Healthy Counties: Engaging State and Federal Partners

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DHHS/OASH – Region IX
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National Prevention Strategy
Strategic Directions and Priorities

Increase the number of Americans who are healthy at every stage of life.
US Health Care Delivery System Evolution

Health Delivery System Transformation Critical Path

Acute Care System 1.0
- Episodic Health Care
- Lack integrated care networks
- Lack quality & cost performance transparency
- Poorly Coordinate Chronic Care Management

Coordinated Seamless Healthcare System 2.0
- Patient/Person Centered
- Transparent Cost and Quality Performance
- Accountable Provider Networks Designed Around the patient
- Shared Financial Risk
- HIT integrated
- Focus on care management and preventive care

Community Integrated Healthcare System 3.0
- Healthy Population Centered
- Population Health Focused Strategies
- Integrated networks linked to community resources capable of addressing psycho social/economic needs
- Population based reimbursement
- Learning Organization: capable of rapid deployment of best practices
- Community Health Integrated
- E-health and telehealth capable

Neal Halfon, UCLA Center for Healthier Children, Families & Communities
Figure 1. Hospital Executives’ Views of the Future of the Health Care System

Community Health Centers

- CHCs serve more than 21 M people / yr
- 1200 centers with 9,000 sites
- Recent expansion of mental health and substance use disorder services
- $50 M funding opportunity to expand behavioral health services in 200 CHCs nationwide
Accountable Care Communities

All of the current major strategies and programs that are being led by the US Dept of Health and Human Services support the goals of Accountable Care Communities --  better care, healthy people / healthy communities, and affordable care for all. “

Communities
Transforming
To make healthy living easier
# Health Risks and the Physical Environment

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<thead>
<tr>
<th></th>
<th>Inadequate Nutrition</th>
<th>Lack of Physical Activity</th>
<th>Alcohol and Tobacco Use</th>
<th>Unsafe Streets or Unsafe Neighborhoods</th>
<th>Polluted Air, Soil and Water</th>
<th>Housing Conditions or Unaffordable Housing</th>
<th>Social Isolation</th>
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### Poor or Inadequate Nutrition

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<tr>
<th>Negative Health Outcomes</th>
<th>Relation to Built Environment</th>
<th>Policy Recommendations</th>
<th>Action Steps for Public Health</th>
<th>Partners</th>
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<tbody>
<tr>
<td>• Cancer</td>
<td>COMMUNITY ACCESS</td>
<td>• Limited access to grocery stores, farmers’ markets, and community gardens</td>
<td>GENERAL &amp; AREA PLANS</td>
<td>• Map food access for all communities</td>
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<td>• Diabetes</td>
<td>• Concentration of fast food, liquor, and convenience stores</td>
<td>• Prioritize access to healthy foods including specific goals for increasing access in underserved neighborhoods</td>
<td>ASSESSMENT</td>
<td>• Identify transportation routes to food retail</td>
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<td>• Hunger</td>
<td>MARKETING</td>
<td>• Proliferation of unhealthy advertising</td>
<td>ZONING</td>
<td>• Assess impact of poor food access on community health and the local economy</td>
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<td>• Heart disease</td>
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<td>OUTREACH &amp; EDUCATION</td>
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[www.healthyplanning.org](http://www.healthyplanning.org) | [www.barhii.org](http://www.barhii.org)
HHS Regional Offices

• 10 Regions throughout U.S. & Territories

• Functions:
  - Facilitators
  - Conveners
  - Collaborators
  - Assistance with cross-agency coordination
Ex. Regional Health Equity Councils (OMH)

- Independent organizations
- Includes leaders and stakeholders
- Primary role to initiate action from the grassroots
HHS Regional Office: Convener

Ex. Advance the national HIV/AIDS Strategy in R-IX

• Targeting resources for greatest impact
• Engaging academia and partners in private sector
Ex. The Medical Reserve Corps (MRC)

• Mission: engage volunteers to strengthen public health, emergency response, & community resilience

• Clearinghouse for info and best practices

• Coordinates with local, state, regional and national orgs & agencies
HHS Regional Office: Technical Assistance

Grants and Broad-based Initiatives

Ex. The Million Hearts Initiative

• Mission: prevent 1 million heart attacks and strokes by 2017

• Make local outreach easy through webinars, downloadable materials, slides, press inserts, promotional tweets, fact sheets, and other resources
3 NPS Priorities

- Tobacco free living
- Healthy eating
- Active living
Tobacco-free Living

• CDC’s Tips from Former Smokers Campaign
• National Tobacco-Free College Campus Initiative
Healthy Eating

• HHS & USDA Collaboration to promote availability of healthy food in underserved communities

• Tools & resources to implement the Dietary Guidelines

• Nutrition labeling in chain restaurants & vending machines through ACA
Active Living

- Let’s Move Active Schools
- Website: letsmoveschools.org
- Provides individual champions with a clear roadmap to create an active school environment
Baby-friendly Hospital Initiative

- Started by UNICEF and WHO
- HHS encourages counties to support hospitals to become “baby friendly”
- Web: babyfriendlyusa.org
Rural Health Care

• Office of Rural Health Policy (ORHP) coordinates activities related to rural health care within DHHS. Administers grants to all 50 states through State Offices of Rural Health and rural hospitals through Flex Grants.

• Border Health Division
• Hospital State Division
• Policy-Research Team
• Office for the Advancement of Tele-health
“Health is too important to be left to the health sector alone.”

