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INSIDE

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Housing Is Critical to Healthcare Plan Success

Help clients find housing, then focus on healthcare

Case management often focuses on patients' social determinants of health as a part of the bigger health picture. Now, there's a small but growing number of organizations that are making one social determinant — housing — an integral part of all healthcare coordination.

"We are still learning how to integrate housing and healthcare," says **Monica McCurdy**, PA-C, vice president of healthcare services for Project Home in Philadelphia.

"We're a large organization, and we started out focusing on ending chronic homelessness," McCurdy says. "Permanent support of housing has been one of the strongest focuses of our work."

Now, Project Home is trying to end chronic homelessness by providing healthcare, as well as focusing on education and employment.

"Forty percent of our young adults living in our program are living with chronic medical conditions," says **Kate Gormley**, LSW, young adult program manager at Project Home.

> "WHEN YOU ARE INSECURELY HOUSED AND COUCH-SURFING, YOU DON'T KNOW WHEN YOUR NEXT MEAL IS COMING, AND PREVENTIVE CARE IS NOT ON YOUR LIST OF PRIORITIES."

Before coming to Project Home, Gormley worked for eight years in a targeted case management program, overseeing HIV-positive patients in Philadelphia. She says she learned through that experience how intrinsically housing and health are linked. "When you are insecurely housed and couch-surfing, you don't

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know when your next meal is coming, and preventive care is not on your list of priorities," she says. "When young people come into our program, we double down on the healthcare piece because that's often been long neglected."

In Salt Lake City, an innovative program uses technology to identify housing vulnerability among a healthcare population.

"A lot of clients are provided homeless case management," says **Sam Taylor**, director of solutions and health and human services at Eccovia Solutions in Salt Lake City.

"We quantify the client situation to see if they're a good fit for Housing First," Taylor says. "One notion in the Housing First perspective is to find low-barrier, permanent housing solutions for the most vulnerable clients in the community."

Another new model, Housing for Health, is based on the understanding that homeless individuals are very expensive to care for and often experience poor outcomes, says **Laurel Rodriguez**, director of marketing for Eccovia Solutions.

"If organizations provide housing as part of the overall healthcare, they can improve the individual's health and save money," Rodriguez explains.

Housing First and Housing for Health are a step up from the Housing Ready model, which was based on improving health — mostly through alcohol and drug treatment — before providing housing. The new models focus not on making people change their lives first, but rather on providing housing that may lead to their making positive healthcare changes.

"How easy is it to manage your medications if you're living on the street?" Taylor says.

Housing First and Housing for Health programs put people in supportive housing, and one goal is to improve their health. Housing for Health programs coordinate supportive housing with case management, medical care, and behavioral healthcare among vulnerable populations. The overarching goal is to improve health outcomes.

Project Home's clients often experience the combination of housing insecurity and poor health. "When we see folks in the clinic, the presentation often times is — whether they're living in the community or unstable in housing — we can't get too far in helping them manage chronic illnesses without addressing the quality of their housing, safety in housing, or

EXECUTIVE SUMMARY

A growing number of healthcare organizations are finding that tackling healthcare access and coordination requires addressing housing insecurity.

- Housing vulnerability often must come first before at-risk patients can address their chronic illnesses and other health concerns.
- One model, Housing for Health, is an idea based on the understanding that homeless individuals are very expensive to care for and often have poor outcomes.
- The Housing First model focuses on providing housing as a catalyst to healthcare changes.

whether they have any housing at all," McCurdy says.

Housing, like food, is a basic need. If someone is hungry or homeless, it's challenging for him or her to take medication on time, she adds.

People with housing vulnerability are helped with that basic need first, and it's integrated with support services to help them with their behavioral and physical health issues, as well as workforce services and other needs, Rodriguez says.

"Let's get them into housing first, and then provide support services," she says. "This started in Canada and is now across the United States."

Various organizations, communities, and states have found they are able to keep people housed more effectively if they start with housing and then move to healthcare and support services, she adds.

"We developed the software solution to support our clients who fill this need," Taylor says.

At Project Home, new private funding has made it possible for the organization to plan a new building for young LGBT (lesbian, gay, bisexual, and transgender) homeless clients. It will include 31 bedrooms, and preventive health measures built into its programming, Gormley says.

Residents will receive preventive care appointments, dental visits, pre-exposure prophylaxis for HIV, vaccinations, and other healthcare.

"There are a lot of medical considerations that happen and get rolled into case management goals when someone comes into care with us," Gormley says.

