45TH LTEN Annual Conference

Population Health and the Role of Pharma

LTEN 2016 Annual Conference

Wednesday, June 15 | 8:30 - 10:00 AM

Annapolis 4

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LIFE SCIENCES TRAINERS & EDUCATORS NETWORK

Introductions

Heather Katz
Bayer Healthcare

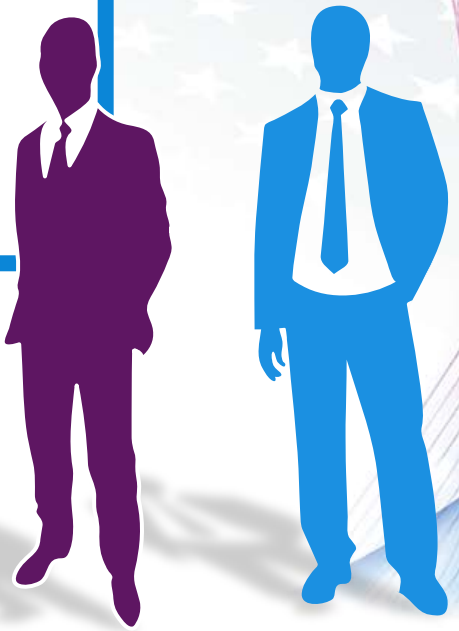
Jane DuBose
DRG Training

What Is Population Health?

What Is Population Health?

"The health outcomes of a group of individuals, including the distribution of such outcomes within the group."

-David Kindig, MD, PhD, and Greg Stoddart, PhD



Why Is Population Health Important?

How many know a person with…

- Asthma?
- Diabetes?
- Cardiovascular Disease?
- Cancer?

Why Is Population Health Important?

How many know a person with…

- Asthma?

  25 million people have asthma
- Diabetes?

  29.1 million people have diabetes
- Cardiovascular Disease?

  85.6 million people are living with some form of cardiovascular disease or the after-effects of stroke
- Cancer?

  14.5 million people with a history of cancer (as of January 1, 2014)

  1,685,210 new cases of cancer are expected to be diagnosed in 2016

What Do You Want to Get Out of This Session?

Objectives of This Session

- Define population health
- Discuss how population health management strategies are determined and implemented
- Connect population health management strategies to value and services pharma can provide
- Learn about how 1 company has implemented training on this type of content

AND

- Answer your questions about population health

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Feel free to interrupt with questions and comments

Population Health Management:

What Is it and How Does it Work?

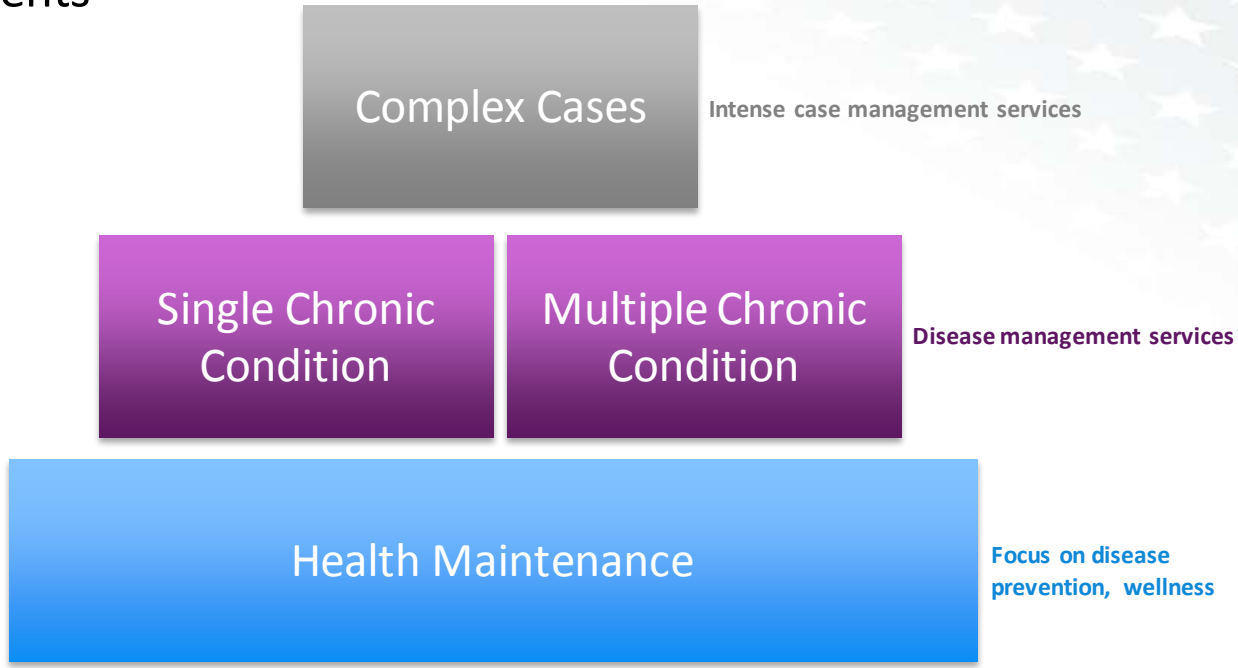
What Is Population Health Management?

