100 Million Healthier Lives: Connecting Primary Care and Community to Improve the Health of the Population

March 15, 2015

These presenters have nothing to disclose
Welcome to the 16th Annual International Summit on Improving Patient Care in the Office Practice and the Community!
Session Objectives

- Understand why, in this stage of ACO and PCMH transformation, it is critical for primary care, community and public health systems to coordinate to improve the health of people, communities and populations.

- Explore new models of connecting primary care with the community to improve the health of the population.

- Get hands-on exposure to how leading innovators are creating pathways toward integration to address the social and behavioral determinants of health, along with funding pathways to support that.
What We *REALLY* Want You to Get Out of This...

- Motivation to pursue health in your communities through meaningful collaboration
- An opportunity to learn from sites “in the trenches” of community partnerships and health transformation and an opportunity to share your own challenges and successes
- A shift toward thinking about assets, strengths, and resources, rather than deficits or problems
- Practice in getting started
## Connecting Primary Care to the Community to Improve the Health of the Population

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:00 – 12:30 PM</td>
<td>Welcome and Introductions; Context Setting</td>
</tr>
<tr>
<td>12:30 – 1:00 PM</td>
<td>Why 100M Healthier Lives? Why now? Why primary care and community?</td>
</tr>
<tr>
<td>1:00 – 1:45 PM</td>
<td>Group Activity 1</td>
</tr>
<tr>
<td>1:45 – 2:30 PM</td>
<td>How Leading Innovators Are Paving the Way: Part I</td>
</tr>
<tr>
<td>2:30 – 2:45 PM</td>
<td>Break</td>
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<tr>
<td>2:45 – 3:30 PM</td>
<td>How Leading Innovators Are Paving the Way: Part II</td>
</tr>
<tr>
<td>3:30 – 4:10 PM</td>
<td>Asset Based Community Development as a Means for Transformation</td>
</tr>
<tr>
<td>4:10 – 5:00 PM</td>
<td>Group Activity 2</td>
</tr>
<tr>
<td>5:00 – 5:20 PM</td>
<td>Putting It All Together: Action Planning</td>
</tr>
<tr>
<td>5:20 – 5:30 PM</td>
<td>Wrapping Up &amp; Evaluation</td>
</tr>
</tbody>
</table>
Minicourse Faculty

- **Laura Brennan**
  - *Executive Council, Communities Joined in Action*
  - *Co-Chair, 100 Million Healthier Lives*

- **Chris DeMars**
  - *Director of Systems Innovation at the Oregon Health Authority Transformation Center*

- **Niñon Lewis**
  - *Executive Director, Triple Aim for Populations Focus Area, Institute for Healthcare Improvement*

- **Leslie Mikkelson,**
  - *Managing Director, Prevention Institute*

- **Sarah Redding**
  - *Co-Executive Director, Center for Pathways Community Care Coordination at the Rockville Institute*
  - *Executive Director, Community Health Access Program*

- **Bert Ruiz**
  - *Senior Manager, Chronic Disease Prevention Programs, YMCA of the USA*

- **Soma Stout**
  - *Executive External Lead for Health Improvement, Institute for Healthcare Improvement*
  - *Primary care physician*
What might be our working agreements for the day?
A Proposal: Our Working Agreements

- Take responsibility for your own learning
- Honor time limits
- Advise the facilitators if you must leave the workshop to handle an emergency
- Participate by sharing your opinions and experiences
- Listen to and consider the opinions of others
- Be curious and experimental
- WHAT ELSE?
Some tips…

Over the next 5.5 hours:
- Translate to your setting and projects
- Track the ideas that jump out

Over the next two days:
- Track ideas from other sessions
- Develop tests for your return

Think about your home team!
WHY 100 MILLION HEALTHIER LIVES?
WHY NOW?
WHY START WITH PRIMARY CARE-
COMMUNITY CONTINUUM?
Multiple Tsunamis

- Aging population
- Increasing prevalence of chronic disease
- Escalating health costs
- Dissatisfied patients
- Over-use of services
- Gaps in the quality of care
- Public scrutiny and regulation
- Social responsibility for judicious management of resources
Our care system was built for a different set of population health issues.
Diabetes management under PCMH

Commonwealth Fund evaluation. NCQA sites = Union Square and Revere
It’s not enough to redesign the delivery system.

Cost of diabetes and prediabetes: $300 billion to $514 billion by 2020; 50% of Americans will have diabetes/prediabetes.
A pathway that leads to an “aha”

- ACO-Primary Care Transformation
- Complex care management
- Realization that social and behavioral determinants of health are critical
Notes: Social services expenditures include public and private spending on old-age pensions and support services for older adults, survivors benefits, disability and sickness cash benefits, family support, employment programs (e.g., public employment services and employment training), unemployment benefits, housing support (e.g., rent subsidies) and other social policy areas excluding health expenditures.

Figure 1. Determinants of Health and Their Contribution to Premature Death.

