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Population Health Management 101

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SAMHSA-HRSA Center for Integrated Health Solutions

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How to ask a question during the webinar

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Today's Agenda

- What to expect from the series
- Definition of population health management
- The four components of population health management
- Next steps

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Defining Population Health Management

A set of interventions designed to maintain and improve people's health across the full continuum of care—from low-risk, healthy individuals to high-risk individuals with one or more chronic conditions

(Source: Felt-Lisk & Higgins, 2011).

Population management requires providers to develop the capacity to utilize data to choose which patients to select for specific evidence-based interventions and treatments (Source: Parks, 2014).

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The Promise of Population Health Management

- Improved Care Coordination
- Improved Services Penetration
- Trains Clinicians & Administrators to use Data to Inform Care Provision/Decision Support/Evidence-based Medicine
- Allows for Quality Metrics to be Linked to Dollars

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First Name	Last Name	DOB	Care Manager	Date of last screen	Systolic BP	Diastolic BP	Risk Category
Jerome	Salinger	3/12/60	Steve				
Bill	Watterson	9/14/55	Steve				
Lori	Moore	3/2/12	Joan				
Katherine	Dunn	12/30/27	Steve				
Curtis	Sittenfeld	6/14/68	Steve				
Irvine	Welsh	2/1/55	Joan				
Joseph	Heller	9/22/64	Steve				
Howard	Zinn	7/29/72	Joan				
Barbara	Ehrenreich	6/6/16	Joan				

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Jerome	Salinger	3/12/60	Steve	1/23/15			
Bill	Watterson	9/14/55	Steve	12/4/14			
Lori	Moore	3/2/12	Joan	11/9/14			
Katherine	Dunn	12/30/27	Steve	3/1/15			
Curtis	Sittenfeld	6/14/68	Steve	2/25/15			
Irvine	Welsh	2/1/55	Joan	4/25/14			
Joseph	Heller	9/22/64	Steve	8/14/14			
Howard	Zinn	7/29/72	Joan	2/25/15			
Barbara	Ehrenreich	6/6/16	Joan	2/25/15			

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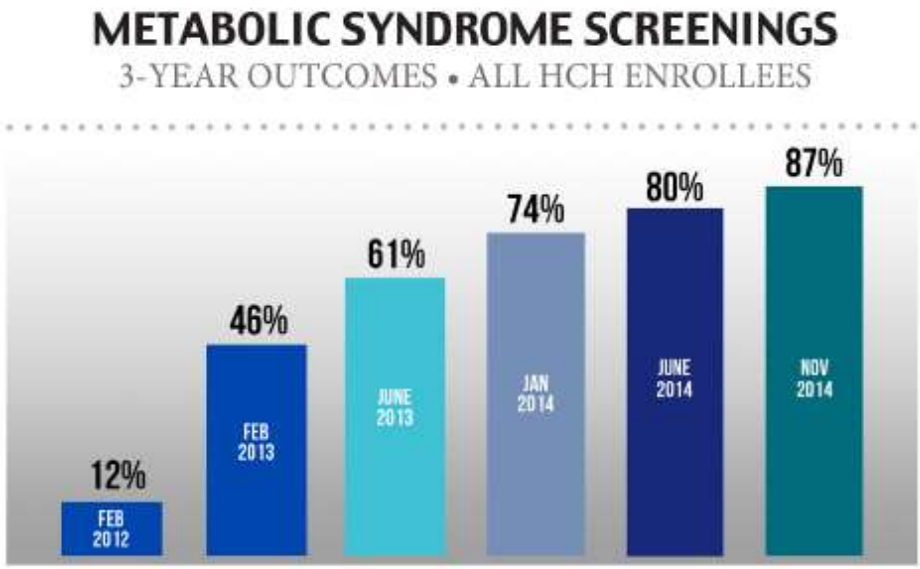
Katherine	Dunn	12/30/27	Steve	3/1/15			

First Name	Last Name	DOB	Care Manager	Date of last screen	Systolic BP	Diastolic BP	Risk Category
Irvine	Welsh	2/1/55	Joan	4/25/14	170	100	
Lori	Moore	3/2/12	Joan	11/9/14	144	87	
Howard	Zinn	7/29/72	Joan	2/25/15	125	85	
Barbara	Ehrenreich	6/6/16	Joan	2/25/15	177	121	
Joseph	Heller	9/22/64	Steve	8/14/14	117	68	
Bill	Watterson	9/14/55	Steve	12/4/14	112	72	
Jerome	Salinger	3/12/60	Steve	1/23/15	139	97	
Curtis	Sittenfeld	6/14/68	Steve	2/25/15	119	83	
Katherine	Dunn	12/30/27	Steve	3/1/15	155	110	

