

Population Health Management and Risk Stratification: The First Steps Toward Value-Based Payments

The Care Transitions Network

National Council for Behavioral Health
Montefiore Medical Center
Northwell Health
New York State Office of Mental Health
Netsmart Technologies



Learning Objectives

By the end of the webinar, participants will be able to:

- Define Value-based Payment, Population Health Management, and Risk Stratification.
- Understand how to stratify populations based on risk and complexity.
- Learn how to organize and provide care appropriate to risk level.

Presentation Overview

1. Defining our Terms
2. Steps required to achieve Population Health Management
3. A worked example of Population Health Management
4. Discussion/Questions

Effective & Efficient Healthcare

Effective Healthcare:

- Right Patient Need(s) Identified
- Right Treatment(s) Provided
- By the Right Professional(s)
- At the Right Time(s)
- Producing the Right Health and Satisfaction Outcome(s)

Efficient Healthcare:

- Clinical and administrative work flow processes that operate within optimal time and cost specifications.



for People with Serious Mental Illness

Three Primary Drivers: Working together to impact the aims



Person and Family-Centered Care Design

Focus on patient and families--- Doing what is right for each, for all.

This allows the practice to combine the evidence base with the voice of patient and family. It allows the practice to tailor care delivery to meet the needs of individual patients and the entire population served. Through the coordinated efforts of an expanded care team, in partnership with patients, families, and community, the practice can promise results.

Continuous Data Driven Quality Improvement

Make quality a part of everything the practice does and innovation and improvement part of everyone's responsibility. It's about understanding performance at all levels and bringing systems, technology, and people together to make the practice better in many ways. It means empowering every person in the practice to innovate and improve.

Sustainable Business Operations

Building, supporting, and documenting practice value

Sustainable business operations provide the Infrastructure and capabilities to support the right workforce, efficient workflows, and a high value product. Success is seen in positive patient experiences, staff that experience joy in work, and resources for investing in the practice's future.

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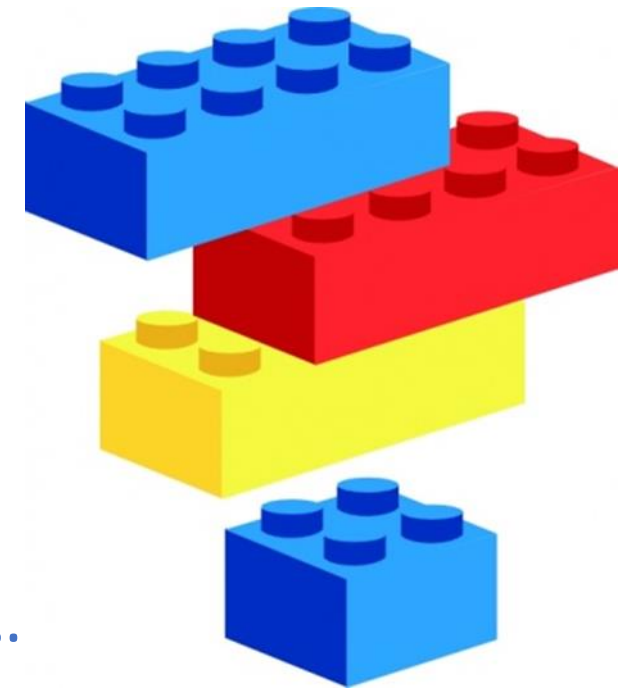
Aligning our Terms!

Value-base Purchasing requires...

Population Health Management which requires...

Risk Stratification therefore...

these concepts are not loosely linked but are structurally contingent on one another.



Value-based Purchasing

An Old Term Getting New Life

"The concept of value-based health care purchasing is that buyers should hold providers of health care accountable for both cost and quality of care. Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers. This strategy can be contrasted with more limited efforts to negotiate price discounts, which reduce costs but do little to ensure that quality of care is improved."

Source: Theory & Reality of Value-Based Purchasing: Lessons from the Pioneer. November 1997. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/meyer/index.html>



