Health Care Transformation Initiatives: Lessons from the Field

Heather Jorna, Vice President, Health Care Innovation

April 23, 2013
Hospitals and health care systems face common challenges in the transforming health care market:

- Shifting demographics of patients and the workforce
- Transition to value-based reimbursement focused on outcomes
- Greater focus on population health management approaches (health and wellness, ACO / PCMH models, chronic disease management)
- Increasing demand for cost and quality data transparency
- Continuous advances in technology and increasing speed of adoption
- Increasing focus on physician leadership, alignment and engagement
- Challenging variations in care
- Need for clinical integration and care coordination to eliminate care fragmentation and improve transitions
- Growing demand for patient and family engagement
- Access to capital for investments
AHA is focusing on health care transformation research, best practices and leadership development

• Research and dissemination of information on key trends, policy issues, innovations, and best practices
  - Reports and toolkits
  - Webinars
  - Articles and newsletters
  - Case studies

• Leadership and skill development for addressing health care transformation challenges
  - Conferences
  - Workshops, training and continuing education sessions
  - Networking forums and membership support
  - Fellowship programs
Health Care Transformation

Agenda

Best Practices and Lessons Learned on Health Care Transformation Initiatives

• Christy Stephenson, Executive Vice President, Strategic and Clinical Transformation, St. Francis Medical Center

• Stephanie Mills, MD, MHCM, President & CEO, Franciscan Health and Wellness Services, Inc. which operates the Healthy Lives employer wellness program

• Heather Jorna, Vice President, Health Care Innovation, Overview of AHA’s Health Care Transformation Fellowship
Community Transformation

- Trenton Health Team
  - St. Francis Medical Center
  - Capital Health
  - Henry J. Austin Health Center
  - City of Trenton

- Population Served - 6 zip Codes

- Community Needs Score
  - Income
  - Insurance
  - Education
  - Housing
  - Culture
“Health Outcomes are more dependent on one’s Zip Code than Genetic Code”
Community Collaboration

- Senior Leadership
- THT Strategic Initiatives-
  - Primary Care Access
  - Care Coordination
  - Community Engagement
  - Utilize data for Population Health
  - Safety Net ACO
- Community-wide alignment of Strategic Planning and Implementation Plans for effective resource allocation
Health Care Transformation Project

- Catholic Health East – Vision 2017
- St. Francis Medical Center
- Trenton Health Team
  - Safety Net ACO
    - Value Committee
    - ACO Business Plan
- Care Coordination
- Community Health Needs Assessment
- Using data for Population Health
Trenton Community Health Needs Assessment

- Community Advisory Board
- Data Sharing and Data Analysis
- PICO interviews and forums
- Validation, Verification and Prioritization by Community
- Creation of a unified TCHNA
- Development of a unified Community Health Improvement Plan
- TCHNA & TCHIP Dashboard
Partnerships and Collaborations
Primary and Secondary Data

Community Forums

Resident Interviews

Community Partners (CAB)

THT Retrospective Data Analysis

Community Health Needs Score (5 Factors)

Federal and State Public Health Data

Homeless Indicators

Crime Data

Health Needs
Requirements

• A completed community health needs assessment (CHNA).

• The involvement of unrelated collaborative tax-exempt or government organizations as partners in the assessment.

• A community improvement plan (CHIP) developed to address the needs identified in the assessment.

• The community health needs assessment and improvement plan that are available to the public.
Healthy Communities

### Access to Health Services
- Adults with Health Insurance
- Children with Health Insurance
- People with a Usual Source of Health Care
- Percent of San Franciscans Who Have Insurance or Are Enrolled in a Comprehensive Access Program

### An Overview of Mortality Data
- Age-Adjusted All-Cause Death Rate: African American
- Age-Adjusted All-Cause Death Rate: Asian/Pacific Islander
- Age-Adjusted All-Cause Death Rate: Latino
- Age-Adjusted All-Cause Death Rate: White
- Age-Adjusted Death Rates (per 100,000 population) for San Francisco and California
- Life Expectancy for Females
- Life Expectancy for Males

