AUTOMATE POPULATION HEALTH MANAGEMENT TO BRIDGE GAPS IN CARE DELIVERY AND IMPROVE CARE COORDINATION

Richard Hodach, MD PhD MPH
Chief Medical Officer, Phytel, Inc.

Karen Handmaker, MPP
Director, Population Health Management Services, Phytel, Inc.

Key Points for Presentation

- Manage the complex patients with the highest costs at the top…***and everyone else*** to achieve clinical and financial goals
- Stratify and prioritize the total population by risk and care gaps ***continuously***
- ***Leverage automation*** to build high performance care teams, drive patient engagement and integrate actionable reporting into population health management and quality improvement workflows

It’s Complicated…

Market Around Quality and Value is Here

80% of healthcare organizations are pursuing an **Accountable Care Organization** by 2015[1]

70% of medical practices are adopting the **Patient-Centered Medical Home**[2]

[1] Wall Street Journal, 12/2011
[2] MGMA 2011 Survey

What Does “Paradigm Shift” Look Like?

Traditional View

30 Patients Per Day

New View

2500 Patient Population

Practices are responsible for total population regardless of engagement status

Let's Have A Show of Hands…

How many of you have:

- A fully-deployed EMR?
- Achieved Patient-Centered Medical Home recognition?
- Applied for Meaningful Use incentives?
- Financial incentives (e.g., P4P) tied to quality measures?
- Chronic condition registries?
- Hired Care Managers?
- Implemented Lean Six Sigma?

But *still* have:

- No total population reports
- Quality committees without practice or provider level data
- Physicians who doubt reports
- Clinical staff who spend more hours compiling patient data than caring for patients
- Inconsistent EMR documentation processes
- P4P money left on the table

Readiness for Population Health?

Strategy and Incentives in Place…

- PCMH, ACO
- P4P, Shared Savings, Bundled Payments

…but Population Health Infrastructure is Incomplete:

- Accessible, multi-level reporting
- Ongoing risk stratification and interventions
- Bi-directional patient communications

A Real Story

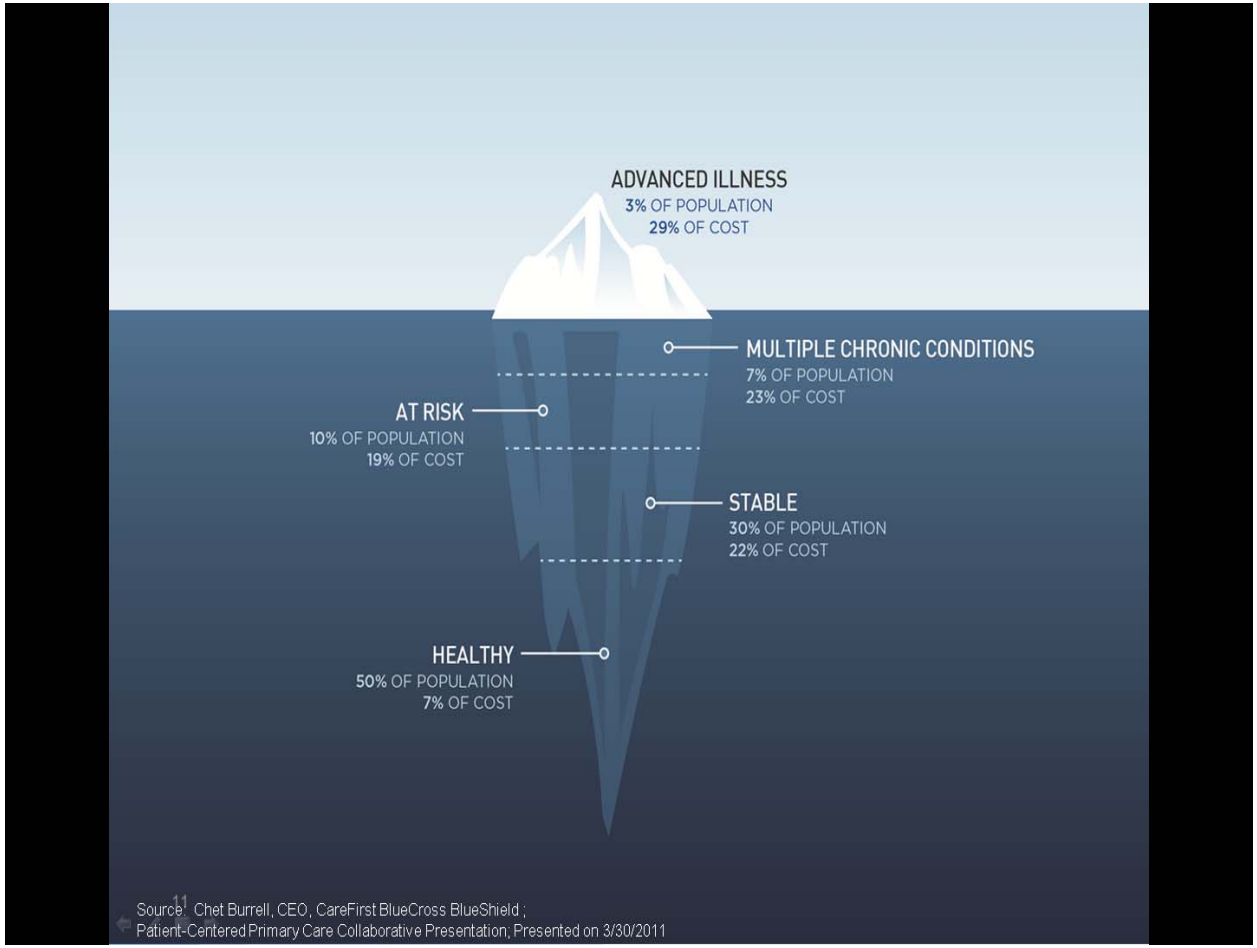
The Drivers are There:

- Pioneer ACO and Commercial capitation contracts started January 2012: 40,000+ attributed patients
- Pursuing NCQA PCMH 2011
- Sophisticated EMR
- Heavy LSS investment
- Automated outreach for preventive and chronic conditions

…but Population Health Infrastructure is Incomplete:

- Need additional FTEs to manage high risk and high cost patients, above and below waterline
- Have limited reporting by provider and condition
- Have limited point of care actionable data
- Have limited automation capabilities to reach and monitor whole population

What Does Managing a Population Mean?



