Goals

Participants will:

- Learn about how new techniques are improving health care delivery
- Gain an understanding of how technology, effective communication and policies can impact health disparities:
  1. On the community level
  2. Through targeted media campaigns
  3. Using technology to foster care delivery
- Explore innovative models for addressing disparities that QIOs, can use to inform their work and address disparities among Medicare beneficiaries.
Healthcare Hotspotting: Innovative Approaches to Caring for Super-Utilizers

presented by Jeffrey Brenner, MD
Executive Director
The Camden Coalition of Health Providers

Using Data to Improve Care of High Cost, Complex Patients

Jeffrey Brenner, MD
Executive Director

Camden Coalition of Healthcare Providers
Camden Health Data

- 2002 – 2011 with Lourdes, Cooper, Virtua data
  - 500,000+ records with 98,000 patients
  - 50% population use ER/hospital in one year
- Leading ED/hospital utilizers citywide
  - 324 visits in 5 years
  - 113 visits in 1 year
- Total revenue to hospitals for Camden residents $100 million per year
  - Most expensive patient $3.5 million
  - 30% costs = 1% patients
  - 80% costs = 13% patients
  - 90% costs = 20% patients

Top 10 ER Diagnosis 2002-2007 (317,791 visits)

<table>
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<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>Visits</th>
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<td>465.9</td>
<td>ACUTE UPPER RESPIRATORY INFECTION</td>
<td>12,549</td>
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<tr>
<td></td>
<td>(head cold)</td>
<td></td>
</tr>
<tr>
<td>382.9</td>
<td>OTITIS MEDIA NOS (ear infx)</td>
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</tr>
<tr>
<td>079.99</td>
<td>VIRAL INFECTION NOS</td>
<td>7,577</td>
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<tr>
<td>462</td>
<td>ACUTE PHARYNGITIS (sore throat)</td>
<td>6,195</td>
</tr>
<tr>
<td>493.92</td>
<td>ASTHMA NOS W/ EXACER</td>
<td>5,393</td>
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<tr>
<td>558.9</td>
<td>NONINF GASTROENTERI (stomach virus)</td>
<td>5,037</td>
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<tr>
<td>789.09</td>
<td>ABDOMINAL PAIN-SITE NEC</td>
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<tr>
<td>780.6</td>
<td>FEVER</td>
<td>4,219</td>
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<tr>
<td>786.59</td>
<td>CHEST PAIN NEC</td>
<td>3,711</td>
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<tr>
<td>784.0</td>
<td>HEADACHE</td>
<td>3,248</td>
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</table>
Types of Hospital Utilizers

- **Low / No Utilization**
  - Rarely visit hospital

- **Medium ED Utilizer**
  - Average 2-3 ED visits in a year

- **High ED Utilizer**
  - Average 8 ED Visits
  - And 1 Inpatient Visit

- **High Inpatient Utilizer**
  - Average 3 Inpatient
  - 1 ED Visit

Source: Cooper Lauferts and Virtus
Hospital and EMRing Area
Jan 2002-June 2008
Utilization Types

<table>
<thead>
<tr>
<th>Low / No Utilization</th>
<th>Medium ED Utilization</th>
<th>High ED Utilization</th>
<th>High INP Utilization</th>
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</thead>
<tbody>
<tr>
<td># of Residents</td>
<td>497</td>
<td>122</td>
<td>18</td>
</tr>
<tr>
<td>% of Building</td>
<td>76%</td>
<td>19%</td>
<td>3%</td>
</tr>
<tr>
<td>Average Age</td>
<td>37.2</td>
<td>59.1</td>
<td>41.5</td>
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<tr>
<td>Average Yrs in Building</td>
<td>4.7</td>
<td>6.0</td>
<td>4.8</td>
</tr>
</tbody>
</table>

www.camdenhealth.org

Utilization typology

<table>
<thead>
<tr>
<th>ED visits, 2011</th>
<th>Inpatient visits, 2011</th>
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</thead>
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<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>0</td>
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<tr>
<td>1</td>
<td>26,128</td>
</tr>
<tr>
<td>2 to 3</td>
<td>13,390</td>
</tr>
<tr>
<td>4 to 5</td>
<td>3,216</td>
</tr>
<tr>
<td>6 to 7</td>
<td>1,020</td>
</tr>
<tr>
<td>8 to 9</td>
<td>386</td>
</tr>
<tr>
<td>10+</td>
<td>339</td>
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### Utilization matrix

