Building a People Centered Health System

Population Health: Past, Present & Future

Cleveland Clinic 2019 Population Health Conference

Rick Gilfillan, M.D.
September 17, 2019
Let’s start with defining our objectives

- The Triple Aim for individuals and communities

- Sustainable health system that doesn’t steal resources from other social sectors

- Others? Professional Satisfaction; Clinical Education; Research; Knowledge Generation
The good news is that we have made great progress over the past 50 years, bad news is we are falling behind other countries.
Bloomberg Global Health index scores for 169 countries, puts US well below others …

Sources: Bloomberg analysis of World Health Organization data; United Nations Population Division and the World Bank
… and 35th overall just below Costa Rica and ahead of Bahrain!

Sources: Bloomberg analysis of World Health Organization data; United Nations Population Division and the World Bank
And, U.S. life expectancy is declining!

US life expectancy declining again

- **At Birth**
  - Both sexes: 78.6 (2016) vs. 78.7 (2015)
  - Male: 76.1 (2016) vs. 76.3 (2015)

- **At Age 65**
  - Male: 18.0 (2016) vs. 18.0 (2015)
  - Female: 20.6 (2016) vs. 20.5 (2015)

**Drug overdose deaths increase 21% in 2016.**

- **Rate of drug overdose deaths**
  - 2016: 19.8 (per 100,000)
  - 2015: 16.3

- **Rate of drug overdose deaths involving synthetic opioid drugs such as fentanyl and tramadol**
  - 2016: 6.2
  - 2015: 3.1

Source: Centers for Disease Control
Within that national data are significant population disparities: 23 years life expectancy spread here in Cleveland.*
Clinical care and genetics account for 30% of the differences in health of populations.

Influencers of Health

- **Clinical Sick Care**: 20%
- **Genetics**: 10%
- **Social and Economic Factors**: 35%
- **Health Behaviors**: 25%
- **Physical Environment**: 10%

“The other 70%”

Social Influencers of Health

U.S. health care spend is almost entirely focused on sick care, not preventive care or public health.

Influencers of Health

- Genetics (10%)
- Social and Economic Factors (35%)
- Health Behaviors (25%)
- Physical Environment (10%)

The other 70%

Social Influencers of Health

- Clinical Sick Care (95%)
- Preventive & Public Health (<5%)

US Healthcare spending is crowding out other social services compared to other OECD countries

**Spend as % of GDP**


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…with resulting lower life expectancy among OECD countries

Numbers above each bar indicate life expectancy:

- FR: 82.4
- SWE: 82.3
- SWIZ: 83.0
- GER: 80.7
- NETH: 81.6
- US: 78.8
- NOR: 82.4
- UK: 81.0
- NZ: 81.7
- CAN: 81.7
- AUS: 82.5

So Who/what is accountable for meeting our Health System objectives for America?

- Cities and States – Public Health
- Federal Government: Healthy People 2020
  - Department of Health and Human Services – (HHS)
  - Center for Disease Control (HHS)
  - Center for Medicare and Medicaid Services (CMS)
  - National Institutes of Health (NIH)
- Hospitals, physicians
- Integrated Health Systems
- Payers: CMS, Insurance Companies – States - Employers
Resources Available

• Federal Health and Human Services – $100 B - net of CMS
• Public Health Spend – $65 B
• Total Medical Spend Nationally – $4 Trillion – 30% estimate to be waste*

• *Institute of Medicine
Conclusion: Lots of Activity – No Accountability

• Improvement doesn’t happen in the absence of accountability for outcomes

• First requirement for improvement in meeting our objectives is to develop a system of accountability

• Hence ACO’s, BPCI and ACC?
1/3 of $4 Trillion Medical Spend – is administrative expenses – much to “manage cost and quality”

- Providers Systems – 16%
- Payers – 15% with margin
- Government – 2 - 4%
- Total Admin = 33 - 35%
Will today's healthcare marketplace deliver the Triple Aim, Sustainability and more resources for social spend?

• Unlikely
Why haven’t healthcare providers done it already?

• No Business Model: results produced will align with the business model – what do I get paid to produce?

