



Population Health Management Series: Webinar #3

February 2019

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Agenda

The slide features a dark blue header with the word "Agenda" in white. Below the header, two dark blue rounded rectangular boxes are stacked vertically, each containing white text. The first box says "Review of Population Health Management Webinars 1 and 2" and the second says "Putting it into practice – Guild and Zumbro". The text in the second box is underlined. At the bottom of the slide, there is a footer with the date "2/25/2019", the text "Minnesota Department of Human Services | mn.gov/dhs", and the page number "2".

Agenda

- Review of Population Health Management Webinars 1 and 2
- Putting it into practice – Guild and Zumbro

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Today, we will review what we discussed in the first and second webinars in this series, and we will hear from two of our BHH services providers and their experiences with population health management.

Review – PHM Webinar #1

The diagram illustrates the Iceberg Model of population health management. The visible tip of the iceberg is labeled 'TACTICS' and 'STRATEGY', with an arrow pointing to it from the word 'VISIBLE'. The submerged part of the iceberg is labeled 'CULTURE', with an arrow pointing to it from the text 'HIDDEN BELOW THE WATER LINE. HIDDEN!'. The water line is represented by a wavy line. The diagram is credited to 'cc: Mihajl Stokich April 2014'.

Technical Competencies

- What is seen
- What is happening

Behavioral Competencies

- Generally unseen, "culture"
- Patterns of behavior, structures, trends

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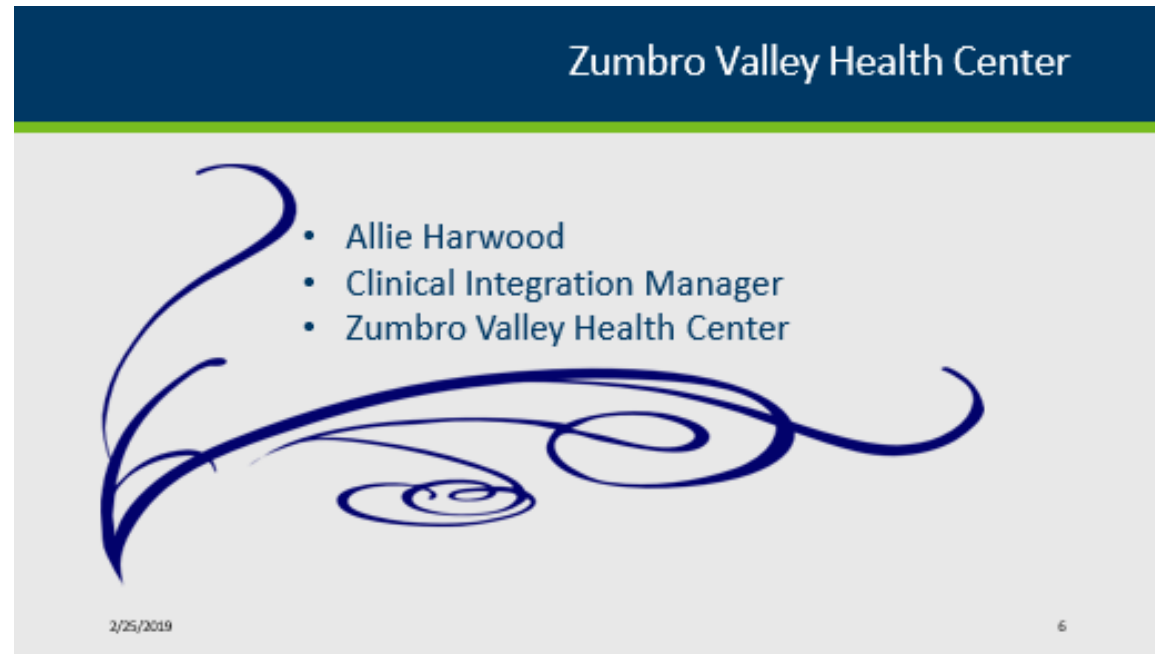
In the first webinar of this series, we discussed the principles of population health management using the Iceberg Model. We also discussed tools to use for population health management.

