

Oregon's Whole System Change: **Various definitions of population health** **and the implications they have for** **public health and ACO/CCO** **relationships**

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“The greatest danger for most of us lies not in setting our aim too high and falling short, but in setting our aim too low and achieving our mark.”

Michelangelo Buonarroti

OBJECTIVE:

Discuss various definitions of population health and the implications they have for public health and ACO/CCO relationships



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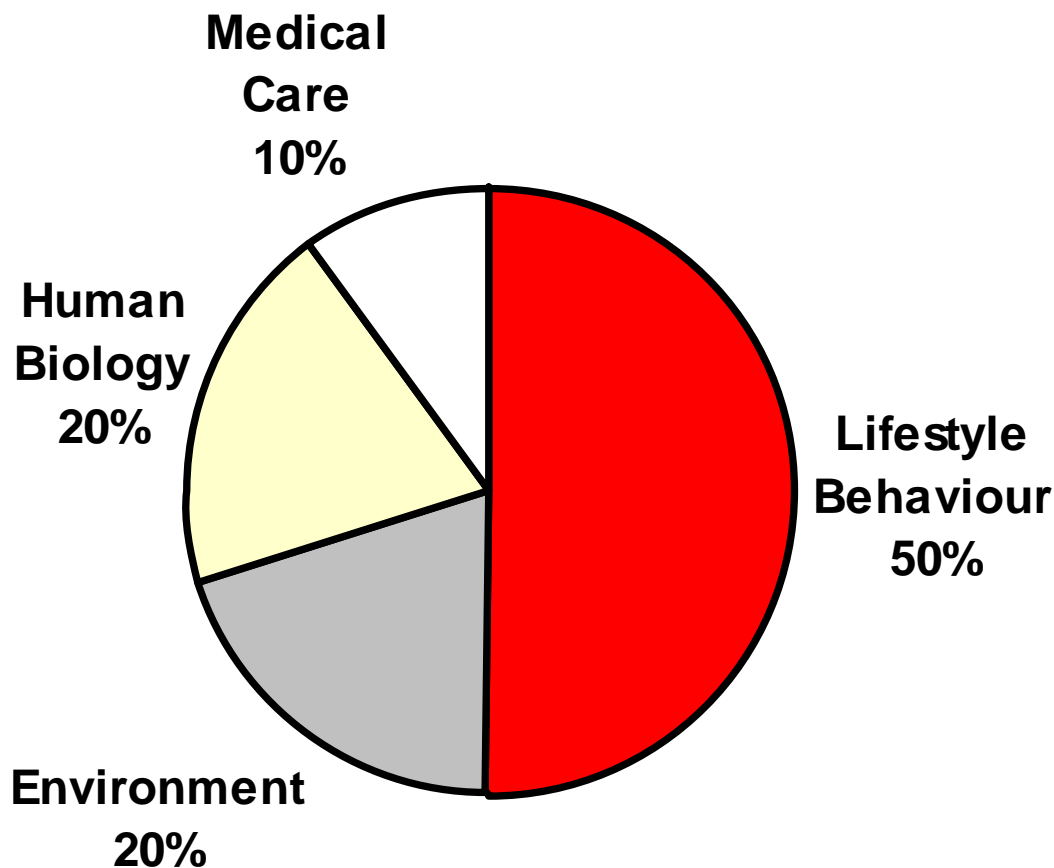
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Now is the Time for Alignment

- Increasing Pressure from Increasing Costs for Health Care (responsible for 10% of the health of the population)
- Affordable Care Act
 - Changes to community benefits
 - Public Health Trust Fund
- Major changes to the delivery system
 - Accountable Care Organizations (ACO)
 - Patient Centered Medical Homes (PCMH)
- DHHS Prevention Plan & Healthy People 2020 Goals

Relative Impact of Factors Determining Health Status in the US



Source: Healthy People 2010, U.S. Department of Health and Human Services

“Triple Aim”

- Better **quality care** for individuals, described by the six dimensions of health care performance listed in the Institute of Medicine’s 2001 report “Crossing the Quality Chasm”: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.
- Better **health for populations**, though attacking “the upstream causes of so much of our ill health,” such as poor nutrition, physical inactivity, and substance abuse.
- **Reducing per-capita costs**

(Don Berwick & IHI)

Population Health

- In the era of Affordable Care Act (ACA) and Accountable Care Organizations (ACOs) the construct of population health is on the agenda nationally
- Population health connotes a high level assessment of a group of people. This epidemiologic framework is often in direct opposition to the manner in which the health care system has cared for patients; one individual at a time.

