Working in Domains 3 and 4: Population health improvement through health care systems and clinical linkages

August 26, 2013

3:00 – 4:00 pm eastern

NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

Agenda

1. Welcome & introductions – *Jeanne Alongi*
2. A national perspective on the topic – *Jim Hester*
3. Field reports – *Kirsten Aird (OR) & Robin Edelman (VT)*
4. Closing – *Jeanne Alongi*

NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

Learning Objectives

- Discuss the appropriate role of state public health departments in working with health care systems.
- Identify state examples of work with health systems to improve population health
- Find resources for further learning.

Domains III and IV

Domain 3: Health Care Systems

Improve the effective delivery and use of clinical and other preventive services in order to prevent disease, detect diseases early, and reduce or eliminate risk factors and mitigate or manage complications.

Domain 4: Community-Clinical Linkages

Ensure that communities support and clinics refer patients to programs that improve management of chronic conditions. Such interventions ensure those with or at high risk for chronic diseases have access to quality community resources to best manage their conditions or disease risk.

NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

Our Speakers

Robin Edelman

Jim Hester

Kirsten Aird

NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

A National Perspective
Jim Hester

NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

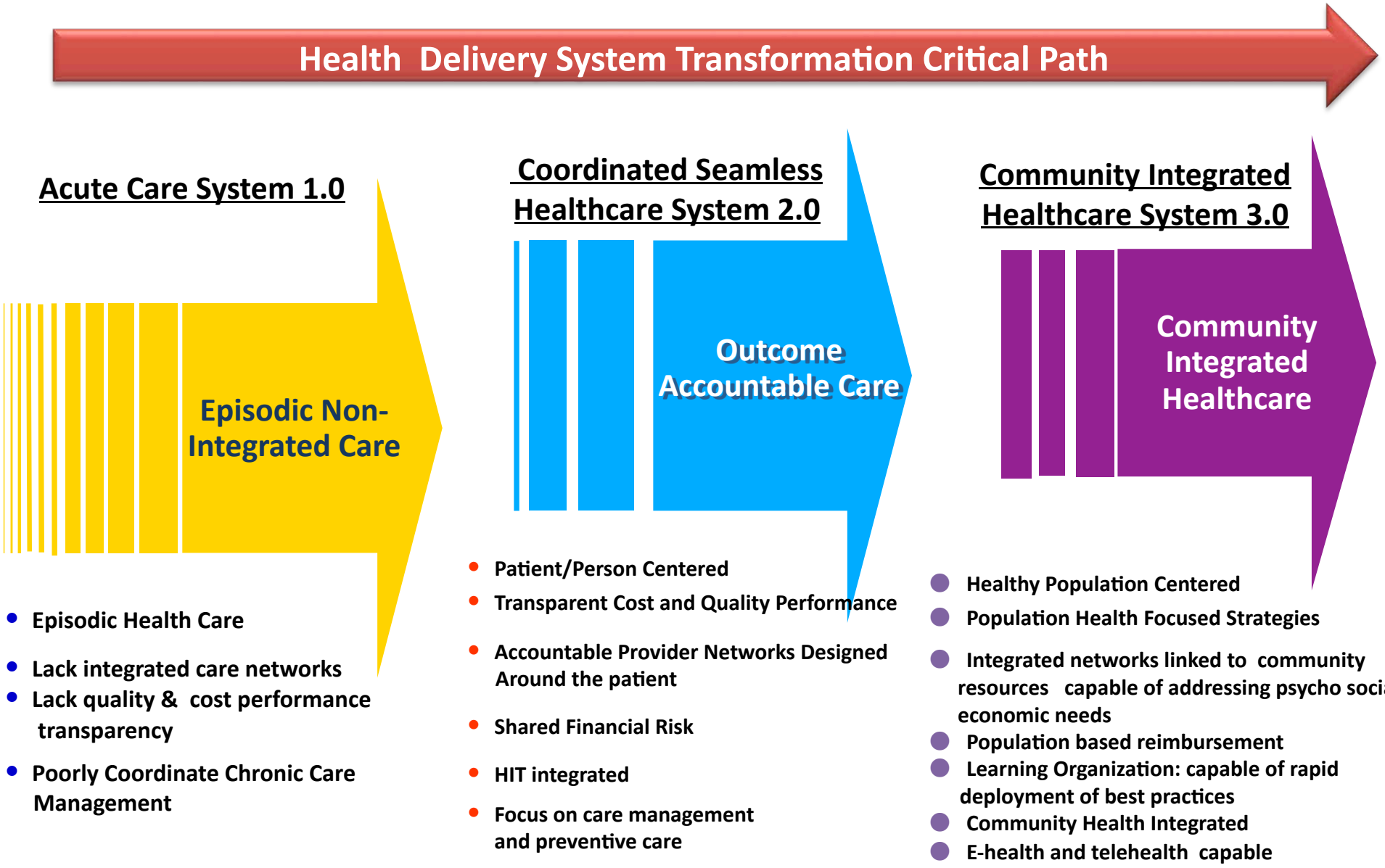
Health Care Reform and Public Health

- Health care reform has the potential for dramatic impacts on public health by
  - Coverage expansion
  - Payment reforms driving Triple Aims outcomes
  - Increased availability of electronic data from EHR's, claims data, registries etc.
- Multiple efforts to understand the opportunities and threats
  - APHA Advisory Comm. Public Health transformation
  - ASTHO: Integrating Public Health & Primary care
  - IOM Roundtable on Improving Health

