Leading as Nudging: Optimizing Healthcare Delivery Systems Management in Mississippi

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Leading as Nudging: Optimizing Healthcare Delivery Systems Management in Mississippi

by
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A thesis submitted to the faculty of The University of Mississippi in partial fulfillment of the requirements of the Sally McDonnell Barksdale Honors College and School of Business Administration for the Bachelor of Business Administration degree.

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ABSTRACT

Rx Mississippi: An Assessment of Healthcare Delivery Systems in Mississippi
(Under the direction of Dr. Milorad Novicevic)

Three factors predominantly affect the delivery of healthcare services in the State of Mississippi: 1) the ability to access comprehensive, preventative care; 2) negative perceptions of the Affordable Care Act and similar reform efforts on the part of state and federal agencies; and 3) evolving reimbursement structures affecting the revenue streams of providers. There is a growing consensus among residents, providers, managers, and policy makers, which are key stakeholders in the overall wellness of our State, that preventative care addressing these three factors could play a pivotal role in improving public health. Through the development of a nudge framework of entrepreneurial leadership, I examine the least researched among public influence mechanisms, the nudge. The use of the nudge in my framework for developed for the case of Mississippi requires my analysis of both latent barriers and potential solutions to increase the likelihood that Mississippians would elect to seek meaningful provider relationships, embrace comprehensive schedules of care, and adopt and practice wellness management strategies. If more Mississippians were nudged with the use of my framework to make sound decisions about their health, the State would increasingly become healthier overall.
ACKNOWLEDGMENTS

The graciousness and patience of Dr. Milorad Noviccevic throughout the entire process of developing this thesis, enduring support of Dr. Young and all proud members of the Sally McDonnell-Barksdale Honors College family, and continuing encouragement of Dr. Jody Holland and the Trent Lott Leadership Institute have made my experience as an undergraduate student at the University of Mississippi truly exceptional.

For JoAnn Edwards’ continuing to believe in and actively challenge me, I thank her. Mr. Gottshall, Mrs. Ann Angle, and Mrs. Stacy Harrison no less brightened many a day and have offered me opportunities to succeed.

To all who have been a part of my time in Oxford, I thank you – it is with much love and adoration for the phenomenon of the place that we share that I am happy to present the following culmination of my research concerning health care management in the State of Mississippi for your consideration.
The Moon Exactly How it is Tonight
Taylor Mali

When Mount Everest was measured in 1856
it was discovered to be 29,000 feet exactly.
But since no one would have believed the figure,
sounding as it does too much like something
rounded off, two extra feet were found,
invented out of thin air, the thinnest on earth,
and added to the mountain's top
to provide the appearance of precision.
Twenty-nine thousand and two.

So too, tonight, a cloud has passed
before the moon in such a way
that were I able to describe it
exactly how it is, no one would believe me.
Which is why I need two extra feet of moonlight
or dark cloud, or to be fair, one foot of each.

The following work is dedicated to my parents, Bobby and Susan, in thanks for their unwavering faith, and to the many residents of Highland Home who inspire me to remember that wellness begins with “we.” Belief is not measured in the height of the achievement, but in the magnitude of faith, support, and love that have made my endeavors possible.
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Chapter One: Introduction

“Illness begins with ‘I.’ Wellness begins with ‘we.”’ – Sivananda Saraswati

Research Context

The system of healthcare delivery in the United States is increasingly viewed as unsustainable (McDonough and Addashi, 2014). In particular, observing the grim prospects for wellness promotion as management strategy Dr. Jo Ivey Boufford, MD, President of the New York Academy of Medicine (NYAM) opened a 2013 compendium, produced in collaboration with the Trust for America’s Health (TFAH), by evaluating the present economic, social, and political forces affecting healthcare delivery in the United States. Introducing a market in which consumer costs have accelerated at unsustainable rates, Boufford cites estimates published by The World Bank (2016) that value healthcare expenditures to amount to 17% of the United State’s gross domestic product. To this end, Boufford notes that among the costliest conditions in the United States – cardiovascular disease, cancer, injuries resulting from acute trauma, osteoarthritis, asthma, high blood pressure, and diabetes – a number of risk factors could be neutralized through the promotion of comprehensive wellness management. (New York Academy of Medicine, 2013, p.1)
Following the 2008 release of a report produced by the Trust for America’s Health, The New York Academy of Medicine and Urban Institute collaborated to analyze the balance of cost containment and prevention initiatives actively deployed throughout the United States. Emphasizing lifestyle interventions that can be implemented as complementary efforts alongside clinical treatments, the joint findings report that stakeholders – be they consumers, clinicians, managers, or policymakers – recognize that savings could result from the deployment of comprehensive wellness strategies.

Among successful clinical screening and therapeutic activity plans, “population-level interventions conducted by non-medical personnel were less well-known” among available options (New York Academy of Medicine, 2013, p.1). During the five-year period between the publication of the TFAH 2008 report and 2013 compendium, a number of researchers had begun to provide positive evidence of the impact of elective interventions and community-level programs as wellness promotion strategies implemented throughout the United States. Moreover, the literature review conducted before publication of the 2008 TFAH publication highlighted 23 examples of community efforts, but this number has grown to 79 presented in 2013. The evaluated interventions were oriented to “direct policymakers to specific interventions ready for broader implementation
and to inspire recognition of the potential to prevent disease and create a healthier population overall” (New York Academy of Medicine, 2013, p.1).

The 2013 compendium provides a set of exemplary case studies, which includes the case of entrepreneurial public leadership in Hernando, Mississippi where leaders effectively engaged the community in wellness promotion activities at the population-level (New York Academy of Medicine, 2013). In this thesis, I structure this case and other exemplary cases to develop a framework for the integration of public influence mechanisms with comprehensive, community-focused preventative care that supplements the delivery of healthcare services in rural Mississippi.

**Research Objectives**

In my framework development, I focus on three factors that have been evaluated as predominately affecting the delivery of healthcare services in Mississippi: 1) the ability to access comprehensive, preventative care; 2) negative perceptions of the Affordable Care Act and similar reform efforts on the part of state and federal agencies; and 3) evolving reimbursement structures affecting the revenue streams of providers. There is a growing consensus among residents, providers, managers, and policy makers, which are stakeholders in the overall
wellness of our State, that preventative care addressing these three factors could play a pivotal role in improving public health. I recognize that multiple tools could be utilized in my framework intended to influence meaningful interaction between these stakeholders and effective delivery of the services themselves, but I give preference to the tool that has been least researched among these options - the nudge. The use of the nudge in my framework developed for the case of Mississippi requires my analysis of both latent barriers and potential solutions to include objectives to increase the likelihood that Mississippians will elect to seek meaningful provider relationships, embrace comprehensive schedules of care, and adopt and practice wellness management strategies. If more Mississippians were nudged with the use of my framework to make sound decisions about their health, the State would increasingly become healthier overall.

In my analysis, I address not only current conditions but also the antecedent causes derived from examining case studies proposing internationally tested and regionally active policy options for implementation. Additionally, I analyze closures of Mississippi rural access hospitals and service providers alongside the shuttering of Louisiana emergency departments as failures that could indicate the degree to which the State requires comprehensive care. Conducting this analysis for the framework development has informed the
integration of the nudge as a mechanism to increase public awareness about opportunities to access care and promote wellness management that will improve healthcare system efficiency and efficacy in Mississippi.

In summary, the purpose of this thesis is to propose a framework aimed at the development, integration, and implementation of community screening and referral protocols that increase the ability of community service providers in Mississippi to become more available to address health-related social needs and manage diagnoses as established in the routine of care, alike. The associated management practices, public policy, economic impacts, and consumer advocacy perspectives are examined in order to evaluate the context of existing partnerships between care organizations. My main goal is to develop a framework through which community resources and funding sources can better integrate their efforts, and which identifies public influence mechanisms to improve overall health performance expressed through increasing the quality of life enjoyed by individual Mississippians.

My proposed framework is developed to help integrate the health-related social needs with strategic concerns relevant to managers operating within the complex domain of health care in order to formulate a holistic wellness management strategy that reduces overall care costs and decreases outpatient
care utilization. By addressing the unmet needs of community stakeholders, the proposed framework is instrumental to a manager to (1) evaluate the health effects of community services that address specific health-related social needs (e.g., housing problems, food insecurity, and the like); and (2) evaluate approaches to linking patients with community services. The use of the framework can motivate beneficiaries to seek appropriate preventative and comprehensive care and allow for managers to meet health-related social needs and facilitate advocacy in the public domain for consumer practice that advances performance along five dimensions:

- **Awareness** - Increasing the overall knowledge of the community beneficiaries about their health, social, and wellness planning resources;
- **Assistance** - Beneficiaries should be equipped to better interact with resources in order to seek screening, preventative care, and treatment for existing conditions;
- **Alignment** - Referral and navigation services to at-risk beneficiaries will better integrate community and clinical activities in order to promote overall wellness;
- **Integration** - Overall linkage between daily living activities, community organizations, and health care providers will increase; and
- **Continuation** - Assessment of the systemic and sustainable impact of implemented projects will be ongoing.
These dimensions are derived from the nudge theoretical foundation and the cases of successful implementation of wellness centers in Switzerland and in Charleston, Mississippi, where the mission of the newly opened Kennedy Wellness Center is to affect both public policy and individual daily living patterns. Based on this determination, the following research question is addressed in this thesis: “How can a nudge framework of entrepreneurial leadership be developed and disseminated to the benefit of public health care management in Mississippi?”
Chapter Two: Theoretical Foundation

“[C]ommunication remains the most identified quality care issue and is often one of the most contributing factors at the root of most quality problems” – Griffin, 2014

In today’s deregulated environment, public actors are innovating their roles and increasingly becoming entrepreneurial. This role innovation has engendered the phenomenon of public entrepreneurship as the process whereby public actors practice innovative stewardship of public resources that is aimed at maximizing public interest. As the process of public entrepreneurship is commonly permeated by the ambiguities of organizing collective action to attain multiple goals and meet multiple performance criteria, the case study design is an appropriate approach to study this phenomenon (Klein et al., 2009).

Public entrepreneurship is the process of exploring and exploiting opportunities for enacting innovation and change in the public non-market domain by changing norms, policies, practices, and institutions in the community (Hill, Kothari, & Shea, 2010; Smothers, Murphy, Novicevic, & Humphreys, 2013). As an innovative entrepreneurial use of public goods is frequently permeated with ambiguity, it requires a rich information exchange to facilitate cooperative collective action. However, public entrepreneurship may also engender conflict among community members as it requires their broad support and engagement,
particularly when it entails institutional change. Specifically, the success of public entrepreneurship depends on the ability of social entrepreneurs to obtain legitimacy from members of the community for collective actions involving their voluntary resource mobilization and engagement (Klein et al., 2009).

In this thesis, I propose nudge leadership as a theoretical framework to enact public entrepreneurship. The concept of the nudge stems from the work of Thaler and Sunstein (2008). Thaler and Sunstein posit that very few members of the general population can exercise the scrutiny necessary to weigh the exact costs and benefits of the thousands of choices we make daily, implying that there is a legitimate need for assistance in decision-making.

Humphreys, Randolph-Seng, Haden, and Novicevic (2014) contextualized nudge in the leadership domain by grounding it in the philosophy of paternalistic libertarianism. The authors posit that “...[L]ibertarian, or soft, paternalistic leaders utilize the choice architecture approach” arguing that nudge leaders

“...seek to nudge followers in directions that will benefit them and create a level of commitment that will ultimately further organizational interests as well. As this is the case, their control is more limited to choice architecture and therefore often indirect. These leaders are committed to follower self-development. As a result, followers choose to consent and respond to the leader’s nurturance with feelings of affection, genuine devotion, and zealous
commitment” (Humphreys, Randolph-Seng, Haden, and Novicevic 2014, n.p.).

