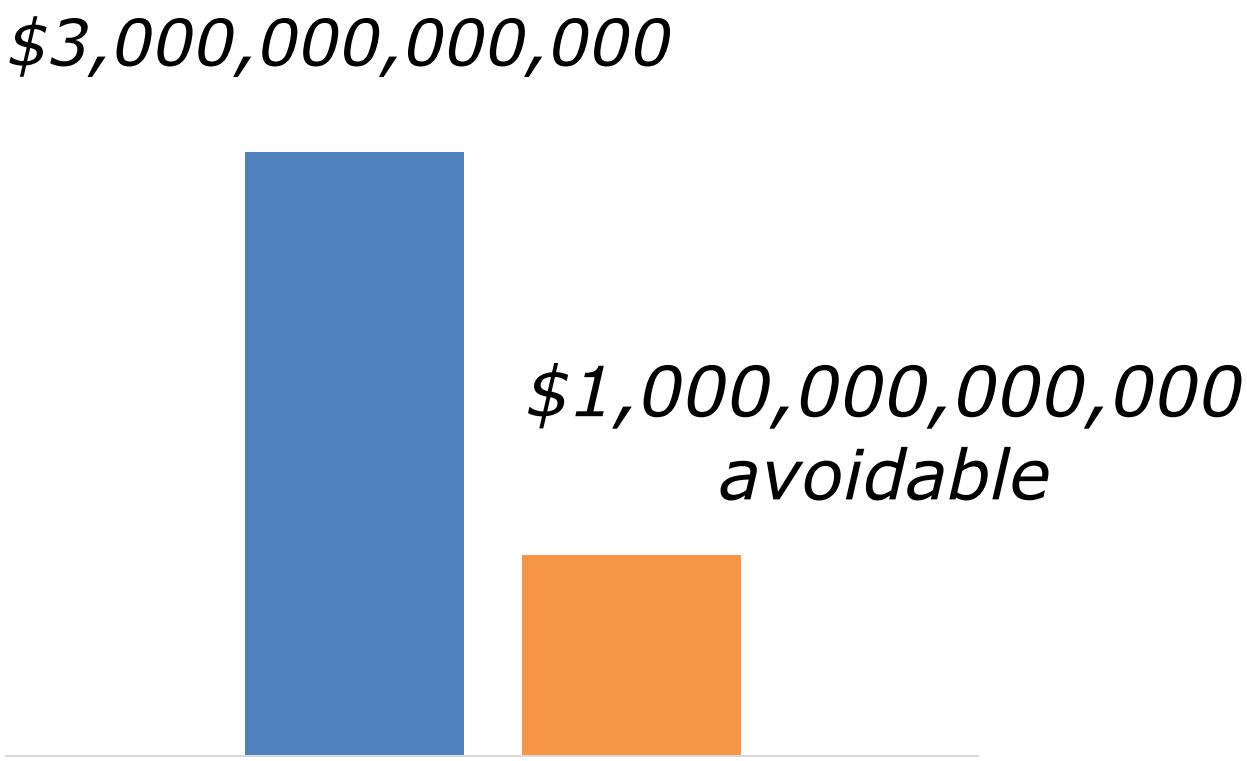
Population Health
or
Single-payer
The future is in our hands

Robert J. Margolis, MD

Outline

- Today’s problems
- Interim steps
- Population health
- Alternatives
- Conclusions



U.S. Health Care Expenditures

50 percent of payments outcome-based in 2018!

Determinants of Health

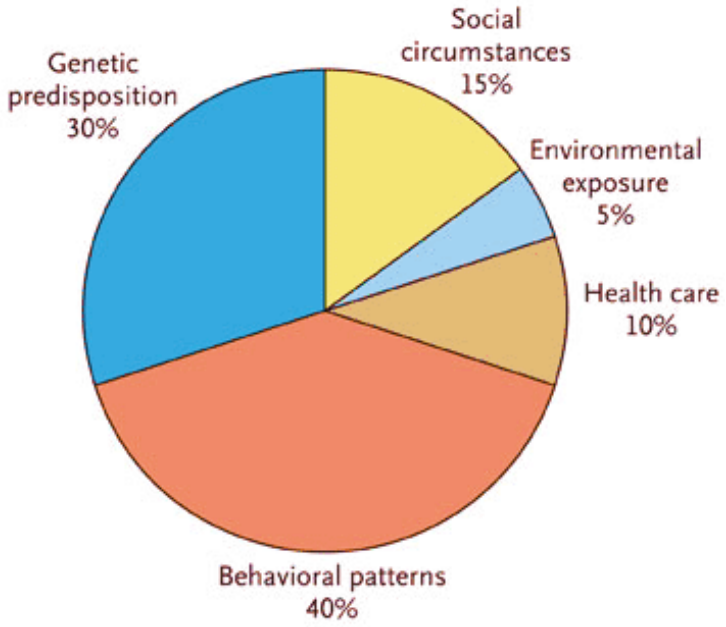


Figure 1. Determinants of Health and Their Contribution to Premature Death

McGinnis, Social Determinants of Health, 2002

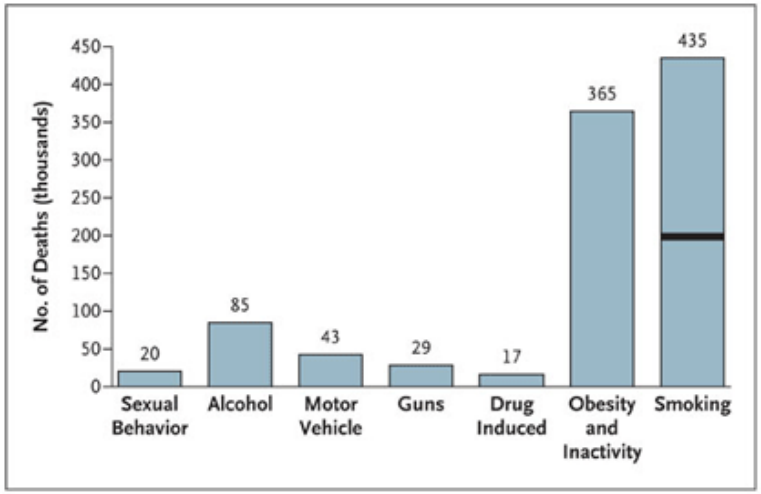
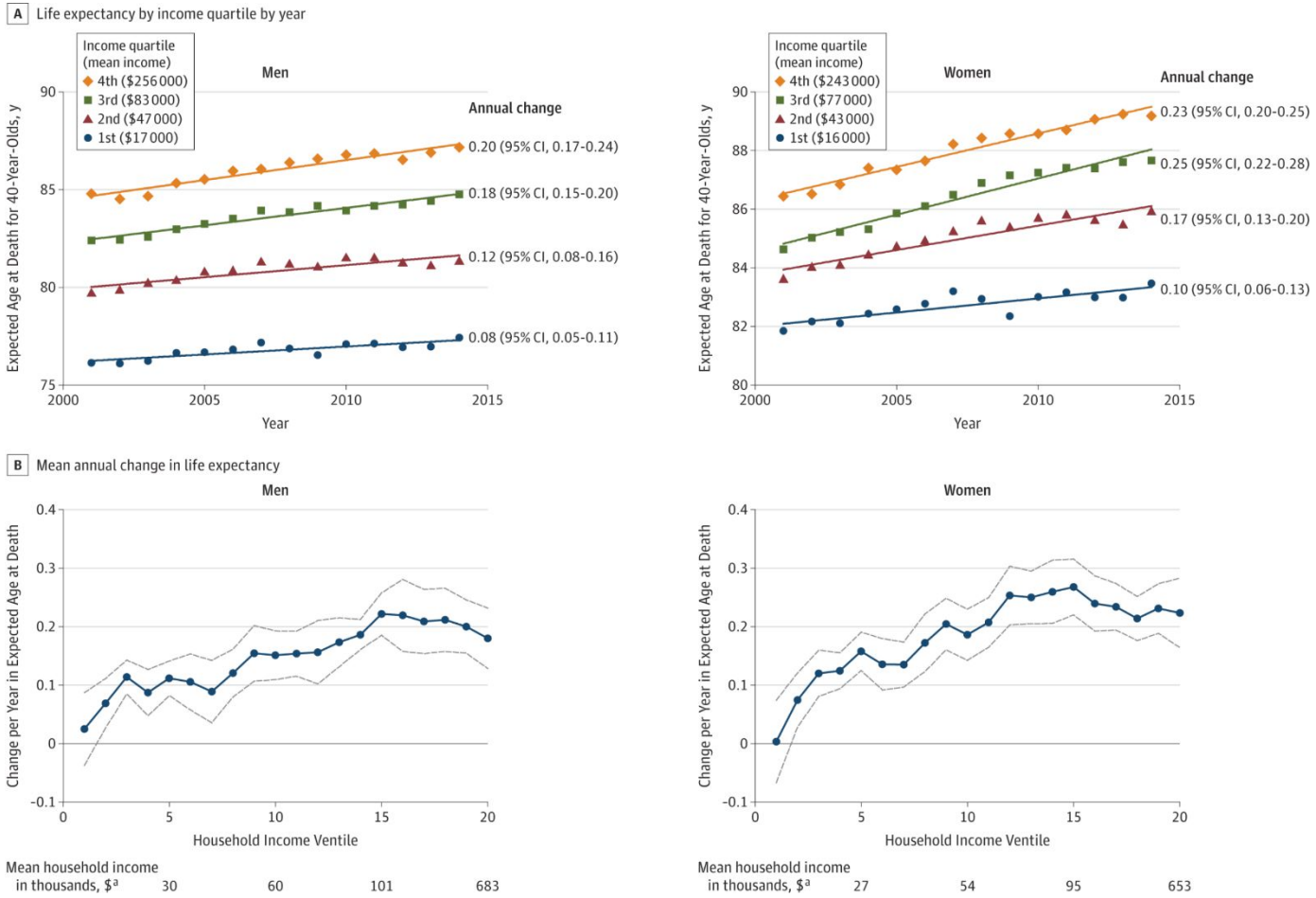


Figure 2. Numbers of U.S. Deaths from Behavioral Causes, 2000.

