

MANAGED CARE

OUTLOOK

The Insider's Business Briefing on Managed Healthcare

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At Presstime

Census Bureau Releases Data

The number of people without health insurance coverage rose from 45.7 million in 2007 to 46.3 million in 2008, while the percentage remained unchanged at 15.4 percent, according to the U.S. Census Bureau's report *Income, Poverty, and Health Insurance Coverage in the United States: 2008*.

The number of people with health insurance increased from 253.4 million in 2007 to 255.1 million in 2008.

These findings are based on information collected in the 2009 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC). Additional findings from the survey show that the number of people covered by private health insurance decreased from 202.0 million to 201.0 million between 2007 and 2008, while the number covered by government health insurance climbed from 83.0 million to 87.4 million. The number covered by employment-based health insurance declined from 177.4 million to 176.3 million. The number of uninsured children declined from 8.1 million (11.0 percent) in 2007 to 7.3 million (9.9 percent) in 2008.

For additional information on the source of the data and accuracy of the estimates, visit www.census.gov/hhes/www/p60_236sa.pdf. ■

How Does Competition Factor into the Health Care Debate?

The debate over health care reform continues to take center stage. That is true not only within health care itself but all across the nation—on Capitol Hill, in town halls, even on front porches in small town U.S.A. It is a topic so encompassing that it has captured the attention of corporations, providers, payers, individuals, employers, governments (state and federal), and perhaps most noticeably, politicians. No one seems immune.

As the debate unfolds, questions regarding the role of competition remain. What exactly is the role of competition? How will it be impacted by current proposals? Is competition helped or hindered by the plans currently on the table?

“Competition is key to a better health care system,” notes Arthur N. Lerner, partner with Crowell & Moring LLP and

(See How Does Competition ... page 3)

Revenue Cycle Management Starts at Registration

Margaret Mayer

Regression therapy is supposed to take you back to previous lives so you can understand what is going on in this one. You don't need to go that far, but if you take several steps back from your revenue cycle and take a look at the data that are poured into your billing system, you may be surprised at the points that are fraught with errors. Those may be the places where your revenue cycle is slowing down.

The registration process is necessarily the point where basic patient demographics and insurance information are captured. If just that process were simplified, automated, and managed,

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National Briefs

HHS Awards AHIMA Foundation \$1.2 Million: The U.S. Department of Health and Human Services (HHS) Office of the National Coordinator for Health Information Technology (ONC) has awarded the American Health Information Management Association (AHIMA) Foundation a one-year, \$1.2 million grant to continue the State-level Health Information Exchange (SL-HIE) Consensus Project to actively assist states with nationwide health information exchange (HIE) adoption, planning, and implementation. The Consensus Project is led by a 13-member steering committee of SL-HIE leaders; it supports an SL-HIE Leadership Forum—open to all states—in which public and private sector HIE leaders can participate, learn, and receive technical support.

RWJF Selects Hospitals for National Collaboratives: The Robert Wood Johnson Foundation (RWJF) has selected 15 hospitals to participate in two new quality improvement programs as part of its *Aligning Forces for Quality* (AF4Q) program. AF4Q is the Foundation's signature program to lift the overall quality of health care in targeted communities, reduce racial and ethnic disparities, and provide models for reform. The *Aligning Forces for Quality: Language Quality Improvement Collaborative* (Language QI Collaborative) will identify and test strategies for hospitals to provide timely, effective language services to patients with limited English proficiency. The *Aligning Forces for Quality: Equity Quality Improvement Collaborative* (Equity QI Collaborative) will identify and address racial and ethnic disparities in cardiac care and test real-world solutions.

Study Finds Administrative Costs Lower Than Previous Estimates: Private health plans' costs to administer benefits represented an average of only 9 percent of premiums across all policies sold, according to a new report by Sherlock Company. Sherlock reviewed data from 36 Blue Cross and Blue Shield companies and non-Blues health plans participating in performance benchmarking studies in 2008. The report found that prior estimates that private health plans' administrative costs were two to three times higher than actual costs were based on estimates that were so old that they did not reflect changes in industry practices, including advances in electronic processing that speed payment to providers and reduce costs.

