Medicare Commits to a Rural Strategy

From “CMS unveils new rural health strategy” by Virgil Dickson, in Modern Healthcare, 5/8/18:

“The Centers for Medicare & Medicaid Services (CMS) has made a commitment to keep rural communities in mind when developing new regulations, releasing an eight-page rural health strategy at https://go.cms.gov/2Ipm6dv which outlined its promises to reduce regulatory barriers to telehealth, improve outreach to providers in these communities to make sure they understand CMS programs, and identify practical solutions that will help better care in these areas. The document did not outline policy announcements.”

“This administration clearly understands that one of the keys to ensuring that those who call rural America home are able to achieve their highest level of health is to advance policies and programs that address their unique healthcare needs,’ CMS Administrator Seema Verma said in a comment.”

“Alan Morgan, CEO of the National Rural Health Association, called the strategy ‘substantial.’ Verma had previously announced a rural plan was coming at an NRHA conference. The strategy’s chief initiative is formally analyzing what impact any future rule-makings will have on rural providers and communities. That practice doesn’t happen consistently now, Morgan said. ‘We are optimistic that this effort at ‘rural proofing’ will provide a better regulatory environment for rural providers,’ he said.”

Key points from the report include:

“To inform the development of a strategic plan to improve health care in rural America, the CMS Rural Health Council sought input on the challenges and local solutions associated with providing high quality health care in rural communities through a series of listening sessions with rural stakeholders and consumers. The result has led to the identification and resolution of several specific health care provider issues, better understanding of the impact of CMS policies on providers and a rural health strategy.”

“The strategy supports CMS’ overall effort to reduce provider burden, and aligns with other CMS priorities, such as improving quality of care and tackling the opioid epidemic. Through the implementation of the CMS Rural Health Strategy and continued stakeholder engagement, we will aim to promote policies that help make health care in rural America accessible, affordable, and accountable.”

1. **Apply a Rural Lens to CMS Programs and Policies**—“Understanding that CMS’ policies and programs may uniquely impact rural and other vul-
nerable populations, CMS recognizes the need to consider policymaking, program design, and strategic planning through a rural lens to promote health equity among all populations that CMS serves. CMS has already taken steps to integrate consistent consideration of the rural health impact of policies under review. By optimizing its policy review and development for health equity, CMS will work to identify areas where it can better meet the needs of vulnerable populations, and avoid unintended negative consequences of policy and program implementation for vulnerable populations and communities.”

2. **Improve Access to Care Through Provider Engagement and Support**—“Rural providers and patients alike have challenges providing and accessing services in rural areas due to a range of barriers that include, but are not limited to, the lack of providers and specialists, difficulty recruiting and retaining health care providers across all levels of care, and limited capacity among clinical and administrative staff. In response to these barriers, the second CMS rural health strategic objective is to improve access to care through provider engagement and support. This objective focuses on maximizing provider scope of practice; providing technical assistance to providers to ensure that they can fully participate in CMS programs; and identifying new ways to overcome patient barriers to access, such as a lack of transportation.”

3. **Advance Telehealth and Telemedicine**—“Telehealth has been identified as a promising solution to meet some of the needs of rural and underserved areas that lack sufficient health care services, including specialty care, and has been shown to improve access to needed care, increase the quality of care, and reduce costs by reducing readmissions and unnecessary emergency-department visits. To promote the use of telehealth, CMS will seek to reduce some of the barriers to telehealth use that stakeholders identified in the listening sessions, such as reimbursement, cross-state licensure issues, and the administrative and financial burden to implement telemedicine.”

4. **Empower Patients in Rural Communities to Make Decisions About Their Health Care**—“Like many patients, rural populations have difficulty understanding their health insurance coverage and navigating the health care system to get the care they need. Rural communities tend to have unique challenges, such as limited access to specialty providers and longer distances to travel for medical care. These barriers accentuate the need to ensure information is reaching rural patients so that CMS can best support and empower them to make decisions about their health care. Understanding that rural communities may need different communication and outreach approaches than their urban and suburban counterparts, CMS will explore different ways to engage rural populations. Patient and family engagement is an essential part of fostering responsibility and partnership in a person’s health care, so CMS will leverage existing rural communication networks to empower patients and families with the information and tools they need to be actively engaged in their health care and strengthen their patient-provider relationships.”

