NEW JERSEY HEALTH CARE QUALITY INSTITUTE

Quality powered.

Garden Practice Transformation Network

Practice Transformation Advisors

Population Management Training

Bryan Wellens

Continuum Health Alliance, LLC

The Transforming Clinical Practices Initiative is supported by Funding Opportunity Number FOA # CMS-1L1-15-003 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services

Introducing…

Bryan Wellens, *Vice President of Value-Based Intelligence*

As Vice President of Value-Based Intelligence at Continuum Health Alliance, Bryan oversees Population Health operations and administration of government and commercially sponsored value based programs. He develops data-driven strategies in collaboration with key leaders, stakeholders and clients, delivering actionable, patient-centered information that helps improve the patient experience, increase quality, and reduce overall costs of care.

About Continuum

Continuum Health Alliance is a physician enablement company that optimizes value-based commerce through population health, practice transformation, applied analytics and network development services. The company offers proven, strategic business and clinical solutions empowering ambulatory and community-based enterprises and other providers to enhance patient access and experience, improve health and lower overall costs. Continuum serves 1,500+ primary care physicians, specialists and nurse practitioners caring for hundreds of thousands of patients across the country.

Learn more at www.challc.net.

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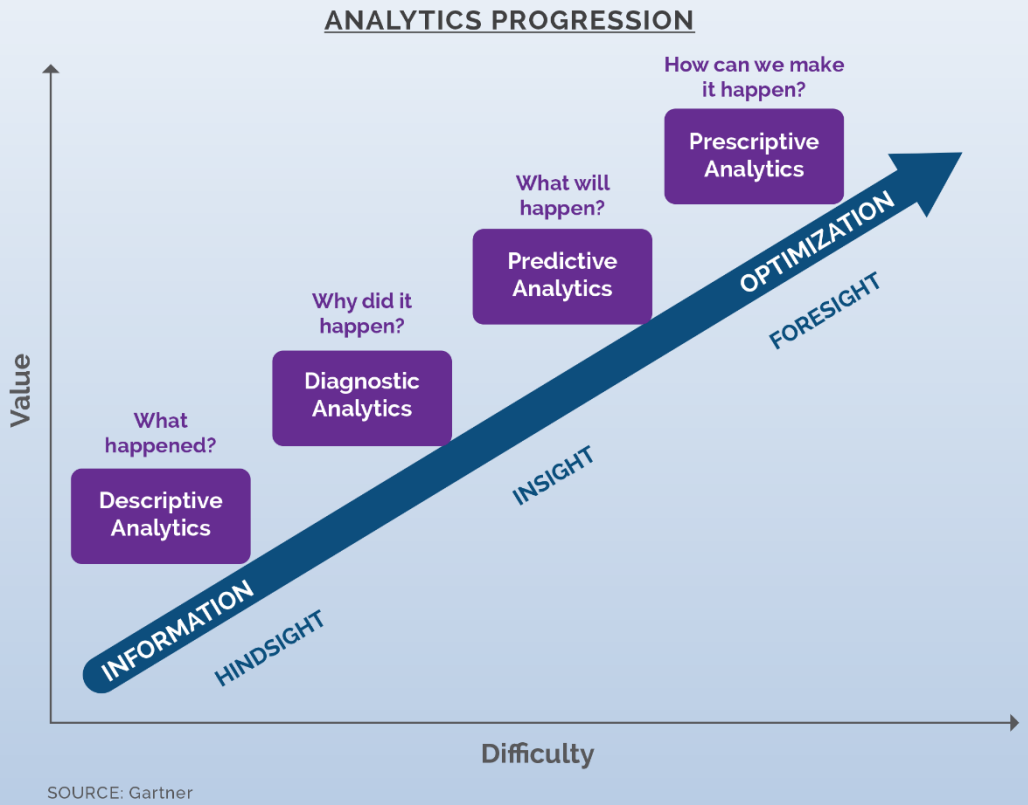
Agenda

- Population health & analytics review
- Understanding your patient panel
- Defining risk stratification
- Recognized stratification methods
- Why risk stratification is important
- Case study
- Steps for managing patients
- Impact of risk stratification
- Recommended action steps for your practice
- Questions

Population Health and Analytics

- Definition of Population Health
  - Health Interventions
  - Determinants of Health
  - Health Status Improvement

- Healthcare Analytics
  - Descriptive – what happened?
  - Diagnostic – why did it happen?
  - Predictive – what will happen?
  - Prescriptive – how did it happen?



