Importancia del Segmento de Salud en la Economía de Puerto Rico

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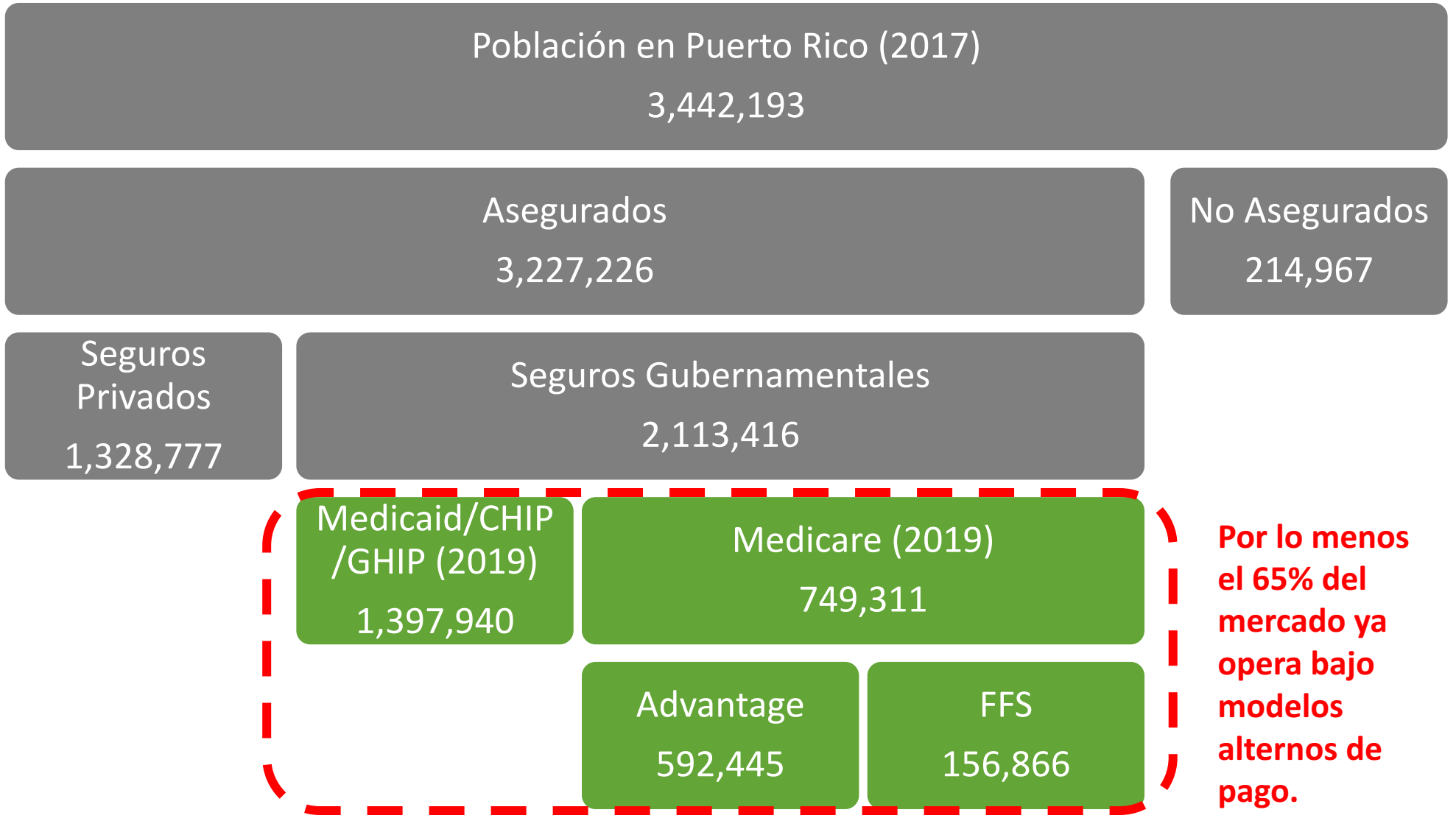
IMPACTIVO
DATA-DESIGN-INSPIRATION

Where are we, and where are we going?

Seguros de Salud y métodos de pago en Puerto Rico

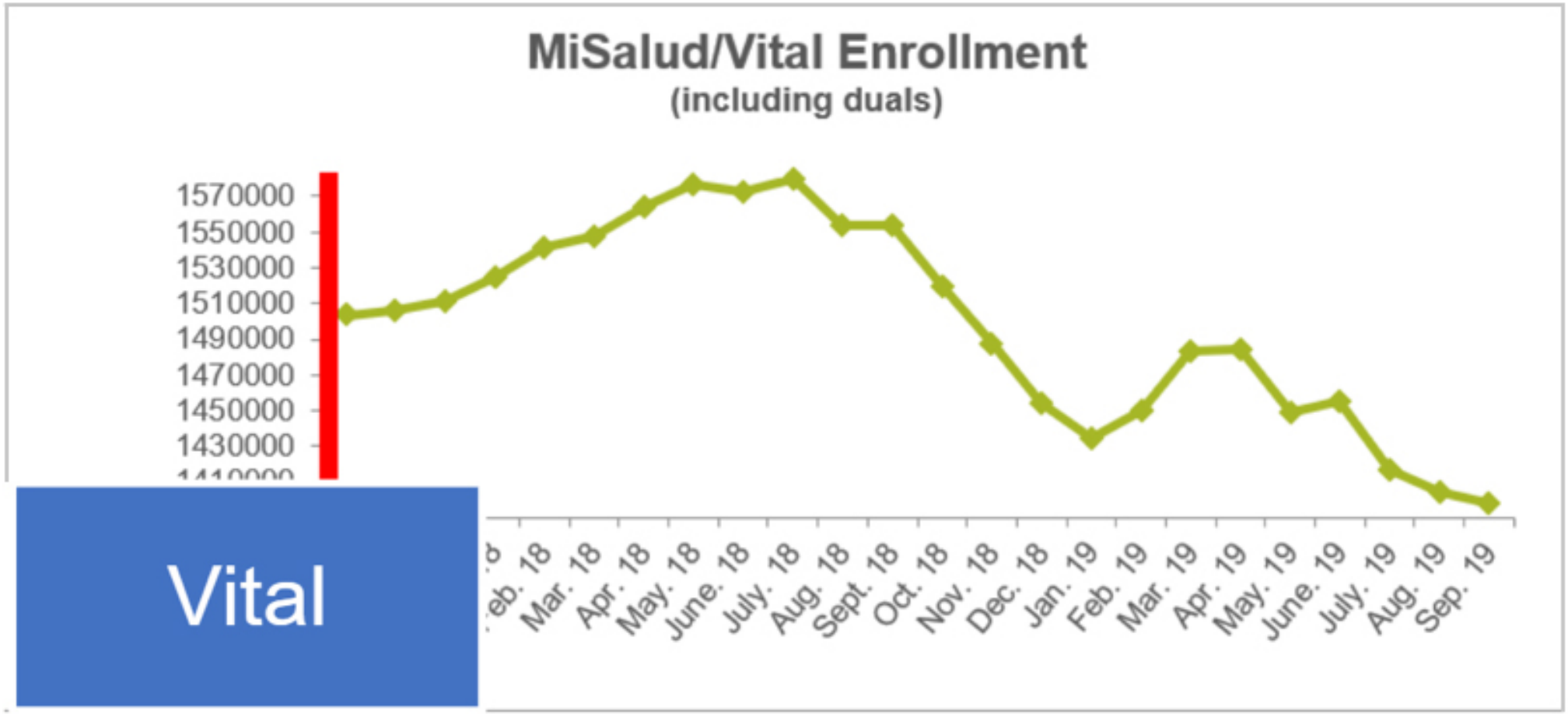
Medicaid y Medicare ambos se han movido a modelos alternos de pago basados en valor para el sistema y el paciente.

- **Medicare**
  - MACRA/MIPS
  - MA Star Clasificación/ Ajuste de riesgo
- **Medicaid**
  - Metodo de pago para enfermedades crónicas y discapacidades



Por lo menos el 65% del mercado ya opera bajo modelos alternos de pago.

US Census 2017, Medicaid Enrollment September 2019, Medicare Enrollment August 2018