5. **Leverage Partnerships to Achieve the Goals of the CMS Rural Health Strategy**—“Finally, because the health care challenges experienced by rural communities in America cannot be solved by CMS alone, a key objective of the CMS Rural Health Strategy is to leverage partnerships with stakeholders, at multiple levels, to achieve the stated goals. This objective recognizes the importance of collaborative partnerships, both on the federal
level and at the regional, state, and local levels. The approach is intended to create a climate of collaboration, collective information, and joint action among CMS and its partners. Additionally, leveraging partnerships will support a smooth, effective, and inclusive implementation of the CMS Rural Health Strategy, extending the dialogue initiated by the listening sessions to provide opportunities for reflection on important milestones as well as an understanding of the rural health community’s role in success.”

“Through the implementation of this strategy, CMS and its partners will help make health care in rural America accessible, accountable, and affordable—resulting in the highest quality of care.”

Evolving Payer-Provider Relationships

From “How is the payer-provider relationship evolving? Both sides weigh in” by Kelly Gooch, Becker’s Hospital Review, 6/16/17:

“Healthcare industry trends such as growth in data analytics and high-deductible health plans are causing payer and provider relationships to evolve.”

“With this evolution comes the need for greater communication and collaboration between the two sides. A recent survey of 40 health plans and 400 practice- and facility-based providers found 53 percent of payers ‘strongly agree’ providers and health plans need to collaborate to be profitable.”

“Craig Samitt, MD, chief clinical officer of Indianapolis-based Anthem, sees collaboration between payers and providers as a mandate rather than an option for managing population health and for the continued evolution and transformation of healthcare.”

“Anthem has changed how it interacts with providers in the last several years. This change is based on the belief that collaboration between health plans and providers leads to better outcomes and lower costs, says Dr. Samitt.”

“Although collaboration is improving, disputes between payers and providers are still a common occurrence, according to Dennis Laraway, executive vice president and CFO of Houston-based Memorial Hermann Health System. He says there are still many legacy payer-provider relationships that are often fee-for-service oriented and unit-price oriented. At Memorial Hermann, for instance, more than 95 percent of the system’s revenue stream is still fee-for-service, claims-based reimbursement.”

“ ‘Even in the day-to-day joint operating activities between payer and provider, you still see a great deal of payment dispute activity over the authorization of the service, and payment arrangements per contract vs. those that were adjudicated in the claim,’ says Mr. Laraway. ‘Again very much a legacy framework, fee for service, that still carries out today between payer and provider.’ ”

“Still, Mr. Laraway acknowledges some evolution of change has occurred, as there are more contemporary arrangements emerging between payer and provider along accountable care structures.”

“ ‘Memorial Hermann’s success as an ACO for the CMS payment demonstration is evidence of our commitment to shift volume into a population-based framework. We’re continuing to work with commercial payers to strive for similar payment models, especially when the member can truly be attributed directly to our provider network,’ says Mr. Laraway.”

“Karim Habibi, senior vice president and chief of managed care at NYU Langone Medical Center in New York City, also noted the payer-provider relationship has become collaborative.”
“These value-based contracts are still laid on the top of the fee-for-service contracts and have the inherent limitations of fee for service, but such contracts are expected to continue to improve and evolve over time,” said Mr. Habibi.

Data analytics—While payers and providers talk in general terms about the relationship between the two sides, they specifically discussed how data analytics now plays a role.”