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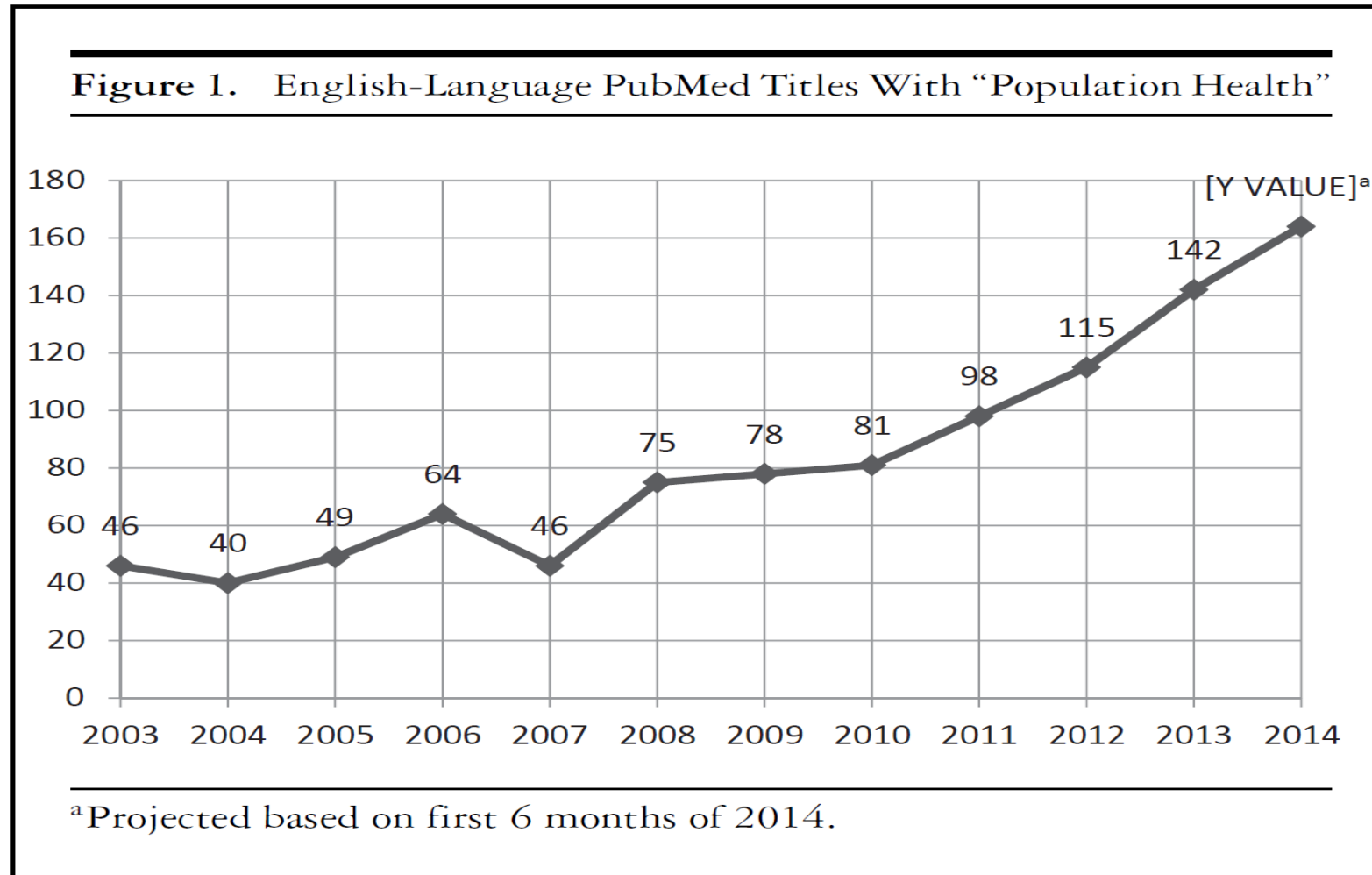
Value-based Purchasing

Financial and regulatory incentives drive...

a delivery system which realizes...

cost efficiency and quality outcomes: *value*

The Rise of Population Health Management



Source: Sharfstein, The Milbank Quarterly (2014)

Population Health Management

- A set of interventions designed to maintain and improve a patient's health across the full continuum of care—from low-risk, healthy individuals to high-risk individuals with one or more chronic condition. (Felt-Lisk & Higgins, 2011)
- Population management requires providers to develop the capacity to utilize data to risk stratify patients into groups and then respond to the needs efficiently and effectively.

The Promise of Population Health Management

- Improved Care Coordination
- Improved Services Penetration
- Clinicians & Administrators who have skills to use Data to inform Care Provision/Decision Support/Evidence-based Medicine provision in other words...*Promotes a Culture of Measurement & Problem Solving*
- Brings Together Utilization Review focus on cost with Clinical Care focus on outcomes in other words it...*Provides means to see how Quality Metrics are Linked to Cost*

Principles of Population Health

1

Population-Based Care: Focus on caring for the whole population you are serving, not just the individuals actively seeking care.

2

Data-Driven Care: Utilize data and analytics in order to make informed decisions to serve those in your population who most need care.

3

Evidence-Based Care: Make use of the best available evidence to guide treatment decisions and delivery of care.

4

Care Management: Engage in actionable care management for the population you serve.

Components of Population Health Management:

1. Knowing what to ask about your population
2. Data registry to describe/risk stratify your populations
3. Proficiency with quality improvement tools to respond to the findings
4. Continuous quality improvement policies/procedures to sustain data specification targets

10 Steps to Achieving PHM Proficiency!

- 1) Survey all of your currently available aggregated databases or any that contain information regarding diagnosis, clinical values (such as screening scores, lab results, blood pressure, etc.) and treatment received by your individual patients.
- 2) Aggregate the data that you already are collecting and have available in a single database.

