New Health Care Models: Will They Help the Poor?

By JOHN FINAN, M.B.A., FACHE

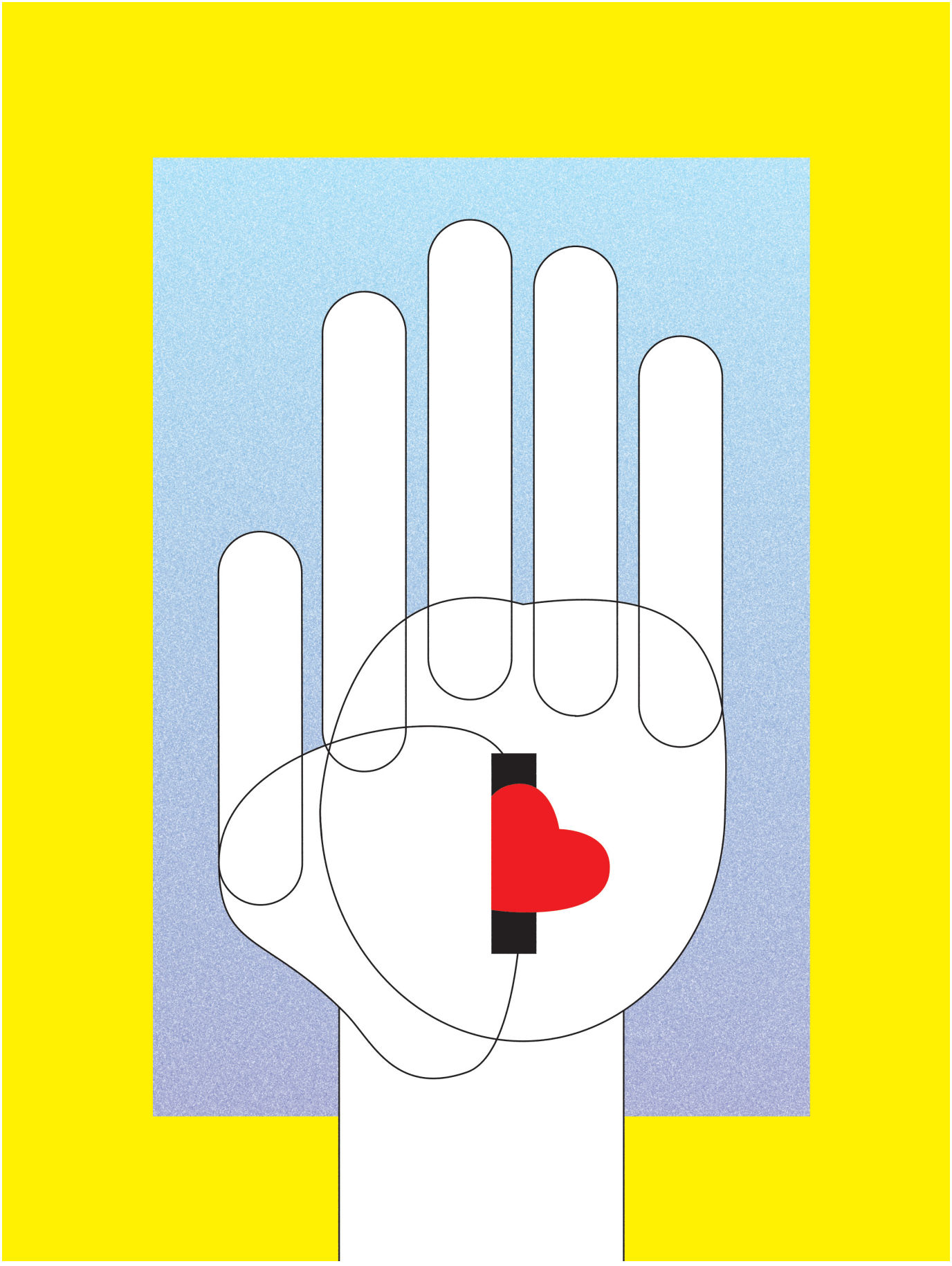
Here's a story that plays out daily in hospitals across the country: A patient — let's call her Margaret — has been to a nearby Catholic hospital's emergency department three times in the last six months because she felt sick from hypertension and diabetes. Margaret knows it isn't smart to let things get so bad that she has to go to the ER, but she doesn't think she has much choice. When she tried to get help at her community clinic, the wait time for a new patient appointment was 16 weeks. Plus, she cringes at the thought of running up medical bills. She is already in debt, and her health problems make it hard for her to keep steadily employed. When she returns to the nearby ER, they take good care of her, and the crosses on the wall make her feel that maybe her prayers have a chance there, too.

The nurse in the ER recognizes Margaret, and a social worker comes over to talk. She tells Margaret she wants to set her up with somebody called a health coach, a person who will keep in touch with Margaret and help her keep up with her sugar checks and her blood pressure. It's good to have someone call to help explain things and keep track, the nurse says, and perhaps that will mean Margaret won't have to come back to the ER before she gets her appointment at the clinic.

Creating a sustainable health care system that delivers consistent quality and better health, especially for people like Margaret, is the goal of Catholic health care providers. We know this is simple in concept but almost insurmountably difficult in application and practice.

The challenge is the same as it ever was: Innovate so we can deliver on our mission of serving those most in need, regardless of our resources.

