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Collaborative Quality Improvement Through the Population Health Cohort

June 11, 2024

Louisiana's Health Initiative

Charmaigne Johnson

- Well-Ahead Louisiana; Heart Disease Prevention and Self-Management Program
- **Heart Disease Quality Improvement Manager**

Well-Ahead Louisiana

- Mission:
  - Connecting Louisiana's Communities to a Healthier Future.
- Vision:
  - Reduce the burden of chronic disease for all Louisiana residents.

Heart Disease Prevention Approach

- Improve Heart Disease Outcomes in Louisiana
  - Chronic diseases places a heavy economic burden on Louisiana.
  - Suggesting a need to form a systematic process using actionable strategies to improve the well-being of our residents.
- Build Connections
  - Empower Leaders to take an active role in Louisiana's fight against heart disease.
  - Ensure residents have access to quality health services by training and educating healthcare professionals on best practices and building connections between the community and clinical sector.

HYPERTENSION IN LOUISIANA

Heart Disease and Stroke in Louisiana

Heart disease is the
No. 1 killer
in Louisiana.

More than
29 Louisiana
residents die of
heart disease
every day.

1 in 3
deaths is caused
by heart disease
and stroke

THE POPULATION HEALTH COHORT APPROACH

The Population Health Cohort

- A collaborative quality improvement opportunity to improve population health in Louisiana.
- Implements strategies aimed at improving population health within a clinical setting, with a specific focus on hypertension, high cholesterol, and undiagnosed hypertension.
- The PHC offers:
  - Coaching to clinical care teams on implementing evidence-based strategies for heart disease prevention and management.
  - Exclusive access to a customized platform for data management and bi-directional e-referrals to social service networks.

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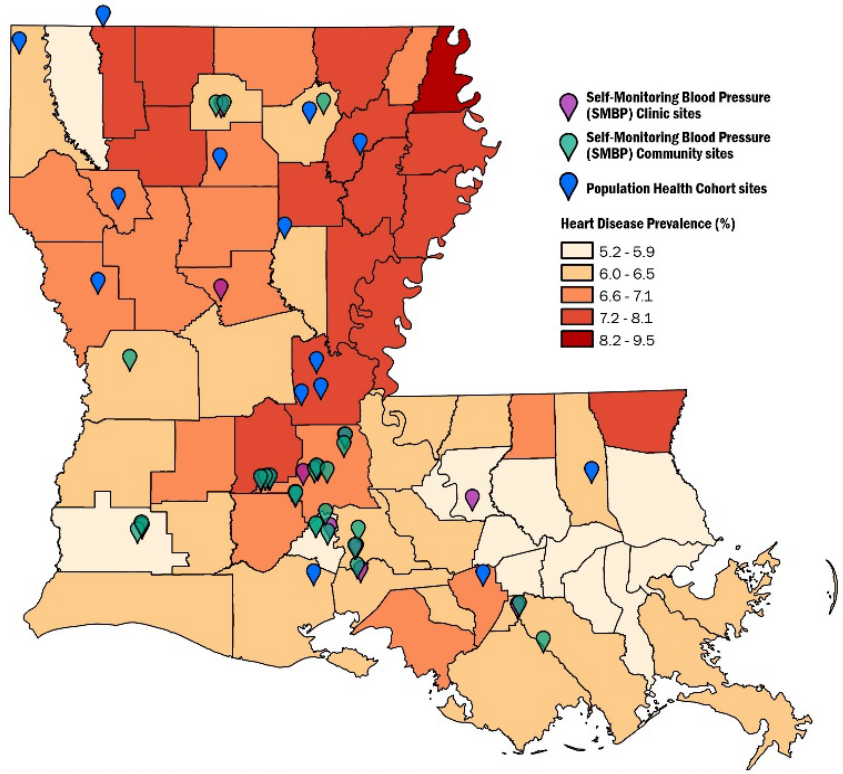
Heart Disease Prevalence and Heart Disease Prevention Programs



Population Health Cohort sites are healthcare organizations that are implementing evidence-based strategies for heart disease prevention and management.