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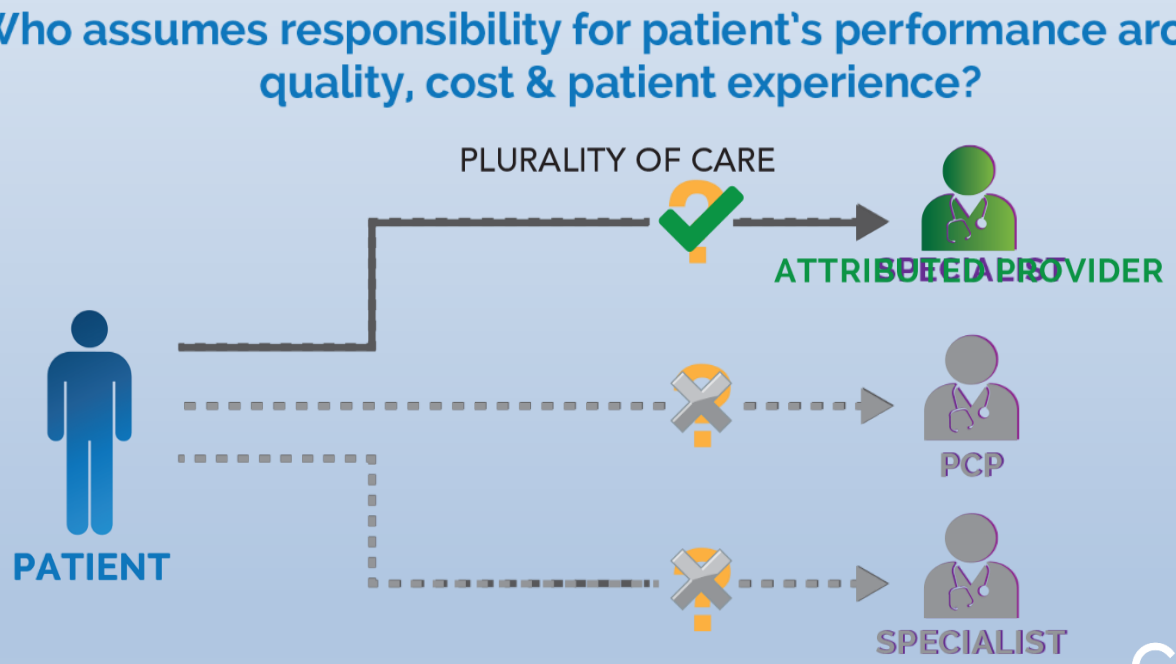
Who are your patients?

Before you can think about focusing on care management for specific patient groups, you must understand the patients attributed to you:

- Who are they?
- Why were they attributed to you?



What is Risk Stratification?

- **Risk stratification** is an approach for identifying— and predicting— which patients are at high risk—or likely to be at high risk—and prioritizing the management of their care in order to prevent unfavorable and costly outcomes.
- Categories of patients are referred to as “cohorts” and may be grouped together by:
  - Patient Demographics
    - Age
    - Gender
    - Address / Zip Code
    - Socioeconomic Status
  - Diagnosis
    - Chronic & Acute
    - Multi-Comorbidities
    - Behavioral Health Indicators
  - Utilization Risk
  - Patient Motivation and Compliance

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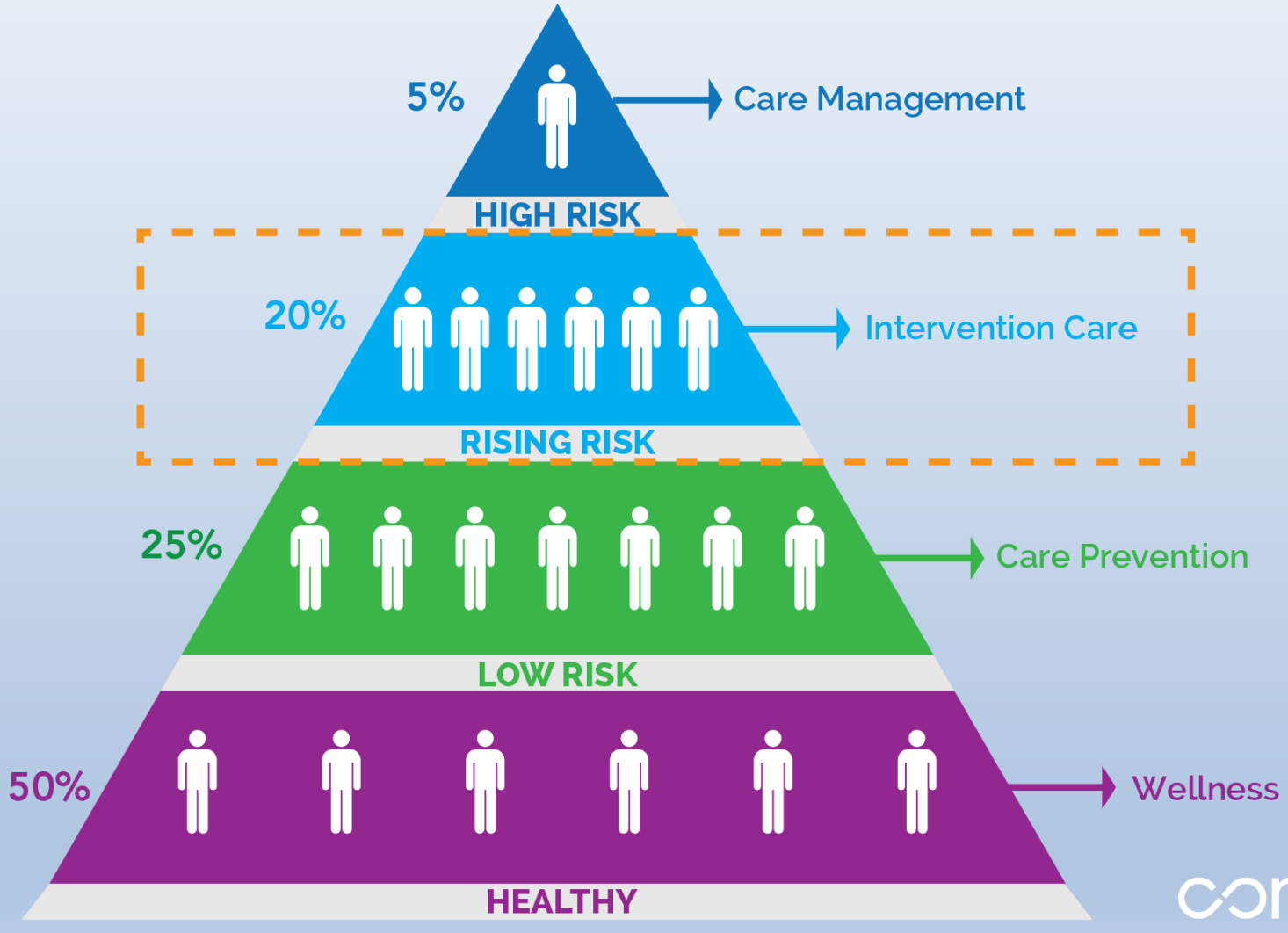
A closer look at a practice's total patient population



