“What’s It All About?”

by Tim Size, Executive Director, Rural Wisconsin Health Cooperative (RWHC), Sauk City:

“What’s it all about, Alfie…” began the first line in the hit song of the same name, the year after I graduated high school. My name isn’t Alfie, but almost fifty years later, I still wrestle with the same question.

As songs sometimes do, it raised tough issues: “are we meant to take more than we give; are we meant to be kind; if only fools are kind, it is wise to be cruel, and if life belongs only to the strong, what will you lend on an old golden ruler?”

This tune came to mind during a recent trip with my wife and a friend to China. The trip held many surprises, as my mind’s eye view of China was often long out of date.

I was overwhelmed by the amount of new construction in the major cities, particularly Shanghai. It made Manhattan look like a sleepy backwater. I had not anticipated how fully Mao’s China had been replaced with a private economy straight out of America’s “gilded” age of capitalist robber barons.

An economist at the World Bank recently said China will surpass America’s gross domestic product (GDP) before the end of the year, although it is spread over four times as many people as in the USA.

In contrast, America has a tradition of understanding the value of competing ideas. By encouraging differences, we have often come up with better and more creative solutions.

But this tradition is eroding, most notably in our political debate where the voices on the extremes are dominating the sound waves with their assertions of holding all truth. Those against home schooling on the left or admitting climate change on the right, or

What’s it all about, Alfie…
avoiding childhood immunizations on the left and the right, are but three examples.

Those who ask hard questions or suggest compromise between opposing views are increasingly shouted down. It has become acceptable to shoot the messenger when we don’t like what the scientific method is telling us or when someone shares a different perspective.

This should be a concern for all of us, especially for those of us who work in rural health care. With decision making about healthcare becoming more centralized in both private and public sectors, we are at risk of fewer and fewer differences being proposed or tolerated.

Some of us believe that the conventional wisdom in health care is becoming less about the relationship between the caregiver and patient and more about navigating complex sets of rules with distant governmental agencies and insurance companies.

I am not arguing for the “status quo” when we question initiatives to improve the way we do business and care for patients. I am saying that being new is not automatically an improvement and being old is not automatically bad.

Rural advocates should not and will not stop speaking up for local access to care, the centrality of the health care practitioner-patient relationship and for diverse models of hospital and clinic ownership and control. We will continue to argue against arbitrary rules from Medicare that are trying to dictate who can be admitted into a hospital and for how long. We will continue to question rules that override the decision of qualified local caregivers about who is needed to provide what type of care in what settings.

If America loses its openness to asking questions and respectfully argue different points of view, we will lose our most important advantage in an increasingly smaller world. My hope for our country is that we keep asking, “What’s it all about?”

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**CMS Proposes Further Blocking Rural GME**

From “CMS Proposed Rule Could Cut Supply of Rural Physicians: *AAFP, Other Family Medicine Groups Call for Revisions*” by Sheri Porter, posted at [www.aafp.org](http://www.aafp.org) on 7/2/14:

“*The American Academy of Family Practitioners (AAFP) and the four organizations making up the Council of Academic Family Medicine have responded to a proposed rule from the Centers for Medicare & Medicaid Services (CMS) that, if finalized as is, could infringe on the U.S. graduate medical education (GME) system and compromise health care for underserved rural Americans.*”

“*In a June 26th letter to CMS Administrator Marilyn Tavenner, the five organizations say their comments stem from a conviction that the primary health care needs of rural America are not being met. ‘Of particular note, the production of primary care physicians, especially family physicians, is a key area where we believe CMS can and should do more to remove barriers to increased production,’ says the letter.*”

“A good portion of the letter deals with CMS’ proposal to treat rural training tracks differently from full rural hospital programs. Stan Kozakowski, M.D., the AAFP’s director of medical education, provided some important historical background on this point in an interview with *AAFP News.*”

“*‘The 2010 census resulted in the reclassification of a number of rural hospitals as urban,’ said Kozakowski.*
'This reclassification has major implications for GME financing for these hospitals and also hampers their ability to increase the number of CMS-funded GME positions in the affected communities.'

