



Bridging the Gap Between Health Care *and* Population Health

SEPTEMBER 19-20, 2013
DALLAS, TX

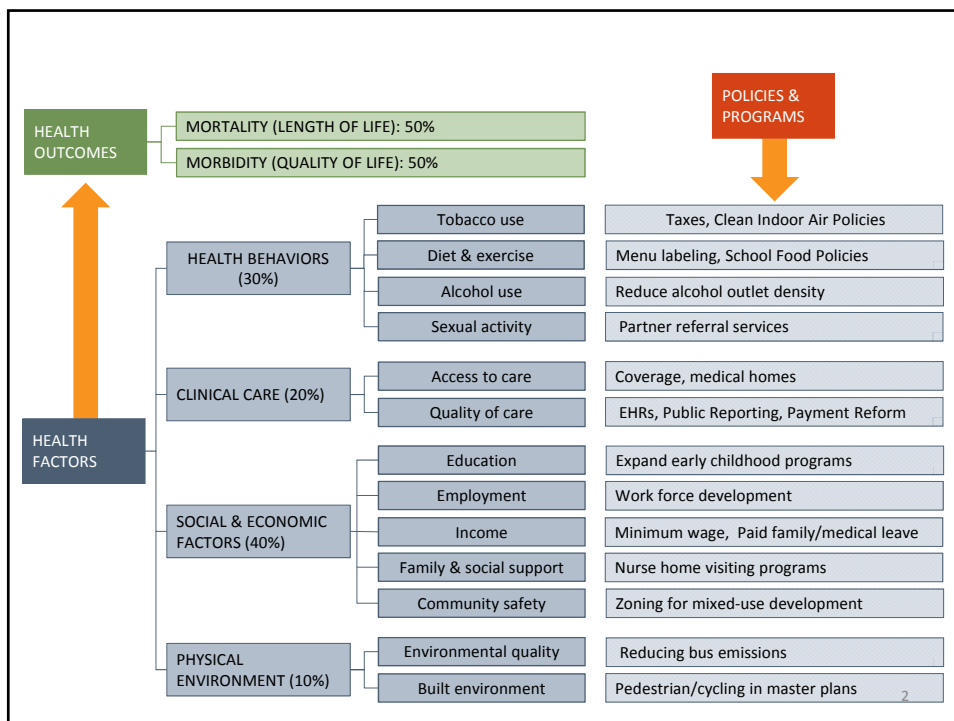
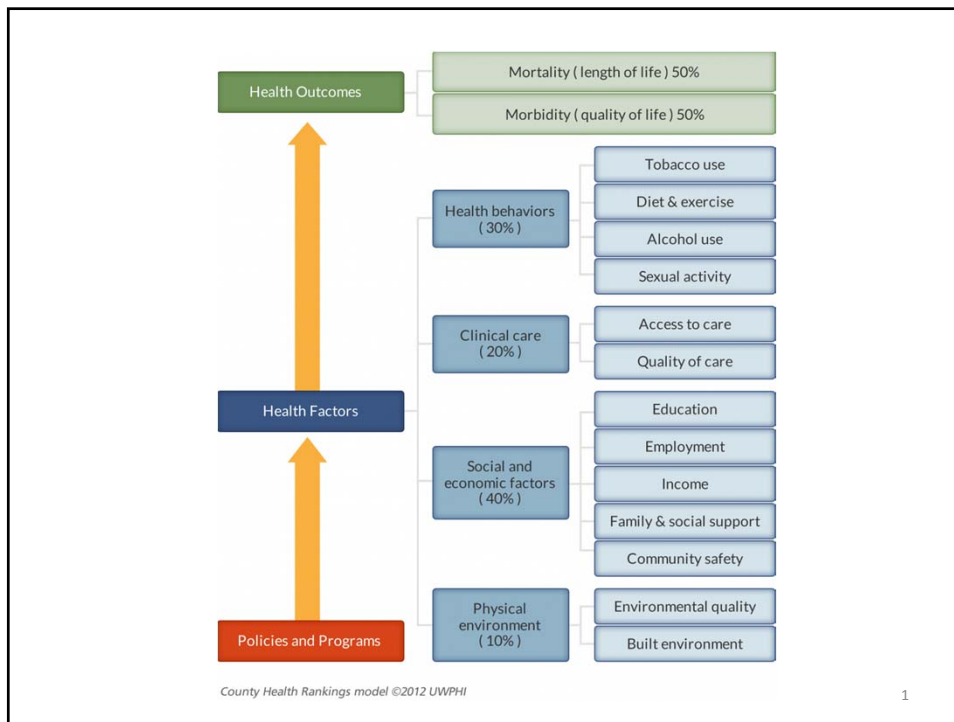
HANDOUT BOOK

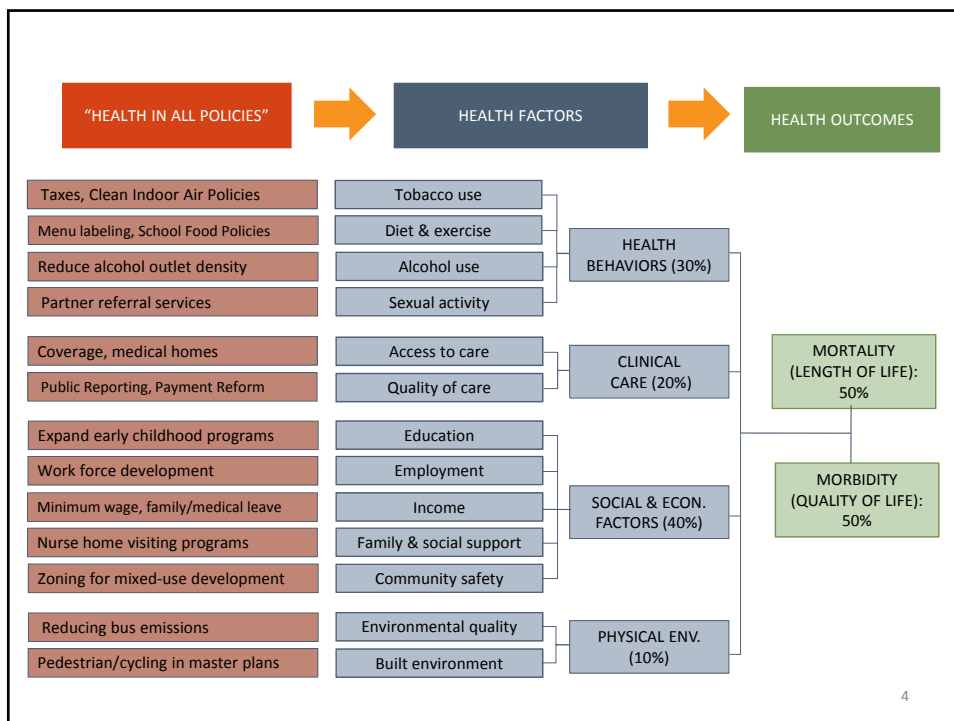
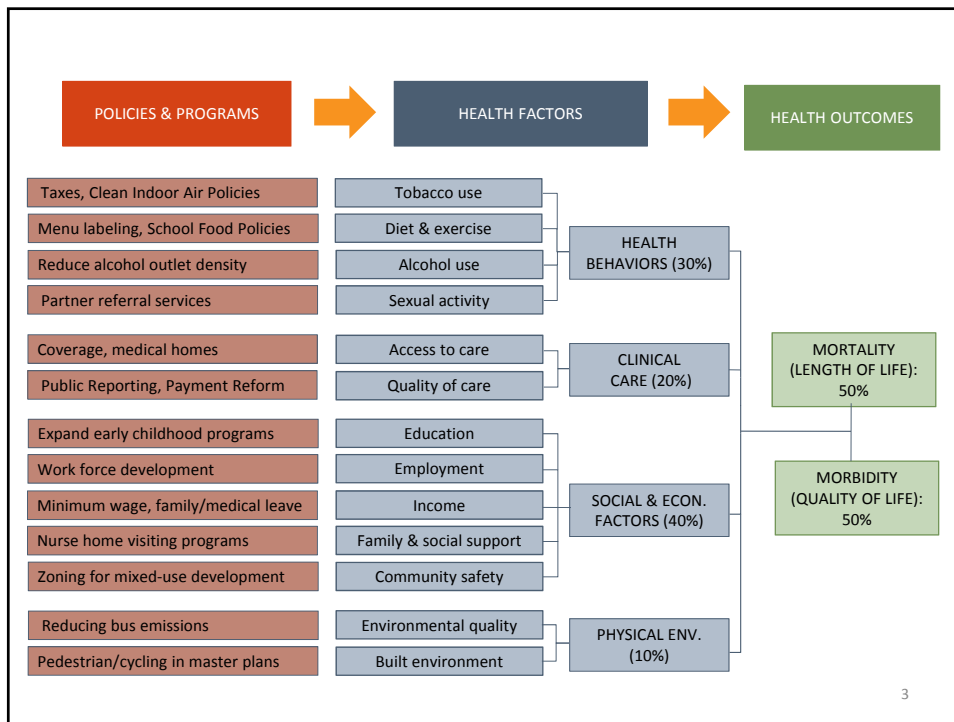


Robert Wood Johnson Foundation

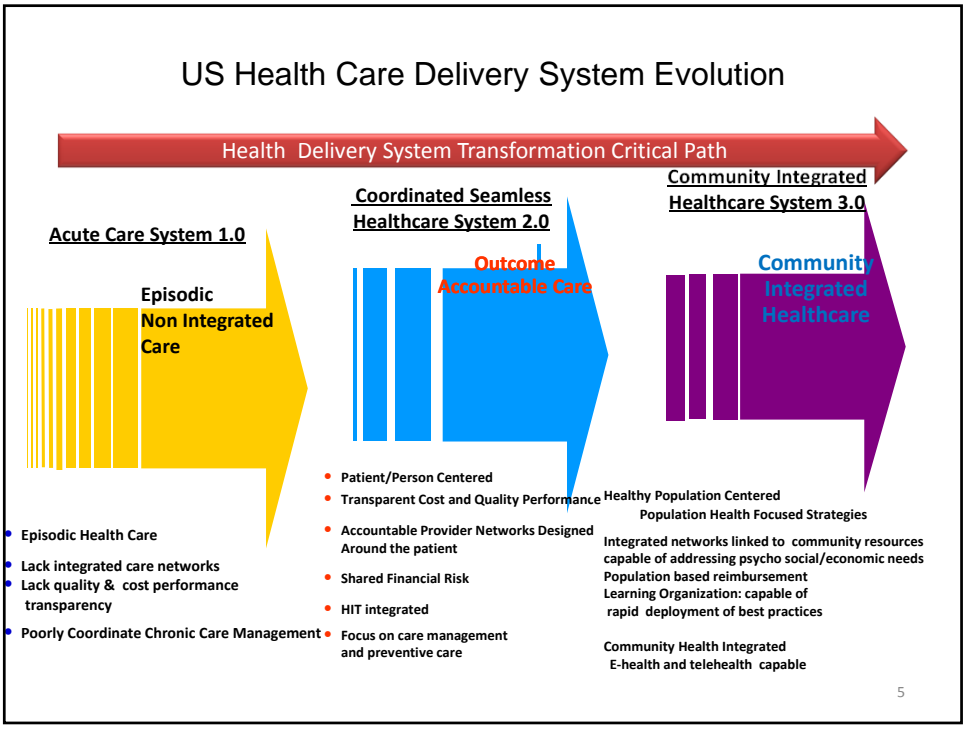
**Aligning Forces
for Quality**

Pulling the Correct Levers to
Successfully Connect
Health Care and Population Health