Adapted from McGinnis et al.¹⁰

Source: Martin A.B. et al., Health Affairs, 2012
McGinnis et al Health Affairs 21(2): 2002
An unprecedented alignment among the major leaders in health and healthcare

- **Governmental**
  - Health and Human Services: Healthy People 2020
  - CMS/CMMI
  - States: Vermont, Illinois, Michigan, Colorado

- **Thought leader/research organizations**
  - Institute of Medicine
  - APHA
  - IHI
  - 100 Million Community

- **Philanthropic organizations**
  - Commonwealth Fund
  - Robert Wood Johnson Foundation
  - Kresge
  - Kellogg
  - Clinton GHI

- **Payers**
  - CareOregon, BCBS, Network Health

- **Delivery systems**
  - Kaiser, Geisinger, Virginia Mason, Southcentral, CHA, Iora…
Defining health based on what matters to each person

- Adaptation of World Health Organization definition:
  - “Complete mental, physical, social, [and spiritual] wellbeing…”

- “Health is not the absence of disease but the addition of confidence, skills, knowledge and connection. But most importantly, it is simply a means to an end—which is a joyful, meaningful life.”
  - Cristin Lind

© Courtesy of Cristin Lind
On October 8, 2014 at 2:52PM we made a commitment: 100 million people living healthier lives (globally) by 2020

We committed ourselves to becoming a community of change agents acting with unprecedented collaboration to pursue this unprecedented result.
What?

An unprecedented collaboration of change agents pursuing an unprecedented result: **100 million people living healthier lives by 2020.**
Key Stats

• **224 members and partners** working on the ground to improve health have committed to being part of the community
• **7 sponsors** willing to providing some level of financial support
• **192 action plans** submitted, detailing how individuals/organizations/networks will take action in improving health
Theory of change – 100 Million Healthier Lives

Unprecedented collaboration + Innovative improvement + System transformation → 100 Million People Living Healthier Lives by 2020
Core strategy

- Connect primary care to community, public health and social services
- Continue to transform patient centered medical homes to person and community centered health homes
GROUP ACTIVITY 1
Imagine you are...

- Pedro, a 67 year old Spanish-speaking man with diabetes and an amputation
- Rhonda, a 16 year old pregnant teen who wants to grow up to be a nurse
- Annabelle, an 83 year old woman who is recently widowed, has high blood pressure and increasing disorientation since she lost her husband
- Mary, Annabelle’s 57 year old daughter who works and is the primary caregiver for Annabelle
- Jonathan, a 40 year old computer techie with an early history of heart disease in the family who works 80 hours a week
- “Blade” a 25 year old youth involved in a gang who is worried that most of his friends from five years ago aren’t around any more
HOW LEADING INNOVATORS ARE PAVING THE WAY: PART I
“Typical” Family at Risk

Marisol, 21
- Pregnant
- Lost job
- No housing
- No transportation
- Depressed?

Angelina, 16 months
- Needs medical home
- Behind on imms.
- Behind on well visits
- Developmental concerns?

Mrs. Garcia, 52
- Diabetic
- Lives in 1 bedroom apt.
- Limited income, works 32 hours
- Financial stressors?
Current *Community* Care Coordination

- HHS
- Medicaid Managed Care
- Early Childhood
- Child Protective Services
- Health Plan

Multiple care coordinators involved – limited communication
“health care delivery accounts for only 10% of preventable deaths. . . .

. . . . consensus is developing that truly controlling health care costs and improving the overall health of the American people will require a much closer partnership, permeable boundaries, and increased interdependence among the health care delivery system, the public health sector, and the community development and social service sectors”
To eliminate health and social disparities in our community by finding those at risk, connecting them to care, and measuring the outcomes.
Pathways Model

1. Find
   - Target population – Find those at greatest risk

2. Treat
   - Confirm connection to evidence-based care

3. Measure
   - Measure the outcomes
Regional Organization and Tracking of Care Coordination

- Demographic Intake
- Initial Checklist -- assign Pathways
- Regular home visits – Checklists and Pathways completed
- Discharge when Pathways completed (no issues)
Richland Help Me Grow – Pregnancy Pathways Contracting Seven Care Coordination Agencies Serving Richland County

2004-2005
Contracting for Process
19 At Risk Served

2005-2006 –
Dollars tied to Performance
Duplication Removed
146 At Risk Served
Low Birth Weight Rates in Ohio and Richland County: 2005-2008
Reducing Risk for Communities

Risk
One Care Coordinator for the Entire Family

Marisol
- Pregnancy PW
- Employment PW
- Housing PW
- Medical Referral PW
- Social Service Referral PW
- Education PW – prenatal, parenting

Angelina
- Medical Home PW
- Immunization Referral PW
- Medical Referral PW
- Developmental Screening PW

