Who Cares for Our Caregivers?

From “The Personal Sacrifices Family Caregivers Make For Their Loved Ones,” Edie Grossfield, Forbes, 11/11/18:

“Unpaid family members and friends who care for loved ones want to provide that care, but they sacrifice their own financial, medical and social needs to do it. This is one of the main findings from a recent survey conducted by the Associated Press-NORC Center for Public Affairs Research,“ <https://goo.gl/DmYXjS>.

“As part of ongoing research into public attitudes about long-term health care in the U.S., AP-NORC conducted the poll to learn more about the stresses and burdens caregivers experience as they help their disabled loved ones remain living in their homes and communities. In earlier research, AP-NORC learned that about 40% of Americans have experience providing long-term care to an older family member or friend.”

“The survey conducted in June and July polled 1,024 caregivers living throughout the U.S. and found these are some of the ways caregivers sacrifice to care for their loved ones:

- 25% have cut back on their retirement savings
- 41% have dipped into their personal savings
- 25% spend 40 hours per week caregiving
- 45% who have outside jobs use some or all of their vacation time for caregiving”

“The study also found that caregivers give up fun activities and time with friends and family to take care of loved ones.”

“‘I think people don’t always appreciate how taxing, both physically and emotionally, the job of caregiver can be for individuals,’ says Michelle Strollo in a video AP-NORC released with the study findings <https://goo.gl/mgea6u>. Strollo is vice president and associate director of the health care department at NORC at the University of Chicago. ‘Caregivers sacrifice their many social relationships, including relationships with their spouses, other friends and family members. And that comes at a cost to them emotionally,’ she says.”

“For Family Caregivers, An Unexpected Life Change–After taking on more responsibilities, caregivers experience multiple impacts to their lives as time goes on, says Jennifer Benz, principal research scientist and deputy director at the Associated Press-NORC Center for Public Affairs Research.”

“Happiness is having a large, loving, caring, close-knit family, in another city.” - George Burns
‘What we know from other data regarding caregiving and long-term care is that a lot of people can find themselves in these caregiving situations very quickly, sort of going from 0 to 60 to becoming a caregiver,’ Benz says, adding that once the caregiving starts, it usually extends from short-term to long-term. ‘And then you have caregivers thinking, ‘Well, I’ll stay up late tonight to help,’ or ‘I’ll get up early tomorrow’ or ‘I’ll put this bill aside this month.’ But as you become a caregiver over an extended period of time, that type of activity just isn’t sustainable.’ ”

Forgoing Health Care to Provide Care—“With the added stress of caring for another, especially if you have a full-time job and other responsibilities, your own health can begin to suffer. About one-third of the survey respondents said they have gone without dental care or a routine physical exam, skipped or failed to schedule a medical test or treatment, haven’t gone to the doctor when they were sick or injured or forgot to fill their own prescription.”

“Thirty-nine percent of respondents indicated they have some kind of physical or mental health condition that impacts their daily lives. And, among those with chronic health conditions, 40% said their caregiving role makes it difficult to manage their own health.”

“Another finding of concern, Benz says, is that just barely half of the people polled indicated they have a plan in place for the people they’re caring for should something happen to the caregivers.”

“The research also shows that many caregivers don’t discuss these issues with their doctors, even as they make sure their loved ones’ medical needs are met. ‘Only a quarter of the caregivers have talked to their own doctors about their caregiving responsibilities and how that’s impacting their lives,’ Benz says. ‘So, that certainly seems like an opportunity to have caregivers speak with professionals and at least start the discussion of how they can find support.’ ”

The Financial Impact—“In addition to many hours spent caring for loved ones, eight in ten caregivers pay for expenses associated with that care, and many of them earn modest or low incomes, according to the research findings. The majority of the survey respondents earn less than $50,000 annually and more than 10% spend over $500 per month on caregiving costs. About two in ten took on debt to cover these expenses.”

“‘That can be a pretty significant burden,’ Benz says. ‘To do that, we see there are trade-offs for the caregiver, in terms of having to reduce savings for their own retirement accounts and things like that.’ ”

How Can These Findings Help?—“Results of the survey can serve as a needs assessment of caregivers to inform communities, leaders and policymakers as they take stock of what services they have available and what they need. Communities differ widely in care services, which can include home care, transportation, meals, adult day care, information and referrals, case management, legal and financial counseling and support groups.”