Self-Monitored Blood Pressure (SMBP) Community sites are community-based organizations providing onsite blood pressure screenings to the community members the organization services.

Self-Monitored Blood Pressure (SMBP) Clinic sites are healthcare organizations partnering with an SMBP Community Site to offer medical services to participants as a follow up of care.

Data source for age-adjusted heart disease prevalence is from the August 2023 release of CDC PLACES

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PHC Outcomes and Impacts; FY23

4 New PHC Sites Established

22 Total PHC Sites

64,000 Patient Populations Reached

22,000 Identified Elevated Blood Pressure

61% Achieved Blood Pressure Control

WHAT TO EXPECT

The PHC Approach

- **Well-Ahead offers hands-on assistance in implementing evidence-based practices including:**
  - Tailored support to help improve quality improvement cycles.
  - Integrate best practices to address the social determinants of health.
  - Expanded EHR capabilities to monitor health outcomes and refer to social services.
- **PHC facilities will be required to complete a full 1-year initiative.**
  - 5 new PHC's selected annually.
  - FQHC's will be prioritized.
  - Selected facilities will be required to sign an agreement that will outline the organization's roles, responsibilities and funding requirements.

PHC Strategies

- **Quality Improvement:**
  - Implement and support the engagement of team-based care (TBC) in a clinical setting.
  - Billing and coding procedures.
- **Expanded Health Information Technology Systems:**
  - Improve the health and quality care for patients at highest risk of cardiovascular disease by tracking and monitoring clinical and support needs.
  - Implementing direct patient referrals to social service networks.
- **Addressing Social Determinants of Health:**
  - Implement systems to link community resources and clinical services to facilitate bidirectional referrals to clinical and community resources.
  - Self-management and lifestyle change strategies to address barriers to accessing care.

PHC Commitments

- **The Participating PHC Facilities Commit To:**
  - Complete an organizational assessment that explores current practices and identifies opportunities to expand or strengthen current practices.
  - Measure progress toward achieving project goals and deliverables determined by Well-Ahead Louisiana.
  - Identify an internal project team, including leads and participants.
  - Identify EHR/data analytic needs and capabilities.
  - Produce registries of patients with hypertension, high cholesterol, and un-controlled hypertension.
  - Participate in virtual or in-person trainings and ongoing technical assistance opportunities.
  - Participate in post-cohort evaluation measures; including surveys and interviews.

PHC Incentives

- **PHC Incentives Include:**
  - Contribute to Louisiana's efforts to improve the health of those at risk for cardiovascular disease.
  - Assist in improving your population health management and quality metrics.
  - Earn a financial incentive of up to ***$15,000/year***.
  - Receive one-on-one technical assistance from Well-Ahead Louisiana.
  - Have opportunities to learn from colleagues and leaders in cardiovascular disease prevention and management.

TARGET:BP™

American Heart Association.