10 Steps to Achieving PHM Proficiency!

- 3) Carefully consider what care gaps you can identify and act on without gathering additional data. It is often quickest and most acceptable for staff to first use the data that is available before undertaking the added administrative burden of collecting more data.
- 4) Begin an ongoing dialogue with your agency staff about the difference between population management–based care delivery and patient complaint–based care delivery.

10 Steps to Achieving PHM Proficiency!

- 5) Focus on interventions that are quick and easy, such as treatment of hypertension, before focusing on interventions that are long-term undertakings (e.g., BMI).
- 6) Choose care gaps that are easily and rapidly treated (e.g., HBP), and have a care manager generate a list of all patients with this condition.
- 7) Identify a set of responses to the indicator and assign a team member to take action.

10 Steps to Achieving PHM Proficiency!

- 8) Provide education specific to the current care gap being pursued.
- 9) Benchmark your progress as an agency and by individual team. Aggregate reporting of progress or the lack thereof is a key part of population management.
- 10) After you have made use of all the significant opportunities available to identify care gaps with the data you are already collecting, conduct a gap analysis of what additional data could be collected easily that would identify actionable care gaps that can be rapidly addressed.

Components of Population Health Management:

1. Knowing what to ask about your population
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The Population Health Management of Depression

Let's look at Depression as an Example

1. Know what to ask about your population

- ✓ *How are we doing with the treatment of our consumers who are depressed?*

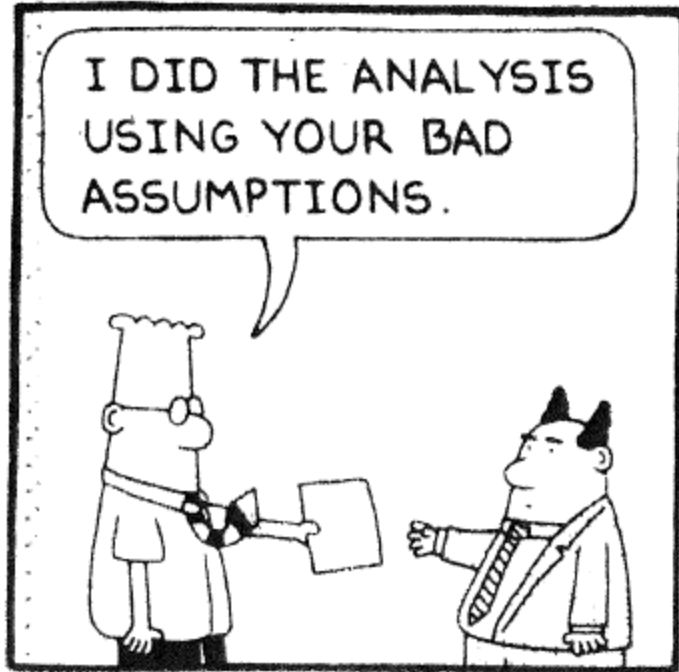
2. Using your registry Risk Stratify the population of Depressed Consumers