“Family members and friends play an integral role in caring for our nation’s older population, as Dr. Donna Benton, research associate professor of gerontology at the University of Southern California, emphasizes in the AP-NORC video: ‘Caregivers are the backbone of our long-term care system. If we didn’t have family caregivers with unpaid help, our health care system would pretty much collapse.’ ”

“And the recent AP-NORC survey shows these caregivers need more help, Benz adds. ‘The results indicate that these caregivers are very invested in providing care to their loved ones, but they have a lot of needs themselves. So, I think the research begs the question—who’s providing support for the caregivers?’ ”
Growing Rural Wisconsin’s Next Doctors

From “Graduate Medical Education Initiatives to Develop the Physician Workforce in Rural Wisconsin” by Kimberly Bruksch-Meck, Byron Crouse, George Quinn, Linda McCart and Kara Traxler in the Wisconsin Medical Journal, December, 2018:

“The shortage of rural physicians continues to increase across the nation, and reports of rural hospital closures continue to rise. Physician shortages and hospital closures are 2 leading factors that contribute to the limited access to health care services that patients experience in rural communities. Travel burden commonly experienced in rural areas has been associated with lower health care utilization, which may lead to an earlier onset of illness or disease and influence more aggressive treatment options when illness or disease is present. Aggressive treatments put patients at a higher risk of infections and mortality and also contribute to higher preventable costs in health care expenditures. This cycle demonstrates how the shortage of physicians impacts growing health risks observed in rural communities.”

“To address the front-end of the physician workforce development continuum, the University of Wisconsin School of Medicine and Public Health (UWSMPH) and Medical College of Wisconsin (MCW) created new educational programs to graduate an increased number of medical students each year. Focused on rural physician workforce needs, the UWSMPH Wisconsin Academy for Rural Medicine (WARM) program in Madison and 2 new MCW campuses in northeastern (Green Bay) and central (Wausau) Wisconsin select students who demonstrate rural origin and interest and provide medical training and curriculum that prepares students for rural practice.”

“In response to advocacy by the Wisconsin Hospital Association, Wisconsin Medical Society, specialty organizations, and the Rural Wisconsin Health Cooperative (RWHC), the state legislature and governor established the Wisconsin Rural Physician Residency Assistance Program (Residency Assistance Program) in 2010 with funding to help develop the infrastructure, network, and processes to design and implement new rural GME programs. In 2013, an additional $2.5 million in the state’s biennial budget was provided for the Department of Health Services GME Initiative (“DHS Initiative”) to target expansion of existing GME programs and further develop new programs. Each year, the Residency Assistance Program and DHS Initiative collectively distribute $3.25 million in state-funded grants to assist rural hospitals and educational institutions in increasing rural GME programs, tracks, and rotations throughout the state. In 2017, ongoing legislative advocacy and demonstrated success resulted in funding increases for both the Residency Assistance Program and DHS Initiative.”

“A key finding from early outreach activities was that interested hospitals and institutions commonly need additional support to manage accreditation requirements in order to develop new rural programs. Rather than providing grants to hire new staff at each site, the Residency Assistance Program and RWHC responded to the collective need through forming and funding a new entity named the Wisconsin Collaborative for Rural GME (Collaborative). The Collaborative was created to address similar administrative needs that exist across the state, which includes providing accreditation assistance and consulting services at no cost to hospitals and educational institutions that are developing new rural GME programs. Their functions expanded to include hosting statewide meetings to serve a broader range of rural GME stakeholders, providing training opportunities for faculty and administrators, and offering a central-
ized online directory and interactive state map that displays new and existing rural GME programs.”

“Ensuring an adequate rural physician workforce has been a challenge for decades and continues today. Initiatives providing educational opportunities in rural settings during medical school and residency are among the strategies to address these shortages. The initiatives reported here demonstrate success in increasing the opportunities for GME in rural Wisconsin with early outcomes indicating this strategy is effective in the recruitment and retention of physicians in rural hospitals and clinics. This success is the result of the efforts of many partners across a continuum, including advocacy and development of community, faculty, and administration support to actual support and implementation of GME activities. Collaborative partners working toward a common goal are paramount in overcoming obstacles to increase the number of practicing physicians in rural communities.”

The complete article is at https://goo.gl/tuy632

Spirituality–Part II

From “The Experience of Health System Leaders in Meeting Patients’ Spiritual Needs” by Charisse Oland, until her recent return to her home in South Dakota, president and CEO at HSHS St. Joseph’s Hospital in Chippewa Falls, WI, and a member of the RWHC Board.

This is a two-part series on the important role that leaders can play in assuring that spirituality is an essential component of healing patients in hospitals. Part I established the foundation of spirituality’s importance to patients and distinguishes what spirituality is and is not. Part II describes how healthcare leaders can create a culture of spirituality, regardless of secular or non-secular affiliation.

