Medicaid Cuts Devastating for Rural America

The following is from an editorial, “Medicaid cuts would be a devastating blow for rural America,” by *The Kansas City Star* editorial board, 6/22:

“This week, Rep. Sam Graves reintroduced a bill called the ‘Save Rural Hospitals Act.’”

“The congressman from Missouri wants a series of regulatory and financial reforms to cut expenses and raise revenue for roughly 2,500 rural hospitals.”

“Without the bill, ‘rural hospitals in Missouri will continue to close,’ Graves said in a statement. ‘This leaves thousands without access to health care, putting lives in jeopardy and affecting every family in middle America. That’s simply not acceptable.’”

“We agree. In fact, Graves’ bill might actually do some good things for rural health care.”

“So why did the congressman vote for the American Health Care Act, the House Republicans’ repeal of Obamacare?”

“The AHCA would cut $840 billion from Medicaid over the next 10 years. It would decimate millions of Americans’ access to health care, particularly in rural areas.”

“The bill leaves ‘millions of the sickest, most under served populations in our nation without coverage,’ the National Rural Health Association says, ‘further escalating the rural hospital closure crisis.’”

“Thursday, Senate Republicans released their own version of an Obamacare replacement bill. It too is crammed with provisions that would harm the very constituents senators have pledged to protect.”

“Senate Republicans say they want to cut premiums, for example, so the bill gives states the right to abandon ‘essential health benefits’ in health plan policies.”

“Make no mistake: Those cheaper premiums will mean bare-bones insurance policies and higher out-of-pocket costs.”

“Tax credits to buy insurance would be reduced. That would almost certainly lead to fewer individuals buying coverage, exacerbating losses for private insurers.”

“And the Senate bill matches the AHCA in its cruelty to low-income Americans, who would face massive cuts in Medicaid.”

“Obamacare’s Medicaid expansion—which has provided health coverage to 11 million Americans—would be phased out. Regular Medicaid would be capped and coverage decisions returned to the states, threatening quality care for 70 million Americans.”
“And those cuts would fall heavily on rural areas, where one in five residents relies on Medicaid. Hundreds of thousands of rural Americans who depend on Medicaid for nursing home care are also at risk.”

“In a statement Thursday, Sen. Pat Roberts of Kansas endorsed the Senate bill while promising to protect rural health care. It can’t be done. A vote for the Senate bill is a vote to devastate rural health care.”

“Obamacare isn’t perfect. It needs important reforms, including a viable option for individuals who can’t find a policy on their local exchange. Coverage formulas and subsidies could also be tweaked.”

“The Republican alternatives come nowhere close to accomplishing those goals. They cut health care for the poor to pay for tax cuts for wealthy Americans.”

“Congress should reject them and start over.”

“Because meth kills slowly, and at lower rates, it isn’t getting the attention that many researchers, law enforcement officials and health workers say it deserves. They worry it will eventually overwhelm the country as heroin, fentanyl and prescription painkillers have.”

“Some states are fighting both epidemics at once—’All of a sudden, it’s everywhere again,’ Wisconsin Attorney General Brad Schimel said. Schimel commissioned a study of meth in his state, which estimated that its use had jumped by at least 250 percent since 2011, a pace that could overtake heroin. ‘We are entering another full blown epidemic with meth,’ he said.”

“Researchers point out that meth addiction has always been a big problem in America. What’s changed, they said, is a switch to mass production in Mexico, an increase in potency and affordability, and deeper penetration by drug cartels into vulnerable communities.”

“Unlike opioids, there is no proven medical treatment for meth addiction—’We can do therapy and that sort of thing, but we don’t have a magic pill,’ said Jane Maxwell, who researches drug abuse at the University of Texas at Austin.”

“Maxwell has documented a meth spike in her home state that includes a rise in deaths, treatment center admissions, poison-center calls, and toxicology lab submissions. ‘I’m concerned that as all this money goes into treating opioid users, what are we going to do for meth users?’”
“A New Surge”–Underlying the crisis is a growing concern that America focuses considerable resources on curtailing the supply of drugs, and punishing those who sell and abuse them, with little impact on the demand.”


“Brownstein and his co-author, Timothy Mulcahy, charted the evolution of meth during the early 2000s from a hyper-local enterprise, produced in small labs and sold and shared among families and friends, to a sophisticated network driven by Mexican drug trafficking organizations.”