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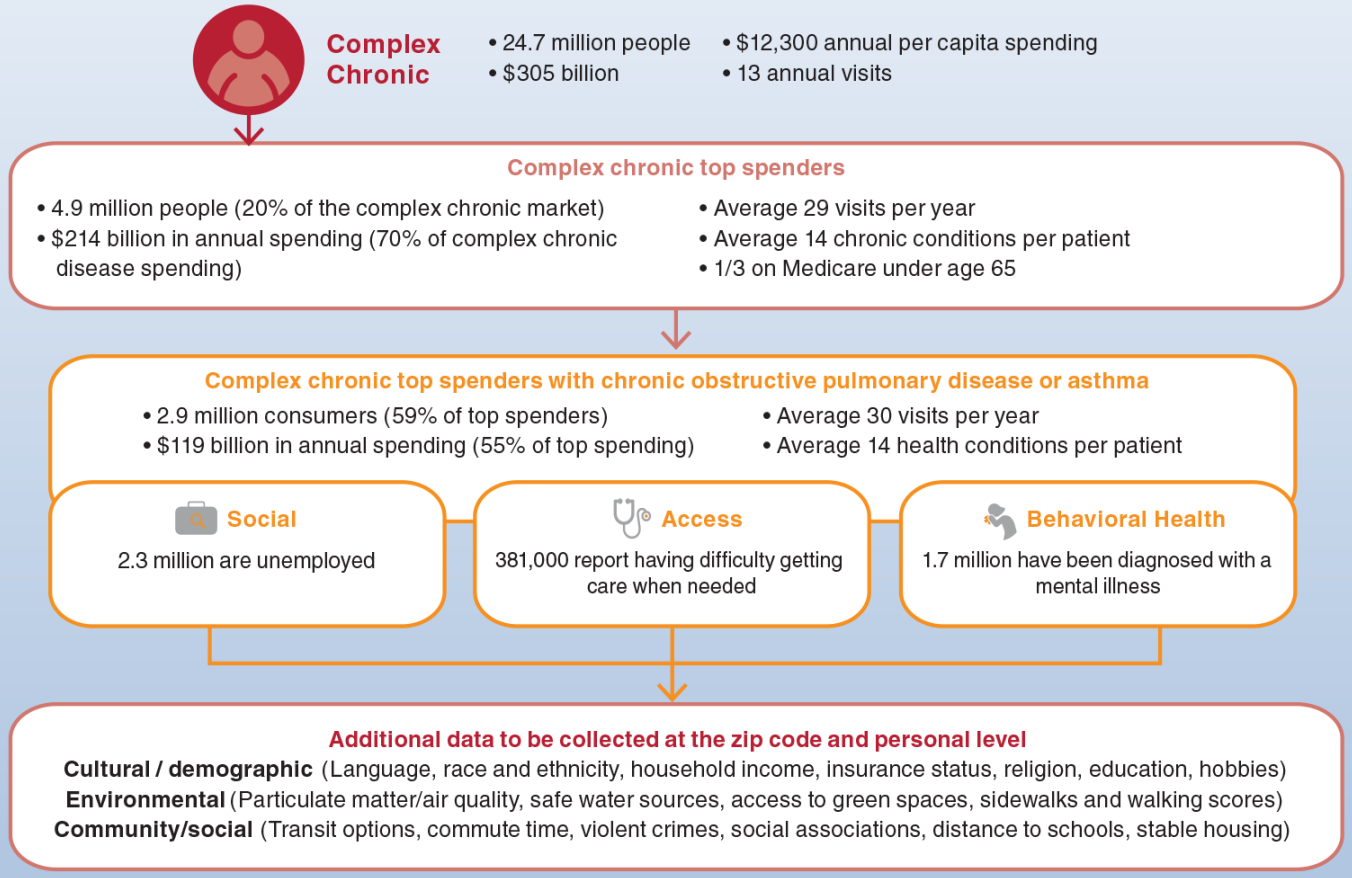
Drilling down to your sickest patients

Figure 2 A closer look at the complex chronic disease market reveals social, access and behavioral health needs



Source: HRI analysis of 2013 Medical Expenditure Panel Survey (MEPS) data on consumer health spending and demographic characteristics.
For more information on primary care consumer markets, read HRI's Primary Care in the New Health Economy: Time for a makeover.

Source: PWC, May, 2016

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Recognized models for stratifying a population by risk

- Examples include:
  - **Hierarchical Condition Categories (HCCs):** Provided by CMS, HCC is a publicly available model that places patients into condition-based categories.
  - **Adjusted Clinical Groups (ACG):** A Johns Hopkins University model, ACG measures the morbidity burden of patient populations based on age, gender and disease patterns.
  - **Episode Treatment Grouper (ETG):** A proprietary model, ETG takes into account claims and encounter-based data to describe complete episodes of care to develop statistically and clinically homogenous groups.