Uninsured Are More Likely to Be Dissatisfied with Quality of Care They Receive: Uninsured Americans are more likely than individuals with insurance coverage to be dissatisfied with the quality of health care they receive and are less confident in various aspects of health care, according to a recent study by the Employee Benefit Research Institute. The gap in satisfaction and confidence has grown over time. For additional information, go to www.ebri.org. ■

How Does Competition ...

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co-chair of the firm's Health Care Group.¹ "Competition keeps premiums down, lower premiums make insurance more affordable, and affordable insurance means increased access to health care. There is a logical connection between competition and greater access, but that doesn't mean the problem is solved. Competition does not ensure that poor people have insurance. Even in the most efficient health care system, health care is expensive; therefore, there must be some type of government or charity care to address that side of the issue, and the two sides must work in tandem."

Simply put, the system needs both a government component of regulation and subsidies as well as a market-based component, which is driven by competition. If they can be harnessed to work together, then competition can play a valuable role in improving access.

Without knowing exactly how things will turn out and what the final plan will include, it is almost impossible to know the effect that health care reform will have on competition, says Lerner. Based on details currently available, however, some conclusions (and assumptions) can be made.

For example, the fact that some of the proposals currently being discussed involve less underwriting and more community rating (or at least some variation of community rating) makes it even more important for health plans to be able to compete, notes Lerner. It is not necessarily who comes in the door or how they set their premiums but instead how efficiently they can operate.

"This will put a renewed emphasis on some of the things that managed care has been trying to do all along but has moved away from, relatively speaking, in terms of looking at selective networks rather than broad networks and working with more selective networks in which the providers are organized into more collaborating units," says Lerner. "To some extent,

the changes being discussed could usher in an opportunity for plans to go back to more coordinated care initiatives that have the potential to stimulate competition. That is certainly one potential impact of the current proposals."

Getting rid of underwriting and preexisting conditions can create a favorable environment for competition, stresses Lerner, as long as everybody is playing by the same rules. If one company is going out and insuring anyone who comes along, without requiring a health screening or health risk assessment to identify preexisting conditions or limitations, that creates a problem. It creates adverse selection, which means that insurer will get a relatively sicker pool of people, and its premiums will increase, which will result in a downward spiral; the insurer will lose its healthier members, and the sicker members will be the only ones remaining. If the government says, "No, you can't do this," it makes it a level playing field for everyone involved.

A factor that could come into play involves whether the government issues a mandate either for individuals to have coverage or employers to provide coverage. Even if there are exceptions—or to the degree that there are new subsidies and alternatives for people who cannot afford it—there will continue to be segments of the population who are uninsured because they cannot afford insurance and others who can afford insurance but choose not to for one reason or another.

"Expanding the pool of people who will be getting insurance obviously creates a marketplace to sell more insurance and more benefits for managed care companies," says Lerner. "It creates opportunities for companies that can take on these populations of people and do a good job with it. It will be interesting to see how easy it will be for smaller plans, specifically with regard to the insurance exchange. There are a number of local or regional plans that are strong. They can do well in this kind of exchange. In fact, there is nothing I have seen

(See How Does Competition ... page 5)

Northeast

CeltiCare to Provide Services to Legal Immigrant Population:

CeltiCare Health Plan of Massachusetts has been selected by the Commonwealth of Massachusetts to manage health care services for Aliens with Special Status (AWSS). This population has been enrolled in the Commonwealth Care insurance program run by the Massachusetts Health Connector. The state's budget constraints resulted in recent cutbacks in health care coverage for this population. Effective October 1, 2009 through June 30, 2010, CeltiCare will provide these Massachusetts legal immigrants with coverage for health services.