"The recent comment letter calls on CMS to completely rewrite portions of the proposed rule or, at the very least, ‘change its definition of ‘new’ under the authority the statute gives the (HHS) Secretary to ‘give special consideration to facilities that meet the needs of underserved rural areas.’"

"‘We are concerned that CMS, in its rulemaking, has not given the issue of production of rural physicians enough consideration,’ says the letter. To bolster its case, the letter cites a recent study that shows only 4.8 percent of all graduates of 759 sponsoring institutions practiced in rural areas. Of those 759 institutions, 198 produced no rural physicians.”

“The organizations note in their letter that this percentage compares unfavorably to the 19.3 percent of the population (about 62 million people, according to Kozakowski) living in rural American communities.”

“We hope CMS will take to heart its authority to provide special consideration for underserved rural areas and will construct regulations that enhance institutions’ ability to produce physicians who will practice in rural areas and serve underserved rural populations.”

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Fair Redistribution of GME Slots Possible?

On June 12, 2014 the Centers for Medicare and Medicaid Services (CMS) announced another round of the redistribution of Medicare residency slots under the Affordable Care Act (Section 5506).

The approximately 27 FTE’s have become available due to the closure of the Long Beach Medical Center in Long Beach, New York.

For those of you not familiar with how Medicare reimburses for graduate medical education (GME) program expenses, one of three ways to raise a prospective payment system (PPS) hospital residency program’s cap on reimbursement funding is by being awarded an additional cap by CMS from a program which has closed. (The other two ways are by starting a rural residency or Rural Training Track (RTT) with a rural hospital or rarely by legislation changes.)

While we will have to wait and see who receives the additional cap, consider that a single urban residency often garners 30 to upwards of 100 slots, and may not graduate a single rural physician.

As we work to expand rural GME, we must continue to have our voices heard against outdated CMS regulations and attitudes about the role of rural GME.

If these 27 slots were set aside for developing or expanding RTTs, it would make a significant dent in the need to train more rural physicians across the country.

For information about applying for these slots:  
http://ow.ly/yY4qn

The deadline to apply is September 2, 2014.
The Courage to Be a Geriatrician

The following is an excerpt from “The Courage to Be a Geriatrician” by James L. Wright, MD in the Journal of the American Geriatrics Society, 6/14:

“The words still haunt me. I was a new doctor in rural Virginia, rounding with a medical student in one of my nursing homes. ‘These people are ending their lives in a nursing home,’ I said. ‘No one wants to be here. I think one of the kindest things we can do is to make sure we don’t keep them alive any longer than necessary.’ I almost immediately regretted saying it, but there it was, heavy with my dislike of the nursing home and, by extension, those who lived there.”

“Maybe I could be excused for this—the facilities I had seen early in my career were depressingly similar in the endless sound of their call bells and dingy hallways filled with worn equipment and harried staff. Nursing homes were places where chronically ill and dependent people went to be ignored—by Medicaid, by society, by physicians. Still, somehow I knew that what I had just said to my medical student had broken something—a rule, an ethical obligation, a trust that had been left in my care.”

“As a newcomer to long-term care, I found it hard to resist breaking that trust, hard to resist the notion that those who lived there were somehow less important. I was an American, raised in a culture that prizes youth and energy and enshrines independence in our national charter; I found it hard not to bring that culture with me to the nursing home. I was not the only one who felt like this, of course. How many times had I heard ‘just shoot me if I ever get like that’ when I told someone where I worked? It was not just me; it was my culture, and in this culture, a lot of us share a common belief: life is of less value when it is lived in dependency.”

“By now, I have read the studies about how able-bodied people always underestimate the quality of life of those with dementia and dependency, but in those early days, I could not imagine that my patients’ lives had much quality at all. The fact that my quality-of-life estimation could vary so greatly from that of my patients meant that those I saw early in my practice were at the mercy of my prejudices, prejudices that were given power in the orders I wrote or declined to write, basing decisions not on whether a medical therapy would support a life but whether that life was worth supporting.”

