Planning Healthcare Facilities: Patient Point of View

By Debbie Jacobs, Don McCall and Lawrence Sterle

A discovery at an academic medical center (AMC) in the central region of the country found that as much as 50% of a patient's admission and discharge days were spent on an activity that added no value to their quality of care or experience: waiting. The patient consumed resources, such as nursing care, a patient room and medical equipment for the equivalent of an entire day—just waiting. At the same time, the AMC struggled with capacity issues that even a new 70-bed patient tower could not resolve. Without some type of action, the capacity strain on the AMC was certain to worsen with the aging of the population and passage of the Affordable Care Act.

This scenario is not unusual and is occurring every day at healthcare organizations across the country. Our experience suggests that, from a patient's point of view, more than 50% of the time spent interacting with a healthcare organization is considered non-value added, resulting in ineffective utilization of costly resources and a poor patient experience. Fortunately, solutions including care stream programming—a process that puts a patient lens on designing facilities that are efficient and eliminate waste at both the departmental and enterprise levels—are available to help healthcare organizations ensure that the desired patient experience is achieved.

While much of the non-value added time the patient experienced at the AMC was attributable to inefficient processes and misalignment of staffing with demands, the location of patient care space, supply storage and medical equipment closets also greatly contributed to wasted time in moving and transporting patients, staff and materials significant distances.

Clinical Practice Guidelines Hold Untapped Potential for Achieving Quality Care

by William Bithoney, M.D., FAAP

With healthcare expenditures consuming nearly 18% of the U.S. gross domestic product (GDP), many clinicians believe the key to improving poor health outcomes and high cost lies in clinicians following standardized clinical practice guidelines (CPGs).

In 2012, healthcare-related costs were approximately $2.8 trillion, according to a Department of Health and Human Services report. More than a third of these expenditures comes from government spending, ultimately funding an inefficient and surprisingly low quality healthcare system. The Commonwealth Fund’s June 2014 report and prior survey and national health scorecards, find that of 11 developed countries, the United States ranked first in healthcare spending and last in quality. CPGs are evidence-based algorithms that doctors can precisely follow to ensure patients receive the best possible care. Such guidelines assist practitioners in making effective and timely decisions for their patients. Because of their potential power to improve care, hundreds of clinical guidelines presently exist. However, while some CPGs are based on excellent data, others unfortunately are not.

Revision identifies gaps

While the American College of Cardiology and the American Heart Association can be cited as organizations that have developed some of the best quality guidelines, a recent study published in The Journal of the American Medical Association determined that of the 619 cardiac guideline recommendations promulgated between 1998 and 2007, only 495 remained unaltered in 2013.
Mobile Unit Supports Enrollment, Access to Healthcare

by Donna Graham

Program Objectives:

- To help our community, particularly residents of Cuyahoga County whose county seat is Cleveland, access the federal healthcare exchange before the March 31, 2014, deadline for open enrollment ended.
- To give our community a clear sense of its healthcare options.
- To improve healthcare outcomes in Cuyahoga County.
- To reach Cuyahoga County residents where they live, work and play, rather than hoping they will access the system on their own.
- After open enrollment ended, continue to promote access to healthcare and to make community members aware of available financial support.

Program Description: With a bright, national spotlight turned to healthcare access in the early months of 2014, The MetroHealth System, the public healthcare system serving Cleveland and Cuyahoga County, saw an opportunity to sign residents up for health Insurance. Realizing the complexity of the federal healthcare exchange and the roadblocks many face in signing up, MetroHealth took on the role of providing accurate, concise information to the community.

The key realization, however, was that many people couldn’t—or wouldn’t—attain healthcare for themselves. As a result, many patients were seeking care in the emergency department for chronic illness rather than looking for preventive care for conditions such as asthma and diabetes before they escalate into a series of emergency department visits. Beyond a hospital’s traditional role of saving lives and fighting sickness, Enrollment on Wheels, the program’s nickname, represents MetroHealth’s commitment to helping people stay well by removing financial barriers to access.

The beauty of the idea is that the Enrollment Outreach RV could—and does—find people where they live and work. The RV has traveled to events for veterans, health fairs, churches, recreation centers, schools and several of MetroHealth’s 16 ambulatory centers. Everywhere it goes, the RV is equipped with PCs for online applications.

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Through patient flow studies to identify the root causes of the non-value added activities and the execution of performance improvement initiatives to eliminate waste, the AMC created the potential for a 10% increase in capacity, translating to the ability to care for as many as 5,000 more patients each year.

