

第五回PHM研究部会

Report on the 2019 Population Health Colloquium in Philadelphia

June 19, 2019

Tokyo, Japan

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& Shoichiro Meguro

Agenda

- Introductions (10 minutes)
- Report on the 2019 Population Health Colloquium in Philadelphia (50 minutes)
 - Top 10 Issues Facing US Healthcare
 - Current State of Population Health Management (PHM) from Stakeholders' Perspectives
 - A Look at Current State of Value-Based Care (VBC)
- Discussion (60 minutes)

Introduction

- Thomas Jefferson University established the first College of Population Health in 2008
- The university convenes a 3-day academic symposium on population health management (PHM) annually in March
- Concurrently, the Population Health Alliance has their annual symposium
- These meetings attract a wide variety of PHM stakeholders including payers, providers, hospital and integrated delivery system (IDS) managers, PHM tool and service vendors vendors, IT vendors, pharmaceutical and medical device companies, and public health officials
- Today, we will review three topics from the meeting:
 - The top ten current issues in US healthcare
 - The status of PHM from a variety of stakeholders' perspectives
 - A look at the current state of value-based care (VBC)

Top Ten Issues Facing US Healthcare Today

- As described by Professor David Nash, Dean of the Thomas Jefferson University School of Population Health

Top Ten Issues - 1

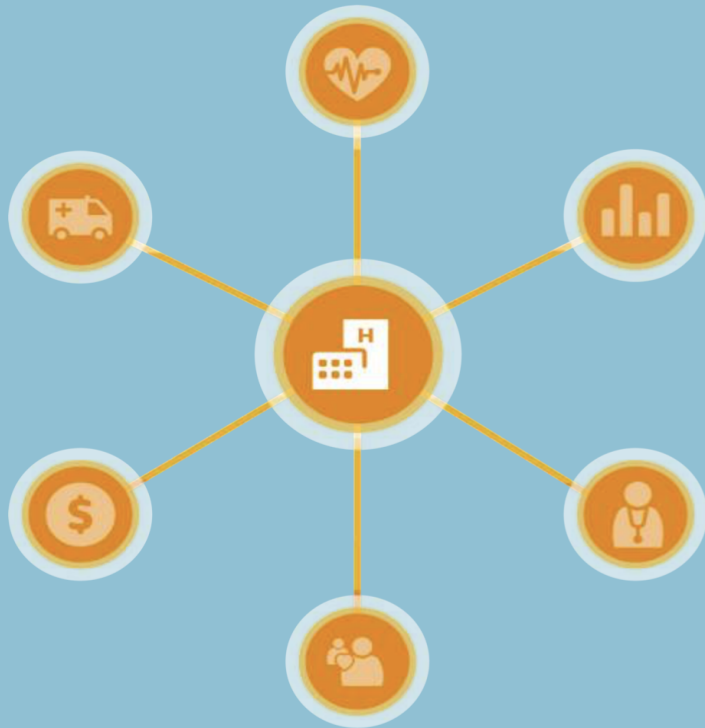
- Rising importance of the influence of the consumer in healthcare; the system must accommodate smart phones, wearables, etc.
- Background
 - Patients demanding care where they are, using smartphones, data from wearables, etc., not just inside the hospital
- Implications
 - Health systems that do not meet this demand will lose patients, especially the young generation

A transformational shift in patient care delivery



From a model

where the health system is the central hub of care delivery...



...to care pathways

that put the patient at the center and meet them where they are



Philips
population
health
solutions



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Top Ten Issues - 2

- Shift from fee for service (FFS) Medicare reimbursement to private sector-led Medicare Advantage plans (i.e. Medicare HMOs); “income based on outcomes” or “value-based care (VBC)”
- Background
 - Centers for Medicare and Medicaid Services (CMS) increasing the need to demonstrate value in exchange for payment through Medicare Advantage
- Implications
 - Providers now have financial incentives to provide quality care
 - Private sector health insurers increasing following CMS’ lead and demanding value from hospitals and physicians

Top Ten Issues - 3

- Steep tax cuts imposed by Trump administration has reduced government tax revenue, which threatens the future of social welfare programs
- Background
 - Among other cuts, Trump administration cut corporate tax rate from 35% to 21%
- Implications
 - National debt will increase ~\$2 trillion over twenty years

Top Ten Issues - 4

- The linkage of new Personalized Medicine with Population Health Management
- Background
 - Many new genetic tests available to determine genetic health risks
- Implications
 - Genetic tests a new additional tool in PHM analytics, increasing the accuracy of risk stratification

Top Ten Issues - 5

- M&A activities in healthcare industry will continue
- Background
 - There are many mergers occurring in non-traditional ways across a variety of healthcare industries
 - E.g. CVS buys Caremark; wanted to buy Aetna
 - E.g. Boots/Walgreens owns 25% of Amerisource Bergen
 - E.g. Amazon buys Pill-Pack mail order pharmacy
- Implications
 - More power to control reimbursement and concentrate market power

Top Ten Issues - 6

- Healthcare delivery systems (i.e. hospitals and doctor groups coming together to form Integrated Delivery Systems (IDS) will continue to consolidate
- Background
 - Hospitals have been merging and acquiring physician groups forming IDSs in order to have enough scale to implement VBC, e.g. as Accountable Care Organizations (ACOs) for Medicare or as IDS for private health insurers
- Implications
 - Larger IDS organizations have more power to make changes in care delivery and negotiate with health insurers in local markets

Top Ten Issues - 7

- Government funding of electronic medical records (EMR) is ending; now there are a new generation of companies that sit on top of EMR data; can they successfully “pull out” the data needed across platforms to better manage patients?
- Background
 - HITECH Act funding to implement electronic medical records (EMRs) in doctors offices and hospitals is now almost complete
- Implications
 - While EMRs now in place, still difficult for doctors and patients to access data across platforms and offices
 - New software that can find and access a patient’s data in multiple locations and display it as a single record that can use health management tools, is needed; i.e. interoperability

Top Ten Issues - 8

- Pharmaceutical companies business models are being disrupted; they need to rationalize the high prices of new medicines, or else the government may implement price controls
- Background
 - New drugs are expensive! Zolgensma, a recently FDA-approved gene therapy drug for Spinal Muscular Atrophy (SMA) has list price of \$2.1 million
- Implications
 - Insurers (including Medicare and Medicaid) may demand guarantee of efficacy, payment over time, etc.
 - Pharmaceutical companies will want to get closer to patient care to help improve quality outcomes in order to get full payment

Top Ten Issues - 9

- The money available for new investment in healthcare from Venture Capitalists continues to grow
- Background
 - Lots of money being made in M&A and IPOs from healthcare venture businesses, especially in biotech and pharmaceuticals
- Implications
 - More investors want to enter the healthcare field

Top Ten Issues - 10

- With the growth in population health management, there is a need for a larger healthcare workforce
- Background
 - PHM approaches require a mix of “high tech” and “high touch”, using nurses, nutritionists, pharmacists, health coaches, etc.
 - As PHM expands, more healthcare workers are needed to provide direct patient support

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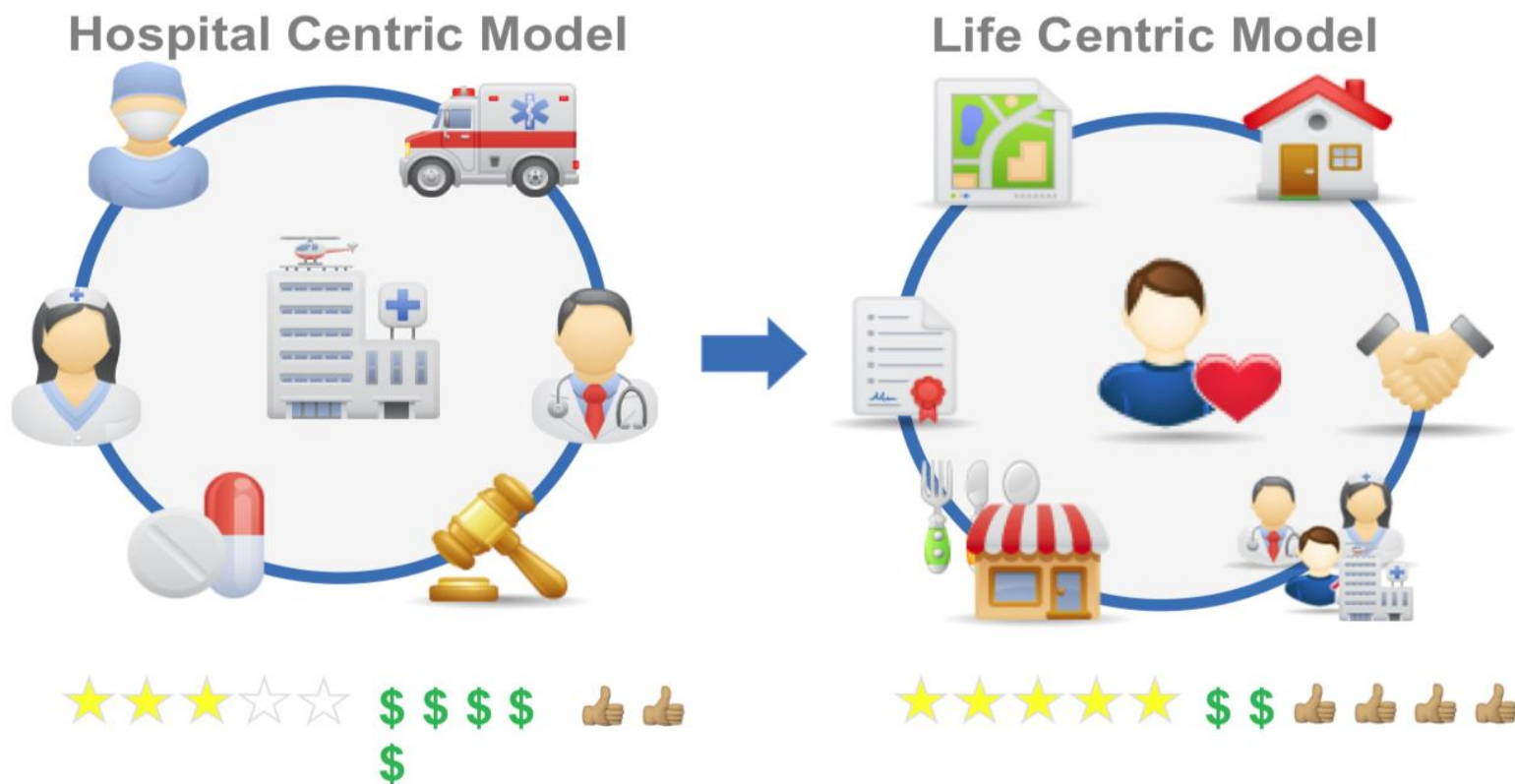
Population Health Management

