The Promise of Nursing in Population Health: The Experience of Banner Health

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Population Health

• Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group (Evan & Stoddart, Kindig & Stoddart)

• The goal of population health is to improve the quality of care and outcomes while managing costs for a defined group of people (Churchill)

• Population health signals a change in the way health care is accessed, provided and utilized — a move away from reactive responses to an individual's health needs. The concept marks a fundamental shift towards outcomes-based, proactive approaches...and prevention efforts while reducing disparity and variation in care delivery (Cohen)

• Population health is the study of health outcomes, patterns of health determinants and disease states in populations (Stanford Medicine)
What is a Health Disparity?

• “Differences in health outcomes that are closely linked with social, economic, and environmental disadvantage”
• Social determinants of health
• $1.24 \text{ trillion} \rightarrow \text{costs of health inequalities and premature death in the U.S. from 2003 and 2006. (JCPES, 2010)}
Model for Analysis of Population Health and Health Disparities

Social Conditions and Policies
Culture, Norms, Racism, Sexism, Discrimination, Public Policies, Poverty

Institutions
Health Care System, Families, Churches, Community-based organizations, Legal System, Media, Political System

Social/Physical Context

Social Relationships
Social Networks, Social Support, Social Influences, Social Engagement

Individual Risk Factors
Age, SES, Education, Obesity, Tobacco Use, Acculturation, Diet, Race

Biologic/Genetic Pathways
Allostatic Load, Metabolic Processes, Physiological Pathways, Genetic Mechanisms

Fundamental Causes

Social and Physical Context

Disparate Health Outcomes

Individual Demographic and Risk Factors

Biologic Responses and Pathways

Warnecke et al., AJPH 2008
Why Navigation?

• Need for great psychosocial support of patients’ needs – It’s about the patient and their family

• Fragmentation of the healthcare system

• Health disparities and promotion of health equity

• Increase quality coordinated care and provision of medical home
Why Navigation?

- Development of support services that are cost-effective, improve efficiency, and provide quality outcomes
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Patient Navigation

- Navigation services and programs should be provided by culturally competent professional or non-professional persons in a variety of medical, organizational, advocacy, or community settings.

- The type of navigation services will depend upon the particular type, severity, and/or complexity of the identified barriers and the organization/system in which the program operates.
Navigation in Action

- Patient is seeking screening, diagnostics or treatment
- Enters into a new system which is fragmented and can be overwhelming
- Patient may not be able to access the system because of lack of information, insurance, etc.

Patient enters the healthcare system

Patient (caregiver) meet with the PN (relationship)

- Identification of barriers to healthcare
- Work with the patient to develop a plan to address barriers
- Work alongside health care provider to address the patient needs and disease management
- May provide basic assessment to better triage patient to appropriate care
- Helps to improve patient/health care provider communication

Patient accesses care, resources and information

- Providing individualized assistance (Information and resources (transportation, utility assistance, tailored info) – patient and caregiver
- Provide emotional support
- Access to hospital resources
- Appropriate identification of health care provider to address psychosocial needs, symptom management (specialty care)
- Re-evaluation of needs throughout the trajectory
Integrating Navigation into Population Health

Commission on Cancer Standard
Patient Navigation

• S 3.1: “The cancer committee conducts an assessment of barriers to care for patients with cancer. A patient navigation process is established to address barriers to care for patients with cancer and health care disparities either on site or by referral. The cancer committee evaluates and reports on the process annually.”

• Provide a navigation process to overcome barriers to care
  – Facilitate timely access to quality medical and psychosocial care
  – Requires an initial needs assessment by the cancer committee
  – Cancer committee responsible for evaluating and reporting on the process each year
Future of Navigation in Population Health

• Clarification on the definition, skills and competencies of lay navigators
• Standardize training: facilitate integration into the health team
• More effective use within the healthcare system
• Maximize nurses’ skills and knowledge - allowing them to work at the top of their license
• Demonstrate cost-benefit; budget impact; cost-effectiveness
Banner Health

• Established in 1999 as a not-for-profit, multi-state (currently seven), healthcare system
• Pioneer ACO
• Operating model emphasizes reduction of variation in all areas
• Operates:
  • 29 hospitals
  • Homecare and Hospice
  • Academic- and community-based delivery
  • Ambulatory Care
  • Banner Medical Group and Banner University Medicine Physicians
• 47,000 employees, somewhat more than 1/3 are nurses
Pioneer Accountable Care Organization (ACO)

