

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

\$3,000,000,000,000



U.S. Health Care Expenditures

50 percent of payments outcome-based
in 2018!

Determinants of Health

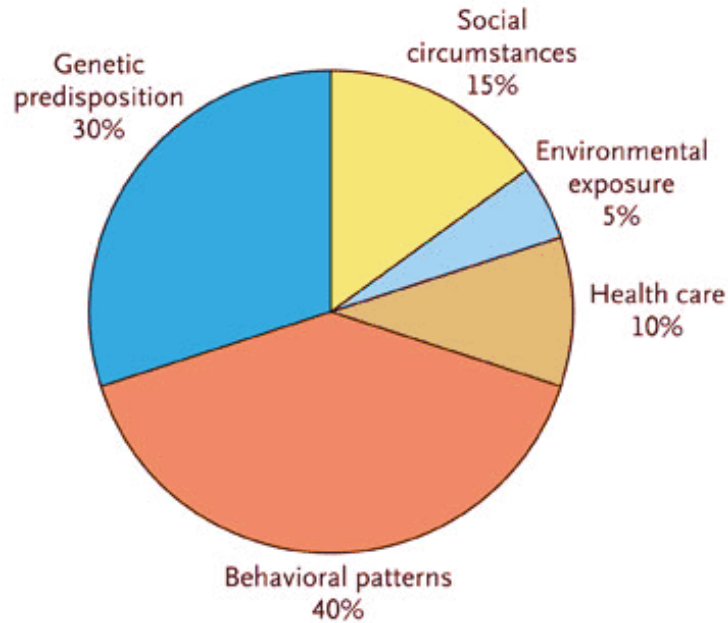


Figure 1. Determinants of Health and Their Contribution to Premature Death

McGinnis, Social Determinants of Health, 2002

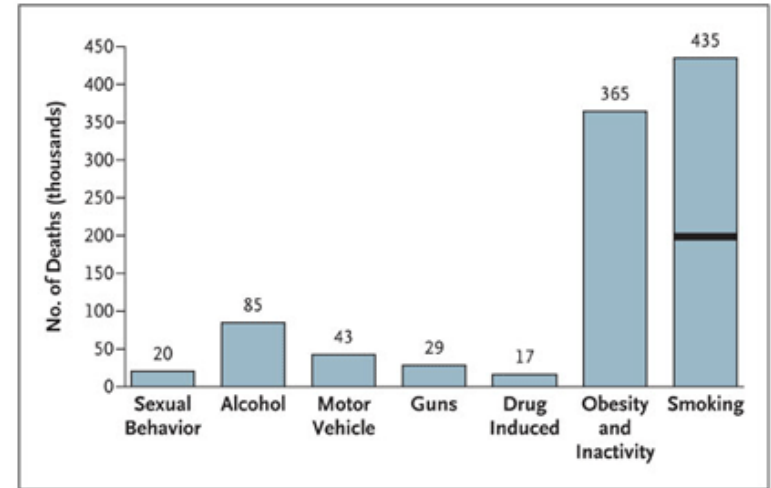
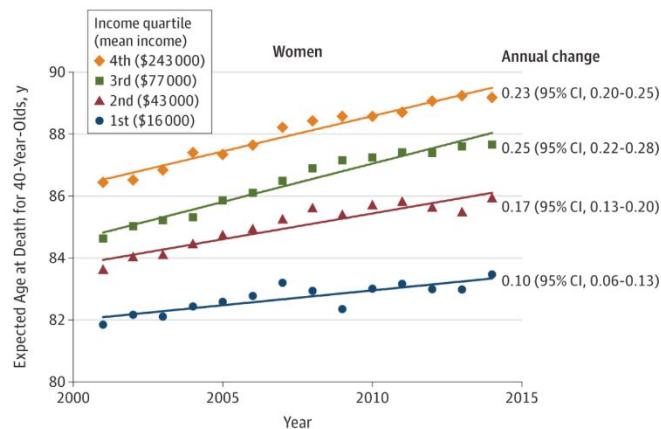
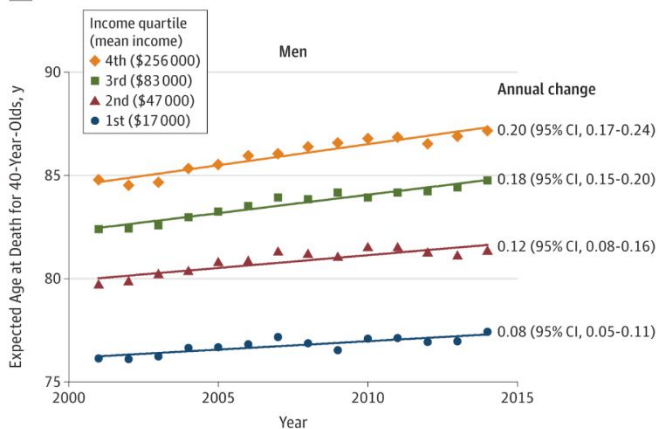


Figure 2. Numbers of U.S. Deaths from Behavioral Causes, 2000.

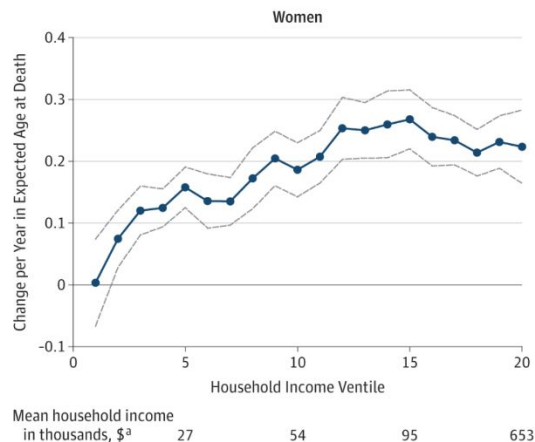
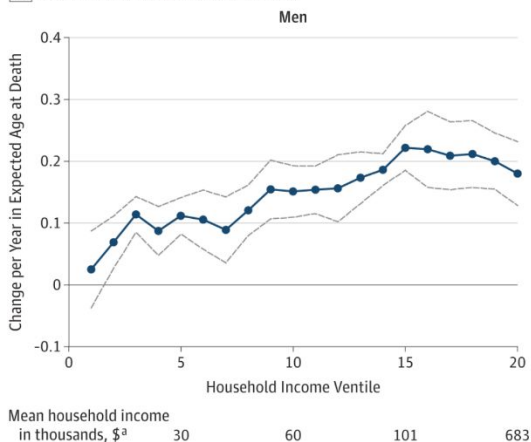
Adapted from Mokdad et al.