These LGBT youth typically would use EDs for their basic health needs, so the housing/case management/preventive care model will serve as a less costly and better quality method for helping them improve their health.

"We made a leap three years ago to become a federally qualified health center," McCurdy says. "We're learning to better integrate housing and healthcare and to track our outcomes, too."

McCurdy says the Affordable Care Act's push for community-based population health could help organizations like Project Home evolve into safety net health centers. "The ACA changed our lives, and we were able to serve people a lot better."

The U.S. Department of Housing and Urban Development (HUD) adopted the Housing First philosophy within the last few years. *(For more information, visit: http://bit.ly/2BvDUNw.)* Health systems nationwide have moved closer to a model that views healthcare from a housing access perspective, Taylor notes.

"In isolating superusers [of healthcare], they've found that many of them are homeless," Taylor says.

Housing for Health, care coordination, and Housing First models all approach the problems of people in housing crisis, who often have healthcare comorbidities, from the perspective of holistic health.

"You can't treat the whole person with only part of the data," Rodriguez says. "Does this person have substance use issues? Is he homeless? Is he employed? Social services and healthcare come together in housing: They're trying to solve the same issue of how to help these people become healthier and reduce the cost." ■

Physician-owned Medical Group Reduces Readmission Rate to 6%

Program seeks to transform care for Medicare patients

A new population health management program in Ohio is expanding to transform care for Medicare Advantage patients. It's building on its success with providing a toolbox of services to patients, centered around primary care.

The new program is designed to improve quality, efficiency, patient experience, and outcomes for Medicare Advantage patients.

"We found, through our own data of 4,000 patients discharged in a year, that we can get the readmission rate down to 6% if the patient keeps that primary care physician visit," says **Bill Wulf**, MD, chief executive officer of Central Ohio Primary Care Physicians (COPC) in Columbus.

"If they don't see the primary care physician, the readmission rate is as high as 28%," Wulf says.

The COPC Senior Care Advantage program takes the value-based model to a new level, focusing on prevention and highly coordinated clinical care. COPC physicians will coordinate all care for enrolled members, including primary care, specialists, major

local health systems and hospitals, laboratories, and all ancillary services. The program also will use data analytics to support clinical decisions.

COPC began treading on the population health pathway in 2014 with a patient-centered medical home (PCMH). Then, the organization moved to a shared savings model with its commercial and Medicare Advantage plans, Wulf explains.

"Now, we want our patients to understand that we're taking both clinical and financial responsibility of their care," he adds. "As primary care physicians who are independent and not tied to procedural specialists or hospital systems, we can look for value for our patients in any situation, and it puts us in an enviable position."

Changing reimbursement models to pay primary care physicians for their patients not experiencing costly medical events is a way to change both a population's health and physicians' and patients' behavior, he says.

COPC will work with a major health system to provide primary care, case management, and wraparound services, he says.

Hospitalists care for primary care patients when they're in the hospital, and transitional care nurses assist with transitioning patients to their homes or to a skilled nursing facility. The transitional care nurses are responsible for the patients until their first primary care physician (PCP) visit. After patients are transitioned to the community, care coordinators, including RN case managers and social workers, handle post-discharge coordination of patients' care. Care coordinators work out of the primary care offices.

With access to patients' medical records from the PCP, hospitalists and transitional care nurses assist with the continuum of care. "Their job is to manage the patient from the hospital to home or skilled nursing facility and to arrange a follow-up to the primary care physician, ensuring it takes place," Wulf says.

"The transitional care nurse calls the patient within 48 hours, saying, 'Hi, this is Kathy. I'm checking in on you. Did you make the adjustment to your meds?'" he says. "Then they check the outpatient record to make sure the patient was seen, and then they are done with the transition."

For high-risk, homebound patients, the program includes two physicians who make house calls. "Two physicians might see one patient per day, but they manage 50 high-risk patients at a time," Wulf says. "They might get a call saying, 'Betty Smith is in trouble, and if we don't see her today, she may end up in the hospital.' The physician goes out to her home and arranges for home care or hospice and prevents hospitalization."

The home visit physicians provide high-intensity visits. They can intervene in an acute situation that could take hours to arrange the patient's necessary services, says **Larry Blosser**, MD, outpatient medical director for COPC.

"The physician spends as much time as needed to get everything buttoned down," Blosser says. "They get care plans in place, get the patient medication, and if the patient needs home health, then they bring in home health."

