Welcome, you're listening to a UC Davis Center for Poverty Research conference podcast. I'm the centers director Ann Stephens. In November 2013, the center hosted the conference The Affordable Care Act and low income. Populations. Lessons from, and challenges for research. The conference featured top healthcare experts from across the country to discuss the roll out of the affordable care act, and what the new system means for poverty in the United States.

In this presentation, Neal Kohatsu talks about the innovation needed to transforms our current health system, into one that bridges health care and public health. Kohatsu is the Medical Director for the California Department of Health Care Services.
>> Now just a little background on Medi-Cal right now there's about eight and a half million members with the Affordable Care Act expansion, one and a half million, or so more will be somewhere in the neighborhood of 10 million members in the next year or two or over.

time representing more than one out of four Californians. If you look at births, Medi-Cal pays for almost half of all births, and with the expansion it may be more than half of all births. So Medi-Cal is a big player in the California health care system. This is a pictorial representation of what Dr.Chapman was talking about.

There's no bridge between the. Silos. technically, I think, on the left's actually a grain bin. My wife grew up in South Dakota. But we'll call 'em silos.
>> And the reason why there needs to be bridging, Dr. Chapman talked about, but if you wanna quantify it, there there have been a number of articles that looked at estimating the impact of healthcare on preventable.

Mortality. Most people say it's in the range of 10 to 15%. There was an article by Mike McGinnis in Health Affairs but, there have been others, including the New England Journal. And, the McGinnis Foege paper, followed by two Mokdad papers from CDC, says somewhere in the neighborhood of 40, 50% of preventable mortality is related to lifestyle.

So. I'm not underestimating the importance of health care. If you need a transplant, then you need a cardiac transplant if you're in advanced-stage congestive heart failure. So we need both systems, but certainly, we need bridging as Dr. Chapman alluded to. I'm gonna say just a little bit about our department's approach.

To trying to bridge the two systems. Health care and population health, or public health if you will. This is just giving you the high level overview of our quality strategy which is modeled after the national quality strategy, which you can Google and find The national quality strategy was actually a part of the Affordable Care Act the development of that was a requirement.

This is essentially these three goals, three linked goals are our version of the IHIAAA and we changed the order, we put, improving the health of all Californians, on top, enhancing care delivery and, and reducing costs. The key of course, and, and I'm glad that the Center For Poverty Research are chaired by economists, the key is to do all three at the same time.

When you do one, we're not gonna get to the, we aren't gonna address the triple analysts when you look at all three domains at the same time. These are the seven over arching principles. I'll highlight the 7th one since Dr. Chan just talked about that, we're working very closely with the primary public health on the office of health equity, we have a report that will be share in public about the next month,.

On health disparities within the Medical population, so these are not in any sort of order. These are, all of these are priorities. Improving patient safety, the second one, def, developing, or delivering effective, efficient, affordable care. Again, think of that as really talking about the new models of care that several sessions have already.

addressed, including patient center, medical home. Addressing super util, utilizers, behavioral health integration, that can all fall into that second, bucket. We think it's critical that we do better, a better job of engaging members, persons and families in their own, health for a number of reasons. Both, shared decision making.

Getting the right decisions at the end of life. All these things require better patient engagement. The fourth one enhancing communication coordination of care that of course embraces advancement of electronic health record, we're really not gonna be able to tackle this level of complexity without a robust. EHR and, and we still have a ways to go, as you know.

I'm that glad our department has, has embraced advancing prevention. For those who are still skeptics, I refer you a Pediatrics article with talking about CDC data that said about, almost a quarter of teens have either prediabetes or diabetes. There's simply not going to be enough endocrinologists and internists and family physicians, if one quarter of the population has diabetes, which then lead to obesity which leads to cardiovascular disease.

You understand the picture. So, I think the healthcare system, including medical and pharmahealthcareservice has to take seriously this upstream look and not. Put it all on Ron's folks. We have to be engaged in that. One example some Kaiser Hospital's actually have farmer's markets right outside the hospital. Is that everything?

No. But, it's a good starting point to say that they're taking upstream prevention seriously. And the same tied in as fostering healthy communities, we have to be engaged in, in thinking upstream that is those of us in the health care system, and I talked about eliminating health disparities.

Let me just say one more, thing about, the second bullet, about the systems of care. I, I think and Hill talked about there a lot of things that perhaps aren't working as quickly as we need, but he talked about system redesign and I think that is absolutely the key.

Even putting aside affordable care act, it was a paper that those in primary care probably know, Talking about how many hours does it take to deliver A, and B preventative services. When you add it all up in an average patient panel. It'll be 7.4 hours. So, Ron, unfortunately, there's no time for chief complaints, or acute care because we would be doing just preventative services.

So, that's just one. Example of the system doesn't work we can't blame primary care doctors for why he does matrix don't look so well. These names I've been talked about it, I just wanna say the ACA is very important fostering a lot of them, things such as evident space, medicine prevention, coordinating care and access, however,.

The challenges are. And I just said a few words about the major system redesign. By the way, I'm, I am not cynical, to think that we can't do it. I think this country can apply the innovation that we see in Silicon Valley, not very far from where we stand, to the healthcare system.

So. Couple of examples of major system redesign I think the approach that Doctor Don the high performance primary care practice when we talk about patients in their medical home it's often in these lofty, we should coordinate care and behavioral health should be a part of it. But he's broken it down into ten building blocks, and at least forty specific items.

