

# How Ochsner, Xavier Are Working Together to Make Louisiana a Healthy State

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**B**y most measures, Louisiana is not a healthy place. History, habits, and culture have combined to place the state at or near the bottom of most health scorecards, including America's Health Rankings, which placed the state 49th in 2020. The ranking reflected Louisiana's high rate of cancer mortality, driven by smoking rates and air pollution; its entrenched poverty and low high school graduation rates; its subpar rates of exercise and healthy eating; and higher-than-average rates of chronic disease and obesity.

For Ochsner Health System, this record of poor health and disparities was no longer acceptable. Two years ago, Ochsner announced a 10-year plan to pull Louisiana out of the health outcomes cellar, by working with state officials and community partners—notably Xavier University—on Healthy State, an initiative to improve access to care for the underserved, invest in health outcomes research, and use data to drive improvements. The goal: to move Louisiana into at least 40th place in America's Health Rankings by 2030.

Leaders from Ochsner, Xavier, and their partners gathered on September 13, 2022, in New Orleans to offer an overview of Healthy State during a session of the Institute for Value-Based Medicine® (IVBM), hosted by *The American Journal of Managed Care*®. Prior to the pandemic, most IVBM sessions focused on value-based initiatives in oncology; the New Orleans gathering was the first IVBM session on population health.

## What Is Healthy State?

Ochsner's initial investment, \$100 million over the first 5 years, includes 3 critical areas: 15 community health centers, including 6 in New Orleans and adjacent Jefferson Parish; the Ochsner Xavier Institute for Health Equity and Research; and the Ochsner Scholars Program, which seeks to address physician and nursing shortages and offer career development for the current staff.

Leonardo Seoane, MD, senior vice president and chief academic officer of Ochsner Health, associate vice-chancellor of academics at Louisiana State University (LSU) Health Shreveport, interim CEO at Ochsner LSU Health System—North Louisiana, and professor of medicine at the University of Queensland in Australia, served as chair for the IVBM session. Seoane explained why Ochsner chose America's Health Rankings as its benchmark. First, it's a measure with a 30-year history. Second, he said, "we like the way they define health," which is that "health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

Seoane shared a list of 20 drivers of poor health, which were familiar to the audience. And then, he asked: "What would it mean, for Louisiana, if we were 40th?"

A lot, it turns out: Moving up 10 places in the rankings would translate into individuals living 3 to 4 years longer, households having up to \$27,000 higher incomes, unemployment rates being 4% lower, and 11% fewer people living in poverty. "That's a different environment. Those are different communities, if we make this happen, and we all know their downstream effects," he said. "As you impact one, it impacts the others."

For too long, Seoane said, Louisiana has experienced downstream effects in the wrong direction: "If we address poverty, we address many of the other things that are on this list for poor outcomes."

From a concept and initial commitment, he said, Healthy State has now grown to 35 leaders representing 32 organizations, covering key stakeholders needed to drive the effort—from large health systems to major insurers to academia.

What do the metrics of 40th place require? Each year, Seoane said, it will mean reducing the number of individuals with chronic conditions by 100,000. It means bringing high-speed internet to another 86,000 homes. It means shrinking by 70,000 the number of households that are food insecure,

among other measures. It will take producing an additional 3000 high school graduates.

That last measure is not just a question of “Can we do this?” Seoane said. “We have a moral obligation to do this.”

## A Health Equity Framework

Speaking next was Eboni Price-Haywood, MD, MPH, Ochsner’s system medical director for Healthy State and medical director of the Ochsner Xavier Institute for Health Equity and Research. She reviewed the drivers of Louisiana’s health outcomes while noting that 80% of outcomes are driven by factors outside the health system—including behaviors and social determinants of health (SDOH). Thus, “in order to achieve and improve the state’s overall health, it must be done through the lens of health equity,” Price-Haywood said.

How should we define SDOH? Price-Haywood said she prefers the World Health Organization definition, which is “the conditions in which people are born, grow, live, work, and age.” She noted that these circumstances are “based on money, power, and distribution of resources.”

She described the interconnectedness of these effects—how social class affects access to education, which in turn can affect choice of occupation, income, and ability to accumulate wealth. This creates “downstream effects,” including “the zip code that you live in, and, therefore, the resources or resources that are available, your working conditions. All of those things are impacted by that rubric of factors that you were born into,” she said, and they all fit into the broader context of a country’s social and economic policies, values, and culture. “What you’ll notice is that the health care system is downstream of all of that,” Price-Haywood said.