- What is Population Health Management (PHM)?
- DEFINITION: A population health management program strives to address health needs at all points along the continuum of health and well-being through participation of, engagement with and targeted interventions for the population.
- GOAL: Maintain or improve the physical and psychosocial well-being of all individuals through cost-effective and tailored health solutions.

From the Chairman of the Population Health Alliance:

- The fundamental aspects of PHM are:
 - Upfront analytics
 - Actions/Interventions
 - Outcome focus
- Many new health support tools feature a combinations of “high touch” and “high tech” (i.e. even with great technology the human touch still important)
- Care in US shifting from a Hospital-centric model to a Life-centric model

Population Health-Inside vs. Outside the Walls



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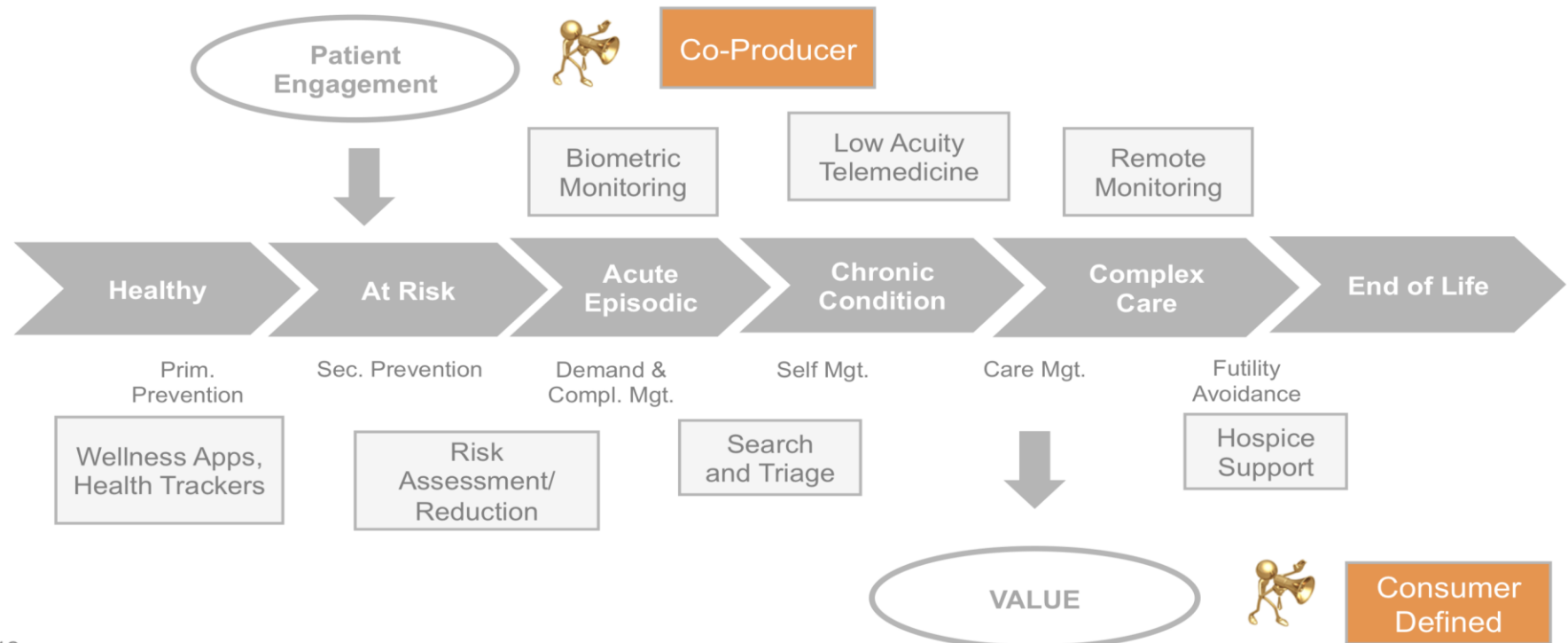
Population Health: One Individual at a Time

“There is recognition that the patient [consumer, member] is co-producer of the outcomes for which the physician [and all of us] is now being held accountable.”

Alan Weil Health Affairs



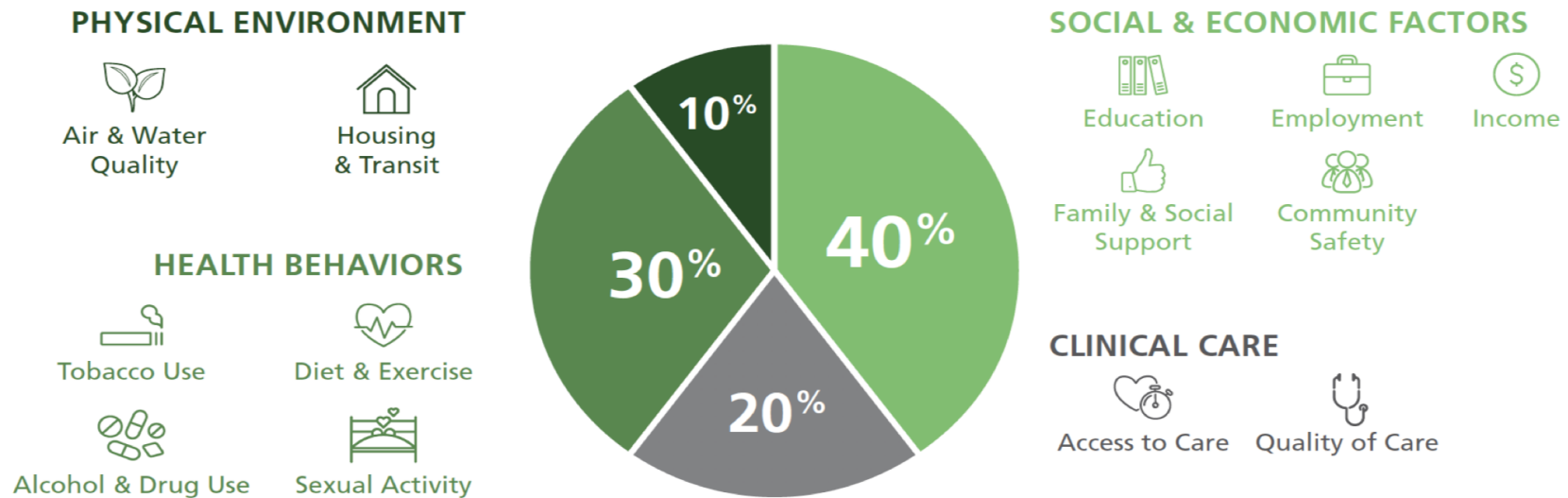
High Touch to High Tech-Full Continuum of Health and Care to Create Impact



SOCIAL DETERMINANTS OF HEALTH

“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*



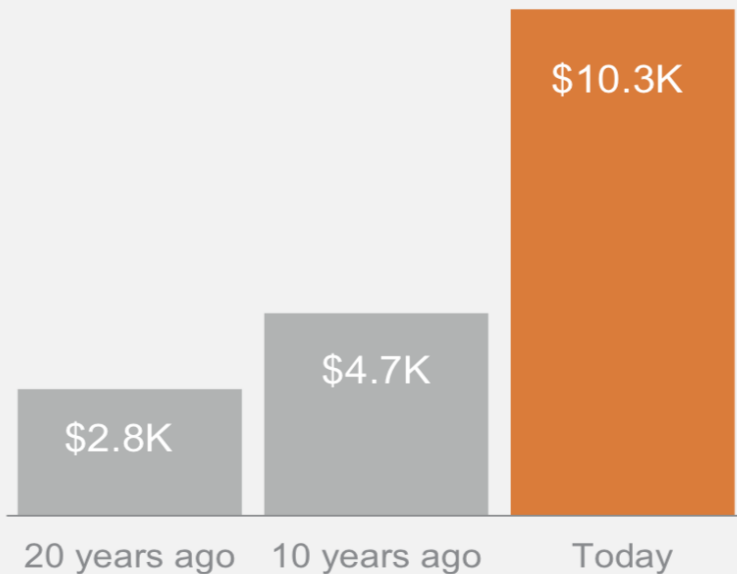
healthypeople2020.gov; National Alliance to impact the Social Determinants of Health (www.nasdoh.org)