And so, for someone in policy that's kind of what is needed. We need to get down to the nitty gritty details. Another example that I'd call out is Rob Reed has a series of articles, in health affairs on group health collaborative's effort at their version of patient center medical home.

Dr. Reed in fact spoke at UC Davis at the Medical Campus not too long, I think it was last year, on Patient Center Medical Home. They actually have shown a positive return on investment. I think they get $1.50 back for every dollar invested so there is a positive ROI but they've made very dramatic changes, albeit a closed system, more like a small Kaiser.

Albeit a closed system, they made some dramatic changes and when we say re-design the healthcare system, has anyone had an appointment with their doctor, or been in the presence of a doctor for 30 minutes in discussion, except maybe where you were on the operating room table, then you've probably had an encounter.

But in the primary care setting, no. So their standard template went from 15 minutes to 30 minutes. They actually hired

more primary care doctors, reduced the panel size. They were actually bleeding from physician burnout so it's just an example. I could tell you more about their system, but system redesign means serious changes in how we deliver.

Care and this notion which you hear on every conference probably was mentioned earlier about operating at the top of the license. Those are the kinds of things we need to think about. So, not just pharmacists. When pharmacists take on a bigger counseling role, they need to pass off work as well.

Pharmacy techs, psych techs in the VA system. Those are just a couple of examples, so think. The major redesign is possible. As Dr. Melnico said, that we're gonna come back to the clinical world and this is something that I think about. I took care of a number MediCal patients at the beginning of when I started after a fellowship in the Lipid Clinic, and I didn't see the patients.

This is Jeff Brenner in the Camden Coalition. I didn't see so many of the. So called super utilized, but I did see people who needed specialty care. And I want to just call out the example of super utilizers, or the hot spotting. He recently won one of the so called genius awards, the McArthur fellow, awarded in September.

This is a neighborhood in coalition, but this could be south central, this could be, parts of South of market, this is why we need to think outside of the hospital and clinic about where our patients are going home to, or actually not home to, because some live in a car, and so this notion of super utilizers is reflected in this, graph, from the Kaiser Family Foundation, In Medi-Cal, and actually my colleagues in Medicaid, we have the so-called five-fifty rule.

The second bar is the five-fifty rule where about 5% of the highest utilizers healthcare, consumers consume about 50% of that, the healthcare spent. If you go to the top 1%, It's about 20% in some sicker populations maybe 25%, so 125, if we go to the other side the reason that some people aren't signing up for healthcare so quickly.

The healthiest 50% utilizers only account for 2 to 3% of healthcare expense so I think attacking this notion of who needs. The super utilizer team, the fraction of one percent, versus who's in the top 15%, what care they need is part of that system redesign we have to sort through, and how do we do it efficiently, and effectively, and within very tight budgets as has been described.

So, in summary, what are the implications for research? Well,. The three year, three to five year NIH or HRQ grant is I think, for Doctor Chapman and me, that's too slow of a pace, and we have to think more of a like what Doctor Don Berwick, the former head of CMS said, which is, and to actually what he saw on the walls at IH.

I, isn't it Dr. Shake, what can you do by next Tuesday? I think that's on the walls of IHI's headquarters. And that's more in the space of Dr. Shake's a colleague who works with me at UC Davis, in quality improvement. That's more the pace that Don Berwick talks about, and he was CMS administrator.

For a very great year and it is in fact about the money, and that's not just to be cynical, incentives and disincentives are very important. Looking at capitated care and that, even in Kaiser, to do the right thing, you have to, to move into a more of a program or develop that.

Or develop a better care program that means adjusting, taking away something in the budget to ply resources other places so its not meant to be a cynical note but for the academic researchers you need to partner. with the researchers in economics, in health economics, and broader economics picture as well, behavioral economics, because for us to be able to carry the political water to convince the inside and outside stakeholders, we need those.

Models, economic modeling, I know that's something Dr. Melanco, Dr. Kaiser, were going to have meetings on that very issue looking at, one particular problem, later this year. We need better data, our data admittedly in the MediCal program, are wanting, we are trying as hard as we can to.

Get it up to speed. But, the point is we can't wait. We have to look at what we have, do the best we can. And we, in fact, are working with partners at UC Davis and other places on looking at super utilizers. Doing the best we can with the data.

Knowing that it is imperfect. And finally I think this theme has been mentioned in several previous talks is we have to look across in more of a system sense using systemness. And that means thinking across to the public health side of the street. Even within. A particular health plan.

We need to think about the impacts on behavorial health which is divided up in substance abuse and mental abuse. We need to think upstream. We need to think about social determinants of health. I know that's bringing a level of complexity, but I'm sorry health and healthcare are complex, and we just need to be apply.

Academics and, and other resources towards solving these complex problems and I will leave it with that. I think we can address system that's working together, but unless we pull together, we're not gonna be able to deal with not only medical issues but the broader. Health care challenges in California, thanks.

>> I'm Ann Stevens, the director of the Center for Poverty Research at US Davis, and I want to thank you for listening. The Center is one of three federally designated poverty research centers in the United States. Our mission is to facilitate non-partisan academic research on domestic poverty, to disseminate this research, and to train the next generation of poverty scholars.

Core funding comes from the US Department of Health and Human Services. For more information about the center, visit us online at poverty.ucdavis.edu.