



## Utilizing Population Health Management and Data to Maximize the Integrated Health Team

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NSI Strategies



**NSI STRATEGIES**

Consulting Support for  
Integrated Healthcare Environments



## Greetings and Welcome

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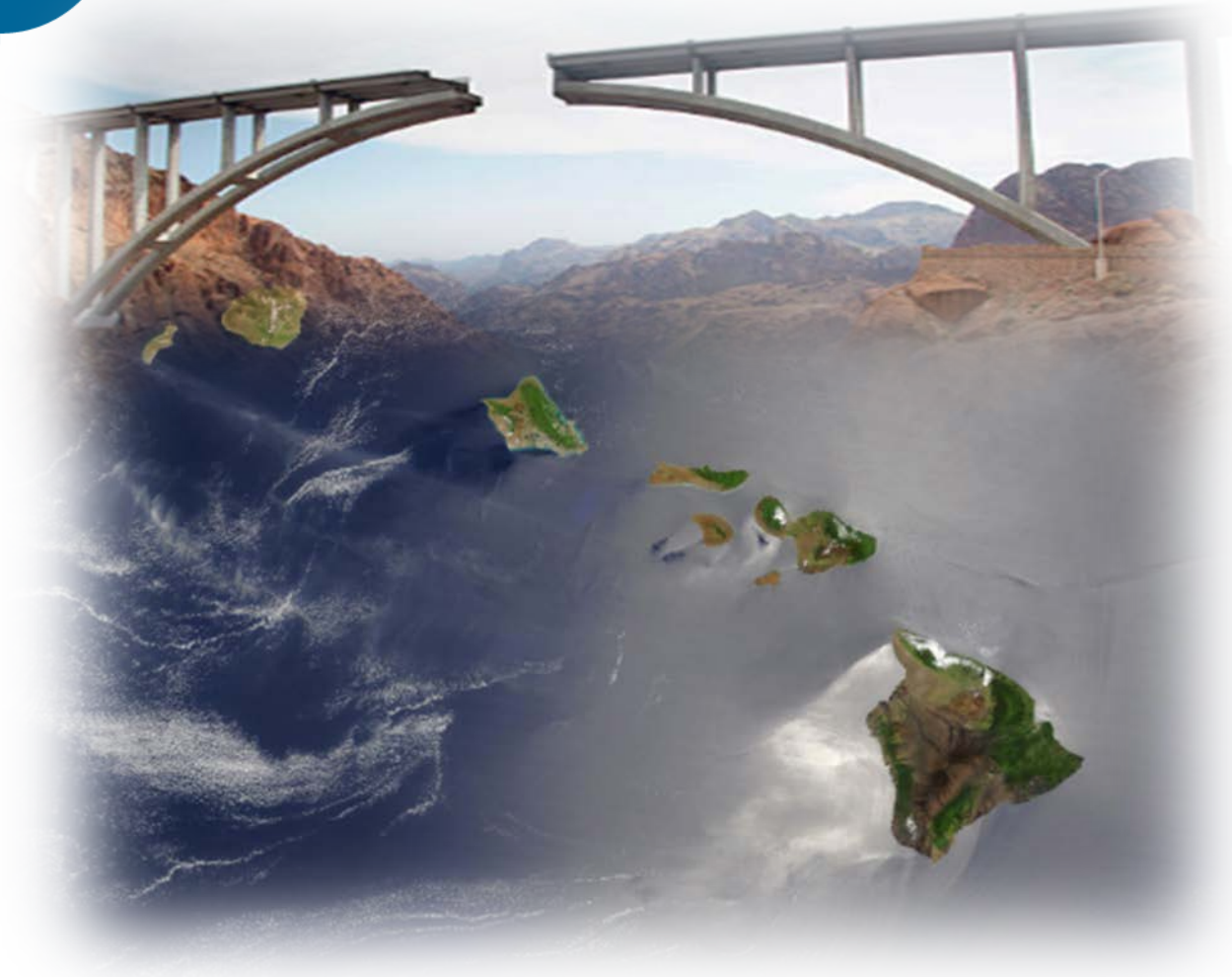
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## Rural Health

What makes us different?





