Building a Prevention Framework

Public Health - Health Care Delivery System Partnership

May 29, 2014

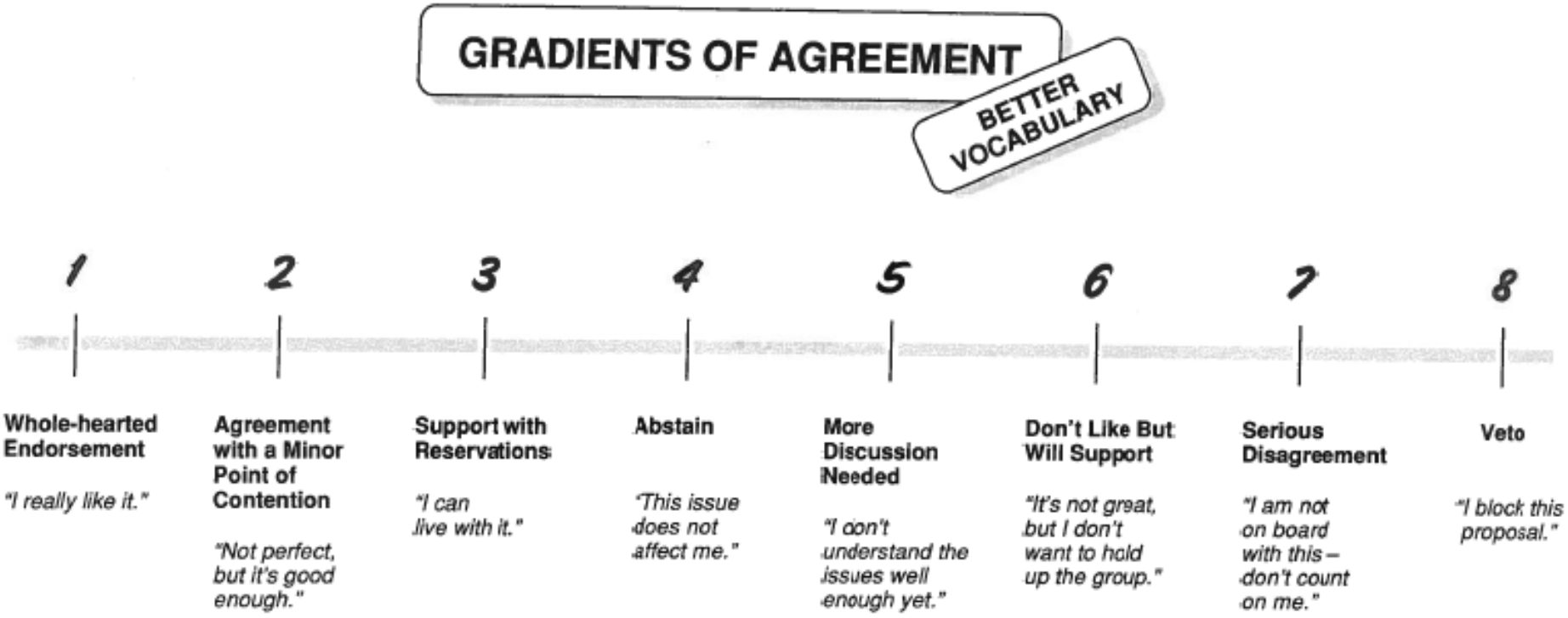
Meeting Objectives

- Come to general agreement on the Foundational Prevention Framework Elements
  (Objectives, Strategies and Priority Areas)
- Come to general agreement of the contents of the Prevention Framework Document
- Review, understand and discuss Foundational Prevention Framework Actions and Measures
- Review and assess alignment of Prevention Framework materials with recent CMMI State Innovation Model Round 2 Funding Opportunity Announcement

Meeting Agenda

- Review Agenda and Meeting Objectives
- Trajectory Review
  - Review Prevention Framework Document and homework results
  - Finalize objectives, strategies and priorities
- High Level review of the CMMI State Innovation Model Funding Announcement
- Small group discussion-Foundational Building Blocks
- *Prevention Framework Prioritized Sequence of Actions* exercise
- Discuss Next Steps

Gradients of Agreement



Prevention Framework Development Trajectory

KEEP IN MIND

- On-going State Health Care Innovation Plan Implementation
- Executive Management Advisory Council Culture Building
- Innovation Legislation: 2572 and 6312
- Funding Opportunity Announcement
- Many other efforts…

February 27, 2014

- Grounding
- Scope
- Definition and purpose
- Priority areas

Homework and participant outreach

March 27, 2014

- Finalize definition and purpose
- Establish principles, goal and objectives
- Review example:
- Broach Strategies

Homework and participant outreach

April 21, 2014

- Finalize principles, goal and objectives
- Review data and decision making criteria
- Agree to initial priority areas
- Discuss draft strategies

Homework and participant outreach

May 29, 2014

- Establish high level recommendations
- Finalize I PF elements
- Discuss measures
- Discuss organizational commitments and next steps

Homework and participant outreach

July 21, 2014

- Provide recommendations to leadership
- Establish next steps and activation of Partnership

- Recommendations brought to EMAC
- Inform ACH
- Process
- Inform SIM 2
- Activate state, regional and local partners
- Continue work?