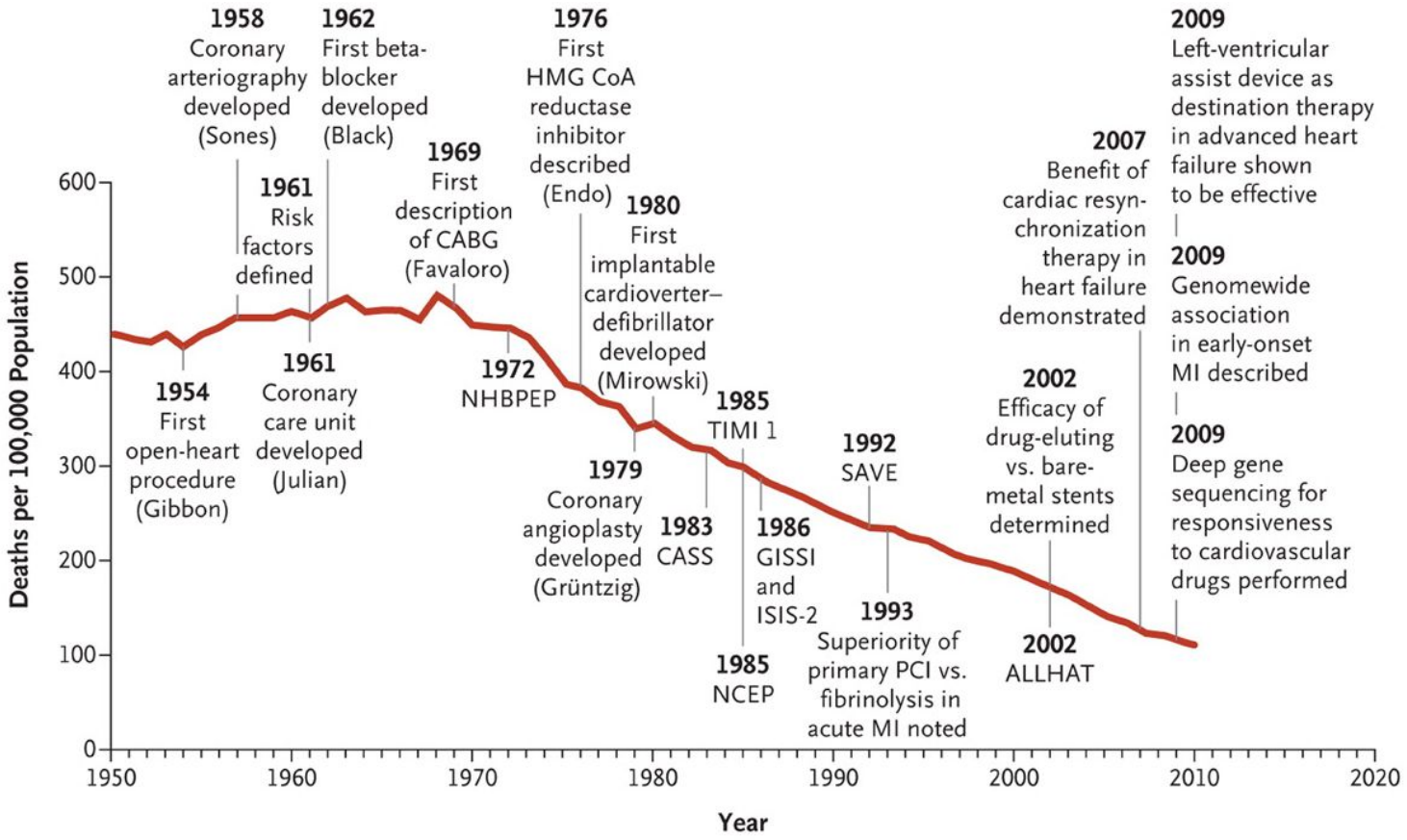
Adapted from Mokdad et al.

From: **The Association Between Income and Life Expectancy in the United States, 2001-2014**



Health care innovation and mortality

Decline in Deaths from Cardiovascular Disease in Relation to Scientific Advances



Nabel EG, Braunwald E. N Engl J Med 2012;366:54-63.

Health Care Progress + Increased Costs

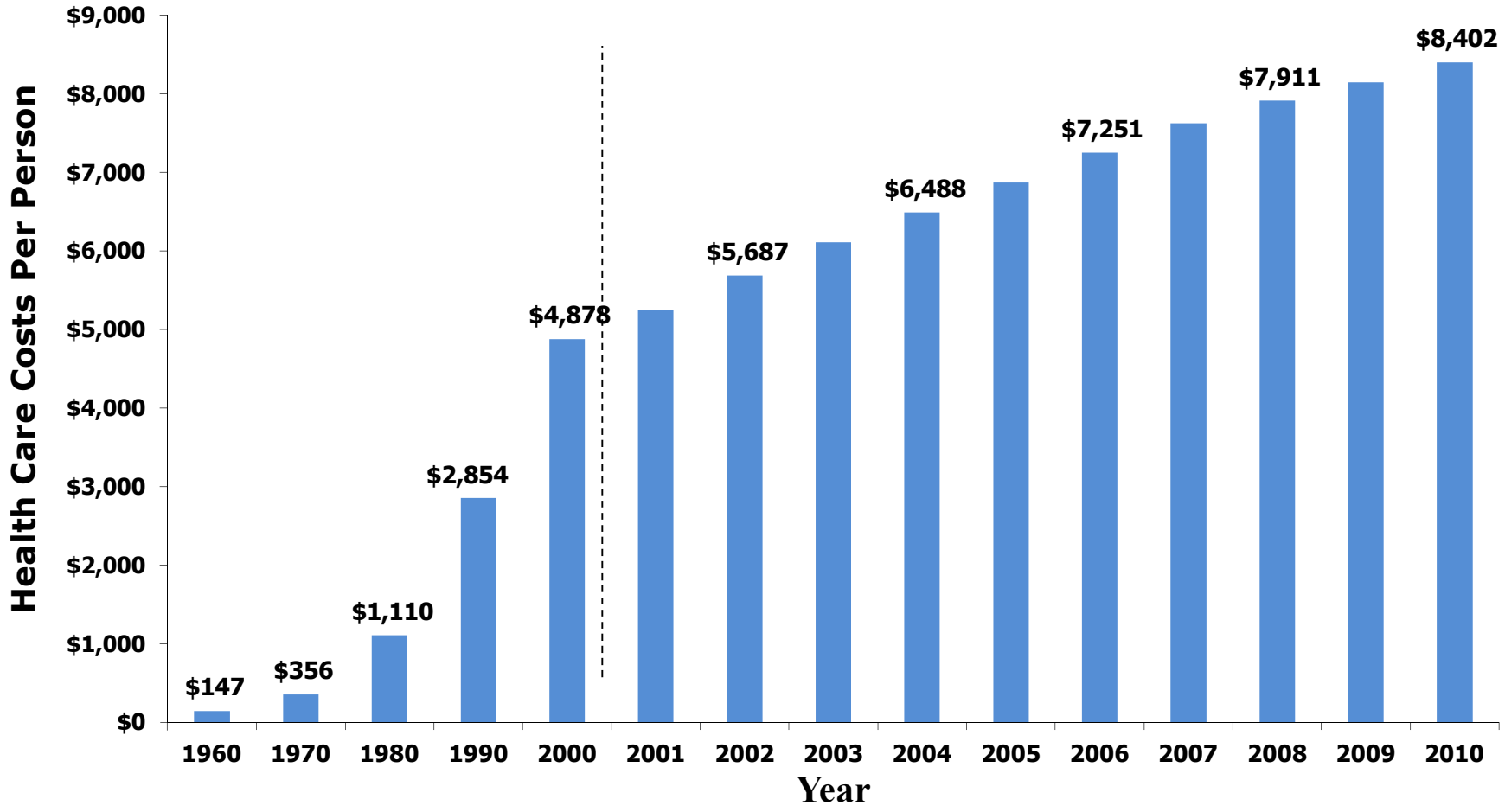
Breakthroughs in Medical Technology

- HIV: fatal → chronic disease
- Cancer: 20% reduction in death rates over 25 years
- Heart disease: 60% reduction in last 50 years
- Significant progress in most diseases and more to come

Result: Generally Rising Costs

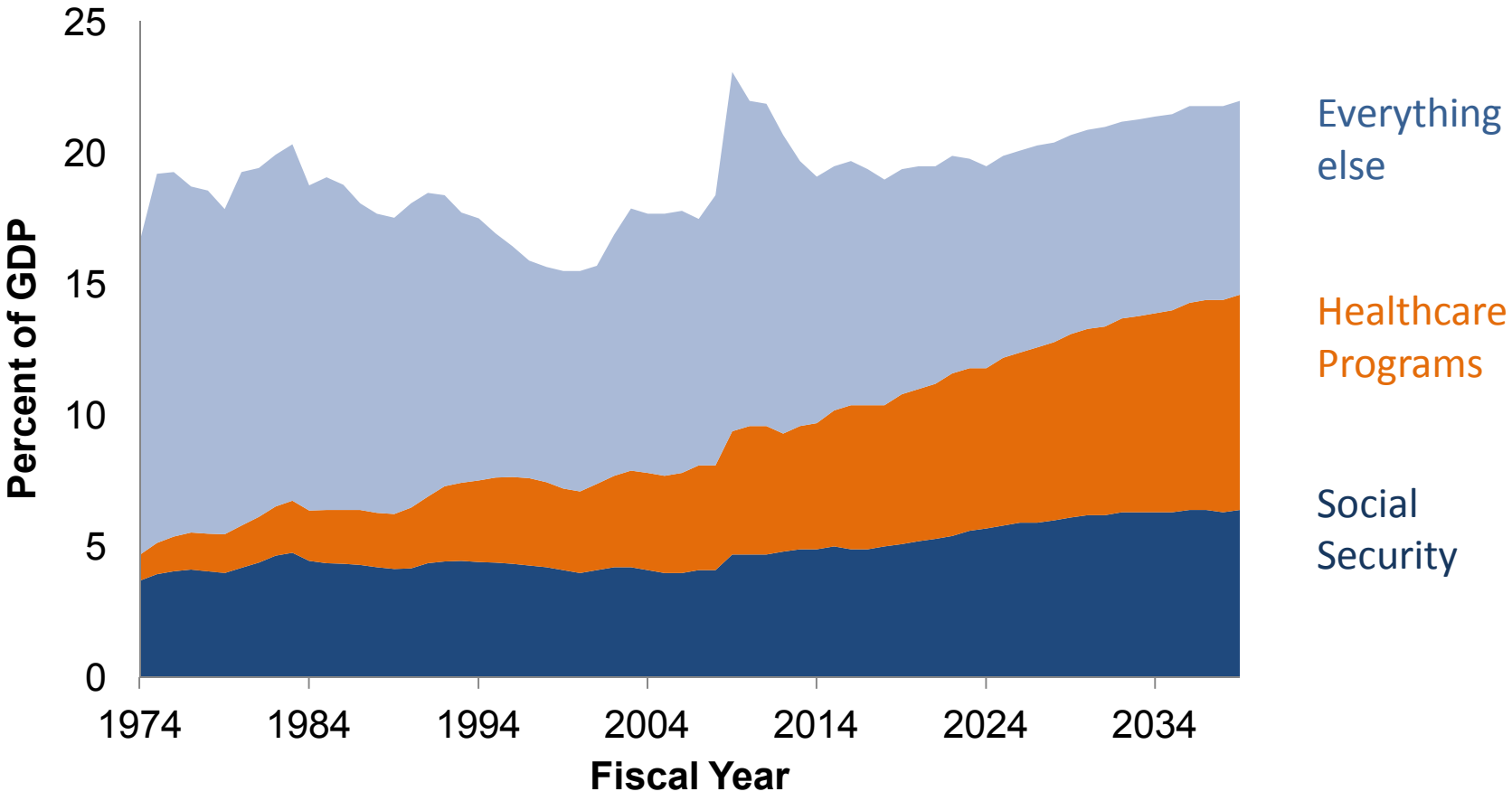
- Demographic trends, availability of more and better treatments
- *Living longer and better is worth a lot*

