Priorities for Success in a Value-Based World

Joseph J. Fifer, FHFMA, CPA
President & CEO, Healthcare Financial Management Association
Today’s Agenda

• Taking the long view on value
• Setting priorities to improve value
• Closing thoughts
It is not enough to be busy.
So are the ants. The question is:
What are we busy about?

HENRY DAVID THOREAU
If you always do what you always did, you will always get what you always got.

ALBERT EINSTEIN
Introducing Enterprise Membership

enterprisesolutions@hfma.org
hfma.org/enterprise
The IHI Triple Aim

The IHI Triple Aim framework was developed by the Institute for Healthcare Improvement in Cambridge, Mass. (www.ihi.org)
Healthcare Spending Growth Is Unsustainable

Total U.S. health spending is projected to rise to one-fifth of the economy by 2025.

National Health Expenditures (% of GDP)

Source: Centers for Medicare and Medicaid Services, National Health Expenditures, July 2016.
Setting Priorities to Improve Value

- Managing chronic conditions
- Integrating mental health & substance abuse
- Addressing social determinants of health
- Optimizing end-of-life care
To Maximize ROI, Focus on the Few

5% of people account for 50% of healthcare spending in America

Healthcare costs are concentrated among those with multiple chronic diseases

Source: Partnership to Fight Chronic Disease. fightchronicdisease.org
Substance Use Disorders—Missed Diagnosis, Missed Opportunity

“The separation of substance use disorder treatment from general health care created unintended and enduring impediments to the quality and range of care options. [As a result,] mainstream health care [has] generally failed to recognize or address substance use-related health problems.”

“The presence of a substance use disorder often doubles the odds that a person will develop another chronic and costly medical illness, such as arthritis, chronic pain, heart disease, stroke, hypertension, diabetes, or asthma.”

# The Opioid Epidemic by the Numbers

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
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<tbody>
<tr>
<td>![Syringe and Spoon]</td>
<td>Fatal heroin overdoses were more than five times higher in 2014 than in 2004.</td>
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<tr>
<td>![People]</td>
<td>The substance use disorder treatment admission rate in 2009 was six times the 1999 rate.</td>
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<tr>
<td>![Prescription Bottles]</td>
<td>In 2012, 259 million prescriptions were written for opioids—more than enough to give every American adult their own bottle of pills.</td>
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<td>![Pills and Capsules]</td>
<td>Four in five new heroin users started out misusing prescription painkillers.</td>
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<td>![Money Bag]</td>
<td>94% of surveyed people in treatment for opioid addiction said they chose to use heroin because prescription opioids were “far more expensive and harder to obtain.”</td>
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Meanwhile, Alcoholism-Related Mortality Is Increasing

Mortality by poisoning, suicide, chronic liver disease, and cirrhosis*

* Mortality by poisoning, suicide, chronic liver disease, and cirrhosis, white non-Hispanics by 5-y age group.

Source: Anne Case and Angus Deaton PNAS 2015;112:15078-15083
To Maximize ROI, Encourage Early Diagnosis

“Providing services to people with mild and moderate substance use disorders in general healthcare settings will likely lessen the need for intensive and costly substance use disorder treatment services later.”

A Major Gap in the Healthcare System: Addressing Social Determinants of Health (SDOH)

“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

Sources: healthypeople2020.gov; Adapted from James Rubin, TAV Health
SDOH Account for 60% of Factors Contributing to Health But Only 9% of U.S. Health Expenditures

Source: Presentation by Karen DeSalvo, MD, MPH, MSc, to Leavitt Partners. "Tomorrow’s Solutions: Enabling Health: Addressing Health Related Social Determinants."

Adapted from James Rubin, MD, TAV Health; *$3.2 Trillion in 2015 (CMS.gov Accessed 5/22/17)
SDOH Are Linked to Chronic Conditions

Predicted prevalence of more common chronic diseases by food security status, adults in low-income households

COPD = chronic obstructive pulmonary disease.
Source: USDA, Economic Research Service calculations using National Health Interview Survey data 2011-2015. Predicted prevalence estimates are adjusted for: survey year indicators, age, gender, employment, marital status, race/ethnicity, insurance status, highest education of any adult in household, number of children, family size, and household income-to-poverty ratio. Sample includes working-age adults in households at or below 200 percent of the Federal poverty line.

What SDOH Screening Looks Like

- Kaiser Permanente’s Life Situation Form is an example of a screening instrument for SDOH issues.

- On the basis of results (yellow-highlighted areas), patients may be assigned to a patient navigator to connect them with community services.

- Information is then shared with other providers.
### SDOH Information Can Change Health Outcomes at Both the Patient and Population Levels

Patient- and population-level data collection tools and uses for data on social determinants of health: case study on food security.

