logether2Goal

AMGA Foundation National Diabetes Campaign Monthly Campaign Webinar

September 15, 2016

TODAY'S WEBINAR

- Together 2 Goal[®] Updates
 - Webinar Reminders
 - 2017 Webinar Topics
 - Goal Post August Newsletter Highlights
 - IQL Conference: Nov. 14-17
- Use a Patient Registry & Publish Transparent Internal Reports (Lehigh Valley Health Network)
 - Sameera Ahmed, MS, RHIA, CHDA
 - Nina M. Taggart, MD, MBA
- Q&A
 - Use Q&A or chat feature

Together 2 Goal.

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WEBINAR REMINDERS

- Webinar will be recorded today and available the week of September 19th
 - Together2Goal.org Website (Improve Patient Outcomes → Webinars)
 - Email distribution
- Participants are encouraged to ask questions using the "Chat" and "Q&A" functions on the right side of your screen





INPUT REQUESTED: 2017 WEBINAR TOPICS



- Beginning planning for 2017
 monthly webinars
- Email topic and/or speaker recommendations to together2goal@amga.org
- Self-nominations accepted



GOAL POST SEPT. NEWSLETTER HIGHLIGHTS



Together 2 Goal

National Day of Action

- Twitter chat
 - Nov. 3, 2-3pm Eastern
 - #T2Gchat
- Online pledge
 - Commit to different
 "actions" on Nov. 3
 - Select from our ideas or create your own!

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GOAL POST SEPT. NEWSLETTER HIGHLIGHTS



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TOGETHER 2 GOAL[®] AT AMGA'S INSTITUTE FOR QUALITY LEADERSHIP (IQL)



Advancing High Performance Health

AMGA 2016 Institute for Quality Leadership

November 15-17, 2016 San Francisco Marriott Marquis San Francisco, California

- Conference Theme: Succeeding Under MACRA and Risk-Based Payment
- To Register: www.amga.org/IQL2016



TOGETHER 2 GOAL® AT AMGA'S INSTITUTE FOR QUALITY LEADERSHIP (IQL)



- Pre-Conference Session*
 - Johnson & Johnson Health Care Systems, Inc. CORE Program
- Tuesday, November 15
 - Chief Quality Officer/Director Leadership Council
 - Improving Care Delivery: Assessing and Addressing CVD Risk
 - Team-Based Approach to Diabetes Care
- Wednesday, November 16
 - Peer-to-Peer Breakout Session
 - New Approach to Improving Diabetes Care with In-Person Professional Education Training Model
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***SUBJECT TO CHANGE**



TODAY'S SPEAKERS

• Sameera Ahmed, MS, RHIA, CHDA

 Senior Healthcare Data Analyst, Lehigh Valley Health Network

• Nina M. Taggart, MD, MBA

Physician Administrator, Population
 Health, Lehigh Valley Health Network







Using Reports and Registries to Support the Management of Diabetes Patients

Nina M. Taggart, MD, MA, MBA, FAAO Sameera Ahmed, MS, RHIA, CHDA

Today's Discussion

- Introduction
- LVHN's population health management strategy
- Development and deployment of patient registries using Optum One

Lehigh Valley Health Network

- Recognized by U.S. News & World Report, Fortune, Modern Healthcare, Leapfrog, others
- 5 hospital campuses, 12 Health Centers
- +10 ExpressCARE locations
- Approx. 1,161 acute care beds
- 1,340 physicians
 (700 network-employed)
- More than 13,000 employees
- Ancillary Services
- Physician Hospital Organization
- Revenues over \$2 Billion



U.S. Healthcare Delivery System Evolution

Acute Care System 1.0	Coordinated Seamless Healthcare System 2.0	Community Integrated Healthcare System 3.0
 Episodic healthcare Lack of integrated care networks Lack of quality & cost performance transparency Poorly coordinated chronic care management 	 Patient/person centered Transparent cost and quality performance Accountable provider networks designed around the patient Shared financial risk 	 Healthy population-centered population health-focused strategies Population-based reimbursement Community health integrated Networks linked to community resources capable of addressing psycho-social/economic needs