Rising per Capita Healthcare Costs



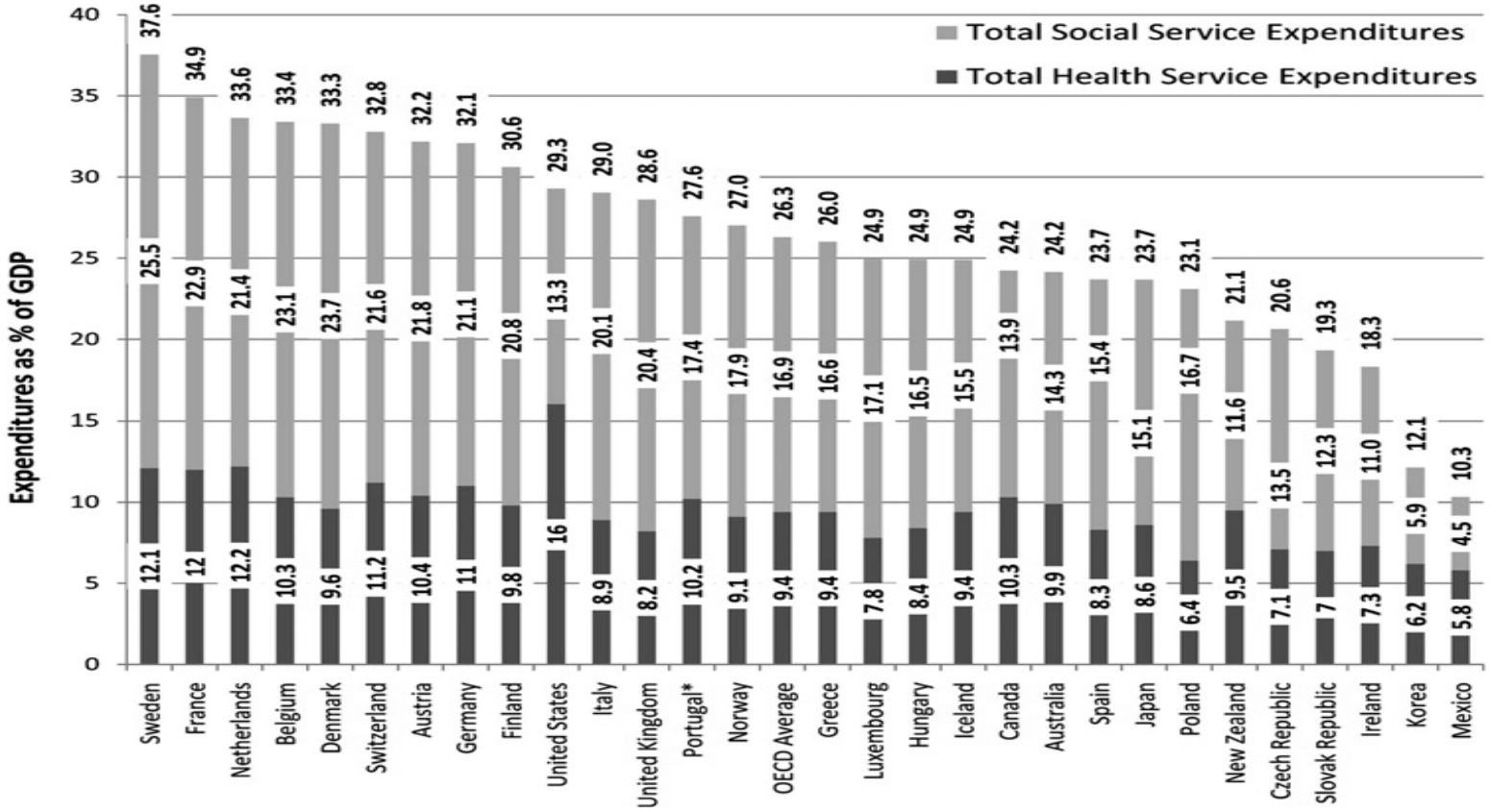
Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary including share of GDP, CY 1960-2010; file nhegdp10.zip).

Health Care and the Federal Budget

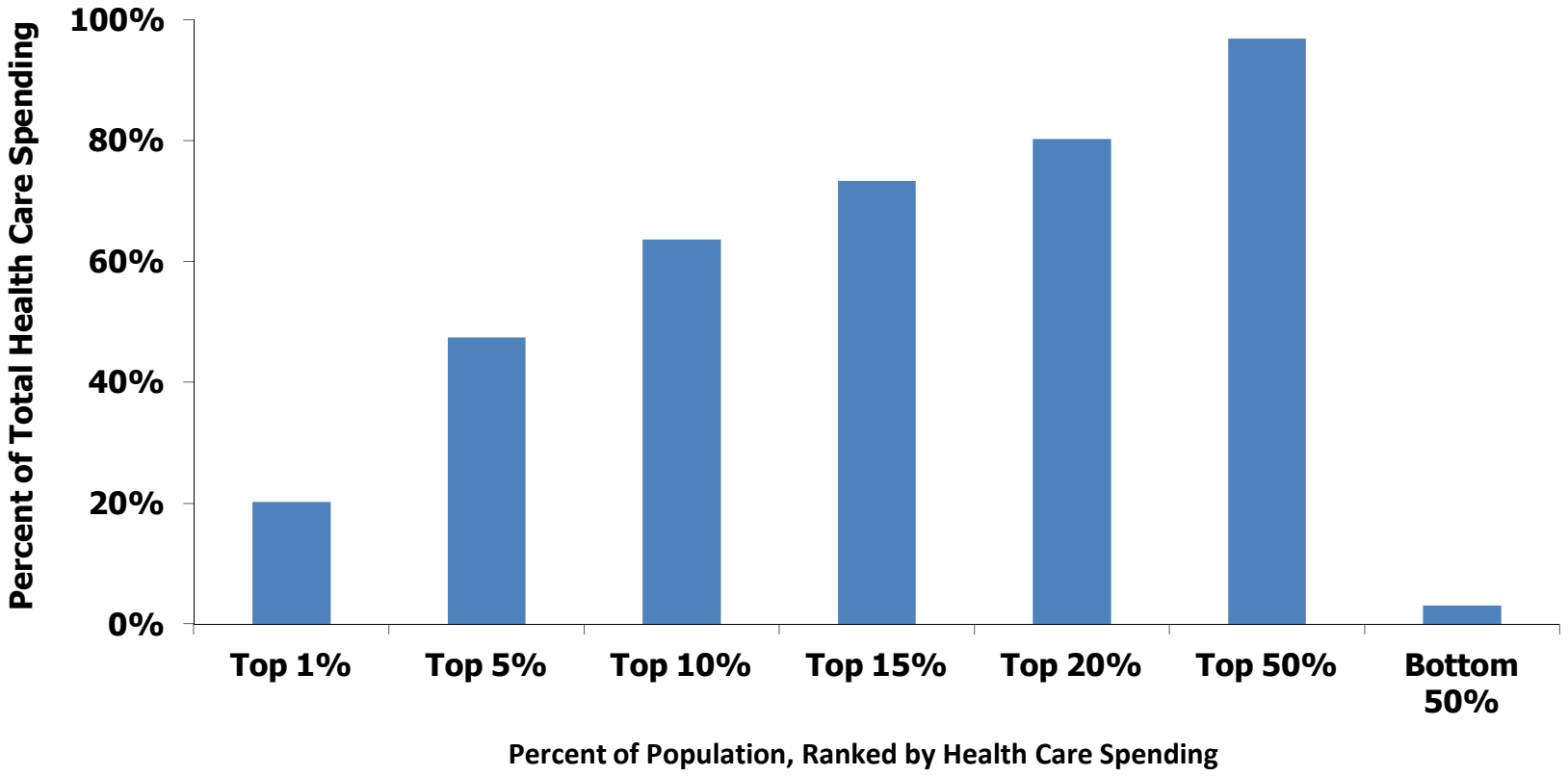


Source: Congressional Budget Office, 2016 Long-Term Budget Outlook.

Total health-service and social-service expenditures for OECD Countries



A small number of patients use most of the resources



Note: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.
Source: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2008.

