Resources: For information related to population health, visit www.hpoe.org.

Suggested Citation:

Managing Population Health: The Role of the Hospital. Health Research & Educational Trust, Chicago: April 2012. Accessed at www.hpoe.org

Accessible at: http://www.hpoe.org/population-health

Contact: Natasha Goburdhun, ngoburdhun@aha.org or 312-422-2623

© 2012 Health Research & Educational Trust. All rights reserved. All materials contained in this publication are available to anyone for download on www.hret.org, or www.hpoe.org for personal, noncommercial use only. No part of this publication may be reproduced and distributed in any form without permission of the publisher, or in the case of third party materials, the owner of that content, except in the case of brief quotations followed by the above suggested citation. To request permission to reproduce any of these materials, please email HPOE@aha.org.

Table of Contents

Executive Summary........ 3

Introduction........ 4

Defining population health........ 4

Why Population Health?........ 5

Forces are driving hospitals toward population health........ 5

ACA encourages hospitals to adopt population health management strategies........ 5

The Hospital's Role in Population Health Management........ 6

How Hospital Leaders View Population Health Management........ 7

The shift from managing individuals to managing populations varies by hospital size........ 7

A focus on population health is already occurring at most organizations........ 7

Population health requires partnerships for success........ 8

Successful Population Health Management: Partnerships Focus on Patients, Family, and Community........ 9

Hospitals are already partnering to achieve goals of population health........ 10

Establish provider collaborations that span the care continuum........ 11

Partner with physicians for an expanded focus on quality and outcomes........ 12

Create hospital-payer collaborations to advance care coordination........ 13

Work directly with community employers to improve health outcomes........ 14

Look beyond clinical care partnerships to improve access to care and other necessary community services........ 15

Work with public health agencies, the government, and other partners to achieve improved health care outcomes........ 16

The Discussion Is Just Beginning........ 17

Endnotes........ 18

Executive Summary

The American Hospital Association Committee on Performance Improvement's inaugural report, ***Hospitals and Care Systems of the Future***, prioritizes population health as a must-do strategy for hospitals and health systems to succeed in the evolving health care environment. As the publication asserts, "The aging population and the onset of value-based payment structures demand hospitals to take a more prominent role in disease prevention, health promotion, and other public health initiatives."

To meet patient needs in the current market, hospitals have traditionally focused their efforts on caring for individuals and personalizing care for each person admitted to their facility. Common community health initiatives, such as mobile vans, health screenings and education fairs, are sometimes delivered apart from an overall strategy or impact analysis. However, external forces to simultaneously reduce cost, improve quality, and implement value-based payment programs command that organizations examine how to manage the health of their patient populations to improve outcomes.

Hospitals and health systems of varying size, patient demographics, and geographic regions have begun to recognize that the main mechanisms to advance population health—improving quality and patient safety, increasing care coordination, and expanding preventive services—are the outcomes of initiatives they are already pursuing. Although the financial incentives are not yet truly aligned, there are efforts that health care organizations can take to improve care delivery in the current volume-based market that will be even more essential in the future value-based reimbursement system.

This guide is designed to define population health, describe strategies to improve the health of a hospital's patient population, inform leaders why these initiatives are essential, and explore potential partnerships that can help achieve the desired goal as illustrated in the diagram below. Short case examples provide supporting evidence and show that every health care organization already possesses some of the capabilities necessary to institute programs that improve health outcomes within a defined population.

Figure 1. Population Health Requires Partnerships to Improve Outcomes

Source: HRET, 2012.

Introduction

Defining population health

Population health can serve as a strategic platform to improve the health outcomes of a defined group of people, concentrating on three correlated stages:

1. The distribution of specific health statuses and outcomes within a population;
2. Factors that cause the present outcomes distribution; and
3. Interventions that may modify the factors to improve health outcomes.

Population health resides at the intersection of three distinct health care mechanisms (see figure 2). Improving population health requires effective initiatives to (1) increase the prevalence of evidence-based preventive health services and preventive health behaviors, (2) improve care quality and patient safety, and (3) advance care coordination across the health care continuum.

Figure 2. Mechanisms to Improve Population Health

Source: HRET, 2012.

Table 1 below outlines the childhood asthma program at Cambridge Health Alliance[1] to illustrate the use of prevention and care coordination strategies to improve population health management.

Table I. Defining Population Health Initiatives at the Cambridge Health Alliance

Source: HRET, 2012.

