Succeed with Population Health Management in a Fee-for-Service Environment and Improve Clinical Quality Measures While Transitioning to Value-Based Care

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Presentation Learning Objectives:

Upon completion of this activity, participants should be able to:

• Discuss the business case for a population health management strategy and the systems necessary to support that strategy.
• Explain why an electronic health record is necessary but may not be sufficient for successful population health management.
• Assess an organization’s capabilities for successful population health management.
The Polyclinic, Seattle WA

- Independent MD-owned Multi-Specialty Group Practice (1917)
- Urban, 8 sites
- 235 providers, 185 MDs, 50 ACPs, 30+ specialties, ancillaries
- 535,000 visits (2014)
- 238,000 patients
- 25% Medicare, MA, MSSP
- Commercial TCC 40,000 lives
Pursuing Perfection

- **Our Patients:**
  Every patient is completely satisfied with every interaction

- **Quality & Safety:**
  All patients receive complete, appropriate care with no preventable adverse outcomes

- **Value:**
  No waste

- **Financial Stewardship:**
  Able to finance our mission

- **Our People:**
  100% of our people are trained, engaged, empowered and performing
• Care delivery must change
• But payment supports the status quo
• Logically one would use payment reform to drive care delivery change
• Yet provider organizations find themselves changing care delivery without the necessary support of payment reform
Anticipating the Tipping Point
Risks of Waiting

• Tools and systems to assist day to day care team operations and care management may be suboptimal and require extra resources and time.
• Quality of care may not improve.
• Missed opportunity to increase patient volumes by closing care gaps.
• May hinder our opportunity to participate in a narrow networks.
• May not realize anticipated shared savings if we are unable to identify cost savings opportunities and care gaps in a timely fashion.
• Extra time and resources will be needed to track and report quality metrics.
• May not be able to provide reliable and timely feedback to our providers and patients.
What would real success look like?

• Better Quality
• Better Patient Experience
• Lower Cost of Care
• Financial Stability
• Workforce Satisfaction
What are we trying to do?

• Identify and track populations
• Identify and close care gaps
• Risk stratify the populations
• Measure cost and quality outcomes
• Support and improve care management (PDSA)
• Engage patients
• Engage caregivers
• Integrate data from many systems (BI/CI)
• Use data to improve
Recognize **The Challenges** In Effecting Change In A Traditional Health Organization

- Organization in Silos – Quality, Primary Care, Care Mgmt., Administration

- Best intention in terms of furthering organizational objectives, however often hampered by:
  - Lack of communication across departments
  - Data segregation
  - Goals not aligned and not prioritized
• Some volume is actually value
• Create your own “payment reform” to drive your delivery system change
Scope

**Population Health and Disease Management**
- Population Risk Stratification
- Patient Centric Registry
- Attribution
- Identify Care Gaps
- Identify High Risk/High Cost
- Preventative Care Measures
- Support Evidence Based Guidelines
- Compliance with Preventative Guidelines and Medications
- Predictive Modeling
- Cost Containment
- Interventions
- Education
- Outbound Reminder Calls
- Pre-visit Planning
- Support Sending Outbound Material i.e. Education, logs
- Linking Episodes of Care – Total Cost of Care

**Utilization Management**
- Medication Reconciliation
- Goals – Short Term and Long Term
- Source of Admission
- Type of Admission
- Date of Service
- Concurrent Review
- Decertification Process
- Grouper or DRG Data
- ALOS
- Discharge Status
- Referral Source
- Basic Assessment
- Interventions
- Cost Analysis for Containment
- Case Status
- Lab Value Trends
Utilization Management
• Referral/Pre-Authorization Management
• Patient Demographics
• Procedure Codes
• Diagnosis Codes

Care Team Delivery
• Automation of workflows related to care delivery, care management and transition of care
• Care team and practice team management of patients at different levels of care
• Reframe Focus of Care Delivery
• Identify best way to manage patients
• Care Management Support
• Manage Total Cost of Care
• Population Risk Stratification
• Narrow Network

Decision Support and Analytics, Reporting
• Support both Aggregate, Specialty and Individual Physician Reporting
• Support Standard Industry Reporting
• Internal Decision Support
• Improved Data Analysis
• CMS
• Dashboards

Quality Management
• Report Cards
• Clinic Initiatives
• Measure Outcomes
• HEDIS
• Star Quality
• Meaningful Use
Comments

Does any of this ring true in your organization?
Going back to ground level . . . .