It's more cost-effective than sending patients to the ED, where they may end up hospitalized, Wulf says. "We have evidence that we have a fairly high conversion rate from home visits to hospice to palliative care," he says.

Congestive heart failure (CHF) patients are the type who might qualify for the home doctor visit. "A lot of times, a CHF patient needs an adjustment in medicine and then to be checked back on every three or four days," Wulf says. "If the patient runs out of medication, then things get worse."

Other examples are patients with exacerbated chronic obstructive pulmonary disease or out-of-control diabetes, and patients who develop infections that can be treated with oral antibiotics, Blosser says.

"Each of those two home visit physicians prevents 40 to 50 hospitalizations a year," he says. "At $10,000 for the average hospital admission, preventing 100 admissions a year makes it easy to pay two doctors to see one patient per day."

The home visits also prevent unnecessary skilled nursing care.

"In central Ohio, there's a tremendous utilization of skilled nursing post-hospitalization," Blosser says. "These visits can prevent 20 days of skilled nursing care and costs."

EXECUTIVE SUMMARY

The Central Ohio Primary Care Physicians Senior Care Advantage program is designed to improve quality, efficiency, patient experience, and outcomes for Medicare Advantage patients.

- Patients in the program who make their primary care follow-up appointments after discharge experience lower readmission rates.
- The program focuses on prevention and highly coordinated clinical care.
- For high-risk patients who are homebound, the program includes two physicians who make house calls, each seeing one or two patients per day.

Patients and families grow comfortable with the home visit physicians and will call them when there's a new symptom or problem. "They might call to say, 'Mom is confused. I think she has a urinary tract infection again,'" Blosser says.

For other members of the patient population, care coordinators become patients' and families' go-to healthcare person.

"Patients have a direct line to the care coordinator's cellphone, and they feel comfortable touching base with them," Blosser says. "The care coordinator becomes the intermediary between the doctor and patient."

Again, the goal is to improve care and prevent hospitalization and ED visits. "Care coordinators can get a patient on the doctor's schedule and have them seen quickly, avoiding the necessity of the patient going to the ER," Blosser explains.

Care coordinators make phone contact and at least one home visit. The number of home visits varies, depending on the patient's condition. Patients stay in the care coordination group for as long as their conditions are high-risk and not improving. Those who improve will no longer need extensive care coordination. Since care coordinators become less effective with too high of a caseload, the goal is to keep the caseload manageable by discharging patients who no longer need such attention.

"We have learned to discharge people from care coordination," Blosser says. "Patients do attach themselves to it, and it's hard to give up. But we reassure them that if they need it again, we'll let them back on." ■

Using Care Coordination Services, a Health Network Saves CMS More Than $73 Million

Focus is on measuring quality scores

Since its first performance year in 2014, one Texas accountable care network (ACN) has maintained a 95% or better quality score and saved CMS more than $73 million.

The Southwestern Health Resources ACN manages care for about 87,500 Medicare beneficiaries in North Texas. The network focuses on reducing costs through care coordination and improving quality and efficiency. The network started with University of Texas Southwestern Medical School faculty and about 60-70 primary care physicians (PCPs) in private practice within the community, says **Mack Mitchell**, MD, vice president of medical affairs and interim executive vice president for health system affairs, as well as a professor at the University of Texas Southwestern Medical Center in Dallas.

"We created infrastructure for community physicians and faculty to measure quality scores and to link to care coordination and support services, including analytics," Mitchell says.

"The physicians in the community were geographically aggregated into a pod structure where they met monthly with the care coordination team and the analysts," he says. "Essentially, a pod representative brings in the quality team to analyze data."

The original group of PCPs has grown to more than 300, and more PCPs, specialists, and advanced practice providers are being added to the network. The ACN also includes Texas Health Physicians Group members and independent community physicians.

"Along the way, we began a discussion about creating a clinical-oriented network that would include all physician groups and approximately 30 hospitals from the Texas health resources and our two universities," Mitchell explains.

A support team of care coordinators and analysts helps the network identify patients who are at high risk for medical issues. They also follow up with those patients to manage their care in a way that improves quality and reduces costs, he says.

The people who are considered high risk often have multiple medical problems, multiple medications, and/or chronic conditions such as diabetes, hypertension, coronary heart disease, chronic liver disease, or arthritis.

"Essentially, you've got data feeding from two directions: claims data given on a monthly basis and data from electronic health records," Mitchell says. "All of it goes into risk stratification software that tells us this person has this risk and it's rising or stable or declining, and that allows us to say, 'These are the folks that are in need of follow-up.'"

