HMA’s Accountable Care Institute Presents

Public Health Departments in the Era of Delivery System Reform

A Presentation of Case Studies

Health Management Associates

November 19th, 2014

Presenters:

Jillian Jacobellis, PhD, Deputy Advisor, Colorado Department of Public Health and Environment

Patricia Harrison, Deputy County Executive for Human Services, Fairfax County

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Colorado Partnership Pilot

**Presenter:**
Jillian Jacobellis, PhD  
Deputy Policy Advisor  
Colorado Department of Public Health and Environment

**HMA Moderator:** Joan Henneberry, Managing Principal, Denver
Colorado Collaboration Between LPHAs and Medicaid

- Outreach and Enrollment
- Population Management
- Care Coordination
- Program-specific Integration
- Integration with Regional Care Collaborative Organizations (Medicaid ACOs)
- Competitors to Public Health
Outcomes of the Pilot

- LPHA and RCCO Memoranda of Understanding
- Use of Preventive Block Grant Dollars to develop partnerships and MOUs
- Focus on chronic disease management
  - RCCOs now at the table with public health
- LPHA developing skills to participate in health systems change – learning to speak the same language
- CDPHE requiring grantees to include systems change efforts in the chronic disease grants
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The Fairfax County Human Services System
Integration within the Local Health Safety Net

Presenter:
Patricia Harrison, Deputy County Executive for Human Services, Fairfax County

HMA Moderator: Pat Terrell, Managing Principal, Chicago
Fairfax County, Virginia

Approximate Driving Times

- Washington, D.C.: 15 minutes
- New York City: 4.5 hours
- Philadelphia, PA: 2.5 hours
- Chesapeake Bay: 1 hour
Context – Community Constraints

- No State Medicaid expansion
- Currently 50,000 estimated uninsured
- Limited eligibility and services funded in Virginia’s Medicaid program
- State health and human services structure forces local replication of silos
Fairfax County Health Services Delivery

PEOPLE SEEKING SERVICES
(Examples of how people seek care include: Coordinated Services Planning (CSP); discharged; emergency services referrals; County website/brochures/outreach; primary care; word of mouth)

DETERMINE THE "BEST FIT" OF PROGRAMS/SERVICES FOR AN INDIVIDUAL OR FAMILY
Screening | Assessment | Intake | Eligibility Determination

- Department of Family Services (DFS)
  DFS Intake
  Health Access Assistance Team (HAA)

- Fairfax-Falls Church Community Services Board (CSB)
  Front Door Services

- Health Department (HD)
  Adult Day Health Care (ADHC) Intake
  Family Assistance Worker (FAW)

- Department of Neighborhood and Community Services (DNCS)
  Coordinated Services Planning (CSP) Access to Human Services

REFERRALS
TO OTHER PROGRAMS IN THE COUNTY, COMMUNITY OR OTHER JURISDICTIONS
(e.g. NOVA Dental, Contract Services, Community Providers, Inova, Federally Qualified Health Center (FQHC), Alexandria, Loudoun, Prince William, etc.)

DIRECT OR CONTRACT PROGRAMS/SERVICES THAT MAY BE IMPACTED BY HEALTH CARE REFORM
- Medical Care Enrollment
  - Community Health Care Network (CHCN)
  - Family Access to Medical Insurance Security (FAMIS) [children's Health Insurance Program (CHIP)]
  - Medicaid
  - Medical Care for Children Partnership (MCCP)
  - Care Coordination

- Behavioral Health and Development Services
- Community Living
- Infant & Toddler Connection
- Primary Care Integration
- Targeted Case Management/Care Coordination
- Treatment

- Adult Day Health Care (ADHC)
- Communicable Disease Services
- Dental
- Maternal & Child Health Services
- Community Health Care Network (CHCN): Primary & Specialty Care

- Recreation & Wellness Programs
- Senior Center Services
- Therapeutic Recreation Services
- Transportation Services

- Homeless Health Care Services
- Long Term Care Services
- Prevention
- Systems of Care for At Risk Youth

May 26, 2011
Integration Continuum

Minimal Collaboration  
Work in Isolation

Mutual Awareness

County HS here now

Cooperation

Collaboration

Partnership

Human Services Redesign

Full Collaboration

Merged Integrated Practices
County Health Service Integration

- Accountability
- Financial Incentives
- Access
- Quality Improvement
- Coordination
- Information

Improved Clinical Outcomes
Recent Efforts

2010
ACA signed into law, County Health Care Reform Implementation Task Force formed to evaluate ACA impacts on County programs/services

