Population Health Management for PACE

Paul Funaro  Brenda Vatland  Kiran Simhadri
Today’s speakers:

- Brenda Vatland, Mediture, VP Business Development
- Paul Funaro, NewCourtland, AVP of Utilization Management
- Kiran Simhadri, Mediture, Chief Technology Officer
Learning Objectives

- Understand Population Health Management
- How can population management principles benefit PACE Programs
- A PACE program’s experience in using components of Population Health Management to manage utilization
Goals of this session:

1. Define Population Health Management
2. Learn how to segment your PACE population
3. Deliver targeted interventions
4. Manage hospital admissions and discharges
5. Engage participants and caregivers
6. Put together a proactive plan to mitigate risk
Population Health definition:

- **Population Health Management** is the aggregation of patient data across multiple health information technology resources, the analysis of that data into a single, actionable patient record, and the actions through which care providers can improve both clinical and financial outcomes. --source: Healthcare IT News website
Population Health definition:

- Improving population health is a key prong of the Triple Aim developed by the Institute for Healthcare Improvement, alongside improving individual quality and patient experience and reducing the per capita cost of care.

  --source: The Institute for Healthcare Improvement
The Triple Aim:

- Improve outcomes while reducing healthcare costs and increasing patient experience
Population Health Management Goal:

- One of the goals of population health management in a PACE environment is to intervene to **improve outcomes** for participants, and **promote a healthier population** while reducing unnecessary Emergency Room visits or hospital admissions to **manage healthcare costs**
Why is PHM relevant?

- Dramatic shift in health care from Fee-for-service to Fee-for-value reimbursement model
Trends in healthcare reimbursement

- Payment models are shifting from fee-for-service to fee-for-value
- Leading provider organizations take on the financial risk of providing health care to a pre-defined population
- Effectively follow their patients and coordinate their experience across the entire continuum of care
Using Business Intelligence:

Population Health Management programs use a business intelligence (BI) tool to aggregate data and provide a comprehensive clinical picture of each patient.

Using that data, providers can track, and hopefully improve, clinical outcomes while lowering costs.
Accountable Care Organization

A best-in-class Population Health Management program brings clinical, financial and operational data together from across the enterprise and provides actionable analytics for providers to improve efficiency and patient care.

PACE Program

We have the opportunity in PACE programs to combine clinical, financial and operations data in a small population to measure results and adjust care plans.
Accountable Care Organization

Delivering on the vision of Population Health Management requires a robust care management and risk stratification infrastructure, a cohesive delivery system, and a well-managed partnership network.

Think Global… ➔ Act Local

PACE Program

The IDT assessments, care plan review cycle, and morning meeting concepts create a robust care management framework.

Every participant in PACE is risk stratified. The population we serve is high risk.

Cohesive delivery system is accomplished with PACE’s authorization process

Partnership Network is managed by your contracts with providers in the community
Step 1: Capturing Data

According to the U.S. Department of Health and Human Services, about 75 percent of the country’s eligible professionals and more than 91 percent of hospitals are on electronic health records certified for Stage 1 meaningful use. With the vast majority of personal health information being recorded in a sharable form, we’re poised to accelerate population health IT. The next major challenge will be sharing data and putting it to beneficial use.
EHR Utilization in PACE

Source: Electronic Health Records in PACE presentation, Teresa Belgin, National PACE Association, October 2014
Focus on the right patients with the appropriate treatments for improving outcomes and managing costs.
Stratify by certain diagnoses that if poorly managed can lead to hospitalization

- **Congestive Heart Failure**

Show me all PACE participants with a diagnoses of Congestive Heart Failure
A successful PHM program will give real-time insights to both clinicians and administrators and allow them to identify and address care gaps within the patient population. A well-developed care management program is the key to better outcomes and cost savings, especially in populations with chronic disease.
Care management is a critical component of Population Health Management. Objectives of care management include:

1. Improving patient self-management
2. Improving medication management
3. Reducing the cost of care – such as admit rates.
Successful Care Management Requires Coordination of Care across multiple care settings
Using data to close care gaps:

Closing care gaps: A fully-integrated BI tool helps close gaps in care by allowing organizations and physicians to have real-time access to track and address patient needs.

Laboratory, billing, electronic health record and prescription data is all incorporated and providers can easily pinpoint unmet needs and gaps in data or service delivery.
How to address gaps in care:

Use data to identify participants who do not have a flu shot

Make it actionable:

• extract information into a list
• assign staff to reach out to participants
• schedule flu shots during center attendance days.

This process drives patient engagement.

