NATIONAL COUNCIL for Mental Wellbeing

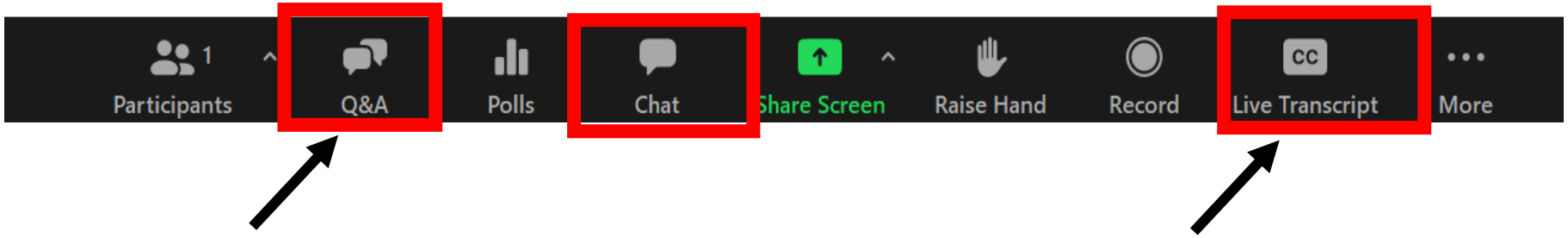
Population Health Management (PHM) Part 1: Introduction to Population Health

December 6, 2022
2-3pm ET

CENTER OF EXCELLENCE for Integrated Health Solutions
Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

Questions, Comments & Closed Captioning

Type in a **comment** in the **chat box**



Type in a **question in the Q&A box**

Click **Live Transcript** and then select **"Show Subtitle"**

NATIONAL COUNCIL *for* Mental Wellbeing

Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).

SAMHSA

Substance Abuse and Mental Health Services Administration

www.samhsa.gov

Poll #1: What best describes your role?

- Clinician
- Clinical Administration
- Revenue Cycle Management
- Health Information Technology
- CEO/Executive Team
- Other (specify in chat box)

NATIONAL COUNCIL for Mental Wellbeing

Population Health Management (PHM) Webinar Series

Next Sessions:

- **January 12th from 2-3pm ET:** Population Health Part 2- Measurement-Informed Care
- **February 7th from 2-3pm ET:** Population Health Part 3- Clinical Pathways for PHM
- **March 9th from 2-3pm ET:** Population Health Part 4- Real World Examples for PHM

NATIONAL COUNCIL for Mental Wellbeing

Today's Speaker

Nick Szubiak, MSW, *LCSW*
Principal, NSI Strategies

NSI STRATEGIES
CONSULTING SUPPORT FOR INTEGRATED HEALTHCARE ENVIRONMENTS

NATIONAL COUNCIL *for* Mental Wellbeing

Learning Objectives

After this webinar, participants will be able to:

- **Understand** the basic concepts of population health management.
- **Recognize** the value that population health management strategies bring to integrated care organizations, including optimizing resources, improving equitable care pathways, etc.
- **Understand** how to utilize population health approaches to support equitable integrated care and best meet the needs of marginalized communities.
- **Identify** opportunities for using population health management (PHM) to support the adoption of changed clinical pathways post COVID-19.

Why We Need to Change: A look at the data

People living with co-occurring Physical Health, Behavioral Health and social determinant of health (SDOH) needs:

- Have higher costs yet experiences poorer health outcomes
- Are faced with significant inequities based on racial, ethnic, and economic challenges across all settings
- Are likely to benefit from evidence-based integrated interventions in whatever setting they are best engaged
- Benefit from higher levels of service intensity

Source: National Council for Mental Wellbeing, CoE-IHS. (2022). *The Comprehensive Healthcare Integration Framework*.

NATIONAL COUNCIL for Mental Wellbeing

A Look at the Data – Real World Examples

- Persons with serious mental illness (SMI) have a higher mortality rate than general population [1]
    - premature deaths in persons with schizophrenia are **due to medical conditions** such as cardiovascular, pulmonary and infectious diseases [2]

- Depression is twice as frequent in people with diabetes compared with those without diabetes [3]

Sources:
1. de Mooij LD, Kikkert M, Theunissen J, Beekman ATF, de Haan L, Duurkoop PWRA, Van HL, Dekker JJM. (2019). *Dying Too Soon: Excess Mortality in Severe Mental Illness.*
2. Liu, N.H.,et al., (2017). *Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas*.
3. Sartorius N. (2018). *Depression and diabetes.*

Golden Opportunities

Contact with primary health care was highest in the year prior to suicide with an average contact rate of 80%. At one month, the average rate was 44%.

The **lifetime contact rate for mental health** care was 57%, and 31% in the final 12 months. In general, women and those over 50 years of age had the highest rates of contact with health care prior to suicide.