- Created by CMS in the Center of Innovation (CMMI).
- Five-year program starting in 2012 and ending 12/31/16.
- Thirty-two entities started in Year One. No further applications were accepted.
- There are now 18 remaining Pioneer ACOs for Year Four, and even fewer for Year Five, as several did the early conversion to Next Generation (starting 1/1/16).
Four Foundational Elements – THE HOW

Banner Health Network

- Care Management
- Air Traffic Control
  - Real time monitoring
- Actionable Data Analytics
- Seamless transitions of care

Banner Health Integrated Care Delivery Model
Network Changes

• For the Pioneer Provider List, we add PCPs and a small subset of primary specialists (e.g., cardiology, oncology, nephrology) as allowed by CMMI.

• We were able to add facilities and ancillary providers, such as hospitals, post acute facilities and home care.

• For Next Generation ACO, we will add the same providers, but they will have different names:
  • Primary Care and Specialists will be Providers/Suppliers
  • Providers in our network who don’t fit the taxonomy codes for Providers/Suppliers can be added as Preferred Providers
  • SNFs will be Affiliates (these providers can be used for 3 Day Waivers)
  • If we participate in Capitation, we can add providers as Capitated Affiliates.
Health Management Model

Member enrolls in BHN plan

Member Needs Assessed

Low Intensity 65-80%
- Preventive Health
- Appropriate Screenings
- Minor Episodic Care

Mid Intensity 15-35%
- Chronic Condition Management
- Team-based Care (eg, PCMH)
- Specialty and Behavioral Care

High Intensity 5-10%
- Acute Care
- Unplanned Care
- Elective Procedures
- Complex Chronic Conditions Care
- Sub acute Care
- End of Life Care
Member

Nurse

Implementation

Surveillance

Member
Current Roles for BSN Nurses at Banner

• Care Coordination
• Medical Management
• Disease-specific focus
• Triage
• Remote, technology-enabled surveillance and intervention
Care Coordination

• Classic Case Management:
  • Ensuring high-risk and other members receive the care, follow-up, education, and programs they need
Medical Management

• Prior authorization
• Concurrent and retrospective review
  • Appropriateness
  • Alignment with contracts
Disease-Specific Focus

- Diabetes
- High-risk pregnancy
- Behavioral health

- Providing:
  - Education
  - Training
  - Follow-up
  - Response to care questions and needs
  - One-on-one or in groups
Triage

• Telephonic
• Webchat
• Member-initiated
• Target high utilizers of most intensive services
• Referred to the appropriate level of care
• Assist with access to care
Remote, Technology-enabled Surveillance and Intervention

• “Air Traffic Control”: Follow algorithms for care enhanced by professional competencies

• Address care gaps: Leveraging the cognitive expertise of the nurse, utilizing the tactics of surveillance, and the enabling technology to manage health across large populations (700 members/3 RNs)

• With and without direct member contact
Example: Intensive Ambulatory Care Program

**Design Concept**
- Extension of the TeleICU and TeleAcute care model
  - Telehealth team manages highest risk, highest cost outpatients

**Care Model**
- “Perpetual" management of high-risk patients with chronic health conditions
  - Targeted population (top 5%) allows high intensity, home-focused care
  - Dedicated IAC care team (physicians, nurses, pharmacists, coaches, MSW, quarterbacks) provides coordinated, proactive care

**Structure**
- Advanced data tools and in home devices enable daily patient assessment and centralized patient management from TeleHealth center
- High touch services for patient education and support
Future Roles for Nurses

• Working with informaticist to hardwire information required in documentation for communication, coding, risk-adjustment
• Remote monitoring
• “Quarterback” of the Population Health Team
• “Managing Up”: ensuring all necessary data is obtained and available in advance of member interaction with the care team
• Maximizing scope of practice with innovation in roles
Education Needed

• Managed Care 101
• Population Health competencies
• Continuum-focus
• Leveraging cognitive expertise using technological tools
• Coaching skills
• Value-based care
• Motivational interviewing techniques
• Ambulatory care delivery models
• Independence in practice
• Coordination of multi-disciplinary teams
• Pattern recognition
• Moving from Novice to Expert in non-linear ways
For Discussion

Where might we focus attention most effectively in order to harmonize educational programs and regulatory requirements such that the nursing workforce has the expertise and competencies needed in the future?