Designing a Population Health Initiative

June 16, 2022

Objectives

- DESCRIBE THE STEPS INVOLVED IN DESIGNING A POPULATION HEALTH INITIATIVE
- DESCRIBE BHH POPULATION AT YOUR AGENCY

Developing a Population Health Initiative

Step One : Picking a Target Population

Step Two: Designing Interventions

- Create a plan to outreach and engage identified population
- Describe each staff person’s role within the plan. Who will do what?
- What interventions/services will you provide?

Step Three: Track and monitor progress

Step 1: Defining Your Target Population

Gathering Data and Picking a Target

- Identify a population you would like to target.
  - Prevalence at agency
  - High need/staff time
  - High cost
  - Age
  - At risk

What are the unique characteristics of this population?

Data Sources:

Tableau

Agency EHR/EMR

Ad hoc reports can be requested at Tableau Support group

Project Notify

Step 2: Designing Your Intervention

Designing Interventions

- Start a healthy eating group to target clients with high BMI's. Offer gift cards to purchase healthy food for clients who attend at least 3 groups.
- Target clients with high blood pressure. Start initiative to increase client's activity levels. Can they take 1,000 steps a day? Provide clients with pedometers. Incentivize progress- gift card for those who reach 1,000 steps 5 times in a month.
- Target clients with depression. Add a 10 minute health topic to clinical groups and IOP's. Topics could be on physical activity and mood, decreasing tobacco use, sleep hygiene etc.
- Is your target population under 25 and overweight? Design initiative that will use apps to track calories, physical activity. Start a group chat for participants where they can encourage and support each other.
- Target clients with one risk factor for diabetes. Complete Type II diabetes screen. Develop plan based on results.

CT Block grant recovery program funding- think creatively about what you may need to implement?

Defining Staff Roles

- Primary Care Consultant- provide staff with information on any health conditions that are part of the initiative. Consult on individual client cases .
- BHH Director – drive the effort to identify target population and the design of the interventions. Communicate plan to staff.
- Case manager/BHH Specialist- work with client and staff to develop goals and objectives. Assess progress on plan, provide services as outlined in plan, and update as needed.
- Admin Specialist – work with BHH Director to identify target population. Provide staff with data regarding target population.
- Nurse care manager – collaborate with the Primary Care Consultant on staff education. Work with client and staff to develop goals and objectives. Assess progress on plan, provide services as outlined in plan, and update as needed.
- Transition Coordinator – work with hospitals if warranted, provide insights into community resources
- Behavioral Health Clinician – work with staff and client to develop goals and objectives. Assess progress on plan, provide services as outlined in plan, and update as needed.

Step 3: Monitoring Progress

Measuring Progress and Outcomes

As part of the design process, think about how you will measure and track progress on the initiative. Develop both short term and long term goals and the steps needed to achieve goals.

- Will you look at service delivery? Do you want to increase service delivery by 5% over a specific time period?
- Will you look at health outcomes? Will you set goal of decreasing the prevalence of a particular health condition? How will you track it?
- Will you look at attendance/participation? How can you track this?