THE HENRY J. KAISER FAMILY FOUNDATION

Alternative Payment Models

Framework for Alternative Payment Models

Category 1

Fee for Service – No Link to Quality & Value

Category 2

Fee for Service – Link to Quality & Value

A: Foundational Payments for Infrastructure & Operations

B: Pay for Reporting

C: Rewards for Performance

D: Rewards and Penalties for Performance

Category 3

APMs Built on Fee-for-Service Architecture

A: APMs with Upside Gainsharing

B: APMs with Upside Gainsharing/Downside Risk

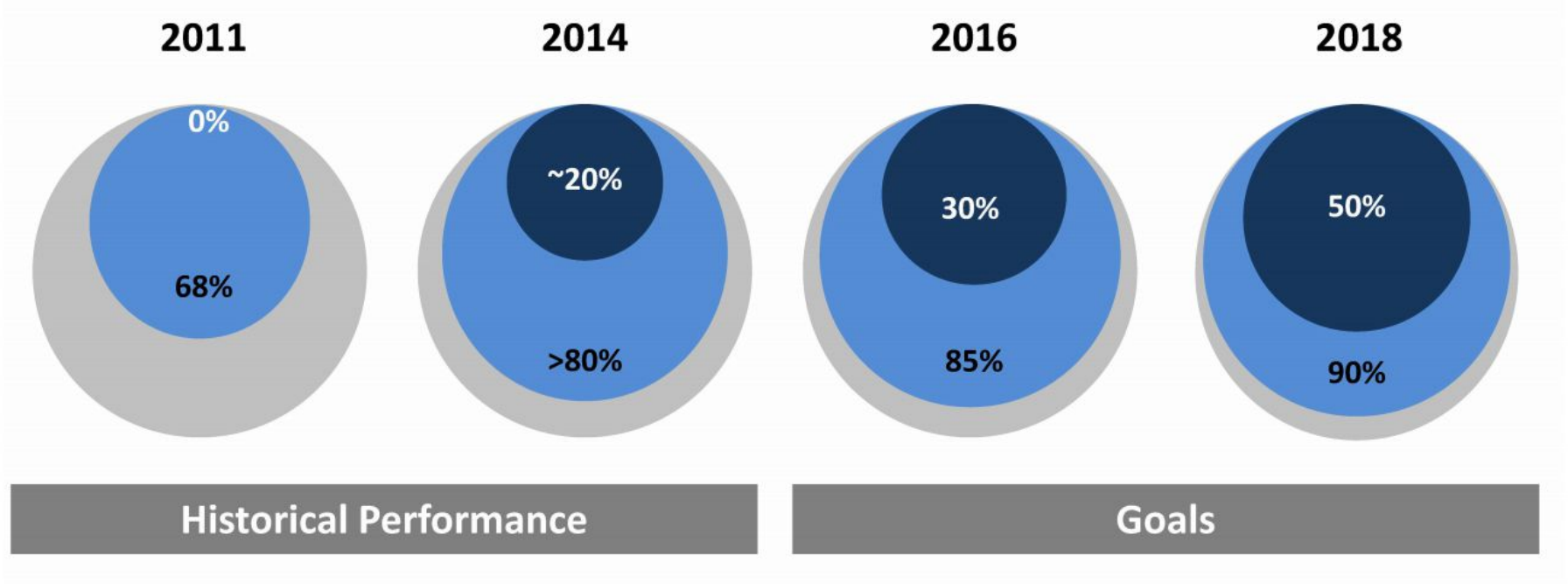
Category 4

Population-Based Payment

A: Condition-Specific Population-Based Payment

B: Comprehensive Population-Based Payment

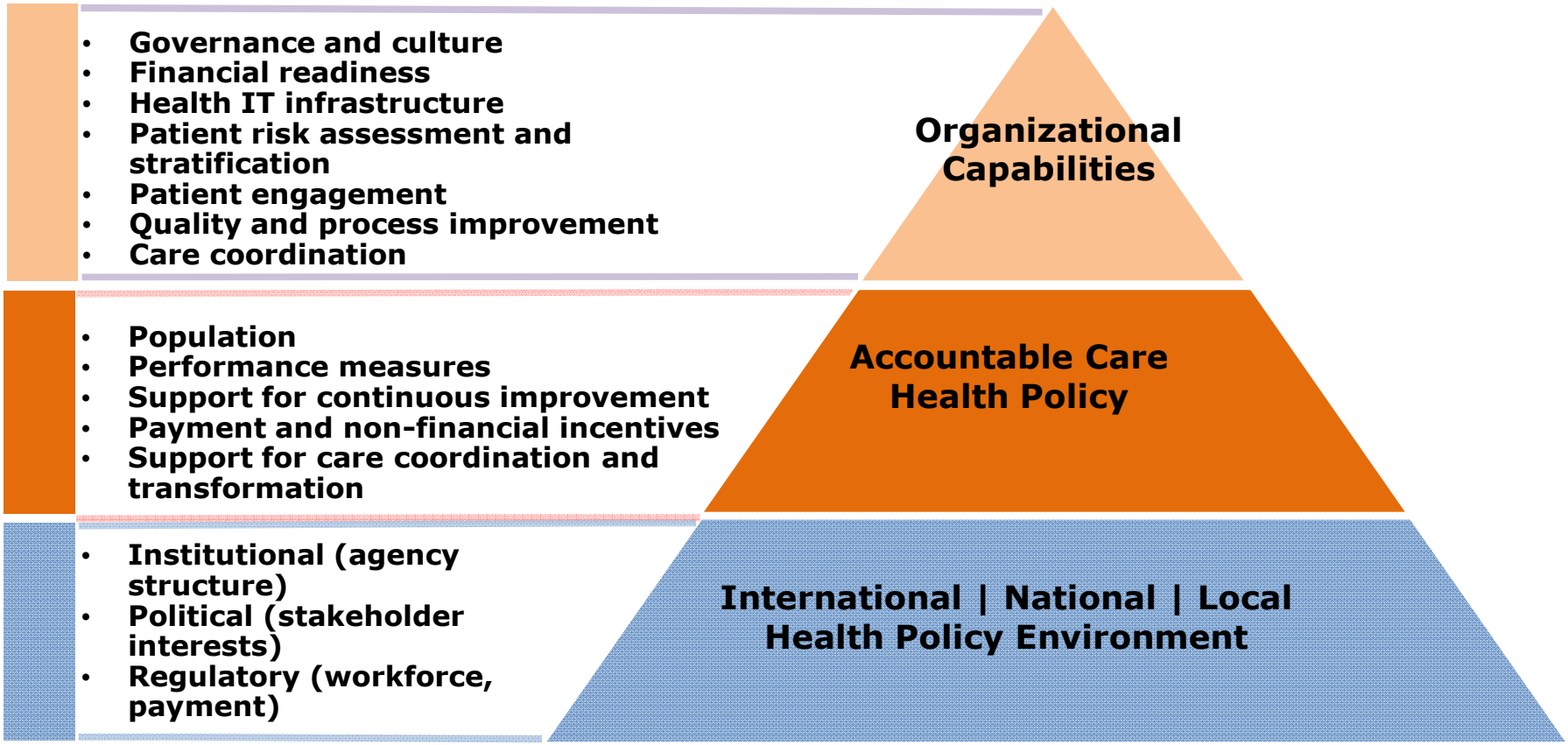
HHS Goals for Alternative Payment Models in Medicare



Organizations Unclear How to Succeed

- Need new care delivery competencies to successfully manage payment reforms:
  - IT infrastructure
  - Internal financing flows
  - Governance and culture
  - Patient risk assessment and identification
  - Care coordination processes

Competencies for Accountable Care



Clinician Leadership

Few full risk-capable providers

Everyone else in one of FFS or Pilots

Does it feel like we're drowning?

Primary Care Physicians & Aligned Specialists

- Patient Navigators
- Control 85% of spend
- PCPs 4% of cost
- 50% of PCPs in small groups with little/no capital reserves

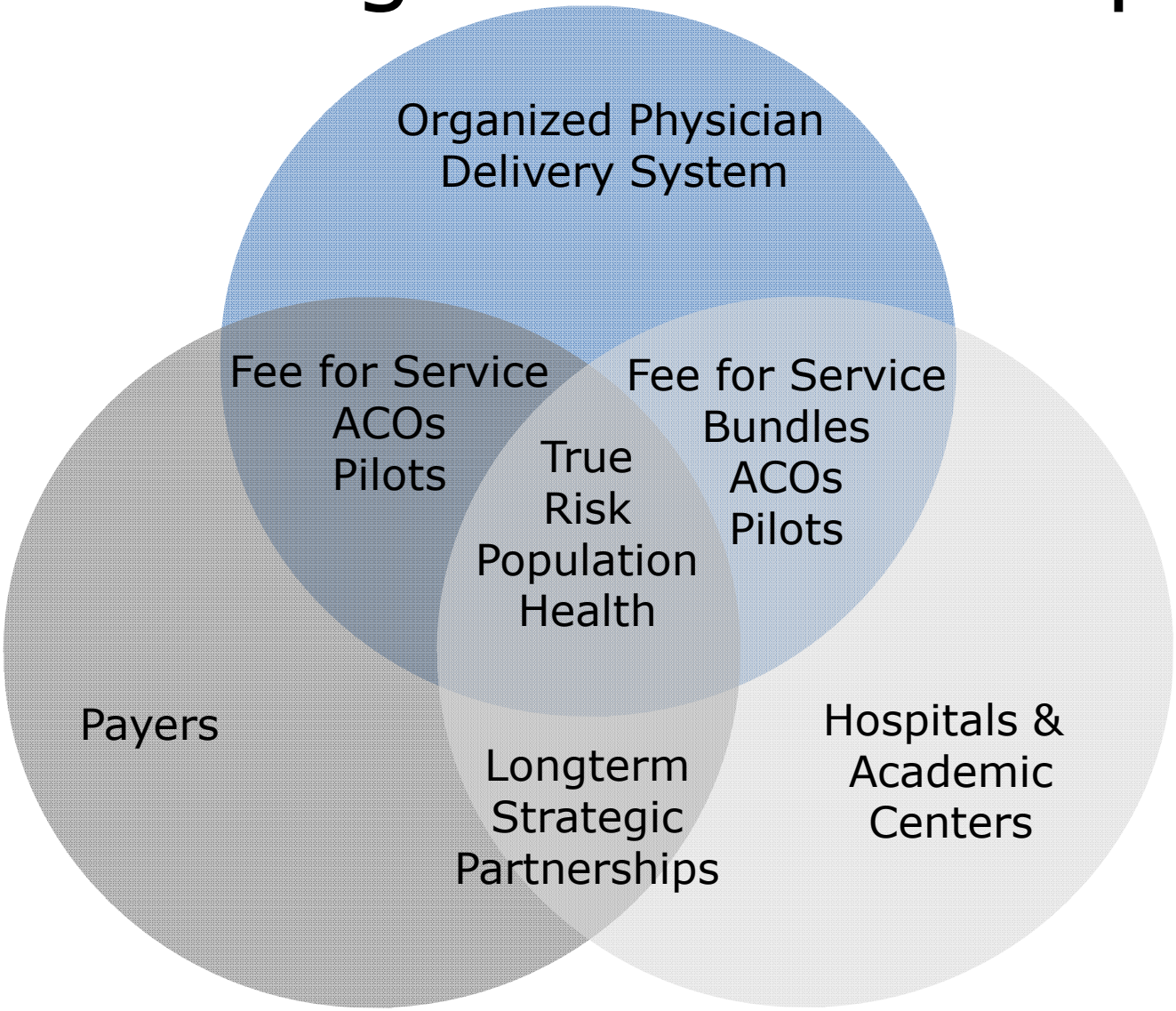
Delivery Systems Reform

- Align primary care docs with selected specialists
- Create scale and access to capital
- Practice transformation
  - Care teams
  - Patient Level Data
- National and local best practices
- CPI and learning networks

