

Review & Commentary on Health Policy Issues for a Rural Perspective – March 1st, 2012

Rural Health's Path to Higher Performance?

From the introduction of “Pursuing High Performance in Rural Health Care” by Clint MacKinney and Keith Mueller, RUPRI Rural Futures Lab Foundation, Paper No. 4, 2012. See <http://ruralfutureslab.org/> for the full report.

“Rural Futures Lab Foundation Papers are intended to present current thinking on the economic drivers and opportunities that will shape the future of rural America. They provide the foundation upon which it will be possible to answer the question that drives the Lab’s work—What has to happen today in order to achieve positive rural outcomes tomorrow?”

“In 2001, the Institute of Medicine (IOM) called for transformation of the United States health care system to make it safe, effective, patient-centered, timely, efficient, and equitable. The journey toward these six aims in public policy and the private sector is underway, but fundamental challenges detailed by the IOM remain. Patients are injured at alarming rates, wide variation in care exists across geographies, patients complain of insensitive and/or inaccessible health care providers, health care costs are nearly twice that in other developed countries, and nearly 50 million Americans lack health insurance. As a result, our health care is often fragmented, uncoordinated, and excessively costly. In fact, the United States health care system has

been called a ‘non-system.’ The rural health care landscape is additionally challenged by independent and autonomous providers often struggling to survive financially, burdensome geographic separations in health care services, and incompatible information technologies. As a result, resources are wasted, patients are harmed, and rural communities are neglected.”

RWHC Eye On Health



“I knew I was going to take the wrong train, so I left early.” (Yogi Berra)

“Despite persistent rural challenges, public policies during the past 30 years have helped build and stabilize rural health care services. New payments have increased revenue for physicians practicing in shortage areas, rural hospitals certified as Critical Access Hospitals (very small hospitals in isolated places), Sole Community Hospitals (larger hospitals also in isolated areas), and Rural Health Clinics (primary care clinics staffed by nurse practitioners and/or physician assistants). New programs continue to provide technical assistance and grants to rural hospitals (Medicare Rural Hospital Flexibility Program), fund installation of tele-

medicine equipment, and promote rural health professions education.”

“These successes have required political capital and developmental resources to support a system that delivers discrete and uncoordinated health care services, provided by specific professionals and institutions, each paid on a per-service basis. Work by the Institute of Medicine (especially the Rural Health Committee document Quality Through Collaboration: The Future of Rural Health Care), the Commonwealth Commis-

sion on a High Performance Healthcare System, and other organizations suggest more effective strategies to improve and sustain the health of rural people.”

“Emerging public policy and private sector innovations have the potential to change the organization, financing, and delivery of rural health care services. What might appear to be threats to rural health care, such as challenges to current special payments and new administrative requirements, may instead be opportunities to update and improve outdated and unsustainable health care service configurations.”

