What Can We Agree On?

By Jeremy Levin, RWHC Director of Advocacy:

For those of you paying particularly close attention to our new form of divided government in Madison, you might be asking yourself the exact same question. The Capitol has seen its last of Governor Evers’ big three speeches for 2019—Inaugural Address, State of the State Address and Budget Address. Now words will start to turn into action.

The next four-plus months will become engrossed by dealing with the budget, as the Executive and Legislative branches hash out their different ideas and priorities, which right now seem incredibly far apart.

Governor Evers seems to be facing this predicament with eyes-wide open, speaking after introducing his budget: “Any time something like this happens—a change in administration or a new budget—there’s going to be a lot of political posturing and huffing and puffing, but at the end of the day we have to find common ground, and I look forward to doing that.”

Governor Evers has included a Medicaid expansion plan in his Executive Budget, an idea he has championed since the early days of his campaign. He recommends that the $300+ million in state savings saved in the 2019-21 biennium through Medicaid expansion be reinvested back to the providers and institutions serving Medicaid recipients.”

Done correctly, this reinvestment could go a long way to reduce Wisconsin’s “Hidden Health Care Tax” that is the result of the current Medicaid program reimbursing hospitals only 65% of what it costs them to provide care. The over $1.1 billion unpaid Medicaid costs each year are ultimately shifted to employers and families when they receive their health care.

While the next several months will witness strong debate over Medicaid expansion, I hope our elected officials don’t lose sight over where there is hopefully broad agreement on state funding that makes a real difference for rural hospitals and their communities:

- The next Executive Budget fully funds the $200 million reinsurance program known as the Wisconsin Healthcare Stability Plan (WIHSP), which saw bipartisan support when created (2017 WI Act 138) and brings stability to Wisconsin’s state budgets received bipartisan support for a strong Medicaid program for beneficiaries. It appears this next Medicaid budget will hinge on whether and how Wisconsin decides to accept a potential Medicaid expansion (like 36 other states have done).

Rural hospitals rely on government payments to maintain access to local care, and while Medicare is a larger share of their patient mix, rural areas still have a significant population of working poor that are covered by Medicaid. These payments are crucial to support rural hospitals in the provision of local care. Recent

“Health care shouldn’t be a matter of where you live.” - Dan McCoy, president of Blue Cross and Blue Shield of Texas

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health insurance exchange and ensures the continuation of a healthy marketplace.

- The budget continues funding for the Graduate Medical Education Consortium that Governor Walker created in his 2013-15 biennial budget, which aims to train health care professionals in rural and underserved areas. The proposed budget seeks to enhance flexibility and expand eligibility for how these valuable funds can be used.

- Further, the next budget is calling for investments in behavioral health, which have less access and resources in rural areas. Assembly Speaker Robin Vos created a bipartisan state Assembly task force on mental health in the 2013 session and has ever since appointed a standing committee on the subject.

- Little else transcends rural economies and communities like access to high speed broadband. The Wisconsin Broadband Office estimates that there will still be over 35,000 households in Wisconsin that will not have access to any or adequate broadband even after all current federal funds are fully deployed. Governor Walker called for broadband expansion grants and providing up to $18 million in his 2015-17 biennial budget for two grant programs. Rural broadband expansion grants have had strong legislative support through the Assembly’s Rural Wisconsin Initiative and through champions like Senate Howard Marklein (R-Spring Green) and his 2017 legislation that sought to expand the Broadband Expansion Grant Program.

So as we get back to the initial question of, “what can we agree on?,” common ground and shared priorities are more numerous than one might think listening to the political rhetoric of the day down in Madison. Voters across Wisconsin spoke last fall and gave us divided government; they did not ask for devoided government. Much good can still be accomplished for rural communities across Wisconsin when Madison shares a focus.

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“Creating Health Neighborhoods”

From the Blog: “Creating Health Neighborhoods: A Place to Live, Work, and Play” by Jennifer Boese, Director of Health Care Policy at CliftonLarsonAllen LLP, posted at www.claconnect.com on 1/18/19:

“As health care continues to evolve, what if some of the current or future brick and mortar locations of our health care delivery system could serve as a mixed-use environment that addresses not only individual health, but expands to consider a community’s population and economic health? Would this new model create communities where people want to live, work, and play?”

“If we look at shifts in the industry today, we can see doors opening for these health neighborhoods, including:
Health care delivery is changing—Care is continuing to move from the inpatient setting to outpatient settings, virtual, or home-based care, and consumers are demanding convenient and customer-focused options. These shifts alone have many implications for incumbent hospitals, health systems, and providers, including the need to revisit their built environments.