“I came out of residency well trained and educated—I was ready to protect my older patients against the dangers of interacting medications, unnecessary procedures, and unfamiliar environments, but I was not ready to protect them against my culture. I was not ready to assume the care of an individual whose measure of their life’s quality was based on something other than achievement and independence.”

“It is easy to find meaning as a doctor—we heal, we comfort, we contribute to a society that rewards us with a decent living, respect, and fascination enough to launch an endless series of television shows. It is easy to drink deeply from this fountain and eventually to become addicted to its waters, unable to separate our identity and sense of self-worth from our work, hard to resist the feeling that in order to be someone of value, we must do something of value. When I walked into my first nursing home as a young doctor, though, I was confronted with the reality that there are places and times in life where productivity, achievement, and independence are nothing other than fading memories.”

“I found nursing homes to be such depressing and fearful places because they were where the ground gave way, where the very foundation of my own value and significance crumbled. It took the conversation with my medical student to bring me to the realization that not only did I not like the nursing home, I was afraid of it and the people who lived there. If I were to fulfill those pledges to treat my patients with their best interests in mind, I would have to find a way not to be afraid of them. I had the smarts to be a geriatrician; what I needed was courage.”

Go to http://ow.ly/ejmLf to learn more.

NRHA Rural Leadership Development

The National Rural Health Association has launched a permanent endowment for programs that identify emerging leaders from and for rural communities.
culture in which meaning is not somehow tied to what we do and how well we do it. Meaning equals doing for many of us, and with the loss of the ability to do, we struggle to find meaning.”

“There is this book by Paul Tillich, a Christian theologian, called The Courage to Be. I read this book once, skimming it quickly for a theology class. I found it while cleaning out my office a few years later and realized this—Tillich, writing in the 1950s, could well be talking about the courage one needed to be a geriatrician in the 21st century.”

“Tillich knew that modern life could appear to be meaningless and the sense of that meaninglessness grew more acute as one became less productive, less a part of something greater. Tillich found the courage to face the threat of this meaninglessness in the teaching that all beings have equal value not because they have earned value but because they have been granted it.”

“Of course it is not just something to be found in theology books. This notion of unearned meaning and equality is found in our Declaration of Independence—‘...that all [people] are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the Pursuit of Happiness.’ Tillich shared the founding fathers’ insistence that people are equal because they have been endowed with equality, not because they have achieved it.”

“So I have been trying this out recently—trying to believe that we are not only created equal, but also that we retain equality through all stages of life. As I am slowly growing in the confidence that the meaning and value of my own life transcends my accomplishments and my failures, I am able to find meaning and value in the lives of my patients. Finding the courage to simply ‘be’ gives me the courage to walk into the nursing home every day and advocate for my patients, recognizing their significance despite all evidence to the contrary.”

“I am a better advocate for my patients now than I once was. Finding courage to face life as dependent and frail helps me to do this, and on my best days, I think I do pretty well. We have a long way to go as a society to balance an emphasis on independence and achievement with recognition of the worth and value of those who have lost it. For now, nursing homes remain the poor houses of the modern age.”

“Meanwhile, I continue to gain inspiration from my patients who find meaning and value in their lives despite their dependency, despite the reminders that society has forgotten them. I have also found others—nurses, aides, nurse practitioners, physicians—who have faced the inevitability of their own future frailty and find the courage to believe that life’s meaning does not depend on their abilities.”

“With the courage simply to be, they must continue to work in recognition of the meaning that all lives hold, and by their presence, the time they take to sit next to a bed or a wheelchair and say ‘What can I do for you today?’ they remind their patients that we are loved even when we are unlovable, accepted even when we are unacceptable. One day, nursing homes may be different and may be places where our society truly supports the notion that not only are all created equal, but that all remain equal throughout their entire lives. We still have a long ways to go, but the courage to get there rests in the courage to be.”