MiSalud/Vital Enrollment
(including duals)
1570000
1550000
1530000
1510000
1490000
1470000
1450000
1430000
Vital
eb. 18
Mar. 18
Apr. 18
May. 18
June. 18
July. 18
Aug. 18
Sept. 18
Oct. 18
Nov. 18
Dec. 18
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Feb. 19
Mar. 19
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July. 19
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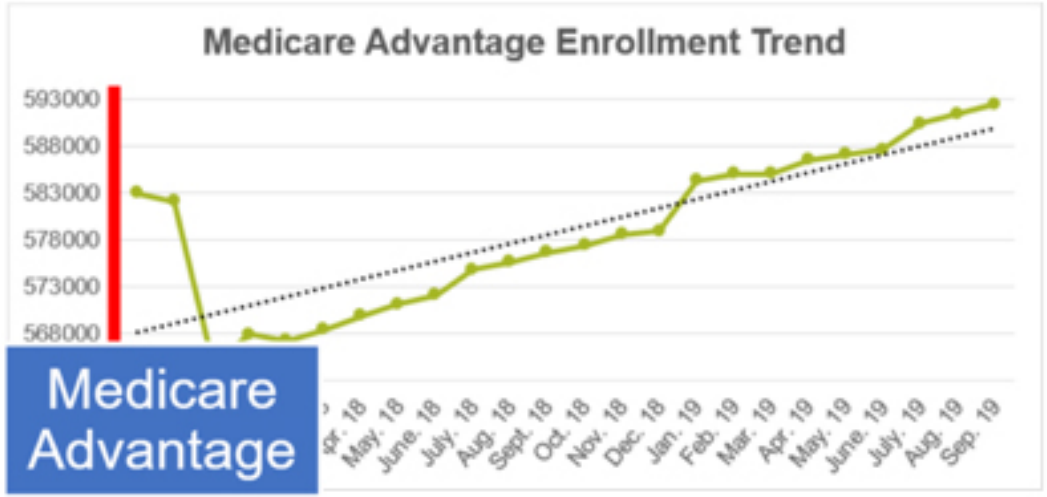
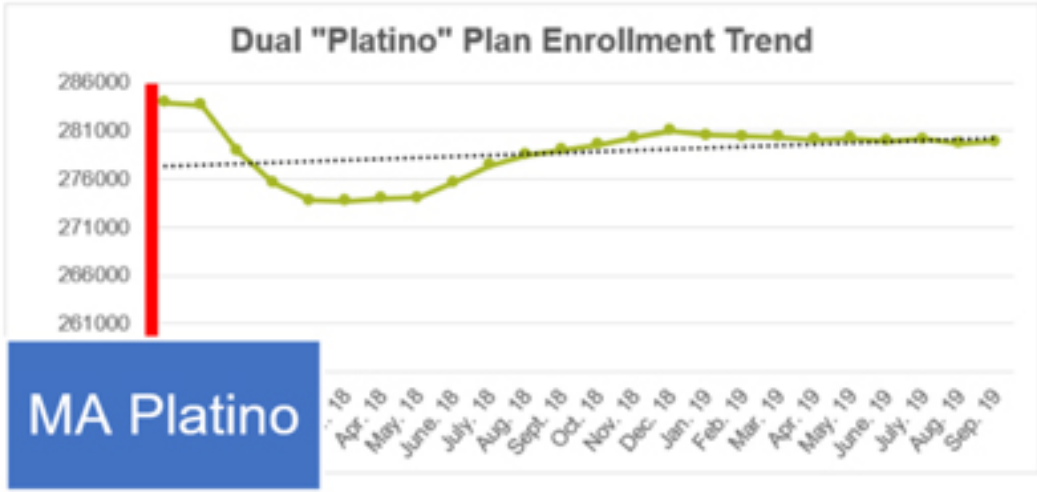
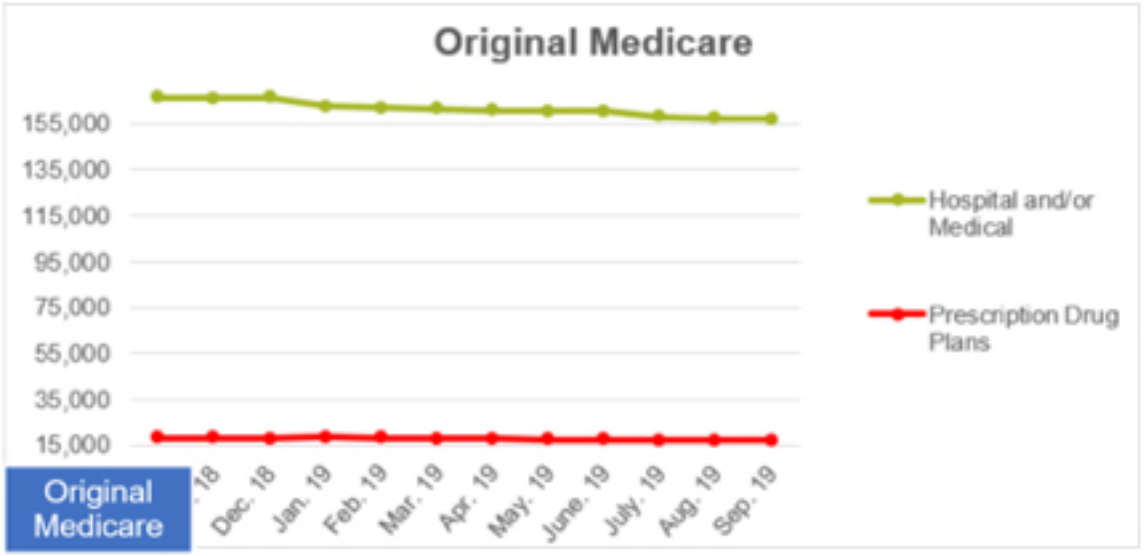
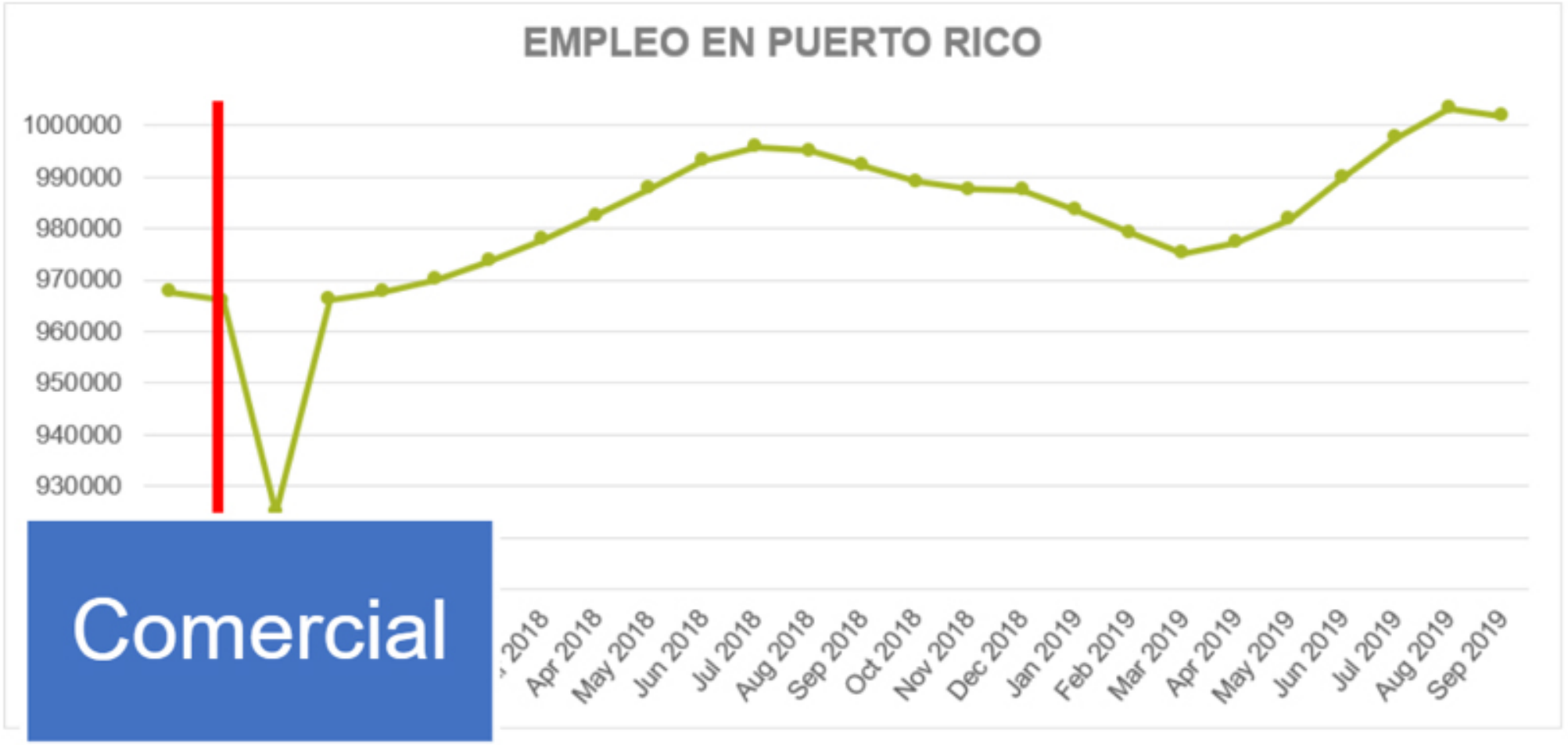
Sep. 19


Medicare Advantage Enrollment Trend
593000
588000
583000
578000
573000
568000
Medicare Advantage


Dual "Platino" Plan Enrollment Trend
286000
281000
276000
271000
266000
261000
MA Platino


Original Medicare
155,000
135,000
115,000
95,000
75,000
55,000
35,000
15,000
Hospital and/or Medical
Prescription Drug Plans
Original Medicare


EMPLEO EN PUERTO RICO
1000000
990000
980000
970000
960000
950000
940000
930000
Comercial
Apr 2018
May 2018
Jun 2018
Jul 2018
Aug 2018
Sep 2018
Oct 2018
Nov 2018
Dec 2018
Jan 2019
Feb 2019
Mar 2019
Apr 2019
May 2019
Jun 2019
Jul 2019
Aug 2019
Sep 2019

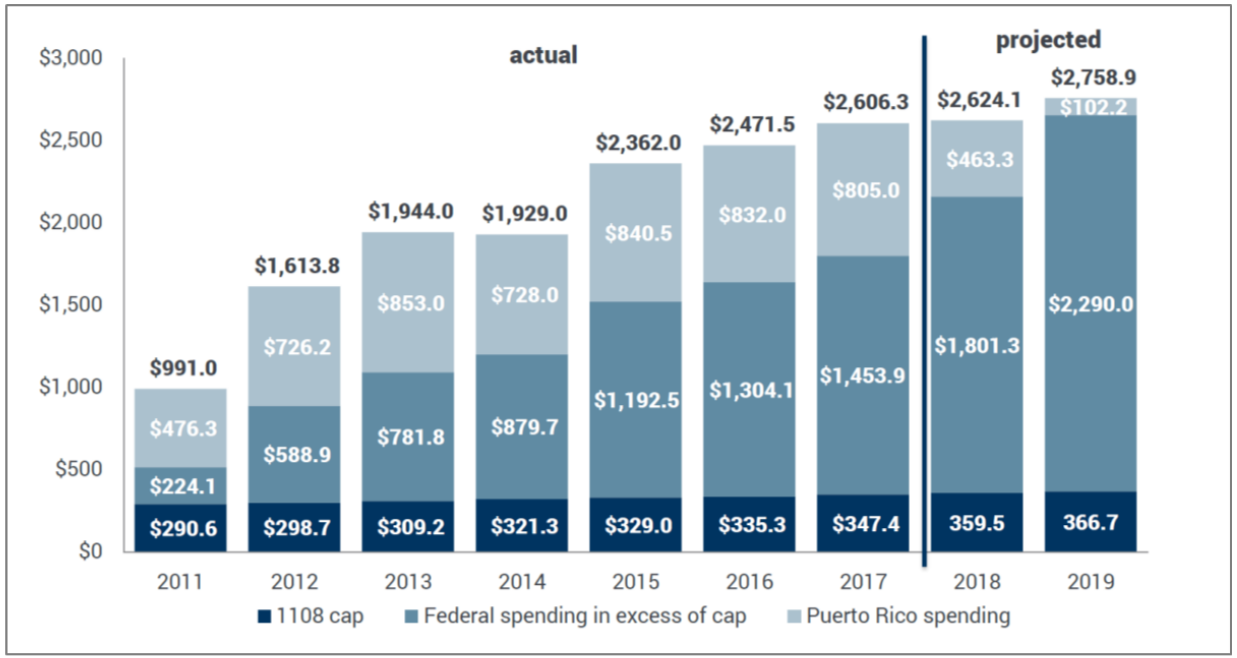
Healthcare indicators: PR vs. US

	Puerto Rico	50 States & DC
Adults reporting poor health status	34%	18%
Adults with diabetes	13.7%	9.5%
Child Mortality (per 100,000)	7.1	5.9
HIV Diagnosis (per 100,000)	17.8	14.7

Source: Presented by Resident Commissioner Hon. Jennifer Gonzalez during the PR Hospital Association Conv. on November 1th, 2019.

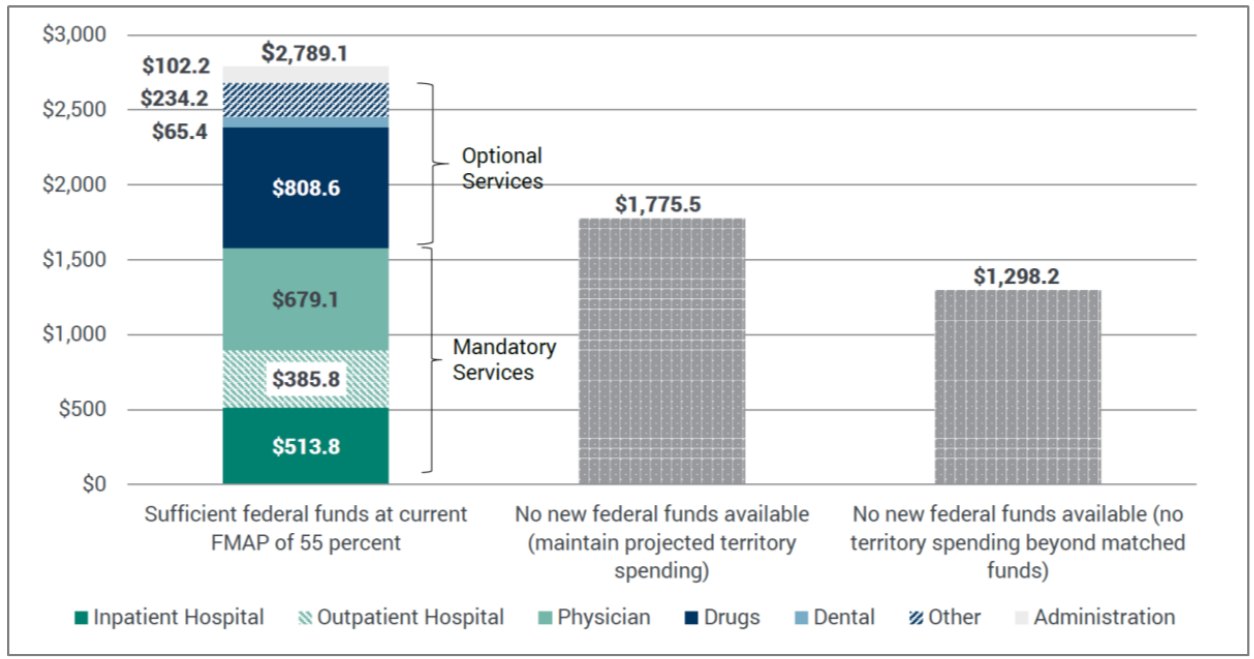
We need to support efforts in Washington DC to increase health funding for Puerto Rico

Medicaid/Chip Spending in Puerto Rico



MACPAC 2018 analysis of CMS-64 financial management report net expenditure data and CMS-37 budget projections; CMS 2016, 2017, 2018.

Financing Scenarios for Medicaid Puerto Rico - FY 2020



MACPAC, March 7, 2019. Medicaid in Puerto Rico: Financing and Spending Data Analysis and Projections, ASES and Milliman 2019.

