# Patient-Centered Care Across the Community

## April 30, 2018

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Patient-Centered Primary Care COLLABORATIVE

# Welcome & Announcements

•Welcome – Ann Greiner, PCPCC President & CEO

•PCPCC Executive Members **Only**:
- Immediately following this webinar, **Executive Members are invited to an exclusive session with the webinar panelists.**
- **Registration**: agross@pcpcc.org

•Upcoming Webinar – May 30, 2018 at 3:00pm EST
- **Topic**: Organizations that work in Pediatrics
- **Registration**: Visit the Events Calendar on the PCPCC Website

- Interested in PCPCC Executive Membership?
  - Email Allison Gross (agross@pcpcc.org) or visit: www.pcpcc.org/executive-membership

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# Panelists

## Robert Dribbon

PCPCC Executive Member Liaison
**Merck**

## David Ehrenberger

Chief Medical Officer
**HealthTeamWorks**

## Marc Rosen

Technical Advisor, Clinical Integration
**YMCA**

## Angie Wolff

Strategic Consultant
**Humana**

Patient-Centered
Primary Care
COLLABORATIVE

HealthTeamWorks®

# Community-Integrated Primary Care

David Ehrenberger MD
Chief Medical Officer
HealthTeamWorks

30 April 2018

# Defining the Optimal Scope of Advanced Primary Care

- Patient Centering as TRUE NORTH of APC design & function
- Beyond the brick and mortar concept of PCMH
- The Odd Couple:  Population Health & Population Health Management

# Perspectives in Primary Care: A Conceptual Framework and Path for Integrating Social Determinants of Health Into Primary Care Practice

*Jennifer E. DeVoe, MD, DPhil*[1,2]
*Andrew W. Bazemore, MD, MPH*[3]
*Erika K. Cottrell, PhD, MPP*[1,2]
*Sonja Likumahuwa-Ackman, MID, MPH*[1]
*Jené Grandmont, MA*[3,4]
*Natalie Spach*[3]
*Rachel Gold, PhD, MPH*[2,5]

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*Ann Fam Med* 2016;14:104-108. doi: 10.1370/afm.1903.

## SOCIAL DETERMINANTS DRAMATICALLY INFLUENCE HEALTH

The United States falls behind other industrialized nations on most health indicators[1] and remains plagued by stark health disparities.[2] Efforts to understand the factors underlying these persistent inequalities and other shortcomings highlight the role of social determinants of health (SDH).

SDH are the nonclinical factors, such as the socioeconomic conditions and neighborhood resources, that influence patients' health outcomes.[3] The World Health Organization defines SDH as "the conditions in which people are born, grow, work, live and age and the wider set of forces and systems shaping the conditions of daily life."[4] A rich body of literature shows that SDH are associated with morbidity, mortality, and other health indicators.[5-12] There is mounting evidence to suggest that SDH influence health outcomes more than medical care.[13] Even so, attempts to address SDH in medical care settings have been limited and, for the most part, ineffective. Serious efforts to reduce health disparities and improve population health will require innovative solutions for systematically addressing SDH in all primary care settings.[14,15]

*Conflicts of interest: authors report none.*

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## ADDRESSING SDH IN PRIMARY CARE SETTINGS

Primary care, the largest health care delivery platform in the United States, is widely regarded as a natural point of integration and coordination between clinical care and public health, behavioral health, and community services.[16] Recognition of and attention to nonmedical factors that influence health are not new concepts in primary care. Some primary care clinics in the early 1900s employed peer health aides and provided recreation and welfare activities for their communities, as well as more formal health care services.[17] These early health centers focused on health promotion and education, seeking to address poor nutrition and other SDH.[17] The recognition that social determinants influence health fueled the creation of community-oriented primary care concepts in the 1940s,[18-20] the development of family medicine as a medical specialty in the late 1960s,[21,22] the passage of legislation to create the neighborhood Health Center Program in 1964 (predecessor to federally qualified health centers),[23] and the Alma-Ata declaration in 1978, which stated that "primary health care…is the first level of contact of indi-

# Community Integrated Primary Care: The DNA of the 5-Part Aim NETWORK

- Beyond the 3-Part Aim
- The Health Network: Patient Centering as System Property of the Community
  - Community Clinical Linkages
    - Medical and community resources
    - Integration/partnership with CHW and Health Navigators
  - Accountable Collaboration
  - IDN development—the foundation for high performing primary care

# Integrated Delivery Network:
## Key Drivers of Performance

| | IDN Domains | IDN Domain Pillars | |
|---|---|---|---|
| 1 | **Organization, Leadership, Vision, Strategic Development** | Integrated Delivery Network: Organization & Governance | Iintegrated Delivery Network: Practice Support Services |
| | | Integrated Delivery Network: Performance Improvement | Care Team and Provider Vitality |
| 2 | **Advanced Network Integration** | Network Collaboration and Care Transitions | Advanced Systems of Primary and Specialty Care |
| | | Integrated Care and Social Determinants | |
| 3 | **Value-Based Performance Payer Contracts & Funds Flow** | Value-Based Contracting & Business Models | Total Cost of Care Efficiency |
| 4 | **Network HIT System** | HIT Optimization | Transformative Analytics |

# Integrating Community Health Workers Into Medical Homes

*Elizabeth A. Rogers, MD, MAS*[1]
*Sarah Turcotte Manser, MA*[1]
*Joan Cleary, MM*[2]
*Anne M. Joseph, MD, MPH*[1]
*Eileen M. Harwood, PhD*[3]
*Kathleen T. Call, PhD*[4]

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## ABSTRACT

**PURPOSE** Though evidence supports the value of community health workers (CHWs) in chronic disease self-management support, and authorities have called for expanding their roles within patient-centered medical homes (PCMHs), few PCMHs in Minnesota have incorporated these health workers into their care teams. We undertook a qualitative study to (1) identify facilitators and barriers to utilizing a CHW model among PCMHs in Minnesota, and (2) define roles played by this workforce within the PCMH team.

