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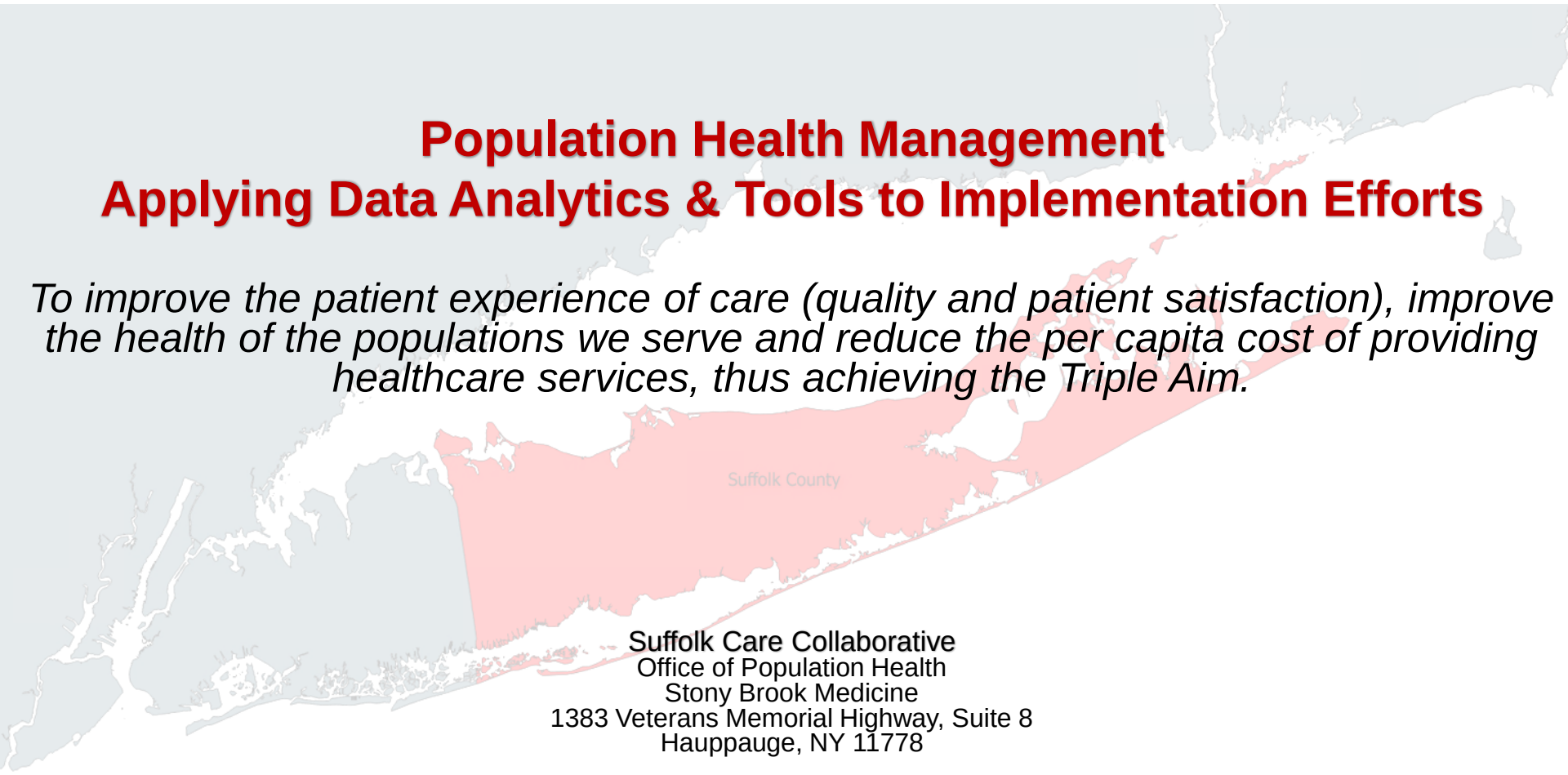
Population Health Management
Applying Data Analytics & Tools to Implementation Efforts