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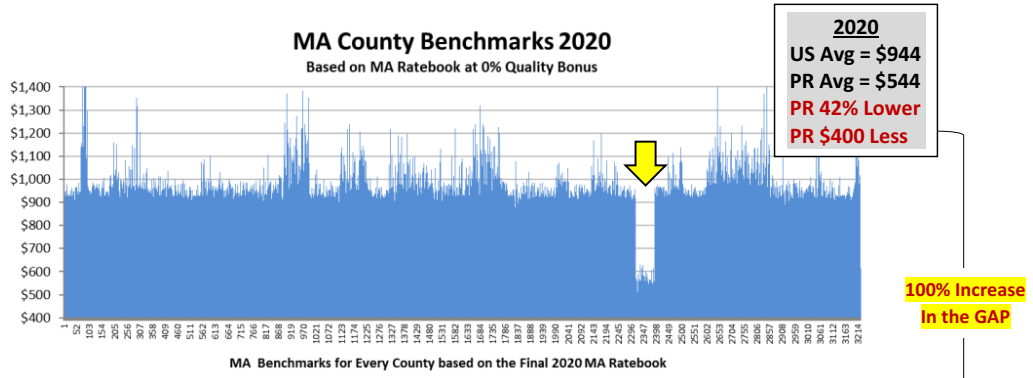
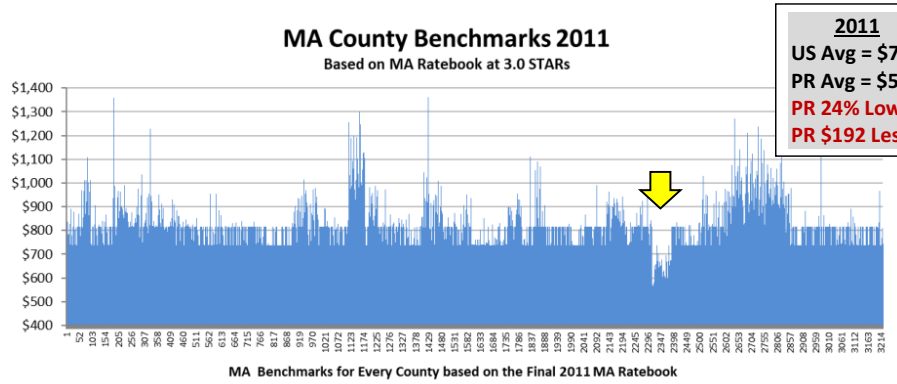
MA Funding Disparity in PR – 2020 v. 2011



2020
US Avg = $944
PR Avg = $544
PR 42% Lower
PR $400 Less

100% Increase
In the GAP



2011
US Avg = $787
PR Avg = $595
PR 24% Lower
PR $192 Less

FIDE · LLC

The economics of a better health system

We know what works...

1. Investing in high quality primary care
2. Enabling patient-centricity and team-based care
3. Empowering patients through health literacy
4. Connecting with communities to address social determinants
5. Addressing mental health
6. Connecting providers and integrating health systems
7. Enabling value-based health care instead of fee for service payment
8. Unleashing technology and reducing bureaucracy

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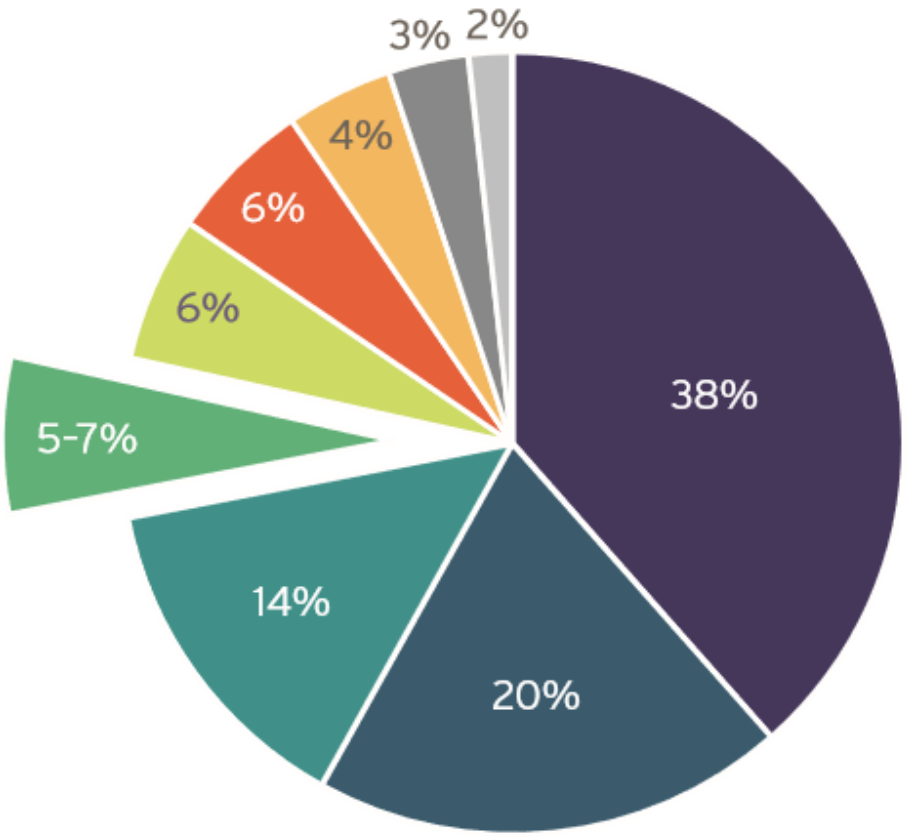
Current investment levels in primary care are not enough!

Patient-Centered Primary Care COLLABORATIVE

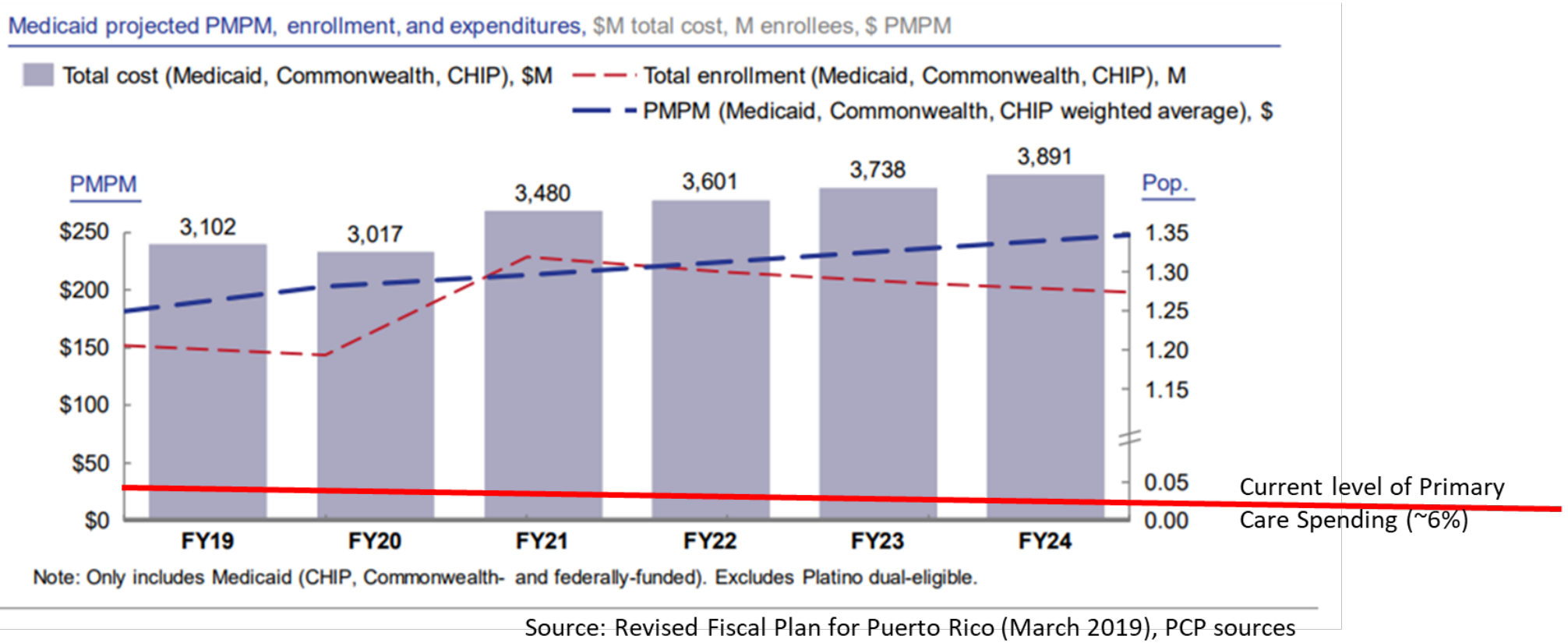
Health Care Spending

- Hospital care
- All other physician and professional services
- Prescription drugs and other medical nondurables
- Primary care
- Nursing home care
- Other health, residential, and personal care
- Dental services
- Home health care
- Medical durables



Vital spending in primary care (not including platino)

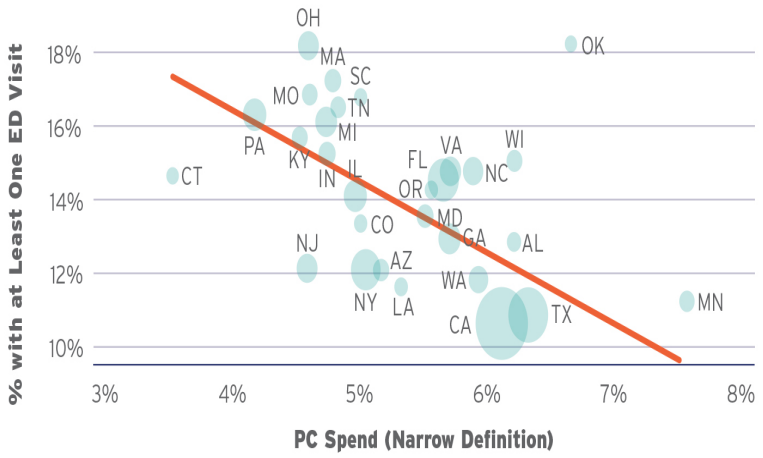
PCP SPENDING IN PR
~$12pmpm x 1.4M enrollees
~$202M PCP Spending (~7%)



Source: Revised Fiscal Plan for Puerto Rico (March 2019), PCP sources

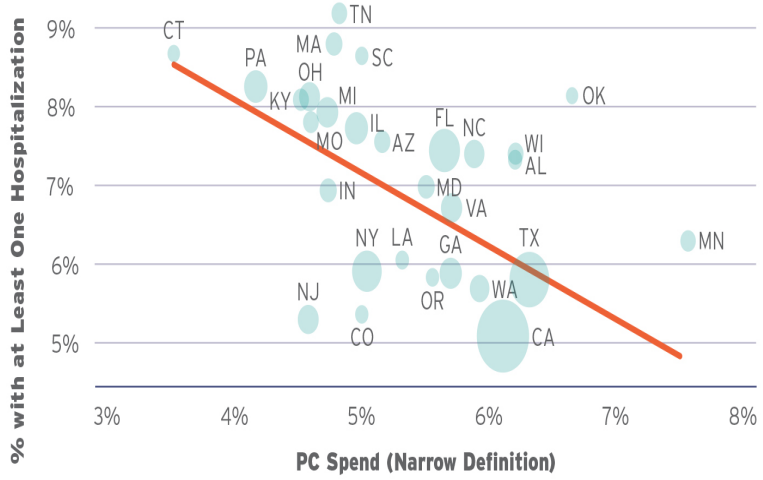
Patient-Centered Primary Care COLLABORATIVE

PC Spend-Narrow vs. Percent with at Least One ED Visit in Last 12 Months



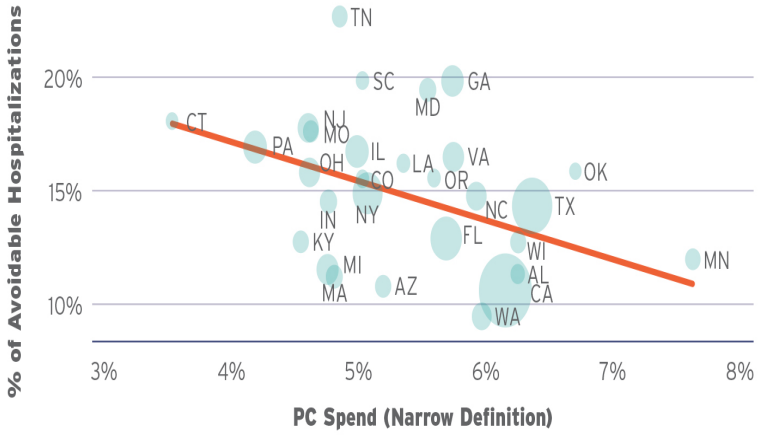
R = -0.58. Note: Size of circles represents the population size of the state.

