Volume 7, Issue 2 February 2020

Population Health NEWS

Considering Becoming an ACO? 5 Common Traits of Success

by Sanjay Seth, Chief Medical Informatics Officer, HealthEC

With pressure to deliver value on the rise, healthcare providers are increasingly turning to Accountable Care Organization (ACO) partnerships to support efforts to improve quality and lower costs. The number of ACOs has climbed dramatically in recent years, growing more than fivefold from 2012 to 2018, according to research from Leavitt Partners.

At ACO formation enables hospitals and physician practices to work together across care delivery settings to bring greater efficiency to population health, disease management and patient engagement.

Healthcare organizations have many options when it comes to partnering with affiliates to positively impact care delivery and the lives of patients. While there is no single approach to ACO formation, there are several factors that are vital to cultivating a successful partnership.

5 common traits of successful ACOs

Effective population health management is at the crux of value-based care. To adapt to the changing landscape of healthcare, ACO leaders need to address population health challenges head on. The most successful ACOs are able to succeed by excelling in five core areas.

1) Securing and maintaining provider engagement

While the idea of better care, lower costs and higher performance incentives is enticing, providers are less enthusiastic about the financial risk, time commitment and new technologies required for participation in an ACO. Winning ACOs invest time, resources and data to help providers adapt to value-based care.

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In This Issue

Mitigating Rural Healthcare's Geographic Penalty: How Telemedicine Helps

by Dr. Talbot "Mac" McCormick, President and CEO, Eagle Medicine

There's been much in the news lately about the geographic penalty rural Americans pay because they don't have access to broadband services. Kids can't do their homework because they can't do research on the internet. Adults can't perform simple activities of modern American life such as paying bills online. Some rural residents have even gone so far as to say the lack of access is discriminatory.

There are rural penalties when it comes to healthcare, too. In many ways it's the same story, one of uneven distribution of resources between the nearly 20 percent of Americans living in rural areas and their metropolitan counterparts. (That 20 percent is nearly 60 million people, including more than 13 million children, in the rural areas that cover 97 percent of the nation's land, according to the last U.S. Census.)

Unlike lack of broadband, however, the lack of adequate health care in rural areas is a matter of life and death. Americans living in rural communities encounter many barriers that limit their ability to obtain the healthcare they need. A shortage and maldistribution of doctors. Little access to specialists within their own communities. Rural hospitals closing at an accelerated rate.

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Coming in February's Medical Home News Supplement

- **The Medical Home And Diabetes Care: What Actually Drives Clinical Improvements?**
- **Federally Qualified Health Centers Can Play A Decisive Role In Value-Based Care**

Population Health News
February 2020, Volume 7 Issue 2
ISSN Print (2333-9829)
ISSN Electronic (2333-9845)

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Population Health News is published monthly by Health Policy Publishing LLC. Newsletter publication administration is provided by MCOL.

Editor's Corner

Greetings readers of *Population Health News*! We are pleased to be providing you with yet another excellent edition of the newsletter. This month we have put together a great collection of experts and thought leaders to tackle a variety of important and pertinent issues. As always, we welcome reader feedback and content suggestions. Please don't hesitate to reach out to me personally if you have questions, comments or concerns.

Kind Regards,

Peter Grant
Editor, *Population Health News*
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Considering Becoming an ACO? 5 Common Traits of Success …

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Successful ACOs offer providers a clear vision of what value-based patient care will look like at practices, and a clearly-defined plan for achieving that vision. ACO leaders should create a customized roadmap that outlines each step, highlighting benefits to incentivize providers to participate. This includes demonstrating how the ACO will help providers navigate data sharing and interoperability issues and support case management and care coordination. This typically includes, but is not limited to, helping providers identify and target:

- Patients at high risk for emergency visits, readmissions, or complications
- Redundant and unnecessary medical care, such as duplication of tests
- Geographic areas with high incidence of disease
- Interruptions in preventive service utilization

"Successful ACOs offer providers a clear vision of what value-based patient care will look like at practices, and a clearly-defined plan for achieving that vision."

2) Mitigating income gaps during the transition

Providers may struggle with the prospect of decreased income during the transition to value-based care. During the transition, a key goal of successful ACOs is to make providers more effective and profitable in their day-to-day work while moving to a more efficient system.

ACOs accomplish this by analyzing current fee-based routines and making recommendations for outreach to patients who need care. For example, there may be patients that have been lost during the follow-up process, whether it's missed wellness visits, chronic care management, or other care that brings in revenue. Assessing and addressing care gaps can be incorporated into the transition process, ensuring that revenue is protected.

From a financial perspective, ACOs also mitigate income gaps for providers by continually analyzing claims, eligibility and remittance performance. Regular analysis and reporting back to participating providers are essential.

3) Ensuring data integrity

Successful ACOs support population health management through aggregation of patient data from multiple sources and analysis of that data from a single actionable patient record. While it's a simple concept, trust in the data does not always come easy. For providers to act on data, it must be accurate. Unreliable data dampens provider trust and the program falls apart.

ACO leaders must also ensure data sharing and interoperability throughout the entire community. EMRs alone are not equipped to handle the complex data sharing required by ACOs. The goal is not to extract data from an EMR, but rather to take all or most of the patient data available within the community and build a data exchange. A single, in-house platform drives greater efficiency and protects data quality.

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Considering Becoming an ACO? 5 Common Traits of Success … *continued from page 2*

4) Supporting care coordination and resource optimization

Successfully applying data aggregation and analysis insights to inform care coordination drives tangible improvements for ACOs. Successful ACOs build workflow cues related to the care path and next steps for each patient. They also suggest which member of the provider's team should be carrying out each task.

