# D: Population Health Toolkit–Cohort Launch Menu

## Purpose

The intent of the following document is to provide examples of cohort definitions. These may serve as 1) a launch point for Networks to start the collaborative process of cohort management but unsure of what populations to identify to determine need, appropriate capacity, etc., and/or 2) a demonstration of how criteria identify a cohort of interest and how that criteria are set in a way that inform ongoing cohort management. By no means is the following list exhaustive or indicative of a more successful or ideal cohort population. **Networks may choose cohorts not listed, or they may choose to use the cohorts and criteria listed as a starting point.** However, chosen cohorts need to align with DSRIP metrics.

## Determining Your Cohort

A Network may select a cohort based on a known need. Regionally, there may be populations experiencing gaps in care or poor outcomes that a Network feels they are equipped to positively impact. Some Networks may choose to independently embark on a formal or informal needs assessment to determine the cohort they would like to engage while others may use the Cohort Launch Menu below as a starting point to research outcomes and trends for the cohorts and assess if the Network is able to meaningfully meet their needs.

## Setting Cohort Criteria

Since, by definition, a cohort is a group of people sharing defining characteristics, determining these characteristics is a crucial first step. For example, it likely is not sufficient to identify "all people with diabetes" for a cohort. Other criteria should be set to determine what this cohort looks like in a way that 1) yields a manageable cohort size (50-200 Medicaid members), and 2) ensures the cohort identified has enough in common that the management program/interventions can be specialized to meet their specific needs or gaps in care. An example of additional criteria that might be set for a cohort is further differentiating the diabetic population by age or utilization of services: "ages 18 and older" and "having one or more inpatient stay(s) in the last 60 days" (see Launch Cohort #12 with additional modifier). Specificity allows for meaningful program development and perhaps a more manageable number of people included in the cohort.

When setting cohort criteria, Networks can choose a dynamic or static cohort. The launch list below provides examples where dynamic or static cohorts may be appropriate. For dynamic cohorts, Networks should keep in mind that cohort membership should be updated on a rolling basis (dynamic cohort). This might mean pulling a list of members every month or flagging individuals automatically as soon as the cohort criteria are met to indicate inclusion in the program and its interventions. In many cases, static lists should be avoided as they quickly become outdated. However, a static cohort may be appropriate

for persons which the Network wants to monitor longitudinally if the person may “come in and out” of the cohort.

## What data can Care Compass Network provide to support cohort development?

Care Compass Network (CCN) receives data from the New York State Department of Health that would allow for some cohorts to be filled with “core membership” of Medicaid Members attributed to the Performing Provider System (PPS). Many of those listed on this Menu could be supplemented with data from CCN. While this is not an exhaustive list, Networks interested in having additional data supplied by the CCN should inquire as to whether or not this is possible.

| Cohort Management Launch List<br>Definitions Page | | | | | | |
|---|---|---|---|---|---|---|
| | Cohort | Age Limitation | Brief Description | Static/Dynamic | Definition Reference | CCN Data Sources |
| | Behavioral Health | | | | | |
| 1 | General Mental Health | Age 18+ | Mental Health Diagnosis - Primary Dx | Static or Dynamic | HEDIS definitions | CCN and/or Partner |
| 2 | Schizophrenia, Bipolar Disorder, Antipsychotic Rx | Age 18+ | Schizophrenia, Bipolar Disorder, Antipsychotic Rx | Static or Dynamic | HEDIS definitions | CCN and/or Partner |
| 3 | Mental Health Discharge (30/60/90 day) | Age 18+ | Mental Health Diagnosis - Primary Dx; Inpatient Stays | Dynamic Only | HEDIS definitions | CCN and/or Partner |
| 4 | Substance Use Disorder | Age 18+ | Mental Health Diagnosis - Primary Dx; Inpatient Stays | Dynamic Only | HEDIS definitions | Partner |
| | Gaps in Primary Care | | | | | |
| 5 | PC Gap - Adults | Age 20 + | No Ambulatory or Preventive Care Visits in Last 10 Months | Dynamic Only | HEDIS definition of Ambulatory & Preventive Care Visit | CCN and/or Partner |
| 6 | PC Gap - Children | Age 1 to 19 | No Ambulatory or Preventive Care Visits in Last 10 Months | Dynamic Only | HEDIS definition of Ambulatory & Preventive Care Visit | CCN and/or Partner |
| 7 | PC Follow Up - ADHD (Initiation + Continuation) | Ages 6 to 17 | Ambulatory visits following New Rx Fills of ADHD Medication | Dynamic Only | HEDIS definition of Ambulatory & Preventive Care Visit, Rx List | CCN and/or Partner |
| | Adult Chronic Conditions | | | | | |
| 8 | Diabetics at risk | Age 18+ | Diabetes Short Term Complications DX | Static or Dynamic | AHRQ PQI #1 - DX list | CCN and/or Partner |
| | | | Diabetes Long Term Complications DX | | AHRQ PQI #3 - DX list | CCN and/or Partner |
| | | | Uncontrolled Diabetes | | AHRQ PQI #14 - DX list | CCN and/or Partner |
| 9 | Hypertension | Age 18+ | Hypertension Dx | Static or Dynamic | AHRQ PQI #7 - DX list | CCN and/or Partner |
| 10 | Heart Failure | Age 18+ | Heart Failure Dx | Static or Dynamic | AHRQ PQI #8 - DX list | CCN and/or Partner |
| 11 | Bacterial Pneumonia | Age 18+ | Bacterial Pneumonia Dx | Dynamic Only - Likely | AHRQ PQI #11 - DX list | CCN and/or Partner |
| 12 | COPD or Asthma | Age 18+ | COPD or Asthma in older adults | Static or Dynamic | AHRQ PQI #5 - DX list | CCN and/or Partner |
| | Children Chronic Conditions | | | | | |
| 13 | Children - Diabetics at risk | Age 6-17 | Diabetes Short Term Complications DX | Static or Dynamic | AHRQ PDI #15 - DX list | CCN and/or Partner |
| 14 | Children - Asthma | Age 6-17 | Asthma | Static or Dynamic | AHRQ PDI #14 - DX list | CCN and/or Partner |
| 15 | Children - Gastroenteritis | Age 6-17 | Gastroenteritis | Static or Dynamic | AHRQ PDI #16 - DX list | CCN and/or Partner |
| 16 | Childhood Obesity | Age 6-17 | Obesity/Overweight Dx | Static or Dynamic | | CCN and/or Partner |
| | Gaps in Medication Adherence | | | | | |
| 17 | New Anti-Depressant Rx (Acute + Continuation = 180 days) | Ages 18+ | HEDIS list of Anti-depressants | Dynamic Only | Acute - 12 weeks; Continuation - 6 months | CCN and/or Partner |
| 18 | Anti-Psychotic Rx Adherence (Schizophrenia) - goal 80% | Ages 18+ | HEDIS definition of Schizophrenia | Dynamic Only | Rx fill information to establish treatment period, covered days of Rx | CCN and/or Partner |
| 19 | Statin Therapy Rx - goal 80% | Male: 21-75; Female: 40-75 | HEDIS def of CVD (event or Dx) | Dynamic Only | HEDIS Definitions | CCN and/or Partner |
| | Post Discharge 30/60/90 | | | | | |
| 20 | Postpartum - Complicated Delivery or C-Section | Female | AHRQ Definitions for Delivery/ Complications | Dynamic Only | AHRQ | Partner |
| | Mental Health (see #3) | See #3 | | Dynamic Only | | |
| | Ambulatory Sensitive Conditions | See #8-12 and #13-16 | | Dynamic Only | | |

