New Strategies for a New Era in Population Health

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Advanced population health management strategies call for segmenting narrow groups of patients in order to design specific treatment protocols and programs. But Morristown, New Jersey–based Atlantic Health System is taking a more expansive approach. While the five-hospital system has systems in place to identify and meet the needs of the chronically ill and other well-defined groups, it is also casting its population health management net wider to measurably improve the health and well-being of its entire service area, which also includes part of New York.

“Our organizational vision is empowering our communities to be the healthiest in the nation,” says Chris Kirk, PhD, director of mission development at Atlantic Health System’s Center for Population Health Sciences, which assesses the health of its communities and works with local organizations to address wellness needs. “We face 1.9 million people. It’s a very diverse population that tends to be highly educated and have great affluence, but it also has great disparities,” he says.

What’s the secret to unleashing population health on such a broad population? It requires good data, a long reach into the community, and the ability to define populations not only by geographical areas, but also all the way down to physician practice, risk level, and disease set.

Atlantic Health System has a solid framework in place, with two ACOs and community health programs aimed at the elderly, underserved populations, and schools. All of these are supported by a continuous feedback loop of research and data. The end result? Atlantic is able to offer impactful community programs along with well-targeted clinical interventions.

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—Chris Kirk, PhD, director of mission development, Center for Population Health Sciences, Atlantic Health System

“The two sides work hand in hand,” notes Kirk. Physicians are able to implement effective interventions based on a defined population’s needs, but physician leaders also acknowledge they are limited when it
comes to prevention because of shortened office visits. This is where community efforts come into play, Kirk says. As physicians work with and make referrals to community programs, results are tracked, data analysis kicks in, and the hospital system is able to build new clinical pathways, he explains.

As population health management becomes an integral part of present and future care strategies, Kirk and other healthcare leaders say the industry needs to evolve its view of patient needs and program design. “A lot of folks in the population health management space talk about what we do inside the clinic, how can we change physician behavior, and how we can use data and risk to stratify people. And that’s very important,” says Kirk. However, he points out, “research shows that 10%–15% of a person’s longevity is predicted by the healthcare services they receive, which means we have got to continue thinking about primary prevention, community support, and social services.”

Healthcare leaders on the West Coast echo Kirk’s sentiments. Richard Afable, MD, CEO of St. Joseph Hoag Health in Orange County, California, has come to a similar conclusion after several years of overseeing a successful population health management strategy. “Many times, people end up in emergency rooms because they don’t have a social support structure. Who would have thought that the way you’re going to do population health involves a very small amount of medical management?” Rather, Afable adds, a great deal of population health involves providing social support for people at home who have complex medical problems.

So how committed is the industry when it comes to investing in broad population health management programs? According to the 2014 Population Health Survey conducted by the HealthLeaders Media Intelligence Unit, which surveyed 349 industry leaders, 80% of respondents have some type of program underway to improve the overall health of a defined population: 49% are fully committed, and 31% are engaged in pilots of experimental programs. Overall, the survey shows that organizations are still on board with population health.

**Designing Community Interventions**

At Atlantic Health System, the organization’s two ACOs, which have a combined total of more than 200,000 enrollees, work with medical groups to form population health management strategies and clinical interventions. But having a larger community strategy that improves health and utilizes research and data is critical to the hospital’s mission. This is where the community-facing Center for Population Health Sciences comes in. “Our physician leaders have acknowledged that there are limitations when it comes to prevention inside a doctor’s visit, based on limited time and the fact that you send people home to a community that has a lot of factors that determine their health. Helping people link up to the right community resources is part of our total population healthcare picture,” says Kirk.

Kirk says the hospital system is focused on creating healthier communities not just through programs, but with actual interventions. “It’s really about applying the research and learning about what works,” he says. “We build the intervention, test them, and put them into play.” For instance, he says, the health system offers three signature community programs, from which it pulls data to develop targeted interventions. Its New Vitality program works with the growing population of adults 65 and older. “We know there’s a lot of data that shows that if we can, for example, keep people healthier longer and keep them at a low to moderate risk, then we can save a lot of money in their Medicare expenditures over time.” New Vitality provides free assessments, individualized coaching, exercise, and nutritional classes to support healthy behaviors, which it tracks over time. Kirk says leaders are excited about early program results. “We’ve already seen some cost savings due to fewer people ending up in the emergency room and fewer being admitted to the hospital, compared to a random sample in the population.”

Through its Healthy Communities initiative, the healthcare system focuses on programs and activities aimed at underserved populations with health disparities, including, for instance, those who tend to make unnecessary visits to the emergency department because they live in areas with primary care physician shortages. “That’s very costly and not very effective, so we have culturally tailored activities,” says Kirk. “Patients can access health screenings and health education at soup kitchens, Laundromats, or via a mobile health van, enabling support and easy access to those services.”

The third initiative is a community strategy that involves working with schools through the Atlantic Healthy Schools program to provide them support, training, and mini grants that help improve students’ physical activity and nutrition.

