Riding the Wave of POPULATION HEALTH MANAGEMENT

Centricity Healthcare User Group

October 14, 2016

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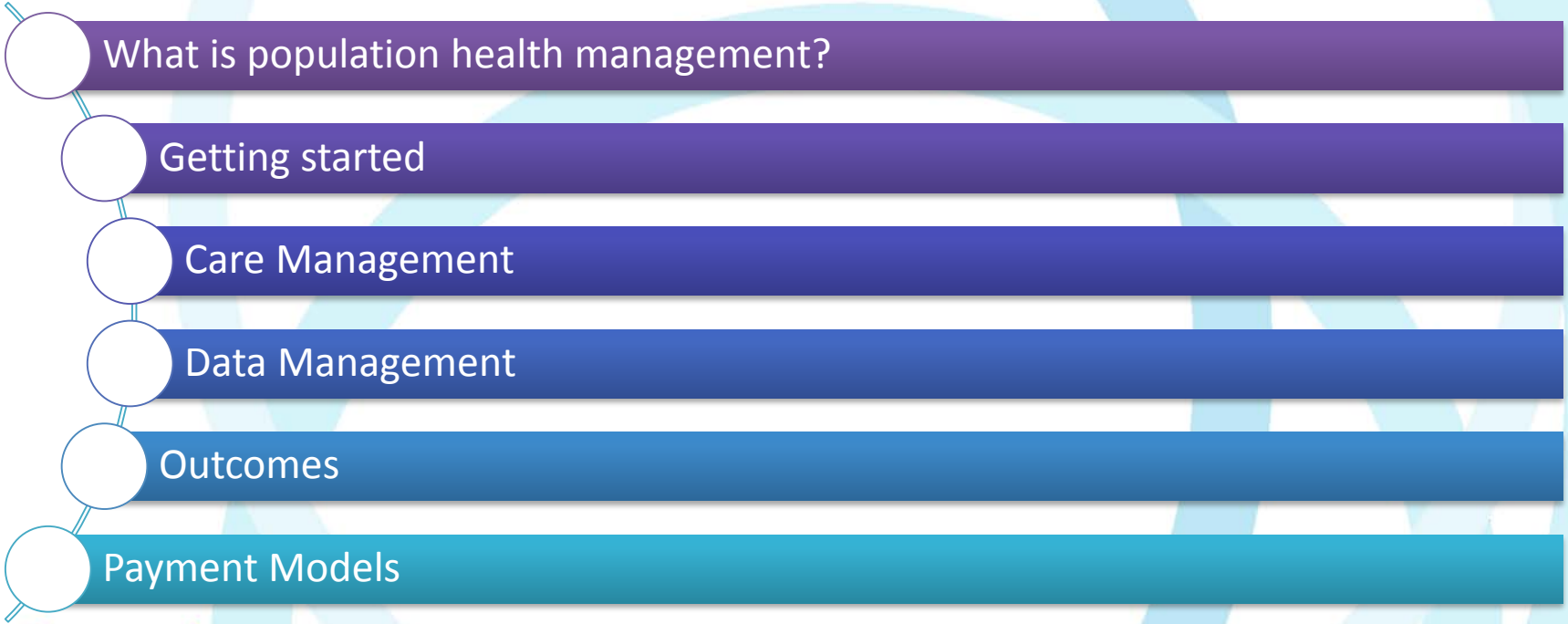
Population Health Management



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Why?