- ✓ *Pull & Aggregate Consumer PHQ-9 Scores by Team and Clinician.*

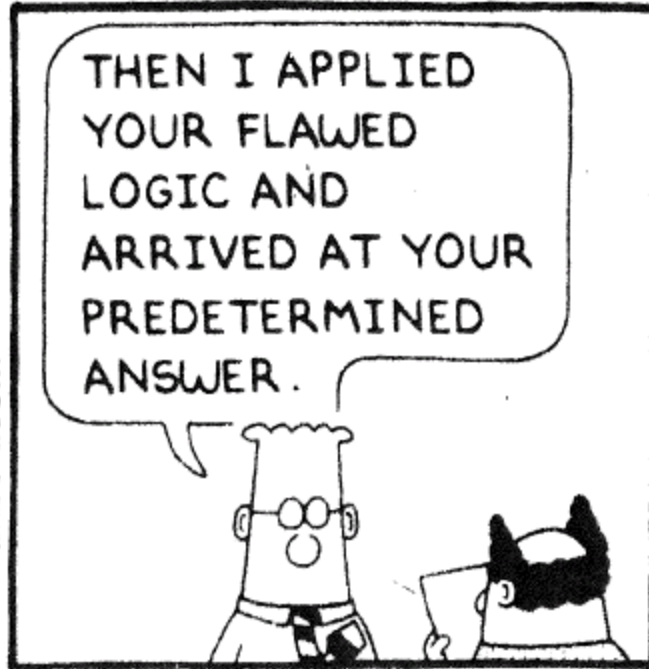


Keep the Analysis & Dashboards Simple to Start

Dilbert



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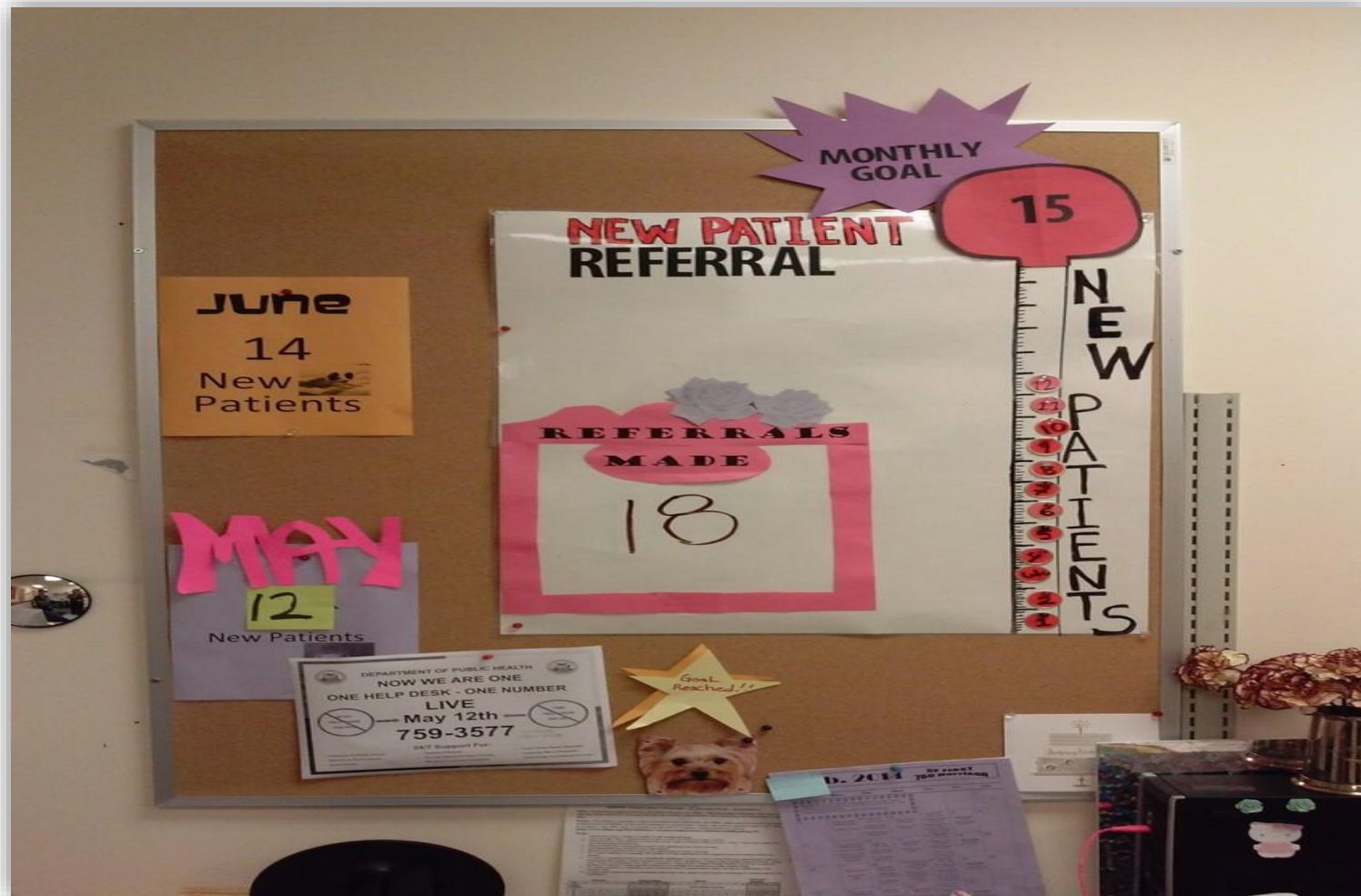