Social determinants of health (SDoH)—Health care providers do not have the ability to address everything that impacts an individual’s health, yet they are increasingly being held accountable for the downstream ramifications of these factors. If health care leaders are willing to consider new models, like a health neighborhood, it could afford them increased opportunities to directly and indirectly impact more SDoH.

Market dynamics and fiscal policies—There are growing pressures on revenues and margins. New competitors are moving into the health care delivery system. Payers, particularly government programs, are driving reimbursements lower and demanding better value and outcomes. This means health care providers may be saddled with high debt loads, decreasing reimbursements, and physical structures that no longer meet the needs of a shifting delivery system. Reimagining those buildings and the surrounding environment could better connect individuals with their local neighborhoods, while also providing new revenue streams.

Changing demographics—There are major shifts in how different generations think about health care and where they want to live, work, and play. Younger generations want to live in walkable cities where health care is convenient and amenities are located nearby. Older generations want to age in place and tend to desire in-person health care delivered close to home.”

“As all of these changes come together, there are ramifications on health care’s long-term physical infrastructure. The fundamental shift underway in health care is pushing out from within the walls of a hospital or clinic and into the community.”

“If we are simultaneously working to keep people (and populations) well and out of hospitals and clinics altogether, and if we agree that economic health contributes to both individual and population health, then revisiting the physical footprint of health care is important. The health neighborhood model creates new ways of imagining health care’s built environment—both current and future facilities—and the areas that surround them to create a new micro community.”

Understanding What Impacts Individual Health

“Looking at the County Healthy Rankings, a collaboration between the University of Wisconsin’s Population Health Institute and the Robert Wood Johnson Foundation, health care itself (hospital care, physician care, etc.) accounts for only 20 percent of what impacts an individual’s health. <https://goo.gl/7c3HtT> This percentage comprises access to and quality of care, which hospitals and providers across the continuum are able to directly affect, and historically, are what they have focused on.”

“However, hospitals, providers, and health systems should also take into account SDoH they cannot control, and yet are increasingly held accountable for, that also impact health outcomes. These remaining 80 percent of factors impacting health are:

- **40 percent**—Social and economic factors (e.g., education, employment, social supports, safety)

- **30 percent**—An individual’s health behaviors (e.g., tobacco use, diet, exercise, drug and alcohol use, sexual activity)

- **10 percent**—Physical environment (e.g., walkable cities, transit, air, water)

Patient case study (current state)—“A patient has had a recent heart event, combined with ongoing obesity, hypertension, and diabetes. He has a difficult
time accessing healthy food, is nowhere near a fitness center, and does not have a car. The hospital has successfully treated him for the heart event, and has indicated he should take cardiac rehabilitation classes, including education on diabetes and the importance of exercise, diet, and nutrition.”

“To date, he has sporadically attended class due to a lack of transportation. He lives in a food desert and frequently gets fast food or frozen meals. His weight, blood pressure, and diabetes is unchanged.”

“Unless these other SDoH are addressed, he could find himself back in the hospital with a worsening condition. Even though these aspects are outside of the provider’s control, under varying payment models or requirements (such as readmissions and value-based payments, among others), providers could be financially penalized for this patient’s higher utilization of services and poor health outcomes.”

“It is completely understandable that providers have focused on the 20 percent of factors they can directly impact, but they will need to determine how to better influence and impact more of the remaining 80 percent. This is where a health neighborhood model could begin to fill in some gaps.”

**Moving Beyond Individual Health Into Population Health**

“Health care providers increasingly need to understand how to better impact population health, and they are well positioned to do so. From relationships with social service agencies and local government to local chambers of commerce and businesses, providers already are active members of their local communities. But could there be another way for providers to leverage these relationships and resources more effectively and efficiently to address the health of local communities?”

“The AHCM is based on emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs. Learn more about the 31 communities participating in this CMMI model at: <https://goo.gl/4N6wkQ>.

“The Centers for Medicare and Medicaid Services (CMS) and its Center for Medicare and Medicaid Innovations (CMMI) Accountable Health Communities Model (AHCM) revolve around this very concept. The model is designed to leverage resources, encourage alignment, and address unmet needs like food insecurity or inadequate housing. In other words, the model seeks to focus on the other 80 percent of SDoH impacting health outcomes.”

“The head of the Department of Health and Human Services, Alex Azar, has also indicated CMMI is looking at other health care models that allow hospitals and health care providers to address SDoH. This would be in addition to what the agency has already undertaken to allow Medicare Advantage plans more flexibility to address SDoH in the future.”

“If a health care provider, say a hospital, could help coordinate resources or locate them directly on its campus or in the surrounding area, it could result in better access and an even stronger and tighter clinical-community linkage. In doing so, it would allow for new ways of leveraging and deploying limited resources in ways that are specifically aimed at the community’s needs. In this sense, re-imagining or re-configuring health care’s built environment to allow
for these types of enhanced linkages presents a targeted, unique opportunity to improve population health.”

