CMS Rural Health Council Visits Sauk City

By Jeremy Levin, RWHC Director of Advocacy:

On March 3rd, the RWHC Board welcomed Cara James and John Hammarlund, the co-chairs of the Centers for Medicare & Medicaid Services (CMS) Rural Health Council, an internal council that brings together experts from across the agency, to our annual Board Retreat.

The Rural Health Council has been focusing on three strategic areas—first, ways to improve access to care for all Americans in rural settings; second, ways to support the unique economics of providing health care in rural America, and third, making sure the health care innovation agenda appropriately fits rural health care markets. Our meeting came towards the end of their year-long set of listening sessions that the Rural Health Council and regional offices have held to hear from rural stakeholders across the country.

Our three-hour listening session in our combined conference rooms packed with more than 60 rural health care leaders, came after a day and a half long plunge for the co-chairs into rural Graduate Medical Education.

Dr. James and Mr. Hammarlund, with multiple degrees from some of our country’s most elite institutions of higher learning and years in the world of government and think tanks, might not seem like the most natural choices to lead the CMS Rural Health Council. But their disarming demeanor and sincere engagement in listening and discussing the concerns and frustrations on the impact of CMS regulations that our rural health care leaders experience every day made for a very productive session.

We worked off a list of 14 specific regulations and policy interpretations that we felt have had a detrimental effect on the provision of and access to care in rural America—jokingly referred to by Cara James as our “fourteen points of light.”

A copy of the whitepaper used during the retreat is available at:

http://ow.ly/CgSY309Kj1Z

“There is a fountain of youth—your mind, your talents, the creativity you bring to your life and the lives of people you love.” Sophia Loren

RWHC Eye On Health, 3/11/17
More broadly, themes of arbitrary timeframes that put up barriers to care, past nonsensical judgements that punish efficient use of space to provide care, and draconian cuts to funding aimed at providing continuum of care in less acute settings were covered in great length and detail to inform the co-chairs of our viewpoint on CMS actions.

We await to see the work product that the CMS Rural Health Council will announce at the National Rural Health Association (NRHA) Annual meeting in May.

During his announcement of the rollout of the Rural Health Council at the 2016 NRHA’s Policy Institute, CMS Acting Administrator Andy Slavitt stated, “The bottom line as I hope you are seeing, is we are investing and must continue to invest in rural America because we believe those investments can pay off for our beneficiaries and are necessary to sustain an equitable system. And we need to do our jobs best by understanding the realities in the front line and maintaining high standards for progress anywhere one of our beneficiaries is served.”

We agree.

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NRHA Letter to President Trump
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A letter to President Trump from Alan Morgan, CEO, National Rural Health Association, 3/6/17:

“Thank you for your commitment to revitalize the American economy and address the needs of Americans who feel forgotten by their government. Rural America has bled jobs since the Great Recession and suffers from rising mortality rates and a catastrophic rural hospital closure crisis. Rural America needs your help.”

“The laudable goals of the Affordable Care Act (ACA) were not fully achieved in rural America. The ACA took critical steps to improve the health of rural populations, who are per capita, older, poorer and sicker than other populations. However, the lack of plan competition in rural markets, exorbitant premiums and co-pays, the co-op collapses, lack of Medicaid expansion, and devastating Medicare cuts to rural providers—all collided to create a healthcare crisis in rural America.”

“The National Rural Health Association urges the Administration and Congress to make health care work in rural America. Rural health care is the critical component to a vibrant rural economy. You cannot have a healthy rural economy without a healthy rural community. Quality rural health care saves lives, provides skilled jobs, attracts businesses, and reinvests millions back into rural communities. A national ‘Rural Health Initiative’ to make rural America work again is needed. Such an initiative must include:

**Stopping the Rural Hospital Closure Crisis**–Harsh Medicare cuts are causing rural hospital closures across the U.S. to escalate at a devastating rate. Eighty rural hospitals have closed since the Afforda-
ble Care Act was signed into law. One in three rural hospitals is financially vulnerable, and at the current rate of closures, 25% of all rural hospitals will close unless the federal government intervenes. Closures of this magnitude will create a massive national crisis in access to emergency services as well as detrimentally harm rural economies.

When a rural hospital closes, rural communities suffer. According to the USDA, rural counties were shedding 200,000 jobs per year and rural unemployment stood at nearly 10 percent during the Great Recession. Economic recovery hasn’t returned to rural America. In fact, 95% of the jobs that have returned after the Great Recession have been to urban, not rural areas. The rural hospital is often the largest or second largest employer in a rural community. When it closes, businesses, families, and retirees leave. Often, rural physicians are hospital-based. When the hospitals close, the physicians leave, soon followed by nurses, pharmacists and other providers. Medical deserts are forming across rural America. Hundreds of rural jobs are lost, home values drop, and those who can’t sell their home are stuck in a dying town.

