Moving Upstream: A science-based approach to dramatically improve health and lower costs for employees

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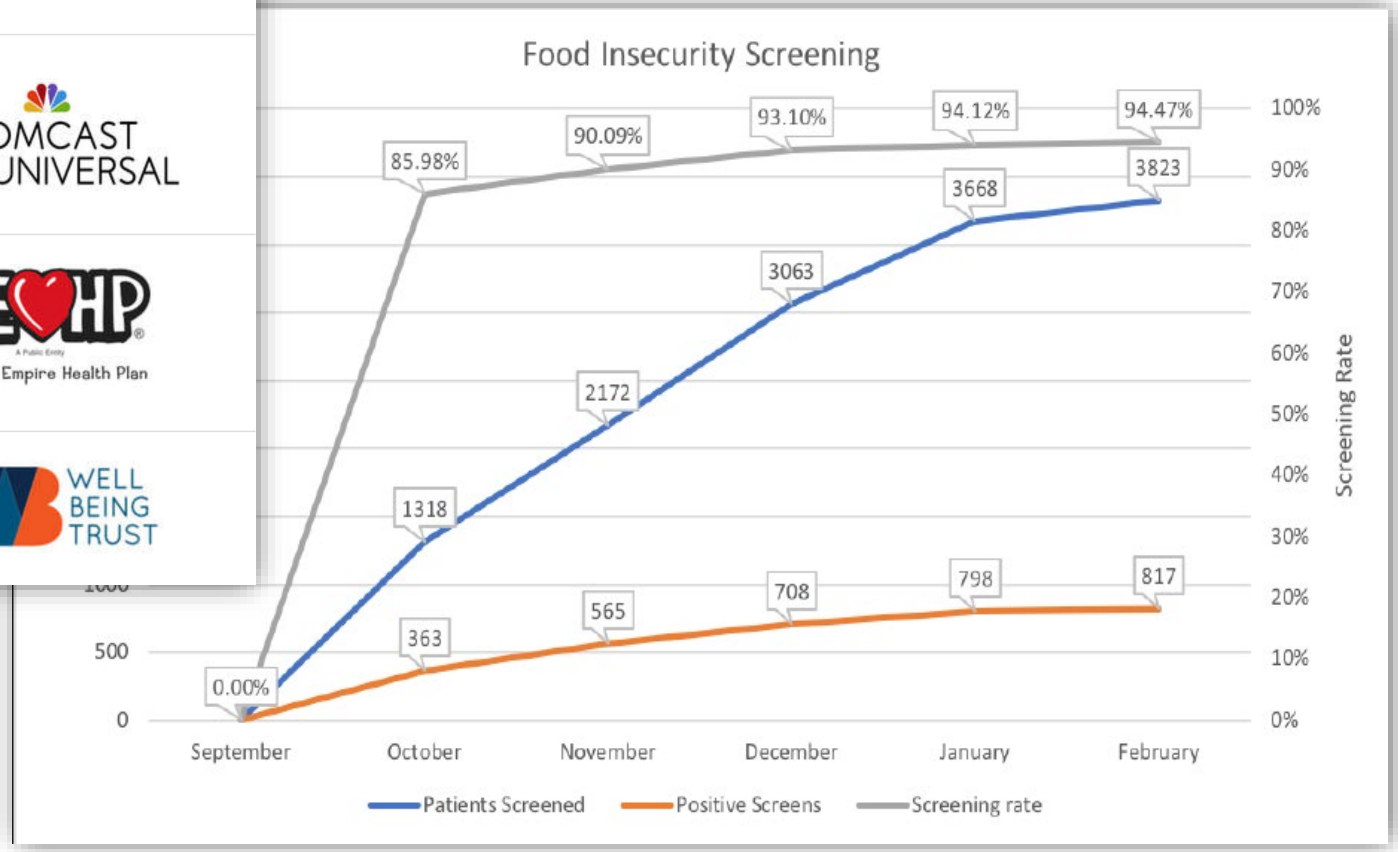
HealthBegins

About HealthBegins

We improve care and "upstream" social determinants of health

Alameda Health System
Allina Health
American Hospital Association
blue of california foundation
CCI Center for Care Innovations
Comcast NBCUniversal
CHA Connecticut Hospital Association
Hospital Association of Southern California
IEHP Inland Empire Health Plan
Mathematica Policy Research
Providence Health & Services
Well Being Trust

Client partners range from health systems and plans to foundations and self-insured employers.



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Accountable Health Communities

Source: Centers for Medicare & Medicaid Services

CMS is testing an approach to identify and address health-related social needs among Medicare and Medicaid beneficiaries.

Goal: Reduce health care utilization and cost.

Disclosure: In 2017, **CMS selected HealthBegins** , along with Mathematica Policy Research and Center for Health Care Strategies to provide implementation and learning system support for AHC bridge organizations.

Key questions

- What are “upstream” social and environmental factors that shape health?
- Why do they matter for employers?
- How can employers address upstream factors to lower costs and improve health and well-being for employees and communities?

What are “upstream” social and environmental factors that shape health?

Parable of 3 Friends

Meet Mrs. M

She's a 46 year old mother of two who also cares for her frail elderly mother. She works at your company.

Her Type II diabetes is poorly controlled (last HbA1c = 8.4) and she has mild heart failure with preserved ejection fraction.

At the end of last month, she nearly fainted at work and was admitted at a local hospital.

The cause of her admission was hypoglycemia (low blood sugar).

Seligman HK, et al. *Health Affairs*. 2014;33(1):116–23

What could have led to Mrs. M's hospitalization?

