hospitals in pursuit of excellence™
Accelerating Performance Improvement

HPOE *Live*!
2015 Webinar Series

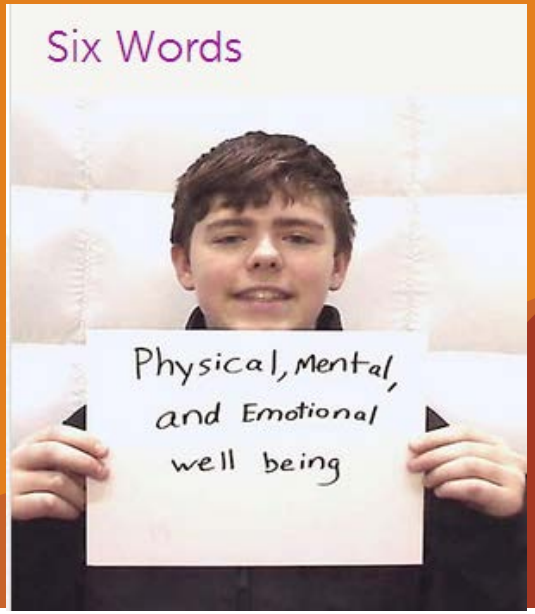
The presentation will begin shortly.

Building a Culture of Health : The Future Begins Now

Paul Kuehnert, DNP, RN

Director

Bridging Health & Healthcare Portfolio



Robert Wood Johnson Foundation

Culture of Health

Vision:

We, as a nation, will strive together to create a culture of health enabling all in our diverse society to lead healthy lives, now and for generations to come.

Being healthy and staying healthy is an **esteemed social value**

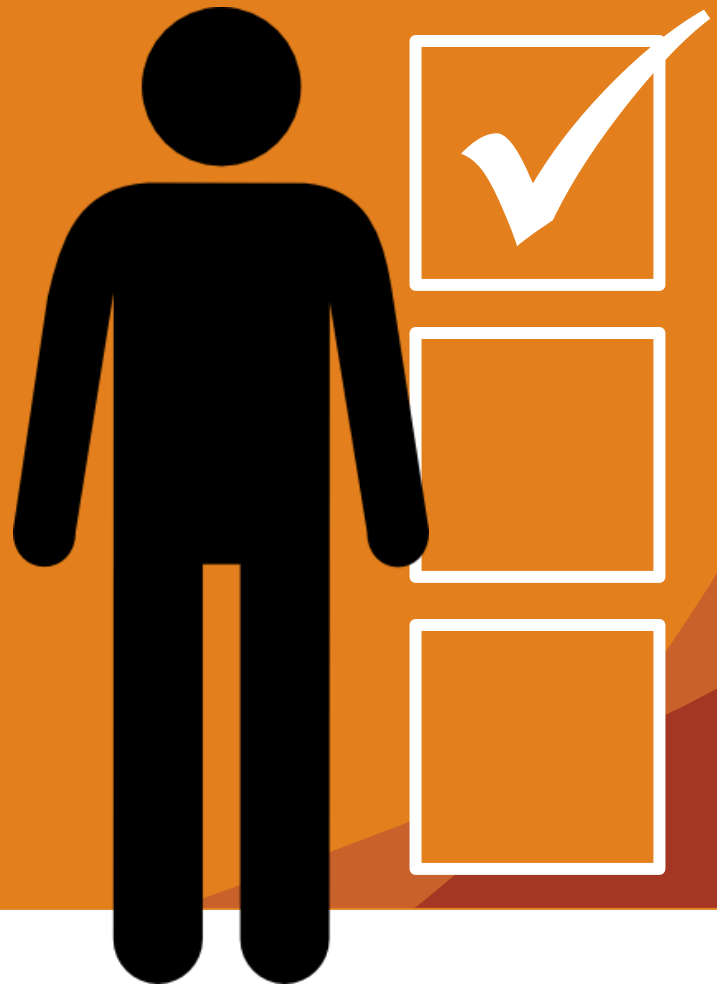



health of the population guides public and private decision-making

geography and demographics
do not serve as barriers to good health.

individuals, businesses and governments **work collectively** to foster healthy communities and lifestyles.

we are all supported to make **proactive choices** that will improve our health.



Areas of Action

1) Building a Shared Value of Health

2) Fostering Cross-collaboration to Improve Well-being

3) Creating Healthier, More Equitable Community Environments

4) Transforming Health and Health Care Systems

“The best way to predict the future is to create it.” -Peter Drucker

HEALTHY DIABETES PILOT

Memorial Hospital of South Bend®

BEACON HEALTH SYSTEM® Care Partner

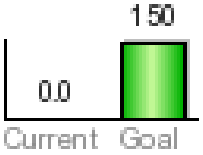
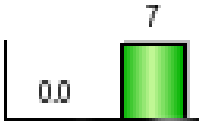
Margo DeMont, PhD
Community Health Enhancement
mdemont@beaconhealthsystem.org

COMMUNITY HEALTH NEEDS ASSESSMENT

PRIORITY NEEDS IN ST JOSEPH COUNTY

 Diabetes Death Rate NEW	 Diabetic Screening	 Diabetes: Medicare	 Adults Overweight or Obese	 Low-Income Preschool Obesity