Mrs. Garcia
- Medical Referral PW – primary & specialty
- Housing PW
- Social Service Referral PW
- Education PW - diabetes
One Care Coordinator for the Entire Family
HUB Certification Pre-requisites & Standards

**Pre-requisites**

1. The Pathways Community HUB (HUB) must be an established community-based organization.
2. The HUB has utilized the HUB model for a minimum of six months.
3. The HUB is the only HUB in its regional service area.
4. The HUB has documentation of coordinating a network of agencies, comprised of a minimum of two agencies, each having at least one care coordinator with assigned caseloads of active at-risk clients identified within the agency’s respective service area.
5. The HUB is able to contract with more than one payer on behalf of participating agencies.
6. The HUB is tracking outcomes using standard Pathways.
7. The HUB ties measured outcomes and results to dollars within financial contracts with payers.
8. The HUB has written program requirements and documentation to include client eligibility for services.
9. The HUB has written policies to ensure HIPAA-compliant client privacy and personal health information protections.
10. The HUB is an independent legal entity or an affiliated component of a legal entity.
11. The HUB is free of actual and perceived conflicts of interest (e.g., the HUB cannot employ care coordinators).

**HUB Standards**
20 Core Pathways

- Adult Education
- Employment
- Health Insurance
- Housing
- Medical Home
- Medical Referral
- Medication Assessment
- Medication Management
- Smoking Cessation
- Social Service Referral
- Behavioral Referral
- Developmental Screening
- Developmental Referral
- Education
- Family Planning
- Immunization Screening
- Immunization Referral
- Lead Screening
- Pregnancy
- Postpartum
<table>
<thead>
<tr>
<th></th>
<th>Normal Risk</th>
<th>High Risk</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Checklists</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Pregnancy Checklist</td>
<td>Completed one time at Member enrollment, 1&lt;sup&gt;st&lt;/sup&gt; trimester engagement</td>
<td>G9001</td>
<td>G9003</td>
</tr>
<tr>
<td></td>
<td>Completed one time at Member enrollment, 2&lt;sup&gt;nd&lt;/sup&gt; trimester engagement</td>
<td>G9001</td>
<td>G9003</td>
</tr>
<tr>
<td></td>
<td>Completed one time at Member enrollment, 3&lt;sup&gt;rd&lt;/sup&gt; trimester engagement</td>
<td>G9001</td>
<td>G9003</td>
</tr>
<tr>
<td>Pregnancy Checklist</td>
<td>Completed at each face-to-face encounter with Member</td>
<td>G9005</td>
<td>G9010</td>
</tr>
<tr>
<td><strong>Pathways</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Kept three scheduled behavioral health appointments</td>
<td>G9002</td>
<td>G9009</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>Educational module delivered.</td>
<td>G9002</td>
<td>G9009</td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
<td>LARC (long-acting, reversible) or permanent method</td>
<td>G9002</td>
<td>G9009</td>
</tr>
<tr>
<td>Family Planning</td>
<td>All other family planning methods</td>
<td>G9002</td>
<td>G9009</td>
</tr>
<tr>
<td>Housing</td>
<td>Residing in affordable &amp; suitable housing for 2 months.</td>
<td>G9002</td>
<td>G9009</td>
</tr>
</tbody>
</table>
• Removes “silos” and fragmentation
• Uses existing community resources efficiently and effectively
• Focuses on common metrics to identify & track risks (risk reduction)
• Holistic community care coordination – one care coordinator
• Pays for outcomes – sustainable
• Owned by the community
REDUCING RISK
YMCA’S DIABETES PREVENTION PROGRAM

Bert Ruiz
Senior Manager
YMCA of the USA

March 15, 2015

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AGENDA

1. BACKGROUND, NEED, AND THE PROGRAM

2. PARTNERING WITH HEALTH CARE PROVIDERS
BACKGROUND, NEED, AND THE PROGRAM
THE STATISTICS

DIABETES
29 million Americans

People who know they have prediabetes

PREDIABETES
86 million Americans (37% of all adults) with progression to diabetes at rate of 11% per year
• The incidence of type 2 diabetes is increasing in epidemic proportions throughout the world.

• Once type 2 diabetes develops, it is difficult to treat.

• Diabetes and its associated complications costs the national economy of the US approximately 245 billion dollars annually. Prevention of type 2 diabetes would result in a significant reduction in social and economic costs.

TIME TO ACT

Source: Centers for Disease Control and Prevention (2014)

ymca.net/diabetes
CHAPTER 1
1997-'02
Y not involved. NIH funded study.

CHAPTER 2
2005-'08
Indiana University School of Medicine works with the YMCA of Greater Indianapolis to successfully translate group based DPP at lower cost.

CHAPTER 3
2009-'10
YMCA of Greater Louisville validates in non-research environment. The Y could recruit participants.

CHAPTER 4
2010 - 2013
National program partnership with CDC and Third Party Administrator creates single system to allow for any third party payors to reimburse the Y. Program dissemination continues.