High-cost imaging and

readmission data also are collected, but ED visit data is less of a chief issue for the Medicare population than it is for other populations, he notes.

"We look at high-cost imaging, like using MRIs when an ultrasound is sufficient, and we look at areas around some medication usage," Mitchell says. "Some primary care physicians overutilize specialists, who overutilize diagnostic services."

The care coordination team reaches out to physicians, telling them of patients they're concerned about. It has bidirectional care coordination and communication. The care coordination plan is adjusted to meet individuals' needs, and most outreach to patients is via phone, not the internet.

"We're looking at this from the standpoint of patients who are older, and the telephone is their preferred method of communication," Mitchell says. "We go out to visit them when necessary, and we coordinate with other caregivers who go into the home."

The network is responsible for all of its patient population's medical issues. Hotspots include diabetes and cardiovascular problems. Chronic kidney disease was moved out of the Medicare accountable care organization (ACO) population, so those in that group are not included in the network's services.

While the network has commercial ACOs, its largest experience is with the Medicare population.

"With the Medicare population, one of our biggest areas for potential savings without compromising quality of care is in the post-acute care area," Mitchell says. "How many days someone spends in a long-term care [LTC] facility or a skilled nursing facility [SNF] can make a huge difference in overall cost of care, and the same is true for home health."

"We have a huge program around minimizing use of SNFs and LTCs," Mitchell adds. "But more importantly, we're cutting length of stay in those by making transitions more quickly and backfilling with care coordination and other services."

These LTC, SNF, and home health services, used appropriately, are great resources. But when used repeatedly for circumstances they were never intended to cover, they are a liability, he adds.

"We use care coordinators to help patients manage their care without sending the home health company into the home for things that don't provide a lot of value," Mitchell explains. "We're also looking for innovative ways of managing care, including direct patient engagement around the administration of IV antibiotics." ■

Federal Report Calls for Action to Improve Healthcare Access for Mentally Ill

The Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) released a report to Congress on Dec. 13, 2017, titled, "The Way Forward: Federal Action for a System That Works for All People Living with SMI and SED and Their Families and Caregivers."

More than 10 million U.S. adults are living with a serious mental illness, meaning their illness impairs their ability to hold jobs or maintain relationships. These individuals have a greater risk of suicide and a life expectancy 10 years shorter than the general population, and they're 10 times more likely to be incarcerated, Health and Human Services (HHS) Acting Secretary **Eric D. Hargan**, JD, said at a Dec. 14, 2017, press conference.

"That's a tragic outcome for illnesses that we know how to treat," Hargan said.

"This is a complicated challenge," he added. "We're working with our colleagues at the Department of Justice because we need to make sure that people with severe mental illness receive treatment and are not put behind bars; we see this as a public health issue and not a public safety issue."

HHS also is working with the U.S. Department of Housing and Urban Development because too many people with serious mental illness end up living on the streets, Hargan said. "The Department of Labor is a critical partner, too, because finding work is an important piece of helping people with serious mental illness lead healthy and independent lives," he said.

The ISMICC report details the incarceration problem and other issues the nation faces in the way it handles mental illness.

"It is crucial to provide access to evidence-based mental healthcare before people experience negative outcomes," said **Elinore F. McCance-Katz**, MD, assistant secretary for mental health and

substance use. McCance-Katz also said in a new report that the U.S. healthcare system can do better and the federal government can marshal its resources to help.

The report provides a roadmap for improving mental health services and focuses on the following five areas:

• strengthen federal coordination to improve care;

• make it easier to receive care that is an evidence-based best practice;

• close the gap between what works and what is offered;

• increase opportunities for individuals with serious mental illness and serious emotional disturbance to be diverted from criminal and juvenile justice systems and to improve care for those involved in criminal and juvenile justice systems;

• develop financial strategies to increase availability and affordability of care.

A video of ISMICC's report to Congress can be viewed at: http://bit.ly/2CjgBHU. The full report can be ordered at: http://bit.ly/2lcMkDe. ■

Medical Home Within ED Serves Needs of Sparsely Populated Region

There is ample evidence suggesting new solutions are needed in the way healthcare is delivered in rural America, according to **Margaret Greenwood-Ericksen**, MD, MPH, an emergency physician in the department of emergency medicine at the University of Michigan, who has been researching this subject.