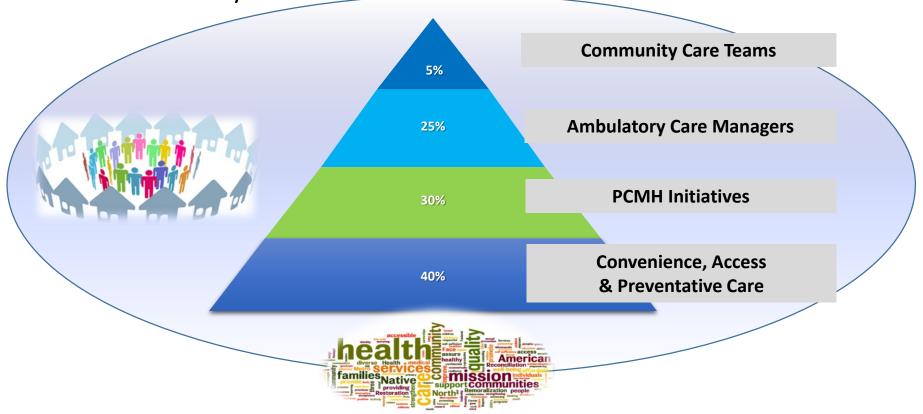
*Halfon N, Long P, Chang DI, Hester J, Inkelas M, Rodgers A. Applying a 3.0 transformation framework to guide large-scale health system reform. Health Affairs 2014;31(11). doi: 10.1377/hlthaff.2014.0485.

Populytics

- Population health management and analytics firm
- Established December 2013
- Integrated services
 - Population Health Analytics
 - Clinical care coordination
- Expert professionals
 - Payer & provider informatics
 - Advanced analytics
 - Insurance and risk management



Integrated Care Management Model for a Healthier Community



Population Health Management Executive Committee

- Clinically driven, includes key network leadership
- Programmatic focus leverages clinical integration and care alignment throughout LVHN
- Shared KPIs
 - Clinical pathways
 - Costs/spend
 - Utilization (Inpatient, ED, Readmissions)
 - Pharmacy costs
- Informs and facilitates concurrent work

Identifying Diabetes Care and Cost Opportunities

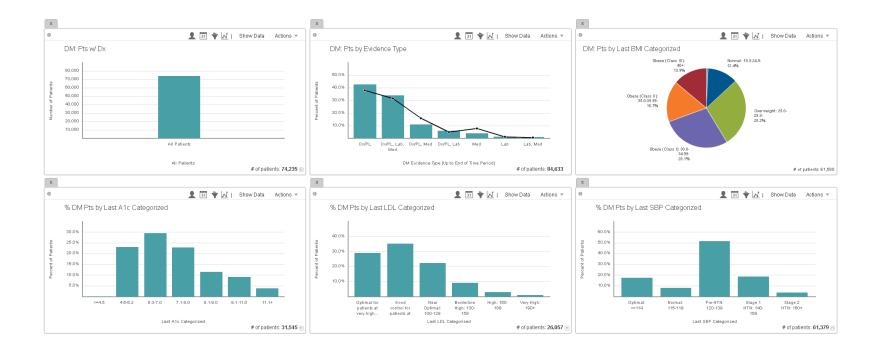
- Claims-based analytic tools used to identify cost drivers by clinical condition for attributed population
- Other measures of interest by clinical condition
 - Number of members
 - Inpatient & ER utilization
 - Comorbidities (CKD, CHF)

