Spotlight on Action MASTER Transcript: “Healthcare Resiliency – Lessons from the Front Lines” Episode 3, Part 2, featuring Emily Brower, Senior Vice President, Clinical Integration and Physician Services at Trinity Health

Aparna Higgins, LAN (00:00:)

Hello, and welcome to Spotlight on Action produced by the Healthcare Payment Learning and Action Network, commonly known as the LAN. I’m Aparna Higgins, your host for today's episode. The LAN Spotlight on Action series features LAN stakeholders, discussing real-world actions and opportunities to transform the healthcare system while aligning with LAN goals and initiatives that advance health equity, healthcare access, and value-based healthcare through adoption of alternative payment models or APMs. Today, I have the pleasure of speaking with LAN Care Transformation Forum co-chair Emily Brower, senior vice president of clinical integration and physician services at Trinity Health. Emily is at the forefront of transforming our healthcare system to one that is more agile and responsive to the needs of patients, rewards providers for positive outcomes, and addresses barriers to care and social determinants of health head-on through both her role at Trinity, as well as her work with the LAN. I would like to welcome you today, Emily, to our podcast.

Emily Brower (01:11):
Thank you so much, me too.

Aparna Higgins (01:15):
I wanted to discuss several broad themes with you today, focused primarily on the work you have done in leading Trinity's transition to value-based payments and how those initiatives can serve as a model for innovation in responding to public health emergencies or the PHE, such as the ongoing COVID-19 pandemic. So, a year ago, the LAN launched the healthcare resiliency framework in response to the COVID-19 pandemic. And as you are well aware, the framework includes both short and long-term actions to build resiliency into our healthcare system. Trinity, obviously as a leader in this field, made a shared as well as an individual commitment to that framework. So I was wondering if you could talk a little bit about some of the actions that Trinity Health System took in the short term during the public health emergency to help create resilience.

Emily Brower (02:08):
Yeah, so I was so excited to be part of that work with the Healthcare Payment Learning and Action Network because what, what I found that I'll speak about was, was not uncommon. And for all of the groups involved to recognize that that the capabilities that they had built in their population health enterprise was there and ready and able to respond to COVID, I think was a wonderful discovery. For Trinity Health, the years that we had invested in creating clinically integrated networks with really robust care coordination and support for populations attributed to the providers in that network through alternative payment models, that's a very sort of long description of our work. That investment we had made, we had built up sort of strengths and muscle during that time that we were then able to pivot and flex and respond to the public health emergency in ways beyond even we had anticipated.

And some of those were the way we responded clinically. So if you think about the clinical team within a population health or ACO or CIN enterprise, right, that what that team does all the time is to look at a population of patients, understand their clinical conditions, prioritize them according to clinical risk and,

and then reach out to develop comprehensive patient-centered care plans and that's sort of a broad general description. So that, the ability to do that meant that team, we could say your new attributed population, if you will, your new attributed population of focus is people at risk of COVID. And so we were able to take those same approaches of understanding a population, their clinical conditions, what put them at risk for the impacts of COVID in this case, and then respond and respond in that same way that team would do for any high-risk population, which is to reach out, make sure people understood their conditions, how to be safe, how to access care, make sure that particularly early-on when many communities were asking people to stay at home and stay safe, to know how they could get home-delivered meals, home-delivered medications. And it was this incredibly effective effort. And I I've told this story before, but one of our care managers said she was doing the best care plan she had ever done because the people we were serving were very eager to know how to stay safe, were very eager for help, and in many cases, they were at home with a caregiver or family member who then was part of that conversation. So it was really that comprehensive care plan that we often talk about in population health, but very detailed right down to all the ways that that patient and family could stay safe and healthy. So we had this incredible clinical response that really leveraged the clinical teams. And then, you know, the other area where the support that we provide for the provider network really shown is we were able to have regular and at some points during the public health emergency, even daily communications with the providers in our clinically integrated networks. And many of these are small practice, one, two independent practices and the neighborhoods that Trinity Health serves and our ability to, keep them informed as we were learning about COVID-19, who is at risk, the treatments, how to stay safe, all of that information that we, as a large health system with infectious disease and a COVID response incident command and access to treatments and testing, and all of that were able to then include those independent providers was really, I think, showed the benefit of this work and how, you know, we always talk about clinically integrated networks are a way for independent providers to move to a more sustainable and resilient practice and payment model so that they can remain independent in the community. But this work during COVID, particularly in the early days when we were all learning, was really showed the benefit of being part of that network and just being part of a health system, having access to all that information and resources.