	Overall	Quality Care	Access	Efficiency	Equity	Healthy Lives
• Best	• UK	• UK	• UK	• UK	• Sweden	• France
	• Switzerland	• Australia	• Germany	• Sweden	• Switzerland	• Sweden
	• Sweden	• Switzerland	• Switzerland	• New Zealand	• UK	• Switzerland
	• Australia	• New Zealand	• Netherlands	• Australia	• Germany	• Australia
	• Germany	• Netherlands	• Sweden	• Norway	• Australia	• Netherlands
	• Netherlands	• **US**	• Norway	• Switzerland	• Norway	• Norway
	• New Zealand	• Germany	• New Zealand	• Netherlands	• France	• Germany
	• Norway	• France	• Australia	• France	• Netherlands	• Canada
	• France	• Canada	• Canada	• Germany	• Canada	• New Zealand
• Worst	• Canada	• Sweden	• **US**	• Canada	• New Zealand	• UK
	• **US**					• **US**

Source: Mirror, Mirror 2014 Update: How the U.S. Health Care System Compares Internationally, the Commonwealth Fund

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What is

POPULATION HEALTH MANAGEMENT

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Population Health Management

- Assess health outcomes of a group of individuals
- Utilizes business intelligence to aggregate data
- Identify patients that may benefit from more intensive care coordination
- Utilize the aggregated data to improve outcomes and reduce costs

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Pathway to Success

- Supply proactive preventive and chronic care to all patients, both during and between encounters.
- Maintain regular contact with patients and support their efforts to manage their own health.
- Care managers must manage high-risk patients to prevent them from becoming unhealthier and developing complications.
- Use evidence-based protocols to diagnose and treat patients in a consistent, cost-effective manner.

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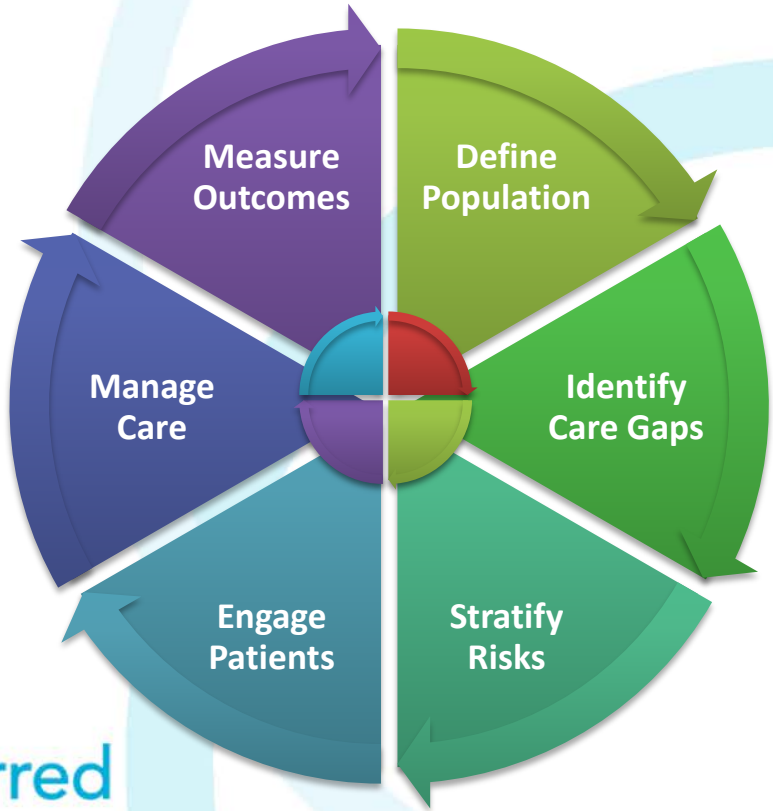
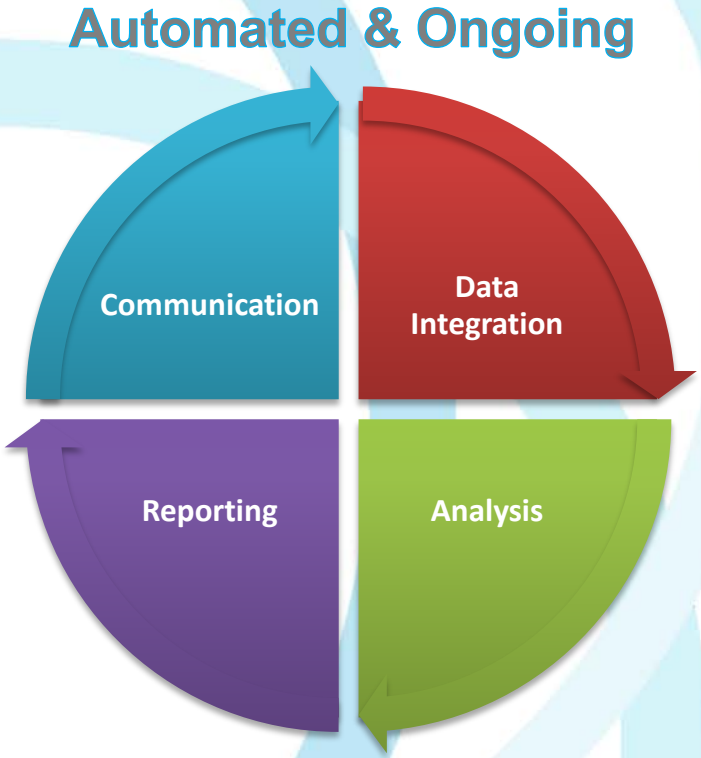
PHM Machine Essentials