"We know things are not going the way we want them to with rural health," she says. "Health outcomes [in rural areas] are worse than they are in the general population, and rather than becoming healthier, like what we are seeing in some communities in urban areas, we are seeing rural populations stagnating, not getting healthier — and in some cases, with some conditions, we are actually seeing worse outcomes over time."

Multiple factors likely play a role, including the fact that there is a significant shortage of both emergency and primary care providers in rural areas, says Greenwood-Ericksen, who notes that there also may be behavioral or cultural factors that keep patients in these regions from accessing the care they need.

"While it is hard to know which of those things is contributing to this, what is clear is that rural health is not headed in a good direction," she says. In particular, Greenwood-Ericksen maintains that policies and models that work well in urban areas do not necessarily produce the same results in rural settings.

For instance, she explains that in an urban setting, you can put a clinic in a community that is struggling and see outcomes improve, but such an approach will not work in a rural area because the residents are spread across a large geographic area.

"Also, both populations have major social determinants of health that can really affect their health outcomes, but they are very different," she observes. "Maybe there is an issue around affordable housing in a city, but for a rural area, housing may be [easily accessible] because it is not very expensive, but the area may have major issues with food insecurity."

For all these reasons, healthcare delivery models must be tailored to the regions they serve, and Greenwood-Ericksen believes the prevailing focus, particularly among payers, on limiting ED use is not a good approach in many rural communities where access to care is a big issue.

"The problem in rural areas is it can be really challenging to get in to see a primary care provider, especially when there are not many available. And there are also not very many urgent care options," she explains. "Emergency departments may be, for many people, one of the only accessible [facilities] in which they can get care."

However, that doesn't mean that there isn't room for innovation in rural healthcare delivery. Greenwood-Ericksen favors the creation of a new model of care whereby both emergency and primary care providers work together at a central location where people are accustomed to accessing their care, and she has published her ideas on this concept.[1]

Focus on Outcomes

In fact, Greenwood-Ericksen notes that Carolinas HealthCare System has developed a model quite similar to what she describes in Anson County, NC, a sparsely populated region about 60 miles southeast of Charlotte.

"I think everyone is aware that in rural communities across the country, rural hospitals are closing," explains **Michael Lutes**, president of

the southeast division for Carolinas HealthCare System. "So what we really wanted to do was focus on a new model of care that was innovative and would truly improve the health status of Anson County."

To do that, investigators looked at historic data and found that about 60% of ED visits at Anson County's legacy facility could have been seen at a primary care provider's office, Lutes explains.

"What would happen is [patients] would come to the ED and we would treat their emergent condition, but not the underlying chronic condition," he says. "Then, three days later, the patients would be back because no one was managing their underlying chronic condition."

Further, the region's health outcomes simply were not what they should be under the old system, Lutes adds.

"That really challenged us to think about a different model," he says.

Planners focused on designing an approach that would direct patients to the right care setting so that their underlying issues would be addressed, thereby breaking the cycle of repeated ED visits, Lutes observes. A lot was riding on the new approach, so to make sure the flow would work as intended, the healthcare system rented a warehouse and built a prototype facility out of cardboard.

"We had physicians, nurses, and all the different clinical staff building this new innovative model," Lutes recalls. "I think we used 6,000 pounds of cardboard."

Employ Flexibility

All this prep work resulted in the healthcare system replacing Anson Community Hospital with a 43,000-square-foot facility that includes 15 inpatient beds and also a 24-hour ED that shares space with a medical home model.

The facility, which opened in 2012, today receives patients who present for care and receive a medical screening exam as required by the Emergency Medical Treatment and Labor Act. Exam results determine whether patients are directed to a primary care provider in the medical home or to an emergency provider. "We have criteria on what is appropriate to transition patients to an emergency provider or the medical home," Lutes explains. "If they get transitioned to the medical home, it is not billed as an ED visit."

Further, once patients are plugged into the medical home and receive subsequent appointments to see a primary care provider, they no longer need to undergo the medical screening exam. They have access to patient navigators who can help them negotiate the healthcare system and access necessary care.

While medical home patients and emergency patients are billed differently, they all are seen in the same space.

"On the right side of the department, the rooms are licensed to the medical home, and on the left side they are licensed to the ED," Lutes notes. "And what we have done is actually built all the rooms to hospital code so that we can flex the rooms to accommodate patient needs."

Early results suggest the approach is working as intended. "The first year we opened, we saw a 125% increase in primary care visits and we saw a 7% decrease in emergency visits," Lutes observes. "We transitioned nearly 2,700 patients who came to the facility to the medical home who would have gone to the ED [if the medical home was not available]."

