Catholic Health Systems Steer the New Course

BY MARK CRAWFORD

Health care systems, traditionally focused on acute care for individuals, have new marching orders under health reform: to direct greater efforts toward improving population health. Some organizations are just starting to strategize about population health; others recognized the importance of managing population health years ago and have implemented groundbreaking programs that are saving millions of dollars each year, improving patient satisfaction and positioning these organizations as visionary leaders that get results — efforts that may prove to be a competitive advantage when the Affordable Care Act (ACA) is fully implemented.

Most health care leaders define population health as managing the care of a discrete group of individuals in a coordinated way that achieves improved outcomes at lower cost. The group can be an entire community, a segment of that community, a base of employees or people who simply are categorized by demographics or condition. The key is focusing on the entire population — how does it access care, and how can its needs be better met through a more integrated approach to health care delivery?

To determine how Catholic health leaders are preparing for this new future, *Health Progress* interviewed executives at four Catholic systems.

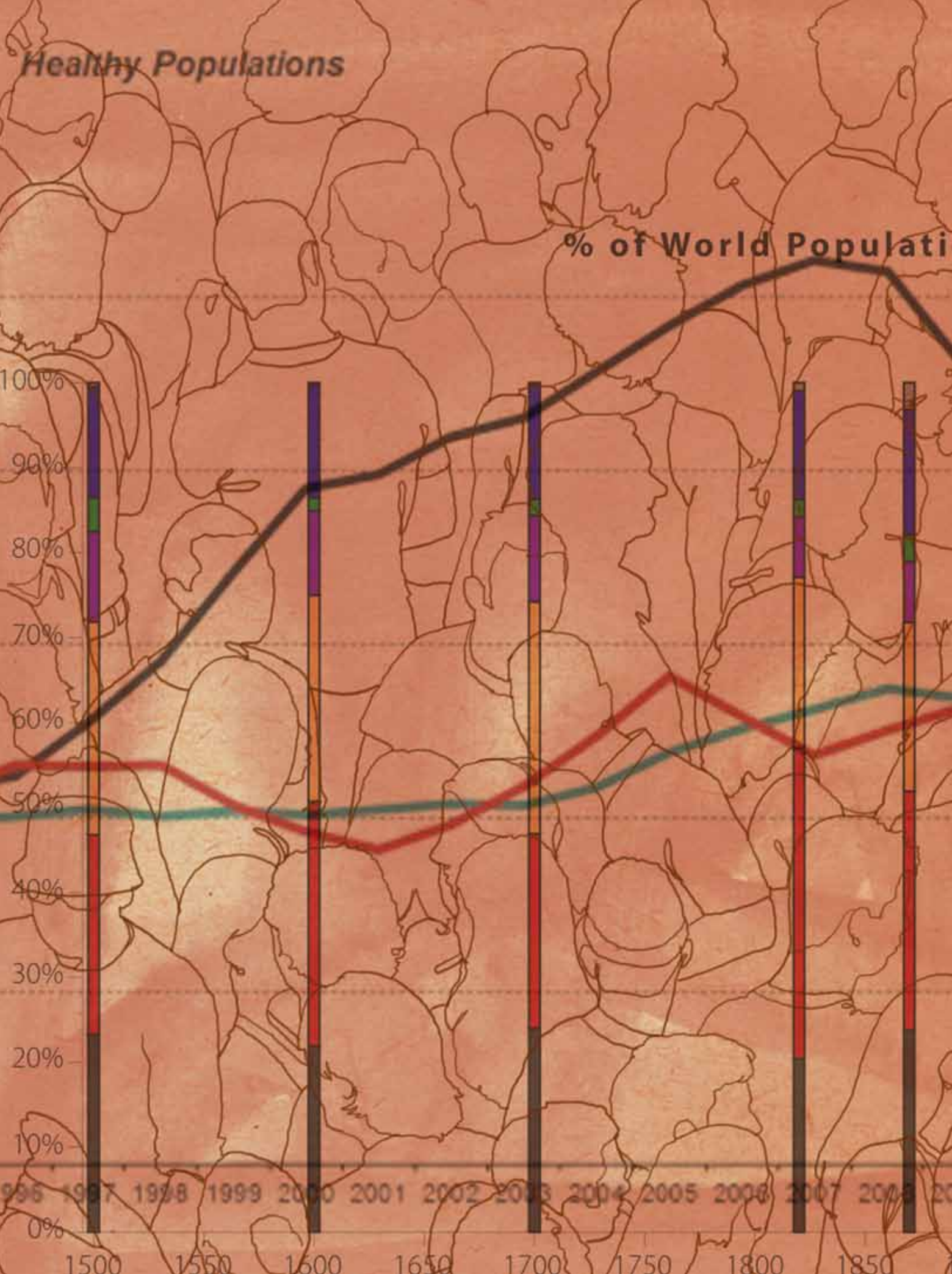
Christopher Stanley, vice president of care management for Catholic Health Initiatives (CHI) in Englewood, Colo., said, "With population health, patient outcomes are improved through a more structured, team-based approach that deals with key areas such as improving quality, managing costs and enhancing the experience of the entire population."

