DEPARTMENT OF HUMAN SERVICES

Population Health Management

March 2018

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Course Objectives

This first webinar is intended to provide an overview and discuss the principles of population health management as well as demonstrate how the MN DHS Partner Portal can support your organization's work in population health management (PHM) for people receiving behavioral health home (BHH) services. Specifically, these are the objectives for today's webinar:
Develop understanding of the principles of population health management and how they support BHH service delivery.
Highlight the components and features of the DHS Partner Portal that support population health management.

Getting Started

Let's start by thinking about a few questions:

Who are we serving in BHH services? What are their ages, sex, race, and primary diagnoses? Are people living with co-occurring substance use disorders or other chronic conditions? What are their primary health and wellness concerns? Where else are they going to seek health care, services and support? In what communities do individuals served in BHH services live?

With this information, what opportunities are there to better deliver services and care for individuals being served? Are there additional connections to be made so that individuals can seek appropriate health care and other services and support? Are there common wellness concerns that can be addressed? Are there unique needs within living conditions and communities that need to be considered in how the service is being provided?

What are the questions that might be most important to ask for the population you serve?

New Strategies for Service Delivery

As a BHH services provider or member of the BHH services team, you are a part of transforming how care is delivered in Minnesota. BHH services provides an opportunity to build a person-centered system of care that achieves improved outcomes for individuals and reduced costs to the health care system. BHH services aims to do this within a population that has experienced disparities in adverse health outcomes. This population consists of individuals, adults and children both, who experience mental health conditions and are enrolled in Medicaid. Population health management is a key strategy to successful implementation of BHH services and how providers can approach care delivery, and requires that organizations develop new skills, capacity, and culture.

Population Health Management (PHM)
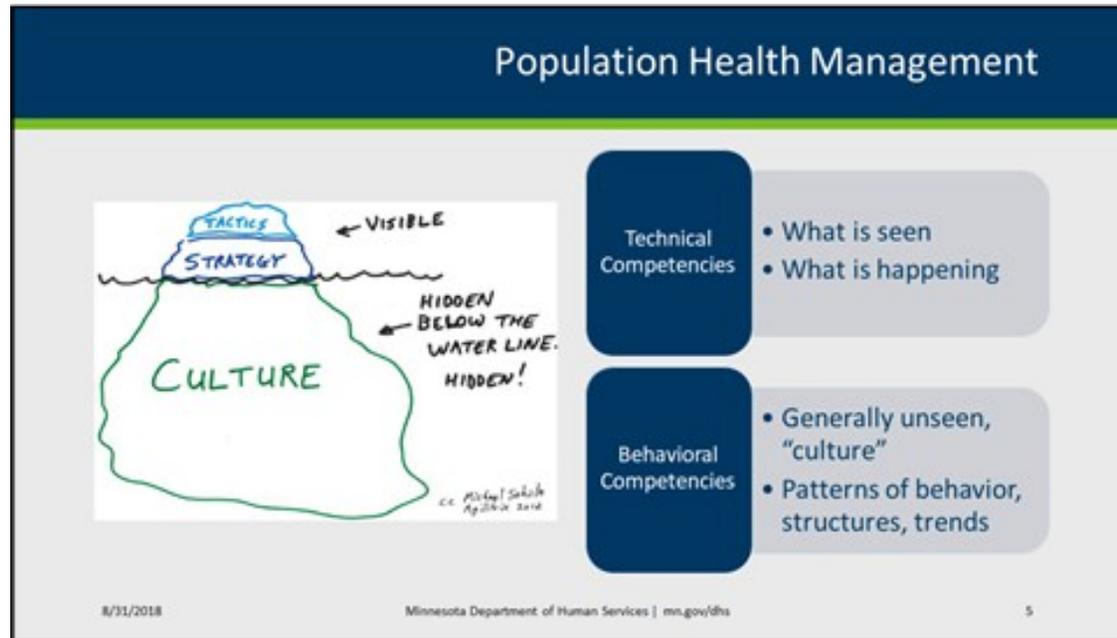
Developing new skills and a cultural shift to support the initial and ongoing implementation of those skills can be likened to the Iceberg Model. Underlying behaviors, structures, and relationships – behavioral competencies – support the ability to successfully implement the knowledge and skills – the technical competencies – as intended. Just as an iceberg has only one- ninth of its volume above water with the rest beneath the surface, the same could be applied to the development of staff competencies within your organization. Although this webinar series will focus on the technical aspects of population health management, there needs to be consideration of "what is below the surface" as that directly influences the usage of acquired knowledge and skills and overall performance of a competency.