# Objectives

1. Understand the impact data has on improving health outcomes
2. Describe the purpose and value of collecting and sharing data
3. Learn effective skills to communicate data to enhance organizational change
4. How to make data part of your health center culture



## A Look at *the* Data

## To Support Using Data

- More than a **quarter of adults** with physical health problems also suffer from mental illness
- Mental illness is common, yet underrecognized and undertreated – 25% of **primary care** patients have depression or anxiety
- Patients with mental illness frequently present to **primary care** with physical health symptoms (e.g., fatigue, insomnia, palpitations)
  - Primary care providers, focusing on physical ailments, can overlook psychological causes
- Primary care providers recognize only half of all mental illnesses
  - Among patients with recognized illness, only half are offered medication

[http://www.hbs.edu/faculty/Publication%20Files/2012.02.29%20Value-Based%20Mental%20Health%20Delivery\\_db29fc61-98a3-421d-a734-2c46d2989c73.pdf#sthash.v3JvdBGX.dpuf](http://www.hbs.edu/faculty/Publication%20Files/2012.02.29%20Value-Based%20Mental%20Health%20Delivery_db29fc61-98a3-421d-a734-2c46d2989c73.pdf#sthash.v3JvdBGX.dpuf)





# Compelling Data

Persons with serious mental illness (SMI) are dying at the average age of 53

- While suicide and injury account for about 30-40% of excess mortality, 60% of premature deaths in persons with schizophrenia are **due to medical conditions** such as cardiovascular, pulmonary and infectious diseases (NASMHPD, 2006)

Up to 45% of individuals who die by suicide have visited their primary care physician within a month of their death

Additional research suggests that up to 67% of those who attempt suicide receive medical attention as a result of their attempt



# “Of course you feel great. Those things are loaded with antidepressants.”

- Fewer than 2/10 see a psychiatrist or psychologist
- 30 million receive an antidepressant Rx in primary care BUT only 25% improve

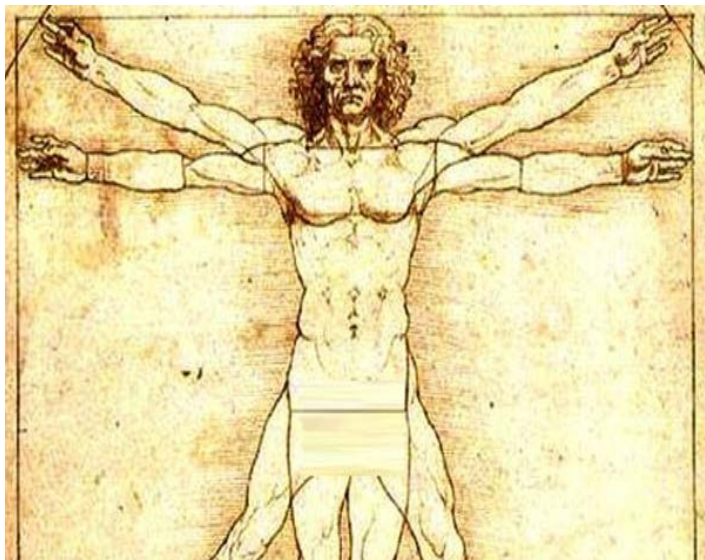
**Depression** affects somewhere around 5 percent of the general population at any given moment, the rate is about 15 to 20 percent for people with **diabetes**.

- With complications, the risk is higher.