Food Insecurity

Diet or exercise

Medications

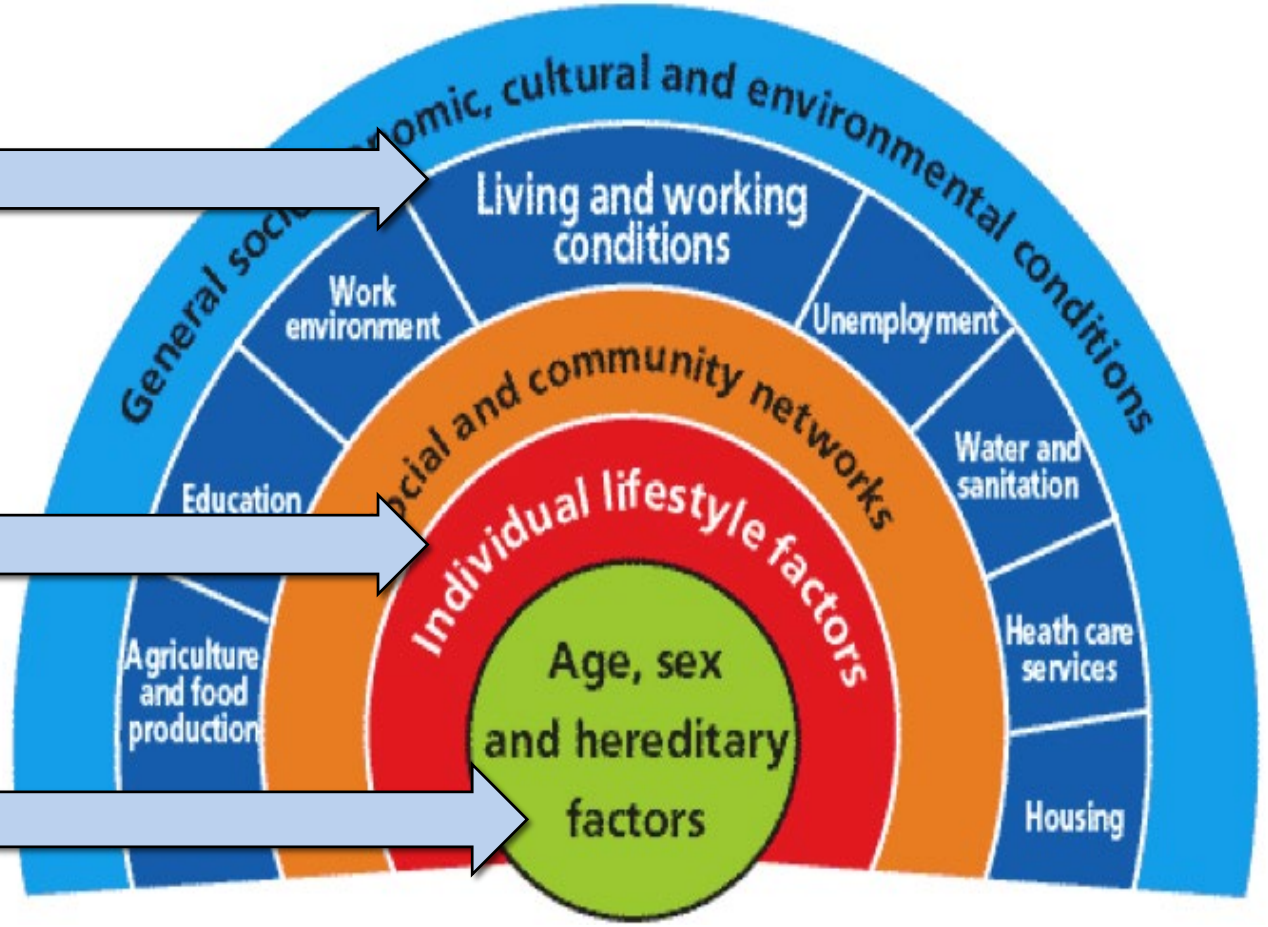

Image source: Dahlgren G, Whitehead M. 1991. Policies and Strategies to Promote Social Equity in Health. Stockholm, Sweden: Institute for Futures Studies.

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Root cause: Food insecurity

Lower-income diabetic adults have a **27% higher rate of hospital admissions** at the end of the month due to food insecurity, compared with higher-income diabetics.

Seligman HK, et al. *Health Affairs.* 2014;33(1):116–23

What is "Food Insecurity"?

"Everyone, at all times, having physical and economic access to sufficient, safe, nutritious food that meets their dietary needs for an active and healthy life." (FAO)

Individuals in food-insecure households are at increased risk for high blood pressure, cholesterol, heart disease and Type II diabetes. (Vozoris)

1. Food and Agriculture organization (FAO). Rome Declaration on World Food Security and World Food Summit Plan of Action. Rome; 1996.
2. Vozoris NT, Tarasuk VS. Household food insufficiency is associated with poorer health. J Nutr. 2003;133(1):120–6.

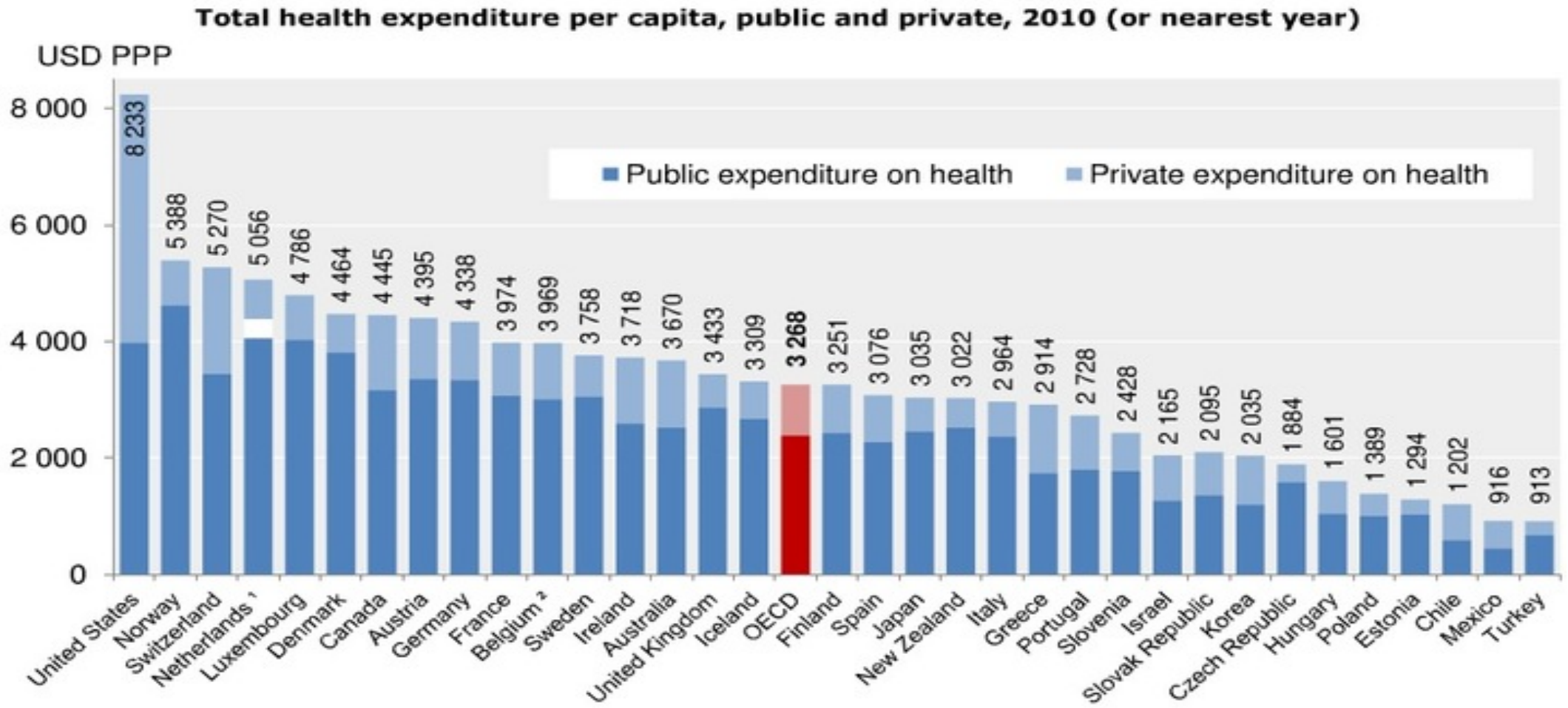
Food insecurity & Type II diabetes

- Food insecure adults are 2-3 times more likely to have diabetes than food-secure adults, even after controlling for important risk factors such as income, employment status, physical measures, and lifestyle factors. (Fitzgerald et al)
- Food-insecure diabetics have **higher** A1c levels than food-secure diabetics and are at increased risk for poorer glycemic control (A1c>7%), even after controlling for socio-demographic and diabetes-related factors. (Gucciardi et al)
- Twice as many hypoglycemic episodes & more hypoglycemia-related ED visits among food-insecure diabetics than among food-secure diabetics. (Seligman et al)

1. Fitzgerald N, Hromi-Fiedler A, Segura-Perez S, Perez-Escamilla R. Food insecurity is related to increased risk of type 2 diabetes among Latinas. Ethn Dis. 2011;21(3):328–34. **2.** Seligman HK, Bindman AB, Vittinghoff E, Kanaya AM, Kushel MB. Food insecurity is associated with diabetes mellitus: results from the National Health Examination and Nutrition Examination Survey (NHANES) 1999–2002. J Gen Intern Med. 2007;22(7):1018–23 **3.** Seligman HK, et akl. Food Insecurity and Clinical Measures of Chronic Disease. Abstract Presentation, SGIM, National Meeting, PA, 2008;

Why does this matter for employers as community institutions?

