Population Health:

1. **Pharmacists supporting population health in patient-centered medical homes.**
   *American Journal of Health-System Pharmacy* 74 (18): 1461-1466. 2017
   Antoinette B. Coe and Hae Mi Choe.
   Purpose. The integral role of pharmacists in supporting population health initiatives in the patient-centered medical home (PCMH) model of care is described. Summary. Population health initiatives focus on the health outcomes of a group of patients; in the PCMH model, such groups of patients, known as panels, may be defined as patients assigned to a care team or provider. The basic characteristics of the PCMH model include physician-led, team-based practice; coordinated and integrated care within the PCMH and in the patient’s community; provision of safe, evidence-based, high-quality care; incorporation of health information technology and continuous quality improvement strategies into panel identification, documentation, and care processes; improved access to care (e.g., through expanded scheduling and innovative communication methods); and value-based payments for participating healthcare professionals. Pharmacists can assist in management of patient panels to help achieve quality and performance metrics through activities typically including comprehensive medication reviews, identification of medication-related problems, and development of care plans and individualized treatment goals. Pharmacists practicing in PCMH settings focus on evaluating and optimizing medication regimens, including therapy initiation and dosage adjustment, to achieve targeted therapeutic outcomes and prevent adverse events. Pharmacists’ role in population health management varies according to the PCMH characteristics and setting. Conclusion. Pharmacists support population health in the PCMH by improving medication use, quality, and safety. Pharmacists’ impact on PCMH quality measures and health outcomes of their patient panels should continue to be evaluated.
   UI 125112217
   [Full Text]

2. **Population health management: Review of concepts and definitions.**
   *American Journal of Health-System Pharmacy* 74 (18): 1405-1411. 2017
   Meghan Swarthout and Martin A. Bishop.
   PURPOSE: The terms population health, population health improvement, and population health management are discussed. SUMMARY: A key concept in defining population health activities is clearly delineating the population(s) of focus. The Institute for Healthcare Improvement’s (IHI’s) Triple Aim Initiative uses the term population health management to describe the work by healthcare organizations to improve outcomes for individual patients to maximize population health. The National Academy of Medicine favors the term population health improvement and uses this term to describe work to identify and improve aspects of or contributors to population health, expanding the focus beyond traditional healthcare delivery systems. As organizations like IHI and the National Academy of Medicine continue to focus on population health, the terms and definitions used to describe these activities will continue to evolve. CONCLUSION: The use of consistent, clear definitions for population health activities is critical to the practice of pharmacy and healthcare delivery.
   UI 28887342
   [Full Text]

3. **Innovations in Population Health Surveillance: Using Electronic Health Records for Chronic Disease Surveillance.**
   Sharon E. Perlman, Katharine H. McVeigh, Lorna E. Thorpe, Laura Jacobson, Carolyn M. Greene and R. Charon Gwynn.
   With 87% of providers using electronic health records (EHRs) in the United States, EHRs have the potential to contribute to population health surveillance efforts. However, little is known
about using EHR data outside syndromic surveillance and quality improvement. We created an 
EHR-based population health surveillance system called the New York City (NYC) Macroscope 
and assessed the validity of diabetes, hyperlipidemia, hypertension, smoking, obesity, 
depression, and influenza vaccination indicators. The NYC Macroscope uses aggregate data 
from a network of outpatient practices. We compared 2013 NYC Macroscope prevalence 
estimates with those from a population-based, in-person examination survey, the 2013-2014 
NYC Health and Nutrition Examination Survey. NYC Macroscope diabetes, hypertension, 
smoking, and obesity prevalence indicators performed well, but depression and influenza 
vaccination estimates were substantially lower than were survey estimates. Ongoing validation 
will be important to monitor changes in validity over time as EHR networks mature and to 
assess new indicators. We discuss NYC’s experience and how this project fits into the national 
context. Sharing lessons learned can help achieve the full potential of EHRs for population 
health surveillance.

