Achieving Real Health Care Transformation: Policy, Populations, and Partnerships

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Successful health care reform will require as much focus on addressing the determinants of health status—the socioeconomic factors of education, health literacy, housing, and employment—as coordinating efficient and effective care delivery among providers and payers. The "3P Solution" embraced by Legacy Health in Oregon emphasizes the need to develop comprehensive national policy. That policy should be based on an understanding of community populations that successfully motivates collaboration among partners in a shared, transformative quest to improve the overall health of our nation.

Introduction—Rethinking Health Care

It's time to think about health care in a broader context that includes the social determinants of health. This is not a new thought. As long ago as 1986, the participants in the first International Conference on Health Promotion developed the Ottawa Charter for Health Promotion. That charter states that "the fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity."

More recently, research from the University of Wisconsin concluded that 40 percent of Americans' health status is determined by the socioeconomic factors of education, health literacy, housing and employment.[1]

Another 10 percent is attributable to the physical environment which includes air and water quality; the "built environment" of transportation, sidewalks, and other infrastructure; and the distribution of resources such as grocery stores.

Health care needs to catch up to what public health has known and advocated for a long time: the social determinants of health are intimately connected to the overall health of a community and they are quite independent of the care provided by hospitals and physicians.

Underscoring these socioeconomic factors and their impact on health looms a very real fiscal reality. Chronic diseases account for 75 percent of all the money spent on health care in the United States.[2]

The annual direct costs are staggering: heart disease and stroke, $78.3 billion; diabetes, $27.1 billion; lung disease, $45.2 billion.[3] The annual direct cost of Alzheimer's Disease is estimated at $140 billion.[4]

The management of chronic disease, much of which is preventable, is essentially diverting excess resources into health care at the expense of investment in equally pressing issues such as infrastructure, education, and job development.

In addition, a recent Institute of Medicine report puts the cost of unnecessary tests, procedures and medications at $210 billion every year.[5] That amount together with the cost of care for chronic diseases is simply mind-boggling.

Using the analogy of a stream, hospitals traditionally have focused their efforts downstream—providing care for acute illness and injury and the consequences of lifelong chronic disease. A little further upstream is the realm of the traditional doctor's office: illness care, secondary prevention of events such as heart attacks, and management of chronic conditions. Furthest upstream is the domain of public health where the focus has for

many years been addressing the social determinants of health mentioned earlier.

Downstream interventions tend to be very expensive and often occur too late to restore health, leading to continued costs and diminishing quality of life. The further upstream an intervention occurs, the less expensive and more effective it becomes. Studies have estimated that for every $1 invested in prevention upstream, somewhere between $2 and $20 is saved in downstream intervention.[6]

Primary prevention of disease is better than secondary prevention of subsequent episodes. Interventions that target vulnerable populations are better still and overall population health protection is the ideal.

Understanding Our Communities

The identification of specific populations within communities is a key imperative in this emerging social determinant-driven health care context. Community populations may be defined by a number of criteria such as geography, income level, age, ethnicity, exposure to environmental risks, and/or the presence of people with certain disabilities. The group of employees of an organization for whom health care coverage is provided by the employer is another illustration of a community population.

For example, let's take a person with diabetes who is a little overweight and has a family history of diabetes. That individual certainly has unique needs, but it is not likely that he or she is the only overweight diabetic in his or her community. This person also may be African-American and again, not likely the only overweight, African-American diabetic. This individual and others in his/her community who share common attributes are considered a "population."

There also is a need to go beyond attributes to identifying and understanding what drives the health behaviors of specific populations. Much of population behavior, including health behavior, is rooted in the community.

According to social learning theory, people learn attitudes, behaviors, and beliefs either through direct experience or by observing others in their community.[7] If unhealthy behavior is perceived to be the norm in a social group or community, the social urge to conform can lead to unhealthy behavior by individuals. The good news is that the reverse also is true: healthy behavior perceived as the norm leads others to adopt the same.

The importance of understanding population-specific health attributes and behavior is most pronounced in communities of color. Compared to their white counterparts:

- The infant death rate is more than twice as high[8] and diabetes rates are double[9] in African-Americans.
- Native Americans have double the incidence of heart disease[10] and diabetes.[11]
- Hispanics have higher rates of obesity,[12] and are more likely to die from diabetes.[13]

The explanation for these health disparities may have some genetic and/or biological basis, but their relative size seems to indicate that socioeconomic factors and health behaviors also play a role.

