Population Health: Connecting Initiatives in Maine

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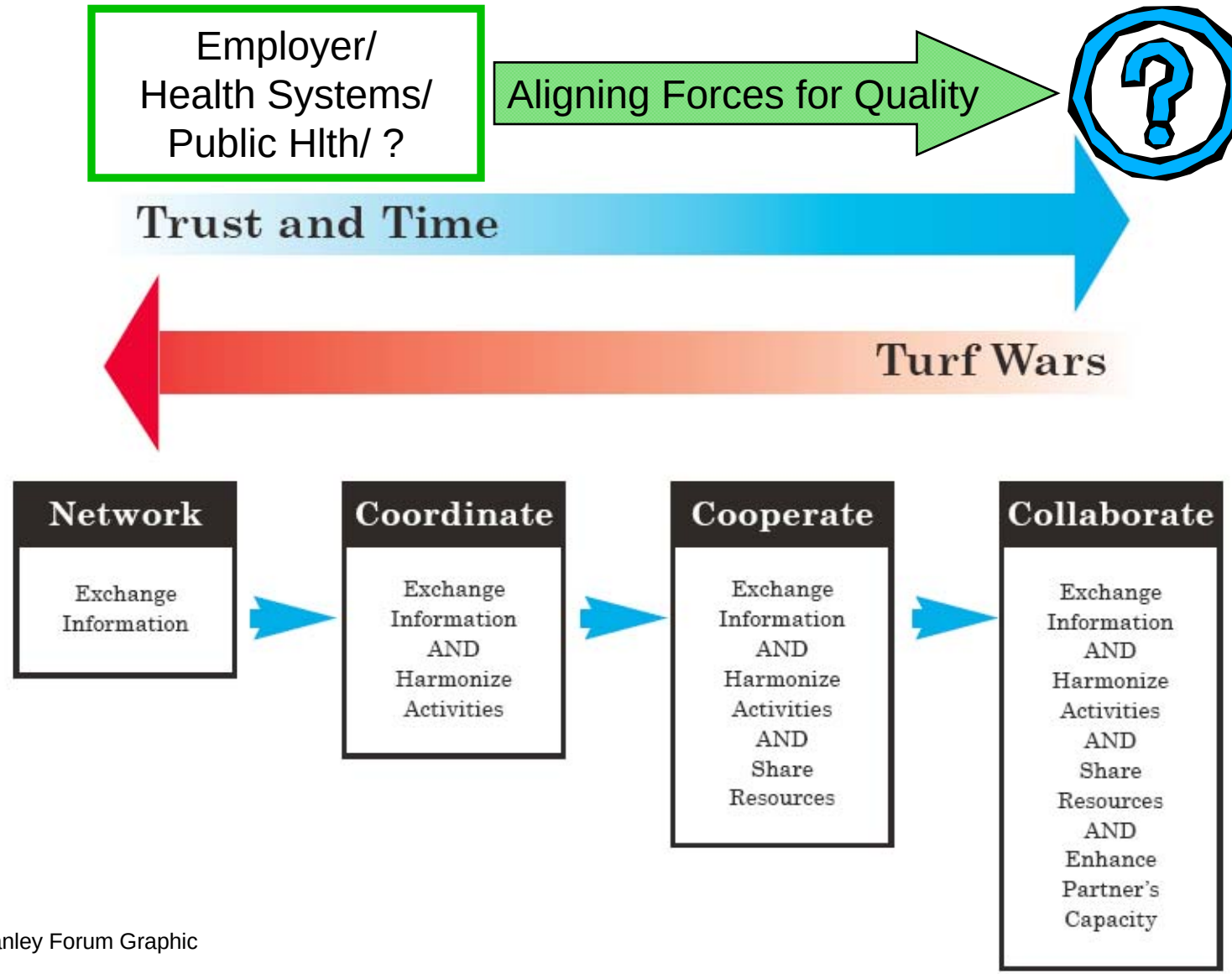
Aligning Forces for Quality | Improving Health & Health Care in Communities Across Maine

An initiative of Quality Counts and the Robert Wood Johnson Foundation.