Use Data to Guide Population Health Management
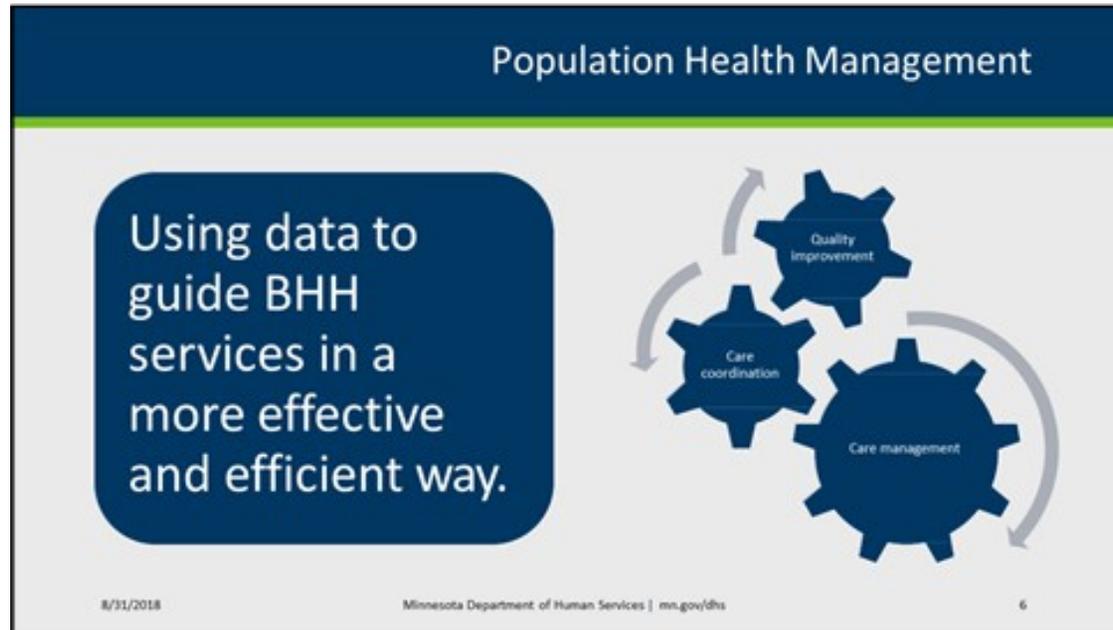
Simply put, population health management is the use of data to guide the delivery of care and services in a more effective and efficient way.

Population health management supports many BHH services related activities, such as care management, care coordination, and continuous quality improvement.

Key Principles

Key Principles of Population Health Management

- Population-Based
- Evidence-Based
- Data-Driven
- Care Management

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There are four overarching principles of population health management and we will go through each one in the following slides.

Principle 1

Principle 1: A population-based approach to service delivery. The BHH services team is responsible for sharing a caseload of individuals served through BHH services and ensuring that nobody within this population is unintentionally neglected or ignored. This approach allows the team to take a proactive approach by systematically assessing and tracking all individuals served in BHH services for gaps and opportunities for improved outcomes, as well as tracking and managing a group's needs and response to services, rather than responding only to those who actively seek services. In a traditional medical framework, gaps are often identified based on a particular health condition or other set of characteristics (such as age, gender, demographics, use of specific services, risk stratification). Within the BHH services framework, the team can expand their focus to support serving the whole person and address not only physical but mental health, substance use, wellness, and social service needs. Incorporating a population-based approach requires significant cultural and workflow changes, including assigning these responsibilities and tasks as part of a staff person's role. Often times this role is assigned to the BHH services integration specialist.

Principle 2

Principle 2: Evidence-Informed

Best available evidence to guide service delivery

Embedded into provision of BHH services

Examples include:

- Preventative screening
- Tobacco & substance use screening
- Referral follow-up
- Readiness to change

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Principle 2: An evidence-informed approach to service delivery.

Evidence-informed care allows the use of the best available evidence to guide interventions and delivery of services. BHH services providers embed evidence-informed guidelines into their population health and care management approaches. Tracking primary care, dental, tobacco, substance use, and other screenings, using national and state guidelines and recommendations, is one way that BHH services providers embed evidenced-informed approaches into the provision of BHH services. Others include tracking referrals to ensure they are completed, followed up on, and that recommendations are addressed; and tracking stages of change or other readiness-to-change indicators to engage with individuals and help determine next steps.

Principle 3

Principle 3: A data-driven approach to service delivery.

Data-driven care can be used to make informed decisions in the delivery of BHH services. Your organization is continuously collecting data. The electronic health record contains numerous data sets available about the individuals you serve – demographic, clinical information, functional status, social determinants, lifestyle behaviors, and many others. BHH services providers also have access to some payer claims information through the DHS Partner Portal. Both types of data – electronic health record data and claims data – have their advantages and limitations. When these data elements are organized into electronic, sortable population management tools – such as a patient registry or in the DHS Partner Portal – the BHH services team is able to better use the data to inform service and care delivery. These tools also support the BHH services team in using data to identify the needs of groups (as in subgroups of the population served), identify opportunities for improvement, monitor performance and progress, identify staff training needs, and facilitate coordination of services across the team.

