Socio-Economic Mix: an Inconvenient Truth

From “Readmissions Penalties Still Don’t Account for Patient Demographics” by John Commins, a senior editor for HealthLeaders Media on 4/6/16:

“Hospitals serving a large volume of low income patients are 2.67 times more likely to be penalized for higher readmissions, America’s Essential Hospitals’ data shows.”

“I have long believed that the Centers for Medicare & Medicaid Services must weigh the socio-economics of a hospital’s patient mix before slapping them with penalties for high readmission rates.”

“Several studies in the past few years have added empirical data to the common sense notion that hospitals serving a poorer, sicker, older patient mix aren’t necessarily providing inferior care, but are nonetheless penalized unfairly because they’re caring for society’s most vulnerable people.”

“That’s exactly what’s been happening for the past several years since the implementation of the Patient Protection and Affordable Care Act’s Hospital Readmissions Reduction Program (HRRP). The most recent round of readmissions penalties announced last fall imposed $420 million in penalties.”

“A brief from America’s Essential Hospitals examined the HRRP and found that hospitals serving a large volume of low income patients are 2.67 times more likely to be penalized for higher readmissions. Further, hospitals that receive higher penalties as a percentage of their Medicare payments also showed the most improvement on readmissions between 2013 and 2016.”

“A study in the Journal for Healthcare Quality used a new measure to examine more than 15 million discharge abstracts from 611 hospitals that accounted for socio-demographics in a hospital’s inpatient population mix and allowed for evaluation of readmissions rates relative to national benchmarks.”

“Not surprisingly, the study found that while clinical conditions were the strongest predictors for readmissions, ‘factors such as age and accompanying comorbid conditions were also important. Socio-economic factors, such as race, income, and payer status, also showed strong statistical significance in predicting readmissions.’”

“For example, the study found that overall African-Americans were 10% more likely to be readmitted than whites. For all patients, regardless of race, the odds for readmissions were 24% higher for Medicare heart attack patients when compared with heart attack patients using commercial insurance.”

“The primary task of a useful teacher is to teach his students to recognize ‘inconvenient’ facts—I mean facts that are inconvenient for their party opinions.” - Max Weber
“That should be obvious, because Medicare patients are older, and likely have more health complications. Nonetheless, hospitals serving higher proportions of African-Americans and/or a Medicare patient mix get hit with more readmissions penalties for the very thing they cannot control—their patient mix.”

“Study co-author John Martin, vice president of research operations at Premier, Inc., says the study shows that risk-adjusted readmissions rates can be tracked in a dynamic database, and that payment models that use these comparisons could result in more equitable payments and improve transparency on socio-demographic disparities.”

“We feel like at least including the socio-economic factors, you are going to improve the ability to predict outcomes, whereas if you leave them out you are losing some of that predictive capability,” Martin says. None of the readmission models that have come out to-date have a really hard predictive capability of some of the other quality measures, such as mortality.”

Unintended Consequences of a Legitimate Concern—“CMS has opposed using socio-economic and demographic measures for hospitals serving lower-income patients. They don’t want to create an expectation that somehow lower-income patients should expect a lower level of care. That’s a legitimate concern, but the unintended consequences of the HRPP have hurt most the hospitals that are serving these vulnerable populations.”

“We’re not advocating an inferior or superior standard,” Martin says. ‘We are saying there are measures for quality and there are measures for payment. The problem comes in with the payment related to that. Yes, we don’t want to marginalize any segment of the population in the quality measurement, but if you are simply going to use the measure for paying the hospital you don’t want to penalize a hospital that is treating patients who are going to be much sicker than others. We want to make sure that if we are going to use the payment penalty, that it is not going to take away from the hospitals that need the money more than other hospitals.”

Rural Population Rebound May Be Underway

From “5 Years of Population Loss in Rural and Small-Town America May Be Ending” by John Cromartie, USDA, Economic Research Service, May 2016:

“The population in U.S. nonmetropolitan (nonmetro) counties stood at 46.2 million in July 2015–14 percent of U.S. residents spread across 72 percent of the Nation’s land area. Nonmetro population declined by just 4,000 from July 2014 to July 2015 after 4 years of population losses averaging 33,000 yearly, according to the latest county population estimates from the U.S. Census Bureau.”

“The 2014-15 improvement in nonmetro population change coincides with rural economic recovery and suggests that this first-ever period of overall population decline (from 2010 to 2015) may be ending.”

“County population change includes two components: natural change (births minus deaths) and net migration (in-migrants minus out-migrants). Nonmetro population growth from net migration peaked in 2006, then declined precipitously in response to rising unemployment, housing-market challenges, and other factors. Suburban expansion and migration to scenic, retirement/recreation destinations were primary drivers of nonmetro migration for several decades, but for the time being at least, their influence has considerably weakened.”