This conceptualization of leadership has implications for using the nudge to motivate both healthcare practitioners and patients. Specifically, Blumenthal-Barby and Burroughs (2012, p.1) write that, “Recently policymakers, employers, insurance companies, researchers, and health care providers have developed an increasing interest in using these principles from behavioral economics and psychology to persuade people to change their health-related behaviors, lifestyles, and habits.” This implies the relevance of nudge leadership for management as a mechanism of meaningful change enacted by promoting the integration of leadership theory, current healthcare practice, and public policy.

Applying the philosophy of libertarian paternalism in the context of leadership demonstrates the “influence process of nudging followers to choose alternatives that make them better off” (Humphreys, Randolph-Seng, Haden, and Novicevic 2014, n.p.). In this way, practitioners can set superordinate organizational goals that embody the whole care of a patient, owing to the use of nudge principles. This means that patient outcome and wellbeing should be the aim of all stakeholders. If patients are also viewed as stakeholders, reasonable means of influencing their choices to “make them better off” should be encouraged. Navigating the intersecting fields of resource constraint, procedural
requirements, and individual needs, however, requires scrutiny because caution should be exercised to ensure that the use of the nudge does not prevail because of expediency, but rather is balanced in an evaluation of both positive effect and minimal impediment. There, it is critical to incorporate values such as commitment, follower self-development, nurturance, affection, and devotion as crucial to developing a statement of organizational goals. As communication is the main aim, the nudge is the best opportunity to structure a marketing message. As “communication remains the most identified quality care issue and is often one of the most contributing factors at the root of most quality problems,” (Griffin 2014) providers such as community health partners engaging Mississippians to seek primary, preventative care should engage individual ability to prefer wellness management in shaping comprehensive strategies to address public health indicator performance as opportunities for improvement throughout different communities and the State as a whole.

**Literature Review of Nudge Leadership**

Research in the area of public policy is increasingly concerned with the design of choice architecture for individuals and organizations that are based on options that nudge them to prefer individually and collectively beneficial choices (Thalen and Sunstein, 2008). Those options are based on default rules and are
structured in terms of specific sequences or menus. For example, food menus can be sequenced to nudge people to make healthier choices (Sobal and Bisogni, 2009). The Practical design of choice architecture is, however, complex not only because of the multitude of options but also because of the multitude of ways in which choices can be sequenced, framed, communicated, and/or incentivized (Felin, 2014).

The primary intention behind designing choice architecture of nudging options is to bound, or frame, various individual situationally-sensitive biases in terms of decision-making behavior (Oreg and Bayazit, 2009). The ideal design would lead to significant consequences with small nudges. In the area of healthcare policy, the main barrier toward achieving this ideal is the fact that most option elements and their interrelationships are regulated, thus significantly increasing the complexity of choice architecture design. As public policy is a super-ordinate constraint, the managerial options presented in a constructed choice architecture must be legally compliant before efficacy can be assessed.

Richard H. Thaler and Cass R. Sunstein coined the term “libertarian paternalism” during the production of their 2008 *Nudge*. Thaler reflects on the ideology presented, offering a layman’s brief description of “Free to Choose, 2.o.”
Thaler and Sunstein utilize agency-contingent definitions to identify *choice architects* as those who “have the responsibility for organizing the context in which people make decisions” (Nudge, p. 3, 2008). Further clarifying the work of such an individual, Thaler and Sunstein reflect on the traditional meanings communicated by the words representing the themes themselves. Nudging, by the cited definition, should “push mildly or poke gently in the ribs, especially with the elbow” (Nudge, p. 4, 2008). With a nod to popular political alignments, Thaler and Sunstein label the conceptual framework of their ideology as one honestly liberty-preserving, hence libertarian, and paternalistic in its commitment to shaping lives that are longer, healthier, and better (Nudge, p.5, 2008). Before engaging in any lengthy recapitulation or application of the theory in practice, the acronym “NUDGES” should be restated as written by Thaler and Sunstein in Chapter 5 (p. 89–109).

**Figure 2.1 Thaler and Sunstein’s Model of Libertarian Paternalism**

N  Incentives  
U  Understand Mappings  
D  Defaults  
G  Give Feedback  
E  Expect Error  
S  Structure
To compose an effective nudge, managers need to consider five issues and derive definite answers:

1. **Outcome**: Impact describes the degree to which choices subject to public optimization are perceived by individuals to affect themselves and others. For example, if people believe that their sub-optimal decision affects others, they are more likely to change their behavioral patterns than they would be if the decision were thought only to affect the individuals themselves.

2. **The frequency of choices** to be nudged should be considered as a determining criterion for those decisions most likely to impact the everyday lives of decision-makers. Salience demonstrated through the comparative “leverage” of a decision should direct the application of the nudge toward choices that are frequently encountered.

3. **Longitude**, the degree to which the decision has a long-term effect, affects the implementation of a nudge. Where decisions are made over a longer period, rather than immediately necessary, it is easier to exert incremental influence.
4. **The scope of influence**, related in terms of the magnitude and diversity of the influenced population, affirms that behavioral mechanisms are more easily refined and targeted than traditional public policy regulations.

5. **The scope of impact**, demonstrated through a preference for immediate or future desired outcome, should be considered regarding how individuals have a natural tendency to discount decisions believed to be costlier concerning today’s effort expended relative to consequences perceived to be distant.

Because choice architectures are more easily adapted than traditional policy mechanisms, managers might find these self-determined elections to be more easily integrated through the overall ability of behavioral mechanisms than they would prefer outcomes through policy measures. To this end, Teppo Felin of the Saïd Business School at University of Oxford writes in a November 2014 paper that managers function, most importantly, as choice architects. Felin believes that as “employees are consumers of choice and are constantly confronted with a large array and interface of options,” managers should construct strategic operation plans such that choice architectures benefit employees and consumer outcomes alike (Felin, 2014, p. 2).
Robert D. Behn of the Kennedy School of Government at Harvard University writes that managers should take care to utilize the platform of nudging in order to execute successful public influence through an approach integrating defined purpose statements, identified performance metrics and current indications, strategies directing efforts toward improving current performance, and long-term objectives. In an October 2011 edition of his Performance Leadership Report, Behn writes that the activities of managers - planning, organizing, leading, and controlling – should be the focus when forming plans to implement nudge leadership. Behn writes that, “The executive has the legal responsibility to follow the jurisdiction’s rules for budget, procurement, and personnel. He or she also has the operational responsibility to administer the organization’s programs and to implement its policies” (Behn, 2011). However, in order to form sustainable competitive advantages through the leadership expressed by a particular executive, Behn identifies effective public agency as the result of properly executed performance leadership.

Differentiating the concepts, Behn writes that, “Performance leadership is conspicuously different from procedural compliance” (Behn, 2011). Where compliance largely compels that a given organization file paperwork, exercise due diligence, and practice within the boundaries of established public policy,
the concept in and of itself does not directly require leadership. Organizations seeking more than mere conscription through compliance, then, must rise to the challenge of producing impact through emphasizing performance over what Behn characterizes as the prevailing “rule-obsessed culture” of management. Although Behn writes that “no legislature—not the U.S. Congress, not a city council—can require leadership,” public executives can receive a gentle nudge towards performance through emphasizing defined purpose statements, identifying performance metrics and current indications, directing strategic efforts toward improving current performance, and articulating long-term objectives through providing positive answers to four questions:

1. What is the purpose of the given agency?
2. What key performance deficits currently demonstrate the gap between the ability of the organization and its achievement of the purpose?
3. What performance objectives have been established to mitigate current deficiencies in order to achieve elimination?
4. What strategies will be implemented to achieve these targets and long-term goals? (Behn, 2010)

Behn writes that the positive contribution of assessments as implementation tools to be employed in the conversion of compliance-directed organizations and leaders into proponents of the nudge lies in the power of these questions to “nudge a public executive to think about performance and then, perhaps, to act to improve performance” (Behn, 2011).
Behn clarifies that, in order to become effective, consistent application of this method must be established as the norm. Managers, policymakers, and other professionals should become automatically prepared such that:

“After three, or maybe seven, sessions, some executives will get the hint. They will come prepared to answer these questions. Indeed, they may come so prepared that (after the formal introductions) they will begin their prepared remarks by answering these four questions immediately” (Behn, 2011).

While it may progress to demonstrate that public execution of the formalized nudge method has become ingrained in shared consciousness, persistence should require positively demonstrating meaningful impact developed through the logic model.

Behn writes that “preparing (not the answering) is the key activity,” affirming that the background work an executive must complete in order to respond positively to the prompts will enable organizational and team performance in accordance with the resulting goals and objectives. Behn indicates that improvements to the agency’s purpose and vision statements will be the result of engaging the first prompt, value chain activities and quality improvement will be improved through preparing for the second question, performance targets and improvement plans will be developed in the third prompt, and strategic planning will give rise to the ability to address the final
question of measuring the distance separating the firm’s current performance from indications of its long-term goals. Summarizing, Behn affirms the impact of effectively implemented nudge leadership through the leadership behaviors undertaken by managers. To this end, Behn writes, “To answer all four questions, a public executive will begin to recognize that with the title comes another, more subtle responsibility: to figure out how to develop the ability to exercise performance leadership” (Behn, 2011).

Former CEO of professional consulting firm RSM Tenon Andy Raynor writes in a June 2012 edition of the Professional Marketing Magazine that nudge leadership is the currently preferred foray in an overcrowded and matured industry. Raynor’s “newer, faster, and simpler model” is comprised of what he defines as “healthy self-doubt applied in three steps: deliberate pausing, analysis, and action with intention” (2012).

Raynor encourages managers to behave like leaders in recalling that thought is the object of deliberation. He writes that, “pausing – thinking – is the most important thing any leader can do” (Raynor, 2012). Raynor asserts, as many leadership theorists previously have, that while management and leadership are both vital to the success of an organization, they are distinctly different processes. Raynor writes that:
“A management response to a leadership issue will fail to give direction, won’t move the rudder. And a leadership response to a management issue can send the ship darting into the wind, endlessly changing course” (Raynor, 2012).

Because managers and leaders alike are required to plan and operate in environments of comparatively high ambiguity more often than not, a proposed logic model for more effectively planning within the boundaries of an organization’s resources is offered in Raynor’s writing that, “leadership is time travel” (Raynor, 2012).

Where Raynor observes management to be a present-oriented series of practices and processes, leadership behaviors are efforts invested in the future performance of an organization. To this end, successful implementation of the nudge in leadership must occupy space in the future and its predicated planning as much as possible. “Sophisticating through simplicity,” Raynor writes that a two-pronged test determines whether or not the behaviors of a leader engage a future-oriented perspective – “Why are we acting, and what comes next?” (Raynor, 2012)

Affirming that leadership is “definitively about going forwards,” asking “Why?” requires that managers become leaders in expressing a goal to work towards achievement while establishing a necessary basis of comparison. To this end, Raynor writes that, “setting a goal to go somewhere without knowing where
you are in the first place will guarantee the wrong course” (Raynor, 2012). While the nature of the question is revealed primarily through the context in which it is asked, Raynor asserts that the impact of “Why?” is in that, “There are no right or wrong answers, but there must be answers, all things must be understood. Without understanding, we build on sand” (Raynor, 2012). The knowledge developed through the continued engagement of leaders with super-ordinate reasoning underpinning their actions represents far more than mere facts and details in the form of assessing strengths, weaknesses, and strategic opportunities to achieve competitive advantage. Raynor writes that, “knowledge is potential energy,” and believes that successfully learning as a leader naturally leads those acting to engage with the second question of “what’s next?”

In action, Raynor writes, the leader derives the goal of the agency and its strategy. Raynor, classifying the varying degrees of influence at work, asserts that knowledge is “the ball at the crest of the hill” and “can become a moving force with just the lightest of nudges” (Raynor, 2012). Understanding market position, diversification, pricing, organizational capabilities, trends, and a holistic purpose statement, managers can function as informed leaders prepared to leverage current abilities to nudge resources in the direction of desired outcomes and necessary change. Raynor writes that the nudge can direct leadership to inform
management to begin answering, “Where can we take that? Where can we go? What’s next?”

