

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

Rural Pharmacist: Small Hospital, Big Rewards

From “Small Hospital, Big Rewards” by Zina Gugkaeva, PharmD, Pharmacist at Memorial Health Center in Medford, WI in the *Journal Pharmacy Society of Wisconsin*, September/October, 2011:

“At 06:45 a.m. on a subzero Wisconsin winter morning, all I can think about is that nothing affects my quality of life more than the proximity of my parking space to the hospital entrance. I am a pharmacist in a small rural hospital and this is my first year in practice. I find a parking spot ten feet from the door, rush inside, and jog up the stairs to my second-floor pharmacy. On my way up, I can smell fresh brewed coffee. This day is beginning well.”

“**My ‘To Do’ List**—The first order of business in the morning is to review patients that were admitted overnight, ensure all their medications are dosed appropriately, and make adjustments as necessary. In August of this year, we introduced a proposal for automatic renal dose adjustment by pharmacist to our Pharmacy and Therapeutic Committee. This allows our pharmacists to adjust medications prior to their first morning dose without contacting physicians, which will save time and improve medication safety at the hospital.”

“Next, I conduct a kinetic review on vancomycin, carbapenems, warfarin dosing and anything else that was requested for the pharmacy to dose. At 7:45 a.m., I am

scheduled to speak at the Medical Staff meeting on the topic ‘Recent trends in antibiotic resistance in our hospital’ and outline a new strategy for empiric treatment of MRSA infections.”

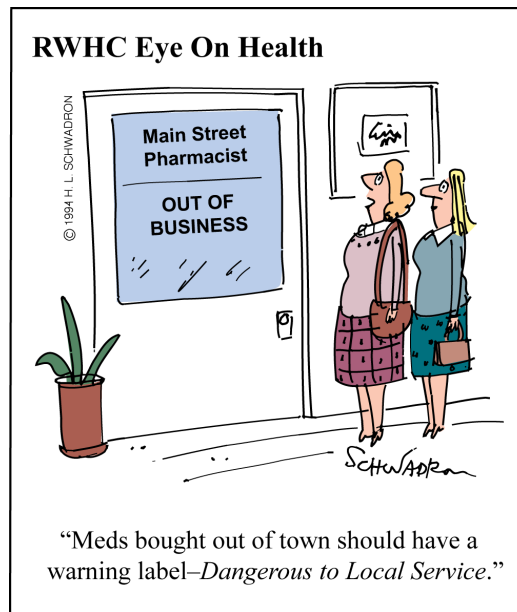
“After that presentation, I will meet with the medical team to discuss therapeutic goals for one of our patients with a chronic lower extremity wound. Based on medical assessment, culture and sensitivity report, the

patient’s kidney function, and the mountain of literature I reviewed over the past seven days preparing for this meeting, I recommend an antibiotic regimen that I predict will allow us to prevent the infection from progressing and slow resistance.”

“Rural hospitals generally do not have the luxury of having numerous specialty physicians on staff. This means that physicians in my hospital rely heavily on pharmacists’ expertise, routinely asking our opinions when choosing medications, especially antibiotics. And

we pride ourselves that we do everything possible to provide consistently strong pharmacy support. Therefore, it is all the more important that I am certain of my recommendations.”

“From 0800 to 1030 I go to rounds, then write orders for dose adjustments, order labs, and head back to the pharmacy to enter my own orders into the computer system and approve them. Somewhere in that time, I grab a second cup of coffee and review all cultures drawn since yesterday and the ones that have results and contact prescribers if any antibiotics need to be changed. Around 11:00, I receive a call from a Nurse



Practitioner in a satellite clinic about 30 miles away. She has a patient with cellulitis who failed on two different antibiotics and has a long list of allergies and contraindications. She would like a recommendation. I ask her to give me 30-40 minutes to review the patient's chart and come up with the solution for her."

"The rest of the day I spend preparing for the upcoming oncology day. Once a week we have an oncologist on staff and almost all our patients receive their chemotherapy that day. We can have anywhere between 10 and 18 patients receiving treatments in one afternoon. The 'Chemo pharmacist' for the week is responsible for dosing medications such as carboplatin and zoledronic acid. We also monitor the patient's labs, weight and call the physician to adjust doses when needed."

