Welcome to

ASTHO’s Payment and Delivery Reform Technical Assistance Call Series

Aligning State Innovation Models Plans and Health Assessments to Improve Population Health

Presented by ASTHO and the Centers for Disease Control and Prevention
Objectives of the call:

■ To highlight how states are aligning SIM population health plans and state health assessments to meet the needs of their population.

■ To increase awareness of opportunities for collaboration between public health and other stakeholder groups to improve population health.

■ To highlight potential benefits of aligning statewide population health plans and other health assessments for states interested in public health accreditation.
Speakers

Donna Marshall, BSN
Senior Director
Performance and Quality
ASTHO
Speakers

Kala Shipley, MBA, RDN
State Innovation Model Project Manager, Office of Healthcare Transformation
Iowa Department of Public Health

Sadie Gasparotto, LMSW, MS, BSW
Community Assessment Planner, Bureau of Planning Services
Iowa Department of Public Health
Speakers

Maria Courogen, MPH
Special Assistant, Health Systems Transformation and Innovation
Washington State Department of Health
Introduction to National Public Health Department Accreditation
National Standards for Public Health Departments

ADMINISTERED BY PHAB: A Non-profit, non-governmental organization that is accrediting body for national public health accreditation

GOAL: To improve and protect the health of every community by advancing the quality and performance of public health departments (state, local, Tribal, territorial).
PHAB’s Vision

Accreditation requires an on-going health departmental commitment to quality improvement and adherence to national standards.

High Performing Health Departments Leading to a Healthier Nation
PHAB Standards & Measures Version 1.5

- Based on the Core public health functions and the 10 Essential Public Health Services (EPHS) (www.cdc.gov)

- 12 Domains: 10 EPHS + Administrative and Governance
The Public Health Standards Address:

- Leadership
- Planning
- Community engagement
- Customer focus
- Workforce development
- Evaluation and quality improvement
- Governance
Twelve Domains

1. Conduct and Disseminate **Assessments** Focused on Population Health Status and Public Health Issues Facing the Community
2. **Investigate** Health Problems and Environmental Public Health Hazards to Protect the Community
3. **Inform and Educate** about Public Health Issues and Functions
4. **Engage with the Community** to Identify and Address Health Problems
5. **Develop Public Health Policies and Plans**
6. **Enforce** Public Health Laws
7. **Promote Strategies to Improve** Access to Health Care
8. **Maintain and Competent Public Health Workforce**
9. **Evaluate and Continuously Improve** Processes, Programs, and Interventions
10. **Contribute to and Apply the Evidence Base** of Public Health
11. Administration & Management
12. **Maintain Capacity to Engage the Public Health Governing Entity**
Fifty Percent of U.S. Population Now Protected by PHAB-Accredited Public Health Departments
State Health Assessment

Domain 1

“Conduct and Disseminate Assessments Focused on Population Health Status and Public Health Issues Facing the Community”

Standard 1.1

“Participate in or lead a collaborative process resulting in a comprehensive state health assessment”
Community Engagement and Partner Collaboration

Collaboration is a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals.

*PHAB Acronyms and Glossary of Terms Version 1.5 (Dec. 2013).*
Public Health and Primary Care Collaboration

### Table 5. Active Engagement with Primary Care Providers, 2014

<table>
<thead>
<tr>
<th>Integration Activities</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementing strategies to increase accessibility to primary care services (n=43)</td>
<td>88%</td>
</tr>
<tr>
<td>Encourage the use of evidence-based public health services (n=42)</td>
<td>88%</td>
</tr>
<tr>
<td>Encourage the use of evidence-based clinical preventative services (n=42)</td>
<td>88%</td>
</tr>
<tr>
<td>Providing population health statistics to primary care associations, providers, and practices (n=42)</td>
<td>86%</td>
</tr>
<tr>
<td>Developing a state or territorial health assessment or improvement plan (n=43)</td>
<td>81%</td>
</tr>
<tr>
<td>Conducting a community health assessment (n=41)</td>
<td>81%</td>
</tr>
<tr>
<td>Receiving clinical data from primary care providers and practices to improve health surveillance (n=42)</td>
<td>76%</td>
</tr>
<tr>
<td>Provide care coordination/case management for patients with complex needs (n=43)</td>
<td>74%</td>
</tr>
<tr>
<td>Participating in a patient-centered medical home (n=42)</td>
<td>48%</td>
</tr>
<tr>
<td>Participating in an accountable care organization, community care organization, or accountable communities of health (n=38)</td>
<td>24%</td>
</tr>
</tbody>
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ASTHO- 2015 Forces of Change Survey Report
State Examples & Lessons Learned

- **North Carolina**
  - Syncing of Community Health Assessment (CHA) and Community Health Needs Assessment Cycles
  - North Carolina CHNA Case Study

- **Kansas**
  - Support for communities conducting CHNAs/CHAs and community health improvement plans through coordinated efforts.
  - Kansas CHNA Case Study

- **Illinois**
  - Aligning the SHA, SHIP, and SIM within “Health Illinois 2021”
  - Illinois Alignment of SHA, SHIP and SIM
Resources