And not only that, but during a time when fee-for-service encounters just really dropped, and people were not seeking care, we were able to bring to those practices shared savings distributions, care management fees, some of the dollars that come through the alternative payment models and for some of those practices, that was, those were the dollars that kept them open. So, really just as I said, I still, every time I think reflect on this work and just share it one more time, I still am struck by how this investment that we had made as a system because it's so important to our mission paid off. That the benefits of that in terms of being a more resilient network of providers and able to respond to the people in the community was, it was really just it, it continues to be a really important story and support for this national change that we're all involved in.

Aparna Higgins (9:43):

Well, that was a great overview of your efforts, and really, I think highlights the, or underscores the importance of alternative payment models and affecting this kind of transformational change. I want to follow up a little bit on a couple of things that you mentioned. You talked about how obviously you've made these investments previously, but you know, you, I think you've said something about the pivoting flexing and responding in ways beyond what you had anticipated. And I'm curious to know how has your response kind of evolved in terms of your response to the LAN resiliency framework, but you know, more broadly in terms of the kind of models that you've implemented, how has that evolved, you know due to the duration intensity of the PHE, obviously we're still in the public health emergency. So if you could talk about that.

Emily Brower (10:38):

Sure. So the experience that I was just speaking of and, and our reflection on that, and really not just our own, but the work we did with the other members of the LAN just really emboldened us to accelerate our alternate payment model journey, if you will. So if you think about the LAN taxonomy, we set very specific goals around increasing our participation, whether you look at, you know, contracts or covered lives or people providers in those total cost of care, population-based prospectively paid models. So, in shorthand moving along towards those category three and even more category four payment models. So how can we get closer to the purchasers of care and meet the needs for the population that they are responsible for, whether it's Medicare as a state Medicaid provider plan or our commercial health plan partners and, and directly with employers. So how do we get closer to that full support of a population where we have even greater clinical and financial accountability? So we, through our recommitment back in October of 2020, right, we set very specific goals around that more aggressive goals, and then we have been working hard to, to make that happen. So across all of those different populations I spoke about.

Aparna Higgins (12:53):

Okay. One other thing I wanted to come back to was you described if, you know, in terms of the outreach and engagement that from your clinical team, relative to the patients that you're accountable for, I think you mentioned that, you know, your, your patients were eager for help and were engaged and wanted to know how to, you know, be safe and so forth. You know, we talk a lot about, you know, beneficiary or person or patient engagement, and certainly looks like in this, you know, in this particular, your experience, you know, speaks to a higher level of engagement. So based on your experience, can you talk about how we, you know, continue that, maintain that, and also ensure that, you know, people and their families are truly engaged in the care?

Emily Brower (13:43):

Yes. Absolutely. So we, we, like others right, moved fast, and were super responsive and continue to be during the public health emergency, but I would say we collaborated even within our own integrated delivery system in ways that we had not before. And we, because of the speed of response that was needed, we just said, okay, what's working here, spread it there. How do we grow this, do more of that? So I would say more development testing and implementation of, of these sort of small tests of change. One of the things that, and those have sustained. So there are, we are not going back, I will say, to the way things were. So I'll use one example which is we have Trinity, Trinity Health like many sort of community-based health systems, and I think particularly you see this and in Catholic healthcare is the commitment to the health of the community. And we had social care hubs to try and make it easier for people to access care in the community. So we needed to quickly put all those pieces together. So that, like in the story I told earlier, our population healthcare managers who are reaching out to put together care plans and service plans for folks, they knew what are those community-based services that would close some of those gaps and engage them. And so that process of working through our community health and wellbeing teams and those social care hubs, that's now just the way we work. So there are many things that we, we did quickly to, to respond quickly to COVID that are now how we work. And so that's been really satisfying, I think for the teams, both how quickly we're able to respond to the needs of our patients and communities. And then that we have now just made that part of part of our overall response to, to any future need that that would come about.

Aparna Higgins (16:22):

Great. Those are some great examples, maybe keeping sort of on the same theme of person-centeredness, as you are well aware, you know, the PHE has laid bare many of the health disparities that

currently exist within our you know healthcare system. Can you sort of build upon what you were talking about relative to your experience and, and describe some of the actions, you know, Trinity has taken to address health disparities, particularly as it relates to, you know, COVID but also more, you know, more broadly.

