WALPEN Population Health Cohort

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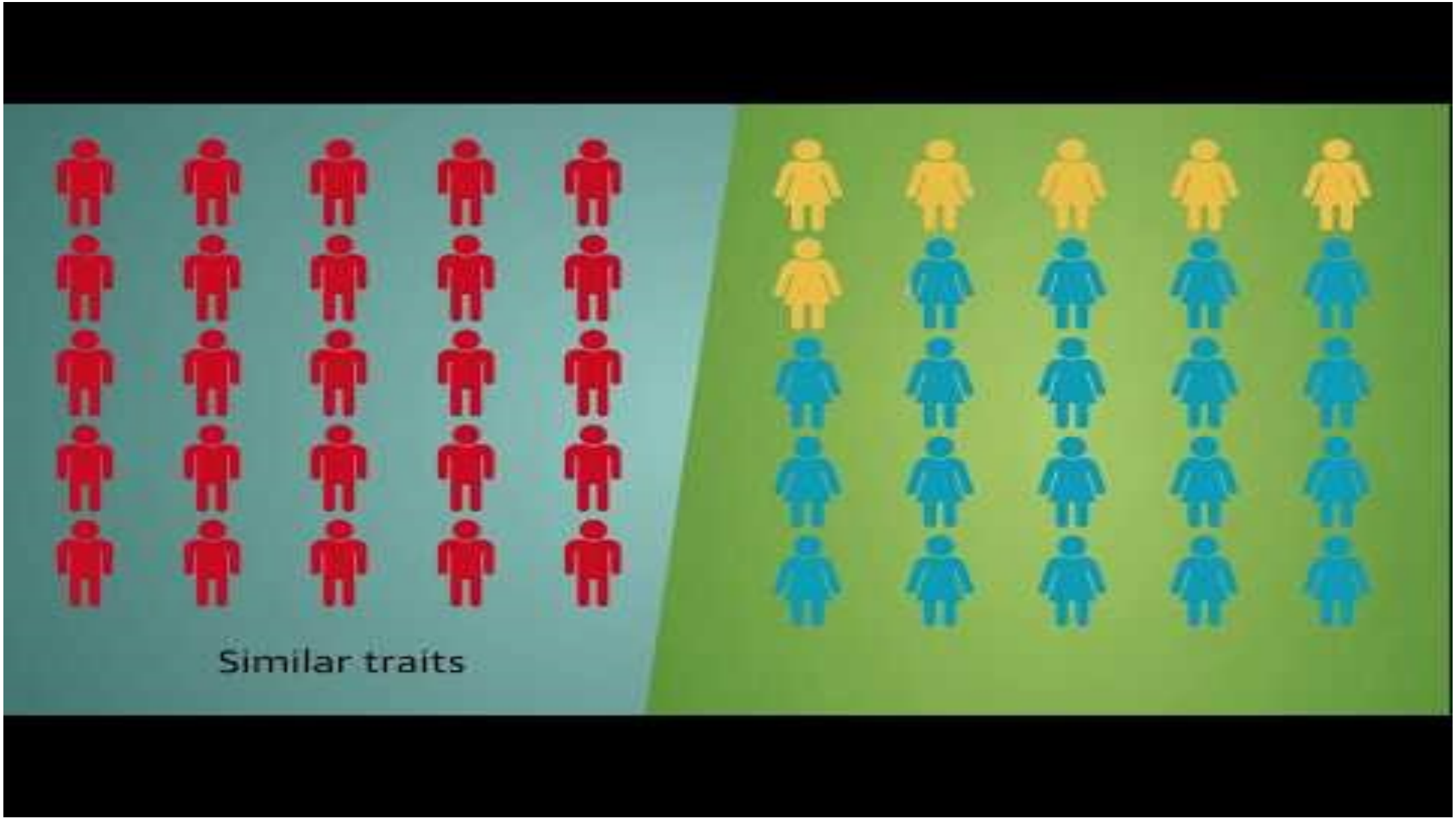
What is Population Health?

