

Population Health Management Applying Data Analytics & Tools to Implementation Efforts

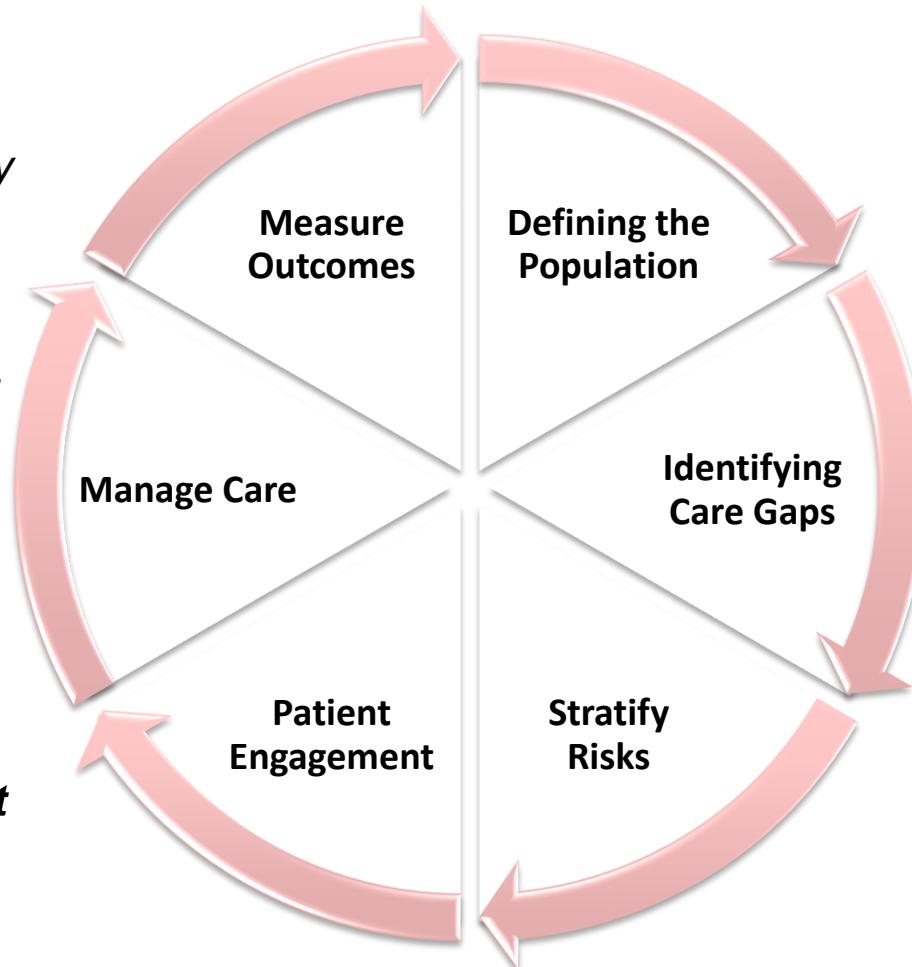
To improve the patient experience of care (quality and patient satisfaction), improve the health of the populations we serve and reduce the per capita cost of providing healthcare services, thus achieving the Triple Aim.



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- We define *Population Health Management (PHM)* as the aggregation of patient data across multiple health information technology resources, the analysis of that data in a single, actionable patient record, and the actions through which care providers can improve both clinical and financial outcomes. It is the technical field of endeavor which utilizes a variety of individual, organization and cultural interventions to help improve patient self-care, morbidity patterns and the health care use behavior of defined populations.
- **Goal of today's presentation will highlight each element of our PHM strategy and share tools in place to operationalize our work.**





