Rural Wisconsin
Health Cooperative

Eye On Health

Review & Commentary on Health Policy Issues for a Rural Perspective – January1st, 2006

Rural Can Keep the "Person" in "Patient"

From "In the Hospital, a Degrading Shift From Person to Patient" by Benedict Carey in *The New York Times*, 8/16/05:

"Mary Duffy was lying in bed half-asleep on the morning after her breast cancer surgery in February when a group of white-coated strangers filed into her hospital room. Without a word, one of them—a man—leaned over Ms. Duffy, pulled back her blanket, and stripped her nightgown from her shoulders."

"Weak from the surgery, Ms. Duffy, 55, still managed to exclaim, 'Well, good morning,' a quiver of sarcasm in her voice. But the doctor ignored her. He talked about carcinomas and circled her bed like a presenter at a lawnmower trade show, while his audience, a half-dozen medical students in their 20's, stared at Ms. Duffy's naked body with detached curiosity, she said."

"Entering the medical system, whether a hospital, a nursing home or a clinic, is often degrading. At the hospital where Ms. Duffy was a patient and at many others, the small courtesies that help lubricate and dignify civil society are neglected precisely when they are needed most, when people are feeling acutely cut off from others and betrayed by their own bodies."

"Some hospitals have worked to address patients' most serious grievances. But in interviews and surveys, people who have recently received medical care say that even when they benefit from the expertise of first-rate doctors, they often feel resentful, helpless and dehumanized in the process."

"In a nationwide survey of more than 2,000 adults published in 2004, 55 percent of those surveyed said they were dissatisfied with the quality of health care, up from 44 percent in 2000; and 40 percent said the quality of care had gotten worse in the last five years. The survey was conducted by Harvard University, the federal Agency for Healthcare Research and Quality and the Kaiser Family Foundation, an independent nonprofit health care research group."

" 'The point is that when they talk about quality of health care, patients mean something entirely different than experts do,' said Dr. Drew Altman, president of the Kaiser Foundation. 'They're not talking about numbers or outcomes but about their own human experience, which is a combination of cost, paperwork and the impersonal nature of the care.' "

Loss of Identity—"It is practically a patient's birthright to complain about arrogant doctors and foul hospital food. These are real problems at some places, and

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"If I had known you would take the idea seriously, I would have kept my mouth shut."

"My idea of an agreeable person is a person who agrees with me." Benjamin Disraeli

since at least the early 1980's, medical schools and hospitals have worked to solve them, giving doctors classes in bedside manner and including patient representatives on staff, among other things."

"Yet a deeper psychological transformation from citizen to patient that occurs in almost any medical setting can be more jarring, and it begins immediately at admission. A clerk, often distracted, often sitting behind glass, hands out confusing forms that demand detailed personal information. The newly designated 'patient' then strips to underwear and puts on a flimsy hospital gown, open at the back, a humiliating uniform that often bears the name of the institution."

"Sandra Ramundt, 52, felt this so deeply that she decided to break out of the hospital while recovering from brain surgery last year. Ms. Ramundt's room was private but despite her expectations, staff came and went without knocking and rarely closed the door, and the hallway noise was relentless. Despite repeated requests, no one cleared away the French fries left by the previous occupant, she said, and sometimes, unwitting attendants would leave her phone just out of reach."

"On the night after surgery to remove a tumor, Ms. Ramundt said she lay in mute agony. The emergency call-button was attached to a retractable railing on her bed, which was in the down position, also out of reach. She fell to the floor reaching for the button and lay there for a long time, she said; a friend found her and helped her back into bed. When, weeks later, Ms. Ramundt had the strength to move, she disconnected her I.V., dressed, stole off the premises and bought herself lunch. She ate it at a neighboring park, before returning to the hospital."

" 'I did it because I could, and because, to be honest, I was concerned about losing my mind,' said Ms. Ramundt, who is a nurse. 'There's this overwhelming sense being a patient of having no boundaries, no privacy, no control over anything, and you feel so awful you can't do anything about it.' At least Ms. Ramundt had some idea how hospitals work, and she could advocate for herself without feeling that she was being unreasonable. Others have found that even minimal objections win them a reputation for being difficult."

