SIM PCMH Initiative Affinity Groups

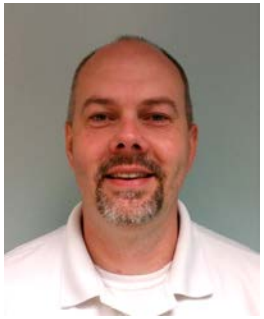
Population Health

The Michigan Care Management Resource Center

November 30th, 2017

Michigan Care Management Resource Center Team Members

Marie Beisel, Senior Project Manager
Introduction



Scott Johnson, Project Manager
Facilitate Participation

Betty Rakowski, Curriculum Designer
Facilitate Questions

Judy Avie, Program Manager
Facilitate Presentation

SIM PCMH Affinity Groups

The care manager and coordinator affinity group facilitates networking and promising practice sharing across the state. This group is open to all Initiative care managers and coordinators offering an opportunity for peer to peer learning. Collaboratively, care managers and care coordinators will identify areas of interest, topic focus, and prioritize challenges. Outcomes include:

- "What works"
- "What has been tried and does not work"
- Shared learning
- Identification of best practices
- Identify educational needs

Care Manager and Coordinator Learning Credits

One hour of SIM PCMH Longitudinal Learning Credit will be earned per each hour of participation in the Affinity Groups.

- Participants must register with their complete information to earn credit, anonymous participants will not earn Learning Credits.
- To obtain Longitudinal Learning Credit participants must join sessions “live” (in real-time).

Instructions for Obtaining a Certificate of Completion

To receive a certificate of completion for the " Population Health" Affinity group

1. Attend and participate in the entire Affinity Group
2. Check inbox for email from MiCMRC for "SIM Affinity group Evaluation"
3. Follow instructions in the e-mail: Attest to completing the Affinity Group, complete the evaluation and submit. This step generates an email to you containing the certificate of completion

For technical assistance please e-mail:

micmrc-requests@med.umich.edu

Care Manager & Care Coordinator Participant Commitment:

Attendees participating in a variety of ways during the interactive virtual meeting

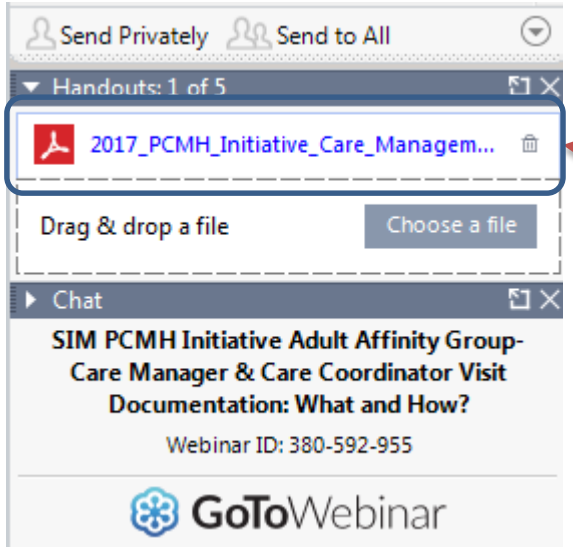
- Posting questions, verbally sharing experiences and lessons learned, responding to polls
- Completion of post meeting evaluation
- Attendee contact information will be shared with the group to promote networking
  - Example: contact information with area of expertise
- Completion of a brief survey to identify future high priority Affinity Group meeting topics