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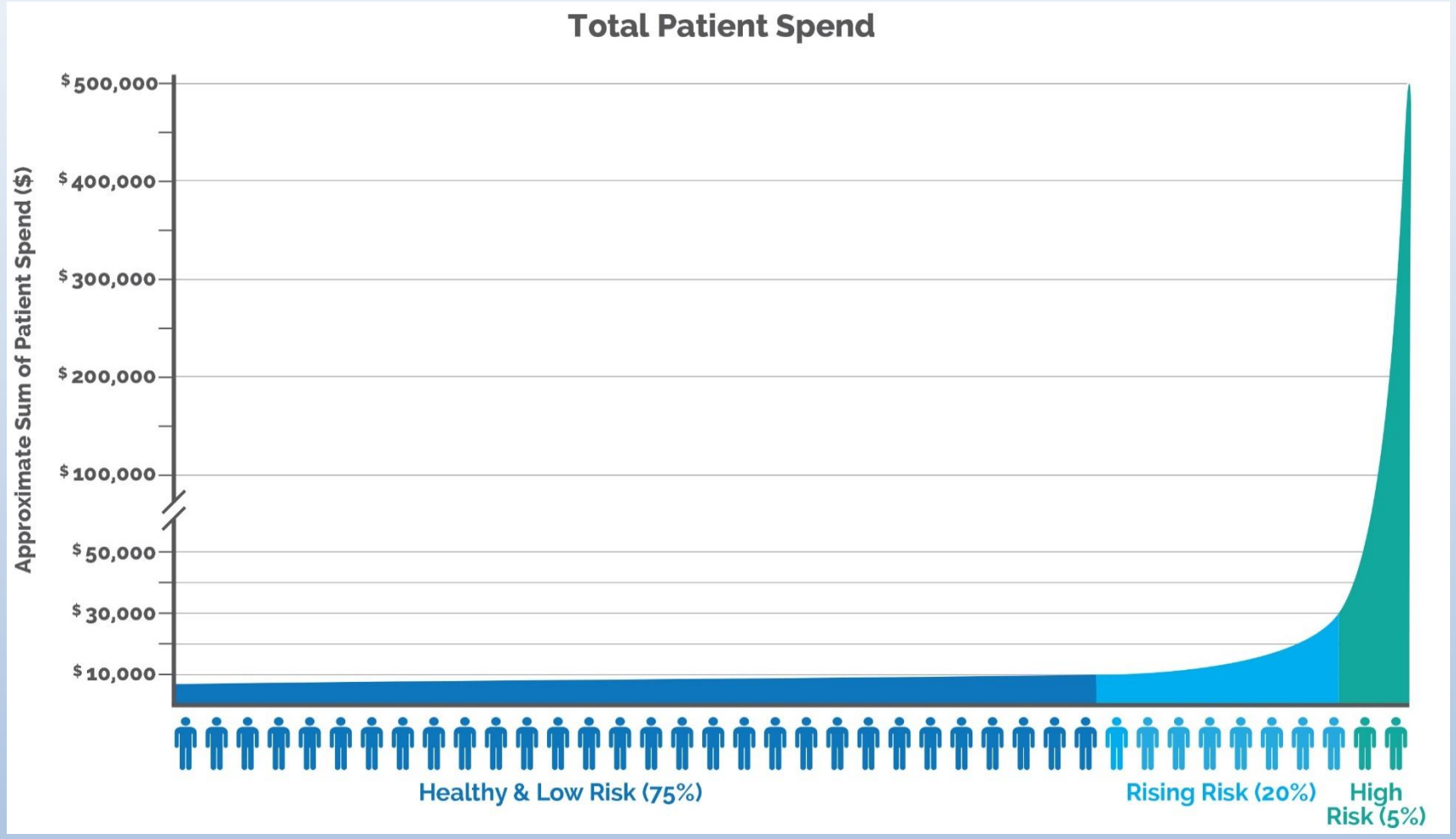
Why is Risk Stratification important?



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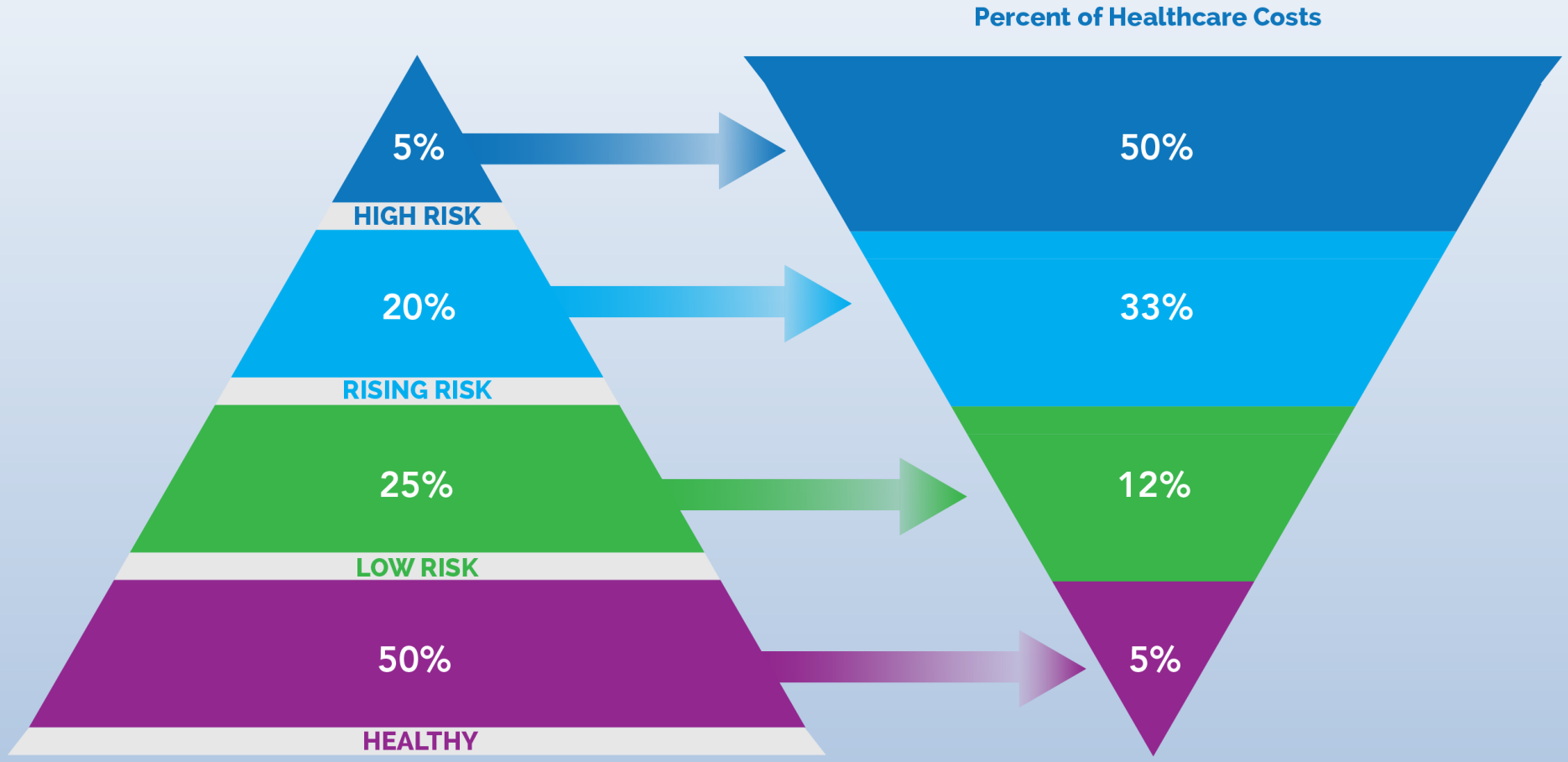
Why is Risk Stratification important?