“Dr. Samitt notes that Anthem’s AIM Specialty Health subsidiary, a specialty benefit management company, which he says makes actionable data available to physicians so they can make better informed treatment decisions in high-risk, high-cost areas such as oncology. Additionally, he noted Anthem’s partnership in California called Vivity, which is a product off the insurer’s California health plan in partnership with seven health systems in the state. Dr. Samitt says Anthem worked to develop an analytics platform in support of Vivity that provides participating health systems with necessary population health information and predictive analytics.”

“At Memorial Hermann, Mr. Laraway says the system has been participating in the introduction of the accountable care models through member attribution logic with the large commercial payers in Houston. ‘It allows us to obtain claim information to then be shared between payer and provider network.’ ”

“As a result, Mr. Laraway says Memorial Hermann is able to link claim information with its clinical information system, allowing the organization to view trends and incidents of its patients and begin making decisions around clinical care management.”

“By having the data, it allows us to stratify the population, work with our physicians around data trends for the patients they’re serving and we can provide value back to the table for the payer. That allows both parties to share in some performance incentives that are now value driven rather than volume driven,’ he adds.”

“Mr. Habibi with NYU Langone believes analytics is crucial to success under value-based contracts. However, he said this requires significant investment in IT infrastructure, which allows providers to integrate claims data from the payers with hospital EMR data and physicians EMR data. He said providers also need the ‘ability to normalize the data to create a clinically enriched data set that can be used to manage the health of the attributed patient population.’ ”

“High-deductible health plans—Along with analytics, the rise in popularity of high-deductible health plans has played a role in the evolving payer-provider relationship.”

“Dr. Samitt says High Deductible Health Plans (HDHPs) have contributed to payer-provider collaboration in two major ways. First, the growth of such plans is essentially transforming healthcare into a retail market, especially for services viewed as commodities like imaging. Second, he believes HDHPs force an imperative for payers and providers to work collaboratively to improve quality while reducing costs.”

“HDHPs have also affected the roles of payers and providers when it comes to the back end of the revenue cycle, as providers are now seeking more payment from the patient rather than the payer, Mr.
Laraway notes. ‘Direct patient billing is perhaps the most difficult aspect of the overall revenue cycle, so further shifting financial responsibility from primary payer to patient puts added pressure on the provider sector to chase payments — one patient at a time.’”

“Still, Mr. Habibi said there is opportunity for providers and payers to collaborate on reducing inappropriate or unnecessary care instead of pushing that responsibility on consumers through HDHPs.”

**Why Study So Many?**—“Most of today’s medical care is based on what happened to the average person in short studies of a few hundred or thousand patients with a specific health condition.”

“And most people who volunteer for those studies are white, leaving questions about the best care for people of different races. ‘One-size-fits-all is far from an optimal strategy,’ Collins said Tuesday in announcing enrollment for All of Us.”

“The project involves ‘precision medicine,’ using traits that make us unique to forecast and treat disease. Learning enough to individualize care requires studying a massive number of participants: The healthy and not-so-healthy, young and old, rural and urban, blue-collar and white-collar—and people of all races and ethnicities.”

“For now, participants must be at least 18. Next year, the study will open to children, too. While there are other big ‘biobanks’ of genetic data from at least 100,000 people, the NIH project aims to be the largest and most diverse of its kind. At least half of the participants must be from groups traditionally under-represented in medical research, Collins stressed.”

**Genes Aren’t The Whole Story**—Sure, what genes you harbor can raise your risk for various diseases. But other factors can increase or reduce some genetic risks.”

“So first volunteers will share electronic health records and blood samples, and answer periodic questionnaires about their diet, sleep, environmental exposures and other lifestyle factors. They might wear fitness trackers and other sensors.”

― Join RWHC’s Executive Director in this big data research adventure. From ‘US seeking 1 million for massive study of DNA, health habits’ by Lauran Neergaard, AP, 5/1/18:

“Wanted: A million people willing to share their DNA and 10 years of health habits, big and small, for science.”

“The U.S. government has opened nationwide enrollment for an ambitious experiment: If they can build a large enough database comparing the genetics, lifestyles and environments of people from all walks of life, researchers hope to learn why some escape illness and others don’t, and better customize ways to prevent and treat disease.”