UI 28426302

4. Improving Population Health Management Strategies: Identifying Patients Who Are 
More Likely to Be Users of Avoidable Costly Care and Those More Likely to Develop a 
New Chronic Disease. 
*Health services research* **52** (4): 1297-1309. 2017
Judith H. Hibbard, Jessica Greene, Rebecca M. Sacks, Valerie Overton and Carmen Parrotta. 
OBJECTIVE: To explore using the Patient Activation Measure (PAM) for identifying patients 
more likely to have ambulatory care-sensitive (ACS) utilization and future increases in chronic 
disease. DATA SOURCES: Secondary data are extracted from the electronic health record of a 
large accountable care organization. STUDY DESIGN: This is a retrospective cohort design. 
The key predictor variable, PAM score, is measured in 2011, and is used to predict outcomes 
in 2012-2014. Outcomes include ACS utilization and the likelihood of a new chronic disease. 
DATA: Our sample of 98,142 adult patients was drawn from primary care clinic users. To be 
included, patients had to have a PAM score in 2011 and at least one clinic visit in each of the 
three subsequent years. PRINCIPAL FINDINGS: PAM level is a significant predictor of ACS 
utilization. Less activated patients had significantly higher odds of ACS utilization compared to 
those with high PAM scores. Similarly, patients with low PAM scores were more likely to have a 
new chronic disease diagnosis over each of the years of observation. CONCLUSIONS: 
Assessing patient activation may help to identify patients who could benefit from greater 
support. Such an approach may help ACOs reach population health management goals.

UI 27546032

5. Population Health Management: Is There Any Role for Orthopaedics?: An AOA 
Critical Issues Symposium. 
Scott D. Boden, Brian T. Smith and Matthew Handley. 
The next phase of health-care reform will accelerate the formation of integrated delivery 
systems and the creation of value and savings through population health management. 
Accomplishing this goal requires 3 key factors, including (1) enabling groups of physicians and 
hospitals to legally work together to cover a broad geographic area, (2) the formation of 
integrated delivery systems that cover the low to high-acuity and post-acute care spectrums, 
and (3) identifying mechanisms through which a subspecialty can impact the health of a 
population of patients. At first glance, it would be easy to assume that this is largely a primary 
care initiative and that orthopaedic surgeons cannot influence population health since they 
often just repair things after they have broken or worn out. This symposium will challenge that 
assumption and demonstrate the potential for orthopaedic surgeons to play a major role in 
population health management. Some of the mechanisms include implementing shared 
decision-making for elective procedures, reducing premature/unnecessary imaging and 
subspecialty referrals, improving bone health (osteoporosis prevention and fall risk 
assessment), and developing payment methodologies to reward population-based, rather than
individual-based, positive musculoskeletal outcomes.

6. **Moving Upstream in U.S. Hospital Care Toward Investments in Population Health.**
   James W. Begun, Sandra Potthoff and Sean H. McKibben.
   The root causes for most health outcomes are often collectively referred to as the social determinants of health. Hospitals and health systems now must decide how much to "move upstream," or invest in programs that directly affect the social determinants of health. Moving upstream in healthcare delivery requires an acceptance of responsibility for the health of populations. We examine responses of 950 nonfederal, general hospitals in the United States to the 2015 American Hospital Association Population Health Survey to identify characteristics that distinguish those hospitals that are most aligned with population health and most engaged in addressing social determinants of health. Those "upstream" hospitals are significantly more likely to be large, not-for-profit, metropolitan, teaching-affiliated, and members of systems. Internally, the more upstream hospitals are more likely to organize their population health activities with strong executive-level involvement, full-time-equivalent support, and coordination at the system level. The characteristics differentiating hospitals strongly involved in population health and upstream activity are not unlike those characteristics associated with diffusion of many innovations in hospitals. These hospitals may be the early adopters in a diffusion process that will eventually include most hospitals or, at least, most not-for-profit hospitals. Alternatively, the population health and social determinants movements could be transient or could be limited to a small portion of hospitals such as those identified here, with distinctive patient populations, missions, and resources.

7. **Getting from here to there: health IT needs for population health.**
   Joshua R. Vest, Christopher A. Harle, Titus Schleyer, et al.
   The United States' decade-long transition from a paper- to technology-based information infrastructure has always been recognized as an initial step—a laying of the foundation—for future changes to the delivery of care. An increasingly important focal area for improvement is population health. Numerous policies and programs now require healthcare organizations to manage the risks, outcomes, utilization, and health of entire groups of individuals. Nonetheless, current health information technology (IT) systems are not ready to support population health improvements effectively and efficiently. Existing health IT systems were designed for organizations that are structurally, operationally, and culturally focused on individual care delivery, rather than improving health for a population. Opportunities exist to align health IT resources and population health management strategies to fill the gaps among technological capabilities, use and the emerging demands of population health. To realize this alignment, healthcare leaders must think differently about the types of data their organizations need, the types of partners with whom they share information, and how they can leverage new information and partnerships for evidence-based action.