**METHODS** We conducted 51 semistructured, key-informant interviews of clinic leaders, clinicians, care coordinators, CHWs, and staff from 9 clinics (5 with community health workers, 4 without). Qualitative analysis consisted of thematic coding aligned with interview topics.

**RESULTS** Four key conceptual themes emerged as facilitators and barriers to utilizing a CHW model: the presence of leaders with knowledge of CHWs who championed the model, a clinic culture that favored piloting innovation vs maintaining established care models, clinic prioritization of patients' nonmedical needs, and leadership perceptions of sustainability. These health care workers performed common and clinic-specific roles that included outreach, health education and coaching, community resource linkage, system navigation, and facilitating communication between clinician and patient.

**CONCLUSIONS** We identified facilitators and barriers to adopting CHW roles as part of PCMH care teams in Minnesota and documented their roles being played in these settings. Our findings can be used when considering strategies to enhance utilization and integration of this emerging workforce.

*Ann Fam Med* 2018;16:14-20. https://doi.org/10.1370/afm.2171.

# Workforce Development--Missing Links

- Community Health Workers
- Health Navigators
- Practice Transformation Coaching
- Executive Physician Leadership
- Clinical Analytics

# Exploring Attributes of High-Value Primary Care

*Melora Simon, MPH*[1]
*Niteesh K. Choudhry, MD, PhD*[2]
*Jim Frankfort, MD*[3]
*David Margolius, MD*[4]
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## ABSTRACT

**PURPOSE** Medicare's merit-based incentive payment system and narrowing of physician networks by health insurers will stoke clinicians' and policy makers' interest in care delivery attributes associated with value as defined by payers.

**METHODS** To help define these attributes, we analyzed 2009 to 2011 commercial health insurance claims data for more than 40 million preferred provider organization patients attributed to over 53,000 primary care practice sites. We identified sites ranking favorably on both quality and low total annual per capita health care spending ("high-value") and sites ranking near the median ("average-value"). Sites were selected for qualitative assessment from 64 high-value sites and 102 average-value sites with more than 1 primary care physician who delivered adult primary care and provided services to enough enrollees to permit meaningful spending and quality ranking. Purposeful sampling ensured regional diversity. Physicians experienced in primary care assessment and blinded to site rankings visited 12 high-value sites and 4 average-value sites to identify tangible attributes of care delivery that could plausibly explain a high ranking on value.

**RESULTS** Thirteen attributes of care delivery distinguished sites in the high-value cohort. Six attributes attained statistical significance: decision support for evidence-based medicine, risk-stratified care management, careful selection of specialists, coordination of care, standing orders and protocols, and balanced physician compensation.

**CONCLUSIONS** Awareness of care delivery attributes that distinguish their high-value peers may help physicians respond successfully to incentives from Medicare and private payers to lower annual health care spending and improve quality of care.

*Ann Fam Med* 2017;15:529-534. https://doi.org/10.1370/afm.2153.

## PATIENT CENTERING ACROSS THE COMMUNITY: **PRACTICAL TAKE-AWAYS**

- •Learn, Grow, Embrace Community Integrated Primary Care
- • Deploy and Integrate Community-Based Health Workers (CHW, HNs)
  - ○ Create Community Clinical Linkages: people, process, relationships, accountability…measure
  - ○ Strategic roadmap: Value-Based Payment Models (ASAP)
  - ○ Define Value Proposition & ROI (Total Cost of Care)
  - ○ Bring Employers, especially self-insured, to the table
- • Make Social Determinants of Health competencies and impact happen
  - ○ But, say NO to SDOH as “Primary Care Pile-On”

Just Do It!

# PATIENT-CENTERED CARE ACROSS THE COMMUNITY

INTEGRATING CLINICS AND
COMMUNITY INTERVENTIONS

April 30, 2018

# OBJECTIVES

1. Discuss trends in population health and the role of the Y in health care transformation
2. Discuss the Y's infrastructure for delivery of chronic disease prevention programs
3. Share leading practices for clinical integration between health care and community-based organizations

