Mini Plenary: The Triple Aim, Population Health, and Cultures of Health

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THE TRIPLE AIM, POPULATION HEALTH, AND CULTURES OF HEALTH

Behavioral Health Specialists as the Lynchpin

Rosalynn Carter Symposium
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SESSION AGENDA
(30-40 mins of prepared remarks, followed by interactive exercises)

• Triple Aim, Population Health & Building Cultures of Health
• The Potential Role of Behavioral Health
• Why this Transformation is Important
• Guiding it toward Improved Value & Sustainability with Data & Analytics
• A Case Study – The Impact of a Corporate Culture of Health
• Directional Recommendations
• An Eye on the Future – A Culture of Wellbeing
• An Exercise to Explore what all of this means to You

Empowering All to Live the Healthiest Lives They Can
THE TRIPLE AIM

Vision for Achieving Sustainable Cultures of Health

- IMPROVE HEALTH STATUS OF THE POPULATION
- IMPROVE EXPERIENCE / SATISFACTION WITH CARE
- REDUCE PER CAPITA COST OF CARE

Don Berwick MD
Institute for Health Improvement

Focus on the 3E’s of Clinical Practice in your Practice

E³
- Efficiency
- Effectiveness
- Experience
POPULATION HEALTH
Managing Across the Continuum to Achieve this Vision

Moving the Population Toward Wellness
A CULTURE OF HEALTH

Incorporating the Broad Array of Influencers
POPULATION HEALTH / BUILDING CULTURES OF HEALTH
Leveraging the Knowledge of Prevention
Starting With Cultural Imperatives

Primordial Prevention
- Culture Imperatives
- Clean Water
- Healthy Food

Primary Prevention
- Lifestyle Change
- Immunizations
- Seat Belts

Secondary Prevention
- Screenings
- Cancer
- Blood Pressure
- Cholesterol

Tertiary Prevention
- Compliance with Care
- Disease Management
WHAT’S THE POINT
INSIDIOUS PROGRESSION OF DISEASE:
*Smoking & Acute Illness leads to Chronic & Catastrophic Illness*

normal ➔ bronchitis ➔ cancer ➔ emphysema

20-Year Lag Time Between Smoking and Lung Cancer

Cigarette Consumption (men)

Lung Cancer Deaths (Per 100,000 People)

1900 1920 1940 1960 1980

Year
WHAT’S THE POINT
INSIDIOUS PROGRESSION OF DISEASE:
Anxious & Stressed leads to Chronic & Catastrophic Illness
WHAT’S THE POINT

INSIDIOUS PROGRESSION OF DISEASE:
Alcoholic Consumption in Excess leads to Chronic & Catastrophic Illness

Occasion Consumption

Binge drinking

Alcoholism

Cirrhosis
LIFESTYLE:

Strongest Determinant of Mortality

Health Behaviors:
The Main Mortality Risk Factors in U.S.

Lifestyle: 51%
Heredity: 20%
Environment: 19%
Health Services: 10%

ALL OF HEALTHCARE IS BASED ON BEHAVIOR CHANGE

Converting Theory Into Practice

Stage of Behavior Change

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance

Patient Activation Measure

Figure 1: 13-Question Patient Activation Measure

ALL OF HEALTHCARE IS BASED ON BEHAVIOR CHANGE

Converting Theory Into Practice

LEVERAGING BEHAVIORAL ECONOMICS & CONSUMERISM

• Use the magic of opt-out
  • Make the preferred choice the default

• Mere measurement
  • Interventional surveys

• Aversion of loss
  • Taking away privileges or rewards

• Value Based Benefit Design
  • Out of pocket costs based on proven value provided by medication or treatment
  • No co-payments for generic “rescue inhalers” for asthmatics

• Provide rewards and recognitions for healthy behaviors
  • Completing health risk assessments
  • Having a non-smoking status
  • Participating in health coaching

• Earn basic, better and best benefit plans

• Mastery
  • Educate leading to self-care
  • Peer mentoring

• Rank Comparison
  • Competition
THE BEHAVIOR CHANGE CONTINUUM

Program Application

ENgage  ↔  EDUCATE  ↔  MOTIVATE  ↔  ACTIVATE

Awareness

Education/Motivation

Intervention

Behavior Maintenance

Ongoing Wellness Programs

Targeted Group Programs and Self-Tracking Tools

Health Coaching

Low Intensity  ↔  High Intensity

Monthly Topics & Other Education Programs

HRA/Biometric Screening & Tracker

Source: Cooper Institute
GOOD NEWS
All Of Health Care Is Based On Behavior Change

- Modifying the physical, emotional, habitual and cultural factors that influence health status
- Paired with usual health care & social services
- Relies on an interdisciplinary approach that relies to educate, support, follow-up, and evaluate efficacy

Behavioral Health Specialists Are Uniquely Positioned to Embrace This Opportunity & Provide the Required Expertise
BAD NEWS
Behavioral Health has Been Focused on Disease
What about Preventive Behavioral Health?