From the Better Medicare Alliance Perspective (i.e. Private Sector Medicare HMO Industry Association):

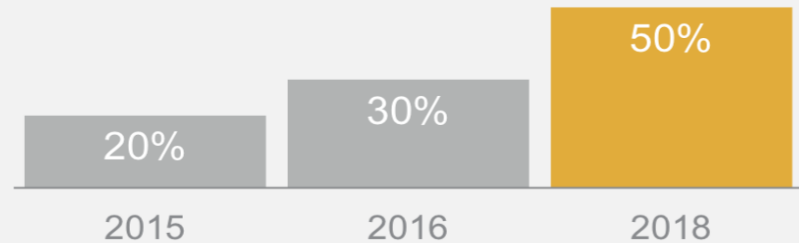
- Medicare reimbursement in US shifting from fee for service (FFS) to value-based care, increasingly provided by Medicare Advantage programs (i.e. Medicare HMOs)
- Expected to reach 40% of Medicare members by 2027

The imperative to lower costs and improve quality will not change

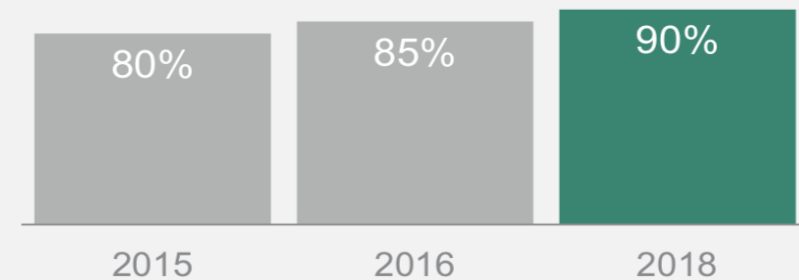
Growing annual **health care costs**
per American



Growing Medicare payments
tied to quality



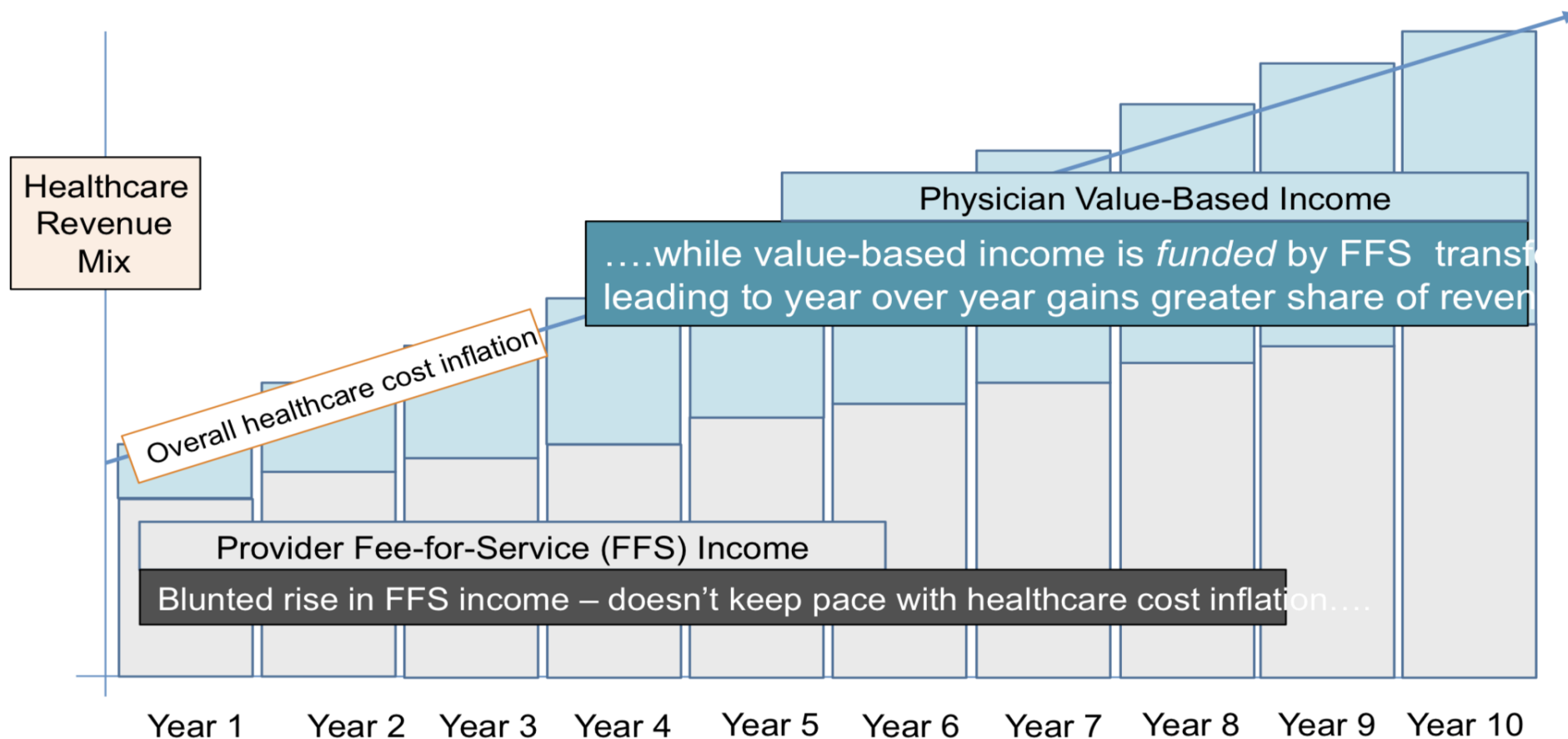
Growing Medicare payments
tied to risk



From the Provider Perspective:

- Primary Care Physicians are struggling with shift to value-based care because:
 - Electronic medical record (EMR) is difficult to use and time consuming
 - Value-based care reimbursement replacing FFS, but no additional payment for additional services required
 - Virtual visits/patient emails may or may not be reimbursed
 - Thomas Jefferson University created physician leadership academy to train doctors how to lead a business

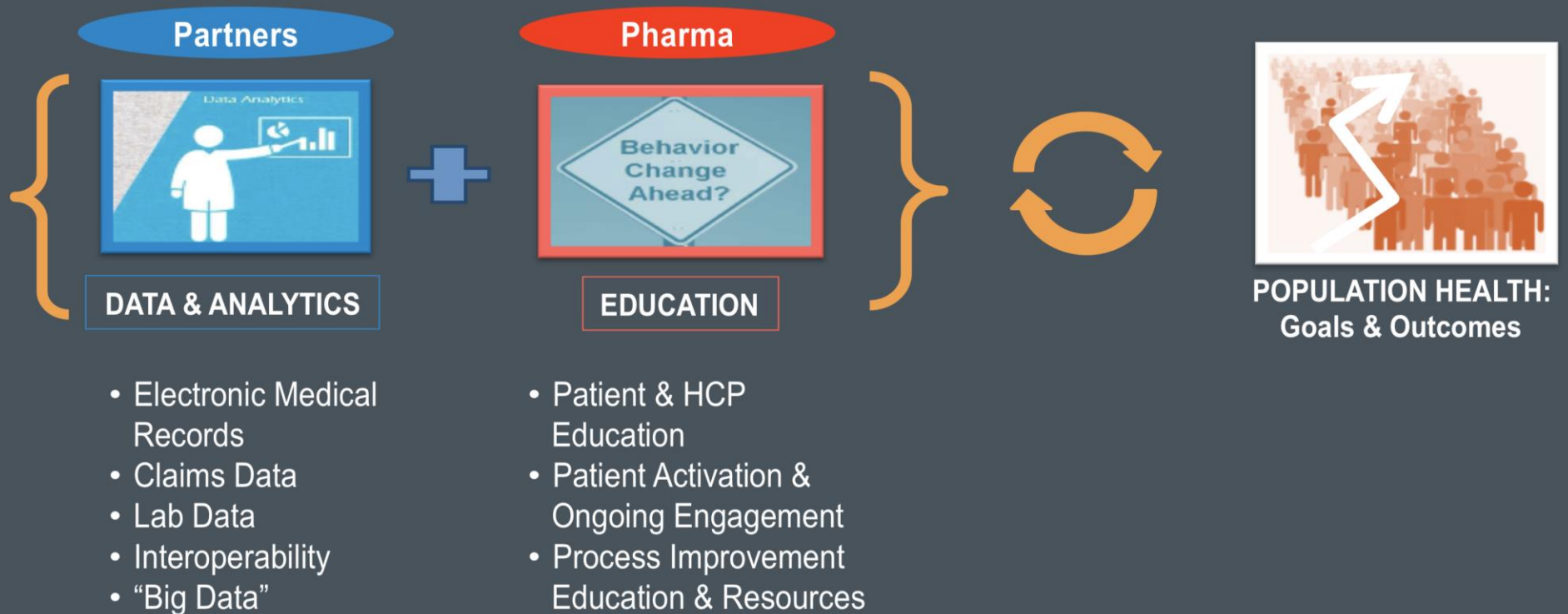
Revenue linked to health outcomes



From the Pharmaceutical Industry Prospective:

- Pharma companies are becoming more directly involved in patient care, as they are increasingly asked to justify the high price of new drugs
 - E.g. Merck is working with health insurers and providers, such as Integrated Delivery Systems (IDS) to pilot new programs such as:
 - Medication adherence program with NCQA
 - Diabetes care program with Aetna
 - Hospital infection control program with Premier to reduce C. diff. infection rates

How Can Pharma Support Population Health Initiatives?



