INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

BOARD ON POPULATION HEALTH AND PUBLIC HEALTH PRACTICE

Roundtable on Population Health Improvement and the ASTHO-Supported PC-PH Collaborative[1]

Workshop: Opportunities at the Interface of Health Care and Public Health

February 5, 2015

AGENDA

Location: National Academy of Sciences, Lecture Room

2101 Constitution Avenue NW, Washington, DC

WORKSHOP OBJECTIVES:

(1) Discuss and describe the elements of successful collaboration between health care and public health organizations and professionals

(2) Reflect on the five principles of primary care-public health integration (which can be applied more broadly to the health care public health relationship): shared goals, community engagement, aligned leadership , sustainability, and data and analysis

(3) Explore the "elephants" in the room when public health and health care interact: what are the key challenges and obstacles, and what are some potential solutions, including strengths both sides bring to the table

8:30 am **Welcome**

George Isham, senior advisor, HealthPartners, senior fellow, HealthPartners Institute for Education and Research; co-chair, Roundtable on Population Health Improvement

Paul Jarris, executive director, Association of State and Territorial Health Officials

8:40 am **Context and overview of the day**

Julie K. Wood, vice president for Health of the Public & Interprofessional Activities, American Academy of Family Physicians; member, ASTHO Integration of Primary Care and Public Health Collaborative; co-chair of the workshop planning committee

Jose Montero, director, New Hampshire Division of Public Health Services; member, ASTHO Integration of Primary Care and Public Health Collaborative; member, IOM Roundtable on Population Health Improvement; co-chair of the workshop planning committee

9:00 am **Case study 1: Payment reform**

Moderator: RADM Sarah Linde, chief public health officer, Health Resources and Services Administration

Mary Applegate, Medicaid director, state of Ohio

Theodore Wymyslo, former state health officer, Ohio; chief medical officer, Ohio Association of Community Health Centers

10:30 am *Break*

[1] Association of State and Territorial Health Officials Primary Care and Public Health Collaborative

10:45 am	**Case study 2: Million Hearts** *Moderator: Paul Jarris, executive director, Association of State and Territorial Health Officials* *Guthrie Birkhead, deputy commissioner, New York State Department of Health* *Joseph R. Cunningham, vice president of health care delivery, and chief medical officer, Blue Cross and Blue Shield of Oklahoma*
12:15 pm	**Lunch and Conversation:** Enhancing a culture of collaboration to build a culture of health *Facilitator: Paul Mattessich, executive director, Wilder Research, Amherst H. Wilder Foundation* *Lloyd Michener, professor & chair, Department of Community & Family Medicine, Duke School of Medicine* *All speakers and audience members*
1:45 pm	**Case study 3: Collaboration between hospitals and public health agencies** *Moderator: Sunny Ramchandani, medical director, Healthcare Business Directorate, Naval Medical Center San Diego* *Lawrence Prybil, Norton Professor in Healthcare Leadership and associate dean, College of Public Health, University of Kentucky* *Nicole A. Carkner, executive director, Quad City Health Initiative (Iowa and Illinois)*
3:15 pm	**Break**
3:30 pm	**Case study 4: Asthma** *Moderator: Terry Allan, health commissioner, Cuyahoga County Board of Health, Ohio* *Margaret Reid, director, Division of Healthy Homes and Community Supports, Boston Public Health Commission; and the Boston Asthma Home Visit Collaborative* *Shari Nethersole, executive director for community health, Boston Children's Hospital; assistant professor of pediatrics, Harvard Medical School*
5:00 pm	**Reflections on and reactions to the day** *Paul Mattessich, executive director, Wilder Research, Amherst H. Wilder Foundation*
5:30 pm	**Adjourn** *David Kindig, professor emeritus of population health sciences, emeritus vice chancellor for health sciences, University of Wisconsin-Madison, School of Medicine and Public Health; co-chair, IOM Roundtable on Population Health Improvement*

For more information about the roundtable, visit www.iom.edu/pophealthrt or email pophealthrt@nas.edu.

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Roundtable on Population Health Improvement and the ASTHO-Supported Primary Care and Public Health Collaborative

OPPORTUNITIES AT THE INTERFACE OF HEALTH CARE AND PUBLIC HEALTH
February 5, 2015

BIOSKETCHES[1]
Speakers, Moderators, and Planning Committee Members

Terry Allan, MPH, †,* is immediate past president of the National Association of County and City Health Officials (NACCHO). Since 2004, he has been the health commissioner at the Cuyahoga County Board of Health, which serves as the local public health authority for 885,000 citizens in 57 Greater Cleveland communities. He holds a Bachelor of Science degree in Biology from Bowling Green State University and a Master of Public Health from the University of Hawaii. Mr. Allan is an adjunct faculty member at Case Western Reserve University's School of Medicine and was a Year 13 Scholar of the National Public Health Leadership Institute. He is the a past president of Ohio's State Association of County and City Health Officials, the Association of Ohio Health Commissioners, and has served as an At-Large member of the NACCHO Board of Directors since 2007. Mr. Allan has worked in public health for 22 years in Greater Cleveland, working to reduce childhood lead poisoning rates by half since 2004 and reducing smoking rates by 11 percent since 2003. He has dedicated his career to cultivating a wide range of partnerships with industry, academia, medicine, non-profits and other governmental agencies at the state, local and national level to address the public health needs of the community. He served as a representative of NACCHO on the Standards Development Workgroup for the National Public Health Accreditation Board (PHAB) and chaired a local health department Site Visit Team during the Beta Test of the PHAB standards. In May of 2009, Mr. Allan had the honor of testifying before the United States House of Representatives Government Oversight and Reform Committee, concerning public health pandemic influenza preparedness and resource needs. Additionally, he participated in a White House meeting on the national response to Novel H1N1 Influenza in September of 2009. In June of 2010, Mr. Allan participated on behalf of NACCHO in a Congressional briefing on local public health job losses.

[1] Notes: Names appear in alphabetical order; "†" = member of the workshop planning committee; "*" = member of the IOM Roundtable on Population Health Improvement.

Mary Applegate, MD, is double-boarded in pediatrics and internal medicine. After over twenty years of experience in rural private practice, Dr. Applegate now serves as the Medical Director of Ohio Medicaid. She is responsible for infusing high quality clinical medicine into the program, driving improvements in health outcomes for Medicaid beneficiaries. Dr. Applegate leads several quality improvement initiatives across multiple agencies and disciplines--particularly in the fields of perinatal health, physical and mental health integration, and the appropriate utilization of high risk drugs such as atypical antipsychotics and opiates. She spearheads the perinatal workgroup for the Medicaid Medical Directors Network and co-chairs the Centers for Medicare & Medicaid Services expert panel to improve maternal and infant outcomes. Her other interests include home and hospice care, patient empowerment, and health system transformation. Dr. Applegate is an honors graduate of The Ohio State University College of Medicine.

John Auerbach, MBA, [†] is a Senior Policy Advisor to the Director at the Centers for Disease Control and Prevention (CDC). Prior to his appointment at CDC, John Auerbach was a Distinguished Professor of Practice in Health Sciences and the Director of the Institute on Urban Health Research and Practice at Northeastern University from 2012 to 2014. He joined the University in after 5 years as the Massachusetts Commissioner of Public Health. As Commissioner he oversaw 3,100 employees and 100 separate programmatic units including those addressing chronic and infectious disease, substance abuse, environmental health and emergency preparedness. He initiated the Mass in Motion initiative, a multi-faceted campaign to prevent obesity and promote wellness. He was a member of the team that implemented the state's groundbreaking health care reform initiative. Prior to his appointment as Commissioner, Auerbach was the Executive Director of the Boston Public Health Commission for 9 years. Under his leadership, the Commission developed new initiatives on tobacco control, cancer, asthma, obesity, emergency preparedness as well as a broad-based and comprehensive campaign to reduce racial and ethnic health disparities. Mr. Auerbach had previously worked at the State Health Department for a decade--first as the Chief of Staff and later as an Assistant Commissioner, overseeing the HIV/AIDS Bureau. He began his career in public health as an administrator in the Uphams Corner Community Health Center and a manager at Boston City Hospital and the Boston University School of Medicine.

Ron Bialek, MPP, [†] has served as Executive Director of the Public Health Foundation since 1996, after gaining 15 years' experience in public health practice and in academia. He brings to PHF a wealth of experience in state- and local-level public health practice, and in linking public health practitioners with academic institutions. Mr. Bialek manages all aspects of the organization and is responsible for the quality of its products. He directed PHF activities over the past three years

that have led to the training of over 10,000 public health professionals annually using distance learning techniques. Mr. Bialek serves on a variety of government advisory groups and co-chaired the Managed Care and Public Health sub-committee of the Public Health Functions Working Group. He works closely with the PHF Board of Directors and public health professionals to develop and implement research, training, and technical assistance activities to benefit public health agencies in their performance of public health services. Before joining PHF, Mr. Bialek was on the faculty of the Johns Hopkins University School of Public Health for nine years and served as Director of the Johns Hopkins Health Program Alliance. In his faculty role and as Director of the Health Program Alliance, Mr. Bialek took the theory of public health practice into the field and developed an outstanding reputation locally and nationally for his efforts in facilitating linkages between academic institutions and public health agencies. At the national level, he has directed such projects as the Public Health Faculty/Agency Forum and the Council on Linkages Between Academia and Public Health Practice. The Forum project resulted in the development of recommendations for improving the relevance of public health education to practice and spelled out the various competencies that are desirable for practicing public health. Still serving as Director of the Council on Linkages, Mr. Bialek continues to play a key role in developing strategies and programs to implement Forum recommendations throughout the country. In addition, Mr. Bialek is Co-directing a national effort to develop public health practice guidelines for use by public and private organizations with population-based responsibilities. At the State and local levels, Mr. Bialek has done much to improve collaboration between public health agencies and Johns Hopkins. He has developed and directed projects such as: assessing community public health needs and resources, developing evaluation protocols for local health department services, providing technical support to and staffing of the Maryland Association of County Health Officers, and establishing a public health grand rounds series for State and local health department employees. Mr. Bialek co-chaired the Coalition for Local Public Health in Maryland, which was successful in getting signed into law funding mandates to support essential local public health services. Mr. Bialek also has served on several State committees and is currently a member of the Prevention Block Grant Advisory Committee for the Maryland Department of Health and Mental Hygiene. Mr. Bialek also has extensive teaching experience in the areas of public health practice, AIDS health policy and management, and community health assessment. He has provided community health assessment training to over 200 health departments and community-based organizations, and currently is developing for the Centers for Disease Control and Prevention a distance learning course in this topic area. Mr. Bialek began serving as President of PHF in June 1999. Mr. Bialek received his B.A. in Political Science and his M.P.P. in Public Policy from the Johns Hopkins University.

