Closing the Gap in Rural Healthcare: The State of Management Training

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Abstract

Healthcare in America has been described as one of the most complex industries that exists—and it is undergoing a massive change. On the front edge of this change is the leadership of healthcare comprised of healthcare professionals who are at the top of their clinical expertise but often unfamiliar with the business of healthcare. This paper explains this skill gap in leadership and its consequences, the unique situation of rural healthcare, needs in leadership training, and how a MBA in Rural Healthcare uses SEAM to respond to this issue.

Key words: SEAM, rural health, leadership gap, leadership training, healthcare business

American healthcare is at a crossroads: It can no longer sustain the complexity, cost, errors, unavailability, and other dysfunctions that characterize it. The burden to change lies primarily on the leadership of healthcare. This is often the physicians, but we are seeing a broadening of leadership across disciplines as well as vertically in healthcare organizations. Leadership must integrate clinical and business knowledge to repair or even reinvent healthcare to meet current and future needs. We will describe the drivers of this healthcare crisis, the unique challenges of rural healthcare, trends in leadership training, and the role of SEAM in developing effective leaders and organizations.

Healthcare delivery is considered one of the most complex industries we have (Glaser, 2013), and the "business of medicine" is now becoming as important as the clinical skills required to deliver healthcare. The economic pressures to reduce cost while increasing quality of care and patient satisfaction is requiring a new set of skills across all levels of healthcare leadership (Pearl & Fogel, 2017). While many healthcare professionals can read physical monitoring printouts, they cannot easily interpret an income statement or balance sheet. Managing multidisciplinary teams also requires an understanding of team dynamics, and effective collaboration and communication skills. These challenges apply to healthcare in general and even more so to the needs of rural healthcare.

Due largely to a misalignment of American healthcare payment, however, the great hospitals of Drucker's are increasingly rare, and the American healthcare system has experienced exorbitant cost, low quality (compared to the rest of the world's developed countries) and inadequate access (Durgin 2010). The misalignment of payment systems occurred when the American federal government, shortly after the Medicare and Medicaid legislation was passed, chose to pay healthcare providers for individual procedures, rather than for quality or value. By

the end of the 20th century, the rapidly escalating cost of healthcare created adverse financial consequences that often devastated families and created significant problems for American companies in the international marketplace.

In 2010, Congress passed the Affordable Care Act, which began the transformation of not only healthcare payment, but also healthcare delivery. The concepts embodied in the bill, were both Democratic and Republican in origin, and although controversy continues to rage about various aspects of the bill, there is bi-partisan support for the new "pay for value" reimbursement system. Since form follows finance, the healthcare delivery system is currently experiencing profound change, with care coordination, better teamwork, disease prevention, and chronic illness management as new organizational goals. In the value-based financial model, fewer surgeries, less brick and mortar, greater integration of services, and keeping patients as independent and healthy as possible, are all rewarded; overproduction, waste, high cost and bad quality are penalized.

The great challenge for hospital leaders today is to guide their extremely complex organizations through the profound changes taking place in the American marketplace. Hospital cultures must be improved, new collaborations must be established, and communication among health care providers and their patients takes on new importance. Leadership has always been the single most important determinant of organizational success, as evidenced by the Malcolm Baldrige model of excellence, which awards twice as much significance to leadership than to any other causal factor (Hertz, 2015). Today, with the extremely rapid pace of healthcare change, leadership's importance cannot be overstated. Rural hospitals, in particular, will need leadership education, strategic planning assistance and various methods of leadership support in the years ahead to keep their hospitals financially solvent.

Rurality

Although most people seem to discuss healthcare as if it referred to a single population, most of the nearly 60 million residents, or 19% of the US population, in rural communities have distinctly different healthcare needs and situations than do urban and metropolitan residents (NRHA, 2018). The demographics of rural populations show that they tend to be older, have lower incomes and unemployment, and lower educational levels. The healthcare demographics often reflect higher chronic diseases and conditions, under- or uninsured health coverage, limited transportation, limited access to physicians and medical specialists, and reduced broadband connectivity for health information or consultation. Rural communities also have growing numbers of immigrant and migrant groups, veterans, and persons with mental health and human service needs (Wagnerman, 2017).

Rural hospitals are having to reduce services and many are closing and at risk of closure. Over the past eight years 87 hospitals have closed, many of these critical access hospitals, and it is estimated that within the next 10 years as many as 700 more are at risk of closure (Harrison & Templeton, 2018; UNC, 2018). Cutbacks on the Affordable Care Act, specifically on the expansion of Medicaid coverage, and state and federal policies eliminate the safety net coverage of rural residents. Consequently, hospitals lose much revenue and their operating budgets are severely strained. Hospitals are also important employers in rural communities and downsizings and closings add to rural stress (Radcliffe, 2017).

