The Leader in Physician-Led Population Health Improvement

Provider-Led Population Health Management WORKS! Real Stories, Real Results

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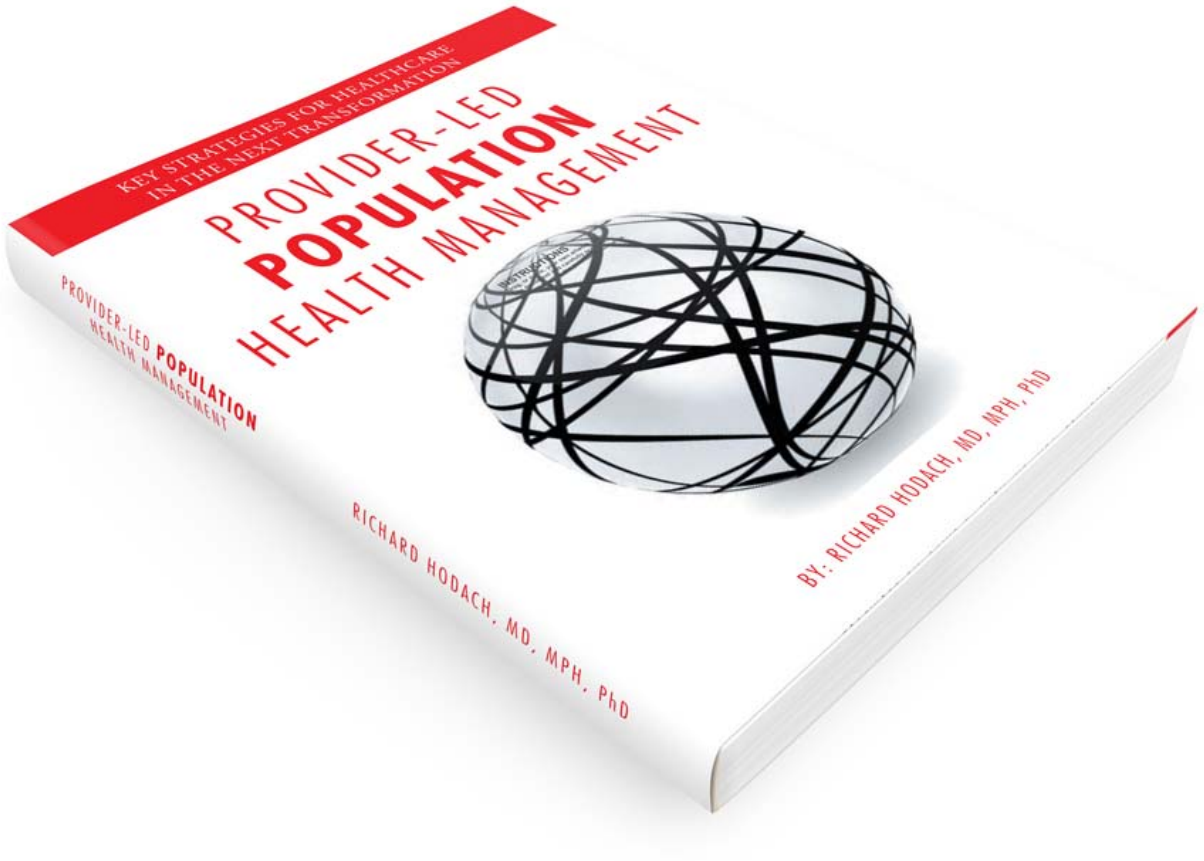
Agenda

