



DEPARTMENT OF  
HUMAN SERVICES

## Population Health Management

# Agenda

Review – Remembering the 1<sup>st</sup> and 2<sup>nd</sup> webinar in the series

Putting it into practice – two of our BHH providers share their experience

Q&A

Upcoming BHH services 2019 learning events

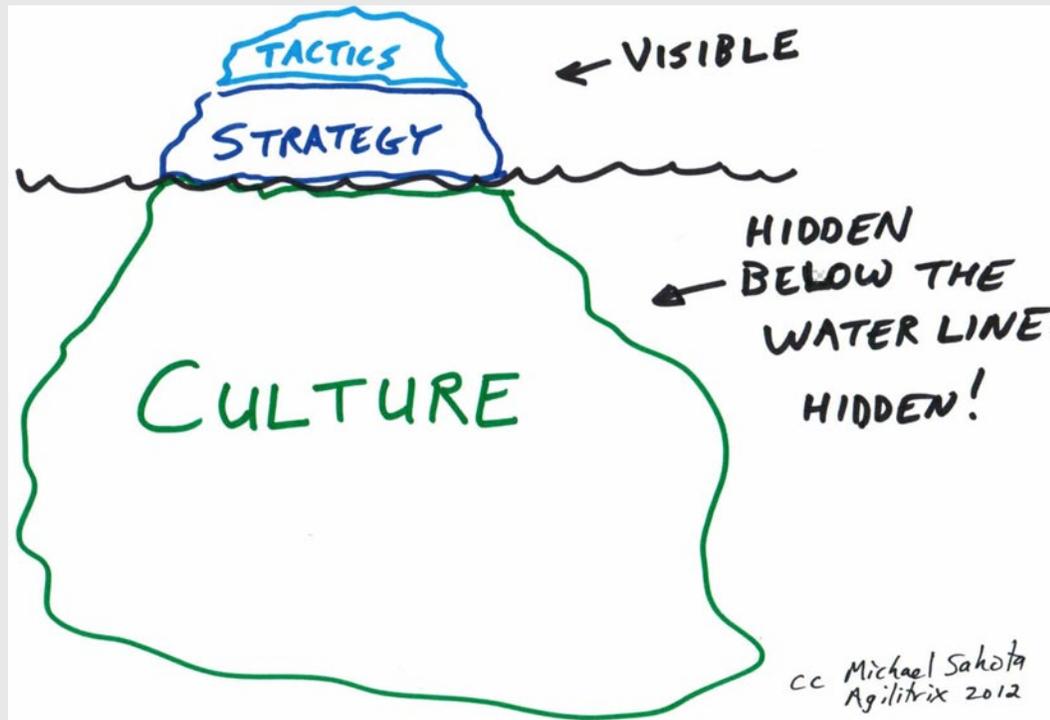
# Course Objectives

Understand the Iceberg Model in terms of PHM from the first webinar and, from the 2<sup>nd</sup> 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