"A small rural hospital such as mine provides an opportunity for pharmacists to create a very positive work environment. I strongly believe that good communication between the members of the medical team is essential for success, so from day one I made sure to get to know the physicians, nurses on the floor, the nutritionist, physical therapists, etc. This helped me provide better recommendations for our patients. The response was exceptionally positive and encouraging. We have some great nurses and dedicated physicians and NPs here. I keep bragging to my friends that even our Chief of Medicine is a real practicing physician."

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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"Finishing my first year as a practicing pharmacist, I have had many sleepless nights worrying about my dosing, hoping those vancomycin troughs and INRs will come out right, and anxiously mentally reviewing my recommendations—hoping and praying new medication regimens will work for the patient. Despite the doubts that accompany a new practitioner, **I receive a great sense of satisfaction knowing that what I do really matters and is appreciated by the rest of the medical team. So for every new pharmacist who finds that kind of lifestyle attractive, I highly recommend considering a small rural hospital for future practice.**"

Rural Telestroke Needs Urban Cooperation

From "Rural Hospitals Get Good News for Stroke Care" by Bill Knight in the *Daily Review Atlas*, 12/30/11:

"For rural hospitals that don't have around-the-clock neurologists on staff, a breakthrough in two-way, audio-video telemedicine delivering stroke care appears to be cost-effective, according to research recently published in *Neurology*, the medical journal of the American Academy of Neurology."

"Having witnessed the unavoidable delays in diagnosis and treatment of a stroke when transportation to Iowa City or Peoria is required, this approach—dubbed 'telestroke'—is great news."

"Risk factors for stroke are more prevalent, and specialized stroke treatment options less available, in rural and remote areas than urban areas' according to the study. Telestroke technology operates on a model in which a specialist neurologist at a stroke-center communicates with community hospital emergency personnel via a video-conference link. During the consultation, the communications use a battery-powered, portable cart with a PC, monitor, webcam and Internet access. Computed tomography (CT) scans and other tests conducted are also shared electronically."

"Working together, the specialist and the emergency staff develop a care plan based on established stroke protocols including, if appropriate, the administration

of tPA, the clot-busting drug that can reduce death and disability from stroke. There are up-front investments involved with the initial installation of telestroke and training practitioners in its usage, researchers conceded.”



RURAL HEALTH CAREERS
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distance consultation to rural areas, increasing the expertise and quality of stroke care at rural hospitals.’ ”

This study was supported by the National Institutes of Health as well as the National Cancer Institute.

“Despite implementation barriers of installation costs, training, and reimbursement uncertainty, however, the vast majority of surveyed stroke specialists and emergency physicians think that telestroke can reduce geographical differences in stroke management and is superior to telephone consultation.”

“The infrastructure required for telestroke includes an IP/ISDN connection for videoconferencing, a high-speed Internet connection, CT or brain image transfer capability, a videoconferencing device that supports standard protocols and encryption, and a desktop computer, according to estimates from the Office of Health Systems Management. The videoconferencing device for the stroke-center typically costs about \$20,000.”

“ ‘If barriers such as low reimbursement rates and high equipment costs are improved, Majersik continued, telestroke has the potential to greatly diminish the striking disparity in stroke care for rural America.’ ”

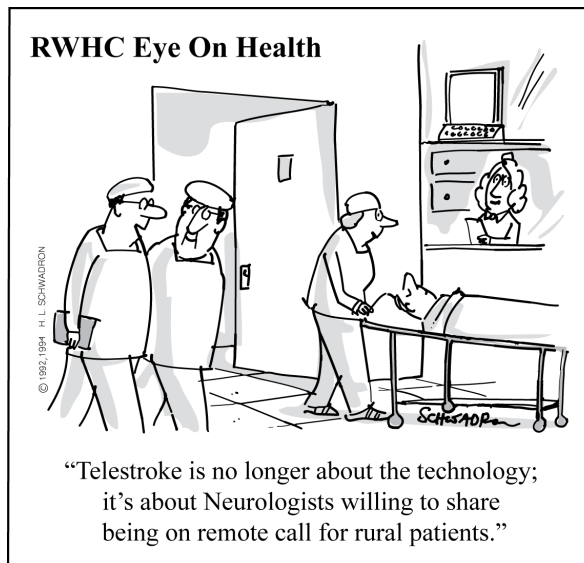
“The study found that the cost of telestroke over a patient’s lifetime was less than \$2,500 per quality-adjusted life year. The threshold of \$50,000 per quality-adjusted life year is commonly cited as the cut-off for cost-effectiveness. Telestroke also can help with increasing the low number of stroke patients in rural areas receiving tPA—medicine that must be given within the first 3 to 4.5 hours after symptoms begin, Majersik said.”

