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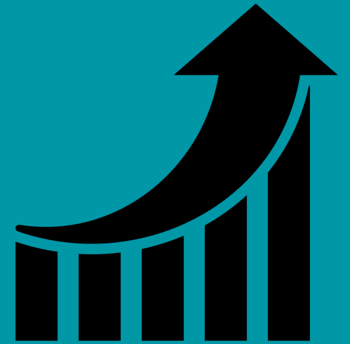
Chronic Disease is Healthcare's Rising-Risk



The move to value-based care is no longer a question of "if" or "when", its "now". As health systems prepare for impending change in their revenue, they must decide if they are going to lead, follow or resist the transformation at their own peril.

Leading health systems are already partnering with value-based payers and creating shared and full-risk contracts. New leadership teams, focused on Population Health Management (PHM) are essential to success under new alternative payment models that reward maintaining a healthy population.

As a competitive business necessity, health systems must continue the acquisition of value-based care payer contracts. Those contracts also include the acquisition of significant financial risk. PHM's task is to identify, track and manage the real drivers of costs across their populations and in doing so, manage the risk.

Felipe Lobelo, MD Ph.D.
Associate Professor of *Emory's Rollins School of Public Health*

Phil Trotter, B.S.
Exercise is Medicine ®
Community Care Collaboratives

Ashley John Heather, B.A.
Co-founder, Off The Scale ®

It's All About Revenue, Risk and Expense

According to the Centers for Disease Control and Prevention (CDC), chronic disease is responsible for 7 of 10 deaths each year, and treating people with chronic diseases accounts for 86% of our nation's total healthcare costs.[1] Even more astounding are the new statistics from the Agency for Healthcare Research and Quality (AHRQ) pointing out that the concentration of healthcare spending is being compressed as chronic diseases progress along the care cost continuum.[2] Health systems must react quickly to chronic disease progression as:

- The top 10% of the population accounted for 64.9% of total healthcare expenditures with an annual individual mean expenditure of $28,808;

Clinicians must integrate the delivery of targeted chronic disease intervention programs into population health care plans that slow, stop or even reverse the progression of their chronic diseases to lower health system financial risk. An example of the evidence in support of such interventions is the United States Preventive Services Task Force (USPSTF) recommendation in 2014 to offer or refer adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions that promote a healthful diet and physical activity for CVD prevention.[3] Rated as a "B" recommendation, this strategy must be included in new health plans under the Affordable Care Act's Prevention and Health Promotion activities.[4] The challenge for clinicians and health systems is how to operationalize and deliver these interventions in cost-effective fashion.

The Population Health Management (PHM) Care Model

Population Health Management (PHM) helps to describe the value-based care evolution that is currently underway. PHM has become a key concept for health systems who are trying to recalibrate their traditional operations to meet the growing challenges of value-based care payment models and accountable care.[5]

Population data and risk scoring provides the ability to define population groups into clearly labeled buckets – (well; low-risk; rising-risk; high-risk) – is a foundational step for developing the standardized, comprehensive care to personalized care and health behavior change framework necessary to address the increasing risks of these chronic disease groups. Connecting chronic disease population groups with community-based chronic care services extends accessibility to health behavior interventions to reduce the rise of risks.

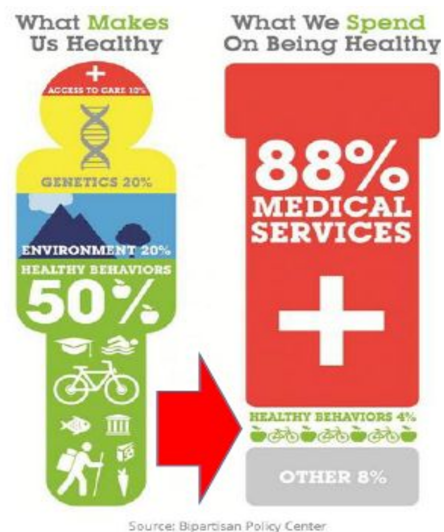
With high-risk/acute patients costing 2-5x more than other population groups, the ability to offer cost effective care management solutions is key. However, even with the best care management practices, the constant influx of rising-risk population groups migrating into the high-risk bucket will potentially offset efforts to maintain or lower costs.