“A national adventure that is going to transform medical care,’ is how Dr. Francis Collins, director of the National Institutes of Health, describes his agency’s All of Us Research Program.”

“Congress has authorized $1.45 billion over 10 years for the project. It all hinges on whether enough people around the country will sign up, either online at https://www.joinallofus.org/en or through participating health centers.”

“There’s already interest: More than 25,000 people got early entry to the project over the past year through an invitation-only pilot test run by participating universities and health providers.”

US Seeks 1 Million Health Research Partners
“Later this year they’ll start undergoing genetic testing, initially to look for so-called ‘variants’ in DNA that affect disease risk, similar to what some private companies now sell, Collins said. Fully mapping the genetic code is too pricey now for a million people, but that more comprehensive approach eventually will be used with some participants, too.”

“Among the first lessons Collins hopes to learn is about resilience: Why do some people stay healthy despite smoking or pollution or poor nutrition? ‘We have no idea how those people escape those odds,’ he said.”

“Learn Your Results—Unlike with most medical studies, participants can choose to see their own test results and share them with their physician long before the study reaches any big-picture conclusions. A caution: There are still many questions about how best to use the results of genetic tests. Still, ‘we will try to help their doctors sort through what it means,’ Collins said.”

“One result that might bring a quick benefit: Genetic variants can signal who is prone to side effects from more than 100 drugs, information that could be used to prescribe a safer drug if only their doctors knew, Collins added.”

“Protecting Privacy—The privacy of DNA databases made headlines last week when investigators used a free genealogy website to track down a suspected California serial killer. That’s pretty different than the security under which medical DNA must be handled.”

“NIH said it has taken as many steps as possible to safeguard against would-be hackers. Volunteers’ medical data is stripped of identifying information and replaced with a code. Only scientists meeting specific security requirements will be cleared to study the data. NIH also said federal ‘certificates of confidentiality’ prohibit disclosure to law enforcement.”

“Privacy wasn’t a worry for Michelle McNeely, 41, an early participant at Dallas’ Baylor Scot & White Health System. She underwent breast cancer treatment in 2016 and considers taking part in All of Us a way to give back.”

“ ‘If they can use my genes and someone’s genes in California and someone’s genes in New York to find some common ground, to help discover some cure—they can use my genes all day long,’ McNeely said.”

All of Us is being implemented in Wisconsin through the Marshfield Clinic Research Institute; Blood-Center of Wisconsin, Milwaukee; Medical College of Wisconsin, Milwaukee; and the University of Wisconsin School of Medicine and Public Health, Madison.

Leadership Insights: “Considering Speaking”

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

“The best tip? Speak MORE. Though nothing replaces experience, Consider these tips as you prepare your next presentation.”

Address the problem the audience needs to solve. “We worry a lot about what to say, but what we need to keep top of mind is what the listener needs to hear. Consider: Where does what you have to say match up with what will make their job easier, their life better, or their skill greater? When we speak to their needs, the audience will engage.”

Line up the message with the messenger. “I attended a presentation on ‘authenticity in work teams.’ It had adequate content, but it didn’t work because the delivery came off, unfortunately, as inauthentic.”

“I sensed that the speaker was trying to pretend he was not nervous. Hear me out: his being nervous was
NOT the problem. Walter Cronkite said, ‘It’s normal to have butterflies; the trick is getting them to fly in formation.’ Almost all speakers get nervous, and most people are very forgiving of this. The problem was that he was talking about authenticity but did not authentically address the elephant in the room. The message and the messenger were out of sync, and it hurt his credibility.”

“He was speaking to a group of professional speakers; who wouldn’t be nervous!? Address it. He could have made a little joke about it, and the whole feel of the presentation would have changed. Humans are wired for empathy, and everyone in the room could have put themselves in his place, putting him and the whole room at ease. Consider: If there is an elephant in the room, how can you acknowledge it? When the message and the messenger are in alignment, it is powerful and authentic. The point of this example is not that we should always speak up about being nervous. In this case, though, it was completely relevant. How do you authentically bring yourself to your speaking to connect to your audience?”