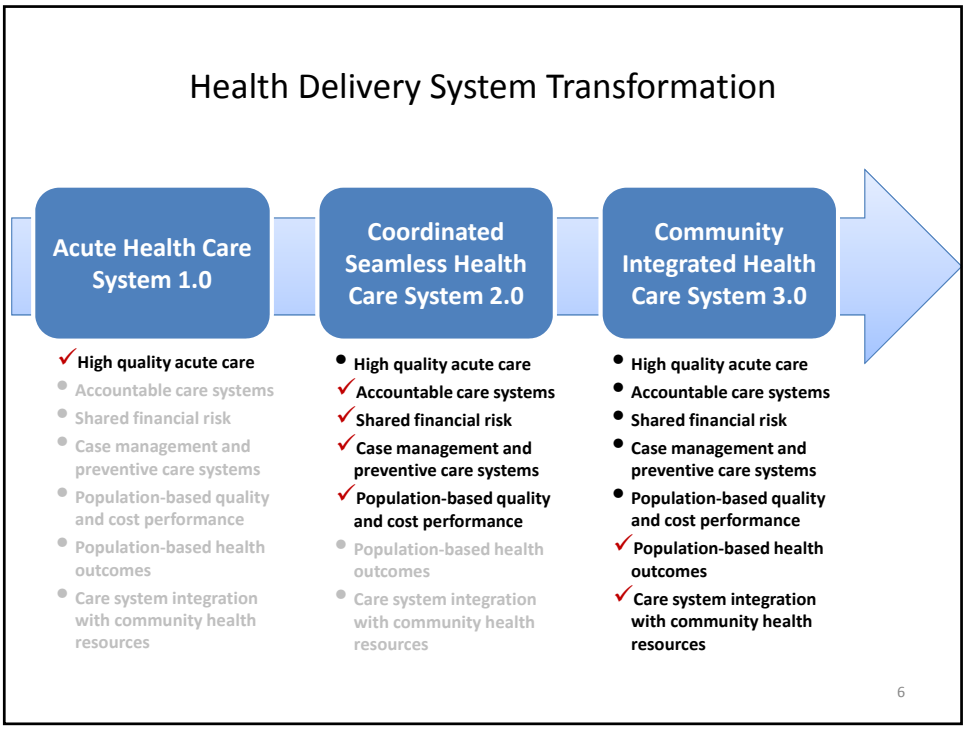




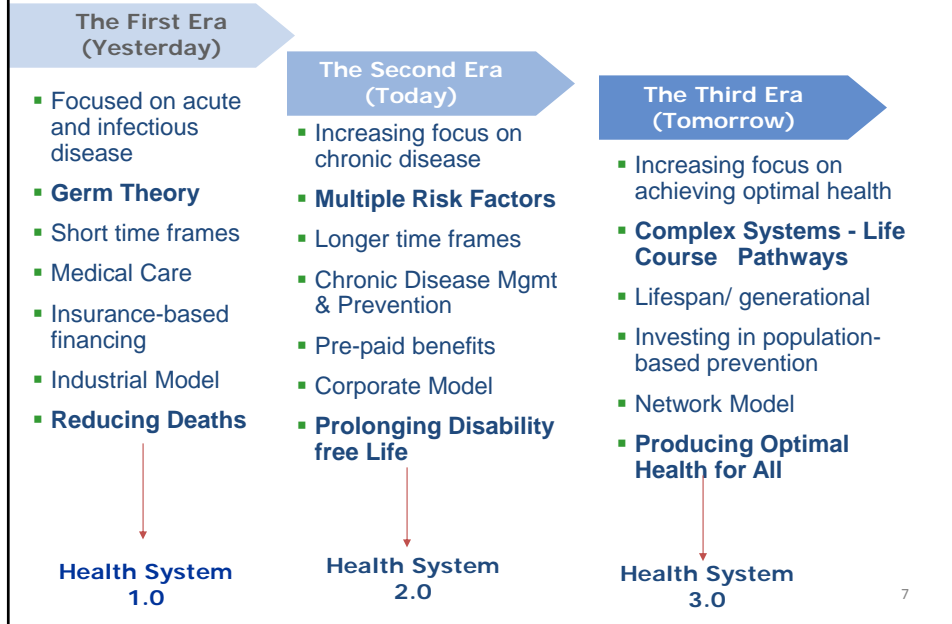
US Health Care Delivery System Evolution



Health Delivery System Transformation



The Evolving Health Care System



The Affordable Care Act and Population Health

The ACA and Population Health: Plugging into Community Benefit



Jessica L. Curtis, JD
Hospital Accountability Project Director
Aligning Forces for Quality Population Health Meeting
September 20, 2013

COMMUNITY BENEFIT: OUR WORLDVIEW

1. Spans access to medical care and population health
2. Systematically responds to **community-identified** needs and priorities, targeting those of vulnerable populations
3. Hospital staff **actively engage** community and public health partners throughout the assessment, implementation, and evaluation process
4. Hospital policies and practices are **transparent** to the public and tailored to fit community preferences, strengths, and issues
5. Opens or sustains lines of **communication and partnership** among community members and organizations, public health, hospitals and other providers
6. **Builds community voice and infrastructure** for achieving “quadruple aim”



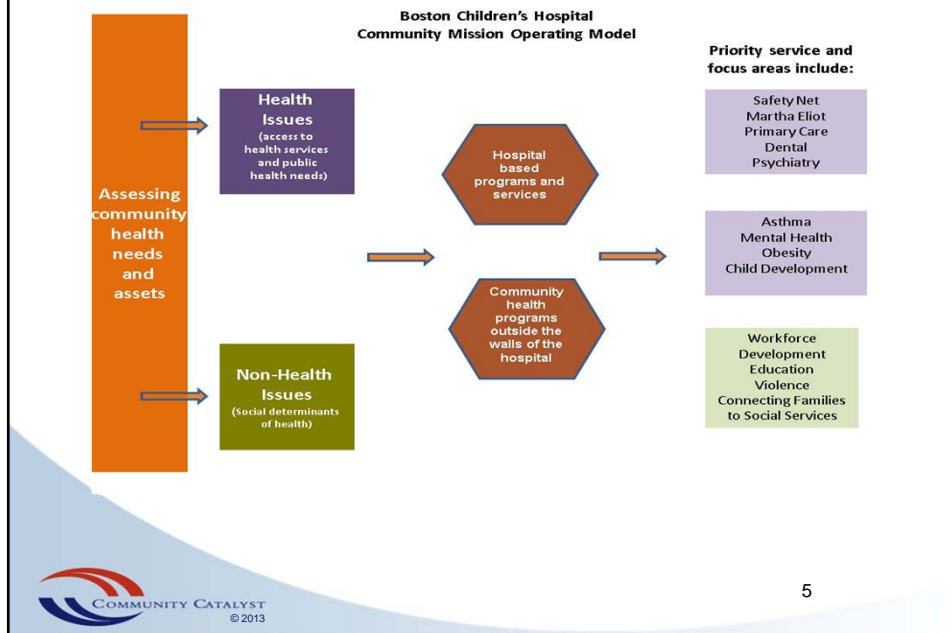
Policy Considerations

- Local hospitals may be subject to federal, state, and/or local standards; scrutiny at all gov't levels appears to be increasing
- ACA added *process* requirements and increased *public reporting* but left key decisions to hospitals
- Broad federal standard on “what counts” = room to maneuver
- Balancing act
 - Hospitals will continue to be a safety net for the remaining uninsured/underinsured, especially in states that do not expand Medicaid or have high numbers of immigrants ineligible for coverage subsidies

Practical Considerations

- Different “lenses” for community benefit
 - As a governance/accountability tool, *e.g.*, as a way to achieve mission or corporate responsibility objectives or to justify tax exemption
 - As a management tool, *e.g.* the planning process for understanding and responding to needs using finite resources
 - As programs and partnerships that build community health and capacity
- Coincides with public health accreditation push
- Resources, partnerships, and goals vary
- Many focusing on implementation
- Potential siloes
 - CB poorly integrated with hospital's strategic plan or mission/vision
 - Disconnect between assessment and implementation
 - CB not integrated with broader efforts in community
 - Needs not selected as hospital priorities continue to go unmet

A Sample Community Benefit Process



How Alliances Can Help

Talk with your hospital partners about their assessment and implementation plans. What did they find? What are they going to do/not do? Where are there opportunities for shared work?

- Relationships - Alliances already have strong relationships with the kinds of partners hospitals need to bring efforts to scale (business, CBO/FBOs, social and human services, public health, other clinicians)
- Break down siloes – Show what's at stake for the community *and* the hospital, what assets the community brings, and what is needed to connect community benefit to a larger strategy for managing population health (e.g., proactively investing community benefit dollars in prevention or primary care to reduce inappropriate ER use)
- Messaging – help hospitals understand and bridge the gap between what “the data” shows and where the community is
- Measuring progress – big gap currently in measuring social impact/return on investment for the community

Thank You



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Population Health and ACO Policy Goals: Five Action Items Alliances Can Do Now

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September 20, 2013

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Population Health and ACOs

The population health policy goals of ACOs embody the shift in thinking around population health that Alliances may wish to adopt.

Focus on keeping the population healthy by assessing, monitoring, and prioritizing factors that affect health outcomes through:

- Community engagement with a focus on activities that reach beyond the clinical setting and incorporate community and public health systems.
- Patient outreach and engagement with a focus on helping patients manage their own care and modify their health behavior.



Population Health and Community Engagement

Focus on activities that move beyond the clinical setting and engage community and public health systems.

1. Public Health Community Measurement:

- CHNA – County Health Rankings
- ACO Measures (starter kit)

➤ **Alliance Example:** P² Collaborative of Western New York

2. Public Health Community Coordination

➤ **Alliance Example:** Let's CHANGE (Commit to Healthy Activity and Nutrition Goals Every day) is a partnership with the Healthy Memphis Common Table and the Shelby County Health Department to fight childhood and family obesity. It includes 37 organizations spanning a broad spectrum of businesses, community-based organizations, and government.

3. Social Determinants: "Bridging the gap" between health care and population health stakeholders, includes a recognition of the importance of social determinants of health ranging from poverty, to education, to housing.

➤ **Alliance Example:** Creating a Healthier Niagara Falls: A Neighborhood Empowerment Approach: the P² Collaborative of Western New York



Medicare ACO's
8 Preventive health measures

- Influenza Immunization
- Pneumococcal Vaccination
- Adult Weight Screening and Follow-up
- Tobacco Use Assessment and Tobacco Cessation Intervention
- Depression Screening
- Colorectal Cancer Screening
- Mammography Screening
- Proportion of Adults 18+ who had their Blood Pressure Measured within the preceding 2 years

¹¹ Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Federal Register (2012). Online. <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf>; 2013; Let's CHANGE. "Healthy Memphis Common Table - Take Charge for Better Health! Healthy Memphis Common Table, 2013. Web. <http://www.healthymemphis.org/af4q.php>; Thompson, Lee, and Melissa Henry. *Creating a Healthier Niagara Falls: A Neighborhood Empowerment Approach - Final Report - Findings from a Process Evaluation*. Client Report. N.p.: AIR.

Population Health and Patient Outreach and Engagement

Focus on activities that help identify and assist patients in managing their own care and modifying their health behavior.

Success of the ACO in Population Health depends on how effective the ACO is at managing the health of its patients (population health management). This is dependent on:

- **Outreach:** The ACO's ability to proactively reach out to patients who need preventive and chronic care and help them access care management (at-risk patients, chronic care patients) will require ACOs to transform their systems for communicating with patients. They must expand patient access to providers and design a range of interventions for very sick patients, those who have less severe chronic diseases, and healthy people who need preventive care.

➤ **Alliance Example:** Puget Sound Health Alliance conducted an outreach campaign to engage consumers in their health care. Own Your Health is a campaign to empower consumers to become active participants in their own health and health care.

- **Engagement:** The ACO's ability to engage patients in managing their own care and modifying their health behavior will require an array of specially designed automation tools and communications systems.



➤ **Alliance Example:** P² Collaborative of Western New York worked with New York eHealth Collaborative (NYeC) and tasked AIR to gather consumer input for the design of a patient portal to help New York state residents better manage their health and health care.

¹² Jurcan, Diane. "Population Health Management: The Lifeblood of ACOs." *ADVANCE Healthcare - Executive Insight*. ADVANCE Healthcare, 21 Sept. 2012. <http://healthcare-executive-insight.advanceweb.com/Columns/ACO-Acumen/Population-Health-Management-The-Lifeblood-of-ACOs.aspx>; "Own Your Health." *Own Your Health*. Puget Sound Health Alliance, n.d. <http://www.wacomunitycheckup.org/ownyourhealth/>; Thompson, Lee, and Cailin Falato. *Engaging New Yorkers in Health and Health Care: Final Report - Findings from Twelve Consumer Focus Groups*. Client Report. N.p.: AIR 2013.

5 Things Alliances Can Do Now in Population Health

Alliances, as neutral conveners, can play a unique role in improving the population health of their communities. Alliances can partner with ACOs, providers and health plans on the following:

Community Engagement:

1. **Public Health Community Measurement:** Coordinate community strategies to address CHNAs and other measurement vehicles
2. **Public Health Community Coordination:** Integrate public health and delivery systems through coordination and partnerships with public health agencies and community organizations, share data and monitor progress on jointly selected health outcomes (e.g., Healthy People 2020 Goals)
3. **Social Determinants:** Focus CHNAs and measurement strategies not just on health outcomes but also social determinants of health to ensure a comprehensive agenda on population health



Patient Outreach and Engagement

4. **Patient Outreach:** Conduct outreach campaigns to engage consumers in their health care
5. **Patient Engagement:** Support patient input on automated tools and communication systems such as patient portals to support ongoing self-care and care management, including wellness management





Health Resources and Services Administration (HRSA) Perspective of the Affordable Care Act and Population Health

Healthy Communities, Healthy People



Mission Statement



“To improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs.”



