CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Supporting Population Health Through Team-Based Practice Re-Design and Broad Community Partnerships

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PAUL WOODS, MD, MS, CCFP

Paul Woods MD MS CCFP

Primary Care:

I’ve looked at health from most sides now

My Journey

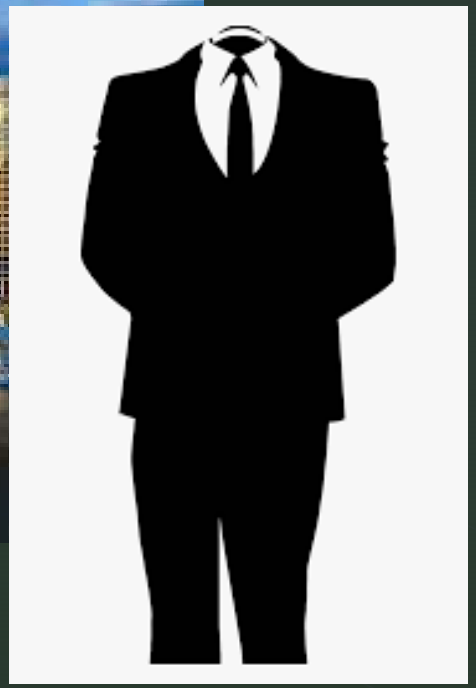
- Did want to be
  - A Doctor
- Didn’t want to be
  - Psychiatrist ✓
  - Administrator ✗
  - CEO ✗

Chapter 1: Paul Woods MD Family Physician

Chapter 2: Paul Woods MD MS, Associate Medical Director CDM

Chapter 3: Paul Woods MD MS
Medical Director DFM

Chapter 4: Paul Woods MD MS Department Chief of Primary Care



Chapter 5: Paul Woods MD MS
SVP Provider Network Organization

Chapter 24: Paul Woods MD MS President and CEO

Chapter 24: Paul Woods MD MS
System Transformation Leader/Stakeholder

Conclusion

- No matter from where you observe health care, the same problems exist whether we all fully see them or not

100 Million Healthier Lives

Supporting Population Health Through Team-Based Care and Community Partnerships

Somava Saha, MD MS; Vice President, Institute for Healthcare Improvement and Co-Executive Lead, 100 Million Healthier Lives

CONVENED BY Institute for Healthcare Improvement

Disclosures

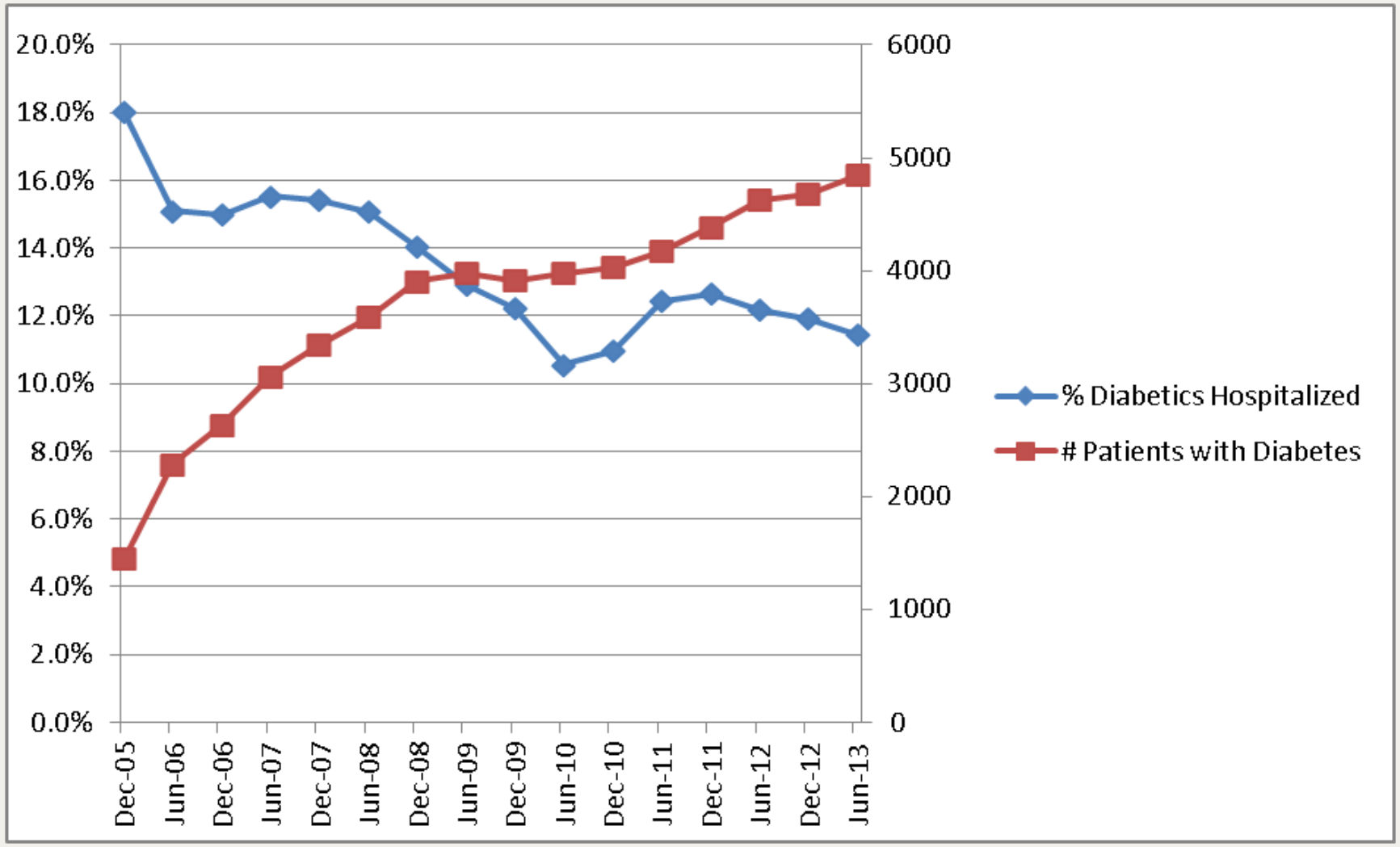
- I have no financial conflicts to disclose.
- I have spent 25 years learning about how we advance health, wellbeing and equity in the world in partnership with communities of solutions all around the world. This has irrevocably shaped my thinking.

The Triple Aim

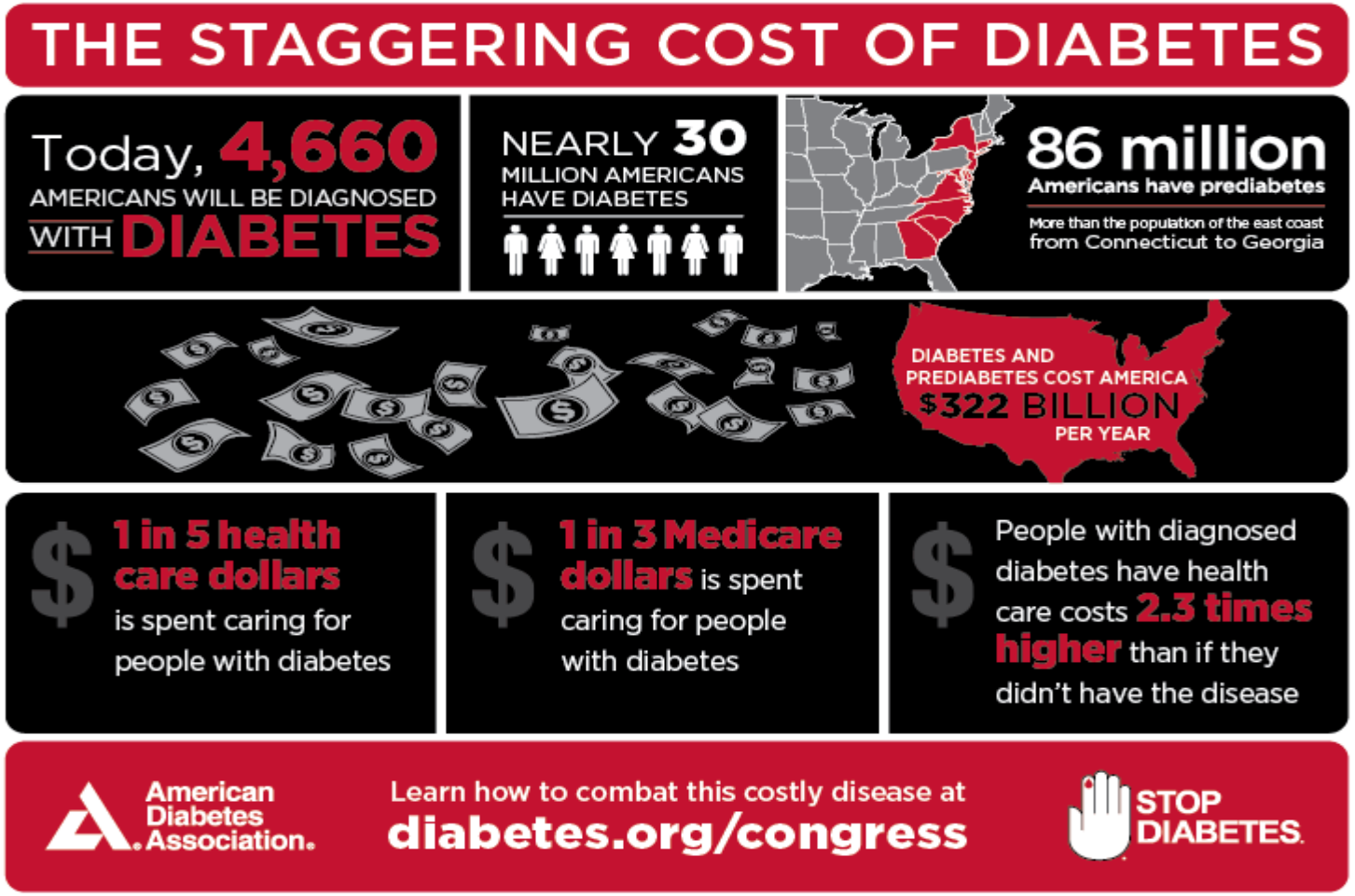
- A System design that is one aim with three dimensions:
  - Improving the health of the populations;
  - Improving the patient experience of care
  - Reducing the per capita cost of health care.

