CMS Needs to Talk with Us to Understand Us

The following is from a letter sent by Congressmen Ron Kind (D-WI) and Reid Ribble (R-WI) to then Department of Health and Human Services Secretary Kathleen Sebelius, shortly before her resignation. Hopefully Secretary Sylvia Mathews Burwell will take up this opportunity once she has a chance to settle in.

“We are writing today to express our deep concerns with recent events and what seems to be a negative perception by the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) regarding the value and role of rural hospitals.”

“Whether it was the Office of the Inspector General’s (OIG) most recent report on Critical Access Hospitals (CAHs) or recent CMS regulations that will undermine the rural health care safety-net, we are concerned by what these policies will mean for the health care needs of our constituents and millions of rural residents across the country. For example, if recommendations in the OIG report were implemented, the OIG indicates that 849 or 64% of current existing CAHs nationally could lose their status. This would lead to massive voids in access to health care across rural America.”

“We have no doubt that you intimately understand the vital role these hospitals play in providing access to health care, economic security for families and seniors, as well as jobs to rural communities across the nation. These hospitals are safety nets for millions of Americans, providing inpatient and outpatient services, as well as 24-hour emergency care. CAHs make it possible for patients with primary care to more complex medical needs to remain at home for care in their rural communities.”

“Rural hospitals serve as local economic engines while providing efficient, cost effective care. In fact, Medicare spends 3.7% less per rural Medicare beneficiary than per urban beneficiary and Wisconsin hospitals remain leaders in federal quality and efficiency measurement.”

“Yet, many of these facilities face significant challenges including: remote geographic locations, administrative workforce scarcity, physician shortages, and limited financial resources. Taking all of these factors into account, we are still in support of smart, thoughtful and targeted Medicare reforms to reduce costs and maintain high quality care. We stand ready to work with CMS on this joint goal.”

“To that end, we would request a sit-down meeting to initiate that constructive dialogue between CMS, Wisconsin Members of Congress and rural hospital representatives from Wisconsin. We would be honored to have you participate in this meeting as well as any others of your leadership team and other CMS staff involved with rural hospitals.”

“Training in the sticks, sticks” - David Schmitz, MD, Director of Rural Training Tracks at the Family Medicine Residency of Idaho.

RWHC Eye On Health, 5/12/14
The Left & Right Need Each Other’s Insights


“This isn’t an accusation from the right. It’s a friendly warning from Jonathan Haidt, a social psychologist at the University of Virginia who, until 2009, considered himself a partisan liberal. In *The Righteous Mind*, Haidt seeks to enrich liberalism, and political discourse generally, with a deeper awareness of human nature. Like other psychologists who have ventured into political coaching, Haidt argues that people are fundamentally intuitive, not rational. If you want to persuade others, you have to appeal to their sentiments. But Haidt is looking for more than victory. He’s looking for wisdom. That’s what makes *The Righteous Mind* well worth reading. Politics isn’t just about manipulating people who disagree with you. It’s about learning from them.”

“To the question many people ask about politics—Why doesn’t the other side listen to reason?—Haidt replies: We were never designed to listen to reason. When you ask people moral questions, time their responses and scan their brains, their answers and brain activation patterns indicate that they reach conclusions quickly and produce reasons later only to justify what they’ve decided.”

“The problem isn’t that people don’t reason. They do reason. But their arguments aim to support their conclusions, not yours. *Reason doesn’t work like a judge or teacher, impartially weighing evidence or guiding us to wisdom. It works more like a lawyer or press secretary, justifying our acts and judgments to others.*”

“Haidt has read ethnographies, traveled the world and surveyed tens of thousands of people online. He and his colleagues have compiled a catalog of six fundamental ideas that commonly undergird moral systems: care, fairness, liberty, loyalty, authority and sanctity. Alongside these principles, he has found related themes that carry moral weight: divinity, community, hierarchy, tradition, sin and degradation.”

“You don’t have to go abroad to see these ideas. You can find them in the Republican Party. Social conservatives see welfare and feminism as threats to responsibility and family stability. The Tea Party hates redistribution because it interferes with letting people reap what they earn. Faith, patriotism, valor, chastity, law and order—these Republican themes touch all six moral foundations, whereas Democrats, in Haidt’s analysis, focus almost entirely on care and fighting oppression. This is Haidt’s message to the left: When it comes to morality, conservatives are more broad-minded than liberals. They serve a more varied diet.”