CHAPTER 5
2014 - 17
Y-USA launches scaling and dissemination plan with the long-term goal of ensuring the program is available to every Y who wants to offer it in their community.
Efficacy

$200 Million NIH-led DPP Trial

Q: What's more effective at preventing Type 2 diabetes – a 1-1 delivered lifestyle intervention or Metformin?

A: 1-1 Lifestyle intervention by reducing body weight by at least 5%.

New England Journal of Medicine, 2002
Q: Could a group-based adaptation of the DPP lifestyle intervention achieve the 5% weight loss of the DPP for a fraction of the cost?

A: Yes

**VALIDATION**

**NIH-Funded**

Indiana University School of Medicine and YMCA of Greater Indianapolis

Ackermann RT et al. AJPM; Oct 2008
SIMILAR RESULTS HAVE BEEN SHOWN ELSEWHERE...

28 TIMES.

- Analysis of 28 studies applying the findings of the DPP research study in real-world settings
  - Average weight change was 4%
- Weight change was similar whether program was delivered by clinically trained professionals or lay educators
- Every additional lifestyle session attended, weight loss increased by 0.26 percentage point

YMCA’S DIABETES PREVENTION PROGRAM

THE PROGRAM IS:
• Led by a trained Lifestyle Coach
• A one-year program: 16 weekly sessions, then 8 monthly sessions
• Open to all community members; YMCA membership is not required
• A Centers for Disease Control and Prevention (CDC)-approved curriculum

PROGRAM QUALIFICATIONS:
• At least 18 years old,
• Overweight (BMI ≥25), and
• Prediabetes confirmed via one of 3 blood tests or previous diagnosis of gestational diabetes
• If no blood test, 9+ score on risk assessment

PROGRAM GOALS:
• Reduce body weight by 7%
• Increase physical activity to 150 minutes per week

Nancy R. from New York City, NY - lost nearly 10% of her starting body weight!

I feel healthier--terrific even--and friends tell me I look great. I’ve changed the way I cook for myself and my daughter, and now [she] is checking the packaging on foods, taking smaller portions for dessert and making wiser food decisions.

I’m now doing something that is positive for both of us, and I want to tell everyone about it.
PARTICIPANTS

• DO NOT need to be members of the YMCA to enroll in the program

• MUST NOT already have Diabetes or blood values in the diabetes range

• Typically receive a participation incentive tied to attendance
**TRAINED LIFESTYLE COACHES**

- Create a motivating environment that is friendly and non-competitive.
- Facilitate group-based problem solving by utilizing motivational interviewing methods.
- Make learning a shared responsibility for the group rather than serving as the “expert.”
- Support and encourage goal setting on a weekly basis.
- Are accessible to participants before and after class. Follow-up with participants when not able to attend.
- Transfer accountability to participant over course of yearlong program.
### YMCA’S DPP – BY THE NUMBERS (1/31/15)

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants attending at least one session</td>
<td>28,458</td>
</tr>
<tr>
<td>Average weight loss at the end of the weekly sessions</td>
<td>4.6%</td>
</tr>
<tr>
<td>Average weight loss at the end of year</td>
<td>5.6%</td>
</tr>
<tr>
<td>Number of states delivering the program</td>
<td>43</td>
</tr>
<tr>
<td>Ys currently trained to deliver the program</td>
<td>173</td>
</tr>
<tr>
<td>Total class locations</td>
<td>1,124</td>
</tr>
<tr>
<td>514 Y sites</td>
<td>581 non-Y sites</td>
</tr>
<tr>
<td>Classes started</td>
<td>3,575</td>
</tr>
<tr>
<td>Average number of sessions attended for 4+ sessions</td>
<td>12.5</td>
</tr>
<tr>
<td>Average minutes of weekly physical activity</td>
<td>117.1</td>
</tr>
</tbody>
</table>

All numbers represent data collected to date.

1 Includes Indiana’s 392 participants from 2005 – June 2010
2 Does not include # of classes in Indiana prior to June 2010
### PARTICIPANT DETAILS

#### Average age | Age breakdown | Gender
---|---|---
56 years | 18-24 years = 0.8% | Female = 76.8%
| 25-44 years = 18.5% | Male = 23.2%
| 45-64 years = 53.4% |
| ≥65 years = 27.4% |
(n=29,381) | (n=29,381) | (n=29,381)

#### Percent low income

17.4% (n=18,423)

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#### Self-Referral Sources

- Health care provider: 26.2%
- Staff member: 11.8%
- Marketing materials: 13.3%
- Other: 10.3%
- Family/friend or word of mouth: 5.6%
- Employer: 3.9%
- Screening/testing event or health fair: 26.3%