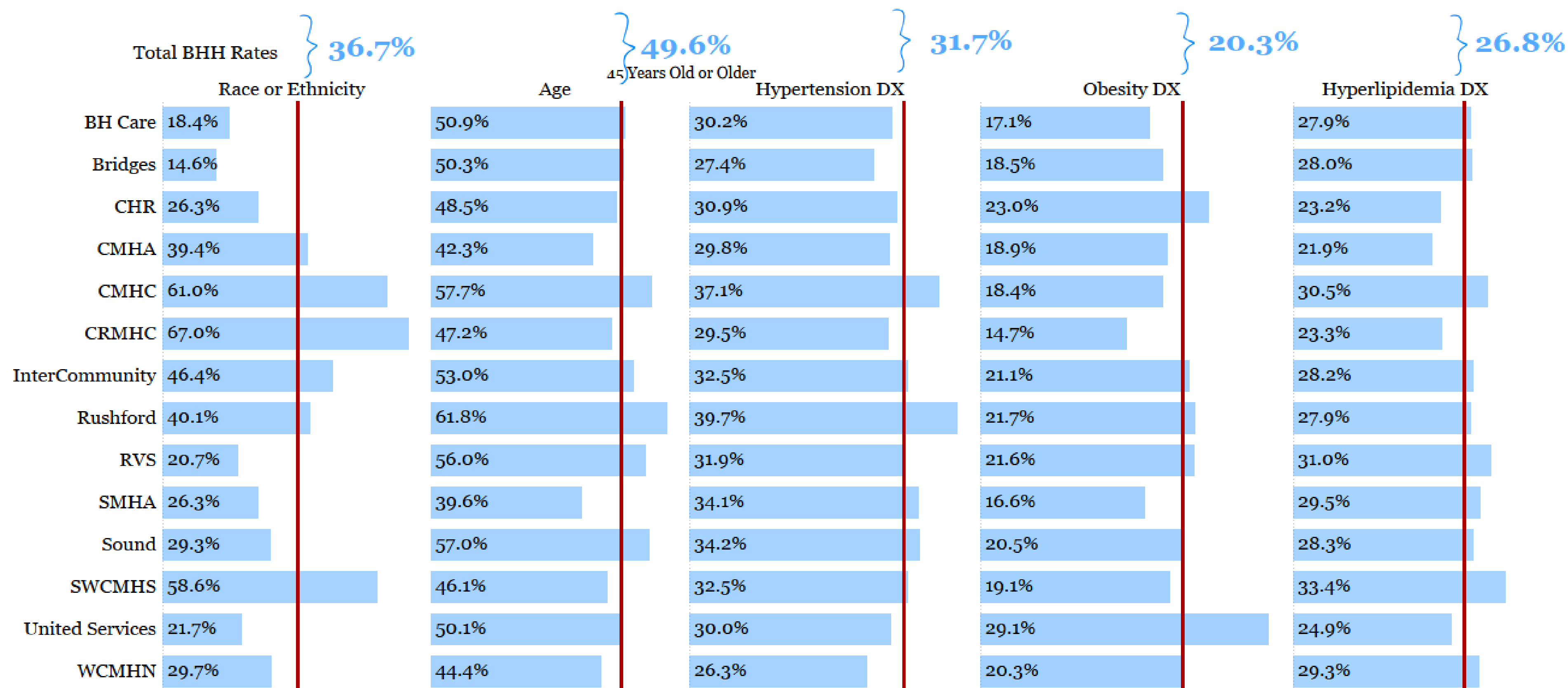
Let’s Practice: Diabetes

Step 1: Defining Target Population

% of BHH Clients At-Risk for Type II Diabetes

Sub Group with <u>At Least One</u> Higher Risk Factor of Developing Type II Diabetes

These tables look at BHH enrollees, enrolled at least 1 day in 2021, without a diagnosis of Diabetes.
Risk factors include: Race, Ethnicity and Age. Non-White or Hispanic enrollees and enrollees over the age of 45 are at higher risk of developing Type II Diabetes. Some of the medical risk factors for Diabetes include diagnoses of Obesity, Hyperlipidema and/or Hypertension.



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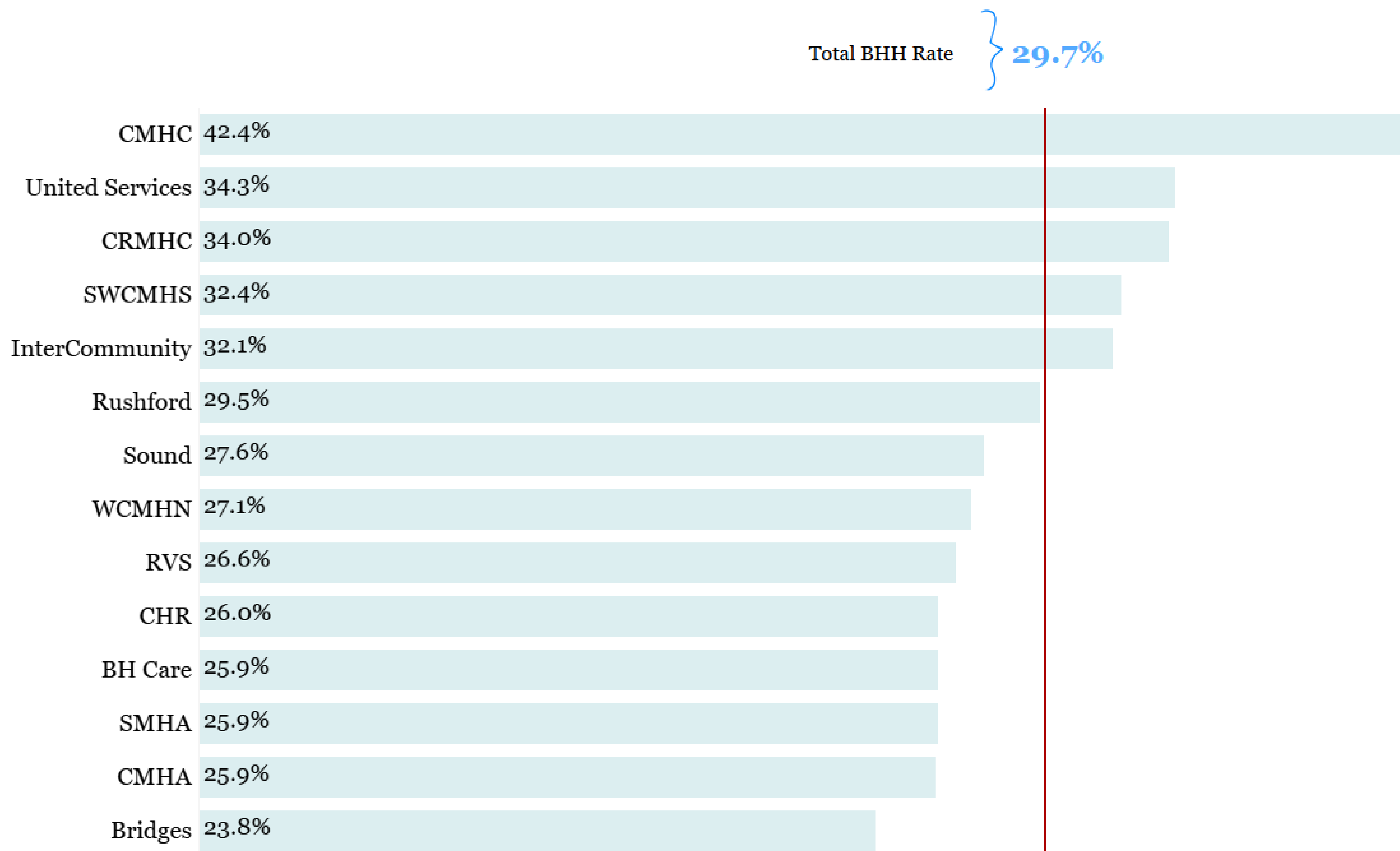
% of BHH Clients on a Medication that May Raise A1c

