Rural Health and the Power of Place

by Tim Size, RWHC Executive Director, Sauk City

Like the rest of us, Garrison Keillor’s Lake Wobegon is aging. It won’t be long until he is telling us that “all elders are strong, all health care is local and all children are returning home.” Healthy rural places are needed now more than ever.

AARP in their handbook Aging in Place reminds us “that aging in place is simply a matter of preserving the ability for people to remain in their home or neighborhood as long as possible. The current healthcare system has not been coordinated with in-home care to efficiently and effectively support the senior population.” AARP suggests that there are five key principles for any community to promote aging in place:

**Choice**—“Healthcare and housing options should be affordable along the income spectrum so all citizens are able to choose from a range of alternatives.”

**Flexibility**—“Individuals will have his or her own concerns and needs; flexible services will allow individuals to tailor different health and housing services to their own situations.”

**Entrepreneurship**—“Economies of scale increase as the number of older adults in a community grows, presenting new opportunities for affordable services.”

**Mixed Generations**—“Maintaining mixed-generation communities—there are valuable links to be made between the needs and skills of different age groups.”

**Smart Growth**—“Designing communities that are more accessible and livable benefits everyone but for many older adults is a fundamental necessity, not just an amenity.”

Rural health care is a discipline focused on “place” that naturally supports these priorities.

But the reality of rural health is a tension between “place” and the potentially different interests of increasingly larger multi-state organizations, as well as a too often unsupportive Federal government. One recent example is the November 4th issue of the Journal of the American Medical Association that passed on two cheap shots against financing rural health care without offering a balancing rural view.

Rural health care has much going for it in support of local communities and the values of “place.”

Healthcare’s mandate for increased quality and decreased cost is good for rural and primary care. Primary care is a local service that does not lend itself to being outsourced overseas, let alone to the next county.

With the growing incentives for healthcare providers to work collaboratively, the distinction is fading between “independent” and “system;” providers in rural communities are often seen as valued partners.
Advances in telehealth are increasing the resources available to rural communities to keep care local.

And perhaps most importantly, as providers are increasingly at financial risk for the health of the population they serve, those organizations with the strongest local connections will be most effective.

The American Hospital Association (AHA) recently reiterated its pledge “to work with Congress and the Administration to make certain that rural hospitals and communities are understood and protected.” Along with the National Rural Health Association, AHA encourages us “to continue to reach out to our legislators to explain the importance of rural hospitals in providing health care to communities across America.”

Malcolm Gladwell in his newest book, *David and Goliath: Underdogs, Misfits, and the Art of Battling Giants*, provides a great reminder to those who feel their community or hospital is at risk: “Giants are not what we think they are. The same qualities that appear to give them strength are often the sources of great weakness. And the fact of being an underdog can change people in ways that we often fail to appreciate: it can open doors and create opportunities and educate and enlighten and make possible what might otherwise have seemed unthinkable.”

Being an underdog can be a source of great strength, if we use it.

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**Fix Longstanding Federal GME Funding Bias**

From “Study Points to Imbalance in Spending on Doctor Training” by Phil Galewitz in *Kaiser Health News*, 11/4:

“Florida and New York have roughly the same population, but New York has five times as many Medicare-sponsored residency training positions and seven times the Medicare funding graduate medical education.”

“The numbers give a glimpse into the ‘imbalance’ in how Medicare distributes its $10 billion a year for graduate medical education (GME), according to a study by George Washington University researchers published Monday in Health Affairs.”

“New York state received 20 percent of all Medicare’s graduate medical education funding while 29 states, including places struggling with a severe shortage of physicians, got less than 1 percent, the study said. Other states at the top of the heap are Massachusetts, Rhode Island, Pennsylvania, Michigan and Connecticut, the study found. Each of these states gets more than $71 in funding per each resident compared to $14 for Florida and $11.50 for Texas. At the bottom is Montana, getting $1.94 per resident.”

“The distribution is important because while some medical residents move elsewhere after training, most practice near where they train. Doctors enter medical residency typically for three or more years after they graduate from medical school.”

“‘Such imbalances play out across the country and can affect access to health care,’ said lead author Fitzhugh Mullan, a professor of medicine and health policy at GW.”