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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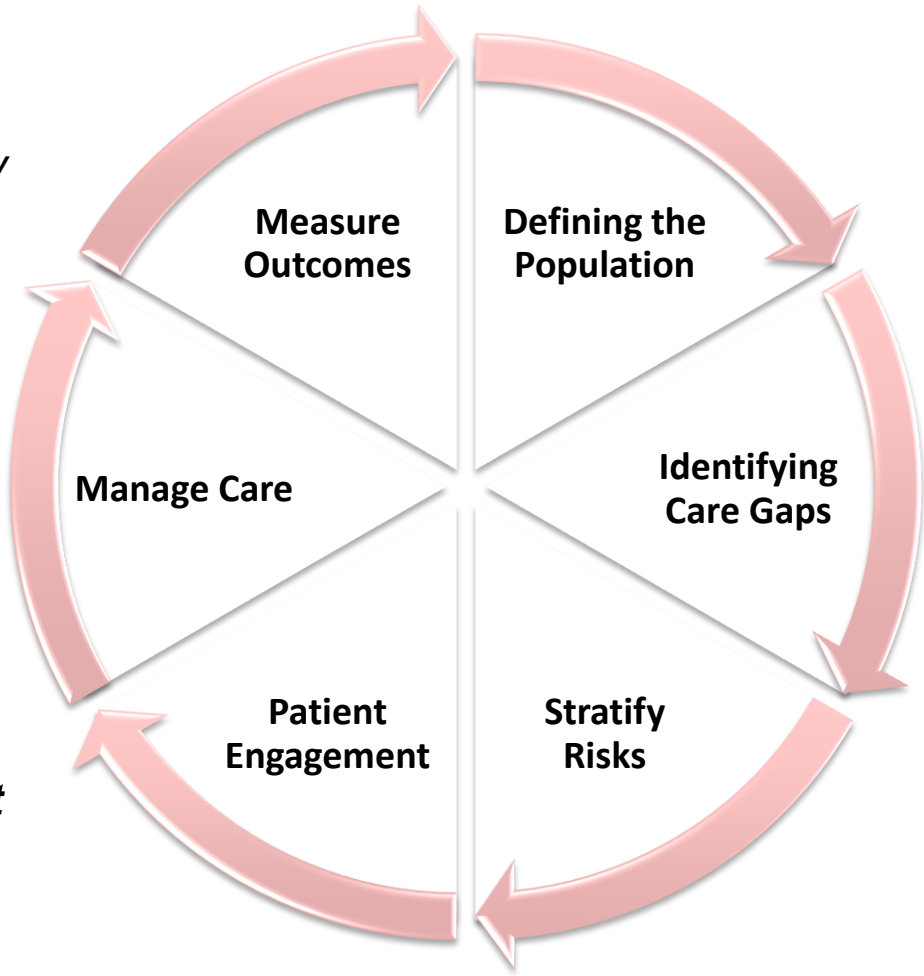
POPULATION HEALTH MANAGEMENT STRATEGY