Dorothy Teeter and John Weisman present to review recommendations

Review of April 21st Meeting

- View and discuss *Culture of Health* video
- Finalize vision, goal, principles
- Discuss strategies and agree for staff to further refinement
- Data discussion with Juliet VanEenwyk
- Priority discussion
  - Clear agreement on Healthy Eating, Active Living and Obesity Prevention, Diabetes, Mental Well Being, Substance Abuse and Use (tobacco), and ACEs

Blueprint: Framework Elements

- Vision
- Principles
- Goal
- Objectives
- Strategies
- Actions steps
  - Recommendations
- Measures

Objectives

1. Reduce the prevalence and incidence of preventable health conditions at all stages of life through effective primary prevention and screening
2. Increase the number of people with improved physical and behavioral health outcomes through engagement in an integrated system with adequate supports and coordination
3. Increase sustainable healthy physical and social environments that promote health and health equity

Strategies

- Reorient health and other systems to improve health, quality, reduce cost and improve experiences for both people and providers
- Reform payment and benefit design to incentivize prevention and health improvement
- Foster and engage people, communities and systems in health promotion activities that enable them to exercise control over their health and environments

Priorities

Prevention and Management of Chronic Disease and Behavioral Health Issues

- *Short Term Focus:* Cardiovascular Disease and Diabetes
- *Long Term Focus:* Healthy Eating, Active Living, Obesity Prevention
- *Short Term Focus:* Mental Illness, Substance Abuse/Use (Tobacco Use)
- *Long Term Focus:* Adverse Childhood Experiences

CMMI SIM Round 2 Testing Grant

- **Must address three focus areas:**
  1) Improving Population Health
  2) Transforming Health Care Deliver Systems
  3) Decreasing Per Capita Total Health Care Spending
- **Due:**
  July 21, 2014
- **Announcement date:**
  October 31, 2014
- **Grant time period:**
  Jan 1, 2015 to Dec 31, 2018
- **Amount of funds:**
  $20 million to 100 million per state for up to 12 states

Round 2 Design and Testing Grant Requirements

- Plan for Population Health
- Health Care Delivery System Transformation Plan
- Payment and/or Service Delivery Model
- Leveraging Regulatory Authority
- Health Information Technology
- Stakeholder Engagement
- Quality Measure Alignment
- Monitoring and Evaluation Plan
- Budget
- Operational Plan

Homework

- Partnership Survey and Subject Matter Experts Recommendations:
  - Request for specific information on key actions to address objectives and strategies
  - Systems supports

- Data group
  - Two phone meetings

Homework Compilation

Three general themes:

- Some information brought forward already in the *State Health Care Innovation Plan*
- Recommendations built on State Health Care Innovation Plan Building Blocks
  - We have named 'Prevention Enhancement recommendations'
- Recommendations directly related to the Prevention Framework objectives and strategies through a lens of our priority areas

01 Build a culture of robust quality and price transparency

02 Activate and engage individuals and families in their health

03 Regionalize transformation efforts

04 Create Accountable Communities of Health

05 Leverage and align state data capabilities

06 Provide practice transformation support

07 Increase workforce capacity and flexibility

STATE HEALTH CARE INNOVATION PLAN

1. Drive value-based purchasing across the community, starting with the State as 'first mover'
2. Improve health overall by building healthy communities and people through prevention and early mitigation of disease throughout the life course
3. Improve chronic illness care through better integration of care and social supports, particularly for individuals with physical and behavioral co-morbidities

