

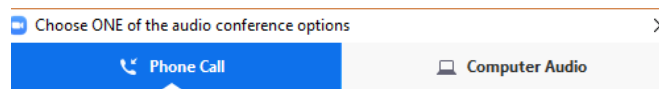
CCBHC-E National Training and Technical Assistance Center


*Optimizing Data Series:
The Role of Population Health Management in CCBHCs.*

May 11, 2022

Zoom Logistics

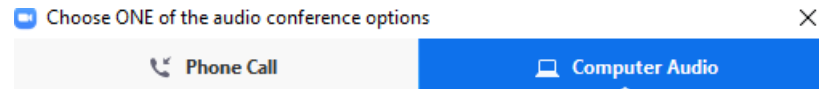
- Call in on your telephone, or use your computer audio option
- If you are on the phone, remember to enter your Audio PIN so your audio and computer logins are linked



 Dial: +1 646 558 8656
+1 720 707 2699

Meeting ID: 316 733 353

Participant ID: **26**

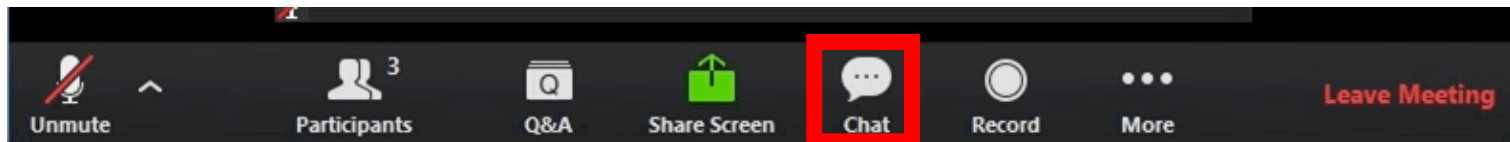


Join with Computer Audio

[Test speaker and microphone](#)

☐ Automatically join audio by computer when joining a meeting

How to Ask a Question



Share questions throughout today's session using the **Chat Feature** on your Zoom toolbar. **We'll answer as many questions as we can throughout today's session.**

Acknowledgements and Disclaimer

This publication was made possible by Grant Number 1H79SM085856 from the Substance Abuse and Mental Health Services Administration (SAMHSA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views, opinions, or policies of SAMHSA, or the U.S. Department of Health and Human Services (HHS).

Your Feedback Is Important To Us!

Please take a moment at the end of this event to complete a brief, post anonymous feedback survey. Your feedback is essential to us to help us better understand your need for training, technical assistance and resources, and to meet the requirements of the SAMHSA IPP reporting.

Today's Presenters



Renee Boak, MPH

Consultant

National Council for
Mental Wellbeing



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Monitoring & Evaluation
Associate

MAHEC



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Senior Director, Quality Management,
Quality Improvement, and Population
Health Research Cascadia Behavioral
Healthcare

Agenda

- Discussion: Optimizing Data: Leveraging Population Health Management and Approaches to Drive Clinical Care
- Cascading Breakout Group Discussion
 - Incorporating and using agency clinic-level data measures to assist with staff buy-in and taking learnings into action
- Wrap-up & Next Steps

The Learning & Action Sessions

- 3-part session on optimizing agency data
- Each session is designed to expand and advance on the previous event
- Each session will explore and showcase:
 - Effective approaches to maximize clinic-level data to drive and improve clinical decisions and outcomes
 - Successful applications for developing and optimize agency data



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The Learning & Action Sessions

<p>The Role of Population Health Management in CCBHCs</p> <p>Today</p> <p>Recording will Become Available</p>	<p>Learning Objectives:</p> <ul style="list-style-type: none">• Increase knowledge of population health management principles and practices• Identify 2-3 new practices/approaches on data collection and analysis that can be incorporated into agency practice• Increase knowledge of how population health management practices address preventative healthcare
<p>Measurement-Based Care Pathways</p> <p>June 8, 2022</p> <p>Register Here</p>	<p>Learning Objectives:</p> <ul style="list-style-type: none">• Increase knowledge of team-based care principles and practices• Learn how to develop population specific care pathways• Identify strategies for how population health management can address health disparities and inequities
<p>Leveraging Health Information Technology</p> <p>July 13, 2022</p> <p>Registration Coming Soon</p>	<p>Learning Objectives:</p> <ul style="list-style-type: none">• Increase knowledge on the role of health information technology (HIT) in population health management• Identify opportunities for how HIT can impact population health management practices• Learn 2-3 strategies for how HIT can improve data sharing between agencies

Population Health as a Tool in Community Behavioral Healthcare

How to apply population health practice, and engage in
data-drive healthcare in reality (and in overwhelm)

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Overview

- Definitions and terminology
- Idealism
 - *Population Health in a neat and tidy world*
- Reality
 - *Population Health in practice*
- Reconciliation
- Population health 2.0



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The Beginning: Terminology

Population Health

- “A conceptual approach to [understanding the drivers of health](#) and consequently the [strategies most useful to improve health](#); includes both the need to consider factors in social and biologic processes impacting health and an explicit concern with [health equity](#).” (Diez-Roux, 2016)

Population Health Management

- “A set of interventions designed to [maintain and improve people’s health across the full continuum of care](#)—from low-risk, healthy individuals to high-risk individuals with one or more chronic conditions.” (Center of Excellence for Integrated Health Solutions)
- Strategies for optimizing the health of an entire client population by [systematically assessing tracking and managing](#) the group’s health conditions and treatment response. (Center of Excellence for Integrated Health Solutions)

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Population Health Management Tools

1. Defining and understanding your population
2. Population segmentation
 - *Identify subpopulations for prevention and intervention opportunities*
3. Risk stratification
 - *Panel management*
 - *Predictive modeling*

Idealism Squashed: Real World Speedbumps

- Data (or lack of)
- Early stages of integration
- Limited clinical capacity
- Limited buy-in or understanding



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Adaptation: Data

- Start with what you have
- Share information on your population as driver for more/better data
- External data sources
 - Payer
 - HIE
 - Additional geographical data
 - Partners (e.g., DCOs)
 - Consumers

Example: Defining and Understanding Your Population

Identify clients using multiple strategies to supplement EHR data

- Ask providers
- Payers
- Invite consumers
- Collect data (surveys)

Be creative and use the resources you have

- Identify staff who are excited
- Move towards sustainability

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Adaptation: Limited Capacity and Buy-in/Readiness

Goal: [Reduce avoidable emergency department visits \(ED\)](#)

Reality

- Loss of key staff
- COVID-19
- Limited capacity of clinical staff
- Burnout of staff
- Competing priorities and buy-in from clinical leadership

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Example: Regular Reporting

Data sharing through regular reports

- Consistency
- Increased familiarity with data
- Allows staff to act on their own timeline