"As a system," noted Vondie Woodbury, director of community benefit for Trinity Health in Livonia, Mich., "our internal discussions around population health often focus on the embedded populations in the health plans we participate in, such as Medicare, Medicaid and commercial plans. However, in the community benefit world, we look at the totality of a community's health — the insured, the uninsured, everyone. This speaks to our historic mission in the community, especially our commitment to social justice and addressing health disparities. At Trinity we define population health as the overall health and well-being of the communities we serve. Population health pushes us to take an inclusive look at the places we live and the people who live there."

Population health management is at the center of the "Triple Aim" initiative proposed in 2007 by the Institute for Health Care Improvement that calls for:

- Improved patient experience of care (including quality and satisfaction)
- Improved health of populations
- Reduced per-capita cost of health care

According to the Centers for Medicare and Medicaid Services, a population of 5,000 is the generally accepted minimum size for a population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group served by an accountable care organization (ACO). However, the methodologies that are considered best practices for population health management are fully scalable; they can be applied to population groups of any size.

"Managing population health is a key part of moving from a payment-for-volume system to payment-for-value reimbursement system," said Craig Wright, chief executive for physicians and clinical programs for Providence Health and Services in Portland, Ore. "Population health initiatives help align the financial incentives needed to achieve 'Triple Aim' outcomes."

DRIVING FORCES

Population health management is essential for achieving the higher-quality, lower-cost outcomes expected under the ACA, which will be providing Medicaid coverage for about 18 million previously uninsured Americans.

"Many states like Oregon are driving toward population health strategies to expand Medicaid coverage at a predictable price," said Wright.

"This is a period of great change where we are confronted with a reimbursement structure that demands we focus on keeping people healthy," said Woodbury. "Health, as we all know, is multifaceted and hard-wired to the community itself. If we are to help people sustain health we must factor in outside variables — the behavioral norms in the community, the environment and other things that influence whether or not our patient populations can maintain health."

Interconnectivity, communication and quick response are key components for any effective population health management strategy.

For example, the ACA is very specific in its challenge to tax-exempt hospitals to work with those who have public health expertise (as well as other community stakeholders) on community health needs assessments.

"This is an expanded footprint for our community benefit function," Woodbury said. "It is an opportunity to get in front of the local factors that drive early onset disease and disability in a population. These assessments are intended to help us understand where there are problems in our communities and encourage expanded partnerships to solve them."

For Catholic health care systems, population health management also fits well with mission. "Mission formation teaches us that our founders embraced their communities and the people who lived there," Woodbury said. "Led by faith, we continue this legacy of improving the lives of all of the people in our communities, with emphasis on the poor and the frail — those who need us the most."

