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Closing the Gap: Best Practices in Population Health Management

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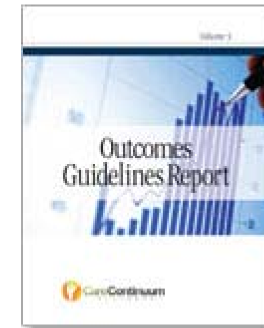
Outcomes Guidelines



Past	Present	Future
• Definitions • Measures • Evaluation Considerations	• Defining best practices • Examples of best practices	• Leading practice efforts • Standards

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Vol. 5 and Beyond

	PHM	Wellness	Chronic Care Management
Definition	✓	✓	✓
Evaluation Considerations	✓	✓	✓
Measures	✓	✓	✓
Standards	C	C	C
Defining Best Practices	✓	C	C
Leading Practice Efforts	C	C	C

✓ – Completed
C – Current Work

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2011 Q&R Areas of Focus

- Population Health Management
  - HERO-CCA Collaboration
  - PHM Integration Strategies
  - PHM Evaluation Checklist
  - PHM Evaluation Measurement Grid for ACOs/PCMHs
- Wellness
  - Engagement
  - Data Aggregation
- Chronic Care Management
  - Medication Adherence
  - Transitions of Care

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Moving towards Guidelines: HERO-CCA Collaboration

Goal: Identify and recommend measures and standards for the measurement of PHM programs for the employer community (though other settings/segments will also benefit).

- Scope: Measures and standards applicable to all programs delivered to an employer's population
- Working Group Domains
  - Health impact
  - Participation
  - Satisfaction
  - Financial outcomes
  - Value on investment
  - Organizational support

HERO-CCA Draft Domain Specifics

Participation

- Health assessment
- Screening
- Coaching (lifestyle & chronic)
- Population-based

Satisfaction

- Client satisfaction
- Participant satisfaction

Health Impact

- Health risk change (population & coaching levels)
- Clinical indicators – chronic, utilization (population & coaching levels)

Financial Outcomes

- Health care cost (i.e., medical, pharmacy)
- Absence
- Disability
- Workers comp
- Productivity

Value on Investment

- Program costs
- Incentive costs
- ROI (health care and total)

Organizational Support

- Corporate culture
- Wellness champion

HERO
HEALTH ENHANCEMENT RESEARCH ORGANIZATION

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HERO-CCA Deliverable Framework

HERO - CCA Domain Workgroup Approach	
Milestone	**Timeframe**
Phase I: Workgroup Kick-off	7/29/2011
Phase I: Define Workgroup Scope	9/1/2011
Phase I: Present Update at 2011 HERO Forum	9/13/2011
Phase I: Define Domain	10/1/2011
Phase I: Current State Assessment and Gaps	4/1/2012
Phase II: Recommend Measures	8/1/2012
Phase III: Develop Process and Measure Standards	12/1/2012

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Leading Practice Efforts:
PHM Integration and Evaluation Strategies

2011 Goal: Research, identify, and demonstrate integration strategies to embed PHM programs within new service delivery models (e.g., ACOs, PCMHs) and recommend strategies for evaluation of new service delivery models that use PHM programs

- Deliverables:
  - Detailed case studies that highlight program integration;
  - Addendum to ACO toolkit with measures and evaluation checklist.

PHM Checklist
(Care Provider – Data Collection)

Initials	Date	
ET	6/20/11	1) Has member had an annual health risk assessment?
		2) Has the member had appropriate lab work?
		3) Have members current concerns and health risks been prioritized?
		4) Evaluated the member's readiness to address a lifestyle risk(s)?
		5) Are preventive exams current?
		6) Has medication adherence been discussed when appropriate?
		7) Has an individual action plan (with goals) been discussed with the person?
		8) Has the action plan been shared with other providers (in/out of network)?
		9) Document the interactions with member?
		10) Document goal achievement?
Repeat each Year		

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PHM Checklist (Administrator – Pop. Evaluation)

