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Population Health NEWS

Running the Race Toward Value-Based Healthcare: Three Keys to Success

by Dave Van Andel

An historical look at U.S. healthcare spending reveals the trends and undercurrents ushering in a new era of unprecedented challenge and opportunity in the healthcare sector. Spending as a percentage of our gross domestic product has continued on a steady upward trend for the last three decades, with sharp inclines seen over the past 15 to 20 years. Up from previous rates of 8.9% in 1980 and 12.1% in 1990, healthcare spending has risen aggressively through the 2000s and now accounts for more than 17.1% of the U.S. GDP.[1] Although other developed nations have seen this same upward trend, the U.S. spending spree represents nearly a 50% greater burden than our nearest cohort, France, where spending accounts for approximately 11.6% of GDP.[2]

These spending trends significantly contribute to national and international dialogue around health, its value and the best methods for providing access to services and optimal outcomes for a population. In the early 2000s, the Institute for Healthcare Improvement (IHI), an independent, not-for-profit organization, led the call for achieving the triple aim for population health—the simultaneous improvement of healthcare access and outcomes while reducing costs. In directing government and private sector attention to these three objectives, the IHI has led the way for policy changes at both the state and federal levels.

By passing the Affordable Care Act, the U.S. federal government ushered in a new era in healthcare policy, establishing the Center for Medicare & Medicaid Innovation (CMMI) within the Centers for Medicare & Medicaid Services (CMS). Its objective is to test "innovative payment and service delivery models to reduce program expenditures… while preserving or enhancing the quality of care" for those individuals who receive Medicare, Medicaid or Children's Health Insurance Program (CHIP) benefits. CMMI has begun testing a variety of payment reform initiatives, providing stimulus for U.S. healthcare 2.0.

A high level understanding of the factors contributing to the steep increase in U.S. spending provides a framework for understanding the variety of policy changes being implemented by CMS.

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In This Issue

Freestanding Emergency Rooms Contribute to Higher Quality Care, Fewer Hospitalizations

by Jay Woody M.D., FACEP

As the healthcare industry trends toward a broader consumerism model, new forms of convenient healthcare outlets will begin to emerge as consumers request them. The healthcare industry is no longer dictated by physicians and medical leaders but rather is driven by the consumer and the type of facility model that works best for a patient. As a result, consumers are influencing a greater say in the type of care they want to receive.

Freestanding emergency rooms (ERs)—facilities not associated with a hospital—and similar offerings have begun to pop up all over the map[1] precisely because they cater to a consumer's needs beyond just having to choose between a primary care physician and hospital setting.

When a patient walks into a freestanding ER and agrees to be diagnosed, they have officially walked into an ER and—regardless of symptoms—will get billed for an emergency care level visit. Over the past four years, the number of these facilities has doubled to close to 400, according to the American Hospital Association.[2]

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Making a Case for Population Health

A Selected Case Study in Population Health Management…

Team Select: Keeping Team Members Healthy, Happy Through Telehealth

Objectives:

- Maintain a healthier employee population of home healthcare employees at Team Select who are delivering care to a vast array of homebound patients with potentially lower immune systems and more vulnerability to common illnesses.
- Leverage a behavioral change model to increase engagement in the HealthiestYou telehealth service to increase access to and affordability of care.
- To decrease absenteeism due to common healthcare conditions.
- Reduce employee visits to urgent care and emergency rooms for common conditions that can be easily treated through the HealthiestYou telehealth service.
- To reduce health insurance claims and thereby hold down healthcare cost increases for an employer and its employees.
- To remove obstacles to getting care by engaging with employees, who may have put off seeking care due to time or money restrictions.

Program Description: Today, approximately 12 million people receive home healthcare by skilled professionals who offer a variety of services.[1] Home care need is vast and is expected to grow as the U.S. population of people 65 years and older is predicted to increase. By 2030, it is projected that more than 20% of the U.S. population will be 65 or older compared to 13% in 2010.[2] In 2014, according to the Center for Disease Control & Prevention, long-term care services were provided by nearly 55,000 facilities and residential care communities, not including approximately 12,400 home health agencies.[3] With the reality of an aging population, combined with traditional employee turnover rates of 30% to 40%, not surprisingly, competition for top health care talent is fierce.

Matching supply to the demands of this dynamic market requires more than just savvy recruitment. It also requires focus on retention and employee care through creative strategies, perks and benefits that substantially reduce turnover and preserve connections and vital care relationships that at-home patients need.

For Phoenix, Ariz.-based Team Select Home Care, a home health services company with more than 800 employees, attracting and retaining the best talent is the cornerstone of its business. Mike Lovell, president/CEO of Team Select, and Fred Johnson, chief financial officer and vice president of strategic operations, are continuously searching for innovative and cost-effective ways to add value to their employee benefit plan, and they found one in HealthiestYou, a telehealth solution.

"By 2030, it is projected that more than 20% of the U.S. population will be 65 or older compared to 13% in 2010."

By focusing on engagement, HealthiestYou reduces visits by its employees to urgent care and the emergency department for common conditions—all of which prevent care costs from becoming insurance claims and, ultimately, higher premiums.

The service provides virtual doctor visits for common conditions that can be diagnosed by accessing board-certified doctors with a phone call or as of last year, through a smartphone app. It also is unlimited, meaning employees can call as many times per month as they need to—all without a copayment or other expenses.