"Population health is defined as **the health outcomes of a group of individuals, including the distribution of such outcomes within the group**. These groups are often geographic populations, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group."

- David Kindig, MD, PhD


Similar traits

36.2% of Louisiana adults are obese

that fills

TIGER STADIUM

16x

22.8% of Louisiana adults smoke

that fills the

SUPERDOME

13x

12.7%
Prevalence of Diabetes

39.3%
Prevalence of Hypertension

5.3%
Prevalence of Heart Disease

Source: 2015 BRFSS

12.7% of Louisiana residents have **diabetes.**

About **60%** of these diabetics are **obese.**

5.3% of Louisiana residents have **heart disease.**

About **50%** of those with heart disease are **obese.**

22.8% of Louisiana residents **smoke.**

Almost **33%** of these smokers are **obese.**

Source: 2015 BRFSS

WALPEN Population Health Cohort

What is the Population Health Cohort?

- **Collaborative quality improvement program** which supports implementation of strategies aimed at improving population management within a primary care setting

- Specific focus on individuals at risk for or diagnosed with **hypertension, hyperlipidemia** and **type 2 diabetes**

How does it work?

- Competitive application process
- Well-Ahead will select up to 15 healthcare organizations
- Complete a signed agreement with Well-Ahead, outlining roles and requirements, including a two year commitment
- Complete an organizational assessment
- Develop and implement a practice coaching plan
- Receive ongoing support and resources
- Participate in networking opportunities for cohort participants

Why should I participate in the cohort?

- Contribute to Louisiana's efforts to improve the health of those at risk for cardiovascular disease and diabetes
- Assistance in improving your population health management and quality metrics
- Financial incentive of up to $10,000/year
- Receive one-on-one support from a Well-Ahead Practice Coach
- Opportunities to learn from colleagues

Project Objectives

- Increase control among adults with known high blood pressure and high cholesterol
- Identify patients with undiagnosed hypertension
- Decrease the number of adults with diabetes with a hemoglobin A1c>9
- Increase the number of adults with prediabetes enrolled in a lifestyle change program who have achieved a 5 – 7% weight loss



Quality Improvement Project - Strategies

#1 Identifying undiagnosed hypertension

#2 Management of patients with HTN and high blood cholesterol

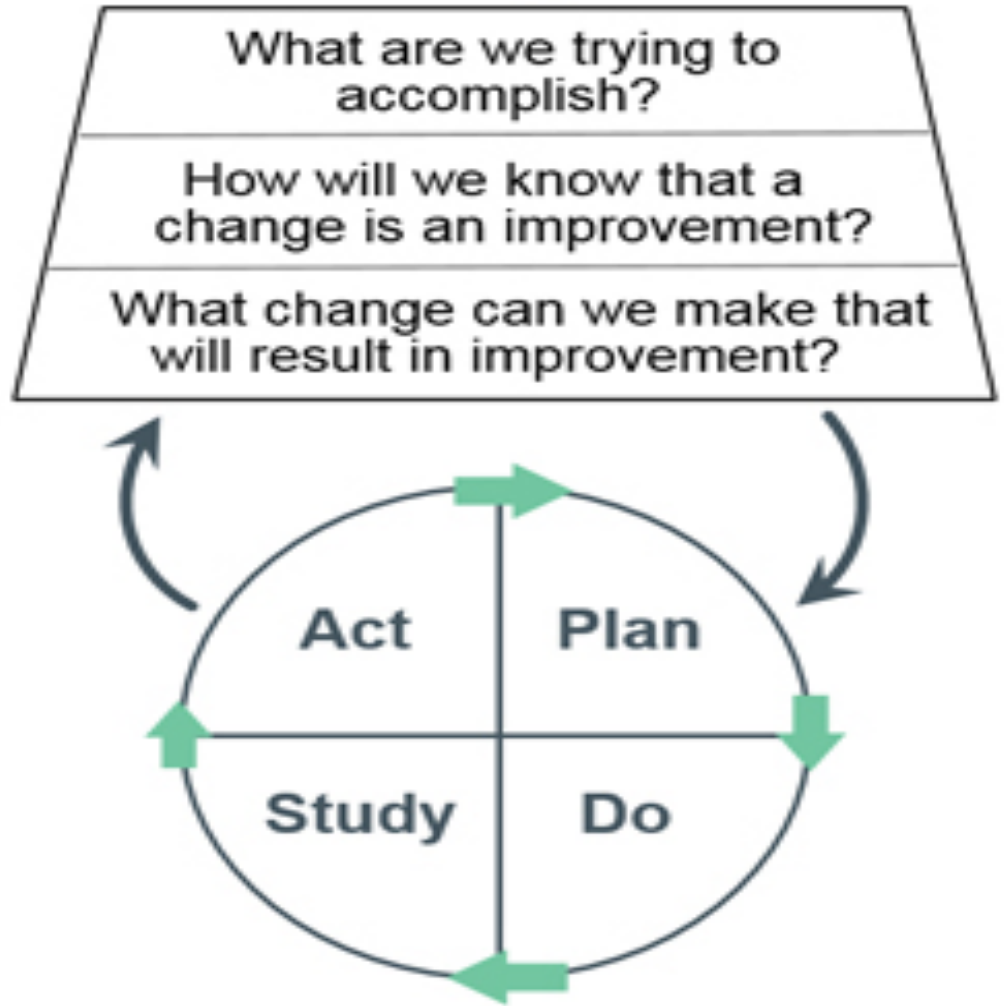
#3 Establishing or expanding MTM services or developing Collaborative Practice Agreements with a local pharmacy

