

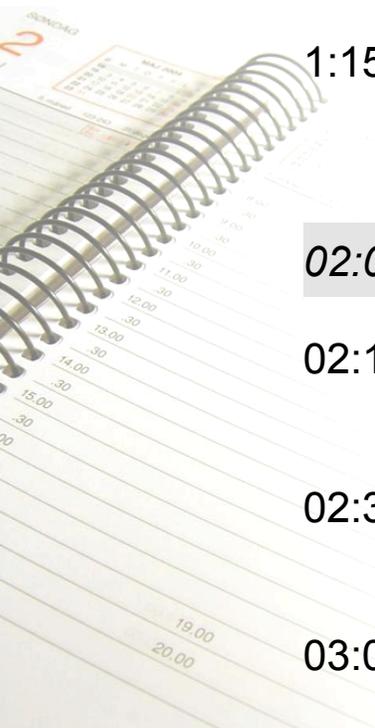
HIP: Population health work group – session 1

Discussion document

November 17th, 2015

November 17th Agenda: Population Health

Work group 1



Time	Session description	Led by	Session type
1:00-1:15	Introduction, overview, and timeline	Secretary Murphy	Presentation
1:15-2:00	Examples of population health innovation initiatives	Dr. Hacker	Facilitated discussion
02:00-02:10	<i>Break</i>		
02:10-02:30	Population health priority areas	Dr. Robinson	Presentation
02:30-03:00	Population health priority Breakout		Breakout groups
03:00-03:45	Population health and value-based payment	Dr. Hacker	Presentation and facilitated discussion
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Goal of work group session 1 is to provide input and align on principles



Purpose/principles

- Gather input from multiple stakeholders with the objective of building a plan with the highest likelihood of success
- Collaborate with stakeholders across the state to align around a set of guiding principles
- Share informed view of what initiatives (led by stakeholders or the Commonwealth) are happening in PA and across the country

Session 1

Provide input and align on principles

Session 2

Test preliminary strategy

Session 3

Refine strategy and identify interdependencies across broader plan

Charter: HIP Population Health Work Group

Group Title: Population Health	Chairs: Dr. Karen Hacker and Dr. Loren Robinson
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Problem statement:

- Population health is a key component of the Health Innovation in Pennsylvania (HIP) planning efforts.
- The Department’s recent State Health Assessment (SHA) and State Health Improvement Plan (SHIP) identified pressing population health concerns, including the priority areas HIP will address: childhood obesity/physical inactivity, diabetes (type 2), oral health, substance abuse, and tobacco use. These priorities will be tackled through a variety of policy levers and patient-provider engagement strategies.
- The Affordable Care Act allows for alignment of public health and health care delivery through the development of a shared agenda.

Mandate for this group:

- Develop tactics and metrics to further the defined population health strategic priorities
- Explore organizations that will lead the efforts into implementation
- Explore strategic deployment of population health resources
- Explore funding opportunities for implementation efforts

Types of decisions to provide input on for the Population Health Plan:

- Determine implementation tactics for the population health priorities, including programmatic, policy, and resource allocation strategies
- Develop metrics to measure health outcomes
- Define regional and county coalitions and/or task forces that will help implement a variety of strategies at the community level
- Identify potential funding opportunities

Participation expectations:

- Communicate updates from work group discussions within your organization and collect feedback to share with the group
- We ask for your commitment and attendance (either virtually or in-person) at all work group meetings.
 - November 5, 2015**– Kick off webinar from 3:00 – 4:00 PM
 - November 17, 2015**- First work group meeting (Harrisburg): Review group charge and priorities
 - January 2016**- Second work group meeting: Review / input on draft model design options
 - March 2016**- Third work group meeting: Review / input on full draft of Population Health Plan
 - Ad hoc meetings as appropriate to move the plan towards completion

Milestones for HIP

July
Stakeholder engagement kickoff at NGA

Nov

- *Webinar briefing for work group members*
- *Work Groups Session 1: Input*

Jan
Catalyst for Payment Reform payer survey

March
Work Groups Session 3: Refine

May
Submit HIP plan to CMMI



2015

2016

Jan
Work Groups Session 2: Test

End of Jan / Feb
Draft (outline) of full HIP plan complete

Summer
Launch payment model according to implementation plan

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Allegheny County Health Department-Live Well Allegheny