At a new employee orientation, employees learn how to download the HealthiestYou app so they can summon care conveniently. The app is one way that employees get care, but they also receive a HealthiestYou wallet card for easy reference with the phone number to call, or they can go online to www.healthiestyou.com to the member portal and log in.

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Making a Case for Population Health … *continued from page 2*

Once the HealthiestYou call center is notified, a board-certified doctor calls within an hour. Prior to the call, a member has already provided a medical history so when the call comes in, doctors are aware of what they need to know to treat patients. A provider also may deem it necessary to call in a prescription. An individual's preferred pharmacy is part of the pre-completed patient profile so providers know where to send a prescription. Many HealthiestYou members claim that they have their consultation completed and prescription in hand faster than it would have taken to drive to and from a traditional doctor's appointment.

"We employ people who take care of other people; our employees are our most important asset. Keeping our team healthy is very important to our business, especially because our employees enter clients' homes to deliver care," Johnson says. "We chose HealthiestYou to encourage our employees to seek care at the first sign of an illness to help them get better faster. Our employees appreciate having the 24/7 option, and we are certain that our customers also appreciate that extra level of attention to our employees' health."

Team Select employs highly skilled workers, such as registered nurses, therapists, medical social workers and home health aides, but employee turnover in the home health industry is notoriously high and so are replacement costs. Recruiting fees can range up to $15,000 for a nurse or therapist with company training, adding approximately another $7,500 to the mix.

Evaluation: The solution quickly proved to be efficient in treating everyday illnesses for their team members and decreasing sick time away from work, becoming an important recruitment and retention tool for an in-demand workforce.

In addition to helping with recruiting and retention, Team Select knew HealthiestYou would be a great help in reducing ever-rising health care costs. It set a goal to reduce annual premium increases to 2% in contrast to the national average of 10%. "Our major cost of sales is employees so even a decrease of a few percentage points has a significant impact on our bottom line," Johnson says.

"HealthiestYou utilization rate was 98% over a nine-month period—on track for an annual utilization rate of 130%."

Since introducing HealthiestYou in 2015, Team Select has exceeded its goal and has held a lid on premiums with no increase for 2016.

Team Select provides services in several states, including Colorado, Oklahoma and Arizona, but it faces a unique staffing challenge in the Arizona market, where the company is headquartered. As the population shifts with people relocating to escape hot summers, the demand for services lessens and then dramatically increases once "snowbirds" flee the cooler climes and head back to Arizona in the winter months.

For efficiency's sake, the company is able to buffer fluctuations in demand by employing a large part-time staff. Some work as little as two hours per month and others, 30 hours per week.

Team Select is planning to offer HealthiestYou to part-time employees, something the company hasn't done previously with any of its benefits. Part-time employees will pay just $8 per month for unlimited virtual healthcare through HealthiestYou.

Results:

- HealthiestYou utilization rate was 98% over a nine-month period—on track for an annual utilization rate of 130% (consults divided by number of lives).
- Reduced turnover to half the industry average.
- Maintained a flat rate on premiums in 2016.
- Enrolled 120 employees taking advantage of 118 consults and 123 prescriptions; 104% of consults resulted in a prescription being written (prescriptions written divided by enrolled lives).
- Team Select covered 100% of the cost of the program. Employees faced $0 out-of-pocket, consultation fees.
- There were seven Team Select locations.
- In 2014 and 2015, insurance renewal costs were up approximately 8%. For 2016, Team Select held flat at 0%, while the industry average was estimated at 10%.
- Decreased 7: missing absenteeism by 14%.
- Savings from avoiding traditional care (primary care doctors, ER, urgent care) was $187,365 on average redirected away from care centers, based on an average of $291 per redirected claim.

Lessons Learned:

- Behavior changes need to start day one of employment. New employees receive thorough training on their healthcare benefit and the importance of receiving necessary care during the company's three-day orientation. The one-on-one training includes downloading the HealthiestYou app.
- Telehealth has improved company's absenteeism rate. HealthiestYou acknowledged that employees would call in sick less or spend less time away from work to go to a doctor's office, and the program lived up to its promise.
- Healthcare can be affordable and convenient. For the price of a couple of Starbucks' drinks per month, the program has improved health and provided an incentive to stay with the company longer.

[1] "Industry Stats: The Home Healthcare Market and Home Care Industry Statistics." Ankota. 2014.
[2] Ortman JM, Velkoff VA, Hogan H. "An Aging Nation: The Older Population in the United States." United States Census Bureau. July 17, 2014.
[3] "Long-Term Care Providers and Services Users in the United States: Data from the National Study of Long-Term Care Providers, 2013–2014." Centers for Disease Control and Prevention. February 2016;3(38).

Freestanding Emergency Rooms Contribute to Higher Quality Care… *continued from page 1*

Urgent care facilities, retail care facilities, freestanding ERs and hybrid model facilities are becoming more common because they offer the easiest and best care level for consumers in many different ways: convenience, cost, time and quality of care. While freestanding ERs affiliated with hospitals or hospital systems have been popular for many years, newer freestanding ERs owned by separate companies and individuals are beginning to propagate.

"Two states, Colorado and Texas, have legislation on the books that allows for freestanding emergency departments unaffiliated with a hospital network."

Two states, Colorado and Texas, have legislation on the books that allows for freestanding emergency departments unaffiliated with a hospital network. Recently, the Colorado House of Representatives proposed additional legislation designed to notify patients of potentially high costs associated with visiting a freestanding ER. State Rep. Beth McCann (D) introduced HB 16-1374, Required Notice & Disclosures Freestanding ERs.