The Psychology of Illness—"Even when doctors, nurses and nurses' aides take care to treat people more graciously, as they often do, the patient may have a vastly different perception of the service."

"In the winter of 1998, Jeanne Kennedy, then the chief patient representative at the Stanford Hospital and Clinics, in Palo Alto, Calif., broke her knee cap rushing to a meeting. A member of her staff wheeled her to the employee health department, where a nurse practitioner she had worked with for years began arranging for her care. But the nurse spoke to the woman pushing the wheelchair and ignored Ms. Kennedy."

" 'It was crazy,' she said. 'Here I was in my own hospital, hurt but perfectly capable, and she's being very professional but she's talking over my head as if I were a child. We worked together; she knew me!' "

"Ms. Kennedy, who retired from Stanford University hospitals in December after more than 25 years and now speaks to health care groups, said injury and illness make people more likely to perceive slights than when they are healthy. 'Even if the nurse says, 'Sure, I'll go get that,' and does so promptly, it can sound rude to the patient in this vulnerable condition.' "

"This vulnerability, many patients say, makes noises seem louder, time seem to slow down and anything that is less than indulgent compassion feel like coldness. People who have had chronic pain know this dynamic intimately. For a nurse responding to a request for pain medication, appearing five minutes later may seem prompt. For the patient, the same minutes may seem a purgatory, or even a kind of punishment, into which a desperate mind can project its worst fears."

The **Rural Wisconsin Health Cooperative**, begun in 1979, is 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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" 'When you are in rip-roaring pain,' Ms. Duffy said, 'you're asking for drugs all the time, and you're thinking: O.K., am I an addict? Am I asking too much? Am I offending the nurses? Are they taking so long on purpose to get back at me?' "

"So it is that hostility grows between conscientious, reasonable nurses or doctors and conscientious, reasonable patients. And once the feeling is there, some patients begin to fear the very people who are caring for them, they say, and are very reluctant to call a patient representative or file a formal complaint."

The Importance of Names—"Names matter enormously, patients say. In modern medicine, patients more commonly become exasperated because they do not know the names of the doctors or other medical staff. At many clinics and hospitals, staff members come and go without introductions, patients say. Name tags are in lettering too small to read easily; the names embroidered in script on doctors' coats can get lost in folds."

"In hundreds of focus groups conducted by Planetree, a nonprofit group based in Connecticut that helps hospitals become more responsive to patients needs, one of the most common complaints that patients had was that they could not tell who was on the care team or who was doing what, said Susan Frampton, president of Planetree."

" 'What we encourage hospital staff to do is introduce themselves, always, and patients should demand it,' Dr. Frampton said. James Edwards of Kinston, N.C., devised an especially effective technique. After being blinded and suffering severe injuries in a chemical plant explosion, Mr. Edwards spent about six months in a burn unit, where he got to know the medical staff by the sound of their voices."

"Mr. Edwards was pleased with his care over all, but he became upset when hospital staff members entered his room without speaking to him."

"After one doctor slipped into the room unannounced and tried to give him an injection, Mr. Edwards decided that he had had enough, said his father, James (Red) Edwards Sr., in an interview. His son posted a sign on the outside of his door. It read:

> **ATTENTION:**
>
> 1) Please announce yourself when you come into my room (let me know your name and why you are here).
>
> 2) Please let me know what you're going to do and how it will feel before you touch me for any reason.
>
> Thanks - Jim and Red

The hospital where he was treated, at the University of North Carolina in Chapel Hill, has included Mr. Edwards's sign in a training video for its staff."

"But if the social and psychological culture of patient care is to improve, it is likely to depend on patients and families knowing their rights and acting on them."