HRSA Strategic Plan



1. **Improve Access to Quality Health Care and Services**
 - Integrate primary care and public health
 - Strengthen systems to support the delivery of quality health services
2. **Strengthen the Health Workforce**
 - Align composition/distribution to best meet needs of communities
 - Support development of interdisciplinary teams
3. **Build Healthy Communities**
 - Strengthen focus on illness prevention and health promotion across populations and communities
4. **Improve Health Equity**
 - Develop and disseminate innovative community-based health equity solutions focusing on populations with the greatest health disparities
 - Further integrate services and address social determinants of health



The Programs We Deliver



- ✓ Community Health Centers
- ✓ National Health Service Corps
- ✓ Workforce Training for Primary Care, Public Health, Medicine, Dentistry, Nursing, and Geriatrics
- ✓ Workforce Diversity
- ✓ Children's Hospital GME
- ✓ Practitioner Databanks
- ✓ Maternal and Child Health
- ✓ Healthy Start
- ✓ Stop Bullying Now!
- ✓ Poison Control
- ✓ Ryan White HIV/AIDS
- ✓ Rural Health Policy & Programs
- ✓ Telehealth
- ✓ Health Care for the Homeless
- ✓ Migrant Health Centers
- ✓ Native Hawaiian Health
- ✓ Vaccine Injury Compensation
- ✓ Hansen's Disease (Leprosy)
- ✓ 340B Drug Pricing
- ✓ Organ Donation & Transplantation
- ✓ And more...

U.S. Department of Health and Human Services
HRSA
Human Resources and Services Administration


Access and Workforce



- Health Centers
- Maternal and Child Health
- Ryan White HIV/AIDS Program
- National Health Service Corps

U.S. Department of Health and Human Services
HRSA
Human Resources and Services Administration

Access and Workforce



- Workforce training
- Rural health care
- Federal organ procurement system
- Poison Control Centers
- 340B low-cost drug program



HRSA - Population Health



1. Electronic Health Records
Implementation in Safety Net Settings
2. Healthy Weight Initiative
3. Integration of Public Health in Primary
Care Settings
4. Medical Home Concept
5. HRSA's Role in ACA Implementation



Theory of Aligned Contributions



- ❖ Call to Action
- ❖ Create Synergy
- ❖ Effective Use of Resources
 - ❖ Enhance communication
 - ❖ Build stronger relationships



1. Academic Institutions
2. Community Organizations
3. Faith-based Organizations
4. Health Care Facilities
5. Law Enforcement Agencies
6. Municipal Officials
7. Public Health Departments
8. Social Services Agencies
9. State and Local Government



Examples of Collaborations



Integration of Public Health and Primary Care: A Practical Playbook



Partners:

Duke University Medical Centers
Centers for Disease Control and Prevention
de Beaumont Foundation

Goal:

To develop a go-to resource for successfully integrating primary care and public health

Actions Taken:

DRAFT playbook near completion communication strategies finalized.
Dissemination date



Healthy Weight Initiative



Partners:

Primary care settings
Public Health Departments
School Districts - Community

Goal:

To prevent and treat obesity in children and families

Actions Taken:

Established sustainable partnerships among stakeholders
Implemented test interventions to achieve healthy weight
Financial support to 50 teams
Lessons learned dissemination



Integration of Behavioral Health Services into Primary Care



Partners:

National Council for Behavioral Health
Substance Abuse and Mental Health Services Administration
HRSA

Goal:

Develop integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions.

Actions Taken:

Training/TA to 93 dually-funded sites



HRSA's Public Health Priorities – Final Thoughts



“The health of the individual is almost inseparable from the health of the larger community. And the health of each community and territory determines the overall health status of the Nation”

(Source: Koh; A 2020 vision for healthy people. N Engl J Med 2010).



For More Information

On the Affordable Care Act, please visit

www.healthcare.gov

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THANK YOU !

Hot-Spotters: High-Intensity Interventions

Southcentral Foundation Nuka System of Care

Alaska Native People Shaping Health Care

- SCF - 2011 Baldrige Winner
- CEO 2004 McArthur Genius Winner

Southcentral Foundation 

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Why listen to our story

- Evidenced-based generational change reducing family violence
- Over 50% drop in ER visits, Hospital Days, and visits to Specialists
- Significant change in primary care utilization – less visits, more other
- 75-90%ile on most HEDIS outcomes and quality
- Benchmarked data nationally and internationally showing top in class performance in utilization, quality, satisfaction
- Employee Turnover rate less than 12% annualized (very low)
- Customer and staff overall satisfaction over 90%
- In an urban Alaska Native community with huge challenges
- Sustained for over a decade and continually improving
- Very long list of external recognitions – Malcolm Baldrige National Quality Award this year.

Southcentral Foundation 

Southcentral Foundation

- Innovative, relationship based, customer driven systems
- 1,600 staff – 150,000 statewide clients
- 55,000 local clients including 10,000 in over 50 remote villages
- Poorly funded by I.H.S. with minimal increases-2% total/yr – less per capita/yr. I.H.S funding is less than 50% of our funding now. Most is Fee for Service.
- Expanding local population (3-5%/yr)



Vision

A Native Community that enjoys physical, mental, emotional and spiritual wellness

Mission

Working together with the Native Community to achieve wellness through health and related services



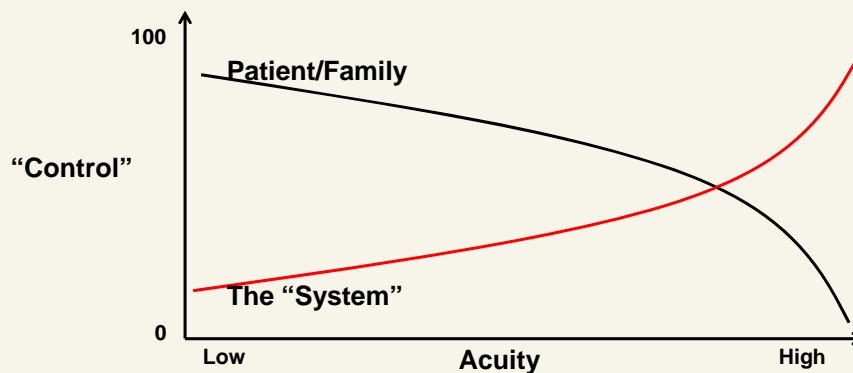
It's All About Customer-ownership and Relationships



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Control: Who really makes the decisions



1. Control – who makes the final decision influencing outcome?
2. Influences – family, friends, co-workers, religion, values, money
3. Real opportunity to influence health costs/outcomes – influence on the choices made – behavioral change
4. Current model – tests, diagnosis, treatment (meds or procedures)

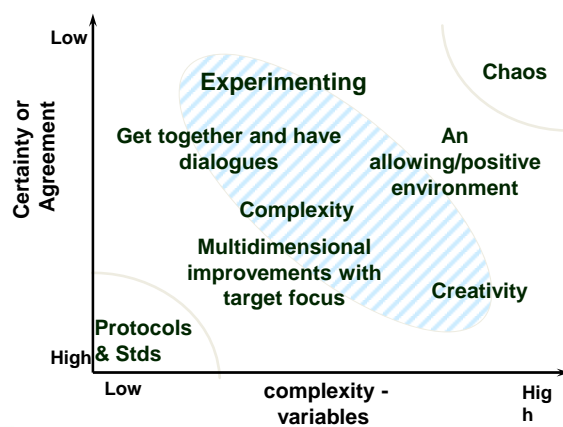
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Hitting the target...

- If you are in a mechanical, manufacturing environment then hitting a target is a matter of throwing a rock – figuring out speed, trajectory, etc.
- If you are in a messy, human, complex, adaptive environment – it is like throwing a bird at a target – it is all about the ‘attractor’
- Medicine throws birds at targets and only thinks about the throwing part...

Some simple rules for improvement

complexity diagram



Reality

- Health is a longitudinal journey
 - Across decades
 - In a social, religious, family context
 - Highly influenced by values, beliefs, habits, and many 'outside' voices.
- Office visits are brief, reactive stop-gaps
- Hospitalizations are brief, intense interruptions
- 5% drive 50% of costs, 80% of frustration – mostly non-physical issues driving utilization
- *MUST fix basic, underlying primary care platform first or nothing else will work well*



Alaska Native Wisdom

- Change in people occurs through long term, personal, trusting, accountable personal relationships
- Learning occurs through real life experiences, stories, modeling, and groups
- Work and learning are done optimally in groups and teams where collaboration and challenge are both valued
- Each person is responsible to play their part in the overall family and community
- The ability to give and receive story well is very key



It's all about Relationships

- It is THE core clinical service that we offer
- It is THE key set of skills we train every person on – Core Concepts
- It is THE way that we manage personnel
- It is THE core priority for how we design services, improve flow, decrease waste, design facilities, measure success, and recognize and reward excellence
- The ability to genuinely connect requires skilled ability to connect in story and walk in trusting, accountable, personal, long-term relationships with barriers removed



Operational Principles

Relationships between customer-owner, family and provider must be fostered and supported

Emphasis on wellness of the whole person, family and community (physical, mental, emotional and spiritual wellness)

Locations convenient for customer-owners with minimal stops to get all their needs addressed

Access optimized and waiting times limited

Together with the customer-owner as an active partner

Intentional whole-system design to maximize coordination and minimize duplication

Outcome and process measures continuously evaluated and improved

Not complicated but simple and easy to use

Services financially sustainable and viable

Hub of the system is the family

Interests of customer-owners drive the system to determine what we do and how we do it

Population-based systems and services

Services and systems build on the strengths of Alaska Native cultures



Components of Medical Home

- **Level One: Caring for a defined population or list – new goal**
 - Defined list – patient panel, registered list – and responsibility for the list of patients;
 - Ability to generate disease registries (ideally computerized); ability to track requirements for effective intervention; longitudinal coordinating relationships
- **Level Two: Delivering barrier free team-based care – new structure**
 - Care delivered by a team – not all doctors; all working at the top of their license;
 - Same day access – delays in access will divert to other care locations. Provision for ‘ad hoc’ contacts – e.g. after hours phone access, urgent-care/walk-inn visits, email?
 - Mind and Body back together – imbedded behaviorists
- **Level Three: Redefining relationship to specialty care – new relating**
 - Redefinition of role of specialists relative to primary care;
 - Movement of care from just illness care to include secondary prevention (optimal management of already existing health issues).
- **Level Four: Shifting to delivering “health” rather than “disease care”**
 - Effective incorporation of primary prevention, including connectivity to other community resources.
 - Becoming truly customer driven more completely, self-care, family-care



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Nuka System – Summary

- Changed Philosophy
- Expanded Medical Home Platform
- Integrated Care Team Members and Roles
- Workforce Emphasis
- Family Wellness Warriors Initiative, Core Concepts
- Use of Data
- Functional Structure
- Tools, Methods, Cascade, Planning
- Deep Listening, Cultural competency
- Traditional Healing/Complementary Medicine
- Facility Design



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Nuka System – summary

- Relationships – trusting personal partnerships
- Customer-owned – Alaska Native values
- Operational Principles
- Giving Story, Receiving Story
- Accountable Performance
- Putting services into culture
- Asset Based positive approaches
- Same Day Access
- Max Packing
- Working at the top of your license in team
- Service Agreements
- Job Progressions, Career Ladders, Mentoring



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Some Improvement Specifics - Clinic

- Advanced Access – appointments when the customer wants – same day primary care
- Case Management/Care Coordination
- Max Packing
- Service Agreements between departments
- Mind/Body back together – BHC - Behaviorists
- Hospitalists in Pediatrics and Internal Medicine
- Bring services to them – BH, Dietician, Pharmacist, Midwife – fully integrated high volume specialists
- Data Mall, Improvement Staff to learn and drive
- Facility Design – at all levels supporting philosophy



At Risk Populations

- Elderly
- Teens
- CMI
- Medically Fragile
- Socially Disintegrated
- 5 year gestation – Preconception to 5yo
- HIV, Diabetes, CHF



High Utilizers

- Approach built on top of whole population platform
- Three subsets – Mental Health, Medically Fragile, Socially Complex/Dependent
- Approaches – Wellness Care Plans, BHC's, Nutaqsiivik, Home Health, Elder Program, Quyana Clubhouse, Family Wellness Warriors Initiative, Dena-A-Coy
- Staff Preparation – Onboarding, Core Concepts, Clinical Mentors, Data Mall, Social/Medical/Geographic Data
- Progress Accountability - Data Mall, Feedback, Team Evals.
- Future – Community Care Coordination, Info., Family Care



Key Improvements - Workforce & Improvement Focus

- Hiring/Onboarding/training
- Leadership/Mgement present
- Employee wellness
- Common words, tools, skills
- Progressions/Ladders
- IA/IS – 10X Investement
- QI/PI tools, methods, training



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Core Concepts (Relationships)

- 🌱 ALL SCF employees – 3 day training – led by CEO and team – re-define the true core skills and priorities – with training – for everyone
- 🌱 Understand how we impact others by:
 - 🌱 Understanding your relational style – shapes, 5 dynamics, CDR
 - 🌱 Understanding how your experiences contribute to how you approach others
- 🌱 Words and Tools – 4 player, ladder, left hand c.
- 🌱 Learn how to articulate your story from heart
 - 🌱 Understand the power of empathy and compassion for your self and others
 - 🌱 Develop THE core skill of deep, effective listening



Provider Role and Expectations

- Healthcare Provider Changes for effective relationships
 - No longer a hero but a partner
 - Judgment about 'compliance' has no place
 - Replace blaming with understanding
 - Provide options not orders
 - Provide customer with resources, support
 - Make it simple, customer-driven



Customer-Owner Role/Expectations

- Customer-owner changes for effective relationships
 - Be active not passive
 - Take responsibility for your health
 - Get information about your health
 - Ask questions about advice
 - Ask for options
 - Engage with whole family/household



Questions?