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<th>Inpatient visits, 2011</th>
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<th>1</th>
<th>2</th>
<th>3 to 4</th>
<th>5+</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>44,728 (85%) patients 5,210 Inpatient visits 63,489 ED visits</td>
<td>28,000,000 (50%) IP payment 25,800,000 (59%) ED payment</td>
<td>985 (2%) patients 1,856 IP visits 4,298 ED visits</td>
<td>503 (1%) patients 2,026 Inpatient Visits 4,144 ED Visits</td>
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</tr>
<tr>
<td>0</td>
<td>1</td>
<td>1,920 (4%) patients 241 Inpatient visits 2,821 ED visits</td>
<td>$10,000,000 (17%) IP payment $1,700,000 (4%) ED payment</td>
<td>503 (1%) patients 2,026 Inpatient Visits 4,144 ED Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>1,563 (7%) patients 1,239 Inpatient visits 6,962 ED visits</td>
<td>$10,000,000 (17%) IP payment $1,700,000 (4%) ED payment</td>
<td>503 (1%) patients 2,026 Inpatient Visits 4,144 ED Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 to 3</td>
<td>4</td>
<td>5,963 (59%) patients 28,447 ED visits</td>
<td>$6,700,000 (18%) in IP payment $2,800,000 (6%) in ED payment</td>
<td>503 (1%) patients 2,026 Inpatient Visits 4,144 ED Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 to 5</td>
<td>5</td>
<td>1,920 (4%) patients 241 Inpatient visits 2,821 ED visits</td>
<td>$10,000,000 (17%) IP payment $1,700,000 (4%) ED payment</td>
<td>503 (1%) patients 2,026 Inpatient Visits 4,144 ED Visits</td>
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</tr>
<tr>
<td>5+</td>
<td>6</td>
<td>4,961 (9%) patients 28,447 ED visits</td>
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<tr>
<td>6 to 7</td>
<td>7</td>
<td>111,500,000 (27%) in ED payment</td>
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<td>503 (1%) patients 2,026 Inpatient Visits 4,144 ED Visits</td>
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</tr>
<tr>
<td>8 to 9</td>
<td>8</td>
<td>1,563 (7%) patients 1,239 Inpatient visits 6,962 ED visits</td>
<td>$10,000,000 (17%) IP payment $1,700,000 (4%) ED payment</td>
<td>503 (1%) patients 2,026 Inpatient Visits 4,144 ED Visits</td>
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<tr>
<td>10+</td>
<td>9</td>
<td>1,563 (7%) patients 1,239 Inpatient visits 6,962 ED visits</td>
<td>$10,000,000 (17%) IP payment $1,700,000 (4%) ED payment</td>
<td>503 (1%) patients 2,026 Inpatient Visits 4,144 ED Visits</td>
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<td></td>
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</tbody>
</table>

### High Inpatient Utilizers

**215 patients (1%)**

<table>
<thead>
<tr>
<th>Mean # ED visits</th>
<th>Mean # IP visits</th>
<th>Mean total LOS</th>
<th>Mean % of all unique primary ICD classified as chronic</th>
<th>Mean % of IP that are 60 day readmissions</th>
<th>Mean total charges</th>
<th>Mean total receipts</th>
<th>Median Age</th>
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</thead>
<tbody>
<tr>
<td>4.48</td>
<td>5.33</td>
<td>54.71</td>
<td>34%</td>
<td>55%</td>
<td>$673,592</td>
<td>$73,143</td>
<td>57</td>
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</table>

<table>
<thead>
<tr>
<th>% total</th>
<th>% total ED</th>
<th>% total IP</th>
<th>% total LOS</th>
<th>% total charges</th>
<th>% total receipts</th>
<th>% total 60 readmits</th>
<th>Total charges</th>
<th>Total receipts</th>
</tr>
</thead>
<tbody>
<tr>
<td>.8%</td>
<td>1.5%</td>
<td>13.0%</td>
<td>27.5%</td>
<td>20.0%</td>
<td>18.8%</td>
<td>23.0%</td>
<td>$144,148,652</td>
<td>$15,652,705</td>
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</table>

<table>
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<th>Diagnosis</th>
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<tr>
<td>RESPIRATORY DISTRESS NEC</td>
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<td>DVT/PE/THROMBOEMBOLIC DISEASE</td>
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<td>1.8</td>
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<td>SHORTNESS OF BREATH [ICD 1998]</td>
<td>24</td>
<td>1.8</td>
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<tr>
<td>REHABILITATION PROG NEC</td>
<td>26</td>
<td>1.7</td>
</tr>
<tr>
<td>ACUTE RENAL FAILURE NEC</td>
<td>25</td>
<td>1.6</td>
</tr>
<tr>
<td>ANEMIA RBC NOS [ICD 1998]</td>
<td>24</td>
<td>1.6</td>
</tr>
<tr>
<td>ACUTE GASTRO INTESTINAL NEC</td>
<td>24</td>
<td>1.4</td>
</tr>
<tr>
<td>URINARY TRACT INFECTION NOS</td>
<td>24</td>
<td>1.4</td>
</tr>
<tr>
<td>RESPIRATORY DISEASE NOS</td>
<td>24</td>
<td>1.3</td>
</tr>
<tr>
<td>ACUTE ON CHRONIC SYSTEMIC HEART FAILURE [ICD]</td>
<td>27</td>
<td>1.1</td>
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</table>
Patient Case Presentation #1

- 55-yr Male, admitted for GI bleed and SOB (November 2011)
- Dual coverage, Lives alone in high-rise apartment
- 6 months- 9 ED visits, 6 Inpt visits
- 12 Medications daily

ESRD
Renal Carcinoma
Hepatitis B
Hypertension
Hyperlipidemia
Peripheral vascular dx

Asthma
Glaucoma (blind in one eye)
Sleep Apnea
Severe Back Pain

www.camdenhealth.org
### Daily Admissions Feed

**Admitted past month, 6 month summary**

<table>
<thead>
<tr>
<th>Admit</th>
<th>Facility</th>
<th>Days 6 mo episodes</th>
<th>Id</th>
<th>ED Name</th>
<th>dob</th>
<th>age</th>
<th>sex</th>
<th>PCP</th>
<th>PracticeName</th>
<th>Insurance</th>
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<tr>
<td>06/13/12</td>
<td>Cooper</td>
<td>40</td>
<td>7</td>
<td>9</td>
<td>OLOL</td>
<td>6/23/1991</td>
<td>90</td>
<td>M</td>
<td>JACOBSOHN</td>
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<td>2</td>
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<td>10/29/1990</td>
<td>72</td>
<td>F</td>
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<td>CAMBA HEALTH</td>
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<td>06/13/1990</td>
<td>70</td>
<td>F</td>
<td>JOHN Korp</td>
<td>CAMBA HEALTH</td>
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<tr>
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<td>3</td>
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<td>06/12/1990</td>
<td>71</td>
<td>M</td>
<td>ND PHYSICIAN</td>
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<tr>
<td>Cooper</td>
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<td>2</td>
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<td>06/11/1990</td>
<td>70</td>
<td>F</td>
<td>MARYHORI</td>
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<tr>
<td>Cooper</td>
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<td>06/10/1990</td>
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<td>F</td>
<td>MARYHORI</td>
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<tr>
<td>Cooper</td>
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<td>2</td>
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<td>06/09/1990</td>
<td>70</td>
<td>F</td>
<td>MARYHORI</td>
<td>CAMBA HEALTH</td>
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</table>

