
# Roper St. Francis Healthcare

*Disruptive strategies for at-risk & under-served populations*

## About this Case Study

This document highlights community strategies implemented by Roper St. Francis Healthcare that focus on quality care, positive patient experiences, and innovative community approaches. In addition to its value-based care initiatives, Roper St. Francis Healthcare coordinates community programs to help the underinsured and uninsured. In 2019, the Centers for Medicare and Medicaid Services (CMS) awarded two of the Roper St. Francis Healthcare flagship hospitals (Bon Secours St. Francis Hospital and Roper Hospital) the highest overall quality rating of Five-Stars (out of five possible), a prestigious honor received by 291 hospitals nationwide.[i] eHealth Initiative interviewed several Roper St. Francis Healthcare to find out the secrets to its success.

## About Roper St. Francis Healthcare

Roper St. Francis Healthcare is a private, not-for-profit health system operating in South Carolina. It includes four hospitals, with almost 700 beds, and more than 125 facilities and physician offices throughout the Lowcountry region. With a 150-year history and more than 900 physicians, **Roper St. Francis Healthcare is Charleston's second largest private employer and the only private, not-for-profit health system with a specific focus on community outreach.**[ii] As a part of its community focus, Roper St. Francis Healthcare has embraced the move to quality by participating in multiple value-based care arrangements, including several accountable care organizations (ACO) and a clinically integrated network (CIN), with savings in the millions.[iii] These arrangements hold Roper St. Francis Healthcare accountable for the health and well-being of more than 79,000 lives, including patients, its own employees, and a local, large aerospace employer population.


**Beyond caring for those individuals in value-based arrangements, Roper St. Francis Healthcare expanded its quality efforts to the whole community by targeting contracted, underinsured and uninsured patients.** South Carolina is not a Medicaid expansion state and has a significant volume of patients who are uninsured.[iv] The uninsured represent one of the largest and most vulnerable populations in the Roper St. Francis Healthcare-service area. More than 20% of residents in Berkeley, Charleston and Dorchester counties are without health insurance at any given time, and nearly 16% of adults do not have a regular provider.[v] Ninety percent (90%) of the uninsured live at 200% or less of the federal poverty level.[vi]

Roper St. Francis Healthcare positioned itself to operationalize community-level strategies by utilizing community-level data. It currently uses the eClinicalWorks outpatient electronic health record (EHR), the Cerner inpatient EHR, more than thirty-five EHRs across its CIN, and multiple payer sources. "Prior to implementing a data and insights platform, we did not have a consolidated analytics program. We purchased several third-party applications, which worked fine until we had to consolidate data across the applications. It turned into a very, very manual spreadsheet exercise," said Jeanne Ballard, MD, chief medical information officer at Roper St. Francis Healthcare.

Using the Cerner *HealtheIntent*® data and insights platform, Roper St. Francis Healthcare was able to offload the heavy lifting of aggregating, normalizing, standardizing, and person-matching data sources to form a 'single source of truth,' otherwise known as a longitudinal record. "*HealtheIntent* pulls the data together in an enterprise warehouse, so we can see fields of data across multiple EHRs and claims data in a common area," stated Kathy Guatteri, chief operating officer of Roper St. Francis Physician Partners. **Roper St. Francis Healthcare uses this 'common area' of readily available, consumable information that spans across its network to strategically target and implement innovative outreach strategies to populations and geographic areas in need.**

## Using Care Managers as a Population Health Resource

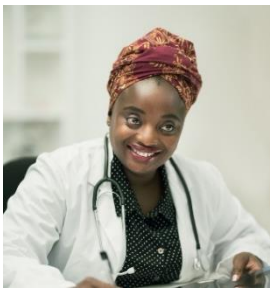
Healthcare is one of those most intricate and personal industries. Patients need continual support and motivation. The Roper St. Francis Healthcare community care management program targets high-risk, high-spend individuals in value-based arrangements to better manage their care between provider visits. Care managers are embedded into primary care practices and work from cloud-based care plans to help patients coordinate appointments, arrange transportation, discuss symptoms and medication compliance, and any other health-related concerns or questions.