# TRENDS IN POPULATION HEALTH: THE Y'S CHANGING ROLE

# IMPACT OF HEALTH REFORM

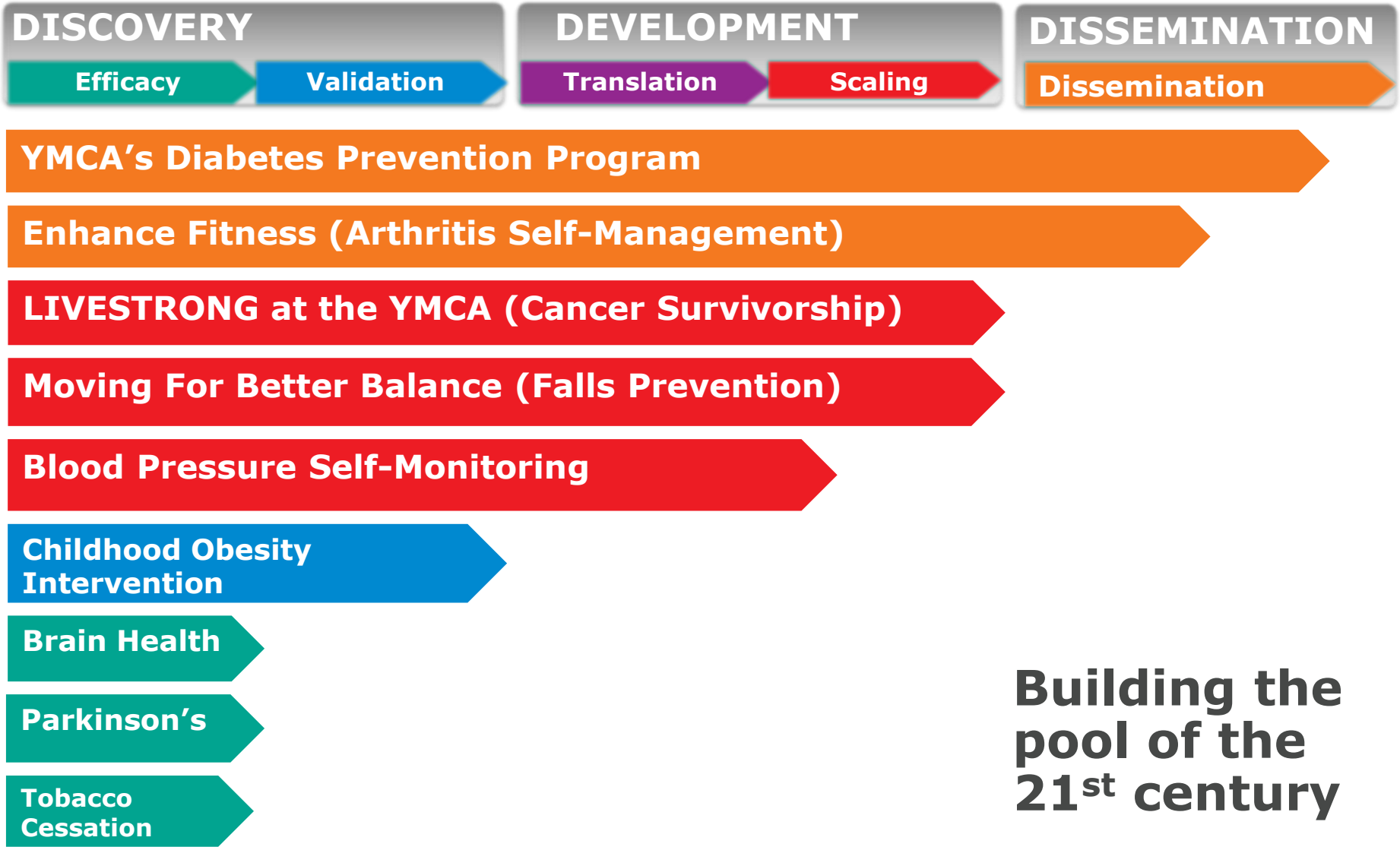
- Health reform efforts are **shifting the financial incentives** from fee-for-service to health outcomes
  - Value-Based Payment Contracting
  - Alternative Payment Models
- Success in a value-based payment contract requires a **progressive population health strategy**
- Best practices in population health align health systems with community-based organizations to **synergize efforts to address targeted health risks** in the community

