

Population Health Davies Site Visit

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CMIO

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Outline

- Problem: Switch from Fee For Service to Value Models
- Solution:
 - Governance
 - Design of Population Health Initiatives
 - Role of Technology/EHR solutions
- Value seen:
 - Quality Outcomes
 - Financial Results

Changing Environment Last Decade

**Drive to Improve Quality, Reduce Cost
and Improve Patient Experience**

- **Value Based Contracts**
- **Capitated Contracts**
- **Ochsner Employees (self insured population)**
- **Bundled Payments**
- **MACRA (MIPS and APM)**
- **Reputational Scores**
 - Leapfrog/USNWR/CMS Stars
 - Transparency to Patients
- **Regulatory Reporting**

ENVIRONMENTAL

Increasing health care expenditures
Suboptimal quality
Cost-shifting to consumers
Clinical and cost variation
Increased price & quality transparency
Explosion of information
Employer aggregation/force



POPULATION HEALTH

HEALTH POLICY

Shift to value-based care
MACRA legislation/APMs
Bundled payments
MSSP & commercial shared savings
Cost-shifting/HDHPs
Health exchanges
New reporting requirements

Taking responsibility for the health and well-being of a population as defined by:

IMPROVED QUALITY

- Safety
- Disease Management/Clinical Programming
- Medication Management
- Behavioral Health
- Wellness/Prevention

REDUCED COST

- Care Transitions/Post-Discharge Intervention
 - ED, Admission/Readmission Avoidance
- Complex Care Management
- Standardized Care Pathways
- Referral Management
- Community Partnerships/SNF

BETTER PATIENT EXPERIENCE

- Access
- Care Coordination (Ochsner On Call, LPN-CCC)
- Patient Activation/Satisfaction
 - HCAHPS, CGCAHPS
- Team-based Care
- Palliative Care

FACILITATING CAPABILITIES

Governance • Leadership Commitment & Priority • Transparency • Advanced Analytics (Clinical + Financial) • Connectivity
Coding/Documentation Excellence • Panel Management • Aligned Incentives/Comp Model • Resource Optimization
Training & Development • Culture of Performance Improvement

Health System

Community Care Framework

Wellness and Prevention

Governance

Population Health Committee

Primary Care Council

IT Functionality (EPIC)

Health Maintenance

Healthy Planet

Patient Portal

Kaboodle

Dashboards

Operations

LPN-Clinical Care Coordinators (CCC) Program – care gap closure

Written Order Guidelines

Care Touch (call center)

My Panel Dashboards (registry driven)

Physician Compensation (Value-based)

Outpatient Case Management – Complex Case Management, Chronic Care Management

Pharmacy Coordination and Management

Governing Committees

- **Population Health Committee**
 - Chair Philip Oravetz, MD, MBA, MPH
 - 30 Members
- **Primary Care Council**
 - Chair Pedro Cazabon, MD
 - 84 Members

Sr. Exec

Admin

Provider

Nursing

IT

Ancillary

Revenue

Technology Design

- Health Maintenance – bulk ordering, order sets, Written Order Guidelines
- Healthy Planet Registries
- Analytics/Reporting – Reporting Workbench/Business Objects, Dashboard
- Health Risk Assessment (HRA) visit – HCC (Hierarchical Condition Category) Calculator, HCC reporting
- Digital Medicine – to be discussed at 3rd session
- Platform Integration – Social Work, Care Harmony
- Social Determinants of Health Care
- GPRO (Group Practice Reporting Option) Tool integration for MSSP

Health Maintenance

Expansion of Preventive Care to include Chronic Disease Management

Health Maintenance

Postpone Remove Postpone Override Remove Override Document Past Immunization Exclude Edit Modifiers Report Update HM Guidelines Health Maintenance User Guide

Due Date	Topic	Frequency	Date Completed
07/04/1997	Foot Exam	1 year(s)	
07/04/2005	TETANUS VACCINE	10 year(s)	
08/31/2013	Lipid Panel	1 year(s)	8/31/2012 9/14/2011 3/4/2011
06/20/2015	Eye Exam	1 year(s)	6/20/2014
07/06/2015	Hemoglobin A1c	3 month(s)	4/6/2015 3/4/2011
08/01/2018	Influenza Vaccine	9 month(s)	
09/19/2020	Pap Smear with HPV Cotest	3 year(s)	9/19/2017 4/7/2016 2/5/2015 8/22/2013

Health Maintenance Modifiers

- Anticoagulation
- Cardio-Onc
- Diabetes Mellitus - Poor Control (A1c Every 3 Months)
- Sexually active