Today, the medical center sees about 16,000 emergency patients and 15,000 primary care patients per year, data that predict improved outcomes down the road, according to Lutes.

"We believe if we can transition 2,000 patients into a medical home each year, then the health outcomes [in the community] five years out will significantly increase because we will now be finally treating those chronic diseases, whereas before such patients would have just gone to the ED."

In addition to providing a medical home to patients, the facility is equipped with a range of resources, including social workers, a pharmacy, an operating room, a lab, and a dedicated behavioral health area, Lutes explains.

"We have a community room that is focused on education because that is so important to improving outcomes," he says.

Lutes adds that a range of specialty services, such as OB/GYN, general surgery, and pulmonary care, offer services through a satellite clinic located on the facility's campus. Also, the center is hooked into the Carolinas HealthCare System's vast telemedicine platform so that patients and providers can, when needed, connect with specialty consults virtually.

Address Staffing

Regarding on-site providers, access to clinical staffing is a frequent barrier in rural parts of the country, and this was certainly the case in Anson County before the new medical center was built. However, the new facility has proven to be a lure to many experienced clinicians, Lutes observes.

"When we built this new facility

and explained our commitment to improve the health outcomes and focus on health disparities in the community, we actually had people who were from Anson County but did not practice there want to come back and practice in the town they grew up in," he shares. "We are fully staffed in our medical home, and, honestly, it is probably the first time we have been fully staffed in a number of years — since before opening the facility." Further, most of the staff members are either from the community or live within 20 minutes of the facility, Lutes adds.

"They are excited about the things we are doing and our commitment to the community," he says.

For instance, in the first three years of operation, the health system focused intensely on access and identifying healthcare needs, Lutes recalls. As part of this effort, the health system deployed a mobile unit into the community that could provide health screenings where they were most needed.

"We utilized heat maps to look for areas of the county that either had high ED utilization or patients that had not been in to see a doctor, and we knew they were eventually going to wind up in our ED," Lutes notes.

The overall goal of this effort was to reduce the rate of the incidence of diseases such as cancer, obesity, and other chronic conditions. These are what Lutes refers to as lag indicators, and the health system expects to see improvements in the coming years. Creating a new healthcare delivery model always is challenging, but it does not have to be more expensive, Lutes observes. Indeed, he notes that the Carolinas HealthCare System built the Anson facility for a modest $20 million. While the facility is quite similar to what is referred to as a micro hospital, the intent behind it differs significantly, he explains.

"Oftentimes, micro hospitals are built in high-growth areas to meet a demand for extra beds," Lutes says. "We built this as a model for how to improve the health outcomes in the community, not as a play to capture more market share."

Lutes adds that the population hasn't increased in Anson County in 50 years, so it is hardly a high-growth area.

Lutes acknowledges that the innovative facility would not have been possible without the expertise and resources of a large healthcare system, but at the same time it was equally important to work closely with the community and, in particular, local providers.

"They were excited because they realized that we needed to do something different, and that the traditional model wasn't working in that community," Lutes notes. "Overall, I think it has been well received."

While Carolinas HealthCare certainly is thinking about using the Anson County delivery model in additional rural areas, other health systems have taken an interest in the approach, too. Eleven health systems from six different states have come to visit the facility.

"Just in the last week, I have heard from three different health systems who want to come tour our model," Lutes says.

One thing that Greenwood-Ericksen finds exciting about the model in Anson County is that it links primary care providers with the ED in a central location where people are accustomed to accessing their care.

It also enables the healthcare system to potentially shift some higher-level costs associated with emergency care to a lower-cost billing structure. However, she notes that further innovations on the billing side would make it easier to deploy such approaches. "The payment structure is a big barrier to implementing these models," she says.

In fact, some states are experimenting with the use of global budgets whereby payers give hospitals a set amount, and then the hospitals can transform the way they deliver care to what they think is best for the community.

"That removes some of these complicated concerns around costs and the fact that the ED is a more expensive setting," Greenwood-Ericksen notes.

One problem is that while some healthcare delivery innovation is taking place in rural areas, information about these efforts often is not disseminated in the scientific literature, making it hard for other health systems to learn about new ideas that could work in their own settings, Greenwood-Ericksen says.

Also, luring emergency providers to work in rural communities remains a stubborn problem.

