Volume 1, Issue 6 September 2014

Population Health NEWS

Standards Guide Medical Respite Care Programs

by Henry C. Fader, Esq.

The homeless population becomes invisible to most, but to healthcare institutions, especially emergency departments, there is never a relief from homeless individuals reaching their doors through walk-ins and by ambulance. The cost of their care can be expensive since the homeless typically do not have a primary care physician or nurse practitioner available to them.

This subset of the general population of the community ends up having a disproportionate share of healthcare emergencies due to chronic conditions and readmissions after initial treatment. Discharge policies relating to the homeless vary among hospitals, some of which might be reluctant to release homeless patients back onto the street or homeless shelters knowing the difficulty they might have complying with medical follow-ups and appointments.

A number of communities have joined together in an approach to organize a medical respite facility in their communities. Not to be confused with long-term acute care or caregiver respite, "medical respite" is acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital."[1]

In effect, this short-term care model permits homeless individuals to recover while giving them access to medical assistance and other supportive services that they need to improve their health and outlook. These facilities vary in terms of physical size, location and funding and range in type from facilities housed in homeless shelters or nursing homes to freestanding buildings. In some communities, motel properties house patients, and local home health and community health centers provide medical services.

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Population Health Requires Healthcare Optimization

by Eugene Litvak, Ph.D.

Shifting the focus of healthcare in America to population health requires a move to healthcare optimization. That's because the capitation underlying payment for population health will not be sufficient to support the excesses created by unwarranted numbers of procedures and building beds to accommodate peak demand—both common practices that capitation is meant to control. Fortunately, the tools needed to make that shift are known. Some are even in place, while others must still be added.

Healthcare optimization is the application of proven techniques of managing operations and patient flow to hospitals, as well as out-patient facilities and medical practices. It's crucial to ensuring quality, safety and efficiency while these operations are optimized.

Optimization increases patient access to existing facilities to ensure their maximum benefit while avoiding unnecessary new construction. It modifies the peaks and valleys of patient flow to smooth the care and improve patient experience.

Building to the peaks has been a prevalent practice among healthcare providers nationwide, which involves constructing as many hospital or clinic beds as needed to accommodate the highpoints of patient activity. That scenario creates inefficiencies, as the healthcare facilities are then underutilized during valleys of activity.

The peaks also create their own logjams, as high volumes for different activities are often not aligned. The notorious overflow in emergency rooms, for instance, is typically caused not by the volume of patients there but by the unavailability of beds when they leave the emergency room. Thus, the peaks in one part of the hospital create stoppages in other parts. And too often the solution has been to build more beds in both parts, magnifying the inefficiencies further.

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Population Health News
September, 2014, Volume 1 Issue 6
ISSN Print (2333-9829)
ISSN Electronic (2333-9845)

Publisher
Clive Riddle, President, MCOL

Editor
Mari Edlin

Population Health News
1101 Standiford Avenue, Suite C-3
Modesto CA 95350
Phone: 209-577-4888 | Fax: 209-577-3557
info@populationhealthnews.com
www.populationhealthnews.com

Population Health News is published monthly by Health Policy Publishing LLC. Newsletter publication administration is provided by MCOL.

Making a Case for Population Health

A Selected Case Study in Population Health Management…

Sixteenth Street Community Health Centers—Caring for the Hispanic Population

by Julia Schuller, M.D.

Program Objectives: Sixteenth Street Community Health Centers based in Milwaukee, Wisc., developed a program with objectives focusing on managing the health of the Hispanic population in several key areas: behavioral health, obesity and chronic conditions including diabetes and asthma.

Behavioral health:

- To provide immediate and integrated access to high-quality behavioral healthcare alongside physical care.
- To align treatment for mental and physical comorbidities, such as depression and diabetes, attention deficit hyperactivity disorder (ADHD) and pediatric care.

Obesity:

- To combat obesity by educating and motivating families to adopt healthier behaviors.
- To develop community leaders and health promoters, who work to increase access to healthier food and physical activity in the neighborhood.

Chronic conditions:

- To better manage diabetes and asthma through patient self-management education and support.
- To reduce and delay the negative health effects of diabetes and asthma by early identification, intervention and care management.

Program Description: Sixteenth Street Community Health Centers serves a largely low-income Hispanic patient population. The behavioral health model began in 1998. Chronic care management for diabetes patients started in 2003 and added asthma the following year. Healthy Choices/*Elecciones Saludables* obesity intervention program launched in 2011.

Behavioral health: Integrated teams of primary care physicians (PCPs) and 19 bilingual, bicultural behavioral health clinicians, residing on the same floor, quickly address concerns. If a physician notices mental health issues during an appointment, he or she can inform clinicians down the hall and bring them into the room. In pediatrics, for example, clinicians walk parents through their child's ADHD questionnaire during their scheduled appointment.

Mental health staff often collaborates with other departments, for example, helping diabetic patients with stress management and relaxation therapy. The focus is on intervention and relief, rather than complicated appointments many patients might fail to attend. The model combines pre-scheduled appointments and crisis sessions recommended by PCPs on an as-needed basis.

Obesity: In the United States, 32% of children between ages 2 and 19 are overweight or obese, but in the Hispanic community, it rises to 40%.[1] For adults in Sixteenth Street's Latino Community on the south side of Milwaukee, the prevalence is an alarming 77%. Sixteenth Street created the *Elecciones Saludables* program, which emphasizes healthy eating and physical activity, with the goal of reversing the obesity epidemic.