Just as leadership is often about enabling the realized strengths of subordinate individuals, Raynor writes that spotting the talents and abilities of an organization is no less crucial to the overall success of a strategic venture in order to engage its ability to affect change. Raynor states, “Whatever the opportunity, whatever the problem faced, wherever, however crucial, the key is to understand, and move on.” Engaging leadership behaviors in a meaningful context allows for stability and direction to emerge as guiding strategy to direct confidence and achievement.
Chapter Three: Methodology

“The absence of an open discussion about theoretical constructs is somewhat surprising given their widespread use in and undeniable importance to management theory.” – Suddaby (2010, p. 346)

Qualitative Methodology

In this thesis, I use a case study design to reconstruct the concept of public entrepreneurship among the dimensions of leading as nudging (Welch, et al., 2016). My goal is to conceptualize nudging entrepreneurial leadership for developing a related practical framework for effective healthcare delivery in Mississippi. I emphasize the importance of prior conceptualizations because in the extant literature of entrepreneurship and leadership, “concepts are treated as empirical facts rather than theoretical constructions. They may be stretched to increase their empirical coverage, without considering the theoretical implications” (Welch, et al. 2016, p. 111).

Therefore, I follow “an alternative pathway for the career of a concept” (Welch, et al. 2016, p. 112) to stretch public entrepreneurship toward the domain of nudging leadership. My main assumption in conceptualizing nudging entrepreneurial leadership in the public domain is that it is not a “property of individuals and their behaviors, but is a collective phenomenon that is distributed
or shared among different people, potentially fluid, and constructed in interaction” (Novicevic, et al., 2016, p. 2). This relevance of collective action for my conceptualization is derived from multiple cases that I examine for the development of a practical framework that serves to specify, analyze, and disseminate knowledge applicable to effective healthcare delivery in Mississippi.

For my framework development, I use Bitektine’s (2008) prospective case design, which has advantages over the traditionally used post hoc case study utilized in the social sciences. Specifically, “The tight coupling of deductive research with quantitative methods in our field has created a situation where theories are tested only on those elements of the social environment that are amenable to quantification, whereas the generalizability of these theories beyond the scarce quantifiable aspects of the social processes remains unaddressed” (Bitektine, 2008, p.160). The case of designing nudging entrepreneurial leadership in healthcare management and delivery mechanisms for the State of Mississippi, moreover, exemplifies a context in which unique circumstances, incongruent quantitative measures, and reductionist generalizations would be required for post hoc study analysis. Therefore, I adopt the suggestion of Bitektine that “theory testing using qualitative case studies can provide a critical test for a theory, similar to a test performed with a single experiment” (160).
Based on the conceptualization of nudge entrepreneurial leadership from multiple relevant cases and using prospective case study design, I propose a framework for successful integration of nudge entrepreneurial leadership in the healthcare contexts of the State of Mississippi. My framework addresses the use of nudge to craft public influence messages and recommends how this can contribute to shaping healthcare management practices in the State of Mississippi through comparing successful integration internationally to the opportunities to deploy the strategy in the State.

The exemplary case of Stadtspital Waid’s integration of the nudge framework in promoting public entrepreneurial leadership has been selected to demonstrate the capacity of directed innovation efforts to improve the ability of a provider to connect with and meet the needs expressed by community members. As Stadtspital Waid was able to increasingly present itself as an integrated neighborhood partner, opportunities to integrate similar promotion patterns in Mississippi delivery networks will be considered in light of comparative scarcity of provider access and reported closures of Louisiana emergency departments. Having established both successful implementation and affirming the comprehensive need for action in Mississippi, opportunities to
continue the positive momentum put in place in Hernando and Charleston will be considered throughout the following proposed framework.
Chapter Four: Mississippi Care Management: State of the Art

“Physicians tend to set up practice in population centers, leaving rural counties with fewer physicians even controlling for the smaller population that lives in these rural areas” – Butts and Cossman, 2008

National Environment

Reimbursement trends which reflect the overall priorities of Federal and State agencies, indicate that a shift toward pay-for-value or quality initiatives has begun to take precedent over the current fee-for-service payment schedules. This shift is a unique challenge to managers because it seemingly engenders motivation for seeking fewer visits with comparatively healthier patients than before. That is, re-hospitalization or incomplete clinical management of an active diagnosis can potentially result in lower reimbursement rates for services rendered. Wellness promotion activities, then, are fit to be integrated in order to protect the quality metrics of a provider, rather than to be viewed as though they reduce projected revenues by shrinking the potential patient pool.

When Secretary Sylvia Burwell, of the Department of Health and Human Services (HHS), announced goals for Medicare to tie 30 percent of fee-for-service payments to quality or value through alternative payment models by the end of 2016 and 50 percent by the end of 2018, she expressed the overall goals of the Fed
in moving toward compensation driven by value demonstrated by outcome rather than volume. The Center for Medicare and Medicaid Services (CMS) has begun to test implementation strategies through the use of alternative payment models, such as accountable care organizations, patient-centered medical facilities and care planning, and bundled payments. While the CMS has invested $960 million USD in state innovation projects, Health and Human Services (HHS) has sponsored similar initiatives in order to improve the connections between clinical providers and community resources. Alternative models for care provision and reimbursement alike assist in the overall alignment of the HHS goals for health care reform and encourage better care quality, better community health performance, and lower systemic costs incurred.

CMS utilization statistics from 2015 indicate that currently, the greater majority of health care costs are encumbered outside of the clinical environment. Concerns such as food insecurity, inadequate or unstable housing, and/or interpersonal violence increase the overall likelihood that individuals will develop chronic conditions and reduce their overall ability to manage these conditions. Where only 20 percent of the variation in health outcomes is due to clinical care experiences, the CMS attributes 40 percent to social and economic determinants, 30 percent to health behaviors, and 10 percent to the physical
environment. An estimated 500,000 hospitalizations annually could be prevented nation-wide if the rate of preventable hospitalizations were the same for low socioeconomic status communities as those of higher performance, and public data reinforces that unmet health-related social needs reinforce current disparity.

Under the present system, health-related social needs have been either inadequately addressed through traditional clinical resources or absent from wellness planning activities altogether. Many providers lack the material resources necessary to develop goal-oriented social screening and referral protocols and have not formed the necessary relationships with existing community service providers. While visiting the emergency room can immediately stabilize patients in need of medical intervention, consumers should prefer to seek preventative care in non-critical settings in order to protect their overall wellbeing and control costs associated with managing their health.

Because illness can best be prevented through longitudinal and multi-faceted interventions, consistent primary care offers a distinct advantage over attention under acute distress. Primary care physicians, nurse practitioners, pharmacists, and similar community health partners are better equipped to communicate with patients how they can prevent illnesses, manage their health,
and protect their well-being over time. These clinical professionals have both relevant history and established relationships to reinforce their efforts, and are potentially both more effective and efficient than triage providers in directing patients toward achieving holistic health. In short, the increased costs associated with emergency care and immediacy imposed upon otherwise manageable conditions necessitate longitudinal public health interventions in order to encourage consumers to prefer preventative, primary care. Minimizing the divide between clinical delivery and community services will crucially activate the ability of rural Mississippi providers to better affect the total wellness management abilities of their patients.

**Salient Public Health Issues in Mississippi**

At the convergence of goals such as cost containment, system optimization, and increasing access is the mimetic quality of healthcare - process is product. As Piña, et al. write in a 2015 edition of the American Journal of Public Health, “Recent and ongoing innovation in systems for the delivery and reimbursement of health care in the United States have broadened stakeholders’ need for standardized methods to describe, measure, compare, and evaluate delivery system changes.”
In order to evaluate both the efficacy and efficiency of Mississippi’s health care delivery system, comprehensive efforts to describe the fiscal, operational, and utilization dimensions of the issue at hand must include a framework for system definition and optimization. Piña, et al. describe the findings of the United States Agency for Healthcare Research and Quality’s (AHRQ) 2014 Stakeholders Group Survey to include six final dimensions of a comprehensively functioning healthcare system: capacity, organizational structure, finances, patients, care processes and infrastructure, and culture. (qtd. in Piña, et al., 2015)

Utilizing funding allocated through the American Recovery and Reinvestment Act, the AHRQ organized the Community Forum Initiative to engage the public in its Effective Health Care Program through developing a broad, inclusive body of stakeholders to participate in surveys regarding perceptions of the most important dimensions of their care experiences. Consumers from a variety of opinions, professional or lay expertise, geographic distribution, gender, and race/ethnicity identifications were included in the survey in order represent constituencies ranging from patients, caregivers, and advocacy organizations; clinicians and administration professionals; hospital systems and medical service providers; government agencies; consumers and
payers; and health care industry agencies, policy researchers, and institutions. (qtd. in Piña, et al., 2015)

Through a series of mediated Delphi research and literature review, the working group sought to refine common definitions of the healthcare system, such as the general offered by the World Health Organization - “all organizations, people and actions whose primary intent is to promote, restore or maintain health.” (Piña, et al., 2015) Piña, et al. describe the findings survey to include six final dimensions of a comprehensively functioning healthcare system: capacity, organizational structure, finances, patients, care processes and infrastructure, and culture (2015).

Piña, et al. define capacity as the “physical assets and their ownership, personnel, and organizational characteristics of a delivery system that determine the number of individuals and breadth of conditions for which the system can provide care” (2015). Efforts, then, to expand the reach of an organization’s care expand the overall capacity of said network. Sustainability of such strategic moves, however, should be evaluated in order to best utilize the organization’s resources. In an effort to encompass the variety of issues inherent to strategic fit, Piña, et al. define the organization’s overall structure to be both the formal and informal elements of functional operation to include the “hierarchy of authority
and flow of information, patients, and resources.” Criteria such as the organization’s configuration, leadership structures, norms of governance, research and innovation practices, and continuing education programs are considered within the process of defining an optimal organizational structure. (Piñya, et al., 2015)

Piñya, et al. identify the evolving reimbursement and payment structures of healthcare providers in the present day to be a source of uncertainty and competitive advantage alike. Successful organizations are comparatively abler to allocate resources, build reserve resources, and operate with contained cost structures. Piñya, et al. amplify the impact of financial solvency as a critical performance metric in current healthcare management trends.

Consumers of healthcare services, principally patients and their families, are identified by Piñya, et al. through multi-faceted analyses to include geographic distribution as a crucially defining factor of a given market. This distinction is most applicable to the discussion of current cases in both Louisiana and Mississippi, as access is most often complicated by adverse geographic dispersion of patient populations in relation to access points to care.
The firm’s practices to develop unique care processes and infrastructures are modeled as the basic defining point of the systems approach as indicated by Piñya, et al. Comparative degrees of task integration and comprehension are offered as a potentially productive measure of the individual system’s ability to both create and effect change. Standardization, performance management, public reporting, quality improvement, health information systems, interdisciplinary and mobilized care teams, clinical decision support, and overall care plan coordination are identified as factors that influence the overall productivity of efforts to align care activities, both internally and strategically. That is, to the extent that individual tasks, duties, and responsibilities may be linked to one another, they ideally should be aligned with overall defined organizational goals and mission.

Lastly, the human factors of a care network are evaluated by Piñya, et al. in order to discuss the importance of functional culture. Defining culture as the “long-standing, largely implicit shared values, beliefs, and assumptions that influence behavior, attitudes, and meaning in an organization,” Piñya, et al. offer patient focus, community engagement and competencies, competitive-collaborative orientation, innovative focus and dispersion, and working climate as indicators defining the boundary of successfully implementing and promoting
functional organizational cultures to benefit both the value of the organization and patient outcomes produced by a provider.