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“Widespread job losses in rural manufacturing caused by the recent economic recession, increased global competition, and technological changes contributed to the downturn in net migration, especially in eastern parts of the United States. However, this downturn appears to have bottomed out in 2012, and improving population trends since then coincide with a marked improvement in nonmetro employment growth.”

“Historically, nonmetro population grew because high rates of natural increase always offset any net migration loss. For example, net out-migration was more severe during the 1980s than in 2010-15, but overall population change remained positive because natural increase contributed roughly 0.5 percent growth annually, compared with 0.1 percent today.”

“The Great Recession contributed to a downturn in natural increase, as fewer births occur during times of economic uncertainty. Lowering rates of natural change from 2008 to 2013 resulted in over 250 nonmetro counties experiencing natural decrease for the first time during 2010-15. Population growth from natural change increased slightly since 2013, in line with a post-recession increase in births nationwide. If current trends continue, both net migration and natural increase will contribute to a recovery of population growth in rural and small-town America in the coming years.”

First-ever period of population loss in rural and small-town America may be ending

![Graph of population change from 1976 to 2015](image)


Rural Health Disparities

From the Rural Health Information Hub at the University of North Dakota supported by the Federal Office of Rural Health and the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS), downloaded on 6/16/16 from [www.ruralhealthinfo.org](http://www.ruralhealthinfo.org):

“Rural Americans are a population group that experiences significant health disparities. Health disparities are differences in health status when compared to the general population, often characterized by indicators such as higher incidence of disease and disability, increased mortality rates, lower life expectancies, and higher rates of pain and suffering.”

“Rural risk factors for health disparities include geographic isolation, lower socio-economic status, higher rates of health risk behaviors, and limited job opportunities. Higher rates of chronic illness and poor overall health are found in rural communities when compared to urban populations.”

“Several studies have shown that rural residents are older, poorer, and have fewer physicians to care for them. This inequality is intensified as rural residents are less likely to have employer-provided healthcare coverage, and if they are poor, often are not covered by Medicaid.”

“Federal and state agencies and membership organizations are working to diminish these disparities and keep rural America healthy and strong. Some provide funding, information, and technical assistance to be used at the state, regional, and local level, while others inform state and federal legislators to help them understand the issues affecting healthcare in rural America.”

More info at: [http://ow.ly/m8m1301jWpx](http://ow.ly/m8m1301jWpx)

Wisconsin Rural Health Conference
June 29-July 1 at Osthoff Resort, Elkhart Lake
Registration: [http://ow.ly/10EOXf](http://ow.ly/10EOXf)
Wisconsin Idea’s Rural Impact on a Staircase

“One of the longest and deepest traditions surrounding the University of Wisconsin, the Wisconsin Idea signifies a general principle: that education should influence people’s lives beyond the boundaries of the classroom. Synonymous with Wisconsin for more than a century, this ‘Idea’ has become the guiding philosophy of university outreach efforts in Wisconsin.”

“The genesis of the Wisconsin Idea is often attributed to former UW President Charles Van Hise, who in a 1904 speech declared, ‘I shall never be content until the beneficent influence of the University reaches every home in the state.’ ”

“As president from 1903 to 1918, Van Hise saw that vision carried out by creating the university’s extension division (known today as the University of Wisconsin-Extension), which oversaw summer courses and other programs that brought university knowledge directly to state citizens.”

“These activities would not formally be described as the ‘Wisconsin Idea’ until 1912, when Charles McCarthy described the philosophy in a book by that name. By that time, Wisconsin had developed a national reputation for legislative innovation. Over time, however, the Wisconsin Idea has come to signify more broadly the university’s commitment to public service.”

“John Steuart Curry’s three-panel painting, ‘The Social Benefits of Biochemical Research’ (center panel below) demonstrates the health benefits of innovations in biochemistry at the University of Wisconsin. Each panel is rich with figures from American farm life.”

“Curry uses strong directional light to distinguish the healthy from the sick. Toward the left of the central panel, a family suffering from pellagra and nutritional deficiencies cowers in the shadows. By the edge of the darkness a doctor approaches a young child with rickets and begins to bring him back into the light. Located in the University of Wisconsin-Madison’s historic Hector F. DeLuca Biochemistry Building, Curry’s painting reminds viewers of the university’s important contributions to everyday life.”

“Curry painted this work during his ten-year residency (1936-1946) at UW-Madison. The first such university-based residency of its kind, this program attempted to inspire artistic production amongst the state’s rural communities. The rural art program dovetailed with the ‘Wisconsin Idea,’ the principle that the university should foster social, intellectual, and economic development across the state through teaching, research, outreach, and public service. Curry subsequently became an important connection between campus and community.”
John Steuart Curry is one of the three most important American Regionalist painters of the 1930s along with Grant Wood and Thomas Hart Benton. Raised on a farm near Dunnottar, Kansas, Curry gained recognition with paintings that depicted the people and landscape of the Middle West.

