IMPROVNG HEALTH BEYOND CLINICAL EXCELLENCE:
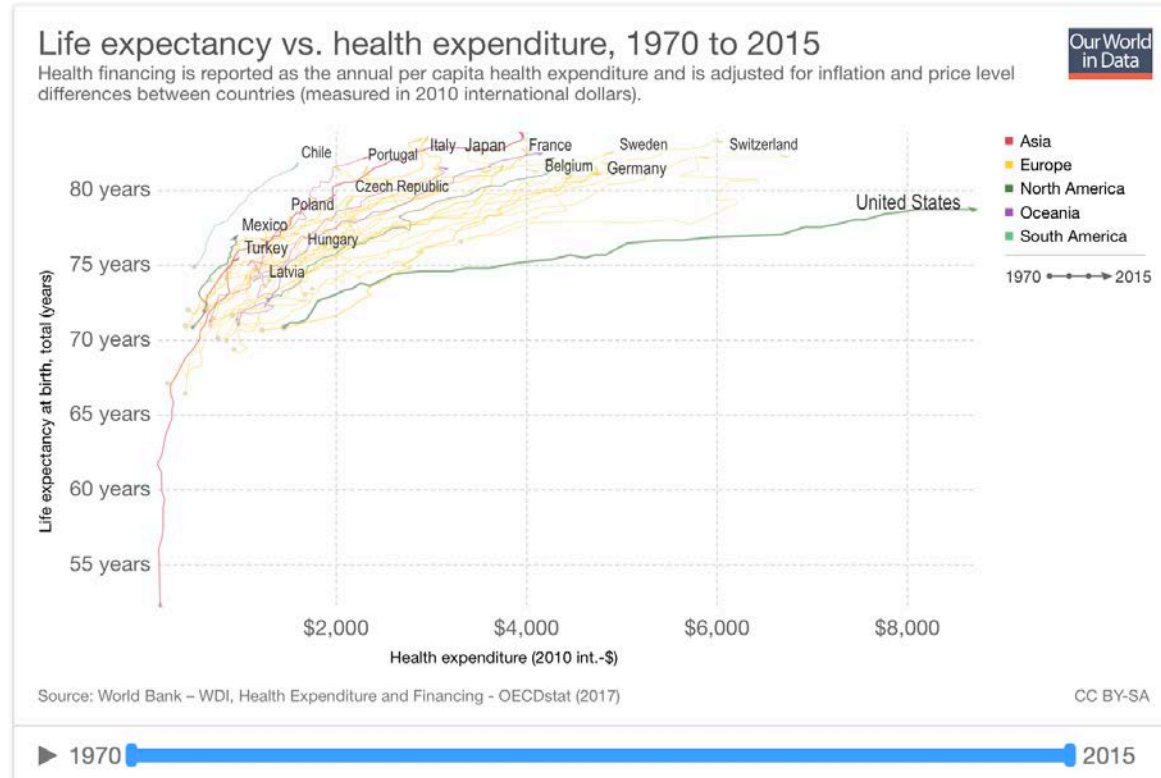
THE NEXT GENERATION OF VALUE BASED CARE

