Population Health, Meet Eldercare!

University of New England
College of Osteopathic Medicine

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InformAge

UNE UNIVERSITY OF NEW ENGLAND
INNOVATION FOR A HEALTHIER PLANET

Population Health, Meet Eldercare!

Agenda

- Population Health
  - What do we mean?
  - Why?
  - How is it practiced?
- Population Health, Eldercare Synergy
  - Patient: example of advance care planning
  - Practicing Population Health
- Summary Discussion

Definition

Population Health
Improve the health of populations one person at a time…

+ Triple Aim
…and reduce the cost of care

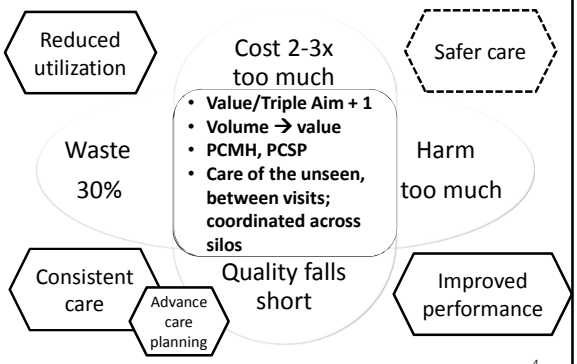
Increased focus on **health outcomes** (as opposed to inputs, processes, and products) and on determining the degree of **change** that can actually be attributed to our work

Maintain and improve the health of the **entire population** and to **reduce inequalities** in health among population groups

Aggregate health outcome …of a group of individuals, in an **economic framework** that balances the relative marginal returns from the **multiple determinants of health**

https://www.researchgate.net/publication/10885614_What_Is_Population_Health

Why Population Health?



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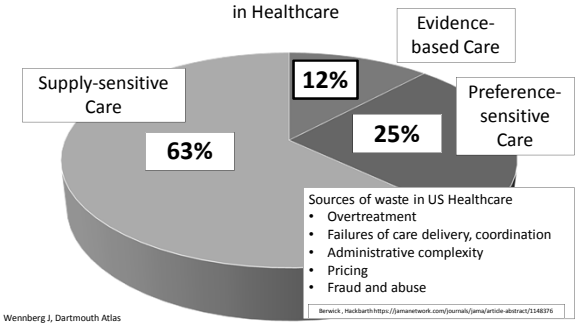
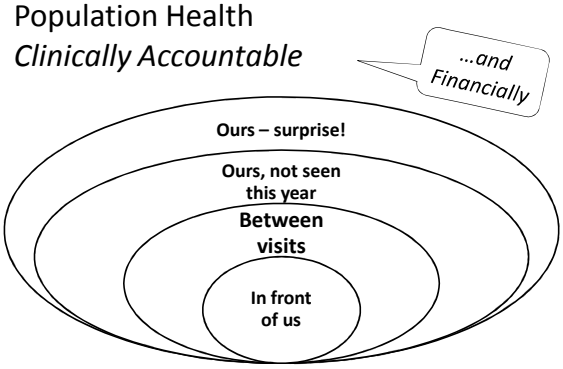
Where to find the Waste?

Proportion of Medicare Spending by Source of **Unwarranted Variation** in Healthcare



Wennberg J, Dartmouth Atlas

Population Health
Clinically Accountable



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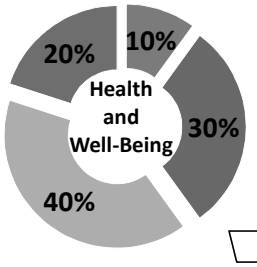
Determinants of Health and Their Contribution to Premature Death