Choose Calculation		Payer	Active Member	PCP Continuity	IP Admits Group	Clinical (Category	Member Cost	
Paid	- <u>e</u>	(All) 👻	(All)	(All)	(All) 🔻	(All)	•	(All)	•
Member Month Type	Filters		No	No PCP	ER Visit Group	Conditio	n Detail		
Cohort Member Months	•		Yes	PCP	(All)	(All)	•		
Detail Clinical Categ	on: Paid						Population Ove	niow	Selected
Endocrinology	Diabetes				\$19.762	901	Members	17,814	17,81
Nephrology	Chronic re	and failure			\$19,672	-	Member Months	211,220	211,22
							PMPM	\$1,338.67	\$1,338.6
Cardiology		eart disease			\$19,540,	149	Total \$	\$282,753,426	\$282,753,42
Cardiology	Congestive	e heart failure		\$9,9	98,698		Admits	13,581	13,58
Neurology	Cerebral v	ascular disease		\$9,29	6,051		Days ER Visits	158,777 20,206	158,77 20,20
Infectious diseases	Septicemia	1		\$8,603	933		Episodes	301,495	301,49
Cardiology	Hypertens	ion		\$7,057,16)		Admits/K	771.6	771.
Orthopedics & rheumatology	Joint dege	neration, localized - back		\$6,308,550			Days/K	9,020.6	9,020.
Orthopedics & rheumatology		neration, localized - knee & lower leg		\$5,968,907			ER Visits/K	1,148.0	1,148.
Pulmonology	COPD			\$5,485,636			Episodes/K	17,128.8	17,128
r unionology	0010			33,403,000		+	ALOS Readmit Rate	11.69 43.32%	43.32
Paid By Relationship				Paid by	Risk				
Dependent \$2,195,087				Well	\$217,252				
			\$271.082.060	Stable	\$1,952,872				
Encollog					1 C C C C C C C C C C C C C C C C C C C				
Enrollee				Moderate	\$5,411,423				
Enrollee Spouse \$9,476,279				Moderate	\$5,411,423	998 388			
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	y Indicator (I	PQI)	-	High	• • • • •	998,388		S:	224,173,490
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Spouse \$9,476,279 Paid by Preventative Qualit Angina Without Procedure Astima in Younger Adults Bacterial Pneumonia	\$34	312		High Very High Top Paid LEHIGH V	S50, By Hospital Facility ALLEY HOSPITAL ALLEY HOSPITAL MUHI		\$18,5:	\$6 58,560	
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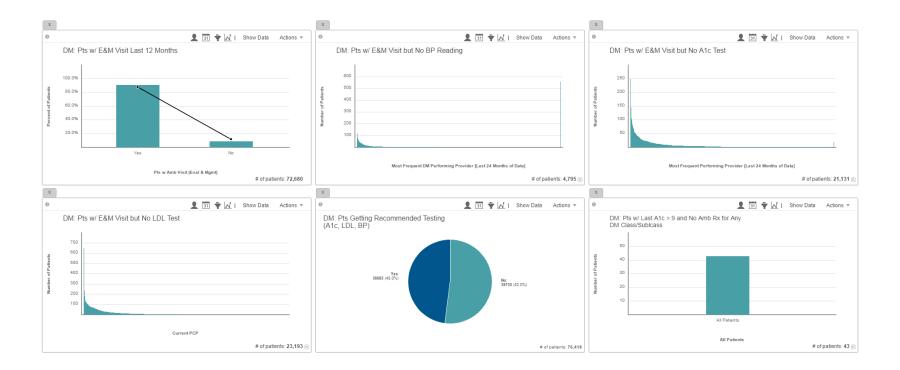
• DM Cohort Demographic Profile