Organization: ACHD
Start date: January 2013
Number of communities: 20, 2 schools

Lead: Karen Hacker, MD MPH
Initiative status: Ongoing
Number of patients: N/A

Goals

- A campaign that uses a health in all policies approach to improve the health of AC residents in all 130 municipalities; particular focus on obesity/poor nutrition, physical inactivity and smoking

What we did

- Created criteria of evidence-based practices for communities, schools, and restaurants to gain live well status
- Held first Allegheny Quits for Life week of events
- Provide website and resources to communities including events
- Engage in events across the county

Results / impact

- 20 communities gain live well status
- 2 school districts gain live well status

Lessons for the state

- Community-based initiatives can be used to engage local municipal and county leadership and contribute to health at the community level. Strategies range from trails to bike paths, to employee wellness programs.

Organization: Temple University Health System

Start date: 2012

Number of providers: 74 (Primary Care) 417 (Specialty)

Lead: Jeff Slocum

Initiative status: Suspended

Number of patients: 2427

Goals

- Decrease all-cause 30-day readmission rates
- Decrease 30-day post-discharge ED visit rates
- Increase 7- and 14-day post-discharge physician follow-up visits
- Increase coordination of care and create partnerships with community providers and agencies

What we did

- We participated in the Community-based Care Transitions Program (CTTP) funded by a CMMI grant by partnering with the Philadelphia Corporation for Aging and Einstein Medical Center. The program utilized our existing Community Health Workers (CHWs) and Office of Aging social workers in a “Bridge Model” transitional care program. Patients received a combination of coordinated interventions, including inpatient visits, community visits, and post-discharge follow-up calls. All patients enrolled in the program received a home care visit within 48 hours and a physician follow-up appointment within 14 days of discharge. The CHWs and Bridge coordinators worked to assure patient compliance with hospital discharge instructions and follow-up appointments.



Results/impact

- The program resulted in a positive impact on all goals:
 - All-cause 30-day readmission rates fell from 25.2% to 15.9%.
 - The 30-day post-discharge hospital emergency department visit rate fell from 14.5% to 11.7%.
 - Seven and 14-day post-discharge physician follow-up visit rates increased from 23.3% to 31.9% and 39.4% to 51.2%, respectively.
- In addition, community partnerships and coordinated care protocols and processes were implemented. The result included improved communication and the ability to address non-medical needs (e.g., transportation, food, housing and other services).

Lessons for the state

- **Lesson #1:** Coordinated care transitions adequately resourced with medical and non-medical personnel are successful in achieving the goals of the Triple Aim and population health.
- **Lesson #2:** The funding is transient but should be permanent. The program was a success, and although it was funded for a third year, our convener and partner is no longer able to participate, so the funding has been discontinued.
- **Lesson #3:** Without the funding, the vulnerable population which we serve may not have access to coordinated care transitions and will revert back to utilization of high-cost care more frequently to meet their needs.
- **Lesson #4:** The grant covered only Medicare FFS patients and we need to capture all patients regardless of payer, in order to create a sustainable impact on the goals for achieving the Triple Aim.

Organization: Lancaster General Health

Start date: 2011

Number of providers:

Lead: Jeff Martin, MD

Initiative status: Ongoing

Number of patients: 200+

Goals

- To provide medical, behavioral health, and socioeconomic services to chronically ill and complex patients who consume disproportionate amounts of care and spend

What we did

- LG Health operates the program in conjunction with Lancaster County Human Services and with support from the PA Department of Public Welfare. The program supports an interdisciplinary team of professionals who closely coordinate care and engage the patients. Patients typically remain in the program for about six months. At that point, their medical issues have been stabilized and they have learned how to navigate the health care system and be accountable for their care.

Results/impact

- Since 2011, Care Connections has enrolled more than 200 patients. About 51 percent have been male; 49 percent have been female. Sixty-one percent of patients who engage in the program subsequently graduate from Care Connections and return to their original PCP office. Of Care Connections graduates, inpatient hospitalizations have decreased 66 percent and emergency room visits have decreased 33 percent. The number of patient days in the hospital has decreased 80 percent, meaning patients stay for shorter times when they are admitted to the hospital. Patients also are more engaged in their care. More than half of Care Connections patients have enrolled in the electronic health record patient portal and actively use the website for communication, refills, and education. In a small 90-day trial of the use of patient engagement tools, more than 70 percent of patients signed up for text message health reminders. Post-intervention medication adherence rates significantly increased. One managed Medicaid payer's analysis showed that in a small subgroup of patients, total spend per month per member went from \$2,550 pre-Care Connections to \$1,760 post-Care Connections.