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By Scott Adams



Basic Dashboard



AIMS Center Free Dashboard Template

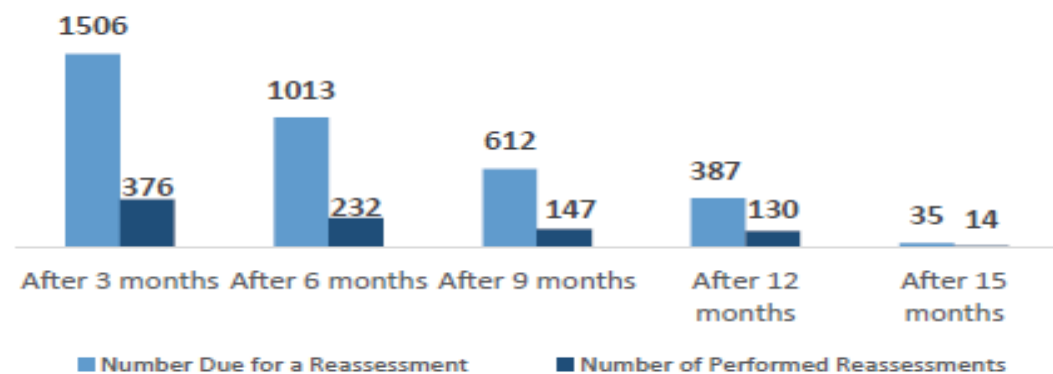
Name	Treatment Status					PHQ-9				GAD-7				Psychiatric Case Review	
	Date of Initial Assessment	Date of Most Recent Contact	Date Next Follow-up Due	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Case Review Note
	! Indicates that the most recent contact was over 1 month (30 days) ago 🚩 Indicates that the next follow-up contact is past due					✓ Indicates that the last available PHQ-9 score is at target (less than 5 or 50% decrease from initial score) ! Indicates that the last available PHQ-9 score is more than 30 days old				✓ Indicates that the last available GAD-7 score is at target (less than 10 or 50% decrease from initial score) ! Indicates that the last available GAD-7 score is more than 30 days old					
Bob Dolittle	3/2/2016	! 4/28/2016	🚩 5/12/2016	3	26	22	19	-14%	! 4/28/2016	12	10	-17%	! 4/28/2016	Flag as safety risk	2/18/2016
Betty Test	12/15/2015	! 6/15/2016	🚩 7/15/2016	10	37	12	✓ 1	✓ -92%	! 6/15/2016	9	✓ 3	✓ -67%	! 6/15/2016		
Susan Test	11/20/2015	! 7/30/2016	🚩 8/13/2016	10	41	22	15	-32%	! 7/30/2016	18	14	-22%	! 7/30/2016	Flag for discussion & safety risk	4/17/2016
John Doe	9/15/2015	! 7/16/2016	🚩 8/15/2016	12	50	20	✓ 0	✓ -100%	! 7/16/2016	14	✓ 1	✓ -93%	! 7/16/2016		6/15/2016
Albert Smith	5/5/2016	! 7/22/2016	🚩 8/19/2016	5	17	18	18	0%	! 7/22/2016	14	10	-29%	! 7/22/2016	Flag for discussion	
Nancy Fake	8/5/2016	! 8/5/2016	🚩 8/19/2016	0	4	No Score	No Score			No Score	No Score				
Joe Smith	6/1/2016	! 8/8/2016	🚩 8/22/2016	5	13	15	9	-40%	! 8/8/2016	11	✓ 7	-36%	! 8/8/2016		7/24/2016

Aggregate Data: Key Data Points at a Glance

Data included represents results from all ages as of September 30, 2015

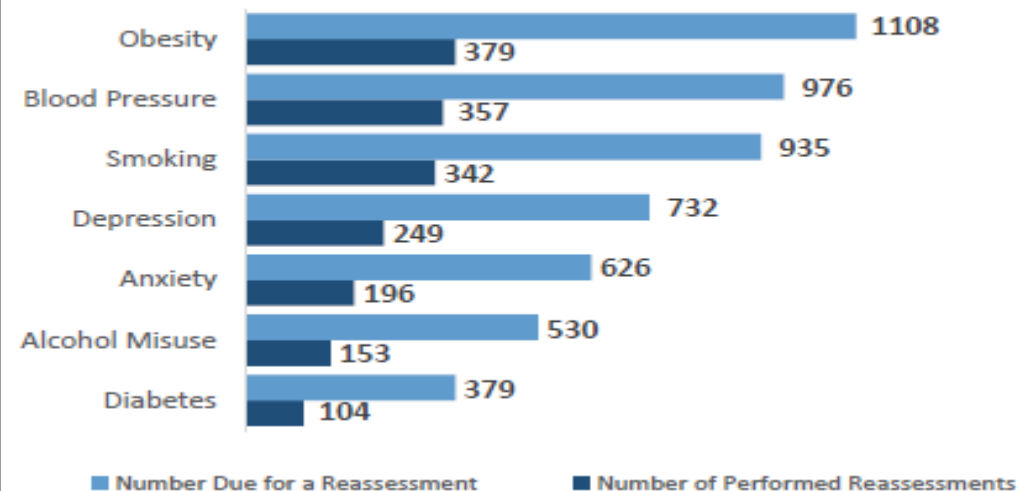
Reassessment Rate for At Risk Participants

