VT Health Care Innovation Project
Population Health Work Group Meeting Agenda

Date: Tuesday April 13, 2016 Time: 2:30-4:00 pm
Location: EXE - 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier
Call-In Number: **1-877-273-4202** Passcode: **420-323-867**

All Participants: Please ensure that you sign in on the attendance sheet the will be circularized at the beginning of the meeting, Thank you.

AGENDA

Item #	Time	Topic	Presenter	Relevant Attachments	Action #
1	2:30	**Welcome, roll call and agenda review**		**Attachment 1:** Agenda	
2	2:35	**Approval of Minutes**		**Attachment 2:** Minutes	
3	2:40	**Project Updates** • VHCIP Operational Plan and Year 3 Budget • Population Health Plan RFP • Accountable Communities for Health: Phase II • CMMI new AHC funds	Georgia Maheras / Sarah Kinsler	**Attachment 3:** A: VHCIP Work Plan B: Conflict of Interest	
4	2:50	**Status of All Payer Waiver and Pop Health** • Implications and application to population health objectives	Michael Costa and Ena Backus/Tracy Dolan		
6	3:00	**Auerbach's 3 Buckets and the ACO "Change Packets"** • Presentation: Framework and initial packets developed • Discussion: Feedback on content and opportunities for use		**Attachment 5:** A: Framework B. Sample Change Packets	
7	3:45	**Open Comments and Next Steps**			

OPEN ACTION ITEM LOG					
Date Added	Action Number	Assigned to:	Action /Status	Due Date	Date Closed
			• .		
			•		
			•		
			•		

Attachment 2: Minutes

Vermont Health Care Innovation Project

Vermont Health Care Innovation Project
Population Health Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: December 8, 2015; 2:30 PM – 4:00 PM; Calvin Coolidge Conference Room, National Life Building, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome, Roll Call, & Approval of Minutes **Agenda Review**	**Welcome** Tracy Dolan called the meeting to order at 2:32pm. **Roll Call and Approval of minutes** A roll call attendance was taken and a quorum was present. The August and September minutes were approved: • A motion to approve the minutes by exception was made by Mark Burke and seconded by Mary Kate Mohlman; • the August minutes were approved with two abstentions from Chris Smith and Josh Plavin; • the September minutes were approved with one abstention from Penrose Jackson **Agenda Review** Tracy Dolan then reviewed the agenda with the group, including an update on the Health in All Policies initiative and a brief update from Jill Berry-Bowen about the RiseVT project (a provider sub-grant awardee.)	
2. Update: Health in All Policies **RiseVT Update**	**Update: Health in All Policies** Tracy provided a brief update on the Health in All Policies initiative. The Vermont task force has met once and Heidi is helping to staff the work group. **Update: RiseVT** Jill Berry-Bowen provided an update on the RiseVT program – a provider sub-grant project partially funded by VHCIP.	

Agenda Item	Discussion	Next Steps
	RiseVT is a community committee on healthy lifestyles – to improve healthy outcomes in Grand Isle and Franklin Counties in Vermont. Their staff includes a coordinator, health coaches to work with businesses, schools, municipalities. They use wellness scorecards that available on the website to help support people as they pursue making healthy changes to their lifestyle. Northwestern Medical Center worked with the Green Mountain Care Board earlier this year to reallocate money in the hospital budget designed to focus on population health in the community: $1.1 M The initiative is leveraging Health Coaching to focus on the more vulnerable populations. E.g. In Alburgh, they will have a health coach to work with schools to support healthy lifestyles. They are using health advocates to make sure that someone is at every community event, town meetings and similar events. They are focusing on improving walkability with adding walking and biking paths. Participants have the ability to track food/nutrition online via the RiseVT wellness website. They have partnered with Healthy Roots to produce storage buildings to have produce year-round. They will be conducting community case management using the funds from GMCB to help navigate the transitions between care settings (for example, moving to primary care from the ER). A Lifestyle Medicine clinic is available (Dr. Fontaine) with wellness coaches to support those seeking to improve their health. They are also exploring how to expand beyond those two counties by partnering with other organizations (such as BCBSVT.) **Update: Alternative Financing Mechanisms Meeting** Jim Hester provided an update about an upcoming alternative financing meeting: 4 VT teams have been invited to a meeting in Boston at the Federal Reserve with CDFIs (Community Development Financial Institutions) to discuss alternative financing vehicles that may be used to help finance this kind of work going forward.	
3. Accountable Communities for Health	**Accountable Communities for Health: Phase II** • Share design • Identify desired outcomes • Discuss questions, concerns, necessary support to communities that are part of the peer learning Heidi created a presentation about the recommendations for next steps of this aspect of work. Heidi is working to draft an RFP to gain support. Heidi walked through the slides in the materials packet. Review: 9 Core Elements of an Accountable Community for Health: 1. Mission	

Agenda Item	Discussion	Next Steps
	2. Multi-Sectoral Partnership 3. Integrator Organization 4. Governance 5. Data and Indicators 6. Strategy and Implementation 7. Community Member Engagement 8. Communications 9. Sustainable Funding What is it that we need in order to explore the concept from the ground up, in order to work in concert with one another to connect to the bigger system reforms that are being proposed in Vermont? • Communities will learn with and from one another and from national innovators; • Identify the practical steps and developmental stages in creating an Accountable Community for Health; • Inform the development of necessary state-level policy and guidance to support regional efforts. This will be a 12-month project, with 3-month planning/design phase and a combination of full-day in-person learning sessions; with webinars to reinforce concepts and discuss progress and challenges; and local facilitation to support ongoing community-level work. There will be Quarterly learning sessions and webinars would engage national experts as faculty. There will be ongoing facilitative support will help communities pull together local leadership; identify potential integrators; review existing data and systems; and determine opportunities for increased coordination/connection. These will be iterative, rapid-cycle learning sessions that alternate in-person learning sessions with virtual and on-the-ground learning and sharing in between. The proposal is that this will be launched in late January/ early February. We need to identify those communities who are interested in participating – who may already have some of the pieces of this kind of work in place and who are looking for a framework in which to help guide their progress toward next steps. We hope to build on existing building blocks such as the UCCs that are already in communities, or via the Blueprint for Health – we will not be determining who will be the participants or who will be the 'Integrator' in each community as we believe that each community will be better positioned to decide that for themselves. Mark Burke asked where are we in identifying those policies that need to change that will be the levers for this work. Heidi responded that we have not determined those yet but that this system will be identifying the strengths and weaknesses in each community and for them to determine those policies that they believe will move them forward toward the ultimate goal. Tracy added that we would not necessarily call this a demonstration project. Mark commented that these things are already happening organically, which can lead to	

