From “Similarities between Democrats, Republicans make them so different” by David Sherman and Leaf Van Boven in the Los Angeles Times, 9/24/14:

“One idea gaining currency among psychologists and political scientists is that Democrats and Republicans are politically polarized because they are fundamentally different. As one science journalist concluded after reviewing the literature: ‘A large body of political scientists and political psychologists now concur that liberals and conservatives disagree about politics in part because they are different people at the level of personality, psychology and even traits like physiology and genetics.’ ”

“Americans are certainly polarized. According to a recent Pew Research Center poll, 36% of Republicans and 27% of Democrats see the opposing party as a threat to the nation’s well-being. But are differences in biology and personality really responsible for political polarization? Perhaps in part. Liberals and conservatives obviously have different ideologies, and research indicates that these ideological differences are correlated with differences in biology and personality.”

“Research published in Current Biology, for example, found that conservatism was associated with increased gray matter in the right amygdala, whereas liberalism was associated with increased gray matter volume in the anterior cingulate cortex. Other research has found personality differences such that conservatives have a greater need for order, structure and authority than liberals.”

“But despite the intuitive appeal of such conclusions, explaining political polarization with differences in biology and personality overlooks a crucial fact: A big part of the reason Democrats and Republicans are at loggerheads is that they are so similar.”

“When Democrats and Republicans in Congress can’t pass legislation—whether on gun control, immigration or climate change—it is often because both sides have dug in with a similar obstinacy. They both think about political information in a partisan, biased manner.”

“Consider the ‘party-over-policy’ effect, illustrated by Republicans when it came to the Affordable Care Act. The law’s basic tenets—including the idea of an individual mandate—grew out of Republican proposals. But once Democrats got on board, Republicans turned against it, even asserting that the individual mandate was unconstitutional.”

“The psychological pull to support one’s own party and oppose the other is true of both the left and the right. Geoff Cohen of Stanford University conducted experiments on welfare policy in which subjects felt very differently about proposals depending on which party they were told supported them. ‘If their party endorsed it,’ the study found, ‘liberals supported even

“Age is an issue of mind over matter. If you don’t mind, it doesn’t matter.” - Mark Twain
a harsh welfare program, and conservatives supported even a lavish one.’ Note the symmetry: Liberal participants were no more likely than conservatives to base their judgments upon the actual content of the policy. Ezra Klein called this kind of party-over-policy thinking the ‘depressing psychological theory that explains Washington.’ ”

“It might seem that political differences could be minimized if people could somehow be encouraged to consider policies and evidence in their own right. But this turns out to be not so easy to achieve.”

“In a recent series of studies on ‘solution aversion,’ Troy Campbell and Aaron Kay of Duke University found that people’s evaluation of scientific evidence was very different depending on whether they saw the policy implications of the science as politically desirable.”

“Republicans and Democrats read a statement asserting that global temperatures will rise 3.2 degrees in the 21st century. They were then asked to evaluate a proposed policy solution to address the warming. When the policy solution emphasized government regulation (e.g., a tax on carbon admissions), only 22% of Republicans said they believed the temperature projection was accurate. But when the proposed policy solution emphasized the free market, 55% of Republicans accepted the basic science. Liberals exhibited a mirror-image bias when presented with information about crime risk. If a proposed solution threatened liberal ideology, they were more likely to question whether the risk was as severe as described.”

“Even though they arrive at very different conclusions, liberal Democrats and conservative Republicans process information in fundamentally similar partisan ways. Such biases occur because humans need to belong to social groups, which provide meaning and value to our lives. Seeing other groups as opponents enables us to accentuate the uniqueness and superiority of our own group and to feel better about ourselves. Rejecting information proposed by the opposing side makes us more confident and certain in our political stances.”

“But being a good group member does not necessarily help relations between groups. The psychological processes that strengthen the bonds of Democrats and Republicans also lead Democrats and Republicans to view the opposing side as fundamentally different—and threatening to the well-being of the country.”

“So when we see those on the left and right in stark disagreement, we should bear in mind that those disagreements are rooted in fundamental similarities.”

David Sherman is a professor of social psychology at UC Santa Barbara. Leaf Van Boven is a professor of social psychology at University of Colorado Boulder.