Percent of ED Visits By Month From Plaza clients with Type II Diabetes and SPMI

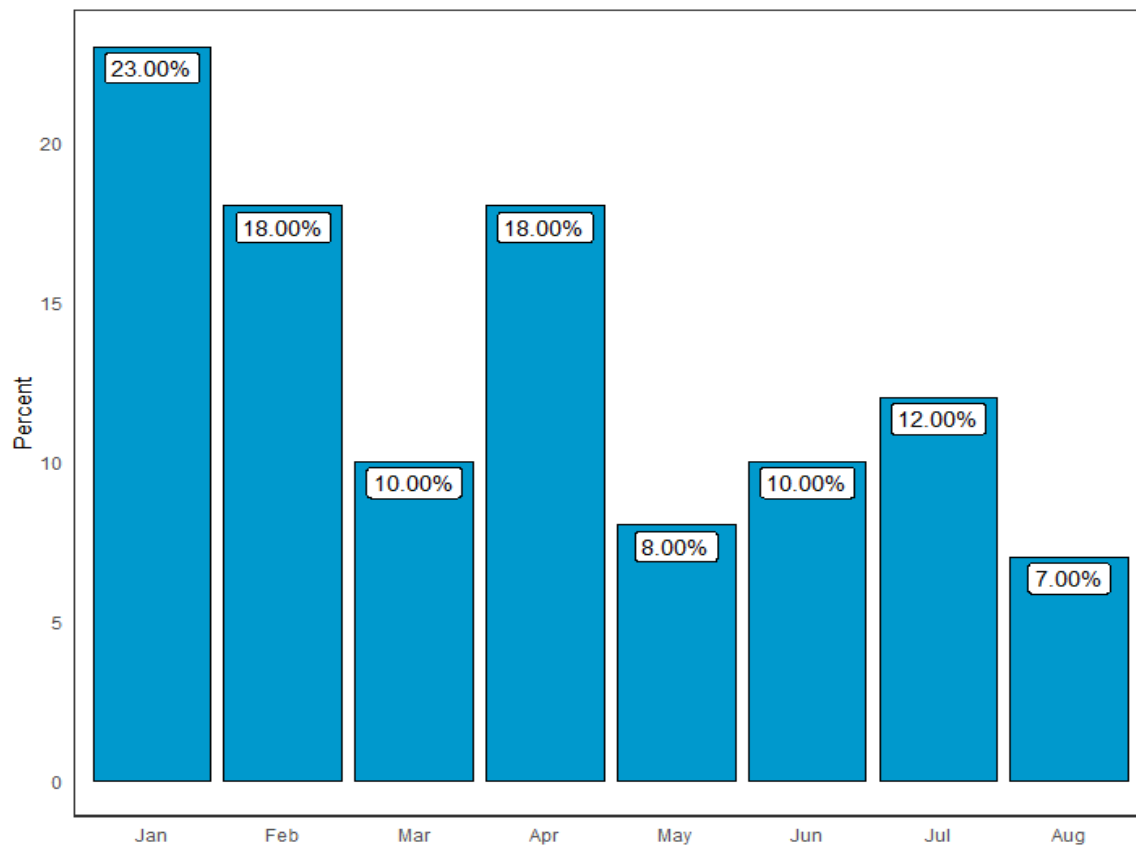


Figure 4. Clients with Diabetes and SPMI identified from behavioral health and diabetes flags in Collective Medical

Emergency department visit trends in Primary Care, YTD

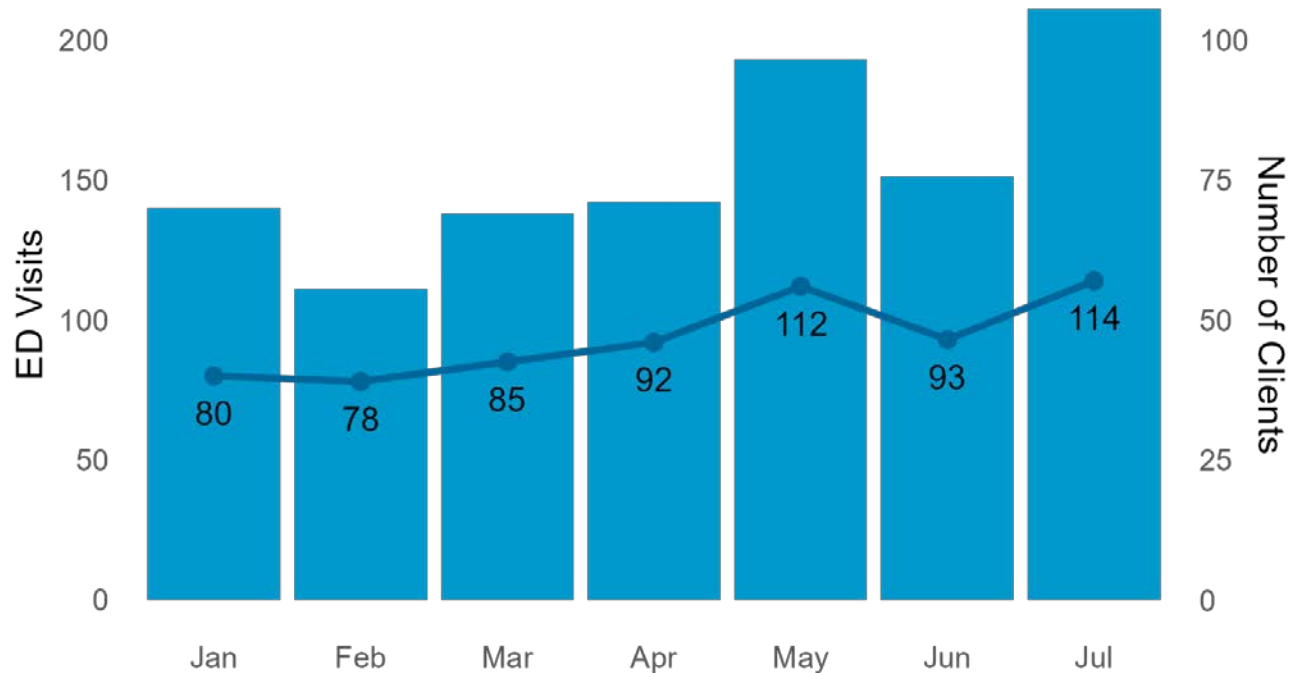
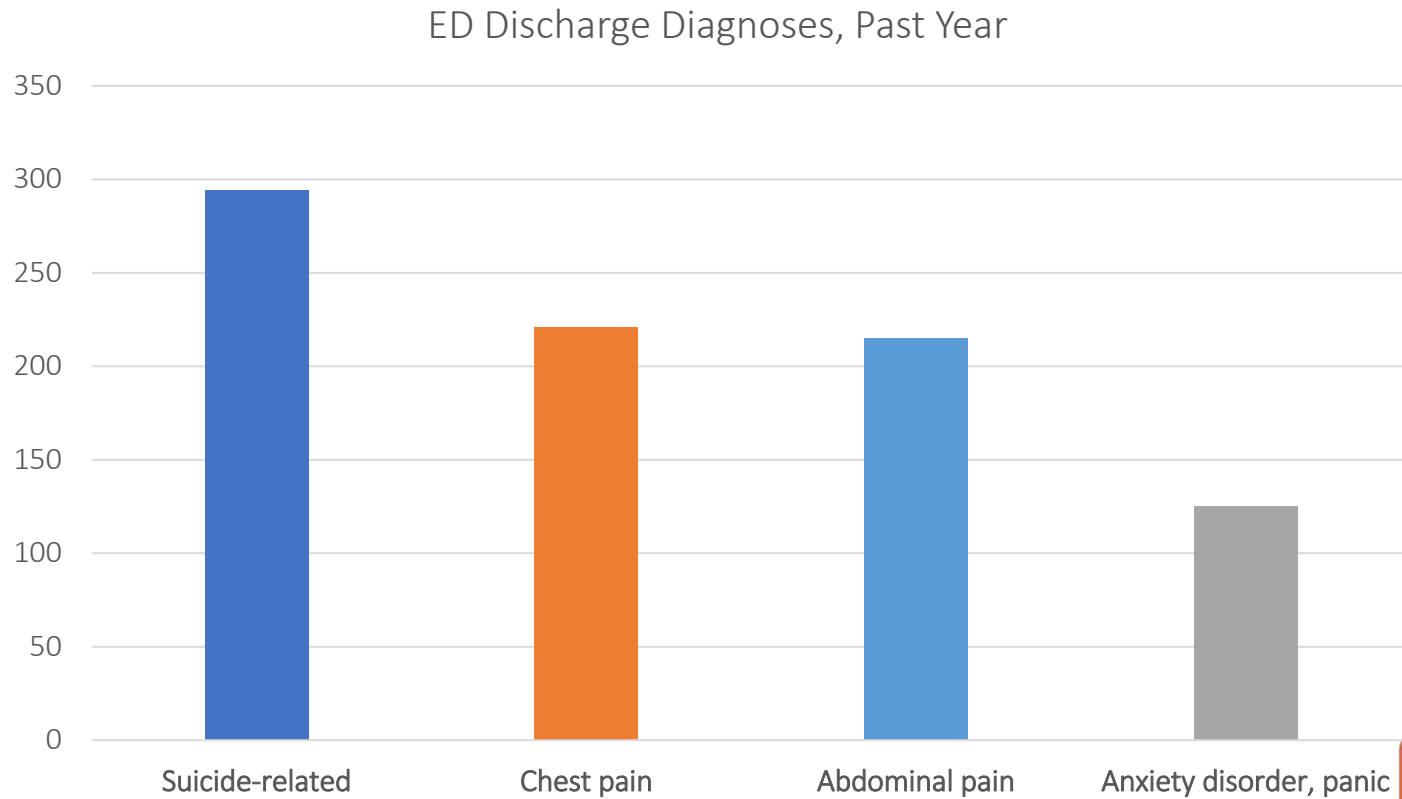