Assistant Secretary for Health Dr. Howard Koh
Questions

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Regional Health Administrator
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Improving Health in a Climate of Change

State Legislatures and the Move to Coordinated Care

January 30, 2014
Overview

• Pressures on state budgets
• Health reform: challenges and opportunities
• Triple aim
• State Innovation Models (SIMs)
• Medical homes
Pressure on State Budgets

Revenues are expected to meet estimates, but growth is expected to taper off.

Spending is generally on target.

Year end-balances generally have improved.

Despite stabilizing fiscal conditions, uncertainties persist.
Statistic of Note

After four years at a 2.3% average annual growth, this recovery is still half the historic average annual growth of 4.6% going back to 1959.

Changes in General Fund Revenues
FY 2013 and FY 2014

Source: NCSL survey of state legislative fiscal offices, summer 2013.
Revenue Outlook for the Remainder of the Fiscal Year

- Expected to Meet Forecast: 39
- Likely to Exceed Forecast: 8
- Unlikely to Meet Forecast: 4
- Not Applicable: 2

Source: NCSL survey of state legislative fiscal offices, fall 2013.
Top Fiscal Issues for 2014 Legislative Sessions

29
Medicaid/ Health Care

13
Taxes and Revenues

13
State Employee Salaries and Benefits

12
Education

9
Infrastructure

6
Corrections/ Public Safety

Source: NCSL survey of state legislative fiscal offices, fall 2013.
Percent Change in General Fund Appropriations for Major Budget Categories in FY 2014 (projected)

- Medicaid: 5.9%
- Higher Education: 5.1%
- Corrections: 2.5%
- K-12 Education: 2.4%

Source: NCSL survey of state legislative fiscal offices, summer 2013
Health Reform: Challenges and Opportunities

• Exchanges
• Medicaid expansion
• “New” coverage gap
• Premium assistance
• Churning
• Interoperability
• Workforce
ACA Medicaid Expansion Decisions, to date

as of Jan. 1, 2014

LEGEND
- Green: Currently not expanding
- Orange: Implementing or exploring expansion alternatives
- Purple: Currently plans to expand
- Pink: Undecided
The “New” Coverage Gap

Median (47%) Medicaid Eligibility for Parents.
There is wide variation among states with regard to adult coverage.

Federal Poverty Level (FPL)

States that have expanded Medicaid to adults with incomes at least 100% FPL
States that have not expanded Medicaid to adults with incomes at least 100% FPL

*Marketplace subsidies are available only to people with incomes between 100% and 400% FPL.

SOURCE: KAISER FAMILY FOUNDATION
Triple Aim – Better Care, Better Outcomes, Lower Cost – Provides Potential for Bipartisan Efforts

• Risk based managed care, non-risk care management, ACOs (CCOs, RCCOs, ACEs), health Homes/PCMHs, integrated primary care and behavioral health
• State Innovation Models Initiative
• Medical/ health home models
Center for Medicare and Medicaid Innovation

“The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care furnished to individuals under such titles.”

---Affordable Care Act
State Innovation Models Initiative
Types of Awards

- Model Testing Awards
- Model Pre-Testing Awards
- Model Design Awards

Source: Centers for Medicare & Medicaid Services
STATE-BASED MEDICAL HOME INITIATIVES

As of August 2013

- Medical home activity (45 states and Washington, D.C.)
- Making medical home payments (29 states)
- Payments based on provider qualification standards (27 states)

Source: Mary
### Why the Medical Home Works: A Framework

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<tr>
<th>Feature</th>
<th>Definition</th>
<th>Sample Strategies</th>
<th>Potential Impacts</th>
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| **Patient-Centered**   | Supports patients and families to manage & organize their care and participate as **fully informed partners** in health system transformation at the practice, community, & policy levels | • Dedicated staff help patients navigate system and create care plans  
• Focus on strong, trusting relationships with physicians & care team, open communication about decisions and health status  
• Compassionate and culturally sensitive care | Patients are more likely to seek the right care, in the right place, and at the right time |
| **Comprehensive**      | **A team of care providers** is wholly accountable for patient’s physical and mental health care needs — includes prevention and wellness, acute care, chronic care | • Care team focuses on ‘whole person’ and population health  
• Primary care could co-locate with behavioral and/or oral health, vision, OB/GYN, pharmacy  
• Special attention is paid to chronic disease and complex patients | Patients are less likely to seek care from the emergency room or hospital, and delay or leave conditions untreated |
| **Coordinated**        | Ensures care is organized across all elements of broader health care system, including specialty care, hospitals, home health care, community services & supports, & public health | • Care is documented and communicated across providers and institutions, including patients, specialists, hospitals, home health, and public health/social supports  
• Communication and connectedness is enhanced by health information technology | Better management of chronic diseases and other illness improves health outcomes |
| **Accessible**         | Delivers **consumer-friendly services** with shorter wait-times, extended hours, 24/7 electronic or telephone access, and strong communication through health IT innovations | • More efficient appointment systems offer **same-day or 24/7 access** to care team  
• Use of **e-communications and telemedicine** provide alternatives for face-to-face visits and allow for after hours care | Focus on wellness and prevention reduces incidence/severity of chronic disease and illness |
| **Commited to quality and safety** | Demonstrates commitment to quality improvement through use of health IT and other tools to ensure patients and families make informed decisions | • EHRs, clinical decision support, medication management improve treatment & diagnosis.  
• Clinicians/staff monitor **quality improvement goals** and use data to track populations and their quality and cost outcomes | Cost savings result from:  
• Appropriate use of medicine  
• Fewer avoidable ER visits, hospitalizations, & readmissions |
Questions

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