Berwick D, Nolan T, and Whittington J. The Triple Aim: Care, Health, and Cost. Health Affairs 27(3): 759-769.

A Fable: 36% Reduction in Hospitalization Rate for Patients with Diabetes at Cambridge Health Alliance



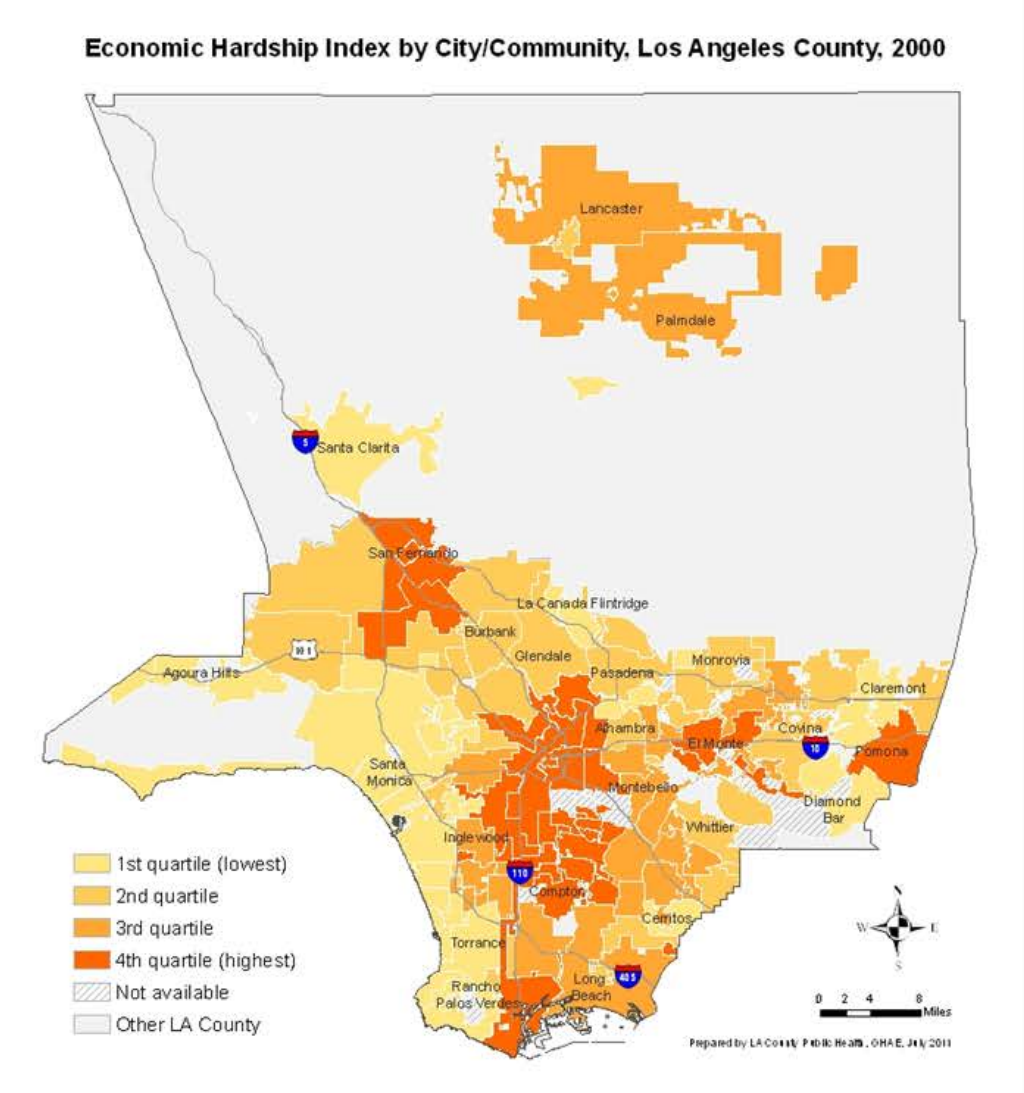
Cost of chronic disease unsustainable

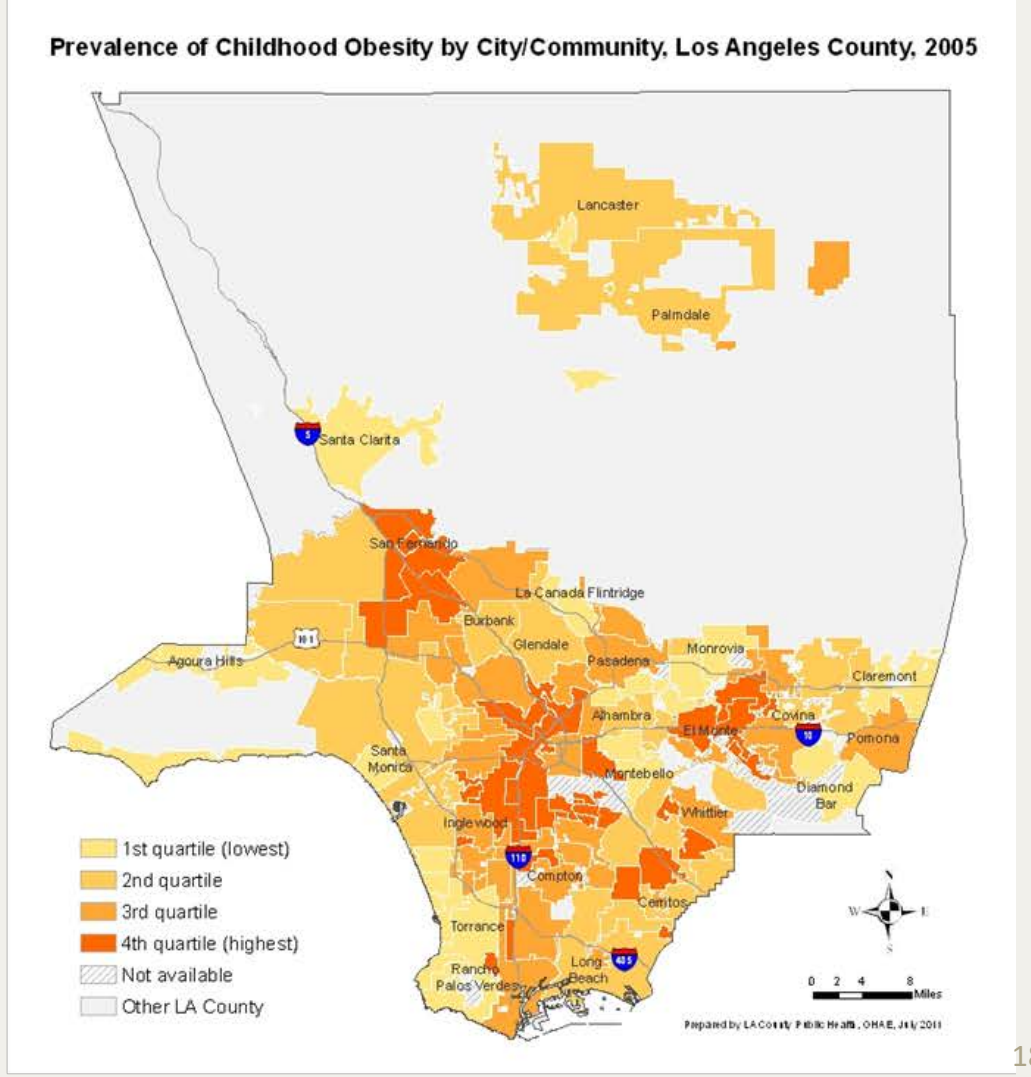


A tale of two boys

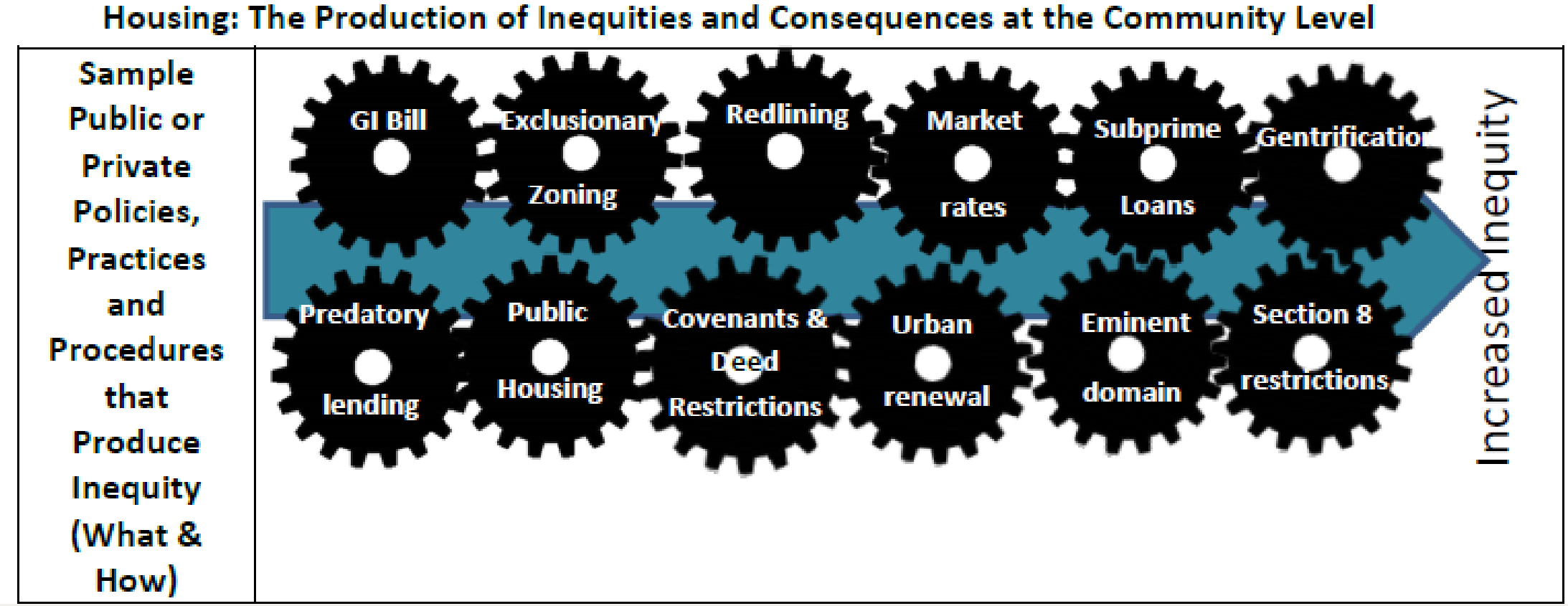
https://wsvn.com/news/us-world/color-blind-boys-scheme-to-get-same-haircut-to-trick-teacher/

Health and Social Inequity are Interconnected and Related to Place



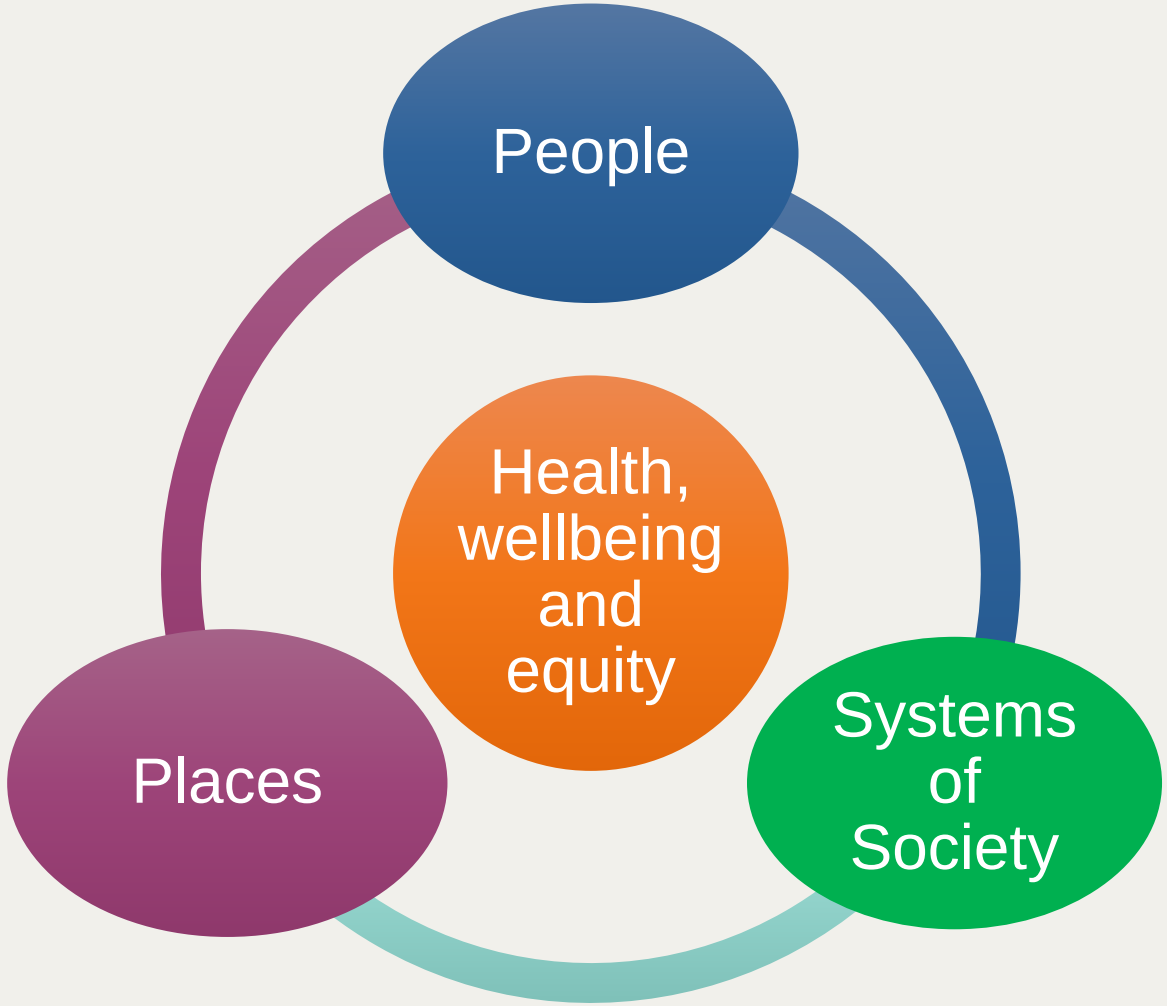