Healthcare

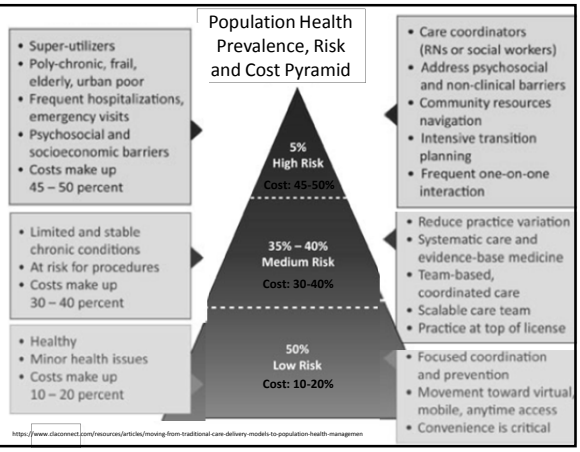
Genetics

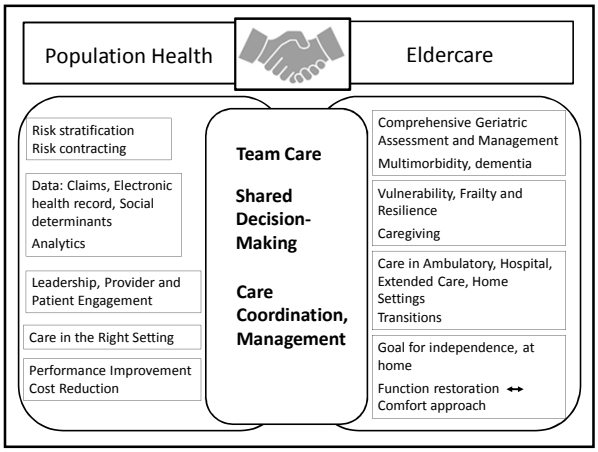
Individual Behavior

Social, Environmental

- http://kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/
- Schroeder S. **Improving the Health of the American People.** N Engl J Med 2007; 357:1221-1228.
- McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Aff (Millwood) 2002;21:78-93

Population Health Prevalence, Risk and Cost Pyramid





Let's Look at How Population Health and Eldercare Synergize

- Complicated older patient
- Comes to the populationist's attention because of high total cost of medical and pharmacy care
- The eldercare team
  - Is not surprised
  - Is working hard to help patient and caregiver
  - "We're doing all we can!"

- Are there other options?
  - Driven by
    - Opportunities to avoid emergency department and potential admission by reviewing ambulatory care-sensitive conditions
    - Eliciting patient/caregiver preferences to discover any unwanted care
- Populo-complexivist collaboration…

Patient

Who Has the A.D. Conversation in an Older Patient with More Limited Prognosis, and When?

- 77 y.o. woman, former smoker, independent
- Aortic stenosis s/p trans-aortic valve replacement 11/2017, diastolic heart failure, chronic obstructive pulmonary disease; HCC score 3.873 (high!)
- Admits 2017: 8, ACSC* 5, heart failure 3
- ED visits 2017: 9, ACSC* 4

*ambulatory care-sensitive condition

Other Conditions
Coronary artery dis. s/p stent
Arial fibrillation
s/p mitral and tricuspid valve replacement for rheumatic heart disease
Transient ischemic attack 4/2017
Hypertension
Diabetes mellitus type 2
Hyperlipidemia
Gastroesophageal reflux dis.

Patient Course Over 2 Months

10/30/17	Nov. '17	12/12/17
TAVR; respiratory failure To SNF 11/10	ED for sore throat 11/18/17	Next visits with PCP, Cardiologist?
Living Will from 1995; entered 10/2/17; no update	Care Coordinator 11/10 – "high risk for readmission "? Palliative care consult after discharge from SNF"	Conversation! …
		…and when patients and providers don't align?