“That switch was largely attributed to the Combat Methamphetamine Epidemic Act, which placed tight controls of over-the-counter cold medicines used to cook meth. The number of meth labs in America dropped precipitously after that law went into effect in 2006, according to authorities.”

“But entrepreneurial traffickers found ways to fill the void. Their innovations led to the growth of Mexican ‘superlabs’ where a cheap and highly potent version of meth was mass-produced for shipment by cartels over the border, ending up in the hands of mid- and low-level American dealers across the South, West and Midwest.”

“The estimated number of meth users, meanwhile, rose from its low point of 314,000 in 2008 to 569,000 in 2014, according to the Substance Abuse and Mental Health Services Administration. At the same time, fatal overdoses involving meth more than doubled from 2010 to 2014, according to the most recent data available from the National Center for Health Statistics.”

“Midwest and West”–These trends point to the inadvertent consequences of the 2006 law, said Mulcahy, a vice president at NORC, a research agency at the University of Chicago. They provide a counterargument to traditional American thinking about drug policy: use enforcement crackdowns as a tool to jack up the price of illegal drugs, and reduce demand, he said. ‘Now we’re at a place where we’re going completely backward,’ Mulcahy said.”

“In many rural and struggling communities, Travis Linnemann, an Eastern Kentucky University sociologist and author of the book ‘Meth Wars,’ said, meth is often singled out as a reason for deteriorating conditions, when much bigger forces—the decline of family farms, the rise of corporate agriculture—are also responsible.”

“A Sinking Boat”–In Wisconsin, those elements are closely linked. Routed from trafficking hubs around Minneapolis/St. Paul, meth is ravaging areas of western Wisconsin that had weathered the first wave, officials say. Things have gotten so bad that local government agencies are running out of places to put children taken from the custody of their hopelessly addicted parents.”
That includes Dunn County, a rural and manufacturing community of 44,000 that has been overwhelmed with meth. Meth addiction there spans generations, and breaks apart families, forcing child-welfare officials to remove children from their homes, health workers say. Kristin Korpela, head of the Dunn County Department of Human Services, recalled having one of her social workers visit a young mother in jail, where she voluntarily gave up her three kids."

‘Meth,’ the mom told the social worker, ‘makes you forget that you ever had children.’ Next door, in Chippewa County, Human Services Director Larry Winter has seen out-of-home placements for children surge from 28 in 2013 to 103 in just the first five months of 2017. Three-quarters of those placements are related to meth abuse, he said."

‘People who may want to come forward to do something about their addiction are afraid they will get charged and DHS will take their kids,’ Winter said. ‘My staff tells me that if they could keep the family and kids together, and have the resources to do it safely, recovery from the addiction is possible and it’s going to reduce the risk, because parents are willing to stay engaged. However, once we make that decision to take those kids into custody, it is very difficult to keep the parents engaged, and often times they’re AWOL.’"

Meanwhile, in eastern Wisconsin, the opioid crisis continues to flourish. John Kumm, an analyst in the FBI’s Milwaukee office, said the two epidemics appear to be moving toward the middle of the state. Already, authorities have documented meth users to turn to heroin to take the edge of their highs, and heroin addicts who turn to meth because there’s less change of an overdose."

This year, the number of criminal meth cases has eclipsed those involving heroin or fentanyl, Kumm said. ‘The biggest point is there is a dual crisis here, and we’re sure it’s not just in Wisconsin,’ he said."

Schimel, the attorney general, likened the twin plagues to holes at each end of a rowboat, with law enforcement authorities and treatment providers trying to bail out water, with more continuing to pour in.”

“The patch, in this case, is an elective prevention strategy, which Wisconsin is still trying to develop, he said.”

‘With opiates, when we discovered the nature of that epidemic—and we’re still working to get out way out of it—we kind of thought this is as bad as it gets,’ Schimel said. ‘And then meth came along.’”

="Patient Engagement versus Experience"

From the Blog Post “Patient Engagement versus Patient Experience” by Adrienne Boissy, MD, MA, in NEJM Catalyst, 5/17:

“My neurologist brain is having a hard time. My brain—and yours—likes order. Yet trying to make sense of the rampant use of health care buzzwords like engagement, experience, consumerism, activation, etc., is causing major brain freeze.”

“The field of patient experience has exploded. At the same time, as population health efforts multiply, efforts to engage patients in their own health have become very popular. Yet these two concepts seem disconnected. Health care professionals talk about engagement in health, but not always the experience of it. We talk about the experience of our patients, but not always their engagement. So… what are we really talking about? Do we even know?”

