Addressing Health Outcomes Challenges at Northwell Health

Northwell Health, the largest employer in the state of New York, is committed to improving health outcomes and reducing disparities within its diverse patient population. While its mission prioritizes advancing health equity, the organization faces challenges related to standardized metrics, technological integration, and infrastructure for addressing social drivers of health. These barriers reflect broader systemic issues, underscoring the complexities of achieving health equity in high-value care models.

Background

Northwell Health serves patients from a highly diverse geography from varied socioeconomic and cultural backgrounds. The health system has recognized the critical role of addressing social drivers of health, which can account for up to 80% of health outcomes. However, without comprehensive standardized metrics, robust data systems, and seamless technology integration, efforts to implement equity-driven interventions face limitations.

Challenges

1. **Lack of Standardized Metrics for Equity**

   Northwell Health has struggled with the absence of consistent health equity metrics, a common issue among healthcare systems transitioning to high-value care. Without standardized health equity metrics, it becomes difficult to measure disparities, assess progress, and compare outcomes across populations. For example, each high-value care contract or arrangement has slightly different attribution models or focuses within the health equity space. It makes it difficult to apply universal approaches to addressing gaps in care through a population health lens. Instead, health systems have to focus on the overlap, as addressing all metrics

in every contract becomes too burdensome from a resource perspective.

2. **Fragmented Technology Infrastructure**

   As Northwell Health moved toward digital transformation, gaps in technology integration emerged as a significant barrier. Legacy systems, coupled with disparate electronic health record (EHR) platforms, hindered the seamless flow of patient data across care settings. The fragmentation makes it difficult to view data across an entire system. For example, information is typically shared through spreadsheets or added to a data warehouse, which requires significant resources and technical expertise. This process leads to fragmentation, limiting the organization's ability to effectively coordinate care and address nonmedical needs, such as housing, transportation, and food security.

3. **Challenges in Data Collection and Utilization**

   Robust data collection is essential for identifying health disparities and developing targeted interventions. However, Northwell Health encountered difficulties in capturing comprehensive social drivers data within its EHR systems. Each EHR system typically has its own workflows and screening tools. To ensure consistency, significant effort is needed to standardize the work. Ramsey Abdallah, assistant vice president of quality at Northwell Health, added, "We are undergoing a significant review of our systems to standardize where possible. This will enable us to obtain the granular data needed to analyze trends and better address the unique needs of vulnerable populations." He went on to add, "The bigger challenge will come with the training and implementation of the new workflows. Given our geographic region and its diversity, we have to tailor our approach to the local community."

4. **Limited Interoperability**

Northwell Health's efforts to collaborate with external partners, such as community organizations and public health agencies, were constrained by interoperability issues. For example, when a social driver such as food insecurity is identified, a referral can be made to a community-based organization. They can easily track the number of referrals, but the current system makes it difficult to detect if the referral loop was closed and if the issue was addressed. In the current state, most of this information is exchanged through spreadsheets, emails, or other non-digital, non-automated methods. These challenges prevented the effective exchange of critical patient data, further complicating efforts to address health inequities holistically.

Strategies and interventions

Despite these challenges, Northwell Health has made concerted efforts to overcome systemic barriers and embed health equity into its care delivery models. Key strategies include:

1. **Investing in Health IT Systems**

Recognizing the limitations of its existing technology infrastructure, Northwell Health prioritized investments in interoperable health IT systems. The health system has elected to migrate to Epic as the enterprise solution. By adopting a single EHR, they are able to capitalize on Epic's enhanced capabilities and more easily build integrations of social driver data. This is driven by the fact that there would be fewer external integrations needed and that Epic has established integrations already available. Northwell Health hopes this will accelerate their ability to gain actionable insights into patient needs and disparities.