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Or log onto our website at www.scf.cc/nuka

SCF Nuka Conference – June 16-20 in Alaska





P² Collaborative
of Western New York
Creating the healthiest community,
One neighborhood at a time

Transforming Health Care: A Neighborhood Empowerment Approach

P² Collaborative of Western New York

Glenda Meeks, BSN, MA
Manager, Clinical Care Coordination
September 20, 2013

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Niagara Falls: A City in Crisis

Socioeconomic Factors	Health Factors
Persistent and substantial economic obstacles	Higher incidence of cardiovascular disease
Social and environmental stressors	Higher rates of hypertension
High unemployment rates	Highest rate of diabetes in NYS
Widespread poverty	High substance abuse rates
High crime rates	Higher rates of poor mental health days
Low rates of higher education	
Shortage of health professionals	



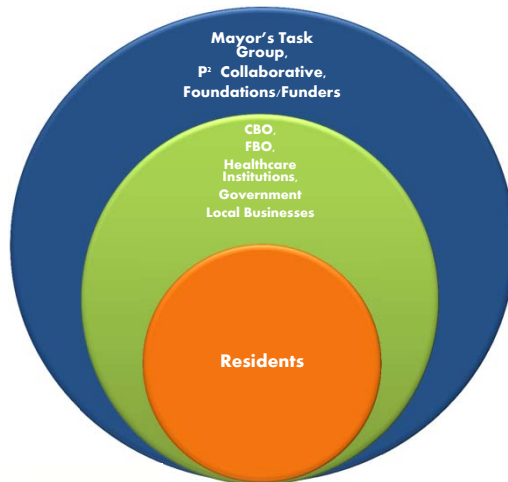
P² Collaborative
of Western New York
Creating the healthiest community,
One neighborhood at a time

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Community Transformation



Community Empowerment Approach

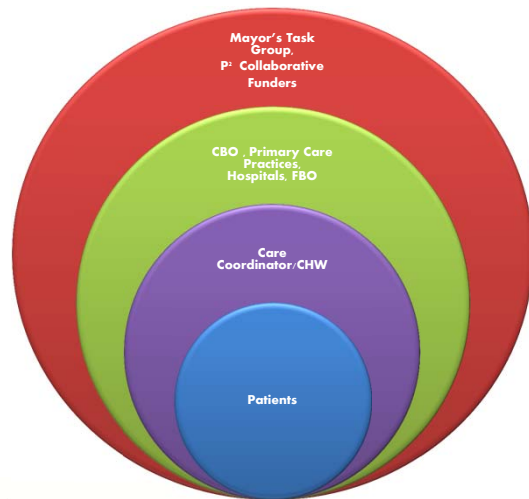


Multi-stakeholder approach; enhanced collaboration between local health care and community; catalyst for change; build community capacity

Integrating and sharing resources; community level interventions; creating opportunity to collaborate among different sectors of the community.

Residents empowered and engaged in community planning process. Increased resident accountability through leadership development. Resident driven initiatives to improve health, safety and quality of life.

Patient-Centered Approach



Multi-stakeholder approach, community-based orientation supported by communication to and from the Mayor's Task Group; tracking health outcomes and cost measures

Linking high utilizers to community resources; integrating community-based model into practice level interventions; creating opportunity to collaborate between hospitals and practices on utilization rates

Social needs assessment; standard processes, care plans, measures and reporting system for the three practices

Patient-centered care planning; patient engagement and activation assessment

Transforming Healthcare Delivery Community Medicaid Collaborative

- A Medicaid Demonstration Pilot
- Three high Medicaid practices in Niagara Falls
- Test the efficacy of a care coordination model inclusive of a care coordinator and community health worker in primary care settings
- Focus on thirty patients (high utilizers) diagnosed with Depression
- Improve quality of care, health outcomes, patients experience and reduce costs

Lessons Learned

- Integrated systems approach is needed
 - Collaboration is key
- Organizations are complex
 - Understand that partners at the table may be representatives of a larger institution and all changes must be made at the speed the organizations are ready to make them
 - Problems must be addressed through a range of mutually reinforcing changes
- Culture change at every level is critical
- Great need for understanding how to integrate and link behavioral health, primary care and other services in the community
 - Care Coordination offers an important transformation pathway
- Structure of the Mayor's Task Force was the foundation on which other initiatives have now been built
- Leverage multiple funding opportunities to make projects viable

AUSTEN BioInnovation

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ABIA: Unique Convergence



John S. and James L. Knight Foundation
Informed, engaged communities.

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Accountable Care Community (ACC)

- **Vision**
To improve the health of the community.
- **Mission**
To design, develop, implement, and serve as a national framework for improving the overall health of an entire community through a collaborative, integrated, multi-institutional approach that emphasizes shared responsibility for the health of the community.
- **Metrics**
The ACC results in job creation, a spin-out business entity, and improved health via higher quality, cost effectiveness and cost saving, and an improved patient experience in health promotion and disease prevention, access to care and services, and health care delivery.

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<http://www.abiakron.org/acc-white-paper>

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ACC vs. ACO

- ACC is not dependent upon providers adopting Medicare infrastructure
- ACC encompasses medical care systems plus grassroots community stakeholders and community organizations
- ACC focuses on health outcomes of the entire population in a geographic region

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Partners, Accountable Care Community



Communities Transforming

To make healthy living easier



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ACC Coalition

Collaborative partnerships leverage multi-sector resources to improve community health.

Benefits of partnership:

- Addresses broad range of issues with greater breadth and depth
- Coordinates services and prevents redundant efforts
- Increases public support
- Allows individual organizations to influence community on a larger scale
- Includes diverse perspectives
- Strengthens connections between existing resources
- Provides shared frame of inquiry for community health concerns



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Janosky et al., Population Health Management, 2013
Aug;16(4):246-54



ACC Components

- Integrated, collaborative, medical and public health models
- Inter-professional teams
- Robust health information technology infrastructure
- Community health surveillance and data warehouse
- Dissemination infrastructure to share best practices
- ACC impact measurement
- Policy analysis and advocacy

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High Level Steps Toward an ACC

1. Develop a system of health promotion and disease prevention, access to care and services, and healthcare delivery based on Healthy People 2020
2. Conduct an inventory of community assets and resources, and mapped to the Health Impact Pyramid
3. Identify and rank health priorities with community stakeholders

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High Level Steps Toward an ACC

4. Realize improved health outcomes for a defined population
5. Utilize benchmark metrics that include short-term process measures, intermediate outcome measures, and longitudinal measures of impact
6. Demonstrate the economic case for healthcare payment policies that lower the preventable burden of disease, reward improved health, and deliver cost effective care

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ACC Strategic Impact Directions and Process Implementation

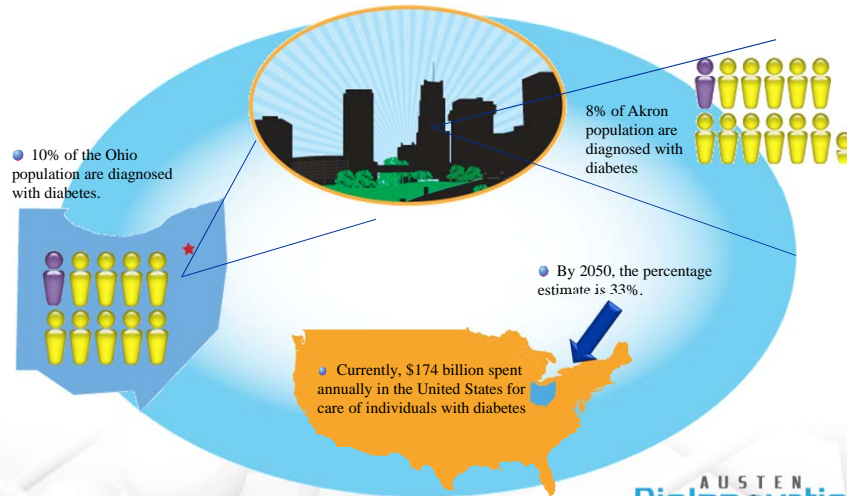


- **TOBACCO-FREE LIVING**
Prevent/reduce tobacco use and protect people from exposure to tobacco smoke
- **ACTIVE LIVING AND HEALTHY EATING**
Prevent/reduce obesity, increase physical activity and improve nutrition
- **HIGH-IMPACT QUALITY CLINICAL AND OTHER PREVENTIVE SERVICES**
Prevent/control high blood pressure and cholesterol
- **SOCIAL AND EMOTIONAL WELLNESS**
Increase health/wellness, including social/emotional wellness
- **HEALTHY AND SAFE PHYSICAL ENVIRONMENTS**
Improve the community environment to support health



42

Diabetes



43

Diabetes has a significant impact on health, economics, and quality of life.

AUSTEN
BiInnovation
INSTITUTE IN AKRON

ACC Success: Personalized Educational and Experiential Modules for Diabetes Management

- Patients with diabetes at 3 independent health systems, varying insurance status (38% private, 31% public, 31% none)
- Multi-disciplinary team with multi-focal modules (medical care, nutrition, physical activity, social and emotional well-being, and self-management)
- Results included
 - Cost \$25/person/contact hour (comparison Diabetes Prevention Project \$37.50/person/contact hour)
 - Better management leading to decrease in A1C and LDL cholesterol levels
 - More than half of participants lost weight, decreased BMI, and reduced waist size (all clinically relevant levels of improvement)
 - No amputations and a decline in emergency department visits because of diabetes
 - Increase in reported exercise and flexibility

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AUSTEN
BiInnovation
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ACC Success: Return on Investment (ROI)

- Examination of ROI program connecting more than 2000 adults with the ACC
- Results included
 - The average cost per month of care for individuals with diabetes reduced by more than 10% per month
 - After one year of involvement, consistent reduction in costs are in excess of 25%

45

Recognized Benefits of Diabetes Interventions

Per Person Annual Health Care Savings of Decreasing HbA1c	
	2012 USD
10% to 9%	\$570
9% to 8%	\$415
8% to 7%	\$285
10% to 9% w/ complications	\$1,955

Per Person Annual Savings of Decreasing % of Body Weight		
	Medical	Absenteeism
5%	\$60	\$30
10%	\$140	\$50
15%	\$210	\$80
20%	\$280	\$110

ACC Results:

- Estimated Program Savings = \$3,185/year
- Average Pre-Program HbA1c = 8.20%
- Average Post-Program HbA1c = 7.74%
- Estimated Program Savings = \$580/year
- Average Weight Decrease = 2%

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Recognized Benefits of Diabetes Interventions

ED Visits per 1,000 Diabetics in Same Condition

Years HbA1c < 8%	ED Visit Rate
0 years under 8%:	276.3
1 year under 8%:	230.6
2 years under 8%:	200.0
3 years under 8%:	127.1
4 years under 8%:	115.9

ACC Results: Total Number of ED Visits

	HbA1c < 8%	HbA1c > 8%
6 Months Prior:	6	9
During Program:	3	7

- Individuals with HbA1c<8% had a total of 6 ED visits six months prior to the program and 3 during the program.
- Individuals with HbA1c>8% had a total of 9 ED visits six months prior to the program and 7 during the program.