Source[11] Chet Burrell, CEO, CareFirst BlueCross BlueShield ; Patient-Centered Primary Care Collaborative Presentation; Presented on 3/30/2011

What Does a Population Look Like?

Chronic Condition Prevalence

Chronic Conditions	Prevalence Census Data *	Panel Size=2500/PCP One PCP	Panel Size=2500/PCP 10 PCP's	Panel Size=2500/PCP 100 PCPS
		2500	25000	250000
Hyperlipidemia	**0.204**	511	5110	51100
Hypertension	**0.189**	472	4720	47200
Depression	**0.047**	118	1180	11800
Asthma	**0.073**	183	1830	18300
Diabetes	**0.058**	145	1450	14500
Arthritis	**0.152**	381	3810	38100
Anxiety	**0.112**	279	2790	27900
Osteoporosis	**0.056**	140	1400	14000
COPD	**0.052**	131	1310	13100
CAD	**0.048**	120	1200	12000

*Prevalence data is from recent US Census Data. Most likely these conditions have higher current rates but used to illustrate the magnitude of conditions in different sized PCP groups.

What Does a Population Look Like?

Health Risk Prevalence

	Risk Prevalence based on self-reported HRA data of 2+ million individuals >17*	1 Physician Panel Size	10 Physicians Panel Size	100 Physicians Panel Size
Health Risk Category	**Population Benchmark***	**2500 patients**	**25,000 patients**	**250,000 patients**
Alcohol Use	**0.22**	550	5,500	55,000
Injury Prevention	**0.16**	400	4,000	40,000
Nutrition	**0.96**	2,400	24,000	240,000
Physical Activity	**0.48**	1,200	12,000	120,000
Sexual Behavior	**0.01**	25	250	2,500
Skin Protection	**0.34**	850	8,500	85,000
Smoking	**0.11**	275	2,750	27,500
Stress	**0.35**	875	8,750	87,500
Depression Symptoms	**0.12**	300	3,000	30,000
Weight Mgt	**0.64**	1,600	16,000	160,000
•Overweight	**0.33**	825	8,250	82,500
•Obese	**0.25**	625	6,250	62,500
•Extremely Obese	**0.06**	150	1,500	15,000

Source: HealthMedia book of business HRA results, based on over 2 million participants, 2010

Layering in Automation to Touch Everyone

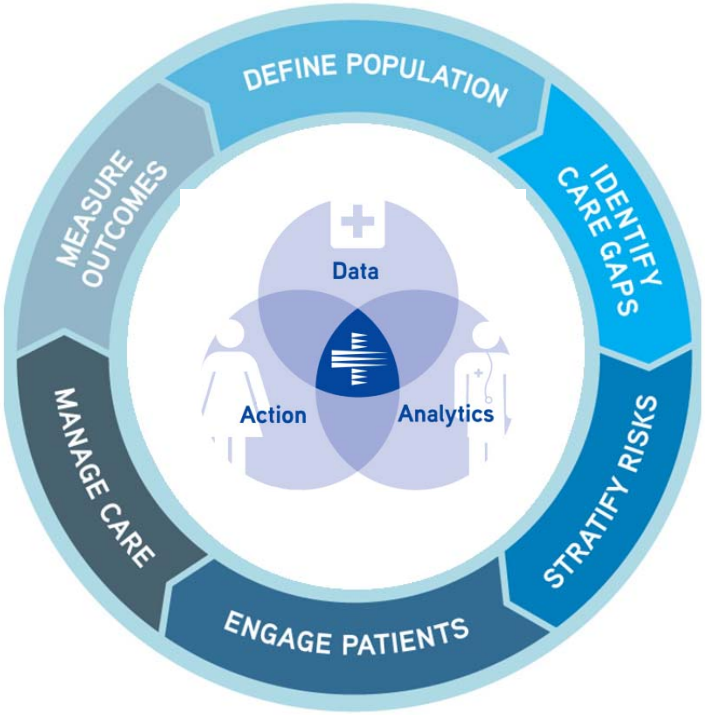
Population Size	5,000					
	No Disease (60%)			Have Disease (40%)		
Risk	Well	At Risk	High Risk	Low Risk	Mod Risk	High Risk
Risk Percentage	0.3	0.25	0.05	0.27	0.1	0.03
Patients with Risk	1500	1250	250	1350	500	150
FTE (case load)	0	0	1 Health Coach (250 cases)	1.35 LPN (1000 cases)	1 RN Care Mgt (500 cases)	1 RN Case Manager (150 cases)
Phytel	Totally Automated	Totally Automated	Automation + Telephonic coaching	Automation + Telephonic coaching + care manager	Automation + Telephonic coaching + care manager	Case Manager
Patient Intervention	Preventive alerts, HRA	Self-management tools and reminders	Telephonic coach support for highest risk/non-compliant	Continuous monitoring with alerts and activities around care gaps and preventive risks, office compliance etc.	Many more alerts and activities around care gaps and preventive risks, office compliance etc.	Same. Many more alerts and activities around care gaps and preventive risks, office compliance etc.
Care Team Intervention	Tracked; only non-compliant exceptions reported for more intervention	Tracked; only non-compliant exceptions reported for more intervention	Health Coaches provide other intervention; e.g., smoking programs, weight reduction etc.	Activity and poor outcomes for process measures being tracked; Care Manager intervention is limited	Activity and poor outcomes for process measures being tracked; need for Care Manager intervention	Needs Case Management to intervene and provide interventions (embedded and telephonic CM)

PCMH Depends on Actionable Reports *and* Automated Processes

NCQA Standards Require:

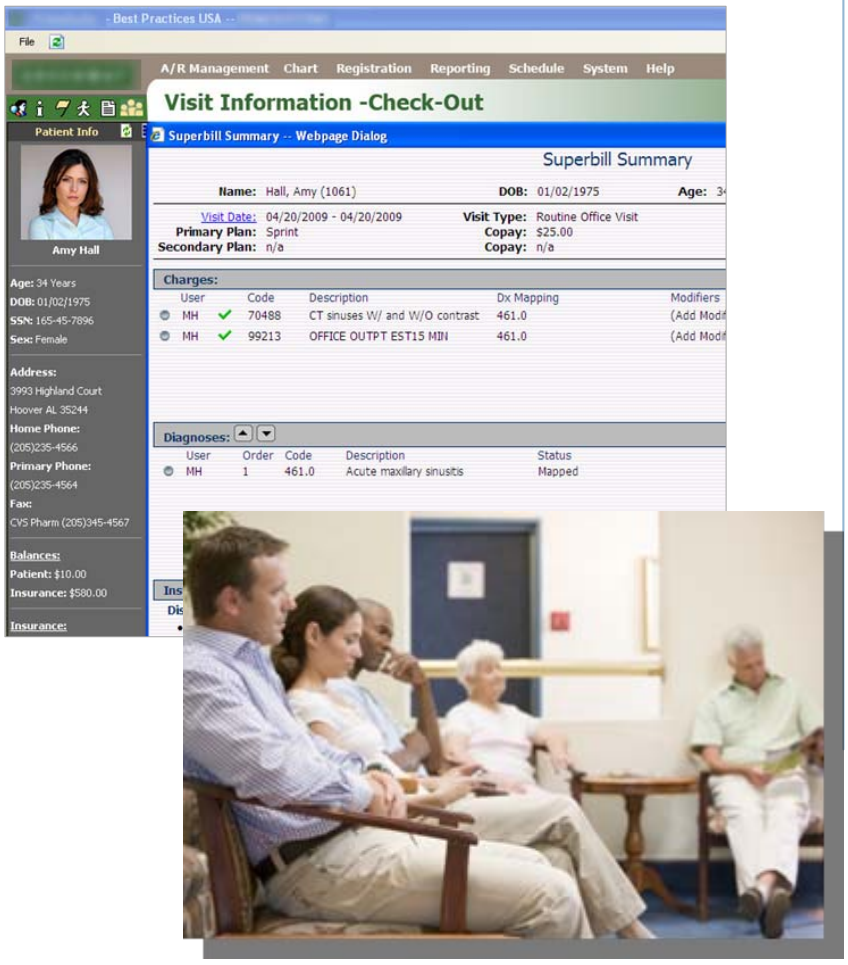
- Reports on total population by condition and provider
- Proactive reminders for all patients of needed care
- Using data at point of care
- Using data to drive continuous quality improvement process