#4 Linking patients to community resources to improve management

#5 Screening, testing, and referring for prediabetes

#6 Management of patients with diabetes, including referral to diabetes education

Model for Improvement



Institute for Healthcare Improvement

What is expected of my health center?

- Complete an organizational assessment that explores current practices and identifies opportunities
- Measure progress toward achieving project goals using quarterly performance measure reports
- Identify staff to participate in the project
- Identify EHR/data analytic needs and assistance
- Participate in regular in-person or virtual trainings and technical assistance calls
- Provide regular feedback to help Well-Ahead meet identified needs

Timeline

Activity	Dates
Kick-off of the Population Health Cohort	June 25, 2019
Application Period Closes	July 31, 2019
Site Selection for Cohort #1	August 2019
Face-to-Face Meeting with Selected Sites	August/September 2019
Complete Organizational Assessment	August/September 2019
Development of Practice Coaching Plan	August – October 2019
Quality Improvement Strategy Work	September 2019 – June 2021
Monthly Meeting and Touch Base	August 2019 – June 2021
Data Reporting	Quarterly; December 2019 – June 2021
Dissemination of Tools, Resources and Networking Opportunities	Ongoing; September 2019 – June 2021
Annual Survey and Reporting	June 2020; June 2021
Cohort #2 Application Period	April 2021
Cohort #2 Kick-off	July 2021
Cohort #2 Duration	July 2021 – June 2023

How do I apply?