“New York received $2 billion in federal GME funding, according to the study. At the same time, the study found Florida received one tenth the GME funding ($268 million) and Mississippi, the state with the lowest ratio of doctors to patients in the country, received just $22 million in these federal payments.”
Physician Workforce Strategy: Waste Less

From “Expanding Primary Care Capacity by Reducing Waste and Improving the Efficiency of Care,” by Scott A. Shipman and Christine A. Sinsky in Health Affairs, November, 2013:

“Most solutions proposed for the looming shortage of primary care physicians entail strategies that fall into one of three categories: train more, lose fewer, or find someone else. A fourth strategy deserves more attention: waste less.”

“A robust primary care workforce is essential to a high-value health care system, and efforts to ensure a sufficient supply of primary care physicians are needed. However, there is a great deal of untapped capacity available in the current primary care workforce. The solution is not to ask hardworking physicians to do more but rather to support them with infrastructure, systems, and staff to enable them to achieve greater efficiency.”

“A major barrier to incorporating innovations is the requirement of up-front investments. Training staff in new and expanded roles requires an investment of time on the part of both trainees and trainers. Buying printers for every exam room requires an outlay without an immediate return on investment. Studying clinic workflow requires dedicated time outside of clinical service. As one physician said, ‘The hardest thing in the beginning is that you first have to take time out to figure out the problem and that takes away from provider time.’ ”

“Yet through this process of discovery, important opportunities to increase efficiency can be identified and targeted. The clinics we have visited show that these efforts yield efficiencies that can improve physician satisfaction, reduce evening and weekend work hours, reduce staff overtime, expand the comprehensiveness of services delivered, and make it possible for more patients to receive care.”

“It may be a challenge to convince some physicians, administrators, and policy makers that non-clinicians can perform many of the day-to-day elements of care as well as or better than a physician, at lower cost. However, the notion that the physician should be directly in charge of every aspect of care is becoming increasingly outdated. Bundled payment, accountable care organizations, and other emerging reimbursement models that incentivize efficient care may catalyze necessary change among practices and providers.”

“The result is that only the physician can turn on the computer, reconcile a patient’s medications, record his or her history, enter orders for tests, compose the after-visit summary, and complete the billing—with all tasks that reduce the physician’s capacity to perform higher value work.”

Support NRHA Rural Leadership Development

The National Rural Health Association has launched a permanent endowment for programs that identify emerging leaders from and for rural communities. The mission is to provide training and resources to help them play a lead role in ensuring access to quality health care for rural Americans.

Go to http://ow.ly/ejmlS to learn more.
“More value can be extracted from the existing physician workforce by empowering other personnel, reengineering work flows, exploiting technology, and updating policies to eliminate waste and leverage the skills of the physician. A medical education is a terrible thing to waste: The unique skills of the physician should be put to use not just a fraction of the time, but the majority of the time.”

“Altogether, there is great potential in primary care to increase physician capacity through enhanced efficiency without relying on more physicians as the chief solution to workforce shortages. Whether that increased capacity would lead to larger panel sizes, improved access for patients (either reduced wait times, improved continuity of care, or both), higher-quality care, or more comprehensive care would depend upon many local factors—including the needs of the population, the predominant payment models, and the goals of the physician.”

“Ideally, the increased capacity would be spread out across each of these desirable outcomes, resulting in primary care providers who served more patients, better met their patients’ needs, earned more, went home earlier, did less work at home, and were thereby motivated to stay in practice longer.”

**Handbook for Rural Health Care Ethics**


“The *Handbook for Rural Health Care Ethics* uses a case-based approach to analyzing, solving and anticipating health care ethics dilemmas. The Handbook is authored by physicians, nurses, health-care ethicists, and hospital administrators who all had scholarship or expertise in rural ethics, and was funded by a grant from the National Institutes of Health (NIH) National Library of Medicine.”

“The *Handbook* recognizes the unique nature of rural health care and the need for a thoughtful, practical discussion of rural health care ethics. Very little recognition has been given to the important and complicated ethics conflicts that occur within rural health care, often as a result of rural health care disparities. The idyllic view of the country doctor seldom includes the high level of stress, long hours, and struggle to maintain patient confidentiality and personal space that rural health care providers typically face.”