2. **Collaborating with Community Partners**

To address gaps in care, Northwell Health expanded partnerships with community organizations focused on housing, nutrition, and transportation. For example, they have partnered with Island Harvest,

Long Island Cares Inc., The Harry Chapin Food Bank, God's Love We Deliver, US Foods, and Baldor to start Food as Health, which helps communities deemed as "food deserts" by delivering healthy foods to homes where residents are hampered by chronic illness due to poor nutrition. Northwell Health is also collaborating with Chicago-based startup NowPow to utilize a platform that connects patients to community-based organizations, as well as with Harlem Grown, a network of urban farms providing underserved children with the skills and knowledge to produce sustainable and healthy food for their families and community. More recently, Northwell Health has continued its efforts to expand access to nutritious food by partnering with InstaCart Health. The leading grocery technology company in North America provides tools and resources to Northwell Health staff, patients, and communities that address social drivers of health, including access to healthy food and transportation. These collaborations enabled the health system to connect patients with essential resources and mitigate nonmedical barriers to health.

3. **Embedding Equity Metrics in High-Value Care Models**

Northwell Health has advocated for the inclusion of health equity metrics in high-value care reimbursement structures. By tying financial incentives to equitable outcomes, the organization seeks to ensure that underserved populations receive the targeted care they need. Additionally, Northwell Health has embedded health equity into its internal dashboards and applies a health equity lens to system priorities. A key example is the Accountable Care Organization (ACO) metrics, through which they track and trend performance by race, ethnicity, and preferred language. By trending data through an equity lens, the organization is better able to identify potential gaps, even in metrics that appear to be performing well in aggregate.

4. **Training and Capacity Building**

   To support these initiatives, Northwell Health implemented staff training programs focused on culturally competent care and the collection of equity-related data. The organization is committed to building a workforce ready to address the challenges of tomorrow. These efforts align with the organization's broader goal of fostering an inclusive and responsive care environment.

Outcomes and lessons learned

While challenges persist, Northwell Health's efforts to integrate equity into its operations have yielded promising outcomes. Improved data collection processes have enabled the organization to identify disparities more effectively and develop targeted interventions. For example, through the integration of health equity data, Northwell Health has been able to identify practices in select ZIP codes where hypertension control rates are lower, enabling the team to design targeted interventions to that community. Additionally, partnerships with community organizations have strengthened Northwell Health's ability to address social drivers of health at scale.

Key lessons from Northwell's experience include the importance of:

- Standardizing equity metrics to ensure consistent measurement and accountability

- Investing in interoperable technology systems that facilitate seamless data sharing

- Engaging community partners to address social drivers of health comprehensively

- Advocating for policy reforms that align financial incentives with equitable outcomes

Conclusion

Northwell Health's journey highlights the complexities of advancing health equity in a fragmented healthcare landscape. While systemic barriers related to measurement, technology, and integration remain significant, the organization's commitment to high-value care provides a strong foundation for driving equitable outcomes. By addressing these challenges through targeted investments, collaborations, and advocacy, Northwell Health continues to serve as a model for other healthcare systems navigating similar obstacles.

Protect Patient Dignity at End of Life

AMGA Goal

Safeguard the dignity and wishes of patients by facilitating open conversations about desired end-of-life medical care and goals and by ensuring benefit designs and models of care enable patients to receive this care in a manner respecting their wishes.

AMGA values the importance of respecting patient wishes as they approach death. To respect the dignity and needs of patients nearing the end of life, AMGA recommends Congress take a holistic approach to improving end-of-life care for Americans by enhancing and improving Medicare coverage for end-of-life care, supporting education and outreach efforts for patients and their families, and engaging with the non-healthcare community to support patients in their communities at the end of life.

End-of-life care encompasses both palliative care, which alleviates suffering for patients undergoing treatment, and hospice care, which focuses on providing comfort for those facing terminal illnesses. Distinguishing between palliative care and hospice care is essential. Palliative care focuses on alleviating suffering and improving the quality of life for patients undergoing treatment for serious illnesses, regardless of their prognosis. Palliative care often is provided alongside curative treatments and addresses symptoms like pain, nausea, and fatigue across various stages of illness. In contrast, hospice care is specifically designed for terminally ill patients who are nearing the end of life and forgo curative treatments in favor of quality of life. The primary aim of hospice care is to provide comfort and to support patients and their families through an approach that addresses physical, emotional, and spiritual care. Both forms of care prioritize comfort but serve patients at different stages, with hospice care reserved for those nearing life's end.