POPULATION HEALTH IN ACTION

Woodbury regards population health management as a "holistic approach" that deals with individuals within their communities — not just in a Trinity waiting room.

"We can improve patient compliance, avoid readmissions and improve health outcomes if we engage in prevention programming or target areas where people struggle," she said. "We would certainly expect to see and measure impacts from the dollars we spend on community benefit. There should also be a reduction in silo-type efforts to solve community problems and an increase in opportunities to work collectively across nontraditional stakeholder sectors."

Improved case management, phone management for chronic diseases and the use of health coaches are some of the strategies being used to better manage population health, Wright said. "We are developing Medicaid programs to help lower-income families and also have mature Medicare Advantage programs we are expanding. We are also working with larger employers to develop medical-home services for their employees and their families."

About three years ago, CHI began developing its own population health strategy. The plan is almost complete and will be rolled out over the next few years. The innovative strategies have been designed to significantly improve care and efficiency while reducing costs. "Key to this success," Stanley said, "will be a patient-centered approach that deals with the upstream causes of poor health, including poor nutrition, substance abuse and lack of physical activity."

One of these strategies is called the Extensive Care Clinic. The concept was initially developed in southern California and focuses on patient-centered care in an outpatient setting. The patient group consists of individuals with multiple chronic conditions who visit hospitals or ERs the most frequently.

"We will place a very skilled doctor — almost

like an intensive-care physician — in an outpatient clinic, supported by a strong clinical team that includes a nurse, case manager, respiratory therapist, pharmacist and possibly even palliative care specialists," said Stanley. "Studies have shown that this kind of approach can reduce the amount of hospital time for these patients by about 50 percent."

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Trinity Health is in the process of implementing a public health curriculum for its leaders that was developed by the Public Health Institute in California. The three modules consist of government public health, population and community health (determinants of health, community partnerships) and community benefit (health needs assessments, health care transformation and strategic investment).

"The initial pilot includes 10 leaders from across the continuum of Trinity Health," said Woodbury. "The online sessions will be supported through expert facilitated discussions conducted by the California Public Health Institute. These discussions will allow for peer-to-peer learning and an in-depth review and practical application of the learning modules."

Several years ago Trinity Health also developed its Community Health Network Area (CHNA) Workbook, which directs its ministry organizations to reach out to public health departments and other groups such as United Way and chambers of commerce. "We did this in advance of passage of the ACA, and now we are starting to see the impact of that decision," said Woodbury. "Many of our ministry organizations are collaborating with other community groups to move beyond the needs assessment function. These types of efforts are really the vehicles for community change."

Trinity Health is also involved with a broad-based national collaborative that is developing and implementing a new website. Partners include the Centers for Disease Control and Prevention, Catholic Health Association, United Way World Wide and health system leaders. The website, called CHNA.org, will aggregate over 7,000 publicly available data sets to streamline the development of needs assessments and reduce the time and cost of pulling data. The site will allow any user to geo-map data — everything from food "deserts" to areas of significant poverty.

"This new tool will let us better understand where we should invest our limited community benefit dollars to target our resources into populations and locations that need help the most," said Woodbury.

MAKING IT WORK

Sisters of Providence Health System (SPHS) in Holyoke, Mass. is one of those health care organizations that started investing in population health management years ago and even established its own ACO. These efforts have improved outcomes and reduced costs by integrating care delivery, limiting or eliminating unnecessary utilization, improving disease and chronic care management, reducing hospital admissions and readmissions and effectively using palliative care when needed.

Mark Fulco, senior vice president of strategy and marketing for SPHS, emphasized the importance of having the necessary tools for launching a population health strategy.

"If it can't be measured, it can't be managed," he said. "There must be a set of tools for recording key information about the population group and tracking the management of its care. There must also be a set of evidence-based, best-practice clinical guidelines used to manage the care of the patient population. Together the tracking tools and guidelines can help assure appropriate care and improved outcomes for individual patients and groups or populations of patients."