Knowing where to deploy limited resources is key. It is critical to be able to know quickly what resources are needed, what the qualifications are for those resources and how they need to be deployed. For example, nurses may be prompted to assign tasks to someone else so that their time is used more efficiently. Even a small change, such as automating the handoff process for tasks and responsibilities, can greatly alter staffing requirements and associated costs.

"if the national average for colonoscopy screenings is around 58%, the ACO should avoid negotiating 75% with payers. Doing the research is paramount to setting attainable goals."

5) Negotiating value-based contracts that position ACOs for success

Leading ACOs effectively manage expectations and set realistic goals when negotiating value-based contracts. Knowldege of established benchmarks helps ACOs avoid setting financial and quality metric goals that the organization will never achieve. This includes understanding state and national averages. For example, if the national average for colonoscopy screenings is around 58%, the ACO should avoid negotiating 75% with payers. Doing the research is paramount to setting attainable goals.

The Bigger Picture for ACOs

ACO partnerships that demonstrate quality and efficiency achievements can provide significant opportunities for hospital and physician affiliates to earn incentives. To succeed, ACOs must be built on a foundation that prioritizes physician involvement, maintains profitability in the transition to value-based care, employs data-driven care coordination practices and enables personalized care plans. With the right tools in place to document and communicate key metrics and a strategy to close patient care gaps, ACOs are best equipped to successfully collaborate to improve cost and quality outcomes.

Mitigating Rural Healthcare's Geographic Penalty: How Telemedicine Helps … *continued from page 1*

But there is help. Telemedicine has proven itself to be the "great equalizer" for rural healthcare, mitigating the geographic penalty for people living in small towns, physicians practicing there, and hospitals serving their local communities.

New Solution, Old Problem

"Patient-to-primary care physician ratio in rural areas is only 13.1 per 10,000 people, compared with 31.2 per 10,000 in urban areas."

While telemedicine's role in bringing quality healthcare to rural communities is a new story, the problem of geographic healthcare penalties in rural areas is not.

A 2003 report by the National Rural Health Association (NRHA) stated that "the maldistribution of health professionals places an obstacle for rural Americans in accessing timely and appropriate primary healthcare services."

The problem is just as real today. The NRHA's website opens with the statement that many factors—economic, cultural, social and the isolation of living in a remote area—have converged "to create health care disparities and impeded rural Americans in their struggle to lead normal, healthy lives." The disparities include:

- **A shortage of physicians.** The national physician shortage of 122,000 full-time physicians by 2032 is felt more acutely in rural communities. Patient-to-primary care physician ratio in rural areas is only 13.1 per 10,000 people, compared with 31.2 per 10,000 in urban areas.
- **Lack of specialists.** The number of specialists per 100,000 people is 30 in rural areas, 263 in urban ones.
- **Poverty.** On average, per capita income in rural areas is nearly $10,000 lower than the average per capita income in the United States. More people are on Medicaid and lack insurance coverage, and have challenges getting the transportation they need to get health care.
- **Poor health.** Rural areas have more frequent occurrences of diabetes and heart disease than non-rural areas. A little over 19 percent of adults in rural areas describe their health status as fair/poor, while 15.6 percent in urban areas do so.

Hospital Closures, Increased Mortality

"More than 100 rural hospitals have closed across the country since 2010."

In addition, hospital closures have hit rural communities hard. More than 100 rural hospitals have closed across the country since 2010, according to research by the North Carolina Rural Health Research Program, many of them in states that turned down the Medicaid expansion available as a result of the Obama administration's Affordable Care Act. But rural hospitals' struggles began decades ago, with more than 200 rural hospitals closures between 1990 and 2000, according to a report from the Department of Health and Human Services.

It was largely the result of changing times. Scientific developments and advances in neurology, cardiology and other specialties were requiring rural hospitals to "up their game," investing in technologies and staffing with specialists who could perform new treatment methods that patients have come to expect.

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Mitigating Rural Healthcare's Geographic Penalty: How Telemedicine Helps … continued from page 3

Add to this picture the economic downturns and outmigration that are leaving rural communities with older, sicker populations more reliant on Medicaid and Medicare, and many hospitals simply can't afford it and have been forced to shut their doors.

> ***"Rural parts of the United States need an additional 4,022 doctors to completely close their coverage gaps."***

The hospitals that remain open are struggling to stay fully staffed. Rural parts of the United States need an additional 4,022 doctors to completely close their coverage gaps. Yet it's harder and harder for rural hospitals to afford the high price tag of hiring new doctors, who carry an average of $200,000 in student debt and have their own tough financial challenges.

The human cost of the dilemma is clear. A 2019 study by the National Bureau of Economic Research found that while the closing of urban hospitals had no impact on their surrounding communities, rural closings caused their populations, which have limited access to healthcare and other services, to see mortality rates rise 5.9 percent.

With 21 percent of U.S. rural hospitals at high risk of closing unless their finances improve, the situation is dire indeed.

Telemedicine Improves the Quality of Life Rural Americans Crave

There are plenty of benefits to life in rural America. A May 2019 report based on a survey conducted for NPR, the Robert Wood Johnson Foundation and the Harvard T.H. Chan School of Public Health, found that a majority of rural Americans are satisfied with their quality of life. They are more likely to see their communities as safe compared to adults nationally. A majority also are hopeful that they can make a difference in their local community and are civically and socially engaged.

The report notes the downside, too. "However, a minority of rural Americans struggle with experiences in areas of life that carry major consequences, including financial insecurity, trouble accessing affordable, quality health care, lack of high-speed internet access, housing problems, and isolation/loneliness," it states.