Agenda Item	Discussion	Next Steps
	duplication and competition for the same dollars. When real dollars are being spent on this (and not around the edges as it is now) that will bring about the high-level policy changes that need to happen to support these efforts Mary Kate Mohlman shared a bit about what the Blueprint is doing with the UCCs and the ACO field teams to help establish quantitative framework. Now that we have the conceptual design – how do we roll this out? Who should be part of the learning? Do we have eligibility criteria? What else do we need to develop to help them be part of the peer to peer learning system – and what kind of policy changes will be needed. The idea is to ground test the concept of ACH – to wrestle with it and understand what a community need to do this kind of work at the policy level and at the state level, so we can put together recommendations at the end of the year – and inform the final population health plan at the end of the SIM grant. Penrose Jackson asked how will this influence and be influenced by the all payer model changes impending for January 2017? Karen Hein responded was that this is the population health "dream come true"….this could be the enabler to allow larger picture thinking about the health of the state. This work (the ACH project) would be one way to position ourselves to feed that information into the larger picture, with further work to be done on what would be the quality measures, what would be the financing mechanisms, what would the ACH look like.	

4. Report from Small Groups	**Report from Small Groups**
	
	The meeting participants broke out into three small discussion groups to answer the following questions:
	• Who:
	    o Who should be invited to participate?
	    o What are some basic eligibility criteria for participation?
	• How:
	    o What existing resources/guidance related to the nine core elements can be shared with emerging ACHs?
	    o What must we develop before we convene the participants?
	
	<u>Heidi's Group:</u>
	Who and criteria: There should be some thoughts about what we think makes success include the 9 elements to help communities self-assess that they're on the right path; the list of participants should include a local employer	

Agenda Item	Discussion	Next Steps
	to be part of the mix; in re: resources, we could create case studies with what already on the ground and in progress; put together an orientation or talking point to give to people to reach out to their partners to help with outreach; need to distinguish between UCC and the current care collaboratives and how they differ from this effort. We need to understand the complementary nature – not just about integrated care and measures but a longer term strategic plan in the community. What are the outcomes we want to see: unified understanding across the care continuum in looking at the care community and the multiple streams of reform and are we in coordination at the community level. <u>Sarah's group:</u> Eligibility: including groups with varied stages of development would be helpful to help jumpstart those who are not as far along as well as energize those further along. Communities should show some level of commitment and that key partners are at the table: Hospitals, local public health, planning, human services, philanthropy, How to approach designing this: Have a defined structure, ongoing partnerships with those who have already done some kind of work together, or at least identified priorities and a plan to move forward. What need: Public health data to guide areas for communities to focus on (IOM Vital Signs) other ways to help define the data (VDH) <u>Tracy's group:</u> Who should participate: Communities who already have strength in the elements; opportunity for new communities to learn thru shadowing or mentoring or a separate track for that. This group landed closer to "It's only a year, we probably should focus on more experienced communities" to participate. What kind of topics: • Medicaid/Medicare financing and how it works now; • Sharing models that have been applied successfully here or elsewhere; • Given competing resources and risk, how do we partner and align priorities? We need expertise in this area. • Financing: how do alternative models work? For social programs, etc…	
5. Population Health Plan RFP	**Population Health Plan RFP** Heidi will take all of this material from today's meeting and synthesize it and put into RFP. And potentially into recruiting materials for the ACH project as well.	

Agenda Item	Discussion	Next Steps
	Even though the Population Health Work Group will be meeting will be quarterly, we will provide a monthly updates to keep the original group apprised of progress, esp. toward the population health plan deliverable. There is currently a VHCIP RFP out not to solicit a vendor to help write that. This group will help advise on the development of that document. We will also be tracking how does our work fit in with the All-Payer Waiver.	
6. Next Meeting and Next Steps	**Next Meeting and Next Steps** The next meeting is February 9, 2016; 2:30 to 4:00 at National Life	

VHCIP Population Health Work Group Member List

Roll Call: 12/8/2015

Mark Burke 1°
Maykalk 2°
w/exception
• 2 abstentions August
• 1 abstention September
Motion carried

Member		Member Alternate		August Minutes	September Minutes	
First Name	Last Name	First Name	Last Name			Organization
Susan	Aranoff ✓					AHS - DAIL
Jill Berry	Bowen ✓					Northwestern Medical Center
Mark	Burke ✓					Brattleboro Memorial Hopsital
Donna	Burkett	Maura	Graff ✓			Planned Parenthood of Northern New England
~~Dr. Dee~~	~~Burroughs-Biron~~	Trudee	Ettlinger			AHS - DOC
Daljit	Clark	Jenney Maykalk	Samuelson Mohlman ✓			AHS - DVHA
Peter	Cobb					VNAs of Vermont
Judy	Cohen ✓					University of Vermont
Jesse	de la Rosa ✓					Consumer Representative
Tracy	Dolan ✓	Heidi	Klein ✓			AHS - VDH
Joyce	Gallimore	Kendall	West ✓			CHAC
Karen	Hein ✓					Dartmouth Medical School
Kathleen	Hentcy ✓	Charlie	Biss			AHS - DMH
Penrose	Jackson ✓				A	UVM Medical Center
Pat	Jones					GMCB
Patricia	Launer					Bi-State Primary Care
Lyne	Limoges ✓					Orleans/Essex VNA and Hospice, Inc.
Ted	Mable ✓	Kimberly	McClellan			DA - Northwest Counseling and Support Services
Carol	Maloney ✓					AHS - Central Office
Melissa	Miles ✓					Bi-State Primary Care
Laural	Ruggles ✓					Northeastern Vermont Regional Hospital
Julia	Shaw ✓					VLA/Health Care Advocate Project
Melanie	Sheehan					Mt. Ascutney Hospital and Health Center
Miriam	Sheehey ✓					OneCare Vermont
Shawn	Skaflestad ✓					AHS - Central Office
Chris	Smith ✓			A		MVP Health Care
JoEllen	Tarallo-Falk	Lori	Augustyniak			Center for Health and Learning
Karen	Vastine					AHS - DCF
Teresa	Voci	Josh	Plavin ✓	A		Blue Cross Blue Shield of Vermont
Stephanie	Winters					Vermont Medical Society
	~~30~~ 30		7			