Total Population Management

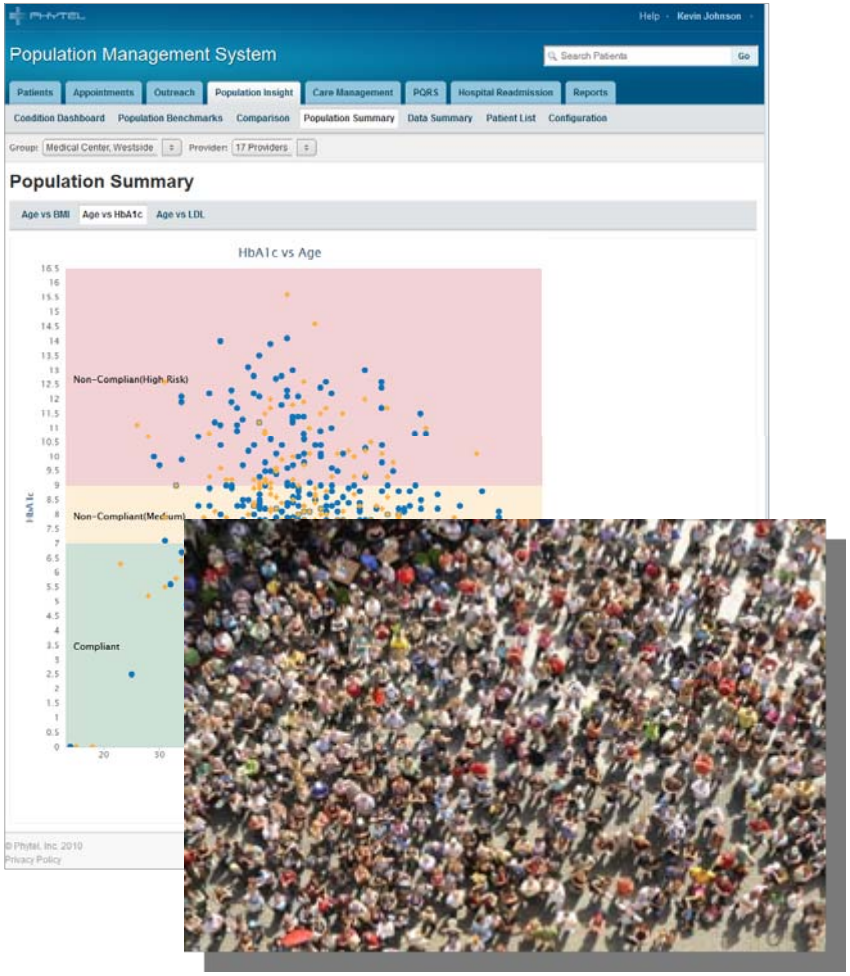


New Tools for a New Environment

FFS: Accountable for Who You See



PHM: Accountable for Your Entire Population



Automation Leverages Care Teams

5 million

=

successful automated outreach events over 18 month period

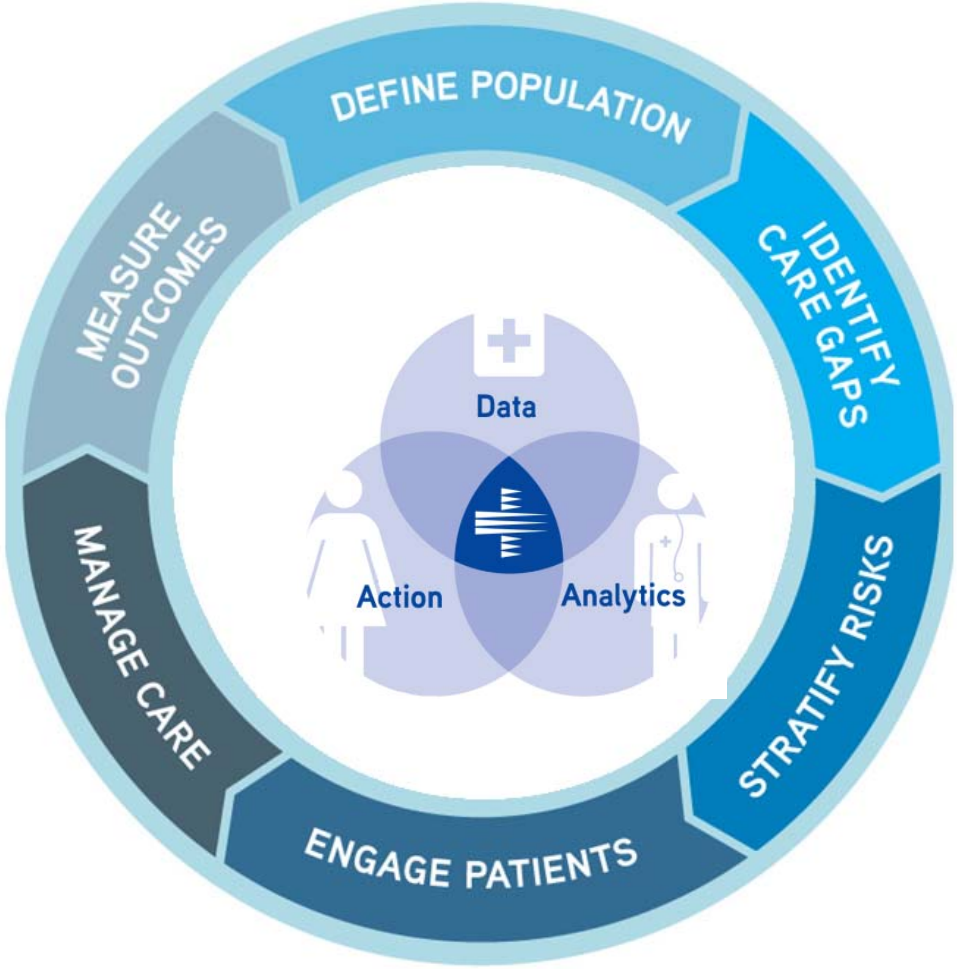
personnel hours saved

110,391

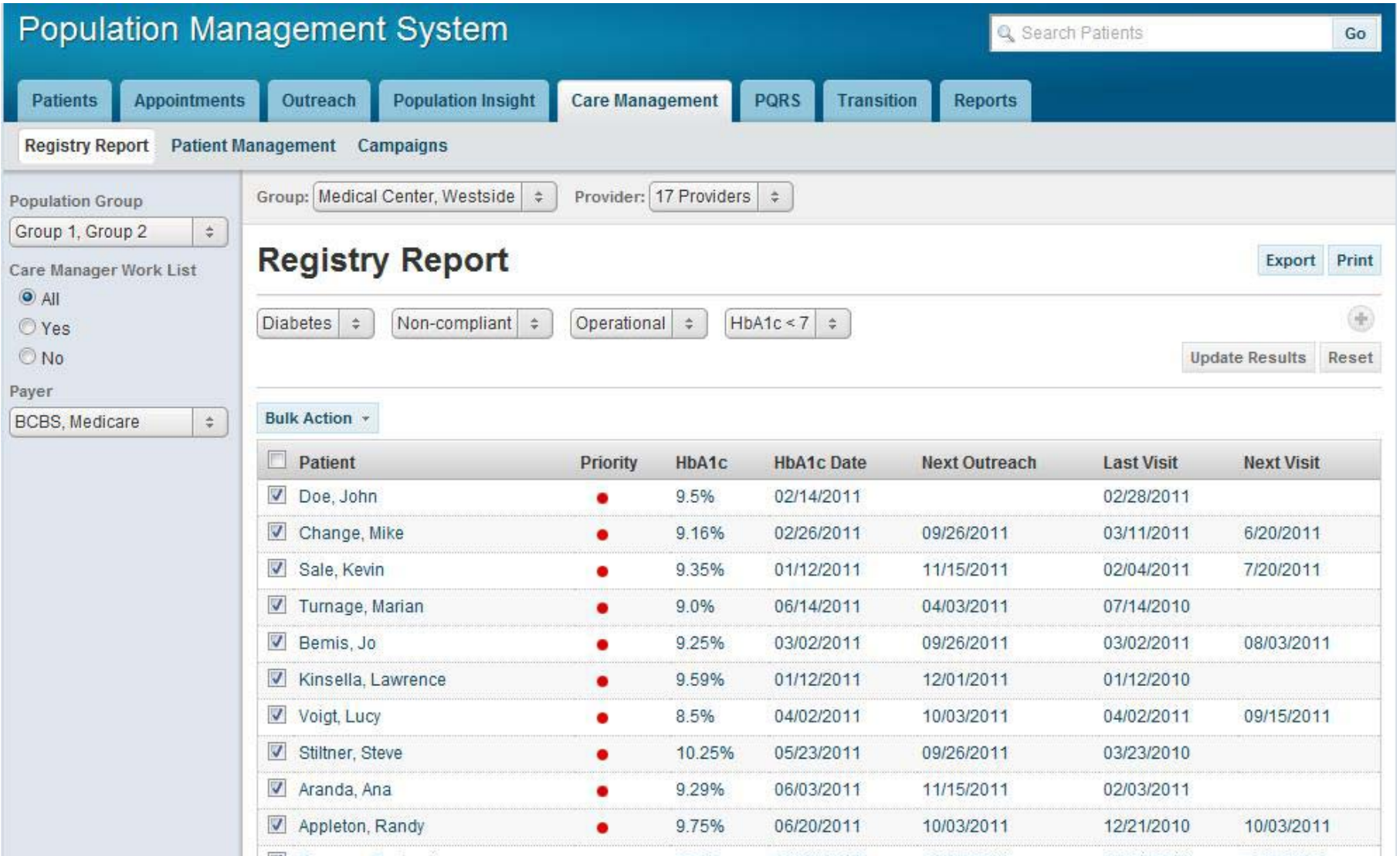
An integrated not-for-profit health care provider serving communities throughout eastern Wisconsin and northern Illinois

