Population Health Management
Agenda

- Review – Remembering the 1st and 2nd webinar in the series
- Putting it into practice – two of our BHH providers share their experience
- Q&A
- Upcoming BHH services 2019 learning events
Course Objectives

Understand the Iceberg Model in terms of PHM from the first webinar and, from the 2nd webinar, review how Guild is using their data to track two sub-populations.

Learn how two providers used population health management techniques and tools to better serve individuals receiving BHH Services at their agency.

Learn about the educational opportunities coming up in 2019.
Review – PHM Webinar #1

Technical Competencies

- What is seen
- What is happening

Behavioral Competencies

- Generally unseen, “culture”
- Patterns of behavior, structures, trends
Zumbro Valley Health Center

- Allie Harwood
- Clinical Integration Manager
- Zumbro Valley Health Center
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
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
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
Zumbro – Where are we going?

Development

Indicators

Results
Zumbro – First Steps

Data you want

Data you have

Data still needed

How to obtain data

How to input the data
# Zumbro - Example Registry – Preventative Screenings

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<th>Client Name</th>
<th>Gender</th>
<th>Age</th>
<th>Physical Exam</th>
<th>Dental Exam</th>
<th>Obesity Screening</th>
<th>BMI Value</th>
<th>Tobacco Use Screening</th>
<th>Tobacco Use Status</th>
<th>Cervical Cancer Screening</th>
<th>Colorectal Cancer Screening</th>
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*Note: BMI values are approximate and may require further validation.*
US Preventative Services Task Force Recommendations

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

Run Reports
Sort Data
Ex. 1
BMI Value
Ex. 2
Smoking Status
Ex. 3
Mammo gram

2/25/2019
Minnesota Department of Human Services | mn.gov/dhs
Other thoughts:

• Julie Plante, RN
• Nurse Manager – Integrated Care
• Vail Place
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
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
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
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
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
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
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
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.
Question and Answer
Thank you
Future Learning Opportunities

**BHH Services Learning Day Event**

Tuesday, April 9, 2019
1:00pm-4:30pm

Continuing Education and Conference Center
University of Minnesota
St. Paul Campus

More info: megan.lokken@state.mn.us
<table>
<thead>
<tr>
<th>Month</th>
<th>Event</th>
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<tr>
<td>May</td>
<td>Webinar for managed care organizations (MCOs) and BHH services providers to discuss results from the statewide evaluation. Regional Meeting.</td>
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<tr>
<td>June</td>
<td>Regional Meeting.</td>
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<td>July</td>
<td>Presentation by Dr. Svetaz, a family practice and adolescent health physician at Hennepin Healthcare and Medical Director of Aqui Para Ti.</td>
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<td>August</td>
<td>Tobacco 101 with Dr. Marc Steinberg, clinical psychologist and the director of the Tobacco Research &amp; Intervention lab at Rutgers Robert Wood Johnson Medical School.</td>
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Thank you!

Questions?
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