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Population Health Strategies Yielding Results

Texas hospitals are linking patients to primary care, focusing on prevention and more

By Mary Ann Roser

As the lone nurse navigator for population health services at Hendrick Health System in Abilene, Tamara Luedtke, RN, knows the value of taking time to understand why some patients are frequent hospital users and what they need to take better care of themselves.

"One real emphasis for our program is the care coordination piece," she said. "What happens when (patients) transition out of the hospital or the emergency room? Patients want to do what they're supposed to do, but they don't always have the tools or education to do that. (Maybe) they didn't understand their discharge instructions. They don't have a physician. They don't have transportation. They can't afford their medications."

For the past two years, she has been visiting patients in their homes, even going with some to doctor appointments. The first year that she worked intensively with 16 patients, their ER visits fell 43 percent.

Now, she visits about 10 patients a month. The hospital, which is staffed for about 390 beds, has established a community health care worker program, and some of them assist with in-home patient education.

"My main goal for these patients is that they become accountable for their health and they're able to manage their disease," Luedtke said.

Texas hospitals of all sizes are focusing on disease prevention and providing better care to specific populations, especially groups with low incomes and chronic illnesses that can cost less to treat when they're better managed.

Population health is not a passing fad, said David Lakey, M.D., vice chancellor for health affairs and chief medical officer for the University of Texas System, as well as former commissioner of the Texas Department of State Health Services. Two key measures of success are fewer emergency room visits and fewer hospitalizations.

To that end, hospitals are building datasets to gain stronger insights into the populations they serve. Increasingly, too, they are helping uninsured patients find health insurance coverage. And, some hospital workers are finding medical homes for patients lacking a primary care physician, along with analyzing how the social determinants of health, including income, education level and ZIP code, affect access to care and health status.

"There's a deeper understanding that what happens outside the hospital has a deep impact on people," Lakey said. Hospitals at the forefront of embracing population health are rethinking how they deliver care and finding innovative ways to advance that work by tapping into government funding, foundation support and their own revenues.

From Hospital to Medical Home

A common strategy is strengthening the hospital's ties to primary care. That's what Peterson Regional Medical Center in Kerrville is doing in partnership with Peterson Medical Associates, the hospital's physician group.

Together, they established Peterson Community Care clinic in 2013 to provide a medical home for patients who are uninsured or underinsured, said Tracey Richard, the practice manager for PMA. The clinic focuses on frequent ER users and those discharged from the hospital without a primary care provider, helping them establish a medical home and access to free or affordable prescriptions.

"It makes no sense to have uncontrolled diabetes when I can put you on a prescription assistance plan," Richard said. Peterson Community Care, which sees 6,000 to 7,000 patients a year, now has a financial specialist who proactively looks at the target population to identify a possible funding source for care and to address patients' needs in a more comprehensive way.

Establishing rapport with patients is essential, said Richard. A future goal is to help with housing, food and other needs, whether by making an agency referral or helping patients complete government assistance forms. "We like to approach every patient with the attitude of, 'What can we do for you?'" she said. "We can't fix everything, but we try to take a holistic approach."

At Hendrick Health System, primary care access remains a challenge, said Brian Bessent, a system vice president. "Through research and data analysis, we discovered that a large number of individuals were utilizing our emergency department on a regular basis rather

than seeking out primary care. We began looking at ways to help patients better navigate their care options."

Bessent said a community development organization has provided about $400,000 to the health system to help the hospital fund its population health initiatives. "The ultimate goal is for the program to pay for itself as Hendrick continues to work toward better navigation of patients with chronic conditions and limitations of access to care," he said.

Targeting Chronic Illness, Women's Health

Guadalupe Regional Medical Center's population health program also focuses on low-income, uninsured patients who have been in the ER or hospitalized, said Rhonda Unruh, RN and vice president of quality. Participating patients needing a medical home are seen in a clinic on the hospital's campus.

This target group also has one or more chronic diseases and often needs extra help to stay healthy, whether it's counseling to manage the disease or specific disease-related services. For example, diabetic patients get eye and foot exams, along with access to a diabetes educator, Unruh said. The educator teaches patients at the hospital and clinic.

In addition, the Guadalupe County Extension Office, the hospital's main population health partner, conducts diabetes education classes in the community. Cooking classes are held at the extension office, as well as the popular "Walk with a Doc" program to encourage exercise, Unruh said.

"We're challenged as health care organizations to provide better care at a lower cost," she said. "We can't do it within the walls of a hospital. We have to look to our community, to where patients live their lives."

The hospital also works with local organizations, churches and a San Antonio food bank to provide healthy nutrition to needy patients. "When we looked at barriers to improving disease management, a lot of it was financial. Do I buy healthier foods, pay for my medications or pay my light bill?" Unruh said.

Health care organizations must break through financial barriers as well. Unruh said the clinic's operating costs are $630,000 per year – costs that are currently offset by the 1115 Medicaid Transformation waiver. In addition, the clinic added a women's health nurse practitioner last year to target another at-risk group: low-income women needing mammograms and Pap smears. That program is being funded with a two-year, $225,000 grant from the Baptist Health Foundation, said Unruh.

The Medical School's Role

Some academic centers, including Dell Medical School at The University of Texas at Austin, are working with medical students, teaching hospitals and local clinics to advance population health. Dell Med has several initiatives underway, including an innovative program that seeks to prevent colon cancer, said Michael Pignone, M.D., chairman of the Department of Internal Medicine and professor of internal medicine, oncology and population health.

What Dell Med is doing differently "and what could be revolutionary," Pignone said, "is we're taking clinical responsibility for a group of people regardless of whether we see them in the clinic."

His aim is to tackle low colon cancer screening rates in Austin, especially among uninsured and underinsured residents.

Working with the city's largest public clinic system, CommUnityCare, and its parent, Central Health, Dell Med combined two datasets of individuals who are age 50 or older, the typical starting age for testing. The analysis identified 25,000 individuals; Pignone said fewer than a fifth of them were up-to-date on colon cancer screening.

Using a $2.3 million grant from the Cancer Prevention and Research Institute of Texas, the school and its partners provided screening kits to the target group and colonoscopies to those needing further care, Pignone said. "Now, a year and half later, we've more than doubled the people who are up-to-date," he said.

When the program started two years ago, 18.4 percent of the targeted CommUnityCare patients had colon cancer screening. The rate is now 41.7 percent.

Pignone said that success has prompted Dell Med researchers to apply for a new CPRIT grant to pursue lung cancer prevention.

Colon cancer screening rates

The way he sees it, population health is about putting patients at the center of care and improving the overall health of the community.

"We're all motivated as health care organizations to try and control health care costs and be able, at the same time, to set patients up for success so they have a better quality of life," said Unruh of Guadalupe Regional. "At the heart of health care is taking care of people. That's why we do it."