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

A Life expectancy by income quartile by year

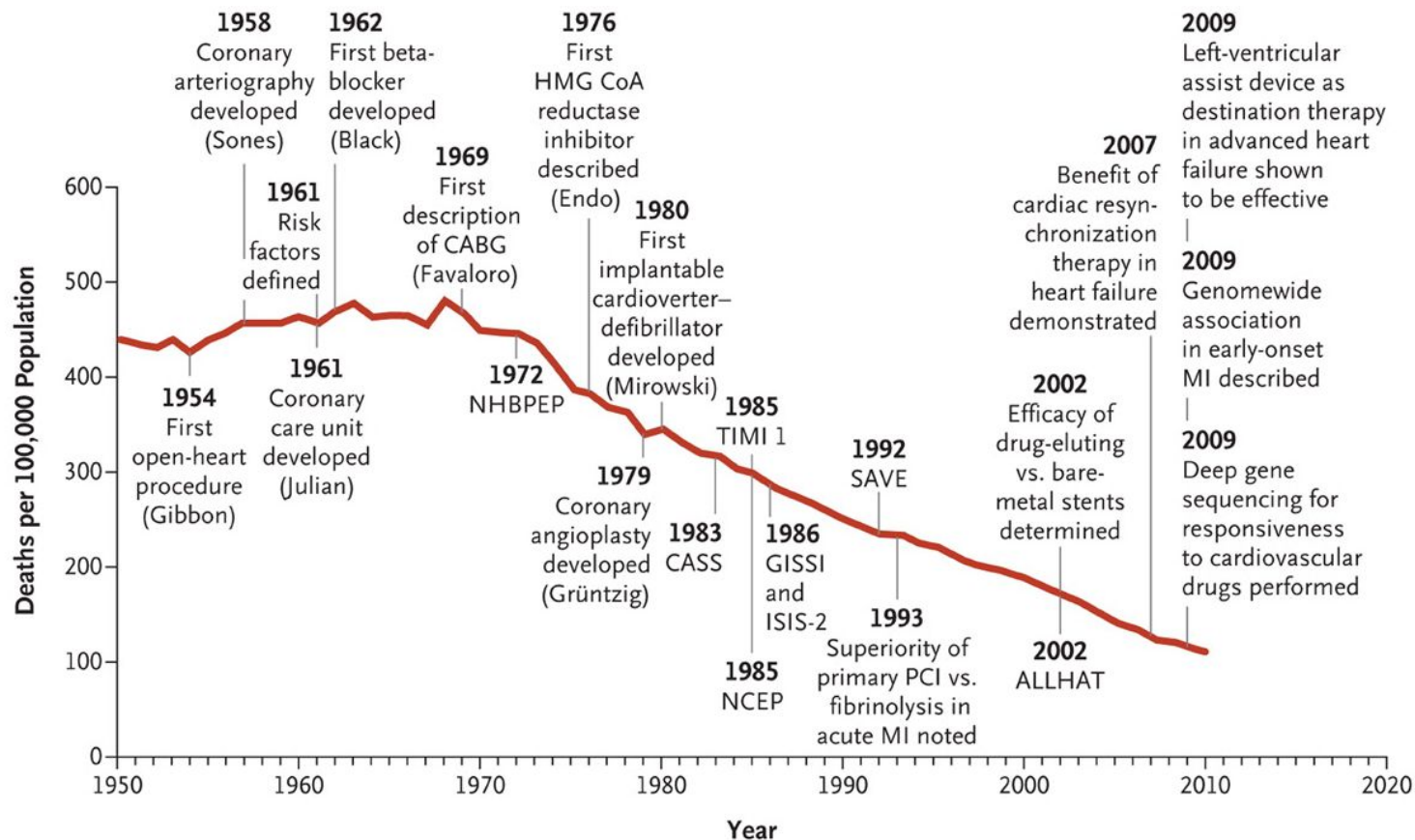


B Mean annual change in life expectancy



Health care innovation and mortality

Decline in Deaths from Cardiovascular Disease in Relation to Scientific Advances



Health Care Progress + Increased Costs

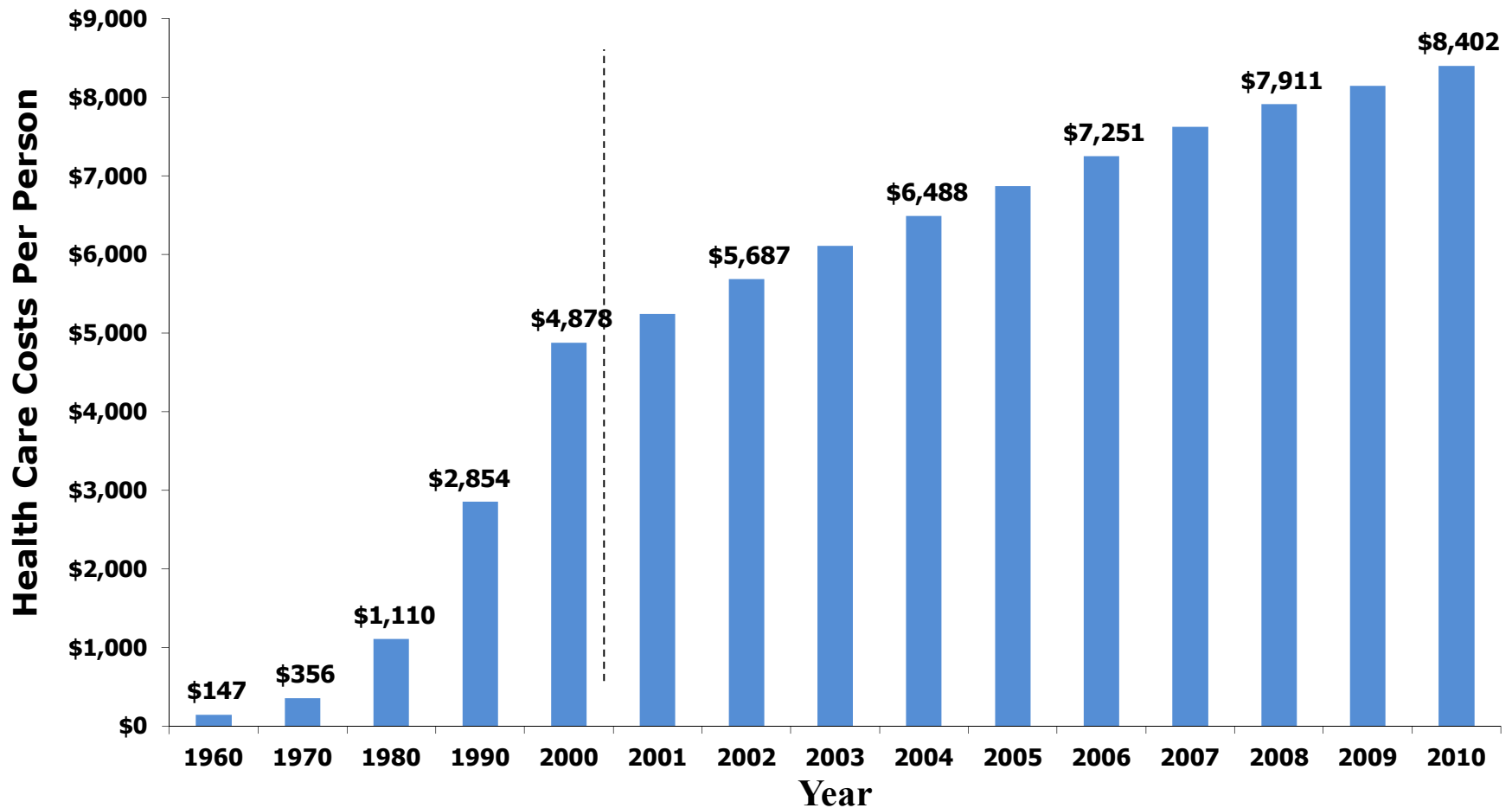
Breakthroughs in Medical Technology

- 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

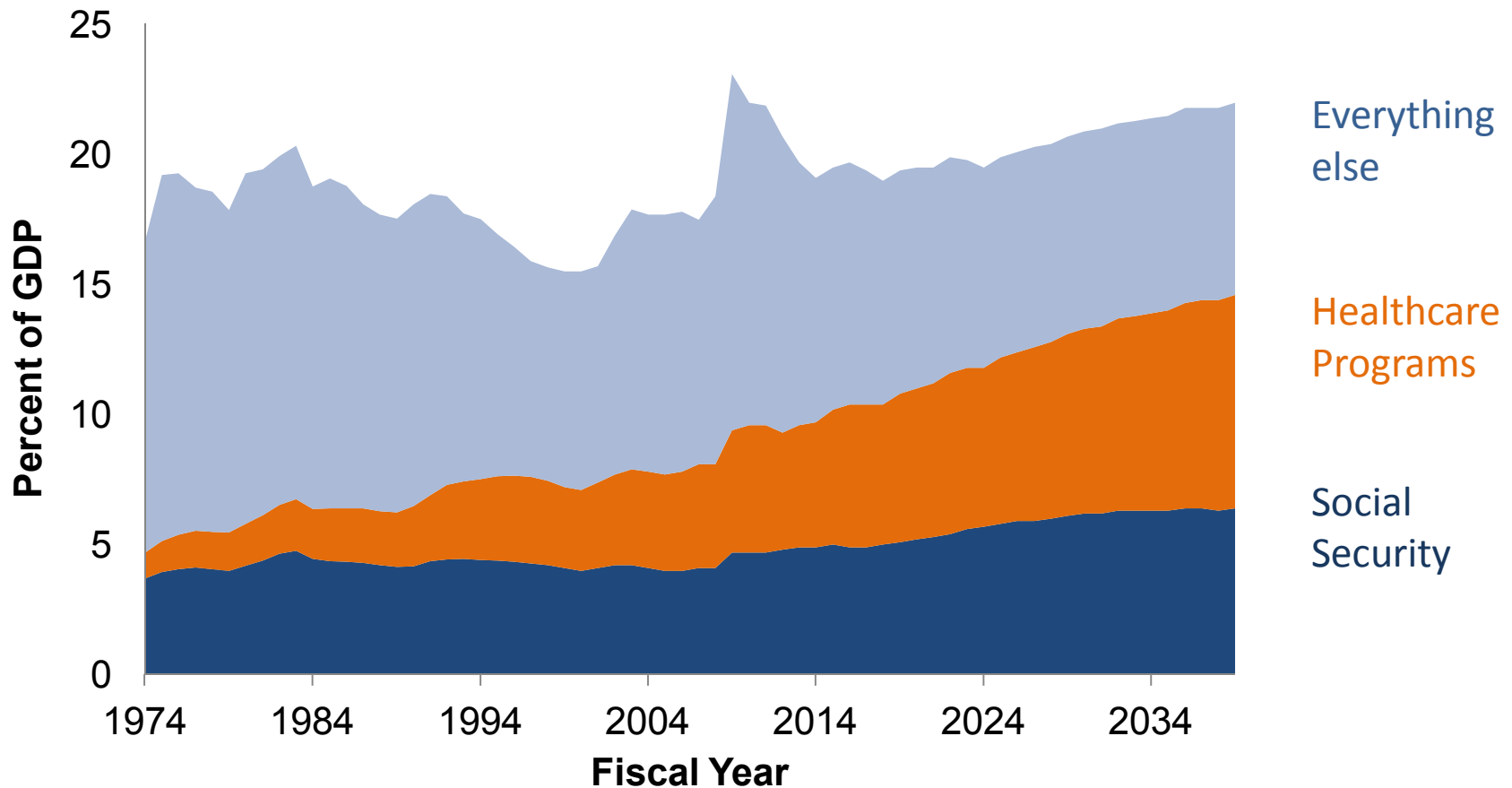
- Demographic trends, availability of more and better treatments
- *Living longer and better is worth a lot*