Be YOU. “Not someone else. That is a clear route to authenticity. Know your own strengths. When I co-present with my colleague, Cella, I just want to be her. She’s funny, flamboyant, loud (in a good way!), theatrical, and can boil down her message to a memorable nugget. In contrast, I fear I am too long-winded, cerebral, reserved and serious. I’ve learned immeasurably from her and have truly lightened up, but I’m still me. When I try too hard to be like her, it falls flat. Consider:

- What is your personality and what gifts are there to serve you? What are your strengths? What is NOT you?

- Get ok with your own niche. Cella admires me, too, and we both bring strengths to the table.

- Pick something you like that other effective speakers do and just try it. See how it goes, keep what works and leave the rest.”

Be in the moment, as much as you can be. “This is where preparation helps. Have a plan, and think it through, practice it, but remember to pay attention to your audience. It is hard to be fully present when you are nervous, but it is possible. Consider: Pause, look up and around the room, make eye contact with a couple of friendly faces (even if you have to plant them), and…

Breathe. “Fear is excitement without the breath,” (Fritz Perls). BREATHING IS CRITICAL. Yes, of course you are doing it right now, and as long as you live you will be doing it. But when we get nervous, we hold our breath, breathe shallowly, and the lack of oxygen hurts our performance. Consider: You have more control over this than you think you do. Right now, try this 3 minute breathing exercise at https://bit.ly/2I5JEVC with my Zen Leadership teacher, Ginny Whitelaw, and experience an immediate impact.”

Strive for IMPerfection. “TED talks feature brilliant minds on fascinating topics at https://www.ted.com. But the speakers I enjoy the most are the ones who are less ‘perfect.’ Watching overly-rehearsed speeches with practiced, overly-rehearsed speeches actually gets a little tiresome. People are not perfect. Consider: Stop fretting over the occasional um, misplaced word, blush, or stutter. It matters to no one. BUT…

Prevent sloppiness. Overuse of fillers can kill your presentation. Consider: Give your talk to a colleague and ask them to count your fillers. Some common ones: um, uh, sort of; like, you know, you know what I mean, does that make sense, etc., kind of; right, I know right? While not illegal, they can prevent your important message from being heard.”

Make use of your audience. “When you speak, you are stimulating thoughts in the listeners. Give them time to process their thoughts and to participate with you. Think of your audience not as consumers, but as partners with you. Consider: What is a partner or triad discussion question you could pose to prime your group for your talk at the beginning, or to give them a chance to engage with the content of your talk partway through?”

Accept the impromptu challenge. “If you are asked on the spot to speak about something you have not prepared for, avoid the ‘deer in the headlight’ look. Consider: Having some ready tactics:
1. Thank the previous speaker or participants for asking for your input, for ideas they have shared so far, for the opportunity to have such a lively discussion, whatever you can thank them for! No one I know is thanked too often.

2. After thanking them for seeking your input, if you are not sure what to say, try: ‘I want to give you a thoughtful response; could you come back to me in a few minutes/at the next meeting so I can consider this a bit?’

3. If you have a response but it is not well formulated on the spot, state, ‘I don’t have a fully ready response, but let me give you some initial thoughts just off the top of my head. I may think of more and will get back to you as I do.’

Introduce skillfully. “Earn the reputation of being the person that others want to have introduce them. Consider: Get their name right. IT MATTERS. Also, share a couple of brief things that make the person being introduced of interest and importance to the person(s) to whom you are introducing them.

Keep trying. “I learned a lot about speaking from singing. No breath, no sound. For so long I was afraid of making a mistake or going for the big note, worrying I would miss it. A more confident (not necessarily better) singer said to me, ‘You know what to do if you miss a note? Move on to the next one.’ Consider: ‘You’ll never hit the notes you don’t try to sing.’”

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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