**Geographic Differences in State Access to Primary Care**

The Mississippi Institute for the Improvement of Geographic Minority Health at the University of Mississippi Medical Center in Jackson and The Social Science Research Center at Mississippi State University examined both the socio-economic and political antecedent causes of suboptimal health care delivery in the State of Mississippi in producing a 2010 report entitled “What if We Were Equal?” Staging the debate concerning the current state of disparities, Mississippi researchers affirmed that “systemic change,” as identified by Satcher, et al. must include increasing health insurance coverage, greater access to primary care, equitable representation of minorities in medical professions, and efforts to eliminate biases in delivering diagnosis and treatment of diseases in order to broadly affect public health metrics (2010). The assessment of Mississippi aimed to answer three questions:

- What would be the impact of improving Mississippi’s health and outcomes to meet the national average?
- What if Mississippi’s majority populations were equal to the nation’s majority baseline indicators? How can minorities in Mississippi be provided healthcare that matches that of the majority nationwide?
- What resources will be required in order to make these changes?
Disparities yield a powerful influence over health outcomes. While genetic predispositions can be blamed for some propensity towards disease, social factors, individual behaviors, and community conditions are the variables examined by the Mississippi team as relevant in the development of sub-optimal delivery.

Honest assessment of Mississippi’s health care delivery system in the present day resides at the nexus of public policy studies, economic analysis, and historical inquiry. While the inter-connectedness of these varying narratives is often forgotten, that disparities emerge in terms of gaps in quality of health, varying prevalence of disease, or incongruent access to care among specific populations is evident in the State of Mississippi. It is not enough to acknowledge that inequalities exist in terms of ability to access care itself and inconsistent quality of care, as such a statement belies the behavioral, environmental, and social factors relevant to the development of said condition.

Admirably, UMMC and The Social Science Research Center distinguish “inequality” from “inequity” in publication. Where inequality is a quantifiable distinction among measurable distances, inequity is a morally considered analysis informed by subjective conceptions of justice, social welfare, and economic promotion. Rather than proposing a theoretical methodology for
reducing inequities, efforts to optimize delivery mechanisms and curtail the influence of conditions resulting in inequality should be the focus of present efforts. Williams and Jackson validate this premise in their writing that “Whether measured by income, education, or occupation, socioeconomic status (SES) is a strong predictor of variations in health. Americans with low SES have levels of illness in their thirties and forties that are not seen in groups with higher SES until three decades of age later” (2005). The disproportionate effects of reduced opportunities to seek care for Mississippi residents with lower SES will continue to be a central assessment undertaken.

**Uneven Distribution of Primary Care in Mississippi**

In response to the popular, often politicized, rhetoric surrounding the availability of healthcare services in the State, researchers from the Mississippi Center for Health Policy constructed a geospatial model of generalist care in Mississippi as of October 2008. Contextualizing their findings in light of campaign messages regarding healthcare offered by then presidential candidates McCain and Obama, researchers point to the statements of a senior Obama health policy advisor in order to affirm that “geographic disparities in where physicians practice limit the availability of and access to primary and preventive care” (Butts and Cossman, 2008). This statement resounds within the State of
Mississippi, as there is a demonstrated need for regular access to care for otherwise preventable or manageable disease such as diabetes, cardiovascular disease, and stroke unable to be met by the current distribution of generalist practitioners and clinics throughout the State.

In order to derive the relative density versus distribution of the State’s physician workforce, Butts and Cossman utilized licensure numbers provided by the Mississippi State Board of Medical Licensure (MSBML). Given this set of actively practicing physicians, researchers placed practices by location at the county level and divided the Census Bureau’s reported population by the resulting number of physicians to derive Mississippi’s physician representation in terms of patient-to-physician representation ratios.

In December 2010, members of the Council on Graduate Medical Education presented the twentieth edition of their annual issue report, focusing the edition on advancing primary care. Estimates published by the Council indicate that there should ideally be 70 generalists to serve every 100,000 members of a population, such that each physician is burdened to care for less than 1,500 individuals in their region. Utilizing an earlier presentation of this estimate, Butts and Cossman compared the distribution of care in Mississippi to the presented number by the COGME in order to assess how well the State of
Mississippi performed in terms of geospatial distribution of care. Constructing a ratio analysis, Butts and Cossman derive that counties with representation less than 1.0 are adequately staffed by COGME standards for patient-to-physician population distributions, whereas those counties in Mississippi with a patient-to-physician ratio above 1.0 lack adequate care infrastructures and have the potential to develop the associated complications demonstrated through poor performance on public health assessments and adverse outcomes in the daily lives of residents.

In 2008, Butts and Cossman identified that there are a number of Mississippi counties scoring above the optimal 1.0 patient-to-provider ratio. Specifically, Mississippi’s 82 counties included only 19 within the COGME identified representations. Sixty-three Mississippi counties, a sizeable majority of the State, lacked adequate access to primary care. Butts and Cossman found that 39 of these counties represented patient loads twice the recommended levels and 20 between two and four times the COGME’s recommended level of residents per general practitioner.

Breaking the ratio representation into tiers of population distribution, Butts and Cossman assert that counties with appropriate access at or above the 1.0 patient-to-provider ratio to care have an average population of 56,741 and
those with adequate access scoring less than 1.0 were the home of 35,831 residents. Sub-optimally performing counties in lower tiers had populations between 14,188 and 19,679 residents.

Table 4.1 Division of Survey Population Ranges

<table>
<thead>
<tr>
<th>Ratio Range</th>
<th>Tier</th>
<th>Average Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suboptimal</td>
<td>4</td>
<td>14,188</td>
</tr>
<tr>
<td>Suboptimal</td>
<td>3</td>
<td>19,679</td>
</tr>
<tr>
<td>Acceptable</td>
<td>2</td>
<td>35,831</td>
</tr>
<tr>
<td>Above-Average</td>
<td>1</td>
<td>56,741</td>
</tr>
</tbody>
</table>

In an effort to present current data, the physician representation density for 2014–2015 has been derived by this writer utilizing the methodology presented previously. Based on 2010 US Census Bureau population counts and 2014 population estimates and licensure numbers published by the Mississippi State Board of Medical Licensure a patient–to–physician ratio similar to that created by Butts and Cossman has been produced alongside a comparative model of practitioner availability in comparison to the demonstrated need, given a county’s population density. Abbreviated findings include that 41 Mississippi
counties were under-served during 2014-2015, with an additional 2 counties, Carroll and Issaquena, lacking county-based licensed general practitioners altogether. Mississippi counties average a patient-to-provider density ratio of 1.23 patients to providers.

Figure 4.1 Mississippi 2015 Population to Physician Representation
Addenda charting attached to the conclusion of this thesis indicate the comparative need of Mississippi counties relative to their populations numerically.

Butts and Cossman affirm that counties with the lowest patient-to-provider ratio are those which have the largest populations overall, writing that, “...[P]hysicians tend to set up practice in population centers, leaving rural counties with fewer physicians even controlling for the smaller population that lives in these rural areas” (Butts and Cossman, 2008). They note that it is relatively difficult to represent the ability of residents to seek care in surrounding counties, but offer a secondary model of care mobility in proposing that the geographic area of contiguous Mississippi counties could be examined as “analytical micro-regions.”

Pairing counties that are members of metropolitan statistical areas, as defined by the US Census Bureau, those that have the natural tendency to support seeking care in adjacent or contiguous areas, Butts and Cossman calculated patient-to-provider ratios by the same methodology in order to produce a physician distribution model more likely to represent the ability of residents to travel for care. Micro-regional analysis indicates that that of Mississippi’s 82 county, 54 have inadequate access to generalists. Of these counties, 46 are
between 100 and 150% of the COGME recommended patient load. Of these counties, 46 are between 100 and 150% of the COGME recommended patient load. Among those remaining to be represented, DeSoto county borders Memphis, TN; Tishomingo County borders Florence, AL; and Greene County borders Mobile, AL. Through deriving the impact of contiguous access to care, Butts and Cossman identify that availability to seek care in neighboring areas increases patient-to-provider representation towards acceptable standards. Where it may not be immediately possible to create critical access points, collaborating with resources within near reach may well prove beneficial to providers and patients alike. However, as Mississippi is a predominately rural state, there is a need to focus the impact analysis on both proximity measures and efficiencies of access. In terms of such a scale, Butts and Cossman analyze the functional areas of Mississippi Area Health Education Centers (MAHEC).

As nonprofit centers working to improve healthcare services in Mississippi through education initiatives, intervention and primary care access, and integration of community resources with schools, providers, and community organizations, Area Health Education Centers work to advance preventative care in the State. Recruiting providers and uniting resources, these agencies are focal points identified by Butts and Cossman that clarify regional population
demographics and their impact on healthcare delivery. Pairing counties within established MAHEC regions to calculate the patient-to-physician ratio within these larger regions, Butts and Cossman find that most of these regions are between 100–150% of the COGME recommended patient loads. North East, North Central, Delta, East Central, and Southwest regions fall between this range, suggesting that an increase of 50% of providers would benefit residents and their access to healthcare services. Concentrated population regions, such as the Central AHEC including the Capitol Metro area and Southern AHEC communities fall within the provider ratios derived from COGME recommendations. While the Southern AHEC region is estimated by Butts and Cossman to be operating at 99% of recommended patient loads, the Central region carries 66% of recommended levels, demonstrating an excess of providers available to consumers. As Butts and Cossman identify only two markets, however, in which excess provider representation is currently demonstrated, the importance of increasing access to primary care across the State of Mississippi is crucial to improve overall performance on public health metrics.

Butts and Cossman write that primary care access asymmetry in the State of Mississippi is a primary issue affecting poor performance on public health assessments. Access to generalists, Butts and Cossman assert, is crucial for both
preventative and referral care necessary to comprehensively diagnose, treat, and prevent illness. Where there is a statewide shortage of physicians, especially one exacerbated in rural areas, residents cannot easily access primary care in order to prevent the development of non-contagious diseases. Similarly, they are less able to seek necessary referrals to specialists in order that they might receive targeted care. Butts and Cossman write that these conditions lead to poor performance overall as, “Preventive practices also suffer from the lack of generalists because people often wait until they have severe and acute health problems to seek medical attention” (2008). When primary care is postponed, conditions naturally tend to become intensified, adversely affecting individuals and communities alike. While efforts to reform reimbursement and supporting policy structures have been made, the overall impact of preventative care in the State of Mississippi has yet to be realized.

**Barriers to Resident Acceptance of Affordable Care Act**

The Center for Mississippi Health Policy commissioned a 2014 study through the School of Public Health at the University of Alabama at Birmingham to survey non-elderly Mississippians in an effort to qualify their “knowledge, attitudes, and behaviors related to health insurance and the Affordable Care Act.” In brief, respondents indicated little self-reported knowledge of the ACA or the
Health Insurance Marketplace, with 60% answering that they knew little to nothing about the ACA and 70% responding that they had little to no knowledge of the functioning of the Health Insurance Marketplace. Unsurprisingly, perhaps, only 37% of adults surveyed believed that they had enough information about the efforts to reform health care to understand how new policies would affect the health care of their households.

Counterfactually, though it may seem, Mississippians individually support many isolated components of the Affordable Care Act, with the exception of the individual mandate. On the whole, nearly 46% of adults in Mississippi do not support the law and 40% of respondents believe they will be worse off as a result of healthcare reform. Less than half (37%) of adults support the ACA and the remaining 17% indicate relative uncertainty. Further indicating that lacking information ultimately undercuts the potential benefits conferred by healthcare reform law, 38% of adults surveyed in the state do not think they will be affected by the ACA or were otherwise generally unsure of the impact.

Census data reported by Kaiser Foundation indicates that roughly a quarter (24%) of Mississippi residents live at or below the federal poverty line. The previously cited Center for Health Policy issue briefing reports surveyor’s efforts to determine the knowledge of Medicaid reform on the part of Mississippi
residents. Nearly three-fourths of those surveyed (69%) indicate that they had heard little to nothing about the Medicaid expansion option offered by the Federal Government and what applicable choices had been made by the Governor and Legislature. Seventeen percent of Mississippians indicated that the Governor and Legislature had elected not to expand Medicaid, 5% reported that they had chosen to expand, and 9% believed that a decision had not yet been made.