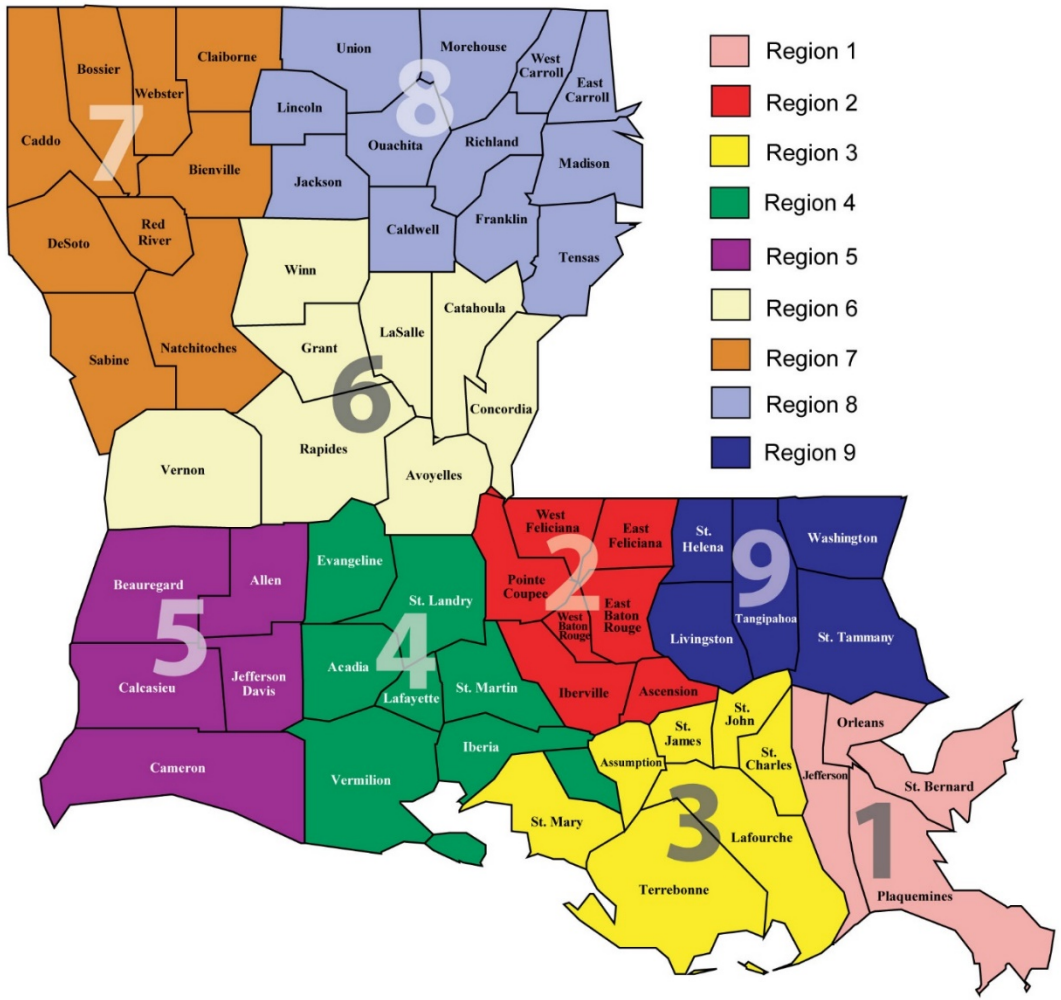
- Complete the paper application available today or online at www.walpen.org
- Application due date: July 31, 2019
- For assistance, please use contact information at the end of this presentation

How will Well-Ahead select sites?

- Preference will be given to:
  - Sites with EHRs
  - Geographic distribution; we will prioritize regions 4, 6, 7, 8
  - Patient population size
  - Patient demographics
  - Health center capacity to implement the different QI strategies
  - Current organizational initiatives
- Selected sites will be notified in August
- For those not selected, Well-Ahead will discuss other available opportunities
- Cohort #2 will begin in July 2021

Region Map

- Region 1: Greater New Orleans
- Region 2: Capital/Baton Rouge
- Region 3: Baton/Houma/ Thibodaux
- Region 4: Acadiana/Lafayette
- Region 5: Southwest/Lake Charles
- Region 6: Central/Alexandria
- Region 7: Northwest/Shreveport
- Region 8: Northeast/Monroe
- Region 9: Florida Parishes/North Shore



QUESTIONS?

Our Team

- Vacant – Region 4 Practice Coach
- Rebecca Wilkes – Region 6 Practice Coach
- Dana O'Neal – Region 7 Practice Coach
- Dr. Georgia Jones – Region 8 Practice Coach
- Latraiel Courtney – Quality Improvement Manager
- Colleen Arceneaux – Population Health Manager
- Kelley Lipsey – Practice Management Consultant
- Tracie Ingram – Rural Health Officer; Health Systems Intervention Manager

Contact Us!

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