A Two-Part Webinar:

DSRIP and Population Health

Introduction

DSRIP and Information Technology to Support Population Health

November 2014
Agenda: Introduction to Population Health

1. Population Health Defined
2. DSRIP and population-based care
3. Key components of population-based care
4. Key considerations for PPS networks
Population health is “the health outcomes of a group of individuals, including the distribution of such outcomes within the group”. Medical care is one factor among many.

Population health management refers to the variety of individual, organizational and societal interventions to integrate healthcare, public health and socio-environmental determinants of health to improve health outcomes of a defined group of individuals.
Population Health Management

Population Health Continuum

Utilization Management Identifies Individuals Along Entire Continuum

Clinical Risk Profiling Continuously Monitors Individuals Along Entire Continuum

Without intervention, individuals can escalate into higher-risk categories

Well  At Risk  Chronic Illness  Catastrophic

Applied interventions move participants towards greater health

Prevention  Integrated Care Management

Wellness and Lifestyle Management

To thrive in the new value-based environment, PPSs must become high performing organizations, working together across the community, to provide a seamless continuum of coordinated, patient or “person-centered” services that are population health focused including:

- Transformation of the health care safety net at the system and state levels with near-term support for safety net providers
- Effective, safe, person-centered, timely, efficient, equitable and coordinated care
- Universal participation across the continuum
- Continuous improvement based on measurable outcomes
- The system has the “right tools” to provide a population health focus including:
  - Infrastructure
  - Personnel
  - Payment reform
  - Information Technology
Projects that specifically focus on population health include, but are not limited to Domain 4:

- 2.a.i. - Integrated Delivery System Using an Evidence-based and Population-based approach
- 2.a.iv. - Create a Medical Village Using Existing Hospital Infrastructure
- 2.b.iii. - ED Care Triage for At-Risk Populations
- 2.c.i. - To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently
- 3.a.i - Integration of Primary Care and Behavioral Health Services
- 3.b.i. - Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only)
- 3.f.i. - Increase Support Programs for Maternal and Child Health (Including High Risk Pregnancies)
- 4.a.ii. - Prevent SA and other mental emotional disorders
- 4.a.iii. - Strengthen mental health substance abuse infrastructure
- 4.b.i. - Promote tobacco cessation
- 4.c.i. - Decrease HIV morbidity
- 4.c.ii. - Increase early access to, and retention in, HIV care
- 4.v.iii. - Decrease STD morbidity
- 4.c.iv. - Decrease HIV and STD disparities
- 4.a.i. - Promote mental, emotional, and behavioral (MEB) well-being in communities
- 4.b.ii. - Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings (Focus Area 3)
- 4.d.i. - Reduce premature births
DSRIP and Population Health Management: Key Components

NYS Prevention Agenda: Patient focus on wellness, disease and chronic care management programs

- Prevent Chronic Diseases Action Plan
- Promote a Healthy and Save Environment Action Plan
- Promote Healthy Women, Infants and Children Action Plan
- Promote Mental Health and Prevent Substance Abuse Action Plan
- Prevent HIV, STDs, Vaccine-Prevent able Diseases and Healthcare Associated Infections
These components are integral to the DSRIP projects including Domains 2, 3 and 4.

These components or strategies will help your PPS achieve improved population health outcomes and cost-effectiveness.
DSRIP and Population Health Management: Key Components (cont)

“Patient-Centered” vs. “Person Centered”

— Central to DSRIP is the consumer and their family

— Culturally, linguistically and ethnically appropriate care
  ▪ Recognizes cultural, racial, ethnic and linguistic needs and preferences
  ▪ Focus on education that promotes self-care
  ▪ Holistic approach that considers the complete needs of the patient – medical, behavioral and psychosocial – and meets them “where they are”
Key Components of Population Based Care Delivery

“Infrastructure and System-ness”

Infrastructure to support the central care delivery and leadership role of the PPS, providers and community-based supports

- Governance consistent with DSRIP requirements
  - “System-ness” refers to how well the components of a system, collectively perform in achieving a common purpose
  - The full continuum of care is addressed

- The PPS is structured to meet the needs of all populations and sub-populations
  - Evidence-based protocols
  - Data
  - Care Management
  - Administration
  - Promotion of best practices
  - Personnel
  - Training
  - Financial Management

- Has the PPS identified the right scale and speed to serve the greatest percentage of the population in areas (or for diagnoses) where the approach makes sense?
Determinants of Population Health

To achieve improvement in health outcomes and lower hospital use at the system and state level, PPSs will need to focus on population health with starting point to understand

- Population segment size and location
- Age Mix-Gender Mix
- Racial and Ethnicity Mix
- Previously Insured or Not (private or public coverage)
- Disease Load and Healthcare Utilization Experience
- Mix of Chronic vs. Acute Conditions (e.g. Diabetes and its complications, COPD, Heart Failure, Cancers vs. Injuries, Infections, Self-Limiting Conditions)
- Behavioral Health Conditions
- Relative Severity of Illness (driving the types and levels of interventions and care settings)
Use the **Community Needs Assessment (CNA)** to select the highest priority DSRIP projects based on population needs

- Use broad data sources: Data books on the DOH website; regional results for metrics that will be utilized to assess PPS outcomes; LHD CNAs in conjunction with the NYS Prevention Agenda (full population)
- Identify and characterize health care resources
- Identify the main health and health service challenges facing the community
- Describe the relationship between the assessment and the projects selected?