Objective Today

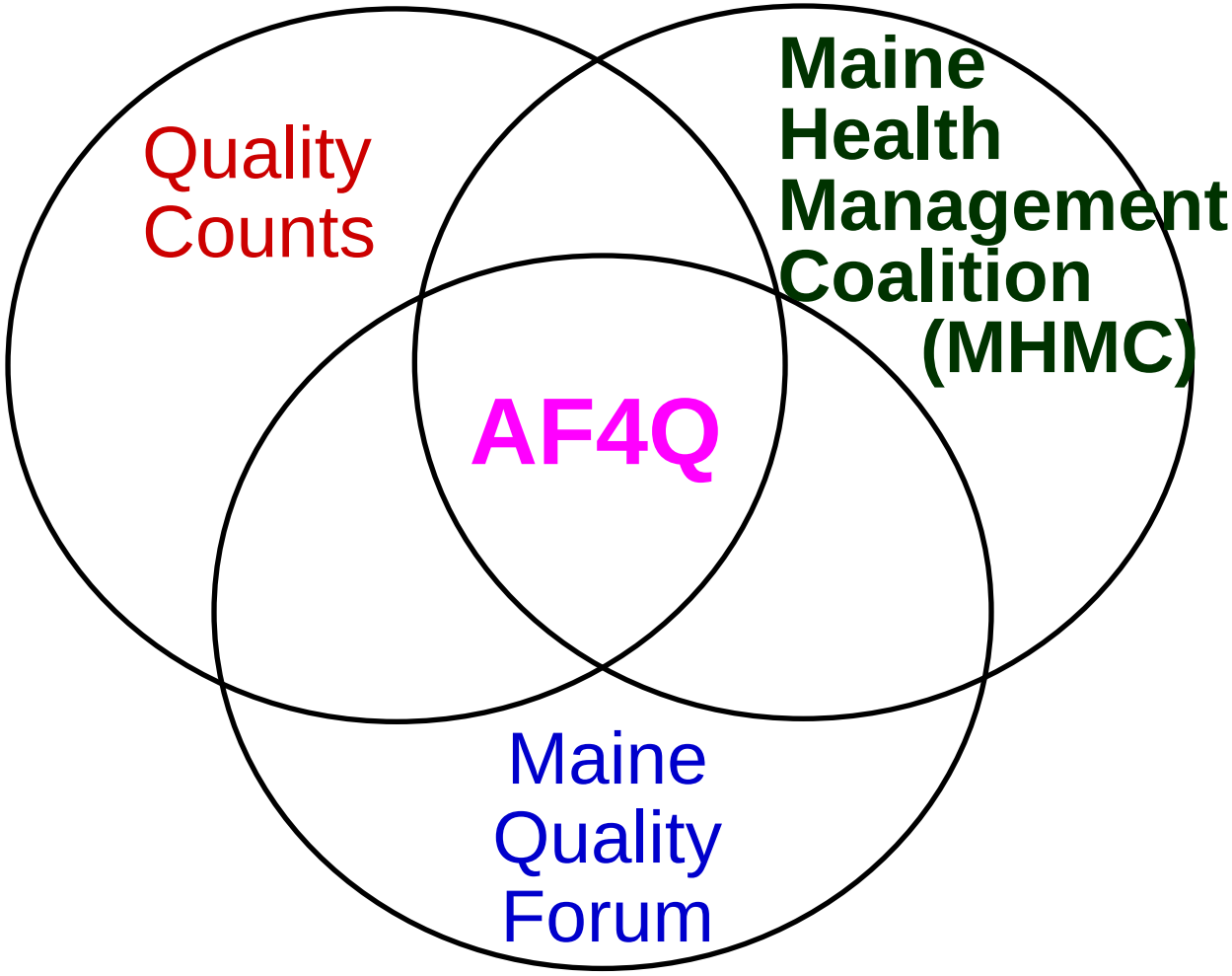
- To illustrate how Maine is trying to connect / coordinate / integrate various public / community health and health care programs to meet future expectations of Triple Aim
  - Improving population health
  - Improving experience of care
  - Improving cost of care

How Far To Go Together? (4-3-08)