“ ‘Only two to four percent of stroke patients receive this treatment, with the lowest percentage in rural areas largely because there aren’t enough stroke experts with experience using tPA,’ she said. ‘Telestroke has the potential to lower this barrier by providing long-

Patient Directed End-of-Life Care

From “Preparing for Life’s Final Stage” by Warren Wolfe in the *Star Tribune*, 9/22/11:

“Soon after he joined the staff at Gundersen Lutheran Hospital in La Crosse, ethicist Bud Hammes concluded that too many patients were dying the wrong way.”



“Telestroke is no longer about the technology; it’s about Neurologists willing to share being on remote call for rural patients.”

“ ‘Instead of spending their final days and weeks in relative comfort, surrounded by family and friends, they were exhausted, in pain or sometimes in a drugged stupor,’ said Hammes, who holds the unusual title of director of medical humanities. ‘It was care nobody wanted,’ he added, ‘and nobody knew how to stop it—not patients, not families and not the doctors.’ ”

“Hammes then launched an experiment called Respecting Choices that has transformed

medical care at the end of life in this Wisconsin border city of 51,000. Today, 96 percent of the hospital’s patients—10 times the national average—have thought about, and written down, specific instructions for end-of-life care.”

“Now two decades old, the La Crosse program has become an international model for end-of-life medical planning and is about to debut on a much larger stage—the Twin Cities. ‘We’ve had living wills and advanced directives in various forms over the years,’ said Sue Schettle, CEO of the Twin Cities Medical Society, the professional association for local doctors, which is co-

ordinating the Minnesota campaign. ‘We’ve made progress in the past, but this feels very different—more like a community conversation.’ ”

“Working with the Citizens League, Twin Cities Public Television and several Minnesota insurers, the doctors’ group will roll out a two-year campaign of broadcasts, community meetings and other events in an effort to change the way people think about and plan for medical care in their final months.”

“On a recent day at Gundersen, Aggie Tippery, 82, changed her care preferences while working through a Respecting Choices document with a counselor. ‘You know, I’m kind of used to being in charge of myself,’ said Tippery, ‘I don’t want to give up control just because my body starts giving out—especially then.’ ”

“Conversations like that happen every day at Gundersen and its clinics in Wisconsin, Iowa and Minnesota. But they also come up in area coffee shops, law offices, churches, beauty parlors and family gatherings. ‘Really, this is as much about how we’ll live at the end of life as about the kind of care we want when we’re dying,’ said La Crosse attorney Maureen Kinney, who incorporates that discussion into her practice. ‘We don’t always talk about death around here,’ she said, ‘but it’s become more or less a normal conversation.’ ”

“**Fine-tuning care choices**—Respecting Choices works with patients in three stages: General medical decisions while they are still healthy, perhaps at middle age; updated specific choices as they develop chronic diseases; and finally a Provider Order for Life Sustaining Treatment, a formal document signed by their doctor, when it’s clear that death could come in the next year or so.”

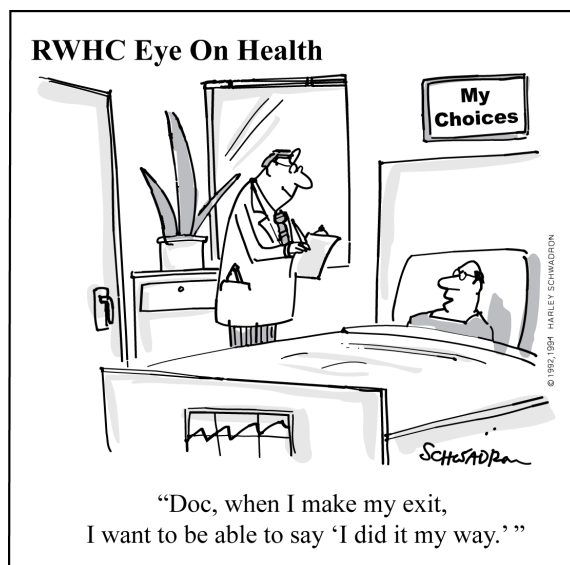
“As patients develop more complex conditions, their end-of-life care options often become more complex. Doctors, nurses and trained counselors then help patients explore the impact of various treatments—chemotherapy, CPR, antibiotics, heart surgery, dialysis

or other weapons against disease. At its heart, Hammes said, Respecting Choices ‘is a process, a series of conversations over years’ with family, health professionals and maybe a trained counselor.”

