Getting Started in Population Health in Primary Care Settings

Breakout A2

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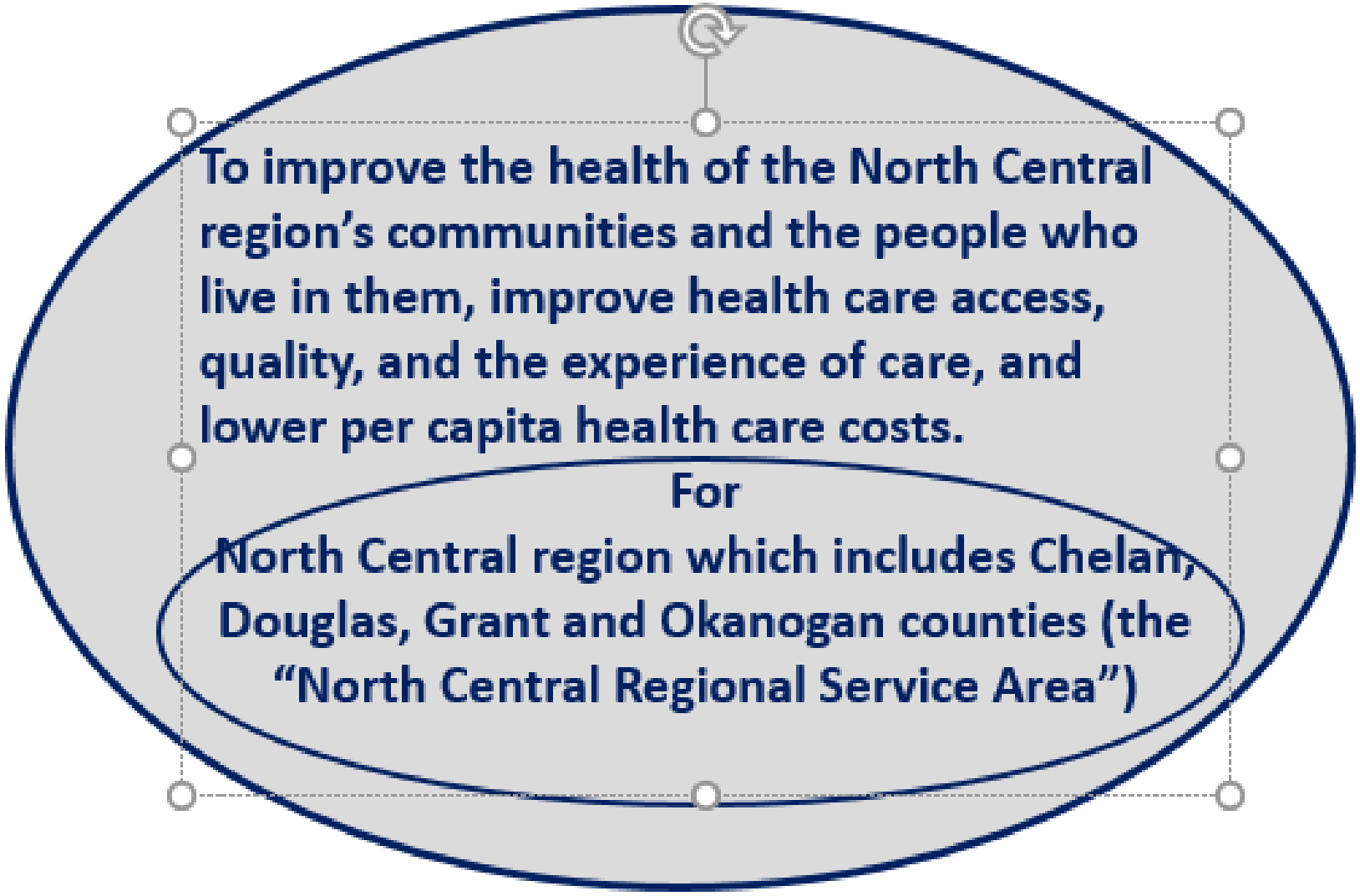
October 4, 2019

Objectives

- Define and Discuss Population Health Management and Primary Care
- Surface what you are already doing
- Identify your areas for improvement work in Population Health LAN