US spends two-and-a-half times the OECD average



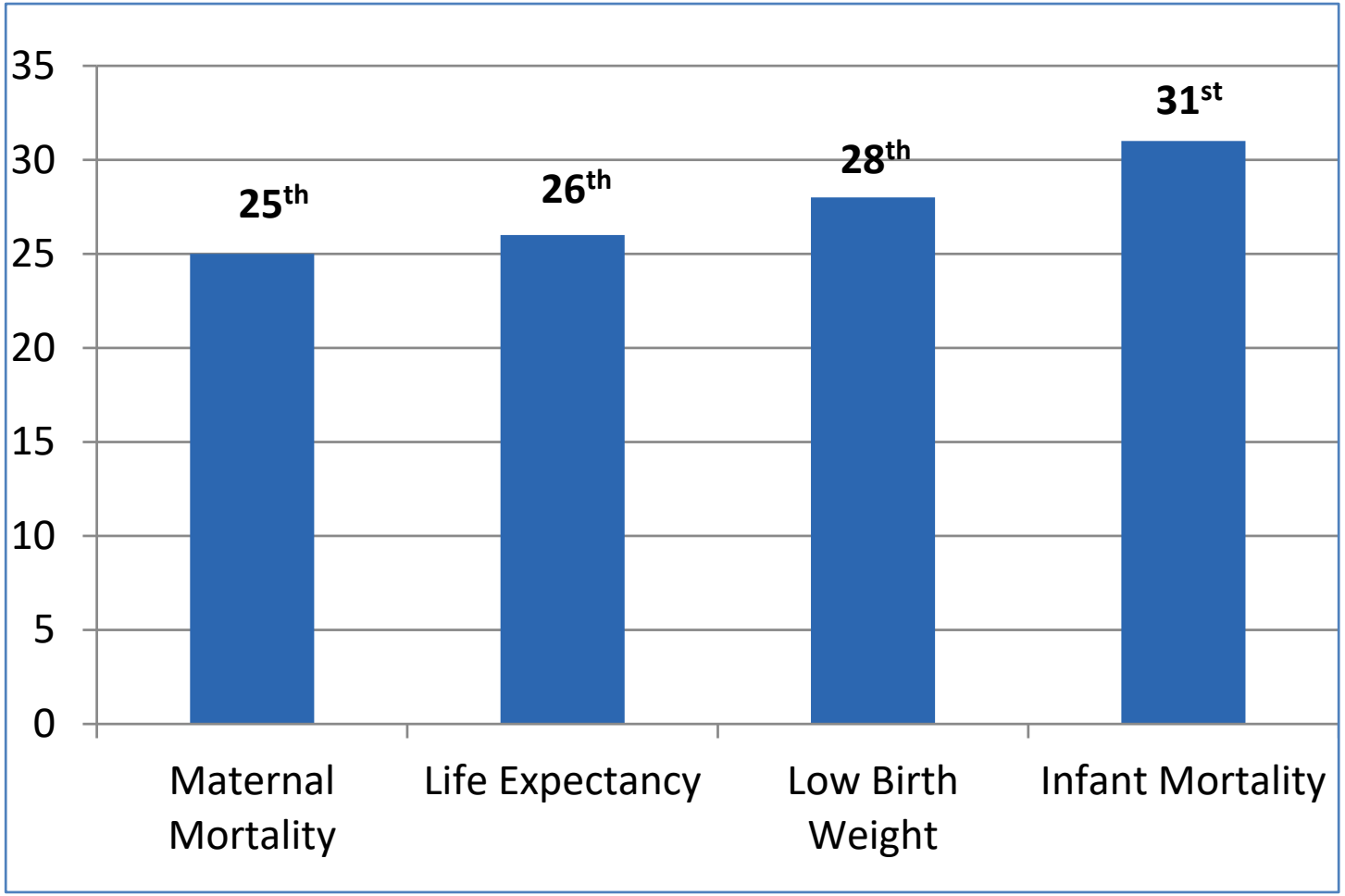
1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.
2. Total expenditure excluding investments.

Information on data for Israel: http://dx.doi.org/10.1787/888932315602.

Source: OECD Health Data 2012.