Operational improvement success stories like this one can be repeated. But oftentimes, the facility itself is the root cause contributing to operational waste. Because this waste is literally built into the facilities themselves, it can be very difficult to remove it from the patient experience.

Traditionally, facility programming generally occurs at the departmental level, often missing the opportunity to reduce non-value activities that are prevalent as the patient transitions from one department or function to the next. Practical application of Principles of Lean in the facilities planning process, which focus on eliminating non-value added activities from the patient experience, provides the framework to reduce process waste and thereby, unnecessary space across the healthcare organization.

To effectively reduce waste and increase patient value, hospitals must integrate Lean principles into the programming process along the entire patient journey, from check-in to discharge, and they must do so early in the planning stages of renovation or construction projects by using care stream programming.

Since care stream programming addresses patients’ experiences during their healthcare encounters, it is developed from a patient’s point of view and therefore, not organized around departmental silos, but rather focused on the transition of patients from one activity to the next. Organizing operational assumptions around care streams facilitates an understanding of how services and activities across the spectrum of a patient visit should best be coordinated to optimize a patient experience. Additionally, it drives the type, size, configuration and location of spaces that should be programmed into the building. This process was applied to the development of a 200-bed replacement facility for a Midwest hospital moving from an outdated facility that imposed limitations on how care could be provided.

The most notable results of the care stream programming effort included:

- Determination of the building and space attributes, such as location, proximities and adjacencies, size and number, to meet patient experience expectations. This information then informed the building entry sequence and the relationship between inpatient and outpatient services.
- Identification of and planning for the information technology functionality required to meet patient and physician expectations early in the process.
- Strong focus on interdisciplinary collaboration and patient transitions ensured the needs and expectations of the patients and providers are met throughout the patient's healthcare journey.
- Development of key performance indicators and metrics early in the process in order to track and measure the organization's progress toward its desired future state.

Facility programming that uses care streams as the framework for design ensures that:

- Patients’ desired experiences through their healthcare journeys are taken into account.
- Patient transitions from one function to the next are facilitated through the optimal configuration and location of services.
- The flow of materials, information, staff and physicians are synchronized to meet patient needs and expectations.
- Error-proofing to prevent rework and adverse clinical outcomes is built into the design.
- Equipment and supply areas are located and sized to match demand so providers do not have to seek out what they need.
- Technologies and communication devices that support the patient’s expectations are accounted for and designed into the building.

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Using Care Streams to Plan Space

For myriad reasons, many organizations move directly from their vision or master plan to the departmental functional and space programs for a new building project. In doing so, they skip a critical step that answers the fundamental question, “How will we work in this new space?” In some organizations, this question is never formally addressed, and the staff adapts its work as best it can to the new building. This situation usually results in process work-arounds—usually a temporary fix—or a potential post-opening remodel.

In other organizations, in the months just prior to opening, staff works furiously to adapt its current processes to the already designed environment. While this approach eliminates confusion regarding how work will be carried out in the new space, future state processes will still be constrained by the given building design. However, well-defined processes, such as care stream programming, give staff the opportunity to define the desired future state operating model and space attributes from patients’ points of view, which can then inform the building design.

How Do Care Streams Add Value to Programming?

To be effective, care stream programming must include the input and collaboration of front line care providers, such as physicians, nurses, therapists, pharmacists, social workers and support staff (i.e., medical receptionists, housekeepers, biomedical staff). These are the folks with the most intimate knowledge of what works and what doesn’t. To achieve value-added care, interdisciplinary teams must work together using the care stream construct to define the desired future state operating model to increase both patient and staff satisfaction.

Patient/family input into a care stream programming effort adds detail and specificity to the design process. In asking patients to define what they value and expect during their healthcare journey, healthcare organizations have a much clearer idea of how the building design can support patient/family expectations. A children’s hospital in Long Beach, Calif., has done just this.

The hospital sought consulting assistance to create a building program for a new ambulatory care center it wanted to develop. The objective was to enhance the patient and family experience by minimizing non-value added steps and to “design in” value in terms of people, process, technology and space. Critical to the success of the project was the input received from both parents and teens, who participated in discussions on patient/family experiences and desired amenities.

Some of the value-added space attributes the team defined included:

- A lobby to serve as an organizing element, orienting patients and families to the building and their current location.
- A staff-supervised play area adjacent to a family resource center to allow parents a short period of free time while keeping their children nearby.
- An education and conference center available for patient and community education programs, as well as for staff educational purposes.
- Exam rooms large enough to accommodate multiple family members in addition to strollers and wheelchairs.