Karen B. DeSalvo, MD, MPH, MSc
September 27, 2018

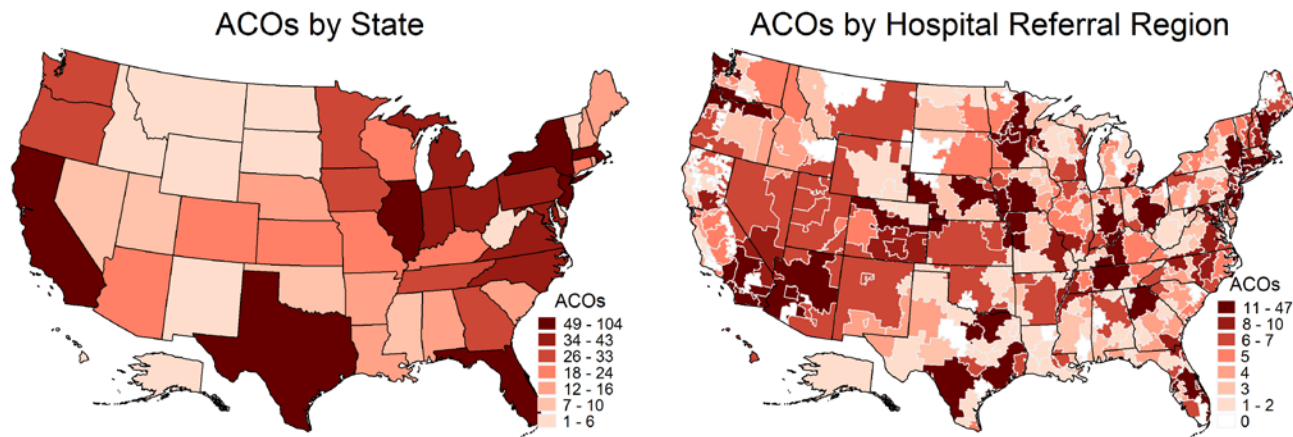# OUR PROBLEM TO SOLVE

Life expectancy vs. health expenditure, 1970 to 2015

BETTER HEALTH CARE

- Move to value

- Public-private sector effort
  - Set goals for Medicare

- Significant Progress
  - Bent the cost curve
  - Quality and safety improved
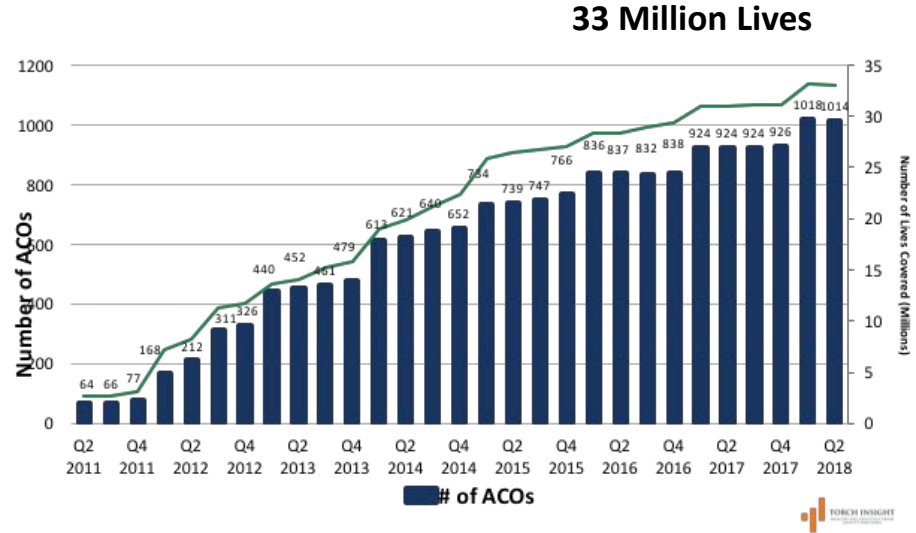 - Patient experience improved
  - Digital transformation

Fryhofer SL, Seshmani M, DeSalvo KB, Conway PH. "Progress and a Path Forward". N Engl J of Med Catalyst. 2017

