CENTRAL DISTRICT HEALTH DEPARTMENT

CENTRAL HEALTH Collaborative
Ada, Boise, Elmore & Valley Counties

Statewide Healthcare Innovation Plan
Improved health, improved healthcare, and lower cost for all Idahoans

Meeting Agenda

Date: Tuesday, April 5th, 2016
Location: Riverside Hotel - Delamar Rm

Time: 1:00pm-2:30pm
Call In: 1-571-317-3122, #445-965-021 – Audio Pin 4

Next Meeting: Tuesday, May 3, 2016

Mission: To orgonize healthcare stokeholders by providing o structured forum for shoring voluoble knowledge, finding common solutions, ond identifying resources to improve health outcomes, improve quolity ond potient experience of core, ond to lower costs of core in the region.

Agenda Item	Outcome	Process	Person
Welcome and Introductions 1:00-1:10	Welcome new CHC Members	Round Robin	Russ Duke
Statewide RC Efforts 1:10-1:30	Improve understanding of other RC structures and direction	Review Handout	Gina
Population Health 1:30-1:40	Improve understanding of spectrum of PH	Definition provided by PH Workgroup	Gina
Cohort 1 Preliminary Priorities 1:40-2:20pm	Increase knowledge of Cohort 1 PCMH priorities Identify areas of CHC Support	Discussion of preliminary clinic needs -Primary Care and Hospital Communication -Behavioral Health Integration -Referral Tracking/Management	All
Wrap-Up 2:20-2:30	Identify CHC member assignments/tasks	Action Item Review	Gina

Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services.

SPECTRUM OF POPULATION HEALTH

Population Health Workgroup

VERSION 6.0 – FINAL – March 30, 2016

Introduction

Due to the continued discussions about the meaning of population health, the Population Health Workgroup has developed a functional definition for use by the Idaho Healthcare Coalition, Regional Health Collaboratives and SHIP partners to align conversations and provide for a more robust understanding of the spectrum of perspectives about population health.

Background

Depending on your perspective, whether you are part of a healthcare organization or office or are a public health practitioner, you could potentially define population health differently. The healthcare sector leans toward measuring the health of specific subpopulations they serve and for which they are accountable and paid (population health management). Public health leans toward a more broad view of populations such as groups of people living within a geographic area with specific, similar health conditions, issues or demographics, regardless of how they are counted among a patient population (total population health). Public health for example, may look at the number of low income people living in a local health district area with type 2 diabetes. We also know that your perspective and involvement in population health and population health management, impacts either very narrowly or broadly the health of the population, without necessarily considering the narrow or broad influence on the other.

Regardless of the vantage point for population health, the fundamental premise is changing behavior and moving toward better health outcomes for populations, narrowly or broadly defined. The relationship between the individual, clinical, provider-level responses to the broader, community-wide response is important and the bridge between the local, narrow impact and broad impact and finding common ground is important. The following language and schematic forms the basis of a dialog between constituents that influence health at the local level through the constituents that influence health at the broad level and the spectrum of influence on population health in between.

To organize this conversation into areas of focus, the Centers for Disease Control and Prevention (CDC) has developed the following concept (modified) to help describe patient health, population health and prevention in terms of buckets.

