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Module 7: Population health and Care Transitions

Topics Covered

- The role of the Healthcare Quality Professional in population health and care transitions by using data analytics to drive and monitor improvement results.
- The relationship between value-based care and population health.
- The care continuum and the importance of incorporating wellness into improvement initiatives.
- The importance in managing care transitions and the impact on the population health of the community.

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Population Health

Population Health

- The distribution of health outcomes within a group of individuals
- Example Groups:
  - Geographic
  - Ethnic
  - Disabled persons
  - Employees

- Determinants of Health:
  - Medical care systems
  - Social environment
  - Physical environment

Why do we want to focus on Population Health

- National Association for Healthcare Quality (NAHQ) Competency Framework
  - Population Health & Care Transitions: Evaluate and improve healthcare processes and care transitions to advance the efficient, effective and safe care of defined populations. Integrate population health management strategies into quality work. Apply a holistic approach to improvement. Collaborate with stakeholders to improve care processes and transitions
- Triple Aim Framework

  IHI Triple Aim is a foundational principle for organizations moving toward value-based payment systems

  Considers population health in its goals by:
  - Improving patient experience of care
  - Improving health for populations
  - Reducing per capita cost of healthcare

Why do we want to focus on Population Health

- National Association of Community Health Centers (NACHC)
  - Encourages quality improvement/performance measurement as one population health management strategy to achieve "quadruple aim"
  - Improved patient experiences
  - Improved clinical outcomes
  - Lower costs
  - Improving work life of health care providers

Why do we want to focus on Population Health

- Data Collection Tools and Population-based Data

- Ability to accurately design appropriate data collection tools and analyse vast amounts of population- based data to:
  - Stratify the population by risk
  - Identify opportunities for improvement
  - Deploy rapid-cycle process changes

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Population Health Management

Population Health Management

Requirements of Comprehensive Population Health Management

- Data Infrastructure

  -The ability to track information in the electronic health record and data registries.

- Community Engagement

  -Understanding the needs of the community and developing relationships with community partners.

- Team-Based Care

  -Creation of interdisciplinary care team. Includes registered nurses, social workers, and pharmacists.

- Panel Management

  -Caring for defined populations, leveraging evidence-based care for preventative and chronic care, ensuring timely completion of related tasks, identifying and addressing inequalities, engaging with patients to close care gaps.

Requirements of Comprehensive Population Health Management

- Patient Risk Stratification
  - Patient Risk Stratification involves the placing of patients into subgroups based on factors such as their health history, including chronic conditions; and the complexity of their care .
- Care Management
  - Includes a number of services that help patients with chronic physical and/or mental conditions, as well as patients with complex conditions to manage their own health. The overall goal is to improve patient health.
- Complex Care Management

  Identifying high-cost and patients with high needs. Using team-based approach to manage needs of patients .

Requirements of Comprehensive Population Health Management

- Self Management Support
  - Engagement with patients to provide education and support to help the patient manage chronic health condition or preventative health measures
- Addressing Social determinants of Health
  - Identifies social needs affecting patients well being. Developing plan to address social needs of a population
- Ensuring Health Quality
  - Identifying and addressing inequalities and care gaps within population to reduce health disparities and improve health outcomes.

Data Integration

Comprehensive linked databases provide information on the influence of tests and treatments on the health of the population

- Data collected from interventions, health outcomes, and other variables gathered from individual patients
- Evaluation of health status and risk stratification of population requires integration of variety of sources of data
  - Electronic health record
  - Health information exchanges
  - Association data
  - Claims data

- According to Centres for Medicare & Medicaid Services (CMS), population health improvement requires commitment across multiple sectors:
  - Tribal agencies
  - Measured entities and payors
  - Community service providers
  - Private sector partners

Health Equity and the Social Determinants of Health (SDOH)

- Population health considers the health outcomes of a group of individuals
- SDOH include: Socio economic status, education, neighbourhood and physical environment, economic factors, employment, social support networks, access to health care
- Identification - reduction or elimination of inequity and health disparities
- Health and longevity driven by nonclinical factors, such as the conditions in which people are born, grow, live, work and age.

