Healthcare Performance Management within a Medical Home:
A Model for the Nation

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Case Study:

HealthyHoward

Abstract

In 2008, Howard County, Maryland launched an innovative program to bring comprehensive healthcare to uninsured residents for about 75 percent of the cost of traditional insurance. The Healthy Howard Health Plan (HHHP) combines a Primary Care Medical Home (PCMH) model and tightly integrated health coaching. Data and business process workflows are automated and managed on a technology platform provided by HHHP's business partner, Healthcare Interactive, Inc., a firm headquartered within the constituent county. HHHP serves as a model case study showing the efficacy of the Healthcare Performance Management Institute's four pillars: measure, manage, engage and automate. Their experience is notable since lessons learned at HHHP are supporting the development of nascent co-op programs in the state of Maryland.

Program Overview

Cities, counties and states all face a common problem: How to cost-effectively provide healthcare and improve health outcomes to the uninsured. In Howard County, Maryland, the Healthy Howard Health Plan (HHHP) is in its fourth year of offering an innovative health plan with one-on-one coaching to uninsured citizens at 117 percent to 300 percent above the federal poverty level (Beilenson 2009).

In 2011, the HHHP was awarded the U.S. Department of Health and Human Services' Healthy Living Innovation Award for innovation in healthcare delivery systems, and in 2010, it was recognized as one of the Harvard Kennedy School of Government's Bright Ideas for government innovation in addressing public concerns.

The Population Served

The population served by the HHHP is representative of the overall uninsured population in the nation. As is true of the nation's uninsured, two-thirds of HHHP members have incomes below 200 percent of the Federal Poverty Line (FPL) (Edsall et al. 2010; KFF 2011), and over three-quarters of the uninsured are in a working family, where one or more family members are employed, but not offered health insurance (Beilenson 2009; KFF 2011).

Beyond socio-economic similarities, the uninsured of Howard County also mirror the uninsured of the nation in their proclivity to forgo preventive care and other necessary medical care (Edsall et al. 2010; IOM 2009). Compounding the lack of care, the Howard County and U.S. uninsured have a significantly higher prevalence of unhealthy behaviors such as smoking (Edsall et al. 2010; Parnes et al. 2002) and lack of physical activity (Edsall et al. 2010; Ayanian 2000).

The Health Plan

Recognizing these problems, Howard County leaders wanted to construct a program to provide better health outcomes to an underserved and higher-risk population. They set out to create a plan that was both affordable to residents ineligible for other medical assistance programs and attractive enough for members to invest in their health with sliding scale monthly premiums.

For as low as $50 a month, individuals and families can purchase health insurance with the HHHP. Upon joining the plan, members are scheduled for a primary care check-up, asked to complete a Health Risk Assessment (HRA), and are referred for various preventive screenings and procedures according to protocols developed by Peter Beilenson, MD, MPH, Howard County health officer, his policy advisors and Healthy Howard staff.

Members are subsequently cared for within HHHP's primary care medical home model, providing primary care contracted through a federally qualified health center (Chase Brexton Health Services, LLC), specialty care, free or reduced-cost prescription medications, referrals, and hospitalization and emergency room treatment. Additionally, members are offered a personal health coach who meets with them, in person and over the phone, throughout the year to assist members in creating personalized Health Action Plans (HAP) and achieving the health goals set forth.

As with many commercially available health insurance plans (Hand 2009), HHHP enforces a disincentive in the premium rates of $10 per month, up to 20 percent of current premiums, as a penalty to those members who decline health coaching. According to the Patient Protection and Affordable Care Act of 2010, the federal government maximum on premium incentives is currently 30 percent and rises to 50 percent in 2014 (KFF 2010).

An Example of Healthcare Performance Management

HHHP is exemplary in its execution of the four pillars of Healthcare Performance Management: Measure, Manage, Engage and Automate. The centerpiece of the plan, the primary care medical home, stems from the premise that it is critical to obtain an immediate clinical baseline **measurement** of each member's health, according to Liddy Garcia-Bunuel, executive director of HHHP. Throughout the member's coverage period with HHHP, health and health concerns are **managed** by an interdisciplinary team of physicians and member services managers to ensure seamless coordination. Members are **engaged** routinely by health coaches to develop and achieve personal health goals, and to stay on track to living a more healthy life overall. Such coordination among stakeholders – the ability to keep costs low and service standards high – is achieved through HHHP's implementation of **automated** data and workflow management tools.

