Whose Values Count?

by Tim Size, RWHC Executive Director

*While the writer is solely responsible for the below content, several conversations with Dr. Clint MacKinney, Clinical Associate Professor at the University of Iowa, added valuable insight into this commentary.*

If you work in health care, you are bombarded daily about the need for health reform—to change our focus from “Volume to Value” (V2V). I understand that we need a system different than what we now have, where too often current market incentives mean “more patient visits, more money.”

The “Value” in V2V is rightfully to improve patients’ outcomes and experiences while minimizing associated costs. But whose personal and corporate values define the outcomes and experiences being sought and whose costs are we counting?

Part of the challenge is that the Value in V2V may or may not align with the values of our patients and local communities. What often feels to be missing in practice are values related to patient-centered care, developing healthier communities and growing viable local economies. Whose interests are being served when a patient barely has the chance to say hello to their doctor before the next patient is knocking on the door?

The fact that there is resistance to some of health reform’s current conventional wisdom isn’t because we don’t see the need for reform but because we feel that we are too often being asked to “throw the baby out with the bathwater.”

While I support the intent of the V2V message, in my experience, its most extreme advocates seem to say that “unreformed” providers don’t have any values and only care about billing as many patients for as many procedures as possible. That does not describe the people in Wisconsin I have been privileged to work with for over forty years.

As we transition to V2V, what we include in its calculation and what we exclude will define the future of American healthcare and health. Here are a few questions that I believe those driving the change and the targets of that change need to address:

- Do we appropriately value systems that provide care close to home; do we count the cost of driving out of town or the additional time missed from work?
- Is the accelerating decline in job satisfaction of physicians, nurses and other clinicians just “whining” that we should ignore as inevitable or a
symptom of the misapplication of manufacturing models to what is inherently a relationship-based enterprise and mission?

- Is there a contradiction in saying that a successful bending of the health care cost curve requires on the ground, locally empowered leadership to promote healthy communities, when at the same time we are encouraging the transfer of previously locally made decisions out of our communities?

- How do rural communities organize themselves to maximize support for local healthcare?

- Is the centralization and corporatization of health care the price of developing more systemic and higher value care?

- What are the most effective models for pooling the risk of smaller organizations together to assess their collective effort toward V2V?

- How do we encourage providers to maximize outreach to patients who are 65 and eligible for a “Welcome to Medicare” visit followed by an annual wellness visit?

- How do we encourage health insurers to offer locally available quality and cost-effective care?

- To accelerate the rate of change in quality improvement, will payers in a region begin to collaborate to use the same set of measures in their individual quality improvement programs?

The question of whose values we promote in V2V is too important of a question to be left to anyone but our communities. It is the responsibilities of providers and payers that we engage them in this critical conversation.

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**New Federal Attack on Affordable Care Act**


“Consumers and insurers face new uncertainty with the Justice Department’s assertion this week that key provisions of the Affordable Care Act are invalid.”

“In a brief filed Thursday, the department asked a federal court to unwind the health law’s protections for individuals with existing medical conditions, such as diabetes or asthma. The law, known as Obamacare, prohibits insurers from refusing to sell coverage to people with preexisting conditions or from charging them more than healthy consumers.”

“The brief was filed in a lawsuit brought by attorneys general that may take months to get through the courts, and it isn’t clear what the outcome will be. Changes would create winners as well as losers. Meantime, insurers face new variables as they are deciding where to sell coverage and at what rates in 2019.”

“Health insurers warned of disruption to the market. ‘Removing those provisions will result in renewed uncertainty in the individual market, create a patchwork of requirements in the states, cause rates to go even higher for older Americans and sicker patients, and make it challenging to introduce products and rates for 2019,’” America’s Health Insurance Plans, a trade group, said in a statement. Below are four ways the case could affect health-insurance markets.”