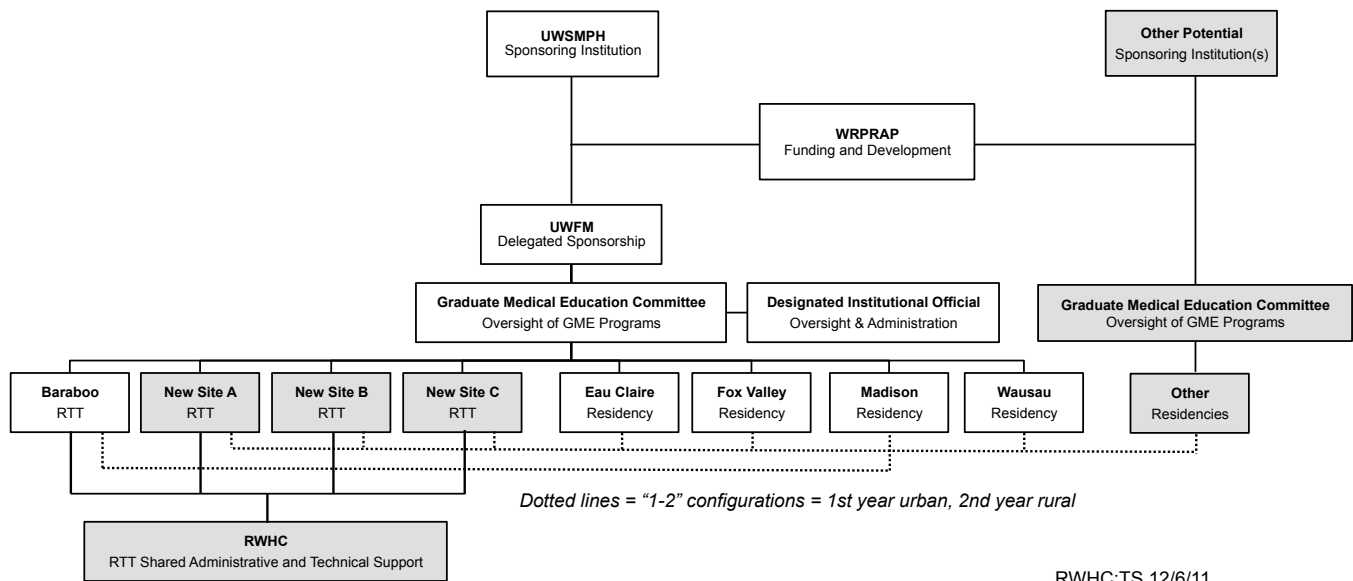
“But as Yogi Berra famously said, ‘You’ve got to be very careful if you don’t know where you’re going, because you might not get there.’ So in the spirit of getting us ‘there,’ the RUPRI Health Panel offers an aspiration, our vision, for a high performance rural health care system. ‘The RUPRI Health Panel envisions rural health care that is affordable and accessible for rural residents through a sustainable health system that delivers high quality, high value services. A high performance rural health system, informed by the needs of each unique rural community, will lead to greater community health and well-being.’ “

Collaboration to Expand Rural Doc Training

The Rural Wisconsin Health Cooperative (RWHC) has begun working with the Wisconsin Rural Physician Residency Assistance Program (WRPRAP) to develop the Wisconsin Rural Training Track Collaborative (WRTTC) in partnership with the Baraboo Rural Training Track, the University of Wisconsin School of Medicine and Public Health (UWSMPH) and several individual rural hospitals. A visual overview of potential partnerships is shown below; new entities and capacities are shown in grey. The model is intended to be fungible, allowing for additional or alternative sponsoring institutions.

A series of exploratory discussions took place in the Fall of 2011 between RWHC and UWSMPH with WRPRAP and others in pursuit of a partnership to create the WRTTC. The maldistribution of physicians in Wisconsin with disproportionate shortages in rural counties is a critical and growing problem. WRPRAP exists to help solve this problem. **Ample evidence points to the fact that several factors predict greater success in recruiting new physicians to rural**

Wisconsin Rural Training Track Collaborative *UWSMPH and/or other potential sponsoring institutions.*



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practice and to success in practicing in a small community, among them: growing up in a rural setting, a service orientation, and spending a considerable portion of the resident training in rural areas.

RWHC is a neutral party with a constituency of rural hospitals and smaller rural communities. RWHC pursues many health-related initiatives. It would like to partner with the UWS-MPH to create more rural residency experiences in South West Wisconsin. Interest among other facilities and programs to create such a collaborative has been established. **The intent would be to take advantage of efficiencies of scale and relieve Baraboo and other to-be-developed local programs of some of the administrative burden of achieving and maintaining accreditation compliance that resident training requires.**

This need for this approach was reinforced by a recent report from the Wisconsin Hospital Association (WHA). At its January 2010 meeting, the WHA Board of Directors created a five person workgroup (including Sandy Anderson from St Clare Hospital in Baraboo and Tim Size from RWHC) and charged it with studying Wisconsin's future physician workforce, to determine whether the projected numbers of physicians would adequately meet the needs of Wisconsin residents, and to identify areas that would need to be addressed together with potential options. The resulting report "100 New Physicians a Year: An Imperative for Wisconsin" was released in November of 2011.