The challenges are daunting ones, but telemedicine offers some hope on the healthcare side. The lack of broadband will restrict the depth and breadth of telemedicine that brings consulting physicians into homes, schools and offices via videoconference. However, most rural hospitals, in our experience, are town-centric enough that they generally have access to the limited broadband services in a community. That access alone is a bright spot, a gateway to bring telemedicine into more rural hospitals that see its benefit. Not to mention, the patients who are treated via telemedicine in a hospital are largely convinced it's a good thing—a very good thing.

Overcoming Payer Care Management Challenges in 2020 and Beyond

by Matt Gagalis

As we move into 2020, it is clear that the Medicare Advantage market will continue to evolve and expand. CMS has announced that premiums will drop an average of 14 percent, which combined with more than 1,200 new plan choices nationwide will help to grow the total Medicare Advantage population by more than 2 million members.

Payers have long realized the need for effective care management, and larger member populations and increased competition will continue to underscore the importance of initiatives that effectively and efficiently help identify and manage high-risk, high-cost and complex patients. Outlined below are several areas where payers can focus in 2020 to support this effort and address care management challenges.

Incorporating real-time data

> ***"CMS has announced that premiums will drop an average of 14 percent, which combined with more than 1,200 new plan choices nationwide will help to grow the total Medicare Advantage population by more than 2 million members"***

Payers have invested significantly in analytics and other capabilities powered by claims data to support member identification, risk stratification and care management efforts. Generally, these initiatives have yielded positive clinical and financial outcomes. Claims data, however, is not without its limitations and may be insufficient in delivering the results expected of high-performing plans in 2020. Given the three- to six-month lag in claims data, as well as the lack of clinical information in claims, many payers may struggle to succeed in quality measures that are closely tied to acute and post-acute care.

Quality care requires knowing when and where a patient receives care, such as when a patient presents at the emergency department or has been discharged to skilled care or home. Today, solutions exist that are capable of providing access to real-time data. With continued policy focus on healthcare data interoperability, the availability of such solutions will only increase. To improve care coordination in 2020 and beyond, payers must incorporate real-time data sources and implement solutions that enable clinically appropriate follow-up and clearer visibility into patient movement across the continuum of care.

Making strides to reduce readmissions

Over the past twenty years, lowering readmissions has been a longstanding challenge for both payers and providers. The CMS Hospital Readmissions Reduction Program receives the credit for declining readmission rates, however evidence suggests that the reduction has actually been driven by an overall decline in all hospital admissions.

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Overcoming Payer Care Management Challenges in 2020 and Beyond … *continued from page 4*

Value-based care agreements have aligned incentives across stakeholders, and advances in telemedicine, in-home care and real-time data availability have also shown the potential to positively impact readmissions. In conjunction with these advancements driven by value-based care, payers and providers must continue to collaborate around strategies such as discharge planning and post-acute provider network management to drive positive outcomes for patients and reduce readmissions.

Improving member experience

With increasing numbers of older Americans choosing Medicare Advantage plans and more high-quality plan options than ever before, payers must deliver a consistently superior experience for their customers. Stars Ratings and other quality initiatives have delivered strong outcomes in areas like medication adherence and preventive care, however payers have historically struggled to move the needle in member experience and satisfaction. As CAHPS and other patient experience and satisfaction measures become increasingly important to health plan reimbursement, payers' continued focus on improvement in these measures is anticipated in 2020 and beyond. Driving satisfaction scores is complicated and multi-factorial, but there are elements within payer control that can make an impact, including more accurate and efficient prior-authorization, more timely care management and support, and better network management and utilization management to ensure patients receive the appropriate level of care from the right provider at the right time.

Prioritizing emerging focus areas and new technologies

Payers must wade through several evolving healthcare solutions as they consider their strategies, but ultimately the key is for decision makers to remain focused on implementing initiatives that are proven to deliver a high impact across multiple high-priority areas.

For example, social determinants of health has emerged as an area of focus for payers. One potential strategy to achieve more effective care management entails a better understanding of how social determinants drive – or inhibit – continued quality improvement. By leveraging new sources of real-time data that extend beyond what is available in claims data, health plans may gain different perspectives on patient challenges and risks, and better insight into the non-clinical social barriers that may play a role in a patient's frequent hospital readmissions or ED utilization. To establish a more complete picture of patients' health, plans must incorporate new sources of data and intervene more quickly to ensure no patients fall through the cracks.

"One potential strategy to achieve more effective care management entails a better understanding of how social determinants drive – or inhibit – continued quality improvement."

Additionally, payers have been barraged with a host of technology solutions that range from telemedicine to patient engagement and remote monitoring. Many of these new solutions highlight the potential of "big data" or "A.I.", both of which have been buzzwords in healthcare for years. Health plans and other organizations have invested significant resources to develop the infrastructure required to collect massive amounts of data from disparate sources, but the data alone will not improve quality or reduce costs. Payers must adopt technology that makes data actionable and contextual – using it to inform clinical decision-making and improve care management. Health plans should seek solutions that can not only provide the data from disparate sources, but that can also surface data and provide alerts in a way that is meaningful and actionable.

Conclusion

Many payers recognize it is critical to prioritize care management, but they must continue to drive initiatives that utilize real-time data to effectively and efficiently track patients within the continuum of care, reduce readmissions and improve member experience. Although still a valuable data source, payers can no longer rely solely on claims data to successfully manage patients – particularly complex and high-risk patient populations. Ultimately, care coordination technologies that provide access to real-time clinical updates and actionable data are essential to help payers address care management challenges in 2020.

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Thought Leaders' Corner

Each month, *Population Health News* asks a panel of industry experts to discuss a topic suggested by a subscriber. This month, there are two questions.

Q. How can the pharmaceutical industry improve medication adherence?

The Pharmaceutical leaders in the U.S. are missing a massive opportunity to stem the loss of more than $250 billion per year due to low medication adherence. It is paramount that the industry tackle this problem to reduce waste, costs and improve bottom-lines – but the solution must start in an unexpected place: the cloud.

