19 hospitals and health systems with unique population health initiatives

Laura Dyrda - Updated Monday, September 19th, 2016

Here are 19 population health programs from hospitals and health systems. The hospitals have reported success in achieving their goals and creating healthier communities.

Becker's Hospital Review will continue updating this list. If you would like to submit a hospital or health system with a population health program experiencing success, contact Laura Dyrda at ldyrda@beckershealthcare.com.

Aria Health, based in Philadelphia, empowered family physician Rob Danoff, DO, to lead population health efforts designed to close the gap in care for high-risk patients. The hospital implemented preventative screening guidelines for chronic disease management to track patients and make sure they are meeting specific screening recommendations. For example, diabetic patients may need annual tests or check-ups and the program has been effective in getting more patients to follow through with these appointments. Aria Health uses software developed to identify patients with specific test needs and alert them when to undergo the tests. The physicians' office staff and case management team contact patients to assist them in making appointments for lab tests or necessary procedures. The program has been effective in reducing hospital readmissions as well.

Atrius Health in Newton, Mass., has been invested in population health for more than a decade to care for patients, combining care coordination with analytic tools and financial tracking to reduce the cost of care. Their initiatives focus on lowering inappropriate hospitalizations and reducing unnecessary lengths of stay in nursing facilities. Atrius Health uses histories from Epic EHRs and pairs them with claims data for alternative payment contracts to address any issues. Atrius Health can identify at-risk groups who may benefit from early interventions and manage those who are already diagnosed with chronic conditions. Then clinical teams and case managers tailor care plans for each patient to receive the right comprehensive care. For example, Atrius can identify patients who are at risk for chronic kidney disease and get them diagnosed and treated sooner.

Bassett Medical Center in Cooperstown, N.Y., is the foundation for Bassett Healthcare Network, a healthcare system serving upstate New York, is focused on providing better care for non-compliant chronic patient populations. Bassett Healthcare partners with IBM Watson to implement the IBM Watson Health solution that drove more than 43,000 additional booked appointments between September 2014 and April 2016. The IBM Watson program offered insight into the best way to gain patient acceptance of automated engagement, including fine-tuning the message's content based on community factors and educating patients and staff on automated outreach.

Baystate Health, based in Springfield, Mass., and serving western New England, used grant funding to build and execute a care management program for patients with chronic medical and behavioral health conditions. The program is powered by technologies such as the Medecision Aerial platform, a SaaS platform for organizations looking to improve population health. The

platform includes solutions for connectivity, interventional and engagement functionality, coordinated workflow and transparency. Since beginning the program, the hospital has reduced readmissions by 15 percent to 60 percent depending on the care setting. Repeat visits to the emergency department are down by 32 percent in patients who frequently use those services and who have complex medical, behavioral and social needs.

Catholic Health Initiatives in Englewood, Colo., has taken steps to fit into the value-based healthcare system by managing the health of key populations and keeping people out of the hospital. CHI covers more than 400,000 people with value-based payment plans and has 10 Medicare Shared Savings Program ACOs with around 252,000 covered lives. It participates in bundled payment for care improvement initiatives at four sites and plans to add five additional sites in the future. The system is also employing more primary care physicians and has implemented an advanced analytics platform by SAS to make its population health strategy more data-driven. Since employing its population health strategy, the system has seen a 21 percent reduction in pneumonia mortality, 27 percent reduction in catheter-associated urinary tract infections, 34 percent reduction in surgical site infections following colon surgery and 45 percent reduction in SSI after hysterectomy. By 2020, the system hopes to derive 65 percent of net patient service revenue from sources other than the hospital inpatient care.

Children's Health, a pediatric system in Dallas, is evolving population health strategies to care for more families in their community. The system has telemedicine programs such as the Remote Patient Monitoring Program, which allows care teams to remotely monitor liver and kidney transplant patients with video conferencing and virtual visits. The system also has a school-based telehealth program, and mobile applications such as My Asthma Pal, a digital action plan for children to manage symptoms and medications. Children's Health is currently also working with GoNoodle to provide family-friendly interactive videos to get kids moving and Pieces Tech, which provides predictive analytics to reduce hospital readmissions for chronic illnesses, to co-develop technology. Children's Health is expanding services to provide care for the entire family through Family Health, allowing the families to see a physician from their home, video kiosk in a local pharmacy or a smartphone.