Rising per Capita Healthcare Costs



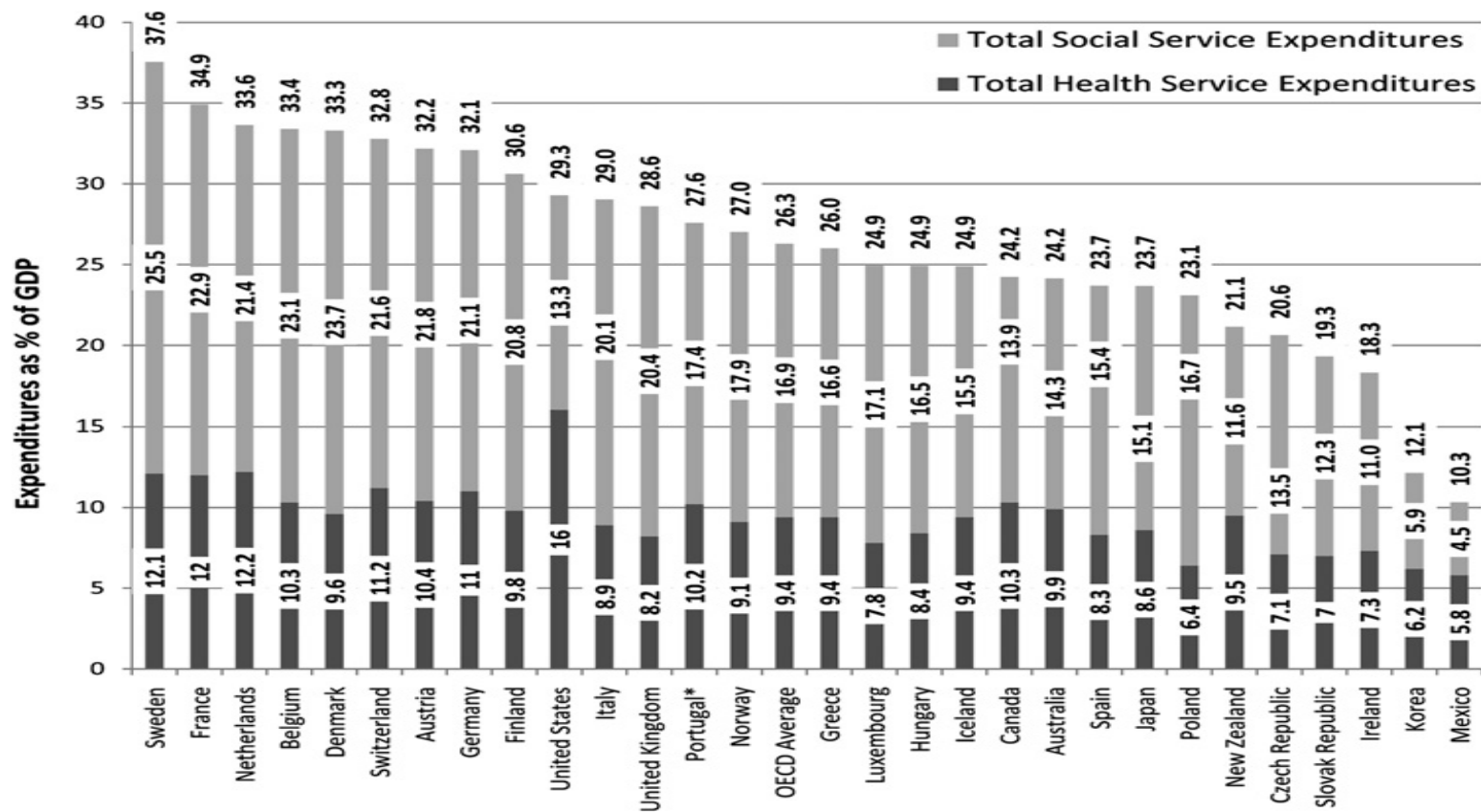
Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (see Historical; NHE summary including share of GDP, CY 1960-2010; file nhegdp10.zip).

