Population Health: Physician Perspective

Presentation objectives:
- Brief Bio
- Population Health – Brief Overview
- Population Health Management
- Examples:
  - CDC-ASTHO NYS Initiative on BP control
  - NYS DSRIP Program
Experience:
- General Pediatrician
- Medical Director – St. Peter’s Hospital outpatient network
- Chief Medical Officer – Whitney M. Young Health Services
- Physician Director – Asthma Coalition of the Capital Region
- Credentials Committee Member – Fidelis Care
- Past Board Member & Vice Chair – Hixny

Credentials:
- Diplomate: American Board of Pediatrics
- Certified Physician Executive: American Association for Physician Leadership
- Certification in H.I.T – University of Connecticut
- NCQA PCMH Certified Content Expert 2011-2013
Key Accomplishments:

- Implementation of Chronic Care Model – asthma, diabetes, HIV
- Establishment of the Asthma Coalition of the Capital Region
- Successful EMR implementation – 2007
- 3 School-based health centers - 2007
- NCQA - Diabetes recognition program 2012
- CDC-ASTHO Million Hearts HTN Learning Collaborative 2013-2014
Population Health:

Population Health:

• Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group
  – Geographic
  – Cultural or affinity
  – Employees or members

• Not just the overall health of a population but also the distribution of health

David Kindig: Health Affairs, 4/6/15
High blood pressure control among New York State adults participating in Medicaid Managed Care plans, 2010

![Bar chart showing blood pressure control by ethnicity.]

- White: 68%
- Black: 59%
- Hispanic: 69%
- Asian: 74%
- Other: 66%
Population Health

“Better care at lower cost for everyone everyday”

Jeffrey Brenner, MD, Camden Coalition
Why is Population Health Important?

• The state of a population’s health provides the foundation for its productivity, creativity, happiness, security and viability.

• US population health is not improving comparable to other developed nations, and in an increasing number of areas is stagnant or deteriorating.

• The rising cost of US health care is not sustainable and is the single biggest threat to the nation’s economic future.

Kenneth W. Kizer, MD, MPH
Why is Population Health Important?

When compared with the average of peer countries, Americans as a group fare worse in at least **nine** health areas:

1. Infant mortality and low birth weight
2. Injuries and homicides
3. Adolescent pregnancy and sexually transmitted infections
4. HIV and AIDS

*U.S. Health in International Perspective – IOM Brief 2013*
Why is Population Health Important?

When compared with the average of peer countries, Americans as a group fare worse in at least nine health areas:

5. Drug-related deaths
6. Obesity and diabetes
7. Heart disease
8. Chronic lung disease
9. Disability

U.S. Health in International Perspective – IOM Brief 2013
Why is Population Health Important?

• The primary business of health care today is managing chronic conditions, and the clinical course of most chronic conditions is influenced by poorly understood genetic factors and behavioral, social and environmental factors outside of medical care.
  – 75% of all health care expenditures are for managing chronic conditions
  – 40% of Medicare patients have 7 or more chronic conditions

• The cost of care is closely correlated with the number of chronic conditions.

Kenneth W. Kizer, MD, MPH
Factors Influencing Health:

Medical care is only one of many factors that affect outcomes

[Diagram showing the relative contributions of various factors to health and well-being]

- Social and Economic Factors: 10%
- Health Behaviors: 30%
- Clinical Care: 10%
- Physical Environment: 10%
- Genes and Biology: 40%
Why Are Americans So Unhealthy?

Multiple likely explanations for the U.S. health disadvantage:
• Health systems
  – Relatively large uninsured, underinsured
  – Limited access to primary care
• Health behaviors
  – Consume most calories per person
  – Higher rates of drug abuse
  – Higher traffic accidents that involve alcohol
  – Higher use of firearms in acts of violence

U.S. Health in International Perspective – IOM Brief 2013
Why Are Americans So Unhealthy?

Multiple likely explanations for the U.S. health disadvantage:

- Social and economic conditions
  - Higher levels of poverty, income inequality and less safety-net programs designed to buffer the negative health of poverty

- Physical environments
  - Communities and built-environment are more likely to be designed around automobiles

*U.S. Health in International Perspective – IOM Brief 2013*
Population Health Management:

- Practice based, proactive, patient-centric approach to health and healthcare that engages patients and clinicians in prevention, wellness, care coordination and care management.

