



Population Health Data Management

Based on the CMSA Standards of Practice for Case Management

Today's Presenter

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Population Health Data Management

Based on the CMSA Standards of Practice for Case Management

OBJECTIVES

At the conclusion of this presentation, the participant will be able to:

- Review of population health
- Review of a registry
- Examine pre-screening processes
- Application to work

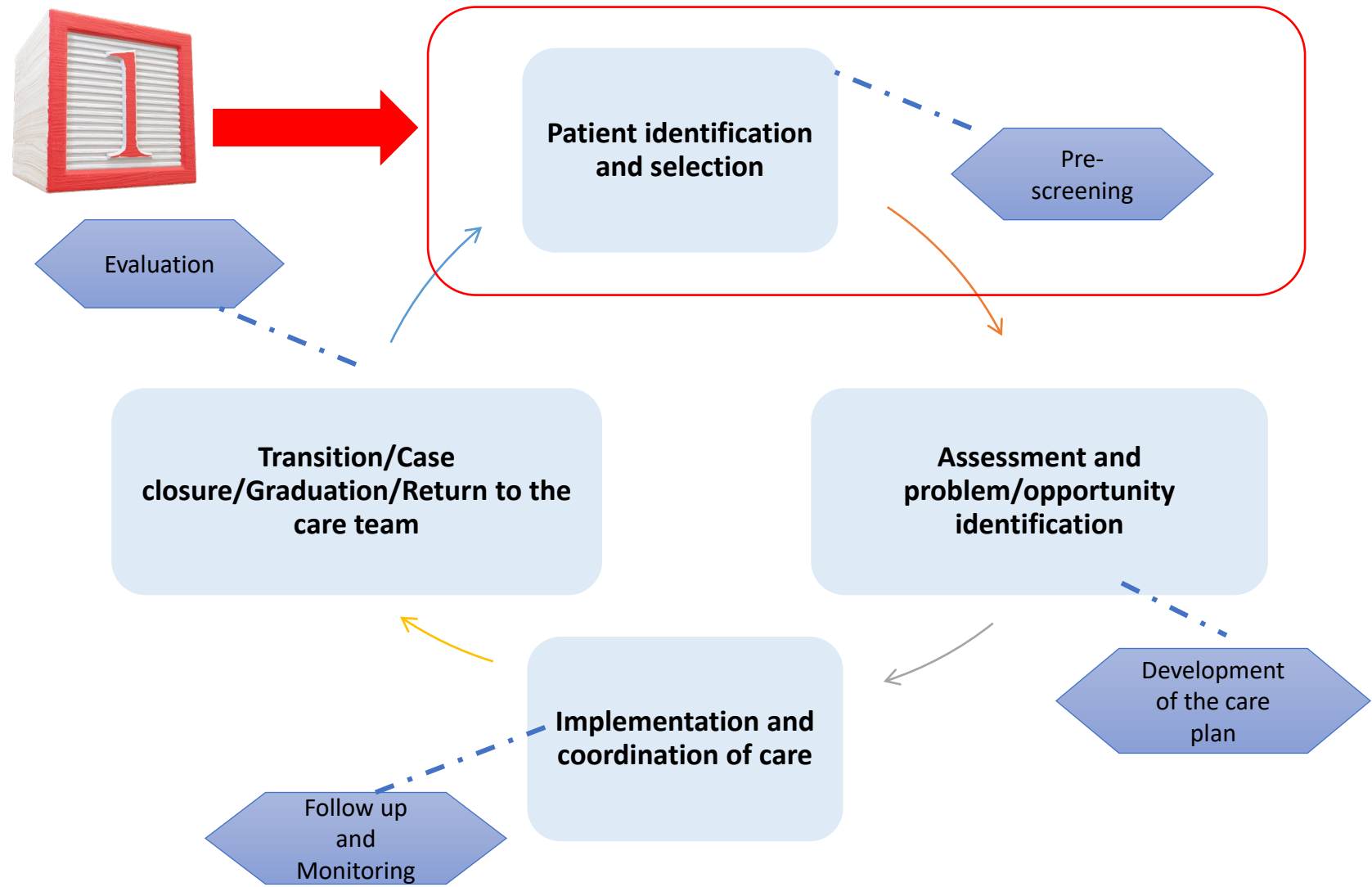


Disclosure

MI-CCSI, or the presenter, does not have any financial interest, relationships, or other potential conflicts, with respect to the material which will be covered in this presentation.