Source: Epstein, Becker, Green

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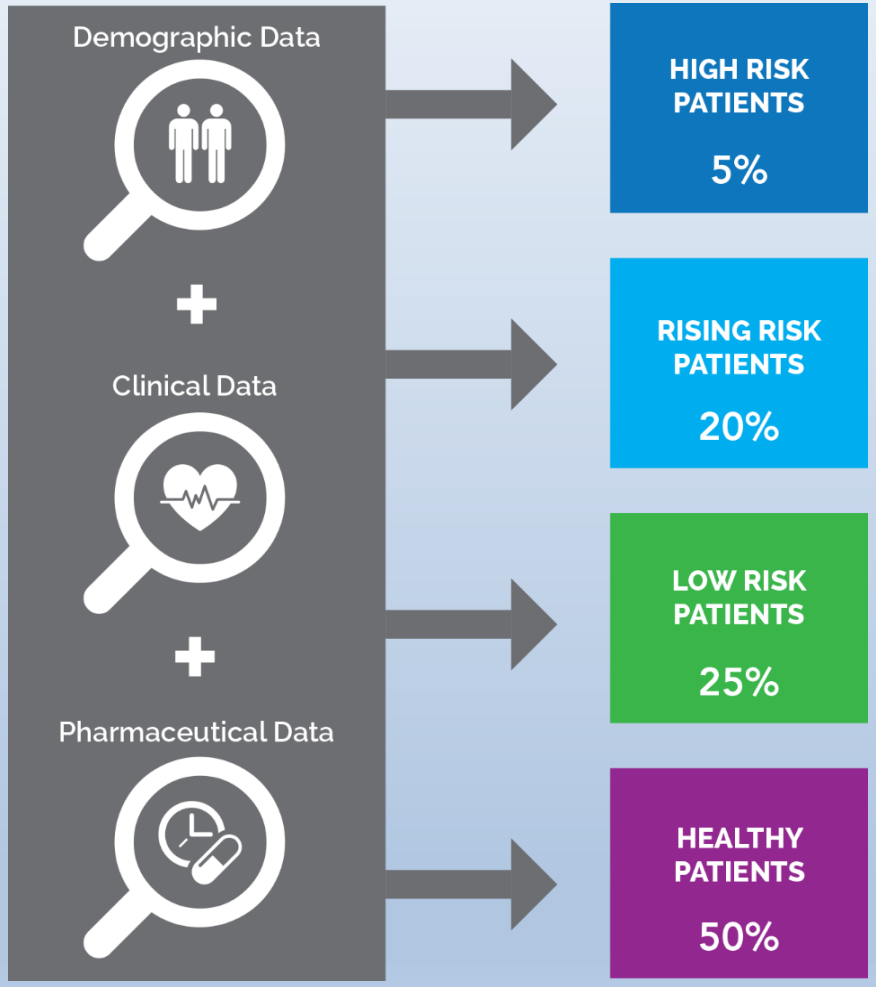
How to Manage Risk Stratified Patients: Step One