Distinct Count of Active BHH Enrollees that are not on the CHN Diabetes report but are on a Medication that May Raise their A1C with the last Medication fill date being in 2022.

Total BHH Rate 32.6%

Provider	Rate
BH Care	28.1%
Bridges	43.0%
CHR	32.3%
CMHA	31.4%
CMHC	31.3%
CRMHC	29.1%
InterCommunity	34.3%
Rushford	33.5%
RVS	23.7%
SMHA	37.3%
Sound	30.9%
SWCMHS	42.0%
United Services	21.9%
WCMHN	35.6%

BHH Enrollees Diagnosed with Diabetes in the 2021 Population Health Profile



Step 2: Designing Your Intervention

Staff Preparation and Education

Primary Care Consultant and Nurse care manager

- What is Diabetes?
- Who Is at Risk?
- What are signs and symptoms?
- How is it treated?
- Who can staff go to with questions?

Type 2 Diabetes

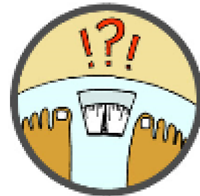
TYPE 2 (90%)-INSULIN RESISTANCE OR LOW INSULIN LEVELS.

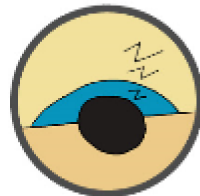
INSULIN RESISTANCE- IS WHEN CELLS IN YOUR MUSCLES, FAT, AND LIVER DO NOT RESPOND WELL TO INSULIN AND CAN'T USE GLUCOSE FROM YOUR BLOOD. THIS RESULTS IN HIGH LEVELS OF SUGAR IN THE BLOOD STREAM.

IF NOT REVERSED INSULIN RESISTANCE WILL RESULT IN THE PANCREAS INCREASING PRODUCTION OF INSULIN, EVENTUALLY CAUSING BURN OUT AND INSUFFICIENT INSULIN PRODUCTION.

Diabetes Type 2- warning signs

DIABETES: WARNING SIGNS





- Increased thirst
- Increased urination
- Increased hunger
- Fatigue
- Blurry vision
- Frequent infections or slow healing sores
- Tingling, pain or numbness in hands or feet