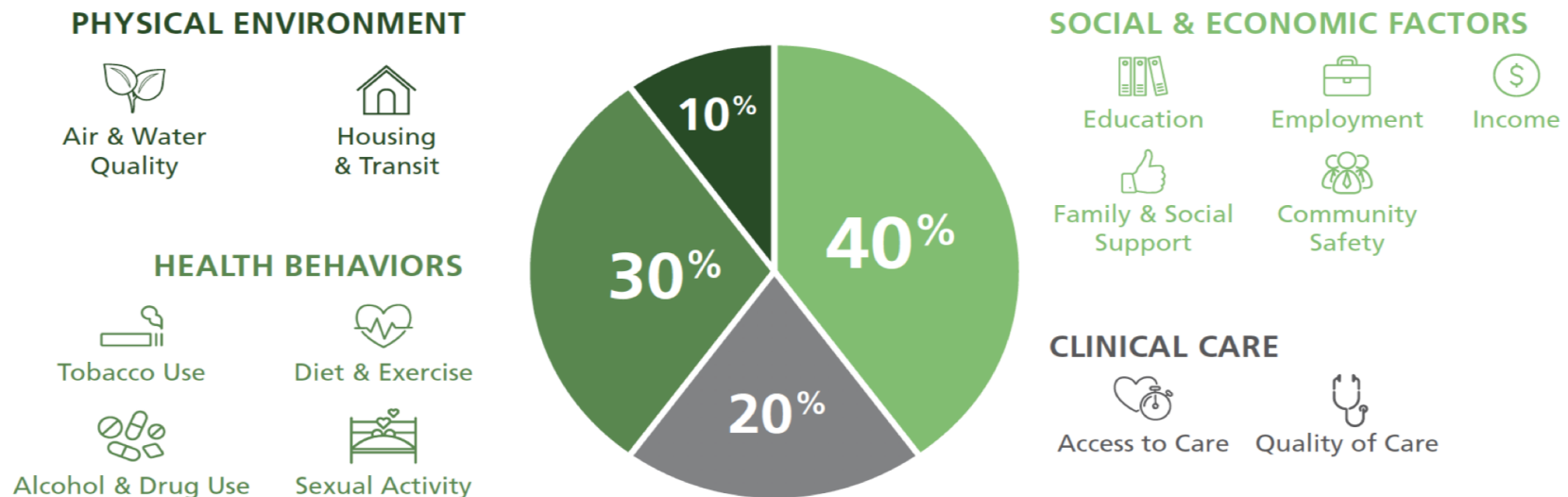
From the Integrated Delivery System (IDS) Perspective:

- Increasing interest in the importance of addressing Social Determinants of Health (SDH) due to its large impact on health status and outcomes
 - Need better analytics to identify SDH needs
- E.g. SDH program run by Geisinger Health in Scranton PA, called “Springboard”
 - Their #1 SDH gap is lack of healthy food, therefore set up “Food Pharmacy” where patients who receive “food prescription” from their primary care doctor can visit weekly to receive free healthy groceries for their family

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- *Healthy People 2020*

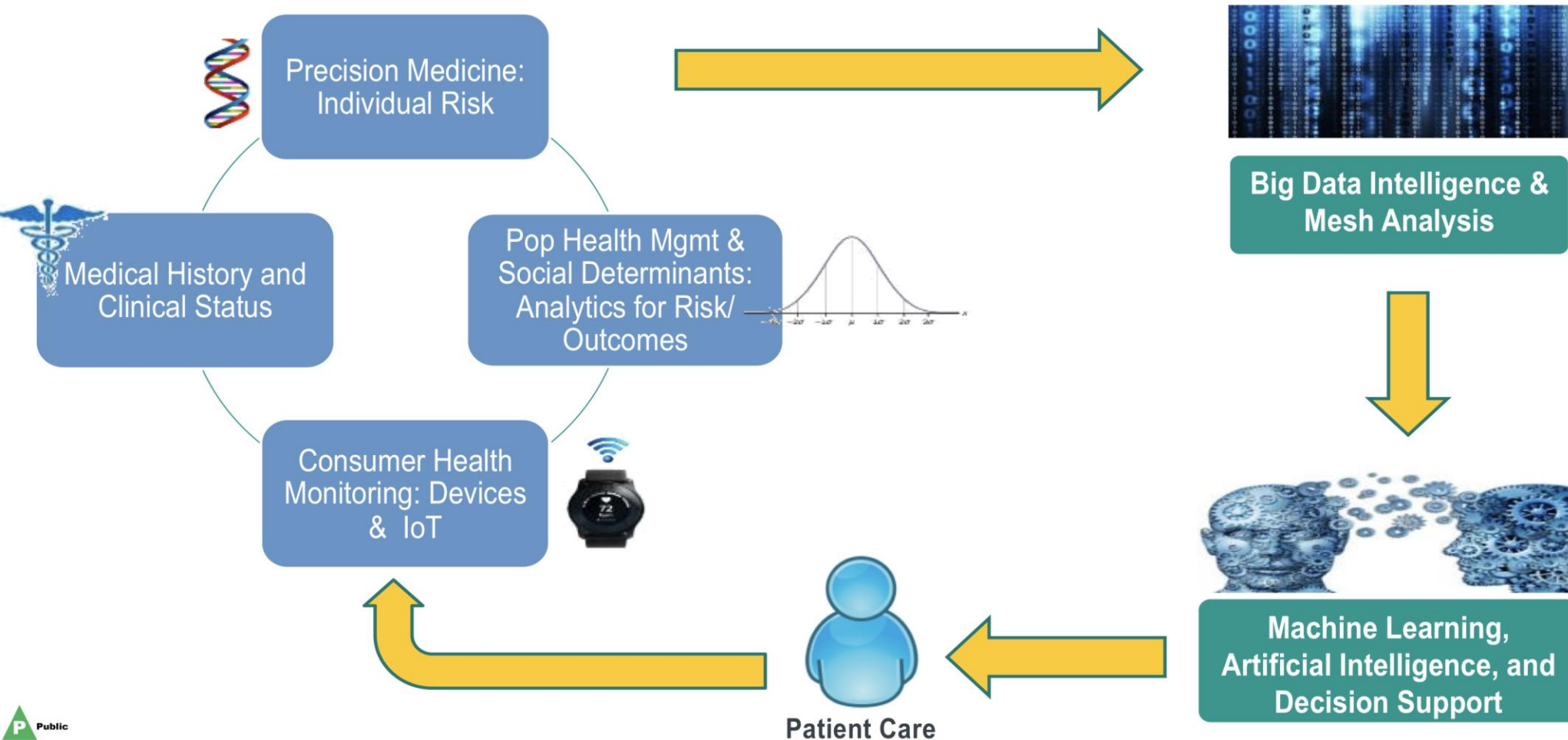


healthypeople2020.gov; National Alliance to impact the Social Determinants of Health (www.nasdoh.org)

From ICT Industry Perspective:

- IT vendors are making progress on integrating regional data from EMRs, hospital billing, health insurance claims data, immunization and other information to make integrated workflows for physicians and the care team in the network

The Future State of Population Health Management



From the ICT Vendor Perspective

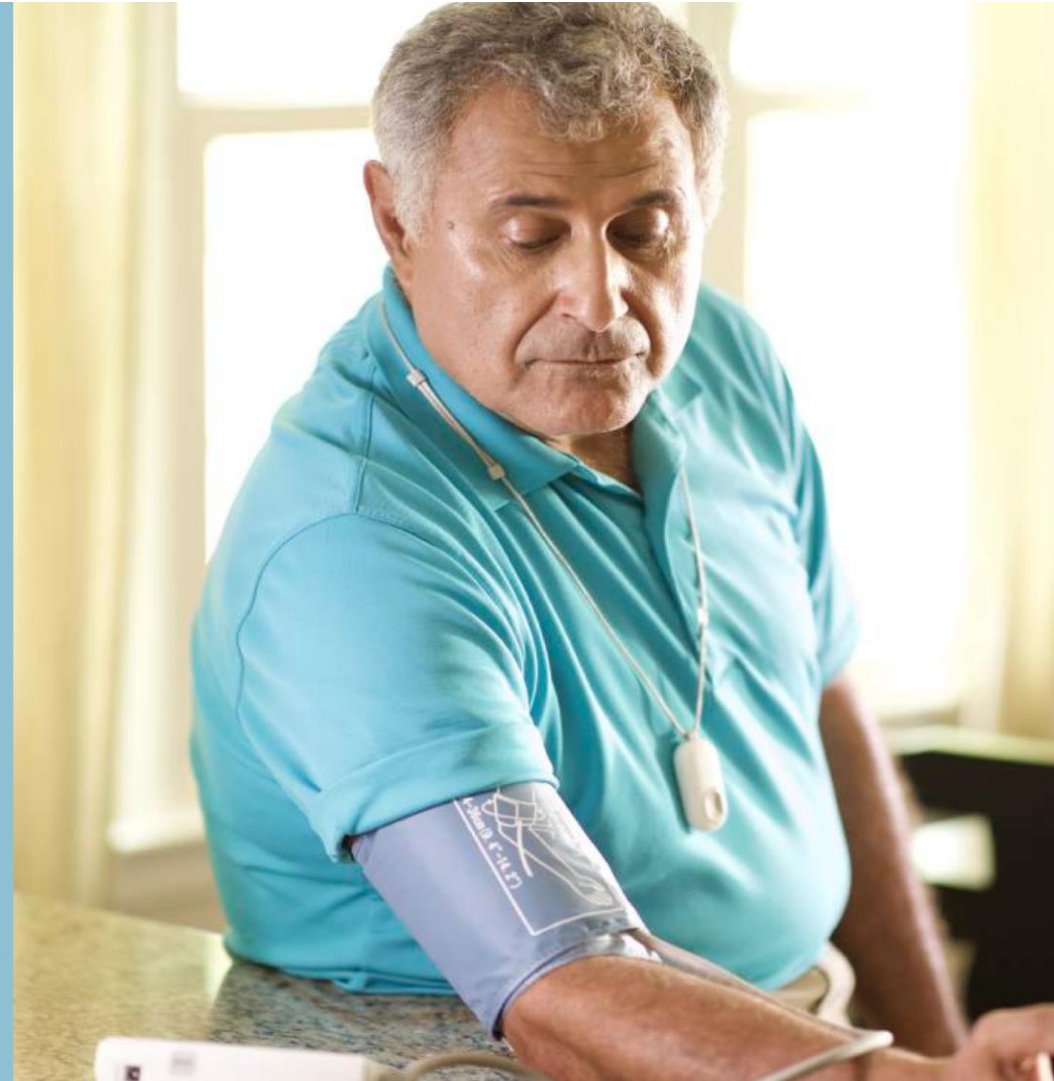
Evolving Care Outside the Hospital to Meet Consumers Where They Are