Guthrie Birkhead, MD, MPH, is Deputy Commissioner in charge of all public health programs at the New York State Department of Health. He is the chief public health physician in the Department and directs the Office of Public Health, which encompasses public health programs in the Center for Community Health (communicable disease control, maternal child health, chronic disease, nutrition), the Center for Environmental Health, the AIDS Institute (HIV, STDs, hepatitis), the Wadsworth Laboratory, the Office of Health Emergency Preparedness, the Office of Public Health Informatics and Project Management, and the Office of Public Health Practice (Article 6 and performance management programs). Dr. Birkhead is board certified in internal medicine and preventive medicine. He is also Professor of Epidemiology and Biostatistics at the School of Public Health, University at Albany.

Nicole Carkner, MBA, has been the executive director of the Quad City Health Initiative since 2001. As Executive Director, Ms. Carkner develops and facilitates cross-sector collaborative partnerships to create a healthier community in eastern Iowa and western Illinois. Formerly, Ms. Carkner was a health care management consultant working across the country with hospital systems, pharmaceutical companies, health care insurers and health-related government agencies. Her expertise includes strategic planning, community health assessments, population health management and project leadership. Ms. Carkner serves on the national Advisory Council of the Association for Community Health Improvement. Ms. Carkner holds a M.B.A. in Health Care Management from the Wharton School of the University of Pennsylvania and an A.B. with majors in Biology and Government from Dartmouth College.

Joseph Cunningham, MD, is Board Certified in Obstetrics and Gynecology. Cunningham spent 21 years in private practice serving as a Staff Physician at St. John Medical Center in Tulsa. He then joined Blue Cross and Blue Shield of Oklahoma in 2007 as the Medical Director of Medical Services over the Utilization Management and Case Management Departments. Two years later, he was named the company's Vice President of Health Care Management and Chief Medical Officer. A native of Siloam Springs, Arkansas, Dr. Cunningham earned an undergraduate degree in chemistry and attended medical school at the University of Arkansas. He also conducted post-graduate studies at the University of Oklahoma – Tulsa. Dr. Cunningham is a Fellow of the American College of Obstetricians and Gynecologists, and he is a member of both the Oklahoma State Medical Association and the Tulsa County Medical Society.

Christopher Holliday, PhD, MPH, is the Director of Population Health at the American Medical Association. Dr. Holliday leads efforts to develop and implement national, public health change strategies for improving health outcomes and reducing costs for two of the nation's most troubling and wide-spread issues: cardiovascular disease and type 2 diabetes. He works with physicians, physician practices, and communities to devise multi-level, evidence-based

interventions targeting key social, environmental, and behavioral determinants of health. Dr. Holliday works to identify and engage population segments in health risk reduction, and advocate for public policy and systems changes that promote healthy lifestyles and reduce inequities. Since 1847, the American Medical Association has promoted scientific advancement, improved public health, and invested in the doctor and patient relationship. The AMA history is a rich narrative that demonstrates the important role the institution and its members have played in the development of medicine in the United States.

Paul Jarris, MD, MBA, [†] has served as the executive director of ASTHO since June 2006. Prior to his appointment at ASTHO, Jarris served as commissioner of health at the Vermont Department of Health from 2003 to 2006. His achievements included conceiving and implementing the Vermont Blueprint for Health, a statewide public-private partnership to improve health while reforming the state's healthcare system. Jarris also led the establishment of Vermont's first inpatient substance abuse treatment program for adolescents and women. Leaving Vermont to lead ASTHO, Jarris continued to combine his passion for family medicine and public health. Under his leadership, ASTHO became a founding organization for the Public Health Accreditation Board, and the Alliance to Make U.S. Healthiest. During the 2009 H1N1 crisis, Jarris positioned ASTHO as a vital link facilitating effective pandemic coordination efforts between state health agencies, the White House, Congress, CDC, and national retail pharmacies. Among many other accomplishments at ASTHO, he fostered partnerships between state health agencies, the March of Dimes, and the Health Services Resource Administration that have dramatically improved preterm birth outcomes. Jarris also oversaw the creation of the ASTHO-supported Primary Care and Public Health Collaborative, a network of 63 leading health care and public health organizations with the mission of implementing integrated efforts to improve population health and lower health cost.

RADM Sarah Linde, MD. [†,*] is a Medical Officer in the Commissioned Corps of the U.S. Public Health Service. She currently serves as the Chief Public Health Officer for the Health Resources and Services Administration (HRSA) which works to improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs. Prior to HRSA, Dr. Linde was the Deputy Director of the Office of Disease Prevention and Health Promotion in the Office of Public Health and Science in the Office of the Secretary of HHS. There, she helped oversee national disease prevention and health promotion activities including Healthy People, the Dietary Guidelines for Americans, and the Physical Activity Guidelines. Her previous assignments include the Food and Drug Administration (FDA) Office of Orphan Products Development which helps in the development of drugs, biologics, and devices for rare diseases and the National Health Service Corps in HRSA where served as the Director of the Shenandoah Valley Family Health Center, a community health center in Inwood, WV. RADM

Linde is board certified in Family Practice and is a graduate of the Uniformed Services University of the Health Sciences Medical School in Bethesda, MD.

Paul W. Mattessich, PhD, has served as executive director of Wilder Research since 1982, building a research team of about 80 people from multiple disciplines who devote themselves to increasing the effectiveness of services, programs, organizations and policies intended to improve the lives of individuals, families, and communities. Dr. Mattessich lectures frequently throughout the United States and the United Kingdom, especially on topics of organization and service effectiveness, collaboration/partnerships, and major social trends. He has authored or co-authored more than 300 publications. Since 2000, he has spent several weeks each year in Belfast, Northern Ireland, working with youth development and civic engagement organizations that promote democratic skills to bring communities together and to resolve conflict. He has served on a variety of government and nonprofit boards of directors and special task forces. He currently sits on the boards of the Hamm Memorial Psychiatric Clinic and of Minnesota Community Measurement. He has an appointment as Adjunct Faculty in the Department of Youth Studies, School of Social Work, at the University of Minnesota. He received his doctorate in Sociology from the University of Minnesota.

Lloyd Michener, MD, is Professor and Chairman of the Duke Department of Community and Family Medicine, Director of the Duke Center for Community Research, and Clinical Professor in the Duke School of Nursing. He co-chairs the Community Engagement Steering Committee for the Clinical Translation Science Awards of the NIH, and is a member of the Board of the Association of American Medical Colleges. Dr. Michener is Past President of the Association for Prevention Teaching and Research and received the APTR Duncan Clark Award in 2013. He is also a past member of the Institute of Medicine Committee that led to the publication of "Primary Care and Public Health: Exploring Integration to Improve Population Health". At Duke, Dr. Michener founded the training programs in nutrition and prevention; helps coordinate the institutional chronic disease programs, and oversees the Master's Program in Clinical Leadership, a joint program of the Schools of Medicine, Nursing, Business, Law, and the Institute of Public Policy. As Chair of the Department, he leads the family medicine, preventive/occupational medicine, community health, informatics, and physician assistant and physical therapy programs. Dr. Michener's primary interest is in redesigning health care to improve community health outcomes, and in rapidly transforming health care delivery systems, with a focus on finding ways of making health care work better through teams, community engagement, and practice redesign. He graduated from Oberlin College in 1974 and from Harvard Medical School in 1978. He was a resident in family medicine at Duke from 1978-1981 and a Kellogg Fellow in Family Medicine from 1981-1982, after which he joined the Duke faculty. In 1994, he was named Professor and Chairman of the Department.

Shari Nethersole, MD, is the medical director for community health at Boston Children's Hospital. For over 25 years, Dr. Nethersole has been a pediatrician caring for children in Boston, and still sees patients in the Children's Hospital Primary Care Center. In her role as medical director, she oversees the hospital's community health mission, which addresses the most pressing health issues affecting children in our cities—currently asthma, mental health, obesity, and child development. She works with community organizations, community health centers, schools and city and state agencies to address health disparities and improve the health of children and families in the community through programming, partnerships and advocacy. She established the Community Asthma Initiative in 2005 as well as the Fitness in the City Program to address childhood obesity. She's also an active advocate at the city and state level for child health priorities. In addition to external collaborations, Dr. Nethersole facilitates the internal hospital connections and collaborations needed to support the community health mission, trying to align the clinical mission and services of the hospital with community health needs.

Lawrence Prybil, PhD, is the Norton Professor in Healthcare Leadership and Associate Dean at the University of Kentucky's College of Public Health. He is a Professor Emeritus at the University of Iowa, where he served as Associate Dean and Senior Advisor to the Dean in the UI College of Public Health. Before returning to Iowa to participate in building its new College of Public Health, Dr. Prybil held senior executive positions in two of our country's largest nonprofit health systems for nearly twenty years, including ten years as CEO for a six-state division of the Daughters of Charity National Health System.Dr. Prybil received his master's and doctoral degrees from the University of Iowa's College of Medicine, and is a Life Fellow in the American College of Healthcare Executives. He has served on the governing boards of hospitals, health systems, state hospital associations, the American Hospital Association, and other nonprofit and investor-owned organizations. He presently serves on the national board of the AHA Center for Healthcare Governance. Dr. Prybil has authored or co-authored 101 publications. He is recognized for expertise in governance and executive leadership, has directed a series of national studies regarding governance practices in nonprofit hospitals and health systems, and recently completed a study of successful partnerships involving hospitals, public health departments and other stakeholders focused on improving the health of communities they jointly serve.

Sunny Ramchandani, MD, MPH, FACP, is commander and medical director in the Healthcare Business Directorate, Naval Medical Center San Diego is a Lieutenant Commander and physician in the United States Navy. He was previously the Integrated Chief of General Internal Medicine at the Walter Reed National Military Medical Center, where he co-founded an innovative primary care delivery model that has enhanced quality, reduced overall costs, and been

adopted by the entire U.S. Military Health System. In 2009, he deployed to Afghanistan as the Senior Medical Mentor for the Afghan National Security Forces, guided the execution of a new healthcare reconstruction strategy, and received the Bronze Star Medal. Dr. Ramchandani earned his M.P.H. from the Harvard School of Public Health and his M.D. from the Yale School of Medicine, where he received the Norman Herzig Award for his dedication to humanitarian service in India. He earned his B.S. from the U.S. Naval Academy, where he was a Truman Scholar and graduated first in his class academically.

Margaret Reid, RN, BA, is director of the Division of Healthy Homes and Community Supports at the Boston Public Health Commission, now serving as its Director. With Ms. Reid's background in community health nursing, she has spearheaded multiple efforts at the BPHC to connect clinical care with public health systems and policy efforts, most recently working with Boston health centers to introduce into pediatric electronic health records tobacco use screening and referral to counseling for parents. Ms. Reid oversees Breathe Easy at Home and the Boston Asthma Home Visit Collaborative, both recipients of national recognition. Ms. Reid has received the Revere Award for Excellence in Public Health, the highest award given to a BPHC employee. Ms. Reid is currently working toward a Master's degree in Public Administration at Northeastern University.