When patients show up at the hospital, all this context arrives with them—the health system may make things better, but there may also be barriers. Thus, working toward health equity means more than giving everyone “equal” care; it also may mean removing the obstacles that prevent equitable care.

A data-driven approach is essential, she said. For example, it’s necessary to realize that providers who treat Medicaid patients will report different outcomes than those who don’t. Now that data in Louisiana are reported this way, “One resounding feedback that we receive is [that we must] be fair to providers who take care of Medicaid patients, because those patients have a larger burden of SDOH. And as such, their providers are doing a lot,” Price-Haywood said. “Just because their numbers don’t look like [those of] another health plan doesn’t mean that the providers aren’t doing the very best for that population.”

Looking ahead, Price-Haywood said, Ochsner is comparing Louisiana data with data from the National Committee for

Quality Assurance, which requires health plan reporting. As the initiative evaluates quality benchmarks for providers who care for patients in Medicaid, there’s a need to find a balance between “aspirational” and “pragmatic.” Gathering data is just a first step, however.

“The initiative is not just about technology, but also about putting the right people, processes, and policies in place to help us solve problems *before* they happen and reduce the harm caused by problems that do happen,” Price-Haywood said.

Quality chasms due to disparities, which got so much attention during the pandemic, were first identified by the Institute of Medicine more than 20 years ago. “On an organizational level, we have to have a pathway to equity, because if we’re going to do something as a state, what you do on your organization level impacts how the state performs,” noted Price-Haywood. “To do that, we must have a commitment [that] identifying and eliminating health care disparities are basic components of quality improvement, by first linking quality to equity.”

Building a culture of health equity and being willing to diagnose where disparities occur is not easy. “This change that I’m talking about is more of a marathon [than] a sprint, because it took us decades to get to where we are,” she said. “Just understanding that, I think, is important for creating the patience that is required to create that culture of equity and transformation.”

To that end, the Ochsner-Xavier initiative is implementing a Health Equity Data Strategy, which has 3 parts:

- Validate data capture in current systems and create consistent data capture points;
- Develop measures and insights, creating dashboards that can be integrated into existing care delivery models; and
- Implement insights into innovative care delivery models and use research to measure impact.

## Collecting the Data

Philip M. Oravetz, MD, MPH, MBA, chief population health officer at Ochsner Health, then walked attendees through the details of how the health system will develop the data elements to drive interventions. This process will involve developing an electronic health record capable of capturing demographic and SDOH data at the point of care, then integrating these data into artificial intelligence (AI) and predictive modeling. In time, Oravetz said, new AI modeling would allow Ochsner to work with public and private payers on models such as the Enhancing Oncology Model or End-Stage Renal Disease Treatment Choices.

Right now, however, there are no national standards for gathering and reporting these types of data—or funding to create them, Oravetz said. “We’re now really in our infancy of

incorporating equity into predictive models,” he said. “But I guarantee by the end of the decade, all of our payers and many of our risk-bearing groups will have this accreditation.”

“We’ve hit an inflection point,” where there is recognition that health equity cannot be achieved without support, he said. “This is going to be a fundamental national challenge for us.”

### Tackling Chronic Conditions

The IVBM session in New Orleans featured a pair of panel discussions. The first, “Hypertension, Diabetes, and Other Chronic Conditions—Building a Holistic Strategy Across Sectors,” brought together clinical and community experts and a representative from the state’s largest payer. They were:

- Richard Milani, MD, chief clinical transformation officer and vice chairman of cardiology, Ochsner Health;
- Kevin Green, MPA, vice president of community health centers, Ochsner Health; and
- Jeremy Wigginton, MD, MBA, CPHQ, LSSBB, system vice president of health quality and innovation, Blue Cross Blue Shield of Louisiana.

