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Health Improvement Opportunities In the State Health Care Innovation Plans

August 29, 2014
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In This Presentation I Will:

- View the state's health care innovations plans through two lenses:
  - Health Care System Improvement
    - Reviewing the state's objectives and funding allocations for improving health care
  - Population Health Improvement
    - Briefly using the obesity epidemic to illustrate what that's all about
    - And reviewing the population health improvement aspects of the state's plans.
- Review the arc of these meetings.

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The Triple Aim and the Three Strategies

1. **Better Health: Improve the health of the population.**

2. **Better Care: Enhance the patient care experience (including quality, access and reliability).**

3. **Lower Cost: Reduce, or at least control, the per capita cost of care.**

1. **Build healthy communities and people** through prevention and early mitigation of disease throughout the life course.

2. **Drive value-based purchasing** by rewarding quality heath care over quantity, with state government leading by example as Washington's largest purchaser of health care “First Mover”.

3. **Improve chronic illness care** through better integration of care and social supports, particularly for individuals with physical and behavioral health co-morbidities .

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The Triple Aim and the Three Strategies

1. **Better Health: Improve the health of the population.**	1. **Build healthy communities and people** through prevention and early mitigation of disease throughout the life course.
2. **Better Care: Enhance the patient care experience (including quality, access and reliability).**	2. **Drive value-based purchasing** by rewarding quality heath care over quantity, with state government leading by example as Washington's largest purchaser of health care “First Mover”.
3. **Lower Cost: Reduce, or at least control, the per capita cost of care.**	3. **Improve chronic illness care** through better integration of care and social supports, particularly for individuals with physical and behavioral health co-morbidities .

Population Health

Health Care System

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Population Health, Health Care System

- Aren't the two connected?
- Of course, but they're not identical.
- Good health care is essential for good community health.
- But community health improvement takes more than health care system improvement.

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Determinants Of Health

Sources:

Chart from SHCIP p. 49.

University of Wisconsin Population Health Institute's County Health Rankings model 2010. http://www.countyhealthrankings.org/about-project/background

The Future of the Public's Health in the 21st Century, Institute of Medicine, National Academies Press, 2002, www.nap.edu

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Population Health, Health Care System

- Population health is determined many factors beyond the health care system.
- To illustrate this further, consider one of the most significant population health challenges we face…
- The obesity epidemic provides a good model for what population health improvement is about.

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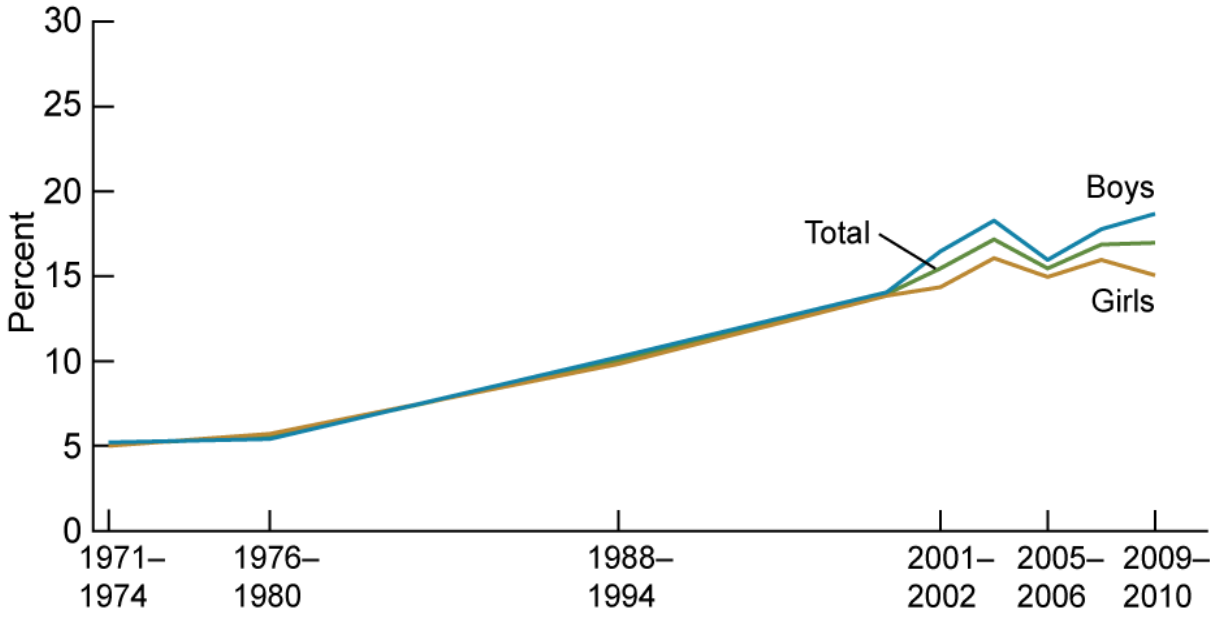
A 3-Fold Increase in Childhood Obesity Since 1980

Figure 1: Trends in obesity among children and adolescents aged 2–19 years, by sex: United States, 1971–1974 through 2009–2010



NOTE: Obesity is body mass index greater than or equal to the 95th percentile of the sex- and age-specific 2000 CDC growth charts.
SOURCES: CDC/NCHS, National Health and Nutrition Examination Surveys (NHANES) I–III; and NHANES, 1999–2000, 2001–2002, 2003–2004, 2005–2006, 2007–2008, and 2009–2010.