47

ACC Metrics for Success

- Community participation
- Local, regional, and national burden of disease (Impact Equations)
- Institute of Medicine Specific Aims for 21st century healthcare
- Primary, secondary, and tertiary prevention indicators
- Community intervention measures
- Care coordination metrics
- Determinants of health
- Health information technology utilization and information sharing
- Clinical improvement
- Patient safety
- Patient self-management
- Patient-centered medical home measures

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ACC Sustainability

- Systemic changes that help move collaborative behavior into the norm
- Sophisticated knowledge management tools to drive positive change
- A knowledge base of policy, financing, and regulatory levers
 - focus on health promotion and disease prevention
 - coordinated and integrated public health, social service, and health systems
 - payment reform

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References

- 2010 Community Health Needs Assessment. http://www.akrongeneral.org/web09/pdfs/ComHlth/CHA_report_1111.pdf
- Behavioral Risk Factor Surveillance System. (2011). Summit County BRFSS Survey, 2008. <http://www.scphoh.org/PDFS/PDF-Reports/BRFSS%20final%20with%20geography.pdf>
- BlueCross BlueShield of Illinois. 2010 Diabetes Q1 Fund Project. http://www.bcbill.com/pdf/clinical/q1/2010_diabetes_program_results.pdf
- Gallup-Healthways Wellbeing Index. State of Wellbeing: State, City and Congressional District Wellbeing Report for Ohio, 2011.
- Gawande, Atul. *The Hot Spotters*. 2011. Medical Report. http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande?currentPage=all
- Gilmer, Todd P. et al. 1997. "The cost of Health Plans of Poor Glycemic Control". *Diabetes Care*. 20(12): 1847-1854.
- Mitchell RJ, Bates P. Measuring Health-Related Productivity Loss. *Population Health Management*, 2010;14
- Ohio Behavioral Risk Factor Surveillance System. Chronic Disease and Behavioral Epidemiology Section, Ohio Department of Health, 2010.
- Ohio Department of Health. Ohio Diabetes Prevention and Control Program. 2012 <http://www.odh.ohio.gov/sitecore/content/HealthyOhio/default/diabetes/odpcp.aspx>
- Ohio Family Health Survey. Health Profile of Summit County, February 2010.
- Policy Research and Strategic Planning, Ohio Department of Development. (2011). *The Ohio Poverty Report*. <https://www.development.ohio.gov/Research/files/p700000000.pdf>
- Summit 2020. Summit 2020 Priority Indicators Disparity Report, 2011. January 2012.
- Trogdon J. et al. 2009. "A Return-On-Investment Simulation Model of Workplace Obesity Interventions." *Journal of Occupational and Environmental Medicine*. 51(7):751-758.
- Trust for American's Health. *F as in fat: How obesity policies are falling in America*. Robert Wood Johnson Foundation (July 2009). <http://65.181.142.130/images/stories/obesity2009report.pdf>
- University of Wisconsin. Population Health Institute. County health rankings, 2011. <http://www.countyhealthrankings.org/ohio/summit>
- U.S. Department of Commerce. (2011). *Income, Poverty and Health Insurance Coverage in the United States: 2010*. United States Census Bureau. http://www.census.gov/newsroom/releases/archives/income_wealth/cb11-157.html

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Camden Coalition of
Healthcare Providers
www.camdenhealth.org

Improving Care Together in One of America's Poorest Cities

Andrea Hallowell Miller
Program Manager

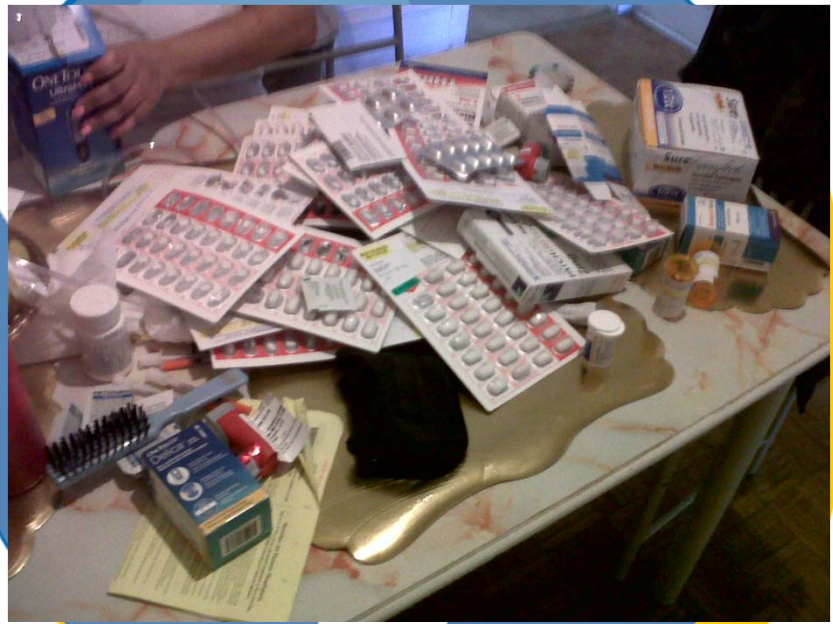
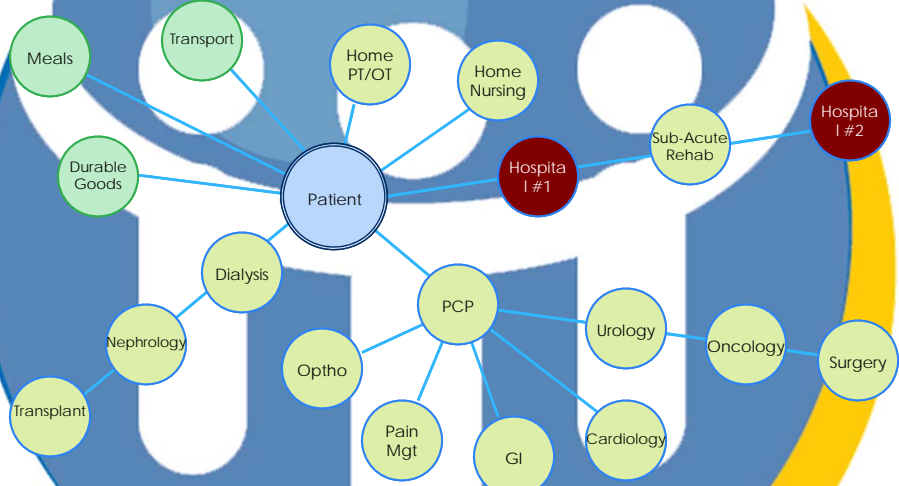
51

Understanding the Problem

- 55-yo Male, admitted for GI bleed and SOB (November 2011)
- Dual coverage, Lives alone in high-rise apartment
- 6 months: 9 ED visits, 6 inpatient visits
- 12 medications daily

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Understanding the Problem





Overview of the Camden Coalition of Healthcare Providers

Vision: Camden will be the first city in the country to bend the cost curve while improving quality.

Mission: To improve the quality, capacity, coordination and accessibility of the healthcare system for all residents of Camden.

- 45 staff, \$4.8 million annual budget
- Mix of foundation, federal grant funding and hospital support
- Membership organization, 20 member board, incorporated non-profit

Hospital Costs – Camden Residents, 2011

Total hospital revenue

\$108 million
\$1,396 per capita

Total inpatient revenue

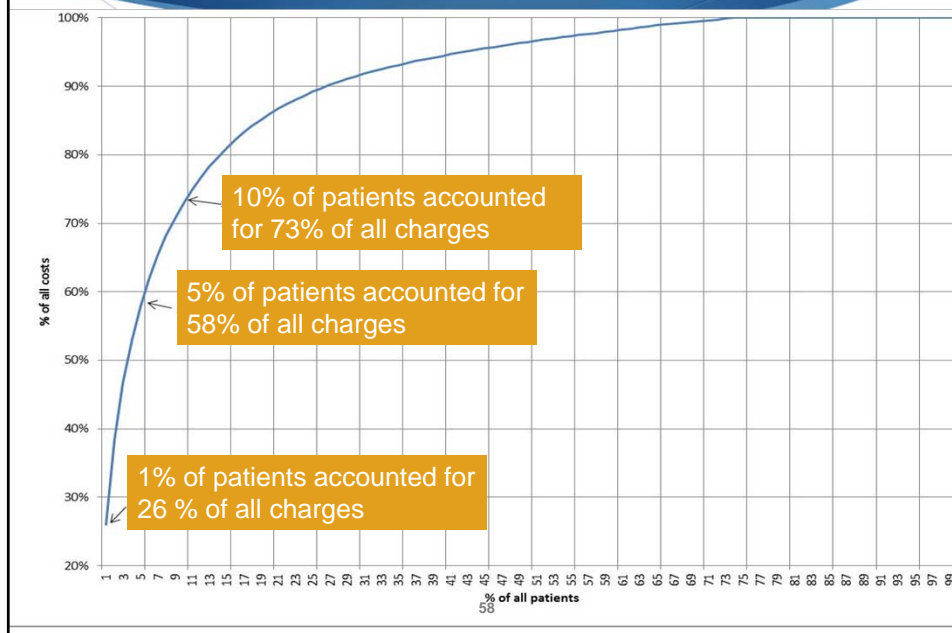
\$79 million
\$1,021 per capita

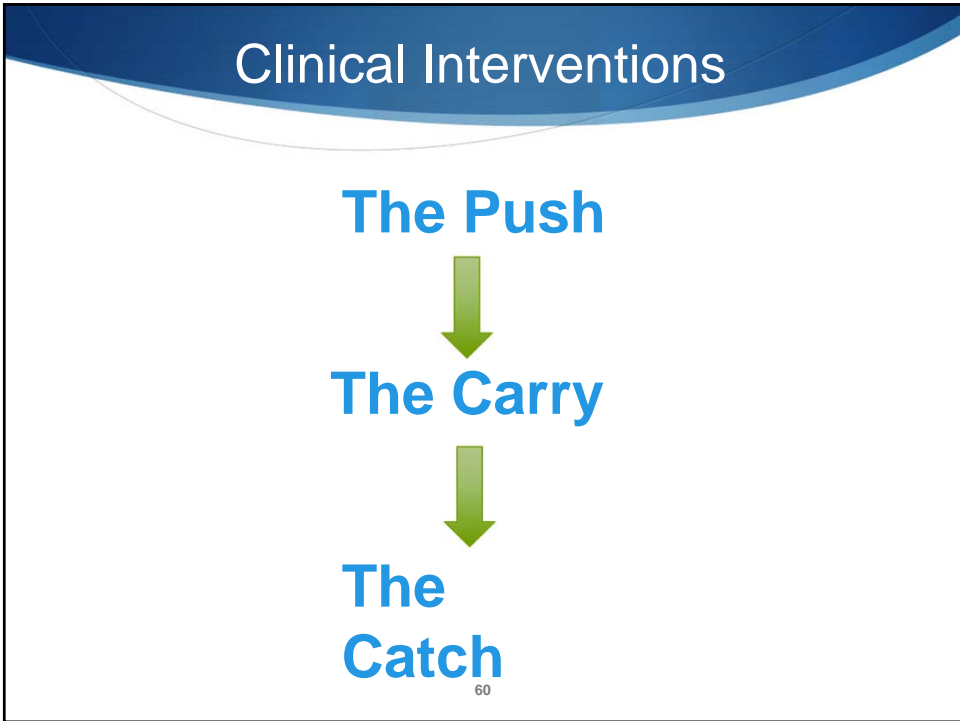
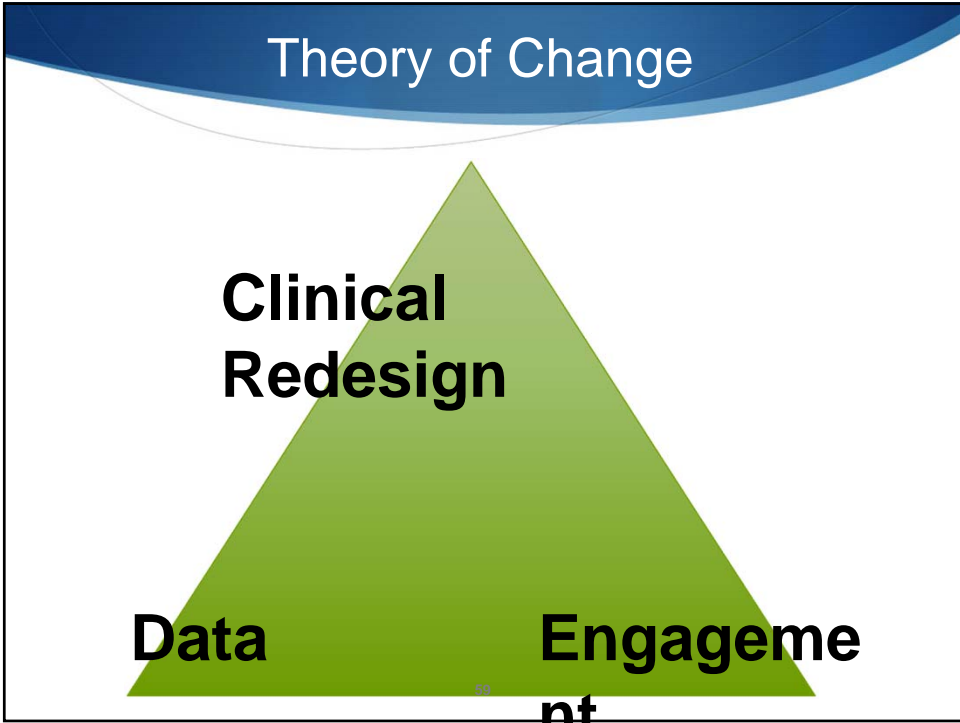
Total Emergency Department revenue