“The hardest part, Haidt finds, is getting liberals to open their minds. Anecdotally, he reports that when he talks about authority, loyalty and sanctity, many people in the audience spurn these ideas as the seeds of racism, sexism and homophobia. And in a survey of 2,000 Americans, Haidt found that self-described liberals, especially those who called themselves ‘very liberal,’ were worse at predicting the moral judgments of moderates and conservatives than moderates and conservatives were at predicting the moral judgments of liberals. Liberals don’t understand conservative values. And they can’t recognize this failing, because they’re so convinced of their rationality, open-mindedness and enlightenment.”

“Haidt isn’t just scolding liberals, however. He sees the left and right as yin and yang, each contributing insights to which the other should listen. In his view, for instance, liberals can teach conservatives to recognize and constrain predation by entrenched interests. Haidt believes in the power of reason, but the reasoning has to be interactive. It has to be other people’s reason engaging yours. We’re lousy at challenging our own beliefs, but we’re good at challenging each other’s.”

“Our task, then, is to organize society so that reason and intuition interact in healthy ways. Haidt’s research suggests several broad guidelines. *First, we need to help citizens develop sympathetic relationships so that they seek to understand one another instead of*
using reason to parry opposing views. Second, we need to create time for contemplation. Research shows that two minutes of reflection on a good argument can change a person’s mind. Third, we need to break up our ideological segregation. From 1976 to 2008, the proportion of Americans living in highly partisan counties increased from 27 percent to 48 percent. The Internet exacerbates this problem by helping each user find evidence that supports his views.”

“How can we achieve these goals? Haidt offers a Web site, www.civilpolitics.org, on which he and his colleagues have listed steps that might help. One is holding open primaries so that people outside each party’s base can vote to nominate moderate candidates. Another is instant runoffs, so that candidates will benefit from broadening their appeal. A third idea is to alter redistricting so that parties are less able to gerrymander partisan congressional districts.

Performance Measures Must Factor in Context


“Federal policies to reward high-quality health care are unfairly penalizing doctors and hospitals that treat large numbers of poor people, according to a new report commissioned by the Obama administration that recommends sweeping changes in payment policy.”

“Medicare and private insurers are increasingly paying health care providers according to their performance as measured by the quality of the care they provide. But, the draft report by an expert panel says, the measures of quality are fundamentally flawed because they do not recognize that it is often harder to achieve success when treating people who do not have much income or education.”

“Low-income people may be unable to afford needed medications or transportation to doctor’s offices and clinics, the panel said. If they have low levels of formal education or literacy, they may have difficulty understanding or following written instructions for home care and the use of medications.”

“The panel found that existing payment policies unintentionally worsen disparities between rich and poor by shifting money away from doctors and hospitals that care for ‘disadvantaged patients.’ ”

“Measures of health care quality and performance—widely used by Medicare and private insurers in calculating financial rewards and penalties—should be adjusted for various ‘socio-demographic factors,’ the expert panel said. The panel was created by the National Quality Forum, an influential nonprofit, nonpartisan organization that endorses health care standards.”

“ ‘Factors far outside the control of a doctor or hospital—patients’ income, housing, education, even race—can significantly affect patient health, health care and providers’ performance scores,’ said Dr. Christine K. Cassel, the president of the organization.”

“The Obama administration commissioned the study, but is not entirely comfortable with the recommendations, officials acknowledged. The existing policies of the National Quality Forum and the government say performance scores should generally not be adjusted or corrected to reflect differences in the income, race or socioeconomic status of patients.”

“Steven H. Lipstein, the president of BJC HealthCare in St. Louis and a member of the panel, said: ‘The administration’s current policy on adjustments for socioeconomic status are quite inadvertently exacerbating disparities in access to medical care for poor people who live in isolated neighborhoods. I’m sure
that’s not what President Obama intended with the Affordable Care Act.’”

“The 26-member panel said policy makers who devise or use performance measures should ‘assess the potential impact on disadvantaged patient populations and the providers serving them,’ to avoid hurting ‘safety net providers.’”