PREVENTION ENHACEMENT RECOMMENDATIONS

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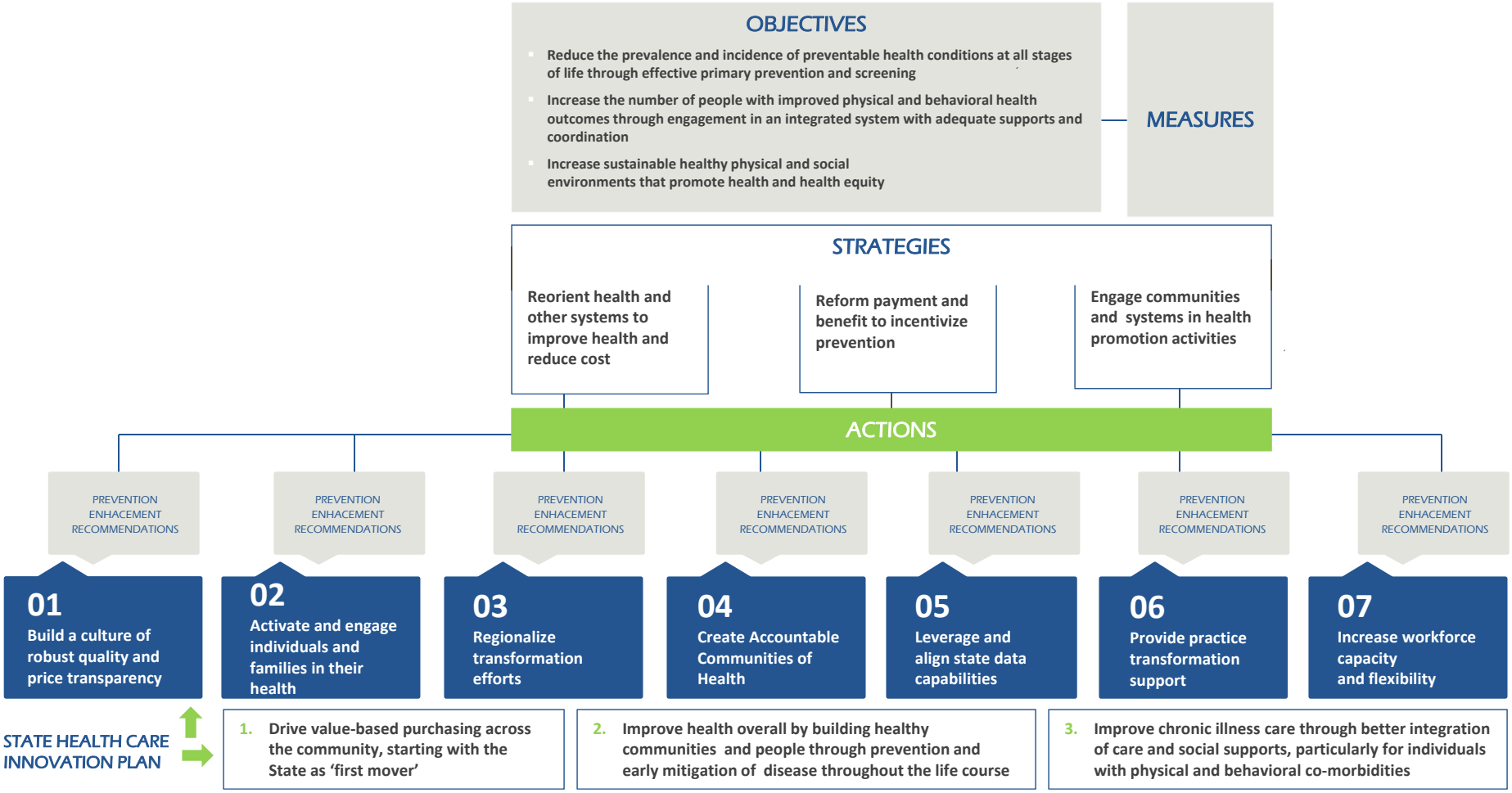
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Reform payment and benefit to incentivize prevention
Engage communities and systems in health promotion activities
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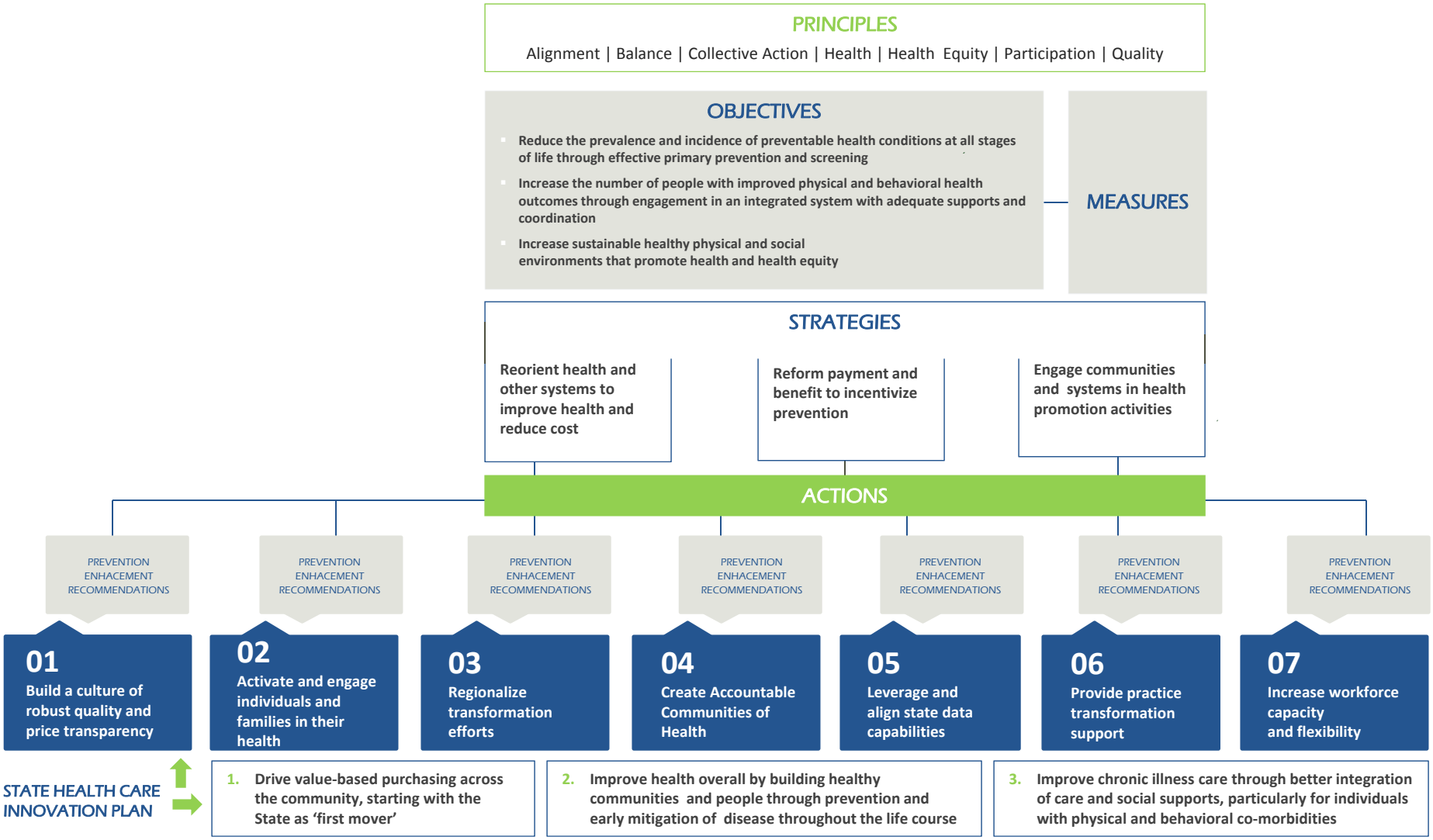
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Alignment | Balance | Collective Action | Health | Health Equity | Participation | Quality
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GOAL