8. **Population Health: A New Paradigm for Medicine.**
   Timothy A. Peterson, Steven J. Bernstein and David A. Spahlinger.
   Healthcare delivery system reform has become a dominant topic of conversation throughout the United States. Driven in part by ever-higher national expenditures on health, an increasing number of payers and provider organizations are working to reduce the costs and improve the
quality of healthcare. In this article, we demystify the term "Population Health," review some of the larger payer initiatives currently in effect and discuss specific provider group efforts to improve the quality and cost of healthcare for patients. Copyright © 2016 Southern Society for Clinical Investigation. Published by Elsevier Inc. All rights reserved.

UI 26802755

9. **A Primer on Population Health Management and Its Perioperative Application.**
   Arthur M. Boudreaux and Thomas R. Vetter.
   The movement toward value-based payment models, driven by governmental policies, federal statutes, and market forces, is propelling the importance of effectively managing the health of populations to the forefront in the United States and other developed countries. However, for many anesthesiologists, population health management is a new or even foreign concept. A primer on population health management and its potential perioperative application is thus presented here. Although it certainly continues to evolve, population health management can be broadly defined as the specific policies, programs, and interventions directed at optimizing population health. The Population Health Alliance has created a particularly cogent conceptual framework and interconnected and very useful population health process model, which together identify the key components of population health and its management. Population health management provides a useful rationale for patients, providers, payers, and policymakers to move collectively away from the traditional system of individual, siloed providers to a more integrated, coordinated, team-based approach, thus creating a holistic view of the patient population. The goal of population health management is to keep the targeted patient population as healthy as possible, thus minimizing the need for costly interventions such as emergency department visits, acute hospitalizations, laboratory testing and imaging, and diagnostic and therapeutic procedures. Population health management strategies are increasingly more important to leaders of health care systems as the health of populations for which they care, especially in a strong cost risk-sharing environment, must be optimized. Most population health management efforts rely on a patient-centric team approach, coordination of care, effective communication, robust outcomes data analysis, and continuous quality improvement. Anesthesiologists have an opportunity to help lead these efforts in concert with their surgical and nursing colleagues. The Triple Aim of Healthcare includes (1) improving the patient experience of care (including quality and satisfaction); (2) improving the health of populations; and (3) reducing per-capita costs of care. The Perioperative Surgical Home essentially seeks to transform perioperative care by achieving the Triple Aim, including improving the health of the surgical population. Many health care delivery systems and many clinicians (including anesthesiologists) are just beginning their population health management journeys. However, by doing so, they are preparing to navigate a much greater risk-sharing landscape, where these efforts can create greater financial stability by preventing major financial loss. Anesthesiologists can and should be leaders in this effort to add value by improving the comprehensive continuum of care of our patients.

UI 27152835

**Full Text**

10. **A Population Health Approach to System Transformation for Children's Healthy Development.**
    Paul H. Dworkin and Aradhana Bela Sood.
    What if the goal of child health services was not "merely" treating, or even preventing, childhood diseases and disorders, but was expanded to that of promoting children's optimal healthy development? Pediatrics has evolved from an exclusive focus on the treatment of illness to the opportunity to promote children's healthy development. This evolution has profound implications for the content of child health services and programs, for system transformation, and for public policy. Enhanced understanding of the impact of social determinants on children's health and developmental outcomes underscores the importance of
an evolving framework for system transformation with key policy implications. Copyright © 2016 Elsevier Inc. All rights reserved.
UI 26980132

A chronic and progressive illness, diabetes requires early diagnosis, effective coordination of care, and self-management to stem its progression. Population health management strategies hold promise to improve outcomes by focusing on reducing the frequency of acute and chronic complications of chronic disease, lowering the cost per service through an integrated care delivery team approach, and promoting patient engagement. This will ultimately result in a better patient experience. The chronic care model targets fragmentation of our health care delivery system and provides a framework for effective care of diabetes and other chronic diseases. Copyright © 2016 Elsevier Inc. All rights reserved.
UI 27823613

The article discusses the multiple demands and challenges inherent in instituting staffing models in ambulatory health care settings in the U.S. Topics covered include the provisions of the Patient Protection and Affordable Care Act (ACA), pay for performance as a quality incentive, and the primary and preventive care in a patient-centered medical home (PCMH). UI 116207566

Total population health is a key tenet of health care reform efforts, evident in initiatives such as the National Quality Strategy, shifts toward population-based payments, and community benefit requirements for tax-exempt hospitals. Representing total population health in a way that guides best practices and establishes shared accountability for geographic communities, however, remains a challenge in part because of differences in how stakeholders define populations. To better understand the landscape of potential denominators for population health, this study examined a selection of relevant geographic units. The approach included a comprehensive review of health services and public health research literature as well as recent pertinent health policy documents. Units were characterized based on whether they: exhibit "breadth" of coverage across the whole US population; are "accurate" or grounded in health care utilization patterns; are "actionable" with mechanisms for implementing funding and regulation; and promote "synergism" or effective coordination of public health and health care activities. Although other key components of a total population health unit may exist and no single identified unit possesses all of the aforementioned features, several promising candidates were identified. Specifically, healthcare coalitions link health care and public health domains to care for a geographic community, but their connection to utilization is not empiric and limited funding exists at the coalition level. Although Accountable Care Organizations do not uniformly incorporate public health or facilitate coordination across all payers or providers, they represent an effective mechanism to increase collaboration within health care systems.
and represent a potential building block to influence total population health.