“Many provisions of the 2010 health law seek to improve care by tying Medicare payments to the performance of doctors, hospitals, nursing homes and health plans. Medicare, for example, is reducing payments to hospitals where an above-average share of patients return within a month of being treated and discharged.”

“But for hospitals with large numbers of poor patients, the panel said, such financial penalties are unfair because ‘readmissions are difficult to avoid in patients who can’t afford post-discharge medications, have no social support to help with recovery at home, have no way to get to follow-up doctor appointments or are homeless.’”

“Two doctors or hospitals that provide the same high-quality care may get very different outcomes if one has mostly low-income patients and the other serves a more affluent population, the panel said.”

“Using the raw data, without any adjustment for poverty or other demographic factors, ‘can lead to incorrect inferences about quality’ and ‘provides the public, including patients, with misleading measures of performance,’ it said. ‘Providers with a disproportionate share of disadvantaged patients will appear to provide lower-quality care than they actually do, and vice versa.’”

“In existing pay-for-performance programs, the panel said, doctors and hospitals serving poor people are more likely to be identified as ‘poor performers’ and to face financial penalties. The penalties deprive these providers of the resources they need to improve care, and ‘it is ultimately the patients who suffer,’ it said.”

“The Obama administration has championed the idea of pay for performance, with financial penalties for hospitals where deaths, readmissions or complications occur at rates above the national averages.”

“Research by the Medicare Payment Advisory Commission, which advises Congress, tends to support the National Quality Forum. ‘Lower-income patients have higher readmission rates,’ the commission said, and major teaching hospitals, which serve large numbers of indigent patients, face the highest penalties.”

“Dr. Atul Grover of the Association of American Medical Colleges, a member of the expert panel, said: ‘Teaching hospitals take care of the poorest, sickest, most vulnerable patients. They should not be penalized for factors outside their control.’”

Rural Telemental Health Update

From the Maine Rural Health Research Center Research & Policy Brief, “Telemental Health in Today’s Rural Health System,” by David Lambert, John Gale, Anush Y. Hansen, Zach Croll, and David Hartley, December, 2013:

“Telemental health has long been promoted in rural areas to address chronic access barriers to mental health care. Policymakers and advocates tend to view telehealth technology as particularly promising given the chronic shortage of mental health clinicians and long travel distances to care. While support and enthusiasm for telemental health in rural areas remains quite high, we lack a clear picture of the reality of telemental health in rural areas, compared to its promise.”
"The term ‘telemental health’ is intentionally used broadly within the literature to refer to the provision of mental health care at a distance. Services provided using telemental health are generally considered to be the same as those delivered in person. In this study, we define a telemental health program as a program in which direct ‘one-on-one’ services for the treatment of a mental health condition are provided through two-way televideo technology with the specialty mental health provider at one location known as the ‘distant’ site and the patient located at another location known as the ‘originating’ site. The distant site may also be referred to as the presenting, hub, specialty, provider/physician, referral, or consulting site. The originating site may also be referred to as the spoke, patient, remote, or rural site.”

“As technology improves and its costs decrease, interest continues to grow in using technology to expand access to mental health services to rural residents. Despite this interest, many telehealth experts note that current barriers to greater use of telehealth are less about the technology and more about the services that can be provided to patients across service delivery settings.”

“At a 2012 IOM telehealth workshop, a representative from the American Telemedicine Association noted a number of ‘deadly’ barriers to the ongoing expansion of telehealth, including (1) money (limited reimbursement rates; fear of driving up costs; attracting technology companies that see large financial opportunities but do not understand health care delivery); (2) licensure and practice regulations; and (3) hype (excitement and enthusiasm that exceed practice realities and challenges).”

“In-depth telephone interviews of 23 programs conducted provide important insight into telemental health’s current and future role in the rural health system. Below we briefly describe some of the key takeaways from our telephone interviews.”

**Access**—“The impetus for first using telemental health in rural areas was to provide a needed service that otherwise would not be available due to the limited number of mental health professionals in rural areas. Equipment and infrastructure costs were substantial, but early demonstration programs established that services could be provided to at least some rural persons needing them. Since then, telemental health technology has steadily improved and its cost has steadily declined. This has led many to assume that telemental health can help reduce the persistent mental health access problem in rural areas.”