ACO’s try to achieve this by triggering email messages to notify a patient that they are due for a flu shot; PACE is much more accessible and interacts with it’s participants much more frequently.
Critical test results that need attention

- Diabetics with elevated A1C levels
- CHF elevated electrolytes
Critical test results that need attention

- Routine medications with CHF: lisinopril

Show me which participants with CHF are prescribed Lisinopril
Identify high utilizers

- Track data on each individual participant’s admissions to Emergency Room and Hospitals
- Aggregate data across PACE population
Patients seen frequently

1. Admission to Emergency Room
2. Hospitalizations
3. Frequent PACE Clinic Visits

Know how to search your EHR to identify your participants with high utilization of services. . . “Stratification”
Admission to ER & Hospitalization

1. Track data on each individual participant’s admissions to Emergency Room and Hospitals

2. Track admission and discharge dates

Show me when Ann was admitted to the hospital, and when she was discharged
Admission to ER & Hospitalization

1. Aggregate data across PACE population:

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Show me all Participants admitted to the hospital for a date range
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<td>Outpatient Facility</td>
<td>ER Facility</td>
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<td>Outpatient Observation</td>
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Admission to ER & Hospitalization

- IDT team: Daily review Hospital Admissions or Discharges

Show me which participants have been admitted to the hospital in the last 3 days
Frequent Specialist Visits

1. Track data in an individual’s chart

Show me what specialists Ann saw, and how frequently
Frequent PACE Clinic Visits

1. Which individuals are your highest utilizers of PACE clinic services?
   - Filter for PCP discipline; view encounter summary

Show me how many times Mary has been seen in the PACE clinic
Identify participants with Out of Network visits

- Be able to identify participants who have received care from out-of-network providers so they can be offered appropriate care within network where it can be more closely coordinated.

Show me Out of Network providers we received claims from
Successful solution requires integration of best in class tools with best organization practices

- A utilization-management tool identifies where patients receive care, how much care they receive, and which areas of the health network are used most.

- This clinical analytics is critical to drive organizational change and enable success under any payment model.

- Benchmarks: utilization in DataPACE 2, PDAC
NewCourtland Senior Services

• **Overview**
  
  *Non-profit organization providing housing, healthcare, and supportive services for low-income seniors in Philadelphia.*
  
  – 500+ employees serving more than 9,000 seniors annually through:
    
    • Affordable Housing – 5 properties with a 6th opening this month
    • LIFE Program – 2 centers (with one opening early 2016) and 2 alternative care sites
    • Senior Centers – 5 branches of the Philadelphia Senior Center
    • Skilled Nursing Care – 5 star nursing home, Germantown Home
    • Services on Site (SOS) – service coordination at 19 locations
Managing Population Health

- Organized System of Care
- Use of Multidisciplinary Care Teams
- Coordination Across Care Settings
- Enhanced Access to Primary Care
- Centralized Resource Planning
- Continuous Care (Internal and External Visits)
- Patient Self-Management Education
- Focus on Health Behavior and Lifestyle Changes
- Use of Health Information Technology for Data Access and Reporting
Utilization Management
Network Reporting

Consolidated Information to Users

Data Warehouse

PACE  Nursing Home  Housing  Senior Centers  Payroll / HR  Financial
Utilization Management

**Utilization Management**
- Prospective
- Manage health care cases efficiently and cost effectively before and during health care administration
- Based on established criteria or guidelines

**Utilization Review**
- Retrospective
- Was health care appropriately applied after it was administered
Utilization Management

Using Data Effectively in PACE

- Identify Data Useful to the Team
- Prevent Data Overload
- Use Data to Tell a Story
- Continue to Assess Whether the Program is Capturing Appropriate Information
Utilization Management

Determine What Process Works Best for Your Program

- Monitor Key Areas
  - Internal Targets and Industry Benchmarks

- Determine Review Process
  - Frequency (Daily / Weekly / Monthly / Quarterly)
  - Format (Dashboard / Summary Reports / Detail Reports / Visuals)
  - Members (IDT, Focus Groups, Executive Team)

- Identify Trends
  - Team Addresses Area of Concern
  - Monitors for Changes
  - Evaluates and Adjusts Plan if Necessary
Utilization Management

**Focus Areas**
- Primary Care / Clinic
- Rx
- Specialists
- Center Attendance
- Home Care
- Transportation
- Staffing
- Living Environment

**Key Areas**
- Opportunity
  - Emergency Department
  - Hospitalization
  - Skilled Nursing Facility
  - Home Care
NewCourtland Senior Services
Utilization Management and Population Health

- Additional Areas To Review When Addressing Utilization
  - Zip Code
  - Living Environment
    - Community
    - Independent Living
    - Nursing Home Transition Housing
    - Nursing Home
  - Caregiver Support
  - Demographics
  - Length in Program
Facilitate team meetings to address concerns and proactively plan for anticipated care needs

- Who leads this at your PACE program?
- How frequently do you meet?
- How do you evaluate the meetings?
Utilization Management

Primary Care

- Home Care
- Nursing Home
- ER / Hospital

Interdisciplinary Team

Participants

Specialists

- PACE Center
  - Nursing
  - Social Service
  - Therapy
  - Nutrition
  - Recreation
  - Personal Care
  - Transportation

- Pharmacy
- Lab / Diagnostics / DME
Implementing Population Management In PACE Environment

Kiran Simhadri
Key Steps

- Define the population
- Measuring Outcomes
- Data Collection, Storage and Management
- Team-Based Intervention
- Population Monitoring and Stratification
- Patient Engagement
Defining the population

- Describe the characteristics of the population
  - Age, Disease, Social Conditions etc...

