Why We Must Invest in Rural Health

By Tim Size, RWHC Executive Director

The next several months in Wisconsin politics will be focused on resolving our State budget. How much to invest in Medicaid, the Federal-State partnership that provides health care coverage for residents without other options, is a major sticking point.

I have no claim on being an expert on the ins and outs of how a final budget will be crafted. But what I do know is rural health and that residents in most of Wisconsin’s rural counties are in worse health and are more likely to die prematurely than their urban county neighbors.

The 2019 County Health Rankings have just been released by the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation. This nationally respected model of measuring community health emphasizes the many factors that influence how long and how well we live. “The Rankings use more than 30 measures that help communities understand how healthy their residents are today (health outcomes) and what will impact their health in the future (health factors).”

The scale of the rural health challenge in Wisconsin could hardly be clearer, as shown in the above picture of the Wisconsin County Health Rankings. Thirty of Wisconsin’s forty-six rural counties (two-thirds) have outcomes below the state average. At the same time, only six of Wisconsin’s twenty-six metro counties (one-quarter) have outcomes below the state average.

This is not a surprise nor is it the failure of talented and hard-working rural healthcare providers. It is what we would expect given that most rural counties are worse than average in the “health factors” or social determinants of health that drive health outcomes, like access to care, education and employment and the alcohol and drug use that occurs in their absence.

Rural hospitals and clinics cannot on their own make rural Wisconsin healthy but as a key part of rural community and state leadership, we can make a real difference addressing the social determinants of health. But rural providers can only help if they are financially healthy.

An excellent example of a healthcare provider partnering to address social determinants of health is ProMedica, a non-profit health care system with locations in northwest Ohio and southeast Michigan. With others, they have launched a 10-year community revitalization initiative that will include housing and community development, job creation and education.

Between 2010 and 2017, the US Census Bureau estimates 38 of Wisconsin’s 72 counties lost residents, with most of those counties being rural. During this same time, Wisconsin’s Department of Workforce Development has documented rural Wisconsin coun-
ties have been much slower to recover from the Great Recession as compared to urban.

Rural health leaders in Wisconsin have the opportunity to work across multiple sectors to expand the non-healthcare jobs and opportunities locally available. There are few roles more fulfilling than providing local access to quality healthcare, but that requires us to assure a stable if not growing local population. And that requires jobs.

For rural hospitals to be or remain financially viable also depends on having a healthcare workforce available to work and live in our rural communities. This is not only due to baby boomer retirements creating a shortage of nurses and doctors but also for our chronically underfunded dental and behavioral health services. With the ongoing opioid and meth epidemic, rural behavioral health services have never been more needed or in more demand. We cannot have a strong rural economy without a healthy workforce.

While Wisconsin has not seen a rural hospital closure in many years, we are not immune from the forces acting on rural health across the country. According to the National Rural Health Association, “97 rural hospitals have closed since 2010, with more than 120 and counting closed since 2005. Right now, 673 additional facilities are vulnerable and could close, representing more than one-third of rural hospitals in the U.S.”

Our Wisconsin State government cannot fix Medicare payments inequities, although our Congressional delegation has long fought, with some success, for needed changes. However, our State government can address shortfalls in Medicaid funding which the Wisconsin Hospital Association has shown statewide to only pay for 65% of costs.

Rural Wisconsin’s healthcare providers and local employers can no longer afford the hidden tax required of them to make up the underfunding of Medicaid and Medicare.

*Eye On Health* is the monthly newsletter of the Rural Wisconsin Health Cooperative. Begun in 1979, RWHC has as its Mission that rural Wisconsin communities will be the healthiest in America. Our Vision is that... RWHC is a strong and innovative cooperative of diversified rural hospitals... it is the “rural advocate of choice” for its Members... it develops and manages a variety of products and services... it assists Members to offer high quality, cost-effective healthcare... assists Members in partnerships to make their communities healthier... generates additional revenue by services to non-Members... ongoing use of strategic alliances in pursuit of its Vision. Tim Size <timsize@rwhc.com>, Editor, 800 Independence Lane, Sauk City, WI 53583

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Rural Healthcare Not Necessarily Higher Cost

From “Rural Health Care Costs: Are They Higher and Why Might They Differ from Urban Health Care Costs?” by Dunc Williams, Jr, and Mark Holmes in the *North Carolina Medical Journal*, February, 2018:

“Do health care costs differ between rural and urban populations, and if so, why might that be? Rural Americans are more vulnerable than their urban counterparts, which could lead us to suspect rural health care costs are higher. The answer may differ depending on how we measure costs and who is paying.”

