Executive Webcast Series:

Population Health: Creating a Culture of Wellness

Presented by: David B. Nash, MD, MBA, Dean, Jefferson School of Population Health
Moderated by: Richard Hodach, MD, PhD, MPH, CMO and VP, Clinical Product Strategy
Q&A facilitated by: Karen Handmaker, MPP, PCMH CCE, VP, Population Health Strategies
1. **Using the control panel** - Use the control panel on the right side of your screen to minimize and expand this panel by clicking on the arrow in the upper right corner.

2. **Ask questions** - You can submit questions using the Question section located near the bottom of the control panel. We will take time to answer as many questions as we can during Q&A at the end of the presentation. If your question was not answered, we will respond to you individually after the event.

3. **After the webinar** – We want your feedback! Please take the short survey at the completion of the webinar. Also, all registrants will receive a copy of the presentation and the recording.
Phytel Executive Webinar Series

“Population Health: Creating a Culture of Wellness”
November 19, 2014

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http://blogs.jefferson.edu/nashhealthpolicy/
Value-Based Payment and Population Health Management

Historical and Current Fee-For-Service
Medical Guesswork
From heart surgery to prostate care, the medical industry knows little about which treatments really work

BY JOHN CAREY (P. 72)
U.S. Health in International Perspective
Shorter Lives, Poorer Health

The United States is among the wealthiest nations in the world, but it is far from the healthiest. Although Americans’ life expectancy and health have improved over the past century, these gains have lagged behind those in other high-income countries. This health disadvantage prevails even though the United States spends far more per person on health care than any other nation.

To gain a better understanding of this problem, the National Institutes of Health (NIH) asked the National Research Council and the Institute of Medicine to convene a panel of experts to investigate potential reasons for the U.S. health disadvantage and to assess its larger implications. The panel’s findings are detailed in its report, U.S. Health in International Perspective: Shorter Lives, Poorer Health.

A Pervasive Pattern of Shorter Lives and Poorer Health

The report examines the nature and strength of the research evidence on life expectancy and health in the United States, comparing U.S. data with statistics from 16 “peer” countries—other high-income democracies in western Europe, as well as Canada, Australia, and Japan. (See Table.) The panel relied on the most current data, and it also examined historical trend data beginning in the 1970s; most statistics in the report are from the late 1990s through 2008.

The panel was struck by the gravity of its findings. For many years, Americans have been dying at younger ages than people in almost all other high-income countries. This disadvantage has been getting worse for three decades, especially among women. Not only are their lives shorter, but Americans also have a longstanding pattern of poorer health that is strikingly consistent and pervasive over the life course—at birth, during childhood and adolescence.
Price, Cost, and Competition in Health Care

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GJ Reinhardt

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L. Gripen, BW Taubner, and K Gupta

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FIRST, DO NO HARM

TO ERR IS HUMAN
BUILDING A SAFER HEALTH SYSTEM

INSTITUTE OF MEDICINE
By Marty Makary

When there is a plane crash in the U.S., even a minor one, it makes headlines. There is a thorough federal investigation, and the tragedy often yields important lessons for the aviation industry. Pilots and airlines thus learn how to do their jobs more safely.

The world of American medicine is far deadlier: Medical mistakes kill enough people each week to fill four jumbo jets. But these mistakes go largely unnoticed by the world at large, and the medical community rarely learns from them. The same preventable mistakes are made over and over again, and patients are left in the dark about which hospitals have significantly better (or worse) safety records than their peers.

As doctors, we swear to do no harm. But on the job we soon absorb another unspoken rule: to overlook the mistakes of our colleagues. The problem is vast. U.S. surgeons operate on the wrong body part as often as 40 times a week. Roughly a quarter of all hospitalized patients will be harmed by a medical error of some kind. If medical errors were a disease, they would be the sixth leading cause of death in America—just behind accidents and ahead of Alzheimer's. The human toll aside, medical errors cost the U.S. health-care system tens of billions a year. Some 20% to 30% of all medications, tests and procedures are unnecessary, according to research done by medical specialists, surveying their own fields. What other industry misses the mark this often?

It does not have to be this way. A new generation of doctors and patients is trying to achieve greater transparency in the health-care system, and new technology makes it more achievable than ever before.

I encountered the disturbing closed-door culture of American medicine on my very first day as a student at one of Harvard Medical School's prestigious affiliated teaching hospitals. Wearing a new white medical coat that was still turned out, I was a nobody. A fellow student whispered, "It stands for Hands of Death and Destruction."