Lessons for the state

- Although LG Health deploys community-based programs, there is a distinct subset of high medical, behavioral, and social risk patients that consume disproportionate amounts of care and spend. Care Connections has learned that integration with the community is crucial to the program's success. This work has been driven by relationship building and outreach. The team collaborates with organizations within the medical community as well as those outside, such as transportation agencies and food banks, to leverage support for patients.

Keystone Rural Health Center

Organization: Keystone Rural Health Center

Start date: April 2015

Number of providers: 16

Lead: Dr. Mike Colli

Initiative status: Ongoing

Number of patients:

Goals

- Cervical Cancer Screening at family medicine and internal medicine 2014 rate was 57.8%.
- The current rate November 2015 is 67.8%.
- Healthy People 2020 recommends screening rate of 93%.

What we did

- Keystone did PDSA cycle which included training, educating, and empowering nurses at family medicine and internal medicine clinics to improve cervical screening rates. The nurses did the following: (1) They revised and updated care guidelines and enhanced standing orders.
- Since the implementation, the screening rates are up, and hopefully they will continue to rise as time goes by.

Results/impact

- The strategy was successful in that we have gone from a screening rate of 57.8% to 67.8% in less than a year.
- This nursing group continues to meet and have added additional revisions to care guidelines and standing orders. Nurses are working at the top of their license and are excited to be in charge of this process.

Lessons for the state

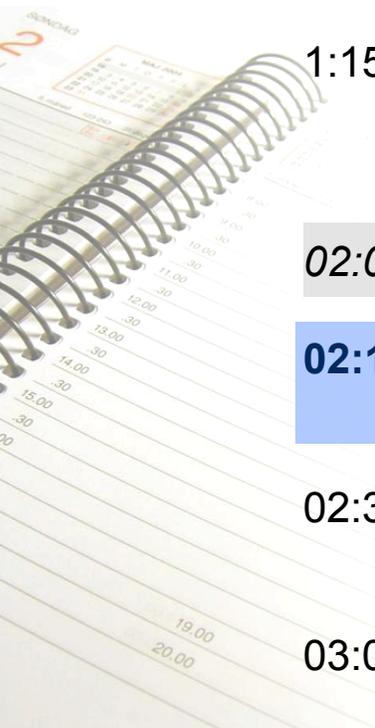
- Change can come from all levels of the organization. The key is to get everyone to take ownership in the process.

Discussion questions

- Which pilots / initiatives are you currently implementing in PA?
- What are the biggest priorities for population health in PA?
- Which stakeholders should be involved?

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Sustained vision for improving population health

- Population health improvement is one of the Center for Medicare & Medicaid Innovation's three State Innovation Models (SIM) Initiative focus areas (others are transforming delivery systems and decreasing per capita spending)
- All should align rather than be three separate activities
- SIM aims to integrate the three focus areas to meaningfully address them in an integrated way
- By focusing on improving population health in the context of payment and delivery reform it will:
 - Advance population health as part of overall health system transformation efforts
 - Maximize the impact of various state and local activities on population health, quality of care, and health care costs through better alignment and coordination

1: Traditional Clinical Approaches



2: Innovative Patient-Centered Care



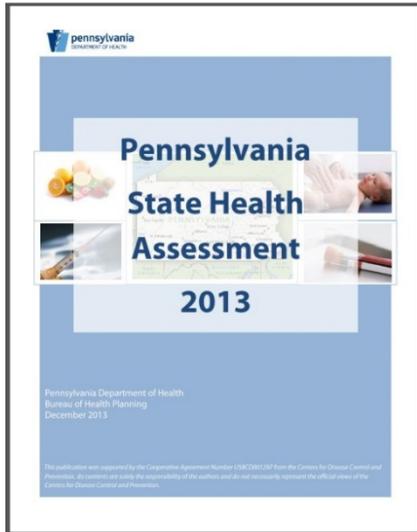
3: Community-Wide Health



What is the SHA and SHIP?

State Health Assessment (SHA):

A systematic approach to collecting, analyzing, and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve the public's health.



State Health Improvement Plan (SHIP):

A long-term systematic plan to address issues identified in the SHA. A SHIP describes how the state health department and the communities it serves will work together to improve the health of the population.



SOURCE: Health Resources in Action, 2015.

