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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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

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."

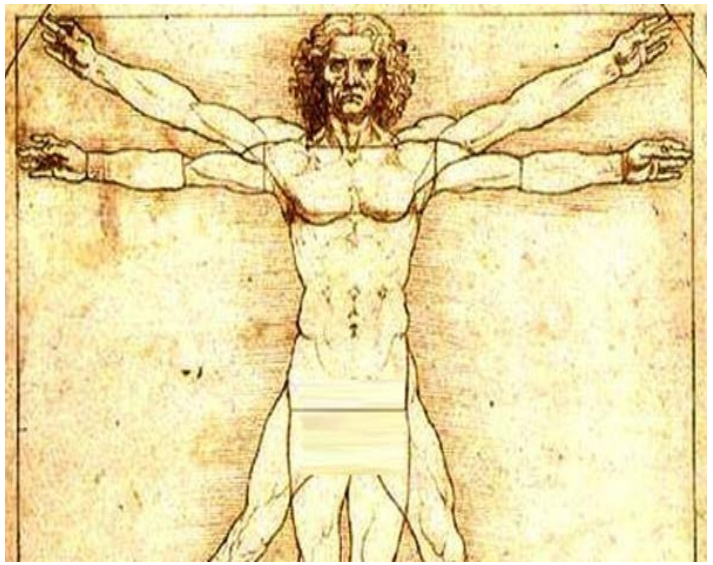
- Fewer than 2/10 see a psychiatrist or psychologist
- 30 million receive an antidepressant Rx in primary care BUT only 25% improve

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."



- 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

•Adults with SMI die approximately eight years earlier than those without, most often due to treatable medical conditions (NASMHPD, 2006)

Accessed from: 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**"*

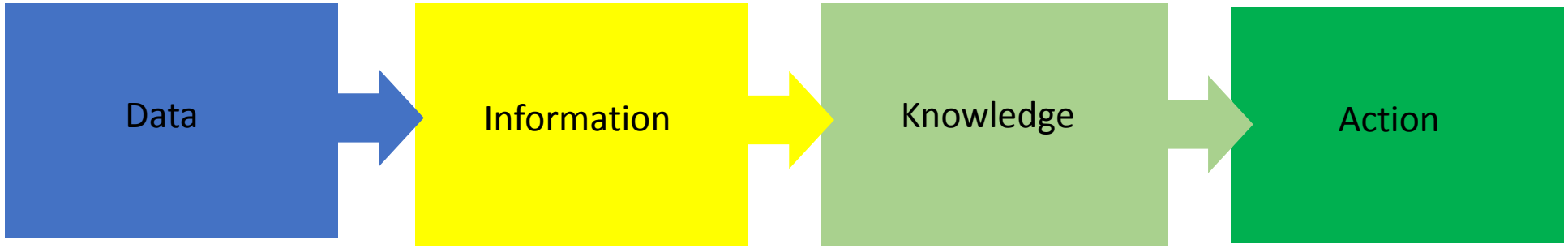
*"If you are not measuring processes **you can't improve**."*

*"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

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	
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	