Initials	Date	
ET	6/20/11	1) Have current population health risks and chronic conditions been identified?
		2) Have year over year risk change on matched cases been identified?
		3) Have interactions and goal completion been summarized?
		4) Has preventive exam compliance been calculated?
		5) Has medication compliance been calculated?
		6) Have clinical metrics on matched cases been measured?
		7) Has provider reporting compliance been assessed?
		8) Have overall results been shared with providers?
		9) Have global action plans been developed and shared to address most prevalent risks?
		10) Have global action plans been developed and shared to address risk prevention?
Repeat each Year		

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Engagement: Use of Incentives

2011 Goal: Examine the use of incentives to engage various populations both initially and long-term

- Deliverables for Q4 2011
  - Q&A document for wellness stakeholders that reviews the following areas:
    - Organizational Culture
    - Psychomotivational Theories
    - Incentive Types/Designs/Evaluation
    - Budget and Legislative Considerations
    - Learning's, Challenges, and Emerging Trends
  - Incentive designs chart that outlines key components of early adopters, enhanced offerings, and best practice designs in the area of incentive program implementation

Draft: Incentive Designs Can Support Population Health Management

Incentives that support <u>Extrinsic Motivation</u> may include but are not limited to:

- Financial e.g. premium reduction, cash
- Health plan design: e.g. waived co-pay or deductibles)
- Gift cards and trinkets
- Recognition

Incentives that support <u>Intrinsic Motivation</u> may include but are not limited to:

- Smart applications
- Social elements including networking, support, competitions
- Personalization, discovery
- Communities for Wellness and/or chronic conditions
- Multi-channel platforms (web, apps, phone, onsite, etc)

Company Profile: Early Programs

Company Profile Enhancing Health

Company Profile: Health Leader

Incentives to support Initial PHM engagement

Examples may include but are not limited to:

- take a Health Assessment
- participate in biometric screening
- register for member portal
- join a gym
- etc

Incentives to support Active Engagement

Examples may include but are not limited to:

- complete onsite programs
- digital or telephonic health coach
- complete an activity or team challenge
- adhere to treatment plan
- close gaps in care
- prevention screenings

Incentives to support risk reduction and improvement in health outcomes Examples may include but are not limited to:

- lose weight
- quit tobacco
- lower blood pressure
- lower blood glucose
- improve quality measures for chronic conditions

Disincentives, if deployed, may include:

- Financial penalties for lack of participation
- Health plan design offerings

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Deloitte-CCA Engagement Initiative

Goal: Summarize leading practices across the care continuum in consumer engagement by leading health industry stakeholder experiences.

- Work to date:
  - Outreach to 39 CCA members for one-hour interviews
- Deliverables:
  - Compendium of best practices, key components and leading thinking on health care consumer engagement, leveraging both research and interviews with select industry stakeholders
  - Summit to explore opportunities to improve consumer engagement capabilities and research