DIABETES INDICATORS

Healthy Diabetics High Risk Graduate A1C Levels at Intake and Graduation	County: St. Joseph	
Number of enrolled participants in the Michiana Family YMCA's Diabetes Prevention Program	County: St. Joseph	
Minutes of increased exercise achieved by YMCA-DPP participants	County: St. Joseph	
Percentage of weight loss achieved by YMCA-DPP participants	County: St. Joseph	
Diabetes: Medicare Population	County: St. Joseph	
Age-Adjusted Death Rate due to Diabetes	County: St. Joseph	

YMCA DIABETES PREVENTION PROGRAM

National Program, Evidenced-based, Focused on Pre-diabetics

Goals:

Individuals at high risk for diabetes

- adopt and maintain healthy lifestyles
- reduce their chances of developing Type II Diabetes

www.qualityoflife.org/memorialcms/index.cfm/che/chronic-conditions/

CHRONIC PHYSICAL DISEASE MANAGEMENT

Healthy Diabetics

Memorial Community Health houses an internal diabetes case management program to educate and support self-management.

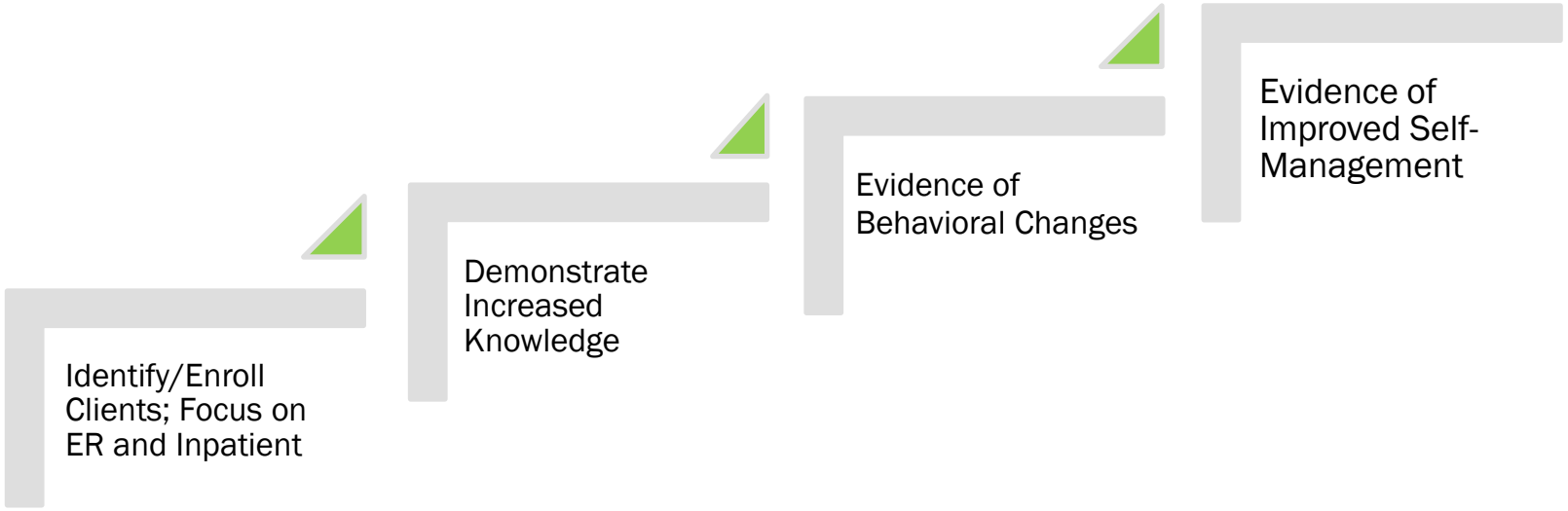
Goals:

- Increase quality of life for participants in Case Management
- Improve client health status
- Increase number of clients in Medical Homes
- Reduce financial impact/cost by avoiding use of the Emergency Room

www.qualityoflife.org/memorialcms/index.cfm/che/chronic-conditions/healthy-diabetics

MEMORIAL'S HEALTHY DIABETICS PILOT (2013)

AIM: To offer culturally and linguistically appropriate diabetes intervention to vulnerable under-insured and uninsured members of our community to enable clients to self-manage their disease.



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DIABETES PILOT - NUMBER OF ACTIVE CLIENTS REFERRAL SOURCE

	Clients	ER	Hospital	Memorial Medical Groups	Self-referral	Other Referral
TOTAL	368	51	42	131	2	142