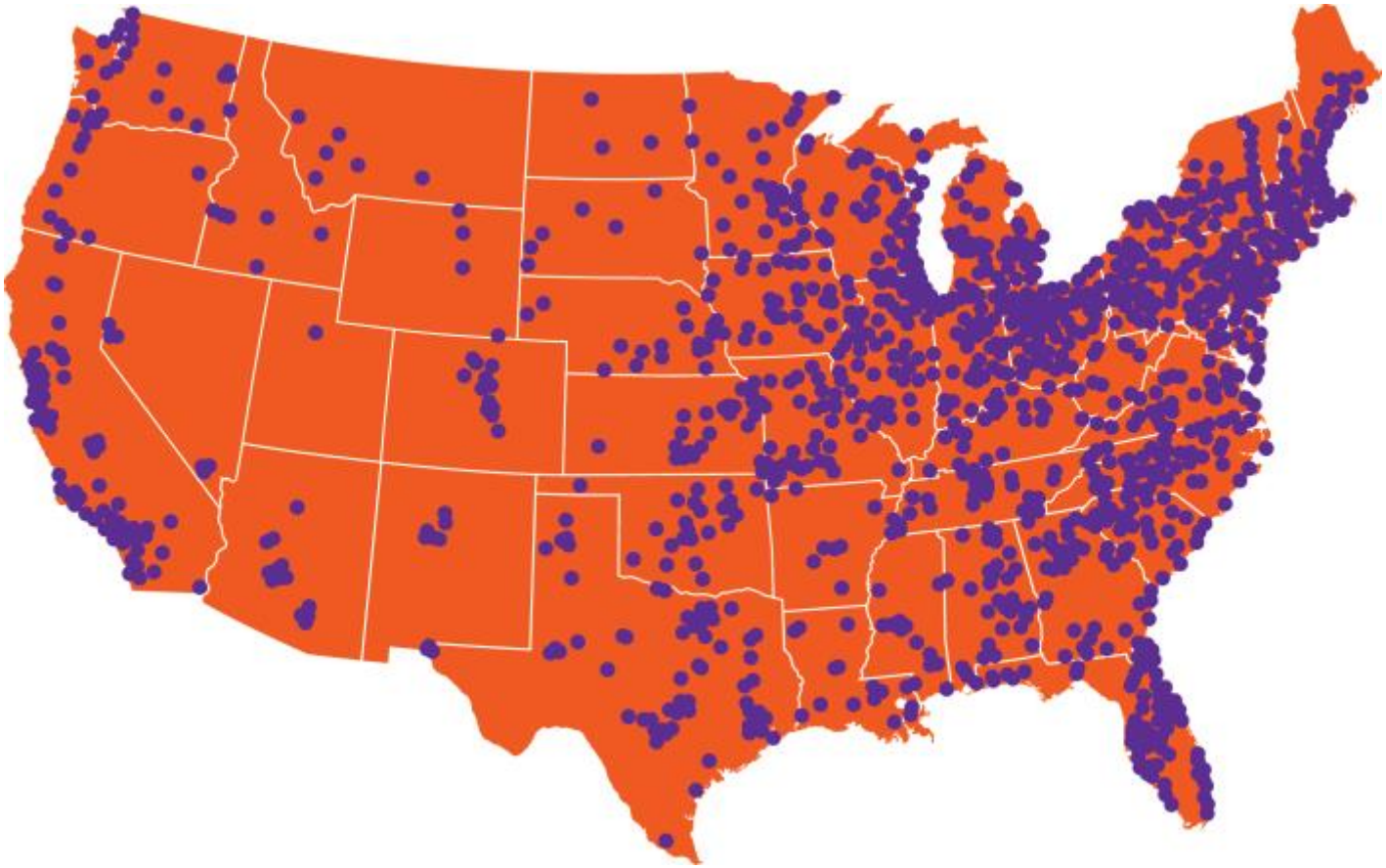
# COMMUNITY INTEGRATED HEALTH

- Comprehensive population health strategy that integrates **health systems, providers, and community-based health promotion programs** to address the breadth of health issues facing a population
- Elements of success:
  - Treatment strategies that fully implement **primary, secondary, and tertiary prevention strategies**
  - Clinical pathways to support placing members in appropriate treatment tracts - based on risk stratification
  - Deployment of **evidence-based programs in community settings**