Risks of Diabetes

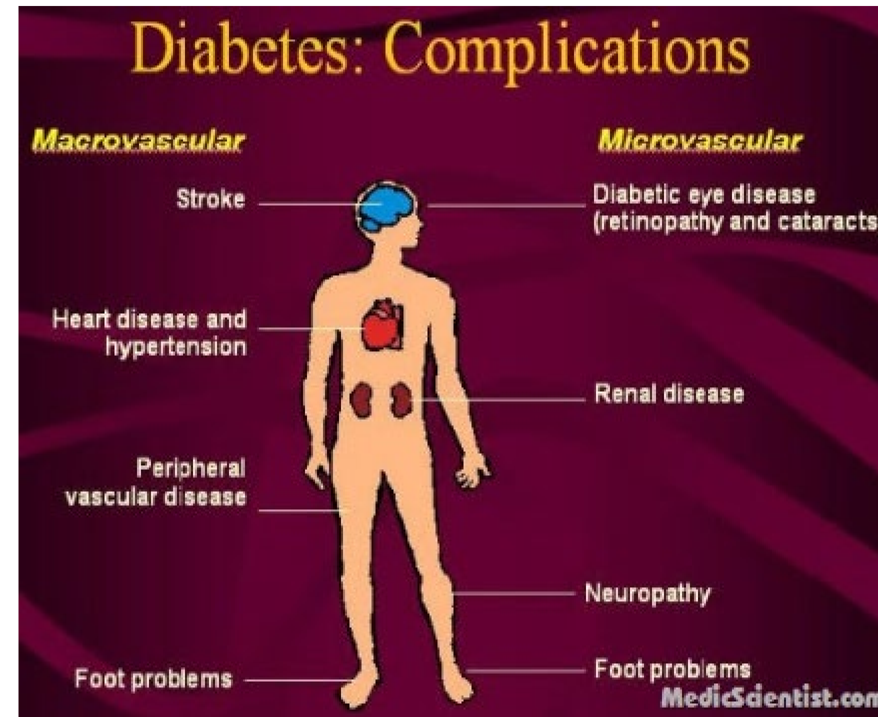
- Family history, genetics
- Increased risks –Asian, Hispanic, African-American
- Obesity
- Lifestyle- exercise, dietary choices
- Medications: antipsychotics, steroids, others

Diabetes/ Prediabetes Diagnosis

HbA1c	eAG	
	mg/dL	mmol/L
Ready reference		
6	126	7.0
6.5	140	7.8
7	154	8.6
7.5	169	9.4
8	183	10.2
8.5	197	11.0
9	212	11.8
9.5	226	12.6
10	240	13.4

- *Fasting* blood sugar
  - <100= normal
  - 100-126= prediabetes
  - >126 =diabetes
- *Random* blood sugar > 200, with symptoms
- **Hemoglobin A1C** (tells average blood sugar for past 3 months)
  - <5.7 = normal
  - 5.7 to 6.4 = prediabetes
  - >6.5 = diabetes

Complications from Unmanaged Diabetes.



Diabetes Management

- **Education**- progressive disease
- **Reduce complications**

Achieve blood sugars close to normal. A1C < 7

-Annual eye exams

-Good dental care

- Decrease **cardiovascular risks**
  - d/c smoking
  - Possibly start low dose aspirin
  - Manage cholesterol
  - Diet
  - Exercise
  - Monitor and treat high blood pressure and kidney function

Blood sugar control through:

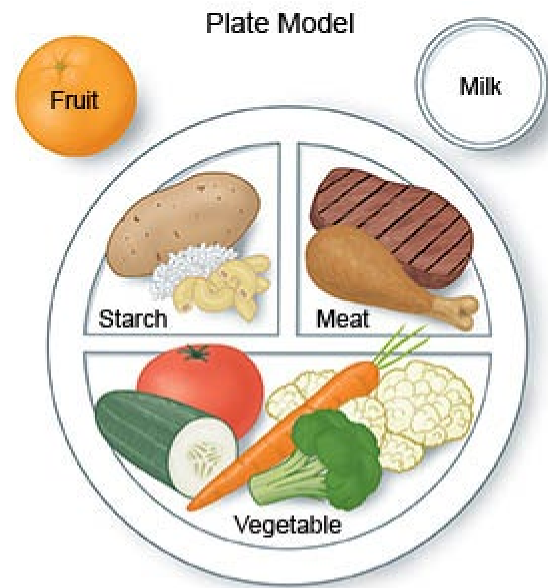
- Diet
- Exercise – 30 minutes most days.

If **Hemoglobin A1C >7.5 to 8.0**, start:

- medication –Tablets- often combination
- Insulin
- Non-insulin injectable

Self monitoring of blood glucose

Diabetic Diet



- Less processed carbs and more
  - Veggies
  - Fruits
  - Whole grains
  - Legumes
  - Dairy
  - Lean protein
  - Fiber
  - Avoid drinks high in sugar

Designing Interventions

All Members of Client Care Team

- Target clients with diabetes. Start a diabetes education group that emphasizes the recommended annual exams. In addition to group, CM/BHH Specialist and nurse care manager work 1:1 with clients. Assess barriers to receiving recommended care- is it transportation, is it knowledge based? Address barriers in 1:1 work as well as group.
- Target clients who take a medication that could raise A1C levels. Collaborate with prescribers. CSP/BHH Specialist and/or nurse care manager meets with clients after appointment to provide psychoeducation. Get baseline A1C if there is none on record. Prescriber can assess current meds and see if potential to change to one with less risk of raising A1C.

Step 3: Monitoring Progress

How do I Evaluate the Initiative?