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Healthy Hospitals Make Healthy Communities

From “Improving Population Health: A Guide for Critical Access Hospitals” by the National Rural Health Resource Center and Stratis Health, 6/14:

“The U.S health care industry is undergoing profound change in financing and service delivery as it shifts from a financial system that rewards ‘volume’ to one that is based on ‘value.’ Value-based payment systems are being designed to address a three-prong approach known as the Triple Aim of providing better care, improving health and lowering costs.”

“Today, small rural hospitals face the challenge of being successful in their current payment systems, while preparing for new value-based payment systems that are being rolled out in various forms across the country. It is more important now than ever for rural hospitals to participate in efforts such as implement-
ing population health strategies to help demonstrate the quality and value they provide rural residents.”

“The improving health component in striving for the Triple Aim is commonly referred to as ‘population health.’ Population health encompasses a cultural shift from a focus on providing care when individuals are sick to a more comprehensive view which includes enhancing and improving the health of communities across a spectrum of ages and conditions.”

“The National Rural Health Resource Center (The Center), hosted a Population Health Summit meeting last March in Bloomington, Minnesota with funding from the Federal Office of Rural Health Policy. The goal of the Summit was to assemble national rural hospital and population health experts to create recommendations for rural hospitals on actions and activities to address population health needs in their communities using a systems-based framework to ensure a holistic approach. The results of this Summit are summarized in a 37 page Guide.”

“The Guide is intended to be a tool for rural hospital leaders to support incorporation of population health principles and programs into strategic planning and operations. Challenges are addressed, resources are provided, and quotes reflecting the Summit discussion are highlighted throughout the Guide's components. Included in the supplemental portion of this document are additional ideas and recommendations from Summit participants as well as resources and references to support rural hospital engagement in implementing population health strategies.”

The Guide is available at http://ow.ly/y5yLC

ICD-10 in Review

Have you completed your ICD-10 basic code set education? Do you feel confident to dive into the ICD-10 transition?

To help you maintain your knowledge of the guidelines and to enhance your ICD-10 skillset, RWHC has developed a comprehensive WebEx series. Each ICD-10 session will highlight a different body system or chapter to review learned ICD-10 concepts and guidelines. The sessions include a lecture/presentation focusing on a body system/chapter, PCS groups and characters, as well as provide hands-on case studies to build and enhance your knowledge of the new system as well as provide practical skill building opportunities. Benefits of the sessions include:

- 30 total hours of ICD-10 education (AHIMA ICD-10 CEU credits)
- WebEx sessions eliminate travel time and are scheduled to accommodate your busy schedules
- Enhance your coding knowledge and skillset
- Increased awareness of the ICD-10 effects
- Peer group discussions regarding problematic coding scenarios
- An opportunity to discuss real life scenarios within group setting
- Address coding productivity prior to ICD-10 implementation
- Led by AHIMA Approved ICD-10-CM/PCS Trainer

To accommodate working schedules and minimize time away from your office, these monthly ICD-10 review sessions will be held from 3:00-6:00 pm on the second Thursday of each month, beginning in October 2014 and to conclude in July 2015. The sessions will be hosted by RWHC’s Coding Consultant Sheila Goethel, RHIT, CCS, CDIP, AHIMA Approved ICD-10-CM/PCS Trainer.

For more information, please go to our website http://ow.ly/yHwV3 or contact Sheila Goethel at sgoethel@rwhc.com or 608-643-2343.

Leadership Insights: “3 Pivotal Conversations”

The Leadership Insights series is by Jo Anne Preston, RWHC Organizational Development Manager. Back issues available at www.RWHC.com.

“When it comes to communicating at turning points, I am a fan of stating the obvious. When something seems obvious, we often decide not to voice our think-
ing, and sometimes this can be a missed opportunity to make things better. Here are three such communication junctures where leaders can make a big difference in the long run, and some ways to ‘say it.’ ”

1. **When you have a new employee.** “Obviously, there are many important discussions with new hires, but one conversation I wish I had known to have 30 years ago was this one that I learned from my accomplished and esteemed colleague Cella Janisch-Hartline, RN, RWHC Nurse Consultant, in the Preceptor Workshop.”