2009 – 2011, so much progress, but several key missing pieces.

Specific Examples:

- Patient Engagement in Diabetes
- ACO population and mammography
- Drilling Down on Hypertension
- An example of where technology was too far ahead
It seems like we had a lot of what we needed to move forward:

EMR installation complete 2011
EMR shared with hospital system
   (tons of data/data format/data governance/EMR governance)
Scheduling/Registration/Billing different system (but it is interfaced)
Data warehouse and a solid IT department
Claims data (scattered/time lag) from payers
Patient portal at end of 2011 (reminders for some preventative care)
Chronic disease management system for diabetes (not interfaced)

2012
• Move diabetes registry into Epic
• Create smart data elements for clinical workflow
• Add a dash of Clinical Decision Support
• Use EMR physician dashboard tool (RWB)
Verisk & Phytel Combined Value

1. Aggregate data set
2. Apply quality and risk measures
3. Stratify high risk and impactful opportunities

Master Patient Index

4. Prioritize highest interventions for each patient
5. Route actions through population engagement
6. Direct to the care team for integrated care plan

Clinical, Financial and Risk Analytics to Drive Cost-Effective Population Health Management

Care Coordination & Population Engagement
## Outreach Patients by Protocol

<table>
<thead>
<tr>
<th>Protocol</th>
<th>Unique Patients Contacted</th>
<th>Adherence Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellness – Bi-Annual Female</td>
<td>14,975</td>
<td>59.2%</td>
</tr>
<tr>
<td>Wellness – Tri-Annual Male</td>
<td>6,138</td>
<td>36.2%</td>
</tr>
<tr>
<td>Wellness – Bi-Annual Male</td>
<td>5,661</td>
<td>72.0%</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>3,406</td>
<td>10.9%</td>
</tr>
<tr>
<td>Well Child</td>
<td>1,621</td>
<td>37.3%</td>
</tr>
<tr>
<td>Thyroid</td>
<td>1,782</td>
<td>59.8%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1,337</td>
<td>69.6%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>3,426</td>
<td>31.4%</td>
</tr>
</tbody>
</table>
Diabetes Outreach Events

Diabetes (Enhanced)
# 2014 Patient Contacts

## Outreach Summary Description

<table>
<thead>
<tr>
<th>Description</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Unique Patients Attempted to Contact</td>
<td>40,351</td>
</tr>
<tr>
<td>Successfully Contacted Patients</td>
<td>37,574</td>
</tr>
<tr>
<td>Successfully Contacted Patients Contact Ratio</td>
<td>93.1%</td>
</tr>
<tr>
<td>Patients Responding With Adherence Event</td>
<td>19,919</td>
</tr>
<tr>
<td>Successful Patient Adherence Event Response Rate</td>
<td>53.0%</td>
</tr>
</tbody>
</table>

## Remind Summary Description

<table>
<thead>
<tr>
<th>Description</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Appointments Attempted To Remind</td>
<td>428,393</td>
</tr>
<tr>
<td>Successfully Reminded Appointments</td>
<td>401,232</td>
</tr>
</tbody>
</table>
ACO Quality Challenges

• Best source of data for each measure in an open delivery system
• Lack of smart data elements for several measures, requiring manual chart review
• TPC is an open system, so some care may happen anywhere in Puget Sound area
Closing care gaps using both new systems

Example mammography in Medicare ACO population

- For all patients attributed by CMS
- Find patients with gap in care using claims
- Scrub list against diagnostic imaging department list of excluded patients
- Use population health system to send communication to patients in need of care
Drilling down further to target specific populations
You will never stub your toe standing still. The faster you go, the more chance there is of stubbing your toe, but the more chance you have of getting somewhere.

(Charles Kettering)
Lessons Learned

• Go slow to go fast
• You can’t have too many stakeholders involved
• Select strategies not systems
• Quick and directionally correct gets you further than analysis paralysis
Questions & Comments

Are there any questions that you would like to ask of us?

Do you have any comments or feedback to share?