As a result of understanding what parents value in their child’s healthcare experience, the hospital has begun to realize its vision of being an integrated ambulatory care destination where the patients and families always come first.

Facility Design Supports Services

The opening of new or renovated space provides a unique opportunity to leverage the physical design and configuration to support the delivery of high quality, safe and efficient healthcare services. In order to secure a competitive advantage in the future healthcare marketplace, hospitals and health systems will need to align their building projects with value-added care streams to optimize the patient and family experience, while ensuring efficient operations.

Ultimately, healthcare organizations that account for the patient and family experience expectations in the facility plan and design will reduce or eliminate non-value added processes, and their related operational costs, as well as the capital investment in space to accommodate them.

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The study reported the guidelines were frequently altered because their recommendations were no longer consistent with current evidence or were deemed potentially harmful to patients. The reasons for these changes largely have to do with the quality of the evidence on which the guidelines depend.

Over the past 20 years, numerous efforts have been made to classify the quality of evidence based on standard research methodology. By way of example, some of the research on which CPGs are founded can be classified as so-called “samples of convenience.” CPGs, which are partly based on such evidence, are often generated from research (typically conducted by tertiary hospitals) sourced from patients who suffered a particular diagnosis. These patients are often dissimilar to those seen in a primary care setting. Additionally, some CPGs exist on the basis of patient observation studies, retrospective analyses of data or even simple expert or consensus opinion when the evidence is not clear.

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Major problems can arise affecting the health of large subgroups when CPGs are not backed by quality research. Recently, the U.S. Preventive Services Task Force recommended against prostate specific antigen (PSA) screenings for prostate cancer in asymptomatic middle-aged men. This recommendation contradicted decades’ old wisdom that PSA screenings saved lives. However, upon the collection and review of large amounts of data, it became clear that many men whose PSAs were elevated did not have prostate cancer. In spite of this, many were screened and designated as high risk over the years underwent invasive procedures and unnecessary testing with potentially quite harmful results.

Another issue that must be addressed concerns seriously ill patients, who more often than not tend to be diagnosed with several comorbidities. For example, the preponderance of patients who have diabetes mellitus and are admitted to a hospital could also have hypertension, some degree of circulatory compromise and/or kidney disease. Current CPGs do not routinely allow for clinical guidance when comorbidities exist. Often, treatment for one disease can worsen another. For example, giving aspirin to an acute myocardial infarction patient who has a bleeding tendency can be dangerous.

CPGs Need Evidence, Technology Support

As the movement for evidence-based medicine becomes more prominent, guidelines will need to become more data-driven. CPGs are meant to be a value-add to the healthcare sector and if used properly, can be just that. The best studies are randomized clinical trials done prospectively. Another excellent source of data is “meta-analyses,” which are studies that aggregate multiple randomized clinical trials and can predict outcomes and pinpoint associations with much more power. Unless guidelines are based on the best evidence, such as randomized clinical trials, they will require frequent revision and result in patients receiving less than optimal care.

A strategy to combat the current variation is to enhance CPGs with the use of technology. In the future, guidelines will need to be designed with interactive “blue buttons” (URLs) to easily direct clinicians to the latest medical information as it pertains to both the primary diagnosis and comorbid diagnoses.

Additionally, CPGs should be integrated into the electronic health record (EHR) and computerized physician order entry (CPOE) software. If a physician is not ordering the most effective guideline-based care and consequently not following the best practice, the systems could prevent the treatment and prompt clinicians to either adopt recommendations or indicate why they chose an alternative plan.

This process would not only allow physicians to circumvent CPGs that could cause potentially greater harm, but also inform senior clinicians monitoring the guideline of the potential need for a revision. On the other hand, clinicians have an opportunity to explain why they prefer an alternative method of care. Once a physician, the ultimate arbiter of what is best for a patient, feeds an explanation into the system, the treatment selected by the provider may proceed. The result is a win-win situation for patients and the development of appropriate guidelines.

CPGs also should be integrated into patient portals of EHRs, some of which could be used by an individual to access and follow an outpatient care plan that providers enter into the system. In addition, portals could generate reminders for patients to follow up on appropriate and timely CPG-recommended care. Multiple studies have recently shown a marked improvement in compliance with guideline recommended care using patient portals and electronic reminders.

Physicians who use EHRs and CPGs to coordinate and communicate with electronic devices ensure that evidence-based care is delivered. For example, if a patient in an ICU is on a respirator, an EHR would be able to “tell” the device a patient’s recorded height and weight—two important variables in setting respiratory pressure or inspiratory volume—and set both appropriately.

