

Review & Commentary on Health Policy Issues for a Rural Perspective – March 1st, 2007

Rural Needs to Get the Lead Out

- The most effective way to eliminate childhood lead poisoning is to repair older homes where lead is likely to be found.

Having more older houses means, all things being equal, more children with lead poisoning. Rural counties in Wisconsin have a slightly higher rate of houses built before 1950 than Wisconsin's urban counties (33% compared to 30%). But rural Wisconsin has a rate of children detected with lead poisoning at well less than half of the urban average (1.4% compared to 3.7%). Maybe rural is just lucky or maybe fewer kids are being tested. In addition to doing a better job of discovering children with lead poisoning, it is better and cheaper to prevent it in the first place. To learn more about what you can do in your local community, contact: George Carns, Lead Poisoning Prevention, Children's Health Alliance of Wisconsin at:

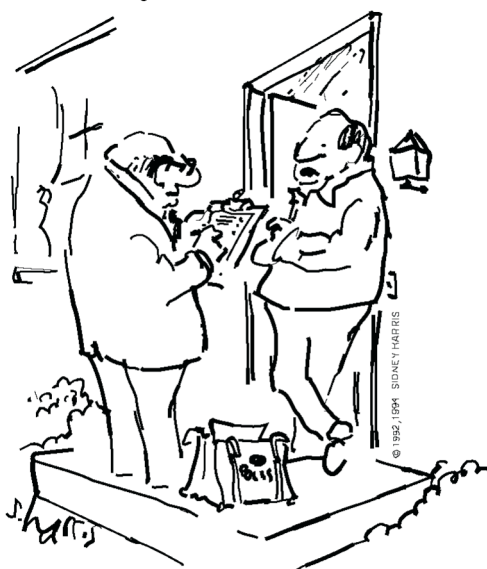
<mailto:GCarns@chw.org> or 414-390-2180.

Key Points About Childhood Lead Poisoning:

- Almost 3000 Wisconsin kids under 6 years old are found each year with lead poisoning.
- Lead impacts the development of young children.
- The only way to determine childhood lead poisoning is thru blood testing.

Did You Know... About Childhood Lead Poisoning?

RWHC Eye On Health



"Why would I want to know something that costs me time and money to fix?"

1. In 2005, there were 2782 children with lead poisoning living in Wisconsin. Since 2000, more than 19,000 children have been poisoned statewide.
2. Most lead poisoned children live in homes built before 1950.
3. Children get lead poisoned from hand to mouth in homes where lead-based paint chips and paint dust have fallen onto floors and windows.
4. Even tiny amounts of lead from lead-based paint chips and dust ingested by a child can reduce IQ levels and increase the likelihood for developing attention deficit hyperactivity disorder and violent behavior as adults.
5. About 466,000 Wisconsin homes contain lead hazards. At any given time, about 80,000 of these unhealthy homes are occupied by families with vulnerable young children.
6. Window surfaces are a major source of lead paint chips and dust in Wisconsin homes. Replacing windows in older homes with new efficient Energy

Star windows reduces home heating bills AND improves our children's health.

7. The rate of lead poisoning among Wisconsin children is nearly three times higher than the national average. Children from low income families and from racial and ethnic minorities are disproportionately affected by lead poisoning.
8. Wisconsin ranks sixth among the U.S. states for the most children reported with lead poisoning. Lead poisoned children have been identified in every one of Wisconsin's 72 counties.
9. Wisconsin Blood Lead Screening Guidelines:
 - a) Test all children who meet one of the following risk criteria at 12 months and at 24 months, and one test between 3 to 5 years of age if child has never been tested for lead poisoning:
 - Enrolled in Medicaid or WIC
 - Lives in or visits a home or building built before 1950
 - Lives in or visits a home or building built before 1978 with recent or ongoing renovations
 - Has a sibling/playmate with lead poisoning
 - b) Test all Milwaukee and Racine children at 12 months, 18 months, and 24 months. All children who meet one of the risk criteria listed above should also be tested annually between the ages of 3-5 years.
 - c) Universal testing of new immigrant children.

The **Rural Wisconsin Health Cooperative (RWHC)** was begun in 1979 as a catalyst for regional collaboration, an aggressive and creative force on behalf of rural health and communities. RWHC promotes the preservation and furthers the development of a coordinated system of health care, which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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**"The National Conference on Small Numbers"
A Unique Conference on a Critical Rural Issue
March 28 & 29th, Dallas Fort Worth Marriott**

Rural hospitals are increasingly dealing with the issue of small numbers as regards both public reporting of quality measures and "pay for performance" contracts.