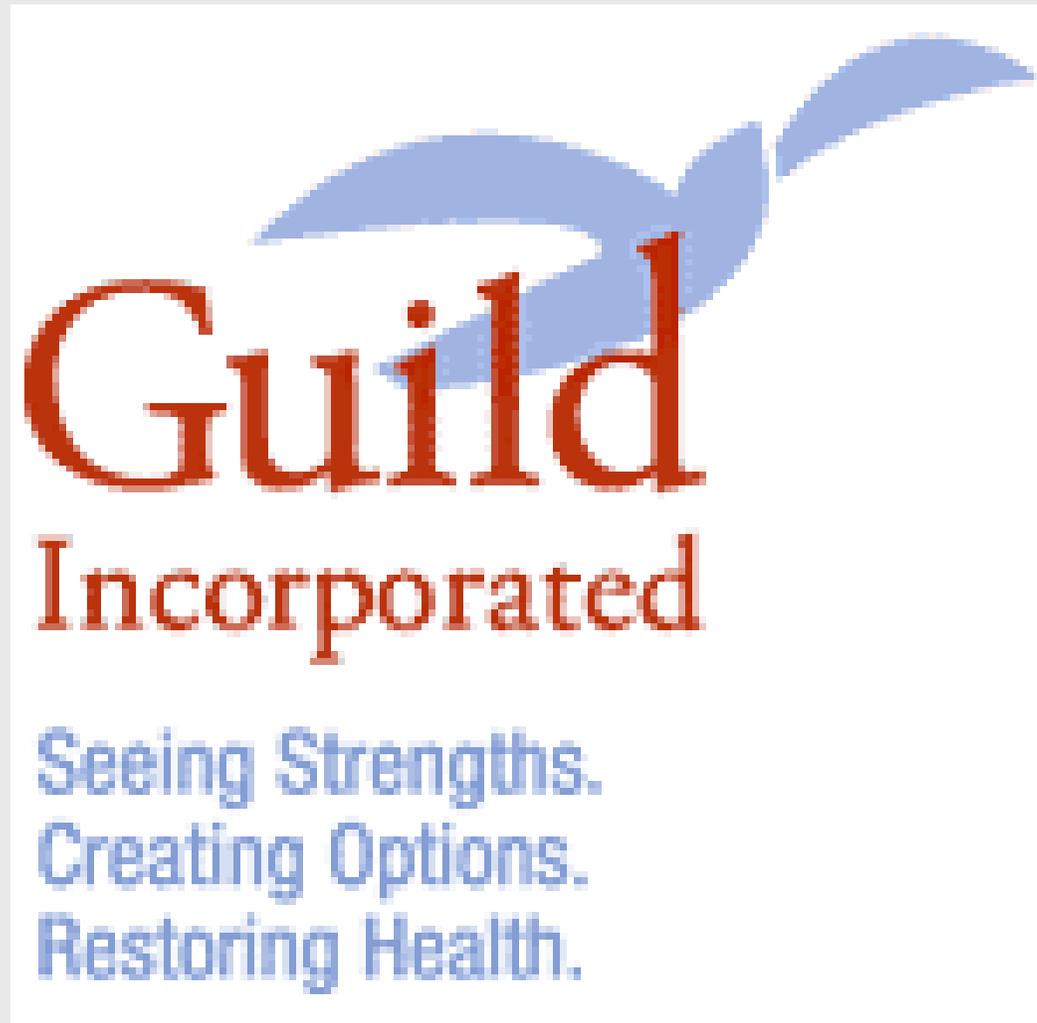
## Technical Competencies

- What is seen
- What is happening

## Behavioral Competencies

- Generally unseen, “culture”
- Patterns of behavior, structures, trends

# Review – PHM Webinar #2



# Zumbro Valley Health Center

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- A large, decorative blue swirl graphic that starts on the left side of the slide, loops upwards and to the right, then loops back down and to the left, ending in a smaller swirl at the bottom center. It frames the central text.
- 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