Provisions of the bill require freestanding ERs to post notices throughout the facility that they are emergency rooms providing emergency services to be billed accordingly.

In addition, the bill stipulates additional notifications be made to patients regarding medical cost rates, insurance coverage and billing procedures. Texas' freestanding ER law already requires this.

In other states, freestanding ERs have the ability to operate as a decentralized department of an attached hospital network. This means that although they may be physically detached from a hospital, they are still directly affiliated with its network. Unaffiliated freestanding ERs are privately owned and not part of a hospital network.

Pros and Cons of Freestanding ERs

- **Convenience**. One of the major benefits of freestanding ERs and urgent care centers is their ability to provide additional access to healthcare services. It's estimated that by the end of 2016, there will be more than 200 freestanding ERs in Texas.[3]

  In this immense state, people no longer have to drive 30 minutes to an hour to reach the nearest hospital nor do they need to call for an ambulance. They can hop in the car, drive five minutes down the road and arrive at a fully equipped ER facility. If patients at a freestanding ER require an overnight hospital stay, they can be transferred to the nearest partnering hospital network. Thus, patients aren't routinely admitted when it's not absolutely necessary as is often the case in a hospital-based, ER setting. However, with freestanding ERs, direct access to a hospital isn't as convenient an option.

  "Emergent care is more readily available, but this benefit does create an obscure issue for patients seeking the difference between emergent and urgent care. The general consumer may not see the difference between these two though their pocketbook will."

  Emergent care is more readily available, but this benefit does create an obscure issue for patients seeking the difference between emergent and urgent care. The general consumer may not see the difference between these two though their pocketbook will.

  There also is a hybrid billing business model, which offers both urgent care and ER services under one roof, eliminating unnecessarily high medical bills for consumers and wasted staff resources for clinics. This is a major game-changer in ER overspend, in which patients are billed based on the severity of their condition (emergency care or urgent care billing) and only charged for the level of care required at the time of a visit.

  For example, a patient walks into a hybrid facility, and the medical staff makes a determination as to whether the care needed is ER-level or urgent care. When patients are sick or injured, they don't have to decide what level of care they need because both levels are available in one setting.

  This hybrid billing model allows providers the ability to establish a cost-effective, more personal and time-efficient way to deliver high-quality medical service at the appropriate cost. By taking the guesswork out of which type of facility to seek, patients can then focus on getting the proper and cost-efficient diagnosis for their injuries or illnesses.

  Freestanding ERs are also conveniently located; they're typically found around residential areas and/or shopping centers. This strategic placement of facilities ensures patients are able to obtain medical help close to their homes and quicker access to services and a faster return to their homes after treatment.

- **Efficiency**. While freestanding ERs offer the same services as a hospital-based ER, they are often more efficient than the typical hospital ER because their resources are self-contained and completely devoted to emergency room patients.

- **Quality**. In an emergency, patients want the best care available. A common misconception is that the level of care is less than standard within the urgent care or freestanding ER world. On the contrary, the quality of care patients receive is the same care they would receive in a hospital-based ER with the exception of overnight stays and surgical privileges.

  "Nearly two-thirds of hospitals now staff their ERs with freelance physicians, who are available 24/7."

  Extremely qualified, licensed, ER-trained physicians and nurses work at these facilities, many of whom are recruited from hospitals and offered good employment packages—better schedules, less stress and often, a slower pace as compared to a hospital ER. Nearly two-thirds of hospitals now staff their ERs with freelance physicians,[4] who are available 24/7.

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Freestanding Emergency Rooms Contribute to Higher Quality Care… *continued from page 4*

Consequently, freestanding ERs are quicker to attend to their patients, as the doctor-to-patient ratio is much lower than it is in a hospital-based ER setting. Those who visit an ER often wait for hours while other more critical patients are treated first. Even if a patient does not have a life-threatening condition, a long wait for treatment might put him/her at a higher risk for problems. Waiting in an ER for attention also raises the probability for patients to be exposed to illnesses from others, which can compromise their health.

- **Cost**. The typical ER bill will have copayment amounts and fees for diagnostic and laboratory tests, radiology services, pharmaceuticals, supplies, facility use, nursing care and physician services. These discretionary ER charges vary so much from facility to facility that it's very difficult to estimate what a visit will actually cost a consumer; however, the cost at a freestanding ER is typically equal to the cost of being treated at a hospital-based ER.[5]

"According to a 2015 Milliman whitepaper, studies have shown that 44% to 65% of ER patients don't need ER-level care but are still charged for it."

According to a 2015 Milliman whitepaper, studies have shown that 44% to 65% of ER patients don't need ER-level care but are still charged for it.[6] Americans waste more than four billion dollars a year on unnecessary ER billing costs. An urgent care, treatable case handled in a hospital ER costs an average of $2,039, while the same case treated in an urgent care facility would run approximately $226. That's a $1,813 difference that could easily be avoided on a case-by-case basis.[7]

Although freestanding ERs are a direct reaction to consumer demand for medical care delivered in an alternative manner than has been traditionally offered, it's important that patients realize what constitutes a freestanding ER versus an urgent care center. There is a much different level of billing between these two types of facilities. Patients will automatically pay more when they visit an ER but if a case requires emergent care, it's necessary for patients to get the proper type of care regardless of cost. Freestanding ERs are ensuring there is adequate emergent care available to consumers.