(n=12,279)
PARTNERING WITH HEALTH CARE PROVIDERS
ESTABLISHING A ROBUST REFERRAL NETWORK EARLY ON

Who
- Health Care Providers, Systems, Other Clinical Staff
- Payors (employers/health plans)
- American Diabetes Association
- Community Coalitions focused on health
- Community Orgs (social service, rotary clubs, etc.)
- State/Local Health Dept’s & State DPP or DCPs
- Faith-based orgs
- Medical or Allied Health Societies

What

Where

When

How
FEEDBACK LOOP

• Physicians will receive a progress report on patient at onset of the program and at session 8 and 16. Report includes:
  – Attendance
  – Weight loss
  – Physical activity minutes

• Participant must consent the Y to provide this feedback
WORKING WITH REFERRAL PARTNERS

• Referral partners often provide unique access to potential program participants

• Help promote the program or provide direct referrals into program – health care providers often viewed as trusted sources of care or information by potential participants

• Offer space, screening opportunities, or connection to other stakeholders

• Health care providers are most common referral source for Ys

• Ys are encouraged to be thoughtful and intentional when engaging partners – relationships take time to build and there is not a “one size fits all” approach
HOW REFERRALS HAVE WORKED TO DATE

• Paper referral forms – where provider gives patient referral to bring to the Y or patient provides consent for provider to share their information with the Y (via paper form)

• Electronic referrals – where patient provides consent for provider to share their information with the Y (electronically)

• Electronic Medical Record system – where provider is prompted in the EMR to fill out a referral any time a patient’s blood value falls into the prediabetes range

• Prompts or Standing orders – where staff in the clinical setting are prompted to screen individuals with certain risk factors (e.g., elevated BMI) for prediabetes and share their information with the Y

• Website portals – where local Y website includes a link for your to enter secure patient referrals
THANK YOU
LET’S BREAK!
Please return at 2:45
HOW LEADING INNOVATORS ARE PAVING THE WAY: PART II
Community Centered Health Homes

Leslie Mikkelsen, MPH, RD
Managing Director
Prevention Institute
Wendy's

BEAT DIABETES
BUY 5 JR FROSTY'S FOR $1
“It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change.”

Institute of Medicine

The Spectrum of Prevention

1. Influencing Policy and Legislation
2. Changing Organizational Practices
3. Fostering Coalitions and Networks
4. Educating Providers
5. Promoting Community Education
6. Strengthening Individual Knowledge and Skills
Community-Centered Health Homes

Bridging the gap between health services and community prevention

This document was prepared by Prevention Institute with funding from the Community Clinics Initiative (a joint project of Tides and The California Endowment)

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Erica Valdivinos, BA

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Prevention Institute is a nonprofit, national center dedicated to improving community health and well-being by building momentum for effective primary prevention. Primary prevention means taking action to build resilience and to prevent problems before they occur. The Institute’s work is characterized by a strong commitment to community participation and promotion of equitable health outcomes among all social and economic groups. Since its founding in 1997, the organization has focused on injury and violence prevention, traffic safety, health disparities, nutrition and physical activity, and youth development. This, and other Prevention Institute documents, are available at no cost on our website.
Community-Oriented Primary Care
“The last time we looked in the book, the specific therapy for malnutrition was food.”

Jack Geiger, MD
A Community-Centered Health Home not only *acknowledges* that factors outside the health care system affect patient health outcomes, but also *actively participates* in improving them.
INQUIRY
Collect data on social, economic & community conditions
Aggregate prevalence data

ANALYSIS
Review health & safety trends
Identify priorities & strategies with community partners

ACTION
Coordinate activity with community partners
Advocate for community health
Mobilize patient populations
Strengthen Partnerships
Establish model organizational practices

Capacities Needed for Implementation:
Partnerships
Innovative Leadership
Dedicated & Diverse Team
Staff Training & Continuing Education
Community-Centered Health Home Model

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Asian Health Services
Inquiry

Photo courtesy of: Asian Health Services, http://www.ahschc.org/safety.htm
Analysis

Photo courtesy of: Asian Health Services, http://www.ahschc.org/safety.htm
Action

Photo courtesy of: Asian Health Services, http://www.ahschc.org/safety.htm
Action

Photo Credit: http://metes.wordpress.com/2009/01/25/diagonal-crosswalks/
Partnerships

brought together:

- Community groups
- Business owners
- City planning agencies
Identifying Priorities

Priority 1: economic development and economic equity

Priority 2: physical development in surrounding communities

Priority 3: current state of transportation development
Catalyst for Change

“An ecological system approach can more effectively address a chronic public health problem . . . health centers can function as catalysts of community and economic development. ”

- Liou and Hirota on the Revive Chinatown! campaign, as described in From Pedestrian Safety to Environmental Justice: The Evolution of a Chinatown Community Campaign
  Spring 2005
Oregon’s Health System Transformation Journey

Chris DeMars, Director of Systems Innovation Transformation Center

3/15/15
Presentation overview

- Oregon’s Health System Transformation: history and the coordinated care model
- Measuring success: CCO metrics
- Transformation Center
- Community Advisory Councils
- Lessons learned from Oregon’s work
Oregon’s health system transformation