Focus Today: Delivery System Transformation

- Federal: CMS Innovation Center (CMMI) Creating new building blocks for states and other stakeholders http://innovation.cms.gov/
- State: Examples of Vermont and Oregon Delivery System Reform - Assembling the building blocks

US Health Care Delivery System Evolution



Building a Community Health System

'Every system is perfectly designed to obtain the results it achieves.'

Approach

- System redesign at four levels
  1. Primary care practice level: Enhanced medical homes
  2. Community health system: 'neighborhood' for medical home, ACO's, Accountable Care Communities
  3. State/regional infrastructure and support e.g. HIT, payment reform
  4. National: CMS, CDC, ONC

The Innovation Center

ACA Charge (S 3021): Identify, Test, Evaluate, Scale

"The purpose of the Center is to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and CHIP… while preserving or enhancing the quality of care furnished."

- **Resources:** $10 billion funding for FY2011 through 2019
- **Opportunity to "scale up":** The HHS Secretary has the authority to expand successful models to the national level

Center for Medicare & Medicaid INNOVATION

Innovation Center Portfolio

NARROW FUNNEL

Primary Care Transformation

- Comprehensive Primary Care Initiative (CPC)
- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home Demonstration
- Graduate Nurse Education Demonstration

ACOs

- Medicare Shared Savings Program
- Pioneer ACO Model
- Advance Payment ACO Model
- PGP Transition Demonstration

Bundled Payment for Care Improvement

- Model1: Retrospective Acute Care
- Model 2: Retrospective Acute Care Episode & Post Acute
- Model 3: Retrospective Post Acute Care
- Model 4: Prospective Acute Care

Capacity to Spread Innovation

- Partnership for Patients
- Community-Based Care Transitions
- Million Hearts (CDC lead)
- Innovation Advisors Program

Initiatives Focused on the Medicaid Population

- Medicaid Emergency Psychiatric Demonstration
- Medicaid Incentives for Prevention of Chronic Diseases
- Strong Start Initiative