Health Maintenance Modifiers

8/22/2013

colonos

Title	Number
Colonoscopy (Every 10 Years)	2109
Not a candidate for colon cancer screening(aka COLONOSCOPY)	18679
Colonoscopy every 1 year	18747
Colonoscopy every 2 years	18748
Colonoscopy every 3 years	18749
Colonoscopy every 4 years	18750
Colonoscopy every 5 years	18751
Colonoscopy every 7 years	18776
Colonoscopy every 8 years	18782

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Health Maintenance Overdue Smart Set

Auto suggested based on Overdue Status

- Pain Contract, Urine Drug Screen, Naloxone, Zoster, Tetanus, HPV, FOBT, Chlamydia, Influenza, Colonoscopy, Mammography, Bone Density, Hep C, Cholesterol, Pneumococcal Vaccine, PSA, Pap Smear, AAA, DM urine micro albumin, DM eye exam, DM A1c

Due Date	Topic	Frequency	Date Completed
01/28/1992	Pneumococcal PPSV23 (Medium Risk) (1)	Sequential	
08/01/2017	Influenza Vaccine	9 month(s)	
03/09/2023	Lipid Panel	5 year(s)	3/9/2018 1/27/2015
01/27/2025	TETANUS VACCINE	10 year(s)	1/27/2015

Opioid Monitoring SmartSets Meds & Orders

Walmart Pharmacy 1353 - HARAHAN, LA - 5110 JEFFERSON HWY Remove End Sign

Overdue Health Maintenance

Health Maintenance

- Influenza click for more
- Pneumococcal Vaccination
 - Pneumococcal Conjugate Vaccine (13 Valent) (IM) Details
 - Pneumococcal Polysaccharide Vaccine (23 Valent) (SQ/IM)
 - Need for pneumococcal vaccination [Z23]
- Follow Up
 - Follow Up click for more
- Additional SmartSet Orders

Search

You can search for an order by typing in the header of this section.

Walmart Pharmacy 1353 - HARAHAN, LA - 5110 JEFFERSON HWY

Associate Edit Multiple Providers Remove End Sign

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Use of Care Coordination Notes

Allows Communication Between HRA visit and Primary Care visit
Tremendously Useful to Close Care Gaps

Care Coordination Note A summarized plan of care for the patient and all providers

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Topic	Date Due
• TETANUS VACCINE	08/29/1958
• DEXA SCAN	08/29/1980
• Zoster Vaccine	08/29/2000

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EPIC Healthy Planet Registry List

Asthma	Headache
ACO	HIV
All Wellness (Adult)	HTN
ALS	IBD
Chronic Benzodiazepine Use	ICU Stay
Breast Cancer Screening	Lung Cancer
Cancer Survivorship	Lupus
Cervical Cancer Screening	Multiple Sclerosis
Chronic Care Management	Obesity
CKD	Chronic Opioid Use
Chronic Liver Disease	Outpt Case Management
Hep C	Osteoporosis
COPD	Readmissions
Colorectal Cancer Screening	Tobacco
Complete Joint Replacement	All Wellness (Peds and Male/Female by age)
CHF	Wound Care
Diabetes	Payor Based – MSSP, BC/BS, Cigna, PHN, Humana

Population Health Registries

Bulk Orders and Bulk Outreach

Bulk Orders/Outreach Schedule

	Patients	Bulk Orders	Outreach			Outreach Type
DM Registry	71,854	Weekly	Quarterly	April/July/Oct		Portal/Mail
Mammo	50,000	Weekly	Monthly	Aug/Sept/Oct/ Nov/ Dec		Portal/Mail
DM Disease Mgt Program	604	Weekly	Weekly	July		Engagement Specialist
CKD	26,623	Weekly	Weekly	July		Portal/Engagement Specialist
CRS	50,000	Fit/Kit	Monthly	October		Mail
CCS						
CLD	150,000	Twice	Once	July/August		Portal/Mail
HTN	193,302					
Tobacco	252,540					