Principle 4

Principle 4: Care management – Putting population management into action

Registries or other PHM tools can help you develop a comprehensive picture of overall care received by the people you serve to identify opportunities and gaps. Not only are you doing this using a population-based approach, or to take a pulse on the big picture, but this is also a key aspect to proactively managing BHH services for an individual. Care management allows the BHH services team to determine which people need immediate attention to remedy gaps around a comprehensive set of needs, and who on the team is the most appropriate to intervene regarding the identified gap(s). Examples of noted care gaps include not having received a recommended preventative care screening, non-adherence to medications, or lack of follow-up with other providers or referrals. It may provide information about an individual's progress towards their goals or about how they are engaging in their care. These processes enable the team to have planned interactions with individuals served by BHH services, ultimately resulting in being able to optimize the health of all the individuals you are currently serving in BHH services.
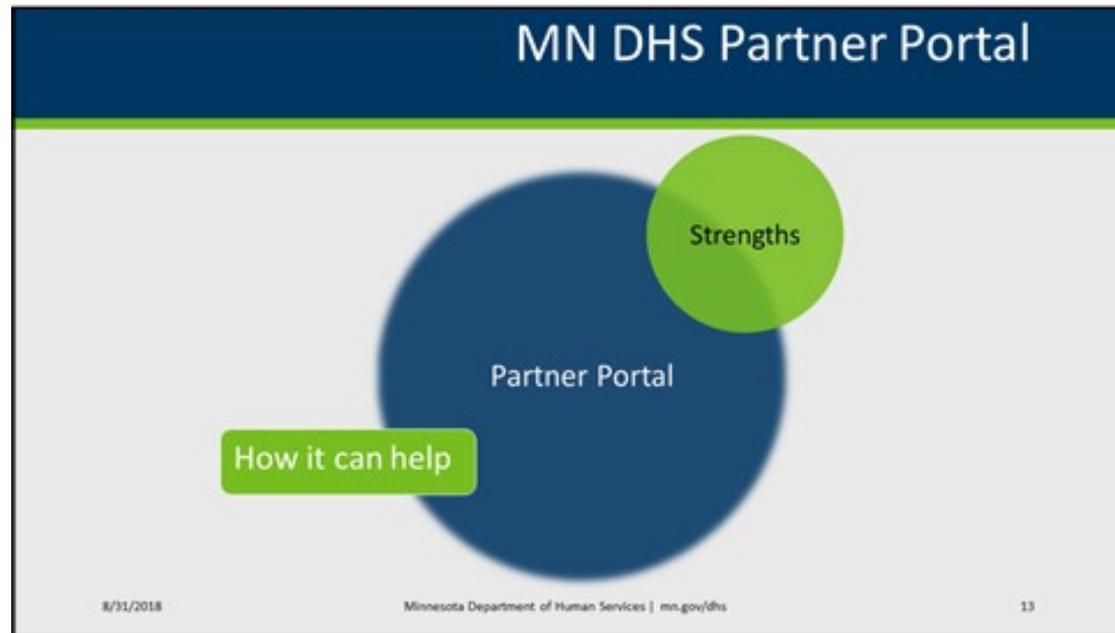
MN DHS Partner Portal

One tool that can help in optimizing the health of your BHH population is the MN DHS Partner Portal for BHH services. The partner portal is a population health management tool that was designed to offer help in developing a comprehensive picture of overall care given, identifying gaps in care as well as different patterns and themes.

Using the partner portal is a requirement of BHH services. It is a secure, web-based reporting tool offering access to information that BHH Providers can use to help coordinate care and manage cost and quality.

Most of the reports in the partner portal are based on the ACG (Adjusted Clinical Groups) System. The ACG system was developed by faculty at the Johns Hopkins Bloomberg School of Public Health to help make health care delivery more efficient and more equitable. Because the ACG System can be used for numerous management, finance, and analytical applications related to health and health care, it has become the most widely used population-based, case-mix and risk adjustment methodology.

Partner Portal: Strengths and how it can help

The partner portal reports can provide information that BHH services providers wouldnot normally see from other providers who bill claims under a shared individual.

The partner portal can be used to develop a comprehensive picture of overall care received and to identify current care gaps for each individual by collecting and organizing, valid clinical data to guide care.

It can be used to focus on the health of a targeted group within your BHH services population by assessing, tracking, and managing a group's health conditions and treatment response.