Definitions of Population Health

- **Population served by an individual provider or payer**
 - Insuring that patients are assigned correctly to PCP
- **Population served by the entire delivery system**
 - Primary care patients
- **Population residing in the broader community**
 - Geographic area, membership in a category of persons that share specific attributes

Accountable Care Organization

- Integrated strategy of delivery system to payment reform
- Manage population of patients under global payment across primary and hospital care
- Example definition: An ACO is a recognized legal entity under State law and comprised of a group of ACO participants (providers of services and suppliers) that have established a mechanism for shared governance and work together to coordinate care for Medicare fee-for-service beneficiaries. ACOs enter into a 3-year agreement with CMS to be accountable for the quality, cost, and overall care of traditional fee-for-service Medicare beneficiaries who may be assigned to it. (CMS Proposed Regulations)



Patient-Centered Medical Home

- Transforming primary care
 - To deliver “patient-centered” care
 - To address the whole patient, including their health and social needs
- Medicaid grants used to support movement to PCMH
- Accreditation process certifies levels of PCMH

Leading Causes of Premature Death Associated with 4 Behaviors

- Smoking
- Unhealthy diet
- Physical inactivity
- Risky alcohol use



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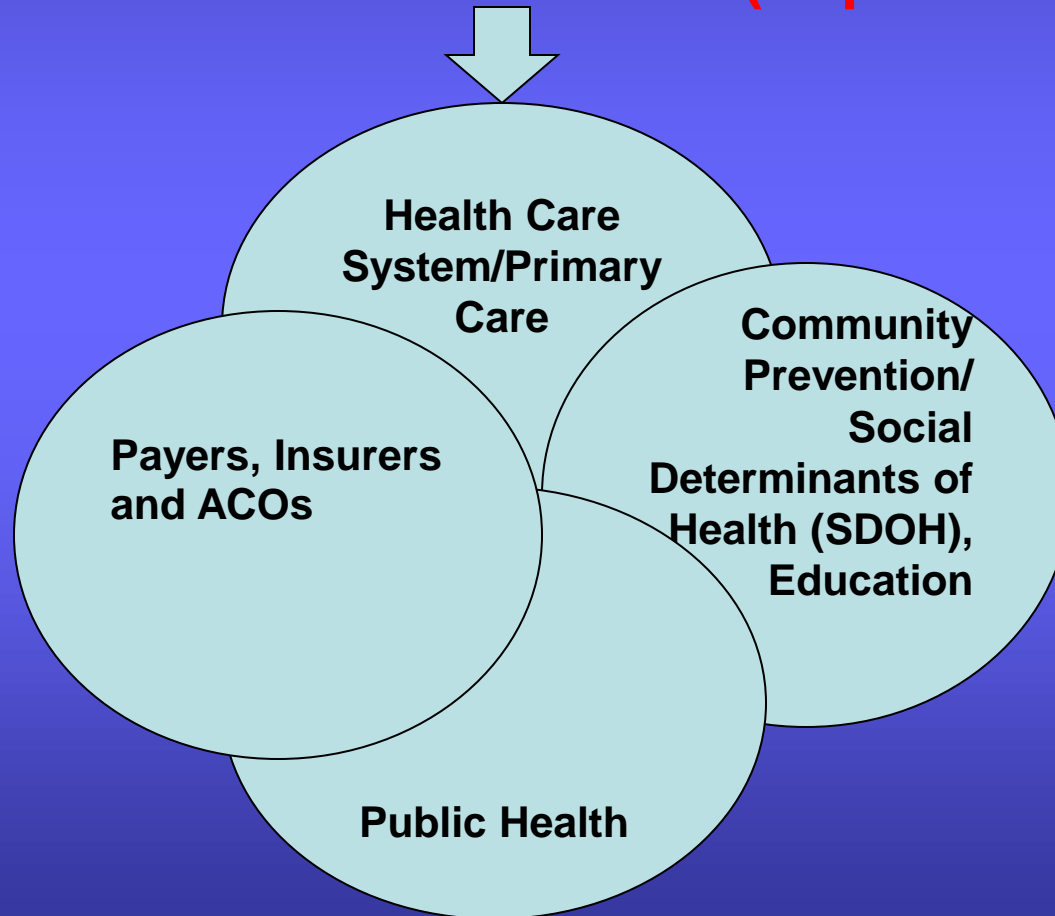


