Three practical approaches to POPULATION HEALTH

Start now, experts advise, with strategies that marry the technical and the personal

BY PAUL BARR

From computers that crunch data to human beings who listen, health care organizations are adopting a variety of population health management tools and techniques.

Hospitals, payers and insurers are taking steps to better manage the care of populations with the goal of preventing or limiting medical issues by treating them earlier and more efficiently. Reimbursement for that kind of care has not yet reached the mainstream, but that’s not stopping some hospitals from jumping into pop health manage-
Population health management techniques are taking hold in different ways across the country.

Technology is playing a big role in population health management, but so is maintaining the human side of the equation.

Ignoring population health is probably a mistake, argue population health experts.

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The network got a boost in 2014 when Cigna funded a patient navigator position to target the 100 most challenging patients in the region, helping to overcome whatever barriers keep them from accessing care appropriately and following treatment regimens. “That community navigator is one of the core pieces of the program,” say Edward Rafalski, senior vice president of strategic planning and marketing for Methodist Le Bonheur. The individual is placed within the community — “where they’re trusted to help people navigate their health issues.”

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Similarly, the Illinois Medicaid program has farmed out a portion of its coverage to NextLevel Health, a company that relies on a team of care coordinators to evaluate every assigned member covered by the program. NextLevel Health is located close to the Chicago neighborhoods it serves, which its managers view as key to its effectiveness. The company also uses technology it co-owns to identify beneficiaries most at risk for health issues and to help determine and manage their care.

“The hospital systems that are going to be successful are making the investments today,” says David Nash, M.D., dean of the Jefferson School of Population Health at Thomas Jefferson University. “They’re doing the blocking and tackling to be prepared for the game.”

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TRINITY HEALTH: Fast-paced, people-centered

Trinity Health in Livonia, Mich., adopted a new approach to care under a program called People-Centered 2020 that includes a strong emphasis on managing health from a population perspective.

“We’re taking a very fast-paced, whirlwind approach to it and really trying to push the envelope on it whenever we see the opportunity to do so,” says Paul Harkaway, M.D., senior vice president of clinical integration and accountable care. “We desire to get out in front on the newer model without abandoning our traditional work.”

A few years back, Trinity set up separate legal entities — accountable care organizations or clinically integrated networks — to enact the system’s population health strategies. The ACOs are then responsible for managing the health of defined populations. The situation under which each entity operates varies; therefore, the degree, pace and way they’ve adopted population health management also varies. “Some places, it’s easier to move fast,” Harkaway says.

Each contract is adapted to fit the marketplace. Some of the models Trinity is using range from a beginner stage in which only its own employees are in risk-based care to more advanced approaches through the Medicare Shared Savings Program for ACOs, risk-based Medicare Advantage programs and commercial risk programs.

“We’re trying to go everywhere fast,” he says. Trinity Health’s regional health system in Grand Rapids, Mich., Mercy Health, runs a care transitions program to improve outcomes for frail, elderly adults. The transitions program takes a complementary, non-disruptive approach to care. “We are very diligent about understanding what other health care touch points the patients are having,” says Nancy Crowe, R.N., program manager in the division of geriatric medicine at Mercy Health Physician Partners. (A second program is focused on preventive care and management of chronic disease.)

One important aspect of the program, says Carlos Weiss, M.D., an internist, geriatrician and medical director of Mercy Health’s Advanced Care Coordination Program, “is that we try to support existing primary care relationships instead of trying to set up a different program.” Patients can opt to have their care co-managed by their primary care doctors and the transitions program, or they can return to their primary care doctors if they would like to consolidate primary care management in the program.

In one scenario, the hospital might refer a patient to the program, and a quick assessment determines if the individual meets some basic criteria. Minimum qualifications include having a primary care doctor who is part of the Mercy system, living in the county and having a stable — or at least safe — home situation, Crowe says.

A team member visits with the patient while he or she is still in the hospital to see if the person is interested in participating; if so, the team member contacts the primary care doctor for approval to get involved. The day after a patient is discharged, a physician or nurse practitioner visits the home for one to two hours to get to know the patient and his or her particular needs.