• Regulations can keep you from doing the wrong things

• But to get people to create an operating entity to sustainably deliver an outcome – you need a business model that drives and reward those outcomes
So in our time Providers should be pursuing several common objectives:

• Improve Outcomes of Care
• Decrease consumption of scarce resources to allow more attention to the Social Influencers of Health
• Become a driver of the collaborative effort needed to impact the SIOH’s in the community

Central to accomplishing these objectives is a business model that provides a sustainable economic engine.
Absence of Economic Engine means it can’t fit with core Hedgehog strategy per Collins “Good to Great”
Here is how Trinity Health is trying to do this:
Trinity Health operates in 22 states through 21 P&L& Outcomes business units supported by system services.

$18.3B
In Revenue

1.5M
Attributed Lives

$1.1B
Community Benefit Ministry

133K
Colleagues

7.8K
Employed Physicians & Clinicians

28K
Affiliated Physicians

94
Hospitals*

18
Clinically Integrated Networks

17
PACE Centers

109
Continuing Care Locations

Data above is for FY18

*Owned, managed or in JOAs or JVs
Trinity Health SBU’s and System Services

• 18 Regional Health Ministries (RHMs)– vary from 1 to 7 hospitals and medical staffs
• 4 National Health Ministries:
  - Trinity at Home
  - Trinity Health PACE
  - Trinity Health Continuing Care
  - Trinity Health Senior Living
• CEO and teams are directly responsible for P&L & Outcomes
• Trinity Health System Services – 4,000 employees providing corporate services and some centralized operational services
Our Mission drives our Vision and strategy

We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Our Core Values

• Reverence
• Commitment to Those Who are Poor
• Justice
• Stewardship
• Integrity
Our Vision is focused on the people we serve

Our Vision
As a mission-driven innovative health organization, we will become the national leader in improving the health of our communities and each person we serve. We will be the most trusted health partner for life.
The Marketplace (CMS) continues to demand fundamental change in what we produce.

### 2015: Producer-Centered
- Retail Health Market
- Value Networks
- Transparency
- Financial Incentives
- Private Exchanges
- Tiered Networks
- HHS Goals

### 2020: People-Centered
- Value for People

#### DRIVERS
- Service Volume

#### HHS Goals
- 2015 - Medicare Access and CHIP Reauthorization Act (MACRA)
- 2017 - Trump Care
- 2019 – HHS/CMMI CPC+ Direct Contracting Models
Amidst many necessary transformations - our focus was on becoming accountable for outcomes

Clinical Care Model
Clinical Business Model
Community Health and Well-being
Ambulatory Network
Marketplace Consumerism
Health Care Professions
IT Infrastructure
Organizational Structure
Precision Medicine

Transformation = Self-disruption
Our Strategy: Create & operate a People-Centered Health Systems that delivers the Triple Aim for individuals, populations and communities
What do we mean when we say Population Health? CDC/IOM use a very broader definition

• Population health “brings significant health concerns into focus and addresses ways that resources can be allocated to overcome the problems that drive poor health conditions in the population”

• Public Health can be defined as what “we as a society do collectively to assure the conditions in which people can be healthy” (Institute of Medicine, 1988). On the other hand, population health provides “an opportunity for health care systems, agencies and organizations to work together in order to improve the health outcomes of the communities they serve.”
What do we mean when we say Population Health?

Our People Centered Health System breaks this into:

- **Population Health Management:**
  - A set of operating activities utilizing clinical staff, data resources, IT platform etc. to improve the triple aim in the *specific populations we are accountable for*.

- **Community Health and Well Being:**
  - A set of operating activities utilizing clinical staff, data resources, IT systems, advocacy and investing activities, coalitions and collaboratives with other parties to drive improvement in the underlying social influencers of health *for the entire population in the communities we serve*. 

Our People-Centered 2020 Strategic Plan - with 17 initiatives - was the blueprint for building the System for the past 5 years.
We are building standard platforms and unified system services to deliver coordinated care

- **TogetherCare** (Epic) implementation for clinical and revenue cycle integration – first-wave installation in January of 2020
- Enterprise Resource Management (ERP) platform for Supply Chain and Finance
- Workday operating for all 129,000 colleagues
- Digital health initiatives advancing with people-centered capabilities at 7 RHMs
- Diversity and Inclusion Program underway
- Trinity Health Leadership System (THLS) is rapidly being adopted
Trinity Health Leadership System (THLS) engages and empowers every colleague in the organization to generate continuous improvement in Prioritized Strategic Aims (PSA’s).