BROADLY DISTRIBUTED

ACOs by State

ACOs by Hospital Referral Region

ACOs
49 - 104
34 - 43
26 - 33
18 - 24
12 - 16
7 - 10
1 - 6

ACOs
11 - 47
8 - 10
6 - 7
5
4
3
1 - 2
0

TORCH INSIGHT
HEALTHCARE ANALYTICS FROM
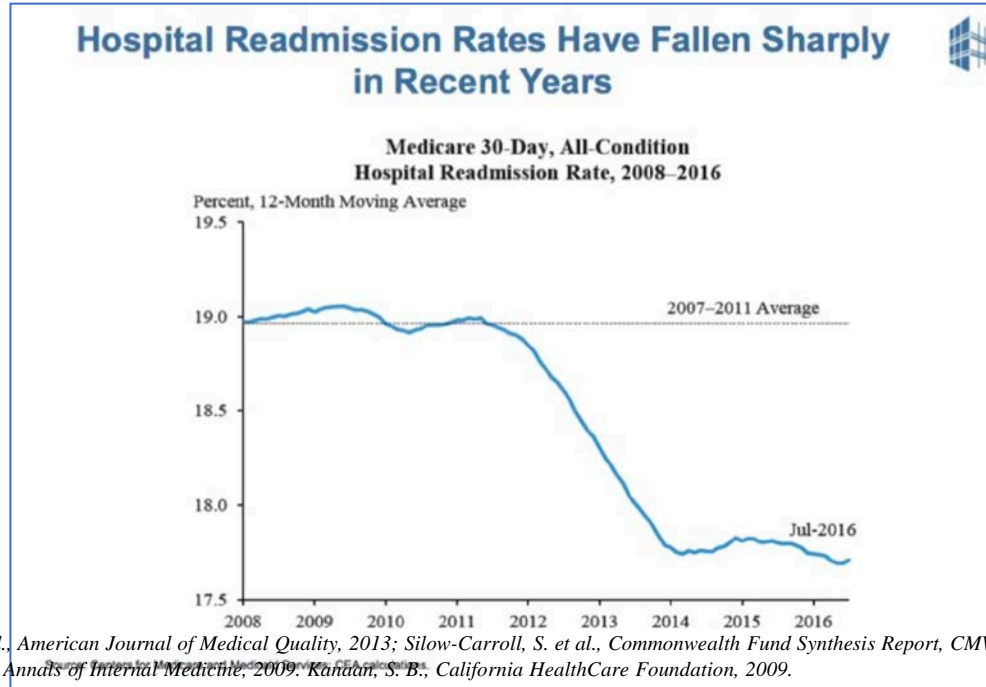LEAVITT PARTNERS

Source: *Leavitt Partners Center for Accountable Care Intelligence*

ONGOING MOVEMENT TO VALUE

- Private sector
- Current Administration
- Congress
- Budgetary pressure
 - Federal outlays
  - State opportunity

33 Million Lives

LIMITS TO OUR PROGRESS

Hospital Readmission Rates Have Fallen Sharply in Recent Years

Medicare 30-Day, All-Condition Hospital Readmission Rate, 2008–2016

Percent, 12-Month Moving Average

2007–2011 Average

Jul-2016

Ahmad, F. S. et al., American Journal of Medical Quality, 2013; Silow-Carroll, S. et al., Commonwealth Fund Synthesis Report, CMWF, 2011; Jack, B. W. et al., Annals of Internal Medicine, 2009. Kanaan, S. B., California HealthCare Foundation, 2009.
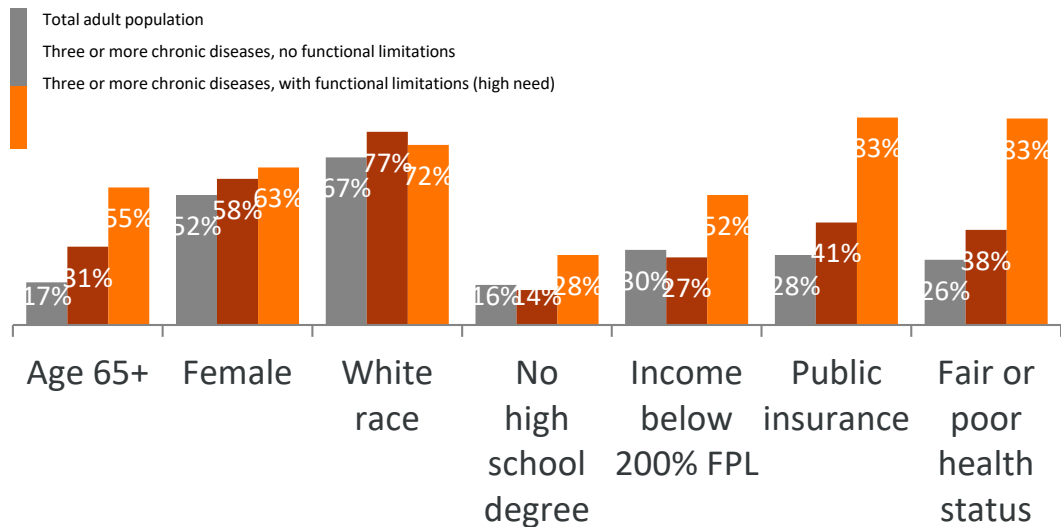
COSTS CONCENTRATED IN A FEW