~~Maura Graff~~ ✓ ~~31~~ Q ✓ PPNE

VHCIP Population Health Work Group Participant List

Attendance: 12/8/2015

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	VHCIP Staff/Consultant
X	Interested Party

First Name	Last Name		Organization	Population Health
Susan	Aranoff	here	AHS - DAIL	S/M
Julie	Arel	here	VDH	X
Lori	Augustyniak		Center for Health and Learning	MA
Ena	Backus		GMCB	X
Susan	Barrett		GMCB	X
Bob	Bick		DA - HowardCenter for Mental Health	X
Charlie	Biss		AHS - Central Office - IFS / Rep for AHS - DMH	X/MA
Mary Lou	Bolt		Rutland Regional Medical Center	X
Jill Berry	Bowen	here	Northwestern Medical Center	M
Mark	Burke	here	Brattleboro Memorial Hopsital	M
Donna	Burkett		Planned Parenthood of Northern New England	M
~~Dr. Dee~~	~~Burroughs-Biron~~		AHS - DOC	M
Jan	Carney		University of Vermont	X
Amanda	Ciecior		AHS - DVHA	S
Barbara	Cimaglio		AHS - VDH	X

Daljit	Clark		AHS - DVHA	MA
Peter	Cobb		VNAs of Vermont	M
Judy	Cohen		University of Vermont	M
Amy	Coonradt		AHS - DVHA	S
Alicia	Cooper		AHS - DVHA	S
Janet	Corrigan		Dartmouth-Hitchcock	X
Brian	Costello			X
Mark	Craig			X
Wendy	Davis		University of Vermont	X
Jesse	de la Rosa	phone	Consumer Representative	M
Micah	Demers		Blue Cross Blue Shield of Vermont	X
Trey	Dobson		Dartmouth-Hitchcock	X
Tracy	Dolan	[illegible]	AHS - VDH	C/M
Kevin	Donovan		Mt. Ascutney Hospital and Health Center	X
Lisa	Dulsky Watkins			X
Suratha	Elango		RWJF - Clinical Scholar	X
Gabe	Epstein		AHS - DAIL	S
Trudee	Ettlinger		AHS - DOC	MA
Kim	Fitzgerald		Cathedral Square	X
Erin	Flynn		AHS - DVHA	S
LaRae	Francis		Blue Cross Blue Shield of Vermont	MA
Joyce	Gallimore		Bi-State Primary Care/CHAC	M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Steve	Gordon	phone	Brattleboro Memorial Hopsital	X
Don	Grabowski		The Health Center	X
Maura	Graff	phone	Planned Parenthood of Northern New England	X
Wendy	Grant		Blue Cross Blue Shield of Vermont	A
Dale	Hackett		Consumer Representative	X
Thomas	Hall		Consumer Representative	X
~~Bryan~~	~~Hallett~~		GMCB	S
Catherine	Hamilton		Blue Cross Blue Shield of Vermont	X
Carolynn	Hatin		AHS - Central Office - IFS	S
Karen	Hein	[illegible]		C/M

Kathleen	Hentcy	here	AHS - DMH	M
Jim	Hester	here	SOV Consultant	S
Penrose	Jackson	here	UVM Medical Center	M
Pat	Jones		GMCB	S/M
Joelle	Judge	here	UMASS	S
Sarah	Kinsler	here	AHS - DVHA	S
Heidi	Klein	here	AHS - VDH	S/MA
Norma	LaBounty		OneCare Vermont	A
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Patricia	Launer		Bi-State Primary Care	MA
Mark	Levine	phone	University of Vermont	X
Lyne	Limoges		Orleans/Essex VNA and Hospice, Inc.	M
Nicole	Lukas	here	AHS - VDH	X
Ted	Mable		DA - Northwest Counseling and Support Services	M
Carole	Magoffin	phone	AHS - DVHA	S
Georgia	Maheras		AOA	S
Carol	Maloney		AHS	X
Mike	Maslack			X
Jill	McKenzie			X
Melissa	Miles	here	Bi-State Primary Care	M
MaryKate	Mohlman	here	AHS - DVHA - Blueprint	X
Chuck	Myers		Northeast Family Institute	X
Annie	Paumgarten		GMCB	S
Luann	Poirer		AHS - DVHA	S
Carley	Riley			X
Brita	Roy			X
Laural	Ruggles		Northeastern Vermont Regional Hospital	M
Jenney	Samuelson		AHS - DVHA - Blueprint	M
seashre@msn.com	seashre@msn.com		House Health Committee	X
Julia	Shaw	here	VLA/Health Care Advocate Project	M
Melanie	Sheehan		Mt. Ascutney Hospital and Health Center	M
Miriam	Sheehey		OneCare Vermont	M
Shawn	Skaflestad	phone	AHS - Central Office	M
Chris	Smith	phone	MVP Health Care	M
Kaylan	Sobel		The Council of State Governments	X

JoEllen	Tarallo-Falk		Center for Health and Learning	M
Karen	Vastine		AHS-DCF	
Teresa	Voci		Blue Cross Blue Shield of Vermont	M
Nathaniel	Waite		VDH	X
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	X
Kendall	West	here	Bi-State	X
James	Westrich		AHS - DVHA	S
Stephanie	Winters		Vermont Medical Society	M
Mary	Woodruff			X
Cecelia	Wu		AHS - DVHA	S
McKenna	Lee		OneCare Vermont	
				93

Attachment 3a -VHCIP Work Plan

Vermont Health Care Innovation Project
2016 Population Health Work Group Workplan

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	Accountable Communities for Health Learning System						
1	Support design and launch ACH peer learning opportunity, and development of ACH Implementation Plan.	Provide information from Prevention Institute research to inform content and direction of leaning opportunity.	November 2015	ACH Peer Learning Opportunity activities and ACH Implementation Plan activities are in collaboration with the Payment Model Design and Implementation Work Group.		Completed.	Peer learning system designed and launched; ACH Implementation Plan developed.
	Population Health Plan						
2	Develop a Population Health Plan (PHP) for CDC and CMMI.	Develop outline for a PHP for CMMI with input from other VHCIP work groups.	Summer 2016	Input from other VHCIP work groups gathered via webinar.	Steering Committee; Core Team	In progress.	Finalized PHP reflects project-wide priorities and SOV goals. Shared understanding of population health and population health goals across all VHCIP work groups.
3		Develop a Population Health Work Group workplan for the PHP to ensure collection of information, exploration of topics, etc.	Spring 2016	Review of key population health definitions and concepts with other work groups. Receive input from Payment Model Design and Implementation Work Group on integrating population health measures into payment models and delivery system reforms.		Not yet started.	
4		Collect and organize materials: population health measures; payment models; care models; financing mechanisms.	Spring 2016			Not yet started.	
5		Execute contract with vendor to draft the PHP.	Spring 2016	DVHA to release RFP, select bidder, and execute contract.		RFP released.	
6		Draft PHP.	Summer 2016			Not yet started.	
7		Share sections with other work groups for comment and revision.	Summer-Fall 2016	Receive feedback from VHCIP work groups.		Not yet started.	
8		Finalize PHP. (Staff Only)	Spring 2017		Steering Committee; Core Team	Not yet started.	