Includes reassessments completed within the valid timeframe.*



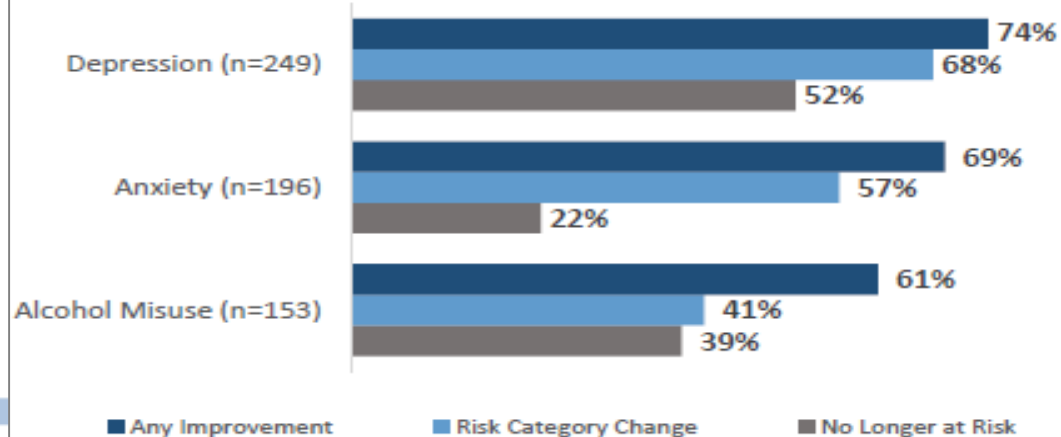
*Valid timeframe is 30 days before or after the time point.

Reassessment Screens Performed for At Risk Participants



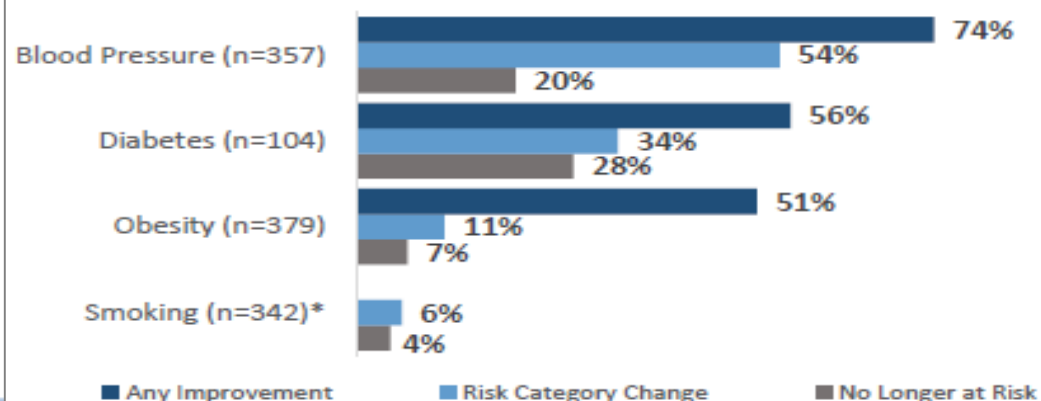
Behavioral Health Outcomes

Any Improvement percentage includes Risk Category Change percentage and No Longer at Risk percentage.



Physical Health Outcomes

Any Improvement percentage includes Risk Category Change percentage and No Longer at Risk percentage.



*The smoking indicator only reports categorical change and no longer at risk.

Let's look at Depression as an Example continued...

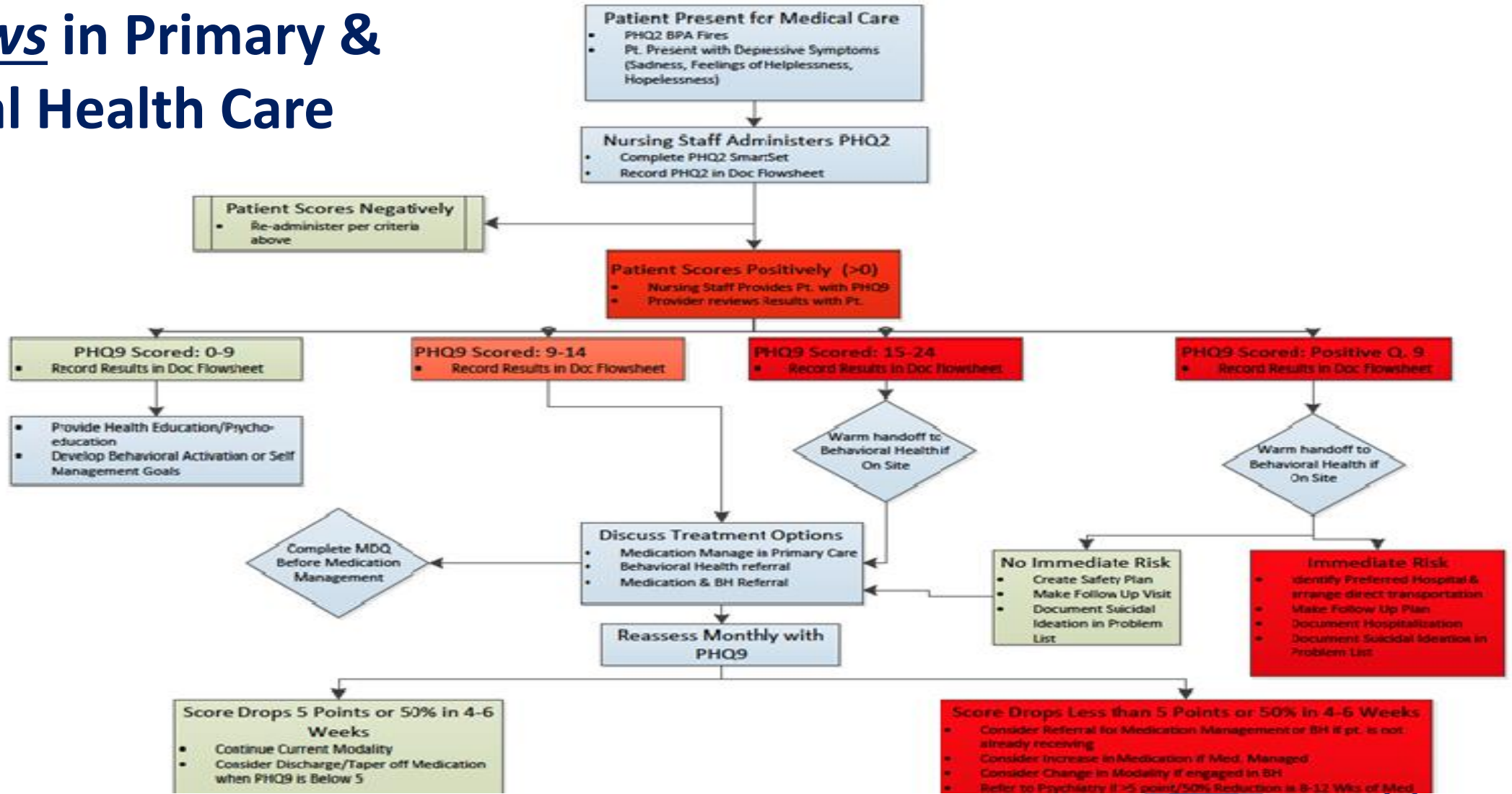
3. Proficiency with quality improvement tools to respond to the findings.

