Implementation of a Population Health Model at Mayo Clinic

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Who We Are
Drivers for Change....
Starting the Process…

• Office of Population Health formed in 2012, later became the Population Health Committee
• Multidisciplinary
• Regional Leads
• Team Leads
To Go From This...

<table>
<thead>
<tr>
<th>Focus Areas &amp; Program Name</th>
<th>Total Projects** / Program (no.)</th>
<th>Project by Stakeholder* (no.)</th>
<th>Project by Population Served</th>
<th>Project Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AZ</td>
<td>FL</td>
<td>ECH</td>
<td>HS</td>
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<tr>
<td>Health &amp; Wellness</td>
<td></td>
<td></td>
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<tr>
<td>Primary Prevention†</td>
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<td>4</td>
<td>5</td>
<td>15</td>
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<tr>
<td>Community Engagement</td>
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<td>11</td>
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<tr>
<td>Continuity Care</td>
<td></td>
<td></td>
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<tr>
<td>Care Coordination‡</td>
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<td>5</td>
<td>5</td>
<td>35</td>
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<tr>
<td>Chronic Condition Management‡</td>
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<td>5</td>
<td>5</td>
<td>34</td>
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<td>Care Transitions</td>
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<td>3</td>
<td>4</td>
<td>17</td>
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<td>Palliative Care</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>3</td>
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<tr>
<td>Both Health &amp; Wellness and Continuity Care</td>
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<td>Patient Engagement</td>
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<td>5</td>
<td>5</td>
<td>15</td>
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<tr>
<td>Access</td>
<td>36</td>
<td>4</td>
<td>4</td>
<td>20</td>
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</table>

*Note: More than 1 stakeholder may be working on the same project.
**Note: 65 projects identified; 56 projects which align with more than 1 program; 2 projects which do not align with a program; 7 projects with 1 program.
†Initial OPHM Program Focus.
To This…

Mayo Model of Community Care

- Appropriate Care
- Team Model
  - Chronic Condition Mgmt.
- Access
- Whole Person
- Wellness
- Risk Assessed
- Prevention
- Proactive
- Lower Cost
- Better Experience
- Better Health
  - Care Coordination
- Patient Engagement
  - Patient Centered
  - Connected
- Community Engagement
  - Care Transitions
  - Coordinated
- Palliative Care
Strategy

Development of MMoCC elements

Limited Implementation/Refinement

MMoCC

Full Implementation
Population Health Programs

- Common Themes
  - Response to Drivers
  - Living in the Moment
  - Everyone Wins
Population Health Programs - Access

- Portal Utilization
  - Arizona Primary Care = 85%
- Patient Empanelment
  - 100%
- Non Visit Care
- Electronic Consults

![Graph showing Portal Utilization and Non Visit Care over years 2014 to 2016]
Population Health Programs - Community Engagement

- Community Health Needs Assessment
  - 2016-2019
    - Access to Care
    - Cancer
    - Homelessness
    - Transplantation Medicine
- Multiple Community Service Events
Population Health Programs-High Risk Patient Management

- Care Transitions
- Complex Care Coordination
  - ED visits from 200 to 88
  - Hospitalizations from 85-30
  - Total Charges 5.4 million to 2.6 million
Population Health Programs- Team Based Care

- Role Definition
- New Care Team Members
- Standardized Rooming
- Medication Renewals
- Non Provider Visits
Population Health Programs - Co-Location

• Building Redesign
Population Health Programs - Quality

Chronic Conditions
- Diabetes
- Vascular Disease
- Hypertension
- Asthma
- Depression

Preventative Care
- Breast Cancer Screening
- Cervical Cancer Screening
- Colon Cancer Screening
- Immunizations
Lessons

• Changing Behavior (Provider and Patient)
• Technology is Everything
• Conflicting Evidence
• Uncertainty
Thank You