Housekeeping: Webinar Toolbar Features

Collapse Toolbar

Raise Your Hand

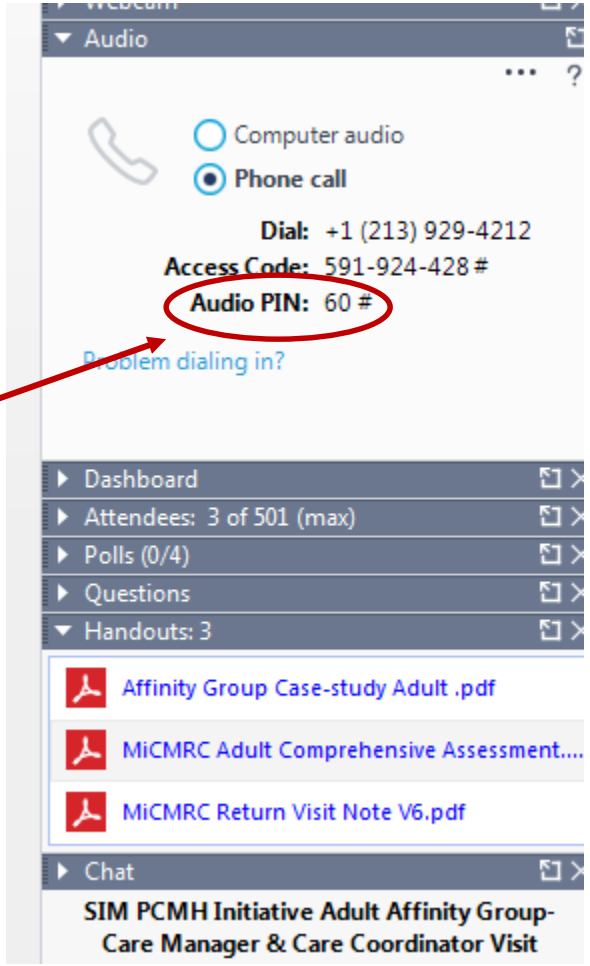
Ask a Question



Access PDF Versions of documents

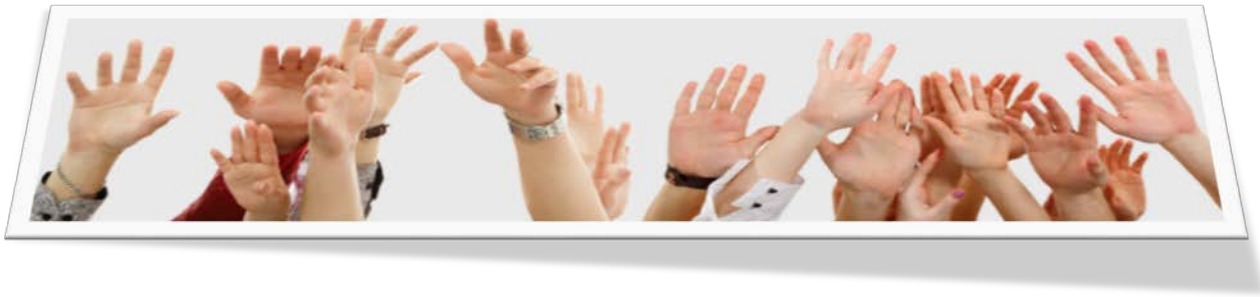
Use question box at any time for your questions and we will try to answer during session.

If you did not enter your audio pin when first dialing in please input it now to allow for unmuting of your phone



How long have you been in care management?

- less than 1 year
- 2 to 5 years
- 5 to 10 years
- Greater than 10 years



- Raise your hand if you are currently involved in population health management?

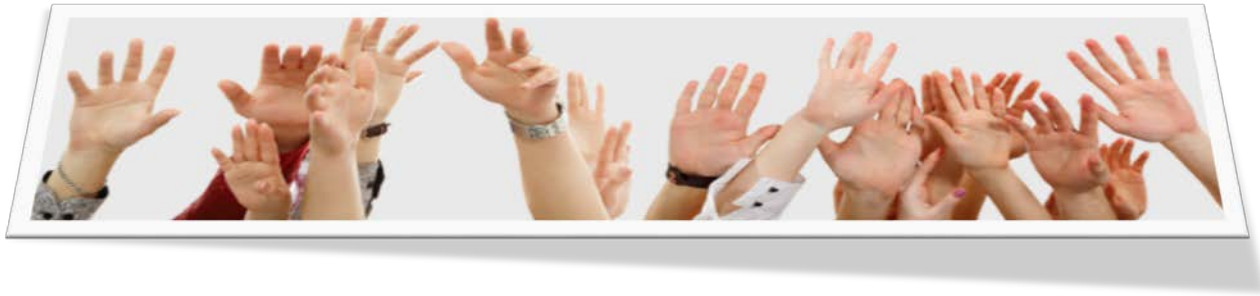
- Provide one question you would like to get answered about Population Health
  – type into question box

Let’s pause a moment to look at the questions or comments in question box

- The population health area you are working on

type into question box

Let’s pause a moment to look at the questions or comments in question box



- Raise your hand if you have been challenged by population health management and would like to share a solution or success

Agenda

- Define population health
- Define population health management
- Discuss population health management issues
- Discuss the team and care manager role in address population health issues
- Share practice examples of population health

Population Health Definitions

- Population Health
  - The health outcomes of a group of individuals, including the distribution of such outcomes within the group
    - 2003 David Kindig, Greg Stoddart
- Population
  - Defined by care relationships
  - Group associated with a provider or care team

Am J Public Health. 2003 March; 93(3): 380–383.