As if these challenges were not enough, they have driven rural hospitals to experience changes that require leaders to have much more business savvy. Affiliations, mergers and acquisitions require strong understanding of operations, finance, legal issues, and organizational culture. Telemedicine involves understanding and working closely with IT specialists to replace or integrate legacy information systems and implement new platforms. Retirements and recruitment involve familiarity with human resources and legal issues as well as promoting a positive culture and building interdisciplinary teamwork. Traditional clinical training does not cover these, and additional new leadership skills are required (see Table 1).

Table 1

Comparison of traditional and new healthcare leadership orientations

Traditional Healthcare Leadership	New Leadership
Competent clinical skills	The "business of healthcare"
Top down administration	Teamwork and leadership at all levels
Stabilize the status quo	Facilitate adaptation and agility
Maximize revenue through number of patients, tests and procedures	The Triple Aim of lowering costs, improving quality/outcomes, and patient satisfaction
Siloed department care	Integrated care and interdisciplinary collaboration
Setting goals	Value-oriented performance outcomes, analytics
Localized problems	Systemic functioning
TFW virus	SEAM treatment

Trends in Leadership Training

The timing of this transition to leadership training and organizational transformation is opportune. Due to growth and aging of the population and retirements in health professions the Bureau of Labor Statistics projects that as many as two million nursing positions will be unfilled in the next eight years and even nursing school enrollments will be insufficient to fill such vacancies (Thomas, 2018). Similar predictions of physicians by the Association of American

Medical Colleges (AAMC, 2018) showed a shortage of up to 120,000 is expected by the end of 2030. In addition, the shortcomings of traditional healthcare has become apparent and is replaced with the Triple Aim of improving patient care quality and satisfaction, improving population health, and reducing the cost of healthcare. Such a shift requires a new orientation of leadership to a transformation in healthcare.

Some hospitals have recognized the need for both clinical and business leadership and have moved to pair a business executive with a clinical executive in a dyadic approach to leadership. While this makes some sense, it also poses the challenge of having two kings running a kingdom: There may be important differences in styles, priorities, perspectives, and communication that can complicate or delay their leadership collaboration, and it can require duplication of resources (Perry, Mobley, & Brubaker, 2017). Research on hospital leadership effectiveness also shows that separating the two disciplines produces worse outcomes than when they are integrated (Bloom, Sadun, Lemos, & Van Reenan, 2017) In addition, top ranked hospitals, such as Mayo Clinic and Cleveland Clinic, prefer physician leaders who are viewed as having more healthcare credibility than separate business leaders (Stoller, Goodall, & Baker, 2016).

Other options for leadership development include business networking events such as professional conferences and local associations that promote healthcare business information and skills (DeLong, 2017). While conferences are often useful, they may not present information in an integrated manner. Similar recommendations have been made about physicians collaborating with HR professionals to help understanding sensitive employee situations such as hiring, supervision, and firing (Jain, 2015).

However, it is not just physician leaders who require these skills. Leadership is perfused throughout healthcare organizations and all health-related professionals require them as well to carry out both management and clinical functions. Five key abilities identified across disciplines include understanding marketing, having a customer focus, motivate and inspire, create a lean organization without reducing quality, and being a change agent for the organization (Lindsey & Mitchell, 2012). A more formal and integrated approach is needed.

Getting “the business” in rural healthcare leadership

In 2010 the authors formed the Lake Superior Systems Thinking Group and began discussing the challenges of emerging healthcare and how to deal with the leadership gap. Much of our thinking focused on the business skills and especially on leadership and change management. The conversations led to a collaboration between the National Rural Health Resource Center and the School of Business and Technology at the College of St. Scholastica (CSS) in which the MBA in Rural Healthcare was developed. Since 2000 MBA programs for

MDs have more than doubled (Gorenstein, 2017). There are about 72 graduate programs for MBAs in the United States with some courses in rural health, but the CSS program is currently the only one with an entire curriculum focusing on rural healthcare.

The curriculum includes traditional core courses in MBA programs such as healthcare economics and finance, marketing, human resource management, healthcare technology, organization development, and strategic management. What makes these courses unique is the explicit instruction to consider how students can apply what they learn to their immediate and future work in rural health settings. The final capstone project or thesis is also an applied project in which they identify a practical healthcare problem in rural settings and propose action plans they could implement.