Person



EHR



Device



HIE



Payer



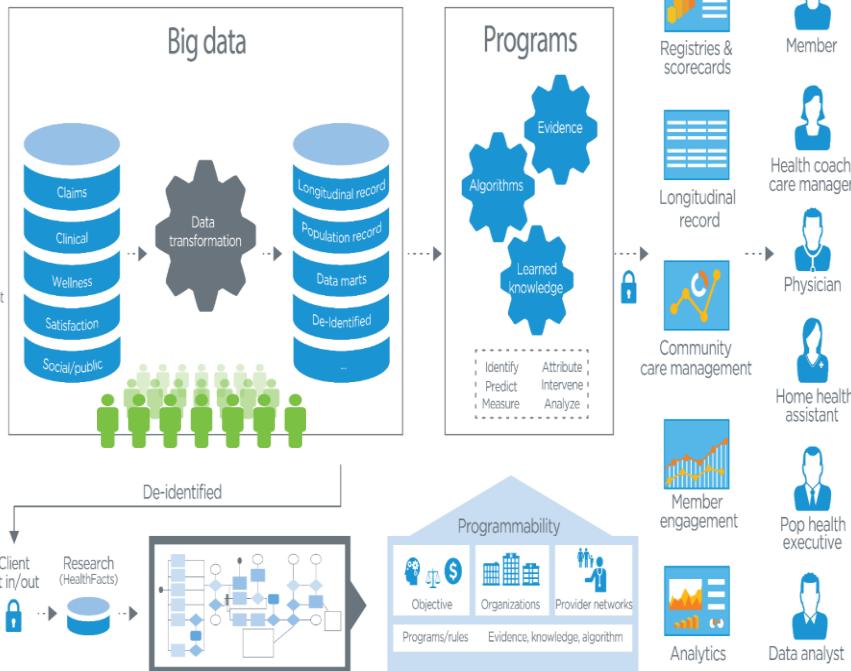
Pharmacy



Post-acute

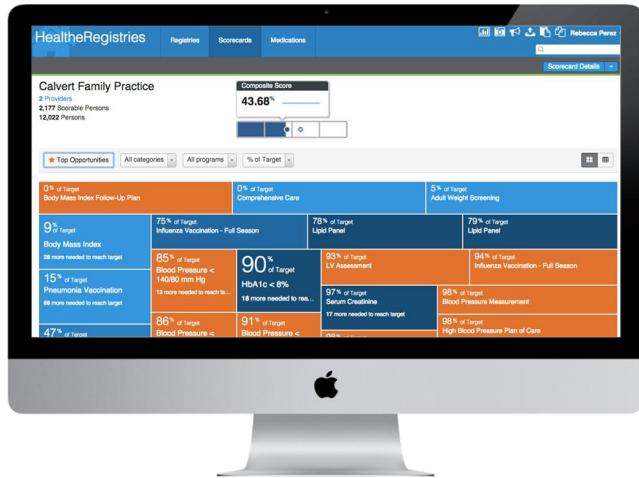


Open data



The SCC has over 50 practice sites engaged in *Technical-onboarding*, a term used to describe a set of tasks to complete data integration into our PHM platform

- We've operationalized a system to integrate data to define our populations
- The programmability of the system allows the SCC to leverage data to create insightful "programs" to best manage a population or condition using real time actionable data.
- Once the data has been processed and intelligence applied, it is presented to end-users in the form of solutions specific to their roles, such as registries, scorecards, care management, analytics, patient engagement, and more.



The SCC has designed a set of Registries and Measures are deployed. Will be offering this tool to all contracted partners and organizations in the “SBUH HUB” permissioning will begin in Fall 2016.

- HealtheRegistries is a comprehensive disease and wellness registry solution, which leverages clinical and financial data across the continuum of care to qualify, attribute, measure and monitor members.
 - Automatically identifies a population for registries and appropriate measures
 - Provides visibility to the quality measures, identify care gaps for the provider's population and performance
 - Risk stratification to prioritize interventions
 - Advanced patient outreach capabilities
 - Provides dashboards with drill-down capabilities

Practice-level registry functionality to address gaps in care and management of chronic conditions!

