Driving Change
The Health Impact Pyramid

Direction of increasing population impact

Increasing effort & cost

Counseling & Education

Clinical Interventions

Long-lasting Protective Interventions

Changing the Context to Make Individuals’ Default Decisions Healthy

Socioeconomic Factors

National Drivers of Change

- The Patient Protection and Affordable Care Act
- Realigning systems from acute to chronic care
- Broader emphasis on prevention and chronic care management
- Support for screenings and other prevention efforts
- Reduction in avoidable readmissions
March 23, 2010 – “Today, after almost a century of trying. Today, after over a year of debate. Today, after all the votes have been tallied, health insurance reform becomes law in the United States of America…We are a nation that faces its responsibilities and faces its challenges. Here in this country we shape our own destiny…That's what makes us the United States of America.”

– President Obama
Accountable Care Organizations

- Health care providing groups, such as hospitals, physicians and other services, who work together to coordinate patient care.

- Goal is to deliver seamless, well-coordinated care within a patient-centered structure that meets standards of care while reducing cost.
Community Care Transitions Program

- Approximately 20 percent of older adults discharged from hospital are readmitted within 30 days. In many cases unavoidable, but sometimes result of poor coordination between hospitals and transfer to other settings.

- Up to $500 million in funding available from 2011 through 2015 for community-based organizations to improve transition services to manage Medicare patients’ hospital discharges.
No Co-Pay Preventive Care

No co-pay screenings and vaccines
- Mammograms
- Colonoscopy
- Pap smears
- Diabetes screening
- Prostate cancer screening
- Vaccines

No co-pay Annual Wellness visit
- Update history, check weight and blood pressure
- Review medications
- Receive advice on healthy lifestyle changes

More than 25 million seniors used a no-copay preventive service in 2011
Addressing Multiple Chronic Conditions

1. Foster health care and public health system changes to improve the health of individuals with multiple chronic conditions

2. Maximize the use of proven self-care management and other services by individuals with multiple chronic conditions

3. Provide better tools and information to health care, public health, and social services workers who deliver care to individuals with multiple chronic conditions

4. Facilitate research to fill knowledge gaps about, and interventions and systems to benefit, individuals with multiple chronic conditions
Drivers for Success

- Interventions responding to prevention/screening/readmission reduction
- Preparation of a workforce to deliver and sustain these interventions
- Prepared patients activated to engage in their care AND able to access self-management supports from the community and health care system
State Drivers of Change

- New York State Prevention Agenda
- Community Health Improvement Plans (CHIPs)
- Community Health Assessment Process