

Review & Commentary on Health Policy Issues for a Rural Perspective – April 2nd, 2006

Leadership Development for Rural Health

This is an excerpt from “Leadership Development for Rural Health” by Tim Size from “Contemporary Issues in Rural Healthcare” in the Jan/Feb ‘06 issue of the *North Carolina Medical Journal* dedicated to Jim Bernstein, a longtime national rural health leader; the complete text and the rest of the issue is available at (<http://www.ncmedicaljournal.com>).

“Rural health has come a long way and yet has a long way to go. With hindsight, some might minimize Jim Bernstein’s leadership, now unaware that much of what he did for rural health was initially just an idea, a hope. It is the midwifing of a vision into reality that is the very heart of leadership. Henry David Thoreau described Jim’s caliber of leadership when he wrote the oft repeated lines: ‘If a man does not keep pace with his companions, perhaps it is because he hears a different drummer. Let him step to the music which he hears, however measured or far away.’ Jim Bernstein leaves a legacy that continues to challenge all of us to care and to achieve more than we first thought possible, whomever our drummer, whatever our position.”

“On July 15th, 2005, the National Advisory Committee on Rural Health and Human Services, advisory to the

Secretary of the U.S. Department of Health & Human Services, adopted a Special Resolution honoring James Bernstein that concluded with the following: ‘The Committee believes that the best way to honor Jim is to consciously work to help develop the next generation of rural health leaders. Jim was a master of creating change by working within the existing policy framework and helping others to build sustainable programs that addressed long-standing problems. The Department should play a lead role by developing a program that identifies emerging leaders from and for

rural communities and provides them with the training and resources to play a lead role in ensuring access to quality health care access in their states and communities. This program warrants support by the Department and it should focus on rural needs within the larger policy context that affects us all. The Committee urges the Secretary to take the lead on this initiative which will serve as a reminder for Jim Bernstein’s fine work.’ ”

“I can hear Jim wincing at such personal attention but I know

he would put up with it in order to help further develop rural health, a process that must include understanding our past. I also believe he would be the first to remind us of the many people who are called to exercise leadership in both large and small ways.”

What Is Leadership Development and Why Do We Need It?—“The weekend I received the opportunity to write this Commentary, our church was



celebrating those living or dead who made a contribution to our faith and to various communities. The service brought forth the image that individuals who exercise leadership are like a river's current—a part flowing past where we now stand, a part yet to come. We have an ongoing need to remember and to look toward the next 'generation.' Rural leaders will arrive without the assistance of any of us but deliberative leadership development will foster more effective and diverse leaders. A key responsibility of those now present is to mentor and to create structures for mentoring, in order to increase the flow and effectiveness of tomorrow's leaders."

"Leadership is the capacity to help transform into reality a vision of the future. This commentary focuses on leadership development more than leader development in order to emphasize that throughout our organizations and communities we have and need individuals who may not be formally designated or recognized as leaders yet who can and do exercise leadership. Leaders recognize that none of us are called to always lead, that sharing or conceding leadership to others is also a key role. None of us is called to lead on every issue; all are called to interact and support the vision and ideas of others."

"We need to recognize that in addition to individuals having the potential to exercise leadership, the potential of leadership also exists 'corporately' for teams, organizations and communities. Individually and collectively, at all levels, all of us are called to lead and

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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are 'born' with traits that can both enable and interfere with opportunities and responsibilities. Wherever the individual or group starts, growth is possible and necessary. We need to structure leadership development for groups and communities as well as individual leaders."

