Developing an Aging Strategy for the Future

Catholic Health East Establishes a 2017 Preferred Health Care Delivery Model

Catholic Health East (CHE) management has been challenged by our sponsors and board to be more than a hospital system, to be "a healing ministry in a variety of settings across the continuum of care." Our core values move us in that direction as we focus on reverence for each person, community, justice, commitment to the poor, stewardship, courage and integrity.

CHE's regional health corporations are located in 11 states from Maine to Florida. With more than 50,000 colleagues, CHE is the eighth largest health system in the country; the fourth largest Catholic health system. It is also the largest not-for-profit provider of home health services in the nation; and, among health systems, the largest sponsor of senior living programs.

As CHE began envisioning its future, its stakeholders engaged in a process that addressed fundamental questions about the ministry: Do we continue to focus on acute care and put our energies into incremental changes in various acute care service lines and new technology? Or, do we take a more radical approach to envision our preferred future for health care delivery? We chose the more radical approach by developing a 2017 Preferred Health Care Delivery Model.

Vision for Continuing Care

The first step in this change process began in November 2004 with continuing care services. CHE's board and sponsors reviewed reports projecting the rapid growth of adults 85 years old and above, the underperformance of the nation's health care delivery system, and the intersection of these two trends. Assessing these findings, these leaders stressed that continuing care services must be a core ministry of CHE and an integral component of our local ministries. That mandate set in motion a series of intensive planning activities, including two rapid design processes of two to three days each.

In these sessions, key leaders – from board members to direct service providers from both acute and continuing care services – engaged in clarifying CHE's vision for continuing care services. Part of the process was to gather service-line experts to explore where their respective continuing care service lines would evolve during the next 10 years and how to position CHE to take advantage of those opportunities. We also set in motion a two-year system for raising awareness about these continuing care opportunities, first by assessing our current scope, capacity and market positioning throughout CHE. It was called our Continuing Care Mission Synergy Initiative.

The vision statement for continuing care urges CHE providers "to be known for facilitating access and providing excellent and coordinated comprehensive care." It encourages staff to do the following:

- employ innovative models of coordination and delivery
- embrace holistic and person-centered approaches for care and service
- use best practices to achieve demonstrated outcomes
- provide a continuum of services that are responsive to people's needs and choices throughout their lives
- apply interactive and integrated information and clinical technology
- lead in preparing the next generation of competent, caring, compassionate specialists and caregivers
- partner with community and faith-based organizations throughout the process

This continuing care focus began to shape the thinking of CHE relative to the future of its overall ministry.

CHE Strategic Management Process

In 2006, CHE launched a system-wide strategic management practice that asked stakeholders to

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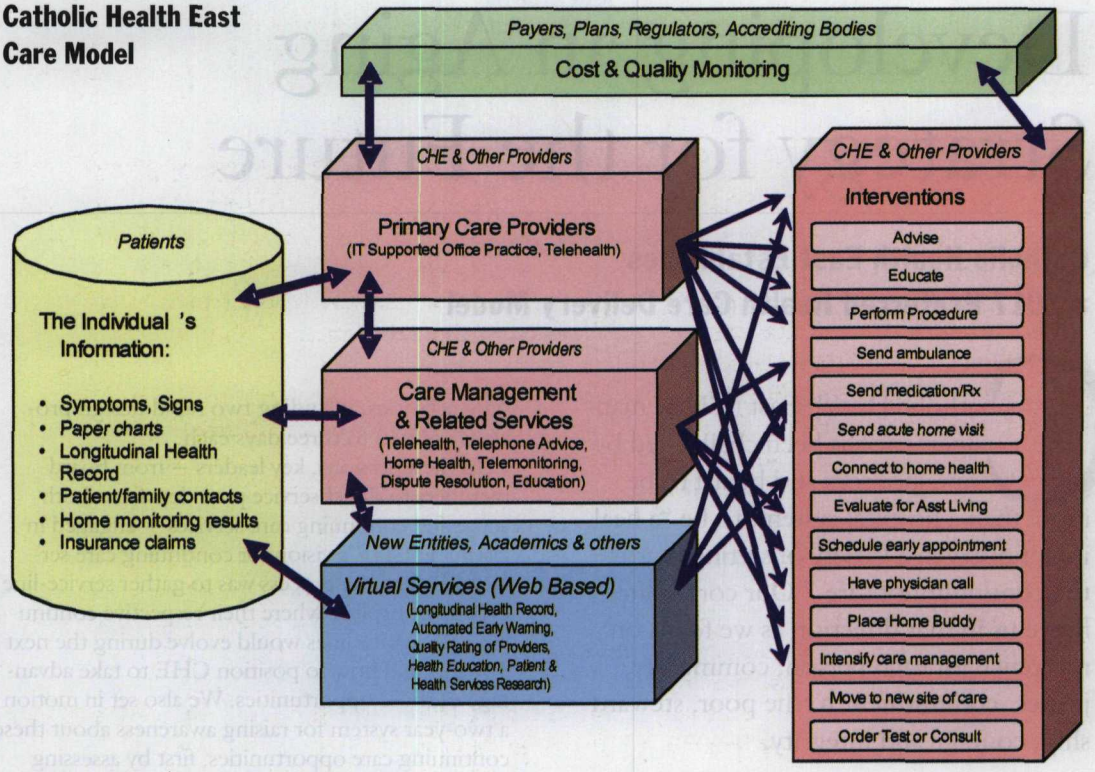
Catholic Health East Care Model