<table>
<thead>
<tr>
<th>Data tools</th>
<th>Patient level</th>
<th>Population level</th>
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<tr>
<td>Social determinants of</td>
<td>Clinical</td>
<td>Medical codes on food security (for example, ICD-10 z-code on food access)</td>
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<tr>
<td>health screening questions</td>
<td>• Link patient with community food resources</td>
<td></td>
</tr>
<tr>
<td>on food security</td>
<td>• Support patient enrollment in food benefit</td>
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<td></td>
<td>programs</td>
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<td></td>
<td>• Research</td>
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<th>Potential uses</th>
<th>Health care organization</th>
<th>Policy and health system</th>
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<tbody>
<tr>
<td>Clinical</td>
<td>• Prioritize quality improvement projects that support food-insecure populations</td>
<td>• Adjust pay-for-performance incentives</td>
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<tr>
<td></td>
<td>• Strengthen community partnerships and referrals to agencies that provide nutritional assistance</td>
<td>• Adjust capitated rates based on predictive effect of food insecurity on use and cost</td>
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<td></td>
<td>• Improve panel calculations by distributing socially complex patients across providers or by reducing panel sizes</td>
<td>• Research</td>
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Source: Laura Gottlieb et al. Health Aff 2016;35:2116-2123
Healthy Alaskans 2020 Health Assessment: Understanding the Health of Alaskans
SDOH: Whose Responsibility Is It?

Who is best positioned to help your patients with these needs?

- Medical Staff
- Administrative Staff
- Someone outside the practice

Information about the price of care to the patient:
- 17% (Medical Staff), 60% (Administrative Staff), 24% (Someone outside the practice)

Information about health insurance including enrolling in public insurance:
- 9% (Medical Staff), 32% (Administrative Staff), 40% (Someone outside the practice)

Help arranging transportation for health care:
- 14% (Medical Staff), 44% (Administrative Staff), 43% (Someone outside the practice)

Help increasing income (through a raise, promotion, or new job):
- 33% (Medical Staff), 18% (Administrative Staff), 50% (Someone outside the practice)

Help getting affordable housing:
- 15% (Medical Staff), 24% (Administrative Staff), 62% (Someone outside the practice)

Information about water quality in the area:
- 28% (Medical Staff), 9% (Administrative Staff), 63% (Someone outside the practice)

Help getting sufficient food:
- 14% (Medical Staff), 15% (Administrative Staff), 70% (Someone outside the practice)

What is the most important reason why the following services/information are not routinely provided to patients?

- Not the appropriate place to deal with this issue
- Other resources are available
- There isn’t enough time
- Physicians are not paid for providing these services
- Something else

- 14% (Medical Staff), 17% (Administrative Staff), 32% (Someone outside the practice)
- 14% (Medical Staff), 30% (Administrative Staff), 25% (Someone outside the practice)
- 22% (Medical Staff), 33% (Administrative Staff), 16% (Someone outside the practice)
- 53% (Medical Staff), 19% (Administrative Staff), 10% (Someone outside the practice)
- 48% (Medical Staff), 29% (Administrative Staff), 14% (Someone outside the practice)

Source: HIP Surveys 2017: Preliminary data

KEY TAKE AWAY: The majority of physicians think important social determinants of health (food, housing, income) are better addressed outside of the doctor’s office.

Total sample; Unweighted; base n = 637; total n = 704; 67 missing

End-of-Life Care Does Not Reflect People’s Wishes
People Are Not Making Their Wishes Known

Putting Wishes for End-of-Life Treatment in Writing

% of U.S. adults who say they have put their wishes in writing

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<tr>
<th>Year</th>
<th>1990</th>
<th>2005</th>
<th>2013</th>
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<tr>
<td>%</td>
<td>16%</td>
<td>34%</td>
<td>35%</td>
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Talking About End-of-Life Wishes

% of U.S. adults who have talked with someone about their wishes

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<th>Year</th>
<th>1990</th>
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<tr>
<td>%</td>
<td>55%</td>
<td>72%</td>
<td>62%</td>
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Source: Pew Research Center.
Last Year of Life Accounts for 25% of Medicare Fee-for-Service Spending

Focus on Opportunities to Move the Needle

If the results achieved by the BPCI LEJR* Program could be replicated on a national scale for all joint replacements, Medicare would save about $400 million per year.

That translates to 0.01% of projected 2016 national healthcare expenditures

It’s equivalent to the annual revenue of one 200-bed hospital

Is this the best ROI for our value-based payment efforts?

* Bundled Payments for Care Improvement Lower Extremity Joint Replacement.

Closing Thoughts
We always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten. Don’t let yourself be lulled into inaction.

BILL GATES
You must do the thing you think you cannot do.

ELEANOR ROOSEVELT