Prior to utilizing the *HealtheIntent* platform, care managers manually scoured individual records to decipher patient eligibility for care management services. Roper St. Francis Healthcare used de-identified data to create, test, and validate an algorithm that identifies populations based on their chronic condition prevalence, spend based on claims data, and participation in value-based programs. **With automated patient identification, the system**


**creates a manageable, prioritized list of eligible care management candidates, helping care managers spend less time identifying patients and more time supporting them.** This care management outreach strategy plays a large role in the Roper St. Francis Healthcare Medicare Shared Savings Program (MSSP) ACO, which achieved a quality score of 95.83%, nearly three percentage points higher than the 2018 national average.[vii] Patients in value-based programs that actively participated in the Roper St. Francis Healthcare community care management program saw an average of $787 in cost avoidance compared to patients who were not actively managed. The patients that were not actively managed had an additional 42 emergency department (ED) visits per 1,000 patients compared to actively managed patients.[viii]

## Creating Medical Homes for the Uninsured

Avoidable ED visits represent a cost-savings opportunity across all populations. Uninsured patients often postpone routine and preventive care and use the ED as their primary care option. Approximately 14% of hospital discharges are conditions that could have been prevented if adequate primary care resources were available. To address ED and inpatient 'super utilizers,' Roper St. Francis Healthcare opened the 'transition clinic' as part of a medical neighborhood approach.[ix]



The transition clinic serves as a medical home for those who do not have one and offers services to promote long-term health, including psychiatry and licensed clinical therapy services.[x] **"I like to think of the transition clinic a as primary care lab where we can put in place interventions to try to overcome barriers to care and demonstrate value in a population that's really difficult to manage,"** said Robert Oliverio, MD, chief executive officer of Roper St. Francis Physician Partners.

When Roper St. Francis Healthcare received funds from a donor to support colorectal cancer screenings, geospatial analysis indicated a high concentration of unscreened, uninsured individuals lived near the transition clinic. As a result, the transition clinic hosted a free colorectal cancer screening, lowering geographic barriers to care for patients and positioning Roper St. Francis Healthcare to make a greater impact with a targeted approach.

## Managing Health and Care Outside of Traditional Venues

Roper St. Francis Healthcare is also using the geospatial capabilities in *HealtheIntent* to identify other institutions that patients frequent, such as churches. In collaboration with the Roper St. Francis Healthcare chief diversity and inclusion officer, the analytics team used geospatial mapping to cross-reference African American patients that had a high prevalence of diabetes and hypertension with the location of African American churches. Working with the churches, the Chief Diversity and Inclusion Officer provided literature, engaged church leaders, and identified nurses who were members of the congregation to conduct screenings and outreach.

After implementing the program, Roper St. Francis Healthcare experienced more than a 30% increase in primary care visits and an improvement in National Qualification Framework (NQF) quality measures for hypertension (~36% improvement in measure NQF 0018) and diabetes (~13% improvement in measure NQF 0061). This success was


observed across the African American population living within five ZIP codes of the targeted church.[xii] Insight into the location of patients; their clinical metrics, conditions, and utilization; and spend provided rich data to better target the population. Dr. Ballard stated, "Using geospatial mapping capabilities within *HealtheIntent*, you can look at publicly available data, such as social determinants of health, average income levels and more. It gives you a flavor of the characteristics of a certain community."

## Conclusion

Roper St. Francis Healthcare is committed to exploring innovative interventions that lead to quality results, continuing its mission of 'Healing all people with compassion, faith and excellence.' According to Dr. Oliverio, **"Working with Cerner, we're able to develop metrics across multiple sources, including EHRs and claims, to show avoidable spend, per member per month costs, ED utilization, and more. It helps us make the business case that operating in a value-based world makes sense."**

Roper St. Francis Healthcare is open to embracing technology as an enabler. It values the role of technology in helping its employees invest their talents in initiatives designed to lead to improved outcomes. "I'm really proud of our providers and teammates," said Dr. Oliverio. "They stepped up to the challenge of using information provided by our technology to enact targeted interventions and improve the quality of care within our patient population. They embraced the technology and helped move Roper St. Francis Healthcare forward."

eHealth initiative would like to thank the Roper St. Francis Healthcare staff for their invaluable input:

- Jeanne Ballard, MD, Chief Medical Information Officer, Roper St. Francis Healthcare
- Kathy Guatteri, Chief Operating Officer, Roper St. Francis Healthcare Physician Partners
- Robert Oliverio, MD, Chief Executive Officer, Roper St. Francis Healthcare Physician Partners

ROPER ST. FRANCIS HEALTHCARE

## Resources

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https://www.medicare.gov/hospitalcompare/search.html?
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https://www.rsfh.com/about/
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[v] Roper St. Francis 2018 Implementation Plan of the 2016 Community Health Needs Assessment
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[vi] AccessHealth Tri-County Network
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[vii] 2018 Shared Savings Program (SSP) Accountable Care Organizations (ACO) PUF
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[viii] Data provided by Roper St. Francis Healthcare. Results based on measurements from January 2018 to March 2019
[ix] Roper St. Francis 2018 Implementation Plan of the 2016 Community Health Needs Assessment
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[x] ABC News 4, Roper St. Francis opens new clinic for those in need
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[xi] Roper St. Francis 2018 Implementation Plan of the 2016 Community Health Needs Assessment
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[xii] Data provided by Roper St. Francis Healthcare. Results based on measurements from 2013 to 2019