Population Health Framework to Inform Integrated Model of Care: Inland Empire Health Plan

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Presentation Overview

1. What is Effective Care Coordination and Management
2. What is IEHP Current State
3. Why Population Health
4. IEHP Population Health Framework & Strategic Plan
5. Core Foundations for Population Health
6. Current Population Health Initiatives at IEHP
7. Next Steps

What Does the Evidence Say Works?

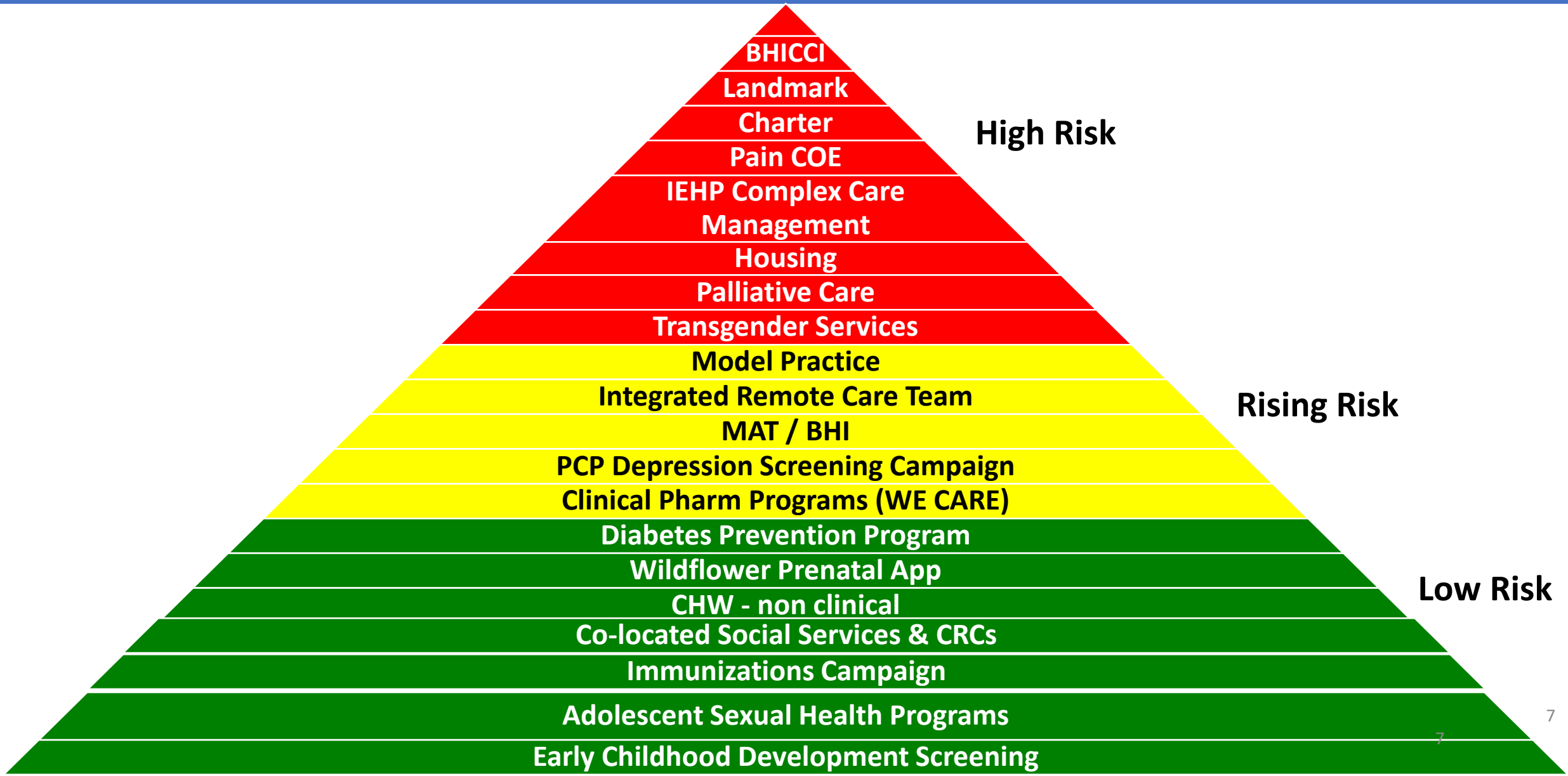
Care Management Attributes that Work

1. Target patients likely to benefit
2. Multidisciplinary teams (nurse, behavioral health clinician, community health worker (CHW)/care coordinator) at point of care
3. Engaged organizational leadership
4. Dedicated care coordinator (single point of contact)
5. Team-based care focused on engagement and skilled communication with members, families, and providers
6. Continuous monitoring of health outcomes and patient/provider experience
7. Continuity across transitions

IEHP Current State

From Disease Management to Integrated Care Management

Current Programs within Each Tier



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Program #1: Behavioral Health Integration Complex Care Initiative (BHICCI)

The Approach

- 31 integrated complex care teams – 12 organizations
- Multidisciplinary care team supported by practice coaches (RN, LCSW/MFT, CC, CHW)
- Whole person complex care
- Behavioral & physical health integration