Chronic place-based inequities are not accidental – there is a system in place that propagates them



"Countering the Production of Health Inequities" Report from the Prevention Institute

Interrelationship between the health, wellbeing and equity of people, places and the systems of society



100 Million Healthier Lives

Identity: An unprecedented collaboration of change agents pursuing an unprecedented result:

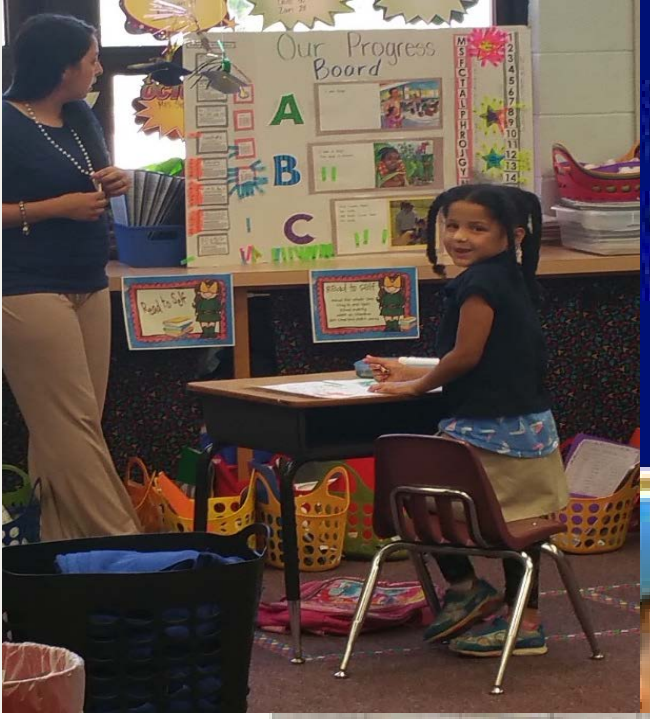
100 million people living healthier lives by 2020

Vision: to fundamentally transform the way we think and act to improve health, wellbeing, and equity.

Equity is the “price of admission.”