About 250 patients have been referred to the program and close to 190 have entered it, which is considered a good acceptance rate, Crowe says.

Finding staff to work in the program takes extra care, given the geriatric skills needed and the nature of the job. “A spirit of adventure is often required,” Weiss says. — PAUL BARR
The Health Research & Educational Trust partnered with the Public Health Institute and the Association for Community Health Improvement on a 2015 survey of hospitals regarding population health. Below are selected results.

### How Hospitals Define a Population

- Users of a hospital or health system: 70%
- Residents of a specified geographic area or community: 69%
- Individuals experiencing a certain disease or condition: 59%
- People for whom the hospital has financial risk: 47%
- Other: 11%

Source: Health Research & Educational Trust, Public Health Institute, Association for Community Health Improvement

### Pop Health Managers: Who Are They?

Position that oversees population health

- Executive manager: 53%
- Senior manager: 27%
- Middle manager: 11%
- Program/project director or manager: 4%
- Program/project staff: 2%
- Other: 3%

Source: Health Research & Educational Trust, Public Health Institute, Association for Community Health Improvement

### Population Help Wanted

Needed skills or background in hospital population health

1. Physicians
2. Nurses
3. Behavioral health
4. Needs assessment/strategic planning
5. Clinicians other than physicians or nurses
6. Change management
7. Community health/organizing
8. Public health

Source: Health Research & Educational Trust, Public Health Institute, Association for Community Health Improvement

### Howdy, Partner

Hospitals are partnering with other health care players to varying degrees

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Source: Health Research & Educational Trust, Public Health Institute, Association for Community Health Improvement
Methodist Le Bonheur Healthcare wanted to make a big impact on its service area in Memphis, Tenn., by adopting population health management techniques. To do that, it chose an approach known as the Camden Model to identify hot spots in the community with unusually high percentages of frequent health care users. A coalition of churches called the Congregational Health Network already was playing a key role in Methodist Le Bonheur’s community engagement efforts.

Using the Camden Model’s combination of computer analysis and community-based evaluations, Methodist Le Bonheur decided to focus on the 38109 ZIP code area. The predominantly African-American region lies in the southern part of the city, west of Elvis Presley’s Graceland Mansion. The average household income is just under $39,000, compared with the national average of nearly $70,000. Patients there had the highest emergency department utilization and the highest consumption of charity care. The 10 most frequent emergency department visitors in 38109 visited more than 200 times, with most of them also suffering from either depression or mental illness. Within that ZIP code, inpatient volume represented 9 percent of visits and 65 percent of costs, as of 2010.

In January 2014, Methodist Le Bonheur launched a pilot program to identify patients with the highest need and provide them with a patient navigator. Funded with a grant from the CIGNA Foundation, the Familiar Faces program included any adult patients in the ZIP code who visited the ED 11 or more times in the year ending April 30, 2013—about 100 patients.

The navigator is charged with becoming an active member of the community, so he or she can become better known by the residents. That happens through weekly wellness events and by serving as a resource to assist patients in getting to appointments. It is common for the navigator to drive patients to appointments or provide taxi vouchers, and also to assist with picking up prescriptions. “Trust is a huge issue when it comes to having a discussion around health,” says Edward Rafalski, senior vice president of strategic planning.

Sandra Bailey, vice president of senior care services and CEO of Methodist Extended Care Hospital, says “a lot of what the navigator spends her time doing is listening and encouraging patients that they can do better, and they can improve their situations.” Persistence also is a useful trait for a navigator to get people to participate in the program. The navigator is notified anytime one of the targeted patients shows up at one of Memphis Le Bonheur’s facilities. The navigator then meets with the patient to explain how he or she can assist with nonmedical needs, such as arranging a ride for a doctor’s visit or even figuring out who is the primary care physician assigned to the patient under Tennessee’s Medicaid programs.