### Cancer
- Age-Adjusted Death Rate due to Breast Cancer
- Age-Adjusted Death Rate due to Cancer
- Age-Adjusted Death Rate due to Colorectal Cancer
- Age-Adjusted Death Rate due to Lung Cancer
- Age-Adjusted Death Rate due to Prostate Cancer
- All Cancer Incidence Rate
- Bladder Cancer Incidence Rate
- Breast Cancer Incidence Rate

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**Infant Mortality Rate**

<table>
<thead>
<tr>
<th>Value</th>
<th>3.7 deaths/1,000 live births</th>
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<tbody>
<tr>
<td>Measurment Period</td>
<td>2009</td>
</tr>
<tr>
<td>Location</td>
<td>County: San Francisco</td>
</tr>
<tr>
<td>Categories</td>
<td>Health / Maternal, Fetal &amp; Infant Health / An Overview of Mortality Data</td>
</tr>
</tbody>
</table>

**What is this indicator?**
This indicator shows the mortality rate in deaths per 1,000 live births for infants within their first year of life.

**Why this is important:** Infant mortality rate continues to be one of the most widely used indicators of the overall health status of a community. The leading causes of death among infants are birth defects, pre-term delivery, low birth weight, Sudden Infant Death Syndrome (SIDS), and maternal complications during pregnancy.

**The Healthy People 2020 national health target is to reduce the infant mortality rate to 6 deaths per 1,000 live births.**

**Technical Note:** The distribution is based on data from 58 California counties.

**Source:** California Department of Public Health

**URL of Source:** [http://www.cdph.ca.gov](http://www.cdph.ca.gov)

**URL of Data:** [http://www.applications.dhs.ca.gov/vaq/default.asp](http://www.applications.dhs.ca.gov/vaq/default.asp)

**Maintained By:** Healthy Communities Institute

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**Time Series Data**

<table>
<thead>
<tr>
<th>Year</th>
<th>Data</th>
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</thead>
<tbody>
<tr>
<td>2004</td>
<td></td>
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<tr>
<td>2005</td>
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</tbody>
</table>
Health Care Transformation Project Status

- Community Health Needs Assessment completed & approved
- Community Engagement
- 990 Obligation turned into Community Asset
- Safety Net ACO Business Plan completed
- Increased understanding of Value and Population Health metrics
- Community-wide Dashboard
Key Findings and Lessons Learned

- Community work with multiple stakeholders takes longer but the payoff is worth the effort.
- No one organization can achieve population health.
- Shift to community-wide comparative data on total cost, avoidable ED and IP utilization and health rankings is effective and enlightening in aligning interests of historic competitors.
- Urban health needs require broad community partnerships.
Health Care Transformation

• Value of AHA Health Care Transformation fellowship
  • Leverage best practices from other communities
  • Focus on lessons learned
  • Accountability with flexibility
  • Acceleration of project
  • Professional growth
  • Community, hospital and system benefits
Contact Information

Christy Stephenson
cstephenson@stfrancismedical.org
Transforming Care

Creating a culture of wellness— a toolkit for success
Our profile: FMOL Health System

Our facilities

Our Lady of Lourdes Regional Medical Center
Our Lady of the Lake Regional Medical Center
St. Francis Medical Center
St. Elizabeth Hospital
Heart Hospital of Lafayette
Assumption Community Hospital
Our Lady of the Lake College
Lake Primary Care Physicians
St. Elizabeth Physicians
Elderly services facilities
Mental & behavioral health facilities
Joint ventures: ASCs, specialty care

Our stats

>1600 acute care beds: 67,000 annual admissions & 573,000 outpatient visits
>10,300 team members
>2,000 medical staff members
>200 employed physicians
40 GME caps/year: 400 LSU residents & 15 Our Lady of the Lake Pediatric residents
$1.4 billion annual revenue
Our vision

To make a significant difference in our communities through Catholic health services…

Improve the value of health care
Build a healthier workforce
Strengthen our communities
The Healthy Lives™ program

Implemented for FMOL Health System in November 2010

• >10,300 employees and >13,000 insured members

• 80% participation rate

• Third year in a row with no premium increase for members

• 1 of 30 companies in the US recognized with a platinum designation *Best Employers for Healthy Lifestyles* from the National Business Group on Health
The Healthy Lives™ program