"The Social Benefits of Biochemical Research is located in the Hector F. DeLuca Biochemistry Building at the University of Wisconsin-Madison. Enter through the west doorway near Babcock Drive. Proceed up a flight of stairs. The mural is on the staircase landing, one story above ground level." Text/photo from www.wisc.edu/wisconsin-idea/ and www.publicart.wisc.edu/

Health Depends on Patients Becoming People

From “The Person Engagement and Provider Partnership Imperative” by Gary Christopherson, Founder, HealthePeople in a Letter published by Health Affairs online on 5/11/16:

“**It is long overdue for us to move away from the term ‘patient.’** For some time, I have argued that ‘person-centered health,’ in its entirety, is the right approach. ‘Person-centered’ is really different than almost any care provided today by any health provider or health system. But if ‘health’ is really what we want to achieve, then ‘person-centered health’ is how we need to operate.”

“Person-centered health is different in attitude, culture, design, and operation. It is different in using the term ‘person’ rather than terms like ‘patient,’ ‘consumer,’ or ‘enrollee.’ It is different in that it views the person and her/his ‘self care’ as necessary to the successful achievement of health. It is different in using the term ‘health’ rather than the term “medicine.” It is different in its focus on health rather than illness and disability. It is different in its focus on health status rather than illness or disease burden. It is different in focusing on health outcomes rather than treatment outcomes. It is different in using the term ‘electronic health record’ versus ‘electronic medical record.’ ”

“A ‘health’ system integrates care inside and outside of medical/health care facilities, while a medical care system focuses more on the care provided within medical/health care facilities. It is not just about ‘care’ but is about all of the factors in a person being healthy or not. The focus is on what is trying to be accomplished rather than on what is being done or what is being corrected or prevented. All of these other terms have value but should not be the primary drivers or define the end goal or how we get to that end goal. **Personal engagement is the imperative. Health is the end goal.”**

An Advocacy Lesson from the Grand Canyon

The following is from a speech by Edward Abbey, author of the classic “Desert Solitaire,” to environmentalists in Missoula, Montana, and in Colorado, which was published in High Country News, (24 September 1976), under the title “Joy, Shipmates, Joy.”

“One final paragraph of advice: do not burn yourselves out. Be as I am—a reluctant enthusiast... a part-time crusader, a half-hearted fanatic. Save the other half of yourselves and your lives for pleasure and adventure. It is not enough to fight for the land; it is even more important to enjoy it. While you can. While it’s still here.”

“So get out there and hunt and fish and mess around with your friends, ramble out yonder and explore the
forests, climb the mountains, bag the peaks, run the rivers, breathe deep of that yet sweet and lucid air, sit quietly for a while and contemplate the precious stillness, the lovely, mysterious, and awesome space.”

“Enjoy yourselves, keep your brain in your head and your head firmly attached to the body, the body active and alive, and I promise you this much; I promise you this one sweet victory over our enemies, over those desk-bound men and women with their hearts in a safe deposit box, and their eyes hypnotized by desk calculators. I promise you this: You will outlive the bastards.”

All Games Not Zero Sum

From “What Forestry Can Teach You About Success in Business” from http://www.ipsocreative.com/ on 6/14/16 (forwarded by Kara Traxler as it describes in a nutshell the goal of RWKC’s work supporting the Wisconsin Collaborative for Rural Graduate Medical Education):

“‘A Candle Loses Nothing From Lighting Another Candle.’ - James Keller”

“That quote reminds me of my eccentric Dominican entrepreneur friend named Samuel and a story he has from when he was learning English.”

“He and I were doing economic development work in the Dominican Republic when he once told me this beautiful story about when he first heard the word ‘grove’. (As in, ‘The secret to success can be found in that grove of trees.’)”

Apparently, there isn’t a direct and specific translation in Spanish. It took some explaining for him to con cep tualize what the word meant. And in this explaining lies the best bit.”

“You see, a grove is more of a technical or content-specific word in English; so in order for him to understand it, someone really had to explain its meaning. As he has come to understand it and re-illustrated to me, a grove is far more than ‘a planting of trees.’ “

“In a grove, with time, a tree’s roots get so intertwined and interconnected with others that it becomes indistinguishable where one set of roots starts and another ends. Overtime, this root network creates a shared foundation and gestalt which is so strong that it’s nearly impossible for one tree to fall. The solid foundational strength of the group raises the bar and foundational strength of each individual tree.”

“We found this to be a powerful metaphor for business (and community). It fits with the essence of our philosophy and our general approach to our work.”