**Depression** is 2 to 3 times more common following a heart attack or stroke and leads to worse clinical outcomes. (University of Washington)



*“Of course you feel great. These things are loaded with antidepressants.”*



- Adults with SMI die approximately eight years earlier than those without, most often due to treatable medical conditions

(NASMHPD, 2006)

- Chronic Health conditions are the leading cause of mortality in the world
  - Represents 63% of all deaths
- Causes 7 in 10 deaths each year in the United States
- 133 million Americans (**almost 1 in 2 adults**) live with at least one chronic illness
- More than **75% of health care costs** are due to chronic conditions; Cost of care for individuals with co-morbid behavioral and physical health conditions can be 60-75 percent higher than for those without mental health conditions
- Affect people of all ages throughout the lifespan

Accessed from: [http://www.who.int/topics/chronic\\_diseases/en/](http://www.who.int/topics/chronic_diseases/en/) and <http://www.cdc.gov/chronicdisease/index.htm>





## Golden Opportunities



- In this data – what do you see?
- You are where they are! Access!
- You are the center of health in your communities
- Using the powers of Data/Population Health Management (PHM) helps all of us



# Transformational Powers of DATA

- Shift from reactive to proactive
- Helps us utilize our resources
  - “target to treat”
- Data is the flashlight

*“If you are not measuring a process you don’t know **what you are doing**, if you are doing it, who is doing it”*

*“If you are not measuring processes **you can’t improve.**”*

*“If you are not measuring processes you are **operating blindly** and therefore are at risk for delivering ineffective and wasteful care at best.”*

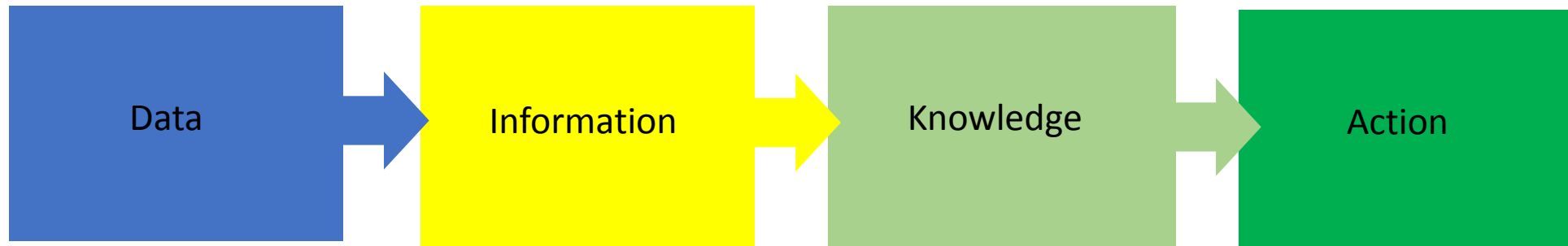


[https://www.integration.samhsa.gov/mai-coc-grantees-online-community/CoP\\_Webinar\\_1\\_Evaluation\\_Building\\_on\\_the\\_Basics\\_for\\_CQI.pdf](https://www.integration.samhsa.gov/mai-coc-grantees-online-community/CoP_Webinar_1_Evaluation_Building_on_the_Basics_for_CQI.pdf)



# Continuous Quality Improvement (CQI)

- **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





## Steps to Utilizing Data and Population Health Management Skills



# Three Ways to Effective Data Utilization

1. Determine your Strategic Plan
2. Communicate your Data in new ways
3. Let's have the data do the work



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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	
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CQI - Evaluate efficiency and effectiveness of the care pathway	Measure submitted to QI Team	
Update and Adjust Admin and Clinical Protocols as needed (PDCA)	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	





## Strategic Plan

Pick an area you want to target to treat.