Proper data analytics will identify "actionable opportunities" that are key moments in responding to a patient's care. For example, what is the trigger behind a patient's visit to a physician's office, ER or hospital?

"If that trigger was an episode related to a chronic illness such as diabetes, for example, that person can be placed in a disease management program that might include more in-home care from a nurse practitioner with telephonic follow-up," said Fulco.

CHI's Stanley agreed that access to timely, reliable, accurate and standardized data is essential for success — which typically involves a significant information technology investment. "A system-wide data warehouse must be developed in which all data, from every point of care, including the hospital, physician's office, pharmacy and payer, is deposited, managed and analyzed," he said.

Patient registries also can be created to sort data according to various parameters to reveal subtle trends. Health systems can produce reports for physicians that show if patients went through all the appropriate steps as recommended by its clinical care guidelines. The data can also reveal

which doctors have the highest rate of hospital admissions or ER visits for their patients, or rates of deviation from clinical guidelines and protocols (the highest amount of "spend") — which might result in a protocol review or peer-to-peer intervention to find the cause of the variance. Identifying referral patterns is also beneficial for tracking compliance — for example, are patients staying in network or going out of network? Data warehousing and data mining can provide these valuable numbers and trends.

This approach has paid off for SPHS. "For example, in our Medicare Advantage patient cohort, the top 3 percent of this group [the most health compromised] consumes about 50 percent of the total spend on that group. When this 3 percent is managed more closely and receives the services they need when they need them, that total spend drops to 42 percent — a savings of $10 million."

CHANGING THE CULTURE

One of the biggest challenges in population health management is the cultural change required in order for it to succeed.

"Physicians must learn to think differently," said Stanley. "They must think beyond the 25 patients they see every day in their office to the hundreds that aren't coming in for various reasons. It is critical to think in broader terms of how to effectively treat a population, instead of just an individual."

This also means moving away from fee-for-service and fundamentally redesigning systems of care so they reward improved population health outcomes. The short-term goal is improving quality of care through innovative best practices that better coordinate medical services. "Longer term," said Wright, "we need to drive waste out of health care services by limiting utilization that doesn't add real value for our patients."

Woodbury urged health care systems to find opportunities to integrate population/community health into their programs and initiatives. "Take one thing and pull a group together — for example, childhood asthma, eating disorders, substance abuse," she said. "Find common ground around an issue and maximize impact. Take that collaborative and create two subgroups — one on prevention and one on treatment. Start communicating and sharing ideas. Be aggressive, and take the time to learn about the very critical role that public health plays in our communities."

In general, savvy health care leaders agree on five essential factors for making a population health strategy work:

- Buy-in from executive leadership and all stakeholders
- Due diligence regarding the systems that will be required (including vendor selection)
- Investment in the infrastructure, IT and staff
- Study and aggressively implement best practices
- Eliminate staff who retain "fee-for-service" mentality and refuse to change practice patterns

Recognizing and responding to community factors is also critical for success.

"To be successful at cost management, reducing readmissions and sustaining wellness for our patients, we cannot avoid the impact of these external community factors," said Woodbury. "In short, we need to think more strategically about the environments in which our patients live. What is the impact of that environment on sustained health improvement? Let's move away from random acts toward collaborative activities and invest in these with others to maximize population health in our communities."

Improved population health also enhances the overall economic performance in a region. Companies want to locate or expand in communities that have easy access to high-quality, affordable health care in order to keep their health care premiums down and also provide a high quality of life for employees.

"Any chamber of commerce president can articulate what a growing business or a possible prospect looks for in choosing a location, such as cost of health coverage, the local environment, levels of poverty, etc.," concluded Woodbury. "A healthy population therefore not only helps the health care system's bottom line, but also the economic vitality of its communities."

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JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

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Reprinted from *Health Progress*, January - February 2013