Horizon Offers New Products for Small Employers: Horizon Blue Cross Blue Shield of New Jersey's (Horizon BCBSNJ's) newest line of products are designed specifically for small employers looking for a savings and value advantage in providing health care to their employees. Horizon BCBSNJ's new health maintenance organization (HMO) Access HSA and Horizon Advantage plans were launched on August 1, 2009, and are now available for purchase.

AmeriChoice, Waterbury Provide Services to HUSKY Participants: AmeriChoice by UnitedHealthcare and Waterbury Hospital have announced an agreement that will provide participants in Connecticut's HUSKY health insurance program access to the hospital's inpatient and outpatient facilities. Waterbury Hospital is a private, nonprofit acute care teaching hospital licensed for 367 beds and affiliated with the Yale School of Medicine, the University of Connecticut School of Medicine, and Connecticut Children's Medical Center.

Midwest

HealthPartners Integrates Electronic X-rays, Radiology Reports into EHRs: HealthPartners is one of the first organizations in the country



to integrate electronic X-rays, magnetic resonance imagings (MRIs) and computed tomography (CT) scans, and radiology reports into patients' electronic health records (EHRs). The images and radiology reports can be accessed quickly by doctors at Regions Hospital and at all 25 HealthPartners Clinics.

ProMedica Introduces Program Series to Target Obesity: ProMedica Health System (PHS) will launch the second year of a health and wellness initiative called *Fields of Green* to address northwest Ohio's and southeast Michigan's obesity problem. According to the 2009 Ohio Family Health Survey, approximately 500,000 children and 5.5 million adults in Ohio are overweight or obese, which exceeds national targets. In 2009-2010, *Fields of Green* will introduce two new programs to raise awareness about the importance of good nutrition and exercise. The first is a program for high school students to compete for \$5,000 college scholarships. Another program called the Healthy Kids Conversation Map[®] Program will be led by PHS employees trained to teach a series of 30-minute interactive sessions in various community settings, focusing on establishing healthy nutrition and exercise habits.

South

PSO of Florida Teams with ECRI Institute PSO: The Florida Hospital Association (FHA) and the South Florida Hospital & Healthcare Association (SFHHA) have announced an agreement with the ECRI Institute Patient Safety Organization (PSO) to support the Patient Safety Organization of Florida (PSO-Florida) with patient safety data collection and analysis. PSOFlorida, a component organization of the FHA and the SFHHA, was established to focus on improving the quality of care that hospitals in Florida provide to the state's residents and visitors. ECRI Institute PSO will support PSOFlorida through a Patient Safety Data Collection and Reporting System and by

analyzing adverse events and other information from participating hospitals and providers.

West

Aetna Awarded a State of Arizona Health Care Contract: Aetna has been awarded a contract to provide health care benefits to Arizona's state employees. The contract is

effective as of October 1, 2009. Aetna is offering state employees three benefit options: an exclusive provider organization (EPO), a preferred provider organization (PPO), and a health savings account (HSA). New Aetna members will have access to 12,500 primary and specialty physicians and 70 hospitals throughout the state. Aetna will be one of four carriers offering medical benefits to the state's employees. ■

How Does Competition ...

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that conceptually would be an obstacle to these or other new, smaller plans.”

Perhaps the biggest question mark is the public plan, which continues to receive a great deal of attention. From a strictly numerical standpoint, adding the government as a competitor means there is one more competitor in the mix. That is pretty straightforward. What is less straightforward is whether it is “good” for competition to have the government in the mix. It is not just about adding another player, says Lerner, but whether the conditions for competition have been enhanced.