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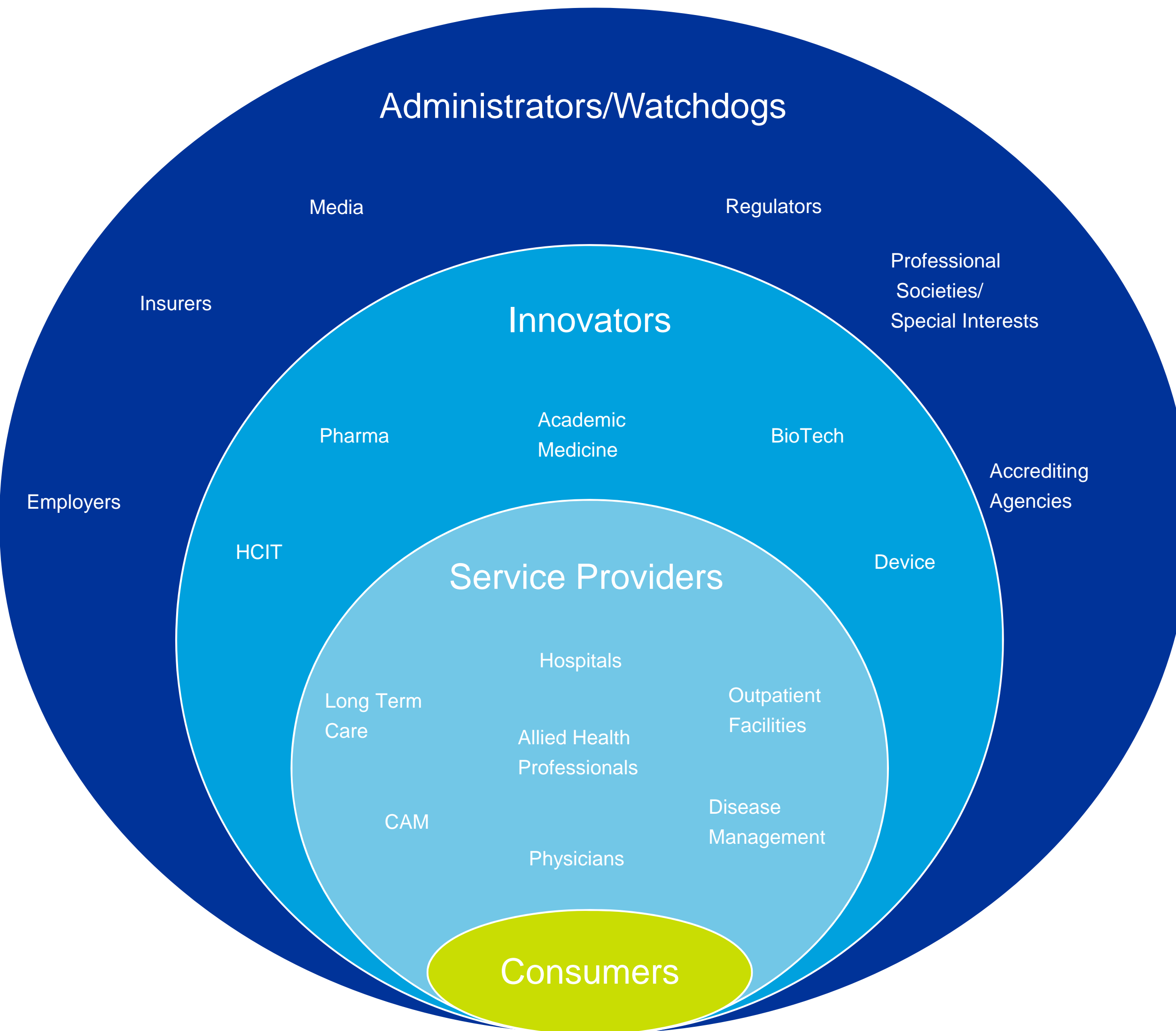
Why Consumer Engagement?

Consumer engagement is a crucial element in the progress of care management efforts



- The evidence based medicine & technology quickly improving
- Providers becoming interested care management efforts and engaging the patient
- Health care reform will put more accountability upon the individual
- Changing health behaviors and engaging the individual is crucial to impacting the outcomes of all of the efforts within health reform