“Hospitals across the country claim to provide holistic care for their constituents: healing the mind, body and spirit of the people they serve. While the mind and body are well cared for in hospital settings, patients agree that the spirit is not. As healthcare leaders we can change this and assure that the care provided is truly holistic, including meeting our patients’ spiritual needs.”

“Being spiritual is the root of many people’s identity, giving life meaning and purpose. Spiritual needs are greatest during our most vulnerable moments in life including and especially during acute or life-threatening illness. Spirituality plays an immensely important role in the healing process and in supporting a peaceful death. Research indicates that patients clearly want health care professionals to address their spiritual needs when they are hospitalized. Yet research-to-date shows that hospital efforts, regardless of religious affiliation status, are often less than effective in meeting patients’ spiritual needs. While many hospitals have chaplaincy programs and chapels as worthy and foundational assets in maintaining core spiritual services for patients and families, the broader and deeper essence of meeting patients’ spiritual needs is a much more complex matter. Serving the spiritual needs of patients is an interesting challenge that falls on the shoulders of the CEO.”

“A recent research study involving leaders at all levels (senior, middle and frontline) of two successful hospitals/health systems in Wisconsin, one secular and one non-secular, offered important insights as to why spirituality thrived in their organizations. Four themes emerged indicating that the experience of the multidisciplinary health system leaders has an impact on an organization’s success or failure at meeting patients’ spiritual needs in multiple ways.”

First, “‘the top leaders’ (CEOs) spiritual beliefs and moral characteristics embody the culture of the organization, while leaders at all levels below align with them. ‘The flavor of the sundae starts at the top,’ says one participant who affirms that the CEOs personal values and accompanying behaviors form the basis of the organization’s belief system. Marker events reaffirmed the values of each of these century old organizations. The loss of religious figures in daily operations in one organization and the retirement of the long-standing CEO of 40 years in the other resulted in the reaffirmation of values for each of the organizations. Three attributes were found to be significant. These include the CEOs implicit belief in spiritual matters, the inward nature of self-
reflection, and the ability to replenish spiritual reserves with restorative activities such as exercise, music, meditation, etc. Authentic CEOs ‘walk the talk.’ Moral characteristics most observed included the ability to trust and be trusted, to be present in the moment when relating to others, to build relationships, honesty, and mentoring/coaching others. The structure of the organization with leaders who are directly aligned in their values and actions allows spirituality to be embedded in the culture.”

Second, “all leaders in this study hold themselves and others accountable to the defined values of the organization and to the behaviors that exemplify them. Leaders enforce accountability for standards of behavior for service, they have a structured process for feedback from staff and patients, and they adhere to similar hiring/termination practices that includes hiring for values as well as technical skills. If colleague behaviors don’t match the organization’s values, they are terminated in order to maintain the organizational commitment to spiritual care.”

Third, “meeting patients’ spiritual needs is a result of actions by both direct and indirect caregivers and is strongly associated with presence.” All staff is empowered and expected to meet the spiritual needs of patients, families and each other. This shared responsibility includes housekeepers, accountants, receptionists, etc. who share in and support the important roles of chaplains or nurses at the bedside. Staff who are trained to ‘fix’ problems learn that not all things are fixable and that presence is a remedy for spiritual suffering. Spiritual presence or being ‘present in the moment’ for patients and for each other is a skill that requires empathy and honoring others humanity with dignity.”

Fourth, “intentionally investing in training with financial resources made a substantial difference in broad cultural development. While basic spiritual training is mandatory for leaders, all staff are offered educational opportunities to advance their own spiritual development, learning about their own spiritual nature, and their impact on patients. In this study, the RISEN (Reinvesting Spirituality and Ethics in Our Networks) program positively impacted participants’ personal and professional growth. It helped to differentiate religion from spirituality and helped individuals become more confident to discussing these matters with patients and with each other.”

In summary, “the CEO must first and foremost authentically embody spirituality, striving for spiritual maturation that emulates ‘a way of being’ for the entire organization. Patient care starts with the CEO. Spirituality is not a task that can be delegated for others to perform. ‘Your vision will become clear only when you look into your own heart. Who looks outside, dreams; who looks inside awakens,’ states well known psychologist Carl Jung. The CEO who looks inside and truly understands his or her own inner nature can connect with others and their suffering. Humanity grows with a foundation of compassion and unconditional regard for others. Bringing forth positive expectations, faith and hope is way of being that exemplifies spirituality. The CEOs positive intention and presence permeates the organization and hence reaches its’ patients. Through their own personal spiritual journeys to find meaning and purpose and to experience connectedness with others, the CEO establishes a culture where spirituality is a way of being for everyone engaged in healing.”
To care, to serve, to help and be present. This is the heart of a champion of health and the commitment of everyone from doctors, nurses and specialists to cooks, housekeepers and administrators in your hospital.