Elecciones Saludables includes two connected components: a 12-week family education program to promote behavioral changes in children and adults, and the development of community leaders who strive to maintain a healthy community, expand education and advocate for access to healthy food and safe venues for physical activity.

The 12-week program offers age- and culture-appropriate nutrition education and teaches stress management, healthy cooking and activities, such as Zumba and Nia. The community leadership and advocacy program started in 2012 with the creation of "Latinos por la Salud," a group of community members who champion health initiatives impacting the whole neighborhood.

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This group, along with Healthy Choices staff, led a Healthy Grocery Store Campaign to introduce new healthy foods into neighborhood grocery stores and provide parent education in local schools.

Chronic conditions: Sixteenth Street provides specific education to help patients manage their long-term health through the Chronic Care Model. Elements of this disease-specific model include self-management support, delivery system design, decision support and clinical information systems.

By leveraging technology, expanding access to health education and adopting evidence-based clinical guidelines, Sixteenth Street moved from episodic care with inconsistent education and tools to planned care with collaborative follow up, comprehensive education and goal-oriented charts, along with patient self-management plans.

Diabetes support classes address topics from basic skills training to emotional health to exercise. Asthma patients receive a severity assessment test and a home assessment to identify environmental triggers that could worsen their condition. Patients and families can access quality education in *their* preferred language in *their* community.

A volunteer corps of veteran chronic care patients, known as Community Health Workers, receives non-credentialed training and acts as a key resource among neighbors, extending the clinic's influence beyond building walls.

Evaluation process: In addition to metrics tracking and other internal evaluations, Sixteenth Street reports data to the Wisconsin Collaborative for Healthcare Quality.

Results

Behavioral health: In 2013, Sixteenth Street conducted more than 18,000 individual mental health sessions. Because patients trust their PCPs, they react more favorably to the personal recommendation and introduction to a behavioral health colleague in the same room. Since behavioral health care is integrated with physical care, the model also reduces fear and stigma. Patients don't need to leave the building or schedule a separate mental health visit that might draw judgment from friends or family. This convenience also helps with treatment follow through.

Obesity: During *Elecciones Saludables'* four years, 220 families have completed the program and hundreds more have been positively affected by the education and neighborhood initiatives. Promising results for BMI reduction and behavioral changes present opportunities to replicate the model locally and nationally. Approximately 68% of participating adults and 29% of children lost weight, and more noted increased consumption of fruits and vegetables, reduction in soda and fast food intake and increased physical activity. An estimated 53% of adults and 35% of children decreased their BMI, and especially important for this patient population, 94% of families spent the same or less on food after making healthy changes. Beyond the direct health benefits, *Elecciones Saludables* fosters the "creation of community." Many immigrant families face social isolation, segregation or hostility, but the program has united different ethnicities and cultures.

Chronic conditions: Approximately 80% of 3,000 diabetic patients and more than 2,500 asthma patients have seen their PCP at least twice in the last 12 months, and nearly all diabetes patients (97%) have established a self-management goal. The clinic matches the national standard for A1c levels while caring for a particularly challenging population in which many patients need to manage their conditions solely through diet and exercise because they cannot afford medications. For 40% of patients, A1c levels are at or below 7%, while 77% reported their hypertension was under control. For asthma patients, an estimated 88% received a severity assessment with appropriate medication prescribed, and nearly a quarter opted for an in-home assessment of environmental triggers. About 40% have an asthma action plan in their electronic health record (EHR).

Lessons learned

Behavioral health:

- A robust EHR system allows for more effective tracking of outcome measures specific to behavioral health.
- When working on an interdisciplinary team, clinicians must be flexible. Communication skills and confidentiality savvy are a must.

Obesity:

- Any program seeking to positively impact food and physical activity behaviors must focus on the ***whole family***, and offer education adapted to the age and culture of participants.
- It's important to teach "why" a change is needed in addition to "what" that change should be.
- Instead of working for the community, organizations, coalitions and programs should work ***with*** the community to generate a common message and action around health.

Chronic conditions:

- Self-management education is the cornerstone to the success of living well with chronic health conditions.
- Metrics from the EHR inform proactive programming, monitor success and support patient-centered care.
- Engaging patients, their families and the community in understanding risk factors related to diabetes and asthma helps move the needle toward prevention and early intervention.
- The Community Health Worker Volunteer Program is an important connection to the community.

[1] "Latino Child Obesity." *Salud America!* 2013.

Julie Schuller, M.D., is the executive vice president and vice president of clinical affairs for Sixteenth Street Community Health Centers. Tatiana Maida, Holly Nannis, R.N., Francisco Enriquez, M.D., Maria Perez, Kathleen Donovan and Liz Claudio also contributed to the article. For project information, contact: Ellyn McKenzie at ellyn.mckenzie@sschc.org or Alison True at alison.true@sschc.org

Standards Guide Medical Respite Care Programs … *continued from page 1*

At last count, the National Health Care for the Homeless Council found 70 medical respite programs in existence in 29 states with many more under development.[2] Medical respite is funded by a variety of methods, including per diem payments, bed reservation agreements, donations of funds and services from hospitals and health systems and grants from local government entities. Due to the vastly different structures and services being provided in these communities, payment for services by third-party payors and government sources, such as Medicare and Medicaid, has not been available.

While there have been findings that demonstrate that cost of care at medical respite facilities compares extremely favorably with acute care or emergency department treatment, stronger research is needed to support that position.[3] With the focus on quality of care throughout healthcare today, including the need for better care coordination for the population, it has been recognized that there are currently no uniform standards for medical respite care. This is particularly frustrating for communities desirous of starting their own respite programs, as well as currently existing programs attempting to improve their current offerings.