**06/12/12**

<table>
<thead>
<tr>
<th>Admit</th>
<th>Facility</th>
<th>Days 6 mo episodes</th>
<th>Id</th>
<th>ED Name</th>
<th>dob</th>
<th>age</th>
<th>sex</th>
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<tbody>
<tr>
<td>Cooper</td>
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<td>9</td>
<td>OLOL</td>
<td>06/08/1990</td>
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<td>M</td>
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<td>Project Hope</td>
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<tr>
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<td>06/06/1990</td>
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<td>Cooper</td>
<td>30</td>
<td>9</td>
<td>OLOL</td>
<td>06/05/1990</td>
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<td>05/27/1990</td>
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<td>LYMANBAZELL</td>
<td>Project Hope</td>
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**Thursday, June 14, 2012**

---
Why is saving money so hard in healthcare?

Theory of Change

Clinical Redesign
Engagement
Data
Research Article

Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults

The Adverse Childhood Experiences (ACE) Study

Vincent J. Felitti, MD, FACP, Robert F. Anda, MD, MS, Dale Nordenberg, MD, David F. Williamson, MS, PhD, Alison M. Spitz, MS, MPH, Valerie Edwards, BA, Mary P. Koss, PhD, James S. Marks, MD, MPH
Fountain of Youth Discovered in Doylestown, PA

Effect of a Community-Based Nursing Intervention on Mortality in Chronically Ill Older Adults: A Randomized Controlled Trial

Kenneth D. Coburn*, Sherry Marcantonio, Robert Lazansky, Maryellen Keller, Nancy Davis

Health Quality Partners, Doylestown, Pennsylvania, United States of America

- 1,700 adults over 65 over 10 years
- Randomized study run by Mathematica begun in 2002
- Part of a Medicare Coordinated Care Demonstration Project
- 25% lower relative risk of death (9.9% vs 12.9%)
- Highest risk patients 48% reduction in death rates
- 33% reduction in hospitalization
- 22% reduction in total cost to Medicare
The Future of Primary Care

presented by Clement Bezold, PhD
Chairman and Senior Futurist
Institute for Alternative Futures

Primary Care Futures: Quality, Care & Equity
Clem Bezold
Institute for Alternative Futures

For
Delmarva Foundation Disparities National Coordinating Center Webinar
April 8, 2014
Introduction/Key Points

- Primary Care and our definitions of quality are evolving rapidly
- Health Equity is part of larger trends and represents the next civil rights movement
- QIOs ensure and accelerate quality

Introduction/Key Points cont’d

- This is an intensely uncertain, challenging and opportunity filled time for health care
- Understand how quality relates to a range of futures and primary care scenarios (outcomes)
- Explore how important it is to know and pursue your vision and preferred future, in support of quality
Futures & Foresight

Futures is about:

- **Plausible futures** -- understanding what might happen
  - Trends, Scenarios

- **Preferred futures** – creating the future you want, pursuing your aspirations, your vision
  - Aspirations Model, Vision

Primary Care 2025

an IAF/NACHC project supported by a grant from THE KRESGE FOUNDATION
Imagine: Primary Care that Works for All

- Virtually all have access to great, effective, lower cost primary care that is
  - Personalized, anticipatory, available (often) in your home or anywhere
  - Driven by protocols that are evidence based, and incorporate your genomic, metabolomic, and bio-monitoring data
  - Digital health coach, personal health avatars widely used
Primary Care that Works for All

- Quality has evolved from the Patient Center Medical Home to the Community Centered Health Home (CCHH)
- Primary care team broadens – Physician, NP/PA, DC/DPT, Social Worker, Pharmacist, Dentist, Community Health Worker

Imagine: Primary Care that Works for All

This is one of four scenarios!
Scenarios: What and Why?

- Scenarios are alternative stories about the future
- Scenarios bound uncertainty and explore major pathways
- Used to understand change, clarify assumptions, track trends, consider alternatives, and develop vision

Scenarios should

- Consider what’s likely and what’s preferable
- Aid in understanding and creating the future
- Lead to enhanced focus on vision, visionary success, and sensitivity to opportunities
- Be constructed around expectable, challenging, and visionary archetypes
Forecast, Scenario Zones: Visionary/Surprisingly Successful, Expectable, Challenging

Key Trends Shaping Primary Care

- In the Macroenvironment
- In health care, especially disruptive innovations
Key Trends: Disruptive Innovations

Disruptive Innovations

Business Model Innovations
- Quality - Triple Aim
- The Home Team – PCMH to CCHH
- Integrated, bundled payments
- Medical tourism (home & abroad)
- Transparency of costs
- Retail clinics

Emerging Technologies
- Personalized medicine & care
- EMR & PHR
- Digital coach/navigator
- Care in virtual space
Health Care Quality is Evolving