AMA AMERICAN MEDICAL ASSOCIATION

Source: https://targetbp.org/

COMMUNITY PARTNERSHIP

CareSouth
MEDICAL & DENTAL

CareSouth Medical and Dental

2023-2024 PHC Site

A Louisiana FQHC

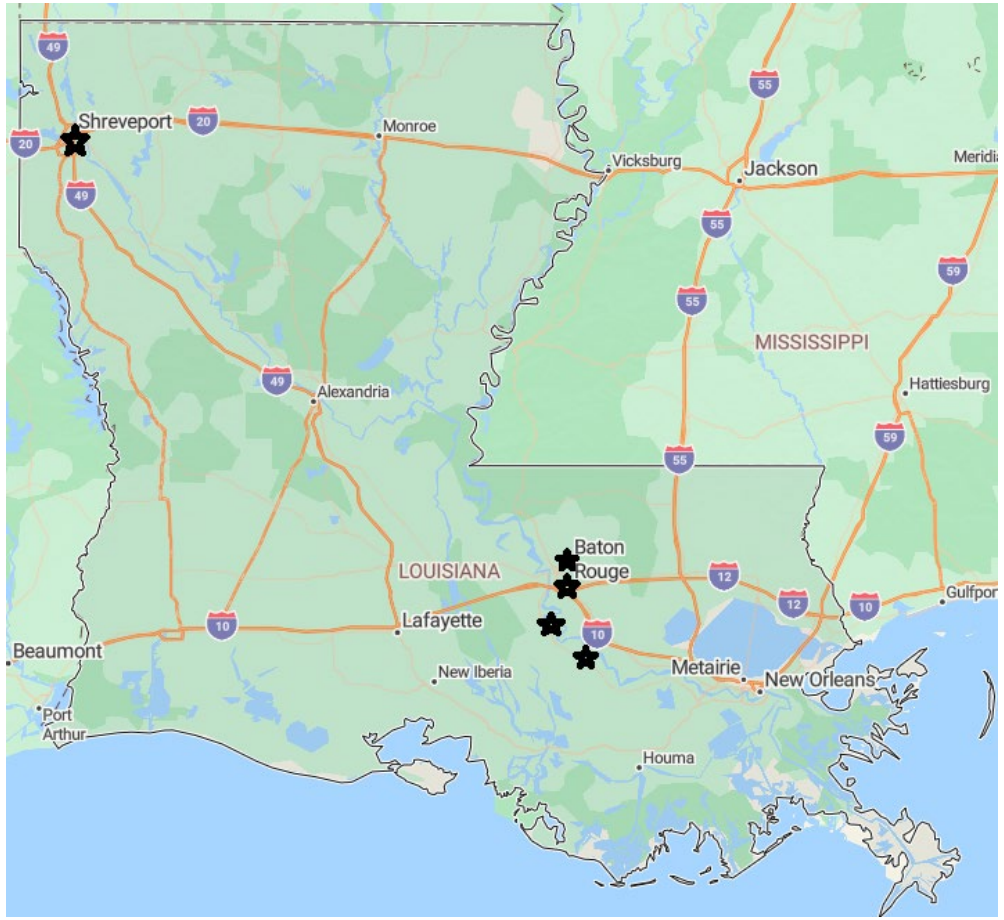
Elosia Lopez

- **CareSouth Medical & Dental**
- Quality Coordinator

CareSouth
MEDICAL & DENTAL

CareSouth Medical and Dental

- Mission – to provide quality, affordable healthcare services with compassion and respect for all.
- Vision- be a trusted community health leader and family-centered medical home that contributes to the quality of life and overall safety and health of the communities it serves.
- Values- compassion, accessibility, reliability, and excellence

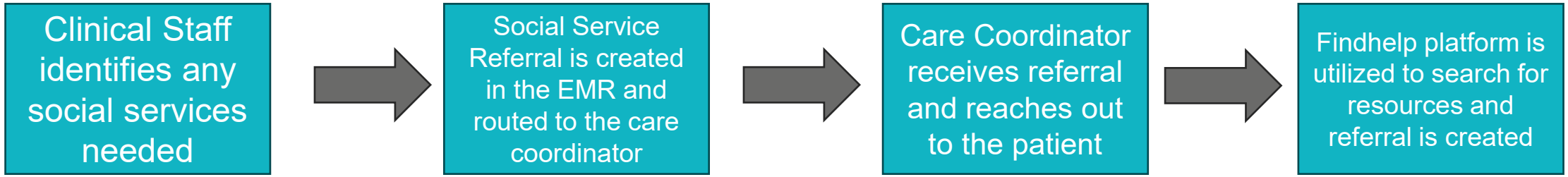


THE POPULATION HEALTH COHORT

PHC Strategy Implementation

Strategy 1: Track and monitor clinical and social services needs to improve health and quality care for patients at highest risk of CVD by utilization of electronic health records.

