Are You Using the Key Drivers to Manage Population Health?

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Session Objectives

- Develop a working knowledge of differences in population management with respect to linkages across social welfare, public health, and care delivery
- Identify the cost drivers that enable a risk-based and/or population management perspective
- Apply the levers to identified opportunities in their home regions/communities/delivery systems
Population Health?

Kindig & Stoddart defined it as “the health outcomes of a group of individuals, including the distribution of such outcomes within the group” inclusive of:

- Health outcomes (shared but accountability difficult)
- Patterns of health determinants
- Policies and interventions that link these two
Improving Value

\[ \text{Value} = \frac{\text{Health outcomes}}{\text{Costs of delivering the outcomes}} \]

Source: Porter, Michael, “What is Value in Health Care?” New England Journal of Medicine, December 2010

<table>
<thead>
<tr>
<th>Cost of Delivering the Outcomes</th>
<th>Health outcomes</th>
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<tbody>
<tr>
<td>Increase</td>
<td>Decrease in value</td>
</tr>
<tr>
<td>Stay the Same</td>
<td>Decrease in value</td>
</tr>
<tr>
<td>Decrease</td>
<td>? Evaluate Carefully</td>
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Kevin Little, PhD, Institute for Healthcare Improvement

Moving from Volume to Value

- We need to think broadly about where to find leverage for achieving a healthier society.
- We can learn from countries that have created government ministries that marry health and social services.
- We need to consider not just how much we are spending but how we allocate those resources we are spending.
- Incentivize collaboration between health care and social service sectors.
**Driver #1**

**Align Financial Models**

In the era of Affordable Care Act, paying for value not volume:

- Focus on prevention
- Recognition of shared accountability leading providers to address upstream factors & central role of primary care
  - Care Coordination
  - Patient engagement & activation
  - Health promotion
- Delivery system collaboration with community partners and public health
- New care models—episodic bundle payment, ACO, CCO

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**Payment & Population Health Context**

Three Elements:

1. Commit to collaborate with geographic responsibility
2. Invest in creative and innovative approaches
3. Participate in coordinated efforts to modify causes of disease.

Example: Coordinated Care Organizations (CCOs) in Oregon
**Oregon CCO Examples**

- **Bud Clark Commons**: integrated housing and health/wellness services using a harm reduction model
- **C-TRAIN**: affordable housing + health care, recovery services, and employment assistance

Documented cost/utilization reductions (>50%) with reduced mortality and morbidity.

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**Driver #2**

**Effective Health Promotion**

Primary challenges:
- The tools we have available.
- The way we train clinicians.
- Legal/policy barriers that limit information exchange.
- Culture change to promote shared accountability.
- Relative financial investment in social welfare, public health, and medical care.
  - Countries with higher ratios of social-to-health spending have statistically better health outcomes (Bradley, 2013)
Health Care Spending in the U.S.

Changing Paradigm in Considering Health & Wellness

“The time has finally come for population-based health principles, philosophy, and methods to be applied in medical education and practice.”

Ibrahim, Savitz, Carey, Wagner 2001
Requisite Principles

- Community perspective
- Clinical epidemiology perspective
- Evidence-based practice
- Emphasis on outcomes
- Emphasis on prevention

Fundamental Presumption

Health = Health Care
Population Health View

Health ≠ Health Care

Figure 1
Impact of Different Factors on Risk of Premature Death

What are Social Determinants?

Factors that influence where we:
- Live
- Work
- Play
- Pray
...and get health (medical) care when needed.

“Adversity is not randomly distributed: instead it tends to cluster and to accumulate present on top of past disadvantage”

David Blane, MSc MD
Driver #3
Measure What Matters

- Socioeconomic factors at the patient and community levels are shown to be related to the probability of readmission, morbidity, and mortality
  - Individual level: Poverty, illiteracy, language proficiency, social support
  - Community level: poverty, housing vacancy, educational attainment rates

- Need to establish common metrics for health care & social services that are shared across sectors:
  - % housed, % employed, %obese, % depressed

- Need to measure what matters to people living in our communities → next generation measures

Patient Reported Measures Key

- Across the lifespan
  - Quality of life
  - Availability of social support
  - Housing security
  - Personal violence experience

- Episodic
  - Physical functioning
  - Pain
Considering Cause & Effect

- “Readmission Rate” as a quality metric & basis for financial penalties assumes that:
  - Readmissions are a result of poor quality, clinical care after adjustment for comorbidities and disease severity

Driver #4
Reduce Unnecessary Care

- Establish Appropriate Use Criteria
  - Better evidence to inform clinician decision making
- Informed Choice via Shared Decision Making
  - Identification of alternative, evidence based treatment options
  - Making that information available to patients/caregivers via decision aids
  - Collaboratively planning treatment decisions
**Driver #5**
High Quality Primary Care, Community

Focus on “at risk” populations
Who can help?

Linked organizations
- Homecare
- LTACH
- Nursing Homes
- Ambulatory clinics

Community agencies, resources
- Shelters
- Schools
- Food banks
- Faith-based groups
- Businesses
- Condition-specific groups
- Housing
- Pharmacies

**Driver #6**
High Quality Hospital Care

HAI's
- Surgical Site
- VAP
- CR-BSI
- Falls
- Falls w/ injury
- PUs

Preventable codes
- Delirium prevention

Palliative care
- Overuse – CT, MRI, blood
- Flow delays
- Early inductions - NICU admits

Readmissions
- Same conditions
- Any reason

Palliative care
- Homecare
- Family, caregiver involvement
- Inappropriate admissions
  - Which patients?
  - Why?

Competing measures
- Lack of follow-up services
- Assure “safe landings”
Driver #7
Innovation, productivity, efficiency

- Project ECHO
- Shape demand, match capacity and demand, redesign care
- Care navigators, community health workers, employees
- Technology - IPads, virtual appointments, wearables,
- Linkages with retail, faith communities, other groups

7 Drivers: Summary

1. Align financial models
2. Provide effective health promotion, prevention, and self-management to improve the health and wellness.
4. Reduce/eliminate unnecessary care
5. Meet the majority of health care needs with high quality primary care and community-based services.
6. Ensure high quality hospital care services are available when needed.
7. Improving innovation, productivity, and efficiency in the delivery of health services.

    cost structure
Our Framework: Five Accelerators

- Demonstrating effective leadership
- Integrating data systems to support performance improvement
- Building robust improvement infrastructure
- Engaging providers and community stakeholders in care redesign
- Leveraging payment models to achieve clinical and financial targets

Selected References