Figure 1. Data include all encounters among Primary Care clients with an ED visit in the past 12 months

ED Discharge by Diagnosis



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Average Number of Monthly ED Visits Vary by Race May, 2021

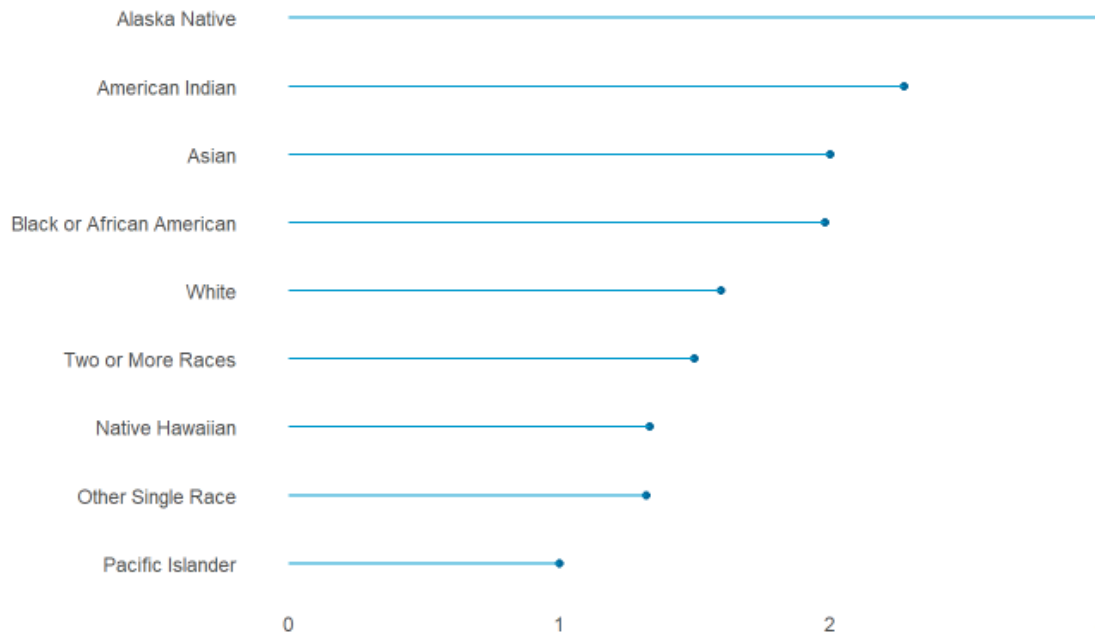


Figure 6. ED visit average per client in May, by race.
Data include clients with 1 or more ED visits in May

Example: Get Creative

- Involve staff in ways that meet their needs and recognize their capacity
- Stress the importance that even very small changes accumulate
- Make it fun and rewarding and recognize staff for their efforts

The Supported Employment program worked together as a team to develop a Make One Small Change goal that feels feasible, yet meaningful. In their collaboration, they discovered that staff were often discussing physical health and wellness with clients during intake, although this was not a formalized part of the intake process. The team recognized that building this practice into their intake process would promote health education and preventative healthcare. Their change goal encourages clients to pursue a check-up/physical with a Primary Care provider when beginning their employment search.



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Portland Area Urgent Care Locations

Urgent Cares are different in their insurance practices and appointment requirements.
Call first to check hours, walk-in options, and confirm insurance.

URGENT CARE NAME	CONTACT		Medicaid / OHP accepted	Medicare Accepted		BUS LINES
North Portland						
Providence Express Care - North Lombard	5308 N Lombard St. Portland, OR 97203	(888) 227-3312	Yes	Yes	Portsmouth	35, 75
Providence Express Care - Interstate	4340 N Interstate Ave #14 Portland, OR 97217	(888) 227-3312	Yes	Yes	Overlook	4, 72, 35, 85
Legacy-GOHealth	3505 N Williams Ave Portland, OR 97227	(971) 202-2910	Yes	Yes	Boise	44, 24, 4
Kaiser Permanente - Interstate Urgent Care	3500 N Interstate Ave Portland, OR 97227	(503) 813-2000	Only OHP Kaiser	Only Kaiser Medicare Senior Adv.	Overlook	4, 35, 24
Northeast Portland						
Portland Urgent Care	4160 NE Sandy Blvd Portland, OR 97212	(503) 249-9000	Yes	Yes	Hollywood	12, 75, 77
AFC Urgent Care - NE Portland	7033 NE Sandy Blvd Portland, OR 97213	(503) 305-6262	Yes	Yes	Roseway	24, 12
Providence Immediate Care	1321 NE 99th Ave Suite 100	(503) 215-9900,				

Example: Involve Staff in Development

Goal: Improve integrated care for clients with diabetes and a mental health issue

- Created workgroup
- Data informed planning
- Decisions driven by clinical members
- Evaluation built into the intervention