The people of Washington will be healthier at every stage of life

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Washington Prevention Framework

Improve the health of Washingtonians through intentional linkages between public health, health service delivery, and systems influencing the social determinants of health

VISION

The people of Washington embrace and sustain a culture of health

GOAL

The people of Washington will be healthier at every stage of life

PRINCIPLES

Alignment | Balance | Collective Action | Health | Health Equity | Participation | Quality

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Foundational Building Blocks

- Prevention Framework Partnership provides recommendations for prevention performance measures
- Price and quality data will be available at a ACH level
- ACH will be held accountable for improvement
- Performance management system should encompass an overall eye to improving the health of the population with a focus on underrepresented populations and geography
- PCMH recognition will be standardized

01
Build a culture of robust quality and price transparency

- Assure materials and engagement strategies are culturally appropriate
- Build and support a statewide health literacy campaign
- Utilize flexible payment methods through contracting, legislative/budget, and/or waiver request , and creative investment funding mechanisms
- PCMH recognition will be standardized
- Shared decision making aids should be in alignment with the focus areas of the Prevention Framework. Decision aids prioritized to mental illness, CVD, diabetes, etc.

02
Activate and engage individuals and families in their health and health care

- Once regions are established Executive Management Advisory Council agency members commit to aligning (where possible) their regional services and programs
- Local needs and priorities from the Community Health Improvement Plan must be tied to the risk bearing entity contracts

03
Regionalize transformation efforts

- Utilize flexible payment methods through contracting, legislative/budget, and/or waiver request , and creative investment funding mechanisms
- Required to address priority Prevention Framework items in addition to locally selected priorities
- Local needs and priorities from the Community Health Improvement Plan must be tied to the risk bearing entity contracts
- Amplify a Health in All Policies approach across State agencies and within communities

04
Create Accountable Communities of Health

Foundational Building Blocks

- Prevention Framework EMAC utilizes data to align resources
- Include measure(s) relevant to prevention of ACEs (e.g. proportion of children who meet developmental milestones of kindergarten readiness in all domains (physical, social-emotional, cognitive, language, literacy, and math)
- Within Washington's developing clinical data repository, it should prioritize the inclusion of an e-referral system which can connect provider based systems with social supports and vice versa, enabling clinical-community linkages

05
Leverage and align state data capabilities

- Create a Washington Transformation Support Regional Extension Service (or Innovation Center)
- The RES at the state level will serve as a backbone support structure for additional transformation efforts beyond clinical. It could provide:
  - Learning Collaboratives
  - Peer-to-peer networks
  - Population health – CHNA, community based policies
  - Technical assistance and support
  - Interpret and deploy data and analytics
  - Resources and best practices
  - PCMH recognition support and tech assistance
- The Community Health Teams hosted at the ACH (acting as the spoke of the RES) will prioritize population health improvements

06
Provide practice transformation support

- Utilize flexible payment methods through contracting, legislative/budget, and/or waiver request, and creative investment funding mechanisms
- CHW will be an essential part of the community health team
- Prioritize development of definition of a CHW, their scope of work, training standards, and financing models. This includes defining CHW qualifications that will allow Washington to take advantage of the new Center for Medicaid Services ruling allowing non-licensed providers to bill Medicaid

07
Increase workforce capacity and flexibility

Small Group Break-Out Discussion

OBJECTIVES OF BREAKOUT

- Review and discuss *Prevention Enhancement Recommendations* made on existing State Health Care Innovation Plan Foundational Building Blocks
- Come to general agreement on the Prevention Enhancement Recommendations and bring forward any suggested additions, edits and other changes

Lunch Break

STRETCH, BIO-BREAK, GRAB LUNCH

Large Group Discussion – 1, 2, 4, All

- Assure understanding of the purpose of documents
- Recognizing supports provided by the SHCIP Foundational Building Blocks and CMMI SIM Round 2 FOA, identify the 'go-first' action recommendations
- Come to general agreement on specific recommended measures each objective and the overall Prevention Framework
- Discuss the ability for you and your organization to commit to carrying recommendations forward that apply to your sector