Source: Stene-Larsen K, Reneflot A. (2019). *Contact with primary and mental health care prior to suicide: A systematic review of the literature from 2000 to 2017.*

NATIONAL COUNCIL for Mental Wellbeing

PHM: Not a new Concept

- The population health perspective represents a shift back to the historical roots of public health, where the focus was on:
  - **Measuring and addressing** the spread of disease
  - **Prevention** of epidemics among the population
  - Identifying and addressing the contributors to disease and epidemics resulting from:
    - where people live, work and play
    - what they eat and breathe
    - the conditions in the communities where populations live
- Shifts the major emphasis to a focus on the **preventable** causes of disease and disability

Source: HITEQ Center. (2017). *Population Health Management Concepts for Health Centers*.

PHM: A process and an outcome

A Process - The means:

- **Population health management** is the set of automated tools and processes available to health care providers to manage and deliver optimized care to a patient population.
- Automation allows health care providers to assess population needs, stratify populations, and target and deliver care efficiently.

The Outcomes - The goal:

- Keep a patient population as healthy as possible;
- Minimize the need for high-cost interventions, admissions, Emergency Department (ED) visits;
- **Create improved, optimal Population health status and outcomes**.

Source: HITEQ Center. (2017). *Population Health Management Concepts for Health Centers*.

Population Health Management Tools and Strategies

- Optimize the workflow and the organization of care delivery to improve efficiency.
- Engage patients and manage care to improve effectiveness and outcomes.
- Motivate the patient to reconnect with the provider and participate in their care and health.
- Optimize the provider-patient encounter with tools, analytics, alerts, and information.
- Extend the reach of the provider beyond the walls of the clinical setting with automated assessments and care management tools, including alerts and messages, reporting and analytics and others.

Population Health: What it does

- Increase our access to patients
- Provide more evidence-based practices (EBP) to our communities
- Trauma Informed Care (TIC)
- Reduces stigma
- More effective
- Client Centered – The patient's treatment plan
- Improves our work environment and culture – Compassion Fatigue/Burnout

Population Health Management (PHM) & Integrated Care

Opportunities within Integrated Care

- Enables an organization to address Social Determinants of Health (SDoH), general/physical health and behavioral health needs.
- PHM targets and proactively treats people where they are in the care continuum.
- PHM transforms the treatment milieu from reactive to proactive.

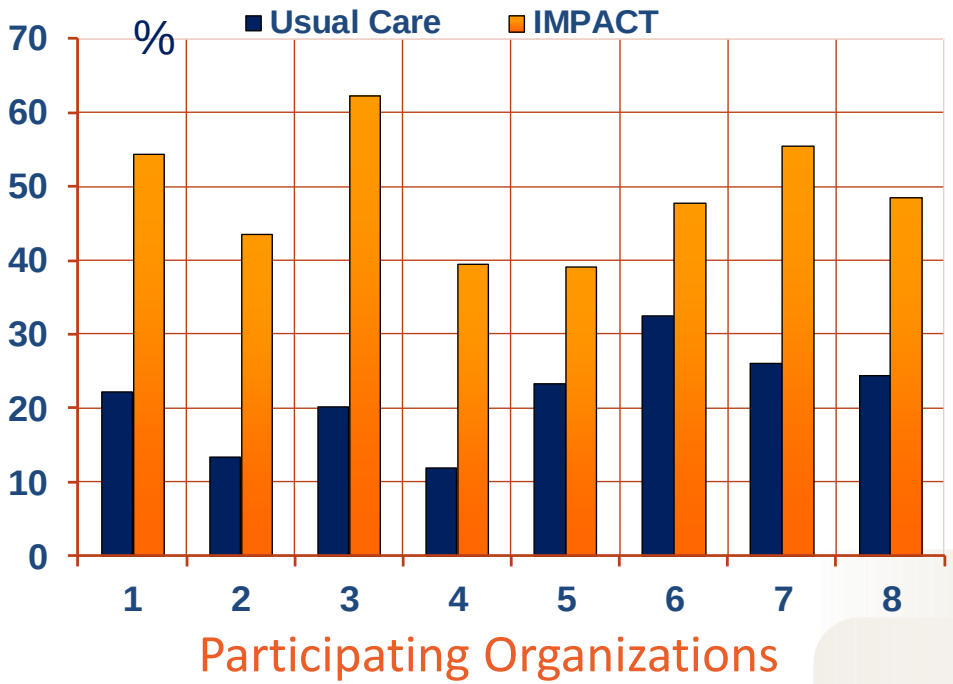
Why it works!

- Integrated care teams have the capacity and skills to address these multiple and co-occurring dynamics.
- Integrated care can deliver what an individual needs simultaneously in patient-centered ways.
- Integrated care teams can effectively utilize data to target care to clients who need it most and deliver that care before higher levels of severity trigger higher level interventions.

Integrated Behavioral Healthcare Models Work!