Medicare-Medicaid Enrollees

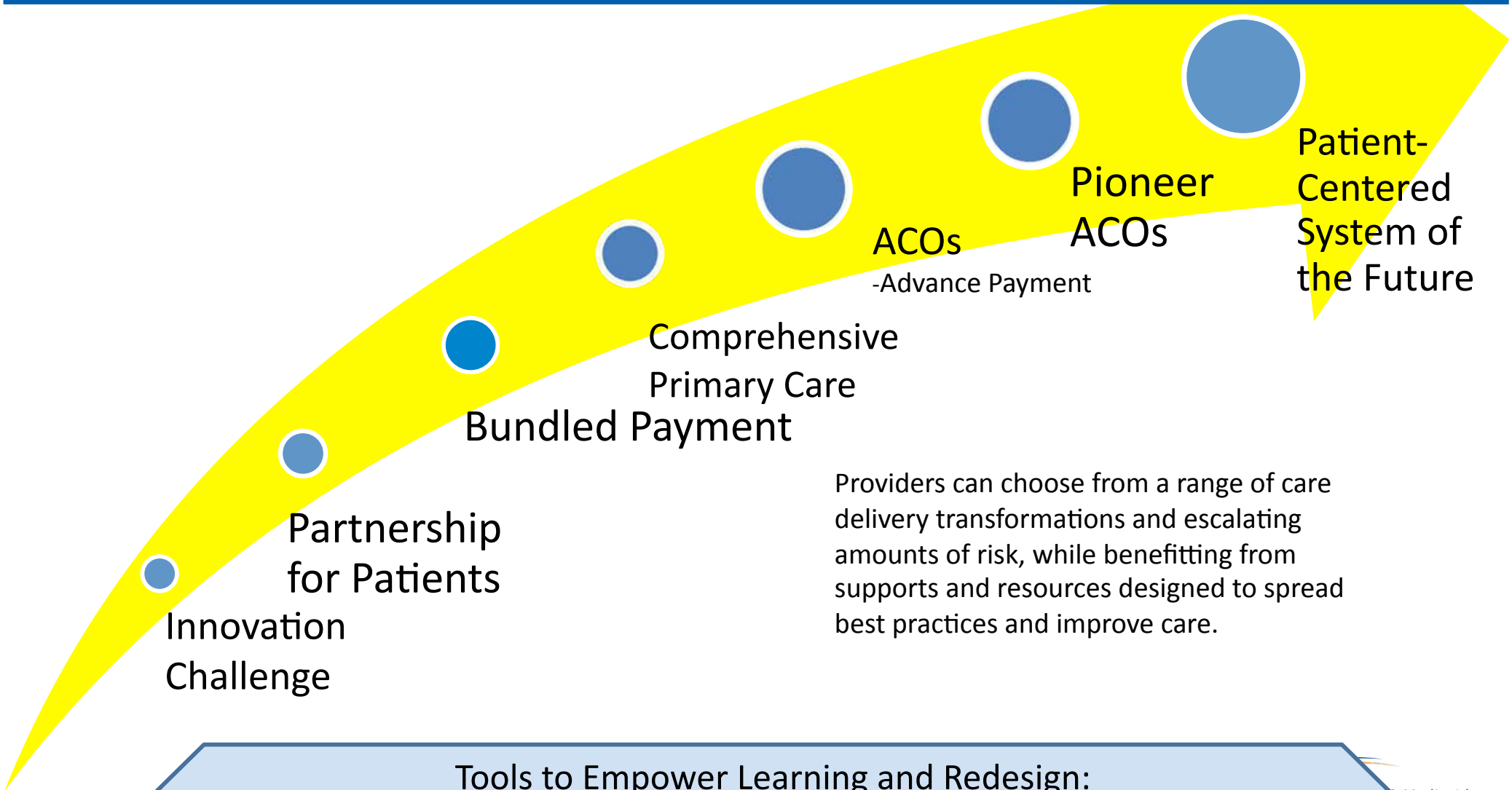
- Financial Alignment Initiative
- Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents

BROAD FUNNEL

Health Care Innovation Awards

State Innovation Models Initiative

Delivery Transformation Continuum



Providers can choose from a range of care delivery transformations and escalating amounts of risk, while benefitting from supports and resources designed to spread best practices and improve care.