PC Spend-Narrow Vs. Percent with at Least One Hospitalization in Last 12 months



R = -0.58. Note: Size of circles represents the population size of the state.

PC Spend-Narrow Vs. Percent Avoidable Hospitalization



R = -0.44. Note: Size of circles represents the population size of the state.

Rhode Island: a case study

Patient-Centered Primary Care COLLABORATIVE

In 2010

- Legislators set a primary care benchmark to transition to **patient centered medical home** (PCMH) and **value-based models**.
- It required insurers to increase primary care spending by **1% point per year.**

Significant results

- 70% of practices transitioned to PCMH
- Primary care investments grew from **$47 million** to **$74 million**
- **Net decline of $88 million** over four years
- Rhode Island was the only state in New England to see an **increased supply of physicians, including specialists.**

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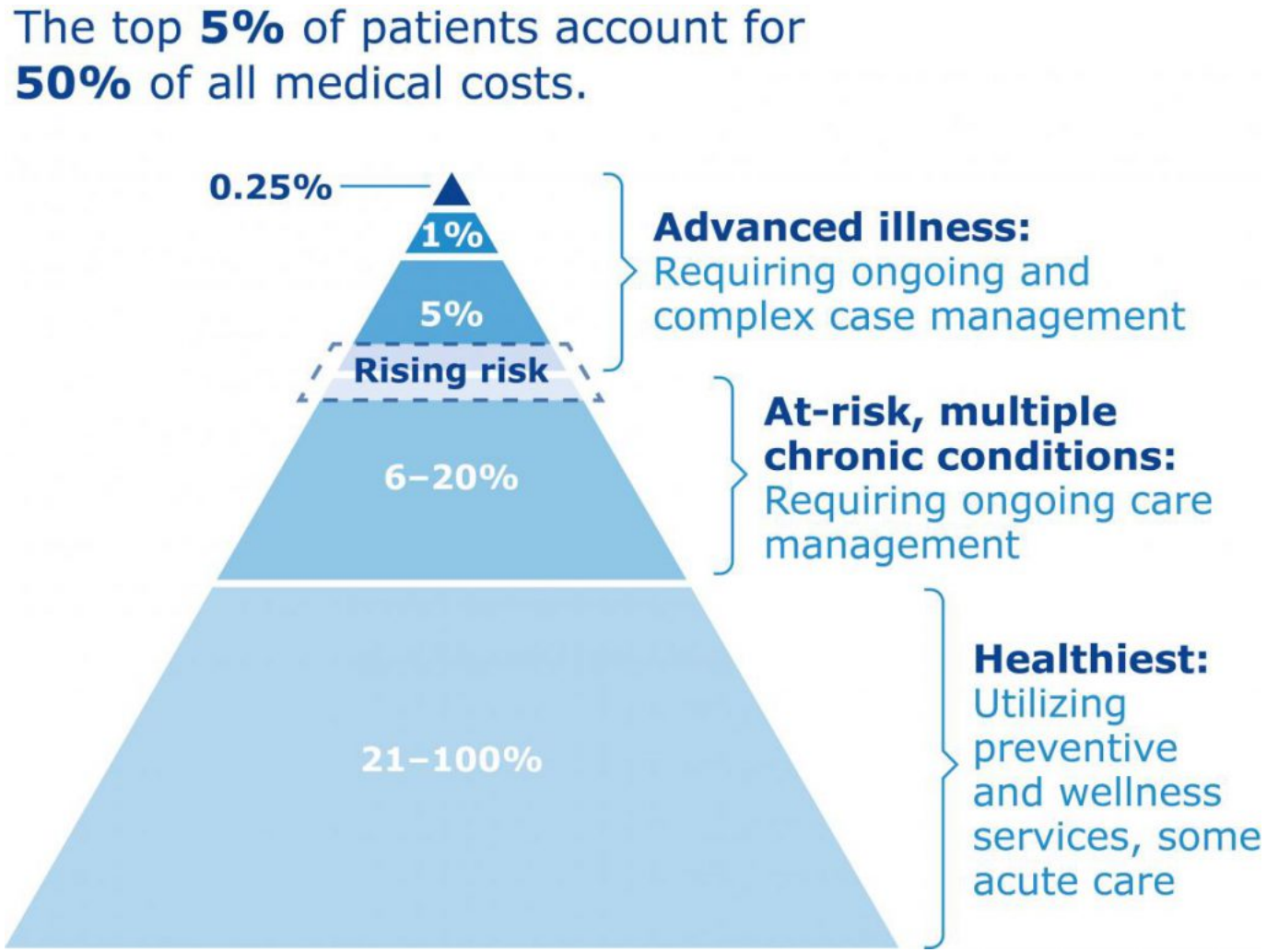
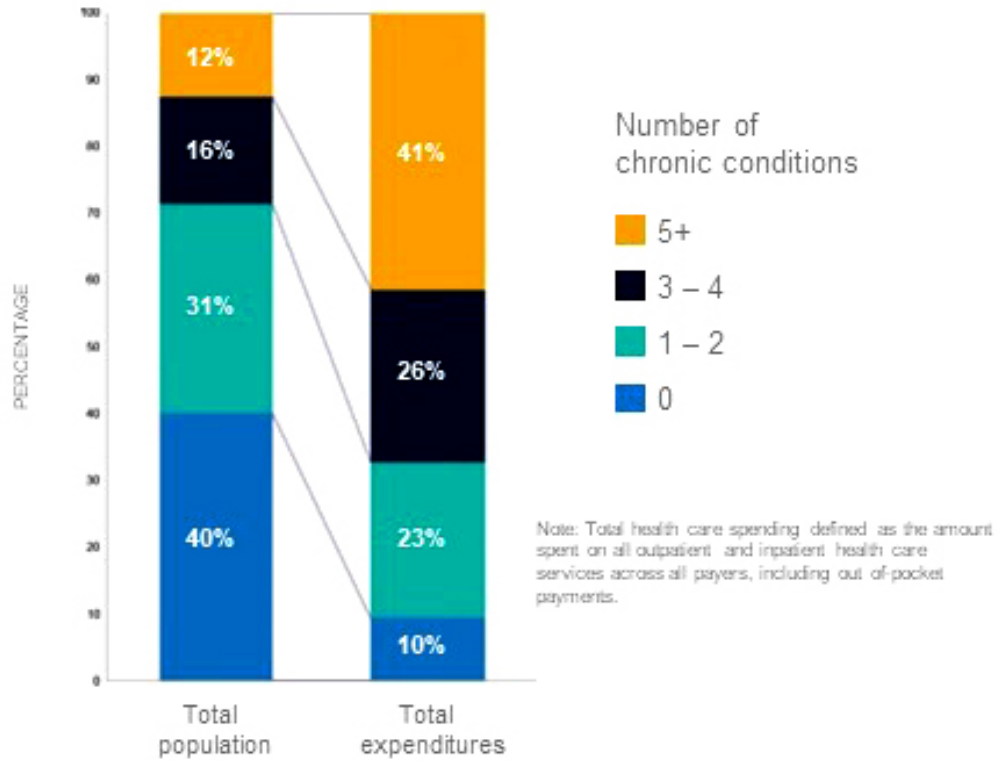
The high cost of treatment for chronic diseases



Treating chronic conditions consumes 90 cents of every dollar spent on healthcare

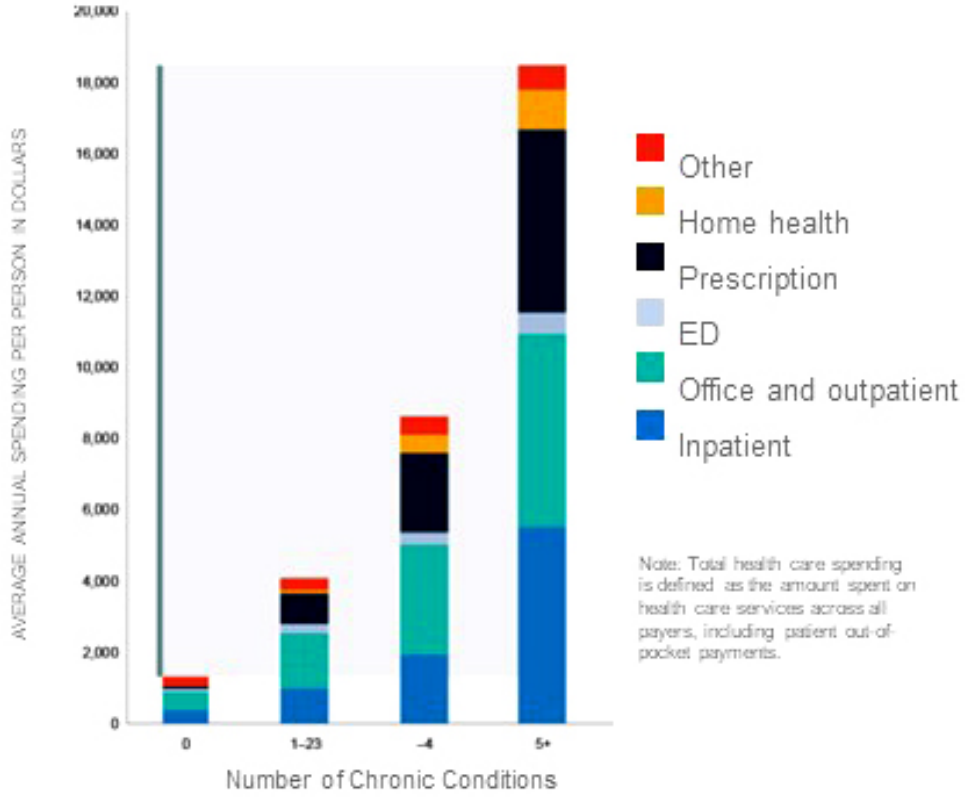
Prevalence and Spending by Number of Chronic Conditions (2014)



Note: Total health care spending defined as the amount spent on all outpatient and inpatient health care services across all payers, including out-of-pocket payments.

Source: RAND Corporation

Health Care Spending by Number of Chronic Conditions (2014)



Note: Total health care spending is defined as the amount spent on health care services across all payers, including patient out-of-pocket payments.

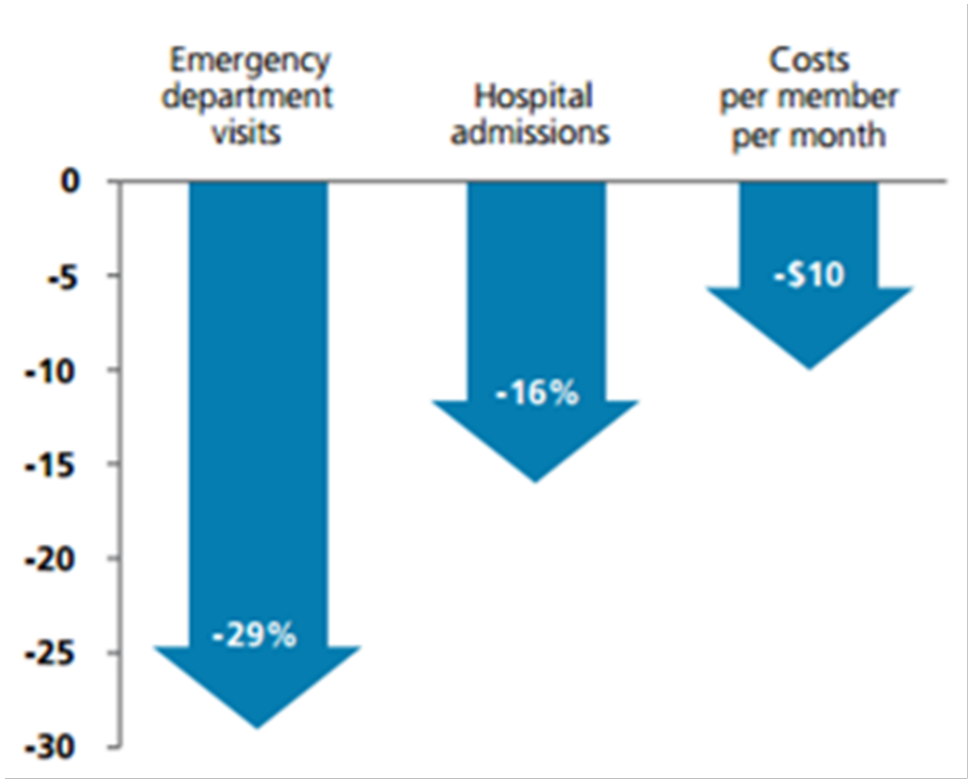
Team-based care models

- Decreases in morbidity, mortality, utilization and cost
- Increase self-management, empowerment, healthy behaviors, patient satisfaction and quality of life
- Address socio-economic challenges faced by low income patients
- Increase job satisfaction for physicians and their teams

The patient-centered medical home is a model of care that puts patients at the forefront of care. PCMHs build better relationships between people and their clinical care teams.