From **Philips PHM**, Niki Buchanan:

- Medicare now reimbursing for remote visits through telehealth
- 70% of doctors now offer some kind of virtual on-demand care
- Philips has a patient-facing health support platform that includes remote patient monitoring for chronic conditions
- Now deployed at New York Presbyterian Hospital system, where they expect virtual patient visits to surpass in person patient visits by 2024
- They have placed kiosks for virtual urgent care visits in Walgreens pharmacies in the hospital's neighborhood

What programs are ripe for remote patient monitoring?

- **Mental health programs**
depression, crisis intervention, prevention, etc.
- **Opioid crisis**
need for daily check-ins and monitoring
- **Diabetes**
obesity and social coaching
- **COPD and CHF**
proven improvements in care

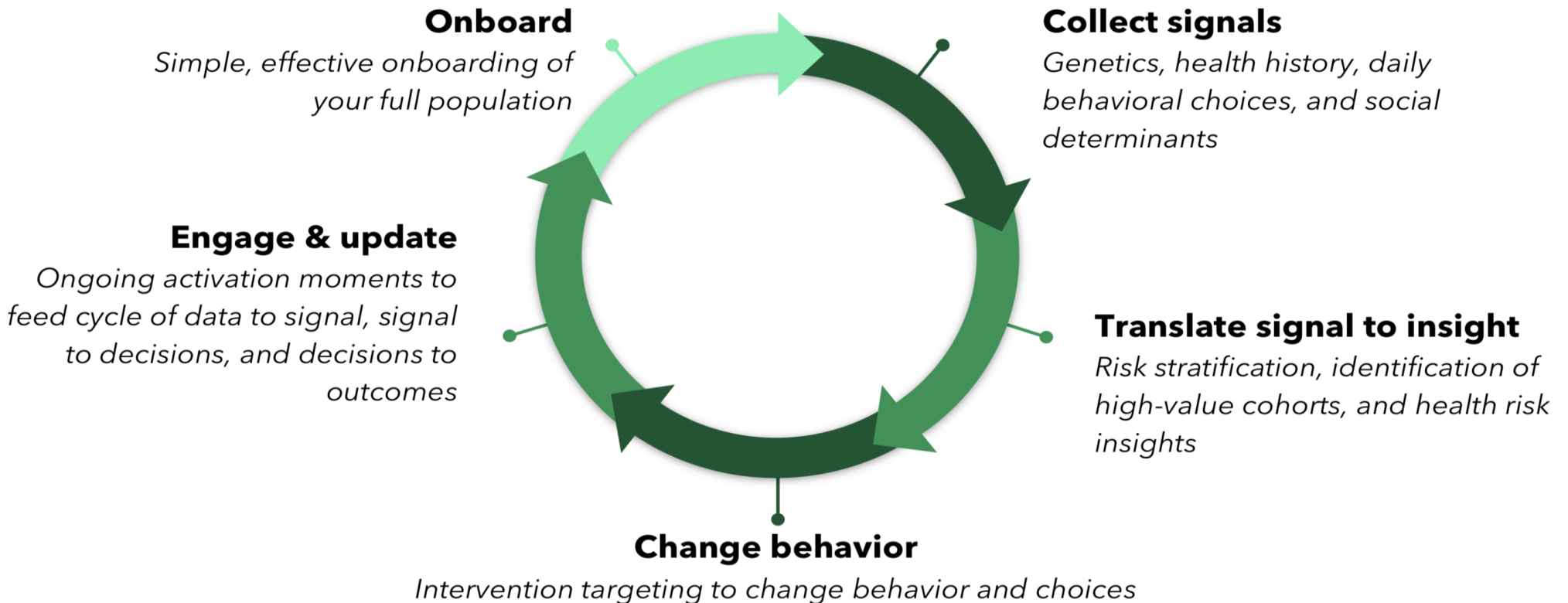


From the Genetic Testing Lab Perspective

From **Color Genomics**, Alicia Zhou:

- Contracts with Employers to offer genetic tests at Color Genomics at no-cost to employees
- Color combines genetic data and the results of an employee's health risk assessment to provide “Data-driven Prevention”
 - This is the intersection of Personalized Medicine and Population Health Management
- Color also has genetic counselors available by telephone to discuss results with employees

Color's model



From the Third Party Accreditation Perspective

From the **National Committee on Quality Assurance (NCQA)**, a third party accreditation organization, Margaret O'Kane:

- NCQA accredits PHM programs and also software tools
- She believes Medicare Advantage programs are currently providing the best example of PHM in the US
- The Star rating system allows members to see ratings of competing Medicare Advantage programs
- NCQA now developing SDH metrics to measure PHM programs ability to assess and intervene in SDH; it is very challenging

Two new Population Health Management Products

Population Health Program Accreditation	Population Health Management Prevalidation
For organization directly providing population health programs to individuals (i.e. interventions)	For software that helps with population health management
Programs can be based on specific population, conditions, or demographics	A “ pre-check ” of software’s capabilities before a health plan (or other organization) uses it
Focuses on whole-person health: person first, the condition second	Eligible tools include: data aggregators, case management systems, risk stratification tools

From the Employer Perspective:

- HealthNEXT has developed new assessment tools to measure an employers readiness to effectively manage employee health, based on a 0-1000 point rating scale
 - An increase in 50 points can lead to a 1% decrease in healthcare costs
 - Intel found that out of its 130,000 employees, 800 people accounted for \$100 million in healthcare costs

OUR METHODOLOGY

ASSESSMENT – GAP ANALYSIS

Single Metric – 700 out of 1000 is Benchmark

HealthNEXT

10 Weighted Categories

- People & management
- Marketing & communications
- Data warehousing
- Health & wellness plan design
- Environment
- On-site health activities
- Health & wellness activities
- Incentives & benefits design
- Engagement & navigation
- Vendor integration

Two Gaps-From-Benchmark Planning Tools

EHOA™

For Large Employers



- 218 “Elements”
- 10 “Categories”
- 11 “Thresholds”
- 5 “Degrees” of completion

EA50™

For Mid-Mkt Employers



- 50 “Elements”
- 10 “Categories”
- 5 “Degrees” of completion

***Health Risk Appraisals (HRA) For An Organization
Generates a 3 year strategic plan to reach benchmark***

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Population Health—our practical definition:



“Population health refers to health care efforts that aim to use health care resources effectively and efficiently to improve the lifetime health and wellbeing of a specific population.”

The “Population Health Way of Thinking”

Population health is more than health care analytics or a new care model. It is a true and lasting shift in the mindset that determines how all the stakeholders in health care approach their work everyday.



It calls for changes in behaviors and ways of thinking in health care:



Planning and collaboration across all specialties and services to maximize overall outcomes—both clinical and financial



Leveraging technology to improve monitoring, access to care, and communications between patients and the care team members



Focus on the sum total of the populations' health experience, as well as the risks and utilization across continuum of care

With the new state of mind, job of actors in the health care system is to plan for and take actions to help ensure better health for a population, both now and in the future