Measure

At mandatory orientation meetings, all health plan members are asked to complete a Health Risk Assessment (HRA) – a survey used to capture the basic health status of a member and identify any risk factors. Topics addressed relate to general health, presence of a chronic disease, known health needs, behavioral/lifestyle risk factors and others (Edsall et al. 2010). The HRA has been described as a "data-driven engine" that can be used to implement prevention programs and direct care (Loeppke, 2010).

As such, the HRA is the measurement collected on HHHP members, followed soon by a clinical baseline recorded by one of the plan's primary care physicians during an initial physical exam. Members are then provided referrals for preventive care services that need to be scheduled. These include, but are not limited to, mammograms, Pap smears, colonoscopies, etc.

Within the first three months of joining the plan, members are contacted by a health coach. Until January 2012, health coaching was compulsory under the HHHP, but it is currently optional, though members opting out are charged higher premiums. During the health coaching program's six-month cycles, members and their health coaches meet face-to-face and speak over the phone to develop a Health Action Plan (HAP) with set goals and action steps.

To ensure consistency and to obtain quantitative data, health coaches work through a HAP workflow associated with each member. Workflows are securely stored on a cloud-based platform called Healthspace, developed by Healthcare Interactive, Inc., a Maryland-based healthcare technology firm. With an Internet connection, health coaches can access their HAP workflows remotely, tracking their meetings, coaching notes, members' health goals and members' progress through the coaching cycle.

Member services are also integrated and are using workflows to process and record data related to enrollment services, specialty referrals, hospital transitional care and more. At this point, the contracted primary care physicians are using their own patient management software and are not using Healthspace's available Electronic Medical Record (EMR) system, yet it remains available and would substantially enhance the measurable data set on each member.

Manage

Health management is second among the HPM pillars and is no less important to the HHHP and its tightly integrated health coaching model. Care is delivered through the PCMH model and supplemented with highly interactive health coaching and concierge-like member services support.

Using a PCMH model where care is coordinated centrally was very important to plan architects. The initial concept of PCMH was developed by primary care physicians and large employers to:

- Encourage comprehensive healthcare;

- Improve patient outcomes; and

- Reduce medical costs,

all of which are outcomes desired by HHHP.

The PCMH approach is additionally beneficial in managing the HHHP members because it provides care in a setting that facilitates a partnership with the patient, the healthcare team and community resources. This partnership aligns with the classic PCMH clinical strategies that include:

- Providing high-quality preventive care;

- Offering effective chronic disease management across the life span; and

- Creating a reimbursement structure that includes coverage for coordination of care and documentation of patient outcomes.

Tightly coupled with the clinical care offered by PCMH providers are the plan's health coaches. Simply stated, it is the goal of the program's coaches to manage member health through "prevention-focused and evidence-based coaching … to decrease the risk of future disease development, maximize social capital and self-efficacy and improve quality of life" (Edsall 2009). For each health coach, managing his/her cohort of many dozen protégés involves keeping abreast of appointment schedules and knowing the membership status of members, HAP cycle phase, goals set and steps each member is trying to achieve to meet goals.

Helping to coordinate member care between the health coaches and clinical staff is HHHP's member services team. In the absence of the administrative quagmire associated with claims that bog down so many traditional insurers' customer support operations, the member services group functions more like a healthcare concierge, reminding members of upcoming appointments, prescriptions that need to be filled, coordination of referrals and inpatient services, etc.

From member services and health coaching to primary care, all three components of HHHP work in a coordinated fashion to manage members' health and likewise manage expenditures.

Engage

Increasing consumer engagement in healthcare is one of the foremost methods cited for having the greatest potential to improve the quality of the healthcare system, and it is the third pillar fundamental to the idea of Healthcare Performance Management. As noted by health policy experts, engaged consumers make better choices and exhibit increased compliance, cooperation and commitment to health and will demand better quality care at reasonable costs (Arnold, 2007). Additionally, Arnold notes a consensus opinion that engaged consumers are looking for "what is good for me," over what is good for people in general, suggesting that a level of personalization is key.

HHHP's business model pushes consumer engagement through a best-practice, research-driven health coaching program, yet the health coaching is extremely personalized and member-driven. [Figure 1]

The health coaching technique employed by HHHP health coaches uses the trans-theoretical model developed and refined from the work of Prochaska & DiClemente on the stages, processes and levels of behavioral change (Prochaska 1986), along with motivational interviewing – an approach first introduced by Miller & Rollnick (Miller 1991).