Partner Portal: Limitations and what it isn't
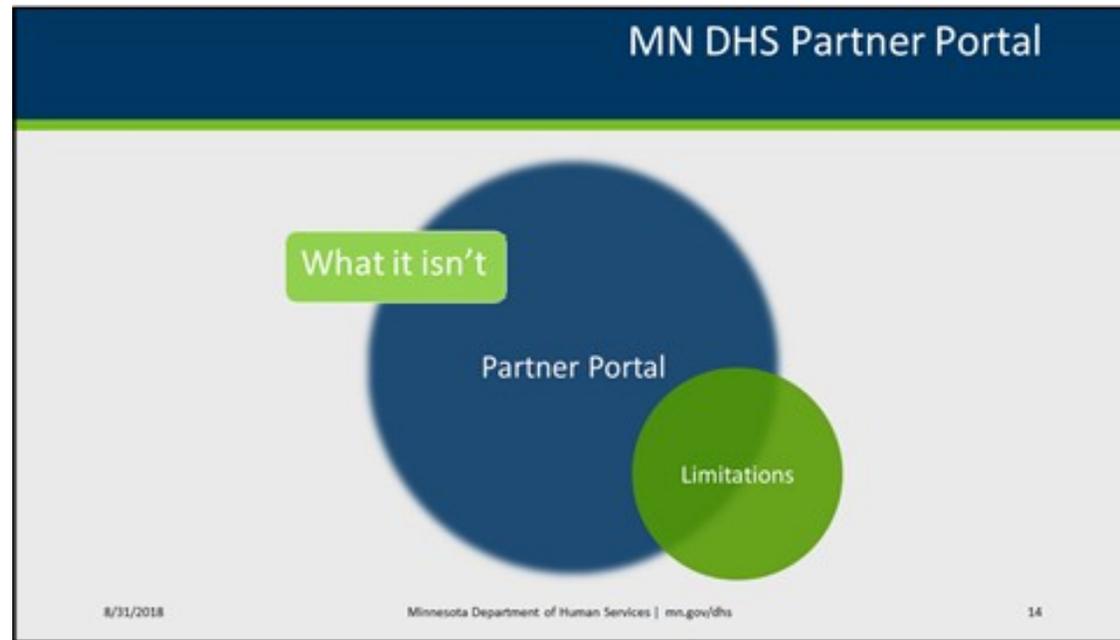
The partner portal is not a real-time reporting tool. Claims data is updated monthly and is dependent on when claims are submitted.

The reports should not be used as a complete list of your BHH services population. BHH services providers can only see data on individuals once a claim is billed for and paid.

The reports can be used to look at your BHH services population as a whole. They do not work well for comparing an individual's progress month to month since you can only run a report by a single month at a time and cannot run them for a single individual. However, if you export the reports to Excel, you can edit the reports to pull an individual's data to a separate spreadsheet.

Using the Care Management Reports (CMR)
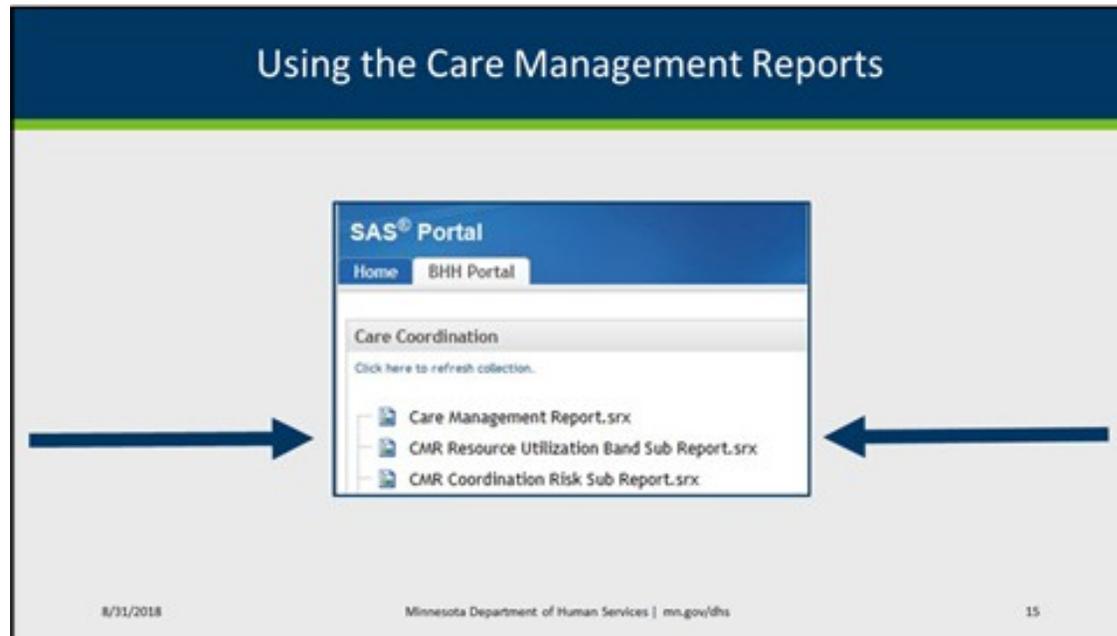
The first report in the partner portal for BHH services is the care management report. This report provides a big picture of your BHH services population.