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**Eye On Health** is the monthly newsletter of the Rural Wisconsin Health Cooperative. Begun in 1979, RWHC has as its Mission that rural Wisconsin communities will be the healthiest in America. Our Vision is that... RWHC is a strong and innovative cooperative of diversified rural hospitals... it is the ‘rural advocate of choice’ for its Members... it develops and manages a variety of products and services... it assists Members to offer high quality, cost-effective healthcare... assists Members in partnerships to make their communities healthier... generates additional revenue by services to non-Members... ongoing use of strategic alliances in pursuit of its Vision. Tim Size, Editor, 880 Independence Lane, Sauk City, WI 53583

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**Feds Blame Rurals for Fed’s Failure to Act**

From “NRHA reacts to HHS report on costs for rural patients” by Brock Slabach, National Rural Health Association, Sr. Vice-President, Member Services, Grassroots Advocacy Forum, 10/8/14:

“The Office of the Inspector General (OIG) of Health and Human Services released a report today on the calculation of patient coinsurance amounts between critical access hospitals (CAHs) and PPS hospitals.

First, some background: CAHs receive cost-based reimbursement for inpatient acute, swing-bed and outpatient services delivered to Medicare beneficiaries. Medicare patients at CAHs owe coinsurance on
outpatient services on the basis of 20 percent of applicable Part B charges.”

“Under the outpatient prospective payment system (OPPS), the coinsurance is based on 20 percent of the OPPS price under the fee schedule for ambulatory patient classification (APC) units. Because the fee schedule is generally much lower than charges, an unintended consequence of cost-based reimbursement is that beneficiaries receiving care at a CAH have a higher coinsurance burden than those going to PPS hospitals.”

“The National Rural Health Association’s response is:

▪ CAHs are billing Medicare and beneficiaries according to Medicare rules and regulations, any deviation from these guidelines would result in fines and penalties resulting from non-compliant billing.

▪ Medicare can correct this policy very simply by holding harmless beneficiaries on coinsurance calculations between CAH and PPS hospitals. This change would increase Medicare payments to CAHs in order ensure that CAHs receive 101 percent of cost.

▪ NRHA disagrees with OIG’s assertion that CAH participation in a possible fix be contingent upon re-certifying their CAH status. All CAHs were designated according to rules and regulations in place at varying points in time historically. The Necessary Provider program allowed for a state’s right to designate hospitals it deemed essential according to an overall rural health plan. These rural health plans were approved, in turn, by CMS. All CAHs should be fully reimbursed at 101 percent of their cost if a coinsurance change is implemented.

▪ NRHA believes that the current CMS policy unfairly penalizes rural patients, which is not the intent of Congress. We ask Congress to direct CMS to not shift the burden to providers or to patients.

▪ This problem was created by Congress and Medicare and can be fixed by them with ease. As the OIG report documents the problem, it’s time to fix this inequity.”

Nursing Shortage & Nursing Education

From “Seeking Strategies to Address Wisconsin’s Nursing Shortage,” by the Public Policy Forum, July, 2014, sponsored by the Wisconsin Center for Nursing, Inc., with the support of the Faye McBeath Foundation:

“In Wisconsin and across the country, one of the greatest workforce challenges facing the health care industry—and employers as a whole—is a shortage of registered nurses. Recent projections from the Bureau of Labor Statistics (BLS) indicate that 525,000 registered nurses (RNs) will leave the profession between 2012 and 2022 and that the national RN workforce will need to expand from 2.71 million to 3.24 million (a gain of 19%, or 526,800 workers) during the same period. Together, the need for replacements of retiring workers and new openings mean that approximately one million nurses will be needed to meet the nation’s demand for nurses by 2022. Similar data indicate, meanwhile, that the State of Wisconsin will need to grow its RN workforce by 24% between 2010 and 2020.”

“The need for registered nurses is triggered by several factors. First, a rash of retirements in the registered nursing profession over the next 10 years is expected—the current average age of a registered nurse (RN) is 47 and roughly one-third of registered nurses are age 50 or older.”

“Second, demand for healthcare is expected to continue to increase, as provisions in the Affordable Care Act (ACA) are enabling more people to access healthcare at the same time that the aging of the ‘baby boomer’ generation is creating a large elderly cohort with attendant healthcare needs.”
“People are living longer, and as the population ages the number of older adults is expected to increase exponentially over the coming decades. This population places demands on nursing for the kinds of services older adults demand: living independently, self-management of chronic illnesses, and treatment of aging-based diseases such as dementia and Alzheimer’s.”