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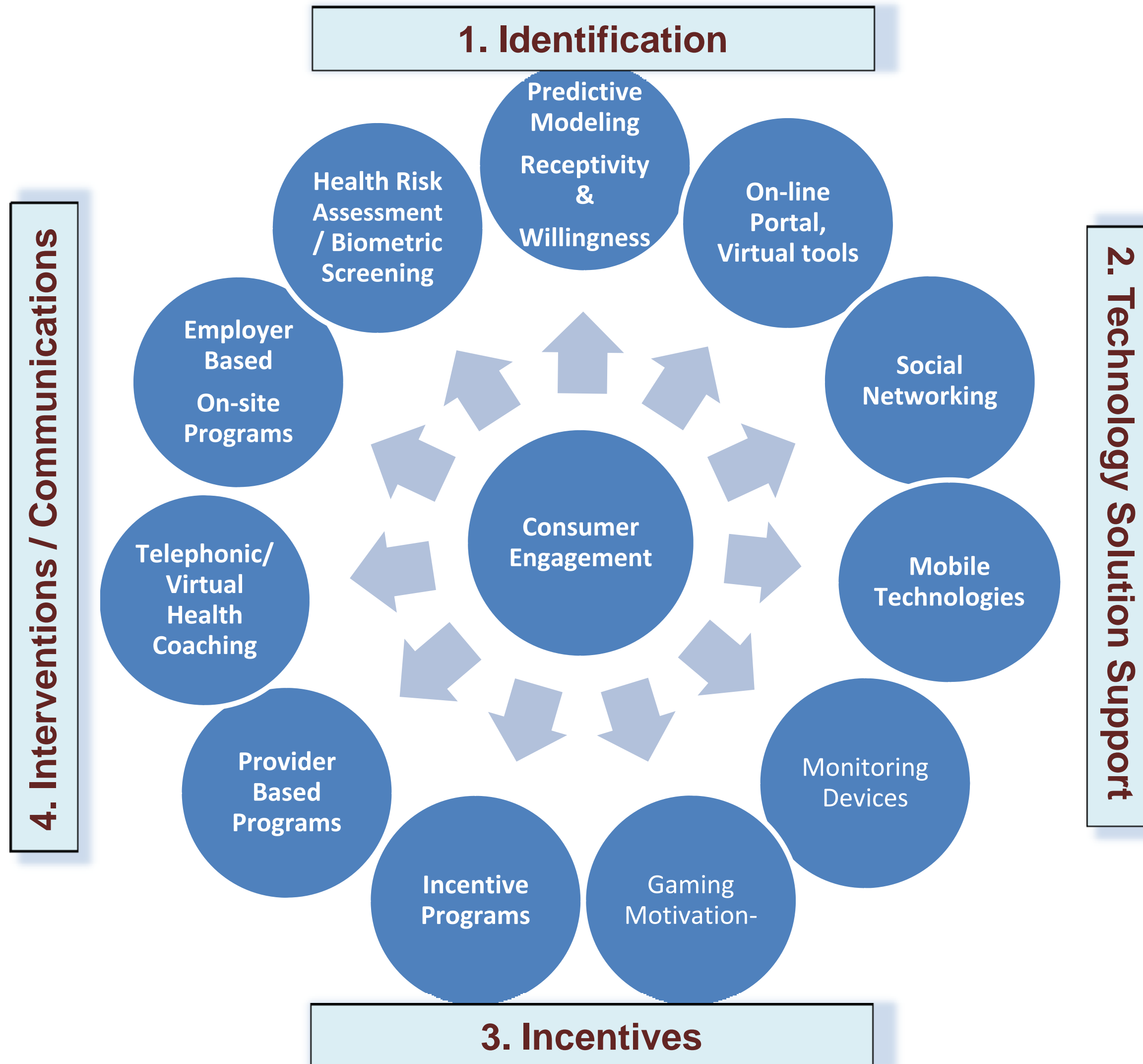
Key Engagement Components

The discussions with experts pointed to some core and promising capabilities being developed to support consumer engagement



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Outcomes Guidelines Continued: Medication Adherence

2011 Goal: Build on and improve the organizational best practice framework for medication adherence to include organizational self-assessment survey, case studies and peer-reviewed literature that supports the fields in the framework.

- Medication Adherence Organizational Best Practice Assessment: [Link to the pilot at http://www.surveymonkey.com/s/DWNSF3M]

Please consider completing the 10-minute assessment.

- Comprehensive medication adherence publication and webinar reporting CCA work to be released in Q4 2011

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Building a Best-practice Approach to Improve Medication Adherence in Organizations*

Level I – Person Assessment	Level II – Identify At-Risk Individuals	Level III - Basic Intervention	Level IV – Advanced Intervention (Goals-Based Management)	Level V – Fully Functional System
				Organization's clinical strategy links improved medication adherence to overall system success
			Organization collectively sets targets & goals to improve organizational performance in medication non-adherence in the population(s) served	Organization actively works to align its value-chain to improve medication adherence across all populations
		Organization aggregates population data to identify medication non-adherence trends	Organization builds formal database to track & report trends in medication non-adherence in the population(s) served	Organization integrates medication adherence data base into daily provider functions, provides decision support for the HCP point of care
	Organization is aligned to assess individual risk of medication non-adherence	Organization IDs critical points of care & interventions to overcome barriers of medication non-adherence in at-risk individuals & populations	Organization offers suite of targeted assessments and interventions to lessen individual risk for medication non-adherence in population(s) served	Organization identifies low HCP performers & challenges them to improve medication non-adherence outcomes
HCPs** have access to validated surveys/tools to assess individual medication non-adherence	At point of care delivery, HCPs use the validated surveys/tools to identify at-risk individuals	HCPs are aware of & assess individuals at critical points of care to ID and overcome medication non-adherence barriers	HCPs: a) Receive/access data for own population; b) Are trained to ID/close gaps; c) Set goals to decrease medication non-adherence	HCPs receive incentives, increased quality payments or reimbursement based on medication adherence performance