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We Believe Improving Population Health Outcome Depends on Transforming the Health System to Coordinate and Integrate Primary Care, Public Health and Community Preventative Efforts

Improved Population Health, Health Outcomes & Lower Costs (Triple Aim)



Oregon's Transformation Building Blocks

Benefits and services are integrated and coordinated

One global budget that grows at a fixed rate

Metrics: standards for safe and effective care

Local accountability for health and budget

Local flexibility



Oregon Chose a New Way

- Governor's vision
- Robust public process
 - 76 public meetings, 8 cities, 4 workgroups with every aspect of the Delivery system represented
- Bi-partisan support
 - D and R's
- Federal waiver approved - \$1.9B
 - Lower per capita costs by 2% points
- 16 new CCOs certified and launched (covers the entire state)
- State Innovation Model Grant \$45M (over 42 months)

Coordinated Care Organizations

- Serve Oregon Health Plan (Medicaid) members
- Must have a Consumer and Community Advisory Board
- Coordinated mental, physical health care and dental health
- Global budget – “All in”
- Designed to encourage wellness, not just treat illness
- Prevention, chronic disease management, community health workers, SES indicators i.e. housing
- Improve and change the model of care delivery
- Outcomes must show progress in achieving equity and the use of incentives to address disparities

Governor's Charge 6/3/13

To the Health Policy Board:

“Create the environment for commercial market place in Oregon that is characterized by our models of coordinated care and growth rate of total health care expenditures that are reasonable and predictive.”

Governor John Kitzhaber



Differing Views of Population Health

- Health Care (Clinical View)
 - Panel of patients
 - High risk patients
 - Patients with specific conditions or utilization
- Public Health View
 - Defined by geography
 - Indicators are community indicators
 - Population within geography may change over time

Attributes of CCO and ACO Systems of Care

Best Practices to Manage and Coordinate Care

- Single point of accountability
- Patient and family-centered care
- **Team-based care that crosses appropriate disciplines**
- Plans for managing care for 20% of population driving 80% of costs
- **Plans for prevention and wellness, including addressing disparities among population served**
- **Broad adoption and use of electronic health records**

Attributes of CCO and ACO Systems of Care cont.

Sharing Responsibility for Health

- Shared decision-making for care among patients and providers
- **Consumer/patient education and accountability strategies**
- Consumer/patient responsibility for personal health behaviors

Measuring Performance

- **Demonstrated understanding of population served**
- **Quality, cost and access metrics**
- **Strategies for targets and improvement**

Attributes of CCO and ACO Systems of Care cont.

Paying for Outcomes and Health

- Payments aligned to outcomes not volume
- **Incentives for prevention and improved care of chronic illness**

Providing Information

- **Readily available, accurate, reliable and understandable cost and quality data**
- Price and value for payers, providers and patients

Sustainable Rate of Growth

- Focused on preventing cost shifts to employers, individuals and families
- Reduced utilization and cost trend



Examples of early efforts to integrate outcomes and funding for populations for public health and clinical interventions



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Multnomah County Diabetes

Prevention through Care

Multnomah County adult population Interventions at the Intersections with other sectors 584,651	Multnomah County adults at high risk for diabetes 323,312	Adults diagnosed with diabetes 35,079	Privately insured adults 23,324	Insured receiving care 20,992
			Adults on OHP/ Medicaid 6,388	OHP/Medicaid receiving care 5,749
			Uninsured/ self pay adults 5,367	Uninsured adults receiving care 4,830



Multnomah County Diabetes Prevention through Care

Multnomah County total adult population

584,651

Primary Prevention

Individual-level:

Health education

Health Literacy

Community-level:

Healthy Retail Initiative

School-based healthy eating

Safe routes to school

Policy-level:

Health considered in built environment decisions

Health Impact Assessments



Multnomah County Diabetes Prevention through Care

Multnomah County adults at high
risk for diabetes

323,312

Primary Prevention

Individual-level:

Health education

Health Literacy

Community-level:

Healthy Retail Initiative

School-based healthy eating

Safe routes to school

Policy-level:

Health considered in built environment decisions

Health Impact Assessments

Secondary Prevention

Individual-level

Health education

Health screening

Community & Policy levels

Same as for primary prev.