This is a rare opportunity to better understand this critically important rural challenge. A brochure and registration is available at <http://rchitexas.org/>.

Job Not Done Until Prevention is Mainstream

The following is from "The Prevention of Cardiovascular Disease: Have We Really Made Progress?" by Thomas A. Pearson in *Health Affairs*, Jan/Feb, 2007:

"Despite reductions in cardiovascular disease (CVD) mortality, current evidence suggests that CVD is not being prevented but, rather, is being made less lethal. Evidence-based guidelines have been developed for secondary, primary, and community-based prevention. To improve compliance with secondary prevention guidelines, programs must better organize and monitor care. Primary prevention requires assessment of risk in asymptomatic people, to yield cost-effective benefits. CVD prevention at the societal level should target deleterious behavior in community settings, using effective public health interventions. Policy options that involve multiple preventive approaches offer the best opportunity to minimize the economic and social burdens of CVD."

"Cardiovascular disease (CVD) is largely preventable, based on several lines of evidence. First, heart disease and stroke mortality rates vary greatly among countries. Second, several studies of people without established CVD risk factors (cigarette smoking, diabetes mellitus, elevated blood pressure, elevated blood cholesterol, and so forth) demonstrate exceptionally low rates of CVD incidence. Third, studies of people without deleterious health behavior (tobacco use, sedentary lifestyle, high saturated fat and cholesterol in the diet, and excess body weight) suggest that a large proportion of CVD incidence could be prevented by lifestyle modifications alone. Therefore, nihilistic assumptions of the inevitability of CVD development in individuals or societies are unwarranted."

“The American Heart Association’s (AHA) “Guide for Improving Cardiovascular Health at the Community Level” is directed at the social and physical environment, rather than the medical care system or even public health agencies. Indeed, the targets for these guidelines are policymakers, community leaders, employers, teachers, and social service agencies. The origins of the targeted behavior are within society; therefore, the solutions for removing these risks are likely to be social and economic. **The clear distinction between primordial and primary prevention relates to primordial prevention activities lying outside the doctor-patient relationship and the medical model.** The social/ecologic model moreover carries economic and social benefits outside the health arena, as well as extending cost reduction to diseases other than CVD.”

“The AHA community guide organizes these efforts along three dimensions: (1) behavior targeted for change; (2) community settings in which intervention might be implemented; and (3) interventions themselves, usually organized along the lines of essential public health services. Some behavior needs to be targeted, including diet, sedentary lifestyle, tobacco use, behavior dealing with seeking screening and treatment for blood pressure and cholesterol, as well as the early recognition of symptoms of heart attack and stroke. The evidence base has tested interventions in specific community settings (such as schools, health care settings, worksites, and religious organizations). The essential public health services specifically deal with interventions at the community level, including assessment of burden of disease (surveillance), public health education involving mass media, the organization and mobilization of communities, the assurance of essential health services, and environmental change through legislation and policy change. The resulting three-dimensional matrix identifies discrete opportunities for intervention by behavior, community setting, and public health strategy.”

Policy Issues in Primordial Prevention

“Is a community approach needed in the presence of clinical programs for primary and secondary prevention?” Risk-factor trends over the past fifteen years

One Set of Definitions for Types of Prevention

“Secondary prevention has been classically defined as the prevention of disease recurrence and death after the onset of symptomatic disease.”

“Primary prevention traditionally has been prevention of the onset of symptomatic disease through the treatment of risk factors for CVD, such as treating hypertension to prevent stroke.”

“Primordial prevention describes efforts to reduce the onset of the risk factors known to predispose people to CVD. For example, lifestyle modifications to maintain ideal body weight and to limit sodium consumption are means of preventing the development of high blood pressure.”

provide a strong rationale for a population approach, even in the setting of large expenditures for primary and specialty cardiovascular care. The National Conference on CVD Prevention documented difficulty in reducing national rates of tobacco use below 25 percent; no change in physical activity, with 40 percent of U.S. adults being sedentary; and dietary increases in carbohydrates and calories. These are major population health issues as well as clinical ones.”