All Members of Client Care Team

- Set goal to increase by x% the BHH members who receive their diabetes screens annually. Can use a previous year to compare. Complete needs assessment of clients who did not receive recommended diabetes care and use information to plan for future activities.
- Set goal to speak with every client on med that can raise A1C. Within 6 months, 80% will have a A1C test. Prescriber and staff will document conversation regarding if possible to switch meds in chart.

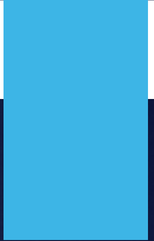
Breakout Groups

What population would you like to target?

What are some interventions you think you will try?

Project Notify and Utilization Trends

CMHA



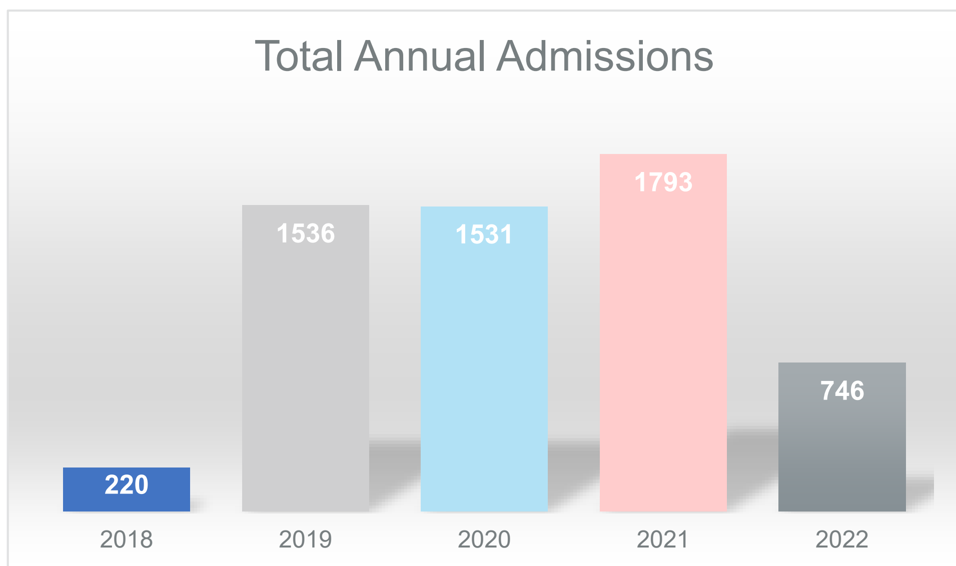
Project Notify Summary

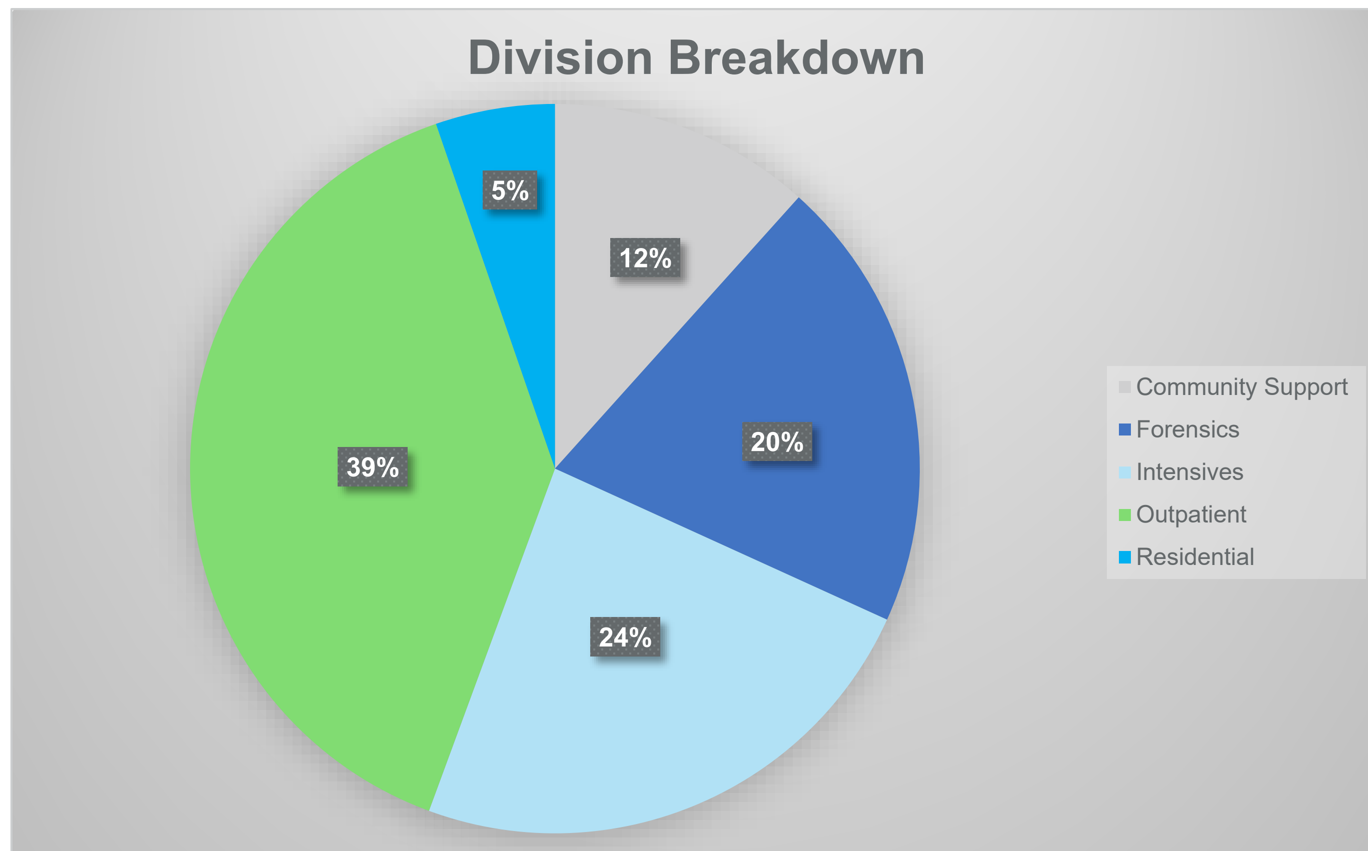
SEAN ROWLAND AND LISA DALEY

JUNE 13, 2022

Overall Totals

- 999 clients with Notifications
- 5826 Notifications
- Average ≈ 1600 visits/year
- (Average ≈ 370 clients/year





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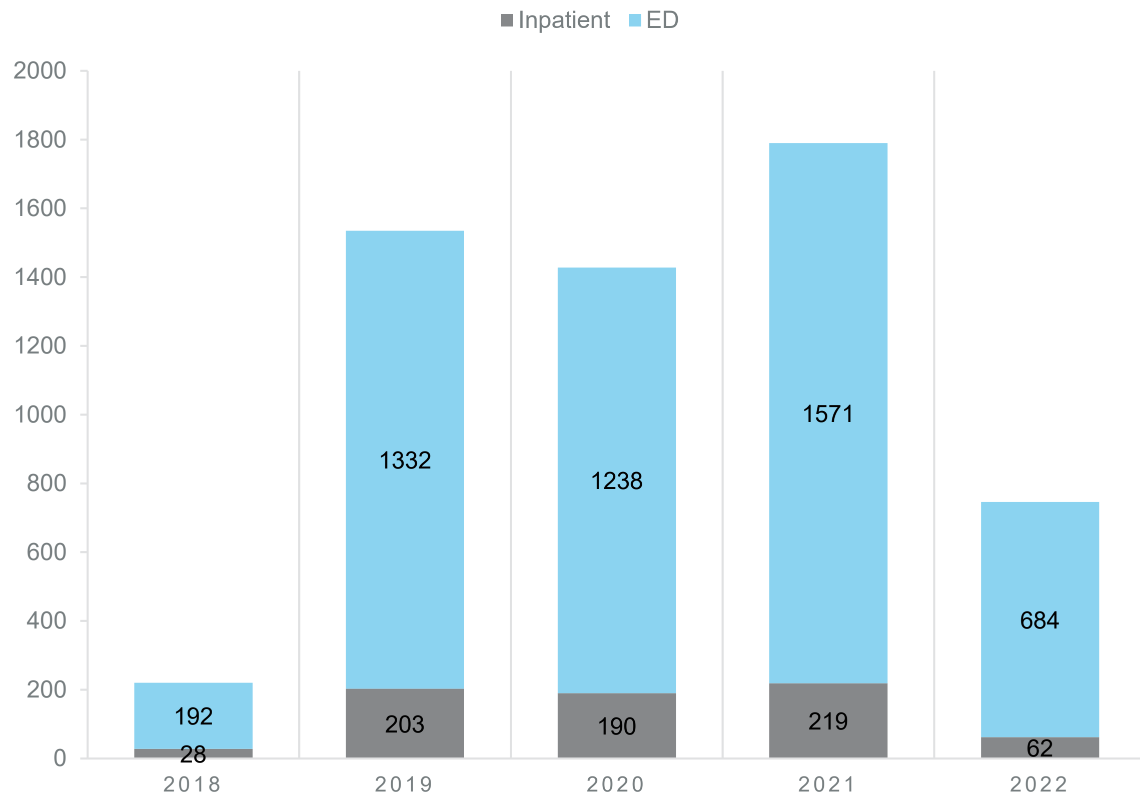
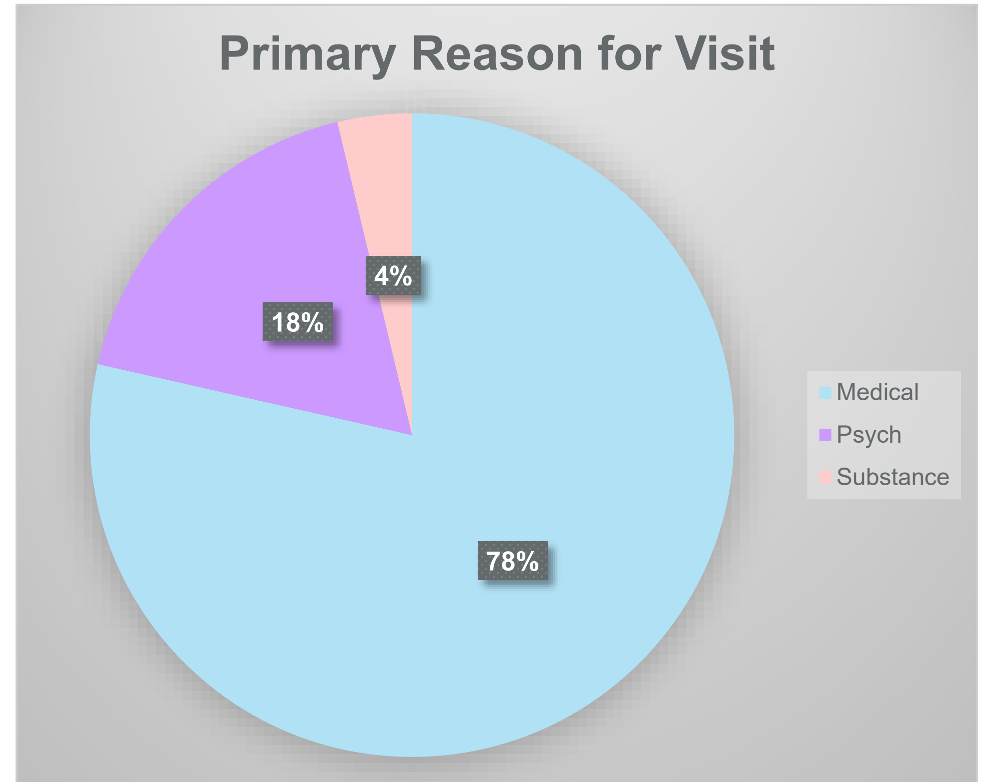
Type of Visits per Year