Stunned, I soon saw just how scary the works of his hands were. His operating skills were hasty and slipshod, and his patients frequently suffered complications. This was a man who simply should not have been allowed to touch patients. But his bedside manner was impeccable (in fact, I try to emulate it to this day). He was charming. Celebrities requested him for operations. His patients worshiped him. When faced with excessive surgery time and extended hospitalizations, they just chalked up their misfortunes to fate.

Dr. Hodad's popularity was no aberration. As I rotated through other hospitals during my training, I learned that many hospitals have a "Dr. Hodad" somewhere on staff (sometimes more than one). In a business where reputation is everything, doctors who call out other doctors can be targeted. I've seen whistleblowing doctors suddenly assigned to more emergency calls, given fewer resources or simply bad-mouthed and discredited in retaliation. For me, I knew the ramifications if I sounded the alarm over Dr. Hodad: I'd be called into the hospital chairman's office, a dread scenario if I ever wanted a job. So, as a rookie, I kept my mouth shut. Like the other trainees, I just told myself that my 120-hour weeks were about surviving to become a surgeon one day, not about fixing medicine's culture.

Hospitals as a whole also tend to escape accountability, with excessive complication rates even at institutions that the public trusts as top-notch. Very few hospitals publish statistics on their performance, so how do patients pick one? As an informal exercise throughout my career, I've asked patients how they decided to come to the hospital where I was working (Georgetown, Johns Hopkins, D.C. General Hospital, Harvard and others). Among their answers: "Because you're close to home;"

25%
Hospitalized patients who are harmed by medical errors
Source: New England Journal of Medicine

98,000
Annual deaths from medical errors in the U.S.
Source: Institute of Medicine

Medical errors kill enough people to fill four jumbo jets a week.
A surgeon with five simple ways to make health care safer.

Please turn to the next page.
CROSSING THE QUALITY CHASM

A New Health System for the 21st Century
Institute of Medicine Report 2001

Outlines Key Dimensions of the Healthcare Delivery System

- **Safe**: avoiding injuries to patients from the care that is intended to help them.

- **Effective**: providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).

- **Patient-centered**: providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

- **Timely**: reducing waits and sometimes harmful delays for both those who receive and those who give care.

- **Equitable**: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

- **Efficient**: avoiding waste, including waste of equipment, supplies, ideas, and energy.

Source: Institute of Medicine 2001; 5-6
Is Population Health the Answer?

1. What’s the question?

2. Where are we now?

3. Where are we going in the future?
Population Health: Conceptual Framework

Health outcomes and their distribution within a population

Health determinants that influence distribution

Policies and interventions that impact these determinants

Morbidity
Mortality
Quality of Life
Medical care
Socioeconomic status
Genetics
Social
Environmental
Individual
Population Health Management

 CONTENTS
• Diabetes Self-Management Program
• Well-Being and Risk of Hospital Events
• Pharmacist MTM Program and Diabetes
• Hospital Variables and Disease Severity
• Compliance and Short-Term Disability
• Health Insurance in Japan
• Depression Remission
• Charlson Comorbidity Index
• Sickle Cell Acute Care

Editor-in-Chief
David B. Nash, M.D., M.B.A.

Managing Editor
Deborah Meiris

The Official Journal of
Population Health Alliance

Jefferson. School of Population Health
Mary Ann Liebert, Inc. publishers
www.liebertpub.com/pop
A Guide to Measuring the Triple Aim:
Population Health, Experience of Care, and Per Capita Cost
Better Health

...He’s back!
What percentage of adult Americans do the following?

1. Exercise 20 minutes 3 x week
2. Don’t smoke
3. Eat fruits and vegetables regularly
4. Wear seatbelts regularly
5. Are at appropriate BMI
Determinants of Health

1. Smoking
2. Unhealthy diet
3. Physical inactivity
4. Alcohol use

Together, these account for 40% of all deaths.
Reforming Health Care or Reforming Health?

1. US spends under 2% of its health dollars on population health.

2. Chronic diseases, which comprise 80% of total disease burden, have no dedicated federal funding stream.
The Tipping Point
How Little Things Can Make a Big Difference

Malcolm Gladwell
The Four Underlying Concepts of Cost Containment Through Payment Reform...