Servant Leadership and Rural Health—"The concept of 'servant leadership' is a perspective held throughout the rural health community and I believe is a major framework for understanding the attributes of leadership we need in rural health. Robert Greenleaf, the man who coined the phrase 'servant-leadership' described his construct of 'the servant-leader is servant first... It begins with the natural feeling that one wants to serve, to serve first. Then conscious choice brings one to aspire to lead.' I do not believe he is saying 'natural' in the sense of 'natural athlete' but that at some point in life the feeling arises to serve that in turn leads to a decision to exercise leadership. What are the attributes of servant leadership, what characteristics or skills must we look for when we recruit a leader; should we look for when we learn, teach and reinforce? For me a good beginning to the question is to compare the attributes of 'servant' and 'traditional' leaders. Cooper McGee and Duane Trammell do just this in *Hero As Leader to Servant As Leader*:"

Examples of Traditional Leadership Skills

- "Highly competitive; independent mindset.
- Uses internal politics to win personally.
- Focuses on fast action.
- Controls information in order to maintain power.
- Accountability is more often about who is to blame.
- Uses humor to control others."

Examples of Servant Leadership Skills

- "Highly cooperative, interdependent; gives credit to others generously.
- Sensitive to what motivates others to win with shared goals and vision.
- Focuses on gaining understanding, input.
- Shares big-picture information generously.
- Most likely listens first, values others' input.
- Accountability is about making it safe to learn from mistakes.
- Uses humor to lift others up."

Principles of Collaborative Leadership—“The challenges we face today in health care require a form of leadership that is less authoritative and more cooperative. Ronald Heifetz and colleagues at the Stanford Graduate School of Business say it very well. These ‘problems require innovation and learning among the interested parties and, when a solution is discovered, no single entity has the authority to impose it on the others. The stakeholders themselves must create and put the solution into effect since the problem is rooted in *their* attitudes, priorities, or behavior. And until stakeholders change their outlook, a solution cannot emerge.’ It is important not to confuse cooperation with endless stanzas of ‘Kum-By-Ya;’ collaboration frequently requires strong external catalytic action.”

“Max DePree in *Leadership Is an Art* offers a model for employer-to-employee relationships based on his experience that productivity is increased to a maximum by designing work to meet basic employee needs. His vision of the art of corporate leadership brought employees into the decision making process. DePree’s experience is primarily in the world of the Fortune 500, yet many have found Max DePree a useful framework for nonprofit and public sector efforts.”

“While DePree was a successful leader of a Fortune 500 Company, some describe him as impractical, a common label thrown by the ‘pragmatists’ at ‘collaborators.’ Robert Greenleaf offers a suggestion that may be helpful in thinking through this dilemma: ‘For optimal performance, a large institution needs administration for order and consistency, and leadership so as to mitigate the effects of administration on initiative and creativity and to build team effort to give these qualities extraordinary encouragement.’ ”

Summary—“Leadership is the capacity to help transform into reality a vision of the future. Individuals who can and do exercise leadership are like a river’s current—some has passed, some is passing, and yet more is yet to flow through. We have an ongoing need to remember and to look toward the next ‘generation.’ A major responsibility of those here now, is to mentor and to create structures for mentoring, in order to allow for the maximum flow and effectiveness of tomorrow’s leaders. When recruiting organizational leaders, the recruitment and interview process must seek individuals who in addition to technical

competence have demonstrated leadership in their prior work and activities.”

“To exercise effective leadership we must work to know who we are, how we relate to others and the environment around us. ‘Servant leadership’ is a perspective held by many throughout the rural health community and offers a key set of leadership attributes useful to rural health. To implement the Institute of Medicine’s recommendations in *Through Collaboration: the Future of Rural Health* we must develop leaders skilled in collaboration, both internal to their organization and across organizations.”

“The National Advisory Committee on Rural Health and Human Services had it right when they said to the Secretary and to the rest of us ‘that the best way to honor Jim is to consciously work to help develop the next generation of rural health leaders.’ There are a

Partnership & Collaboration Development Resources

“Through its affiliation with the American Hospital Association, Health Research & Educational Trust accesses valuable resources, data and thought leadership. HRET publications showcase the organization’s research, education and demonstration project outcomes. The publications aim to inform and assist the health care field in transforming research into successful practices.” The following excellent resources are available for purchase at (<http://www.hret.org/hret/>).

