



New Models Of Community Care

By JOHN MORRISSEY

Community-based health care management is racing ahead in Bridgeport, Connecticut. Under the auspices of St. Vincent's Health Partners, a 3-year-old entity championing clinical integration, 275 physicians in 90 practices are working under one set of aims and rules for coordinating and improving care. Four skilled nursing facilities and four home health care agencies recently were added to bring post-acute care into the equation.

At the other extreme, St. Catherine Hospital in Garden City, Kansas, has helped inspire a community health coalition of 50 organizations across Finney County, organized to collectively improve the prospects for healthy living in myriad ways that often have nothing to do with health care, in the strict sense. Among the achievements: helping to create a public bus system, a ban on smoking in public areas and classes for parents that teach them how to select and prepare food that will help their children grow up healthy.

Both models for community health will surge in urgency with the emergence of fixed reimbursements for bundled services, sharing with payers the savings from less expensive care, and going at risk for the health-related costs of a

defined population for a contracted level of payment. Call it an inside/outside strategy: making provision of area health services as efficient and coordinated as possible (the inside), while working alongside public health agencies, schools, village halls and community improvement organizations to thwart medical crises and tame chronic illness (the outside).

There also is a middle ground straddling both sides of the strategy: arranging for community players to extend the reach of clinical care and for clinicians to advance the aims of community initiatives. Go to Cheshire County in New Hampshire, and you'll see this all the time, said Art Nichols, CEO of Cheshire Medical Center/Dartmouth-Hitchcock Keene.

As the clinical practices integrate increasingly with public health and advocacy groups, Nichols said, "We're beginning to see a blurring of the lines between what's going on in the doctor's office and what's going on in the community." Cheshire and its community partners have worked to decrease the incidence of uncontrolled hypertension and diabetes, lower teenage pregnancy rates, combat childhood obesity and train families to understand and pursue healthy habits.

In western Kansas, a formal not-for-profit

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structure is managing millions of dollars in grants for everything from parenting skills, adolescent drug/alcohol avoidance and chronic disease reduction, to wellness initiatives and anti-violence programs, said Scott Taylor, CEO of St. Catherine, which is an anchor member of the 501(c)(3) organization. “In today’s health care environment, collaboration is absolutely essential; wellness is as important as sick care,” he said.

NEW TERRITORY

The wellness imperative and its cousin, community health, took on elevated importance after two news flashes in late January 2015. A study in *Health Services Research* determined that nearly 60 percent of national variation in hospital readmission rates, for which Medicare penalizes acute-care facilities, was explained by community-level factors rather than a hospital’s performance. The Centers for Medicare and Medicaid Services, which through pilot testing had nudged the infiltration of value-based payments to about 20 percent over the last decade, set explicit goals to have 30 percent of Medicare payments tied to value by the end of 2016 and 50 percent by end of 2018.

That means hospitals have to get out of their comfort zone — diagnosing and directing treatment for illness — and organize both the continuum of community care and the basic preservation of health in surrounding neighborhoods. Initiatives such as the one at St. Vincent’s are

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fashioning clinically integrated networks to better provide health care and get ready to, for example, follow patients for three months after a treatment or procedure reimbursed through a bundled payment. Preventing costly near- and long-term health problems, however, gets hospitals into unfamiliar realms they are not trained to navigate.

“Hospitals are experts at healing and delivering that special care within four walls,” said Ste-

phen Martin, PhD, executive director of the Association for Community Health Improvement, Chicago. “In this transformation, some of these health outcomes cannot be changed in an acute-care setting. So now we’re asking our hospitals that are tremendous experts in one area to somehow, overnight, become experts in another area — which is [historically] also out of their business model.”

Though community health is now a material factor in achieving value-based objectives, “we shouldn’t be asking our hospitals to step into it all by themselves. And they’re not necessarily built that way,” he said.

Instead, care systems “have to tap into community collaborations and create conditions that are looking at the big picture of health,” said Diane Jones, vice president of healthy communities for Catholic Health Initiatives, Englewood, Colorado. “If we know that the medical delivery system accounts for anywhere from 10 to 15 percent of what creates health, how do we work with other sectors in the community ... to say how can we focus on creating policies, creating environments that are all designed to promote health?”

LISTEN FIRST

Before any venturing into the neighborhoods, hospital and physician leaders have to rein in their take-charge urges and let existing community entities advise how to proceed.