Research shows that PCMHs:

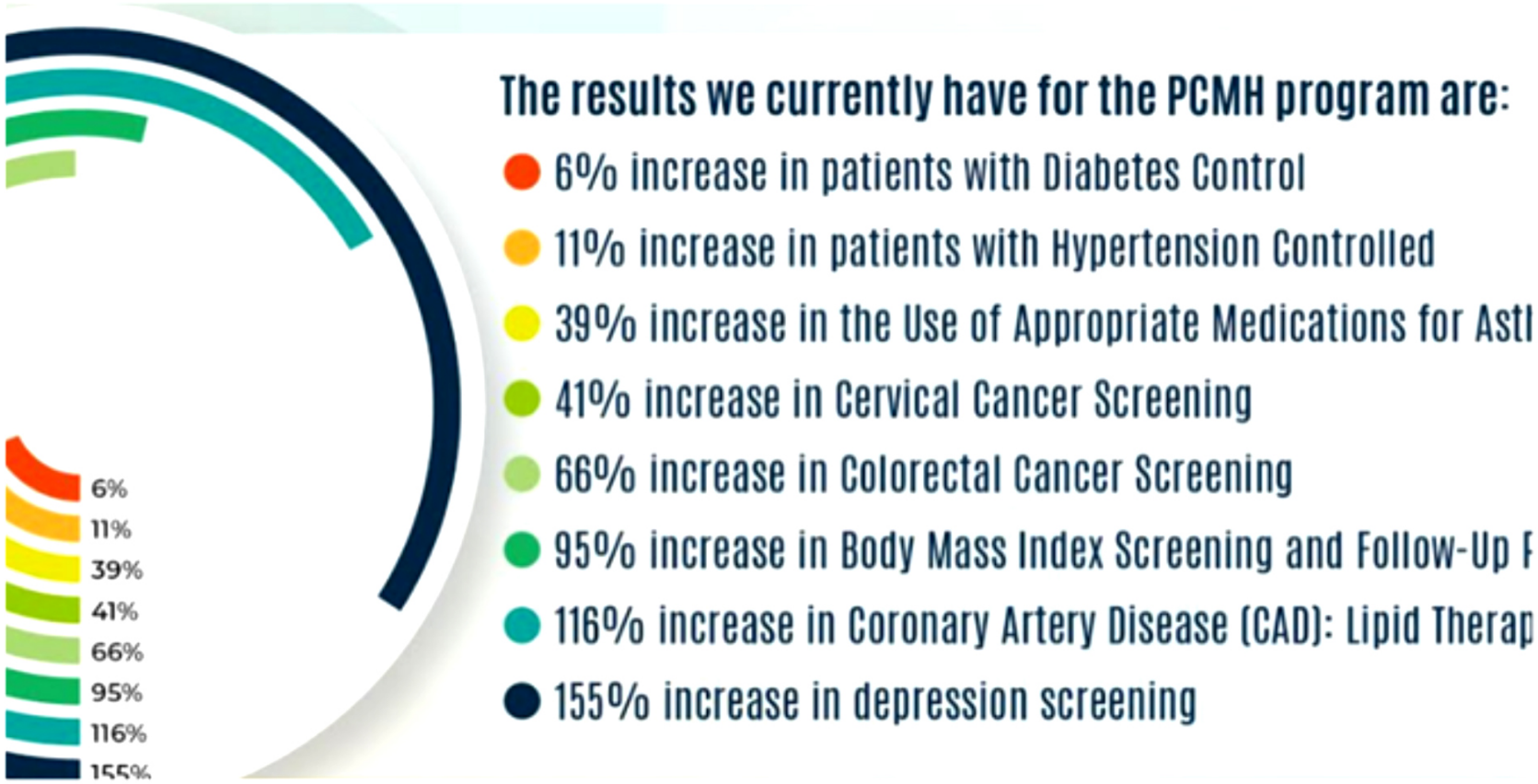
- **Improve quality.** Patients get the treatment they need, when they need it.
- **Reduce costs.** They prevent expensive and avoidable hospitalizations, emergency room visits and complications—especially for patients with complex chronic conditions.
- **Improve the patient experience.** They provide the personalized, comprehensive coordinated care that patients want.
- **Improve staff satisfaction.** Their systems and structures help staff work more efficiently.



Source: Robert Reid, Katie Coleman, Eric A. Johnson, Paul A. Fishman, Clarissa Hsu, Michael P. Soman, Claire E. Trescott, Michael Erikson, and Eric B. Larson, "The group health medical home at year two: cost savings, higher patient satisfaction, and less burnout for providers," *Health Affairs*, 2010, 29(5): 835-843.

PATIENT-CENTERED MEDICAL HOME NCQA RECOGNIZED PRACTICE

Results of IMPACTIVO's transformations to PCMH showed improvement in ALL quality metrics



Blue Cross Blue Shield of Tennessee - PCMH Journey

2009

- Started with 2 pilot practices
- Commitment to 5 years of investment
  - PCMH CCE support
  - Support for transformation
  - Technology
  - PCMH/Physician advisory council

Today

- 37 practices, 346 locations, 2151 providers, 323K members.
- PCMH practices show an average 2.4 average ROI
- Significant improvement in 10/15 HEDIS Measures
- 6.1% reduction in hospital admissions
- For chronic population showed savings of approximately $8.46 PMPM

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The CDC estimates that…

Eliminating 3 risk factors:

- Poor diet
- Inactivity
- Smoking

Would prevent:

- 80% of heart disease and stroke
- 80% of type 2 diabetes
- 40% of cancer

Practice Benefits of This Level of Engagement

Health care costs are up to **21 percent** higher among patients who lack knowledge/ability to manage their own care compared with highly engaged patients.

Research links the level of activation with health care costs

For patient engagement in care of the individual, there is good evidence that specific interventions can improve patient knowledge, self-efficacy, and some outcomes, and reductions in utilization or costs of care have been reported in some studies

Robert Wood Johnson Foundation Quality Field Notes Issue Brief "What We're Learning: Engaging Patients Improves Health and Health Care, No. 3, March 2014
http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf411217
Activation Source: Judith Hibbard, University of Oregon

Action:

We need **collaboration** between general doctors, nurses, pharmacists, allied health professionals and community health workers to improve patient literacy

(i.e. Interprofessional collaborations provide the best care possible).

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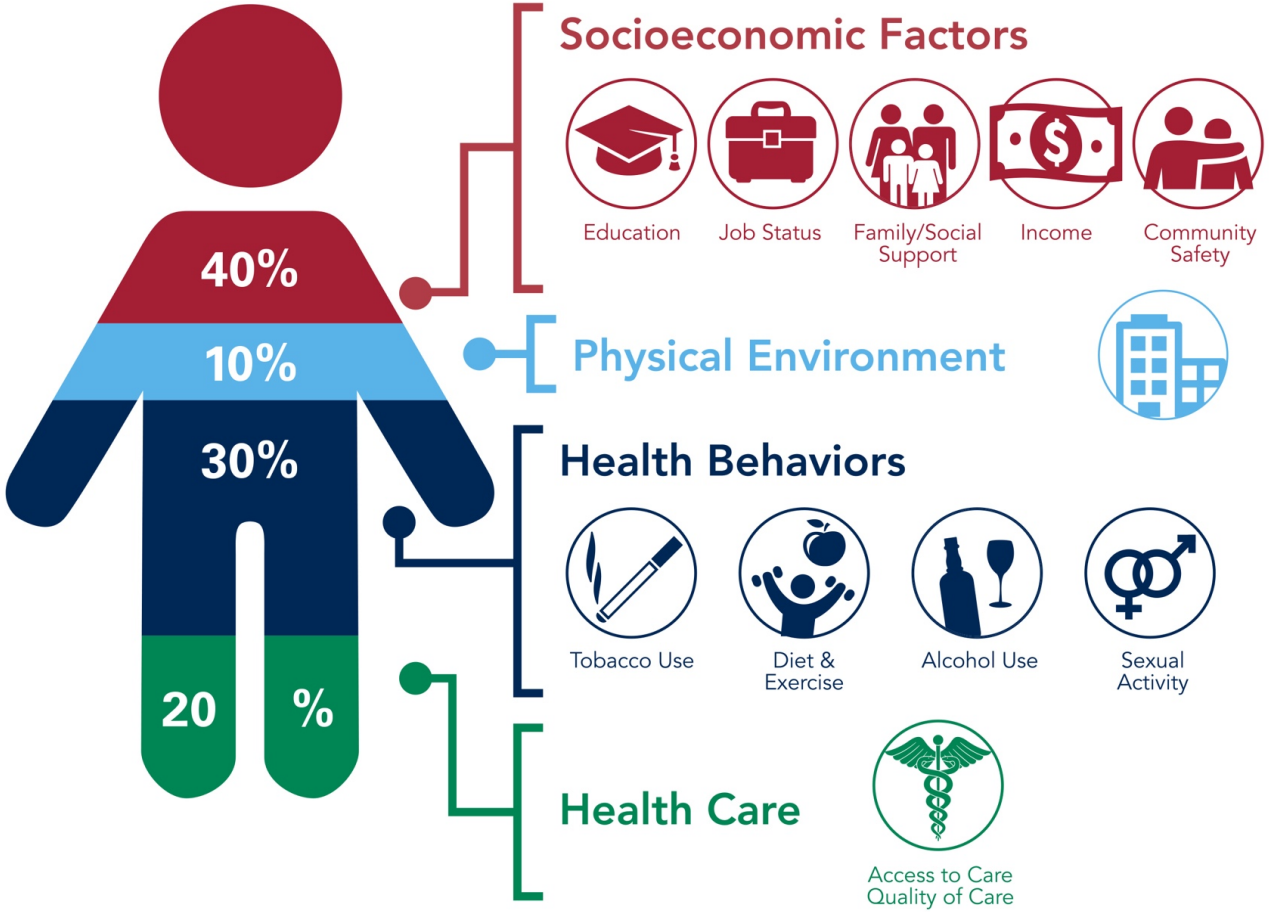
Is the problem in the definition?

- Healthcare is the **maintenance or improvement of health** via the prevention, diagnosis and treatment of
  - Illness
  - Injury
  - Disease
  - And other physical or mental impairments
- However, health is also largely influenced by **economic** and **social factors that need to be incorporated into the definition.**

For those patients at elevated risk of developing chronic disease, episodic care is simply insufficient to meet their needs. Chronic disease does not occur in isolation. Conditions such as diabetes, asthma, heart disease and obesity are all tied very closely to the environment, cultures, and behaviors that surround individuals.

IMPACT OF SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have tremendous affect on an individual's health regardless of age, race, or ethnicity.



SDOH Impact

- **20 percent** of a person's health and well-being is related to **access to care** and **quality of services**
- The **physical environment**, **social determinants** and **behavioral factors** drive **80 percent** of health outcomes

Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014 Graphic designed by ProMedica.

