



SAMHSA-HRSA Center for Integrated Health Solutions

Population Health Management Introductory Webinar

December 19, 2014



SAMHSA-HRSA Center for Integrated Health Solutions

**Slides for today's webinar are
available on the CIHS website at:**

www.Integration.samhsa.gov

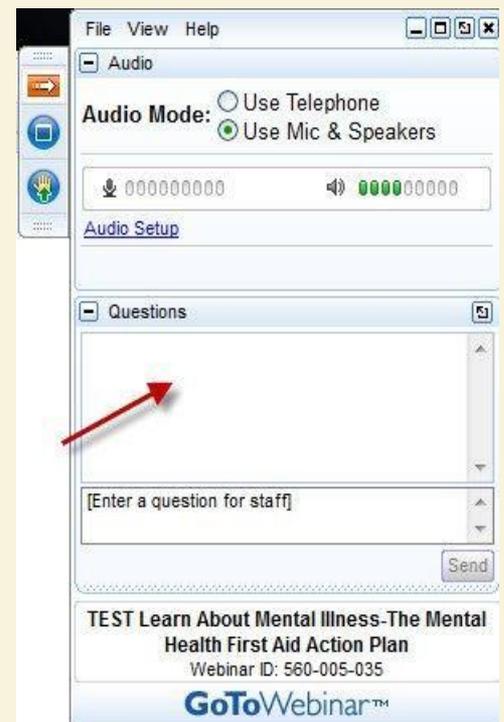
under About Us/Innovation Communities

How to ask a question during the webinar



If you dialed in to this webinar on your phone please use the “raise your hand” button and we will open up your lines for you to ask your question to the group. **(left)**

If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions. **(right)**



Today's Agenda

- Welcome
- Overall Goal for the Innovation Communities
- Goal for the Innovation Community
- About Your Team
- What to Expect from the Innovation Community
- Participant Expectations
- Next Steps

Innovation Communities Purpose

The IC's are designed to engage organizations in acquiring knowledge & skills to implement measureable improvements in a high priority area related to healthcare integration. Lessons learned over the course of the IC will be compiled & shared with the healthcare field so other organizations can benefit.

The IC focuses on topics and approaches that align with the following:

- Widespread relevance & applicability across integrated care settings
- Addresses a challenging problem related to integrated care
- Establishes practical & meaningful performance indicators achievable in a 9 month timeframe
- Continuously monitors progress, implementation barriers, & effective strategies
- Identifies tools & resources associated with successful implementation
- Records the lessons learned about the systemic & organization specific factors affecting the adoption & sustainability of integrated health innovations

Innovation Communities

- Chronic Disease Self Management in Behavioral Health Settings
- **Population Health Management in Behavioral Health Providers**
- Who is Responsible for Care Coordination?
- Developing High Functioning Primary Care Teams
- Building Integrated Behavioral Health in a Primary Care Setting

Goals for PHI IC

- All agencies will be able to define PHM.
- All agencies will develop a plan to operationalize PHM in their organization.
- All agencies will be able to use one or more PHM approach(es) to more effectively & efficiently provide services.

About your team:

- Jeff Capobianco, CIHS
- Hannah Mason, CIHS
- Joe Parks, State of Missouri Medicaid Office
- TBA

Resources:

- Faculty are here to support you with educational materials, supportive monitoring of participant progress toward achieving work plan goals, & timely follow-up to requests from participants.
- Dedicated page on the CIHS website

What to Expect

- Monthly webinar sessions (total of 8) composed of expert teaching, discussion, participant presentations & guided cross-participant coaching.
- 4 facilitated coaching calls where the participants will receive targeted support from faculty members.
- Small group calls in a focus group format.
- Closing webinar (3 hours).

Participant Expectations

- Active engagement in the learning process as evidenced by attendance & participation in all IC activities.
- Completion of an agency self-assessment & work plan.
- Completion & submission of evaluation materials (e.g., satisfaction survey materials).

Instant Poll # 1

**Which electronic health record
does your agency use?**

1. Netsmart Product
2. Epic Product
3. NextGen
4. “home grown” EMR
5. Other

Instant Poll # 2

Where would you rate your agency in its ability to conduct population health management?

New

("PHM is completely new to us")

Intermediate

("We do PHM but not a lot")

Advanced

("We do PHM well & are looking to refine/enhance our PHM skills/capacity")

Defining Population Health Management

A set of interventions designed to maintain and improve people's health across the full continuum of care—from low-risk, healthy individuals to high-risk individuals with one or more chronic conditions (Felt-Lisk & Higgins, 2011).

Population management requires providers to develop the capacity to utilize data to choose which patients to select for specific evidence-based interventions and treatments (Parks, 2014).

The Promise of Population Health Management

- Improved Care Coordination
- Improved Services Penetration
- Trains Clinicians & Administrators to use Data to inform Care Provision/Decision Support/Evidence-based Medicine
- Allows for Quality Metrics to be Linked to Dollars
- What else?

Let's do this!! Where to Begin...?

1. Identify the Need (*Completed!*)
2. Allocate Resources to Address the Need (*Completed!*)
3. Conduct an Agency Needs Assessment (Jan-Feb)
4. Use the Needs Assessment Findings to Develop your Work Plan (Feb-March)
5. Execute the Work Plan with Passion & Urgency (March-August)
6. Seek Out Resources (Dec-August)
7. Share What you Learn!! (Dec-August)

Next Steps

Scheduled webinars:

- Tuesday, January 20, 3-4pm Eastern
- Tuesday, February 17, 3-4pm Eastern

Homework:

- Complete & Submit a PHM
Organizational Self-Assessment

Holiday Reading Assignments

Felt-Lisk, S. & Higgins, T. (2011). Exploring the Promise of Population Health Management Programs to Improve Health. Mathematica Policy Research Issue Brief. http://www.mathematica-mpr.com/publications/pdfs/health/PHM_brief.pdf

Parks, J., et al. (2014) Population Management in the Community Mental Health Center-based Health, Center for Integrated Health Solutions Homes http://www.integration.samhsa.gov/integrated-care-models/14_Population_Management_v3.pdf

For More Information...

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Thank you for joining us today.

Please take a moment to provide your feedback by completing the survey at the end of today's webinar.