“If you look at Medicare, the Medicare Advantage plans all compete with traditional Medicare, which means commercial plans are sharing the space, so to speak, with a

government-type plan,” explains Lerner. “In contrast, in the Federal Employees Health Benefits Program, which is a government program, all the plans are private plans. There is no “government FEHBP” plan. They are all contract health plans offered by a carrier. If the public plan is operated in such a way that it functions as a regulated entity that pays providers at nonmarket rate, the big concern is that it is not a level playing field and does not create conditions conducive to reasonable competition. That's been a huge debate with the commercial carriers and one that is sure to remain until the issue is resolved.” ■

Endnote:

1. Art Lerner directed the Federal Trade Commission's (FTC's) health care antitrust program from 1982 to 1985. Before that, while at the Commission, he served as attorney advisor to the chairman, assistant to the director of the Bureau of Competition, and as an FTC trial attorney in health care antitrust.

Revenue Cycle Management ...

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imagine the effect on the revenue cycle. There are ways to improve the collection of information at the point of registration. Let's look at how some hospitals are improving their registration process to positively affect their revenue cycle.

As part of a corporate-wide strategic plan, the information technology (IT) department at

Credit Valley Hospital in Mississauga, Ontario (Canada) was evaluating areas within the hospital that would yield the greatest benefit from process improvement. The team focused on registration, knowing that an improvement in the quality of data captured at that point would significantly impact a number of areas, including patient care and the business office.

There were a number of reasons why Credit Valley chose to reinvent its registration process. With more than 90 registration areas (six areas

off-site) and 170 registration users, it was difficult to monitor the accuracy or consistency of captured data. Inaccurate data capture leads to lost revenue, incorrect patient demographics, inaccurate abstract data sent to the Canadian Institute for Health Information (providing part of the basis for hospital and facility planning and funding, disease surveillance, public health expenditures, physician referral patterns, and other community based services), incorrect contact information (needed for effective disease surveillance), and the inability to standardize for addresses, postal codes, and residence codes.

Credit Valley began by working with the registration clerks to identify all the fields on registration screens that were misused, misinterpreted, or simply ignored. To enforce standardization, it developed an “electronic manager,” which would monitor users to ensure that all fields would be properly detected and completed. To ensure data quality and recover revenue, the hospital integrated an address validation product into the registration process, providing automated address look-ups.

As a clerk steps through the registration, popup screens stop the process and prompt for corrective action whenever a field is missed or if the data within the screen does not match acceptable rules, such as spelling out “Road” rather than using the abbreviated “Rd.”

Since completing this project, Credit Valley has experienced an 80 percent drop in address inaccuracies that slow revenue recovery. Any process enhancement, including this one, requires constant improvement and upgrades, but the hospital realizes that the financial and strategic rewards are well worth the work.

The Absent Patient

Sometimes the patient being admitted is actually a specimen being sent from a physician office or clinic. Generating accurate demographics from the third NCR copy that was hastily written out to accompany the specimen has lab workers hoping they can read the information correctly. These handwritten

forms often contain many inaccuracies, including wrong insurance or the wrong address. With lab personnel taking time to register patients using this information, there is a delay in ordering the lab work, and ultimately, there are billing delays, costly corrections, and re-billing issues.

Mount Auburn Hospital in Cambridge, Massachusetts, is part of CareGroup, Inc., representing more than 1,500 beds in seven acute care facilities with 53 sub-acute, ambulatory, and home health care facilities. The information systems (IS) director and his staff realized that if the samples and/or patients could be pre-registered, then the lab personnel could order the lab work needed without having to perform the registration based solely on the information delivered with the specimen. In addition, accurate pre-registration would save time and money by smoothing the billing process.

By automating the registration from the physician’s office IDX system directly to the hospital Meditech system, Mount Auburn has realized faster turnaround in billing with fewer corrections, and lab personnel is ordering lab work instead of registering patients.

Which Comes First, the Appointment or the Registration?

The chief information officer (CIO) and his staff at Saint Claire’s Hospital in Denville, N.J., have been focused on making information pervasive to the organization and in a format that allows for data mining, proper management oversight, accountability, and trending analyses. Along with making information accessible, they are charged with reducing and eliminating manual processes that are used to get data into critical systems. Among the many ways the hospital has been successful is pre-registering patients from the hospital’s scheduling system.

