Assessing Hospital Preparedness for Transitions to Population Health

Learning Outcomes:
By the end of this presentation, you should be able to:

- Describe how care management fits into Population Health
- Identify starting point for building a Population Health Strategic Plan
- Identify current community resources available for your Population Health Program

Assessing Hospital Preparedness for Transitions to Population Health

Angie Charlet, DBA, MHA, RN,
Director of Quality & Educational Services, ICAHN

Angie Charlet, RN, holds a Doctorate in Business Administration with a focus in healthcare management and executive leadership. She has over 27 years' experience in the healthcare industry, with most recent hospital experience as Chief Operations Officer prior to joining ICAHN in 2011 as the Director of Quality & Education and Compliance Officer. Her past experiences demonstrate team building, network engagement, and evidence-based practice changes along with new models that promote rural health. Ms. Charlet sits on the Board of Directors for the National Association of Rural Health Clinics since 2012 and is the past-president (2014-15) for the Illinois Organization of Nurse Leaders. Angie also holds a Master's degree in Healthcare Administration and certified in Lean Six Sigma, Black Belt Six Sigma and CPHQ.

Assessing Hospital Preparedness for Transitions to Population Health

How do we make the transformation to population health successful in a rural hospital?

- Involves assessing and continually improving the way patient care is delivered at all levels
- Occurs when an organization rejects existing practice patterns that deliver inefficient or less effective results and embrace a common goal
- Involves shared commitment to patient safety, clinical outcomes and quality care
- Involved process redesign and information technology implementation
- Involves blending people, processes and technology
- Involves commitment across facilities, departments and clinical fields of expertise
- Involves developing new systems and roles and overcoming resistance to change
- Involves transitioning to provide wellness care AND illness care

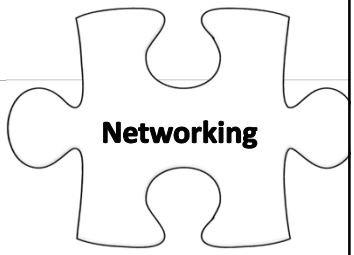
What is Population Health?

Population health management has been identified as a critical strategy for improving **value** in an era of reform.

It is a model of care management designed to enhance **coordination of care** and services for specific patient populations, such as Medicare patients or patients with chronic disease, and more actively **engage consumers** in improving and maintaining their health.

This model has the potential to significantly **reduce costs** for healthcare purchasers and consumers.

Population Health Forum



Poll Questions & Forum Topics

How many today are part of an ACO?

Yes
No
Considering for 2019

Defining Terminology Related to Population Health

Population Health

- Programs targeted to a defined population that use a variety of individual, organizational, and social interventions to improve health outcomes.

Accountable Care Organization (ACO)

- Groups of doctors, hospitals, and other health care providers who join together to provide coordinated, high quality care to well-defined populations of patients such as Medicare and commercial) patients.

Clinically Integrated Network

- A structured collaboration among physicians, hospitals, and other providers to improve the access, quality and efficiency of health care across broad geographies.

Public Health

- Aims to protect and improve the health of communities by promoting healthy lifestyles, conducting research for disease and injury prevention, and controlling infectious diseases

6

8 Goals of the Population Health Program

- Keep population healthy
- Minimize need to ED visits; promote PCP-Patient Relationships
- Decreased need for hospitalization
- Reduce readmissions
- Reduce interventions, procedures, imaging, tests etc.
- Lower costs
- Improve quality and health outcomes
- Maintain and improve person's health across the continuum of care

Population Health Forum

Poll Questions & Forum Topics

Our hospital has identified population health practices as part of our current Strategic Plan:

Yes
No
In process of review for 2018

Components for Success:

Population Health

A Leadership Team ready for Population Health….

- Is actively engaged in change management as part of transformation
- understands hospital transformation and population health management principles
- supports and takes responsibility to implement the strategic plan
- considering or interested in developing Clinically Integrated Networks (CIN) and advancing population health efforts in the community.
- has provided education on ACO concepts to governing board, physicians and others
- maintains both formal and informal means of communication and encourages new ideas and informal feedback

Components for Success:

Population Health

A Governing Board ready for Population Health….

- is involved and supports hospital transformation and organizational change
- is actively involved in the development of its strategic plan
- understands and supports quality and performance improvement principles (board priority)
- participates in ongoing education and training on care coordination and transformation principles

Components for Success:

Population Health

A Leadership Team as whole has prepared the organization by….