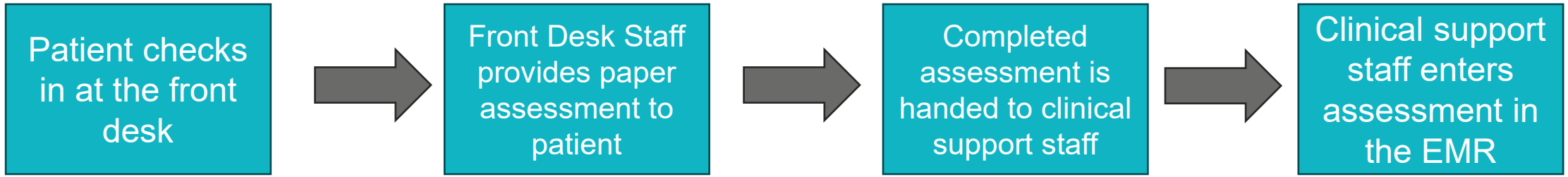
Utilization of EHR platform Azara to locate and refer patients for social services through the *FindHelp tool*. .



In AZARA's *FindHelp tool*, the referral status can be viewed. Also, the number of referrals can be pulled for monitoring.

PHC Strategy Implementation

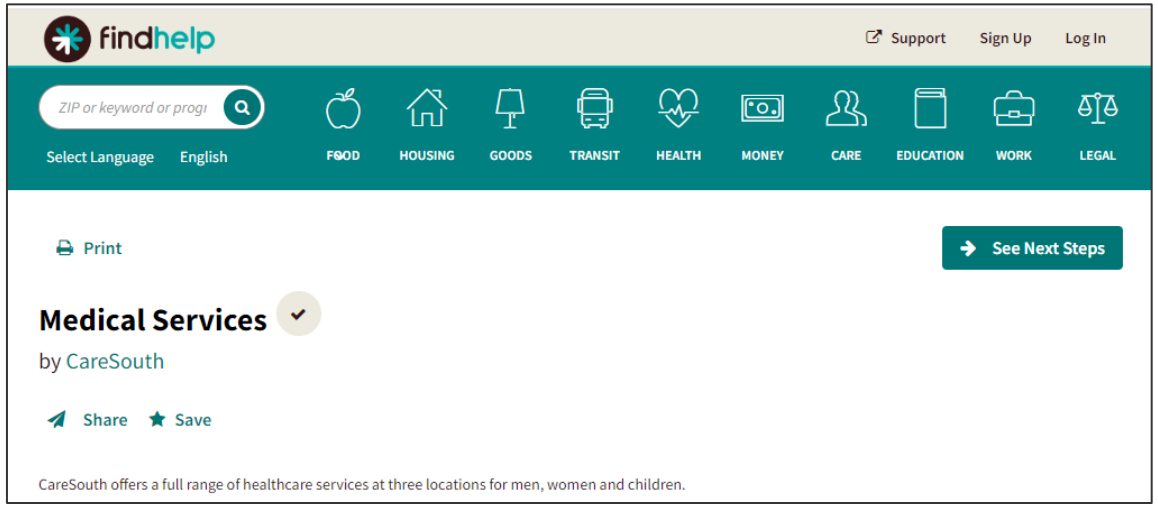
Strategy 2: Implement and support the engagement of team-based care (TBC) in a clinical setting. Utilization of the PRAPARE assessment to screen for social determinants of health.



In Athena, a screening report can be pulled to track the number of PRAPARE assessments.

PHC Strategy Implementation

- **Strategy 3:** Implement systems to link community resources and clinical services.
  - CareSouth is listed as a resource within FindHelp and UniteUs platforms.
  - CareSouth provides the patient with access to care coordinator, community health worker, and case manager.



Projections

- After the completion of the population health cohort, the intent is to extend the PRAPARE assessment to the entire patient population
  - The goal is to support the patient and reduce or eliminate social barriers.

PHC APPLICATION LAUNCH

FY25 PHC Application Launch!

- **FY25 PHC Application Launches TODAY!**
  - June 11, 2024
- **Application Deadline:**
  - July 31, 2024
- **PHC Selection Announcement:**
  - August 14, 2024
- **FY25 PHC Term Dates:**
  - September 1, 2024 - June 30, 2025

QUESTIONS?

Contact Us!

Reotta Pierce; *Heart Disease Program Manager*
Email: Reotta.Pierce@la.gov

Charmaigne Johnson; *Heart Disease Quality Improvement Manager*
Email: Charmaigne.Johnson@la.gov

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Thank You for Joining Us!