- Measurement based care & population health

Target Population

- 4,500 IEHP members
- One chronic medical condition *and* at least one behavioral health condition
- Benefit from care management
- Stratify using Johns Hopkins ACG risk scores

Timeframe

- January 2016 to July 2018

BHICCI Framework

Patient

Care Management Team

PCP

Other Clinical Resources

Practice Change

- Quality Improvement Framework
- Multidisciplinary Team-Based Care
- Measurement Based Care
- Population Health Analytics
- Complex Care Management/ Care Coordination

Primary Care

- Skilled Nursing
- Hospital
- ED

Mental Health & Substance Use

- Substance Use Treatment
- Acute Psychiatric Care
- Residential Treatment Programs
- County MH Services

Community Resources – Family and Friends

- Employment
- Housing
- Corrections
- Peer Supports
- Other Community Based Services

MEDICAL SYSTEMS

BH SYSTEMS

COMMUNITY SUPPORTS

Program #2: IEHP Housing Initiative

$10M annually towards permanent supportive housing (PSH) for IEHP Members across Riverside and San Bernardino Counties

PSH is permanent housing first model that includes *Supportive Services* with goal of retention in housing and improved clinical outcomes

Two Populations:

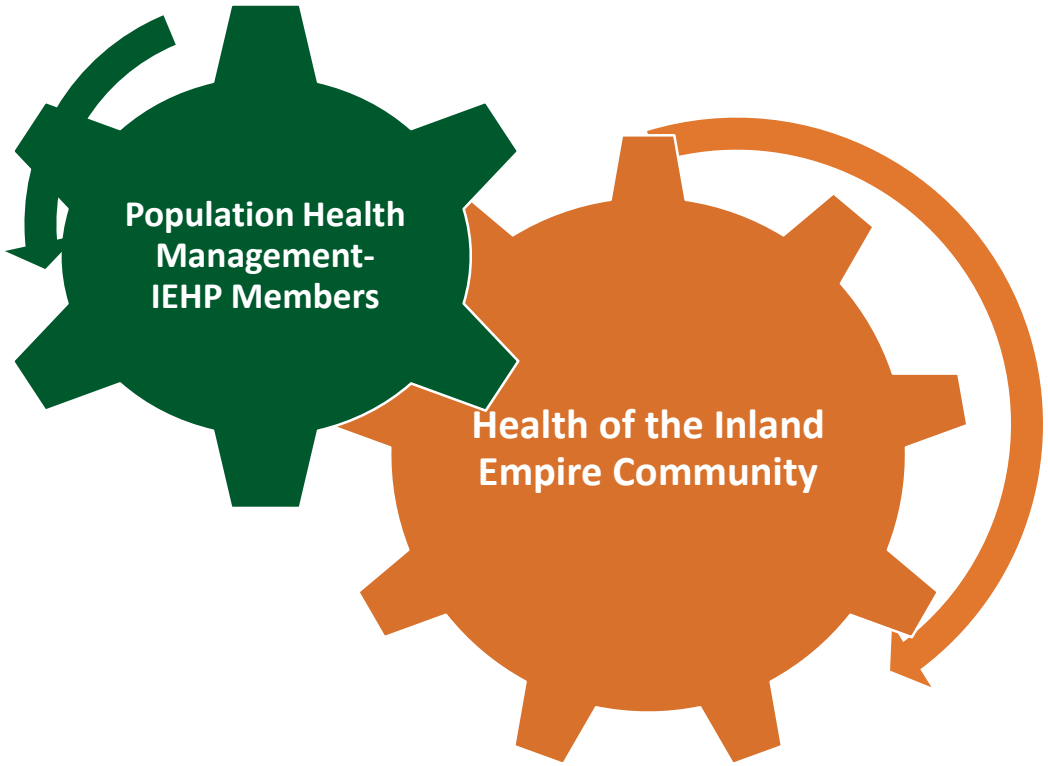
- Members in Long Term Care who are not in need of skilled care but have no home in the community
- IEHP Members who are **H**igh cost, **H**igh utilizers of health services, and **H**omeless = **3H** Members