**Common tools for continuous improvement**
- Lean
- Visual management

**Colleague engagement and empowerment**
- Daily huddles
- Idea boards
- High Reliability and Zero Harm
THLS Visual Management ensures alignment on PSA’s from…

System Office…

Trinity Health System Office Executive Leadership visual management

…to the regional ministries…

Saint Agnes Medical Center (Fresno, Calif.) regional system visual management

Trinity Health Operating Platform
...to direct care units

Saint Agnes (Fresno, Calif.) Emergency Department visual management

Trinity Health Operating Platform
We have made significant progress on all three People Centered Health System components over the past 5 years:
THLS PSA’s are driving improved clinical outcomes – but still room to improve patient satisfaction

Episodic Health Care Management for Individuals

Readmissions 14.6%
Hospital Acquired Conditions Trending to top Decile

Likelihood to Recommend
Acute Care 72.5%
Emergency Departments 65.7%
Medical Groups 92.6%
We are the only national system in IBM Watson top Quintile – mostly based on Acute Care Metrics*

- Allina Health System
- Avera Health
- Banner Health
- BayCare Health System
- Cleveland Clinic
- Duke University Health System
- Hospital Sisters Health System
- Inova Health System
- Intermountain Health Care
- Mayo Foundation
- Mercy (MO)
- Mercy Health (OH)
- Northwestern Medicine
- SCL Health
- Sentara Healthcare
- St. Luke’s Health System
- **Trinity Health**

*Source: Watson Health 15 Top Health Systems Study 2019
Trinity Health Leadership System initiatives have resulted in significant improvements in cost of delivering care

THLS Annual Run Rate Savings of $1.5B

Incremental Annual Savings

Cumulative Annual Savings

2014-16: $595M
2017: $421M
2018: $406M
2019*: $128M
Cumulative: $1.5B

*For 6 months period ending 12/31/2018
Economic Engine: FFS Reimbursement + P4P + Accountability for the Triple Aim is rewarded through our large BPCI Program

**Bundled Payment for Care Improvement**

- **Annual Medical Cost**: $475 Million
- **Attributed Lives**: 16,800

**Key Results:**
- Decrease Post-Acute Expense
- Decreased Readmissions
- Positive ROI
- Decreased SNF Admits and LOS
- Savings of 7% of total cost
- Net positive operating margin today
We have made significant progress on all fronts over the past 5 years:
Population Health Management has a long history with interesting twists and turns – This is Phase 5

- **Phase 1:** 1920’s Pre Paid Group Practice (PPGP’s) – 7 million people enrolled at peak
- **Phase 2:** 1973 – HMO’s – HMO Act
  - 1973 – 1990 PPGP’s convert to Federally Qualified HMO’s – Group and IPA Models
  - 1980’s – California IPA Risk Models
  - 1980’s – Blues create HMO’s
Population Health Management has a long history with interesting twists and turns – This is Phase 5

- **1990 – 2000’s** – gradual dissolution of many PPGP HMO’s
- **1990’s** – PPO’s take on price levels of HMO’s without Population Health
- **1996** – Aetna acquires US Healthcare for $9 B
- **Phase 3:** HMO’s Fade 1998
  - United Healthcare abandons Managed Care & lightens up on Population approach
  - 1998 – “As Good As it Gets” revolt vs Managed Care
- **2000’s** – Consumer Directed Health Plans – put onus on patients
- **Phase 4:** 2010 The New ACO Provider Pop Health Accountability
- **Phase 5:** 2016 – Social Influencers of Health start coming to the fore
Population Health Management Operating Activities are well known across the industry

- PCP Practice activities/Medical Home
- Care Management
- Care Gaps Improvement
- Referral Management
- ER Care Management
- SNF Care Management
- Risk Pool Management
- Network Management
- Medical Cost Analysis
- Data Systems and Predictive Analytics
Conclusion from the Population Health History:

- There is good knowledge about how to be effective
- There must be a business model to make it sustainable

Note: - Organizations will seek out the easiest way to meet goals – if they don’t have to produce excellent pop health outcomes – they haven’t and they won’t
Trinity Health built many of these out using a standard model that integrates RHM System Office operating capabilities

**RHM Activities**

Standard ACO care management model with prescribed staffing levels

Network Management - 15,000 physicians across 18 Clinically Integrated Networks (CINs)

