Population health 101
Emory’s journey toward creating value

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How do you remain financially viable AND increase quality?

“What if we don’t change at all ... and something magical just happens?”
How do you remain financially viable AND increase quality?

Using Payment Models to Improve Value: A Journey from Inaccuracy to Precision
Population Health Management

Engagement & Wellness

Acute & Chronic Conditions

Care Plans

Medically Vulnerable & Clinically Complex

Care Plan Failures

Care Coordination

Registry Outreach
Population Management at Emory

Hi Risk 5%
Rising-Risk 20%
At-Risk 40%
Healthy Patients 35%

Care Coordination for Medically Complex / Vulnerable Patients
Patient Centered Medical Home (PCMH): Population Health Training
Care Episode Re-design & Targeted Interventions

Analytics & IT Infrastructure supporting Population Health
Narrowing Population Management to an individual Patient’s Experience

Mr. Lee
- 46 yr-old male
- Has seen multiple Emory Physicians in last 3 years
- Insurance: BCBS EHN Shared Savings Attributed member

Dr. Smith
- GPR = PCP
- 2 visit in last 2 years

Emory PCP

Dr. Jones
- 2 visits in last 2 years

EHN PCP (Private)

Dr. Moore
- 2 visit in last 2 years

Non-EHN Cardiologist

EUH
- Inpatient stay Jan 2016
- Non-Emory ED Visit Dec 2015
Narrowing Population Management to an individual Patient’s Experience

- 46 yr-old male
- Type 2 diabetes, hypertension, obesity
- Multiple social stressors

• Has Mr. Lee received all of standard care elements diabetic patients need to receive each year?
• Is his blood pressure under control? Who is responsible for that? How to avoid re-ordering tests since he’s cared for my multiple providers?
• When is he coming into see a physician next? Who is responsible for coordinating that care? Will someone reach out to him?
EHN HealtheIntent Data Input

- Registry workflow in Powerchart
  - Workflow for 2 use cases in Powerworks, third in Web portal
- Evaluation for Registries & Measures
- Patients are Attributed to Physicians
  - Physicians are Linked with Orgs

Data enters HealtheIntent from EHRs & Claims

Data is normalized in HealtheIntent

EHC-Powerchart

BCBS/AETNA- Paid Claims for Shared Savings Lives
EHC- Pre-adjudicated claim
SOURCE: EHC Data Warehouse

EMORY HEALTHCARE
Cerner Ambulatory Care
Powerchart/Powerworks
SOURCE: Millennium and ASP
Domain A- Discreet Data Crawl

EHN PRIVATE PRACTICE
Allscripts/Athena/Cerner/eClinicalWorks/GE/Greenway
SOURCE: HIE - CCD Data

PAYER/CLAIM DATA
EHR
EHR
Disease Registry Use Cases: 1 clinical approaches to population management

REGISTRY FUNCTIONALITY
- Identifies patients with specified conditions
- Tracks care plans for each specified condition

Pre-Visit Planning
- Care team identifies future apts
- Registry identifies gaps to be closed for those patients
- Teams plan for gap closure

Visit Decision Support
- Registry reviewed upon visit
- Open gaps closed by team

Registry Outreach
- Registry reviewed by condition
- Team plans outreach for those with gaps in care

Mr. Lee
Disease Registries: HealtheRegistries

Disease specific Registries

- Diabetes
- IVD/ CAD
- Asthma
- Heart Failure
- Hyperlipidemia
- Hypertension
- COPD
- Depression
- Atrial Fibrillation
- Chronic Kidney Disease
- Hepatitis C
- Leukemia
- Breast Cancer
- Prostate Cancer
- Back Pain
- MDS

Wellness

- Adult wellness
- Senior Wellness
- Pediatric Wellness
- Maternity

Decision Support & Outreach

Patient-specific Gaps in Care

Practice & Physician specific Score cards
Attribution Logic: Which Patients are “Mine”?

1. Hard attribution: Primary Care Physician declared by physician
   • Patient Registration $\rightarrow$ Millennium $\rightarrow$ Powerworks
   • Tiebreaker: Most recent visit

2. Soft Attribution: Visit-based attribution
   • Limitation for Soft attribution: All outpatient encounters are classified as “TEC_Visit”
   • E&M CPT Codes from Billing (Centricity) & Adjudicated Claims (Payers)
   • At least 2 visits in past 2 years
   • Tiebreaker: Most recent visit

3. Hard attribution: Payer Enrollment files
   • Ensures that ALL shared savings patients have attribution
Other Pop Health Efforts: HealtheCare Supports Care Coordination

**PREDICT HIGH RISK**
- Analytics
- Hospitalization
- Repeated ED visits
- Direct Referral

Standardized screening assessment → Risk stratification → Structured follow up

Oversight of Medically Complex & Clinically Vulnerable
EHN Care Coordinator Program

- 3.5% Highest Complexity with Average Risk Score of 5.5
- Centralized Multidisciplinary Team covering At Risk Lives

8-Member Multidisciplinary Team – Aligns Transitions of Care with Patient Specific Needs

<table>
<thead>
<tr>
<th>4 Registered Nurses</th>
<th>2 Care Coordinator Associates</th>
<th>1 Health Educator</th>
<th>1 Social Worker (LCSW)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex/High Risk Focused Nursing Assessments</td>
<td>Follow-Up Appointments</td>
<td>Chronic Disease Management</td>
<td>Psychosocial Assessments</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>Reminder Calls</td>
<td>Health Education</td>
<td>Transportation Gaps</td>
</tr>
<tr>
<td>Prescription Renewals</td>
<td>Payor Data Retrieval</td>
<td>Lifestyle Modification</td>
<td>Behavioral Health Intervention</td>
</tr>
<tr>
<td>Targeted Payor Review Calls</td>
<td>Referral Tracking</td>
<td>Goal Setting</td>
<td>Community Resources</td>
</tr>
<tr>
<td>Transitional Care</td>
<td>Mailings</td>
<td>Gap Closure</td>
<td>Referral Management</td>
</tr>
</tbody>
</table>

Reduced ED Use by 15 visits/Month
Reduced Hospital Use by 7 Adm/Month
In 1,800 Patient Pilot
HealtheCare: Care Coordination Workflow Support

Previous State:
- Multiple data sources
- Manual assignment
- Access database for workflow and productivity
- EMR for clinical documentation

HealtheCare:
- Data Sources integrated
- Automated risk stratification & Assignment
- Workflow support
- Panel Management