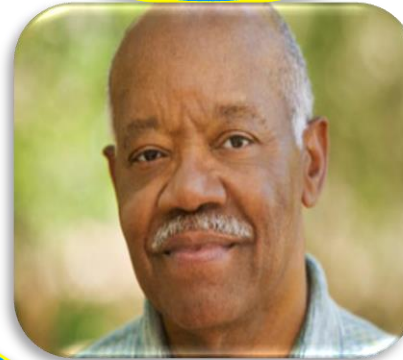
Population Health Cycle

Identify Care Gaps

Pre Visit Work



Orders placed using the
Primary Care
Written Order Guidelines



Visit Work

Close care gaps

Population Work

Registry work –place bulk orders and patient notifications

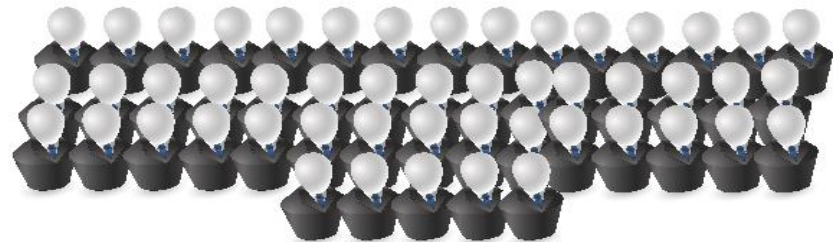
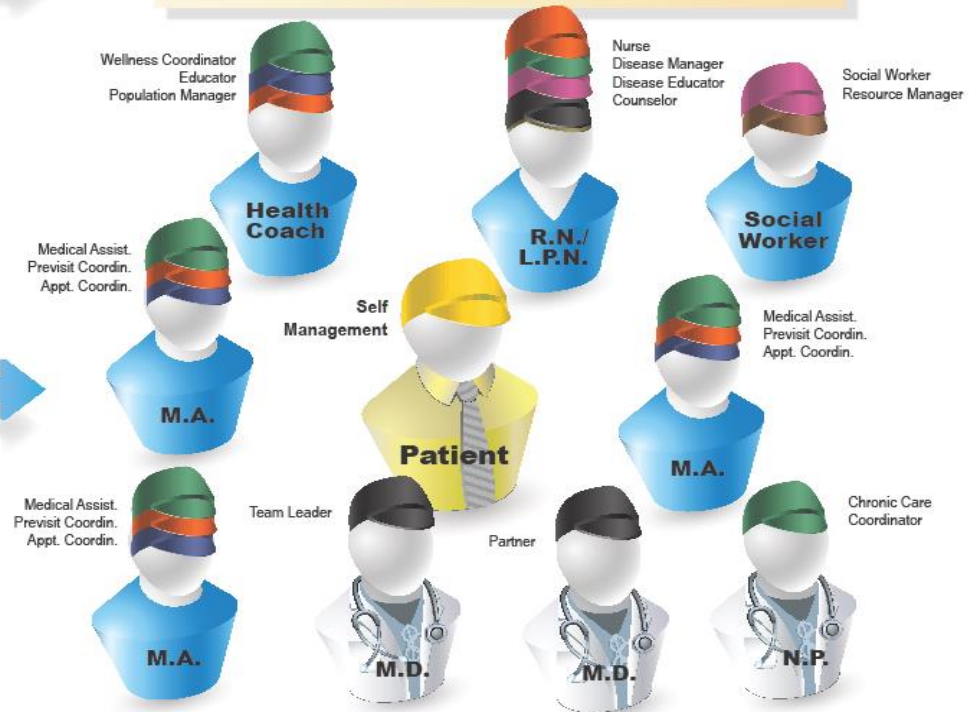
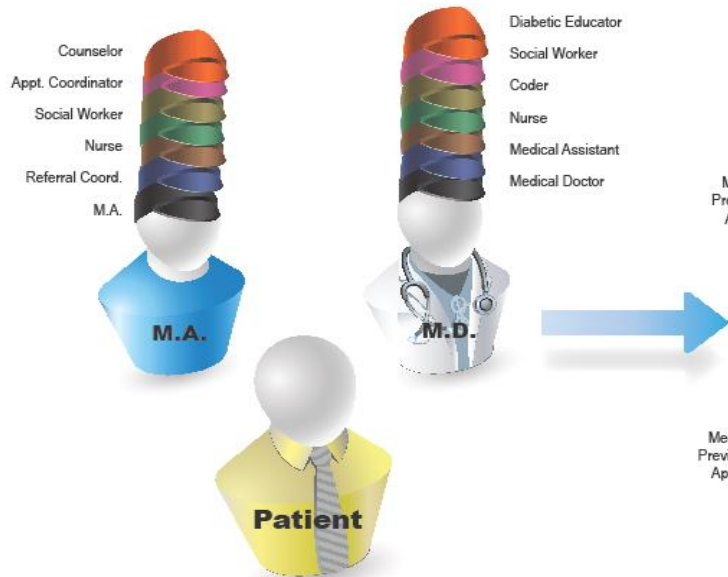