Children's Hospital of Orange County (Calif.) has a population health initiative with physicians working in the community to innovate in comprehensive care delivery. Mike Weiss, MD, and Shahab Dadjou are leading the hospital's efforts to partner with private practice pediatricians to develop ambulatory care guidelines for continuity of care and five disease-specific patient registries. The hospital is also investing in technology infrastructure with an EHR platform to enhance information sharing and care coordination between CHOC Children's and community providers. The hospital is working with physician leaders to develop care models that drive quality, value, outcomes and patient experience. CHOC participates in a health information exchange with several other Orange County entities.

Christiana Care Health System in Wilmington, Del., piloted a population health management program for ischemic heart disease. CMS funded the program — which began four years ago as a first-of-its-kind for practical applications of population health strategies. The program ran for three years and provided several "lessons learned" that inform the "population health 2.0" program, which has evolved into a care coordination system aggregating rich patient-level data sets in real time. The program also weaves regressive and predictive analytics into care management to enable more precise care for high-risk populations.

Cone Health in Greensboro, N.C., partnered with the University of North Carolina at Greensboro, the Greensboro Housing Coalition and others to develop a pilot project to impact

childhood asthma. The project included 41 families with asthmatic children and examined their environment. Participants were able to improve heating and air systems, remove the causes of mold, eliminate pests, battle dust mites and improve cleaning methods in the homes of asthmatic children. As a result, Cone Health saw fewer asthma attacks which resulted in less rescue medication use and fewer trips to the ED. The housing interventions showed a substantial reduction in hospital costs and charges from $8,650 before the intervention to $4,100 after — a 52.6 percent reduction. The post-intervention hospital treatment for asthma services also reduced costs from $9,607 on average to $1,199, an 82.5 percent reduction in hospital costs. Children reported sleeping better and parents were less stressed worrying about their children and missed fewer days of work to care for their asthmatic child.

Hardin Memorial Health in Elizabethtown, Ky., is a 300-bed healthcare facility that uses Transcend Insights' HealthLogix platform for population health and care applications. The platform helps Hardin Memorial Health organize data into actionable insights to improve outcomes and wellness. The tools help engage the community to reduce ER visits and hospitalizations.

FirstHealth of the Carolinas in Montgomery County, N.C., began FirstReach, a diabetic outreach initiative, in 2007. The hospital created the program in response to Community Health Assessment data showing high diabetes mortality in the county. FirstHealth Moore Regional Hospital, FirstHealth Montgomery Memorial Hospital, FirstHealth Richmond Memorial Hospital — a division of Moore Regional Hospital — and FirstHealth Moore Regional Hospital-Hoke Campus are participating in the FirstReach program for population health. FirstHealth leveraged resources and developed interventions to improve diabetic health outcomes. The American Hospital Association awarded FirstReach the NOVA Award in 2014.

Genesis Healthcare System in Zanesville, Ohio, began focusing on improved care for chronic obstructive pulmonary disease patients after CMS added COPD to the Medicare readmissions penalties list. Genesis worked with its advisory board to develop the COPD Navigator Program so all patients received the necessary care post-discharge. The program includes nurses who work with COPD patients to coordinate care between different clinicians seeing the patient, such as physicians, pharmacists, dietitians and respiratory therapists. The program also provides education and disease management. Genesis reported a 34 percent decrease in 30-day hospital readmissions for COPD patients and avoided more than $500,000 in charges over a six-month period.

