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Population Health Improvement Projects: Lessons Learned from the Field

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Definition of Total Population Health (Adapted from NY Academy of Medicine)

- Improving total population health means improving the health and wellbeing of all people in a population within a given geographic area while eliminating health inequities.
- Substantive partnerships with communities, and across sectors affecting health (including but not limited to public health, health care, housing, education, and social services), as well as shared responsibility/accountability and supportive financing models, are required to achieving these goals.
- Health system reform efforts will continue to focus on outcomes improvement of populations receiving clinical care within identified systems and/or insured by specific programs, but it is important to align these "enrollee" and "panel" population health efforts with broader initiatives to achieve "total" population health.

Population health management is essential …..

- as a component for practice transformation to advanced primary care;
- for delivering and documenting value-based primary care;
- to promote sustainability in evolving/devolving health reform initiatives at national and state levels.

Core Domains of Population Health for Community Health Centers

- Population Identification
- Assessment of major social determinants of health - including social environment, physical environment, availability of health services, and economic circumstances - for target population
- Risk Assessment
- Stratification of target population according to risk
- Engagement of target population & Community Partners
- Patient Centered Interactions
- Impact Evaluation & Quality Improvement

Aims of the RCHN CHF Population Health Initiative

- To support community health centers in fulfilling mission as a provider of comprehensive primary care and agent of positive change for at-risk populations & communities
- To support health center-level progress toward improving population health management capacity and outcomes
  - Strengthen capacity to identify, engage and manage health in a defined population
  - Deepen features of patient- and community- centered health home
  - Influence social determinants of health
  - Encourage local and regional collaborations and broader opportunities for sharing best practices

Program Logic Model (1)

- *Assumption*: Holistic approach to population health management that addresses social determinants of health is necessary for achieving and sustaining health outcomes while demonstrating value for patients, policy makers and payers.

- *Issue*: Health centers require strong leadership, additional capacity, effective partnerships and appropriate resources for population health management

- *Community Needs & Assets*: Although high-risk patient populations and capacity gaps pose significant challenges, health center capabilities and other local/state or national assets and partnerships need to be recognized and used to their fullest

Program Logic Model (2)

- ***Desired results***:
  - Participating organizations successfully identify and engage an at-risk target population and apply interventions that strengthen local partnerships and address social determinants of health, leading to improved health processes and outcomes.
  - Health centers then expand population health management that address social determinants of health to additional patient populations and additional social determinants

- ***Strategies***: With grant support and TA, participants identify and develop interventions, practices and partnerships for successful population health management that will be shared and improved over time through productive learning community interactions.

RCHN CHF Grant Process and Timeline

- Released white paper describing context and purpose of population health management grant program (August 2015)
- Solicited letters of Interest from community health centers and primary care associations focused on
  - Partnering to engage in local/state initiatives for "health neighborhoods" addressing a challenge in population health management.
  - Identifying and disseminating a spectrum of best practices
  - Building upon past & current initiatives to address gaps in services programs, processes
  - Establishing a learning community among grantees
- Of >100 LOIs, 25 applicants invited to submit full proposals after comprehensive criteria-driven review process
- Seven grants awarded (beginning July 2015)

Outcome Objectives

- Strengthened capacity for population health management that addresses social determinants of health
- Implementation of population health management interventions to achieve documented outcomes/ impact
- Strengthened or new partnerships with organizations addressing health and the social determinants of health.
- Development of enhanced potential for sustainability and expansion of interventions to additional populations, strengthened population health management capacity, and strengthened partnerships.
- Development and implementation of learning community to share information, processes.

Supported projects

- **Health outcomes in defined geographic areas:**
  - African American Infant Mortality (Erie County Community Health Center, Ohio)
  - Smoking reduction in New York City's Chinatown (Charles B. Wang CHC, New York, N.Y.)
- **Patients identified with defined health center or system of care**
  - High-risk, chronically ill homeless individuals (Santa Rosa Community Health Centers, Ca)
  - Patients with uncontrolled diabetes (Access Family Care, Joplin, Missouri)
  - Colorectal and other cancers (Adelante Healthcare, Phoenix, Arizona) and cervical cancer screening (CO Community Health Network, Colorado)
  - Pediatric emergency room utilization & enhanced care coordination for children (Hudson Headwaters, Queensbury, New York)