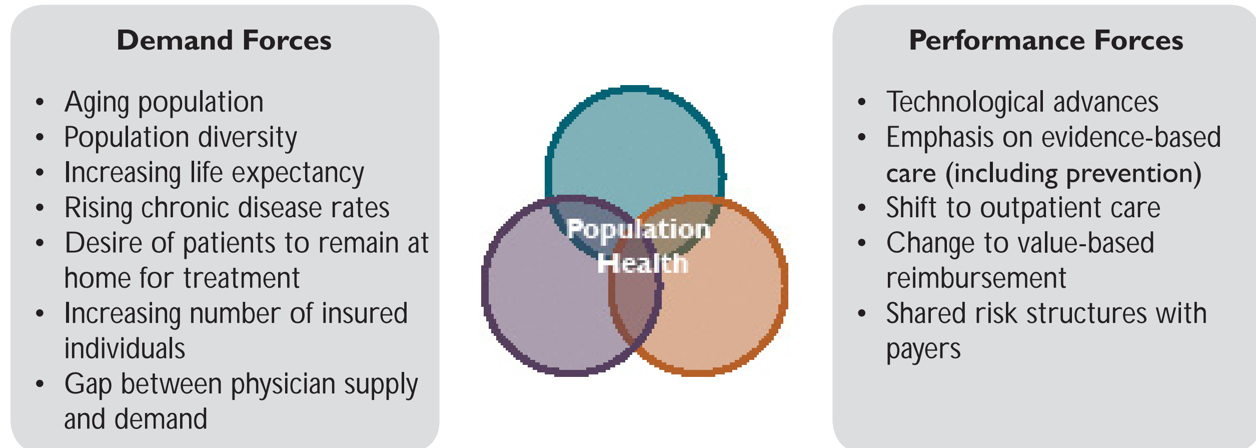
	Process Questions	Results
Outcomes	What health statistics are inadequate for our catchment area and what population does this affect?	• Asthma is the leading chronic disease among children. • Cambridge Health Alliance was seeing a high number of pediatric inpatient admission for asthma.
Factors	What is causing the outcome that we are seeing?	• Low adherence to medication regimen. • Lack of knowledge about asthma attack triggers in children.
Interventions	What initiatives can we implement to modify and improve on the factors listed above?	• Web-based registrey used by physicians and school nurses to assess correct prescription and medication adherence. • Home visits by providers to help parent decrease or remove asthma triggers.
Impact	What are the results of the intervention?	• Increased adherence to asthma medication regimens. • Astha-related hospital admissions dropped by 45% from 2002-2009. • Asthma-related ED visits dropped by 50% over the same time period.

Why Population Health?

Forces are driving hospitals toward population health

The current volume-based reimbursement system is designed to address acute care needs, and in this system, hospitals can succeed by treating patients that come to them. The increasing rates of chronic disease and the change to a value-based reimbursement system are among the demand and performance forces pressing organizations to take a more proactive approach to patient care—that is, reaching out to the population beyond the traditional four walls of the hospital.

Figure 3. Forces toward Population Health



Source: HRET, 2012.

ACA encourages hospitals to adopt population health management strategies

Several sections within the Patient Protection and Affordable Care Act (ACA) are driving hospitals toward population health management by promoting and incenting prevention, quality and safety, and care coordination strategies. Table 3 summarizes the most actionable initiatives.[2]

Table 2. Population Health Management Strategies through ACA

1. ACA requires tax-exempt hospitals to conduct community health needs assessments every three years and adopt implementation strategies that meet the identified needs, including identifying reasons why any such needs are not being addressed.

2. The law expands coverage for a wide range of prevention and wellness services, increasing incentives for employers that establish wellness programs and eliminating copayments for immunizations, screenings, and other clinical preventive services.

3. The elimination of payment for unnecessary readmissions and the development of delivery payment pilots increase the hospital's accountability for care outside its four walls.

4. Medical home demonstrations, coordination grants, and increased financial support for health centers encourage partnerships between hospitals and other community organizations.

5. ACA creates a fund to provide sustained national investment in preventive and public health programs, including those offered by hospitals to increase access to clinical preventive services and create healthier communities.

Source: HRET, 2012.

The Hospital's Role in Population Health Management

As hospitals move toward population health management, they face considerable barriers to practicing it as an overall strategy. For example, the current volume-based reimbursement system does not provide significant funding to pursue population health initiatives. Additionally, the traditional definition of population health encompasses a broad range of factors that may change health outcomes—everything from the physical environment to social structure to resource allocation. As a result, hospitals may find it difficult to identify which population health factors they can directly impact with their limited resources.

Hospitals and health systems have started to realize that the mechanisms to advance population health —improving quality and patient safety, increasing care coordination, and expanding preventive services— support the patient initiatives they are already pursuing. Although the financial incentives are not yet fully aligned, specific efforts by organizations to improve care delivery in the current volume-based market also will be essential for care delivery in the future value-based market.

Table 3 identifies factors typically included within population health, grouped according to those outside the health care system and those inside the health care system. Another tier separates the factors within control of the health care system into groups based on care delivery and the external regulatory environment. The orange box in the middle represents opportunities for hospitals to explore. Not all efforts to improve the health of the population necessarily address the entire community. Some organizational efforts may focus on changes for one segment of the overall patient population.

Table 3. Factors Influencing Population Health[3]

Outside Health Care System	Related to the Health Care System	
Societal Factors	**Care Delivery**	**Regulatory Environment**
• Food safety • Healthy food availability • Housing conditions • Neighborhood violence • Open space and parks/ recreation availability • Genetic inheritance • Disease prevalence • Income levels • Poverty rates • Geographic location • Unemployment rate • Uninsured/underinsured rate • Median age • Sex • Race/ethnicity • Pharmacy availability • Care-seeking behaviors • Health literacy • Patient choice • Morbidity rates • Transportation availability	• Quality of care • Efficiency • Access • Physician training • Health IT system availability • Distance to and number of hospitals, primary and urgent care centers, retail clinics, etc. • Provider supply (MDs, RNs, etc.) • Physician mix (primary versus specialty care) • Payer contracts • Physician employment and payment structure • Disease management • Population subgroup disparity • Advanced technology availability • Care integration and coordination • Behavioral health availability • Cultural and linguistic access	• Medicare payment rates and policies • Medicare and Medicaid care delivery innovation • CON regulation • Medicaid/CHIP policies (payment rates, eligibility) • Implementation of ACA • Local coverage determinations (LCDs) • Other local, state, and federal laws that impact the way health care is delivered and which treatments are provided