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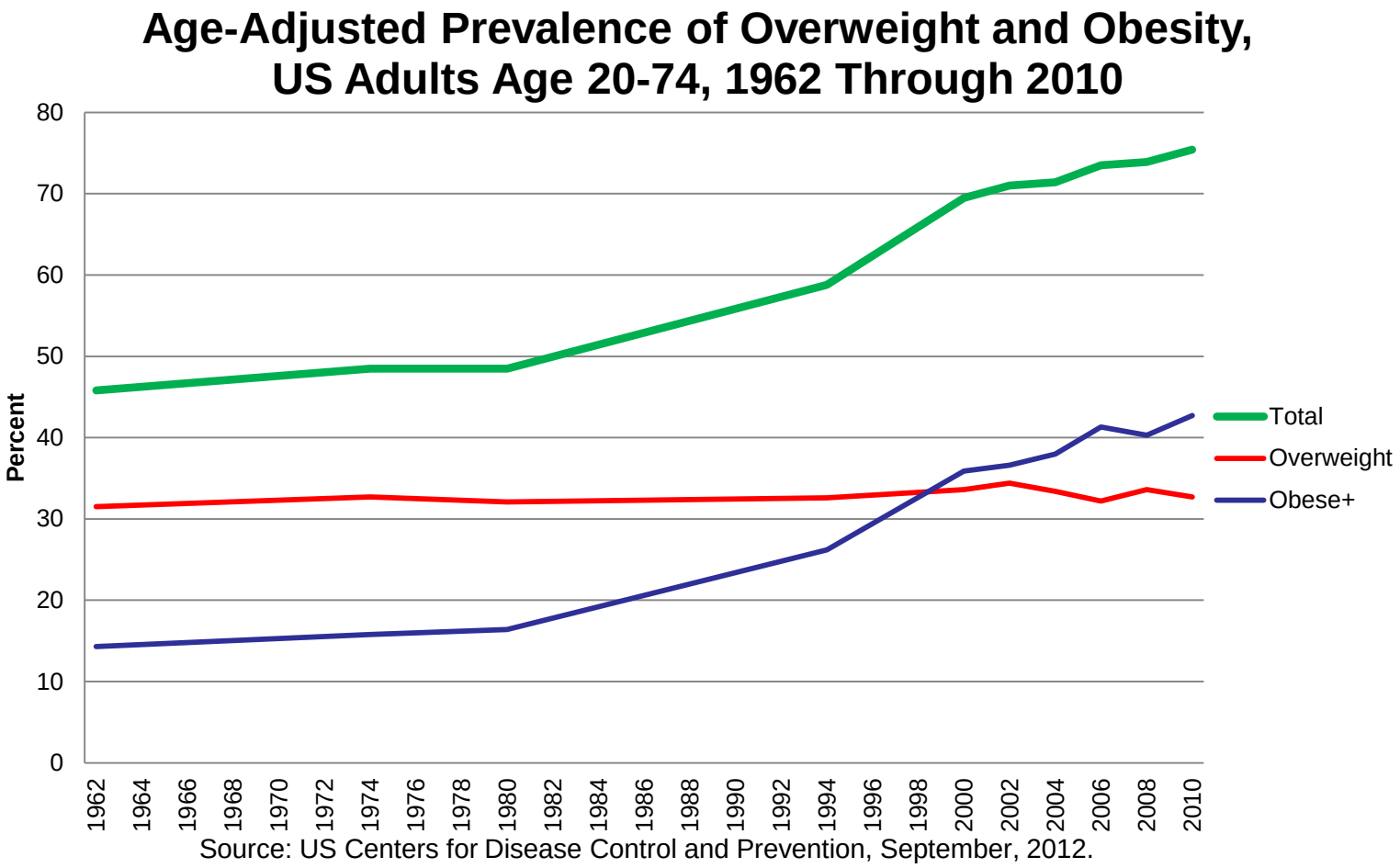
For Adults, Also a Sharp Increase Since 1980

(Mainly in the more severe forms of obesity and extreme obesity.)



Source: US Centers for Disease Control and Prevention, September, 2012.

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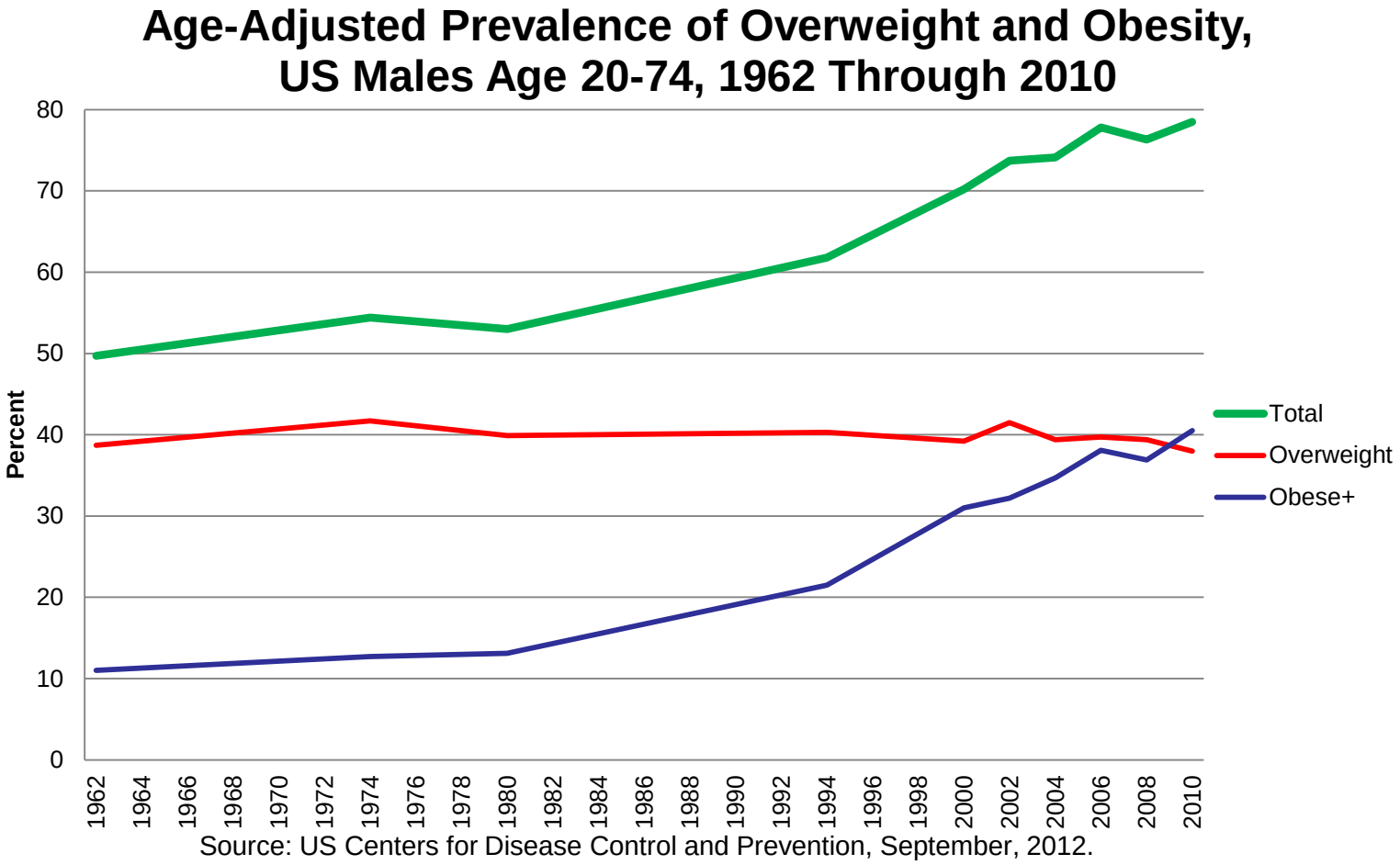
For Men…



Source: US Centers for Disease Control and Prevention, September, 2012.