Each registry has a set of measures:

REGISTRY	MEASURE
Hypertension	Blood Pressure Measurement High Blood Pressure Plan of Care Lipid Panel Influenza Vaccination - Full Season Tobacco Use Screening and Cessation Blood Pressure Control
Pediatric Asthma	Asthma Action Plan Medication Management Influenza Vaccination - Full Season Hospital Visit/Admission
Asthma	Action Plan Complete Medication Management Influenza Vaccination - Full Season Pneumonia Vaccination Tobacco Use Screening and Cessation
Depression	Alcohol Use Screening Illicit Drug Use Screening Medication During Acute Phase Medication During Continuous Phase

Chronic Disease Registries

7 Complete

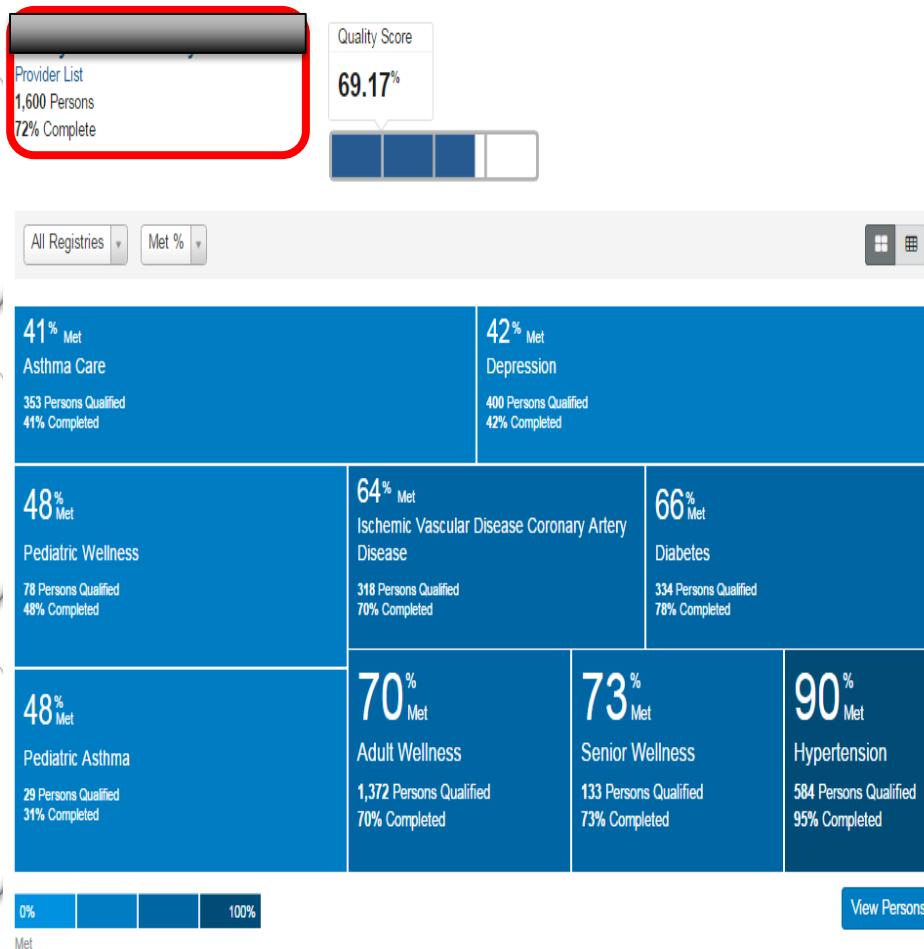
- Hypertension
- IVD/CAD
- Diabetes
- Depression
- Schizophrenia
- Asthma
- Pediatric Asthma

Wellness Registries

3 Complete

- Pediatric Wellness
- Adult Wellness
- Senior Wellness

View overall practice performance



Aligns with DOH reporting requirements

Identify registries that need most improvement

Users will be able to view the overall performance of meeting registry measures by physician **practice level**.

Registries and measures align with DOH reporting requirements, allowing users to identify registries that need the most improvement.

These registries and measures will also be used in planned pay for performance models.

Nov. 2015 - Today



Embedded in 4
PCP Practices



Providing TOC
services to 1
hospital

Current Staffing Model:
10 RN Care Managers
8 Social Workers
**5 Community Health
Associates**

Our Vision:
To build a patient-centered, coordinated, integrated delivery system.

The PPS sponsored CMO will serve those patients currently not aligned to an existing CMO.