Why Population Health?

What Is Population Health & IEHP Vision

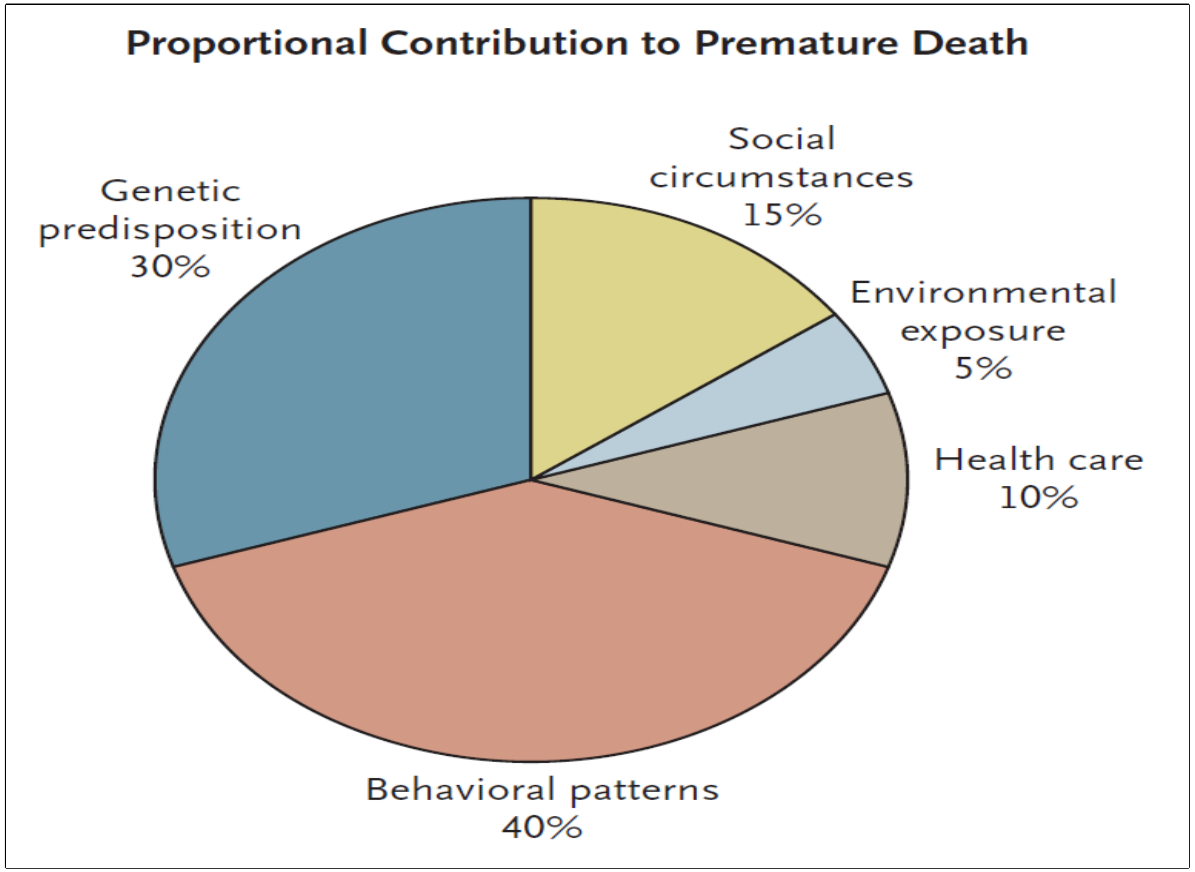
- **Population Health Management Definition:** population health management refers to strategically managing the engagement, treatment, and clinical outcomes of selected populations