The second and third reports are sub-reports that focus on the amount of health resources used by an individual and the degree to which your agency's BHH services population is at risk for issues with coordinating care.

CMR columns: Resource Utilization Band (RUB) and Adjusted Clinical Group (ACG)

Care Management Report – Resource Utilization Band

Resource Utilization Band	Rescaled Reference Weight	ACG Code	Recipient Member Months	Prior Total Cost
1	0.094	5110	3	$288.40
5	3.843	4930	11	$34,360.45
5	4.677	5060	12	$4,549.25
3	0.423	4100	2	$2,300.18
3	0.787	2700	5	$6,045.25
5	3.843	4930	6	$8,489.02
4	2.895	5050	4	$7,020.29
4	2.230	4920	9	$17,367.16
3	0.342	3900	11	$3,305.78
3	0.763	3700	12	$7,413.75
5	11.110	5070	12	$237,421.20
4	2.230	4920	6	$19,628.14
3	0.630	4610	10	$7,695.32
5	11.110	5070	9	$61,629.90
3	1.134	4720	12	$16,625.23
4	1.485	4620	5	$14,498.91

RUB score

- Ranking of overall morbidity level

ACG value

- measure of expected or actual use of health services

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As a provider you may want to focus on certain parts of the report, such as the individuals who have a high Resource Utilization Band score (RUB). A RUB score is a simplified ranking system of overall morbidity level, instead of grouping by type of illness.

Individuals who are expected to use the same level of resources are grouped together, even if they have very different illnesses with different disease patterns.

Individuals are assigned a RUB score based on sorting their ACG value into one of six categories. The ACG value is a relative measure of the individual's expected or actual consumption of health services.

CMR Resource Utilization Band Category
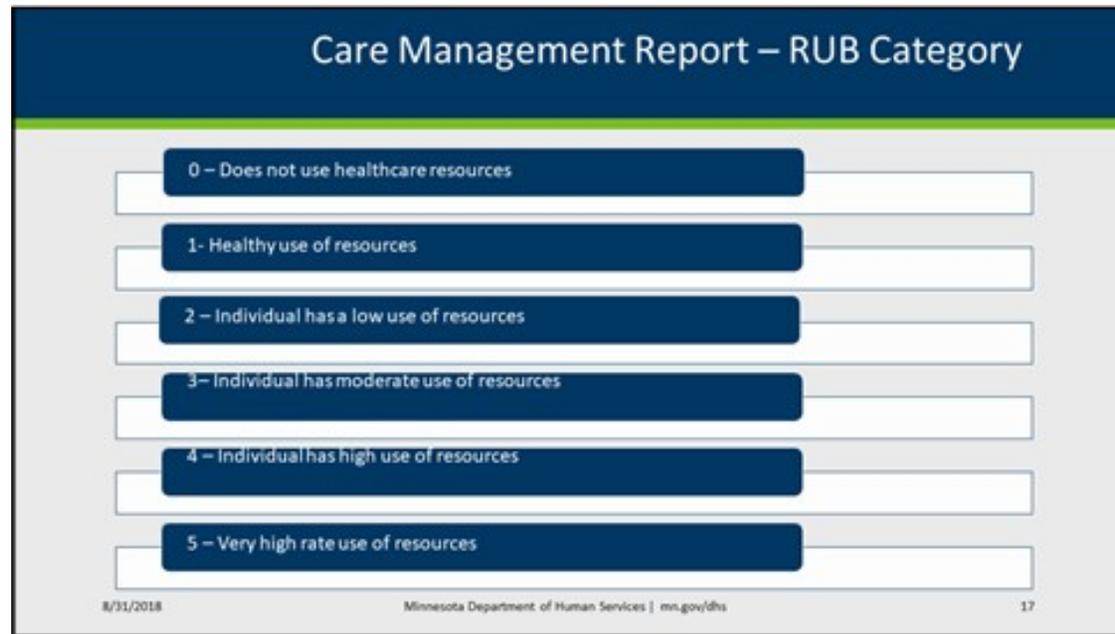
An individual with a RUB score of
0 does not use health care resources,
1 is a healthy user of resources,
2 is low,
3 is moderate,
4 is high and
5 is a very high user of resources
Individuals who have a score of 0 through 2 are rarely hospitalized.

CMR – Care coordination claims

The Care Coordination Claims column in the Care Management report can help you determine if a person has had a duplicative service. If the cell under the coordination claims column is "yes" that person may be receiving a duplicative service. The date shown as the "date of last CC visit"

simply means that during the month of that date the person received a care coordination service. If they were also receiving BHH services during that month then that means that there may have been a duplicative service. Examples of coordination visits are:

targeted mental health case management or

health care home care coordination services.