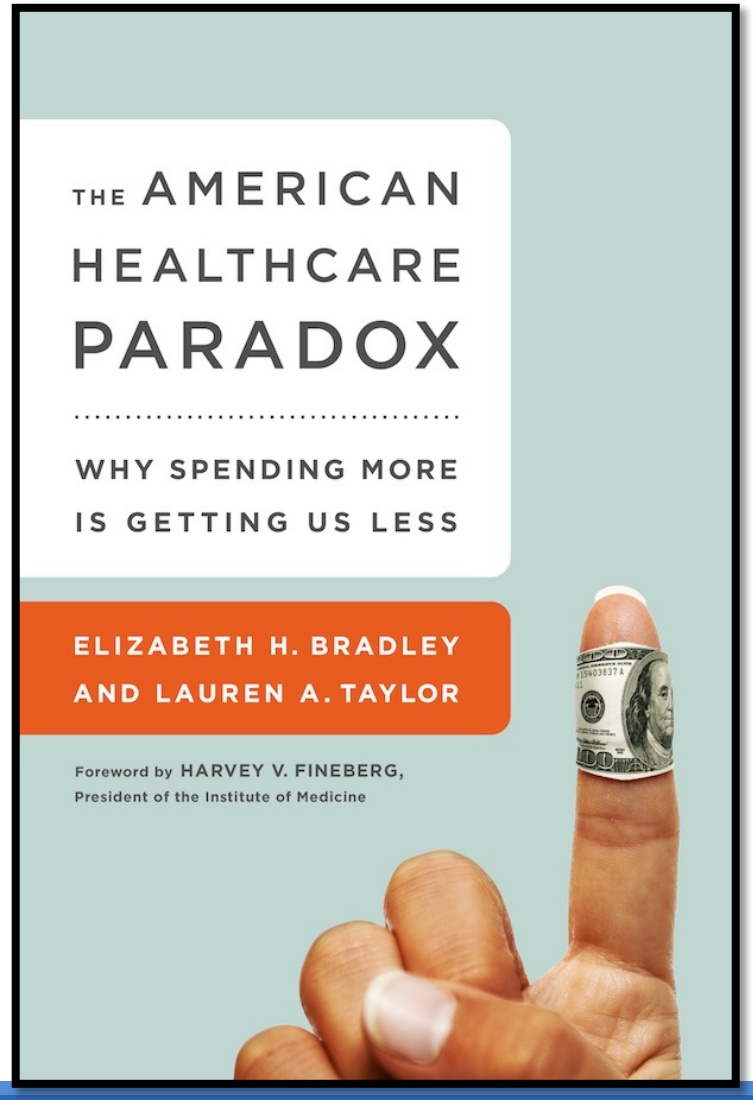
The return on our spending is poor

US Ranking among 34 OECD Countries

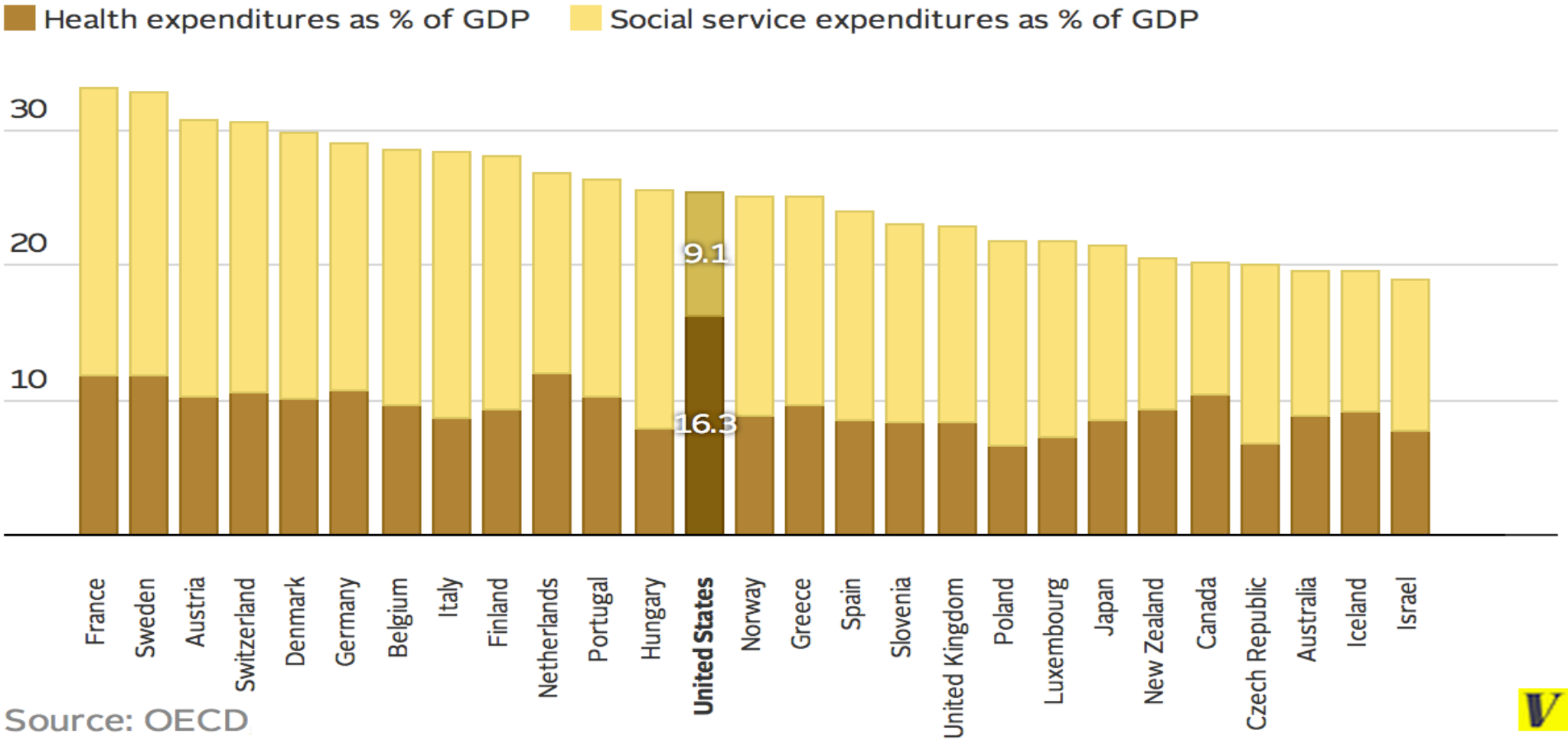


Source: OECD, *Health at a Glance 2009*: OECD Publishing

Why this paradox?



The U.S. is an anomaly in health and social spending patterns



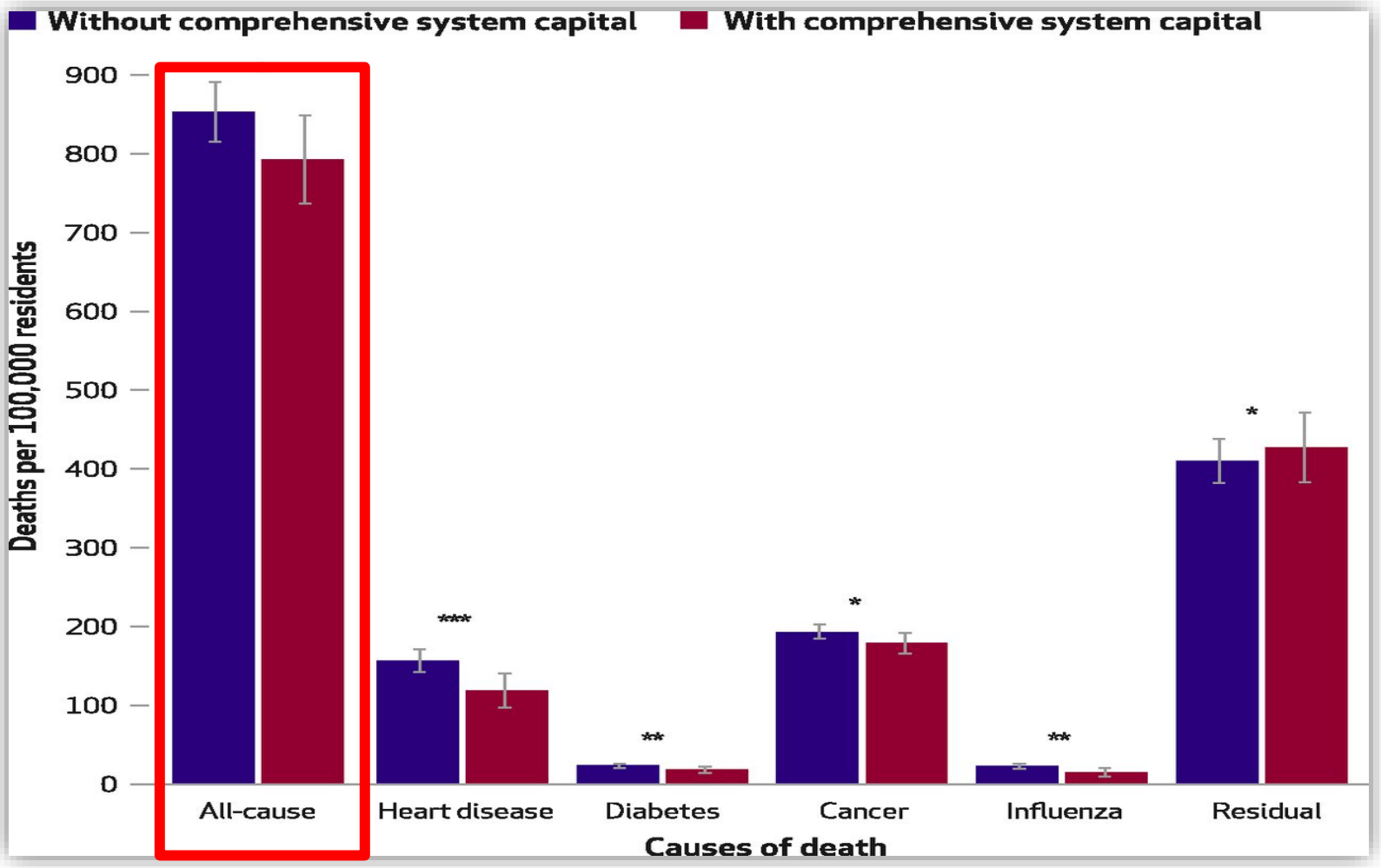
In the US, for $1 spent on health care, about $0.55 is spent on social services

In OECD, for $1 spent on health care, about $2.00 is spent on social services

Strong communities aren't just better places to live.