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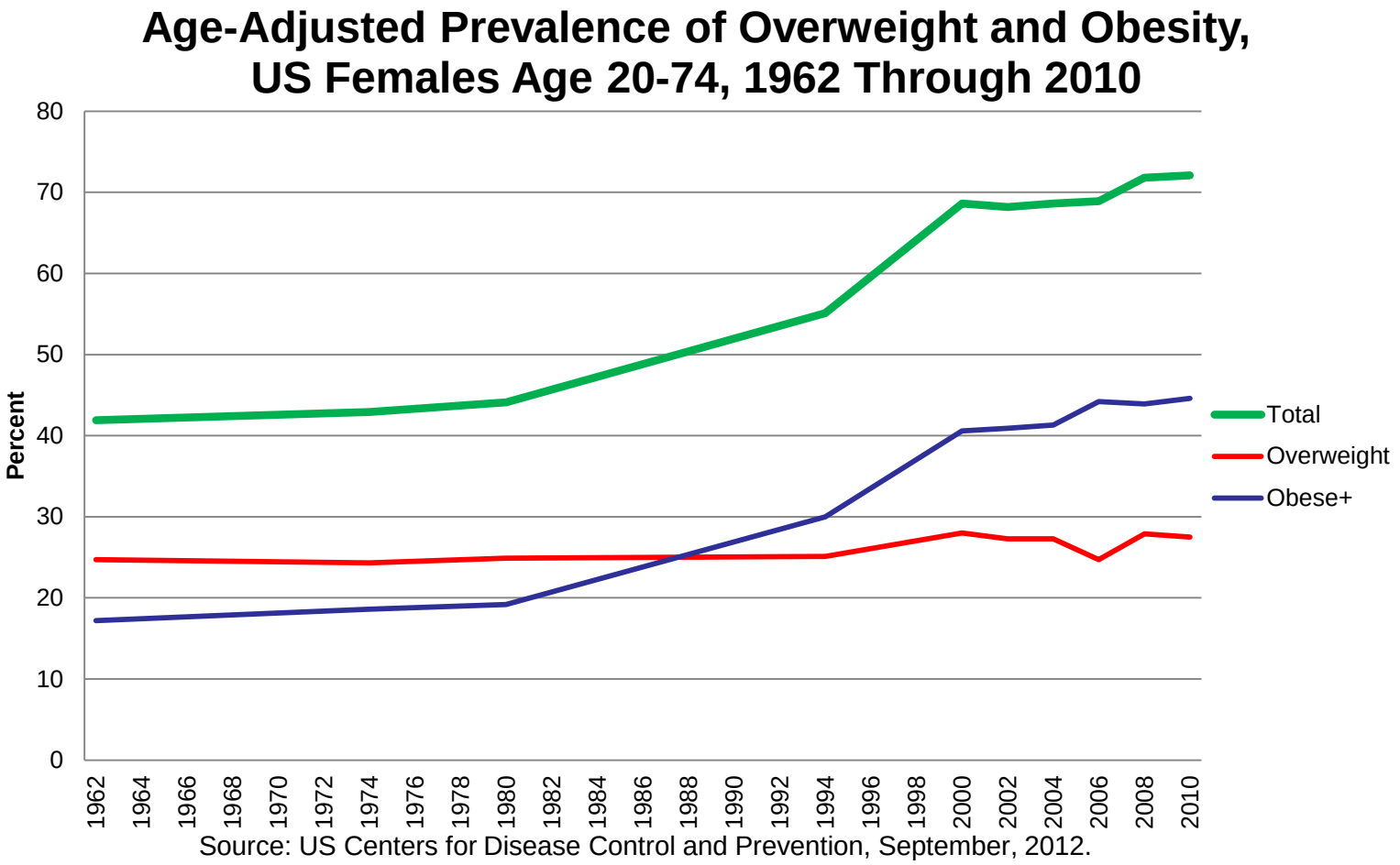
And For Women…



Source: US Centers for Disease Control and Prevention, September, 2012.

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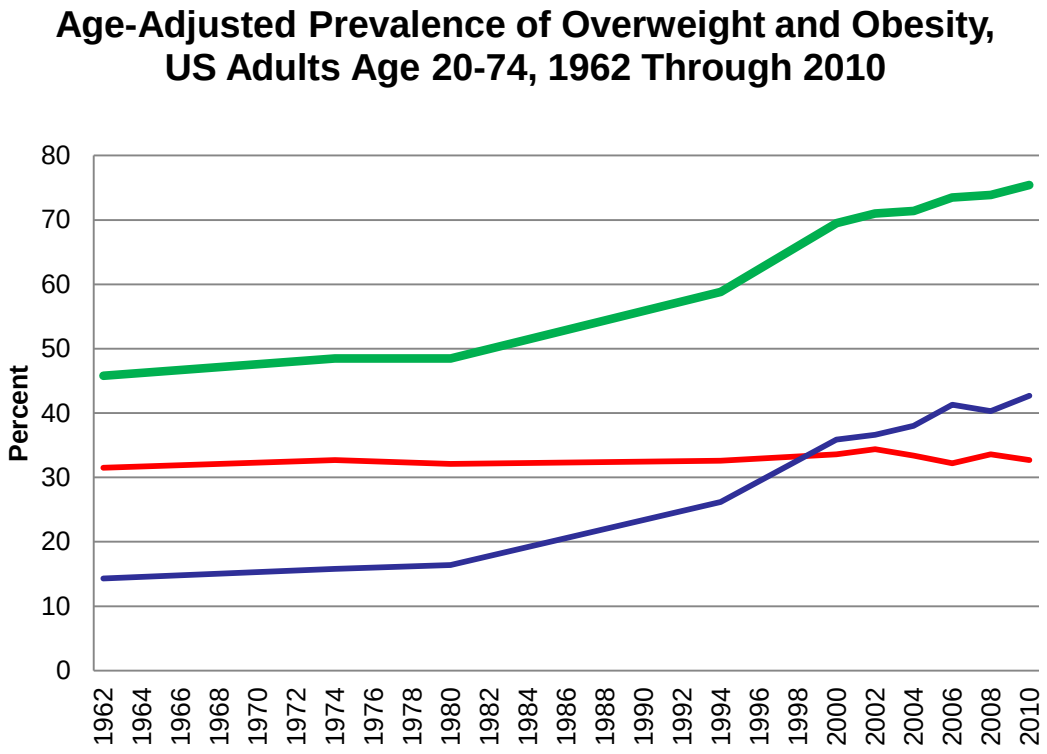
How big a deal is this?



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Institute of Medicine and National Research Council 2009:

When people look back 50 years from now, childhood obesity may well stand out as the most important public health issue of our time. The prevalence of childhood obesity has tripled in just three decades, contributing to the ever more frequent appearance in children and youth of what were once chronic diseases and conditions usually associated with adulthood—"adult-onset" diabetes, high blood pressure, and high cholesterol. There is no more sobering thought than the growing *consensus that the life expectancy of many of today's children will be less than their parents*' because of the impact of early and continuing obesity on their health.

Local Government Actions to Prevent Childhood Obesity, Institute of Medicine and National Research Council, 2009,

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Why did this happen?

- Clearly, it is not that the health care system suddenly started doing something wrong around 1980.
- Multiple societal causes are involved.
- It isn't caused by the health care system, and it can't be entirely fixed by the health care system.
- It's a population health problem requiring community-wide responses.

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What can we do about it?

Community health improvement requires a many-faceted approach, lasting for years, with aims such as:

- **Change the built environment to maximize safety and to make healthy choices (like exercise) the easy choices. For example, safe and well lit walking paths and streets.**
- **Adopt public policies that promote health (such as smoking bans).**
- **Promote healthy choices for children in schools and daycare through physical activity, healthy eating, etc.**
- **Deliver early childhood interventions known to help reduce the impact of Adverse Childhood Experiences (ACEs), which predispose people to both physical and emotional problems.**

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What we can do about it, continued:

Community health improvement requires as many-faceted approach, lasting for years, with aims such as:

- **Change the message environment, in all the places and media where people find themselves, persistently over time, to assertively promote healthy instead of unhealthy products and choices.**
- **Improve the nutritional choices available to consumers, emphasizing healthier and de-emphasizing unhealthy foods.**
- **Overall, create what Robert Wood Johnson Foundation calls a "culture of health."**

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What we can do about it, continued:

- It takes an ambitious effort by many partners persisting over decades.
- This is often compared to our efforts on Tobacco.
- That took 50 years and we're not done, though we've made major progress. Health care had an important role but was far from the whole story.
- It wasn't cheap or easy.
- We should expect the same for the obesity epidemic.