At the time of the survey, approximately 23% of adults reported not currently being covered by a health insurance policy. When asked to explain why they were not covered by a current insurance policy, almost half (49%) indicated that cost was a determining factor in their decision not to seek insurance. A small percentage of respondents (9%) stated that not qualifying for coverage through their employer, or their employer not offering insurance, as the predominant cause for their lacking coverage. Longitudinally, this is not a new problem. Eighty-four percent of those who indicated they did not currently have health insurance coverage had been uninsured for over a year, and 68% of adults surveyed had not been covered for over two years. Unlike the general preconception of young, healthy adults being the largest group uninsured, the majority of those identified in the survey (55%) were between the ages of 45-64.
Roughly a quarter (27%) of those covered by insurance in the state of Mississippi had Medicare, Medicaid, or another government-offered coverage option.

Lack of Primary Care Delivery in Rural Mississippi

Merely assessing the difficulties affecting access to insurance coverage in the State of Mississippi is inadequate in order to comprehensively address the number of issues affecting the critical factors preventing access to preventative care. Given that 54 percent of Mississippi resides in a rural setting, the comparative distribution of Mississippi’s population can be demonstrated to be a primary socioeconomic and geographic factor affecting access to healthcare in the state. As the delivery mechanisms and reimbursement structures of the United States healthcare system evolves, the impact on comparatively small providers such as rural hospitals has increased. Most recently, the Center for Mississippi Health Policy has identified news of closures and layoffs as indicative of the challenges facing access to healthcare in rural Mississippi. The Center for Mississippi Health Policy has identified 58 rural hospitals that have closed nationally since 2010, with a concentration of closures occurring in the South. Two of such closures have affected Mississippians, and 22 more hospitals in the state have been identified among the 283 nationally classified as “vulnerable.” A 2014 report of the Mississippi Office of the State Auditor entitled “The Financial
Health of Publicly Owned Rural Mississippi Hospitals” corroborates the findings of the Mississippi State University SSRC. Together, the findings illustrate 9 “most at risk hospitals” as illustrated below.

**Figure 4.2 Mississippi Hospitals Identified as “Most at Risk”**

McDoom, Chang, Gnuschke, and Mirvis of the MSU team identify that the closure of these hospitals would post losses of 2,600 jobs across the state, $8.6 million local and state tax revenues, and have the overall economic impact of $289.2 million dollars (2014). Scarce access to primary care has been demonstrated throughout previously reported findings to be a predominately negative factor affecting the ability of Mississippi to realize its healthiest potential, and the additional complication of endangering emergency departments further should compel action.
Chapter Five: Exemplary Case Analysis

“Thaler and Sunstein’s vision could be described as the au pair state: a more informal, less heavy-handed, but still ever so slightly intrusive creature.” – Aditya Chakrabortty, The Guardian 11 June 2008

Exemplary Case One: Lessons from Louisiana Suboptimal Delivery

Rural hospitals are not the only providers who currently in danger of insufficient funding, as indicated by the closure of emergency departments in neighboring states. Previously cited literature produced by Piña, et al. describes the “escalating complexity and heterogeneity of health care delivery systems” in the United States as a primary cause of market fragmentation. Citing The Commonwealth Fund Commission on a High Performance Health System, Piña writes that “traditional health care in the United States as a cottage industry wherein fragmentation occurs at the federal, state, and local levels.” Notable examples of fragmentation can be seen in Louisiana’s attempt to restructure the delivery of charitable care to low-income patients.

Margaret Newkirk of Bloomberg writes on March 24, 2015 that a, “Baton Rouge Emergency Room Shows the Cost of Obamacare Fight” in summarizing the current conditions of diminishing public access to healthcare services in
Louisiana. Former Governor Bobby Jindal’s refusal to participate in Medicaid expansion compounded longstanding mismanagement of charitable hospitals in the State resulting in market conditions that led to the closure of Baton Rouge General Hospital’s Mid City emergency department. The event attracted national attention not only because of the politicized nature of the immediately influential causes, but also because of the broad effects on residents of all socioeconomic statuses. (Newkirk, 2015)

In the State of Louisiana, public funding has been traditionally allocated for the operation of charity hospitals in major markets for providing healthcare services to low-income residents of the State. Post-Katrina, markets such as Baton Rouge faced an influx of non-covered and under-insured populations nonetheless requiring care. Coupled with Governor Jindal’s spending habits, refusals to expand Medicaid adversely impacted the funding available through the Affordable Care Act to offset the costs borne of increased resident coverage. The result: insufficient funding for the charity model in place. (Newkirk, 2015)

Private and public regional hospitals had absorbed, for lack of better description, some of the market of uninsured or underinsured patients because of their legal obligation to provide immediate care through emergency departments. Because of dwindling funding for the reimbursement of these
unpaid services, managers of hospitals such as Baton Rouge General have been faced with the possibility of having to discontinue emergency services in order to remain financially solvent. In north Baton Rouge, one of the most impoverished areas of the city, the decision was made to shutter the emergency department. Newkirk summarizes:

“In Louisiana, Baton Rouge General’s Mid City hospital was already caught in that vise. It was flooded with the uninsured after a nearby charity hospital was closed. Louisiana provided a one-time injection of funds last year from the federal aid program that’s about to be cut. With that money gone, the hospital is closing the emergency room.”

One fourth of Baton Rouge’s nearly 230,000 city residents are reported by Bloomberg to reside at or below the poverty line, and have been further displaced by the closure of the Mid City hospital’s emergency department.

Newkirk’s interview of then Secretary of Louisiana Department of Health and Hospitals Kathy Kliebert highlights the financial constraints imposed upon Baton Rouge General. Kliebert identified the market forces of rival specialty hospitals attracting insured customers and the influx of uninsured patients as pivotal factors preceding Governor Jindal’s refusal to expand Medicaid and efforts to partially privatize the State’s hospital system. Kliebert indicated that Mid City has had substantial financial decline over the last 10 years and was
unable to leverage revenue generated by other operating activities to sustain de-facto charitable operation of its emergency department.

Without adequate coverage, many seek guaranteed services through the emergency departments of hospitals, where they cannot legally be turned away for their inability to pay. Lacking access to charitable treatment under the established model, unable to be seen in close proximity to their home community, and without opportunities for preventative, routine care, residents of north Baton Rouge seek services where available, in other emergency departments. Neither cost nor disproportionate impact had been reduced under Governor Jindal’s plan.

As Newkirk identifies, Jindal, a health-policy scholar who previously served as chief of the State’s hospital system in 1996, preferred partial privatization of charitable services to expanding Medicaid in the State of Louisiana. Implementation did not include an expansion of preventative services or initiatives for community wellness - efforts discussed at greater length in later sections of this thesis - as cost reduction strategies that benefit public health. Rather, the systemic cost centers of charitable care were merely divided and redistributed, resulting in a perpetuation of suboptimal health care delivery. The cases evident in Louisiana should serve as caution, informing public policy
leaders and managers in Mississippi as they navigate evolving reimbursement structures and engage in debate concerning the implementation of the Affordable Care Act.

**Exemplary Case Two: Effective Entrepreneurial Public Leadership in Hernando, Mississippi**

In a February 2013 Trust for America’s Health (TFAH) online publication, researchers documented the model for active living and comprehensive wellness management promoted in the Hernando community. TFAH researchers praise that while average health insurance premiums for the private sector between 2000 and 2010 doubled, costs encumbered in Hernando are a demonstrated exception. In 2013 alone, Hernando lowered its health insurance costs by 15 percent, totalling $130,000 in savings for its 14,000 residents, without reducing benefits. (Trust for America’s Health, 2013)

Mayor Chip Johnson and City leadership have engaged in the development and deployment of a comprehensive wellness program for municipal employees in order to offer free screenings for high blood pressure, diabetes, and other chronic conditions pervasive in Mississippi. Offering assistance to stop smoking at no cost to program participants, and encouraging City employees to exercise
regularly, Hernando’s leadership believes that the wellness program has been a driving force in reducing healthcare expenditures. Hernando Mayor Johnson arranged savings of $21,000 annually on health insurance for City employees by gathering support to encourage all municipal employees not to smoke at work during active hours, even while on break. Praising the commitment of his staff as crucial to succeeding in lowering costs, Johnson noted in an interview with TFAH that three employees had stopped using tobacco altogether while participating in the pledge. (Trust for America's Health, 2013)

Citizens of Hernando have benefitted from 20 years of growth as a bedroom community housing suburban-seeking Memphians. An influx of professionally engaged, comparatively affluent residents has led to stable growth of capital, both social and economic, to support the creation of bike paths, playgrounds, and common spaces for exercise. While Hernando does not maintain records on obesity and health outcomes of its residents, a third of Desoto County adult residents are obese. Bearing the highest overall obesity rate in the country, one third of Mississippi’s adult residents in 2013 were obese. Pressured by the highest reported rates of hypertension and physical inactivity among adults, Mississippi is adversely affected by a number of co-morbid
conditions alongside obesity. Almost 12 percent of Mississippi adult residents are diabetics, the third highest rate nationally (Trust for America's Health, 2013).

TFAH estimates for 2008 state expenditures number more than a billion dollars spent on obesity-related care, with expectations that costs could rise to $4 billion USD by 2018 (Trust for America's Health, 2013). Mayor Johnson and managers of a number of the City’s businesses and social organization have encouraged residents to become more active. Through the charismatic leadership of Mayor Johnson, “Complete Streets Laws” requiring pedestrian spaces on all new road construction have been passed in the City and supported by residents, enabling the City to build nearly a mile of sidewalks to connect low-income neighborhoods to nearby elementary schools in order to encourage students and their parents to walk between home and school and make use of existing space for outdoor activities. (Trust for America's Health, 2013)

Seeing another opportunity for local market activity in the benefit of public health habits, Hernando began weekly farmers’ market offering fresh produce, meat, and dairy products sourced from nearly 65 North Mississippi vendors. Nearly 400 customers visit from March to November, with the City accepting food stamp benefits as payment for the produce in an effort to make the event as accessible to all residents as possible. Similarly, a public garden
cultivated by a number of church and youth groups with civic clubs and private citizens offers fresh produce a low or no cost to Hernando’s low-income residents. (Trust for America's Health, 2013)

Advocating for small, consistent efforts with existing resources, Mayor Johnson speaks with public- and private-sector leaders throughout the State to encourage increased implementation of similar plans. The City of Hernando has received more than $800,000 from external sources to encourage activity and healthy eating. The inertia created by City leadership has encouraged local businesses to host weight-loss contests, implement tobacco use cessation programs, and increasingly emphasize wellness benefits. No less, religious and civic organizations have begun to care for the whole health of their memberships. Oak Hill Baptist Church in Hernando and Reverend Michael Minor have measured a walking track in their property’s parking lot, started a walking club, and formed working groups to partner with the National Baptist Convention and other funding sources to develop “Healthy Congregations” groups at local churches. (Trust for America's Health, 2013) By engaging multiple organizations and opportunities, the City of Hernando has substantially reduced its healthcare costs and increased access to comprehensive wellness resources outside clinical environments.
Exemplary Case Three: Swiss DRG and Nudge Marketing of Healthcare Services

In Switzerland, the nudge is being utilized to form specified marking campaigns aimed at improving public health through encouraging engagement with wellness management strategies and resources made available to the public within clinical settings at established hospitals. Maurice Codourey, writes in a 2013 edition of the journal *Economics & Sociology* that cost challenges arising from the implementation of a tariff system enacted in Switzerland to increase quality of care while shortening the average duration of a hospital stay have encouraged managers to seek opportunities to both promote community wellness and position their network as the preferred provider in order to retain revenue flows from public reimbursement formularies.

