Objectives

• Learn what the Quadruple AIM is and why it is important
• Discuss the role of MOWS in the Expanded Chronic Care Model
• Learning how to make the value proposition to Healthcare providers and hospitals
• Learn strategies to engage healthcare providers, payers and community members to utilize MOWS services
Environmental Scan

Quadruple Aim
Public Policy Framework for Improving Population Health: What Really Drives Health Outcomes?

- Genes and Biology, 10%
- Physical Environment, 10%
- Clinical Care, 10%
- Health Behaviors, 30%
- Social and Economic Factors, 40%


Healthcare Transformation has Begun
Healthcare’s Blind Side

- 2011 RWJF survey of 1,000 primary care physicians
  - 85%: Social needs directly contribute to poor health
  - 4/5 not confident can meet social needs, hurting their ability to quality care
  - 85% of physicians say patients’ social needs are as important to address as their medical conditions
  - 1 in 7 prescriptions would be for social needs

THE EXPANDED CHRONIC CARE MODEL:
INTEGRATING POPULATION HEALTH PROMOTION

The Expanded Chronic Care Model, (Burr, Robinson, Marin-Link, Underhill, Dotts, Ravensdale, & Salivaras, 2003).
Managing chronic conditions
- Chronic disease self-management
- Diabetes self-management
- Nutrition programs (counseling, education & meal provision)
- Education about Medicare preventive benefits
- Peer supports
- Telehealth/telemedicine

Preventing hospital (re)admissions
- Transitions from nursing facility to home/community
- Person-centered planning
- Self-direction/self-advocacy
- Transportation
- Personal assistance

Activating individuals
- Diversion/Avoiding long-term residential stays
- Information, referral & assistance/system navigation
- Employment related supports
- Community/beneficiary/caregiver engagement
- Community training
- Supported decision-making
- Assistive technology
- Financial management services
- Independent living skills
- Behavioral health services
- Nutrition education
Community-Based Integrative Care

Social Determinants
- MOWs
- Housing, Transportation and Living environment
- LTSS Supports-Care Transitions
- Level of independence, caregiver and/or social supports
- Financial stability and access to benefits
- Cultural and social barriers to care
- Social Inclusion
- Education
  - Access to Health Care
  - Health Disparities
  - End of Life Planning
  - Medication management and reconciliation
  - Compliance and adherence to care and self-management
  - Patient Centered Care coordination, navigation, assessment

Population Health
- Behavioral Health Supports
- Motivational Interviewing
- Chronic Disease Management Programs
- Values, preferences, and advanced directives
- Tool to manage health and chronic conditions
- Patient and Caregiver Activation and engagement

Patient Activation Engagement

The Tide is Shifting!

Making the Value Proposition for MOWs

- Strategy
- What is the Evidence?
- Health Community Health Assessment
- Identifying Need
- Creating Demand
- Meeting Demand
- Examples Aetna Medicaid in Cincinnati

Creating and Maintaining a Sense of Urgency

- Finding Physician, Insurer, Health System Champions
- Build relationships
- Market the program, have to rely on the stories first then data and stories
- Elevator speech to key stakeholders
The Importance of Data

• Are you collecting it?
• How is it being collected?
• Can it be aggregated and utilized?

Value Proposition of MOWs Program: Getting Access to Data!

• Outcomes
  • Patient activation
  • “Days at home”
  • Admissions/1000
  • Functional Measures
  • Advance Directives
  • Falls in community
  • Depression

• PDSA Cycles of Improvement-are you engaging in these??
• How does data and information get shared?
Stories of Impact on MOWS Stakeholders and Staff

What Can You Do to Build the Case??

• Write up Stories
• Faith Based Organizations advocating for Nutrition and war on poverty
• Community Organizing
• Restaurants/Food Stores donating food for community nutrition days
• Other ideas??
Questions?

Thank You!