	Ongoing Discussions, Brainstorms, and More						
9	Identify opportunities to build upon reforms and utilize other policy levers for population health improvement	Research opportunities for population health improvement beyond VHCIP – GMCB, VDH, private-sector activities, etc.	Ongoing				
10		Review promising innovations in other states.	Ongoing				
	Ongoing Updates, Education, and Collaboration						
11	Receive regular updates on activities of interest from other VHCIP Work Groups.		Monthly			Ongoing.	Written and verbal monthly updates on all payment models.
12	Review 2016 Population Health Work Group Workplan.	Review and discuss draft workplan.	January 2016				Workplan finalized.
13	Coordinate and collaborate with other VHCIP Work Groups on other activities of interest.	Identify activities of interest and establish mechanisms for regular coordination and communication with other work groups.	Ongoing	Coordinate to identify activities of interest and establish regular communication (Other VHCIP Work Groups).		Mechanisms established for monthly co-chair meetings and work group reports to Steering Committee.	Well-coordinated and aligned activities across VHCIP.
14		Provide updates to other work groups on Practice Transformation Work Group activities.	Ongoing			Ongoing.	
15		Obtain regular updates from other work groups.	Quarterly	Obtain regular updates on work groups' progress as appropriate.		Ongoing.	
16	Provide input into VHCIP Sustainability Plan.	Review and comment on VHCIP Sustainability Plan Draft.	Late 2016			Not yet started.	Work Group input incorporated into VHCIP Sustainability Plan.
17	Contribute to VHCIP Webinar Series.	Contribute topic, speaker, and moderator suggestions for VHCIP's optional monthly educational webinars for staff and participants.	Monthly			Not yet started.	Twelve webinars conducted on staff- and participant-developed topics.

Attachment 5a - Framework

Commentary

The 3 Buckets of Prevention

John Auerbach, MBA

The US health care system is in a time of unprecedented change. The expansion of insurance coverage, redesign of the reimbursement systems, and growing influence of patient-centered medical homes and accountable care organizations all bring opportunities for those interested in the prevention of disease, injury, and premature death for entire communities as well as individual patients.[1,2] It is, in short, a time when public health can come to the fore.

Public health practitioners can assist clinical providers in assuring that newly insured people receive services that promote health and do not simply treat illness. They can help insurers identify the quality measures and incentives that yield better health outcomes and control costs. They can provide evidence of effective interventions that were previously funded by public health grants but can now be brought to scale if paid for by the health care sector. And they can even point to ways to complement traditional health care treatment with community-oriented population health measures.

It is obvious that none of this will come easily. Nonetheless, at this moment—unprecedented in the careers of most public health practitioners, and of uncertain duration—it is critically important to try.

Public health practitioners need to be on the lookout for the circumstances in which their expertise may be of value—such as those created by the Center for Medicare & Medicaid Innovation's State Innovation Model grants or its Accountable Health Communities initiative. Once the potential opportunities are identified, the next step is to get to the table where the discussions occur. But even more important, once public health practitioners get a seat, they must be prepared to make a positive contribution. That requires familiarity with and sensitivity to the needs, concerns, and goals of clinical providers and the insurance industry—and readiness to offer concrete and specific suggestions that fit the occasion. Awareness of all these factors, however, is complicated by the multiple interpretations of prevention (primary, secondary, tertiary) and varying definitions of population health (a patient panel, a payer's covered lives, a total community).[3]

Rather than choosing between one approach and another, the Centers for Disease Control and Prevention (CDC) has developed a conceptual population health and prevention framework with 3 categories—or as we have come to call them, "buckets"—of prevention (Figure). Each one will be needed to yield the most promising results for a population, regardless of whether the population is defined narrowly, as, for example, the patients in a medical practice, or broadly, as, for example, the residents of a state. This 3-part framework may be particularly useful as a way of maximizing the likelihood that clinicians, insurers, and public health practitioners attend to traditional office-based as well as innovative clinical approaches and do not neglect the community factors that have an enormous impact on health.

What Are These 3 Buckets?

Traditional clinical preventive interventions

These approaches involve the care provided by physicians and nurses in a doctor's office during a routine one-to-one encounter. They have a strong evidence base for efficacy in health improvement and/or cost-effectiveness. Examples include seasonal flu vaccines, colonoscopies, and screening for obesity and tobacco use. While such traditional clinical preventive interventions have historically been reimbursed by

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The findings and conclusions in this commentary are those of the author and do not necessarily represent the views of the Centers for Disease Control and Prevention/the Agency for Toxic Substances and Disease Registry.

The author declares no conflicts of interest.

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FIGURE ● **Three Buckets of Prevention**

insurers, and many are now even mandated for most plans by the Affordable Care Act without cost sharing, there is often room for improvement in their promotion and rate of adoption. Improvement can be achieved by various action steps by insurers (eg, increasing the weight with which various preventive interventions are financially incentivized as quality measures), by clinical practices (eg, carefully monitoring that each clinician in the practice provides them), and by public health practitioners (eg, designing social marketing aimed at the public and/or clinical providers and promoting best practices).[4,5]

A new effort that focuses on the patient-oriented buckets—the first 2 in this list—is the CDC's *6|18 Initiative*, which is designed to promote the adoption of evidence-based interventions by health care purchasers and payers (www.cdc.gov/sixeighteen). The name comes from the initial focus on *6* high-burden health conditions and *18* evidence-based interventions that can improve health and/or save money in a relatively short time period. The CDC has tapped subject matter expertise within the agency and culled public health and clinical research to pinpoint those clinical preventive approaches that offer some of the clearest and strongest evidence of effectiveness. For example, the *6|18 Initiative* proposes the elimination of cost sharing for medications to treat hypertension and cholesterol and for tobacco cessation drugs, since, as research points out, even low co-pay charges for such drugs discourage many patients from taking them.[6-9] It also highlights the benefits of comprehensive reproductive care by including information about long-acting reversible contraception, which has proven to be highly effective in preventing unintended pregnancies.[10-12]

Innovative preventive interventions that extend care outside the clinical setting

The approaches in bucket 2 are, like the approaches in bucket 1, clinical in nature and patient-focused. But they include interventions that have not been historically paid for by fee-for-service insurance and occur outside of a doctor's office setting—interventions that have nonetheless been proven to work in a relatively short time.[13] Several have been piloted within the public health sector with grants from governmental agencies and foundations.

