Population Health Management Programs, Models, and Tools

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Agenda

Introduction
Goals and Objectives
Population Health Management and the PHA
SAMHSA Innovation Community for Population Health Mgt.
The Behavioral Health Integrated Capacity Assessment Tool
Wrap-up and Questions
Introduction – Health Home Development

- Providing direction and support to network providers to develop and improve the performance of Health Homes.

  - Support provider Health Home development, including assessment of preparedness and monitoring progress and outcomes.
  - Oversee program development guidance related to health home wellness programs.
  - Develop and oversee implementation of the Population Health Management Administrator role, including development of performance improvement strategies.
  - Promote the use of health information technology to support the improvement of Health Home services provided to members.
Goals and Objectives

- Define Population Health and Population Health Management
- Understand the Population Health Management Administrator (PHA) role within the Cenpatico Integrated Care Network.
- Understand how IHI’s Model for Improvement can be used as a common framework across a network of providers.
- Receive an update on Cenpatico Integrated Care Network’s participation in the SAMHSA Innovation Community for Population Health Management.
- Learn about the Behavioral Health Integrated Capacity Assessment (BHICA) tool for Health Home and Population Health Development.

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Population Health Management
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 (Felt-Lisk & Higgins, 2011).
Care Continuum Alliance’s Population Health Conceptual Framework provides a good illustration of the process and activities associated with population health as defined by Felt-Lisk & Higgins.
Figure 1. Population Health Conceptual Framework
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
Health Assessment

**The effort to assess the health of a specific population (i.e., diabetic population, co-morbid conditions, etc.).**

**May draw on available information, including self-reported health questionnaires, health insurance claims, laboratory and pharmacy data and clinician documented information.**

**Analytics and the ability to combine and analyze this data is a key part of this process.**
Health Risk Assessment (HRA)

Completed with case management assistance. Used by the CM to guide conversation about the member’s health needs/concerns.
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

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

PRIMARY CARE

Feedback Loop
While there is an initial assessment, repeated measures over time are necessary to demonstrate changes in health status of members and populations over time.

This monitoring of results in a continuous feedback loop for the care team facilitates documenting the progress of any population-based care over time, establishing new baselines and adjusting care interventions in a continuous cycle of quality improvement and improved patient experience.
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Community Resources

PRIMARY CARE
Stratify patients into meaningful categories for patient-centered intervention targeting, using information collected in the health assessments.

This process yields information that the system can use to divide the patient population into different levels for Care Management, Care Coordination, or Coordination of Care.

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).

Second definition of PHM: 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).
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Organizational Interventions (Culture/Environment)

Tailored Interventions

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Primary Care

PHA
Population Health Management Administrator (PHA)
The Population Health Management Administrator (PHA)

To succeed in a performance-based purchasing environment, we need to be able to engage in population management that identify, engage, and intervene with patients who are high need/high cost.
The Population Health Management Administrator (PHA)

The top 5 percent utilizers within the Medicaid population account for around half of all Medicaid expenses.
Each Cenpatico-contracted Intake and Coordination of Care (ICC) Agency is required to have a Population Health Administrator (PHA) on staff, reporting directly to the provider CEO or other senior manager.

The PHA leverages information provided by Cenpatico through the Provider Portals to improve member care and achieve health outcomes.
The Population Health Management Administrator (PHA)

The PHA is required to perform two core functions:

- Disseminate actionable data to the appropriate resources through their EHR system, or the best means possible, to close gaps in care.
- Facilitate process changes and process improvement projects that address core performance gaps.
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)
Cenpatico uses its Centelligence suite of technology and analytical tools (management solutions that uses advanced analytics and algorithms to identify high-risk members and deliver actionable data) and our broad data warehouse to identify care gaps, such as overdue well person visits, follow up after inpatient care, and more.
Provider Portals

Actionable data is distributed quickly to providers via the Cenpatico Provider Portals.

