



SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Using Population Health Management to Increase Staff Efficiency & Effectiveness

Jeff Capobianco, PhD, LLP
National Council for Behavioral Health
Center for Integrated Health Solutions

Overview of Today's Presentation

1. Identify key components of population health management
2. Understand how to implement a population health management approach in your clinic
3. Outline components needed to leverage population health management to increase staff workflow efficiency and effectiveness

At the simplest Level this is What Health Care Providers are Striving for...



Efficient & Effective = Optimal Care Provision

Effective: Doing the right things.

(i.e., Work flows that align the right intervention, at the right time, in the right place and for the right consumer)

Efficient: Doing the right things right.

(i.e., Work flows that contain cost and optimize time)

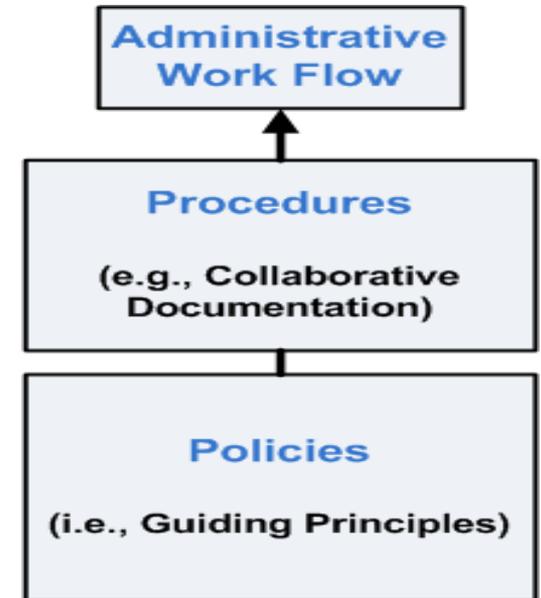
How do we create Activated Consumers and a Sustainable Business Model?

- Must understand the clinical and business aspects of service delivery
- Must have the tools to monitor and know if we are producing activated and health consumers while keeping costs contained.
- Population Health Management & Continuous Quality Improvement are the key to achieving this goal!

Before we go any further lets look at the day-to-day work you do...