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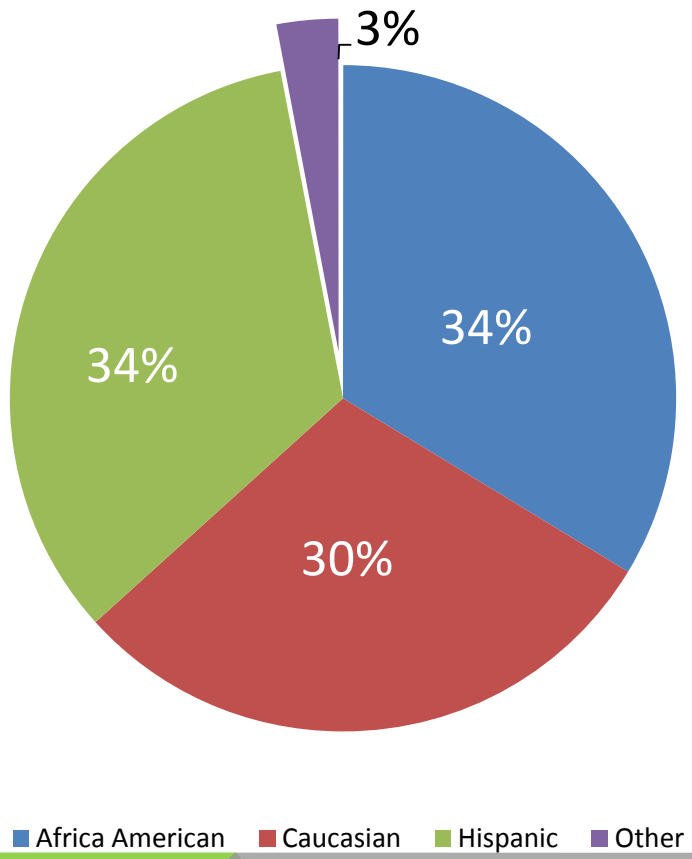
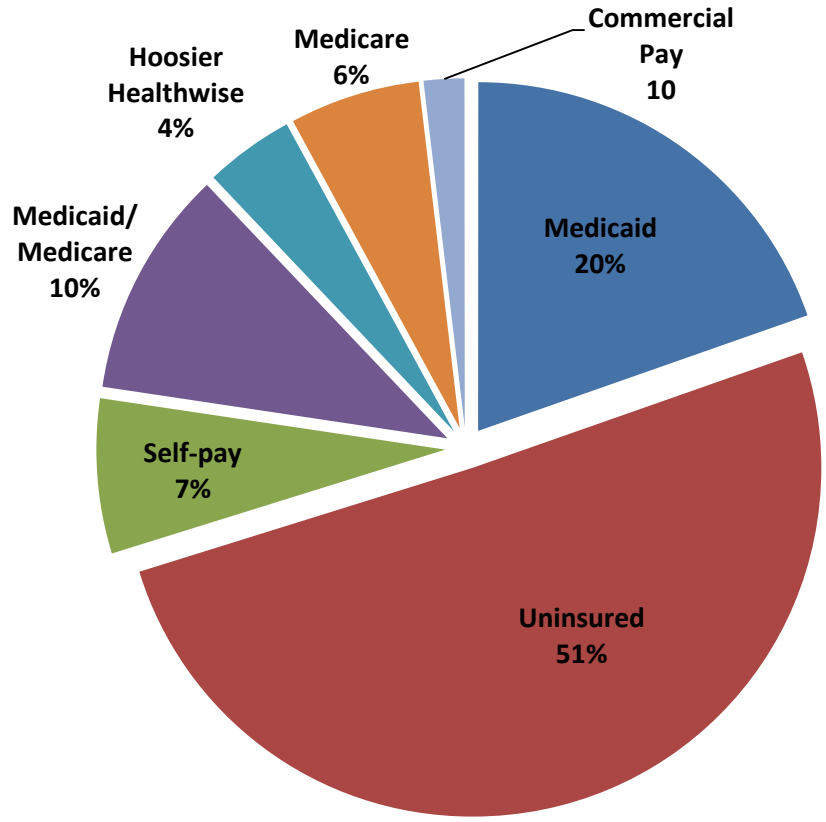
RACE / ETHNICITY



PAYOR MIX



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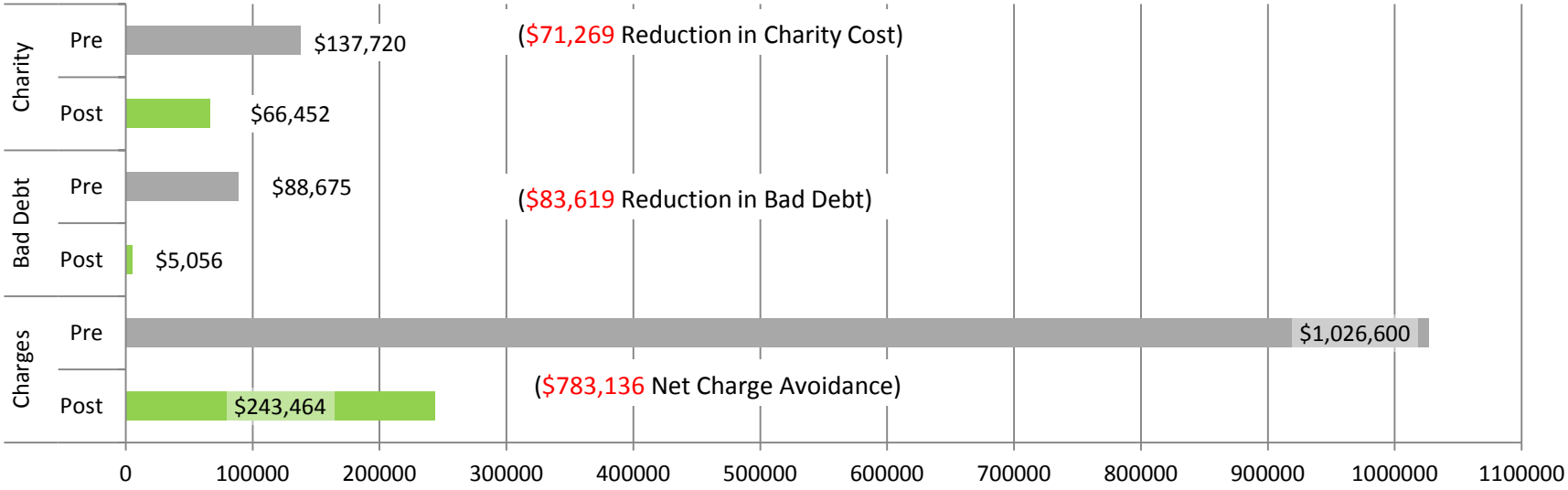
FINANCIAL IMPACT
(Medicaid, uninsured and self-pay)
Goal = $500,000