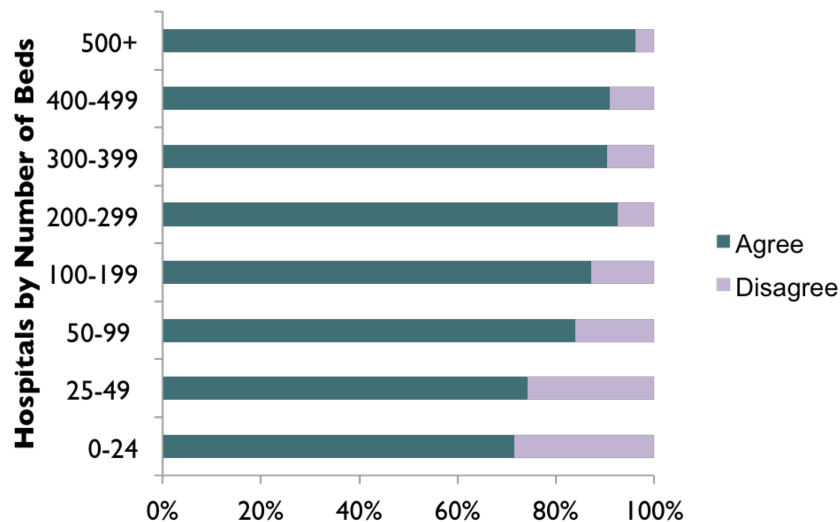
Source: HRET, 2012.

How Hospital Leaders View Population Health Management

The shift from managing individuals to managing populations varies by hospital size

A recent American Hospital Association survey of hospital chief executives shows that leaders of larger facilities are more likely than leaders of smaller facilities to focus on population health management as a necessary strategy in the current market to guarantee success in the future. The variation is attributed to the overall size of the organization's patient population—the larger the patient base, the stronger the push will be to examine and explore solutions in the aggregate. Additionally, smaller rural and critical access hospitals typically will have neither the human capital nor the financial resources to implement overarching population health strategies in ways comparable to larger facilities.

Figure 4. Hospital CEO alignment to pursue population health by bed size (n=652)



Source: SchellingPoint, LLC, and AHA Committee on Performance Improvement survey, November 2011.

A focus on population health is already occurring at most organizations

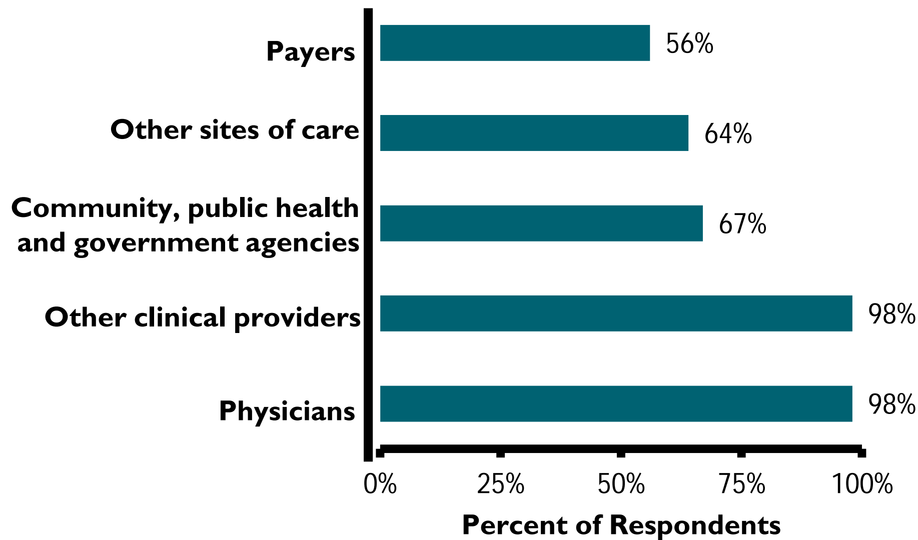
The AHA survey revealed that 98 percent of chief executive respondents agree, at least at some level, that hospitals should investigate and implement population health management strategies. More than 75 percent of senior management, even at the smallest organizations, recognizes the value of exploring these initiatives. Anecdotal quotes from organizational leaders indicate that it is not "if" they will have to pursue these strategies but "when" — within the timed shift to a value-based reimbursement system.

Responses from hospital leaders are more varied when they detail their individual roles within the overall strategy for population health management. The chief executives of smaller and more rural hospitals and health systems indicate they will most likely be collaborating on a larger organization's charge toward population health rather than implementing their own strategy. As previously noted, many larger organizations with more resources are already pursuing population health strategies such as chronic disease registries and disease management programs for their bigger base of patients.

Population health requires partnerships for success

The mechanisms to improve population health—improving quality and patient safety, increasing care coordination, and expanding preventive initiatives—demand greater accountability from all parties within the health care system. Hospital leaders point to a variety of collaborations that may help them achieve these goals, exhibited in figure 5. Although the area of most agreement among executives is the desire to work with physicians and other clinical providers, a majority indicated the need to go beyond historical partnerships and explore relationships with community organizations, payers, and other clinical care sites to address health care issues that they cannot accomplish on their own.