“ ‘This is not a ‘death panel’ kind of thing,’ Hammes said, referring to fears that such conversations are designed to hasten death of expensive patients. ‘You may want less invasive care at the end of life. Many people do,’ he said. ‘But some want to get everything that might help—for religious, or family or other reasons. And that’s fine.’ ”

“ ‘**This feels very different**’—Already, 16 Twin Cities area hospitals and clinics have begun pilot programs to use the tool, called Honoring Choices Minnesota. With some room for local variation, the new program follows Gundersen’s protocols. That includes making sure that the patient’s Honoring Choices documents are entered in their electronic health records so that they can be consulted instantaneously—which can be critical in emergency situations.”

“Like the La Crosse program, Honoring Choices goes beyond simply filling out a form. It focuses on choosing an advocate to speak for the patient if necessary, and fine-tuning end-of-life decisions as the patient’s health changes.”



“Allina Hospitals and Clinics was the first to start an Honoring Choices pilot program in 2008. Now it has been implemented system-wide. One result: About 38 percent of Allina hospital patients older than 65 have an end-of-life document on record, more than double the figure in 2007.”

“ ‘Families and patients say they’re highly satisfied with the experience, even though some said they first thought talking about death would be too sad,’

said Sandra Schellinger, a nurse practitioner who helped implement the program at Allina. ‘The topic can seem daunting,’ she added. ‘But the results typically bring great satisfaction—and better care at the end of life.’ ”

DVD Injury Prevention for Rural Athletes

“On Monday evening, Philip Friest, 82, spent two hours with an Allina counselor and his two children at his Burnsville apartment creating a new advanced care directive to replace the one he did years ago in his attorney’s office. ‘I feel better,’ said the retired accounting professor from the University of Minnesota-Duluth. ‘We talked about things we’ve never talked about before—medical decisions, but really quality of life decisions. I trust my kids to do the right thing, but now they know what I think the right thing is.’”

“**Consultation, and surprise**—Aggie Tippetery was certain she knew what choices she would want for end-of-life care. It was an exercise she’d been through before—first with her husband, who died two years ago, then filling out her own advance directive. But with her health growing more fragile, it was time to enter the second phase of planning for the care she may want at the end of life.”

“With her son, Jim, beside her, Tippetery sat down one afternoon in a Gundersen conference room with counselor Rita Erlandson. The result surprised her. She was clear on most of her choices: No CPR. No dialysis. A nursing home if necessary. And at first, she was ready to have doctors use machines to keep her going even if she no longer could communicate with people. ‘Wait! Is that what they call brain dead?’ she asked. ‘Oh, no. I guess I hadn’t worked that one out yet. If my brain is already checking out, let my body check out, too.’”

“Doctors, too, have noticed changes. ‘We’re trained to fight to the death over a patient’s disease, and sometimes that’s not what the patient wants,’ said Dr. Ben Waldro, who was just coming off the night shift at Gundersen’s emergency center. ‘When the ambulance comes screaming up here after your heart attack or stroke or accident, I absolutely want to know your instructions for me. Nine times out of 10, I can punch that up on the computer immediately,’ he said. ‘That makes me a better doc.’”

“The Rev. Mark Jolivette has seen a change in the way many of his parishioners at Our Savior’s Lutheran Church in La Crosse are prepared for dying. ‘Talking about death and dying is not easy for most people, but it’s important,’ he said. ‘Talking and planning can help dispel the demons we sometimes create. We don’t hide from death quite as much anymore.’”

