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Population Health Management (PHM) Part 2: Pop Health and Measurement-Informed Care

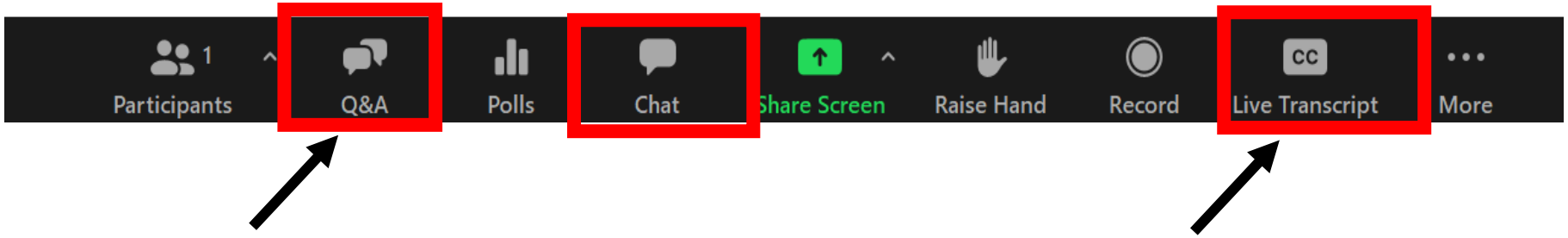
Thursday, January 12th from 2-3pm ET

CENTER OF EXCELLENCE for Integrated Health Solutions

Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

Questions, Comments & Closed Captioning

Type in a **comment** in the **chat box**



Type in a **question in the Q&A box**

Click **Live Transcript** and then select **"Show Subtitle"**

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Poll #1: What best describes your role?

- Clinician
- Administrator
- Policy Maker
- Payer
- Other (specify in chat box)

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Webinar Series Details

Upcoming Series Sessions:

- February 7th from 2-3pm
  ET: Population Health Part 3- Clinical Pathways for PHM
- March 9th from 2-3pm
  ET: Population Health Part 4- Real World Examples for PHM

Past Series Sessions:

- Part 1: Intro to Population Health

Today's Speakers

NSI STRATEGIES
CONSULTING SUPPORT FOR INTEGRATED HEALTHCARE ENVIRONMENTS

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UCSF
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Assistant Professor, UCSF
Affiliate faculty, SIREN

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Learning Objectives

After this webinar, participants will be able to:

- **Recognize** key components of a strategic plan for utilizing population health strategies to improve patient outcomes within integrated care settings.
- **Understand** how to select population health metrics based on key components of a strategic plan.
- **Identify** strategies to use data as a tool for accelerating change, improving patient outcomes and increasing equity in integrated care.
- **Explore** opportunities for collecting and utilizing data to understand and address social determinants of health needs and cultural and linguistic characteristics of populations within integrated care settings.

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Part 1 Webinar Recap

- Basic concepts of population health management
- Clarifying terminology
  - Social determinants of health; social drivers of health
  - Social risks
  - Social needs
- Described the value that population health management strategies bring to integrated care organizations, including optimizing resources and improving equitable care pathways.
- Explored how to utilize population health approaches to support equitable integrated care and best meet the needs of marginalized communities.
- Identified opportunities for using population health management (PHM) to support the adoption of changed clinical pathways post COVID-19.

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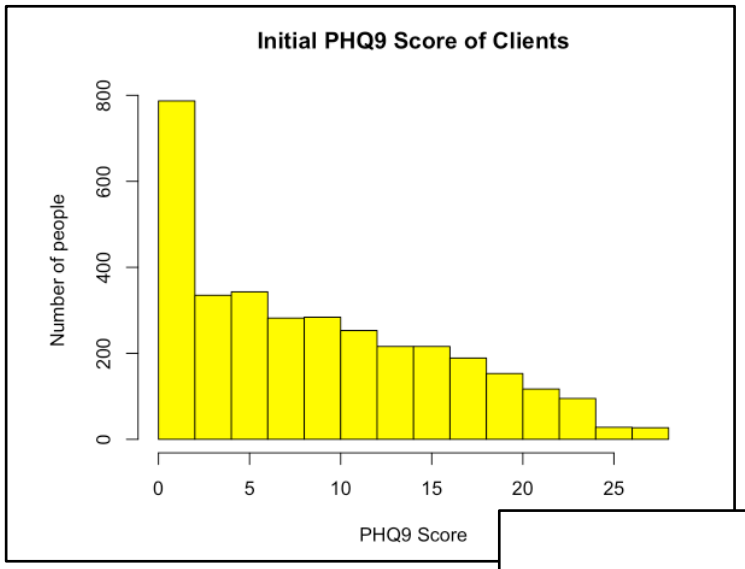
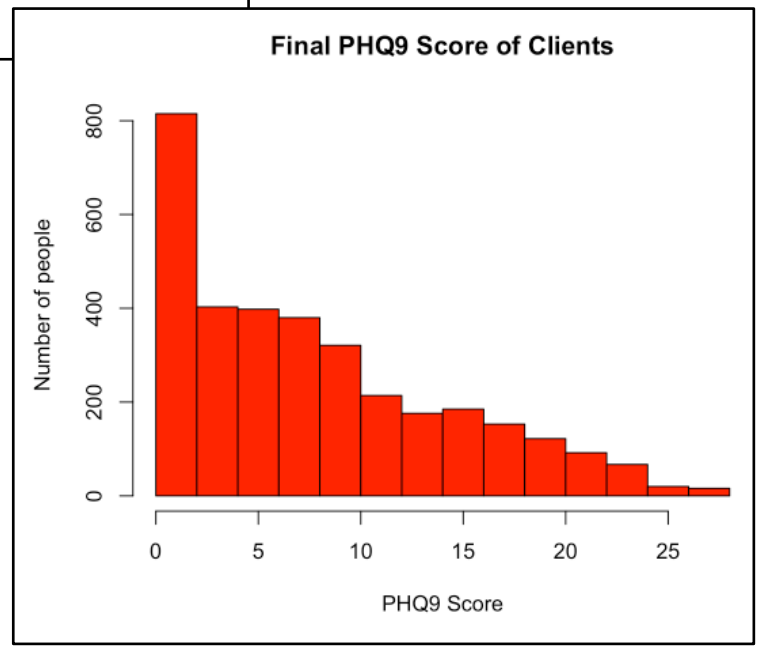
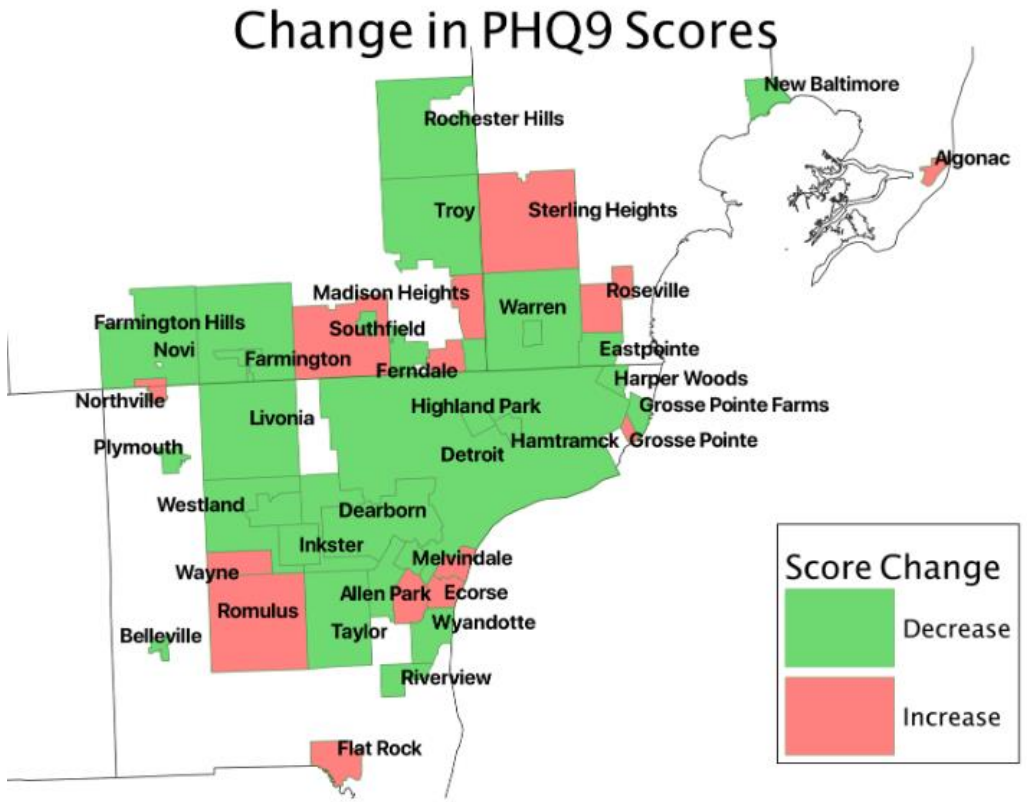
PHQ9 Score Comparison (1 of 2)

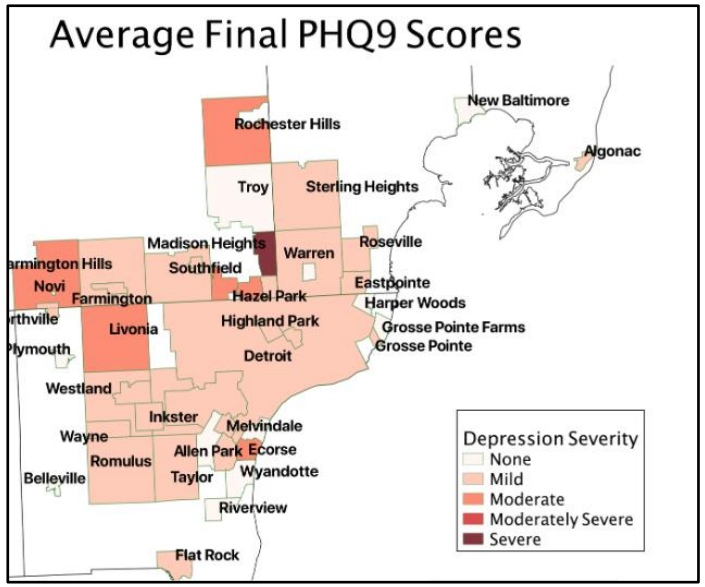


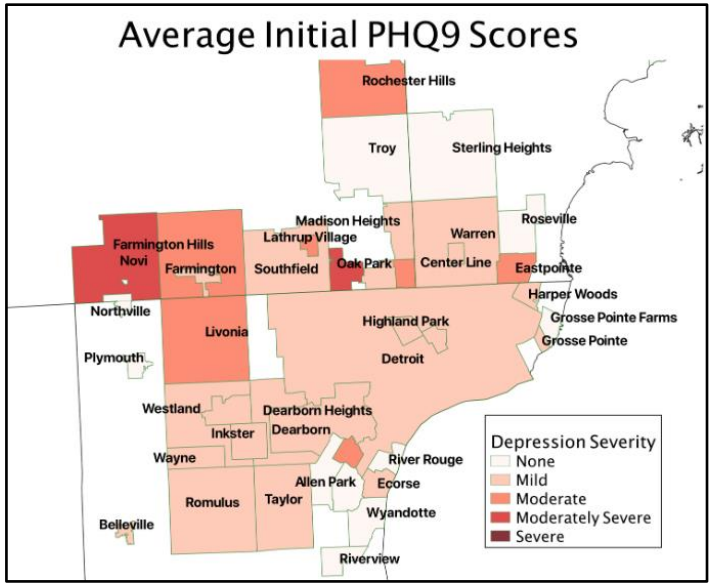




Source: Susan Wu, (n.d.). [Comparing PHQ9 Scores](#).

PHQ9 Score Comparison (2 of 2)



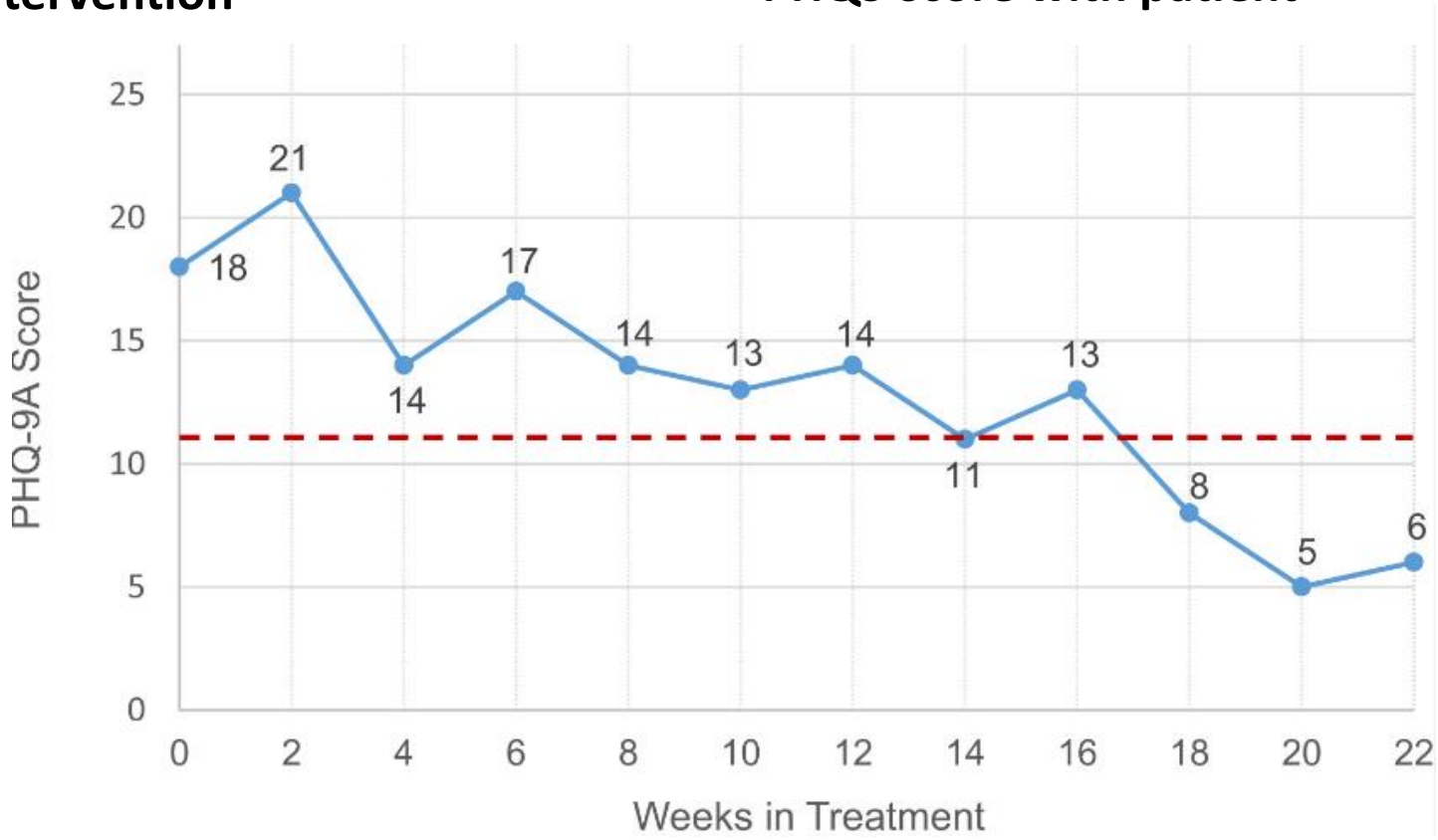


Source: Susan Wu, (n.d.). [Comparing PHQ9 Scores](#).

Using the Data

When we started intervention

Compare the patient mood report and PHQ9 score with patient



Source: Susan Wu, (n.d.). Comparing PHQ9 Scores.

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A Strategic Plan

Where do we start?

What do my teammates need support with?

What do our clients and patients need support with?

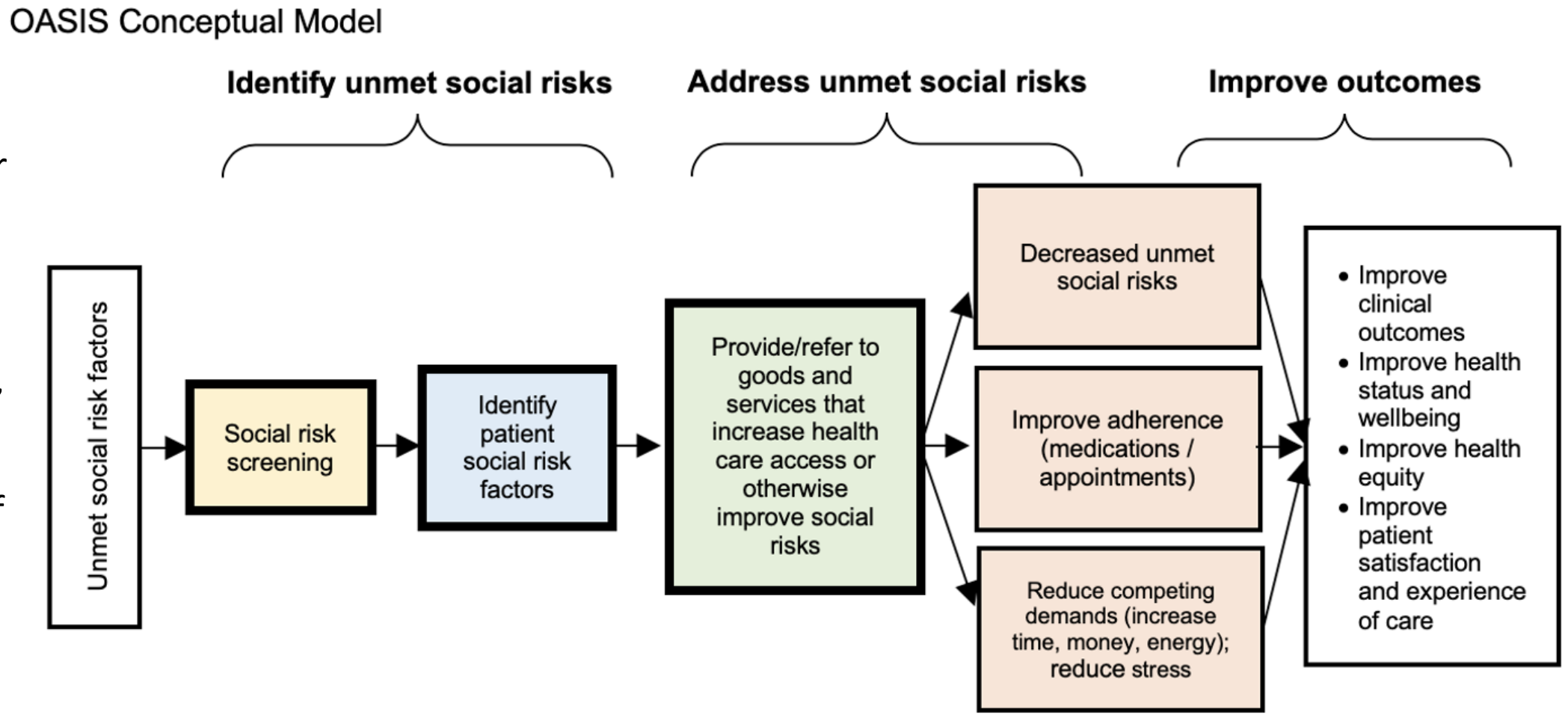
What are the strengths of our integrated care team?

What are the existing quality indicators we are already accountable for?

What data can we pull out to create into a report?

Using Data to Understand Population Health Needs

Opportunities for collecting and utilizing data to understand and address adverse drivers of health, and cultural and linguistic characteristics of populations



Source: Gurewich, D., et al. (2020).[Addressing Social Determinants of Health Within Healthcare Delivery Systems: a Framework to Ground and Inform Health Outcomes]

Using Data to Understand Population Health Needs

Collecting data on social risks

- Standardized screening tools
- Guidelines / best practices for screening

Evaluating collected data

- Who is getting screened
- Who is screening / documenting risks
- Risks experienced across patient populations

Acting on data

- 6A's for integrating medical and social care

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6 A's for Integrating Medical/Social Care

Awareness Identify social risk factors	**Adjustment** Accommodate care to social risk	**Assistance** Intervene on social risk factors
Advocacy Develop new resources	**Alignment** Align existing resources	**Abolition** Apply an abolition frame across A's

Source: National Academies of Sciences, Engineering, and Medicine. (2019). Integrating social care into the delivery of health care: Moving upstream to improve the nation's health.

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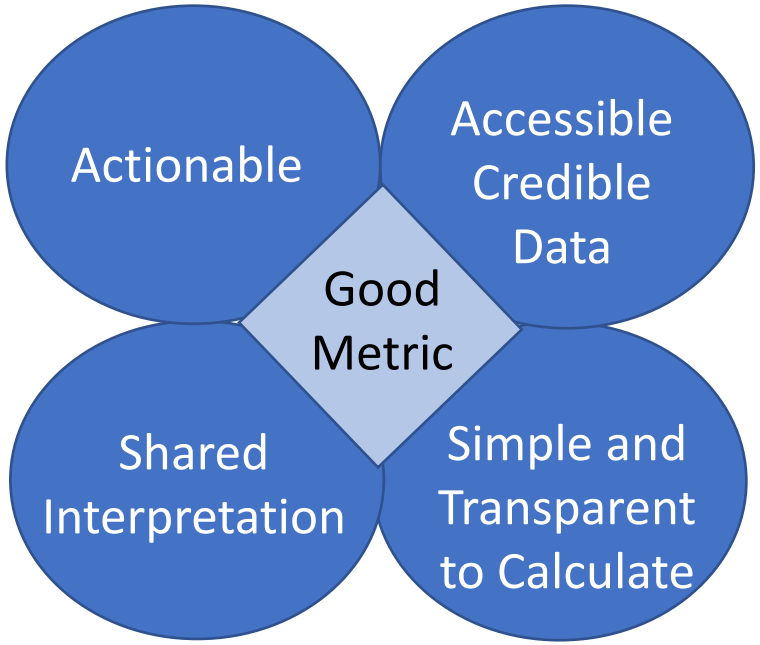
Choosing your Metric or Key Performance Indicator



Source: Stoto MA. (2015). *Population health measurement: applying performance measurement concepts in population health settings.*

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Risk Stratification

- **Risk-stratified care management:** process of assigning a **health risk status classification** and using it to direct and improve care.
  - A consumer is at risk when he/she reaches an **established threshold** or cutoff that **triggers a step-in care** (i.e., up or down).
  - High utilizers are the most familiar example of a risk group.[1]
- Risk stratification helps patients achieve the best health and quality of life possible by:
  - **preventing** chronic disease
  - **stabilizing** current chronic condition
  - **preventing acceleration** to higher-risk categories and higher associated costs [2]

Sources
1. Porter S. (2019). AAFP Outlines Quality Measurement Strategy for Primary Care.
2. NACHC. (2019). Population Health Management Risk Stratification.

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Population Health & Measurement Informed Care

PHQ9 Scores and Proposed Treatment Actions		
PHQ9 Score	**Depression Severity**	**Proposed Treatment Actions**
0 to 4	None	None
5 to 9	Mild	Watchful waiting; repeat PHQ9 at follow-up
10 to 14	Moderate	Treatment plan; consider counseling and/or therapy
15 to 19	Moderately Severe	Active treatment with medication and/or therapy
20 to 27	Severe	Medication treatment and if member shows severe impairment and poor response to therapy, refer to mental health specialist for psychotherapy and/or collaborative management

Tips for Measurement Based Care

- Evidenced Based Screening Tool/Standardized Validated Instrument
  - Is this in the EHR?
  - Can we repeat this measure?
  - Capable of discerning between populations that may or may not benefit from services
  - Why this instrument?
  - Leadership buy in?
  - Staff involved? Staff training?
- Frequency
  - in accordance with the standard?
  - in accordance with the population?

Source: Susan Wu, (n.d.). Comparing PHQ9 Scores.

5 Steps to Develop Measure Specifications

Step	Example
1. Brief measure description/Strategic Plan	All clients with an A1C score greater than 7% or a PHQ9 score greater than 5 receive a behavioral health psychotherapy intervention or referral to primary care.
2. Definition of measure numerator	Numerator - Clients with A1C score greater than 7% or a PHQ9 score greater than 5 that receive behavioral health intervention or primary care intervention.
3. Definition of measure denominator	Denominator – Clients with A1C score greater than 7% or a PHQ9 score greater than 5
4. Exclusions to measure, if applicable	Exclusions – Clients under 18 years old.
5. Reporting Periods	Reporting periods – monthly for one year.

Data 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.

4 Steps to Create a Data Registry

Step	Example
1. Compile a list of clients	All clients, 18 years or older
2. Sort clients by condition	Clients with A1c greater than 7%; consider also accounting for other co-morbidities or level of A1c
3. Stratify clients into target groups	Group clients by A1c and co-morbidities and/or level of A1c. High risk clients could have A1c in highest quartile and/or greatest number of co-morbidities.
4. Design care models and target interventions for each risk group	Based on internal/external resources, design behavioral health psychotherapy intervention(s) or strategies for referral to primary care to meet needs of clients within risk groups.

Source: NACHC. (2019). Population Health Management Risk Stratification

Data Registry Tools

- **Examples of EHR vendor population health tools**
  - Epic's Healthy Planet
  - NextGen's Population Health (formerly Eagle Dream)
  - athenahealth's Population Health
  - Oracle Cerner population health management solutions
  - MEDITECH's Expanse Population Insight

- **Example of other vendor tools**
  - SyntraNet by UpHealth

PHM Strategic Workplan Tool

[Download the tool]

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Questions? Contact Nick Szubiak
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NSI Strategies Population Health Management Strategic Workplan Tool

Work Plan Deliverables	Training Scenario Example	Your Health Center info
Strategic Plan	Decrease A1C scores by increasing access to BH supports	
Convene Core Implementation Team	PCP, BH, Nursing, IT, Finance	
What is our Quality Metric/Key Performance Indicator Definition	All patients with an A1C score greater than 7% and receive a BH	
Metric Numerator	Pts with A1C score greater than 7% that receive BH intervention (90832,90834,90837)	
Metric Denominator	Pts with A1C score greater than 7%	
Metric Exclusions	Under 18	
Report Period	1x per month for 12 months	
Data Registry	Utilize EHR/Excel	
Performance Target Outcomes	1. Increase population to Behavioral Health support 2. Decrease A1C scores	
Map the Care Pathway	Completed	
Policy and Procedure	Submitted to P&P Committee	
Review Evidenced Based Interventions	In Process - BH training on Behavioral Activation Planning	
Clinical and Admin Protocols	MD to order standing order	
Pilot the Care Pathway	In process	
CQI - Evaluate efficiency and effectiveness of the care pathway	Measure submitted to QI Team	
Update and Adjust Admin and Clinical Protocols as needed (PDSA)	Next meeting review data	
Performance Indicator/Quality Metrics for Ongoing Monitoring	N/A	
Date to Roll-out Expansion	Champion Team 1-2 Months, Site A 2-4 months; Health Center Wide 5-6 months	

Housing Your Data

- Provider Excel Intranet or Shared Files
- Electronic Medical/Health Record (EHR/EMR)

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Define Target Outcomes

Increase population's access to Primary Care or Behavioral Health

Decrease A1C scores

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Questions about next steps?

- How do I get the intervention to my target?
- How do I make this data actionable?

Tune in to Webinar 3- Clinical Pathways for Pop Health!

Thank you!

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Questions, Comments?

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References

- Gliklich RE, Dreyer NA, eds. (2010). Registries for Evaluating Patient Outcomes: A User's Guide. 2nd ed.
- Gurewich, D., et al. (2020). "Addressing social determinants of health within healthcare delivery systems: A framework to ground and inform health outcomes." J Gen Intern Med **35**(5).
- National Academies of Sciences, Engineering, and Medicine. (2019). Integrating social care into the delivery of health care: Moving upstream to improve the nation's health. Washington, DC: The National Academies Press.
- National Association of Community Health Centers (NACHC). (2019). Population Health Management Risk Stratification
- Porter S. (2019). AAFP Outlines Quality Measurement Strategy for Primary Care.
- Soto, M.A., (2014). Population Health Measurement: Applying performance measurement concepts in population health settings.
- Susan Wu, (n.d). Comparing PHQ9 Scores.

Tools & Resources

- Access for Everyone: Addressing Health Equity & Racial Justice within Integrated Care Settings
- Addressing Health Equity & Racial Justice NCMW Webpage
- **Past Training & Events - Recordings & Slides**
  - Understand Health Inequities, Health Disparities & Social Determinants of Health within Integrated Care Settings
  - Resources to Advance Health Equity through Integrated Health
  - Breaking Down Health Literacy, Cultural and Linguistic Barriers in Integrated Care Settings
  - SDoH: Screening for Patient Social Risks in Integrated Care Settings
  - SDoH: Integrated Care Screening Tools & Implementation Considerations
- University of San Francisco California – Social Interventions Research & Evaluation Network (SIREN)
- OCHIN/KP Social screening & referral implementation guide
- Other social care implementation guides
- Comparison of social screening tools
- NSI Strategies – Consulting Support for Integrated Healthcare Environments

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Upcoming CoE Events

CoE-IHS Office Hour: February Health Equity Office Hour - Black History Month Focus

Register for the Office Hour on Thursday, February 16th, 2-3pm ET

Peers Part 1 Webinar: Peer Support in Integrated Care Settings

Register for the webinar on Tuesday, February 28th, 12-1pm ET

Interested in an individual consultation with the CoE experts on integrated care?

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Questions?

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