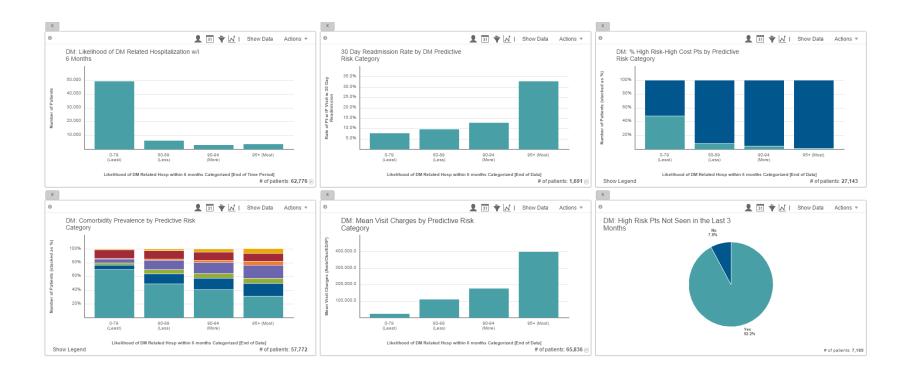
• DM Cohort Clinical Profile



• DM Care Gap Overview

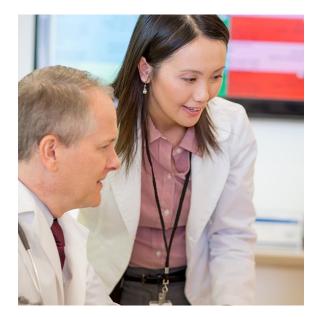


• DM Predictive Risk Overview



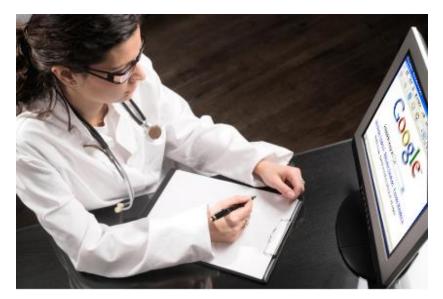
Turning Data into Actionable Information

- Engage care teams
- Identify clinical opportunities for improved care
- Determine strategy for targeted interventions
- Develop patient registries for population health and practice team



Practice Team Information Needs

- Predictive analytics
- Meaningful clinical indicators
- High utilizers (IP admits, ED Visits)
- Behavioral health information
- Social determinants



Predictive Analytics

- Prompts proactive outreach
- Predictive models assessing the likelihood of chronicdisease related admission and disease progression
 - DM
 - DM to CKD

🕨 General 🔺	Patient Data	Hospitalization F	Likelihood of DM Related Hosp within 6 months [End of Data]
Chronic	▶ Labs	CKD Risk	
▶ Conges	Medical Care		
▶ Coronai	Clinical Risk		
🕨 Diabete			

🕨 General 🔺	Patient Dar	 Hospitaliza 	DM Pt Likelihood of Developing CKD within 12 Months Categorized (Percentiles) [End of Data]
▶ Chronic	Labs	CKD Risk	DM Pt Likelihood of Developing CKD within 12 Months [End of Data]
Conges	Medical Ca		
Corona	Clinical Ri:		
Diabete			
Dvslipid			

Meaningful Clinical Indicators

- DM
 - Last A1c
 - SBP/DBP
 - LDL
 - BMI
 - ACE/ARB
 - eGFR
 - Endocrinologist
 - Eye exam



Other pertinent patient information

- Frequency of ED Visits, IP admits, readmits
- Behavioral health
 - Dx of depression
 - Rx for depression
- Need for social services
 - Patient is self pay

 Patient Data Clinical Obs Labs Medical Ca 	servations	 Amb Visits ED Visits Skilled Nursing Facilit Hospital Admits 	y Visits		#of ED Visits # of ED Visits Missing 7 Day Amb Follow-up Pt Has Had ED admission within 3 Days Pt Has Had ED admission within 7 Days
 Patient Dat Clinical Ob Labs Medical Ca 	servations	 Amb Visits ED Visits Skilled Nursing Facil Hospital Admits 	ity Visits	•	 Follow-up Readmission # of Hosp Admits Longest time to Follow-up between IP and Amb visit
 Patient Data Clinical Obs Labs Medical Ca 	servatio	Amb Visits ED Visits Skilled Nursing Facilit Hospital Admits	 Follow-up Readmission # of Hosp Admits Longest time to Follow-up betw 	•	 # of IP Visits w 30 Readmission # of IP Visits w 7 Day Readmission Pt w IP Visit w 30 Day Readmission Pts w IP Visit w 7 Day Readmission
Patient Clinical Labs Medical	 Demograp Severity High Risk Most Recent C 	Mental Health Pt is Pregnant Pts w Antiphospholipid Pts w Antiphospholipid	Syndrome Condition Syndrome Condition (Ever)	•	Pts w Depression Pts w Depression [Ever] Pts w Dx of Major Depression Pts w Dx of Major Depression [Ever]

Collaboration with users

- Review other available variables with practice team members
 - DCSI Score
 - Charlson Score
 - HCC-RAF Score
 - # Primary Care Visits
 - Has a Next Visit/Date of Next Visit
 - Clinic of Provider for Next Visit
 - Total Charges