**Knowing How to Use the Data**

At the same time, working with utilization data, the hospital system is working to make significant changes at a community health level. “Recently, we have begun looking at our utilization data and tracking ED hot spots to drive our community intervention,” says Kirk. One research finding pointed to a high number of alcohol-related ED admissions. The organization was able to pinpoint four addresses where most of the admissions were coming from, he says. “Now we are beginning to say, ‘How do we go in those places and support them, and figure out how to work together?’” However, he warns, organizations can’t rely on big data for all of the answers, especially in the case of ED overuse. “We may assume that we just need to put up a billboard that says, ‘Don’t go to ED for certain health situations,’ when in reality the issue may not be educational.” The issue, instead, may be a lack of primary care providers that speak a
patient’s language. “Those are the sort of things we hear when we go to the community.”

**Transitioning From Scarcity to Abundance**

Richard Afable at St. Joseph Hoag Health is also exploring the next iteration of population health management. He points out that California offers fertile ground for population health management initiatives, given its lengthy history in managed care. Today, St. Joseph Hoag Health, which was formed in 2013 through the affiliation of St. Joseph Health and Hoag Memorial Hospital Presbyterian, is making great strides toward what Afable calls managed care 2.0. “A lot of it is due to the effect of Kaiser Permanente, which has been a managed care provider for over half a century,” says Afable. “There’s a culture here that allows for managed care to occur.”

For the healthcare network, which includes five hospitals and the Hoag Orthopedic Institute, population health management is more about abundance and less about the scarcity of early managed care. “The abundance model lets us determine what people need based upon data and information and other capabilities available today that weren’t available 10–20 years ago,” says Afable. To that end, the system’s population health management strategy starts with segmenting patients—whether they come by way of Medicare, employer groups, or an ACO—into four distinct populations: the healthy, the mostly healthy, those with a chronic medical condition, and patients who have multiple conditions and are at high risk of being hospitalized soon. St. Joseph Hoag Health, which has a service area of 3.1 million, also is a partner in two ACOs with two different health plans in Southern California, which offer an array of services and programs.

**Targeting the Very Sick and the Very Healthy**

For its 50,000 chronically ill patients, St. Joseph Hoag Health has multiple services, including a Web portal that allows the system to interact with providers and family members. It also has nurse navigators who provide 24/7 care. Chronically ill patients participating in the system’s ACO with Blue Shield of California and the California Public Employees’ Retirement System, or CalPERS, also receive transitional care services. If they are hospitalized for any reason, they are required to make a visit to a transitional care unit within two to three days of discharge. This program, alone, decreased admissions per 1,000 by about 12% during its first year of operation.

Another significant piece of the organization’s population health management strategy is offering wellness centers that provide a wide range of services. Through the St. Joseph Hoag Health Wellness Corner, people can take yoga and a host of other classes as well as receive health-care services and education. So far, the system has centers in residential, business, and retail areas. “These pilot projects offer an additional way for well and healthy people to access wellness services and nurse practitioners or therapists who can help and guide them if they have a specific health need,” says Afable.

He says the organization plans to roll out a total of six wellness centers by 2016. “It is a bit of an experiment, if you will, because we are assuming these investments will improve the health of the population, but we do not have a way to calculate a return on investment yet. We’re doing this for the health of the population, but we would also like to know how it pans out financially.” St. Joseph Hoag Health is in good company. According to the HealthLeaders Media Population Health Survey, 60% of those polled expect to implement wellness-related public outreach programs.

**Unearthing New Data**

Data, of course, plays a big role in the organization’s population health management strategy. Through its ACO partnerships, St. Joseph Hoag Health receives more data and more accurate information—from health plan records and patient biometric screening—than in the past, which is making a big difference in how it designs care protocols. “In the old days when health plans were merely negotiating contract rates with hospitals and doctors, we would never get any data from the plan,” says Afable. “We could only get the information retrospectively, oftentimes one year later or longer.” Overall, the two ACOs have been successful, due in part also to partnerships with employers and employees, says Afable. Through the Blue Shield of California/CalPERS ACO, St. Joseph Hoag Health has saved $15 million in expected costs during the first two years of operation. “This is the evidence that told us population health was going to work for us,” he says.

Now that St. Joseph Hoag Health has been applying strategic population health programs for several years, Afable says the organization has deeper insight into how to make the most difference with certain patient populations. For instance, he says he’s learned that physicians aren’t required to perform the majority of care when it comes to individuals at the highest risk for medical illness. Instead, most care and navigation can be done by nurses or other trained personnel who are specifically attuned to particular conditions. “There is a lot of low-hanging fruit to improve the care of these patients,” says Afable, adding that this speaks to the abundance model. “It’s about paying attention to them on a continuous basis and giving them the kind of therapies and intervention that they need, proactively.” Another surprising finding, Afable says, is that the medical model is only part of the equation. “Early on, we discovered that paying close attention to people and their social structures can make a very big difference.”

