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Home Health Care

The Healthcare Executive
FOR LEADERS DEVELOPING SOLUTIONS

FRANKLIN UNIVERSITY

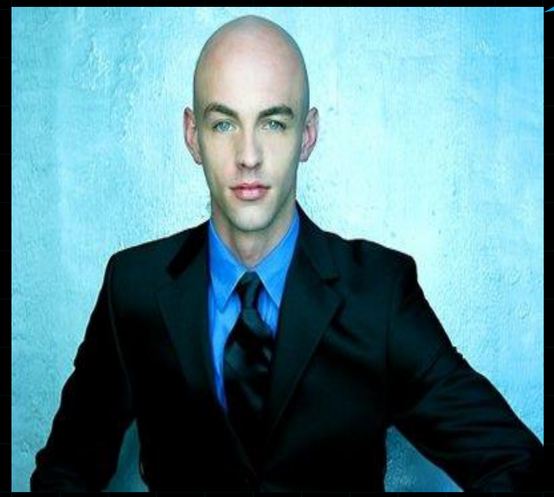
POPULATION HEALTH MANAGEMENT

BUILDING A CULTURE OF WELLNESS & PREVENTION

www.TheHealthcareExecutive.com

Iowa Counties Public Health Association

HELLO AND WELCOME !!!



I'M GREG AND I WILL BE YOUR GUIDE FOR THIS PRESENTATION

- We listen to you -

DISCOVERY & DATA-ANALYSIS

THEHEALTHCAREEXECUTIVE.COM IS AN EXECUTIVE EDUCATION CONSULTANCY

At the initial planning stages for a healthcare education webinar, we immediately go into a state of exploration. We listen for our community's needs as they are ultimately our customer. We may even dive deeper into the specific concerns of an individual organization. Even though our webinars attract broad audiences, our willingness to listen to individual concerns enables detection of your unique issues. This shapes our perspectives and drives us to achieve the intended outcome. An analysis of customer problems should be data-driven; therein, we examine with as little bias as possible.

SO LETS GO!

TOPICS WE WILL DISCUSS

Population Health is a transformative factor in reducing chronic illness and a key component of health care reform. It is dedicated to creating a fundamentally different culture and perspective focused on wellness and prevention.

This program will provide new insights about topics related to chronic illness management. wellness and prevention, health promotion, and access to care. It will also provide an update on current and proposed models of population health management.

- Provide a current summary of healthcare challenges
- The role of population health management in rewarding value over volume
- Conducting community health needs assessment to address priority health needs
- Assess the role of population health programs in reducing length of stay, readmissions and costs from hospital to home
- Evaluate the role of shared decision making and patient experience in managing population health
- Provide an understanding of the policies related to health care reform
- Consider current and proposed models of care to improve quality, standardization and access, reduce costs, and promote accountability of care
- Provide specific examples of successful population health programs
- Discuss the application of evidence based medicine to improve health care
- Develop meaningful outcomes measures and collecting related data
- Supporting improvement in clinical outcomes through interoperable health information technology
- Which models of care have demonstrated most potential in improving quality and reducing cost of care in specific healthcare settings
- Does your organization use advanced analytics to drive population health management initiatives

Greg Wahlstrom, MBA, HCM

President & CEO
The Healthcare Executive

Greg Wahlstrom is a result-oriented senior healthcare executive with more than 15 year's of broad background in business, healthcare, and human services and has extensive operational and administrative expertise. He is currently the President and Chief Executive Officer of The Healthcare Executive leading organizational performance assessment in multiple program areas, followed up with customized c-suite healthcare training that speaks to identified needs.

Greg has delivered focused programming around key elements to achieve success, based upon best practices and emerging best practices that show promise of improving health care organizations nationally and internationally. He has led webinars and face-to-face seminars for thousands of healthcare administrators and executives through American College of Healthcare Executives . Prior to The Healthcare Executive, Greg worked as an Assistant Administrator, Director of Social Services and as a Behavioral Health Case Manager.

Greg received a Master's degree in Business Administration and Health Care Management and a Bachelor's degree in Business Administration from the University of Phoenix. He has also completed studies abroad at Shanghai University in Shanghai, China. He is a member of the American College of Healthcare Executives. Greg is also the current Immediate Past Chairman of the Healthcare Executive Education Committee for the Central Illinois Chapter of ACHE.

LETS GO!

Dr. Mandeep Mangat, MD, MPH

Senior Administrator
Population Health Management & Clinical Integration
BAYDA Home Health Care

Mandeep K. Mangat, MD, MPH is a Senior Administrator of Population Health Management at Bayada Home Health Practice. She directs the ongoing development, implementation and coordination of population health initiatives aimed at enhancing quality of patient care and clinical outcomes at a system level.

Prior to joining this position in 2014, she worked as a Physician, Public Health Professional and Director of General Medicine Department in acute care settings. She has over 14 years of extensive healthcare experience in hospital medicine, home health, clinical operations, population health and operational efficiency improvement in both national and international settings. Her interests include outcomes management, results driven continuous improvement and multilevel determinants of population health.

She received her medical degree (MD) from Saint Petersburg Medical Academy, Master's degree in Public Health (MPH) degree with a focus in Healthcare Administration from West Chester University and Lean Six Sigma Healthcare Process Improvement Master's Certification (LSS) from Villanova University.

LETS GO!

Dr. Leslie Mathew, MD, MS, EMBA, FACHE

Chair, Healthcare Management Program
Franklin University

Dr. Mathew has thirty five years' experience in the healthcare industry, having worked internationally over the years. After completing his MD in 1979, he specialized in the medical diagnostic area and has pioneered and chaired Departments of Pathology and Laboratory Medicine in India and the Middle East, always involved with teaching and patient services in the different positions he has held at academic medical centers over the past 3 decades. He has been awarded numerous Teaching Excellence Awards in recent years.

Besides earning a Master's in Biotechnology Enterprise from Johns Hopkins University, he also had the privilege of completing the Executive MBA program from The Fisher College of Business while working as Administrative Director of Operations at The Ohio State University Medical Center, Columbus, Ohio.

Dr. Mathew has taught at both undergraduate and graduate levels in Healthcare and Business, in both non-profit and for-profit institutions. Most recently, he worked as a Dean of Education for a higher education group that had 52 schools with mainly Allied Health Programs around the United States.

Currently the Program Chair for the Allied Healthcare Management and Healthcare Management Programs at Franklin University, College of Health and Public Administration, Columbus, Ohio. He has been an active member of the ACHE, and earned the distinction of being a Fellow of the College.

LETS GO!

Shawn Zierke, MPH

Executive Director
ICPHA Iowa Counties Public Health Association

Shawn Zierke is a Public Health Policy and Administrative healthcare executive with more than 10 years of experience, blending organizational management, understanding of healthcare practice, and advocacy for Iowa's aging and disability communities. Current projects and volunteer activities include work with policy related to public health, rural health, population health management, state level legislative advocacy for aging and disability communities and developed tool-kit to increase collaborations between county public health and Accountable Care Organizations (ACOs).

Developed and delivered 67 customized cross-walk toolkits for Iowa's county public health departments to collaborate with their regional Medicare ACO to achieve quality measures and earn shared savings incentives. Shawn received a 2014 Health Sciences Research Week Poster Competition - (T-4) Translational Research Award for presenting research of the highest caliber during the 2014 Health Sciences Research Week Post Session - "Reducing Unplanned 30-Day Hospital Re-Admissions Among Patients with Pneumonia and CHF over age 65“.

Shawn received her Master’s in Public Health Policy from the University Of Iowa College Of Public Health, and is currently completing her Master’s in Business Administration in Social Entrepreneurship. She is currently the Executive Director for Iowa Counties Public Health Association, representing Local Public Health Administrators from 101 public health departments across the state of Iowa.

LETS GO!