Population Health Management

- Proactive approach to health care
- Goal of population health management
  - To keep a patient population as healthy as possible, i.e. minimizing the need for expensive interventions such as emergency department visits, hospitalizations
- Focus is the health of their **entire** patient population, not just patients who come in for visits

Why Population Health

- Disease Burden of Chronic Conditions
  - 117 million Americans - chronic diseases (2012)
  - 1 in 4 adults - 2 or more chronic diseases (2012)
  - 1 in 3 adults - cardiovascular disease (2017)
- Disease Cost
  - 86% of healthcare spending is for people with chronic and mental health conditions (2014)

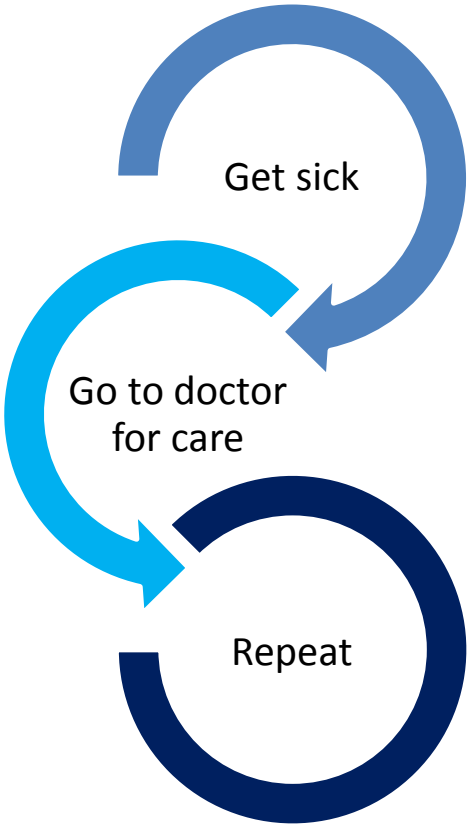
https://www.cdc.gov/chronicdisease/overview/

What percentage of your case load is using expensive resources (ED Urgent Care) to meet care needs?

- 0 to 20%
- 20% to 50%
- Greater than 50%

Practice Challenges

Where is the chronic care?

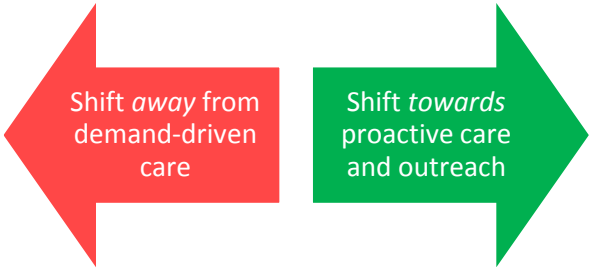


- Issues
  - Waiting for patients to come in for visits to meet their needs and problems
  - Visits are focused on urgent needs, not chronic care management
  - Problems are often identified late, after symptoms occur
  - Problems with chronic illness might be missed
  - Focus on urgent issues leads to missed important preventive services
  - Lack of preventative care contributes to poor health outcomes

http://www.improvingprimarycare.org/work/population-management

Practice Transformation

- Regularly reviewing patient population data
- Identifying issues
- Taking action
  - Shifts away from just **responding to patient-initiated visits**
  - Shift to **reaching out to patients for needed care**



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http://www.improvingprimarycare.org/work/population-management

Where is your practice transformation?