Better health, better care and lower costs through fundamental changes that will:

- Better coordinate care at patient and financing level
- Integrate public, physical, mental and dental health
- Leverage public health strategies - recognizes that 10% of health happens in medical system
- Measure performance
- Engage people in their own health
- Pay for outcomes, not activities
- Provide clear and transparent information
Oregon’s health system transformation

• Began implementing the coordinated care model within coordinated care organizations (CCOs)
  o CCOs are networks of all types of health care providers (physical health, addictions and mental health, and dental care) who work together to serve Oregon Health Plan (Medicaid) members

• Now spreading the coordinated care model to other payers
PHASES OF OREGON’S HEALTH SYSTEM TRANSFORMATION
Oregon HST 1.0 – 2009 and beyond

2009
Oregon Health Authority (OHA) created through HB 2009. Public Health, Addictions & Mental Health, Medicaid, Public Employees Benefits Board and Oregon Educators Benefits Board under one roof.

2010
Governor Kitzhaber elected

2011
Policy: Extensive public process resulting in: HB 3650. Requires OHA to seek federal waiver and begins process for coordinated care model for Medicaid/OHP.
Policy: SB 1580 - Created coordinated care organizations for Oregon Health Plan/Medicaid clients

Policy: Federal waiver that holds Oregon to coordinated care model for Medicaid. Feds invest $1.9B in our effort.


Purchasing: Contractual standards and metrics; agreements with local public health, long-term care. Requirements for transformation plans, community health assessments and community health improvement plans.

Leadership: SB 1580 also created Transformation Center to drive innovation.

Leadership: OHA committed to transforming internally.
Oregon HST 2.0

**2013**

**Policy/Leadership:** Increase focus on prevention and moving upstream

**2013-2014**

**Policy:** Strategies to mitigate cost shift, decrease health insurance premiums and improve quality of care in private market

**2013 - ongoing**

**Policy:** Recommend strategies to move Oregon’s health insurance exchange and commercial marketplace toward coordinated care model

**2013-2015**

**Purchasing:** Incorporate coordinated care model into PEBB and OEBB contracts for public employee health benefits
Oregon’s Coordinated Care Model

- Best Practices to manage and coordinate care
- Paying for outcomes and health
- Transparency in price and quality
- Sustainable rate of growth
- Shared responsibility for health
- Measuring Performance

BETTER HEALTH
BETTER CARE
LOWER COSTS
## CCM within CCOs: before and after

<table>
<thead>
<tr>
<th>Before CCOs</th>
<th>With CCOs</th>
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<tbody>
<tr>
<td>Fragmented care</td>
<td>Coordinated, patient-centered care</td>
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<tr>
<td>Disconnected funding streams with unsustainable rates of growth</td>
<td>One global budget with a fixed rate of growth</td>
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<tr>
<td>No incentives for improving health (payment for volume, not value)</td>
<td>Metrics with incentives to improve quality and access</td>
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<tr>
<td>Health care services paid for</td>
<td>Flexible services beyond traditional medical care may be provided to improve health</td>
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<tr>
<td>Health care delivery disconnected from population health</td>
<td>Community health assessments and improvement plans</td>
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<tr>
<td>Limited community voice and local area partnerships</td>
<td>Local accountability and governance, including a community advisory council</td>
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</table>
CCOs are innovating to achieve better health and value

- Focus on chronic disease management
- Focus on comprehensive primary care and prevention
- Coordination: physical, behavioral and dental health
- Alternative payment for quality and outcomes
- Traditional health workers
- Electronic health records – information sharing
- Tele-health
- New care teams
- Use of best practices and centers of excellence
MEASURING SUCCESS
CCO Performance

OHA Accountability & CCO Incentives

State Performance Measures
- Annual assessment of statewide performance on 33 measures
- Financial penalties to the state if quality goals are not achieved

CCO Incentive Measures
- Annual assessment of CCO performance on 17 measures
- Quality pool paid to CCOs for performance
- Compare current performance against prior baseline year
CCO Incentive Measures

• Originally, Incentive Measures focused on clinical care

• New Incentive Measures focus on population health:
  o Dental sealants on permanent molars for children (2015)
  o Effective contraceptive use among women at risk of unintended pregnancy (2015)
  o Tobacco use prevalence (2016)
Early successes

Performance Report on CCO Quality Measures

- Staying within budget
- Decreased emergency department visits
- Decreased hospitalization for chronic conditions
- Increased developmental screening
- Increased primary care
Statewide, emergency department utilization has continued to decline.

(Lower scores are better)
Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 90th percentile
Statewide, patient-centered primary care home enrollment continues to increase.

Data source: CCO quarterly report
2014 benchmark source: n/a
TRANSFORMATION CENTER
Why a Transformation Center?

