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
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.

5.3% of Louisiana residents have heart disease.

22.8% of Louisiana residents smoke.

About 60% of these diabetics are obese.

About 50% of those with heart disease are obese.

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

Connect with us at wellahead@la.gov