POPULATION HEALTH MANAGEMENT, PROGRAMS, MODELS, AND TOOLS

A. LEE MARTINEZ
DBH-C, MA, LAC, CPHQ
Learning objectives
At the conclusion of this session, the participant will be able to:

- **Learning Objective 1:** Relate the findings of the 2015 SAMHSA Innovation Community for Population Health Management to your own organization.

- **Learning Objective 2:** Define Population Health and Population Health Management and understand the role of the Population Health Management Administrator (PHA) within that framework.

- **Learning Objective 3:** Articulate the importance of a solid foundation of data for improvement and how IHI’s Model for Improvement can be used as a common framework across a network of providers.
Meeting the Triple Aim

- Improved Patient Experience
- Improved Population Health
- Reducing Per Capita Cost of Health Care

This presentation will help behavioral health organizations to understand their population, think of strategies for identifying common diagnoses, and develop targeted approaches for specific chronic illnesses.

By identifying and sorting the population they are serving by health condition, organizations will have the ability to develop cost effective interventions and track health improvement over time.
SAMHSA Innovation Community for Population Health Management

• On December 11, 2014, Cenpatico of Arizona was informed they had been selected, with 34 other agencies nationwide, to participate in the SAMHSA-HRSA Center for Integrated Health Solution’s (CIHS) Innovation Community (IC) for Population Health Management

• Reportedly the selection process was very competitive

• Those who were selected were informed that it was directly related to reporting well developed goals and objectives for leveraging population health
SAMHSA Innovation Community for Population Health Management

Goals for the Innovation Community

- All agencies will be able to define population health management (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
Program

- Monthly webinar sessions (total of 8) composed of expert teaching, discussion, participant presentations & guided cross-participant coaching
- 4 facilitated coaching calls where the participants will received targeted support from faculty members
- Small group calls in a focus group format.
- Closing webinar (3 hours)
Program timeline

1. Identify the Need (Dec 2014)
2. Allocate Resources to Address the Need (Dec 2014)
3. Conduct an Agency Needs Assessment (Jan-Feb 2015)
4. Use the Needs Assessment Findings to Develop a Work Plan (Feb-March 2015)
5. Execute the Work Plan with Passion & Urgency (March-August 2015)
7. Share What you Learn!! (Now!)
Innovation Community: Population health Management in behavioral health providers

3. Conduct a network wide needs assessment (January – February 2015)

www.integration.samhsa.gov/about-us/PHM_IC_Self_Assessment_Jan_2015.doc

The Self-Assessment tool is designed to help your organization identify the elements necessary to conduct PHM and to determine the degree to which your organization needs to develop or improve upon one or more of these elements.

- Organizational Culture & Leadership
- Analytic Capability
- Health Information Technology Capability
- Quality/Performance Improvement Capability
Innovation Community: Population health Management in behavioral health providers

4. Use the Needs Assessment Findings to Develop Network Wide Work Plans (February – March 2015)
A variety of work plan themes were developed, including:

- Create an evidenced-based outcomes program linked to a disease registry
- Use population health data to develop the business case for partnering with hospitals, managed care and federally qualified health centers
- Identify cost of consumers served
- Educate staff about PHM and identify and establish data outcomes tools
- Use rapid cycling continuous quality approaches to understand population health needs and services impact
Lessons for Sharing included:

- Ensure leadership was actively involved in development, rollout and most importantly the ongoing communication about the PHM initiative
- Start with data that is available, clean, and meaningful to staff
- Explain to staff the “Why” then move to the “What” of PHM
- Make sure to use Plan-Do-Check/Study-Act cycles to monitor rollout
- Find organizations that are doing PHM well and talk to them
- Make sure terms like PHM are defined and understood
- Remember it is easy to get distracted by the many needs and avenues for improvement, stay focused until project is complete then take on next your objective
- Engage staff early and often regarding the definition of PHM and provide training
Defining Population Health Management

Population management requires providers to develop the capacity to utilize data to choose which patients to select for specific evidence-based interventions and treatments (Parks, 2014)
Which Electronic Health Record (EHR) does your agency use?

Poll Results (single answer required):

- **Netsmart product**: 11%
- **Epic product**: 2%
- **NextGen**: 8%
- **Homegrown**: 9%
- **Other**: 70%

Where would you rate your agency in its ability to conduct population health management?

Please select one:

- **New (PHM is new to us)**: 46%
- **Intermediate (We do PHM, but not a lot)**: 46%
- **Advanced (We do PHM and are looking to enhance capacity)**: 7%
Defining Population Health Management

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

• 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 (Felt-Lisk & Higgins, 2011)
Figure 1. Population Health Conceptual Framework

- Population Monitoring/Identification
  - Health Assessment
  - Risk Stratification
    - Health Continuum
      - No or Low Risk
      - Medium Risk
      - High Risk
      - Patient-Centered Interventions
        - Health Promotion, Wellness
        - Health Risk Management
        - Care Coordination/Advocacy
        - Disease/Case Management
      - Organizational Interventions (Culture/Environment)
      - Tailored Interventions
        - Patient
      - Community Resources
    - Operational Measures
      - Impact Evaluation Outcomes
        - Psychosocial Outcomes
        - Behavioral Change
        - Clinical and Health Status
        - Patient & Provider Productivity, Satisfaction, QOL
        - Financial Outcomes