- The Transformation Center helps good ideas travel faster!
- OHA’s hub for health system innovation and improvement
- Goals:
  - Champion and promote transformation in partnership with CCOs, providers and communities
  - Build an effective learning network for CCOs and CAC members
  - Foster the spread of the coordinated care model beyond Medicaid to other payers
Transformation Center: areas of support

Transformation Center programs support:
• Leadership development
• Community engagement
• Clinical delivery system redesign
• Integration of care
• Health equity promotion
• Financial alignment
• Accountability and transparency
COMMUNITY ADVISORY COUNCILS & COMMUNITY HEALTH
Community Advisory Councils (CACs)

CCOs must have a CAC “to ensure that the health care needs of the consumers and the community are being addressed.”

CACs:

- Consumers (majority), community, government
- “Identify/advocate for preventive care practices”
- Oversee community health assessment and community health improvement plan to serve as “strategic guidance for the CCO to address health disparities and meet health needs for the communities in their service area(s)”
Community Health Improvement Plans: summary of priorities

• Public health/social determinants/health equity: 60% of CHIP priorities
  o Public health: maternal and child health/early childhood; chronic disease; tobacco use; obesity prevention
  o Social determinants: housing, transportation, jobs
  o Health equity: addressing disparities; cultural competency; health literacy

• Clinical: 40% of CHIP priorities
  o Mental health/substance abuse; oral health; access
INNOVATIVE CAC PROJECTS
Reducing readmissions through community partnerships

Meals on Wheels Program (PacificSource – Columbia Gorge CCO)

- **What**: new partnership with local Meals on Wheels program for all Medicaid members discharged from the hospital
- **Why**: to improve health and well-being and minimize adverse health outcomes following hospitalization through the delivery of meals
- **Outcomes**:
  - 250 meals served
  - No re-hospitalizations or infections
  - All clients satisfied; stress alleviated
Fostering health equity through the Community Health Worker model

Community health worker for Latino high school students (Malheur County CAC, Eastern Oregon CCO)

- **What**: Community health worker provides culturally and linguistically competent services and referrals to pregnant or parenting Latino adolescents in Malheur County high school
- **Why**: Community health assessment identified barriers for Latinos in accessing traditional health services (such as adolescent well-care visits)
- **Outcomes**:  
  - CHW helped a parenting teen apply for safe and affordable housing through the local community housing agency
Integrating chronic disease management in supported housing

Chronic Disease Management Programs in Supported Housing Environments (Health Share of Oregon)

- **What**: Integrate a public health nurse and Living Well classes in supported housing environments
- **Why**: Support chronic disease management where members live
- **Outcomes**:
  - Public health nurse engaged 162 clients
  - Interventions include health teaching, referral and follow-up, counseling, advocacy, screening and case management
  - Started weekly walking group
  - Made improvements to community spaces in four housing communities
Lessons learned from Oregon’s transformation journey

Importance of:

- Relationships/trust-building
- Leadership:
  - from the top
  - from stakeholders, community members, OHP members
- Financial incentives/Incentive measures
- Built-in local infrastructure
- Central hub for spread
Health System Transformation

Health.Oregon.gov

More information at:
TransformationCenter.org
CORE CONCEPTS FOR ASSET-BASED HEALTH PARTNERSHIPS & TRANSFORMATION
Integrated Health System for Achieving Triple Aim Results at Scale

- Activation Mechanism
- Community Assets
- Geographic Population with Health Issues
- Health Care Delivery System
- New Designs of Care
- Triple Aim Results for Defined Geographic Population
Three Levels of Activation:

- **Activating individuals:** Community organizing, storytelling, facilitative leadership

- **Activating organizations:** Community collaboration and governance

- **Activating communities**
  Understanding community assets, participatory decision making
A Shift From Needs-Focused Assessment

- A need is defined as a *gap or difference between a current situation and the ideal or desired situation.*
- Most needs assessments are used to identify what the gaps are within a community, how to prioritize those gaps, and how to make decisions about which needs can be addressed through a particular intervention.
- *Sounds great, right?*
Asset Based Community Development (ABCD)

- John McKnight and John Kretzman
- Built on the notion that communities have never been built on their deficiencies, rather on the capacities and assets of the people and the place.
- Does not imply ignoring problems and needs and throwing out rational, strategic planning; rather it is a rallying point for collective action.
“Can you tell us what people who live here have done together to make things better?”