The Report named "The Need to Expand Wisconsin Graduate Medical Education" as its top priority. "When graduates of a Wisconsin medical school also have their residencies in a Wisconsin program, there is a 70 percent chance that they will practice in Wisconsin. Given the impact that the combination of these two factors appears to have on physician retention for Wisconsin, both medical schools should identify and implement programs that enhance communication between their undergraduate and residency programs and

RWHC Seeks Rural Training Track Development & Support Manager

The Rural Wisconsin Health Cooperative in Sauk City, Wisconsin (30 minutes north of Madison) seeks a Rural Training Track Development & Support Manager. This position will be responsible for the development and support of the Wisconsin Rural Training Track Collaborative under a cooperative agreement with the Wisconsin Rural Physician Residency Assistance Program at the University of Wisconsin-Madison. Applicants who are a current or former Designated Institutional Official or Education Coordinator for a Family Practice Residency Program are preferred. The position description is online at www.rwhc.com Resumes should be sent to Monica Seiler at mseiler@rwhc.com.

residency programs should better inform undergraduate medical students about the benefits of their programs." Dean Robert Golden was reported in the *Wisconsin State Journal* as saying that "the medical school would further expand if more residency positions and clinical training sites for third- and fourth-year students were available."

The Baraboo Rural Program, established in 1996, is a one-two program affiliated with the University of Wisconsin-Madison Family Medicine Residency Program. Two residents per year for a total of six residents are now accepted into the Baraboo program. "Their program offers strong unparalleled training in maternity care and medical/surgical procedures. Residents experience total continuity of care, following patients from office to hospital to nursing home and back to the community. Their flexible curriculum emphasizes a positive teaching methodology, gradually increasing responsibility, and lifelong learning. The Baraboo training experience is rural medicine." More information is available at:

<http://www.fammed.wisc.edu/residency/baraboo>

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 to partner with others to make their communities healthier... generates additional revenue by services to non-Members... actively uses strategic alliances in pursuit of its Vision.

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Website: www.RWHC.com  : RWHC  : RWHC
Blogs: www.ruraladvocate.org/ www.worh.org/hit/

Email office@rwhc.com with *subscribe* on the subject line for a free e-subscription.

Baraboo residents spend the first year doing traditional first year rotations in Madison with the 42 Madison-program based residents. First year Baraboo residents drive to Baraboo one day per week to begin their outpatient practice at Baraboo Medical Associates. During the second and third years, residents move to Baraboo and spend most of their time in Baraboo in an apprenticeship rural practice with opportunities for specialty rotations in Baraboo and Madison. They are excused from all practice duties on Wednesday mornings and have the option of traveling to Madison for weekly Wednesday morning educational conferences or they can use the telecom system that functions in Baraboo to participate in these required conferences.



RURAL HEALTH CAREERS
WISCONSIN

RWHC has a long and productive history of working with the UWSMPH, starting with the incorporation of RWHC in 1979 subsequent to an outreach initiative from Tim Size, who was then an Associate Superintendent at University of Wisconsin Hospital and Clinics. RWHC has grown into a member-owned network of 34 rural and community hospitals with eight affiliates (urban hospitals and integrated networks) and four strategic partners (the Wisconsin Hospital Association, Wisconsin Medical Society, Wisconsin Office of Rural Health, and Wisconsin Primary Health Care Association.) RWHC is considered to be one of the earliest and most successful models for collaboration among rural health providers in the country. RWHC provides a wide range of programs and services to members and non-members alike, including: advocacy, education, professional roundtables, financial consulting, legal services, coding consultation, quality programs, workforce development, health information technology resources, and various clinical services. See www.RWHC.com for more information.

Hospitalists No Longer a Rural Rarity

From: "The Use of Hospitalists in Small Rural Hospitals" by Michelle Casey, MS, Deputy Director, Rural Health Research Center and Ira Moscovice, PhD, Mayo Professor and Director, Upper Midwest Rural Health Research Center in a *Minnesota MHA e-*

Briefing, 2/16/12. The complete briefing is available at:

<http://www.sph.umn.edu/>

"The use of hospitalists who assume responsibilities for patient care during inpatient hospital stays is a relatively new phenomenon. Hospitalist programs were initially established in the mid-1990s in markets with high rates of managed care enrollment and large urban teaching hospitals, and most research has focused on the implementation and outcomes of hospitalist programs in teaching hospitals and other large urban hospitals. The use of hospitalists has spread to smaller rural hospitals, but studies in the peer-reviewed literature have not examined their use in these settings."