"Ms. Duffy now works as a hospital volunteer, giving other breast cancer patients advice on how to avoid situations like her post-operative humiliation: Stop being a good girl, she says; you've got a mouth; you should use it. Have someone with you at all meetings with doctors, if possible. And take notes. 'Otherwise,' she said, 'you cease being a person and become 'the carcinoma in Room B-2,' like I was.' "

Reform: Go Beyond Treating Symptoms

From "The Rise in Health Care Spending and What to Do About It" by Kenneth E. Thorpe in the 12/05 *HealthAffairs* at **http://www.healthaffairs.org/**

"Reforms for slowing the growth in health care spending and increasing the value of care have largely focused on insurance-based solutions. Consumer-driven health care represents the most recent example of this approach. However, much of the growth in health care spending over the past twenty years is linked to modifiable population risk factors such as obesity and stress. Rising disease prevalence and new medical treatments account for nearly two-thirds of the rise in spending. To be effective, reforms should focus on health promotion, public health interventions, and the cost-effective use of medical care."

The growth in real per capita health care spending is simply the growth in spending per treated case times

the number of medical conditions treated (treated disease prevalence). Elsewhere my colleagues and I have apportioned the rise in spending over time into these two categories and concluded that approximately 63 percent of the rise in real per capita spending is traced to a rise in treated disease prevalence. This rise is caused by rising prevalence of disease in the population, changing clinical thresholds for diagnosing and treating disease, and innovations (new technology) in treatment. The discussion distinguishes among these sources, since some of the rise in treated prevalence is likely desirable (primary prevention of hypertension, more aggressive treatment of patients with the metabolic syndrome, lipid control, and treatment of prediabetic patients), while other sources could be prevented, such as the rise in obesity."

"To be effective, options for reforming health care need to include both population-based/public health approaches and economic incentives for the cost-conscious use of services. Much of the current debate over health care spending has focused on demand-side innovations, such as consumer-driven health care, that target overuse of health care by consumers. However, most of the rise in health care spending is traced to the rise in population risk factors and the application of new technologies to treat chronically ill patients. Even if widely adopted, these demand-side fixes would do little to reduce the rise in obesity prevalence and other key risk factors. Maintaining or reducing the population prevalence of disease represents a strategy with large potential payoffs, without the side effects of rationing and other interventions such as managed care that have proved politically unpopular."

The Business Case for Investing in Health

From "Employee Health Promotion Programs: What is the Return on Investment?" by Daniel Zank and Donna Friedsam in the *Wisconsin Population Health Institute Policy Brief*, 9/05:

"Many employers, as part of their efforts to contain rising health care costs, are implementing worksite programs variously described as health promotion, lifestyle programs, health and productivity management, population health management or, simply, well-

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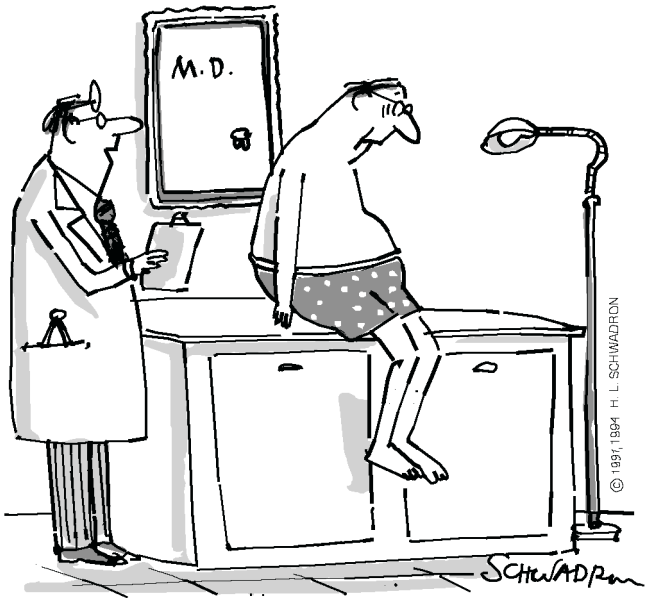

"I'm a medical doctor, not a mechanic, and you're a person with choices, not a car ."

ness programs. If so, do they in turn reduce utilization of health care services and reduce health care expenditures? The popular media have done much to promote the concept of worksite wellness. Last year, *In Business: Madison* magazine printed a story accompanied by a table reporting an impressive range of returns on investment (ROI) ranging from $1.81 to $6.15."