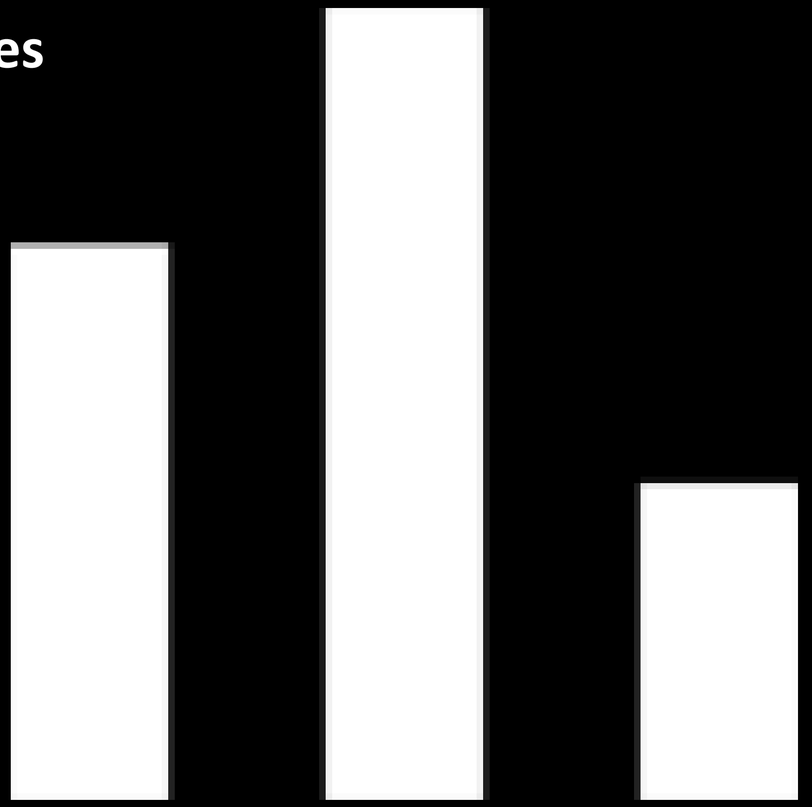
LET'S ASK THE AUDIENCE A POLL QUESTION

How many in the audience are international attendees versus domestic?

Answer:

International

Domestic



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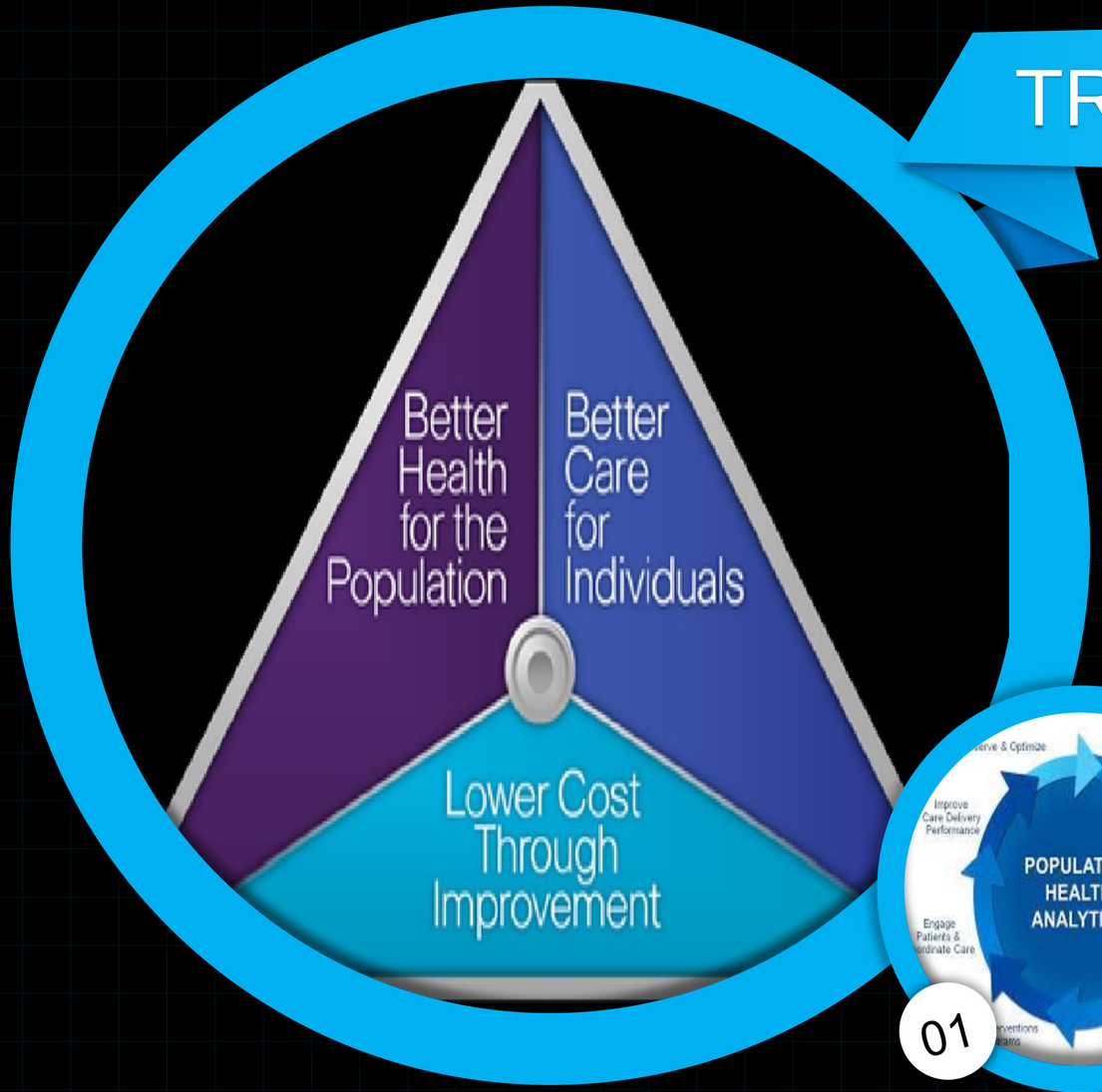
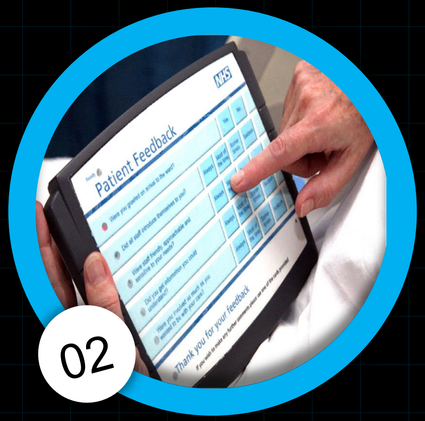
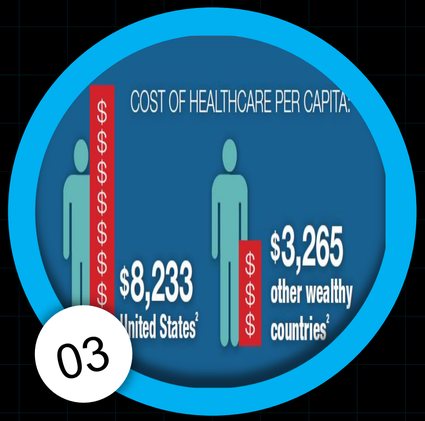
TRIPLE AIM Description



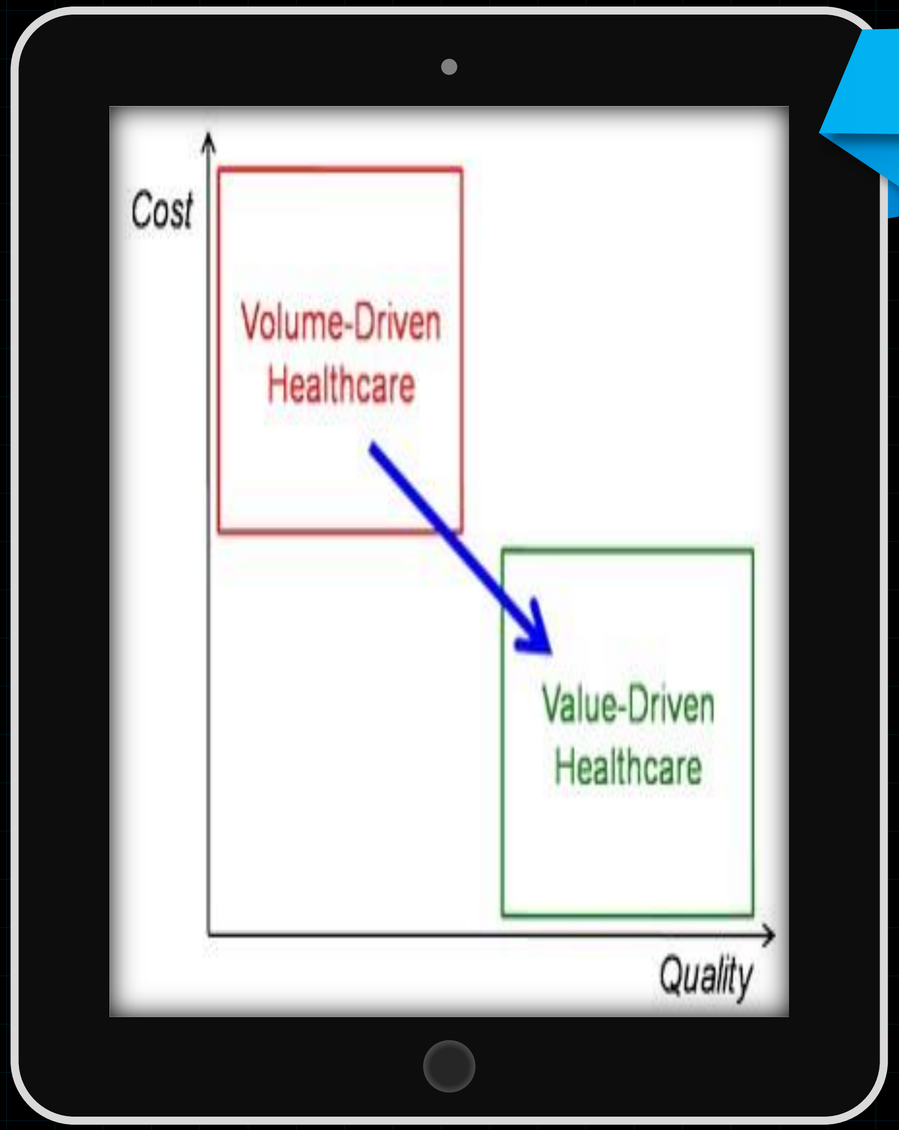
- Drive Toward Cost Efficiency
- Value-based reimbursement
- Population Health Management
- Cost and quality data transparency
- Advances in technology