- Respond to patient initiated visits
- Reaching out to patients to set appointments

What are Population Health Management Issues

- Which Population to Tackle?
  - Wellness Management and Preventive Care
  - Chronic Care Management
  - Acute Care Management
  - Utilization Management of Hospital and ED

http://www.improvingprimarycare.org/work/population-management

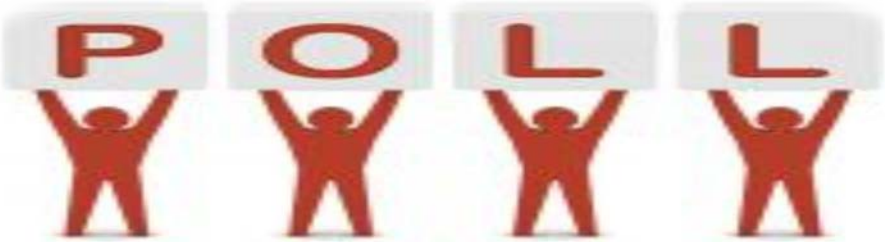
Issues and Interventions

- Preventive Care and Wellness Management
  - Use registry to identify care gaps, annual visit gaps
  - Use reminders like phone calls, post cards, text, portal messages to alert and educate patient about care needed
  - Use pre-visit planning calls help identify and resolve barriers

- Chronic Care Management
  - Use pre-visit or planned visits for chronic condition management
  - Use condition-specific pathways or protocols for chronic conditions visits
  - Use self-management coaching and action plans to alert care needs, when to call office

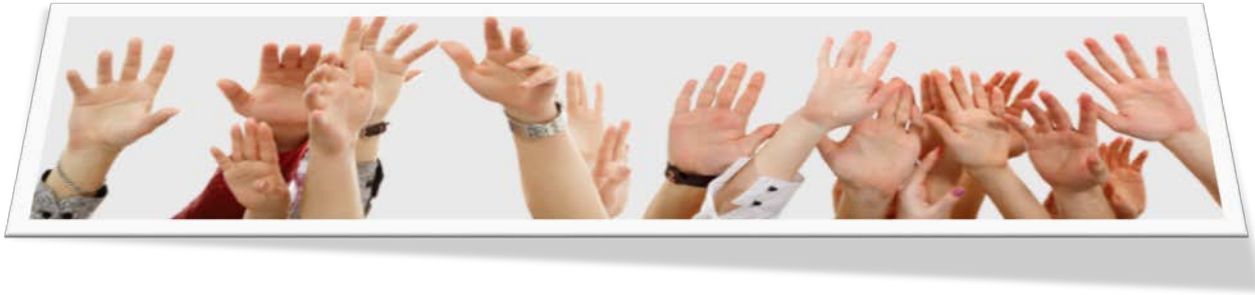
Issues and Interventions

- Acute Care Management
  - Use same day access to care
  - Use alternative to traditional office visit, phone calls, portal
  - Use after visit follow-up and monitoring
- Utilization Management
  - Monitor use of ED and Hospital
  - Use TOC call
  - Planned post-event follow up



Is your practice working on one of the population health issues?

- Wellness Management and Preventive Care
- Chronic Care Management
- Acute Care Management
- Utilization Management of Hospital and ED
- Not sure



Raise your hand if you will share
your practice's patient population issue and approach

Steps to Implement Population Management

- Select Patient population and issue
- Select a strategy
- Adopt clinical practice guidelines
  - Use evidence-based national guidelines
- Prepare staff
  - Investment will lead to better care for your patients and improved efficiency in your practice
  - Start with training a couple key staff members who then train their counterparts as the new process is adopted throughout the practice

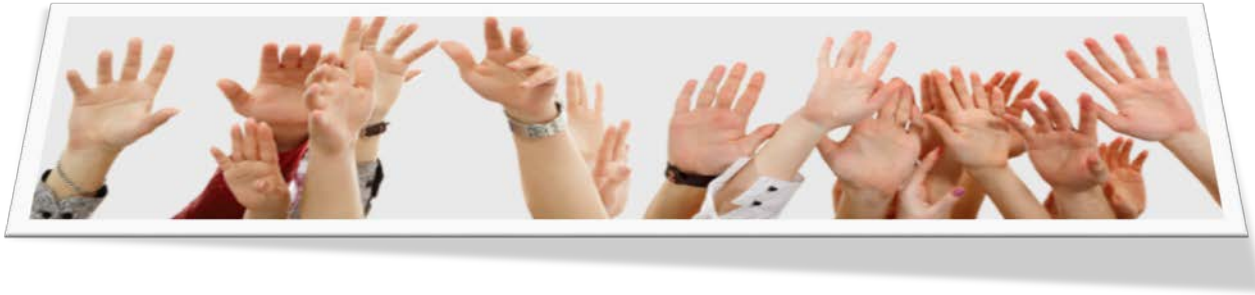
How do practices identify populations and collect this population health data