- **IEHP's Population Health Vision:** IEHP commits to *assure a Culture of Health and Equity, internally and along with our members, providers, and partners,* **where everyone in the Inland Empire has the opportunity to live their healthiest and most joyful life.**



Dr. David Kindig, *American Journal of Public Health* 2003

Social Determinant of Health (SDOH)



IEHP invests in interventions to address both clinical conditions and social determinants:

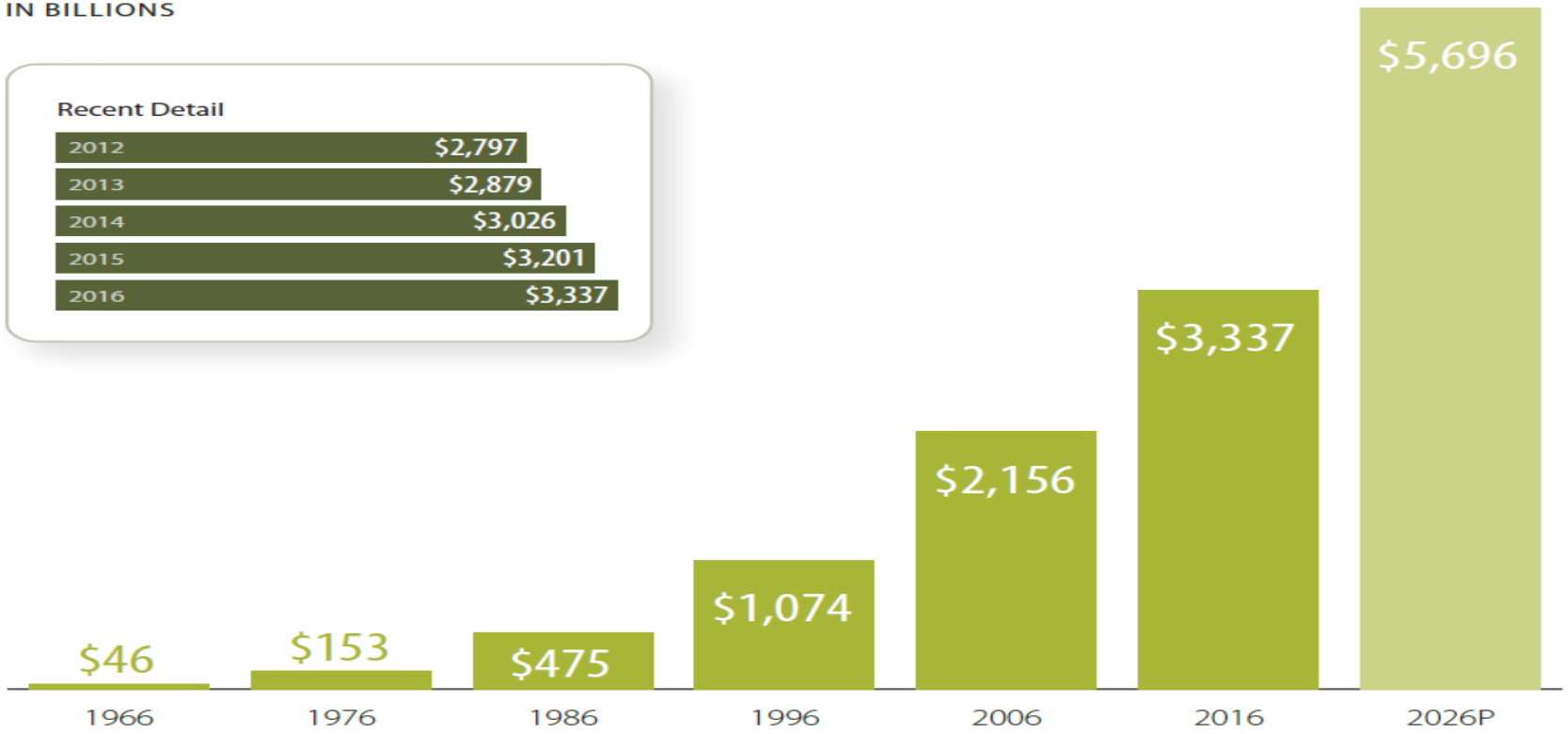
- Housing Program
- Community Resource Centers
- Behavioral Health Integration and Complex Care Initiative
- Health Homes Program