Emily Brower (16:52):

Yeah, absolutely. So Trinity Health has always been very clear through the way that we deliver care, communicate engage communities that racism is a public health crisis, and as you pointed out, many of the disparities in access in treatment in outcomes, many of those inequities were just amplified have been amplified with COVID. And that sort of has led us to double down on our advocacy for racial justice commitment to internally moving faster on our own journey for equitable compensation and talent and the culture of inclusion that we strive to create within our organization and also for the people we serve. So we've been doing sort of accelerating our work on anti-racism training, diversity equity and inclusion work, including things like supply chain.

So our journey around addressing racism in healthcare as part of our commitment to the “common good” sort of falls under that general umbrella for us, that has just been accelerated as well. And that really flows through in terms of how it, how it showed up with COVID is really our accelerated response to the community to access to, to care, to treatment, to vaccination. So just really huge commitment to our communities in terms of increasing vaccination community-based vaccination, testing and making sure that communities of color have robust access to that. So it's been a very big piece of our commitment as an organization, as well as our sort of COVID response.

Aparna Higgins (19:23):

Okay. And then how can you talk a little bit about how some of these steps have you taken as it pertains specifically to, COVID also translate into addressing health disparities, you know, more broadly, you know, outside of COVID within your organization.

Emily Brower (19:37):

Yeah, absolutely. So there's a, I'll give you one example because there are many, but that sort of ties back to what we were talking about earlier in terms of the rapid response the, that, that needed, that was needed. And that how rapidly we responded to COVID and what we learned from that, that we could do, and particularly in our work and integrating more of our community investments and community supports on those social care hubs. But, we said, well, gee, who’s, what's the population? How can we use this experience to inform our work in population health and alternative payment models and what, what can we take and move into some longer-term change? And so we spent some time, you know, and this was happening sort of across the organization, but obviously for me, focused on our work in population health and value-based care, we said, well, we know we have data on populations attributed to us. What do we know about health disparities and how they show up in some of our day-to-day work in caring for an attributed population? And so sort of across our organization, every team was choosing focused efforts where they could, in whatever area they were, address health disparities and inequities. And so what we looked at is, well, in our Medicare ACO population, we do have some information about race and ethnicity. But we also found that in the populations who are dually enrolled for Medicare and Medicaid, where we actually had, there was actually a flag in the data that tells you, this is the population. It's not an exact match, you know, for, for race and ethnicity, we're not, you know, saying that, but it was a population that we could look across the organizations because we have Medicare ACO's in almost every market. We could say, what can we do to address disparities in that population in particular. And that's where we did really a deep dive into if you took our sort of typical population health metrics that we use to measure the impact we're having on the health of a

population. And we dive into that and look for those disparities. What we found is that for those who are dually enrolled in Medicare and Medicaid, we found greater disparities and things like preventable ED visits, preventable hospitalization, some of our typical measures. So that's an area where we decided to focus for this year. So we have a very specific now clinical set of clinical interventions that we do for that population. And we are looking in a very, you know, sort of data-centered way are we moving the needle on reducing preventable hospitalizations?

And we use our ambulatory care sensitive condition, admission measure, which is very it's, there's also a measure in our, in our ACO quality data that's very similar. And, and we said, okay, we're going to do something different for this population and then we're going to measure the impact. So for that population, when you dig into those ambulatory care sensitive conditions, you find tremendous disparities and things like poorly controlled diabetes, or, you know, sort of, pick your chronic illness. And so that's where we're focusing, and we're doing that through adding to our usual care team, the community health worker. So we've have a whole initiative across all of Trinity Health to train, hire, deploy - as part of our population healthcare team - community health workers. We've had a lot of great experience with that. And now it's just the way we work for that population to get closer to those underlying issues that, that show themselves through the data. And then and then expect that we will be able to better meet the needs of that population with that additional member of the care team providing support and connection, and then the use of the that whole network that we've developed through our social care hubs.

Aparna Higgins (25:13):

Wow. well, it's, you know, it's a great example. I think of how you've used, you know, data to drive sort of establishment of goals, and then redesigning and deploying your care delivery team to help meet those goals. I wanted to tie this back to something you said earlier around, you know, specific goals you've established or working towards within your organization in terms of moving along the continuum of the LAN APM framework and moving more to category three and four, potentially category four models, which are the true population-based payment models, based on your experience, can you talk a little bit about the role APMs can play in intentionally addressing issues pertaining to health equity?