- Increase our access to patients
- Provide more EBP to our communities
- More effective
- Reduces stigma
- Client-centered – the patient's treatment plan

50% or greater improvement in depression at 12 months



Source: Unützer J, et. Al. (2022). *Collaborative Care Management of late-life depression in the primary care setting: A randomized controlled trial*. U.S. National Library of Medicine.

NATIONAL COUNCIL for Mental Wellbeing

Social Determinants of Health

Defined by the **World Health Organization:**

- "The circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness."
- "These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics."

Source: World Health Organization (2022). *Social Determinants of Health*.

Social Determinants of Health cont'd

- Race or ethnic group
- Religion
- Socioeconomic status
- Gender, Age
- Mental health
- Cognitive, sensory or physical disability
- Sexual orientation or gender identity
- Genetics

- Geographic location: urban, rural, transportation
- Environmental conditions: clean air and water, housing
- Health and public health services
- Social supports and culture
- Individual behavior

Source: World Health Organization. (2013). *Social Determinants of Health: Key Concepts*. World Health Organization.

PHM and Social Determinants

- Managing and improving population health means measuring and improving services that address social determinants of health (SDoH).
- Addressing SDoH helps to modify the factors that cause and exacerbate disease.
- An understanding of patients' social and environmental factors helps support patients to participate in care and adhere to care plans.

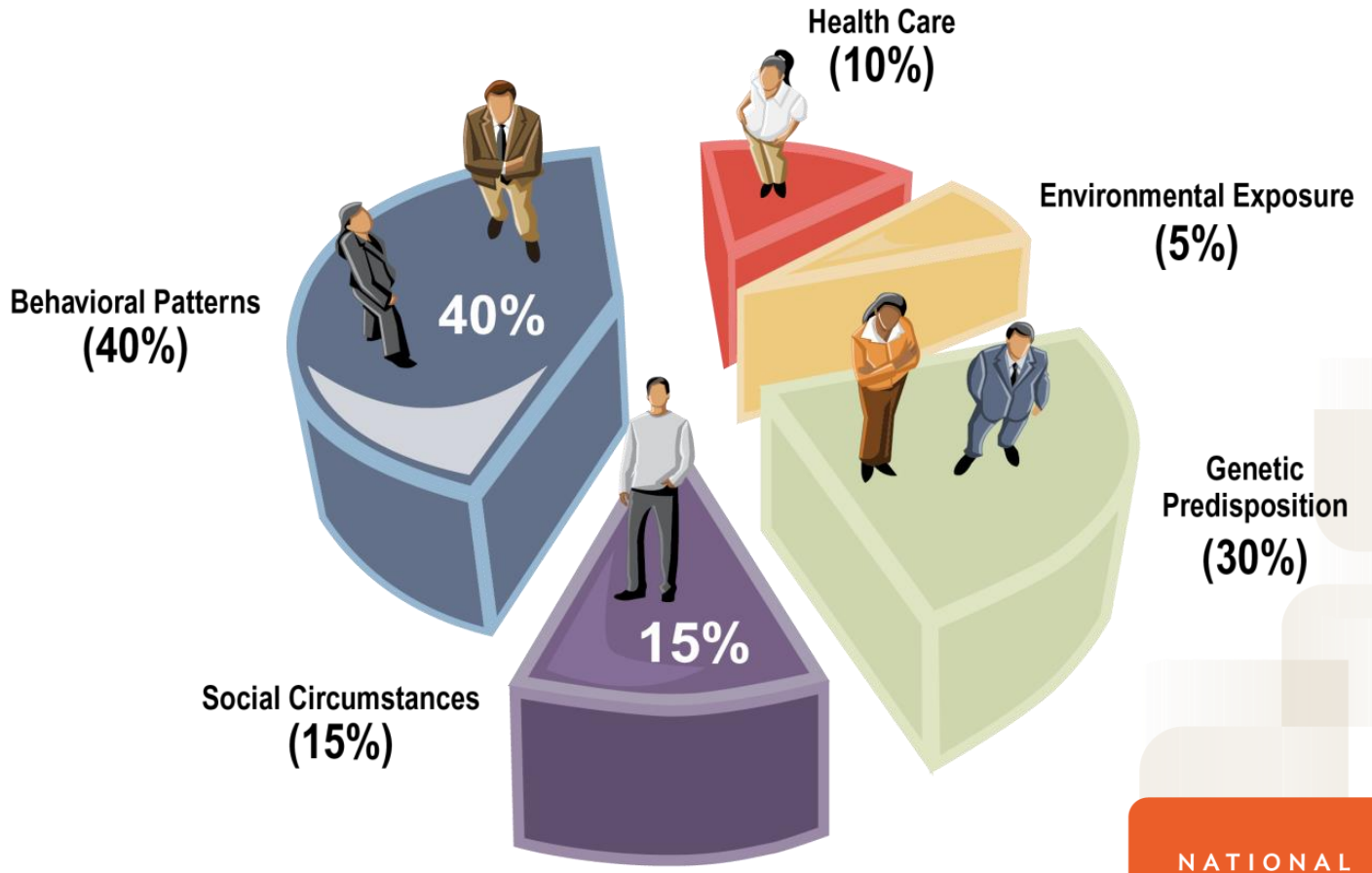
Measuring patients' SDoH:

- Identify the upstream socioeconomic drivers of poor outcomes and higher costs.
- Measure and document the increased complexity of patient populations.
- Integrate services and establish community partnerships.
- Measure and demonstrate value.