NCACH Mission and Population



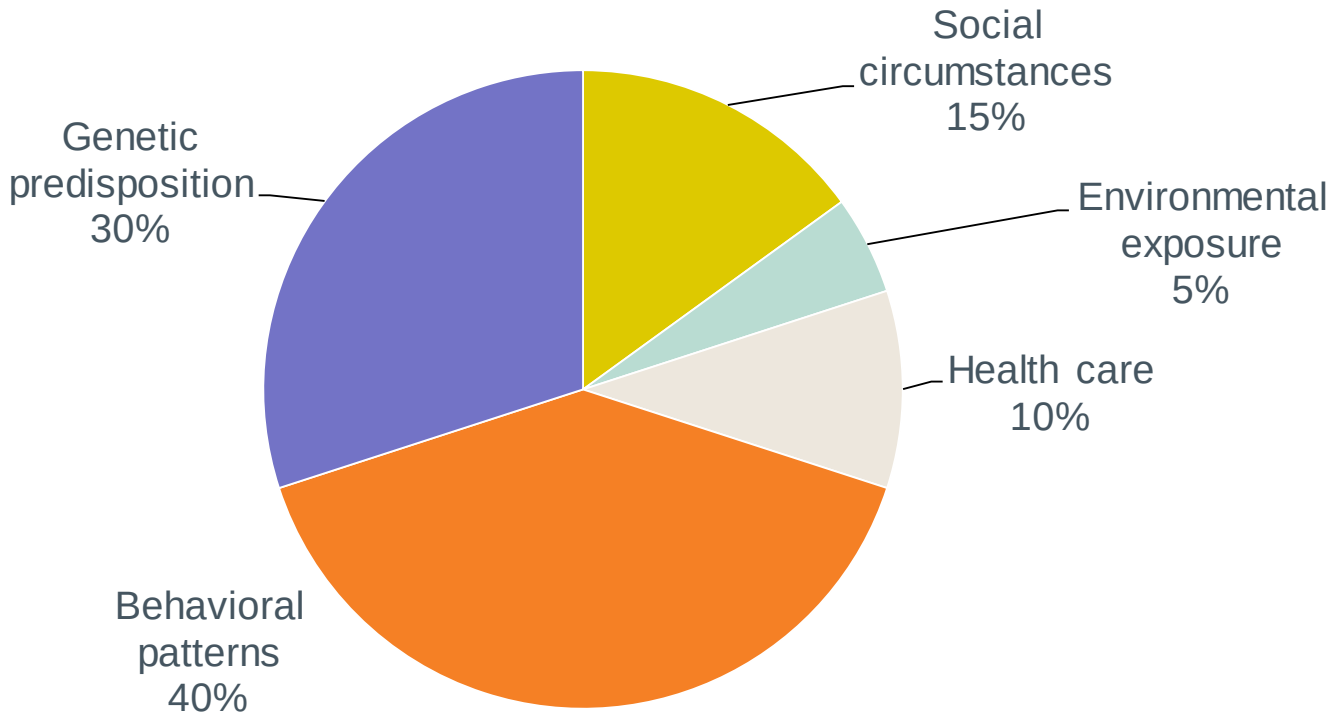
Definition: Population Health

"Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group."

