

Prevention and Health System Change: New Opportunities to Advance Public Health

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February 13, 2014



A national perspective on the California Wellness Plan

- Healthy Communities
- Optimal Health Systems Linked with Community Prevention
- Accessible and Usable Health Information
- Prevention Sustainability and Capacity
 - How health reform, health system change, health information technology, and a growing recognition of the social determinants support this roadmap

Bottom line

- Achieving good health requires partnerships
- The role of public health is changing in a dynamic way:
 - Who leads, who pays, what technology we use, who implements are all shifting
- Public health as the chief strategist for communities
 - Federal government inconsistent partner

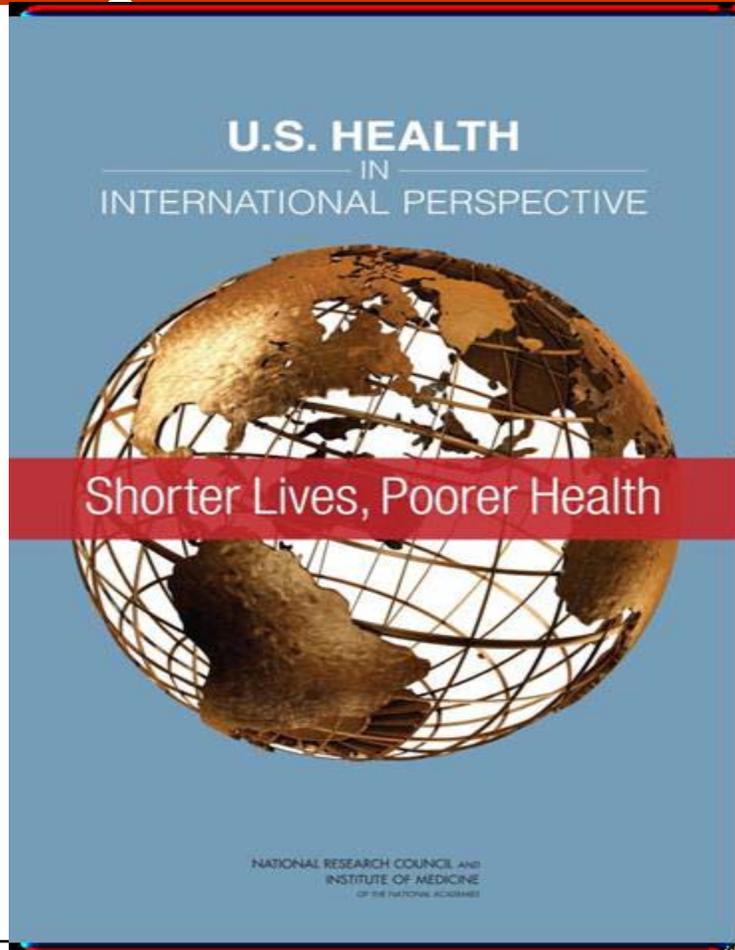
It is all about the Triple Aim

- “Better care for patients, better health for our communities, and lower costs” -- CMS
 - Quadruple Aim: Add equity
- Achieving the Triple Aim requires new partnerships
 - Community-clinical; public health-health care; health-non health (social determinants)
- Nature of partnerships will vary based on capacity of all parties
- Partnerships required regardless of your definition of population health