Evolution of Primary Care at Ochsner

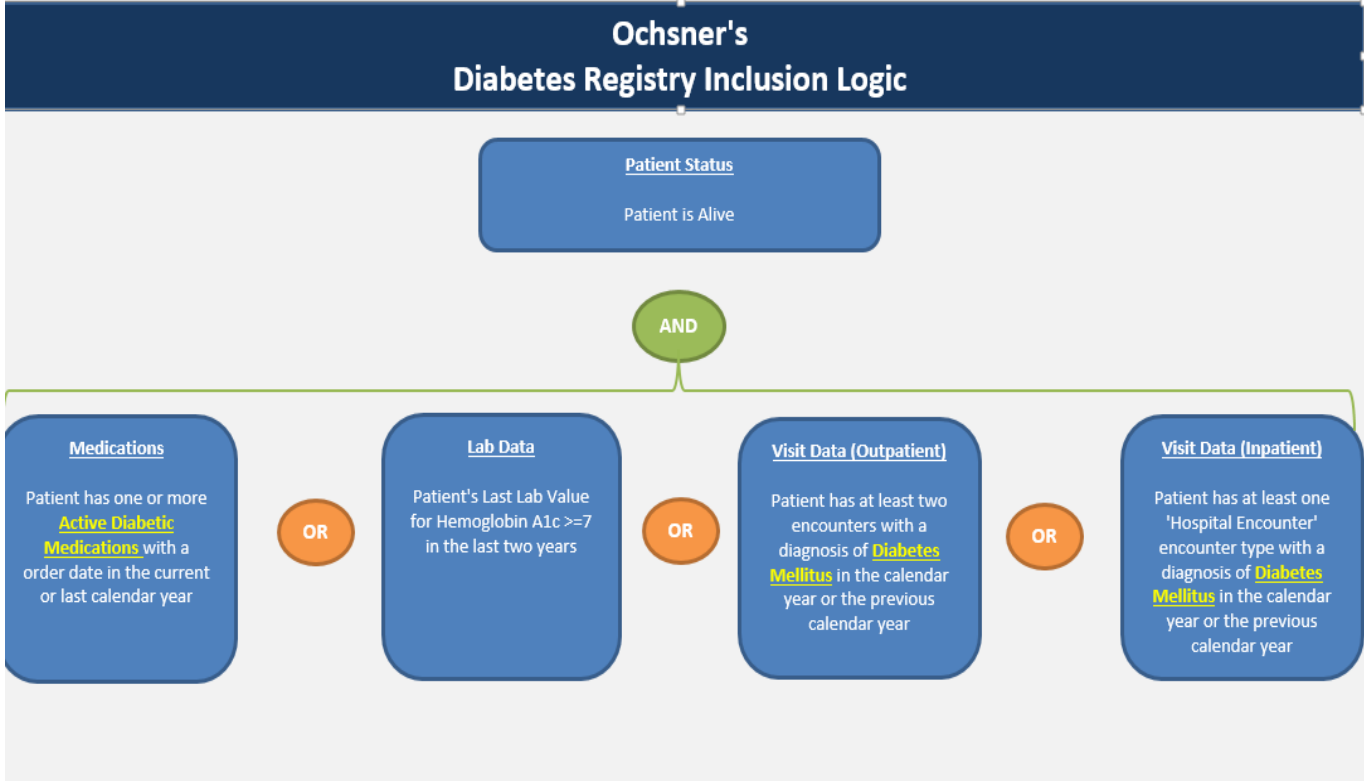
ENCOUNTER-BASED CARE



**ENCOUNTER-BASED CARE +
POPULATION-BASED CARE + DISEASE-BASED CARE +
PREVENTIVE + WELLNESS**



Diabetic Registry: Inclusion Criteria



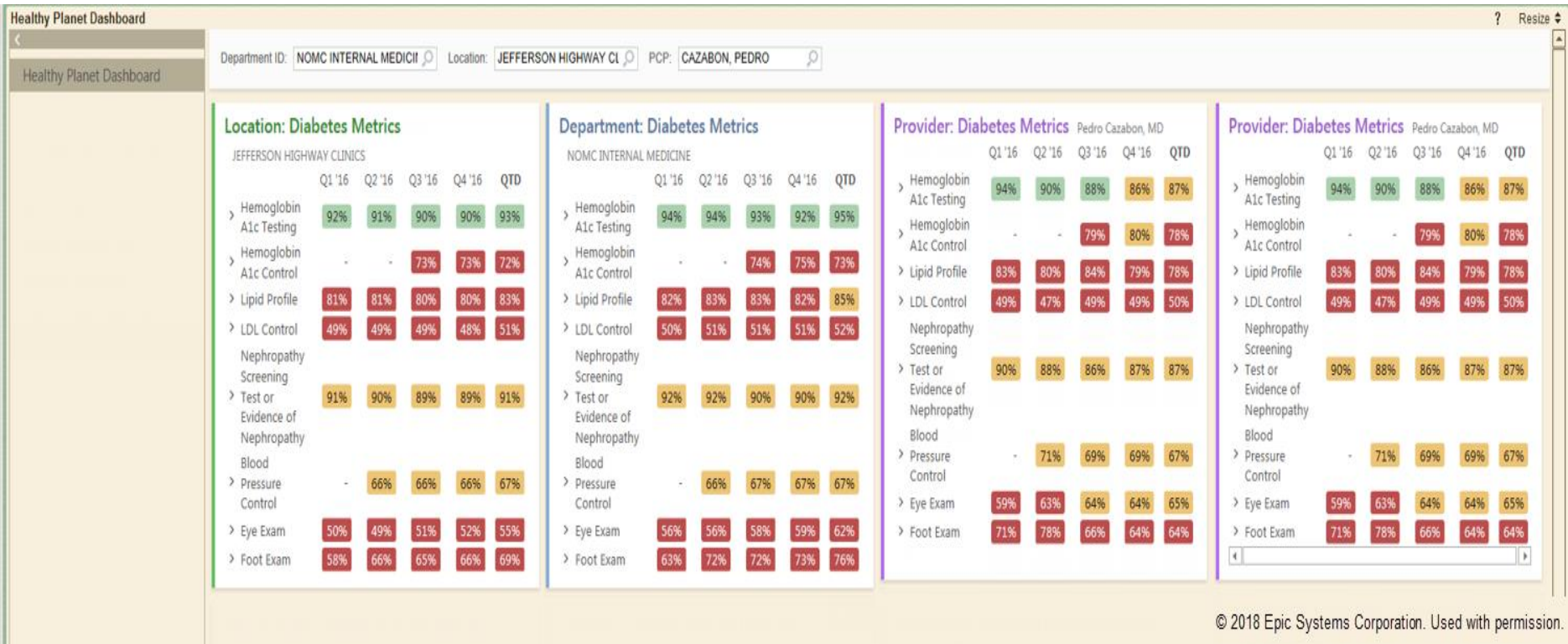
Diabetic Registry Metrics

- Hemoglobin A1C testing
- Hemoglobin A1C control <8
- LDL testing
- LDL control < 100
- BP control <140/90
- Nephrology screening
- Retinal Eye Exam
- Foot Exam
- Statin Medication

Diabetes Registry: My Panel Metrics

- This metrics calculates the percentage of patients 18 to 75 years of age in the registry who had a hemoglobin A1c (HbA1c) testing done within the last 12 months. This metric references specific lab values and health maintenance activity for the last testing date.
- Data is update/refreshed daily
- Metrics are a rolling 12 months