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What we can do about it, continued:

- The obesity epidemic may be tougher than tobacco.
- Think of the vast social pressure already pushing us to be young and slim, not to be fat. The immense resources expended on weight loss. Yet still we have this remarkable trend.
- Not something you can fix with a few public info campaigns and some rah-rah about healthy living.
- And it can't be done with a little good intentioned volunteerism. Someone has to pay for a lot of it.
- So far, regarding the obesity epidemic we are falling far short of a response commensurate with the seriousness of the problem.
- And of course obesity isn't our only population health challenge.

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So…back to the SHCIP…

- It wants to address <u>both</u> health care system improvement and population health improvement.
- Those are two related but different things.
- What does it actually propose:
  - with regard to health care system improvement, and
  - with regard to population health?

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A reminder on how the plans fit together:

- **The State Health Care Innovations Plan (SHCIP) is the overall plan, developed under Round 1 State Innovation Models federal funding and finished in January, 2014.**
- **The State Innovation Models Round 2 grant proposal, submitted in July 2014, requests about $93M and explains how the state would use the money to implement the SHCIP over 4 years beginning in 2015.**
- **So let's look at the Innovation Models Round 2 grant objectives regarding health care improvement, and then look at the plans related mainly to population heath improvement.**

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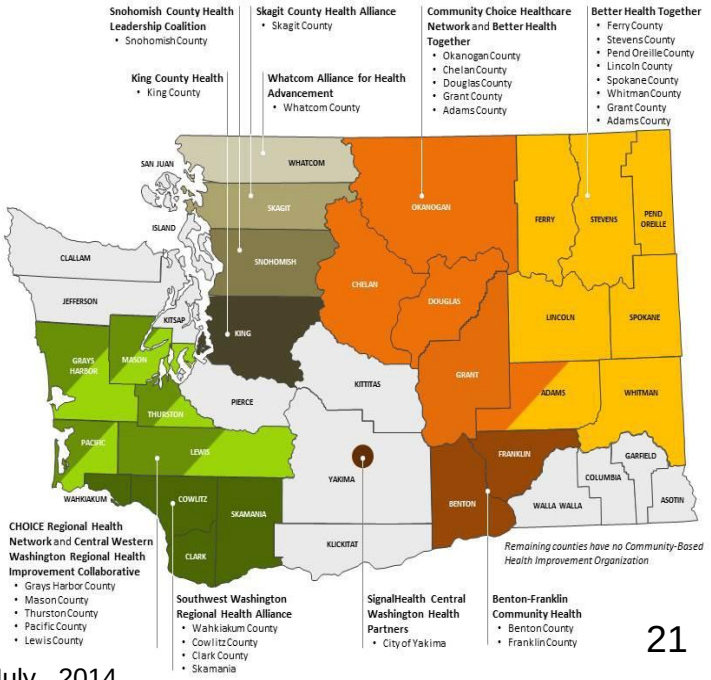
Key Concept: Accountable Community of Health

- **Regionally based, voluntary collaboratives to align actions to achieve healthy communities and populations, improve health care quality and lower costs.**
- **Based on the premise that no single sector or organization in a community can create transformative, lasting change in health and health care alone.**
- **Clinical, community, and government entities must coordinate their efforts and actions around clearly defined goals that support whole-person health.**
- **Shift from traditional State- community engagement approaches to those of partnership to achieve mutual aims.**



Slide content courtesy of John Wiesman, DrPH, Washington State Secretary of Health, July., 2014

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Key Concept: Accountable Community of Health

- **Collectively impact health** through regionally driven priorities and solutions
- Develop and **work in partnership with the state** on health systems transformation
- **Maintain a local identity** while aligning with State efforts
- **Develop a region-wide health assessment and regional health improvement plan**, including Medicaid purchasing alignment
- **Driver of accountability** for results
- **Forum for harmonizing** payment models, performance measures and investments
- Health **coordination** and workforce **development**

- **But…there remain many unanswered questions on ACHs**

Slide content courtesy of John Wiesman, DrPH, Washington State Secretary of Health, July., 2014

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Health care system improvement objectives in the Innovation Models Grant Operational Plan

❖ Accountable Communities of Health

- …invest in Accountable Communities of Health (ACHs) that will develop a sustainable presence in their communities and partner with the state to achieve the project's goals.
- ACHs will provide the organizational capacity for local communities to implement the plan for population health, link community supports with practice transformation, and enhance local data collection and analytic aptitude.
- **So ACHs serve both health care and population health improvement purposes. More on the pop health aspects of ACHs below.**
- **$12.9M**

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Health care system improvement objectives in the Innovation Models Grant Operational Plan

- **Practice Transformation Support**
  - Education, training and consulting services aimed at providers and provider organizations.
  - "…integrate physical and behavioral health, develop clinical community linkages and…value-based purchasing models….[apply] expertise in clinical practice transformation….[provide] tools to engage individuals and families in their health."
  - All about making health care delivery better.
  - $22M

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Health care system improvement objectives in the Innovation Models Grant Operational Plan

- **Payment Redesign – Four test models**
  1. Early adopter regions integrate physical and behavioral health financing and services.
  2. Pioneer new payment methodologies and service delivery models for FQHCs, Rural Health Clinics; new flexibility for Critical Access Hospitals.

  3 and 4 – Accountable delivery and payment models featuring total cost of care accountability with high value networks and consumer oriented benefit design.
- Medicaid purchasing of physical, mental health and chemical dependency tx fully integrated by 2020.
- Move 80% of purchasing away from fee-for-service by 2019.
- $7.3M

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Health care system improvement objectives in the Innovation Models Grant Operational Plan

- **Analytics, Interoperability, Measurement**
  - …improved alignment, adaptability and analysis of existing and newly acquired data…will drive real-time health system improvement and long term health technology innovations…[and] amplify current clinical data collection efforts…critical for effective delivery of health care. Greater price & quality transparency.
  - Key element is all-payer database.
  - $36.6M

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What about population health improvement objectives?

- Along with Project Management ($13.1M), the list we have just reviewed includes all of the main objectives and all of the funding described in the State Innovation Models Round 2 proposal.
- These objectives and funding allocations relate mainly to health care system improvement.
- Where the plan gives relatively specific objectives, and where money is committed, the subject is primarily health care system improvement.
- But the plan does include some themes and ideas related to population health improvement.

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The Prevention Framework

- Developed in 2014 through a public-private multi-sector collaboration.
- A very well informed list of priority prevention measures, both clinical and community-based.
- Strong participation by public health, medical community, insurers, provider organizations, etc.

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The Prevention Framework

- Surely this is a good thing, but so far it is a really good list of things that ought to be done somehow.
- It isn't what you can actually call a plan, and no funding is associated with it.
- But there will be a "plan for population health" to be completed in January 2016.
- "Ultimate accountability for the final plan for population health will be placed with the Secretary of Health."