1 Galewitz P. "'Wildfire' Growth of Freestanding ERs Raises Concerns About Cost." *Kaiser Health News.* July 15, 2013.
2 *Ibid.*
3 Jones J. "Freestanding Emergency Rooms Bring Competition, Confusion to East Texas Healthcare." Ark-La-Tex.com. April 19, 2016.
4 Kieler A. "Why Emergency Rooms Are a Hotbed for Surprise Medical Bills." *Consumerist*. Nov. 5, 2015.
5 "*FAQ." Texas Association of FREESTANDING Emergency Centers*.
6 "Avoidable Emergency Department Usage Study." Truven. 2013; "Potential Saving When Moving From an Emergency Department to an Urgent Care Setting in Commercial Populations (for Dallas MSA)." Milliman. 2015.
7 *Ibid.*

"An urgent care, treatable case handled in a hospital ER costs an average of $2,039, while the same case treated in an urgent care facility would run approximately $226."

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Running the Race Toward Value-Based Healthcare: Three Keys to Success… *continued from page 1*

Historical fee-for-service, healthcare models draw significant blame for rising costs. These reimbursement incentives drive healthcare procedures and interventions without regard to quality or outcomes, incenting providers for billing more rather than less. This payment model has allowed providers to neglect the outcome of their assessments and interventions, fooling the populace into believing more is better when it comes to healthcare spending. These incentives, combined with short-term, cost-reduction strategies, continue to drive spending on acute management of chronic conditions without the need to invest in long-term cost containment and outcomes.

Beyond the dysfunctional payment model, the challenge of defining, measuring and incentivizing optimal outcomes has stalled provider accountability and perpetuated the spending spree. Meaningful Use of electronic health records; the World Health Organization coding system (ICD-10); renewed efforts to capture patient-reported outcomes; and multi-disciplinary initiatives for evidence-based practice have begun to turn the tide towards capturing relevant data, telling the story of healthcare value.

Charged with changing the trajectory of healthcare spending, the CMMI has made several policy changes aimed at transitioning traditional fee-for-service models to fee-for-value ones. The Bundled Payment Care Initiative[3] and the Comprehensive Care for Joint Replacement[4] represent renewed efforts to address triple aim goals. It seems clear that rather than destabilizing the healthcare system with a radical overhaul, CMS has started wringing out the "excess spending sponge," one twist at a time.

When viewed collectively, the goals of reorienting the broken reimbursement system to decrease the cost of care, improving access to enhance population health with improved quality, present seemingly monumental obstacles. These goals will require ingenuity and a healthy dose of technology to assist payers, providers and patients along the path to triple aim success.

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Running the Race Toward Value-Based Healthcare: Three Keys to Success… *continued from page 5*

Here are three areas where technology will need to be leveraged to make a difference in population health:

1. **Connected health.** Although this term may mean different things to different people, the general idea of connecting the flow of health data surrounding patients and their episodes of care will gain importance when redundancies, duplicative services and misunderstandings result in decreased reimbursement for providers. The walls between a patient's everyday use of technology and the technology of their healthcare providers will slowly break down.

   "The walls between a patient's everyday use of technology and the technology of their healthcare providers will slowly break down."

   As more health information and data are collected via wearables, social media sites and smart phones, the value of this information in managing health will grow increasingly important. A patient's personal wearable health data will inform provider decisions, while HIPAA security and patient rights will continue to drive innovation and cooperation among vendors, making everyone involved in the coordination of care more dependent upon technology integration to provide continued security and privacy.

2. **Personalization *and* standardization.** Although it sounds counterintuitive to consider a coordinated care plan being both personalized and standardized, this will be the challenge of a healthcare provider in the world of fee for value. Systems will seek a standardized approach to optimize outcomes through data-driven metrics. This will require a "measure everything" approach to care, meaning more data will be collected throughout an entire care cycle. No one will be spared from data collecting efforts. Patients, clinicians and administrators will all be required to contribute with various levels of interest and participation. Using data, health systems will try to strike the balance of knowing when to veer off of the care pathway to optimize an outcome with personalization and when to play the numbers for staying on course.

3. **The move home.** A new frontier of personalized health data available through activity trackers and other quantified self-tools will begin to see connections with a care plan. As technology makes data more prevalent and connected to daily function, healthcare will begin to move towards case management in the home versus crisis management in the hospital system.

   Chronic disease management, where daily habits, patterns and activities play a critical role in reducing expense, has the most to gain from connecting with patients in the home. Patient-centered medical homes will bring best practices around a multi-disciplinary approach to condition management, while focusing on a holistic view of patients—their social support, culture, health and environment.

In contrast to today's healthcare, this move toward a patient's home recognizes that the most cost-effective and cheapest healthcare treatment methods will often occur in a patient's environment rather than in a hospital. Technology will allow greater monitoring and insight to occur remotely, providing the information and communication a provider seeks, while allowing patients greater autonomy and freedom in their care plans.

"In contrast to today's healthcare, this move toward a patient's home recognizes that the most cost-effective and cheapest healthcare treatment methods will often occur in a patient's environment rather than in a hospital."

Building the bridge to healthcare 2.0 requires technology platforms that improve care coordination, assist in standardization and personalization and help clinicians case manage in a home. Innovative payment models, engaged patients and data-supported clinicians are the hallmarks of this new world, providing a more sustainable healthcare delivery model.

[1] Squires D, Anderson C. "U.S. Care From a Global Perspective." The Commonwealth Fund. Oct. 8, 2016.
[2] *Ibid.*
[3] "BPCI Model 3: Retrospective Post Acute Care Only." Centers for Medicare & Medicaid Services. CMS.gov.
[4] "Comprehensive Care for Joint Replacement Model." Centers for Medicare & Medicaid Services. CMS.gov.