The IOM 6 AIMS

The Triple Aim

Population Health

Experience of Care

Per Capita Cost
### Major Factors Shaping Health

<table>
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<th>M2002</th>
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<th>CHR</th>
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<td><strong>Behavior</strong></td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td></td>
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<tr>
<td><strong>Socioeconomic</strong></td>
<td></td>
<td></td>
<td>50%</td>
<td>40%</td>
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<tr>
<td><strong>Environment</strong></td>
<td>20%</td>
<td></td>
<td></td>
<td>10%</td>
</tr>
<tr>
<td><strong>Social</strong></td>
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<td>15%</td>
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<tr>
<td><strong>Physical</strong></td>
<td></td>
<td>5%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td><strong>Genes</strong></td>
<td>20%</td>
<td>30%</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td><strong>Healthcare</strong></td>
<td>10%</td>
<td>10%</td>
<td>25%</td>
<td>20%</td>
</tr>
</tbody>
</table>

The Home Team – from Patient Centered Medical Home (PCMH) to Community Centered Health Home (CCHH)

The Home Team – PCMH
The patient-centered medical home (PCMH) is a centerpiece in defining primary care. Its features include:

- Enhanced access to care
- Care continuity
- Practice-based team care
- Comprehensive care
- Coordinated care
- Population management
- Patient self-management
- Health IT
- Evidence-based
- Care plans
- Patient-centered care
- Shared decision-making
- Cultural competency
- Quality measurement and improvement
- Patient feedback
- New payment systems

Who’s on the Team

- Health care personnel and teams – all practicing at top of licenses
- MD/DOs; NPs, PAs; DCs, DPTs; RNs; PharmDs, Behavioral; MAs and CHWs
  Incl. Community Health Workers going into homes with the intelligence and caring of the system

The Home Team – from Patient Centered Medical Home (PCMH) to Community Centered Health Home (CCHH)
Community Centered Health Home = PCMH plus:

- Work with community partners to collect data on social, economic, and community conditions
- Aggregate health and safety data; systematically review health and safety trends
- Identify priorities and strategies with community partners and coordinate activity
- Act as community health advocates
- Mobilize patient populations
- Strengthen partnerships with local health care organizations and establish model organizational practices

Disruptive Emerging Technologies
Personalized Medicine and Care

- Genomics, Biomonitoring
  - Epigenetics, Zipcodeomics
- Personalized definitions of “normal” and disease
- Massive data on treatments & side effects analyzed and results used for personalized prescriptions for individuals

Health Care Knowledge Advances

- Electronic Medical Records
- “Dr. Watson” Expert Support for providers
- Digital Health Coach (“avatar”)
- Digital health agents, gaming, social networking
Health Care Knowledge Advances

- Personalization
  - Biomonitoring
  - Genomics, epigenetics, zipcodeomics
The Home & the Doctor’s Office
Digital Health Coach Aided By Technologies

Wellness & disease mgmt. apps

Digital coach ("avatar")

Noninvasive biomonitoring

Big name vendors offer free avatar-based health coaching if other integrated health products and services are purchased

Personal health record

Facilitated Disease Network

Key Trends shape Scenarios

- Expectable
- Challenging
- Too Visionary or Surprisingly Successful
The Four Scenarios

1. Many Needs, Many Models
2. Lost Decade, Lost Health
3. Primary Care That Works for All
4. “I Am My Own Medical Home”
1. Many Needs, Many Models

Expansion of Patient-Centered Medical Home

Some shortages of PCPs. All PCMH team members practice at top of license

Prevention

Where Americans receive primary care:

40% Use integrated systems – capitated, continuity
30% Use semi-integrated systems – FFS & P4P
30% Use fee-for-service – lucky poor use CHCs

1. Many Needs, Many Models

Electronic Medical Records

“Dr. Watson” Expert Support for providers

Personalized Vital Signs

Digital health agents, gaming, social networking
1. Many Needs, Many Models

Employers drop insurance → Health Insurance Exchanges

Significant disparities remain for access and quality

2. Lost Decade, Lost Health

Recurrent severe recessions

Declining physician revenue

Shortage of primary care providers

Where Americans receive primary care:

- 30% Use fully integrated systems – capitated, continuity
- 20% Use semi-integrated systems – mixed FFS- P4P
- 35% Use fee-for-service – episodic, often poor quality
- 15% Use concierge fee-for-service – sophisticated tech.
2. Lost Decade, Lost Health

Those with good insurance access great care with advanced technology

Many more uninsured

Many turn to black market care & unreliable online advice

3. Primary Care That Works for All

- Expanded team of providers

Where Americans receive primary care:
(Near universal health insurance coverage)

- 85% Use integrated systems – capitated, continuity
- 10% Use concierge fee-for-service
- 5% Uninsured use Community Health Centers & ERs
3. Primary Care That Works for All

- Addressed local, social & economic foundations for equitable health, creating healthy communities
- Capitation – if it is smart, we will pay for it (leading to reduced costs)

Proactive electronic records, virtual access, coaching.
Advanced knowledge technologies and community mapping allow for identification and remediation of “hotspots” of ill health.

4. “I Am My Own Medical Home”

*Advanced knowledge technologies allow self-care*

Where Americans receive primary care:
- 40% Consumer Directed Health Plans – self-managed care
- 40% in integrated Care systems
- 10% Concierge Care
- 10% Uninsured – use ER and CHCs

- Big name vendors offer free avatar-based health coaching if other integrated health products and services are purchased.