PHM Operational Construct:

Automation is Essential

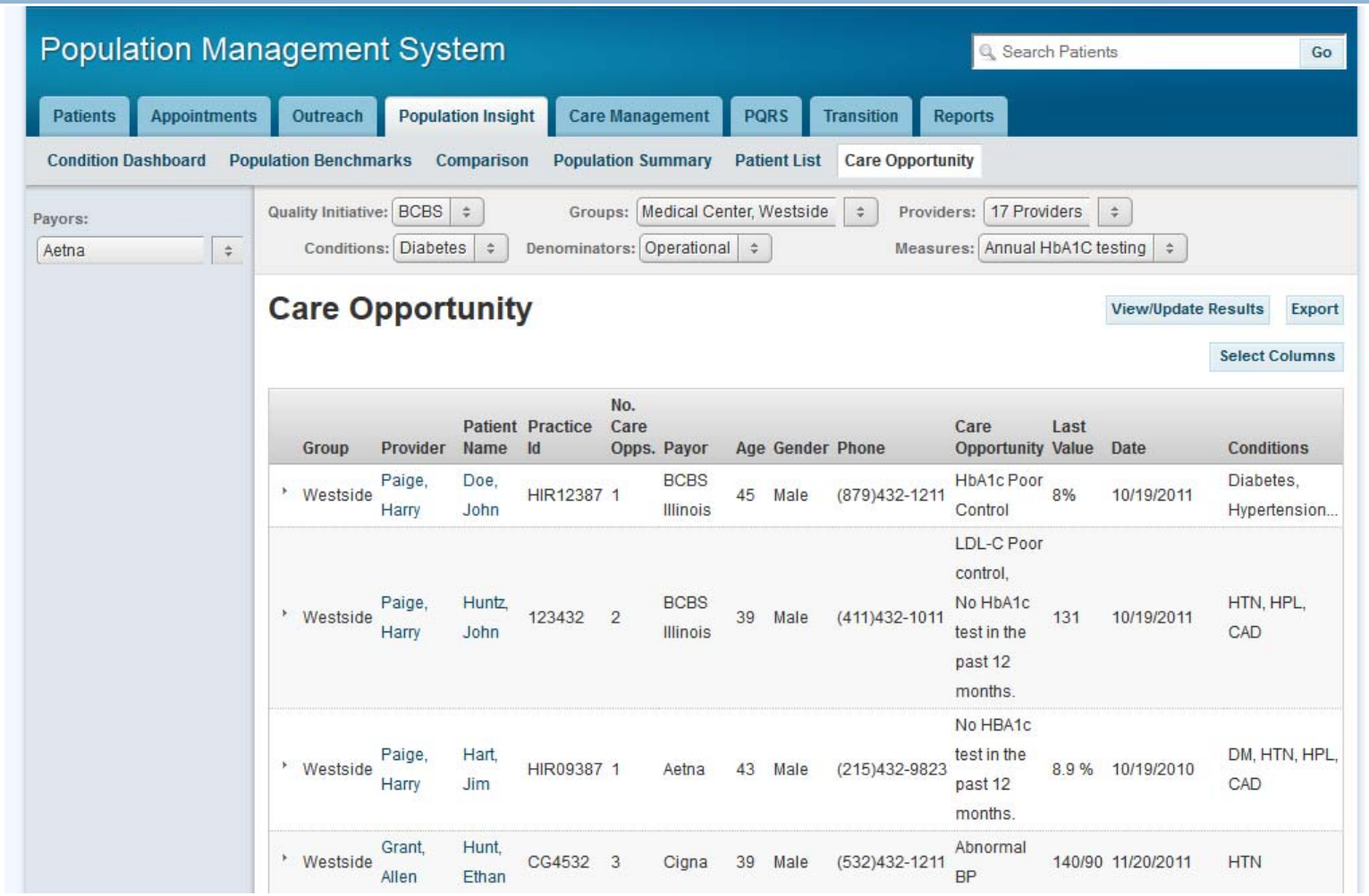


Data Management and Registry



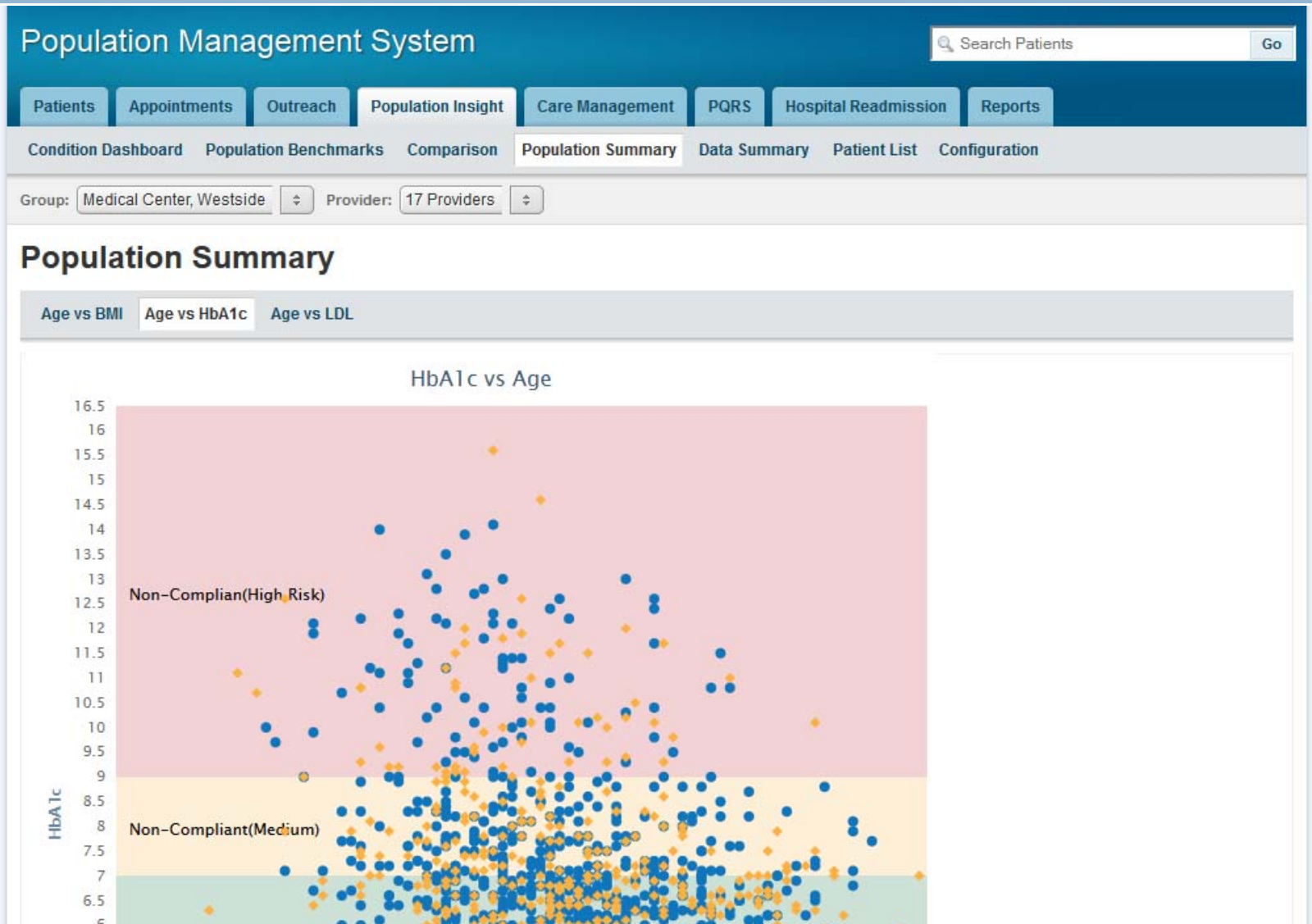
Define Population

Identify Care Gaps

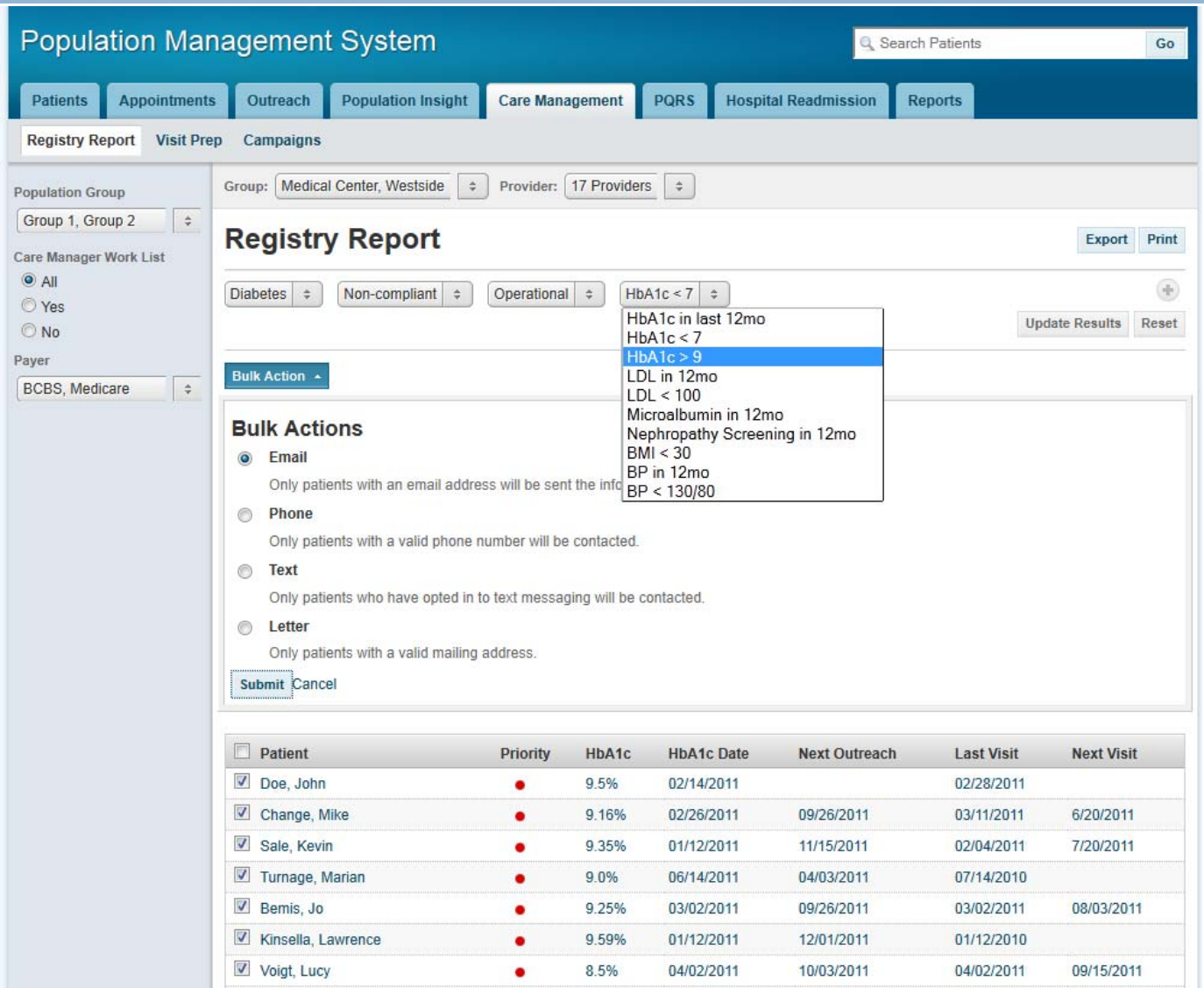


Group	Provider	Patient Name	Practice Id	No. Care Opps.	Payor	Age	Gender	Phone	Care Opportunity	Last Value	Date	Conditions
Westside	Paige, Harry	Doe, John	HIR12387	1	BCBS Illinois	45	Male	(879)432-1211	HbA1c Poor Control	8%	10/19/2011	Diabetes, Hypertension...
Westside	Paige, Harry	Huntz, John	123432	2	BCBS Illinois	39	Male	(411)432-1011	LDL-C Poor control, No HbA1c test in the past 12 months.	131	10/19/2011	HTN, HPL, CAD
Westside	Paige, Harry	Hart, Jim	HIR09387	1	Aetna	43	Male	(215)432-9823	No HBA1c test in the past 12 months.	8.9 %	10/19/2010	DM, HTN, HPL, CAD
Westside	Grant, Allen	Hunt, Ethan	CG4532	3	Cigna	39	Male	(532)432-1211	Abnormal BP	140/90	11/20/2011	HTN