GOAL: DECREASED ER USAGE > 25%

	TOTAL # PEOPLE	TOTAL # VISITS	TOTAL CHARGES
Pre-Program ER Use (12 month history per person)	74	119	$1,373,447
Post-Program ER Use 9/1/12-12/31/13	37	67	$295,460
TOTAL Net Avoidance	-50%	-44%	-$1,077,987

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BEACON HEALTH SYSTEM® Care Partner

GOAL: SELF-MANAGEMENT IMPROVED A1C LEVELS

A1C Tests	Active Clients	Low Risk 5.0-6.9	Medium Risk 7.0-8.9	High Risk 9.0+
Entry Level	n=366	n=96 (26.2%)	n=123 (33.6%)	n=147 (40.2%)
1st A1C in program	n=264	n=121 (45.8%)	n=97 (36.7%)	n=46 (17.4%)*
2nd A1C in program	n=154	n=74 (48.1%)	n=57 (37%)	n=23 (14.9%)*
3rd AIC in program	n=74	n=40 (54.1%)	n=25 (33.8%)	n=9 (12 .1%)*

*$p = < .001$

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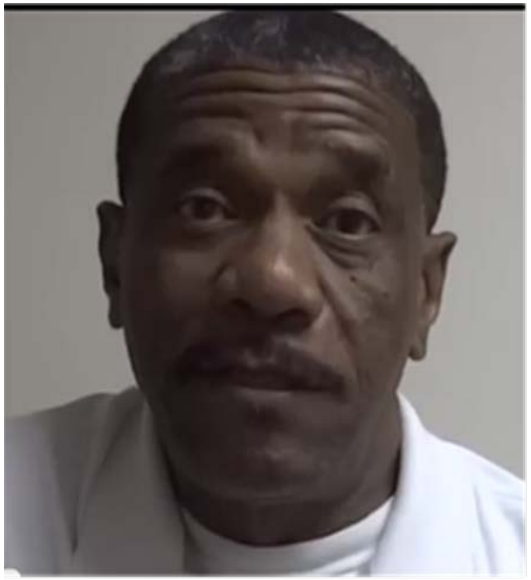

"At first it was such a dark diagnosis. It was like, 'you've got diabetes, now you're just one step from being dead.' And now, thanks to this program, I don't feel that way at all. I feel like diabetes is just something I have, but it's manageable."

Mr. Love, Diabeticos Saludables client

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BEACON HEALTH SYSTEM Care Partner

Diabetes Pilot
Tithing
12/31/2013

	Actual	Budget	Actual FTE	Budget
Revenue	3,948	0		
Labor	479,358	547,774	10.0	11.6
Non-Labor	53,427	64,989		
Total Expenses	532,785	612,763		
Net Contribution	(528,837)	(612,763)		

ER Cost Avoidance:

	Pre-Intervention Charges	Post Charges	
All Patients	$1,373,447	$295,460	-1,077,987

Community Health Is Measured One Person At A Time

Memorial Children's Hospital

Bebes Dulces sin Azucar: Gestational Diabetes / FQHC

YMCA Diabetes Prevention Program

HealthWorks! Kids Museum, Children and Family Camps

Community-wide/Collective Impact: Childhood Obesity

Food Bank: Healthy Choices Market / Unity Gardens, Inc.

Diabetes Education and Research Institute (2015)

Elkhart General Hospital Expansion (2017)

BUILDING A CULTURE OF WELL BEING

BEACON HEALTH SYSTEM

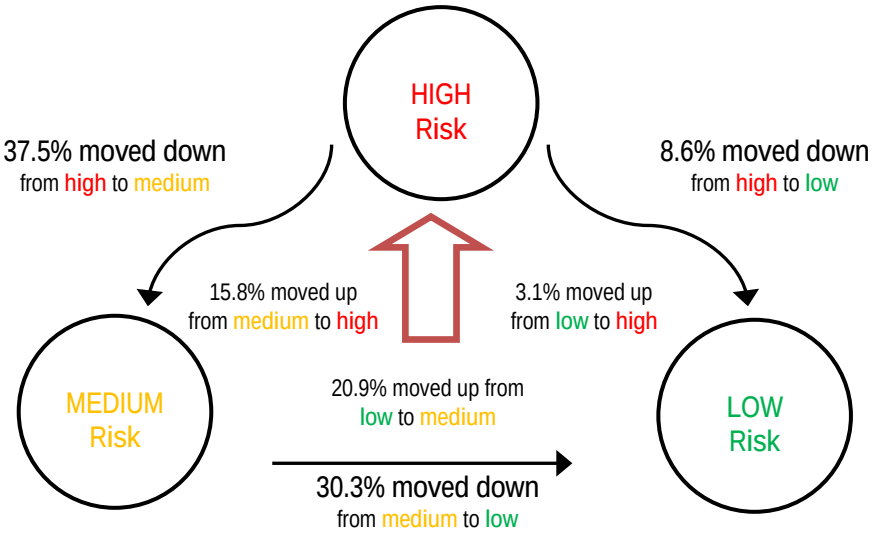
Living in Good Health Together

WELLNESS PLAN COMPONENTS

- HRA
- Biometrics
- Behavior
  - Prevention
  - Community
  - Mind
  - Physical
  - Nutrition
  - De-stress
  - Financial