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Developing Content that Supports Behavior Change

by Rachel Weatherly

The solution to meeting the healthcare triple aim of simultaneously improving patient experiences, improving patient outcomes and reducing healthcare costs will likely be as complex as the challenge itself. It will require integration and collaboration across the entire healthcare ecosystem to succeed. Although a monumental task, creating healthy patient behaviors stands to have a huge impact on every dimension:

1. **Improve patient care experiences.** Better health reduces the need for care and makes preventive care visits more pleasant for doctor and patient. When change is needed, well-designed intervention strategies with built-in support mechanisms lay a solid foundation for patients to feel they can succeed, while motivating them to start their behavior change journey.
2. **Improve patient outcomes.** The transformation to value-based payment, which bases reimbursement for service on quality and clinical effectiveness of care provided, will drive providers, hospitals and health systems to increase their collective stake in helping keep patients healthy. In addition, high-deductible health plans are becoming more prevalent, which relies on patient self-care and self-management. Health and wellness programs that teach and support healthy behaviors are critical.
3. **Reduce healthcare costs.** Dave Chase, a senior executive in healthcare and digital health at Cascadia Capital, estimates that the combined economic impact of changing patient behavior for just six key health influences (obesity, tobacco use, drug and alcohol use, sleep and sexual activity) could save up to half a trillion dollars in the United States alone.[1]

"Dave Chase, a senior executive in healthcare and digital health at Cascadia Capital, estimates that the combined economic impact of changing patient behavior for just six key health influences (obesity, tobacco use, drug and alcohol use, sleep and sexual activity) could save up to half a trillion dollars in the United States alone."

Healthcare providers play an integral role in driving change as one-on-one interactions between doctors and patients can be especially effective but are limited by patient numbers and scheduling possibilities. Whether educating patients on the need for change or helping them find the motivation to begin creating new habits, learning materials have the power to engage in a meaningful way. Hospitals, health systems and even insurance companies and employers have a much larger megaphone for broad communication across populations digitally. Finding a better way to define populations and target messages accordingly is crucial to success.

- **Empathize with an audience.** Start by knowing an audience and how it relates to both health information and technology. This knowledge is crucial to designing better behavior change solutions that engage audiences and move them along a path to new and healthier habits.

  An increased level of understanding leads to better predictions of user behavior and if it is possible to predict behavior, it is possible to influence it. Digital platforms offer significant opportunities for facilitating change as they pervade every aspect of everyday life and have the benefit of following patients out of a clinical setting into the real world. Scalability, flexibility and reach make digital tools a logical investment for reaching patients, and recent trends in health-related platform adoption reinforces the available market.

  Human-centered design focuses on an empathic approach to designing solutions. Empathy is the human element that goes beyond just defining a target audience to also understanding its perspective—the lens through which a group interprets the world. The result is the ability to connect on a human level and extend that connection to deeper engagement.

  By analyzing various perspectives represented in an audience, an organization can subset a larger audience into groups based on their likely behaviors to target interactions more effectively. For example, some consumers are more likely to look for health information online as a primary source, while others are more apt to ask a medical professional or other trusted person. Based on those behavioral parameters, it's a logical assumption that reaching the first group will require search engine optimization and social media strategies. To engage the second group, outreach through intermediaries such as community health workers is more likely to yield results.

"When trying to define large and diverse audiences, traditional segmentation creates too many variables for a manageable data set. Using empathic indicators, such as needs, challenges, habits and influences, to segment audiences creates an actionable data set based on typical and likely behaviors."

  The very concept behind population health creates a unique opportunity for applying behavior change strategies. When trying to define large and diverse audiences, traditional segmentation creates too many variables for a manageable data set. Using empathic indicators, such as needs, challenges, habits and influences, to segment audiences creates an actionable data set based on typical and likely behaviors. Cross-referencing that information with available data through population health adds considerable dimension to an audience profile and allows for another level of tailored messaging.

- **Build influence through engaging relationships.** Effective behavior change initiatives require concerted, comprehensive strategies to succeed. A key part relies on the level of engagement with an audience, in this case patients or healthcare consumers. Behavior interventions seek to change the relationship someone has with an existing habit. Relationships yield influence, and the relationship a person has with a particular habit must be replaced to establish a new one.

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Developing Content that Supports Behavior Change … *continued from page 7*

> ***"At the highest level, the keys to affecting lasting behavior change are engaging the audience's head through awareness and education, the heart through emotional connection and desire and finally the body through action to deepen engagement and extend influence with an audience."***

Engagement is the basis for any successful behavior change strategy because it builds and strengthens all relationships. It allows an organization to amplify its influence on an audience because as engagement increases, so does influence.

Well-designed behavior change strategies lead patients along an engagement pathway that builds a relationship and influence along the way. The engagement pathway lies between where an audience starts and desired outcomes for them. There are two journey maps that will aid in designing engagement strategies. First, the ideal journey from point A to point B maps the steps necessary to achieve a desired outcome. It's a good place to start, but a patient rarely experiences an ideal journey for many reasons, not the least of which is the huge differences between people. Secondly, mapping a different typical journey's experiences and examining the deviations patients take from an ideal journey allow providers to integrate tactics that prevent abandonment or help patients get back on track.