# 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



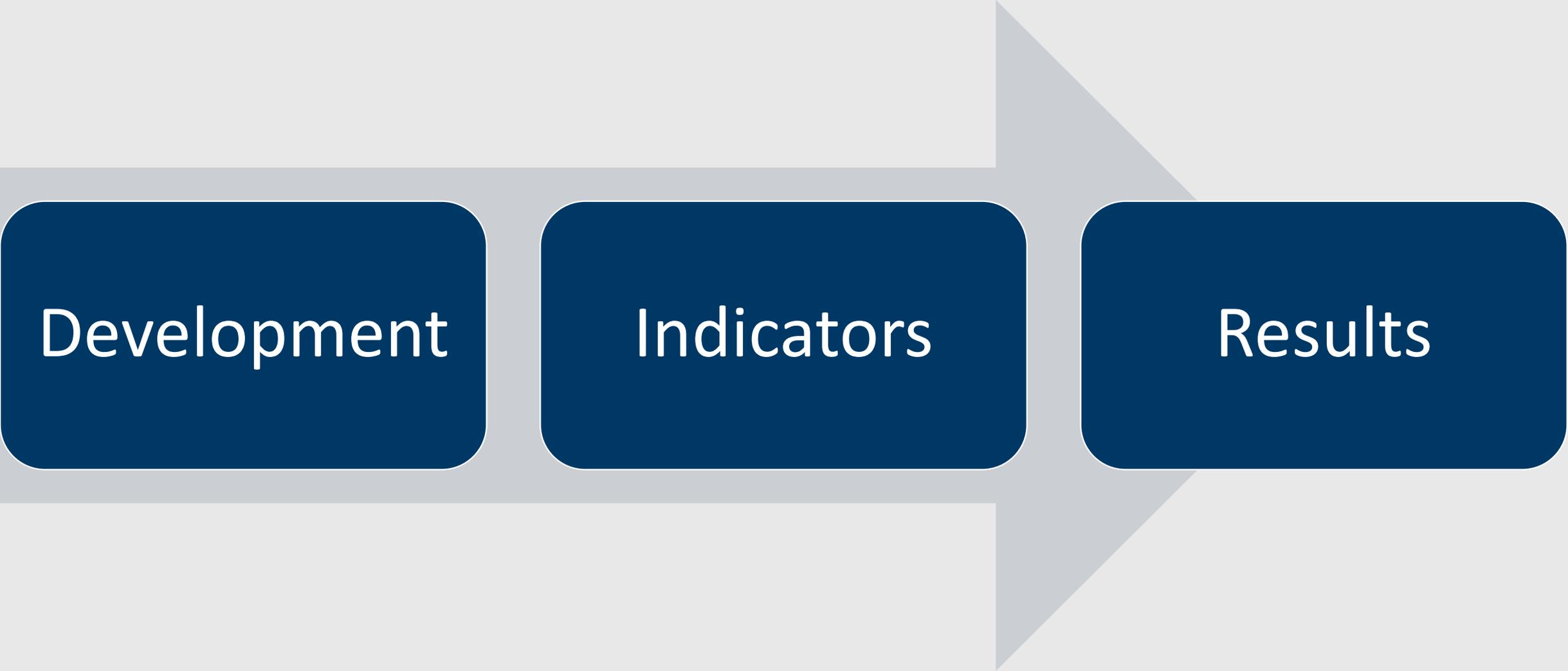
# Zumbro – Lessons Learned

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

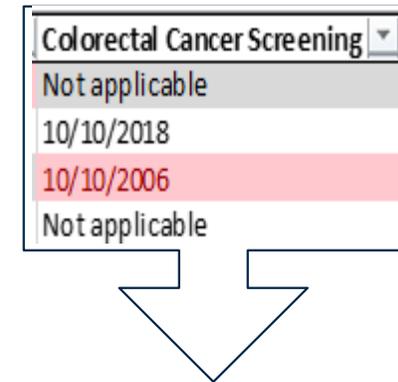
Results

# 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



Client ID	Client Name	Gender	Age	Physical Exam	Dental Exam	Obesity Screening	BMI Value	Tobacco Use Sreening	Tobacco Use Status	Cervical Cancer Screening	Colorectal Cancer Screening	Breast Cancer Screening
3456	Jane Doe	M	45	12/10/2017	10/10/2018	10/10/2018	19			10/10/2003	Not applicable	10/10/2018
7890	Eric Doe	M	55		10/10/2018	10/10/2018	42	10/10/2018	Non-User	Not Applicable	10/10/2018	Not Applicable
2345	Alan Doe	M	65	10/10/2018	6/10/2018	2/10/2018	25.5	10/10/2018	Non-User	Not Applicable	10/10/2006	Not Applicable
6789	Linda Doe	F	20	10/10/2018	10/10/2018	10/10/2018	24	10/10/2018	User	10/10/2018	Not applicable	Not Applicable

# Zumbro - Registry – Preventative Screenings

## US Preventative Services Task Force Recommendations

Breast Cancer Screening

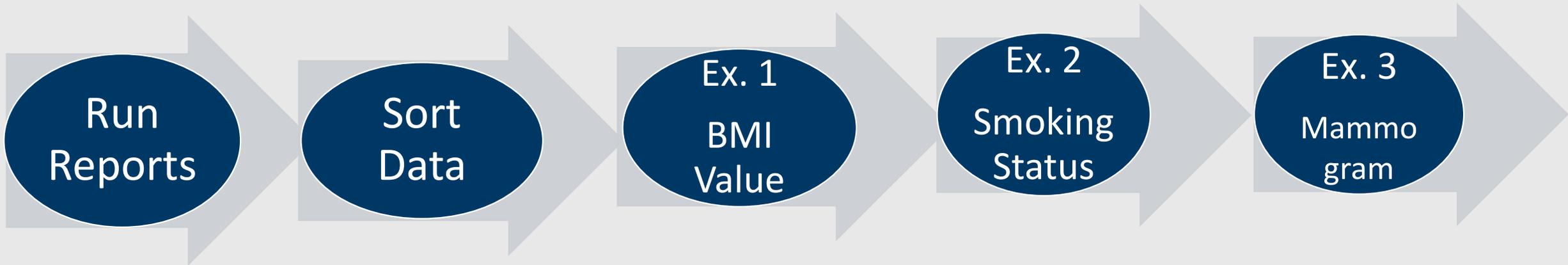
Cervical Cancer Screening

Colorectal Cancer Screening

Obesity screening and counseling: adults

Tobacco Use counseling and interventions: non-pregnant adults

# Zumbro - Registry Utilization



# Other thoughts:



# Helpful resources

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

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

- 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

## 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

### 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

# 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

# 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.

# 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](mailto:megan.lokken@state.mn.us)**

# Future Learning Opportunities (cont.)

May

Webinar for managed care organizations (MCOs) and BHH services providers to discuss results from the statewide evaluation

Regional Meeting

June

Regional Meeting

July

Presentation by Dr. Svetaz, A family practice and adolescent health physician at Hennepin Healthcare and Medical Director of Aqui Para Ti

August

Tobacco 101 with Dr. Marc Steinberg, clinical psychologist and the director of the [Tobacco Research & Intervention lab](#) at Rutgers Robert Wood Johnson Medical School.

# Thank you!

Questions?

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