“This resource is designed to be useful for clinicians and administrators of rural health care facilities. The *Handbook* draws on the available research and real-life examples to paint a picture of challenging, yet all-too-familiar ethics conflicts. The professionally diverse group of authors is strongly committed to ensuring high quality and ethically sound health care to every Wisconsin. Projections indicate there is a pending nursing workforce crisis with the shortage of Registered Nurses (RNs) growing to nearly 20,000 nurses in Wisconsin by 2035. Simultaneously, there is a need to increase the educational preparation of nurses to meet evolving healthcare needs.”

**WI RN Shortage Forecast to Grow to 20,000**

“The Wisconsin Nursing Workforce: Status and Recommendations” from the Wisconsin Center for Nursing is available at [www.wicenterfornursing.org](http://www.wicenterfornursing.org).

“The nursing workforce is integrally related to the delivery of healthcare and, as a professional group, nurses are a critical asset and economic driver for Wisconsin. As the largest professional healthcare workforce in the state, the supply of nurses directly impacts the availability of most healthcare services and the health outcomes for Wisconsin. Projections indicate there is a pending nursing workforce crisis with the shortage of Registered Nurses (RNs) growing to nearly 20,000 nurses in Wisconsin by 2035. Simultaneously, there is a need to increase the educational preparation of nurses to meet evolving healthcare needs.”
rural patient. Because every author has worked or is working and living in rural America, each brings a rich and unique perspective to their writing. The case-based *Handbook* provides an important framework for managing all-too-common challenges.”

“The authors hope that rural clinicians and administrators from across the United States are able to take the concepts and suggestions presented here and apply them to better overall patient care and clinician, administrator, and community satisfaction.”

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**One Size Doesn’t Fit All**

From “Black River Memorial Uses Flexible Approach” by Rachel Landen, *Modern Healthcare*, 10/25:

“At Black River Memorial Hospital in Black River Falls, Wis., creating a positive working environment is about recognizing that one size does not fit all. That philosophy has helped Black River land in the No. 6 place overall in *Modern Healthcare*’s rankings of the 100 Best Places to Work in Healthcare for 2013 and No. 4 in the medium-size employer category, those with 100 to 999 staffers.”

“According to Holly Winn, vice president of human resources and ancillary services, hospital leadership puts a lot of effort into getting feedback from staff and then tailoring employee benefits and initiatives to fit their specific needs and wants. ‘You want to find one shoe that fits everyone, but we recognize that it's not appropriate in every situation,’ Winn says.’

“That's where flexibility comes in, particularly in scheduling. Employees are afforded the opportunity to adjust their hours to better meet their outside obligations, perhaps arriving and leaving early in order to adapt to their children's schedules.”

“‘If I need to leave work to take care of my family as a working mom, that has never ever been a problem,’ says Amy Yaeger, marketing and business development manager. Or for the employee who wants to start work 30 minutes later to attend an exercise class, that's acceptable, too. In fact, it's encouraged.”

“Fitness and dietary support are two of the areas where Black River offers incentives to employees. The hospital provides employees with a personal trainer and a dietitian and will help pay for weight-management programs or gym memberships. There's even a gym on-site that employees can access on their breaks. What started out as just a treadmill has now turned into a fitness room with an elliptical machine, rowing machine, weights, a television and even a refrigerator with free bottled water.”

“Of course, use of the fitness center is not required, and neither is participating in a health-risk assessment. But for employees who do agree to the risk assessment, they're given extra ‘cafeteria dollars’ that they can use to offset the cost of their insurance plan, buy additional benefits, invest in their retirement plans or withdraw as cash.”

“Communicating with employees is also critical, Winn says. Whenever new hires start at the hospital, management hosts a breakfast on the first day of employment so that both sides can share information about themselves and get to know one another. Ninety days later (as well as six months and a year into new employment), managers host another breakfast to solicit feedback on how the organization is living up to expectations. Senior leaders also invite employees to lunch after each five-year period on staff to get their input on what the hospital can do better.”

“‘We get so much positive feedback,’ Winn says, ‘and they tell us how they never met leaders at other places.’”