Transform Data to Actionable Information

- Cloud-based patient-relevant clinical information
- Patient-specific care planning and guided care management
- Deep population analytics and segmentation
- Predictive modeling (The Golden Goose)

Form Aligned Partnerships



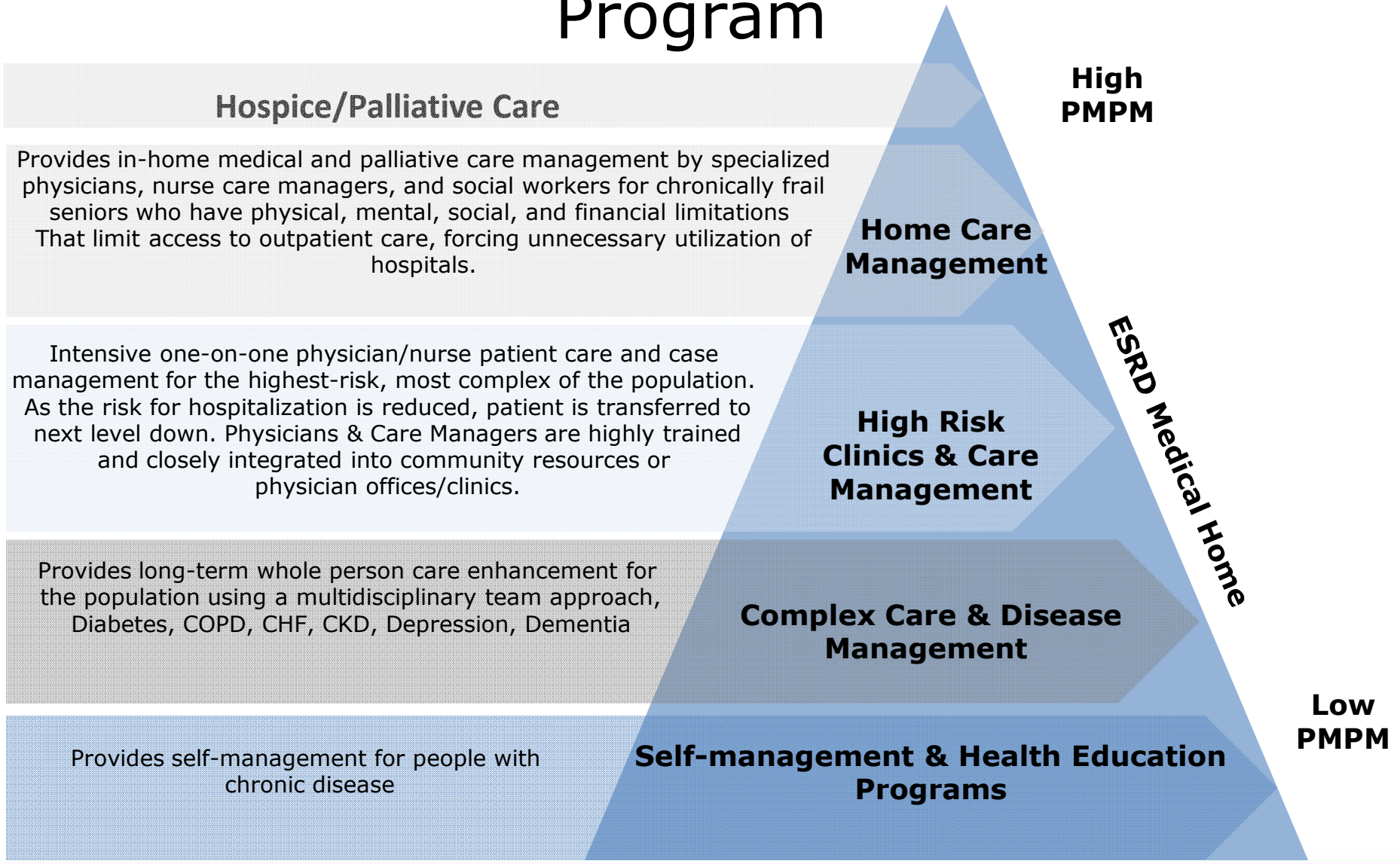
One Story

Health Care Partners Programs & Results

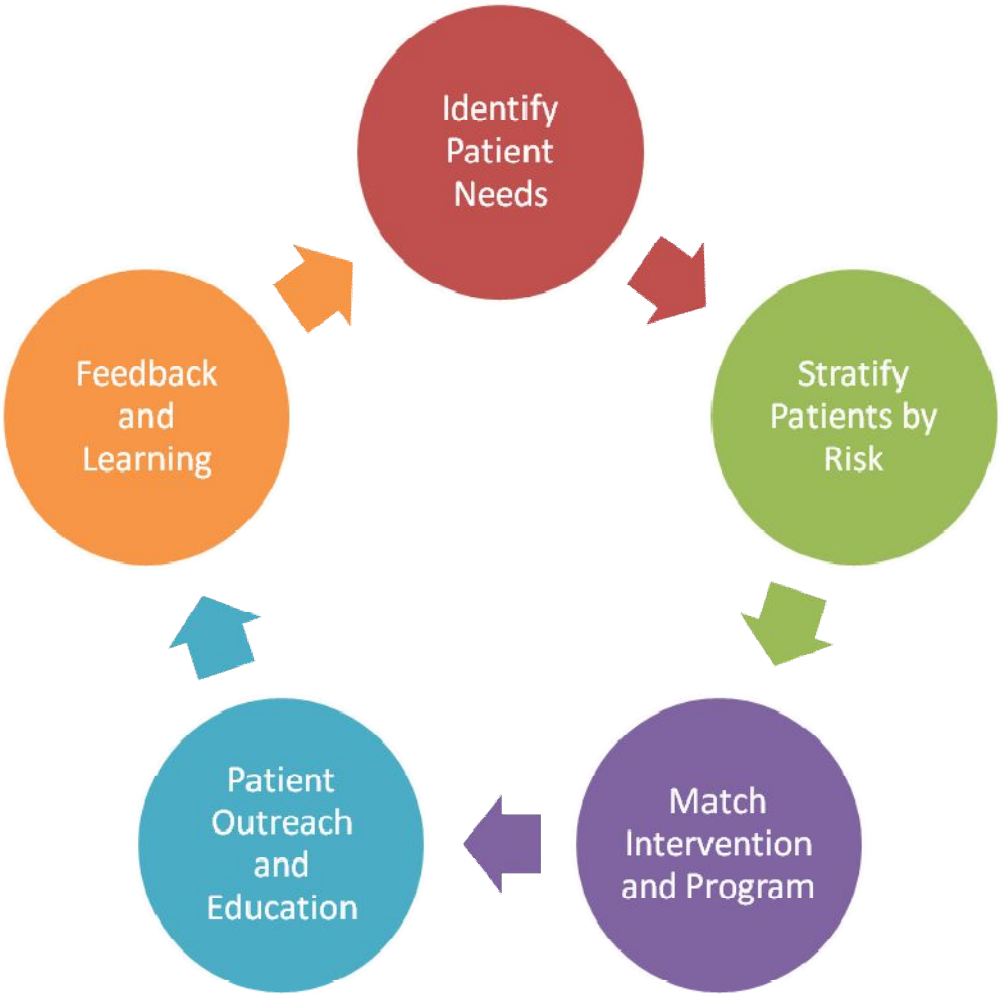
Under Population Health Management

- Improved quality, significant financial savings
- Scalable, approximately 11,000 total physicians in 5 states
- Millions of total patients, approximately 1 million lives under Population Health Management

Stratifying Patients into the Appropriate Program



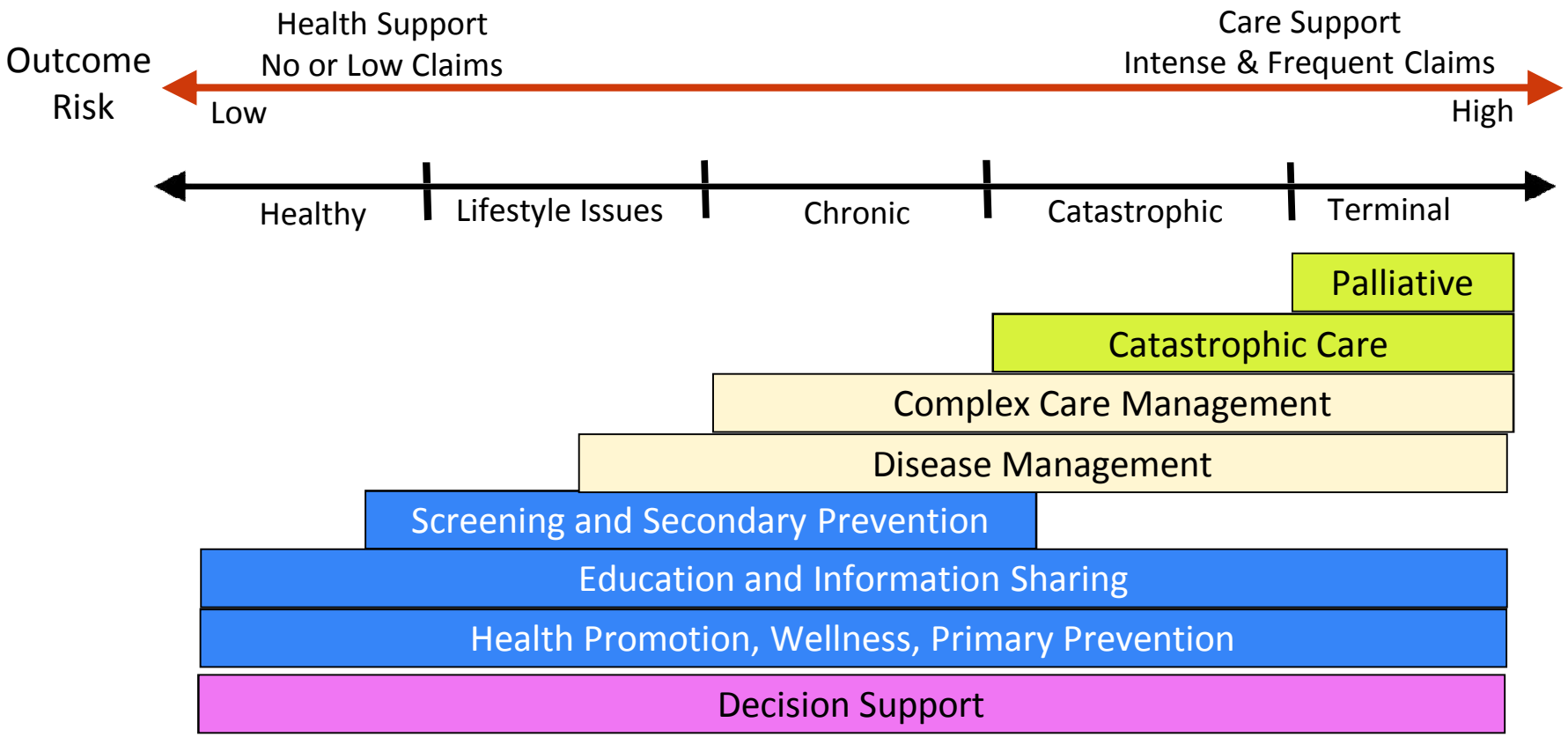
Proactive Population Management



The continuous 'Virtuous Cycle' of Improved care and outcomes is at the heart of HCP's proactive population management