POPULATION HEALTH - RISK CATEGORY MOVEMENT

2,862 INDIVIDUALS 2011 COMPARED TO 2013



High Risk	Medium Risk	Low Risk
> 4 Risk Factors	3 – 4 Risk Factors	0 – 2 Risk Factors

POPULATION HEALTH – RISK FACTOR MOVEMENT

2,862 INDIVIDUALS 2011 COMPARED TO 2013

- **68.2%** who had a high risk factor based on Physical Activity reduced their risk to Medium or Low
- **64.5%** who had a high risk factor based on Stress reduced their risk to Medium or Low
- **52.2%** who had a high risk factor based on Blood Pressure reduced their risk to Medium or Low
- **40.2%** who had a high risk factor based on Cholesterol reduced their risk to Medium or Low
- **28.4%** who had a high risk factor based on Smoking reduced their risk to Medium or Low
- **26.4%** who had a high risk factor based on a Fatty Diet reduced their risk to Medium or Low
- **22.4%** who had a high risk factor based on Blood Sugar reduced their risk to Medium or Low
- **10.29%** who had a high risk factor based on their BMI reduced their risk to Medium or Low

ANNUAL PREMIUM INCENTIVE
EFFECTIVE JANUARY 1, 2016

POINT WEIGHTING

HRA (50 points)	**5%**
Biometrics (600 points)	**60%**
Behaviors (350 points)	**35%**

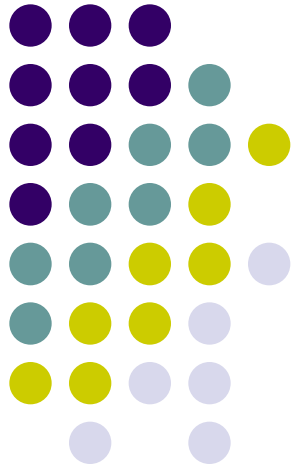
INCENTIVE STRUCTURE

0 – 399 points	25% premium
400 – 799 points	20% premium
800 – 1000 points	15% premium

QUARTERLY LOTTERY INCENTIVE
EFFECTIVE JANUARY 1, 2015

- **Every 25 points equals one lottery ticket** (associate and spouse)
- **Lottery Prizes** (taxable)
  - $500 Cash
  - $500 Gift Certificate to Dick's Sporting Goods
  - PTO Day (associate only)
- **75 Points for the quarter receive $10 Subway Gift Card**

Hospitals & Public Health Aligning in the 21st Century



Presented by:

Derek Brindisi, Director,
Worcester Division of Public Health
&
Monica Lowell
Vice President, Community Relations
UMass Memorial Health Care, Inc.

Webinar Objectives

- Developing a framework
- Learn strategies that embrace cross-sector collaboration
- Identify opportunities to leverage resources and ensure long term sustainability
- Future strategies/opportunities to enhance the work

Public Health
Prevent. Promote. Protect.