Hanley Forum Graphic

Maine AF4Q

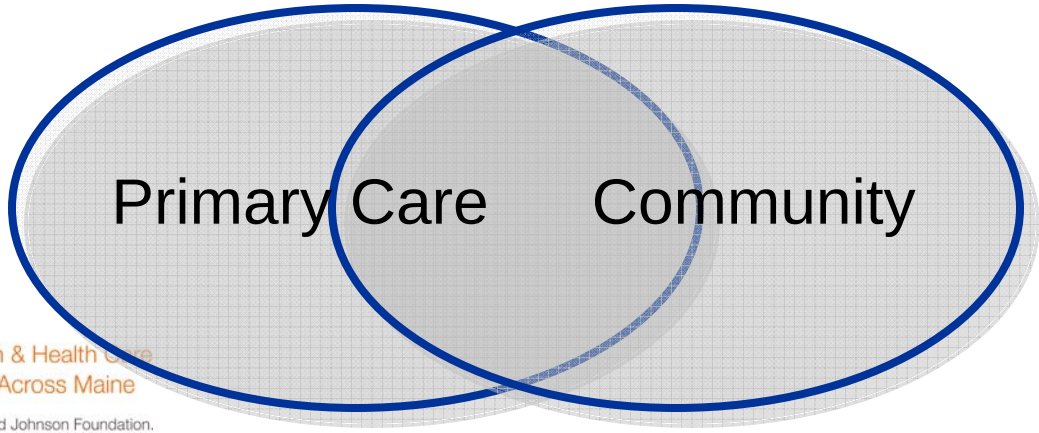

Quality Counts
Maine Health Management Coalition (MHMC)
AF4Q
Maine Quality Forum

Maine Landscape

- Maine AF4Q:
  - Quality Counts
  - Maine Health Management Coalition
  - Maine Quality Forum
  - Others
    - MaineCDC
    - Chronic Disease Partners of Maine
- MaineCDC
  - District Health Coordinating Councils
  - Healthy Maine Partnerships

NPP: Who is responsible?

- Key preventive services
  - Primary Care practices
- Healthy lifestyle behaviors
  - Primary Care/Work/School/Community etc.
- Community health index
  - Community



A Call to District Action: Linking Public Health Strategies to Reduction of Avoidable Hospitalizations

CUMBERLAND DISTRICT, MAINE (2010)

GOALS: To reduce avoidable hospitalizations by 50% by 2015 (through prevention, proper management, and appropriate treatment of disease).

	Prevention Quality Indicators (PQI's) that measure the potentially avoidable hospitalization rates that are major cost drivers in the state of Maine*:	Current Rates (Adjusted rate of admissions per 100K)	Goal (Reduction by 50% by 2015)	Cost savings in District given a 50% reduction by 2015
	Respiratory Infections			
1	Adult asthma admission rate*	43	22	$245,205
	Bacterial pneumonia admission rate*	235	118	$1,818,610
	Chronic obstructive pulmonary disease admission rate*	151	76	$1,033,765
	Heart Failure			
2	Congestive heart failure admission rate*	319	160	$2,610,120
	Hypertension admission rate*	18	9	$103,715
	Diabetes			
3	Diabetes short-term complication admission rate*	31	16	$279,815
	Diabetes long-term complication admission rate*	77	39	$1,004,060
	Uncontrolled diabetes admission rate*	7	4	$31,300
	Rate of lower-extremity amputation among patients with diabetes*	27	14	$494,595
		Total potential cost savings for Cumberland District:		$7,621,185

Population Health Indicators: If these indicators are addressed comprehensively by the system, there will be a measureable reduction in the rates of avoidable hospitalizations.