“Here is my (left) brain’s attempt to differentiate engagement and experience, based on my roles as a practicing neurologist and Chief Experience Officer of the Cleveland Clinic.”

RWHC Eye On Health, 7/11/17
“Clearly, there are significant differences between the two concepts. Yet the comparison raises important, head-scratching questions for clinicians and patients alike:

1. Who is at the end of what we are talking about? Focusing only on patients is limiting. It seems **people engagement** might be more fitting, as it is rare that the patient is navigating his or her health alone—clinicians, communities, and the patient’s friends and family likely also have a significant role in patient care.

2. Is the patient an active or passive participant? As a colleague of mine has pointed out, an engaged patient interacts with their health or the delivery of care, but a patient experience can be passive. In that way, experience is something that happens on a roller coaster, for example, patients can get on the ride, close their eyes, and wait for it to be over; or they can scream and throw their hands in the air and have fun. Both takes are valid.

3. What’s the context? Engagement means to interact with something, so what and who is the patient interacting with? The options include his or her own health, a clinician, the health care system, a community, and/or technology. This context matters and defines the measurement.

4. What is the locus of control, and who decides what the engagement looks like? If health care systems are held accountable for managing populations and will be reimbursed based on whether patients are engaged or not, then what happens to patient choice? Alternately, if a patient doesn’t want to engage, will we respect this or enforce our engagement strategy regardless? I often use the example of a young mom with multiple sclerosis who works full time. She doesn’t want to be reminded she has MS and actively minimizes her touchpoints. That doesn’t mean she is ‘noncompliant’ or disengaged—it means she has choice.

5. What’s the ideal state of engagement? If a clinician has highly engaged patients who order their own tests, schedule appointments online, and get all preventative care, but the care team is completely burned out, the power of relationship-centered care is absent.”

“For patients to be truly engaged in their health, they must demonstrate certain behaviors that reflect their engagement. The best statement I have seen builds on a behavior engagement framework put forth in 1996 by the Center for Advancing Health, based on the work of J.H. Hibbard and others on patient activation. It defines engagement as ‘actions individuals must take to obtain the greatest benefit from the health care services available to them.’ In other words, a patient must engage with the resources available in order to maximize his or her own health. I like it.”

“In the end, patient engagement and patient experience both have this funny word in front of them: patient. Ultimately, patients must play a significant role in these definitions.”
Priming the WI Rural Health Workforce Pump

We all recognize the growing challenge of the recruitment of health professionals to live and work in our communities. This is particularly true for rural communities, but increasingly urban and rural alike.

Young people having exposure to health professionals talking about their work is a key part of the workforce pipeline puzzle. We need to expand the number of students and educators in Wisconsin who have this opportunity.

That is where Students and Leaders Network (SLN), a 501(c)3 nonprofit organization, founded in 2010, enters the picture. SLN is dedicated to providing free career information to students, educators and parents. The program features live Q&A video discussions and a digital library of topics that provide information and insight on careers and life challenges for students. SLN has developed an awesome network of school teachers around the state but they need our assistance to further expand and keep updated their library of videos.

The cost to sponsor a new video is $2,500 per presenter and includes all activities required, including promotional material, scheduling, a session moderator, video production and promotion of streaming videos to educators. **SLN needs recommendations for sponsors and presenters; either would be appreciated.**

To date, 148,765 Wisconsin students have participated in live sessions and streaming SLN videos to their classes. 48,245 students participated in the 2015/16 school year. Evaluations of live sessions show that 99% of educators and 87% of students strongly agree/agree the sessions are of value. Over 29,000 students have viewed 45 live and streamed 25 minute videos of presenters in health careers. **For More Information re SLN, contact:**

**Students & Leaders Network**
10 East Doty St. Suite 800 Madison WI 53703
www.studentcareerinfo.com
info@studentsandleadersnetwork.com
608.251.5887

Collaborating to Reduce Preventable Diseases

From the Press Release: “RWHC Awarded Federal Grant for Primary Care Quality Improvement”:

“Sauk City, WI. (7/3/17) – Rural Wisconsin Health Cooperative (RWHC) is grateful to announce it has received a $300,000 grant from the Health Resources and Services Administration (HRSA) Network Development Grant Program for a primary care quality improvement initiative intended to drive improvements in the care of patients with diabetes and hypertensive disease. The grant award is for the first year of what is anticipated to be a 3-year initiative.”