**SNF Networks**

**System Office Activities**

- Build Standard Operating Activities
- Data Infrastructure including claims from 47 different data feeds covering 1,075,000 lives
- Reporting System providing standard reports to all ACOs
- Care Evolution care management system for care gap management
- Home Care
- SNF Management
Digital Innovations: Home Care Connect – virtual to virtual care sites – reduces readmissions by 30%

- Virtual Care Center 24/7 operation
- Team of specially trained THAH RNs supporting patients nationally
- Enhanced connection and connectivity between patient, family, home care team and physicians
- 12,700 patients served
- 1,400 average daily patient census
- Serving 10 states
- 30-day re-hospitalization rate reduced to 9.3% from 13% prior to launch
- 98% of patients are satisfied
- 96% would recommend
- Heart failure #1 population served
We currently hold $9.7B* in cost of care accountability for 1.5M people

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Annual Medical Cost</th>
<th>Attributed Lives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare ACOs</td>
<td>$3.4 Billion</td>
<td>290,000</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>$1.4 Billion</td>
<td>150,000</td>
</tr>
<tr>
<td>Bundled Payment for Care Improvement</td>
<td>$475 Million</td>
<td>16,800</td>
</tr>
<tr>
<td>Commercial &amp; Medicaid**</td>
<td>$4.1 Billion</td>
<td>1,055,000</td>
</tr>
<tr>
<td>PACE/ LIFE</td>
<td>$323 Million</td>
<td>4,000</td>
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</tbody>
</table>

*For 12 months period ending 12/31/2018
**Commercial ACO lives and Medicaid ACO lives; does not include full-risk, health plan lives
We are demonstrating better quality outcomes, lower costs and shared savings

Trinity Health ACO

- $8.4M shared savings
- 96.04% overall quality performance score
- 100% score on preventive health
- 100% score on at risk population

Trinity Health Integrated Care

- $12.5M shared savings
- 2nd in gain share savings out of 16 MSSP Track 3 ACOs
- 12th out of 159 MSSP ACOs achieving shared savings
Economic Engine: FFS payments + plus care management fees + net shared savings = Breakeven

<table>
<thead>
<tr>
<th>(in millions)</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
<th>FY18</th>
<th>Mar FYTD 19 Adjusted (NOTE)</th>
<th>Cumulative Impact FY14-Mar FYTD19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment in ACOs, CINs - net</td>
<td>$17</td>
<td>$26</td>
<td>$40</td>
<td>$40</td>
<td>$54</td>
<td>$52</td>
<td>$229</td>
</tr>
<tr>
<td>BPCI</td>
<td>--</td>
<td>$1</td>
<td>$14</td>
<td>$16</td>
<td>$13</td>
<td>$14</td>
<td>$58</td>
</tr>
<tr>
<td>TOTAL Investment in Population Health before Gainshare/loss</td>
<td>$17</td>
<td>$27</td>
<td>$54</td>
<td>$56</td>
<td>$67</td>
<td>$66</td>
<td>$287</td>
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<tr>
<td>Net Gainshare/loss</td>
<td>--</td>
<td>($4)</td>
<td>$5</td>
<td>$33</td>
<td>$52</td>
<td>$72</td>
<td>$158</td>
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<tr>
<td>Net Result</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>($129)</td>
</tr>
</tbody>
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We have invested $287M to date – but with only 0.7% shared savings achieved - still have much room for improvement.
Major Challenge for Trinity Health is to scale known interventions in system focused on Acute Care

- Change Management
- Matrix Management
- Eclectic EHR platform being remedied with Epic Install
- We have made RHM CEO leader of all components – this may need to change
We have made significant progress on all three dimensions over the past 5 years:
Clinical care and genetics account for 30% of the differences in health of populations – SIOH = 70%

Influencers of Health

- Clinical Sick Care 20%
- Genetics 10%
- Social and Economic Factors (35%)
- Health Behaviors (25%)
- Physical Environment (10%)

“The other 70%”

Social Influencers of Health

Community Benefit previously addressed this need but not really

• Definition – Uncompensated costs of Medicaid, uninsured plus education costs, + Proactive Spend on Community Services etc.
• Mostly a function of financial calculation
• Typically less that 10% of the calculated benefit represented proactive spend toward the Triple Aim
• Limited proactive spend was more related to marketing/health promotion and “safety net” care sites
• Good work – but not strategically focused
CHWB objective is to address SIOH - the other 70 percent
Improving Community Conditions by … Addressing Individuals’ Social Needs
Our work to build a *Well Community* is organized into three Focus Areas pursued by RHMs and supported by System Services.
Our work to build a *Well Community* is organized into three Focus Areas pursued by RHMs and supported by System Services.