Julie K. Wood, MD, FAAFP [†]**,** became the Vice President for Health of the Public and Interprofessional Activities in 2013 after a lengthy period of member service with the AAFP, including serving on its Board of Directors. She has oversight responsibilities for the public health, scientific, and research activities of the AAFP, as well as the AAFP's relationships with other medical organizations in the United States and abroad. Through these relationships, Wood facilitates the continued development of family medicine and coordinates the AAFP's international activities. Wood oversees AAFP efforts to involve family physicians in targeted public health activities, including tobacco, obesity, exercise, and immunization. Science staff develops clinical policies and supports, conducts, and disseminates practice-based primary care research with the aim of improving health and health care for patients, their families, and communities. Under Wood's direction, the AAFP helps lead family physicians in health promotion, disease prevention, and chronic disease management as outlined in the AAFP's mission and strategic plan. She leads the AAFP in its efforts to explore collaborative opportunities in additional areas related to the health of the public, such as health disparities, patient education, social determinants of health, and medical genomics. As Vice President, Wood also helps direct organization-wide strategy and policy-development activities in addition to participating actively in the work of the AAFP Board of Directors. She is based at the AAFP's headquarters office in Leawood, Kansas. Wood has been a practicing family physician for nearly 20 years, starting out as a solo rural family physician in her hometown of Macon, Missouri. She

has a breadth of experience in family medicine, serving a diverse range of patient populations. Before joining the AAFP staff, Wood served as associate director of Research Family Medicine Residency Program in Kansas City, Missouri. She also served as the medical director of Goppert-Trinity Family Care, a 55-provider outpatient clinic. Wood served as the physician lead for the clinic's involvement in a multi-center, patient-centered medical home pilot project, which led to the clinic being among the first in Kansas City to achieve NCQA recognition as a level-3 patient-centered medical home. She is enthusiastic to promote the PCMH model through her work with the AAFP. A member of the AAFP since 1988, Wood has served on numerous committees and commissions, including the Commission on Public Health and Science, the Commission on Health Care Services, the Commission on Membership and Member Services, and the Committee for Special Constituencies. She most recently served as chair of the Commission on Public Health and Science. Wood earned her undergraduate degree and her medical degree from the University of Missouri Kansas City. She then completed her residency at Via Christi-St. Francis Family Medicine Residency Program in Wichita, Kansas. She is board certified by the American Board of Family Medicine and has the AAFP Degree of Fellow, an earned degree awarded to family physicians for distinguished service and continuing medical education.

Theodore Wymyslo, MD, is a family physician with over 30 years of experience as a clinician. He has held leadership roles in family practice residency training, medical student teaching, local and state professional associations, free clinic and homeless shelter healthcare delivery, public health, and Patient-Centered Medical Home (PCMH) advocacy across the state of Ohio. He is the immediate past director of the Ohio Department of Health (2011-2014) appointed by Ohio Governor John Kasich. Prior to his appointment at the Ohio Department of Health, Dr. Wymyslo served as the director of Family Medicine Dayton, a PCMH initiative. As ODH director, Dr. Wymyslo established the Ohio Patient Centered Primary Care Collaborative, convene stakeholders from across Ohio to effect healthcare delivery reform.
Today Dr. Wymyslo serves as the Chief Medical Officer of the Ohio Association of Community Health Centers, with 43 Federally Qualified Health Center members serving 563,000 patients in 208 sites across the state, 84 of which are PCMH-recognized. He is also Senior Advisor to Better Health Greater Cleveland, an alliance for improved healthcare in Northeast Ohio with 70 primary care practices across 7 counties engaged in a regional learning collaborative.
Dr.Wymyslo sits on the boards of the Ohio Academy of Family Physicians and Better Health Greater Cleveland, and serves as a volunteer Family Physician at the Physicians Free Clinic at Columbus Public Health. He graduated from The Ohio State University College of Medicine, is board certified in Family Medicine and a Fellow in the American Academy of Family Physicians. He served as the Program Director of the Miami Valley Hospital Family Medicine Residency Program for over 20 years, with a teaching appointment in the Department of Family Medicine at the Wright State University Boonshoft School of Medicine.

For his involvement in teaching and community service, Dr. Wymyslo has received a number of recognition awards, including the American Academy of Family Physician Foundation's Philanthropist of the Year Award in 2003, American Medical Association Foundation's Pride in the Profession Award in 2006, the Ohio Academy of Family Physician's Torchlight Leadership Achievement Award in 2009, the Ohio State Medical Association's Physician Advocate of the Year Award in 2014, and most recently the Patient-Centered Primary Care Collaborative's first Primary Care Community Leadership Award in November 2014. With many years of experience in both primary care and public health, he continues his efforts to identify opportunities for collaboration between these disciplines in an effort to improve population health.

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ROSTER OF ROUNDTABLE ON POPULATION HEALTH IMPROVEMENT

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Senior Fellow, HealthPartners Institute for Education and Research
HealthPartners, Inc

David A. Kindig, MD, PhD (Co-chair)
Professor Emeritus of Population Health Sciences
Emeritus Vice Chancellor for Health Sciences
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Centers for Disease Control and Prevention

José T. Montero, MD, MHCDS
President, Association of State and Territorial Health Officials
Director
New Hampshire Division of Public Health Services

Mary Pittman, DrPH, MPH, MCP
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Pamela Russo, MD
Senior Program Officer
Robert Wood Johnson Foundation

Brian Sakurada, PharmD
Senior Director, Managed Markets and Integrated Health
Systems
Novo Nordisk Inc

Martin Jose Sepúlveda, MD, FACP Fellow and Vice President, Health Research, IBM Research
International Business Machines Corporation

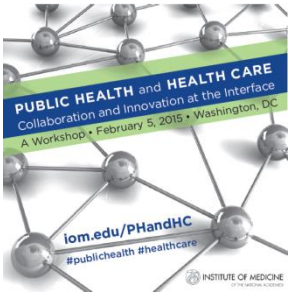
Andrew Webber
CEO
Maine Health Management Coalition

Select Resources

Collaboration at the Interface of Public Health and Health Care

Workshop of the IOM Roundtable on Population Health Improvement and the ASTHO-supported Primary Care and Public Health Collaborative

February 5, 2015



Please browse the starred items before the workshop if possible!

Additional resources on health care and public health collaboration:

1. **Prybil, L., F. D. Scutchfield, R. Killian, A. Kelly, G. Mays, A. Carman, S. Levey, A. McGeorge, and D.W. Fardo. 2014. Improving Community Health through Hospital–Public Health Collaboration: Insights and Lessons Learned from Successful Partnerships. Commonwealth Center for Governance Studies, Inc. http://www.uky.edu/publichealth/studyOverview.php
2. IOM. 2012. Primary care and public health: exploring integration to improve population health. Washington, DC: National Academies Press. http://www.iom.edu/Activities/PublicHealth/PrimaryCarePublicHealth.aspx

   The report identified five "principles of successful integration":

   - A shared goal of population health improvement;
   - Community engagement in defining and addressing population health needs;
   - Aligned leadership that (a) bridges disciplines, programs, and jurisdictions to reduce fragmentation and foster continuity, (b) clarifies roles and ensures accountability, (c) develops and supports appropriate incentives, and (d) has the capacity to manage change;
   - Sustainability, key to which is the establishment of a shared infrastructure and building for enduring value and impact; and
   - The sharing and collaborative use of data and analysis.
3. **IOM. Primary care and public health: exploring integration to improve population health. Report video (2012): http://www.iom.edu/Reports/2012/Primary-Care-and-Public-Health/PCPH-Video.aspx
4. Practical Playbook. (2014 and ongoing). www.practicalplaybook.org

   The Practical Playbook ("Public health. Primary Care. Together.") is a resource, i.e., a database and more, that includes hundreds of examples of collaboration contributed by organizations from across the US. The Playbook is a joint project of the DeBeaumont Foundation, Duke Community and Family Medicine, and the CDC, and consists of a database containing hundreds of examples of collaboration from around the country, searchable by cross-cutting topic (e.g., avoidable hospitalizations) or disease-specific topic (e.g., asthma).
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   http://www.atsdr.cdc.gov/communityengagement

   Especially note the graphic on page 8, which, according to Lloyd Michener, "describes community engagement as a journey from outreach to consultation, involvement, collaboration, and shared leadership."

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    http://www.qualityforum.org/Publications/2014/07/improving_pop_health_guide-1.aspx

    The Guide for Community Action is a handbook for anyone who wants to improve health across a population, whether locally, in a broader region or state, or even nationally. The Guide's purpose is to support individuals and groups working together at all levels — local, state and national — to successfully promote and improve population health over time. It contains brief summaries of 10 useful elements important to consider during efforts to work with others, along with actions to take and examples of practical resources, to build a coalition that can improve population health.

On collaboration more broadly

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    http://www.amazon.com/Collaboration-Research-Literature-Influencing-Successful/dp/0940069326

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http://www.wilder.org/Wilder-Research/Research-Services/Pages/Wilder-Collaboration-Factors-Inventory.aspx
(This is a free online tool which many organizations use to assess their collaborative initiatives on the 20 research-based factors in Collaboration: What Makes It Work.)

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Synopsis

"Improving Community Health Through Hospital - Public Health Collaboration: Insights and Lessons Learned from Successful Partnerships"

(Commonwealth Center for Governance Studies, Inc., November 2014)

Prepared for Discussion at Meeting of IOM Roundtable on Population Health Improvement - February 5, 2015

A. Purpose

To identify and examine successful partnerships involving hospitals, public health departments, and other stakeholders who share commitment to improving the health of communities they jointly serve and ascertain **key lessons** learned from their collective experience.

The study is intended to accelerate change, encourage collaboration, and contribute to building a "culture of health" in American communities.

B. Phases of the Study

1. Identify the core characteristics of successful partnerships.
2. Invite partnerships in operation for two years or more that demonstrate "core characteristics of successful partnerships" to participate in the study.
3. Select highly successful partnerships from a pool of 157 nominees through a four-step process involving members of our National Advisory Committee.
4. Plan and conduct site visits to selected set of twelve diverse partnerships that appear to be exceptionally successful.
5. Review, verify, and tabulate data obtained through the nomination process, official documents, individual interviews with partnership leaders, and small-group discussions during site visits.
6. Through qualitative analysis, determine findings, discern patterns and conclusions, and formulate recommendations for local leaders and public policy makers.