Case Management

It's A Process

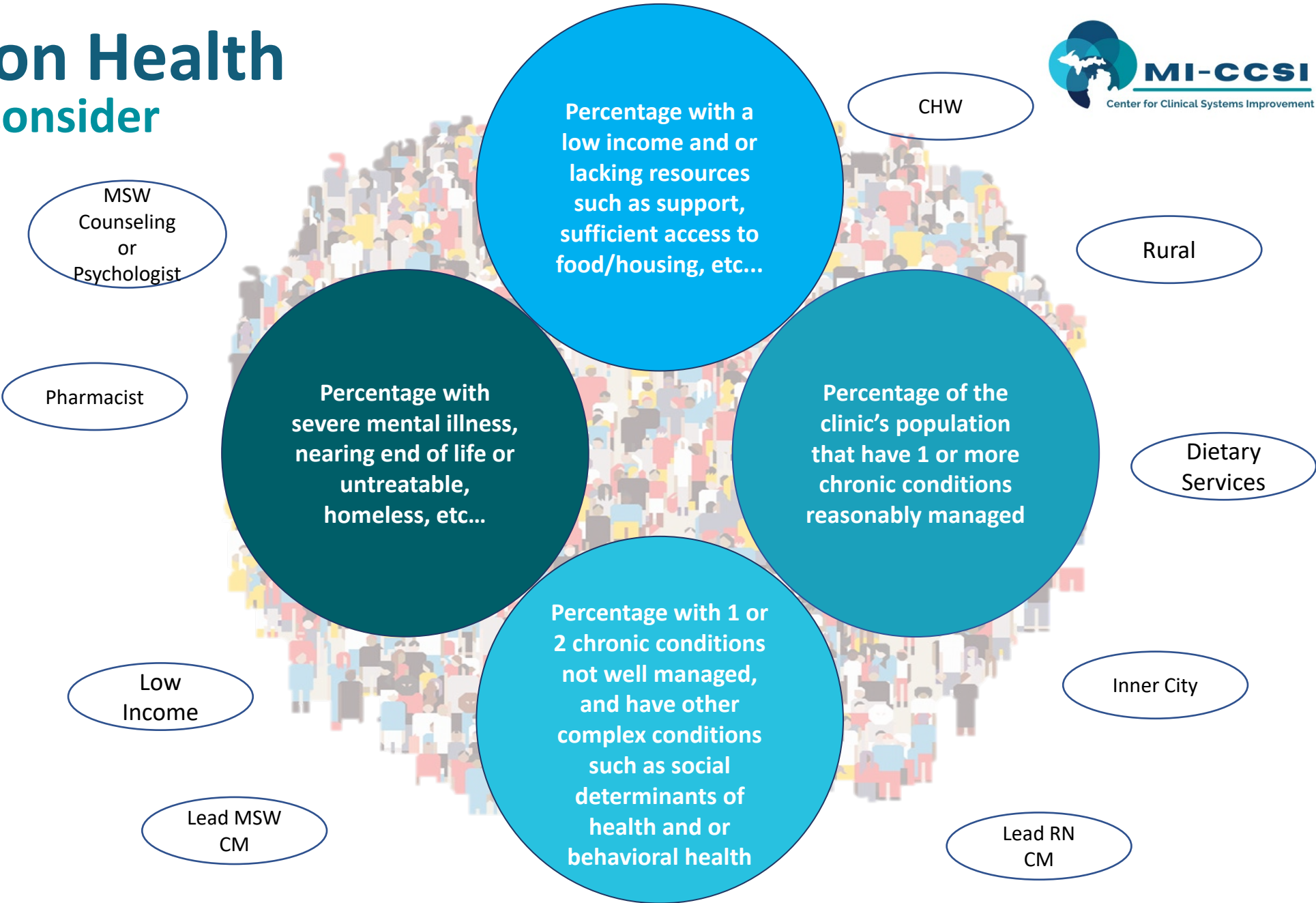


Population Health

Factors to Consider



Aligning the
clinic
population
needs with
the available
services in
the clinic



Practice Setting Considerations

Population Management – Who we serve



Reimbursement Method – How we get paid



Team Structure and available healthcare disciplines (RN, MSW, NP's) – Who is on the team



Care Setting (PCP practice, specialist, safety net) – What is the structure (centralized, independent, system, etc.)

COMPLEXITY

Medical

Diagnosis
Co-morbidity
Targets

Behavioral

Screening
Conditions treated
Approach
Collaborative
Co-location
Referral

Determinants of health

Barriers to better health

Utilizing community resources

Resources in the clinic

Determining who will be targeted for CM Services

Population Health Management

Goal of Population Health Management: Keep a patient population as healthy as possible, minimizing the need for expensive interventions such as emergency department visits, hospitalizations, imaging tests, and procedures.

- Focus on
 - High risk patients who generate the majority of health costs
 - Systematically addressing the preventive and chronic patient



Population-Based Care

- Goal: Maximize the health outcomes of a defined population
- Efforts are made to assure that all relevant members of a population receive needed services
- Use registry for *planning* office visits and patient outreach



Adapted from Improving Chronic Illness Care; www.improvingchroniccare.org

Population Management

Essential Infrastructure



Integrated registries aggregate clinics patient registries to maintain a current, accurate list of population served.



Use the integrated registry to identify the population served, support performance measurement, outreach, information sharing and process management across providers.



Supports care processes that cross provider boundaries (PCP, ED, specialists, facilities, laboratories, etc.) Sharing information includes assuring that it flows into the care process and the medical record.

Registry Goal

Goal: Enable providers to manage their patients both at the population level and at point of care through use of a comprehensive patient registry.

- Improve patient outcomes
 - Close gaps in care
- Report the practices quality metrics