"Illness and injury associated with an unhealthy lifestyle or modifiable risk factors is reported to account for at least 25% of employee health care expenditures. The most significant of these risk factors are stress, tobacco use, overweight or obesity, physical inactivity, excessive alcohol use, and poor nutritional habits. Over the past two decades, a variety of groups at the local, state, and national levels have promoted the concept that health risk reduction and care management programs can improve employee health, and that worksite health education, health risk management, and benefit counseling should complement standard health insurance benefits."

"The intensity of worksite health promotion programs range from bulletin board, pamphlet or newsletter information to onsite fitness facilities, health risk reduction classes, and personal lifestyle change coaching. Wellness programs today often include a health risk assessment to evaluate each employee's

modifiable risk factors of disease. Program coordinators then target interventions to those that are at increased risk through personal communications and individual follow-up."

"Comprehensive health promotion programs may include classes on health risk reduction and job safety, fitness and exercise activities, health club memberships, and reductions in co-payments or premiums for employees who adhere to recommended medical screening guidelines. Along with this, some employers are restructuring health benefits and encouraging employees' cost-sensitivity when accessing health care. These changes are intended to reduce employees' need for and utilization of health care, yielding reduced group health care costs."

"The empirical research has produced results as varied as the popular media on ROI. Nonetheless, evidence continues to grow that well-designed and well-resourced health promotion and disease prevention programs provide multi-faceted payback on investment. Our analysis shows that ROI is achieved through improved worker health, reduced benefit expense, and enhanced productivity."

"In addition to immediately quantifiable cost reductions, researchers have reported a variety of spin-off benefits: greater productivity, intellectual capacity, and reductions in disability and absenteeism. Such programs may also have positive effects on employee perceptions of the company and worker morale, even among non-participants. These outcomes go beyond savings in direct health care costs to provide non-health related ROI."

"Health promotion programs aim to reduce the health risks of employees at high risk while maintaining the health status of those at low risk. A variety of disease management interventions are available to fit the specific risk profiles of various worksites. Insurers and corporations now seek to calibrate their interventions in order to achieve optimal risk reduction and cost effectiveness."

"Despite the abundance of positive program evaluations, several caveats remain. Negative results are less likely to be reported or published, thus biasing the ROI upward. Uncertainty persists regarding the specific impact of the various program components. But as these programs take hold, further research and evaluation will enable fine tuning of program investments."

"Meanwhile, the preponderance of data and the strength of the published research stand in favor of a positive ROI for health promotion programs. Indeed, the business case for such programs is now well enough defined that some insurance brokers offer discounted rates to companies that institute or subscribe to wellness programs."

"Future questions will focus on how to best combine comprehensive and focused interventions, the intensity of elements, and how to calibrate the dose-response model to achieve a target ROI. Here, employers, employees, and researchers will need to collaborate to define mutual goals in terms of both clinical and cost outcomes."

Growing Your Own

From "Growing Your Own Health Care" by Thomas D. Rowley, 10/6/05. Tom Rowley is a Fellow at the Rural Policy Research Institute (RUPRI). RUPRI provides objective analysis and facilitates public dialogue concerning the impacts of public policy on rural people and places.

"When rural health professionals speak of 'growing their own,' they aren't talking about marijuana-for medical use or otherwise. Rather, they're referring to the tried-and-true strategy of raising up a crop of doctors, nurses, dentists and other providers from within the community who will stay and practice in the community. And for places that find it difficult if not impossible to attract such folks from outside, it's the best (and often only) way to make sure care is available locally."

"A recent trip to south Texas, however, opened my eyes to a different spin on the strategy: growing your own health administrators, especially of the entrepreneurial kind."