Full Text

Drew Harris, Katherine Puskarz and Caroline Golab.

"Population health" has come to describe an array of initiatives supporting new care and reimbursement models that reward health outcomes rather than volume of services. However, without a standard definition of population health and a comprehensive inventory of the core competencies and knowledge its practitioners must possess, ongoing efforts to address community health outcomes will be hampered. A literature search of peer-reviewed and gray literature, a curriculum scan of current graduate health programs, and an expert panel of industry stakeholders were conducted to develop a comprehensive curriculum framework that broadly defines population health. The result is a concept map consisting of 6 domains--3 knowledge and 3 skills--based-and subcategories. This article discusses the implications for teaching population health and the need for further scholarship to define the field from the point of view of health system leaders, academics, and others who need to hire health professionals with these skills.

UI 26828293

Full Text

Value-based Health Care:

James M. Naessens, Monica B. Van Such, Robert E. Nesse, et al.

The majority of quality measures used to assess providers and hospitals are based on easily obtained data, focused on a few dimensions of quality, and developed mainly for primary/community care and population health. While this approach supports efforts focused on addressing the triple aim of health care, many current quality report cards and assessments do not reflect the breadth or complexity of many referral center practices. In this article, the authors highlight the differences between population health efforts and referral care and address issues related to value measurement and performance assessment. They discuss why measures may need to differ across the three levels of care (primary/community care, secondary care, complex care) and illustrate the need for further risk adjustment to eliminate referral bias. With continued movement toward value-based purchasing, performance measures and reimbursement schemes need to reflect the increased level of intensity required to provide complex care. The authors propose a framework to operationalize value measurement and payment for specialty care, and they make specific recommendations to improve performance measurement for complex patients. Implementing such a framework to differentiate performance measures by level of care involves coordinated efforts to change both policy and operational platforms. An essential component of this framework is a new model that defines the characteristics of patients who require complex care and standardizes metrics that incorporate those definitions.

UI 28353502

Full Text

Laura Medford-Davis, David Marcozzi, Shantanu Agrawal, Brendan G. Carr and Emily Carrier.

Although emergency departments (EDs) play an integral role in the delivery of acute
unscheduled care, they have not been fully integrated into broader health care reform efforts. Communication and coordination with the ambulatory environment remain limited, leaving ED care disconnected from patients’ longitudinal care. In a value-based environment focused on improving quality, decreasing costs, enhancing population health, and improving the patient experience, this oversight represents a missed opportunity for emergency care. When integrated with primary and subspecialty care, emergency care might meet the needs of patients, providers, and payers more efficiently than yet realized. This article uses the Merit-Based Incentive Payment System from the Medicare Access and CHIP Reauthorization Act as a framework to outline a strategy for improving the value of emergency care, including integrating quality and resource use measures across health care delivery settings and populations, encouraging care coordination from the ED, and implementing robust health information exchange systems.

Full Text

17. Patient-Centered Specialty Practice: Defining the Role of Specialists in Value-Based Health Care.  
*Chest* 151 (4): 930-935 . 2017  
Lawrence Ward, Rhea E. Powell, Michael L. Scharf, Andrew Chapman and Mani Kavuru.  
Health care is at a crossroads and under pressure to add value by improving patient experience and health outcomes and reducing costs to the system. Efforts to improve the care model in primary care, such as the patient-centered medical home, have enjoyed some success. However, primary care accounts for only a small portion of total health-care spending, and there is a need for policies and frameworks to support high-quality, cost-efficient care in specialty practices of the medical neighborhood. The Patient-Centered Specialty Practice (PCSP) model offers ambulatory-based specialty practices one such framework, supported by a formal recognition program through the National Committee for Quality Assurance. The key elements of the PCSP model include processes to support timely access to referral requests, improved communication and coordination with patients and referring clinicians, reduced unnecessary and duplicative testing, and an emphasis on continuous measurement of quality, safety, and performance improvement for a population of patients. Evidence to support the model remains limited, and estimates of net costs and value to practices are not fully understood. The PCSP model holds promise for promoting value-based health care in specialty practices. The continued development of appropriate incentives is required to ensure widespread adoption. Copyright © 2017. Published by Elsevier Inc.