begin with the end in mind, to envision a preferred future for health care delivery for the year 2017. Again, we gathered various key leaders from across the system, including board members, sponsors, executives, managers and direct caregivers. We asked them what kind of health system they themselves would want to experience by 2017. Many of them currently are caught up in the process of caring for their children and families, as well as for aging parents. They spoke from personal experience describing their hands-on difficulties and frustrations in dealing with the episodic, acute-focused, fragmented care delivery system.

CHE again used a rapid design process to develop key concepts with these stakeholders about a preferred health care delivery model. The results of the process were vetted with more than 400 colleagues throughout CHE giving them an opportunity to comment on the vision and direction being crafted.

Key elements of CHE's 2017 Preferred Health Care Delivery Model were articulated as follows:

- universal access to information that is available regardless of whether the provider is a member of CHE
- a secure IT infrastructure that enables access to one's personal health records by oneself and professionals providing care
- integrated care management that provides each person with a written health assessment, multi-disciplinary care plan and access to the broader health care delivery system
- establish linkages with other components of the health care system that ensure seamless and flawless transfer from one level to another
- effective management of chronic disease and help in coping with the aging process

In this role, CHE would develop a mechanism to provide linkages between persons and the services they need, potentially acting as an advisor or broker. The tactic highlighted the need for tighter connections with non-traditional community partners as well as new forms of community-based services. CHE becomes the coordinator of care in this new preferred delivery model, a role that would enhance the provision of comprehensive care management across the continuum, particularly for functionally frail elderly persons and those with chronic, debilitating conditions.

Comprehensive Care Management

In response to these articulated elements, a task force was formed to develop CHE's comprehensive care management model, which is defined as "a value-based, person-centered collaborative system of support and caring that promotes health-enhancing relationships through efficient and effective care (see chart above). Comprehensive care management connects individuals with infor-

mation to make informed decisions about provider services and programs that support their holistic and spiritual needs throughout their lives. The goal is to optimize each individual's potential through informed decision-making, effective communication and process facilitation resulting in the right care delivered in the right setting at the right time."

CHE's 2017 Preferred Health Care Delivery Model includes the two missing pieces in the current health care delivery system. First, virtual services would largely be available through web-based electronic records. Through these web-based services that will exist either through a new entity or linked with current providers, we will have a comprehensive database to store data for longitudinal health records that will provide a range of services, such as automatic early warnings relative to preventive services and notifications of new treatments.

Second, CHE's approach to care management would fill another gap. This is where we, as a health system, want to make a difference. Our goal is to be patient-focused, during the patient's lifespan, in a holistic way that includes attention to physical, emotional and spiritual needs. The function needs to be highly IT-enabled and to cut across the entire continuum of care, enabling higher integration with primary care providers. A care management approach will serve as a resource for advice; for monitoring even in the home; for assisting with the coordination of care for persons serving as their advocates; and a source of personal support as they move through the health system.

To achieve our vision for care management, a range of application software, technology and integration, and other telecommunications capabilities will be required. These include a patient portal; a secure online mechanism for patients to manage their care and to interact with CHE. It's a safe way to communicate with their provider at any time, ranging from requesting appointments, prescription renewals, or getting test results. A second category of IT-enabling services includes patient management tools, such as personal health records and home monitoring systems.

This care management process will require the development of long-term relationships based on trust. We must be able to convince patients and their families that we are there for their benefit, even if this means referring to care outside of our entities or facilities. To be successful, a care management entity must earn and keep the respect of the patients it serves. The patients and their families must be certain they are being referred to the best provider, not to the one with a financial relationship with the care management entity. CHE officials intend to create the financial incentive structure necessary to establish and maintain that trust.

As we build this new system, we undoubtedly will need to enter into joint ventures with our physicians. In that regard, information must flow freely. We will have to move beyond the barriers that we have constructed regarding sharing of information with physicians and other providers. We acknowledge that components of the new model are performed today by individuals and small teams with varying degrees of collaboration and efficiency, generally without adequate information and system support. We also recognize that in many cases the reimbursement models do not encourage, reward, or even permit the development and deployment of this comprehensive model. However, we are convinced that patients need and want such a model and that they, and ultimately all payers, will reward plans and providers that deliver the envisioned services.

