CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Promoting Prevention in Medicaid and CHIP

Linking State Medicaid and CHIP Programs with Federal Prevention Initiatives

May 7, 2013

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Welcome

Caya Lewis, MPH
Counselor to the Secretary of Science and Public Health
U.S. Department of Health and Human Services

Agenda

- Welcome
  - Caya Lewis, MPH, Counselor to the Secretary of Science and Health, U.S. Department of Health and Human Services
- Why promote prevention in Medicaid and CHIP?
  - Foster Gesten, MD, Medical Director, Office of Quality and Patient Safety and former Medicaid Medical Director, New York
- Opportunities to mobilize Million Hearts in Medicaid programs
  - Janet Wright, MD, Executive Director, Million Hearts
- Community Transformation Grants
  - Nicole Flowers, MD, MPH, Chief Medical Officer, Division of Community Health, Centers for Disease Control and Prevention
- Childhood Obesity Research Demonstration Projects
  - Brook Belay, MD, MPH, Obesity Prevention and Control Branch, Division of Nutrition, Physical Activity and Obesity, Centers for Disease Control and Prevention
- Upcoming sessions

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Linking State Medicaid and CHIP Programs with Federal Prevention Initiatives – Part One

Why Promote Prevention in Medicaid and CHIP?

Foster Gesten, MD

Medical Director, Office of Quality and Patient Safety and former Medicaid Medical Director

New York State Department of Health

Why Promote Prevention?

- Vital to 'Triple Aim' goals
- Tremendous opportunity
  - Demographics
  - Disparities
- Levers are there
  - Federal requirements
  - Contracting
  - Measurement

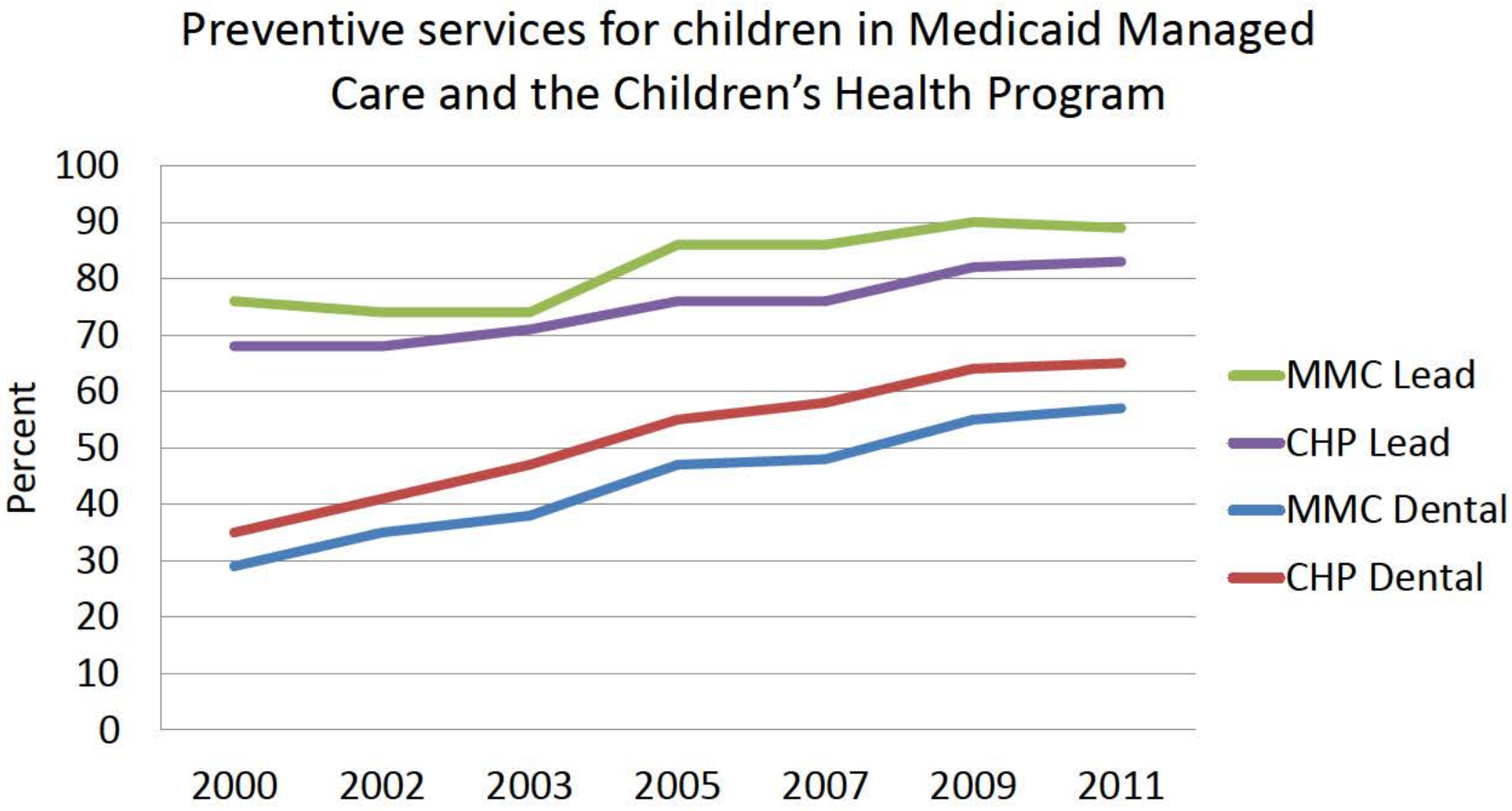
Opportunity

- Almost 50% of all children under 19 in NY in Medicaid and CHP program
- Almost 50% of all births in NY to Medicaid enrolled women
- Prevalence of tobacco use over 50% higher in low income populations

Focused Efforts Work

- Prevention measure improvement over time
- Disparities can be reduced and eliminated

Child Preventive Care (Medicaid and CHIP)

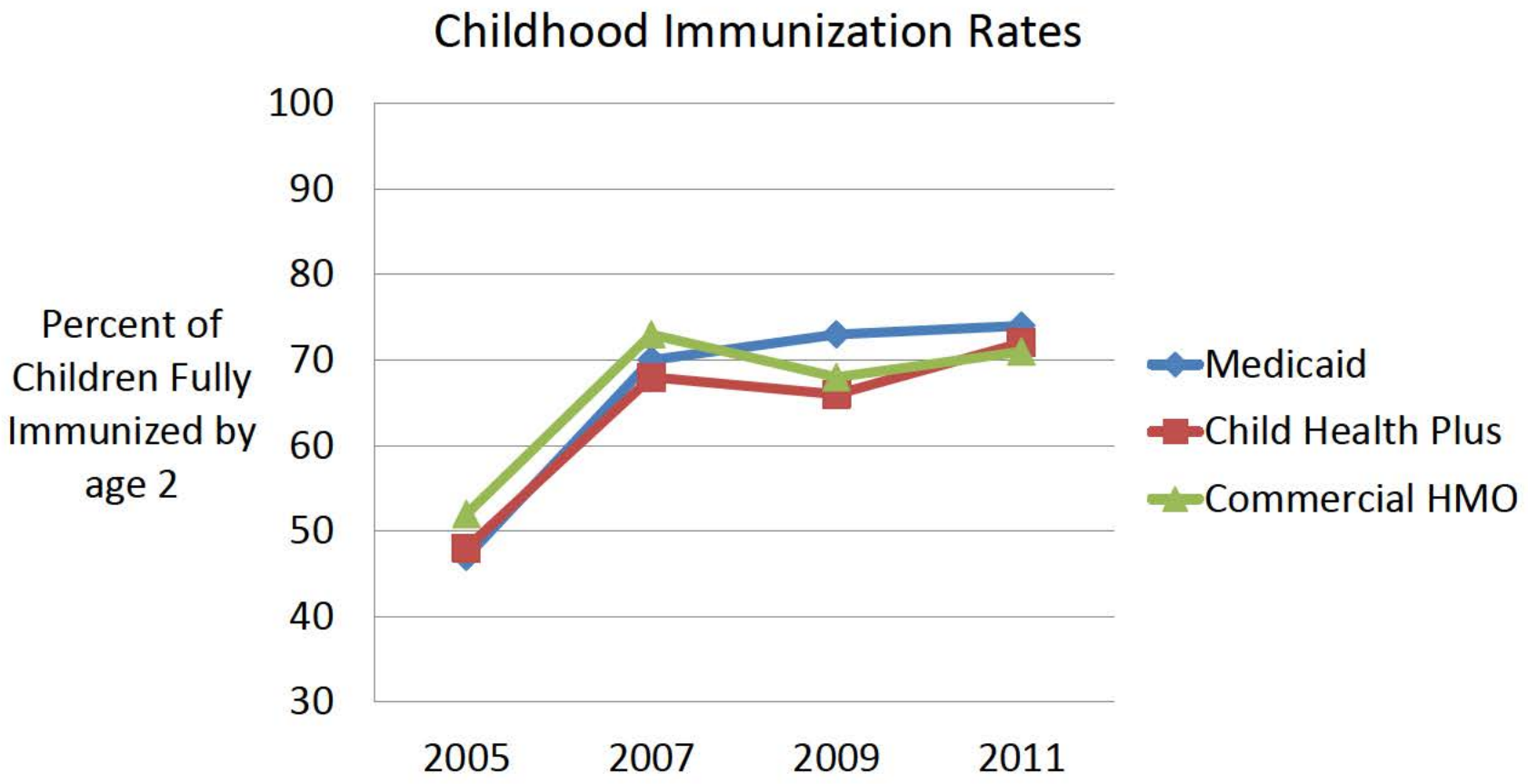


Lead = Lead Testing – One or more blood tests for lead by 2 years of age.

Dental = Annual Dental Visit – One or more dental visits during the measurement year for children, ages 4 -21.