It is their dedication and expertise that heal us. And their kind words, smiles and ability to understand that soothe us. These are the people who choose to work and live here. To be a champion for you. To be a champion for this community.

When you choose a health plan, ask for (your hospital or health system name here).

YOUR HOSPITAL NAME & LOGO HERE

Join the Health Champions Campaign.

Contact Tim Size at RWHC to discuss how this campaign can drive patient choice in your local markets.
Leadership Insights: “Transparency”

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

“Thirty years ago when I taught, I used ‘transparencies,’ clear pieces of film written on with a sharpie, projected onto the wall from a lighted screen. Today, transparency means shining a light onto the truth.”

“The truth can be uncomfortable, and deeply entrenched in our leadership culture is an unwritten rule that we must look good, smart, right. This rule leads us to squirm around the truth, which actually destroys our leadership credibility.”

“Transparency is the current buzzword. I hear employees saying (and gurus recommending), ‘Leaders need to be more transparent.’ I watch leaders’ frozen faces as they question, ‘Surely I am transparent, right?’ Reflect on:

What transparency IS:

Keeping people informed. “Inform in a way that connects to what is important to THEM, in language that makes sense to THEM, minus the jargon and assumption that everyone knows what you know. They don’t. Information vacuums are quickly filled with suspicion and drama which you will spend hours navigating.”

Being vulnerable. “Don’t dismiss this by thinking vulnerability means you have to open up about your personal life, cry, say ‘I love you,’ or any mushy stuff. Vulnerability does mean:

- Admitting you don’t have all the answers, not making them up. This makes you human, not flawed.
- Owning up when you make a mistake. It is incredibly healing to all when a leader who has erred owns it.
- Following-up that ownership with sincere change. ‘I’m sorry’ is hollow if not followed by corrective action.”

Exposing data. “Like Door County Medical Center does, put your quality data and strategic metrics up on the wall for all to see. No secrets. ‘Here’s where we are, where we are headed, and what we need to do to get where we want to go.’ ”

Unearthing your real agenda. “If you need support, say so. Be clear about what that support looks and sounds like. If you need something unpopular, it’s ok to acknowledge that, but don’t throw blame elsewhere.”

Trusting your team. “Don’t underestimate what people can handle. Most people can handle the truth MUCH better than the worrying that accompanies silence and waiting for the shoe to drop.”

Matching actions and words. “Walking your talk is transparency at its best. Review your organization’s excellence standards. Does your behavior match those standards? There is no way you can hold others accountable who are falling short of those standards if you don’t demonstrate them yourself.”

Empowering. “One barrier to being open is the belief that you will lose power. This is a myth. Your superpower is your team, and teams are engaged when they understand your challenges so they can bring their great ideas and solutions to the table, with a vested interest in the outcome.”
What transparency IS NOT:

Sharing confidential personnel information. “I once had to terminate an employee, someone beloved by the other employees who did not see it coming. They wanted to know why. I worked to build trust by letting them know that all personnel discussions are confidential, and that they could count on me to honor that no matter who it was. I also listened for what was not being said. The concern was, ‘What gets a person fired, and am I at risk?’ Those questions I could answer.”

Tell-all about your personal details. “Keep in mind, people do want to know you as a person, but you get to decide what to share about your life outside of work. Try the ‘share-check-share’ method. Open up a little and see how that goes, and take it from there.”

Emailing. “Face-to-face is required of you if you want people to know where you stand and find you approachable. Electronic communication has its place but you can’t hide behind it and still be transparent.”

A one-way street. “As you make space for others to be transparent, you may hear things that are not so easy to hear. When someone gives you honest feedback or disagrees with you, take care to manage your defensiveness.”

“What gets a person fired, and am I at risk?”

“Think of leaders you respect and admire. How do they demonstrate transparency?”

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.

Upcoming RWHC Leadership Programs

2/28 - Walk the Talk
3/8 - Lateral Violence: Dealing with Disruptive Behaviors
4/2 - Project Management and Team Facilitation
4/10 - At the Heart of the Matter: Engaging Your Staff
5/14 - Building a Resilient Workforce Culture
5/29 - Peer Today, Boss Tomorrow
6/28 - Empowering vs. Enabling

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

Space Intentionally Left Blank For Mailing