The Nursing Shortage and Nursing Education—“The task of preparing more nurses to meet the future demand in Wisconsin and nationally is complicated by several factors related to our system for educating nurses. Simply put, the growing need for quality health care nationwide—driven by an aging and more diverse population, stipulations in the ACA, and technological change—is in turn driving an increased demand for nurses with higher levels of nursing education, such as the Advanced Practice Registered Nurse (APRN), the Doctorate of Nursing Practice (DNP), and the PhD.”

“Specifically, advanced degree nurses are expected to take on new roles because of an increased emphasis on primary care providers and the assertion that APRNs will be a key factor in increasing accessibility to high-quality, advanced medical care in specialty areas. For example, advanced-degree nurses will be called upon to take positions in community health care settings, primary care, healthcare informatics, research settings, and hospital management. The renewed focus on primary care especially will require the expansion of graduate-prepared Nurse Practitioners in programs such as Family Nurse Practitioner, Adult Nurse Practitioner, Pediatric Nurse Practitioner, and Gerontology Nurse Practitioner.”

“Despite this growing need, experts argue that there are not currently enough students in the advanced-degree nursing ‘pipeline,’ which will create a shortage of both RNs and advanced-practice nurses in the near future. This shortfall is forecast for nearly all 50 states (with the exception of Massachusetts and South Dakota), with the gap for Wisconsin estimated to be 10,500 by 2030.”

November 12: “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; at Glacier Canyon Lodge located in Wisconsin Dells. Register at http://ow.ly/Ad583

Conclusion—“It is a virtual Gordian knot to address the projected nursing shortage. How do we produce doctorate-level faculty and advanced-practice nurses when there are not sufficient doctorate-level faculty available to train them? While shortening the time required to achieve subsequent degrees is a necessary step the profession has taken, other barriers remain. Exploration of next steps will need to focus on financial circumstances for both the student and the program. Solutions should recognize that a systemic and community-wide approach to building academic faculty and infrastructure is needed, as new public funding sources likely will be limited.”

The full report is available at: http://ow.ly/CwRSZ

Act Now to Close Gap in Behavioral Health

From “Close the gap in behavioral health treatment” by Nick Turkal, CEO of Aurora Health Care, in the Journal Sentinel, 9/27/14:

“Today, one in four adults will suffer from a diagnosable behavioral health disorder. Behavioral health disorders are the leading cause of disability in the United States, and, by comparison, anxiety disorders are more common than diabetes. Health care providers are better able to recognize, diagnose and treat behavioral health conditions than at any other time in our history.”

“Still, there is a significant gap between the number of people suffering from behavioral health disorders and the number who are receiving treatment. Those who do seek treatment from public programs often find that care is delayed, inefficient, fragmented and uncoordinated—if accessible at all.”

“This problem is dire in most American communities. Our families, schools, businesses, criminal justice system and other facets of our society are under incredible stress from people suffering from behavioral health issues, from severe mental health disorders to
addiction problems. And there is still social stigma even though these conditions are highly treatable. As a first step, it’s critical that we begin conversations to diminish this stigma and shine a brighter light on behavioral health issues.”

“This affects everyone, and we must make significant changes. Health care providers must be on the leading edge on this issue, but we can’t own it alone. Based on abundant research and Aurora’s own experience, I offer three imperatives for meaningful, sustainable change regarding behavioral health care.”

**Improve overall access:** “Provider shortages throughout the field—psychiatrists, psychiatric advanced practice nurse practitioners, psychologists and psychotherapists—are creating significant access problems. Our industry needs to support workforce development through residency and student placements and providing training opportunities. We must bring the supply of providers up to meet demand.”

“The recent government grant to the University of Wisconsin-Milwaukee for youth-oriented substance abuse and trauma counseling is a good example. Other components of improving access include shifting capacity and associated reimbursement levels from inpatient to outpatient settings and leveraging technology to improve access. There needs to be community coordination and the appropriate support from a number of entities.”

**Integrate behavioral health with primary care:** “Behavioral health and physical health are interconnected, and the care should be as well. It’s been estimated that up to 70% of primary care visits stem from psychosocial issues, even though the patient presents with physical complaints. Integration helps ensure we treat the whole person.”