Key Findings

- "Hospitalist use by Critical Access Hospitals (CAHs) and other rural hospitals has increased over time. In 2009, 14% of CAHs and 41% of other rural hospitals reported using hospitalists, compared to 61% of urban hospitals."
- "Medical staff requests are the most common reason why rural hospitals use hospitalists. Other primary reasons include covering call and reducing the workload for medical staff; quality of care; allowing physicians to focus on their clinical practices; and recruitment and retention of physicians."
- "Thirty-five percent of CAHs and 40% of other rural hospitals employ their hospitalists. About one-third of CAHs and other rural hospitals contract with a hospitalist physician group."
- "Hospitalists care for the majority of inpatients in rural hospitals that use them. They are most likely to care for adult medical and surgical patients."
- "Survey respondents report strong positive impacts of hospitalist use on quality, recruitment and retention, and patient and physician satisfaction. The financial impacts of hospitalist use are more mixed."

Leader of Network of Networks

From “An Interview with Rebecca Davis” in the Winter 2012 issue of the Rural Assistance Center’s *Rural Monitor*, at www.raconline.org/newsletter/:

Rebecca Davis is the Executive Director of the National Cooperative of Health Networks Association (NCHN), a role she has served since July 2006. NCHN is the only national level professional membership organization dedicated to supporting and strengthening health networks across the country. She is also the manager of Rural Health Network Resources, LLC, a for-profit company, wholly owned by NCHN.

“What is a rural health network (RHN)?—RHNs may also be referred to as collaboratives, consortia, partnerships, and alliances. The definition approved by our Board of Directors last year states that a RHN ‘is a collaboration of at least three like-minded entities that join together to improve health outcomes for rural communities’... that ‘advance a common mission.’ We believe that, by working together as a network organization, they are able to obtain a greater collective value.”

“I feel that the work of health networks across the nation is some of the most important work being done in health care delivery. The network leader and the network is the structure behind a large number of programs and services provided to patients that most people never know about! Rural health networks provide the opportunity for independent organizations to combine efforts and funding to provide more services, increase efficiency, improve quality, share information, and increase recruitment of health professionals. Networks are positioned to overcome many of the barriers to health access that are common in rural areas.”

“Are there different types of health networks?—How many networks are in NCHN?—Each

network is unique, but all networks have some core likeness. There are two broad categories: horizontal networks and integrated vertical networks. Put simply, a horizontal network is comprised of one type of provider and an integrated vertical network is comprised of different types of providers. Networks can be formed for behavioral/mental health, chronic disease prevention, EMS, quality improvement, workforce, group purchasing, etc. NCHN’s members represent regional and statewide networks, while some actually reach across state lines. We currently have approximately 60 network organizations as members. The networks consist of as few as three members, to more than 50. Some have been in existence for over 30 years and some are just forming.”

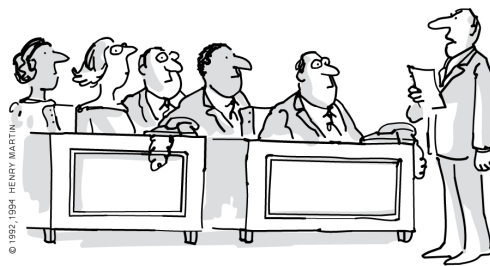
Success Requires Work Built on Trust

The following book review of *The Speed of Trust* by Stephen M.R. Covey is by Dwayne Gandy at www.power-train.net (Stephen M.R. Covey is the son of Dr. Stephen Covey, the author of *The Seven Habits of Highly Effective People*):

“In the book *The Speed of Trust: The One Thing That Changes Everything*, Covey concludes that trust is the one thing that can build or destroy every human relationship. The lack of trust will bring down the most powerful countries, bankrupt the most profitable companies, and destroy the happiest of marriages. However, trust is the least studied and least understood element of business success.”