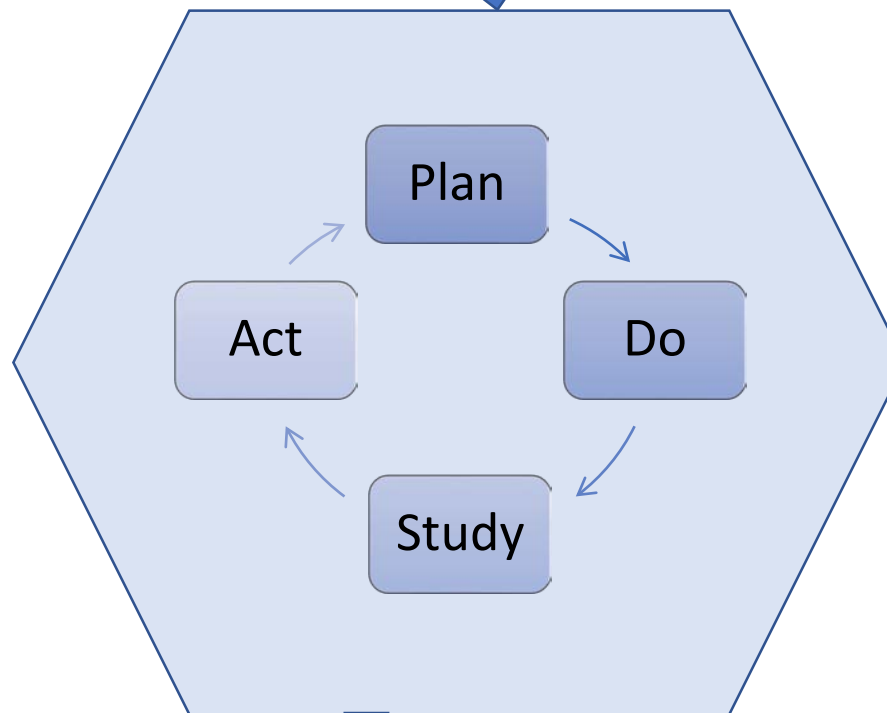
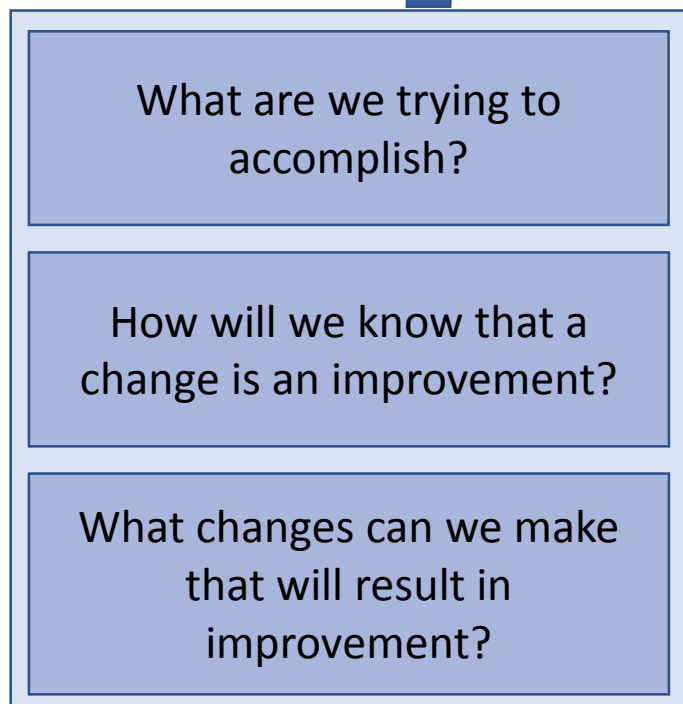
### Questions to Guide

- What do my Primary Care Providers need support with?
- What are the strengths of the Behavioral Health Team?
- What kind of data can I get?