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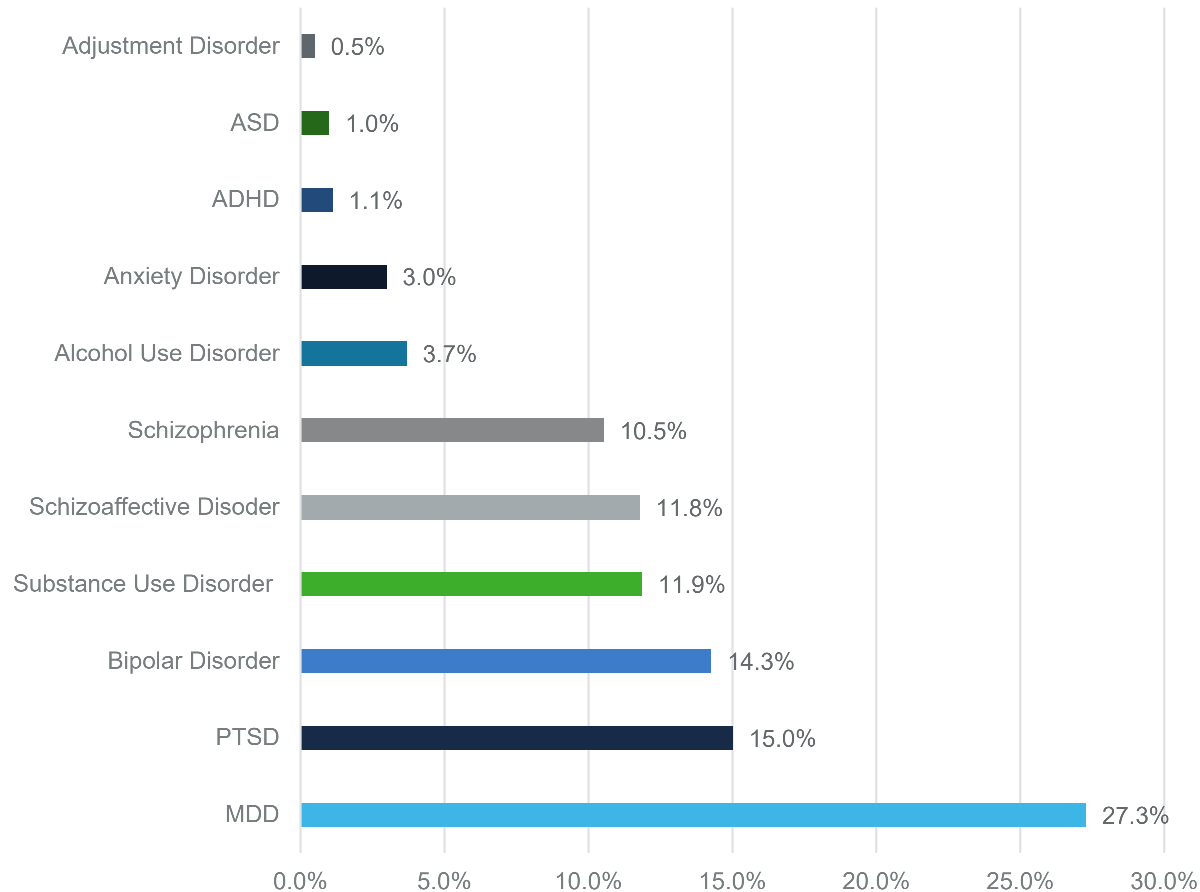
Primary BH Diagnosis (2021-22) and Hospital