“If settings are too low, a patient might be inadequately oxygenated and if it is too high, a patient’s lung might literally explode and result in a collapsed lung. A respirator would not accept a potentially erroneous setting until it checked the clinician about the accuracy of the input.

If EHRs “spoke” to medical devices in an Apple-type universe where all medical devices communicated, these errors would be precluded. Such systems are at work today in some advanced ICUs, with more are on the way.

CPGs require annual revision, to remain current, and should be modified more frequently when major new studies make them obsolete. Such strategies will obviate and prevent harm caused by guidelines that are not interactive and are not cognizant of comorbidities. The right care, the right drugs and the right screening tests at the right time from the right clinician ensure the right outcome.

1“Health Expenditure, Total (% of GDP).” The World Bank.
2http://www.cms.gov

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Quality Management: Achieving Clinical and Financial Objectives in Population Health

by John Khoury, Pharm.D.

Vital to the success of population health management is the ability to manage clinical and financial outcomes for a payer’s defined group of members. Collaborative, value-based contracts, with well-chosen quality, cost and utilization metrics and effective incentives may assist providers in the value-based care journey by enabling better clinical, operational and patient outcomes. Appropriate tools and resources give providers the actionable information needed to enhance population management and enable them to achieve the desired results outlined in these value-based contracts.

As a result, primary care providers (PCPs), usually patients’ attributed physicians in such contracts, are able to receive greater incentives when they deliver high-quality services at reduced costs as stipulated in their contract. But achieving the desired outcomes requires engaging the entire care team including PCPs, care managers and patients.

High-quality ratings, however, are often difficult to achieve and even harder to maintain over time for health plans, health systems and physician practices. A focus on data tracking and trending, continuous process improvement based on the trends identified and incentives that enable these activities are needed. These strategies increase the importance of working with a defined population, ensuring that desired clinical and financial outcomes are being achieved, and then expanding the model to other, well-defined groups. With a strategic and tactical approach to quality management, organizations can achieve remarkably improved clinical and financial outcomes and develop the ability to capitalize on those successes for future defined groups.

Payers Incentivizing Providers

One of the best ways to manage the quality focus of providers is to incentivize a limited, but meaningful, number of high-impact quality measures that are targeted to a provider’s specific opportunity areas (e.g., gap in care closure, adherence to medical/procedure appointments, patient care plans and maintenance schedules). With many value-based contracts, the payer is responsible for providing ongoing support and tools to providers and their care teams in order to help them meet the selected quality, cost and utilization measures identified within value-based contract. The provider focus on these incentives might enable the desired behavior change across the care continuum.

Since population health management focuses on a defined population, payers and providers need tools that offer a complete view of the population and provide actionable insights at the level of the health plan, provider and an individual patient’s profile. In order to view the clinical and financial objectives, the tools need to integrate data from across the care continuum. These tools are necessary for the providers to recommend screenings and identify tests that have already been completed.

With a powerful solution backed by the right technology, payers and providers will be able to better stratify patients for outreach, thus, differentiating themselves from their peers. With access to data to close gaps in care and data transparency to benchmark their performance against other provider groups and national data, PCPs can become true “quarterbacks of care” and earn quality-based bonuses as part of value-based contracts.

Many healthcare organizations currently rely on the electronic medical record (EMR) to manage population health; however, these electronic tools are often limited because they provide an incomplete picture of the population. All of the data available for patient groups, including claims, labs, prescriptions and EMR data, need to be integrated and combined into a single platform that can be used by the PCP and all members of the care team. These combined data will then provide a complete picture of the population and each member within it, and this provides the ability to manage quality based on cost, utilization and member adherence to care plans.

Empowering the Care Team

Another area of focus for improving outcomes for population health is the care team who works in conjunction with an accountable physician to provide care directly to patients. Providing the team with actionable information, tools, reports and dashboards allows them to interact with the providers and patients in innovative ways. In other words, the provider can’t do it alone; they need the buy-in, help and support of care team members to achieve the outcomes under the same value-based contracts. Arguably, the members of a care team with the most influence over clinical and cost outcomes are patients and their family members, who might serve as caregivers.

As patients move between different healthcare providers and settings, the right tools and resources can help the team coordinate care. For example, episodic management of high-risk patients after hospital stays decreases the likelihood of adverse outcomes and readmissions while helping manage costs. The right complex care and disease management programs may curtail increased healthcare costs, especially with the wave of millions of new unmanaged members seeking coverage under the Affordable Care Act.