If there is a duplicative service then one of claims for those services for that month will not be paid.

As a reminder this data is not in real time. It is updated monthly and dependent on when claims are submitted by all providers.

CMR emergency department, outpatient and inpatient counts
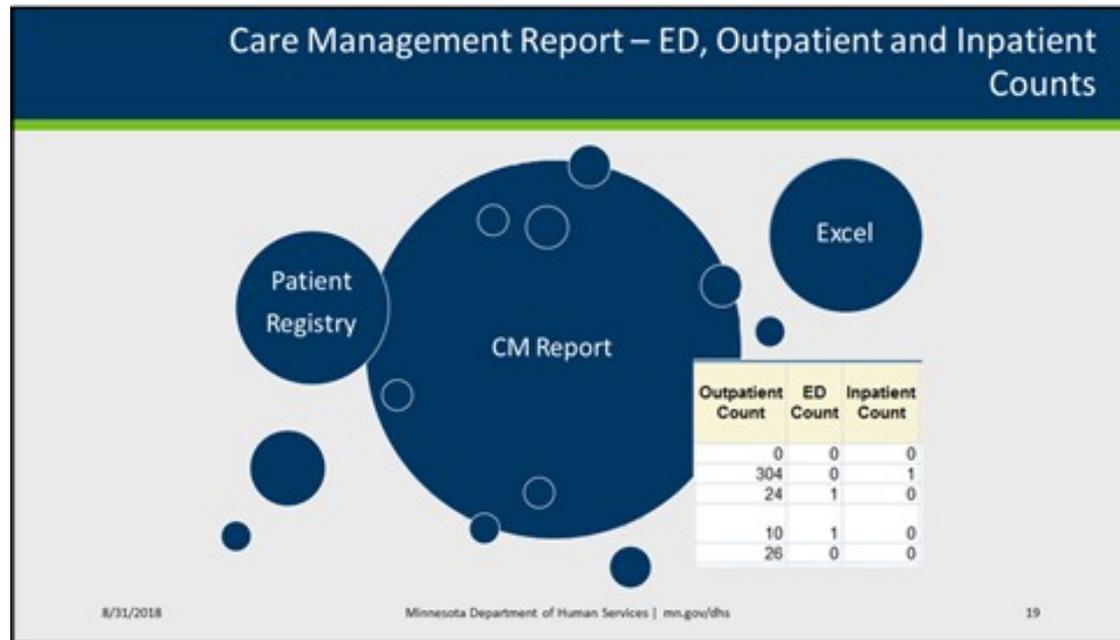
You can also use the care management report to sort recipients with high emergency department (or ED), outpatient and inpatient counts for the month and, over time, which recipients have lower or higher counts by comparing reports month to month. If you are tracking specific individuals' counts you could copy these numbers and add columns to your patient registry to track these counts or create a separate excel document for tracking.

These are only a few examples of the data that is provided in this report and how it can be used.

CMR Resource Utilization Band Sub Report

The two care management sub-reports are snapshots of the care management report.

The CMR resource utilization band sub report focuses on utilization, cost information and chronic condition indicators.

If resource utilization is a specific focus for your agency then this report will give you a condensed version of that utilization piece from the care management report. This report houses the ED, outpatient and Inpatient counts as well as the RUB score.

CMR Coordination Risk Sub Report
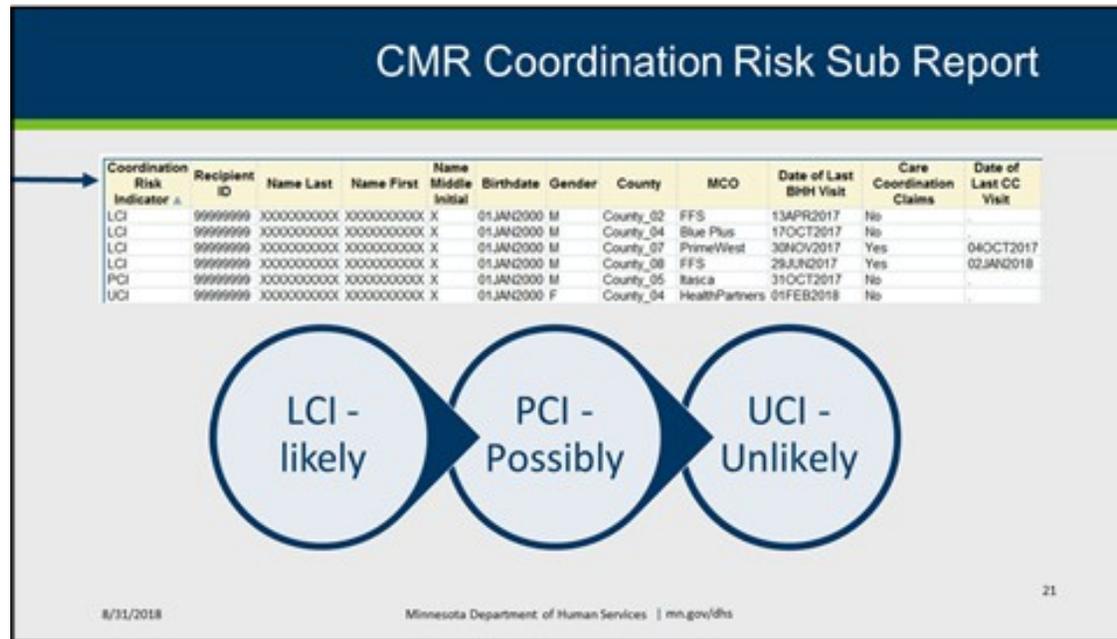
The CMR coordination risk sub-report focuses on care coordination indicators or scores which can be used to classify the likelihood of coordination issues into three categories: likely to, possibly or unlikely to experience coordination issues.