Lower — **Systematic Approach** — *Higher*

*Organization: any organization playing a treatment or support role in the health care space of individuals including: integrated and non-integrated health care delivery systems, pharmacies (retail or Pharmacy Benefits Manager (PBM)), analytics companies, population health management vendors, health plans, etc.

**Health care practitioners (HCPs): a provider/practitioner of any type, including physicians, case managers, pharmacists, ancillary practitioners who provides treatment or support to patients/consumers/program participants.

Medication Adherence Organizational Best Practice Assessment – Why?

- Help organizations learn about and determine best practice in medication adherence for their specific organizational type
- Surveys current activity and identifies areas for future development
- Springboard for discussions and development of interventions within the organization
- Research current health care industry activity regarding systematic approaches to medication adherence

Directional Insight from Initial Pilot Results

Q2: To what extent is the organization aligned to assess individual risk of non-adherence?

- Pilot Responses: somewhat aligned, mostly aligned, slightly aligned

Q3: At point of care delivery, health care practitioners use validated surveys/tools to identify at-risk individuals.

- Pilot Responses: sometimes, usually, rarely

- Health care practitioners do not yet make the link between adherence and outcomes, want to know how to determine if patient is non-adherent.
- How can we raise awareness with health care practitioners?
- Is there a prevalent belief that all prescriptions are filled and taken once written?

Leading Practice Efforts: Transitions of Care

2011 Goal: Develop a comprehensive best practice framework for transitions of care that improves efficiency and outcomes of care.

- Deliverable - Web page release October 2011
  - Transitions diagram depicting relationships b/t service settings and PHM components;
  - Transitions map depicting objectives, strategies, gaps and tactics for acute to post discharge/home;
  - Transitions maturity model;
  - Case Studies addressing population-level and individual case examples;
  - Resource section.