Full Text

*Clinical Orthopaedics & Related Research* 475 (5): 1305-1308 . 2017  

Full Text

19. Association Between Hospitals’ Engagement in Value-Based Reforms and Readmission Reduction in the Hospital Readmission Reduction Program.  
*JAMA Internal Medicine* 177 (6): 862-868 . 2017  
Andrew M. Ryan, Sam Krinsky, Julia Adler-Milstein, Cheryl L. Damberg, Kristin A. Maurer and John M. Hollingsworth.  
Importance: Medicare is experimenting with numerous concurrent reforms aimed at improving quality and value for hospitals. It is unclear if these myriad reforms are mutually reinforcing or in conflict with each other. Objective: To evaluate whether hospital participation in voluntary value-based reforms was associated with greater improvement under Medicare’s Hospital...
Readmission Reduction Program (HRRP). Design, Setting, and Participants: Retrospective, longitudinal study using publicly available national data from Hospital Compare on hospital readmissions for 2837 hospitals from 2008 to 2015. We assessed hospital participation in 3 voluntary value-based reforms: Meaningful Use of Electronic Health Records; the Bundled Payment for Care Initiative episode-based payment program (BPCI); and Medicare's Pioneer and Shared Savings accountable care organization (ACO) programs. We used an interrupted time series design to test whether hospitals' time-varying participation in these value-based reforms was associated with greater improvement in Medicare's HRRP. Main Outcomes and Measures: Thirty-day risk standardized readmission rates for acute myocardial infarction (AMI), heart failure, and pneumonia. Results: Among the 2837 hospitals in this study, participation in value-based reforms varied considerably over the study period. In 2010, no hospitals were participating in the meaningful use, ACO, or BPCI programs. By 2015, only 56 hospitals were not participating in at least 1 of these programs. Among hospitals that did not participate in any voluntary reforms, the association between the HRRP and 30-day readmission was -0.76 percentage points for AMI (95% CI, -0.93 to -0.60), -1.30 percentage points for heart failure (95% CI, -1.47 to -1.13), and -0.82 percentage points for pneumonia (95% CI, -0.97 to -0.67). Participation in the meaningful use program alone was associated with an additional change in 30-day readmissions of -0.78 percentage points for AMI (95% CI, -0.89 to -0.67), -0.97 percentage points for heart failure (95% CI, -1.08 to -0.86), and -0.56 percentage points for pneumonia (95% CI, -0.65 to -0.47). Participation in ACO programs alone was associated with an additional change in 30-day readmissions of -0.94 percentage points for AMI (95% CI, -1.29 to -0.59), -0.83 percentage points for heart failure (95% CI, -1.26 to -0.41), and -0.59 percentage points for pneumonia (95% CI, -1.00 to -0.18). Participation in multiple reforms led to greater improvement: participation in all 3 programs was associated with an additional change in 30-day readmissions of -1.27 percentage points for AMI (95% CI, -1.58 to -0.97), -1.64 percentage points for heart failure (95% CI, -2.02 to -1.26), and -1.05 percentage points for pneumonia (95% CI, -1.32 to -0.78). Conclusions and Relevance: Hospital participation in voluntary value-based reforms was associated with greater reductions in readmissions. Our findings lend support for Medicare's multipronged strategy to improve hospital quality and value.