In November 2011, the Respite Care Providers Network (RCPN) began an effort to develop a universal set of standards for medical respite programs, which were released in January 2014.[4] The standards apply to programs with limited resources and encourage medical respite programs to grow both in size, quality and breadth of service, as well as assisting in increasing care coordination and quality of care and reducing cost of care for the homeless population.

In its public statements, the RCPN provided its rationale: "A universally adopted set of standards will not only improve quality and health outcomes, but will improve research and opportunities for more stable funding."[5]

There are currently seven medical respite standards released by RCPN[6] that are designed to encourage medical respite facilities to exceed the standards if they have the resources and initiative to perform at higher levels. The proposed standards are:

SEVEN STANDARDS FOR MEDICAL RESPITE CARE

1. ***Safe and quality accommodations.***
2. ***Infectious disease/biomedical waste safety.***
3. ***Safe and timely care transitions.***
4. ***High-quality patient care.***
5. ***Staff that can assist patients in utilizing the healthcare system.***
6. ***Discharge planning.***
7. ***Data collection and continuous quality improvements.***

Standard 1. Medical respite programs provide safe and quality accommodations. Since these programs vary in physical facilities and amenities, this standard was developed to ensure that the focus is on safe spaces for operations and patient care. Requirements are providing beds 24 hours a day, accessibility and three meals a day and promoting personal hygiene by offering laundry facilities and showers. Programs also must meet local sanitary standards and ensure that staff and patients understand emergency plans. The standard requires the program to have a code of conduct for its residents.

Standard 2. This standard focuses on safety, including the ability to manage infectious disease, appropriately handle biomedical and pharmaceutical waste and generally follow local, state and federal guidelines for clinical operational issues. Because patients arriving in medical respite programs typically have prescriptions or medications provided to them upon discharge, there needs to be policies and procedures in place for the storage, dispensing and disposal of medications. Typical healthcare standards for reducing exposure to blood-borne disease and bodily fluids need to be in place. As for communicable diseases, policies and procedures must be provided to ensure diseases are identified and not transmitted to others and if required by law, reported to public authorities.

Standard 3. Providing safe and timely care transitions is a key to medical respite care, including being aware of patients' conditions; ensuring they are appropriate for the program; giving homeless patients an option to choose medical respite care after discharge from a hospital; and education and training of staff at referring facilities. Making medical respite a valid choice for transfer requires the involvement of medical personnel in the admission process. Programs should have written transfer agreements to establish the necessary relationships and protocols.

Standard 4. This standard focuses on ensuring high-quality patient care from medical respite providers and should include an individualized care plan for each patient. Maintaining a collaborative, multi-disciplinary team is encouraged. Medical professionals should overlook the care of patients, share observations and discuss patient progress toward goals. Providers should follow evidence-based, clinical practice guidelines and integrate alternative treatments when necessary.

Standard 5. Medical respite programs are uniquely positioned to coordinate care for a complex population of patients, who may otherwise face barriers to adequately navigating and engaging in support systems. As a result, medical respite facilities are encouraged to hire staff that can assist patients in utilizing the healthcare system, coordinate with primary care providers, establish follow-up appointments and arrange for transportation. This standard also establishes case management services to help patients access permanent housing based on their needs and make referrals to community support groups for mental health and substance abuse counseling.

Standard 6. As with other inpatient clinical settings, there is an emphasis on discharge planning for each patient upon admission. The standard sets forth the requirements for discharges policies, prior notice of discharge, follow-up care and appointments, aftercare instructions and discharge medications. Policies and procedures must be in place to properly safeguard and transfer patient information in accordance with HIPAA and any other confidentiality laws and policies.

Standard 7. Medical treatment of the homeless is sometimes a daunting task for clinical providers. This standard requires that medical respite programs collect data and continuously make quality improvements to the level of care provided. The standard recommends self-audits of programs and encourages making changes to operations as needed using various clinical tools. In addition, the standard outlines requirements for validating clinical staff credentials, establishing job descriptions and ensuring competency. If medical providers work outside of the respite program, their roles and responsibilities should be defined.

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Population Health Requires Healthcare Optimization … *continued from page 1*

That solution was viable, however inadvisable it may have been, under a "cost plus" reimbursement scenario. With the shift to population health, the focus will be on keeping people out of the hospital. In that case, the relative height of the peaks should fall in the first place, but the need to smooth the peaks and valleys will become even more crucial for two reasons. First, it will be even harder to justify the empty beds in the valleys. Secondly, the peaks—where staffing is inevitably most over-taxed—are where the greatest incidences of medical errors, readmissions and even mortality typically occur.

"…the need to smooth the peaks and valleys will become even more crucial for two reasons. First, it will be even harder to justify the empty beds in the valleys. Secondly, the peaks—where staffing is inevitably most over-taxed—are where the greatest incidences of medical errors, readmissions and even mortality typically occur."

Smoothing the peaks is not just a matter of efficiency or even cost-savings; it's essential to achieving the uniformly high-quality care that healthcare providers should deliver. That is a core goal of population health.

An article published in the *Joint Commission Journal on Quality and Patient Safety*[1] says, "Increases in adverse clinical outcomes have been documented when hospital nurse staffing is inadequate.

Since most hospitals limit nurse staffing to levels for average rather than peak patient census, substantial census increases create serious potential stresses for both patients and nurses. By reducing unnecessary variability, hospitals can reduce many of these stresses and thereby improve patient safety and quality of care."

Fortunately, the techniques of operations management and patient flow are proven. They must now be applied more consistently to healthcare providers across the nation.