Strong communities save lives.

Higher community-level 'social capital' is associated with lower mortality



Differences in county mortality rates associated with comprehensive population health system capital, 2014.

Glen P. Mays et al. Health Aff 2016;35:2005-2013

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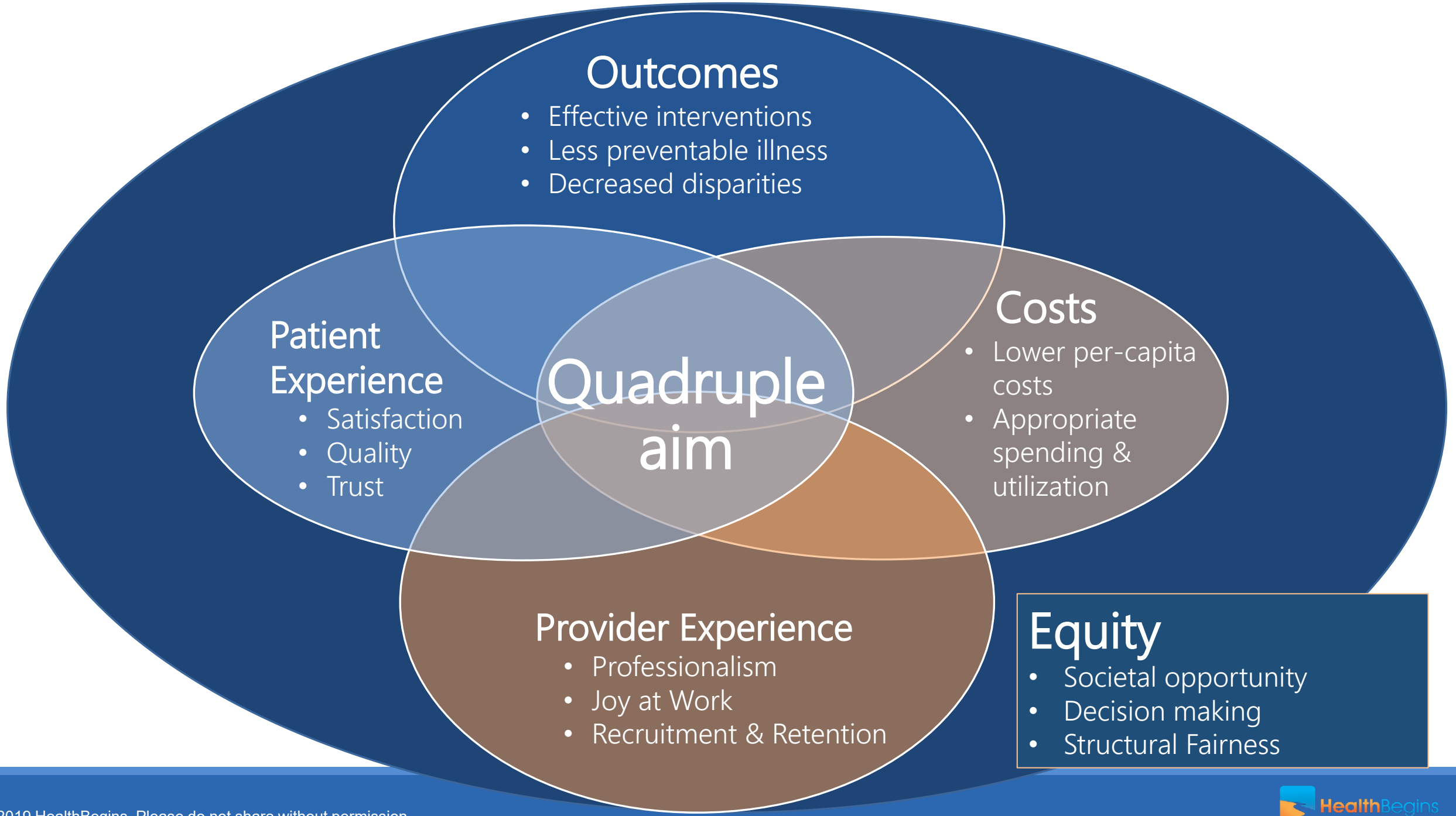
Why does this matter for employers as purchasers?



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Costs Fell by 11% When Payer Addressed Social Determinants of Health

The group reporting that all their social needs were met experienced an 11 percent reduction, or **$2601, in total healthcare costs in the year after social service referrals**.

...the medically tailored meals program yielded **net savings of $220 per patient,** while the non-tailored program saw $10 in net savings.

Meal delivery programs reduce cost of healthcare in dually eligible Medicare and Medicaid beneficiaries

About 13 percent of U.S. households report food insecurity.

https://healthitanalytics.com/news/costs-fell-by-11-when-payer-addressed-social-determinants-of-health

Why are health systems addressing social determinants of health?

Increasingly, it's what the most effective care delivery systems will (need to) be doing

- Value-based payments
  - CMS Accountable Health Communities Model
  - Medicare Advantage
  - Medicaid
    - State 1115 Medicaid waivers and Delivery System Reform Incentive Payment (DSRIP)
- Regulatory standards
  - NCQA PCMH standards
  - NCQA Health Plan Accreditation (HPA) standards for Population Health Management


SCHNEIDER
LICE

Care Models

Fee for service

Biomedical risk

Conventional care settings

Individualistic

Care Models

Fee for service	Value-based
Biomedical risk	Rising biopsychosocial risk
Conventional care settings	Convenient care
Individualistic	Community-based

Scenario: Calculating ROI

A health system and a community-based organization are negotiating a partnership providing nutritional support to high need patients with food insecurity.

- The outcome the health system seeks is to reduce cost through lower admissions and readmissions.
- What is the ROI?
- What payment system makes the most sense?
  - Capitated rate for a 30-day bundle rate of all required services
  - Fee-for-service basis
  - Gain sharing

Bottom line:

	Health Sector Partner		CBO
Payment System	**PMPM** *(Monthly net Income)*	**ROI**	**PMPM** *(Monthly net Income)*
Full Cost Recovery	n\a	n\a	n\a
Fee for Service	$543.87	361.1%	$11.80
Case Rate	n\a	n\a	n\a
Capitation	$532.07	327.6%	$23.60
Gain Sharing	$500.10	257.3%	$55.57

Parable of 3 Friends

Does this sound familiar?

"I'm a primary care physician [in a rural county]…meth addiction, high school drop out rate… Many more issues. Understand upstream approach for years.