Population Health and Eldercare Synergy

From Big Picture to Patient and Back Again

Example: Serious Illness in a Medicare Population, 2017

- 2300 candidates (10%) with very high need for Advance Care Planning (ACP) or Palliative Care (PC)
- Algorithm based on CMS-adjudicated diagnosis claims (3 mo. delay)
- Illness burden (HCC score – hierarchical condition categories), annual expenditure, ACP visits, PC consultations

Avg. HCC Score (Illness Burden)	Avg. Total $ for Care	N (%) with ACP visit	with PC consult	with ACP/PC vis./ cons.	with Advance Directive	Total with ACP/PC/AD
2.846	$40,673	27 (0.1%)	235 (1.1%)	8 (0.0%)	109 (0.5%)	379 (1.7%)

- Serious illnesses

Failure to Thrive	Dementia	Cancer	COPD	Heart Failure	CKD/ESRD	Liver Disease
7% (151)	21% (482)	28% (650)	55% (1,266)	56% (1,294)	36% (836)	4% (100)

Excludes 90 patients in hospice and 10 deceased patients. Adapted data courtesy of Beacon Health, Eastern Maine Healthcare Systems.

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From Population to Patient 1

Eldercare Team

- Who are our **High ACP/PC Need** patients?
  - How many in our practice?
- Let's see if the claims are identifying the right patients.
  - From the populationist's list to the patient's EHR
  - ACP documentation
    - No note
    - Note but no billed visit (>15 min.)
    - Gave advance directive forms; no follow-up
    - No structured information for a covering, ED or hospital provider
- Hmmm…
  - Let's get to work!

From Population to Patient 2

Eldercare Team

- Goal: Raise our ACP/PC rate from 15% → 40%
- How?
  - Patient/caregiver
  - Practice workflow
  - **Provider**

PCP	# of patients
Provider 1	33
Provider 2	15
Provider 3	4
Provider 4	3
Provider 5	3
Provider 6	2
Provider 7	2
Provider 8	1

From Population to Patient 3
Eldercare Team - Provider

- Very High Need for ACP/PC
- *No evidence of ACP/PC*

Patient	HCC Score	Admits	ED	PCP Visit in Last 10 Months	Any Last PCP Date	PCP
				Yes	11/18/16	Provider 1
				Yes	11/25/16	Provider 6
				Yes	11/23/16	Provider 2
4	3.044	0	1	Yes	3/2/17	Provider 3
5	1.154	0	0	Yes	12/14/16	Provider 5
6	1.657	2	4	Yes	1/17/17	Provider 8
7	4.238	0	1	Yes	3/7/17	Provider 4
8	2.307	2	4	Yes	2/22/17	Provider 7

- Lots of opportunity
- Book ACP next visit!

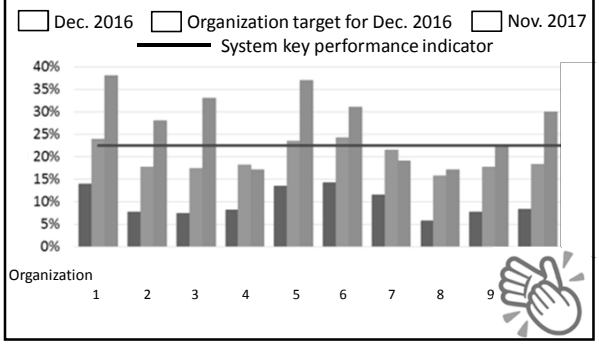
From Population to Patient 4
Eldercare Team Strategies to Reach ACP/PC Goal

Patient	Practice	Provider
• ____	• **Training**	• ____
• ____	• **Scheduling**	• ____
• **Conversation Starter Kit (ref.)**	• ____	• **Serious Illness Conversation Guide (ref.)**
• **Training**	• **Referral**	• **Training**

From Patient and Practice Back to Population 1
Eldercare Team: What Outcomes, Best Practices?