“Recent interest in the health of rural populations has increased in policy circles. However, this recent interest belies a longer interest in rural health policy, largely historically framed around issues of access and equity. Although the increase in the rate of rural hospital closures is one contributor, other policy issues—for example, the increase in suicides and the opioid crisis—
are also more pronounced in rural communities. Federal policy has often struggled to reconcile, or has flat out ignored, fundamental issues facing rural health care delivery. For example, the 1983 introduction of Medicare’s Prospective Payment System relied on average costs of delivery calculated for larger, urban hospitals and did not account for the higher fixed costs associated with lower volumes faced by rural hospitals. As a result, Medicare reimbursement was insufficient to cover the costs of care in low volume (rural) hospitals, and the late 1980s and early 1990s saw a marked increase in the number of rural hospital closures across the nation. These closures led to various policies aimed at ensuring sufficient access to care for rural populations."

“Although the history of federal health policy in the late part of the 20th century is often framed around access, it ultimately has its roots in costs. Inattention to rural-specific issues led to decreases in access, and decades of Medicare reimbursement policy for inpatient services have attempted to remedy this inequity. While the economics of fixed costs in an inpatient setting are generally straightforward (dividing capital costs across fewer patients means the cost-per-patient is higher), there may be other issues leading to a difference in health care cost per person between urban and rural populations. Rural residents are generally older, have lower income, face more chronic diseases, are more likely to partake in risky behaviors, and are generally in worse health."

“One approach we used is the Medical Expenditure Panel Survey (MEPS), an annual survey sponsored by the Agency for Healthcare Research and Quality, to examine the differences in ‘expenditure’ between rural and urban residents. One limitation of this approach is that the MEPS started suppressing metropolitan status in 2013, so the latest data file available is 2012. We use a Poisson regression, accounting for the complex survey design, to explore the relative (proportional) difference in expenditures as we sequentially adjust for various factors known to affect costs. First, we calculate the simple (relative) difference between total health expenditures among rural and urban residents. In this simple analysis, we find a statistically insignificant estimate that rural residents spend more. We then sequentially adjust for additional factors: age, sex, and race; previous region of the country; previous health insurance status; previous family income; and (for adults) physical and mental health, obesity status, smoking, and diabetes diagnosis. After adjusting for all these factors, urban residents have 16% higher expenditures, and the result is statistically significant (P < .05). Thus, although expenditures appear to be equal, once we account for factors known to affect health care expenditures, rural residents appear to spend less.”

“In today’s age of enhanced stewardship of the health care dollar, increased interest has focused on geographic variation in health care costs. Although actors in the health care system are interested in different notions of cost (e.g., premiums, expenditures, reimbursement), we find that what we adjust for (if anything) and for what population (e.g., everyone, Medicare, privately-insured) is important to compare rural and urban costs. We showed with 2 approaches that a broad view of expenditures found little evidence of higher costs among rural communities; if anything, rural residents spend less than urban residents.”

The complete article is at https://bit.ly/2LBI9Av
Imagine a Healthier Tomorrow

By Alison Page, CEO, Western Wisconsin Health

Most people want to live a long and healthy life. The question is, how we can best achieve that goal? Of course our genetics play a role in our life expectancy, but most of us have the capacity to make it well into our early 90’s. How?

In 2004, National Geographic researcher Dan Buettner was given an assignment to locate pockets around the world where people live longer and better. He and longevity researchers identified five geographical areas or populations with the highest life expectancy or with the highest proportions of people who reach age 100:

**Barbagia region of Sardinia, Italy**—Mountainous highlands of inner Sardinia with the world’s highest concentration of male centenarians.