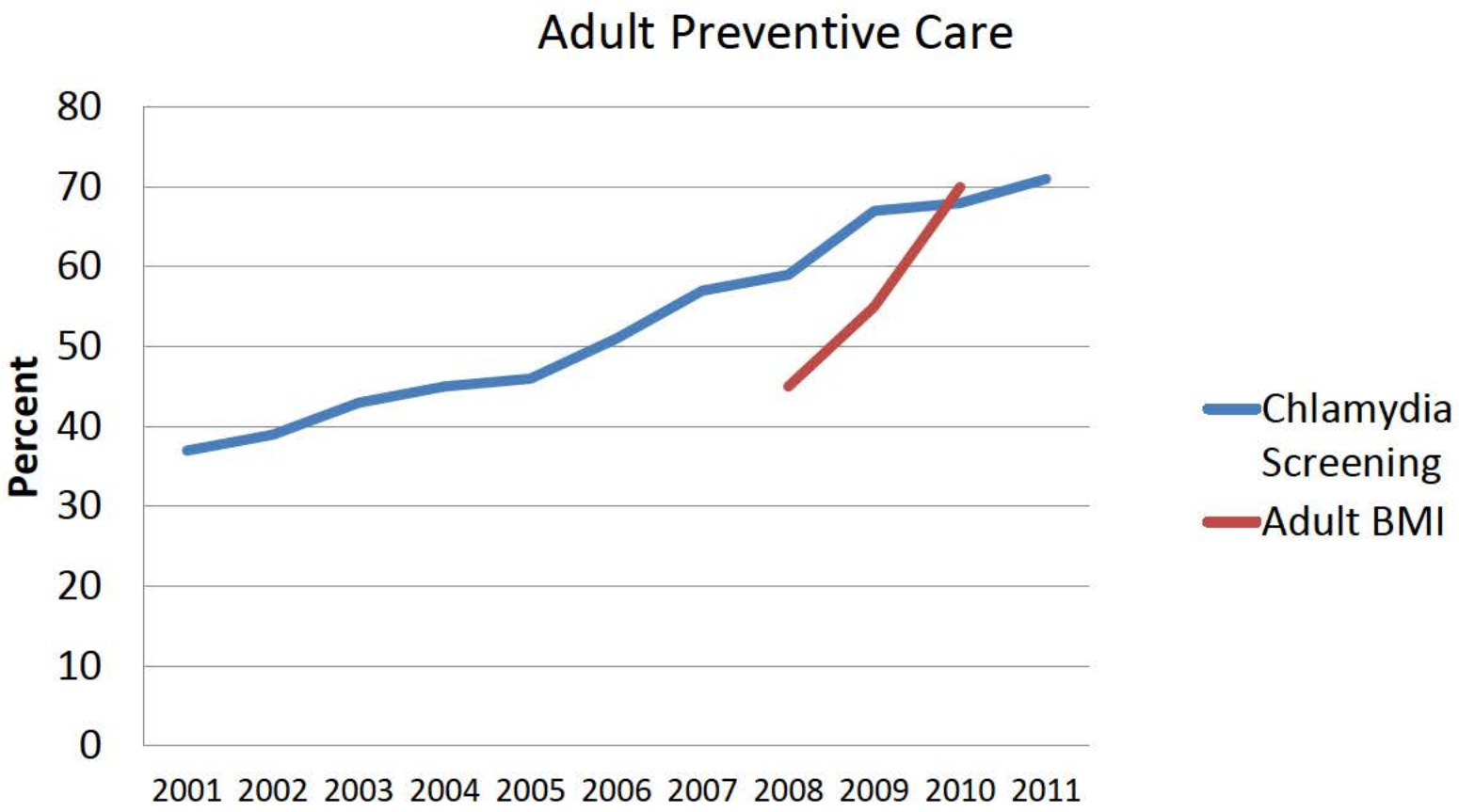
NYS's CHP program provides coverage up to age 19.

Childhood Immunization Rates



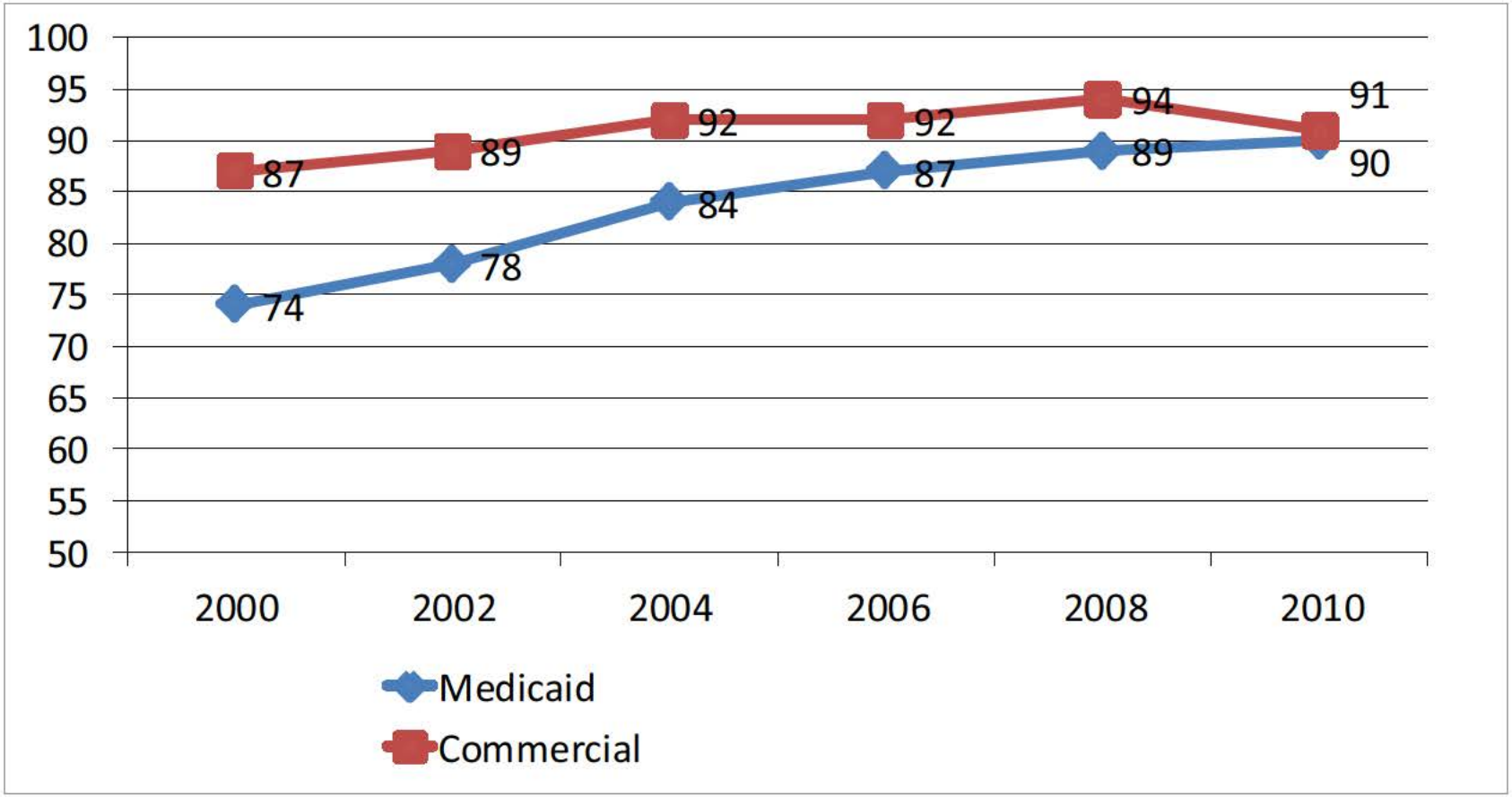
'Fully Immunized' consists of 4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 VZV, and 4 pneumococcal conjugate vaccines. For 2009, only 2 Hib vaccines were needed.

Adult Preventive Care (Medicaid and FHP)