Highlighting the work undertaken by the Stadtspital Waid, Codourey evaluates the extent to which the development of a “public handshake/pushed gossip strategy” made possible through nudging public opinion constructively promoted the hospital’s services as a learning environment, engaged community intelligence, and bound providers to patients. Hosting a children’s clinic in which parents visited the hospital with their children and plush toys familiarized attendees with available services. Stadtspital Waid aimed to make children more
comfortable in the clinical environment, overall. Presentations on a variety of topics, generally non-medical issues of interest to the community hosted through the Hospital’s Waidfokus+ program positioned the organization though “deliberate disturbance” in order to affirm the Hospital’s intention to become totally engaged as a community stakeholder. Counterfactually, though it may seem, Codourey finds that these extra-clinical activities engaged former patients and those who had never been to the hospital alike, attracting broad public attention. (Codourey, 2013)

Instituted 1 January 2012, the Swiss DRG program introduced the managerial concept of diagnostic related groups into public reimbursement formularies, resulting in flat reimbursement rates paid per case of “stationary patients,” or those who are admitted for care and observation on a continuing basis rather than treated for an acute condition and discharged in the same day. While larger hospitals have taken the opportunity to develop marketing departments to craft promotional messages in line with their organizational quality initiatives, Codourey focuses research on the impact the legislation has had on smaller providers. Similar to the evolution of public funding and reimbursement structures that has begun to take place with the continual implementation of the Affordable Care Act in the United States, providers in
Switzerland are incentivized to reduce the number of active in-patient days per case while increasing quality of care experienced overall. Codourey presents the overall trend toward changing revenue streams through the following diagram.

**Figure 5.1 Swiss DRG Reimbursement Formulary**

The overall cost weight established by Swiss health administrators is leveraged against the base rate of reimbursement validated by negotiations between providers, insurers and public resource agencies in order to produce the fixed rate per case. Managers of public health resources and organizations seek to maximize revenue where reimbursement multipliers have the ability to directly affect their bottom line, and have begun to engage in marketing efforts in order that they might appeal to a broader consumer base. (Codourey, 2013, p.12)

Codourey writes that providers have been challenged to improve their competitive strategies in a relatively short period of 3 to 5 years in order to reach a level of productivity amenable to the ends of broadening consumer appeal and securing favorable reimbursement. Improving community perception and promoting the comprehensive services and the provider have predominately
been the traditional responsibility of marketing professionals. Hospital managers in Zürich however, the largest city in Switzerland, must attract business from 380,000 inhabitants in 88 km².

Seeking to differentiate itself from ten others in the “predatory market,” as characterized by Codourey, Stadtspital Waid is the smaller of two public hospitals to reorganize after the institution of SwissDRG. Stadtspital Waid has successfully positioned itself for growth, with 261 beds open as of September 2013, compared to the 39 before its temporary closure. Efforts to promote the location as “the hospital of your choice” and “the central provider of Zurich North” have proven effective in engaging the community to seek wellness and acute services through Stadtspital Waid.

Codourey describes the overall mechanism previously employed by Stadtspital Waid as “send only,” in that the primary marketing message offered by clinicians, managers, and other liaisons have communicated to community members rather than with them about the offerings of the organization. While the longstanding effort is to develop a conversant space that encourages discourse regarding the status of public health and offerings of Stadtspital Waid that reinforce shared wellness goals, marketing professionals have been challenged
to develop nudge methodologies to encourage the use of “send and receive” communications engaging multiple groups.

Codourey identifies the “public handshake” as a product of Draper and Rayportz work inspiring the creation of viral marketing. As employed by Stadtspital Waid, the strategy serves to direct the target public to greater discourse and engagement with public health issues promoted through the hospital’s marketing efforts. Creating a conversant space in which individuals discussed not only health issues, but came to identify Stadtspital Waid as an authoritative knowledge base and solution provider, nudge activities delivered growth far exceeding the performance traditionally manifest by brochures, online marketing, and press information released by the hospital. Engaging in the previously articulated “send and receive” communication with the targeted population of Zurich, marketing messages promoted by Stadtspital Waid empowered a triadic approach including nudges, community knowledge, and constructive learning opportunities.

Codourey defines the “constructivistic didactic” resulting of nudging as one in which those exercising influence form a basic conceptualization of an ideal outcome, provide a structure of planned incentives in decision making, chart the path, and plan for potential drift zones (Codourey, 2013, p. 14). While the
marketing knowledge transfer takes place outside of the domain of traditional didactic theory – the classroom – Codourey asserts that the “twofold situation” of a send and receive messaging mechanism allows for standard evaluation. Codourey offers two theories clarifying the nature of nudge knowledge transfer:

“When knowledge transfer is made fascinating and the learners learn a learning object according to their own truth without being restricted in their own freedom but being at the same time excited about the learning situation the knowledge transfer shows potential to be spread as a remarkable experience to the personal periphery of the learner. (Codourey, 2013, p. 14)”

Codourey writes that Stadtspital Waid began with public handshake and pushed gossip in 2011 in an effort “to be open about the continuous development and ongoing adaptations of the practice model” (Codourey, 2013, p. 15). Engaging Gerald Hüther’s theory of municipal intelligence, Codourey writes that the most effective community education might result of the public hospital communicating as a participatory member of the Zurich community providing meaningful care and discussion to the benefit of residents in their everyday living activities.

Where Hüther’s emphasis is invested primarily in generating interest such that the targeted population becomes excited by a particular marketing message, Codourey and the management of Stadtspital Waid sought to engage the experiences of the hospital’s neighbors in an effort to shape meaningful
connections yielding future comfort with the provider’s structure and expertise. Codourey points to Hüther’s etymological assertion that a municipal body is more than an administrative unit through writing that, “the origin comes from ‘community’ – family, village, city” (Codourey, 2013, p. 15). Where Stadtspital Waid successfully engaged these varying stakeholders and interests, the hospital was able to leverage its unique abilities through knowledge dissemination, public influence, and provision of innovative services to promote public wellness.

Stadtspital Waid opened in 1953 and has since often encountered the community in unknown, uncomfortable, or unsure circumstances, as characterized by Codourey. While the hospital itself has demonstrated a commitment to excellence in its practices, engagement with the wellness promotion or preventative health initiatives that include the greater majority of the public are recent inventions. Effectively, the circumstances in which individuals and families found themselves in need of the Stadtspital Waid’s services allowed for the development of “affective opinions, legends, assumptions, and gossip” steeped in the narrative experience of illness.

Initially, the hospital began to evolve its 24-hour emergency department’s service delivery through collaborative efforts with local general physicians. Working as a project of Zurich’s quality initiative “Gesundheitsnetz 2025,” the
development of a comprehensive provider network allowed Stadtspital Waid to develop a three-phase implementation of daytime partnerships with local referring clinicians, traditionally staffed night hours operated by the hospitalist services, and increased communication across disciplinary and practice model lines. Shared gains were demonstrated through the effect of knowledge transfer between referring clinicians and hospitalists, as partner clinics fielded the greater majority of daily walk-in traffic for acute conditions otherwise addressed without need for emergency care in the Stadtspital Waid’s 24-hour triage unit.

Codourey notes that the approach was so effective in establishing a positive culture of collaboration between these diverse providers that in 2009 Stadtspital Waid constructed a small, bungalow-inspired clinic alongside the main entrance of the hospital to house the daily operation of the referring clinician’s practices. Through differentiating itself, both in design and operational strategy from what is generally expected in a hospital, the clinic succeeds in attracting customers totaling more than 60 percent of stationary patients in Stadtspital Waid’s care. Operating under the principle that followed care builds meaningful trust between a provider and patient, the admitting rights of the clinic’s providers required that upon admission to the care of the hospitalist service, care planning and discharge coordination were to occur
under the supervision of the bungalow clinician. Serving between 20 and 50 individuals daily, the clinic provides individualized care in cooperation with a larger infrastructure that has generated positive regard throughout the community. Cooperation with community physicians has increased the number of referrals to Stadtspital Waid and its affiliate clinic for case management, resulting in an increasingly aware and preferentially engaged customer base. (Codourey, 2013, p. 17)

In the spring of 2009, Stadtspital Waid sought to expand its ability to influence community health and wellness strategy throughout Switzerland through online communication platforms. The hospital was offered controlling interest in the operation of the State-hosted SeniorWeb services page in order to revitalize and provide permanent physician support for an online wellness forum and accepted the task with great optimism. A year of optimization work allowed Stadtspital Waid to deploy an enriched version of the platform in 2010, allowing Swiss citizens the opportunity to ask about a variety of health concerns anonymously and receive input from board-certified physicians. (Codourey, 2013, p. 18)

While the platform removes all personally identifying information from public postings, data collection regarding basic demographic and health histories
enable physicians responding to submissions to advise individuals in a one-to-one manner remarkably similar to traditional physician consultation. Codourey recalls the case of a 73 year-old Swiss man living in New Zealand who sought the advice of physicians in his home country regarding cardiac concerns he had yet to address with a local physician. Suspecting that the man was at risk for complications, the cardiologist made contact encouraging that he be seen at a local hospital immediately. The man survived and avoided cardiac emergency through the interventions recommended by a physician some 11,651 miles away. (Codourey, 2013, p.18)

While the Stadtspital Waid made no profit off of the case Codourey recalls, the impact of a regional hospital successfully exhibiting nationwide and international expertise demonstrates the power of a well-timed and appropriately placed nudge. Discretion, commitment to accessible care, and promotion of collaborative expertise had begun to allow a mid-size Zurich hospital to emerge as a leader in consultation and wellness advising services. Successful implementation of nudge marketing strategies had allowed a regional hospital to impact national public health performance. Stadtspital Waid had begun to establish itself, broadly, Zurich’s preferred provider through developing
a functional internal learning environment that engaged external concerns. (Codourey, 2013, p. 18)

In April 2011, Stadtspital Waid sought to engage a wider public audience in the promotion of the hospital’s varying services and opened the now annual Teddy-Klinik, inviting that young Zurich residents bring their stuffed animal friends for a checkup while touring the Stadtspital Waid with their parents. While the hospital did not have a children’s department or maternity ward at the time, the event uniquely offered parents and families the opportunity to become more comfortable with the hospital. Codourey celebrates the success of the event, as the trademark has now been licensed as a wellness promotion activity licensed for use in other hospitals.

Participants were guided through the entire hospital campus through a simulation that involved all aspects of a traditional hospital visit:

1. Check-In: At a welcome table, the child’s name and stuffed animal’s name and vitals are recorded in order to create a chart with the initial case details.

2. Participants wait in the hospital’s lobby with toys, entertainment, and information aimed at engaging the attention of adults accompanying their children throughout the event.
3. Physicians volunteered time to consult with the owners of the stuffed animals in order to understand the illness, accident, or problem presented. Conference with parents and children resulted in a diagnosis to be confirmed with appropriate testing.

4. During a tour of imaging, the stuffed animal has a sample x-ray image produced.

5. Anesthesiology and surgery confer with family and stuffed animal in order to prepare for surgery demonstration under covering sheet. If the child’s plush pet presented wear and tear, surgeons repaired damaged stitching, added stuffing, or performed small repairs.

6. Children assisted in the bandaging and care planning of their stuffed animals through outpatient therapy consultation in order to develop exercise plans to include playtime that benefited the activity levels of both stuffed animals and children charged with their care.

7. The children, accompanying parents, and stuffed animals treated throughout the visit were discharged through the hospital’s traditional protocol in order to familiarize all with continuing care
plan documents. A visit to the pharmacist required the filling of a candy prescription.

More than 2700 Zurich residents visited the TeddyKlinik during its one-day presentation in 2011. The treatment of 230 stuffed animals both promoted to goodwill for the hospital, and resulted in the issuance of licensing material. (Codourey, 2013, p.19-20)

More important than any revenue generated, effective nudging was demonstrated through the reduction and anxiety for children and creation of conversant space for families and individuals to begin to regard Stadtspital Waid as a preferred provider. Because of the growing popularity of the event “powered by City Hospital Waid,” smaller inceptions of the event have been staged in recent years to continue promoting engagement with the facility while managing costs associated.