At global and national levels, pharmaceutical spend has been in the spotlight for decades. In recent years that spotlight has been magnified by greater demands for *proof* that pharma leaders are investing in lowering drug costs and boosting innovation, a mandate coming from multiple fronts: government, consumer and healthcare organizations. In short, pharmaceutical leaders who ignore or underestimate these demands in the next year or two are going to fail.

A large part of the problem is the pharmaceutical industry's belief that current technology doesn't meet the actual needs. This is simply untrue. The opportunity to make a change is here and it's in the cloud, specifically cloud-enabled platforms that consolidate information and data across the entire drug delivery continuum. Leveraging a platform will allow companies to focus more on patient safety and outcomes, while addressing the cost component by providing greater efficiencies in the overall process and developing more predictive indicators around effectiveness and availability of drugs.

Platform solutions have become prevalent across multiple industries and are the catalyst to solving the previously unsolvable medication use dilemma. Here's why:

- It consolidates information across multiple different industry participants, populations and demographics, which leads to greater insights – the drug delivery process becomes a true network, allowing the digital tracking of each dose as a node on that network.
- It provides the ability to leverage industry expertise to deliver greater consumer experiences—in safety and effectiveness
- It enables us to take advantage of the combined use of automation, technology and applications to drive greater outcomes.
- It allows us to take a broader look across the entire ecosystem of medication management and make discrete changes to optimize the efficiency of each step in the process.

When these elements are combined, we start to see details of medication use that we couldn't before, delivering greater insights, and prescriptive recommendations of actions to improve outcomes. Ultimately, we will be able to deliver the desired patient outcomes while removing cost barriers.

The cloud-enabled platform is the key foundation of the Autonomous Pharmacy. The medication management space is streaming towards automation, with an eye on a key milestone of zero-touch distribution. At its core, zero-touch provides two major cost-improvement drivers: zero-error and complete visibility within our system. It refocuses clinician time to the patient, and removes the burden of focusing on the drug delivery process.

We already have much of the automation and control of this process in place, it's been well-tested and refined to serve as a precision tool – but the promise of the cloud ensures seamless and safe information transfer to make it even more powerful, leveraging insights and analytics for predictability of desired outcomes. The closer we get to realizing the full potential and adoption of Autonomous Pharmacy, the sooner we will bring down costs for consumers, clinicians, pharmacists, healthcare organizations, and, yes, pharmaceutical companies.

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Industry News

American Academy of Allergy Asthma & Immunology

Racial Differences in Asthma Outcomes for Older Adults Persist Even After Controlling for Social Determinants

Even after accounting for multiple social determinants, racial differences still had an impact on asthma outcomes in older adults, according to a new study published in The Journal of Allergy and Clinical Immunology: In Practice (JACI: In Practice), an official journal of the American Academy of Allergy, Asthma & Immunology (AAAAI).

A total of 4,700 adults, all age 55 or higher were included in this study. Respondents self-identified as Non-Hispanic White, African American, or Hispanic. Of this group, African American and Hispanic respondents were twice as likely to visit the emergency room for asthma compared to Non-Hispanic White individuals.

"As the population continues to age, it's important that researchers look at the impact of asthma on older populations and how it differs from younger patients," said first author Nicole M. Cremer, MD. "The number of older adults with asthma is going to increase, and understanding these health disparities is crucial if we hope to provide effective treatment."

Data was collected and analyzed from the 2015 Behavioral Risk Factor Surveillance Survey and the Asthma Call-Back Survey and was restricted to adults aged 55 and older with current asthma. Asthma outcomes were assessed based on healthcare utilization, including emergency department visits, and asthma control.

Social factors, such as healthcare access and healthcare costs as well as additional demographic data, were collected. African American and Hispanic respondents reported higher BMIs, lower levels of educational attainment, and lower annual household incomes.

They were also more likely to be former or current smokers. They reported higher proportions of impaired access to health care because of cost as well as gaps in healthcare coverage. A higher proportion of African American and Hispanic respondents reported not using asthma medication.

According to the study, 32% of African Americans and 23% of Hispanics reported ER visits in the past 12 months due to asthma compared to 14% of Non-Hispanic Whites. After regression analysis, this translated to African Americans and Hispanics being twice as likely as Non-Hispanic Whites to have visited the emergency department due to asthma symptoms.

Despite this, African Americans and Hispanics were 40% less likely to report frequent uncontrolled daytime symptoms compared to Non-Hispanic Whites. These findings suggest certain populations may be under-treated, putting them at higher risk for severe symptoms.

"While social determinants certainly account for some asthma outcomes, we found that didn't account for all of them," said Dr. Cremer.

-Racial Differences in Asthma Outcomes... *continued*

"While these groups are also less likely to be on an inhaled corticosteroid, we find they are still more likely to visit an emergency room after controlling for medication use. That means there are still factors out there leading to African Americans and Hispanics requiring more frequent ER visits."

Asthma disparities in older adults require additional studies, particularly in relation to racial differences when it comes to asthma control, emergency room visits and mortality. As the American population continues to age, the burden of asthma on these older populations will be more keenly felt. This burden can be reduced by identifying the areas of prevention and treatment needed to effectively treat older adults with asthma.

caravanhealth

Caravan Health Offers Rural Clients a Risk-Free ACO Solution

Caravan Health announced a groundbreaking new Rural Risk-Free Solution to support rural health systems in the Medicare Shared Savings Program. By 2021, all ACOs in Medicare will be in the Pathways to Success Program, which requires paying back certain higher-than-expected Medicare costs during the agreement period. Caravan understands that taking on this financial risk can be daunting for any provider new to risk-based payment—and next to impossible for rural hospitals and clinics.

