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The pop health journey: The value of strategy

By Jason Mitchell, M.D. | May 11, 2017

As a family practice physician, I love seeing my patients improve their health, whether that means quitting smoking, lowering high blood pressure, or managing diabetes. The challenge is considerable, but so is the potential reward.

The opportunity to make this kind of sustained improvement across an entire population of patients is even more exciting. Still, as a leader of a large healthcare organization, I know that embarking on a population health journey is daunting. The challenges include determining which value-based programs to implement, how to best measure progress through data and analytics, and the scale of the organizational investment.

At Presbyterian Healthcare Service — a not-for-profit integrated healthcare system in Albuquerque, New Mexico with eight hospitals, a health plan, and a medical group — we have long focused on measurable initiatives targeting specific conditions. In December 2015, we launched a strategic approach to drive the planning, structure, and leadership of a centralized population health department. One specific priority was engaging physicians in population health work. For this reason we created a Physician Accountability Council and are also beginning a population health fellowship.

We also knew it was critical to align Presbyterian's strategic goals with our population health effort. This has enabled us to create joint value-based care approaches across our entire organization — and deliver effective care while lowering costs.

Now that our population health department is well-established, our biggest strength is our awareness of the needs of our patients and members. Our greatest challenge is quickly responding to the demands of the ever-changing healthcare industry.

Three examples of how we've managed to transform care stand out.

The right care in the right setting

In the first year of our new strategic approach, one project focused on using data and analytics to analyze cost and quality drivers in our senior population. We identified a variety of opportunities in the post-acute setting and worked closely with clinicians to ensure

that patients were set up for best outcomes and were transitioning to the best care setting.

We also partnered with clinical leaders and facilities to share best practices and decrease the length of stay. As a result, skilled nursing facility costs for the Medicare Advantage HMO population declined more than 21 percent, and inpatient rehab facility costs dropped more than 10 percent from 2015.

We were also able to bend the overall cost curve (which includes medical, pharmacy, and behavioral health costs) to a negative 0.49 percent trend for the Medicare Advantage HMO in 2016. This was down from the increase in our overall cost of more than 3 percent the year before.

Support for Medicare Advantage patients

Our Complete Care program focuses on Presbyterian Health Plan's Medicare Advantage members with the most serious illnesses, who account for about half of costs for this population. They have one number to call 24 hours a day and have access to intensive RN in-home case management that is integrated with our palliative care and house call programs. The care team comes to the patient in their home, providing support that prevents illnesses from worsening and supports independent living.

So far, the program has driven real results. Readmission and hospitalization rates are 50 percent of those predicted for this population. Many ED visits have been avoided. And we've seen very significant cost savings for the members we serve.

Controlling blood pressure for the entire population

Another program, which actually predates the 2015 initiative, focuses on identifying patients with high blood pressure and developing new ways to manage it. These methods, begun in 2013, include evidence-based protocols for clinicians and support staff, point-of-care decision support through the electronic health record system, clinical population health registries, standardized rooming procedures, and free blood pressure checks and medication checks.

As a result of this team-based approach, Presbyterian was one of 30 healthcare systems across the country recognized by the U.S. Department of Health and Human Services' Million Hearts initiative for success in helping patients control high blood pressure. We continue to sustain nationally excellent performance in the recognition and treatment of hypertension.

Looking toward the future

We are committed to improving the way we can forecast and prepare for changes that affect the populations we serve. As with most efforts focused on meaningful outcomes, we know that data and analytics are critical to our success.

We have established a standard set of metrics that can be tracked and measured against key performance indicators. We continue to grow our capabilities, strengthening our ability to make improvements more quickly to support clinical outcomes and care delivery.

At Presbyterian, we were positioned for success because we have an engaged physician network, strong post-acute partnerships, a system-wide electronic health record system, and existing cost and quality measures. By setting a strategic vision, and putting resources behind it, we were able to align those assets and drive results.

The investment of time, expertise, and technology needed to create a successful population health program can feel overwhelming. But if you can improve the health of the population you serve, there is no greater satisfaction.

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