Direct medical spending associated with social determinants of health for people over age 65 in 2016

Social determinant	Associated spending*
Transportation	$17,780,915
Food stamps	$82,373,205,456
Poor or near poor poverty level	$98,107,908,207
Fair or poor mental health	$105,150,748,622
Patients with restricted low fat food diet	$267,815,560,816
All Americans over age 65	$582,052,417,044
Total US direct spending on health	$1,617,531,007,315

**Spending data are not mutually exclusive*

Source: PwC Health Research Institute analysis of Medical Expenditure Panel Survey data for 2016

https://www.pwc.com/us/en/health-industries/health-research-institute/pdf/CMS-expands-MA-social-determinants_PwC_Jan2019.pdf

Sample of MA Supplemental Benefits

Alternative Therapies

- Acupuncture
- Alternative Therapies
- Routine Chiropractic Services

Enhanced Disease Management

- Case Managers
- Education activities on specific disease/condition
- Routine monitoring of measures of specific conditions

Home-bound Services

- Bathroom Safety Devices
- In home safety assessments
- Personal Emergency Response System
- Post-discharge In-home Medication Reconciliation
- Readmission prevention
- Remote Access technologies
- Telemonitoring services

Healthy Lifestyles

- Fitness Benefit
- Nutritional/Dietary Benefit
- Weight Management Programs
- Counseling Services (life changes, conflict resolution, grief)
- Health Education
  - Group sessions
  - One-on-one
  - Interactive web or telephone coaching

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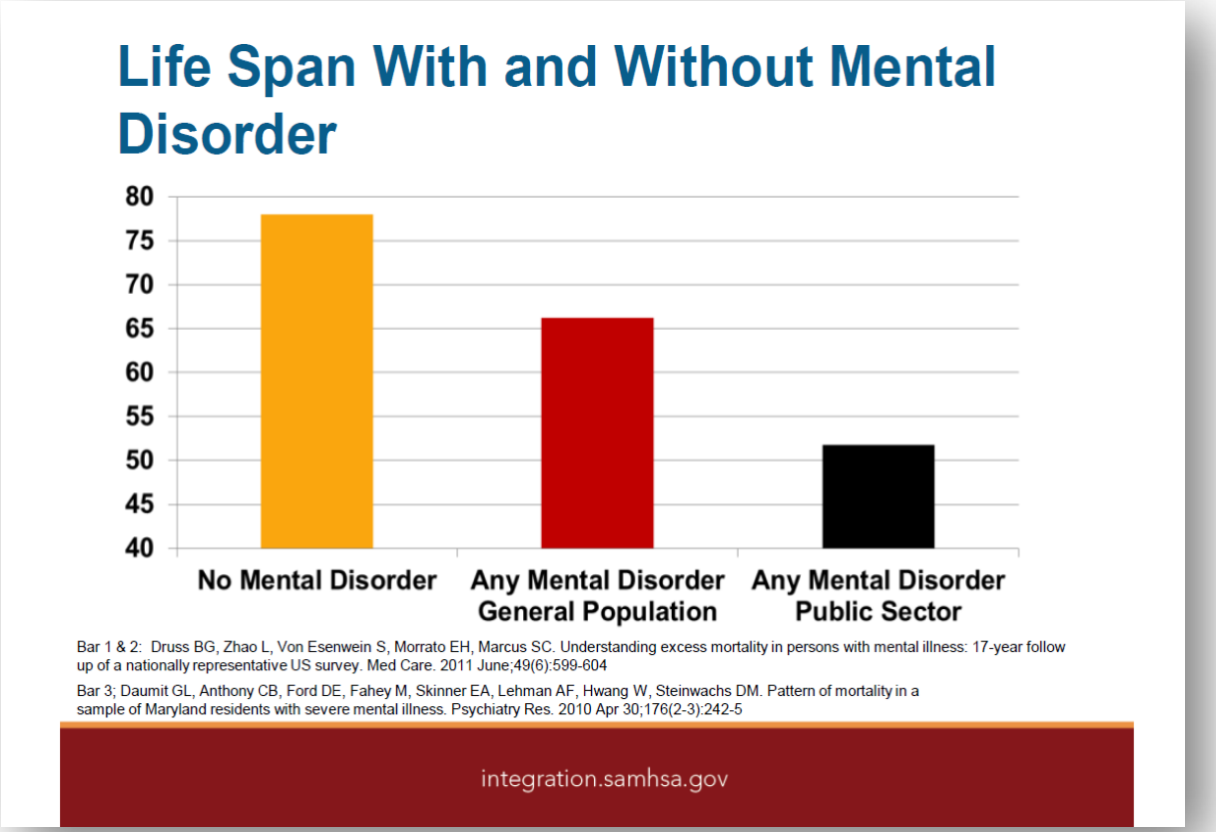
Why integrate these services?

Patients with serious mental health problems:

- Worst prognosis with chronic conditions
- Increase in mortality
- Reduction of life expectancy
- They suffer the cumulative effect of problems such as:
  - Smoking, substance use
  - Social vulnerability
  - Polypharmacy
  - Violence and poverty



Back to Basics presentation. SAMHSA-HRSA Center for Integrated Health Solutions.

we need to get to a level 6 of behavioral health integration...

Coordinated Key Element: Communication		Co-Located Key Element: Physical Proximity		Integrated Key Element: Practice Change	
Level 1 Minimal Collaboration	**Level 2 Basic Collaboration at a Distance**	**Level 3 Basic Collaboration Onsite**	**Level 4 Close Collaboration with Some System Integration**	**Level 5 Close Collaboration Approaching an Integrated Practice**	**Level 6 Full Collaboration in a Merged Integrated Practice**
Behavioral health, primary care and other health care providers provide care:					
Separate systems; Communicate rarely; Have limited understanding of roles.	Separate systems; Communicate periodically; Appreciate each others roles.	Separate systems; Communicate regularly; Collaborate; Part of informal team.	Share some systems; Communicate in-person; Collaborate; Have basic understanding of roles/culture.	Seek system solutions; Communicate frequently in-person; Collaborate frequently; Have in-depth understanding of roles/culture.	Function as one integrated system; Communicate at system, team, individual levels; Collaborate driven by shared concept of team care; Blended roles/cultures.

LEVEL OF INTEGRATION IN PUERTO RICO

Heath B, Wise Romero P, and Reynolds K. ***A Review and Proposed Standard Framework for Levels of Integrated Healthcare***. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

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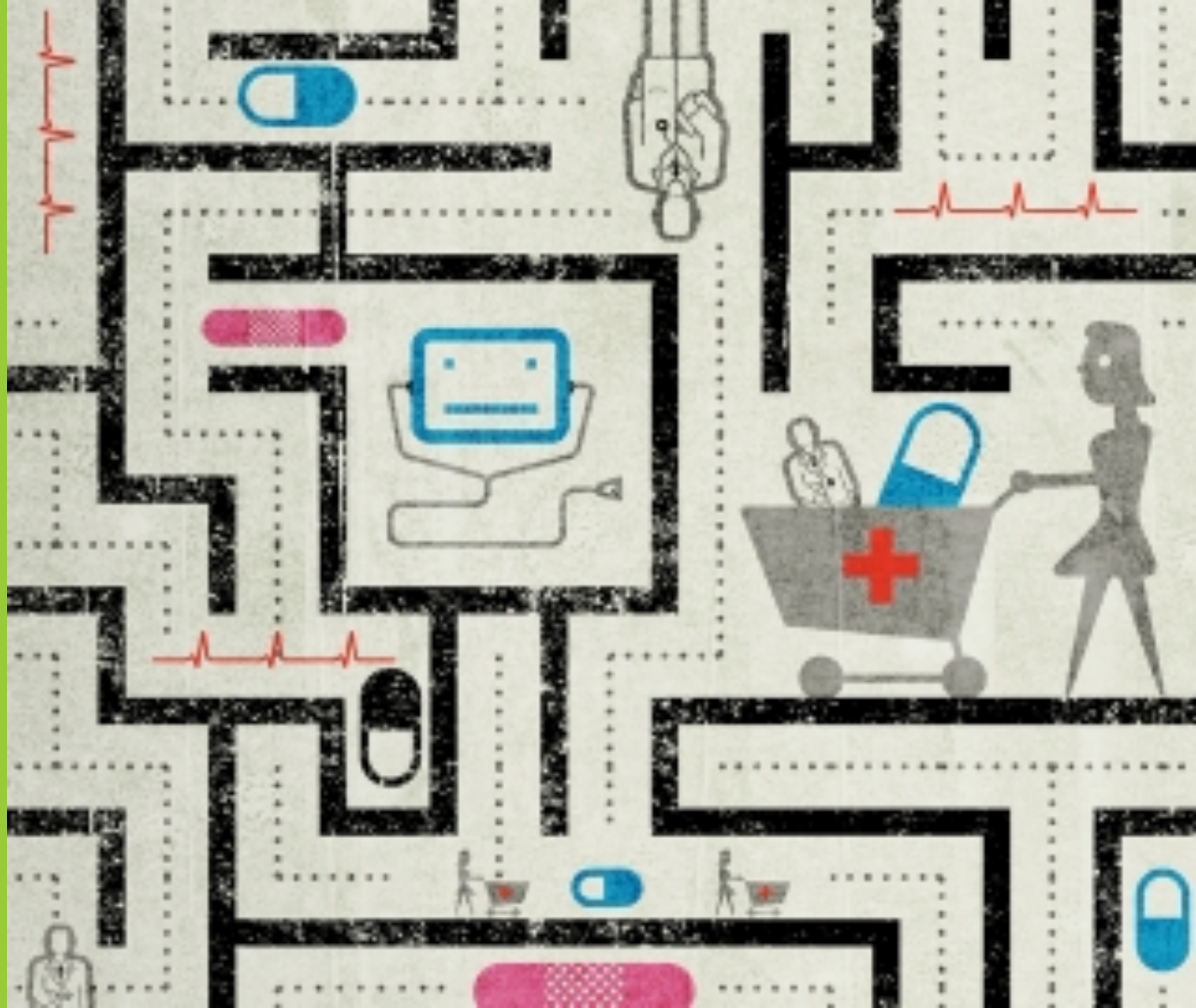
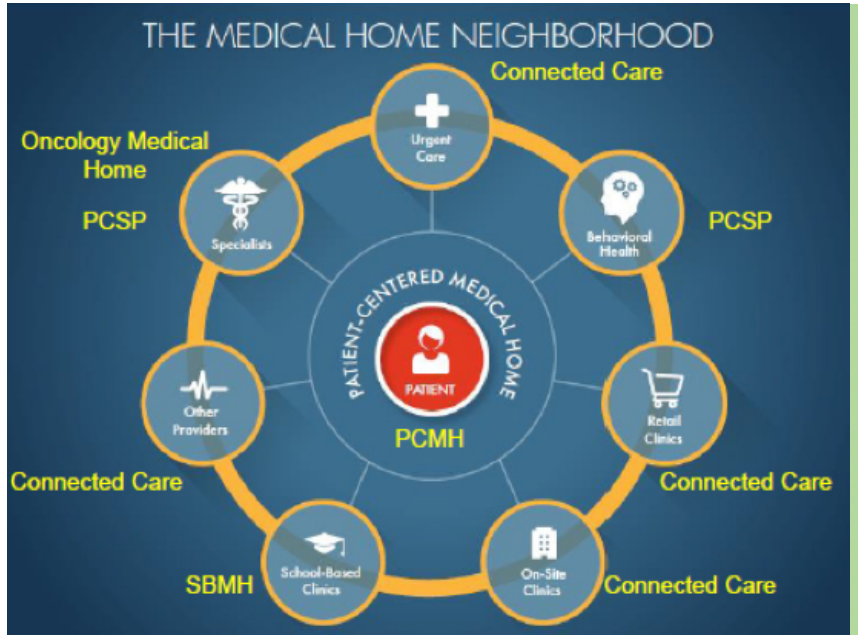
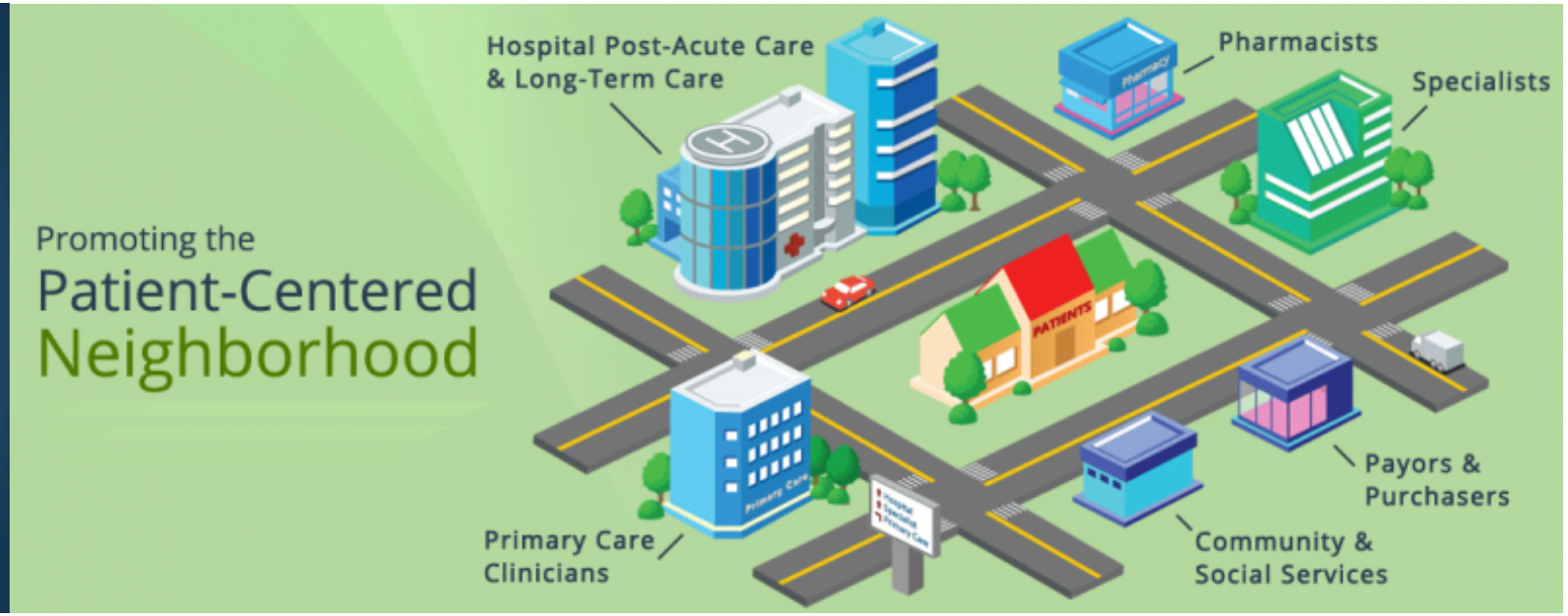
For patients, healthcare can feel like a maze



The Medical Home Neighborhood / Patient-Centered Neighborhood





NCQA
Measuring quality. Improving health care.