# THE Y'S PORTFOLIO OF EVIDENCE-BASED (RCT PROVEN) PROGRAMS




**Building the pool of the 21st century**



# OUR REACH

## FACTS

YMCAs
**2,700**

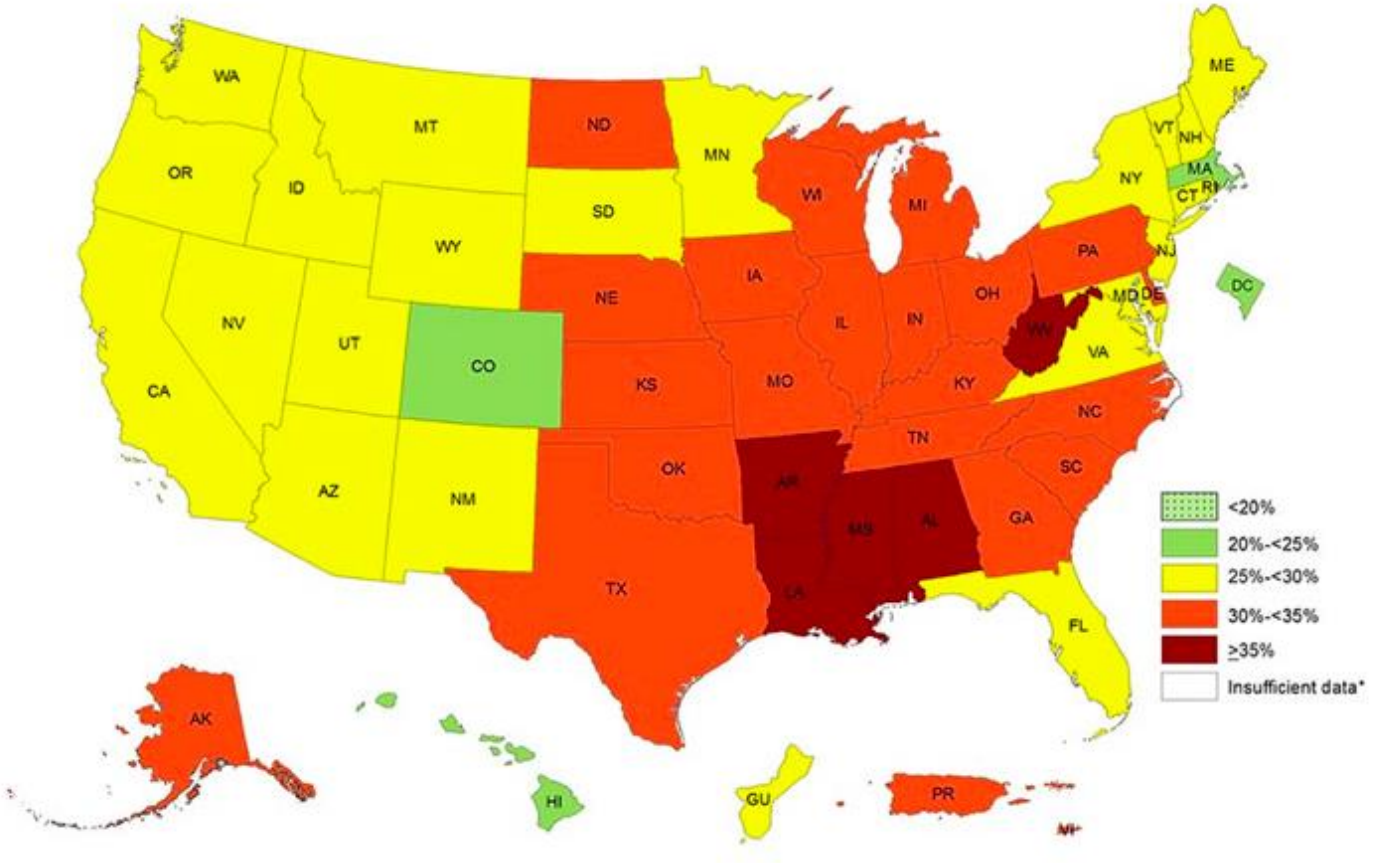
COMMUNITIES SERVED
**10,000**

YMCAs IN COMMUNITIES WHERE HOUSEHOLD INCOME IS BELOW THE NATIONAL AVERAGE
**58%**

STATES
**50 plus**
**District of Columbia and Puerto Rico**

# DEVELOPING CLINIC-TO-COMMUNITY PARTNERSHIPS

# PREVALENCE OF SELF-REPORTED OBESITY AMONG U.S. ADULTS BY STATE AND TERRITORY, BRFSS, 2016



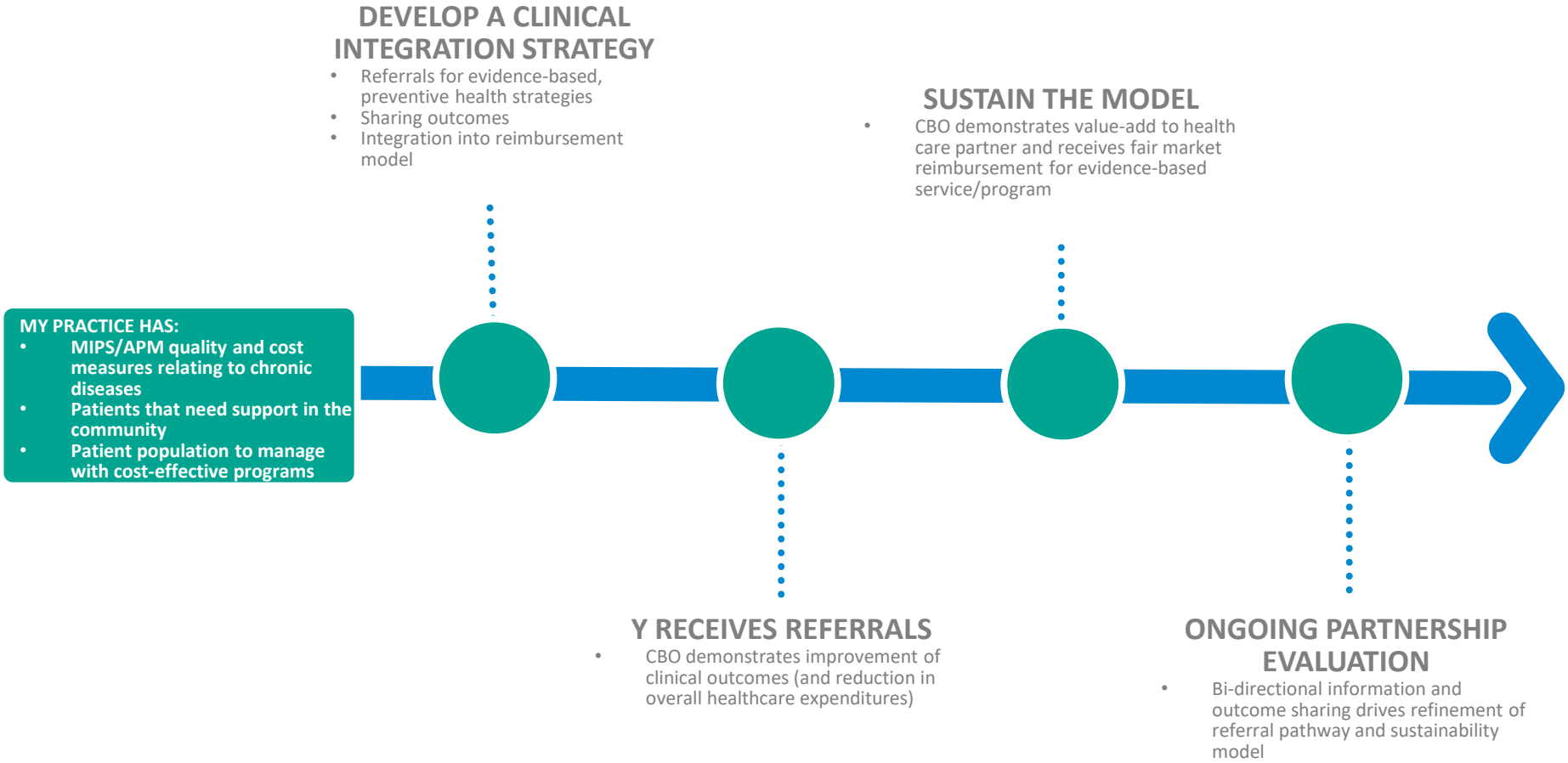

Source: Centers for Disease Control and Prevention. Available Online: https://www.cdc.gov/obesity/data/prevalence-maps.html