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Multnomah County Diabetes Prevention through Care

Adults diagnosed with diabetes

35,079

Privately insured adults

23,324

Insured receiving care

20,992

Adults on OHP/ Medicaid

6,388

**OHP/Medicaid receiving
care**

5,749

Uninsured/self pay adults

5,367

**Uninsured adults
receiving care**

4,830

Tertiary Prevention

Individual level

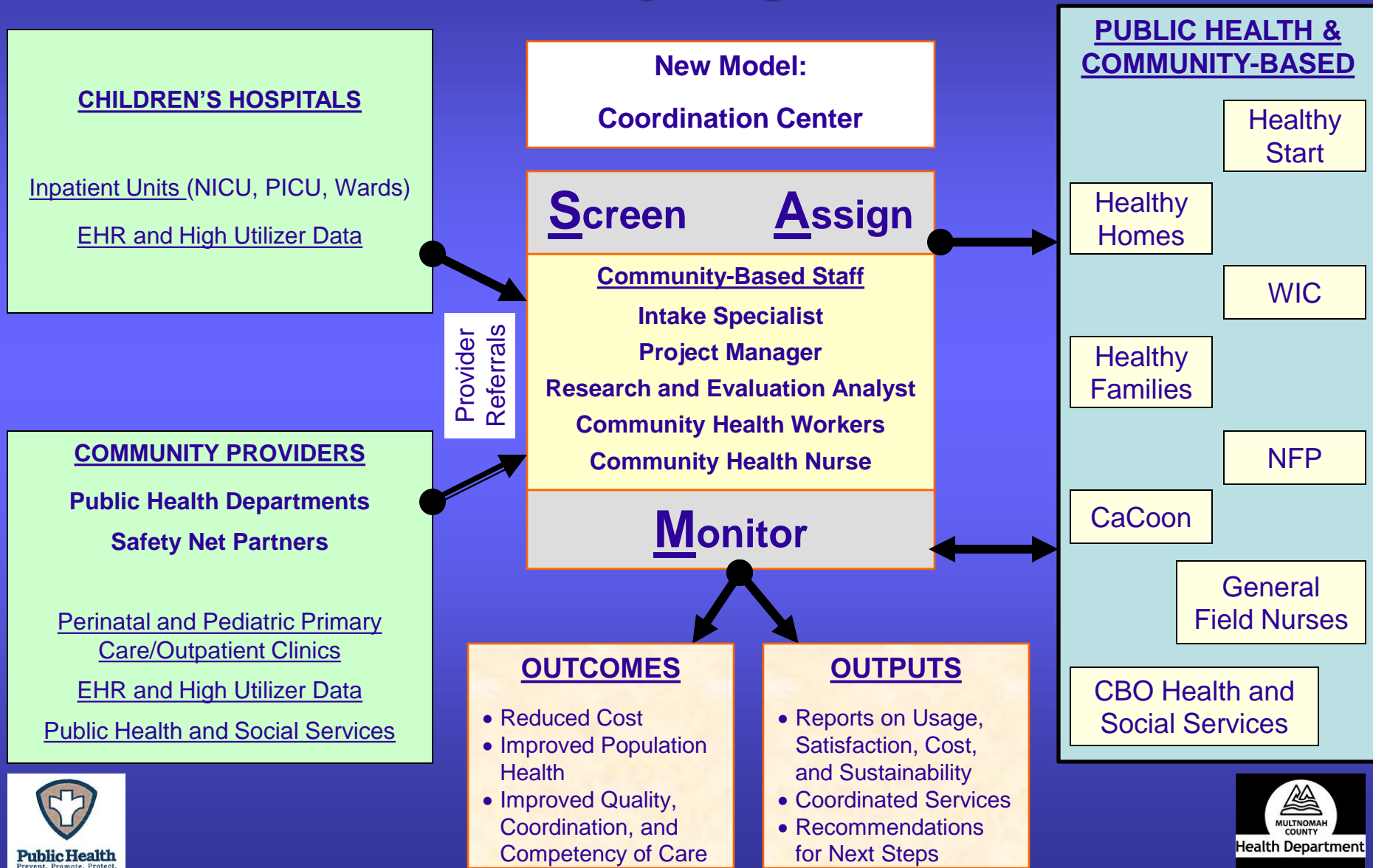
Chronic disease self-management
education