UMassMemorial
Health Care

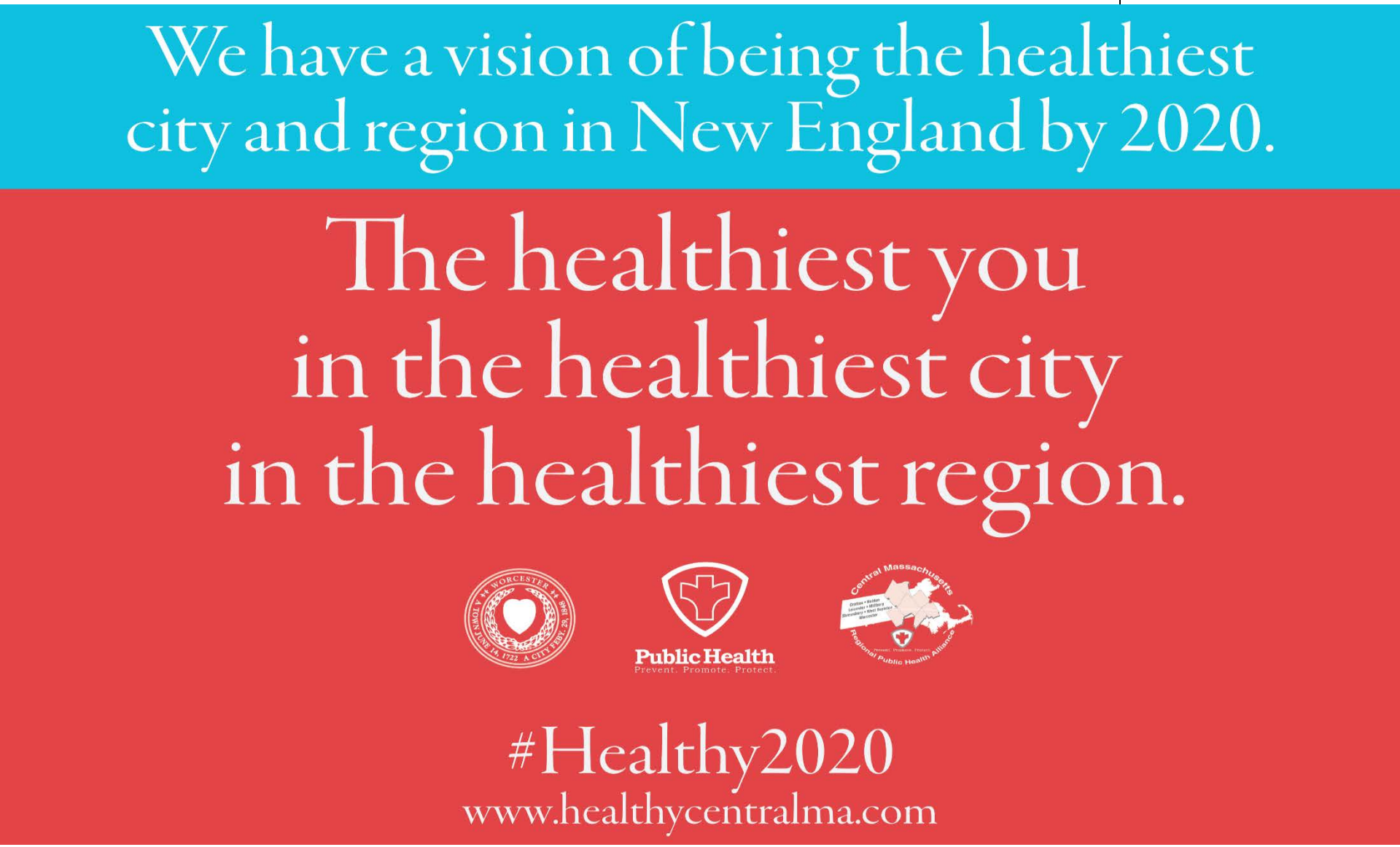
Planning Together with Public Health

- UMass Memorial and the Worcester Division of Public Health (WDPH) have a long history of working together.
- Hospital supports Public Health infrastructure since 2004.
- Worcester City Manager and Hospital CEO assembled a Public Health Task Force that produces a report with recommendations to serve as a road map to address identified needs.
- Collaborative efforts include; Youth jobs, Wheels to Water, Tobacco pharmacy ban, establishing a Youth Office.
- Strong partnership lead to WDPH and UMass Memorial co-chairing the development of the 2012 Community Health Needs Assessment (CHA) and Greater Worcester Community Health Improvement Plan (CHIP).
- Regionalization and Accreditation of the WDPH is supported by the CHIP.

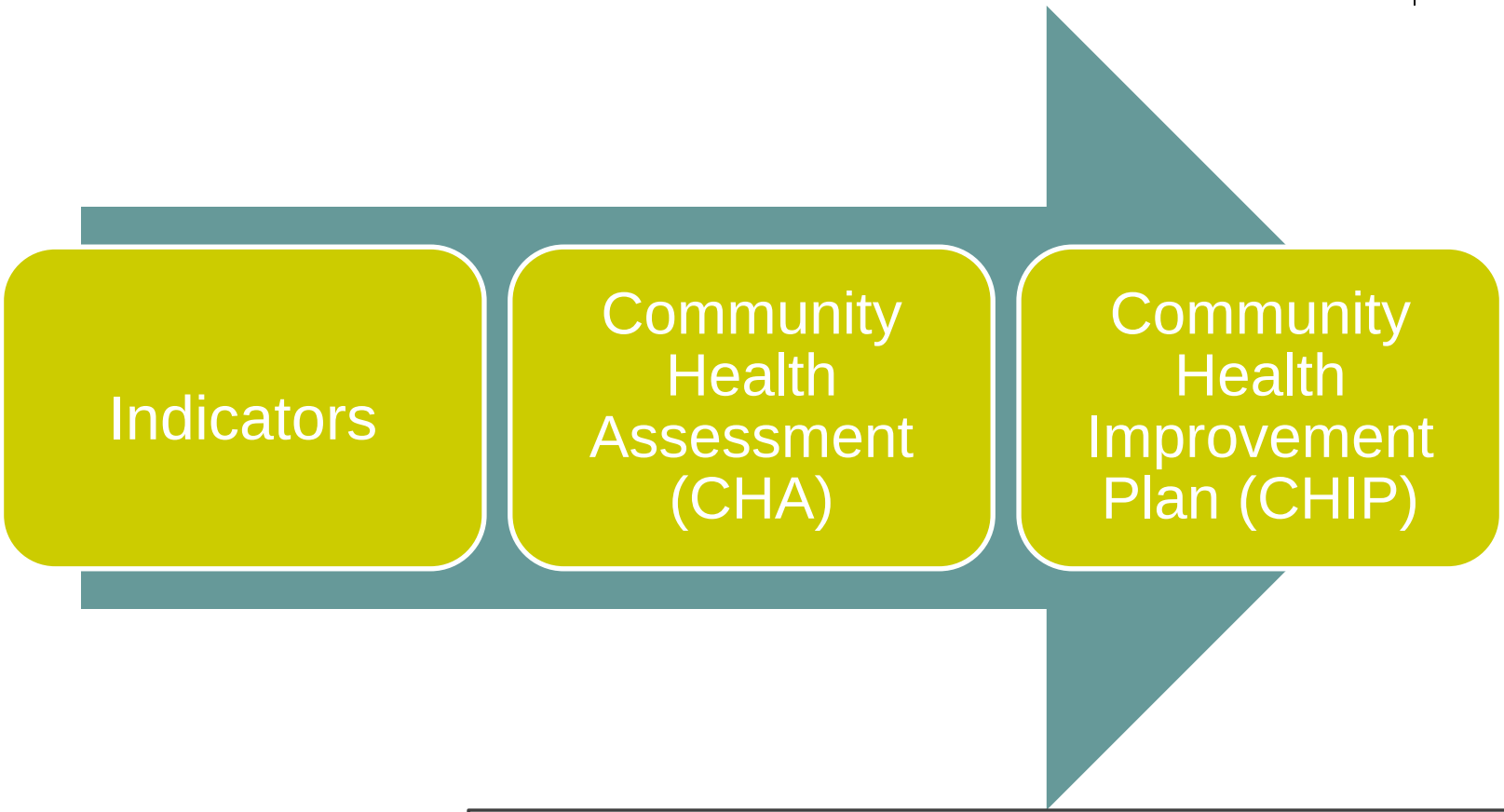
Public Health
Prevent. Promote. Protect.