Figure 5. Percentage of CEO respondents who would explore collaborations with the following partners (n=652)



Source: SchellingPoint, LLC, and AHA Committee on Performance Improvement survey, November 2011.

Successful Population Health Management: Partnerships Focus on Patients, Family, and Community

True population health improvement is not an outcome that hospitals and health systems will be able to achieve without collaboration and shared ownership of goals with other sectors. As depicted in figure 6, several segments of the health care system play roles in population health management. The solid lines in the diagram represent the sectors that have more direct interaction with individuals within the population, whereas the dotted lines signify a service relationship with the population more generally. While each sector plays a distinct role, all follow the mechanisms to advance population health—improving quality and safety, increasing care coordination, and expanding preventive care services for patients, their families, and the overall community. The methods to achieve successful outcomes will vary by the missions and abilities inherent within each sector of the health system.

Figure 6. Population Health Requires Partnerships to Improve Outcomes

Source: HRET, 2012.

Hospitals are already partnering to achieve goals of population health

Hospitals already have an established record of partnering to improve population health. Collaborations with other sectors enable hospitals to have a deeper and more comprehensive reach in population health management and to share financial and other resource commitments necessary to pursue their goals. The organizations that have started the collaboration process recognize the need to establish these relationships now, so operations will be in place before the transition to a value-based reimbursement system. If organizations wait for financial incentives to align with these initiatives, they may not be prepared to succeed.

Table 4 identifies partnerships that are currently in place between various segments of the health care system, with the goal of improving population health through changing care delivery. As evident by the outlined (in orange) box, hospitals and health systems are in the unique position of partnering with every other other segment.

Table 4. Current Health Care System Partnerships to Improve Population Health

	Physician	Hospital	Payer	Employer	Social Services	Public Health
Physician	•	•	•	X	X	•
Hospital	•	•	•	•	•	•
Payer	•	•	X	•	X	X
Employer	X	•	•	X	X	X
Social Services	X	•	X	X	•	•
Public Health	•	•	X	X	•	•

X = Partnership not yet common in population health management

• = Partnership common in population health management

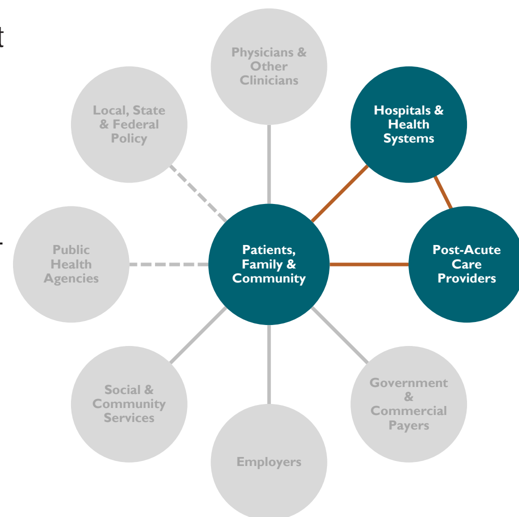
Source: HRET, 2012.

The following pages describe the characteristics of different collaborations across the health care system. Short case examples profile organizations that have implemented these initiatives, already recognizing the partnerships' benefits despite financial challenges.

These collaborations illustrate how population health initiatives can focus on patient subgroups large and small, on frequent hospital users, and on those who need more preventive screening and more support to improve health literacy and change health behaviors. Some partnerships are more common than others and have realized specific benefits already. Others will take more time to gain prominence and prove they can produce positive outcomes. The case examples further emphasize that many hospitals have already been pursuing population health management to some degree, and those that have not yet done so have the tools to start. The examples also highlight many partnerships that involve more than two segments of the health care system and their keys for success.

Establish provider collaborations that span the care continuum

The reality of future payment restrictions is one factor that has encouraged hospitals to analyze segments of their patient populations to determine if they are being treated in the right location at the right time with the most appropriate services. Unnecessary ED visits and readmissions are the obvious targets. Collaborations with other sites of care such as clinics, long-term care providers, urgent care centers, and even other hospitals can ensure that the population is receiving the appropriate level of care. The case studies below provide two examples. The capacity and characteristics of the partnerships vary according to the needs of each organization and its population. Both Summa Health System and the University of Chicago Medical Center found success by identifying other organizations that were open to collaboration and serving as facilitators in the partnerships between a large number of competitive institutions. While these case examples focus on the resulting hospital benefits, successful provider collaborations also will lead to a better distribution of patient volume across partners and ensure patient populations have access to the appropriate providers based on their care needs.



Who: Care Coordination Network at Summa Health System, Akron, Ohio

Outcomes: Summa was seeing lower quality outcomes, longer hospital stays, and higher rates of readmissions for patients transferred to and from SNFs.

Factors: Impractical transfer forms, area SNF competition, and the complex patient population all led to ineffective communication and unnecessary hospital readmissions.

Interventions: Summa collaborated with 37 local SNFs to create the CCN, which streamlined patient transitions. They worked to create an electronic referral process, an easy-to-use form, and encouraged regular meetings among the parties to encourage collaboration.

Impact: Analysis has shown fewer readmissions from SNFs, reduced length of stay, improved schedule adherence, and better volume distribution at SNFs.[4]

Who: University of Chicago Medicine and UCM's Clinics, Chicago, Illinois

Outcomes: About 40% of the more than 55,000 visits to the adult emergency department at UCM were either preventable, low acuity and treatable in a different setting, or both.