Drivers of change

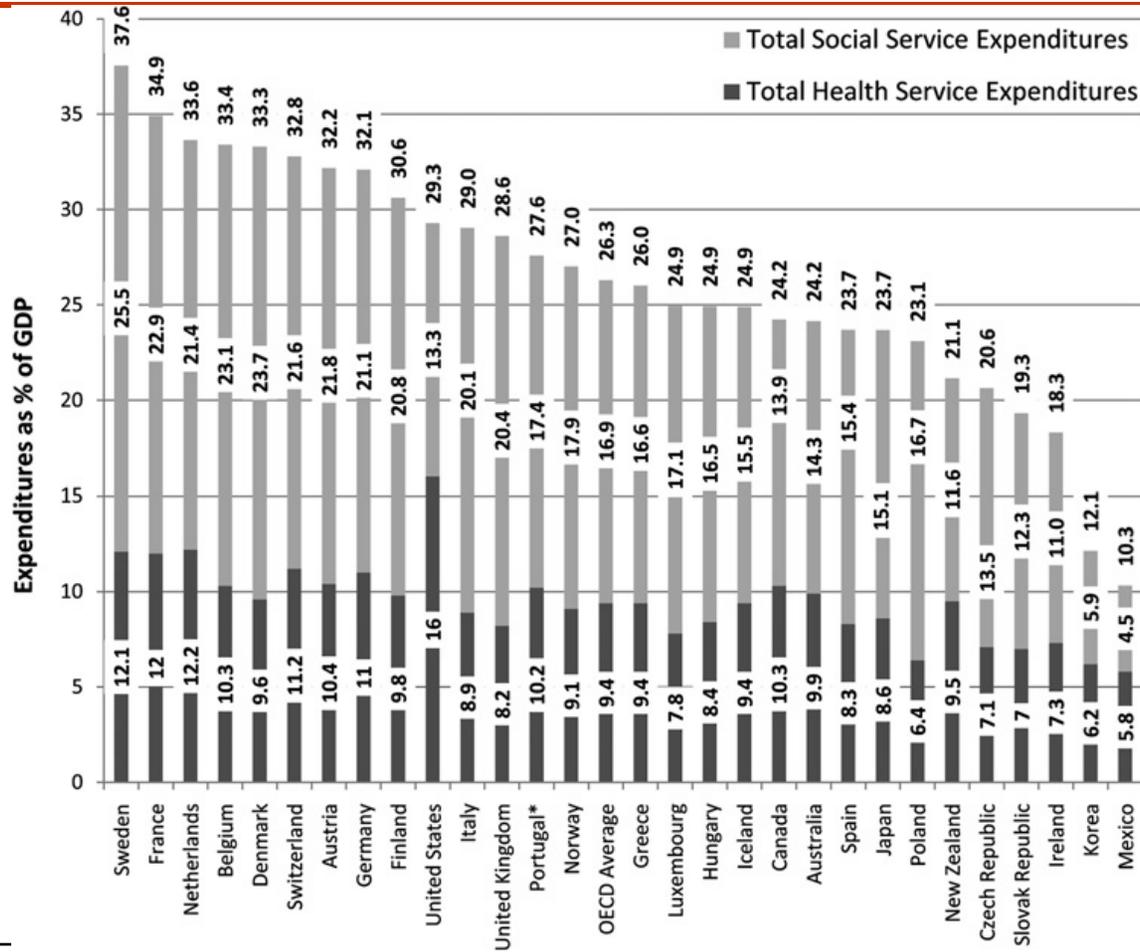
- The health system is changing only in part because of the ACA
 - Focus on outcomes
 - Focus on cost containment
- Expectation of return on investment from *both* clinical and public health interventions
 - Not whether, but timeframe and extent
 - Who shares the savings and how are they used?

Status quo is not an option



- ❑ NCD mortality rate (16/17)
- ❑ CD mortality rate (14/17)
- ❑ Last in life expectancy
- ❑ Youth least likely to survive to 50
- ❑ Highest level of income inequality; poverty; child poverty
- ❑ Third lowest rate of pre-school education and secondary school completion

Bradley, et al. BMJ Qual Saf



We know how to fix this

- Addressing social determinants of health requires new partnerships
 - Moving beyond health in all policies
 - Examples abound of new partners across housing, education, community development
- National Prevention Council/National Prevention Strategy as a federal base