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Beyond the not-yet-written plan, population health improvement is addressed mainly through three concepts:

1. **Collaboration via Accountable Communities of Health.**
2. **Social improvement bonds.**
3. **Redirection of savings.**

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1. Collaboration via ACHs

- ACHs as "core infrastructure through which the population health plan will be accelerated after its completion."
- ACHs will "leverage state, federal and private philanthropic resources…and capture savings for reinvestment…"
- Will also conduct community health needs assessments and develop regional plans, including plans for population health improvement.

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1. Collaboration via ACHs, continued

- No specific population health objectives so far.
- No Innovation Models grant money or other funds committed to population health improvement activities.
- Some question as to how bringing us all together in an ACH will somehow cause the appearance of significant resources we've never noticed before.
- But of course collaboration is good, and perhaps we can better use existing resources.

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2. Social Impact Bonding

- **The concept involves 4 principles:**
  - **Reliable evidence that a proposed intervention will produce promised savings.**
  - **Contractual agreement among those who will reap savings to repay the loan, bond, or revolving fund.**
  - **Savings realized shared among those who did the work and replenish the funding source, so that additional projects can be created.**
  - **The goal will be to fund a "balanced portfolio" of projects that address a full spectrum of needs.**

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2. Social Impact Bonding – Concerns

- **Exciting ideas but only a few successful examples to date.**
- **Requires someone to risk large amounts of money on future savings which may be a long way off. Such capital has been scarce so far.**
- **Many important pop. health measures have very long timelines for ROI, and the returns are often diffuse, involving diverse parties. So many don't fit this model very well.**
- **In the proposal, no objectives as to its use.**
- **No Innovation Models funding committed to it.**

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3. Redirection of Cost Savings

- Mentions the possibility that health care cost savings could be redirected to population health efforts.
- In Model Test 1 (integration of mental and physical health care & financing), counties within each early adopter region will receive 10% of state savings resulting from the integration models.
- "ACHs will…capture savings for reinvestment and sustainability."
- "Continued financing to sustain project initiatives…[will come] from multiple sources including but not limited to…Public and private savings leveraged for ongoing investment…."

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3. Redirection of Cost Savings, cont'd:

- There are some questions:
  - Payers may or may not redirect savings.
    - If Medicaid cost inflation is 2% less than expected, will the leg give some of the 2% to pop health? Would Premera if it saved money?
  - Provider organizations will be under more not less financial pressure – harder not easier for them to fund population health initiatives.
  - Redirected savings are tapped as a source of support not only for pop. health improvement but also for health care improvement efforts and ACH operations.
  - No specific objectives about this, beyond the one test model.
  - No Innovation Models funding committed to it, beyond the one test model.

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So where does that leave us?

1. **Better Health: Improve the health of the population.**	1. **Build healthy communities and people** through prevention and early mitigation of disease throughout the life course.
2. **Better Care: Enhance the patient care experience (including quality, access and reliability).**	2. **Drive value-based purchasing** by rewarding quality heath care over quantity, with state government leading by example as Washington's largest purchaser of health care “First Mover”.
3. **Lower Cost: Reduce, or at least control, the per capita cost of care.**	3. **Improve chronic illness care** through better integration of care and social supports, particularly for individuals with physical and behavioral health co-morbidities .

Population Health

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Health Care Improvement and Population Health Improvement In the SHCIP

- **Overall, the SHCIP and Innovation Models plans for health care system change are more specific than their plans for population health improvement.**
- **The plans are also much more specific on ways to fund health care system reform than on ways to fund population health improvement.**
- **Can't really blame them. One initiative can't do everything, and Innovation Models $s are limited. Population health improvement is expensive.**
- **But it is helpful to be realistic about what the plan does and doesn't include.**

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We can respond in both dimensions.

- **Obviously, improving the health care system is important to all of us.**
  - **We will be discussing just how we want to participate in the SHCIP's health care system initiatives.**
  - **…and how/whether that involves participation in an Accountable Community of Health.**
- **But let's not lose track of our opportunities for population health improvement.**
  - **At a minimum, the possibility of better collaboration among community partners is an important opportunity for population health improvement.**
  - **One I hope we do not miss.**
  - **And just possibly, there could be some greater focus and funding re population health improvement.**

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This series of meetings

- Is an opportunity to explore these initiatives together
- And, together, to decide how we want to respond.
- Our product is expected to be a plan or report that will become part of the regional plan submitted to HCA under the regional planning grant.
- The form, content and specificity of that plan are up to us.

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This series of meetings

- **Today's Meeting:**
  - **Common understandings of the state's proposals.**
  - **Share our initial views, concerns and questions.**
  - **Begin to define common themes.**
- **Meeting Two – September 26:**
  - **Put our questions directly to an HCA leader.**
  - **Review developments since first meeting, including discussions in other NCW counties.**
  - **Clarify the concept of an Accountable Community of Health**
  - **Clarify our views and explore the extent of consensus on how our community should respond to state health care initiatives.**

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This series of meetings

- **Meeting Three – October 31:**
  - **Subject to change based on earlier meetings.**
  - **Review developments since second meeting, including discussions in other NCW counties.**
  - **Determine major points for Chelan/Douglas aspect of regional plan/report to HCA.**
  - **If there is consensus, express it. If not, describe our diversity of views and plans as clearly as possible.**
- **Meeting Four – November 21:**
  - **Subject to change based on earlier meetings.**
  - **Review developments since third meeting, including discussions in other NCW counties.**
  - **Finalize major points for C/D plan/report to HCA.**

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Thanks for listening.

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Other slides.

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US Life Expectancy

Among Affluent Nations

1980 – 15th

2009 – 27th

Source: CDC/NCHS. *National Health Interview Survey 2010, Family Core And Sample Adult Questionnaire*. Published in National Center for Health Statistics.
Health, United States 2011: With Special Feature on Socioeconomic Status and Health. Hyattsville, MD: 2012.
www.cdc.gov/nchs/data/hus/2011/056.pdf.
Accessed November 29, 2012.

1980	Rank	2009
LE = 76.7 Iceland	1	Japan LE = 83.0
Japan	2	Switzerland
Netherlands	3	Italy
Norway	4	Spain
Sweden	5	Australia
Switzerland	6	Iceland
Spain	7	Israel
Canada	8	Sweden
Greece	9	France*
Australia	10	Norway
Denmark	11	Canada**
France	12	New Zealand
Italy	13	Luxembourg
Israel	14	Netherlands
LE = 73.7 United States	15	Austria
Finland	16	Korea
Belgium	17	United Kingdom
New Zealand	18	Germany
United Kingdom	19	Greece
Germany	20	Belgium
Ireland	21	Finland
Luxembourg	22	Ireland
Austria	23	Portugal
Portugal	24	Denmark
Slovenia	25	Slovenia
Slovak Republic	26	Chile
Czech Republic	27	**United States LE = 78.5**
Poland	28	Czech Republic
Chile	29	Poland
Estonia	30	Mexico
Hungary	31	Estonia
Mexico	32	Slovak Republic
Korea	33	Hungary
Turkey	34	Turkey