- Registry reports
- EHR with registry capability and reports

Use of Registry Reports

Identify patients

- With chronic conditions
  - Due for tests, services
  - Out of control parameters
- Due for preventive services
- Need pre-visit planning or planned visits
- Need gaps in care closed



- Raise your hand if you have a registry or an EMR with registry

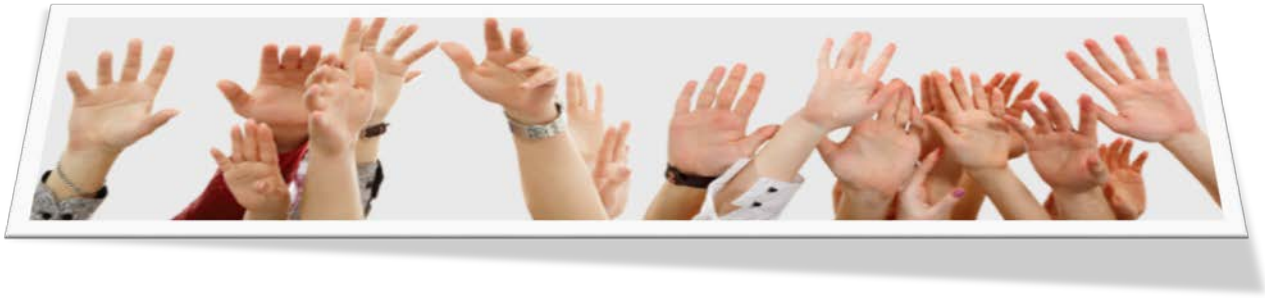
Examples of Team Roles

- Panel Manager
  - Runs gaps in care reports
  - Does outreach to patients, and set up appointment for planned visits
  - Places flags in charts of patients with upcoming visits for follow up
- Referral Coordinator
  - Facilitates making referral before patient leaves office
  - Follows up on referrals to gain reports
  - Follows up on referrals not completed to provide assistance
- Care Coordination
  - Links to community resources, i.e. transportation
  - Patient self-management goals and coaching
  - Patient engagement and health literacy
- Care Manager
  - Closes Gaps in Care for patients in case load
  - TOC calls
  - Coaching self management

Examples of Team Roles

- Pharmacist
  - Follow up on medication reconciliation and medication compliance, immunizations
- Diabetic Educator
  - Works with patients with A1c control
- Behavioral Health Specialists
  - Works with patients on depression management, medication management, behavior change

For more information see
http://www.improvingprimarycare.org/team



- Raise your hand if your practice has successfully implemented a new role and you can share

Team Based Care Example for High BP

- Population: all patients with blood pressure above normal
  - Use registry or EMR to generate list of population
- Determine which actions to take
  - Treatment team meeting to incorporate medication use
- Patient groups with target actions
  - Untreated hypertension with no antihypertensive medication
    - Action: contact patient for follow up with primary care provider to start the patient on antihypertensive medication
  - Treated with an antihypertensive medication
    - Action: contact patient to screen for adherence
    - If patient adherent, contact patient for follow up with primary care provider to start the patient on second antihypertensive medication
    - If patient nonadherent, contact patient for coaching and education to reduce barriers
- Working smarter, not harder
  - Preventative care is incorporated into appointment process
  - primary care provider or to do a medication adherence check and uncover barriers to treatment

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https://www.integration.samhsa.gov/integrated-care-models/14_Population_Management_v3.pdf

Elevated Risk & Planned Visits Example

- Population: Patients with elevated cardiovascular risk without an appointment in six months
  - Can customize for other chronic diseases (asthma, cardiovascular disease, depression, diabetes)
- Team outreach may include:
  - Call to schedule visits
  - Provide letters and education on need for visit
  - Message through portal