“At some level we all desire to cultivate this strong grove in our work and lives—seeking the prosperity of the larger community, one business at a time, and in turn creating a shared value and raising the standard for the entire industry. To operate in a world where when one of us wins, we all win. A space where the game is not zero sum.”

“Benjamin Zander, the conductor of the Boston Philharmonic Orchestra, knows what we’re talking about. He’s realized that ‘the conductor of an orchestra doesn’t make a sound. [His power depends] on his ability to make other people powerful.’ (The quote is from EntreLeadership by Dave Ramsey.)”

“What can you do this week to cultivate your network into an unstoppable ‘grove?’ To give gifts and fortify your foundational network to where it’s almost impossible for you to fail?”
Honoring Choices: “Conversation Sabbath”

From the Wisconsin Medical Society:

“This fall, in conjunction with a national celebration called ‘Conversation Sabbath,’ Honoring Choices Wisconsin (HCW) is leading a Wisconsin-based effort to engage faith communities in advance care planning.”

“During Conversation Sabbath, November 11-20, clergy, faith ambassadors, community health educators, and HCW teams will commit to teaching or preaching about advance care planning within faith-based communities. To help its partners prepare for this effort, HCW is developing tools and resources, as well as offering a free webinar on Wednesday, Sept. 21, from noon to 1 p.m. Please save the date for these events. Complete details and registration information will be available in August.”

For more information about Conversation Sabbath, view a video at http://ow.ly/to7a301iuOZ or e-mail Becca Wanta at rebecca.wanta@wismed.org. More information about Honoring Choices Wisconsin is available at: http://ow.ly/8PYY301iuk7.

Leadership Insights: “Bias”

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

“Imagine being sick, lying in a hospital bed. Now picture a nurse coming in to take your vital signs, and beginning to take care of you.”

“When you pictured a nurse, was it male or female? It’s highly likely that your mental image of the nurse was female, a simple example of how unconscious bias operates in our brains. About 90% of U.S. nurses are female, so it is not really surprising given that both experience and culture shape our biases.”

“The example is about gender, but biases—unconscious beliefs based on limited data—are evident everywhere, daily impacting our interactions and decisions. The research clearly validates that our brains register beliefs and feelings about situations and people, even without us knowing—or believing—it is happening. Check out this test for yourself to see it—the Harvard Implicit Association Test at http://ow.ly/jEir301isii.”

Why bother to look at our unconscious biases, if consciously we believe in fairness? “As a leader, bias can show up in small to major differences in how you interview, hire, delegate assignments, pay people, etc. Bias is not always negative; it can even operate in a way that intends to be helpful, but actually robs others of opportunity.”

Pause and choose vs. react. “Rollo May, psychologist and author, said that, ‘Freedom is the capacity to pause between stimulus and response.’ Think about this: you see or hear something, and before your brain reacts, you hit ‘pause.’ During that pause we have the moment it takes to choose more wisely what we say or do. Howard Ross, author of Everyday Bias, suggests developing a mental habit to PAUSE in situations where bias may arise. Using the nursing example again, for someone who has a negative response:

P—Pay attention to what is happening behind your initial judgments (‘A man as a nurse doesn’t seem natural; they wouldn’t be nurturing; messages I have seen about male nurses have come from society saying a man should be tough, not tender.’)

A—Acknowledge your own reactions and feelings about it (‘It feels uncomfortable because it is unfamiliar or doesn’t fit with my image of nursing.’)

U—Understand that there may be other potential reactions to consider (‘Maybe men can bring many strengths to nursing; anyone can want to help others heal.’)

S—Select the response that is most empowering (‘I will see male nurses as those who want to heal others.’)

E—Execute it (‘I treat male nurses with equal respect.’)”
“We won’t pause all the time. It would be impossible to notice EVERYTHING that comes into contact with our senses all day long. But finding daily opportunities to PAUSE helps us to develop critical thinking, which can interrupt bias. Put another way, it’s taking a moment to ‘think about your thinking.’”

1. **Start by assuming that you are biased.**
   “It’s a little like AA, until you can acknowledge that you have bias, it’s hard to correct it. Decide to become aware of what your biases are. If you would like to truly state, ‘I am a fair and equitable leader,’ being open to the biases that are operating under your radar will help you make that statement true.”

2. **Take note.** “How strongly do you feel about it? The stronger your emotional reaction or attachment to your belief, the more likely bias is at play.”

3. **Seek evidence.** “Where can you learn more than you think you already know? Seek out different viewpoints, spend time with people who are different from you, and avoid seeking opinions that will confirm what you already think (which is another form of bias in itself, called ‘confirmation bias’).”

4. **It is OK to be uncertain.** “One function biases serve is to reduce our anxiety by putting the big world into neat categories, black and white. Anytime you are quite sure of something, it is a time to ask yourself critical questions about what biases might be in place to make you think as you do.”

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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