Population health management is about organizing and managing healthcare delivery so the care is clinically effective, safe, and cost efficient.

- Applies to a defined group of individuals with similar healthcare needs (eg, diabetes, cancer)
- Proactively applies interventions
- Seeks to provide effective care at the lowest possible cost

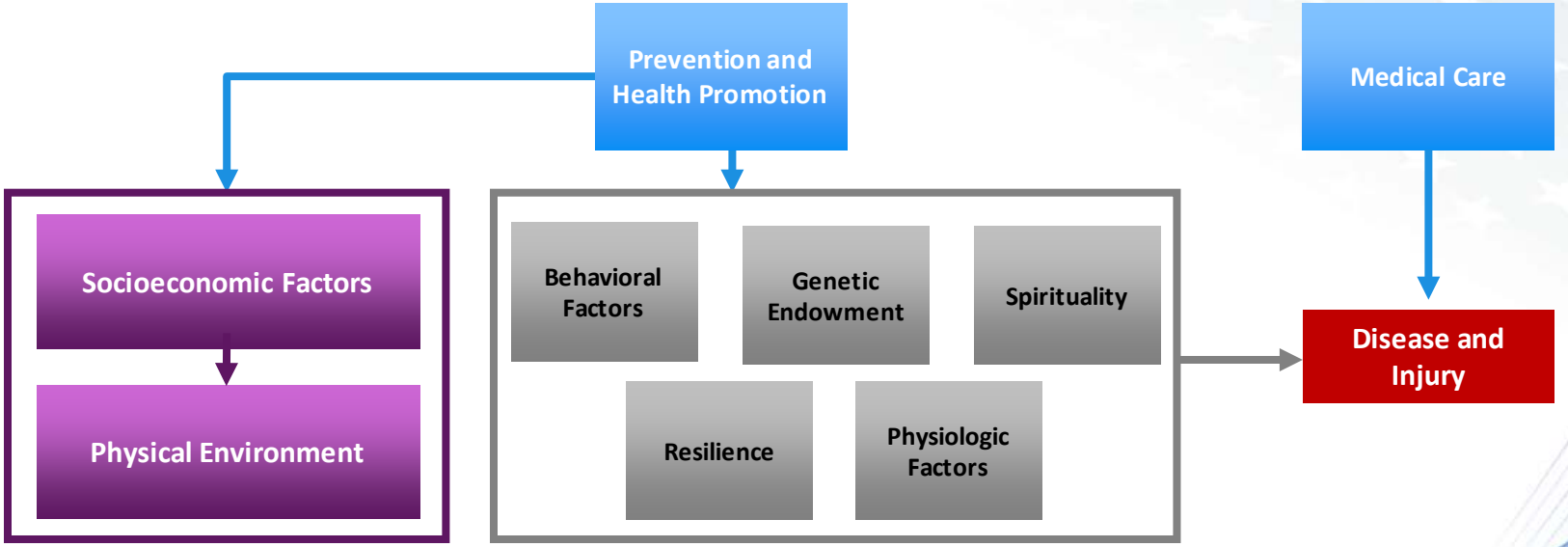
How Do You Implement Population Health Management Strategies?

Stratify Patients



Population Health Model Encompasses Aspects Outside Medical Care

Provide services appropriate for their healthcare needs



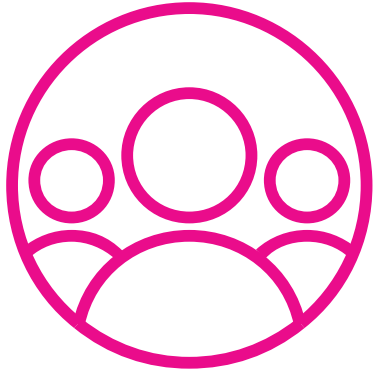
What do population health management systems do in prevention? Screenings, immunizations, health alerts, health fairs, web-based tools, and more.