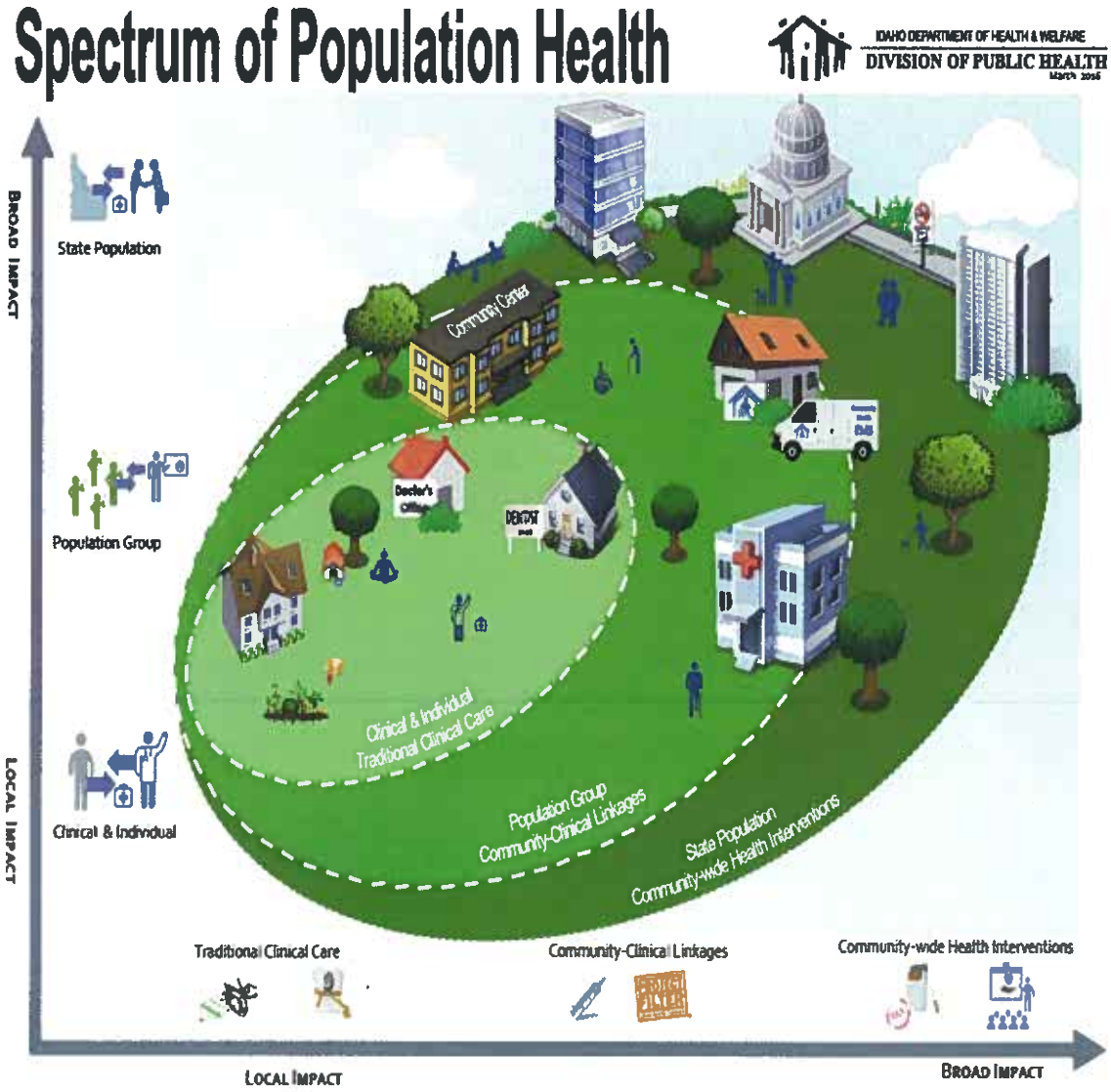
- Bucket One - what we commonly understand to occur in the clinician setting with a single patient as a one-on-one interaction. When we think about factors that affect health, clinical interventions have a narrower impact.
- Bucket Two – the intersection between the individual clinical patient care with an extension into the community for support to achieve a larger health impact. This is sometimes called clinical-community linkage.
- Bucket Three - broader approach that has a larger impact on health because it helps change the environmental context to help make the individuals' choice to be healthy the easy choice. With a community wide focus and community construct it is more likely that socioeconomic factors and social determinants of health can be addressed.

Further elaborating on the three buckets and their intersection and fluidity, a healthcare provider operating in a small rural clinic might not consider how their practice for managing their patient population who smokes might influence the smoking behaviors of the surrounding community. Conversely, the policies, practices and culture in their community related to smoking might influence the behavior of their patients who smoke. The provider might simply tell an individual patient to quit smoking without providing any resources. Or they might have a referral mechanism to cessation resources – either in person, online and/or telephonic – that are free. The cultural norm of the community, however, might be very supportive of smokers through limited clean indoor air policies, easy access to tobacco products and an "everyone is doing it" mentality. Or, the cultural norm of the community might be the opposite and support people in quitting, limit where smoking is allowed, having an active public health district and city council on which the physician can participate to influence the cultural norm through policy change so the healthy choice for their patient population of smokers is the easy choice.