Building Communities From the Inside Out, 1993
Community Asset Mapping: A Shift From Needs-Focused Approach

<table>
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<tr>
<th>Needs</th>
<th>Assets</th>
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<tr>
<td>• Focus on deficiencies</td>
<td>• Focus on strengths</td>
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<tr>
<td>• Result in fragmentation of responses to local deficiencies</td>
<td>• Build relationships among people, groups, and organizations</td>
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<tr>
<td>• Make people consumers of services; builds dependence on services</td>
<td>• Identify ways that people and organizations give of their talents and resources</td>
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<tr>
<td>• Give residents little voice in deciding how to address local concerns</td>
<td>• Empower people to be an integral part of the solution to community problems and issues</td>
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Key Elements of An Assets/Strengths-Based Approach

1. **Focus on the capacities or gifts that are present in the community**, not what is absent
2. **Stress local leadership, investment, and control** in both the planning process and the outcome
3. **Surface both formal, institutional resources** (such as programs, facilities, and financial capital) as well as individual, associational, and informal strengths and resources
4. **Seek to link the strengths and priorities of all partners**, including the people
Beginning Your Asset Mapping Effort

- **Primary Building Blocks:**
  - Assets and capacities located inside the community, largely under community control

- **Secondary Building Blocks:**
  - Assets located within the community, but largely controlled by outsiders

- **Potential Building Blocks:**
  - Resources originating outside the neighborhood, controlled by outsiders
Needs-Focused Map

McKnight & Kretzmann, 1996
Assets-Focused Map

McKnight & Kretzmann, 1996
Healthy Northeast Initiative
Quality of Life

Population
Total Population under 18
3,410 (31.8%) 10,711

Race
Black, non-Hispanic
2399 (22.4%)
Hispanic
7,815 (79.3%)
white, non-Hispanic
178 (1.7%)
Asian, non-Hispanic
49 (0.5%)
Other race
270 (2.5%)

Education & Literacy
College Graduates
5.3%
Completed HS
57.7%

Housing
Total housing units
4,658
Occupied housing units
3,840
Housing vacancy
818 (17.7%)
Eviction Hearings
548 (2012 thru Sep 12)
Zip Codes 06112 & 06120

Public Safety & Crime
Violent Crimes
193
Crimes against property
989

SOURCE: 2010 census figures
Healthy Northeast Initiative Community Asset Map
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<td>COVENTRY ST</td>
<td>HARTFORD</td>
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<td>06112</td>
<td>(860) 714-3764</td>
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<td>32</td>
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<td>SUBSTANCE ABUSE</td>
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<td>(860) 714-3760</td>
<td>MON-FRI</td>
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Beginning Your Asset Map

- Who is doing work now?
- **Who are the movers and shakers? Who gets things done?**
- How has the community met challenges or accomplished goals in the past?
- **What is the nature of social connectedness, cohesion and affiliation among neighbors (social capital)?**
- What are the prominent community values and interest groups?
- **What are the perspectives on what a healthy and thriving child /family/person is?**
- Where are the sources of community pride?
Some Lessons

- Get to know your population. Intimately.
- Understand your purpose in relation to your population; you’re going to need it.
- It’s in the telling of “war stories” that builds the will and confidence across sectors, not always in “best practice”
- Get real about self interest.
- Health Care as a Second Language “HCSL”
Some Lessons

- Ask what the organization or individual does or has now, but also what they would like to do or be prepared to offer with additional support.
- “You have one mouth and two ears, use them proportionally”
- Decisions are made by the those who show up.
- Assume that you will need to lose a bit of control for much, much more power.
Assets vs. Deficits

Assets Thinking:
- Strengths based
- How can we create community spirit?
- What can I do?
- We’re all in this together
- We’re getting there
- Work with engaged people
- People have the answers
- People control their lives

Deficit Thinking:
- Problem orientated
- How to fix this problem?
- Someone needs to sort this
- Us versus them
- Problems are embedded
- Do things to people
- People are a problem
- People can’t be trusted to make decisions or be in control
“Nothing about this community without this community.”
GROUP ACTIVITY 2
Beginning Your Asset Map

INDIVIDUAL/CAPACITY: (e.g., Movers and Shakers, Talents, Resiliency)

INSTITUTIONAL/GOVERNMENTAL: (e.g., Churches, Libraries, Schools, Transportation, Universities, Social Services)

ORGANIZATIONAL: (Third Sector, Local Small and Large Businesses, Radio/TV/Media, Associations, Community Ctrs, Networks)

SOURCES OF COMMUNITY PRIDE: (e.g., Sports Teams, Historical Events or Attractions, Cultural Events or Awards)

OTHER CAPITAL: (e.g., Publically-Available Data, Financial Capital such as Grant Funding for Programs)
Exercise: Start Your Asset Map

- Start by thinking through your Primary Building Blocks in each of the areas.
- This is just the start of your map. You’ll refine and continue with your home team.
Exercise: Start Your Stakeholder Analysis and Outreach Plan

- It is clarifying to spend some time thinking about the issue from their perspective.
- Start by listing each of the stakeholder groups or individuals and try to imagine what their interests on your issue might be.
- This is a first step: Of course, the best way to really know is to talk to them and ask them directly! But this stakeholder analysis is a first step.
PUTTING IT ALL TOGETHER: ACTION PLANNING
Putting it all together

- Final thoughts and questions
- Applying to your work
THANK YOU FOR JOINING US AND HAVE A GREAT SUMMIT!