An effective population health management solution focusing on improved clinical and financial outcomes needs to include the ability to manage disease-specific programs and gaps in quality care and cost management, especially for high-utilizing and high-risk members. This allows each individual to receive the most appropriate care, operationalized through interactive work lists and care plans.

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Engaging the Patient

As PCPs assume greater risk related to quality, cost and utilization, they are increasingly accountable for the actions taken by the patient. These providers need new engagement strategies and workflows that empower patients to make educated health choices and take a more active role in guiding their own healthcare.

Effective patient engagement in a value-based care environment successfully encourages healthy behavior changes and adherence to treatment plans. With appropriate incentive arrangements between payers and their network of providers, physicians are motivated to improve patient access to information to strengthen the patient/provider relationship. Blended engagement strategies can also be incorporated into the care team's workflow to enhance quality outcomes, including motivational interviewing, working with patients who have to make difficult decisions and educating patients on how to work with the care team to efficiently coordinate services.

By creating high-touch accessibility to information and resources, patients can become active managers of their own health outcomes, and one by one can help to improve the clinical and financial outcomes of the managed population. Various communication channels to engage members are increasing in popularity, including the use of direct outreach (text messages, telephonic outreach from the provider office, email or videoconferencing) and provider/patient portals that allow connectivity via the Internet. Integrated data and tools can help care teams increase patient adherence because they will have the appropriate clinical information available to share with patients, either during the appointment or through these collaborative communication channels.

Collaboration, Integrated Data Lead to Success in Value-Based Contracts

Optimally managing quality for improved clinical and financial outcomes requires the entire care team. With the appropriate strategy, a collaborative payer can create a cycle of success with defined populations by incentivizing providers to provide better care at reduced costs. Also, by enabling care teams with integrated data, tools and resources to succeed in value-based contracts, payers can create a business model that can then be extended to other defined populations.

The healthcare ecosystem and all its players have a role in managing the quality, cost and utilization of populations. The PCP and care team members engage the patients to make sure they are being seen on schedule, receiving any required screenings and tests and adhering overall to their care plans. With the right information, patients are acting to make sure they stay healthier, or they’re working to be healthier at less cost. The payer is creating contracts that incentivize providers to make the “right” thing the “easy” thing to do, and is also incentivizing patients for taking steps to actively manage their own health. Together, all members of the team are incentivized, empowered and engaged to achieve the desired quality management initiatives of better financial and clinical outcomes.

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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. What is the Impact of Narrow Networks on Population Health?

Narrow networks, where participation is offered to providers based on their ability to offer network beneficiaries (who are also referred to as patients!) evidence-informed and value-oriented care, can tremendously enhance all the goals of population health. Within those arrangements, narrow network providers can receive incentives for addressing all the key elements of effective population health, including preventive, acute and chronic care, and for their collaboration with other providers, as well as with patients through a range of metric-driven payment models.

To achieve this positive population health outcome requires a shared and sustainable long-range view between the providers in the network and the network administrators about what high-value population health-oriented care is, how it is measured and how it is reimbursed. Importantly, buyers of care should be aware that a narrow network constructed from cost data alone could have a significant negative impact on population health.

It could perhaps achieve short-term cost management goals, but costs could balloon in later years because of lack of attention to chronic conditions, such as diabetes or cardiovascular disease, and because of reduced rates of immunization and cancer screenings.

It’s therefore critical that both public and private purchasers scrutinize and understand the requirements of narrow network participation and the availability and quality of data that underpin those inclusion/exclusion decisions before entering into arrangements in which a narrow network strategy is being used to achieve population health goals.

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The term “narrow networks” is typically used to describe a restricted network of providers based on various carrier network determinations of quality and cost. It may also extend to direct contracting arrangements with select providers for select services, such as transplants or orthopedic procedures. These providers may be contracted based on pay-for-performance models or other negotiated fee arrangements. The result is the opportunity to drive higher quality and lower healthcare cost with high rates of utilization.

Narrow networks can have a potentially significant impact on population health. When providers are paid for validated outcomes and adherence to agreed-upon treatment protocols, the impact to member health is notable.

For example, if individuals with chronic disease, such as diabetes, can be proactively managed with regular office visits, high rates of medication compliance and biometric values that can be maintained in healthy ranges, the costly and unnecessary complications such as renal disease can be avoided.

Narrow networks can lead to less utilization of higher cost, invasive procedures, such as back surgery, in favor of other alternatives.