Developing new skills and a cultural shift to support the initial and ongoing implementation of those skills can be likened to the Iceberg Model. The underlying behaviors, structures, and relationships – the behavioral competencies – support the successful implementation of the knowledge and skills – the technical competencies. We also reviewed the care management reports in the DHS Minnesota partner portal.



During the second webinar, we heard from Guild, Inc., about how they collect data and how they focus on sub populations (specifically people with high ER visits and people with diabetes) to provide interventions and track outcomes.

We also discussed the three Partner Portal reports: chronic condition, provider alert and members lost report.



Allie Harwood is the clinical integration manager for Zumbro Valley Health Center. Today, she will talk about how Zumbro has developed their patient registry and how they use it to track preventative screenings which allows their BHH services team to easily identify care gaps, implement strategies to improve patient care and outcomes through education, referral to primary care and other community partners.

Zumbro: Population Health Management (PHM)

Prevention, diagnosis, and treatment of an entire population rather than a single person

Utilization of patient registries and databases to identify care gaps

Systematic, targeted interventions based upon data

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Zumbro – Where are we now?

Patient registry of *required* elements for BHH

- Ability to run report from EHR

Focus on dental and physical exams

- Care gap identified during HWA
 - No service established or service overdue
- Intervention
 - Referral is made to primary care/dental or
 - Appointment is scheduled with already established provider
- BHH team to follow through and ensure referral loop is closed or appointment is kept
- Address barriers (transportation, accompanying client, etc.)

Much time spent on day-to-day needs of individuals

Database which is not being utilized

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Zumbro – Lessons Learned

Start small

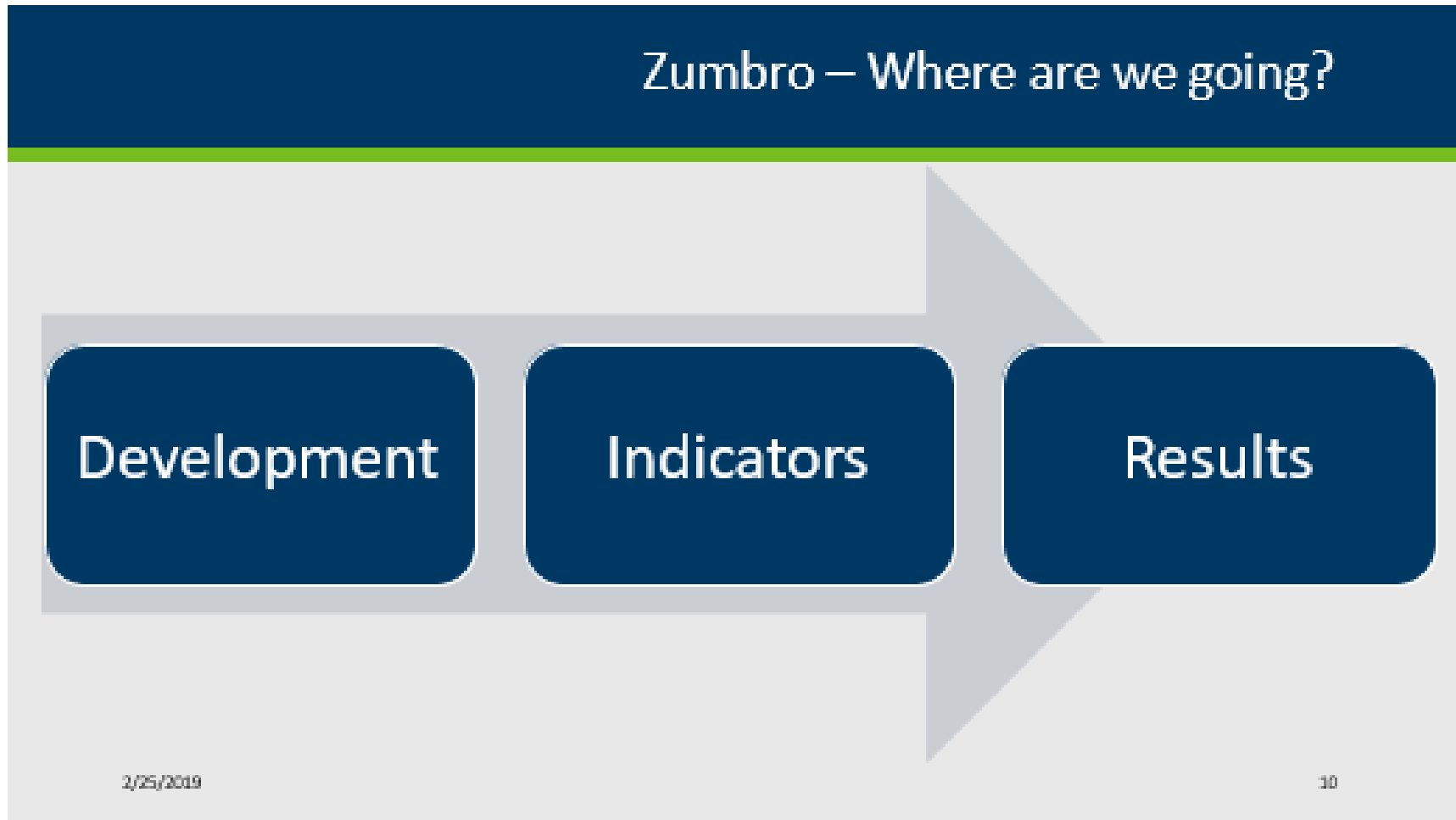
Determine outcomes/indicators that are important to your team, your clients, and your community partners