- Since 2021, most common Primary BH Diagnoses:
  - MDD (27%)
  - PTSD (15%)
  - Bipolar Do (14%)
  - Schizophrenia/Schizoaffective Do (22%)
- 89% of notifications were from THOCC

Hospital Name	Total
Hospital of Central Connecticut	5172
Hartford Hospital	378
Midstate Medical Center	82
Charlotte Hungerford Hospital	41
Yale New Haven Hospital	30
Other	109

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Next Steps

Task	Deadline
Identify Population- send to Katharine and Denise	07/19
Written overview of Your Pop Health project – send to Katharine and Denise	08/31
Staff Roles, how will you engage with clients, what materials will you need?	
Review and ask questions on Pop Health project. Prepare for implementation.	September provider calls
Agencies present on their Pop Health Initiatives	October BHH Workgroup meeting

Resources

BHH Health Promotion Service

Evidence-Based Resources and Education Guide

Diabetes

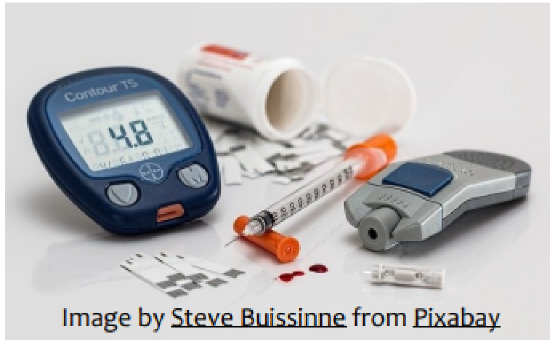

Image by Steve Buissinne from Pixabay

Self-Management Resources

⇒ **Association of Diabetes Care and Education Specialists:** Resources for People Living with Diabetes

⇒ **National Institute of Diabetes and Digestive and Kidney Diseases:** 4 Steps to Manage Your Diabetes for Life

⇒ **Center for Disease Control:** Living with Diabetes

Overview Resources

⇒ **National Institute of Diabetes and Digestive and Kidney Diseases:** Diabetes

⇒ **Diabetes Research Institute:** What is Diabetes

Staff Training Resources

⇒ **Center for Disease Control:** Diabetes Self-Management Education and Support

⇒ **Johns Hopkins Medicine:** Diabetes Self Management Patient Education Materials

⇒ **National Council on Aging:** Diabetes Self-Management Training: Information Resource

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https://www.ctintegratedcare.com/upload/2021-03-26-Health-Promotion-Resources.pdf

Resources

- Practical Tools for Behavioral Health Staff Supporting the Medical Care of People with Serious Mental Illness (smiadviser.org)
- Utilizing Next-Generation Digital Health Technology to Improve Care for People with SMI (smiadviser.org)
- Monthly Tableau Support group

Diabetes Risk Tests

Our 60-Second Type 2 Diabetes Risk Test

Are you taking this test for yourself, or for a loved one?

FOR MYSELF

FOR SOMEONE ELSE

Select Language

Discover your BMI

Not sure if you need to or how much weight you need to lose? This tool is for you—after all, knowing your BMI is a great first step on your lifestyle change journey.

Try the BMI Calculator

https://www.diabetes.org/tools-support/tools-know-your-risk