**Combining population health with economic health**—“Current models do not typically aim to improve the economic health of communities, yet this factor influences both individual and population health outcomes.”

“Oftentimes, health care providers are economic lynchpins in their communities; not only do they provide access to health care close to home, but they provide direct and indirect jobs, and economic impact. By considering the built environment in and around the hospital or clinic, health care leaders can extend that impact even further via a reimagined, mixed-use neighborhood of health care, retail, and even residential options.”

“For example, a hospital campus could serve as an anchor business in an area, bringing with it a built-in customer base of patients and visitors. The hospital could work with the city, businesses, and local community to understand retail and housing needs. As it builds the hospital campus, it could consider more mixed-used space (retail and housing) to help address local community needs, as well as create more economic activity. In turn, this creates an even more attractive business climate.”

“When we consider combining this with the potential of different housing options in and around the area, it adds in another dimension and customer base. When more individuals live, work, and play in closer proximity, the area lends itself to a broader tax base. Population centers also provide the potential for collaborations with local government on better public transit options, public investment in improved walking or biking routes, and more.”

**The new health neighborhood model**—“In this reimagined built environment, a health neighborhood model holistically combines the individual health, population health, and economic health of a community. Symbiotically, these three pillars will ideally work together to benefit all.”

“Let’s see how overlaying our SDoH factors onto this model addresses needs:

**Health care: 20 percent**—Access to and quality of care could actually increase by facilitating new care delivery models, like hospital-at-home or regular in-person home visits for complex patients. A health neighborhood (large or small) could serve as a competitive advantage, even drawing people in because of the accessibility of both health care and retail needs in one trip. It could also serve in attracting or retaining health care providers, including the younger generations who may want to live within walking distance of where they work and play.

**Social and economic factors (e.g., education, employment, social supports, safety): 40 percent**—A health neighborhood will not be able to address every factor, but it could certainly provide new opportunities for employment (via new retail locations, for example), better collaboration, integration, and use of social supports, and even new educational partnerships with tech colleges or training and mentoring programs within the neighborhood itself. The neighborhood may even qualify as an opportunity zone with additional tax advantages [https://goo.gl/EPHUCz].

**An individual’s health behaviors (e.g., tobacco use, diet, exercise, drug and alcohol use, sexual activity): 30 percent**—Health neighborhoods could begin to impact individual’s behaviors by initiating collaborations that spark programs or classes, and provide better access and availability to support groups, a fitness center, healthier food options, and a grocery store, all located within walking distance.”

**Physical environment (e.g., walkable cities, transit, air, water): 10 percent**—Health care providers can work to make their built environments greener, and encourage other businesses in the health neighbor-
hood to do the same. This may include working with city planners to create or facilitate better walking trails in the area, and advocating for better transit options to or within the health neighborhood.”

“Imagine a health system building a new micro hospital to address the needs of a local community with these factors in mind. They host brainstorming sessions with the city, businesses, and community leaders, during which they identify key retail needs and collaborate on shared goals. The health system develops plans and space that will be filled by a local social service organization, a fitness club, small grocery store, locally-sourced restaurant, and co-working office space that will also serve as an incubator for start-ups. The whole neighborhood will have access to community Wi-Fi.”

“During these brainstorming sessions, housing needs in the area also arise. They discuss condos, senior living, and even an intergenerational living community. <https://goo.gl/VWmp6b>. Additional residential options in the area would provide for the housing needs of health care workers and others who want to live in the area. Senior living, or intergenerational living, allows for better aging in place and addresses different generational needs. The health system works to develop or support opportunities to meet these residential housing needs. The area sees growing economic vibrancy. There is less social isolation as more individuals live in community. ”

“Health care providers and social services begin to cluster in this area, creating a cohesive deployment of resources to meet specific, local needs. New health care delivery models emerge that allow for better chronic care management, prenatal care, wellness, and more. Individual and population health needs begin to improve, which result in providers seeing better quality outcomes, reduced readmission rates, reduced utilization of resources, improved patient satisfaction, and increased patient-centered care.”

**Patient case study (future state: health neighborhood model)**—“When the cardiac patient from earlier is placed in this model, he is able to take public transportation (a bus stop was added due to the health district) to his new job at a business in the health neighborhood. He is also able to walk to his cardiac rehab classes at the hospital nearby. His physiological data is being monitored remotely, and he is checking in regularly via telehealth with his exercise physiologist, nutritionist, and doctors. As a team, they are working together on behavior modifications, healthier food choices, an exercise program, and any physical or mental health needs that arise.”