- *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.***



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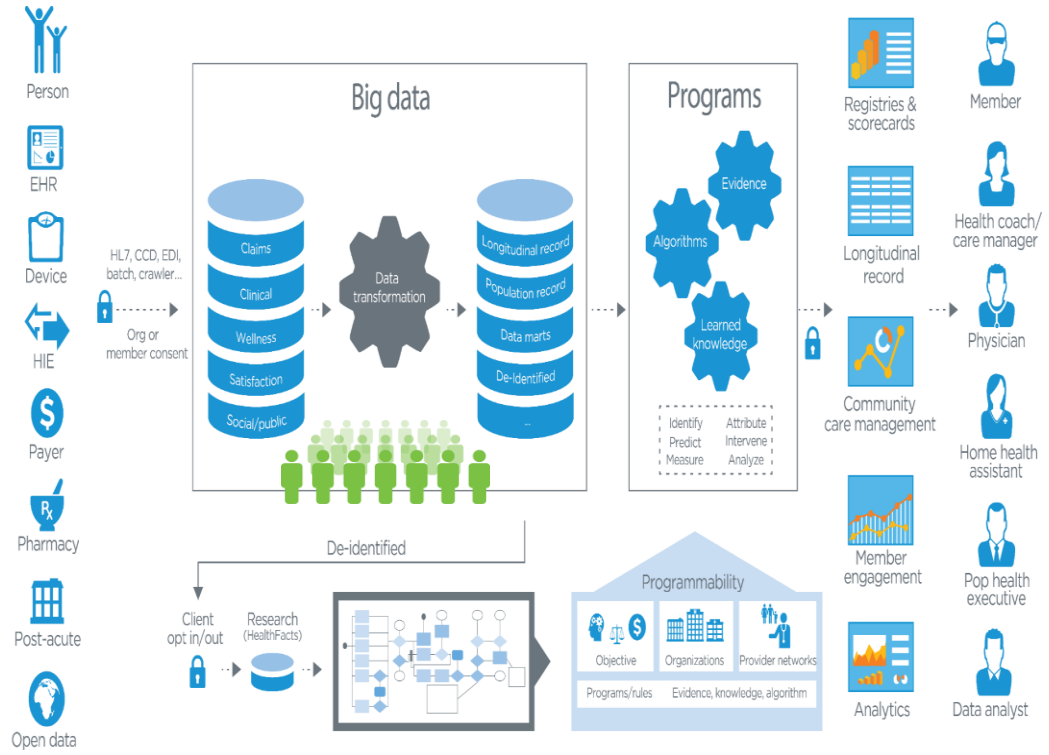
Defining the Population → Identifying Care Gaps → Stratify Risks → Patient Engagement → Manage Care → Measure Outcomes



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 out 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.

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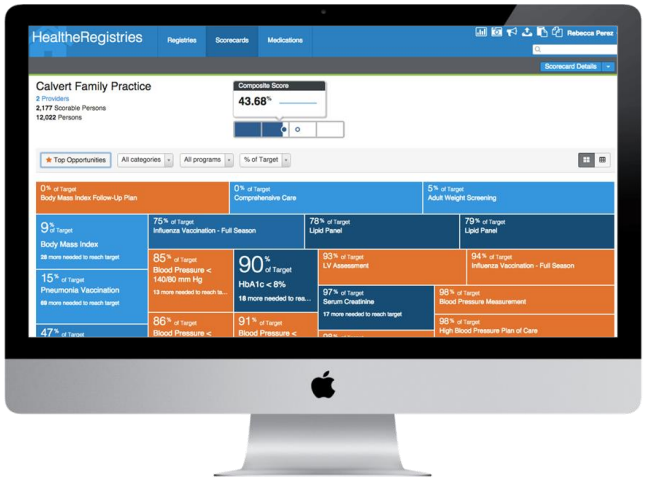
Defining the Population → Identifying Care Gaps → **Stratify Risks** → Patient Engagement → Manage Care → Measure Outcomes



- 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

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.