- Successful PHM is a key means by which to achieve the “Triple Aim”:
  - Improving the patient experience.
  - Improving health outcomes.
  - Reducing the total cost of care.
Population Health Management (PHM):

Principles of PHM:

- Keep healthy customers healthy
- Help individuals with acute conditions get healthy
- Help individuals with chronic conditions manage their condition
Population Health Management:

Core Processes:

• Identify population of focus
• Define the appropriate care management program
• Design the program with input from clinicians
• Educate the clinicians & the staff on the programs
• Engage the patient
• Measure the performance and the success of PHM
Population Health Management:

Core Processes:

• Identify population of focus: 3 ways to find needy patients
  – Analytics
  – Sentinel events: hospitalizations, ED visits
  – Clinician referral

• Care management programs:
  – Disease specific or population specific

• Effective clinician & staff engagement

• Multi-channel, risk-based patient engagement strategies

• Implement a comprehensive performance improvement initiatives
Population Health Management:

**Technology:**
- Identify high-risk populations
- Identify outlying clinicians
- Identify effective interventions

**Application infrastructure to include:**
- Electronic health records
- Health Information Exchange (HIE)
- Analytics and Predictive Modeling
- Care management platform
- Personal health records, patient portals
- Telemedicine/Telehealth
- Automated outreach, patient registries
Population Health Initiatives:
Examples
Hypertension in New York State

NYS Million Hearts Learning Collaborative Team

Albany, NY
ASTHO Million Hearts Learning Collaborative Stakeholders’ Meeting
October 31, 2013
High blood pressure among New York State adults, by BRFSS survey year
High blood pressure prevalence among adults in New York State, 2011 BRFSS

![Bar chart showing high blood pressure prevalence among adults in New York State, 2011 BRFSS](chart.png)
Age-Adjusted Prevalence of Hypertension (Ages 18+) by County, New York State 2008-09
HIGH BLOOD PRESSURE IN NEW YORK STATE

Medication Use &
Actions to Control High Blood Pressure In Hypertensive Adults
Taking medication to control high blood pressure, BRFSS 2011

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### Controlling High Blood Pressure

**Commercial and Medicaid Managed Care Plans, 2012 NYS eQARR**

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<th>Average</th>
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<tr>
<td>National</td>
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<tr>
<td>NY Commercial HMO</td>
<td>66%</td>
<td>52%-74%</td>
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<tr>
<td>National</td>
<td>63%</td>
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<tr>
<td>NY PPO</td>
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<td>45%-74%</td>
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<tr>
<td>National</td>
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National average is based on 2012 report from the National Committee for Quality Assurance (NCQA).

Controlling HBP is a rotated measure in NY QARR; data presented reflect measures from 2010.
High blood pressure control among New York State adults participating in Medicaid Managed Care plans, 2010

![Bar chart showing high blood pressure control percentages by race in New York State adults in Medicaid Managed Care plans, 2010. The percentages are as follows: White 68%, Black 59%, Hispanic 69%, Asian 74%, Other 66%.]
BARRIERS TO HYPERTENSION CONTROL

• Lack of knowledge and awareness of hypertension
• Lack of access to primary and preventive health care in underserved communities
• Modifiable risk-factors pose challenge to manage (obesity, sedentary lifestyle, poor nutrition – high sodium consumption)
• Non-compliance with prescribed treatment due to cost, lack of follow-up, side effects
CDC-ASTHO
Million Hearts Collaborative 2013-2014

Whitney Young Jr. Health Services
### Million Hearts Project

- Collaboration with state and local partners to develop and implement clinical practice guidelines to create a “clinical pathway” that leverages team-based care and patient self-management to improve identification and clinical management of hypertension.

- The pathway targeted two patient groups:
  - Patients aged 18-85 with undiagnosed hypertension: two or more blood pressure measurements ≥140/90 at visits over the past 12 months, and no diagnosis of hypertension in their medical record.
  - Patients with a diagnosis of hypertension in their medical record but whose hypertension is uncontrolled.
Identification of Population of Focus

- Utilized i2i tracks registry to,
  - identify patients with uncontrolled and undiagnosed hypertension
  - generate lists of patients due for pre visit planning/ health educator visit scheduling/ post-visit telephone call by a clinician
  - generate lists of patients due for follow-up visits
Pre-visit planning

- Conducted “pre-visit planning calls” with patients scheduled to be seen during the following week.
- Purpose:
  - Decrease “no-show” rates,
  - Increase patient engagement in hypertension management
  - Gather information such as medication lists
Clinical System Improvements:

- Development and Implementation of evidence-based adult hypertension treatment guidelines to establish standardized clinical management for all diagnosed patients.
- Improving accuracy of office-based blood pressure measurements through staff training, and ensuring appropriate equipment is available in each room.
- Patient education on hypertension self-management.
- Patient training on proper use of home blood pressure monitors.
- Post-visit calls with patients to support self-management and medication adherence.
Whitney Young HC – Blood Pressure Control