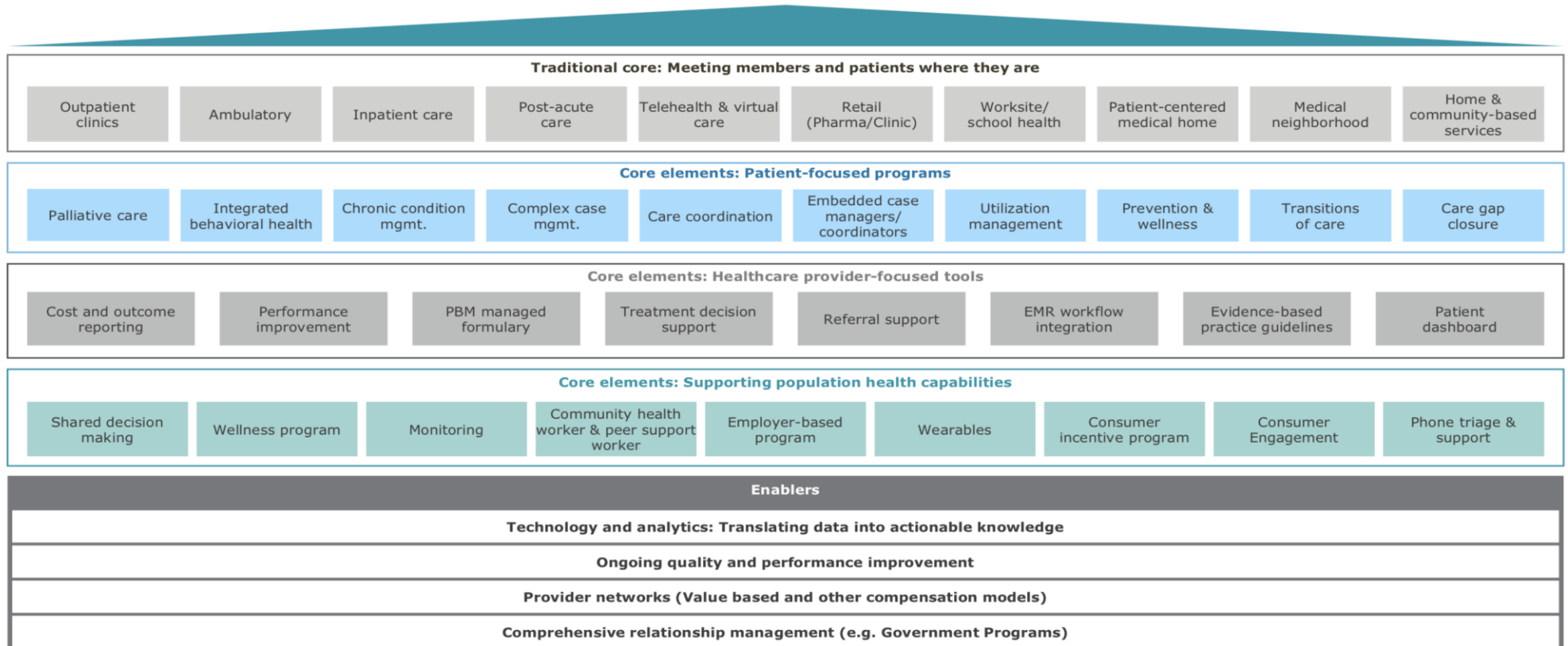
Access and share My Take “Defining and Delivering Population Health” at:

<http://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/health-care-current-october13-2015.html>

Access and share Es’ Blog post ‘The new population health state of mind’ at

<http://blogs.deloitte.com/centerforhealthsolutions/the-new-population-health-state-of-mind/>

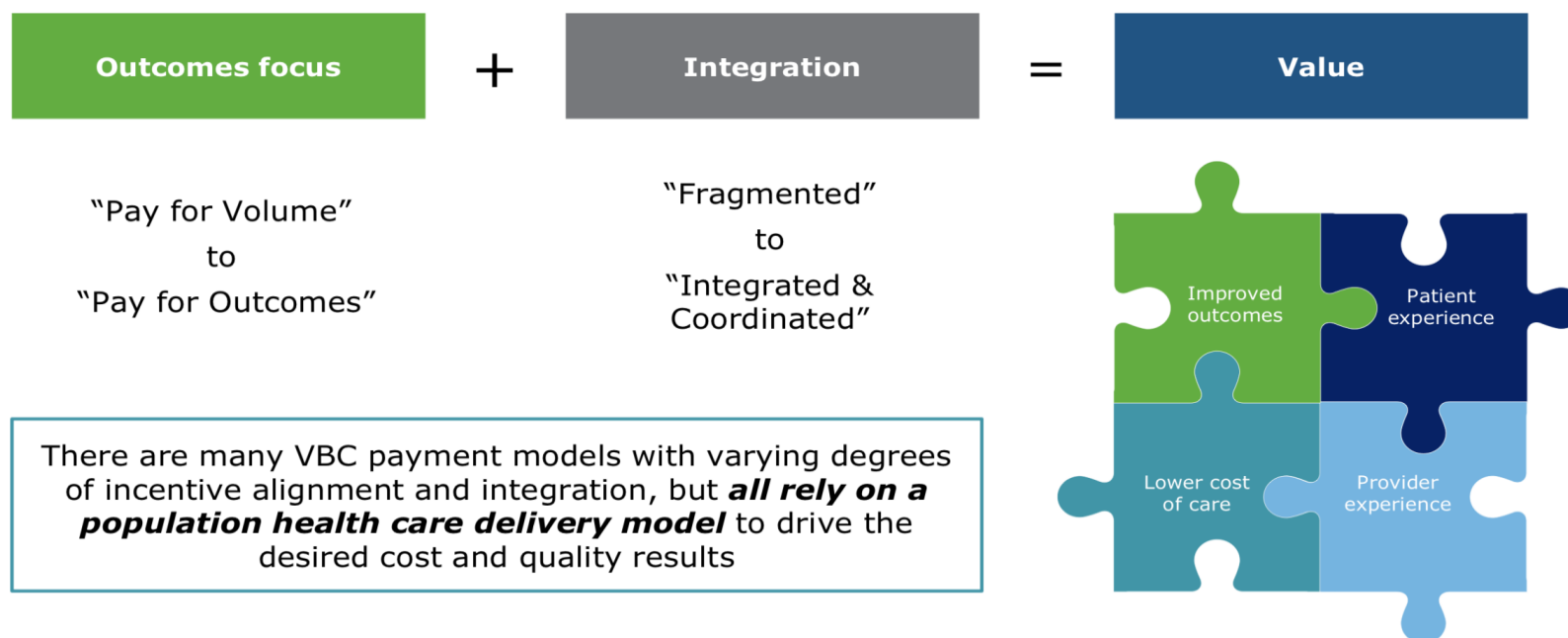
A comprehensive suite of capabilities is needed to support population health in a value-based care model.....but we have yet to see a health care organization with all



VBC: Where pop health meets reimbursement

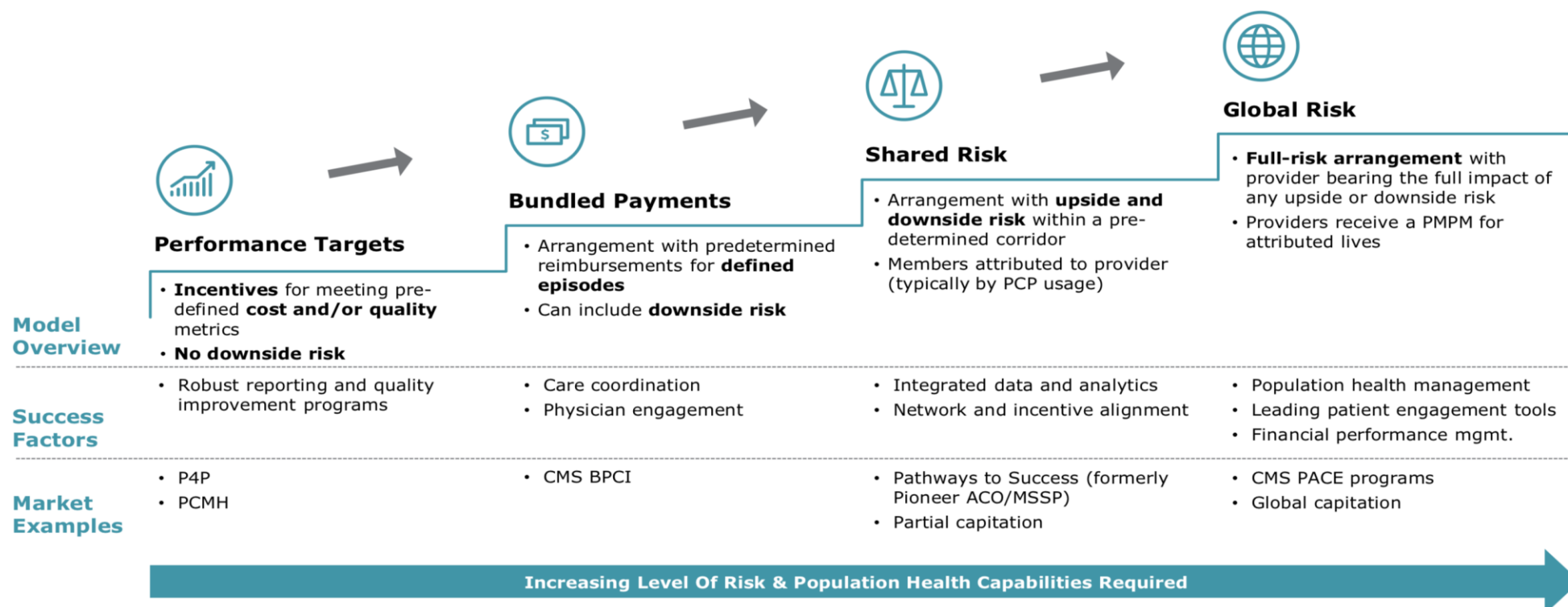
What is Value Based Care?

Value Based Care (VBC) is fundamentally different from fee-for-service because it focuses on outcomes, clinical integration, and aligned financial incentives to create value. VBC payment models require population health delivery models to succeed.



