



SAMHSA-HRSA Center for Integrated Health Solutions

Population Health Management In 4 Steps...

January 20, 2015



SAMHSA-HRSA Center for Integrated Health Solutions

**Slides for today's webinar are
available on the CIHS website at:**

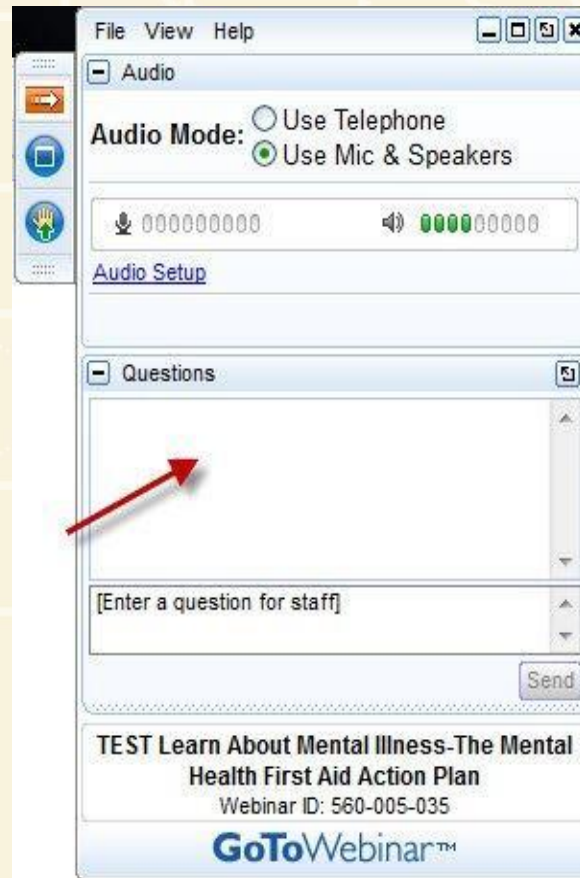
www.Integration.samhsa.gov

under About Us/Innovation Communities

Today's Agenda

- Welcome
- Overall Goal for the Innovation Communities
- Goal for the Innovation Community
- About Your Team
- What to Expect from the Innovation Community
- Participant Expectations
- Next Steps

Our format...