Tools to Empower Learning and Redesign:
Data Sharing, Learning Networks, RECs, PCORI, Aligned Quality Standards

Measures of Success

Better health care:	Improving patients' experience of care within the Institute of Medicine's 6 domains of quality: *Safety, Effectiveness, Patient-Centeredness, Timeliness, Efficiency,* and *Equity.*
Better health:	Keeping patients well so they can do what they want to do. Increasing the overall health of populations: address behavioral risk factors; focus on preventive care.
Lower costs through Improvement:	Lowering the total cost of care while improving quality, resulting in reduced expenditures for Medicare, Medicaid, and CHIP beneficiaries.

Assembling the Building Blocks

State plays key role in creating supporting infrastructure

- Convener of public and private payers
- Evidence based interventions and goals
- Training and facilitation
- Data and information exchange

Requires new set of skills for

- Collaboration
- Financial analysis
- Learning new language and culture

Concerns

- Public health has not consistently been at the health reform table in many states
- Funding cuts have eroded key capabilities and capacity
- Potential development of duplicate capabilities by new stakeholders eg ACO's
- Need to articulate the 'business case' for functions and initiatives
  - Spotty evidence
  - New language and culture
- Need to develop stronger collaborative relationships in initiatives often led by others

Field Report: Oregon

Kirsten Aird

NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

How Governmental Public Health Can Work with Health Systems to Drive Improvement

Kirsten Aird, MPH
Interim Chronic Disease Program Manager

Center for Prevention and Health Promotion
Public Health Division

Health System Transformation in Oregon

- **Better health, better care, 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 that10% of health happens in medical system
  - Measure performance
  - Engage people in their own health
  - Pay for outcomes, not activities
  - Provide clear and transparent information

Public Health and Health System Transformation

- Important to recognize in Oregon this is not Health CARE Transformation… it is Health SYSTEM transformation.
  - Reinforces a culture of public health engagement at the onset and that the delivery system cannot do this alone.
- Public health role:
  - Data, data, data.
    - Data driven decision making
    - Community health assessments
    - Community health plans
  - Evidence-based population-health strategies outside of the health delivery system
    - Focuses on what happens when the patient leaves the clinic or hospital.

Field Report: Vermont
Robin Edelman

(Enter) DEPARTMENT (ALL CAPS)
(Enter) Division or Office (Mixed Case)

Complementary & Synergistic Attributes
In Domains 3 and 4

Community Health

- The 10 Essential Public Health Services
- Population surveillance
- Prevention Framework:
  - Assess, plan, implement, evaluate
- Patient-centered neighborhoods
- Focused on the larger concentric circles of the socio-ecological model

Clinical Health

- The Planned Care (Chronic Care) Model
- Patient panel management
- PDSA cycles for QI:
  - Plan, do, study, act
- Patient-centered medical homes
- Focused on the smaller concentric circles of the socio-ecological model

A Learning Collaborative from 2 Perspectives

Why Asthma? Public Health

- Current asthma prevalence in VT is 11% for adults
- Vermont asthma prevalence is ~ 2% higher than national average
- Adults in VT with asthma report:
  - Well controlled: 29%
  - Not well controlled: 56%
  - Poorly controlled: 15%

  (VT Asthma Callback Survey, 2008-10)

Why Asthma? Clinical

- 52% of people in VT with asthma had no routine asthma visit in past year
- 32% of adults with asthma report ever having an asthma action plan

  (VT Asthma Callback Survey, 2008-10)

Panel Discussion

Robin Edelman

Jim Hester

Kirsten Aird

NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

Questions

Please enter your questions into the chat box

NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

Thank you for attending!

For more information…

- www.chronicdisease.org/?page=CDD_D3&4

- Jeanne Alongi
  jalongi@chronicdisease.org
  916-452-2440 (pacific time zone)

NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.