4. “I Am My Own Medical Home”

- Much of the population opts for self-care and high deductible insurance.
- Consumers buy health-related products and services through competitive markets that offer high transparency of costs and quality.
- Demand for human primary care providers declines.
- Health care costs are significantly reduced.
Comparing Scenarios

<table>
<thead>
<tr>
<th>Scenario #1</th>
<th>Scenario #2</th>
<th>Scenario #3</th>
<th>Scenario #4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many Needs, Many Models</td>
<td>Lost Decade, Lost Health</td>
<td>Primary Care that Works for All</td>
<td>“I am my medical home”</td>
</tr>
</tbody>
</table>

### Characteristics of primary care

<table>
<thead>
<tr>
<th>#1</th>
<th>#2</th>
<th>#3</th>
<th>#4</th>
</tr>
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<td>Lost Decade, Lost Health</td>
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</tr>
</tbody>
</table>

### Payment forms

<table>
<thead>
<tr>
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<th>#3</th>
<th>#4</th>
</tr>
</thead>
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<td>“I am my medical home”</td>
</tr>
</tbody>
</table>

### HIT, knowledge technologies

<table>
<thead>
<tr>
<th>#1</th>
<th>#2</th>
<th>#3</th>
<th>#4</th>
</tr>
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<td>“I am my medical home”</td>
</tr>
</tbody>
</table>

### Health Care share of GDP

<table>
<thead>
<tr>
<th>#1</th>
<th>#2</th>
<th>#3</th>
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</tr>
</tbody>
</table>

## Comparing Scenarios

### Characteristics of primary care

- Biomonitoring integrated to EMR & care protocols
- Consumer PHR & integration
- Health Avatars, digital coaches
- New vital signs & community health measures

### Payment forms

- EMR’s are not interoperable
- Little consumer uptake (due to both cost and relevance)
- New vital signs, biomonitoring, most effective avatars, available for the affluent

### HIT, knowledge technologies

- Interoperable EMRs that include genetic, epigenetic, biomic, community and other factors
- Health avatars support individual and community health
- Quality standards for avatars, both sold and given for free
## Likelihood and Preferability

Write in the percentage for each scenario, from 0 to 100%:
How likely is the scenario? How preferable is it?

<table>
<thead>
<tr>
<th></th>
<th>Likelihood (0 to 100%)</th>
<th>Preferability (0 to 100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scenario #1</strong></td>
<td></td>
<td></td>
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<tr>
<td>Many Needs, Many Models</td>
<td></td>
<td></td>
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<tr>
<td><strong>Scenario #2</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Scenario #4</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“I am my medical home”</td>
<td></td>
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</tr>
</tbody>
</table>

## Conclusion

- Quality and Health Care are Evolving

- It is important to know the range of likely futures, particularly primary care scenarios – it is even more important to know and pursue your vision, your preferred future

- Equity – eliminating health disparities is a critical part of quality
IAF’s Aspirational Futures

cbezold@altfutures.org
Institute for Alternative Futures
www.altfutures.org

Addressing Disparities: Innovations in Coordinated Medicare/Medicaid Initiatives

presented by Edo Banach
Senior Advisor, Acting Director, Models, Demonstrations and Analysis Group, Medicare-Medicaid Coordination Office

Institute for Alternative Futures
www.altfutures.org
Addressing Disparities: Innovations in Coordinated Medicare/Medicaid Initiatives

Edo Banach
Senior Advisor
Acting Director, Demonstrations, Models and Analysis Group
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services

Medicare-Medicaid Coordination Office

Section 2602 of the Affordable Care Act

Purpose: Improve quality, reduce costs, and improve the beneficiary experience.

– Ensure dually eligible individuals have full access to the services to which they are entitled.
– Improve the coordination between the federal government and states.
– Develop innovative care coordination and integration models.
– Eliminate financial misalignments that lead to poor quality and cost shifting.
Innovations for Medicare-Medicaid Beneficiaries

- MMCO Initiatives that aim to improve care and reduce cost through coordination:
  - Nursing facility demo (Initiative to Reduce Avoidable Hospitalizations)
  - Financial Alignment demo
  - PACE initiatives (budget)
- Broader CMS initiatives:
  - Bundled Payments for Care Improvement (CMMI demo)
  - ACOs – Shared Savings Program and Pioneer
  - Health Care Innovation Awards
  - Independence at Home
- 2105 Budget Proposed Reforms:
  - Bundled payment for certain post-acute providers beginning in 2019
  - Payment updates for some post-acute providers

Initiative to Reduce Avoidable Hospitalizations

**Goal:** To reduce preventable inpatient hospitalizations among residents of nursing facilities.

**Overview:** Partnering with 144 nursing facilities. Each organization will have on-site staff to partner with the existing nursing facility staff to provide preventive services as well as improve assessments and management of medical conditions. **All organizations are currently serving beneficiaries.**

**Selected Organizations:**
- Alabama Quality Assurance Foundation (Alabama)
- Alegent Health (Nebraska)
- The Curators of the University of Missouri (Missouri)
- Greater New York Hospital Foundation, Inc. (New York)
- HealthInsight of Nevada (Nevada)
- Indiana University (Indiana)
- UPMC Community Provider Services (Pennsylvania)
Opportunity for Care Coordination: Financial Alignment

Background: In 2011, CMS announced new models to integrate the service delivery and financing of the Medicare and Medicaid programs through a Federal-State demonstration to better serve the population.

Goal: Increase access to quality, seamless integrated programs for the 9 million Medicare-Medicaid enrollees.

Demonstration Models:
- **Capitated Model**: Three-way contract among State, CMS and health plan to provide comprehensive, coordinated care in a more cost-effective way.
- **Managed FFS Model**: Agreement between State and CMS under which States would be eligible to benefit from savings resulting from initiatives to reduce costs in both Medicaid and Medicare.

Financial Alignment Initiative Vision

The Financial Alignment Initiative will promote a more seamless experience for beneficiaries by:
- Focusing on person-centered models that promote coordination missing from today’s fragmented system
- Developing a more easily navigable and simplified system of services for beneficiaries
- Ensuring beneficiary access to needed services and incorporating beneficiary protections into each aspect of the new demonstrations
- Establishing accountability for outcomes across Medicaid and Medicare
- Requiring robust network adequacy standards for both Medicaid and Medicare
- Evaluating data on access, outcomes and beneficiary experience to ensure beneficiaries receive higher quality, more cost-effective care
Other Key Demonstration Information

• **Rated**: Participating plans receive capitation rate reflecting the integrated delivery of Medicare and Medicaid benefits based on:
  – Baseline spending in both programs.
  – Anticipated savings resulting from integration & improved care.