6 Month Look Out



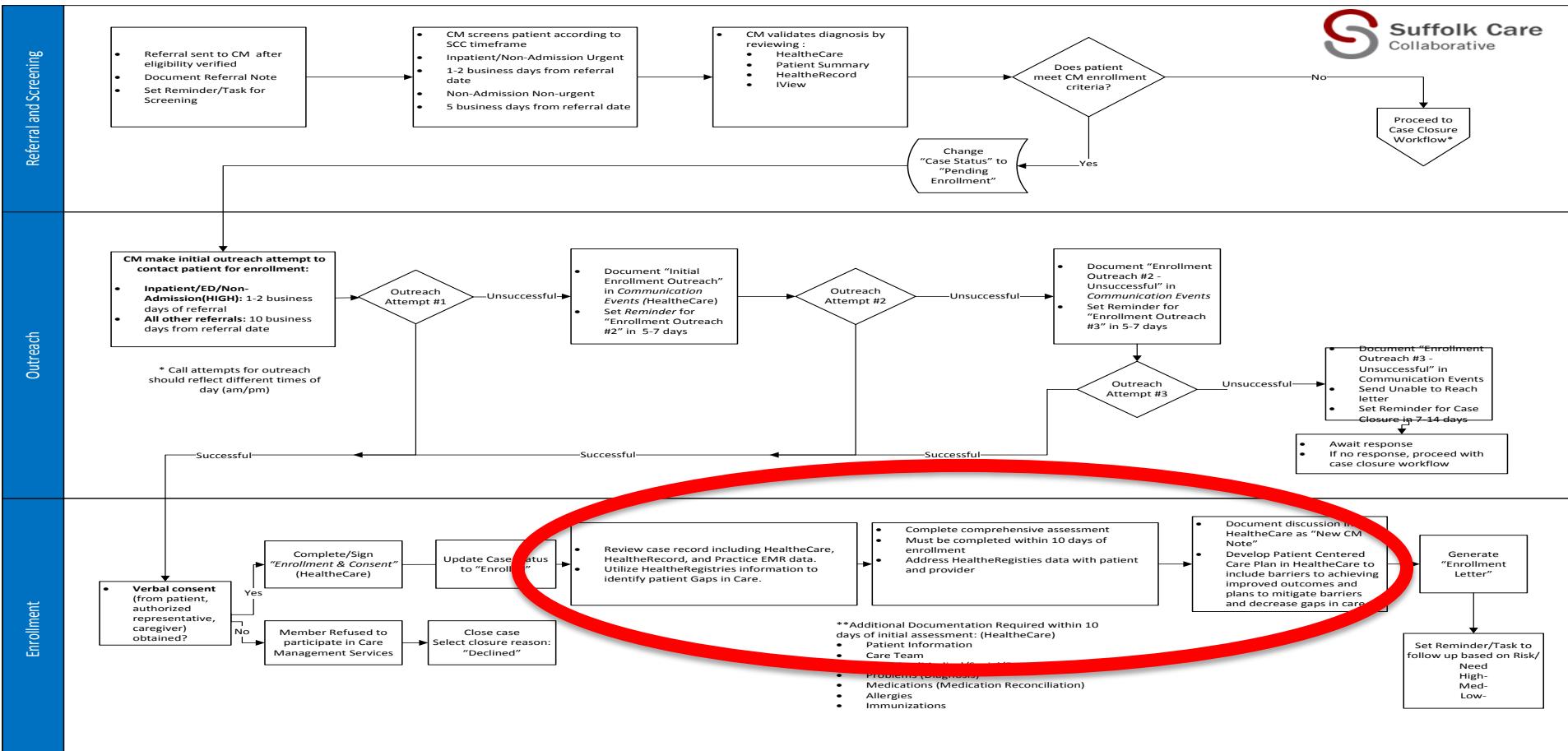
Support 40 PCP
Practice Sites with
Embedded/
Community Resources