C. Study Population: 12 Partnerships Located in 11 States

- National Community Health Initiative
  Kaiser Foundation Hospitals and Health Plan
  Oakland, California
- California Healthier Living Coalition
  Sacramento, California
- St. Johns County Health Leadership Council
  St. Augustine, Florida
- **QUAD CITY HEALTH INITIATIVE**
  QUAD CITIES, IOWA-ILLINOIS
- Fit NOLA Partnership
  New Orleans, Louisiana
- HOMEtowns Partnership
  Portland, Maine
- Healthy Montgomery
  Rockville, Maryland
- Detroit Regional Infant Mortality Reduction Task Force,
  Detroit, Michigan
- Hearts Beat Back: The Heart of New Ulm Project
  New Ulm, Minnesota
- Healthy Monadnock 2020
  Keene, New Hampshire
- Healthy Cabarrus
  Kannapolis, North Carolina
- Transforming the Health of South Seattle and South King County, Washington
  Seattle, Washington

D. Core Characteristics of Successful Partnerships

1. **Vision, Mission, and Values** - The partnership's vision, mission, and values are clearly stated, reflect a strong focus on improving community health, and are firmly supported by the partners.

2. **Culture** - The partners demonstrate a culture of collaboration with other parties, understand the challenges in forming and operating partnerships, and enjoy mutual respect and trust.

3. **Goals and objectives** - The goals and objectives of the partnership are clearly stated, widely communicated, and strongly supported by the partners and the partnership staff.

4. **Organizational structure** - A durable structure is in place to carry out the mission and goals of the collaborative arrangement. This can take the form of a corporate entity, an affiliation agreement, or other less formal arrangements such as community coalitions.

5. **Leadership** - The partners jointly have designated well-qualified and dedicated persons to manage the partnership and its programs.

6. **Partnership Operations** - The partnership institutes or facilitates programs and services that operate effectively.

7. **Program Success and Sustainability** - The collaborative partnership has been operational for at least two (2) years, has demonstrated operational success, and is having positive impact on the health of the population served.

8. **Performance Evaluation and Improvement** - The partnership monitors and measures its performance against agreed upon goals, objectives, and metrics.

E. Some Common and Important Challenges These Partnerships Face

First, creating, organizing, and leading all types of "partnership" models is inherently difficult. While flexible, partnerships are not as organizationally durable as corporate models and a substantial proportion of all forms of partnerships do not succeed and survive.

A **second** challenge that is inherent in partnerships --- particularly relatively informal coalitions of alliances where many of the partners have not made substantial financial investments or legally-binding obligations --- is creating and sustaining the partners' interest and engagement.

A **third** and very fundamental challenge for *all* of these partnerships is the intrinsic difficulty of bringing about measurable improvement in the overall health of the community or population group they are serving. "Bending the curve" on overall measures of population health such as rates of infant mortality or obesity and the incidence and prevalence of cardiovascular disease is exceedingly difficult to accomplish and nearly always requires large amounts of time, resources, and carefully focused efforts.

A **fourth** major challenge for most of these partnerships is securing sufficient and sustainable funding. In some instances, large, successful healthcare organizations with deep commitment to improving the health of the communities they serve have contributed a high level of on-going support of the partnerships, and this has provided a solid financial foundation; most are not this fortunate.

The limitations and uncertainties in funding support translate directly into a **fifth** challenge for most of these twelve partnerships; i.e., limited staff support for the partnership directors and heavy reliance on volunteers to perform a major share of the partnership's work.

A **sixth** basic challenge for many of these partnerships is to build community recognition, credibility, and respect. With few exceptions, these partnerships are relatively small entities without a long history of community service. The partnership directors and their policy setting bodies are challenged to find appropriate ways to inform the communities they serve about their partnership's mission and the important work that the partnership --- in collaboration with their partners --- is doing for the community.

F. Recommendations

Our team believes the findings demonstrate that formal partnerships involving hospitals and/or health systems, public health departments, and other stakeholders who share real commitment to improving community health have an important social role and can serve as effective vehicles for collective action. However, this is difficult work, and there are substantial challenges involved in organizing and operating partnerships. To advance the development of effective and durable partnerships, the team formulated eleven recommendations for community leaders and policy makers:

1. To have enduring impact, partnerships focused on improving community health should include hospitals and public health departments as core partners but, over time, **engage a broad range of parties** from the private and public sectors.
2. Whenever possible, partnerships should be built on a foundation of pre-existing, trust-based relationships among some, if not all, of the principal founding partners. Other partners can and should be added as the organization becomes operational, but **building and maintaining trust** among all members is essential.
3. In the context of their particular community's health needs, the capabilities of existing organizations, and resource constraints, those who decide to establish a new partnership devoted to improving community should adopt a **statement of mission and goals** that focuses on clearly-defined, high priority needs and will inspire community-wide interest, engagement, and support.
4. For long-term success, partnerships need to have one or more **"anchor institutions"** with deep dedication to the partnership's mission and commitment to provide on-going financial support.
5. Partnerships focused on improving community health should have a **designated body with a clearly-defined charter** that is empowered by the principal partners to set policy and provide strategic leadership for the partnership.
6. Partnership leaders should strive to build **a clear, mutual understanding of "population health"** concepts, definitions, and principles among the partners, participants, and, in so far as possible, the community at large.
7. To enable evidence-based evaluation of a partnership's progress in achieving its mission and goals and fulfill its accountability to key stakeholders, the partnership's leadership must specify the **community health measures** they

want to address, the particular **targets** they intend to achieve, and the **metrics** they will use to track and monitor progress.

8. All partnerships focused on improving community health should place priority on developing and disseminating **"impact statements"** that present an evidence-based picture of the effects the partnership's efforts are having in relation to the direct and indirect costs the partnership is incurring.
9. To enhance sustainability, all partnerships focused on community health improvement should develop a deliberate strategy for **broadening and diversifying their sources of funding support.**
10. If they have not already done so, the governing boards of nonprofit hospitals and health systems and the boards of local health departments should establish **standing committees with oversight responsibility** for their organization's engagement in examining community health needs, establishing priorities, and developing strategies for addressing them including multi-sector collaboration focused on community health improvement.
11. If they have not already done so, local, state, and federal agencies with responsibilities related to population health improvement and hospital and public health associations should adopt **policy positions that promote the development of collaborative partnerships** involving hospitals, public health departments, and other stakeholders focused on assessing and improving the health of the communities they serve.

Collectively, the 12 partnerships in the study population have involved hundreds of public and private organizations and thousands of community citizens. Through engaging community organizations and citizens in their programs and activities, these partnerships are generating collective interest and action, building community spirit and social capital, and helping to create a "culture of health" within the communities they serve.

Our team believes a paradigm shift is occurring in America: there is growing realization that controlling the increase in health expenditures and improving the health of our nation's population will require major changes in traditional policies, practices, and organizational models. We view these partnerships as bold pioneers and, we hope, as harbingers of a new era of innovation and multi-sector collaboration focused on building a robust culture of health in communities throughout America.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

MILLION HEARTS COLLABORATIVE NEW YORK

Guthrie Birkhead, MD, MPH
Deputy Commissioner, Office of Public Health

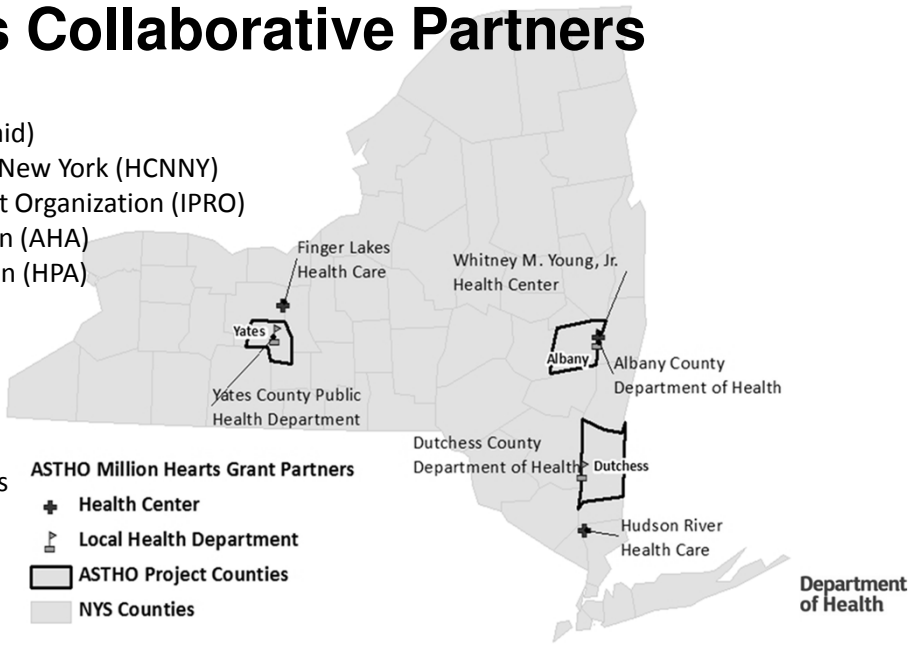
February 3, 2015

New York's Collaborative Partners

Statewide Partners:
-NYSDOH (including Medicaid)
-Health Center Network of New York (HCNNY)
-NYS's Quality Improvement Organization (IPRO)
-American Heart Association (AHA)
-NYS Health Plan Association (HPA)

Regional Partner:
RHIO (HIXNY)

Local Partners:
County Health Departments
FQHCs
Americore workers
Cornell Coop Extension

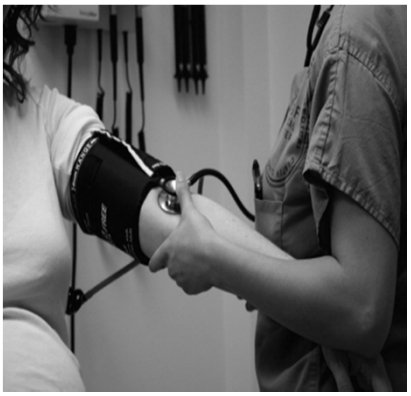


New York's Million Hearts Programmatic Innovations

Project Aim: 10% improvement in 1 year in HTN control and identification of undiagnosed HTN.

FQHCs used the IHI model for improvement to implement system changes via PDSA cycles to improve HTN control:

- Established clinical treatment protocols (CDC)
- Implemented systems changes in the FQHCs
- Implemented home BP monitoring program:
  - Automated BP monitors
  - Educational materials developed by AmeriCorps collaborators.