Why Do We Care?

Health Spending

United States, 1966 to 2016, Selected Years, and 10-Year Projection

IN BILLIONS



Notes: *Health spending* refers to national health expenditures (NHE). Projections shown as *P*.

Sources: NHE historical data, 1960–2016 (www.cms.gov) and NHE projections, 2017–2026 (www.cms.gov), Centers for Medicare & Medicaid Services.

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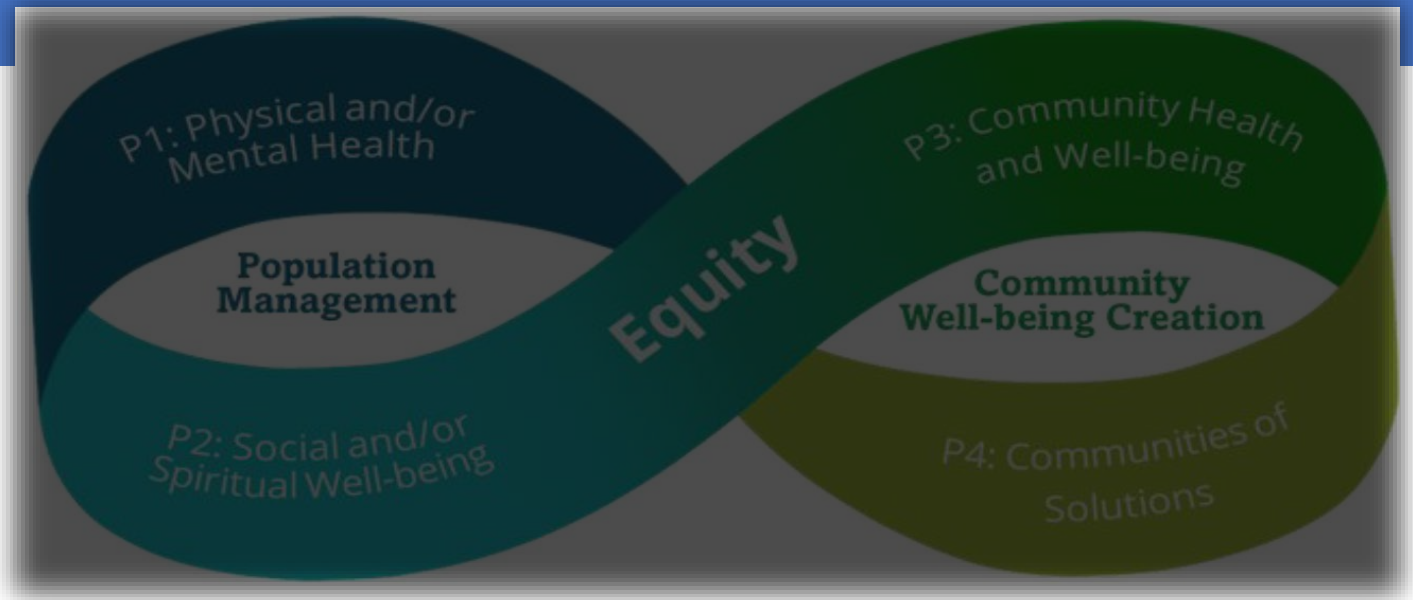
H… …are Costs 101