-David Kindig, MD, PhD

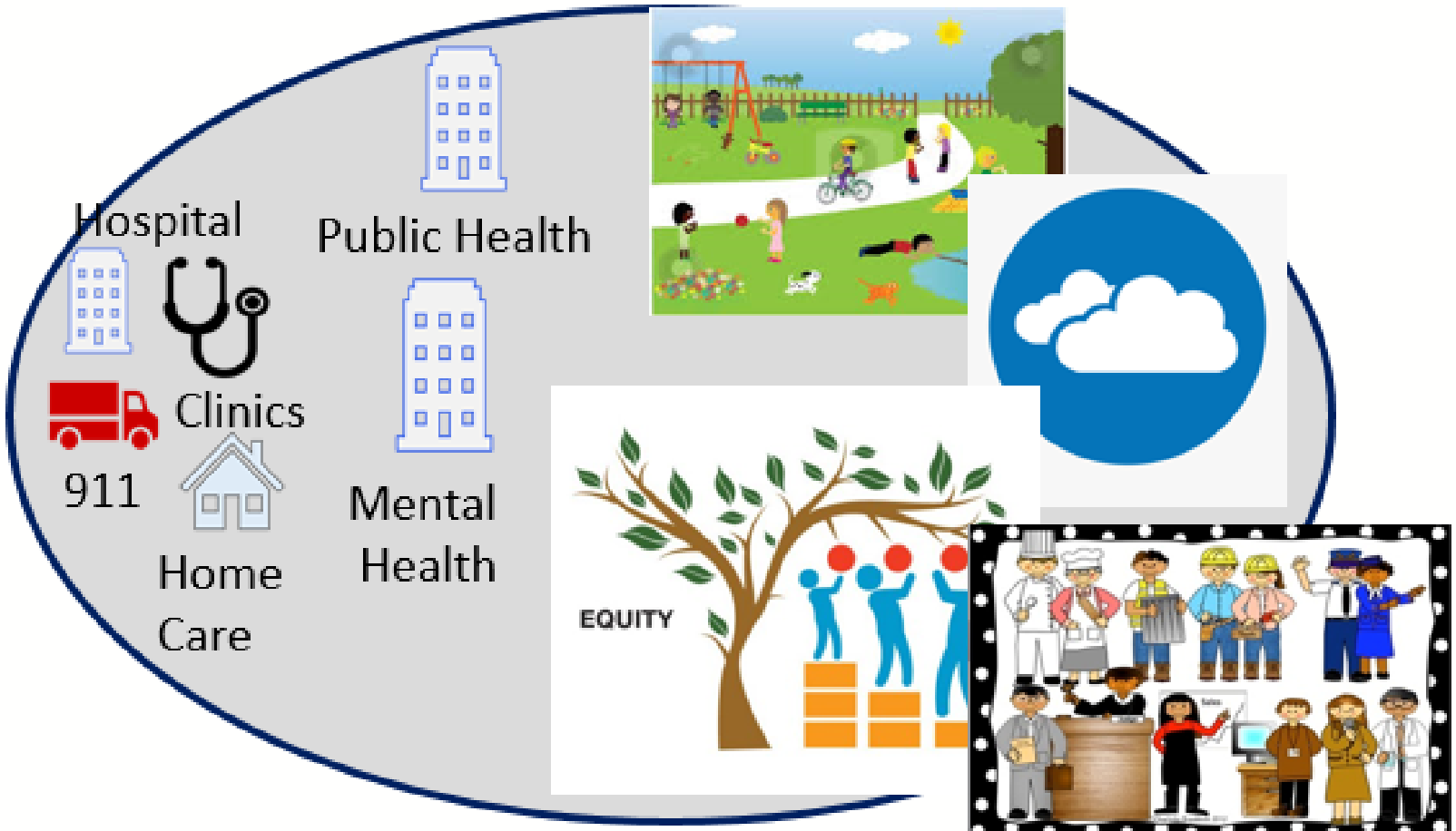
David Kindig and Greg Stoddart. What Is Population Health? American Journal of Public Health March 2003: Vol. 93, No. 3, pp. 380-383. Kindig and Greg Stoddart. What Is Population Health? American Journal of Public Health March

