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States Aren’t the Only Ones Reforming Health Care.

Some of the most promising experiments to improve quality of care while cutting expenses are taking place at the local level.

Richard was a textbook case for Hennepin Health. The county-run Medicaid plan in Minneapolis had targeted a specific, expensive-to-treat population with the aim of reducing health-care costs and Richard—45 years old, uninsured and homeless—fit the bill. Instead of having his health problems, which included chronic back pain compounded by drug and alcohol abuse, managed through medication and therapy, Richard checked into an emergency room whenever he needed help. He had become what’s known in the emergency medicine world as a frequent flyer. Not only were his visits adding to the state’s already substantial tab for uncompensated care, the emergency room could not provide a long-term plan for his care. That’s why Richard was identified by Hennepin Health as the perfect candidate for a new, coordinated approach to handling chronic, costly users of emergency medical services.

Richard was assigned a coordinator to help him get ongoing medical attention through a regular primary care physician, as well as help in other areas of his life; it turns out that he had been homeless since he was 15. Under Hennepin Health, he’s now living in stable housing and is receiving regular preventive care for the first time in his life. Richard also is now living sober.

Multiply Richard’s experience times thousands or millions of patients, and a program like Medicaid can begin to see a substantial increase in quality of care for its beneficiaries and a decrease in the costs of providing that care.

The Hennepin approach is one of many cost-control experiments taking place nationwide. Such customized pilot programs have the backing of the Affordable Care Act (ACA), which specifically bankrolls ideas that shake up the way health care is delivered and providers are paid. There are three big ideas gaining interest and acceptance to attack persistent problems: the lack of coordinated care to treat the whole person, not just medical issues; the misuse of health care among people who have trouble navigating the complexities of the system; and the poor level of collaboration between health-care providers and the public and private sectors. Cost-containment efforts by states, including pilot programs in Arkansas and Oregon, have been widely reported. But some of the most promising experiments are taking place at the local level.

The driving goal behind Hennepin Health, which began as a pilot two years ago, is to provide holistic care for the urban poor and do it in a way that motivates everyone involved—from medical providers to county health-care officials—to save money. The incentives certainly seem right: Under Hennepin Health, the state gives the county a set amount of money per Medicaid client each month. Whatever the county manages to save goes back to the doctors in its network and also to future investments in the model.

The key to the approach is straightforward. It involves identifying frequent users of emergency rooms, such as Richard, and then steering them into primary care and other services. Hennepin officials use data from partner hospitals to identify individuals who regularly visit emergency rooms

and who, in the past, weren't connected to a primary care physician when they left. These individuals are now assigned a service coordinator, essentially a health-care and social services "quarterback" who oversees all of a patient's health and social services needs. The coordinator then matches clients to clinics or health-care networks that offer a wide variety of services, from dental to mental health care. In fact, dental services alone have proved so attractive to clients that it has been a useful tool for keeping sometimes unreliable, unpredictable patients in the system, says Jennifer DeCubellis, area director of the Hennepin County Human Services and Public Health Department.

But the goal of creating a truly comprehensive, integrated system that meets more than just the clinical needs of patients requires a high level of coordination and cooperation among medical providers, government officials and other service providers. That's never been easy to accomplish. Hennepin County had to persuade providers to allow it to embed county human services staff in hospitals, where they are now responsible for connecting patients with housing, employment and transportation, in addition to coordinating their care. "The biggest thing was getting people to see that each system didn't have to build its own resources, and actually that [doing so] was detrimental," DeCubellis says.

The experiment appears to be paying off. In its first year, Hennepin reduced projected costs by more than 5 percent per patient, and the county will put $1 million into new programming that's expected to return another 30 percent in savings next year. For the costliest patients—the top 5 percent, who used 64 percent of program funding—the county has already saved between 40 and 95 percent per client. Those are the kinds of numbers that have drawn the interest of not only other localities in Minnesota, but health-care officials and providers nationally.

This more holistic, coordinated and preventive approach to health care isn't new. North Carolina won an Innovations in American Government award in 2007 for Community Care of North Carolina, which consists of 14 regional health-care networks organized by community physicians, hospitals, and health and social services departments as a way to focus more coordinated and preventive care on high-cost users. Now the approach pioneered by North Carolina is catching on in places as varied as rural Minnesota and the urban northeast.

Southern Prairie Community Care, a 12-county consortium of health-care providers and county agencies in southwest Minnesota, is launching its own North Carolina- and Hennepin-style integrated, collaborative Medicaid program. In calculating whether it was feasible to introduce such a program in an area characterized by its far-flung geography, Mary Fischer, the group's executive director, says that whatever challenges the group faced logistically were more than offset by long-established relationships among agencies and providers, which made the whole notion of coordination and cooperation feasible. "We will never be a place that can co-locate everything, but we see lots of opportunities in just aligning the various services and decreasing fragmentation through closer communication," says Fischer.

The next step for Minnesota is using a statewide ACA innovation grant to move beyond Medicaid and Medicare patients and on to the rest of the state's population by involving private health insurance companies. That will take negotiating with the insurers that have to structure the payments, but it will also require threading the needle with private doctors, says Scott Leitz, assistant commissioner of health care for the state Department of Human Services. "We're not there yet."

A key challenge in establishing a coordinated, cooperative and preventive program is tracking down the people who ought to be in it. Camden, N.J., tried an unusual approach: bringing aspects of police "citystat" programs to health care. Dr. Jeffrey Brenner, who had become familiar with mapping crime hot spots as a citizen member of a police improvement commission in the city, decided to see if the stat method might be applied to honing in on the city's costliest patients. What he and Camden

officials found was startling: 20 percent of patients accounted for 90 percent of hospital costs, and nearly half of the 77,000 city residents visited an emergency department at least once a year.