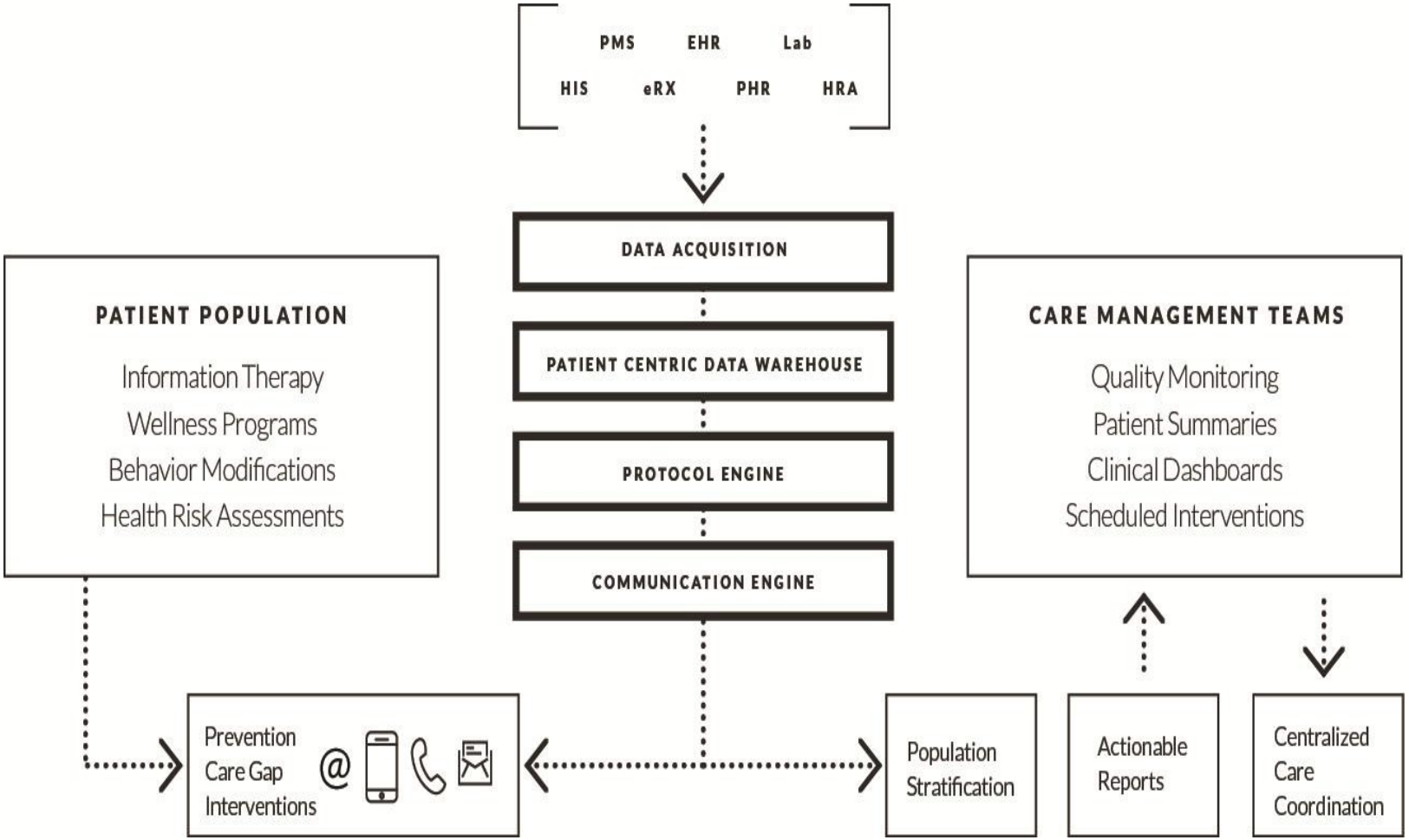
- ***Provider-Led* Population Health Management**
  - Why it's different, why HIT is fundamental
- **New Delivery Models**
  - Tipping point towards value-based care is in sight
- **How to Get There—System View**
  - Changing culture, creating CINs, maximizing revenue
- **Implementing Change—Practice View**
  - Putting information in the hands of the care team
- **Key Messages**


HOW MANY PEOPLE DO YOU NEED TO REACH TODAY?