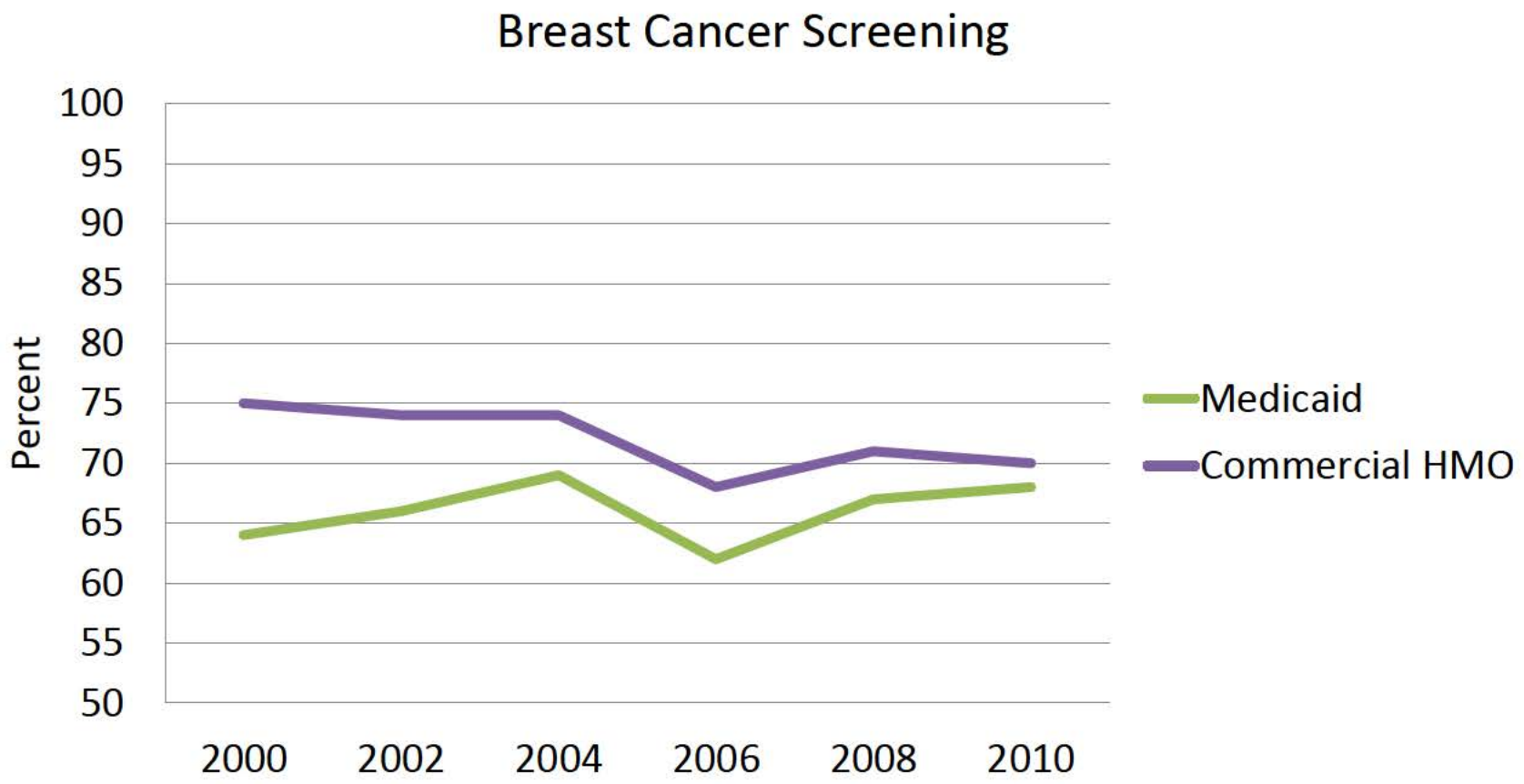


Adult BMI first collected in 2008. Rotated for 2011

Closing the Gap: Timeliness of Prenatal Care

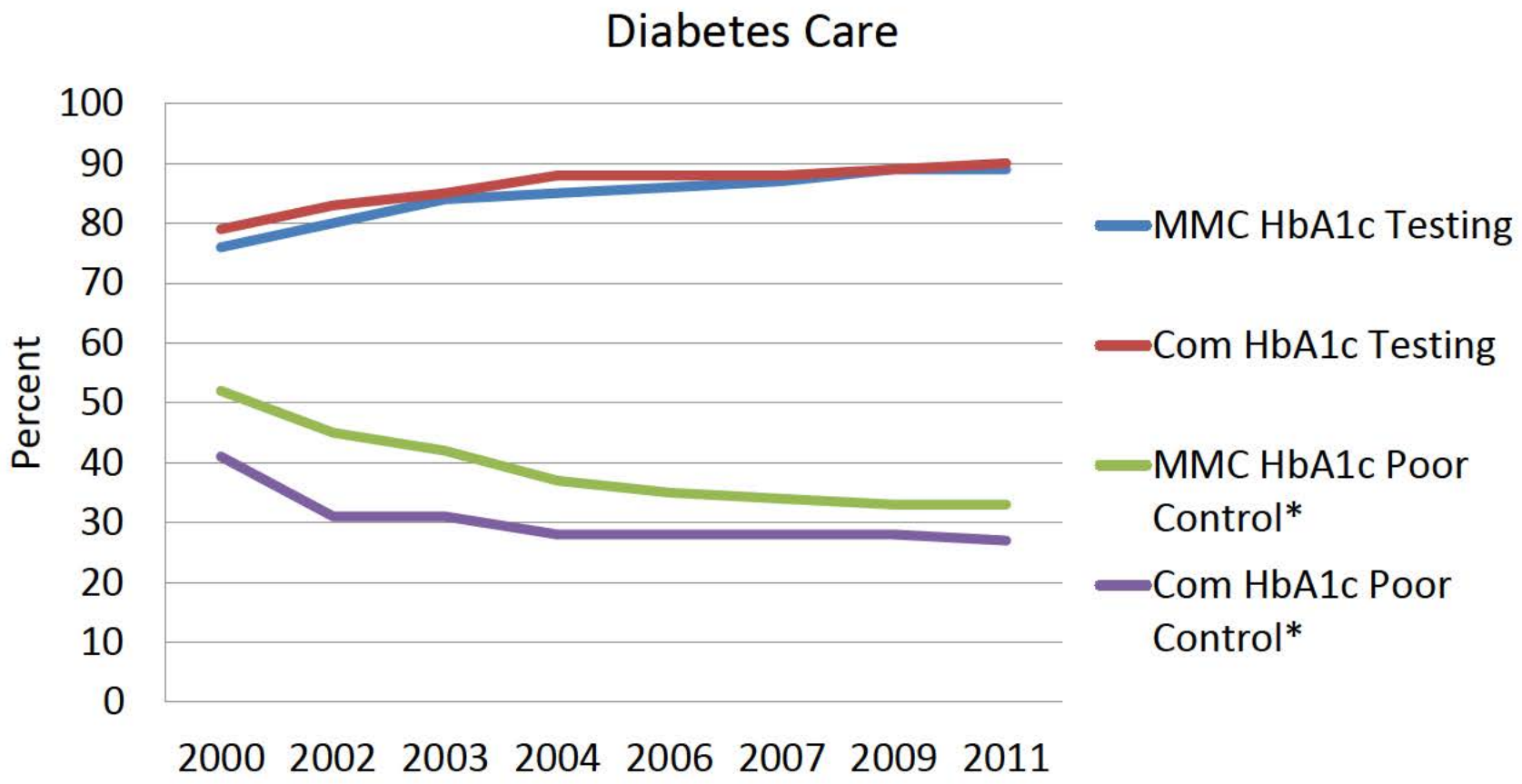


Closing the Gap: Breast Cancer Screening



In 2006, women age 40 to 49 were added to the measure.

Closing the Gap: Diabetes Care



*A low rate is desirable.

HbA1c Poor Control = No Test, missing test result and HbA1c over 9.0%

Million Hearts

Measure	Payer	Measurement Year					
		2006	2007	2008	2009	2010	2011
A – Appropriate Aspirin Therapy							
Aspirin Use and Discussion	Commercial HMO	2011 data submission will be the second year needed for the two year rolling averages. 2012 will be the first reporting of results and will be in aggregate.					
	Commercial PPO						
B – Blood Pressure Control							
Controlling High Blood Pressure	Commercial HMO	58	Rotated	63	Rotated	66	Rotated
	Medicaid	60	Rotated	65	Rotated	67	Rotated
Blood Pressure Control for People with Diabetes (Below 140/90 mm Hg)	Commercial HMO	63	65	Rotated	64	Rotated	66
	Medicaid	61	61	Rotated	65	Rotated	66
Persistence of Beta-blocker Treatment After a Heart Attack	Commercial HMO	74	77	78	76	79	84
	Medicaid	NC	NC	NC	NC	NC	77
Adult BMI Assessment	Commercial HMO	NC	NC	40	48	56	Rotated
	Medicaid	NC	NC	45	55	70	Rotated
C – Cholesterol Control							
Cholesterol Management for Patients with Cardiovascular Conditions (LDL <100mg/dL)	Commercial HMO	54	60	Rotated	58	Rotated	62
	Medicaid	46	47	Rotated	51	Rotated	52
LDL Control (<100mg/dL) for People with Diabetes	Commercial HMO	43	45	Rotated	47	Rotated	47
	Medicaid	39	41	Rotated	44	Rotated	47
S – Smoking Cessation							
Advising Smokers and Tobacco Users to Quit	Commercial HMO	77	80	81	81	82	82
	Medicaid	Rotated	74	Rotated	74	Rotated	78
Discussing Medication Cessation	Commercial HMO	49	56	59	57	59	60
	Medicaid	NC	50	Rotated	52	Rotated	56
Discussing Cessation Strategies	Commercial HMO	47	50	54	51	51	51
	Medicaid	NC	46	Rotated	47	Rotated	48

QARR Results 2006- 2011. NC – Not collected for that payer for that measurement year.

Implementation Package

- Science/Evidence
- Requirements
- Measurement/Accountability
- Support for Improvement
- Incentives
- Patience/Persistence

Linking State Medicaid and CHIP Programs with Federal Prevention Initiatives – Part Two

millionhearts.hhs.gov

Opportunities to mobilize Million Hearts in Medicaid

Janet Wright, MD
Executive Director
Million Hearts

Million Hearts

Goal: Prevent 1 million heart attacks and strokes in 5 years

- National initiative co-led by CDC and CMS
- Partners across federal and state agencies and private organizations

Heart Disease and Stroke Leading Killers in the United States

- Cause 1 of every 3 deaths
- More than 2 million heart attacks and strokes each year
  - 800,000 deaths
  - Leading cause of preventable death in people <65
  - $444B in health care costs and lost productivity
  - Treatment costs are ~$1 for every $6 spent
- Greatest contributor to racial disparities in life expectancy

Roger VL, et al. Circulation. 2012;125:e2-e220.
Heidenriech PA, et al. Circulation. 2011;123:933–4.

Status of the ABCS

Metric	Definition	Status
Aspirin	People at increased risk of cardiovascular events who are taking aspirin	47%
Blood pressure	People with hypertension who have adequately controlled blood pressure	47%
Cholesterol management	People with high cholesterol who are effectively managed	33%
Smoking	People trying to quit smoking who get help	23%

MMWR. 2011;60:1248-51

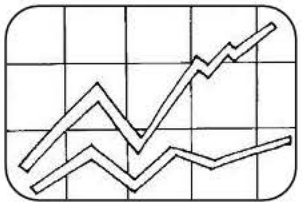
Key Components of Million Hearts

Excelling in the ABCS
Optimizing care

Minority Health

Keeping Us Healthy
Changing the context

Prioritizing the ABCS



Health tools and technology

Innovations in Care Delivery

Public Sector Support

- Administration on Community Living
- Agency for Healthcare Research and Quality
- Centers for Disease Control and Prevention
- Centers for Medicare and Medicaid Services
- Food and Drug Administration
- Health Resources and Services Administration
- Indian Health Service
- National Heart, Lung, and Blood Institute, National Institutes of Health
- National Prevention Strategy
- National Quality Strategy
- Office of the Assistant Secretary for Health
- Substance Abuse and Mental Health Services Administration
- U.S. Department of Veterans Affairs

Private Sector Support

- Academy of Nutrition and Dietetics
- Alliance for Patient Medication Safety
- America's Health Insurance Plans
- American Association of Nurse Practitioners
- American College of Cardiology
- American College of Physicians
- American Heart Association
- American Medical Association
- American Medical Group Foundation
- American Nurses Association
- American Pharmacists' Association and Foundation
- Association of Black Cardiologists
- Association of Public Health Nurses
- Blue Cross Blue Shield Association
- **Commonwealth of Virginia**
- Georgetown University School of Medicine
- HealthPartners
- Kaiser Permanente
- **Maryland Dept. of Health and Mental Hygiene**
- Medstar Health System
- Men's Health Network
- National Alliance of State Pharmacy Assns
- National Committee for Quality Assurance
- National Community Pharmacists Assn
- National Consumers League
- National Forum for Heart Disease and Stroke Prevention
- National Lipid Association Foundation
- **New York State Department of Health**
- Ohio State University
- **Pennsylvania State Department of Health**
- Preventive Cardiovascular Nurses Association
- UnitedHealthcare
- University of Maryland School of Pharmacy
- Walgreens
- WomenHeart
- YMCA of America

Excelling in the ABCS
Optimizing Quality, Access, and Outcomes

Focus on the ABCS

- Simple, uniform set of measures
- Measures with a lifelong impact
- Data collected or extracted in the workflow of care
- Link performance to incentives

Measures that Matter

Domain	Measures
Aspirin use	Ischemic Vascular Disease (IVD): Use of aspirin or other antithrombotic % of patients ≥18 yrs with IVD with documented use of aspirin or other antithrombotic PQRS 204/NQF 0068
Blood pressure control	Preventive care and screening: Hypertension % of patients ≥18 yrs screened for HTN (PQRS 317)
	Control of Hypertension % of patients 18-85 yrs with diagnosis of HTN whose BP was adequately controlled (<140/90) during measurement year PQRS 236/NQF 0018
Cholesterol management	Preventive care and screening: Cholesterol – Fasting Low Density Lipoprotein Test Performed AND Risk-Stratified Fasting LDL % of patients 20-79 yrs whose risk factors were assessed and a fasting LDL test was performed AND who had a fasting LDL test performed and whose risk-stratified fasting LDL is at or below recommended LDL goal (PQRS 316)
	Diabetes Mellitus: Low Density Lipoprotein Control % of patients 18-75 yrs with diabetes mellitus who had most recent LDL-C level in control (<100 mg/dL) PQRS 2/NQF 0064
	IVD: Complete Lipid Panel and LDL-C Control % of patients ≥18 yrs with IVD who received at least one lipid profile within 12 months and who had most recent LDL-C level in control (<100 mg/dL) (PQRS 241/NQF 0075)
Smoking cessation	Preventive care and screening: Tobacco use % of patients ≥18 yrs screened for tobacco use one or more times within 24 months and who received cessation counseling intervention if identified as a tobacco user PQRS 226/NQF 0028

Why focus on the Million Hearts measures?