• **Readiness Review**: Ongoing process to assess plans’ Medicare and Medicaid experience and Demonstration readiness.
  – Two-step process that includes an onsite and desk review of participating plans.

Other Key Demonstration Information

• **Implementation and Monitoring**:
  • Ongoing milestones that allow CMS and States to monitor demonstration plan as enrollments begin.
  • CMS and the State have the right to stop enrollment at any time.

• **Evaluation**:
  • Contracted independent evaluator (RTI); and
  • State-specific evaluation plans
Demonstration Update

• Eight states have approved capitated Demonstrations: Massachusetts, Ohio, Illinois, California, Virginia, New York, South Carolina, and Washington State.
  – Massachusetts and Illinois plans now serving enrollees
• Colorado and Washington State have approved managed fee-for-service Demonstrations. WA’s began in July.
• Minnesota approved for alternative model.

PACE Flexibilities

• Pilot for serving younger individuals in FY 2015 budget
• Regulatory flexibilities
Polling Question: 7

Opportunities for care coordination for dual eligibles include:

a) Financial alignment
b) Restricting the number of dual eligibles
c) Leaving it up to the states
Polling Question: 8

Patient centeredness refers only to what happens in doctors’ offices.

a) True
b) False
Addressing Disparities: Innovations in Coordinated Medicare/Medicaid Initiatives

presented by Sandy Hilfiker, MA, Principal, Director of User Centered Design, CommunicateHealth Inc.

Innovations in User Centered Design to Increase Health Literacy

Sandy Hilfiker, MA
Principal, Director of User Centered Design

CommunicateHealth
Presentation Overview

1. What is user centered design?
2. Getting to know your audience
3. Organizing your information
4. Testing a draft
5. Involving participants with limited literacy

User Centered Design (UCD)=

Involving end-users (your audience) in the design and development of a product, message, or campaign

CO-CREATION
PARTICIPATORY DESIGN
The UCD Process

1) Research the user/audience
2) Design a prototype
3) Test it
4) Tweak it
5) Test it again

5 Reasons to involve your users

1) Just because you think your material is awesome doesn’t mean that your audience does.
2) You can waste a lot of time and money developing materials and products that nobody uses.
3) It’s the only way you can be sure that your messages will be understood.
4) Target audience members will be empowered and invested in the success of your product.
5) It will make you a better communicator.
What’s the point?

You want your design to be:

+ Usable
+ Useful
+ Appropriate
+ Appealing
Do I need to worry about health literacy?

About 9 in 10 Americans have limited health literacy skills.

All users benefit from improved readability and usability

Comparing time-on-task on the original site with a prototype (designed to support users with limited literacy skills):

<table>
<thead>
<tr>
<th>Time on Task (Mean)</th>
<th>Original Site</th>
<th>Prototype</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>High literacy</td>
<td>14:19</td>
<td>5:05</td>
<td>+182%</td>
</tr>
<tr>
<td>Lower literacy</td>
<td>22:16</td>
<td>9:30</td>
<td>+134%</td>
</tr>
<tr>
<td>All users</td>
<td>17:50</td>
<td>6:45</td>
<td>+164%</td>
</tr>
</tbody>
</table>

High Literacy Users:
- 3x as fast with the revised site
- 93% success rate on revised site (compared to 68% with original)

Who is your audience?

Sample Method: Collaging

+ Participants create a collage that represents the characteristics they would like to see in a new Website or product

+ **Result:** Provides insights into users’ needs normally not revealed in interviews and focus groups
Participant Voices: Collaging

“This is how I feel, free and full of energy. I want my doctor to understand that this is how I want to feel with her help.”

What’s the best way to organize your content?
Sample Method: Tree Testing

+ A technique for evaluating how easy it is for people to locate information within a material or website structure.

+ Participants are given a topic to find within a text version of a site map or table of contents.

Tree Testing: User Interface
How do I know if my product is usable?
Sample Method: Click Testing

+ A technique for gathering quick feedback on wireframes or mock-ups of webpage designs

+ Provides a ‘heat map’ of where participants expect to find specific types of information on page mock-ups

+ Provides the ability to gather feedback on specific labels and visual design elements

Click Testing: User Interface

Image of a webpage with interactive elements for click testing.
Click Testing: Sample Results

Sample Method: Usability Testing

+ Participants explore a website or application in a natural way through real-life scenarios.

+ Result: Provides more realistic results & exposes unexpected usability issues.
Fill in the Blank

Usability testing with 5 participants will reveal _____% of usability problems.

+ 15%
+ 35%
+ 60%
+ 85%
+ 95%

[Source: Nielson Norman Group, 2000]

Involving Participants with Limited Health Literacy
Top Ten Tips

① Partner with community organizations to recruit special populations
② Screen for participants with limited health literacy using proxy measures
③ Develop screeners, consent forms, and moderator’s guides in plain language
④ Limit the use of Likert-style questions
⑤ Use cash incentives when possible

Top Ten Tips

⑥ Screen for participants for limited technology use
⑦ Limit the number of tasks
⑧ Pre-test your protocol with at least one participant with limited literacy skills
⑨ Choose a moderator with experience conducting research with limited literacy participants
⑩ Conduct testing sessions in a setting that is familiar and accessible to participants
Health information for the 90%!

75% of adults have looked for health or medical information.

60% of adults have searched for health information online.

Searching for health information is one of the top 3 most popular online activities.

