Creating A New Care Management Model: Individual Care Management and Population Health Initiatives

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"Improving Ohio's Health" is an on-going series of articles and webinars that are developed to help providers in the care management of patients with hypertension and/or diabetes.

This article explores the collaboration between the Ross County Health District and Adena Health System as they work to improve the health of all their patients in a very rural area of Ohio.

Many thanks are extended to Ross County Health District personnel for their invaluable insights into the potential role of public health in supplementing private sector care management: Jeffrey C. Hill, MD, MPH, the Health Commissioner for Ross County (and Medical Director for Adena Health System's Occupational Health Department); Sharon A. R. Stanley, PHD, RN, RS and COL (ret), US Army, President, Board of Health at Ross County; Ben Avery, RS, REHS, Administrator; and Kathy Wakefield, CNP, Director, Community Health, Ross County. Also providing a comprehensive perspective on population health and care management is Bambi Huffman, MS, BSN, RN, Adena Health System's Vice President of Population Health.

The jigsaw puzzle box is open and pieces out, colors sorted, edges and borders stacked, but the pieces don't want to go together. No amount of nudging makes those two border pieces line up. Wait…hmmm, pieces of two puzzles were thrown into the same box. Is it possible to get sorted into one unified picture?

That's the feeling many groups are having around care management. It may seem impossible to keep straight all the people responsible for care management: hospitals trying to get a handle on readmissions, practices involved in new payment models such as ACO, CPC+ and PCMH, as well as new Medicaid medical home behavioral health models. This is in addition to the care management that many payers do as part of their traditional management of higher risk patients. These parts play into what is traditionally considered care management of an individual, a 1-1 approach of trying to improve an at-risk patient's health.

Population Health: More than care management in a provider's office

With more emphasis on the psycho-social needs of patients (i.e., social determinants of health), the need to expand the horizon of care management becomes painfully clear. Good care

management means not only addressing the chronic care needs of patients. The patient may be at risk due to underlying hypertension or diabetes, but providers may not be able to address the chronic conditions without addressing the social ones. Issues like nutrition and transportation can affect the success of any care management program, no matter how well-run it might be.

This is the advantage of involving public health agencies. When care management extends to a larger group of patients or to the community level, this is population health. Population health takes many of the aspects of individual care management and looks at adapting it to improve the health of the community. How well these programs can be coordinated can determine how successful a plan for population health will be.

"Public health is what we do together"

Dr. Sharon Stanley, President of the Ross County Board of Health, sums up the role of public health: "Public health is what we do together to ensure conditions where everyone can be healthy. It's about the health of the population as a whole." The role of population health management has traditionally been in the public sector, led by the Centers for Disease Control and Prevention (CDC) at the national level, the Ohio Department of Health (ODH) at the state level, and the county or city health districts at the local level. Each of these groups has a role, providing funding or data to local personnel who can translate it into local programs that support a given community's health.

As Dr. Stanley points out, though, there is a sea of change occurring with the changing population health challenges. The lines are blurring now—new payment models are requiring private organizations to expand their definition of care management to include a broader look at the population, be it Medicare, Medicaid or some other specific at-risk population.

At Adena Health System, located in Ross County, the organization's approach to care management now includes analysis of social determinants of health. Ms. Bambi Huffman, Adena's Vice President of Population Health, feels that any successful population care management program must include more information than just the list of chronic conditions for a given patient. She believes that any attempt to understand Emergency Department overutilization must include information on the broader population. This is especially true for the at-risk Medicaid population.

Public Health Can Add Data for a Comprehensive Care Management Program

Public health holds the key to analyzing the needs beyond the physician's office for a given population. As Dr. Clint Koenig, the ODH Medical Director has stated, "Public health has long been a leader in community health. It's time that expertise is better integrated into the medical neighborhood."

Public health districts and ODH can provide valuable information for a practice or a health system about the health of the overall community. This data can be reported at the community level or down to the census tract level. The data that is available for analysis comes from a variety of data sources:

Data Sources for County Level Information on Populations

Data Source	Organization Managing Data
Vital Statistics	State of Ohio
Behavioral health data from the Behavioral Risk Factor Surveillance System (BRFSS)	CDC; ODH
Ohio Disease Reporting System (ODRS)	ODH
Ohio Cancer Incidence Surveillance System (OCISS)	ODH
Environmental Health Data	Local Health District; ODH
Healthy People 2020	Office of Disease Prevention and Health Promotion (ODPHP); CMS

Using the data available to them, the Ross County Health District develops information about the top health issues and the leading causes of death in Ross County:

Ross County Health Overview (2016)

Top Health Issues	Leading Causes of Death
• Addiction	• Heart disease
• Obesity and diabetes	• Cancer (lung cancer accounted for 37% of all cancers in 2014 and 2015)
• Depression and anxiety	• Unintentional injury (over 55% due to drug overdose)
• Lung diseases and respiratory issues	• Pulmonary respiratory disease
• Infant mortality	• Stroke

This type of information can then help focus the work of providers in the private sector, such as those at Adena Health System in Chillicothe. As Ms. Huffman stated, data analytics can enrich any population health management program. Adena is responsible for managing 9,000 Medicare beneficiaries and 14,000 Medicaid beneficiaries that are participating in the new payment models (Medicare Shared Savings, CPC+, Medicaid CPC and other private health plan programs). To focus this care management, Adena receives claims information on each patient, including a patient's sex, age, diagnoses, chronic conditions, risk factors, hospital and emergency department admits and treating providers. By taking this raw data and pushing to a data warehouse, Adena can develop a meaningful approach to working with these designated populations.

A Partnership: Moving to a unified approach

What seems clear, though, is any data analysis that includes data from the specific counties will give a fuller picture. There is more that a public health department can provide the private sector if the health department is willing to rethink its role in health management, especially in chronic care programs. As Dr. Stanley points out, "The health department of the future is going to have to have *lasting* partnerships in the community that move beyond project-based work. We need to align our population health mission with others in our county and region who are also working towards health for all in our community. We shouldn't lose services like our traditional infectious disease/tuberculosis control programs, but neither can we afford to continue to do isolated programs."

The first step to creating a more complete population health plan is to come together around common goals. This includes assessing the resources (personnel, technical and programmatic) to see where the public health programs can support private care management and vice versa. This survey will lead to a greater understanding of how a given community can create a comprehensive care management approach to population health. No two communities will be identical in how they build their population health or what steps they may take to prevent emergency department overutilization or inpatient readmissions.

One key element is engagement of the patient. As Dr. Jeffrey Hill, the Health Commissioner for Ross County Health District, emphasizes: “We need always to have as our primary goal the aim of engaging the patient in his or her own health care.” Patient buy-in of their own health needs will assure that those jigsaw pieces of care management ultimately fit together into an overall picture of community health.

Re-sorting the jigsaw pieces

When rethinking these traditional roles, all parties know that the answer is changing the process, not looking for quick fix answers. Sorting the jigsaw pieces is only the first step to understanding what that larger picture will look like. As Dr. Hill points out, even with providers tracking quality metrics for chronic conditions, it may realistically be years before we can see the impact on population health. But these first steps are the all-important drivers of community success in population health.

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