The Wisconsin Partnership Program awarded a Development Grant of \$50,000 to RWHC for “Sports Related Lower Extremity Injury Prevention in Rural High Schools.” The proposal was developed by Jill Thein-Nissenbaum, PT, DSc, Assistant Professor, UW School of Medicine and Public Health, Department of Orthopedics and Rehabilitation, and Mary Jon Hauge, RWHC Assistant Director of Programs and Services.

The project addresses health disparities in rural Wisconsin, specifically the limited resources available in rural areas combined with the high risk of sports-related injuries in adolescent females. Project activities include implementation of a web-based, strength training, flexibility, balance, and agility program to reduce sports related knee and ankle injuries in junior high and high school female athletes in rural Wisconsin. The following is from the joint application:

“Rural adolescents are the least healthy when compared to adolescents in suburban and urban communities; they are over 2 times more likely to exhibit health risk behaviors. Sports participation can minimize unstructured time and decrease risk-taking behaviors. However, sports participation rates are lowest in rural areas, especially for adolescent girls. Since a positive association exists between sports participation in adolescence and adulthood, it is vital to keep adolescent females in rural areas active.”

“Sports-related knee and ankle injuries are common and more severe in adolescent females as compared to males. This may result in decreased adolescent physical activity, which may result in less adult physical activity. Utilization of a supervised injury prevention program decreases lower extremity injury rates; however, supervision is not feasible in rural areas. The goal of our initiative is to determine the feasibility of implementing an at-home, DVD-based, sports-related injury prevention program to reduce sports-related knee and ankle injuries in high school female athletes in rural Wisconsin.”

“Eight weeks prior to the start of the basketball season, female high school basketball players will perform

jumping and lower extremity strength pre-test measurements. They will then be randomly placed into an exercise (EXER) group or a control (CON) group. The EXER group will perform the at-home, DVD-based, sports-related lower extremity injury prevention program 3x/week for 8 weeks. The CON group will not perform the program. After 8 weeks (and immediately prior to the start of basketball season), both groups will perform post-test measurements. EXER group participants will continue their program throughout basketball season on a 2 x/week basis; the CON group will not perform the program. During basketball season, licensed athletic trainers will log hours of practice, competition and injuries sustained for all participants; participants will prospectively log any health care utilization that occurred for any sports-related lower extremity injuries sustained.”

“We will determine if an at-home, DVD-based injury prevention program: (1) improves strength, balance and jumping skills in adolescent female basketball players; (2) is associated with decreased knee and ankle injuries during basketball season; (3) decreases lower extremity injury-related healthcare utilization by basketball players; (4) can be implemented independently by licensed athletic trainers.”

“After the Workshop”

The following is from the December Issue of RWHC’s *Leadership Insights* newsletter by Jo Anne Preston. Back issues are available at:

<http://www.rwhc.com/News/WhatsNew.aspx>

“Does it feel like this? (1) Go to a workshop. (2) Get great ideas. (3) Come back to work and keep doing things the old way because change is hard.”

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

“It is true, change can be hard. Researchers* have identified **predictable stages of change** that can help us move forward more successfully in our efforts. Following are the 6 stages, using the time management example of someone who has been feeling overwhelmed, unprepared for meetings and generally behind in their work due to no time to plan. This person’s desired change: ***at the end of each day, spend 15 minutes planning for the next day.*** [*James Prochaska and Carlo DiClementa developed the Stages of Change Model at the University of Rhode Island.]”

“Stage 1: Pre-Contemplation—Ignorance is bliss. At this point, the individual has not conceived that a change is really needed, or the extent of the problem. In our scenario, this individual has not even thought about time management techniques, or of attending the workshop, but ***perhaps the people who are frustrated or disappointed with him have thought of it for him!***”

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

“Stage 3: Preparation—This is where you will start to take some *initial* steps in making the change. You decide to try the 15 minutes planning thing today. It helps to have support for this, so think about who can help you and ask them to remind you. You’ll think about the obstacles to making the change (mostly old habits), but you’ll come up with some solutions (shutting your door, a reminder on your calendar, not answering the phone or email during that time, etc.). You’ll try it, and you’ll see the next morning that there is some payoff to doing it.”

“Stage 4: Action—Here is where you start making the 15 minutes planning time a habit. You’ll think about what you are giving up to be able to do the new habit, but there will be some payoffs that will offset what you give up. ***Tip for building new habits:***

the only part you need willpower for is getting started. Once you start, the ball is rolling downhill.”