Fragmentation Continues

2015 Malpractices Risks in Communication Failures Report[1]

48% of miscommunication happened in ambulatory settings

57% of the cases reflected miscommunication between two or more healthcare providers

Costs:

$1.7 Billion

2,000 Lives

[1] Malpractice Risks in Communication Failures. 2015 CRICO Strategies National CBG Report. https://www.rmf.harvard.edu/Malpractice-Data/Annual-Benchmark-Reports/Risks-in-Communication-Failures

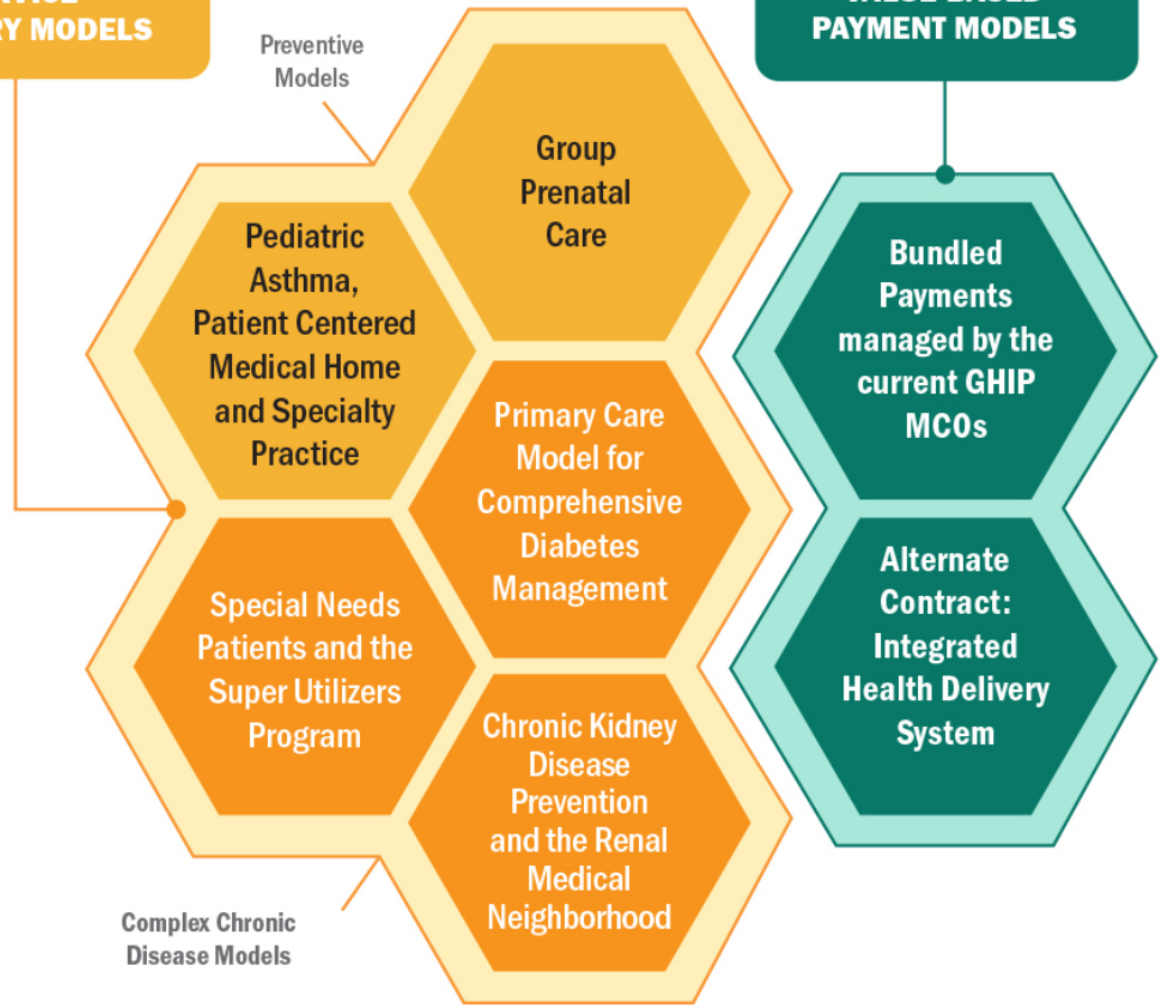
PROPOSED TESTING MODELS

CORE MODEL COMPONENTS

- Behavioral Health Integration
- Patient Centered Medical Home
- Group Visits
- Patient Centered Specialty Practice
- Patient Engagement

5 SERVICE DELIVERY MODELS

2 VALUE-BASED PAYMENT MODELS



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Relationship Between Payment Methods and Organizational Models

Adapted From: Shih A, Davis K, Schoenbaum S, Gauthier A, Nuzum R, McCarthy D. Organizing the U.S. Health Care Delivery System for High Performance. The Commonwealth Fund. 2008.

NCQA

The transition to value-based healthcare requires:

1. A focus on quality, spending and infrastructure supports for providers.
2. Strong payer-provider relationships focused on increasing alignment.
3. Development of value-based payment programs that align to the quadruple aim.
4. Shared measurement across payer contracts.
5. Alignment of individual physician incentives to institutional value-based contract incentives.

We know what works...

1. Investing in high quality primary care
2. Enabling patient-centricity and team-based care
3. Empowering patients through health literacy
4. Connecting with communities to address social determinants
5. Addressing mental health
6. Connecting providers and integrating health systems
7. Enabling value-based health care instead of fee for service payment
8. **Unleashing technology and reducing bureaucracy**

PUERTO RICO STATE HEALTH INNOVATION PLAN

PLAN ESTATAL DE INNOVACIÓN EN SALUD PARA PUERTO RICO

DEPARTAMENTO DE SALUD DE PUERTO RICO | STATE INNOVATION MODEL (SIM)

HEALTH INFORMATION TECHNOLOGY INFRASTRUCTURE

Establish HIT/HIE Governance and Roadmap that leverage federal investments to establish:

1. Encounter notification
2. Medication Adherence Tracking
3. Master Patient Index
4. Healthcare Provider Directory
5. Public Health Registries
6. Core Quality Metrics
7. Summary of Care Exchanges
8. Care Management Solutions
9. Population Health Analytics
10. Enable Value Based Payment

- All payer data clearinghouse
- Tele-health

Access to our full presentation...

Send us an email!

support@impactivo.com with subject: CAMARAPR

IMPACTIVO webinar: Policy Engagement to Increase Investment in Primary Care

November 21, 2019

10:00 am – 11:00 am

http://bit.ly/Policy-Engagement

region2 public health training center
A Member of the Nation's Network of Public Health Training Centers

IMPACTIVO
DATA-DESIGN-INSPIRATION

Taller Virtual

Desarrollando Política Pública para Aumentar la Inversión en el Cuidado Primario

Taller para líderes de la salud cuyo objetivo es definir el concepto de política pública, entender los procesos y leyes y discutir su rol como activista profesional.

jueves, 21 de noviembre de 2019
10:00am - 11:00am

Regístrese visitando el siguiente enlace:
http://bit.ly/Policy-Engagement

Maria Levis
CEO IMPACTIVO

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IMPACTIVO
DATA-DESIGN-INSPIRATION

What is Impactivo?

Impactivo is a social impact consulting firm that works with leaders to make health and wellbeing accessible to communities.

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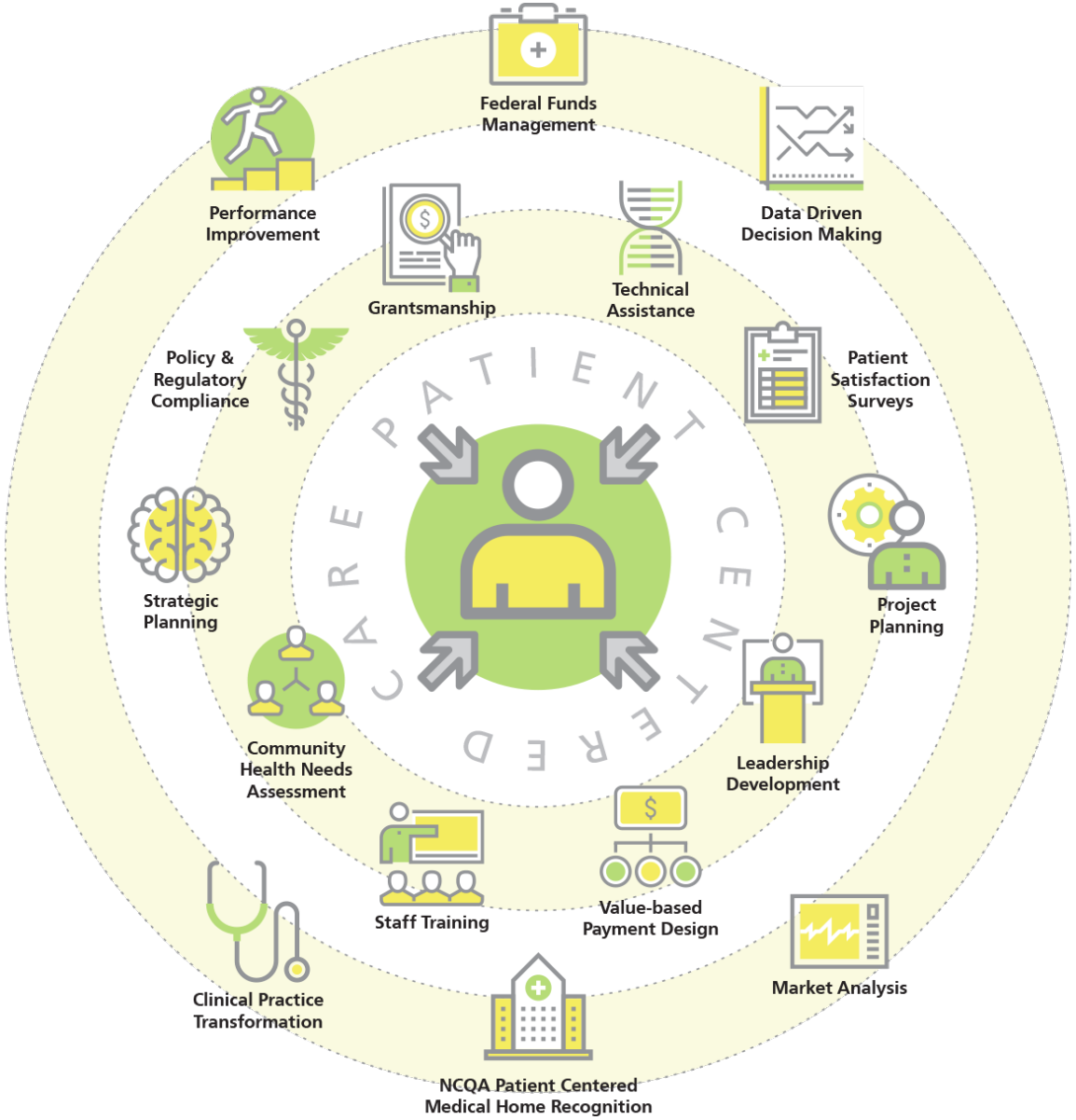
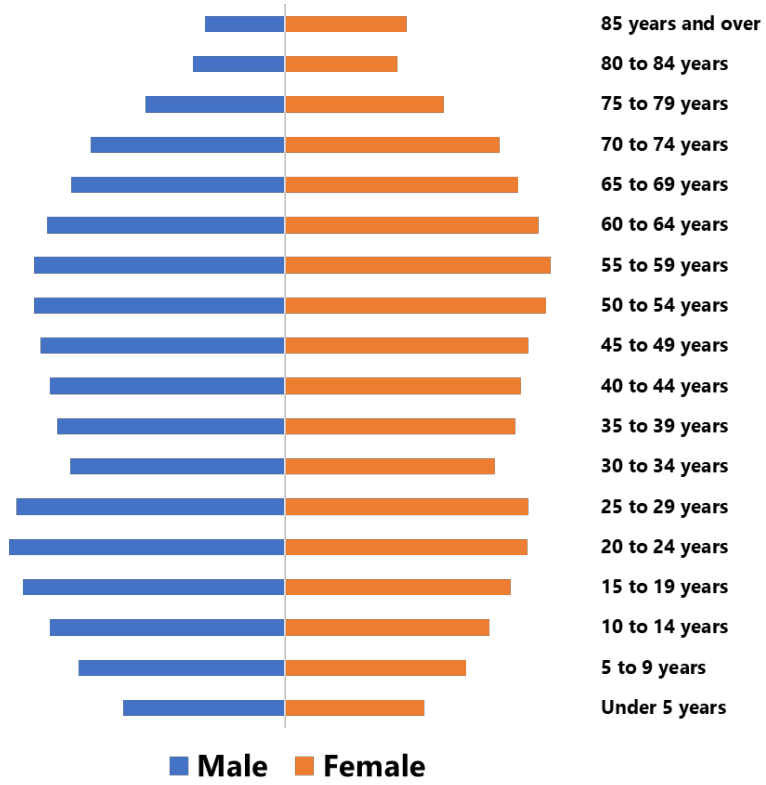
Thanks!