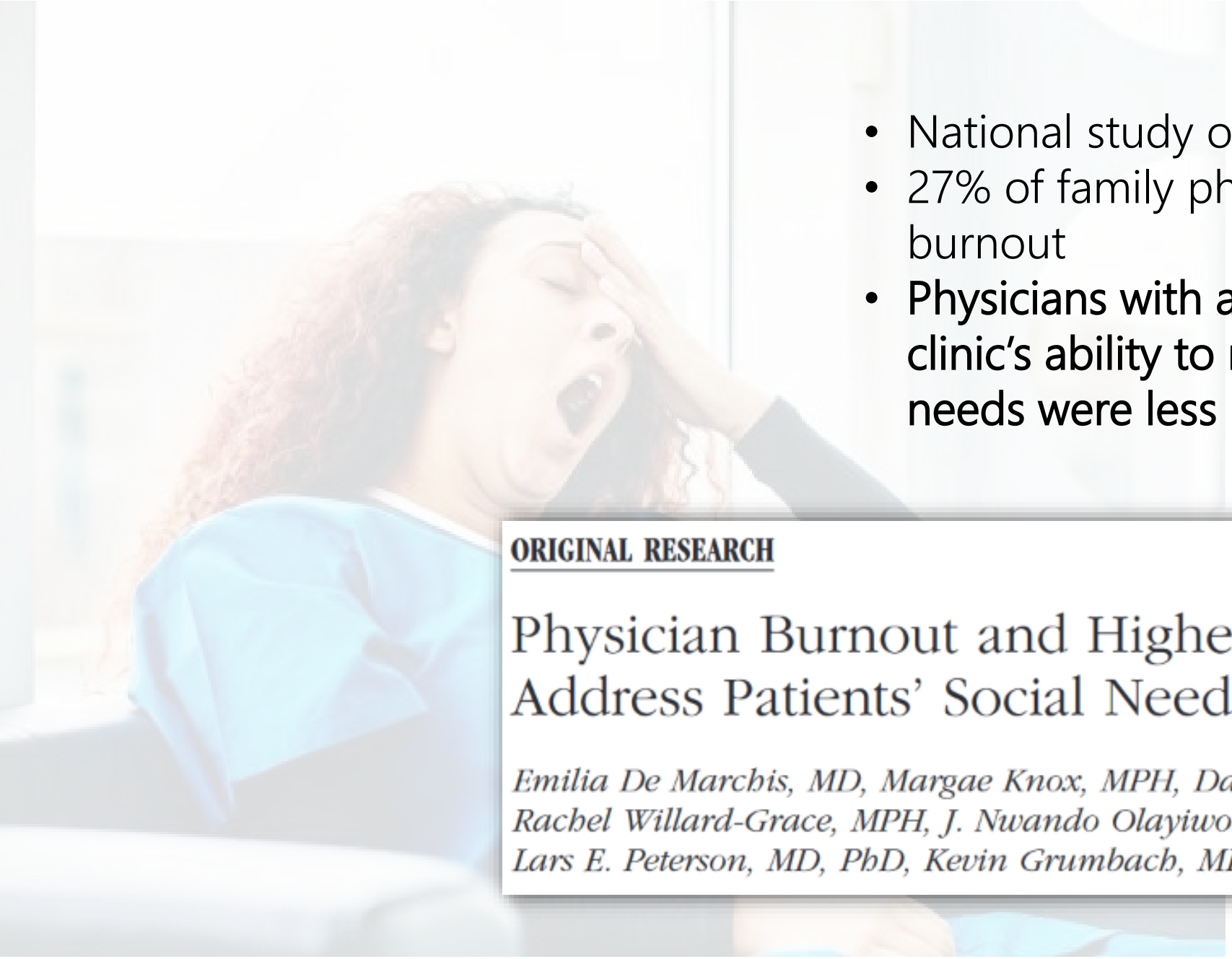
Try my best but falls by the wayside as I don't have resources – No help, city/ county overwhelmed. Patients lost to follow up- I'm seeing over 30 a day. How to manage? Would like to discuss."

- Physician

Health professionals are burning out because our systems are not equipped to deal with upstream problems

Why?

An *upstream* efficacy gap



- National study of 1298 family physicians
- 27% of family physicians reported burnout
- **Physicians with a high perception of their clinic's ability to meet patients' social needs were less likely to report burnout**

ORIGINAL RESEARCH

Physician Burnout and Higher Clinic Capacity to Address Patients' Social Needs

Emilia De Marchis, MD, Margae Knox, MPH, Danielle Hessler, PhD, Rachel Willard-Grace, MPH, J. Nwando Olayiwola, MD, MPH, Lars E. Peterson, MD, PhD, Kevin Grumbach, MD, and Laura M. Gottlieb, MD, MPH

AAFP 2017 Survey

IDENTIFYING AND ADDRESSING PATIENTS' SOCIAL NEEDS

83% agree FPs should identify and help address patients' SDoH

80% don't have time to discuss SDoH with patients

ENGAGING WITH AND EMPOWERING COMMUNITITIES

78% agree FPs should partner with community organizations to address community health disparities

64% aren't properly staffed to address risk factors with patients

ADVOCATING FOR HEALTHY COMMUNITITIES

75% agree FPs should advocate for public policies that address SDoH

56% feel unable to provide solutions to patients

https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/sdoh-survey-results.pdf *The 2017 Social Determinants of Health survey was mailed to 5,000 active AAFP members in July 2017. A total of 484 surveys was received, yielding an overall response rate of 9.7%. Data from this survey were weighted to assure a response set that accurately

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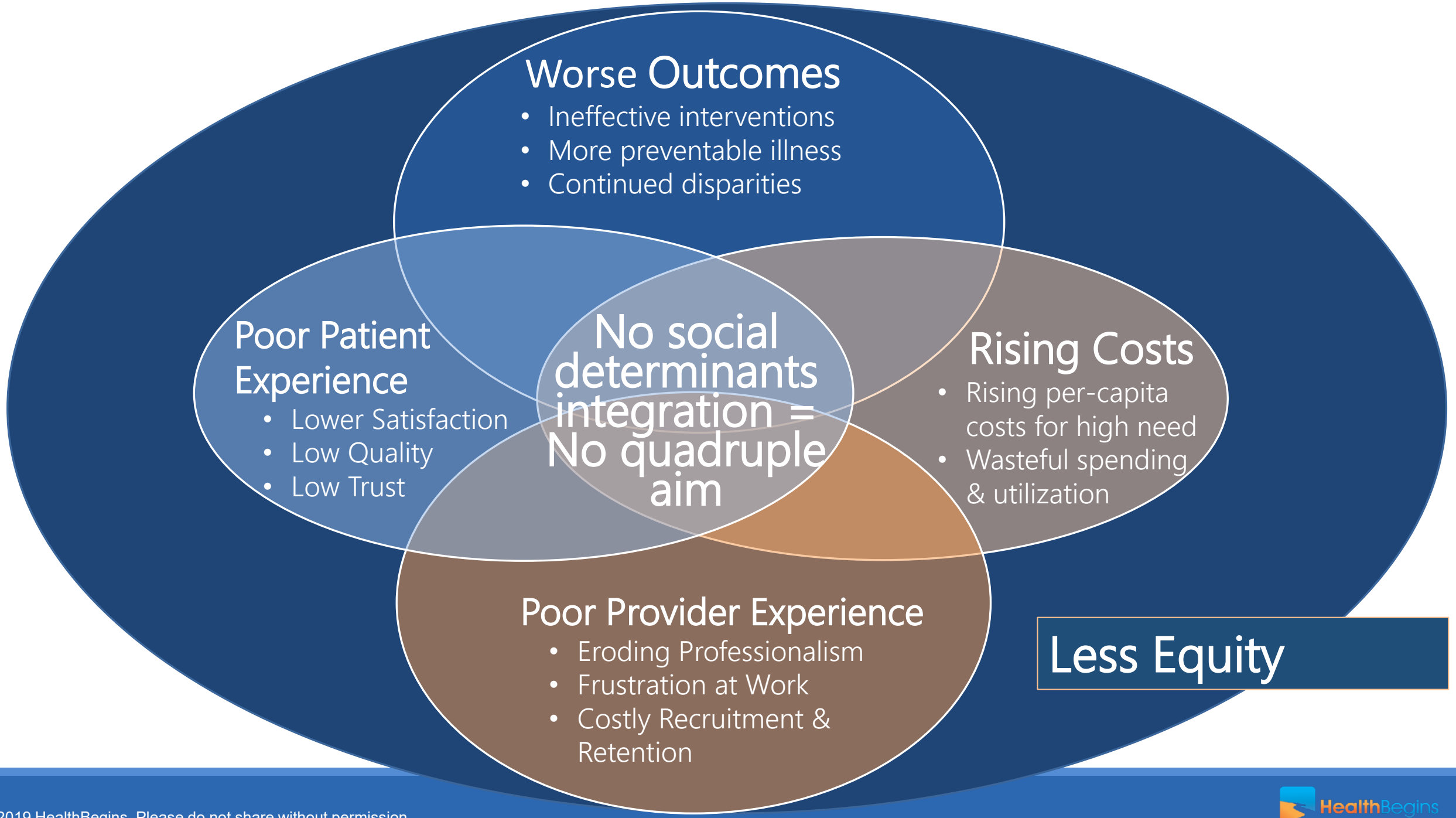

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The question is no longer whether to address the upstream needs of patients and populations, but how.