- Physician Leadership
- Variations In Care
- Clinical Integration And Care Coordination
- Patient And Family Engagement





The Volume-to-Value Revolution



The industry is in midst of a rapidly accelerating shift from fee-for-service to various forms of “pay for value”

PATIENT-CENTERED

Population Health Model

01. Define Population

Who is your population?

02. Identify Care Gaps

Have we identified care gaps based on evidence based algorithms?

03. Stratify Risks

How are patients slotted into low, moderate or risk?

04. Engage Patients

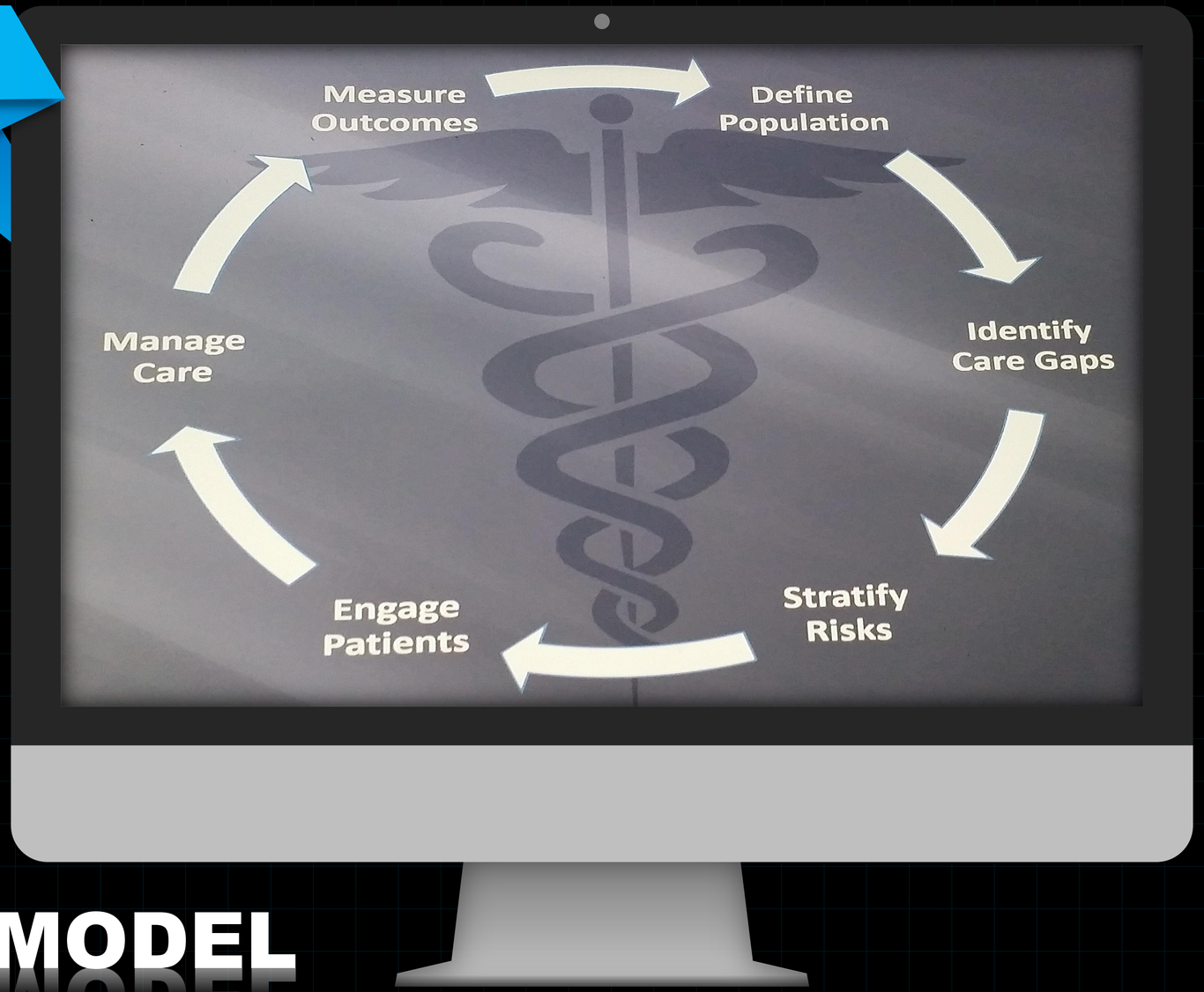
Once moderate or high risk is identified; what care pathways need to occur?

05. Manage Care

Are we targeting interventions to the right patients?

06. Measure Outcomes

What key performance indicators will provide support of PHM success?



POPULATION HEALTH MODEL

COMMUNITY HEALTH NEEDS ASSESSMENT

Community Engagement

Collection, Analysis And Interpretation Of Data On Health Outcomes And Health Determinants

Identification Of Health Disparities And Resources That Can Be Used To Address Priority Needs

Develop Strategies To Prioritize Needs

Required By The Federal Government Of Not For Profit Hospitals To Maintain Their 501(c) tax-e

Community HEALTH NEEDS ASSESSMENT

As part of the ACA, each nonprofit hospital is expected to complete community wide health needs assessment

Many organizations have been doing it on a voluntary basis.

Population Health

COMMUNITY HEALTH NEEDS ASSESSMENT

Table 1: Community Health Assessment for Population Health Improvement: Most Frequently Recommended Health Metrics*

Health Outcome Metrics		Health Determinant and Correlate Metrics			
Mortality	**Morbidity**	**Health Care (Access & Quality)**	**Health Behaviors**	**Demographics & Social Environment**	**Physical Environment**
Mortality - Leading Causes of Death (9)	Obesity (6)	Health Insurance Coverage (6)	Tobacco Use/ Smoking (8)	Age (9)	Air Quality (4)
Infant Mortality (6)	Low Birth-weight (3)	Provider Rates (PCPs, Dentists) (5)	Physical Activity (5)	Sex (6)	Water Quality (3)
Injury-related Mortality (3)	Hospital Utilization (4)	Asthma-Related Hospitalization (4)	Nutrition (4)	Race/Ethnicity (9)	Housing (5)
Motor Vehicle Mortality (3)	Cancer Rates (4)		Unsafe Sex (3)	Income (9)	
Suicide (4)	Motor Vehicle Injury (4)		Alcohol Use (4)	Poverty Level (6)	
Homicide (4)	Overall Health Status (4)		Seatbelt Use (3)	Educational Attainment (6)	
	STDs (chlamydia, gonorrhea, syphilis) (4)		Immunizations and Screenings (5)	Employment Status (6)	
	AIDS (3)			Foreign Born (3)	
	Tuberculosis (4)			Homelessness (3)	
				Language Spoken at Home (3)	
				Marital Status (3)	
				Domestic Violence and Child Abuse (3)	
				Violence and Crime (4)	
				Social Capital/Social Support (4)	

* Numbers in parenthesis indicate the number of 10 Guidance Documents that recommended that specific outcome or determinant/correlate.