A \$1,000 Prize for the Best Rural Health Paper by a University of Wisconsin student is given annually by RWHC’s Hermes Monato, Jr. Memorial Fund. Write on a rural health topic for a regular class and submit a copy by April 15th. Info re submission is available at <http://www.rwhc.com/Awards/MonatoPrize.aspx>

“Policies to encourage healthy lifestyles. The AHA community guide contains fifty-nine recommendations to attain nineteen goals for policy change. For example, policy recommendations for changes in one risk behavior (physical activity) with the use of one essential public health service (environmental change) include five recommendations for improving access to physical-activity opportunities in schools, worksites, and whole communities. One area with major success from policy formulation has been the reduced initiation of tobacco use by adolescents and young adults. Policies related to taxation, elimination of tobacco advertising to young people, and restriction of tobacco sales to minors are examples of policies that have successfully targeted risk behavior.”

“Adequate reimbursement for clinical preventive and rehabilitative services. Advocacy positions must emphasize the empirical evidence supportive of primary and secondary prevention services, including behavior modification programs, nutritional counseling, tobacco-use cessation, physical activity regimens, and cardiac rehabilitation. The current reimbursement for diabetic counseling services but not for other CVD

Letter to Editor in the *New York Times*, February 12, 2007

“Serious proposals for universal coverage for all citizens, be it by presidential candidates or state governments, have largely ignored the most important rate-limiting factor in creating any system that is both high quality and cost-effective: generalist physicians who would provide community-based medical care for 48 million more people.”

“Decades of studies comparing national health systems have demonstrated that those places—Britain, Scandinavia, Canada—that have the best ratio of primary care to specialty physicians are the ones with the best and most enduring health outcomes.”

“At a time in our country’s history when career choices of medical students have almost killed primary care and where we are importing over 50 percent of the new family doctors from other countries, we may arrive at universal coverage but have no one to lead it.”

John J. Frey III, M.D. The writer is a professor of family medicine, University of Wisconsin School of Medicine and Public Health.

ment of individual risk factors. A balanced approach by policymakers should create a comprehensive program across the risk spectrum, rather than focusing on one risk factor, one segment of risk, or one type of intervention.”

Nap—Life You Save May Be Your Own

From “Napping May Be Good for Your Heart” from <<http://scientificamerican.com/>>, 2/12/07:

“Like to kick back for an afternoon siesta? Good news: A new study shows that regular napping may cut your risk of dying of a heart attack or other heart problems.”

risk factors appears inconsistent with the overall goals of the program—namely, the reduction in disease progression leading to disability, poor quality of life, and additional health care spending. Such reimbursement needs to be extended universally for control of all established CVD risk factors.”

“Further reductions in CVD mortality will likely need to involve the entire range of opportunities to prevent CVD. Secondary prevention programs have driven case-fatality rates to extremely low levels, which suggests that there are relatively limited opportunities to make inroads on mortality through this approach alone. However, persistent treatment gaps should be removed. Primary prevention will require expansion of risk-factor assessments and global-risk scoring, with prioritization of cost-effective interventions in moderate- and high-risk individuals.”

“The best opportunity to reduce CVD may be at the community and societal levels, where improvements in diet, exercise, and tobacco use have recently been elusive and where an obesity epidemic threatens to overwhelm progress made on the clinical treat-

“In the largest study to date on the effects of midday snoozing, researchers from the Harvard School of Public Health (HSPH) and the University of Athens Medical School in Greece, tracked 23,681 apparently healthy men and women, ages 20 to 86, for more than six years. Their findings, published in today’s *Archives of Internal Medicine*: those who took afternoon siestas of 30 minutes or more at least three times a week had a 37 percent lower risk of dying from heart disease than those who did not.”

“Even more impressive: researchers found that working men who took regular or occasional naps had a 64 percent lower risk of death from heart attacks or other heart-related ills than their nonnapping peers.”

“Trichopoulos, a cancer prevention and epidemiology professor at HSPH, says researchers decided to look into this issue, because coronary mortality tends to be low in populations in which the prevalence of siestas tends to be high. ‘Our working hypothesis has been that napping may have stress-releasing properties,’ he says. Researchers specu-



late that the extra shut-eye may help reduce chronic stress—which has been implicated in heart disease—by giving workers a break from angst-ridden jobs.”

“Trichopoulos says that if further studies net similar results, ‘then lifestyle changes that would allow afternoon napping might have to be considered.’ Of course, that’s easier said than done, especially in the United States, where employers are not exactly known to encourage workers to nap. ‘I am fully aware that the lifestyle in the U.S. does not leave much room for changes of this type,’ he says.