Aligning health priorities

- Education and outreach are our priorities
- Pennsylvania communities struggle with high rates of tobacco use, unhealthy eating and inactivity, poor oral health, and high rates of drug-associated deaths
- Opportunity for changes in policy and regulation



Priority	Pennsylvania (National findings)	Pennsylvania (State Health Assessment)	Healthy People 2020 Goal (based on 2008 rates)
Obesity	30.2% of adults were obese in 2014	29% of adults were obese in 2011	Reduce the proportion of adults who are obese from 33.9% to 30.5%
Diabetes	For every 1,000 adults in PA, 7.8 were newly diagnosed with diabetes in 2013	In 2010, 19.6 per 100,000 population deaths were attributed to diabetes	Reduce the annual number of new cases of diagnosed diabetes from 8.0 to 7.2 new cases per 1,000 population
Substance abuse	In 2010, 15.3 per 100,000 people had a drug-associated death	--	Reduce drug-associated deaths from 12.6 to 11.3 deaths per 100,000 population
Oral health	In 2012, 54.6% of people were served by public water systems that are fluoridated	72.3% of adults reported visiting a dentist or dental clinic in the past year in 2010	Increase the proportion of the U.S. population served by community water systems from 72.4 to 79.6%
Smoking	21.0% of adult residents are current smokers	In 2011, 22.4% of adults smoked cigarettes in the past 30 days	Reduce proportion of adults who are cigarette smokers from 20.6 to 12.0%

SHIP and SHA priorities inform the 5 CHIP Priorities

SHIP priorities +

Three health priority areas defined:

- ✓ Behavioral / mental health for adults and children, drug and alcohol abuse by adults
- ✓ Obesity, physical inactivity, and nutrition
- ✓ Primary care, preventive screenings

SHA priorities +

Major Risk and Protective Factors

- ✓ Tobacco use and exposure
- ✓ Obesity and overweight, physical activity
- ✓ Alcohol and drugs
- ✓ Oral health

Chronic Diseases

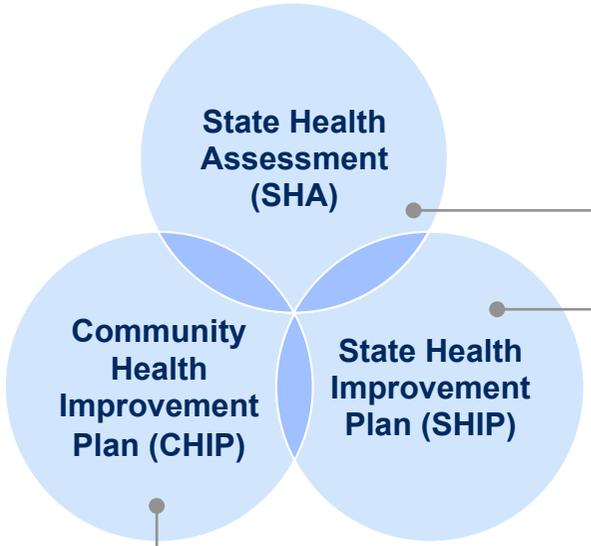
- ✓ Diabetes

CHIP Priorities

- 1 Childhood obesity / physical inactivity
- 2 Diabetes prevention and self-management
- 3 Oral health
- 4 Substance abuse
- 5 Tobacco use

Population Health Plan for Innovation

Integration of SHA, SHIP, and CHIP



Population Health Priority

Childhood Obesity/ physical Inactivity	Diabetes	Oral Health	Substance Abuse	Tobacco Use
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Communities chose their own areas of priority (local perspective)

Defining priorities

- Leverage the findings of the State Health Assessment (SHA), State Health Improvement Plan (SHIP), and local community health needs assessments (CHNAs) to identify priority initiatives
- Engage the CDC and a regionally-representative Population Health Work Group to strategically deploy evidence-based resources that will directly impact population health
- Priorities:
 - Childhood obesity / Physical inactivity
 - Diabetes prevention and self-management
 - Oral health
 - Substance abuse
 - Tobacco use
- These health priorities are all risk factors for the leading causes of death – heart disease and stroke



Childhood obesity / Physical inactivity Policy

SHA

- In an effort to combat childhood obesity across the Commonwealth, the DOH will leverage community partnerships and policy work already underway to determine the feasibility of gaining more time within a child's school day to promote physical activity.
- Methods include:
 - Collaborating with the Department of Education on the feasibility of legislatively mandated regular recess periods (i.e., 60 minutes per week)
 - Piloting integration of in-school activity breaks (i.e., 3-5 minutes during class time)