Factors: Lack of patient knowledge and of familiarity with accessible health centers to manage chronic illnesses.

Interventions: UCM created the Southside Healthcare Collaborative, a partnership to encourage patients to find a medical home. Patient advocates were placed in the emergency department to refer low-acuity patients to high-quality care faster or to help find a primary care physician for follow-up visits.

Impact: The number of unnecessary ED visits decreased by 10% in the first year of the program (2005–2006). More than 5,600 patients gained a medical home, and the number of clinic appointments increased by 40% in the same period (2006–2010).[5 6]

Partner with physicians for an expanded focus on quality and outcomes

According to an AHA survey, more than 98 percent of hospital chief executives believe they should seek further alignment with physicians and other clinical providers. Both parties understand that they all will be held more accountable for their patients' health outcomes in the future, and collaborations are the best way to ensure that high-quality care is provided across the continuum. Hospitals have the clinical data resources to analyze and reduce unnecessary variation and establish best practices in quality improvement interventions, and physicians have the direct patient interaction to support individual behavior change. Successful partnerships will facilitate improved care coordination, reduce unnecessary admissions, and improve physician access to appropriate evidence-based standards—leading to better population health outcomes.

Who: Billings Clinic, Billings, Montana

Outcomes: Billings had a large diabetes population not following typical care protocols.

Factors: Diabetes care is challenging in rural areas where there can be a limited number of primary care physicians. These physicians typically have limited resources, and patients have fewer local educational opportunities to better manage their chronic diseases outside of physician visits.

Interventions: Billings enrolled patients, regardless of insurance status, in its disease registry and disease management program, emphasizing the physician's role to achieve compliance with clinical guidelines. PCPs are provided with data profiles on diabetes patients before appointments, including real-time reminders on various diabetes health outcome measures to facilitate necessary discussions. The Billings-sponsored EMR allows physicians to input patient-specific report cards to monitor health progress and make changes to treatment as necessary.

Impact: More than 7,000 diabetes patients are enrolled in this program, and physician compliance has increased significantly.[7]

Who: Wenatchee Valley Medical Center, Wenatchee, Washington

Outcomes: Average annual cost of care for their costliest Medicare population was $17,500, compared to the $6,000 average annual cost for traditional Medicare patients in the same region.

Factors: About 48% of costs for these patients were due to ED visits and inpatient hospital charges; a lack of care coordination with physicians increased these expenses.

Interventions: WVMC entered into a CMS payment demonstration project to improve care coordination for these patients. They secured provider involvement by (1) holding meetings with providers to create a "shared vision," (2) acting on those providers' suggestions, (3) incenting physicians with shared savings, and (4) creating a collaborative culture.

Impact: WVMC saw a decrease in inpatient admissions, length of stay, ER visits (17.7%), and SNF days, as well as an 18% increase in outpatient visits. The cost of providing care to the experimental group decreased as compared to the control group.[8]

Create hospital-payer collaborations to advance care coordination

In the current fee-for-service system, hospitals continue to undertake quality and efficiency initiatives. Savings from these programs, however, have the potential to be realized mostly by the payer if new financial arrangements are not established. As both parties face increased accountability for quality and cost, hospital-payer collaborations have the potential to improve care for the population by sharing data, encouraging alignment with physicians, and facilitating a focus on primary care. This does not mean that all organizations must consider becoming accountable care organizations. Less complex arrangements still lead to incentives to provide preventive care and to adhere to evidence-based protocols. While formal programs with federal payers are more common, relationships with private payers are increasing as well.

Who: Eastern Maine Health Systems and Cigna, Bangor, Maine

Outcomes: Like other hospitals and health systems, EMHS was seeing increased chronic disease rates and a push to reduce costs.

Factors: There was a lack of care coordination across the continuum. Situated in a very competitive market, EMHS could not follow patients leaving the system for other care providers.

Interventions: Cigna entered into a "collaborative accountable care" arrangement with EMHS. Covering 12,000 lives, Cigna aids EMHS to embed care coordinators within primary care practices, provides semiannual reports on patient utilization, and compares EMHS utilization with other organizations. Analysis showed that EMHS was seeing higher ED rates than other area hospitals.

Impact: EMHS care coordinators follow up with patients who have been in the ED unnecessarily the night before and with those who have three or more ED visits within six months, to monitor health and provide information on other available care sites. EMHS also built walk-in care centers to accommodate patients with nonemergent health care issues.[9]

Who: Baptist Health System, San Antonio, Texas

Outcomes: Discharges for specific cardiac and orthopedic procedures were the most costly.

Factors: There was lack of physician engagement in clinical improvement.

Interventions: Baptist applied and was accepted into the Medicare Acute Care Episode Demonstration, which bundled Medicare Part A and B payments for 29 cardiac and orthopedic diagnosis-related groups. The program required the hospital to create standard order sets for routine cases and initiated gainsharing with physicians after four hospital- and physician-level cost and quality goals were met. Baptist committed to a lower base payment from Medicare, with incentives if spending across the continuum was reduced.