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

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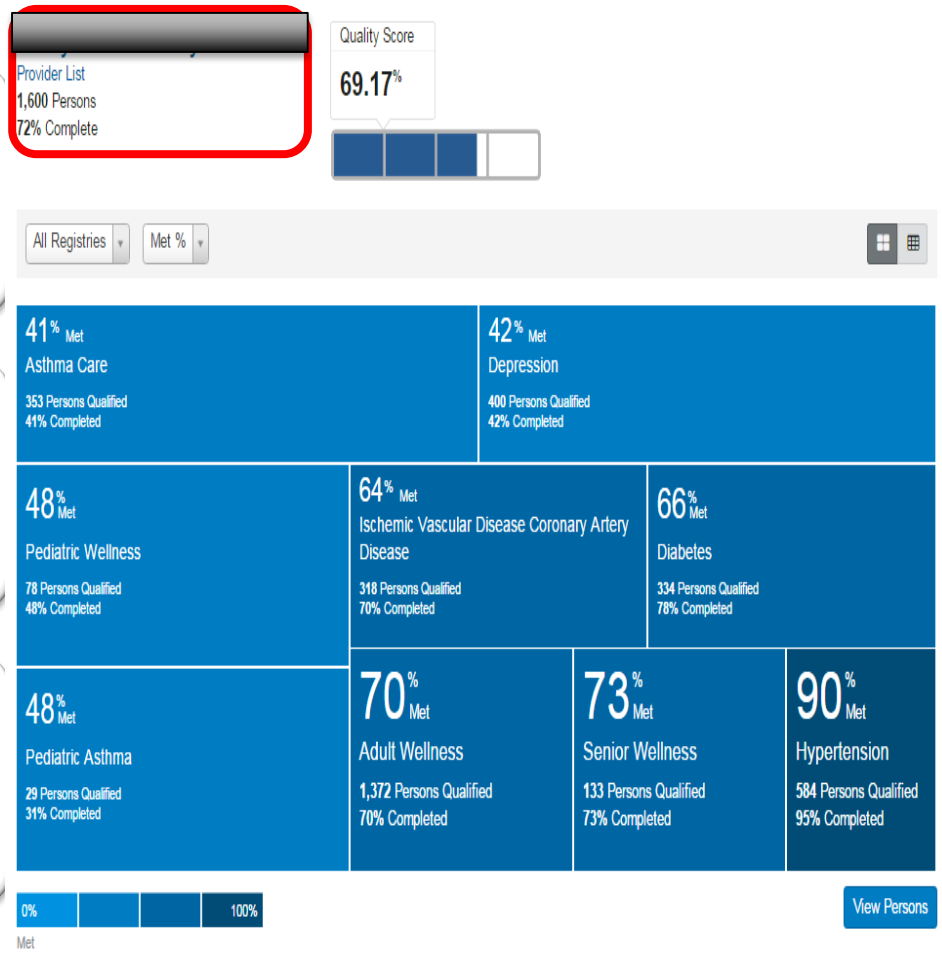
PROVIDER/PRACTICE REGISTRIES OVERVIEW

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.

CERNER POPULATION HEALTH

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SCC CARE MANAGEMENT ORGANIZATION IS OPERATIONAL

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.