- ✓ *Develop/review work flows to see what process steps need to be changed/improved to bring the PHQ-9 scores to the benchmark target.*

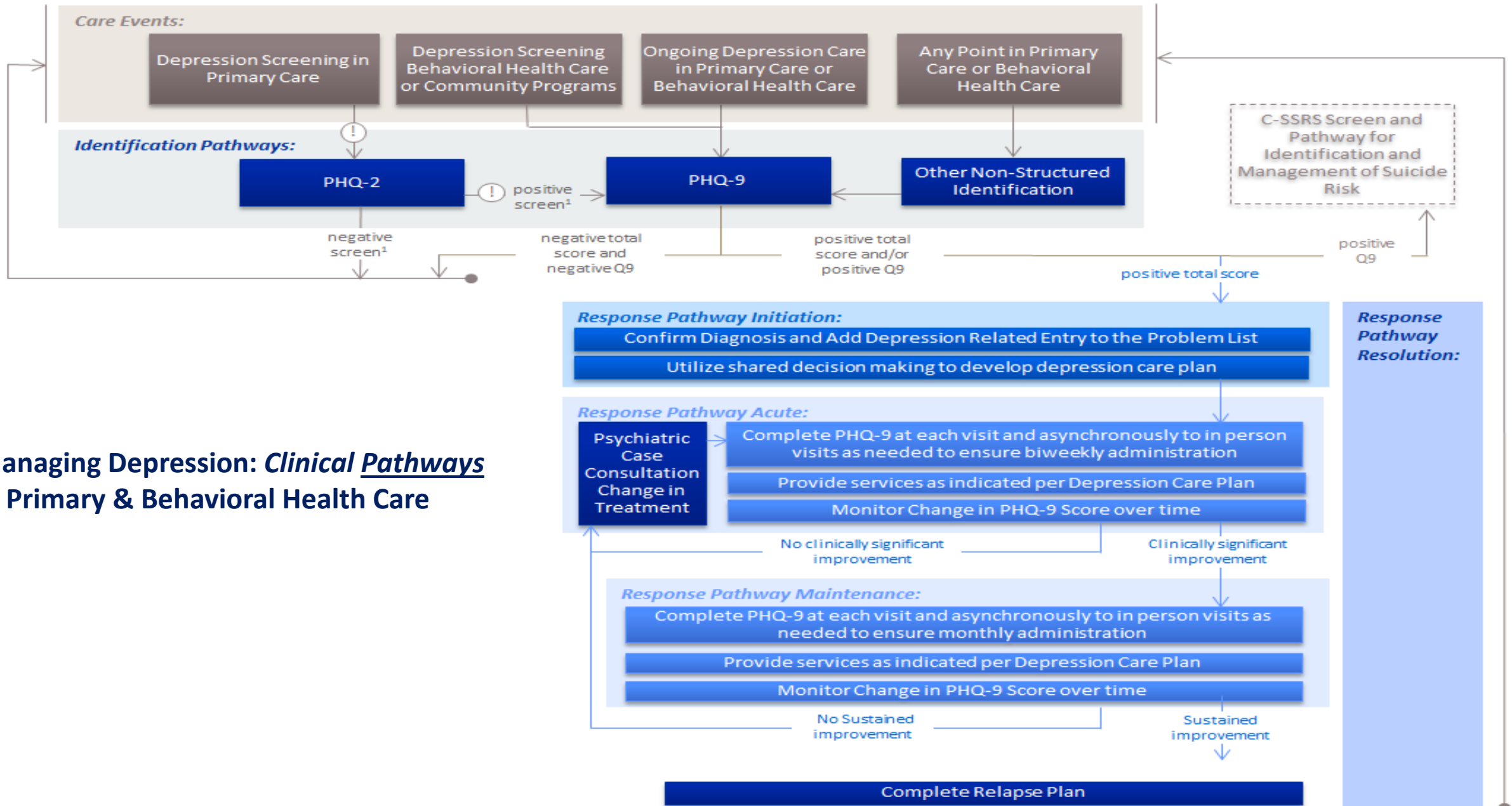
4. Continuous quality improvement policies/procedures to sustain data specification targets.