“But afternoon siestas have long been a part of daily life in Greece, where the study took place, as well as in other Mediterranean and some Latin American countries, which tend to have low mortality rates from coronary disease. The Mediterranean diet, rich in fruits, vegetables, beans and olive oil, has also been credited for keeping a lid on heart disease. Trichopoulos says the study controlled for diet, physical activity and other factors that are predictive of coronary mortality.”

“ ‘No firm conclusions can be drawn on the basis of this study alone, except that the issue is worth further investigation,’ Trichopoulos says. ‘Right now, we would only reassure those who take a siesta that this may actually be not simply pleasant and relaxing, but also a healthy habit.’ His advice: ‘For those whose lifestyle allows having a nap, go ahead and do so.’ No doubt your boss will be thrilled.”

Pharmacist Shortage, an Inconvenient Truth

From “U.S. Pharmacist Shortage Looms: Many are over 55, and new recruits are drawn to part-time work” by Alan Mozes, *HealthDay Reporter*, 3/17/06:

“U.S. pharmacists could become a rare breed over the coming decade, as aging male practitioners retire and workers of both genders choose part-time work over a full-time work week, a new survey reveals.”

“The shortage looms even as the demand for prescription services rises, and pharmacists themselves

call for more time to focus on patient care beyond dispensing medications.”

“ ‘The key message is that there is a shortage of pharmacists,’ said survey project director David A. Mott, an associate professor in the school of pharmacy at the University of Wisconsin. And certainly, pharmacists are busier than ever, and they may not have enough time to spend with patients answering questions about how to take their medications.”

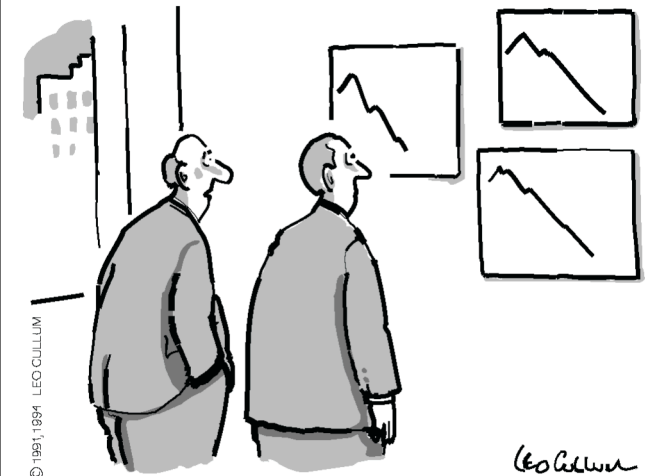
“Mott and his colleagues reviewed written questionnaires completed in 2004 by 1,470 pharmacists randomly sampled from across the United States. The surveys collected information on the pharmacists’ demographic and employment status, hours worked per week, type and quality of work environment, and his or her future work plans.”

“The portrait that emerges is one of a shrinking workforce and the potential for a real shortage over the coming decade. Almost 46 percent of practicing pharmacists are now female, the survey revealed—up from 31 percent in 1990 and rising slightly since 2000. More than a quarter of these women are working part-time.”

“Just over 15 percent of male pharmacists were also found to be working similarly shortened hours. Pharmacists are also an aging group, particularly men. More than 40 percent of male pharmacists are over 55, compared with just 10 percent of female pharmacists.



RWHC Eye On Health



“Maybe if we give out more pill splitters we can make up for retiring pharmacists.”

The researchers also found that, overall, both full- and part-time pharmacists—whether stationed in a chain, supermarket, independent business, or hospital—are working less than they did four years ago, while earning an average 38 percent more for their time.”

“Yet, despite a cutback in their work week, pharmacists are actually handling more prescriptions now than in the past—presumably taking advantage of a rise in the number of non-pharmacist technicians who now assist drugstore customers.”

“Technology may also figure in pharmacists’ ability to maintain service levels more efficiently. More than 60 percent of those surveyed said new equipment—such as refill phone systems, bar coding, and medication counters—have improved both productivity and quality of care, while boosting job satisfaction.”

“However, as technology improves service, it appears to be geared more toward enabling the faster dispensing of drugs, rather than expanding patient-care services such as face-to-face consultations.”