“We found that telemental health programs are providing more types of services than in the past in a variety of settings. However, many of the programs we studied, particularly smaller programs, reported serving a relatively modest number of patients through their telemental health services. The smallest programs served only several patients per week.”

“Providers also reported using telemental health services to address emergent issues at remote sites, when the providers were not present. Typically, programs were able to say that telemental health enabled them to provide services to rural persons that otherwise would not be available, but often were not able to indicate with any certainty how much additional volume or new services they might be able to deliver in the future.”

**Reimbursement**—“Despite receiving some level of third party reimbursement, many respondents reported that they may not be able to sustain the services without grant funding or other supplemental support. It was difficult to determine whether the challenge of sustaining services stemmed from reimbursement barriers, productivity levels, or characteristics of the populations served (e.g., low income, self-pay, uninsured patients, or fee schedules that don’t cover costs).”

**Patient and Provider Satisfaction**—“Respondents reported that, in general, their patients are satisfied with telemental health services and did not report any resistance to their use. Providers are also generally satisfied with using telemental health technology to provide services.”

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**23rd Annual $2,500 Monato Essay Prize**

A $2,500 Prize for the Best Rural Health Paper by a University of Wisconsin student or recent graduate. Write on a rural health topic for a class and submit by June 1st. Submission info available at [www.RWHC.com](http://www.RWHC.com)
Successful Use of Telemental Health—“Telemental health can be implemented with greater success in certain settings and/or organizational delivery systems than others. For example, smaller practices that contract with private mental health or hospital-based providers to deliver telemental health services frequently report difficulty recruiting a replacement when their existing provider terminates their agreement. This seems to be less of an issue for larger network or system-based programs as they can rely on the resources of the larger organization. These programs can also deploy the services of their clinicians, usually located at a central location, to serve rural locations within their system. Consequently, there is usually less interruption of services when a clinician departs.”

The full article is at http://ow.ly/wlkuD

Honoring Choices WI Seeks Rural Participants

Honoring Choices Wisconsin (HCW), the advance care planning initiative of the Wisconsin Medical Society, is recruiting rural hospitals and clinics for its fall round of trainings.

HCW serves to promote and improve processes for advance care planning across the state in clinical settings and communities. It emphasizes advance care planning as a process for preparing for future medical decisions, including decisions at the end-of-life.

Through HCW, organizations can ensure that quality advance care planning conversations are consistently offered, scheduled, conducted, documented, and entered into the medical record.

“Honoring Choices did a fantastic job of helping our patients engage in these critically important conversations,” said Mike Wallace, President and CEO of Fort HealthCare in Fort Atkinson. “I highly recommend the program to my colleagues in rural medicine.”

Since 2012, HCW has trained 170 facilitators in 16 organizations across the state, who have in turn facilitated thousands of advance care planning conversations. These programs can result in:

- Improved understanding of advance care planning, hospice and palliative care among physicians, other health care professionals and patients.
- Higher advance directive completion rates.
- Significant improvement in end-of-life care.
- Fewer hospital readmissions and patient intensive care unit days and increased hospice utilization.
- Greater satisfaction among family members after the death of a loved one.

The Society serves as convener, coordinator and catalyst for HCW. To facilitate this approach, the Society:

- Organizes design and implementation, facilitator and instructor training courses.
- Helps participants form pilot teams and develop their work flow.
- Provides a forum for information sharing.
- Engages physicians on the importance of advance care planning.
- Drives community involvement and education.
- Publicizes the project and its participants.

The initiative asks that participants commit to a shared approach to advance care planning, common language and documentation, to collaborate and share innovation, and for a financial commitment to the program.

For more information, contact John Maycroft, Society Director of Policy Development and Initiatives, at john.maycroft@wismed.org or 608.442.3766 or visit www.honoringchoiceswi.org.

The name “Honoring Choices Wisconsin” is used under license from East Metro Medical Society Foundation.

Support 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. The mission is to provide training and resources to help them play a lead role in ensuring access to quality health care for rural Americans.

Go to http://ow.ly/ejmLf to learn more.
Leadership Insights: “Are You Happy?”