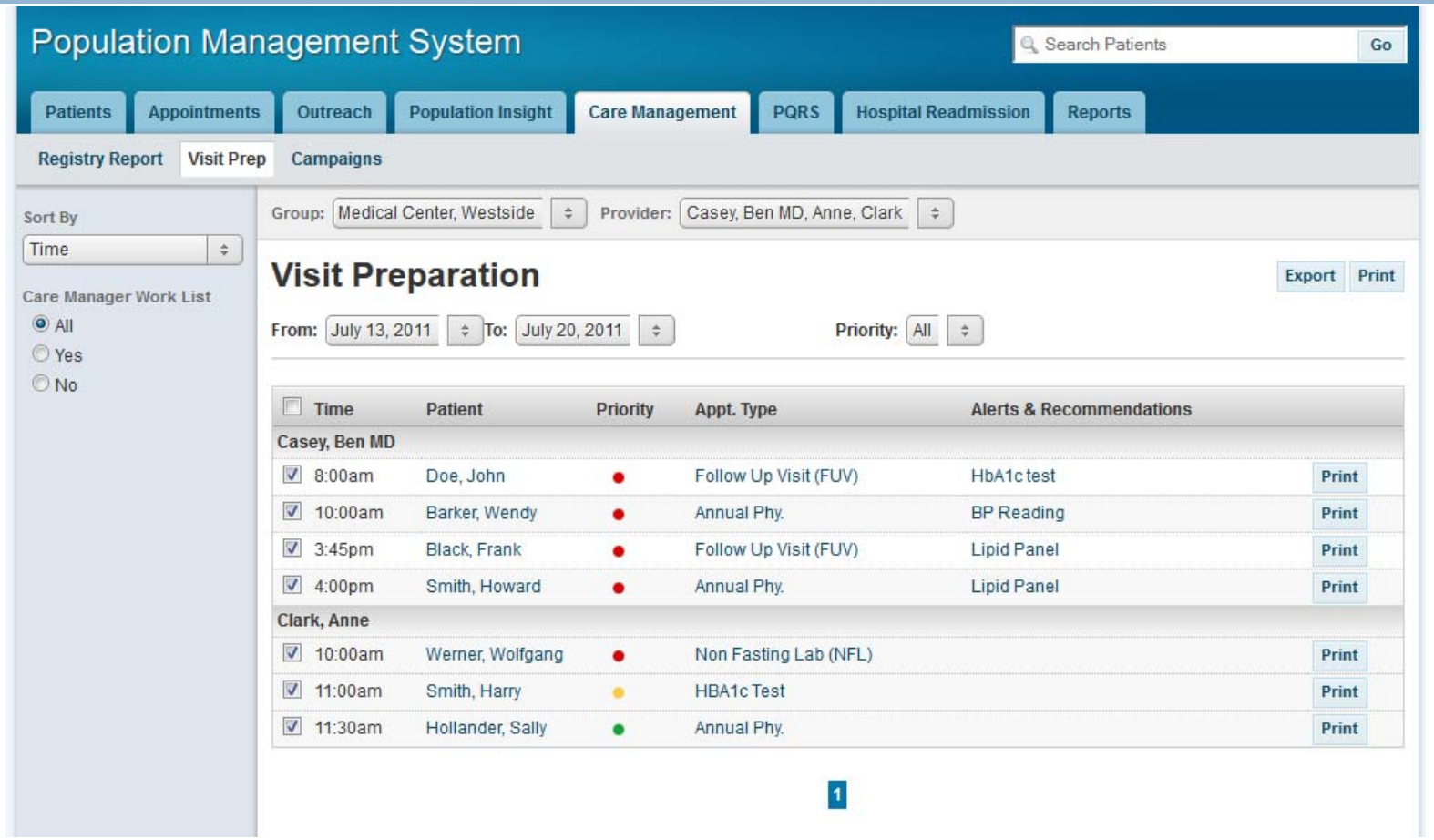
Stratify Risks



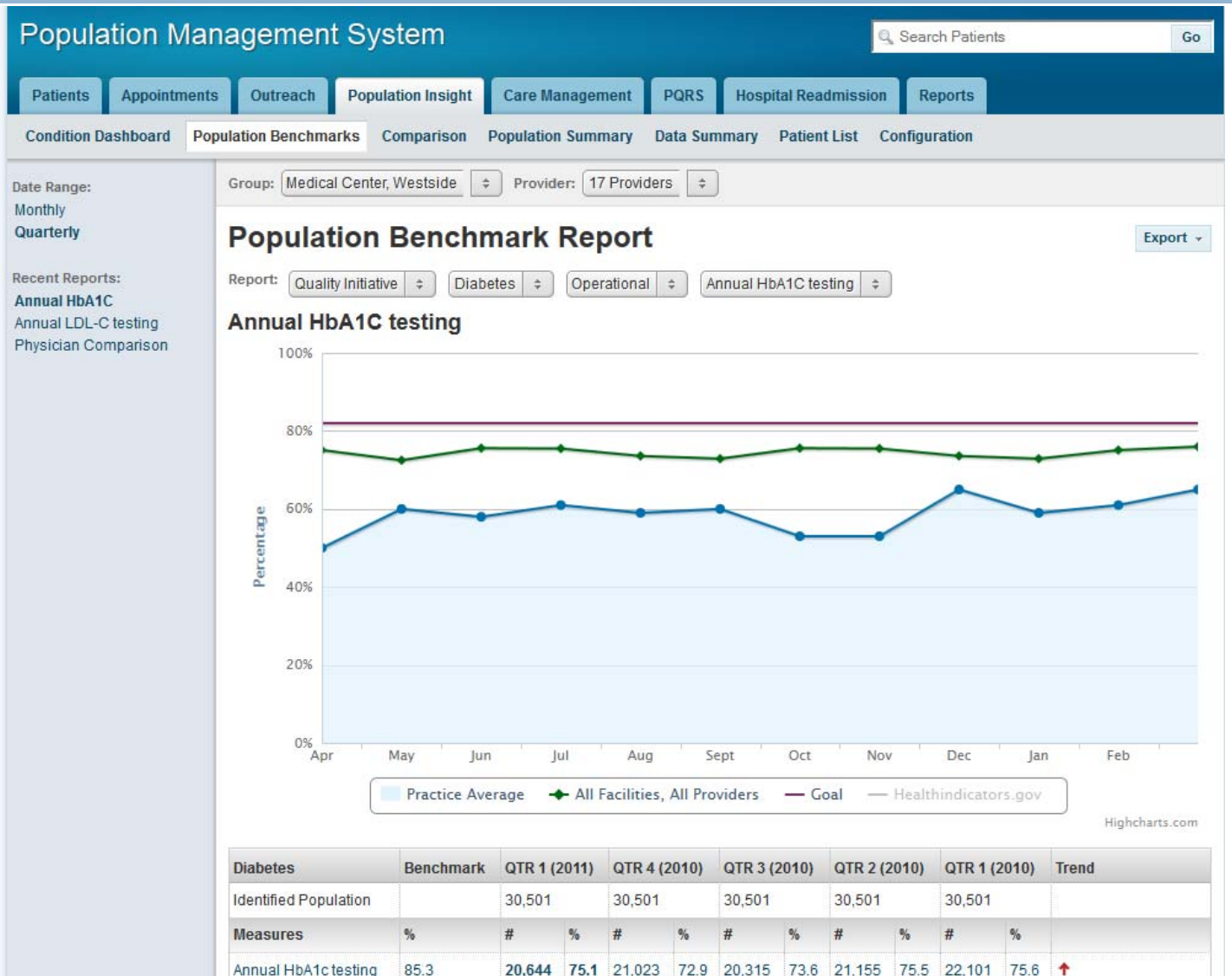
Engage Patients



Manage Care


Population Management System
Search Patients
Go
Patients
Appointments
Outreach
Population Insight
Care Management
PQRS
Hospital Readmission
Reports
Registry Report
Visit Prep
Campaigns
Sort By
Time
Care Manager Work List
All
Yes
No
Group: Medical Center, Westside
Provider: Casey, Ben MD, Anne, Clark
Visit Preparation
Export
Print
From: July 13, 2011
To: July 20, 2011
Priority: All
Time
Patient
Priority
Appt. Type
Alerts & Recommendations
Casey, Ben MD
8:00am
Doe, John
Follow Up Visit (FUV)
HbA1c test
Print
10:00am
Barker, Wendy
Annual Phy.
BP Reading
Print
3:45pm
Black, Frank
Follow Up Visit (FUV)
Lipid Panel
Print
4:00pm
Smith, Howard
Annual Phy.
Lipid Panel
Print
Clark, Anne
10:00am
Werner, Wolfgang
Non Fasting Lab (NFL)
Print
11:00am
Smith, Harry
HBA1c Test
Print