Expanding our model

• 28 organizations in 8 states
• Fully and self insured
• Companies ranging in size from 30 – 6000 employees
• Variety of industries
  • Government and municipalities
  • Oil and gas
  • Education
  • Manufacturing
  • Banking
  • Health care
• Health care consulting
Building a new competency

- Focus on “health” and not “hospital”
- Learn how to manage risk within populations
- Drive value-based care: cost and quality
- Connect some of the silos within health care
- Foster relationships in care delivery
Strategic touch points

• Improve the health of your own employees & families
• Strengthen employer relations
• Develop innovative care models
• Spark clinical integration
• Care for populations
• Link to new payment models
Healthy Lives™ health plan results

Healthy Lives™ acute care utilization

NUMBER OF INPATIENT HOSPITAL VISITS PER 1000 LIVES

- 2009: 115
- 2010: 93
- 2011: 75

AVERAGE NUMBER OF DAYS IN HOSPITAL

- 2009: 3.94
- 2010: 3.25
- 2011: 3.03
Healthy Lives™ quality metrics

Higher is better

- Wellness/Prevention: Dec-2009 38%, Dec-2010 41%, Dec-2011 44%
- Diabetes: Dec-2009 38%, Dec-2010 49%, Dec-2011 56%
- Hyperlipidemia: Dec-2009 45%, Dec-2010 54%, Dec-2011 57%
- Hypertension: Dec-2009 36%, Dec-2010 42%, Dec-2011 51%
Driving value

PROGRAM SERVICES
- Medical Homes & Providers
- Healthy Lives
  - Analytics
  - Wellness programs
  - Health coaching
- Member Engagement
  - Healthy Lives screening
  - Healthy Lives portal
  - Healthy Lives rewards

EMPLOYER BENEFITS
- Annual Enrollment
- Achieving Results
- Health Coaching
- Healthy Lifestyle Activities
- Claims Analysis
- Healthy Lives Screening

MEMBER BENEFITS

$
Healthy Lives™ ROI targets: FMOL Health System

$4 to $1 ROI

Status quo

Best practice

Total costs: no intervention
Healthy Lives net costs
Consistent performer targets
How it works…

1. Analytics & Consulting
2. Health Assessment & Screening
3. Healthy Lives Wellness Services
4. Health Coaching
Health care is local. Wellness should be, too

- Comprehensive health & wellness services in partnership with health systems
- Strengthen your relationships with employers
  - Data-driven programs that deliver results
  - Prevention, screening & awareness
  - Local & on-site wellness resources
  - Holistic health coaching to target areas of need
  - Patient-centered medical homes
  - Direct contracting
- Diversify your competencies as a provider
  - Create a foundation for population health management
  - Implement practical, value-based care models
Stephanie Mills, MD MHCM
President & CEO
Franciscan Health & Wellness Services
stephanie.mills@fmolhs.org
225.526.4114
Overview

• 9 month, interactive fellowship program

• Provides senior health care leaders with implementation skills to execute on care delivery and payment system transformation

• Appropriate for C-suite or leadership staff in finance, operations, marketing, strategy, physician relations, clinical leadership, population health management

• Key areas of focus:
  - Clinical integration and new care delivery models
  - Physician leadership and engagement
  - Navigating financial risk
  - Population/community health management
  - Other health care transformation issues
Program Components

• **Learning retreats:** Three 1.5 day in-person sessions

• **Web seminars:** Four 1-1.5 hour webinars

• **Action project:** Participants complete a defined project that increases their individual learning while supporting their organization’s goal to implement a new care delivery or payment reform model

• **Advisory sessions:** Coaching and discussion sessions with faculty and AHA staff

• **Networking and information-sharing opportunities:** among industry experts, individual fellows and other membership organizations pursuing similar strategies
### 2011-2012 Fellowship Organizations