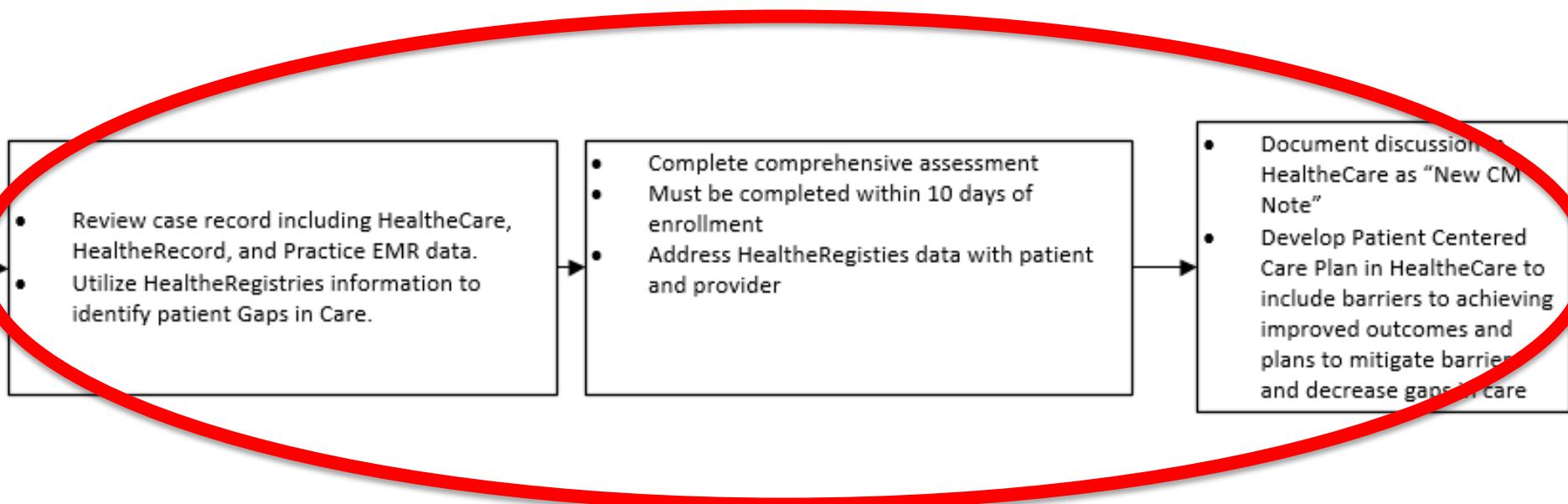


Provide TOC
services to 5
hospitals

Our Goal: Enhance patients' self-care abilities, improve access to community-based resources, break down care silos and reduce avoidable hospital admissions and emergency room visits through Population Health Management.

Enrollment Workflow





Care Management
Tool receives direct
data flow of
HealtheRegistries
data

MRN:10000744 Sex:Female

Events (15)

HealtheCare

100% Enrollment Active Case Close Case

HealtheRegistries (4)

Quality Score: 87% Viewing: Not Achieved Collapse All

Diabetes (9 out of 10 met)

- ✖ LDL < 100 mg/dL

⌚ 06/13/2017	Not Achieved	06/13/2016
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- ⌚ Hypertension (6 out of 6 met)

Measures are hidden by an applied filter.
- Ischemic Vascular Disease Coronary Artery Disease (7 out of 8 met)

 - ✖ LDL < 100 mg/dL

⌚ 06/13/2017	Not Achieved	06/13/2016
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Senior Wellness (7 out of 9 met)

- ⌚ Alcohol Use Screening

⌚ 09/24/2013	Not Achieved	09/24/2012
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- ⌚ Colorectal Cancer Screening

⌚ 09/29/2011	Not Achieved	09/29/2010
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Notes/Reminders (0)

Result Range: All

- ⌚ Sticky Notes (0)
- ⌚ Reminders (0)

No results found

Care Plan

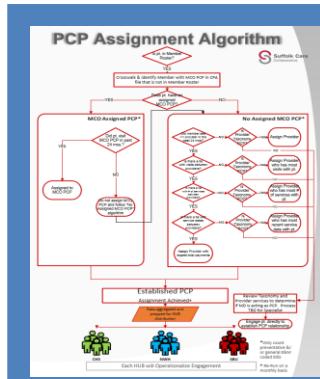
Priority	Goal
1	Blood Pre Managed
2	Resident Managed
3	Diabetes Optimally

Care Team

Performance Measurement Data Strategy

Finalizing Business Rules to Pay Providers for Performance

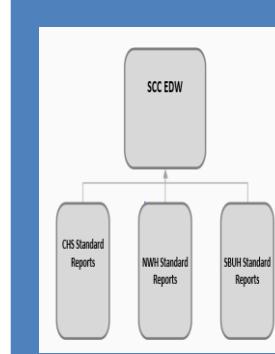
Testing PCP Soft Attribution Algorithm to identify the Established Physician