Diabetes prevention and self-management

Programmatic and provider-led

SHA

- Expand upon diabetes prevention and self-management activities already underway by:
 - Reviewing evidence-based programs occurring within the Commonwealth as well as nationally for models of care
 - Looking at combined diet and physical activity promotion programs aimed at preventing type 2 diabetes among people who are at increased risk of the disease
 - Using the following:
 - Trained providers in clinical or community settings who work directly with program participants for at least 3 months
 - A combination of counseling, coaching, and extended support
 - Multiple sessions related to diet and physical activity, delivered in-person, or through other methods



Oral health promotion

Policy and provider-led

SHA

SHIP

- Promote oral health for children (i.e., preventing childhood dental caries) by:
 - Partnering with oral health advocacy agencies to review the feasibility of policy and / or legislation around water fluoridation
 - Promoting oral health assessments and dental sealant applications in children ages 1-3 by:
 - Pediatric dentists
 - Pediatricians
 - Family medicine physicians



- Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP) established a comprehensive PDMP within the DOH
- Major Purposes:
 1. Alert medical professionals to patient's prescription history and refer to treatment when necessary
 2. Allow patients to obtain a record of their controlled substance prescriptions
 3. Aid regulator and law enforcement agencies in the detection and prevention of fraud, drug abuse, and the criminal diversion of controlled substances
- Strategies will include:
 - Promote public education and awareness for preventing prescription drug and opioid misuse, abuse, and overdose
 - Reduce access to prescription drugs for misuse and abuse

Tobacco use

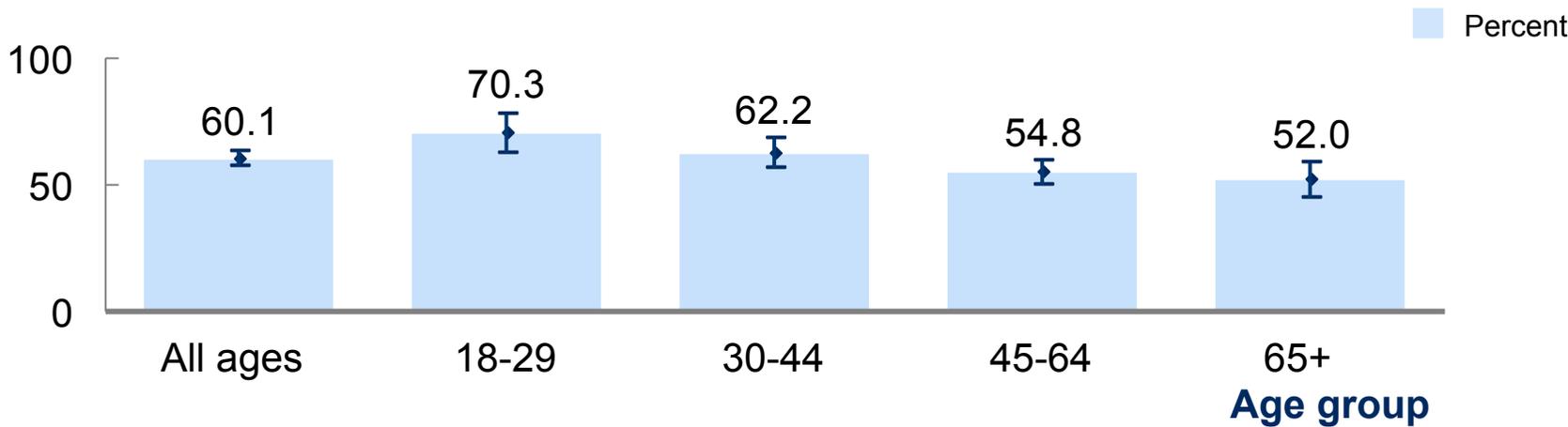
Programmatic, policy and provider-led

SHA

SHIP

- Expand upon tobacco control efforts already underway by targeting women ages 18 to 44 and pregnant women who smoke during pregnancy
- This will be accomplished through the following:
 - Implementing a communication/media campaign utilizing a mixed methodology approach targeting Pennsylvania residents
 - Collaborating with health care providers to increase referrals to the quitline
 - Review of The Clean Indoor Act, Act 27 of 2008

Percent of Smokers Attempting to Quit by Age Group Pennsylvania 2014 BRFSS, %



Population health priority Breakout - Discussion questions

- How do we operationalize the proposed strategies regionally and locally?
- What do you see as barriers and assets to implementation?
- What local policy levers can help support implementation?
- How do we best engage community stakeholders?
- Are there programmatic examples that have been particularly successful in these health priority areas?
- How would you anticipate strategic deployment of resources?