When an appointment is booked into the scheduling software, an interface carries it to the McKesson hospital information system (HIS) for registration. In addition, the automated process creates a log file, emails

results, and closes the applications. In this case, consistent and accurate patient demographics flow from system to system, eliminating corrections that can slow the revenue cycle.

As a result of automating the registration process, St. Claire's has reduced the number of manual pre-registers that need to be done by 80 percent and has liberated between one and three-quarters of a full-time employee (FTE).

Eligibility Checking

The ability to check on insurance eligibility at the point of registration is going to enhance the revenue cycle. Historically, hospitals have manually contacted third-party payers to obtain eligibility and coverage information. Currently, many payers offer Internet access on a single patient inquiry basis or use service bureau firms that provide these transactions in a batch or real-time mode. These transactions, however, have a cost associated with them, which the hospital must pay.

While efficient for many hospitals, very large organizations have visit volumes that make traditional per-transaction costs a significant budgetary burden. University of Pittsburgh Medical Center (UPMC) is one of these. To avoid these per-transaction charges, UPMC developed an automated process that goes directly to payers' Web sites to electronically obtain real-time insurance eligibility and then automatically post that information to the patient accounting portion of their McKesson

HIS. UPMC eliminated the service bureau costs and provided an alternative if the service bureau could not support a payer.

Given that UPMC has annual visit volumes of more than one million, the organization was able to eliminate the per-transaction costs and significantly reduce the risk of eligibility rejections and claims resubmissions. The process also eliminated most manual intervention, including the need to contact individual payers on the Web or by telephone, resulting in improved efficiency. By automating the file movement process in both directions, UPMC handled eligibility as a production job that did not require human intervention and could be run during the day or at night.

Registration data is the fuel for your revenue cycle. There are hundreds of touch points within the hospital that affect the revenue cycle. If you can ensure that the basic patient demographic information captured during registration is clean, accurate, and complete, you will establish the basis for quicker reimbursements in the short term and a faster, more remunerative revenue cycle in the long term. ■

Margaret Mayer is a director with Boston Software Systems. For more than 10 years, Ms. Mayer has been focused on workflow automation and systems integration for the health care industry. At Boston Software Systems, she directs all marketing activities, including market strategy, field and technical marketing management, marketing communications, and public relations. Prior to Boston Software Systems, she served as the vice president of corporate marketing at New Era of Networks.

High-Tech Tools Offer Hope in the Battle against Health Care Fraud

In 2009, health care fraud will cost the United States as much as \$485,000 *per minute*, according to statistics from the National Health Care Anti-Fraud Association (NHCAA),¹ which conservatively estimates that at least 3 percent (*i.e.*, \$60 billion) of the \$2 trillion spent on health care each year in this country is lost to fraud. While that is a staggering number by any standard, others have put a much higher

price tag on medical fraud, with some going as high as \$600 billion. While the exact number may never be known, the reality is that the number is huge, and it represents more than just lost dollars.

While speaking to the Senate Committee on the Judiciary, Subcommittee on Crime and Drugs earlier this year, Malcolm Sparrow, who

teaches regulatory and enforcement policy and operational risk control at Harvard's John F. Kennedy School of Government, made the following statement:

The units of measure for losses due to health care fraud and abuse in this country are hundreds of billions of dollars per year. We just don't know the first digit. It might be as low as one hundred billion. More likely two or three. Possibly four or five. But whatever that first digit is, it has eleven zeroes after it. These are staggering sums of money to waste, and the task of controlling and reducing these losses warrants a great deal of serious attention.²

"That is a pretty compelling statement," says Joel Portice, chief operating officer at Health-Care Insight (HCI), a Verisk Health company and a provider of clinically validated fraud, abuse, and overpayment prevention solutions for private and public-sector payors. "It recognizes that no matter what the first digit is, we are talking about a massive number. If you think about it in terms of the constraints of financing health care reform, it becomes even more significant. How many uninsured lives could be covered by the amount lost on health care fraud? How many programs could be sponsored, how much research could be conducted if this money could be repurposed in an attainable way? Maybe it can't complete the financing gap, but it certainly seems like a reasonable way to help supplement it."