“Stage 5: Maintenance—

Here it will feel weird NOT to do things the new way. Maintenance is the stage where consistency starts to come in. When something messes with your 15 minutes planning time, you miss it, and you’ll notice that your next day doesn’t go as well. Maintenance is where the 15 minutes planning time will just be a part of what you do each day, kind of like brushing your teeth. *Very often when we think of making a change, we think it starts HERE, but it doesn’t. We can get disillusioned and want to give up. But there are a few stages to go through first so don’t be hard on yourself when you are not 100% successful day 1.*”

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

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

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.

Former Police Chief: “Collaborate or Perish”

From a Crown Business press release, 1/7/12:

“In their new book, *COLLABORATE OR PERISH! Reaching Across Boundaries in a Networked World*, William Bratton, former Los Angeles police chief and New York City police commissioner, and Zachary Tumin, senior researcher at Harvard Kennedy School’s Belfer Center for Science and International Affairs lay out a field-tested playbook for collaborating across the boundaries of our networked world. Based on their ex-

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tensive experience in the field and the classroom, Bratton and Tumin have joined forces for the ultimate guide on collaboration, a streetwise blueprint for in-

dustry, government, and citizens taking action on the crucial challenges of today.”

“Bill Bratton is a global leader and voice for citizens, government, and industry collaborating for safety and security. Favoring engagement over confrontation, Bratton’s strategies have for decades helped industry, governments, and millions of citizens around the world unleash the power of collaboration.”

“As a leader in the financial services industry and researcher at Harvard Kennedy School, Zach Tumin has led generations of senior executives dealing with urgent national challenges of defense and intelligence, safety and security, and education and public health. The lessons learned in classrooms and executive sessions are shared here: collaboration is the only winning strategy.”

“Together, Bratton and Tumin draw on in-depth accounts from Fortune 100 companies such as Alcoa, Wells Fargo, Harrah’s, Visa, and Toyota; from masters of collaboration in education, social work, and the military; and from Bratton’s own storied career. Among the specific strategies they share:

- Start collaboration with a broad vision that supporters can add to and make their own
- Right-size problems, and get value in the hands of users fast
- Get the right people involved—from sponsors to grass roots
- Make collaboration pay in the right currency—whether recognition, rewards, or revenue.”

“Today, when everyone is connected, Bratton and Tumin argue, collaboration is the game changer. Yet companies and managers face unique challenges—and opportunities—in reaching out to others. Technology helps make it happen; but people make the difference. Agencies and firms, citizens and groups who can collaborate will thrive; those who go it alone will perish.”

Hospital, Police Organize Med Collections

The following is from the Wisconsin Hospital Association at www.wiservepoint.org/: “The hospital mission lives in the communities that hospital serve as they strive to not only cure, but prevent disease and improve the health of the community.” Here is one story:

“Robert Hayward of Camp Douglas said he was glad Tomah Police and **Tomah Memorial Hospital** provided a safe way for him to get rid of his unused prescription medications. ‘It was very important for me,’ said Hayward, who was one of more than 250 residents who dropped off nearly 4,000 bottles and packages of tablets, capsules, liquids, creams, ointments, aerosols, inhalers, medication patches, plus animal and pet medications during the April 22 Earth Day event coordinated by Tomah Police and the Hospital.”

“Officials dubbed the event ‘an overwhelming success’ collecting 280 lbs of unwanted and outdated prescription and over-the-counter medications that were taken to the La Crosse County Hazardous Materials Facility

for final disposal. The \$840 disposal fee was split between the hospital and police department.”

“Tomah Memorial Employee Health and Infection Control Nurse Jan Path said it was evident residents understood the impact the meds could have on the environment. ‘I think having the event on Earth Day made people realize that it was something good they could do for the environment,’ Path said. ‘Some people just instinctively held onto pills for years and knew that they didn’t want to flush them or throw them in the garbage.’”

“They commented when they brought their pills in that they had held onto them and were looking for a safe way to dispose of them,’ she added. ‘So many people just thanked us over and over for having the event; they were just so happy to have a way to dispose of their medications.’ ”

“Tomah Police Chief Wes Revels said as a result of planning meetings with the hospital, research is underway to possibly make the police department a permanent medication drop-off location.”

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