   “‘I want you to be successful here! My intention when I give you feedback on your performance is for this purpose. So I will tell you when I see you hitting the mark, and I will also give you feedback when I see something that is getting in the way of your success—whether a technical skill or a behavior that I believe could undermine you.’ This statement paves the way for both of you to have a difficult conversation if it is needed because you can always reference back to the purpose of feedback being for their success, making it less painful for them to hear and less of a chance that you will avoid giving feedback.”

   “‘You bring a fresh set of eyes. Talk to us about your experience, especially as you go through these first few months. Help us be better, too.’ Maybe you already say this but do you really mean it? Too often we either forget check back in and genuinely ask or we get defensive if they say anything less than positive. Even if we’re not openly guarded, we have to make it easier for employees to tell us what they see because it is not comfortable for most new employees to do this. Decide to mean it when you say it and respond to any negative comments with, ‘Tell me more about that,’ rather than defensiveness.”

   “‘If you are here a year from now, what would you like to be able to say about your first year?’ This can tell you volumes about what a new employee is going to need from you. Everyone at the front end wants it all to work out and investing in a retention plan unique to each employee makes it more likely.”

   “A follow-up inquiry to the previous, ‘How would I know if you were struggling in this first year?’ And don’t accept, ‘Oh you’ll know,’ for an answer. Many new employees, especially those with experience in other organizations or roles, underestimate their learning curve. Ask them to think about what struggling might look like for them, what they may or may not say about it, and what would help them feel more comfortable in speaking up and asking you for help if they needed it.”

2. **When you are managing a former manager.** “This is a tricky situation, especially if they were YOUR former manager. You both need it to go well, but there are land mines, even when it is a voluntary role change for the former manager. Role changes always require a shift in perception on everyone’s part and can leave people with a lack of clarity. Sometimes age and experience differences add to the challenge of employees fully placing you in the manager role as well. Most former managers don’t intend to undermine you, but may do so unknowingly. To prevent problems, you might try the following starters with the former manager:

   ‘I’d really like your support.’ Again, states the obvious, but we can’t assume support so be bold and ask directly for it.

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**Hold November 12th for “Building a Culture for Patient-Centered Team Based Care”** sponsored by the Wisconsin Council on Medical Education and Workforce (WCMEW). The purpose of the conference is to showcase successful health care teams with dialogue about how cooperation among health professionals leads to continuous improvement of patient care. Will be at the Glacier Canyon Lodge located in the Wisconsin Dells; registration not yet open.
‘Here’s what your support would look like: (fill in the blank).’ DO fill in the blank. The word ‘support’ means different things to different people so be specific. Have a dialogue such as:

- ‘When employees come to you with supervisory issues, let’s discuss how you can respond.’ Making this a dialogue instead of telling them exactly what you want them to say engages you both in the solution and gets their buy-in.

- Once you settle the first issue, follow with, ‘Now let’s talk about what other issues might come up because of the role change so that we are both ready for them.’ Shed a light on any potential problems before they occur, prepare—even role play—for them and reconnect around your shared goal of the team’s success.”

2. When anyone wants to engage you in gossip. “There are usually plenty of opportunities for us to practice this pivotal conversation in most workplaces. The response is pretty simple. ‘I’m just not comfortable talking about this person when they aren’t here.’ If you have gossiped in the past (most of us have), ‘I know I have talked about this person before with you, and I don’t feel good about it. I need to stop. If one of us has a concern with her, we need to talk with her directly.’ Wouldn’t it be amazing if we all committed to this?”

Contact Jo Anne Preston for individual or group coaching at jpreston@RWHC.com or 608-644-3261. For Info re the RWHC Leadership Series 2013 go to www.RWHC.com and click on “Services” or contact RWHC Education Coordinator Carrie Ballweg at cballweg@RWHC.com or 608-643-2343.

### Upcoming RWHC Leadership Programs

- **July 30:** Become A Dynamic Communicator
- **August 11 & 12:** Preceptor Training Program
- **August 28:** Leading Change When Change is Hard

To register, go to: [www.RWHC.com/Services.aspx](http://www.RWHC.com/Services.aspx)