What Are the Obstacles?

What Are the Obstacles?

A change in perspective for:

Physicians



Provider Systems

Patients

Population Health Is a New Way of Thinking

Physicians are incentivized differently—on the value and results of care; rather than the volume of services provided.

"[Population health] will reduce hospital admissions, but that is our long-term goal. It's especially counterintuitive to hospital executives. Once hospitals were revenue centers, and now they are cost centers."

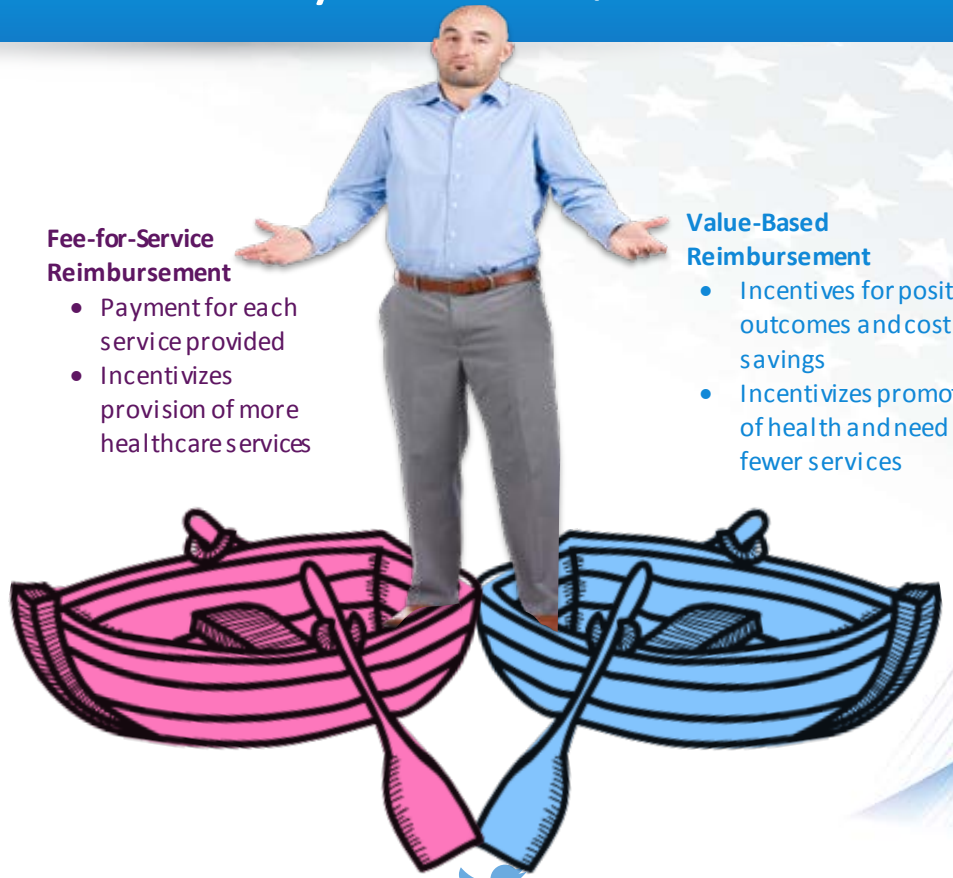
—Michael Rowan, President of Health System Delivery and COO of Catholic Health Initiatives

Patients need to take responsibility for their care; to participate in the process of managing their health.

A New Perspective for Physicians/Providers

"Success under multiple reimbursement models requires physicians to embrace a team mentality—any strategy launched by central administrators will fail unless the physician community embraces it."

-Athenahealth, Inc. White Paper



A New Perspective for Patients

Patients are expected to participate in their own care.

"A growing body of evidence demonstrates that patients who are more actively involved in their health care experience better health outcomes and incur lower costs."