Health Care and the Federal Budget

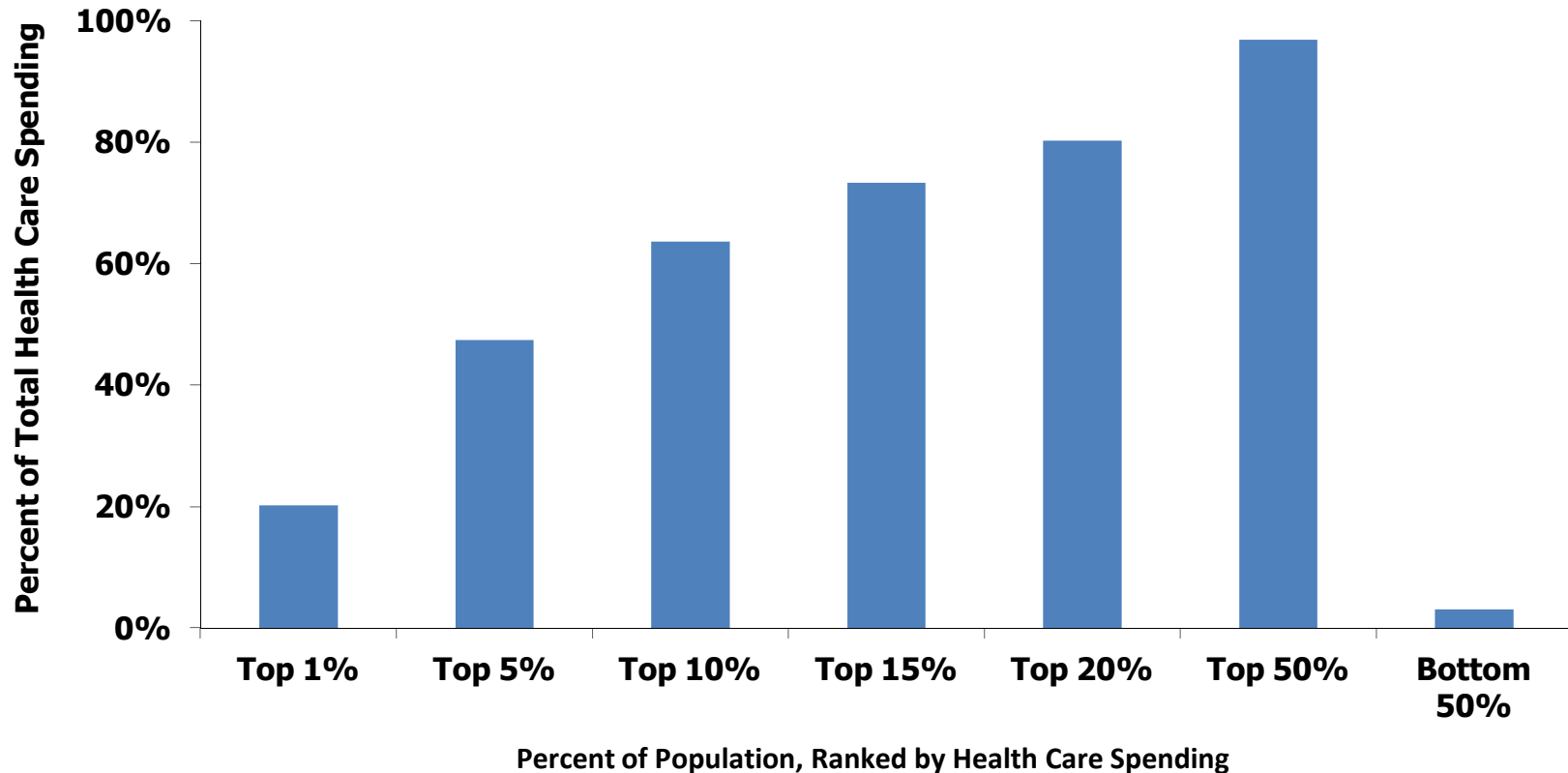


Source: Congressional Budget Office, 2016 Long-Term Budget Outlook.

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.