To create economic vitality in rural America – to make rural America work again – the rural hospital closure crisis must end. Stopping Medicare cuts to rural hospitals, as in the Save Rural Hospital Act, will stabilize rural hospitals and rural communities.

**Investing in Rural America Work Force and Infrastructure**–Healthcare work force shortages plague rural America. Twenty percent of the population lives in rural America, yet only nine percent of physicians practice in rural America. A January 2017 CDC study indicates that “the death rate gap between urban and rural America is getting wider.” The rates of the five leading causes of death–heart disease, cancer, unintentional injuries, chronic respiratory disease, and stroke–are higher among rural Americans. Access is key to addressing these health care disparities. A strong investment in programs such as the national Health Services Corps and Area Health Education Centers help train and place health providers in workforce shortage areas. Investment in improved access to broadband, technology grants, and access to capital, also would go far in rebuilding aging infrastructure and create economic vitality.”

“Mr. President, rural America voted for you by a three to one margin. In many cases, this vote represented a loss of hope among a population which has long been overlooked and marginalized–the rural middle class, and rural low-income. A national ‘Rural Health Initiative’ will let rural America know that you heard their plea for help. Additionally, empowering both the White House Rural Council and the Centers for Medicare and Medicaid Rural Council to identify burdensome regulations will also ensure that rural America has a strong voice within the vast federal government.”

“The National Rural Health Association thanks you and your leadership. We look forward to partnering with you and your Administration to improve access to affordable, quality health care to rural America.”

**A Rural View Needed on Population Health**

The National Advisory Committee on Rural Health and Human Services delivered its most recent policy brief to the Secretary of HHS, on the broad range of factors that affect health outcomes in rural areas. “The committee examined these factors–poverty, access to services, economic opportunity, rates of chronic disease, homelessness, domestic violence, life expectancy–and reports that there are distinct rural considerations that policymakers must keep in mind.”

“The social determinants of health are becoming an increasingly important framework for understanding and taking into account the broad range of factors that affect health outcomes in the United States. As the De-
Department of Health and Human Services (HHS) considers how to incorporate the social determinants of health in its programs and policies, it will be important to understand the unique characteristics of rural communities that influence the ways that the social determinants manifest. For this reason, the National Advisory Committee on Rural Health and Human Services (NACRHHS or the Committee) offers this policy brief, informed by a field meeting and site visits in New Mexico, to provide recommendations as to how HHS can best contribute to addressing the social determinants of health in rural communities.

Setting a Rural Context—“Over the years, the Committee has examined individual social determinants of health—poverty, access to services, economic opportunity, rates of chronic disease, homelessness, intimate partner violence, life expectancy—and found that rural communities often fare worse than their urban and suburban counterparts. While the social determinants of health serve as a general policy construct, the Committee believes that there are distinct rural considerations that policymakers must keep in mind when deciding how to develop and align health and human service systems such that they are able to improve population health in rural communities. This will be increasingly important in the coming years as the social determinants of health framework becomes embedded into HHS efforts. The Committee made the following recommendations:

1. HHS should develop a federal ‘Healthy Communities’ designation that recognizes place-based, community-driven plans to address the social determinants of health and provides inter-agency federal support through preference points, technical assistance, and consolidated funding streams.

2. HHS should facilitate coordination and collaboration among hospitals, health systems, and human service providers on Community Health Needs Assessments and Community Benefit Agreements to support the development of local strategies to address the social determinants of health.

3. HHS should structure grant review panels to allow rural applicants to be reviewed as a separate cohort in order to compete against similarly resourced communities.

4. HHS should encourage the use of priority points for rural applications that face unique structural challenges related to the social determinants of health such as but not limited to geographic isolation, low population density, higher poverty and lower life expectancy.

5. HHS should offer technical assistance and Funding Opportunity Announcements which highlight ways rural organizations can factor in the administrative costs of effectively managing grants into their budgets and project plans.”

“The recommendations associated within this brief encourage the department to work across sectors to address the multi-dimensional health and socioeconomic challenges of individuals and families.”

The report is available at: http://ow.ly/8w34309JRHR

Structure, Mine & Present EHR Big Data

The following is from the blog “The Electronic Health Record and The Golden Spike” by Frank D. Byrne, MD, former President of St. Mary’s Hospital in Madison, Wisconsin, and Senior Executive Advisor to HealthX Ventures at www.healthxventures.com:

A.J. Russell image following the 1869 driving of “The Golden Spike” at Promontory Summit, Utah
“On May 10, 1869, at a ceremony in Utah, Leland Stanford drove the final spike to join the first transcontinental railroad across the U.S.”