## PDSA Cycle



<https://www.ahrq.gov/health-literacy/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool2b.html>



## Define Target Outcomes

- Increase population's access to Behavioral Health support
- Decrease A1C scores





## Bring in your Champions

### Four things that champions do:

1. Educate (customized message)
2. Advocate (why change)
3. Build relationships
4. Navigate boundaries (between professions/departments)

### Requires:

- Skilled communication
- Must be personable, well-respected, capable of building intra-organizational relationships
- Excellent institutional knowledge

Source: Soo et al, Healthcare Quarterly 2009: 123-8



## Three Ways to Effective Data Utilization

1. Determine your Strategic Plan
2. **Communicate your Data in new ways**
3. Let's have the data do the work





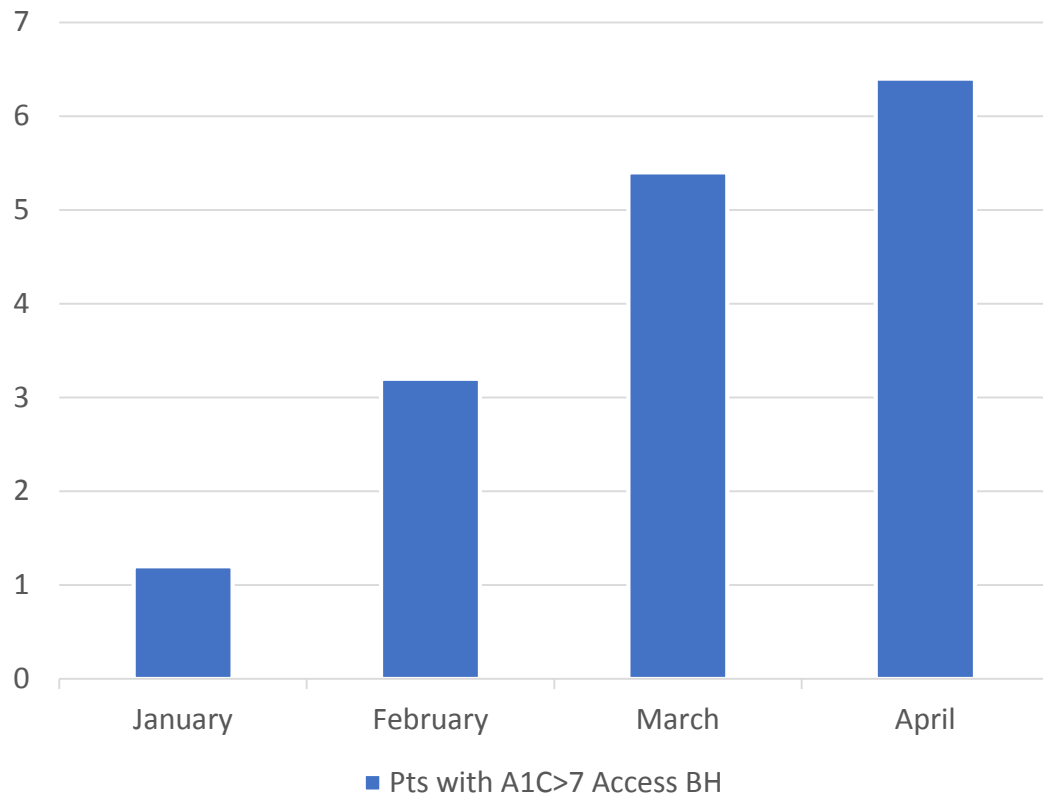
## Dashboards – Making Data Matter

- The data tells the story – not you!
- Keep it "simple" to start
- Target only a few key aspects of population & their care