**Options next year:** “In the short term, some health-insurance markets could see fewer options if com-
Companies react to renewed uncertainty by leaving the marketplace, said Sabrina Corlette, a research professor at the Georgetown University Health Policy Institute. ‘Are some insurers going to cry uncle?’ she asked. ‘Maybe there are some companies that say, ‘Enough already.’”

“The marketplace experienced similar tumult about a year ago, as insurers were setting rates for the coming year amid questions about whether the White House would end some ACA subsidies—a step the administration in October announced it was taking. In some cases, state insurance regulators scrambled last year to ensure markets would be viable. Roughly one-quarter of consumers in the individual insurance markets have only one company selling coverage, according to data from the Henry J. Kaiser Family Foundation. Company exits could leave consumers with no options, though last year new entrants emerged to sell coverage.”

Rates next year: “Many insurers are already seeking double-digit increases in premiums for 2019. ACA premiums are expected to rise 15% next year, on average, largely because Republicans in their tax law last year got rid of the health law’s penalty for the uninsured, according to the federal Congressional Budget Office. The ACA’s backers argue that lets healthier people opt out of coverage. Ms. Corlette said insurers could seek further increases as a way to buffer their operations against the latest uncertainty over the health law. ‘Consumers eligible for ACA subsidies will see that financial assistance rise with premiums, but not all shoppers in the marketplace qualify for subsidies,’ Ms. Corlette said.”

Lower premiums for some people: “Should the courts invalidate the requirements on covering people with pre-existing conditions, healthy consumers likely would see cheaper insurance, said Larry Levitt, senior vice president at the Kaiser Family Foundation. Their premiums would no longer be an average market rate that ensures those with pre-existing conditions pay the same premiums, he said, but could reflect the likelihood that healthy consumers would require less-expensive care. Young, healthy buyers have already seen their options increased by other moves taken by the Trump administration to allow plans that offer limited coverage for a lower price.”

Expensive or hard-to-get coverage for some people: “People with pre-existing conditions could find they are no longer able to get coverage, should insurers return to practices followed before the health law of charging more to such consumers or refusing to insure them, Mr. Levitt said. That would vary by state, as some states have their own laws seeking to protect consumers with pre-existing conditions. The Kaiser Family Foundation estimates about 27% of non-elderly adults have pre-existing conditions.”

In Rural Health, Location Matters

From “In Rural Health, Location Matters” by Taylor Sisk in the Daily Yonder, 6/6/18:

“Results of the 2018 County Health Rankings show that rural communities face significant challenges. But in many cases the resources to address them are at hand.”

“When it comes to your health, place matters. If you live in a rural county, the bottom-line truth is that you’re less apt to be healthy than if you lived in a more urban one. A couple of recent reports shed some light on both the issues and potential solutions.”

“According to the 2018 County Health Rankings (https://bit.ly/2G2Jt8a), published by the Robert Wood Johnson Foundation with the University of Wisconsin Population Health Institute, rural counties lag behind more urbanized ones in factors that play a critical role in a community’s overall including child poverty, low birthweight babies and teen birth rate.”
“But rural communities have within their DNA the resources to rise to these challenges.”

“In another report, Exploring Strategies to Improve Health and Equity in Rural Communities, researchers at the University of Chicago’s NORC Walsh Center write that while much of the research exploring rural health issues in the U.S. focuses on disparities—increased health risks ‘related to geographic, socioeconomic, environmental and other factors’—seldom is attention paid to the strengths and assets within these communities that can be, and often are, deployed to improve health.”

“These communities’ greatest assets, the researchers assert, are their people: ‘Commonly reported individual assets include civic and community engagement in the form of volunteerism, strong entrepreneurship, and the resilience and adaptive capacities of rural residents.’”

“The County Health Rankings report is a call to action. It petitions community ‘changemakers’ to explore the data to better understand the nature of the challenges, and to then more fully leverage assets within the community to address them, implementing strategies that will allow every community member to lead the healthiest life possible.”