By engaging providers with resources and financial rewards, we create a shared and collaborative healthcare delivery model. Issues of access across geographies and scope of services, as well as the acceptance of mandated narrow networks (compared to softer steerage approaches), will influence the overall impact.

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Clinical and Audit Practice Leader
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The impact of narrow networks on population health will depend on the behaviors of insurers, patients, providers and government.

If payers construct narrow networks to include providers who are truly higher quality and lower cost, and set the cost to patients of going outside the narrow network high enough, then steering of patients to better providers through this benefit design will improve population health.

Narrow networks will have the biggest impact on population health through the changes in provider behavior that they induce. Providers can’t afford the reductions in patient volume that will result from being excluded from a network, or from the higher out-of-pocket costs patients will face if they go out of network. In a value-oriented marketplace, providers thus have a strong incentive to improve the quality and lower the cost of the care they deliver in order to gain market share by being included in a narrow network.

Experience has shown, however, that providers who are excluded from narrow networks and patients who don’t want their choices constrained will try to get government to ensure that networks remain broad.

If designed properly, and not over-regulated, narrow networks can help achieve the Triple Aim.

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With resurgence in the deployment of narrow networks still largely underway post-ACA, it is likely too premature at this time to draw any definitive conclusions as to their impact (positive or negative) on overall population health. Nonetheless, it does stand to reason that if developed and overseen in a highly conscientious and diligent manner, such networks do represent a very valid opportunity to better drive competition and lower healthcare costs, while simultaneously delivering a higher level of quality in care.

Critical to achieving such objectives, however, is the need for insurers to properly prioritize issues of quality, accessibility, education and cost in network development. Foremost in these endeavors is creating a network based upon quality of care delivered by providers. In today’s era of advanced data, analytics and healthcare technology, this capability is much more readily achievable and reliable. Secondly, development of such a network requires the establishment of reasonable standards for network adequacy and patient accessibility. Thirdly, to help make narrow networks more consumer-friendly, payers must ensure adequate member education and full transparency with regard to price, product and quality. Finally, but also of critical importance, plans must have the ability to creatively contract with doctors and hospitals who have a track record of delivering higher quality care in an effort to effectively drive lower costs.

As many are aware, narrow networks are not a new phenomenon, having been attempted with limited success in the 1980s. Today however, we live in a different healthcare world, with different needs, different priorities and more progressive ways of achieving success. Preliminary evidence, such as the Centers for Medicare & Medicaid Services (CMS) composite value-based purchase scores, does provide an optimistic view into the patient experience and outcomes within narrow networks.

Additionally, organizations like CMS have also set quantitative standards around areas like network adequacy, and accrediting bodies such as the National Committee for Quality Assurance (NCQA), URAC and the Joint Commission on Accreditation of Healthcare (JCAHO) will continue to drive appropriate standards of quality in care delivered. With all of these pieces in place, narrow networks may now be “ready for primetime” in helping our nation achieve much needed improvements in quality and cost efficiency set forth by healthcare reform.

David Calabrese
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Narrow network trends cannot necessarily be a scientific argument for or against optimal population health in a workforce but rather a greater managerial argument. Since relevant clinical theories and specifications with clear results for optimal population health are not uniformly understood or proven when under severe constraints (clinical and/or economic) and time, the default continues to be simplification by non-clinical decision makers who hold the funds to pay for population health. By default then, choices become more about satisfying versus exceeding established expectations. In healthcare, the result becomes an economically efficient (and driven) means to achieve a reasonable clinical endpoint (outcome).

For example, a self-funded employer who desires an optimal state of member (population) health, a self-contradictory action by managing health becomes a minimalist advance or regressive trend in healthcare delivery. Limiting or narrowing networks as part of a health benefit strategy can become a slippery slope for some while establishing a better opportunity for sustainable success with others in healthcare. Health of any population size is not a simple undertaking, and ignoring the complexities, legal or regulatory constraints and real financial risks at stake has been clearly proven and understood for decades. The true impact of narrow networks on populations remains an open question for the long term—an important consideration if attempting to impact the health cost curve over time.

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Making a Case: Mobile Unit Supports Enrollment…continued from page 2

"All Cuyahoga County residents should be able to access quality, affordable healthcare coverage," says Cuyahoga County Executive Ed FitzGerald. "I applaud MetroHealth for the successful launch of the Enrollment on Wheels program and look forward to continuing our collaborative efforts to expand healthcare access in Cuyahoga County."

“This is an opportunity for Clevelanders to get quality healthcare, and MetroHealth’s effort is a good way to increase the ability for people to get covered,” says Cleveland Mayor Frank G. Jackson.