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Foundational Elements

Information-powered clinical decision making

Primary care centered care delivery

Patient engagement and personal responsibility

Care coordination through wellness and chronic care management programs

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Factors Affecting Population Health Management

- Medical care
- Public health interventions
- Social environment: income, education, employment, social support, and culture
- Physical environment: urban design, clean air and water
- Genetics
- Individual behavior

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Getting started with

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REALITY CHECK

At this time, no one is connected well enough to aggregate and analyze all of the data!

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Identify Key Stake Holders

Patients

Specialists

Health Systems

Insurers

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Who Are Your Patients?

Define your patient panel

- From your medical records
- Attributed patient panel from insurers

Specify & Stratify Populations

- Healthy patients – need health wellness and prevention
- At risk for health problems – need screening and lifestyle changes
- Chronic conditions – need to prevent further complications

Identify most common comorbidities

- Inquiries based on diagnosis
- Start learning care management with this information

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How Do Your Patients Specialize?

Specialists

- Do they communicate with you?
- Do they share information with you?
- Do they send consult reports in a timely fashion?
- Do they practice evidence-based medicine?
- Do they order tests appropriately?
- Are they unbiased?
- Do they have good outcomes?
- Are they cost-effective?
  - => If not, are you ready to change your referral patterns?
- Do your patients self-refer?

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Where Are Your Patients?

Which health systems?

Which ERs & urgent cares?

Which specialists?

How easy can your patients access you?

KEEP YOUR PATIENTS UNDER YOUR CARE!

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Who Insures Your Patients?

Insurers Define

- Your patient panel
- Quality measures
- Reimbursement

Insurers Provide

- Individual patient healthcare spending
- Individual physician healthcare spending
- Facility healthcare spending

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Care Management in

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Care Management

Care management is a critical element and the key to better outcomes and cost savings, especially in dealing with chronic disease.

Care management revolves around improving patient self-management, improving medication management, and reducing the cost of care.