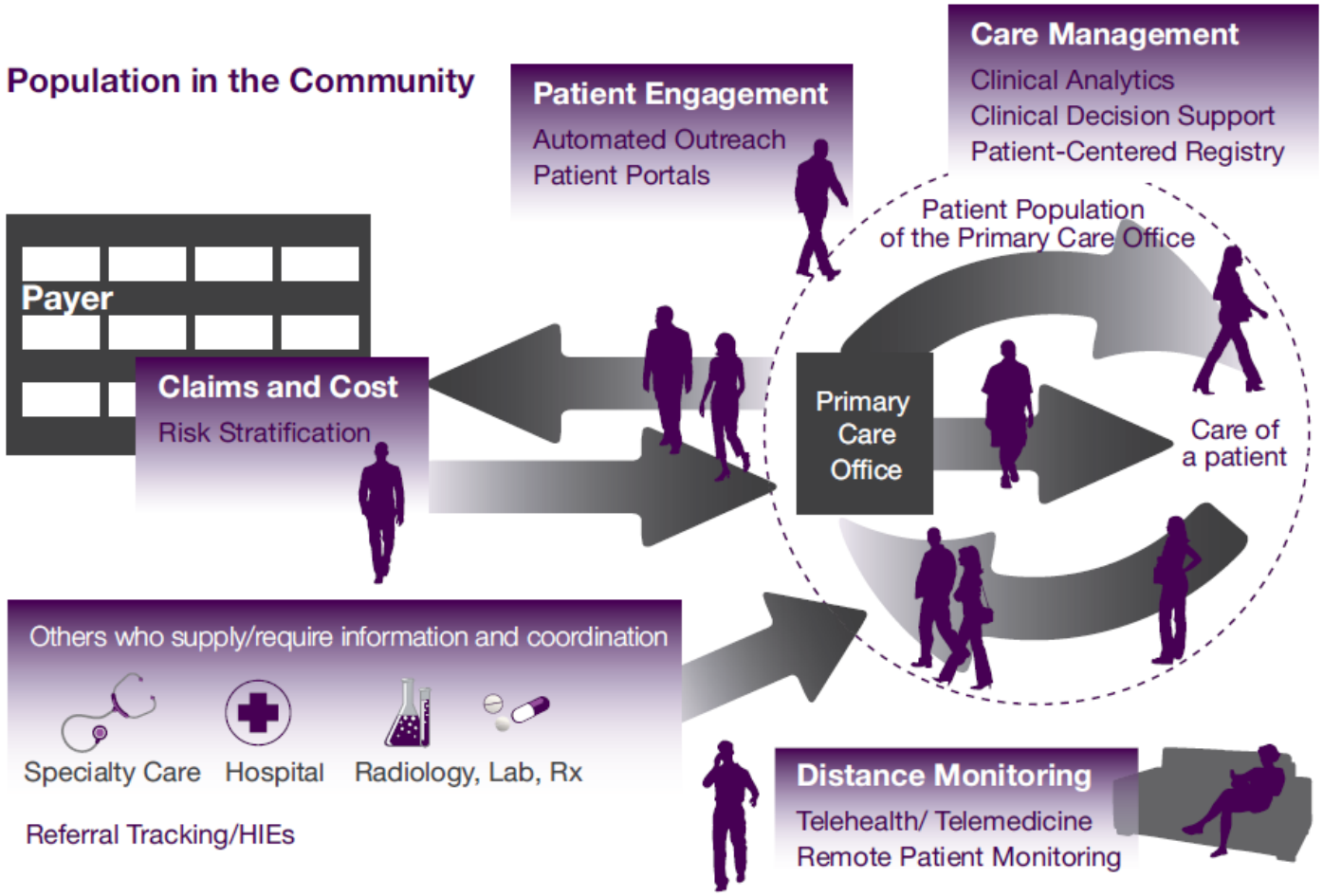
We Wrote the Book



New Delivery Models Require Integrated Data…

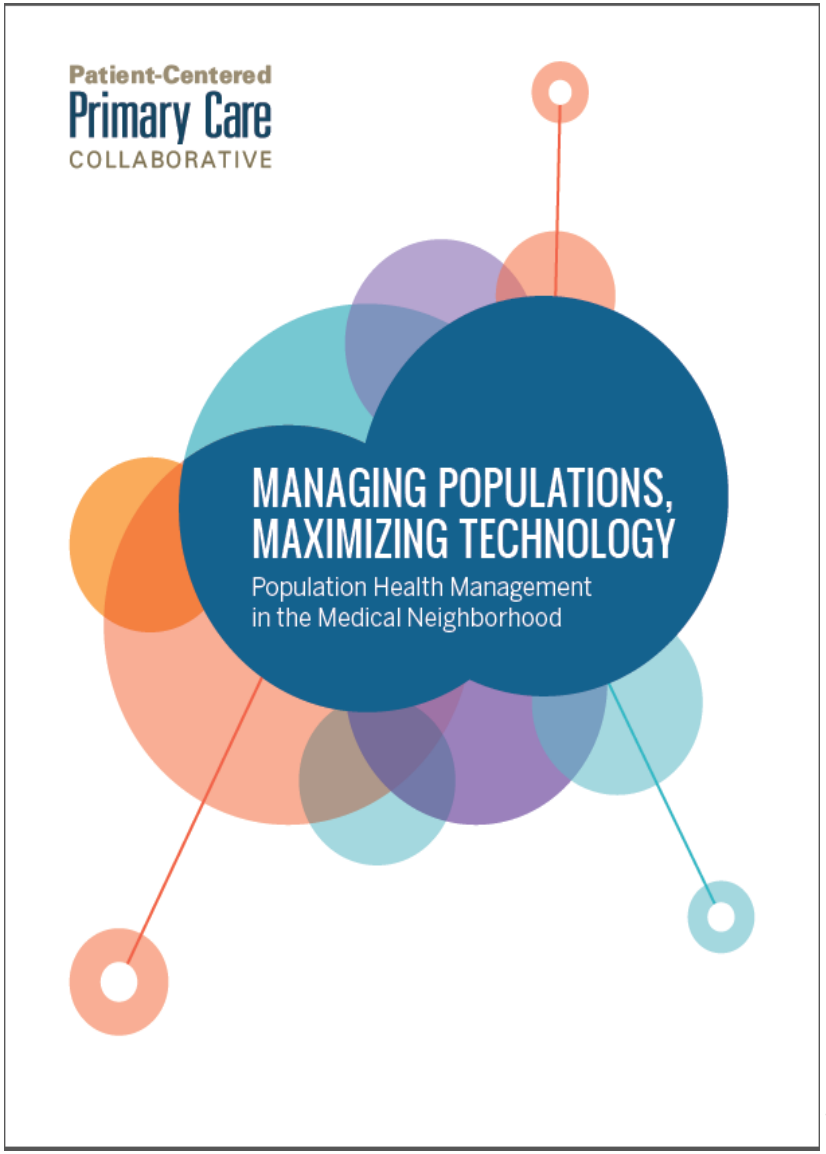


…and Automation of PHM Functions



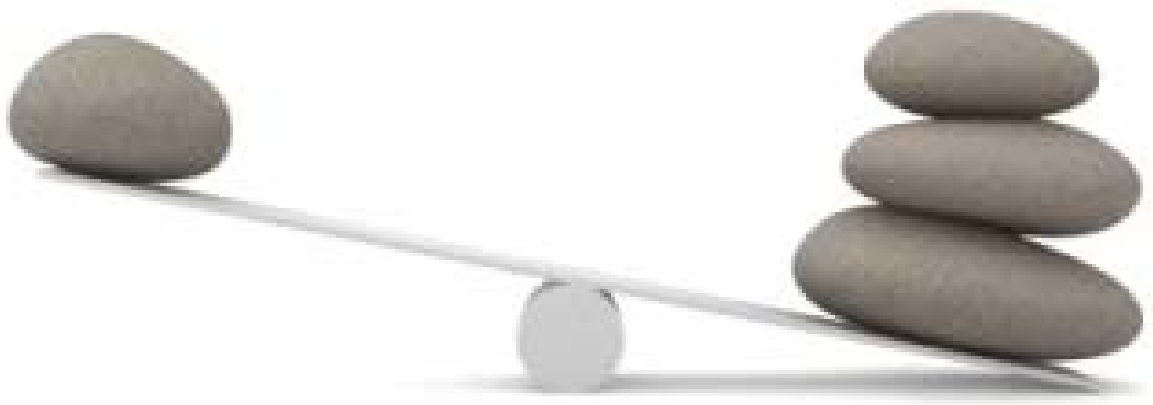
Ten Recommended HIT Applications for PHM

1. EMRs
2. Patient registries
3. HIE
4. Risk stratification
5. Automated outreach
6. Referral tracking
7. Patient portals
8. Telehealth/Telemedicine
9. Remote patient monitoring
10. Advanced population analytics and cognitive computing