Source: HITEQ Center. (2016). *Population Health Management, social determinants of health and how these fit.*

Contribution of SDH to Population Health

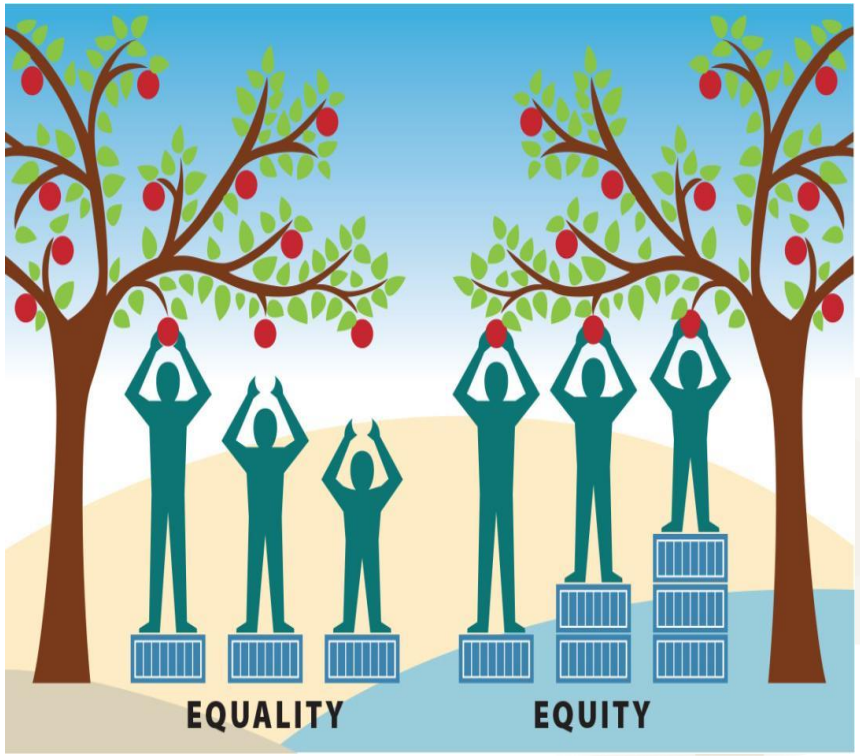
The social determinants of health account for 90% of the contribution to premature mortality.



Source: HITEQ Center. (2022). *Population Management, Social Determinants of Health & How These Fit*.

PHM supports Health Equity

- HRSA has established a strategic goal of improving health equity. [1]
- **Health equity** is attaining the highest level of health for all people, regardless of cultural, demographic or socio-economic factors. [2]
- **Health inequity** are the differences in health between groups of people that are avoidable, unfair, and unjust. [2]
- We can improve health equity in communities by **mitigating the impact of the social determinants** on health and wellbeing. [3]



Sources:
1. HRSA. (2016). *Hrsa Strategic Plan FY 2023 (interim)*.
2. SAMHSA Center of Excellence for Integrated Health Solutions (2022). *Health Equity Toolkit*.
3. Whittington , J., & Laderman, M. (2016). *A framework for improving health equity: IHI*. Institute for Healthcare Improvement.