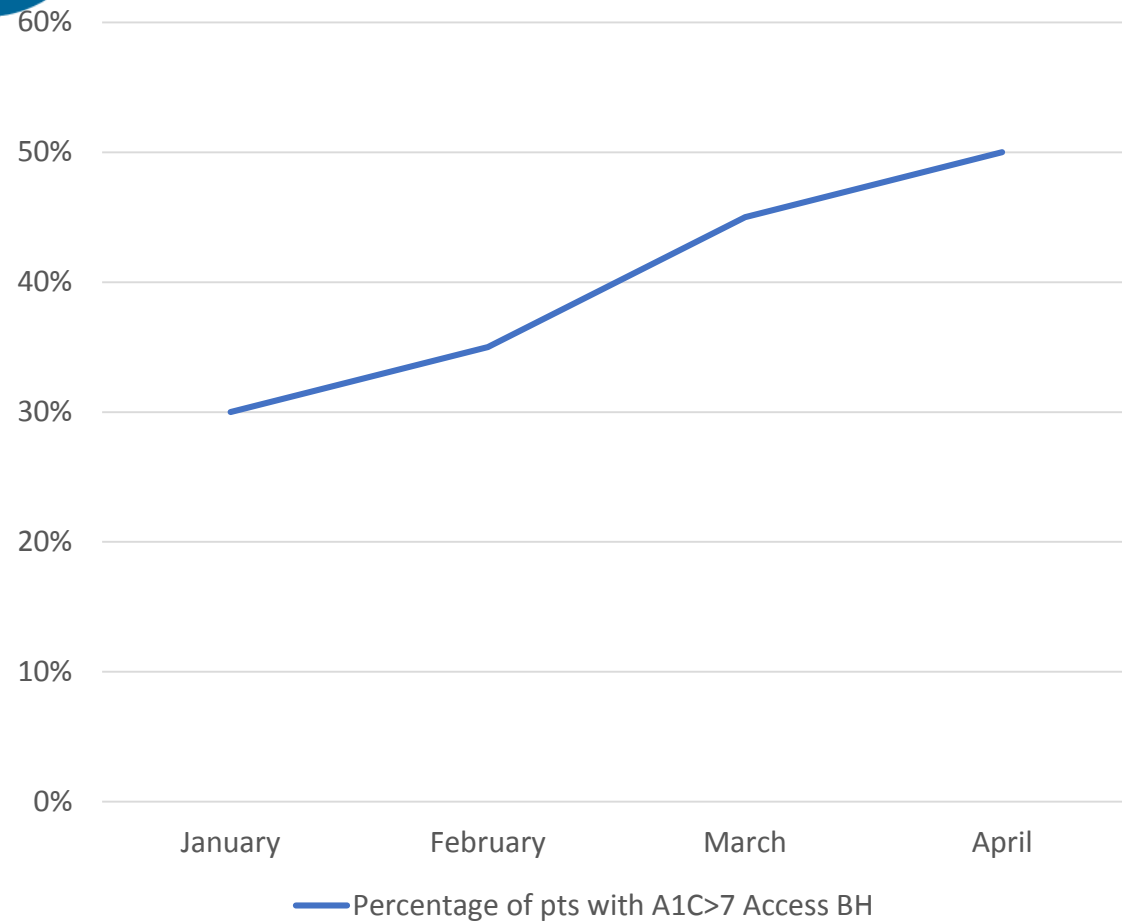




Pts with A1C>7 Access BH



Percentage of pts with A1C>7 Access BH





## Making Data Matter

- Huddle/Daily planning meeting
- Clinical supervision
- Data report out by provider, team, nursing station, site
- Clinical case review, population health management and treatment planning
- Hallway conversations/consults
- Use of EMR decision support tools including messaging and dashboards



# Tools to Support Population Health Success

- Policy and Procedures
- Standing Orders
- Using the EHR notifications/alerts
- Data flagging systems
- Chart pop-up messages

ARAMIS, BEN    DOB    Location MSU-5    PCU MEDSURG    Hospital No 66666611

ies nonsteroidal anti-inflammatory agent, penicillin,    Sex    Ht 165.00 cm    Wt 70.000 kg    BSA 1.77 m<sup>2</sup>

Prob Congestive heart failure /

s Crush all medications    Timeline    Assessment    ATTMD - RASHID, SAI ?