Public-Private Partnerships to Improve Health Care—

“This informative summary highlights the evaluation of the National Community Care Network Demonstration Program. Spanning from 1995-2003, the program focused on 25 private-public partnerships from 20 states, and their efforts to create a better health care system. The information summary provides value and guidance to all community health improvement efforts.”

Collaboration Primer—“Building on the lessons learned from the National Community Care Network Demonstration Program and Evaluation, this HRET publication provides recommendations for building a successful collaboration.”

Community Care Notebook: A Practical Guide to Health Partnerships—

“In this comprehensive how-to guide, you will find useful information on how to build, manage and sustain your health partnerships. You will learn from real-life examples and practices drawn from the National Community Care Network Program, as well as other collaboratives. More than 30 topics cover the entire partnership lifecycle. Useful tools, templates and other resources are provided for the novice or veteran health partnership member.”

multitude of leadership institutes, programs and courses throughout America; this is not a call for yet another separate entity. But it is a call for all of us in rural health to assure that we are deliberative in how

we identify 'emerging leaders from and for rural communities and provide them with the training and resources to play a lead role in ensuring access to quality health care access in their states and communities.' ”

“There are many ways of doing and leading the work of rural health throughout America. There is leadership in place and that needs to be developed to make the vision of a healthy rural people a reality. Those privileged to know Jim Bernstein saw a man with that vision and with the leadership skills to make it happen. We must continue and expand on his example.”

Meth Is No Lake Wobegone

From “Meth Taking Hold in State, Law Officials See Its Impact in Jails, Crime” by Robert Imrie, Associated Press, 3/14/06:

“The latest illegal drug craze—the highly addictive methamphetamine—has gripped one western Wisconsin county, where the sheriff says his budget has skyrocketed because of it. And he’s not alone. ‘It is driving everything right now,’ St. Croix County Sheriff Dennis Hillstead said. ‘Of the inmates, roughly 65 percent are in for either meth or meth-related crimes. They are doing burglaries to get money to buy meth.’ In neighboring Polk County, where deputies have investigated users as young as 11 years old, billboards have been erected, warning meth dealers, manufacturers and users to stay away.”

“ ‘It is creeping. You are over there by Wausau. It is coming your way,’ Polk County Sheriff Tim Moore told the Associated Press. La Crosse County Sheriff Michael Weissenberger, president of the Wisconsin Sheriff’s and Deputy Sheriff’s Association, said the

RWHC Rural Health Essay Competition 14th Annual \$1,000 Prize - April 15 Deadline

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www.rwhc.com/Awards/MonatoPrize.aspx

methamphetamine problem is concentrated in northwest Wisconsin because the drug is manufactured in rural labs and those counties are close to markets in the Twin Cities.”

“The crime is adding pressure on crowded jails, he said, calling it the worst drug in his 35 years in law enforcement. ‘I have seen heroin and crack cocaine and PCB, but meth is definitely a nasty drug that I think is going to be forerunner of the majority of our problems in the future, both for law enforcement and for health agencies in the county,’ he said. ‘It is all made out of chemicals, which makes it worse.’ ”

“The drug is cheap to manufacture, creates a tremendous high initially for users and ‘you always want to get that high again,’ making people potential addicts for life, he said. Last summer, Gov. Jim Doyle signed legislation restricting access to cold medicines that contain a key ingredient to make methamphetamine, pseudoephedrine, in a move to fight against the drug.”

“Wisconsin law enforcement officials busted 56 meth labs last year, compared with 90 in 2004 and eight in 1999, according to the state Department of Justice. The state Crime Laboratory processed 726 meth cases last year, compared with 546 in 2004, the agency said. Rural labs are being shut down in Wisconsin, but now there is a pipeline of suppliers from Mexico and other areas, law enforcement experts say.”

“Jennifer Michaelson, 25, of rural Balsam Lake, said she first used meth as a teenager, in part because she was interested in dating a young man. ‘I went over there one day and he and his friends were doing it. They asked me if I wanted to do it. I gave in and said yes,’ she said. In no time, Michaelson said, she and her new boyfriend were using methamphetamine every day, and their lives spiraled downward—financial troubles, violence in the relationship and isolation from family members.”