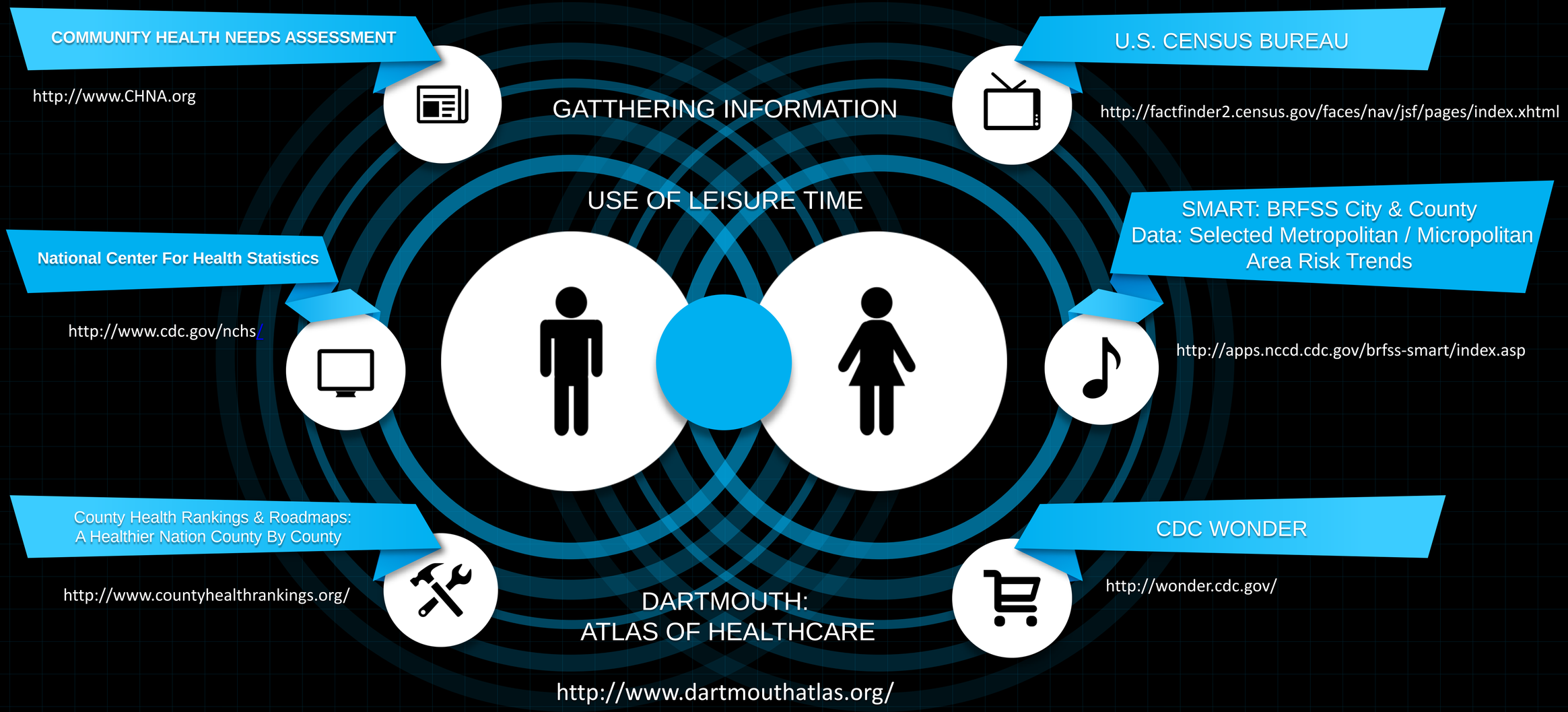
This Community Health Assessment for Population Health Improvement is meant to be a time-saving resource for identifying and analyzing data for community health assessments.

The report identified 42 metrics, broadly categorized as those characterizing the status of health outcomes or health determinants.

The majority of the 42 metrics have indicators available at the level of metropolitan statistical area, county, or sub-county

Most FREQUENTLY RECOMMENDED HEALTH METERICS

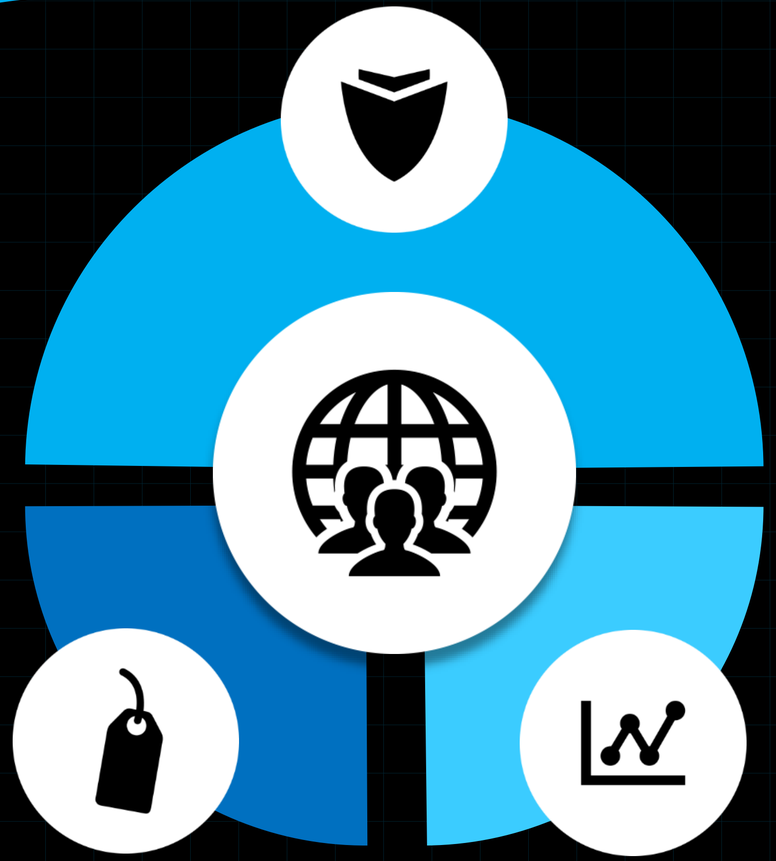
USEFUL RESOURCES FOR CHAs



PREVENTABLE READMISSIONS

New Government Incentives

Programs



REGULATIONS
On Preventable Readmissions (FY 2015)

Beginning in FY 2015, CMS will scrutinize readmissions for acute exacerbation of COPD, elective total hip arthroplasty and total knee arthroplasty.

GOVERNMENT
PARTNERSHIP FOR PATIENTS

CMS is paying community based organizations a set amount per discharge for managing Medicare beneficiaries at high risk for readmission.

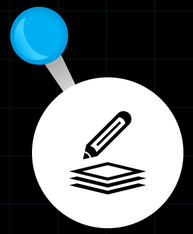
PAYMENT
BUNDLING

Model 1: Retrospective Acute Care Hospital Stay Only
Model 2: Retrospective Acute Care Hospital Stay Plus+ Post-Acute Care
Model 3: Retrospective Post-Acute Care Only
Model 4: Acute Care Hospital Stay Only

ACCOUNTABLE CARE
ORGANIZATIONS

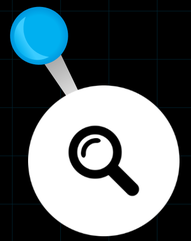
ACOs have a strong incentive to cut readmissions in order to generate savings that they can share.

POST - DISCHARGE CARE PRACTICES



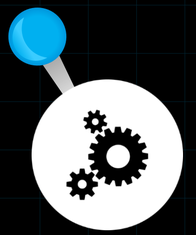
IHIs PATIENT CENTERED APPROACH

- ✓ Recommends cross continuum teams that involve all community stakeholders.



COLEMAN CARE TRANSITIONS INTERVENTION

- ✓ Emphasizes the use of transition coach to develop patient and caregiver self-management skills.



NAYLOR TRANSITIONAL CARE MODEL

- ✓ Involves care coordination by a transitional care nurse.

SHARED DECISION MAKING

Patient Centered Approach

“The process through which clinicians and patients share information with each other and work toward decisions about treatment chosen from medically reasonable options that are aligned with the patients’ values, goals, and preferences.”