UI 28395006

Full Text

Thomas J. Hwang, Aaron S. Kesselheim and Ameet Sarpatwari.
UI 28692713

Full Text

Andrew M. Ryan, Sam Krinsky, Kristin A. Maurer and Justin B. Dimick.
BACKGROUND: Starting in fiscal year 2013, the Hospital Value-Based Purchasing (HVBP) program introduced quality performance-based adjustments of up to 1% to Medicare reimbursements for acute care hospitals. METHODS: We evaluated whether quality improved more in acute care hospitals that were exposed to HVBP than in control hospitals (Critical Access Hospitals, which were not exposed to HVBP). The measures of quality were composite measures of clinical process and patient experience (measured in units of standard deviations, with a value of 1 indicating performance that was 1 standard deviation [SD] above the hospital mean) and 30-day risk-standardized mortality among patients who were admitted to the hospital for acute myocardial infarction, heart failure, or pneumonia. The changes in quality measures after the introduction of HVBP were assessed for matched samples of acute care hospitals (the number of hospitals included in the analyses ranged from 1364 for mortality among patients admitted for acute myocardial infarction to 2615 for mortality among patients admitted for pneumonia) and control hospitals (number of hospitals ranged from 31 to 617). Matching was based on preintervention performance with regard to the quality
measures. We evaluated performance over the first 4 years of HVBP. RESULTS: Improvements in clinical-process and patient-experience measures were not significantly greater among hospitals exposed to HVBP than among control hospitals, with difference-in-differences estimates of 0.079 SD (95% confidence interval [CI], -0.140 to 0.299) for clinical process and -0.092 SD (95% CI, -0.307 to 0.122) for patient experience. HVBP was not associated with significant reductions in mortality among patients who were admitted for acute myocardial infarction (difference-in-differences estimate, -0.282 percentage points [95% CI, -1.715 to 1.152]) or heart failure (-0.212 percentage points [95% CI, -0.532 to 0.108]), but it was associated with a significant reduction in mortality among patients who were admitted for pneumonia (-0.431 percentage points [95% CI, -0.714 to -0.148]). CONCLUSIONS: In our study, HVBP was not associated with improvements in measures of clinical process or patient experience and was not associated with significant reductions in two of three mortality measures. (Funded by the National Institute on Aging.).

Full Text

Mark E. Helm.
Value-based insurance design (VBID) represents an innovative approach to health insurance coverage. In the context of pharmacy benefits, the goal of VBID is to minimize access barriers to the most effective and appropriate treatments for specific medical conditions. Both private and public insurance programs have explored VBID pharmacy projects primarily for medical conditions affecting adults. To date, evidence for VBID pharmacy programs for children and youth with special health care needs (CYSHCN) appears lacking. There appears to be potential for VBID concepts to be applied to pharmacy coverage benefiting CYSHCN. An overview of VBID pharmacy principles and guiding principles are presented. Opportunities for the creation of pharmacy programs with a value-based orientation and challenges to the redesign of pharmacy benefits are identified. VBID pharmacy coverage principles may be helpful to improve medication use and important clinical outcomes while lowering barriers to medication use for the population of CYSHCN. Pilot projects of VBID pharmacy benefits for children and youth should be explored. However, many questions remain.

Full Text

23. The Shift Toward Value-Based Payment: For PTs, now is the time to prepare. PT in Motion 9 (9): 8-12 . 2017
Kara Gainer and Heather Smith.
The article focuses on the U.S. health care's shift away from the fee-for-service payment structure toward value-based payment, also known as alternative payment models (APM). An APM refers to a payment approach that offers incentives to providers to collaborate to provide high-quality and cost-efficient care. Topics discussed include the various types of APMs, the implication of this change for physical therapists (PT), and the steps PTs should take to plan for value-based payment.

Full Text

Byron C. Scott and Tricia L. Eminger.
The article examines an increase in bundled payment programs in Medicare in the U.S. The trend is attributed to a new focus on value-based care and alternative payment models (APM)
following the implementation of the Affordable Care Act (ACA). Focusing on a patient’s entire episode of care, bundled payments extend beyond inpatient acute care to include postacute care services.

Jo Ann Brooks.
This column is designed to provide a nursing perspective on new hospital quality measurements. Future articles will cover the various quality indicators hospitals face and the role of the nurse in meeting mandated benchmarks. Reader responses to this column are welcome and will help to make it more useful to nurses in meeting the challenges posed by health care reform and changing Medicare reimbursement programs.

Tina Shah, Valerie G. Press, Megan Huisingh-Scheetz and Steven R. White.
Of those patients hospitalized for an exacerbation of COPD, one in five will require rehospitalization within 30 days. Many developed countries are now implementing policies to increase care quality while controlling costs for COPD, known as value-based health care. In the United States, COPD is part of Medicare’s Hospital Readmissions Reduction Program (HRRP), which penalizes hospitals for excess 30-day, all-cause readmissions after a hospitalization for an acute exacerbation of COPD, despite minimal evidence to guide hospitals on how to reduce readmissions. This review outlines challenges for improving overall COPD care quality and specifically for the HRRP. These challenges include heterogeneity in the literature for how COPD and readmissions are defined, difficulty finding the target population during hospitalizations, and a lack of literature to guide evidence-based programs for COPD readmissions as defined by the HRRP in the hospital setting. It then identifies risk factors for early readmissions after acute exacerbation of COPD and discusses tested and emerging strategies to reduce these readmissions. Finally, we evaluate the current HRRP and future policy changes and their effect on the goal to deliver value-based COPD care. COPD remains a chronic disease with a high prevalence that has finally garnered the attention of health systems and policy makers, but we still have a long way to go to truly deliver value-based care to patients. Copyright © 2016 American College of Chest Physicians. Published by Elsevier Inc. All rights reserved.