—*Health Affairs* Health Policy Briefs | A RWJF Collection

More/New Care Providers Are Involved

Nurse Case Managers Are Primary Patient Contacts

Multi-Level Team Allows Coverage of Clinical, Non-Clinical Patient Needs

Primary Care Physician

- Exclusive clinical practice
- Time saved by team averages 15 to 20 minutes per day

Additional Care Management Program Team Members

- Social Worker
- Pharmacist
- Medical Director

Community Resources Specialist

- Non-clinical background
- Handles non-clinical patient issues that interfere with clinical outcomes

Nurse Case Manager

- Average 200 patients in panel
- RN 20+ years experience
- Primary contact for patient

Patient Social Assistance

- Transportation arrangement
- Appointment reminder
- Community health resources
- Caregiver assistance
- Socialization groups
- Friendly phone calls to isolated patients

Resources Coordinator

- Compiles repository of community resources
- Forges relationships with local organizations
- Fields direct patient requests

Non-Clinical Home Services

- Durable medical equipment ordering
- Medical device replacement
- Home care service
- Meals on Wheels

Buy-in From All Is Needed for Population Health Strategies to Work

Optum's 5 Population Health Principles

Physician engagement

- Information transparency

Provider incentives

- Population scale

Patient engagement

OPTUM®

What Do PCMHs and ACOs Have to Do With Population Health?

The Foundation: Patient-Centered Primary Care

Patient-centered medical homes are common vehicle for population health foundation

Benefit design tied to measurable behavior changes and outcomes

Expanded access through innovation

Aligning care management with the delivery system

Exchange of meaningful information

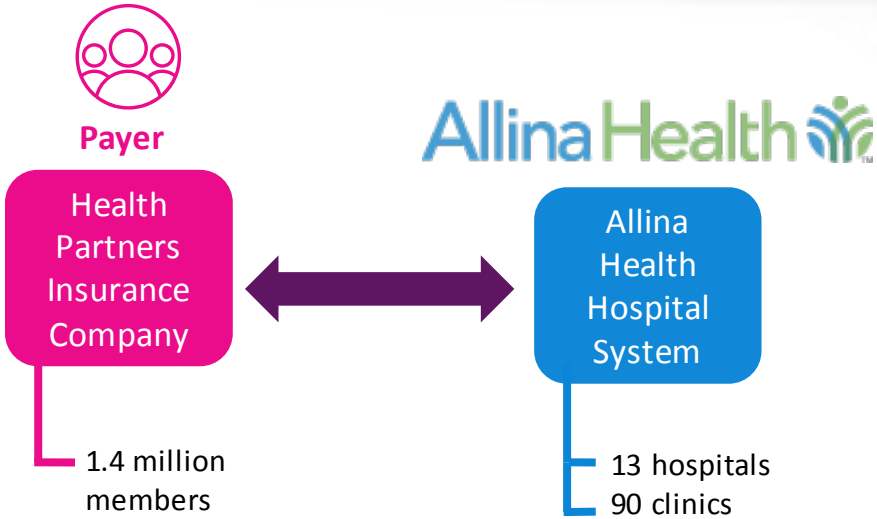
Four Foundational Pillars

Population Health and ACOs Go Hand in Hand

Accountable care organizations (ACOs) contracts now total more than 1,000, covering ~20M patients

- ACOs have all of the pieces of the population health model and quality metrics already in place
  - ACO success depends on its ability to meet quality targets
  - If quality targets are met, ACOs can share in savings from managing healthcare costs
- By managing costs and meeting quality measures, ACOs can improve the health of a population

Putting Population Health Management Into Practice: Northwest Metro Alliance



2015 Focus Areas

- Prevention and community health
- Care integration
- Care management and coordination
- Primary care access
- Specialty care partnerships
- Continuum of care and alternate venues
- Mental health continuum of care
- Pain management
- Continued engagement of physicians, staff, and leaders

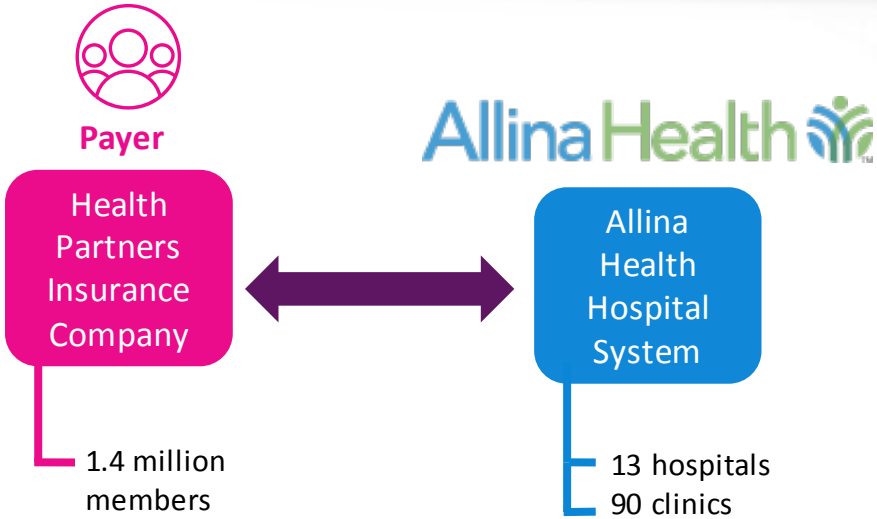
Have You Heard of the Hospital Readmissions Reductions Program?