Bucket #1: Traditional Clinical Approaches	Bucket #2: Innovative Clinical Care Patient-Centered	Bucket #3: Community Wide Health
Focused on an individual; patient construct		Focused on broad population; community construct
Typical clinical services done in a one on one patient interaction	Linkages that support patients in the community and that provide services outside the clinical setting	Broader, mostly policy-focused aimed at supporting the broad community and the overall health of the population in the community
DIABETES Example		
Screening for pre-diabetes, diagnosis, treatment, medication, clinical guidance, A1C monitoring, eye exam, foot exam	Linkages and referrals to Diabetes Self-Management Education (DSME) classes, Registered Dietitian-Nutritionist referral, dental referral, CHW or CHEMS support for blood sugar monitoring and medication management	Community policy and practice to provide healthier communities; easier access to physical activity and proper nutrition; policies to reduce tobacco usage and trans fats in foods
OBESITY Example		
Diagnosis, medication, weight and height to calculate body mass index and monitor, blood pressure, cholesterol screening, physician/patient counseling	Linkages and referrals to Diabetes Self-Management Education (DSME) classes, Registered Dietician-Nutritionist referral, dental referral and cavity risk assessment, CHW or CHEMS support for blood sugar monitoring and medication management	Community policy and practice to provide healthier communities; easier access to physical activity and proper nutrition; mandatory changes in school vending and physical education courses
TOBACCO Example		
Screening patients for smoking, ensuring smoking cessation referral, physician/patient counseling	Linkages that support patients in community or medical-health neighborhood, linking patient to cessation class or quit line	Practices and policies that support lower smoking rates statewide (clean indoor air policies, tobacco tax, etc.)

The Spectrum of Population Health

The graphic below depicts the spectrum of population health from the individual, provider and local impact to the broader impact of the community at large including policies, community supports, etc. Social determinants of health influence all levels of the spectrum.



Conclusion

The purpose of the Population Health Workgroup, as an arm of the Idaho Healthcare Coalition, is to support the Regional Health Collaboratives in the development of tools and messages that support their work to help transform primary care within their region and improve the health outcomes of the patients served in the clinics and the people living within their communities.

This is done through educating the clinics and medical-health neighborhood about what the spectrum of population health entails and how each level or point in the spectrum (bucket) is interrelated with the next. Collectively, population health is shared accountability for improving health outcomes for all Idahoans by bridging the gap of community determinants of health and the emphasis on healthier lifestyles through interventions, policies and data, to include preventative care, physical activity, nutrition and behavioral risk reduction as they relate to the Triple Aim.

Adopted by the Idaho Healthcare Coalition 3/9/16

Region: Central

COMMUNITY HEALTH ASSESSMENT REVIEW	
Population/ Community Served	These results are a summation of community health assessments completed in the Central District Public Health region.
Priority health issues identified in assessments	Alcohol use and abuse, binge drinking, substance abuse, illicit drug use, vehicle crashes, accidents, diabetes, mental health, safe-sex education, tobacco use, tobacco prevention, weight management, obesity, wellness /prevention, high cholesterol, skin cancer, suicide, physical inactivity, hypertension, nutrition, low fruit and veg consumption, asthma, skin cancer, high teen birth rate, sexually transimitted infections, senior services, high percent of the population reporting fair or poor general health, health care access including mental health, lack of health insurance coverage, lack of medical home, , lack of healthy safe and nurturing relationships, high cost of oral health, lack of access to health food, lack of prenatal care.
Positive population measures. What's working?	Availability of outdoor recreation, access to healthy foods, good air quality, low levels of violence and abuse, veterans services, prenatal care programs, community exercise programs, Years of Potential Life Lost lower than national average, low level of low birth weight, SNAP, CASH public assistance, P-16 Project, suicide prevention efforts, Treasure Valley Education Partnership, Bank On Treasure Valley, 211, emergency food assistance, clinics with sliding fee scales, emergency shelter, legal assistance, transportation assistance, crisis child care, elder care assistance, long term comprehensive care for people with disabilities.
Populations, sub groups or geographic areas prioritized	Young children, ages 18-64, income < $35,000, no high school diploma, adults, low income, individuals without a high school diploma, children in poverty.
Factors identified that contribute to higher health risks and poorer health outcomes	**Lack of:** education support, prenatal care, physical activity, public transportation, providers accepting public insurance, screening programs, social support. **High percentage/rate of:** hypertension, high cholesterol, suicide, children in poverty, preventable hospital stays,uninsured adults, poor mental health days, people living in poverty, unbanked and under banked families,mammography screening, high level of access to fast food. Decrease in median household income (with inflation adjustment lower than it was in 1980).
Gaps in services, community resources, funding etc.	Lack of access to: Mental health providers, affordable health insurance, job training services, nutrition education, affordable healthcare, behavioral health services, primary care provider, children and family services, healthy foods, health care services, mental health, health insurance coverage, affordable dental services, medical home, transportation to and from appointments, chronic disease management, Medicaid dentists, immunization education and low cost options, funding for transportation to Boise for specialty services, prenatal care 1st trimester, wellness and prevention programs, mammography screening. Lack of: job training services, safe sex programs, Community hubs, In-Home Service, Central One- Stop Shop, recreational facilities, ability to advertise and increase community participation in education and physical activity programs, communication of community resources, public transportation, basic knowledge (i.e. available resources, education levels), nutrition education, substance abuse services and programs, tobacco prevention programs, publicizing current opportunities, creative wellness programs for young ages, consulting access for safety-net providers.