A considerable amount of work and scientific research have explored how to move patients along a behavior change journey. At the highest level, the keys to affecting lasting behavior change are engaging the audience's head through awareness and education, the heart through emotional connection and desire and finally the body through action to deepen engagement and extend influence with an audience.

Those three levels of interaction—the head, the heart and the body—set the guidelines for effective engagement through content development. Keeping in mind where an audience is in its journey, an organization should educate, connect or call consumers to action. Moving too fast can cause an audience to revert on its journey or abandon progress altogether.

- **Engage on consumers' terms**. Detailed audience profiles, along with ideal and typical journey maps, provide a great deal of information about what information an audience needs and when to help it succeed on its behavior change journey. Digital analytics provide details to determine the best content formats and platforms for engaging an audience, as well as data for customizing engagements and personalizing experiences to increase efficacy.

For example, tracking what content is accessed on what devices throughout the day and what types are most popular allows developers to create content users desire, as well as establish publishing cycles that capitalize on when users are most likely to consume it. Analytics are a powerful tool, and the information that can be tracked is becoming more detailed and more accurate. A harder task is creating a culture of developing content based on data-driven decisions. Not getting emotionally attached to content and being willing to throw out the status quo to experiment and embrace the direction an audience prefers can be difficult at first, but the risk of letting audiences' needs lead pays off in engagement.

Taking the concept of customized experiences to the next level, flexible open content models allow users to create their own adventure as they navigate. In an on-demand world, audiences have become accustomed to exploring content on their own terms—when, where and how they want. Health information should allow users to scan bite-sized chunks of information quickly to see what's available and to dive deeper for more information as desired. For those looking for more scientific, in-depth material, they can continue to explore further.

- **Amplify influence.** Getting an audience to act is just the tip of the behavior change iceberg. Continuing to connect and reinforcing successes helps keep patients on track for the long term, moving them beyond acting to maintaining. When patients successfully change an action to a new habit, they can become the most powerful advocates for helping others start their own journey or get back on track. Successful patients personify the benefits of healthier behaviors and evangelize the need for change to others. Their success stories make excellent content as audiences connect with and trust content more readily when they see themselves and their lives reflected in it. Success stories from everyday people holds up a mirror for audiences.

> ***"When patients successfully change an action to a new habit, they can become the most powerful advocates for helping others start their own journey or get back on track."***

Patient behavior change is a critical part of any population health effort, and developing effective content that encourages, influences and supports behavior change is a powerful tool for health providers. The key is to balance an organization's goals with an audience's needs, and make a population audience feel as if it is a priority. The more content resonates, the more effective it will be and the bigger the ripple effect based on loyalty and advocacy.

[1] Chase D. "Report: The Future Health Ecosystem Today Provides Look Into Healthcare's Future." *Forbes*. Feb. 3, 2016.

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Thought Leaders' Corner

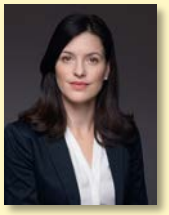
Each month, *Population Health News* asks a panel of industry experts to discuss a topic suggested by a subscriber.

Q. What Role Should Behavioral Health Play in Population Health Management?

Behavioral health is essential for improvements in population health management. There are factors that have an impact on a person's health that cannot be changed, such as a person's genetic makeup and predisposition to diseases. There are systemic factors that have a negative impact on health that are very difficult to change, such as a person's environment and socioeconomic status. However, it is well known that a person's own behavior has a significant impact on his/her mental and physical health.

Behavioral interventions allow us to target negative behaviors that have an adverse effect on health, such as addictions, depression, obesity, smoking and sexually transmitted infections. Behavioral health interventions can target individuals, families and communities, and these interventions can also be designed and implemented at these levels allowing us to target both at-risk populations and specific health issues in a population. However, it is crucial that behavior modification principles are followed to ensure effective interventions are delivered.

There are many benefits of using behavioral health interventions; it is cost effective to deliver an intervention to multiple people at once rather than the single patient model seen in most health settings. Outcome performance of an intervention can be measured and evaluated to determine its effectiveness and value. In addition these interventions can be delivered by various agencies and professionals, and via non-traditional modalities to increase user engagement with a program by using social media and mobile platforms, for example. Behavioral health is a vital and accessible ingredient in improving health outcomes for a population.



Lauren Callaghan
Director
Clinical Psychologist and Cognitive Behavioral Therapist
The MindWorks, Inc.
London, England

Over the last two decades, our country's reimbursement models and provider training programs have erected silos around mental health conditions and substance use disorders. In the process, we dehumanized medical care and put up barriers for a large segment of behavioral health patients, sending them into our communities where social service agencies, law enforcement and the criminal justice system were ill-equipped to meet their needs. In the process, we unwittingly criminalized mental illness.

While the population with serious mental illnesses is relatively small, its plight underscores the shortcomings of our outdated approach to behavioral health services.

To broadly improve population health, we must remove the stigma of mental health services and move toward a care model that tightly integrates biopsychosocial needs. This approach requires providers and payors to collaborate on innovative payment models that will allow us to develop and sustain integrated behavioral health systems of care. Community-based partnerships are also essential to complete the unique set of clinical and supportive services that are necessary to identify and address primary and secondary behavioral health needs much earlier. This approach has been demonstrated to engage patients more effectively in managing their conditions. Moreover, it improves treatment compliance, breaks the cycle of recidivism and reduces the burden on crisis systems. And it lower costs while delivering better outcomes and improving population health.

Theodore Michalke
Senior Manager
ECG Management Consultants
Chicago, Ill.