Provider
Data



DOH MAPP/Salient
Data will be used for
pay for performance



HealthAnalytics™
will be used for
concurrently
measuring
performance

PCP HealtheAnalytics Scorecard



SCC Performance Scorecard

SUFFOLK CARE COLLABORATIVE Domain 2 and 3 Performance Results											
Measures	Data Source	Numerator	MY1 Denominator	MY1 Performance	MY1 Target	Performance Goal	Target MY2	# Pts Needed to Close GAP MY2	High Perf. Target MY2	# Pts Needed to Close GAP MY2	P4P DY
Adherence to Antipsychotic Medications for People with Schizophrenia	Claims	639	1007	67.58% (Baseline 68.59)		76.47%	64.76%	13.13			DY2
Adult Access to Preventive or Ambulatory Care - 20 to 44 years	Claims	28880	37129	81.78% (Baseline 80.75)	91.08%	79.11%	492.75				DY3
Adult Access to Preventive or Ambulatory Care - 45 to 64 years	Claims	17516	20585	87.98% (Baseline 87.27)	94.35%	86.02%	191.22				DY3
Adult Access to Preventive or Ambulatory Care - 65 and older	Claims	1433	1637	88.79% (Baseline 88.16)	94.44%	88.23%	11.33				DY3
Antidepressant Medication Management - Effective Acute Phase Treatment	Claims	1081	1983	54.51% 52.06%	60.00%	55.06%	10.84	55.61%		21.75	DY2
Antidepressant Medication Management - Effective Continuation Phase Treatment	Claims	802	1583	40.44% 39.30%	43.48%	40.75%	6.07	41.05%		12.02	DY2

Training Strategy

- Developed Extensive Workforce Training Strategy
- Facilitate Partner Onboarding Program Addressing Performance Requirements
- Developed Learning Center and Clinical Guideline Summaries to Educate Partners
- Created Core Curricula Guidelines for all participating provider practices.



Project goal: Immediate integrate evidenced-based strategies and clinical guidelines for cardiovascular disease prevention and self-management for high-risk patients with a diagnosis of hypertension. The high-risk affected population includes patients with a history of stroke, heart attack, or diabetes, and those with a family history of cardiovascular disease. The goal is to improve the quality of care for these patients by providing them with clinical guidelines and self-management tools to reduce their risk of cardiovascular disease.

Long-Aim: Improve access and management of hypertension and hyperlipidemia in Suffolk County as demonstrated by the number of patients with a diagnosis of hypertension (HTN) and/or a diagnosis of hyperlipidemia (HDL) and without a cardiovascular risk factor (e.g., age 60 to 79, regardless of risk factors and women, age 60 to 79, regardless of risk factors and men) who are currently taking aspirin daily or every other day.

Clinical Metrics:

- Admission of Risks and Benefits of Aspirin Use (CAPPS Survey):** The number of respondents who are men, age 60 to 79, regardless of risk factors and women, age 60 to 79, regardless of risk factors who are currently taking aspirin daily or every other day.
- Aspirin Use (CAPPS Survey):** The number of respondents who are men, age 60 to 79, regardless of risk factors and women, age 60 to 79, regardless of risk factors who are currently taking aspirin daily or every other day.
- Controlling High Blood Pressure -** The number of patients, who are men, age 60 to 79, regardless of risk factors and women, age 60 to 79, regardless of risk factors who are currently taking aspirin daily or every other day.
- Pt Status of HTN (CAPPS Survey):** The number of respondents who are men, age 60 to 79, regardless of risk factors and women, age 60 to 79, regardless of risk factors who are currently taking aspirin daily or every other day.

Interventions:

Cardiovascular disease is a significant issue and the 3rd leading cause of avoidable admissions in Suffolk County. The Miller Index (2012) estimates that 1 in 3 adults in the U.S. will have a heart attack and strokes by 2022. The goal of this project is to improve the quality of care for these patients by providing them with clinical guidelines and self-management tools to reduce their risk of cardiovascular disease.

