Moving From Acute and Ambulatory Care To Population Health Management

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Medical Director, Health initiatives
National Jewish Health
What does population health mean?

Triple Aim
- improve population health
- reduce cost of care
- enhance patient care experience
Another Way To Look At Population Health

Value Based Care

For patients, this means safe, appropriate, and effective care with enduring results, at reasonable cost.

For providers of care, it means employing evidence-based medicine and proven treatments and techniques that take into account the patients’ wishes and preferences and is provided in a cost effective manner.

For BOTH it also means a good way of assessing value through measurement, both in the short term and over time.

Dartmouth-Hitchcock 2016
What Is The Difference Between FFS and Population Health

**FFS**
- Episodic Care
- Payment for care delivered
- Little emphasis on Prevention
- Deals with small numbers
- Small emphasis on behavioral change
- Rewards to Providers

**Population Health**
- Episodic Care
- Risk payment across population
- Major emphasis on Prevention
- Deals with entire population at risk. Involves the “community”
- Major emphasis on behavioral change
- Rewards to Providers AND Participants
Using Population Health Approach to Deal with a Population Health Problem

OBESITY
Is Obesity Treatment Possible?

90% of physicians believe patients can’t lose weight by changing diet and activity

“How easy or difficult do you think it would be for your overweight and obese patients to lower their weight by eating healthier foods and getting more physical activity? Do you think for the majority of your overweight/obese patients this is going to be …

Healthcare costs associated with obesity now exceed those associated with smoking

#1 Obesity
Type 2 diabetes
Coronary heart disease and stroke
Respiratory disease
Hypertension
Arthritis
Obesity-related cancers

#2 Smoking
Coronary heart disease and stroke
Chronic obstructive lung diseases
Lung cancer
Other smoking-related cancers

It Is NOT Easy

- Chronic disease care accounts for 80% of healthcare spending
- Four modifiable risk factors account for the majority of chronic disease: tobacco use, poor diet, lack of physical activity, stress
- Addressing these risk factors requires helping people to make lifestyle changes that produce sustainable results
- To succeed we have to change a lot of what we do as health care professionals to be successful addressing lifestyle issues
- Physicians are not the right resource to counsel patients on behavior change, but be the key player for Ask - Advise - Refer - Prescribe interventions
- Sustainable programs must be developed to provide solutions for implementing population health management programs for the top drivers of chronic disease and medical costs
- Programs and systems have to be developed to reach the maximum number of people that are scientifically proven, cost-effective and financially sustainable
How to get ahead of the chronic care curve?

4 modifiable risk factors account for the majority of chronic disease and leading causes of death:
- tobacco use
- poor nutrition
- lack of physical activity
- stress

Move patients to the left on risk curve (1° and 2° prevention)
Reduce risk factors through lifestyle counseling and community activism

PATIENT / MEMBER POPULATION

Healthy 26%
Low Risk 48%
Rising Risk 21%
High Risk 5%

COMMUNITY POPULATION

Healthy / Low Risk
Encourage 1° prevention programs (self-guided)
Offer 2° prevention programs (lifestyle modification counseling)
Promote social engagement

Rising Risk
Offer 2° prevention programs (lifestyle modification counseling)
Promote social engagement
Provide coordinated case management services

High Risk
Deliver episodic care

Community
Support community-based interventions to address modifiable risk factors:
- cooking / nutrition classes
- grocery shopping
- food banks / food assistance
- community food gardens
- fitness / wellness classes
- school programs
Population Management Addresses the Major Risk Factors For Chronic Disease

Major modifiable risk factors for the top chronic conditions:

<table>
<thead>
<tr>
<th>LIFESTYLE RISK FACTORS</th>
<th>Obesity</th>
<th>Hypertension</th>
<th>Hyperlipidemia</th>
<th>Mental Health</th>
<th>Allergies &amp; UR</th>
<th>Arthritis</th>
<th>Diabetes</th>
<th>Asthma</th>
<th>CAD</th>
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</thead>
<tbody>
<tr>
<td>poor diet</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>being overweight</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>lack of physical activity</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>tobacco use</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>stress</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>alcohol abuse</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>tobacco smoke exposure</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>lack of medication adherence</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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</tr>
</tbody>
</table>
Common elements of population health

- Stratify patients
- Address lifestyle
- Engage and empower
- Coordinate care

- Measure outcomes
- Use health technology
- Provide actionable info
- Seek value-based pay
Common Elements of Population Health

**stratify and manage patients**
- by number of chronic conditions
- by modifiable risk factors
- by demographic group
- by attitudes toward health

**engage and empower patients**
- communicate with patients (patient portal, email)
- use shared decision-making tools
- Create financial incentives
- tailor interventions to individual (personalized treatment, precision medicine)

**address lifestyle to get ahead of chronic care curve**
- reminders for screening / preventive services
- provide resources for lifestyle modification
- monitor patient adherence (treatment, medication)
- address barriers: home, travel, community, $

**measure outcomes**
- quality of care
- patient satisfaction
- clinical team satisfaction
- population prevalence

**coordinate and distribute care**
- primary care physician as “conductor” of care team
- leverage physician extenders and community based resources
- funnel to least expensive option (outcomes-based)