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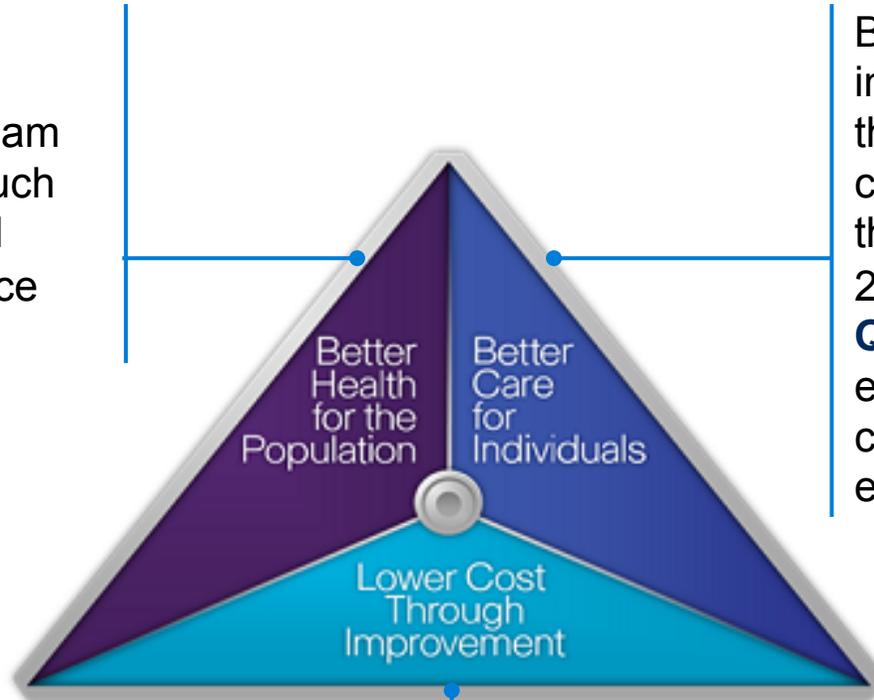
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“Triple Aim”

Better **health for populations**, through addressing “the upstream causes of ill health,” such as poor nutrition, physical inactivity, and substance abuse.



Better **quality of care** for individuals, described by the six dimensions of health care performance listed in the Institute of Medicine’s 2001 report “**Crossing the Quality Chasm**”: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.

Reducing per capita costs
(Don Berwick & IHI)

Payment reform: “Value-based reimbursement”

- Payment that rewards value; value-based reimbursement
- Payment that rewards quality
- Providers who are organized as accountable care organizations to share in cost savings
- Bundled payments
- Global payment with various risk-sharing arrangements
- Cost-sharing arrangements



Definitions of population health

Population served by an individual provider	<ul style="list-style-type: none">▪ Patients assigned to primary care provider
Population served by the entire delivery system	<ul style="list-style-type: none">▪ Primary care patients
Population residing in the broader community	<ul style="list-style-type: none">▪ Geographic area

Differing views of population health

Health Delivery (Clinical View)

- Panel of patients
 - High-risk patients
 - Patients with specific conditions or utilization
-

Public Health View

- Defined by geography
- Indicators are community indicators
- Population within geography may change over time