NEW YORK STATE OF OPPORTUNITY. Department of Health

New York's Million Hearts Data Innovations

1. HCCNY provided data extracts (HTN registry function) using eClinicalWorks EHR
2. Undiagnosed HTN Metric – developed and piloted.
   - Elevated BPs on 2 occasions with no Dx of HTN.
3. HTN medication adherence using Medicaid datamart.
   - Proportion of days covered (CDC methodology)
   - Primary non-adherence (initial prescription filled?)
4. Population HTN surveillance pilot in one county using HIXNY (RHIO) HIE data to assess:
   - Overall population prevalence,
   - HTN control,
   - Undiagnosed HTN,

NEW YORK STATE OF OPPORTUNITY. Department of Health

FQHC Hypertension Prevalence

Health Center	Baseline Sep 2013 Rolling 12 Months	Sep 2014 Rolling 12 Months	Net Diff (Percent Change)
Health Center 1	30.5%	30.6%	0.3%
Health Center 2	29.9%	30.6%	2.3%
Health Center 3	40.1%	44.8%	11.6%
Center Average	**33.5%**	**35.3%**	5.5%
National Average (CDC, 2012)	**29.1%**	**29.1%**	

N = 9,512 patients

NEW YORK STATE OF OPPORTUNITY. Department of Health

FQHC Undiagnosed Hypertension

Health Center	Baseline Dec 2013 Rolling 12 Months	Sep 2014 Rolling 12 Months	Net Diff (Percent Change)
Health Center 1	6.05%	4.39%	-27.44%
Health Center 2	8.18%	6.00%	-26.65%
Health Center 3	6.21%	6.16%	-0.81%
Center Average	**6.81%**	**5.52%**	-19.03%

N= 202

NEW YORK STATE OF OPPORTUNITY. Department of Health

FQHC Hypertension Control (NQF 0018)

Health Center	Baseline Sep 2013 Rolling 12 Months	Sep 2014 Rolling 12 Months	Net Diff (Percent Change)
Health Center 1	70.2%	79.9%	**13.8%**
Health Center 2	58.2%	67.1%	**15.4%**
Health Center 3	52.3%	59.0%	**13.0%**
Center Average	**56.9%**	**68.7%**	**20.7%**
HP 2020 Benchmark	**61.2%**	**61.2%**	

N=2,814

NEW YORK STATE OF OPPORTUNITY. Department of Health

Lessons Learned

- Collaboration across sectors/various partners key to capacity for success
- Senior leadership involvement at all levels in all systems is essential.
- Clear, consistent communication generated common understanding.
- Efficient use of patient registries for planned care accelerates improvement.
- Common EHR platform was critical
- The newly developed and tested undiagnosed HTN metric was successful in identifying patients in need of further evaluation.
- FQHC's highly regarded their collaboration with their LHDs.
- Demonstrated improvement in short timeframe– HTN control improved by an average of 20.7% above baseline across the FQHCs.

NEW YORK STATE OF OPPORTUNITY. Department of Health

Advancing the Million Hearts Initiative Role of Public Health

State Level

- Engage executive and senior leaders.
- Access resources to support initiate.
- Direct the collaborative; convene internal and external partners.
- Align with other state initiatives.
- Medicaid and Managed Care involvement
- Provide population level data to assess burden and monitor outcomes.
- Promotion of evidence based strategies.
- Monitor performance and report outcomes.
- Spread innovation across other initiatives.

Local Level

- Key Primary Care/Public Health QI team member.
- Collaborate to identify integrated clinical and community priorities.
- Identify and connect Primary Care with community resources and evidence based programing, e.g. Cooperative Extension for Home BP monitoring
- Identify and fill gaps in local program delivery.
- Assist with performance monitoring.
- Going forward: strengthen models of team based care adding Community Heath Workers.

NEW YORK STATE OF OPPORTUNITY. Department of Health

Opportunities for Improvement

- Enable prescribing a 90 day supply of HTN medication
  - The Evidence: 90 day medication supply increase adherence/control
  - NYS Medicaid allows, but MMC plans are concerned about cost and waste
  - Follow up with Medicaid and MMC plan directors
  - Maintain 30 day prescription until patient is on stable regimen
- Electronic communication when patient fills prescriptions
  - Need to leverage State Health Information Network (SHIN-NY) and develop data sharing agreements between Medicaid and providers
- Notify provider when patients goes to ED
  - Currently health plan is notified.

NEW YORK STATE OF OPPORTUNITY. Department of Health

Expansion and Spread

- CDC 1305 Health Systems Collaborative program grant
  - Expand to 9 FQHC/LHD collaborations (63 clinic sites) by 2018
  - Expand the focus to diabetes control and pre-diabetes ID and follow up
- CDC 1422 State and Local Chronic Disease program grant
  - Improve data exchange using RHIOS and FQHC data warehouse – overcome EHR system differences; Improve alerting and communications over the SHIN-NY
- Inform local implementation of high-level initiatives to redesign systems of care and improve population health outcomes
  - NYS Prevention Agenda – State Health Improvement Plan
  - State Health Innovation Plan (SHIP) / State Innovation Model (SIM) grant
  - Medicaid DSRIP Waiver Program
  - Population Health Improvement Program (PHIP) – regional public health detailing
  - IPRO CMS grant – cardiac population health initiative in 200 primary care practices

NEW YORK STATE OF OPPORTUNITY. Department of Health

NYS PREVENTION AGENDA

Priority Areas:

- Prevent chronic diseases
- Promote a healthy and safe environment
- Promote health women, infants, and children
- Promote mental health and prevent substance abuse
- Prevent HIV, STDs, vaccine-preventable diseases, healthcare associated infections

State Health Innovation Plan (SHIP)

Pillars and Enablers

- Improve access to care for all New Yorkers
- Integrate care to address patient needs seamlessly
- Make the cost and quality of care transparent
- Pay for healthcare value, not volume
- Promote population health
- Develop workforce strategy
- Maximize health information technology
- Performance measurement & evaluation

ALIGNMENT:

NYS Million Hearts Collaborative

MEDICAID DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM

Key Themes:

- Integrate Delivery – Performing Provider Systems
- Performance-based payments
- Statewide performance matters
- Regulatory relief and capital funding
- Long-term transformation & sustainability

POPULATION HEALTH IMPROVEMENT PROGRAM (PHIP)

PHIP deliverables:

- Identify, share, and assist with implementation of best practices/strategies to promote population health
- Support and advance the NYS Prevention Agenda
- Support and advance the SHIP
- Serve as resource to DSRIP Performing Provider Systems

Acknowledgements

NYS DOH

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- Meg Meador

FQHCs

- Finger Lakes Health Ctr.
- Hudson River HealthCare
- Whitney Young Health Ctr.

Local Health Departments

- Yates County DOH
- Dutchess County DOH
- Albany County DOH

Health Information Xchange (Hixny)

IPRO – QIO/QIN

Thank You

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NYS Department of Health

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Bureau of Community Chronic Disease Prevention
NYS Department of Health

IOM Roundtable on Population Health Improvement Workshop:

Health Care and Public Health – Opportunities at the Interface

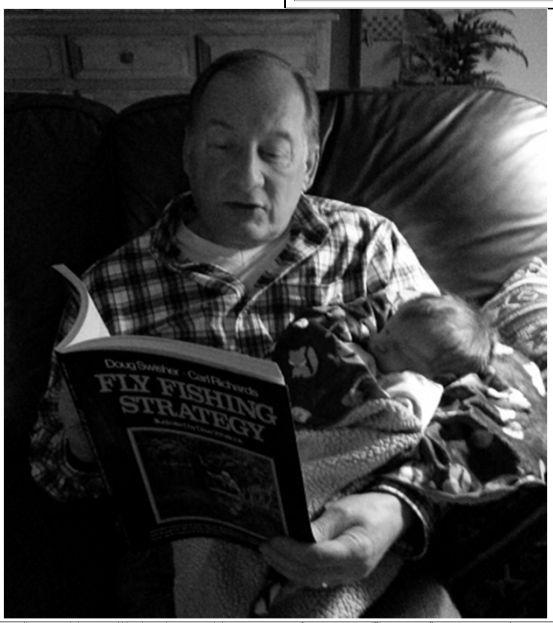
Keck Center of the National Academies
Washington DC

February 5, 2015

Case Study 1: Payment Reform and How the Public Health and Health Care Relationship Advances It

- Moderator - Sarah Linde , HRSA
- Panel - Mary Applegate, Medical Director – Ohio Medicaid
  - Ted Wymyslo, CMO – Ohio Association of Community Health Centers, former Director Ohio Department of Health


Mommy's
little
roar!


Doug Swisher Carl Richards
FLY FISHING
STRATEGY

Transformation of Healthcare in Ohio

Regional Collaboratives – Cinci, Cols, Cleve	
Office of Health Transformation(OHT)	1/11
Ohio Department of Health – PCMH directive	2/11
OHT Innovation Framework	7/11
Ohio Patient-Centered Primary Care Collaborative	11/11
IOM Report – Integration of PH/PC	3/12

OACHC
OHIO ASSOCIATION OF COMMUNITY HEALTH CENTERS

Ohio | Governor's Office of Health Transformation

Innovation Framework

Modernize Medicaid	Streamline Health and Human Services	Pay for Value
Initiate in 2011	***Initiate in 2012***	***Initiate in 2013***
Advance the Governor Kasich's Medicaid modernization and cost containment priorities	*Share services to increase efficiency, right-size state and local service capacity, and streamline governance*	*Engage private sector partners to set clear expectations for better health, better care and cost savings through improvement*
• Extend Medicaid coverage to more low-income Ohioans • Eliminate fraud and abuse • Prioritize home and community services • Reform nursing facility payment • Enhance community DD services • Integrate Medicare and Medicaid benefits • Rebuild community behavioral health system capacity • Create health homes for people with mental illness • Restructure behavioral health system financing • Improve Medicaid managed care plan performance	• Create the Office of Health Transformation (2011) • Implement a new Medicaid claims payment system (2011) • Create a unified Medicaid budget and accounting system (2013) • Create a cabinet-level Medicaid Department (July 2013) • Consolidate mental health and addiction services (July 2013) • Simplify and replace Ohio's 34-year-old eligibility system • Coordinate programs for children • Share services across local jurisdictions • Recommend a permanent HHS governance structure	• Participate in Catalyst for Payment Reform • Support regional payment reform initiatives • Pay for value instead of volume (State Innovation Model Grant) – Provide access to medical homes for most Ohioans – Use episode-based payments for acute events – Coordinate health information infrastructure – Coordinate health sector workforce programs – Report and measure system performance