Next Steps

- Revise documents based on discussion today
- Most likely schedule interim webinar to:
  - Review revised materials
  - Check-in on measures
  - Further discuss possible organizational commitments
  - Gain insight on CMMI SIM Round 2 Plan for Improving Population Health
  - Discuss approach for final meeting with John and Dorothy

Closing

- Reminder: Next Meeting
  Monday, July 21st – 9:30 am to 3:30 pm*
- Meeting evaluation
- Final thoughts

*Same day SIM Round 2 is due

Appendix

Foundational Building Block Enhancement: Diabetes

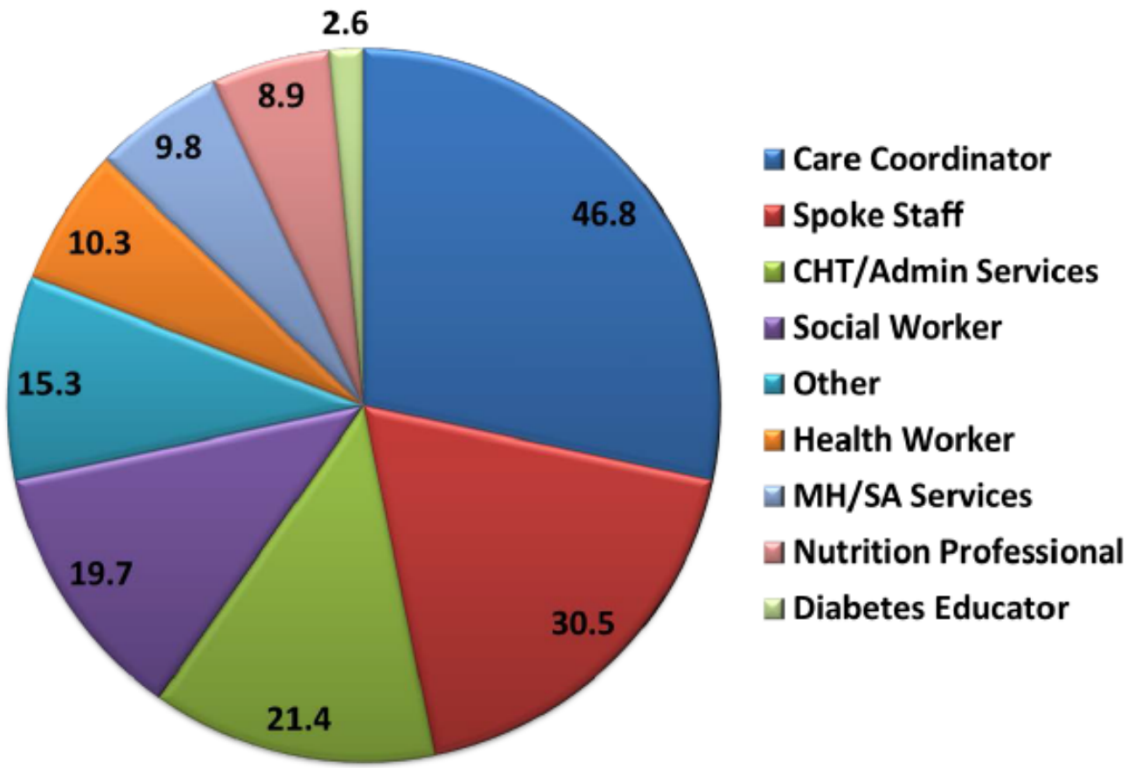
- Standardized PCMH recognition across WA (2)
- **ACH**:
  - Regional Health Improvement Plan addresses Diabetes as required component (4)
  - Multisector partners broaden their contributions through a health in all policies lens and resource commitment. (4)
  - Shared decision making includes diabetes (2)
  - Risk bearing contracts are tied to the Regional needs assessment (3, 4)
  - CHW are in place and provide Diabetes Prevention Programs (6, 7)
- Practice transformation support provides resources and best practice, learning collaboratives for ALL partners (6)

Community Health Team Example

VERMONT
Department of Vermont Health Access

VERMONT Blueprint for Health
Smart choices. Powerful tools.

