

Obamacare Going Forward with Divided USA

From “Presidents Win Is Reprieve For ‘Obamacare’ ” by Jay Hancock, *Kaiser Health News* Staff Writer posted at www.kaiserhealthnews.org on 11/7/12:

“President Barack Obama’s victory cements the Affordable Care Act, expanding coverage to millions but leaving weighty questions about how to pay for it and other care to be delivered to an increasingly unhealthy, aging population.”

“ ‘The reelection of Obama and the Democrats holding the Senate will solidify the law in American history,’ said Len Nichols, a health economist at George Mason University who supports what both sides have come to call ‘Obamacare.’ ‘By 2016 you’ll see the vast majority of states with operational [insurance] exchanges and the Medicaid expansion, and we’ll be on a path-way to a more humane system.’ ”

“Republican presidential candidate Mitt Romney had promised to repeal the act and replace it with something that would loosen government’s involvement in health care. Conservatives portrayed the law’s survival as limiting the freedom of patient and doctor and adding to a federal debt that recently exceeded \$16 trillion.”

“ ‘The law will have significant problems in implementation because so many of the American people

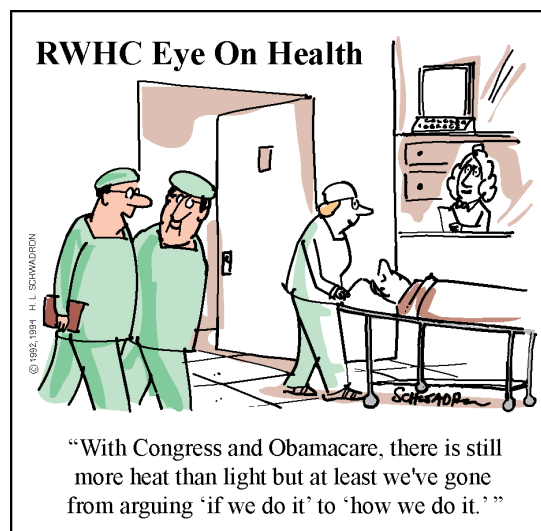
object to so many of its provisions,’ said Grace-Marie Turner, president of the pro-markets Galen Institute, noting that voters in Alabama, Montana and Wyoming voted Tuesday to reject the law’s requirement for individual coverage. ‘You’re going to see almost civil disobedience. People are saying, ‘I’m just not going to comply.’ ”

“The Republican-controlled House of Representatives could also prove an obstacle, using its purse-string power to press for delays or watering down the act as part of a deficit-reduction bargain.”

“Obama won despite criticism that he chose the middle of a financial catastrophe to seek the biggest change to health care in nearly half a century. Although aspects of the Affordable Care Act receive high marks, polls show the mandates for individuals and employers to buy coverage are still unpopular.”

“The president’s first term was about getting a bitterly divided Congress to approve the legislation and then defending it against unexpectedly vigorous legal challenges. His second term will be about bringing the law to life. He referred to the act in his acceptance speech early Wednesday, talking about an Ohio family with an 8-year-old daughter ‘whose long battle with leukemia nearly cost the family everything, had it not been for health care reform passing just a few months before the insurance company was about to stop paying for her care.’ ”

“Analysts forecast coverage for as many as 30 million previously uninsured Americans even as economic



pressures lead to fewer choices and higher cost-sharing for those already covered by private insurers and Medicare.”

“ ‘It’s full-steam ahead with implementation,’ said Dan Mendelson, a consultant who ran the health portfolio in the Office of Management and Budget under President Bill Clinton. ‘They will be aggressively working to make all the timelines that are articulated in the law. I don’t think it will benefit Obama at all in defining a legacy to let those timelines slip. He will push that hard.’ ”

“The administration’s immediate job is launching online insurance marketplaces, known as exchanges, and managing the law’s expansion of the state and federal Medicaid program for low-income patients even as a budgetary showdown looms.”

“Only 13 states and the District of Columbia have said they’ll open exchanges offering subsidized coverage from private insurers. Republican governors in Texas, Louisiana and many other states halted exchange preparations before the election. Many also balked at the Medicaid expansion after the Supreme Court gave states the ability to opt out of that aspect of the health overhaul.”