First Name	Last Name	DOB	Care Manager	Date of last screen	Systolic BP	Diastolic BP	Risk Category
Irvine	Welsh	2/1/55	Joan	4/25/14	170	100	HIGH - 2
Lori	Moore	3/2/12	Joan	11/9/14	144	87	HIGH - 1
Howard	Zinn	7/29/72	Joan	2/25/15	125	85	Prehypertension
Barbara	Ehrenreich	6/6/16	Joan	2/25/15	177	121	HIGH - 2
Joseph	Heller	9/22/64	Steve	8/14/14	117	68	Normal
Bill	Watterson	9/14/55	Steve	12/4/14	112	72	Normal
Jerome	Salinger	3/12/60	Steve	1/23/15	139	97	HIGH - 1
Curtis	Sittenfeld	6/14/68	Steve	2/25/15	119	83	Prehypertension
Katherine	Dunn	12/30/27	Steve	3/1/15	155	110	HIGH - 2

First Name	Last Name	DOB	Care Manager	Previous Risk Category	Current Risk Category	Was Desired Health Outcome Achieved?	Add or Reduce Costs?
Irvine	Welsh	2/1/55	Joan	HIGH - 2	HIGH -2	No	Add
Lori	Moore	3/2/12	Joan	HIGH - 1	HIGH - 1	No	Add
Howard	Zinn	7/29/72	Joan	Prehypertension	Normal	Yes	Reduce
Barbara	Ehrenreich	6/6/16	Joan	HIGH - 2	HIGH - 1	Yes	Reduce
Joseph	Heller	9/22/64	Steve	Normal	Normal	Yes	Reduce
Bill	Watterson	9/14/55	Steve	Normal	Normal	Yes	Reduce
Jerome	Salinger	3/12/60	Steve	HIGH - 1	HIGH - 2	No	Add
Curtis	Sittenfeld	6/14/68	Steve	Prehypertension	Prehypertension	No	Add
Katherine	Dunn	12/30/27	Steve	HIGH - 2	HIGH - 1	Yes	Reduce



DIABETES

3-YEAR OUTCOMES
(FEB 2012 - JAN 2015)

Good Cholesterol
↑ 37%

Normal Blood Pressure
↑ 42%

Normal Blood Sugar
↑ 46%

HYPERTENSION & CARDIOVASCULAR DISEASE

3-YEAR OUTCOMES
(FEB 2012 - JAN 2015)

Good Cholesterol
(Clients with CVD)
↑ 34%

Normal Blood Pressure
(Clients with HTN)
↑ 41%

REDUCTION IN
HOSPITALIZATIONS
IN THE FIRST YEAR

↓ 9.1%

(CMHC HEALTH HOME CLIENTS)

COST SAVINGS

(YEAR ONE)

Missouri Health Homes have saved **$30,996,642.**

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Components of Population Health Management:

1. *Knowing what to ask about your population*
2. Data registry describing your population
3. Engage in CQI process to respond to the findings
4. Use dashboards for making data understandable

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What are the questions you want answers to about your populations?

1. Who are you serving? Who are you not serving but could/should be?
2. What are the costs for the average patient?
3. What kind of services are they getting, where, & when?
4. What is the patient's response to treatment?
5. What is the patient's opinion of their care?

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PHM Measures Must have *Specifications*

The measure specifications will provide the following:

- Brief measure description
- Definition of measure numerator
- Definition of measure denominator
- Exclusions to measure, if applicable
- Description of report periods
- Tables detailing the dx and billing codes

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PHM Measure Specifications

Ambulatory Care—Sensitive Condition Admission (SCA)*

The acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to hospital, per 100,000 population younger than 75 years of age.

Numerator: The total number of acute care hospitalizations for members under 75 years of age with an ambulatory care sensitive condition as a primary diagnosis (Table SCA-A).

Denominator: The total number of health home members under 75 years of age at the midpoint of the report period.

Exclusions: Deaths prior to discharge.

Formula: (Total number of acute care hospitalizations for ambulatory care sensitive conditions younger than 75 years of age / total mid-year population younger than 75 years of age) x 100,000.