UMassMemorial
Health Care

Identifying a Shared Vision for Community Health

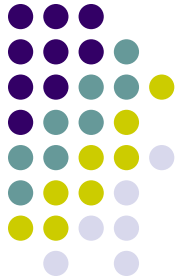


Partnering With Public Health; Pathway to a Community Health Improvement Plan (CHIP)



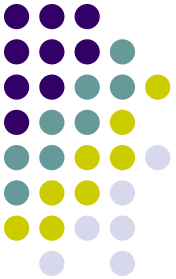
- ***Vision: Worcester will be the Healthiest City in New England by 2020***

Broad Community Engagement & Input



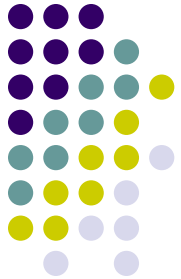
- Established a Community Advisory Committee to support development of the CHA & CHIP.
- CHA & CHIP Included collection and analysis of data from multiple primary and secondary sources, key informant interviews.
- Responses by more than 1,300 individuals to an online survey was also incorporated.
- In total, approximately 1,745 individuals representing a range of populations and institutions including neighborhoods, youth, immigrants, seniors, government, philanthropy, education, social services and health care provided input.

CHIP Domains (Priority Areas)



- Healthy Eating & Active Living
- Behavioral Health (Includes Smoking/ATOD)
- Primary Care & Wellness
- Violence & Injury Prevention
- Health Equity & Health Disparities

Alignment and Engagement



- To maximize impact in addressing identified needs, UMass Memorial's Community Benefit Strategic Implementation Plan aligns with priorities identified by the CHA and CHIP.

- Other stakeholders lead and participate in CHIP Domain Working Groups and have adopted CHIP priorities and strategies.
  - Designated Domain Work Group Chairs reports progress quarterly
  - Yearly update of full CHIP report completed and publicly announced
  - CHIP updates to be announced to the community

YouthConnect Worcester

www.youthconnectworcester.org

YouthConnect Executive Partners

Boys & Girls Club
Girls Inc.
Friendly House
Worcester Youth Center
YMCA of Central MA
YWCA Central MA
YOU, Inc.

Supporting Partners

HOPE Coalition ▲ Edward M. Kennedy Community Health Center ▲ Safe Homes ~ The Bridge of Central Massachusetts ▲ Worcester Public Schools ▲ United Way of Central Massachusetts ▲ Fred Harris Daniels Foundation ▲ Family Health Center of Worcester ▲ Worcester Community Connections Coalition ▲ Compass Network ▲ Worcester Police Department ▲ Worcester Violence Prevention Coalition ▲ African Community Education ▲ Ivy Child International ▲ 15-40 Connection ▲ Planned Parenthood League of Massachusetts ▲ Greater Worcester Community Foundation ▲ Worcester Department of Public Health ▲ Let's Get Ready ▲ UMass Memorial ▲ UMass Medical School