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

“ ‘Are you happy?’ Personal question, I know. Am I on thin ice putting such a ‘squishy’ topic as happiness in a leadership development article? The topic came to me when I was compelled to pull my car over to write down a profound statement I heard (NPR, March 2014) in reference to Pope Francis, a person who is on multiple lists of most influential, most powerful leaders:

‘Unfeigned happiness on the part of a public figure is not that common.’ ”

“Clearly genuine happiness is an asset to the Pope in maximizing his influence and connecting with people. People describe him as transparently happy as he:

- Is completely comfortable in his own skin
- Shows humor and informality
- Waits in line like others, eats with others, travels with others—all things for which he could get special treatment but he doesn’t ask for it”

“After hearing this report, I started finding some very interesting data:

- 25% of job success is predicted by IQ, but
- 75% of success at work is predicted by optimism level, social support and ability to see stress as a challenge instead of a threat (Estrada, Isen and Young, 97). Know anyone like this?”

“Shawn Achor, Harvard professor and researcher on the topic of happiness has shown that, when we are happy we are more creative, productive and accurate. He goes on to state in his very entertaining TED talk on The Happiness Advantage <http://ow.ly/wmFBT> that our formula for happiness has been backwards. The trouble with this formula is that our brain never gets to feel the promised happiness, because there is always ‘the next thing’ on the horizon that you will need to achieve to reach that happiness. It’s a chase. The trick is to be positive in the present moment, because that is when we are at our best.”

“Pay attention to happiness in your hiring decisions (and if you are looking for promotion). Years ago I heard a human resource conference speaker from a Fortune 500 company say that his policy on hiring was to ‘only hire happy people,’ implying the job can’t make you happy if you aren’t already. People want to hire the happier person, and employees want to be around people who are fun and funny.”

“Observe leaders who have willing followers and you will see their spark of genuine happiness. Consider this quote from The Truth about Leadership by James Kouzes and Barry Posner: ‘If you think you are a leader, and you turn around and no one is following you, you are just out for a walk.’

“Here is a quote from the Dalai Lama on a hint on how to be happier: ‘If you want others to be happy, practice compassion. If you want to be happy, practice compassion.’ ”

“Showing compassion not only makes us feel happier, but compassion has also been demonstrated to increase DHEA, the hormone that interrupts the aging process. Compassion also reduces the stress hormone cortisol.”

“Our brain neurons also change in a positive way when we alter our habits and thought patterns. Try on these two simple habits daily for three weeks to increase your happiness via compassion:

1. Try the ‘Just like me’ exercise. Think of others with whom you struggle, and fill in the sentence, ‘Just like me, this person is...’ In the midst of your differences, where are you similar? Sometimes we judge colleagues for their different management or work style. Try thinking differently: ‘Just like me, this person ...wants things to achieve success, wants to be right, is learning the best they can, etc.’

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2. **Practice gratitude.** Find 3 things you are grateful for each day and consciously note them. You might even write them in a quick note to a staff member for something they have done for you. This is not just a ‘nice thing to do.’ Research has shown that increasing our sensitivity to gratitude heightens our feelings of happiness.”

“Leaders influence us. Happiness influences us. It makes sense that the two together have an impact greater than the sum of the parts. It’s not about demanding happiness, but it may be about looking differently for it if it seems like it’s always around the corner.”

“The thing I remember best about successful people I’ve met all through the years is their obvious delight in what they’re doing and it seems to have very little to do with worldly success. They just love what they’re doing, and they love it in front of others.” *Fred Rogers, The World According to Mister Rogers*

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**Team members newly hired? Recently promoted?**

**Looking to brush up on some management skills?**

RWHC offers a series of leadership development workshops that focus on the critical areas of success for health care leaders. Topics include skills like coaching, conflict resolution, clear communication, leading change—and many more. Workshops are offered to attendees at RWHC in Sauk City, and can also be custom designed to work with your leadership team in your community. This option has many advantages for your team as they learn together and it also saves you time and travel.

- **June 27:** **Teams: Building Blocks and Facilitation Tools**
- **July 10:** **The Power of Three: Time Management, Delegation & SMART Goals**
- **July 30:** **Become A Dynamic Communicator**

To register or see the complete catalogue: [www.RWHC.com/Services.aspx](http://www.RWHC.com/Services.aspx)

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