Prevention and Wellness Advisory Board

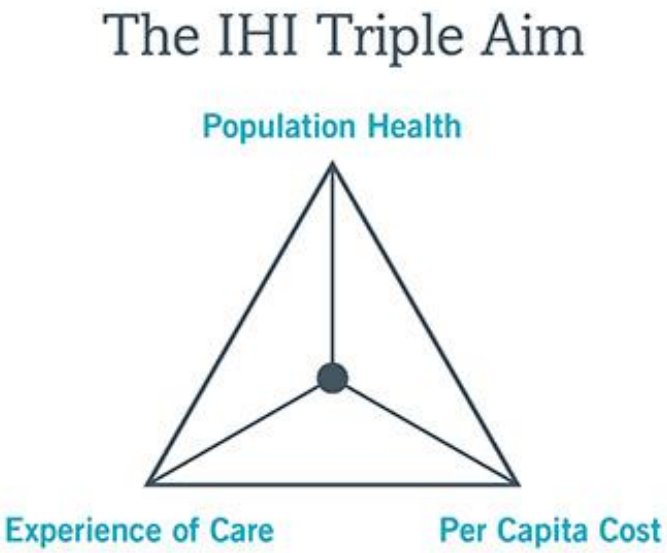
October 2, 2014

Grantee Update

Laura Coe, MPH, CPHQ
PWTF, QI Coach

PWTF Overarching Program Goals

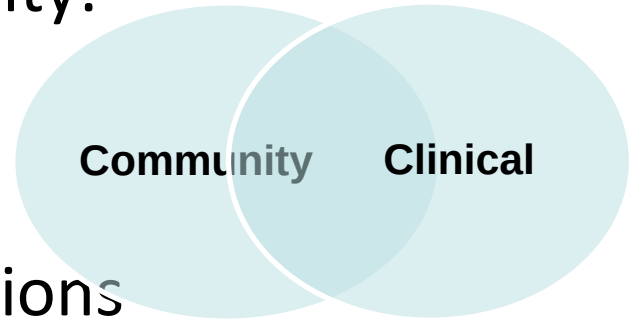
- Improved health
- Cost containment
- Focus on prevention
- Systems change
- Integration of clinical and community interventions



- PWTF goals align with national healthcare Triple Aim goals

Key Components of the Program Model

- Selected priority conditions based on associated interventions with 3 to 5 year ROI
- Integration of clinical and community:
  - Bringing partners together
  - Integrating care and management



- Promote evidence-based interventions
- Collaborative model for shared learning
- Data Driven Quality Improvement approach
- All grantees required to use bi-directional e-Referral
- Sustainability