“In this respect, Mott and his team found that as pharmacies change, pharmacists still spend most of their time doing what they’ve always done: dispensing medications. In fact, pharmacists indicated that nearly half of their time is spent filling prescriptions, much as it was in 2000. Patient consultation takes up 19 percent of their time, followed by business management (16 percent) and drug-use management (13 percent).”

“In general, the pharmacists said this emphasis on filling prescriptions takes away from consultation and drug-use management. More than one out of every two pharmacists said their workload was high or excessively high, with 58 percent stating that their workload had increased (sometimes greatly) over the prior year.”

“Stress also figured into the work mix. Pharmacists often complained of inadequate staff, workloads that may hamper the level of service they can provide, difficulties with hard-to-handle patients, and being interrupted by people and phone calls. Yet, despite these reservations, the survey did uncover several positive indicators. The pharmacist’s attitude toward his or her job, for example, has become a more rosy

one since 2000, particularly among those employed by independent stores.”

“More than 77 percent said they have a high level of job satisfaction, up from 66 percent in 2000. Mott’s team believes the nation’s pharmacy schools need to emphasize this good news, while acknowledging that the industry is changing.”

“We’re looking 10 or 15 years down the road at a real change in our pool of pharmacists,” said Mott. “There are only about 100 pharmacy schools in the country that graduate about 80 to 100 students [each] per year, so there’s a limit to how we can deal with a shortage.”

“Sharlea Leatherwood, a past president of the National Community Pharmacists Association and a pharmacy owner in Kansas City, MO., agreed that the problem is real and looming. ‘We are experiencing a very large growth in the boomer population, and they are the ones who are taking a very large number of the meds,’ she noted. ‘So, the need for filling prescriptions grows just as we are losing pharmacists. This makes for a very serious situation.’ ”

Rural America at a Glance

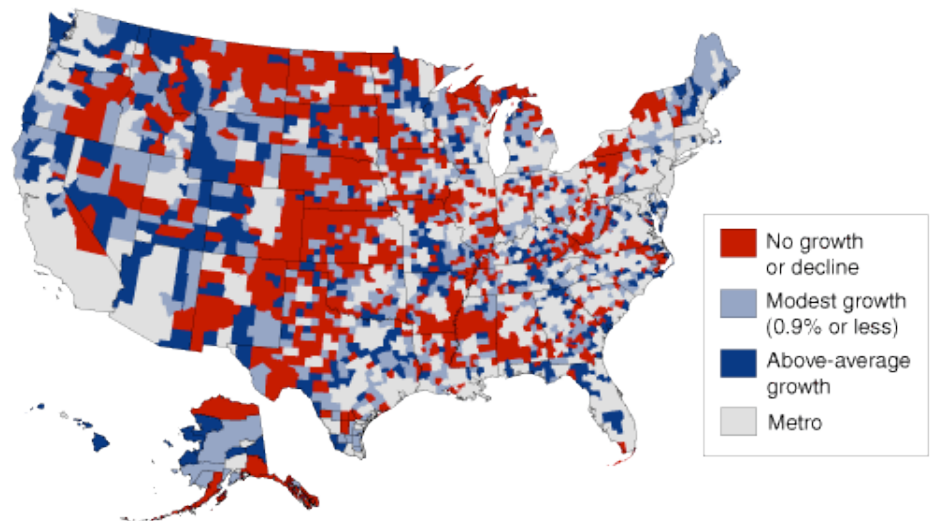
The U.S. Department of Agriculture Information Bulletin No. (EIB-18), “Rural America at a Glance, 2006” highlights the most recent indicators of social and economic conditions in rural areas for use in developing policies and programs to assist rural areas. The six page brochure provides information on key rural conditions and trends for use by public and private decision-makers and others in efforts to enhance the economic opportunities and quality of life for rural people and their communities. Available online at: <http://www.ers.usda.gov/Publications/EIB18/> (The map on the next page is best in its original color.)

“From 2000 to 2005, the nonmetro population in the United States grew by 2.2 percent. International migration supplied nearly a third of the growth in nonmetro areas, and accounted for all nonmetro population growth in the Midwest. Growth was concentrated in nonmetro (rural) counties adjacent to metro areas.”

“The nonmetro population is aging, like the U.S. population as a whole, with implications for health care, housing, and transportation. Between 2000 and 2005, the nonmetro population 40-59 years old grew by 8 percent, while the nonmetro population under 20 years of age declined by 5 percent.”

