The presentation will begin shortly.

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Building a Culture of Health: The Future Begins Now

Paul Kuehnert, DNP, RN
Director
Bridging Health & Healthcare Portfolio

Six Words

Physical, mental, and emotional well being
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

Margo DeMont, PhD
Community Health Enhancement
mdemont@beaconhealthsystem.org
COMMUNITY HEALTH NEEDS ASSESSMENT

PRIORITY NEEDS IN ST JOSEPH COUNTY

- Diabetes Death Rate
- 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

Number of enrolled participants in the Michiana Family YMCA’s Diabetes Prevention Program

Minutes of increased exercise achieved by YMCA-DPP participants

Percentage of weight loss achieved by YMCA-DPP participants

Diabetes: Medicare Population

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.

- Identify/Enroll Clients; Focus on ER and Inpatient
- Demonstrate Increased Knowledge
- Evidence of Behavioral Changes
- Evidence of Improved Self-Management
### DIABETES PILOT - NUMBER OF ACTIVE CLIENTS

<table>
<thead>
<tr>
<th>REFERRAL SOURCE</th>
<th>Clients</th>
<th>ER</th>
<th>Hospital</th>
<th>Memorial Medical Groups</th>
<th>Self-referral</th>
<th>Other Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL</strong></td>
<td>368</td>
<td>51</td>
<td>42</td>
<td>131</td>
<td>2</td>
<td>142</td>
</tr>
</tbody>
</table>
## FINANCIAL IMPACT
(Medicaid, uninsured and self-pay)
Goal = $500,000

<table>
<thead>
<tr>
<th>Category</th>
<th>Pre</th>
<th>Post</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charity</td>
<td>$137,720</td>
<td>$66,452</td>
<td>($71,269 Reduction in Charity Cost)</td>
</tr>
<tr>
<td>Bad Debt</td>
<td>$88,675</td>
<td>$5,056</td>
<td>($83,619 Reduction in Bad Debt)</td>
</tr>
<tr>
<td>Charges</td>
<td>$1,026,600</td>
<td>$243,464</td>
<td>($783,136 Net Charge Avoidance)</td>
</tr>
</tbody>
</table>

Charges: $1,026,600 (Pre), $243,464 (Post)
**GOAL: DECREASED ER USAGE > 25%**

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

Memorial Hospital of South Bend®

BEACON HEALTH SYSTEM® Care Partner
### GOAL: SELF-MANAGEMENT IMPROVED A1C LEVELS

<table>
<thead>
<tr>
<th>A1C Tests</th>
<th>Active Clients</th>
<th>Low Risk 5.0-6.9</th>
<th>Medium Risk 7.0-8.9</th>
<th>High Risk 9.0+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry Level</td>
<td>n=366</td>
<td>n=96 (26.2%)</td>
<td>n=123 (33.6%)</td>
<td>n=147 (40.2%)</td>
</tr>
<tr>
<td>1st A1C in program</td>
<td>n=264</td>
<td>n=121 (45.8%)</td>
<td>n=97 (36.7%)</td>
<td>n=46 (17.4%)*</td>
</tr>
<tr>
<td>2nd A1C in program</td>
<td>n=154</td>
<td>n=74 (48.1%)</td>
<td>n=57 (37%)</td>
<td>n=23 (14.9%)*</td>
</tr>
<tr>
<td>3rd A1C in program</td>
<td>n=74</td>
<td>n=40 (54.1%)</td>
<td>n=25 (33.8%)</td>
<td>n=9 (12.1%)*</td>
</tr>
</tbody>
</table>

* *p = < .001
“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
# Diabetes Pilot Tithing 12/31/2013

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>3,948</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Labor</td>
<td>479,358</td>
<td>547,774</td>
<td>10.0</td>
</tr>
<tr>
<td>Non-Labor</td>
<td>53,427</td>
<td>64,989</td>
<td></td>
</tr>
<tr>
<td>Total Expenses</td>
<td>532,785</td>
<td>612,763</td>
<td></td>
</tr>
</tbody>
</table>

Net Contribution      (528,837)       (612,763)

ER Cost Avoidance:

<table>
<thead>
<tr>
<th></th>
<th>Pre-Intervention Charges</th>
<th>Post Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Patients</td>
<td>$1,373,447</td>
<td>$295,460</td>
</tr>
</tbody>
</table>

-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
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
- > 4 Risk Factors

Medium Risk
- 3 – 4 Risk Factors

Low Risk
- 0 – 2 Risk Factors

HIGH Risk
- 37.5% moved down from high to medium
- 8.6% moved down from high to low
- 15.8% moved up from medium to high
- 20.9% moved up from low to high
- 3.1% moved up from low to high
- 30.3% moved down from medium to low

LOW Risk
- 20.9% moved up from low to medium
PO 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

<table>
<thead>
<tr>
<th>Category</th>
<th>Points</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRA</td>
<td>50</td>
<td>5%</td>
</tr>
<tr>
<td>Biometrics</td>
<td>600</td>
<td>60%</td>
</tr>
<tr>
<td>Behaviors</td>
<td>350</td>
<td>35%</td>
</tr>
</tbody>
</table>

INCENTIVE STRUCTURE

<table>
<thead>
<tr>
<th>Points Range</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 399</td>
<td>25%</td>
</tr>
<tr>
<td>400 – 799</td>
<td>20%</td>
</tr>
<tr>
<td>800 – 1000</td>
<td>15%</td>
</tr>
</tbody>
</table>
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
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.
Identifying a Shared Vision for Community Health

We have a vision of being the healthiest city and region in New England by 2020.

The healthiest you in the healthiest city in the healthiest region.

#Healthy2020
www.healthycentralma.com
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 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

YouthConnect Worcester

www.youthconnectworcester.org

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.

Common Outcomes for Youth

- Increase the High School Graduation Rate for at-risk youth
- Reduce the childhood obesity rate
- Reduce the child poverty rate

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
- Compass Network – Homebase youth network
- EHR 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
- 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
- Racism addressed specifically and intentionally in staff development
- Shared anti-racist values influence program development and implementation

Overarching and embedded values and purposeful activities

Convene leaders to develop youth-friendly transportation

Develop a collective web presence

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

Year-round youth development access for at-risk youth

Trust, learn from, share with and support each other

Engage supporting partners to fill gaps

Collaborate for funding and resource development

Youth move freely between partners

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.
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
Questions & Answers
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