# ADDRESSING OBESITY AND CARDIOMETABOLIC SYNDROME

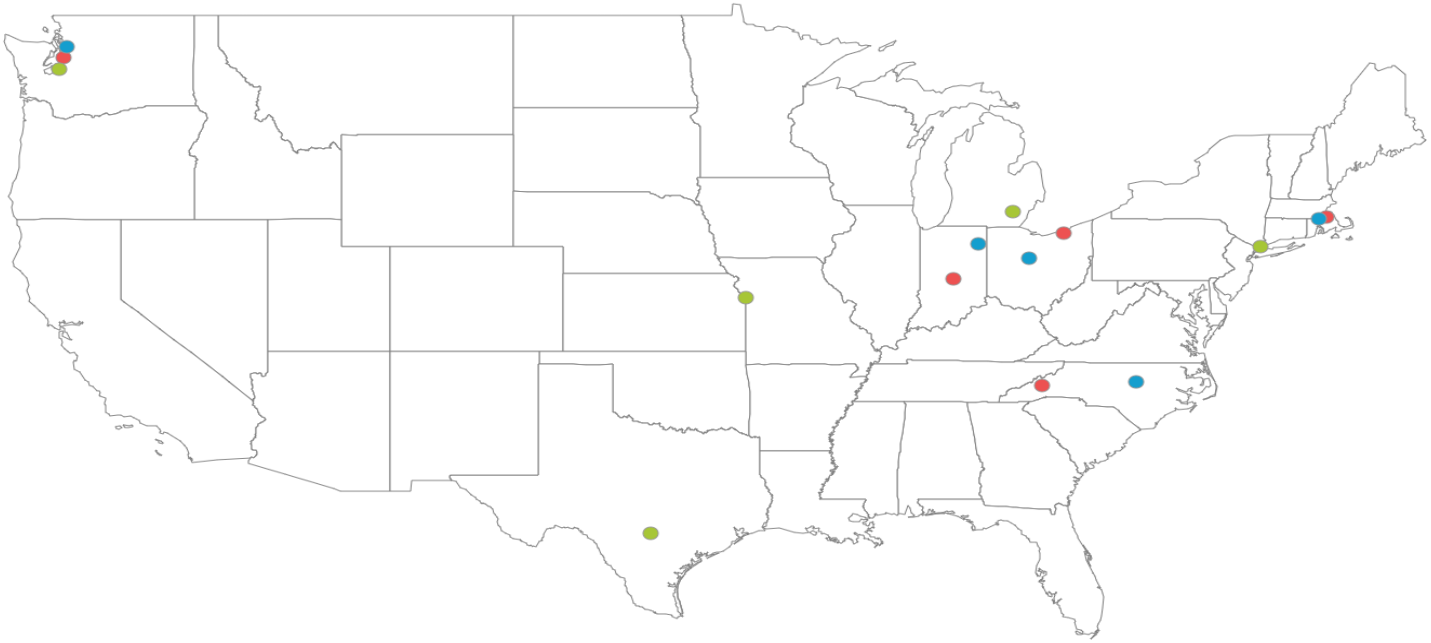
- Community Integrated Health (CIH) partnerships that target the range of conditions impacted by cardiometabolic syndrome
  - **Obesity** (evidence-informed weight loss interventions in community settings - IBT for Obesity)
  - **Prediabetes** (DPP)
  - **Diabetes** (DSMT/MNT/TCT2™)
  - **Hypertension / Cardiovascular disease** (Blood Pressure Self- Monitoring, Remote Patient Monitoring)
  - **Arthritis and joint disease** (Enhance®Fitness, Fall Prevention)

# CHARACTERISTICS OF SUCCESSFUL CLINICAL INTEGRATION PARTNERSHIPS



# DOCUMENTING BEST PRACTICE MODELS OF CIH



Robert Wood Johnson Foundation

the YMCA

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# THANK YOU

**Marc Rosen, MPH**
**Technical Advisor, Clinical Integration**
**YMCA of the USA**
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## CONVENING COMMUNITIES AROUND A BOLD GOAL