Impact: After one year of implementation, there were significant improvements in orthopedic quality metrics as well as increased standardized order set utilization (0–87%). About $1 million was distributed in shared savings to both patients and physicians, and Baptist saved approximately $8 million from June 2009 through December 2011.[10] They reduced cost by more than $2,000 per case.[11]

Work directly with community employers to improve health outcomes

Many health systems and hospitals have recognized that one of the easiest ways to reach a large portion of their patient population is by working directly with local employers. These collaborations can begin by offering community wellness classes on prevention and common illnesses or preventive screenings at employers' offices during work hours. Other organizations have established onsite health clinics and more direct contract payment relationships. For the employer, working with hospitals has the potential to decrease health care costs and employee absences while increasing productivity and employee morale. For hospitals, working with employers can help them reach a wider demographic for preventive services at patients' convenience, thereby increasing the patient populations seeking care at the right place and time.

Who: AtlantiCare Special Care Center, Atlantic City, New Jersey

Outcomes: Local 54 Health and Welfare Fund provides benefits for 14,000 union workers employed by restaurants, hotels, and casinos. These employees were experiencing rising insurance costs due to increased rates of chronic diseases. AtlantiCare was seeing high rates of uncompensated care spending for preventable ED use and hospitalizations

Factors: There was a lack of care coordination for complex patients, typically those with low socioeconomic status, multiple chronic conditions, and low health literacy.

Interventions: AtlantiCare opened the Special Care Center for Local 54, which is a primary care center for patients with chronic illnesses that features personalized health coaches, longer visits with physicians, protocol-based planning, multidisciplinary clinical care, no pharmacy copayments, and salaried physicians. The health coaches work directly with patients to proactively manage care. Local 54 pays AtlantiCare per member per month rates for all primary care.

Impact: According to analysis conducted between 2008 and 2009, SCC patients experienced 41% fewer inpatient admissions and 48% fewer emergency visits. There were improved outcomes in pharmaceutical compliance, quality indicators, and generic use. Spending on primary care visits, prescription use, labs, and testing increased because patients were more compliant with care protocol.[12 13]

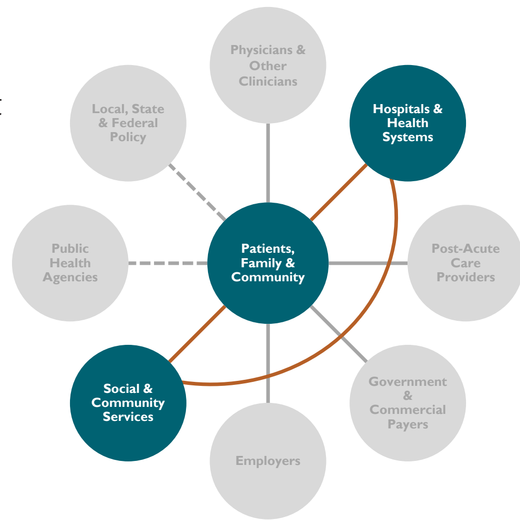
Who: Indiana University Health Goshen, Goshen, Indiana

Interventions: To encourage partnerships with employees of local businesses, this 125-bed facility started "Get Fit, Get Health," an employee wellness program. Working at the employers' work sites, the program includes health risk appraisals for employees and onsite wellness clinicians and health coaches to share confidential individualized reports and suggest care plans. Periodically, Goshen provides the employers with summary reports, to track employee health improvements.

Impact: While results have varied by partner employer, Goshen's employer partnerships have helped employees lose weight, lower cholesterol, and reduce blood glucose levels.[14]

Look beyond clinical care partnerships to improve access to care and other necessary community services

Hospitals recognize that if they help improve community access to health care, preventive care, and healthy lifestyle behaviors, they have the ability to significantly reduce the incidence of chronic diseases and reduce unnecessary inpatient admissions and ED visits. Hospitals also realize that this is something they cannot do on their own, due to limitations in both financial means and expertise. Therefore, organizations have begun to partner with social service organizations ranging from community and wellness centers to schools and soup kitchens to tackle health issues such as obesity, diabetes, and unhealthy habits. Community organizations have a thorough understanding of population needs and which programs have the most potential for success. These collaborations may be difficult to evaluate based on short-term health outcomes, as these initiatives may identify and expand access for populations with significant health care needs. Promoting prevention and improving the societal factors that support good health are long-term strategies.



Who: Rush University Medical Center, Chicago, Illinois

Outcomes: Humboldt Park had a14% type 2 diabetes rate, two times the national rate.

Factors: A predominantly uninsured and underinsured population, the neighborhood population also has difficulties accessing care due to low health literacy and language barriers.

Interventions: RUMC partnered with the Sinai Urban Health Institute, Norwegian American Hospital, Saint Mary and Elizabeth Medical Center, the Puerto Rico Cultural Center, the Greater Humboldt Park Community of Wellness, and Pueblo Sin Fronteras to create the "Block by Block" program. Captains conduct door-to-door diabetes screenings, connecting residents to community PCPs and other resources available through the newly established Greater Humboldt Park Community Diabetes Empowerment Center. The center has a test kitchen that offers discussions of healthy food options, educational programs, and is staffed by nurses and clinicians who answer clinical questions.

Impact: RUMC committed to accept diabetes patients from Humboldt Park for ongoing care. More than 1,000 residents have been connected to a health care provider to discuss their diabetes risk.[15 16 17 18]

Who: Chadron Community Hospital, Chadron, Nebraska

Interventions: A rural critical access hospital, Chadron has three different food banks, partners with two community action agencies to provide low-cost dental services, and has collaborated to create "Closer to Home," a soup kitchen for the area's homeless population. The hospital works with the local college and primary school systems to provide various nursing services, in addition to developing an alcohol education program with area law enforcement agencies.

