Population Health Management
Identifying and Measuring Social Determinants of Health

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Webinar Tips

We recommend that you listen to the webinar over your computer speakers.

Your microphone or telephone will be muted but you can ask questions throughout the webinar, as shown on the next slide.
Welcome

This orange button on the upper right of your screen shows or hides the control panel.

Type your questions and comments here and press send to “entire audience”
Objectives for Today

- Enhance your ability to collect information for analysis in an efficient way;

- Effectively communicate the data you have collected to justify outcomes; and

- Track service delivery progress in real time.
Outline

• High Risk Population and The Social Determinants of Health
• Barriers to Progress
• Proven Service Delivery Models
• Strengths – A Community Approach
• Population Health Data Collection and Analysis
High Risk Populations and The Social Determinants of Health

- Low income
- Medicaid/Duals (*Have both Medicare and Medicaid*)
- Adult Orphans
- Low health literacy
- Polypharmacy
- Caregiver burnout
- Mis/un-diagnosed biological and psychological issues
- High risk diagnosis: CHF, COPD, Pneumonia, Hypertension, Diabetes, etc.
- Behavioral Health and Substance Abuse issue
Barriers to Progress

- Hospitals are deciding whether to build or buy services to address the social determinants of health
- Hospitals lack the capacity to see all of their high risk members face to face
- Most health systems are only providing telephonic case management services, which is not having the impact on high risk members that hospitals would like to see
- Payers, hospitals, and physicians have limited or no knowledge of the existing Area Agency on Aging or Community Based Organization network
- CBOs typically have a limited capacity to collect and analyze the data related to their service delivery
- CBOs are finding it difficult to get their message to key decision makers at hospitals across the US
Preferred Community Health Partners - Proven Service Delivery Models

• Community-based Care Transition Program (CCTP)
  • Working with 26 sites across the US
    • Average cost per readmission across the US - $10,913
    • Prevented 20,050 readmissions
    • CMS estimated cost savings - $103,935,054
  • Preferred Community Health Partners results
    • Reduced hospital readmissions by 41%
    • Gross Medicare Savings $7,833,600
    • Net Medicare Savings $4,365,467
Proven Service Delivery Models

- Aging Brain Care
  - Population Health Management Solution for Dementia & Depression
  - $15 million invested to date and 9 years of validated research
  - 3 Active programs with 5000 patients
  - Validated cost savings of 30-40%
  - CMS Innovation Award
  - Harvard Health Care Innovation Semi Finalist
    - 1 of 18 semifinalist from 478 applicants
    - 29 Countries and 43 States represented
Service Delivery Model - Collaborative Care

**Primary Care Clinician:**
- Detect and treat delirium
- Detect and treat behavioral and psychological symptoms
- Reduce exposure to medications with adverse cognitive effects (Anticholinergics; Benzodiazepine, Histamine 2 Antagonists)
- Prescribe appropriate medications for Alzheimer disease and Major depression

**Patients and Family Caregivers:**
- Coaching in Problem solving skills
- Increase Knowledge
- Respite care
- Support group

**AAA/CBO Liaison**

**Expert Team:**
- Geriatrician
- Social Psychologist
- GeroPsychiatrist

**General Environmental Modification:**
- Medication adherence support
- Home safety assessment
Strengths – A Community Approach

• Preferred Population Health Management
  • Population Health Logistics and the Aging Brain Care data collection tools
  • Macro and Micro data collected and analyzed as it relates to a patient’s social determinants of health
  • Interoperable system that allows for connection with Health Information Exchange systems such as the Indiana Health Information Exchange (IHIE) to monitor patients who are admitted, discharged, or transferred to a health care facility
POPULATION HEALTH LOGISTICS SYSTEM CAPACITIES

INFORMATION INFRASTRUCTURE
- Increased staff efficiency for information collection & entry
- Tracks client data across programs
- Maintains client records for intermittent contacts & multiple interventions
- Provides risk stratification and data analytics
- Ability to customize intervention to meet multiple contract performance requirements

Staff Efficiencies Gained!

INTEROPERABLE HEALTH IT PLATFORM
- Secure electronic data transfer (with medical e-MRs and other payers)
- Ability to connect with state health exchange systems; can monitor for referrals
- Direct billing capability and integration with financial systems
- ROI calculation (to build the business case for contract opportunities)

Facilitates NEW contracts for established services!

SERVICE PLANNING & REFERRAL MANAGEMENT
- Ensures person centered planning
- Captures caregiver data & need for support
- Real-time access to available community resources
- Electronic transfer of referral information & referral tracking
- Aligned with NCQA Standards; facilitates accreditation

NEW source of revenue from providers!

POPULATION HEALTH MANAGEMENT
- Embedded Population Health Management program
- Validated for complex patients with depression and dementia
- Anticholinergic Burden Scale
- New business line for AAA's

NEW business line to sell!
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