Report Period:

- Report Period 1: October 1, 2012 – December 31, 2012
- Report Period 2: October 1, 2012 – March 31, 2012

Table SCA-A: Codes to Identify Sensitive Conditions

Description	Primary ICD-9-CM Diagnosis Codes		Secondary ICD-9-CM Diagnosis Codes
Grand mal status and other epileptic convulsions	345		
COPD	491, 492, 494, 496		
	466, 480–486, 487.0	*AND*	496

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Patient Registry

"…an organized system to collect uniform data (clinical and other) to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure, and that serves one or more predetermined scientific, clinical, or policy purposes."

Source: Gliklich RE, Dreyer NA, eds. (2010). Registries for Evaluating Patient Outcomes: A User's Guide. 2nd ed.

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Registry Examples

- Provider Excel/ACCESS database (simplest)
- Managed Care Portals
- Electronic Medical Records
- Health Information Exchanges (typically do not have registries)

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Data, Information, & Knowledge

What is data?

- Granular or unprocessed information

What is information?

- Information is data that have been organized and communicated in a coherent and meaningful manner

What is Knowledge?

- Information evaluated and organized so that it can be used purposefully

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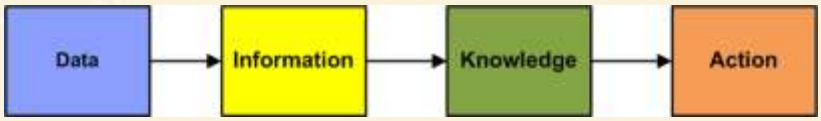
What is the ultimate purpose of collecting & sharing data?

To turn it into action!

(AKA Continuous Quality Improvement)



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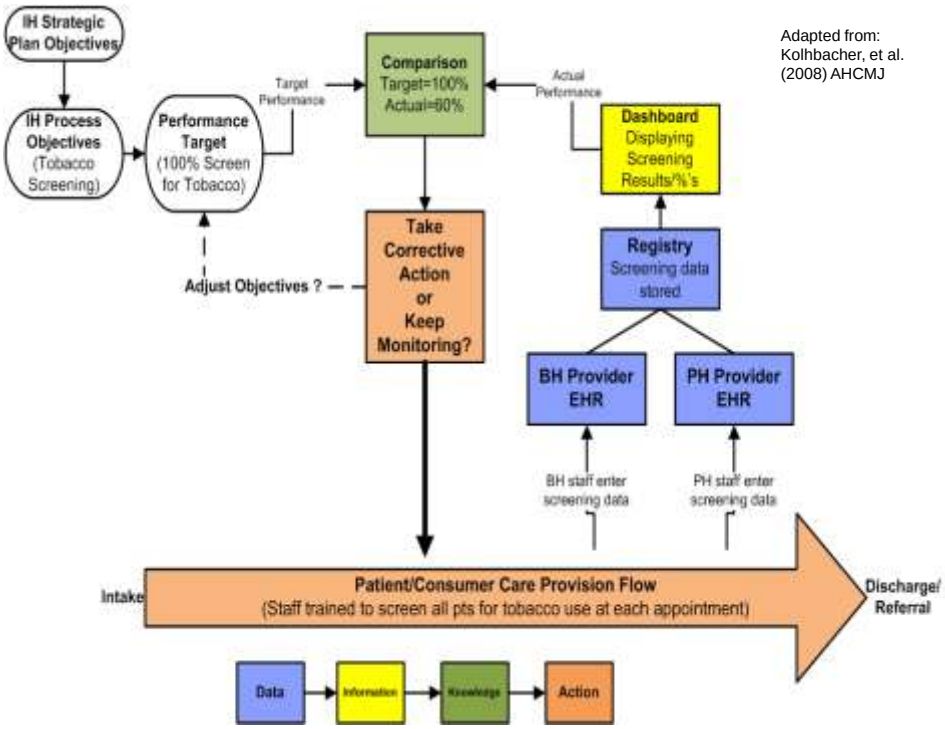
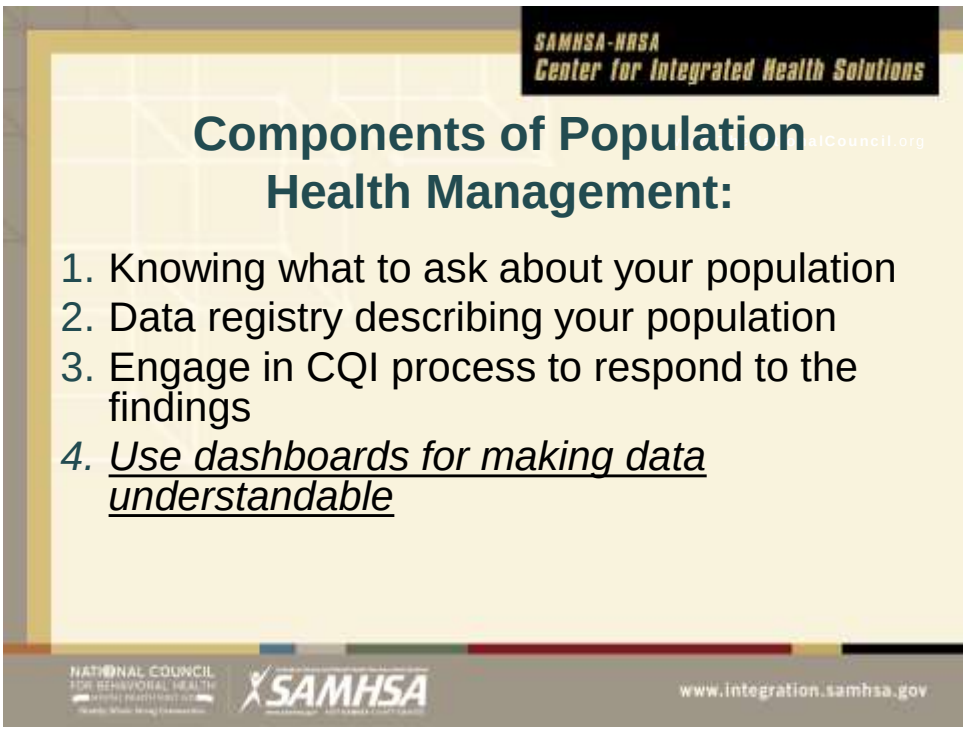