- Better Care
- Better Quality
- Better Efficiency
- Better Patient Experience

Program Overlap



Clinical Support Teams

In-patient

Physician and Patient Support Teams

Ambulatory

Physicians

Patients

Home Care

Urgent Care

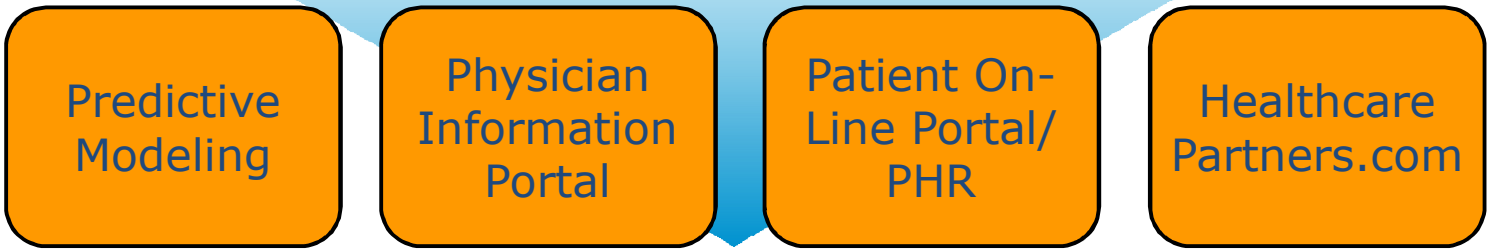
Over 900 Care Management Resources

Examples of Team Involvement

- Focused patient education & expectations via nurses
  - Embed in primary care sites
  - Accountable for entire population
  - Enhanced care transition for discharged patients
  - Structured interventions for seniors and high risk commercial
  - Actively monitor patients for 60 days
- Use of Health Advocates: dedicated, non-licensed liaison for coordinating care for newly enrolled members
  - Perform Health Risk Assessment and assist with outbound calls to improve medication adherence and other care coordination activities

Technology Backbone

- Allscripts / Touchworks EHR
- NextGen for affiliated or IPA model
- EPIC practice management and EHR
- IDX practice management
- All systems feed to an integrated Data Warehouse



Medical & Clinical Management

- Focus on disease states that most impact cost & quality
  - CHF
  - COPD
  - CKD
  - Depression
  - Diabetes
  - Dementia
  - CAD
  - Asthma
- Data analysis identifies high impact clinical interventions
  - Same-day access
  - Urgent Care
  - Admission risk management
  - Special programs
    - Home care
    - Anti-coagulation clinic
    - CHF program

Example: Point-of-Care Reminders

HEALTHCARE PARTNERS **PATIENT INTERVENTION REPORT**

REPORT DATE: 4/16/2010

Region(s): [redacted] **Site(s):** [redacted] **PCP(s):** [redacted]

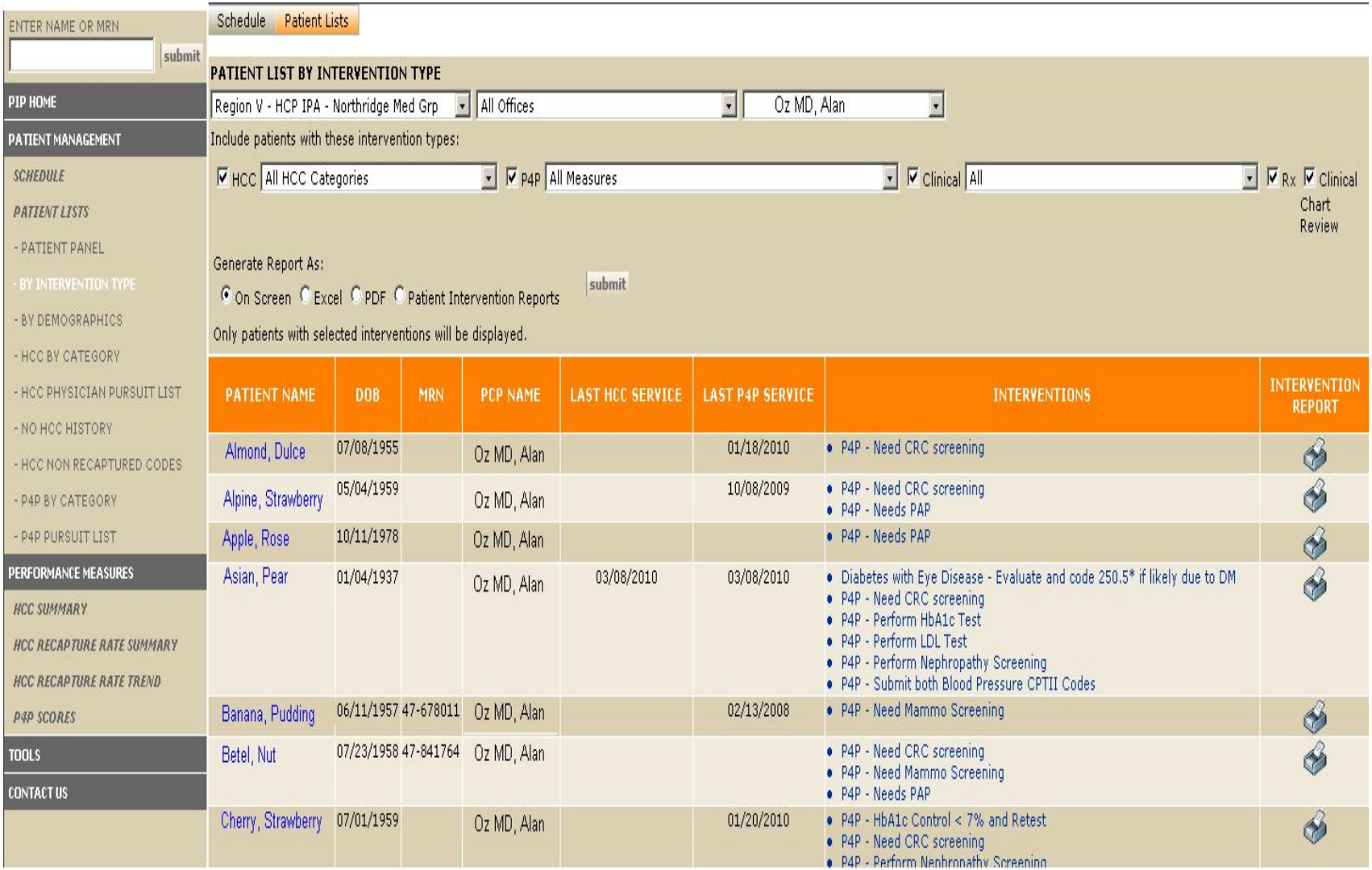
Name	[redacted]	Telephone	[redacted]	Address	[redacted]
MRN	[redacted]	Enrolled	Y	City/Zip	[redacted]
DOB	02/21/1949	Gender	F	Next PCP Appt	

PIR Summary 2010:

Intervention Type	Description	Suggested Actions
P4P	Comprehensive Diabetes Care	Perform HbA1c Test Perform LDL Test Perform Nephropathy Screening Submit both Blood Pressure CPTII Codes
	Colorectal Cancer Screening	Need CRC screening
	Women Wellness Screening	Need Mammo Screening
HCC	15 Diabetes With Renal Or Peripheral Circulatory Manifestation 250.40 Diabetes W/renal Manif, Type II Or Unspec, Controlled	Needs Coding
	16 Diabetes With Neurologic Or Other Specified Manifestation 250.60 Diabetes W/neuro Manif, Type II Or Unspec, Controlled	Needs Coding

Example: Customized Registries

Lists of Patients Needing Interventions



ENTER NAME OR MRN

submit

PIP HOME

PATIENT MANAGEMENT

- SCHEDULE
- PATIENT LISTS
- PATIENT PANEL
- BY INTERVENTION TYPE
- BY DEMOGRAPHICS
- HCC BY CATEGORY
- HCC PHYSICIAN PURSUIT LIST
- NO HCC HISTORY
- HCC NON RECAPTURED CODES
- P4P BY CATEGORY
- P4P PURSUIT LIST

PERFORMANCE MEASURES

- HCC SUMMARY
- HCC RECAPTURE RATE SUMMARY
- HCC RECAPTURE RATE TREND
- P4P SCORES

TOOLS

CONTACT US

Schedule | Patient Lists

PATIENT LIST BY INTERVENTION TYPE

Region V - HCP IPA - Northridge Med Grp | All Offices | Oz MD, Alan

Include patients with these intervention types:

☑ HCC: All HCC Categories ☑ P4P: All Measures ☑ Clinical: All ☑ Rx ☑ Clinical Chart Review

Generate Report As:

(•) On Screen ( ) Excel ( ) PDF ( ) Patient Intervention Reports

submit

Only patients with selected interventions will be displayed.