“Covey builds the business case for trust. He shares a trust formula. He states ‘When trust goes up, speed will also go up and cost will go down.’ The inverse is also true. ‘When trust goes down, speed will go down and costs will go up.’ He uses the example of air travel. After 9/11 trust went down, speed also went down and cost went up.”

RWHC Eye On Health



“Accounting wants to know who ordered in an anchovy pizza on the 11th and why?”

“The ability to build trust with customers, bosses, co-workers and subordinates is essential to business success. The ability to build trust with your spouse, children and friends is essential to personal success.”

“The good news is that trust can be built. The better news is that trust can be rebuilt faster than most of us think. Trust is built on two things: competence and character.”

“Covey breaks trust down into five waves: (1) Self trust, (2) Relationship trust, (3) Organizational trust, (4) Market trust, (5) Societal trust.”

Leadership: Friends & Relationships

The following is from the January issue of RWHC's *Leadership Insights* newsletter by Jo Anne Preston. Back issues are available at:

www.RWHC.com/News/RWHCLeadershipNewsletter.aspx

“I love Marcus Buckingham's statement, ‘If you don't care about people, get out of management.’ But is building ‘friendship’ the same as building a caring ‘relationship’? Like many things, there are plusses and minuses when it comes to friendships at work. **For a manager**, the downside of being friends with the people who report to you means you might get accused of playing favorites (which may—or may not—be true). People may claim you are unfair, or that their confidential information risks being shared with the friend, affecting trust in your team. Boundaries can start to blur and make giving difficult feedback even harder than it already is if your friend has a job performance issue. A parting of ways can leave you feeling vulnerable.”

“The Gallup organization in its workplace engagement research of thousands of working adults shows that the **plus side of friendship at work outweighs the risks**. When employees

have a best friend at work they are more committed, safe, productive and likely to stay.”

“In fact, in his book *Vital Friends*, Tom Rath says that ‘employees who have a close friendship with their manager are more than 2.5 X more likely to be satisfied with their job.’ He proposes that all of our friends play different ‘vital’ roles in our lives. Two friend roles, the **Companion** (the one who is there for you at all times), or **Collaborator** (with whom you share common interests) might have the most potential to result in the downside of friendships between managers and employees. It requires diligence and consistency to prevent misunderstandings and anxiety with the rest of your team. And it takes the long view of leadership because trust will build over time when you consistently show fairness and keep confidences. But if you can expand your view of ‘friendship’ to be able to match what your employees need from you, **everybody** wins.”

“So *what kind of friend can you be* to your employees? Some of the friendship roles from *Vital Friends* are listed here, with tips on how to be that role in employees' lives:

Builder—Like it sounds, build people up. Notice and point out the best in your people. Nudge them to do more than they think they can.

Champion—Manage your employees ‘up.’ Tell others of their accomplishments. Use your influence to open doors for them. Help them see where new skills can take them.

Connector—Let employees know you want them to use you as a resource to connect them to networks and others who can help them, then put them in touch. Introduce your employees to others who might be able to give them a leg up.

Energizer—Make people laugh. Brighten their day with your mood. Be the person that lights up a room when you walk into it. Encourage fun and laughter.

RWHC Eye On Health



“Relax Driscoll, I just needed a break from the office Kumbaya sing-a-long.”

Mind Opener—Ask meaningful, thought provoking questions that challenge conventional thinking. Invite employees to educational opportunities that help them see a different view.

Navigator—Help struggling employees see the big picture. Be a sounding board. Encourage critical thinking skills. Share a little about challenges you have overcome. Help them re-focus to being successful at work if they do share personal struggles.”

“Sound like any of the friends in your life? Maybe your own manager? They are all good coaching tips, which use the *power of the relationship* in different types of friendship for the employees’ success.”

Contact Jo Anne Preston for individual or group coaching at jpreston@rwhc.com or 608-644-3261. For Info re the RWHC Leadership Series 2011-2012 go to www.rwhc.com and click on “Services” or contact RWHC Education Coordinator Carrie Ballweg at cballweg@rwhc.com or 608-643-2343.