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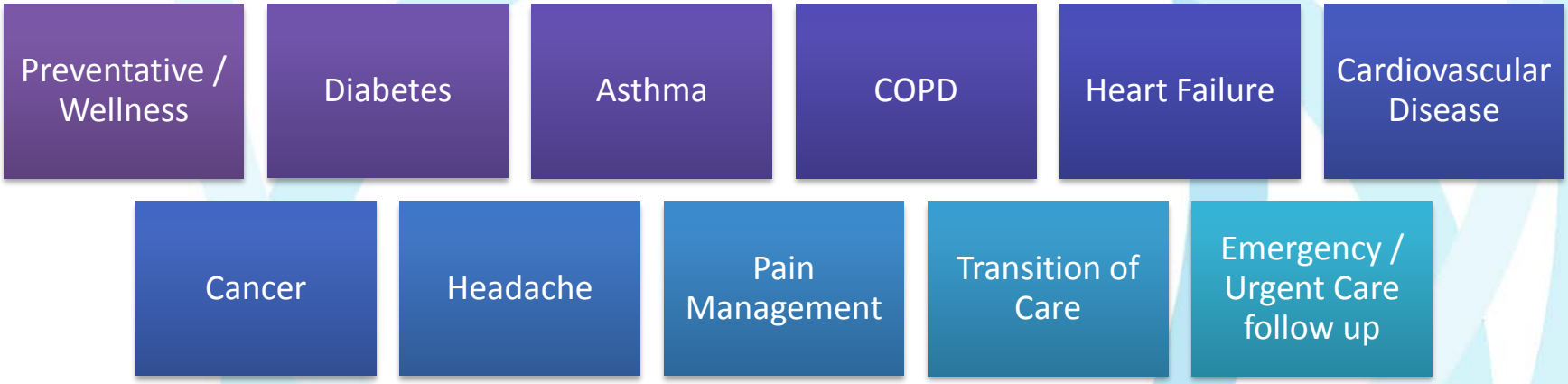
Areas of Focus

- Tackle one area at a time
- Add areas of focus as your care managers develop skill



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Care Management 101

Begin with diabetes

- Run inquiries
- Begin to reach out to your patients

Care Manager

- Meet with your diabetics at every office visit
- Follow up with your diabetics between office visits
- Reach out to your patients who do not follow up.

Assess

- Are they taking their meds?
- Are they checking their blood sugars?
- Are they eating well?
- Should they meet with a nutritionist?

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Care Management 102

- Aggregate the data at a higher level

Diabetics

- who did not have a pneumonia or flu vaccine
- who are not on an ACE inhibitor or an ARB
- who are not on a statin
- who did not have a urine microalbumin
- with repeated ER visits for hypo/hyperglycemia

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Data Management in

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Data Input

Enter data correctly to optimize EHR utilization (Meaningful Use)

- Immunization Management Form
- Hand updating the flowsheet
- Interactive forms that prompt you and allow you to enter data at the point of care

Interface as many as health systems and providers as possible

- If set up correctly, will input structured, retrievable data
- The more information at hand, the better you can track your patients

IF YOUR DATA HOUSE IS NOT IN ORDER, YOU WILL STARVE!!!

- Poor data = poor quality scores

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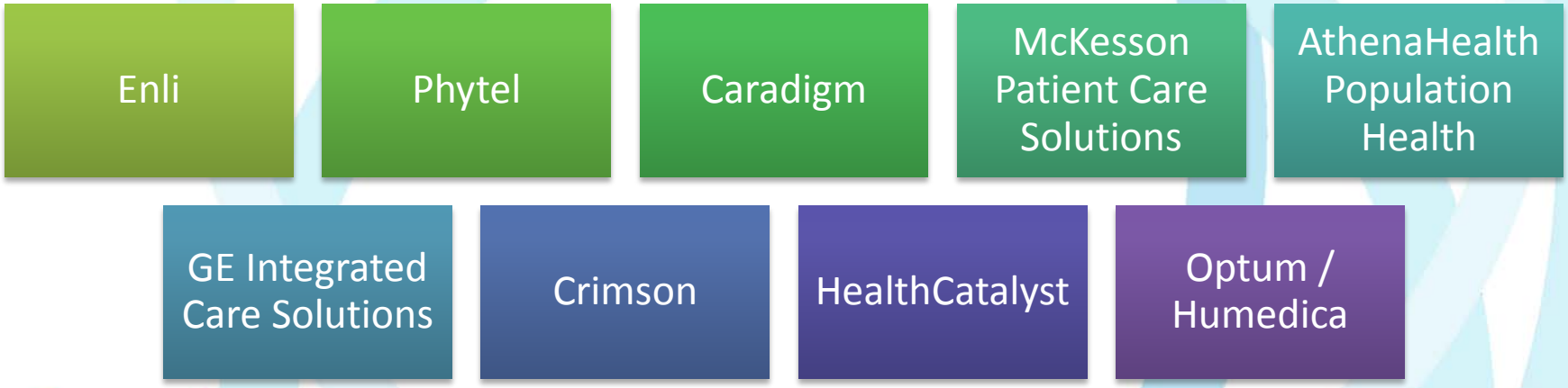
Population Health Management Software