The evidence of the techniques' compelling impact is clear. The New Jersey Hospital Association, for instance, recently joined with the Institute for Healthcare Optimization in a 15-month, 14-hospital, patient-flow collaborative as part of the Center for Medicare and Medicaid Innovation's hospital engagement program. The results were dramatic:

- Additional patients—11,800 to 17,300—were treated without adding inpatient beds or operating rooms.
- Hospital emergency departments accommodated roughly 20,000 additional patients.
- Wait times for emergency department patients to be admitted to a hospital bed decreased 21% to 85%.

To implement healthcare optimization within healthcare systems—or across multiple systems as was the case in New Jersey—new analytical tools are often needed.

The basic infrastructure is growing rapidly nationwide because of the federal government's commitment of nearly $20 billion to the widespread adoption of health information technology by healthcare providers. That is expanding the core systems needed for effective data collection and analysis dramatically.

But for the most part, electronic medical records (EMRs) are utilized for the collection and accessibility of clinical information on patient health and care, as well as to reconcile that information. Typically they don't provide the data needed for healthcare optimization.

Information on a patient's condition, for instance, will not tell who needs access to what care and when. It also does not reveal how long the care will be needed.

For healthcare optimization, it is necessary to find out how long a particular patient will be in a particular bed, how many people need to see a certain doctor or receive a certain procedure on a particular day and where that patient will go afterwards.

Scheduled procedures must be separated from emergency ones so that holding capacity for emergencies doesn't interfere with the efficient scheduling of elective surgery. The crucial distinction is between practice (the delivery of care) and need (the demand for care).

Understanding the need is crucial to optimization: the need for beds, for procedures, for particular physicians. If the need is properly understood, then the demand can be accommodated and scheduled with precision, and that precision can in turn yield the desired optimization.

"Understanding the need is crucial to optimization: the need for beds, for procedures, for particular physicians. If the need is properly understood, then the demand can be accommodated and scheduled with precision, and that precision can in turn yield the desired optimization."

There are three keys to understanding the need. The first is typically available: a system of EMRs to capture and make accessible the required data. The second is new data that often necessitates modifications to booking and scheduling systems, as well as adaptations of the EMR system to incorporate needed fields. The third is the active engagement of healthcare staff, whose inputting of that data is essential.

The good news is that implementation, while demanding, is not arduous, and the direct improvement that stems from it is quickly evident and inspiring. That improvement benefits the healthcare system, its staff and its patients. It's a win-win-win, and one that will need to be celebrated widely for population health to become a reality.

[1] Litvak E, Buerhaus BI, Davidoff F, Long MC, et al. "Managing Unnecessary Variability in Patient Demand to Reduce Nursing Stress and Improve Patient Safety." *Joint Commission Journal on Quality and Patient Safety.* June 2005; 31(6):330-338.

Eugene Litvak, Ph.D., is president/CEO of the Institute for Healthcare Optimization and adjunct professor, Harvard School of Public Health.

Informed Consumers Make Right Choices

by Brandon Cady

The consumer has never had so much influence in this country. From Amazon to AppleTV and Roku to Airbnb and Uber, consumers are disrupting longstanding business models in publishing, entertainment, hospitality and transportation and many would argue, getting a much better value for same or higher quality services.

But what about healthcare? Where is the revolution?

It is little wonder that consumers are confused about what goes into the bill for healthcare services when news reports abound with details on wide variation in prices for diagnostic tests, surgical procedures and drugs—even in the same city. According to a recent *New York Times* article[1] on why consumers should know the price of medical tests, the most common argument against providing upfront prices for these services is that patients are less educated consumers of healthcare and tend to assume that high prices mean better quality.

For imaging specifically, the vast majority of consumers haven't known that they had a choice in where they receive their out-patient diagnostic tests—a key issue in driving affordability. In fact, in a survey[2] asking health plan members how willing they would be to select a set of doctors, hospitals or clinics if they could save 10% to 15%, as many as 65% indicated they would likely make a change specific to an MRI or other high-level scan. While the escalation and variation among imaging costs have been widely reported in journals, industry magazines and even mainstream media in the past few years, the gap persists.

"U.S. medical spending has almost doubled in the last decade, reaching $2.6 trillion in 2010, according to government statistics. A brain MRI, for example, can range from $504 to $2,520."

A report[3] estimates MRI use at about 62 MRIs per 1,000 in the commercial insured population, which means that about 6% of commercial members will need an MRI in a given year.

U.S. medical spending has almost doubled in the last decade, reaching $2.6 trillion in 2010, according to government statistics.[4] A brain MRI, for example, can range from $504 to $2,520.[5]

Huge variations in cost exist even when equalizing provider capabilities. Applying metrics developed by AIM Specialty Health and its external advisors to assess these capabilities (equipment, staff credentials, accreditation and service metrics) still reveals an average disparity of $850 in the same geographic markets for routine MRIs.

Initially, it was believed that physicians who order these expensive tests were the answer to reducing the unwarranted cost variation. If physicians received communication about the MRI cost differential among providers with similar capabilities, it was assumed they would be motivated to share the information with their patients or even write orders for high-quality, lower cost facilities that might also result in lower out-of-pocket costs for the patient. While it was a first step in the price transparency movement, providing this information directly to referring physician offices didn't create these desired changes in behavior.

In the meantime, employers were exploring creative options—reference-based benefit designs and higher out-of-pocket costs—to ensure that employees had a better understanding of how healthcare costs were increasing and encourage them to be more active consumers.

A number of entrepreneurial companies began catering directly to employers by creating apps that compared pricing of specific services to empower employees to be more cost-conscious in their health spending.