Population Health Management Strategies to Reduce Readmissions

Focus on managing discharge

Skilled Nursing Facilities (SNFs)[1]	Complex Patients (Northwest Alliance)[2]	Leveraging Technology[3]
• American Health Care Association has goal to mobilize SNFs in reducing re-hospitalizations by 15% • Reconciling medication, treatment plans between acute and post-acute care	• Multidisciplinary transition conferences for complex patients • Standardized approach to communicate recommendations from discharging physician to PCP	• Geisinger uses remote monitoring from telehealth company AMC Health • Increases touches with patients in first 2 weeks after discharge

Remember Northwest Metro Alliance? Strategies Show Early Success!



Results

- Use of high-tech imaging at Mercy Hospital ED—went from 6% above market to 12% below
- Mental health admissions after ED visit down from 63% to 57% in 1 year
- Hospital readmissions declined by 17% actual to expected
- Adherence for medications treating asthma/COPD; diabetics (oral); and patients with high cholesterol improved by 14% after 1 year

Population Health Management:

How Is Pharma Involved?

Industry Enters Population Health Via Technology. . .

Johnson & Johnson and Sanofi are working with Watson Health's Discovery Advisory Team to teach Watson to read and understand scientific data that detail clinical trial outcomes

Watson Health (IBM) and **Teva Pharmaceuticals** are partnering to use big data for technology to create disease models and advanced therapeutic solutions

"Watson holds promise to provide Teva with better insights, real-time feedback and options for clinicians to consider to improve patient care."

Guy Hadari, SVP and CEIO for Teva

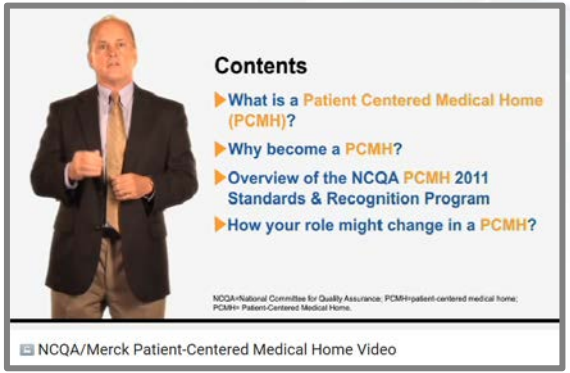
. . .and Other Initiatives

Merck + Geisinger
Partnership focuses on innovative ways to ensure shared decision making between patients/physicians for improved adherence to treatment plans

Merck + NCQA
Merck sponsors video explaining patient-centered medical homes

Boehringer Ingelheim + Humana

Partnership helps with early identification of COPD diagnosis



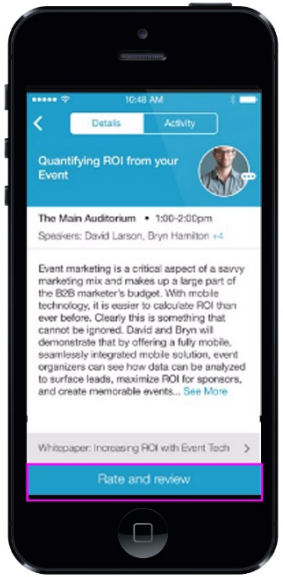
Other Examples?

Questions?

Your Feedback is Important to Us

Please take a moment to complete the workshop evaluation located in the mobile app. LTEN looks to your feedback to help improve the program each year.

1. Open the Mobile App
2. Click on the Agenda
3. Select the Session you are Evaluating
4. Select the Rate and Review Button



If you do not want to complete the survey in the mobile app, you can collect a hard copy form at the registration desk.

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