MAR    Worksheet    Assessment    Orders    Observations    Reports

xy Admission - 07/10 13:45 - HCS    Discharge - 07/08 14:52 - HCS    MED Orders

Continue	Stop	Class	Source	Description	Brand	Dose	Ro ute	Frequen cy	PR
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> anti-infectives	I	penicillin V potassium 250 mg TAB	V-Cillin K	250 MG	PO	QID	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> cardiovascular agents	I	hydrochlorothiazide-triamterene 50 mg-75 mg TAB	Maxzide	1 TAB	PO	DAILY	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> cardiovascular agents	H	metoprolol 50 mg ERT	Toprol-XL	50 MG	PO	Q1400	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> cardiovascular agents	I	metoprolol 50 mg TAB	Lopressor	50 MG	PO	DAILY	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> central nervous system agents	I	acetaminophen 325 mg TAB	Tylenol	650 MG	PO	Q4H	
<input type="checkbox"/>	<input type="checkbox"/>	DC <input checked="" type="checkbox"/> central nervous system agents	H	baclofen 10 mg TAB	Lioresal	10 MG	PO	TID	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> central nervous system agents	I	divalproex 250 mg ECT	*Depakote	250 MG	PO	BID	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> central nervous system agents	I	phenobarbital 30 mg TAB	*PHENOBARB	30 MG	PO	DAILY	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> central nervous system agents	I	tramadol 50 mg TAB	Ultram	50 MG	PO	Q4H	P

intestinal agents



# Resilient Communication

## 8 times 8 ways

1. Leadership Team
2. Email
3. Policy and Procedures
4. Training
5. Meetings
6. Quality Assurance
7. Indicator/Measure
8. Oral Tradition



**THERE.  
IT'S FIXED.**





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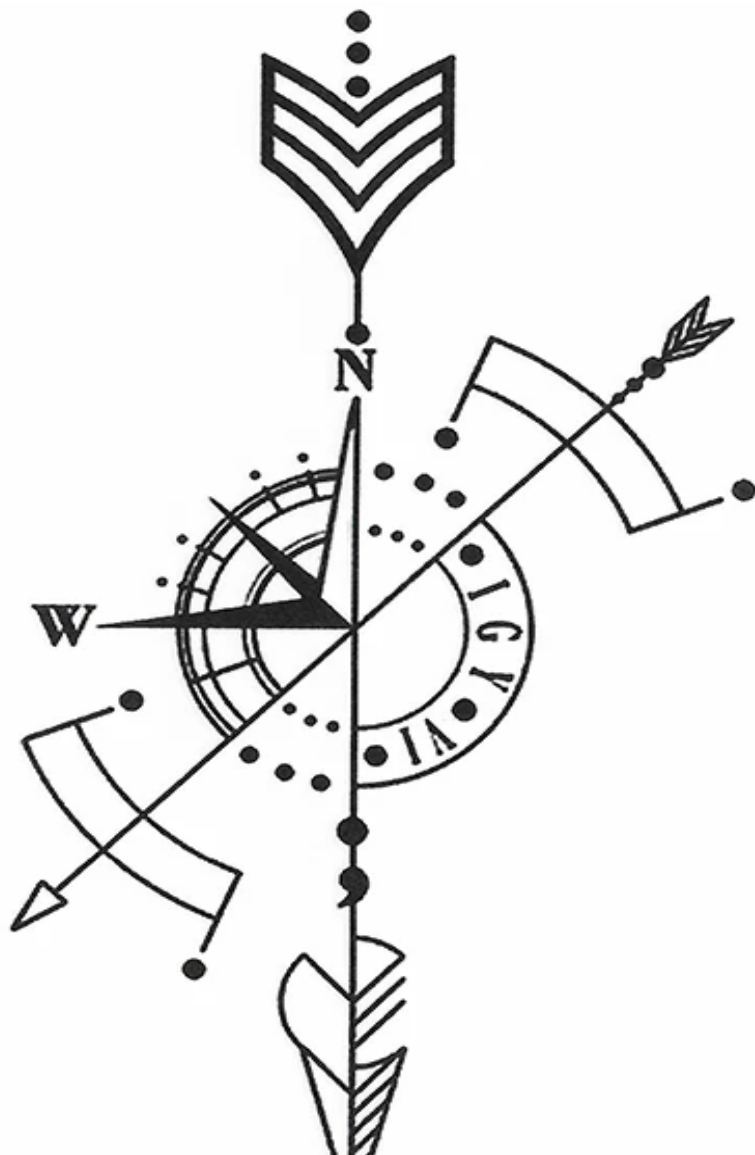
# Managing and Sustaining PHM