Other employers worked with their insurers to develop benefit designs that also help to maintain quality while decreasing costs. A pilot program for the California Public Employees' Retirement System (CalPERS) and Anthem Blue Cross of California lowered the price of members' hip and knee replacement surgeries by 19 % in one year, while also demonstrating similar-to-better outcomes at lower-cost hospitals.

As part of the intervention for the reference-based pricing program, members of the CalPERS received a list of designated facilities that charged less than $30,000 for in-patient costs associated with each knee and hip replacement surgery. Members were able to either choose from 46 facilities on the list that would result paying little-to-no, out-of-pocket costs beyond a deductible or co-insurance or pay the difference if they used another facility that charged more than $30,000.

The result was that CalPERS health plan costs dropped significantly—by 19%, from $35,408 to $28,695, per surgical-related admission. And, many hospitals that originally charged more than $30,000 and were not on the list called the insurer to renegotiate pricing to encourage CalPERS members to get their procedures done at their facilities.

Clearly, transparency about costs changes consumer behavior and has the potential to create competitiveness. That led AIM Specialty Health to expand its member engagement approach with its Specialty Care Shopper, reaching out to health plan members directly to let them know about other choices at same or similar quality facilities that cost significantly less when there is a meaningful difference in imaging study cost disparity

A study of WellPoint affiliated plans conducted with HealthCore, a clinical outcomes research subsidiary of WellPoint, found that consumers who chose less expensive MRIs after receiving price information helped save $220 per test in total health system costs. These results were published in the August issue of *Health Affairs*.[6]

The study also showed that this awareness was linked to a shift in consumer behavior, decreasing the use of high-cost hospital-based MRIs and ultimately reducing price variation between hospital and non-hospital facilities for consumers. The $220 in savings represents a combination of consumer out-of-pocket expenses and health plan or employer medical costs.

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Informed Consumers Make Right Choices ... *continued from page 6*

There also was a shift in the type of facility used. After the intervention, members in the program were less likely to use typically more costly hospital-based facilities.

And, interestingly enough, the basic principles of economics took hold as providers also approached these plans to renegotiate MRI prices so they could compete on the basis of price and not just their reputations. This also helped to increase the MRI savings.

These savings were efficiently captured even though only 15% of those who received a call acted on it. During the time period covered by the study, the only information consumers received was on overall MRI cost differences. A program enhancement will be able to tell members while they are on the phone what their specific "out-of-pocket" savings will be, based on the provider selected.

Today, more stakeholders within the healthcare ecosystem are working collaboratively to drive more appropriate, safe and affordable healthcare services. It seems that many consumers are ready and willing to embrace the fundamental principles of economics and "shopping" within the role of patient. Price is no longer a secret to the masses until the final bill arrives for services already rendered. Consumers, armed with the proper information at the time of decision-making, will be holding the healthcare industry more accountable for delivering both quality services AND value measured in terms of fair market pricing.

Isn't that the "American way"?

[1] Rosenthal E. "Why We Should Know the Price of Medical Tests." *New York Times*. Aug. 5, 2014.
[2] WellPoint Member Survey, 2010.
[3] AIM Specialty Health Claims Analysis based on 38 million health plan member lives.
[4] "National Health Expenditures 2010 Highlights." Centers for Medicare and Medicaid Services. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf
[5] "What's Fair?" *Consumer Reports Health*. March 2012.
[6] Wu S. "Price Transparency for MRIs Increased Use of Less Costly Providers and Triggered Provider Competition." *Health Affairs*, Aug. 8. 2014;33(8):1391-1398.

Brandon Cady is CEO of Chicago-based AIM Specialty Health, and can be reached at cadyb@aimspecialtyhealth.com.

Thought Leaders' Corner

Each month, *Population Health News* asks a panel of industry experts to discuss a topic suggested by a subscriber. To suggest a topic, write to MLEdlin@comcast.net. Here's this month's question:

Q. How Do Population Health Strategies Prevent Hospital Readmissions?

The biggest impact of population health strategies is the change in mental models from episodic care based on a hospital event to global management of care to reduce all complications, including avoidable admissions. While payment penalties, public reporting and national initiatives, such as the Partnership for Patients, focus on 30-day readmissions, population health management tries to reduce all avoidable admissions—not just ones within a defined timeframe. So preventing the initial admission is as important, if not more, as preventing subsequent ones.

The other area that emerges is challenging populations, such as patients with behavioral health issues, either primary or secondary, and homeless populations. Creating an environment in the ambulatory setting to manage these groups will make breakthrough reductions in avoidable admissions. But it requires a commitment to better "non-acute" care to be successful—exactly what we will see as population health management takes off.

Bruce Spurlock, M.D.
President/CEO
Cynosure Health Solutions
Roseville, Calif.

Population health management is founded on understanding population and subgroups' clinical needs and utilization patterns and by being informed by tools and tactics to predict future risks and utilization. These are exactly the strategies we need to successfully reduce readmissions: Know your data and why your patients are readmitted; identify readmission risk factors, broadly defined; address and mitigate those risks; and ensure successful linkage to follow up and services in the community. Readmission reduction is a training ground for population health management capabilities.

Amy E. Boutwell, M.D., MPP
President
Collaborative Healthcare Strategies
Lexington, Mass.

Readmissions are a cross-continuum population health (PH) problem, but readmissions are likely only to be solved using PH tools and strategies. Readmission prevention requires review of large amounts of patient information and the ability to find the interventions, settings and patient populations that are most appropriate. PH tools take large, cross-continuum data and analyze them with robust analytics to accurately find patient cohorts (populations and sub-populations). The best PH tools target institutions, interventions and resources to the right patients, populations and providers.