Milani kicked off this discussion by highlighting Ochsner Health’s successful remote patient management (RPM) program for hypertension and diabetes, which has achieved the Triple Aim of improved health measures, improved patient experience, and cost savings. Milani, Price-Haywood, and their coauthors reported results of the program earlier in 2022. The authors found that Black patients were more likely than White patients to report SDOH that were barriers to achieving hypertension control.<sup>1</sup>

This RPM program produced a customer experience measure, called a net promoter score (NPS), of 87.5, which is far above the health care industry’s 2021 average NPS. Milani said it’s safe to say that patients like the program’s approach. This is especially due to how the program prioritizes the patient by working around their schedule, allowing them to stay home, and communicating asynchronously.

A team of specialists can also make changes to pharmacologic and nonpharmacologic management based on changing guidelines; this leads to better patient outcomes, care satisfaction, and hitting the goals of the Triple Aim. Through this program, Ochsner Health decreased per-member per-month costs by more than \$200 for hypertension and just under \$60 for diabetes through its RPM program.

“I think the lesson we’ve learned is that we can’t expect humans to come to our office for everything,” Milani said.

“There are things that need to be more convenient for them [and operate] around their work-life schedules.”

Building off the point of convenient care for patients, Green expanded on how exactly patients’ health is improving as a result of telehealth’s growing popularity.

When patients were mainly coming to brick-and-mortar health care clinics, Ochsner saw about 40% management in hypertension and about 30% management in diabetes among patients. When implementing telehealth and other similar modern methods, Green said these numbers jumped to 70% and 63%, respectively.

Ochsner isn’t the only health system taking this patient-first approach. As Wigginton discussed, Blue Cross Blue Shield of Louisiana is continuously working toward affordable health plans for 1.9 million patients in the state. As part of this, self-funded health plans represent a major proportion of Louisiana’s insurers.

“About 60% of our business is actually self-funded; it’s not actually fully insured, so it’s dollars actually coming from the pockets of Louisiana employers,” Wigginton said. “So, we really have a duty to help partner with providers, as well as with employers and local businesses, to help manage those costs, and we really want to make those data visible both to providers and members as much as we can.”

### The Challenge of Smoking

Seoane and Joseph Kanter, MD, MPH, state health officer for the Louisiana Department of Health, then turned to one of the top drivers of poor health: smoking. For leaders of Ochsner Health, smoking represents a great irony: Their founder and namesake, Alton Ochsner, MD, was the first to expose the connection between cigarette smoking and lung cancer.<sup>2</sup> And yet Louisiana does little to discourage tobacco use, from taxing cigarettes at very low rates to allowing a hodgepodge of local tobacco ordinances. It’s little wonder that the state’s 22% smoking rate is well above the national average of 16%. Making headway against smoking is a key target of Healthy State—the initiative seeks to reduce annual adult smokers by 214,000 a year through 2030.

Additionally, Kanter said, 30% of Louisiana youth 17 years or younger have smoked tobacco in some form over the past year, which he said will translate into 98,000 teenagers having a shortened life span due to complications from tobacco use. “It’s not hard to find tobacco stats that are compelling,” he said. “This is one of the most compelling ones I’ve seen.”

He highlighted progress that has resulted from the Tobacco Cessation Trust, created in 2011. The trust targeted 200,000 smokers whose habit began before September 1, 1988, and has enrolled its last patients. Since then, Louisiana’s smoking

rate has dropped 7.4%, which is 1.7% faster than the nation's overall rate. Today, the heart of the state's cessation efforts is the Louisiana Quitline, which has both a phone line to reach patients directly and a website to connect them with resources. Kanter said the quitline does not charge users who lack insurance; for those who have coverage, the quitline does recover some costs.

Both Kanter and Seoane emphasized the need to reduce barriers to quitting, whether those be prior authorization or even getting the smoker to make the first call. Louisiana's quitline has launched a program that allows physicians to refer patients to a service that will call the patient proactively within 48 hours.

In national surveys, Kanter said, "current smokers will tell you they want to quit, but only half of them will have attempted over the past year, [and] only 10% of them will have been successful," he said. "One of the reasons for that is only a third who actually attempted did so with an evidence-based treatment modality."

Ochsner's tobacco cessation model works, Seoane said. A review of 15,000 patients from 2015 to 2021 found quit rates of 30% through a combination of behavioral counseling and nicotine replacement. "The literature clearly says it takes 8 to 11 quit attempts before someone successfully quits," Seoane said, but health plans do not always recognize this.