- **Ensure care delivery models assess and address the needs of vulnerable patients.**
- **Expand utilization and availability of community-based SIOH services.**
- **Transform communities through policy, system and environmental change.**
Each focus area has specific operating activities/work streams to meet our objectives in that space.

Ensure care delivery models assess and address the needs of vulnerable patients.

- Support the development of data infrastructure and capabilities to capture and analyze the SIOH and Health Inequities.
- Ensure the screening of patients for tobacco use, obesity and social needs using a standard platform.
- Ensure the creation of referral pathways to community resources.
- Design “wraparound” care delivery model in safety nets that address needs of those who are vulnerable.
Pharmaceutical Assistance Strategy has helped more than 50K patients with a total of $2M savings to patients

<table>
<thead>
<tr>
<th>Significant Discounts</th>
<th>Available to Everyone – EMR Integration</th>
</tr>
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<tbody>
<tr>
<td>Low Cost</td>
<td></td>
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<tr>
<td>$4/free List</td>
<td>340B program</td>
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<tr>
<td>Program Variation</td>
<td></td>
</tr>
<tr>
<td>Free</td>
<td></td>
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<tr>
<td>Immediate/In-Office</td>
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</table>

Ensure care delivery models assess and address the needs of vulnerable patients

Utilizing partnerships to make prescriptions consistently affordable and accessible.
The Good Samaritan Initiative adds Community Health Workers to care teams to improve the care of at-risk patients.

Addressing patients’ needs and barriers to health and wellness using the Pathways model:
- Linked to ACO/BCPI patients
- 891 GSI patients enrolled
- 50% had a pathway initiated
- Providers report patient compliance improving

Ensure care delivery models assess and address the needs of vulnerable patients.
11 birthing hospitals have been designated “baby-friendly” by Baby Friendly USA

- In 26 months, increased from 7.5% to 25% hospitals designated
- 4,944 to 16,180 babies born in Baby Friendly designated hospitals

Ensure care delivery models assess and address the needs of vulnerable patients
Each focus area has specific operating activities/work streams to meet our objectives in that space.

- Expand utilization and availability of community based services
- Ensure RHMS conduct and utilize comprehensive Community Needs Assessments to identify needs and strategies
- Link our patients to available community resources through referral management systems and tools
- Establish, support and monitor effectiveness of Tobacco and Obesity interventions within communities
- It Support – Aunt Bertha, Unite Us
7 communities are now part of the National Diabetes Prevention Program targeting lifestyle change to prevent type 2 diabetes

National Partners

Expand utilization and availability of community based services
Each focus area has specific operating activities/work streams to meet our objectives in that space.

- Support development of and provide grants or low interest loans to community coalitions that seek to transform communities
- Advocate for and impact policy that address tobacco, nutrition and improve social conditions within our communities
- Promote and support Local sourcing and local hiring initiatives
- Support Environmental stewardship in communities we serve
Eight of our communities are using policy, system and environmental change strategies to improve health.

Transforming Communities Initiative (TCI) invests in communities using evidence-based system change to accelerate community health.

Grants: $18M  
Community Match: $7M  
Capital Loan Access: up to $40M
Improving social influencers of health in our communities using place-based investing with loans exceeding $36M

- Food, $2,100,000, 6%
- Housing, $15,400,000, 43%
- Health, $2,700,000, 8%
- Education, $5,400,000, 15%
- Facilities, $5,200,000, 15%
- Childcare, $1,100,000, 3%
- Energy & Environment, $600,000, 2%
- Business Development,

Transform communities through policy, system and environmental change
Advancing corporate responsibility with shareholder advocacy

**Tobacco**
- Smoking in youth-rated films
- Marketing practices of tobacco makers
- Pharmacy sales of tobacco

**Food/Nutrition**
- Nutritional offerings, marketing practices & lobbying efforts of food and beverage companies
- Affordability & display of healthy foods

**Health/Medications**
- Drug company pricing behavior
- Corporate/governance oversight to curb opioid misuse
- Global access to vaccines

**Climate Change**
- Heavy greenhouse gas emitters to reduce emissions
- Use of toxic chemicals in products

**Violence**
- Safety of gun products
- Lobbying efforts of gun makers & distributors

©2018 Trinity Health
23 Trinity Health communities have passed T21 at state and/or local levels