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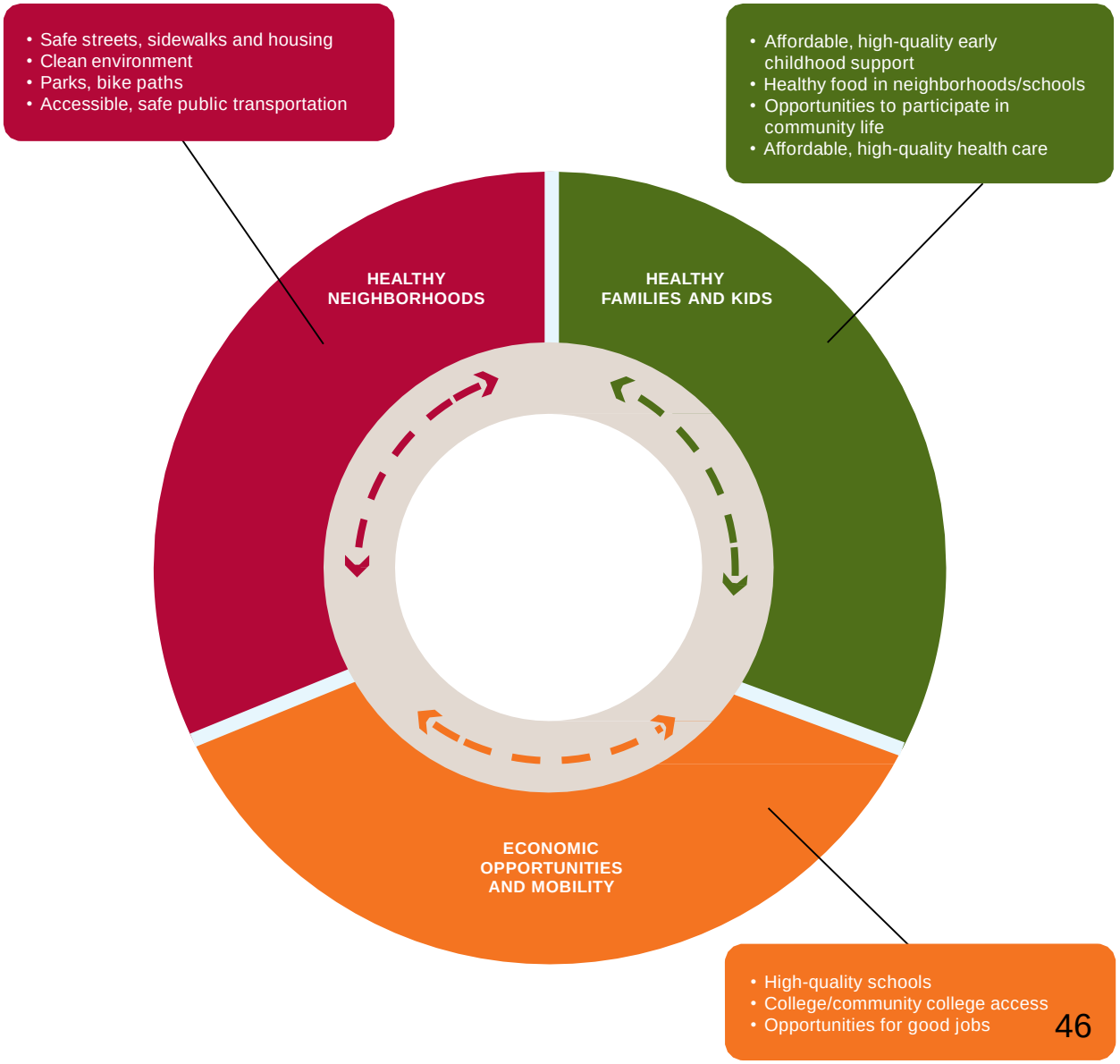
Building Communities Where the Healthy Choice is the Easy Choice



Sources:

Andrews, N. People and Place: A New Vision for Healthy Communities. Testimony Prepared for the Robert Wood Johnson Foundation Commission to Build a Healthier America. June 2013. *www.liifund.org/wp-content/uploads/2013/06/People-and-Place-A-New-Vision-for-Healthy-Communities.pdf.* Accessed December 12, 2013.

Time to Act: Investing in the Health of Our Children and Communities. **Recommendations From the Robert Wood Johnson Foundation Commission to Build a Healthier America**. Robert Wood Johnson Foundation, 2014.

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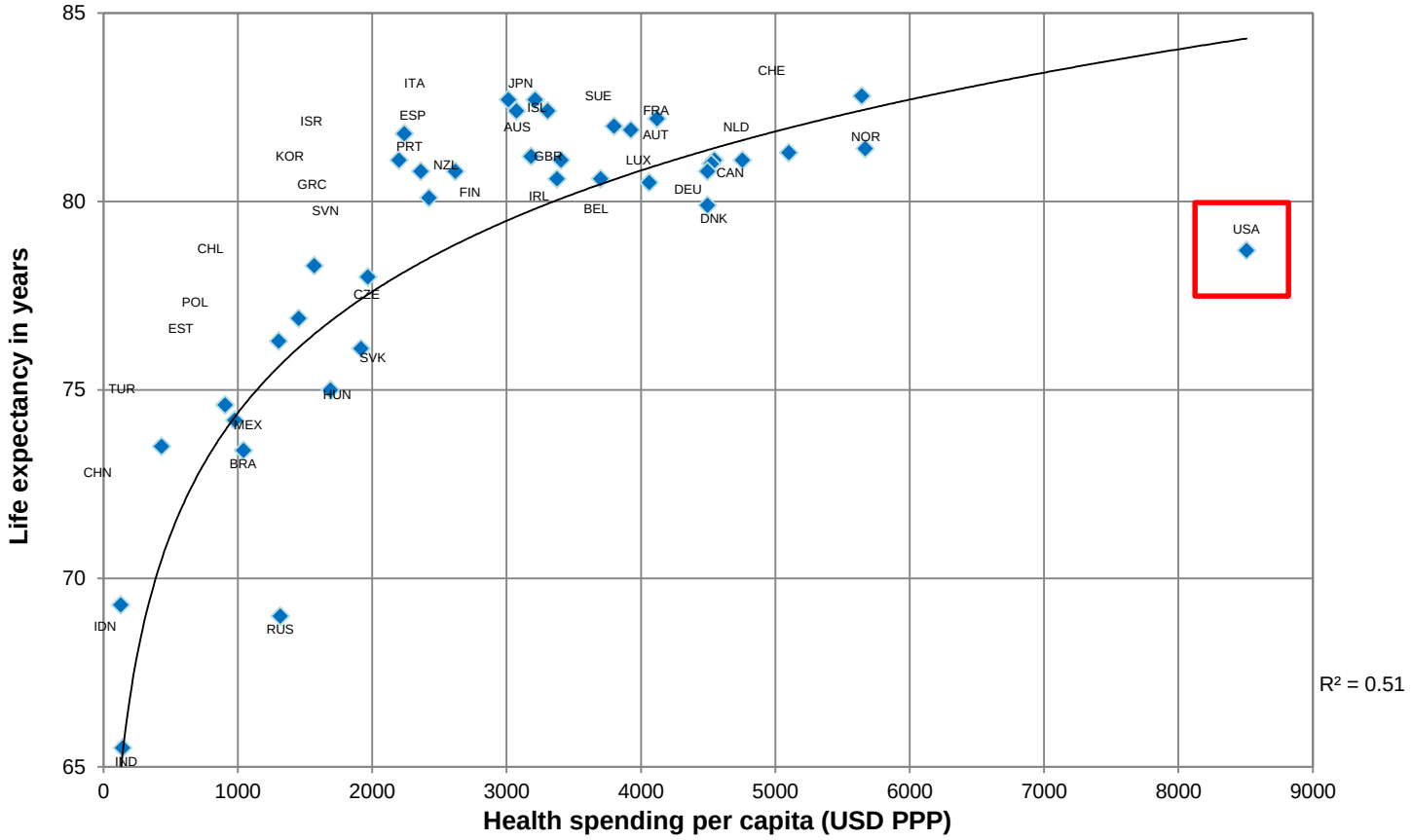
Life expectancy at birth and health spending per capita, 2011



Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en; World Bank for non-OECD countries.