Step 1: Identify & Prioritize



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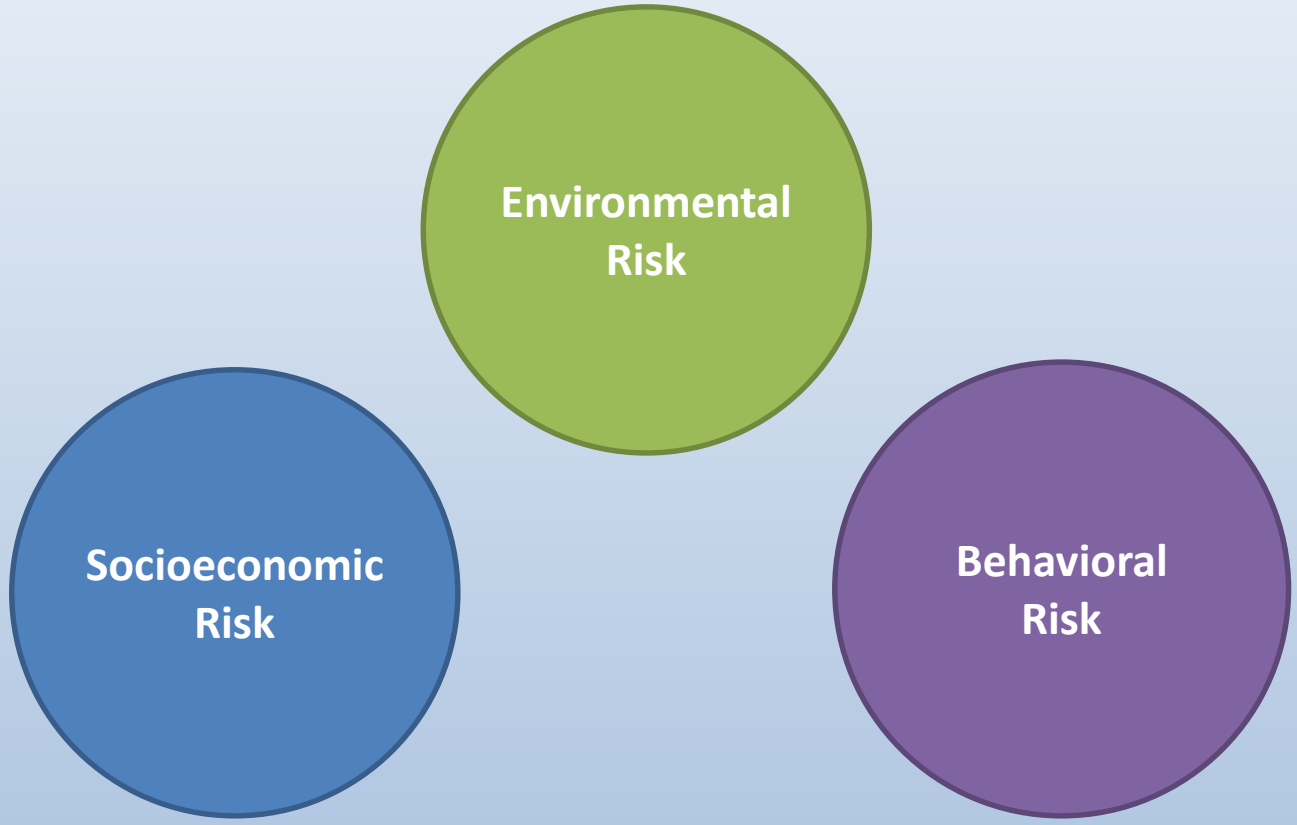
How to Manage Risk Stratified Patients: Step Two

Step 2: Assess Root Cause (beyond obvious markers)



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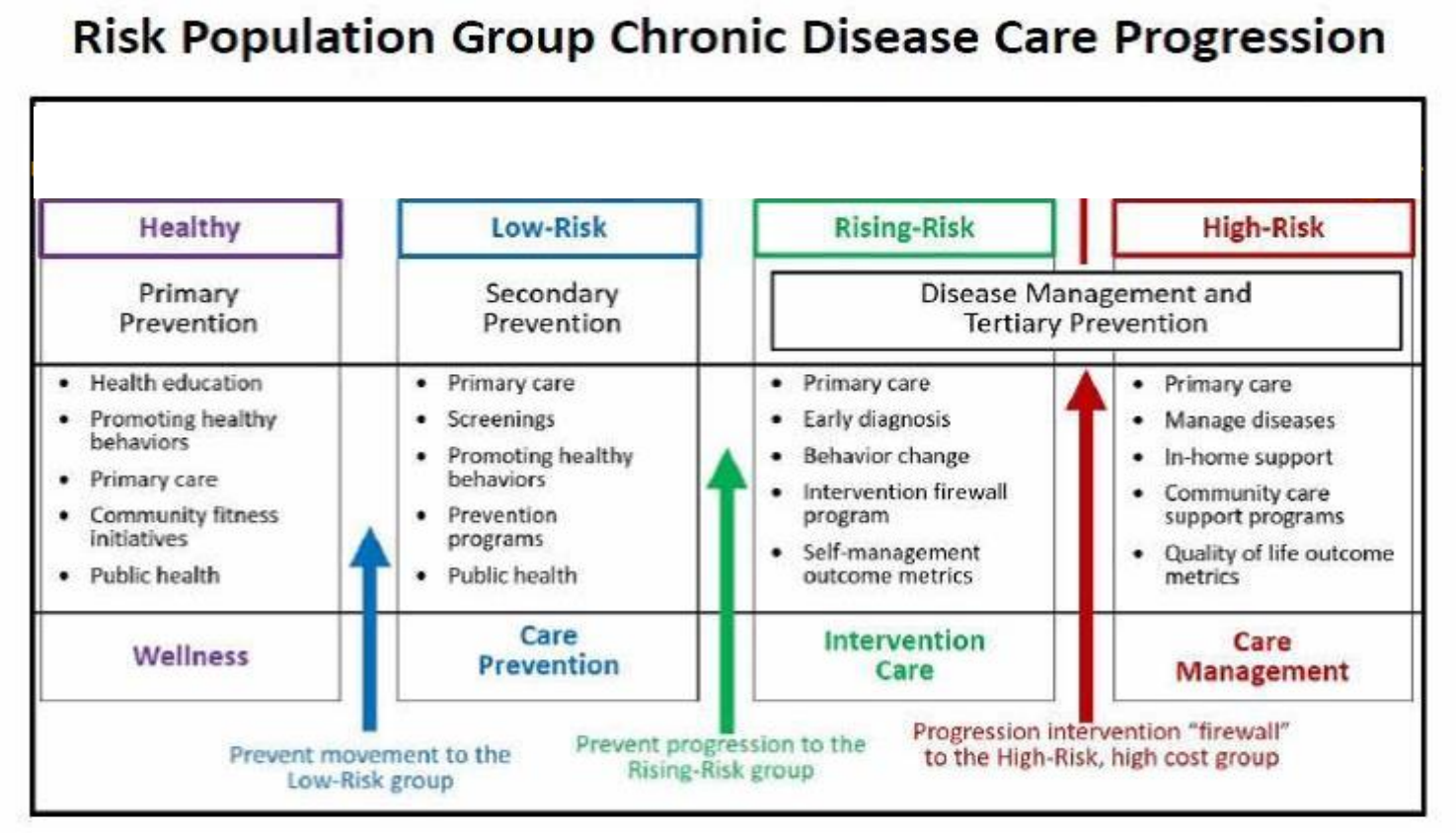
How to Manage Risk Stratified Patients: Step Three