PATIENT NAME	DOB	MRN	PCP NAME	LAST HCC SERVICE	LAST P4P SERVICE	INTERVENTIONS	INTERVENTION REPORT
Almond, Dulce	07/08/1955		Oz MD, Alan		01/18/2010	• P4P - Need CRC screening	
Alpine, Strawberry	05/04/1959		Oz MD, Alan		10/08/2009	• P4P - Need CRC screening • P4P - Needs PAP	
Apple, Rose	10/11/1978		Oz MD, Alan			• P4P - Needs PAP	
Asian, Pear	01/04/1937		Oz MD, Alan	03/08/2010	03/08/2010	• Diabetes with Eye Disease - Evaluate and code 250.5* if likely due to DM • P4P - Need CRC screening • P4P - Perform HbA1c Test • P4P - Perform LDL Test • P4P - Perform Nephropathy Screening • P4P - Submit both Blood Pressure CPTII Codes	
Banana, Pudding	06/11/1957	47-678011	Oz MD, Alan		02/13/2008	• P4P - Need Mammo Screening	
Betel, Nut	07/23/1958	47-841764	Oz MD, Alan			• P4P - Need CRC screening • P4P - Need Mammo Screening • P4P - Needs PAP	
Cherry, Strawberry	07/01/1959		Oz MD, Alan		01/20/2010	• P4P - HbA1c Control < 7% and Retest • P4P - Need CRC screening • P4P - Perform Nephropathy Screening	

High Risk Programs – CCC California

Comprehensive Care Clinic

- Advance care planning
- Medication reconciliation
- Disease and Care Plan education
- Behavioral health assessment
- Access to additional community resources
- Post – Hospitalization Clinics
- Comprehensive Care Centers
  - Geriatrics Centers of Excellence
  - Commercial Patients - Biopsychosocial Medicine

	APT	DPT	ER/1000	UC/1000
Pre-Program	1334	4624	611	2022
In-Program	1157	4617	53	200

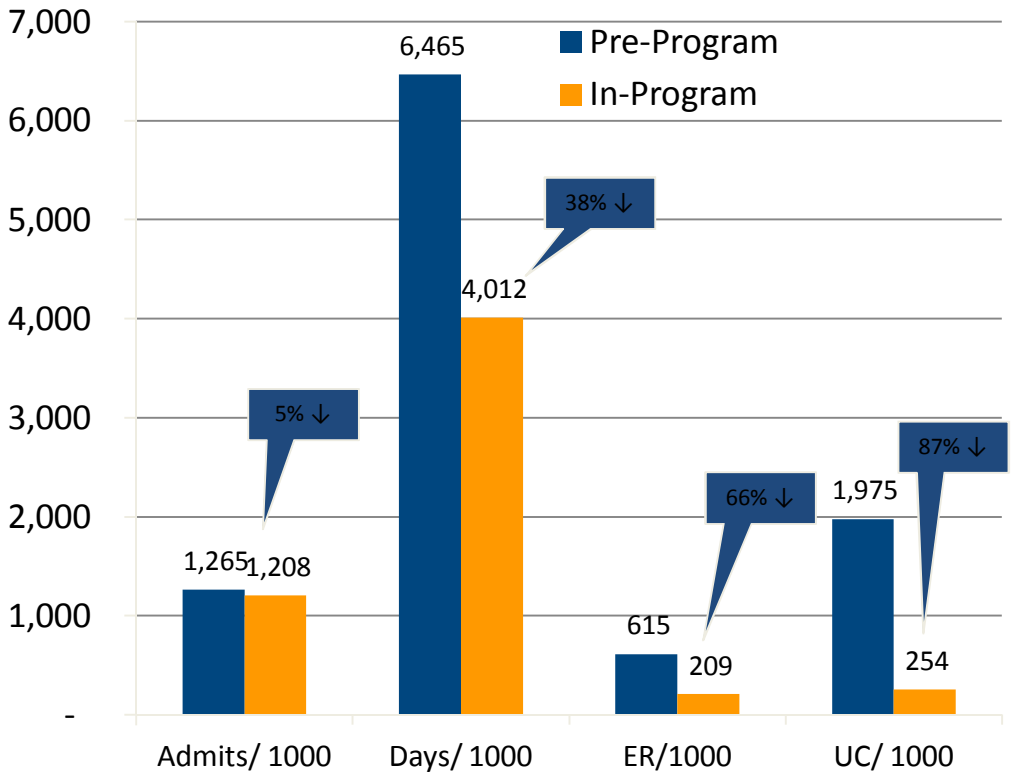
High Risk Programs – Home Care

Home Care Program

- Top 2-3% most at-risk patients
- Comprehensive assessment:
  - and behavioral health Living conditions
  - Social and financial needs
  - Medication regimen
  - Medical
- Advanced Care Planning
- Palliative care

	APT	DPT	ER/1000	UC/1000
Pre-Program	1339	5460	959	534
In-Program	1144	4261	141	130

Example: ESRD Program



ESRD Program

- Targeted CKD Stage IV & V
- Complex care management
- Enhanced primary care
- Pre-care emotional & physical preparation for patients & caregivers
- Early access placement
- Reduce emergency vascular interventions
- Increase treatment adherence

Integrated Processes

- Physician leadership uses data engine to develop programs and solutions
- Interventions executed by integrated clinical teams
- Continuous monitoring, feedback and adaptation

Example of HCP COPD Program

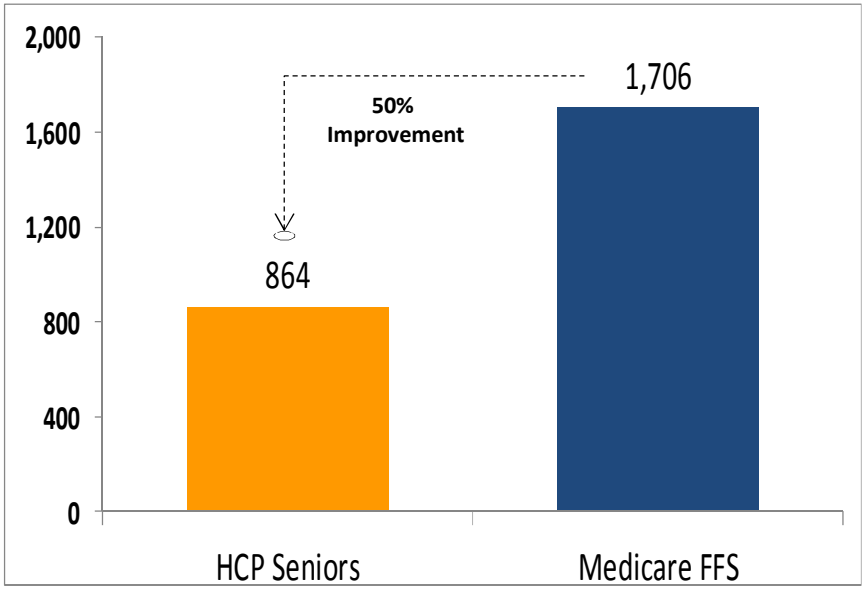
- 30% more frequent visits with COPD patients
- Involvement of integrated, multidisciplinary care team
- Immediate intervention at clinical trigger points

Higher satisfaction and improved quality for the patient as well as significant cost savings

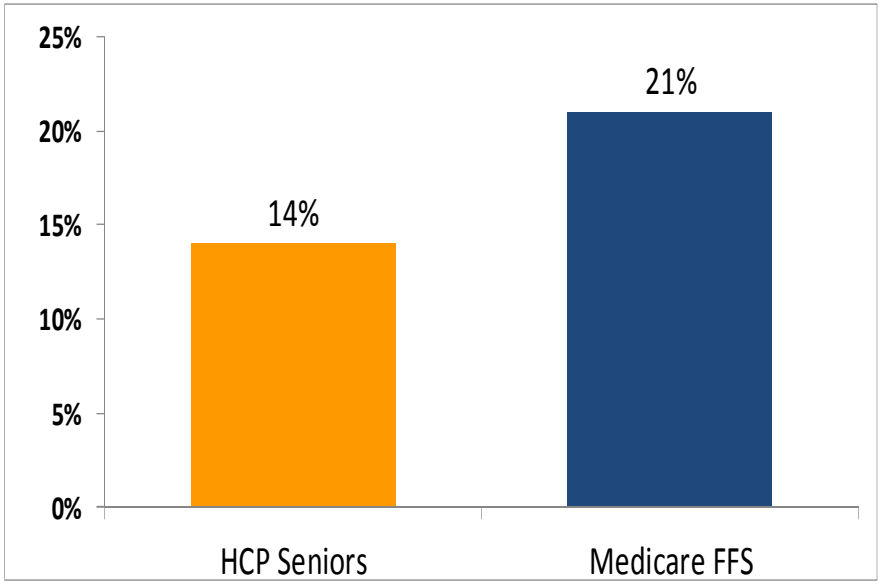
	% Change
Drug cost est.	3% ↑
Total admits	30% ↓
Total bed days	39% ↓
Total ED visits	23% ↓
Cost of care (all paid-pmpm)	34% ↓

Cost Savings Impact

Inpatient Acute Bed Days/1,000 pts



30-Day All Cause Re-admit Rate



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Financial Impact
(who pays for team-based care?)