Social Determinants of Health (SDOH)

- Determinants of population health engage organizations outside the traditional definition of health care providers. Some examples:
  - Housing organizations
  - Employers
  - Schools
  - Correctional centres
  - Transit systems
  - Land developers
- Key to successful population health management, engagement with right partners to design effective, equitable, and sustainable care and service delivery systems

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Screening for Social Determinants of Health (SDOH)

Non-medical social needs create problems with:

- Access to care
- Adherence to treatment plans
- Impede providers' ability to deliver evidence-based care
- Contrary to the goal of health equity

SDOH screening tools:

- Identify patients early enough to provide treatment and avoid or reduce symptoms and other consequences
- Improve health outcomes of the population at a reasonable cost

Increasing number of resources and tools available to help screen for SDOH:

- Data collection plans based on strategy for population health management
- Include both internal and external data depicting organization's population health and include SDOH

Population Health Improvement Initiatives and the Role of the HQP

- HQP role to determine the cost/benefit of integrating population health strategies into improvement initiatives
  - Evaluate the return on investment of population health activities
  - Data used for analysis includes:
    - Billing
    - Clinical
    - External data
    - Social Determinants of Health
- Evaluate outcomes related to process measures and structural measures developed for population health management:
  - Access to care
  - Clinical outcomes
  - Coordination of care and community services
  - Health behaviours
  - Preventive care and screening
  - Health service utilization
- Coordinate prioritization of improvement initiatives with leaders of organizations, stakeholders, and community partners

Population Health Models and Frameworks

- Population Health Management (PHM) Conceptual Model:
  - Developed by National Committee for Quality Assurance (NCQA)
  - Outlines the key activities necessary for a comprehensive population health management strategy.
  - NCQA offers Population Health Program (PHP) accreditation

Population Health Models and Frameworks

- Pathways to Population Health partnership between 5 key organizations:
- American Hospital Association (AHA), Institute for Healthcare Improvement, Network for Regional Healthcare Improvement, Public health Institute, and Stakeholder Health
- Six foundational population health concepts for model:
  1. Health and well-being develop over a lifetime.
  2. Social determinants drive health and well-being outcomes throughout the life course.
  3. Place is a determinant of health, well-being, and equity
  4. The health system needs to address the key demographic shifts over time
  5. The health system can embrace innovative financial models and deploy existing assets for greater value
  6. Health creation requires partnership because health care only holds a part of the puzzle

Population Health Models and Frameworks

- The Care Continuum Alliance Population Health Improvement Model:
  - Focuses on delivery and coordination of appropriate, cost-effective care:
  - The care delivery and leadership roles of the primary care physician
  - The critical importance of patient activation, involvement, and personal responsibility
  - Patient focus and capacity expansion of care coordination provided through wellness, disease, and chronic care management programs

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Population Health and Value based care

How do the current value-based care models impact Population Health?

Value-based Reimbursement models

Focused on:

- Improving quality
- Improving access
- Improving outcomes
- Reducing costs through the effective management of a population's health

Value-based reimbursement models require population-based quality measures

HQP can support value-based reimbursement models through:

- Proficiency in risk stratifying the population
- Using data analytics and predictive modelling
- Leveraging rapid-cycle improvement methodologies to achieve established outcome measures

CMS Shared Savings Program and Accountable Care Organizations

- ACOS enable healthcare providers and suppliers to work together to achieve improved healthcare outcomes at lower cost of care
- Comprehensive care coordination is vital in value-based payment arrangement
- Essential components of a population health program:
  - Understanding the characteristics of the population
  - Identifying the patients most at risk for costly healthcare utilization
  - Developing targeted interventions to manage population across the care continuum
- Identification of high-utilizers and high-cost patients by ensuring the education of the billers on appropriate coding for chronic conditions and social determinants of health
- HQP uses analysis of code-based data to evaluate the population and identify appropriate quality improvement initiatives

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Care Transitions

Care Transitions

- Focus has been from:
  - Inpatient hospital setting to other care setting
  - Improvement surrounding readmissions due to excessive costs and poor health outcomes
- Continuum of Care is complex and includes many additional care settings
- Care transitions can present opportunities and challenges for health care providers and systems of care

Effective Transition of Care Standards(American Case Management Association (ACMA)

- Standard 1

  Identify patients at risk for poor transitions. This allows appropriate measures to be taken by the care team at either the sending or receiving location to ensure optimum patient health outcomes.

- Standard 2

  Complete a comprehensive transition assessment. This is especially important for patients that are at a high risk of a poor transition. It involves evaluating family engagement, patient and family goals, utilization of healthcare across the continuum, and self-management capabilities.