**use health technology**
- share records electronically (interoperability)
- aggregate clinical, financial and other patient data across settings and time
- encourage use of health apps
- expand clinical picture (wearable devices)

**provide actionable intelligence**
- patient alerts and reminders based on triggers
- real time health alerts to manage chronic care
- predictive analytics to identify specific patients
- prescriptive analytics to guide treatment decisions

**use value-based payment models**
- bundled payments
- managed care (eg, Medicare Advantage)
- accountable care organizations
- direct employer contracting
Stratify interventions by chronic disease or risk factors

4 modifiable risk factors account for the majority of chronic disease and leading causes of death

- tobacco use
- poor nutrition
- lack of physical activity
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<th>High Risk 5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy / Low Risk</td>
<td>Healthy patients have no chronic conditions or risk factors</td>
<td>Low risk patients have 1 chronic condition or risk factor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rising Risk</td>
<td>Rising risk individuals have 2 to 3 chronic conditions or risk factors for chronic disease</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>High Risk</td>
<td>High risk individuals have at least one complex illness and 4 or more chronic conditions</td>
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Community

Catalogue prevalence of chronic conditions and risk factors by demographic subgroup in target communities
Why Do All Of This?

“The goal is to minimize expensive and duplicative interventions (emergency department visits, hospitalizations and tests) by managing health problems at the least expensive point of care.”
Who is Responsible for Providing Preventive Care?

“This continuum-of-care approach requires that providers establish and maintain contact with patients, and support their efforts to manage their own health.”

IS THIS REALISTIC?
Who is Responsible for Providing Preventive Care?

Primary Care: Is There Enough Time for Prevention?

Kimberly S. H. Yarnall, MD, Kathryn I. Pollak, PhD, Truls Østbye, MD, PhD, Katrina M. Krause, MA, and J. Lloyd Michener, MD

Objectives. We sought to determine the amount of time required for a primary care physician to provide recommended preventive services to an average patient panel.

Methods. We used published and estimated times per service to determine the physician time required to provide all services recommended by the US Preventive Services Task Force (USPSTF), at the recommended frequency, to a patient panel of 2500 with an age and sex distribution similar to that of the US population.

Results. To fully satisfy the USPSTF recommendations, 1773 hours of a physician’s annual time, or 7.4 hours per working day, is needed for the provision of preventive services.

Conclusions. Time constraints limit the ability of physicians to comply with preventive services recommendations. (Am J Public Health. 2003;93:635–641)

Common barriers identified to lack of prevention services:
✓ lack of time during the office visit
✓ inadequate insurance reimbursement
✓ patient refusal to discuss or comply with recommendations
✓ lack of physician expertise in counseling techniques
Reallocation Resources is Key To Maximize the Cost and Effectiveness of Care

The Case for MCOs and Patient Centered Medical Homes

Comprehensive care from prevention to episodic care across large populations

Focus is on the Patient and the family, primarily for care and prevention of chronic disease

The organization is responsible for coordinating care across all related parties and organizations

Services and care are accessible through a variety of resources 24/7

Commitment to quality and safety
Comprehensive care from prevention to episodic care across large populations: Providing comprehensive care requires a team of care providers. This team might include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators.

Focus is on the Patient and the family: The central practice actively supports patients in learning to manage and organize their own care at the level the patient chooses. Integrating the family into this is critical.

The organization is responsible for coordinating care across all related parties and organizations: The primary care medical home coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports.
Services and care are accessible through a variety of resources 24/7: The organization delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as email and telephone care.
How do our obesity programs address the risk continuum?

PATIENT / MEMBER POPULATION

Healthy 26%
Low Risk 48%
Rising Risk 21%
High Risk 5%

COMMUNITY POPULATION

Healthy / Low Risk
Get ahead of the chronic care curve by promoting healthy behaviors and addressing any risk factors for chronic disease

Rising Risk
Address risk factors for chronic disease to keep patients from becoming high risk or using acute services

High Risk
Trade high cost acute care for less costly services where clinically effective and feasible

Community
Reach outside the healthcare system to sponsor primary and secondary prevention programs.
Moving from FFS (96%) to Population Management (4%)

Requires

1. A new way of thinking: From Episodic Care to Prevention
2. Resources to deliver preventive care that is behaviorally related and cost effective
3. Resources to gather data across the population on the effectiveness of the preventative interventions
4. Systems in place to recognize positive behavior and reward prevention activities by both Providers and Population
5. Willingness to invest in prevention that takes time to realize an ROI
6. Commitment and buy-in from the top to the bottom: A new culture.
At Risk Population
Integration into health decision process
Prevention becomes part of daily life decision-making
Access to information and care shared across multiple modalities
Has to be relatively easy to make these changes

Provider Community
Needs to want to change
Gradual change in care delivery process
Be an integrated part of decision team
Develop recognition and reward policies that are meaningful and effective
Have reliable data collection and reporting
Moving From Acute and Ambulatory Care To Population Health Management

Moving from Episodic Care to Prevention AND Episodic Care