Congresswoman Marcia Fudge and Secretary of Labor Thomas Perez also paid a visit to the Enrollment Outreach Unit, thus spreading awareness. Widespread media coverage helped inform people in the Cleveland area of the van’s presence. Articles appearing in The Plain Dealer, Cleveland’s leading newspaper; Crain’s Cleveland Business; and ideastream (public radio), along with social media coverage, helped alert the public.

Program Results
With the Affordable Care Act and Medicaid Expansion in Ohio, we saw new opportunities to expand coverage. We continued to align our financial programs to reach out to uninsured and underinsured community members. With the innovative approach of Enrollment on Wheels, we have helped more than 250 community members in 37 locations better understand their healthcare options and enrolled them in programs commensurate with their personal needs.

Success was immediate. Some Cuyahoga County residents were without healthcare for years. In less than an hour, however, without ever walking into a government office or hospital, they could be covered with a health insurance plan and have their names securely placed in MetroHealth’s electronic health records.

Lessons Learned:
- Executive leadership is critical to support any major initiative, especially one that involves outreach to the community.
- Collaboration is also key to success. We actively seek partnerships with government and groups within the community. We have found that if we collaborate with organizations, their representatives will assist with getting the word out to different neighborhoods.
- Our mission is our catalyst with a healthier community being the goal.
- Don’t let weather be a deterrent—even in rainy Cleveland. Rain or shine, and even on a snowy day, Enrollment on Wheels has a presence. Providing the opportunity to have healthcare coverage, or to remove financial barriers from the continuum of care, makes any event worthwhile.
- Be flexible to accommodate a variety of personal schedules. We have started as early as 8 a.m. and ended as late as 8 p.m., and we’ve had events on every day of the week.
- Be creative. With limited space on the RV, we wanted to maximize our options. We conceived of a certified application counselor who could also legally drive the RV, navigate and provide valuable services to our patients, expediting the enrollment process during these events.
- Look inward. Sometimes, some of your best candidates are already working for you. We found that in our search for a driver/certified application counselor.

Links to articles about Enrollment on Wheels
1) http://www.metrohealth.org/enrollment-unit
4) http://www.cleveland.com/healthfit/index.ssf/2014/03/metrohealths_enrollment_on_wh e.html

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New Survey Instrument Measures Well-Being

Washington, D.C. and Nashville, Tenn. — Global well-being improvement leader Healthways and management consulting firm Gallup have achieved the next milestone in their joint venture to advance the science of well-being measurement and improvement. The new Gallup-Healthways Well-Being 5™ is a comprehensive and scientifically validated survey instrument that measures, reports and tracks well-being at individual, local, national and global levels. It measures the five interrelated elements of well-being: purpose, social, financial, community and physical.

Healthcare organizations, employers, communities and governments are increasingly turning to well-being improvement as a means to positively impact quality of life, longevity and productivity, while more effectively managing population health and reducing health-related costs. Research has shown overall well-being to be a stronger predictor of health and performance outcomes over time than demographic characteristics, prior health utilization and costs and behavioral and physical health risks alone.

“The most important dial on any leader’s dashboard for the next 20 years will be well-being,” says Jim Clifton, Gallup chairman/CEO. “The money that well-being improvement means for companies—both for performance and productivity gains as well as healthcare cost reduction—is substantial.”

Catching Up With...Tricia Nguyen...continued from back page

Population Health News: How does a health system move from a fee-for-service to a value-based model? What are the biggest challenges?

Tricia Nguyen: Moving from fee-for-service (a reactive, sick model of care) to a value-based model (proactive, well-being model) is a strategic imperative for Texas Health. This requires strong physician leadership and alignment of incentives. Physicians are trained to diagnose and prescribe treatment. There is limited training, if any, of the skills needed to lead and manage care teams in many medical schools or residency programs.

In the value-based model, physicians are being asked to practice fundamentally different than how we were trained—to address one patient at time and rely on patients to self-identify when they have a sign or symptom of malady. In value-based models, however, we are asking physicians to monitor and perform surveillance on their patient panel to proactively identify patients who are at risk and invite them to be evaluated and mitigate those risks.

Additionally, the fee-for-service model does not pay for the value-added activities or services required to proactively manage a population. There is not a billable code for the time primary care physicians spend on reviewing their patient panel with the care team, delegate outreach activities, telephonically consult with specialist peers on complex patients or communicate with their patients asynchronously. Another example is that care transition managers have a vital role in patient transition, from acute to post-acute care, but there is no procedural code for this value-based function.