“Taking what he’s learned, he shops at the local market for groceries before heading home. Due to a partnership between the hospital and local social service agency, when his cardiac rehab classes end, he can continue his exercise regime at a local fitness club that has opened up nearby. As a result of these changes, he has lost 15 pounds, his blood pressure is moving in the right direction, and his diabetes is better managed. He is hopeful about his future, and his care team is pleased with his progress and that he has not needed any additional care.”

“Does this all sound a bit too utopian? Perhaps. But if we are in a time period when health care is being re-considered, then re-imagining health care’s physical footprint and leveraging the role it can play—small or large—is important, as well. Doing so offers the opportunity for forward-thinking health care leaders to dream differently, envision health care delivery in new ways, and push further into the very fabric of their communities. The goal: to create better spaces to live, work, play, and be well.”
From the Policy Brief: “Dying Too Soon: County-level Disparities in Premature Death by Rurality, Race, and Ethnicity” by Carrie Henning-Smith, Ashley M Hernandez, Marizen Ramirez, Rachel Hardeman and Katy Kozhimannil, University of Minnesota Rural Health Research Center, March 2019:

“Counties with a majority of non-Hispanic Black and American Indian/Alaskan Native residents had significantly higher premature death rates (defined as years of potential life lost before age 75 per 100,000 people) than counties with a majority of non-Hispanic White residents, regardless of rural-urban location. Comparing counties with similar racial and ethnic compositions, rural counties had higher rates of premature death than urban counties. The highest rates of premature death were observed in rural counties where a majority of residents was non-Hispanic Black or American Indian/Alaskan Native.”

Download the full report is at: https://goo.gl/XiAdSr

Leadership Insights: “Summarizing”

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

“A picture is worth a thousand words,” could be the motto for the communication skill of summarizing. Less is more. Imagine that you have just participated in a lengthy project meeting and your manager asks you for a brief summary of what transpired. It is not as easy as it sounds to do this well. What do you leave in? What details get weeded out? The devil may be in the details, but the details do not belong in the summary. Sorting, discerning and zeroing in on the broad message to quickly and clearly articulate it is a skill you can strengthen and doing so increases your ability to influence others.”

Practice summarizing the following example: “Your project meeting covered overtime work on the project causing budget over-run issues, maternity leaves in a particular department resulting in fewer available staff to help, unrealistic timelines causing delays, and difficulty scheduling meetings due to time constraints. The meetings have been scheduled by the project manager based on her schedule and it is hit or miss for attendance because people have other standing meetings that interfere. The minutes are lengthy and come out right before the next meeting so there is little usefulness to them. The team came up with a plan for establishing agreed-upon limits on overtime, revised the project timeline to accommodate the leaves, and set regular recurring meeting dates to improve attendance. Several ideas were shared for improving the minutes for people who had to miss, including using the agenda as a guide to meeting notes (with agenda items revised to be written as SMART goals) and noting only decisions made instead of ‘discussion’ items which just went on and on and people did not read them. There were decisions made about revisions to the budget and how to adapt the original plan to still meet the goals without having to request additional funds and doing this by first identifying and then eliminating some costs that were not value added. The role and responsibility worksheet was updated to identify who would take action on each action item with timelines added to keep people on track. This worksheet also helped to confirm that everyone had a piece of the work and was taking ownership.”

Start with the punch line. “Unlike jokes, make your ending statement first. Here you are looking for bottom line meaning. Without any actual details about the content discussed, write a one sentence statement that conveys the essence of the meeting.”

Look for themes. “If you put all the meeting details onto separate post-it notes and then scanned and sorted them into piles with some commonalities, what headings would you put at the top? These headings reveal your themes…”
“And the **Rule of three applies**. Limiting yourself to three can help to prevent you from getting too granular and it is a good number for your listener to grab onto. Any one of your three themes opens up opportunities for more detailed discussion if requested, but remember, the listener has asked for a summary, not a detailed report. **List the details included in the project example on separate post-it notes and see if you can sort them into three piles. Then, create a heading on each one – these are your three themes.**”

**Raise your lens.** “The project example above is fairly straightforward but when a discussion is quite diverse and can’t seem to fit into themes, start instead with a higher level adjective. Robust, divergent, enlightening, enthusiastic and painful are examples of words that set the big-picture tone for the listener. **Think of a discussion like this that you have been involved with and pick an adjective that could fit it. Follow with...”**

**Compare and contrast.** “With a big body of work, summarize by showcasing breadth. **Add to your adjective a phrase showcasing the extremes of the discussion.** Example: “The heated discussion on this project covered the gamut of ditching the project altogether all the way to some members digging in their heels to keep it on life support, and everything in between, ending with no firm decision.”

“At your next meeting (or workshop, or book you read, or discussion), practice summarizing with a partner and ask for feedback. Come up with the punchline, themes, adjectives and any compare and contrast to describe the breadth of the discussion. See if you can state these in 90 seconds.”

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