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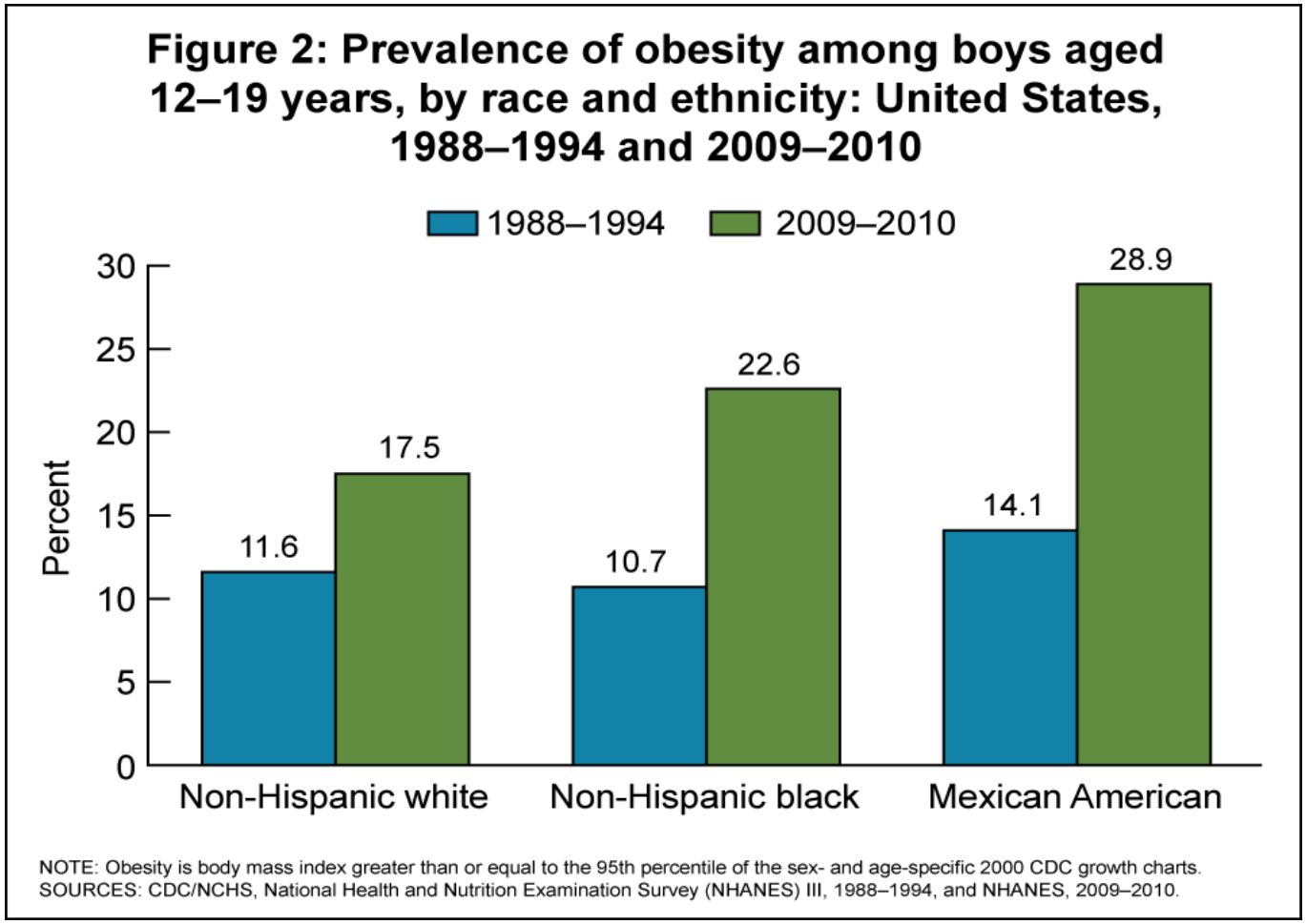
Important Across All Races For Boys…



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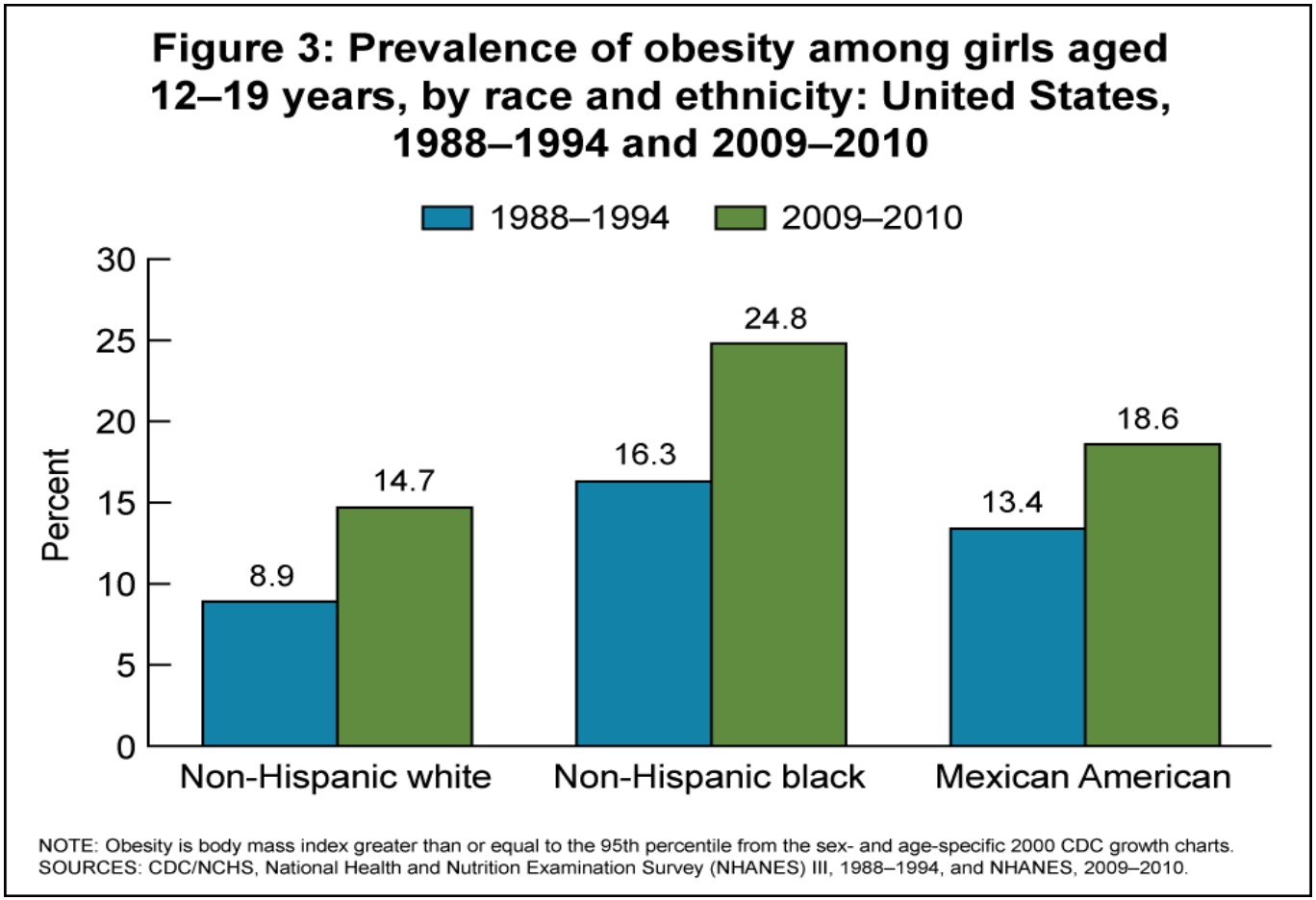
And Important Across All Races For Girls…