These tools can drive results, such as a 20% reduction in readmissions for heart failure patients and elimination of pneumonia readmissions altogether. Current readmissions reduction strategies have been focused primarily on cost-avoidance, but with the addition of PH tools, readmission reduction strategies will leapfrog to true prevention status, a PH goal. If used properly, PH tools will also help find opportunities for appropriate utilization, improved productivity and even revenue capture.

Barbara Harvath
Senior Director
Performance Technologies, Population Health and Real Time Stategies
The Advisory Board Company
Washington, D.C.

Thought Leaders' Corner

Our population health strategies support increasingly positive trends in our hospital readmission rates throughout the Children's Health System of Texas. A robust approach to data strategies, our overall technical infrastructure and a highly intentional and measurable collaboration across the care continuum are providing our foundation for success.

Examples of these essential components include the following:

1. Predictive analytic software that mines biometric and claims data, allowing us to focus our limited resources on those most likely to be (re)admitted.
2. Care management tools, such as a multi-lingual patient-family nurse line that reaches out to patients with chronic conditions or who have a new diagnosis.
3. Improved coordination of community resources, including our own wellness organization comprised of more than 40 multi-sector, non-profit organizations and social service agencies. They are currently focused on mitigating asthma triggers in high-readmission neighborhoods.
4. Improved and coordinated access to primary care, including school-based telemedicine, not only reduces the frequency of readmissions, but also serves to prevent the initial admission.

Ray Tsai, M.D.
President and Chief Medical Officer
MyChildren's, a pediatric practice of Children's Medical Center
Dallas, Tex.

Readmissions: It's the Data Stupid!

There are two parts to the hospital readmission dilemma—inside and outside—and real-time data is the key to both.

Flow disruptions inside the hospital are often triggered by lack of real-time access to data, including voice, text, lab, progress notes and imaging. The measure of these disruptions reveals that many hospital errors leading to longer stays and readmissions are caused by a lack of situational awareness. Caregivers—doctors, nurses, lab/imaging technicians, operating room teams, IT and facilities—need, but rarely have, real-time information from outside their departments.

If anything, the "outside" the hospital flow of information and care coordination is more important than it is in the hospital. Patients need to receive education on aftercare guidelines and expectations, easy-to-use tools and services per discharge instructions and efficient follow-up.

Yet that rarely happens. Home care agencies rarely have access to paper or even electronic hospital records, and the patient and the patient's caregiver can't be expected to know all the relevant information. The home care nurse then has to "reinvent the wheel," re-gathering a small segment of the information that the hospital already has.

Both inside and outside the four walls of the hospital, the key to coordinating care and reducing readmissions is immediate access to all the data. This is especially true for increasingly complex, multiple comorbid patients who comprise the majority of readmissions. Solving the problem of readily available data will put a major dent in the readmission rate.

Al Lewis
President
Disease Management Purchasing Consortium International, Inc.
Founder/Past President
Disease Management Association of America
Wellesley, Mass.

Mari Edlin serves as editor of *Population Health News*. She invites you to submit bylined articles on population health issues and case studies illustrating successes with the model. She can be reached at MLEdlin@comcast.net.

Industry News

New Jersey's CarePoint Health System Selects eClinicalWorks

WESTBOROUGH, Mass.—BUSINESS WIRE—eClinicalWorks®, a leader in ambulatory healthcare IT solutions, announced that Northern New Jersey's CarePoint Health System, an integrated health network, has selected eClinicalWorks comprehensive electronic health records (EHR) solution for its 45 medical practices and will utilize the eClinicalWorks Care Coordination Medical Record® (CCMR) for population health management. This agreement will enable CarePoint to bring cloud-based technologies to standardize its separate practices on a single EHR platform and improve care coordination.

Employing eClinicalWorks EHR solution in a cloud environment, CarePoint will streamline processes between practices and have more of a focus on delivering preventive care. The solution will also assist in improving continuity of care across multiple settings, allowing critical information to be accessible at the point of care.

eClinicalWorks CCMR is designed to provide visibility into a patient's care across all settings, facilitate smooth transitions of care, engage patients and providers in preventive care, improve outcomes among populations and reduce costs. A vendor-neutral, open network securely connects ambulatory EHRs with hospital in-patient systems and payer claim feeds.

Indiana Health Plan Improves Preventive Care for At-Risk Children, Adults

PLANO, Texas—BUSINESS WIRE—ZeOmega Inc. announced that Indiana's largest not-for-profit health plan, MDwise, has improved preventive care and related outcomes for at-risk children and adults in a pilot program supported by Jiva™, the population health management solution from ZeOmega.

MDwise saw a 50% improvement in adolescent well-care visits and a 75% improvement in LDL related to diabetic care for the target individuals from the previous year. The plan also has seen a 50% year-over-year improvement in adult preventive care in identified members.

MDwise recognized that a significant number of its members were non-compliant with routine medical preventive care, but were frequently visiting statewide community mental health centers (CMHC) for behavioral health services.

The organizations decided to partner so that front-line case managers could intervene with mutual patients to close certain medical care gaps, particularly well-child visits and adolescent well-care visits. MDwise also hoped to leverage the initiative to improve LDL levels related to diabetic care.

MDwise provided CMHCs with a list of members who hadn't received needed preventive care and asked them to help schedule visits for them. "We also set up an incentive program with CMHCs based on the percentage of members who had a completed primary care visit," says Caroline Carney, M.D., chief medical officer of MDwise.