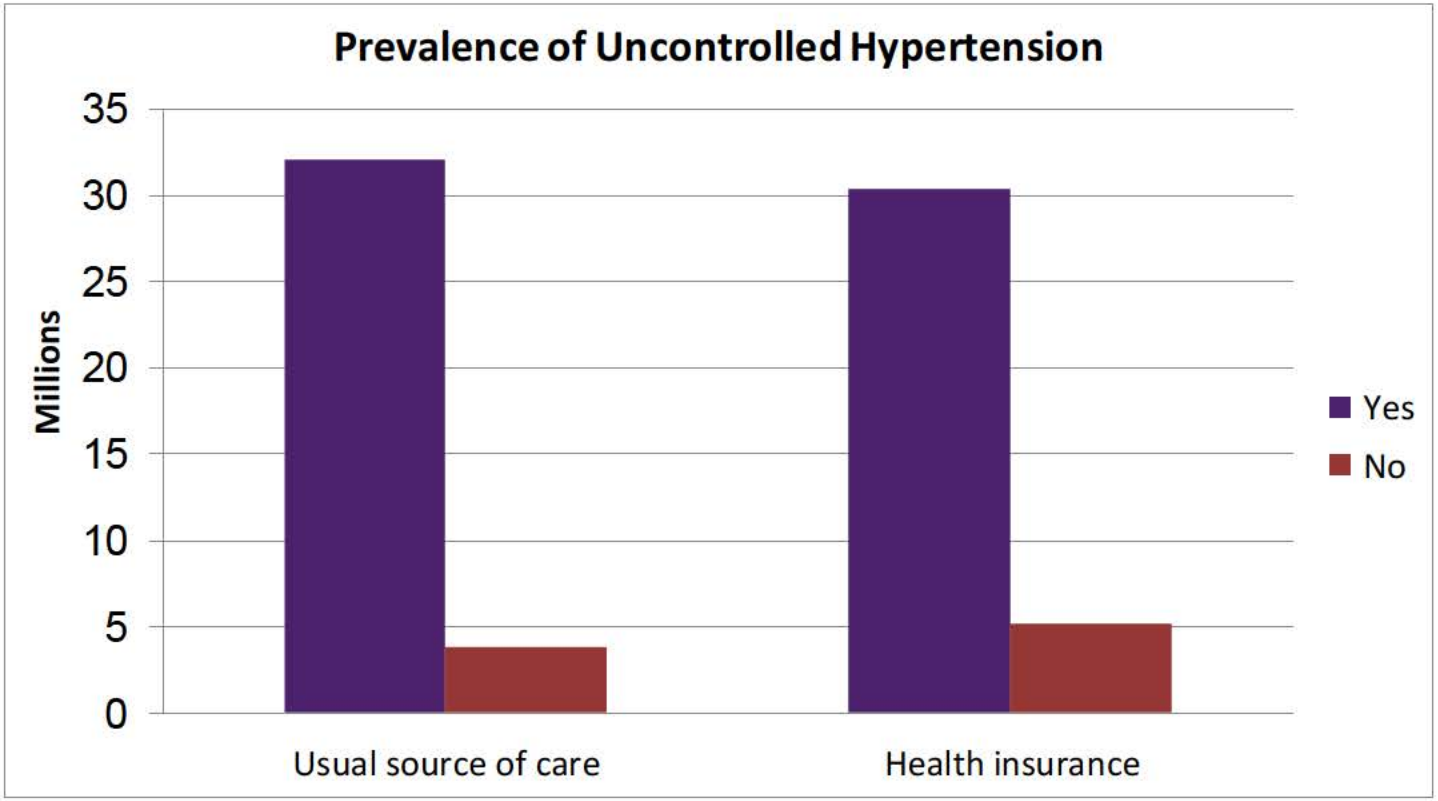
- Simplified, increasingly uniform set of measures
  - Collect once…….Report wherever
- Embedded in the flow of care to minimize burden
- High performance linked to recognition and reward for clinicians, systems, and patients.
- And, MOST IMPORTANTLY, these measures matter when it comes to preventing heart attack and strokes

Getting to Goal

Intervention	Baseline	Target	Clinical target
Aspirin for those at high risk	47%	65%	70%
Blood pressure control	47%	65%	70%
Cholesterol management	33%	65%	70%
Smoking cessation	23%	65%	70%
Sodium reduction	~ 3.5 g/day	20% reduction	
Trans fat reduction	~ 1% of calories	50% reduction	

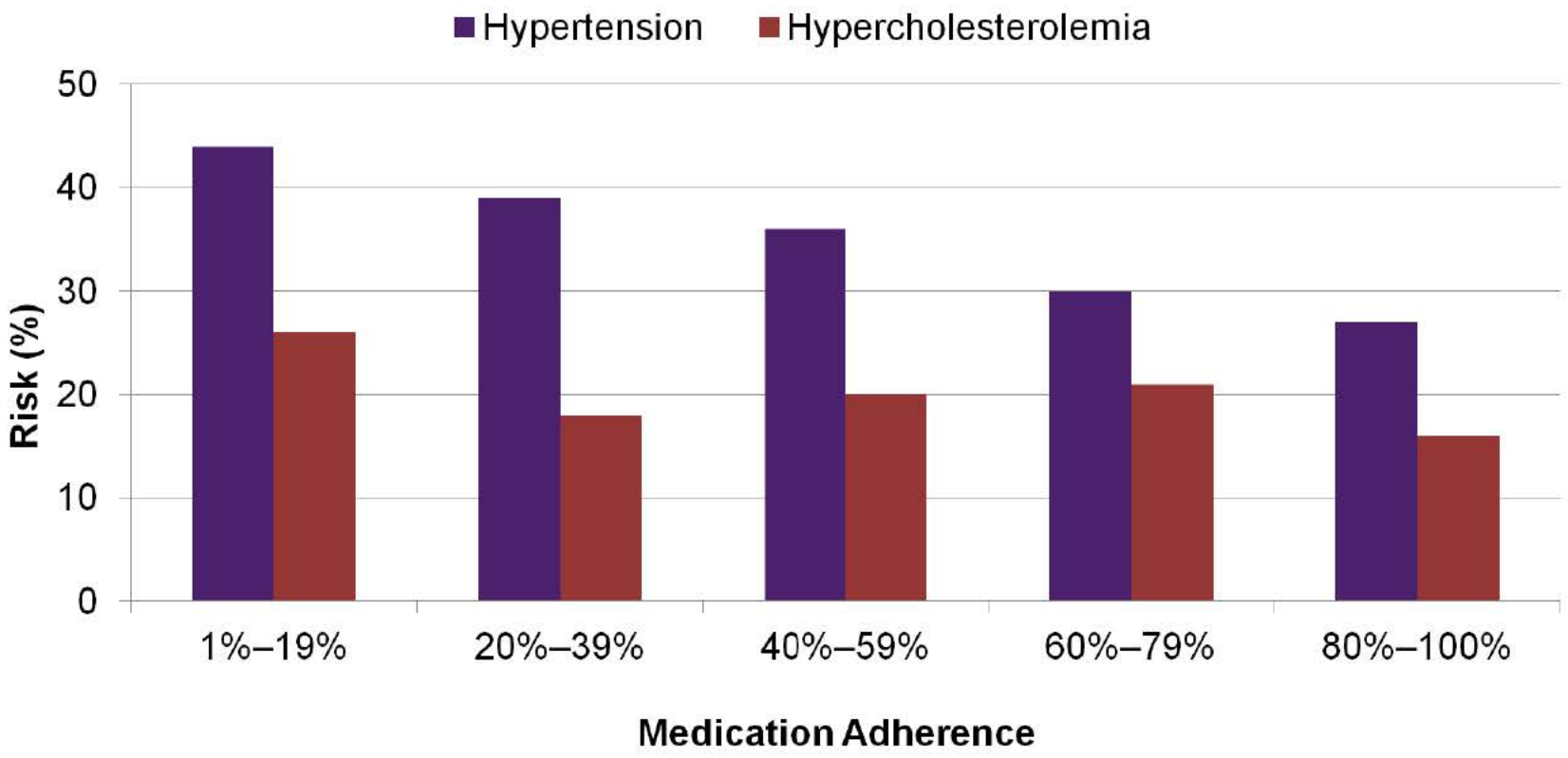
Unpublished estimates from Prevention Impacts Simulation Model (PRISM).