- No one can manage their data by themselves.
- Utilize business intelligence to continuously manage, analyze, and report the data in a useful form.



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PHM Software Competencies

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Utilizing Data to Make Point of Care Decisions

- Using your data and evidence-based guidelines to make decisions on patient care at the time of the office visit
- Enables real-time decision making
- Requires standardized data
- Requires accurate clinical decision support

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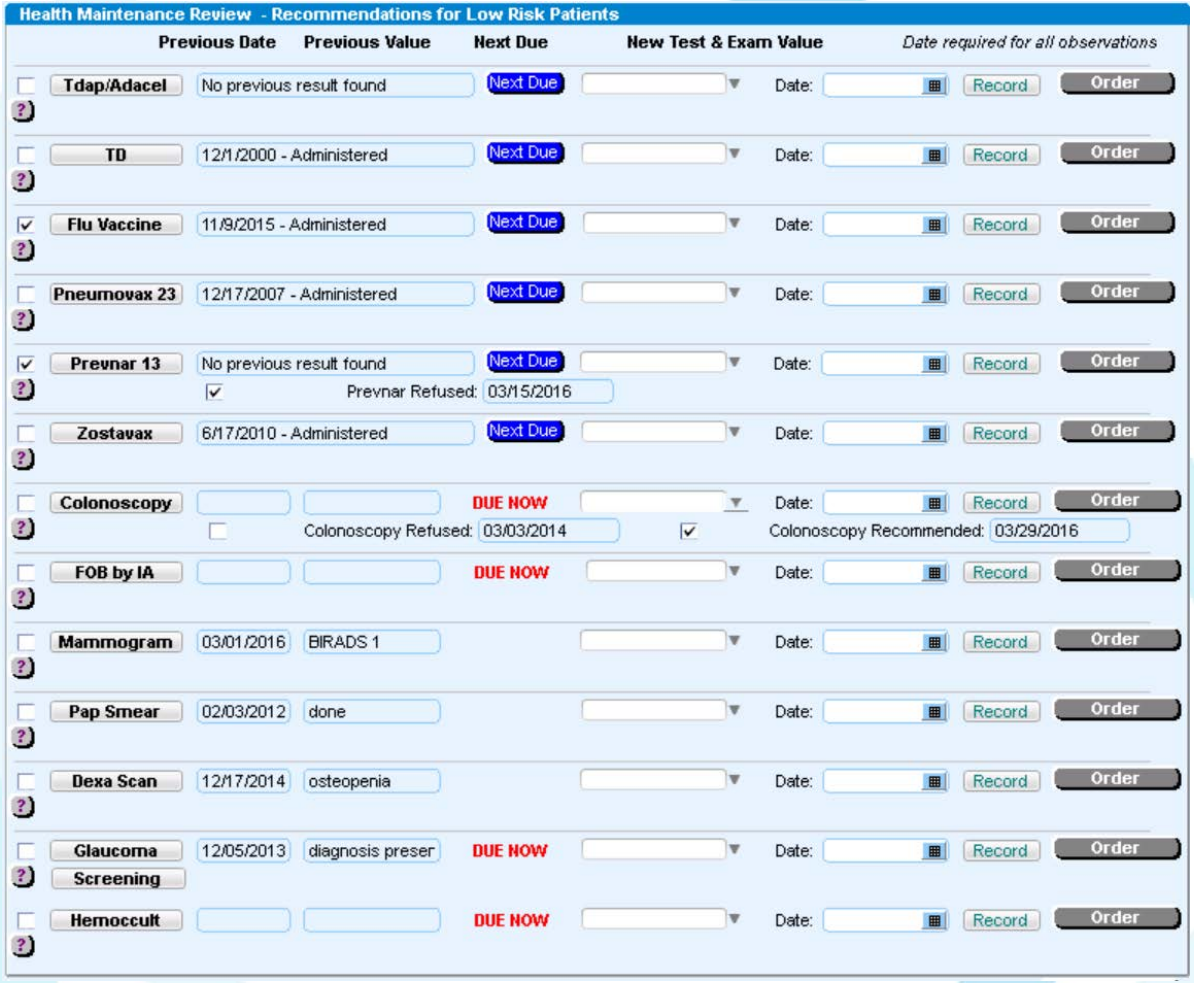