“Delivering behavioral health services in a primary care setting, improves the access point crisis, facilitates monitoring of patients over time, helps prevent hospital re-admissions, is more cost-effective and reduces the stigma of behavioral health issues. Emerging evidence suggests that various care models can successfully support integration of behavioral health with primary care.”

**Share the right information to coordinate care:** “The recently passed HIPAA Harmonization bill removes a major barrier. The new law is more in line with HIPAA privacy rules. This gives health care providers faster access to more useful information about the individual’s diagnosis, enabling more appropriate and effective treatment overall. All the better if this sharing is done as part of an integrated primary care model, via a common electronic health record.”

“Untreated and undertreated behavioral health disorders harm individuals, families, communities, businesses and society. As a community we must stay engaged as we, collectively, engage in this vitally important work.”

**WI Health Systems Leadership Preparation**

“The School of Business at Edgewood College has a proud almost 30 year history of teaching business principles and practices, and an alumni base of more than 3,000 undergraduate and graduate students. Our programs evolve to adapt to a diverse and dynamic world economy. Fifteen full-time and fifteen part-time executive faculty teach a broad array of courses relevant to the future demands of business and society for ethical leadership, entrepreneurship, and sustainability in a global economy.”

“The Health Systems Leadership Program was designed in close collaboration with the Henry Predolin School of Nursing and local healthcare system leaders. Courses are based on the Commission on Accreditation of Healthcare Management Education Competency Criteria.”

**The Health Systems Management Graduate Certificate** “provides an opportunity to upgrade your health systems knowledge and leadership skills in just
one year. The Certificate consists of 15 total credits, which may be applied toward the MBA in Health Systems Leadership if you decide later to pursue that degree.”

The MBA in Health Systems Leadership “prepares future executives to make a meaningful difference in a wide range of healthcare delivery and financing organizations. The curriculum consists of 42 total credits, 24 of which are directly related to health care topics.”

The general MBA with a concentration in Health Systems Management “allows students some additional flexibility in choosing elective courses. The curriculum consists of 48 total credits, but only 15 credits must be related to health care topics.”

Six of the core courses are already on line and Edgewood College’s Deming Way campus on the west side of Madison is accessible to students throughout Southern Wisconsin. To learn more, please visit www.edgewood.edu or call graduate admissions counseling at 608.663.4299. Or contact Tim Size at timsiz@rwhc.com to be put in contact with the Program’s Coordinator.

New RWHC Behavioral Telehealth Network

Sauk City, WI. - The Rural Wisconsin Health Cooperative (RWHC) has received a 3 year Rural Health Network Development Grant to establish a Behavioral Telehealth Network. The $897,000 grant from the Health Resources and Services Administration will improve access to behavioral health in rural Wisconsin communities.

The RWHC Behavioral Telehealth Network will be designed to align behavioral health resources available in urban locations with the need for such services in rural communities. Access to behavioral health clinicians is a challenge statewide, but especially for those located in mental health professional shortage areas. Eight rural community hospitals in Wisconsin have committed to driving improvement in patient access to behavioral health services by participating in the development of the network.

“Access to behavior health services is one of the most difficult challenges for rural health. Using technology to connect rural patients to new or existing service locations has great promise,” said Tim Size, RWHC’s Executive Director.

“We have long worked with our member hospitals on broadband and electronic medical record related services. We helped establish Wisconsin’s statewide information exchange, WISHIN. This grant award will help RWHC take the benefits of technology to rural communities to the next level.”

For more information, contact Louis Wenzlow, Director of Health Information Technology, at 608-644-3237 or Dave Johnson, Director of Member Relations & Business Development, at 608-644-3227.

RWHC Welcomes New Corporate Sponsors

Created in 2007, the RWHC Corporate Member program provides participants with an opportunity to support the work of RWHC through promotions, networking, and educational presentations to RWHC Member Hospitals. We would like to welcome our newest participants!

Camera Corner Connecting Point is an IT and AV value added reseller with services throughout Wisconsin. For more information, contact Dave Pisani, 920-544-8102, www.cccp.com.