# Improving Health by Addressing Social Determinants of Health

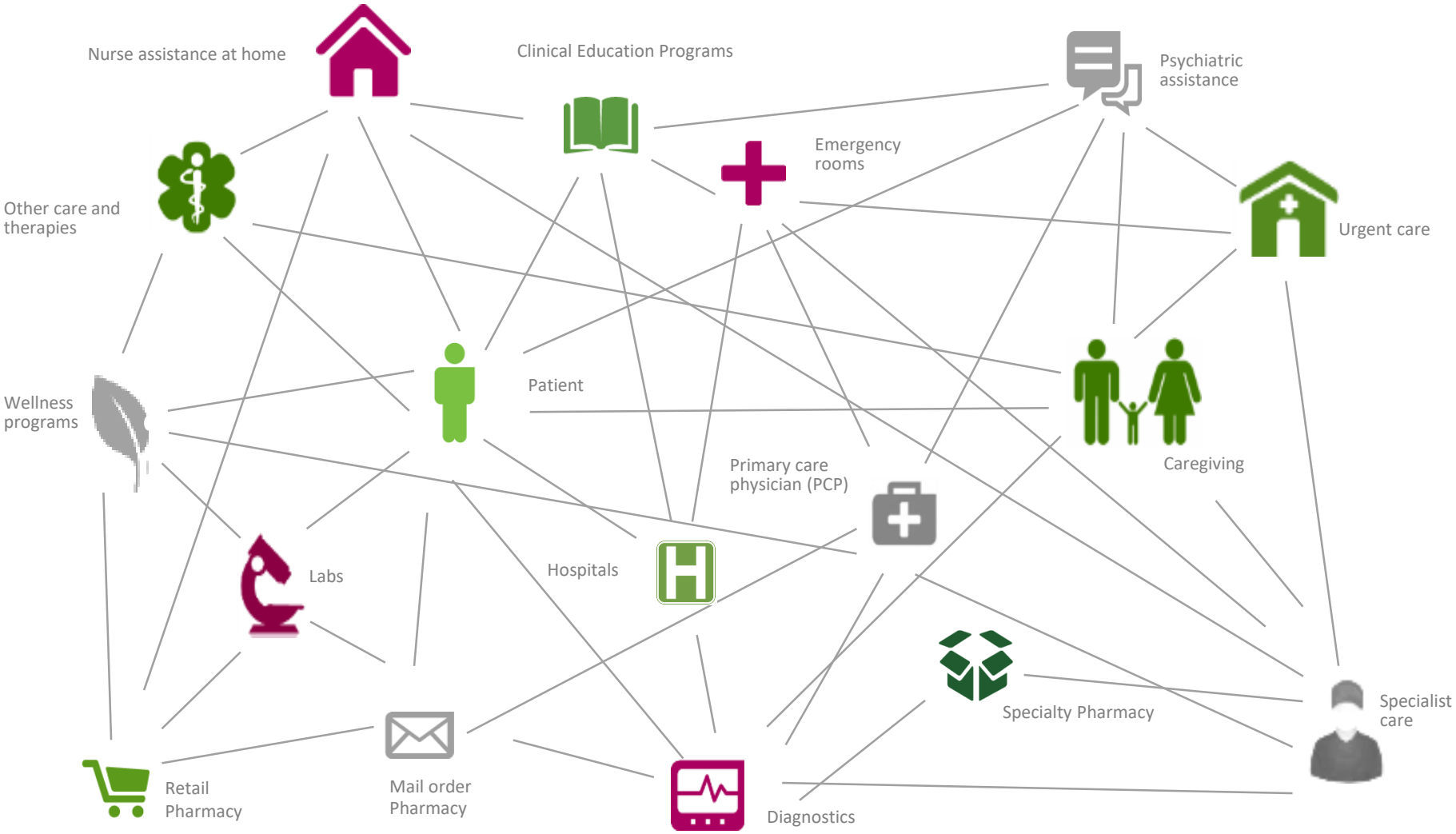
Angie Wolff

**Bold Goal | Office of the Chief Medical Officer**

Humana

# GOOD HEALTH IS HARD

# Our health care system is too complex




Treating disease, not the whole person

That's why we set a

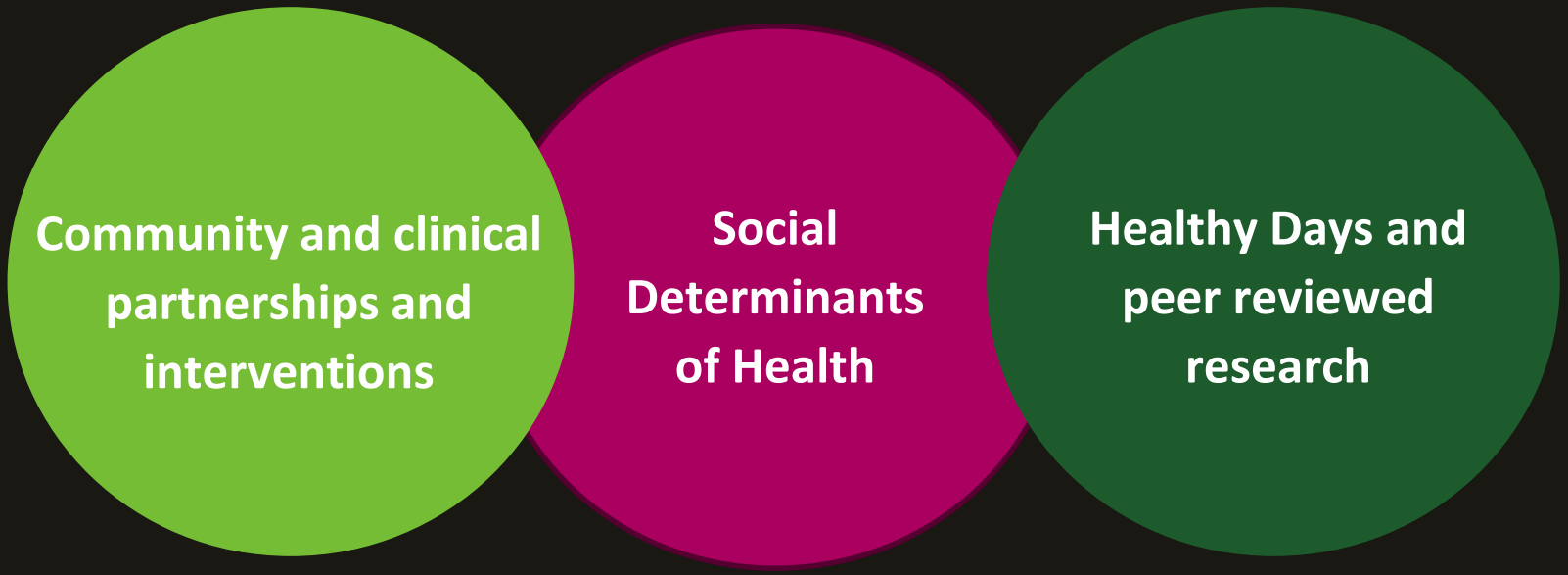
# BOLD GOAL

## 20% HEALTHIER BY 2020

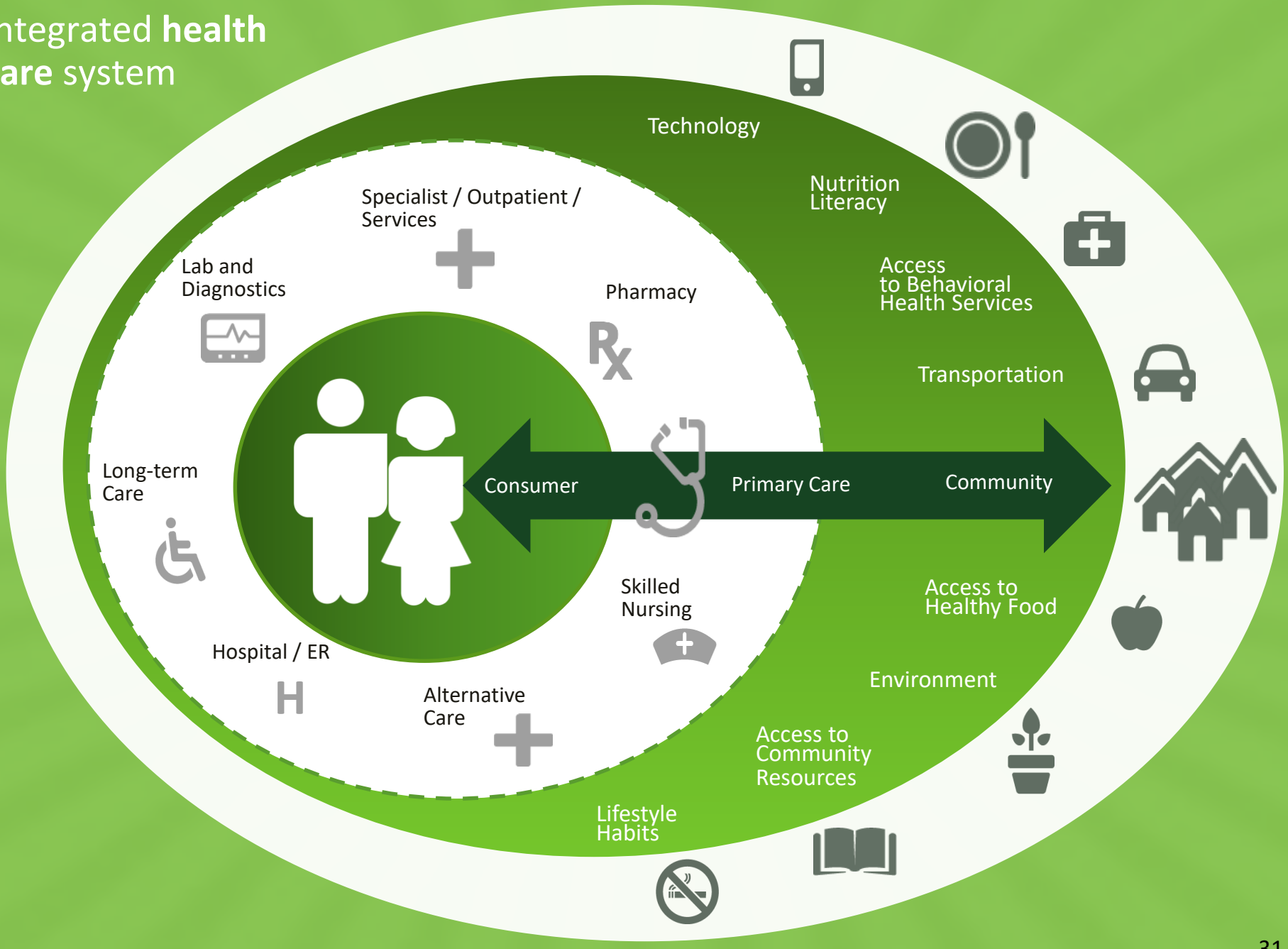
# Our Bold Goal



The communities we serve will be ***20% healthier by 2020*** because we help make it easier for people to achieve their best health both inside and outside of the clinical setting through clinical and community interventions that focus on addressing social determinants of health.



# Integrated **health care** system



# Working locally to help make health easier

## OUR BOLD GOAL CREATES A UNIQUE BUSINESS OPPORTUNITY

Nonprofit organizations

Government leaders and agencies

Community members

Physicians and clinicians

For-profit companies

**Building strong relationships are at the core of our business and path to value**


OUR BOLD GOAL