Talk with IT/data analyst on site if you have one about the best ways to collect and organize the data and reports

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Zumbro – First Steps

- Data you want
- Data you have
- Data still needed
- How to obtain data
- How to input the data



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Determine what data you want to have in the registry

Determine what data is already being collected in the EHR

- Health Wellness Assessment (HWA) – physical exam date, dental exam date, tobacco use screening, tobacco use status
- Vitals Page – obesity screening date, BMI value

Determine what data is still needed

- Cervical cancer screening date, colorectal cancer screening date, breast cancer screening date

Determine how to obtain the data which is still needed

- Example: Registry – Preventative Screenings Add screening tool to complete during HWA
- If age or gender applicable, ask about dates of last colonoscopy, mammogram, PAP screening tests
- Work with MCOs to obtain the needed information
- Currently working with UCare to obtain dates of the last screenings for BHH services UCare clients and the dates in which people are due or next eligible for the screening

Determine how to best enter this data into the EHR

- Consult IT or data analyst
- Is there a configurable form already somewhere in the EHR that these data pieces can be easily added to?
- Do you need to come up with a new form altogether?

Zumbro: preventative screenings

Zumbro - Example Registry – Preventative Screenings

Colorectal Cancer Screening ->
 Not applicable
 10/30/2018
10/30/2006
 Not applicable

↓

Client ID	Client Name	Gender	Age	Physical Exam	Dental Exam	Chlamydia Screening	HBV Value	Tobacco Use Screening	Tobacco Use Status	Cervical Cancer Screening	Colorectal Cancer Screening	Breast Cancer Screening
0000	Jane Doe	W	44	10/10/2018	10/10/2018	10/10/2018	0.0	10/10/2018	Never/Now	Not Applicable	10/10/2018	Not Applicable
0001	Eric Doe	M	50	10/10/2018	10/10/2018	10/10/2018	0.0	10/10/2018	Never/Now	Not Applicable	10/10/2018	Not Applicable
0002	Alan Doe	M	50	10/10/2018	10/10/2018	10/10/2018	0.0	10/10/2018	Never/Now	Not Applicable	10/10/2006	Not Applicable
0003	Lucia Doe	F	20	10/10/2018	10/10/2018	10/10/2018	0.0	10/10/2018	Now	10/10/2018	Not applicable	Not Applicable