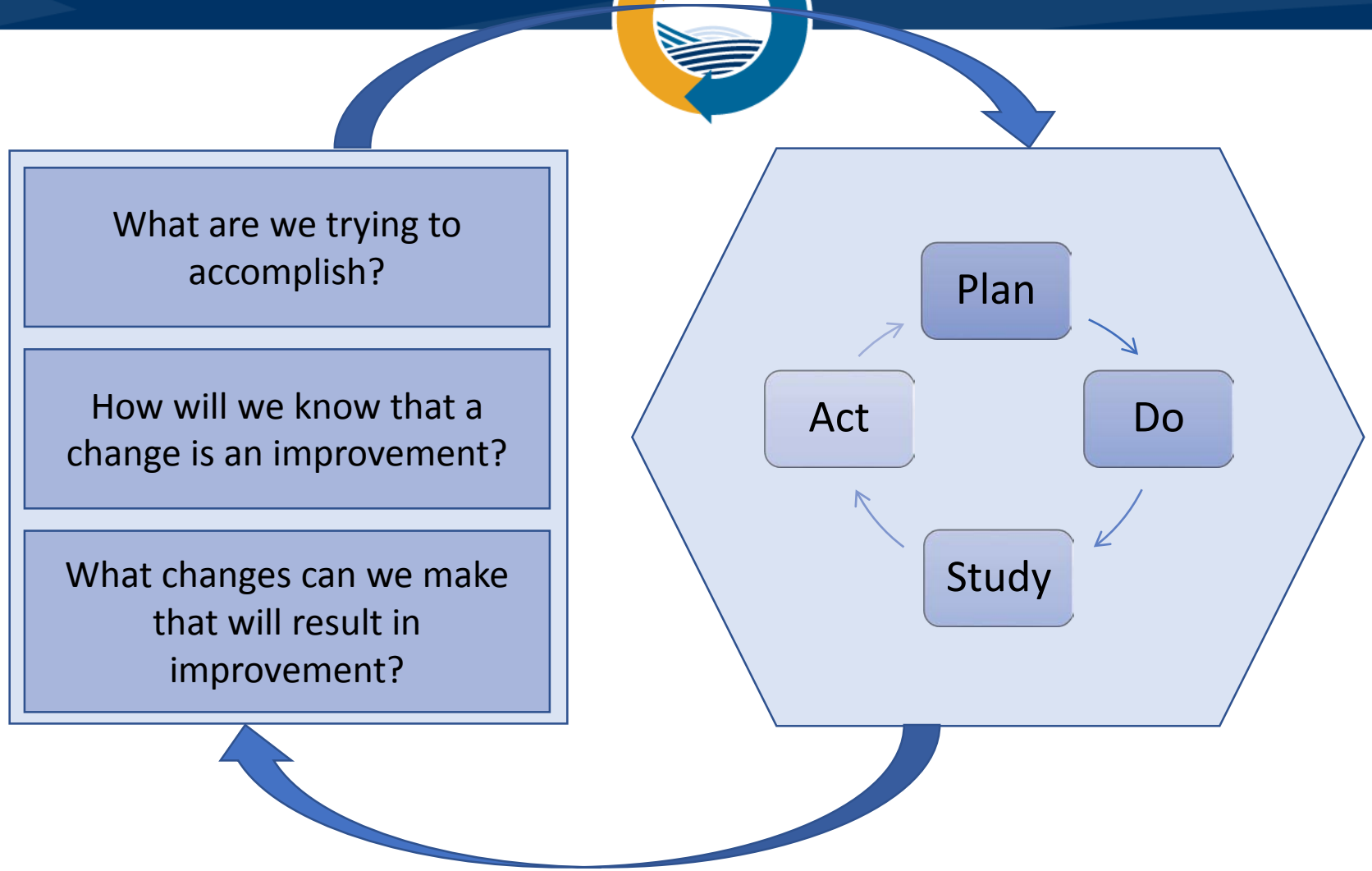
Strategic Plan

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

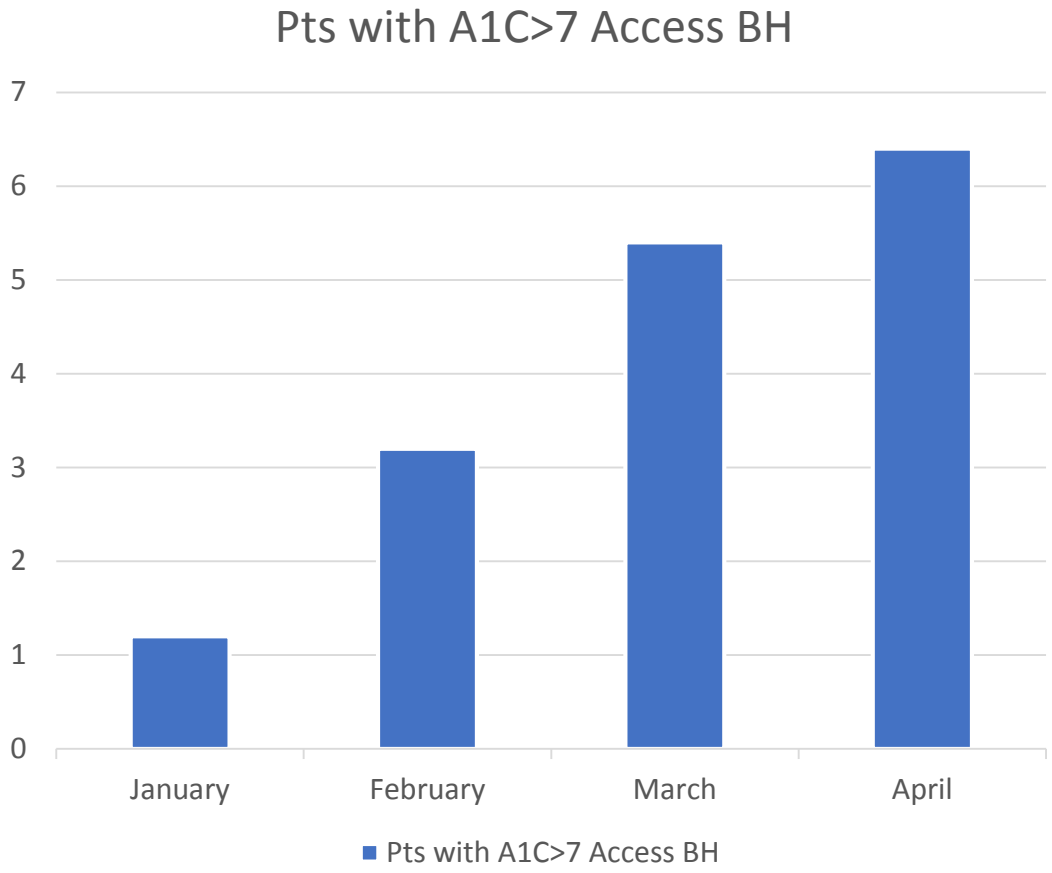
Source: Soo et al, Healthcare Quarterly 2009: 123-8

