they are not absolute truths; they are intended to start conversations, not end them.

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<td>30. Cars Optional.........................................................................................</td>
<td>Cars (Often 4 Wheel Drive) Required</td>
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Rural emergency rooms are often mentioned as the #1 service by hospitals due to rural farming accidents, vehicle accidents, overdose, stroke, and cardiac events. This requires 24/7 staffing which is very difficult and often requires the use of very much more expensive interim staff from agencies. If 24/7 coverage is lost, lives will be lost and the community less attractive to live in and to start businesses in.

Preventable deaths are higher in rural Wisconsin. The current shortage of Certified Medical Assistants can lead to practitioners not having time to discuss important health improvement opportunities, such as diet, exercise, vaccines and mammograms.

A personal example of the impact of the growing healthcare workforce shortage is that my cardiologist retired almost a year ago and I am still on a waiting list as my clinic struggles with recruitment. And I live in Madison.

But what about the longer term; one that we must address NOW so to limit the damage of MAJOR SHORTAGES in the not too distant future?

To ramp up production for advanced care practitioners, like nurses with a bachelor’s degree or physicians, it is not unreasonable to estimate ten to fifteen years from seeking an expansion of education and training sites to having experienced practitioners in the field ready for a full practice.

In that light, we are already in a crisis, as the Wisconsin Center for Nursing is forecasting a statewide deficit of Nurses equal to 15% in ten years and with the Wisconsin Council on Medical Education & Workforce forecasting a statewide deficit of Primary Care Physicians equal to 14% in fifteen years.

Statewide figures of this magnitude will hit most communities very hard, but especially our rural communities who, as noted earlier, traditionally experience staff shortages even when times are good.

The Federal Centers for Disease Control released a report in early November that rural communities continue with higher rates for all five of the leading causes of death—heart disease, cancer, unintentional
injury, chronic lower respiratory disease and stroke. One of the root causes of these disparities is rural Wisconsin’s slow recovery from the last Great Recession—leading to fewer jobs and less income, major contributors to poor health. A second is the chronic shortages of rural healthcare workforce.

The Bottom Line: The workforce shortages our state is already experiencing and will increasingly experience will make access to affordable health care unacceptably more difficult, no matter how it is paid for.

We Get the Rural Access We Train For

From “Let’s Fix Rural Americans’ Inadequate Access to Care” by Kyle Leggott, M.D., AAFP News, 10/30:

“Rural Americans face greater socioeconomic barriers (income inequality, transportation, internet access, etc.) than their average urban counterparts. In addition, rural communities have higher incidence of poor health outcomes, including higher rates of all five leading causes of death in the United States (heart disease, cancer, unintentional injury, chronic lower respiratory disease and stroke).”

“It should come as no surprise that residents in these communities face significant barriers in accessing affordable health care. Rural patients are seven times as likely as urban patients to report difficulty obtaining needed health care.”

“Given the health disparities, it would make sense to prioritize the allocation of resources to rural communities. Part of the problem is the lack of physicians in our rural communities. According to the 2016 Census Bureau report, 20% of the U.S. population lives in rural areas, but only 12% of primary care physicians and 8% of subspecialists practice in these areas.”

“From 2013 to 2015, the total number of physicians in the United States grew by 16,000, but the number of physicians practicing in rural areas fell by 1,400. Attempts to attract physicians to rural areas, including loan repayment programs, have been inadequate to meet the health care needs of rural Americans.”

“Growing a rural physician workforce that is foundationally strong in primary care is not going to be an easy task. The solutions will have to be multifaceted and address physician training, payment reform, insurance reform and more.”

“Where you train matters—and we aren’t training enough physicians in rural communities. The current geographic maldistribution of the physician workforce reflects the highly urbanized graduate medical education system because most family medicine graduates will practice near their residency training programs. Only 414 family medicine residents and four general surgery residents are in rural residency programs.”

“So how do we train family physicians in rural communities? Rural Training Tracks (RTT) which train resident physicians in high-need areas with critical physician shortages, represent one successful example. RTTs are often structured with the first year of training at a sponsoring institution, usually an urban academic hospital, with the following two years based in rural community training sites. Multiple studies have demonstrated that at least half of RTT graduates will practice in rural areas, and they are more likely to practice in health professional shortage areas and safety net hospitals—exactly the places we need them.”