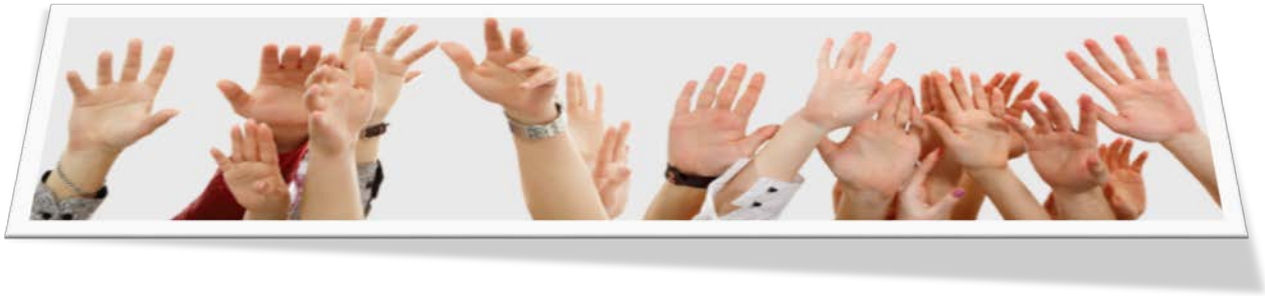
- Registry reports can be or preventive services, including immunizations and cancer screenings
- EHR reports can identify groups of patients with diabetes and their hemoglobin A1c levels.
  Care team can identify and contact patients who do not have planned visits

https://pcmh.ahrq.gov/sites/default/files/attachments/Information%20Technology%20to%20Support%20Transformation%20to%20Proactive%20Primary%20Care.pdf

Preventive Health Example

- Population: women in need of mammography
- Registry preventive care reminder system
  - Identifies those patients eligible ages 40-75 for preventive services
  - Identifies whether or not they have received those services
  - Sent letters three months before they were due for annual screening
- New role for appointment secretaries
  - Sent letters to patients inviting them to undergo mammography
  - Track patient follow up
  - Non-responding patients were telephoned for follow up

https://www.integration.samhsa.gov/integrated-care-models/14_Population_Management_v3.pdf



- Raise your hand if your team has implemented a team based practice you can share

SIM Sites selected Population Health Set the following Goals

- To improve HTN and Diabetes quality scores
- To close gaps-in-care in preventive screening
- To reduce HF admissions
- To reduce Emergency room visits for ambulatory sensitive conditions

*In 2018 all SIM site will be setting a population health goal

- Raise your hand to share your experience as SIM practice who had a 1st year population health goal

Innovative Community Partnerships

Health care system and community sectors with influence on health (public health, education, transportation, employers, and others) are increasing.

Multi-sectoral approaches to combat:

- Obesity - ***Let's Move*** national strategy, ***Walking this Weight*** state strategy
- Diabetes - ***YMCA diabetes prevention program***
- Violence - ***Cure Violence*** program
- Childhood asthma - ***WIN for Asthma***

Vermont Blueprint, a statewide health care reform program led by the Vermont Department of Health Access. The program includes partnerships among health care delivery systems, Patient Centered Medical Homes, payers, communities, and public health entities to improve the health of all Vermont residents.

Department of Vermont Health Access. Vermont blueprint for health
http://blueprintforhealth.vermont.gov/