Rural health systems are hesitant to take on downside risk for good reason. There are serious health access issues facing rural communities, including widespread hospital closures, provider shortages, long distances and even longer wait times. These pressures make rural providers understandably reluctant to dive into value-based payment without the right help.

"With this new Rural Risk-Free Solution, Caravan Health will give rural providers and communities the boost they need to thrive in value-based health care," said Lynn Barr, Caravan Health founder and executive chair. "This new initiative is the latest chapter in our strong tradition of supporting rural health. From our earliest days working with rural hospital leaders, to our role in establishing the ACO Investment Model (AIM), we are proud to stand with our rural colleagues and patients."

With the Rural Risk-Free Solution, Caravan Health will be responsible for 100 percent of the Shared Savings Program performance risk for rural clients in a Caravan-sponsored ACO. This means Caravan's rural clients would never have to pay money back to CMS resulting from downside risk in ACO participation. To participate, rural clients simply have to remain in good standing in an ACO and execute Caravan Health's playbook for ACO success. Health providers can visit the Caravan Health website to determine eligibility.

Industry News

Children with ADHD More Likely to Receive Medication if They Live in Poorer Areas

Children with ADHD from the poorest areas are significantly more likely to receive medication as children with ADHD from the most affluent areas, according to the first UK study of its kind.

Previous research has shown that children in poorer areas are more likely to be diagnosed with ADHD. This new research in BJPsych Open, published on behalf of the Royal College of Psychiatrists, is the first UK study to show an association between deprivation and the likelihood of receiving medication for ADHD.

The finding is unlikely to have a single, simple explanation, but suggests that children from poorer areas are less able to benefit from treatments which don't involve medication, such a behavioural management classes for parents. Parents in poorer areas may find it more difficult to attend these regular classes, because of economic insecurity, for example working multiple jobs.

Dr Samuel Nunn, junior doctor at Leeds Teaching Hospitals NHS Trust and lead author of the paper, said, "This finding is important because it has implications for those in clinical practice and for policymakers. Further research would inform development of possible interventions to tackle the effects of social deprivation, though progress may be difficult unless the broader social determinants of health are addressed."

Researchers investigated a sample of 1,354 young people with a diagnosis of ADHD in the Sheffield area. Household postcodes were used to derive a standard measure of socioeconomic deprivation.

Statistical analysis showed that higher deprivation was associated with a higher likelihood of receiving medication, after controlling for age, sex, religion, ethnicity and the presence of other diagnoses.

Humana's Partners in Primary Care and Welsh, Carson, Anderson & Stowe Form Joint Venture to Expand the Nation's System of Value-Based Primary Care Centers Focused on Serving Medicare Patients

Humana Inc.'s (NYSE: HUM) Partners in Primary Care and Welsh, Carson, Anderson & Stowe (WCAS) have entered into an innovative joint venture that will expand access to value-based primary care for Medicare patients. The joint venture will develop and operate senior-focused, payor-agnostic, primary care centers, which will be managed by Humana's wholly-owned, primary care subsidiary, Partners in Primary Care, and operated under the Partners in Primary Care brand.

Humana's Partners in Primary Care *... continued*

WCAS, a leading private equity firm specializing in healthcare and technology, together with Humana, is making an initial commitment of approximately $600 million to the joint venture. WCAS will have majority ownership in the new company; Humana will own a small minority stake.

Humana is committed to a strategy of improving the health of seniors through a value-based health ecosystem that brings simplicity and connectivity to the healthcare experience. Humana will continue to pursue that strategy through both a network of market-leading partners and its proprietary primary care businesses. The new joint venture is expected to more than double Partners in Primary Care's footprint of senior-focused primary care centers over the next three years. Partners in Primary Care currently operates 47 care centers located throughout Kansas, Missouri, North Carolina, South Carolina, Texas, and Florida. This joint venture will further allow Partners in Primary Care to scale its core operations to facilitate the continued expansion of its care model.

"There is a significant unmet need for value-based, senior-focused primary care in the U.S.," said David Caluori, General Partner of WCAS. "WCAS has a 40-year history of successfully building world-class healthcare companies. This transaction represents another example of how WCAS creatively partners within the healthcare ecosystem to enhance access to innovative healthcare services to improve patient care. Through this new joint venture, Partners in Primary Care is now well resourced to accelerate the deployment of its proven care model in areas across the country that need it most. We are thrilled to be able to partner with Humana and Partners in Primary Care to expand access to quality care to the millions of seniors living in underserved areas throughout the nation."

"Partners in Primary Care is well positioned to meet the health needs of the growing senior population with our integrated primary care platform. Our integrated, whole-person, value-based care model comprehensively and proactively addresses chronic conditions, wellness and social determinants of health. We bring a differentiated offering and experience to seniors, often in areas where access to primary care is limited," said Renee' Buckingham, Segment President, Humana's Care Delivery Organization. "We are excited to accelerate our growth through our partnership with WCAS. Together, we will be able to make this model available to more seniors and in more communities."

Partners in Primary Care will receive a management fee, including performance-based incentives, for the management of all joint venture centers. In addition, the agreement includes a series of put and call options through which Partners in Primary Care may acquire WCAS's interest in the joint venture, and through which WCAS may require Partners in Primary Care to purchase its interest in the joint venture, in stages over the next 5-10 years.

For clarification, Humana's wholly owned Conviva operations, which operates 104 payor-agnostic senior-focused primary care centers located primarily in south Florida and Texas, is not party to this agreement.

The transaction is expected to have an immaterial impact to Humana's earnings in 2020.