To some, much of what has been described sounds idealistic. However, the reality of care management is not new. There are examples of care management approaches with primary care providers relative to discharge planning; specialists, particularly in disease-focused situations, have comprehensive approaches for dialysis, congestive heart failure, and some include telehealth. In home care, we similarly see examples of comprehensive care plans and monitoring approaches. Today, however, care management is limited in scope, focused on utilization rather than on quality, and is not supported by comprehensive information systems or by reimbursement mechanisms that are coordinated across the continuum. It is toward this goal of comprehensive care management across the continuum of care that CHE is determined to move.

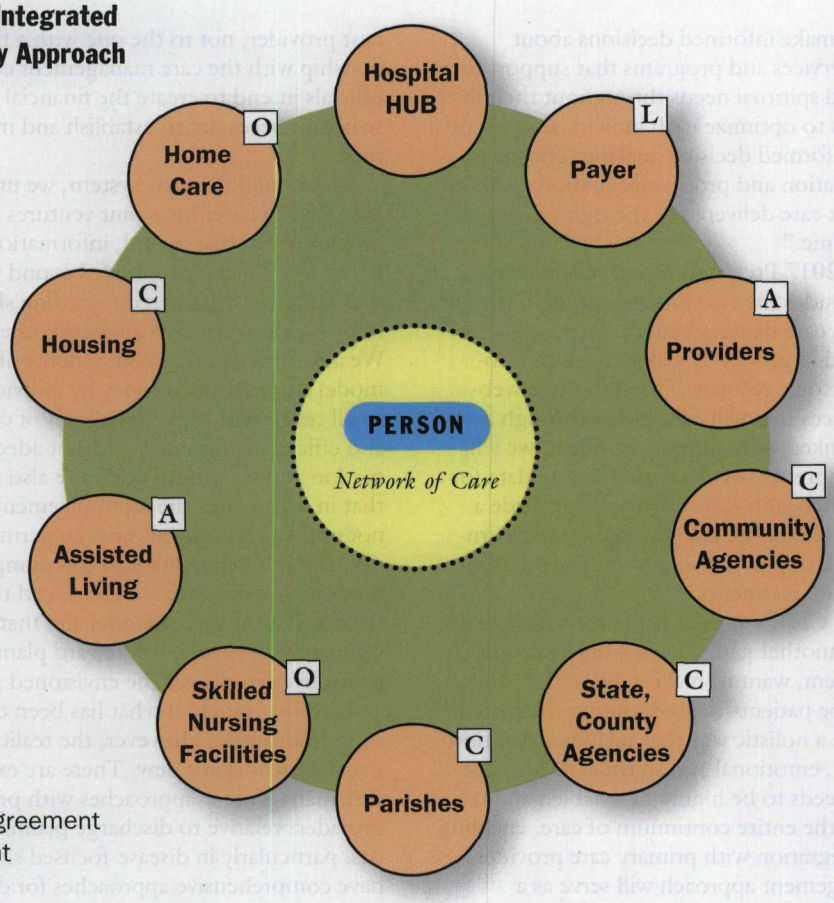
How Do We Get There From Here?

CHE has envisioned the 2017 Preferred Health Care Delivery Model just described. To "get there from here" with our regional health systems, we outlined four phases:

Phase I: In-House Restructuring

This includes an in-house regional health corporation restructuring. It calls for reorganizing hospital services into a "HUB" where the potential for heightening care management coordination, streamlining of processes and planning can take place. Engagement of physicians, payers, related departments and programs within and without

Phase III: Integrated Community Approach



Examples—RHC
O — Owned
A — Affiliate
C — Collaborative Agreement
L — Legal Agreement

the hospital is essential. Comprehensive care management "champions" are instrumental for the success of this process as well. Involving stakeholders in initiating a change management process across component areas, bringing key processes together in one department as internal hub, developing manual and automated linkages, and initiating payer dialogue are key requirements of this phase. The intended outcome will be a more streamlined, coordinated approach to care management.

Phase II: Enabling Initiatives, Primarily IT

This deals primarily with IT-enabling initiatives. The focus is on a) having stakeholders identify information services needs and gaps; b) developing and refining standard nomenclature across all entities; c) developing and adapting disease-management protocols and patient-friendly content; and d) implementing personal electronic record and patient portals for patient electronic access to providers. In this phase, we will develop the ability to capture clinical data in all treatment settings across the continuum and store these data in a longitudinal repository. The outcome we seek is IT-enabled, seamless care processes with patient connectivity.