Who: Suburban Hospital, Bethesda, Maryland

Interventions: As a result of its community health assessment, Suburban increased cardiovascular outreach and access in the surrounding county in conjunction with the NIH Heart Center, providing free vascular and blood pressure screenings. The hospital donated money directly to two area nonprofit clinics to expand their own services. For the hospital's aging population, Suburban provided more than 1,000 home visits and 68 senior health education seminars and senior-focused exercise classes.[19]

Work with public health agencies, the government, and other partners to achieve improved health care outcomes

Most local, state, and federal governments are dealing with large budget deficits that have forced them to turn to various means to cut spending, and attention has turned to reducing health care costs. The requirement for hospitals to conduct community health assessments will help identify areas for collaboration between hospitals and public health and other governmental agencies, leading to new programs with the potential to reduce costs in the long run. Policy changes create opportunities to significantly increase access to care for complex patients and also help create community conditions that support people's ability to enjoy healthier lives. Combining the expertise in patient care that hospitals have with the broader perspectives and public health experience of the government, this type of collaboration can improve overall population health outcomes.[20]

Who: Woman's Hospital, Baton Rouge, and East Jefferson General Hospital, Metairie, in conjunction with 19 other Louisiana hospitals and the Louisiana Department of Health and Hospitals

Outcomes: The National Center for Health Statistics ranked Louisiana 49th in several birth outcomes including infant mortality, percentage of low-birthweight babies, and preterm births.

Factors: There was a lack of collaboration among hospitals, health care agencies, and the government to make perinatal education and services a priority.

Interventions: In late 2011, Louisiana became the first state to adopt a "39 Week Initiative." A voluntary program, participating hospitals agreed to eliminate the practice of scheduling and performing elective deliveries prior to 39 weeks' gestation. Woman's and EJGH leaders, in addition to DHH administrators, met with other hospitals throughout the state to encourage participation. Additionally, the state worked with the largest malpractice provider to reduce malpractice rates for physicians who participate in training related to this topic.

Impact: Though the initiative is still in early stages for most of the state, Woman's and EJGH have reduced NICU admissions and cesarean section rates by eliminating early term elective deliveries.[21]

Who: Healthy San Francisco, a partnership between the San Francisco Department of Public Health and more than 30 other hospitals and community clinics

Outcomes: The city had a growing number of uninsured residents, leading to high ED usage.

Factors: Uninsured and underinsured populations have reduced access to necessary health care services.

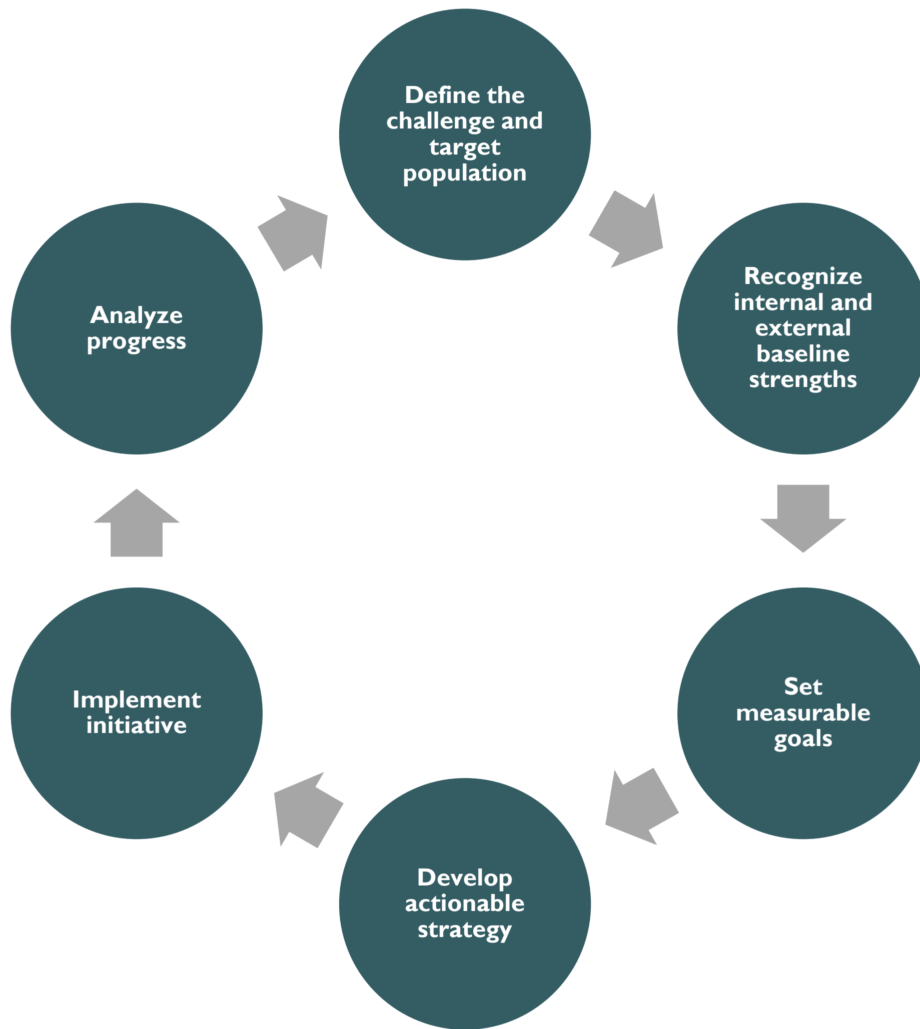
Interventions: The participating hospitals and clinics created Healthy San Francisco, a safety-net consortium of providers for the uninsured coordinated by SFDPH. Emphasis lies on improved care coordination and early treatment, utilizing the medical home model for primary care. Enrollment is offered in a subsidized health care system. Rather than covering uninsured patients with a health insurance product, the consortium provides services through a network of clinics that meet all medical, dental, and vision needs.