NATIONAL COUNCIL for Mental Wellbeing

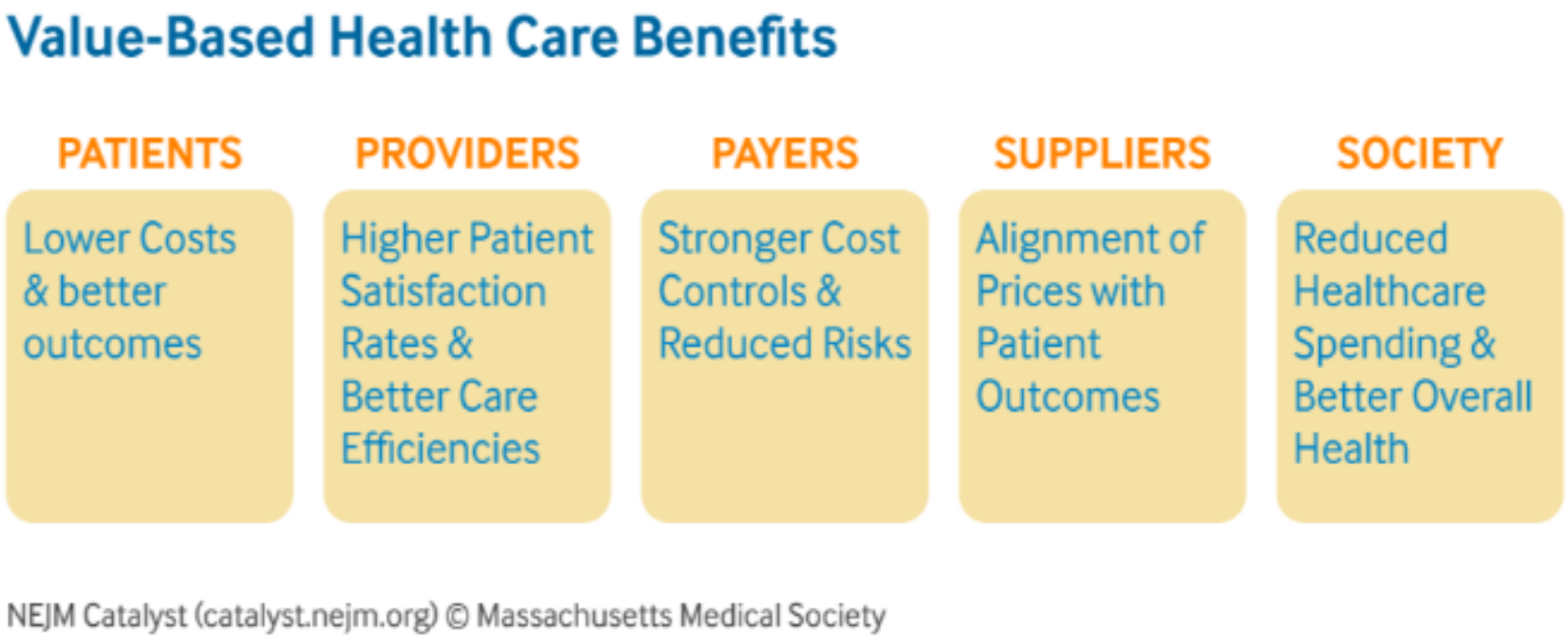
Financial Opportunities with PHM

Financial benefits of addressing health inequity and health disparities:

- Reduce costs:
  - Focus on high-risk patients
  - Identify and reduce gaps in care
- Preparing for the future: value-based care targets will be impossible without reducing disparities.

Source: Laderman M, Whittington J. (2016). *A framework for improving health equity. Healthcare Executive*.