How can employers address upstream factors to lower costs and improve health and well-being for employees and communities?

Identify and test approaches to address your employees' upstream needs

- Identify the prevalence of food insecurity, financial insecurity, housing instability/homelessness, transportation barriers and social isolation among EEs and families

- Test methods to address upstream needs through your benefits plan, on-site/near-site clinics, and/or wellness vendors

Advance upstream goals in your negotiations and contracts

- As employers make demands to lower out-of-control healthcare costs, incorporate solutions for **medical debt** prevention and other upstream goals into your negotiations and direct contracting with healthcare systems and insurers

- Contract with nonprofits, social service providers, and public health agencies to provide targeted benefits to employees with financial insecurity, food insecurity, housing instability, and other health-related social needs

- Support healthcare-community efforts to identify social and financial ROI

More than 1 in 3 Americans struggle to afford the cost of their medical care

Medical expenses put 10.5 million Americans in poverty in 2016, making it the largest contributor to increasing the number of individuals in poverty.

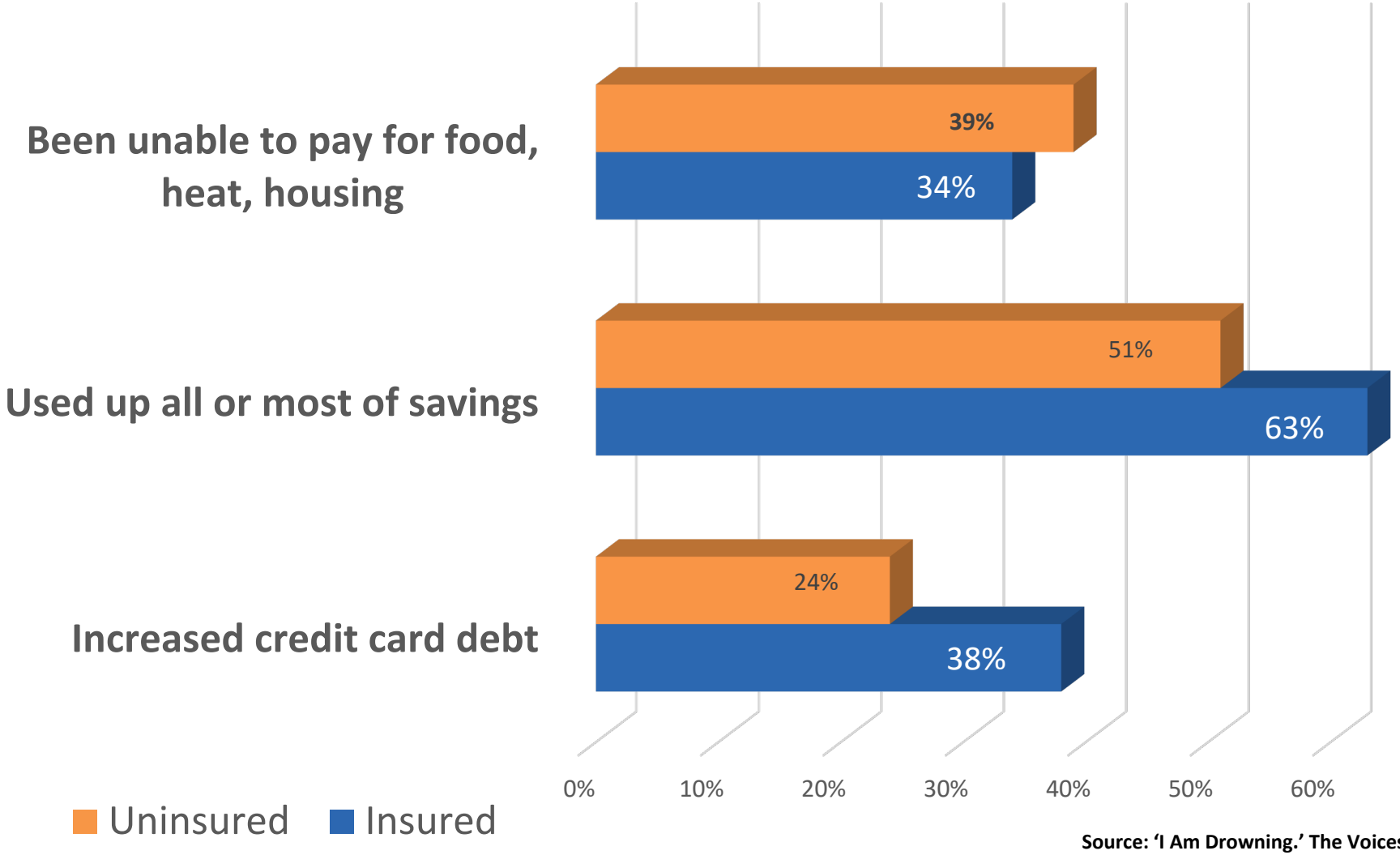
Over 40 million Americans owe about $75 billion in past-due medical debt.

"We had insurance we could afford and still wound up with huge medical bills after a sickness and hospital stay. The following year, 2015, our monthly premium doubled.

Our monthly went from $440 to almost $900. We divorced so that the kids and father could be on Medicaid. We had no choice but to legally divorce." –Joseph Gilbert

Source: Bloomberg News. John Tozzi. Dec 18 2017. https://www.bloomberg.com/news/features/2017-12-18/a-hospital-giant-discovers-that-collecting-debt-pays-better-than-curing-ills
Source: 'I Am Drowning.' The Voices of People With Medical Debt. The New York Times. Jan 11, 2016. https://www.nytimes.com/interactive/2016/01/11/upshot/12up-medicaldebt.html
Source: US Census Bureau, Supplemental Poverty Measure. 2016. https://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-261.pdf

People who reported problems paying medical bills in the last year told pollsters they'd done the following:



"I can't afford food and shelter anymore [due to medical bills]. Was living on my own and now live in the basement of neighbors who also share their food with me." –Adam

Source: 'I Am Drowning.' The Voices of People With Medical Debt. The New York Times. Jan 11, 2016.
https://www.nytimes.com/interactive/2016/01/11/upshot/12up-medicaldebt.html

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What drives medical debt?

- 2/3 of medical debt is caused by a one-time or short-term medical expense (e.g. hospital stay or an accident).