“ ‘It’s poison,’ she said. ‘There is not any word that I could use to describe how bad it is and how powerful it is.’ She quit after a doctor told her that her newborn

son tested positive for meth, county social services workers took the baby and she spent 60 days in a treatment center. 'The only thing I cared about in my life more than meth was that little baby boy,' Michaelson said. 'I have been clean a little over two years.' "

"In February, the Governor announced a grant to be used by 12 counties and one Indian tribe to develop prevention and treatment techniques for meth users. According to Doyle, 289 people from those counties sought treatment for meth problems in 2004; for the first six months of 2005, there were 223 admissions."

"Ralph Johansen, a member of the Polk County Board and the county's meth drug task force, estimates the methamphetamine problem costs his county up to \$7 million a year, mostly for law enforcement and social services. 'It's the scourge,' he said. Two years ago, St. Croix County added 48 beds to its jail, costing \$1.7 million. Hillstead said 'our medical costs in jail have gone from \$80,000 a year to pretty close to \$300,000. We have had to go to a full-time nurse at jail because of the physical problems that meth brings.' "

"In a recent six-week span, 35 burglaries in Polk County were linked mostly to meth users, Sheriff Moore said. It's believed the goods, including televisions and guns, were traded within hours for meth. In the last 2-3 years, his agency has investigated a murder, a suicide and a drowning, all related to methamphetamine, he said. The suicide came after a 12-hour standoff with police, the sheriff said. The medical examiner believed that the victim was using methamphetamine during the confrontation."

"Sheriff's Lt. Mike Knoll, administrator for the Pierce County jail, said his 29-bed jail has been overcrowded for years and the meth problem just adds pressure and brings in prisoners with more serious medical problems. 'We are seeing adults with teeth falling out, people with sores on their body,' he said. 'Our fear is this is the harbinger of things to come.' "

"Jason Olsen, the father of Michaelson's baby and a recovering meth addict, too, said it won't be easy to eliminate the meth problem. 'When one guy is gone there is two to replace him because you can make so much money on it,' he said. 'It is like trying to stop a common cold that spreads once it gets going.' "

Medicare Prescription Drugs in the Heartland

From 'How Part D Plays in the Heartland in Wisconsin, frustration and glitches dampen the startup of the new medicare benefit, but the process is improving.' by Barbara Basler in the *AARP Bulletin*, 3/06:

"Rob Wilkinson's office is in a squat concrete building out on Wisconsin state Highway 51, not far from the Rock County jail. Even though it's on the very edge of Janesville—a small, gritty factory town surrounded by farmland—scores of county residents have been making the pilgrimage to see Wilkinson, driving into the parking lot clutching brown paper bags full of their medicine bottles."

"All of them—the half dozen or so who come to his door each day and the 20 to 50 others who phone—are looking for help with Medicare's new prescription drug coverage. 'It's a good benefit,' says Wilkinson, a retired Janesville police officer trained by the state to guide county residents through the complexities of the program. 'But it's so hard to figure it out. People are confused by it. And they're afraid of it.' "

"But every day more of that confusion is dispelled, federal officials say, and the mechanics of enrollment are improving, too. New enrollees, they say, are unlikely to experience the turmoil that dogged the system when the drug coverage took effect in January."

"With the May 15 deadline looming for current beneficiaries to sign up for a Medicare plan, counselors, pharmacists, insurance plans and the federal Centers for Medicare & Medicaid Services (CMS) are bracing for a resurgence in enrollments as Americans scramble to pick a plan and avoid a late penalty that would result in higher premiums. 'People may not understand anything else about the Medicare Part D, but they understand there is a penalty,' says Vickie Baker, a state Medicare counselor in Madison. 'The penalty is out there loud and clear.' "

"In fact, she says, even people who have employer or other kinds of 'creditable' insurance plans—those that offer prescription drug coverage that is as good

as or better than the standard Medicare benefit—are calling in, fearful they will be penalized.”