Medical Homes for Diabetes Care &
Case Management

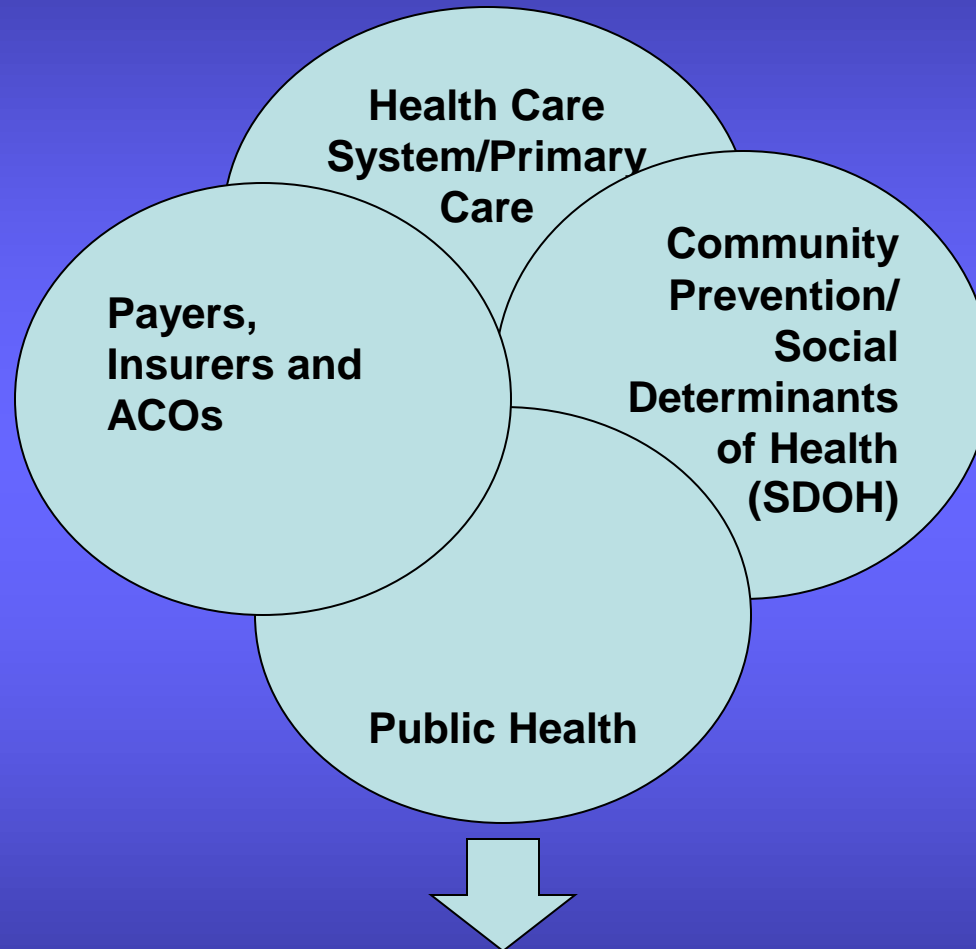


Achieving TRIPLE AIM

Pilot for Medically High Risk Children

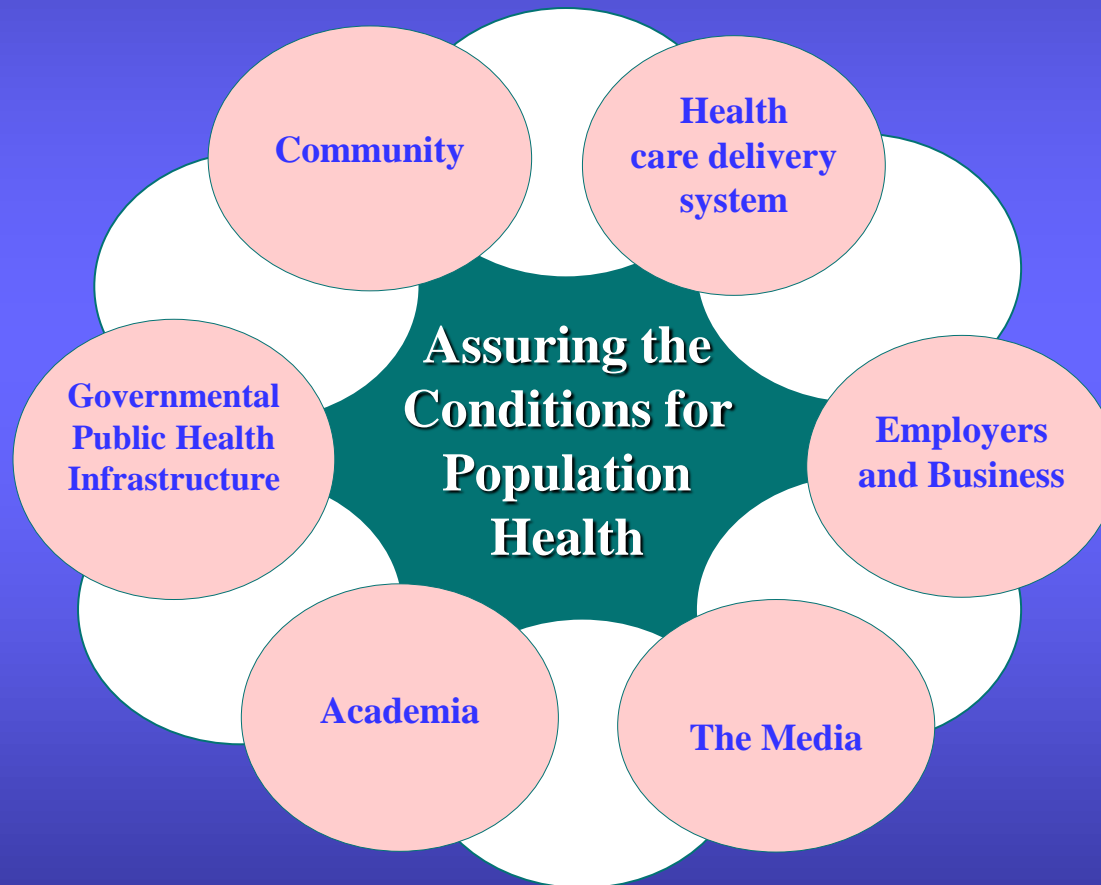


Leading Causes of Death Liver Disease: Tied for 9th

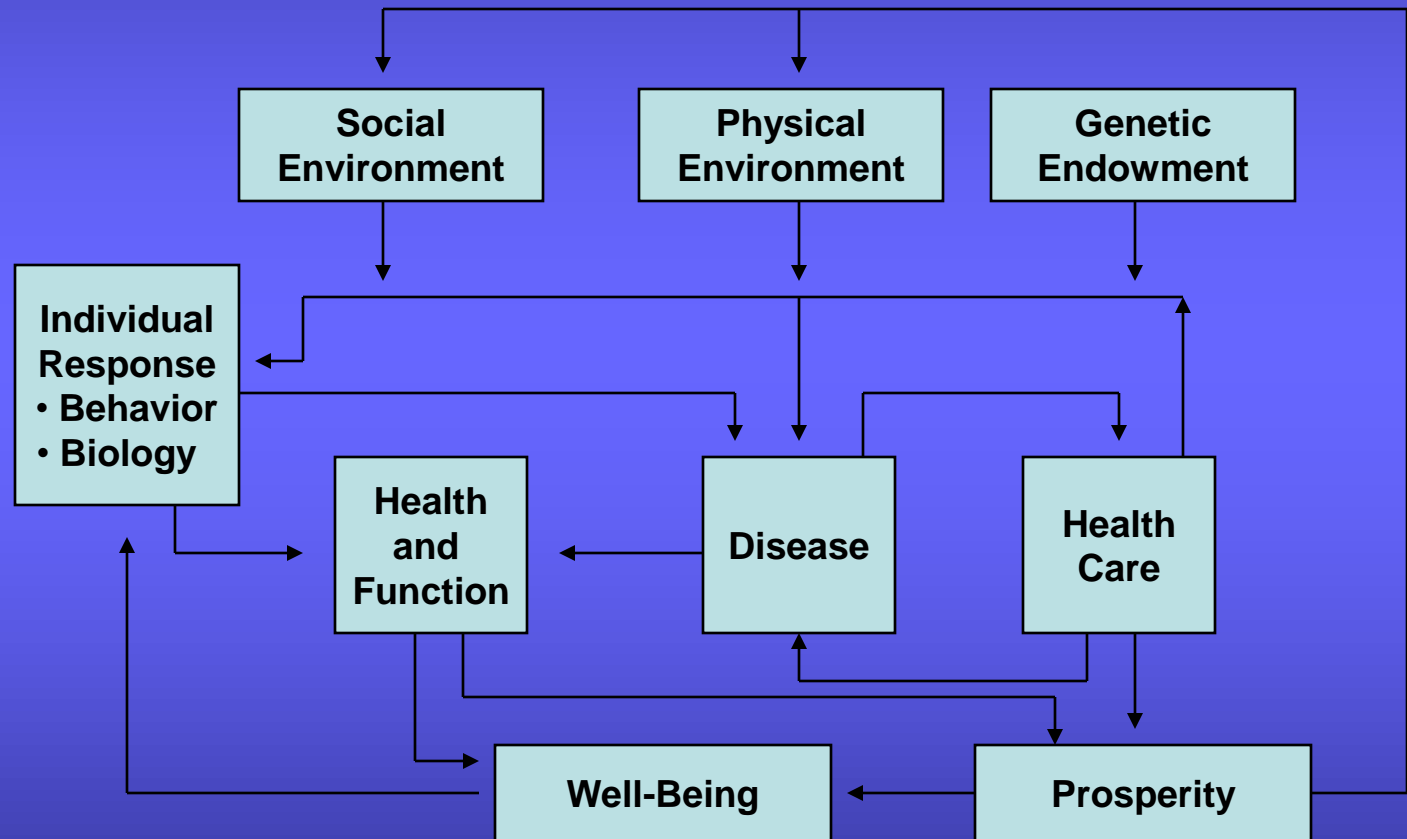


Improved Population Health, Health Outcomes & Lower Costs (Triple Aim)

The Public Health System



A Model of the Determinants of Health



Source: R.G. Evans and G.L. Stoddart, 1990. *Social Science and Medicine* 31:1347-1363; used with permission from Elsevier Science



Changing Behavior is Hard

- Need a multi-sector, multi-component approach
- No one intervention in a single sector will produce lasting behavior change
- Need consistent reminders and messages, including use of social media
- Need a shared accountability approach from all sectors
- Need to consider social determinants of health
- Need data for ongoing monitoring and improvement

Population Health Synergy

- Population defined by geography or a community (e.g., city, county, regional, state or national levels)