S… … Levels

Health spending reached $3.3 trillion in 2016 and is projected to reach $5.7 trillion by 2026. Between 2017 and 2026, health spending is projected to grow at an average rate of 5.5% per year.

Inland Empire Health Plan Population Health Framework

IHI Pathways to Population Health (P2PH) Framework



Description:

- Developed in 2018 by Institute for Healthcare Improvement (IHI) 100 Million Healthier Lives, with support from RWJF and several national partners
- Seeks to address two broad domains of work:
  - **Population Management**
  - **Community Well-being Creation**

- Further divides efforts into four domains or “portfolios” (next page)

IEHP Adoption P2PH

Portfolio I: Behavioral and/or Physical Health

Focus: Optimize clinical care for a defined populations

- Patient empanelment & care management
- Access
- Evidence-based practice
- Risk stratification
- Transitions of care
- Behavioral Health integration

Portfolio II: Social and/or Spiritual Well-Being

Focus: Optimize social and spiritual drivers for a defined population

- Identify key social and spiritual drivers of health for a population
- Design Interventions to address (i.e. housing)
- Screen individuals for social and spiritual needs
- Include social determinants in RS methodology
- Track improvements in social and spiritual needs

Portfolio III: Community Health and Well Being

Focus: Improve health outcomes of a hot-spotted community

- Use geo-maps to identify hot-spotted communities
- Collaborate with community based organizations and set collective goals
- Establish learning and improvement system
- Develop and use infrastructure for collaborative work

