Improving Quality Through Population Health Management

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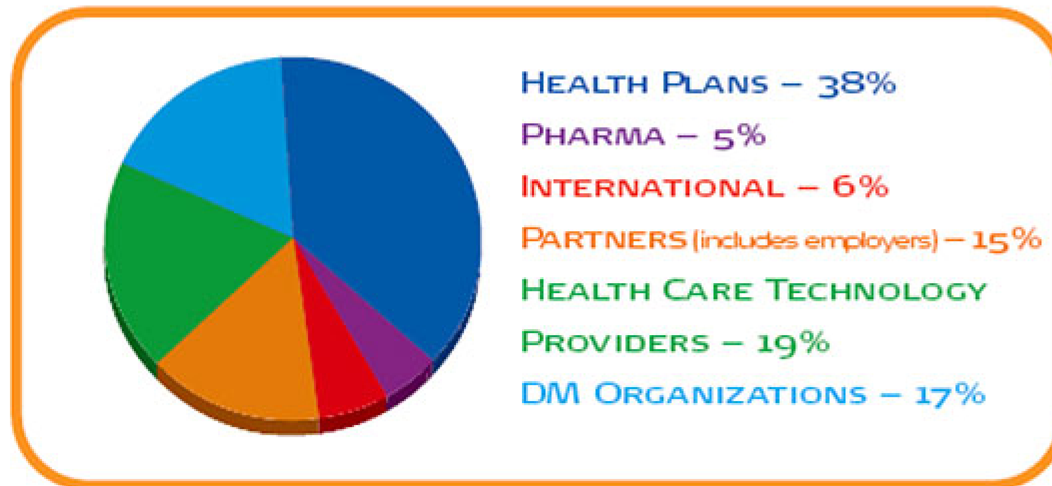
Overview

- Who we are
- Evolution of Industry
- Measuring Quality
- Medicaid Case Studies

Our Membership

- Convenes all stakeholders providing services along the care continuum.



DMAA corporate members

DMAA Goals

- Promoting population health improvement to:
  - Raise the quality of health care
  - Improve health care outcomes
  - Reduce preventable health care costs
- Through:
  - Health and Wellness Promotion
  - Disease Management
  - Care Coordination

Evolution Toward Multiple Conditions, Prevention

CHF
1994

Chronic
1998

Clinical Risk Factors
Current

Behavioral Risk Factors
Our Path

Current Model

- Programs recognize importance of managing multiple conditions including obesity and depression.
- HIT plays increasingly important role.
- Policy makers increasingly look to population health strategies for public health programs.
- Demand for reliable, consistent outcomes measures.

Population Health Improvement

- Moves beyond “disease management”.
- Incorporates strategies ranging from wellness through complex care management.
- Manages needs of individual patients to achieve goals for an entire population.
- Supports and engages all members of the health care team.

The Continuum of Care

- Wellness and Prevention
- Population Health Improvement
- Population-Based Disease Management
- High-Risk Disease Management
- Case Management

Quality Improvement Needs

- Systemic Fragmentation calls for patient-centered approach
  - 2-5 Chronic, co-morbid conditions
  - Multiple care providers
  - Variations in health literacy, adherence
- NEJM Study, 2003: Chronically ill patients prescribed recommended care only 56% of the time.
  - Prescribed vs. Received?

Quality Enhancements

- PHI identifies well, at risk, ill and fragile to:
  - Provide appropriate management and intervention
  - Promote adherence and preventive care
  - Reduce exacerbations

Measuring Quality

- Dictionary of Disease Management Terminology
- Outcomes Guidelines
- Participant Satisfaction
- Provider Satisfaction

PHI & The Chronic Care Model

- Common Approaches, Common Goals
  - Patient self-management
  - Evidence-based decision support
  - Systems for feedback, reporting
  - Clinical information systems, HIT
  - Organized, coordinated care

PHI
& Medical Home Management

- PHI:
  - Supports practitioner-patient relationship.
  - Utilizes a plan of care across the health care continuum (preventive, chronic, acute, end-of-life).
  - Resources to physicians to fill gaps in patient health literacy, knowledge, timeliness of treatment.
  - Provides assistance to physicians and groups with limited resources for care coordination.
  - Supports adherence to evidence-based processes.

PHI Leverages Technology

- Health IT an increasingly important component of chronic disease care.
- Remote monitoring technologies, Web-based education and assessment, electronic health records contribute.
- New roles for familiar technologies, such as wireless telephones and cable television, to deliver interactive, easily accessible health content.
- Emphasis on reaching those with chronic disease where they live, work.

Case Study: Wyoming

- *Healthy Together!*: EqualityCare Medicaid Clients
- Services Provided
  - Free, 24-7 access to HC professionals
  - Care Coordination for hospitalized or complex
  - Health Literacy and Educational Materials
  - Addressing Barriers caused by rural environment

Case Study: Wyoming

- 2005 Savings to Wyoming Medicaid
  - Cost avoidance of $13 million
  - Decrease in ER Visits, Admits and ALOS
- 2007 Program Expansion
  - Deploying on-site nurses in CHCs
  - Supporting WY Total Health Record and P4P projects
  - Including oral health, maternal weight, childhood behavioral issues

Case Study: Florida

- *Florida: A Health State*
  - 180k chronically ill Medicaid beneficiaries
- Program Designed at Individual Level
  - Coaching, education, intervention
  - Asthma, diabetes, hypertension, and/or CHF
  - Networked 10 hospitals; 60 care managers
  - 24-7 nurse and health service hotline

Case Study: Florida

- Quality Improvement Outcomes
  - Lower A1c; lower blood pressure; improved heart functions
  - Clients increased use of preventive services: CHF patient admits down 22%; physician visits up 23%
  - Overall ED visits down 12%; Admits down 28%
- Financial Outcomes
  - Total Savings for 3 year period: $97m
  - Medical Cost Savings: $70m

Challenges

- Demonstrating financial value through reliable consensus measures.
- Moving reimbursement models away from episodic, acute care and toward prevention, wellness and ongoing condition management.
- Patient engagement and trust.
- Coordination of all providers.

Learn More

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