

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

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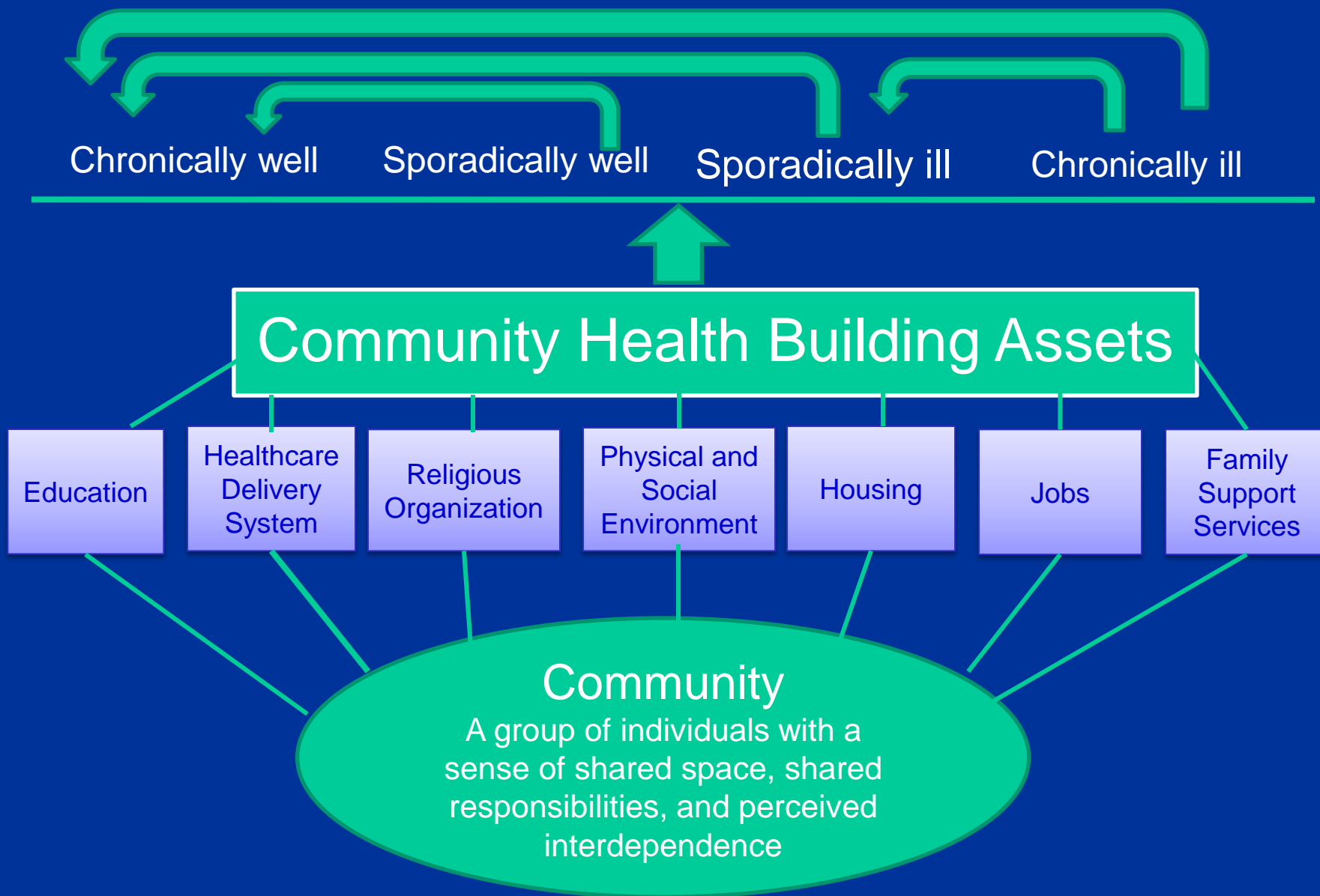
PREVENTION and PUBLIC HEALTH APPROACH