## Cohort Launch Menu Populations (CCN and No PPS Attributed by 9 Designated Counties May 2017 to April 2018)

| Cohort Group | BROOME | CHEMUNG | CHENANGO | CORTLAND | DELAWARE | SCHUYLER | STEUBEN | TIOGA | TOMPKINS |
|---|---|---|---|---|---|---|---|---|---|
| **Behavioral Health** | | | | | | | | | |
| General Mental Health & Substance Use | 11,125 | 1,445 | 2,024 | 2,054 | 1,004 | 659 | 1,772 | 1,812 | 3,051 |
| Schizophrenia, Bipolar Disorder, Antipsychotic Medication | 3,971 | 492 | 617 | 696 | 318 | 186 | 653 | 679 | 1,027 |
| Substance Use Disorder | 7,623 | 749 | 1,325 | 1,209 | 584 | 267 | 890 | 1,120 | 1,479 |
| **Gaps in Primary Care** | | | | | | | | | |
| Adult- Primary Care Gaps | 19,572 | 4,474 | 4,376 | 3,979 | 2,414 | 1,453 | 4,452 | 4,052 | 6,191 |
| Children - Primary Care Gaps | 7,979 | 1,299 | 1,539 | 1,797 | 783 | 418 | 1,283 | 1,825 | 2,068 |
| Children - ADHD Medication | 1,354 | 190 | 265 | 467 | 202 | 119 | 325 | 360 | 460 |
| **Adult Chronic Conditions** | | | | | | | | | |
| Diabetics At Risk | 2,000 | 283 | 400 | 324 | 157 | 76 | 325 | 389 | 386 |
| Hypertension | 4,459 | 674 | 906 | 678 | 415 | 255 | 760 | 756 | 919 |
| Heartfailure | 476 | 85 | 112 | 106 | 47 | 44 | 115 | 109 | 105 |
| Bacterial Pneumonia | 687 | 119 | 169 | 197 | 72 | 64 | 158 | 131 | 161 |
| COPD or Asthma | 751 | 101 | 133 | 147 | 52 | 43 | 141 | 126 | 165 |
| **Children Chronic Conditions** | | | | | | | | | |
| Children - Diabetics at risk | 5 | 4 | 3 | | | 1 | | 6 | |
| Children - Asthma | 311 | 42 | 32 | 106 | 39 | 28 | 39 | 51 | 83 |
| Children - Gastroenteritis | 491 | 67 | 86 | 70 | 35 | 49 | 97 | 104 | 115 |
| Childhood Obesity | 366 | 54 | 79 | 127 | 88 | 52 | 36 | 76 | 157 |
| **Medication Adherence** | | | | | | | | | |
| New Anti-Depressant Rx (members w/ first time fills) | 6,669 | 889 | 1,255 | 1,265 | 582 | 306 | 1,314 | 1,267 | 1,758 |
| Anti-Psychotic Rx Adherence (members w/ Rx fill) | 1,995 | 196 | 260 | 239 | 110 | 61 | 257 | 226 | 378 |
| Statin Therapy Rx (members w/ Rx fill) | 2,800 | 368 | 607 | 498 | 237 | 113 | 605 | 588 | 495 |
| **Post Discharge 30/60/90** | | | | | | | | | |
| Postpartum - Complicated Delivery or C-Section | 529 | 64 | 68 | 71 | 30 | 21 | 64 | 80 | 100 |

**Source**: CCN Team Analysis using Salient Interactive Miner (May 2017 to April 2018). Counties are counties of fiscal responsibility. Individuals included are attributed to CCN under the DSRIP program or have no PPS attribution.