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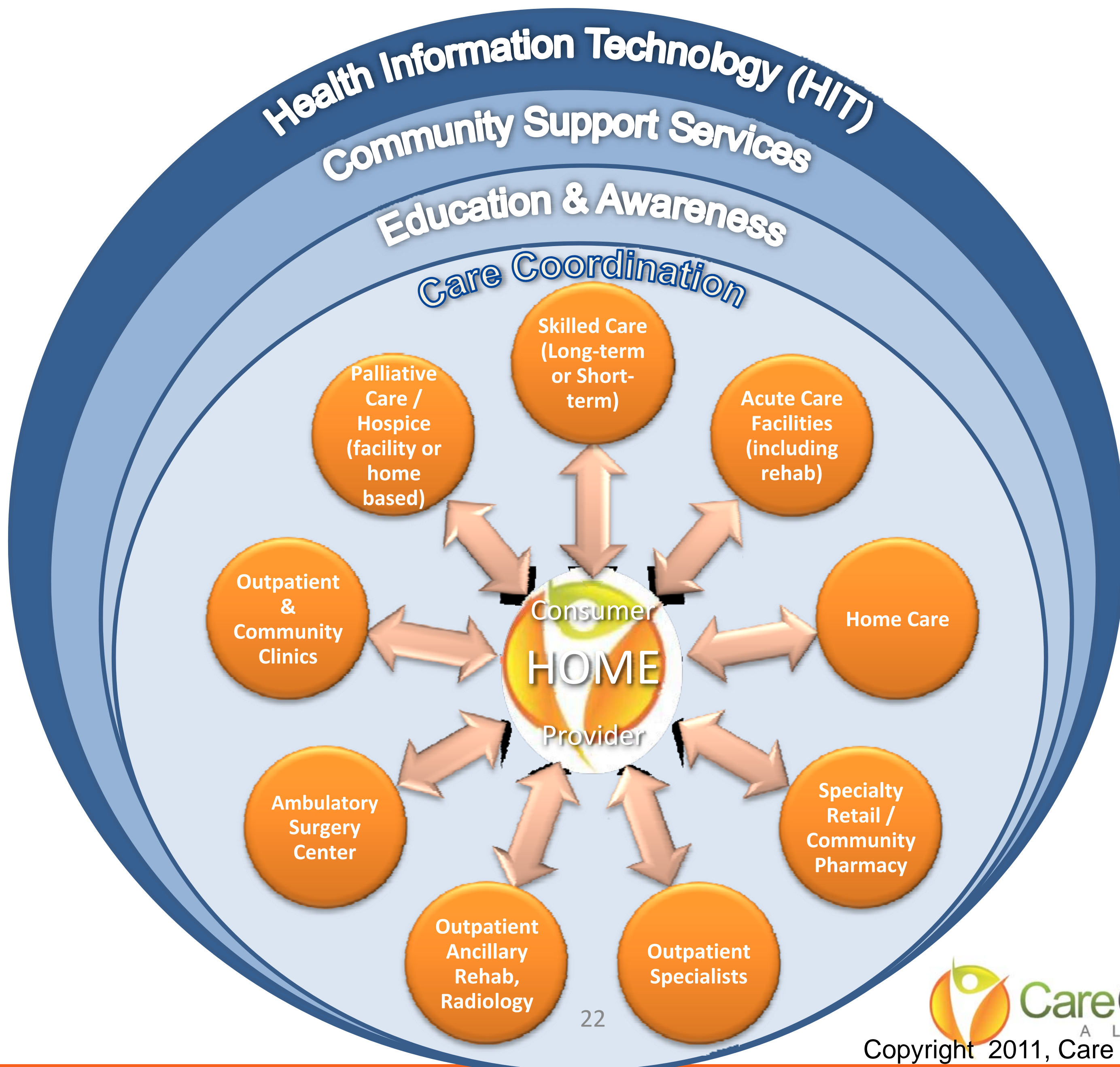
Wellness / Health Maintenance	Chronic Care	Acute Care	Post Acute	Palliative EOL



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Transitions from Acute to Post Discharge - HOME

Goal/Objectives

Ensure that systematic, patient-centered approach is utilized to support successful transitions from acute care to the home setting or an alternative lower level of care. Such an approach must emphasize care coordination principles including engagement and education of the consumer/patient and their families and collaboration among health care providers.

- Prevent Complications
- Reduce or Prevent Readmissions
- Ensure Timely Follow up with Providers
- Improve Patient/Caregiver Engagement in their Care
- Promote Self Management
- Return to Previous Level of Functioning and Improve Quality of Life

Strategies	Integrated Care Management	Resource Efficiency	Self Management Support	Community Resource Base
Tactics	Condition Management	Waste Reduction	Health Education & Information Libraries	Assessment of Patient Barriers to Maintain Community Tenure
	Case Management	Leverage Resources of Other Team Members	Decision Support Tools	Barriers Minimization Plan
	Expanded Access to Care	Level of Care Optimization	Preventative Screening	Ongoing Network of Support Groups and Resources
			Health Coaching	

HIT: PHR – EMR – HIE - Mobile Messaging/Remote Monitoring – Care Management Platforms

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Transitions Case Studies

- Highlight successes and lessons learned in a variety of transitions of care programs.
- Case studies to date
  - OptumHealth – acute to home
  - Health Dialog – acute to home

We will continue to add case studies to the Website.
Please consider submitting.

2012: Proposed Q & R Priorities

***In order of priority**

1. Demonstrate how new care delivery models can leverage best practices and tools to improve PHM.
2. Demonstrate CCA's value to the marketplace.
3. Expand CCA collaborations.
4. Identify key strategies for public sector population management programs.
5. Expand research on value of wellness programs.

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Questions?

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