Focus on Addressing Self-Identified Gaps in Services/ Programs

- Access to off-site specialist care
- Care coordination across settings
- Capacity of patient registries & analytic reports for care care planning, support and timely follow up
- Patient engagement & self-management by a pro-active, well prepared and trained practice team
- Workforce development to support effective team care
- Quality improvement systems focused at the practice level with on-going feedback to improve patient health management systems, go beyond categorical disease or prevention outputs
- Access and coordination with community services to address social determinants of health

Outcomes Evaluation Approach

- **Evaluation Framework**
  - Program logic model and modified domains of Comprehensive Framework for Implementation Research (CFIR)
- **Assessment of Process and Inputs**
  - Grantee quarterly reports
  - In-person, team-focused site visits for all grantees
  - Individual technical assistance conference calls
  - Initial grantee self-assessment of priorities and capacity
  - Learning Community calls based upon grantee-identified needs and priorities.

Promising early outcomes, project specific and overall

- Improved glucose control and care coordination for people with diabetes mellitus
- Improved screening rates for colorectal, cervical and breast cancer
- Participation in smoking cessation counseling program progressed to quit dates and quit attempts
- Decrease in inappropriate pediatric ED utilization
- Improved care coordination for homeless people affected engagement in primary care, connection to needed social services, inappropriate ED use, and 30 day hospital re-admission rates
- Initial planning grant led to new screening protocols for high-risk pregnant women resulting in new care models, expanded care focus
- Strengthened local/regional collaboration and new partnerships

Learning Community Principles

- Shared values and vision
- Collective responsibility - team members contribute to and share in leading discussions.
- Collaborative planning of sessions based on data from grantee surveys
- Culture of trust and respect that supports productive questioning and learning
- Openness to new ideas from external sources
- Participation open to all team members
- Broad participation by organizational champion and other staff
  - Quality Coordinator
  - Health Educator
  - Improvement Specialist
  - Nursing Director
  - Care Manager
  - Chief Operating Officer
- Post-call evaluations and re-assessment of learning needs used to establish priorities for future calls

Learning Community Themes

- **Collaborative approach, shared learning**
  - #1 Orientation and Learning Needs Assessment
  - #2 Provider & Team Engagement
  - #3 Identifying & Engaging Target Populations & Care Coordination
  - #4 Health Information Technology & Data Analysis
  - #5 Approaches to auto-indexing
  - #6 Expert post-election policy update
  - #7 Complex care management

Year Two Program Expansions

In year two, projects expanded to address additional patient or community populations and additional social determinants

- **Colorado Community Health Network:**
  - Expand cervical cancer screening to 3 additional CHCs in CO
  - develop comprehensive women's health model in original cohort
- **Hudson Headwaters Health Network:**
  - Identify all members of health center pediatric population with risk factors, independent of ED use
  - Address systems barriers to access and care
- **Charles B. Wang Community Health Center**
  - Expand smoking cessation initiative to additional site and community (Flushing Queens, NY)
- **Access Family Care**
  - Extend core program to additional CHC sites
- **Adelante Healthcare**
  - Collaboration with state PCA to share best practices with other CHCs
- **Erie County CHC**
  - implement PCMH and CHW following planning grant
- **Santa Rosa Community Health Centers**
  - Strengthen coordination & provision of enabling & mental/behavioral and housing services through participation in state health home initiative (Section 2703)

Key Observations

- Health center organizations are appropriately focusing on understanding needs and developing the best models and interventions, rather than obtaining immediate outcomes.
- A deep understanding of the target community, engagement of community stakeholders, patients and families and ownership across collaborating entities are prerequisites for a successful program.
- Change requires both external focus on appropriate partnerships to help address the social determinants of health and the specialty needs of patients, and internal commitment, resources and capacity to plan and manage change, access timely information for clinical decision making, and obtain and coordinate services for comprehensive care.
- Health center team members need support to develop or strengthen new skills, especially for productive patient interactions, and need a voice in and support for designing and engaging in new or refined team roles and work processes.
- This is an adaptive, encompassing effort akin to design innovation and goes beyond technical fixes focused on improving specific clinical or business processes. Requires committed leadership at all levels and a multi-year organizational strategy.

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Thank You

Please feel free to contact us for more information

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