Program Implementation: A Cohort-based Approach

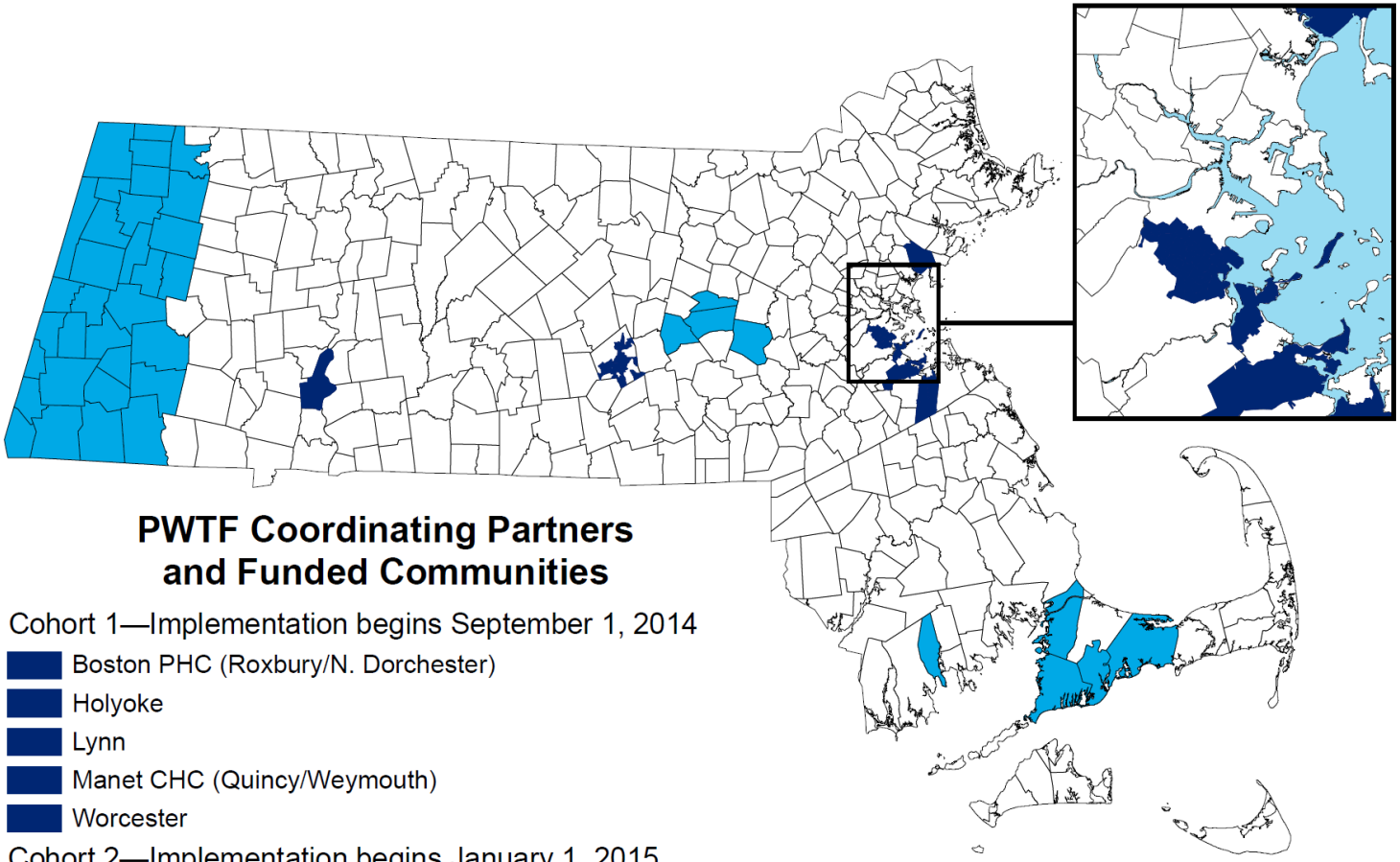
Cohort 1:

- Boston Public Health Commission
- Healthy Holyoke
- Lynn
- Quincy / Weymouth
- Worcester

Cohort 2:

- Barnstable
- Berkshire
- MetroWest
- New Bedford

Partnership Distribution



PWTF Coordinating Partners and Funded Communities

Cohort 1—Implementation begins September 1, 2014

- Boston PHC (Roxbury/N. Dorchester)
- Holyoke
- Lynn
- Manet CHC (Quincy/Weymouth)
- Worcester

Cohort 2—Implementation begins January 1, 2015

- Barnstable (Barnstable, Mashpee, Falmouth, Bourne)
- Berkshire (all of Berkshire County)
- Hudson (Framingham, Hudson, Marlborough, Northborough)
- New Bedford

Focus on Health Conditions that Yield Positive ROI *within 3-5 years*

Priority Conditions (2 of 4 are required, at minimum)	**Optional Conditions (Not Required)**	**Other Conditions (not specified)**
Tobacco use Asthma (pediatric) Hypertension Falls among older adults	Obesity Diabetes Oral health Substance use	Proposed by applicant

Vulnerable Populations and Co-Morbid Mental Health Conditions

Plans to address the conditions listed above should also include specific strategies to reduce disparities in the burden of these conditions (e.g., racial and ethnic disparities). Behavioral health conditions, such as depression, may be viewed as co-morbid to any of the above. Interventions may be proposed and tailored for populations affected by behavioral health conditions.