<table>
<thead>
<tr>
<th>Organizations</th>
<th>Organizations</th>
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<tbody>
<tr>
<td>Advocate Health</td>
<td>Henry Ford Health System</td>
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<tr>
<td>Ascension Health</td>
<td>NuHealth System</td>
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<tr>
<td>Baptist Health</td>
<td>Parkview Health</td>
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<tr>
<td>BayCare Health System</td>
<td>Pennock Health Services</td>
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<tr>
<td>Baylor Health Care System</td>
<td>Piedmont Healthcare</td>
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<td>Blanchard Valley Health System</td>
<td>ProMedica Health System</td>
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<td>Care New England</td>
<td>Provena St. Joseph Medical Center</td>
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<td>Carilion Clinic</td>
<td>RehabCare</td>
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<tr>
<td>Catholic Health</td>
<td>San Luis Valley Regional Medical Center</td>
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<td>Catholic Health East</td>
<td>St. Charles Health System</td>
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<tr>
<td>Covenant Health</td>
<td>St. Francis Care</td>
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<td>Franciscan Missionaries of Our Lady Health System</td>
<td>University of Texas Medical Branch</td>
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<td>Fairfield Medical Center</td>
<td>Shore Health/Innovation Health Services</td>
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<tr>
<td>Hancock County Memorial</td>
<td>Tampa General</td>
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<tr>
<td>Holy Family Memorial</td>
<td>University of Washington</td>
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What You Will Learn

• Key foundational competencies for implementing care delivery

• Skills to spread successful implementation of new models across health systems

• How to demonstrate value to stakeholders by implementing new care delivery and payment models

• Effective ways to manage cost and navigate risk in the shift toward value-based reimbursement and new payment models

• How to support physician leadership development and increase physician alignment

• Population health management skills
Example Fellowship Projects

1) Develop both a primary care and post-acute strategy with the ultimate goal of meeting requirements for an ACO

2) Align IPA with hospital network and local payers to manage population health

3) Develop a medical home pilot project in partnership with local commercial insurance provider, with goal to improve care, reduce unnecessary readmissions/ED use, and prepare for ACO development

4) Create clinically integrated network with payers that incorporates physician incentives for quality

5) Develop a health and wellness pilot program with the organization’s self-insured employee base; implement a health coaching model to improve quality, costs, member engagement, provider participation, and develop population health management capabilities

6) Create evidence-based bundles of care to reduce readmissions for heart failure
<table>
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<tr>
<th>Key Dates</th>
<th>Activities</th>
<th>Location</th>
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<tr>
<td>May-Jun. 2013</td>
<td>One-on-one coaching</td>
<td>Teleconference</td>
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<tr>
<td>July 22-23, 2013</td>
<td>• Learning Retreat #1: Clinical Integration – Engaging Physician Leadership</td>
<td>San Diego, CA</td>
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<td>in Managing Population Health</td>
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<tr>
<td>July 25-27, 2013</td>
<td>• AHA/Health Forum Leadership Summit (optional, included in tuition)</td>
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<td>Jul.-Oct., 2013</td>
<td>One-on-one coaching</td>
<td>Teleconference</td>
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<td>Aug.-Oct. 2013</td>
<td>Webinar #1 and 2</td>
<td>Web</td>
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<td>Nov. 6-7, 2013</td>
<td>Learning Retreat #2: Navigating Financial Risk through Health Care’s</td>
<td>Chicago, IL</td>
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<td>Transition to Value</td>
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<td>Nov.–Mar. 2014</td>
<td>One-on-one coaching</td>
<td>Teleconference</td>
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<td>Jan.–Feb. 2014</td>
<td>Webinar #3 and 4</td>
<td>Web</td>
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<td>Mar. 3-4, 2014</td>
<td>• Learning Retreat #3: Building Partnerships to Enhance Population Health</td>
<td>Orlando, FL</td>
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<td>Strategies</td>
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<tr>
<td>Mar. 5-7, 2014</td>
<td>• Association for Community Health Improvement (ACHI) Annual Meeting</td>
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<td>(optional, included in tuition)</td>
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**Tuition**

- $19,500 per organization (*discounts may be available*)
- Includes fellow, plus 1 or 2 additional colleagues
- Covers:
  - All program materials for learning retreats and webinars
  - Registration fees for 2013 AHA/Health Forum Leadership Summit in San Diego
  - Registration for 2014 ACHI Annual Meeting in Orlando, FL
  - Breakfasts, lunches and some dinners during fellowship retreats
- Space limited to 20 organizations

**Application**

- Deadline extended until **Friday May 10, 2013**
- Application available at: [www.AHACareTransformationFellowship.org](http://www.AHACareTransformationFellowship.org)
- Contact [HCTfellowship@aha.org](mailto:HCTfellowship@aha.org) or (877) 243-0027 for more information