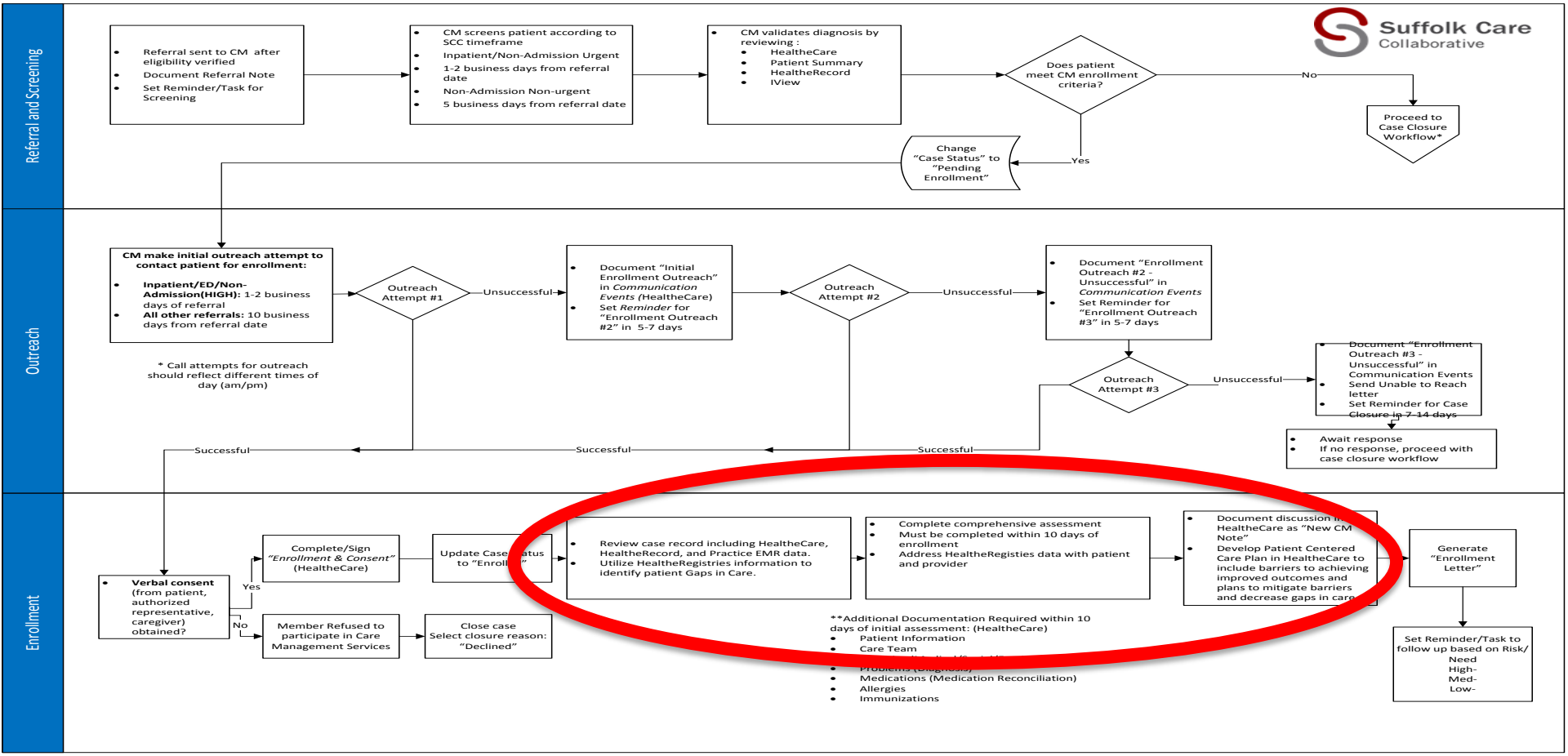
6 Month Look Out

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



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