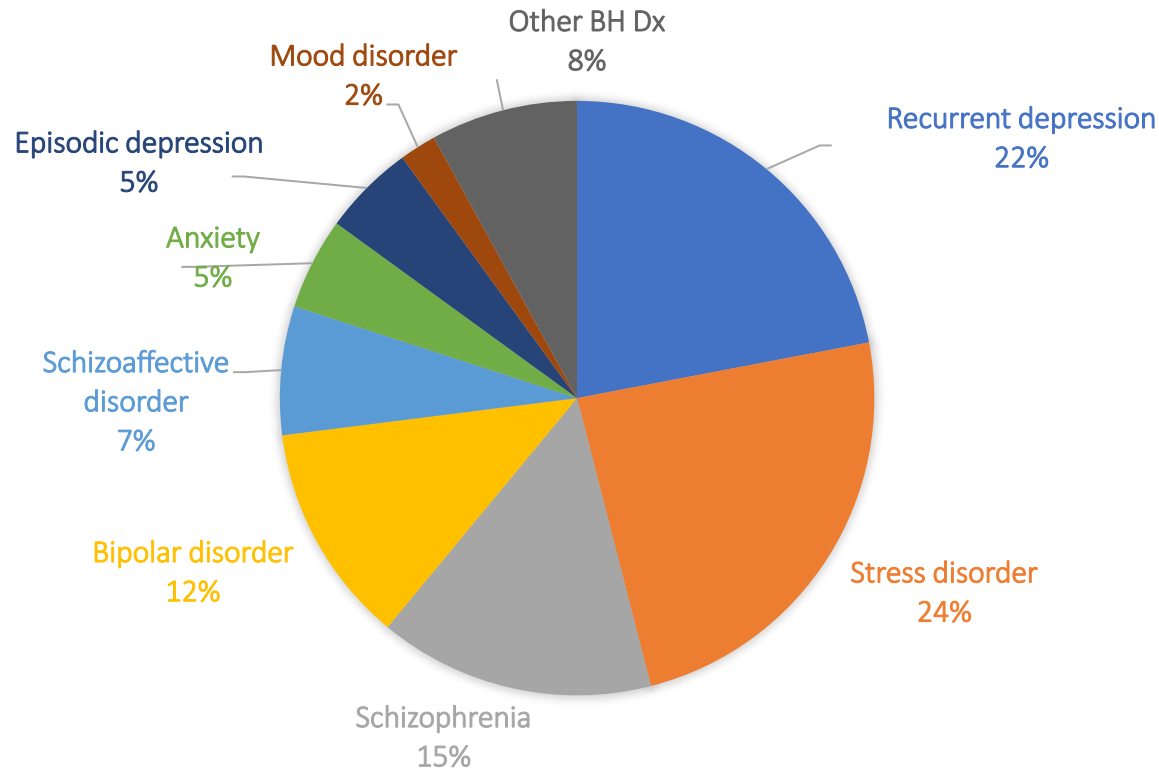


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Example: Risk Segmentation Applied

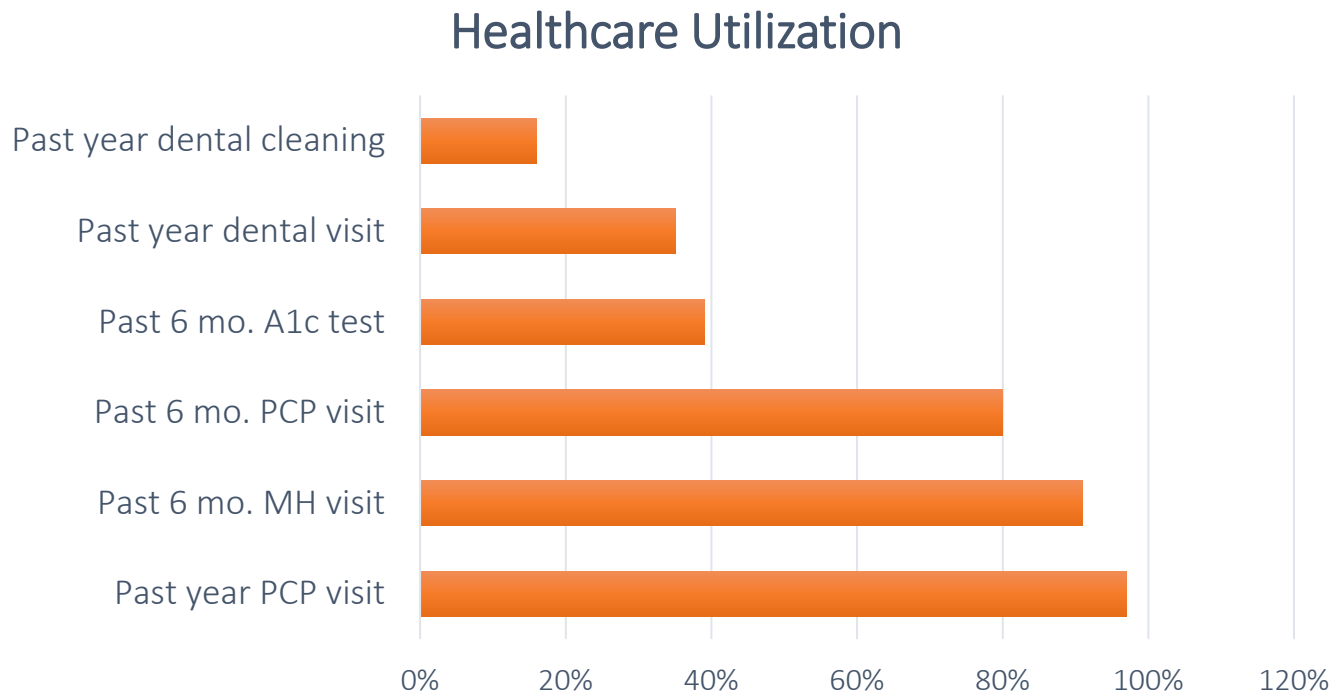
- Data informed decision-making
- Increased “objectivity” in identifying needs
- Can be coupled with clinical input (not best as a stand-alone tool)