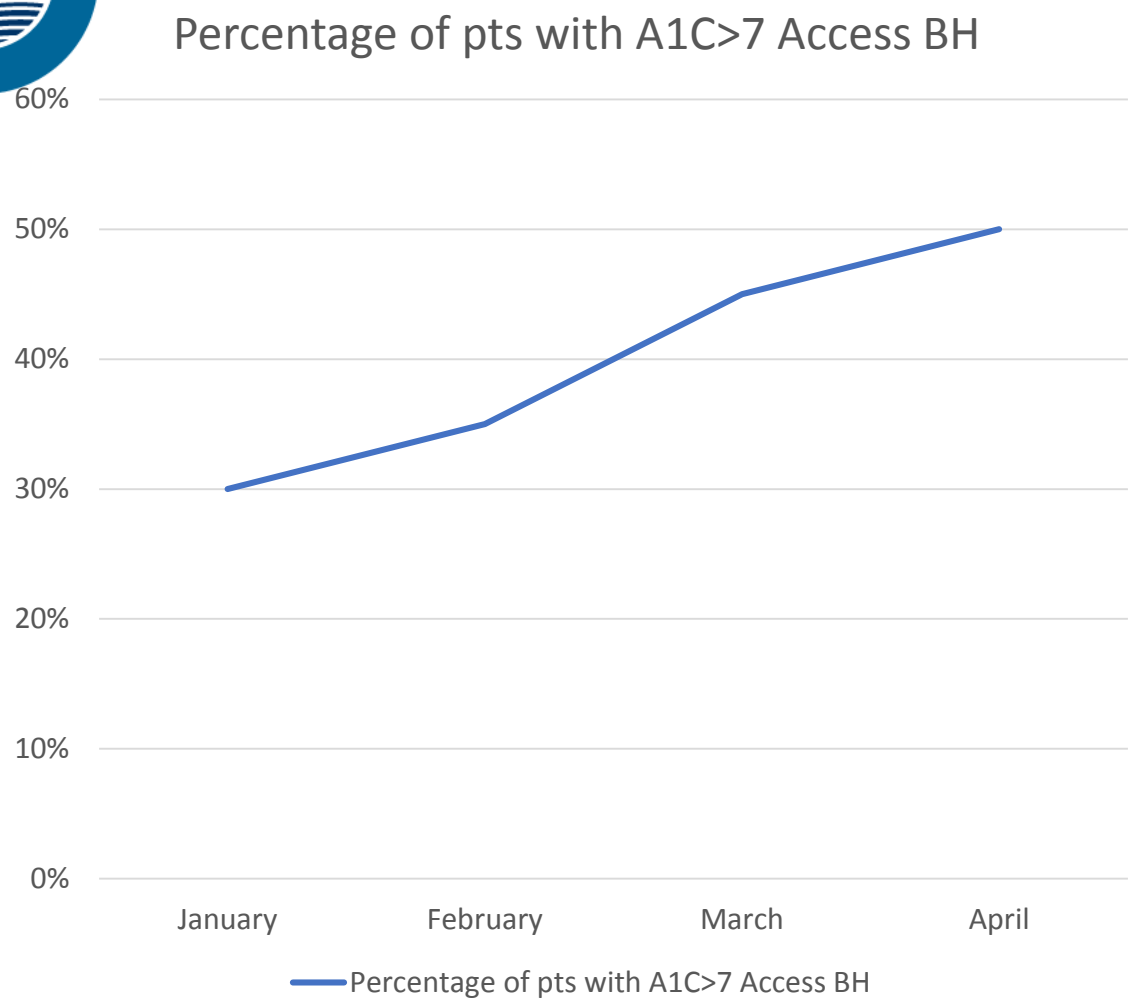
Three Ways to Effective Data Utilization