The coordination score provides a quick means for identifying those members most at risk of coordination issues. Members with poorly coordinated care are more likely to have excess utilization as a result of redundant testing, potentially harmful drug-disease interactions and overall lower quality of care.

A BHH services provider can use this information to identify the people with a score of "LCI," try out specific interventions then track to see if their score goes down.

How to sort, filter and hide columns in reports

The reports can be modified without exporting to Excel.

We will be going over modification and exporting throughout this webinar series. Today we will talk about sorting, filtering and hiding columns in the reports.

All the information we will go over today can be found in the Report Reference Documentation you have been sent if you requested access to the partner portal. The Report Reference Documentation is also located on the DHS Behavioral Health Homes Services website.

After you run a report, you will see a blue arrow next to a column name that indicates that a table is sorted by that data field. Right click the column names in the table and select SORT ASCENDING or SORT DESCENDING to change the sort order.

Filter and Rank

To filter results in a table:

First, right-click in the center of a data cell and select FILTER AND RANK.

A pop-up window will appear. Select the data field you wish to filter on, and either type in the value(s) you want filtered or click GET VALUES and select from the list.

For example, if you want to see only the individuals with a RUB score of "5," in the pop-up window click "Filter" and enter "5" in the "Type a value to add," click the arrow to add it to the Selected Values, then click "OK." The report will display individuals with a RUB score of "5." You could export this to Excel for future reference, or compare reports month to month that way.