**Trinity Health Communities/TCI**

**Community passage**
1. New Albany, OH – 2015
3. Columbus, OH – 2016
4. Chicago, IL – 2016
6. Ann Arbor, MI – 2016
7. Schenectady County, NY – 2016
8. Genesee County, MI – 2017
9. Trenton, NJ – 2017
10. Maywood, IL – 2017
11. Powell, OH – 2017
12. Berwyn, IL – 2017
13. Onondaga County, NY – 2017
14. Springfield, MA – 2018
15. Hartford, CT – 2018
16. Cook County, IL – 2019

**State passage**
2. New Jersey – 2017
3. Oregon – 2017
4. Massachusetts – 2018
5. Illinois – 2019
7. Delaware – 2019

Tobacco

Transform communities through policy, system and environmental change

National Partners
We will measure our success using three methods

1. Priority Strategic Aims – Focused initiatives and measures that will move us the furthest and the fastest in a given fiscal year

2. Initiative Dashboard – annual progress toward multiple system and local initiatives

3. Community Vital Signs – long-term overall community wellness
We use our Priority Strategic Aims to direct attention to this work across the System

Community Health & Well-being PSA Results – Dec 2018

December 2018

Tobacco Screening/Cessation
85.3%

Obesity Assessment/Intervention
64.5%

Community Health Needs Assessment
On target

Social Influencers of Health
On target
Trinity Health’s 21 Community Vital Signs to assess a Well Community that is Healthy, Viable, Just and Connected

<table>
<thead>
<tr>
<th>Health Outcomes &amp; Behaviors</th>
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<tbody>
<tr>
<td>1. Life expectancy</td>
</tr>
<tr>
<td>2. Health equity</td>
</tr>
<tr>
<td>3. Mental health status</td>
</tr>
<tr>
<td>4. Low birth weight</td>
</tr>
<tr>
<td>5. Tobacco use</td>
</tr>
<tr>
<td>6. Obesity</td>
</tr>
<tr>
<td>7. Drug overdose</td>
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<tr>
<td>8. Preventable hospitalizations</td>
</tr>
<tr>
<td>9. 30-day hospital readmission</td>
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<thead>
<tr>
<th>Health &amp; Health Care</th>
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<tbody>
<tr>
<td>10. Uninsured population</td>
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<td>11. Recent primary care visit</td>
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<table>
<thead>
<tr>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Population with no high school diploma</td>
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<thead>
<tr>
<th>Economic Stability</th>
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<tbody>
<tr>
<td>13. Income inequity</td>
</tr>
<tr>
<td>14. Food insecurity</td>
</tr>
<tr>
<td>15. Poverty rate</td>
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<thead>
<tr>
<th>Social Support &amp; Community Context</th>
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</thead>
<tbody>
<tr>
<td>16. Segregation index score (social equity)</td>
</tr>
<tr>
<td>17. Violent crime</td>
</tr>
<tr>
<td>18. Social cohesion (lack of social or emotional support)</td>
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<thead>
<tr>
<th>Neighborhood &amp; Build Environment</th>
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<tbody>
<tr>
<td>19. Food access-food desert</td>
</tr>
<tr>
<td>20. Air quality – particulate matter</td>
</tr>
<tr>
<td>21. Housing cost burden</td>
</tr>
</tbody>
</table>
CHWB Economic Engine: limited at present

• Community Benefit Calculation
• Avoidance of cost for uninsured individuals
• Accountable Health Communities Model – could lead to new reimbursement Model?
Our People Centered Health System is driven by the dynamic interaction of our three components …

**15,000 Clinicians**
Clinically Integrated Network

**Employed Physicians & Clinicians**
7,800

**Episodic Health**
$19 B Revenue*

**Population Health**
$9.7B Total Cost of Care*

**Home Health**

**Physician ACO**

**FFS POP**

**VBP – CMS**

*FY18

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… to support a sustainable health system that improves the health for individuals and communities.
A People Centered Time out: Operating in all three pillars of our people-centered health system impacts people’s lives
Meet our patient: Ami

• Healthy 43-year-old woman with no history of vascular disease suddenly had trouble walking
• Emergency Department vascular surgeon diagnosed a blood clot, performed complicated surgery
• Cardiologist found a congenital hole in her heart; performed minimally invasive catheter-based procedure
• Care team coordinated with her own hematologist to discover a rare, inherited blood clotting disorder which had caused the clot
• Physical therapists supported Ami’s recovery