Tipping Point to Value-Based Payment is Near

- **CMS, 1/26/15:**
  - **By 2018, 50% of all Medicare FFS payments will be tied to alternative value-based payment models**
- **Commercial payers, 1/28/15:**
  - **By 2020, 75% of contracts will be value-based**



How to Get There: System View

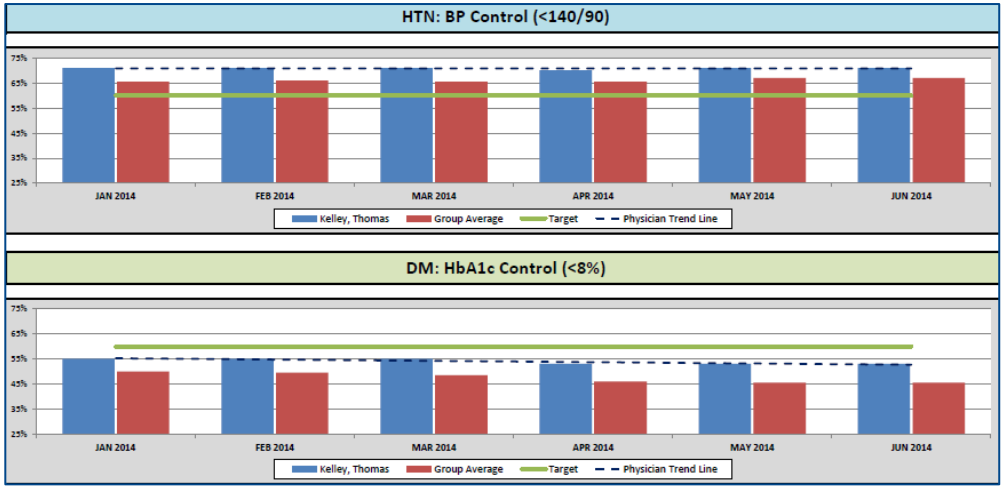
“Doctors will agree on this”…Not So Fast

Creating CINs with Aligned HIT and Incentives

- Adhere to EBM protocols
- Connect EMRs
- Define single set of measures
- Collect & share data
- Evaluate performance
- Tie participation to performance