“The Rural Wisconsin Primary Care Outcomes Improvement Project is a collaborative effort between RWHC, the Wisconsin Collaborative for Healthcare
Quality (WCHQ), the Wisconsin Hospital Association (WHA), Physician Compass, and eleven RWHC member hospitals. These project partners will be working together to achieve their common goals of improving HbA1C and blood pressure control in the project’s patient population.”

“Rural Wisconsin communities have higher than average rates of poverty, obesity, and tobacco use, three key risk factors for diabetes and hypertensive disease,” said Tim Size, RWHC’s Executive Director. “We are promoting wellness through collaborative self-management and lifestyle improvement in order to reduce related risk factors. RWHC is very excited to have received funding to do this important work.”

For more information, contact: Louis Wenzlow, RWHC Director of HIT and Strategic Initiatives/CIO, at 608-643-2343 or LWenzlow@rwhc.com

Leadership Insights: “Helping Too Much”

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

“Compassion is taking action to alleviate suffering. When leaders seek to help their employees, it is to some degree an act of compassion, and the following quote gives us pause to consider our frame of mind when we help:

‘Compassion is not a relationship between the healer and the wounded. It’s a relationship between equals.’ - Pema Chodron”

“Helping is culturally ingrained as the right thing to do, and I agree! Being of service is central in the framework of the servant leader, a bedrock of health care leadership. ‘It’s better to give than receive’ is a cultural touchstone most leaders have grown up hearing, leading them to bring their huge heart to work and do ‘for’ others. You might hear it in comments like, ‘I don’t ask them to do anything I won’t do,’ or, ‘I don’t want to burden my staff because they are already so busy.’ Well intended, originating from a desire to be fair and not an ogre, it’s wise to consider the times when helping might not leave people feeling equal, where you might be helping too much:

- **You miss the forest for the trees.** People want you to lead, that is why you are in that role. You have a hard time leading strategically if you are always offering to fill in shifts. Reflect on how much of your time is spent doing the job you got promoted from. Working managers have to do this sometimes, but it can slip into the default position. This trap is deceptively easy to fall into because it satisfies the need to do work that makes us feel competent. **INSTEAD:** Get support for your leadership role to learn the new skills you need to be successful. Understand and accept that there is a learning curve and it’s normal to feel unsure of yourself at times! Face the discomfort of the unknown. You will eventually learn the new roles and skills, but only if you are willing to be uncomfortable for a while.

- **Employees miss opportunities to learn.** Like struggling through your own learning curve and getting to the other side where competency is, your employees need that, too. We worry about their struggle and want to make it easier for them, but who are we to say that this person doesn’t need this very struggle to grow into the person they are meant to be? Who has not learned from a challenging situation? Sometimes when we take over another’s struggle, rather than helping, we actually get in the way of their growth. **INSTEAD:** Resist the urge to step in and fix. Show support by facilitating their learning through their own discomfort.
Employees may believe that you don’t trust them, leading to disengagement. Your staff feels empowered when they know you trust them. If you are too quick to take over rather than empowering staff to try, it can unintentionally send the message, ‘I know better; you can’t be trusted to figure this out.’ INSTEAD: Extend trust, starting with reminding yourself that others are capable too.

Others will respond to your offer to pitch in with, “Awesome, it’s yours!” You get to feel virtuous for a short while, but then you begin to notice that they get their vacation days, a lighter load, and you don’t ever get to take a day off or leave on time. Reflect on if you feel overwhelmed, like you are working harder than others, or even resentful. These may be signs that you are rescuing too quickly and too often. Remember that we teach people how to treat us. INSTEAD: Respond to a request for help with inquiry:

✓ ‘What ideas do you have to solve the problem?’

✓ ‘What would you try if you couldn’t reach me?’

✓ ‘My covering this is not an option. Work with your team to bring back alternative solutions.’”

“Being a good leader and manager IS helping. Even the Beatles made that point in their 1965 hit HELP which is useful to play as a reminder as you shift from ‘pitching in on the floor’ to ‘moving the rocks out the road ahead.’”

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.

Upcoming RWHC Leadership Programs
8/21 - Leading Change When Change is Hard
8/23 & 24 - Preceptor Training Program
9/22 - Teams: Building Blocks & Facilitation Tools
Non-Members Welcome. Register & other events at: www.RWHC.com/Services.aspx