Final List of Registry Variables

- 60+ different variables covering:
 - Patient Demographics
 - Providers
 - Utilization
 - Upcoming appointments
 - Risk Scores
 - Predictive Analytics
 - Behavioral Health
 - Costs
 - Medications
 - Clinical Observations/Labs



Registry View

Panel: Not Recorded 🔻 🛉 Quick Filters: Default (Not Filtered) 🔻 Showing 5,000 of 7,358 records 0

🗄 Columns 🛛 🎝 Actions 🔻 🕔

Date Added 💠	DCSI Score [Curr 💠	DM Pt Likelihood of Developing CKD within \bullet	Likelihood of DM 🔶	HCC-RAF [Last 1 🔶	Last A1c (09/01/2 🔶	Date of next visit 🜲
07-20-2016	1	98	60	0.810	6.9	12-08-2016
08-13-2016	1	98	62	1.202	6.3	
07-20-2016	0	98	63	1.050	10.1	09-28-2016
07-20-2016	5	98	76	1.015	9.4	10-27-2016
07-20-2016	2	98	83	1.342	8.0	
08-11-2016	1	98	66	0.437	6.8	07-20-2017
07-20-2016	1	98	74	0.629	7.7	11-14-2016
07-20-2016	0	98	46	0.429	8.0	09-27-2016
07-20-2016	1	98	79	0.771		12-01-2016
07-20-2016	3	98	94	4.019	6.2	
07-20-2016	2	98	94	1.420	8.6	
07-20-2016	0	98	60	0.907	7.9	09-26-2016

Defining Standard Work

- Set standard filters to guide outreach efforts and care gap closure for DM patients
- High Likelihood of DM Related Hospitalization
 - Likelihood >= 80%
- High Utilizers
 - ED Visits >= 2, Hosp Admits >= 3 in 12 months
- High Risk, Low Spend
 - HCC-RAF in high risk range, Total Charges <= \$15,000

-	Lastity for onor cowering med (05/01/2013 - 05/		
	Last Rx for for Any Oral DM Med Class/Subclass		
	Last Rx for Insulin (09/01/2015 - 09/11/2016)		
√	Likelihood of DM Related Hosp within 6 months [is greater than or equal to 80	i
	Most Frequent Endocrinology Provider [Last 12		
	Patient Status		
	Patients known to be deceased [Current]		
	Pt w Dx of Type 1 DM (09/01/2015 - 09/11/2016)		
	Pt w Dx of Type 2 DM (09/01/2015 - 09/11/2016)		
	Pt w IP Visit w 30 Day Readmission (09/01/2015		
	Pts w Chronic Kidney Disease: CCS (09/01/2015		
	Pts w Depression (09/01/2015 - 09/11/2016)		
	Pts w Diabetic Retinopathy (09/01/2015 - 09/11/2		
	Pts w Dialysis (09/01/2015 - 09/11/2016)		
	Pts w DM with Neurological Complications (09/0		
	Pts w DM with Renal Complications (09/01/2015		
	Pts w Eye Exam - PQRI (09/01/2015 - 09/11/2016)		
	Pts w Foot Exam - PQRI (09/01/2015 - 09/11/2016)		
	Pts w Rx for ACEI/ARB (09/01/2015 - 09/11/2016)		
	Pts w Rx for Any Depression Med Class (09/01/2		
	Pts w Rx for Any DM Med Class/Subclass (09/01/		
	Pts w Rx for Any Oral DM Med Class/Subclass (0		
	Pts w Rx for Aspirin (09/01/2015 - 09/11/2016)		
	Pts w Rx for Chol Lowering Med (09/01/2015 - 09		
	Pts w Rx for Insulin (09/01/2015 - 09/11/2016)		

Apply Cancel

Coordinating Patient Care

- Identify patients with comorbidities or complications
- Identify barriers to seeking care and assist in resolutions
- Connect patient to resources across settings and episodes of care
- Engage patients in ongoing plan of care with PCP/Endocrinologist



Next Steps

- Integration of tool set with Epic
 - Risk scores
 - Predictive models
 - Registries
- Include more social determinants of health in standard workflow
- Submitting data to payers to support enhanced scoring on quality measures for incentive programs



Questions?