OPCPCC

Ohio Patient-Centered Primary Care Collaborative

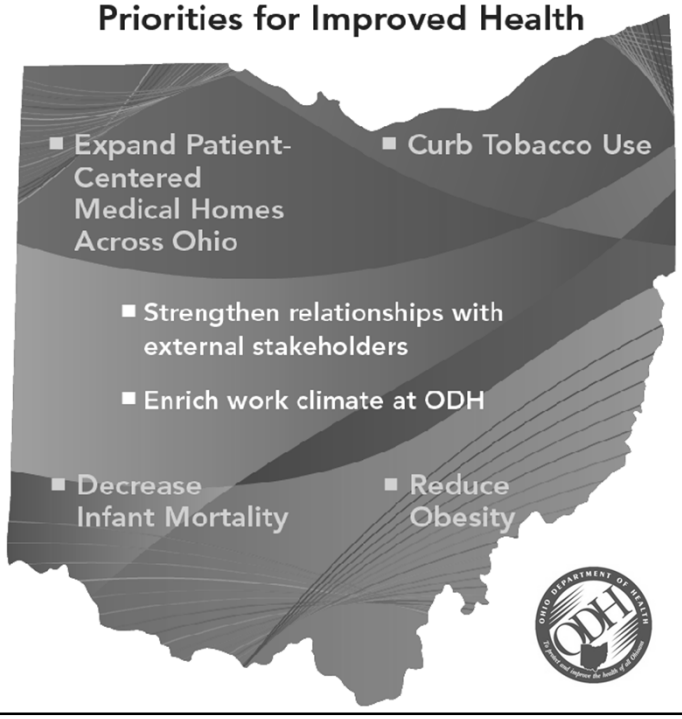
- Coordinates communication among existing Ohio PCMH practices
- Facilitates statewide learning in collaborative PCMH practices in Ohio
- Facilitates new PCMH practice startup in Ohio
- Shapes policy in Ohio for statewide PCMH adoption

Facilitated by the Ohio Department of Health

OACHC

OHIO ASSOCIATION OF COMMUNITY HEALTH CENTERS

Priorities for Improved Health



Transformation of Healthcare in Ohio

Ohio PCMH Education Pilot Project - startup	**7/11**
CMMI- Comprehensive Primary Care Initiative	**11/11**
Governor's Advisory Council on Healthcare Payment Reform	**1/13**
CMMI State Innovation Model (SIM) Planning Grant	**2/13**
Medicaid Extension in Ohio	**1/14**
CMMI SIM Testing Grant	**12/14**

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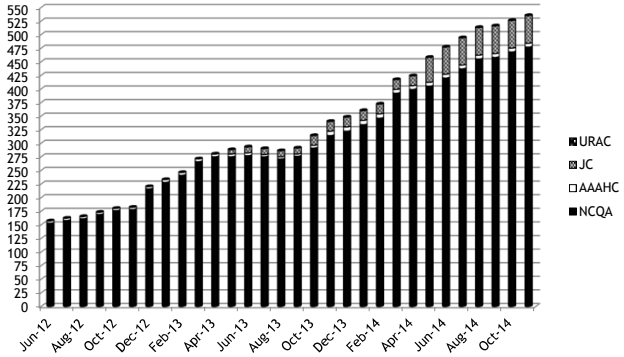
Community Health Centers ● The Healthcare Solution

Ohio PCMH Recognized Sites November, 2014



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Community Health Centers ● The Healthcare Solution

If you want to build a ship, don't drum up people to collect wood and don't assign them tasks and work, but rather teach them to long for the endless immensity of the sea.

-Antoine de Saint-Exupery

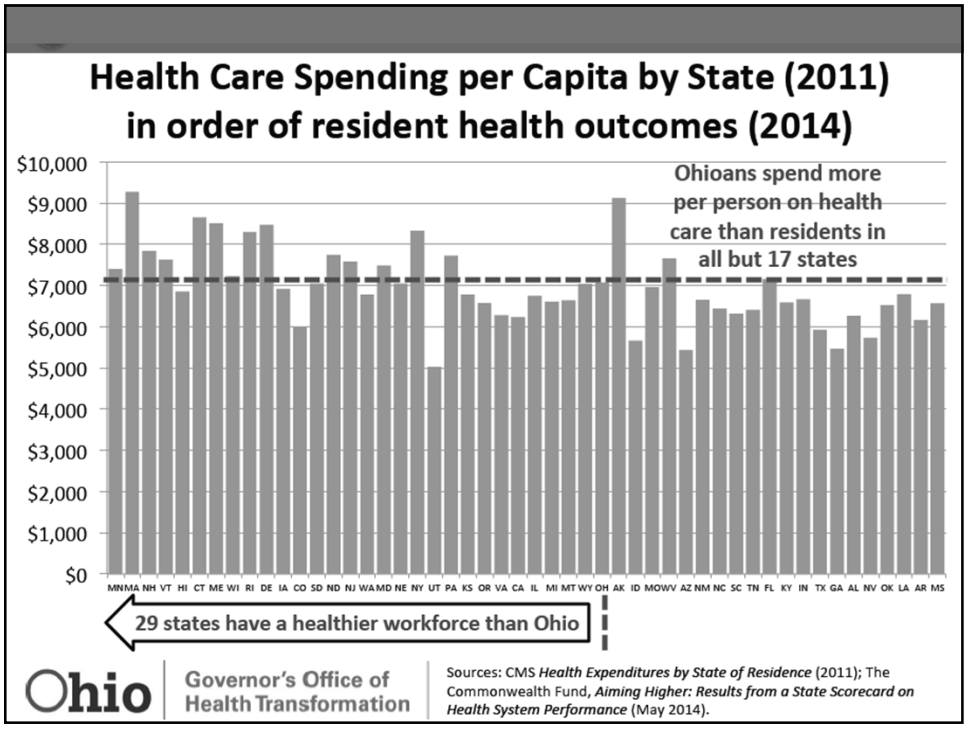
OACHC
OHIO ASSOCIATION OF COMMUNITY HEALTH CENTERS