- aligning its mission and vision with population health
- Promoting a culture that positively embraces population health and change implementing its Community Health Needs Assessment plan targeting the needs of its community and those we serve
- having a process to identify patients for population health management
- Having a strategic plan that includes initiatives to prepare for hospital transformation and population health management

Components for Success:

Population Health

A Financial team ready for Population Health…

- is actively engaged in hospital transformation
- financially supports care navigation programs – inpatient and outpatient
- has identified budget items required for care transitions and population health management for next fiscal year
- has tools to analyze service line value and return on investment
- financially supports population health management initiatives

Population Health Forum

Poll Questions & Forum Topics

Our greatest struggle with care management is:

a. **Understanding care transitions and HCAHPS scores**
b. **Managing patients through the health care network**
c. **Communication between providers of care**
d. **Implementing CCM/TCM processes**
e. **All the above**

Components for Success:

Population Health

A Hospital prepared for Population Health in Care Transitions…

- has a centralized scheduling program
- has a system for patient reminders/appointment changes
- has dedicated staff to provide community education programs
- offers wellness programs. (for employees, business partners, community
- has a plan to shift more patient services to the outpatient setting, which includes retraining staff
- has begun education to staff on care transitions and care management
- participates in readmissions and chronic disease management programs
- provides resources for clinical areas to incorporate evidence-based practice
- has a organization-wide customer service program
- has implemented Lean practices throughout the organization with staff engagement
- has incorporated performance/productivity based measures
- has initiated a chronic disease wellness program for employees and/or community
- Case managers and other have reviewed the Community Health Needs Assessment

Components for Success:

Population Health

A Hospital prepared for Population Health in Patient Care Management…

- has an inpatient case management program
- case manager is 'on call' for after-hours discharges and difficult patient care situations
- has an outpatient case management program
- has a discharge call-back program and includes Emergency room visits, D/C from nursing floors, Outpatient visits
- Nursing staff utilizes a discharge assessment tool to determine patient readiness for discharge
- Nursing and other health professionals incorporate evidence-based practices into the clinical setting and hospital policies and procedures
- Nursing has established bedside reporting program
- Nursing/case management includes patient and family in the care planning process
- Medical providers are part of the care management team
- Discharge program includes making appointments for follow-up visit with medical providers and/or therapy services as needed

Components for Success:

Population Health

A Hospital prepared for Population Health in Patient Care Management…

- Nursing/case management conducts at least weekly multidisciplinary care management meetings
- Hospital has established ongoing communications with area nursing homes, local health departments, referral centers, home health, hospice and other social services and behavioral health programs
- Hospital staff has established ongoing communication with primary care providers to ensure continuity of care and improvement in care and hospital services
- Hospital has a means to identify and monitor high-risk chronic disease patients and create a care plan based on needs and resources
- Hospital staff is engaged in care transition from one level of care to next
- Hospital has behavioral health resources readily available for inpatient and outpatient care needs

Components for Success:

Population Health

Hospital has initiated a population health management plan
Hospital has established at least one outpatient chronic disease management program (i.e. diabetes, congestive heart failure, obesity) If yes, please indicate in comments
Hospital offers annual wellness education and screening program for the community
Hospital provides onsite education and screening in cooperation with local medical primary care providers
Hospital has established a community health education program, providing at least one program quarterly, and based on population health needs
Providers have a well-designed process in place for referral tracking and obtaining feedback from specialists
Hospital is actively engaged with local health department programs and initiatives
Medical providers actively support and refer to hospital's chronic disease management and community education programs

A Hospital prepared for Population Health in Disease Management…

- initiated a population health management plan for its employees
- established at least one outpatient chronic disease management program (i.e. diabetes, congestive heart failure, obesity)
- offers an annual wellness education and screening program for the community
- provides onsite education and screening in cooperation with local medical primary care providers
- has established a community health education program, providing at least one program quarterly, and based on population health needs
- Providers have a well-designed process in place for referral tracking and obtaining feedback from specialists
- actively engaged with local health department programs and initiatives
- Medical providers actively support and refer to hospital's chronic disease management and community education programs

Population Health Forum

Poll Questions & Forum Topics

We currently have wellness programs for staff?

Yes
No
Considering for 2018

Patient Engagement Ideas

- Track blood pressure, weight, blood glucose
- Exercise plan, physical accomplishments
- Seek employer engagement
  - Healthier employees = healthier population
- Employee wellness programs
- Employee wellness coaches
- Lunch n learn events/cooking events
- Community promotion/education
- Home visits
- School education: target younger obese population

Components for Success:

Population Health

A Hospital prepared for Population Health in Quality…

- has an active hospital-wide quality improvement program and reports findings to the board
- has established a program to measure readmission rates and actively monitor trends/improvement methods
- Medical providers report quality improvement measures, including practices and clinics
- participates in programs, such as Project RED,BOOST, pursuit of High Reliability Organization(HRO) or other programs
- Leadership rounds a minimum of once a week
- staff has embraced quality as part of the organization's culture and practice
- staff is aware of the quality measures and participates in data collection and improvement of care and service
- provides a transparent view of quality measures to the public – reports required measures to Hospital Compare
- Providers are monitoring PQRS quality metrics for improvement

Components for Success:

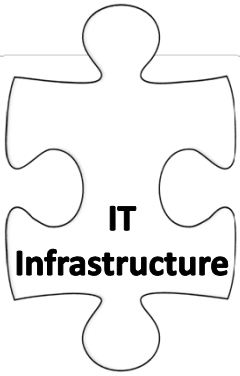
Population Health

A Physician team and Medical Providers ready for Population Health….