Structure

Short comments from experts
Specifics from their point of view

Polling You

Every 20-minutes
Finding the “temperature” of the group

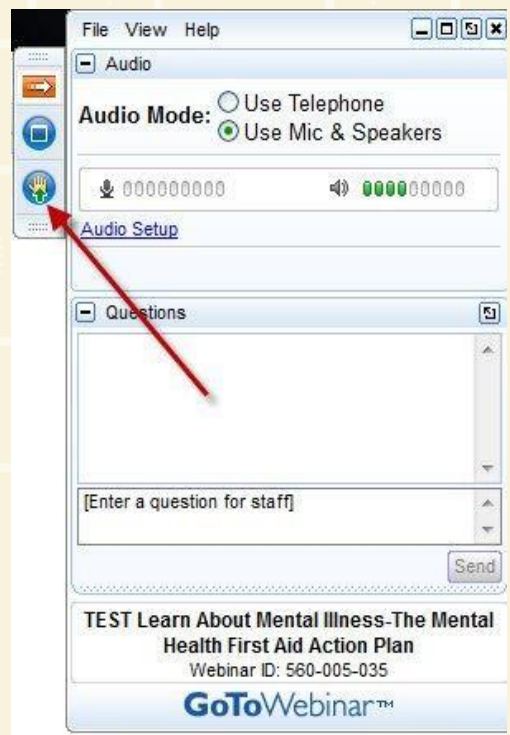
Asking Questions

Watching for your written questions

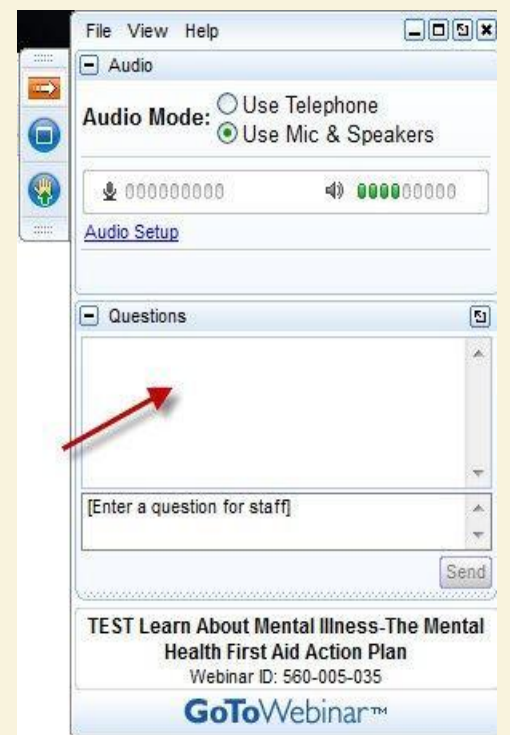
Follow-up and Evaluation

Ask for what YOU want or expect
Ideas and examples added to the
AOS Resource Center

How to ask a question during the webinar



If you dialed in to this webinar on your phone please use the “raise your hand” button and we will open up your lines for you to ask your question to the group. **(left)**



If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions. **(right)**

Innovation Communities Purpose

The IC's are designed to engage organizations in acquiring knowledge & skills to implement measureable improvements in a high priority area related to healthcare integration. Lessons learned over the course of the IC will be compiled & shared with the healthcare field so other organizations can benefit.

The IC focuses on topics and approaches that align with the following:

- Widespread relevance & applicability across integrated care settings
- Addresses a challenging problem related to integrated care
- Establishes practical & meaningful performance indicators achievable in a 9 month timeframe
- Continuously monitors progress, implementation barriers, & effective strategies
- Identifies tools & resources associated with successful implementation
- Records the lessons learned about the systemic & organization specific factors affecting the adoption & sustainability of integrated health innovations

Goals for PHI IC

- All agencies will be able to define PHM.
- All agencies will develop a plan to operationalize PHM in their organization.
- All agencies will be able to use one or more PHM approach(es) to more effectively & efficiently provide services.

Let's do this!!

1. Identify the Need (*Completed!*)
2. Allocate Resources to Address the Need (*Completed!*)
3. Conduct an Agency Needs Assessment (Jan-Feb)
4. Use the Needs Assessment Findings to Develop your Work Plan (Feb-March)
5. Execute the Work Plan with Passion & Urgency (March-August)
6. Seek Out Resources (Dec-August)
7. Share What you Learn!! (Dec-August)

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).

Population Health Management

Strategies for optimizing the health of an entire client population by systematically assessing tracking, and managing the group's health conditions and treatment response. It also entails approaches to engaging the entire target group, rather than just responding to the clients that actively seek care.

(Source: Behavioral Health Homes for People w/ MH & S/A Conditions.
National Council for Behavioral Health, 2012)

Population Health Management atCouncil.org

Approach to better managing all aspects of pt. health from wellness to complex care, by assessing health & health provision beyond a single episode of care. PHM helps clinicians assess their entire population and stratify it into various stages across the spectrum of health:

- Those who are well & need to stay well by getting preventive tests completed
- Those who have health risks & need to change their health behaviors so they don't develop the conditions they're at risk for
- Those who have chronic conditions & need to prevent further complications by closing care gaps & changing health behaviors

source: adapted from phytel.com

Collecting, Using, & Sharing Health Data

BENEFITS

- More efficient workflow (e.g. less time spent handling laboratory results)
- Improved access to clinical data
- Streamlined referral processes
- Improved quality of care--Better health outcomes
- Improved patient safety, including fewer prescribing errors and fewer hospital readmissions
- Cost savings (e.g. eliminating costs of storing paper records)
- Downsizing personnel
- Increased revenue (e.g. government incentives for use of health IT)
- Pay-for-performance incentives

BARRIERS

- Lack of Leadership
- Lack of strategic plan for data use & health IT
- Costs of EHR implementation
- Cost of establishing and maintaining links between EHRs and HIE networks
- Security and privacy issues
- Liability Provider's concern to be held liable for information from outside sources/labs
- Misaligned incentives (who pays and who benefits)
- Provider reluctance to relinquish control of patient information to competing systems
- Technical barriers (e.g. lack of interoperability among EHRs)
- Lack of IT training and support

Source: Fontaine, Ross, et al. (2010). Systematic Review of HIE in Primary Care Practices, JABPM

Analytics at Work: Smarter Decisions Better Results

by Davenport, Harris & Morison

Requirements for analytics:

- Analytical Leadership
- Accessible High Quality Data
- Enterprise/Future Orientation
- Strategy Targets
- Analysts

Components of PHM: www.TheNationalCouncil.org

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

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?