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US Preventative Services Task Force Recommendation: Colorectal Screening

- Men and women
- Beginning at age 50, continuing at recommended intervals until age 75
- Jane Doe: colorectal screening is **“Not applicable”** because she is not yet 50 years of age
- Eric Doe: colorectal screening is **normal color** and **font** because he is 50 and was screened this year
- Alan Doe: colorectal screening is **RED** because it was over 12 years since his last screening, which is outside the recommended timeframe

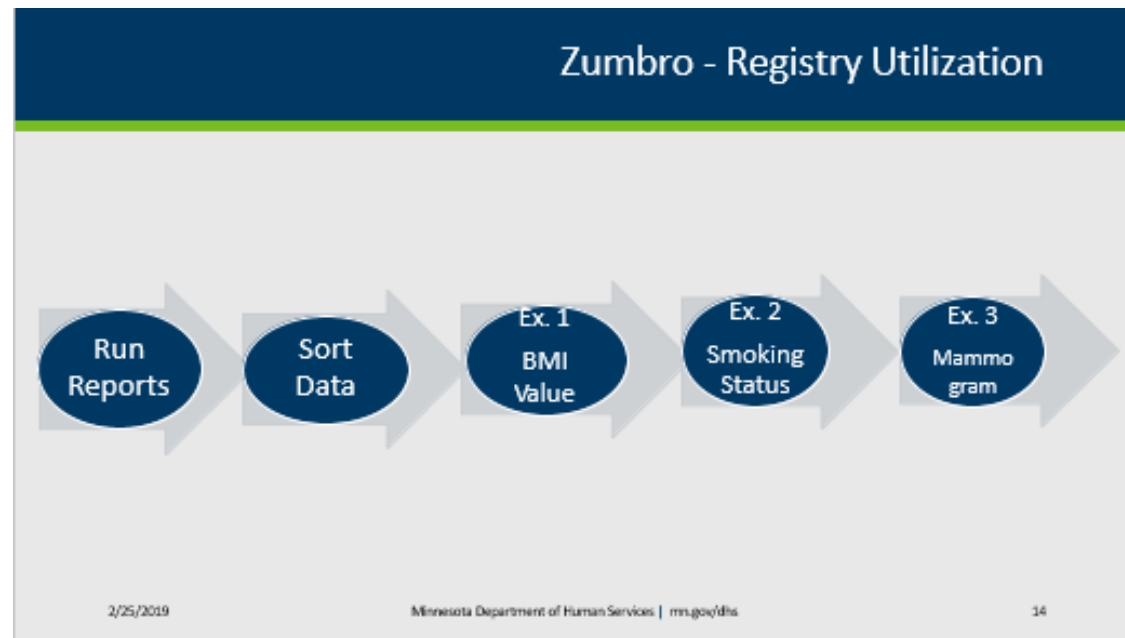
The slide features a dark blue header with the text "Zumbro - Registry – Preventative Screenings". Below the header is a light gray background with a green horizontal line. The main content is titled "US Preventative Services Task Force Recommendations" and lists five categories of screenings, each with a blue bar and a white box to its right:

- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Obesity screening and counseling: adults
- Tobacco Use counseling and interventions: non-pregnant adults