		Cumberland District	Maine	Goal (Movement of trend)

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		Cumberland District	Maine	Goal (Movement of trend)
1,2,3	Percent of adults overweight or obese [2008]	57	62	↓
2,3	Percent of high blood pressure among adults [2008]	26	31	↓
2,3	Percent of high cholesterol among adults [2008]	37	41	↓
2,3	Prevalence of diabetes among adults (%) [2008]	9	8	↓
3	Percent of adults with diabetes who have received a Hemoglobin A1c test at least once yearly [2008]	94	93	↑
1	Percent of adults with asthma [2008]	9	10	↓
1,2,3	Adult smoking prevalence (% current smokers) [2008]	13	18	↓
1,2,3	Adolescent smoking prevalence, 6-12 graders (%) [2008]	11	12	↓
1,2,3	Percent of high school youth that are overweight or obese [2007]	n/a	26	↓
2,3	Previous 30-day alcohol use, 9th-12th graders (%) [2008]	38	35	↓
1	Percent of child and youth asthma, <18 years old [2007]	n/a	9	↓
1,2,3	Percent of adults reporting fair or poor health status in last 30 days [2008]	11	13	↓
1,2,3	Percent of adults with >=14 days of frequent mental distress in past month [2008]	11	10	↓
1	Percent ever had Pneumococcal vaccine, >=65 Years [2008]	76	72	↑
1	Percent, Influenza vaccine past year for adults >65 years [2008]	76	75	↑
1,2,3	Access to primary care physician (population to physician ratio) [2004]	759::1	978::1	↑
2,3	Percent of adults with a routine dental visit in past year [2008]	77	70	↑
1,2,3	Number of visits to KeepMEWell.org (count)	n/a	125,000	↑

Context: Socioeconomic status.			
	Cumberland District	Maine	
Total population [2008]	276,047	1,316,456	
Percent individuals living in poverty [2007]	10	12	
Population density (people per mi^2) [2008]	330	43	
Percent of population non-white [2008]	7	5	
Percent of population between the ages of 18-64 years old [2008]	65	65	
Percent 65 years and older [2005-07]	14	14	
Percent of adults with lifetime educational attainment less than high school [2000]	10	15	
Percent of householders >=65 Living Alone [2000]	10	11	
Percent of adults with no health insurance [2008]	7	11	
Percent of children age 0-18 years without health insurance [2006]	6	7	

CMS/AF4Q Goals (for PCMH Practices)

- Inpatient admissions:
  - - 6% reduction in respiratory admissions (COPD, Community Acquired Pneumonia)
  - - 7% reduction in cardiovascular admissions (Heart Failure, Coronary Artery Disease)
- ED visits:
  - - 5% reduction in Emergency Dept visits
- Specialties
  - - 5% reduction in Specialty Consultation visits
- Imaging
  - - 5% reduction in Standard Imaging
  - - 5% reduction in Advanced Imaging
- Total projected savings of $10.21 pmpm per Medicare beneficiaries in each practice

ACOs: 3 Tests

1. Accountable for what?
   - A defined population's care across continuum
2. Accountable to whom?
   - Patients, families, payers, the public (with payer contracts to reward better care and lower costs)
3. Accountable how?
   - Measured value reported to the public
     - Health outcomes
     - Health care quality
     - Costs of care

ACO starter sets proposed by Brookings-TDI** & Premier
(See handout for Brookings-TDI)

Proposed Core Measures - 3

- Measures of care experiences
  - Quality of MD-Patient Interaction
  - Health promotion
  - Shared decision making
  - Access to needed care
  - Care coordinated (e.g., CTM-3)
- Measures of health outcomes
  - Disease status
  - **Functional status (e.g, vr-12)**
  - **Risk status (e.g., ARD)**

← ***Getting to Gretzky Metrics***

Could be computed through patient survey

Health Systems

- Working on some sorts of ACO development
- Most working on community health
  - MaineHealth working with UnitedHealth indicators
- 28 Healthy Maine Partnerships often sitting within health systems

Upcoming Bridge Function?

- Community Health Teams
  - Going beyond the limits of practice based care management
  - Part of Medical Home and Neighborhood
- Patterned after VT and NC
- ? Pay for population health – Jim Hester
- Start up funding:
  - MeHAF
  - AF4Q 3.0
  - CMS Medical Home Demo

Questions

- Where do health systems and public/ community health
  - Overlap?
  - Complement?
  - Compete?
- How to fund
  - Does public health get “shared savings”?
  - If not, does health system build own capacity in era of shrinking budgets?