Follow-up reports will continue to be developed over time and put out on both a scheduled and Ad Hoc basis, to ensure customized delivery of information.
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
- Training skills, including mentoring of mid-level staff.
- Report staff performance related to the actionable activities to senior leadership.
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
- CPQH certification preferred
PHA Qualifications

Population Health Management Experience

• Understands the Triple Aim
• Understands Payment Reform
• Understands the role of the Care Manager
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
Process Modeling

1. Modify input
2. Combine steps
3. Eliminate hand-off failures
4. Eliminate step
5. Reorder sequence
6. Smooth work flow in a step
7. Replace with better value step
8. Based on outcome, redesign the process
9. Perform tasks parallel with main process
10. Listen to customers (patients, families, staff)
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.
Rapid Cycle PDSA
SAMHSA-HRSA Center for Integrated Solutions Innovation Communities
Innovation Community Purpose

Innovation Communities are designed to engage organizations in acquiring knowledge and skills and applying their learning to implement measurable improvements in a high priority area related to healthcare integration.

The Innovation Community is designed to address three key components associated with innovation implementation including:

- Topic specific foundational information, knowledge, and best practices
- Innovation implementation planning
- Adoption of the innovation and sustainability
Innovation Community: Population health Management in behavioral health providers

This innovation community was created to help behavioral health organizations:

• Understand their population
• Think of strategies for identifying common diagnoses
• Develop targeted approaches for specific chronic illnesses.

By identifying and sorting the population by health condition, organizations will have the ability to track health improvement over time.
Innovation Community: Population health Management in behavioral health providers

Step 1: 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.
  o Organizational Culture & Leadership
  o Analytic Capability
  o Health Information Technology Capability
  o Quality/Performance Improvement Capability
Step 2: Use the Needs Assessment Findings to Develop Network Wide Work Plans (February – March 2015)


- Twelve agencies participated in the survey. Based on the results, Cenpatico recommended developing a work plan for 2c (dashboard reports) and 2d (development of an electronic data registry to aggregate data specific to the disease conditions we treat), which demonstrated the most interest and need across the majority of agencies.
Innovation Community: Population health Management in behavioral health providers

Step 3: Execute the Work Plan with Passion & Urgency (March - August 2015)

• In Process
Innovation Community: Population health Management in behavioral health providers

ファイル Step 4: Share What you Learn (August – December 2016)
Behavioral Health Integration Capacity Assessment (BHICA)
The Behavioral Health Integration Capacity Assessment (BHICA) is designed to assist behavioral health organizations in assessing their ability to integrate primary care services.

The BHICA allows behavioral health organizations to evaluate their current processes related to three approaches to integrated care: coordinate care; co-locate care; or build primary care capacity in-house.

The tool was developed by The Lewin Group and The Institute for Healthcare Improvement (IHI) under a contract with the Medicare-Medicaid Coordination Office.
The BHICA is designed to facilitate a candid analysis of the current practices and processes within your organization that support integration.

The scoring tool will also help you to identify possible next steps in your integration work.

Staff working in the behavioral health setting are asked to evaluate their population, their organization’s processes, and their cultural norms.
Providers and organizations that want to move towards integration need to address core operational capabilities, including, but not limited to the following population health capabilities addressed in the BHICA:

- Capacity to Collect Data, Exchange Information, and Monitor Population Health
  - **Capability:** Organizations use an electronic health record (EHR) or other methods to collect individual and practice-level data that allows them to identify, track, and segment the population.
  - Ideally, organizations have a reliable system for collecting data that supports aggregation of data, information sharing, and identification of high-risk populations.

- Progress and Outcome Tracking Capability
  - **Capability:** The organization is able to measure the effectiveness of the treatment provided.
  - Ideally, organizations are able to track individuals’ medications, lab results, and symptom management and use this data to adjust treatment as needed.
Summary

Offered a couple of definitions of Population Health and Population Health Management relevant to our work at Cenpatico.

Learned about the Population Health Management Administrator (PHA) role within the Cenpatico Integrated Care Network and explored how IHI’s Model for Improvement is used as a common framework across a network of providers.

Received an update on Cenpatico Integrated Care Network’s participation in the SAMHSA Innovation Community for Population Health Management and learned about a survey tool that is available for PH development.

Learned about the Behavioral Health Integrated Capacity Assessment (BHICA) tool for Health Home and Population Health Development.

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Wrap-up & Questions