Distribution of health expenditures for the U.S. population, by magnitude of expenditure, 2013

Population **Share of Health Spending**

1%
5%
10%

50%

22%

49%

65%

97%
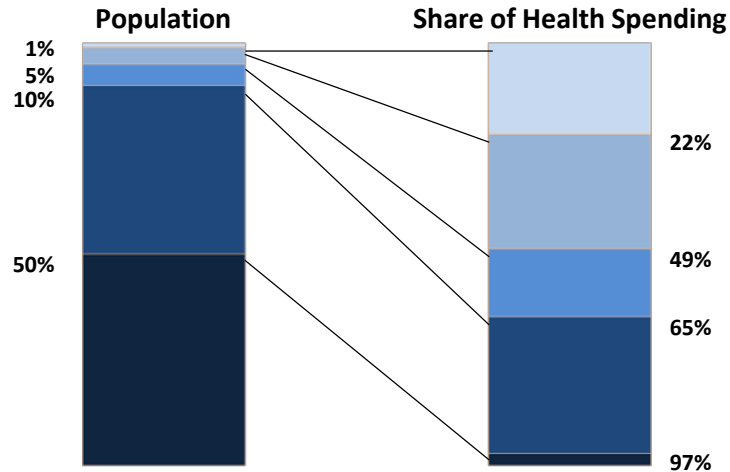
•*Agency for Healthcare Research and Quality analysis of 2013 Medical Expenditure Panel Survey; MEPS Statistical Brief 480.*

MEDICALLY & SOCIALLY COMPLEX

Total adult population

Three or more chronic diseases, no functional limitations

Three or more chronic diseases, with functional limitations (high need)

	Age 65+	Female	White race	No high school degree	Income below 200% FPL	Public insurance	Fair or poor health status
Total adult population	17%	52%	67%	16%	30%	28%	26%
Three or more chronic diseases, no functional limitations	31%	58%	77%	14%	27%	41%	38%
Three or more chronic diseases, with functional limitations (high need)	55%	63%	72%	28%	52%	83%	83%

Notes: Noninstitutionalized civilian population age 18 and older. Public insurance includes Medicare, Medicaid, or combination of both programs (dual eligible).
Data: 2009–2011 Medical Expenditure Panel Survey (MEPS). Analysis by C. A. Salzberg, Johns Hopkins University.
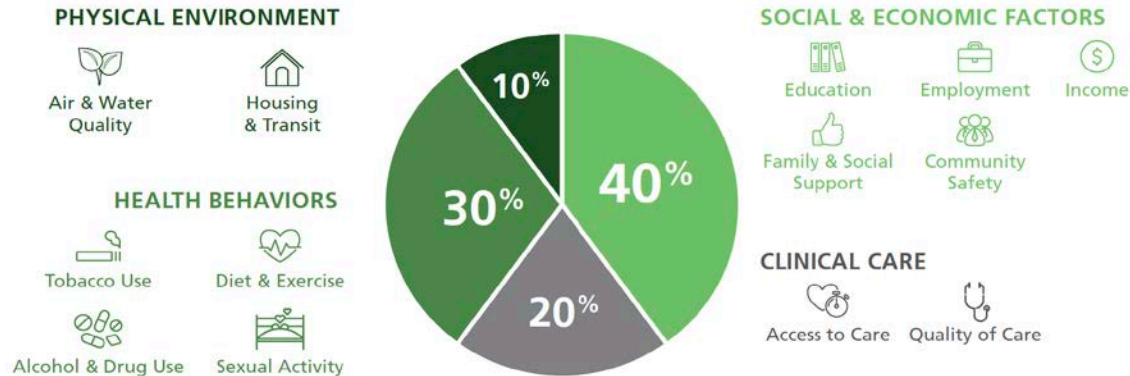
The COMMONWEALTH FUND

