

# Creating an Integrated Population Health Network.

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# Creating an Integrated Population Health Network

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## DESCRIPTION

The Population Health Department (PHD) provides comprehensive, integrated care coordination in primary and specialty care practices in the community by addressing the physical, socioeconomic and psychosocial needs of high risk patients. The PHD is comprised of Social Workers (MSW), Behavioral Health Specialists (LCSW or LPC), RN Care Managers and Clinical Pharmacists.

## AIM

To improve patient's overall health and wellbeing through the Triple Aim (Better Care, Better Cost, Better Health).



## ACTIONS TAKEN

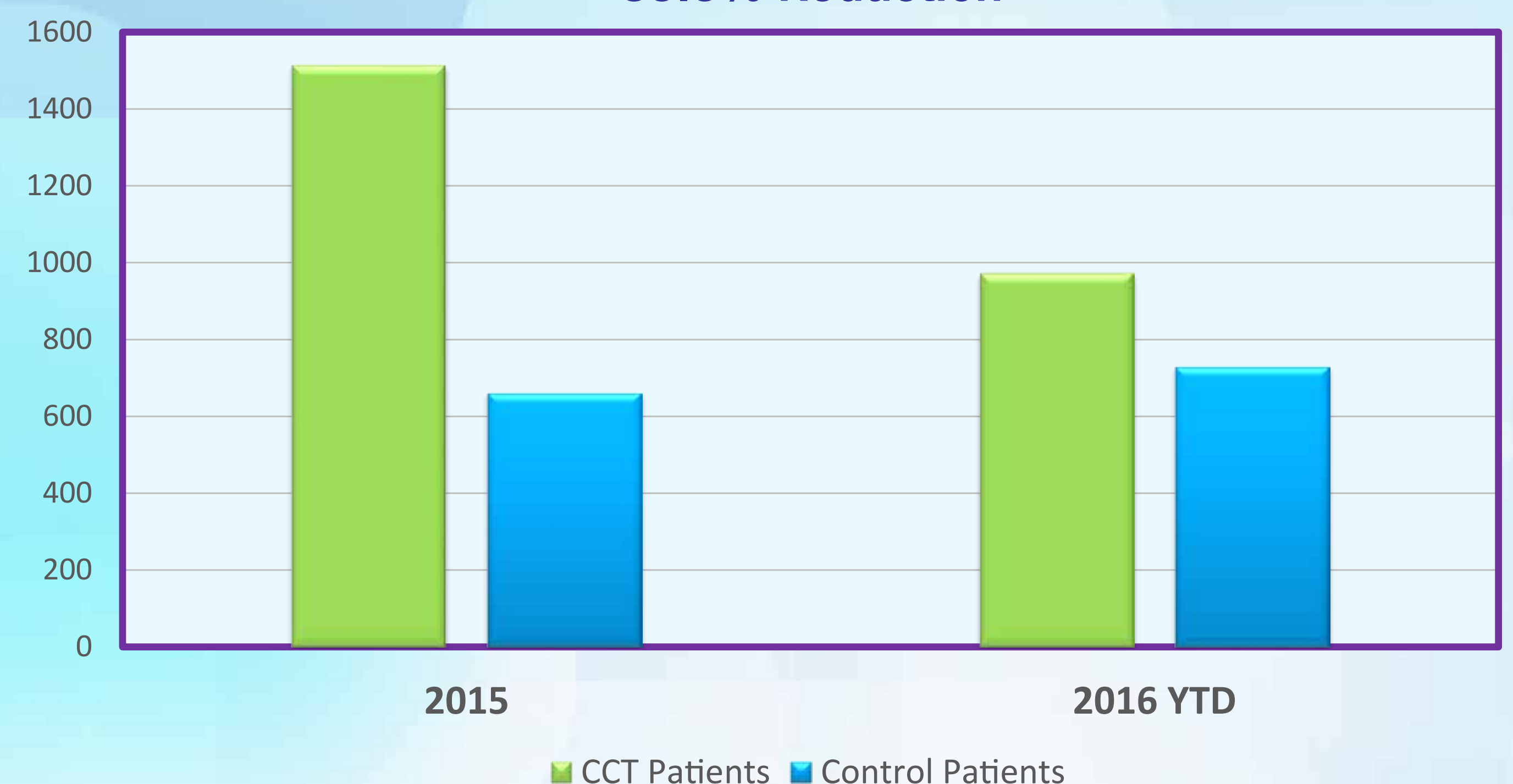
In partnership with LVHN's Physician Hospital Organization (PHO), the PHD embedded interdisciplinary teams to 37 primary and specialty care practices in the community as well as an additional 80 primary care practices through regionalized interdisciplinary teams in order to meet patients' physical, socioeconomic, and psychosocial needs in a continuous, comprehensive, and integrative way.



## SUMMARY OF RESULTS

Initial outcome data of this model was published in the *Journal of Clinical Outcomes Management* (2014) and demonstrated the importance of team based care to improve population health management. Since 2014, this work has expanded and further results indicate that patients who received Population Health (PHD) interventions have been shown to have decreased utilization (observation, admission and ED). Patients with more than one PHD intervention in CY15, with measurement in the first half of CY16 experienced 36% fewer ED visits and 34% fewer hospital admissions than in the previous six months. A severity matched control group experienced a 6% increase in ED visits and a 17% increase in admissions.

ED Visits Per 1,000  
35.6% Reduction



Hospital Admissions Per 1,000  
33.9% Reduction