“So, if RTTs are so great, why don’t we have more of them? Too many rules and regulations. GME financing is complicated, especially in rural areas. CMS funding, responsible for more than 90% of GME, disadvantages RTTs by using regulations and funding formulas that do not account for the diversity of care provided in rural settings. The funding a hospital receives is directly related to how many Medicare patients it sees. As rural hospitals often have smaller Medicare populations relative to urban hospitals, this approach does not cover costs for smaller rural training sites.”

“Rural Americans lack access to affordable health care in part due to the inadequate number of rural physicians. Growing the rural physician workforce is going to require multifaceted solutions that address training, payment and insurance. We know that where you train matters and RTTs represent one evidence-based way to train physicians in rural commu-
nities. For RTTs to flourish, we need to fundamentally change the way we pay for them.”

“We need to produce a physician workforce that meets the needs of our population.”

Leadership Insights: “After the Workshop”

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

“Does it feel like this?

1. Go to a workshop
2. Get great ideas
3. Go back to work and keep doing things the old way because change is hard”

“Or your #3 could be: Go home and do something different to get great results.
At our leadership workshops, our intention is that you develop skills you can apply right away. But a participant asked at the end of a recent workshop, ‘This is great, but how do I make myself go back and do these things?’”

“It is true, change can be hard. There are predictable stages of change that can help us move forward. Following are the 6 stages, using the time management example of someone who has been feeling overwhelmed, unprepared for meetings and generally behind in their work due to no time to plan. This person’s desired change: at the end of each day, spend 15 minutes planning for the next day.”

Stage 1: Pre-Contemplation—“Ignorance is bliss. At this point, the individual has not conceived that a change is really needed, or the extent of the problem. In our scenario, this individual has not even thought about time management techniques, or of attending the workshop, but

people who are frustrated with him may have thought of it for him!”

Stage 2: Contemplation—“Oops, a colleague has expressed irritation that you continue to come to meetings without your assigned work done, even though you have explained you are so busy. You can’t ignore this completely now but you are still wavering on if you really want to or could change. Inside you know you need to change but you remain on the fence and in fact wish you didn’t have to change. You are in charge of deciding when or if you take the next step. This is a good stage to write down the pros and cons of making the change.”

Stage 3: Preparation—“This is where you will start to take some initial steps in making the change. You decide to try the 15 minutes planning thing today. It

New Application Cycle Opens Fall 2019

The Wisconsin Healthy Communities Designation is a three-year recognition program celebrating local communities for their efforts to improve health and promote cooperation across multiple sectors. Designated communities have a tangible way to demonstrate their progress toward creating conditions where all residents have the opportunity to be healthy.

Applicants must demonstrate how their efforts follow these six guiding principles:

1. Defining health broadly
2. Sustainable, long-term solutions
3. Commitment to a fair and equal opportunity for health
4. Cross-sector collaboration
5. Maximizing resources
6. Measuring and sharing results

For more information about eligibility and the application process, visit: www.wihealthycommunities.org

Letters of Interest due January 17, 2020

Questions? Contact us at wihealthycommunities@wisc.edu

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helps to have support for this, so think about who can help you and ask them to remind you. You’ll think about the obstacles to making the change (mostly old habits), but you’ll come up with some solutions (shutting your door, a reminder on your calendar, not answering the phone or email during that time, etc.). You’ll try it, and you’ll see the next morning that there is some payoff to doing it.”

Stage 4: Action—“Here is where you start making the 15 minutes planning time a habit. You’ll think about what you are giving up to be able to do the new habit, but there will be some payoffs that will offset what you give up. Tip for building new habits: the only part you need willpower for is getting started. Once you start, the ball is rolling downhill.”

Stage 5: Maintenance—“Here it will feel weird NOT to do things the new way. Maintenance is the stage where consistency starts to come in. When something messes with your 15 minutes planning time, you miss it, and you’ll notice that your next day doesn’t go as well. Maintenance is where the 15 minutes planning time will just be a part of what you do each day, kind of like brushing your teeth. Often when we think of making a change, we think it starts HERE; it doesn’t. We can get disillusioned and want to give up.”

Stage 6: Relapse—“Think in advance about what could throw you off your new habit, then you will be less likely to be derailed by it.”

“These stages apply to all kinds of individual change or habits one tries to break. So, how about that new year’s resolution just around the corner?”

Above is a reprint from December 2011

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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