Key Capabilities For Managing Populations

Care Teams That Enable Clinicians To Operate On Top Of Their Licenses

Lean Approach To Improve Work Processes

HEALTH IT

Analytics & Automation Applications

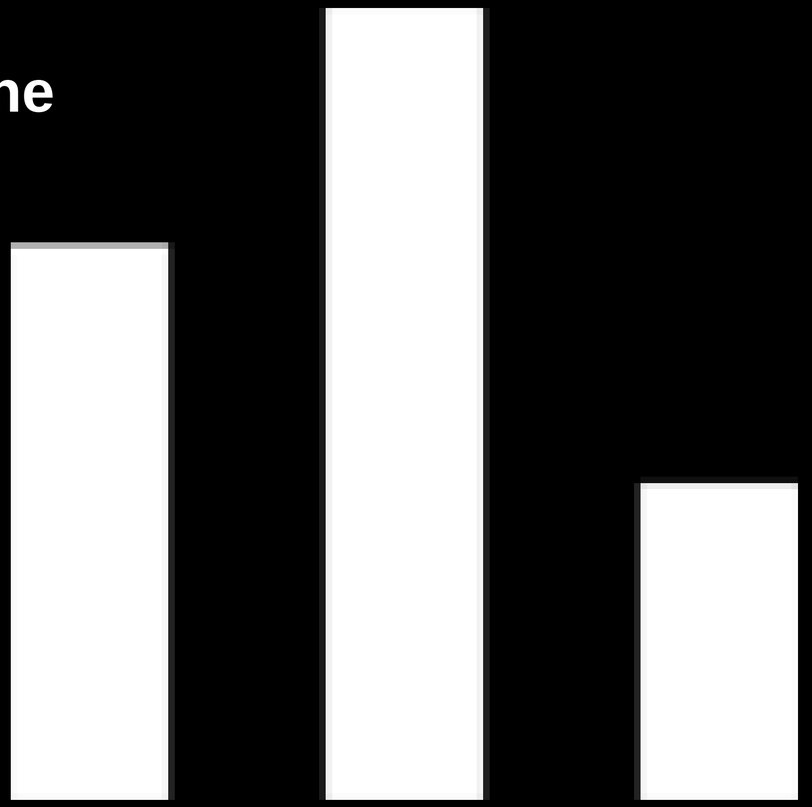
Patient Generated Data Filtered With Sophisticated Algorithms

Sophisticated Information Technology To Support Patient Engagement & Medical Decision Making

LET'S ASK THE AUDIENCE A POLL QUESTION

Do you think your organization has grasped the basics of POP Health?

Answer:
Strongly Agree
Agree
Marginal
Disagree
Strongly Disagree



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The key always you

FRANKLIN UNIVERSITY

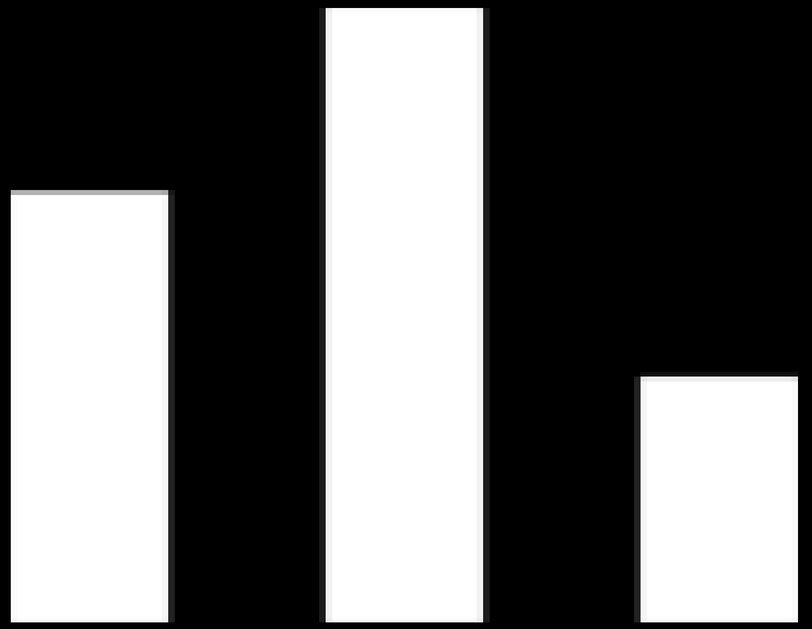
LETS ASK THE AUDIENCE A POLL QUESTION

How many in the audience are working in population health management?

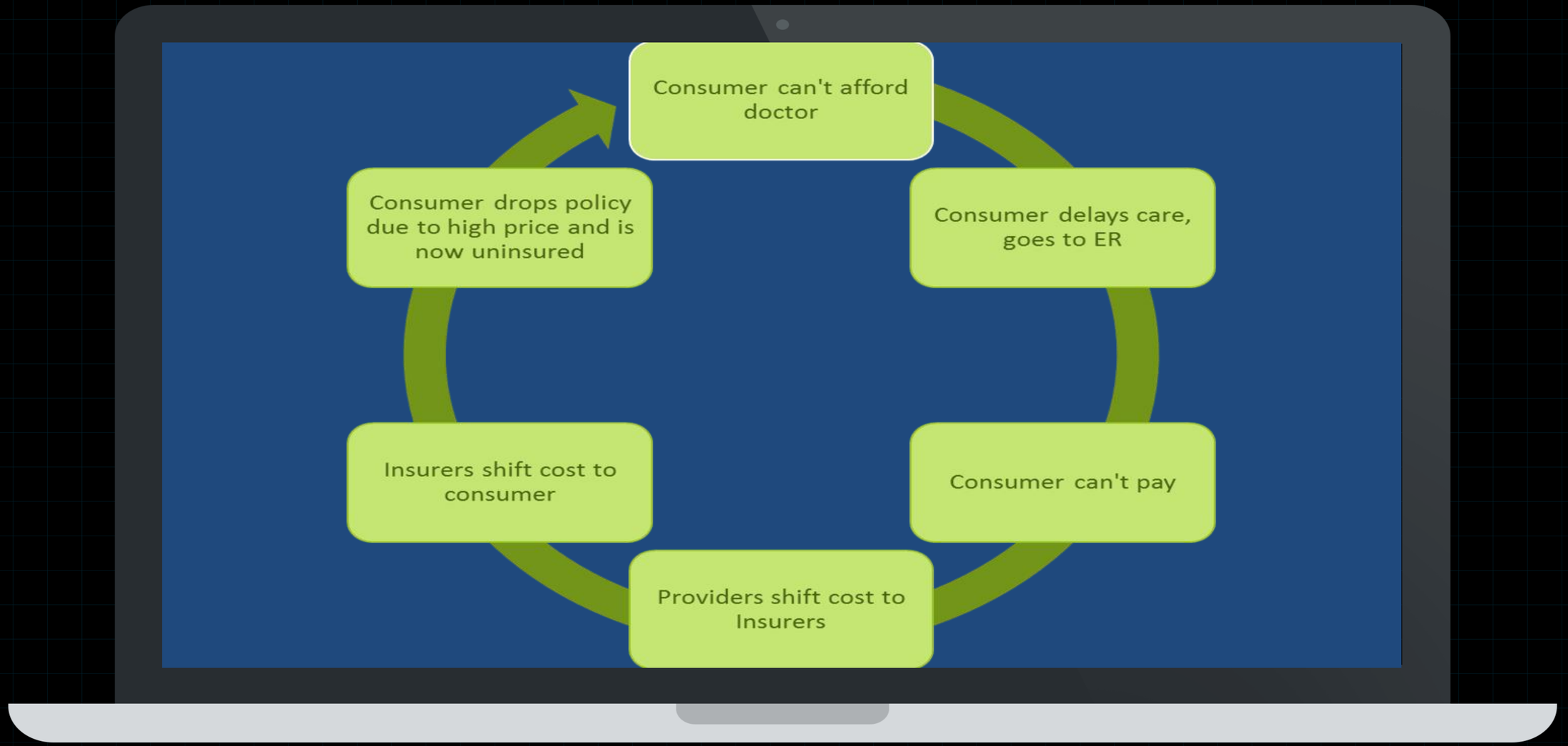
Answer:

Yes

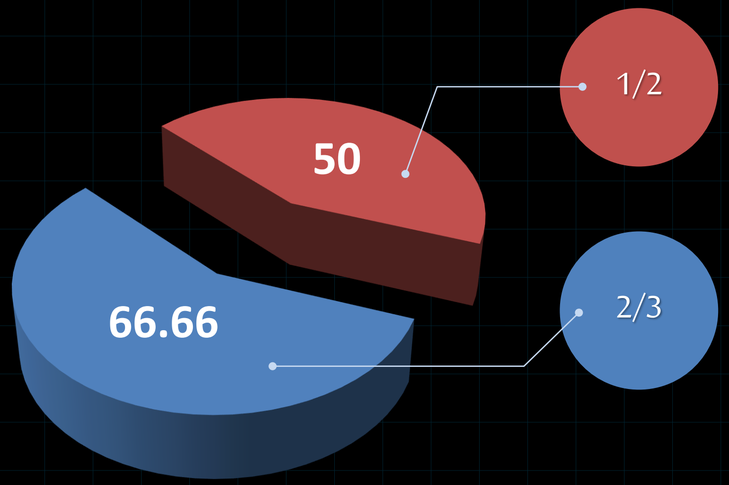
No



Provide An Understanding Of The Policies Related To Health Care Reform



The Burden of Chronic Disease

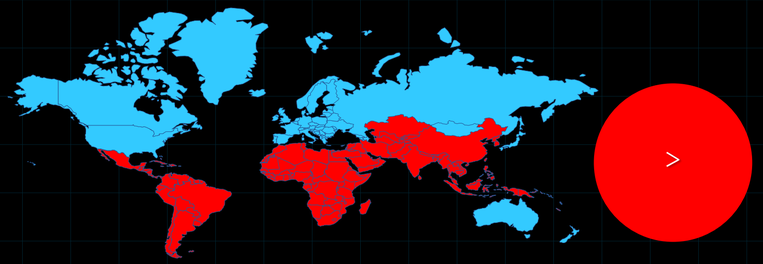


Chronic Disease

Responsible for more than half of all deaths worldwide

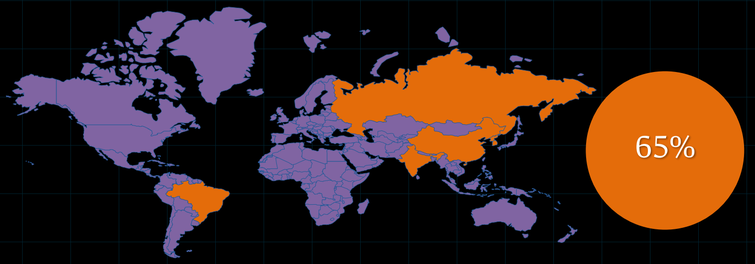
Chronic Disease Projection

To account for two thirds of all deaths in the next 25 years



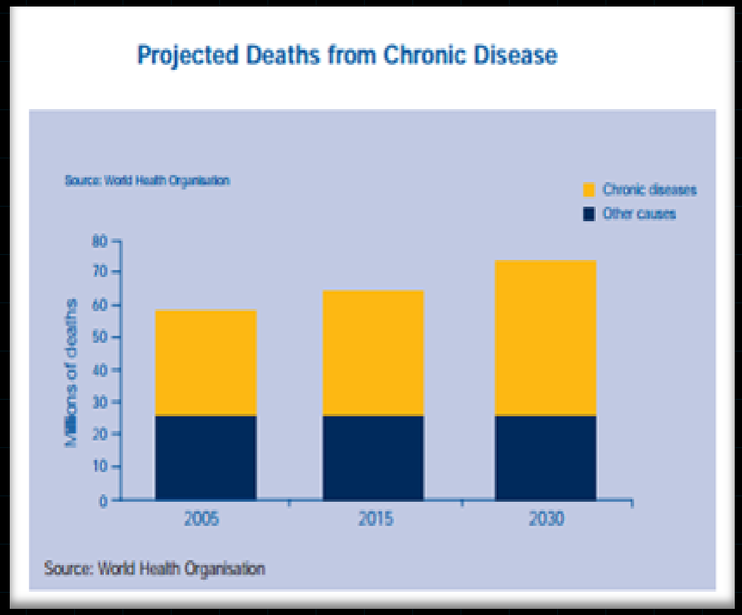
Emerging Economies

Initially concentrated developed countries, increase is now even greater in emerging economies



Loss of Productive Life-Years

Brazil, Russia, India, China lose more than 20 million productive life-years annually to chronic disease, projected to grow by 65% by 2030

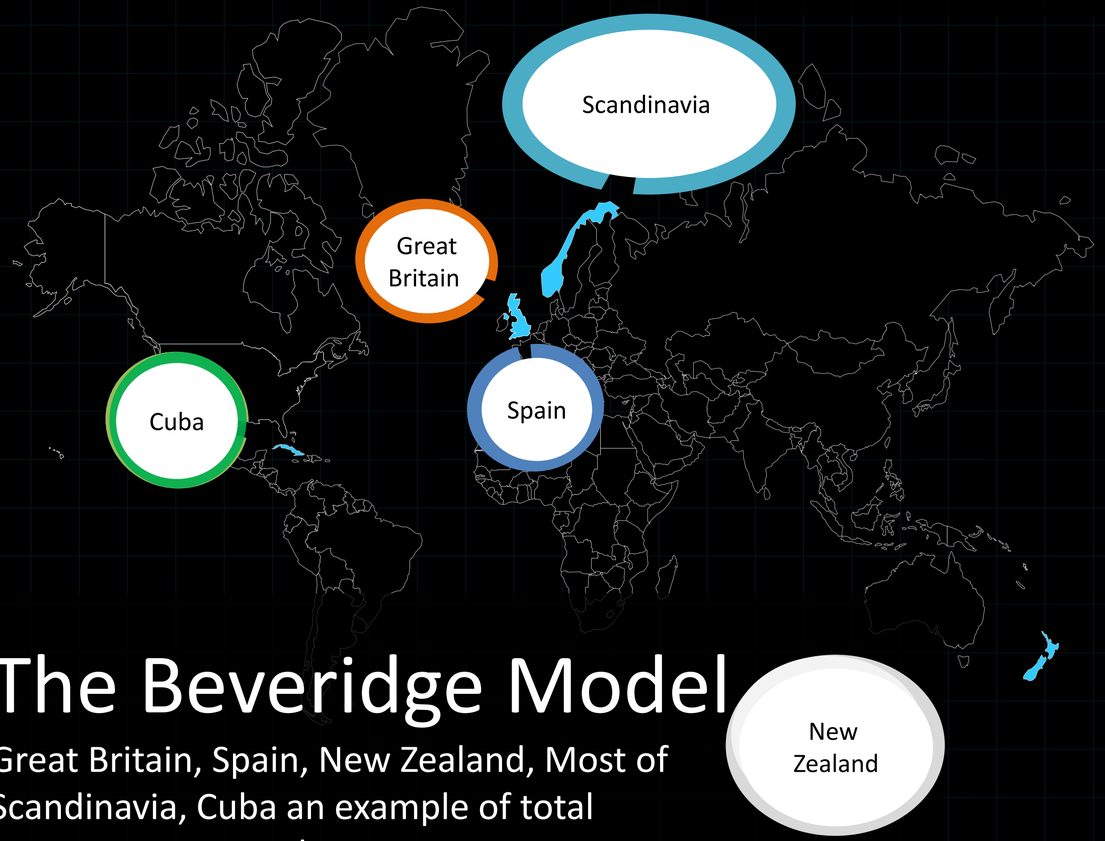


PREVENTION FOR FOUR REASONS:

- Drives Healthcare Costs
- Productivity Losses
- Positively Impact Human Capital Investments
- Sustainability Threatened

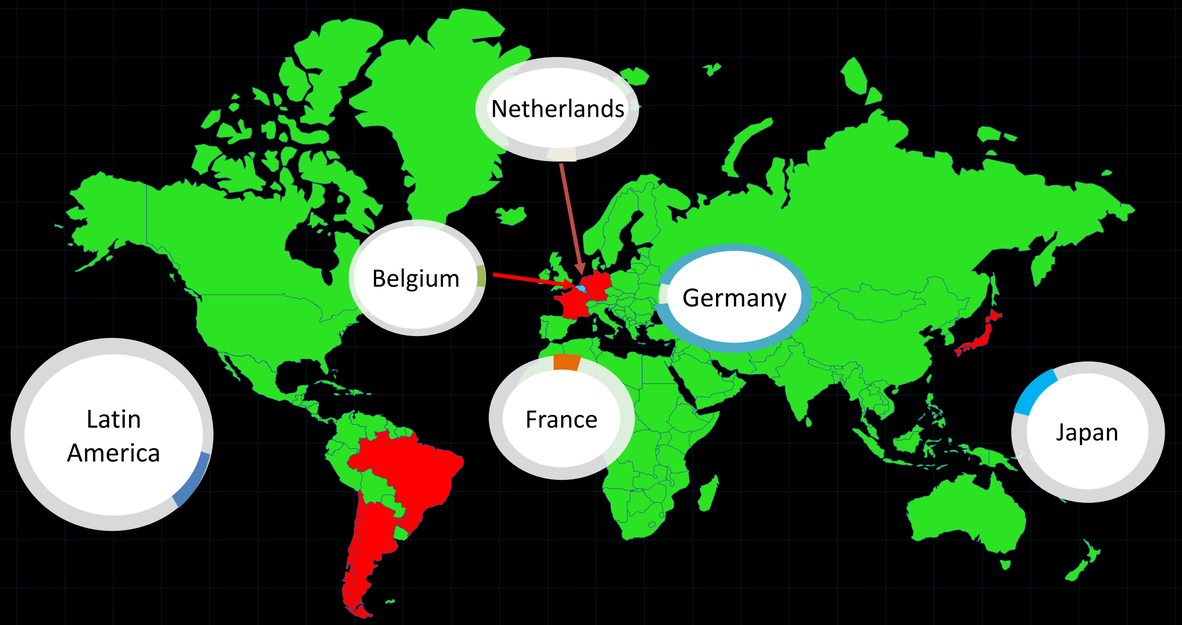
Consider Current & Proposed Models Of Care To Improve Quality, Standardization & Access, Reduce Costs & Promote Accountability of Care

Four Basic Models



The Bismarck Model

Germany, France, Belgium, Netherlands, Japan, Switzerland, some parts of Latin America