“She had a good acceptance rate, though sometimes she would have to go back a second time,” Bailey says. “In one individual’s case it was three times before he finally said, ‘Are you going to come every time I come to the hospital?’ And she says, ‘Yeah, pretty much.’”

Through most of 2014, per patient cost within the program fell 43 percent to $1,369 from $2,783 and monthly ED visits fell to 10.3 on average from 19.

The health system is seeking to have its results validated by a third party. The University of Tennessee has funded a postdoctoral student who will create a model for testing results. “We’re not only testing it from a management operations perspective, which is certainly good, but we’re going to put it through the rigors of an academic test as well,” Rafalski says. “We’re excited about that.” — PAUL BARR
**EXECUTIVE CORNER**

Population health management doesn’t have to be the daunting endeavor it can sometimes resemble. Hospital executives may want to get assistance from an insurer, as Methodist Le Bonheur did. Aetna also is active in that arena. And some hospitals enact pop health first with their own employees, as Centura Health did with a wellness application.

**Aetna** is promoting the use of population health management techniques with providers with which it works, both in theoretical and practical terms, says Dan Finke, CEO of Accountable Care Solutions at Aetna. “What we’re trying to be is not only a thought leader in the changing markets ... but we’re also trying to push the local markets to consider moving faster.” Aetna’s population health approach is centered on three areas: risk-based contracting, care management services and data and technology management.

**Centura Health** implemented a machine-learning wellness technology with its 18,000 employees and recently rolled it out to patients of Centura Health Heart and Vascular Network. Based on a Welltok mobile application that uses IBM Watson natural language processing, the idea is to make it easier for its patients with heart failure and those in cardiac rehab to make smarter decisions regarding such questions as what to eat or how to exercise. “The app customizes its responses based on the questions they are asking,” says Jon Gardner, vice president of the heart and vascular network. The plan is to spread its use to the broader patient community.

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**NEXTLEVEL HEALTH: Melding high-touch with technology**

A company in Chicago is working to overcome the major obstacles to wellness often found among Medicaid populations. It uses a systematic approach that combines hands-on personal attention with technology.

NextLevel Health, one of six Medicaid Care Coordination Entities in Illinois, employs a team of care coordinators drawn from the communities being served. The aim is to get a better handle on its beneficiaries’ health by aggregating face-to-face evaluations with two years of state claims data, and creating a three-tiered risk profile that serves as the basis for a care plan.

“Providers typically have a difficult time working with seniors and those with disabilities because of the length of time it takes to manage them,” says Jacquelyn Smith, R.N., chief operating officer for NextLevel. “Giving [those providers] some assistance and some data to work with is one of the things we do.”

NextLevel relies heavily on a tech platform for population health that it helped to refine and now co-owns, says Michael Kinne, the for-profit company’s president. The company is responsible for about 17,000 beneficiaries this year and has 42 care coordinators.

The technology’s main job is to make sense of the reams of data produced by the state. “It’s not actionable, telling me what I need to know today to get from Point A to Point B,” Kinne says. “It’s like putting a huge steak in your mouth and trying to eat it in one bite.”

In addition to the technology, the other important component of NextLevel’s population health management program is the one-on-one evaluation of patients. “The community-based model, with the data you have going in, helps you to set up the best outcomes for that individual because you’re sitting there face to face doing these assessments,” Smith says.

The initial screening preferably takes place in the patient’s home, so the environment can be evaluated; however, anywhere that’s comfortable and accessible for the beneficiary will work.

The claims and qualitative data collected from the screening are combined, including criteria related to the number of ED visits and inpatient stays the patient has had in a set period, and the number of medications he or she is taking.

NextLevel’s approach is to be as welcoming to the beneficiaries as possible, officials say, and drawing on residents from the community to do outreach is an important part of that. In addition, care coordinators are available any time to assist with such things as arranging rides to assigned physician offices, which aren’t always conveniently located. Coordinators also take call rotations for overnight assistance.

“You feel as though you’re having a peer-to-peer interaction, you’re dealing with an individual who’s from your community, looks like your community, feels like your community, talks like your community and sounds like your community,” Kinne says. — PAUL BARR