SOCIAL DETERMINANTS

"conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."
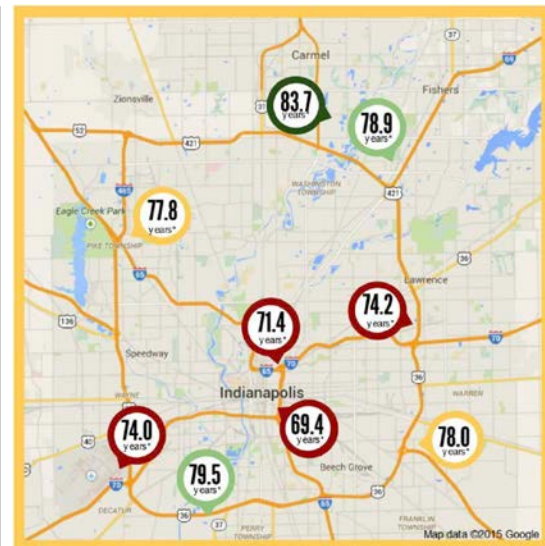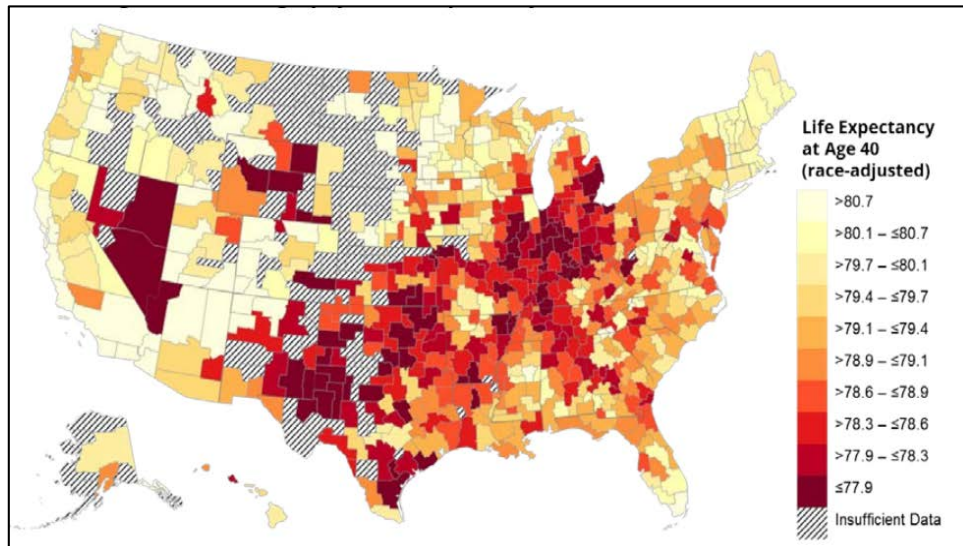- *Healthy People 2020*

healthypeople2020.gov; National Alliance to impact the Social Determinants of Health (NASDOH.ORG)

DEATHS OF DESPAIR

BROOKINGS NOW

Working class white Americans are now dying in middle age at faster rates than minority groups

Alison Burke · Thursday, March 23, 2017

BROOKINGS NOW

Our Zip Code Affects Our Health More Than Our Genetic Code...

Chetty et al. *JAMA* 2016;315(16):1750-1766; Weathers TD, et al (2015, July). *Worlds Apart: Gaps in Life Expectancy at www.savi.org.*

SOCIAL DETERMINANTS LINKED TO OUTCOMES

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	
Medical Bills	Playgrounds	Higher education			Quality of care
Support	Walkability				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Expectations.