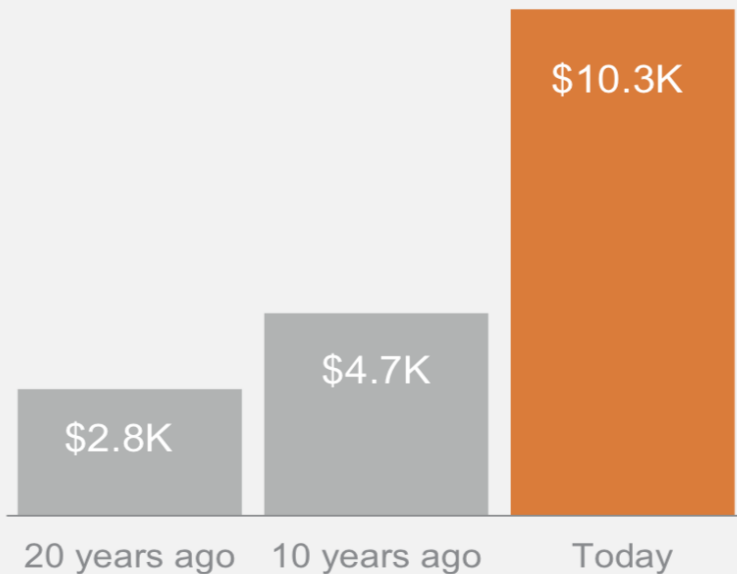
VBC payment model structures

There are many VBC payment models, each with varying incentive structures aimed to scale up the clinical integration and population health delivery approaches along with level of risk required for sustained value.

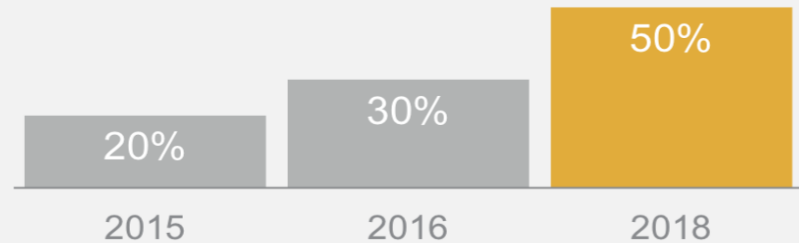


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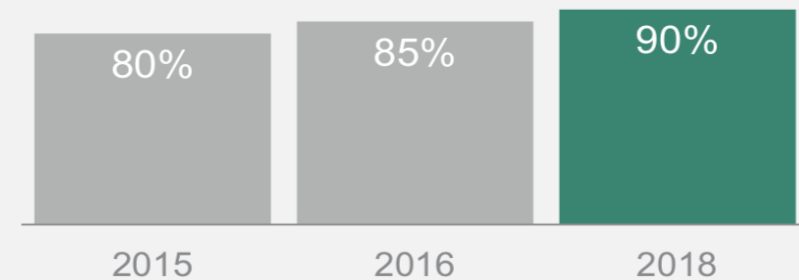
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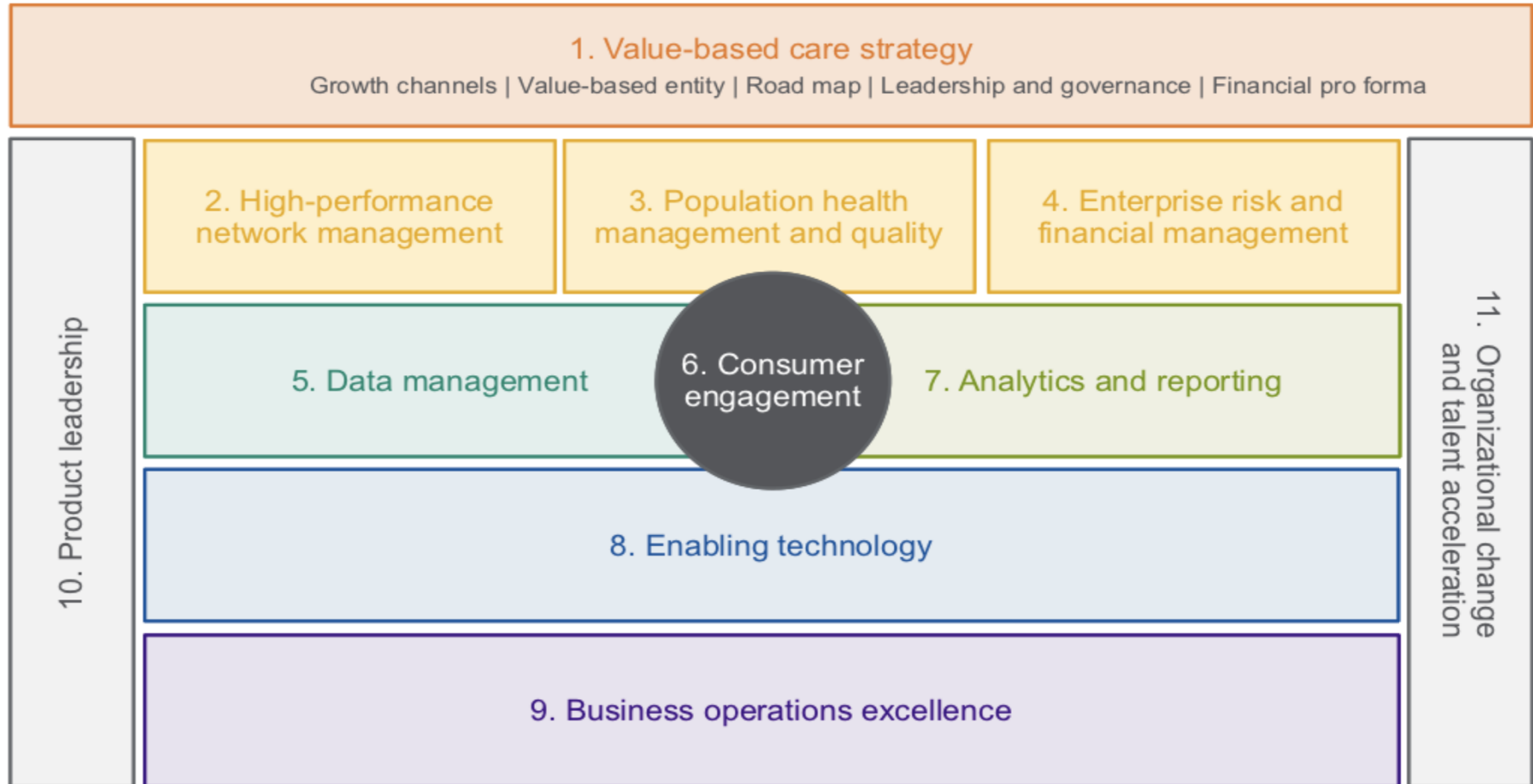
Growing Medicare payments
tied to quality



Growing Medicare payments
tied to risk



Framework for value-based care



There are minimum requirements for success



Risk management and growth strategy

Craft a sustainable value-based strategy with a solid financial foundation for profitability and growth.



Network formation and contracting

Develop an aligned physician network; match cross continuum and regional partnerships to market opportunities.



Integrated care delivery

Develop and implement comprehensive, customized, scalable and standardized clinical programs and services.



Integrated partnership

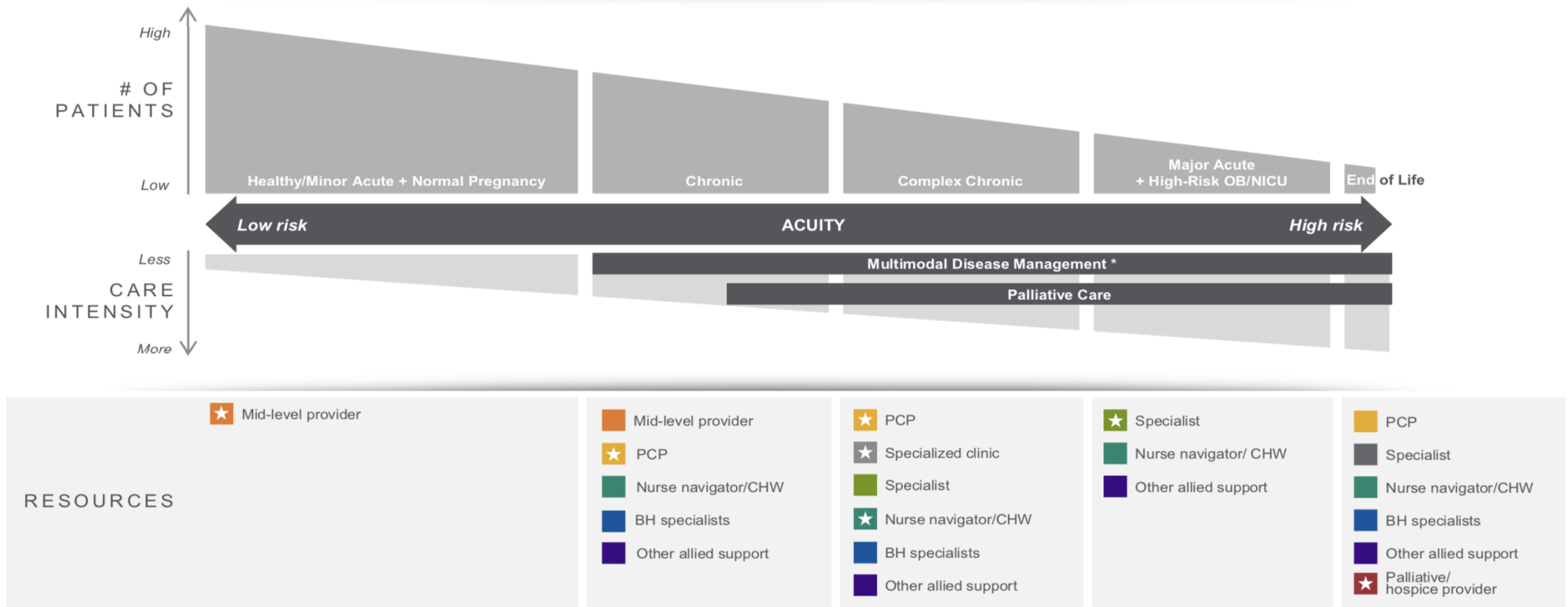
Develop partnerships, centralized infrastructure and local market governance to drive efficient operations. Integrate data and analysis and drive patient health at lower costs.