The Beveridge Model

Great Britain, Spain, New Zealand, Most of Scandinavia, Cuba an example of total government control

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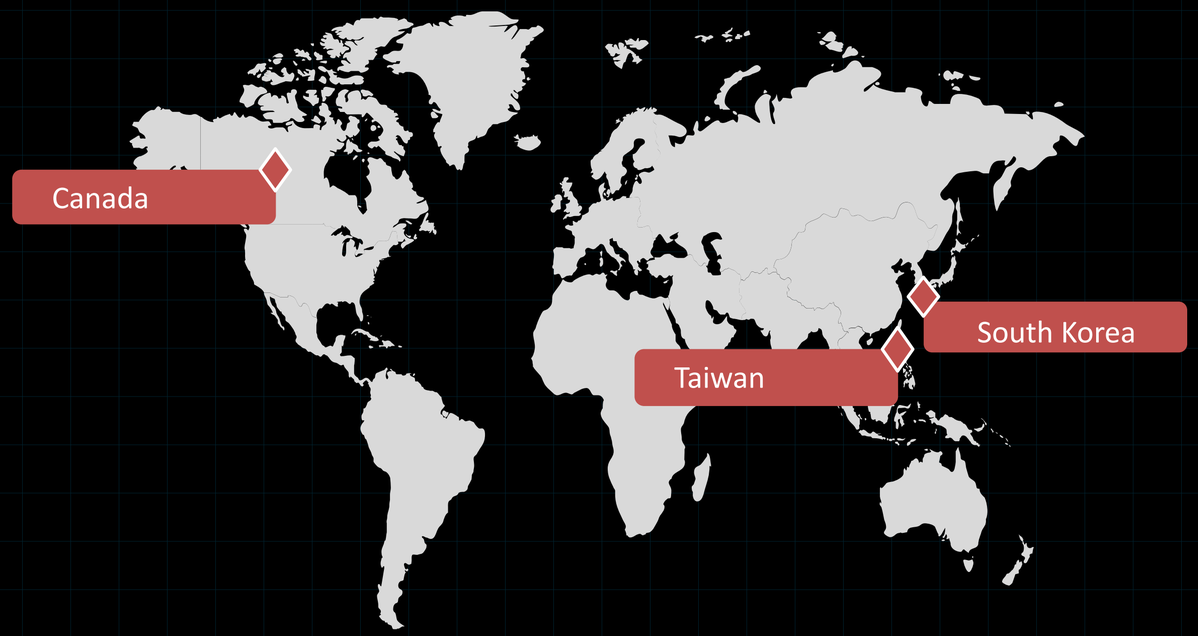
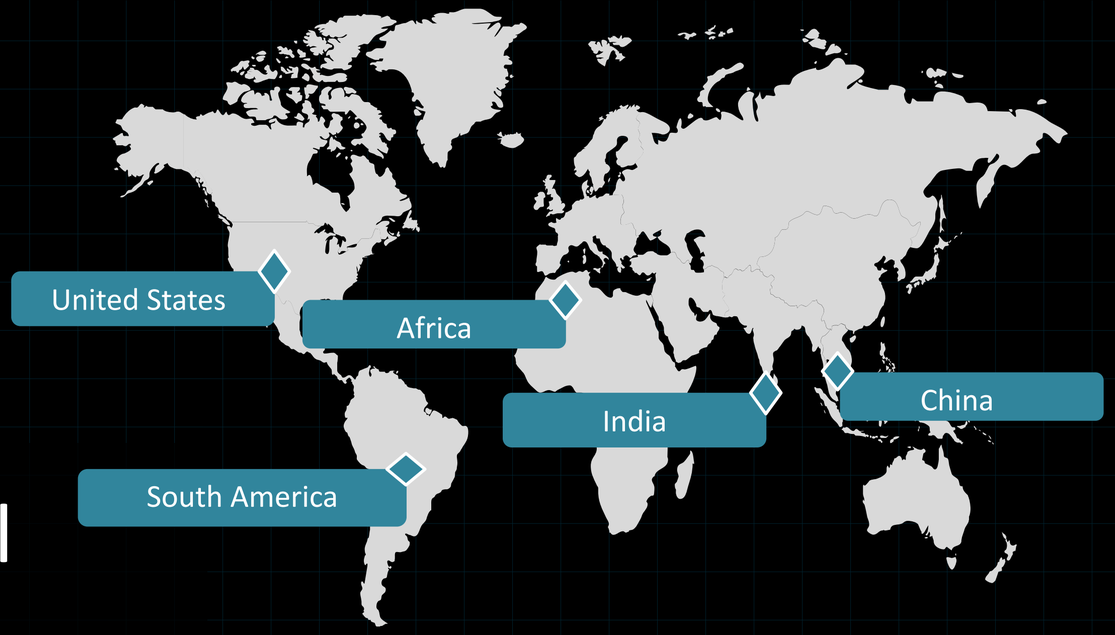
Four Basic Models



The Out-of-Pocket Model:

Rural Africa, China, India, South America and % of U.S. population who have no health insurance



The National Health Insurance Model

Has elements of both Beveridge and Bismarck, Canada, Taiwan, South Korea

ACCOUNTABLE CARE

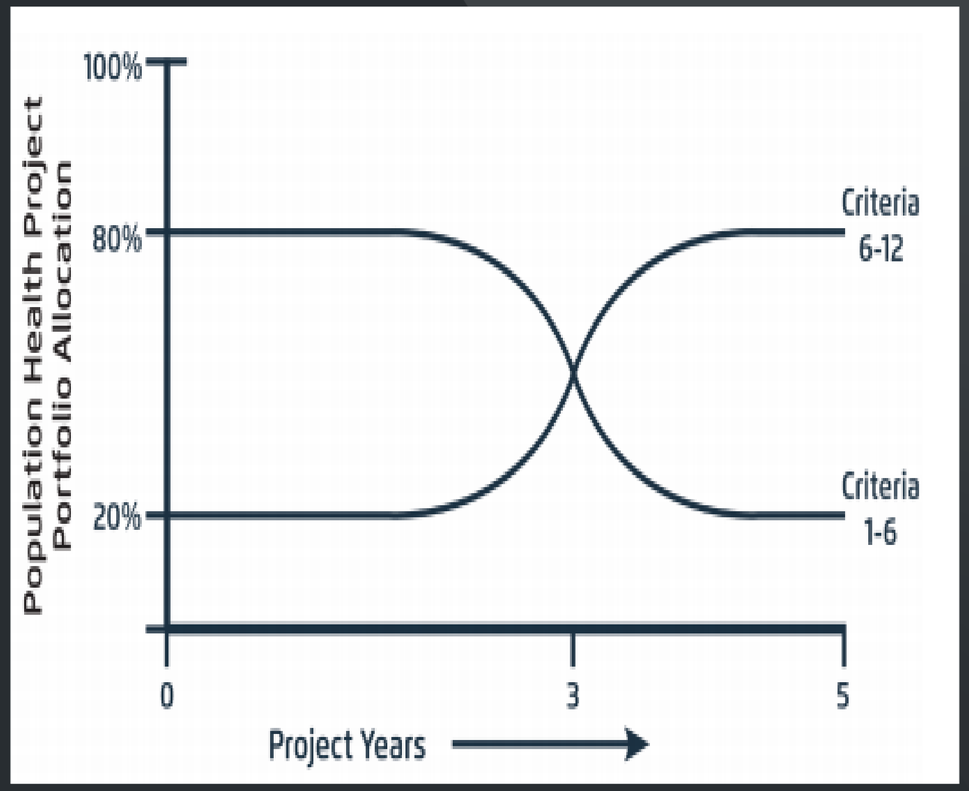
Optimization

Triple Aim

Let's Focus On The Outer Circle!

Data Management Requirements In PHM

Recommended Allocation For Assets



Category 3

Universal Exchange Plan
Manhattan Institute For Policy Research

- Repeals ACA individual, employer mandate, all tax hikes ex. “Cadillac tax”
- Frees exchanges from costly federal regulation, combats hospital monopolies
- Migrates most Medicaid enrollees & future retirees onto reformed exchanges

- 30-yr deficit reduction of $8trillion, 30-yr revenue reduction of $2.5 trillion
- Makes Medicare Trust permanently solvent, reduces private sector premiums

- For Medicaid population, improves provider access by 98% medical productivity by 159%
- By 2025, Increase coverage by 12.1 Million above ACA levels.