- ✓ *Put the changes/improvements into policy/procedure (e.g., supervision, huddles, administration meetings, etc.).*

Managing Depression: *Clinical Work Flows* in Primary & Behavioral Health Care



Source: Institute for Family Health

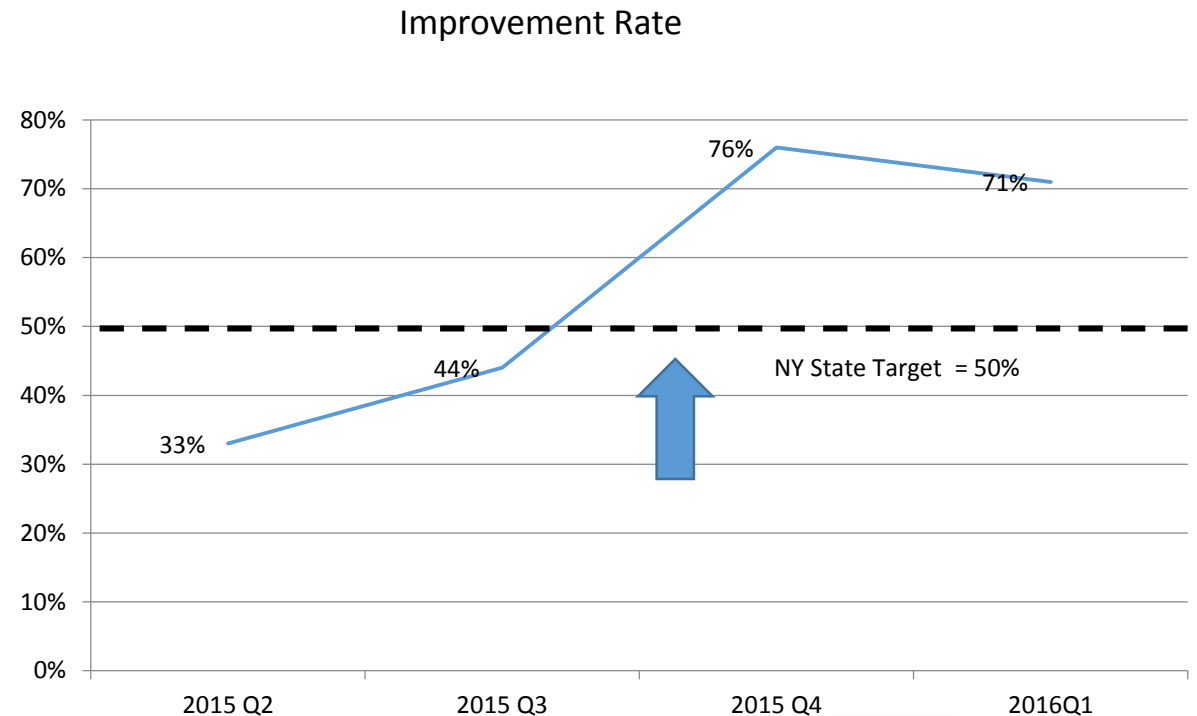


Managing Depression: Clinical Pathways in Primary & Behavioral Health Care

Monitoring: Depression Care Population Outcomes

Metric	Definition
Improvement Rate:	Number (#) and proportion (%) of patients in treatment for 70 days (10 weeks) or greater who demonstrated clinically significant improvement either by: a 50% reduction from baseline PHQ-9 or a drop from baseline PHQ-9 of at least 5 points and to less than 10.

Year	Quarter	Improvement Rate
2015	Q2	33%
2015	Q3	44%
2015	Q4	76%
2016	Q1	71%



Source: Institute for Family Health



Resources

Population Management in Community Mental Health Center Health Homes – The National Council for Behavioral Health

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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