

AT WORK: POPULATION HEALTH AND CARE TRANSITIONS



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When it comes to the growing role of population health and care transitions, Terry Altpeter, PhD EJD RN CPHQ PCC, has a simple and rather direct message for fellow NAHQ members: “It’s coming, so be prepared! Seek the chance to learn about population health and care transitions. Read about it, discuss it with colleagues, turn to other healthcare quality subject matter experts, and embrace change.”

Why? Because “it is a new day in healthcare, and those of us in the profession are experiencing something exciting,” she says. “We need to support each other, no matter what area of healthcare we work in. Increasingly, data is transparent and technology is linking all of us together.”

Altpeter concedes that there is much to learn about population health and care transitions, both inside and outside of healthcare. Each sector influences the other—a lesson she learned hearing about prisoner population health while studying to become a certified population care coordinator (PCC). Likewise, her active involvement in NAHQ’s Population Health and Care Transitions work group has “opened [her] eyes to the experiences that other quality professionals have in different areas” of population health and care transitions, including insurance.

It’s just one of the reasons why she loves the NAHQ project work, although she is quick to credit NAHQ with connecting her with other state affiliates and providing a means for networking. “I really enjoy the national Population Health and Care Transitions work group. I am honored to colead a team with such expertise from various parts of the country and in various aspects of healthcare,” says Altpeter, who currently serves as president of the Kentucky Association for Healthcare Quality.

She also encourages colleagues to earn their CPHQ, believing the certification helps distinguish healthcare quality professionals. And with so much change in healthcare today, “if you are

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a healthcare quality professional and have your CPHQ, you’re going to be part of the population health movement in some way,” she says.

As such, Altpeter stresses that healthcare quality professionals should pay close attention to the wellness movement in coming years. “High-risk patients are already getting the services they need because we know who those patients are. However, the people in the middle—those who don’t know how to self-manage or learn wellness behaviors, or don’t have a support system in place at home—need resources and services to avoid becoming high-risk patients in the future.”

Although the electronic medical record (EMR) helps patients navigate the healthcare system—from hospitals to primary care physician offices to clinics and surgery centers—more needs to be done to track patients throughout the entire continuum of care, including those at home and in the community, she says. Then, more focus needs to be paid to social issues affecting care beyond inpatient care.

“We need to evaluate the social issues that impact the ability of a patient to remain at home, remain healthy, and have access to services so they can self-manage their condition. There are many evidence-based models that demonstrate care transitions, which lead to population health models,” Altpeter says.

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She notes that when her hospital piloted a transition-of-care program to track patients for a month after discharge, it found that instituting various postdischarge touch points with patients—visiting the home, making follow-up calls, writing a good care plan, helping patients maintain personal health records, looking at medication and diet issues—greatly affected hospital readmissions. In fact, hospital readmissions were double for those who were not enrolled in the program compared to those in the program.

Population health studies can often reveal some surprising results, Altpeter adds. She recalls that when reviewing a county assessment for a PCC certification class, she found that, in a Kentucky county closely tied with tobacco production, healthcare costs were actually more linked to alcohol-related deaths than tobacco use, obesity, or diabetes.

On a personal note, Altpeter says she enjoys focusing on patients transitioning from inpatient care to other providers, such as home, subacute, home health, or rehabilitation. “It’s interesting to look at those transitions and actually develop some type of program around that,” she says. “One of my goals is to institute processes and services that meet the needs of a given population. I enjoy working with community agencies and resources in care coordination and, ideally, would like to lead these efforts and evaluate outcomes.”

CHALLENGES

Still, challenges wait in the areas of care transitions, community-care delivery, and disease management. “One challenge is that patients don’t present with just one chronic disease, but with a variety of them. You can’t place a person in one bucket to do disease management; you pretty much have to widen your vision or scope because patients fall into multiple buckets,” she says. Likewise, “you can’t discharge patients to one entity, such as a heart failure clinic, when they have other conditions such as chronic obstructive pulmonary disease.”

She adds: “We’ve become a chronic disease country with more complex needs. I believe that the population health movement will try to allow patients to self-manage their recovery or illness, but we need community resources to do that. Community entities and healthcare systems need to break down walls and be more collaborative than competitive. In population health, you may need to partner with other healthcare providers and community-based agencies because they may have a particular service you don’t have. Not everybody is going to have everything that meets patients’ needs. We must try to make sure that patient and family needs are met.”



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