“ ‘We tell callers to take a breath, relax,’ Baker says. ‘If you have creditable coverage, you are OK. You will not be penalized if you are dropped from that plan later and have to go on a Medicare drug plan.’ ”

“Then there are those who call, literally crying on the phone, says Donna Bryant, lead counselor for the State Health Insurance Assistance Program in Madison. ‘You have older people with poor vision who don’t have computer skills, and this whole program is online,’ she says. ‘That’s very frustrating for them.’ ”

“Although the Medicare hotline provides the same information as its website, some people who were reluctant to go online postponed acting on the benefit. CMS says that in January the wave of last-minute signups overloaded the computer system, and they were not processed by the time the beneficiaries went to their pharmacies. Now, a CMS official says, ‘those who enroll before the deadline on May 15 should get their drugs beginning June 1, because plans will have time to process enrollments and mail out cards.’ ”

“The massive prescription drug benefit, the most important change since Medicare became law in 1965, is processing 1 million prescriptions a day. Its debut, however, was marked by computer crashes and overloaded telephone help lines that left some of the most vulnerable low-income Americans without their prescription drugs.”

“Acknowledging the troubled rollout, Mark McClellan, head of CMS, said last month, ‘We make no excuses for these problems. They are important, they are ours to solve, and we are finding and fixing them.’ ”

“Since January, Wisconsin has added part-time workers to its three state Medicare help lines while CMS has beefed up its national phone banks and

added counselors to help callers choose a plan or fix a problem. Wait times for help lines have been reduced and computer systems improved. Information on the drug insurance program, experts say, is widely available. But they can sense the hesitation and confusion.”

“ ‘I’ve seen people who would save \$200 to \$300 on Medicare stay with their insurance company because of all the uncertainty,’ says Gail Brooks, a case manager at the Colonial Club, a popular Sun Prairie senior center with imposing white columns and handsome carriage lamps.”

“Sitting near the fireplace in the center’s living room, Martha Tonn, 87, a retired teacher, says, ‘I’ve come to the point where I’m just not interested in this program. When I looked at the pile of material I had on

this—something came in the mailbox every single day—I just felt it was too much, too overwhelming,’ she says. ‘I don’t take many drugs, and I’m satisfied I can take care of them myself.’ ”

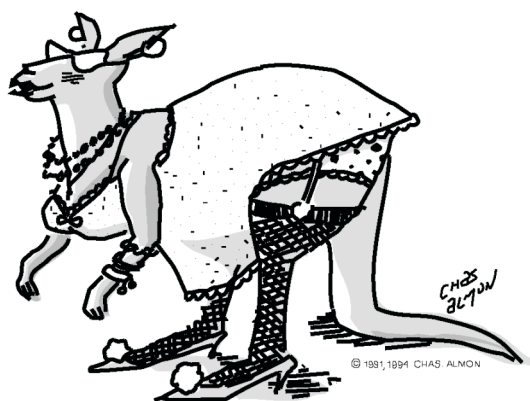
“Scott Procknow, a pharmacist at the O’Connell Pharmacy in Sun Prairie, says, ‘There has been so much negative press, we’ve talked to people who are ready to give up.’ But when customers came in ‘and we sat

down and took them through the [Medicare] process and plugged in their meds, the majority signed up,’ he says. ‘When we show them they can save money, they light up. It’s like a Christmas present.’ ”

“Pharmacists are doing yeoman’s work, fielding queries from customers, running eligibility checks when insurance cards haven’t arrived and dispensing medicines even when the plans’ computers can’t find the enrollee.”

“More than half the states, including Wisconsin, have stepped in and paid for the prescriptions of many ‘dual eligibles,’ low-income and disabled residents who were automatically switched from Medicaid to a

RWHC Eye On Health



“An imperfect idea may be better than no idea at all.”