Educated in these psychosocial intervention techniques, health coaches carefully follow workflow-driven protocols to shepherd members along a path toward better health. Although the protocol is rigid, the health goals are member-created, so the endpoint meets the member's needs, and the path each member takes to reach his/her goals is also self-created. The health coach serves as an advisor, confidant and record-keeper, providing both encouragement and accountability while keeping track of progress.

Interestingly, while analysis of HHHP member data found that previously uninsured adults did not have higher rates of chronic disease, members did have significantly higher rates of unhealthy behaviors such as physical inactivity, tobacco use and poor diet. The health coaches give the HHHP members a means to participate in their own health destiny, thus drawing upon the resultant increased compliance, cooperation and commitment associated with such engagement. In fact, when member health goals are analyzed in aggregate, the majority can be placed into six categories which align with the population's behavioral challenges. The categories that predominate are: smoking cessation, increased physical activity, healthy eating, weight loss, health condition management and socio-economic-life goals. [Figure 2]
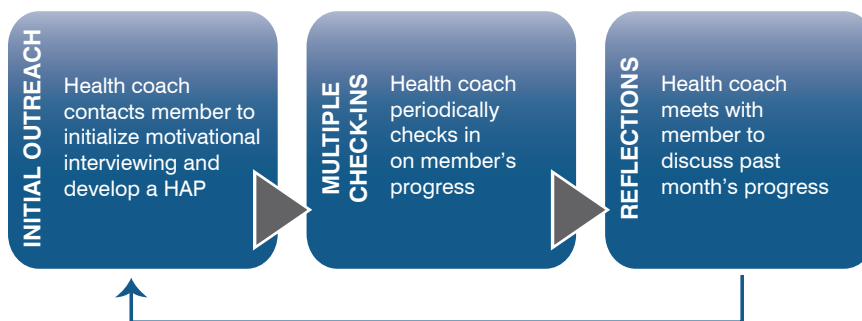
Figure 2

Six Most Popular Goals Identified by Plan Members

Smoking Cessation
Increased Physical Activity
Eating Healthier
Weight Loss
Health Condition Management
Socioeconomic-Life Goals

By identifying aspects of members' lives and their desire to change, health coaches, and the HHHP more broadly, are engaging members in their health destiny. A growing body of research suggests that in the long run, by facilitating the concept of consumer engagement, both the consumer and the plan benefit.

Figure 1

INITIAL OUTREACH — Health coach contacts member to initialize motivational interviewing and develop a HAP

MULTIPLE CHECK-INS — Health coach periodically checks in on member's progress

REFLECTIONS — Health coach meets with member to discuss past month's progress

Automate

As with any organization, productivity gains are often made through automation, and the healthcare industry is no different. As such, the fourth, and final, pillar in Healthcare Performance Management is automation. HHHP's automation is driven at the core by assistance of business partner Healthcare Interactive Inc.'s healthcare operating system, known as the Healthspace Cloud™.

As the name suggests, HHHP's membership, health coaching and claims data are maintained on a remote cloud that is secure, yet accessible by authorized employees anywhere an Internet connection is available. Healthspace also houses all of the workflows used by the various departments at HHHP, ensuring integrated access to members' electronic health records at all times.

Healthspace's unique system places each member at the center of his/her universe and extends data and information related to them as it is generated. In this manner, a member services representative can coordinate a member's care more efficiently by knowing which providers are involved with a member, what types of health services they provide the member and what outstanding gaps may exist.

On the other hand, such broad access to coordinated data calls into question the mandate to protect the member's privacy and limit access to information according to federal HIPAA regulations. A network of roles and relationships among members and employees facilitates appropriate credentialing and ensures security.

Another aspect of HHHP's work that has been automated is the inter-agency transmission of application data. To apply for coverage with HHHP, potential members must first complete an electronic application created by Social Interest Solutions. If an applicant is found to be potentially eligible, an enrollment workflow is initiated in HHHP's cloud.

From application through termination, HHHP's utilization of Healthspace's automated, cloud-based services enables efficiencies in all departments of the HHHP workplace. This leverages the workflows, as well as enhances levels of member service, health coaching and care coordination.

Benefits

Healthspace helped HHHP consolidate data and workflows into a single application environment, allowing staff to deliver consistent service in a manner they could not have accomplished before.

At the end of the day, Healthy Howard was able to deploy an advanced IT infrastructure that it didn't have to build, yet was custom-configured to match its business areas and unique business processes. Had it not been delivered through the cloud,

it would have been unaffordable. Instead, the cloud-based solution was an affordable $1 to $1.50 per person per month, turnkey solution that was implemented within 90 days and officially launched in four months.