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

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

Components of PHM: TheNationalCouncil.org

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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.

Registry Examples ationalCouncil.org

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

Components of PHM: w.TheNationalCouncil.org

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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

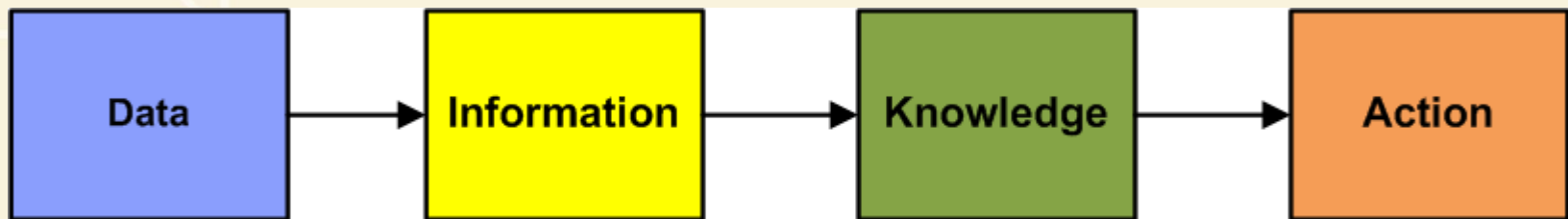
What is Knowledge?

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

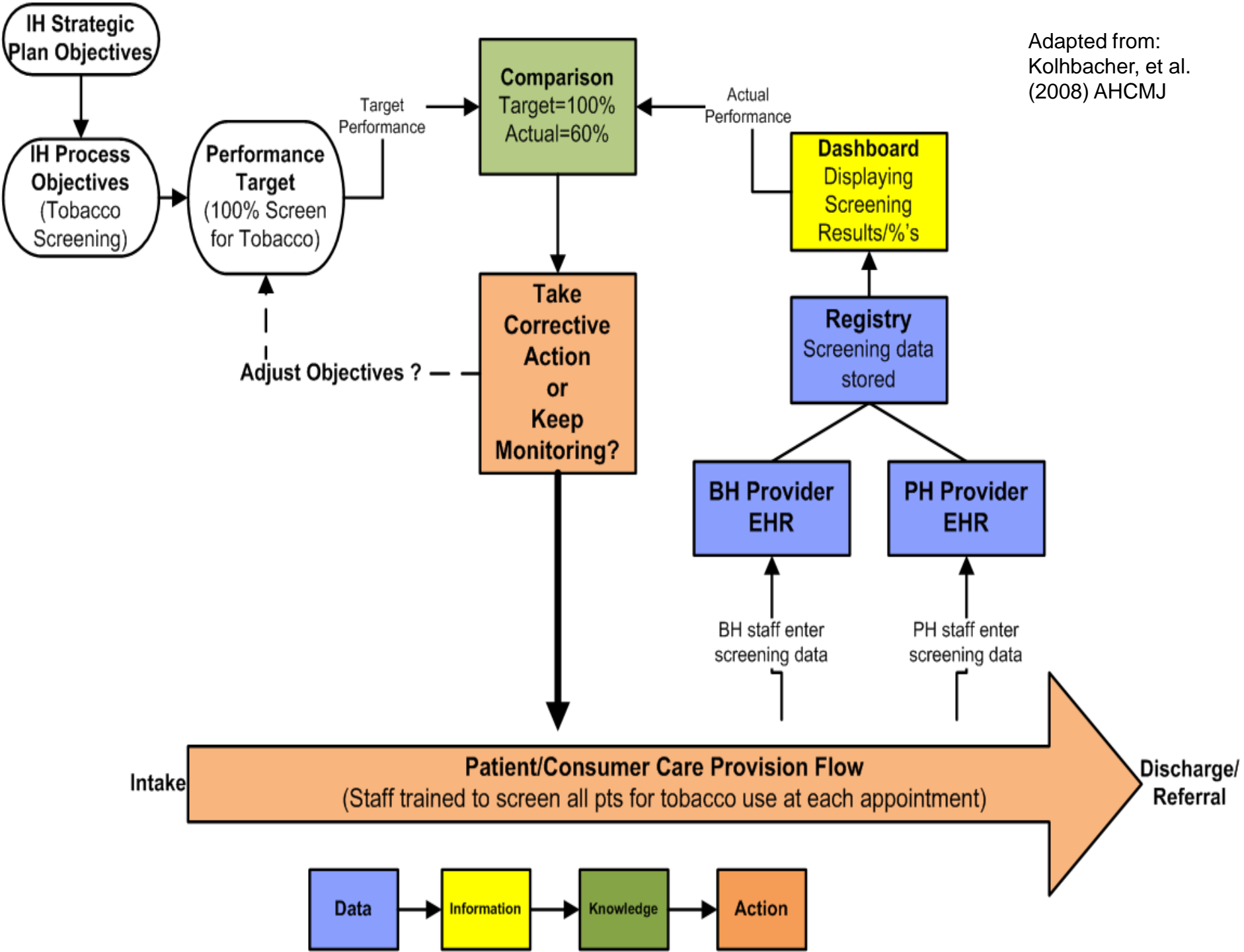
**What is the ultimate purpose of
collecting & sharing data?**