"Twenty-two years ago, low-income people in and around Uvalde had limited health care options. There were a few doctors in town, but not many accepting

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

The Hermes Monato, Jr. Prize of $1,000 is awarded annually for the best rural health paper. It is open to all students of the University of Wisconsin. Students are encouraged to write on a rural health topic for a regular class and then to submit a copy to the Rural Wisconsin Health Cooperative as an entry by April 15th. Previous award winners, judging criteria and submission information are available at:

http://www.rwhc.com/Awards/MonatoPrize.aspx

new patients or patients on Medicaid. There was the hospital emergency room, overflowing with non-emergency cases. And for those who could somehow afford to make the trip, there was Mexico-75 miles away. As a result, many in the area simply went without care or sought it much too late. Rachel Gonzales-Hanson knows the story all too well. She lived it."

"A mother of two, Gonzales-Hanson sometimes worked three jobs just to make ends meet. Trouble was, those jobs paid her 'too much' to qualify for Medicaid. When she did qualify for Medicaid, she couldn't find a doctor who'd accept it. She and her children were some of the very people who needed the Community Health Center that had just been established. And as it turns out, she was just the person needed by the Center."

"In a nutshell, here's what happened. When the city manager and county commissioner who had been instrumental in setting up the Center began recruiting board members, Gonzales-Hanson's name came up. (Fifty-one percent of a CHC's board members must be actual clients.) She accepted and became the board's secretary. When it came time to hire staff, other board members encouraged her to apply for the executive secretary position. She did and was hired. Only a year and a half later, the executive director resigned and, once again, Gonzales-Hanson got the nod and moved into the lead position."

"She went from client to board member to CEO in a few short years. And under her direction the Center has grown and grown some more. Today, the Uvalde native runs an operation with a $6.7 million budget, 100 staff and clinics in three towns. It provides services from dental to radiology to obstetrics. It also offers language translation and public health services like immunization, diabetes management and sexually transmitted disease prevention and treatment."

"And she isn't finished. The Center is planning on lengthening its hours of operations to 12 hours a day, five days a week, plus weekend hours; bringing in behavioral health care, adding to its dental department; and opening a teaching kitchen to educate people about healthy cooking. All of that will, of course, cost money, but finding funds is something that Gonzales-Hanson has proven remarkably adept at. 'I light candles, pray, and keep an awesome grant writer on staff,' she said."

"Thanks to the center, people in Uvalde and the surrounding region enjoy access to care that once they could have only imagined. According to Gonzales-Hanson, the Center sees some 10,000 people per year or one-third of the population of its three-county service area. Of those 10,000 people, 68 percent are uninsured. Of that number, 90 percent are at or below 150 percent of poverty level."

" 'I believe we've made a big difference,' Gonzales-Hanson said in what can only be called an understatement. To ensure that difference continues, Gonzales-Hanson is also doing what she can to grow *her* own—to raise the next crop of providers and administrators and instill in them a sense of what she calls 'communidad'-loyalty to the community and the desire to give back to it."

"Sensing how attractive she'd be as candidate for elected office, I asked about her loyalty and whether she might not have her sights set on Austin or Washington. In response, she smiled and said simply, 'This is my dream job. This is home.' One could almost hear the collective sigh in Uvalde."

National Rural Health Association
2006 Rural Health Policy Institute

The NRHA 2006 Policy Institute will be held February 27 - March 1 at the Grand Hyatt in Washington, D.C. Rural health advocates face a number of renewed threats over the next couple of years. Register now online at:

http://nrharural.org/conferences/index.html

Nursing Ed. Not Expanding Fast Enough

From a *Press Release* "U.S. Nursing Schools Turn Away More Than 30,000 Qualified Applications in 2005; Enrollment Increase Falls Far Short of Meeting the Projected Demand for RNs," by the American Association of Colleges of Nursing, 12/12/05:

"The American Association of Colleges of Nursing (AACN) released preliminary survey data which show that enrollment in entry-level baccalaureate nursing programs increased by 13.0 percent from 2004 to 2005. Though this increase is welcome, surveyed nursing colleges and universities denied 32,617 qualified applications due primarily to a shortage of nurse educators. AACN is very concerned about the increasing number of qualified students being turned away from nursing programs each year since the federal government is projecting a shortfall of 800,000 registered nurses (RNs) by the year 2020."