"If you look at the health outcomes, about \$1.9 billion is the toll of health care services rendered for tobacco-related illness in a given year in Louisiana, and \$2.5 billion is the loss of productivity related to tobacco-related illness," Kanter said. "So, if you're talking about a potential return on investment, this is a no-brainer."

## The Future Workforce

The IVBM session's second panel discussion was "Building the Health Care Workforce With a Health Equity Framework," in which panelists discussed programs to address unmet needs, maintain diverse workforces, and deliver equitable outcomes. Taking part were:

- Reynold Verret, PhD, president, Xavier University of Louisiana;
- Missy Sparks, PhD, vice president of talent management and workforce development, Ochsner Health; and
- Deborah Grimes, RN, JD, MSHQS, system vice president and chief diversity officer, Ochsner Health.

A major theme in this discussion was the importance of early education, with Verret expanding on the partnership between Ochsner Health and Xavier University of Louisiana, the only Catholic historically black college or university in the country. For generations, Xavier has trained an outsize share

of minority students for careers in the medical professions, and plans are in the works for the university to open its own medical school.

The partnership with Ochsner, Verret said, has developed over many years and builds on this legacy. Today, there is an emphasis on training students in areas where there are acute needs, such as the physician assistant and genetic counseling realms; the students usually have both the clinical skills and the cultural competency to serve diverse communities.

"It's important that we have representation in the clinics [and] in practice that looks like us," Verret said, adding that representation is also important in the realm of research.

A recent study found that the proportion of US physicians who are Black has increased by only 4% over the past 120 years, and the share of doctors who are Black men remains unchanged since 1940.<sup>3</sup> Additionally, a cross-sectional study of 2019 data from the American Community Survey and the Integrated Postsecondary Education Data System showed that Black, Hispanic, and Native American individuals were underrepresented in the 10 health care professions analyzed.

Data like these are behind Xavier's decision to create a new medical school, Verret said. The numbers of new minority physicians are rising, but only incrementally, despite efforts by the nation's extant medical schools. "It's not that they have not been trying," he said, but systemic barriers including affordability stand in the way.

Verrett noted that the Flexner Report, which transformed medical education in the early 1900s, also called for the shuttering of a handful of medical schools affiliated with Black institutions, including a school in New Orleans.<sup>4</sup> Looking at the data, he said, the "missing students" from these long-lost medical schools might have helped close the diversity gap among physicians.

The point is not simply to create a more diverse physician network, he explained, "but also practitioners who are asking the questions [that] need to be asked."

Sparks added that barriers in early education create long-term barriers that prevent students who want to work in the medical field from reaching their potential. According to Sparks, 50% of high school graduates in Louisiana want to pursue a career in science, technology, engineering, or math, but only 9% of students graduate with the adequate education to do so.

"While we're looking at a health care workforce that is seeing 1 in 5 leave the health care profession since the start of the pandemic, and [we] continue to see a workforce that is strained and stressed, it is important for us not to forget the unlimited possibility," she said.

The US Bureau of Labor projects that more than 1.1 million new nurses will be needed by 2030. Five- and 10-year projections for other roles, including physicians, medical assistants, and home health aides, are equally critical.<sup>5</sup>

“You can’t decide to be a physician in college. You really have to decide and attract people to wanting to be a physician early on, and that’s in early education,” Grimes added. “If you attract them with the ‘what,’ you will get them interested in the ‘how.’”

In discussing more deeply what early education should involve, the 3 panelists agreed that diversifying the health care workforce begins with outreach to underserved and underrepresented communities.

It will also require attention to the significant gaps in representation and income between White and non-White male physicians, which could be reflective of pay discrimination and unequal access.

Ochsner’s work toward reducing these disparities is partly reflected by the Medical Assistant Now (New Orleans Works) training program launched in 2013. “We found a true benefit in working within the community to help us identify individuals who are unemployed or underemployed who would like a career pathway in health care,” Sparks said.

Sparks further explained that the women who graduated the 6-month program were hired by Ochsner. After 2 years, they found a 94% retention rate of women who were employed through the program, compared with a 55% retention rate of

those who joined Ochsner through a different path.

Insights from graduates of the program are helping improve this model further.

“We will continue to build them from the inside out, so we can be intentional about making sure we’re caring for the whole person through an intentional pathway,” Sparks said.

“It starts with intentionality,” Grimes emphasized.

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