Effective Transition of Care Standards(American Case Management Association (ACMA)

- Standard 3

  Perform and communicate a medication reconciliation. This medication reconciliation is completed at each point in the care transition. It includes both prescription and non- prescribed medications.

- Standard 4

  Establish a dynamic care management plan that addresses all settings throughout the continuum of care. This plan is developed with input from the patient, their family and their primary caregiver. It includes the identification and documentation of their primary ambulatory care provider and all other preferred services

Effective Transition of Care Standards(American Case Management Association (ACMA)

- Standard 5

  Communicate essential care transition information to key stakeholders across the continuum of care. The key stakeholders may include the patient and caregivers, their primary care provider, clinicians at other care settings and other service providers. The information communicated includes clinical data and social determinants of health.

Care Management

- Care Management - a set of activities intended to improve patient care and reduce the need for medical services by enhancing coordination of care
- Care management creates an infrastructure to effectively manage the health of a population by supporting patients through the continuum of care
  - Defined interventions
  - Care planning
  - Programs
- Outcome measures

Continuum of Care

- Continuum of care includes:
  - Acute care hospitalization
  - Ambulatory/community-based outpatient settings
  - Rehabilitative or skilled nursing home environments
  - Patient homes with or without home care services
  - Palliative and end of life care
- Implemented by care or care managers, normally are registered nurses or social workers
- Care manager must engage with patient, their families, and caregivers across the entire continuum
- Goal to have a seamless transition from one level of care to the next

Caring for the Population

- Health and Wellness
  - Focus on wellness and disease prevention for stratified population
  - Helps to improve overall health outcomes and reduce utilization
  - Individualized prevention plans aid in development of activities and interventions to work toward patient-specific health goals
- Chronic Disease Management
  - Heart failure, chronic obstructive pulmonary disease, asthma, diabetes and others
  - Care managers help patients prevent exacerbations of illness and seeking care at appropriate level (primary care vs emergency department), identify appropriate post-acute care services, and educate themselves in managing their chronic conditions
  - Standardized care pathways and protocols to ensure adherence to guidelines and reduce variability
- Primary Care
  - Care managers assess patient care needs, develop and monitor care plans, provide patient education, communicate information across clinicians and settings, and connect patients to community resources and social services
  - Patient Centered Medical Home (PCMH) - "model where the primary care provider is the central point of contact for primary care.

Managing Care Transitions

- Transitions of care:
  - The movement of patients between healthcare locations, providers, or levels of care
  - Set of actions designed to ensure coordination and continuity of care
- Consequences of ineffective care transitions:
  - High rates of re-hospitalization
  - Unintended Emergency Department (ED) visits
- Care manager role:
  - Leverage a variety of policies, processes, workflows, and assessments
  - Create the transitional care plan and ensure smooth transitions
- HQP can support care transitions by:
  - Understanding the quality measures impacted by care transitions
  - Designing processes to ensure transition of care quality measures are monitored and addressed

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Population Health and the Healthcare Quality Professional

Key Organizational Activities in support of population Health goals

- What is my role as an HQP in managing Population Health?

- **Implement Population Health Policies, Programs, and Services**
  - Population health policies, programs and services
  - Align with organizational strategic goals and community needs
  - Integrate with strategic plans, goals, and objectives
- **Develop and Maintain a Solid Infrastructure**
  - To support patient engagement and positive clinical outcomes

Key Organizational Activities in support of population Health goals

- Prioritize Improvement
  - Create healthcare processes and care transitions to advance efficient, effective and safe care of defined populations
- Facilitate Exchanging of Data and Information
  - Data exchange between stakeholder organizations
  - Integrate into improvement initiatives for community and public health initiatives
- Integrate Population Health and Care Management Analytics Tools
  - Electronic health records
  - Registries
  - Telemedicine
  - Analytics tools
  - Providers, health systems, and community partners can better predict and manage illnesses and diseases

Summary

- We discussed that Population Health and Care Transitions is defined as the distribution of health outcomes within a group of individuals. These groups are defined as geographic, ethnic, disabled persons, employees, or others
- We discussed the social determinants of health and the impact on the health of a population within a community
- We looked at Population Health Frameworks and Models and how they can be utilized by your organization
- We looked at how Population Health is related to Value-based Reimbursement, Shared Savings Programs and Accountable Care Organizations
- We discussed Care Transitions and how patients are managed across the complex continuum of care within a community