Region: Central

Assets and resources identified to address health issues	Adequate senior services, high level of flu and pneumonia immunizations, Boise State University, branch location for other universities, outdoor activities, colleges Northwest Nazarene University, College of Western Idaho, Hispanic Cultural Center, education and exercise opportunities but people are not aware. YMCA, Boise VA Medical Center, safety-net clinics, sliding fee scale providers.
Data used in the assessment	County Health Rankings, United Way, Saint Al's, expert interviews, University of Wisconsin Population Health Institute, Youth Risk Behavior Surveillance, affected population surveys, Idaho Economics, the Robert Wood Johnson Foundation, Boise Independent School District #1 Meridian Joint School District #2 Kuna Joint School District #3 Independent LEA #454 – Rolling Hills Public Charter School (K-8) Independent LEA #455 – Compass Public Charter School Independent LEA #456 – Falcon Ridge Public Charter School (K-8) Independent LEA #459 – DaVinci Charter School Independent LEA #475 – Sage International School of Boise Nampa School District#131 Caldwell School District#132 Wilder School District#133 Middleton School District#134 Notus School District#135 Melba Joint School District#136 Parma School District#137 Vallivue School District#139 Independent LEA #451 – Victory Charter School Independent LEA #458 – Liberty Charter School Independent LEA #463 – Vision Charter School Independent LEA #478 – Legacy Charter School Independent LEA #481 – Heritage Community Charter School, County Health Rankings United Way, Saint Al's, expert interviews, University of Wisconsin Population Health Institute, Youth Risk Behavior Surveillance, Affected population surveys, Idaho Economics, exercise facilities

SHIP Goal 3:

Establish seven Regional Collaboratives to support the integration of each PCMH with the broader medical neighborhood.