Convened by the Institute for Healthcare Improvement as a partnership across organizations and supported by WE in the World.

www.100mlives.org



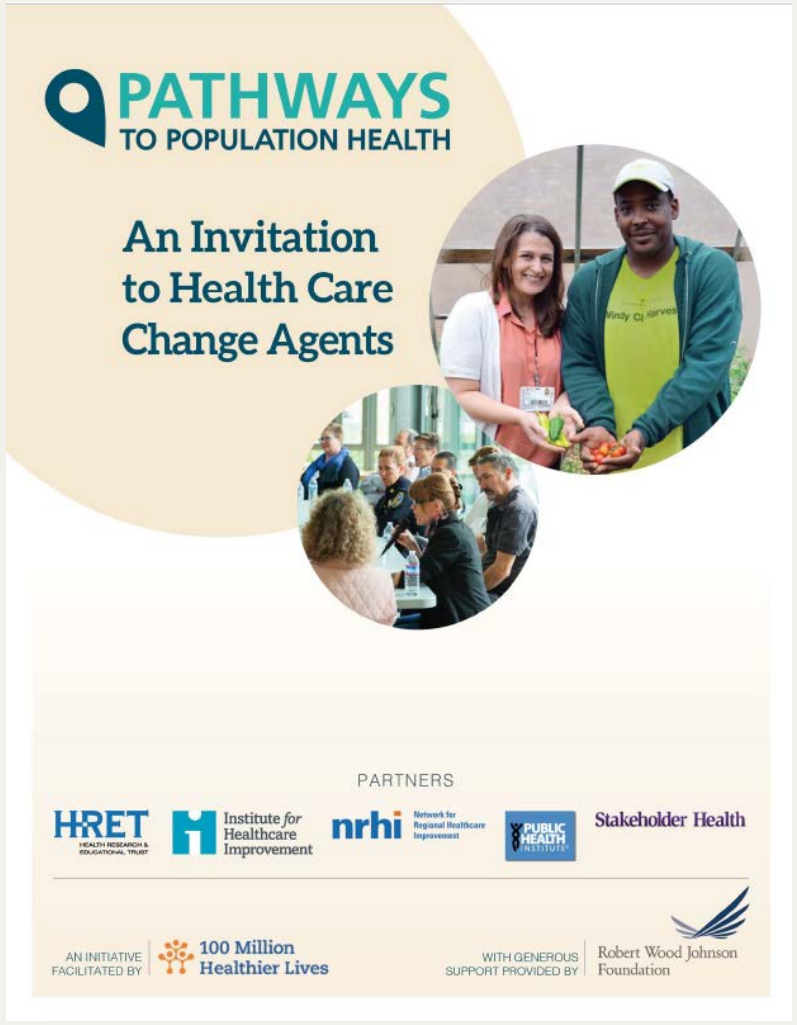
The Health Advocates In-Reach and Research Campaign (HAIR)

https://vimeo.com/83703623

Communities of Solutions

St Nin

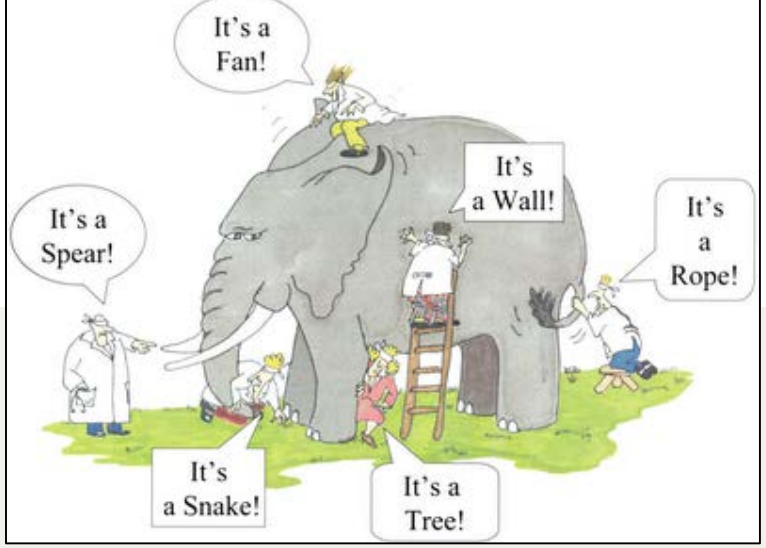
Pathways to Population Health



1. Framework
2. Compass
3. Oasis of resources

Championed by 30+ major organizations including the American Hospital Association, IHI, NRHI, Public Health Institute, Stakeholder Health, ASTHO and many others.

Common Language: Two kinds of populations



A Defined Population (Well-being of People)

Defined by a common characteristic

- Patients at a community health center
- Children with sickle cell disease who live in the midwest
- People attending a megachurch

Geographic or Place-Based Population (Well-being of Places)

Defined by a place

- Children living in three neighborhoods of Chicago
- Residents of rural West Virginia

Six Foundational Concepts of Population Health Improvement

1

Health and well-being develop over a lifetime.

2

Social determinants drive health and well-being outcomes throughout the life course.

3

Place is a determinant of health, well-being, and equity.

4

The health system needs to address the key demographic shifts of our time.

5

The health system can embrace innovative financial models and deploy existing assets for greater value.

6

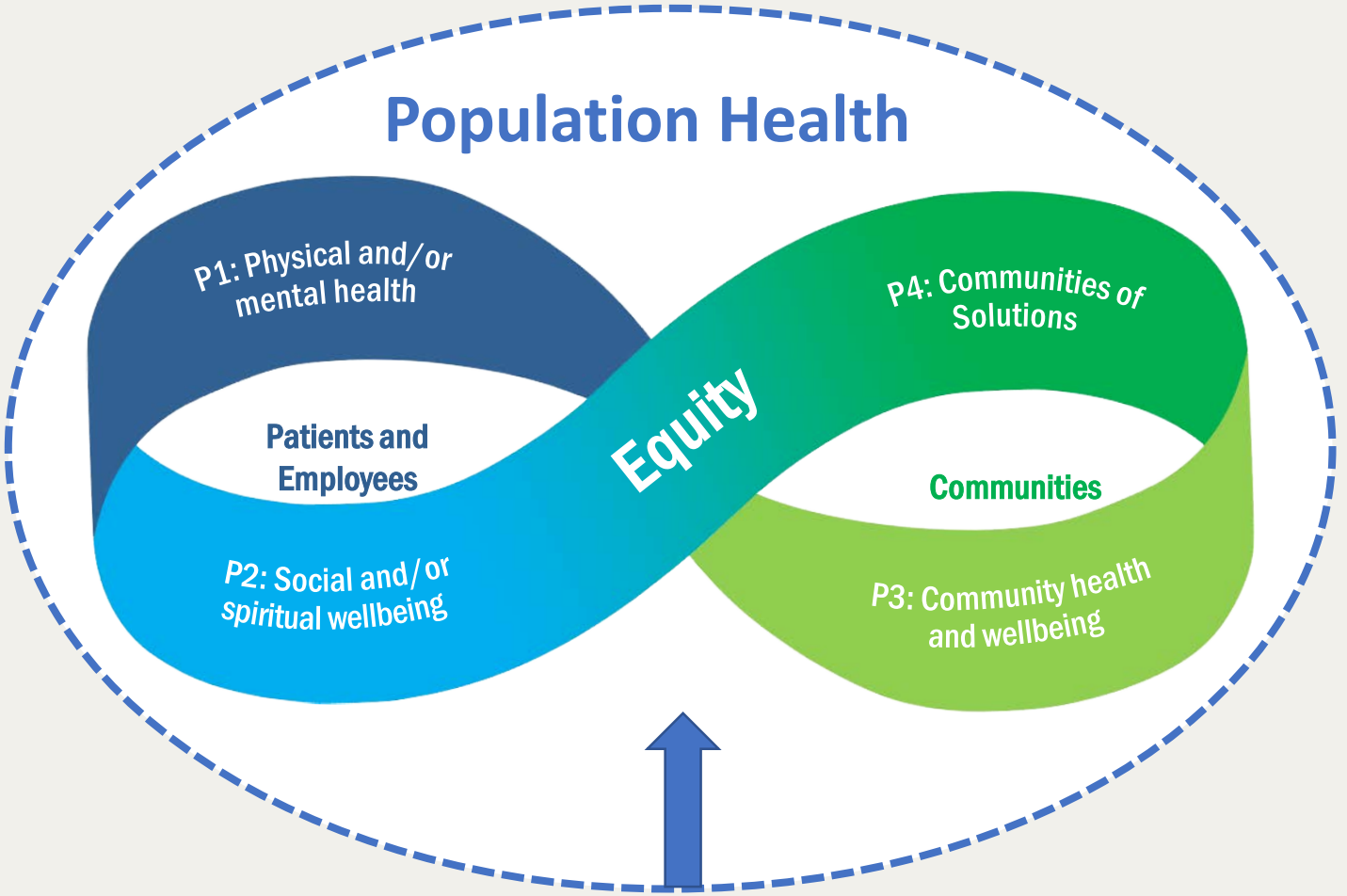
Health creation requires partnership because health care only holds a part of the puzzle.

What creates health?

How can health care engage?