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

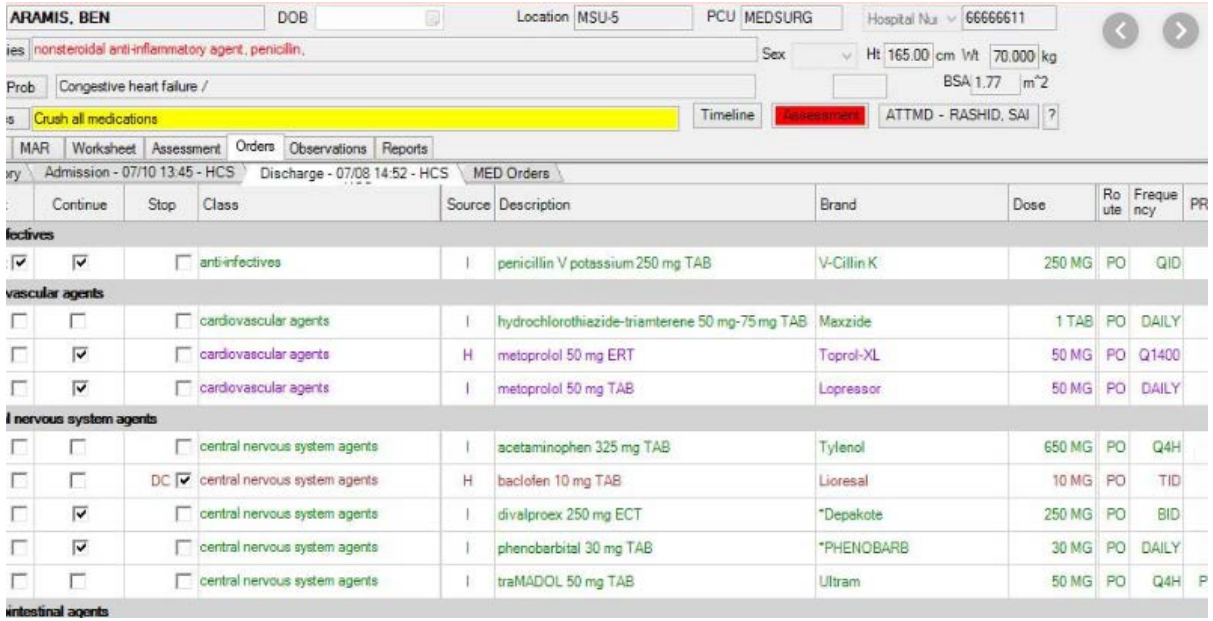

Pts with A1C>7 Access BH
7
6
5
4
3
2
1
0
January
February
March
April
Pts with A1C>7 Access BH


Percentage of pts with A1C>7 Access BH
60%
50%
40%
30%
20%
10%
0%
January
February
March
April
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

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.