Primordial Prevention
Intrinsic Motivation

Primary Prevention
Lifestyle Change

Secondary Prevention
Early Identification

Tertiary Prevention
Compliance with Care Disease Management

Behavioral Health Specialists May Require Re-Training / Re-Focus to Provide the Required Expertise
WHY BUILD A CULTURE OF HEALTH?
Benchmark Companies Achieve Meaningful Advantage

• Their Healthcare costs are declining - employees are healthier and more productive (Sources: Mercer, MarketScan, Truven, Navistar)

• Their COH results in a positive ROI (Source: Health Affairs, based on multiyear studies of Johnson & Johnson & Navistar data)

• Their Stocks outperform the market (Source: Journal of Environmental & Occupational Medicine)
ACHIEVING THIS GOAL: THE LARGER CONTEXT
The Value Problem Vexing U.S. Health Care

● High costs
  At 17.1% of GDP in 2013, 50% higher than next-ranked France

● Middle-of-the-road outcomes
  U.S. 27\textsuperscript{th} among all OECD countries in life expectancy in 2012

● High levels of waste
  \approx 34\% of national health expenditures in 2011

Needed:
A system-wide leap toward greater value

Commonwealth Fund
THE DRIVE TOWARD GREATER VALUE

Guiding Principles

Better Outcomes, Lower Costs

Achieved Sustainably

Via new stakeholder collaboration

Driven by measures that matter
THE EMPIRICAL WATERFRONT

From Data to Information

Data Elements

- Productivity Self-Reports
- Absence STD, LTD
- Claims
- HRA, EAP, DM
- Lab Values
- HR (Payroll, Eligibility)
- EMR
- Program Costs
- Chronic Care Management
- Benefit-Design
- Direct / Indirect $$
- Resource Utilization
- Productivity Profiles
- Burden of Illness
- EE Engagement
- Health-Risk Management
- Therapy Management

Reports

Source (adapted from)
Bunn, Allen, Stave & Naim, JOEM, 10/10
SHAPING & GUIDING ACTION

*With the Total Population in View*

<table>
<thead>
<tr>
<th>Healthy</th>
<th>Healthy At-risk</th>
<th>Acute</th>
<th>Chronic</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active</td>
<td>Low</td>
<td>Med</td>
<td>High</td>
<td></td>
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**Prevention: Primary** → **Secondary** → **Tertiary**

- **Disease-related Prevalence**
- **Productivity** (Absenteeism, Presenteeism, FMLA)
- **Disability** (STD, LTD, WC)
- **Healthcare Costs** (Direct, Indirect, Program, DM)
- **Employee Care** (Wellness, QoL, EAP)

**Source**
Bunn, Allen, Stave & Naim, *JOEM*, 10/10
THE POTENTIAL OF THESE PRINCIPLES: EMPLOYER CASE STUDY

Beyond Behavioral Health per se, but Instructive

- Largest US maker of trucks and engines
- Global population 17,000, US 11,000
- Retiree to active ration 3:1
- Older, mostly male, large union representation
- History of high health costs
COMPANY APPROACH

Multi-faceted

Management
• Strategic: Total Population / Supply & Demand
• Tactical: Primary, Secondary & Tertiary prevention
• Health personnel at all major sites
• On-site clinics; 16 disease management programs
• Evidence-based health benefits management

Measurement
• Dashboard reporting on monthly basis / internal
• Special studies: Longitudinal / externally directed
• Analyses: included adjustments for workforce changes
• 22 publications
AGGREGATE DIRECT COST TRENDS: 1999-2009

Year-on-year Percent Changes

- First estimate below trend in year 5 (2003)
- Relative to national trend, estimated ROI: 34 to 1

Source
Allen, JOEM, 1/15
COST REDUCTIONS ACCOMPANIED BY SHARP GAINS IN VALUE...