Determinants of Health and Their Contribution to Premature Death

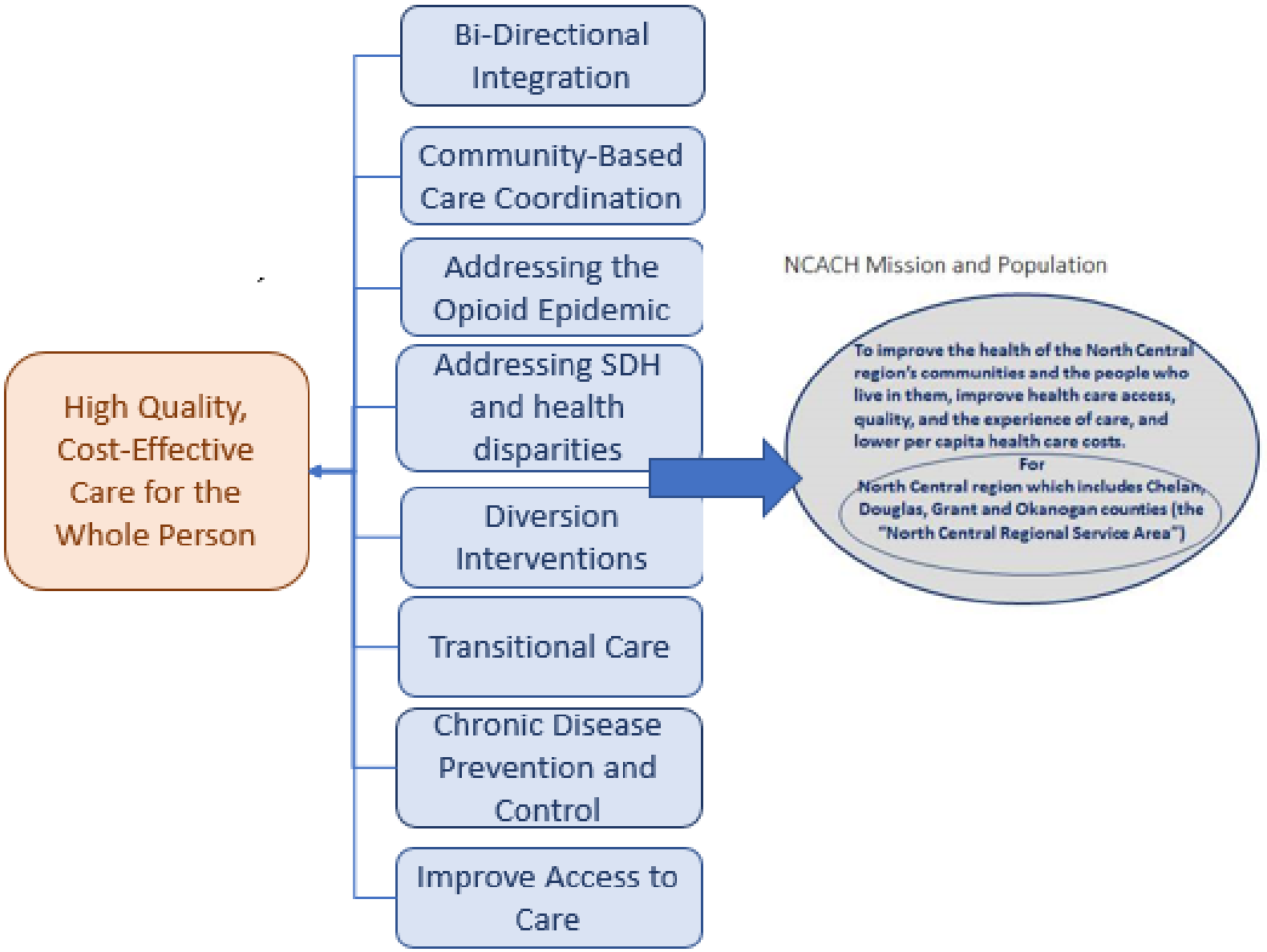


Adapted from: McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Aff (Millwood) 2002;21(2):78-93.

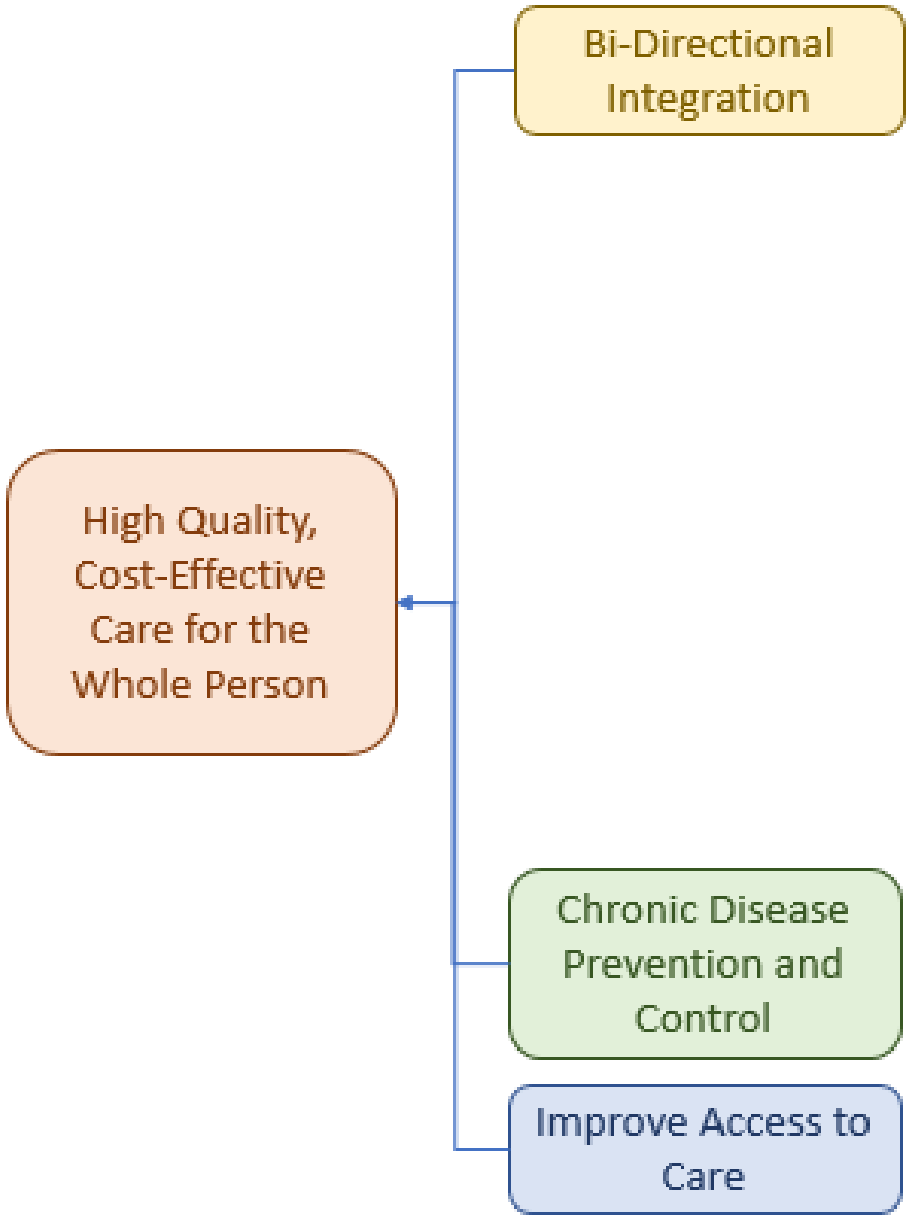
Levers- Change Concepts You Can Use to Influence Access