“To advance this initiative, the County Health Rankings & Roadmaps program sends coaches out to assist individual communities.”

“We’ve been partnering with the National Association of Counties for the past two years on the Rural Impact County Challenge (https://bit.ly/2lcLtlw) working with counties who bring teams together to think about opportunities to take action addressing children in poverty,’ says Aliana Havrilla, one of those coaches. ‘But in my experience, it’s become a much broader conversation about opportunities and assets that exist at the local level.’”

“Slow Recovery—The County Health Rankings underscore the primary role poverty plays in health outcomes and indicate that while child-poverty rates are declining, they remain at levels higher than before the recession.”

“In the wake of the Recession, rates of children in poverty stayed high and, despite improvement in recent years, remain higher than before the recession,” says Anne Roubal, an analyst for the Rankings & Roadmaps work.”

“Rates of recovery, she stresses, vary by place and race (https://bit.ly/2JQluuS). ‘In general, child-poverty rates have not bounced back in many rural counties or those with a greater share of people of color.’”
“Rural counties continue to have the highest child poverty rates (23.2%), followed by large urban metro (21.2%), smaller metro (20.5%) and suburban counties (14.5%). The County Health Rankings authors write that poverty limits opportunities and increases the likelihood of poor health.”

“Children living in poverty are less likely to have access to quality schools and have fewer chances to prepare for living-wage jobs leading to upward economic mobility and good health. ‘Children in poverty is an upstream measure that assesses both current and future health risk,’ they write. ‘Recent data on poverty show that rates among children and youth are at least 1.5 times higher than rates among adults aged 18 and older.’ ”

**Disparity among Neighbors**—“Health outcomes in the County Health Rankings are measured by how long people live and how healthy they feel. Length of life is measured by premature death—deaths that occur before individuals reach their statistical life expectancy. Quality of life is measured by the percentage of days people report poor or fair health, the percentage who report physically and mentally unhealthy days within the past 30 days and the percentage of low birthweight babies.”

“The disparity between rural and urban counties in these measures and others is often stark. Take, for example, the North Carolina counties of Wake and Robeson. Wake County, where Raleigh, the state capital, is located, is part of a thriving metropolitan area with more than 2 million residents. It ranks first in the state in the report’s health outcomes.”

“Robeson County, an hour-and-a-half drive to the southeast, is largely rural. The largest city, Lumberton, has a population of about 21,000. It’s ethnically diverse, roughly 40 percent Native American, 30 percent white and 25 percent black. Robeson ranks last, 100th, in health outcomes in the state.”

“County Health Rankings data indicate that Robeson County residents reported more than twice as many days being in poor or fair health than Wake County residents (29% vs. 13%). Nearly twice as many Robeson County residents reported physically unhealthy days within the past 30 days (5.4% vs. 2.9%) and more reported mentally unhealthy days (5.4% vs. 3.6%). A Robeson County adult is also much more likely to be obese (39% vs. 23%).”

“The data further indicate that there are more than two and a half times as many premature deaths each year in Robeson County than in Wake County.”

“According to a report published by the child advocacy group NC Child (https://tabsoft.co/2MooOPy), life expectancy in Wake County in 2014 was 81.4 years; in Robeson, it was 74.2 years.”

“Now consider poverty. Its correlation with poor health outcomes is underscored in the contrast between these two counties.”

“Robeson County has the highest rate of poverty in the state (https://unc.live/2MnQtjL) among the highest in the country. Nearly a third of all residents live below the federal poverty level (in 2017, $24,600 for a family of four); nearly half of all children live in poverty. Almost twice as many Robeson residents as Wake residents are unemployed (7.9% vs. 4.2%) and twice as many are uninsured (20% vs. 10%).”

“Lumberton, the county seat of Robeson County, is 100 miles and a world of difference from Raleigh.”