Impact: Since its inception, HSF has enrolled 100,000 uninsured residents, 85% of the analyzed uninsured population. Data for 2010–2011 suggest that HSF beneficiaries utilize primary care at the same rate as the national Medicaid population (three office visits per year), go to the ED for avoidable conditions at half the state rate (9% versus 18%), and have a hospital readmission rate at half the national rate (9% versus 18%).[22]

The Discussion Is Just Beginning

This guide is designed to define population health for the hospital executive, describe population health approaches and potential partners, and explain why these initiatives are essential for the future value-based market. The American Hospital Association's Hospitals in Pursuit of Excellence initiative will continue the conversation with more action-oriented case studies based on the framework depicted below. Information and resources are available on the HPOE website at www.hpoe.org.

Figure 7. Framework for Population Health Improvement Initiatives



Source: HRET, 2012.

Endnotes

1. Bielaszka-DuVernay, C. (2011) Taking public health approaches to care in Massachusetts, *Health Affairs*, 30(3) 435-438.

2. Bilton, M. (2011, October). Executive Briefing 3: Community Health Needs Assessment. *Trustee*, 21-24.

3. The American Hospital Association. *Regional Policy Board,* Fall 2010.

4. "Cooperative Network Improves Patient Transitions Between Hospitals and Skilled Nursing Facilities, Reducing Readmissions and Length of Hospital Stays." *AHRQ Health Care Innovations Exchange.* Page accessed 2/6/12.

5. Japsen, B. U. of. C's Urban Health Initiative Growing. *Chicago Tribune.* July 29, 2010. Accessible at: www.chicagotribune.com Page accessed 2/6/12.

6. Thomas, K. *UHI advocates connect patients to medical homes on Chicago's South Side*. http://www.uchicago.edu/features/20091119_uhi.shtml University of Chicago, Page accessed 2/6/12.

7. Berenson, RA. Challenging the status quo in Chronic Disease Care: Appendix with detailed case studies. California Healthcare Foundation. Accessed at: www.chcf.org September 2006.

8. Freed, SD. Delivering Patient-Centered, Accountable Care. *AHA Health Care System Reform Fellowship Retreat 3: Physician Alignment and Clinical Integration.* July 14, 2011. San Diego, CA.

9. Interview with Dick Salmon, M.D., national medical director for performance measurement and improvement at CIGNA. September 2011.

10. Zucker, MC. Implementing Bundled Payment Arrangements. *AHA Health Care System Reform Fellowship Retreat 1: Transforming Care Delivery.* February 16, 2012. Tampa, FL.

11. Mechanic, RE. Opportunities and challenges for episode-based payment. *N Engl J Med* 2011; 365: 777-779. September 1, 2011.

12. Blash, L et al. "The Special Care Center: A Joint Venture to Address Chronic Disease." Center for the Health Professions Research Brief. February, 2011.

13. Page, L. *10 ways Atlanticare's Special Care Center improves outcomes and lowers costs.* http://www.beckershospitalreview.com/hospital-management-administration/10-ways-atlanticares-special-care-center-improves-outcomes-and-lowers-costs.html Becker's Hospital Review. Page accessed 2/4/11.

14. Harkins, K. *Cutting out the middle man: opportunities for hospitals to partner directly with employers*. http://www.beckershospitalreview.com/hospital-management-administration/cutting-out-the-middle-man-opportunies-for-hospitals-to-partner-directly-with-employers/all-pages.html Becker's Hospital Review. Page accessed 2/7/12.

15. *Block by block: a campaign to combat disease.* http://www.rush.edu/rumc/page-1270050437599.html Rush University Medical Center. Page accessed 2/7/12.

16. *Block-by-block*. http://www.chausa.org/Pages/Our_Work/Diversity_and_Disparities/Disparity_Programs/Block-by-Block/. Catholic Health Association of the United States. Page accessed 2/7/12.

17. *Diabetes empowerment center opens its doors to the Humboldt Park community*. La Voz del Paseo Boricua. Page accessed 2/7/12.

18. The New Breed Health System: Adapting Strategy to the Evolving Market Environment. The Advisory Board Company. 2011.

19. Suburban Hospital Community Benefit Report 2010. Suburban Hospital. Accessible at: www.suburbanhospital.org Page accessed 2/7/12.

20. Stine, NW, and Chokshi, DA. Opportunity in austerity—a common agenda for medicine and public health. *N Engl J Med* 2012; 366: 395-397.

21. Louisiana becomes first state to target elective births before 39 weeks; 20 hospitals sign on to 39-Week Initiative. July 13, 2011. Accessible at http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1970. Page accessed 2/2/12.

22. Healthy San Francisco Annual Report to the San Francisco Health Commission FY 2010-2011. Accessed at: http://healthysanfrancisco.org/files/PDF/2010-11_HSF_Annual_Report.pdf