Preparing us for the future – Value-Based Care

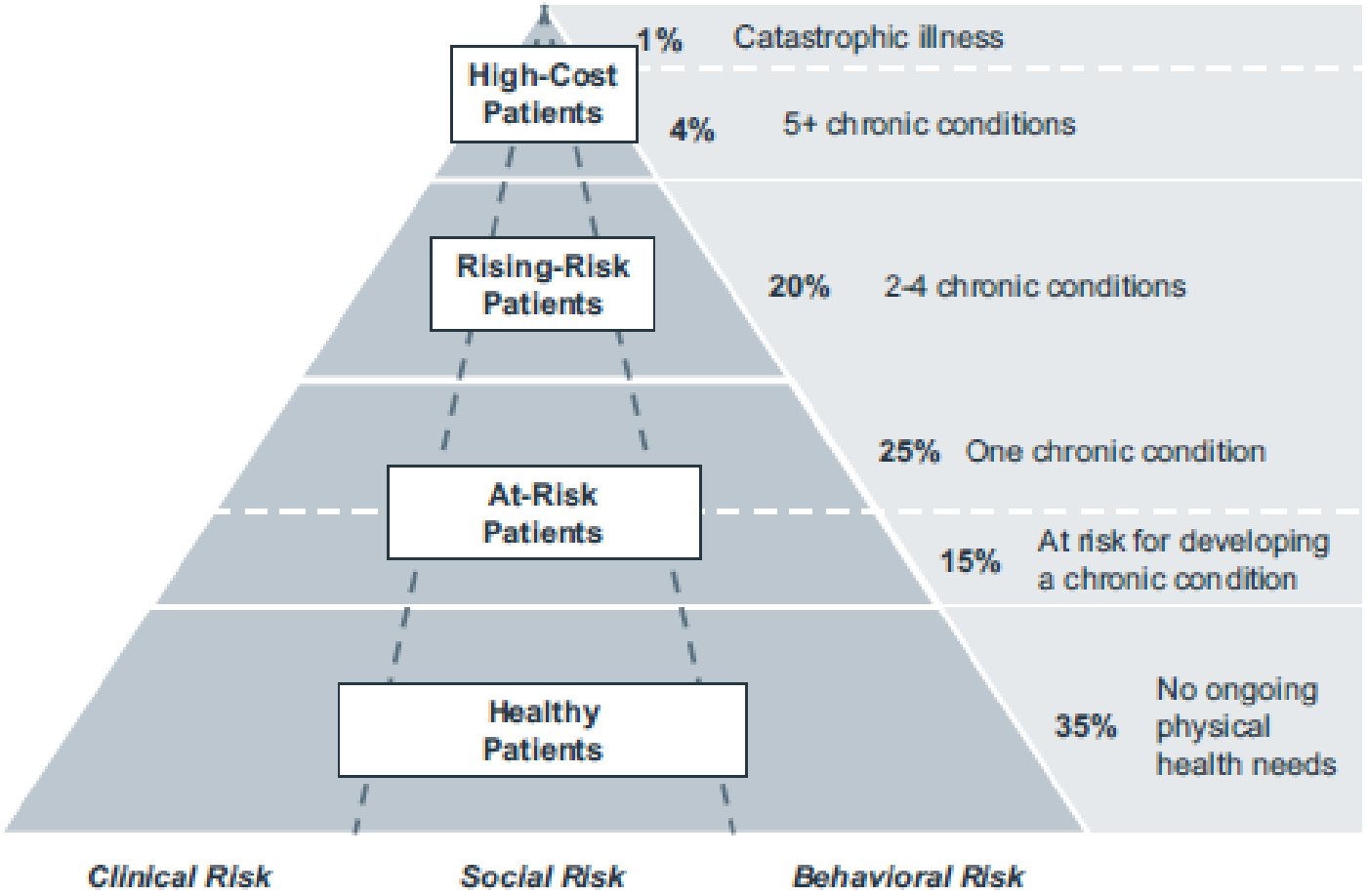


Source: Massachusetts Medical Society. (2019). *What is Value-Based Healthcare?*

NATIONAL COUNCIL for Mental Wellbeing

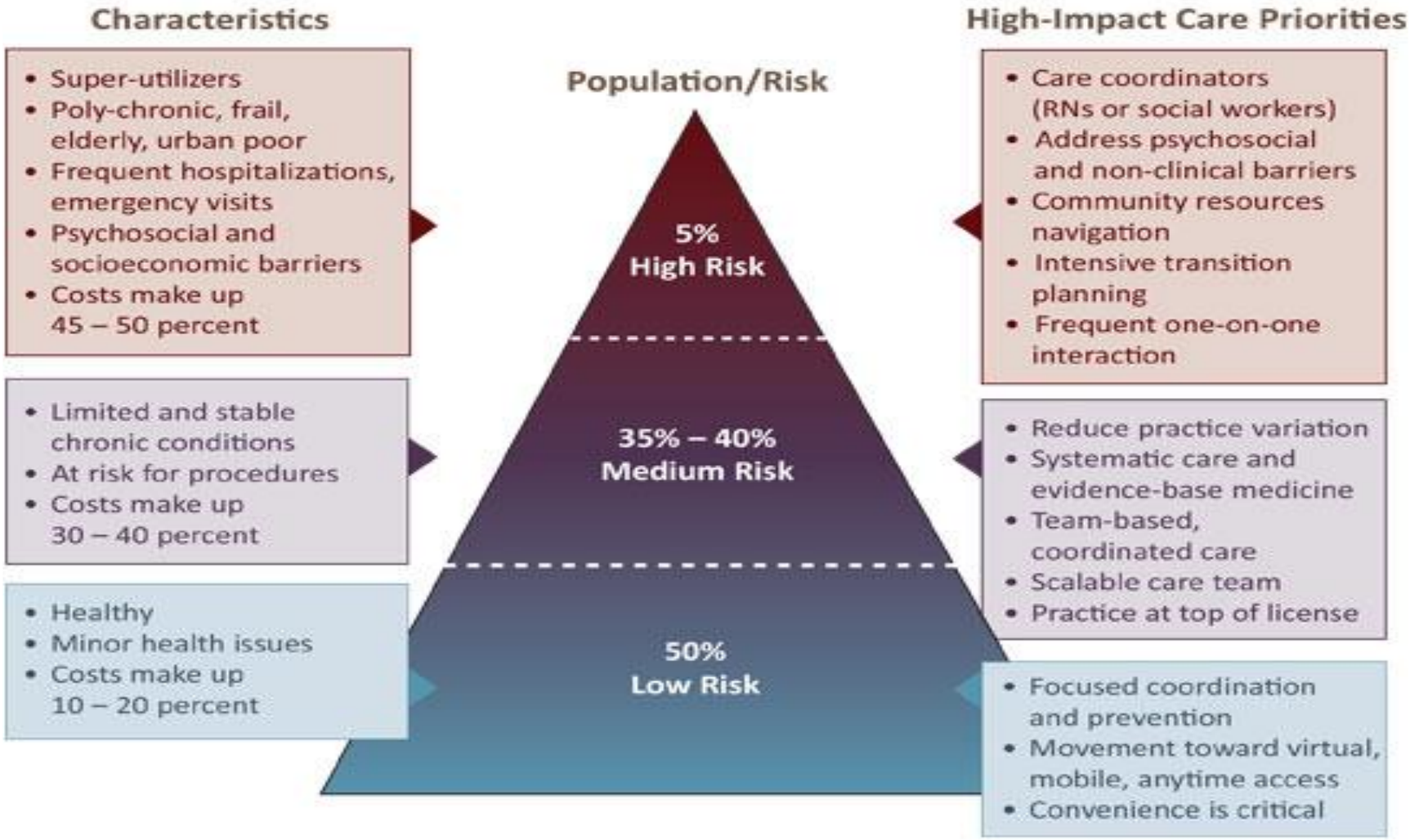
Moving from Episodic "Sick Care" to PHM

Pareto principle – the 80/20 rule – the sickest 20% of the population is at highest risk to utilize 80% of high-cost services



Source: HITEQ (2016). *Population Health Management Concepts for Health Centers*.