4 Interconnected Portfolios of Work

Improving the health and wellbeing of people



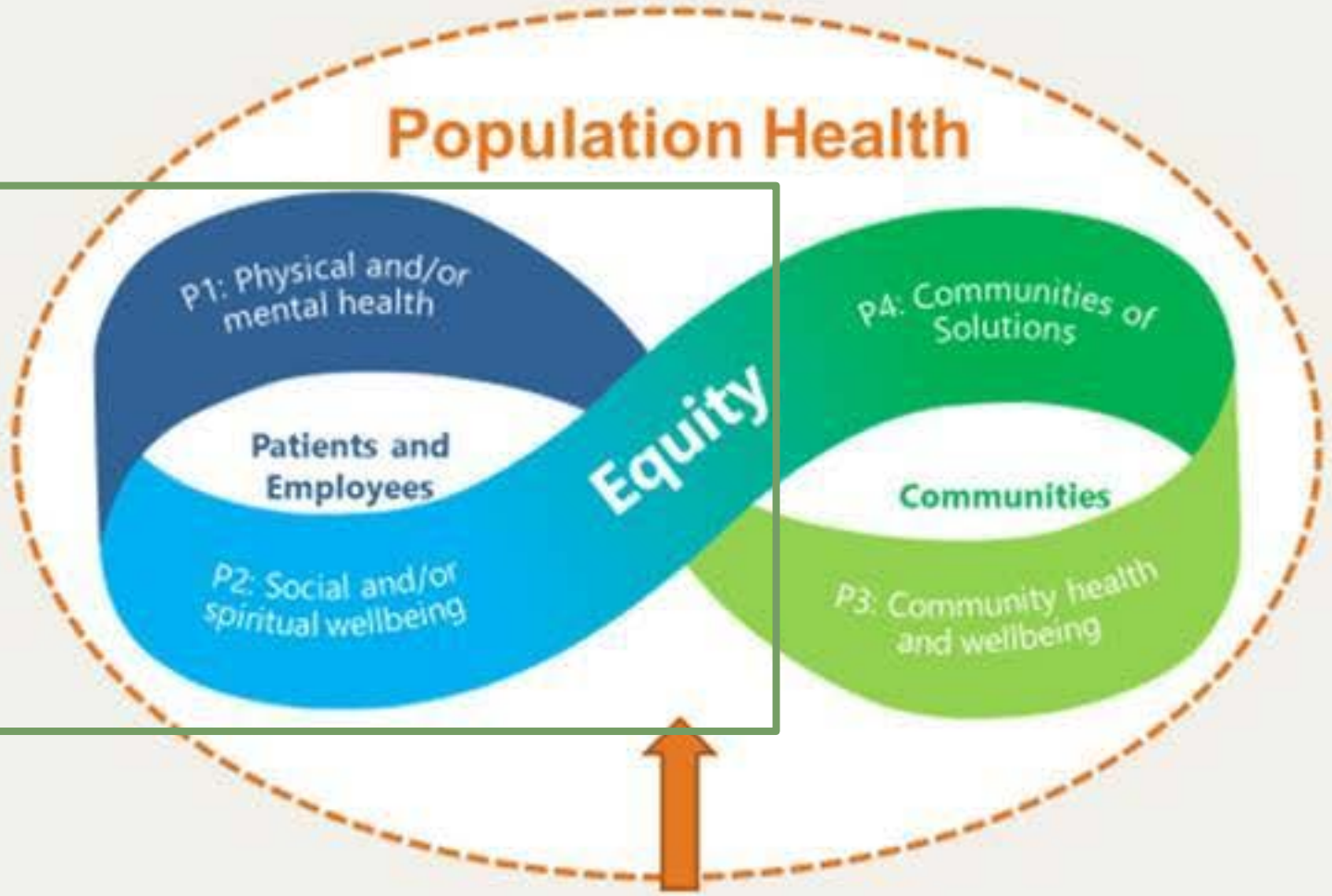
Improving the health and wellbeing of places

Improving the systems of society

www.pathways2pophealth.org

4 Interconnected Portfolios of Work

Improving the health and wellbeing of people



Improving the health and wellbeing of places

Improving the systems of society

Care Delivery Model: Improving the Health and wellbeing of people

Components

- Equity
- Physical and Mental Health
- Social and/or Spiritual wellbeing

People Challenges

Patients/Consumers:

- Access to care
- Rise of Consumerism
- Experience of Care
- Quality
- Cost/Affordability

Provider Challenges

Providers:

- Administrative Demands
- EHRs
- Quality of care and moral distress
- Eligibility and moral distress

BURNOUT

Business/System Challenges

System/Administrative

- Two Curve Problem
- Access
- Cost
- Productivity
- Efficiency

? Value Proposition of Having a Model Cell

- Skunkworks: Development of what is next and beyond
- Operational: Make it work together
- Develop scalable model components that can be used now and have future utility (understand the business value)
- Prestige

Advanced Primary Care Models: Biopsychosocial Framework

- Anatomy: Structure and Resources
- Physiology: Function and Processes
- Psychology: Roles and Autonomy/Professionalism
- Sociology: Mindset and Culture

Enhanced Primary Care

- Grand Rapids MI
- The challenge:
  - “De novo”
  - No specifications and little in the way of constraints
  - Took what I had learned at U of Calgary

EPC: Anatomic Components examples

- Interprofessional teams
- Co-location: No offices
- Flow Cells
  - Flow Manager and Provider
- Care Team Lead

EPC: Physiology (Processes) examples

- Shared patients
- Advanced Access
- The LIGHTS!!!!!
- In Basket Management: Early win
- Systematic Case Review
- Collaborative Care Models
- Group Visits

EPC: Psychology examples

- Shared Patient Panels (although attachment)
- No Cross Coverage
- Standardized care pathways
- The psychology of our In Basket management
- Patients own their story and their data: Open Chart

EPC: Sociology (Culture) examples

- Shared Accountability
- Shared Panels
- Flow Management
- Systematic Case Review
- Care pathways (academic detailing)

EPC: So What???

- Access: TNA dropped from several weeks to 2 days
- Panel: Went from 3700 to 6500 in under 2 years
- Encounters: Increased by 27%
- CPT Codes: Increased by 29%
- Quality: MiPCT
- Patient Satisfaction: LTR Went from 90% to 97%

IPC

- Grand Rapids MI: Different (competitor) system
- Additional bells and/or Whistles
- Desire to create a scalable model that could be adapted for 22 markets
- “Health Care Unified Field Theory”

? Value Proposition of Having a Model Cell

- Prestige
- Skunkworks: Development of what is next and beyond
- Operational: Make it work together
- **Develop scalable model components that can be used now and have future utility, now in 22 markets (understand the business value)**

IPC

- Design: Human Centered Design
- Lean as Operating, Management and Improvement Systems
- Team documentation
- PAM
- Social Determinants and CHW

EPC and IPC: The rest of the stories

- EPC:
  - Still going great guns
  - System has scaled many of the components but took years
  - Continue to innovate: Self Sustaining
- IPC:
  - A year in
  - Struggling with clarity
  - Somewhat unclear level of support from system

If APC Models work, so what?

- The Unstated Question:
  - Is it possible to have a win both in volume and value based payment models?
  - Answer: Yup
- Scalable or just a nice demonstration?

Deployment Strategy:

1. Start with No Fail Four
2. Roll out quickly and in standard way
3. Evaluate business case for other bundles
4. Look for synergies
5. Deploy the non- No Fail Four Bundles as business case arises

No Fail Four

1. Risk Adjusted Panels
    1. Volume: Utilization/10,000 in FFS
    2. Value: Capitated Lives
2. Access
    1. Volume: Productivity
    2. Value: Keepage and Care Gaps
3. Network Integrity
    1. Volume: Productivity
    2. Value: Keepage and TCOC
4. Production Cost
    1. A winner in any scenario

Critical Success Factors

- Leadership: System
  - Protection
  - Advocacy
  - Intent to scale from the beginning
- Leadership: Team
- Team Culture: Ownership
- Team Culture: Teammate Selection
- Clear Vision and Objectives
  - Throughout the system
- Focus on Principles and vision upfront
- Engaging the team in developing the model
- Care and Feeding: Ongoing support including resources

Failure Modes

- Pilot thinking and Rossi's Iron Law
- Existential Drift
  - Lack of alignment about why you are doing what you are doing
- Lack of Sponsorship at leadership level
- Poor choices in providers and other team members
- Lack of attention to culture
- Starving for resources: Clear business proposition
- Failure to demonstrate ongoing value proposition