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/Downsi
de Risk



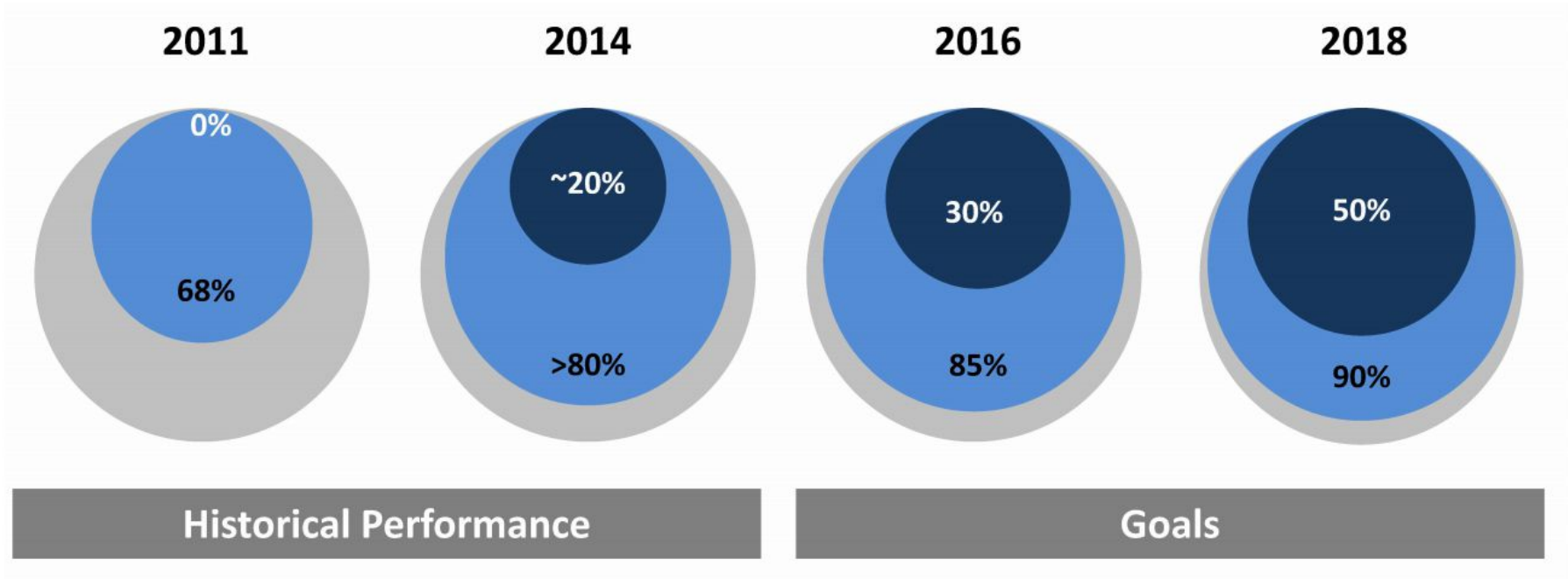
Category 4

Population-Based
Payment

A: Condition-Specific
Population-Based
Payment

B: Comprehensive
Population-Based
Payment

HHS Goals for Alternative Payment Models in Medicare



Alternative Payment Models

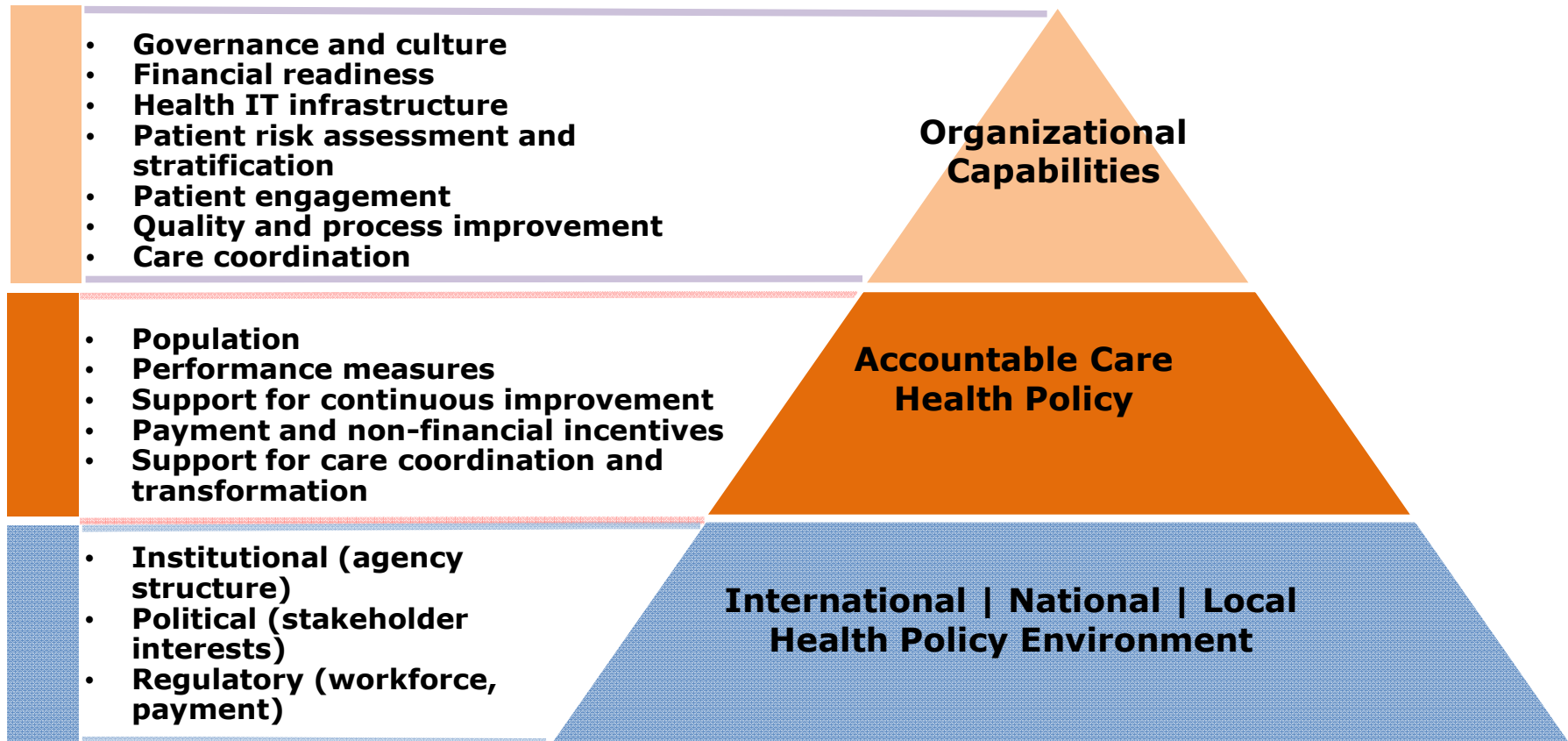
FFS Linked to Quality

Total Medicare FFS Program

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

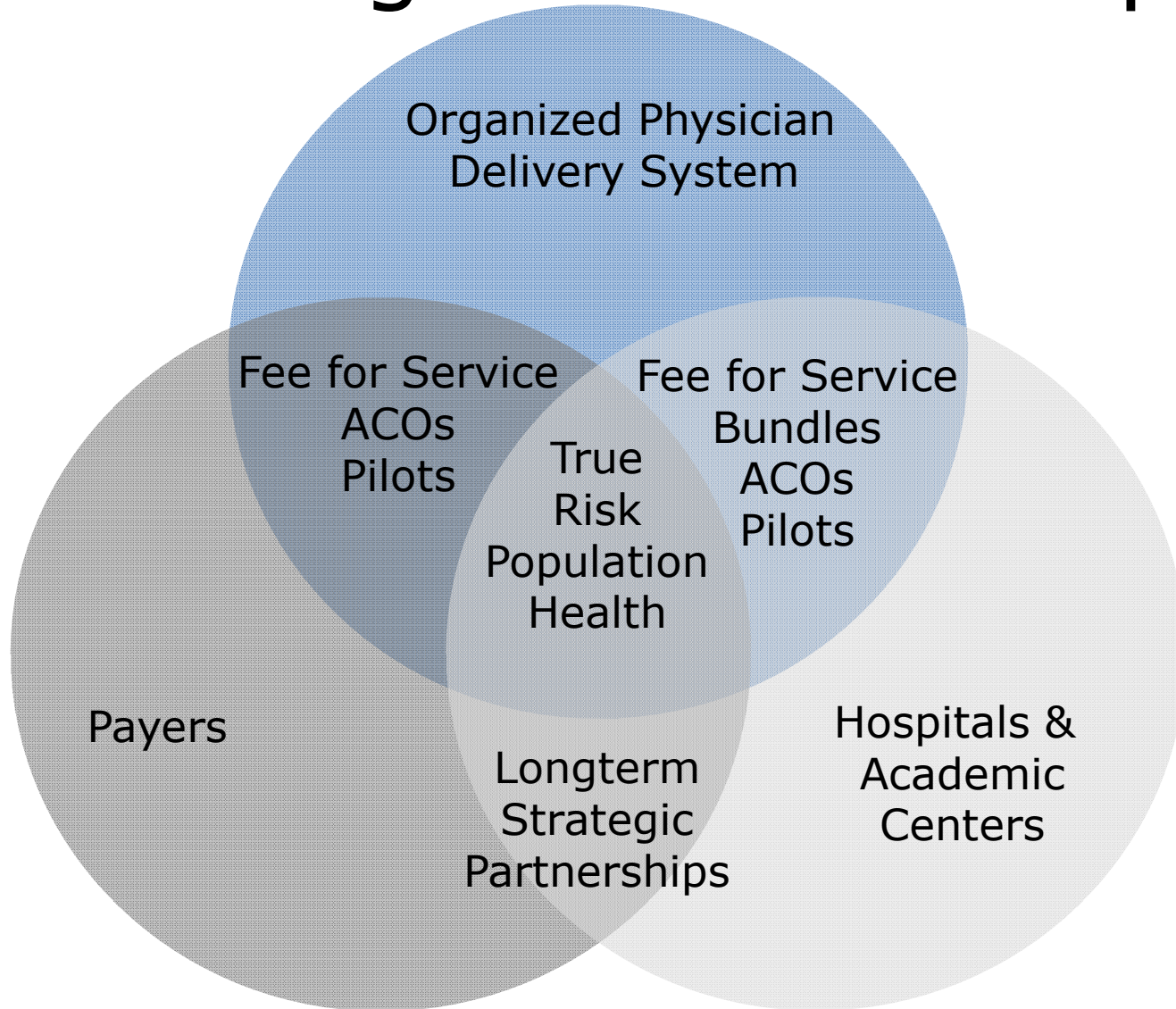
Delivery Systems Reform

- 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

Hospice/Palliative Care

Provides in-home medical and palliative care management by specialized physicians, nurse care managers, and social workers for chronically frail seniors who have physical, mental, social, and financial limitations That limit access to outpatient care, forcing unnecessary utilization of hospitals.

Home Care Management

Intensive one-on-one physician/nurse patient care and case management for the highest-risk, most complex of the population. As the risk for hospitalization is reduced, patient is transferred to next level down. Physicians & Care Managers are highly trained and closely integrated into community resources or physician offices/clinics.

High Risk Clinics & Care Management

Provides long-term whole person care enhancement for the population using a multidisciplinary team approach, Diabetes, COPD, CHF, CKD, Depression, Dementia

Complex Care & Disease Management

Provides self-management for people with chronic disease

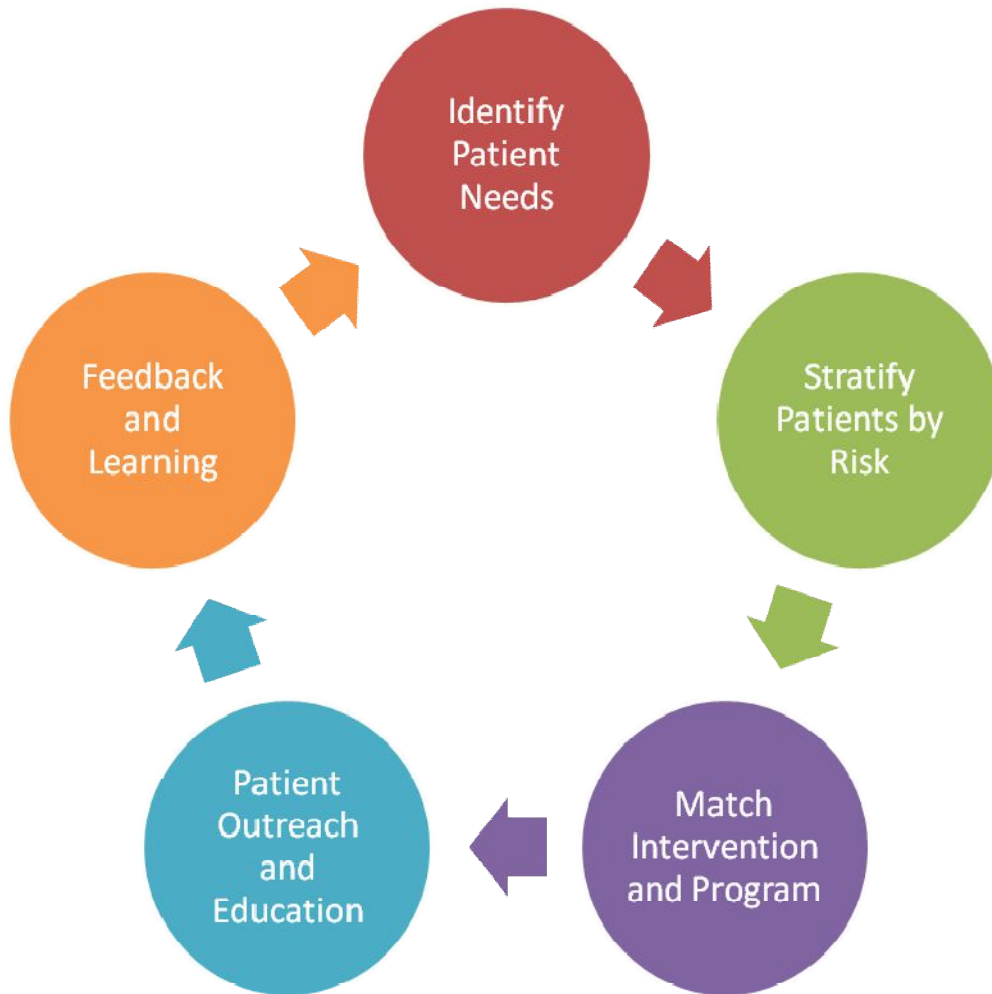
Self-management & Health Education Programs