Step 3: Take Action/Select Tactical Approach



Source: Health IT Outcomes, "Chronic Disease is Healthcare's Rising-Risk"

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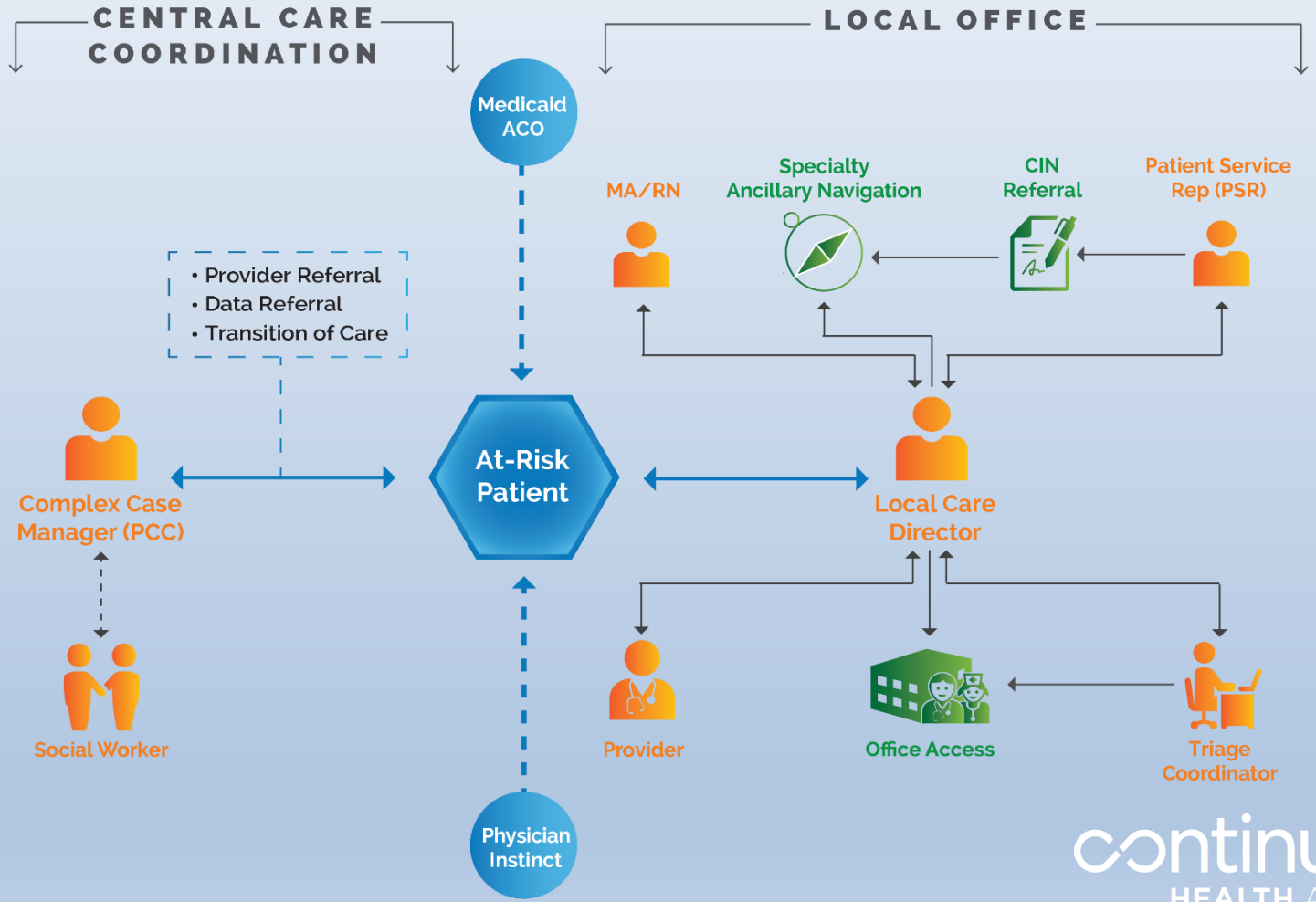
How to Manage Risk Stratified Patients: Step Three

Step 3: Take Action/Implement Workflow



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How to Manage Risk Stratified Patients: Step Four

Step 4: Monitor, Measure & Adjust

Sample Scorecard:

Patient Type	# of Patients	# of Patient Contacts (E&M visits, phone calls, etc.)	% Completed
At-Risk	X	Monthly	Y
Rising Risk	X	Quarterly	Y
Low Risk	X	Semi-Annually	Y
Healthy	X	Annually	Y