Health Conditions to be Addressed

Coordinating Partner	Tobacco	Hypertension	Pediatric Asthma	Falls in Older Adults	Other Conditions
Cohort 1					
Holyoke	✓	✓	✓		Obesity, Oral Health
Worcester		✓	✓	✓	
BPHC		✓	✓	✓	
Lynn	✓	✓	✓	✓	
Quincy/Weymouth	✓	✓		✓	Substance Use
Cohort 2					
Barnstable		✓		✓	Diabetes
New Bedford			✓	✓	Substance Use
MetroWest	✓	✓	✓	✓	
Berkshire	✓	✓		✓	Diabetes

Tiered Approach to Interventions

Tier 1

- Straightforward access to data
- Strong evidence base for clinical impact
- **High likelihood of producing Return on Investment (ROI)**

Tier 2

- Available data sources
- Inconsistent or emerging evidence base
- **Low to moderate likelihood of producing ROI**

Tier 3

- No PWTF evaluation and little technical assistance
- Minimal budget

Tier 1 Interventions

Condition	Clinical and Community Interventions
Tobacco	• Implement USPSTF Recommendations for Tobacco Use Screening and Treatment (5) • Tobacco Cessation Counseling (3)
Pediatric Asthma	• Care Management for High-Risk Asthma Patients (3) • Home-Based Multi-Trigger, Multi-Component Intervention (5)
Falls	• Comprehensive Clinical Multi-Factorial Fall Risk Assessment (7) • Home Safety Assessment and Modification for Falls Prevention (4)
Hypertension	• Evidence-based guidelines for hypertension screening (8) • Chronic Disease Self-Management Programs (5)

PWTF TA Framework

Resources and Tools

- Templates
- Toolkits by condition

SharePoint

- Overarching program page with resources
- Individual partnership pages

Webinars (monthly)

- Topic specific trainings
- Showcase partnerships with best practices

Weekly e-Newsletter

Individualized TA

QI Plan

QI Model and Components

Model:

- IHI Model for Collaborative Learning
  - Rapid cycle tests of change QI method/PDSA
  - Data driven approach

Components:

- Quarterly Learning Sessions
- Coaching Site Visits
- Individualized 1:1 support
- Access to subject matter experts
- Communities of Practice (CHWs)
- Trainings:
  - Internal: DPH staff on QI topics
  - External: Condition specific (e.g. Accuracy of BP measurement)

Learning Session 2: Highlights

Energized about the collaborative model

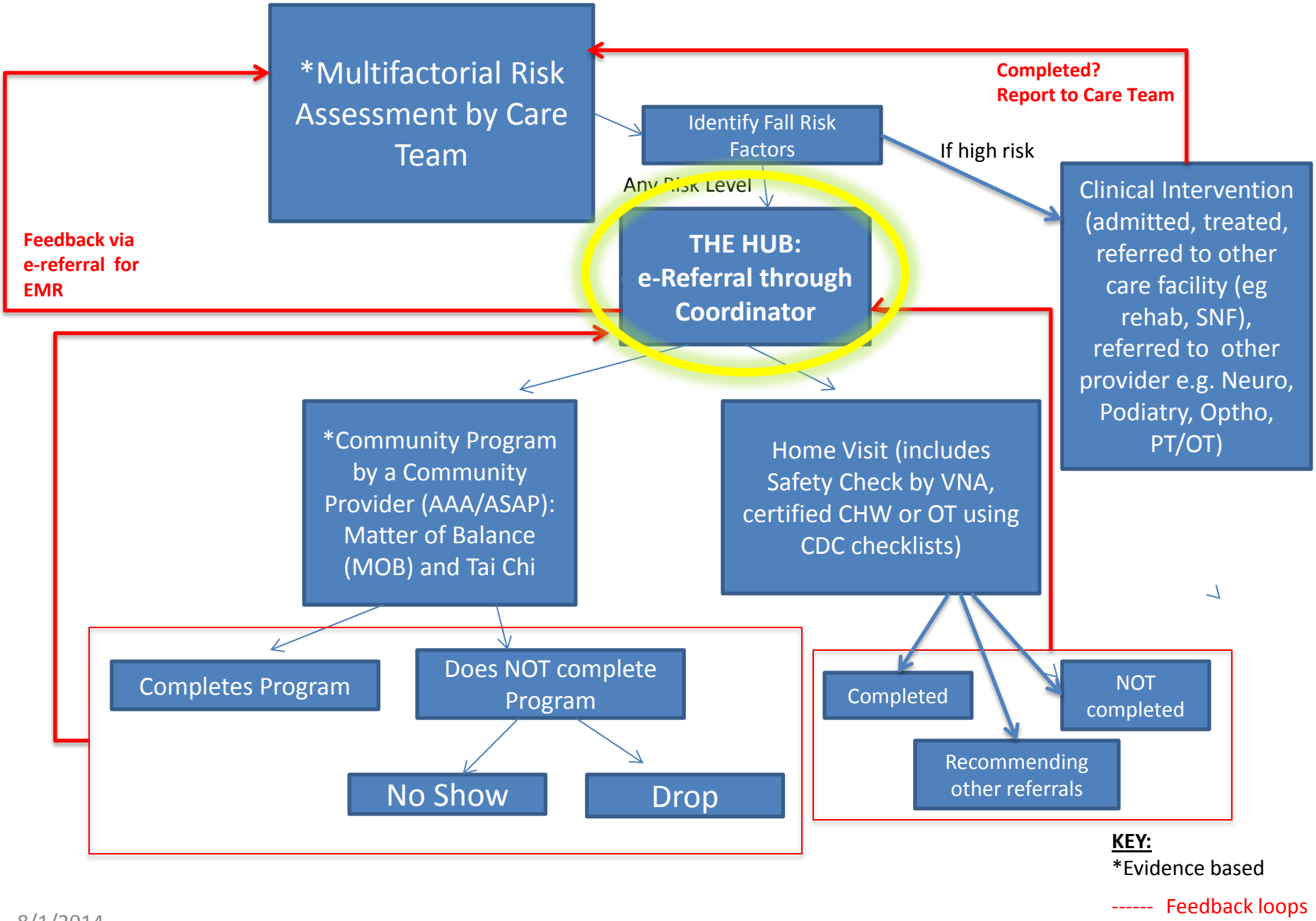
- Sharing with others, hearing where others are at, and getting to network rated highest
- Appreciate being part of diverse collaborative from which they can learn from a variety of perspectives and approaches.