- Iterative process improvement
  - Plan / Do / Study / Act cycles
- Practice re-design
  - Scheduling for ACP visits
    - Annual wellness visits by nurse
    - Co-appointment with ptovider
  - Collaborative practice protocols
  - Share among providers, practices, organizations
- Incentives?
  - Patients
  - Providers

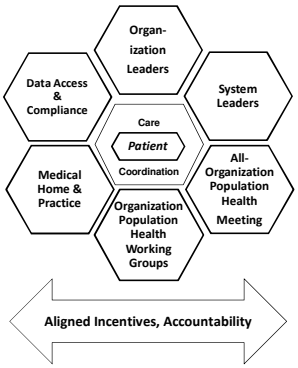
From Patient and Practice Back to Population 2
Interim Progress to Goal



You Are Practicing Population Health!

Set Targets and Work Together to Achieve Them

- **Cost targets -** adjusted for quality, chronic disease
- **Quality targets –** 90th percentile or better
- Individualized for each organization
- New data ***monthly***



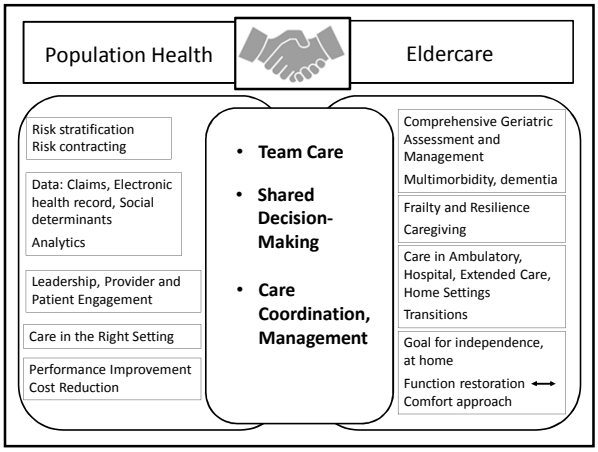
Eldercare Informs Population Health

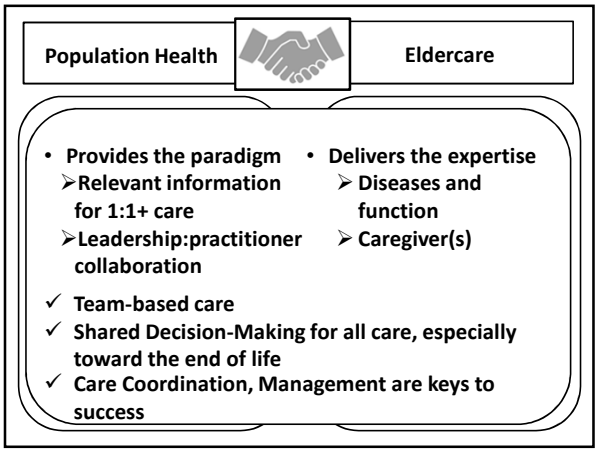
- Example of advance care planning and palliative care
- Same process for quality measures and utilization challenges
  - Potentially avoidable emergency department visits, admissions and readmissions
  - Eldercare-specific examples
    - Quality: Assessing Care of Vulnerable Elders (ACOVE)
    - Falls prevention with tai chi exercise intervention
- Your thoughts?

All In For Better Elder Population Health
A Note to Providers

We Practitioners	They Leaders
Practice evidence-based medicine Uphold quality, safety, regulatory goals	Provide information, services and education for high quality and low burden
Report quality data	Provide clear, timely information
Come to meetings and performance feedback sessions	Include providers in work and decision-making
Pay attention to information	Seek providers' feedback
Accept decisions by physician leaders	Maintain primary loyalty to and confidentiality of providers
Be flexible, share ideas; behave as professionals	Communicate, communicate, communicate
Collaborate with colleagues and hospitals	Negotiate well to align incentives

Fernandez K, Memorial Herrmann, Houston TX; The Leaders' Board, Dallas TX, Nov. 2015





Summary

- Population Health
  - US healthcare quality, safety, spending
  - Waste, accountability; social determinants
  - Big data ⟺ One patient at a time
- Eldercare
  - Strong tradition of team care
  - Complementary strengths in assessment, balanced intervention
- Many opportunities for synergy
  - Eldercare teams enhance their embrace of Population Health

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…and thank you!

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