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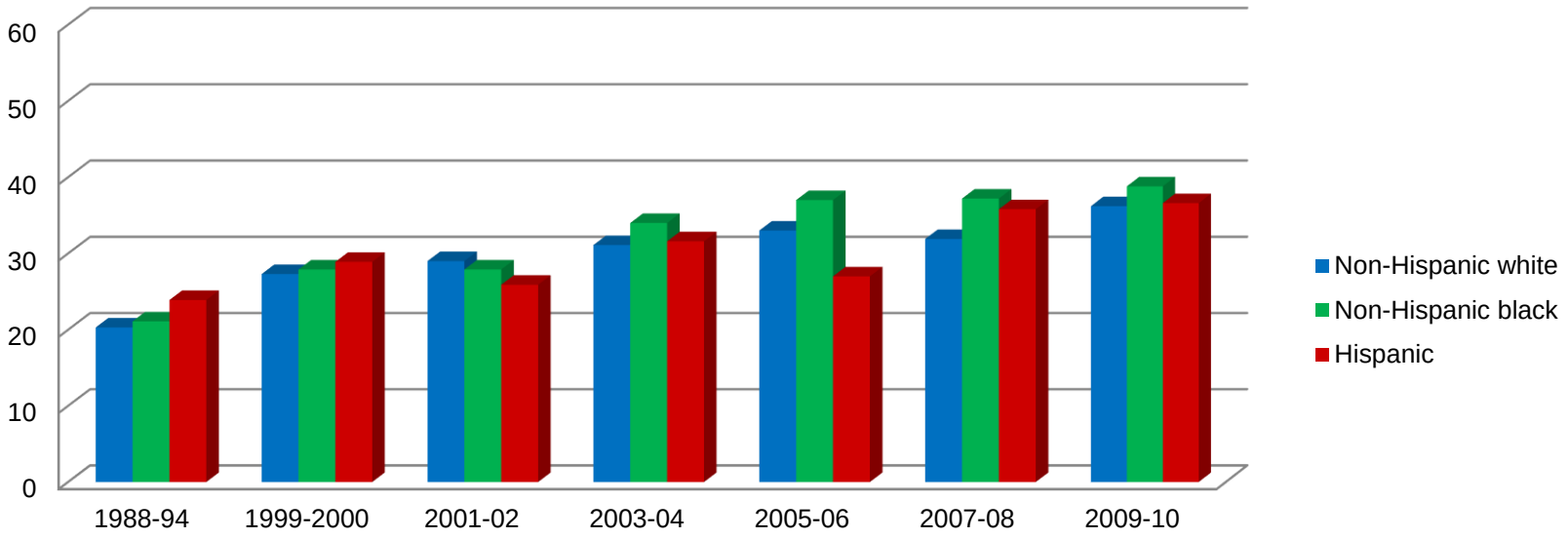
Across Races, for Men

Age-adjusted prevalence of obesity among US males aged 20+ by race and ethnicity, 1988-1994 through 2009-2010



Source: US Centers for Disease Control and Prevention, September, 2012.
Obese defined as BMI > = 30kg/m2.

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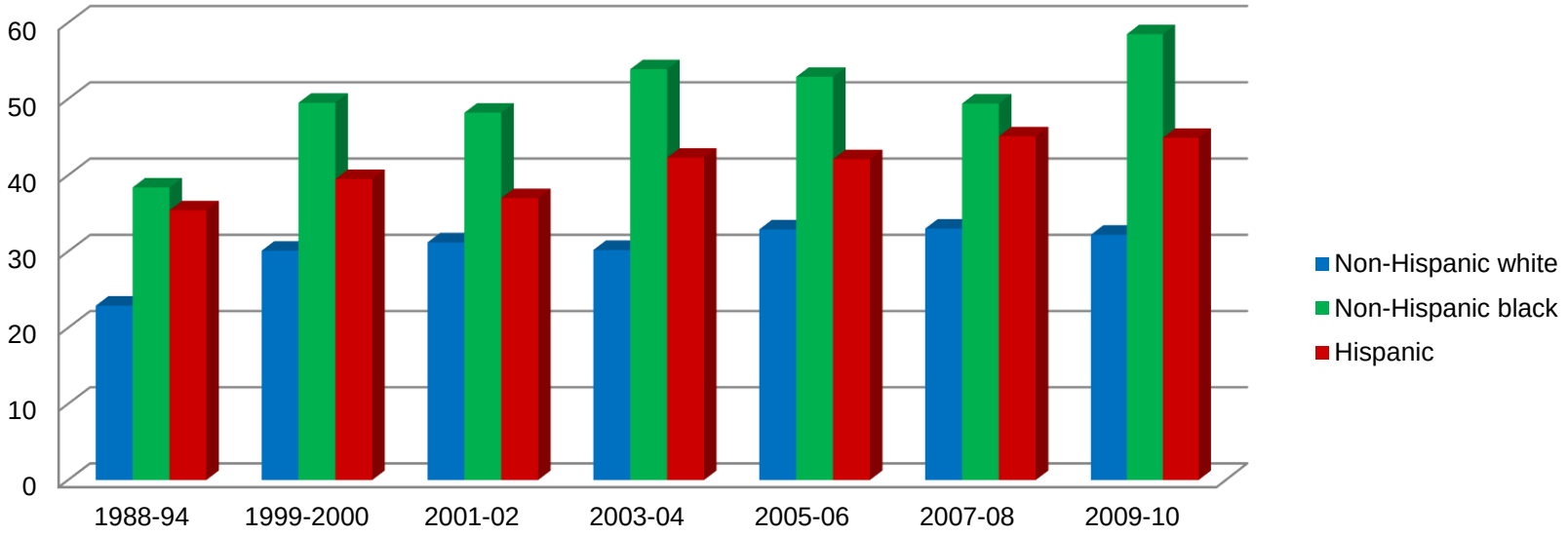
And for women

Age-adjusted prevalence of obesity among US females aged 20+ by race and ethnicity, 1988-1994 through 2009-2010



Source: US Centers for Disease Control and Prevention, September, 2012.
Obese defined as BMI > = 30kg/m2.