READMISSION ↑	NON-ADHERENCE ↑	COST ↑

OUTCOMES ↓	SATISFACTION ↓	RISK ↑

FROM THE FIELD

HEALTH **BEYOND** CLINICAL EXCELLENCE

Health generators

Health care 20%

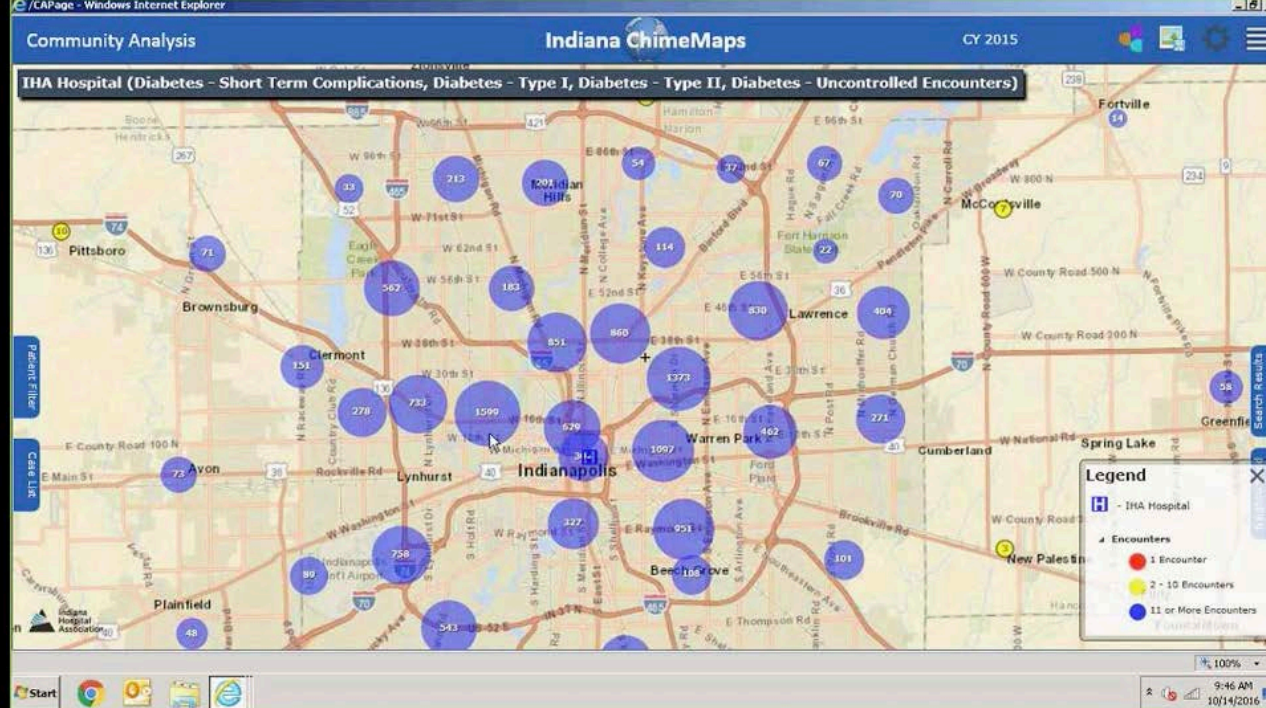Social, environmental, behavioral factors 60%

Genetics 20%
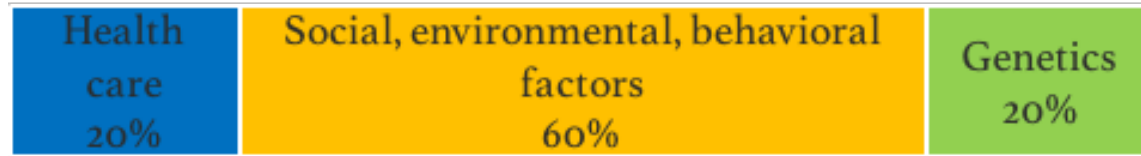
www.healthypeople2020.gov; Leavitt and DeSalvo, Modern Healthcare, 2017; adapted from James Rubin, TAVHealth

APPROACHES TO ADDRESSING SOCIAL DETERMINANTS

- *Focused on significant <u>health challenge</u>*

- *Focused on a <u>specific population</u>*

- *Focused on a specific <u>social determinant of health</u>*

STEPS TO ACTION

Identify Target Population

Identify Social Needs

Assess Community Resources

Develop Workflow to Support Referrals

Assess Impact

IDENTIFY TARGET POPULATION

iana ChimeMaps Demo

IDENTIFY SOCIAL NEEDS

- SDOH Assessment tools
  - Many now available
  - Most focused on "health-related social needs"

- Sample tools
  - PRAPARE
  - Center for Medicare and Medicaid Services
  - Many homegrown

Box 1 | Accountable Health Communities
Core Health-Related Social Needs Screening Questions

Underlined answer options indicate positive responses for the associated health-related social need.
A value greater than 10 when the numerical values for answers to questions 7-10 are summed indicates a positive screen for interpersonal safety.