This kind of program develops leadership and its three roles: Relational roles that emphasize interpersonal competency, business roles for operational efficiency, and strategic roles of vision and planning. As healthcare leaders assume broader roles within organizations the ratio among these required skills tends to change (Perry, Mobley & Brubaker, 2017). At the lower clinical levels of an individual practitioner or leader, relational roles of provider-patient interaction are foremost, followed by business and strategic roles. As a market, group or enterprise leader, strategic and business roles strongly emerge, with relationship still important, but subsumed under the former. These non-clinical roles required for successive levels of leadership require greater understanding of business and strategic change thinking, while still being able to foster a strong interpersonal culture.

The program has a strong emphasis on combining business skills and change management with the professional skills of the students. The new emphasis on interdisciplinary teamwork in healthcare is evident in the variety of graduate students and their current professions, nearly all of which are in rural settings. Professionals enrolled in the program include physicians, nurses, pharmacists, social workers, counselors, physical therapists, healthcare attorneys, health information technologists, radiologists, medical technologists, exercise physiologists, and financial and rehabilitation specialists. Case studies and real-world examples from student's experiences are discussed from multidisciplinary perspectives to facilitate greater understanding across disciplines as well as promote teamwork that can be extended into the workplace.

In each of these courses and capstone, students are presented with challenges of how to introduce change in these settings and how to integrate their clinical experience with new leadership skills. The theme of organization development runs as a thread through the curriculum with the principles of SEAM explicitly presented in courses involving organization development.

The SEAM Approach

The Sixth Annual SEAM conference was held at the College of St. Scholastica in May 2018 with a thematic focus on the practice of SEAM in healthcare. A discussion with our graduate students on the socio and economic dysfunctions in healthcare reflected many of the core issues that require changes in leadership education (see Table 2).

Table 2

Student-identified examples of Socio-Economic dysfunctions in rural health

Socio	Economic
Feeling automated and objectified as a professional	Emphasis on production and billable patient contact hours
Interference with personal and family time; staying late/take work home	Documentation must be timely, often requiring overtime or during patient contacts
Feel overwhelmed catching up or shorter meetings with double-scheduled clients	Back to back patients/clients & double scheduling
Time pressure to get everything done	Required training & continuing education
Lack variety of clients & practice	Stereotyped referrals due to specialization but limiting broader professional development
Thinking about turnover, lower commitment	Lower pay than other providers
Frustrated with diversion from primary duties & professional obligations	Turnover requires coverage of tasks and resulting overtime
Frustration with inefficient multitasking	Required but inefficient multitasking

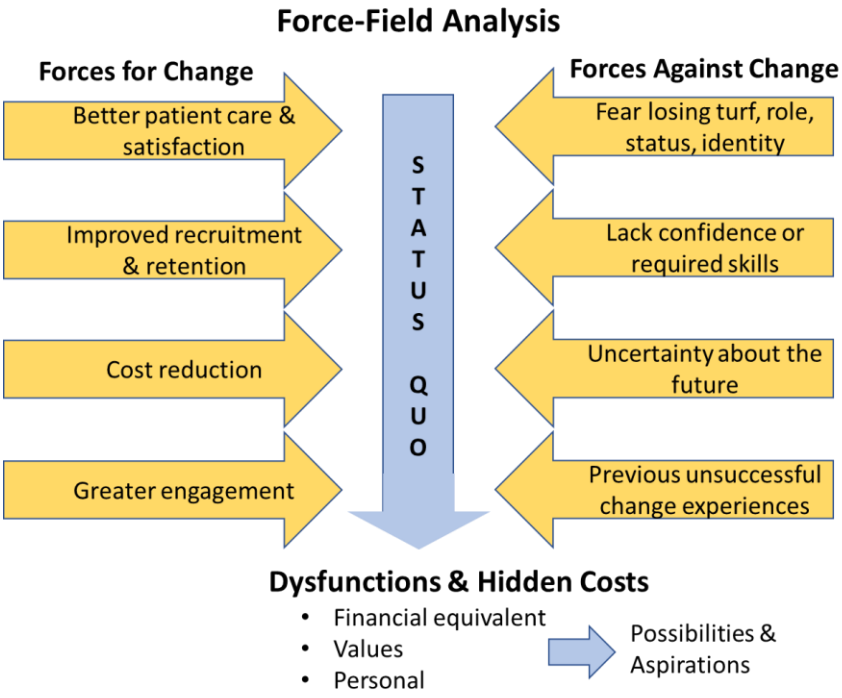
Most organizations and people within them typically are not comfortable with change and seek to maintain the familiar status quo. Rural health leaders at all levels need to find ways to clarify resistances, reduce them, and develop a more adaptive attitudes and engagement toward change. Traditionally, top-down mandates to change results in some voluntary adopters of change, but other segments of the organization may be passive participants, and others are outright resisters to the proposed changes (Rogers, 1983). Resisters often say, “the devil you know [status quo] is better than the devil you don’t know.” Other change approaches tend to use Lewin’s Force Field Analysis (FFA) that examines the forces or drivers for and against change (Cumming, Bridgeman, & Brown, 2016; see Figure 1).