- are involved in hospital decision-making and are supportive of the hospital strategic plan
- participate in ongoing education and training on clinical integration and population health management
- are actively involved in quality Improvement
- are involved in hospital decision-making and are supportive of hospital's strategic plan
- understand Patient Centered Medical Home and have implemented concept
- support and incorporate evidence- based medicine in practice

Components for Success:

Population Health



A Hospital prepared for Population Health in IT Infrastructure and Data…

- Hospital has conducted a facility-wide analysis of internal improvements required for statistical data and informatics reporting through EMR
- Hospital has or will meet Meaningful Use Stage II by December 2017
- Clinic will meet Meaningful Use Stage I by 2017
- Hospital has IT connection to all departments, including physician practices, clinics and off-campus services, such as home health
- Hospital EMR connects to one or more physician practices or clinics for exchange of patient information
- Medical providers have the ability to share data electronically with other medical providers
- Hospital participates in a statewide, regional or system-wide health information exchange
- Hospital utilizes a clinical information specialist
- Hospital utilizes a discharge call management software program
- Hospital has initiated or plans to launch a patient portal within six months for its customers
- Hospital IT system provides for medical provider e-prescribing with pharmacies and others
- Hospital IT system has modules for population health management (trend and track data)

Population Health Forum

Poll Questions & Forum Topics

We use EHR data to drive change through:

a. **Quality of care outcomes**
b. **Understand our disease management**
c. **Determine readmissions (LACE)**
d. **None of the above**
e. **All of the above**

Identifying the Population(s)

- What patient data sets are available?
- What can your EHR query by diagnosis?
- Most at risk for disease progression
- Who are your high utilizers of care?
- Who are your frequent users in ED?
- Most at risk for hospitalization? Readmission?

Establish Criteria for Disease Registry

Asthma

- Age range? > 1 yr. old with at least (one of the following)
  - New diagnosis
  - Persistent rescue inhaler use
  - Needs education
  - > 2 ED visits in past 6 months
  - > 1 hospitalization as primary diagnosis in past 12 months
  - Considered risk population in community

Establish Criteria for Disease Registry

COPD or CHF

- Age range? > 18 yr. old with at least (one of the following)
  - New diagnosis
  - Medication management
  - Use of specialist for care
  - No office visit in past 6 months
  - Needs self management program
  - > 2 ED visits in past 3-4 months
  - > 1 hospitalization as primary diagnosis in past 6 months
  - Considered risk population in community

Thoughts

Questions to answer:

1. What factors affect a person's health? Community?
2. How should we assure care coordination across the continuum?
3. How do we engage individual's in their health and subsequently their care?
4. What types of staff and technologies do we need?
5. Are there community agencies that we need to partner with, and how do we begin those conversations?
6. Is creating an infrastructure important?
7. Are we using evidence-based protocols?
8. Are we using LACE to determine likelihood of readmission

Consider

- Patient Centered Medical Home Model of Care
- Team Based Care
- Motivational Interviewing Training
- Transition in Care Management
- Working with local nursing homes
- Managing discharges
- Determine quality metrics (MIPS)
- TeamSTEPPS for Office Setting
- High Reliability Organization Assessment
- CDSMP: Chronic Disease Self Management Program

Where We Started Quick Review

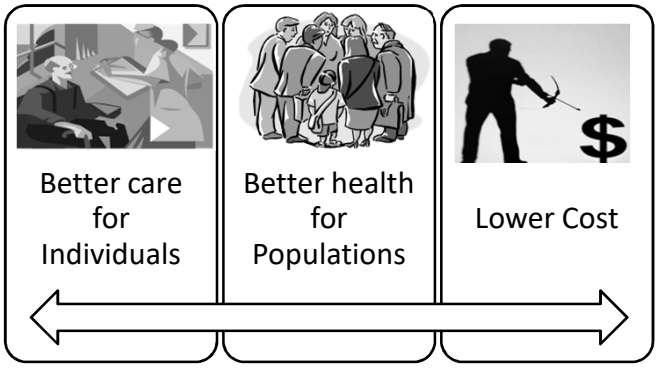
Six Specific Categories

- Governance and Leadership
- Operations
- Patient Care Management
- Population Health/Disease Management
- IT Infrastructure

Lesson Learned

- ✓ It may seem simple but change is hard
- ✓ Not everyone is engaged right from the start
- ✓ Ongoing communication is essential to success
- ✓ Ensure you have the right people at the table
- ✓ Understand current workflow before looking to improve

The Triple Aim



Assessing Hospital Preparedness for Transitions to Population Health

Learning Outcomes:
By the end of this presentation, you should be able to:

- Describe how care management fits into Population Health
- Identify starting point for building a Population Health Strategic Plan
- Identify current community resources available for your Population Health Program

Population Health Forum

Moderators:

Jimmy Lewis, Chief Executive Officer - HomeTown Health, LLC.

Dr. Angie Charlet, Director of Quality Services - Illinois Critical Access Hospital Network (ICAHN)