Prevalence of Uncontrolled Hypertension by Selected Characteristics



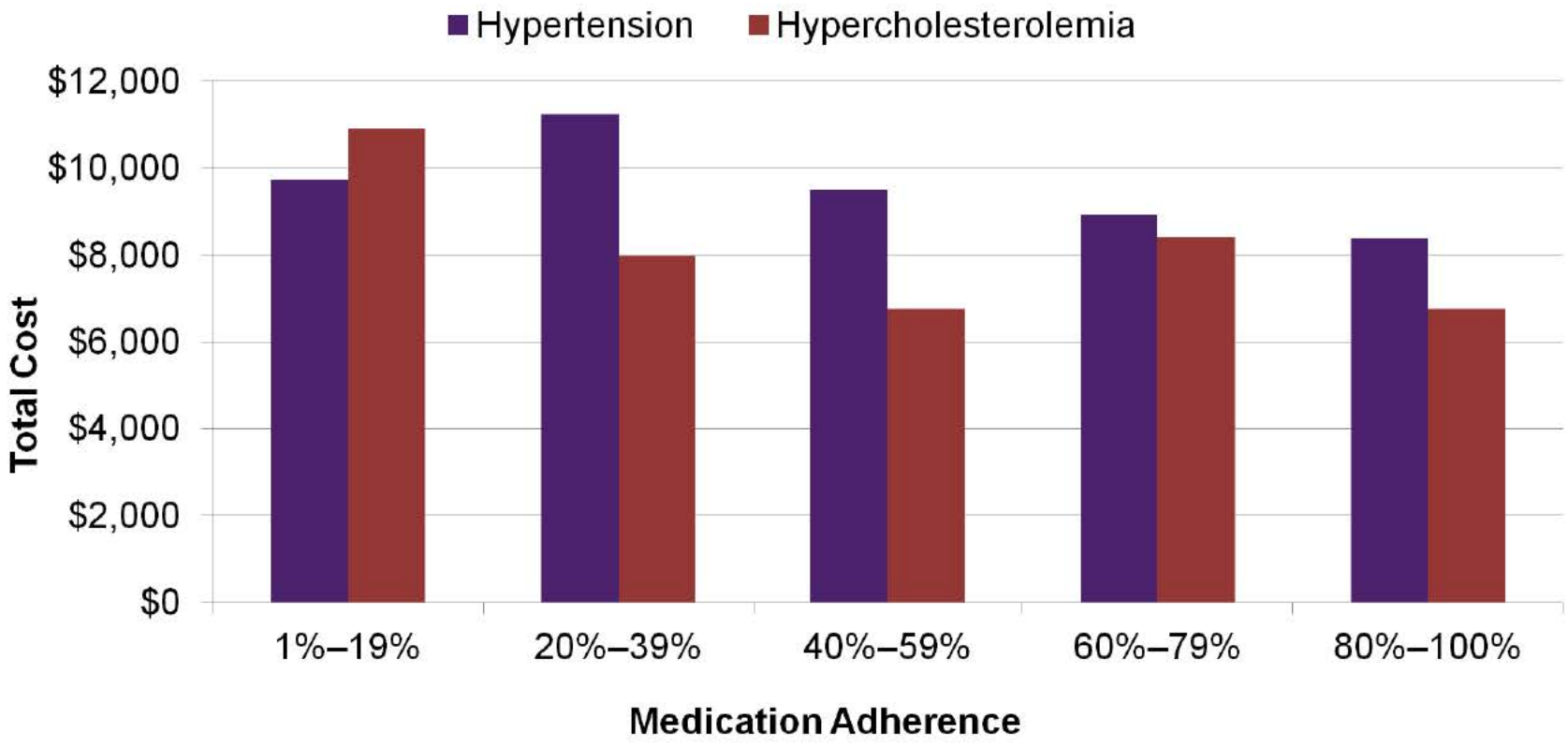
CDC. MMWR. 2012;61(35):703–9.

All-Cause Hospitalization Risk Falls as Adherence Increases



Sokol MC, et al. Med Care. 2005;43(6):521–30.

Total All-Cause Health Care Costs Drop as Medication Adherence Increases



Sokol MC, et al. Med Care. 2005;43(6):521–30.

What it Will Take
Detect, Connect, Control

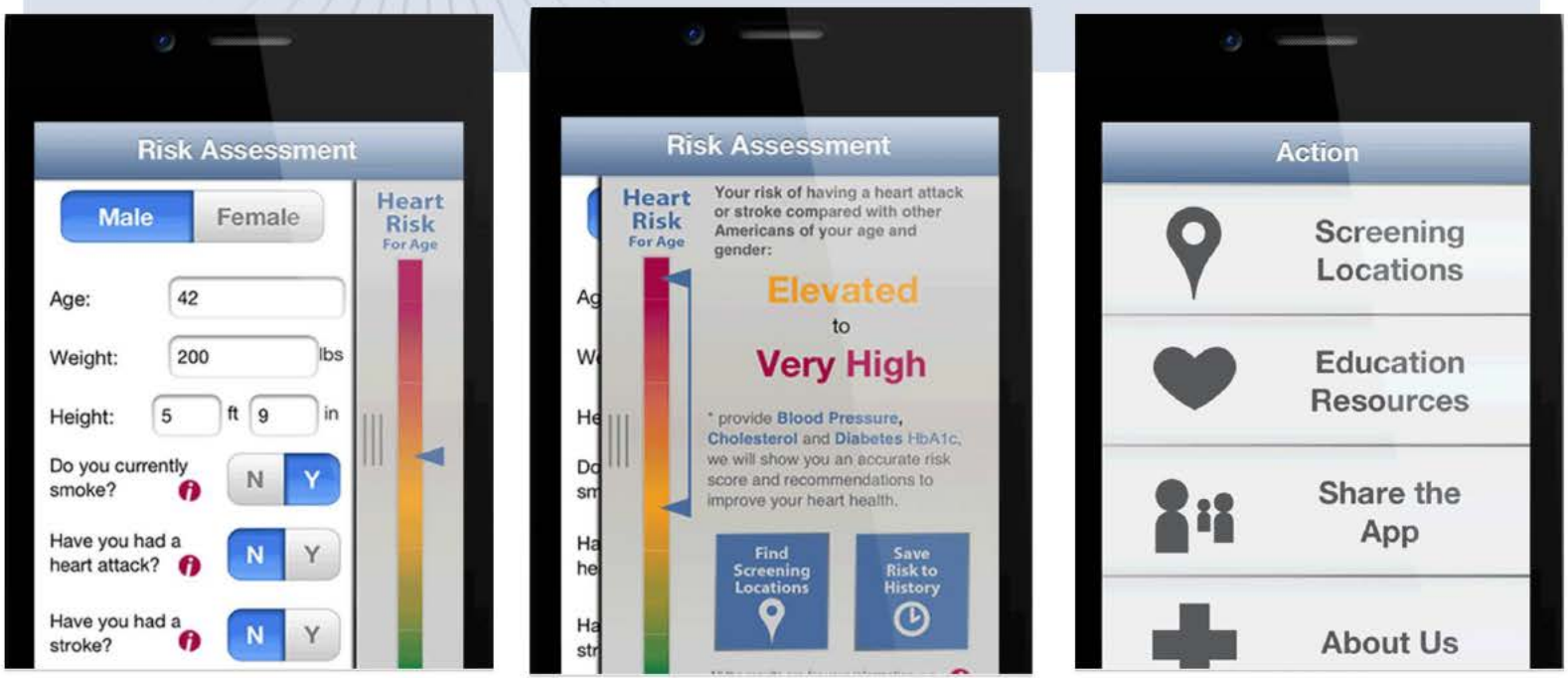
- Awareness of performance gaps and actions
- Skills to measure, analyze, improve
- A blanket of BP monitors
- Standardized protocol or algorithm
- Timely, low-cost loop of measurement and advice
- Effective team care models
- Access and persistence to meds
- Business case

The Nation's BP Control Plan

1. Identify the undiagnosed **14 Million**
2. Move the treated to controlled
3. Coach self-management
4. Drive measurement and reporting
5. Educate and activate about high Na intake

Free through Feb 2014!

HeartHealth MOBILE

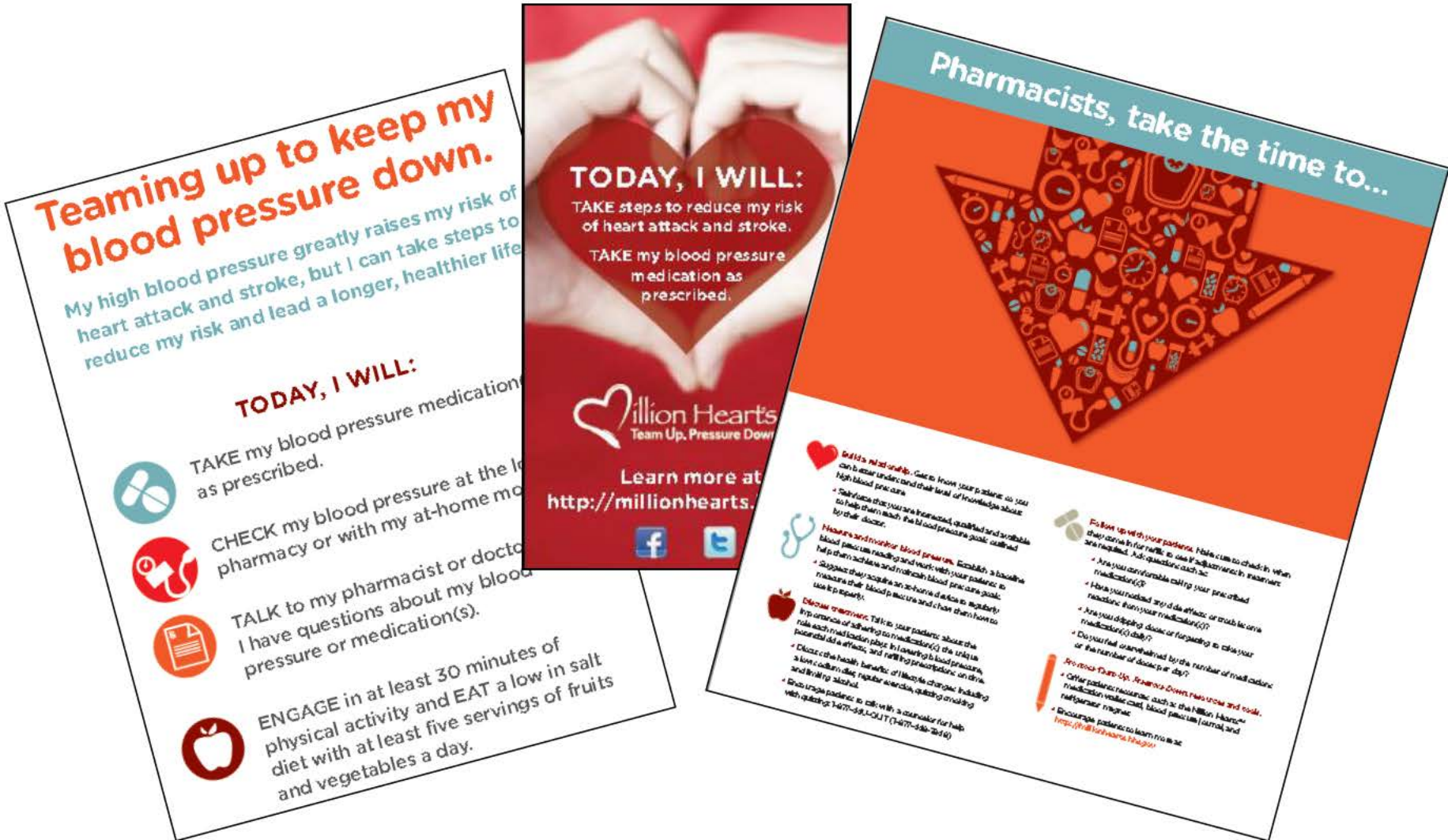


Marshfield Clinic and Archimedes IndiGo – HeartHealth mobile website: www.hearthealthmobile.com

The Nation's BP Control Plan
Move the Treated to Controlled

1. Identify the undiagnosed **14 Million**
2. Move the treated to controlled **16 Million**
3. Coach self-management
4. Drive measurement and reporting
5. Educate and activate about high Na intake

Million Hearts
Team Up. Pressure Down.