“Considered one of the great technological feats of the 19th century, the railroad would become a revolutionary transportation network that changed the young country.”

“For the past few years, the healthcare industry and the patients in its care have experienced a similar ‘Golden Spike Era’ through the deployment of the electronic health record (EHR). Others have used this analogy, including author Dr. Robert Wachter at a recent excellent presentation at the American College of Healthcare Executives 2016 Congress on Healthcare Leadership.”

“Why is this comparison relevant? While the Utah ceremony marked the completion of a transcontinental railroad, it did not actually mark the completion of a seamless coast-to-coast rail network. Key gaps remained, and a true coast-to-coast rail link was not achieved until more than a year later and required ongoing further improvements.”

“Similarly, while a recent study for the Office of the National Coordinator for Health Information Technology indicated that 96% of hospitals possessed a certified EHR technology and 84% had adopted at least a basic EHR system in 2015, there is still much more needed to achieve optimized deployment of the EHR to make healthcare better, safer, more efficient, and to improve the health of our communities.”

“Nonetheless, the EHR is one of the major advances in healthcare in my professional lifetime. It is an essential tool in progress toward the Institute for Healthcare Improvement’s ‘Triple Aim for Healthcare’—better patient experience, lower per capita cost, and improved population health. We cannot achieve those laudable goals without mining and analyzing the data imbedded in the EHR to generate useful information to guide our actions. Advances in data science are enabling the development of meaningful predictive analytics, clinical decision support, and other tools that will advance quality, safety, and efficiency.”

“But there is much work to do. Dr. Christine Sinsky, vice president of professional satisfaction for the American Medical Association, and others have written with concern about dissatisfied physicians, nurses, and other clinicians who feel the EHR is distracting them from patients’ care and meaningful interactions with their patients.”

“‘Contemporary medical records are used for purposes that extend beyond supporting patient and caregiver... The primary purpose, i.e., the support of cognition and thoughtful, concise communication, has been crowded out,’ Sinsky and co-author Dr. Stephen Martin in the 4/25/16 issue of The Lancet.”

“Perhaps you’ve also seen the sobering drawing by a 7-year-old girl depicting a doctor focused on the computer screen with his back to her, his patient.”

“Some of the EHR’s shortcomings may be the result of lack of end user input prior to implementation, possibly due to the implementing organization not incorporating the extensive research gathered by the EHR providers. Further, even if one gets end-user input prior to implementation, there’s always challenges prior to go-live, and it seems to me that optimization after implementation has been under-resourced. And let’s not look at
temporary ‘fixes’ as the best and final answer. I was dismayed recently to see ‘hiring medical scribes’ listed as one of the top 10 best practices in a poll in the May 7th, 2016, issue of *Modern Healthcare.*

“Don’t get me wrong, to have a long game, you must have a successful plan to get through today, and if hiring scribes can mitigate physician dissatisfaction until the systems are improved, so be it. But scribes are a temporary work-around, not a system solution.”

“As a Senior Executive Advisor to HealthX Ventures, an early-stage venture capital fund, I’ve enjoyed listening to many interesting and inspiring pitches for new technology solutions. Initially, my algorithm used to rate these ideas was:

1. Is it a novel idea?
2. Will enough people or organizations pay for it?
3. Do they have the right customer?
4. Do they have the right revenue model?”

“Thanks to the input of physicians, nurses, therapists, and other clinicians, and the work of Dr. Sinsky and others, I quickly added a fifth, very important vital sign: Will it make the lives of those providing care better? Similarly, author, speaker and investor Dave Chase added a fourth element to the Triple Aim, caregiver experience, making it the Quadruple Aim.”

“When I was in training, we carried the Washington Manual and Sanford’s Antimicrobial Guide in the pockets of our white coats as references and thought we had most of the resources we needed to provide exceptional care. Now, caregivers suffer from information overload of both clinical data and academic knowledge. Some query Google right in front of their patients to find answers.”

“In healthcare today, we work within a community of diverse skills and backgrounds, including clinicians, non-clinicians, computer scientists, EHR providers, administrators, and others. To achieve our goal of improving health and healthcare for individuals and communities, we must work together to organize, structure, mine, and present the massive amounts of data accumulated in the EHR. To me, the concept of population health is meaningless unless you are improving health and outcomes for my family, my friends and me. Just as the placement of ‘The Golden Spike’ was only the beginning of railroad transportation becoming a transformational force in American life, the fact that 96% of U.S. hospitals possess a certified EHR is just the beginning.”

