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Moving toward proactive care

Group Plan: UCHealth Brings on Chief Population Health Officer

By Tyler Smith

Just two words encompass a transformation taking place in patient care: population health.

But its simplicity is deceptive. It's a concept that requires health care providers and systems to change the ways they think about delivering care, said Jean Haynes, recently named the first Chief Population Health Officer for University of Colorado Health.

"Population Health is about promoting health, early detection, and prevention, and being proactive in treating individuals as opposed to reactive to a person's illness. But in the past, health care finance has not paid for or supported that kind of care."

UCHealth Chief Population Health Officer Jean Haynes says the system must find ways to reduce fragmented care.

That's because three letters rather than two words have for decades dominated the world of health care finance: FFS, short for fee-for-service. It's a payment system that rewards volume: Hospitals, physicians, and other providers get paid for admissions, office visits, lab procedures, imaging studies, and so on. Outcomes and patient satisfaction don't play much of a role.

But years of rising costs, steady growth of the Medicare population, and an expansion of people covered by Medicaid and other insurance have combined to focus payer and provider attention on new methods of reimbursement. It's far too early to declare the demise of FFS, Haynes said. But she added that across the country, payers and the health care system are moving toward payment methods that reward quality instead of quantity.

For example, the Centers for Medicare and Medicaid Services (CMS) has pushed both hospitals and physicians in the direction of so-called value-based purchasing systems that offer incentives for improved clinical and patient satisfaction outcomes and impose penalties on underperformers. Commercial insurers are also following CMS's lead in demanding high-quality care for their dollar, Haynes said.

Paradigm shift. That's a far cry from the FFS world, in which the incentive for providers was to deal with each patient's health issues on a piecemeal basis. Now the incentives are turning in favor of providers who demonstrate a commitment to applying quality measures to the care they deliver and proactively managing their patients' health – particularly those with chronic conditions, such as diabetes, heart failure, and COPD. Instead of waiting for problems to occur, population health-oriented providers remind patients of needed treatments, help them get their medications, ensure they get regularly scheduled check-ups, and so forth – the aim being to improve their health rather than repeatedly treat problems that arise from poor management of their conditions.

"It is a different mindset than fee-for-service, and it's a complete shift from treating an episode of care as it presents," Haynes said.

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University of Colorado Health, which has increased its attention to population health the past several years, took another step in that direction last month by bringing in Haynes. She has some 25 years of experience in health care management and finance with large integrated systems, most recently as president and CEO of Univita Health Inc., in Eden Prairie, Minn.

The concept of population health isn't new, said Haynes, who spent her first decade in health care working as a critical-care and emergency-medicine nurse at St. Francis Medical Center in Peoria, Ill., the largest hospital in the OSF Healthcare system. She moved to Florida in 1990, serving three years as director of quality management at Humana Hospital St. Petersburg. In 1994, a physician leader launching a Medicaid health plan in Tampa asked her to join as director of quality and risk management. She focused on finding ways to improve patient outcomes while managing costs.

Preventive measures. "The major initiative that improved outcomes was connecting patients with a primary care provider," Haynes said. "We worked aggressively to build a network of PCPs closer to home." The pay-off was greatest among patients who had made repeated visits to the emergency department, she added.

The plan aimed to control the number of preventable ED visits with strategies that included working with patients to manage their blood pressure, detecting diabetes earlier, and reducing the incidence of acute asthma exacerbations in children, Haynes said. The approach also included building strong relationships with community- and home-based patient services, Haynes said.

These strategies are still mainstays of population health, but UCHealth and other systems have strengthened their ability to track outcomes by investing in electronic health records (EHRs), Haynes said. With large repositories of patient data, she said, providers have greater opportunities to develop standardized, evidence-based treatments and prevention protocols, reach out to patients when they need tests or visits, and analyze the results. This month, for example, UCHealth implemented the "Slicer Dicer," an analytic tool that allows physicians to mine data from the Epic EHR on specific patient populations.

Haynes emphasized that shifting to a population-based patient care model will require that payers and clinical care providers "align their goals" – in essence, that they share the financial risk of providing and paying for health care. To explain how that can be done, she cited an example from her time as president and CEO of Geisinger Health Plan and executive vice president of insurance operations for Geisinger Health System in Pennsylvania.

Mutual benefit. In 2008, Haynes said, Geisinger set out to improve clinical outcomes, reduce costs, and boost engagement among its cardiac bypass surgery patients. A key to the approach was developing a bundle of some 40 evidence-based practices of care and building them into the EHR – in which Geisinger had invested heavily since the mid-1990s. Patients and providers were expected to follow all the steps in the bundle, and surgeries were cancelled for those who refused to do so.

The program, which took a year to implement, decreased mortality, complications, and readmission rates, and increased the numbers of patients discharged home early. Average length of stay fell, as did hospital charges. The results were published in a case study sponsored by The Commonwealth Fund.

In addition to redesigning how care was delivered, the Health Plan also modified how medical care was paid for. A study was conducted to calculate the three-year average cost of care for managing the pre- and post-operative care of the cardiac bypass surgery population in its service area, Haynes said. Based on the analysis, the Health Plan and the Health System struck a bargain: The Health Plan would pay less in total costs of what it had been paying for managing the patients and the Health System would be paid more for the improved patient outcomes, Haynes said. In essence, the physicians and the system were rewarded for improved quality, while the insurer got better patient care while decreasing costs.

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The effort illustrates what the Institute for Healthcare Improvement (IHI) calls the "Triple Aim for Populations," Haynes said – improving the patient experience and clinical outcomes while containing costs.

Reaching that ideal consistently throughout the UCHealth system is one of Haynes's main goals in her new position.

"It's important that we align our clinical and quality goals across the enterprise and with payers because we have limited capital and information technology resources to focus on our priorities," she said. "IT can build the infrastructure we need, but if we're pursuing different clinical and quality goals, we can't succeed."

Consistent care. For example, the diabetes patient who is past due for an eye exam should be flagged in the EHR and proactively contacted no matter where he or she gets care in the UCHealth system, Haynes said. "With our goals selected, we can support the care with our infrastructure."

Nor will the challenges of transitioning to a population health-based system end when patients leave a UCHealth hospital or clinic, Haynes said. Under CMS's Readmissions Reduction Program, for instance, hospitals with excessively high 30-day readmission rates for patients with heart failure, COPD, and other select conditions will receive financial penalties, regardless of the reason for the readmission. The same applies for hospital-acquired infections and other quality measures in the value-based purchasing program.

That makes it more important than ever for UCHealth to establish strong relationships with providers across the continuum of care, Haynes said.

"Today, there are gaps geographically and in clinical and social services," she said. Social workers and case management staff in the hospitals, she added, will play vital roles in identifying barriers to care, such as difficulties getting medications, that could send them back to the hospital.

Ultimately, support and coordination of plans of care and consistent communication between providers, along with improved documentation, promise not only better clinical outcomes but also greater satisfaction for patients, Haynes said. In the eyes of CMS and other health care payers, that's far more than feel-good fluff.

"As satisfaction scores are increasingly factored into payment rates, these improvements have financial benefits for providers as well," she said.