" 'With the nation's health care system calling for more baccalaureate-prepared nurses in the workforce, AACN is pleased to see that the trend toward enrollment increases has continued for the fifth consecutive year,' said AACN President Jean E. Bartels. 'Despite the successful efforts of schools nationwide to expand student capacity, our nations nursing schools are falling far short of meeting the current and projected demand for RNs.' According to research conducted by Dr. Peter Buerhaus from Vanderbilt University, enrollments in nursing programs would have to increase by at least 40 percent annually to replace those nurses expected to leave the workforce through retirement."

"AACN's latest data confirm that interest in nursing careers continues to grow, which is good news considering the projected demand for nursing care. Last year, the U.S. Department of Labor identified Registered Nursing as the top occupation in terms of job growth through the year 2012. According to the latest projections from the U.S. Bureau of Labor Statistics, more than one million new and replacement nurses will be needed by 2012."

"Though interest in nursing careers is strong, access to professional nursing education is becoming more difficult. AACN's preliminary findings show that 32,617 qualified applications to entry-level baccalaureate programs were not accepted in 2005 based on responses from 432 schools. The number of qualified students turned away each year from these programs continues to increase with 29,425, 15,944 and 3,600 students turned award in 2004, 2003 and 2002, respectively. The primary barriers to accepting all qualified students at nursing colleges and universities continue to be insufficient faculty, clinical placement sites, and classroom space."

" 'To stabilize the nursing workforce, the federal government and other stakeholders must focus on increasing nursing school enrollments at the baccalaureate level,' said AACN Executive Director Geraldine 'Polly' Bednash. 'Besides adding to the RN workforce, graduates of baccalaureate nursing programs are much more likely to pursue graduate education and achieve the credentials needed to serve as nurse educators. Efforts to address the nursing shortage will fail unless decisive action is taken to resolve the underlying shortage of nurse faculty.' "

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"Exercising leadership I get, but I'm not sure about this followership thing."

For Physicians, Small is Beautiful, to a Point

From "Is Large Really Beautiful? Physician Practice in Small versus Large Scale Communities" by George E. Wright, Ph.D. and Ira Moscovice, Ph.D. in

the *University of Minnesota Rural Health Research Center Working Paper #56*, 9/05:

"We examine the effect of community size on how physicians view their practices as reported by respondents to two waves of a national sample survey conducted as part of the Community Tracking Study. We look beyond simple rural-urban dichotomies, by using the survey's geographic identifiers to examine the effects of a range of community population size. Our underlying assumption is that population size is a proxy for the complexity of both the formal and informal health system in which physicians practice. The larger the community population size, the more likely its physicians have ready access to local referral specialists and technology but also face increasingly complex systems of care. We hypothesize that physicians in both very large and very small settings report lower perceived quality and professional satisfaction."

"We estimated eleven outcomes that control for a wide range of personal and practice characteristics. In most cases all rural settings score higher than the largest metropolitan statistical areas (MSAs), but there is an evident inverted U-shaped relationship with the best evaluations for rural centers in counties with towns over 7,500 and small MSAs under 500,000 population. The multivariate models exhibit this curvilinear relationship on five major characteristics with evidence that mid- to large size rural and small urban centers combined access to key technology and specialists without the disadvantages of negotiating poor communications in a large unwieldy system."

"Our results suggest that bigger is not necessarily better when it comes to physicians perceptions of their practice. A key challenge is whether larger urban-based practices can be decomposed into smaller clinical microsystems that can benefit from the strengths of physician practices in small city or rural settings yet retain the presumed benefits of larger scale organizations."

STATISTICS FOR DUMMIES by Deborah Rumsey, PhD

"This book arms you with the ability to decipher and make important decisions about statistical results (for example, the results of medical studies), being aware of the ways in which people can mislead you with statistics and how to handle them."

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