The Use of Analytics to Combat Health Care Fraud

As technology continues to grow and evolve, more and more emphasis is being placed on predictive analytics and data modeling to track down, prevent, and recoup fraudulent activity in the health care industry. Properly designed analytics have the ability to recognize established patterns and emerging trends prior to money exchanging hands for a service.

"The application of sophisticated analytics and predictive modeling is critical," says Portice. "It breaks away from the pay-and-chase

method of billing and relies on intuitive pattern recognition to spot abnormalities."

For example, predictive modeling allows the system to recognize that peer providers in a specific region may practice in a homogenous way that is separate and distinct from other regions of the country. As the system filters through the data, it looks at providers and establishes acceptable practices and guidelines; it also recognizes any providers that fall outside of the norms by using statistical analysis. It can tell the difference between a single incident of abnormality and a consistent pattern of irregularity. It also can identify problems that occur at a specific code or procedure level (*e.g.*, a code typically used for small segments of the population being used with frequency).

Unlicensed Health Care Professionals

Health care fraud, however, is not just about inappropriate billing and coding, be it intention or unintentional. There is also the issue of individuals trying to cheat the system by billing for procedures for which they are not eligible to bill. In these instances, it's not just an issue from a plan's perspective or a self-funded employer's perspective of paying money to ineligible, inappropriate, or unqualified providers but also an issue of quality and the risk that the patient's care could be compromised as a result of an unlicensed health care professional.

For this reason, it is important to make sure that the information used to confirm the qualifications of these professionals is consistently updated and validated, says Portice, who is also co-founder of Enclarity, a health care information solutions company that manages and verifies data in real or near real time. "Too much is at stake for there to not be an emphasis on ensuring that providers are who they say they are. The tools and the resources are out there to identify claims before they are submitted or at the least allow payers to have access to the most current and complete information about the licensure and qualifications of those providers who are submitting claims. Given the enormity of the problem, the implications of not checking, and the efficiency with which someone can

now carry out the task, there really is no excuse for not checking.”

Are We Making Any Progress?

Despite the heightened attention on health care fraud over the last 10 or 20 years, the industry continues to struggle with the issue, admits Portice. “I have been in the health care technology space for over 15 years, and it simply amazes me that fraud is still an issue at the level it is. Unfortunately, whenever you have something that represents such a significant portion of our country’s gross domestic product, people who want to steal from it will figure out a way to do it.”

That doesn’t mean we shouldn’t be diligent in our efforts to stop fraud and abuse, stresses Portice. “There is a lot of runway left when it comes to detecting, preventing, and recouping fraudulent activity, and we must continue to fill the gap. We have made significant strides in health care, and we cannot give up that effort. There is too much at stake—from a financial perspective, but more importantly, from a patient perspective.” ■

Endnotes:

1. www.nhcaa.org.
2. www.hks.harvard.edu/news-events/news/testimonies/sparrow-senate-testimony.

Remote Monitoring Devices Help Rural Health Centers Keep A Closer Eye on the Chronically Ill

In 2004, the North Carolina Health and Wellness Trust Fund (HWTF) voted to address the growing problem of health disparities in that state by allocating funds for a three-year initiative focused on reducing disparities for children, youth, and adults related to obesity and chronic diseases. Although Phase I of the health disparities project officially ended in June, a second phase has extended the project for another three years.

Roanoke Chowan Community Health Center (RCCHC), a federally qualified health center located in Ahoskie, North Carolina, was one of the original organizations selected for the health disparities project. In July 2006, RCCHC was awarded a grant from HWTF to implement a patient-provider telehealth network, with a focus on patients with cardiovascular disease, diabetes, or hypertension who have frequent hospitalizations, frequent emergency room visits, or restricted access to care.