**Ikaria, Greece**—Aegean Island with one of the world’s lowest rates of middle age mortality and the lowest rates of dementia.

**Nicoya Peninsula, Costa Rica**—World’s lowest rates of middle age mortality, second highest concentration of male centenarians.

**Seventh-Day Adventists**—Highest concentration is around Loma Linda, California. They live 10 years longer than their North American counterparts.

**Okinawa, Japan**—Females over 70 are the longest-lived population in the world.

These zones were called the “blue zones” for no particular scientific reason. It’s just that one of the researchers happened to circle these areas on a map with a blue marker. The study’s goal was to identify the lifestyle characteristics of these older people that might explain their long life.

Looking, for example, at the one Blue Zone in the United States, Loma Linda in Southern California; its residents lead the nation in the longest life expectancy. Their lifestyle provides us with some clues.

Loma Linda is the center of activity for the Seventh-Day Adventist Church. Their faith embraces what we may call healthy living. That includes volunteerism, which inspires a sense of purpose and keeps their community strong. The Sabbath is observed and is considered important “sanctuary in time” from work day stressors. Many of the Adventists have a vegetarian diet heavy in nuts and fresh California fruits and vegetables. They experience less obesity, which lowers their risk of certain types of cancers. And they have a lifelong commitment to regular moderate exercise, many belonging to a gym.

Further study by the research team revealed a pattern of behaviors that are common amongst the residents of Blue Zones around the world. Dan Buettner outlined these characteristics, called the Power 9 on the Blue Zone website (www.bluezones.com).

**Move Naturally**—The world’s longest-lived people don’t pump iron, run marathons or join gyms. Instead, they live in environments that constantly nudge them into moving without thinking about it. They grow gardens and don’t have mechanical conveniences for house and yard work.

**Purpose**—The Okinawans call it “Ikigai” and the Nicoyans call it “plan de vida;” for both it translates to “why I wake up in the morning.” Knowing your sense of purpose is worth up to seven years of extra life expectancy.
Down Shift—Even people in the Blue Zones experience stress. Stress leads to chronic inflammation, associated with every major age-related disease. What the world’s longest-lived people have that we don’t are routines to shed that stress. Okinawans take a few moments each day to remember their ancestors, Adventists pray, Ikarians take a nap and Sardinians do happy hour.

80% Rule—“Hara hachi bu” – the Okinawan, 2500-year old Confucian mantra said before meals reminds them to stop eating when their stomachs are 80 percent full. The 20% gap between not being hungry and feeling full could be the difference between losing weight or gaining it. People in the Blue Zones eat their smallest meal in the late afternoon or early evening and then they don’t eat any more the rest of the day.

Plant Slant—Beans, including fava, black, soy and lentils, are the cornerstone of most centenarian diets. Meat—mostly pork—is eaten on average only five times per month. Serving sizes are 3-4 oz., about the size of deck or cards.

Wine @ 5—People in all Blue Zones (except Adventists) drink alcohol moderately and regularly. Moderate drinkers outlive non-drinkers. The trick is to drink 1-2 glasses per day (preferably Sardinian Cannonau wine), with friends and/or with food. And no, you can’t save up all weekend and have 14 drinks on Saturday.

Belong—All but 5 of the 263 centenarians we interviewed belonged to some faith-based community. Denomination doesn’t seem to matter. Research shows that attending faith-based services four times per month will add 4-14 years of life expectancy.

Loved Ones First—Successful centenarians in the Blue Zones put their families first. This means keeping aging parents and grandparents nearby or in the home (It lowers disease and mortality rates of children in the home too.). They commit to a life partner (which can add up to 3 years of life expectancy) and invest in their children with time and love (They’ll be more likely to care for you when the time comes).

Right Tribe—The world’s longest lived people chose—or were born into—social circles that support-ed healthy behaviors, Okinawans created "moais"—groups of five friends that committed to each other for life. Research shows that smoking, obesity, happiness, and even loneliness are contagious. So the social networks of long-lived people have favorably shaped their health behaviors.

There are many ways to weave these characteristics into our own lives and communities to create our own Blue Zone. Imagine what that could look like!

