Expert forum: Tales from the trenches of population health

By Lia Novotny | January 23, 2017

For healthcare organizations, the ongoing shift to population-level management can feel like turning an ocean liner. So it's worth examining the experience of community health centers, which have been focusing on patient outcomes, making evidence-based decisions, and targeting at-risk subpopulations for years.

These smaller organizations are often well-versed in difficult aspects of the transition, such as executing operational changes and offsetting the initial costs of transformation. From providing team-based care to integrating behavioral health into other aspects of patient care, the community health model addresses the many factors that influence patient health —factors that larger organizations are incorporating into their own models.

athenaInsight spoke with community health clinicians and administrators about the challenges and rewards of population health management.

Here are edited excerpts from our conversations; please add your observations in the comments section, or tweet us your thoughts @athena_Insight.

On the integrated continuum of care

Myechia Minter-Jordan, M.D., MBA, president and CEO, the Dimock Center, Boston: On our campus, we have Head Start and Early Head Start, behavioral health, and the health center. We do dental, optometry, and orthopedics within our primary care site. Under the behavioral health umbrella, we have inpatient detox and outpatient mental health and addiction services; the outpatient is integrated into our adult and pediatric clinics.

As much as we talk about "patient-centered care," I think of our program as "family-centered care." However a family comes to us, we want to make sure that they can take advantage of all of the programs and services.

Anne Nash, M.D., medical director of quality, Southern Illinois Healthcare Foundation: We have several sites that have integrated behavioral health in terms of being able to come into the room at the time that the patient is there and do a brief intervention and then get them scheduled for follow-up. And integrating behavioral health into our pediatric

practice is letting us catch postpartum depression. We have been trying to make sure that we get all our moms scheduled for postpartum visits, but we're also screening the moms at the baby visits.

Minter-Jordan: We integrated our behavioral health with our pediatric clinic long before many others and followed in those footsteps to do the same with OB/GYN and then internal medicine. It has really helped to support what we knew was the most effective way to deliver patient care, and the data prove that these are the most effective ways to reduce costs and create better efficiency, better patient satisfaction, as well as better provider satisfaction. Now we're in a position where it is fully recognized that without behavioral health, you can't practice primary care.

On team-based delivery and cultural competency

Kirsten Meisinger, M.D., medical director, Cambridge Health Alliance Union Square, Cambridge, Mass.; and national co-chair, Centers for Medicare and Medicaid Services Transforming Clinical Practice Initiative: Increasingly, people understand that shared decision-making is the only effective way to manage chronic disease. We have invested very heavily in relationship-based team care. We have very highly developed professional relationships across the team, allowing us to support each other in the care of a challenging population. By feeding those professional relationships, we actually get a more profound patient focus.

Nash: A care team for us at a larger site is usually the providers, a nurse, and a medical assistant. And then we also have clinical pharmacists and our behavioral health team, they kind of go between teams as a shared resource. At the smaller sites, it's going to be your nurse, your MA, your provider.

Wayne Sottile, CFO, Esperanza Health Centers, Chicago: We created healthcare teams and added care coordination. The team of the physician, the MA, and the care coordinator assess patients, assign them a risk score based on their health, and develop a strategy to treat that patient in an ongoing model.

Meisinger: For us, the structure of the interaction is based on team meetings — 30 minutes each week on a different health topic. So, this week is depression. We have a team member focused on the registries, which is the mechanism of integrating population management into primary care and other clinical environments. She has reviewed the registry ahead of time and met with the nurses every week, so they're already the experts. We sit as a group and discuss the cases: "What do we need to do next? Who has pieces of information about their life that the group needs to know?" And because the work has been teed up, it's very fast.

Minter-Jordan: We practice in teams in the health center, and our teams are incredibly diverse. Even if the provider is not of the same country of origin as their patient, someone on the team is, so the diversity in teams is really where people learn about the cultural competency.

Sottile: It doesn't end with the patient seeing their provider or sitting with a care coordinator. We developed a diabetes program with classes teaching them how to manage diabetes through diet, lifestyle, and exercise. We do the same thing with hypertension patients. And we've opened up our diabetes classes not only to our patients, but their families, whether that's a spouse, children, parents, grandparents — whoever has a hand in helping that patient maintain a healthy lifestyle.

Minter-Jordan: It's just part of our culture that we are all in this together. The case manager is just as important on the team as a physician, because if the case manager can't find the patient stable housing, then the medical issues will never get addressed. There is a recognition of the important role that each person plays in the patient's healthcare plan.

Meisinger: Your staff is just as important in providing good care to your patients as the doctor is. Without them, you can't get your job done.

On data-driven population health management

Nash: We developed a centralized tracking system so that everybody tracks their data in the same way and stores their data on a shared drive. And the data enables us to work with the staff to offload many things from the providers, because our goal is to have each person in a team working at the highest level of their license. A lot of population health doesn't need to be done by the provider — we would rather they focus on caring for the patient and have the staff care about whether they need their pneumonia shot or whether they are up to date on their colonoscopy. We have dramatically increased the completed labs and have an easier way to track them.

Sottile: We found a very effective way to handle colorectal cancer screenings. We probably had 30 to 35 percent of our patient population that needed screenings having them done. A lot of our patients don't have access to colonoscopies, either because they're uninsured or the cost to them was exorbitant. We found what are called "fit kits," like a stool sample. All they have to do is bring it back to the clinic, and our lab tests it. If it's positive, we get them in sooner for a colonoscopy. And we're now a little over 70 percent compliant.

Nash: We try to focus on the key quality measures there that are compelling for the doctors that make them say, "Yes, we have improved the overall health of our patient population." So showing quantitatively that you're doing a better job controlling certain conditions, like diabetes or high blood pressure, can really have a big impact. And I think the patients are starting to feel the difference, to feel that we're more invested in their care and trying to get them in for preventative care. And I am hoping that it makes them feel like more active partners in their care.

On financial and operational support for the shift

Sottile: You have to be willing to take on some investment up front, typically in staffing, and have the financial strength to take on that cost. It took us probably nine to 12 months before we really started seeing some of the benefits in terms of higher quality measures and lower costs.

Minter-Jordan: It's a matter of prioritization and understanding that it's an investment, but the investment has a payoff — not only from the business standpoint but more importantly from the patient and the provider standpoint. Be very strategic as to how you supplement potential losses, through growing another line of service, through thinking about mergers and acquisitions. You have to think about how you maximize those other areas of service in tandem with making the organizational changes.

Sottile: Another piece would be working with some of your more progressive payers and saying, "Here's the model that we want to implement. How can you help us offset some of this initial cost for the long-term gain of both of us?" Because as we improve outcomes for our patients and drive down the overall costs of healthcare, it will benefit the payer.

Minter-Jordan: The healthcare system is changing. It's going to change whether or not people make this move, so it's either you get out in front of it and you drive it, or you are driven by it.

Lia Novotny is a regular contributor to athenaInsight.