Population Health: Meaningful Connections²

LOMA LINDA UNIVERSITY
HEALTH
CMS Projections for National Healthcare Spending
CY 2003 - 2018

National Health Expenditures (billions)
National Health Expenditures as a Percent of Gross Domestic Product

Source: Centers for Medicaid & Medicare Services - NHE Projections 2008-2018, Forecast Summary and Selected Tables
Defining Population Health
high HS graduation rate  low commute to work scores
high household broadband use
high home care scores  low school absenteeism rate
low household toxicity scores <25  high ACT scores
zero pedestrian deaths  zero strokes, HAI, c-section rate
household walkability scores 75+
Social Determinants of Health

Adapted from: WHO (1990)

Individual-level health education efforts

Negative Health Outcome

Determinants of health

- Inadequate systems
- Unhealthy environments
- Unemployment
- Lack of education
- Poor Housing
- Poverty
New Financial Stress and Opportunities for New Models of Delivery

• Executives must have the necessary information to understand the organizations risk profile

• When and how do we start managing risk population health and assuming more risk?

• Where on the risk continuum do we want to be?

• What will it take to move our organization to where we want to be?
<table>
<thead>
<tr>
<th>Patient Health</th>
<th>Population Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Entire populations</td>
</tr>
<tr>
<td>Action oriented</td>
<td>Stage based</td>
</tr>
<tr>
<td>Passive-reactive</td>
<td>Proactive</td>
</tr>
<tr>
<td>Clinic based</td>
<td>Home based</td>
</tr>
<tr>
<td>Clinician delivered</td>
<td>Technology</td>
</tr>
<tr>
<td>Standardized</td>
<td>delivered</td>
</tr>
<tr>
<td>Single behavior</td>
<td>Tailored</td>
</tr>
<tr>
<td>Efficacy</td>
<td>Multiple behaviors</td>
</tr>
<tr>
<td>Fragmented</td>
<td>Impact</td>
</tr>
<tr>
<td></td>
<td>Integrated</td>
</tr>
</tbody>
</table>
## Why Population Health

<table>
<thead>
<tr>
<th>Population Diversity</th>
<th>Emphasis on Evidence Based Care (Including Prevention)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing Life Expectancy</td>
<td>Shift to Outpatient Care</td>
</tr>
<tr>
<td>Rising Chronic Disease</td>
<td>Shift to Value Based Care</td>
</tr>
<tr>
<td>Desire for Patients to Remain at Home</td>
<td>Shared Risk Structures</td>
</tr>
<tr>
<td>Gap Between Physician Supply and Demand</td>
<td>Newly Insured</td>
</tr>
</tbody>
</table>
Transformative Strategies from the Top of the Mission to the Bottom Line

• Shifting unmanaged charity care into strategies for community health improvement

• Connecting Community Health Needs Assessments (CHNA) directly to strategy

• Integrating care to address socially complex residents at the neighborhood level

• Engaging communities in transformative partnerships with shared accountability
Social-Ecological Model
# New Paradigm for Population Care Management

<table>
<thead>
<tr>
<th>Current Reality</th>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease Treatment</td>
<td>Prevention</td>
</tr>
<tr>
<td>Hospital and Physician Centered</td>
<td>Community Centered</td>
</tr>
<tr>
<td>Hospital &amp; Physicians Dispensers of Information</td>
<td>Open Access to Information</td>
</tr>
<tr>
<td>Return on Investment</td>
<td>Return on Life</td>
</tr>
<tr>
<td>Charity Care/Under-reimbursed Medicaid and Medicare</td>
<td>Community Health Development</td>
</tr>
</tbody>
</table>
Population Health Requires Partnerships to Improve Outcomes
Future Health Data Analysis

- Census Demographics
- Health Status Indicators
- Service Utilization
- Primary Care Network Design
- Community Assets
- Market Potential
Community Health Management System