Population segmentation

Phase I: Maintain focus on med-high/high risk with emphasis on supplemental income adults with chronic conditions

Phase II: Expand to cover all segments of initial risk contracts

Future state: Expand segmentation to cover all populations in all risk contracts



LEGEND: *Multimodal disease management (e.g., education, online engagement, remote monitoring); Other allied support: social worker, pharmacist/medication mgmt, educator, dietitian)
★ Lead provider

Source: 10000 Lives Model of Population Health Care Delivery

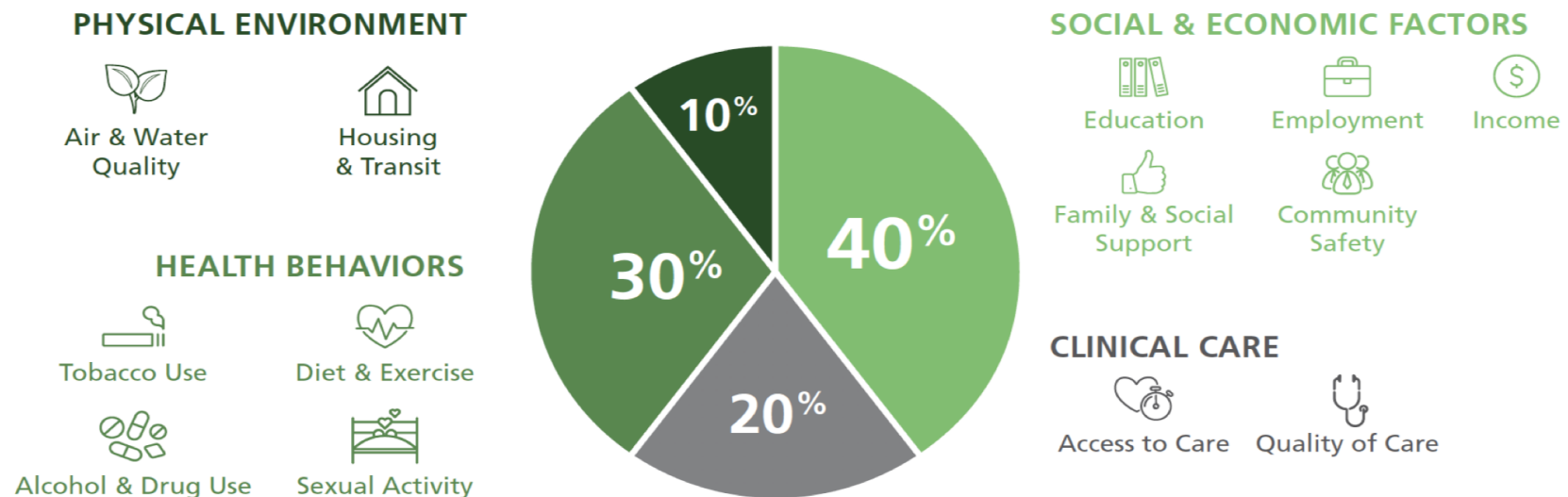
Q: Why are Payers and Providers/IDS's interested in SDH?

A: They MUST BE, since increasingly they are responsible for overall health outcomes for a population, not just individuals

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- *Healthy People 2020*



healthypeople2020.gov; National Alliance to impact the Social Determinants of Health (www.nasdoh.org)

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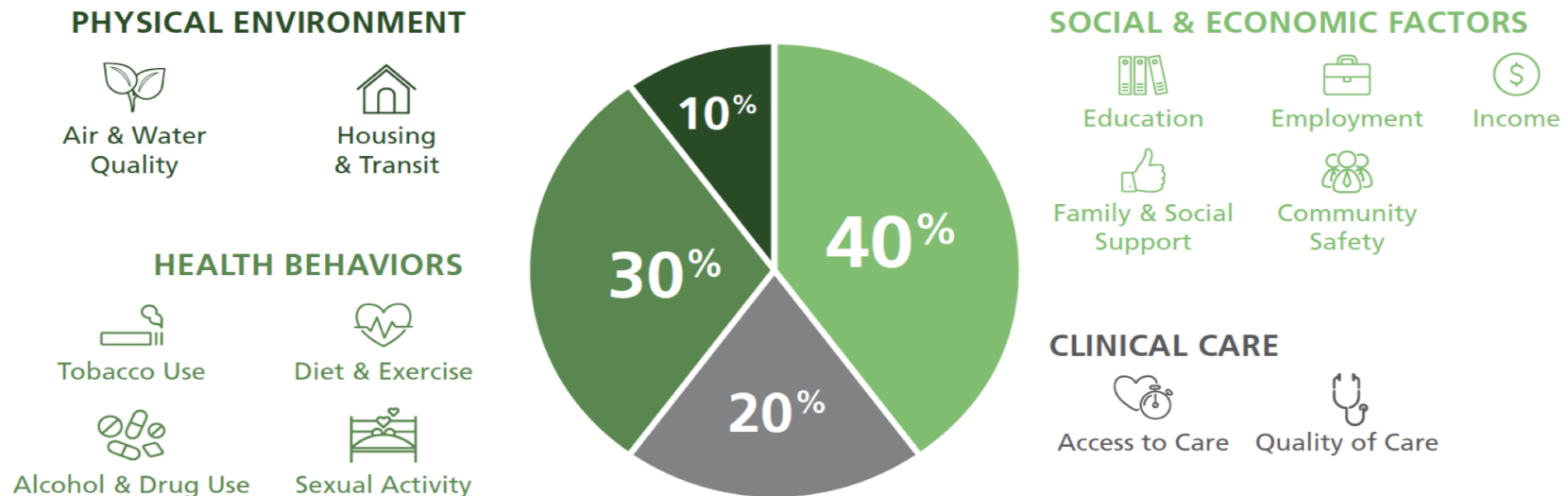
Q: Why is the Employer interested in SDH?

A: Because employee health affects absenteeism, and productivity, in addition to healthcare costs

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Q: Who is best positioned to apply PHM health support to employees?

A: -Payer, IDS/Providers, Employer can **ALL** apply PHM outside Clinical Care

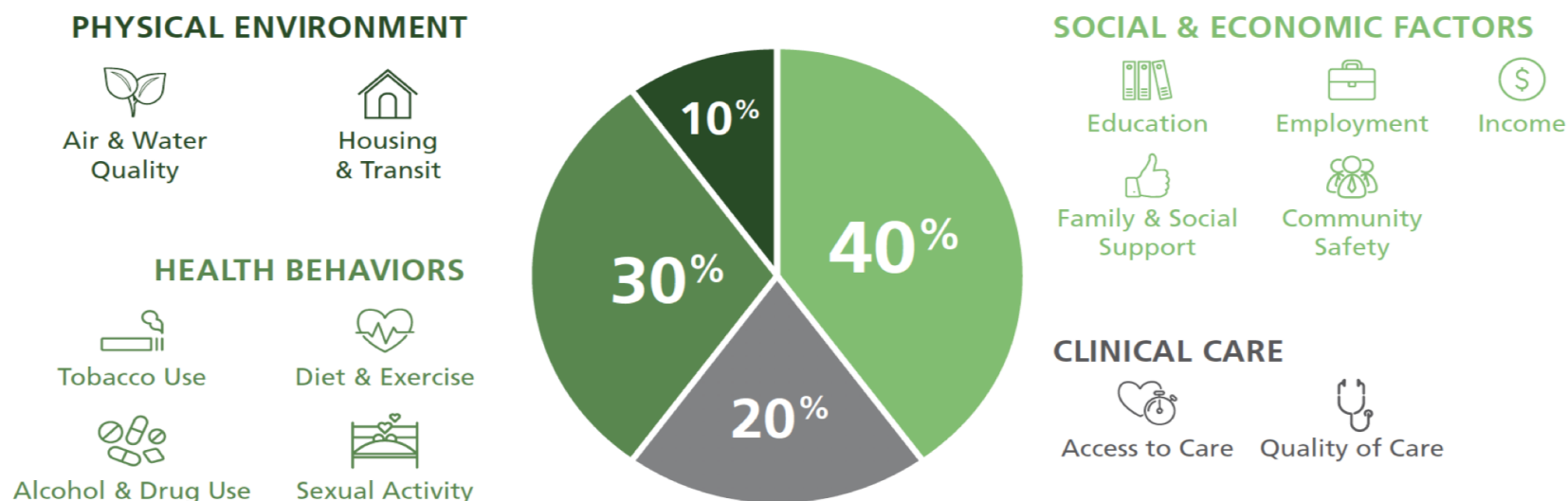
-**Only** IDS/Providers can apply PHM within the clinical care setting.

-Who is at risk determines who pays.

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Discussion

Please email me if you have any questions!
gregglmayer@mac.com

Appendix

- What is PHM?
- What types of PHM are there?
 1. Remote Monitoring
 2. Disease/Case Management
 3. Coaching
 4. Consumer-oriented
- Who pays?
 - Payer
 - At-risk IDS
 - Employer
 - Patient