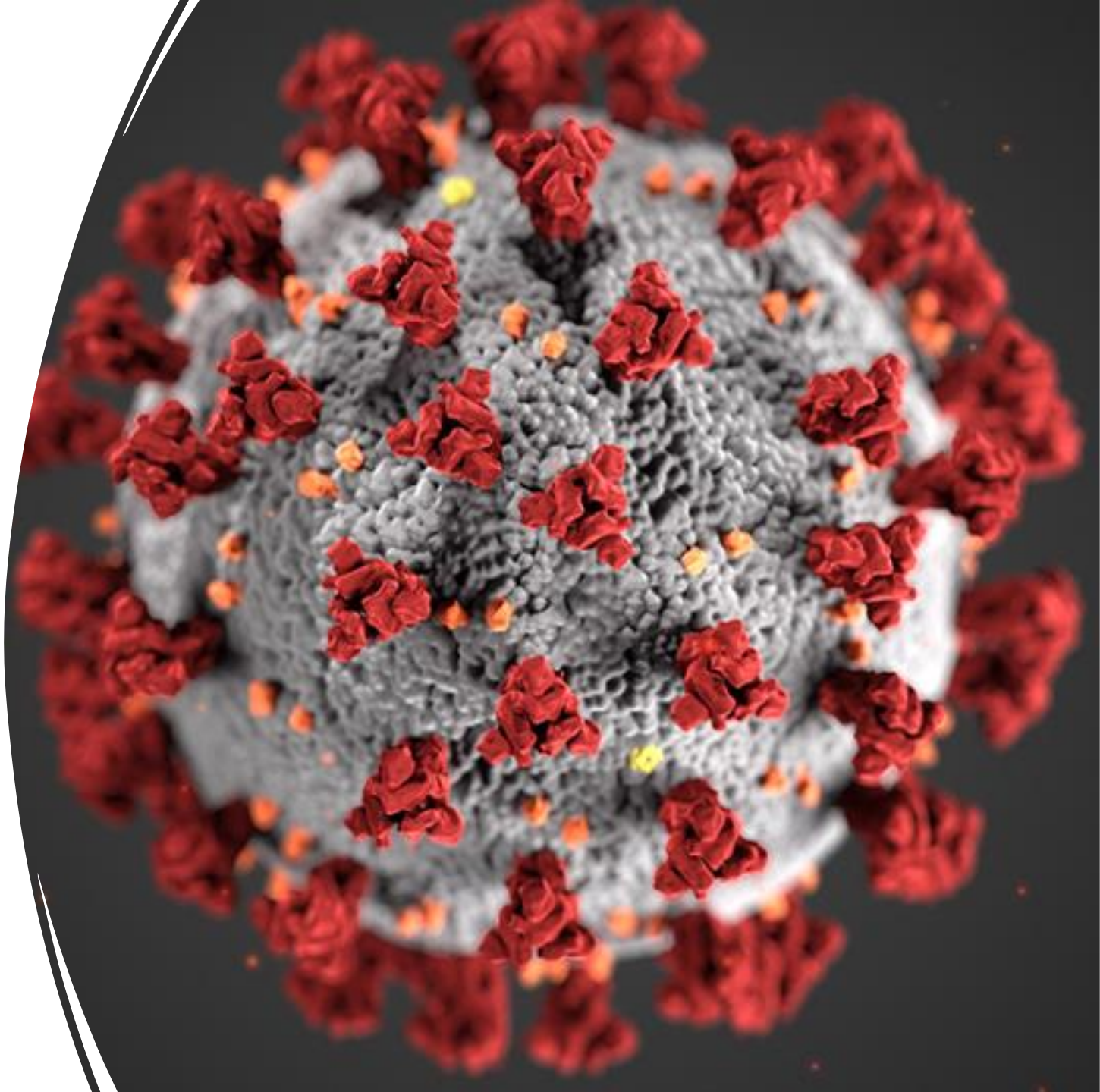
Population Health Pyramid



Source: Clifton Larson Allen. (2015). *Moving From Traditional Care Delivery Models to Population Health Management*.

NATIONAL COUNCIL *for* Mental Wellbeing

COVID-19



Continuous Quality Improvement (CQI)

Population Health breathes new life into CQI!