“It takes tapping into a different mindset,” Jones explained. “Most of us came into health care to solve problems — mostly other people’s problems. Diagnose a problem, prescribe a solution for people to follow our direction.”

That approach doesn’t work in communities, she observed: “It needs to be a shared creation, so that you build the capacity of people whom you’re working with, not to or for.”

On its own, a well-meaning hospital task force might want to promote physical activity by prescribing 20 minutes of walking per day. But the community might be more concerned about having good sidewalks to walk on, said Martin. Access to care could be a focus, things like getting health coverage for people or making sure primary care is convenient. Those are laudable pursuits, but just getting to a clinic via good public transit could be the community access issue that resonates. “If hospitals don’t understand the dynamics of the



community before they launch their initiative, it could be dead in the water,” Martin said.

Governmental and not-for-profit groups likely have been working on community health since the local hospital’s inception, but in pieces and not working with one another, he added. Successful community collaboratives have used the local

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hospital as an organizing and startup funding agent to bring the various organizations and provider entities together with shared responsibility to pursue common causes.

In Kansas, St. Catherine Hospital started out by working with a small coalition of “future-minded organizations who knew that collaboration was the key to working together to improve the health of the community,” said Taylor. That was 15 years ago. In those early days, the group attracted “tens of thousands of dollars” in grants, a manageable level that did not warrant a separate infrastructure. But in the past decade, “the coalition literally grew to a point that it needed to be a partner with St. Catherine, not necessarily a sub-agency,” Taylor said.

The hospital helped create a community board, including itself as a governing member, to channel money to appropriate agencies and ensure that grant programs were meeting requirements of reporting, service and disbursement. Once the management capacity of the not-for-profit entity increased, it pursued and received larger grants and more of them, partly because the disciplined organization created more trust from first local and then state and federal sources, according to Taylor.

“It works. It allows most of the executive team within the hospital to focus on traditional caring for those that are ill, while we work collaboratively with a highly motivated group of subject matter experts across the community to improve

the health of the residents that we serve,” he said. “Working with them, instead of trying to re-create a whole new infrastructure, is better for the community, it’s better for those agencies and it’s better for the hospitals.”

Clinical practice and community entities can overlap in many creative ways. St. Catherine clinics and the Finney County coalition teamed up to increase the activity levels of people identified with hypertension, obesity, diabetes and heart disease. An extensive network of employed physicians has “an exceedingly close relationship with our FQHC [federally qualified health center] here in town, Mexican-American Ministries,” Taylor said. Formal ties with the FQHC, a local behavioral health provider and the coalition extend the hospital system’s capabilities to care for those who are ill.

MARRIAGE OF VALUES

Cheshire Medical Center/Dartmouth-Hitchcock Keene in New Hampshire has been involved with community health for more than 20 years, originally in an initiative around teen pregnancy. The effort had a dramatic effect in lowering the teen pregnancy rate, and that made people feel good about working together, said Donald Caruso, MD, chief medical officer. Next up was pediatric dental care, which was more hospital-centric but also pulled in schools and others.

Caruso is big on “social capital,” the relationships upon which Cheshire draws to solve problems. “You’ve got to figure out how people can want to work together, and how you actually take the values you share and use that as your common denominator to make a difference,” he said. That marriage of values has become “very ingrained in our community. Now, as we start to think about an integrated approach to wellness with the health system, it’s a lot easier,” he said.

Caruso’s perspective arises from the realization that as a primary care physician, he can only do so much to make an impact on patients. For example, a significant increase in obese kids in Keene foreshadows a future of costly diabetes care. But even when a physician clearly lays out this and other dangers to a family, he can’t conquer social determinants that work against him. That’s when the health system needs to get community influenc-

ers involved on behalf of its physician practices, Caruso said. “If the practice can identify the issue, and the community has resources, and the practice of medicine can channel those individuals into the right community resource, you can have much more significant outcome changes.”

Cheshire’s approach to controlling hypertension is a community/clinical blend that has produced nationally recognized results. The condition is the biggest cause of heart-related deaths and costly complications, but steps to lower blood-pressure readings can’t be limited to people who show up in doctors’ offices. Caruso advocated using the community for, first, an education program on why blood pressure control is important, and then going out to nursing homes, home health agencies, adult day care, and volunteer services such as in churches and businesses, all to uncover the uncontrolled.