“Romney’s defeat, the promise of billions in federal subsidies and the prospect of federal regulators run-

ning exchanges in the absence of state leadership should push most governors into line, analysts said.”

“ ‘The states are not going to give up the money,’ said Gerard Anderson, professor of health policy at The Johns Hopkins University Bloomberg School of Public Health. ‘There are just too many dollars. The hospitals and insurers, but mostly the hospitals, are going to say, ‘Excuse me, we need the money.’ ”

“But that’s not to say everything will go according to schedule. Deficit-reduction talks triggered by the Jan. 1st ‘fiscal cliff’ of tax-cut expirations and spending reductions could change significant parts of the health act. For example, Democrats might scale back the act’s coverage and subsidies in return for revenue increases or other concessions from Republicans, analysts said.”

“ ‘If many state-run exchanges might not be ready by 2014, it’s also far from certain that the Department of Health and Human Services, which has delayed publishing exchange-related regulations, will be prepared to impose substitutes.’ ”

“ ‘What is the state of readiness to implement both state insurance exchanges and the federal backup?’ said Paul Ginsburg, president of the Center for Studying Health System Change. ‘The administration has been extremely silent about this.’ ”

“Looming over everything are still-growing, economy-wide health expenses and the limited means of government and businesses to pay them. Deficit-reduction deals with a Republican House could modify not only the health act but Medicare, which Republicans would like to convert to a ‘premium support’ program in which seniors would get coverage fixed amount of money to purchase private coverage or traditional Medicare, analysts said.”

“Expect more cost-control efforts such as higher deductibles in private insurance, managed-care Medicare plans for seniors and more restricted medical networks for patients, they said, as well as new pressure on reimbursements for doctors, hospitals and other providers.”

Eye On Health is the monthly newsletter of the Rural Wisconsin Health Cooperative. Begun in 1979, RWHC has as its **Mission** that rural Wisconsin communities will be the healthiest in America. Our **Vision** is that... RWHC is a strong and innovative cooperative of diversified rural hospitals... it is the “rural advocate of choice” for its Members... it develops and manages a variety of products and services... it assists Members to offer high quality, cost-effective healthcare... assists Members to partner with others to make their communities healthier... generates additional revenue by services to non-Members... actively uses strategic alliances in pursuit of its Vision.

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“Now that Obama has nailed down his signature accomplishment, the need to pay for it could generate more industry cuts than many expected from a second Obama term, analysts said.”

“ ‘Many policy changes that are not normally politically feasible become feasible in the context of significant deficit reduction—as we saw in 1982 and 1997,’ Ginsburg said. ‘So if the time for deficit reduction is here, health care has to be an important part of that, because that’s where so much of the spending and so much of the growth in the spending in the future is.’ ”

Walking the Talk of the Wisconsin Idea

The following is from a talk given by RWHC Executive Director Tim Size to the Department of Family Medicine at the University of Wisconsin’s Annual Renner/Hansen Awards Ceremony on 11/14:

“Neil Heinen, the editorial director for *Madison Magazine*, wrote about ‘Wisconsin’s Great Idea’ in their January 2012 issue. He reminds us that the philosophy that connects the University of Wisconsin with the greater state is now a century old, or at least of the publication of the two major books that ‘explored the idea.’ He asks what does the Wisconsin Idea mean today? And how about in the next hundred years?”

“Heinen observes that the original Wisconsin Idea has appropriately grown in scope. He noted that those boundaries may now be global. UW-Madison Chancellor David Ward is quoted as saying, ‘no doubt, but we can’t forget our roots.’ ”

“Chancellor Ward goes on to say: ‘I think, in the short run, if we have a sense of the welfare of the Midwestern region and more particularly of Wisconsin,

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we have to try to find some balance.’ He states: ‘I think the Wisconsin Idea does remind you not to forget the local and the regional. However global you may be, you

come back to that original idea... There’s got to be something local and regional in this, otherwise it’s not the Wisconsin Idea.’ ”

“I couldn’t agree more—the boundaries of the University being the boundaries of the World is OK, as long as we include rural Wisconsin in that world.”