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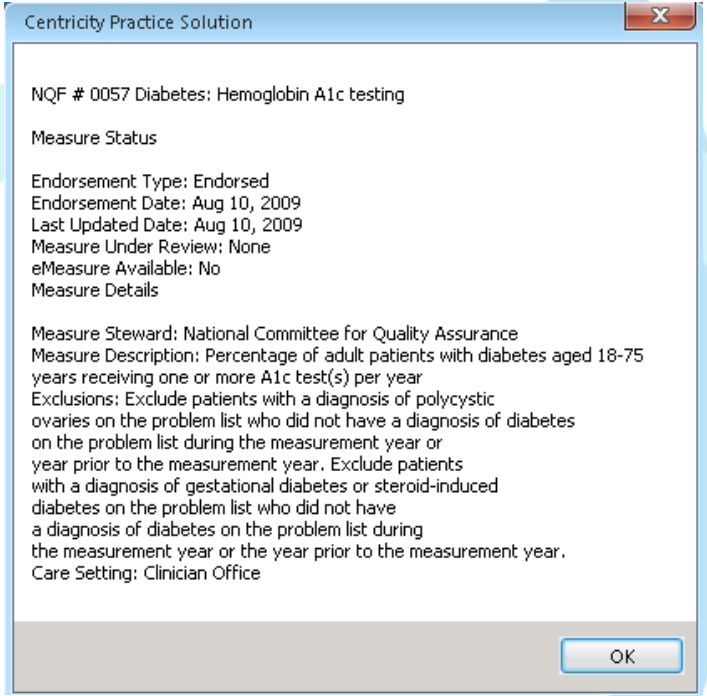
Access to Guidelines

Click on the Question Mark to access the Clinical Quality Guidelines



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Outcomes in

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Clinical Outcomes

Preventive measures

- Keep your population healthy

Screening measures

- Identifying at risk populations

Chronic care measures

- Disease specific outcomes

Clinical quality measures

- Measures how well you manage your specific population

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Payment Models in

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Why?