The Nation's BP Control Plan
Coach Self-Management

1. Identify the undiagnosed 14 Million
2. Move the treated to controlled 16 Million
3. Coach self-management **67 Million**
4. Drive measurement and reporting
5. Educate and activate about high Na intake

100 Congregations for Million Hearts
The Commitment

For one year, we will focus on two or more of the following actions and share our progress:

- Designate a Million Hearts Advocate
- Deliver CV health messages
- Distribute wallet cards for recording BP readings
- Promote and use the Heart Health Mobile app
- Facilitate connections with local health professionals and community resources

The Nation's BP Control Plan

Drive Measurement and Reporting

1. Identify the undiagnosed 14 Million
2. Move the treated to controlled 16 Million
3. Coach self-management **67 Million**
4. Drive measurement and reporting > **67 Million**
5. Educate and activate about high Na intake

2012 Million Hearts
BP Control Champions

Kaiser Permanente Colorado and Ellsworth Medical Clinic

Ellsworth Team Million Hearts

What the Ellsworth Team Does

- Pre-visit chart review by clinic staff
- The laboratory technician double checks tests
- Exam room magnet for blood pressure alert
- Empower all clinical staff to order lab tests
- Printed visit summaries and follow up guidance
- Return-to-clinic reminders in the EHR, tracked by front office staff for patient reminder
- Drop in blood pressure checks
- Between visit follow up to check medication

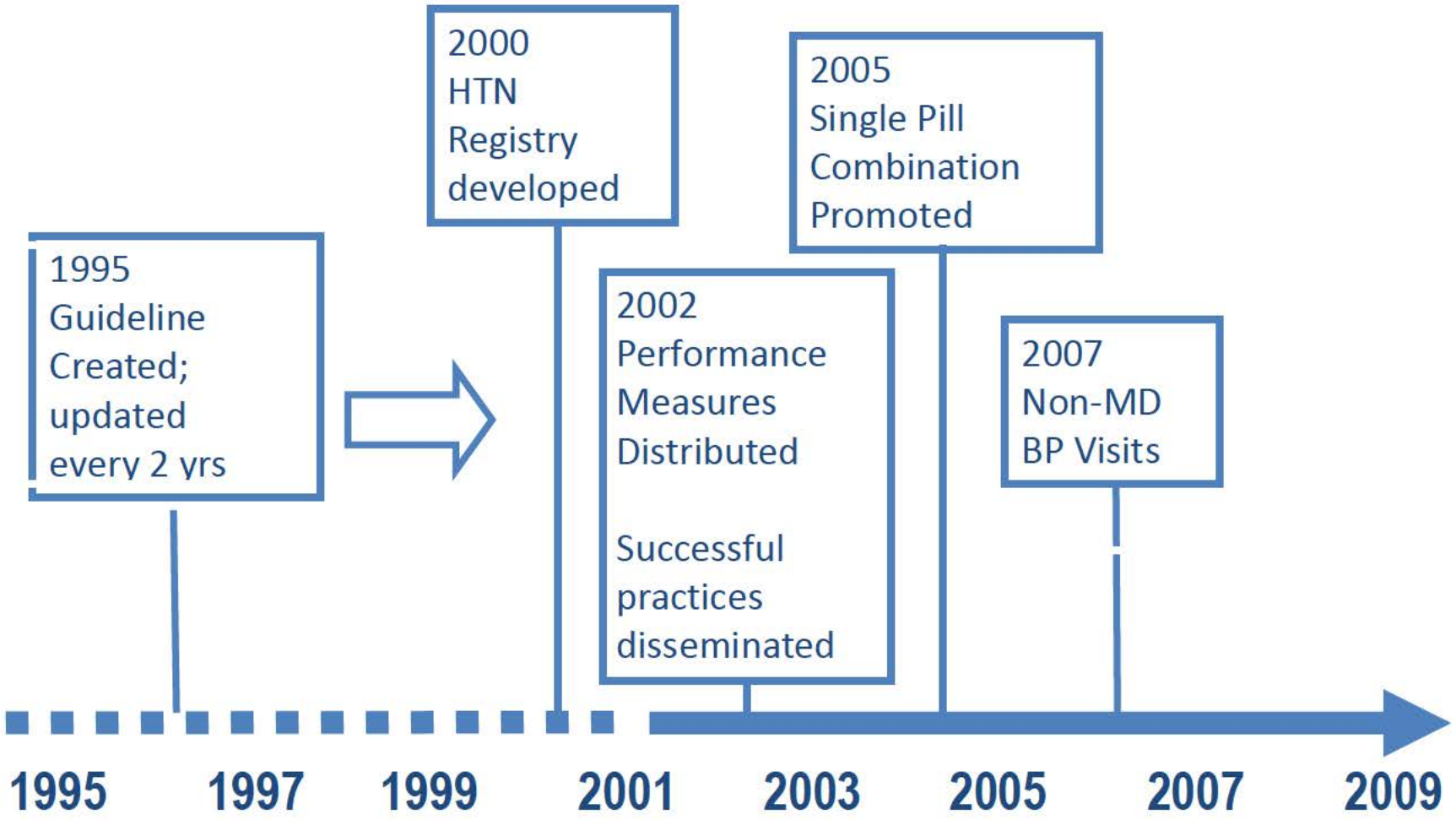
The Nation's BP Control Plan

Educate and Activate about High Na Intake

1. Identify the undiagnosed 14 Million
2. Move the treated to controlled 16 Million
3. Coach self-management **67 Million**
4. Drive measurement and reporting > **67 Million**
5. Educate and activate about high Na intake **314M**

New Resources

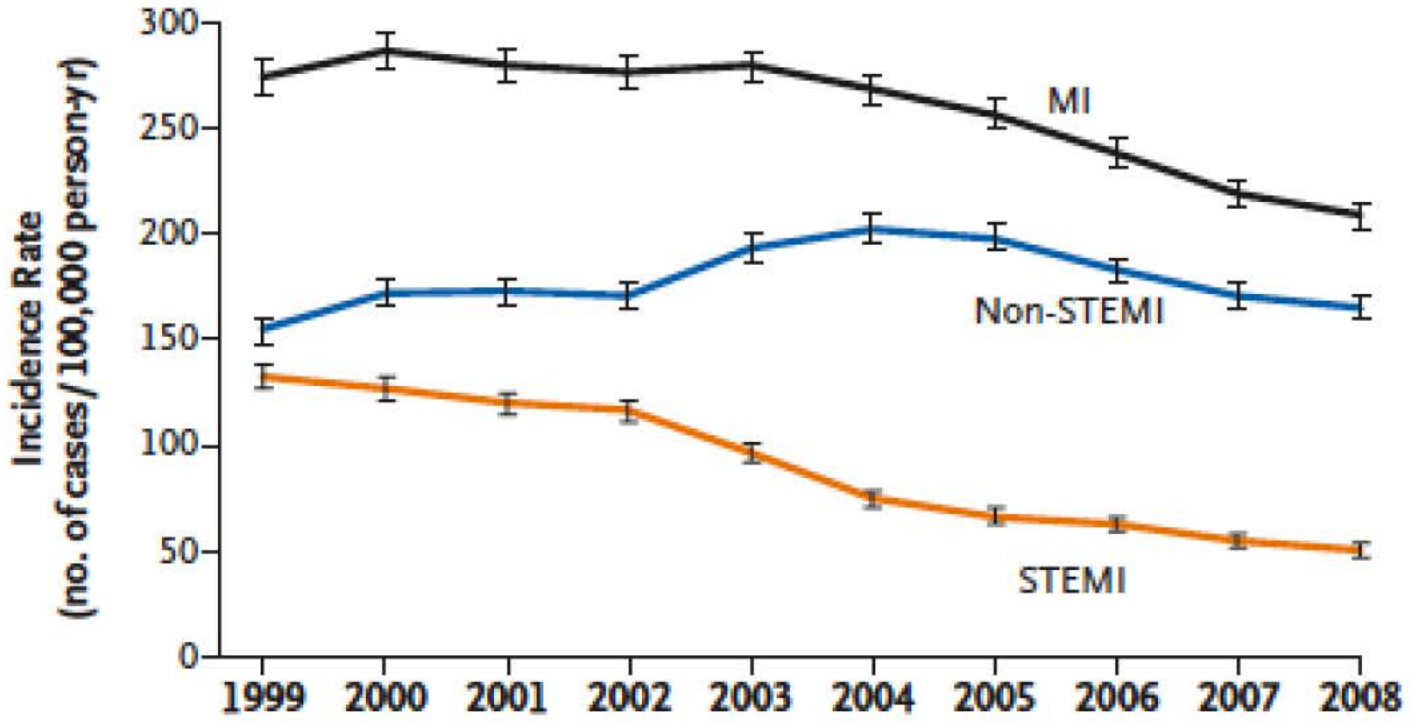
Kaiser Northern California Implementation Timeline



Heart Attack Rates Fall in Kaiser No California

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 JUNE 10, 2010 VOL. 362 NO. 23



What is a Health Care Professional to Do?