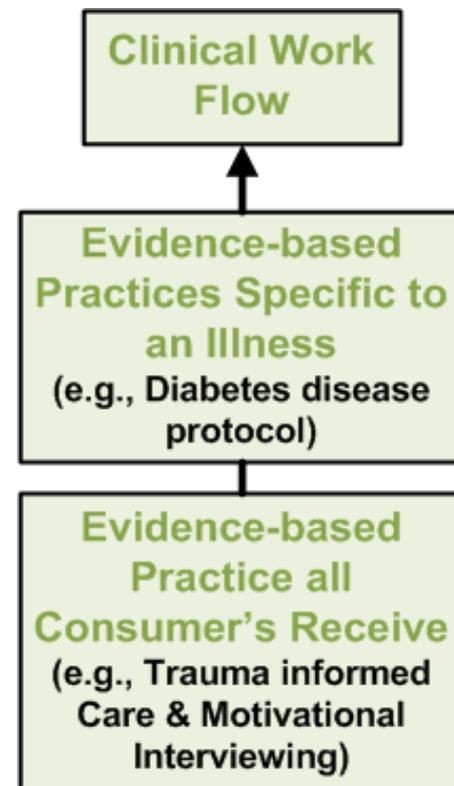
Administrative Work Flow

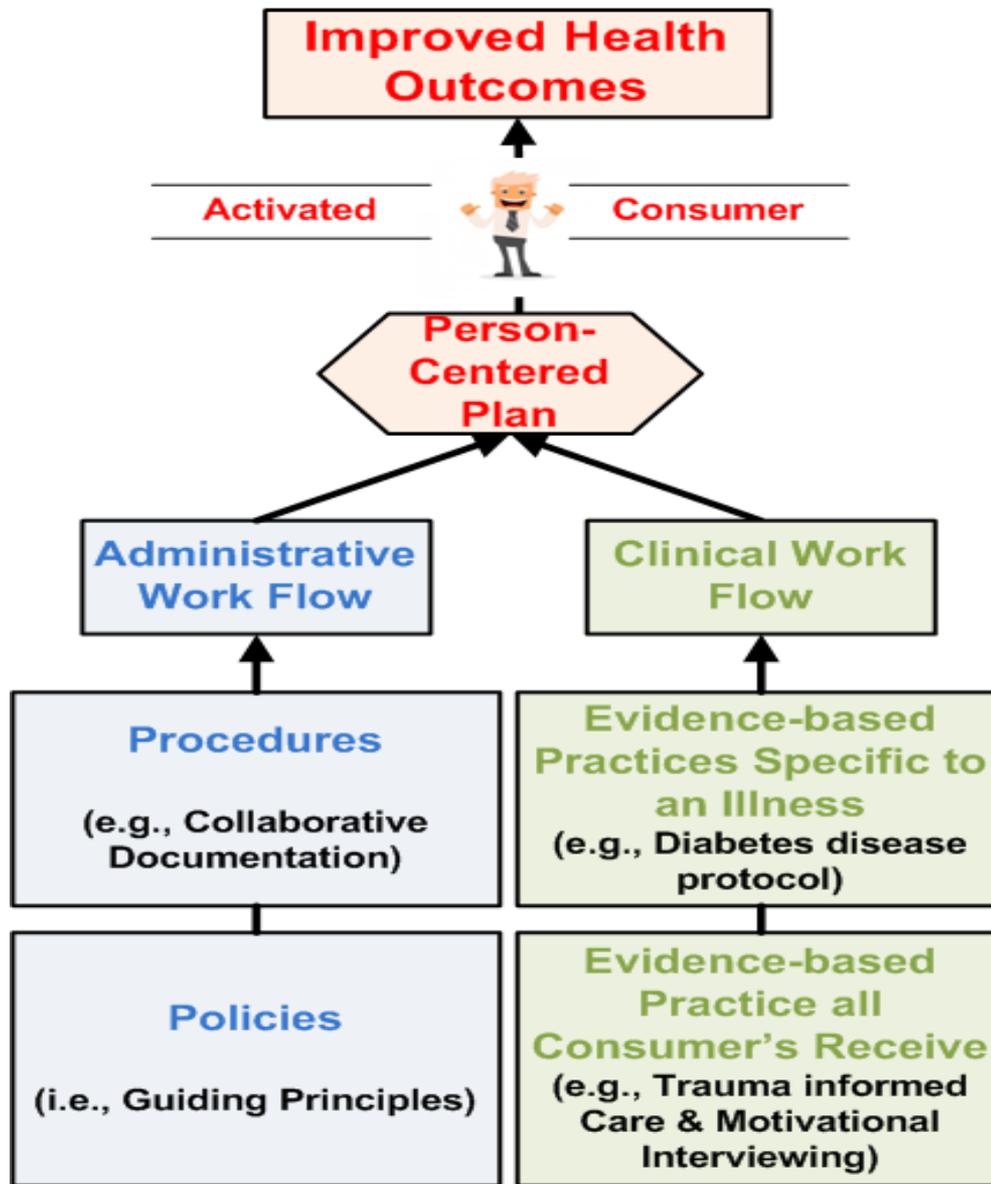
The day-to-day work administrative and clinical staff engage in using policy and procedure as a guide to efficiently and effectively operate the business aspects of care. (e.g., billing, data entry, data review, continuous quality improvement, supervision, team meetings, etc.)