Welcome  Dora Barilla  Today is Wednesday, March 11, 2015

<table>
<thead>
<tr>
<th>Health Status</th>
<th>Admissions</th>
<th>Re-Admissions</th>
<th>Health Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td>% of Tot</td>
<td>Status</td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>23%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BlueCross</td>
<td>5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uninsured</td>
<td>1%</td>
<td></td>
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</tr>
</tbody>
</table>

Re-Admissions

Chronic Disease Management
Re-admissions
ED Treat & Street
Expected ER Caseloads

Priority Areas

Loma Linda University and Loma Linda University Health System has identified three priority areas in the Inland Empire for 2013-2015 to help improve the health of the communities most in need of health improvement. Together we are much greater than the sum of our parts and thank you for helping us move towards greater collaboration.
ED Visits Asthma (Children < 18 yrs)
Strategy

Analysis and Development
Environmental Scan
Strategy Alignment and Deployment
Community Health Needs Assessment

Center for Strategy & Innovation

Functions
Community Health Management System - ESRI/GIS
Consulting Services
Educational Forums
Innovation Facilitation
Strategic Planning
Whole Community Care
Innovation

Creating Networks and Multidisciplinary Teams
Informal Networks to Incubate New Ideas
Piloting New Care Models within the System
Transforming the Experience and Delivery of Healthcare

Enhanced Support
Community Health Development
Business Development
Clinical Decision Support
Finance
Philanthropy
Purpose:
Establish a Center for Strategy and Innovation to support the LLUH strategic planning process and to innovate new delivery models that engage the community.

Future:
Center of Joint Regional Initiatives and Strategy Development

Strategy
- Strategy Development
- Strategic Analysis
- Environmental Scan
- Strategy Deployment and Alignment
- Community Health Needs Assessment

Innovation
- Creating Networks and Multidisciplinary Teams
- Informal Networks to Incubate New Ideas
- Piloting New Care Models within the System
- Transforming the Experience and Delivery of Healthcare

Community Engagement
- Community Benefits
- Community Health Needs Assessment
- Grant Writing
- Collaborative Initiatives/Civic engagement

Enhanced Support
- Community Health Development
- Business Development
- Clinical Decision Support
- Finance
- Philanthropy

Functions
- Health Services Utilization/Data Integration
- Health Surveillance
- Community Engagement
- Innovation
- Strategic Decision Support
- Strategy/Innovation Think Tank

Functions
- Community Health Management System - ESRI/GIS
- Consulting Services
- Educational Forums
- Innovation Facilitation
- Strategic Planning
Imagining a Healthy Community

What do we want our community to be?

Where are we today?

How will we get to where we need to be?

What makes your community healthy?
Imagine...

Being wholistic in understanding the community’s problems and capacity
Imagine...

Approaching information as an asset not a cost
Imagine...

Increasing our communication and interaction with our communities
Leading Change with Influence

- Create new mental models for health improvement
- Merge the conversation about health and healthcare reform
- Partnerships with community are imperative
“Defining goals that matter to people is critical, because the most powerful way to change a complex, soft system is to change its purpose”

Mark Bittman
3 Barriers to Collaboration and Innovation

Voice of Judgment

Voice of Cynicism

Voice of Fear

Theory U, Otto Scharmer
3 Enablers to Collaboration and Innovation

Open Mind

Open Heart

Open Will
Dialogue Practice:
Key to collaboration and innovation

Speak from experience
Listen to learn
Surface patterns and themes
Be aware of impacts
Be aware of diverse worldviews
Dialogue: Round 1

Share your name

Your healthcare location

From where you sit, what are the greatest challenges and opportunities in healthcare?
Round 2

Share your name

Your healthcare location

From where you sit, what is the role of volunteerism in serving these challenges and opportunities?
Whole Group Insights

What intervention points are you noticing?

What AHA moments are emerging?
Thank you

Thank you for being amazing and working in this complex system that needs your attention and care!