Phase III: Integrated Community Approach

In years 2 to 5, this phase includes assuring linkages for an integrated community approach. With the patient as the center of the care delivery system, we will reach out to others through building, buying, networking or developing collaboration scenarios for filling gaps in our continuum of services. The goal will be a connected network of services across the continuum. (See chart above.)

Phase IV: Regional Strategies

This is achieved in years 5 through 10, addressing a more regionalized approach. Since we have more than one regional health corporation in a geographic area or state, we may be able to create a hub that serves more than one of our regional health corporations. The outcome is a free-standing, trusted comprehensive care service.

Supporting Continuing Care Services Development

To help our regional health corporations understand and implement the preferred delivery model just described, CHE is launching three initiatives:

1. Pilot Projects

To test these concepts, Catholic Health East is developing pilot projects to explore various aspects of the relationships/incentives operative between and among physicians, insurers and the hospitals, all linked with a unified and integrated comprehensive care management approach. Three pilots are currently in development. One pilot at Mercy Health System of Southeast Pennsylvania, beginning in 2008, explores the potential of an insurance company, physicians and the hospitals to address the needs of two populations, one with complex health needs and the other being those who are uninsured. Three areas are being pursued initially: 1) designing the flow of finances to provide incentives to drive the model; 2) building a network that has care management incorporated and is sized and configured to high-risk, high user patient needs; and 3) using the model to improve care of and decreased use by the uninsured.

Another pilot will focus on a CHE hospital, joined in a global capitation arrangement with a large physician group, which is exploring ways to enhance patient outcomes through a person-centered, clinical system of comprehensive care management across the continuum of care. A third under consideration is enhancement of a "transition program" that offers on a fee-for-service basis, counseling for life transitions with coordination of aftercare and continuity of services. We plan to test the impact of IT enablement and integration of the hospital and other providers, particularly physicians, into the model.

2. Educational Collaborative

CHE has used educational collaboratives as an approach to accelerate clinical improvements; achieve results; define, document and disseminate good ideas; and create leaders who embrace change. To enable our regional health corporations to adapt to these changes described, in 2008 CHE will be hosting an educational collaborative on comprehensive care management in which we will engage our clinicians across the system in testing various strategies to improve services for those in their care. These ideas, once tested, will be shared across the entire organization and then adopted and adapted as appropriate. In this process, everyone learns, everybody teaches, a sense of urgency is achieved and accomplishment is recognized and supported.

3. Continuing Care Management Services Network

To foster and promote the development of a continuum of continuing care services, both within and outside of our health system, CHE has established the Continuing Care Management Services Network. This is a separate, not-for-profit corporation that will build on the current skills and capabilities within the organization and bring them to bear at regional health corporations as they are enhancing and/or launching new continuing care programs.

A network leader, with a core team of staff at the system office, will link in a distributed virtual network with key continuing care service line experts, who reside at various regional health corporations. The network will provide an array of management and consultative services to the regional health corporations. Standardized systems, models and templates for program development will support local staff in implementing continuing care services or enhancing existing programs.

What Will be Different?

As with any major change, there are those who question the proposed reform and whether it will make a difference to our patients, our staffs, and our organization. Though the plans described here are the initial steps on a long journey, we believe they will lead to significant change within CHE's approach to health care delivery by the year 2017. These areas of significant difference include:

- a conscious, intentional coordination of care across the full continuum – from acute to continuing care services
- IT enablement for transfer of data to be seamless for professionals, caregivers, family and the person involved
- persons navigating through the health care system at lower cost with better outcomes and higher satisfaction as a result of care management
- essential payer participation, coordination and access to common data via the web to determine lengths of stay and eligibility for service
- alignment of incentives and gain sharing with physicians
- care delivered in varied locations, including the home, and supported by technology and care management
- care that is continuous and appropriate regardless of site

Conclusion

The concepts discussed here are not new. The Institute of Medicine's 2001 report, "Crossing the Quality Chasm: A New Health System for the 21st Century" called for reform of the health care system and stressed three elements:

- an information-rich environment supported by health information technology
- the patient's (or advocate's) engagement in all aspects of care
- coordination among caregivers

Calls for reform and change in health care delivery and quality are continuous and growing stronger. The moral, social and economic reasons are compelling. The health care needs of functionally frail elders and those with disabilities and chronic diseases, indeed, of all of us, require a more coordinated integrated system of care that reaches into the community and into the home. We intend that our model has the capacity to be accessible for all, especially for those who are poor. At CHE, we believe the changes that occur now will be in our hands, achieved because of our efforts and those of many other providers who believe that our best option is to move toward a preferred health care delivery model. This type of change will require a rebuilding of relationships among all of us engaged in the health care enterprise. It will ask us to trust one another as we test and pilot new and more effective ways of working together, aligning incentives and achieving the patient care outcomes we seek. ■