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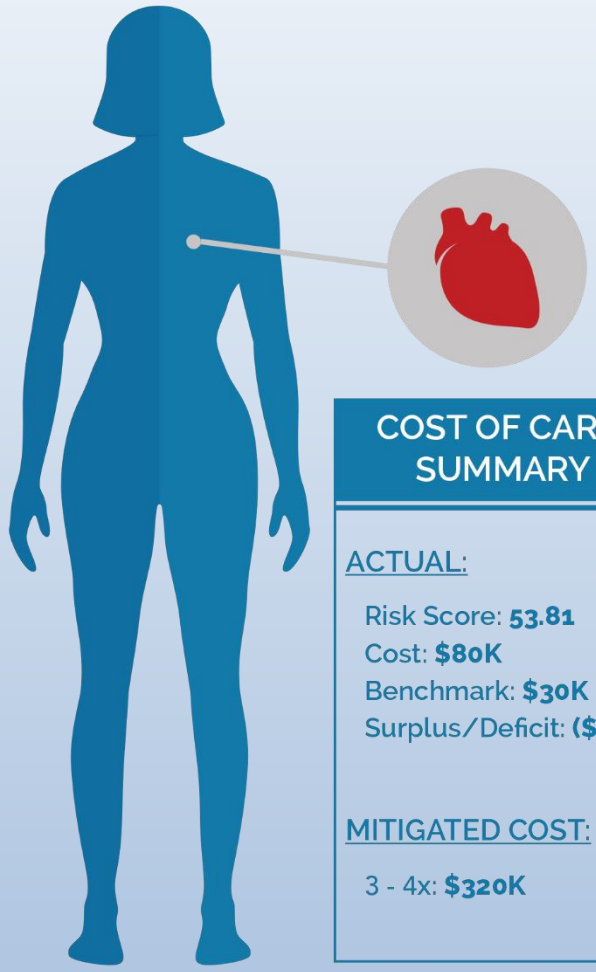
Risk Stratification Use Case

- Physician selected 77-year-old female patient for preventative & proactive care via care coordination
- Stratified as “risking risk” (multiple comorbidities: CHF, COPD, HTN, Diabetes)
- Patient experienced acute episode requiring double bypass surgery
- During cardiac rehab, patient became homeless; social worker arranged extended care & housing
- Results over 12 months:
  - ❑ 10-day LOS
  - ❑ 0 readmissions
  - ❑ 0 ER visits



COST OF CARE SUMMARY

ACTUAL:

Risk Score: **53.81**
Cost: **$80K**
Benchmark: **$30K**
Surplus/Deficit: **($50K)**

MITIGATED COST:

3 - 4x: **$320K**

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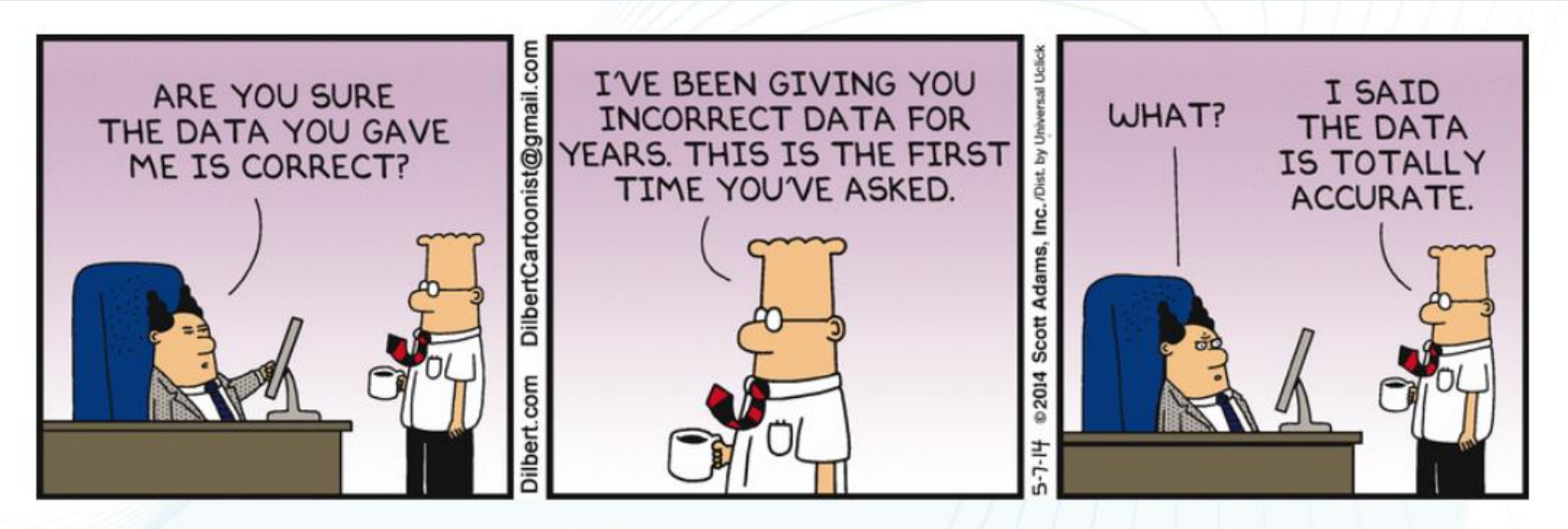
Get to Know Your Data



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Questions?

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Upcoming Webinars

12/13/16 1:30 PM-3:00 PM EST

Population Management with Dr. Stephen Kolesk

Senior Vice President of Clinical Integration, Virtua

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