- **PHAB**
  - [www.phaboard.org/accreditation-process](http://www.phaboard.org/accreditation-process)

- **ASTHO**
  - [www.astho.org/Programs/Accreditation-and-Performance/](http://www.astho.org/Programs/Accreditation-and-Performance/)
  - [www.astho.org/Profile](http://www.astho.org/Profile)

- **NACCHO**
IOWA: STATE INNOVATION MODEL
State Innovation Model (SIM)

• Iowa is one of 11 Round Two Test States
  • 1 implementation year and 3 model test years

• Broad-based, multi-payer approach that improves health for all Iowans
  • Involve innovative approaches that encompass private-public partnerships
  • Population health improvement and payment reforms
The Iowa SIM Vision: Transforming Health Care to Improve the Health of Iowans

AIMS

**Improve Population Health**
- Focus: Diabetes, Obesity, Tobacco use, OB, HAI, Med Safety, SDH

**Transform Healthcare**
- Focus: Preventable Utilization (ED visits and Inpatient admissions)

**Promote Sustainability**
- Focus: Providers participating in value-based purchasing and Financial Impacts to health care system/Iowans

**Goals: by 2018**

**Improve** the health of Iowans in three areas:
- Tobacco: Increase quit attempt rate by 5.1%
- Obesity: Decrease prevalence rate by 2.9%
- Diabetes: Increase A1C test rate by 4.1%

**Reduce** the rate of preventable readmissions by 20% in the Medicaid and Wellmark population

**Reduce** the rate of preventable ED visits by 20% in the Medicaid and Wellmark population

**Increase** participation in Value Based Purchasing in Iowa, by evidence of 50% of Medicaid, Wellmark, and Medicare payments linked to VBP contracts

**Primary Driver**

Plan to Improve Population Health

Care Coordination

Community-Based Performance Improvement

Value Based Purchasing (VBP)

**Secondary Drivers**

- Assess local and state environment to identify population health needs
- Develop and deploy interventions, including statewide strategies
- Establish and monitor key population metrics
- Execute integrated community-based strategies
- Inform providers for better care coordination
- Execute care coordination models
- Optimize use of Health Information Technology (HIT)
- Engage leadership & receive leadership Commitment
- Develop & implement quality improvement strategies
- Conduct rapid cycle evaluation of performance data to stakeholders
- Align payers in value reimbursement and Quality strategies
- Implement VBP into the new Managed Care system in Medicaid

Ongoing Evaluation
Plan to Improve Population Health

• Statewide Strategy Plans
• Plan to Improve Population Health by January, 2019: Tobacco, Diabetes, and Obesity
Overview Of Healthy Iowans

- Healthy Iowans sets the agenda for solving priority health issues facing Iowans
- The plan is the outcome of a statewide needs assessment involving public and private partners as well as individuals
- Since the 1990s, Healthy Iowans has included a set of measurable goals with objectives/action steps
- IDPH coordinates ongoing technical assistance, tracking yearly progress, and making revisions
Healthy Iowans Methodology

Local Community Priorities
Data Source: Analysis of local CHNA&HIPs.

Healthy Iowans Recommendations
Data Source: Analysis of stakeholder input.

Burden on Iowans: Is Iowa in bottom 20 states nationally?
Data Source: America's Health Rankings, other secondary data sources.

Health Inequity: Are certain populations disproportionately affected?
Data Source: IDPH data, Iowa Health Profile, secondary data sources.

Gap Analysis: Is there evidence for other issues not already identified?
Data Source: IDPH data, Iowa Health Profile, H.P. 2020, Secondary data

Result: Combine information into State Health Assessment
Local Public Health In Iowa

- Decentralized system of Public Health within the state of Iowa
- 99 County Boards of Health
- 2 City Boards of Health
- The assessment and planning processes that occur at the local level serve as the foundation for Healthy Iowans
Local Public Health In Iowa

• Local boards of health lead community-wide assessment and planning process to develop a Community Health Needs Assessment and a Health Improvement Plan (CHNA/HIP)

• These processes look different across the state but typically include many local stakeholders such as human services agencies, hospitals, individuals, sector of government, etc.

• 38 Local Public Health Agencies are based in a health system or hospital
Collaboration with Hospitals

- Federal IRS requirements for nonprofit hospitals to conduct a CHNA

- Many local public health agencies across Iowa are partnering with hospitals in different ways to help align with CHNA/CHIP processes
What does Alignment Look Like?