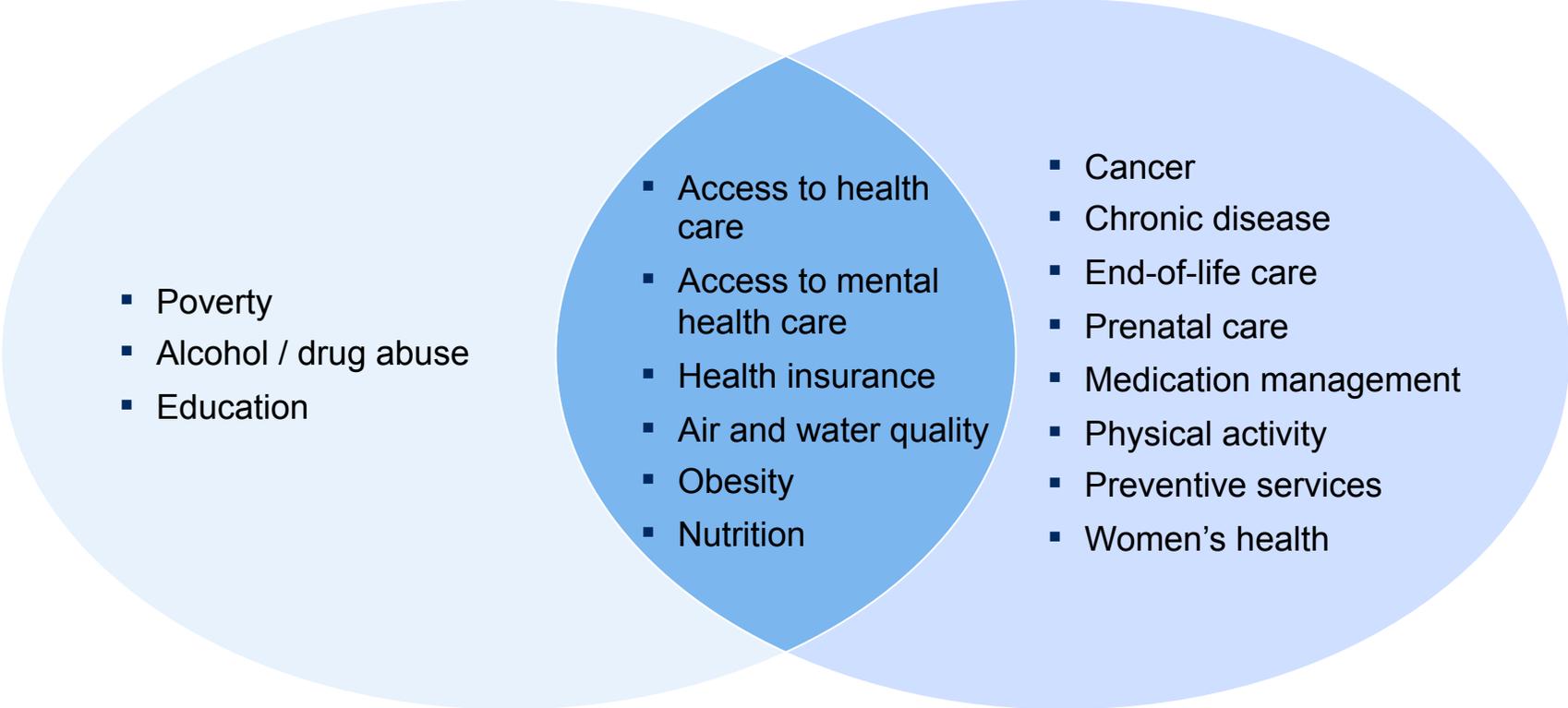
Hospital needs assessment

- Non-profit hospitals mandated every 3 years to maintain 501c3 status
- Garner input from the broader community, including public health experts
- Hospitals must describe how they are addressing needs identified and also needs not being addressed with explanation as to why not
- CHNAs must be made widely available, including through information on form 990s

Community health concerns

Health Indicators Survey (Allegheny County residents)

Community Health Needs Assessment (Not-for-profit hospitals)