Mental Health Dx, Clients With Diabetes



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Healthcare Visits by Type

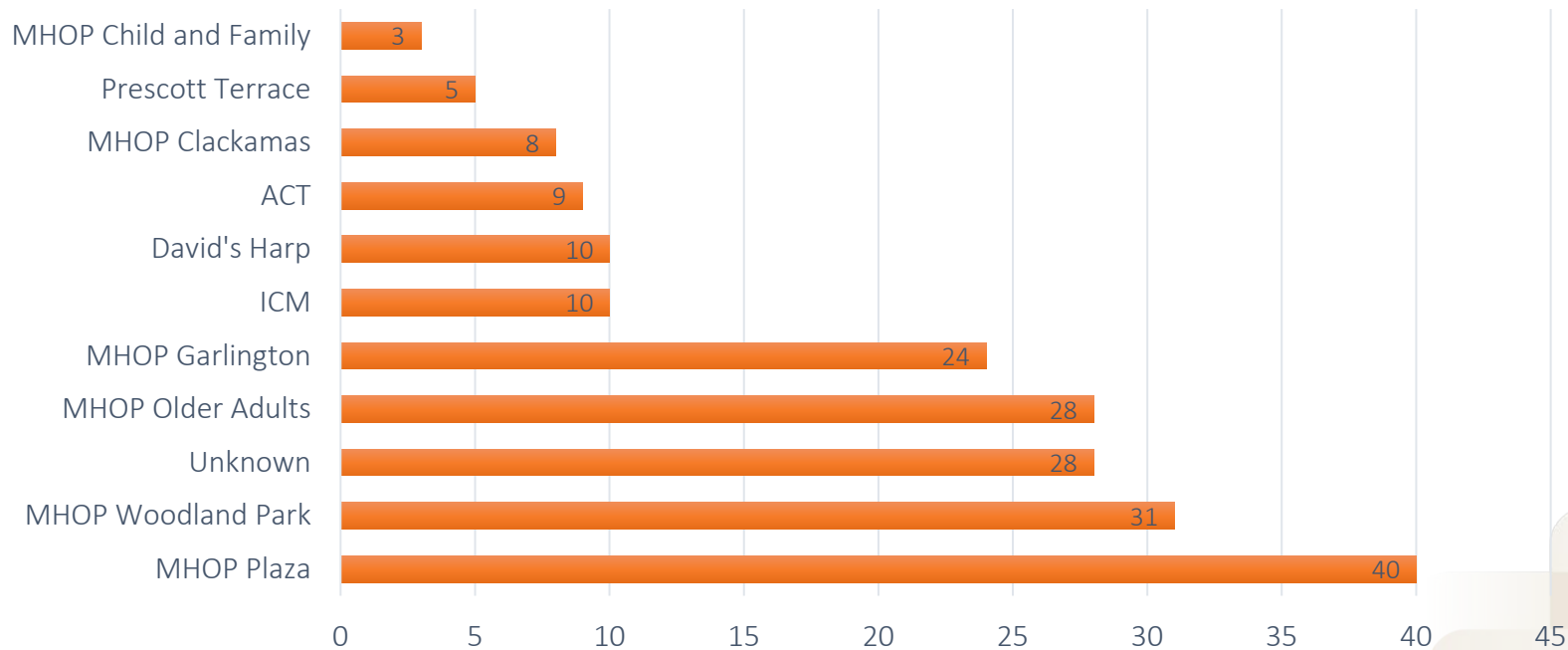


- Lower rates among Asian and Native Hawaiian, Pacific Islanders
- 3.33 ED visits per client in past year (range 0-125)

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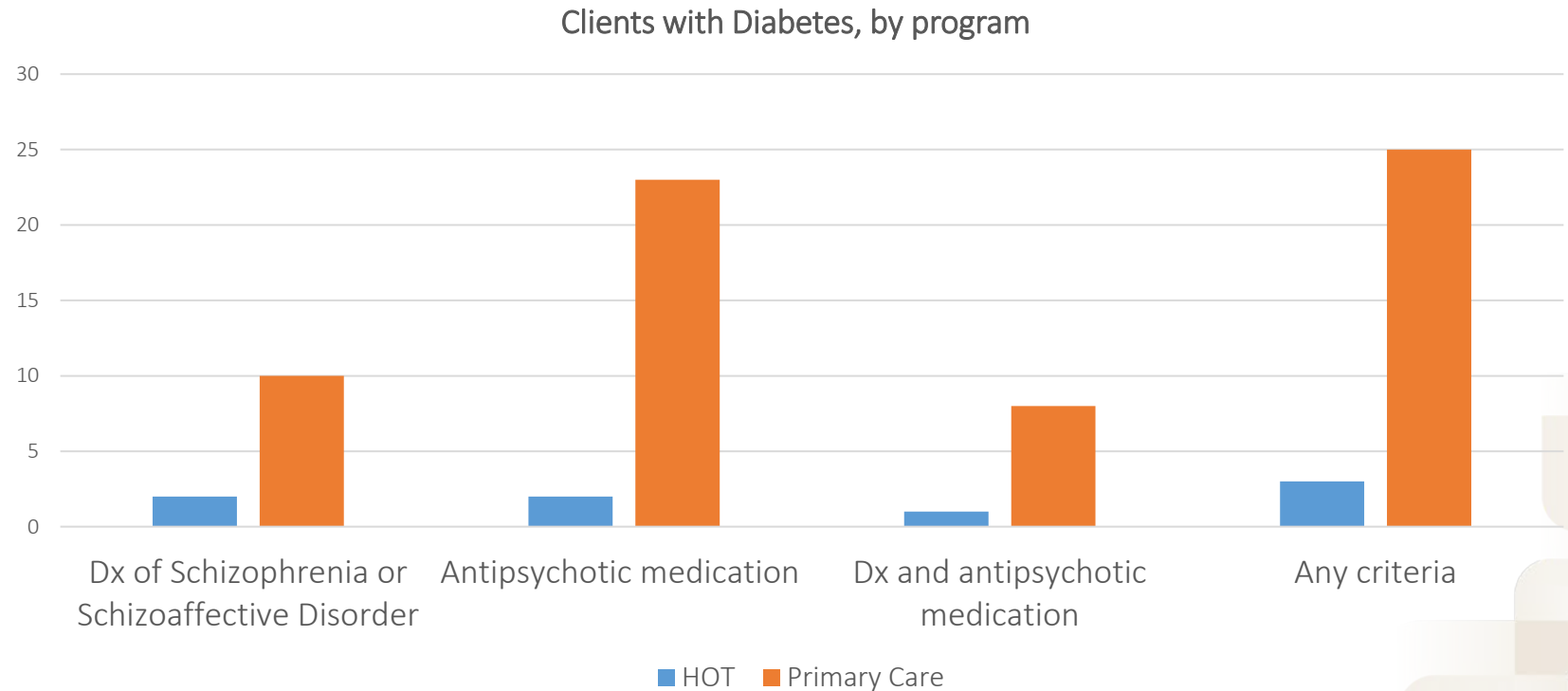
Diabetes and Any Criteria, by Team

Any criteria, Dx or Antipsychotic Medication



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Diabetes and Dx, Pc and Hot



Risk Segmentation Applied

Taking Charge of My Health

- Schizophrenia/schizoaffective disorder
- Clients in BH + PC
- Clients engaged in PC but low A1c testing frequency

Population Health team identifies clients eligible for intervention

- Clinical staff “scrub” the roster

APPOINTMENT PLANNING WORKSHEET

MY NEXT MEDICAL APPOINTMENT IS:

Date:		With (provider):	
Time:		Location:	

PREPARING FOR MY VISIT:

■ Questions for my doctor: _____

■ How I have been feeling since my last appointment: ☐ Better
☐ Same
☐ Worse

■ Explain: _____

■ New symptoms I have been experiencing: _____

MEDICATIONS

■ Current medications: _____

■ Notes, questions, or concerns about my medications: _____



HEALTH & WELLNESS PLANNING

The following table lists aspects that people often talk about with their healthcare providers. Completing this activity can help plan for your appointment.