How we plan to support your implementation

- **Next Session:** Population Health Part 2- Measurement-Informed Care, **January 12th from 2-3pm ET**
- Population Health Part 3- Clinical Pathways for PHM, **February 7th from 2-3pm ET**
- Population Health Part 4- Real World Examples for PHM, **March 9th from 2-3pm ET**

- **Strategic Plan:** Pick an area you want to target to treat and developing a metric that measure and track progress.
- **Developing a Core Implementation Team**: We are the Champions
- **Implementation into existing clinical pathways** – using data to support the change

PHM Strategic Workplan Tool

[Download the tool]

Questions? Contact Nick Szubiak
nick@nsistrategies.com
(808) 895.7679
www.nsistrategies.com

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	

Tools to Support Population Health Success

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

NATIONAL COUNCIL for Mental Wellbeing

Managing and Sustaining the Change

- Population Health Management is your guide
- Manage and expect the ebbs and flows without judgement
- What works now may not work later

Thank you!

Nick Szubiak, MSW, LCSW
Integrated Health Consultant, NSI Strategies

nick@nsistrategies.com
(808) 895.7679

www.nsistrategies.com
twitter.com/nszubiak
linkedin.com/in/nick-szubiak

NSI STRATEGIES

Consulting Support for
Integrated Healthcare Environments

Questions, Comments?

NATIONAL COUNCIL *for* Mental Wellbeing

References (1 of 3)

- Clifton Larson Allen. (2015). *Moving From Traditional Care Delivery Models to Population Health Management*.
- de Mooij LD, Kikkert M, Theunissen J, Beekman ATF, de Haan L, Duurkoop PWRA, Van HL, Dekker JJM. (2019). *Dying Too Soon: Excess Mortality in Severe Mental Illness.*
- HITEQ Center. (2016). *Population Health Management, social determinants of health and how these fit*
- HITEQ Center. (2017). Population Health Management Concepts for Health Centers.
- HITEQ Center. (2022). *Population Management, Social Determinants of Health & How These Fit*.
- HRSA. (2016). HRSA Strategic Plan FY 2023 (interim).
- Laderman M, Whittington J. (2016). *A framework for improving health equity. Healthcare Executive*
- Liu, N.H.,et al., (2017). *Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas*.

References (2 of 3)

- Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002, June). *Contact with mental health and Primary Care Providers before suicide: A review of the evidence*.
- Massachusetts Medical Society. (2019). *What is Value-Based Healthcare?*
- National Council for Mental Wellbeing, CoE-IHS. (2022). *The Comprehensive Healthcare Integration Framework*.
- SAMHSA Center of Excellence for Integrated Health Solutions (2022). *Health Equity Toolkit*.
- Sartorius N. (2018). *Depression and diabetes.*
- Stene-Larsen K, Reneflot A. (2019). *Contact with primary and mental health care prior to suicide: A systematic review of the literature from 2000 to 2017.*

References (3 of 3)

- Unützer J, et. Al. (2022). *Collaborative Care Management of late-life depression in the primary care setting: A randomized controlled trial*. U.S. National Library of Medicine.
- Whittington , J., & Laderman, M. (2016). *A framework for improving health equity: IHI*. Institute for Healthcare Improvement.
- World Health Organization. (2013). *Social Determinants of Health: Key Concepts*. World Health Organization.
- World Health Organization (2022). Social Determinants of Health.

Tools & Resources

- Access for Everyone: Addressing Health Equity & Racial Justice within Integrated Care Settings
- Addressing Health Equity & Racial Justice NCMW Webpage
- **Past Training & Events - Recordings & Slides**
  - Understand Health Inequities, Health Disparities & Social Determinants of Health within Integrated Care Settings
  - Resources to Advance Health Equity through Integrated Health
  - Breaking Down Health Literacy, Cultural and Linguistic Barriers in Integrated Care Settings
  - SDoH: Screening for Patient Social Risks in Integrated Care Settings
  - SDoH: Integrated Care Screening Tools & Implementation Considerations
- University of San Francisco California – Social Interventions Research & Evaluation Network (SIREN)

Upcoming CoE Events

CoE-IHS Office Hour: Growing the Workforce Pipeline through Strategic Community Partnerships

Register for the Webinar on Thursday, December 8th, 2-3pm ET

CoE-IHS Webinar: Population Health Part 2- Measurement-Informed Care

Register for the Webinar on Thursday, January 12th, 2-3pm ET

Interested in an individual consultation with the CoE experts on integrated care?

Contact us through this form here!

Looking for free trainings and credits?

Check out integrated health trainings from Relias here

Subscribe for Center of Excellence Updates

Subscribe here

NATIONAL COUNCIL for Mental Wellbeing

Thank You

Questions?

Email integration@thenationalcouncil.org

SAMHSA's Mission is to reduce the impact of substance abuse and mental illness on America's communities.

www.samhsa.gov

1-877-SAMHSA-7 (1-877-726-4727) 1-800-487-4889 (TDD)

NATIONAL COUNCIL for Mental Wellbeing