“We said to the primary care providers, ‘Give us your worst chronically ill patients, the ones at greatest risk of developing complications from diabetes or heart disease,’ and we will help those patients who can’t help themselves,” notes Bonnie Perry Britton, MSN, RN, telehealth

clinical network director and development director for RCCHC. “We started with 25 in-home monitors and set up indicators based on what their primary care providers told us about their health. We then developed a set of questions for each patient, which helped us generate data specific to the patient and the patient’s condition. Based on that information, a nurse began monitoring the patient’s health remotely. The data then looped back to the primary care provider, who determined appropriate treatment for the patient.”

Britton grew up in the rural Northeastern corner of North Carolina but left for college immediately after high school to pursue a career in health care. In 2004, she returned to the area after a long absence only to find that nothing had changed. Health disparities were the same. Access to care was the same. Poverty and illiteracy were the same. The region was number one in the state for heart disease, diabetes, and childhood obesity.

“I was stunned at what I saw,” says Britton. “Twenty-one percent of our residents were uninsured. We have only a 41 percent high school completion rate. The median income in the region was \$21,000 per year. We have a

general lack of education on exercise, diet, and disease management. A lot of patients don't even know what a normal blood pressure is. Many do not have basic transportation to get to and from a doctor's visit. Needless to say, there were some barriers to overcome."

Some of those barriers, however, are beginning to crumble, says Britton. For example, transportation is no longer the barrier it once was because of the decreased need for patients to physically go to a physician's office for a visit, thanks to remote monitoring devices now being used. Health care professionals can now "see" these patients from a distance.

RCCHC has served 198 patients through the HWTF project to date. The average length of stay is between six and seven months, and reduction in hospitalization is at 39 percent, from six months prior to receiving the remote monitoring devices to the six months spent actively participating in the program. There was also a 70 percent reduction in total hospital charges. In addition, the program has helped increase patient medication compliance and increased the patients' understanding of their disease, notes Britton.

RCCHC has moved into Phase II of the project, thanks to an \$870,000 grant from the HWTF Commission aimed at replicating the results of Phase I in six additional community health centers in North Carolina. For the next three years, these clinics will use Ideal Life's wireless remote monitoring devices to monitor Medicaid patients with heart failure or cardiovascular disease, who will monitor their weight fluctuations with the Ideal Life Body Manager (digital scale) and the Ideal Life BP Manager (blood pressure device).

Each blood pressure device and digital scale wirelessly and automatically sends readings to health care professionals who monitor the data and intervene, if necessary, by contacting the patient's primary care provider. This can help avoid a health crisis that might otherwise require a costly visit to the emergency room or re-hospitalization—a significant plus for

those without close proximity to major medical centers.

Community health centers participating in Phase II of the HWTF project include RCCHC, Bertie Rural Health, Greene County Health Services, Kinston Community Health Center, Rural Health Group, Tri-County Community Health Center, and Cabarrus Community Health Center.

Ideal Life

The technology behind Ideal Life is designed with a very clear purpose, explains Jason Goldberg, Ideal Life's founder and president. That purpose is to create a technology bridge between Visit A to the physician and Visit B to ensure fewer gaps of information flow and thereby improve patient care.

"With the increasing trend of health care moving out of the institutional setting and patients becoming more mobile, it is even more critical to ensure there are no gaps in communication," notes Goldberg. "What if a Type I diabetic heads out for a meal at a restaurant or a friend's house and decides to check his blood sugar? A continuous blood glucose monitor allows him to do so. The idea [of remote monitoring devices] is to create an engine that allows data to be captured and collected around the lifestyle of the consumer."

The technology embedded in the Ideal Life medical devices can attach to existing devices in the field, allowing the medical device to act as a window of communication. The information is then communicated to a gateway, such as a Bluetooth enabled cell phone, a land line, or the Internet. The patient's data is then communicated to a remote repository that manages and communicates the data to the appropriate parties involved in the continuum of care for the patient.