Conclusion

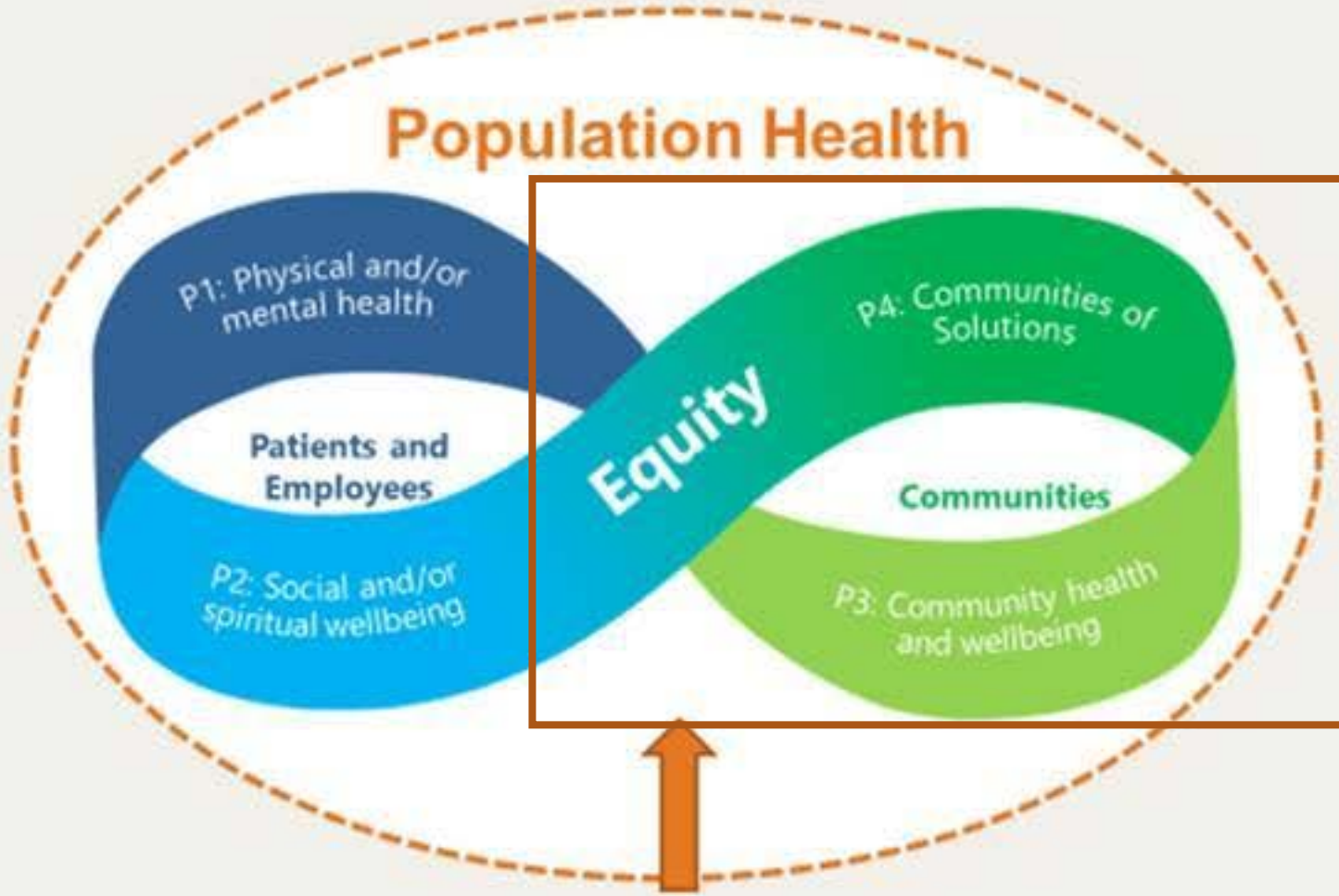
- Healthcare has deep systemic challenges no matter what perspective you hold
- Payment changes alone won’t accomplish what we need without deep structural, cultural and cognitive change
- Advanced Primary Care Models hold great promise in driving to many of the required outcomes
- They can be effective in helping today’s challenges as well
- There are many places where they can fail to deliver but with proper engagement from all levels can be transformative

100 Million Healthier Lives

Putting it into action through community partnerships

4 Interconnected Portfolios of Work

Improving the health and wellbeing of people



Improving the health and wellbeing of places

Improving the systems of society

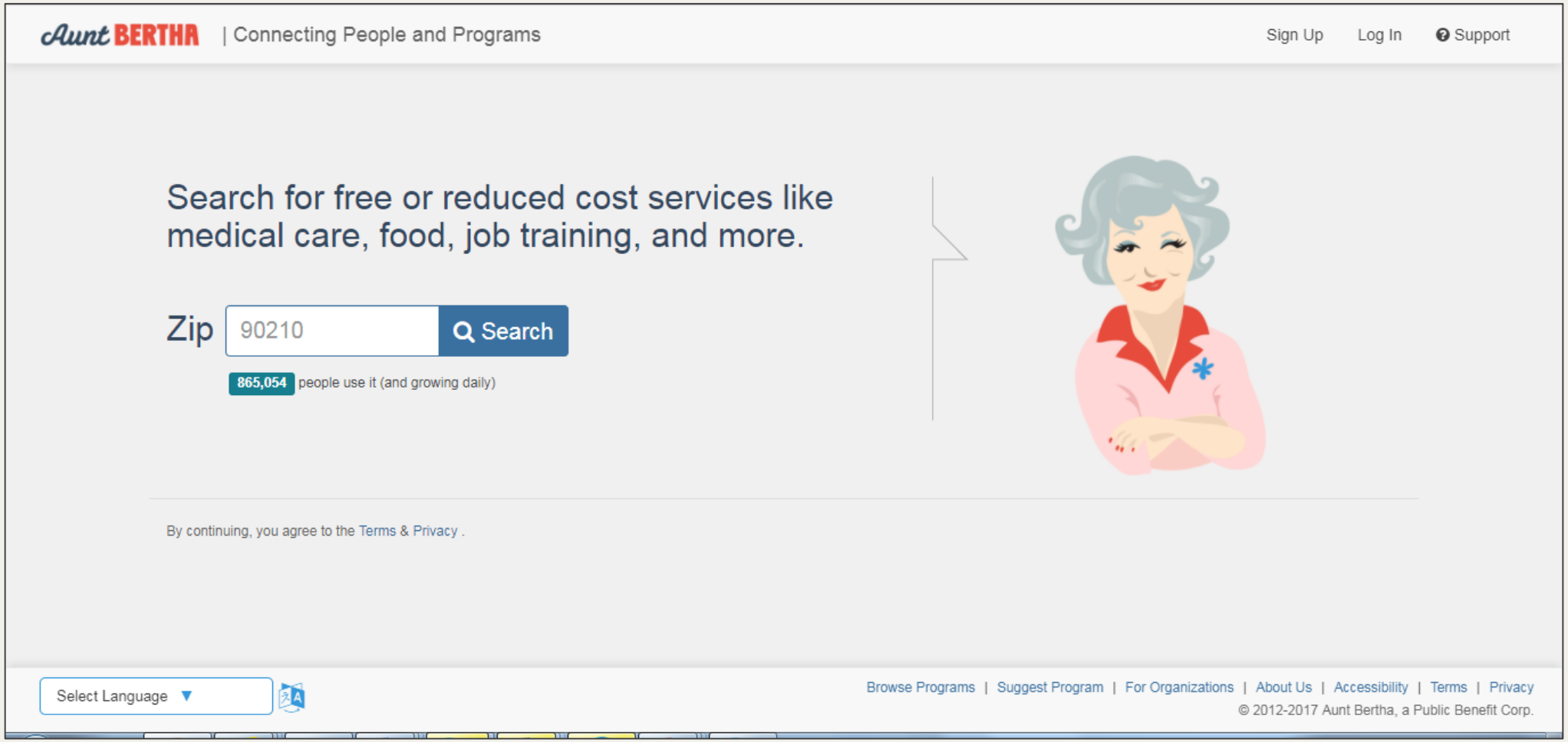
Portfolio 1: Optimize mental and/or physical health and cost

- Alaska Native people who took over their health care system
- Built a health system based on relationships, trauma informed care
- Integrated mental health
- Community based treatment of trauma
- 50-75% improvement in outcomes and cost