 - Monitor the population level performance over time of the practice and physician organization



Patient Registry

Definition:

- A database that enables population-level management
- Generating point of care information
- Allows providers to view patterns of care and gaps in care across their patient population

A registry contains several dimensions of clinical data on patients to enable providers to manage their population of patients.

Registry Features

- Provides access to lab data, test results, and across settings in your system
- Guidelines and prompts are included for needed services
- Identify populations and subpopulations of patients



Adapted from Improving Chronic Illness Care; www.improvingchroniccare.org

Registry Features

- Allows stratification of patients
 - complexity, disease severity for care management services
- Captures all critical clinical information
- Captures outcomes by practice, physician



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Use of the Registry

- Create population-specific reports
- Facilitate external reporting requirements
- Create dashboard reports of the practice as a whole
 - Quality metric reports – to identify benchmarks and performance of the practice with meeting the identified goals
 - How is the practice doing with closing the gaps in care?



Adapted from Improving Chronic Illness Care; www.improvingchroniccare.org

A registry typically has electronic prompts which are designed to support evidence-based patient care

Prompts can be delivered:

- At the time of visit
- Through population reports
- Via exception reports
 - subset of patients requiring active management with particular chronic illness management needs



Adapted from Improving Chronic Illness Care; www.improvingchroniccare.org

Sample Registry Report

PO	Practice	Provider	MRN	Name	A1C >8	New this Month	Last A1C Date	Last A1C
					A1C>8	*NEW	2014-04-03	9.5
					A1C>8	*NEW	2014-04-23	10.1
					no	*NEW	2014-10-17	6.4
					no	*NEW	2014-04-09	7.4
					A1C>8	*NEW	2014-08-09	8.4
					A1C>8	*NEW	2014-09-19	8.9
					A1C>8	*New	2014-09-26	10.7



ACTIVITY

- What chronic conditions is CMHCM focusing on?
- For these conditions what metrics would be monitored?
- From this population, which patients would have actions to follow up on?
- Who on the team will do this?
- How and who communicates that?