Join the Champions of Health Campaign

RWHC has launched a campaign, The Champions of Health on behalf of local rural health care to:

- Educate residents about the health care available in their communities.
- Dispel negative misconceptions about local care.
- Encourage patients to proactively choose their local health care providers.

The campaign is implemented and branded locally using a toolkit designed by Hailey Sault, a health care marketing agency based in Duluth, MN, based on direction from a steering committee of rural hospitals. The toolkit contains templates for:

- Digital Display Ads & Outdoor Ads
- Pull Up Banners & Indoor Posters
- External Banners, Print & Radio Ads
• Employee Brochures & Infographic
• Talking Points & FAQs
• Suggestions for a “Champion Awards” Program
• Search Engine Text & Recommended Keywords
• Talent Release Form (for photography)

RWHC has spent $125,000 on developing the tool-kit as a contribution to rural health nationwide. All subscription revenue will be used to expand the tool-kit. The one-time subscription of $2,000 covers any expansions of this tool-kit going forward.

To join the campaign, contact Tim Size, RWHC Executive Director, at timsize@rwhc.com.

Navigating Politically Hot Conversations

“Managing conversations when you disagree politically” from the American Psychological Association, downloaded from https://bit.ly/2vKSkb8 on 5/7/19:

“Navigating hard conversations surrounding sensitive topics like politics, racism, religion, gun control, or abortion can cause strain on any relationship, whether it be with friends or acquaintances, co-workers, family or even a spouse. Knowing or discovering that you have different ideologies or beliefs than those you care about can be uncomfortable, especially if you are in conversation about those topics. According to the 2017 Stress in America Survey, 27 percent of adults strongly or somewhat agree that the political climate has caused strain between themselves and their family members. It’s important to have healthy conversations, but also to be mindful of when the discussion escalates and becomes unproductive.”

“Here are some helpful tips to guide the conversation in a more positive direction:

Find areas where you agree. You may disagree with someone but instead of strongly reacting, actively listen to the other person about what is important to them. For example, you might have different ideas about gun control but underneath you share the same concern for keeping your kids safe and healthy. You may find that by discussing shared viewpoints, areas of disagreement will feel less intense and your stress may decrease.

Be open and kind. When having conversations, avoid polarizing language and personal attacks. Remember with whom you are having the conversation. It may be a family member or someone important to you. Communicate effectively. Try to be mindful of your words and tone and not let the conversation become hostile or combative, as that could have potential to negatively affect the relationship in the future.

Keep calm when tensions rise. Preparing for how you might react in advance of a conversation will increase your self-awareness and may give you more options if you want to de-escalate tension. If you find yourself quick to react in a heated conversation, it may benefit you to take a step back and remind yourself to be calm. Try taking deep breaths when you find yourself getting worked up or politely change the topic of conversation. Only you can control your emotions and being aware of them will help you to lessen tension with others.

Have conversation goals. Understanding your goals when it comes to communicating with others, may be helpful to having productive conversations. Whether the conversation is on a sensitive topic, such as healthcare, or not, it’s important to determine what you hope to achieve from the conversation. Is it that you want to change the person’s mind or to simply hear and better understand their point of view? Establishing easy attainable goals, when communicating with others will help to ease tension in a conversation.

Accept that you may not change the other person’s mind. When in conversation, you may notice that the other person may not agree with your opinions or statements. Having conversations, specifically on sensitive topics, will not always be easy going. Recognize that you may not be able to change their viewpoints. Use the conversation as an opportunity to share views, not to convince anyone that your view is best.

Disagreeing with someone you care about is ok. It is important to remember that you are not always going to agree with everyone. It is ok to agree to disagree. Your personal opinions and beliefs make you unique.
It might be hard to accept that a loved one or friend may have opposing ideologies than you, but understanding their viewpoints will help contribute to healthy relationships.

**Know when to end the conversation.** If the conversation has not come to a resolution, you may want to find an appropriate time to end the discussion peacefully. It may be that you change the topic of conversation or suggest another activity, but reinforce maintaining the relationship you have with the other person. Even though there wasn’t an agreement, continue to participate in activities you enjoy together.