Adapted from:
Kolhbacher, et al. (2008) AHCMJ



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What is a Dashboard?

- A dashboard translates your organization's strategy into metrics that provide timely information and insights that enable staff to proactively improve decisions, optimize processes, and plans.
- In short it, enables staff to monitor, analyze, and manage their work.

Source: Performance Dashboards: Measuring, Monitoring, & Managing Your Business. 2nd Edition 2011 Wayne Eckerson

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How to use a Dashboard

1. Monitoring: Convey information at a glance
2. Analysis: Identify exceptions & drill down to details
3. Management: Improve alignment, coordination, & collaboration

Source: Performance Dashboards: Measuring, Monitoring, and Managing Your Business. 2nd Edition 2011 Wayne Eckerson

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Dashboards

- Should allow the data to tell a story about the people you serve & the care provided
- Should be "simple" to start -- target only a few key aspects of population & their care
- Should be colorful -- use red, yellow, green to draw the eye

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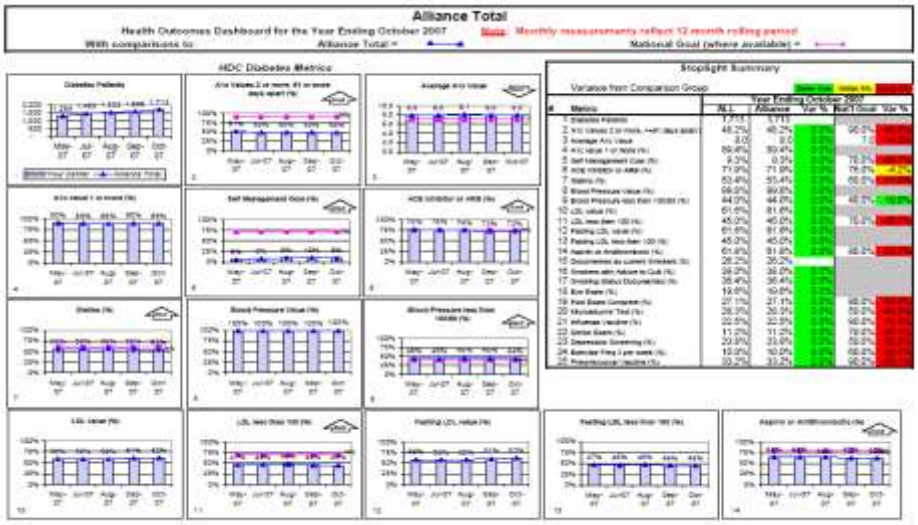
Dashboard Example



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Next Steps
Population Management using CDP
March 31, 3-4 pm EDT
Population Management using SPSS
April 7, 3-4 pm EDT
Population Management using Access
April 14, 3-4 pm EDT
Individual Coaching Calls – always
Jeff Capobianco, jeffc@thenationalcouncil.org
Aaron Surma, aarons@thenationalcouncil.org
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