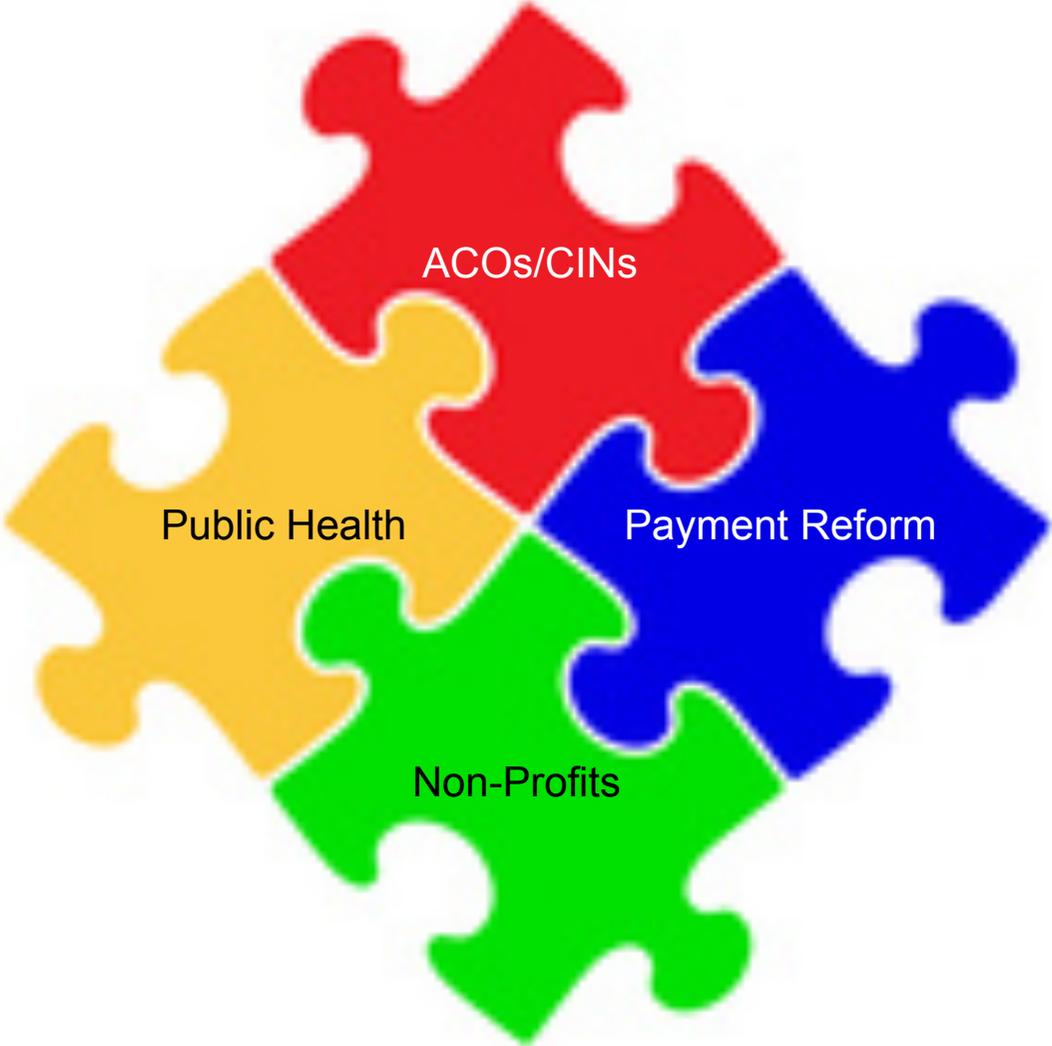
- Poverty
- Alcohol / drug abuse
- Education

- Access to health care
- Access to mental health care
- Health insurance
- Air and water quality
- Obesity
- Nutrition

- Cancer
- Chronic disease
- End-of-life care
- Prenatal care
- Medication management
- Physical activity
- Preventive services
- Women's health

SOURCE: Allegheny County Health Department Health Indicator Survey, 2014
Non-Profit Hospital Community Needs Health Assessment

Population health



What public health can do

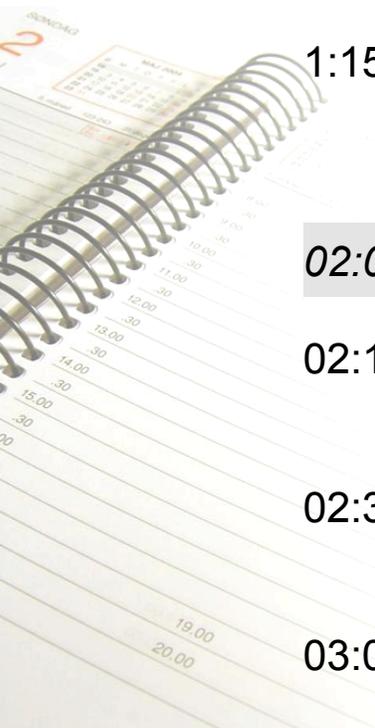
- Meet and align with health delivery systems
- Provide the following to joint efforts
 - Collect and provide data at the community level
 - Effective, scalable interventions with potentially large impact on population health
- Participate in collective and focused efforts
 - Identify optimal strategies at all levels across all sectors
 - Rally resources and partnerships
 - Communicate about successes / challenges along the way
 - Accelerate efforts to make measurable impact on health

What is the best approach to link public health outcomes to payment reform?



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Next steps

- Participate in follow-up webinars/calls
- Meet in January for work group session 2 to test preliminary strategic plan
- Continue to provide input on payment model strategic plan; preliminary draft to be shared prior to work group session 2

Questions