Although the FFA proposes to reduce resistances rather than overcoming them, such an approach can also result in polarizing conflict and delaying actual change. SEAM bypasses this issue by identifying the current dysfunctions and costs of the status quo that makes it untenable to remain in the status quo—no other change approach does this. The identification of dysfunctions enables participants to also identify the financial equivalent of inefficiencies and waste, discuss violations of personal values and goals, and can excite participants by offering

"baskets" of priorities that systematically move then toward achieving personal and organizational goals.

Figure 1

Force-Field Analysis and SEAM's bypassing it



Based on the authors' experience as healthcare and OD consultants, there are several components of SEAM methodology that address essential challenges in healthcare and its leadership.

The idea and practice of "command and control" is alive and well in healthcare (Morris, 2016; Sweetwood, 2018). Using a model similar to air traffic control systems, hospitals use information technology to coordinate functions. While this assists in providing structure to information and patient flows, the danger is to remove people from the dialog that creates such structures and creates a culture of sharing and collaboration. To meet federal guidelines and mandates, providers take on more administrative responsibilities, enter increasing detail in documentation, and schedule more patients for less time.

In our consultation with various healthcare groups we often hear the expectation of "do more with less" that is an impossible task referred to as "magical thinking" (Conbere & Heorhiadi, 2016). The result is work overload and emotional exhaustion by staff, and lower ratings of providers on HCAHPS and Press Ganey surveys by patients who resent their provider

entering data rather than attentively listening to them (Murphy, 2018). The time management tool in SEAM can be used to clearly identify the variety, duration, appropriateness, and time-cost of duties. The results, especially across a staff unit, can reflect massive wastes of time and resulting opportunity and financial costs. The shocking reality of such information, even when conservatively estimated, can help to "unfreeze" people from the status quo.

Identifying dysfunctions and "hidden costs" are a key feature of SEAM (Conbere & Heorhiadi, 2011) and a differentiator from other OD approaches. Hidden costs are those that do not appear on the standard balance sheet, and in healthcare are related to inefficient use of medical equipment, improperly performed medical services, inconsistent purchasing plans, maintenance mis-scheduling, staff-patient ratios, and poor control over medicine distribution, to name a few (Kister, 2014). Given the current emphasis on revenue deficits in healthcare, being able to reduce expenses and improve efficiency is a critical business skill. In our courses we introduce the concept of hidden costs that has rarely been considered by students and they are usually surprised with the extent of waste and inefficiency of the status quo. We have them conduct a hidden cost analysis of their current work to personalize it and consider what they could do if such time and financial costs were recovered. This opportunity cost and subsequent mirror effect of the dysfunctions can be shocking to client systems and is a useful pivot point to start identifying priorities for "bucket" projects.

One of the commonly acknowledged problems in healthcare structure is the "siloing" of healthcare organizations in which service departments tend to be functionally separated from each other, with limited communication and coordination among them. This is partly due to each profession being educated separately and hierarchical organizational structures being a legacy of the TFW virus. The cost of this structure lies in delays and miscommunication, failure to provide effective work flows for staff and services for patients and interference with the cost and quality requirements of healthcare reform (Rodak, 2012). Siloing reflects all five of the root causes of lack of steering, lack of synchronization, lack of negotiation, lack of cleaning up, and poor information systems. SEAM works with the whole organization, viewing organizations as integrated systems and engages everyone to help create solutions. Likewise, our MBA program enrolls interdisciplinary professionals in structured discussions on the application of SEAM to mitigate root causes and understand how their personal roles, relationships, and work flows interact.

For ourselves as consultants and for our graduate students who implement these practices, SEAM has been a challenge to shift our thinking from more rapid "fixing" of problems to a more relaxed and deliberate engagement of all stakeholders in an ongoing discussion of the nature of the dysfunctions. The use of time estimates is not as exacting as some people would like but taking a conservative approach to estimating makes it a stronger talking point. Finally,

the discussions themselves are a powerful tool to establish trust, build new conversational and problem solving norms, and set inspiring and prioritized goals in solving rural health issues.

Conclusion

Effective leadership in healthcare in general and rural healthcare in particular is more than just understanding and having credibility in clinical skills. It is an integration of business and clinical skills that are perfused throughout the organization in a very dynamic marketplace. Leaders across the organization and disciplines must understand how business skills, especially strategic skills of organization change, are required in this turbulent environment. SEAM offers a comprehensive approach to understanding how organizations resist change, a methodology and way of thinking to reduce such resistance and dysfunctions, and reorientation of the organizations toward the Triple Aim.

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