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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Vice Chair, Oregon Health Policy Board
“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
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

Medical Care: 10%
Human Biology: 20%
Environment: 20%
Lifestyle Behaviour: 50%

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
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)

Health Care System/Primary Care

Community Prevention/Social Determinants of Health (SDOH), Education

Payers, Insurers and ACOs

Public Health

Thanks to TFAH & California Endowment & Kresge Foundation
## Oregon’s Transformation

### Building Blocks

<table>
<thead>
<tr>
<th>Benefits and services are integrated and coordinated</th>
<th>One global budget that grows at a fixed rate</th>
<th>Metrics: standards for safe and effective care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local accountability for health and budget</td>
<td>Local flexibility</td>
<td></td>
</tr>
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</table>
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
### Multnomah County Diabetes Prevention through Care

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
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<tr>
<td>Multnomah County adult population</td>
<td>584,651</td>
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<td>Interventions at the Intersections with other sectors</td>
<td>323,312</td>
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<td>Adults diagnosed with diabetes</td>
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<td>Privately insured adults</td>
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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**

**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.

**Multnomah County adults at high risk for diabetes**
- 323,312
Multnomah County Diabetes
Prevention through Care

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**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

CHILDREN’S HOSPITALS
- Inpatient Units (NICU, PICU, Wards)
- EHR and High Utilizer Data

COMMUNITY PROVIDERS
- Public Health Departments
- Safety Net Partners
- Perinatal and Pediatric Primary Care/Outpatient Clinics
- EHR and High Utilizer Data
- Public Health and Social Services

New Model: Coordination Center
- Community-Based Staff
  - Intake Specialist
  - Project Manager
  - Research and Evaluation Analyst
  - Community Health Workers
  - Community Health Nurse

Screen Assign Monitor

OUTCOMES
- Reduced Cost
- Improved Population Health
- Improved Quality, Coordination, and Competency of Care

OUTPUTS
- Reports on Usage, Satisfaction, Cost, and Sustainability
- Coordinated Services
- Recommendations for Next Steps

PUBLIC HEALTH & COMMUNITY-BASED
- Healthy Start
- Healthy Homes
- WIC
- Healthy Families
- NFP
- CaCoon
- General Field Nurses
- CBO Health and Social Services
Leading Causes of Death
Liver Disease: Tied for 9th

Health Care System/Primary Care
Community Prevention/ Social Determinants of Health (SDOH)
Payers, Insurers and ACOs
Public Health

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

Assuring the Conditions for Population Health

- Community
- Health care delivery system
- Governmental Public Health Infrastructure
- Employers and Business
- Academia
- The Media
A Model of the Determinants of Health

Social Environment

Physical Environment

Genetic Endowment

Individual Response
- Behavior
- Biology

Health and Function

Disease

Health Care

Well-Being

Prosperity

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 population

• 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

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
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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