\$29 million
\$375 per capita

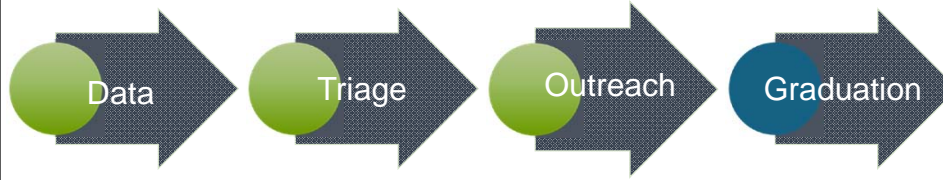
57

Camden Cost Curve, 2011





The Carry: Community Based Care Coordination



Daily Admissions Feed

Admitted past month, 6 month summary

		Days 6 mo episodes									
Admit	Facility	Inp	ED	Name	dob	age	sex	PCP	PracticeName	Insurance	
06/13/12											
Cooper	40	7	3	XXXXXXXXXXXXXXXX	xx/xx/xxxx	55	M	JACK GOLDSTEIN	CMC Dept of		
Cooper	44	3	2		xx/xx/xxxx	73	F	MARILYN GORDON	CAMcare Health		
Cooper	79	3			xx/xx/xxxx	57	M	JOHN KIRBY	Cooper Physician	HORIZON NJ PPO	
Cooper	35	2	3		xx/xx/xxxx	21	M	NO PHYSICIAN			
OLOL	1	2	1		xx/xx/xxxx	56	M			SELF PAY -	
Cooper	5	2	1		xx/xx/xxxx	51	M			SELF PAY	
OLOL	4	2	1		xx/xx/xxxx	54	M				
Cooper	27	2			xx/xx/xxxx	47	M	MARILYN GORDON	CAMcare Health		
06/12/12											
Cooper	15	13	1		xx/xx/xxxx	22	F	MIGUEL MARTINEZ	Cooper Physician		
Cooper	18	3	2		xx/xx/xxxx	55	M	NO PHYSICIAN		AMERHLTHKEYST	
Cooper	99	3	1		xx/xx/xxxx	64	M	DANIEL HYMAN	Cooper Physician		
06/11/12											
Cooper	9	9	5		xx/xx/xxxx	48	M	LYNDA BASCELLI	Project Hope		
OLOL	43	9	1		xx/xx/xxxx	71	F			INTERNAL BILLING	
OLOL	17	5	5		xx/xx/xxxx	66	F			HORIZON NJ	
Cooper	27	5	3		xx/xx/xxxx	52	M	LYNDA BASCELLI	Project Hope		
OLOL	35	5	1		xx/xx/xxxx	70	F			BRAVO HEALTH	
OLOL	46	4	5		xx/xx/xxxx	73	F			HORIZON NJ	
OLOL	51	3	2		xx/xx/xxxx	56	F			SELF PAY	
Cooper	2	3	1		xx/xx/xxxx	68	F	MINH HUYNH			
OLOL	1	3	1		xx/xx/xxxx	73	F			HORIZON NJ	
Cooper	34	3			xx/xx/xxxx	62	F	ANNA HEADLY	Cooper Physician		
Cooper	131	2	10		xx/xx/xxxx	35	M	NO PHYSICIAN			
OLOL	54	2	6		xx/xx/xxxx	49	F			SELF PAY -	
OLOL	177	2	4		xx/xx/xxxx	91	F			HORIZON NJ	
Cooper	3	2	2		xx/xx/xxxx	51	M	NO PHYSICIAN		MEDICAID	
OLOL	139	2	2		xx/xx/xxxx	87	F			HORIZON NJ	

The Catch: Primary Care Redesign

Embedding staff and resources within primary care practices to:

- Ensure every hospitalized patient gets priority attention from the practice
- Provide practice-based care coordination for the sickest patients
- Use data to proactively manage patient panel

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Data Analysis

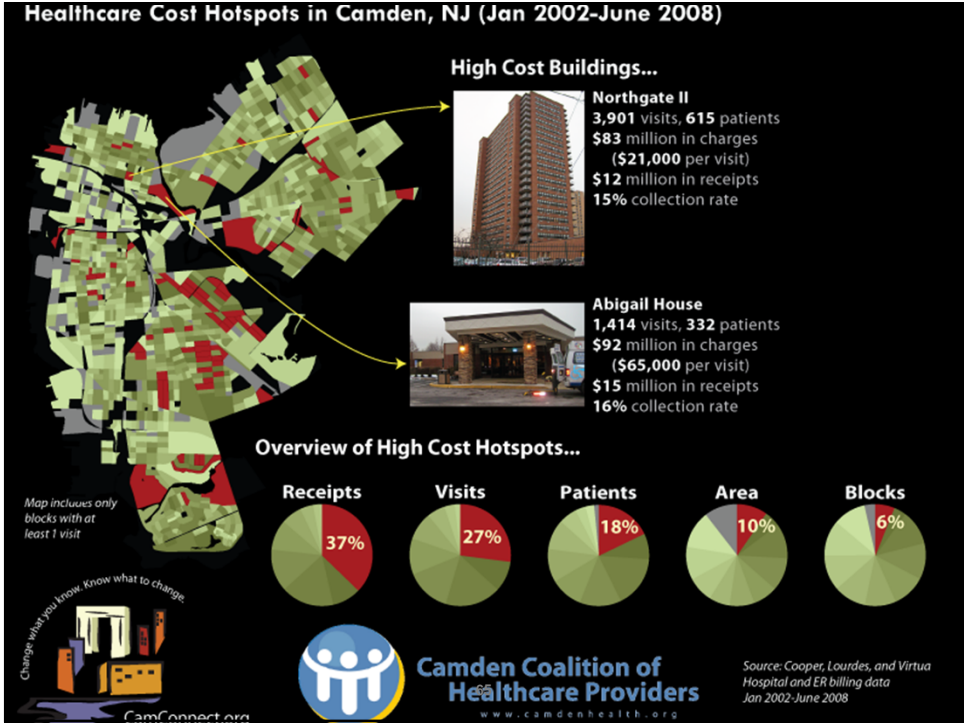
**Identifies Accountable
Providers**

**Highlights
Geography**

**Exposes
Complexit**

64

v



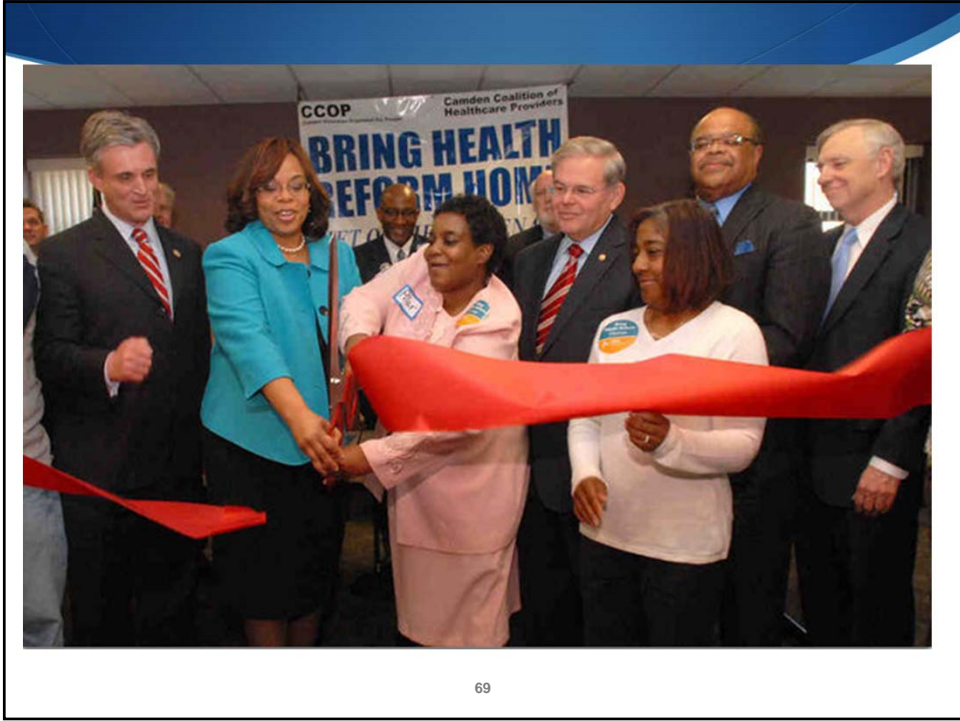
Train local residents to participate in decision-making over health care resources

67

Promote collaboration among providers and between providers and the community

CAMDEN CHURCHES ORGANIZED FOR PEOPLE

68



NJ's Medicaid ACO Model

SENATE, No. 2443

STATE OF NEW JERSEY

214th LEGISLATURE

INTRODUCED DECEMBER 6, 2010

Sponsored by:
Senator **JOSEPH F. VITALE**
District 19 (Middlesex)

SYNOPSIS

Establishes Medicaid Accountable Care Organization Demonstration Project in DHS.

CURRENT VERSION OF TEXT

As introduced.

71

Questions?

- info@camdenhealth.org
- www.camdenhealth.org
- Twitter: [@camdenhealth](https://twitter.com/camdenhealth)

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What Could Work?

Hennepin Health

Description: Hennepin Health is a Medicaid demonstration project formed by four organizations governed by Hennepin County in Minnesota – the Metropolitan Health Plan, Hennepin Healthcare System Inc. (dba Hennepin County Medical Center), NorthPoint Health and Wellness Center (FQHC), and the county’s Human Services and Public Health Department (including Health Care for the Homeless, the county’s Mental Health Center, and social services). It started January 1, 2012. It serves approximately 6100 expanded MA enrollees (18- 64 year old adults with no dependent children, income is < 75% fpl) who reside in Hennepin County in a limited network. The Care Model is built on the concepts of a primary care medical home (called Health Care Home in MN), with strong care coordination, AND the importance of addressing the social determinants of health such as housing. The project is ultimately governed by the County Commissioners, with representation from the 4 partners at the table. Operationally, the county has a Deputy Director for Hennepin Health who works with a variety of committees (Care Model, Finance, Analytics, Operations) to make decisions. The financial model is a capitation, PMPM, payment from the state to the health plan. The providers bill the plan on a FFS basis. The partners then split the gain (or loss) at the end of the year. There was a gain in 2012 and a portion of that is being reinvested in social programs such as a sobering center and vocational services support. A separate data warehouse , with claims from the plan, Epic information, and some social services data, as well as an analytic support structure were developed.

Differences with common conception of an ACO: the population is enrolled vs attributed and can thus be identified in the record; based on a county and the county governance structure vs. an individual health system; single payer vs. multi-payer; defined network vs. open; focus on social determinants of health vs. strictly medical; capitation payment vs risk/gain share.

Learning points:

- Implementing strong care coordination structure and processes across multiple different partners is challenging; developed workflows, role definitions, training; now focusing on assigning a single accountable individual (vs. a myriad of case managers)
- HIPAA considerations delayed the development of the data warehouse – getting consensus from county attorneys and the individual organizations’ privacy officers was a lengthy process; we have also been plagued by some data integrity issues
- The eligibility “churn” every six months with this population makes achieving outcomes more difficult; we are looking forward to the 2014 change to 1 year eligibility!