Thought Leaders' Corner

Despite multiple attempts to legislate "parity" between behavioral health and medical benefits, until recently we have been largely unsuccessful in fully integrating the two disciplines. Our fragmented networks of care, the medical orientation benefit plans and even the social stigma associated with behavioral health diagnoses have contributed barriers to this lack of care integration.

Fortunately, clinicians and healthcare executives are finally recognizing the critical role behavioral health conditions play in determining the overall health status of patients and the costs for caring for these individuals. Simple factors, such as medication adherence and healthy eating, are greatly impacted by patients' comprehension abilities and willingness to engage in their own health improvement. For example, a report by the Medicaid and CHIP Payment Commission found that about 20% of Medicaid beneficiaries have a behavioral health diagnosis, yet account for 48% of Medicaid spending.[1]

In order for the integration of behavioral and medical health to be effective, two things must occur. First, all of a patient's healthcare needs—physical and behavioral—must be identified as early as possible regardless of how or why a patient enters the healthcare system. Second, we must be prepared to apply the core principles of patient-centered care across all practice settings, including effective care coordination support in navigating the system.

Many innovative provider systems are making great progress in these integration efforts using effective screening mechanisms and integrated health homes. But much more needs to be done.

[1] "Behavioral Health in the Medicaid Program—People, Use, and Expenditures." MACPAC. June 2015.

Henry W. Osowski
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As risked-based care expands and the consumerization of medicine picks up pace, payers and delivery systems are looking to improve value delivery to all stakeholders. Aided by governmental mandates and incentives, the healthcare industry has developed experience identifying physical health conditions which influence clinical outcomes and utilization patterns.

Advanced delivery systems have operationalized predictive models to identify these physical health risk factors a priori and intervene clinically to deliver better outcomes. Payers have developed robust actuarial risk models based on utilization and administrative data to improve population management efforts that are heavily weighted toward physical health conditions. Yet progress on consistent evaluation, recognition and treatment of behavioral health comorbidities is lagging.

Decades of research have demonstrated the impact of mental health conditions on physical health outcomes and utilization, but delivery systems and payers have not fully integrated the assessment and treatment of behavioral health conditions into their population management efforts, especially those efforts to preemptively identify risk factors for mental health conditions and appropriately intervene.

Limited access to screening tools, clinical personnel and non-integrated payment vehicles all contribute to this lag. But market conditions are forcing delivery systems and payers to improve behavioral health-focused, data acquisition and integration and incorporate them into their overall risk-assessment, risk mitigation and clinical optimization efforts.

Organizations should start small and focus on specific patient populations to learn more about how to integrate data findings with ongoing population management initiatives, a strategy that will lead to a competitive advantage in a value-based market.

Steven Spalding, M.D.
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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

'Virtual Dental Homes' Prove Safe, Effective

Bringing "virtual dental homes" to schools, nursing homes and long-term care facilities can keep people healthy—reducing school absenteeism, lessening the need for parents to leave work to care for an ailing child and helping to prevent suffering for millions of people who have no access to a dentist, a six-year study by University of the Pacific demonstrates.

The findings were reported by the Pacific Center for Special Care. Pacific developed the teledentistry system and has evaluated it in more than 3,000 patients across California since 2010. More than $5.5 million in federal, state and other grants supported the demonstration project.

The virtual dental home is a community-based, oral healthcare delivery system that uses telehealth technology to link specially trained dental hygienists in a community with dentists in dental offices and clinics.

"Our six-year demonstration project confirms that this is a safe, effective way to bring care to people who need it," says Pacific Center Director Paul Glassman, a professor of dentistry at University of the Pacific who developed the approach. "Basing a virtual dental home in a school, a nursing home or other community setting allows dental hygienists to prevent or treat the majority of oral health problems on site, and also brings prevention information to patients, families and caregivers. Finally, it connects onsite care in the community to dentists in dental offices."

Since the demonstration project began, Glassman and his team have implemented the system in 50 California Head Start preschools, elementary schools, community centers, residential care facilities for people with disabilities, senior centers and nursing homes. Preliminary findings persuaded Oregon, Hawaii and Colorado to also pilot the system.

The school's dental "home" is a cheery room, just off the cafeteria, where kids can have their teeth checked by a dentist via telehealth. The school's part-time, grant-funded dental hygienist cleans teeth, treats some small cavities and teaches tooth brushing, flossing and tooth-friendly nutrition. She gives away free toothbrushes to children and their family members, with as many free replacements as needed.

AcademyHealth Explores How Payment Reform Can Support Population Health

AcademyHealth, supported by the Robert Wood Johnson Foundation, is leading a new effort called Payment Reform for Population Health to identify where momentum and opportunities exist to close the gap between payment reform and community-wide population health. As a neutral broker of information, AcademyHealth supports the generation of new knowledge and the transfer of knowledge into action. Supported by a broad and diverse network of researchers, policymakers and practitioners, AcademyHealth is well positioned to collaborate and facilitate connections, create shareable resources and co-create strategies for using payment reform to support population health improvement.

AcademyHealth Explores Payment Reform...*continued*

This cross-team, multidisciplinary effort brings together AcademyHealth's experts in payment reform, population and public health, healthcare data management and research and analytic methods to identify where payment reform and population health intersect.

In a time of significant healthcare transformation, many health insurers and healthcare providers are moving toward payment models based on the quality of care rather than quantity in an effort to attain the triple aim of better care, smarter spending and healthier people. The U.S. Department of Health and Human Services is working toward tying 90% of Medicare payments to quality by 2018, and at the state level, many are exploring a variety of new payment approaches through State Innovation Models funded by the Center for Medicare and Medicaid Innovation.