Portfolio IV: Communities of Solutions

Focus: Improve long-term impact on entire community, not just populations

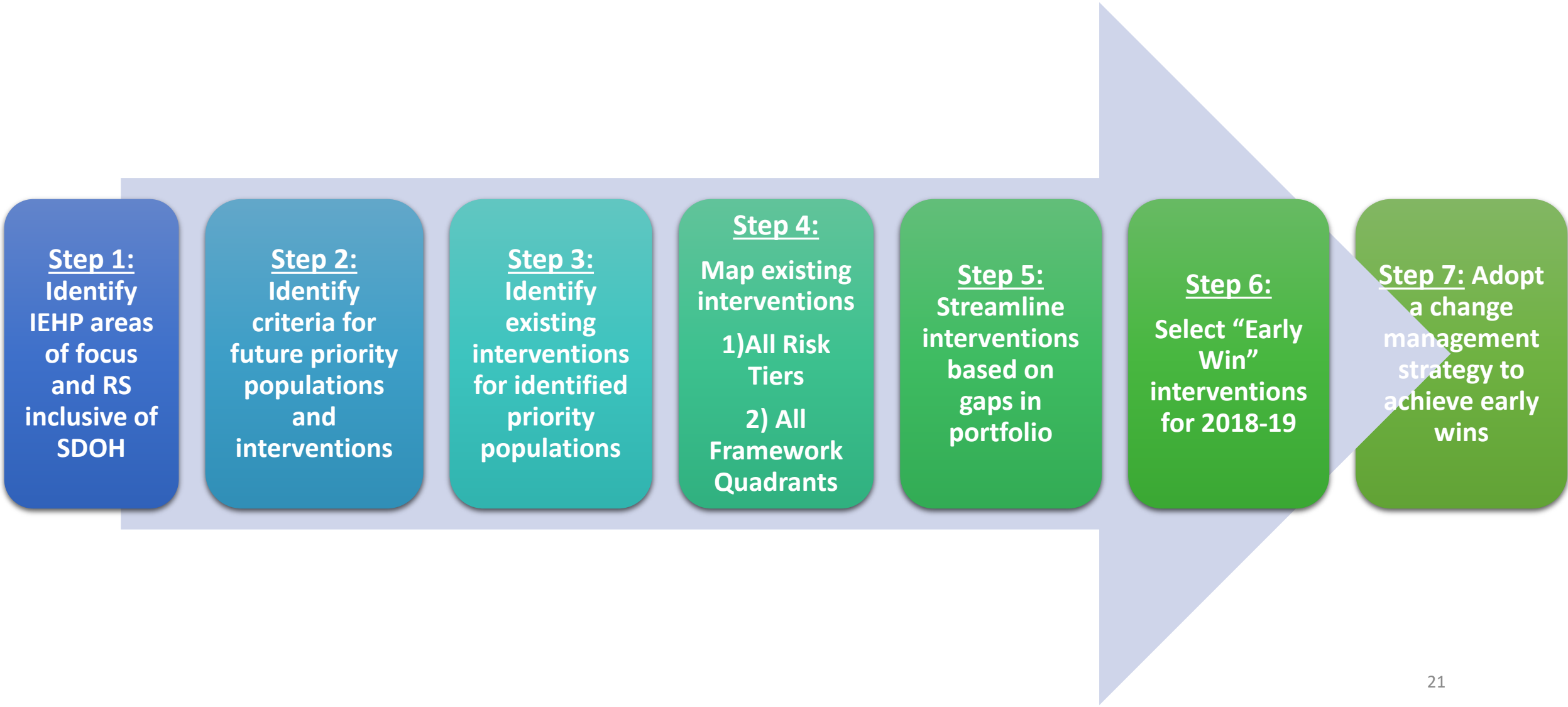
- Leverage roles such as a purchaser, employer and investor to improve overall community well-being
- Build on community assets by participating in community coalitions
- Advocate for community agreed upon policy changes

Next Steps for IEHP

Moving from Pop Health Framework….