Medicare drug plan on Jan. 1. These beneficiaries discovered that they didn't show up on their plan's computer or their subsidies were not flagged in the computer and that their copayments would be \$50 to \$100. Pharmacists were told to fill the prescriptions and bill the state."

"Jeff Seabloom, the owner of the only pharmacy in Elcho, a tiny town tucked in the northern corner of the state, says he has had to take out a \$50,000 line of credit to ensure he will be able to pay his bills until he is reimbursed. 'We are subsidizing this program now, and it's not fair,' Seabloom says."

"At Mallatt Pharmacy in Madison, owner Mike Flint says, 'We're on the phone 14 hours a day trying to process prescriptions and figure out plans. We call the plans and they put us on hold 30, 45 minutes. We listen to the music. Then we get disconnected. We call again.' "

"Then there are the calls on behalf of his 200 or so patients in assisted living residences too ill to make the decision about a plan on their own. Flint sent their relatives and the people who hold their power of attorney letters last summer explaining the benefit, giving deadline dates and instructing them about enrollment. But he's had to telephone scores of these people a number of times because they didn't take care of signing up the beneficiaries."

" 'Sometimes I wind up speaking to a bank, and they say, 'You decide,' ' he says. 'They want me to fill out the paperwork and send it to them. I tell them that's not my job, that it's not even legal.' Flint adds, 'My staff has gone to unbelievable lengths to make this work.' "

Medicare Drug Benefit Basics

This is an excerpt from *Twenty Things Medicare Beneficiaries Should Know About the Medicare Drug Benefit* by Thomas R. Clark, RPh, MHS, at the American Society of Consultant Pharmacists, 11/3/05; the twenty page brief can be available at: (<http://www.ascp.com/MedicareRx/>).

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"The Medicare drug benefit program is extremely complex and it is important to know how to make an informed decision about whether to participate in the program, and which plan to choose. The twenty things Medicare beneficiaries should know about the Medicare drug benefit are:

1. Signing up for the Medicare drug benefit could be a serious mistake for some people.
2. Many Medicare beneficiaries are exempt from the late enrollment penalty.
3. There are two major types of Medicare drug benefit programs, and it is very important to understand the difference.
4. Some of the Part D organizations that are offering a Medicare drug benefit in 2006 are not likely to stay in business in 2007.
5. When comparing drug benefit plans, don't forget about the 'doughnut hole.'
6. Not all spending on medications counts toward the \$3,600 limit where Medicare begins paying for all but 5% of the drug costs.
7. The \$3,600 catastrophic limit applies only in 2006. This dollar limit goes up every year. Premiums and deductibles will also increase.
8. Congress chose to exclude some medications from coverage under the Medicare drug benefit.
9. In addition to medications excluded by Congress, each of the Prescription Drug Plans will also exclude some medications from coverage as well.
10. Just because a medication is on the list of drugs covered by the plan does not mean that the plan will necessarily pay for that medication.

11. The cost of individual medications included on the formulary of the drug plan will vary widely.
12. The Medicare drug benefit provides limited or no assistance if you need to receive intravenous medications at home to avoid a hospital stay.
13. In addition to finding out if your medications are covered, it is important to know if your pharmacy is in the network of the plan.
14. If you take a lot of medications, ask the plan about Medication Therapy Management Services before enrolling.
15. If you are a Medicare beneficiary who also has coverage from the Medicaid program, you lost your Medicaid drug benefit on January 1, 2006.
16. The people who are expected to assist Medicare beneficiaries or their caregivers in evaluating plans and choosing the best plan have a very difficult time understanding the complicated drug benefit program.
17. The ‘tools’ on the Medicare.gov web site, designed to provide comparative information about the Medicare drug plans, have serious limitations.
18. The people who are in the best position to help beneficiaries evaluate options to choose a plan that is best for them are prohibited from doing so.
19. Beneficiaries who lack the ability to choose a plan and sign up by themselves may be locked out of participating in the program.
20. The enormous complexity of the Medicare drug benefit, combined with the pressure to decide quickly to avoid the late enrollment penalty, creates fertile territory for scam artists.”



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