- Prioritize excellence in the ABCS
  - start with hypertension
- Set a goal and measure the way to better outcomes
- Get personal when it comes to risk
- Emphasize adherence as critical to heart health
  - obstacles: cost, # pills/day, habits, side effects
  - Improve processes: ease of refills, pillboxes, med “nurse”
- Deploy team members to teach & reinforce & badger
  - Cardiac rehab, Pharmacist, Community health worker
- Share what works--and doesn’t--with us

Million Hearts Resources

- Million Hearts: www.millionhearts.hhs.gov
- Vital Signs: Where's the Sodium? www.cdc.gov/VitalSigns/Sodium/index.html
- Innovations and Progress Notes: How others have achieved high performance
- www.millionhearts.hhs.gov/aboutmh/innovations.html
- Vital Signs: Getting Blood Pressure Under Control www.cdc.gov/vitalsigns/Hypertension/index.html
- Team Up. Pressure Down. http://millionhearts.hhs.gov/resources/teamuppressuredown.html
- Community Guide: Team-Based Care www.thecommunityguide.org/cvd/teambasedcare.html
- SDOH Workbook: Promoting Health Equity, a Resource to Help Communities Address Social Determinants of Health www.cdc.gov/nccdphp/dach/chhep/pdf/SDOHworkbook.pdf
- Program Guide for Public Health: Partnering with Pharmacists in the Prevention and Control of Chronic Diseases www.cdc.gov/dhdsp/programs/nhdsp_program/docs/Pharmacist_Guide.pdf
- Data Trends & Maps: http://apps.nccd.cdc.gov/NCVDSS_DTM

Linking State Medicaid and CHIP Programs with Federal Prevention Initiatives – Part Three

Community Transformation Grants

Nicole Flowers, MD, MPH
Chief Medical Officer, Division of Community Health
Centers for Disease Control and Prevention

Community Transformation Grants Focus is on Where We…

LIVE

LEARN

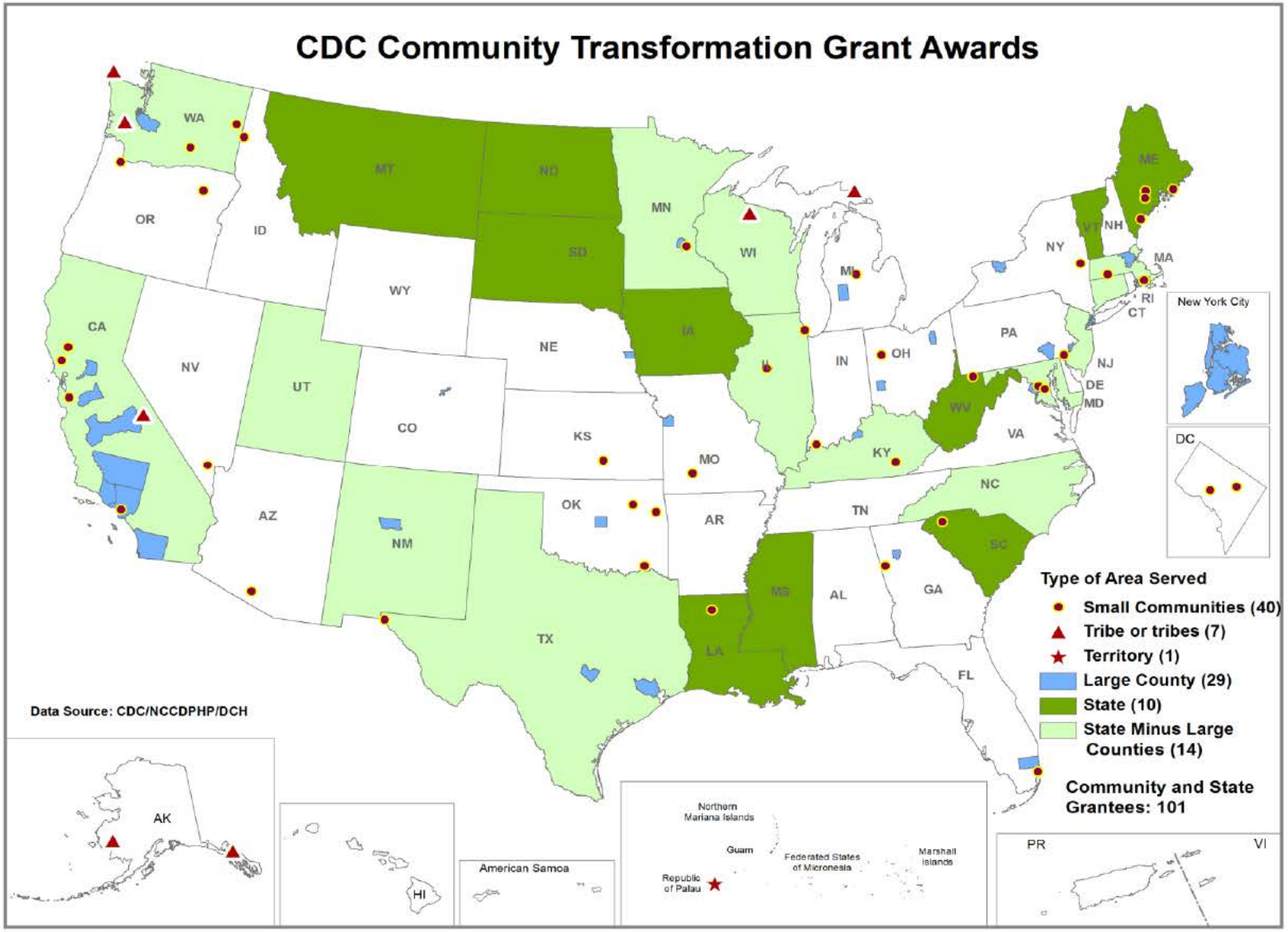
WORK

PLAY

Community Awards

- Total Awards – 101
  - Implementation – 70
  - Capacity Building – 26
- Areas to be served:
  - 40 Small Communities
  - 29 Large Counties (>500,000)
  - 10 States (to serve the entire state)
  - 14 States minus their Large Counties
  - 7 Tribes/ 1 Territory
- Rural / Frontier Areas emphasized

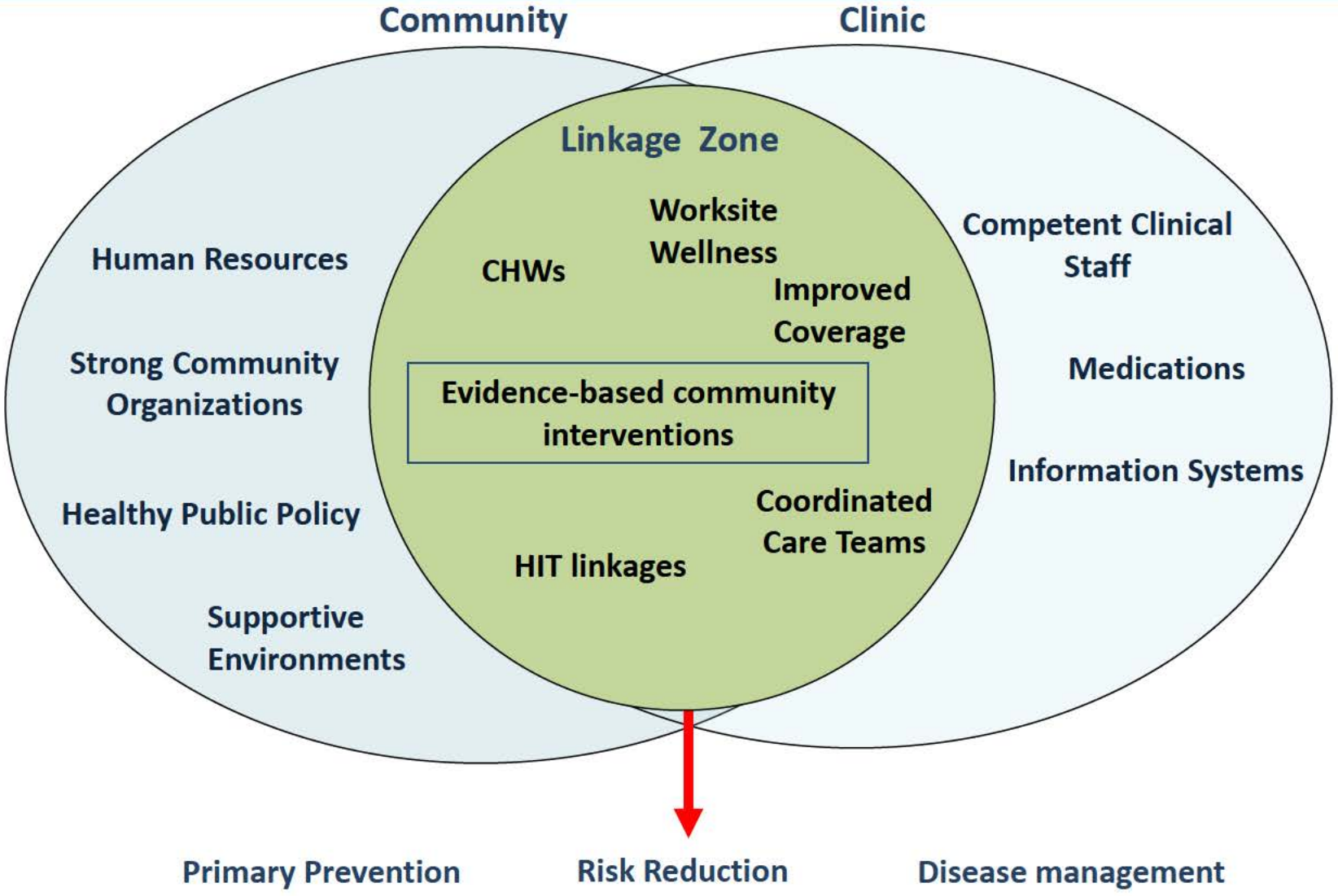
Community Transformation Grant Awards



Reaching 1 in 3 U.S. Citizens Through Community Transformation Grants

- Goal of CDC's Community Transformation Grants (CTG) - Create a healthier America by:
- Building capacity to implement evidence- and practice-based policy, environmental, and infrastructure changes to prevent chronic disease
- Supporting implementation of interventions across five broad areas:
  - Tobacco–Free Living
  - Active Living and Healthy Eating
  - Clinical and Community Preventive Services
  - Social and Emotional Wellness
  - Healthy and Safe Physical Environment

Linking Setting, People, Resources & Strategies



Goal for Clinical and Community Partnerships in CTG

Use CC linkages to decrease the prevalence of chronic diseases and improve the health of individuals who already have chronic diseases, especially Diabetes, HTN and HBC through a health equity lens.

Clinical and Community Preventive Services Priority Strategies

- Use of pharmacists to promote control of hypertension and high blood cholesterol.
- Use of community health workers/ patient navigators.
- Working with employers and insurers to improve access to and coverage of preventive clinical and community services
- Use of health information technology
    - Panel management registries
    - Clinical decision support
    - Monitoring the quality of care

CTG: Promoting HC Partnerships Minnesota

- Minnesota

  - AIM: have improved health insurance coverage/ reimbursement for preventive services
  - Partnering with insurers, community representatives, rural health organizations.
  - Coverage of weight and disease self-management, and tobacco cessation programs.
  - Coverage for services by health coaches, CHWs, and paramedics.