Valued smaller group formats to facilitate discussion

- Found breakout speakers knowledgeable and their content extremely helpful

"You did a wonderful job bringing all the partners together and providing TA to help achieve success. Thank you for making this extra effort"

BPHC PWTF Falls Prevention Phase 2: Implementation



Grantee Highlights: Pediatric Asthma

BPHC:

Working to develop formal linkages with the Boston Public School system to improve pediatric asthma care management.

Worcester:

Using CHWs to identify high risk asthma patients for a Home-Based Multi-Trigger, Multi-Component Intervention and working with the public school system to educate school nurses and parents on pediatric asthma management.

Grantee Highlights: Elder Falls

Quincy and Weymouth:

Working closely with the Departments of Health in Quincy and Weymouth to identify vulnerable populations to ensure they are connected to a medical home for appropriate referrals for falls risk, chronic disease self-management, and behavioral health services.

New Bedford: Piloting a model program to systematize the comprehensive clinical falls risk assessment utilizing a team approach that will be used to develop training for other grantees.

Grantee Highlights: Hypertension

Lynn: Expanding integrated bi-directional referrals and patient management between the Lynn Community Health Center and the Greater Lynn Senior Services.

Berkshire: Expanding a blood pressure cuff program to provide cuffs with patient education to identified patients to promote self-monitoring.

Barnstable: Developed a unique partnership among 3 Community Health Centers linking patients to a formal network of chronic disease self-management programs for hypertension and diabetes.

Grantee Highlights: e-Referral

Holyoke:

High level of engagement and expertise around e-referral and taking steps toward connecting clinical partners (Holyoke Medical Center, Holyoke Health Center, and physician groups) to optimize e-referrals to community partners (e.g. the Y) for interventions.

Grantee Highlights: Integration

MetroWest Partnership:

Developing a model partnership among 4 Boards of Health (Hudson, Framingham, Northborough and Marlborough) to integrate efforts via a shared community calendar for interventions and novel use of CHWs by Boards of Health.

Conclusions

Positives:

- Innovative strategies
- Excited and engaged
- Critical thinking about systems change
- Teams are asking critical questions
- Improving internal processes
- Culture of feedback and trust

Challenges:

- Eagerness to begin implementation
- Building new relationships between clinical and community partners
- DPH capacity building and anticipating needs
- Balancing evidence-base to drive ROI with innovation and expanding the evidence

Balancing Evidence and Innovation

- Evidence-base
- ROI analysis
- Program Fidelity

- Expanding the evidence
- Promoting innovation
- Promoting cost saving strategies