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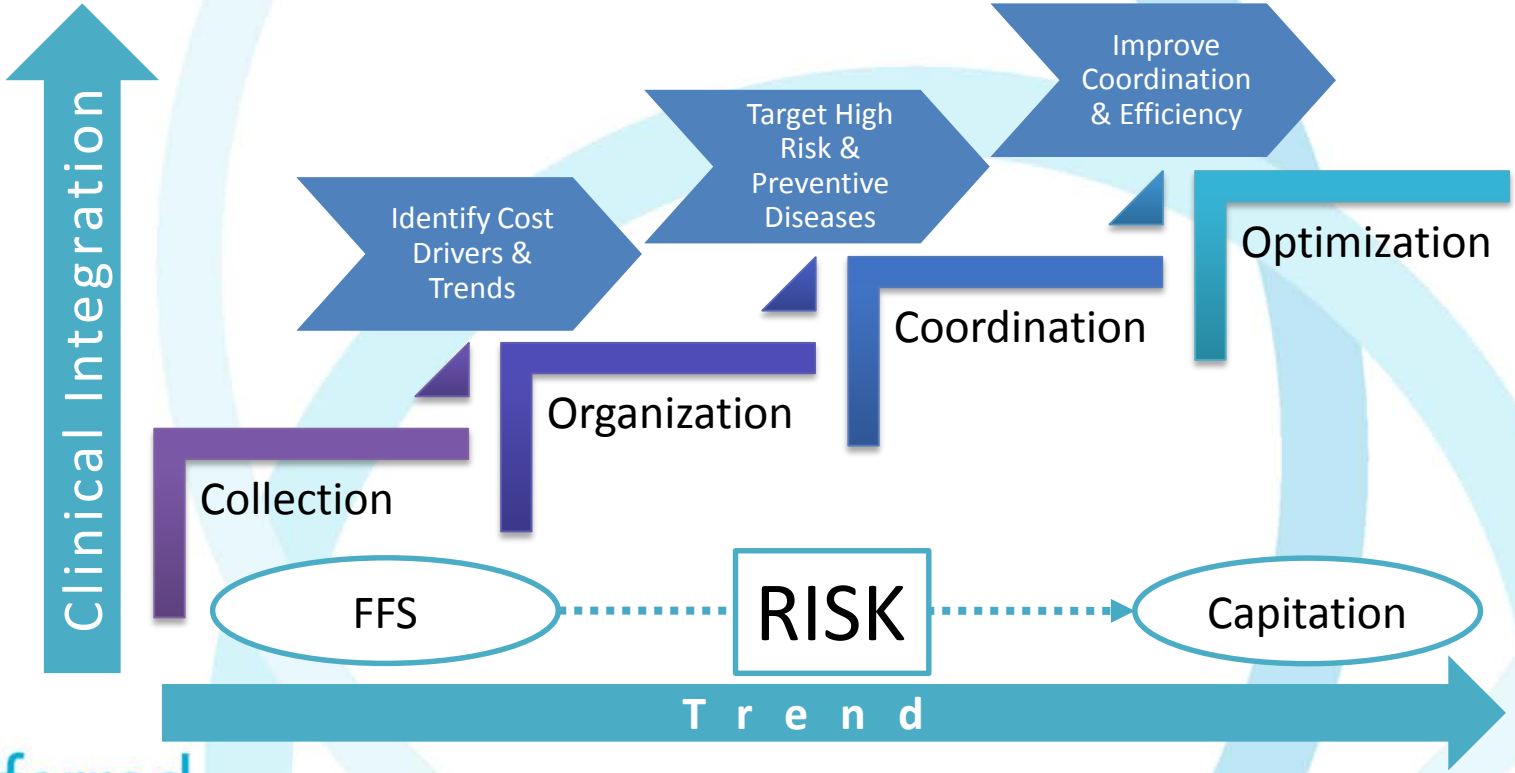
Transition to Value-Based Reimbursement



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Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)

Repeals the Sustainable Growth Rate (SGR): Method used by CMS to control spending by limiting increases in the fee schedule

Extends Children's Health Insurance Program (CHIP) funding for two years.

Creates two payment tracks to reward providers for giving better care.

- Merit-Based Incentive Payment System (MIPS)
- Alternative Payment Models (APMs)

Combines existing quality reporting programs into one new system.

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Merit-Based Incentive Payment System (MIPS)

Consolidates quality programs including:

- Physician Quality Reporting System (PQRS)
- Value-based Payment Modifier (VM)
- Advancing Care Information (replaces Meaningful Use)

Establishes a composite performance score based on

- Quality
- Resource Use (Cost)
- Advancing Care Information
- Clinical Practice Improvement

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Merit-Based Incentive Payment System (MIPS)

Quality

- Accounts for 50% of the total score in year one of the program.
- Clinicians choose to report six measures from a range of options that accommodate differences among specialties and practices.