High
PMPM

ESRD Medical Home

Low
PMPM

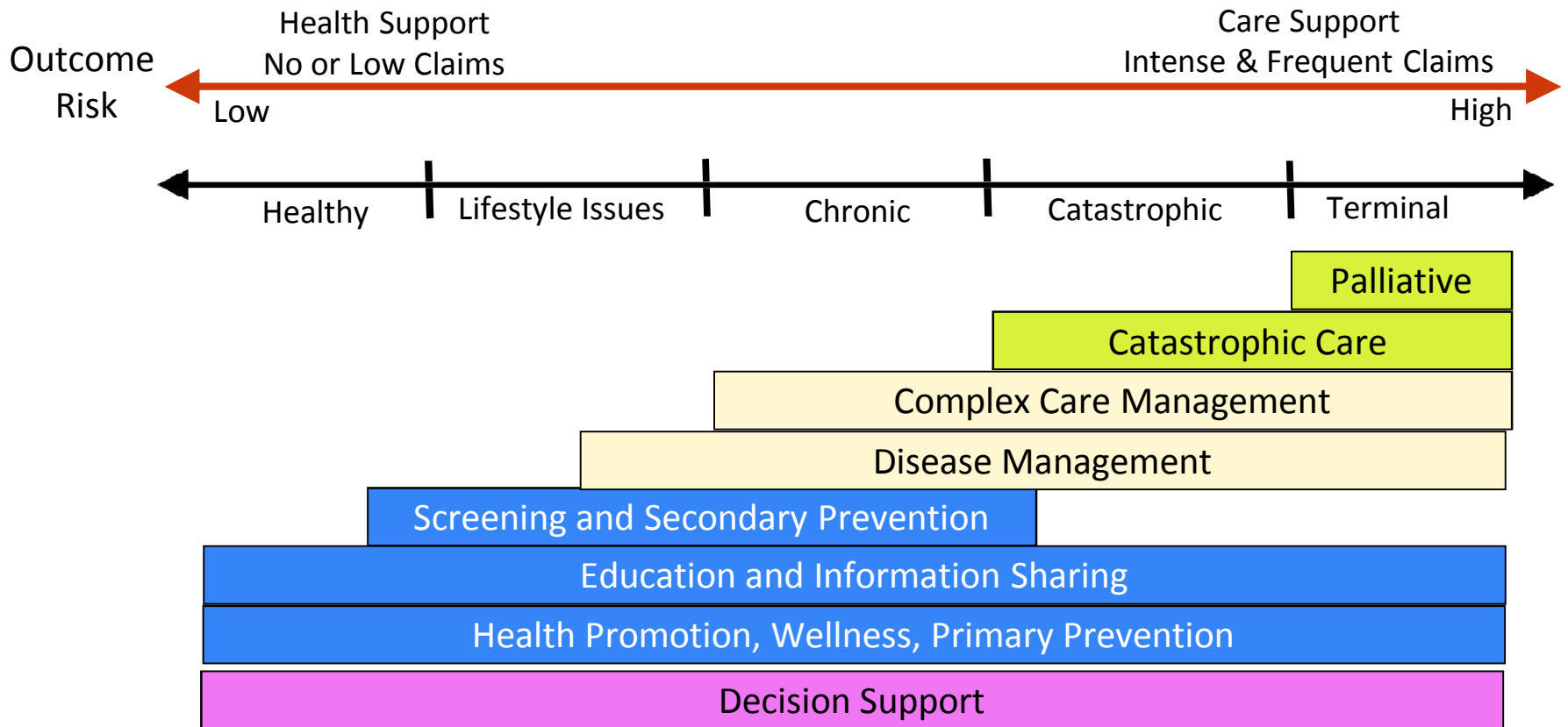
Proactive Population Management



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



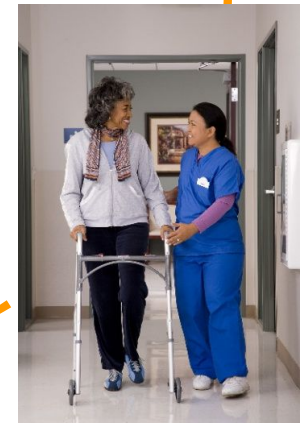
Physicians



Patients



Home Care



Urgent Care

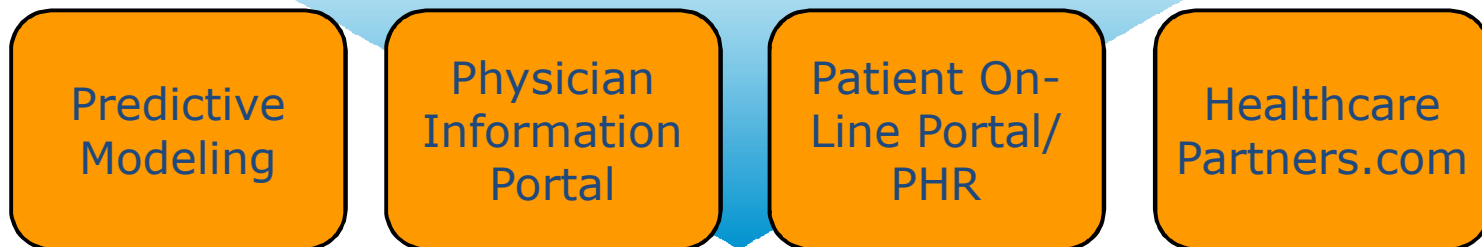
Over 900 Care Management Resources

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

Page 1 of 1

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

HR Diabetics w CHF and CKD and GFR less 30 NO ACEARB

HCP Reporting Services Development
Home > DZReg > ReportModel

Home | My Subscriptions | Help
Search for: Go

Contents Properties

New Folder New Data Source Upload File Report Builder Show Details

- ChfDetailReportModel
- Commercial Group Diabetics LDL 150 NO LIPID RX
- DiabetesDetailReportModel
- dzreg
 - dzreg
 - HR Diabetics w CHF and CKD and GFR less 30 NO ACEARB**
 - JH HR Group Diabetics All Regions
 - JH HR IPA Diabetics All Regions
 - R1 Diabetic Eye Exam Call List Commercial Group Patients
 - R1 Diabetic Eye Exam Call List Senior Group Patients
 - R2 and R4 Senior Group Diabetics LDL GR130 No LipidRx
 - R2 Group Seniors BMI Greater 30 and SHTN
 - R2 Group Seniors LDL Greater 100
 - R3 Senior Group Diabetics LDL GR130 No LipidRx
 - R4 Bixby Group Diabetic Commercial w LDL Greater 100
 - R4 Bixby Group Diabetic Seniors w LDL Greater 100
 - R4 Bixby Group Diabetic Seniors WO LDL 2yr
 - R4 Bixby IPA Diabetic Seniors w LDL Greater 100
 - R4 Bixby IPA Diabetic Seniors WO LDL 2yr
 - R4 CHF SCAN Patients
 - R4 Group Diabetic Patients Senior N Commercial No LDL
 - R4 Group Seniors GFR Less 60
 - R5 Senior Group Diabetics With Systolic Hypertension LDL G100
 - R5 Diabetics A1C Greater8 and SHTN
 - R5 Group Diabetic Patients Senior N Commercial LDL Greater Than 100 On Lipid Rx
 - R5 Group Seniors BMI Greater 30
 - R5 Group Seniors GFR Less Than 30 No CKD Dx
 - R5 Group Seniors GFR Less Than 45 No CKD Dx
 - R5 Group Seniors GFR Less Than 60 No CKD Dx
 - R5 IPA Seniors GFR Less Than 30 No CKD Dx
 - R5 IPA Seniors GFR Less Than 45 No CKD Dx
 - R5 IPA Seniors GFR Less Than 60 No CKD Dx
 - R5 Senior Group Diabetics With Systolic Hypertension LDL Uncontrolled
 - Region 4 Diabetics LDLGreater 100 Lipid Rx
 - Region 4 Diabetics LDLGreater 100 Lipid Rx Bixby
 - Region 4 Diabetics LDLGreater 100 Lipid Rx Katella Docs
 - Region 4 Diabetics LDLGreater 100 No Lipid Rx
 - Region 4 Diabetics LDLGreater 100 No Lipid Rx Katella Docs
 - Region 4 Diabetics No LDL All Patients Group_IPA
 - Region 4 Diabetics No LDL Bixby