“At Black River, that approach—communication and engagement—is hardwired into the culture. Managers set goals with employees annually, compile and respond to suggestions on a quarterly basis, go on rounds with staff monthly, and then recognize workers as often as weekly for their successes. That could mean recognizing the laundry department for processing a large volume of laundry, or it could be thanking the nurse who fostered a patient's dog until the patient went home. Whatever the story, individuals and departments are frequently recognized by their peers, managers and senior leaders through Black River’s traveling trophies, newsletters, gift cards and thank-you notes.”
“I have never received a thank-you note at home in the mail from the head of anything until I came to Black River,’ Yaeger says. ‘I got a card before I started to say we are so happy to have you on the team.’

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Collaboration to Reduce Binge Drinking

RWHC is very pleased to announce that the Healthier Wisconsin Partnership Program (HWPP) at the Medical College of Wisconsin (MCW) has funded “A Collaborative Response to Reduce Binge Drinking in Rural Wisconsin Communities.”

“Alcohol-related deaths are the fourth leading cause of death in Wisconsin behind heart disease, cancer, and stroke. Wisconsin tops the nation in harm and death associated with its drinking culture. We find ourselves in a culture that in some ways is tolerant of excessive, dangerous, unhealthy, and illegal drinking, associated with a host of societal problems such as homelessness, child abuse, crime, unemployment, injury, health problems, hospitalization, suicide, fetal abnormalities and early death.”

“According to the Centers for Disease Control and Prevention’s Behavioral Risk Factor Surveillance System data for 2008, Wisconsin ranked first in the rate of adult drinkers, second in the rate of adult heavy drinkers (60 or more drinks per month) and first in the rate of adult binge drinking (5 or more drinks on an occasion). In 2008, Wisconsin adults reported the highest rates of binge drinking (23%), current alcohol use (67%), and heavy drinking (8%) in the country. Annual per capita consumption was also among the highest in the nation (3.0 gallons per person in 2007). On par with Wisconsin’s binge drinking rate, the combined average rate of binge drinking is 23% in the four target communities for this project (Boscobel, Friendship, Monroe, and Platteville).”

“Armed with these facts, the overall goal of this project is to reduce the prevalence of binge drinking in rural Wisconsin communities. RWHC and its participating member hospitals and clinics, along with MCW partners, will develop, deliver and evaluate three key programmatic features to achieve this goal:

- A curriculum to inform and educate primary care providers on AUDIT and monitor adoption of AUDIT in their local communities.
- Hospital-initiated community advisory teams to help assess and coordinate all binge-drinking related efforts and tools (including the AUDIT), composed by a broad set of individuals (e.g., public health, local employers via wellness civic organizations, churches).”
- A tele-health program that would allow trained health educators to meet with individuals with positive screens when there is not an educator on site.”

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RWHC ICD 10 Training Opportunities

For an in-depth training and educational ICD-10 experience, choose RWHC for your optimal learning environment.

We provide expert trainers and a face-to-face approach—all integral parts of a comprehensive learning atmosphere. Our ICD-10 education includes comprehensive self-paced pre-course work to augment awareness and understanding prior to classroom instruction. The face-to-face session allow students to interact with instructors as well as fellow students, and a post-test will provide proficiency and competency awareness for management and individual ICD-10 certification process. Limited classroom size ensures your staff will obtain suitable attention and the level of instruction needed to prepare your team for accurate ICD-10 code assignment.

By starting your ICD-10 education now, your coding team will be able to conduct actual hands-on coding. Dual coding is important, for it will allow coders to gain confidence as well as speed in ICD-10. In addition, your staff will be able to recognize the nuances unique to ICD-10, and identify data elements not yet present in your documentation. This approach will maximize confidence and efficiencies to account for coding productivity, as well as identify physician educational/documentation opportunities. An organized and steady education approach will allow your staff to
apply learned concepts and provide necessary training in time for the October 2014 deadline.

CM (diagnosis) education will be conducted on February 16th and 17th and PCS (Inpatient procedure) education will be conducted on February 23rd, and 24th. Because students need to complete pre-course work exercises/tests, and fees include all ICD-10 code books and manuals, the registration deadline for the February session is January 24th, 2014.