**Local Connections**—“‘Things are improving,’ Anne Roubal says of the national outlook—slowly. ‘Starting in 2008, we saw a jump in poverty pretty much everywhere and that trend continued for three years.’ Things then began to improve, but not as quickly as they’d gone into decline. ‘We’re still not back to where we were in 2006 and 2007.’ ”

“The resources needed to recover and to build healthier communities are found in rural America. Health care institutions in many rural regions are taking innovative approaches to meeting their communities’ needs. In Robeson County, the local hospital, Southeastern Health, is tackling its community’s health care (https://bit.ly/2MqhkLZ) by remaining independent and offering a broad range of care under one roof.”

“But it’s often individuals who step forward. According to the NORC Walsh Center report, ‘participation
in community life in rural areas often stems from strong individual relationships and connections that people form with one another.’ Such connections ‘lead people to participate in volunteering, community organizing and coalition building.’ ”

‘One thing I really appreciate about rural communities is that they have a culture of such strong collaboration,’ Aliana Havrilla says. ‘Sometimes, it’s everybody knows everybody because many people wear many hats. There’s also often just that tight-knit community feel... a strong asset-based collaborative approach that they’re bringing to this work addressing complex issues.’ ”

“Recommendations from the 2018 County Health Rankings report for addressing child poverty:

- Invest in education from early childhood through adulthood to boost employment prospects.
- Increase or supplement income and support asset development in low-income households.
- Ensure that everyone has adequate, affordable health care coverage and receives culturally competent services and care.
- Foster social connections within communities and cultivate empowered and civically engaged youth.”

Rural Likes Nurse Practitioners

From “Nurse Practitioners Boost Presence By 43% In Rural America” by Bruce Japsen in Forbes, 6/5/18:

“Nurse practitioners have dramatically increased their presence as the go-to primary care providers in rural America thanks in part to regulatory changes that allow patients to more easily see these health professionals.”

“Nurse practitioners now account for 1 in 4 medical care providers in U.S. rural practices—a ‘significant’ 43.2% increase from 2008 to 2016, according to new research published in the June issue of the journal Health Affairs.”

“‘We found a growing presence of NPs among rural practices,’ University of Delaware’s Hilary Barnes and her coauthors wrote. ‘From 2008 to 2016, NPs increased from 17.6% of providers in rural areas to 25.2%—a significant increase of 43.2% from 2008.’ ”

“These gains can be attributed in part to changes in state regulations under so-called ‘scope of practice’ laws that increasingly favor direct access by patients to nurse practitioners. There are now 22 U.S. states plus the District of Columbia and Guam that have full practice authority for NPs and many of them eased scope of practice laws in recent years.”

“Nurse practitioners are educated to perform myriad primary care functions, diagnose, prescribe medications and conduct physical exams, but state scope of practice laws historically prevented them from such care unless they have an agreement with an overseeing physician.”

“But Americans are becoming more comfortable with NPs and generally familiar with them in a variety of settings, particularly as their numbers have grown. The number of nurse practitioners has nearly doubled to more than 234,000 from 120,000 in 2007, according to the American Association of Nurse Practitioners (AANP).”

“‘This study confirms what we’ve long asserted,’ said AANP President, Joyce Knestrick. ‘NPs are one of the most significant factors in expanding patient access to primary, acute and specialty care, especially at a time when demand is high and physicians remain concentrated in more urban and affluent areas. This has led to NPs quickly becoming the first choice as primary care providers for thousands of people across rural as well as urban America.’ ”

“NPs have also gotten a boost as the primary care giver in thousands of retail clinics run by CVS Health, Walgreens Boots Alliance and Walmart. NPs have also benefitted from the team-based approach to medical care.”

RWHC Eye On Health, 6/15/18
“Our findings imply that primary care practices are embracing a more diverse provider configuration, which may strengthen health care delivery overall.”