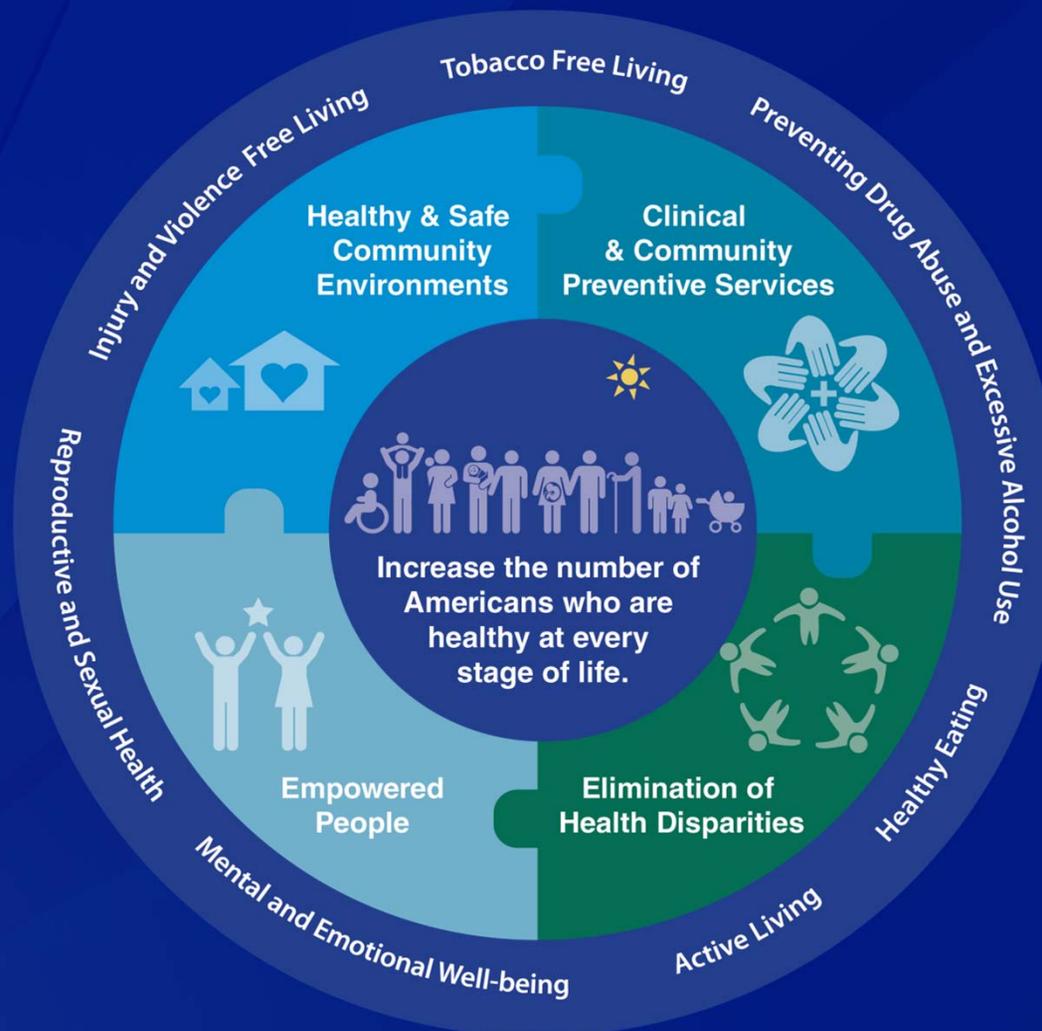
It seems overwhelming... what matters is that we start

- Different communities at different starting points
- Different motivators – from traditional disease management to social determinants or community economic competitiveness
- All paths lead to new partnerships and collaborations and to broader impact than imagined

ACA envisions new partnerships -- National Prevention Council

Bureau of Indian Affairs	Department of Labor
Corporation for National and Community Service	Department of Transportation
Department of Agriculture	Department of Veterans Affairs
Department of Defense	Environmental Protection Agency
Department of Education	Federal Trade Commission
Department of Health and Human Services	Office of Management and Budget
Department of Homeland Security	Office of National Drug Control Policy
Department of Housing and Urban Development	White House Domestic Policy Council
Department of Justice	Department of the Interior
Office of Personnel Management	General Services Administration

National Prevention Strategy: Goal - Strategic Directions - Priorities



Levers in the ACA

- Accountable Care Organizations (and variants)
- CMMI Innovation Awards (population health models that address social determinants)
- SIM grants and global budgets
- Medicaid essential health benefits rule
- Community benefit requirements for non-profit hospitals
- Prevention and Public Health Fund

Example: Accountable Care Community in Akron, Ohio

- Formed to improve health and create jobs
- Serves entire community – coalition of 70+ organizations, including all major providers and plans
- Shared savings model – started with local foundation support; also CTG funding
- “Precompetitive” collaboration
 - California State Innovation Model

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

ACC Return on Investment

- Interventions:
 - Traditional disease management
 - Community change: “public lands for public health,” faith-based community partnerships; complete streets; “roads on a diet”
- At one year: 25% savings on diabetes (\$3,185/per person/per year)
 - Reductions in ER use, A1C and LDL, no amputations, improved self-related health