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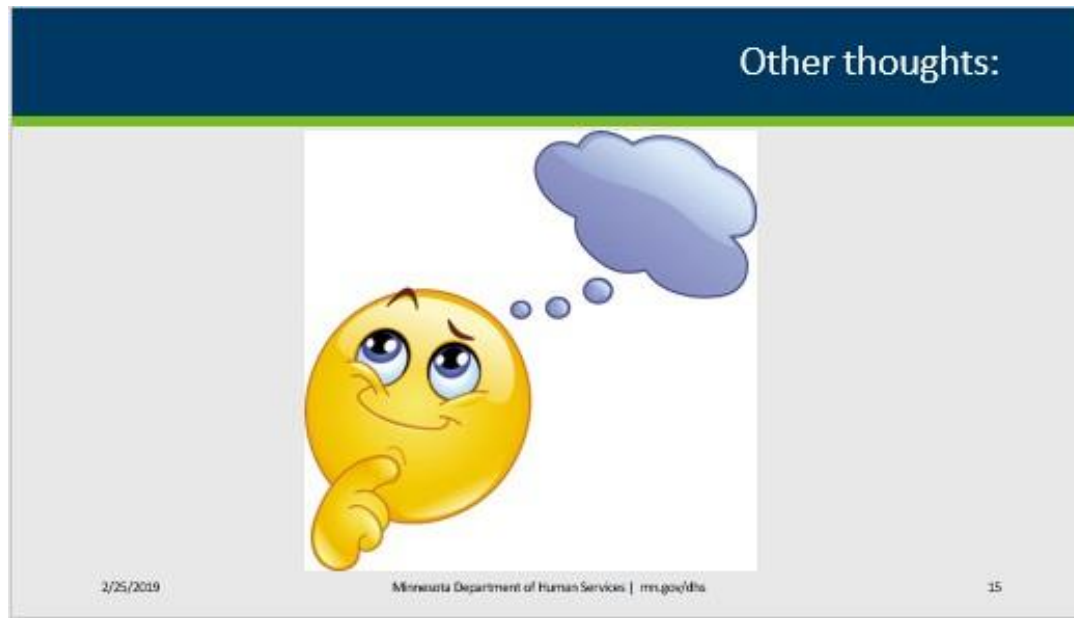
US Preventative Services Task Force Recommendations

- Breast cancer screening: Women, ages 40+, mammography every 1-2 years
- Cervical cancer screening (updated August 2018):
 - Women, ages 21-29: Every 3 years with cervical cytology alone
 - Women, ages 30-65: Every 3 years with cervical cytology alone OR every 5 years with high-risk HPV (hrHPV) testing alone OR every 5 years with cervical cytology and hrHPV combo
- Colorectal cancer screening: Men and women, starting at age 50 and continuing until 75
- Obesity screening and counseling (updated September 2018): Adults, BMI (height and weight), if BMI > 30, refer to intensive, multicomponent behavioral interventions
- Tobacco use counseling and interventions: Non-pregnant adults, ages 18+, screen for tobacco use. Advise to stop using and provide behavioral intervention.



- Run report at regular intervals to track progress: daily, weekly, monthly, depending on data tracked
- Sorting the data
 - Example 1: BMI Value – Sort BMI highest to lowest value to determine which clients are obese/highest risk – Intervention examples: Incorporate motivational interviewing into BHH monthly visits, provide education on healthy diet/exercise – Referral to local fitness center/gym – Referral to HyVee free dietician service for grocery store walkthrough – Referral to community ed. healthy cooking class – Referral to ExercisAbilities ☑ some Medicaid covered programs for those considered pre-diabetic – Coordinate with primary care provider
 - Example 2: Smoking Status – Sort to identify who the tobacco users are - Interventions: Incorporate motivational interviewing into BHH monthly visits – Provide education on smoking cessation – Offer QuitPlan resources – Smartphone applications (QuitGuide) – Coordinate with primary care providers
 - Example 3: Mammogram: Sort (or utilize automatic indicators – cell should be red) to determine women over 40 who have not had a mammogram | Intervention: Provide a reminder to those individuals via the phone, letter, or in person – Determine if eligible for insurance incentives Example: UCare Rewards and Incentives – some plans offer \$50 gift card for getting a screening. If eligible, coordinate with primary care provider to schedule appointment