- Data is your guide
- Data in supervision
- Data in performance Reviews
- Manage and expect the ebbs and flows without judgement
- What works now may not later
  - Dashboard contests
  - Pizza Party
  - Team based for provider driven



## Population Health

- A proactive approach to care
- Gets care to the patients who need evidenced based care the most
- Enhances by focusing the strengths of the collaborative care team
- Monitor patient progress, helps us understand what works and what is not working
- Patient centered care - changes to care plans based on risk or progress to step care up or down
- Monitor practice performance by tracking consumer data and comparing with national guidelines or internal benchmarks



# RURAL PARTNERSHIP



# DEVELOPMENT MEETING



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The screenshot shows the NSI Strategies website. At the top is the NSI Strategies logo, a hexagon made of smaller hexagons in purple, blue, and pink, followed by the text "NSI Strategies" and "Consulting support for integrated healthcare environments." Below this is a blue banner with "NSI NEWS" and three news items. The main content area has three colored boxes: "INTEGRATED CARE" (pink), "RESILIENT LEADERSHIP" (blue), and "POPULATION HEALTH MANAGEMENT" (purple), each with an icon and a "Read More >" link.

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**NSI NEWS**

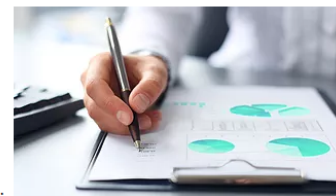
- Discuss Resilient Leadership with Nick at the Northwest Regional Primary Care Association Conference 10/5-8!
- Read our MAT article in Social Work Today about how behavioral health providers can support MAT!
- NSI provides expertise for Social Work Today article about cannabis implications for SUD assessment and treatment.

**INTEGRATED CARE**  
Read More >

**RESILIENT LEADERSHIP**  
Read More >

**POPULATION HEALTH MANAGEMENT**  
Read More >

NSI Strategies provides consulting support that integrates technology, data, and analytics to develop risk stratification registries, thus making population health part of your continuous quality improvement (CQI) process. We will also teach your team how to effectively utilize performance benchmarking to maximize the strengths of your behavioral health and clinical teams, as well as transform clinical pathways.



If you would like to discuss more, email Nick at [nick@nsistrategies.com](mailto:nick@nsistrategies.com).

Download **NSI Strategies Population Health Management Implementation Tool** to help your health center implement population health strategies.

[Schedule a Free Consultation](#)

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NSIStrategies.com





# Resources

- **Population Health Implementation Tool:** <https://www.nsistrategies.com/copy-of-evidence-based-care>
- **Team Based Care Toolkit** [http://www.integration.samhsa.gov/workforce/team-members/Cambridge\\_Health\\_Alliance\\_Team-Based\\_Care\\_Toolkit.pdf](http://www.integration.samhsa.gov/workforce/team-members/Cambridge_Health_Alliance_Team-Based_Care_Toolkit.pdf)
- **Two articles on Workforce Competencies for BH working in PC** [https://integrationacademy.ahrq.gov/sites/default/files/AHRQ\\_AcadLitReview.pdf](https://integrationacademy.ahrq.gov/sites/default/files/AHRQ_AcadLitReview.pdf)  
<http://farleyhealthpolicycenter.org/wp-content/uploads/2016/02/Core-Competencies-for-Behavioral-Health-Providers-Working-in-Primary-Care.pdf>
- **Population Management in Community Mental Health Center Health Homes** [http://www.integration.samhsa.gov/integrated-care-models/14\\_Population\\_Management\\_v3.pdf](http://www.integration.samhsa.gov/integrated-care-models/14_Population_Management_v3.pdf)
- **AIMS Center Dashboard Templates** <https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data>



# Thank you!

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