PRIMARY CARE

CARE CONTINUUM ALLIANCE
Population Identification

- Medicaid eligible individuals with a serious mental illness
- Medicare-Medicaid dual-eligible individuals with a serious mental illness
- Medicaid eligible individuals with general mental health/substance abuse needs
- Medicaid eligible children
- Non-Medicaid eligible individuals with a serious mental illness
- All residents in a region
Risk Stratification

• Stratify patients into meaningful categories for patient-centered intervention targeting, using information collected in the health assessments
• Cenpatico uses mathematical algorithms to predict risk
• Stratification helps align members with appropriate intervention approaches, thereby maximizing the health improvement impact of care
• This process is designed to aid both our providers and clinicians by helping them focus appropriate resources on those patients and segments of the population with greatest need (e.g. HN/HC)
Figure 1. Population Health Conceptual Framework

- Population Monitoring/Identification
- Health Assessment
- Risk Stratification

Health Continuum:
- No or Low Risk
- Moderate Risk
- High Risk

Patient-Centered Interventions:
- Health Promotion, Wellness
- Health Risk Management
- Care Coordination/Advocacy
- Disease/Case Management

Organizational Interventions (Culture/Environment)

Tailored Interventions

Community Resources

Primary Care

Impact Evaluation Outcomes:
- Psychosocial Outcomes
- Behavior Change
- Clinical and Health Status
- Patient & Provider Productivity, Satisfaction, QOL
- Financial Outcomes

Primary Care Continuum Alliance
The Population Health Management Administrator (PHA)

The PHA pulls together upper management, technical, and clinical staff where appropriate to assist in designing systems and processes to overcome barriers to optimum member care.
The Population Health Management Administrator (PHA)

- Responsible to report to the CEO on elements of the triple aim affecting the population they serve.
- This means PHA facilitated projects are focused on value-based interventions (i.e., working smarter, not harder)
PHA Qualifications

Strong leadership skills and management presence.

- Report directly to senior management, preferably the CEO and is seen as representing the EMT when in the field
- Ability to affect change within the entire organization
- **Ability to act on data (data fluency)**
- Training skills, including mentoring of mid-level staff
- Report staff performance related to the actionable activities to senior leadership
PHA Qualifications

- Expert communication/presentation skills (written and verbal)
- Strong quality improvement (QI) and quality management (QM) skills in a health care setting
  - Familiarity with the Institute for Healthcare Improvement (IHI)
  - Experience using the Model for Improvement, including expertise in Plan>Do>Study>Act (PDSA) rapid cycle project development
  - CPHQ certification preferred
Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

Act

Plan

Study

Do
Rapid Cycle PDSA
Highly Adoptable Improvement Model

* The person icon represents the collective recipients of the change; those individuals required to carry out the tasks associated with the intervention.
Population Health Management Experience (Ideal)

- Understands the Triple Aim
- Understands Payment Reform
- Understands the role of the Care Manager
So who is Don Berwick?

Donald M. Berwick, MD, MPP, FRCP

- Founded an organization called the Institute for Healthcare Improvement (IHI)
- IHI developed:
  - The Triple Aim
  - The Model for Improvement
- Former Administrator of the Centers for Medicare & Medicaid Services (CMS)
Your Mission… Should You Accept It

Watch 5 YouTube Videos in Preparation for Advanced Training that will be Conducted on October 21st

1. Quality Improvement or QI in Healthcare
2. The Model for Improvement
3. Levels of Measurement
4. Measures of Central Tendency
5. Normal Distribution

Make sure you understand these concepts very well before the 21st!
QUALITY IMPROVEMENT
OR... QI
in Healthcare

https://www.youtube.com/watch?v=jq52ZjMzqyl
The Model For Improvement

https://www.youtube.com/watch?v=SCYghxtioIY
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<tr>
<td>9:00</td>
<td>Introductions</td>
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<tr>
<td>9:30</td>
<td>Pre-Test</td>
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<tr>
<td>10:00</td>
<td>The value of displaying data graphically vs. table of numbers, pie charts, or summary statistics</td>
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<td>11:30</td>
<td>LUNCH/Introduction to Shewhart charts</td>
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<td>1:15</td>
<td>Pareto charts, histograms and scatter plots</td>
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<td>1:45</td>
<td>Matching each of 5 fundamental tools to the question being asked</td>
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<td>2:00</td>
<td>Learn how the CRC in Tucson has leveraged Xbar charts to improve internal operations</td>
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<td>3:00</td>
<td>Review Test Answers</td>
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<td>Close</td>
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5 Tools to Learn from Variation in Data
A. Lee Martinez

📞 480-489-3095

📧 lemartinez@cenpatico.com
Lee is Manager of Health Home Development for Cenpatico Integrated Care. In this role, Lee is responsible for the development of Health Homes serving the Title 19 Adult SMI population across the network. Lee is starting his last year in the management track of the ASU Doctor of Behavioral Health (DBH) program. As part of his role, Lee provides training, consulting, and mentoring to 19 population health management administrators (PHAs) across the network in Southern Arizona on projects based on IHI’s Model for Improvement.


Questions