An example of a bucket 2 approach grew out of epidemiologic analysis by the Camden Coalition of Health Providers in New Jersey. By geocoding Camden health data, Camden Coalition staff identified a disproportionate number of symptomatic asthmatic patients living in 2 buildings. In response, they designed home-based approaches to identify and reduce environmental triggers and provide customized, home-based preventive educational counseling.[14-16]

The *6|18 Initiative* has identified a number of the interventions in this bucket as well. For example, it has summarized the evidence for the use of community health workers to provide Camden-like home-based education and trigger remediation for the families of children with moderate to severe asthma.[17-20] In addition, it highlights the benefits of the use of the well-established CDC National Diabetes Prevention Program and its multisession, community-based, behavioral change interventions to prevent or reduce the symptoms associated with diabetes.[21-23] Both of these are examples of extending care for individuals from the clinical setting to the community.

Total population or community-wide interventions

With bucket 3, the focus shifts. It includes interventions that are no longer oriented to a single patient or all of the patients within a practice or even all patients covered by a certain insurer. Rather, the target is an entire population or subpopulation usually identified by a geographic area. Interventions are based not in the doctor's office but in such settings as a neighborhood, city, county or state.[3] This bucket is the one that is most unfamiliar to the clinical sector but quite comfortable to the public health sector.

While public health has significant experience with such total population approaches, not all of them have a proven and strong evidence base. Interventions may be associated with, say, promoting a healthy behavior or preventing an unhealthy one—although research to confirm the impact may not have been conducted. In some total population interventions, the impact is shown to occur over the course of many years or even a generation. Such interventions may be a lower priority to insurers and stakeholders who are focused on a short-term return on investment. The longstanding Guide to Community Preventive Services (Community Guide) offers clear direction on which approaches have the strongest track records.

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Nonetheless, some total population interventions do have a strong evidence base regarding improved health and/or cost within a relatively short time. For example, cigarette taxes, smoking ban regulations or laws, and well-designed advertising campaigns have each been shown to have a rapid impact on reduced cigarette use.[24] And a reduction in cigarette use has been associated with a statistically significant decline in serious health consequences within 18 months.[25] There is also evidence that community-wide, multifactorial, coordinated efforts to promote healthful eating and increased physical activity have resulted in a decline in the childhood risk for obesity within a few years.[26] Similarly, housing policies that reduce environmental triggers have been shown to reduce active asthma symptoms and health services utilization within a few years.[20,27]

Clearly, pilots are needed to prove the feasibility of financial incentives for clinicians for the promotion of total population health interventions. Some initial efforts are under way to link global payments to improvement in specific health indicators in community populations.[3] States such as Vermont and Oregon are considering total population health measures in their delivery system reform plans. The larger the market share of a clinical provider, the more likely that a community-wide intervention will be seen as being in its financial interest.

In addition to its *6|18 Initiative,* CDC has also created the Community Health Improvement Navigator Web site (www.cdc.gov/CHInav), with information and resources that illustrate how the clinical sector can support evidence-based approaches with the targeted and strategic use of community benefits by nonprofit hospitals. Other tools in development will summarize the evidence for total population intervention.

Coordinated multisector initiatives that promote all 3 buckets simultaneously may result in the largest gains. One example of this occurred in Massachusetts after it implemented its health care reform initiative in 2007. The state expanded its cost-free insurance Medicaid coverage for tobacco cessation medications, linked patients to counselors on a Quitline, and promoted the increased accessibility and overall benefit of tobacco cessation interventions in public information campaigns. When work in each bucket was focused on a single goal, smoking rates plummeted.[28-30]

Summary

In summary, this is a critical moment in health system transformation in America. Change of this magnitude may not occur again in our lifetimes. Full participation of public health practitioners in the process will help achieve the goal of ensuring access to high-quality and effective clinical preventive services, both traditional and innovative, while at the same time working upstream to promote health and wellness in community settings. Public health practitioners should have at their fingertips specific, evidence-based, prevention-related proposals that fit multiple settings—from the doctor's office to the insurer's conference room to the neighborhood meeting to the state house.[2]

An optimal strategy is one in which prevention approaches span the 3 buckets—traditional and innovative clinical preventive as well as total population interventions.[2,31,32] Each bucket requires its own prioritized interventions and funding sources.[13] At some "tables" and in some settings, only 1 of the 3 buckets may be of interest to the participants. Public health professionals add value when they stand ready to adapt their proposals to fit the opportunity at hand. But ultimately, a holistic preventive strategy requires a focus on all 3 buckets delivered in a thoughtful and coordinated manner—taking advantage of the greatly expanded possibilities that stand before the public health community.[2,5,13]

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Attachment 5b - Sample Change Packets

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Clinical & Community Strategies to Improve Adolescent Well-Care Visits

The following table highlights evidence-based strategies to improve adolescent well-care visit rates in clinical and community settings.