District	Executive Leadership (chair, co-chair, PHD Director	Membership Composition	Board Status	Anticipated Direction	Concerns and Questions
D1 Panhandle HC	Dr. Scott Dunn Dr. Mike Dixon Lora Whalen	Family Health Center of Sandpoint, Family Medicine, Panhandle Health District, IDHW, Heritage Health, Kootenai Health, Pediatric Dental Care of North Idaho, Shoshone County EMS	• 12 members • Two full membership meetings • RC meetings bi-monthly, future meetings scheduled	• Opioid prescribing • Fluoride varnish • RC kickoff meeting with first year cohort is planned for the end of March	
D2 North Central HC	Dr. Glenn Jefferson Dr. Kelly McGrath Carol Moehrle	Valley Medical Center, Orofino Health, North Central District Health, Valley Medical Center, St. Mary's Clinic, Community Health Association of Spokane	• 20 members • Kick off meeting was a great success with 100% attendance of invitees • Executive Leadership is meeting monthly and the RC is alternating conference calls and face-to-face meetings	• No specific projects identified yet • Developing topics for outside speakers to present to the RC in March (CHEMS, CHW, IHDE)	• Questions regarding the future of payments to the pilot clinics • Questions on data collection and analytics
D3 Southwest HC	Dr. Andrew Baron Dr. Sam Summers Nikole Zogg	Terry Reilly Health Services, St. Alphonsus Medical Center, Adams County Health Center, Treasure Valley Hospice, Idaho Quality of Life Coalition, National Alliance on Mental Illness (NAMI), Human Supports of Idaho (HSI), Emmett Family Medicine, Nampa Smiles Dentistry, St. Alphonsus Medical Group, St. Luke's Health System, West Valley Medical Center, Two Rivers Medical Clinic	• 17 members • 2 meetings in-person with conference line available • Future meetings scheduled, every first Tuesday	• Form topic workgroups (pilot elderly and latino/latina focus workgroups and introduce in 3-6 months) • Advocate to IHC re: need for support for telehealth payment and BH data exchange • Form PCMH workgroups	• Payment for telehealth • Support for enhancing BH information exchange • Possibility of future referral management capacity in the IHDE
D4 Central HC	Dr. Kevin Rich Dr. David Peterman Russ Duke	Family Medicine Health Center, Primary Health Medical Group, Central District Health Department, St. Luke's McCall, Wellness Impact Nutrition, LLC., Region IV Behavioral Health, Blue Cross of Idaho, Valley Regional Transit, Glenns Ferry Health Center, Terry	• 18 members • One representative from each county • 2 meetings in-person with conference line available • Future meetings scheduled	• Education on SHIP and RC's roles and responsibilities • Refining medical health neighborhood concept for Region 4 • Understanding individual member roles in the	• Concern re: conflict of interest for members whose clinics are part of the cohort – this concern has been addressed and resolved

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District	Executive Leadership (chair, co-chair, PHD Director	Membership Composition	Board Status	Anticipated Direction	Concerns and Questions
		Reilly Health Services, FMRI, Benchmark Family Dentistry, St. Luke's - West Region Primary Care, Garden Valley Family Medicine, St. Alphonsus Medical Group, St Luke's Health Partners		community and how we can harness social and intellectual capital	
D5 South Central HC	Dr. Keith Davis Dr. Steven Kohtz Rene LeBlanc	Shoshone Family Medical Center, St. Luke's Magic Valley, South Central Public Health, Family Health Services, The Walker Center, Shoshone Family Medical Center, Minidoka Medical Center	• 8 members • RC is meeting monthly • Future meetings scheduled through June, 2016.	• No specific projects have been identified yet. • Executive Leadership is pursuing additional members • Planning to meet with District 5 CHEMS representatives to discuss programs	• Questions regarding data collection and analytics
D6 Southeastern HC	Dr. Bill Woodhouse Dr. Mark Horrocks Maggie Mann	Idaho State University Family Medicine, Health West, Southeastern Idaho Public Health, Not-tsoo Gah-nee Indian Health Center, Pocatello Children's Clinic, Portneuf Primary Care and Behavioral Health, Blackfoot Fire Department , Excel Weight Loss Solutions Healthy Connections Following Institutions were identified as potential members: Area Agency on Aging, Head Start, School District 25, Shoshone Bannock Tribes, Pocatello Suicide Prevention Action Network, Fort Hall, Portneuf's Diabetes Education Clinic	• 15 members (aprox.) • Three-tiered approach: Executive Leadership, Clinic Committee, Medical Health Neighborhood Committee • 4 meetings of the Executive Leadership • Future meetings scheduled	• The Clinic Committee will be comprised of the Executive Leadership members and staff members from cohort 1 clinics • Co-Chair Dr. Mark Horrocks will lead this tier	
D7 Eastern HC	Dr. Boyd Southwick Dr. George Groberg Geri Rackow	Complete Family Care, Driggs & Victor Health Clinics, Family First Medical, Madison Memorial Rexburg Medical Clinic, Rocky Mountain Diabetes, Tueller Counseling, Upper Valley Community Health	• 25 members (multiple representatives from individual institutions) • First meeting successful • Clinics from Cohort 1 were chosen to be part of initial RC • Recurring monthly meetings scheduled	• No specific projects have been identified yet • Developing referral resources and pathways	• Idaho Health Data Exchange – no clinics or hospital connected to IHDE from this side of the State yet. It is something that the RC knows and wants to change in this area

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