Other thoughts



- Potentially partnering with local community provider
- Identify pre-diabetic clients on BHH caseload/agency-wide. Criteria include:
 - 18+ years of age
 - BMI \geq 25 (or \geq 23 if Asian)
 - No previous diagnosis of type 1 or type 2 diabetes (gestational diabetes mellitus OK)
 - Diagnosis of prediabetes within the past year (must check at least one)
 - HbA1c: 5.7-6.4% (range means higher chance of getting diabetes)

Helpful resources

American Medical Association. (2018). Panel Management. Retrieved from <https://edhub.ama-assn.org/steps-forward/module/2702192>

[HealthIT.gov](https://www.healthit.gov/playbook/population-public-health/). (2018). Population & Public Health. Retrieved from <https://www.healthit.gov/playbook/population-public-health/>

A presentation slide with a dark blue header containing the text "Vail Place". Below the header is a light gray area with a large, stylized blue graphic of a plant or leaf. To the right of the graphic is a bulleted list. At the bottom of the slide, there is a date, a website URL, and a page number.

Vail Place

- Julie Plante, RN
- Nurse Manager – Integrated Care
- Vail Place

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Julie Plante, nurse manager at Vail Place, is here to talk about how Vail identified sub-populations to gather more detailed information that helps provide more intensive interventions.

Vail Care Population Health Journey: The First Year.



Part 1: Identifying Our Subpopulations/Getting Started

Part 2: Initial Challenges & Outcomes

Part 3: A New Action Plan for the Coming Year

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Part I: Identifying Subpopulations

Initial decision made to focus on 3 subpopulations

Adults with Type II Diabetes, Obstructive Lung Disease, and/or Chronic Pain r/t Specific Medical Diagnosis

Intention was to gather more detailed information and offer additional health coaching support and interventions based on standard care pathway for the illness

Determined methods to gather data and tentative process for how to analyze it and make care recommendations in response

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Part I: Getting Started

- Additional questions asked during HWA
- Records requested to fill in gaps in knowledge
- Care pathways were identified
- Started gathering additional health education and health coaching materials r/t these conditions

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Part 2: Initial Challenges/Outcomes



Challenges/Barriers

- Lack of community understanding about what the program is
- Inability to collect data
- Social Determinants of Health
- People being referred were typically in “crisis mode.”
- Difficulty with maintaining engagement
- Lack of time to invest in health coach training and prepping of materials

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Part 2: Initial Challenges

Resulting in...

- Backlog of requests for info
- Backlog of records to review
- Inability to get traction with targeted interventions
- Staff expected to provide TCM level of service without the TCM access to resources
- Staff feeling overwhelmed with too many competing priorities

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Part 2: Outcomes

Lessons Learned:

a new "to-do" list

- We needed to revamp our data collection plan
- IS/RN needed to provide more instruction and oversight to health coaching/education efforts
- Need for continued education to community partners about the program and how it operates differently than traditional case management models.
- Need to streamline how the work week is organized to promote efficiency and provide time for adequate attention to administrative and follow-up tasks

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Part 3: A New Action Plan for the Coming Year

Smarter Processes

- Eliminating waste: develop new plans for what and when to request data from outside sources
- Creating more standardized questions to ask at intake and at each 6 months thereafter
- Initiating Health Education protocols right at intake with delivery of carefully selected printed materials and tools which can be used by all staff to support members in health goals

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Part 3: A New Action Plan for the Coming Year (cont.)

Smarter Staff

- Monthly “lunch and learn” sessions.
- Training the trainers: RN ensuring all staff are capable and competent in the use of all educational materials and self-help tools to be used with our members.
- RN providing summary of health and wellness needs and ideas for interventions on each new client after completion of the HWA.

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Thank you



Thank you!

Questions?

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