ACO Measure: Core-2 (NCQA HEDIS): Adolescent Well-Care Visit (AWCV)
The percentage of attributed individuals 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
• Increase insurance access ▫ Promote use of *Vermont Health Connect* resources including website, phone number, and local navigators, brokers, and certified application counselors ▫ Assist adolescents and families to understand insurance benefits and address perceived barriers to care (e.g., AWCV frequency, EOB descriptions, etc.) • Adopt current *Bright Futures* guidelines for health supervision ▫ Adopt *Bright Futures* core tools (i.e. pre-visit questionnaires, documentation, education handouts) ▫ Educate families and adolescents on annual AWCV recommendation (including guidelines outlined in the periodicity schedule) and the benefits of these visits ▫ Adopt evidence-based screening tools ▫ Ensure all practice staff are aware of annual recommendations (including systems for scheduling and reminder-recall) • Provide adolescent-centered and informed care ▫ Ensure the physical space is welcoming and age-appropriate for adolescents ▫ Provide training and tools to ensure all practitioners are adolescent-friendly ▫ Use or create adolescent-friendly materials; test materials with adolescents	• Utilize mobile devices, e-mail, and social networking sites to promote prevention education and services; new media vehicles offer low-cost avenues to develop and distribute tailored health care messages ▫ Use social networking to reach adolescents and caregivers ▫ Use texting to reach adolescents and caregivers • Develop partnerships with key community stakeholders ▫ Work with school-based and community health centers ▫ Work with partners to explore alternate funding sources ▫ Partner with Title V (maternal and child health) agencies ▫ Engage key community stakeholders ▫ Pediatric and Family practice providers can establish relationships to assist with transition of care from adolescence into young adulthood ▫ Partner with the Health Department/	• Make state-adopted periodicity schedules well known to all clinical and community providers *(Bright Futures is Vermont's EPSDT periodicity schedule)* • Educate families and adolescents on annual AWCV recommendation (including guidelines outlined in the periodicity schedule) and the benefits of these visits

Revised 11/30/15

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
▫ Consider strategies to ensure continuity of provider care (i.e. adolescents seeing the same provider annually) ▫ Address potential concerns for adolescents and parents/caregivers related to confidentiality and EOB/ billing issues ▫ Communicate the confidential nature of visits to adolescents and parents/caregivers, and ensure private consultation time with their patients ▫ Consider expanded or tailored office hours that fit with adolescent demands (i.e. school, sports, and work) and lifestyle ▫ Hold specific slots for AWCVs ▫ Consider ways to evaluate satisfaction with care, privacy and confidentiality • Improve quality of adolescent care ▫ Ensure providers are well-trained to understand adolescent needs ▫ Ensure providers and office staff are aware of the *Bright Futures* guidelines ▫ Adopt the use of a strengths-based approach as described in *Bright Futures* • Leverage missed opportunities to increase well-care visits ▫ Maximize patient encounter opportunities by ensuring that AWCVs are scheduled: episodic, acute care, sports physicals, contraceptive counseling, sexual health services, immunizations, etc. ▫ Motivate adolescents to make and keep AWCV appointments ▫ Inform caregivers on the importance of AWCVs	Office of Local Health designees and leadership ▫ Review local Youth Risk Behavior Survey data ▫ Partner with School Nurses to ensure all students are receiving AWCVs, and improve communication between schools and provider offices ▫ Partner with supervisory union or school district's *Whole School, Whole Community, Whole Child* wellness teams	

Resources

Bright Futures Guidelines: brightfutures.aap.org/Pages/default.aspx
Paving the Road to Good Health Strategies for Increasing Medicaid Adolescent Well-Care Visits
medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Paving-the-Road-to-Good-Health.pdf
National Adolescent and Young Adult Health Information Center: http://nahic.ucsf.edu/

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Clinical & Community Strategies to Improve Adult Hypertension Control

The following table highlights evidence-based strategies to improve adult hypertension control rates in clinical and community settings.

<u>ACO Measure</u>: Core-39: Controlling High Blood Pressure

Screen for hypertension (HTN) in adults 18 years or older. Patients with a blood pressure reading of 140/90 or higher should be offered multicomponent education, behavioral interventions, and take-home resources to reduce and maintain blood pressure control.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies

• Implement a **standardized hypertension (HTN) treatment protocol** using an evidence-based protocol – see HTN protocol examples and templates at Million Hearts[i]
 	
• Screen all adults for blood pressure
  o Calculate Blood Pressure using accurate blood pressure measurement technique such as the technique recommended by the American Heart Association[ii]
  o Create a blood pressure measurement station where all patients can rest quietly for 5 minutes before measurement and that is designed to support proper measurement techniques (e.g., feet on floor, proper arm position, multiple cuff sizes conveniently located).
 	
• Use motivational interviewing to discuss Blood Pressure findings with patients
  o For patients with blood pressure readings over 140/90, offer multicomponent behavioral interventions include the following components:
	• Motivational Interviewing: (http://motivationalinterviewing.org/) Providers should be trained in these techniques to best assist patients.
	
	• Community-based Chronic Disease Self-management programs: (http://myhealthyvt.org/)
	  o Healthier Living Workshop: Chronic Disease – problem solving and action planning; Nutrition; exercise; medication use; emotions; talking with doctors
	
	• Use of Community Pharmacists and pharmacy locations to promote self-measured blood pressure and provide patient support
	
	• Use of Community Health Workers to provide culturally and socially relevant support and clinical referrals to community members
	  o Social support interventions in communities: Weight Watchers; Curves; TOPS (Taking off Pounds Sensibly)
	
	• Fruit and vegetable prescriptions
		• Blood Pressure Monitors placed in community wide locations such as libraries, schools, grocery stores, etc.
		• Create or enhance access to healthy eating and physical activity.
		• Increase sidewalks, bike paths, farmers markets, community gardens
		• Provide incentives to food retailers to locate in underserved areas and to offer healthier food and beverage choices
		• Employer supported interventions:
		  o health insurance coverage with no or low out-of-pocket costs for medications or home blood pressure monitoring devices

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
▪ Behavioral management activities, such as setting weight-loss goals ▪ Improving diet or nutrition and increasing physical activity ▪ Blood Pressure Self-monitoring (SM) techniques using resources such as the Million Hearts self-measured BP video[iii] ▪ Strategizing about how to maintain a lifestyle change • For patients taking hypertension medications, discuss the medication(s) they are taking to ensure they understand how and when to take the medication o Encourage use of medication Adherence tools such as pillboxes and mobile apps to increase medication compliance[iv] • Provide patients with information, resources, and tools to increase patient engagement. Patient tools available at Million Hearts include:[v] o Blood pressure journal o Blood pressure wallet card o Medication infographic o Factsheet for HTN control goals o Links to self-monitored BP technique	o Encourages patients to eat more fruits and vegetables. Park prescriptions o Encourages patients to be more physically active. See http://vermontfitness.org/exercise-is-medicine/ for more information. • Gym memberships o Ladies First provides funding for lifestyle programs and gym memberships to women meeting income thresholds http://healthvermont.gov/prevent/ladies_first.aspx • Health coaching o Health coaching continues the conversation with patients to encourage taking next steps on healthy eating and increasing physical activity. • Tobacco Cessation: 802 Quits o Vermont Quit Partners – participants meet once a week o Vermont Quit Line: help by phone: 1-800-QUIT-NOW o Online Quit Help	o Increased healthy eating and physical activity options at worksites o Worksite gardens o Onsite blood pressure monitor stations o Flex time for physical activity o Healthy food incentives (Smoothie day, veggie platter) o Encourage increased availability of healthy foods and beverages at public service venues and in vending machines o Aim for at least 30% healthy items in vending machines o Include healthy choices at snack bars, cafeterias and events.