To turn it into action!

***(AKA Continuous Quality
Improvement)***



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



Components of PHM: www.TheNationalCouncil.org

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What is a Dashboard? www.TheNationalCouncil.org

- 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

How to use a Dashboard

www.TheNationalCouncil.org

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

Dashboards

www.TheNationalCouncil.org

- 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

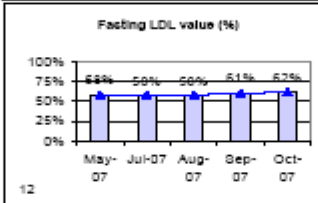
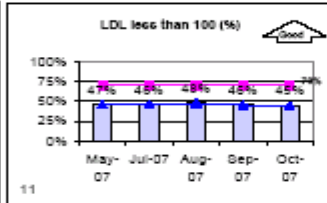
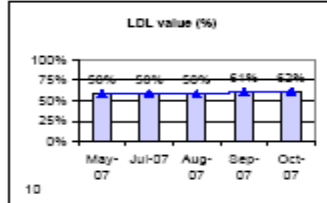
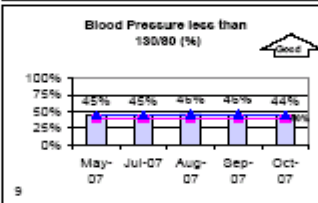
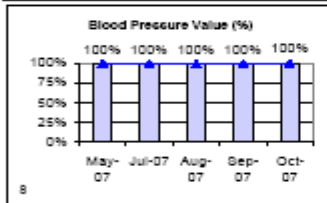
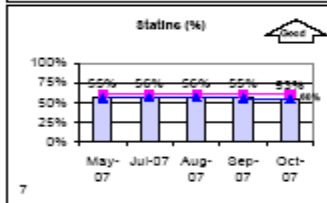
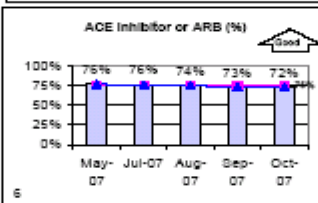
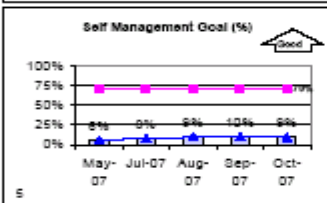
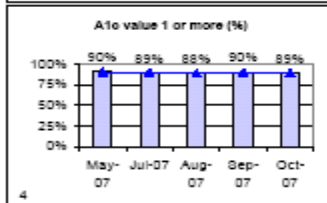
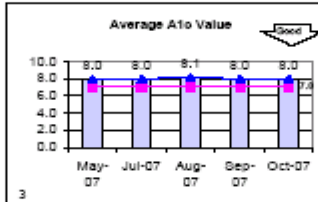
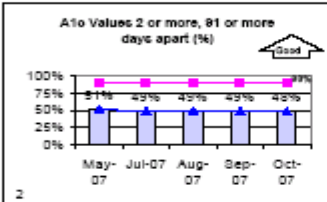
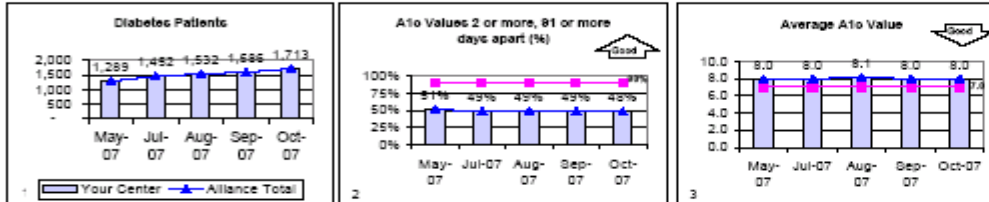
Dashboard Example