Strategic planning managers for the hospital began to regard planned engagements with the public as viral marketing opportunities. Codourey notes that in 2013, strategic planning executives for the hospital began working towards participation in the largest city festival celebrating the contributions of local businesses, The Wümmetfäscht Höngg. In order to interface with community members, referring physicians, suppliers, and complimentary providers,
Stadtspital Waid set up a booth alongside artisans, restaurants, and other businesses in order to promote the hospital’s presence as a participating community-directed organization. (Codourey, 2013, p.21)

Having set up a market booth with a table, poster presentations, and brochures, Stadtspital Waid physicians offered demonstrations of laparoscopic surgical techniques developed by the Hospital by chief and senior physicians ready to engage the curious public and a portable rendition of the TeddyKlinik featuring anesthesiology demonstrations with flavored imaginary sleeping gas and surgery requiring the assistance of the present child.

In a deliberate effort to demonstrate the proximity of Stadtspital Waid, its clinical resources, and willingness to extend efforts to the benefit of the surrounding Zurich community, the distance between the booth’s location at the City center to the Hospital’s campus was presented through a banner at the entrance. The festivity hosted over 10,000 visitors and engaged conversations lasting as long as 42 minutes. The TeddyKlinik treated 300 pets, encouraging 280 children to learn through experiences aimed at reducing fear with parents and adult guardians simultaneously coming to appreciate the work of the Hospital along the way.
Codourey notes that the constructive action of the event provided a learning environment that was both able to engage a number of different consumer perspectives and educated about a number of different unique offerings of the Hospital. Building the municipal knowledge carried by participants, Stadtspital Waid successfully executed nudge marketing both in the event and hosting previously mentioned learning opportunities such as the online forum. Uniting the resources of clinicians with technical knowledge with the direct needs of Zurich residents in the market booth, TeddyKlinik, wellness promotion forum, and clinic contributed to the value proposition of Stadtspital Waid as a neighborhood provider. No less, the elements of forced gossip encouraged repeat visits to the TeddyKlinik for follow ups with stuffed animals and drew community attention to the variety of comparatively open platforms available for either passive or active engagement with the Hospital’s resources to the benefit of the community. Participants in the forum, visitors to the clinic, and those who toured the Hospital through the TeddyKlinik had the option to receive information or choose not to engage and enthusiastically participated. After the number of new visitors naming other’s experiences as the mechanism through which they learned of Stadtspital Waid’s innovations and the affirmations of repeat visitors, organizational acceptance of the marketing practices solidified
internal lines such that organizational support would be secured in order to continue promoting the provider as “the committed neighbor.” (Codourey, 2013, p.23)

Additional initiatives were launched following the successes of earlier events in an effort to increase the reach of the Hospital’s viral marketing efforts. Non-medical presentations were hosted on the Stadtspital Waid campus under the Waidfokus+20 banner, inviting the public to engage with largely undiscovered city resources in a new environment. Management were willing to host the series of talks unrelated to the direct medical practice since the Stadtspital Waid had already successfully provided presentation opportunities through members of its internal medicine, surgery, triage, geriatric care, and specialty departments. Codourey recalls the concept as further developing the desired perception of the Hospital as “the committed neighbor through an unlogical concept” (Codourey, 2013, p.23) Waidfokus+20 was structured to encourage public engagement through:

- Presentations of “unknown” specialists and the nature of their work in the City of Zurich and its administrative departments,
- Demonstrated links to impact of the presenter’s work to the lives of Zurich citizens,
• Duration lasting no more than 1.5 hours and including public Q&A, and

• An absence of marketing materials or presence from the Hospital.

When compared to previous efforts hosted by the Waidfokus+ medical presentation team, the Waidforum presentations utilized the Hospital’s presence in order to solidify the predominately social claim that the facility serves a dynamic icon representing innovative practices and supporting the whole health of the Zurich community. Hosting discussions ranging from personal security presentations from the City Police to Green City Zurich’s record breaking attendance of 250 patrons for a seminar covering the varying number of species that could be encountered within the City limits, residents of all ages, backgrounds, and interests were invited to visit the campus of Stadtspital Waid.

Codourey writes that the Hospital was happily surprised to find that the event appealed to young patrons who might not otherwise have but a limited opportunity to interface with the facility. Women were far more present than men, indicating that there may still be a demographic sector in need of targeted efforts. However, the urban population’s comfort with attending Waidfokus+ as entertaining, engaging events complimenting the various other evening activities
city life has to offer and self-reporting a significant willingness of 83 percent of attendees to recommend the event to others.

Focusing on the function of the Hospital as neighbor, employer, and community platform for knowledge transfer, residents can learn in a new environment directly about the topics named and the facilities themselves through indirect, passive contact. The constructive didactic identified by Codourey provides a positive learning environment about a variety of community resources while simultaneously affirming the positive impact of the provider and its partners in the life of the community. Open formatting allows participants to connect through the lens of their own experiences, ask questions organically provoked, and connect ideas to form new knowledge in the hopes that positive regard for the Hospital will be encouraged through the experience.

Codourey writes that the Waidfokus+ initiatives “created a kind of a ‘fanclub’” (Codourey, 2013, p. 23). With the creation of a marketing list of individuals interested in presentation schedules and engagement with the Hospital overall, Stadtspital Waid has successfully integrated itself into the life of Zurich residents seeking knowledge and, ultimately, reduced the number of residents who have never visited the hospital campus before.
Stadtspital Waid is pushing transformational marketing strategies through innovative methods to advance both its position as a provider navigating the various complications of reimbursement systems recently implemented by Switzerland. As described by Codourey, within the “predatory market of Zurich and Switzerland for hospitals will engage new ideas, and the public handshake and the pushed gossip as a method of viral marketing by the City Hospital Waid works better and better” (Codourey, 2013, p. 24). Enabling participants to engage their awareness through a variety of means may well result in performance difficult to assess in directly quantifiable forms – gossip – but has consistently proven to increase employee engagement, draw diverse customer demographics to interaction with the clinical environment, and increase community education overall.

Codourey notes that the management team “found out that viral marketing is connected to people,” thereby making the process equally unique and powerful. Connecting resources available in the emergency ward, surgery, clinic, or other departments of the Hospital to experiential learning and viral marketing was admittedly risky, but has proven to be a source of competitive advantage placing a small city hospital in the national awareness as an innovative leader.
Chapter Six: Proposed Framework for Mississippi Case

“Disparities in health can occur not only as inequalities in quality of and access to medical care but also as inequalities related to behaviors, environmental conditions, and societal opportunities.” – Cosby, et al., 2011, p. 3

Mississippi Context of Care: Activating Community Wellness Centers

The work of community wellness centers in the State of Mississippi has been the subject of inquiry by organizations ranging from the Center for Medicare and Medicaid Services to University of Mississippi Medical Center, as the facilities represent a unique opportunity among currently implemented intervention strategies aimed at reducing the impact of health disparities in the State. Exploration of the market to include a variety causes of current suboptimal delivery will allow for the examination of potential solutions in forming a hypothetical optimization engaging providers, policymakers, patients, and managers.

By way of example, The University of Mississippi Medical Center (UMMC) has become increasingly engaged in promoting telehealth service administration and e-visits with Jackson-based physicians as an opportunity for rural emergency departments to enrich the care offered in their own triage facilities.
Through growing the number of trained Nurse Practitioners and deploying a Teleemergency network, UMMC is not only expanding its network of care, but is allowing critical access hospitals to remain open and engaged in the care of their communities.

Underutilized in the current day, community wellness centers are a unique opportunity to provide telehealth services to community members in need of routine or preventative care that would otherwise be cost prohibitive to the individual, or incur an increased systemic cost when financed through public access initiatives such as Medicare or Medicaid. In either case, an effective optimization should increase opportunities for all Mississippians to have equitable access to healthcare services while reducing the number of emergency department visits for non-critical illnesses through comprehensive wellness strategies.

Referent Case for Framework: Kennedy Wellness Center in Charleston, Mississippi

In Charleston, Mississippi, the work of one University of Mississippi alumnae is actively engaging the community in promoting wellness in such a manner, reducing the impact of non-communicable diseases prevalent in the
area – hypertension, diabetes, and obesity. Dr. Catherine Woodyard of the University of Mississippi utilized community-based participatory research approaches to model individual and community health in developing a formative needs assessment in Charleston, Mississippi in 2013. Engaging in bi-directional communication aimed at simultaneously educating and learning from community members, Woodyard identified health concerns affecting the community to include obesity, diabetes, hypertension, asthma, stroke, cancer, stress, depression, prescription drug non-compliance, heart disease, lack of access to health care, lack of access to healthy foods, and lack of health knowledge. The greatest social concerns identified were high school dropout rate, teen pregnancy, poverty, domestic violence, poor housing, alcohol abuse, drugs, smoking, no jobs, lack of education, illiteracy, and few social opportunities. Findings revealed the environmental concerns were chemicals from farming, smoking, the water supply system, and the lack of recycling available in the community.

Woodyard writes of the original project, that intended outcomes included developing a comprehensive, sustainable network of community partners to improve public health outcomes, identification and prioritization of health issues, presentation of community-identified needs in comparison to resources
available, assessment of the physical and nutritional environment, and an evaluation of public health policy. In establishing the need for comprehensive provider resources in Charleston, Woodyard successfully demonstrated the need for a wellness promotion agent within the community. I similarly aim to propose a model for intervention to be examined for its potential efficacy throughout the State.

Community wellness centers and health promotion agencies, such as the Kennedy Wellness Center in Charleston, MS will serve as the primary actors in implementing the work of screening, referring, and managing current individual wellness and health-related social concerns. Where there are community identified and ranked health and health-related social concerns and an able community partner to begin linking available resources from clinical and social venues alike, a unique opportunity to shape the implementation of wellness promotion strategy and public policy may reduce total health care costs and optimize outpatient care utilization. In addressing the unmet needs of community stakeholders, the model integration will (1) evaluate the health effects of community services that address specific health-related social needs (e.g., housing problems, food insecurity, and the like); and (2) evaluate of approaches to link patients with community services.
Health concerns identified by Charleston residents during the community needs assessment include a variety of conditions — obesity, diabetes, hypertension, asthma, stroke, cancer, stress, depression, prescription drug non-compliance, heart disease — many preventable, or well-managed, through comprehensive wellness services. Inactivity, poor nutritional hygiene, and other lifestyle factors increase both the prevalence and severity of these diseases, and are among the primary social causes identified – high school dropout rate, teen pregnancy, poverty, domestic violence, poor housing, alcohol abuse, drugs, smoking, no jobs, lack of education, illiteracy, and perceived lack of social opportunities within Charleston. Resolving both health and health-related social needs through the established venue of a wellness center with comprehensive abilities enjoined with Tallatchie General Hospital in Charleston, Mississippi would benefit community residents and proposes an option for adoption across the state.

The resource of a multi-million-dollar flagship wellness center within Charleston offers access to education, disease prevention, and wellness-management resources unparalleled in the community. Where the Kennedy Center is uniquely able to engage with Charleston and surrounding residents as a neighborhood advocate for public health promotion, the Center can potentially
engage in public influence activities to continue establishing itself as a location where community members can bring their children to play on a safe playground; walk, bike, or run through paved and well-lit trails; take an exercise class; learn to monitor their blood sugar, A1C, or blood pressure; get tested for HIV and receive sexual wellness services without visiting a specified provider; and be encouraged to promote wellness in their everyday lives.

Centralized expertise in a variety of clinical disciplines supported by the comparative anonymity afforded by the Center’s variety of daily exercises decreases the barrier to care most prominently created by stigmatization of illness. Moreover, the perception of the Emergency Department as both first and final step necessary to protect one’s health is dangerous to the individual seeking care — many cases should be discovered as gradual trends indicate a variance in individual patterns. By way of example, it is far better to assess and address hypertension before an individual suffers a stroke. Having an opportunity to be held accountable for wellness activities outside of the frame of their immediate clinical care team and the ability to seek acute care through a variety of services, residents at risk in Charleston are more likely to improve their health and that of their whole community.
As indicated by the successful integration of public wellness promotion strategies in the City of Hernando, the capability of wellness centers – be they in thought or, ideally, physically present as in Charleston – to activate and affect change. Promoting education, supporting nutrition access and awareness, and preventing interpersonal violence are not the traditional roles of clinicians employed outside established venues of social services. The ability of the Kennedy Center to shape the daily lives of residents, however, affects socially-relevant health determinant behaviors and antecedent conditions through forming meaningful relationships and engaging as a neighborhood partner in service of the community.