Sources:

Project Impact: Mobilizing Community Based Organizations to Address Health Disparities

presented by Sara Minsky, MPH
Assistant Director
Center for Community-Based Research
Dana-Farber Cancer Institute
Project IMPACT: Mobilizing Community Based Organizations to Address Health Disparities

Sara Minsky
Center for Community Based Research Dana-Farber Cancer Institute

Significance

• Our focus is whether we can change the public agenda and political will to address the complex problem of health disparities

• We are asking if we can use community assets to address health disparities

• We would like to go beyond the discussion on SES and race/ethnicity to examine the combined and interactive effects of both within the structural context

• Goal is to build community capacity to change the public agenda through local media coverage to ensure sustainability
Lung Cancer Disparities Center

Project IMPACT: Influencing Media & Public Agenda on Cancer & Tobacco Disparities  
Pl: K. Vish Viswanath  
PREVENTION

Project CLIQ: Community Linked IVR to Quit  
Pl: Jennifer Haas  
PREVENTION

Socioeconomic adjustment of racial disparities in lung cancer relative survival  
Pl: Jarvis Chen  
EPIDEMIOLOGY

Racial Differences in Lung Adenocarcinoma Mutations  
Pl: Matthew Meyerson  
ETIOLOGY, DETECTION, DIAGNOSIS, TREATMENT

Racial and Socioeconomic Disparities in Lung Cancer: A Multifactorial Analysis of CanCORS  
Pl: John Ayanian  
TREATMENT, SURVIVAL

Study Investigators

Principal Investigator: K. “Vish” Viswanath, HSPH/DFCI/DFHCC

Co-Investigators:
Alan Geller, HSPH
Icharo Kawachi, HSPH
Elaine Puleo, U Mass, Amherst
Glorian Sorensen HSPH/DFCI/DFHCC
David Williams, HSPH
Members of the Lab

- Jaclyn Alexander-Molloy, MS
- Cabral Bigman, PhD
- Carmenza Bruff, BS
- Josephine Crisostomo, MPH
- Rachel McCloud, MPH
- Minsoo Jung, PhD
- Leesa Lin, MSPH
- Samuel Mendez
- Divya Ramamurthi, MA
- Nancy Klockson, BS
- Lisa Lowery, BS
- Yudy Muneton, LCSW
- Sara Minsky, MPH
- Rebekah Nagler, PhD
- Shoba Ramanadhan, ScD

www.viswanathlab.org

Community Partners on Project Advisory Committee (C-PAC)

- Comprised of community leaders and study investigators
- Meets at least quarterly
- Provides study oversight

Heather McMann
Executive Director
Groundwork Lawrence

Diane Knight
Director Northeast Tobacco Free Community Partnership

Vilma Lora
Co-Director of Women's Services
YWCA of Greater Lawrence
Coordinator of the City of Lawrence Mayor's Health Task Force

Paul Muchuthett
Regional Director
Department of Public Health and City of Lawrence Board Health
Community-Based Participatory Research (CBPR)

- Build on strengths and resources of our community partners
- Promote a co-learning and empowering process
- Involve a cyclical, iterative process
- Address health from both positive and ecological perspectives
- Disseminate findings and knowledge gained to all partners

Specific Aims

- **Aim 1: Public Agenda Assessment**
  - To examine the public agenda about health disparities—including tobacco disparities (TRHD)
Methods
(Public Agenda Assessment)

• Public agenda about health and tobacco disparities were assessed in three ways:
  – *Media Environment* - Content analysis of the local newspapers in Lawrence, MA
  – *Public Opinion* - Surveys of probability-based samples of residents of Lawrence, MA
  – *Community Leadership Interviews* - In Depth Interviews

Specific Aims

• **Aim 2: Intervention Development**
  – To use findings from our Public Agenda Assessment (Aim 1) to design a model intervention to influence the public agenda on health disparities with specific attention to TRHDs, including the development of:
    • a media training program for community-based organizations (CBOs) through a series of workshops
    • a toolkit for journalists
Specific Aims

• Aim 3: Intervention
  – This intervention will be used to train community-based organizations (CBOs) that work with the underserved, on how to work with local media to advance their agenda around health disparities (with specific focus on SES and race/ethnicity)

Hypothesized Outcomes

Greater engagement of the CBOs with the media
More coverage in the media about tobacco disparities and more emphasis on social and contextual framing
Shift in public opinion, placing a higher priority on tobacco disparities and framing the causes and solutions in more social contextual terms
Community Change through Media Mobilization

**Media Sources**
- Government
  - Federal
  - State
  - Local
- Scientists
- Community-based Organizations

**Media Coverage of Health Inequalities**

**Media Training with Community Groups**

**Public Opinion of Health Inequalities**

**Findings from Public Agenda Assessment**

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Intervention Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Opinion Survey</td>
<td>Illustrated individual responsibility is current dominant frame in Lawrence</td>
</tr>
<tr>
<td></td>
<td>Provided examples of current attitudes towards health priorities and reasons for tobacco use</td>
</tr>
<tr>
<td></td>
<td>Gave data on current smoking rates</td>
</tr>
<tr>
<td>Content Analysis</td>
<td>Illustrated that health news and health disparities are not often covered</td>
</tr>
<tr>
<td></td>
<td>Highlighted missed opportunities in media coverage</td>
</tr>
<tr>
<td>Community Leadership Study</td>
<td>Indicated community leaders’ perception of lack of media coverage on health disparities</td>
</tr>
<tr>
<td></td>
<td>Provided suggestions on how to address this gap</td>
</tr>
</tbody>
</table>
What do Lawrence residents think are important factors that affect health?