Outcome:
• Today, this wife and mother is back at work
• Although she has lost some feeling in her foot, she can walk without a cane, ride a bike with her children and enjoy life
Free mammogram event changes perspectives

Meet our patient: Barbara

• Barbara, 63, had not received a mammogram for many years due to fear of the process; does not have a primary care provider
• Attended free mammography event at MercyOne Waterloo Breast Center
• Cost of the mammograms was covered by community partners; translation services, free breast self-examination training and provider services were provided
• Mammographers, nurses, colleagues and volunteers staff the event

Outcome:
• Received self-exam instruction, provider care
• Learned importance of yearly exams

- MercyOne Waterloo, Iowa
Students benefit from School Health Services Program

Our Program:

• SJHS School Health Services provides nursing services to local schools with the goal of keeping students in class
• 26,977 students served at 53 schools
• Identify and treat illnesses and injuries, counsel students with physical and emotional issues
• Manage chronic conditions like diabetes and seizures
• This year, partnering with the dioceses to provide 2 nurse coordinators for services at 18 schools in 3 counties

Outcomes:

• 290,313 school visits in 2018
• Revenue generated in FY19: $1.35 million

- Saint Joseph Health System, Indiana

Sally Dikos, R.N.
Looking Forward
We are looking for ways to integrate our care models and technologies across the System

Episodic Care

- Fee for Service
- Today’s Customers, Technologies, Competitors
- Leverage current competencies
- Compete in current environment

Population Health

- Alternative Payment Models
- Payer Partnerships
- Medigold/Medicare Advantage
- Multi-Specialty Medical Groups
  - Primary Care, Urgent Care, Focused Need Primary care
  - Home Care and Home Care Connect
  - PACE
  - Epic, Digital Health, Telehealth
  - Clinically Integrated Networks
  - Palliative Care
  - Innovative Care Models (e.g., “Whatever It Takes”)

Community Health

- Safety Net Care
- Behavioral Health
- Healthy Villages
- Priority Social Influencers of Health

Trinity Health
We are fragmenting acute care in bad ways:
  • Hospitalists, SNFists, Intensivists, Laborists, Extensivists
  - Digital Start-ups
  - Insurance Carve Outs
We have been improving care coordination and accountability for populations
But we are losing accountability for individual patients when they need it most
The movement towards greater accountability, Population Health and addressing SIOH is not a given

- The first order of business needs to be ensuring that the drivers of this movement continue

  - Alternative Payment Models in all three spaces
  - Explicit Strategic Conversations in Health Systems
  - Board Education
  - Advocacy at State and National Levels

- Thank you for your participation in the HCTTF
Insurers – and increasingly - providers prefer profitability of Medicare Advantage to ACO Model

**ACO**
- Open Network
- No Referrals
- No Precertification/UM
- No claim review or denials
- HCC Coding – minimal impact
- Rebasing is a constant
- No enhanced benefits
- Improves Quality as much as MA
- Saves money for CMS/US
- 1-2% shared savings

**Medicare Advantage**
- Limited network & Choice
- Referral Management
- Precertification/UM
- Claim Review – denials
- HCC Coding – locks in 5-10% margin
- No rebasing
- Improves Quality like ACO
- Better benefits for patients
- Costs more than FFS – Increases CMS costs
- 5-7% profits

For many the focus on HCC coding activities may limit actual population health management
Population Health Management Future Opportunities

- Full Capitation Contract to really make change in delivery model
- Hospital at Home
- Increased Home Care
- Digital Interventions – Virta – Diabetes Reversal?
- Growth in population and contracts – picking up with payers
- Refined Predictive Analytics – both to identify right patients, right interventions, and dispositions
- AI-Machine Learning Techniques could bring entirely new perspectives on opportunities to improve outcomes and operations
- Site of Care Differentials in Commercial Population contracts
- Broader Community wide capabilities – interoperability etc.
- Integrate all sites of Care Management
- Reintegrate Care!
- Caution:
  - Most organizations have plenty of data today – stay focused on executing the known opportunities first
The most compelling threat to persistence of CHWB is the absence of a driving business or economic engine

• Will interest in being accountable for populations drive continued interest in the term issues of social determinants?
• Why haven’t historically interested pop health management entities been persistent in their work on this?
• Who are the population health entities?
• Where is place of the insurance companies in this work?
Future Opportunities for Community Health and Wellbeing

• It requires real collaboration across local institutions
• Parties will need a shared set of goals and a plan
• Public Commitment will be essential
• Must have a grounding of some sort that will compel ongoing engagement - ? Pull local employers into the conversation
• What does the experience of “Cleveland Tomorrow/Greater Cleveland Partnership” teach us about how to drive community wide change?