2011
George Mason University Report: Recommendations to the Fairfax County Health Care Reform Implementation Task Force

2012
County Action Plan: actions outlined to address recommendations from George Mason report

2014
HMA hired to provide recommendations to support implementation of the County’s action plan
Organizing the Work

Goal: Develop a strategy that will ensure an effective, seamless and efficient delivery system for the Medicaid and uninsured populations residing in Fairfax County

Planning Group (County, Inova, FQHC)

Health Integration Steering Committee

Primary Care and Care Management Work Group

Data Analytics and Systems Information Management Work Group

Health Care Financing Work Group

Specialty Care Work Group

Oral Health Work Group
Primary Care and Care Management

Objectives:
• Create a model community health safety net provider network that assures consistent and quality health outcomes for participating patients.
• Create a coordinated care/case management services for individuals served by the health safety net in Fairfax County

Planning Group (County, Inova, FQHC)

Health Integration Steering Committee

Data Analytics and Systems Information Management Work Group

Health Care Financing Work Group

Specialty Care Work Group

Oral Health Work Group
Data Analytics and Systems Information

Objectives:
• Determine all health information reporting and analytics for human services and integration of planning and evaluation programs
• Establish an information management system that supports effective care management and transitions of care for patients within network
Health Care Financing

Objective:
• Research, review and make recommendations on proposed and new financial and revenue generating opportunities for the network

- Planning Group (County, Inova, FQHC)
- Health Integration Steering Committee
- Primary Care and Care Management Work Group
- Data Analytics and Systems Information Management Work Group
- Health Care Financing Work Group
- Specialty Care Work Group
- Oral Health Work Group
A Phased Approach

**Phase 1:** Planning Group (Local Hospital System (Inova), County, FQHC)

**Phase 2:** Broaden the Network of Providers

**Phase 3:** Full Functioning of the Network
New model opportunity

Co-location opportunity

- Test an integrated care coordination model
- Co-location of county funded behavioral health services, primary care services, hospital funded adult behavioral health treatment, dental care – adults and children
- Opportunities for coordination of pharmacy and lab services, financial assistance enrollment (SNAP, TANF, Medicaid) and prescription assistance programs
Measuring Success – what it looks like

- Better stewardship of current community investment in health care for uninsured, low income persons and those facing barriers to appropriate health care
  - Curb spending, improve quality, enhance health outcomes
- Continued partnerships with all community health providers – the county, local hospitals, Federally Qualified Health Centers, health care practitioners, universities, specialty care providers, free and low cost health care coalitions/providers, others
- TRIPLE AIM measures (improved health outcomes, improved value, and improved patient experiences)
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Illinois Department of Public Health
Moving Towards Healthier Communities

Presenter:
Leticia Reyes-Nash, MBA
Chief of Health Policy

HMA Moderator: Margaret Kirkegaard, MD, Principal, Chicago
Presentation Overview

- Illinois’ Health Transformation Efforts
- Building on Community Infrastructure
- Regional Health Improvement Collaborative
## Alliance Plan’s Key Innovations

### Triple Aim
1. Improve the health status of people and their communities
2. Improve the efficiency and effectiveness of clinical care
3. Reduce costs to make health care more affordable

### Objectives (Primary Drivers)

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<tbody>
<tr>
<td>1</td>
<td>Create comprehensive, integrated delivery systems, along with payment reforms to support them.</td>
<td>2</td>
<td>Ensure additional supports and services for people with specific needs.</td>
<td>3</td>
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Work Group – Public Health Integration

<table>
<thead>
<tr>
<th>Purpose</th>
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<td>Recommend strategies for enhancing the ability of the health care system to engage in population health management by leveraging public health resources, and encouraging linkages between public health and health care delivery systems.</td>
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<tr>
<th>Focus Areas</th>
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| • Regional Health Improvement Collaborative  
• Enhancing Population Health Management  
• Asset-Based Community Development  
• Coordination of Community Needs Assessments |

<table>
<thead>
<tr>
<th>Initial Tasks</th>
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</table>
| • Development of Regional Health Improvement Collaborative  
• Asset-Based Community Development |
Example of Community Infrastructure

We Choose Health

• Illinois programs supported by Federal CDC Community Transformation Grant
• 19 sub-awardees reaching nearly 60 counties to establish policy, system and environmental changes that address:
  – Healthy Eating and Active Living
  – Smoke-free Living
  – Healthy and Safe Built Environment
• Healthy Hearts
• NAP-SACC
• Baby Friendly Hospital Initiative
Overview of the Regional Health Improvement Collaborative

• **Regional Health Improvement Collaborative:** A local model that integrates “population health management” and community health using the 10 Essential Public Health Services.
RHICs will engage in processes to:

1) **Align** current planning efforts in the region

2) **Identify** target health priorities that address population and community health needs and ensure health equity