- Define Measure Goals
  - What are you going to measure
  - Frequency
  - Targets

- PACE Population
  - Nursing home level
  - Chronic conditions
  - Medicare/Medicaid

- PACE goals
  - Maintain functional independence?
Data Collection, Storage and Management

- Gather Patient-Centered data from multiple sources
- Integration with Health Information Exchanges
- Reconcile and manage multiple identifiers
- Improve data accuracy by automation
- Adopt structured data against unstructured data
- Avoid redundancies between MU, PQRI etc...
- PACE model of care naturally promotes gathering of Patient-Centered data
- Integration with HIE is useful but not critical
- Multiple identifier challenge can be addressed by consolidating systems
- Improve data accuracy by automation
### Data Collection, Storage and Management

**Figure 4. The failure rate for information exchange is unacceptably high**

<table>
<thead>
<tr>
<th>Interface</th>
<th>Measure</th>
<th>Failure Rate</th>
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<tbody>
<tr>
<td>Physicians ↔ Laboratories</td>
<td>Lab results available during physician visit</td>
<td>17%</td>
</tr>
<tr>
<td>PCPs ↔ Emergency Departments</td>
<td>Medical record and laboratory results available upon ED visit</td>
<td>33%</td>
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<tr>
<td></td>
<td>PCP informed of care delivered during ED visit</td>
<td>30%</td>
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<tr>
<td>PCPs ↔ Specialists</td>
<td>Specialist consultation report sent to PCP within four weeks of specialist visit</td>
<td>45%</td>
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<tr>
<td></td>
<td>Patient information sent to specialist upon referral</td>
<td>49%</td>
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<tr>
<td>PCPs ↔ Hospital Physicians</td>
<td>PCP provided with discharge plan and medications in recent hospital stay</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>PCPs provided with discharge plan within one week of hospital discharge</td>
<td>80%</td>
</tr>
</tbody>
</table>

PCP – Primary Care Physician; NEJM – New England Journal of Medicine
Source: T. Bodenheimer, Coordinating Care – A Perilous Journey through the Health Care System, NEJM.
Population Monitoring and Stratification

- Stratification by risk, conditions, or other criteria important to the practice
- Automated algorithms and report filtering tools allow clinical teams to prioritize, distribute and monitor intervention activity and results continuously
- Target patients in greatest need of services by narrowing subpopulations
- Make data on patients actionable by generating alerts to patients to seek appointments with their providers
Stratification by risk, conditions, or other criteria important to the practice

Monitoring based on
- Wellness Program
- Disease Management

Stratification by Goals of Care:
- Longevity
- Functional
- Comfort Care

Target patients in greatest need of services by narrowing subpopulations

Proactive management of immunizations and preventive care services
Patient Engagement

- Health risk appraisal
- Biometric screening (e.g., blood pressure, cholesterol)
- Smoking cessation
- Weight loss
- Diet and nutrition
- Stress reduction
- Exercise and fitness programs
- Ergonomic programs
- Safety (both at the workplace and home)
- Sleep hygiene
- Health advocacy
- Disease screening
- Immunization

- IDT assessment
- Patient and Caregiver involvement in care planning process
- Participant adherence to Care Plan
Team Based Interactions

- Primary Care is at the heart of PHM
- Challenges for Primary Care Practice
  - Shortage of PCPs
  - Insufficient incentive model
  - Inadequate technology tools for provider collaboration
- Push towards Medical Home model of practice
- Inter Disciplinary Team care is at the heart of PACE
- Center based model is an advantage for Care Coordination
- Capitated- Full risk payment model provides the needed incentive
Measuring Outcomes

- Improve member access to needed services
- Relate Care Management goals to Target Population
- Improve access to essential services
- Improve access to affordable care
- Improve Care Coordination
- Improve Transitions of care
- Improve access to preventive services
- Optimal Service Utilization
- Improve health outcomes
Thank you for attending our session!

Population Health Management recap:

- Understand Population Health Management
- How can population management principles benefit PACE Programs
- A PACE program’s experience in using components of Population Health Management to manage utilization
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  brenda_vatland@mediture.com

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