NACHC Changes



Population Health LAN



DEFINITION:
Population Management

The design, delivery, coordination, and payment of services for a defined group of people to achieve specified cost, quality and health outcomes for that group of people.

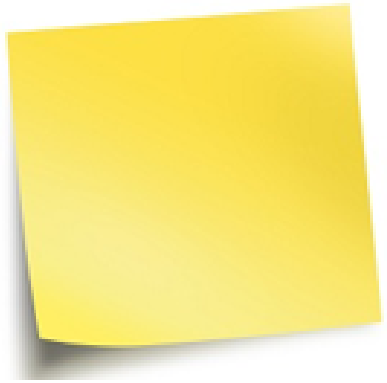
Lewis, Ninon. "Populations, Population Health, and the Evolution of Population Management: Making Sense of the Terminology in US Health Care Today." *IHI Leadership Blog*. Institute for Healthcare Improvement, 19 Mar. 2014.

System Design that Supports Pop Health Management in PC

We can say	Key Element	Population Health
Partnering with patients to thrive is at the core of our work.	Self-management support	Efficiency and effectiveness
We provide care and roles are optimized and distributed.	Team-based care	Roles crafted to meet the needs
We know the patients for whom we are responsible.	Empanelment	Accountability and support
We see our patients.	Continuity	Decreased demand and increased health
We have processes to achieve our daily, weekly and seasonal work.	Supply=demand	Increase access
We know how each of our patients are doing on key clinical outcomes and activities.	Registry	Knowledge on POF and data driven
We are prepared to meet patients needs in or out of the office visit.	Pre-visit planning proactive care outreach	We are designed to impact the POF

What are you already doing?

- Take a minute and write down what you are already doing from the previous list.
- One activity per sticky note.
- Include the name of your clinic.
- When ready, put each sticky note on the flip chart paper under that item.



How does it help you with your population health management?

Challenges and Questions

- By yourself jot down (1 minute):
  - What are the challenges you face around population health?
  - Where would you like to focus your efforts?
- Pair up and share your thoughts (2 minutes):
  - What is similar?
  - What is unique?
- In groups of 4 (4 minutes):
  - Identify common themes and questions.
- Round Robin Report Out: Share one important theme that surfaced.

Helpful next steps

Examples of Alternative Visit Types

- Group Visits
- DIGMA (Drop In Group Medical Appointment)
- Pharmacist visit
- Nurse visit
- Community Health Worker/Promotors
- Peer advisors
- Social Workers visit
- At home visit
- EMS visit
- Telehealth

Group Visit Example

100 Diabetes Patients- Traditional

- Protocol 4 visits a year
- 400 visits needed
- $100 reimbursement
- 10% No shows
- 360 Net due to no-shows
- $36,000 in revenue
- -$4,000 lost revenue plus ancillary services

100 Diabetes Patients- Group Visit

- Protocol of 10 patients in a group visit.
- Need 40 Group Visits/Year
- 360 new slots opened
- $36,000 revenue from cohort
- $36,000 new revenue - $3,600 for now shows- $32,400
- Net $68,400