The Care Gap

The rising-risk chronic disease population group typically represent 20-30% of a defined population, and due to their numbers, can actually account for a higher total healthcare spend than the high-risk group. The rising-risk group is not yet sick enough for expensive clinical care, and they are past the point where wellness solutions are effective. This is the care gap.

In addition, about 18% of rising-risk population group can become high-risk each year.[6] PHM can now target the risk factors and behaviors that are the root causes of multiple chronic diseases, rather than to just recognize the diagnosed chronic diseases. This enables healthcare managers to coordinate the rising-risk populations to intervention care that will combat the chronic disease progression.

Chronic diseases appear gradually. If unchecked, the illness eventually becomes a life threat. This is a fundamentally different model of illness than that of acute illness, and healthcare has not totally grasped that difference. A chronic disease is not like a raging house fire. It's like a smoldering fire in a pile of leaves that slowly reaches the point of flame.



Source: Bipartisan Policy Center

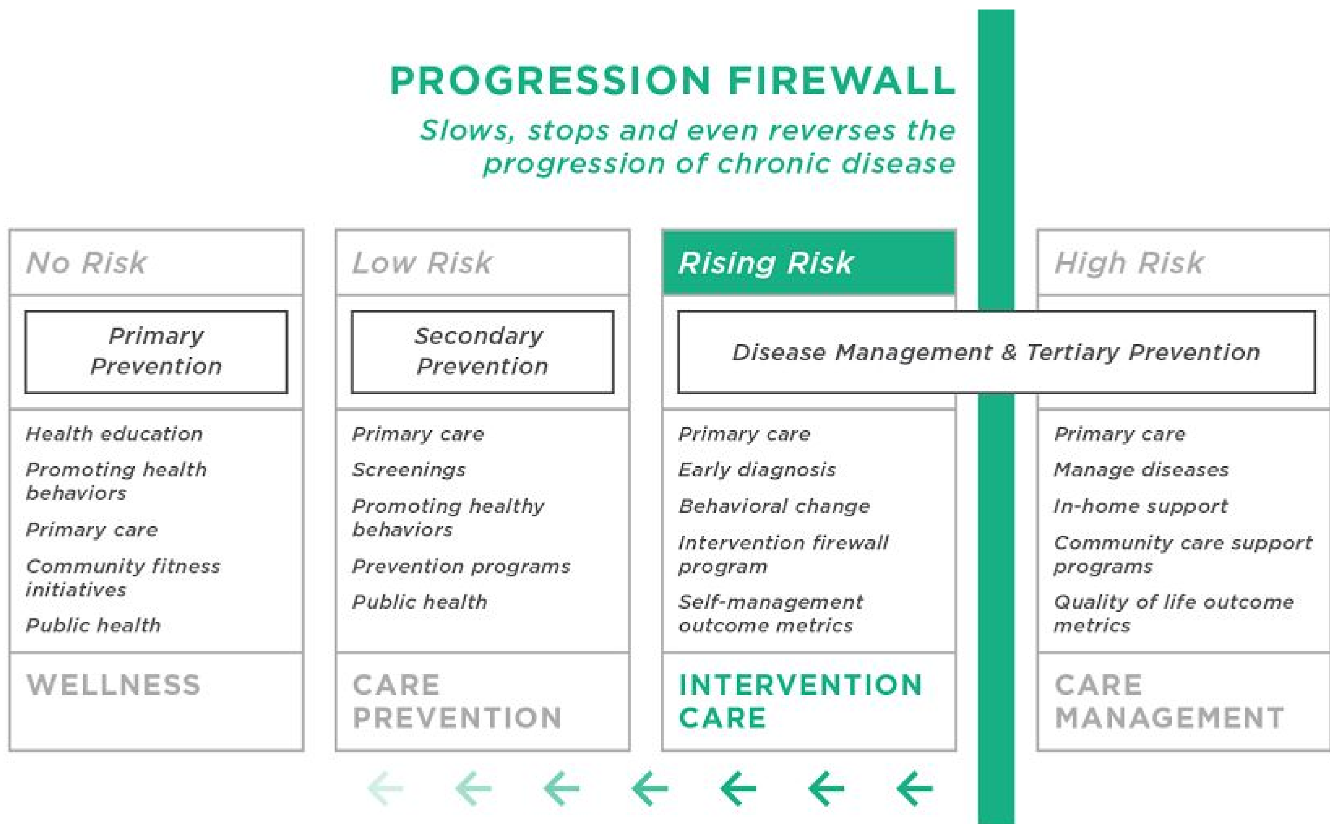
Healthcare has designated a staggering amount of resources around the life ending fire, and ignored 90% of the smoldering chronic disease progression that is steadily increasing population risk of health and cost.