Three Ways to Effective Data Utilization

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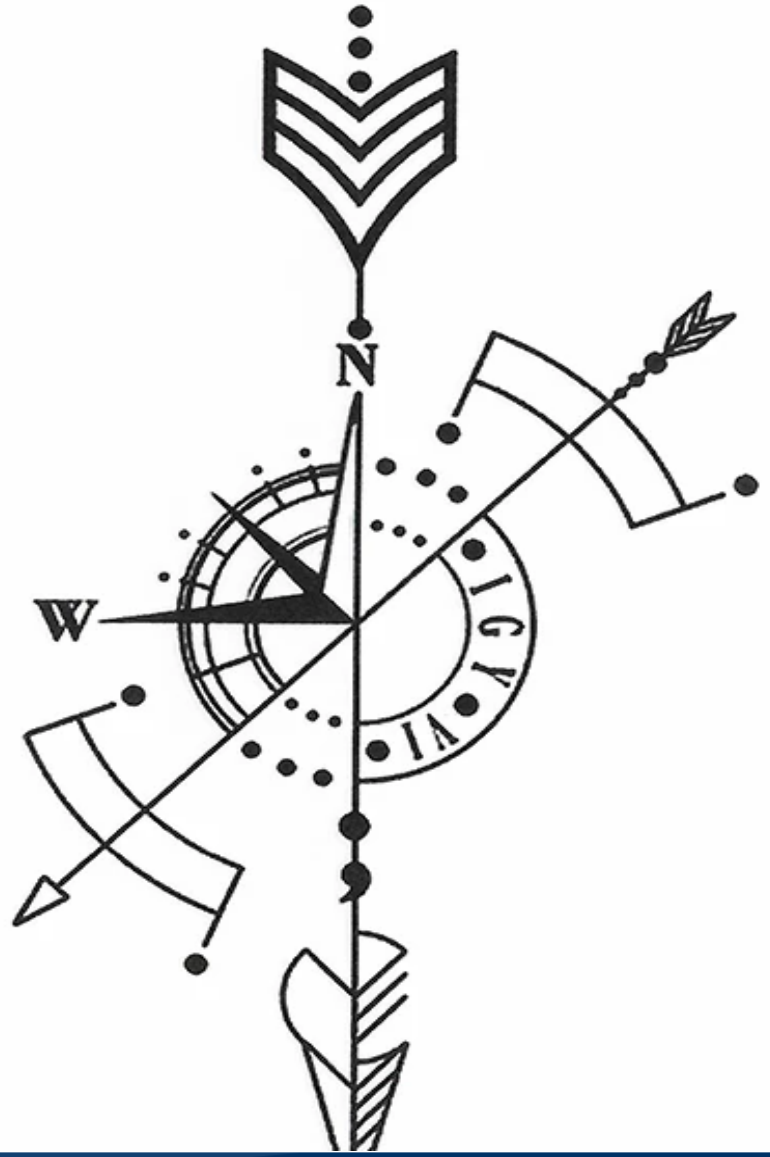
Managing and Sustaining PHM

- 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

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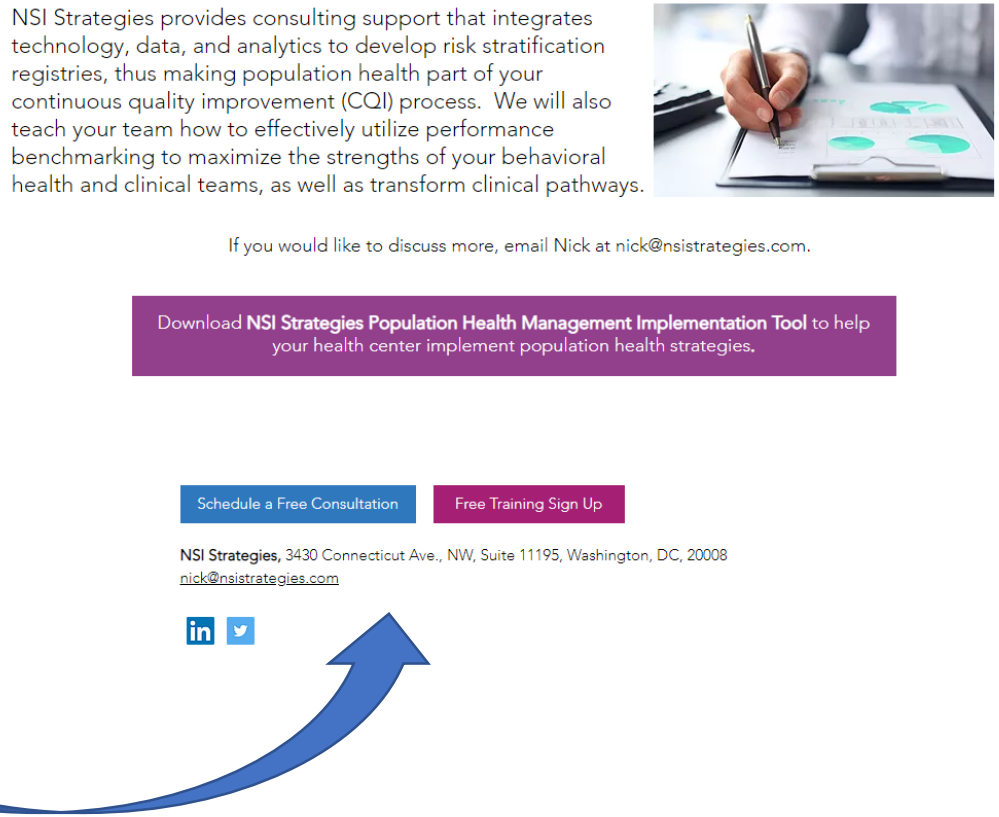

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Resources

- **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

- **Two articles on Workforce Competencies for BH working in PC** 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

- **AIMS Center Dashboard Templates** https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data

Thank you!

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