"I think a concern of emergency physicians working in a rural area is that they feel like they are going to be pretty unsupported," she says. "By that, I mean that they feel as though they won't have a lot of outpatient resources available to them."

The model in Anson County addresses this issue by pairing emergency providers with primary care providers in the same space. "It assures emergency providers that they have adequate and appropriate outpatient access," Greenwood-Ericksen says.

"I think the more you can provide resources for physicians and a sense that they are part of the community ... and that they are supported

by both the hospital and the community, the more they are going to like their job and ... stay in it."

Greenwood-Ericksen has engaged in discussions with some rural hospitals that are interested in redesigning their healthcare delivery process, and one of the things she always addresses in these conversations is what the obstacles are to making such a change. Communication is high on the list.

"There are different methods you can use to communicate, and they need to be tailored to the setting you are in, but that really involves getting your primary care providers together with your emergency medicine providers and having that conversation about what is going to work for people," she advises. "It is really hard to line that communication up in an effective way, so it is a big issue, but I think electronic medical records will help with that."

Another big barrier is resource availability. "Rural areas tend to have fewer resources available to them partly because less funding goes to rural areas and hospital margins are so much tighter," Greenwood-Ericksen notes. "You may have some really good ideas for care delivery redesign, but you might not have the resources available."

One possible way to get around a resource problem is to partner with other organizations in the community.

For example, some hospitals work with community partners to manage patients with substance use problems, but these pathways need to be developed, Greenwood-Ericksen observes.

Finally, with any large-scale change, one must find a way to pull all staff in the same direction. "Change is hard and no one likes it, even if you think it is going to make things ultimately better," Greenwood-Erickson says. "It is hard to get everyone on board to agree to revolutionize the care you provide, so getting buy-in from your physicians and other providers is potentially a barrier, but also an opportunity." ■

REFERENCE

1. Greenwood-Ericksen MB, Tipirneni R, Abir M. An emergency medicine-primary care partnership to improve rural population health: Expanding the role of emergency medicine. *Ann Emerg Med* 2017;70:640-647.

Site Infections Reduced for Post-op Cesarean Section Patients

Infection levels in mothers who had undergone cesarean sections were reduced at a California hospital with a remarkably simple fix: providing the right size bandage so too-large ones didn't have to be cut by hand.

The issue was recognized by a team at Sharp Mary Birch Hospital for Women & Newborns in San Diego, a freestanding women's hospital with more than 9,000 deliveries per year. Superficial surgical site infections (SSIs) were partly responsible for increasing readmissions each year, and they were becoming more common with an increasing number of cesarean sections, explains **Lauren Korrub**, RN, BSN, clinical nurse at the hospital.

They also were costly for the hospital and there was no standard reimbursement. In addition, SSIs are reportable events to the California Department of Public Health.

Korrub and others at the hospital worked on the issue in the Clinical Scene Investigator (CSI) Academy sponsored by the American Association of Critical-Care Nurses. Their goal was to reduce superficial SSIs in postoperative cesarean section patients by 50% and to provide education to 100% of staff on superficial SSI prevention. They also sought to increase hand hygiene patient education to above 95%.

The team developed the slogan "A healthy wound is a happy wound." They provided interactive learning to staff, with monthly giveaways of gift items and spa days. Staff also received badge clips with the motto and the project's smiley face logo.

Patient education also was important. The team developed a patient handout in English and Spanish, which was available electronically in the medical record and as a handout located near discharge folders. The patient handout explains how superficial SSIs happen, why they are dangerous, and how to prevent them. It provides specific advice such as checking the incision daily, keeping the wound open to air after 48 hours, and not using any lotions, creams, powders, or ointments on the incision.

The team also introduced a container of hand sanitizing wipes to the patient's bedside table, accounting for the fact that cesarean section patients are confined to bed for days and can't easily wash or sanitize their hands in the bathroom or with the hand sanitizer on the wall.

But the most effective intervention also was the simplest. The team realized that the size of the bandages supplied for cesarean section incisions was contributing to infection rates.

"We observed our nurses and some of the habits we had when we were taking care of incisions after removing staples and applying Steri-Strips," Korrub explains. "Our OR had pre-cut Steri-Strips that were the right size for their needs, but we had to cut ours in half to make them the right size after we removed staples. We realized nurses were taking scissors and cutting them in half, which introduced bacteria on to the Steri-Strip."

The supply orders were changed so that nurses had the smaller bandages available for post-op cesarean section patients, and nurses were instructed to stop cutting bandages to fit. Hand hygiene also was emphasized more during the staple removal process.