Population Health

One Person At A Time

Pre-screening

- Most current data
 - Sources
 - Medical Record, Primary Care, inpatient and specialist
 - Registry or EMR registry like reports
 - Payer reports
- Provider input and approval
 - Sources
 - PCP, Specialist, and other care team members
- Patient & Care Giver Interview
 - Patient knowledge of disease/situation
 - Most up-to-date information
 - Desire to work with the care manager
 - Participate in self-management
 - Willingness
 - Ability

Use of the Registry

- Establish and implement processes using registry data
 - identify and reach out to patients with chronic conditions
 - due for tests, services
 - out of control parameters
 - to identify patients due for preventive services
 - conduct pre-visit planning
- Close care gaps



Adapted from Improving Chronic Illness Care; www.improvingchroniccare.org

Gaps in Care

- Use registry reports to identify gaps
 - including both prevention and chronic disease gaps
- The evidence - based care guidelines are incorporated in the registry
 - ex. Standard of care = Patient with diabetes has an A1C every 6 months



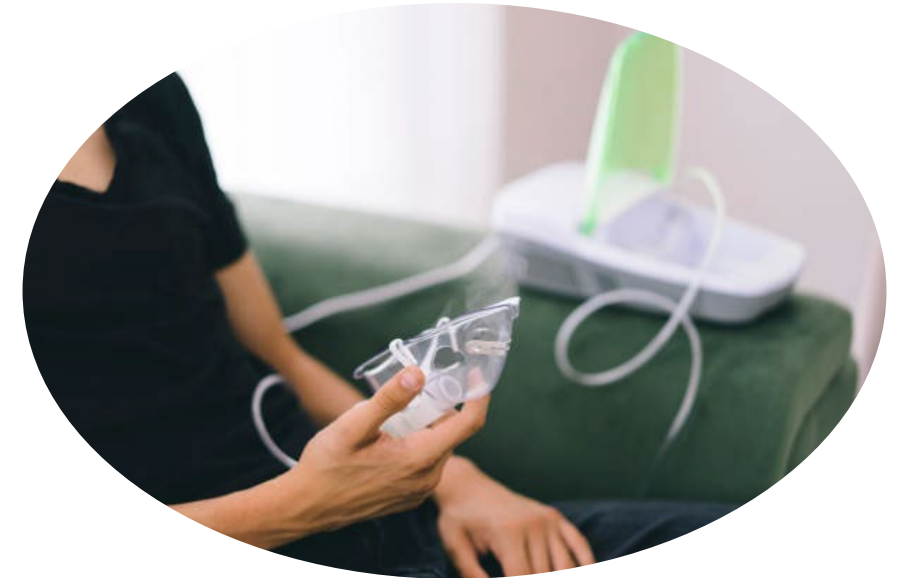
Case Study

Population health, Use of the registry, Pre-screening

Background: 18-year-old young man, Felix, diagnosed with Asthma, recently in ER, admitting diagnosis was recurrent exacerbation of asthma. Given treatment and sent home.

Felix plays soccer, based on the ER notes, he was not using his rescue inhaler, and has a dog that he reported he sleeps with.

Felix also has been diagnosed with bipolar disorder in the last year. He has an appointment with the psychiatrist tomorrow afternoon after school.



Case Study

Population health, Use of the registry, Pre-screening



Population Health:

- Why would Felix show up on the population health report?
- What tool would you use to identify Felix?
- What key information would you review from the tool?

Pre-screening actions:

- What other sources of information would be helpful to have available prior to the visit?
- What gaps would you inquire on?
- What information would be helpful to secure directly from Felix and if in agreement with his family?
- Who on the team will do this?



Q & A