- 1/3 of medical debt is related to treatment costs for chronic conditions. The most common chronic conditions driving medical debt are
  - Cancer
  - Heart disease
  - Diabetes

- 55% of those with medical bill problems report debt of $2,500 or more.
  - 13% report bills of at least $10,000.
  - Costs related to emergency room visits, hospitalization, dental care, and diagnostic tests like X-rays and MRIs account for the largest share of what people owe.

Self-insured employers can help reduce and prevent the harms of medical debt in America.

How?

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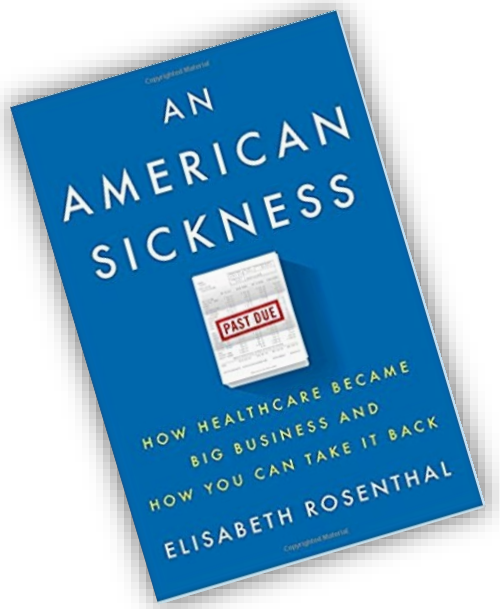
Do one thing to prevent medical debt



A) Educate employees about their right to ask for:

- A complete itemized bill
- Bill reduction
- Bill forgiveness, and/or
- A 0% interest repayment plan

B) Provide, or link to, nonprofit financial counseling services

- Resource: National Foundation for Credit Counseling
- Other resources to compare prices at other hospitals. Healthcare Bluebook & Clear Health Costs

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Do one thing to prevent medical debt

C) Advocate against surprise out-of-network bills ("balance billing"), especially for ambulance rides

- Most states do not have laws that directly protect consumers from balance billing by an out-of-network provider for care delivered in an ED or in-network hospital.
  - In states without protections, advise employees and families to write in ***"as long as the providers are in my insurance network"*** before signing forms accepting financial responsibility.
- Most state laws that *do* protect patients from surprise billing do not apply to ground ambulance rides

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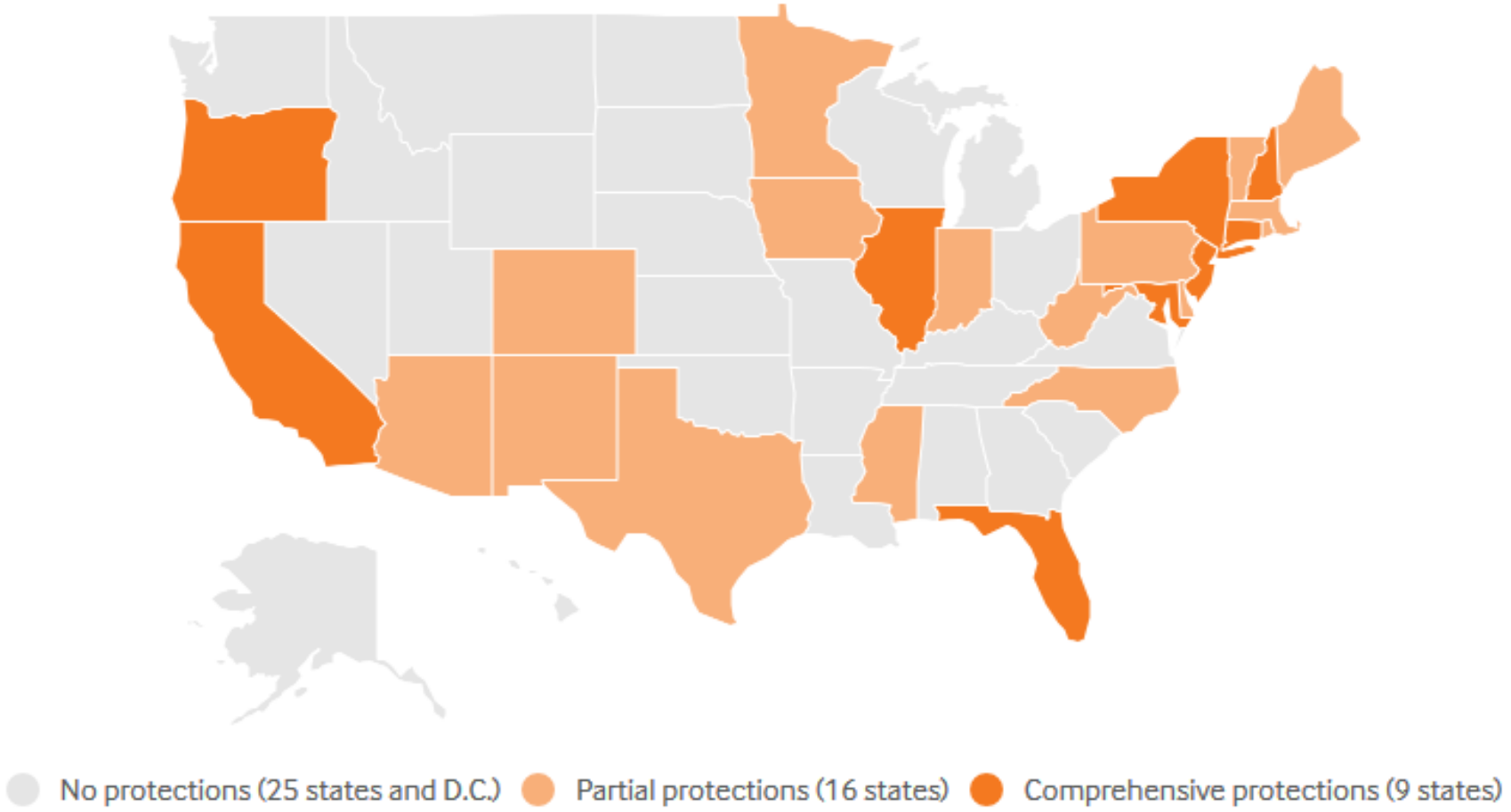
State Laws Protecting Against Balance Billing by Out-of-Network Providers in Emergency Departments or In-Network Hospitals



Source: Jack Hoadley, Kevin Lucia, and Maanasa Kona, "State Efforts to Protect Consumers from Balance Billing Continue, While Momentum Builds for Federal Action," *To the Point* (blog), Commonwealth Fund, Jan. 18, 2019. https://doi.org/10.26099/G10E-A246

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Do one thing to prevent medical debt

D) Make contributions to HSAs, especially for lower-wage workers, and establish wage-based benefit design

- Employees with high-deductible health plans (HDHPs) are more likely to report medical bill problems than those in plans with lower deductibles (26% vs 15%). The adverse effects of HDHPs are greatest among lower-wage workers.
- Resource: National Alliance of Healthcare Purchaser Coalitions, Action Brief

E) Encourage hospitals to strengthen their Financial Assistance Policies (FAPs) and community health improvement efforts

- Resource: Community Catalyst

F) Add your voice to strengthen medical debt protections

- Resource: Campaign to End Medical Debt www.endmedicaldebt.org
- Resource: National Consumer Law Center

Questions?

Thank you!

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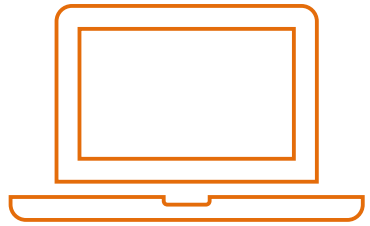

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