[Graph showing percentage of blood pressure control from 2009 to 2014 with specific percentages marked for each year: 48% in 2009, 52% in 2010, 44% in 2011, 69% in 2012, 56% in 2013, and 71% in 2014. The graph also includes a linear trend line labeled "Linear (WMY data)".]
NYS Delivery System Reform Incentive Payment (DSRIP) Program
NYS DSRIP

• The NYS Delivery System Reform Incentive Payment (DSRIP) Program is a NYS Medicaid incentive payment model that rewards providers for performance on delivery system transformation projects that improve care for low-income patients.

• Funded federally, shifts hospital supplemental payments from paying for coverage to paying for improvement efforts.

• Federal initiative: CMS has approved 7 programs to date

• Built upon Performing Provider Systems (PPS), regional groups of hospitals, primary care providers and community based organizations.

Center for Health Care Strategies - 2014
AMCH Performing Provider System (PPS)

- Comprised of health care, social service providers, and community-based organizations across the continuum of care

- Committed to;
  - improving the health of Medicaid and uninsured populations
  - transforming the current health care delivery system to a patient-centered, effective, transparent, collaborative, and value driven system of care.

- Partnership with more than 175 community healthcare providers covering Albany, Columbia, Greene, Saratoga and Warren Counties.
AMCH Performing Provider System

• Center for Health Systems Transformation
  – Executive Sponsor: Ferdinand J. Venditti Jr., MD
  – Executive Director: George Clifford, Ph.D.
  – Medical Director: Kallanna Manjunath MD

• 11 projects in three broad categories:
  – System Transformation
  – Clinical Improvement
  – Population Health Management
AMCH PPS: Key Project Activities

11 projects in three broad categories:

• System Transformation – 5
• Clinical Improvement – 4
• Population Health Management – 2
AMCH PPS: List of Projects

**System Transformation:**

1. **Create an Integrated Delivery System** focused on Evidence-Based Medicine and Population Health Management
2. **Health Home At-Risk Intervention Program:** Proactive Management of Higher Risk Patients Not Currently Eligible for Health Homes
3. **Create a Medical Village/Alternative Housing** Using Existing Nursing Home Infrastructure
4. **ED Care Triage** for At-Risk Populations
5. **Implementation of Patient Activation Activities** to Engage, Educate and Integrate the UI and LU/NU populations into Community Based Care
AMCH PPS: List of Projects

Clinical Improvement:

6. Integration of Primary Care and Behavioral Health Services
   – embedding behavioral health staff in primary care sites
   – establishing new care management capabilities in primary care sites

7. Behavioral Health Community Crisis Stabilization Services

8. Implementation of evidence-based best practices/guidelines for Adults with cardiovascular conditions – Million Hearts

9. Implementation of evidence-based best practices/guidelines for Asthma Management: 2 - 64 years of age
AMCH PPS: List of Projects

Population Health Management:

10. Promote tobacco use cessation, especially among low SES populations and those with poor mental health

11. Cancer prevention: Increase screening rates for:
   – colorectal cancer
   – breast cancer
   – cervical cancer
Better Care
Less Cost

- Patient-Centered Medical Home
- Behavioral Health Integration

- Clinical Protocols & Care Management

- Care Transitions

- Patient & Population Engagement

Health Care Workforce
Information Technology & Clinical Information Systems
Payment Reform
Integrated Delivery System
DSRIP – Personal Perspectives

• A unique, unprecedented opportunity;
  – for **physicians and other clinical staff to lead** a regional effort to improve the quality of life for historically under-served communities.
  – to redesign care delivery system and enhance the quality of life for our patients.
  – to create a system of care to enhance **patient, clinician and staff satisfaction**.
  – to receive financial incentives for better performance.
  – to reduce the cost of care.
  – to prepare us for the anticipated value-based payment model.

• Adjectives used to describe DSRIP – “nerve-racking, challenging, enormous, daunting, exciting”!
Summary:

Population Health:

- Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group.
- The rising cost of US health care is not sustainable and is the single biggest threat to the nation’s economic future.
- Medical care is only one of many factors that affect outcomes.
- Successful PHM is a key means by which to achieve the “Triple Aim.”
- Technology is the means to identify high-risk populations, outlying clinicians and effective interventions.
- Principles of PHM: Keep healthy customers healthy, help individuals with acute conditions get healthy, help individuals with chronic conditions manage their condition.
Thank you!