Population Health Management in the Medical Neighborhood

Executive Roundtable

Authors:
Michelle Shaljian, MPA
Marci Nielsen, PhD, MPH

November 12, 2013
1:30 PM - 2:30 PM EST
Managing Populations, Maximizing Technology

Population Health Management in the Medical Neighborhood

ACKNOWLEDGMENTS

The PCPCC gratefully acknowledges the following individuals for their thoughtful review of this publication:

Michael Barr, MD, MBA, FACP
American College of Physicians

Ted Epperly, MD, FAAFP
Family Medicine Residency of Idaho

Shari Erickson, MPH
American College of Physicians

Charles Gross, PhD
Amerigroup

Richard Hodach, MD, MPH, PhD
Phyetel

Jill Rubin Hummel, JD
Wellpoint

Anne X. Kempo
Kaiser Permanente,
Permanent Federation

Janhavi Kirtane Fritz, MBA
Office of the National Coordinator,
Beacon Community Program

Thomas A LaVeist, PhD
Johns Hopkins Bloomberg School of
Public Health

Guy Mansueto, MM
Phyetel

David K. Nace, MD
McKesson Corporation

David B. Nash, MD, MBA
Thomas Jefferson University
Jefferson School of Population Health

L. Gregory Pawlson, MD, MPH
Stevens & Lee

Jill Rosenthal, MPH
National Academy for State Health
Policy

Jaan Sidorov, MD, MPH
Sidorov Health Solutions

PCPCC also thanks James Crawford, Joslyn Levy, John Steidl and members of the eHealth group for their contributions to this report.

http://www.pcpcc.org/resource/managing-populations-maximizing-technology
Today’s Panelists

Jaan Sidorov, MD, MHSA, FACP
Principal
Sidorov Health Solutions

Robert Fortini, PNP
Chief Clinical Officer
Bon Secours Medical Group

Richard Hodach, MD MPH PhD
Chief Medical Officer
Phytel
The growth rate of health care spending far exceeds how fast our national economy and average wages are growing.

Percentage of cumulative, real, per capita growth in national health expenditures, gross domestic product, and real wages.

Reducing Waste in Healthcare

```
<table>
<thead>
<tr>
<th>Category</th>
<th>Cost to Medicare and Medicaid</th>
<th>Total cost to US health care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>Midpoint</td>
</tr>
<tr>
<td>Failures of care delivery</td>
<td>$26</td>
<td>$36</td>
</tr>
<tr>
<td>Failures of care coordination</td>
<td>21</td>
<td>30</td>
</tr>
<tr>
<td>Overtreatment</td>
<td>67</td>
<td>77</td>
</tr>
<tr>
<td>Administrative complexity</td>
<td>16</td>
<td>36</td>
</tr>
<tr>
<td>Pricing failures</td>
<td>36</td>
<td>56</td>
</tr>
<tr>
<td><strong>Subtotal (excluding fraud and abuse)</strong></td>
<td>166</td>
<td>235</td>
</tr>
<tr>
<td>Percentage of total health care spending</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td>Fraud and abuse</td>
<td>30</td>
<td>64</td>
</tr>
<tr>
<td><strong>Total (including fraud and abuse)</strong></td>
<td>197</td>
<td>300</td>
</tr>
<tr>
<td>Percentage of total health care spending</td>
<td>21%</td>
<td>34%</td>
</tr>
</tbody>
</table>


**Notes:** Dollars in billions. Totals may not match the sum of components due to rounding. *Includes state portion of Medicaid. Total US health care spending estimated at $2.687 trillion.

**“Health Policy Brief: Reducing Waste in Health Care,” Health Affairs, December 13, 2012.**
http://www.healthaffairs.org/healthpolicybriefs/
Managing Populations, Maximizing Technology

Ten Recommended Health IT Tools to Achieve PHM:

- Electronic health records
- Patient Registries
- Health Information Exchange
- Risk Stratification
- Automated Outreach
- Referral Tracking
- Patient Portals
- Telehealth / Telemedicine
- Remote Patient Monitoring
- Advanced Population Analytics
Six Topics for Population Health

1. Cultural PHM
2. Scale / Automation
3. Transitions of Care
4. Patient Engagement
5. Remote Monitoring
6. Claims Analytics
Today’s Format

• 6 topics areas
  – Part 1 – Cultural PHM
  – Part 2 – Scale / Automation
  – Part 3 – Transitions of Care
  – Part 4 – Patient Engagement
  – Part 5 – Remote Monitoring
  – Part 6 – Claims Analytics

• 1-2 minute topic set up
• 10 minute dialog and discussion
Cultural PHM

• What types of business process and cultural changes enable a successful transition towards PHM in the medical neighborhood?
• How can organizations influence the academic curriculum and encourage the cultural shift to PHM?
• What key roles are increasingly required to reside in the PCMH-N to support PHM?
Scale / Automation

• Which of the HIT elements described in the paper can have a dramatic difference on the health of the population?

• One aspect of “advanced medical home projects” is leveraging automation to trigger messaging to patients with gaps in care. Can you elaborate on how messaging and portals are moving towards a patient-centric care?

• What has to exist in portals to have patients more actively engage in their care?
Transitions of Care

• Without assuming an HIE is in place, what simple IT strategies can be used to better transition care and improve coordination?
• How effective are predictive risk models and stratification at identifying unnecessary readmissions?
• How do you see the models evolving to become more effective (specificity and accuracy)?
• What tools are they leveraging to align with the “care management” efforts in the ambulatory setting?
Patient Engagement

- How do you see new payment models supporting technology for providers to make use of patient supplied health data?
- Healthcare organizations are now using distance monitoring for high risk patients, how is that process implemented with the care delivery model?
- Health Risk Assessments provide valuable information on the patient’s health status. How best can care teams leverage this data?
Remote Monitoring

• How are virtual visits evolving through the use of technology in your organizations?
• What are the patient/provider expectations around monitoring these devices?
• How do you see the payment model supporting technology for remote care?
Claims Analytics

- How can claims data be effectively integrated inside of the current care team workflows?
- How are best can providers reconcile the out-of-network care gaps with the patient’s EMR and clinical record?
- How best can cost be included within the care management function to lower the cost of care while improving quality / outcomes?
QUESTIONS?
Patient-Centered
Primary Care
COLLABORATIVE

Contact Name
Title
Phone
XXXXX@pcpcc.net
www.pcpcc.org