BRIDGING THE DIVIDE BETWEEN HEALTH AND HEALTH CARE

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THE AFFORDABLE CARE ACT

Is the Sunlight Pouring Through?
For Population Health?

Is It Really $10 Billion
For Population-Based Disease Prevention
and Health Promotion Activities?
The Challenge Is To Move From a Culture of Sickness to a Culture of Care to a Culture of Health

How Do We Create a Market for Health?
Pay Technology-Enabled, Team-Based Systems Of Care to Keep People Well

Requires **People** Engagement
Not Just Patient Engagement

Requires **Community-Wide Population** Focus
Not Just Individual ACO or Integrated Delivery System Focus
Changing Payment Toward Risk-Based Global Budgets Unleashes Great Opportunities For Innovation
**Workforce (Title V)**

- Increased Medicare and Medicaid payments for primary care providers

- Incentives for new doctors and other health professionals to practice primary care; loan repayments and scholarships

- No cost-sharing in Medicare and new private plans for certain preventive services and incentives for states to do same in Medicaid

- Funding for population-based prevention activities

- National Workforce Strategy
PREVENTION and PUBLIC HEALTH APPROACH

• Employers
  • Offer health prevention

• Schools
  • Policy development, school-based screening programs, physical education

• Workforce
  • Expand loan repayment (social work and public health)
  • Programs to retain workforce in rural and underserved areas
PREVENTION and PUBLIC HEALTH APPROACH (cont’d)

• **Government**
  • National strategy for public health
  • Invest in state and local public health and built environment

• **Individuals and Families**
  • Promote personal responsibility
Community Health Building Assets

- Education
- Healthcare Delivery System
- Religious Organization
- Physical and Social Environment
- Housing
- Jobs
- Family Support Services

Community
A group of individuals with a sense of shared space, shared responsibilities, and perceived interdependence

Population-Based Health Continuum Goal: Creating the Chronically Well

Chronically well  Sporadically well  Sporadically ill  Chronically ill

Building Blocks of the Community Health Care Management System

- Community population-based needs assessment
- Identification of community assets, capabilities, and resource requirement
- Alignment of service providers, managers, and governance within and across medical, health, and community sectors

Knowledge about desired end states

Information Systems

- Results
- Strategies, action plans
- Continuous quality improvement

Components Needed to Achieve Population-Based Health

<table>
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<tr>
<th>Strategic</th>
<th>Structural</th>
<th>Cultural</th>
<th>Technical</th>
<th>Result</th>
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<td>Inability to capture the learning and spread it throughout the organization</td>
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<td>Lasting system-wide impact</td>
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DELIVERY SYSTEM CHANGES

• Redefine The “Product”
  • From Illness to Wellness
  • From Patients to Healthy People

• Redefine The Place
  • From Office, Clinic or Hospital Bed to Home, Workplace, School

• Redefine The “Providers”
  • Beyond Healthcare Professionals to Teachers, Social Workers, Architects, Urban Planners, Community Development Specialists
Early Evidence from Primary Care Medical Home Interventions

**Group Health Cooperative of Puget Sound (Seattle, WA)**
- 29% reduction ER visits; 11% reduction ambulatory sensitive admissions

**Health Partners (Minnesota)**
- 39% reduction ED visits; 34% reduction hospital admissions

**Gesinger Health System (Pennsylvania)**
- 18% reduction in all-cause hospital admissions; 36% lower readmissions
- 7% total medical cost savings

Source: Karen Davis, Commonwealth Fund, July 21, 2012
Early Evidence from Primary Care Medical Home Interventions (cont’d)

Mass General High-Cost Medicare Chronic Care Demo (Massachusetts)
• 20% reduction hospital visits; 20% reduction ED uses
• Mortality decline: 16% compared to 20% in control group
• 4.7^ net savings annually

International Health Care (Utah)
• Lower mortality; 5% relative reduction in hospitalization
• Highest $ savings for high-risk patients

Source: Karen Davis, Commonwealth Fund, July 21, 2012
Population Health Data Management

- Collect individual health status data
- Stratify populations based on risk/need for care
  - predictive model
- Tools to engage people in their health and health care
- Health information exchange capabilities – portability of records
- Workflow tools for providers to use evidence-based protocols
Public Health Sector Changes

• Greater Flexibility in Use of Funds

• New Partnerships with Delivery Systems

• Better Targeting of Those Most in Need of Preventive Services

• Joint Development of Goals with Metrics to Measure Progress

• Shared Infrastructure for Sustainability of Workforce
Community-Development & Social Service Sector Changes

• “Health in All” Policies

• Health Effects of Zoning Regulations, Housing Permits, Transportation, Labor, and Educational Policies
SOME EXAMPLES

- Cambridge Health Alliance
- Robert Wood Johnson Foundation and Federal Reserve Board Human Capital Investments
- Ontario Family Health Networks
- Others on the IOM Roundtable
A BOLD PROPOSAL

CMS and OTHER PAYERS

Create a Risk-Adjusted Population-Wide Health Budget To Be Overseen by a Community-Wide Entity Tied to Multi-Year Performance Targets

Examples Might Include:

- Reduction in Newly Diagnosed Diabetics
- Reduced Infant Mortality
- Reduced Pre-Term Births
- Reduced Obesity Rates – Children and Adults
- Lower Blood Pressure for CHF Patients
- Reduced Disability and Work Loss Days Due to Illness
- Greater Functional Health Status Scores among Samples of the Population
SOME INTEREST IN CALIFORNIA

Payment Reform Ideas (1 = Low to 10 = High)

Create Accountable Care Communities Focused on Population 7.5

Pilot Incentives in a Community to Link Delivery System and Community Efforts to Improve Health 7.0

Is your Organization Attempting to Link Patient Care with Private or Public Community Efforts to Improve Population Health? Yes = 67%

Source: CAL SIMS Project, Integrated Health Association, May 16, 2013
KEY CHALLENGE

Building the Needed Partnerships

Based on Shared Goals, Shared Information,

Innovations in Use of Human Resources, and

Cross-Sector, Cross-Boundary Leadership
Thank You

“Healthier Lives In A Safer World”