While the vigil for health reform's final rules persists, and organizations explore new requirements for care delivery and reporting, debate continues over whether the Affordable Care Act's payment guidelines will actually drive improvement. What keeps me up at night is, Will we be able to improve the management of care at a rate that is faster than the growing restraint in resources? Fixing health care for people like Margaret will require participation and teamwork from multiple sectors. Providers, employers, payers, government and families can reduce disparities if we act now, without delay, to find solutions. As providers, our obligation is leadership, knowing all along that efforts will be far from perfect but that failure to act is not an option. Taking action now will encourage others, who are so vital to long-term success, to do so as well.



Catholic health care providers have been serving those most in need and working to eliminate disparities for more than a century. It never has been easy, yet millions of lives have been saved and improved. Even with health reform, the challenge for Catholic providers is the same as it ever was: Innovate so we can deliver on our mission of serving those most in need, regardless of our resources.

Health care ministries never have had a time of surplus funding or more resources than needed, yet we have persevered and succeeded. Now, whether we are introducing new roles for caregivers, using technology to connect providers with patients, finding new community partners and innovative financing, health care systems must confront the challenges. The most advanced health care in the world demands our best attention and action. So does Margaret, and everyone like her that we serve.

Experience from our ministry, the Franciscan Missionaries of Our Lady Health System, suggests organizations need not choose between access and quality. Indeed it would be tempting to acquiesce to the many challenges presented by the grim state of health care in Louisiana, the state we serve. Growing numbers of uninsured, high poverty and chronic disease rates, exacerbated by state budget shortfalls and a stalled economy, challenge every provider in our state. Today, we choose to roll up our sleeves to find new solutions and partners that mean better lives for individuals and long-term improvement in the health status of our communities.

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Across our health system, we have tackled the challenges of reform by implementing several innovations in care delivery, especially improving the management of care, which we believe will prove valuable regardless of what happens with legislation or payment models. We can learn best through experience, from others' as well as our own, taking advantage of scale within our own geographical footprint. In addition, we are interested in models that can be either instructional or replicated by others.

We have introduced medical homes for the medically underserved. At St. Francis Medical Center in Monroe, La., a community where unemployment averages about 8 percent and the median household income for a family of four is about $50,000, access to outpatient care and management of chronic disease are delivering positive results. We operate the NCQA Level III-certified St. Francis Employee Medical Home, promoting working healthy and living well, while recognizing the quality of health depends on the physical, psychological, emotional and spiritual well-being of each person. Similarly, we extend our outreach beyond the wall of the organization by bringing expertise to the St. Francis Community Health Center and St. Francis' School-Based Health Center. Operations at each are enhanced by the collective learning and sharing.

We have entered a public-private partnership, the first of its kind, with Louisiana State University (LSU) and the State of Louisiana to collaborate as the site for graduate medical education for Baton Rouge-based physician-training programs beginning in late 2013. We will expand access to our hospital for Medicaid and uninsured patients previously receiving care at the LSU hospital. LSU will expand the number of outpatient clinics serving their clinic populations. This saves the state money and allows us to serve a larger population in need.

This approach is both innovative and uncertain, and it is an example of how providers and other stakeholders must invest today for the future health of all families and communities.

Any view of the future must include efforts to keep individuals well and in better health. We created Franciscan Health and Wellness Services to expand our competencies in managing population health, initially serving the 12,000 members of our own health benefits plan through a program called Healthy Lives. More than 80 percent of our benefit plan members have elected to access the health risk assessment to understand their personal health profile. Health coaches are provided to individuals who are classified as moderate or high-risk. Having demonstrated improvements in health status, outcomes and cost, we now offer Healthy Lives to other employers in our communities, as well as in communities not previously served by our organization.

Today, people are living longer than ever before, and our sponsors place significant prior-

ity on care for the elderly. We have been fortunate to have innovative opportunities for this unique population as well. The Program for All-inclusive Care of the Elderly (PACE) provides managed care to dual-eligible individuals in the Medicare and Medicaid programs. An important goal of PACE is to provide care in the most effective way, avoiding institutional care as much as possible. The PACE rules allow the provider to make decisions in a holistic context, thereby improving health and preserving resources. Lessons from PACE inform not only care for seniors, but for everyone we serve.

For the fictional Margaret, who represents those persons most in need who choose care based primarily on where it is most accessible, the causes of disparities are complex. To deliver on the overall intent of health reform, we have to reach outside of the current model — where we wait for patients to come to us when they need care either for acute or chronic conditions. We must try new things and learn from each opportunity.

We are blessed to serve people in the Louisiana communities in which we operate and believe that our mission in Catholic health care calls us to use our blessings to reach those who need care most. We share and support the fundamentals of reform. But we are also "flying the plane while it is being built," with the final blueprints of reform's design yet to be delivered.

Great work is already underway across Catholic ministries throughout the country. We must also be catalysts for partnership and collaboration. High-performing organizations today must invest in the partnerships whether that is in public health innovation, state government for financing mechanisms or other mission-driven provider models that drive the same level of process and accountability to achieve the goals of reform.

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Catholic health care can be bold in both policy and practice. We cannot simply say, "No, thanks," when the road of reform is rough. Quite the opposite. To extend the healing ministry of Jesus in a secular environment compels us to be a voice for the underserved and a voice that brings people together. And we absolutely must bring our best always in terms of quality and results. Across the country, we must tirelessly pursue new partners and new models of care for all persons in all communities. Only then can we precisely meet the goals of needed reform and our call to ministry.

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