Resource use

- Accounts for 10% of total score in year one
- Based on Medicare claims, meaning no reporting requirements for clinicians.
- This category uses 40 episode-specific measures to account for differences among specialties.

Advancing Care Information

- Accounts for 25% of total score in year one.
- Clinicians choose to report customizable measures reflecting their use of technology in day-to-day practice – with a particular emphasis on interoperability and information exchange.
- This category does not require all-or-nothing EHR measurement or redundant quality reporting.

Clinical Practice Improvement

- Account for 15% of total score in year one
- Rewards clinical practice improvements, such as activities focused on care coordination, beneficiary engagement, and patient safety.
- Clinicians select activities that match their practices' goals from a list of more than 90 options.

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Alternative Payment Models (APMs)

Pays health care providers for quality care and cost containment

- Requires taking on risk
- Not subject to MIPS
- Increased transparency of physician-focused payment models
- 5% bonus from 2019-2024
- Starting in 2026, offers some participating providers a higher fee schedule.

Examples include:

- Accountable Care Organizations (ACOs)
- Patient Centered Medical Homes (PCMH)
- Bundled payment models

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Alternative Payment Models (APMs) Qualifications

Qualifying APM based on existing payment models

- Medicare Shared Savings Program
- CMS Innovation Center Model
- Medicare Healthcare Quality (MHCQ) demonstrations
- Acute Care Episodic demonstrations

Eligible APM based on criteria of payment model

- Quality measures comparable to MIPS
- Use of certified EHR technology
- More than nominal risk OR Medical Home Model

Qualifying APM Participant

- Based on individual provider payment or patient volume

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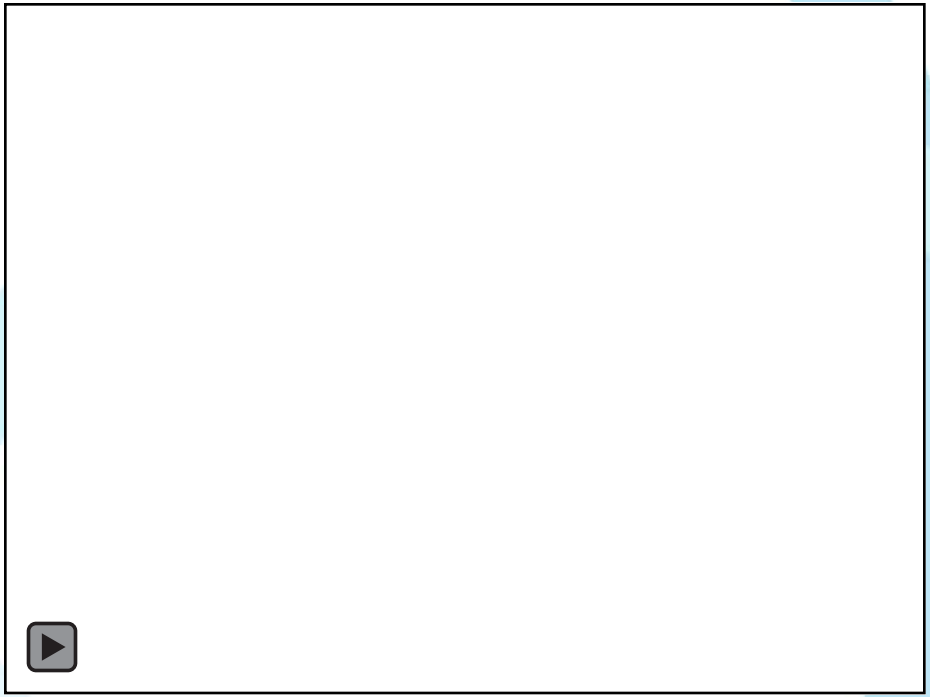
Introducing Payment Reform



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Discussion about

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