Industry News

Partnership Brings New Level of Healthy Living Services to Walnut Square Affordable Housing Property

Operation Pathways, a subsidiary of The NHP Foundation and provider of a robust range of resident services, announced today at an onsite kick-off event for residents, that it has partnered with Centene Corporation's Social Health Bridge™ Trust which helps community based organizations and healthcare entities work more effectively to address the social determinants of health – the non-medical barriers to health such as food insecurity, housing instability/homelessness, unemployment, and lack of access to transportation.

The partnership connects high-need residents living in low to middle income housing to social services integrated with their care plan, ensures care gap closure, and reduces reliance on local hospital ERs. Additionally included are health fairs, nutritional demonstrations, and visits from financial professionals for tax preparation and education.

"Social Health Bridge seeks out stable, experienced partners like Operation Pathways to bring our evidence-based, results-oriented programs to communities in need," said Michael Monson, Senior Vice President of Medicaid and Complex Care for Centene. "Overcoming barriers to more easily navigate the health care system helps bridge the gap between healthcare and community organizations resulting in improved health outcomes for families and individuals."

Resources provided by Social Health Bridge at Walnut Square include assistance with buying affordable healthy foods, bill-paying, transportation, job-training and job search, low-cost quality childcare, safety concerns, and programs to combat loneliness and isolation.

"We encourage our residents to get involved with Social Health Bridge and work together to access their healthy living tools," says Tiffany Martinez, Resident Services Coordinator, Operation Pathways, "The programs are tailored for individuals to choose how best to work towards overcoming barriers and reaching lifestyle goals."

All Social Health Bridge and Operation Pathways resources are available free of charge to the 466 Walnut Square residents who can also join the Operation Pathways Advisory Committee to impact local Social Health Bridge programming in their community.

"For twenty years, NHPF's Operation Pathways has provided children and youth programming, financial education and employment services, and healthier living programs at Walnut Square Apartments," added Ken White, Executive Director Operation Pathways, Inc. "Now in collaboration with Social Health Bridge, we will build on the deep relationships we have made with residents as we introduce them to an even more robust array of on-site services leading to a healthier and more vibrant community."

Gaps in Cure Rate Appear Linked to Race and Insurance Status for a Common HPV-Related Cancer, According to New Research

Survival outcomes for HPV-positive oropharyngeal squamous cell carcinoma of the head and neck (SCCHN) have made significant gains in recent years, but new research in the February 2020 issue of JNCCN—Journal of the National Comprehensive Cancer Network finds some groups are being left behind. Researchers from Massachusetts General Hospital—along with Yale University School of Medicine, UT Southwestern Medical Center, and UNC Chapel Hill School of Medicine—conducted the largest population-based analysis to date on the socioeconomic factors that affect outcomes in this cancer type, and found significant racial and socioeconomic disparities.

"When we examined outcomes by race and insurance status, adjusting for all clinical factors, those patients who were non-white or uninsured or poorly insured had much reduced cancer-specific survival compared to their white and well-insured peers," said Luke R. G. Pike, MD, DPhil, Department of Radiation Oncology, Massachusetts General Hospital. "It's unsettling that black and Hispanic men and women with HPV-positive oropharyngeal carcinoma—a disease we now recognize to be curable in many patients with even very advanced disease—appear to do disproportionately poorly as compared to their white peers. We also speculate that patients with insufficient insurance were unable to access high-quality radiotherapy, surgery, and chemotherapy, which is crucial to the successful treatment of locally advanced HPV-positive oropharyngeal cancer. We must strive to ensure that all men and women, no matter their insurance status or race, can get access to high-quality treatment for head and neck cancers."

The researchers used a custom SEER Database to identify 4,735 adult patients who were diagnosed with primary nonmetastatic SCCHN with a known HPV status in 2013 or 2014. The data showed that among those patients with HPV-positive oropharyngeal cancer, there was a 5.6% rate of cancer-specific death at 20 months for white individuals, compared to an 11.2% rate for non-whites. Separately, the rate of cancer-specific death for persons with health insurance was 6.2%, versus 14.8% for the uninsured. Those outcome disparities were not seen for non-oropharyngeal cancers, or prognostically less favorable HPV-negative SCCHN.

"The study by Pike, et al. highlights the socioeconomic differences between patients with HPV-positive and HPV-negative SCCHN and identifies striking racial disparities among individuals with HPV-positive oropharyngeal SCCHN, whereby non-white and uninsured patients with HPV-positive cancers had worse cancer-specific mortality," commented Francis Worden, MD, University of Michigan Rogel Cancer Center, and Member of the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) Panel for Head and Neck Cancers—who was not involved in this research.

Industry News

Gaps in Cure Rate Appear Linked to Race... *continued*

"While the exact reasons for these findings are speculative given the retrospective nature of this work, their data bring to light the importance for early diagnosis and treatment of all patients with HPV-positive oropharyngeal cancers and the importance of identifying and eliminating barriers to care. HPV-positive cancers are highly curable, but data does show that patients who present with higher stage disease (due primarily to delays in diagnosis and thus delays in treatment) have lower overall survival rates.

Additionally, lower income, non-white populations may be less likely to obtain care at larger, more experienced cancer centers that treat higher volumes of head and neck cancers. Published data suggest that patient care at such centers of excellence leads to improved outcomes due to expertise in administering complex treatment plans and the high level of support that is provided during medical care."

SIMPSON COLLEGE

Individuals With Down Syndrome Face Geographic Barriers to Specialty Care

A new study co-authored by Simpson College (simpson.edu) associate professor of mathematics Heidi Berger found that one in five individuals with Down syndrome have to travel more than two hours to receive care at the nearest specialty clinic. The study, in collaboration with Simpson alumni Nick Joslyn '18 and Emma Campbell Endowed Chair on Down Syndrome at Mass General Hospital for Children Dr. Brian Skotko, found that geographic barriers prevent a significant portion of the population from the most basic healthcare needs.