Using that data, Brenner in 2007 teamed up with a nurse and social worker, and they started making individual house visits in areas of high hospital utilization. The team then helped connect people to the services they needed to keep them out of emergency rooms. With the help of support from funders like the Robert Wood Johnson Foundation, Brenner ultimately created the Camden Coalition of Healthcare Providers. Today the organization's staff numbers about 65 and is expanding with the aid of a grant from the Centers for Medicare & Medicaid Services. It's also bringing the idea of medical "hot spotting" to new communities both urban and rural.

The approach that has evolved out of Brenner's first hot-spotting visits remains simple: Teams made up of nurses, community health workers, dieticians, social workers—whoever is needed—are dispatched to patients who frequently visit the hospital. While the work can start in the hospital, home visits are typically an integral part of the hot-spotting approach. The work runs the gamut: helping patients understand their medicine regime, arranging for transportation to follow-up appointments, and connecting clients to primary care. Coordinators might even help a client obtain a gym membership or set him up with volunteer opportunities as a way to move him back into the mainstream and, potentially, a paying job.

Offering a range of services is critical to the success of such an approach, says Andrea Miller, the Camden Coalition's senior program manager for new hot-spotting initiatives. "There's such a stigma around high utilization [with the sense that those patients] are just not compliant," says Miller. "But the truth is there are many barriers preventing them from getting what they need."

With its first 36 patients—who as a group averaged 62 hospital and emergency room visits per month—Camden reduced average monthly health-care costs for the group from $1.2 million to about $500,000. Other communities have seen the same kind of hot-spotting success. A group based in eastern Maine, for example, started hot spotting in January 2012. Among the 44 patients who have 12-month post-intervention data, there's been a 76 percent reduction in emergency department use and an 86 percent reduction in hospital admissions.

Last month, Maryland's Howard County Health Department became the first government entity to launch its own hot-spotting team, with guidance from Camden. Using a $250,000 state grant, Howard is now hiring a nine-member team of registered nurses, community health workers and data managers to intervene with people who make frequent trips to the county's general hospital. If Howard County realizes the same savings as other jurisdictions, the hope is to make the pilot a permanent fixture by getting both public and private insurers—as well as providers—to help fund the program, says Dr. Maura Rossman, Howard County health officer. "We think this might be something where anyone from insurers to hospitals may be interested in partnering," she says.

One of the most obvious avenues for applying a more comprehensive and prevention-focused approach to the high cost of health care is to focus on such chronic conditions as asthma, diabetes, congestive heart failure, depression and chronic obstructive pulmonary disease.

Take Akron, Ohio, where about 11 percent of adults have Type 2 diabetes, several points above the most recent national median as calculated by the Centers for Disease Control and Prevention (CDC). That number alone may not seem jaw-dropping, but the trend is: If Akron and surrounding Summit County do nothing and the growth rate in Type 2 diabetes continues, fully one-third of the population will be diabetic by 2050. Compounding the problem is the fact that many of those with Type 2 diabetes don't seek medical care until the situation is dire, and 31 percent of the diabetic population has no insurance. With hospitals losing more than $50 million a year in unreimbursed care costs,

and with a widespread concern in the community that disease prevalence is a drag on the workforce, the city and county launched an initiative to tap the resources of as many groups as possible.

A research group, called the Austen BioInnovation Institute, took the lead as coordinator between more than 70 groups that cut across government, the health-care sector, religious organizations and nonprofits—each with a role in prevention as well as managing the care of people who are already diabetic. The institute, funded by Akron's three major hospital systems, was the logical choice to lead the effort since it was created to do research and advance community health. With the help of a $500,000 CDC grant, what Akron calls its Accountable Care Community launched in 2011.

The core of the concept is to bring public health and clinical medicine together on a community level. "If you looked at a community," says Dr. Frank Douglas, Austen BioInnovation's president, "and mapped out whatever opportunities there were for care and prevention and could bring together resources on a local basis, then anyone living in a particular set of ZIP codes could reach out to an identified source who could triage them into an appropriate place so they don't wait until an emergency [to seek care]."

Three competing hospitals offered the data to help make that possible. They've also lent their staff to teach nutrition and wellness classes, to host screenings at churches and to offer free care at libraries and elsewhere. Nonprofit community health groups have redeployed staff to monitor the cases of diabetics and ensure they're managing their disease in cooperation with their primary care provider. The Summit County Public Health Department is also boosting its efforts, embedding staff in low-income housing to meet with people flagged by the hospital system. "You spend an hour at the doctor's office and the other 23 hours at home," says Donna Skoda, deputy commissioner of the Summit County Public Health Department. "That's where those supports have to be."

Government efforts aimed at encouraging healthier habits among citizens haven't been limited to only public health or social services departments. Planning and transportation officials have also helped by making areas more walkable and providing greater access to public parks. Austen BioInnovation took a page out of Camden's playbook, finding high-concentration areas of diabetes and then getting city planners to implement "road diets"—reducing the number of car lanes while adding bike lanes.

As in other jurisdictions that are trying to reduce health-care costs among their citizens, the early results in Akron are encouraging. Among a sample of 2,000 diabetics after the first 18 months, average monthly costs for health care have gone down more than 10 percent, saving $3,185 per person a year. More than half of participants lost significant amounts of weight, and emergency room visits were lowered by a range of one-third to one-half.

The program picks up on the lessons of others that have come before it: linking patients to their next step, and thinking beyond what they need from their doctors to stay healthy.

"It's teaching people to lift up your head, look at what services are available around them, and finding ways to partner when we can," Hennepin's DeCubellis says. "If you're not connecting people to their next location, their next program, they're going to fall apart after they leave."

Governing

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