The human toll here is obvious. From a financial perspective, it is estimated that health care expenditures would drop by more than $57 billion a year if the prevalence of these and other chronic conditions in minority populations was even just *equal* to the prevalence in the white population.[14]

The Inconvenient Truth of Personal Responsibility

It is ironic that "accountable" care, as it is usually described and put into policy and practice, makes everyone accountable—except the patient. It's an inconvenient truth that personal behaviors are responsible for 30 percent of health status, according to the University of Wisconsin research cited earlier.[15]

To underscore this point even further, the Centers for Disease Control (CDC) indicates that there are four major causes of chronic disease, all of which are "modifiable risk factors": lack of physical activity, poor nutrition, tobacco use, and excessive alcohol use.[16]

The CDC further estimates that childhood obesity has tripled in the United States in the past thirty years.[17] Data from Oregon and Washington in 2009 indicate that 62 percent of adults are overweight or obese, consistent with national trends.[18,19] Sugared soda is estimated to put 82 million pounds of excess weight on Oregonians every year.[20]

Not surprisingly then, $1.6 billion, approximately one-tenth of Oregon's annual health care expenditures, are attributed to obesity.[21] Tobacco use in Oregon and Washington is around 16 percent,[22,23] once again consistent with national trends. According to the Oregon Liquor Control Commission, alcohol abuse is a $3.2 billion annual hit on Oregon's economy.[24]

What do all these modifiable risk factors have in common? They manifest as personal health behaviors that, without modification, become significant contributors to the health care burden associated with chronic disease management.

When it comes to health, most people want to do the right thing, but sometimes doing the right thing is difficult. It's doubtful that anyone wants to have a life that is shorter or of lower quality than expected.

For instance, the absence of a nearby supermarket with fresh produce can be a barrier to eating well. Living in a dangerous neighborhood may make an evening walk for exercise less likely to occur. In addition, the exposure to harmful health behaviors is pervasive and well-funded. A single mother of three working two jobs would likely find it very tempting to feed her family at a fast food restaurant for $6; especially when compared to the cost in time and dollars for shopping, cooking, and cleaning up.

Modification of risky personal health behaviors requires greater emphasis on health literacy. An estimated 53 percent of Americans have basic or below basic health literacy and, therefore, have difficulty obtaining and using health information to make informed decisions and practice good self-care.[25]

If people can't effectively participate in their own care, true transformation of health care is not possible.

Transformation Begins at Home

Health care transformation, like charity, begins at home. Legacy Health is one of the founding organizations of Health Share of Oregon (Health Share), the largest coordinated care organization (CCO) in the state, providing care to over 40 percent of all Oregon Health Plan (OHP) members.

The 11 organizations that comprise Health Share are working together to address the fundamental question of health care transformation: Can we collectively improve health outcomes and the care experience for patients *and* save money as we're doing it?

This OHP, or Medicaid, population represents a microcosm of the region served by Health Share: Clackamas, Multnomah, and Washington counties (Tri-County). It provides a laboratory for learning more about population health, including the opportunity to teach the population about its own health.

Ultimately, the learning from this initial endeavor with OHP members will be used by the Health Share partner organizations to transform care for the greater Tri-County community.

As a member of Health Share, Legacy Health also is participating in a grant initiative, called "Health Commons," which is funded by the Centers for Medicaid and Medicare Innovation. Health Commons aims to improve care and manage costs in the Medicaid population by focusing on the heaviest users of services.

This approach, driven by the fact that 25 percent of Medicaid patients account for 85 percent of Medicaid costs,[26] addresses several components, including emergency room utilization, hospital readmission risk and behavioral health. There is a community outreach component that connects all of the patients cared for under this grant to community services that are intended to augment health care and ultimately help decrease utilization.

At the local level, Legacy Health helped fund a detox center at Central City Concern (CCC), a Portland organization that provides extensive services for the uninsured, ranging from health care to housing to employment assistance.

The presence of this detox center provides police with an appropriate alternative to hospital emergency rooms as a destination for the care of inebriated homeless people. CCC provides this population with medical attention and a safe place to stay and sober up along with subsequent help finding housing and work and staying sober. This leaves hospital emergency rooms with more capacity to care for individuals with true medical emergencies.

Another example of community partnership can be found at the Rockwood Building in Gresham, one of the poorest areas in the Health Share region. This building houses a federally qualified health center called Wallace Medical Concern and Meals on Wheels and Head Start programs along with mental health and family services. It also has low-income housing on its upper floors.

Legacy Health is funding a health literacy initiative targeted at communities of color served by the organizations housed in the Rockwood Building. The goal is to improve the health of this population by integrating health literacy best practices into the daily operations of the participating organizations.

In addition, the Wallace Medical Concern clinic is working with the Emergency Department at nearby Legacy Mount Hood Medical Center (LMHMC) to direct uninsured Hispanic patients cared for at LMHMC back to Wallace for ongoing health care services.