Today, almost 88% of U.S. healthcare dollars are spent on medical care – access to physicians, hospitals, procedures, drugs, etc. However, medical care only accounts for approximately 10% of a person's health.[7] The other determinants of a person's health – their lifestyle and behavior choices, genetics, human biology, social determinants, and environmental determinants – account for approximately 90% of their health outcomes. Healthcare resources and dollars must now be dedicated to improving lifestyle and behavior. PHM helps to achieve the overall goal of identifying the rising tide of populations with multiple chronic diseases that need intervention care.

In addition, reports have shown that approximately half the decline in U.S. deaths from coronary heart disease from 1980 through 2000 may be attributable to reductions in major risk factors (systolic blood pressure, smoking, physical inactivity).[8] However, more recent data shows evidence of stagnation that may be explained by the increases in obesity and diabetes prevalence. Healthcare resources and dollars must now be dedicated to improving lifestyle and behavior. The overall goal of population health management (PHM) centers around combating chronic disease with progression intervention programs, delivered via robust and standardized clinical-community linkages.[9]

Health System Chronic Disease Progression Firewall

Health systems must be able to stop the rising-risk flow along the care continuum towards and into the high-risk groups. Care costs escalate exponentially while moving along the continuum after chronic disease diagnosis. Given the dramatic rise in financial risk, a new standard of care needs to be created, that will act as a "firewall" between the rising-risk and high-risk. This "firewall" or "intervention" needs to address population groups with one or more chronic conditions, and work to slow, stop and even reverse the progression of those diseases.



Health Systems Cannot Delay

As a matter of health system survival, the move to value-based care contracts acquisitions cannot wait. Most chronic diseases are not curable, but can be managed. Changing health behaviors can slow, stop or even reverse the progression of a chronic disease, particularly from the point where symptoms emerge until a life threat develops. Rather than curing chronic illness, health systems are learning to manage its progression. Systems need to adopt chronic care intervention to fill this gap in care. As patients are diagnosed and populations stratified, clinical care teams will transition chronic disease groups to community care teams for intervention program participation in more accessible, lower cost settings. This is the "firewall" program and new standard of care that health systems must have to reduce the migration of the rising-risk into the high cost category.

Phil Trotter, *B.S., leads the Exercise is Medicine® (EIM) on-the-ground team to integrate physical activity as a standard component of intervention, prevention and care management programs that support the implementation of Community Care Collaboratives and the necessary resources for community-based delivery of healthcare to payer, patient and underserved populations. Phil is a Community Care thought leader and Collaborative subject matter expert consulting with health system leadership and population health management executives and their teams.*

Felipe Lobelo*, MD Ph.D., is an associate professor of Global Health at Emory's Rollins School of Public Health and directs the EIM Global Research and Collaboration Center (EIM-GRCC). The EIM-GRCC is the academic hub in charge of leading the evaluation of the EIM initiative, in collaboration with partnering health care systems, community organizations, and fitness and technology companies.*

Ashley John Heather*, B.A., co-founder of Off The Scale ® a turnkey, chronic disease intervention platform.*

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