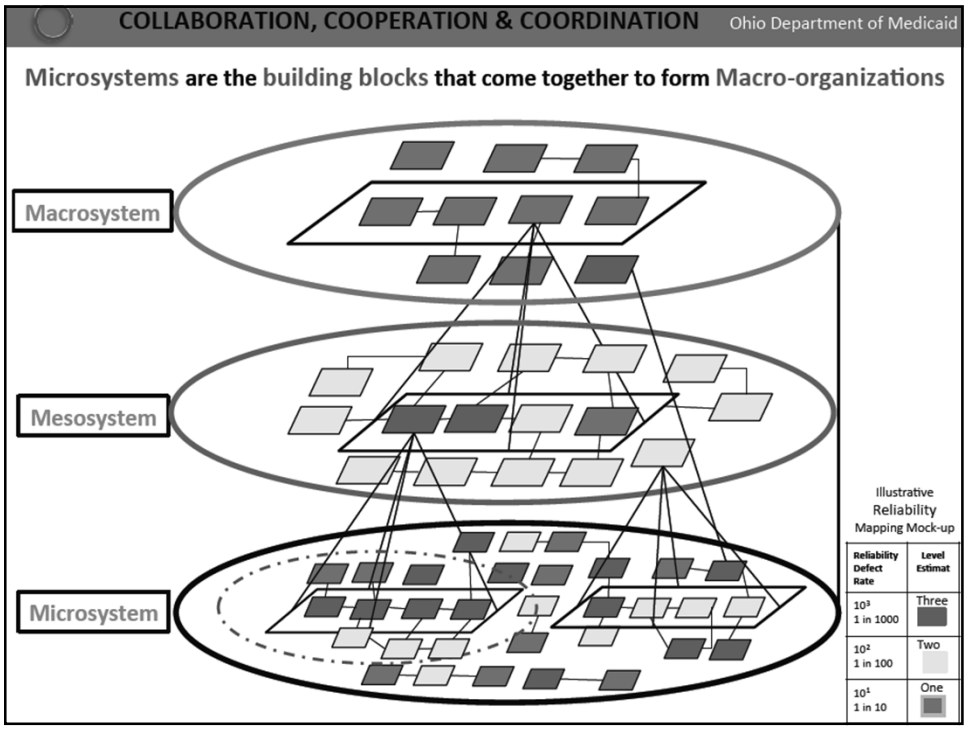
Ohio Department of Medicaid

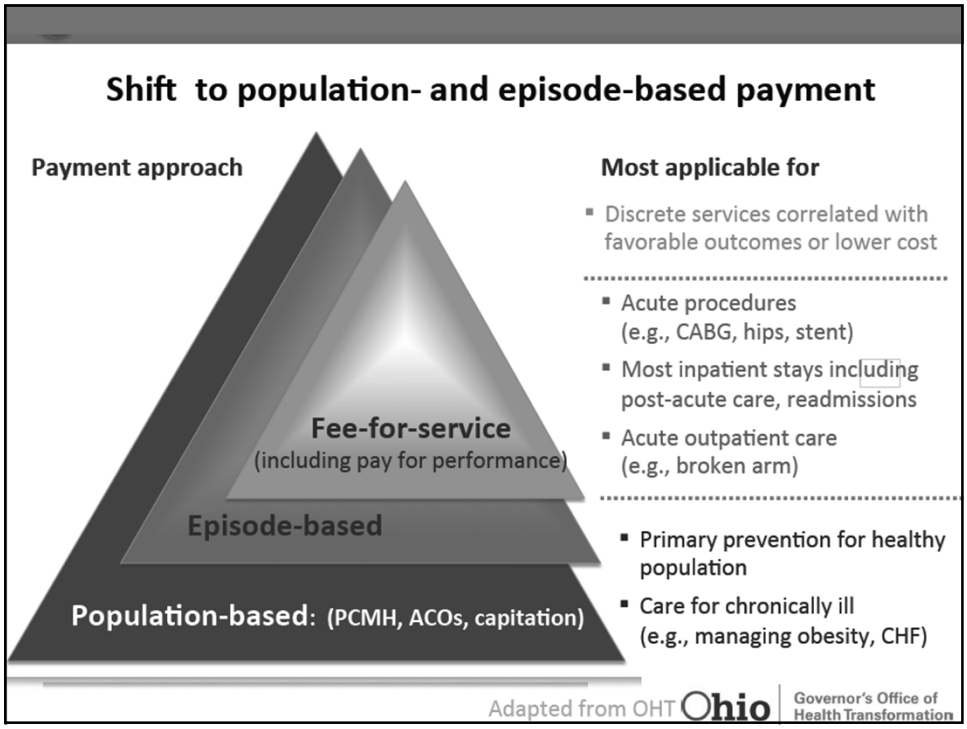
Text

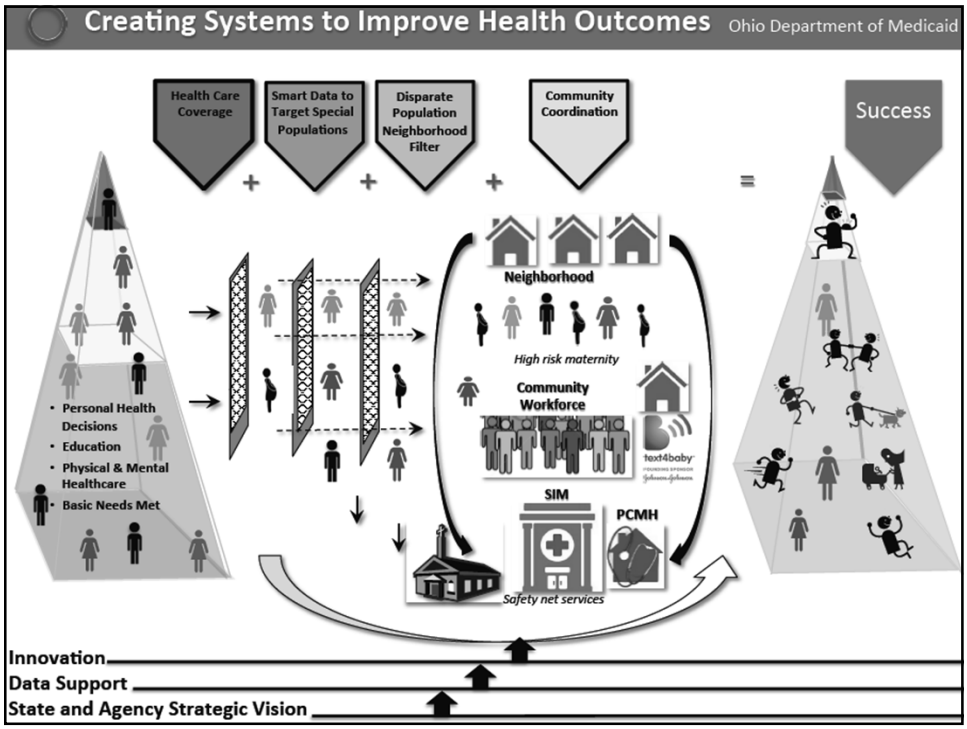
Prescription for Population Health: **Working Together** to Make A Difference

We
Align
Design
Develop
Implement a PLAN
Focused on a population
With specific measurement targets
Based on sound evidence of best clinical practice
In the context of public health and sociopolitical systems
Then figure out how to sustain through value-based purchasing

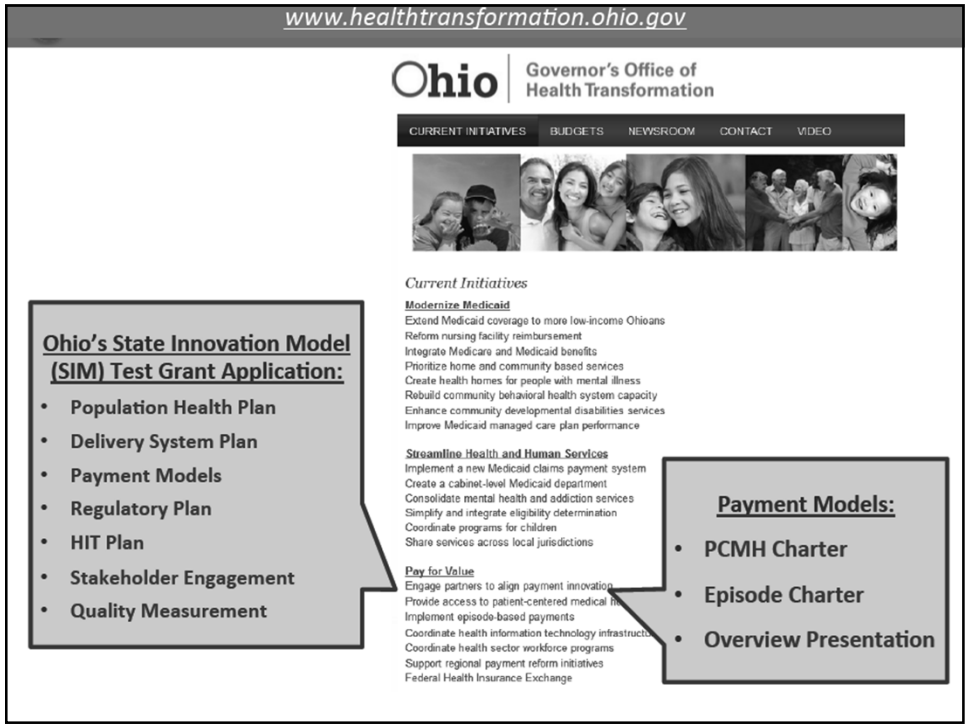

Health Care Spending per Capita by State (2011)
in order of resident health outcomes (2014)
$10,000
$9,000
$8,000
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
Ohioans spend more per person on health care than residents in all but 17 states
MN MA NH VT HI CT ME WI RI DE IA CO SD ND NJ WA MD NE NY UT PA KS OR VA CA IL MI MT WY OH AK ID MO VV AZ NM NC SC TN FL KY IN TX GA AL NV OK LA AR MS
29 states have a healthier workforce than Ohio
Ohio
Governor's Office of Health Transformation
Sources: CMS Health Expenditures by State of Residence (2011); The Commonwealth Fund, Aiming Higher: Results from a State Scorecard on Health System Performance (May 2014).


COLLABORATION, COOPERATION & COORDINATION
Ohio Department of Medicaid
Microsystems are the building blocks that come together to form Macro-organizations
Macrosystem
Mesosystem
Microsystem
Illustrative Reliability Mapping Mock-up
Reliability Defect Rate
Level Estimat
10³ 1 in 1000
Three
10² 1 in 100
Two
10¹ 1 in 10
One


Shift to population- and episode-based payment
Payment approach
Most applicable for
Discrete services correlated with favorable outcomes or lower cost
Fee-for-service
(including pay for performance)
Acute procedures
(e.g., CABG, hips, stent)
Most inpatient stays including post-acute care, readmissions
Acute outpatient care
(e.g., broken arm)
Episode-based
Primary prevention for healthy population
Care for chronically ill
(e.g., managing obesity, CHF)
Population-based: (PCMH, ACOs, capitation)
Adapted from OHT
Ohio
Governor's Office of Health Transformation


Creating Systems to Improve Health Outcomes
Ohio Department of Medicaid
Health Care Coverage
Smart Data to Target Special Populations
Disparate Population Neighborhood Filter
Community Coordination
Success
Personal Health Decisions
Education
Physical & Mental Healthcare
Basic Needs Met
Neighborhood
High risk maternity
Community Workforce
text4baby
SIM
PCMH
Safety net services
Innovation
Data Support
State and Agency Strategic Vision

www.healthtransformation.ohio.gov



Ohio's Innovation Model

- Governor Kasich created the Office of Health Transformation to improve overall health system performance
- Pay for health care value instead of volume across Medicaid, state employee, and commercial populations
  - Launch episode based payments in Q1 2015
  - Take Comprehensive Primary Care to scale in 2015
- Partners include Anthem, Aetna, CareSource, Medical Mutual, and UnitedHealthcare, covering ten million Ohioans
- Build on momentum from extending Medicaid coverage, Medicare-Medicaid Enrollee project, etc.
- Comprehensive, complementary strategies for health sector workforce development and health information technology
- Active stakeholder participation: 150+ stakeholder experts, 50+ organizations, 60+ workshops, 20 months and counting …

Ohio | Governor's Office of Health Transformation | www.healthtransformation.ohio.gov

Ohio | Governor's Office of Health Transformation

5-Year Goal for Payment Innovation

Goal

80-90 percent of Ohio's population in some value-based payment model (combination of episodes- and population-based payment) within five years

State's Role

- Shift rapidly to PCMH and episode model in Medicaid fee-for-service
- Require Medicaid MCO partners to participate and implement
- Incorporate into contracts of MCOs for state employee benefit program

	Patient-centered medical homes	Episode-based payments
Year 1	▪ In 2014 focus on Comprehensive Primary Care Initiative (CPCi) ▪ Payers agree to participate in design for elements where standardization and/or alignment is critical ▪ Multi-payer group begins enrollment strategy for one additional market	▪ State leads design of five episodes: asthma acute exacerbation, perinatal, COPD exacerbation, PCI, and joint replacement ▪ Payers agree to participate in design process, launch reporting on at least 3 of 5 episodes in 2014 and tie to payment within year
Year 3	▪ Model rolled out to all major markets ▪ 50% of patients are enrolled	▪ 20 episodes defined and launched across payers
Year 5	▪ Scale achieved state-wide ▪ 80% of patients are enrolled	▪ 50+ episodes defined and launched across payers

Elements of the episode definition

Category	Description
1 Episode trigger	▪ Diagnoses or procedures and corresponding claim types and/or care settings that characterize a potential episode
2 Episode window 3 Claims included	▪ **Pre-trigger window**: Time period prior to the trigger event; relevant care for the patient is included in the episode ▪ **Trigger window**: Duration of the potential trigger event (e.g., from date of inpatient admission to date of discharge); all care is included ▪ **Post-trigger window**: Time period following trigger event; relevant care and complications are included in the episode
4 Principal accountable provider	▪ Provider who may be in the best position to assume principal accountability in the episode based on factors such as decision making responsibilities, influence over other providers, and portion of the episode spend
5 Quality metrics	▪ Measures to evaluate quality of care delivered during a specific episode
6 Potential risk factors	▪ Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate an increased level of risk for a given patient in a specific episode
7 Episode-level exclusions	▪ Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate a type of risk that, due to its complexity, cost, or other factors, should be excluded entirely rather than adjusted

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Retrospective episode model mechanics

Patients and providers continue to deliver care as they do today

1 

Patients seek care and select providers as they do today

2 

Providers submit claims as they do today

3 

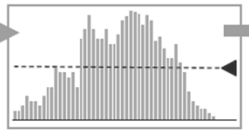
Payers reimburse for all services as they do today

Calculate incentive payments based on outcomes after close of 12 month performance period

4 

Review claims from the performance period to identify a **'Principal Accountable Provider'** (PAP) for each episode

5 Payers calculate **average cost per episode** for each PAP



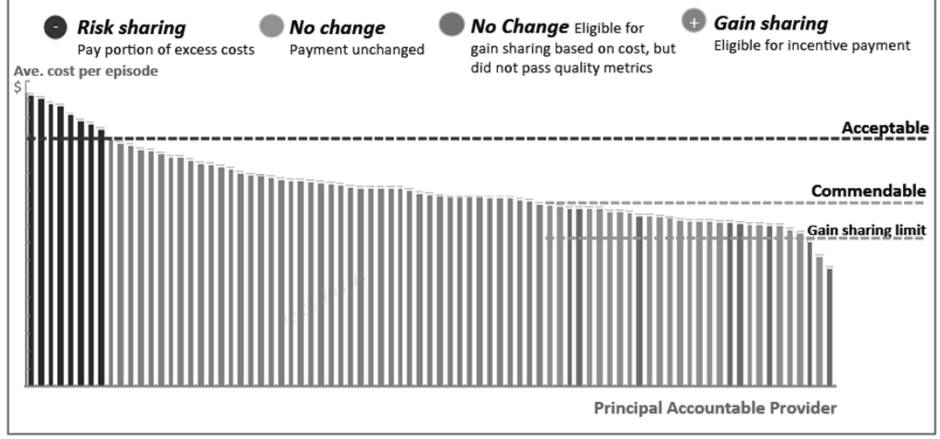
Compare average costs to predetermined "commendable" and "acceptable" levels