*Changes in Drivers of Lost Productivity (Indirect Costs)*

<table>
<thead>
<tr>
<th></th>
<th>Unadjusted</th>
<th>Adjusted</th>
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<tbody>
<tr>
<td></td>
<td>2001/2</td>
<td>2008/9</td>
</tr>
<tr>
<td>Presenteeism: % limited</td>
<td>9.9</td>
<td>7.3</td>
</tr>
<tr>
<td>Absenteeism: Hrs/EE/yr</td>
<td>72</td>
<td>55</td>
</tr>
<tr>
<td>WC: Incidents/100 EEs/yr</td>
<td>12.24</td>
<td>6.34</td>
</tr>
<tr>
<td>LTD: Incidents/100 EEs/yr</td>
<td>0.53</td>
<td>0.08</td>
</tr>
<tr>
<td>STD: Incidents/100 EEs/yr</td>
<td>15.33</td>
<td>8.38</td>
</tr>
</tbody>
</table>

Reductions on all drivers reflected improvements in health

Source
Allen et al, JOEM, 8/12
.... SPANNED THE HEALTH CONTINUUM

Total Direct & Indirect Costs: From 2001/2 to 2008/9

Significant reductions in direct & indirect costs across healthy & disease groups

Source
Allen et al, JOEM, 8/12
Researchers Honored for Outstanding Contribution to Medical Literature on Cost-effective Treatment for Low Back Pain


https://www.acoem.org/HAllen.aspx

Guideline-inconsistent imaging/surgery/meds linked to major increases in STD days, while guideline-inconsistent PT/Chiro visits linked to major decreases in STD days.
IMPLICATIONS FOR THE BEHAVIORAL HEALTH WORKFORCE

Some Directional Recommendations

• Cultivate the “balancing” mindset: outcomes vs. costs
• Solidify & broaden (where feasible) offerings across health continuum
• Anticipate & prepare for the need to show value
• Develop and standardize measurement protocols
• Strengthen “within-specialty” cohesion
• Forge new collaborations / alliances with other stakeholder groups
• Explore guideline refinement: A convening issue with much potential
• Nurture the continuous quality improvement perspective
Exercise

Relating all of this to your work and the work of your organization
QUESTIONS FOR DISCUSSION

1. How has the TRIPLE AIM informed your work and the work of your organization? Try to identify specific examples of products or services that have been influenced by the intent of the TRIPLE AIM – greater efficiency, advancing effectiveness and improved consumer experience?

2. Has your role and the work of your organization begun its transformation from serving individual patient care to managing the health status of the population served? Have you and your organization transformed from a provider of products or services to a steward of population health and a promoter of a culture of health and well-being?

3. As you consider the extent to which your role and your organization have begun this transformation, what is being done to measure and manage value -- outcomes, satisfaction and costs -- in relation to your organization’s products or services?

4. What two or three steps might be the next ones taken by you or your organization to incorporate the tenets of the Triple Aim, Population Health and Cultures of Health & Well-being?
PEERING INTO THE FUTURE
A Culture of Well-being

- Physical environment – safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health.

- Education – low education levels are linked with poor health, more stress and lower self-confidence.

- Employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions.

- Income and social status - higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health.

- Social support networks – greater support from families, friends and communities is linked to better health.

- Culture - customs and traditions, and the beliefs of the family and community all affect health.

- Genetics - inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses.

- Personal behavior and coping skills – balanced eating, keeping active, smoking, drinking, and how we deal with life’s stresses and challenges all affect health.

- Health services - access and use of services that prevent and treat disease influences health

- Gender - Men and women suffer from different types of diseases at different ages.
A “2020” VISION OF PATIENT-CENTERED PRIMARY CARE
All in the context of Population Health & Building Cultures of Health

- Superb access to care & social services
- Patient advocacy & engagement
- Clinical information systems that support high-quality care, practice-based learning, and quality improvement
- Care coordination
- Integrated and comprehensive team care
- Routine feedback to clinicians
- Publically available information – consumer transparency
- System focused on elevating the health status of the population served
- Community focused of health and well-being of its citizenship
WHO Definition of Health

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity

Components of Wellness

Social
Physical
Emotional
Career
Intellectual
Environmental
Spiritual
EYEING THE PRIZE

*What is the Goal? Creating Systems & Environments that:*

- Seek out ways to prevent illness & disease
- Reward better health and outcomes
- Are Holistic, Stigma Free
- Promote individual well-being
- Produces resilient & thriving individuals, companies & communities
- Enhances Performance & Prosperity