Housing Instability

1. What is your housing situation today?
   - I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
   - I have housing today, but I am worried about losing housing in the future.
   - I have housing

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)
   - Bug infestation
   - Mold
   - Lead paint or pipes
   - Inadequate heat
   - Oven or stove not working
   - No or not working smoke detectors
   - Water leaks
   - None of the above

Food Insecurity

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.
   - Often true
   - Sometimes true
   - Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
   - Often true
   - Sometimes true
   - Never true

https://nam.edu/wp-content/uploads/2017/05/ Standardized-Screening-for-Health-Related-Social-Needs- in-Clinical-Settings.pdf.

- Leveraging clinical and claims data

- Scraping retail and other data

- Create social risk categories and scores

- Target action

Algorithms predict need for social determinants of health services

By
Greg Slabodkin

Published
February 22 2018, 6:42am EST

More in
Patient data
Healthcare delivery
EHR documentation
Data sharing
Mental health
Affordable housing

Print

Reprint

Algorithms developed by Indiana University-Purdue University Indianapolis and the Regenstrief Institute have been shown to accurately predict the need for social determinants of health (SDOH) service referrals among patients at a safety-net hospital by leveraging clinical and community-level data.

IUPUI and Regenstrief researchers utilized data from 48 socioeconomic and public health indicators to build the "random forest" decision models predicting the need for mental health, dietitian, social work and other SDOH service referrals for patients at Eskenazi Health in Indianapolis.

ASSESS RESOURCES

DIGITAL SUPPORTS

- Automating the process

- Linking to resources

- Closing the loop

- Generating data about met and unmet needs

- Creating opportunity to determine business case

STEPS TO ACTION

MOVING FURTHER UPSTREAM

CHANGING THE CONTEXT

- Go beyond addressing social determinants of <u>care</u>

- Change upstream <u>context</u> – social determinants of health

- Evolving levels of engagement:
    1. Refer to housing agency
    2. Pay for housing supportive services or Air-conditioner
    3. Build housing

- Anchor institution concept

*www.democracycollaborative.org; www.essentialhospitals.org; www.healthypeople2020.gov/ph3; DeSalvo K, Harris A.
"Bending the trends." Annals of Family Medicine, Jul/Aug 2017*
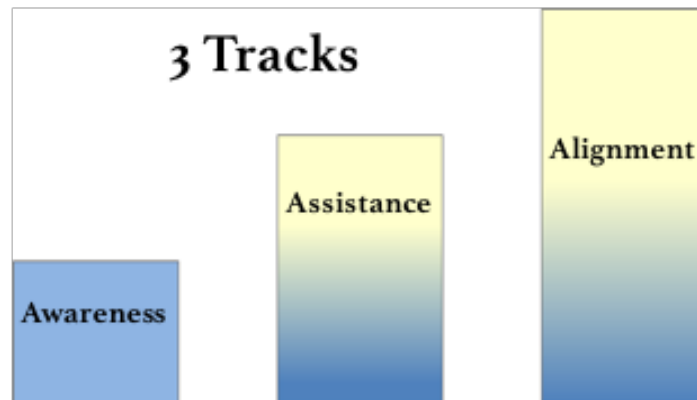
RESOURCES FOR ACTION

HOW WILL WE PAY FOR THIS?

FINANCING

- Philanthropy
- Community benefit
- Health care dollars
  - Private plans
  - Medicaid
  - Medicare

3 Tracks

Awareness

Assistance

Alignment

Track 2 Assistance – Provide community service navigation services to *assist* high-risk beneficiaries with accessing services

Track 3 Alignment – Encourage partner *alignment* to ensure that community services are available and responsive to the needs of beneficiaries