Example: Hennepin Health – A Social ACO

- Medicaid expansion, full risk by county
- Very high need population: continuum of care, behavioral health and social services
 - EHR and social services linkages
- \$1 million reinvested in first year from captured savings
 - Dental clinic, sobering center, interim housing, behavioral health counselors, employment counselors

Example: Health Systems Learning Group (Stakeholder Health)

- 40 nonprofit health systems--“invest in community health with a true integrative strategy”
- Quadruple aim: add reduced health disparities
- Integrated care for socially complex *people* in socially complex *neighborhoods*: Social ROI
 - Individuals and place; redesign care; community based prevention; partner on social determinants
 - Financial metrics and accountability

Tapping resources beyond health

- Community Reinvestment Act
- Purpose Built Communities
- Innovative financing models
 - Social impact bonds
 - Solving the “wrong pocket” issue

What does this have to do with chronic disease prevention?

- Each model in different ways:
 - Recognizes the relationship between what happens inside and outside the doctor's office
 - Broad-based partnerships within and beyond the health system
 - ROI is a goal
 - Primary vs. secondary prevention and ROI
 - Seeking sustainable funding

How does public health change?

- New leadership role
- Convener/integrator/catalyst
- New skills within health departments
- Assurance vs. delivery of services/programs

Public Health as Chief Health Strategist for Communities

- Showing the way through:
 - Prevention: effective, common sense way to improve health, reduce health care costs and increase productivity.
 - Diagnose biggest, most expensive problems in a specific community; develop most effective, cost-efficient strategies and public and private partnerships to improve health and reduce disease rates.
 - Convene or catalyze the new partnerships

How does public health change? (2)

- Every American served by foundational capabilities
 - Information systems and resources;
 - Health planning;
 - Partnership development and community mobilization;
 - Policy development analysis and decision support;
 - Communication; and
 - Public health research, evaluation and quality improvement.
- Demonstrated through the accreditation process

How does public health change? (3)

- True modernization of core systems
 - Surveillance and epidemiology as case study
- Streamlined categorical programs
 - Break down silos
 - Emphasize approaches that have cross cutting impact – within health
- Focus investment in partnerships
 - CTGs model for leadership and sharing resources

How does public health change? (4)

- Pay for services only when insurance cannot (means new models or integration with health system for services -- such as becoming Federally Qualified Health Centers)
- Doing what public health must do, not necessarily what it has always done
- Public health becomes the “chief strategist” for a community

How does the workforce change?

- Foundational capabilities
- Policy/systems/community change
 - “Health in all policies”
 - Coalition building
- Health IT
 - Integrated with EHRs
 - Technical and analytic capacity
- Integrator role
 - Individuals (CHWs)
 - Systems – within health and outside health (convening/leadership)
- Direct services vs. quality assurance
- Health promotion beyond government public health

How do federal agencies change?

- Within agencies – streamlining and efficiencies
- Consolidate federal surveillance and survey systems
- Across agencies – recognition of need for more integration
 - Health care and behavioral health parity
 - Closer linkage between screening and treatment

Implementation challenges

- ❑ A system that is changing as we try to partner with it
- ❑ Constituency building just beginning beyond public health
- ❑ Scary fiscal times can result in circling the wagons
- ❑ Devil is in the details, to say the least

Omnibus update

- Protection of Prevention & Public Health Fund (nearly \$1 billion)
- Termination of Community Transformation Grants
- Re-expansion of REACH (\$50 million)
- New Community Prevention Grants
- \$146 million for coordinated chronic disease
- Doubling of Preventive Services Block Grant (+\$80 million)
 - Community prevention still embraced; lessons to be applied from discontinued programs

Can we do it?

- Four years ago we considered the following to be dreams or too much of a stretch
 - Accreditation
 - Health reform
 - National Prevention Council, Strategy
 - Mandatory funding for public health
 - Major new prevention programming
- Status quo is not an option

California's position of strength

- ❑ California Wellness Plan
- ❑ Let's Get Healthy California – metrics incentivize partnerships
- ❑ Health in All Policies experience
- ❑ Local health departments strengthened by CTG experience
- ❑ California State Innovation Model opens many doors

Questions?

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Thank you.