Experienced Resources provides health care organizations immediate leadership support to accomplish mission critical work, by matching client needs to our team of experienced leaders. Contact Mary Christensen, 952-888-4635, www.experiencedresources.net.

Please Support Rural Leadership Development

The National Rural Health Association is growing a permanent endowment for programs that support emerging leaders, broadly defined, from and for rural communities.

Go to http://ow.ly/ejmLj to learn more.
**Bonded Collectors of Wisconsin, Inc.,** has been working with providers in rural Wisconsin for more than 60 years. For more information, contact Dave Voelker, 608-742-4124.

**First American Healthcare Finance** works with hospitals, providers, and clinics to identify equipment financing and leasing options that are the best fit for their needs. For more information, please contact Michael Haines, 585-643-3318, [www.fahf.com](http://www.fahf.com).

If you are interested in learning more about RWHC or about the RWHC Corporate Member program, please contact Dave Johnson at [djohnson@rwhc.com](mailto:djohnson@rwhc.com) or 608-643-2343, [www.RWHC.com](http://www.RWHC.com).

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**Leadership Insights: “Communicating Power”**

The *Leadership Insights* series is by Jo Anne Preston, RWHC Organizational Development Manager. Back issues available at [www.RWHC.com](http://www.RWHC.com).

“Be careful how you communicate. Four basic styles of communication demonstrate our comfort with power which, as written in last month’s newsletter, is not something all leaders are comfortable with. Claim–or tame–your power by honing your assertive communication skills.”

“**ASSERTIVE** communication is about equal power. In assertive communication, both parties respect their own rights and the rights of others. It’s face to face and honest, offering a fair hearing of all sides. Essentially it is, ‘say what you mean, mean what you say, without being mean.’”

“**Assertive example:** ‘I know we all want our xyz project to succeed. I need to talk with you about the deadlines you have missed at the last several meetings. It has stalled the progress of the team. I am concerned that we will fail unless we get back on track, and I need your full commitment to your part of the work, and for it to be completed on time. How will you fix this?’”

“This is assertive because it begins with a shared goal, it is clear about the effect of the behavior and the expectations, and is direct but not judgmental. It also keeps responsibility for fixing it with the right person by asking ‘how will you fix this?’ instead of taking it on yourself.”

“**AGGRESSIVE** communication is power over others. It demonstrates an unequal power by talking over others, putting others down, interrupting, telling others what to do instead of eliciting their ideas in shared decision making. Being aggressive has its place, like yelling when your child runs into the street, but as a regular approach, it shuts people down. Sometimes people confuse aggressive with assertive.”

**Scenario aggressively addressed:** “You need to get your part of the work done for this team; we are behind because you’re being irresponsible.” It is certainly clear. It’s not untrue. But it has a punishing tone that closes down further dialogue. You get to be right and in charge, but you lose respect and engagement from people. **Do you have aggressive tendencies?** Consider and then start difficult conversations with the mutual goal or purpose you share. Avoid judging words (like ‘irresponsible’) and replace them with specific behaviors. Wait until the other person is completely done speaking before you start to speak. Reflect back what you hear from others before you make your point.”

“**PASSIVE** communication is letting others have power over you. It includes behaviors like not speaking up when you do have an idea/opinion, saying, ‘It’s ok’ when it is not, letting someone else decide for you that which affects you.”
“Scenario passively addressed: ‘That’s ok, I know everyone is busy.’ Follow this with a decision to do the work yourself just to get it done, and you end up feeling frustrated and burdened. Passivity leads to poor delegation and misguided accountability. Does being passive keep you from getting what you need? Fear of coming off too strong is one thing that keeps passive people from speaking up. Practice what you want to say, starting by writing it down. Remember assertive is not the same as aggressive. Having no power is not fair to you or anyone else for whom you are role modeling.”

“PASSIVE AGGRESSIVE communication is one minute you have no power, the next you have the power to destroy. It is unequal power flipping the tables – saying, ‘It’s ok’ when it is not, and later throwing the other person under the bus, gossiping and undermining.”

“Passive aggressive response to the scenario: In the meeting you say, ‘It is ok, we’re all busy,’ but then you talk about individuals behind their back, including other bits about how they are not reliable or competent. If passive aggressive is your style, take stock of how you are misusing your power. Put an end to gossip, including venting. It takes guts to be assertive; no guts, no leadership.”

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.

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