Share Your Innovation in Primary Care

From “Innovations in Primary Care: Garage Tinkerers and Great Deeds” by John J. Frey, III, MD, Associate Editor, Annals of Family Medicine, May/June 2018:

“Throughout history, innovation and creativity have more often come from ‘outsiders’ than from inside institutions. From carriage house tinkerers at the beginning of the aviation age to garage tinkerers at the beginning of the information age, experimentation has been carried out where the consequences of failure have been personal and practical more than professional or corporate.”

“Doing something rather than studying is a hallmark of community practice. The practice environment is full of bright, energetic, and creative people who are testing ideas in places where they can quickly be evaluated, changed, or replaced. The time between noticing a problem and devising ideas to fix it is often short. Many of the most creative ideas can be found in smaller community practices or in smaller branches of large systems. But unless the flow of ideas is omnidirectional, successful local innovations are often never adopted beyond the place they originate.”

“To quickly get ideas about improving clinical care and practice into discussions about practice redesign, the Annals of Family Medicine now publishes ‘Innovations in Primary Care,’ short reports without the traditional research structure. In the first year of publishing, we have found that the great majority of submissions have come from outside academic health centers—from small private practices and community settings across many countries.”

“‘For journals to get those attempts at change into the public realm, they must find different contributors and different ways of communicating their ideas. The Annals will continue to try to be an important contributor to that process.’ We hope that those who witness or create innovations will send us a one page description.” To do so, go to https://bit.ly/1ykEtDV.

A Rural Asset: Happiness

From “People Who Live in Small Towns Are the Happiest, According to Research” by Joanie Faletto at www.curiosity.com, 6/6/18:

“The hustle and bustle of a big city isn’t for everyone. And neither is the slow, humble life in a quaint town or rolling rural space. To each his own, ya know? But in terms of happiness, research tells us that one option is more favorable than the other.”

With Homes Wide Open—“If you’re currently holed up in your compact studio apartment in a bustling Chicago high-rise, first of all, we feel that. Secondly, you may not necessarily agree with or love the results of a working paper released last month, but here it is: according to a team of happiness researchers at the Vancouver School of Economics and McGill University, small towns and rural areas are home to the happiest people (in Canada, anyway). ‘Life is significantly less happy in urban areas,’ the paper concluded.”

Won’t You Be My Neighbor?—“The researchers compiled 400,000 responses to a pair of national surveys to parse out the distinctions in self-reported well-being. Through cross-referencing the happiness responses with other data, they were able to see which factors might correlate with happiness. Wealth? Education? Religiousness? The main takeaway was that happiness appears to be correlated with population density. Why? Aside from having

Rural is happiest because low bandwidth reduces the daily political news.”
fewer people take up space on your block, living in a small town comes with a number of benefits. The researchers identified some other things that correlated with a person’s happiness in Canadian communities:

- Shorter commute times
- Less likely to spend more than 30 percent of their income on housing
- More likely to have lived in the area for more than five years
- More likely to attend church
- More likely to feel a ‘sense of belonging’ in the neighborhood

“Interestingly, the happiest portions of urban areas were also more likely to check those boxes. It seems that a short commute and cheaper rent makes everybody happy, no matter where you live.”

“If none of those points surprised you much, maybe the things that didn’t affect happiness might. According to the research, income, employment, and education were not strongly correlated with happy or un-happy communities. See? Money really can’t buy happiness—and neither can a swanky job or impressive degree.”

“However, if you’re a city-dweller who feels happy where you are, don’t fret. The happiest portion of urban communities was almost as happy as the happiest portion of rural communities. It’s just that when it’s bad, it’s really bad: the unhappiest urban portion was ‘substantially less happy than its rural equivalent,’ the authors write.”

“Sure, this research was limited to Canadian communities. Yet the findings aren’t far off from what has been dubbed the ‘rural-urban happiness gradient’ in the United States. This says that the farther away from cities people live, the happier they tend to be.”

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