Population Health News: How will a model focusing on prevention, well-being and better management of chronic disease improve population health?

Tricia Nguyen: The old adage of “an ounce of prevention is worth a pound of cure” is what we are trying to achieve in a population health model. Improving population health starts with surveillance and monitoring of the population to identify those at risk and proactively deploying resources to help those individuals mitigate their risk. For example, identifying a cohort of individuals with metabolic syndrome and proactively engaging them in lifestyle modification tools and resources is important in reversing their risk of developing diabetes or cardiovascular disease.

Not only will this improve their physical health, it will also have a direct impact on their mental and financial health. There is a lot of evidence to support that people who eat healthy and are physically active live longer and happier lives. In addition, spending less on healthcare leaves consumers more discretionary spending dollars.
Catching Up With ....

Tricia Nguyen, M.D., MBA is executive vice president for population health at Texas Health Resources and president of the Texas Health Population Health, Education & Innovation Center.

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Population Health News: Since you have had experience working with providers, hospitals and payers, what commonalities do you find among them in terms of their objectives for achieving population health management?

Tricia Nguyen: Every player in the care delivery space—providers, hospitals and payers—is working towards achieving the Triple Aim (better health, better care, lower cost). In order to be successful, it will require proactive surveillance of the population and seamless coordination of health services among providers and the care team on behalf of consumers. Therefore, most organizations are focused on operational excellence. This requires eliminating silos (internally across departments and externally across providers, services and care settings) and streamlining workflow. The result is a more transparent, collaborative workflow that is convenient and supports the consumer’s “life-flow.”

With the current advances in technology and the ubiquities of smart phones and devices, most organizations are continually innovating and leveraging technology, not only to automate workflow, but also to create more access points and connections between the care team and consumers. For example, both payers and providers are either implementing or experimenting with remote monitoring of high risk consumers and deploying top-of-license resources to help those individuals mitigate the risk of decompensating and hospitalization.

Another commonality is that everyone is focused on growth by attracting and retaining market share. All stakeholders are figuring out how to maintain their relevance in the healthcare continuum (and guarding against becoming commoditized) by creating a signature (differentiated) service experience that delights the consumers and establishes trust in their brand. For example, many organizations are investing in customer relationship management tools to understand individual consumer needs and deploying appropriate resources, such as people, processes and technology to meet their needs.

Population Health News: Why did Texas Health Resources decide to launch a population, education and innovation center in 2013? What has it accomplished thus far?

Tricia Nguyen: Texas Health has long recognized that healthcare costs are unsustainable, and we have the opportunity to bend this trend. As a result, we are in the eighth year of a bold 10-year strategic plan to transform healthcare and become a nationally recognized leader in improving well-being, engaging physicians and coordinating care across the continuum of healthcare settings. The Texas Health Population Health, Education and Innovation Center (the Center) serves as the nexus for our activities to achieve the Triple Aim across the continuum of care. These initiatives include individual health improvement programs and resources customized for the populations or communities we serve. The community (defined as affinity groups) may be cohorts of individuals that live, work, play or worship together, or it could be a cohort of diabetics or heart disease patients.

We have accomplished a lot over the past year. Of note, we are in the implementation phase of the care management redesign, which is aimed at improving care transitions across the continuum. We are also in the implementation phase of bundle payment for select surgical conditions. We are on target to launch a physician leadership development academy later this fall. In addition, we are implementing Blue Zones in Fort Worth—a community well-being improvement initiative that focuses on changing the built environment to make the healthy choice, the easy choice for individuals.

Population Health News: When we talk about “clinical integration” in healthcare, what does that mean?

Tricia Nguyen: Clinical integration means seamless coordination of health information and services across the continuum of care (health status, site of service, providers and care teams) on behalf of consumers to help them live healthier and happier lives. Also, clinical integration is a mechanism to align incentives to achieve the Triple Aim through increased accountability of measurable outcomes and provider performance.

It requires forging partnerships among health plans, employers and providers, and investment in information technology infrastructure to facilitate the sharing of information to deliver on the promise of seamless coordination. Today, each organization has a different technology solution to manage its business functions and collect data about consumers. We are living in a data-rich and knowledge-poor world. We’re drowning in data, but starving for information because the data are so disparate and not in a sharable format that can be easily integrated. For example, each organization has its own consumer-unique identifier. This makes matching unique consumers across multiple systems one of the biggest challenges in integrating data, not to mention the velocity and volume of data that are being generated by consumers with their own health apps and social media avenues.

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