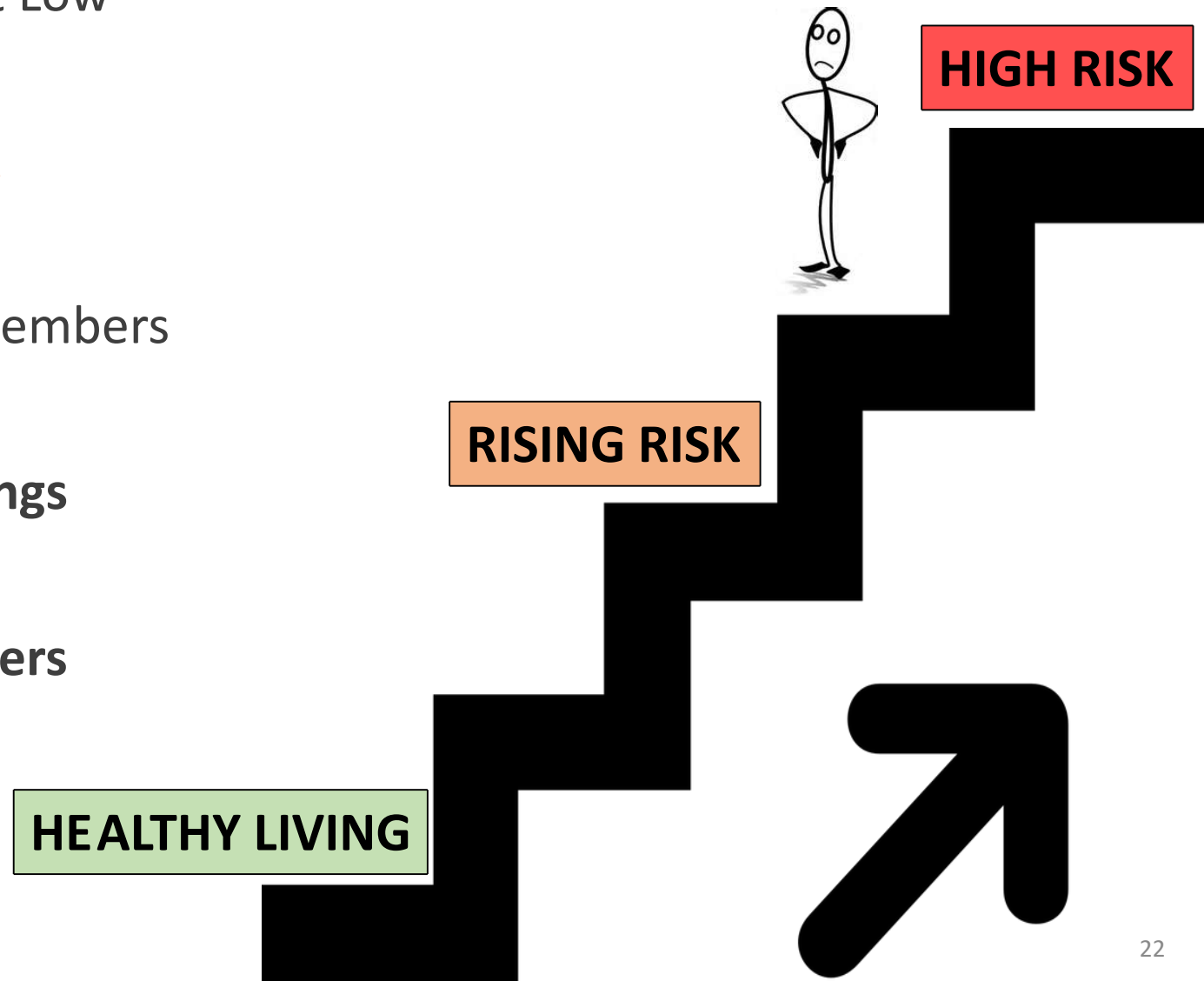
To IEHP Pop Health Strategic Plan

Ideal Strategic Plan Development



IEHP Areas of Focus: Linked to NCQA Requirements

1. **Keeping members healthy** (Members at Low Risk)
2. **Managing members with emerging risk** (Members at Rising Risk)
3. **Managing multiple chronic illnesses** (Members at High Risk)
4. **Patient safety or outcomes across settings** (Transitions of Care)
5. **Healthy and engaged IEHP team members** (IEHP Staff Health)



Examples of Criteria for Pops and Interventions

Populations Criteria

- Balanced Across Levels of Risk
- Informed by Various Assessments: Pop Health Assessment; HEDIS; Cost
- Respect Organizational Priorities

Interventions Criteria

- Balanced Portfolio
- Evidence-Based
- Direct Impact on HEDIS and CAPHS Scores

Core Foundations for Population Health

What is Foundational for Pop Health?

Integrated Care Management Model

1)Design Evidence-Based Approach to Care Coordination and Management for High and Rising Risk

2)Incorporate Interventions Aimed at Members who are Healthy

IEHP Internal Integration

1)Integrate IEHP Depts. that Support Whole Person Care

2)Begin with BH, CM, and some UM functions

3)Overtime, more impacted depts to be engaged

Pop Health IT Solution

1)Design clinical information system to facilitate data sharing between Care Team, Primary Care, and Health Plan

2)Core functionality: stratification, comprehensive assessment, care coordination, and shared care planning

IEHP Next Steps

1. Finalize Design for Point of Service Integrated Complex Care: (*BHICCI → Health Homes*)
2. Ongoing investment in *Training and Practice Coaching*
3. Build out *Care Director:* IEHP Pop Health Tool Front End (Back End already built)
4. Draft, vet with stakeholders, and finalize *Pop Health Strategic Plan*
5. *Design Evaluation* for Core Pop Health Interventions
6. *Create Outcomes Dashboard* for Core Pop Health Interventions

Discussion