6 **Providers may:**

- **Share savings**: if average costs below commendable levels and quality targets are met
- **Pay part of excess cost:** if average costs are above acceptable level
- **See no change in pay:** if average costs are between commendable and acceptable levels

Retrospective thresholds reward cost-efficient, high-quality care

Provider cost distribution (average episode cost per provider)



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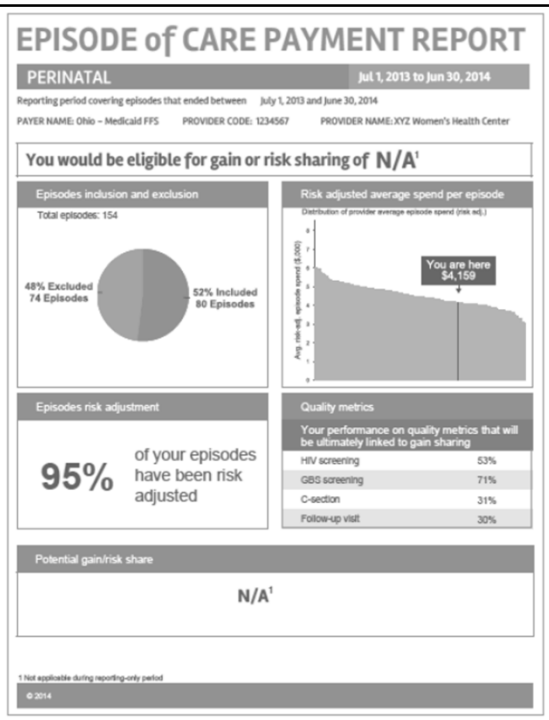
NOTE: Each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost

Anthem
aetna
UnitedHealthcare
MEDICAL MUTUAL
CareSource
MOLINA HEALTHCARE
Buckeye Community Health Plan
PARAMOUNT ADVANTAGE

This is a sample report; actual reports will be released in 2015

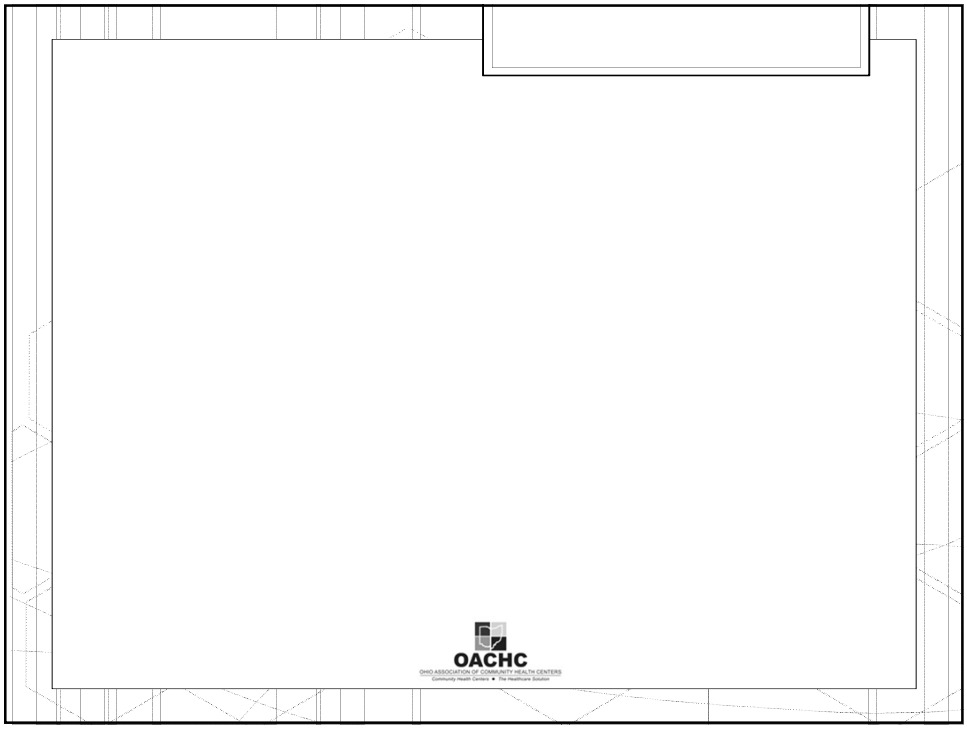
Ohio | Governor's Office of Health Transformation

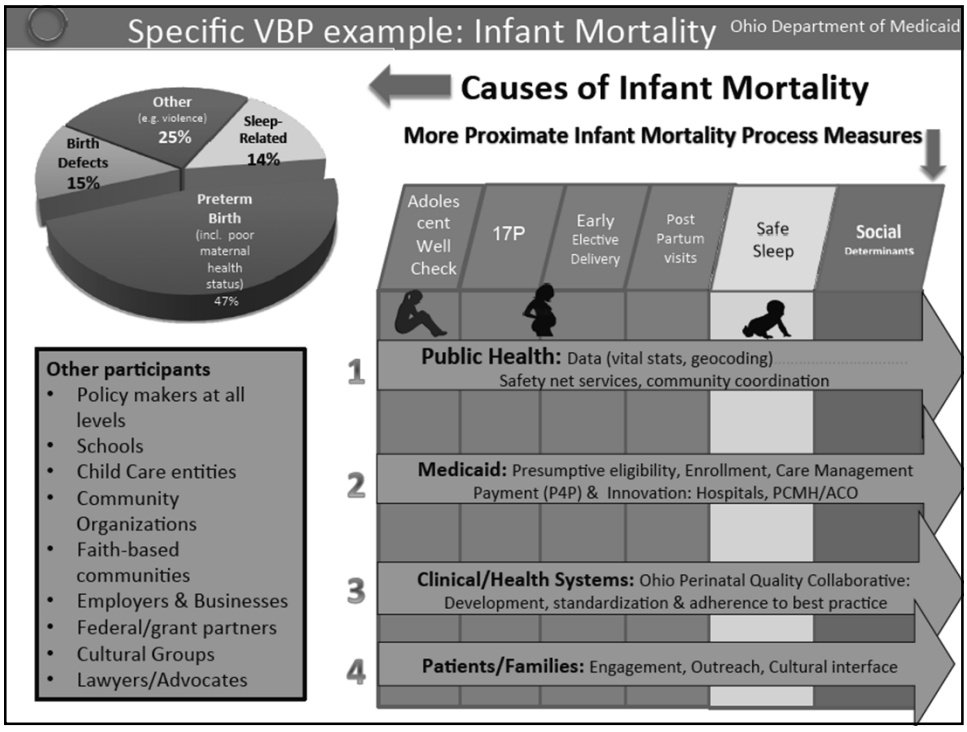


Creating Systems to Improve Outcomes

- What can YOU do to save a baby?
- What can **we** do better together?

Mary.applegate@medicaid.ohio.gov
& public health partners


OACHC


Specific VBP example: Infant Mortality
Ohio Department of Medicaid
Causes of Infant Mortality
More Proximate Infant Mortality Process Measures
Other (e.g. violence) 25%
Sleep-Related 14%
Birth Defects 15%
Preterm Birth (incl. poor maternal health status) 47%
Adolescent Well Check
17P
Early Elective Delivery
Post Partum visits
Safe Sleep
Social Determinants
Other participants
• Policy makers at all levels
• Schools
• Child Care entities
• Community Organizations
• Faith-based communities
• Employers & Businesses
• Federal/grant partners
• Cultural Groups
• Lawyers/Advocates
1 Public Health: Data (vital stats, geocoding) Safety net services, community coordination
2 Medicaid: Presumptive eligibility, Enrollment, Care Management Payment (P4P) & Innovation: Hospitals, PCMH/ACO
3 Clinical/Health Systems: Ohio Perinatal Quality Collaborative: Development, standardization & adherence to best practice
4 Patients/Families: Engagement, Outreach, Cultural interface

Ohio Department of Medicaid

State of Ohio Infant Mortality Plan: **Designed** to Address Disparities

Why?

Infant mortality is considered the mark of the overall health of a city, state or nation. Despite enormous efforts, Ohio lags behind other states.

2011 Infant deaths	Numbers of babies that died	Infant Mortality Rate per 1000 births
Overall	1087	7.88
White	703	6.3
African American	373	15.45

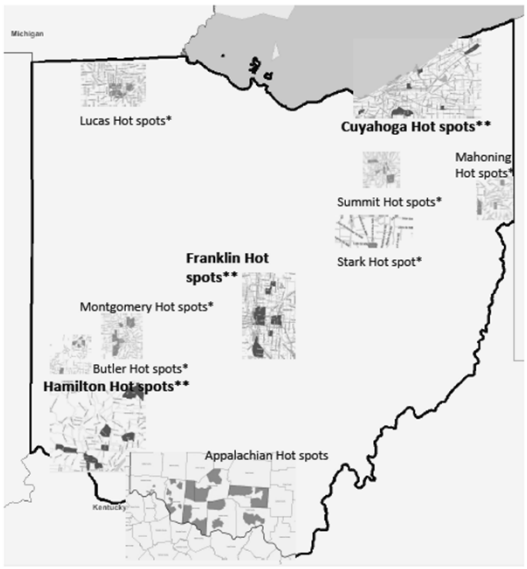
How to Bring Focus to Develop a Plan?	What to Measure? By diverse subpopulations
Preterm births are the single largest contributor to death rates---------- greatly influenced by the **declining health of Ohio's women** prompting the focus on	Measure: Vital stats- birth record
1. **Adolescent health** (Pre-Conception population) and----------	Core Medicaid Measure, HEDIS
2. **Post Partum visits** (gateway to Inter-conception health--------- – until "Well Woman measure established for population)	Core Medicaid Measure, HEDIS
3. **Cultural** issues	Measure the differences, Census tracts for all
Unsafe sleep environments and ----------	Hospital safe sleep audits, campaign numbers
Exposure to **tobacco products** are also important causes----------	ICD-10 claims that include tobacco use

Ohio Department of Medicaid

State of Ohio Infant Mortality Plan: **Designed** to Address Disparities

Where?

Use data for strategic focus:



What to do?

1. **Target neighborhoods** with highest preterm birth & low birth weight rates
2. **Utilize Community Health Workers,** maximizing opportunities to receive enhanced maternal care through Medicaid Managed Care
3. **Invest in innovative care** models
4. **Link** hospitals & clinicians to local public health for community coordination & future sustainability
5. **Leverage** existing systems w data transparency & payment innovation