Implementing a Population Health Program at your Community Health Center

Benjamin Oldfield, MD MHS
Lori Reynolds, LPN
Fair Haven Community Health Care, New Haven, CT
Objectives

At the end of this session, participants will be able to:

• Understand the imperative for population health management at community health centers
• Brainstorm local levers that can enable resource allocation towards population health management
• Develop a short- and long-term plan for implementation of a population health program at your institution
Outline

**Large group**: key definitions, need for population health management in CHCs, facilitators and barriers

**Neighbors**: brainstorm place-specific levers that can enable resources towards population health management

**Large group**: develop near-term steps and long-term goals towards program implementation
Definitions

Population health

“The health outcomes of a group of individuals, including the distribution of such outcomes within the group” (Kindig and Stoddart, 2003)
Population health management

“A clinical perspective focused on delivering care to groups and a broader perspective on the health of all people in a geographic area and emphasizes incorporation of nonclinical interventions to address social determinants of health.” (CMS 2015).
Why community health centers?

- Historical emphasis on uniting primary care and population health strategies
- Now provide care for more than 27 million Americans
- Formalize patient engagement by requiring a governing board of at least 51% patients
- Mandate the public reporting of clinical, operational, and financial metrics
- Can provide wrap-around services including primary care, behavioral health services, care coordination, and others
A word about our CHC

One of two CHCs in New Haven, CT
Population 130,000

Shared EMR with Yale/New Haven Hospital
EPIC

18,000 patients
1/3 pediatric, 2/3 adult

~20% uninsured

Population Health Program formally launched in July 2018

Medical Director of Population Health
Population Health Nursing Coordinator
Care Coordination Team
Data Team

@FairHavenCHC
Pillars of our Population Health Program

- Improving the health of defined populations
- Addressing social and structural determinants of health
- Building community capacity
- Empowering clinical teams to drive population health management
Barriers and facilitators of PHM at CHCs

- Barriers

- Facilitators
Barriers and facilitators of PHM at CHCs

Barriers
- Time and resources
- Report generating
- How to demonstrate ROI
- No known models

Facilitators
- Forward-thinking leadership
- Patient-centered medical home plus (PCMH+)
- Partnership with researchers at academic medical center
- Shared EMR with hospital
- Community trust and existing partnerships
Levers to facilitate program building

ORGANIZATIONAL PRIORITIES
FINANCIAL INCENTIVES
EXISTING PARTNERSHIPS
Levers to facilitate program building

ORGANIZATIONAL PRIORITIES
• Develop a model
• Enhance data capacity
• Improve quality metrics of interest

FINANCIAL INCENTIVES
• Anticipating APMs
• Cost savings

EXISTING PARTNERSHIPS
• Academic researchers
• Trainees
• Community-based organizations
Population health management tools

**Technology**
- EHR
- Call services and text-messaging
- Other platforms

**Community partnerships**
- Addressing social determinants
- Outreach
- Advocacy

**Care coordinators**
- Screening for social determinants
- CBO linkages

**Clinical teams**
- Panel management
- Ideas and innovation
Example project: improve asthma management

Contractual partnership with CBO that provides in-home asthma care
- CT State Innovation Model (SIM) Preventive Services Initiative

Specialty asthma clinic for those with uncontrolled disease and/or prior high utilization
- Identified through EHR queries

Referrals from asthma clinic to CBO

CBO has been taught/authorized to use EHR

Constructing an age- and risk-matched “control” cohort

Outcomes of interest:
- Process measures
- ED and hospital utilization
- Days of school or work missed
Population Receiving the Intervention (n = 78)
Age and risk-matched “virtual cohort” (n = 156)
Difference in difference

$\text{CHANGES IN WORK/SCHOOL DAYS OR CHANGES IN ED/HOSPITAL VISITS FOR INTERVENTION GROUP} - \text{CHANGES IN WORK/SCHOOL DAYS OR CHANGES IN ED/HOSPITAL VISITS FOR CONTROL GROUP} = \text{DIFF IN DIFF (IMPACT OF THE INTERVENTION)}$
**Example project: increase engagement in adolescent well-child care**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Build capacity for adolescent well-visits by blocking slots among interested providers</td>
</tr>
<tr>
<td>2.</td>
<td>Identify persons 12-21 who have not had a preventive visit in the prior 12 months</td>
</tr>
<tr>
<td>3.</td>
<td>Outreach to SBHCs to cross-identify those enrolled there</td>
</tr>
<tr>
<td>4.</td>
<td>Outreach to these individuals/families using text messaging and interactive voice response technology (Emmi Prevent).</td>
</tr>
</tbody>
</table>

**Outcomes of interest:**
- Chronology-adjusted monthly completion of adolescent well-visits
- Disparities in engagement in care by race, ethnicity, gender, language.
# Emmi<sup>®</sup> Prevent

**EmmiPrevent Campaign Summary**

FAIR HAVEN WELL CHILD

This report provides an overview of the performance of the PV1 call campaign. The top table displays how the population engaged with the campaign. The bottom table provides a more detailed look at the interactions captured. For patient-specific responses, please refer to the By Patient Report located on EmmiManager.

## Campaign Overview

<table>
<thead>
<tr>
<th></th>
<th>Patients Called</th>
<th>Calls Made</th>
<th>Patients Engaged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>1,249</td>
<td>1,249</td>
<td>289</td>
</tr>
</tbody>
</table>

## Patient Engagement Detail

### 289 Patients Engaged

#### Engaged Patients by Call Interaction

<table>
<thead>
<tr>
<th>Interaction</th>
<th>Num Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transferred to schedule</td>
<td>47</td>
</tr>
<tr>
<td>Location confirmed</td>
<td>23</td>
</tr>
<tr>
<td>Requested callback</td>
<td>45</td>
</tr>
<tr>
<td>Cancelled</td>
<td>27</td>
</tr>
<tr>
<td>Reminded to schedule</td>
<td>147</td>
</tr>
</tbody>
</table>

*Engaged patients: assessed for call and confirmed identity.
Next steps

DEVELOPING RISK SCORES

INCORPORATING CLINICAL AND CLAIMS DATA INTO EMR

MEASURING IMPACT OF INTERVENTIONS ON DISPARITIES IN CARE

@FairHavenCHC
A word on technology

• Population health programs ideally are:
  • Integrated
  • Accurate (and verifiable)
  • User-friendly
Develop your plan

- **Existing resources**
- **Coalition-building**
- **Immediate next steps**
- **Short-term goals ("early win")** ~90 days
- **Medium-term goals** 6-12 months
- **Long-term goals** 2-5 years
Discussion
Objectives

At the end of this session, participants will be able to:

• Understand the imperative for population health management at community health centers

• Brainstorm local levers that can enable resource allocation towards population health management

• Develop a short- and long-term plan for implementation of a population health program at your institution
Thank you (and stay in touch)

Benjamin Oldfield, MD MHS
b.oldfield@fhchc.org

Lori Reynolds, LPN
l.reynolds@fhchc.org