*The ability to clearly justify your population-based (and all other) DSRIP projects using data from your CNA accounts for a significant portion of the total possible points for each project.*
## Community Need Identification #

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<tr>
<th>CNA Title</th>
<th>Brief Description</th>
<th>Supporting Data</th>
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| CNA 18: High Diabetes   | High diabetes prevalence                                                          | • Diabetes rate is higher in Suffolk (11%) than statewide (9.7%).  
• Among the Target Population, it’s 15.7%                                                                                                       |
| Limited EHR linkages    | Providers are unable to share patient information due to limited interconnectivity, limiting the PPS’s ability to deliver a population based approach | While some providers have joined RHIOs, they do not currently comply with state standards for information sharing as currently being developed.  
Survey of PPS members indicates that:  
• 40 different EMRs are in use  
• 63% are not connected to a RHIO  
• 60% don’t or can’t do clinical data exchange at this time  
• 8% don’t or can’t do data exchange of Charge data  
• One facility reported no access to Internet |
Engagement and Outreach of Populations Identified

How do you outreach and engage Medicaid consumers?

— Outreach
  - Direct communications with the member (e.g. F2F, mail, electronic or telephonic using claim or referral data)
  - Escalation if the member doesn’t respond (e.g. letters to follow calls if no contact is made)

— Meet them “where they are”
  - “No wrong door”
  - Homeless individuals
  - In the community
  - Using motivational coaching
Data-Driven Quality Measurement and Improvement

- Data must be aggregated across the population
- Data must be risk stratified to inform population needs
- Data is shared on population-based outcomes at the aggregate level, at the group level and for individual provider outcomes
- Data is stratified: by chronic condition (e.g. Serious Mental Illness + X co-morbid conditions; by race, ethnicity and primary language, by income strata)
- Data informs population health (e.g. gaps in care, outreach, registries) to identify opportunities to close gaps and improve quality overall
- The system values continuous learning and benchmarking of results; “defects” are seen as opportunities
Key Components of Population Based Care Delivery (cont)

Care Management and Care Coordination

• Multidisciplinary approach across the full population and the full continuum to:
  — Identify and track (e.g. Advanced Population Analytics, risk stratification, patient registries)
  — Outreach (e.g. automated, telephonic and in-person)
  — Assess needs (e.g. evidence-based assessment tools)
  — Plan for care delivery (e.g. electronic care plans)
  — Deliver care (e.g. using shared Electronic Health Records, patient and provider portals, remote patient monitoring, telemedicine, referral tracking)
  — Evaluate outcomes

• Some key elements of a population-based approach include:
  — Ability to address complex multi-morbid needs
  — Motivational interviewing/Health coaching and self-care
  — Shared decision-making
  — Single plan of care across settings and providers including non-medical supports and community-based care
Key Components of Population Based Care Delivery (cont)

Value-based Payment Practice Will Drive Performance
Evidence-Based Protocols and Best Practices

Practical decisions made should: (1) be based on research studies and (2) that these research studies are selected and interpreted according to some specific norms characteristic for EBP. Typically such norms consider **quantitative** studies according to a narrow set of criteria of what counts as **evidence**.

- Take a population-based approach and consider consumer needs
- Consider racial, ethnic and linguistic adaptations
- Seek out best practices nationally with data behind them
- Design adaptations and implementation strategies with your providers to achieve buy-in and identify champions
Key Components of Population Based Care Delivery (cont)

Information Technology to identify, track and inform providers re: performance

— Meaningful Use IT, rigorous analysis and evidence-based assessment Aids in clinical decision-making support patient care, improved safety and prescribing patterns

— Tools and technology that support sharing of information are highly valued:
  - Electronic Health Records (EHR)
  - Patient Registries
  - Health Information Exchange (HIE)
  - Risk stratification tools
  - Automated outreach
  - Patient and provider portals
  - Remote patient monitoring
  - Advanced population analytics
  - Telehealth/telemedicine
  - Referral tracking
DSRIP Application Guidance

• Understand population health needs based on Community Needs Assessment data
• Respond to the specific requirements for each project with an eye toward population health
• Describe *how and what* your PPS will do – don’t just say you will meet the requirements
• Answer the question with an eye toward population health – no more and no less
• Participate in a webinar on IT and Population Health by the DSRIP Support Team, available shortly
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