As the industry gets deeper into population health strategies, it is important to recognize that not every area of the country is ready to enact those strategies, points out Afable. “The culture of a community, whether it is a state, city, or area of the country, will have a big effect on whether these ideas and principles will ultimately work.”

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**NEW STRATEGIES FOR A NEW ERA IN POPULATION HEALTH**

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Establishing efficient physician communication channels is critical as more providers transition to population health management models. Outdated practices and patchwork communication technologies, however, can slow down collaboration, impact care quality, and chip away at profitability under a risk-based contract, says Terry Edwards, CEO of PerfectServe. Edwards discusses new systems that are more attuned to how physicians work and prefer to communicate.

Q: How do physicians and care teams communicate today, and what is the future vision?

Edwards: As we think about population health and care coordination across interdependent organizations, the phone is the primary way individuals are connecting with each other today. However, poorly designed and managed workflows involving call centers, answering services, auto-attendants, and office front staff make it difficult for providers to talk to one another in a timely manner. A recent Harris Poll survey of 955 healthcare professionals (conducted on behalf of PerfectServe) found that 71% of physicians say they have wasted time trying to communicate with the broader care team, and 69% say patient care is often delayed while waiting for important information about the patient. The majority of healthcare professionals feel communication with patients must improve in order to succeed at population health management. While physicians still prefer communicating face to face or by phone, they also want secure and unified communication via technology that is up to date and easy to use.

Q: How is population health management challenging current communication models?

Edwards: As economic and reimbursement models change, we are seeing an environment where communication that needs to happen is just not occurring between providers today because it’s either too difficult or there are just no incentives to do so. We see it in physician referrals. For example, it could be as simple as a referring physician making a referral to another physician when there’s a question about whether or not the referral should actually even occur in the first place. If that referring doctor had made a brief phone call to the other physician, he or she may have concluded that a referral was unnecessary, but medical offices with busy phone lines often prevent doctors from connecting right away. Under population health management, if both doctors are working under the same risk-based contract, there is an incentive for them to collaborate and maybe eliminate an unnecessary referral to save money and improve the patient experience.

Q: How can healthcare organizations improve communication patterns?

Edwards: They must replace common manual processes with redesigned workflows and automation that streamline processes. In the case above, a software platform with advanced algorithms can enable communication processes tailored to the specialty, the practice, and the physician’s workflow and communication preferences, enabling the referring physician to easily reach the appropriate specialist. Using these streamlined practices and technologies, some larger healthcare systems are facilitating deeper communication between providers. They are making primary care doctors aware, for instance, when their patients are presenting in the emergency department, which is resulting in fewer unnecessary readmissions. The primary care and emergency room doctors are having a conversation and determining that the patient can be seen in the doctor’s office, which is a lower-cost setting.

Another example involves emergency room call systems. When a specialty consult is required in the emergency department, the ED doctor typically calls the hospital switchboard to assemble a specialist and care team. It can take 30 minutes before everyone is contacted, which can drastically impact outcomes, for instance, in the case of a patient presenting with a stroke. New technology and workflows are effectively replacing switchboards and three-ring binders to quickly mobilize specialists and other care team members via Web and mobile applications. This allows the ED doctor to get a message to everyone on that team instantly.
WHO, WHAT, HUH?
There’s a fundamental problem standing in the way of improving population health—doctors and nurses still struggle to get in touch with each other to coordinate care of their patients.

71% of physicians indicate they have wasted time trying to communicate with the broader care team.

52% of clinicians admit they don’t always know the correct care team member to contact in a given situation.

71% of primary care physicians agree HIPAA regulations pose an obstacle to efficient communications and collaboration within the care team.

48% of physicians report being contacted erroneously when they’re not caring for the patient in question, contributing to wasted time and unnecessary delays.

TECHNOLOGY NOT APPROPRIATELY UTILIZED TO IMPROVE PATIENT CARE

Only about 1/3 of clinicians and administrators utilize mobile and remote technologies to facilitate timely care.

Nearly 3 in 10 are not satisfied with the technology their organization uses for secure communications.

Of those who are dissatisfied, dissatisfaction largely arises because:

- 68% members of the community use different technologies.
- 55% not all team members have access to secure communication technology.

Visit perfectserve.com/survey to download the full report. PerfectServe Synchrony™ solves this breakdown in communication so you can reach the right care team member the first time, every time. Whether you are looking for secure messaging or an enterprise-wide solution, PerfectServe Synchrony helps you improve care transitions and speed time to treatment. Call 866.844.5484 to request a demo.

About the Survey: The PerfectServe survey was conducted online by Harris Poll on behalf of PerfectServe between February 12 and March 6, 2015. The research was conducted among 955 hospitalists, primary care physicians in offices, specialist physicians in hospitals, specialist physicians in offices, hospital administrators, office managers/practice administrators, nurses in hospitals, and case managers. For complete survey methodology, including weighting variables, please contact Michelle McCleerey, vice president product marketing at mmccleerey@perfectserve.com.