While these payment reform efforts have a clear tie to the smarter spending aspect of the triple aim, what about their impact on people's health? Right now, most of these value-based payment models, as they're known, focus on clinical services and specifically focus on the needs and outcomes of a particular healthcare provider's patients, a health plan's enrollees or a purchaser's employee subscribers.

Other payment models focus on a targeted sub-population of individuals with a defined clinical condition, such as patients with diabetes or depression. As such, payment and financing models are not yet adequately supporting community-wide, that is, geographically based, population health. The incentives in these models do not yet reward healthcare providers for creating healthy communities nor do they incentivize other sectors—transportation, housing, education—for population health improvements.

In collaboration with AcademyHealth's Guiding Committee, practitioners and other key stakeholders, objectives are:

- Leverage and learn from efforts underway and work to support and enhance these activities.
- Assist in the spread of ideas, knowledge and evidence.
- Support initiatives to overcome persistent, yet surmountable barriers, to achieve success.

AcademyHealth also has identified several barriers to payment reform for population health, including:

- Multiple definitions of population health.
- Complexity of how various payment models can impact social determinants of health.
- Misalignment of financial incentives.
- Lack of appropriate data and adequate outcomes measures.
- Insufficient evidence for which population health initiatives might have the greatest impact.
- Inability to replicate and scale innovations across various communities.
- Lack of a business case or return-on-investment for such activities.

Next steps include digging deeper into these challenges and working to identify and disseminate promising solutions to overcome shared challenges.

Catching Up With ….

Kari Bunkers, M.D., serves as a family physician with the Mayo Clinic Health System in Owatonna, Minn., and is co-chair for Mayo Clinic's Office of Population Health Management, which has responsibility for redesigning all of Mayo's community practices in the Midwest, Southeast and Southwest to align with emerging value-based, reimbursement models.

- **Board-certified, Family Medicine and Clinical Informatics**
- **Former Chief Medical Information Officer, Mayo Clinic Health System**
- **Former Medical Director, Mayo's Global Business Solutions' Care Management Service Line**
- **Serves on numerous Mayo Clinic Committees in addition to Population Health:**
  - **Data Governance Committee**
  - **Office of Information and Knowledge Management**
  - **Plummer Steering Committee**
  - **Outpatient Care Delivery Platform**
  - **Analytics Program Oversight**
- **Undergraduate degree, College of St. Benedict, St. Joseph, Minn.**
- **College of St. Benedict Distinguished Alumnus Award 2013**
- **Medical degree, University of Minnesota Medical School**

***Population Health News**: Why did the Mayo Clinic decide to develop an Office of Population Health Management? What are its goals and what is your role?*

Kari Bunkers: Mayo Clinic launched the Office of Population Health Management four years ago to better understand and study the efforts of our community practice's transformation to a value-based delivery model. The Mayo Model of Community Care is the population health framework for our transformed delivery model, and I served as the medical director for the office and oversaw the development and launch of the 10 programs within the Office.

During the last year, we merged our strategic and implementation arms into a single committee, and I now serve as co-chair of Mayo's Population Health Committee and chair of its Business Intelligence and Discovery subcommittees. Our Business Intelligence Subcommittee has oversight of data acquisition strategies, as well as the dashboards and analytic tools that drive our population health delivery model toward our triple aim goals. The Discovery Subcommittee is responsible for the future strategic direction and for vetting new ideas to be implemented into future phases of our model.

***Population Health News**: What kinds of programs has the Mayo Clinic implemented to move from volume- to value-based care?*

Kari Bunkers: The Office of Population Health Management originally launched 10 programs that together have driven the strategy for implementation of our population health delivery model across our community practices. Team-based care is the key program which drives many of our initiatives around using our staff to the highest level of licensure; standardization of processes such as standardized rooming and panel management to close gaps in care; and the addition of medication therapy management (MTM) pharmacy and behavioral health staff to our care teams.

High-risk patient management, care coordination and primary palliative care focus on preventing high-cost, avoidable utilization, while the chronic condition management and prevention programs focus on standardizing and automating decision support for evidence-based, best practice into our multiple electronic medical records (EMRs). Community and patient engagement align resources and strive to understand what patients want, need and expect from their care teams.

***Population Health News**: How does care management align with Mayo's direction toward value-based care?*

Kari Bunkers: Care management is a vital component of Mayo's transforming delivery care model. Supply and demand are showing us that we need to utilize our entire care team in more efficient ways as our population ages and our primary care provider shortage continues to increase. A key aspect of this is care management that allows us to reach patients beyond the time they are in the office and to manage their chronic diseases more proactively and ideally with better outcomes, experience and at a lower cost.

We have essentially three tiers of care management: *Panel management* is for patients that have one or two uncomplicated chronic conditions. *Rising risk management* identifies patients before their chronic conditions become complex and offers services such as MTM and others to prevent long-term complications, and our *complex care coordination programs* offer highly individualized services to our most complex and high-risk patients. Our access program oversees patient attribution tools and processes, as well as opportunities to serve patients in alternative settings such as e-visits.

***Population Health News**: The industry is focusing on alternative payment models so what is the Mayo Clinic doing in the area of reimbursement?*

Kari Bunkers: Mayo is exploring several alternative payment models. We work closely with both our government and our commercial payers to explore contracts that drive quality and value for our patients.