"We know that Down syndrome specialty clinics improve the health of our patients," said Skotko, an associate professor of pediatrics at Harvard Medical School. "For the patients with Down syndrome who do not have access to these clinics, fewer than 10 percent are up-to-date on the most basic healthcare recommendations from the American Academy of Pediatrics," said Skotko.

The study included more than 64,000 individuals with Down syndrome in the contiguous 48 states. It found that access to specialty care varied by region. In the South, for example, only 37 percent of individuals have access to specialty care within 30 minutes of their home. That compares to 80 percent in the Northeast.

"This work highlights the need for innovative technologies in the care model for individuals with complex medical needs, not just individuals with Down syndrome," said Berger, whose 5-year-old son, Isaac, has Down syndrome. "Telehealth, telemedicine and online, automated medical information portals might provide creative solutions."

Skotko and his team are developing one solution, a first-of-its-kind virtual clinic scheduled to launch later this year.

Individuals With Down Syndrome ... *continued*

"Since building more in-person Down syndrome specialty clinics is not a financially sustainable solution, we need to start leveraging innovative technology to meet these needs," Skotko said.

Funding for the research was provided by the Hal and Greta Bryan Summer Research Program at Simpson College. Joslyn is currently enrolled in the Applied Physics program at the University of Michigan.

THE CONFERENCE BOARD

Amid Aging Population, CED Publishes Plan for Expanding America's Workforce

An aging population, declining birth rates, and a slowdown in immigration are threatening the nation's continued economic growth, according to a new report, The Aging Workforce: Tackling the Challenge, from the Committee for Economic Development of The Conference Board (CED). It marks the second in a series of 2020 Solutions Briefs that address the central challenges to sustaining capitalism.

The Aging Workforce sounds the alarm bells for America's business and policy leaders, who can no longer ignore the demographic challenges posed to US economic growth. Labor force participation rates, the share of adults working or looking for work, have remained disappointing even in the midst of the longest economic expansion in US history and a tightening labor market. With the continuing exodus of retiring Baby Boomers, the US must swiftly enact a multi-part plan to bolster labor force participation and expand the workforce.

A push for additional workers comes as the US experiences historically low birth rates—and fewer births overall than at any point in the past 30 years—with worrying implications for workforce growth in the decades to come. Similarly, while the US has experienced a sharp decline in immigration in recent years, it is also forecast to have slowing rates of growth from immigration throughout the first half of this century.

"Without a plan to counter the seismic demographic shifts underway, a dwindling pool of workers will undermine both the success of American businesses and the living standards of the nation's citizens," said CED President Lori Esposito Murray. "Tasked with the challenge of attracting and retaining talent, the business community is well-positioned to make the case for reform to the policy community, which must enact multiple solutions to help generate long-term, broad-based prosperity. Doing so will help sustain capitalism for decades to come."

The new CED brief calls for policymakers to enact the following recommendations:

- Expand and increase the Earned Income Tax Credit for adults without qualifying children in order to incentivize more people to enter the labor force and remain working.
- Lessen barriers to labor force participation through improved employee-employer matching and increased mobility by reducing geographical limitations, information gaps, and unnecessary occupational obstacles.

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Amid Aging Population, CED Publishes *…continued*

- Modernize immigration policy, including reforming the H-1B visa application and approval process, increasing economically-motivated offers of permanent residence, and piloting a "fast-track" entry program for top international recruits.
- Support older workers who wish to remain working, including by eliminating health insurance cost disparities, piloting a modification of the Social Security retirement earnings test, and supporting flexible work arrangements.

A growing majority of the healthcare community understands that holistic interventions to improve outcomes in many disorders require care teams to look to the mouth. They see treating the mouth and oral cavity as essential to lowering costs and improving disease outcomes. As a result, more effort and point of care solutions are being focused on aligning the dental and medical worlds. On the animal health side, the demand for oral health products and services continues to grow with increased understanding that animal dentistry can improve the quality and lifespan of pets.

"Medical, dental and veterinary equipment and technology continues to evolve to provide healthcare organizations the new approaches, innovative technologies and proven solutions to improve the quality of care and outcomes delivered and enable a better care experience for caregivers and patients at the point of care," continued Schwieterman.

MOLINA HEALTHCARE

Molina Healthcare Announces Launch of Social Determinants of Health Innovation Center

Molina Healthcare, Inc. (NYSE: MOH) ("Molina" or "the Company") today announced the launch in Columbus, Ohio, of its National Molina Healthcare Social Determinants of Health Innovation Center.

The Innovation Center will expand member engagement and support by developing programs and best practices to address health care access barriers created by social factors, with a goal of enhancing patient-centered care across Molina's service areas throughout the United States.

Social determinants of health, or SDOH, impact individuals' opportunities to access the social and physical environments that are needed to promote healthy, safe and independent living. Led by a seasoned staff trained to identify areas for improvement, the Innovation Center seeks to partner with local and national community-based organizations, providers and stakeholders to better serve the social and physical needs of Molina members.

"As an organization that prides itself on its regional focus and partnerships, Molina looks forward to applying SDOH best practices across our nationwide footprint to benefit all the local communities we serve," said Dr. Jason Dees, chief medical officer, Molina Healthcare. "The Innovation Center will closely collaborate with and support our local and national partners, as we look to identify, test, implement and scale best practices throughout our service areas."

Ami Cole, president of Molina Healthcare of Ohio, said, "We are thrilled to have the Innovation Center based in Ohio.