Why End-Of-Life Care?

About 15 to 20 years ago, I admitted an elderly gentleman four times to the hospital in a six-month period. After he subsequently died of heart failure, his family approached me and thanked me for taking care of their loved one. Their only regret was the "suddenness" of his passing.

I felt very small at the point. Their loved one had been slowly dying from the day we met, as he had heart failure, and the only thing I could do was tweak medications when he had a brat during the Packer's game. But I failed to prepare them, as I had tunnel vision and was treating symptoms and not the patient.

— **Paul Pritchard, MD, MBA**, *Vice President and Chief of Quality, Prevea Clinic*

Understanding and distinguishing these forms of care is vital for improving patient experiences and outcomes. End-of-life care involves providing medical, emotional, and supportive services to individuals nearing life's end, aiming to enhance their quality of life and uphold their dignity.

The current landscape of end-of-life care is influenced by Medicare Hospice Benefit's per diem reimbursement and six-month prognosis criteria, which is based on hospice's traditional focus on cancer patients. This focus, however, is shifting due to changing patient demographics, as hospice patients are increasingly diagnosed with non-cancer conditions.

AMGA recommends Congress:

- **Establish a Total-Cost-of-Care Model for End-of-Life Care**: Develop a comprehensive framework that encompasses all aspects of care delivery and reimbursement to address the holistic needs of patients.

- **Engage Community and Non-Healthcare Stakeholders**: Support partnerships with community organizations to foster collaborative discussions that broaden support for end-of-life care. Engaging various stakeholders promotes a more inclusive dialogue around patient preferences and needs.

- **Implement Outreach and Education Programs**: Launch initiatives involving healthcare providers, community leaders, and advocates to create a supportive environment for end-of-life care discussions. These programs empower patients and families to make informed decisions about care options.

- **Expand Medicare Coverage for End-of-Life Care**: Adjust fee-for-service models to better account for advanced illness planning and care coordination services. Additionally, build on existing models to include individuals who do not require nursing home-level care, offering broader comprehensive support for those facing serious health challenges.

Establish a total-cost-of-care model for end-of-life care

The integration of end-of-life care into high-value care models has emerged as a vital component in the effort to transform healthcare systems, ensuring that patients receive compassionate and respectful care during their final days. AMGA supports this initiative by advocating for policies that prioritize patient-centered approaches to end-of-life care. This integration honors the dignity and wishes of individuals, while addressing the distinct needs of an aging population.

Incorporating end-of-life care within high-value care models not only meets patients' emotional and physical needs but also supports health system efficiency. By encouraging open discussions among providers, patients, and families, patients are empowered to make informed choices that align with their preferences. Benefits of prioritizing end-of-life care within high-value care frameworks include increased patient satisfaction, better resource management, and lower costs associated with hospitalizations and aggressive interventions. Further, palliative care improves quality of life for patients and their families, while also avoiding unnecessary care.[1] Congress has previously considered the importance of such advanced care planning, and AMGA strongly encourages Congress to build on its previous work.[2]

Integrating end-of-life care within high-value care frameworks presents challenges. Many providers lack necessary training to engage in meaningful conversations about patients' goals and preferences. Additionally, existing

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1. World Health Organization Fact Sheet on Palliative Care, August 5, 2020
2. "Collins, Warner Introduce Bipartisan, Bicameral Legislation to Expand Access to Advance Care Planning," Nov. 24, 2022. www.collins.senate.gov/newsroom/collins-warner-introduce-bipartisan-bicameral-legislation-to-expand-access-to-advance-care-planning