CTG: Promoting HC Partnerships San Diego

- San Diego, CA
  - AIM: establish health information exchange throughout the county
  - Partnering with regional extension center (ONCHIT); primary care practices; health systems
  - Aggregated community data monitoring and data sharing
  - Training and HIT for standardized quality measures
  - Providing feedback across the system on quality of care.

CTG: Promoting HC Partnerships Beaverton, OR

- Beaverton, OR

  - AIM: have systems in place to support 83K residents with chronic disease
  - Partnering with Providence health system, Garcia Health Center (FQHC) , social services and mental health providers.
  - Establish assessment and referral system for chronic disease self management programs and tobacco cessation.
  - Electronic and web-based information sharing between agencies

Linking State Medicaid and CHIP Programs with Federal Prevention Initiatives – Part Four

Childhood Obesity Demonstration Projects

Brook Belay, MD, MPH

Obesity Prevention and Control Branch, Division of Nutrition, Physical Activity and Obesity

Centers for Disease Control and Prevention

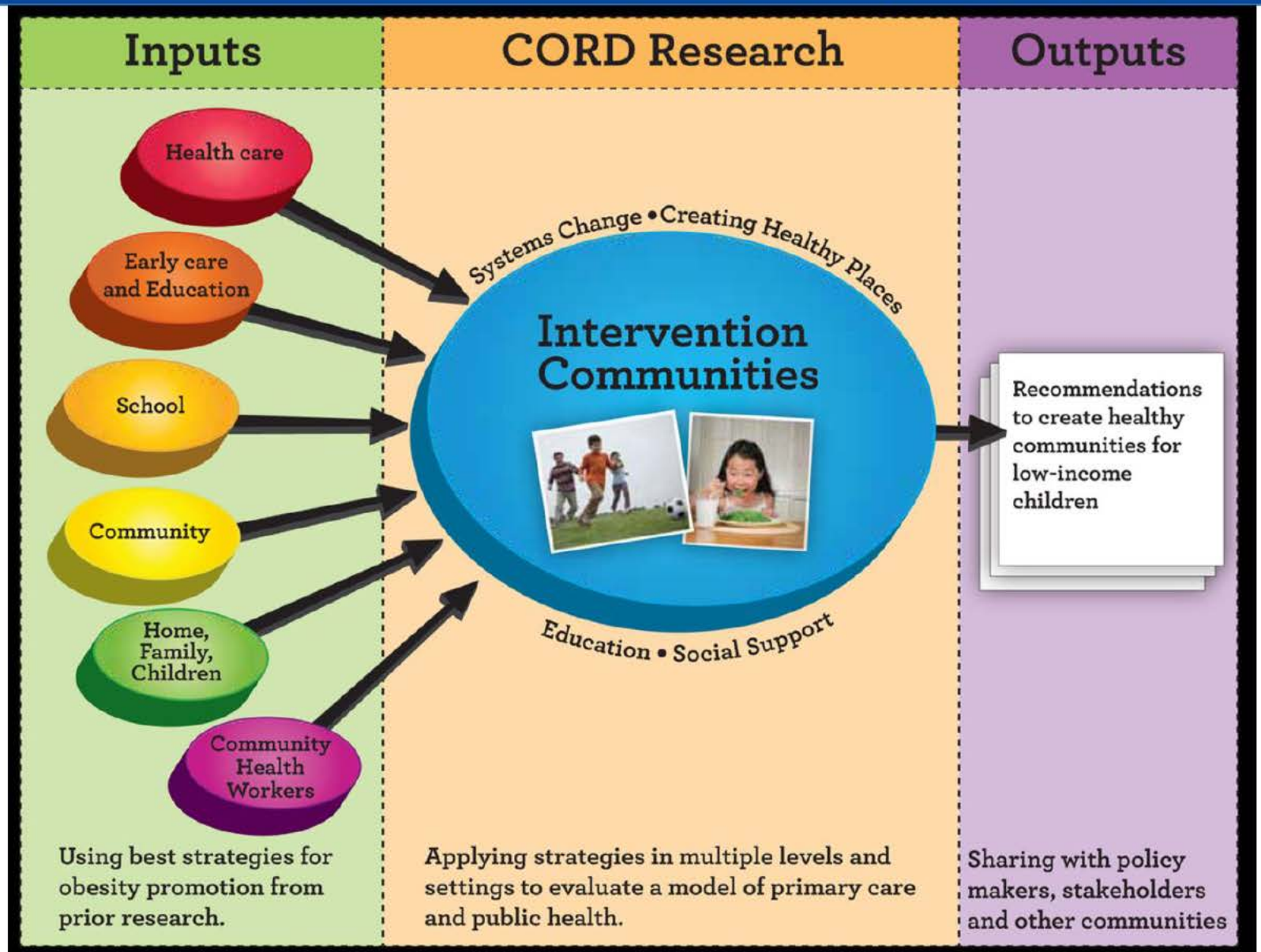
Presentation Outline

- Background
- Overview
- Evaluation
- Next steps

Background

- Goal of CORD
  - Improve diet and activity and ultimately reduce childhood obesity among underserved children
  - Test a model of public health and healthcare
- Population
  - CHIP-eligible children 2-12 years old and their families
- CORD components
  - Implement in multiple settings and multiple levels
  - Include CHWs to bridge public health and healthcare activities
  - Assess coalition and PSE changes in these settings

CORD Model


Inputs
CORD Research
Outputs
Health care
Early care and Education
School
Community
Home, Family, Children
Community Health Workers
Systems Change • Creating Healthy Places
Intervention Communities
Education • Social Support
Recommendations to create healthy communities for low-income children
Using best strategies for obesity promotion from prior research.
Applying strategies in multiple levels and settings to evaluate a model of primary care and public health.
Sharing with policy makers, stakeholders and other communities

CORD Grantees and Sites

- San Diego State University & Imperial County Healthy Dept.
  - Imperial County California
- University of Texas School of Public Health and Children's Nutrition Research Center, Baylor University
  - Austin and Houston
- Massachusetts Department of Public Health, Harvard Pilgrim, Harvard University
  - New Bedford and Fitchburg
- University of Houston (Evaluation Center)

Timeline

- Year 1: Start-up (Sept 2011—Sept 2012)
- Year 2: Implementation (Sept 2012-Present)
- Year 3: Analysis and Evaluation
- Final Report

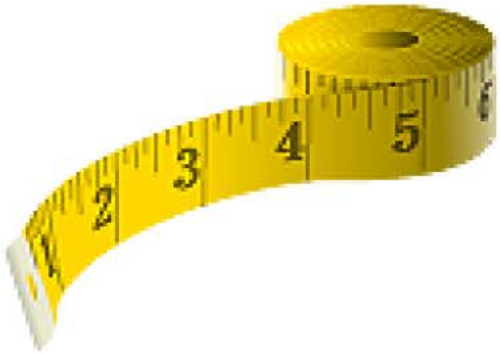
Cross-site Evaluation

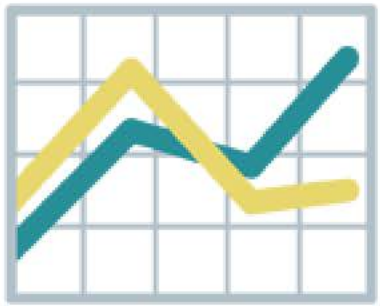
- Performed by University of Houston
- Common measures key component of cross-site evaluation
- Evaluation components
  - Outcome
  - Process
  - Cost effectiveness

Common Measures

Purpose

- A set of core outcome and process measures that are the same across all sites
- Aid in analyses within sites and across sites
- Used in addition to demonstration sites own measures
- Developed through consensus





Common Measures: Individual Level

Common measures (Individual)

- Taken from validated instruments
- Questions standardized for parent report or child self report

Measures

- BMI
- Behavioral outcomes
  - F/V intake, PA, screen time, sugar drinks, water, sleep
- Demographic variables
  - SES
- School/ECE
- Acculturation
- Quality of life
- Parenting skills
- Satisfaction with care

Common Measures: Settings

- PSE assessments to look at variation (within and across sites)
- ECE: WellCat and NAP SACC
- Healthcare: PSE assessment of clinic
- Schools (>50 schools): PSE assessment
  - District wellness policies
  - Tools used by sites: Healthy School Inventory, SHPPS, TX-SPAN
  - Observational data: SOFIT, SPAPA, water access
- Community: PSE assessments
  - State and local policies
  - Built environment
  - Availability and access to healthy options PA/nutrition (GIS)

Common Measures: Process

- Common measures (Process)
  - Dose delivered, received and fidelity
  - Community assessment
    - Coalitions/partnerships
    - Consistent messages
    - Promotion
    - Public education

Evaluation Methods

- Process evaluation
  - Using Re-Aim framework
  - Explore issues of reach and effectiveness
  - Explore issues of implementation
    - Dose
    - Fidelity
- Qualitative component
  - Highlight different CHW models
  - Describe coalitions, resources needed for implementation
  - Provide lessons learned

Cost Analysis

- Required
  - Done as part of the cross-site evaluation
- Limited number of cost studies for childhood obesity
  - Analysis by sector
  - Leveraging; incremental gain

Next Steps

- Planning as outlined above
- Report
  - Data analysis
  - Story and process
- Foster innovative care and collaboration

Promoting Prevention in Medicaid and CHIP

Upcoming Sessions

Working with Managed Care Organizations to promote prevention
May 21, 3:00-4:00 p.m. (Eastern)
877-267-1577; Meeting ID: 8494, https://webinar.cms.hhs.gov/ppmc2/

Using health IT to improve access to preventive services
May 30, 2:00-3:00 p.m. (Eastern)
877-267-1577; Meeting ID: 0374, https://webinar.cms.hhs.gov/ppmc3/

Building partnerships and financing prevention in Medicaid and CHIP
June 13, 2:00-3:00 p.m. (Eastern)
877-267-1577; Meeting ID: 2168, https://webinar.cms.hhs.gov/ppmc4/
This session is presented in partnership with ASTHO

References and Resources

Million Hearts: www.millionhearts.hhs.gov

CTG: www.cdc.gov/communitytransformation/

- Contact: Dr. Nicole Flowers: NFlowers@cdc.gov

CORD: www.cdc.gov/obesity/childhood/researchproject.html

New Prevention resources on Medicaid.gov:

- www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prevention.html
- www.medicaid.gov/AffordableCareAct/Provisions/Prevention.html

Prevention TA Mailbox: MedicaidCHIPPrevention@cms.hhs.gov