Use of IT:

- The plan sends the monthly enrollment file to HCMC’s EHR team who then put each patient into Epic even if they did not come to one of the providers; a “modifier” is also applied to identify patients in the header (beyond just the payer/plan)
- Every partner has Epic: HCMC, NorthPoint, and the county MHC and Healthcare for the Homeless are affiliates; this was expanded with restrictions to certain staff at the plan and social services at the county; many community based partners have EpicCareLink
- Epic’s registry and Radar support for dashboards have been important tools for care coordination
- We built a rudimentary care plan in Epic that can go across the continuum



Hennepin Health

People.Care.Respect



September 2013
Nancy Garrett, Ph.D.

Hennepin County, MN

working for you 

1



What is Hennepin Health?

Minnesota Department of Human Services (DHS)

&

Hennepin County

Collaborative for Healthcare Innovation

Hennepin County Partners:

Hennepin County Medical Center (HCMC)

NorthPoint Health & Wellness

Human Services and Public Health Department (HSPHD)

Metropolitan Health Plan (MHP)

working for you 

2

Population Served

- MA Expansion in Hennepin County
- 21 - 64 year-old Adults, without dependent children in the home
- At or below 75% federal poverty level (\$677/month for one person)
- Targeting ~10,000 members/month
- Start date: January 2012 (two year demonstration project)



working for you 

3


Premise

- Need to meet individual's basic needs before you can impact health
- Social disparities often result in poor health management and costly revolving door care
- By coordinating systems and services, we can improve health outcomes and reduce costs



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4




The Business Case

Problem:


- High need population
- Top 5% utilizing 64% of dollars
- Crisis driven care
- System fragmentation
- Safety net - cost shifting

Need:

- Address social disparities
- Improve patient outcomes
- Increase system efficiencies
- Increase preventive care


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5




Population Characteristics

- ~68% Minority status
- ~45% Chemical Use
- ~42% Mental health needs
- ~30% Chronic Pain Management
- ~32% Unstable housing
- ~30% 1+ Chronic diseases



Joe Jones
Patient, Coordinated Care Clinic,
Hennepin County

working for you 

6

Goals: Years 1 and 2

Improve Residents Health Outcomes, Reduce Overall Costs

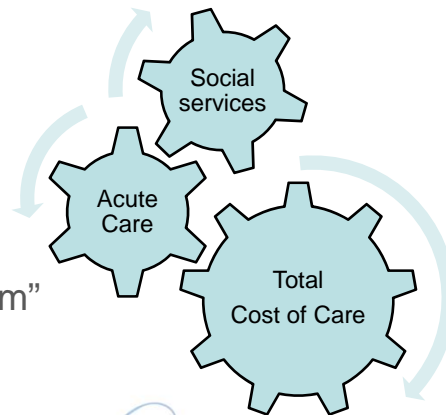
- Decrease admissions/readmits by >10%
- Reduce emergency department visits by >10%
- Increase primary care “touches” by >5%
- Reduce churn. Maintain coverage by >95%

working for you 

7


Finance model

- 100% at risk contract
- Partners share risk/gains
- Tiering approach
- Fee for Service → “pmpm”
with outcome contracts




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8



System Opportunities (sample)

- 5% utilizing 64% of health care funds
- Individuals “stuck” in hospital beds
- Individuals failing transitions between programs
- Individuals misusing crisis care venues
- System fragmentation and duplication
- Low medical literacy



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System Investments Year 1 (sample)

<u>Initiative</u>	<u>Outcome</u>
<ul style="list-style-type: none"> • Same day dental care • Care Coordination • Data Warehouse • Patient Radar Reports 	<ul style="list-style-type: none"> • >30% average cost reductions • >50% hospital reduction - Tier 3 • Ability to see across systems • Work prioritization



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System Investments Year 1

(sample)

Initiative

- Pharmacy MTM
- Health Plan/Provider record
- Same day access to primary care



Outcome

- Reduce medication costs >50%
- Near real time data, reduced duplication of efforts
- Reduction of ED - crisis care

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System Investments Year 2

Project

- Sobering Center
- Transitional Housing
- Behavioral Health Continuum
- Psychiatric Consult model
- Intensive primary care - clinic expansion
- Vocational services

Return on Investment

- 80% cost reduction ED to sobering center
- One month of housing < 2 days of hospitalization
- 30 - 50% cost reduction expected

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12

Where do we need to be?



working for you 

13

SIM and Health Care Reform

- Significant opportunity in “managing” care
- Significant benefit in “Systems” (health plans, providers, public health) being on level playing field
- Systems motivated to shared outcomes - create huge opportunities (both health and savings)



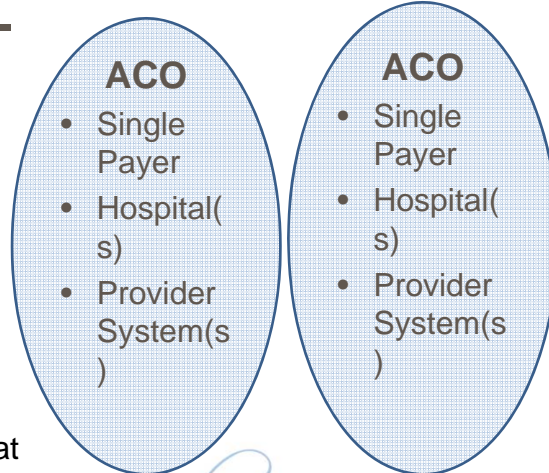
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ACO Models-

Risks:

- Larger silos
- System fragmentation
- Competition vs. transparency/collaboration

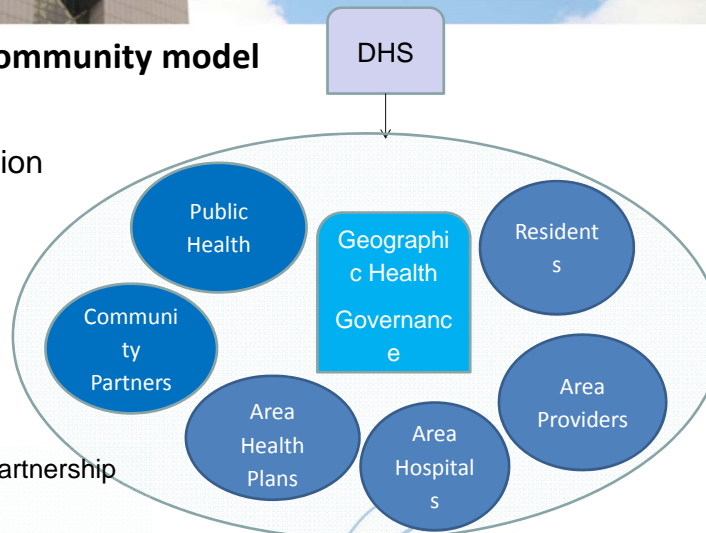


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Geographic-Community model


Risk:

- Standardization
- Complexity




Shared risk/gain partnership across systems

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Health Readiness

- Creation of collaborations
 - who are your critical partners
- Emphasis on “tool box” education
- Assess current environment (position to “fill the need”)
 - Services expanding
 - Services shrinking
 - Gaps in services
 - Reduction in “duplication of effort”


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Existing Health Care

- Fee-for-Service (do more, get more)
- Payer driven interventions
- System response - we provide what they pay for
- Success = Structure, Workflows, standardization, ‘program’ approach

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Future Health Care

- Consumer driven (choice and competition - quality matters/access matters)
- Payer - High Quality and Low Cost demands
- System Response - “smart health care”- we provide what patients need
- Success =
 - **Innovation** ~ (non-traditional health care)
 - Net clinics, E-Visits, Virtual teaming-consults
 - Data driven, with return on investment (low cost, high health outcomes)
 - **Adaptive/Decisive leadership**
 - Major system changes, incremental/planned, nimble decision making
 - Flexibility to meet patient needs (not program needs) in order to get quality outcomes at low cost
 - **Lean Processing**
 - Reduce waste (paperwork, interventions without value-add to patient outcomes)
 - Streamline systems/Align leaders

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Hennepin Health

Bringing systems and people together

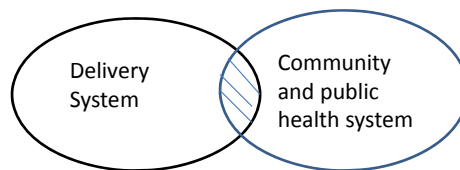


Video and more information:
www.hennepin.us/healthcare

working for you 

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Population Health Efforts Cambridge Health Alliance



Cambridge Health Alliance

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CAMBRIDGE HEALTH ALLIANCE

An Integrated, Academic, Public Health Care System in MA

Mission: To improve the health of the community

DELIVERY SYSTEM

- Network of primary and specialty health centers, hospital campuses, employed physicians, cultural and linguistic expertise, academic programs, and public & community health programs serving 90,000 primary care patients – 80% public payer

COMMUNITY RESPONSIVE PROGRAMS

- HIV/AIDS
- Community Health Centers
- School Health Centers
- Health Care for the Homeless
- Multilingual Interpreters
- Linguistic Mental Health Teams

PUBLIC AND COMMUNITY HEALTH

- Manage the Cambridge Public Health Department
- Department of Community Affairs
- Institute for Community Health
- Multiple community partners (schools, churches, coalitions, mental health providers)
- Public and Community Health indicators on scorecard (obesity, substance use/tobacco/immunizations)



Cambridge Health Alliance

22

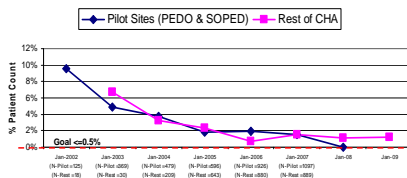
Population Health Strategy

- Community and Public Health Committee
- Review data
 - Billing and EMR data
 - Behavioral Risk Factor Surveillance Survey
 - Youth Risk Factor Surveys
 - Hospital Discharge Data
- Determine shared priorities with community partners
- Use evidence based practices
- Identify roles and responsibilities
- Monitor progress

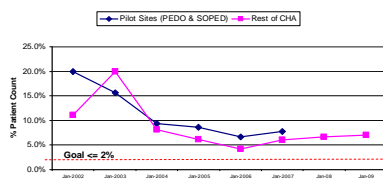
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Childhood Asthma

**Childhood Asthma:
% Patients with Asthma Admissions**



**Childhood Asthma:
% Patients with Asthma ED Visits**



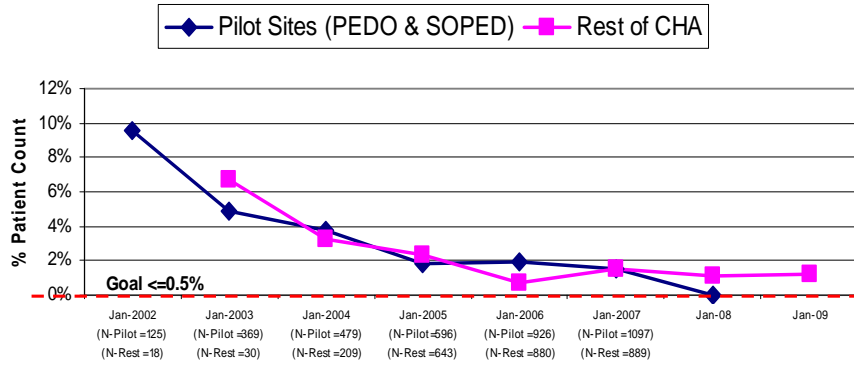
DELIVERY SYSTEM

- Asthma Registry: information shared with all (ED, pediatrician). NHLBI guidelines
- Proactive outreach to patients by Planned Care Team to get them controlled on asthma medications (over 99%).

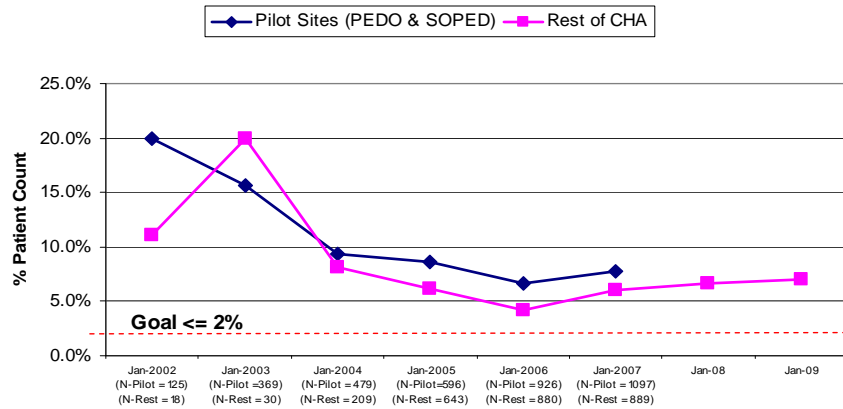
PUBLIC/COMMUNITY HEALTH

- Healthy Homes assessment
- Shared information with school nurses

Childhood Asthma: % Patients with Asthma Admissions

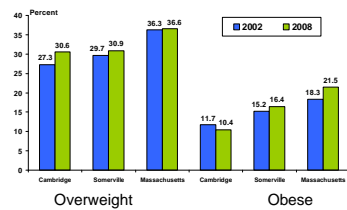


Childhood Asthma: % Patients with Asthma ED Visits



Obesity Prevention

Change in Obesity from 2002 to 2008: Cambridge, Somerville, and MA



Overweight = BMI between 25.0 and 29.9; Obese = BMI greater than or equal to 30.0
 * About 24% of the 2008 survey respondents are missing the weight variable necessary to calculate BMI.