Lists of Patients Needing Interventions

ENTER NAME OR MRN

submit

Schedule **Patient Lists**

PATIENT LIST BY INTERVENTION TYPE








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

PATIENT MANAGEMENT: 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	<ul style="list-style-type: none"> • P4P - Need CRC screening 	
Alpine, Strawberry	05/04/1959		Oz MD, Alan		10/08/2009	<ul style="list-style-type: none"> • P4P - Need CRC screening • P4P - Needs PAP 	
Apple, Rose	10/11/1978		Oz MD, Alan			<ul style="list-style-type: none"> • P4P - Needs PAP 	
Asian, Pear	01/04/1937		Oz MD, Alan	03/08/2010	03/08/2010	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • P4P - Need Mammo Screening 	
Betel, Nut	07/23/1958	47-841764	Oz MD, Alan			<ul style="list-style-type: none"> • P4P - Need CRC screening • P4P - Need Mammo Screening • P4P - Needs PAP 	
Cherry, Strawberry	07/01/1959		Oz MD, Alan		01/20/2010	<ul style="list-style-type: none"> • P4P - HbA1c Control < 7% and Retest • P4P - Need CRC screening • P4P - Perform Nephropathy Screening 	

- 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

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

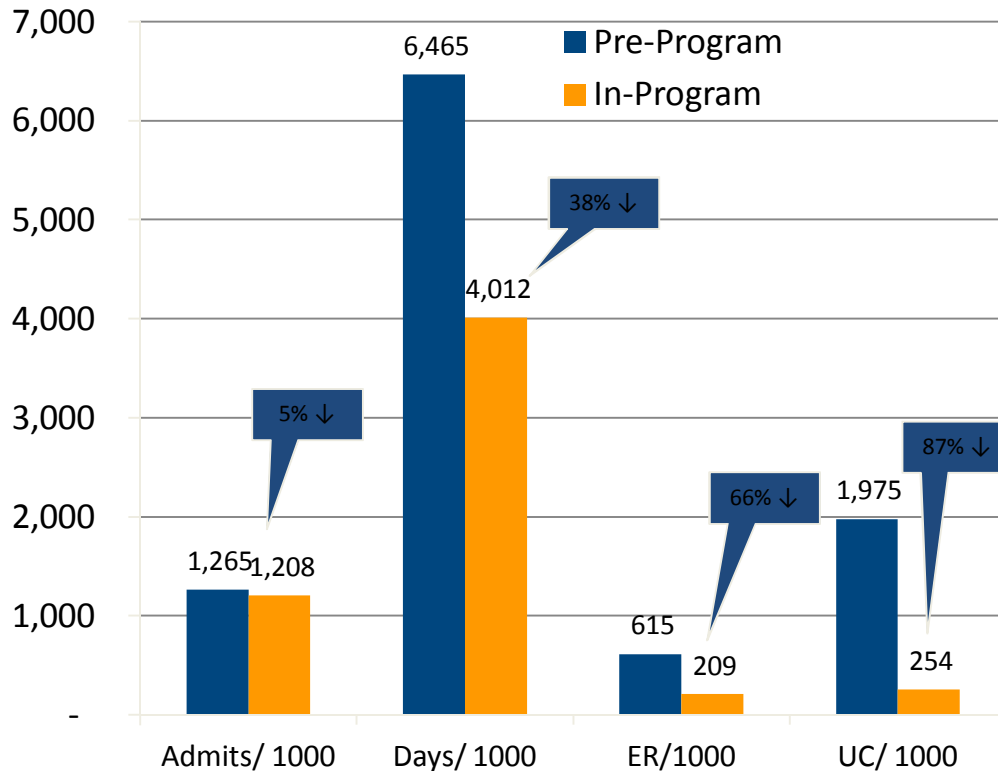
High Risk Programs – Home Care

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

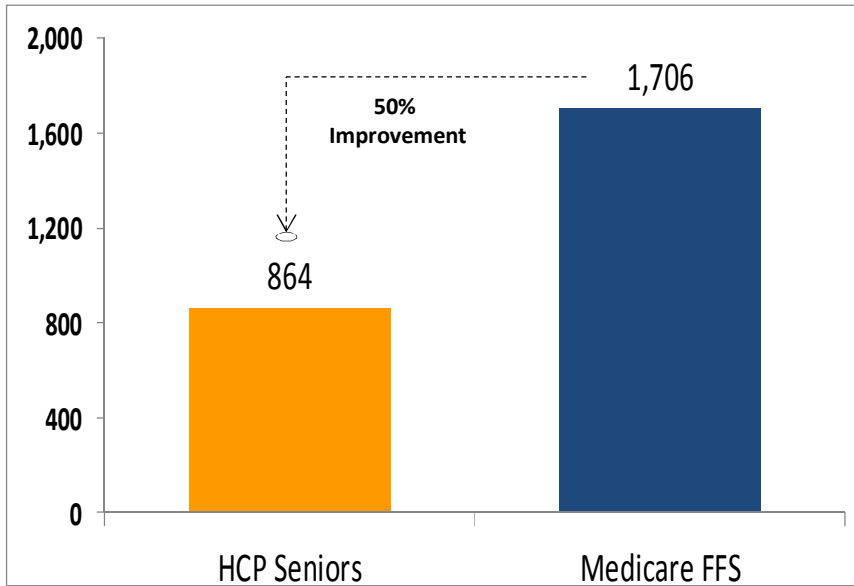


Higher satisfaction and improved quality for the patient as well as significant cost savings

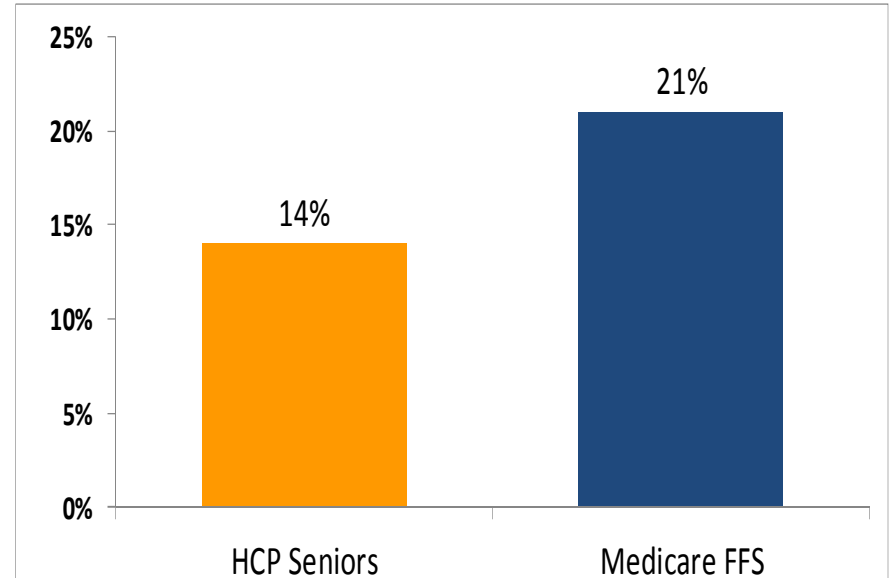
	% Change	
Drug cost est.	3%	↑
Total admits	30%	↓
Total bed days	39%	↓
Total ED visits	23%	↓
Cost of care (all paid-pmpm)	34%	↓