HealthEast Care System and Entira Family Clinics, both in St. Paul, Minn., collaborated to form Community Health Network, a Twin Cities ACO. The ACO set a goal to reduce all-cause admissions annually by 50 percent. The ACO created a patient engagement program and saw a steep reduction in readmissions; the readmission rate for the patients in the patient engagement program was 4 percent, compared with 18 percent among patients who didn’t enroll in the program. The ACO, participating in the Medicare Shared Savings Program, saved $1.4 million in its first year and met the threshold for shared savings in 2015 as well, earning more than $2 million. The ACO is building on the success of its patient engagement program for patients with heart failure and Medicare patients transitioning home to also include a chronic obstructive pulmonary disease program to reduce avoidable readmissions as well as a diabetes program.

Lee Memorial Health System in Fort Myers, Fla., undertook a project decades ago to align community leaders around measurable goals to improve healthcare and the health delivery system in Lee County, Fla. The project grew into The Healthy Lee Initiative. The collaboration is now led by 60 members and has a distribution list of 300 active participants. Its goals include

promoting health lifestyles, primary care alternatives to the ED, chronic disease prevention and management, behavioral health, public engagement, healthcare workforce shortage and EMR implementation. Healthy Lee won the 2015 Gage Award for Population Health from America's Essential Hospitals.

Mercy Health System based in Conshohocken, Pa., and serving the greater Philadelphia region, partnered with Mercy Physician Network and Mercy Accountable Care to integrate a social work and community health worker dyad model in one of the most socioeconomically disadvantaged areas the system serves. The program is implemented in the system's West Philadelphia community to eliminate barriers to health and wellness, including transportation issues, financial restraints, behavioral health and substance abuse. The program deploys a licensed social worker and non-clinical community health worker to serve as resources for the ACO's RN care manager and embedded population health nurse. The social worker and community health worker assess social issues relevant to the most vulnerable patients and visit those patients in their home to help relay pertinent information back to the clinical team to better serve the patients along the continuum of care.

Montefiore Health System in New York employed the "Shop Healthy" campaign with its offices of community and population health. The health system used its own data on obesity trends in the Bronx and identified a few specific neighborhoods that would benefit from targeted initiatives to improve access to healthier food and preventative healthcare. In April, the Bronx Borough President honored two of the local markets for selling healthier food to help people with restrictive diets due to diabetes, hypertension and/or obesity.

Nemours Children's Health System's Jessup St. Clinic, an urban pediatric primary care practice serving Wilmington, Del., enacted multiple initiatives in concert with Nemours Health and Prevention Services. The hospital's patient coordinator Michael DiSalvo, a social worker by training, coordinates the programs, which include a resource room with computers, internet access and books for adults and children to use for homework, job searching, diagnosis research or improved literacy. There is also a community health worker and staff psychologist available onsite. The hospital serves breakfast to children and their families over the summer and has a weekly onsite farm stand where people can purchase fresh produce. The hospital partners with local churches and the Boys and Girls Club to increase safety for children and their families, and sends a community health worker to home visits for patients with asthma to address environmental stressors.

NorthShore University HealthSystem in Evanston, Ill., is developing and implementing testing methods for patients most susceptible to inherited cancers. The system is also looking into which cancers are likely to turn deadly compared with those that won't do any harm after cancer is diagnosed. NorthShore researchers developed a highly validated Generic Risk Score performed on a small sample of either blood or saliva to provide personalized risk assessment for prostate, breast, colorectal and other major cancers. The system is also part of several large international studies trying to identify patients susceptible to aggressive forms of prostate cancer and efforts to understand the inherited risk associated with genes passed from generation to generation.

St. Joseph Hoag Health Wellness Corner in Irvine, Calif., focuses on preventative healthcare services for business and residential communities. Services include physical examinations, minor illness treatment, telehealth, medical aesthetics, travel medicine and lab services. There are also lifestyle management and health and wellness programs available onsite, including yoga, sleep improvement and personalized weight and fitness management. The program also

includes nutrition coaching and menu planning. The center reports 60 percent of users saved two or more hours by having preventative healthcare available at the office and 92 percent report saving an hour or more of actual work time by visiting the Wellness Corner instead of their primary care physician. Customer satisfaction for the St. Joseph Health corporate office wellness corner was 9.99 out of 10.