Resources:
US Preventive Services Task Force: http://www.uspreventiveservicestaskforce.org;
The Community Guide to Preventive Services: http://www.thecommunityguide.org/index.html
Million Hearts Initiative: http://millionhearts.hhs.gov/

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[i] http://millionhearts.hhs.gov/tools-protocols/protocols.html;
[ii] http://hyper.ahajournals.org/content/45/1/142.full
[iii] http://millionhearts.hhs.gov/tools-protocols/tools.html
[iv] http://millionhearts.hhs.gov/files/TipSheet_HCP_MedAdherence.pdf
[v] http://millionhearts.hhs.gov/tools-protocols/tools.html

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Clinical & Community Strategies to Improve Adult Type 2 Diabetes Control

The following table highlights evidence-based strategies to reduce poor A1C control in clinical and community settings.

ACO Measure: Core-17: Diabetes Mellitus: Hemoglobin A1C Poor Control >9%

A1C testing is recommended quarterly for adults who do not meet treatment goals. Performance measures apply to adults 18 – 75 years of age. Patients with an A1C greater than 9 percent should be offered multicomponent interventions to improve blood glucose control.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
• Implement a standardized diabetes treatment protocol using evidence-based clinical practice recommendations – Diabetes Care Clinical Practice Recommendations[i] • Diabetes self-management education/support (DSME/S), medical nutrition therapy (MNT), counseling on smoking cessation, education on physical activity, guidance on routine immunizations, and psychosocial care are the critical components of diabetes management • Use motivational interviewing techniques to discuss behavior change goals and action plans o For patients with A1C greater than 9 percent offer multicomponent behavioral interventions include the following: ▪ Achieving a realistic body weight ▪ Improving nutrition and increasing physical activity ▪ Achieving blood pressure control ▪ Scoring diabetes distress[ii] and reducing it ▪ Treating depression ▪ Establishing realistic priorities for lifestyle improvement ▪ Adjusting diabetes medications ▪ Adjusting plans for self-monitoring of blood glucose	• Motivational Interviewing: (http://motivationalinterviewing.org/) Providers should be trained in these techniques to best assist patients • Community-based diabetes self-management programs: (http://myhealthyvt.org/) o Healthier Living Workshop – Diabetes for problem solving and action planning; healthy eating; exercise; monitoring blood sugar; managing stress; using good foot care; and handling sick days • Use of Diabetes Self-Management Education (DSME) Programs provided by Certified Diabetes Educators in the local health service areas • Use of Registered Dietitians who provide medical nutrition therapy (MNT) available through the local Community Health Teams • Consumer-based support groups • Park prescriptions o Encourages patients to be more physically active. See http://vermontfitness.org/exercise-is-medicine/ for more information	• Community-based YMCA's Diabetes Prevention Program to reduce diabetes risk • Create or enhance access to healthy eating and physical activity • Increase sidewalks, bike paths, farmers markets, community gardens • Provide incentives to food retailers to locate in underserved areas and to offer healthier food and beverage choices • Employer supported interventions: o health insurance coverage with no or low out-of-pocket costs for medications and supplies for self-monitoring of blood glucose o Increased healthy eating and physical

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies

• For self-management support
  o Encourage use of patient portals, community-based programs and services, consumer support groups
• Provide patients with information and resources available in the local health service areas and statewide including
  o Learning to Live Well with Diabetes
  o Single Page Guide For Diabetes Care
  o DASH Eating Plan
  o A1C…what's Your Number?
	• Gym memberships
	  o Programs such as Ladies First provide funding for lifestyle improvement and gym memberships to women meeting income thresholds http://healthvermont.gov/prevent/ladies_first.aspx
	• Health coaching
	  o Health coaching continues the conversation with patients to encourage taking next steps in achieving healthy behaviors
	• Tobacco Cessation: 802 Quits
	  o Vermont Quit Partners – participants meet once a week
	  o Vermont Quit Line: help by phone: 1-800-QUIT-NOW
	  o Online Quit Help
		activity options at worksites, e.g. Worksite gardens
		o Flex time for physical activity
		o Healthy food incentives (Smoothie day, veggie platter)
		o Encourage increased availability of healthy foods and beverages at public service venues, work meetings, and in vending machines
		o Aim for at least 30% healthy items in vending machines
		o Include healthy choices at snack bars, cafeterias and events

Additional Resources: **3/30/16**

Centers for Disease Control and Prevention, Diabetes: http://www.cdc.gov/diabetes/home/
NIH Diabetes HealthSense: http://ndep.nih.gov/resources/diabetes-healthsense/
American Diabetes Association: http://www.diabetes.org/
Vermont Department of Health Diabetes Prevention and Control: http://www.healthvermont.gov/prevent/diabetes/diabetes.aspx

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[i] http://care.diabetesjournals.org/site/misc/2016-Standards-of-Care.pdf
[ii] http://www.diabetesed.net/page/_files/diabetes-distress.pdf

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Clinical & Community Strategies to Improve Adult BMI Screening and Follow Up

The following table highlights evidence-based strategies to improve adult BMI screening rates and follow up in clinical and community settings.