Community Health Team Staffing (FTEs)
December, 2013



VERMONT

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Barre HSA

Full Network

Node color indicates sub-network membership

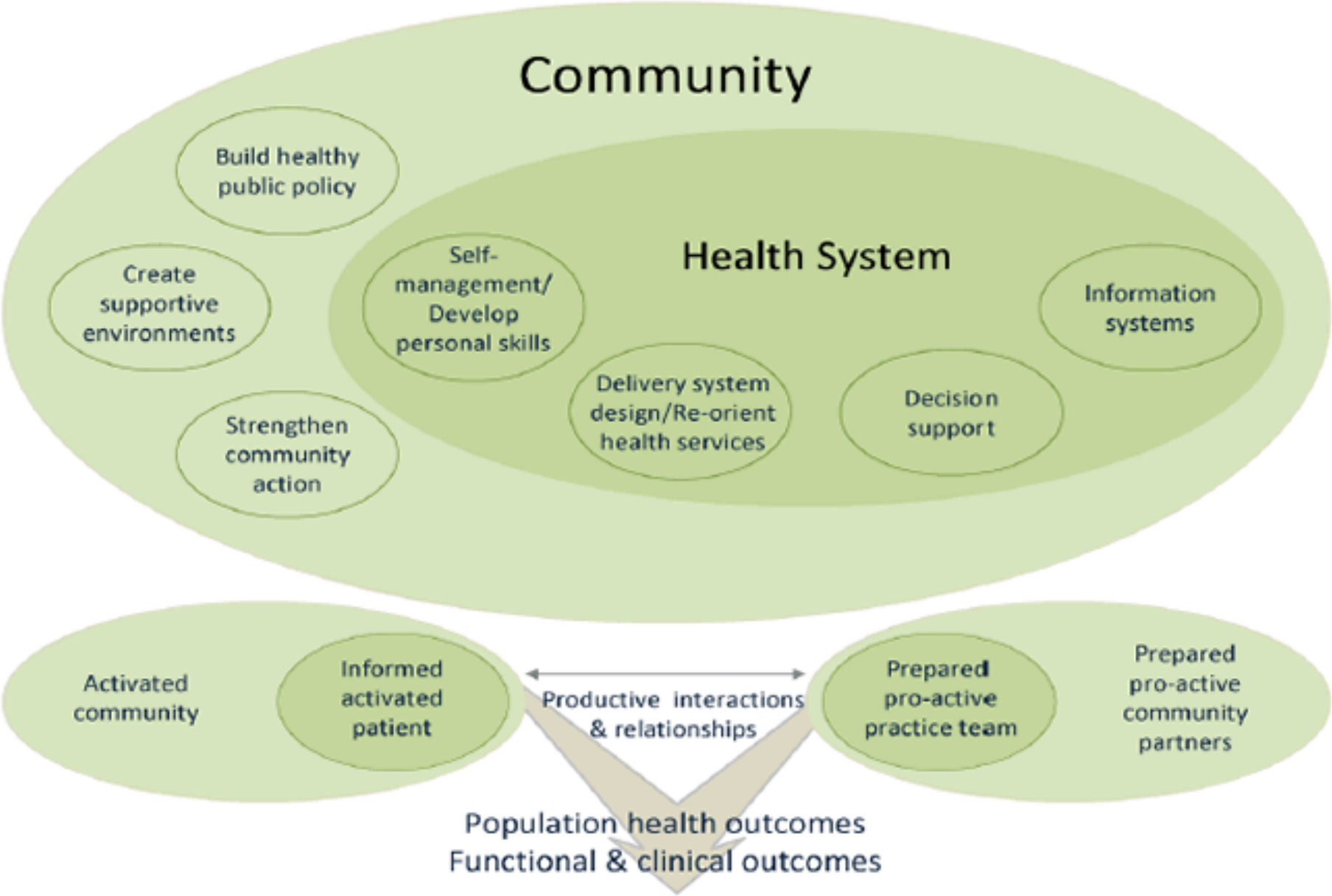
Node size indicates Betweenness Centrality

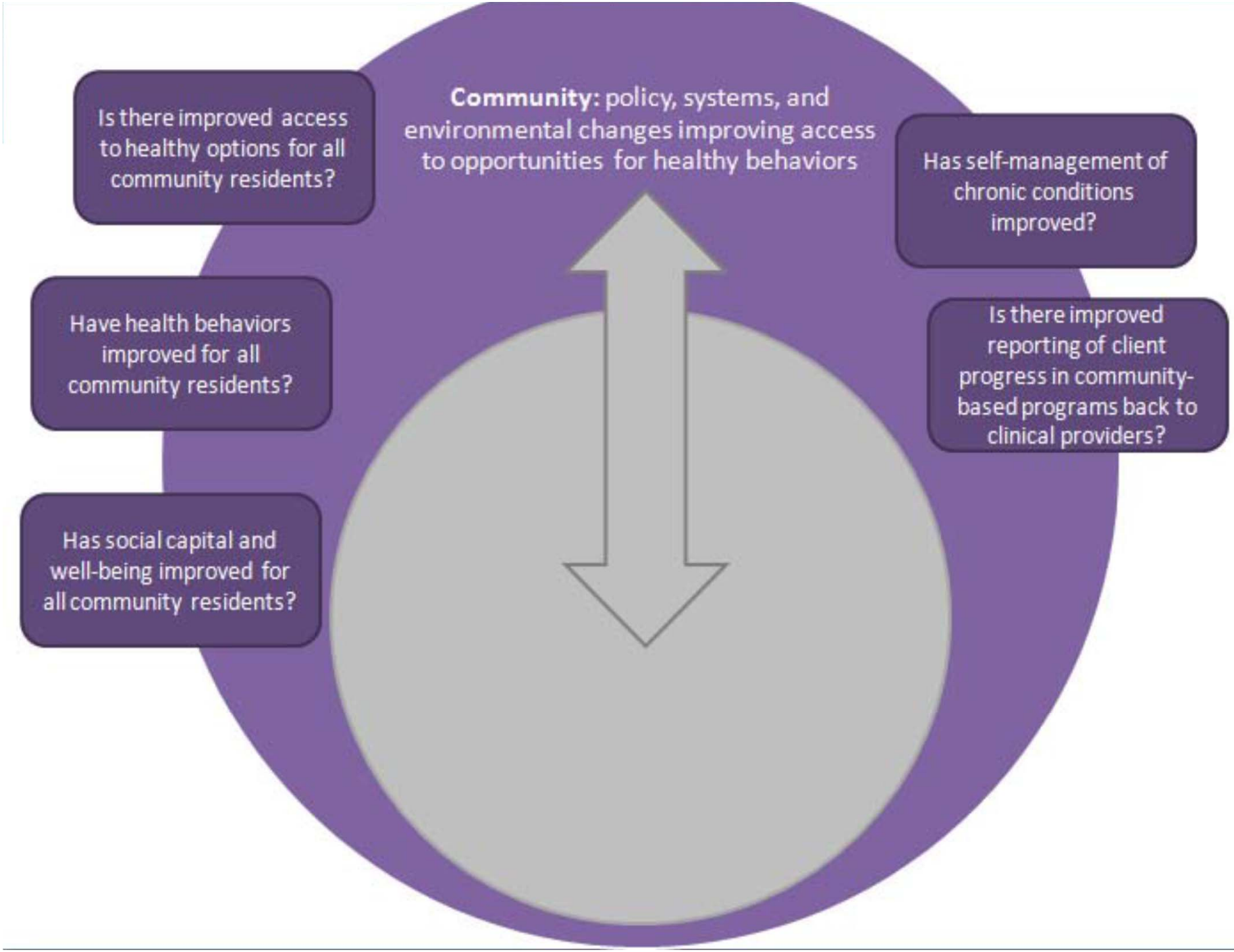
Community: policy, systems, and environmental changes improving access to opportunities for healthy behaviors
Community-Clinical Linkages: improving access to high-quality preventive and chronic care services and promoting healthy behavior
Clinical: policy and systems changes improving quality and coordination of care