<table>
<thead>
<tr>
<th>Tying payment to evidence and outcomes rather than per unit of service</th>
<th>“Bundling” payments for physician and hospital services by episode or condition</th>
</tr>
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<tbody>
<tr>
<td>Reimbursement for the coordination of care in a medical home</td>
<td>Accountability for results Patient management across care settings</td>
</tr>
</tbody>
</table>
Range of Models in Existence or Development

Current State: Payments for Reporting

Incremental FFS payments for value

Bundled payments for acute episode

Bundled payments for chronic care/disease carve-outs

Accountability for Population Health

Accountable Care Organizations
Population Benchmark Report

Annual HbA1C testing

- Practice Average
- All Facilities, All Providers
- Goal
- Healthindicators.gov

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<td>Identified Population</td>
<td>2,183</td>
<td>2,167</td>
<td>2,180</td>
<td>2,166</td>
<td>2,168</td>
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</table>

- Annual HbA1c testing
- HbA1c > 9.0
- HbA1c < 7.0
OCTOBER 2013

Population Health Management: Steps to Risk Sharing and Data Analytics

An independent HealthLeaders Media Survey supported by

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ACCOUNTABLE CARE ORGANIZATIONS

By Susan DeVore and R. Wesley Champion

Driving Population Health Through Accountable Care Organizations

ABSTRACT Accountable care organizations, scheduled to become part of the Medicare program under the Affordable Care Act, have been promoted as a way to improve health care quality, reduce growth in costs, and increase patients’ satisfaction. It is unclear how these organizations will develop. Yet in principle they will have to meet quality metrics, adopt improved care processes, assume risk, and provide incentives for population health and wellness. These capabilities represent a radical departure from today’s health delivery system. In May 2010 the Premier healthcare alliance formed the Accountable Care Implementation Collaborative, which consists of health systems that seek to pursue accountability by forming partnerships with private payers to evolve from fee-for-service payment models to new, value-driven models. This article describes how participants in the collaborative are building models and developing best practices that can inform the implementation of accountable care organizations as well as public policies.

Susan DeVore (susan.devore@premierinc.com) is president and chief executive officer of the Premier healthcare alliance, in Charlotte, North Carolina.

R. Wesley Champion is a senior vice president at Premier Consulting Solutions, in Charlotte.
Lucky 7
Population Health TO DO LIST

1. What about your own associates?
   (HRAs, Wellness & Prevention)
2. Keep the well, well
3. PCMH’s (who will lead?)
4. Registries
5. Retail clinics (Walgreens, CVS)
6. Managed Care Partners
7. Leadership Training
What Does This All Mean?

Major Themes Moving Forward

1. Transparency
2. Accountability
3. No outcome, No income
How Might We Get There?

Change the Culture

1. Practice based on evidence
2. Reduce unexplained clinical variation
3. Reduce slavish adherence to professional autonomy
4. Continuously measure and close feedback loop
5. Engage with patients across the continuum of care
Escape Velocity to a Culture of Health: 100 Million Healthier Lives
Retail Senior Segment
Medical Management of Members Across a Continuum on Needs

We are focused in managing high cost / high acuity patients both Acute and Chronic

Percent of Total Costs

<table>
<thead>
<tr>
<th>Percent</th>
<th>Engagement Methods</th>
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<tr>
<td>41%</td>
<td><strong>Humana Cares</strong>, Integrated Medical-Behavioral Health, Medication Therapy Management, SeniorBridge, Model of Care, Disease Management, Humana Active Outlook, Seminars, Web and Print Guidance</td>
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<tr>
<td>34%</td>
<td><strong>Integrated Medical-Behavioral Health</strong>, Medication Therapy Management, SeniorBridge, Model of Care, Disease Management, Humana Active Outlook, Seminars, Web and Print Guidance</td>
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<td>18%</td>
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<td>6%</td>
<td><strong>Model of Care</strong>, Humana Active Outlook, Seminars, Web and Print Guidance</td>
</tr>
<tr>
<td>1%</td>
<td>Humana Active Outlook, Seminars, Web and Print Guidance</td>
</tr>
</tbody>
</table>

Percent of Members

Must manage both ACUTE episodes and CHRONIC conditions
“The institutionalization of leadership training is one of the key attributes of good leadership.”

John P. Kotter,
Harvard Business School
Thank you!

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Next Executive Series Webinar:

*Communicating Within the HIPAA Rules: Texting and E-mail with Patients*

Adam McCoy, Product Owner, Phytel
December 16, 2014
12:30 – 1:30pm ET

Click [here](#) to register.