**Be proactive.** If you are concerned about potentially difficult conversations at family gatherings, such as during the holidays, remember these events are about bringing people together, not driving them apart. Focus on good memories and what you and your family have in common. Plan activities that foster fun and laughter, such as playing a family game or looking through old photo albums.”

**Leadership Insights: “The Cost of Blame”**

The *Leadership Insights* series is by Jo Anne Preston, RWHC Workforce & Organizational Development Senior Manager. Back issues at [www.RWHC.com](http://www.RWHC.com).

“It’s not easy to admit that we can be bound by childhood playground norms. ‘She started it, it’s her fault!’ We learn early in life to look for someone to blame to avoid punishment, and that thought process is hard-wired. Some things we learned in Kindergarten we need to UN-learn, and blaming is one of them.”

“We would likely naturally outgrow this behavior if it wasn’t so self-reinforcing, getting us quickly off the hook and feeding our ego. It comes at a cost, and though the exact dollar amount is hard to pinpoint, the cost shows up in healthcare as:

1. **Rework and work-arounds.** Work takes extra and sometimes repeated steps when problems can’t get fixed while we dwell on whose fault it is instead of solutions.

2. **Drama drain.** Hours are spent away from our work while we go around defending our (right) version to people to get their support and justify that someone else is wrong. Some estimates are that up to 2.5 hours of every workday is spent in drama which means nothing else is getting done!

3. **Disengaged or departing workforce.** A blaming environment reflects and breeds fear. People don’t take risks in a fear-based culture. Healthcare needs bold innovators and your best and brightest will go elsewhere if the culture doesn’t support trying new things even if they fail.

4. **Death!** It is more permanent than getting in trouble. Problems go unreported because of the fear of blaming the messenger. This ripples out to the patient who can have a bad outcome, even death, when a problem that could have been prevented remains hidden because it was unsafe to speak up.”

**The flip side of blame is personal accountability.** “Your leadership credibility relies on stepping into accountability—a word often thrown around without the deep dive it needs. It is worth your time to self-assess your blaming tendencies and work to let them go. It makes no sense to walk through life with an unconscious fear of getting into trouble when ALL of us are designed to be human mistake-makers. You are welcome to join my support group, ‘Hi, I am Jo Anne and I make colossal mistakes.’”

**Today, notice your blaming thoughts.** “You will have to pay careful attention to your thinking because blaming is so ingrained that you may not even know you are doing it. Tune in when someone asks you for work that you don’t have done, when you’re unable to do a task, when you have forgotten something or things aren’t turning out right. Pay attention during moments of frustration for the temptation to blame. Listen for thoughts that sound like an excuse or ‘reason’ for any of your circumstances.”

**Search for whatever part you own.** “Maybe someone else truly didn’t deliver and you do need their input to move something forward. You still have something to own. What is it? Respond with what you do have control over. The other person in your situation...
has their own accountability, but like they say in AA, ‘Take your OWN inventory.’”

**Don’t flip from blaming others to blaming yourself.**
“That’s not an improvement! Owning up can carry some guilt, but when guilt is excessive it is more likely a reflection of low self-esteem or manipulation. Accountability is about acknowledging, apologizing and amending, the triple A (AAA) approach. Own it, express genuine regret for your part and move to fixing it. Doing all three A’s consistently and appropriately is a clear action to take on behalf of your self-esteem.”

**Compare these two perspectives on power:**

- “Blaming conveys power in the moment, but that power is fragile, relies on continued blaming and keeps problems unresolved.

- Authenticity builds power over the long view, and results in credibility, respect and solutions.”

“Where do you have opportunities to build your power and credibility over time through authentic accountability?”

**Be courageously accountable.** “The righteousness we feel when we blame is the easy way out when it is scary to stick our neck out. Remember F.E.A.R. can mean False Evidence Appearing Real, so use your critical thinking on that ‘evidence.’ Columnist David Brooks offers a simple description of culture change as, ‘when a small group of people find a better way to live and the rest of us copy them.’ It is powerful when a leader owns up because it paves the way for others to follow, and that begins the shift from a costly blaming culture to a just and accountable one.”

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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