- The more the overlap of the ACO/CCO panel and the community population, the more both the panel's health and the community population's health will be impacted by the actions of each

What ACO/CCO's Can Do

- Determine in which geographic communities patients reside and what the overlap is between the ACO panel and the community population
- Compare the health of the population served by the ACO with that of the community
- Decide what level of overlap in any geographic area merits collaboration.
- Engage in collaboration with public health and key community agencies,

What ACO/CCO's Can Do

- Collaboratively select health outcomes for focus
- Set up a formal agreement with the public health authorities to share data and monitor progress toward goals in clinical and community settings
- Identify population health indicators to be included on the ACO dashboard
- Use a portion of global payment fee to support community public health activities

Hacker, K., & Walker, D.K. (2013). Achieving population health in accountable care organizations. *American Journal of Public Health*, 103 (7), 1163-7.



What Public Health Can Do

- Meet and align with health delivery systems
- Provide the following in collaboration
 - Collect and provide data at the community level
 - Know, effective, scalable interventions with potential large impact on population health
- Participate in collective and focused efforts
 - Identify optimal strategies at all levels across all sectors
 - Rally resources and partnerships
 - Communicate about successes/challenges along the way
 - Accelerate efforts to make measurable impact on health

Tobacco Cessation Strategies

PUBLIC/COMMUNITY HEALTH

- Smoke Free Restaurants and Bars
- Tobacco-free Hospital Campus
- Non-Smoking Parks
- Smoke Free Public Housing

DELIVERY SYSTEM & PAYERS

- Tobacco as vital sign
- Assessment and Education Inpatient
- Mapping Smokers
- Work with Housing Authority
- Tobacco Cessation Programs

The Road Ahead



Clinical Care Public Health Integration Can Be Built If Everyone Comes Together



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Cast the Net Widely



- Partner and Collaborate across Clinical, Community and Public Health Settings
- Advocate and Share Accountability for Population Health

But It's About the People



Thank you!

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