Cost Savings Impact

Inpatient Acute Bed Days/1,000 pts



30-Day All Cause Re-admit Rate



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

1000 MA Patients

Reduce hospital days from 1800k-800k

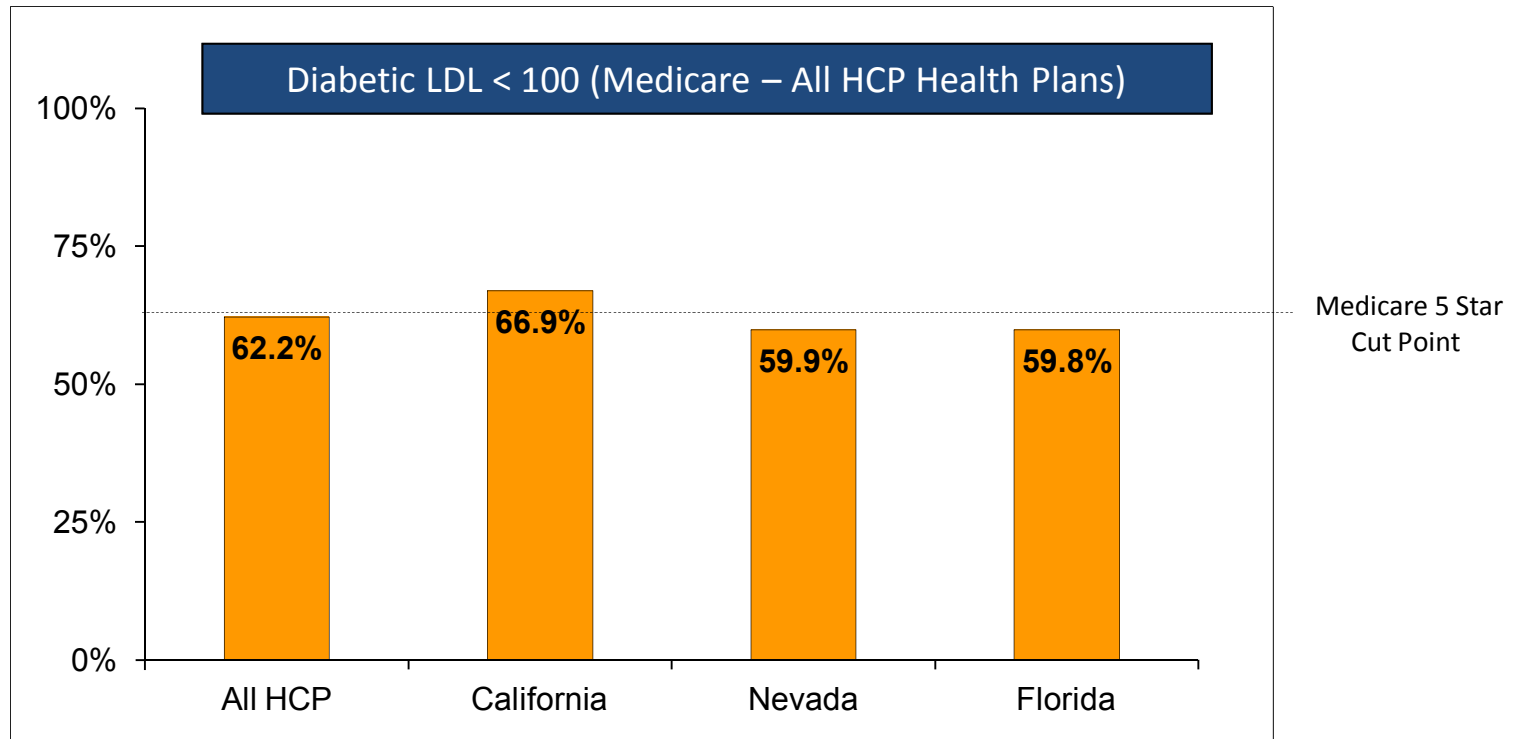
Hospital Average Per Diem \$3000

$1000/1000 = 1 \times 1000 \text{ days} \times \3000

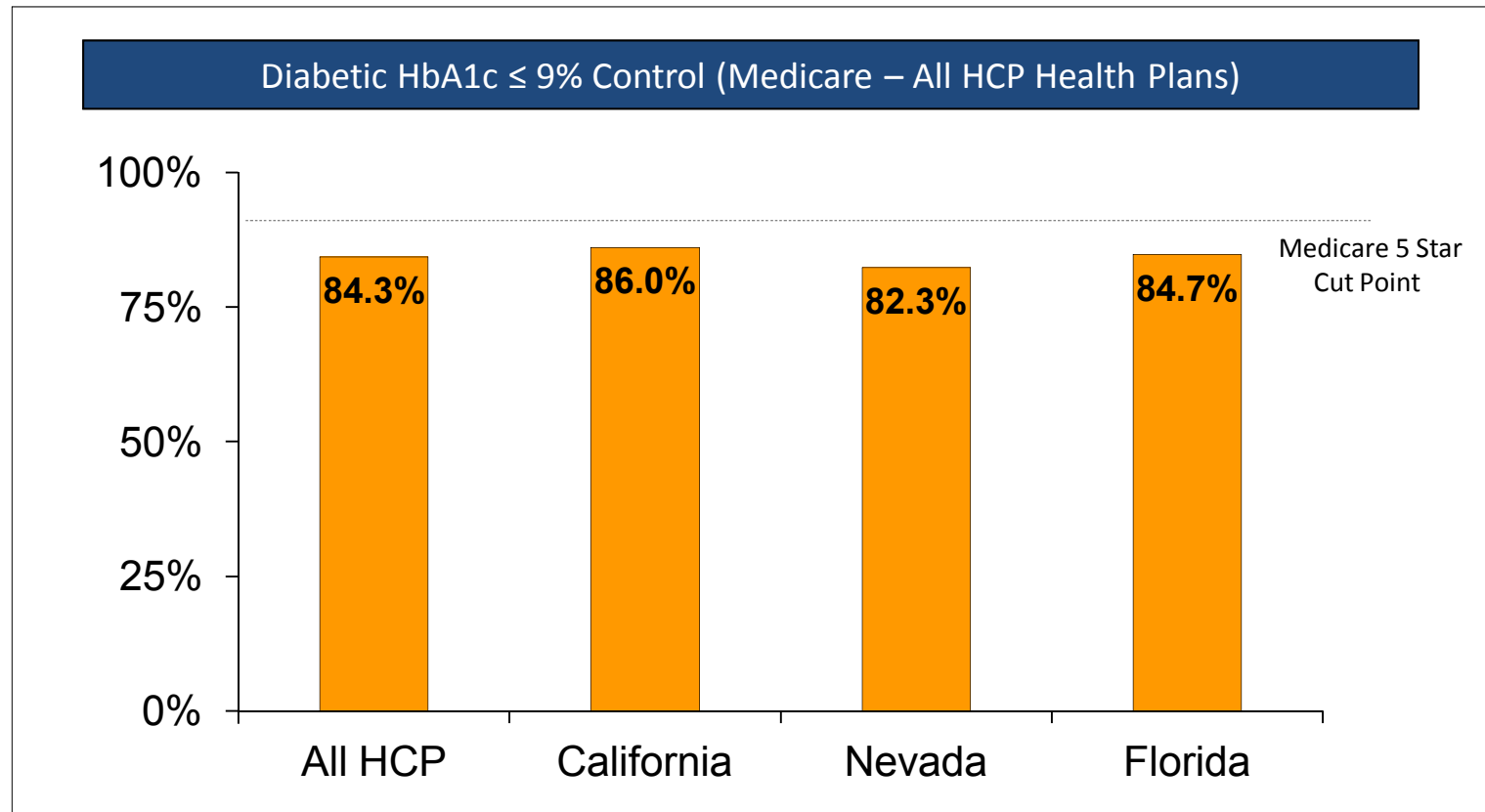
Total: \$3,000,000 or \$250 pmpm savings!

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

And Transparently Reported

Testing Blood Sugar for Diabetes Patients - Medical Group Ratings - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites Refresh Print Mail Print Mail Print Mail

Address http://opa.ca.gov/report_card/MedicalGroupmeasure.aspx?Category=IHA&Topic=DiabetesCare&Measure=TestingBloodSugarForDiabetesPatients&County=LOS_ANGELES_TORRAI Go

CA.GOV California Office of the Patient Advocate

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THE PATIENT ADVOCATE

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Related links

About the Medical Group Ratings

What Is a Medical Group?

How to Choose a Medical Group

California Association of Physician Groups (CAPG)

Integrated Healthcare Association (IHA)

IHA Top Rated Medical Groups

[Doctors and Medical Groups](#) ▶ [Medical Group Ratings](#) ▶ [Diabetes Care](#) ▶

Testing Blood Sugar for Diabetes Patients

Los Angeles - Torrance and South Bay

[Choose a different county](#)

Testing Blood Sugar for Diabetes Patients

We compared each medical group's patient records to a set of national standards for quality of care.

Look for differences of at least 4%. Smaller differences usually are not significant.

		(Worse) 0%	(Better) 100%
Talbert Medical Group	91%		
HealthCare Partners Medical Group	89%		
Southern California Permanente Medical Group - South Bay/Harbor City	89%		
AltaMed Medical Group	89%		

What Was Measured?

What percentage of medical group members with diabetes had their hemoglobin A1C level checked at least once in the year?

These results are based on patient records from the medical group or HMO.

Why Is It Important?

Keeping your blood sugar from getting too high is key to keeping diabetes under control. High blood sugar damages your heart, eyes, feet, and many other parts of your body. Medical groups that earn high ratings check your blood sugar regularly. They also help you learn to test your blood sugar yourself.

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:

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

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