1000 MA Patients

Reduce hospital days from 1800k-800k

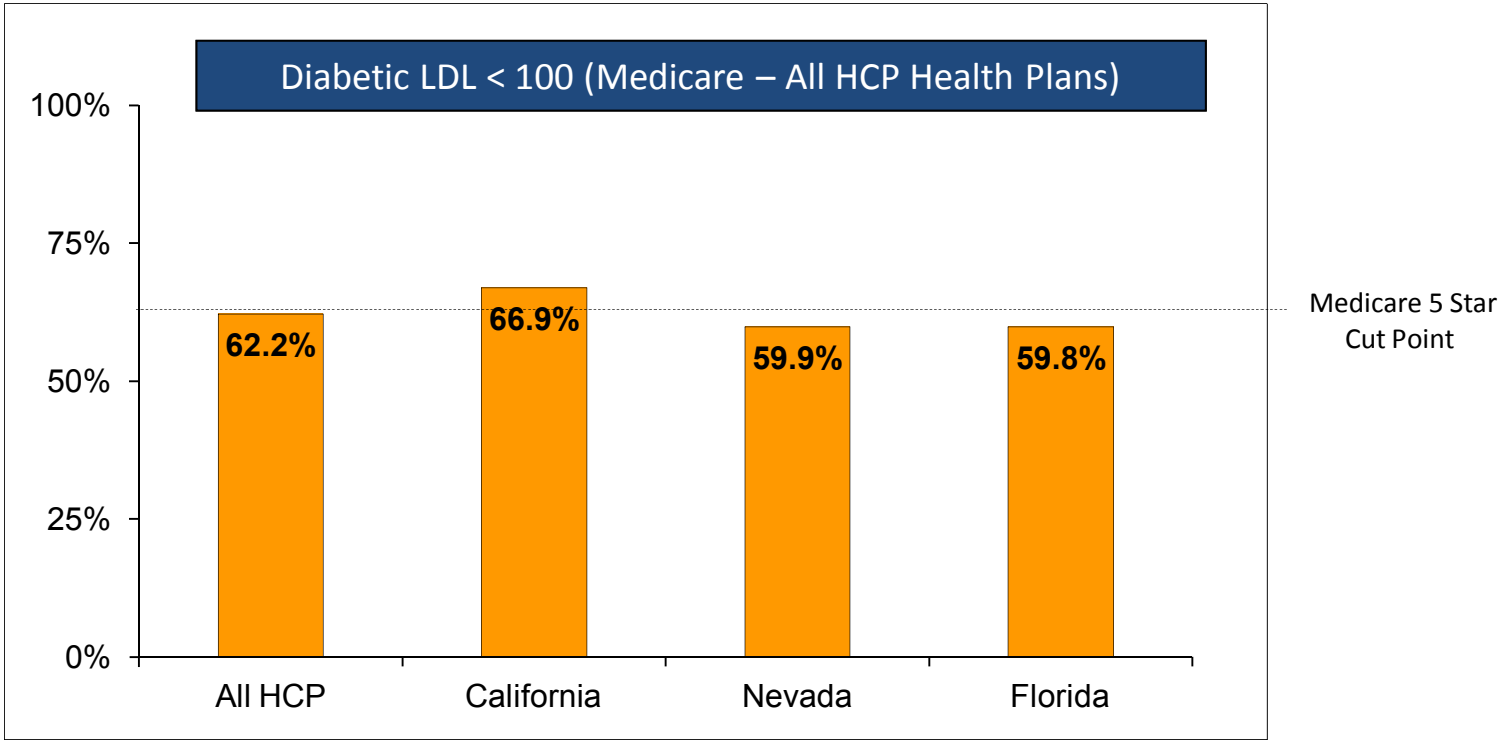
Hospital Average Per Diem $3000

1000/1000 = 1x 1000 days x $3000

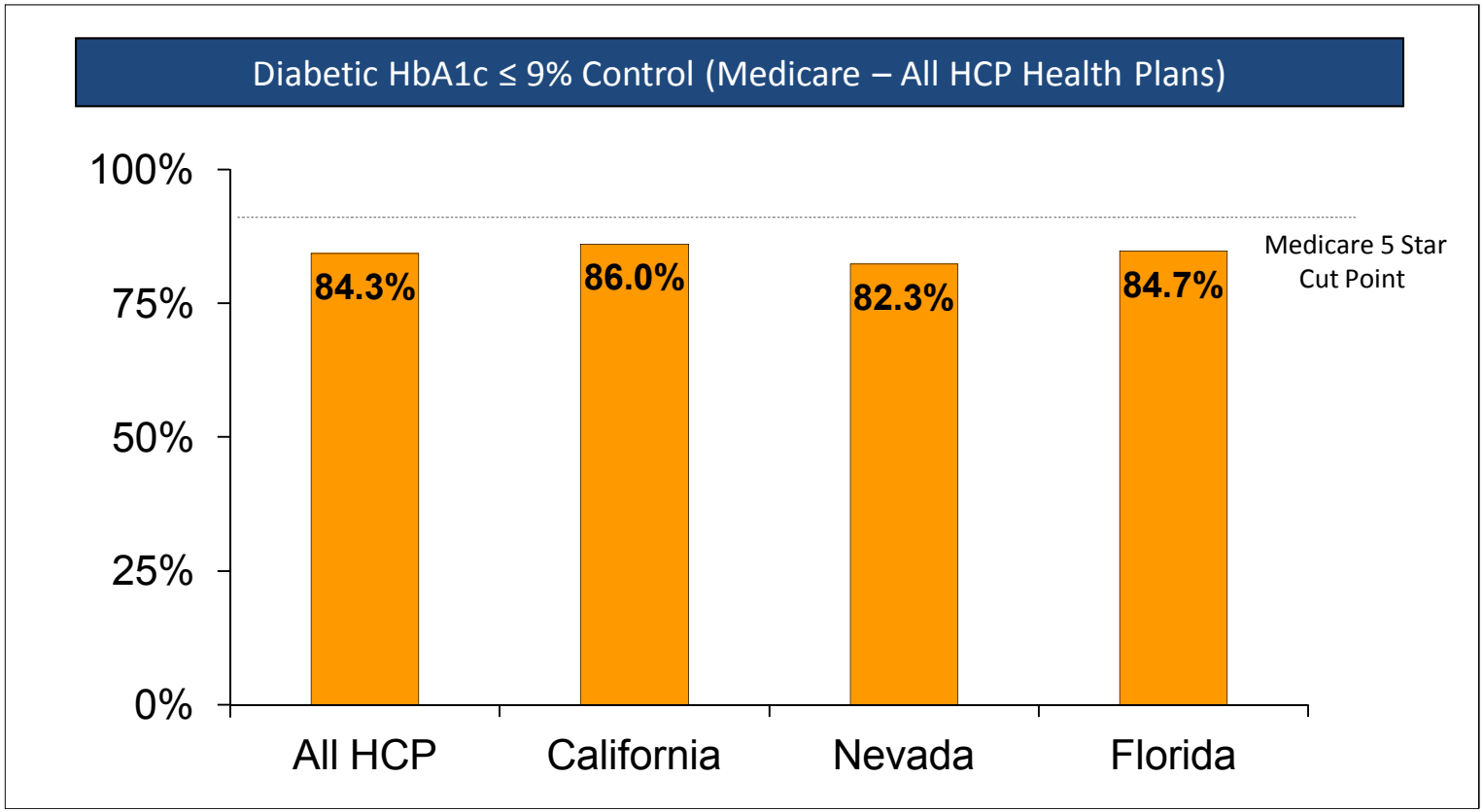
Total: $3,000,000 or $250 pmpm savings!

Example: Clinical Quality Efforts

- Enterprise-Wide Quality Improvement Programs
  - High Risk, Chronic Conditions, Complex Cases



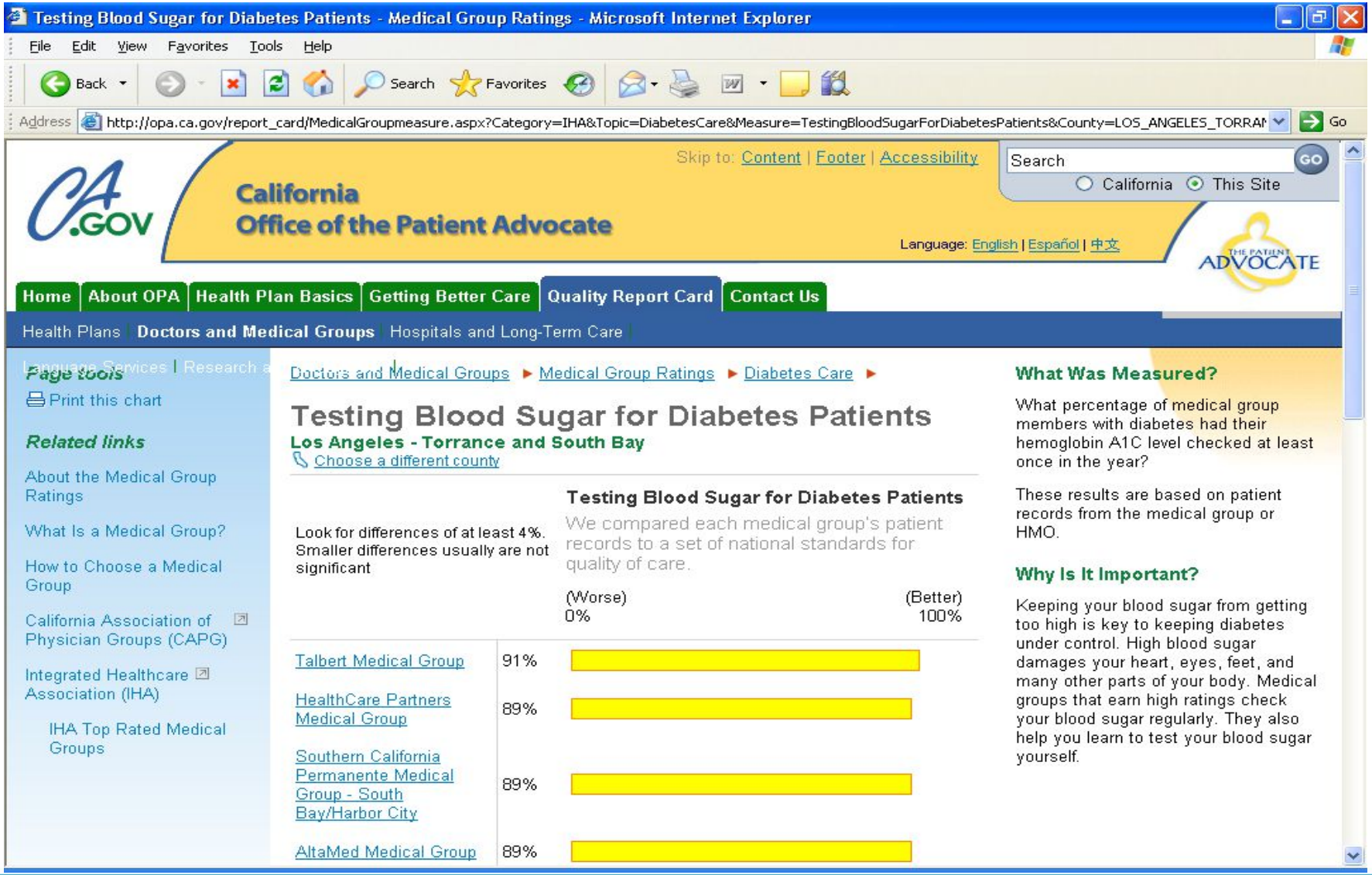
Clinical Quality Efforts (continued)



Ongoing initiatives to standardize quality best practices/ procedures

42
42

And Transparently Reported



The Likely Alternatives

- Uncontrolled cost increases will be met with a solution.
- If we as healthcare professionals can not show significant value creation defined as:

$$\frac{\text{Quality + Patient Experience}}{\text{Cost}}$$

Government single payer with price controls & salaried care providers looms large!

Conclusions

- Americans all deserve access to high quality, personalized, high-touch, affordable health care.
- Reorganizing healthcare delivery to meet this goal is within our grasp.
- To paraphrase Oliver Cromwell:

"We can hang together or surely we'll hang individually."

Medicine is too noble a profession to be left to Congress.

Thank you