COMMUNITIES
Milwaukee
Chicago
Kansas City
Louisville
Tidewater
Richmond
Knoxville
Jacksonville
Daytona
Baton Rouge
New Orleans
Tampa Bay
San Antonio
Broward County
Phase I – Listening & Learning
Phase II – Market Expansion

# FOOD INSECURITY

- **1 in 8 Americans**
- **$121.92 billion was spent on direct related costs tied to food insecurity in 2014**
- **2x as many Unhealthy Days**

Sources: Feeding America, Feeding Tampa Bay, Hungerreport.org, Clinical Analytics, Humana

# Healthy Days has become a barometer for our organization

**Healthy Days takes into account the whole person**

CDC


Now, thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

Now, thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

# WE'RE AT THE CENTER OF SOMETHING


Together, we can make health easier, reduce costs and improve clinical outcomes.

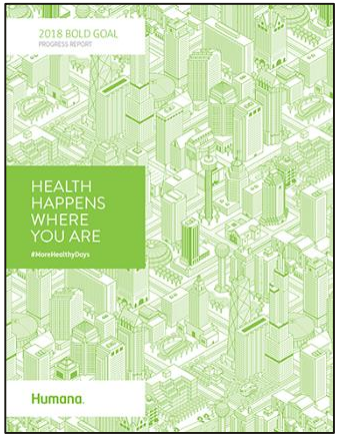
Humana.

# Discover more about our Bold Goal


**HUMANA.COM/ BOLDGOAL**

**TOOLKITS**


**BOLD GOAL PROGRESS REPORT**



# Questions?

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