The Healthspace Cloud solution has yielded a number of additional benefits for Healthy Howard such as the ability to access and cross-reference data that previously had been stored in multiple databases, and the bonus that required reporting duties can

now be done in a quarter of the time previously required. Coordination among departments has drastically improved since the collaborative workflows can involve staff members in different areas contemporaneously. These workflows also allow members to "see" the status of others' work. All in all, "It's better for the consumer," Garcia-Bunuel says. "I think in the future, as organizations use cloud technology, it will bend the cost curve a lot on healthcare."

Summary

Healthy Howard's primary care home model is revolutionary for many reasons:

- HHHP measures members' health as they enter the plan, establishing a health baseline and emphasizing preventive care.

- HHHP manages a member's health through information-rich member services and health coaching resources.

- HHHP engages members in the community via a face-to-face health coaching model.

- HHHP has adopted Healthcare Interactive's Healthspace Cloud operating system to automate data management, automate business processes via workflows, manage members' electronic health records and maintain quality member service.

Conclusion

The issues of cost and affordability are central to providing the uninsured with access to healthcare. In 2011, the average annual premium for single coverage in an employer-sponsored health plan was $5,429 (KFF 2011b), equating to an annual cost of $4.3 million to provide traditional private insurance to HHHP's approximately 800 members. [Figure 3]

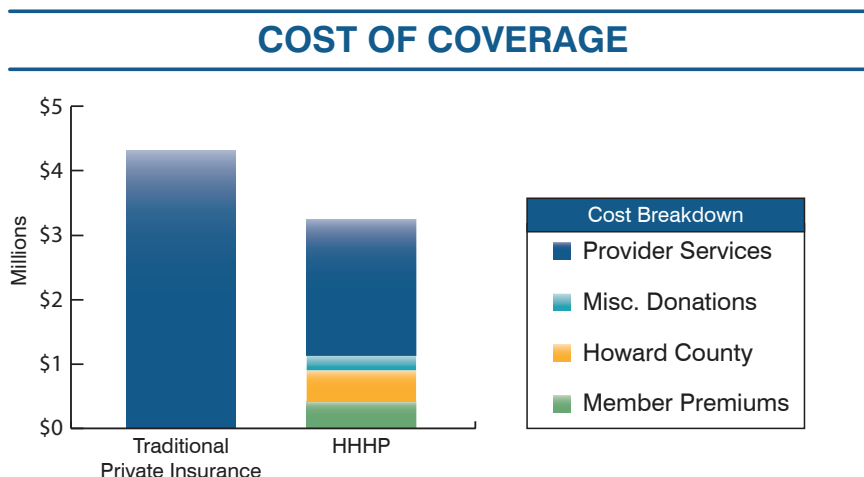HHHP's 2011 operating budget, in contrast, equated to only about $3.2 million, 25 percent less than an equivalent private insurance solution, and included a combination of revenue sources – member premiums, a Howard County grant, medical provider service donations and other cash/in-kind donations. Lessons learned from HHHP's unique business model are being used in the ongoing development of a regional insurance co-op, thanks to the potential for federal funding of such plans.

"Healthy Howard has made a name for itself in the national healthcare conversation by taking innovative and fiscally-responsible action to help the uninsured," says Ken Ulman, Howard County executive.

Healthy Howard's operational success illustrates the value attainable when the political will exists to confront the challenge of aiding the uninsured, leveraging expert resources from public agencies and private sector innovators to deliver solutions. Most importantly, the HHHP story must be shared as its success is repeatable, scalable and able to be modified as policy changes.

Instead of building a system from scratch, a prospect that is not only costly but also risky, Healthy Howard was able to operationalize its business using HCI's Healthspace Cloud for a mere $15,000 a year. For municipalities trying to make a difference in the lives of the uninsured in their community, providing affordable access to care is an implementable social mandate with a fiscally responsible return on investment.

Figure 3

COST OF COVERAGE

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About the HPM Institute

The Healthcare Performance Management Institute is a research and education organization dedicated to promoting the use of business technology and management principles that deliver better and more cost-effective healthcare benefits for employers who cover their employees.

The Institute's mission is to introduce and develop a new corporate discipline called Healthcare Performance Management (HPM), a technology-enabled business strategy that tackles the challenge of controlling healthcare costs and quality in much the same way that enterprises have optimized customer relations, supply chain management and enterprise resource management. Supported by its four key pillars—Measure, Manage, Engage and Automate—HPM provides organizations with visibility and control over their healthcare benefits spending trends and risk-management postures while protecting individual employee privacy.

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