The community campaign, added to a hospital effort to get all specialists to take and report the blood pressure of all patients, funneled many

Medicare and Medicaid Services singled out for an award in conjunction with its Million Hearts program to save lives through preventive heart health.

Another example of scouring the community for hard-to-reach populations is an initiative to uncover people with uncontrolled diabetes, identified by too-high levels of a marker in the blood, said Nichols. “The trick is for us to use our electronic medical record to go out and find people we know have had difficulty with hemoglobin A1c and get them in here. That’s the first hurdle. They may be home and have just not bothered with it.” If tests identify the problem, collaborative care nurses work with those patients to lower blood sugar. In the first four months, the number of patients with the most severely uncontrolled diabetes decreased from 400 to 315.

Add to that a push to curb the diabetes problem on the front end. An initiative to reduce the number of obese children, in concert with local schools, has been bearing fruit. In a key area measure of obesity in third grade, recent

results showed the incidence at 25 percent, down from 33 percent in 2011. “We help define health problems,” said Cheshire CEO Nichols, “but then a lot of the individual groups will pick up these health problems and run with them.”

CLINICAL COMMUNITY

To meet payment reform head-on, health care organizations have to foster cooperation not just with the community but within the entire clinical care sphere. St. Vincent’s Health Partners has written the book on unifying the continuum of care — literally. In a process guided and controlled by its doctors, the clinically integrated network published and copyrighted a “playbook” detailing life as a network member.

For example, it explains more than 140 types of transitions and specifies the least amount of information required to transfer a patient — from the emergency department to the home, from home directly to an inpatient bed, from hospital to skilled nursing facility and so on — and be able to manage at the same level of awareness of condition and care needs at the new site, said Michael Hunt, DO, chief medical officer and chief medical information officer.

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more people into an existing free clinic staffed by nurses who provide education, administer medication and perform monitoring tasks such as blood pressure screening. In the first week of the program, visits to the clinic increased by 600 people, said Caruso. Cheshire set up a registry of all known hypertensive people and assigned staff to look at it daily and respond to treatment needs via set protocols. If a patient hasn’t had his or her blood pressure checked in six months at any of a variety of clinic and community locations, someone makes it happen, he said. Hypertension control for Cheshire patients identified with high blood pressure is now around 85 percent, good enough to be one of nine programs the Centers for



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Health Partners, and its parent, St. Vincent's Medical Center, seek to be at the forefront of organizations moving from fee-for-service to quality-based care, particularly the Medicare bundled payment initiative that will depend on managing patients at a higher quality while decreasing unit cost. Their objective is to transform operations and do all the learning while fee-based care is still dominant, so the health system isn't scrambling two years from now and losing revenue because it wasn't ready with the type of infrastructure to meet requirements of bundled payment.

To follow patients 90 days after discharge, members of the network need to know whom they're sending patients to, and have a close partnership, said Hunt. The network's recent expansion to skilled nursing facilities, home health providers and a nurse practitioner group "will redefine how we manage patients at the transitions of care," he said. That includes changing referral patterns to situate more services in the community.

"We believe that skilled nursing facilities to some degree have been overutilized in post-acute care," Hunt said. One reason for expanding to home health agencies is that the home has been shown to be often the best place to go after a hospital stay. "That's a big change in health care today," he said. "Every day, doctors will ask me, 'Who do you think you are, telling me where to send that patient?'" They feel the progression is

acute care to skilled nursing, then skilled nursing to home care. But the justification for skipping that step is all in the playbook, which logs evidence for acute care, chronic illness and preventive disease options, with all the metrics against which those are measured to be successful with payers, Hunt said.

STARTING POINTS

Health care systems have a ready instrument to compose their community model: the community health needs assessment that all not-for-profit providers have had to conduct to maintain their tax-exempt status under a requirement of the Affordable Care Act. The assessment is a working document that ideally is put together with help from the community organizations that know the needs, said Martin. In planning to address those needs, "it's about working with those key stakeholders to drive the community to wellness," he said.

The needs assessment for St. Catherine is one of the working documents directing the Finney County coalition's activities, said CEO Taylor. The plan was aggressive in seeking the input of community partners, including working with state agencies to develop comprehensive needs and measures to improve upon.

If performed thoroughly, and "done in the spirit of inclusion," said Martin, the needs assessment and implementation plan will serve as a blueprint, something all participating organizations can use to understand the nature of community challenges articulated in one authoritative presentation. Then the inside/outside journey begins.

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