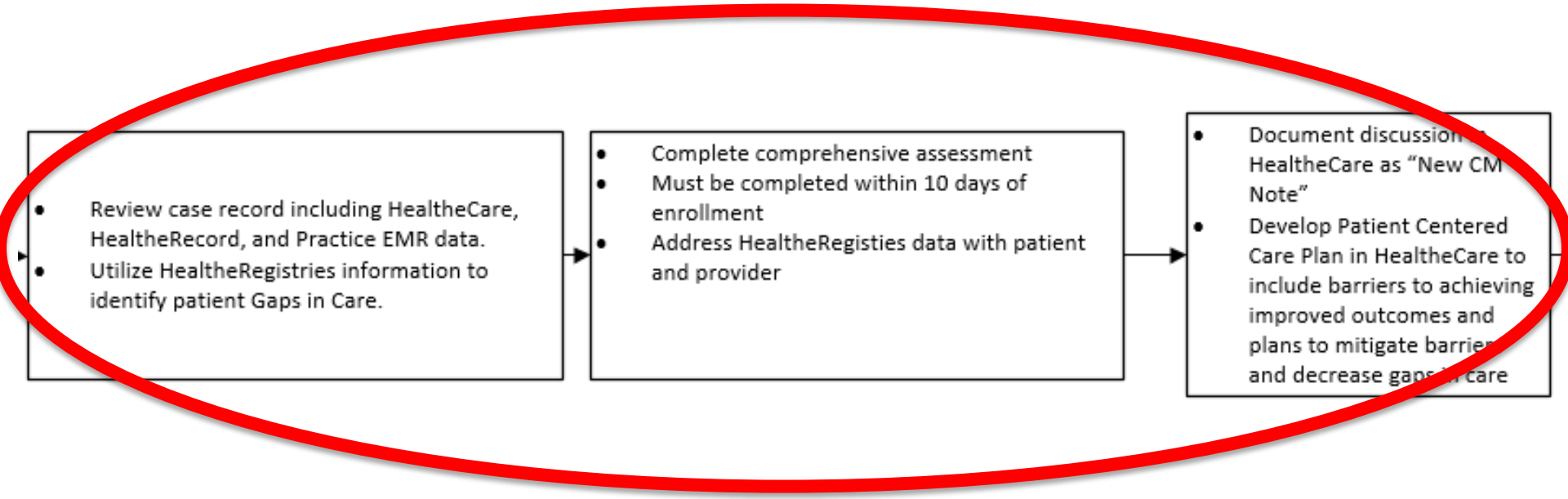
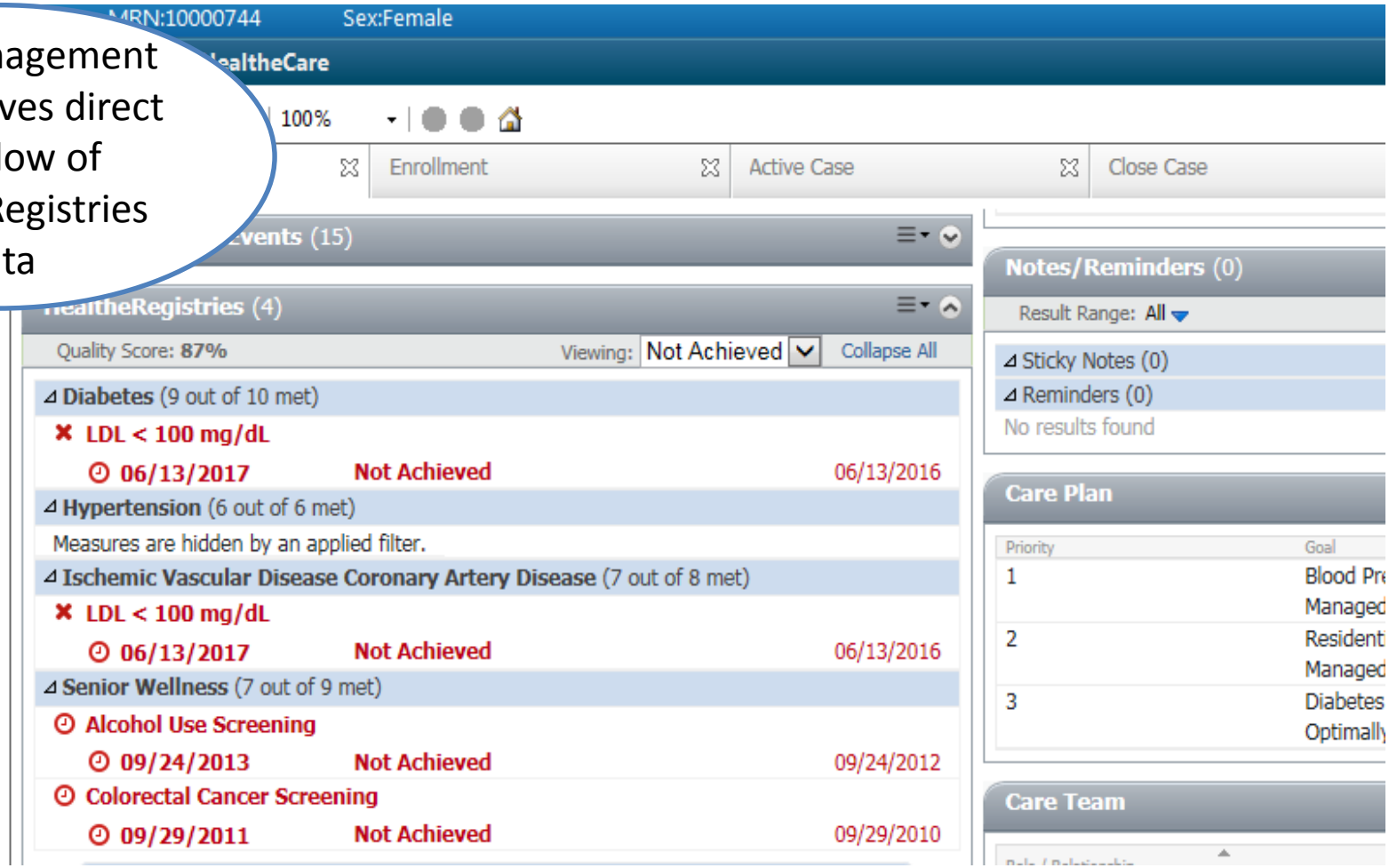
UTILIZING CARE MANAGEMENT TO CLOSE GAPS IN CARE