dbMotion

DISEASE STATE SELECTION:
QUALITY IMPROVEMENT GOALS



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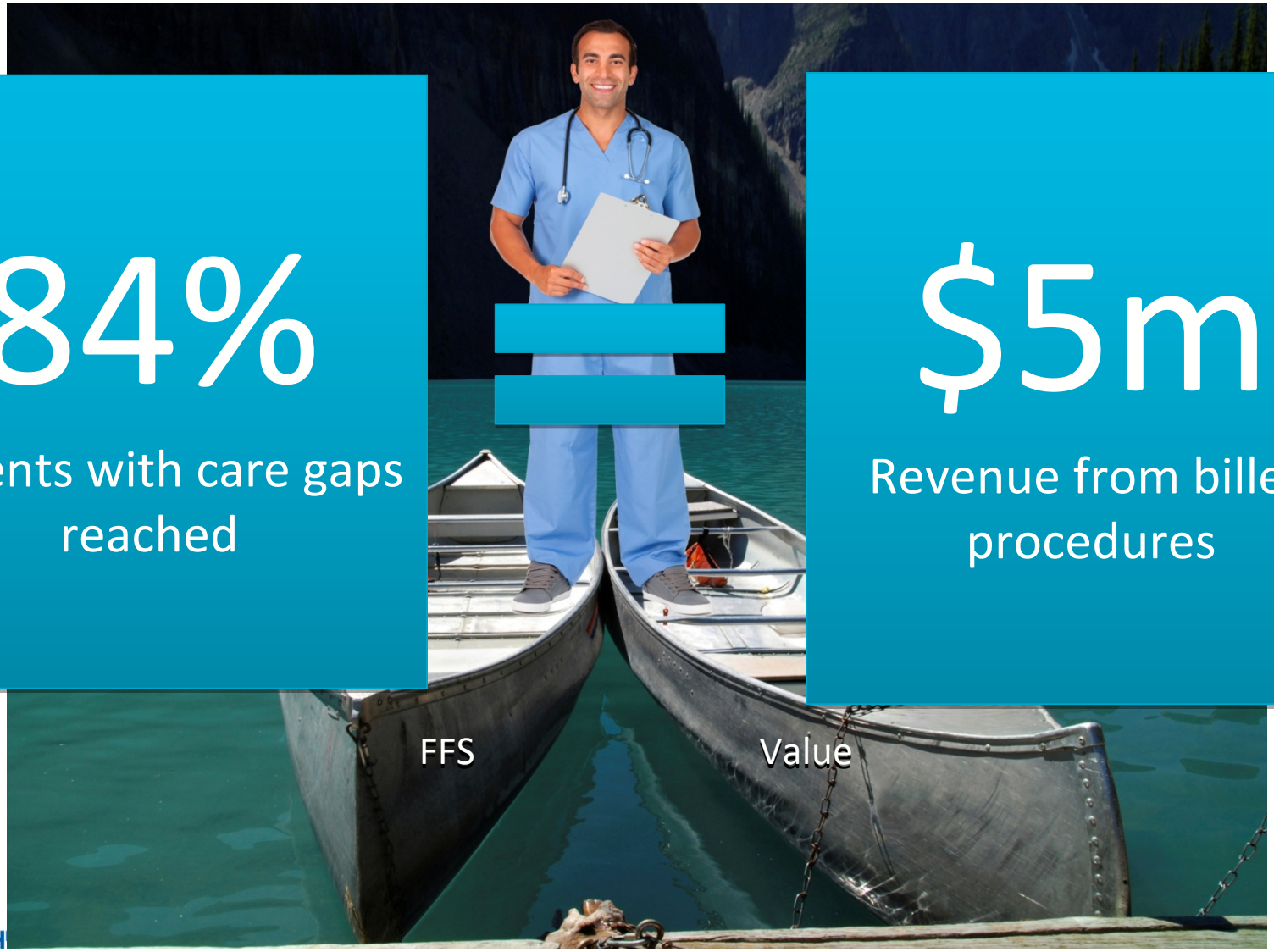
Maximize Revenue for PHM Related Services