At the organizational level, the Legacy employee health plan has been restructured to encourage healthy behaviors and discourage unhealthy ones. The new plan is intended to improve care and reduce costs by requiring employees with chronic disease conditions to participate with a care coordinator and/or health coach in the management of those conditions.

If an employee chooses to not participate, reimbursement for his/her cares decreases dramatically. Similarly, employees and their dependents who smoke are now paying more for their health care coverage.

Financial Reality: Another Inconvenient Truth

Currently, the fiscal challenges of health care are being addressed one biennium at a time in terms of government programs and in real time relative to commercial insurance programs. The public coffers are effectively empty.

The business community and commercial insurance ratepayers are making up the difference. This cost shifting takes resources away from the business community, precluding its ability to make other investments for the public good.

In Oregon, the Medicaid budget for the 2011-2013 biennium had a $646 million shortfall due to reductions in both state and federal funding. That gap was filled by the first installment of a federal commitment of $1.9 billion successfully secured by Governor Kitzhaber to help ease the transformation of care.

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In return, Oregon committed to reducing the rate of growth of Medicaid spending by 2 percentage points a year. This would save about $470 million in the next biennium and $1.1 billion in the 2015–2017 biennium. Achieving these savings while maintaining quality and access is the work of the CCOs.

Also looming is the imminent expiration of the hospital and premium taxes in 2014. Loss of those revenues and the corresponding federal match would take another $2.6 billion out of the 2013–2015 biennium, and more in following years. This would significantly compound the transformation and sustainability challenge.

Until sustainability is achieved, the funding gap will have to be made up by Health Share and the other Oregon CCOs along with continuing the cost shift to commercial insurance ratepayers.

Conclusion—The 3P Solution

True health care transformation must move beyond transactions and acute care. It is a long-term endeavor that will require ongoing cooperation among many participants. We must address the "3Ps": policy, populations, and partners.

This will no doubt involve numerous hard conversations that should result in definitive and sustainable solutions for balancing the fundamental health care equation of demand vs. resources. Simply put, it is just no longer realistic to think that unlimited demand can continue to be met with limited resources.

A rational national policy that sets acceptable levels for population health, patient experience, and level of cost should be developed. That policy should lay out standards of care for certain conditions as well as a fair and effective methodology for the allocation of care.

Once community populations are identified, health care providers should learn everything

they can about those populations such as general demographics, socioeconomics, type and prevalence of disease, cultural implications, availability of access to health care and how those factors influence people to engage in harmful health behaviors.

The goal is to provide meaningful, culturally relevant information, tools and services that change health behavior in a way that improves the health of any given population.

Successfully addressing the issue of behavior change requires expertise that goes beyond the conventional communication approach: "If we just explain it to them, they will change."

Social scientists, and increasingly those marketing professionals who practice behavior change or "social" marketing, say that communication is necessary, but not sufficient to change behavior. Barriers should be removed and the offer of value in return for behavior change must also be part of the approach.[27]

Higher deductibles may help in some cases while lower deductibles may help in others. Offering incentives is another value offer tool that has shown promise. The greatest potential gains, however, lie in removing barriers to behavior change.

The primary care health home is a key venue for this new way of communicating with patient populations. In these health homes, a physician leads a team that focuses on individual patient needs as well as the needs of populations. This requires engaging patients as active partners, treating them as equals, and empowering them to make informed decisions with reasonable clinical guidance.

Technology supports this approach through the use of automated telephone calls, text messages, and e-mail. Patient web portals allow patients to access key information, correspond with health home providers, make appointments, and refill prescriptions.

Technology is augmented by care coordination whereby trained staff reach out to patients with reminders, advice, and proactive assessment; this coordination is a critical component of managing patients with chronic disease.

In addition to mastering behavior change and communication, a truly transformed health care system must know how to deliver care beyond traditional health center or clinic locations. That means knowing where the population of a community gathers and interacts. These naturally occurring "hubs" are often places such as community centers, churches, schools, and hair salons. Wherever they are, these hubs are vital links to the populations being served and, as such, represent the best opportunities for successful outreach to a given population.

All of this requires providers, payers, the community, government, private business, community organizations, and patients to collaborate as partners in the transformative quest to improve the health of a community. Health care providers cannot solve these problems on their own and neither can the government.

Health care providers are being asked to make major changes in their fundamental business models. In a transformed health care system, empty hospital beds will be better than full ones and fewer tests and procedures will be better than more.

As with health behavior change, knowing it is the right thing to do does not make doing it any easier. It will take time to retool the current health care business model, especially given its size and complexity, while reducing resources.

In the meantime, it is imperative that everyone understands the macroeconomics of health care, especially the cost of failing to improve the health of the community. Failure to change unhealthy behavior and prevent it from developing into chronic disease carries a tremendous long-term price tag, both in human and financial terms.

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