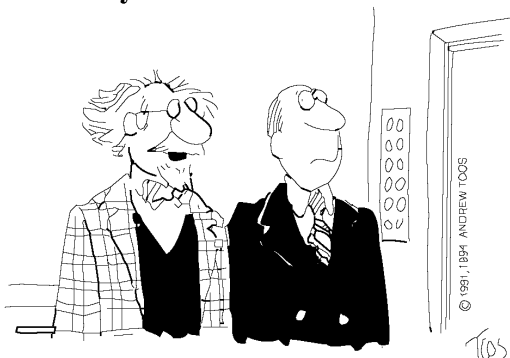
“So what do I believe this means for the University of Wisconsin’s Department of Family Medicine? Many of us believe that Wisconsin is about to face a critical shortage of physicians, particularly in primary care. As you all know, the cause is a two part reality: (1) that nationwide we are finally about to insure another 30 million Americans as well as further expanding those eligible for Medicaid and (2) that a huge cohort of baby boomers are starting to retire from being caregivers into being patients. We are not well prepared for either sea change.”

“The longstanding maldistribution of physicians in underserved areas of our state, both rural and inner city, is likely to go from bad to worse if we don’t continue to change how and where we educate medical students and train residents.”

“There are cynics who say that young doctors just aren’t interested in rural family medicine. But the growth in demand for too few Rural Training Tracks tells a different story. Around the country the trend in demand is beginning to outstrip the supply. Typical is Wisconsin’s only Rural Training Track in Baraboo. This year they are interviewing 26 well qualified applicants (with 13 more on a waiting list) for just two open positions. This is twice the level of interest compared to last year.”

“The success of the Wisconsin Academy of Rural Medicine and

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“The boundaries of the University being the world is OK as long as we include rural Wisconsin in that world.”

the planned expansion of the Medical College of Wisconsin are major and most welcomed events.”

“But expanding medical school graduates will make little difference to rural Wisconsin if we do not also expand the opportunities for these and other medical school graduates to experience and learn about rural medicine in Wisconsin through new or expanded rural residencies, rotations and fellowships. The research is clear that where and how people receive their graduate medical education is highly predictive of where they will practice.”

“This reality has led to the partnership between the Wisconsin Rural Physician Residency Assistance Program (within the UW Medical School) and the Wisconsin Collaborative for Rural Graduate Medical Education based at RWHC. We need your help to make a difference.”

“I will close with thoughts from the Collaborative about what we hope for from the Department of Family Medicine and other academic partners:

- **Include Rural as a Priority**—Acknowledge the need to address the health of the whole state by preparing physicians to serve in both rural and urban communities.
- **Lead By Example**—Work with us to create alternative models for funding graduate medical education in Wisconsin.
- Encourage the major health care systems to collaborate in graduate medical education even while they compete with each other.
- Ingrain a team approach to care delivery as you help to prepare the medical delivery system for the future.
- **Enhance Collaboration**—Identify champions within the Department for increasing the commitment to expanding rural graduate medical education.
- Foster collaboration between residency programs and rural health providers; encourage exchanges between residency programs and new rotation sites to mutually better understand what each offers.

- Pursue stronger relationships between the Department of Family Medicine, the Medical College of Wisconsin and the WI Academy of Rural Medicine (WARM) to take advantage of the rurally-focused WARM program as a path for increasing the number of physicians committed to rural health.”

Residencies Lead to Rural RN Job Satisfaction

From “Are rural and urban newly licensed nurses different? A longitudinal study of a nurse residency program” by Marilyn Meyer Bratt, PhD, RN, Marianne Baernholdt, PhD, MPH, RN and Jessica Pruszynski, PhD in the *Journal of Nursing Management*, 11/12:

“Recruitment and retention of newly licensed nurses are critical to sustaining the nursing workforce. New nurses are particularly needed to offset the nursing shortage that is anticipated because of the need to replace the aging nurse workforce and the escalation of health needs of our ageing population.”