27. **Current State of Value-Based Purchasing Programs.** *Circulation* 133 (22): 2197-2205. 2016
Tingyin T. Chee, Andrew M. Ryan, Jason H. Wasfy and William B. Borden.
The US healthcare system is rapidly moving toward rewarding value. Recent legislation, such as the Affordable Care Act and the Medicare Access and CHIP Reauthorization Act, solidified the role of value-based payment in Medicare. Many private insurers are following Medicare’s lead. Much of the policy attention has been on programs such as accountable care organizations and bundled payments; yet, value-based purchasing (VBP) or pay-for-performance, defined as providers being paid fee-for-service with payment adjustments up or down based on value metrics, remains a core element of value payment in Medicare Access and CHIP Reauthorization Act and will likely remain so for the foreseeable future. This review article summarizes the current state of VBP programs and provides analysis of the strengths, weaknesses, and opportunities for the future. Multiple inpatient and outpatient VBP programs
have been implemented and evaluated; the impact of those programs has been marginal. Opportunities to enhance the performance of VBP programs include improving the quality measurement science, strengthening both the size and design of incentives, reducing health disparities, establishing broad outcome measurement, choosing appropriate comparison targets, and determining the optimal role of VBP relative to alternative payment models. VBP programs will play a significant role in healthcare delivery for years to come, and they serve as an opportunity for providers to build the infrastructure needed for value-oriented care.

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28. Value-Based Medicine: Dollars and Sense.
   Brian L. Erstad.
   With ever-increasing total healthcare expenditures and expenditures on new pharmaceuticals, there is a temptation to enact relatively simple silo-based, cost-control measures such as attempts to control a burgeoning health-system medication budget by limiting physician and ultimately patient access to medications without considering cost-effectiveness or overall value. Such an approach with a singular focus on dollars does not make sense. The challenge is to think beyond a pure dollars approach in a specialty of health care where the high cost of care is acknowledged but the dynamics are not always understood. This will take a thoughtful, coordinated effort by a team of dedicated health professionals that includes a clinical pharmacist with expertise in optimal and comprehensive medication management.

29. What Is the Value of Value-Based Purchasing?
   Sandra J. Tanenbaum.
   Value-based purchasing (VBP) is a widely favored strategy for improving the US health care system. The meaning of value that predominates in VBP schemes is (1) conformance to selected process and/or outcome metrics, and sometimes (2) such conformance at the lowest possible cost. In other words, VBP schemes choose some number of “quality indicators” and financially incent providers to meet them (and not others). Process measures are usually based on clinical science that cannot determine the effects of a process on individual patients or patients with comorbidities, and do not necessarily measure effects that patients value; additionally, there is no provision for different patients valuing different things. Proximate outcome measures may or may not predict distal ones, and the more distal the outcome, the less reliably it can be attributed to health care. Outcome measures may be quite rudimentary, such as mortality rates, or highly contestable: survival or function after prostate surgery? When cost is an element of value-based purchasing, it is the cost to the value-based payer and not to other payers or patients' families. The greatest value of value-based purchasing may not be to patients or even payers, but to policy makers seeking a morally justifiable alternative to politically contested regulatory policies.

30. CNE SERIES. Hospital Value-Based Purchasing And 30-Day Readmissions: Are Hospitals Ready?
   Rob Haley, Mei Zhao and Aaron Spaulding.
   The article discusses the readiness of hospitals for the implementation of Hospital Value-Based Purchasing (HVBP) program and 30-day readmissions under the Patient Protection and Affordable Care Act of 2010 (ACA) in the U.S. Topics covered include coordinating transitions
Clinically Integrated Networks:

31. **Partnering and Collaborating to Drive Value.**
Anonymous
The shift to value-based care has spurred innovative partnerships, often between what once were considered competitors. In a panel discussion, health system leaders examined the keys to making such collaboration successful.
UI 27526511

32. **Four Ways to Better Time the Transition to Value.**
James J. Pizzo and Andrew S. Cohen.
The article presents information on improving the transition to value-based care delivery by hospitals, physician groups and healthcare providers in the U.S. Topics include the roles of accountable care organizations (ACOs), clinically integrated networks (CINs), and patient-centered medical homes, the need for proper risk sharing, and the assessment of a healthcare's contracting arrangements. It also discusses an organization's readiness for value-based care provision.
UI 117078508

33. **Understanding clinically integrated networks.**
*Medical economics* 93 (3): 41-44 . 2016
Elaine Pofeldt.
UI 27089572