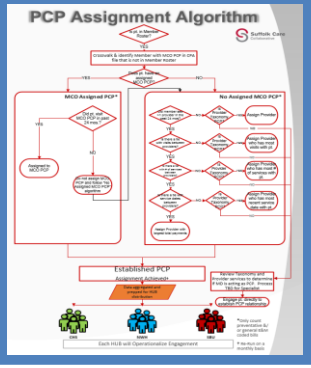
Care Management Tool receives direct data flow of HealtheRegistries data



Performance Measurement Data Strategy

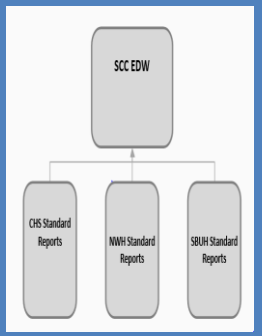
Finalizing Business Rules to Pay Providers for Performance

Testing PCP Soft Attribution Algorithm to identify the Established Physician



Provider Data

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



HealtheAnalyticsTM will be used for concurrently measuring performance

PCP HealtheAnalytics Scorecard

SCC Performance Scorecard

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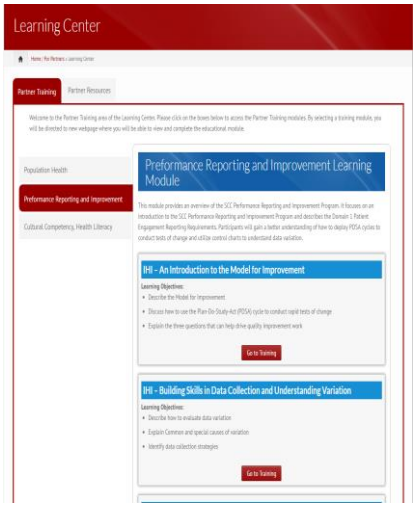
Domain 2 and 3 Performance Results

Measures	Data Source	MY1 Numerator	MY1 Denominator	MY 1 Performance	MY1 Target	Performance Goal	Target MY2	# Ple Needed to Close GAP MY2	High Perf. Target MY2	# Ple Needed to Close GAP MY2	P4P DY
Adherence to Antipsychotic Medications for People with Schizophrenia	Claims	639	1007	63.46%	67.58 % (Baseline 66.59)	76.47%	64.76%	13.13			DY2
Adult Access to Preventive or Ambulatory Care - 20 to 44 years	Claims	28880	37129	77.78%	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	85.09%	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	87.54%	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	1983	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.



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OPERATIONALIZING AN ACTION PLANNING PROCESS

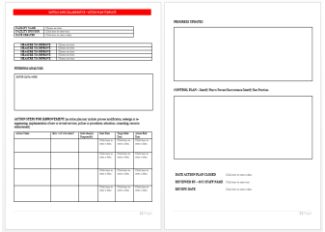
"In variance" refers to when a partner falls below the agreed-upon standard for one or more metrics

The PI toolkit includes:

Action planning Template

PDSA Cycle Template

Data Collection Plan



Trigger: Partner is in variance for 2 consecutive quarters

Corrective Action Plan

Action plans may include:

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

Is the metric out of Variance for 2 consecutive quarters?

YES

Action Plan Closed and Completed

NO

Clinical Committee determines next steps

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MOVE FROM PAY FOR REPORTING TO PAY FOR PERFORMANCE

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.