"As a company, we felt it was important to deliver devices in the consumer's home that were natural extensions of existing behaviors, but we also wanted to develop an open technology platform that allowed easy-to-use

information gathering for all parties involved,” says Goldberg. “As an extension of that, we also wanted the platform to be flexible to allow the different groups to share data and customize that data to their own needs. A doctor might want to see long-term trends. Family members might want to see progress on a daily basis. The health plan might want to ensure that care plans are followed. Our mission

was to accommodate those different needs without adding yet another screen to the mix.”

For additional information about the NC Health and Wellness Trust Fund, go to www.HealthWellNC.com. For additional information about Ideal Life, go to www.ideallifeonline.com. For additional information about RCCHC, go to www.rcchc.org. ■

State Governments Now Have Access to NaviNet Health Information Exchange

In a letter sent out recently to governors across the country, NaviNet Chief Executive Officer Brad Waugh announced the availability of the NaviNet Health Information Exchange (HIE) to all state governments and U.S. territories *free of charge*. Effective immediately, states can utilize the HIE as their technology backbone for statewide initiatives, thereby linking health care providers and payers through one common communication network.

The NaviNet HIE enables physicians, clinicians, hospitals, ancillary care providers, insurers, and existing HIEs to exchange information in real-time within NaviNet’s established, secure, and trusted network of more than 770,000 providers nationwide. Participation in the NaviNet HIE requires minimal to no investment in new technologies and offers a rapid, cost effective way to connect stakeholders for electronic health information exchange. NaviNet is already used by two out of every three U.S. health care providers and leading national, commercial, and Blues health plans.

“As we were watching the market and hearing renewed conversations at the state level about the need for HIEs, we realized states might begin to scramble around and try to figure out how to implement these systems without realizing they have something working in their state that essentially does this for them,” explains Kendra Obrist, chief marketing officer of NaviNet. “We did not see the need for states to invest any dollars in creating something

that already exists. It makes a lot more sense for them to simply build on top of what has already been developed.”

It goes beyond the cost of development, however, says Obrist. “One of the challenges states face—or at least the regions we have worked with—is that they oftentimes rely on grant money to develop health exchanges. This has its limitations. There may be enough cash to get something started, but there’s no business model or ongoing revenue stream to cover daily operating expenses. One of the things we bring to the table is an existing, ongoing revenue model.”

Much of the emphasis on statewide HIEs stems from the federal government’s recent push to have states take a more active role in defining and creating information exchanges or else miss out on federal stimulus dollars, notes Obrist. The federal government will only disburse stimulus funds at the state level—an intentional move by the federal government to create cohesion with each state and give states more control over the way the exchanges are developed.

“The government said, ‘There will be this definition of meaningful use and a set of criteria that must be met;’ if not, there will be no incentives, and there could even be penalties down the road,” explains Obrist. “The federal government told physicians they must participate in statewide initiatives to

fulfill these criteria and, therefore, earn their stimulus dollars. At the same time, the federal government told states to come up with an exchange to allow the physicians to reach these goals. It's a complicated web. Each state will approach it a little differently, but the emphasis of the federal government was on giving the states the power to create governance and policy that was consistent across the state, thereby increasing the chances of getting these exchanges off the ground successfully.”

States will have to decide how they want to approach the development of these initiatives, adds Obrist. Do they simply want to play a governance and policy role and let the free market and private market create the exchange

within that construct? Do they go out and choose a company to implement and run the exchange for them? Do they run the exchange themselves? There are a lot of options, and each state will have to decide independently how to achieve success.

The foundation of the exchange is up and running already. The next major piece of functionality that will be added is a peer-to-peer messaging channel, which allows anyone who uses a NaviNet network to communicate with another physician, hospital, laboratory, et cetera. That feature will be available early next year.

For additional information about NaviNet, go to www.NaviNet.net. ■