• Does it mean working together to establish a common timeline or maybe a common group of stakeholders?
• Does it mean one all-inclusive process?
• Does it mean a few different processes that inform and build upon each other?
• Does it mean having common needs or issues that everyone is working on in different ways?
SIM Plan To Improve Population Health

Focus Areas: Diabetes, Tobacco, and Obesity

1. Assessment
2. Existing Population Health Efforts
3. Roadmap to Improve Population Health
SIM Plan To Improve Population Health

Focus Areas: Diabetes, Tobacco, and Obesity

1. Assessment
2. Existing Population Health Efforts
3. Roadmap to Improve Population Health
Roadmap to Improve Population Health

Three Buckets of Prevention:

• Traditional Clinical Approaches
• Innovative Patient-Centered Care
• Community-Wide Health

Questions: Kala Shipley
Sadie Gasparotto

http://idph.iowa.gov/SIM

SIM Partners
The Intersection of SIM and Public Health in Washington State

Maria Courogen, MPH
Washington State Department of Health
May 5, 2016
Outline

• Review of Healthier Washington Initiative
• Performance Measures
• The Plan for Improving Population Health
• State Health Assessment
• Intersections for Public Health
Healthier Washington
Healthier Washington: Better Health, Better Care, Lower Costs

Healthier Washington will transform health care in Washington State so that people experience better health during their lives, receive better care when they need it, and so care is more affordable and accessible.
Washington’s vision for creating healthier communities and a more sustainable health care system by:

- Improving how we pay for services
- Ensuring health care focuses on the whole person
- Building healthier communities through a collaborative regional approach
- Improving how we pay for services
Community Empowerment and Accountability

Accountable Communities of Health will:

• Bring together diverse public and private community partners to work on shared regional health goals.

• Identify opportunities for the ACH and community partners to understand and bridge health and quality of life issues.

• Coordinate systems so that services address all aspects of health at both the community and individual levels.
Analytics, Interoperability, and Measurement

Washington State will:

- Develop a consistent set of measures for health performance.
- Enhance our capacity to exchange information.
- Bolster analytic capacity.
Performance Measures

Washington State Common Measure Set for Health Care Quality is a set of 52 measures to:

- Standardize the way we measure performance as a state, reducing unnecessary burden on health systems.
- Ensure equal access to high-quality health care by reducing variation in care and improving health outcomes.
- Publicly share results to develop a common understanding of what needs to improve and where it needs to improve.
What is Population Health?

Population Health

WA State Population
Sub-Population (e.g. Medicaid, clinic panel)
Clinical & Individual focus
Community Clinical Linkages
Public health usually focuses here...
5% Starter Measures

Clinical & Individual focus
Community focus

Healthier WASHINGTON
The Prevention Framework

• Developed and submitted with SIM grant application
• Establishes priority of prevention and management of chronic disease and behavioral health issues while addressing root causes.
• Initial focus areas:
  • Cardiovascular disease and diabetes
  • Healthy eating, active living, tobacco free living, and obesity prevention
  • Mental health, substance abuse/use (opioids)
  • Trauma informed practices
• Objectives and strategies
The Plan for Improving Population Health

- Will guide how the state and local communities can best implement population health improvement strategies

- Process tools and resources that will allow communities to take any health priority and implement public health and clinical interventions that:
  - Assess
  - Engage
  - Measure impact
  - Quantify return on investment
  - Apply the latest evidence

- Advisory groups
- Measure development
State Health Assessment
State Health Assessment

- A State Health Assessment is a collaborative process of collecting and analyzing data and information for use in educating and mobilizing communities, developing priorities, garnering resources and planning actions to improve the populations health.

- When WA was accredited through PHAB in 2013, we received criticism that there was little stakeholder input for the state health assessment.

- We have multiple avenues for stakeholder engagement, including the Healthier Washington initiative.
State Health Assessment - Criteria

- High burden
- High cost
- Actionable at multiple levels
- Easy to communicate
- Align with other state and national health indicators
- Valid and reliable data source
- County level data for 80% of counties

And
- Measures across lifespan
- Measures that demonstrate health disparities
State Health Assessment - Alignments

- America’s Health Rankings
- County Health Rankings
- Healthy People 2020 Leading Health Indicators
- CDC Community Health Status Indicators
- WA State Local Public Health Indicators
- Institute of Medicine Core Metrics
- CDC 6I18 Initiative
- WA Prevention Framework
- Common Measure Set
State Health Assessment - Domains

• Background
• Health Outcomes
• Health Behaviors
• Healthcare Access and Preventive Care
• Physical Environments
• Social Determinants
State Health Assessment - Timeline

- March 2016 – Indicator development
- May/June 2016 – Initial presentation, prioritization for analyses
- Fall 2016 – Winter 2017 – Data presentation
- Fall 2016 – Spring 2017 – Report development
Assessment and Public Health
ACHs and Foundational Public Health Services

Foundational Programs
- Communicable Disease Control
- Chronic Disease & Injury Prevention
- Environmental Public Health
- Maternal Child Family Health
- Access to Clinical Care
- Vital Records

Foundational Capabilities
- Assessment (surveillance and epidemiology)
- Emergency preparedness and response (all hazards)
- Communications
- Policy development and support
- Community partnership development
- Business competencies

Additional Important Services
Resources
The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S Department of Health and Human Services, Centers for Medicare & Medicaid Services.

The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.
Q&A

If you have a question, you may type it into the chat box now or press the phone commands to have the operator unmute your line.
Thank you for joining us!

Please complete our webinar evaluation survey:

http://astho.az1.qualtrics.com/SE/?SID=SV_cOvdMrvq0393Gnz

Visit ASTHO’s website for additional resources and to access a recording of today’s presentation:

http://www.astho.org/Programs/Health-Systems-Transformation/Delivery-and-Payment-Reform-TA-Call-Series/

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