Southcentral Foundation

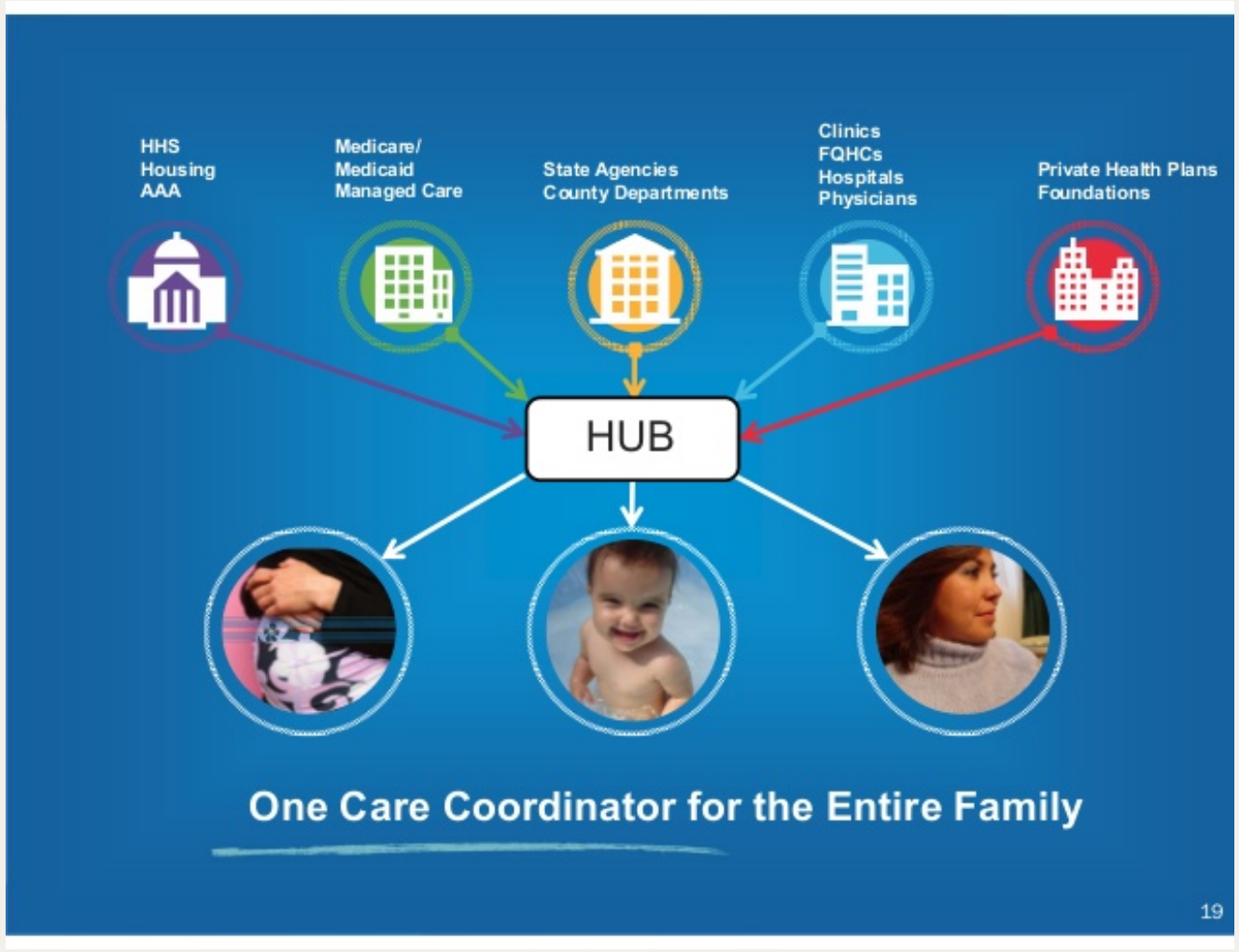
https://www.youtube.com/watch?v=V1DL62iUxgU

Portfolio 2: Address social and spiritual drivers or health and wellbeing



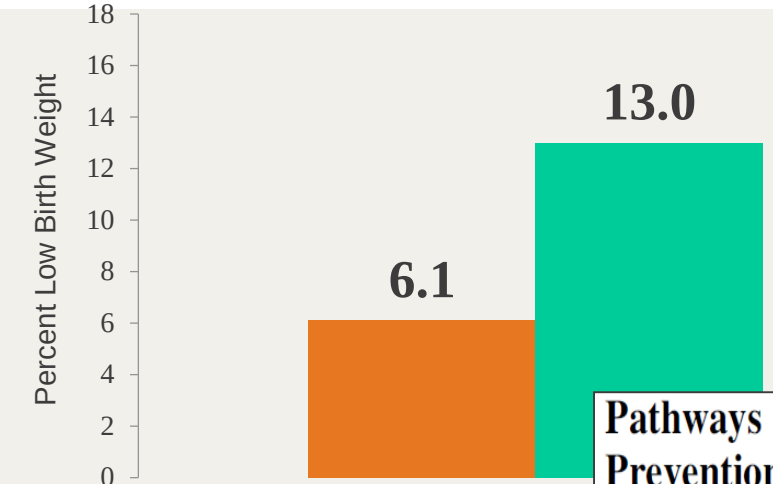
Connecting people to services: Aunt Bertha

Portfolio 2: Address social and spiritual drivers or health and wellbeing



Pathways Community Hub Model

Pathways Hubs lead to Triple Aim Outcomes



Pathway intervention over 4 years

Cost Savings: $3.36 for 1st year of life; $5.59 long-term for every $1 spent

Pathways Community Care Coordination in Low Birth Weight Prevention

Sarah Redding · Elizabeth Conrey · Kyle Porter · John Paulson · Karen Hughes · Mark Redding

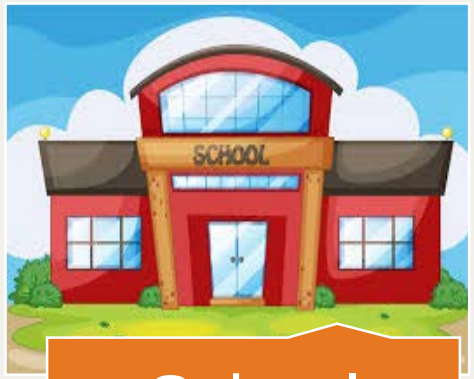
Abstract The evidence is limited on the effectiveness of home visiting care coordination in addressing poor birth outcome, including low birth weight (LBW). The Community Health Access Project (CHAP) utilizes community health workers (CHWs) to identify women at risk of having poor birth outcomes, connect them to health and social

Women participating in CHAP and having a live birth in 2001 through 2004 constituted the intervention group. Using birth certificate records, each CHAP birth was matched through propensity score to a control birth from the same census tract and year. Logistic regression was used to examine the association of CHAP participation

Portfolio 2 Address social and spiritual drivers or health and wellbeing

Palo Alto Medical Foundation

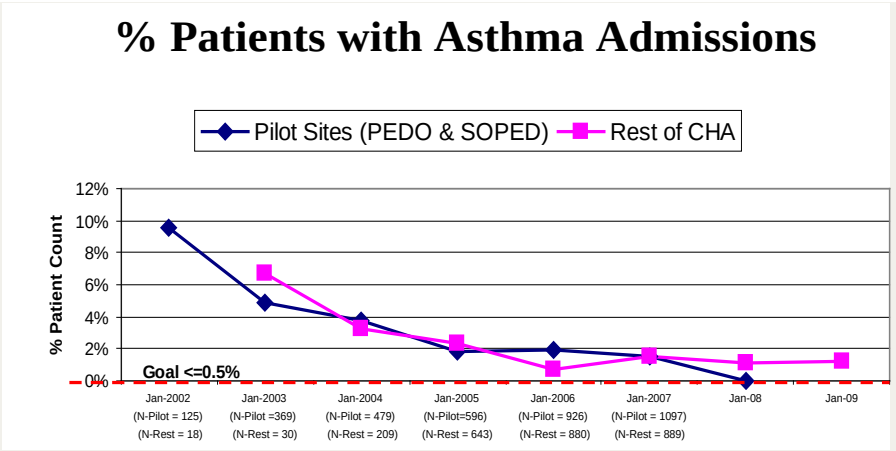
Portfolio 3 Community Health and wellbeing: Childhood Asthma Outcomes at Cambridge Health Alliance