<u>ACO Measure</u>: Core-20: Adult Weight Screening and Follow-Up
Screen for obesity in adults 18 years or older. Patients with body mass index (BMI) of 30 or higher should be offered or referred to intensive, multicomponent behavioral interventions. Those with BMI of 25-30 should also be referred for nutrition and physical activity interventions.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
• Screening all adults for overweight or obesity. o Calculate BMI using BMI calculator (available online) o Use motivational interviewing to discuss BMI findings with patient o For obese patients: Intensive, multicomponent behavioral interventions include the following components: ▪ Behavioral management activities, such as setting weight-loss goals ▪ Improving diet or nutrition and increasing physical activity ▪ Addressing barriers to change ▪ Self-monitoring ▪ Strategizing about how to maintain a lifestyle change o For overweight patients: Learn about current diet and physical activity patterns and counsel on changes to encourage weight loss. ▪ Nutrition Counseling ✓ Increase the percentage that eat the daily recommended servings of	• Motivational Interviewing (http://motivationalinterviewing.org/) Providers should be trained in these techniques to best assist patients. • Community-based Chronic Disease Self-management programs (http://myhealthyvt.org/) o YMCA's Diabetes Prevention Program, an evidence-based program, assists patients diagnosed as pre-diabetic with supported weight loss and physical activity. • Technology-supported multicomponent coaching or counseling interventions intended to reduce weight (http://www.thecommunityguide.org/obesity/TechnologicalCoaching.html) • Social support interventions in community settings. o Weight Watchers o Curves o TOPS (Taking off Pounds Sensibly) • Fruit and vegetable prescriptions o Encourages patients to eat more fruits	• Create or enhance access to healthy eating and physical activity. o Increase sidewalks, bike paths, farmers markets, community gardens • Provide incentives to food retailers to locate in underserved areas and to offer healthier food and beverage choices • Promote increased healthy eating and physical activity options at worksites o Worksite gardens o Flex time for physical activity o Healthy food incentives (Smoothie day, veggie platter) • Encourage increased

Revised 2/4/16

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
fruits and vegetables. ▪ Screening for physical activity habits and counseling to maintain or improve habits ✓ Increase the percentage that meet the recommendations for adult physical activity. o For patients at a healthy weight: Learn about current diet and physical activity patterns and encourage continuation.	and vegetables. • Park prescriptions o Encourages patients to be more physically active. See http://vermontfitness.org/exercise-is-medicine/ for more information. • Gym memberships o Ladies First provides funding for lifestyle programs and gym memberships to women meeting income thresholds http://healthvermont.gov/prevent/ladies_first.aspx • Health coaching o Health coaching continues the conversation with patients to encourage taking next steps on healthy eating and increasing physical activity.	availability of healthy foods and beverages at public service venues and in vending machines o Aim for at least 30% healthy items in vending machines o Include healthy choices at snack bars, cafeterias and events.

Resources

US Preventive Services Task Force: http://www.uspreventiveservicestaskforce.org
The Community Guide to Preventive Services: http://www.thecommunityguide.org/index.html

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Strategies to Improve Developmental Screening Rates

The following table highlights evidence-based strategies and best practices to improve developmental screening rates in clinical and community settings.

ACO Measure: Core-8 (NCQA HEDIS): Developmental Screening in the First Three Years of Life
The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life, that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Strategies
Patient education & tools • Adopt *Bright Futures* (i.e. pre-visit questionnaires, documentation, education handouts) • Educate families on developmental milestones • Establish a multidisciplinary team within your practice to implement universal developmental screening **Validated screening tool and protocol** • Review and identify a primary structured, validated developmental screening tool • Implement structured developmental screening using a validated tool at the 9, 18 and 30 month well visits • Implement developmental screening at other visits **Training and roles** • Ensure practitioners and staff are trained on accurate administration of screening tool • Identify and assign roles/responsibilities across the practice	**Parent/Family resources** • Increase parental education on early child development • Provide parents/caregivers with 2-1-1-phone number and encourage outreach to *Help Me Grow* (HMG) • Provide informational materials customized for specific audiences to increase knowledge of HMG resources • Provide information on community-based resources and education in support of early childhood development (e.g. parenting classes, library services) **Partnership building/referral resources** • Promote educational resources and materials with providers and partners (e.g. *Bright Futures*, Learn the Signs Act Early) • Outreach to community stakeholders (e.g. early care and education providers, CIS, schools) • Identify appropriate referral resources and capacity	**Help Me Grow** • Enhance utilization of *Help Me Grow* (HMG) by providers, families, and community resources • Collect feedback from HMG community stakeholders and families to improve service delivery **Quality improvement** • Integrate QI activities in support of universal developmental screening (i.e. medical home, early care and education, Unified Community Collaboratives) • Connect providers (medical home and early care and education) to VCHIP-supported quality improvement activities • Spread VCHIP's early care and education learning collaboratives by adding new regions each year **Improvements to the system of care** • Strengthen referral and evaluation systems at the community-level • Build relationships to improve communication and collaboration around referrals • Conduct a community-level gap analysis and needs assessment to identify levers to enhance the system of care

Revised 12/9/15

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Strategies
• Consider strategies to ensure continuity of practitioner care (i.e. children seeing the same practitioner for well care) **Documentation and tracking** • Determine where screening results will be documented • Identify all children eligible for screening • Track current developmental screening rates • Develop recall/reminder systems to ensure timely screening • Use a tool (e.g. EHR report, paper log) to track children in need of screening **Referrals** • Identify children in need of evaluation and/or referral • Initiate referrals and track progress until completion • Ensure receipt of evaluation/referral reports **Quality improvement** • Create a process flow map to identify barriers to screening	• Maintain an up-to-date list of referral resources • Track referrals, timeliness, and outcomes **Care planning** • Develop and/or contribute to patient's individual care plan • Ensure individual care plans are routinely implemented and updated	• Convene stakeholders as needed to ensure consistency of services and plan for future innovations **Provider education and training** • Continue collaboration among AHS (VDH, AOE), VCHIP, VB5, LAUNCH to support provider education and training **Developmental screening registry** • Implement broad use of developmental screening registry (i.e. medical homes, early care and education, CIS) • Identify a training plan and roll-out for the implementation of the registry • Mitigate barriers to utilization of the registry • Disseminate population-level registry reports to inform community-wide decision making • Develop processes to import data from EHRs electronically into the registry • Revise and refine population-level data reports to maximize relevance for specific audiences **Health reform** • Coordinate Universal Developmental Screening activities with Vermont's ACOs and the Blueprint to leverage health reform and enhanced payment opportunities • Engage health reform stakeholders in use of registry data and in planning enhancements

Resources

Bright Futures Guidelines: brightfutures.aap.org/Pages/default.aspx
Vermont's System for Universal Developmental Screening (Birth – 8 Years): uvm.edu/medicine/vchip/documents/UDSLinks_000.pdf
Help Me Grow: helpmegrownational.org/ and cdn.buildingbrightfutures.org/wp-content/uploads/2015/01/Final-Fast-Facts-Help-Me-Grow4.pdf