Consider Current And Proposed Models Of Care
To Improve Quality, Standardization And Access, Reduce Costs,
And Promote Accountability Of Care

Universal Health Care

Discuss The Application Of Evidence Based Medicine To Improve Health Care

Evidence-Based: Integrating 2 Approaches

- Evidence Base Guidelines
- The recommended actions must be practical and feasible
- There must be good evidence that each test or procedure recommended is medically effective in reducing morbidity or mortality
- The medical benefits must outweigh the risks
- Evidence-Based Individual Decision Making
- The costs of each test or procedure must be reasonable compared to it expected benefits

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Shawn Zierke, MPH - Policy

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The key always you

Developing Meaningful Outcome Measures & Collecting Related Data

COMMUNITY HEALTH NEEDS ASSESSMENT
&
COMMUNITY HEALTH IMPROVEMENT PLANS COLLABORATIVE APPROACH

GETTING ON THE SAME CYCLE

NON-PROFIT HOSPITALS – Every 3 yrs.
PUBLIC HEALTH DEPARTMENTS – Every 5 yrs.

GREAT EXPECTATIONS

DATA COLLECTION ON - GOING

SOURCES

BRFSS, County Health Rankings, Healthy People 2020, Falls by County, CDC, CMS Data, Nutrition and Weight Status Map, Member/Stakeholder Surveys, State Cancer Profiles, MMWR Health Disparities and Inequalities Report, Family Planning and Education Map, Access to Health Services – Insurance Map, Network Infrastructure and Communication Map

Collaboration & Relationships Among Diverse Groups Of Community Stakeholders

Collaboration

So who should have a seat at the table?

DATA MEASURES | ANALYSIS

- More Collaboration Needed
- Hospital release de-identified data for the purposes of a joint data collection process to local public health for the purposes of collaboration on CHNA/HIP

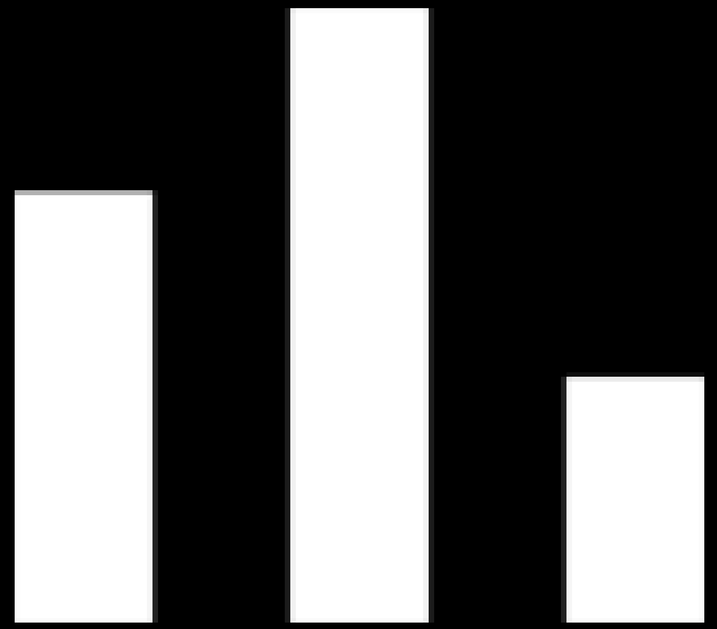
LET'S ASK THE AUDIENCE A POLL QUESTION

Does your healthcare organization work w/ the Local Public Health Department?

Answer:

Yes

No



Supporting Improvement In Clinical Outcomes Through Interoperability Health Information Technology (Shawn Zierke)

01

Care coordination is impacted due to lack of connectivity between hospital systems, community providers, public health providers and other stakeholders

EHRs have the potential to integrate and organize patient health information and facilitate its instant distribution among all authorized providers involved in a patient's care. For example, EHR alerts can be used to notify providers when a patient has been in the hospital, allowing them to proactively follow up with the patient.

Better care coordination can lead to better quality of care and improved patient outcomes.

When fully operational, personal health information, entered into a system once, becomes available to patients *where-ever* they are & *when-ever* they need it.

02

With EHRs, every provider can have the same accurate and up-to-date information about a patient. This is especially important with patients who are:

- Seeing multiple specialists
- Making transitions between care settings
- Receiving treatment in emergency settings

Issues: cost, portability (paper for patients), reporting requirements differ from provider to provider

Better availability of patient information can reduce medical errors and unnecessary tests.

Better availability of information can also reduce the chance that one specialist will not know about an unrelated (but relevant) condition being managed by another specialist.

03

Models of care demonstrated most potential in ***Improving Quality*** & ***Reducing Cost*** *of Care* in specific healthcare settings

BOOST© Addresses AHRQ's "Big Three"

- Discharge Planning
- Medication Reconciliation
- Care Coordination
  - 24hr, 72 hr f/u calls
  - Public Health Innovations in Rural Communities
    - i.e. Dallas County, Iowa
  - Telemedicine
- Patient & Family Information
  - Teach Back Method

Improving Quality & Reducing Cost

DOES YOUR ORGANIZATION USE ADVANCED ANALYTICS TO DRIVE POPULATION HEALTH MANAGEMENT INITIATIVES?

5% of the population accounts for 50% of healthcare costs, so how do you identify your

5 %?

Data analytics support Care Teams and Health Coaches, so PCPs can spend more time with patients, and less time entering in data.

- Connect complex cases with community resources, follow up, patient education, and supportive services.
- This is where on-going data analysis between CHNAs can be applied to real time adjustments in HIPs at the macro level and micro levels.

Partner with payers to supply more data from community providers associated with a specific patient (fills the holes in the care team).

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WILL **YOU** BE PART OF THE **DISCUSSION RIGHT NOW**?

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HEALTH

Population Health Management *Subject Matter Experts*

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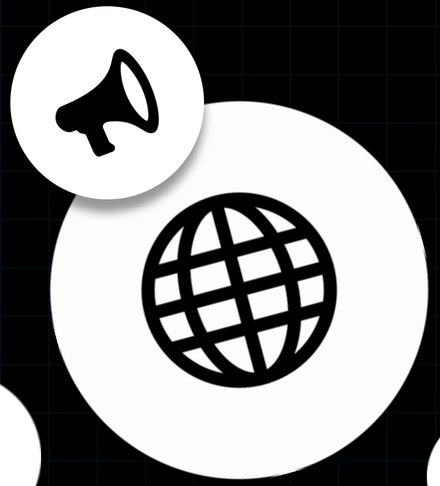

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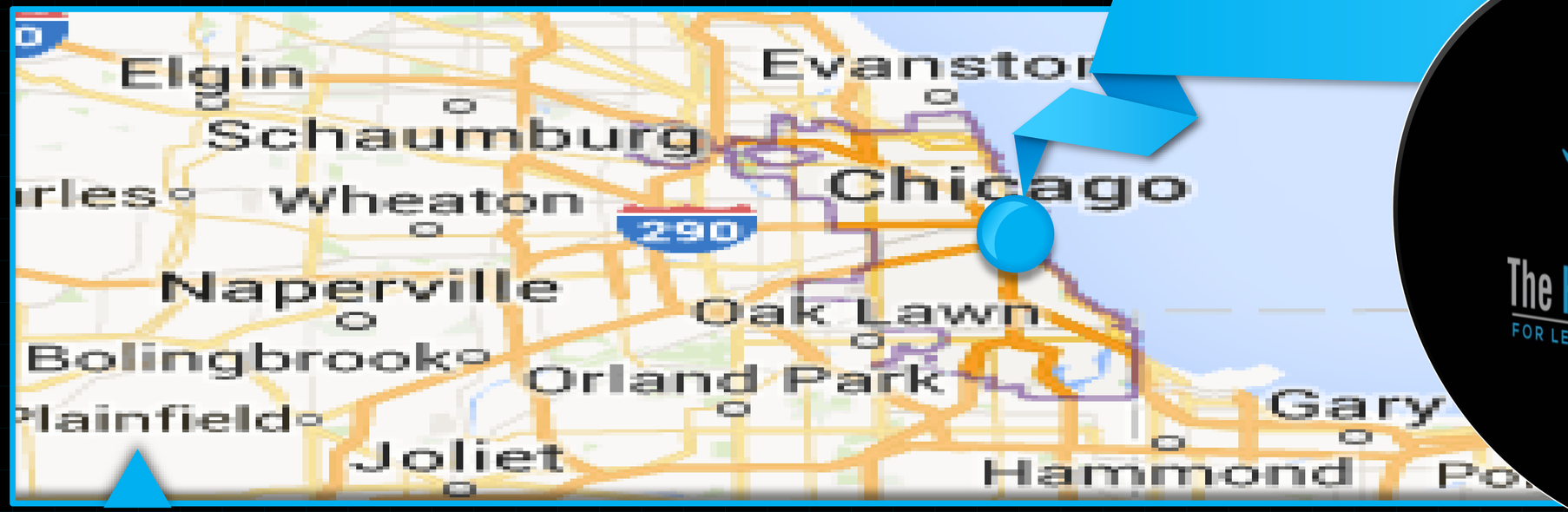
BECAUSE
SHARING IS CARING



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