School

Home

Pediatrician



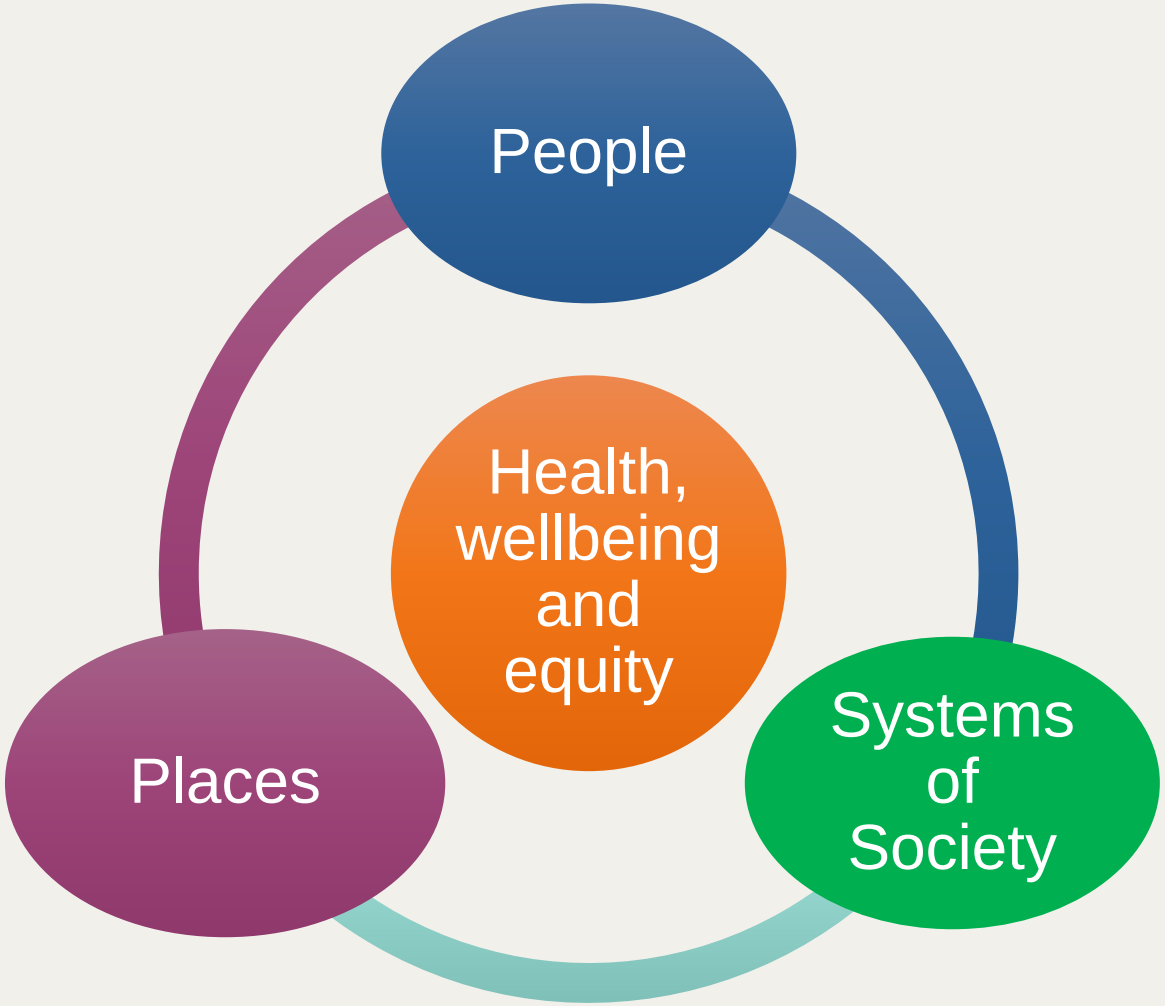
Portfolio 4: Communities of Solutions

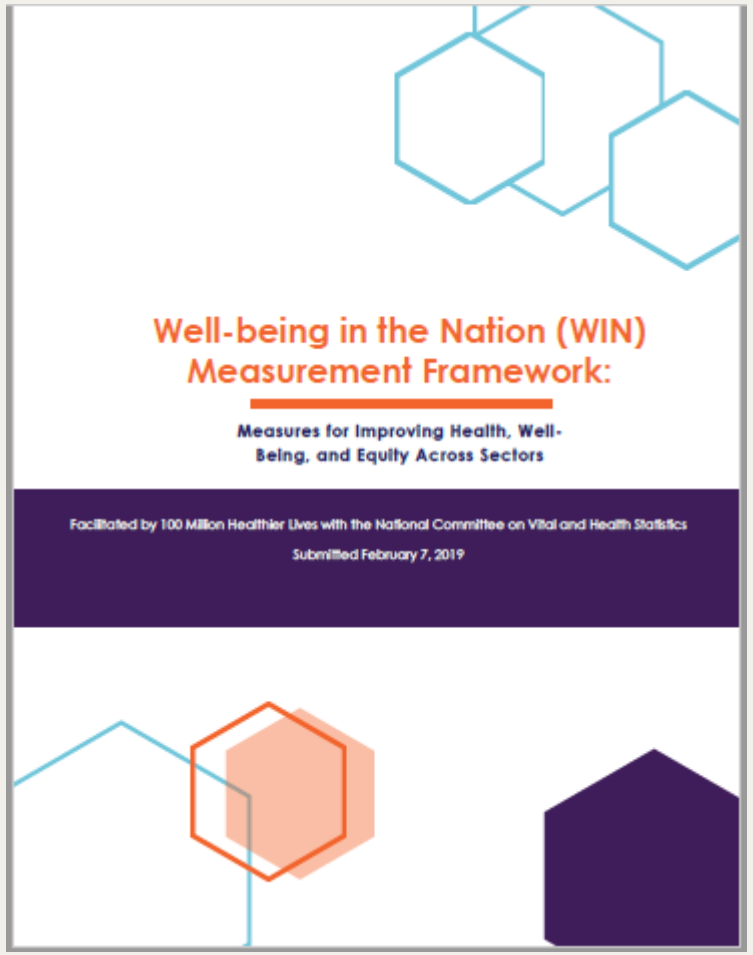
- University Hospitals in Cleveland – Economic develop in poorest 7 zip codes surrounding the hospital.
  - “Buy local, hire local, live local” in addition to community benefits. Impact: 5200 jobs created, $500 million infused into communities with worst life expectancy.
  - A school in a hospital at Metrohealth
- Dignity health – invest a part of the retirement portfolio to give low income loans to community-based businesses, low income housing developers

Rhode Island Health Equity Zones

- Place-based mapping of the state in health equity zones
- “All in” effort to invest in places in a way that advances equity together
- Focus on everyone contributing their piece and asking “What could we do together that we couldn’t do alone?”

Well-being In the Nation Measures: People, places and the systems of society that drive health inequities

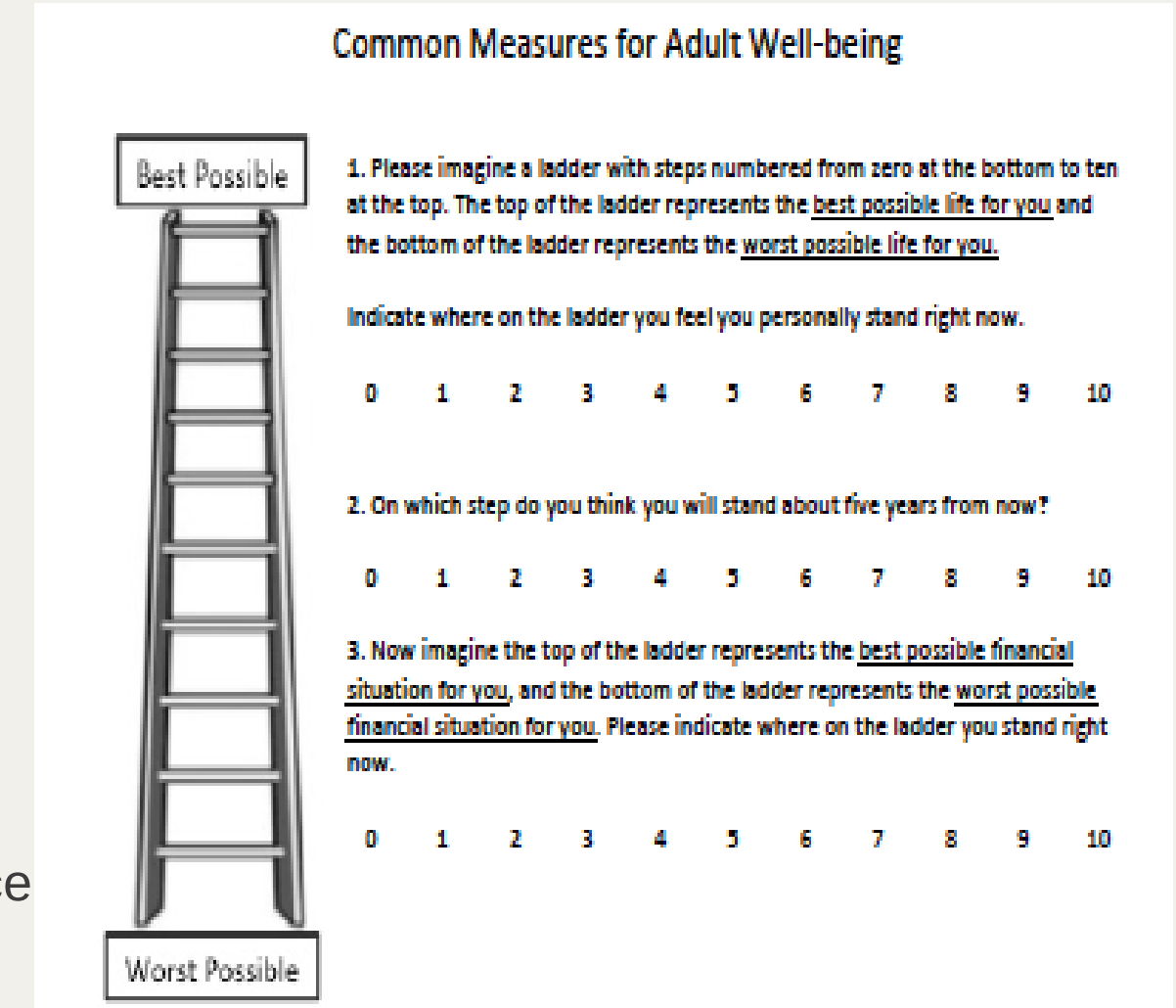




www.100mlives.org

Well-being In the Nation (WIN) Core Measures

1. **Wellbeing of people**
   - People's perception of their well-being
   - Life expectancy
2. **Wellbeing of places**
   - Healthy communities index (USNWR/CHRR)
   - Child poverty
3. **Equity**
   - Differences in subjective well-being
   - Years of potential life gained
   - Income inequality, graduation rates
   - Differences by demographic variables (race, place educational level, language, etc.)



www.winmeasures.org

What you can do

1. Commit to thinking and acting differently.
2. Go to www.pathways2pophealth.org to take the Compass to assess where you are on the journey and set goals
3. Think about the whole person, the whole community. Consider whole person measures – www.winmeasures.org.
4. Get to know your partners in community and join the team! You don't have to go it alone.
5. Join the movement! www.100mlives.org