11:30am
Hollander, Sally
Annual Phy.
Print
1

Measure Outcomes

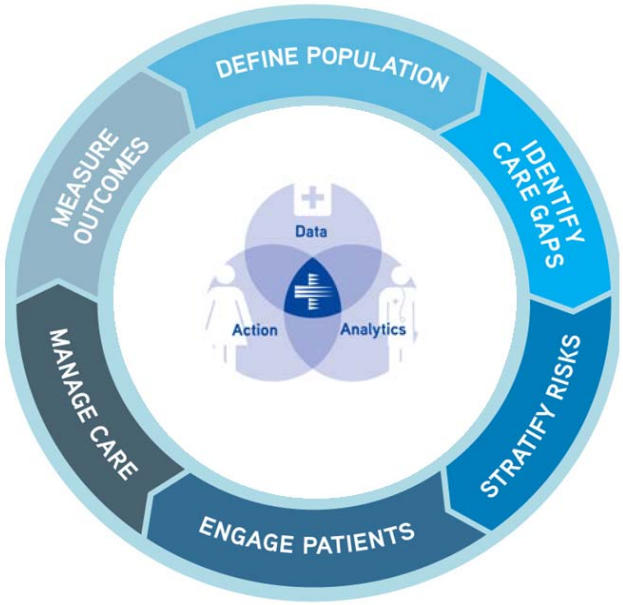


Diabetes	Benchmark	QTR 1 (2011)		QTR 4 (2010)		QTR 3 (2010)		QTR 2 (2010)		QTR 1 (2010)		Trend
Identified Population		30,501		30,501		30,501		30,501		30,501		
Measures	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	
Annual HbA1c testing	85.3	**20,644**	**75.1**	21,023	72.9	20,315	73.6	21,155	75.5	22,101	75.6	↑

Compare Outcomes

Automation and Quality Data Are Fundamental to Medical Home

Total Population Management



- Supports Practice Transformation
- Helps Achieve PCMH, MU and ACO Readiness
- Improves Quality Outcomes
- Increases Revenue for Appropriate Services

CONTACTS

Richard Hodach, MD
Chief Medical Officer
Richard.hodach@phytel.com

Karen Handmaker, MPP
Director, Population Health Management Services
karen.handmaker@phytel.com

PHYTEL
Engaging Patients. Better Outcomes.