Aspirin use (CAPPS Survey) - The number of respondents who are men, age 60 to 79, regardless of risk factors and women, age 60 to 79, regardless of risk factors who are currently taking aspirin daily or every other day.

Controlling High Blood Pressure - The number of patients, who are men, age 60 to 79, regardless of risk factors and women, age 60 to 79, regardless of risk factors who are currently taking aspirin daily or every other day.

Pt Status of HTN (CAPPS Survey) - The number of respondents who are men, age 60 to 79, regardless of risk factors and women, age 60 to 79, regardless of risk factors who are currently taking aspirin daily or every other day.

Health Literacy (CAPPS Survey - QHL, 13, 14, 15) - The number of respondents who are men, age 60 to 79, regardless of risk factors and women, age 60 to 79, regardless of risk factors who were asked if they understood the instructions given to them and what to do if the disease/condition got worse or came back.

Learning Center

Welcome to the Partner Training area of the Learning Center. Please click on the links below to access the Partner Training modules. By selecting a training module, you will be directed to new wedge-where you will be able to view and complete the educational module.

Population Health

Performance Reporting and Improvement Learning Module

The module provides an overview of the SCC Performance Reporting and Improvement Program. It focuses on an introduction to the SCC Performance Reporting and Improvement Program and describes the Domain 1: Patient Engagement Reporting Requirements. Participants will gain a better understanding of how to deploy PSCA tools to conduct sets of change and utilize controls that understand data variation.

Performance Reporting and Improvement Learning Module

Performance Reporting and Improvement Learning Module

Health Literacy

PHI - An Introduction to the Model for Improvement

Learning Objectives:

- Describe the Model for Improvement
- Describe how to use the Plan-Do-Study-Act (PDSA) cycle to conduct rapid tests of change
- Explain the three questions that can help drive quality improvement work

Go to Training

PHI - Building Skills in Data Collection and Understanding Variation

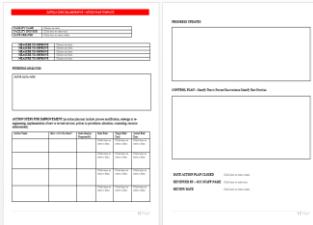
Learning Objectives:

- Describe how to include data variation
- Explain common and special causes of variation
- Identify data collection strategies

Go to Training

“In variance” refers to when a partner falls below the agreed-upon standard for one or more metrics

The PI toolkit includes:
Action planning Template
PDSA Cycle Template
Data Collection Plan



Action Plan
Closed and
Completed

Trigger: Partner is in variance for 2 consecutive quarters



Corrective Action Plan



YES

Is the metric
out of
Variance for 2
consecutive
quarters?

NO

Clinical
Committee
determines
next steps

Action plans may include:

- Process Redesign
- Further Trending
- Implementation of new service or procedure
- Education
- Counseling
- Focused Audit

5-year Performance-based Funds Flow Model for Participating Providers & Organizations is Operational and included in all SCC Participation Agreements

Funds flow distribution example: Primary care providers

Performance Factor	Description
Engagement Payment	Complete SCC On-boarding documentation as outlined in the SCC Contracting Plan Agreement to ongoing: Good citizenship, Timely and complete quarterly Domain 1 patient engagement reporting , Data sharing, Participation in Population-wide-prevention programs (D4), Updates towards successful completion of the Domain 1 Process Measures & Participation in Project 2ai Integrated Delivery System program & SCC Care Coordination program.
Technical On-boarding	1. Complete Technical On-boarding, i.e. technical data integration and system interoperability between the Partner's source system and the HUB data-warehouse, which will then feed the Suffolk PPS Population Health Platform. 2. EHR meets connectivity to RHIO's HIE and SHIN-NY requirements
Clinical Improvement Programs	Meet requirements of Primary & Behavioral Health Integrated Care Program Meet requirements of Cardiovascular Health Wellness & Self-Management Program Meet requirements of Diabetes Wellness & Self-Management Program Meet requirements of Promoting Asthma Self-Management Program
PCMH Certification	Receipt of NCQA 2014 Level 3 PCMH Certification
Performance Measurement	Adhere to the Performance Reporting and Improvement Plan establishes a planned, systematic, organization-wide approach to performance reporting, performance measurement, analysis and improvement for the healthcare services provided.