Find more resources- MICMRC

- Care management interventions
- Guidelines
- Quick tools

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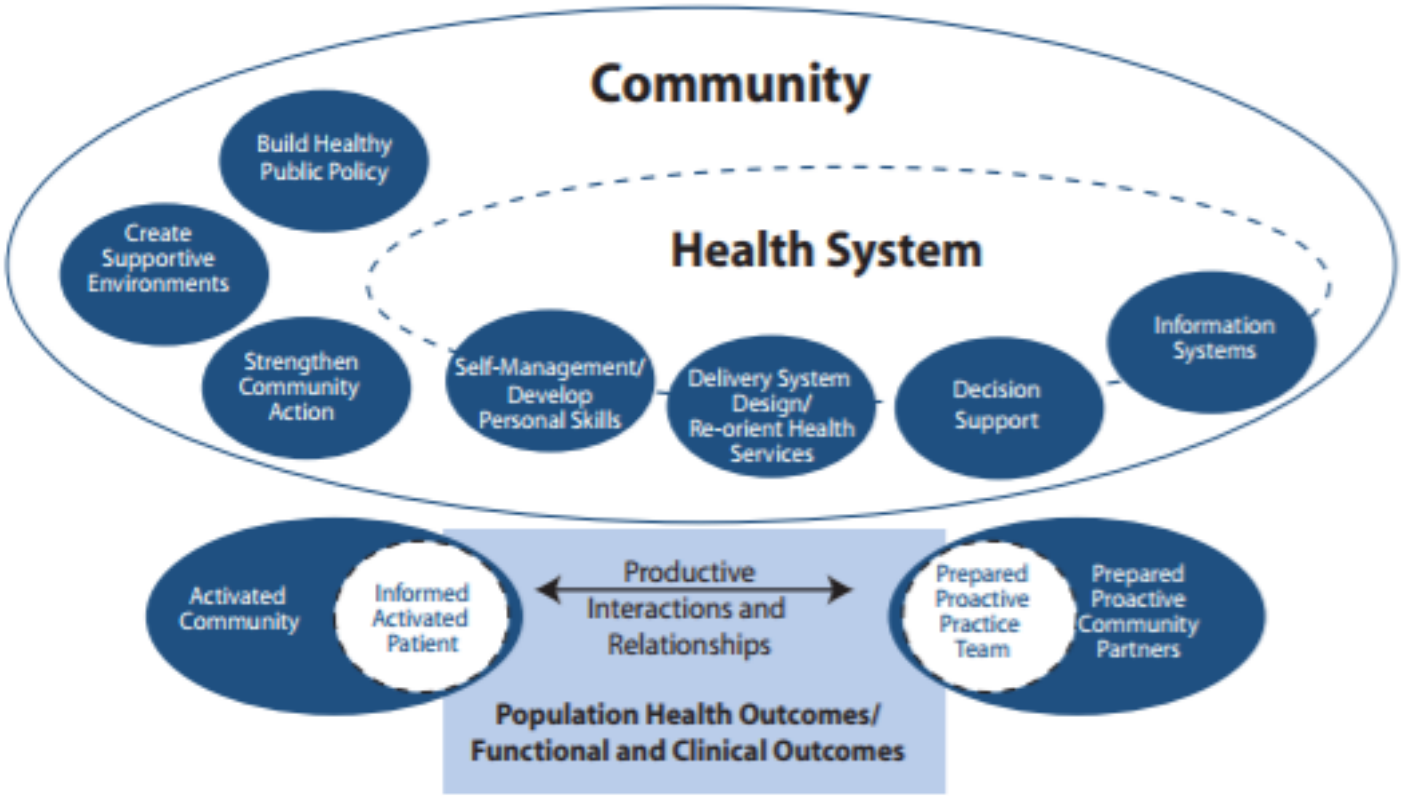
Expanded Chronic Care Model



Created by: Victoria Barr, Sylvia Robinson, Brenda Marin-Link, Lisa Underhill, Anita Dotts & Darlene Ravensdale (2002) Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L. (2001). "Does the Chronic Care Model also serve as a template for improving prevention?" *The Milbank Quarterly*, 79(4), and World Health Organization, Health and Welfare Canada and Canadian Public Health Association.(1986). Ottawa Charter of Health Promotion.

Highlights from the Improving Primary Care Population Management Tool Kit

- Define your patient population
  - Condition, control, engagement with team
- Select which data elements to track
  - How will we find our population?
  - What does good look like?
- Accountability
  - Ensure each patient is linked to a specific practice team
- Select and train population management staff
  - Select population health resources or all frontline staff?
- Develop criteria that specify when to take action

Find the tool kit at….

http://www.improvingprimarycare.org/work/population-management

Highlights from the Institute for Health Technology Transformation Population Health Management Roadmap

- The group identify populations and care gaps
- Established outreach program
- Use secure text, email, or phone to bring the patients in to see their providers
- Patients who may receive these notifications are diabetes, hypertension, and hyperlipidemia.
- Patients are also alerted when they are due for wellness visits, immunizations, mammography, or colonoscopy.
- Outreach programs cover 25–30 different indications.

“They’ve been really successful in driving appropriate volume, based on clinical care needs,”

Find the roadmap at
https://www.pcpcc.org/sites/default/files/resources/PHM-IBM_Watson-RR.pdf

Questions or comments

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