SIOH’s are largely driven by poverty – income disparity!
Maybe a place to start is to understand your current status on total social/Healthcare spending?

Spend as % of GDP

We need to confront the part we play as providers

We do not manage the use of health care resources in FFS business . . .
  - No appropriateness screening at point of care
  - No profiling of physicians’ use of resources
  - Large variation in testing and procedures

... we extract $ through very high prices
  - 200 - 300% of Medicare (Rand Study)

... supporting excess capacity across the system –
  - ?50% total “plant utilization” if you consider weekend occupancy
The National Perspective
U.S. Health Care: – we are one big frog in the boiling pot of water – we have adapted to an irrational system that meets no one’s needs!
Health care spending is using larger share of household income
50% of non-elderly Americans are worried about paying their health care bills

Percent of People Worried about ability to pay medical bills - 2017
We are pushing individuals into high-deductible coverage which delays needed care: 24% have > $4,000 deductible

Women who were switched to HDHPs experienced relative delays of:

- 1.6 months to first breast imaging,
- 2.7 months to first biopsy
- 6.6 months to incident early-stage breast cancer diagnosis
- 8.7 months to first chemotherapy

Irrespective of demographics! – Reverse Healthcare Equity
U.S. Health Care: Providers are tolerating arbitrary denials of care and adapting to prolonged delays for approvals

UnitedHealthcare posts $3.5B profit in Q1

-Becker’s Hospital Review

UnitedHealthcare 40% increase in denied claims in FY2019 for Trinity Health

(More than $50 million in operating margin impact!)
Rampant denial activity approaching 10% of claims with 60 – 70% overturned because of arbitrary denials of care . . .

*UnitedHealthcare*
posts $3.5B profit in Q1

*Becker’s Hospital Review*

*UnitedHealthcare*
40% increase in denied claims in FY2019 for Trinity Health

(More than $50 million in operating margin impact!)
Patients experiencing delays in care for insurer approval process:

Scheduling Cardiac Stress Test: “We leave one week for the insurer to give us an approval.”
We are spending 1/3 or more on administrative expenses – much to “manage cost and quality”

- Providers Systems – 16%
- Payers – 15% with margin
- Government – 2 - 4%
- Total Admin – 33 - 35%
We need to confront the part we play as providers

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... supporting excess capacity across the system –
- ?50% total “plant utilization” if you consider weekend occupancy
We are the only country on earth that created an opioid epidemic killing more people each year than the Vietnam War or the AIDS Crisis.

**National Overdose Deaths**
Number of Deaths Involving Opioids

- **Vietnam War Peak US Death Rate** – 15,000
- **AIDS Peak Death Rate** – 50,000

Source: National Center for Health Statistics, CDC Wonder
And, U.S. life expectancy is declining!

**US life expectancy declining again**

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Our teams operating all three pillars of our people-centered health system make a difference for people every day and are representative of great health care professionals across America.
Out Teams – and the people we serve – deserve a better system

• We need a national discussion about the state of our country’s health care system:
  - What are core principles for the health care system?
  - Is health care a right?
  - Should health care be equitable for all?
  - How should we finance health care?
  - How should we finance clinical education?
  - What are the right, respective roles for government and other payers vs. professionals and providers?
  - Who is accountable for the overall outcomes of the system?
  - Medicare for All/Public Option/All Payer Model/Market Solution
We need to “pull the cord” on our country’s health care system: This train needs to stop

- Commercial costs are unaffordable
- Denials are increasing
- Our death rate is climbing
- Our health is declining – life expectancy
- Clinicians are burning out
- People don’t have access, or are delaying care, or are bankrupted
- Insurance profits are soaring
- Provider sustainability is declining
Conclusion – the ability to make the system right is in our hands – healthcare professionals – it is our duty and it is a privilege. We should seize it, engage patients and lead the effort – not wait for others.
Thank You

Questions/Comments