Rethinking Value: How Hospitals Can Drive Value for the Communities They Serve

The Johns Hopkins Population Health Management Approach

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Outline

• Universal Trends in Healthcare
  – Challenges and Questions
• The need for a multiple sector approaches
  – Population Health and the Role of Hospitals
• Case study: The Baltimore, Maryland experience
• Keys to Moving Systems Beyond Clinical Care
• Measuring Value
• Vision for Future Systems
• Questions
Universal Trends in Healthcare

• Universal Challenges:
  – High economic and social burden of chronic diseases
  – Wide variation in health outcomes
  – Unsustainable trajectory of health care systems costs

• Common goals:
  – How to improve health outcomes, increase patient satisfaction, and reduce costs?
  – How to better manage health care across multiple care settings
  – How can health systems shift from a focus on tertiary care to upstream prevention?
Drivers of Health are Complex and Multifaceted

Figure 1. National Academy of Sciences, Engineering, and Medicine (NASEM) conceptual framework for social risk factors for healthcare use, outcomes, and cost.
Patient Needs Vary Across the Risk Spectrum

Population Risk Pyramid

- Low Risk
- Emerging Risk
- High Risk

Curative, Palliative Care
Preventive Care
Education, Self Management
Social and Behavioral Factors Contribute More to Outcomes than Clinical Factors

- Studies demonstrate that social and economic factors may contribute most to health outcomes (40%)

- Health behaviors, including substance abuse, diet and exercise contribute 30% to these outcomes

- Key Finding: Changing health outcomes requires a focus beyond just “clinical care and coordination”
How do Health Systems Address the Multiple Drivers of Health Outcomes?

• **Focus on Population Health:**
  – A cohesive, integrated and comprehensive approach to health care considering the distribution of health outcomes within a population, the health determinants that influence distribution of care, and the policies and interventions that are impacted by the determinants.

• **Population Health Management:**
  – The process of addressing population health needs and controlling problems at the population level; strategies to address population health needs.
Importance of Community Partnerships: Neighborhood Factors and Health Outcomes

Neighborhood factors are linked to a range of health and cost outcomes, including:

- Birth and early childhood outcomes (e.g. infant mortality and asthma rates)
- Obesity
- All cause mortality
- Morbidity (in particular chronic conditions)
- Inappropriate emergency department use
- Readmissions
Why is Multisector Action Critical?

- High utilizers of healthcare services also high utilizers across multiple systems, including:
  - healthcare
  - housing
  - criminal justice
  - Social care
- Opportunity = cost savings across sectors if social and behavioral determinants can be addressed collectively
- Indicates need for multi-sector approach to addressing high utilizers and SDH

Why Population Health Matters for Hospitals

- Efficient use of scarce resources
- Manage capacity for patients needing inpatient care
- Improve quality of tertiary care for sickest patients
- Maximize patient experience through improved quality and outcomes
- Higher quality care and better outcomes creates better value proposition for working with payers

- Promote links back to primary care for better management of patients’ health needs
- Maximize effectiveness of resources spent on community improvement
- Increase long-term sustainability of health care systems

Improving care across settings
Integrated Approach Needed for Effective Population Health Management

- Individual Factors and Behaviors
- Social Support and Family
- Healthcare and Community Organizations and Infrastructure
- Policy and Environmental Context

Service and Accountability Integrator

- Shared Data
- Shared Financing
- Shared Leadership
- Shared Vision

Reduced duplication and inefficiency in services

Enhanced Effectiveness

Improved quality, coordination and communication

Improved Health Outcomes
Advantages of multisector approach include:

- More efficient allocation of resources/less duplication of efforts, (particularly important in public systems)
- Improved care coordination
- Better patient outcomes and satisfaction
- Population health approach that addresses needs of individuals at all risk levels
- All partners share in improved cost outcomes
Hospital-Led Population Health Management Example

JOHNS HOPKINS EXPERIENCE
BALTIMORE, MARYLAND, USA
Hospitals in Maryland are:

– Charged with controlling costs, improving quality and improving patient outcomes across geographies

– Required to partner with other hospitals and community-based organizations in the region

– Measures include population health outcomes across communities, specific costs, patient satisfaction and system level health outcomes measures
High Risk Geographies in Baltimore

"The only thing more astonishing than this 19-year gap in life expectancy is the short distance you have to travel in Baltimore to get from one extreme to another." - Washington Post

Life expectancy at birth is the average number of years a newborn baby can be expected to live based on current mortality trends.


Life Expectancy (number of years, 2013)

- Number of years:
  - > 76 to 85
  - > 73.6 to 76
  - > 72.2 to 73.6
  - > 69.5 to 72.2
  - 66 to 69.5
Maryland Regional Partnership Interventions

• Maryland regional partnership designed large scale population health programs to meet state requirements

• Hospitals partnered with community based organizations to address clinical factors, health behaviors, and social factors through:
  • Integrated Care Teams
  • Behavioral Health Team
  • Convalescent Care for Homeless
  • Home Based Primary Care
  • Neighborhood Navigators
  • Patient Engagement Training
Outcomes from the Baltimore Experience

The JHHC population health management approach led to:

- Creation of multidisciplinary programs
- Decrease in total cost of care for all Medicaid beneficiaries (-$1,643 per beneficiary per quarter)
- Decreases in hospitalizations, emergency room visits, and readmissions for Medicaid beneficiaries
- Decrease in emergency room visits for dual eligible beneficiaries
- Decrease in potentially avoidable hospitalizations for all Medicaid beneficiaries
Keys to Population Health Transformation

1. High quality data and information systems
2. Evidence based, “Whole Person Approach” to health programs, delivered across risk spectrum according to need and supported by data
3. Integrated Delivery Systems (beyond just medical care)
   - Alignment of incentives to promote population health
   - Expanded systems view to include community, social services, public health, and other
   - Patient and stakeholder engagement
Keys to Cross Sector Collaboration

- Need “Orchestrator” to serve as convener of community partners towards:
  - Shared vision
  - Shared decision making
  - Shared financing
  - Shared data

- Public health providers are a natural fit for “integrator” role, but hospitals and health systems can also serve in this role for communities
Measuring the Value of Population Health Approaches

• Health status is the result of sustained health behaviors, exposures to social determinants, genetics, and access to and the quality of the health systems:
  – changes in health outcomes happen slowly

• Shifting care healthcare upstream to change these determinants requires new ways of measuring value

• Measuring the value of partnerships that focus on multiple determinants of health requires leading and lagging measures
# Measuring Value of Partnerships

## Clinical Aspects
- Return on Investment
- Resource utilization
- Quality measures, Mortality

## Social/behavioral aspects of health
- Patient self-efficiency and empowerment,
- Improvements in social determinants within communities
- Efficiencies gained through partnerships and reductions in other types of public spending (social spending, criminal justice system spending)
- Job creation/unemployment rates in communities
- Improvements in access to and use of preventive services
Future Vision for Sustainable Health Systems

- Empowered communities work across sectors to reduce morbidity and mortality
- Efficiencies gained by de-duplicating efforts and partnering to provide programs for individuals across sectors
- Strong primary care systems caring for individuals and helping prevent and manage chronic disease
- Sustainable, high functioning health systems
Thank you