Hide Column Name
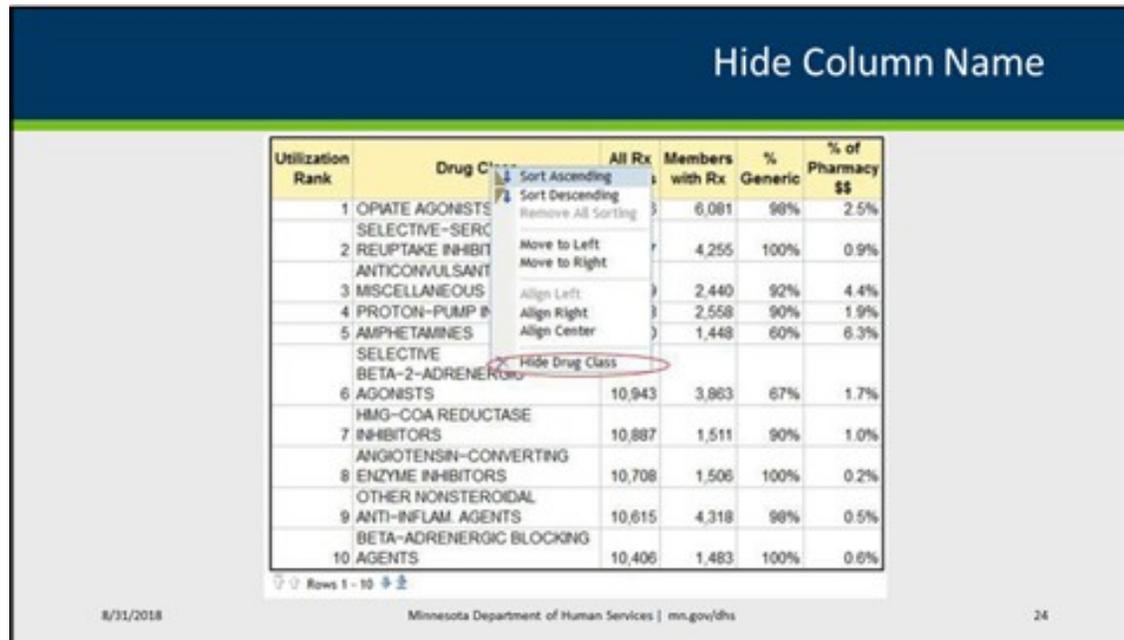
Hide Column Name

Utilization Rank	Drug Class	All Rx	Members with Rx	% Generic	% of Pharmacy $$
1	OPIATE AGONISTS		6,081	98%	2.5%
2	SELECTIVE-SERO REUPTAKE INHIBIT		4,255	100%	0.9%
3	ANTICONVULSANT MISCELLANEOUS		2,440	92%	4.4%
4	PROTON-PUMP IN		2,558	90%	1.9%
5	AMPHETAMINES		1,448	60%	6.3%
6	SELECTIVE BETA-2-ADRENERGIC AGONISTS	10,943	3,863	67%	1.7%
7	HMG-COA REDUCTASE INHIBITORS	10,887	1,511	90%	1.0%
8	ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	10,708	1,506	100%	0.2%
9	OTHER NONSTEROIDAL ANTI-INFLAM. AGENTS	10,615	4,318	98%	0.5%
10	BETA-ADRENERGIC BLOCKING AGENTS	10,406	1,483	100%	0.6%

Context menu: Sort Ascending / Sort Descending / Remove All Sorting / Move to Left / Move to Right / Align Left / Align Right / Align Center / Hide Drug Class

Rows 1 - 10

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To hide a column, right click the column name and select HIDE COLUMN NAME.

By hiding columns you can shrink the report to bring the columns that you want to see closer together and then, of course, hide the columns you don't want to see.

How to rearrange columns

Alternatively, you may rearrange, add or hide columns to a table by right clicking in the center of a data cell and selecting ASSIGN DATA.

A window will appear with all available data fields listed. Click and drag any data field under HIDDEN and move it to wherever you want it to appear in the table under COLUMNS, or move a data field listed under COLUMNS to HIDDEN if you want it to disappear.

Unfortunately anything you hide or show will not be saved once you log out of the portal. You can print the report or export it after hiding or showing different columns. This will capture hiding and showing different columns that you have selected.

Webinar summary
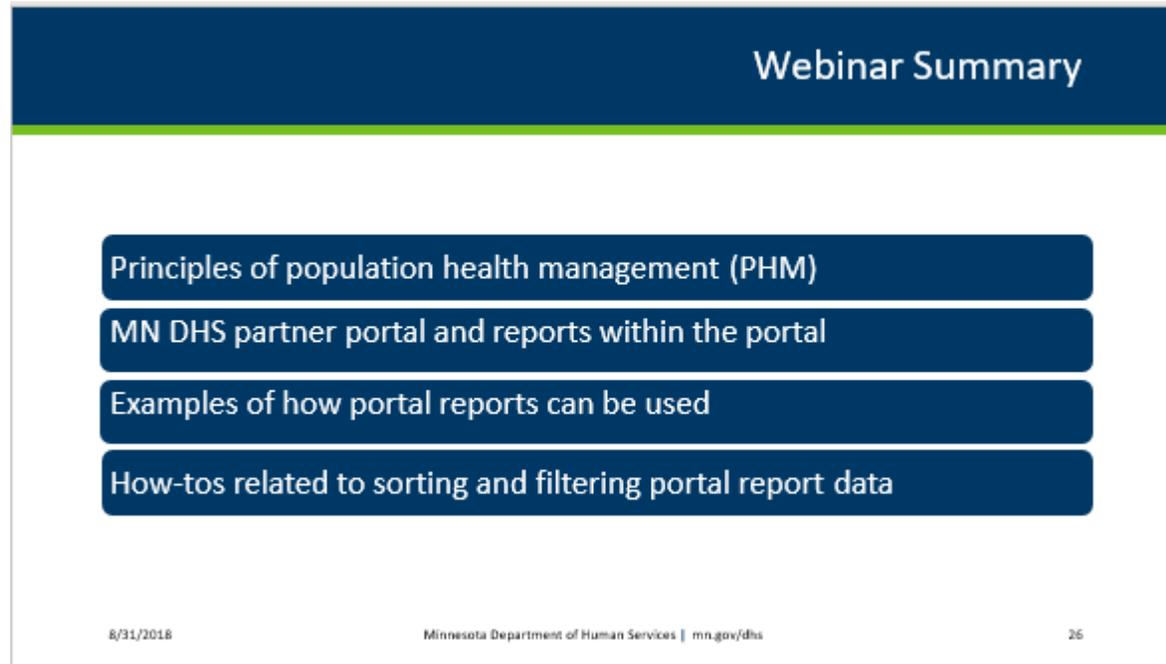
In summary, we discussed:
The principles of population health management
The MN DHS Partner Portal and specific reports within the Portal
Examples of how the reports can be used to support population health
Some "how-tos" related to sorting and filtering data within the portal

Thank you