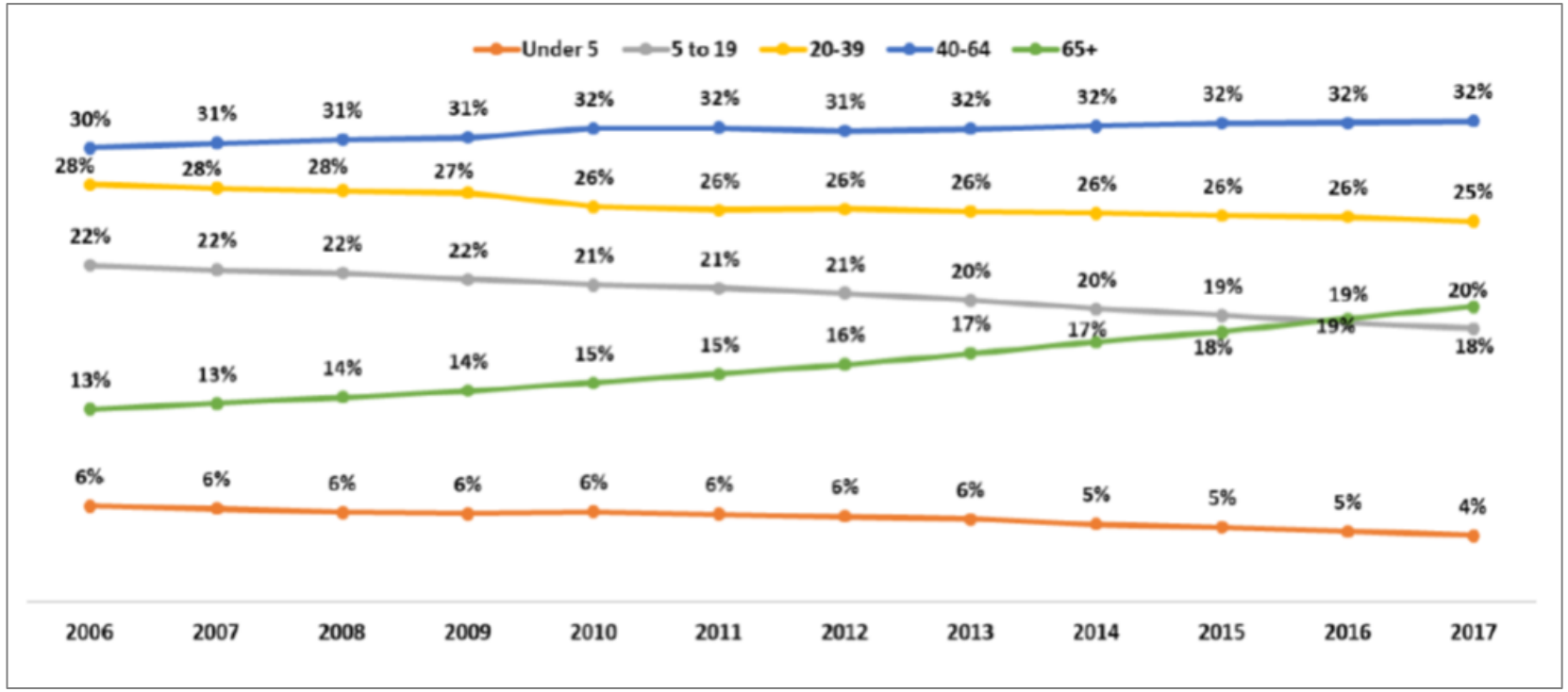
Appendix

Puerto Rico demographics



- Population estimate: 3,195,153
- Less births
- Growing population over 65
- Median age: 42.8, an aging population
- Population change between 2010-2018: -14.3%
- Median Household income: $19,775
- Persons in poverty: 44%
- Unemployment rate: 8%

Population by age… we're getting old



U.S. Census Bureau, Puerto Rican Community Survey 2006-2017 (1-year estimate)

Population health profile

Cancer

- 78,000 cumulative cases
- 14,000 new cases per year

Diabetes

- 400,000 cumulative cases
- 10,000 new cases every year

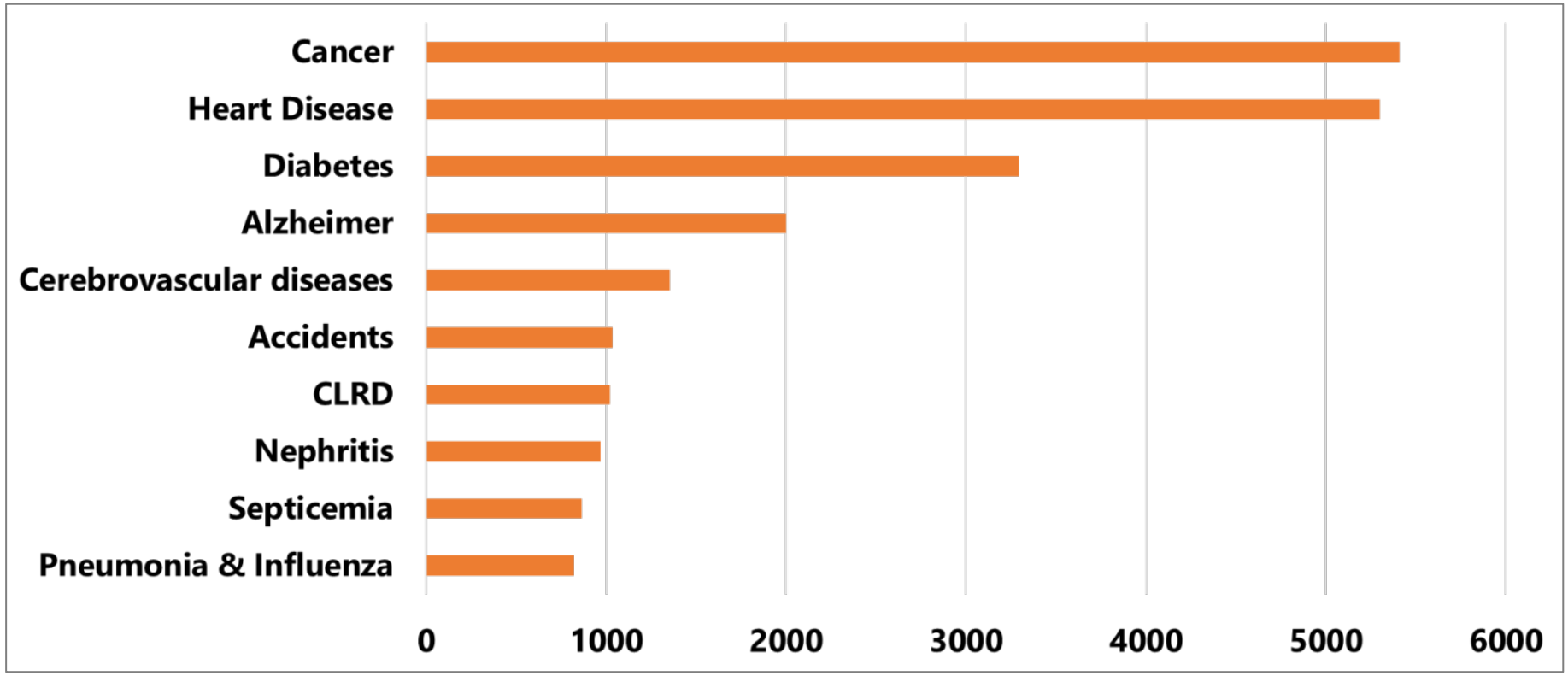
Cardiovascular Disease

- 42% prevalence
- 35% of cost cover by patients

Arthritis

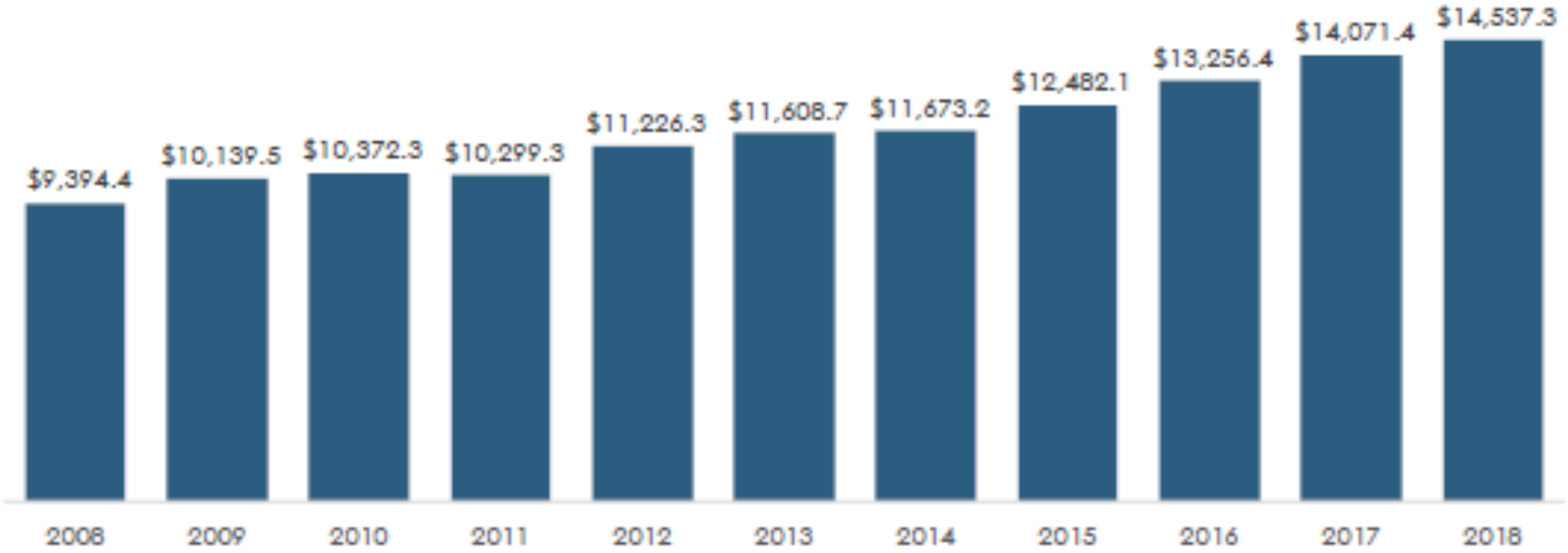
- 0.6%
- 25,000 of cases not diagnosed

Top 10 causes of death



Personal Health Expenditures

Fiscal Years



Source: PRPB 2019.

Estudios Tecnicos

Main barriers to access healthcare services

- Economic - high costs
- Geographic - transportation
- Issues related to healthcare system
- Lack of health insurance coverage
- Physician shortage/coverage
- Health literacy
- Lack of knowledge of available resources
- Lack of services
  - Transportation
  - Nutrition
  - Access to medications
  - Adherence to treatment
  - Mental health meds and treatment
  - Housing