Molina Healthcare Announces Launch *…continued*

We have many strong community partners actively engaged in testing new models to address social determinants of health, and we are excited to further expand upon these efforts and share our local learnings on a nationwide scale."

The Innovation Center will act under a shared services model and be accountable for driving the Company's SDOH strategy. It will be an arm of the office of the chief medical officer and will optimize Molina engagement efforts across national and regional partners. The Innovation Center will integrate SDOH into Molina's models of care through several initiatives, including: the collection and analysis of data on members' SDOH needs to inform partnerships and program development; the documentation of SDOH interventions with Molina's local partners; the development of national programs aimed at advancing health outcomes through various SDOH supports; and the creation of a database of Molina SDOH member outcomes that will inform programmatic refinements and the development of best practices for implementation throughout the enterprise.

Kamari

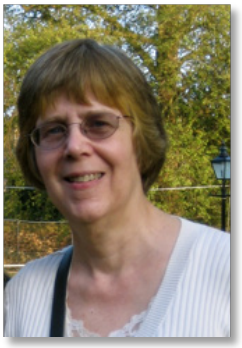
Kamari and ZeU Announce Digital Medical Data Marketplace and Incentivization Program for Africa

Kamari, an infrastructure project building a network of payments across the African continent, and ZeU Crypto Networks (CSE: ZEU), a leading Canadian blockchain technology innovation and development company, have announced a plan to roll out a new blockchain-based identity and medical record system across the African continent. This technology combined with the mobile blockchain wallet and incentive programs being built by Kamari, in collaboration with ZeU, looks to advance public health initiatives, enable individual data ownership, and drive preventative medicine for millions of people without bank accounts and digital records.

Africa's GDP is predicted to increase from $2 trillion today to $29 trillion in today's money by 2050. The "Blockchain Opportunity in Africa" will also have mobile technology at the center of its massive growth across the continent as the unbanked will gain access to new, life-changing financial services. Kamari looks to develop the fundamental infrastructure that will serve Africa's population as it doubles to two billion over the next several decades. The company has secured national lottery lic-enses across multiple African countries that, once built, will allow them to market to over 50 million adult customers exclusively.

ZeU's Software as a Service (SaaS) infrastructure for healthcare is a turnkey solution for clients to leverage the monetizable value of their data. Healthcare data is an emerging market requiring large amounts of information to be collected, curated, and aggregated in a responsible and unbiased way. The value contained in the data can be extracted, refined, and put to use throughout the health care and insurance industries. ZeU's SaaS safeguards sensitive medical data and promotes more accurate health care records. It also empowers users to derive value from their data while allowing government and healthcare entities to analyze metadata for research and medical advancements. Global deployment could lower healthcare costs while creating healthier populations. ZeU's SaaS is customizable to client requirements.

Catching Up With ....



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Elizabeth J. Davidson is a professor in the Department of Information Technology Management in the Shidler College of Business, University of Hawaii Manoa. She teaches courses in management information systems at the undergraduate, MBA and PhD levels. Her specialties are systems analysis and project management, management of the IT function, and IT and business strategy. She has also developed and taught courses in Health Informatics and Human Resource Information Systems for masters students.

***Population Health News**: What has been the primary driver of the population health movement?*

Dr. Davidson: The population health movement has been driven, in large part, by the shift from fee-for-service to value-based payment for healthcare providers. The movement has been fueled by the digitization of clinical health data in electronic health records systems (EHRs), advances in computer processing and in analytics and visualization software, and development of health informatics knowledge. However, whether population health will result in improvements in the health of populations depends on several key factors beyond these information technology (IT) advances.

***Population Health News**: What role has evidence based medicine played?*

Dr. Davidson: In the past, evidence on the efficacy of clinical protocols depended on small-scale randomized clinical trials or longitudinal panel survey data. Now, with the "big data" captured by EHRs and administrative IT systems, healthcare providers can rely on data that are more timely and representative of the population of patients they actually serve. These "big data" can also be analyzed with greater specificity of patient characteristics and health conditions. To improve population health, this knowledge must be translated into clinical practice guidelines and applied in day-to-day practices. Embedding guidelines into EHRs can be an effective method to translate knowledge and affect clinical decision-making.

The second factor is the infusion of an evidence-based approach throughout the organization. Buying data analytics tools, hiring consultants and setting up a small pool of "data scientists" will produce few results unless the majority of clinicians and administrators are fully on board with the program. For decades, businesses have tried to reap the benefits of data analytics, business intelligence, and now data science, often with little to show from these investments. The most effective firms have fully integrated an evidence-based analytics approach into the organizational culture from top management down. This will be true for healthcare organizations and population health programs as well.

Third, the health of a population cannot be improved without the engagement of the members of that population, that is, patients. Patients interact with a broad spectrum of healthcare providers, third-party payers, health behavioral coaches and even mobile health apps. Each setting offers opportunities to "nudge" patients towards healthier self-care practices and also generates data on patients' health engagement and status. To realize the full potential of "big data" and analytics requires data interoperability and aggregation challenges be met as well as effective collaborative partnerships across the care spectrum. Accountable Care Organizations (ACOs) are tasked with these dual challenges to Population Health.

***Population Health News**: How do financial incentives figure into all of this?*

Dr. Davidson: Linking Population Health with providers' financial reimbursements and incentives must be done with care. Financial incentives tied closely to performance metrics drive self-interested and short-sighted behaviors as well as desired behaviors. In the 1990s, some Health Maintenance Organizations (HMO) focused on cutting costs at the expense of quality and patient access. This led to patient and provider revolts against managed care practices. Today, sophisticated analytics tools are available to utilize healthcare's "big data." However, third- party payers must work cooperatively with health provider organizations and patient advocacy groups to develop balanced, meaningful metrics to ensure that population health programs indeed improve the health of the populations served.