<table>
<thead>
<tr>
<th>Factor</th>
<th>% of respondents who said these factors were important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal health practices</td>
<td>71</td>
</tr>
<tr>
<td>Health insurance coverage</td>
<td>65</td>
</tr>
<tr>
<td>Environment (i.e., air &amp; water)</td>
<td>57</td>
</tr>
<tr>
<td>Quality of housing</td>
<td>54</td>
</tr>
<tr>
<td>Income level</td>
<td>53</td>
</tr>
<tr>
<td>Education level</td>
<td>47</td>
</tr>
</tbody>
</table>

Source: Project IMPACT’s door-to-door Public Opinion Survey

What are the local media saying?

- Our content analysis of *Rumbo* and the *Eagle-Tribune* found some coverage of health topics – but almost no coverage of health inequalities.

- Most stories focused on healthcare reform, fundraisers for cancer and other diseases, and heroic tales of people who’ve battled against illness.

- This situation represents a missed opportunity for our community partners!
The Project IMPACT Intervention

**Intervention Details**

- Five workshops in total from 2013-3014
- Two half-day sessions
- Approximately 15-20 participants each
- Workshop will help our CBO partners understand the *competing frames* they may encounter when working with the media on stories about health disparities.
Intervention Components

- Workshops for members of community-based organizations
- Interactive in-class exercises
- A training manual with guides for reaching out to the media
- A wiki providing additional resources
- Continuing networking and alumni events
- Workshops were evaluated pretest, posttest, 6-months

Project IMPACT (Influencing Media and Public Agenda on Cancer and Tobacco Disparities) aims to increase the capacity of community-based organizations (CBOs) in Lawrence, MA, to influence the public agenda on health and tobacco-related disparities.

Funded by the National Cancer Institute (NCI), Project IMPACT aims to (a) alter the informational environment in the community about health disparities in general and tobacco disparities in particular, (b) build community capacity by providing training to CBOs to enable them to effectively engage with local media in influencing the public agenda.

As part of the study, participants of CBOs will receive a training workshop that will enhance their knowledge on how news is gathered and the role of framing news stories. They will also receive educational resources to supplement the training and will be provided access to networking opportunities.

Intervention Learning Objectives

To educate workshop participants on the following:

- Health inequalities impact health and well-being
- How the news media helps set the public agenda
- News can be “reframed” in order to help reduce health inequalities
- Framing can be a tool to promote change
- The utility of communication in changing policy and behavior
- Effectively pitching and responding to media queries
- Fostering media relations
Day 1: Addressing Social Determinants

- Examples focus on tobacco-related determinants and solutions at different levels
- Teaches participants to examine environmental factors that may lead to health disparities
- Gives examples on tobacco
  - Policies
  - Availability of tobacco cessation products
  - Pro- and anti-tobacco messaging
  - Public Opinion Survey findings for tobacco use in Lawrence

Day 2: Working with the Media

- Fostering media relations
- Pitching stories
  - Journalists' considerations
  - Exemplars
  - Choosing a messenger
- Media channels
- Writing press releases and op-eds
Skills gained from the workshop

- All (100%) participants agreed/somewhat agreed that the workshop helped them to:
  - Understand that where people live, work, and play have an important effect on their health
  - Learn strategies for communicating about health inequalities
  - Learn strategies for interacting with the media

6 Month Follow-Up with first cohort

<table>
<thead>
<tr>
<th>Activities since the workshop</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total n</td>
<td>15</td>
</tr>
<tr>
<td>Used social media to promote org</td>
<td>60%</td>
</tr>
<tr>
<td>Written a press release</td>
<td>40%</td>
</tr>
<tr>
<td>Developed a communication plan</td>
<td>40%</td>
</tr>
<tr>
<td>Given an interview to the press</td>
<td>27%</td>
</tr>
<tr>
<td>Called in to a radio show to discuss org</td>
<td>27%</td>
</tr>
<tr>
<td>Organized a media event</td>
<td>20%</td>
</tr>
<tr>
<td>Pitched a story to a journalist</td>
<td>20%</td>
</tr>
<tr>
<td>Testified at a public hearing</td>
<td>7%</td>
</tr>
</tbody>
</table>
Next Steps

- Final Media Workshop
- In depth interviews with high and low utilizers of the workshop components to learn about their barriers and facilitators to using these skills
- Dissemination

Innovative Technology Applications in Healthcare

presented by Gigi Sorenson, RN, MSN, NAH
Director of Telehealth
Care Beyond Walls and Wires
Innovative Technology Applications in Healthcare

Gigi Sorenson RN, MSN
Northern Arizona Healthcare
Strategy before Technology

• Definition of telehealth care need
• Who are the partners in care delivery
  ▫ Providers
  ▫ Patients/Family
  ▫ Technology Support
• One size does not fit all needs
Technology Selection

• Privacy and Security Needs
  ▫ FDA Approval
• Integration into existing technology
• Connectivity Compatibility
• Ability to grow/expand
• Ease of use
• Cost
• Ease of installation/maintenance

Technology

• Carts
• Remote Monitoring Tools
  ▫ Weight Scale
  ▫ Blood Pressure
  ▫ Pulse Oximeter
  ▫ Transmission Pod
• Software Connections
• Mobile Phones
Applications

- Pre-Hospital Care Assessment
- Patient Education
- Acute Care Specialty Consultation
- Provider to Provider Consultation
- Provider to Patient Consultation
  - Virtual “Office” visit
- Transition Care
  - Consultations
- Chronic Care
  - Outpatient

• [Link](http://www.washingtonpost.com/sf/brand-connect/wp/2013/03/25/wireless-changing-us-healthcare/)
THANK YOU

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THANK YOU FOR JOINING US!

Please complete our evaluation by clicking HERE!

April 8, 2014
12:00-4:00 PM Eastern Time