- **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

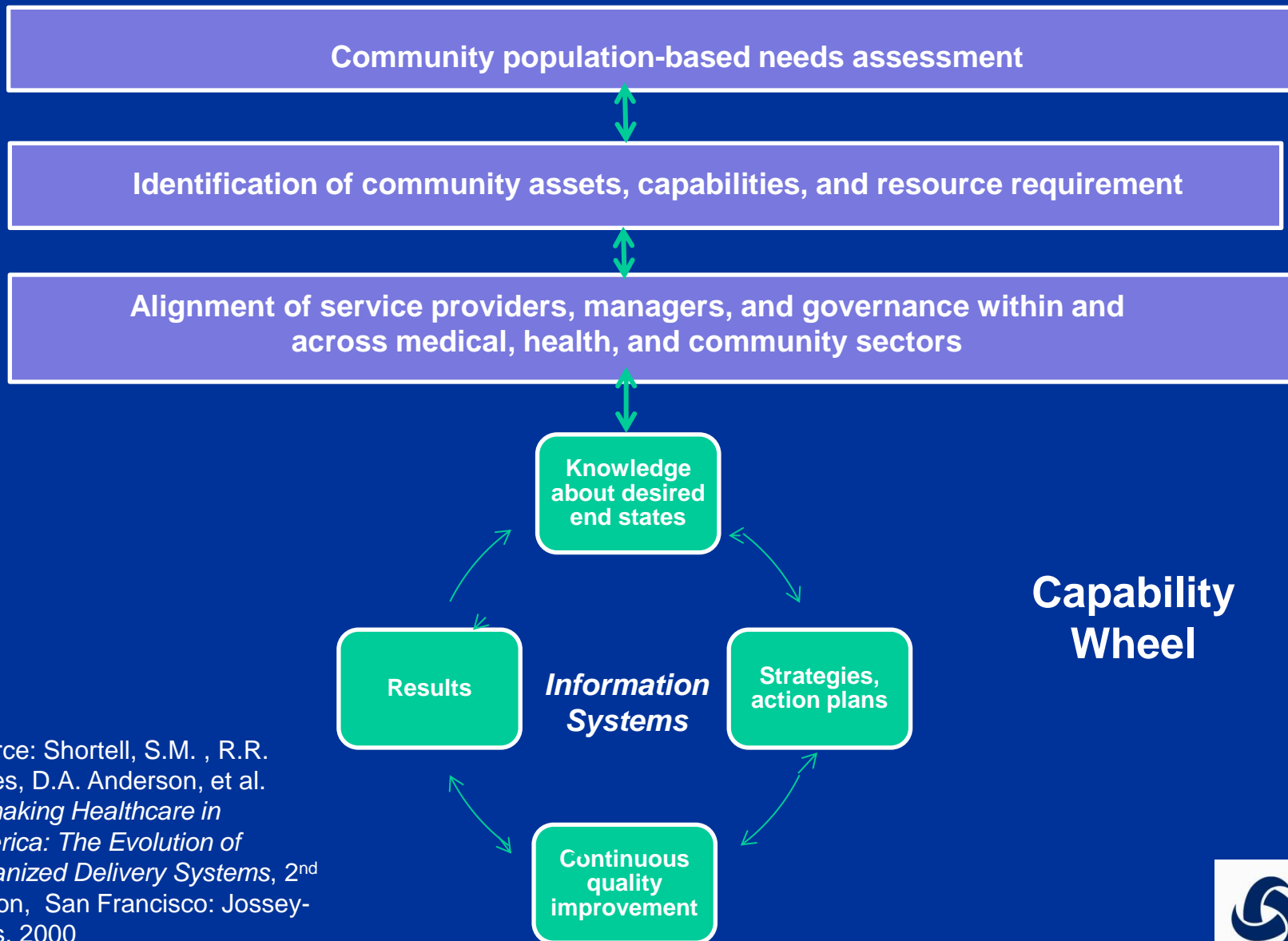
PREVENTION and PUBLIC HEALTH APPROACH (cont'd)

- **Government**
 - National strategy for public health
 - Invest in state and local public health and built environment
- **Individuals and Families**
 - Promote personal responsibility

Population-Based Health Continuum Goal: Creating the Chronically Well



Building Blocks of the Community Health Care Management System



Source: Shortell, S.M. , R.R. Gillies, D.A. Anderson, et al. *Remaking Healthcare in America: The Evolution of Organized Delivery Systems*, 2nd edition, San Francisco: Jossey-Bass, 2000

Components Needed to Achieve Population-Based Health

Strategic	Structural	Cultural	Technical	Result
0	1	1	1	No significant impact on anything really important
1	0	1	1	Inability to capture the learning and spread it throughout the organization
1	1	0	1	Small, temporary effects; no lasting impact
1	1	1	0	Frustration and false starts
1	1	1	1	Lasting system-wide impact

Source: Shortell, S.M. , R.R. Gillies, D.A. Anderson, et al. *Remaking Healthcare in America: The Evolution of Organized Delivery Systems*, 2nd edition, San Francisco: Jossey-Bass, 2000

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”