Alliance Total

Health Outcomes Dashboard for the Year Ending October 2007 Note: Monthly measurements reflect 12 month rolling period

With comparisons to: Alliance Total = National Goal (where available) =

HDC Diabetes Metrics



Stoplight Summary

Variance from Comparison Group: Better than Within 5% Worse 5%

#	Metric	Year Ending October 2007			
		ALL	Alliance	Var %	Nat'l Goal Var %
1	Diabetes Patients	1,713	1,713	0.0%	90.0% -46.5%
2	A1c Values 2 or more, >=91 days apart	48.2%	48.2%	0.0%	7.0 14.3%
3	Average A1c Value	8.0	8.0	0.0%	
4	A1c value 1 or more (%)	89.4%	89.4%	0.0%	
5	Self Management Goal (%)	9.3%	9.3%	0.0%	70.0% -86.7%
6	ACE Inhibitor or ARB (%)	71.9%	71.9%	0.0%	75.0% -4.2%
7	Statins (%)	53.4%	53.4%	0.0%	60.0% -11.0%
8	Blood Pressure Value (%)	99.8%	99.8%	0.0%	
9	Blood Pressure less than 130/80 (%)	44.0%	44.0%	0.0%	40.0% 10.0%
10	LDL value (%)	61.6%	61.6%	0.0%	
11	LDL less than 100 (%)	45.0%	45.0%	0.0%	70.0% -35.7%
12	Fasting LDL value (%)	61.6%	61.6%	0.0%	
13	Fasting LDL less than 100 (%)	45.0%	45.0%	0.0%	
14	Aspirin or Antithrombotic (%)	61.8%	61.8%	0.0%	80.0% -22.7%
15	Documented as current Smokers (%)	26.2%	26.2%	0.0%	
16	Smokers with Advice to Quit (%)	38.0%	38.0%	0.0%	
17	Smoking Status Documented (%)	36.4%	36.4%	0.0%	
18	Eye Exam (%)	19.6%	19.6%	0.0%	
19	Foot Exam Complete (%)	27.1%	27.1%	0.0%	90.0% -69.8%
20	Microalbumin Test (%)	28.3%	28.3%	0.0%	50.0% -43.5%
21	Influenza Vaccine (%)	22.5%	22.5%	0.0%	90.0% -75.0%
22	Dental Exam (%)	11.2%	11.2%	0.0%	70.0% -84.1%
23	Depression Screening (%)	23.6%	23.6%	0.0%	50.0% -52.5%
24	Exercise Freq 3 per week (%)	10.0%	10.0%	0.0%	60.0% -83.3%
25	Pneumococcal Vaccine (%)	33.2%	33.2%	0.0%	90.0% -63.1%

Next Steps

Scheduled Webinars:

- Tuesday, January 20, 3-4pm Eastern
- Tuesday, February 17, 3-4pm Eastern

Office Hours:

- January 23; 12-3pm EST
- February 20 12-3pm EST
- Or By Appt.

Homework:

- Complete & Submit a PHM Organizational Self-Assessment
- Sign-up for “office hours”
- Reading Assignment (see next slide)

Reading Assignment

Title: Population Health Management: A Roadmap for
Provider-Based Automation in a New Era of Healthcare
Publisher: Institute for Health Technology Transformation

http://www.exerciseismedicine.org/assets/page_documents/PHM%20Roadmap%20HL.pdf

Questions?

**KEEP
CALM
AND
ASK
ON**



For More Information...

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Thank you for joining us today.

Please take a moment to provide your feedback by completing the survey at the end of today's webinar.