"People were touching the bed and going back to take out a staple, not being as clean as they could when they were taking out staples and caring for the incision," Korrub says. "We also had nurses in the habit of putting a pad across the incision site, but we stopped doing that because the doctors' orders are to remove any dressing after the first 48 hours."

From June 2015 to June 2016, the hospital had 13 readmissions for superficial SSIs, with *Escherichia coli* and *Staphylococcus aureus* isolated from wounds when cultured. The average loss to the hospital was $30,197 per readmission. In the same one-year period after the intervention, there were only four readmissions for superficial SSIs. That amounted to a savings of $272,769.

Hand hygiene showed improvements, according to nurses' documentation of their own habits. Patients also showed evidence of better understanding of superficial SSIs, with 97% of post-discharge patients saying the tape stayed adhered to skin and 97% saying they showered and checked the incision daily.

"Everything took a lot longer than expected, but the results were worthwhile," Korrub says. "It can take a long time to make changes in a hospital, even something as simple as getting the right size Steri-Strips. It's not enough when your manager says it's a great idea, because she has a manager, and they have a manager, and it's a whole process to go through. Stick with it." ■

HHS Secretary Holds Opioid Epidemic Meeting

In response to President Donald Trump's call to action on the opioid crisis, Health and Human Services (HHS) Acting Secretary **Eric D. Hargan** held a meeting on Dec. 12, 2017, with healthcare leaders to address the growing opioid epidemic. *(For more information on the meeting, visit: http://bit.ly/2zHsbK4.)*

HHS laid out the following five-point strategy to combat the opioid crisis:

- better prevention, treatment, and recovery services;
- better targeting of overdose-reversing drugs;
- better data on the epidemic;
- better research on pain and addiction;
- better pain management.

Also, the HHS Office for Civil Rights (OCR) has produced new tools and initiatives in response to the opioid crisis.

"HHS is using every tool at its disposal to help communities devastated by opioids, including educating families and doctors on how they can share information to help save the lives of loved ones," OCR Director **Roger Severino** said in a news release. *(For more information, visit: http://bit.ly/2Dq8Q2e.)*

The latest actions, implemented on Dec. 18, 2017, include the following:

- Two new HIPAA webpages — one for consumers and one for professionals — focus on mental and behavioral health information. The webpages use existing guidance, making it more user-friendly and providing a one-stop resource for new guidance and materials.
- There is new HIPAA guidance on sharing information related to mental health and substance use disorder treatment with patients' family, friends, and others. The new information contains fact sheets, an infographic, decision charts, and materials tailored to the parents of children who suffer from a mental health condition.
- Partner agencies within HHS are collaborating to identify and develop model programs and materials for training healthcare providers, patients, and their families regarding permitted uses and disclosures of the protected health information of patients seeking or undergoing mental health or substance use disorder treatment.
- There is updated guidance on HIPAA and research per the 21st Century Cures Act. *(More information can be found at: http://bit.ly/2pPW9M3.)*
- HHS has launched a working group to study and report on the uses and disclosures under HIPAA of protected health information for research purposes. ■

CASE MANAGEMENT ADVISOR™

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CE QUESTIONS

1. **Which of the following is the model for helping people find supportive housing as a catalyst to making healthcare changes?**

   a. Housing First
   b. Housing Ready
   c. Housing Satisfaction
   d. Housing Not Streets

2. **Central Ohio Primary Care Physicians (COPC) offers a Senior Care Advantage program that focuses on prevention and highly coordinated clinical care. Which of the following is one of its features?**

   a. The program uses data analytics to support clinical decisions.
   b. COPC works with major health systems to provide primary care, case management, and wraparound services.
   c. Hospitalists care for the primary care patients when they're in the hospital, and transitional care nurses assist with transitioning patients to their homes or to a skilled nursing facility.
   d. All of the above

3. **As part of the Senior Care Advantage program of Central Ohio Primary Care Physicians, there are two home visit physicians who each help prevent how many hospitalizations a year?**

   a. 30-35
   b. 40-50
   c. 60
   d. 75

4. **The Southwestern Health Resources ACN program to improve a Medicare population's health focuses on which data to identify high-risk patients?**

   a. Physician referrals
   b. Nurse case manager referrals
   c. Claims data and electronic health records
   d. None of the above

CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how the clinical, legal, legislative, regulatory, financial, and social issues relevant to case management affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities.