Population Management in the Safety Net

28th Annual National Forum on Quality Improvement in Health Care

December 6, 2016

Session Faculty

- **Paula Cousins**, Director of Population Health
  Samuel U. Rodgers Health Center

- **Tam Duong**, Project Manager
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- **Molly Hart**, Healthcare Analytics Strategist
  Community Health Center Network

- **Ninon Lewis**, Executive Director, Triple Aim for Populations Focus Area
  Institute for Healthcare Improvement

- **Kim Schwartz**, Chief Executive Officer
  Roanoke Chowan Community Health Center
Objectives

- List the core components of a population management framework for a safety net organization
- Describe how three different safety net organizations have used that framework and QI tools to accelerate their population management efforts

Population Health

“Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group.”

-David Kindig, MD, PhD

Source: www.ihi.org/communities/blogs/_layouts/ihi/community/blog/itemview.aspx?List=81ca4a47-4ccd-4e9e-89d9-14d88ec59ee8&ID=50
Health Equity

Health equity is achieved when **every person has the opportunity to attain his or her full health potential** and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.


“To build a Culture of Health we must build a society where everyone, no matter who they are or where they live, has the opportunity to lead a fulfilling, productive and healthy life. There’s no one-size-fits-all solution. Each community must chart its own course and everyone has a role to play for better health in their homes, in their neighborhoods, in their schools and in their towns.”

Risa Lavizzo-Mourey MD, President and CEO, Robert Wood Johnson Foundation

Determinants of Health and Their Contribution to Premature Death

<table>
<thead>
<tr>
<th>Factor</th>
<th>Proportional Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetic predisposition</td>
<td>30%</td>
</tr>
<tr>
<td>Behavioral patterns</td>
<td>40%</td>
</tr>
<tr>
<td>Health care</td>
<td>10%</td>
</tr>
<tr>
<td>Environmental exposure</td>
<td>5%</td>
</tr>
<tr>
<td>Social circumstances</td>
<td>15%</td>
</tr>
</tbody>
</table>

Adapted from: McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Aff (Millwood) 2002;21(2):78-90.
The IHI Triple Aim

System designs that simultaneously improve three dimensions:
- Improving the health of the populations
- Improving the patient experience of care (including quality and satisfaction) and
- Reducing the per capita cost of health care.

Triple Aim Populations

- **Defined Populations**: A defined population that makes business sense (e.g. who pays, who provides) around the Triple Aim
- **Community-Wide Populations**: Working in a geographic area to accomplish the Triple Aim for the community
Population Management

The design, delivery, coordination, and payment of services for a defined group of people to achieve specified cost, quality and health outcomes for that group of people.

Source: ihi.org/communities/blogs/_layouts/ihi/community/blog/itemview.aspx?List=81ca44d7-4c0d-4e9e-85dd14c88f74e0&ID=50

Foundational Setup for Population Management

1. **Choose a relevant Population** for improved health, care, and lowered cost.

2. **Identify and develop the Leadership and Governance** for your effort.

3. **Articulate a Purpose** that will hold your stakeholders together.
Managing Services at Scale

- Identify a population segment on which to focus.
- Conduct a needs and assets assessment
- Develop a portfolio (group) of projects that will yield Triple Aim results
- Design or redesign services to meet the needs of the population
- Develop a plan for delivery of services at scale
- Expand the capabilities of “integrator” organizations

Managing Services for a Population

Diagram showing the process of managing services for a population, including population segmentation, needs assessment, service design, coordination, delivery of services at scale, and population outcomes.
Learning System for Population Management

1. System level measures
2. Explicit theory or rationale for system changes
3. Learn by testing: PDSA cycles, sequential testing of changes, Shewhart time series charts
4. Use informative cases: “Act with the individual learn for the population”
5. Learning during scale-up and spread with a production plan to go to scale
6. People to manage and oversee the learning system

Improving Community Health:
Population Management in the Safety Net

Sponsored by: Kaiser Permanente Community Benefit
Population Management in the Safety Net

Kim A. Schwartz
Chief Executive Officer
Roanoke Chowan Community Health Center

December 6, 2016
He who has any WHY can bear any HOW.
- V. Frankel

Who we are

RCCHC:

- FQHC
- 140 employees serving approx. 17K patients per year in 50-55K visits.
- 4 Locations: Ahoskie, Murfreesboro, Colerain and Creswell.
- 1 in-house 340b pharmacy and 4 contract pharmacies
Where we are

- Hertford County: Pop. 24,308 with median income of $26,422
- Bertie County: Pop. 21,282 with median income of $25,177
- Northampton: Pop 22,099 with median income of $26,652
- Gates: Pop. 12,197 with median income of $35,647
- Washington: Pop. 12,722 with a median income of $28,865

How We Got Here and Where to Go
The expedition: How to Start and Who to Focus On Using a Population Grid

<table>
<thead>
<tr>
<th>Total Population</th>
<th>Size</th>
<th>Subpopulation (Your total population segmented)</th>
<th>Size</th>
<th>Target Population (Focus of your initial projects)</th>
<th>Size</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients within the care of RCCHC</td>
<td>Approx. 16,000</td>
<td>Medicare/Medicare ACO patients</td>
<td>Approx. 3500</td>
<td>RCCHC patients with high utilization of the ED for the 2015 year</td>
<td>1088</td>
<td>$612,000 total ED costs from patients. AVG $305.33 per visit.</td>
</tr>
</tbody>
</table>

Understanding what Resources we Had
What the Conversation Turned to

The IHI Triple Aim

Quadruple Aim

What Reaching Out to 5 PTs Looked Like

<table>
<thead>
<tr>
<th>Pt</th>
<th>Assets</th>
<th>Needs</th>
<th>Patient Level Goal</th>
<th>Tasks: Who will do what?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Family Support</td>
<td>Smoking Cessation</td>
<td>Decrease patient smoking level by 1 pack per week until cessation. Also suggest “E-sigs” as a “lesser of 2 evils” option. See improvement in COPD control.</td>
<td>Involve PCPs/ Care managers to educate and plan</td>
</tr>
<tr>
<td>2</td>
<td>Family Support</td>
<td>Transportation (utilities) Nutritional guidance</td>
<td>Pt current BMI is 36 Target goal is a BMI &lt;30 within 1 year’s time.</td>
<td>PCPs regular monitoring/ counseling Care managers - dietary info. Along with info. on local exercise clubs/programs.</td>
</tr>
<tr>
<td>3</td>
<td>Positive attitude</td>
<td>Behavioral Health Counseling</td>
<td>Come off of Tenazepam for insomnia by learning better sleep hygiene practices.</td>
<td>Set appointment for next visit with Behavioral Health team to discuss sleep habits and fixes.</td>
</tr>
<tr>
<td>4</td>
<td>Access to care</td>
<td>Declined having any needs</td>
<td>Increase exercise therapeutically to help improve asthma Sx. Currently on multiple controller medications that fail to control.</td>
<td>PCP/care manager plan to increase activity stepwise to improve asthma Sx.</td>
</tr>
<tr>
<td>5</td>
<td>Access to care</td>
<td>Better health education</td>
<td>LDL &lt;100 and to decrease meds related to GERD Diet correlates to GERD and Hyperlipidemia.</td>
<td>PCPs/Care managers can reach out with diet/exercise materials and establish connections to local sponsored gyms to incentivize exercise.</td>
</tr>
</tbody>
</table>

http://www.insigniahealth.com/products/pam-survey
“The Need to Act Overwhelms Any Willingness People Have to Learn”

- Peter Schwartz

What we learned from the Expedition: Key Points

What we thought the process would be

What the real process was like
Challenges we experience as a safety net organization

Closing Moment of Zen

“That which is not said is invisible”
Contact Information

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Samuel U. Rodgers Health Center

- Founded in 1967
  - Fourth federally qualified community health center in the nation at that time
  - Opened in the Wayne Miner Housing Project
- Today
  - 25,000 patient visits 2015 (UDS)
  - 50% Medicaid, 3% Medicare, 47% Self-pay
  - 31% primary language is not English

ER admissions overlap with

- Poverty
- Race/Ethnicity
- Preventable conditions
- Food deserts
- Unemployment
- Mortality rate
- Life expectancy at birth

Colorectal Screenings Barriers

• Not always addressed by provider
• Not always documented in designated field
• No pre-visit planning or follow-up process in place
• Screening kit required 3 samples and had dietary restrictions
• Instructions only in English
• Patients not always able to return kit to clinic (work, transportation, child care)

Colorectal Screening Process Improvements

• Care Coordinator completes pre-visit planning
• Providers recommend screening in OV
• Nurse or Care Coordinator provides education and instructions
• New screening kit: 2 samples, no dietary restrictions
• Postage-paid envelopes provided to patients
• Written instructions provided in patient’s language
• Care Coordinator monitors Incomplete Lab Orders report; follows up with patients as needed
Results

Entry into Prenatal Care
Impetus / Barriers

• Healthy Start: program aim to reduce infant mortality in zip codes with highest infant mortality rate
• Pelican Club, prenatal classes offered to pregnant women not in Healthy Start zip code
• Consistently low performance on UDS measure
• No ownership of referral process
• Confusion over zip code-based programs
• Healthy Start staff turned over completely
Entry into Prenatal Care
Process Improvements

• Custom SQL report created: Confirmation of Pregnancy result, Last Menstrual Period, patient information with zip code and preferred language
• Bilingual Care Coordinator worked report, confirmed New OB appointment, made NOB if necessary
• Sorted results by zip code and routed to Healthy Start or Pelican Club team outreach

Entry into Prenatal Care Results

• Too early to tell on UDS measurement
  • Identified a mapping problem that is being addressed
• Healthy Start: More than 40 pregnant women enrolled since mid-September
• Pelican Club reached its goal of 20 pregnant women
• LPN Care Coordinator position approved in Women’s Health
Lessons Learned

- Plan from the beginning for full scale
- Think about the reports you'll need at the beginning of project
- Flexibility and an open mind are key
MOLLY HART
COMMUNITY HEALTH CENTER NETWORK

Population Health Management at Community Health Center Network

Molly Hart, MPA, IA
Healthcare Analytics Strategist
Community Health Center Network
December 6, 2016
Population Health Management at Community Health Center Network

Agenda:

- Who we are and what we do
- How we use data to support our clinics
- Overview of Community Health Strategy
- Successes and challenges
Community Health Center Network & Alameda Health Consortium

The Alameda Health Consortium is the regional association of community health centers headquartered in Alameda County, CA. We were founded in 1974 to provide advocacy, insurance enrollment and service coordination for uninsured and low-income communities.

Community Health Center Network (CHCN) was established in 1996 to support our health centers with rapidly expanding Medi-Cal managed care business and administration. We have grown to also provide health IT and data analytics support, case management, and advancement of clinical best practices to drive better health outcomes for vulnerable patients.

Our Goals:

- Reduce ER visits and readmissions
- Connect patients to specialty care
- Support case managers and community health workers
- Broker services for highest need patients
- Inform practice through clinical quality and financial data reporting
- Foster a provider learning community

CHCN is a designated Innovation Hub, an initiative of Center for Care Innovations with support from the California Healthcare Foundation, and one of four national Technology for Healthy Communities pilots.
The Data

- **CHCN Managed Care**
  - Data warehouse for all Medi-Cal managed Care members
  - Claims for primary care, pharmacy, specialty, ER and inpatient utilization.

- **CHC Regional Network**
  - Joint Data Governance Committee
  - Improve data analytics capabilities. EHR data from each of our 8 organizations into our data warehouse.

Together, these data sources allow us to provide valuable and actionable information to our clinics to better serve their members and patients.
Population Health Management Programs

- CHCN Gap in Care reports
- Rapid Improvement Plans
- P4P funds tied to outcomes

- Complex case management for high risk patients
- Algorithm to identify patients
- Embedded clinic-based community health workers
- Connect patients to community resources and support

PHASE

- PHASE is a Kaiser Permanente Northern California funded grant program to reduce heart attacks and strokes in the safety net.

- Key Elements:
  - Comprehensive patient registry (DM, HTN, ASCVD)
  - Evidence-based clinical guidelines
  - Team based care
  - Patient engagement and addressing lifestyle risk factors
  - Development and sharing of performance metrics
PHASE

Preventing Heart Attacks and Strokes Everyday

Network level support with analytics and training:

- Quality measure dashboards
- Visit planning and panel management support
- Motivational interviewing/health coaching training
- Seed funding for site level innovation and incentives
- Actionable data
  - Medication adherence report matches EHR prescribing data with prescription fill claims data
  - Patient level BP history, medication adherence rate and filter for upcoming appointments

Population Health Management Programs

Payment Reform (APM/value-based care)

- Pilot of capitated payments for managed care members with quality metrics and triple aim goal
- Supports alternative visit types, team care and more flexibility from the hamster wheel of billable visits
- Requires patient stratification of managed care data, financial data and clinical quality data
Population Health Management Programs

- CHCN Population Health Strategy employs IHI population management strategies to achieve triple aim goals
  - Stratification of patient populations
  - Engaging patients and care teams
  - Using IHI's Model for Improvement
  - Tracking quality metrics
  - Sharing of best practices and learning community

Our Successes

- Improvement in data analytics capabilities at our clinics
- Care team transformation efforts across network
- Connecting patients to community resources
- More patient-centered care

Example Results:

- 6% increase in hyper tension control across the network, 14% increase at individual clinics under PHASE
- Decreased inpatient utilization by 43% and decreased ER visits by 21% through Care Neighborhood
Our Challenges

- Data integrity and data capture
- Multiple systems for data analytics and population health across the network
- Competing priorities for time and resources
- Difficulty in shifting to value based models while still in FFS world

Questions?
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Thank You for Joining Us!

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