“For the newly licensed nurse, poor work environments, incivility and high stress levels impede nurses’ role transition and assumption of professional identity. As these factors contribute to nurse turnover they further exacerbate the looming shortage. In rural settings the supply and demand of nurses is more significantly imbalanced because of the increasing proportion of rural elderly needing care and a growing trend of younger rural residents migrating to urban areas.”

“This study is part of a series of investigations involving newly licensed nurses in the federally funded Wisconsin Nurse Residency Program. The underlying goals of the residency program are to foster professional role transition and skill development and to promote factors that contribute to retention, such as job satisfaction.”

“The specific program outcomes are to increase nurse residents’ decision-making ability, job satisfaction, nursing role performance, organizational commitment and to decrease job stress. Characteristics and perceptions regarding the orientation experience, work environment, and skill development of residency program

participants who were newly licensed nurses employed in rural hospitals (rural nurse residents) and those employed in urban hospitals (urban nurse residents) were compared.”

“*Aim*—This study aimed to compare rural and urban nurse residency program participants’ personal and job characteristics and perceptions of decision-making, job satisfaction, job stress, nursing performance and organizational commitment over time.”

“*Background*—Nurse residency programs are an evolving strategy to foster transition to practice for new nurses. However, there are limited data available for program outcomes particularly for rural nurses.”

“*Method*—A longitudinal design sampled 382 urban and 86 rural newly licensed hospital nurses during a 12-month nurse residency program. Data were collected at the start of the program, at 6 months and at the end of the program.”

“*Results*—**At the end of the program, rural nurses had significantly higher job satisfaction and lower job stress compared with urban nurses. Across all time periods rural nurses had significantly lower levels of stress caused by the physical work environment and at the end of the program had less stress related to staffing compared with urban nurses.** Perceptions of their organizational commitment and competency to make decisions and perform role elements were similar.”

“*Conclusions*—Differences in these outcomes may be the result from unique characteristics of rural vs. urban nursing practice that need further exploration.”

“*Implications for nursing management*—Providing a nurse residency program in rural and urban hospitals can be a useful recruitment and retention strategy.”

Regarding Marilyn Bratt’s ongoing work, she can be reached at marilyn.bratt@marquette.edu; contact Cella Janisch-Hartline at chartline@rwhc.com for information about the RWHC Program that was launched in partnership with Marilyn Bratt and HRSA funding.

Wisconsin’s ABCD Going National

From “Milwaukee Breast Cancer Support Group to Expand Nationwide” at WISN.com on 10/31:

“A Milwaukee organization that offers one-to-one mentoring for breast cancer patients is branching out nationwide. ‘Once it’s completed, ABCD (After Breast Cancer Diagnosis) will be the largest one-to-one breast cancer support group in the country,’ Melodie Wilson’s husband Wayne Oldenburg said. Longtime Milwaukee broadcaster Wilson founded ABCD in 1999 after her own breast cancer diagnosis.”

“ ‘She started getting calls from women who after their diagnosis simply didn’t know what to do,’ Oldenburg said. Wilson wanted to bring together people who were newly diagnosed with those who had gone through it, so free, one-to-one mentoring for breast cancer support was born. But even as ABCD thrived in Wisconsin, Wilson believed more needed to be done.”

“ ‘Melodie’s dream was to serve more people because unfortunately, there are so many people that need that kind of help,’ Oldenburg said. On Wednesday, that dream was realized, as ABCD acquired the assets of the now bankrupt national breast cancer support group, Y-Me. This means ABCD will be able to reach more patients, more often.”

“The difference is we’ll be able to do it 24/7, with an inquiry volume that is tens of thousands larger than we already do,’ ABCD Executive Director Ginny Finn said. Implementing the expansion will come in stages. In the meantime, anyone who needs such a mentor can reach ABCD by calling 800-977-4121.” Or go to www.abcdbreastcancersupport.org

“Vaccine-Skeptic” More Than “Anti-Vaccine”?

By Kristen Audet, Wisconsin Population Health Fellow and Coordinator for the *Southern Wisconsin Immunization Consortium*.