For more info, email RWHC Coding Consultant Sheila Goethel, RHIT, CCS, CDIP, sgoethel@rwhc.com or call (608) 643-2343. Thanks.

Leadership Insights: “Great Expectations”

The following is from the current issue of RWHC’s Leadership Insights newsletter by Jo Anne Preston, RWHC Organizational Development Manager. Back issues are available at: www.RWHC.com.

“More than just a classic Dickens novel, Great Expectations are part of everyday life. On a conscious or unconscious level, most of us ask ourselves these questions every day:

- What do I expect of myself today?
- What do I expect of others?
- What difference or impact will it make if I do-or don’t-meet my own or others’ expectations of me?
- How will I communicate my expectations?
- Is what I am expecting fair?”

“Here are some ‘Great Expectations’ thoughts and tips for leaders to consider.”

Optimistic expectations alone won’t cut it. “Let’s say for a moment that the website for the new Affordable Care Act health insurance exchange is acting like any new huge website, and delays and problems were to be expected. Statements such as, ‘Here is what we can expect in a worst case scenario and how we will address it if it happens,’ could have been helpful in preventing some of the frustration. Some studies do indicate that optimists have the edge when it comes to longevity and physical and mental health, but when optimism blocks awareness of realistic downsides, plans can backfire. Believe in people, and pre-empt uproar by acknowledging what could go wrong and sharing your plan for addressing it if expectations are not met.”

Don’t expect anything and you won’t be disappointed. “How sad. This phrase makes me want to pull the covers back over my head and not even try. Obviously borne from having been disappointed so many times that one fears another disappointment will do them in, it is not very motivating. Maybe the lesson from it is that even if it is hard, we have to ‘manage’ our expectations much like we have to manage our anger in a conflict, or manage our fear when speaking in public. Try this reframe: ‘I’ll expect the best from myself and know that whatever the outcome, I will have met my own expectations.’”

From those to whom much is given, much is expected. “Unlike the last quote, this message gets me out of bed. It’s the heart of the phrase Servant Leadership coined by Robert Greenleaf, the foundation of which is that leaders expect that they will serve others vs. expecting others to serve them. Ask yourself: What are my gifts and talents? Who could benefit from them? How can I share them to meet others’ needs? What am I grateful for that I now can push myself to ‘pay forward’?

They should have known what I expected! “Maybe they should have, but they didn’t. Perhaps I neglected to tell them that I expected it. Perhaps I assumed they were in sync with what was in my head (it was so clear to me after all). Perhaps I did tell them, and made the assumption that they understood-two very different things. If you are disappointed in someone because they ought to have known, it may be that you need to be clearer in expressing your expectation. If your inner thought is, ‘I shouldn’t have to tell them’ that is a good marker for when you probably need to. This is especially true if you hope that your own behavioral example is enough to demonstrate what is.
expected of others. Sometimes it is enough, but not always. Examine your expectations of others, even what might seem obvious, by writing down a list. Share that list as a starting point for a two-way dialogue where the intention is to understand mutual expectations.”

Suspend your expectation biases. “One common bias in the workplace is that young professionals should act like we did when we entered the workforce. However, one of the qualities of managers successful with Gen Y is the ability to set aside where you EXPECT them to be (like you at their age) and to consider where they actually ARE in their development (which because of different parenting and societal norms can sometimes result in a different maturational place at which they are entering the workforce). **Tip:** Develop the patience to meet them where they are at instead of where you think they should be. The relationship you develop with them will be the foundation for setting-and meeting-expectations going forward.”

“One thing is clear: everyone has a different opinion about whether or not one should even acknowledge expectations. Sounds like we wrestle with them one way or another; **how can you make expectations work for you?**”

Contact Jo Anne Preston for individual or group coaching at jpreston@RWHC.com or 608-644-3261. For Info re the RWHC Leadership Series 2013 go to www.RWHC.com and click on “Services” or contact RWHC Education Coordinator Carrie Ballweg at cballweg@RWHC.com or 608-643-2343.”

Upcoming RWHC Leadership Programs

December 5: Manage Stress Before It Manages You
January 9: Walk the Talk: Leadership Accountability
January 22: Peer Today, Boss Tomorrow

Go to www.rwhc.com/Services.aspx to register as well as to see the schedule for 2014.

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