84%

Patients with care gaps reached

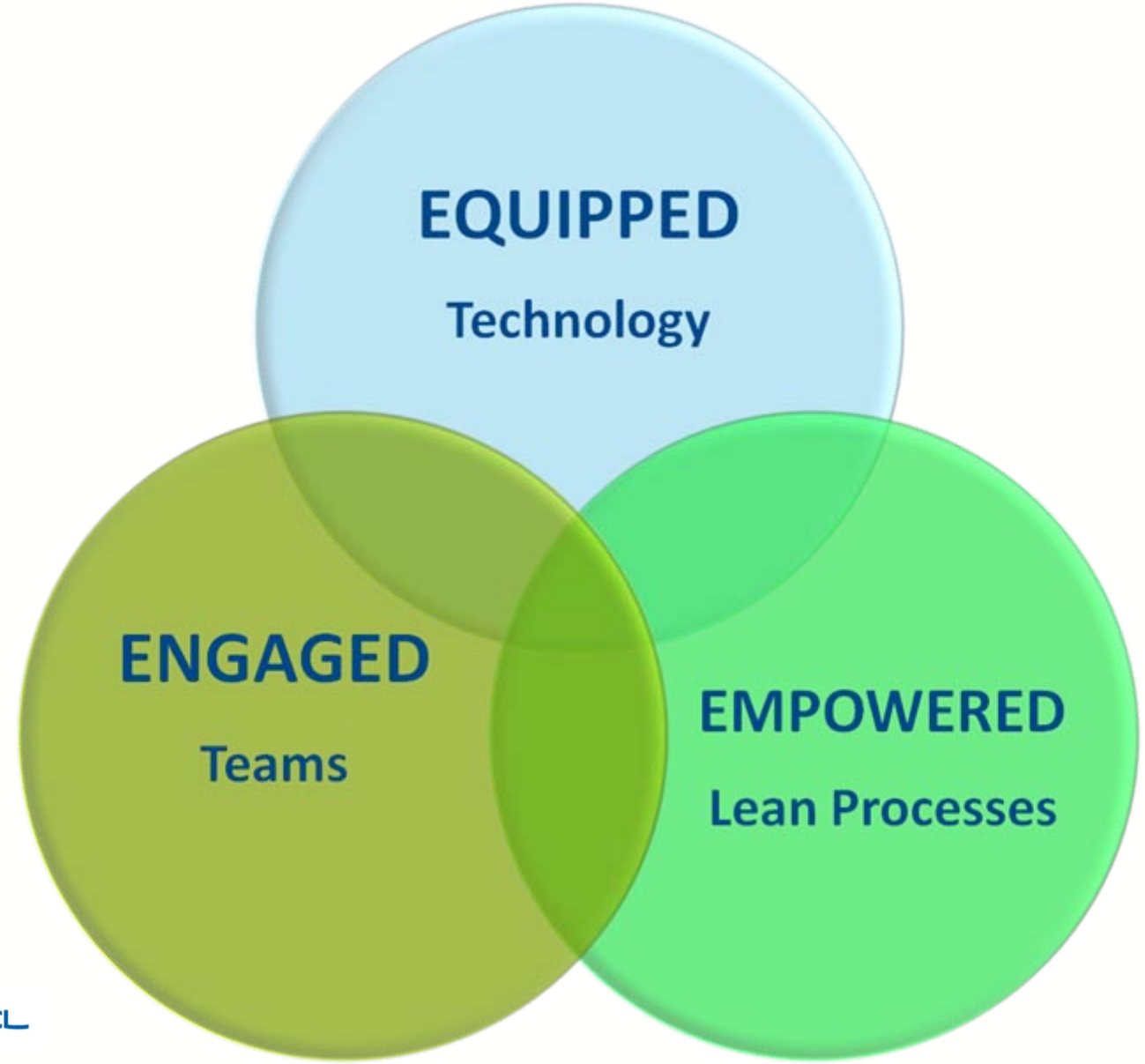
=

$5m

Revenue from billed procedures

Implementing Change: Practice View

Triple Focus of Transformed Care Teams



Practice Coaches: Drive and Sustain Transformation

- Facilitate team meetings
- QI methodology
- Training
- Workflow design
- Dissemination of change
- Team building
- Project management
- Transformation strategy
- Plan organization-wide collaboratives

Team Results: 85% Hypertension Control

- Engage providers and create team
- Develop standard workflow
- ✓ **Need to know patient list**
- ✓ **Set and monitor tangible goal: fix 6 patients = 1percentage point improvement**
- ✓ **Reduce manual work; maximize use of HIT tools**
- Optimize visit by engaging patient before, during and after visit
- START SMALL FOR QUICK WINS

Engaging People "Lost to Follow-Up" is Key to PHM

"…We use a magic genie to do all of the communications that we don't have time to do."

COMMUNICATIONS	**7,601**
UNIQUE PATIENTS	**3,713**
Lab Follow Up	3,942
Never Had Yearly	1,565
Pre-Visit Yearly	749
Pre-Visit Diabetes	711
COPD Research Study	367
Due for Yearly	221

Make HIT A Member of the Care Team

EMR

Registries

Portals

Mobile Devices

Risk Stratification

Care Gap Profiles

Pre-Visit Prep

Automated Outreach

Quality Reporting'

Strategic PI

MA / Patient Service Team

- Scheduling
- Execute Standing Orders & Protocols (Triage, Med Refill)
- Pre & In-Between Visit Communication

MA / Nurse

- Pre-Visit Planning
- Execute Standing Orders & Protocols (Care Gaps)
- Med Reconciliation
- Foot Exams
- Education
- Referrals to Care Mgmt

Care Manager

- Highest Risk / Most Complex patients by risk score
- Outreach to patients with complex needs
- Coaching, Goal Setting, Education
- Transitional Care

Physician

- Refer high risk patients to Care Mgmt
- Aim to address all care gaps at every encounter
- Population Health focus

Quality / PI Leaders

- Review performance by location and provider
- Provide progress reports with MD's and Care Teams; plan PI

Key Messages

- Population health is a provider-led game
- HIT is essential for SCALE to achieve PHM goals
- HIT includes but is not limited to the EMR
- Make HIT a member of the care team for efficiency, actionable data and top of license performance