Indiana Health Plan…*continued*

The project's success relied on MDwise's ability to bi-directionally share patient health information with CMHCs. The primary goal was to increase communication between MDwise case managers and CMHC staff to improve overall patient health. Monitoring performance against certain quality achievement goals for quality scores and satisfaction scores was also a priority.

To execute the program, MDwise used Jiva's provider and member portal functions to extend read-only status of patient records to the participating CMHCs, giving their staff and MDwise case managers a shared and complete view of patient medications, emergency room visits, gaps in care and behavioral and medical health information.

Lightbeam Health Joins Greenway as Value-Added Partner

IRVING, Texas—PRNewswire—Lightbeam Health Solutions, LLC, announced it has joined the Greenway Health online marketplace of value-added partners for users of Greenway's integrated Electronic Health Record (EHR) and practice management solutions.

Being named a marketplace-approved partner signifies cooperative efforts between Lightbeam Health and Greenway to provide comprehensive, mission-critical health IT solutions that support the delivery of high-quality, cost-effective care.

"Lightbeam's synchronized enterprise data warehouse and risk stratification unravel the complexities of clinical and claims data feeding from multiple sources," says Jerry Shultz, president of Lightbeam Health Solutions. "The predictive modeling will enable Greenway providers to lower the cost of healthcare by identifying patients with avoidable high-cost events, and the care management capabilities allow timely interventions improving patient health."

Survey Shows Improvement in Type 2 Patients Enrolled in Population Health Management

BURLINGTON, Mass.—PRNewswire—Decision Resources Group finds that according to a survey, managed care organizations (MCOs), endocrinologists and primary care physicians (PCPs) anticipate the percentage of their beneficiaries and patients with type 2 diabetes enrolled in population health management (PHM) programs will increase over the next two years, reflecting greater overall adoption of this treatment model in healthcare.

Respondents report that an average of 72% of their patients with type 2 diabetes are included in a PHM program, a rate that they forecast will increase to 81% in the next two years. These programs are largely in place for patients that are defined as high risk—having elevated A1c levels, presence of a comorbid indication or specific LDL levels—but will increasingly apply to less-risky population groups.

Catching Up With…James L. Holly… *continued from back page*

The principles, which have guided and sustained us for the ensuing 15 years, are:

1. Pursue electronic patient management rather than an EHR.
2. Bring to bear upon every patient encounter what is known rather than what a provider knows.
3. Make it easier to do it right than not to do it at all.
4. Continually challenge providers to improve their performance.
5. Infuse new knowledge and decision-making tools throughout an organization instantly.
6. Establish and promote continuity of care with patient education, information and plans of care.
7. Enlist patients as partners and collaborators in their own health improvement.
8. Evaluate the care of patients and populations of patients longitudinally.
9. Audit provider performance based on the Physician Consortium for Performance Improvement data sets.
10. Create multiple disease-management tools that are integrated intuitively and interchangeably, giving patients the benefit of expert knowledge about specific conditions and the benefit of a global approach to their total health.

***Population Health News**: Why did you decide to develop a medical home? How has that model contributed to the health of your patients?*

James Holly: A medical home became a logical and essential progression for SETMA. In the quest for excellence, medicine must not be seduced by technology with its numbers and tables. In the future of medicine, the tension—the dynamic balance—must be maintained between humanity and technology. Technology can contribute to solving disease problems but ultimately cannot solve "health problems." The energy of "health home" is to rediscover the trusting bond between patient and provider. In the health home, technology becomes a tool to be used and not an end to be pursued. The outcomes of technology alone are not as satisfying as those where trust and technology are properly balanced in healthcare delivery.

SETMA whole-heartedly embraces science, while retaining the sense of person in caring for our patients. Public reporting of our performance of quality metrics has made us better clinicians/scientists. But what makes us better healthcare providers is our caring for people. This is what we call a true PCMH. In reality, SETMA did not so much “decide” to become a PCMH, but the fact that we arrived at a point in our development where it was the only logical next step. As an EHR had transformed our approach to healthcare and to patient encounters, a PCMH provided a method for achieving the results we wanted.

***Population Health News**: SETMA takes quality metrics seriously. How do you as a leader of the organization instill in your group the importance of achieving a variety of clinical measures?*

James Holly: After surveying SETMA, The Joint Commission commented that everything at SETMA is founded upon a philosophical foundation, where they know “what they are doing,” but more importantly, they know “why they are doing it.” SETMA is not the result of random efforts but of innovations and advances, which are consistent with a structured set of ideals, principles and goals, all of which are driven and sustained by an internalized passion for excellence.

Optimal health at optimal cost is the goal of quality care. Metrics are like a healthcare GPS system that tells you where you want to be, where you are and how to get from here to there. No metric alone provides a granular portrait of the quality of care a patient receives but all together, multiple sets of metrics can give an indication of whether the patient’s care is going in the right direction; however, a collection of metrics should be incidental to excellent care and should not be the object of care. Consequently, the design of the data aggregation in the care process must be as non-intrusive as possible.

Auditing gives providers a coordinate of where they are in the care of a patient or a population of patients. Ultimately, success will be measured by the well-being of patients, but the guideposts to that destination are given by the analysis of patient-population data.

This philosophy and our intuitively designed tools that automatically aggregate the data make it easier for providers to do what is right rather than not to do it at all, which makes the effort sustainable.

[1] Senge PM. *The Fifth Disciple: The Art & Practice of the Learning Organization*. March 21, 2006.
[2] Holly JL. “More Than a Transcription Service: Revolutionizing the Practice of Medicine: And Meeting the Challenge of Managed Care With Electronic Medical Records (EMR) Which Evolves into Electronic Patient Management.” May 1, 1999.