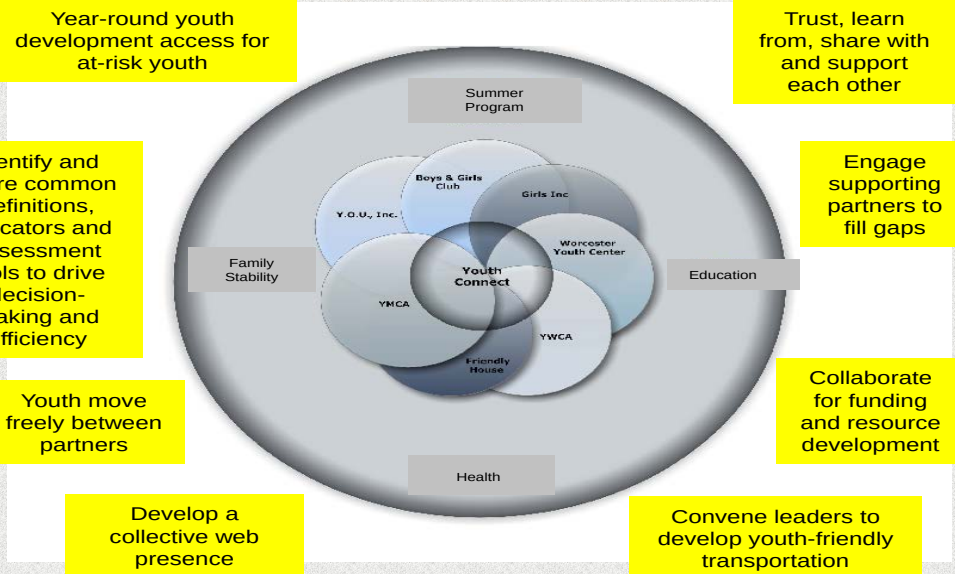
Goal: Provide high quality neighborhood-based recreational, educational and cultural activities to isolated and underserved Worcester youth aged 5-24 with focus on the middle school years. Establish a seamless, inclusive youth-serving system; a consortium modeled on best practices and built on a framework that delivers positive outcomes for health, education, and family stability.

Year-round youth development access for at-risk youth

Trust, learn from, share with and support each other

Identify and share common definitions, indicators and assessment tools to drive decision-making and efficiency

Engage supporting partners to fill gaps



Youth move freely between partners

Collaborate for funding and resource development

Develop a collective web presence

Convene leaders to develop youth-friendly transportation

Worcester's Community Health Improvement Plan

Domain I: Healthy Eating and Active Living

- Physical Activity through 6-week summer program
- Year-round physical activity at YC agencies
- Project Bread
- Nutrition components at some agencies

Domain II: Behavioral Health

- Mentors, study groups
- High-yield learning activities
- Relationship-building
- Bullying prevention, peer mediation and conflict resolution
- Leadership development

Domain III: Primary Care and Wellness

Supporting Partner Services and Activities

- Compass Network – Homeless youth network
- EMK Health Center – Primary care and education
- Family Health Center – Pregnancy Prevention and Adult PREP
- 15-40 Connection – Cancer Awareness and Advocacy
- Planned Parenthood – Sexual Health, pregnancy prevention, education

Domain IV: Violence and Injury Prevention

Activities

- Targeted outreach
- Mentors
- Leadership skill development
- GPS Girls Promoting Safety

Supporting Partner Services and Activities

- HOPE Coalition – Civicism and Peer Leadership
- Worcester DPH
- Worcester Police Department
- Worcester Violence Prevention Coalition

Domain V: Health Equity and Health Disparities

Overarching and embedded values and purposeful activities

Racism addressed specifically and intentionally in staff development
Shared anti-racist values influence program development and implementation

Common Outcomes for Youth

Increase the High School Graduation Rate for at-risk youth: Increase youth participation in educational support activities, improve youth academic skills and achievements

Reduce the childhood obesity rate: Healthier youth through healthier eating habits and increased physical activity

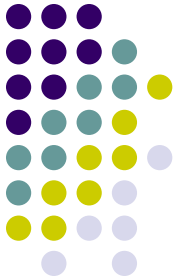
Reduce the child poverty rate: Prevention and support for youth in low income neighborhoods and subsidized housing, to reduce youth violence and reduce childhood poverty through a better prepared workforce

Prevention and Wellness Trust Fund; Developing Community/Medical Linkages

Leveraging Opportunities Through Collaboration:

- Building on the CHIP, Worcester was selected as one of nine communities in Massachusetts to receive a 2014 Prevention and Wellness Trust Fund (PWTF) grant.
- WDPH and UMass Memorial convened and led a group of diverse community partners for the application process.
- PWTF targets improving health outcomes for chronic conditions while reducing health care costs.
- The award will bring more than $7 million over 30 months for three citywide interventions: Pediatric Asthma, Hypertension and Falls Prevention.
- The PWTF grant is funded through Chapter 224 of the Acts of 2012 Massachusetts Health Care Reform/Cost Containment.
- Grant strategies address preventable health conditions using evidence-based and -informed program policy and system change.

Leveraging Resources



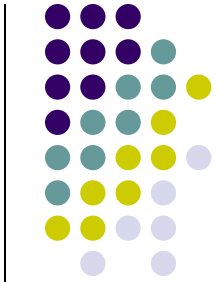
Bridging Health Care and Public Health with Academia

- Center for Public Health Practice– Feeds the CHIP
- With Clark University at the helm, provides students and faculty from several academic institutions to support CHIP activities
- Community Benefits funding leverages other funding sources

Future Opportunities

- Policy and Advocacy development to enhance prevention
- Securing timely data from hospitals that aligns with public health
- Bringing in non-traditional stakeholders to support population health around community/medical linkages and prevention efforts

Strategy for Collaborative Success



- Imperative: Develop a Strong Relationship with your Local Government
- Assess Together
- Plan Together
- Establish a Vision together
- Foster Buy-In from Other Stakeholders and Capitalize on their Assets
- Measure Ourselves
- On-Going Communication on Progress

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Questions & Answers

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Thank you!

Upcoming HPOE Live! Webinars

- January 27, 2015
  - Bridging Worlds: The Future Role of the Healthcare Strategist
- February 17, 2015
  - Human Trafficking: What the Health Care System Can Do

For more information go to www.hpoe.org