Community Needs Assessment Resource

The following is from <http://ruralhealthworks.org/>:

“The National Center for Rural Health Works has become the national focal point for analysis of the economic impact that selected health policies have on rural America. The Center will continue to provide training to our State partners and to develop the community health engagement process and health service profitability studies.”

“The Center has provides community health needs assessment for many years. The ‘OLD’ process is the Community Health Engagement Process (CHEP) and is still a very viable assessment tool. With the passing of the ‘2010 Affordable Care Act,’ all 501(c)(3) hospitals (not-for-profit or non-profit hospitals) must conduct a community health needs assessment process to meet the U.S. Department of Treasury and Internal Revenue Service (IRS) rules.”

“The ‘NEW’ process is a more streamlined process, referred to as the Community Health Needs Assessment (CHNA) template. The CHNA template was developed over the last year by the National Center. The CHNA template is illustrated below in detail. The CHNA template will enable hospitals to conduct the process themselves or allow other organizations to facilitate the process for the hospitals. The CHNA template includes the documents for each product in their original formats, i.e., Microsoft Word, Excel, and/or Powerpoint, in order for the documents to be easily utilized and replicated.”

“Either process may be utilized and can fulfill the new legislative requirements. CHEP has more detailed products, typically more meetings, and derives community input through a phone survey conducted by an outside contractor (higher costs). The CHNA template has more streamlined products, fewer meetings, and options for community input that include focus groups or surveys. The analysis of the community input method is typically performed locally to avoid high costs.”

Both templates are available online at:

<http://ruralhealthworks.org/community/>

Rural Hospital Like a Family

The Wisconsin Hospital Association (WHA) annually surveys its member hospitals and asks them to describe and quantify the programs, services and activities that they provide at or below cost, solely because those programs fulfill a health need in the community. Wisconsin hospitals typically provide over a billion dollars in community benefits; the 2011 Report is available at www.wha.org/communityBenefits.aspx Below is one of many stories from the report:

“Diabetes is a complicated disease that can slowly get worse if not managed properly. But today—diabetes isn’t slowing down Jill H. of Fennimore thanks to Grant Regional Health Center.”

“Diagnosed with diabetes over five years ago, Jill wasn’t surprised as it runs in her family. Jill’s complications turned serious when her toes became infected to the point she needed one removed. In October 2010, another infected toe refused to heal. Her regular provider Kelly Muench, physician assistant, consulted with Dr. LaMantia; Dr. Chubb, podiatrist; and Dr. Yurcek, general surgeon. ‘I felt like I had an entire team looking out for me! They tried everything to help my condition,’ explained Jill. But after being hospitalized for four days with intense antibiotic therapy, it was improving—but not enough to risk keeping the toe. It was decided that surgery would be necessary to remove the toe.”

“ ‘Dr. Yurcek and his surgical team took excellent care of me through the surgery and the Outpatient staff followed by administering IV treatments and wound vac treatments for the next four months,’ explained Jill. ‘It was so nice to come through the door and everyone knew my name. They were all so friendly.’ ”

“Jill owns and operates an in-home daycare, so being self-employed she had minimal insurance coverage. Jill was worried about the cost of the surgery and

lengthy hospital stay, so she was encouraged to apply for assistance through Grant Regional’s Community Care Program. After reviewing her financial situation, Grant Regional Health Center forgave 100 percent of the charges incurred for her surgery and hospital stay—totaling more than \$40,000.”

“ ‘Going through all this without family in the area was difficult—but the staff at Grant Regional treated me just like family. It really made all the difference in the world!’ Jill explained. ‘They cared so much—that when the nurses were concerned about possible returning infection—they called Dr. Yurcek in on Christmas Eve. He didn’t question it and came in right away. My entire experience has been incredible. My health, my career and my future are all looking bright because of Grant Regional Health Center.’ ”

\$2,500 Monato Rural Essay Prize

RWHC is seeking submissions for the **20th Annual Prize** for the best rural health paper by a University of Wisconsin student. Write on a rural health topic for a regular class and submit it by April 15th; info available at www.RWHC.com

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