Emily Brower (26:01):

Yeah, absolutely. And I think this is very much coming out of the experience that I was speaking about earlier, which is when you participate in alternative payment models that basically assign you a population of patients and say, you the providers are now accountable for the clinical and financial outcomes and the experience of care for this population, what comes with that is data and claims data. If that's, if that's how the data comes to you for this population, and it often does, right, the set of encounters that historical encounters for the population, all the diagnoses, and information that come with that really help you to understand a population of patients in a much richer way than you would, if you were only looking at your own encounter data. So what you might have in your primary care practice, for example, because those are people you're caring for.

Once you've got that full claims data set, and you can see all of the conditions that that group of patients or any one individual patient is, is being treated for, all the different providers who are providing their care and and all those points along the continuum, that just becomes a much more enriched understanding of a patient and a population of patients. So, it works really on two levels, the patient in front of you or the patient you're focusing on, you now have a much more complete understanding of the care they are seeking, the clinical conditions they have, right? So on that patient level, it's very enriched, but at a population level, what that does for you is I once had one of my clinical partners say, it's sort of like doing a differential diagnosis on a population, like you can see for an entire population, where do we need to be focusing? What- boy am I seeing a lot of folks who are getting

multiple admissions for congestive heart failure, for example, and that bubbles up into a pattern of care that then enables you to say, I'm going to design a population-based intervention for that. So it's both that individual patient and the richer understanding of their care and their conditions, as well as being able to take that more integrated, systematic approach to redesigning care for a population.

Aparna Higgins (29:12):

Okay. I'm curious, I mean, obviously Trinity has been making these invents- investments over multiple years and has been on this incredible journey in terms of advancing value. So based on your experience and lessons learned, what kind of advice or guidance would you give to other payers or providers who were contemplating this journey towards value-based care?

Emily Brower (29:43):

Yeah, sure. It's long road is what I will say. I was talking to some friends of mine about, wow, it's, you know, it's been 10 years since the Affordable Care Act. And, and we're still sort of doing this blocking and tackling, you know, every day creating, you know, one more small bend in the cost curve, if you will. And did we think it was going, we were still going to be here that the journey would be this long and sort of, I think many people thought this would happen much faster. So, stick-to-itiveness, patience is, you know, I'm not the most patient person. But I think to be able to look; this is all about the long run, right? We see this in the results of, say, ACOs and those that achieve a year-over-year improvements in quality and cost, right? Those are the ones who've been in it the longest. So it's that, it's the patience and stick-to-itiveness, and being sure to call out, to find and call out those small bends, because they do add up over time to some pretty significant improvements in the care of a community or a population and, and making care more affordable. So there's that long-term horizon, right? This is, we are very much in this for the long-term. So that's one piece, I guess that's a, don't lose hope, stick with it. So there's that piece. The other is, I think the reason that this has been, that the Trinity Health has made this commitment over time is because it's absolutely central to our mission. So Trinity health is the, is really the leading health system in this work. If you look at the number of communities we serve, the number of people that are that are attributed to us, if you will, the number of people that we're caring for through these population health models, the number of providers, and the success that we've had. And that is absolutely because it is central to our mission to transform the health of the communities we serve. So, all of that is to say it's really important when you were doing this kind of huge change, to be able to speak to how central it is to the, the mission and goals of the organization. So we really keep that front and center of our organizational strategy, our, you know, our work with our health plan partners, like it really infuses through the organization. And it goes back to that, you know, we will be that healing, transforming presence in the communities we serve. It is just central to our mission. And I think, I think that, that's why it has staying power because it is going to be it's a long-term play. And so it needs to be really core to the organization's mission and values and vision.

Aparna Higgins (33:23):

Great. Unfortunately we, I feel like we could, you know, I could talk to you for another hour, unfortunately, that's all the time we have, you know, for, for today. Of course, we'd love to have you back whenever your schedule permits. Emily, thank you so much for joining us today and for such a wonderful conversation and for sharing your experience and insights. We also thank you very much for all that you do to help guide the LAN to reach its goals of expanding healthcare, access, improving health equity, and expanding adoption of APMs. Thank you again.

Emily Brower (33:58):

Well, thank you so much. It's, it's an absolute privilege to do this work you know, and to be able to share the experiences with the others. So thanks for letting me do that.

Aparna Higgins (34:11):

Thank you. For all of you listening, thank you for joining us. If you enjoyed this conversation, please keep checking the LAN website for more from our Spotlight on Action series, highlighting work to advanced, advance value-based care. This episode and future spotlights will also be posted on our social media accounts. So be sure to follow our Twitter handle at @payment_network and on LinkedIn, by searching for Healthcare Payment Learning and Action Network.