What is working for me lately:	What is challenging for me lately:	What I would consider changing or working on:
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Physical Health	<input type="checkbox"/> Physical Health	<input type="checkbox"/> Physical Health
<input type="checkbox"/> Medications	<input type="checkbox"/> Medications	<input type="checkbox"/> Medications
<input type="checkbox"/> Daily Routines	<input type="checkbox"/> Daily Routines	<input type="checkbox"/> Daily Routines
<input type="checkbox"/> Stress Management	<input type="checkbox"/> Stress Management	<input type="checkbox"/> Stress Management
<input type="checkbox"/> Pain Management	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Pain Management
<input type="checkbox"/> Sleep	<input type="checkbox"/> Sleep	<input type="checkbox"/> Sleep
<input type="checkbox"/> Eating Habits	<input type="checkbox"/> Eating Habits	<input type="checkbox"/> Eating Habits
<input type="checkbox"/> Physical Activity	<input type="checkbox"/> Physical Activity	<input type="checkbox"/> Physical Activity
<input type="checkbox"/> Support System	<input type="checkbox"/> Support System	<input type="checkbox"/> Support System
<input type="checkbox"/> Drug/Alcohol Use	<input type="checkbox"/> Drug/Alcohol Use	<input type="checkbox"/> Drug/Alcohol Use
<input type="checkbox"/> Housing	<input type="checkbox"/> Housing	<input type="checkbox"/> Housing
<input type="checkbox"/> <u>Something Else:</u>	<input type="checkbox"/> <u>Something Else:</u>	<input type="checkbox"/> <u>Something Else:</u>

Population Health 2.0

Risk stratification

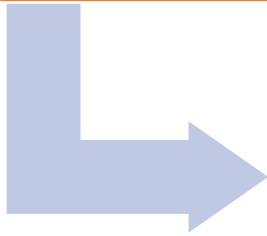
- Identify the best level of care and services for different subgroups of the population
- Focus resources on a smaller percentage of clients who need more support (triage)
- Assign a level of risk based on pre-identified characteristics and existing clinical knowledge and research



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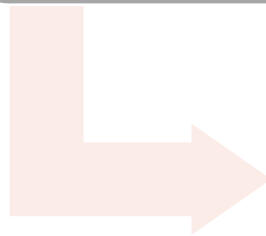
All clients with
diabetes or
prediabetes

- Compile information on all clients with a diabetes



Stratify clients into
high risk, rising risk,
low risk

- Sort individuals by key factors (MH Dx, level of healthcare engagement, use of emergency services)
- Consider demographic and other SDoH factors
- Develop risk groups



Design care models
or interventions for
risk groups

- Select one or more risk groups on which to focus
- Develop programs, care pathways, interventions for risk group(s)

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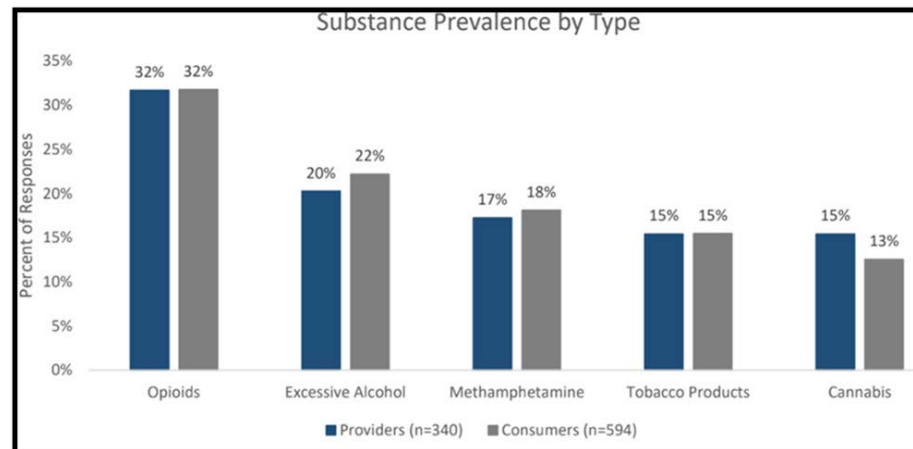
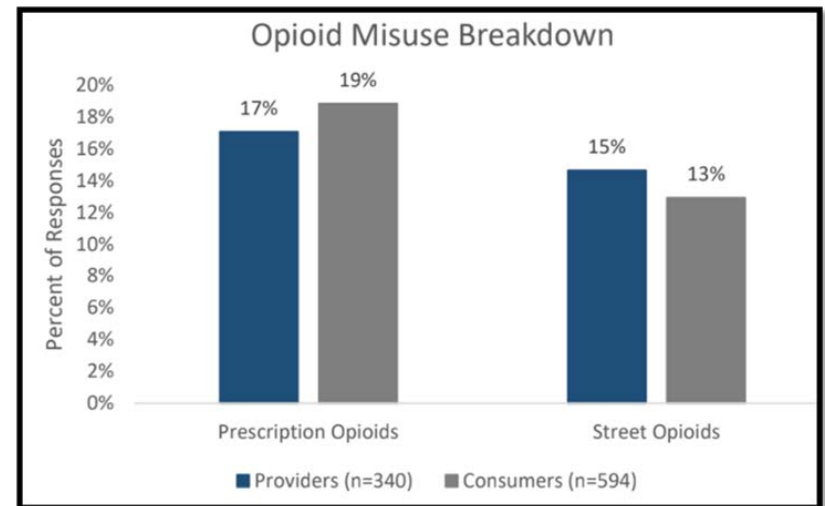
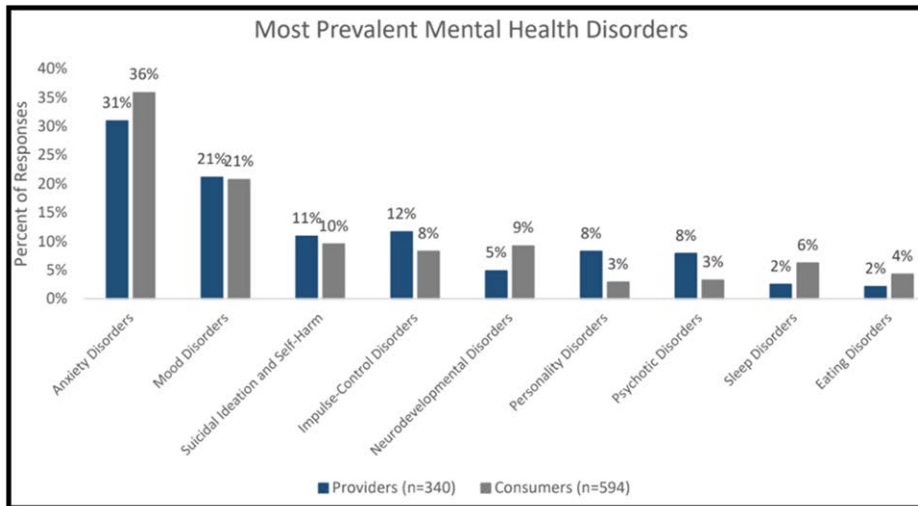