RETHINKING THE RESOURCES

Health and Social Care Spending
Percent of GDP
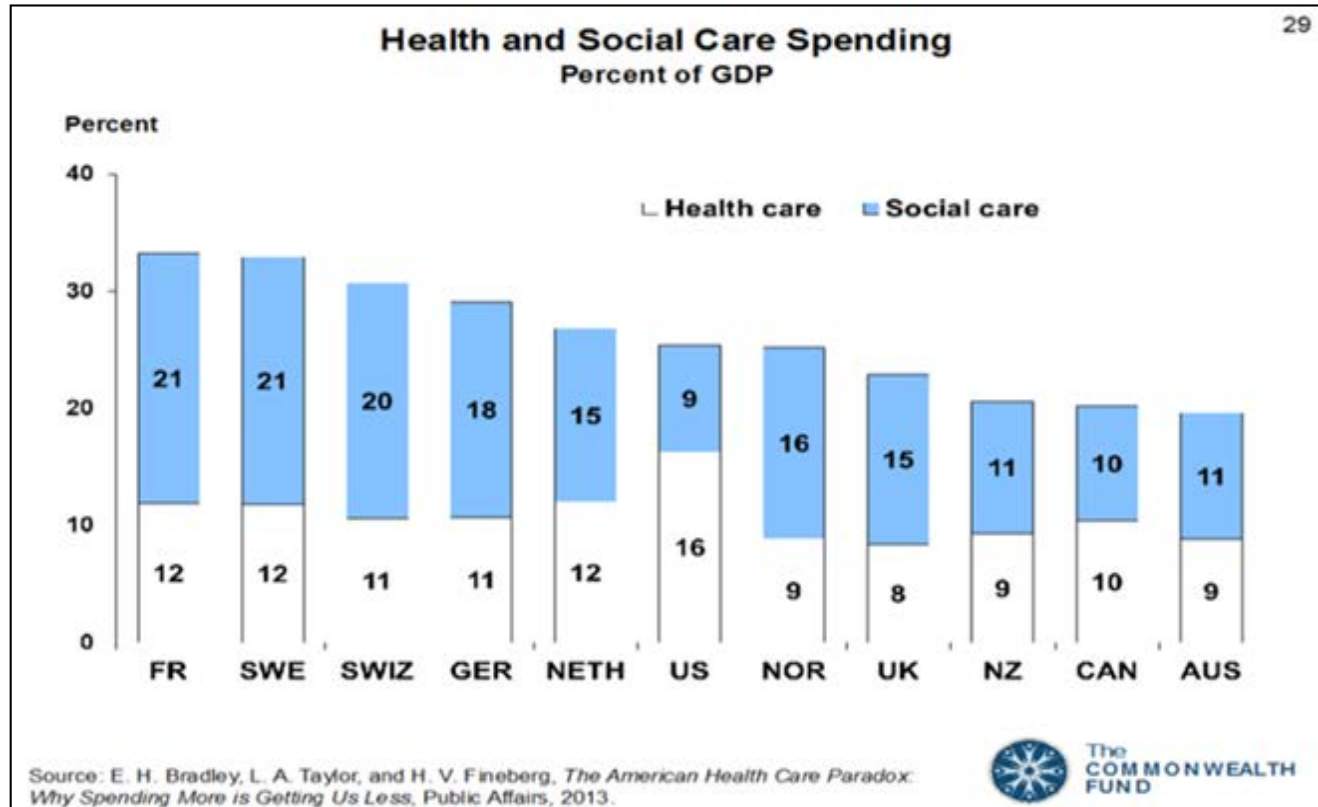
INNOVATION

INNOVATION OF SOCIAL SERVICES

How Rideshare Companies Can Address Social Determinants of Health

Rideshare companies have become an important vehicle for driving better patient care access and addressing the social determinants of health.

HEALTH <u>WITHOUT</u> HEALTH CARE

CVS Health goes virtual with telemedicine visits

By Rachel Z. Arndt | August 9, 2018

Following in the footsteps of Walgreens and Rite Aid, CVS Health is getting into the telehealth game.

CVS Health will now offer virtual visits for minor health problems, move that could help the pharmacy chain reach consumers it tries to stay competitive in a space that might soon include A reportedly launching primary-care clinics for its employees in

Direct to consumer relationship...

Know their social determinants and health needs before they do.

KEY TAKEAWAYS

1. Begin with <u>better</u> health care – move to value

2. Health <u>beyond</u> health care

3. Build a healthy <u>community</u>

4. Opportunities for <u>innovation</u>

CLOSING THOUGHTS

- Improving health and bringing value to the health care system will require **more than clinical excellence**

- No one sector can do this alone

- Will require public-private collaboration

- Test and learn…scale…spread

- Stakes are high

- Opportunity window *that requires bold, strategic, collaborative and accelerated action*
    - ***By you – as health care leaders and as civic leaders***

Thank you!

@kbdesalvo