34. **Patient access innovations: integrating patients within the system of care.**
*Healthcare Financial Management* 69 (12): 48-54 . 2015
Daniel J. Marino, William Faber and Meredith Duncan.
Clinically integrated networks seeking to ensure in-network access and strengthen patient engagement should adopt five strategic areas of focus: Extend access beyond traditional models. Manage out-migration. Make it easy for patients to stay in the network. Build patient engagement into clinical care models. Explore innovative methods to engage patients.
UI 26793943

35. **7 ways to improve the performance of an integrated care network.**
Keith D. Moore and Dean C. Coddington.
UI 26665341
36. **Taking smart steps toward clinical integration.**
*Healthcare Financial Management 69 (3): 56-64. 2015*
Dorrie Guest, Danna Campbell, Sara Larch and Bob Williams.
Health systems should take five key steps in the early phases of establishing a clinically integrated network (CIN): Establish the operating model and implementation timeline. Identify who to include. Define what's in it for the physicians. Agree on the tenets that will make the CIN stick. Understand when to say no.
UI 26492759
*Full Text*

37. **Clinician Staffing, Scheduling, and Engagement Strategies Among Primary Care Practices Delivering Integrated Care.**
Melinda M. Davis, Bijal A. Balasubramanian, Maribel Cifuentes, et al.
PURPOSE: To examine the interrelationship among behavioral health clinician (BHC) staffing, scheduling, and a primary care practice's approach to delivering integrated care. METHODS: Observational cross-case comparative analysis of 17 primary care practices in the United States focused on implementation of integrated care. Practices varied in size, ownership, geographic location, and integrated care experience. A multidisciplinary team analyzed documents, practice surveys, field notes from observation visits, implementation diaries, and semistructured interviews using a grounded theory approach. RESULTS: Across the 17 practices, staffing ratios ranged from 1 BHC covering 0.3 to 36.5 primary care clinicians (PCCs). BHC scheduling varied from 50-minute prescheduled appointments to open, flexible schedules slotted in 15-minute increments. However, staffing and scheduling patterns generally clustered in 2 ways and enabled BHCs to be engaged by referral or warm handoff. Five practices predominantly used warm handoffs to engage BHCs and had higher BHC-to-PCC staffing ratios; multiple BHCs on staff; and shorter, more flexible BHC appointment schedules. Staffing and scheduling structures that enabled warm handoffs supported BHC engagement with patients concurrent with the identification of behavioral health needs. Twelve practices primarily used referrals to engage BHCs and had lower BHC-to-PCC staffing ratios and BHC schedules prefilled with visits. This enabled some BHCs to bill for services, but also made them less accessible to PCCs in when patients presented with behavioral health needs during a clinical encounter. Three of these practices were experimenting with open scheduling and briefer BHC visits to enable real-time access while managing resources. CONCLUSION: Practices' approaches to PCC-BHC staffing, scheduling, and delivery of integrated care mutually influenced each other and were shaped by the local context. Practice leaders, educators, clinicians, funders, researchers, and policy makers must consider these factors as they seek to optimize integrated systems of care. © Copyright 2015 by the American Board of Family Medicine.
UI 26359470
*Full Text*

38. **Integrated Care at the Interface of Psychiatry and Primary Care: Prevention of Cardiovascular Disease.**
Robert M. McCarron.
Patients with mental illness, particularly serious mental illness, are more likely to suffer from common disorders without optimal treatment. Changes in preventive practice patterns cannot be fully realized on a large scale until clinicians are trained how to routinely provide this care. Psychiatrists may consider using preventive care strategies in the area of cardiovascular health, as cardiovascular disease is the most common cause of death and disproportionately affects patients with mental illness. At minimum, psychiatrists are well positioned to work collaboratively with primary care providers to address psychopathology that may interfere with adherence to the treatment plan. Copyright © 2015 Elsevier Inc. All rights reserved.
UI 26300033
39. **A strategic approach to healthcare transformation.**  
Laura Jacquin.  
Transforming the care model is a necessary first step to succeeding under value-based payment models where payment is linked to outcomes. To maintain acceptable margins while improving quality of care and reducing costs, healthcare executives should develop strategies for: Managing care across the continuum. Reducing readmissions for all diagnoses. Building and supporting the patient-centered medical home model. Achieving clinical integration.  
UI 24757877

39. **Success factors and barriers on the journey to CLINICALLY INTEGRATED NETWORKS.**  
*Trustee* 67 (10): 8-12. 2014  
JOHN MORRISSEY.  
UI 99716813