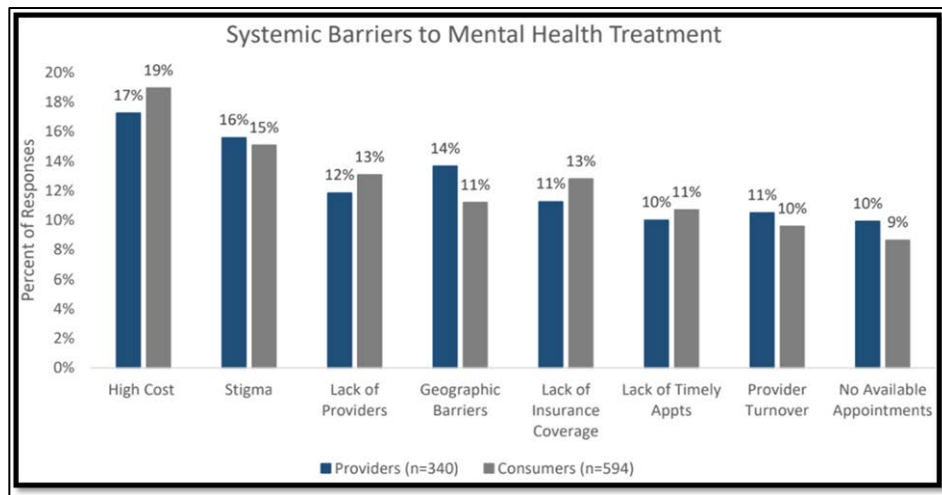
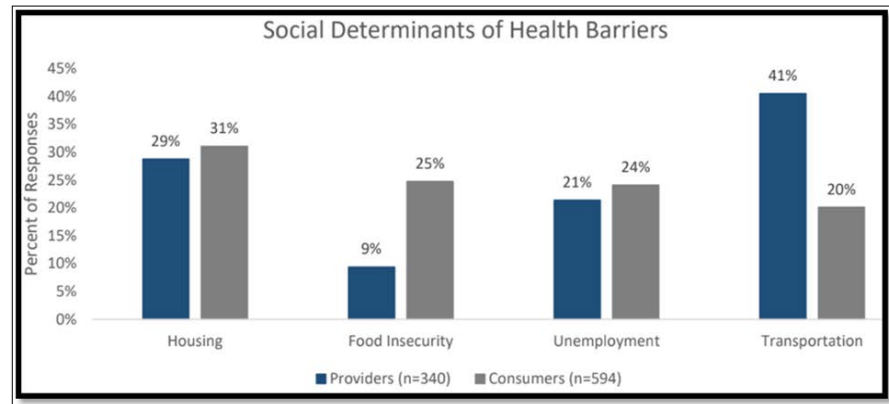
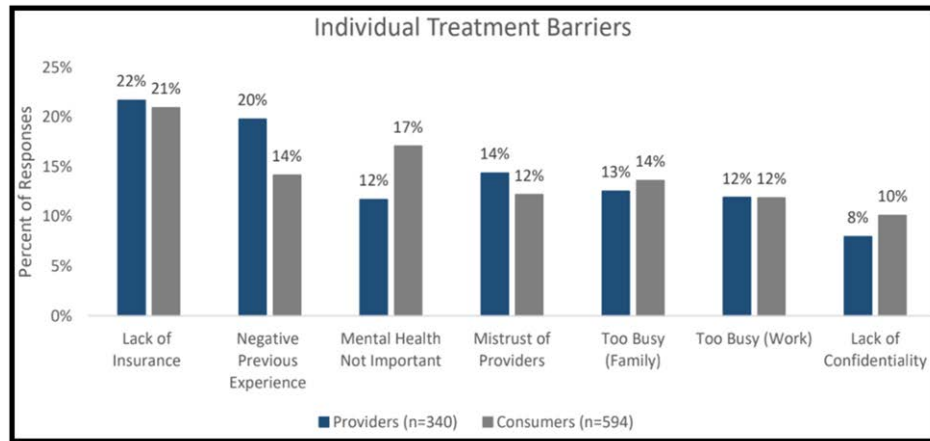
Gap Analysis: Needs Assessment of WNC



Demographics

- The majority of both provider and consumer respondents: white, female, and ages 30 - 59 years old.
 - Providers
 - 55% worked in the healthcare industry
 - 33% worked in a healthcare-related field
 - 42% were mental health licensed professionals
 - Consumers
 - 26% were from the education industry
 - 16% were unemployed
 - The majority (64%) were unimpaired, but of those with a disability, vision was the most commonly identified impairment.
 - 79% were insured, either with private health insurance or Medicare/Medicaid.





Barrier	Priority*
<i>Barriers to Optimizing Services*</i>	
Inability to Address SDOH	1
Low Reimbursement Rates	2
Poor Insurance Coverage	3
Lack of Support Staff	4
Low Patient Retention	5
Time Constraints	6
Lack of Culturally-Appropriate Models	7
Lack of LGBT Health Training	8
Optimization Not Required	9
Lack of Continuing Education	10

*Barrier determined by forced ranking of survey provider (n=225) responses.

Capturing NOMS

MAHEC Intranet Allscripts

MAHEC

Dashboard

NOMS

NOMS for Allscripts Patient: **MAHEC, JAX** DOB: 29-DEC-2020

REDCap NOMS

Child NOMS Baseline

MAHEC Intranet Allscripts

Help My Workflows ccoales Logout

MAHEC

Dashboard

NOMS

NOMS for Allscripts Patient: **MAHEC, TIM ADP** DOB: 01-JAN-1996

Baseline Next Assessment Discharge View PDF Unlink

General	
Record ID	1525
redcap_event_name	baseline_emo_1
Who is administering this questionnaire? (First and Last Name)	Tim Thacker
Today's Date	2021-08-23
Date of Appointment	2020-10-20
Patient's First Name	Tim ADP
Patient's Last Name	MAHEC (Test)
Patient's Date of Birth	1996-01-01
Patient's Email	tcemail@noms.com
Patient's Phone Number	(848) 555-5555
Please check this box if the survey was not completed.	0
Why was the survey not completed?	0

MAHEC

Adult NOMS Baseline

Please complete the survey below.

Thank you!

Who is administering this questionnaire? (First and Last Name)
* must provide value

Today's Date
* must provide value

Date of Appointment
* must provide value

Patient's First Name
* must provide value

Patient's Last Name
* must provide value

Patient's Full Name: _____

Patient's Date of Birth
* must provide value

Patient's Email
* must provide value

If no email is available, please include a "dummy" address (i.e. noemail@none.com)

Evaluation Dashboard: Data on Demand

CCBHC Evaluation Dashboard



CCBHC Evaluation Dashboard



Surveyor Need-to-Know

Year One NOMS Summary

Adult

Year One Captured
1173

Top 3 Surveyors
Natascha Harvey,
Joshua Schactman,
Lauren Preston

Child

Year One Captured
530

Top 3 Surveyors
Melisa Enclave,
Rachel Henry,
Laura Hopkins

Surveyor Resources

Surveyor Training

NOMS Monthly Check-in Recordings

Tues CCBHC Monthly Check-in Meeting

Fri CCBHC Monthly Check-in Meeting

Evaluation Team Interns

NOMS pdfs (English & Español)

CCBHC Appointments & Recalls

MAHEC's Reports

Gap Analysis Findings

Year 1 NOMS Report

NOMS Updates, Announcements, & Reminders

Monthly NOMS Check-in Meeting:

Tuesday March 8th, 12:00-12:30PM & Friday March 11th, 8:30-9:00AM

-> Click "CCBHC NOMS Monthly Check-in Meeting" link under Surveyor Resources to join!

-> Meeting recordings are under "NOMS Monthly Check-in Recordings"

passwords are located next to meeting link

-> We now offer two Monthly Check-in meetings! You can attend whichever best suits your schedule!