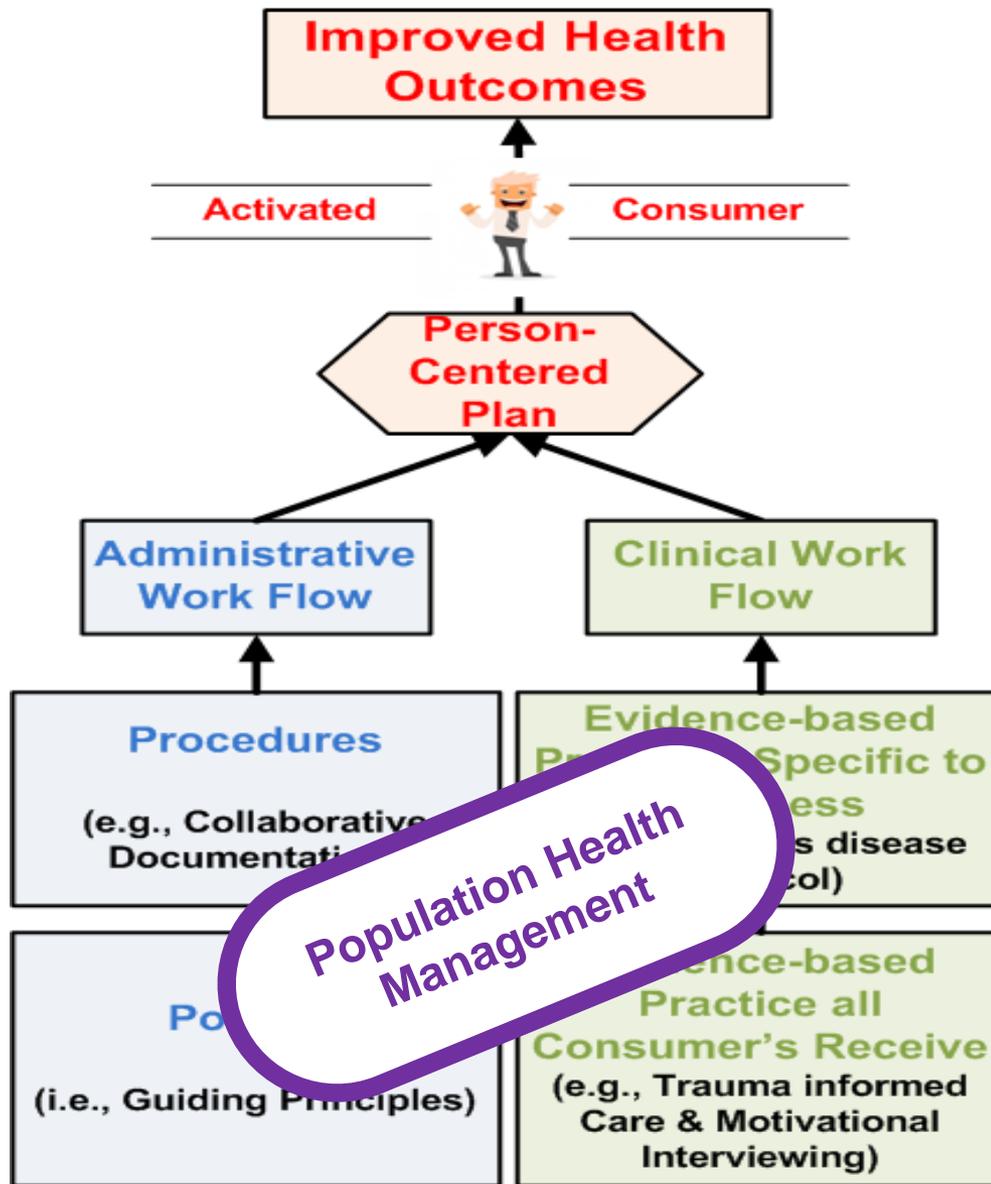


Clinical Work Flow

The day-to-day clinical work done to help consumers recover from illness. This includes both targeted practices for specific illnesses and general practices for engagement and activation (e.g., trauma informed care and motivational interviewing approaches)







Population Health Management (PMH)

Think of it this way....PMH is Continuous Quality Improvement applied to groups of consumers through defining, measuring, analyzing, improving through new work flows (using PDSA) and monitoring the outcomes so they persist (e.g., the healthy behavior remains).

Think of groups you are working with: hospital high utilizers, people with untreated diabetes, people with high BMI, etc.

What do you need to do PHM?

- 1. Choose a Question:** Ask the questions about your efficiency/effectiveness! (e.g., what's not working for the people you serve or what you are interested in knowing more about?)
- 2. Gather Data Specific to the Question:** Pull data that is reliable, valid, and analyzable specific to the question (e.g., TRAC as a dataset/registry)!
- 3. Develop a Solution:** Ability to conduct Continuous Quality Improvement PDSA Rapid-cycles to test a new approach
- 4. Make the Solution Stick:** Have a dashboard to monitor the improvement/to keep the data within control/specification

Let's Look at an PHM Example

Question: Why do we have so many people no-showing/not returning for their NOMS reassessment?

Gather Data: Pull demographic data from TRAC describing the people who no-show. Maybe we learn this group is more likely to be homeless &/or speak English as a second language

Let's Look at an PHM Example Continued...

Develop a Plan:

- **Plan for ESL Consumers:** Update protocol on how translation staff are mobilized so staff can be present during intakes; Provide staff with cultural competence skills/knowledge training; etc.
- **Plan for Homeless:** Put protocol in place for early outreach to homeless before reassessment; better collaboration with homeless outreach workers, etc.

Let's Look at an PHM Example Continued...

Do the Plan for 1-3 months:

- **For ESL Consumers:** Train staff and implement new translator protocol
- **For Homeless:** Put protocol in place for early outreach to homeless before reassessment; better collaboration with homeless outreach workers so they can help message importance of reassessment and support consumers in getting to their appointments, etc.

Let's Look at an PHM Example Continued...

Check/Study Impact after 1-3 months:

- Did the intervention work?
- Review data and see if ESL and Homeless Consumers are they attending reassessment appointments?
- **If no**, return to the Plan stage and redesign the intervention
- **If yes**, make the protocol standard practice and move on to monitoring the data using a Dashboard

Let's Look at an PHM Example Continued...

Make the Solution Stick through Monitoring:

- Make sure the new intervention has a protocol that is enforced in team meetings and during one-on-one supervision.
- Develop a dashboard metric for this indicator (e.g., ESL and homeless no show rate) and monitor

Poll Question: When it comes to PHM we struggle with this the most:

- a) We don't know where to start/what questions to ask of the data
- b) We need the technology to capture and analyze the data
- c) We need help designing our dashboards
- d) We need more training on how to Rapid Cycle PDSA
- e) We actually doing pretty well...don't struggle much
- f) Other (please be willing to share what the other is...)

Let's Discuss!

Please type your
questions/discussion points in the
chat box!