3) **Select** evidence-based clinical and community interventions to address health priorities, but also encourage innovative community interventions

4) **Align** community resources and assets

5) **Implement** interventions

6) **Evaluate** the interventions’ effectiveness
RHIC Core Principles

- Primary goals of improvement in the health of populations (including mental health) and achieving health equity, including improvement of population management, and community health

- Establishes community engagement through defining and addressing health needs

- **Aligned leadership** that recognizes that accountability for health outcomes is shared and bridges disciplines, programs, and jurisdictions to reduce fragmentation and foster continuity

- Identifies priorities, clarifies roles, and increases accountability

- Utilizes clinical and community evidence and practice-based approaches to improve health
RHIC Core Principles (cont.)

• Develops and supports appropriate incentives
• Manages changes effectively
• Provides technical assistance support to effectively implement interventions
• Plan for sustainability, key to the establishment of shared infrastructure to ensure enduring value and impact
• Establish ROI of community health interventions
• The sharing and collaborative use of high quality data (pooled from diverse public and private sources) in order to support robust clinical, epidemiologic and economic analytic approaches
Regional Collaborative
Beyond the Walls of the Facility

Geographic region
- Defined region
- e.g., Hospitals, Community Health Centers, Local Health Departments, Payers, Business, Employers, others

Service area
- e.g., Hospital catchment area

Attributable population
- e.g., Facility/network census
Example of a Regional Health Collaborative

Regional Health Collaborative

- 7 Public Health Departments
- 5 Community Health Clinics
- 13 Head Start Centers
- 3 Hospitals
- 3 Payers
- 10 Businesses
- 4 Employers
- 5 Social Service agencies
- Other stakeholders
# Sample Core Health Indicators Balanced Portfolio Examples

<table>
<thead>
<tr>
<th>Health Area</th>
<th>Clinical Approaches</th>
<th>Community Approaches</th>
<th>Clinical Measures</th>
<th>Community Measure</th>
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</thead>
<tbody>
<tr>
<td><strong>Smoking</strong></td>
<td>• Screenings</td>
<td>• Quitline</td>
<td>• Tobacco use assessment</td>
<td>• Smoking rates, adults (BRFSS)</td>
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<tr>
<td>(short-term)</td>
<td>• E-referral</td>
<td>• Smoke-free public places and multiunit housing</td>
<td>• Tobacco cessation intervention</td>
<td>• Smoking rates, adolescents (YRBS)</td>
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<td>• Medication</td>
<td>• Enforcement of sales</td>
<td>(Source: EHR)</td>
<td>• Quit rates (BRFSS)</td>
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<td>• Media &amp; education campaigns</td>
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<td>• Quitline utilization</td>
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<tr>
<td></td>
<td></td>
<td>• Support Health Collaborative</td>
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<td></td>
<td></td>
<td>• Multidisciplinary team-based care, including CHW</td>
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<tr>
<td><strong>Asthma</strong></td>
<td>• Guideline based diagnosis, care and treatment, including</td>
<td>• Home visits: Environmental interventions (dust mites, etc)</td>
<td>• Asthma assessment</td>
<td>• ED visits (syndromic surveillance)</td>
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<td>(intermediate-term)</td>
<td>• Action plans for all patients</td>
<td>• School nurse f/u</td>
<td>• Use of appropriate medications</td>
<td>ED visit and Hospitalizations and costs</td>
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<tr>
<td></td>
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<td></td>
<td>• Influenza vaccination rates</td>
<td>• Avoidable ED visits (HHDB/AHRQ algorithm)</td>
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<td></td>
<td>(Source: EHR)</td>
<td>Asthma attacks, asthma related missed school and activity limitation (BRFSS asthma call-back survey)</td>
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Investing in Population Health Improvement Costs for RHIC

State Support
- TA
- Project Manager/Liaison
- Coordinator
- Data Manager
- Epidemiologist
- Data enhancements*
- Grant Manager
- Training/Conferences

Regional Health Collaborative
- Local Manager
- Coalition Facilitator
- Lead Evaluator
- Convening/meeting expenses
- Consultant for governance structure
- EB-interventions
- Community Health Team(s)

ROI
- Consultant
  - e.g., UIC economist

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- Twitter: [www.twitter.com/IDPH](http://www.twitter.com/IDPH)
Questions?
Resources:
www.accountablecareinstitute.com

The Accountable Care Institute’s accompanying paper, *The Critical Role of Public Health Departments in Health Care Delivery System Reform*, can be found by clicking here, or by visiting http://www.healthmanagement.com/expertise/accountable-care-institute/

Have additional questions? Contact us:
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