Achieving breakthrough improvements in health, wellbeing and equity

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Cambridge Health Alliance Experience

- Changed our payment model and our delivery model from fee for service to global payments (230 people to 60% population)
- Improved experience
- 10% reduction in total cost (15% reduction compared to rest of network for Medicaid managed care)
- Improved quality health outcomes for a safety net population to above the national 90%ile
- Improved joy and meaning of work for the workforce
- Chosen by HHS ASPE as “one of four innovative and effective transformations in the country”; numerous national awards
36% Reduction in Hospitalization Rate for Patients with Diabetes
Cost of chronic disease unsustainable

The Staggering Cost of Diabetes

Today, **4,660** Americans will be diagnosed with **Diabetes**

Nearly **30** million Americans have diabetes

86 million Americans have prediabetes

More than the population of the east coast from Connecticut to Georgia

Diabetes and prediabetes cost America **$322 billion** per year

**1 in 5 health care dollars** is spent caring for people with diabetes

**1 in 3 Medicare dollars** is spent caring for people with diabetes

People with diagnosed diabetes have health care costs **2.3 times higher** than if they didn’t have the disease

Learn how to combat this costly disease at diabetes.org/congress

American Diabetes Association

STOP DIABETES
When the external becomes internal: How we internalize our environment

Allostatic Load

Inadequate Transportation Long Commutes

Stress

Housing

Stress

Lack of social capital

Stress

High Demand-Low Control Jobs

Lack of access to stores, jobs, services

Crime

Source: Anthony Iton, MD, JD, SVP, The California Endowment
Health and Social Inequity are Interconnected and Related to Place

2 newborns will have a 25 year gap in life expectancy 2 miles apart based on where they grow up.

Economic Hardship Index by City/Community, Los Angeles County, 2000

Prevalence of Childhood Obesity by City/Community, Los Angeles County, 2005
Interrelationship between the health, wellbeing and equity of people, communities and populations
5 key shifts we need to make

- From a “sick care system” to a “health and wellbeing system”
- Take our work on addressing racism and equity from “doing good” to a recognition that we are interconnected and cannot afford the price of poverty and inequity in terms of health and life outcomes or cost
- From people and communities of poverty to people and communities of trapped and untapped potential
- From pathology to vision – change is possible
- From scarcity to abundance
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.”

www.100mlives.org
Core strategies + equity as the price of admission

1. Create healthy, equitable communities
2. Build bridges across sectors
3. Create a health care system that is good at health AND good at care
4. Promote peer-to-peer approaches
5. Create enabling conditions
6. Develop new mindsets
Pathways to Population Health: For Health Care Change Agents

- Developed through unprecedented collaboration and thought partnership of over 50 leading health and health care organizations together

- 5 partners took the lead in implementation of the framework:
  - American Hospital Association/HRET
  - Institute for Healthcare Improvement
  - Network for Regional Healthcare Improvement
  - Public Health Institute
  - Stakeholder Health

www.pathways2pophealth.org
1. Health and wellbeing develop over a lifetime.

2. Social determinants drive health and wellbeing outcomes throughout the life course.

3. Place is a determinant of health, wellbeing and equity.

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

5. We need to embrace new financial models and deploy our existing assets for greater value.

6. Health creation requires partnership because we hold only a part of the puzzle.

What creates health? How can health care respond?
Two major jobs that health care organizations need to embrace

- Improve the health and wellbeing of communities
- Improve the health and wellbeing of patients

Population health, wellbeing, and equity
Four Interconnected Portfolios of Population Health for Health Care Organizations

Portfolio 1: Physical and/or mental health
Portfolio 2: Social and/or spiritual wellbeing
Portfolio 3: Community health and wellbeing
Portfolio 4: Communities of Solutions
4 Interconnected Portfolios of Work

Population Health

P1: Physical and/or mental health
P2: Social and/or spiritual wellbeing
P3: Community health and wellbeing
P4: Communities of Solutions

Patients and Employees
Communities
Common across all portfolios

- **Equity**
  - Portfolio 1 & 2: Applying an equity and social determinants lens to clinical care
  - Portfolio 3 & 4: Applying a place-based equity lens; addressing structural racism using all of own’s assets
  - All four:
    - Being accountable for everyday racism and structural racism inside and outside the walls
    - Partnering with people with lived experience of inequity

- **Community integration**
Portfolio 1: Mental and/or physical health for patients/employees

- Intermountain Healthcare
- 22 hospitals, 1400 physicians
- High functioning primary care, behavioral health integration into primary care, telemedicine; functioning as an ACO
- Saved $500 million in medical expense alone
- Returning savings to employers and patients as reduced premiums
Portfolio 1: Philadelphia

- Integrated mental health in primary care
- 10,000+ citizens trained in mental health first aid
- Universal screening at pharmacies for mental health disorders
- Narcan available through pharmacies
- Murals created by people with and without mental health disorders
- Walks to destigmatize mental health in the community
Welcome to Big White Wall. Having a tough time? Feeling down or stressed? Start feeling better now.

Read more about the service Big White Wall offers and what it can do to help.
Portfolio 2 Address social and spiritual drivers of health and wellbeing

- Screening for and addressing the social determinants of health
- Partner with local social service agencies, faith communities, housing organizations, and other community-based organizations to address social needs
- Develop faith-health partnerships
- Address social isolation, purpose and meaning in life
Building clinic capacity to address social and behavioral determinants strongly improves joy in work in the health care workforce.
Portfolio 2: Addressing social and spiritual drivers or health and wellbeing in the community

Pathways Community Hub Model
Pathways Hubs lead to Triple Aim Outcomes

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 services, and monitor pregnancy and birth outcomes. The CHAP protocol consists of 40 hours of care coordination over 4 years. The CHAP protocol was compared with a control group which received standard care. The study was powered to detect at least a 5% difference in LBW births from a baseline rate of 10%. The results of this study will provide evidence on the effectiveness of home visiting care coordination in addressing LBW as a key component of the Triple Aim.
Portfolio 3 Community Health and wellbeing: Focused improvement in communities

Childhood Asthma Outcomes at Cambridge Health Alliance
Portfolio 4: Communities of solution

- Shared long-term stewardship between community residents and system leaders across sectors to improve health, wellbeing and structural inequity
- Trust and governance to leverage shared resources to achieve goals
- Using assets nimbly and creatively to move forward the priority goals of the community (anchor approach)
- Growing the leadership of people with lived experience of inequity as a core strategy
- Processes to create rapid change through unprecedented collaboration, innovative improvement and system transformation
Using All Our Levers

- Care provider
- Employer
- Restauranteur
- Purchaser
- Investor
- Advocate / Policymaker
- Environmental Steward
- Insurer
- Needs assessor
- Funder
- Community partner
- Placemaker
- Systems change agent
- Trusted advisor
- Others?
Portfolio 4: Communities of Solutions

- University Hospitals in Cleveland – Addressing equity 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.

- Dignity health – invest a part of the retirement portfolio to give low income loans to community-based businesses, low income housing developers
What you can do

1. Commit to thinking and acting differently.
   - Consider becoming a pioneer sponsor of the Pathways to Population Health framework.  [www.pathways2pophealth.org](http://www.pathways2pophealth.org).
   - Approach population health as mental, physical, social and spiritual wellbeing for people and communities together.
   - Look at your outcome data by race, class, and place—and close the gap together with your patients, your workforce and your community.
   - Approach this work from a mindset of abundance; bring your assets together. Consider coopetition in communities.

2. Take a step forward—big or small.

3. Find partners—join tables where people have been waiting for you.
100 Million Healthier Lives

www.100mlives.org

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