Last month I traveled to the American Public Health Association's Annual Meeting. The convention was held in San Francisco, California, a city that lives and breathes public health; you walk down the street and see the mandated composting bins at every establishment and signs proclaiming that vendors are no longer able to bag your purchases in plastic, but would you like to use a re-usable bag?

I attended a packed, standing-room-only panel presentation, 'Vaccination Controversies in Historical Perspective.' Dr. Robert Johnston, Heidi Lawrence, and Dr. Elena Conis presented three thought-provoking papers discussing the way vaccination programs and 'vaccination-skeptics' have been viewed throughout history. Lawrence drew the distinction between the various exigencies of vaccination campaigns in American history, for example, polio was a potent and palpable risk to the American public and it was thus easy for public health professionals to demonstrate the need for the vaccination.

In contrast, the 1976 National Influenza Immunization program had a harder go of it because the disease was not as visible, indeed they did not have the visuals of polio-stricken children to use in their campaign. Lawrence described polio and the 1976 flu as different "rhetorical situations."

This idea of differing rhetorics came on the heels of Dr. Johnston's paper urging current practitioners to be more respectful of "anti-vaccinationists," arguing that indeed some scientists that were high respected in their time were in fact anti-vaccine and it may be beneficial to the current "pro-vaccine movement" to engage further with their assumed counterparts.

Finally, Dr. Conis explored comparisons between the anti-vaccine movement and earlier environmental and feminist

movements. In sum, all three speakers encouraged what seemed to be a room full of "pro-vaccinationists," to consider a broader perspective when fighting for their cause.

Support NRHA's New Rural Health Foundation

The National Rural Health Association has launched a foundation that will build a permanent endowment to support programs that identify emerging leaders from and for rural communities and will provide them with training and resources to play a lead role in ensuring access to quality health care for rural Americans. Go to <http://ow.ly/ejmlf> to watch a short video from some of the Foundation's founders or to make a donation to NRHA's foundation today.

At the end of the presentations and Dr. James Colgrave's summing up perspective as discussant, a county health officer stood up and offered that while all this information was excellent in context of cultural competency

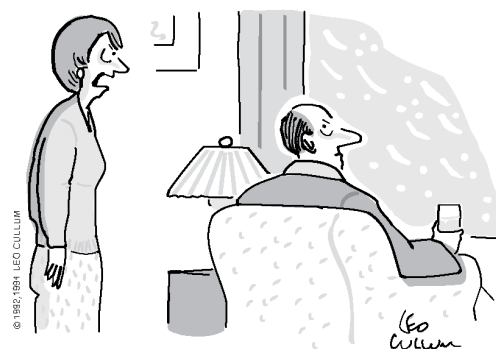
and other ideations of theoretical complications surrounding the controversy, he was struggling to translate this into the actual, every day practice of raising immunization rates. I too, struggled with this question.

One panelist later suggested we shift to calling the movement "vaccine-skeptics" instead of "anti-vaccine," as many members of the movement are merely questioning the safety of vaccines, and not the overall efficacy of inoculation. The suggestion to reconsider what we call "the other side" gave me pause and I wondered how we might use these considerations in our practice in rural Wisconsin.

The Southern Wisconsin Immunization Consortium has always been open to anyone concerned about vaccinations in the region. Our mission and goals relate directly to raising immunization rates across the population, but we have always held an open door policy. If anyone wanted to join our meetings who was "skeptical" of vaccines, he/she would not be turned away. Yet—no skeptics have emerged.

However, I have begun to think that we may need some. Listening to these panelists present made me consider how to best "fight" the "other side," and the difference between silencing and "dialoging," (a word which in this instance I will not shy away from saying for me is closer to "discrediting"). I would welcome some further pushback. I think

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"It would save us a lot of time if you'd just admit you're a self-serving idiot."

that our initiative can only be strengthened from learning from the vaccine skeptics. Instead of completely shutting each other out, I encourage us to learn from each other.

RWHC is committed to work with all others in rural Wisconsin to improve the rate of childhood immunizations through the Southern Wisconsin Immunization Consortium (SWIC); more info is available at: www.rwhc.com/SWIC.aspx or email Kristen Audet at SWICOffice@rwhc.com.

Leadership Insights: “Right... or Effective?”