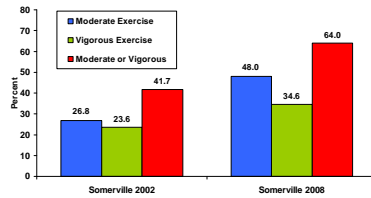
PUBLIC/COMMUNITY HEALTH

- Policies-5-2-1
- BMI monitoring in schools
- Gardens
- Enhanced exercise options

DELIVERY SYSTEM

- Monitoring BMI
- Employing Alerts
- Chronic care model
- Employee health

Met Definition of Physical Exercise City of Somerville: 2002 and 2008



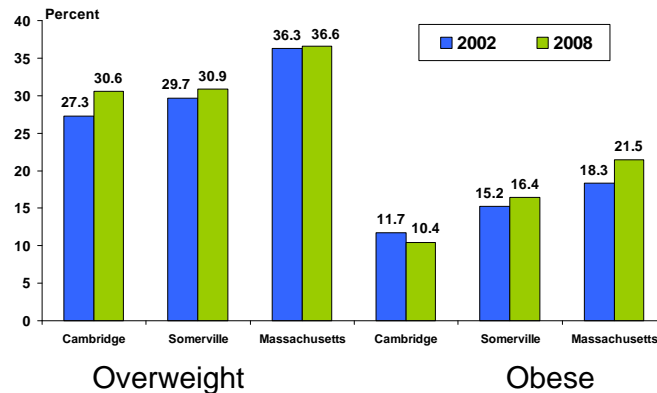
Differences between 2002 and 2008 are statistically significant.

*Moderate: Adults w/ 30+ minutes of moderate activity 5 or more days per week.
 *Vigorous: Adults w/ 20+ minutes of vigorous activity 3 or more days per week.



Cambridge Health Alliance

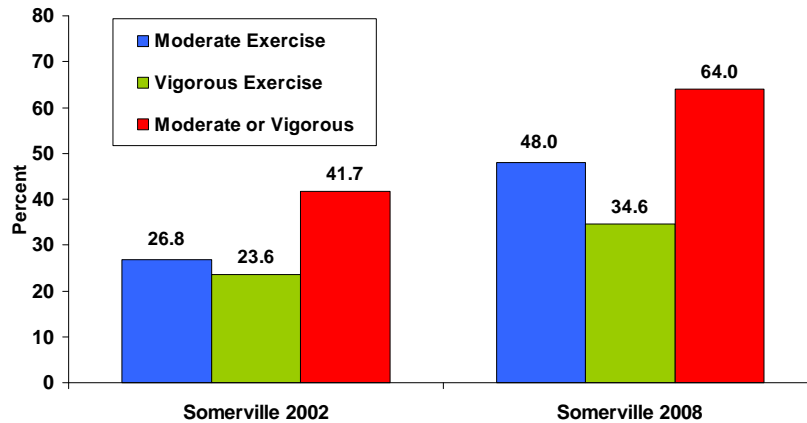
Change in Obesity from 2002 to 2008: Cambridge, Somerville, and MA



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* About 24% of the 2008 survey respondents are missing the weight variable necessary to calculate BMI.²⁸

Met Definition of Physical Exercise City of Somerville: 2002 and 2008



Differences between 2002 and 2008 are statistically significant.

***Moderate:** Adults w/ 30+ minutes of moderate activity 5 or more days per week.

***Vigorous:** Adults w/ 20+ minutes of vigorous activity 3 or more days per week.

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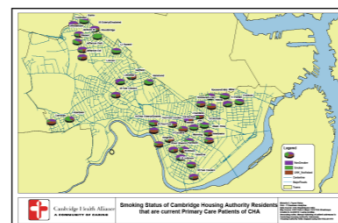
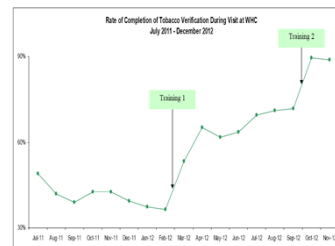
Tobacco Cessation

PUBLIC/COMMUNITY HEALTH

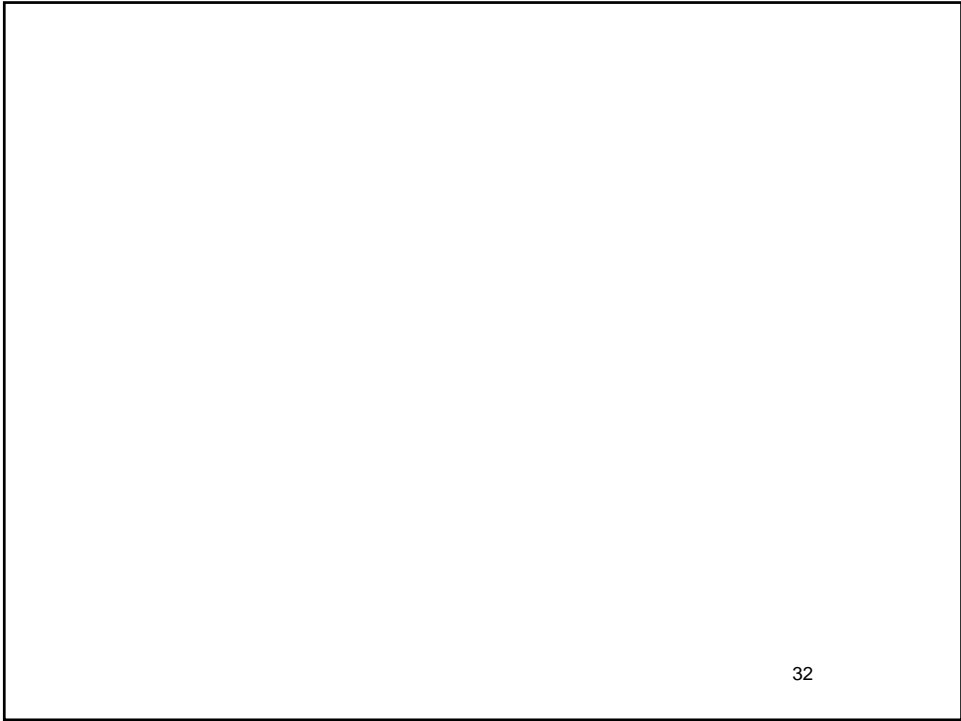
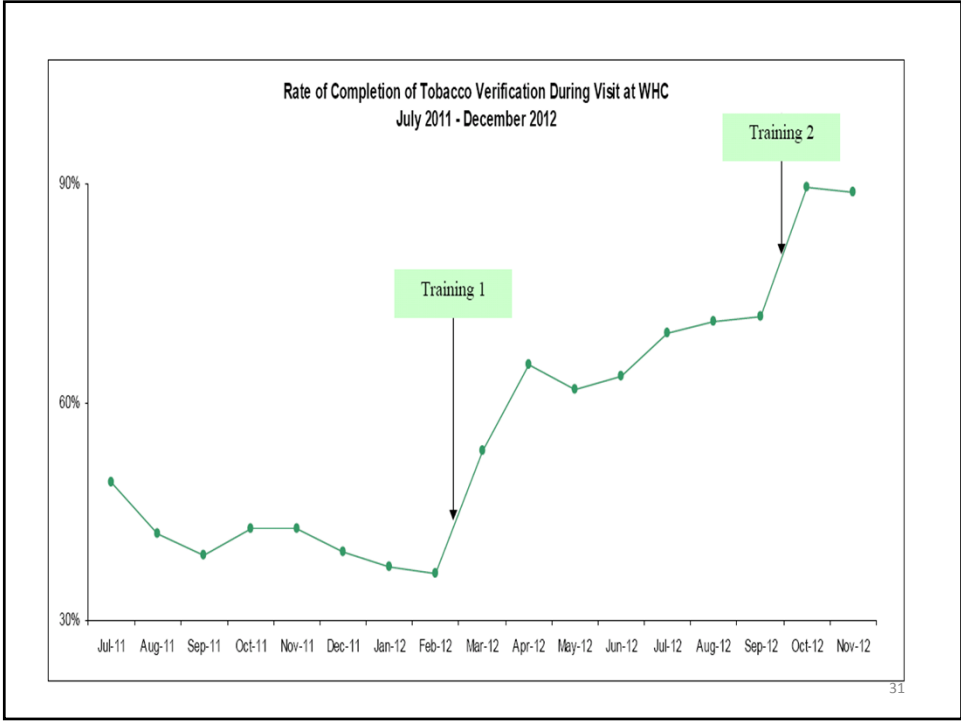
- Smoke Free Restaurants and Bars
- Tobacco-free Hospital Campus
- Non-Smoking Parks
- Smoke Free Public Housing

DELIVERY SYSTEM

- Tobacco as vital sign
- Assessment and Education Inpatient
- Mapping Smokers
- Work with Housing Authority
- Tobacco cessation programs



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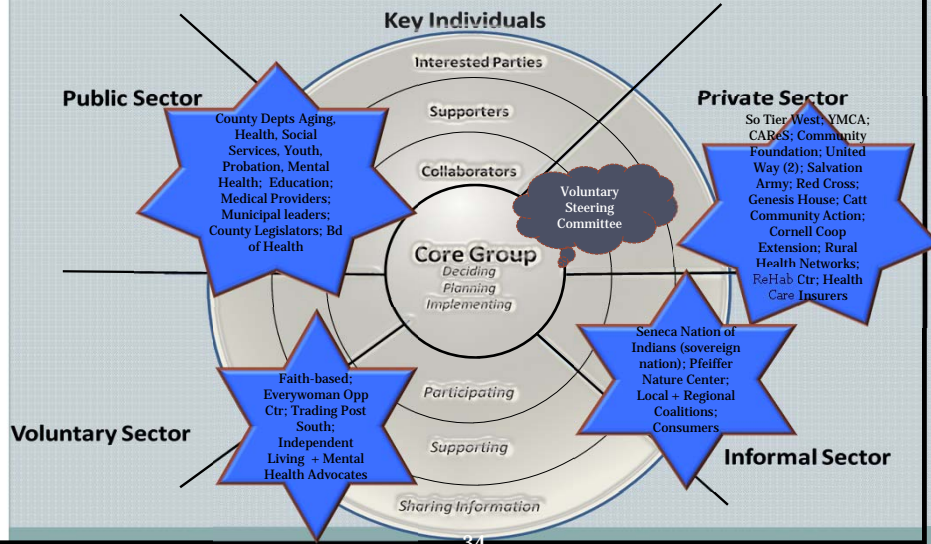




Cattaraugus County Collaboration: Healthy Livable Communities Consortium

Circles for Involvement

Healthy, Livable Communities Cattaraugus County



ASSESSING NEEDS & RESOURCES

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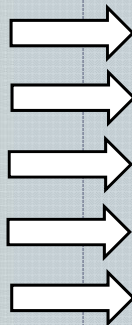
- What works
- What/ who is missing
- How to leverage “working” to address “missing”?
- Assets Inventory by categories



Priorities → Next Steps/ Successes



- Children in Poverty
- Built Environment
- Tobacco Use



- Ongoing Community Conversations
- > County Health Rankings
- Integration of Health Equity and Social Determinants
- *CHA/ CSP/ CHIP completion
- CTG funding receipt
- Additional funding
- Data Reserve creation
- Mentoring other counties

* Community Health Assmt/ Community Services Plan/ Community Health Improvement Plan per NYS DOH



Questions???



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Vision: Five years from now, with the support of the community and policy makers, Cattaraugus County will offer a higher quality of life through improved and equitable access to wellness* opportunities and healthier lifestyles within livable communities.

*defined as physical, mental, social, cultural, environmental, financial, and educational wellness