“Following a short recession in 2001, and a subsequent period of economic growth without employment growth, the United States has undergone a broad-based economic expansion since 2003, with employment growth occurring in sectors representing more than eighty percent of total U.S. employment. As a result, U.S. employment grew between 2004 and 2005, particularly in the West and the metro South, and unemployment rates were the lowest since the 2001 recession. However, forty-six percent of nonmetro counties were still below their 2000 employment levels in 2005. After a decline of more than fifteen percent between 2000 and 2003 in both metro and nonmetro areas, manufacturing employment in early 2006 remained relatively stable for the third year in a row.”

Nonmetro population change, 2003-04



Source: *Rural America At A Glance*, USDA/ERS, EIB-4

USDA Economic Research Service

can to infuse more rural-relevant research into the Advisory Board’s findings.

RWHC is extremely proud of its partnership with the Wisconsin Nurse Residency Program and that it was recently featured in a *Nursing Executive Center Practice Brief* by the Advisory Board Company.

The Wisconsin Nurse Residency Program (WNRP) is an innovative, structured learning experience for new registered nurses designed to promote effective transition into professional practice. It is a federally funded statewide collaboration between Marquette University and rural and urban acute care health care partners in Wisconsin. This innovative program builds on undergraduate education and clinical competencies through several key components:

Professional Development Plan—In order to address the unique needs of new practitioners, WNRP helps the new nurse create an individualized plan to build skills and develop competency. Tailored to individual learning styles and learning needs, the plan outlines specific activities and strategies to achieve professional career goals.

Facilitated Learning Sessions—Every month, a six-hour learning session is provided that engages participants in an enriching learning process to encourage critical reflection on nursing practice. Facilitated by advanced practice nurses and healthcare experts, par-

WI Rural RN Program National Best Practice

The Rural Wisconsin Health Cooperative (RWHC) has enjoyed a two-year partnership with the Advisory Board Company, a health research organization based in Washington, DC. The Advisory Board provides best practice resources and analysis to the health care industry, focusing on business strategy, operations and general management. Currently, various subsets of RWHC members take advantage of the Health Care Advisory Board, the Nursing Executive Center, and/or the Human Resource (HR) Investment Center.”

“This is a unique situation: the RWHC arrangement is the only membership agreement the Advisory Board maintains with a network of independent, rural hospitals. As such, all parties have done what they

Fill 'er up

("Asides & Insides," Modern Healthcare, 1/29/07) "Slips and falls inside hospitals frequently cause preventable injuries. But it was the potential for falls in the hospital parking lot that steered Ripon (Wis.) Medical Center to a classic American solution: the drive-through blood draw. Hospital phlebotomist Sharon Schlueter 'noticed patients were having problems,' says the facility's laboratory director, Connie Sina."

"The critical-access hospital, located nearly 80 miles north-east of Madison, lets the emergency bay double as a stop for those with scheduled phlebotomy appointments. Donations helped Ripon Medical Center buy a mobile blood-draw cart that can be wheeled up next to the passenger-side window."

"Stroke survivor Bob Levonowicz became the first to test the service in December. Levonowicz lost the use of an arm and leg and relies on his wife, Judy, to help him move from car to wheelchair and back again during monthly visits to the medical center for blood work. 'I roll down the window in the car and stick my arm out,' he says. Schlueter 'comes over and draws the blood. And that's it. It's convenient and safe.' "

medical-surgical practitioner, and ability to function within the healthcare team, the organization, and the profession.

Clinical Coaches—When nurses enter the program, they are partnered with an experienced nurse designated as a clinical coach. Focused on guiding the new nurse's learning and professional development, the coach focuses on making the new nurse succeed. The coach is a nurse who understands the new nurse's job, unit, strengths, and is committed to helping her or him become a competent practitioner. Through regular touch-points the coach provides ongoing support, encouragement, and valuable feedback to help the new practitioner reach his or her fullest potential.

Web-based Learning and Discussions—Providing enrichment for these monthly sessions is a web-based learning management system Desire2Learn. A variety of resources are included on the specially designed residency "course" including articles, websites, best practices, and learning activities through discussion forums and "chat rooms" that connect to participating nurse residents across Wisconsin. *Additional information is available at:* <<http://www.wnrp.org/>>.

ticipants are guided in the application of knowledge to stimulate critical thinking, advance clinical judgment skills and ability to effectively problem solve. Curriculum is designed to build capacity as an acute care

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