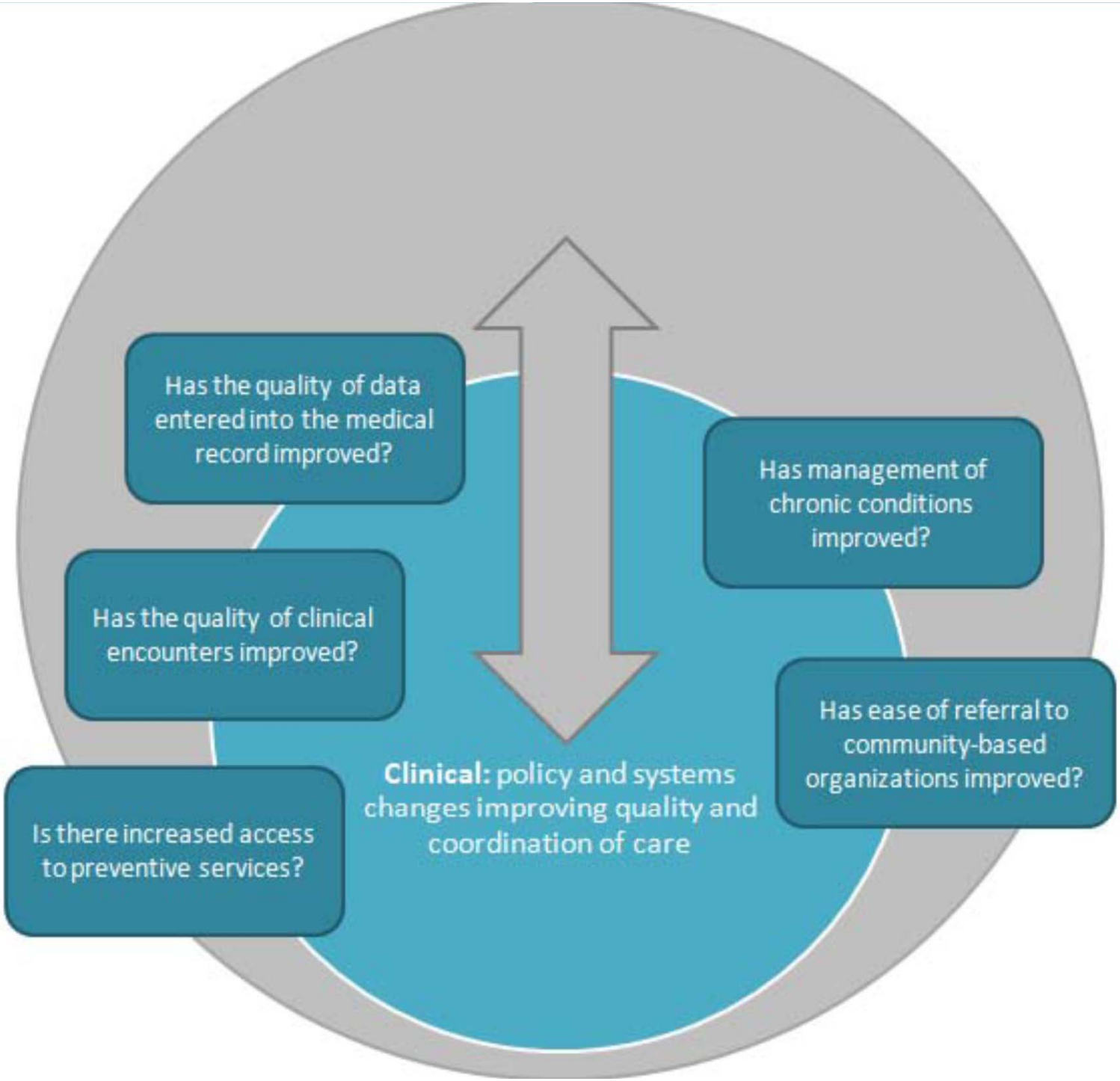
Social Ecological Model

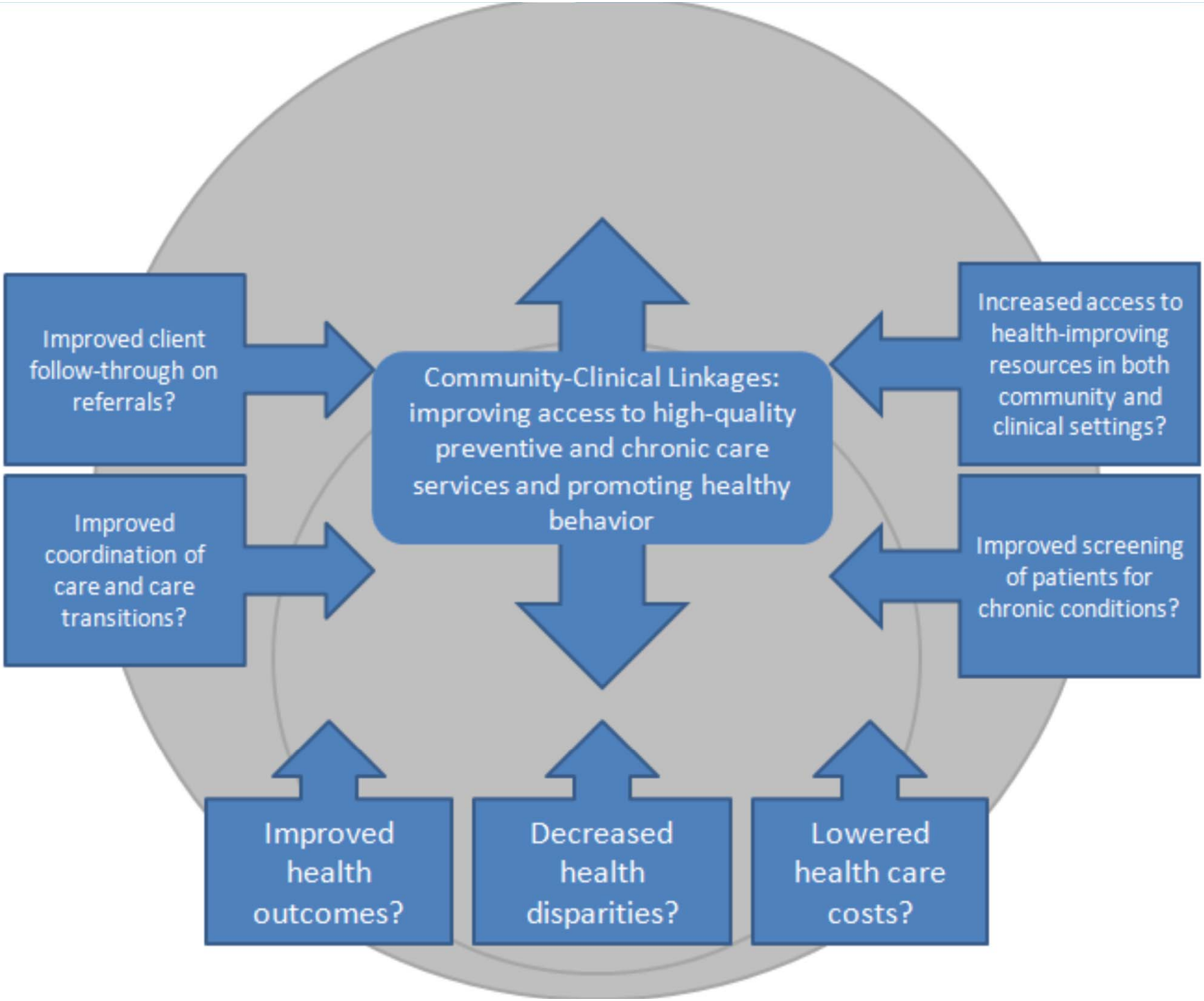
Image Example

Chronic Care Model Image




Community: policy, systems, and environmental changes improving access to opportunities for healthy behaviors
Is there improved access to healthy options for all community residents?
Have health behaviors improved for all community residents?
Has social capital and well-being improved for all community residents?
Has self-management of chronic conditions improved?
Is there improved reporting of client progress in community-based programs back to clinical providers?


Has the quality of data entered into the medical record improved?
Has management of chronic conditions improved?
Has the quality of clinical encounters improved?
Has ease of referral to community-based organizations improved?
Is there increased access to preventive services?
Clinical: policy and systems changes improving quality and coordination of care


Improved client follow-through on referrals?
Improved coordination of care and care transitions?
Community-Clinical Linkages: improving access to high-quality preventive and chronic care services and promoting healthy behavior
Increased access to health-improving resources in both community and clinical settings?
Improved screening of patients for chronic conditions?
Improved health outcomes?
Decreased health disparities?
Lowered health care costs?