- **NOMS Workflow:** Reference "Accessing NOMS through Workflows" training document under Surveyor Training link. Universal baseline links have been removed from this dashboard, please use new Workflows for any baseline NOMS. This training includes how to properly document NOMS in EHR.
- Please reach out to a member of the evaluation team if you need impromptu support with NOMS!
- If you have any questions or concerns regarding a particular patients' NOMS status, please contact Jackie or Courtney to clarify.
- Evaluation NOMS Phone Number: (828) 407-2404

CCBHC Personnel

- Joe Yurchak - CCBHC Program Director
- Kim Wood - Manager of Program Evaluation
- Courtney Coules - Monitoring & Evaluation Associate
- Jackie Herring - Monitoring & Evaluation Specialist

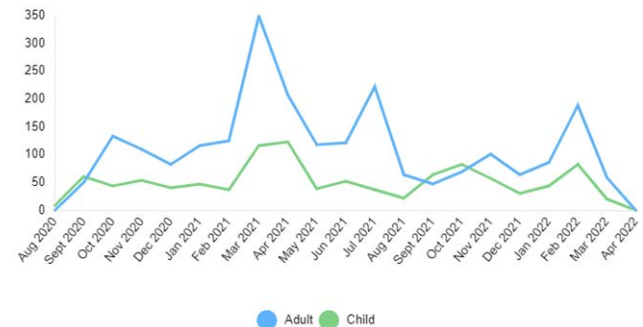
Reassessment Window

Last NOMS Conducted Between:
August 9 - October 12, 2021

Active Interns & Schedules

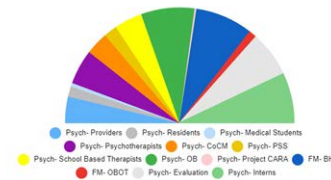
Raylen Earwood Tues/Thurs 8am-12pm

Baseline NOMS by Month

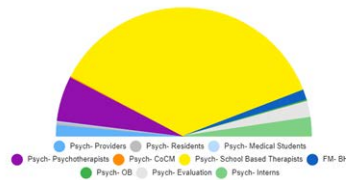


Baseline/Reassessment/Discharge Performance Measures

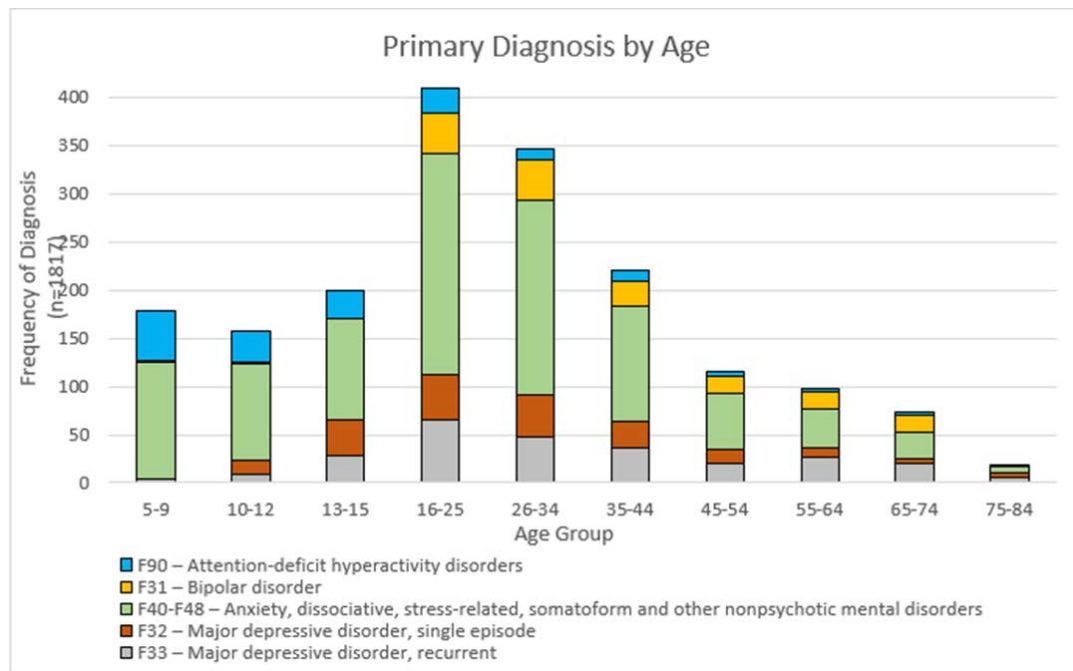
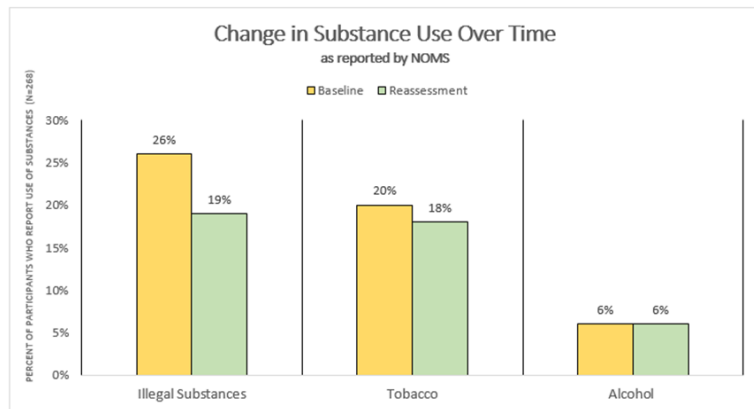
NOMS Adult Baseline Tracking by Department



NOMS Child Baseline Tracking by Department



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What's Next for MAHEC?

- Recently launched a completion rates dashboard
 - Shows which surveyors collect the most NOMS
 - Shows NOMS Opportunities for every surveyor
 - Has leader board – stimulate competition
 - Patient recall to easily identify who needs NOMS and when

Breakout Discussion

Discussion Questions

- *Consider how your organization is currently using data collected for CCBHC Expansion grant.*
 - *What other opportunities, outside of grant reporting requirements, exist (e.g., how is your agency using data for CQI, population health management, or sustainability efforts)?*

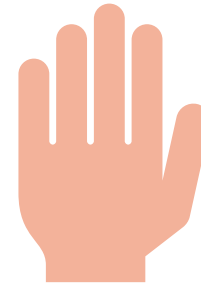
Convener will report-out for the group!

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Welcome Back!



Please share in the chat takeaways from breakout room.



If you'd rather speak you can unmute and share.

Things to Consider

- Facilitate a conversation with your CCBHC leadership team – share lessons from this session on population health management practices and recommend to adapt one (if one is not already in place).
- *Consider identifying additional data points needed (including utilization data) to engage in population health management.*

Wrap-up:

Preparing for Our Next Session

Now that you have taken the time to consider how your organization will be leveraging Population Health Management approaches...in the next session we will focus on how to optimize team-based care provisions through designing and implementing measurement-based care pathways.

Tips

- *Take inventory of how your organization address health disparities!*



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Questions or Looking for Support?

Visit our website and complete the **Request Technical Assistance** form

<https://www.thenationalcouncil.org/ccbhc-e-nttac/>



Receive assistance from our team of experts!

The CCBHC-E National Training and Technical Assistance Center provides consultation and technical assistance on CCBHC implementation to expansion grantees. Fill out this form to request assistance today.

Request Training/Assistance

Fields marked with an (*) are required.

First name *	Last name *
<input type="text"/>	<input type="text"/>
Title *	Organization/Company *
<input type="text"/>	<input type="text"/>

Thank You

Please take a moment to share your feedback in the
post-webinar survey.

It will pop up once the webinar is closed.



References and Resources

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- [Risk-Stratification-Action-Guide-Mar-2019.pdf \(nachc.org\)](#)
- Swarthout M, Bishop MA. Population health management: Review of concepts and definitions. Am J Health Syst Pharm. 2017 Sep 15;74(18):1405-1411. doi: 10.2146/ajhp170025. PMID: 28887342.