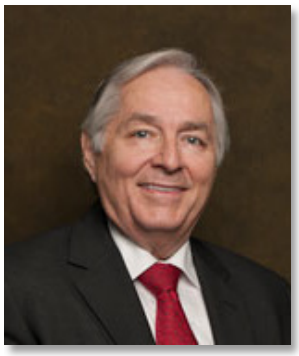
Standards Guide Medical Respite Care Programs… *continued from page 4*

As the country wrestles with providing medical care and treatment to the homeless, interest in medical respite programs is growing. These standards will help guide the future development of existing and new programs, which also should lead to better and more uniform quality of care for patients, foster additional research into the benefits of respite care and provide a way to obtain more permanent funding streams for providers.

[1] http://www.nhchc.org/resources/clinical/medical-respite/, last accessed Aug. 11, 2014.
[2] *2014 Medical Respite Program Directory*. National Health Care for the Homeless Council, Inc. Nashville, Tenn. 2014.
[3] Buchanan D, et al. “The Effects of Respite Care for Homeless Patients: A Cohort Study.” *American Journal of Public Heath*. 2006;96(7): 1278-1281.
[4] “Proposed Medical Respite Standards.” Respite Care Pre-Conference Institute Preambles and Standards, Respite Care Providers Network. May 2014;1-17.
[5,6]. Ibid.

Henry D. Fader, Esq., is a healthcare attorney at Pepper Hamilton LLP in Philadelphia.

Catching Up With ….



James L. Holly, M.D. is founder/CEO of Southeast Texas Medical Associates (SETMA) based in Beaumont, Tex. He also serves as an adjunct professor of family and community medicine at Texas Medical School in San Antonio and as associate clinical professor in the Department of Internal Medicine, Texas A&M College of Medicine.

James L. Holly, M.D.

- **HIMSS /Davies Award and Stories of Success recipient**
- **eHI Innovator of the Year, 2012**
- **HIMSS Physician IT Leadership Award recipient, 2012**
- **Writer and lecturer**
- **Medical degree, University of Texas Medical School**

***Population Health News**: How did you become interested in the technology side of healthcare?*

James Holly: My interest started when I realized it was possible for healthcare providers to be overwhelmed by the volume of medical decision-making information. And that information is not easily accessed at the point of care. In the early 1990s, we began to see that electronic patient records had the potential for making information available for improving the quality and safety of treatment.

In 1995, I read *The Fifth Disciple,*[1] in which Peter Senge states: "System thinking is needed more than ever because for the first time in history, humankind has the capacity to create far more information than anyone can absorb, foster far greater interdependency than anyone can manage and accelerate change far faster than anyone's ability to keep pace."

Senge concludes that healthcare provider confidence is undermined when the vastness of available, valuable and applicable information is such that it appears futile to try and "keep up." In healthcare, once confidence is undermined, responsibility is surrendered as providers tacitly ignore best practices, substituting experience as a decision-making guide. While experience is not without merit, in medical decision-making, it is not the best guide.

***Population Health News**: In 1998, electronic medical records were barely on any physician group's radar. How did SETMA know how to implement them and determine that it would make sense to adopt the then very new technology?*

James Holly: Thirty-seven years ago when I started a practice, I bought a Dictaphone, which I could not get to work. A few months after I had returned the device to the supplier, a patient suing a fast-food chain subpoenaed my records. Not being terribly busy, I took my medical record and showed up in court. When I was sworn in, the judge asked if I had my records. I passed them to him. Looking over his glasses, the judge turned to me and asked, "Can you read this?"

I looked and said, "No, sir." To which he responded, "Son, I recommend that you get a Dictaphone." I did; I repurchased the same instrument I had returned three months before.

Although a Dictaphone and transcription improved the legibility of paper records, they did not solve problems with their portability, availability and interoperability. Paper-based records only created an accurate and complete account of a healthcare encounter, but the information still was static because there were no data in the record that could be correlated or analyzed and non-integrated because the record couldn't interact with other systems in the medical office. In addition, the record stayed in one place.

When SETMA was founded in 1995, we realized that pencil and paper (19th century medical record technology) and dictation and transcription (20th century medical records technology) would not support 21st century healthcare advances. In March 1998, we bought our electronic medical record (EMR) and by January 1999, we had built a usable system, and we were off and running.

***Population Health News**: How difficult was the learning curve for adopting technology in your medical group? Has it paid off?*

James Holly: Only four months after SETMA deployed its electronic health record (EHR), we experienced four seminal events. First, we realized that an EHR was too hard and too expensive to develop if all we gained was the ability to document a patient encounter electronically, while not leveraging the power of electronics to improve the care of all patients. So we immediately morphed into pursuing electronic patient management with disease management, clinical decision support and a focus on care quality and safety.

Simultaneously, my co-founding partner was discouraged and said, "We're not even crawling yet." "You're right," I said, "but we have begun, and I am going to celebrate that. If in a year, we have not advanced, I will join your lamentation, but today I am going to celebrate our beginning." That celebratory spirit became and remains the core of SETMA's culture.

The third event was a paper I wrote, published and distributed, entitled "More Than a Transcription Service: Revolutionizing the Practice of Medicine: And Meeting the Challenge of Managed Care With Electronic Medical Records (EMR) Which Evolves into Electronic Patient Management."[2]

The fourth seminal moment was the development of 10 principles of a model of care and an EHR. These principles foreshadowed our adoption of a patient-centered medical home (PCMH) before we ever heard the term.

(continued on page 11)