Moreover, the adaptability of the model integrated throughout the Swiss Stadtspital Waid case indicate that public handshake, forced gossip, and public entrepreneurship may complement one another in being applied to efforts aimed at addressing the overall health conditions plaguing the State of Mississippi. Where providers can extend their own resources across disciplinary lines, collaborative efforts are activated to form networks that empower managers, policy makers, and consumers alike to prefer the most efficient distribution of care. Hernando’s officials produced positive returns utilizing minimally invasive means through the implementation of public entrepreneurship to the extent that
an exchange of information allowed for the collective development of prioritizations which reduced healthcare costs and improved quality of living. Recalling the sentiments of Klein, “the success of public entrepreneurship depends on the ability of social entrepreneurs to obtain legitimacy from members of the community for collective actions involving their voluntary resource mobilization and engagement” (Klein et al., 2009). As the Kennedy Center activates meaningful opportunities to increase knowledge, engage in care activities, and access comprehensive wellness services, the support it enjoys as an institution embodying public entrepreneurial leadership should be expected to increase, as indicated through the enduring success of the Stadtspital Waid and its clinical partners.

Policies modeled after the initiatives of Hernando, Mississippi city leadership should be implemented in public and private ventures alike in order to allow managers to function as choice architects engaging in the overall health of their respective workforces and communities. These efforts complement the educational events and marketing orientation presented by Codourey, suggesting that municipalities and organizations alike should engage in assessment of their community’s health and health-related social concerns and
begin to shape marketing messages and activities that enrich their ability to interact with consumers on an individual level.

Referencing the five dimensions of framework listed previously, the following activities are crucial to integrating the wellness center as a prevention effort:

- **Awareness** - Community initiatives to educate and promote prevention and management of conditions named in community needs assessment conducted by Woodyard will engage obesity, diabetes, hypertension, asthma, stroke, cancer, stress, depression, prescription drug non-compliance, and heart disease screenings;

- **Assistance** - Beneficiaries will receive wellness management instruction and consultation across professional disciplines and will be encouraged to participate in community wellness activities hosted through social institutions and the Kennedy Wellness Center in order to establish connectedness among resources and promote awareness of availability;

- **Alignment** - Referral and navigation services to at-risk individuals will better integrate community and clinical activities in order to promote overall wellness and will lead to immediate management of current diagnoses and clinical management plans;

- **Integration** - Overall linkage between daily living activities, community organizations, and health care providers will increase engagement across the disciplines; and

- **Continuation** - Assessment of the systemic and sustainable impact of implemented projects will be ongoing.

Enjoying the support of a completed community needs assessment to guide the efforts of its operation, the Kennedy Wellness Center should begin evaluating the
perception of its offerings, identify objectives for care improvement and the gap separating current levels of performance from the desired outcome, and plan for the implementation of innovative public entrepreneurial leadership to the benefit of its supporting community. Where Bitektine, and others, have provided the analysis supporting proscriptive case study design, the primary recommendation of this author is to design, implement, and evaluate a nudge framework of promotion, education, and care provision in rural Mississippi providers. Initial deployment of the activities described should take place in such an environment as exemplary Kennedy Wellness Center because of its integration with clinical resources, established needs assessment, and ability to begin defining its relatively young identity as a provider.
Chapter Seven: Discussion

“Success consists of constancy to purpose.” – Benjamin Disraeli

In the first section of this chapter, I will summarize the development of a nudge framework of public entrepreneurial leadership to the benefit of public healthcare management practice in the State of Mississippi. Morally relevant dimensions necessary to present a complete discussion of the use of nudge frameworks will be provided before examining the overall implications of framework implementation. Summarizing policy recommendations will close the chapter alongside stating future implications of this thesis for future research on public entrepreneurial leadership in healthcare management in the State of Mississippi.

Summary of Nudge Framework for Public Entrepreneurial Leadership

Maurice Codourey reports in a 2013 edition of the journal *Economics & Sociology* how the nudge is being utilized to better integrate the abilities of Swiss public hospitals in presenting the provider as an institutional citizen engaged in public entrepreneurial leadership through the variety of unique marketing and service offerings made available to the consumer public. Through the exemplary
case of Stadtspital Waid, principles of nudge leadership have been illustrated as both applicable and effective when considering public influence mechanisms available for the use of improving public health outcomes. Moreover, where the organization is able to garner community support, the efficacy of its efforts increases, both in terms of the direct reach and positive regard enjoyed by the provider. To this end, Klein, et. al (2009) write that, “The success of public entrepreneurship depends on the ability of social entrepreneurs to obtain legitimacy from members of the community for collective actions involving their voluntary resource mobilization and engagement.” Public participation in events and utilization of clinical resources outside the emergency departments and specialized venues of the hospital in the case of acute need demonstrate that, while a comparatively small provider, Stadtspital Waid has implemented innovative methods of exerting public influence and emerged as a leader.

Social, economic, geographic, and political forces have continued to affect the delivery of healthcare in comprehensive, preventative schedules throughout the State of Mississippi and surrounding region, and demonstrate that three factors have emerged as particularly prominent in the work to achieve universal access to primary care: 1) the ability to access comprehensive, preventative care; 2) negative perceptions of the Affordable Care Act and similar reform efforts on
the part of state and federal agencies; and 3) evolving reimbursement structures affecting the revenue streams of providers. Through present case analysis and the evaluation of prior indications, case study designs solidify the need for the development of a public model for entrepreneurial leadership in order that the overall delivery system for healthcare in the State of Mississippi continue to innovate and improve.

**Implications of the Nudge Model for Public Entrepreneurial Leadership**

Woodyard, et. al. (2015, p.2) write that there have historically been disconnections preventing a researcher from engaging their subject entirely which are reduced through community bases needs assessments such as that conducted in the development of the exemplary case of the Kennedy Wellness Center in Charleston. Modeling public entrepreneurial leadership to innovate both research methodologies and functions as an established provider, Woodyard, et al. (2015, p.2) reflect on the power of establishing a functional leader-follower relationship within the domain of public health research:

“Historically, instances of collaboration between researchers and community members have been formalized to address and improve the health and social issues facing communities in need. With limited data and minimal knowledge of the community, developing services and programs to provide quality education and access to resources conducive to health are challenging. Furthermore, rural communities often present unique challenges for the sustainability of public health programs and outcomes due, in part,
to resource limitations common in small communities (Downey et al., 2010). Thus, the use of CBPR provides a means to develop community capacity and engagement, thereby enhancing the potential for sustainability and effectiveness of health programs and outcomes.”

As the Kennedy Center was established through the use of community-based research which engages the municipal intelligence in forming a model of salient issues and priorities, the function of the organization would profit from the implementation of a comprehensive public influence framework continuing the tradition of public leadership established through the meaningful, bi-directional exchange process of community-based research. As Woodyard, et. al. (2015, p.3) write, “A critical component in creating strong community partnerships is the use of CPBHR as it allows community members, community leaders, and university researchers an opportunity to collaborate and participate actively in the research efforts.”

**Regarding the Morality of the Nudge**

Opponents of the use of public influence mechanisms such as the nudge argue that there are moral implications inherent to affecting the ability of individuals to completely freely exercise their self-determination. Among such thought leaders is French economist Giles Saint-Paul of the Toulouse School of
Economics. In his 2011 *The Tyranny of Utility*, Saint-Paul argues that rational function of the individual, as an immutable right, is disregarded through the use of paternalistic means. He writes to this end that:

“[F]or individuals to be rational it must be that they are unitary – in other words, that they have a unique ‘self.’ That means that their behavior is driven by consistent preferences, which allows them to rank alternatives. Otherwise, the very notion of their best interest would not be defined” (Saint–Paul, 2011, p.12)

Saint–Paul asserts that social policy should not be the mere product of utilitarianism directing that society should be organized so as to yield the greatest level of welfare precisely because of the reliance on governmental agency as a regulatory presence. While economists have long argued alongside Saint–Paul that there should be limits to the utilitarian interventions promoted by governments, as individuals inherently know what is the best course of action as it can be related to their wellbeing. The work of behavioral economists, Saint–Paul asserts, dilutes the will of the sovereign individual in determining the course of their daily lives. Writing that governmental intervention cannot be defended on purely instrumental grounds, Saint–Paul writes for individual liberty to be restored as a central value in our society. He compares the current condition to Robert Louis Stevenson’s *The Strange Case of Dr. Jekyll and Mr. Hyde*, poignantly indicating that “the choices made by Mr. Hide during the night harm Dr. Jekyll
during the day”. And “this composite individual is not unitary: there is no meaningful sense in which one could say that he acts in his own interest. If people are not unitary but instead like Stevenson’s monster consist of several incarnations, imposing the discipline of individual responsibility on them fails both morally and operationally”. Concluding that “it is unfair to punish Dr. Jekyll for the deeds of Mr. Hyde, and it does not work to threaten Dr. Jekyll with punishment to convince Mr. Hyde to act otherwise,” Saint-Paul seeks to reduce the number of instances in which public influence is exercised to correct perceived failures, biases, and individual inconsistencies.

Previously cited literature produced by Blumenthal-Barby and Burroughs presents the morally relevant dimensions of utilizing the nudge in healthcare contexts through engaging the amount of incentive offered, whether the incentive will result in a disadvantage to those who do not meet the performance objective, how the incentive will affect those in most need, whether or not the incentive will affect the patient–physician relationship, and whether or not the incentive is fairly directed (Schmidt, Voight, and Wikler, 2009 qtd. in Blumenthal-Barby and Burroughs, 2012, p. 2). Delineating nudge leadership from instances in which public influence constrains the ability of targeted populations in
functioning as a shove, Blumenthal-Barby and Burroughs (2012, p.8) present six dimensions of ethical consideration:

1. **Incentives** – The amount and kind of incentive offered should not disadvantage those who fail to meet the performance objectives and should be structured so as to not constrain the patient–provider relationship. Where the incentive is fairly directed, beneficiaries will freely elect to seek improvement of their health rather than becoming motivated through the perceived threat of loss.

2. **Defaults** – Individuals should be aware of the presence and intention of defaults, and the defaults selected should not presume elections which would be disadvantageous to the influenced population.

3. **Salience and Affect** – Balance in presentation should be encouraged through the selection of influence mechanisms that are neither grossly exaggerated nor likely to be perceived as negative.

4. **Norms and Messenger** – Factual representation of intended influence structures and motivational mechanisms should be
structured such that power is not disproportionately concentrated in the hands of influencers.

5. Priming – The average individual should be able to seek the direction influenced for the achievement of evidence-based goals through justified subliminal messages preferred over direct argument. That is, there should be substantial reason to prefer subconscious priming over explicit description to the benefit of the common good.

6. Escalation of Commitment – Influence mechanisms should refrain from the use of the ego over logical appeal and should discourage individual commitments to short-term ends, preferring long-term benefits.

Where the use of a nudge framework can successfully integrate the concerns described above, morally sound applications of public influence have been performed. Blumenthal Barby and Burroughs (2012, p.9) “encourage policymakers, healthcare providers, and others to consult and consider these dimensions before they employ techniques from behavioral economics and behavioral psychology.”
Future Research Directions

The use of a nudge framework of entrepreneurial leadership to be developed and disseminated to the benefit of public health care management in Mississippi is encouraged by the successful implementation of public innovation throughout the State and in international demonstration of private adoption of nudge promotion methodologies. Municipalities and private facilities, policymakers and practitioners alike should engage in the discourse surrounding the development of nudge frameworks and should similarly solicit community input as frequently as possible. While the realization of comprehensive care in Mississippi is not yet a reality, better connected present resources and informed consumers are more prepared to address the extant conditions affecting delivery in the status quo. Aligning knowledge of wellness management with positive attitudinal perception of healthcare through the use of my framework would enable more individuals to make sound decisions about their health, and the State would increasingly become healthier overall.
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