“I have been accused of being a relentless optimist, but I firmly believe we can use the EHR to improve the caregiver and patient experience (I believe patients will and should have access to their entire medical record, for example), and fulfill the other necessary functions that Sinsky and Martin describe as distractions from the medical records’ primary purpose: ‘quality evaluations, practitioner monitoring, billing justification, audit defense, disability determinations, health insurance risk assessments, legal actions, and research.’ ”

“And, lastly, there is one more similarity to ‘The Golden Spike.’ In 1904 a new railroad route was built bypassing the Utah track segment that included that historic spot. It shortened the distance traveled by 43 miles and avoided curves and grades, rendering the segment obsolete. Already, many EHR tools, applications and companies have come and gone. Many of the tools we use now remain rudimentary compared with what we really need. We must use what we have to learn and continuously improve, and frankly, we need to pick up the pace. The patients, families and communities depending on us deserve no less.”
“The 7 Habits of Highly Depolarizing People”

From the *American Interest* in a piece by David Blankenhorn at [http://ow.ly/oUre309MSw6](http://ow.ly/oUre309MSw6):

- Criticize from within
- Look for goods in conflict
- Count higher than two
- Doubt
- Specify
- Qualify
- Keep the conversation going

“If polarization is all around us, what about its opposite? What would depolarization look and sound like? Would we know it if we saw it, in others or in ourselves?”

**Leadership Insights: “Change Challenges-II”**

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

How do I “sell” a change that I can’t buy into myself, or believe won’t be in my team’s best interest? Won’t I lack credibility if I just act like I love it when I don’t? Go to the decision makers and be honest. You might say, “I need help understanding this change from my employees’ perspectives. I want to support the organization’s direction but to be able to do that I need more information about why we are doing this, how it will impact people, what will be better because of it and what is at stake for them if we are not successful.” Even after this you still may not love it, but resist the temptation to throw the organization or administration under the bus when back with your team. It likely will backfire on you.

Sometimes you just have to communicate that a change, even if unpleasant, needs to be embraced. Let your team know, “We need to use our best effort and talent to make it successful. If we give it our all and it still doesn’t work, then we’ll deal with that, but we won’t know unless we give it our best.”

I have a number of my staff on board with the change but there are still some lagging behind. How do I engage everyone? You don’t need 100% buy-in to get things rolling. The majority on board will be the momentum that will help you bring the remaining ones along. Find opportunities to recognize and reward the supporters. Point out how they are getting results. Ask those who are not on board what they need to get going on the change, and be sure you are not subtly giving the message that change is optional.

How do I address the fears of what can go wrong with a change when the fears are extreme and very unlikely? The temptation is to suggest that those fears are irrational, but this may just take fears underground and that is not going to help you or them. Instead, help the fearful explore the worst case, bleakest scenario possible. Once you are clear on that, invite a discussion about how you would know those bad things were starting to happen, and problem-solve how you could address them if they do. Ask for their help to be on the lookout and keep you informed as you move forward.

How can I lead a change if my primary stakeholders can’t even get to meetings? Maybe you can’t. Hold your “yes/go” until you have the commitment of your key stakeholders, or you may find yourself spinning your wheels. Examine your “I can’t say no to anything” stance. Is it really true? If you do get commitment but meeting attendance still becomes a problem, ask for alternative communications.

Does EVERYONE need to come to EVERY meeting? Create together a communication matrix that identifies communication goals (why), methods (how-meeting? email? quick huddle updates?) and outcomes (what and when), and use it throughout the project.
How do I implement a change in behavior when it should already be happening? Anytime you think you shouldn’t have to speak up about something, it’s a good indicator that you likely need to. Life and leadership is really all about having skillful conversations when sometimes you wish you didn’t have to. If you are thinking, “This is common sense,” you are probably assuming others’ sense of what is right may not be in common with yours, so you have to be explicit about what you are looking for.

How do I keep the momentum in a really long term change project? No one can stay motivated forever without any feedback or reinforcement. You must plan for and build in quick and recurring wins. These wins won’t just announce themselves; propose them as part of your project plan from the very beginning. Celebrate milestones that get you to the ultimate goal. Engage your team on the front end to identify what those milestones will be (when you hit certain targets, achieve specific goals, etc.)

What timeframe works best for following up with my team to see how they are doing with a change project? There is no “one size fits all” in following-up, but you can’t just abdicate all responsibility once you have delegated. You might ask:

“How would I know if you were:

☐ struggling?
☐ halfway through?
☐ running into roadblocks?
☐ needing my help or support?”

So much of what makes change successful is about skillful communication and solid project management. Work on those two things and your changes will have a better chance of success!

Contact Jo Anne Preston for individual or group coaching at jpreston@RWHC.com or 608-644-3261. For info re the RWHC Leadership Series go to www.RWHC.com/Services.aspx or contact Carrie Ballweg at cballweg@RWHC.com or 608-643-2343.

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