“The following is from the November issue of RWHC’s *Leadership Insights* newsletter by Jo Anne Preston. Back issues are available at:

www.RWHC.com/News/RWHCLeadershipNewsletter.aspx

“Ever hear of Dr. Ignaz Semmelweis (1818-65)? I recently learned that he was the man known – long after his death—as the father of infection control. He discovered the connection between hand-washing and preventing infections, but was highly unsuccessful at getting people on board with him to change. **Sometimes being smart or right is easier than being effective.**”

“Dr. Semmelweis’s approach with people got in the way of him being recognized for his discovery during his lifetime, well before others more influential came to the same discovery. An article in the *British Medical Journal* tells the story of his mistakes and why he was ineffective at getting people to buy into a new and better way of doing things.”

“It was **NOT** helpful when Dr. Semmelweis:

- Didn’t share important data
- Finally published, but wrote so poorly that no one read or understood it
- Tried to humiliate people into changing
- Acted arrogant and righteous (because he was right)

- Insulted people who disagreed with him
- Accused senior leaders of harmful intent when they clung to their beliefs
- Divided people by creating an ‘us against them’ environment
- Abandoned supporters when he didn’t get his way”

“While we can’t underestimate the culture’s desire for the status quo (after all, we don’t have 100% compliance with hand-washing even today!), there are things that we can learn from his experience when we are the ones trying to influence change. ***What could he have done differently, and how can we apply it to changes we are working on today?***

- In reality, **data talks, %^}*## walks**. If you really are right, there will be data to show it. How can you document what you are attempting to do?
- **And make your data understandable**. Complicated charts and graphs that don’t connect the dots for people don’t get looked at. What makes the change interesting *from the audience’s perspective*? Tell *that* story.
- Shaming people into change is a failure strategy. **Start with mutual respect**. Just like in conflict resolution, when you have two opposing views, consider where you *agree*. What do you and the one who resists the change both want? How can you make it safe to have a dialogue?
- Arrogance may work if you don’t need people, but its opposite—**genuine humility**—makes you **approachable** when you can’t do it alone. When we know we are right, it can be so satisfying that we don’t always see that we are coming across as arrogant. Find a peer you trust to tell you the truth and ask, *‘How do I come across when I talk about my idea? Do I leave room for others to share credit? Do I make sure not to step on toes? Am I understandable? How am I managing my defensiveness when others disagree?’*
- Rather than insult those who disagree, **invite and welcome their questions**. Don’t perceive questions

as personal attacks. This is your opportunity to engage skeptics and reach for understanding. Manage your defensiveness by reminding yourself that questions, by forcing you to be clearer, can help you improve an idea and ultimately gain support.



portive colleagues could have wielded in infection control if they had focused their efforts on reaching out and positively influencing the masses, communicating effectively, shaking hands (washed, of course) with those whose support they sought. Who do you need to reach out to? It may be the person or group you least desire to reach out to, but whose support could help you the most.

- Most senior leaders don't lay awake at night and strategize how they can block your good ideas. Work at **assuming good intent**. If they can't see it, demonstrate how your idea will *help them* be successful at what is important to them. Are you frustrated because you didn't get the answer you wanted from them? Consider, even ask, what might they need from you to be convinced to give you a try? What details, big picture plans, system issues, people or other resources, barriers, etc. might be on their radar that you overlooked? Then address those.
- "Us against them" is a battle; instead **change begs for win-win**. Management literature claims that you need about 75% of the people *with* you to be successful at implementing change. Think of the power that Dr. Semmelweis's small group of sup-

- It is tempting to give up in the face of resistance, but your supporters need you to **take the long view**. Much of health care innovation takes YEARS to go from research to practice. It rarely goes as quickly as the initiators would like (and often due to these same mistakes that Dr. Semmelweis made)."

Contact Jo Anne Preston for individual or group coaching at jpreston@rwhc.com or 608-644-3261. For Info re the RWHC Leadership Series 2011-2012 go to www.rwhc.com and click on "Services" or contact RWHC Education Coordinator Carrie Ballweg at cballweg@rwhc.com or 608-643-2343."

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