Analytics: Dashboards



Physician Scorecard Reports: DM Registry

Healthy Planet - ST TAMMANY WEST REGION YTD October 19 2016

DIABETES M. MEASURES	Covington	Abita Springs	Mandeville	STW Region (AVG)	OHS	GOAL	5 Star	4 Star	3 Star
Panel Size	2541/15438	336/3428	303/2366				Cut Points		
Hemoglobin A1C Testing	96%	98%	96%	97%	91%	88%	88-100	80-87	0-79
Hemoglobin A1C control	77%	77%	74%	76%	71%	86%	86-100	80-85	0-79
Lipid Profile	88%	94%	88%	90%	82%	91%	91-100	85-90	0-84
LDL Control	50%	51%	46%	37%	47%	62%	62-100	53-61	0-52
Nephropathy Screening	93%	93%	93%	93%	90%	94%	94-100	85-93	0-84
Blood Pressure Control	66%	72%	80%	73%	66%	75%	75-100	63-74	0-62
Eye Exam	55%	48%	42%	48%	48%	77%	77-100	64-76	0-63
Foot Exam	72%	82%	62%	73%	66%	90%	90-100	70-89	0-69
Covington	Orange	Brown	Black	White	Red	Yellow	Cov. TG (AVG)	GOAL	
Panel Size	357/1826	189/1044	8 out of 82	295/1603	309/1759	231/1362	1389/7676		
Hemoglobin A1C Testing	95%	95%	100%	97%	97%	93%	96%	88%	
Hemoglobin A1C control	77%	73%	84%	78%	80%	72%	77%	86%	
Lipid Profile	83%	83%	100%	91%	92%	73%	87%	91%	
LDL Control	43%	51%	50%	57%	59%	39%	50%	62%	
Nephropathy Screening	88%	92%	100%	94%	90%	82%	91%	94%	
Blood Pressure Control	60%	56%	34%	68%	72%	68%	60%	75%	
Eye Exam	63%	48%	50%	56%	67%	47%	55%	77%	
Foot Exam	66%	70%	84%	66%	79%	59%	71%	90%	
Covington	Purple	Green	Purple	Pink	Blue		Cov. MC (AVG)	GOAL	
Panel Size	394/2599	208/1339	89/586	317/2089	145/1153		1153/7766		
Hemoglobin A1C Testing	98%	96%	97%	97%	98%		97%	88%	
Hemoglobin A1C control	83%	77%	80%	77%	84%		80%	86%	
Lipid Profile	96%	96%	92%	90%	90%		93%	91%	
LDL Control	60%	43%	63%	52%	50%		54%	62%	
Nephropathy Screening	94%	99%	97%	94%	96%		96%	94%	
Blood Pressure Control	67%	81%	63%	66%	60%		67%	75%	
Eye Exam	58%	75%	50%	47%	52%		56%	77%	
Foot Exam	74%	82%	78%	71%	80%		70%	88%	

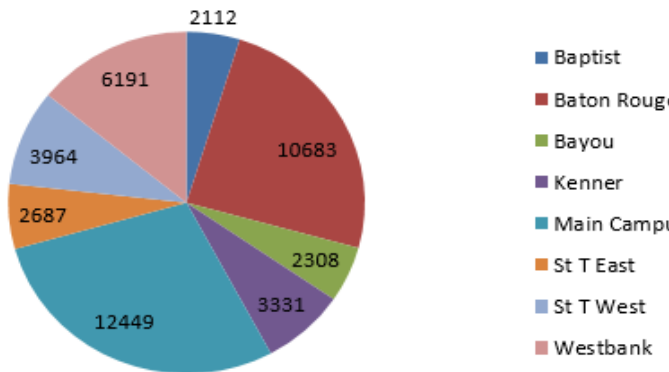
St. Tammany West

Diabetic Registry Outreach Outcomes

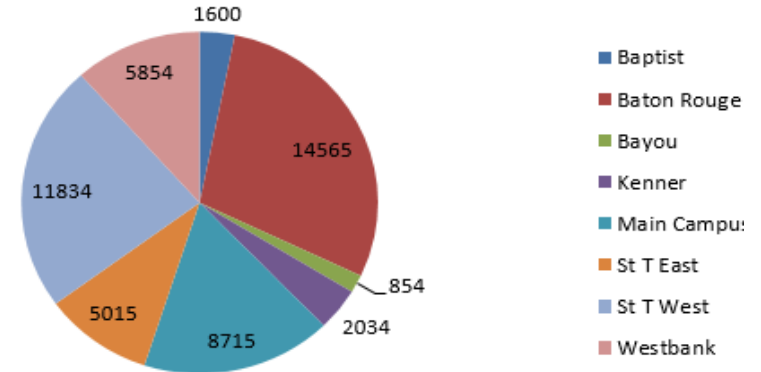
January – December 2016

REGIONS	Registry # Patients	Outreach Count	Patients Receiving Outreach	Labs/Tests Completed	Unique # of Patients Completing Labs	Avg # of Labs/Tests Completed per Pt	% of Patients Completing Labs
Baptist	2112	837	568	1600	452	3.54	79.6%
Baton Rouge	10683	6849	4158	14565	3499	4.16	84.2%
Bayou	2308	665	310	854	256	3.34	82.6%
Kenner	3331	1210	701	2034	578	3.52	82.5%
Main Campus	12449	4469	2791	8715	2372	3.67	85.0%
St T East	2687	2298	1397	5015	1215	4.13	87.0%
St T West	3964	7372	2855	11834	2691	4.40	94.3%
Westbank	6191	3945	2089	5854	1746	3.35	83.6%
Totals	43725	27645	14869	50471	12809	3.94	86.1%

Registry # Patients



Labs/Tests Completed



Bulk Orders Placed and Completed

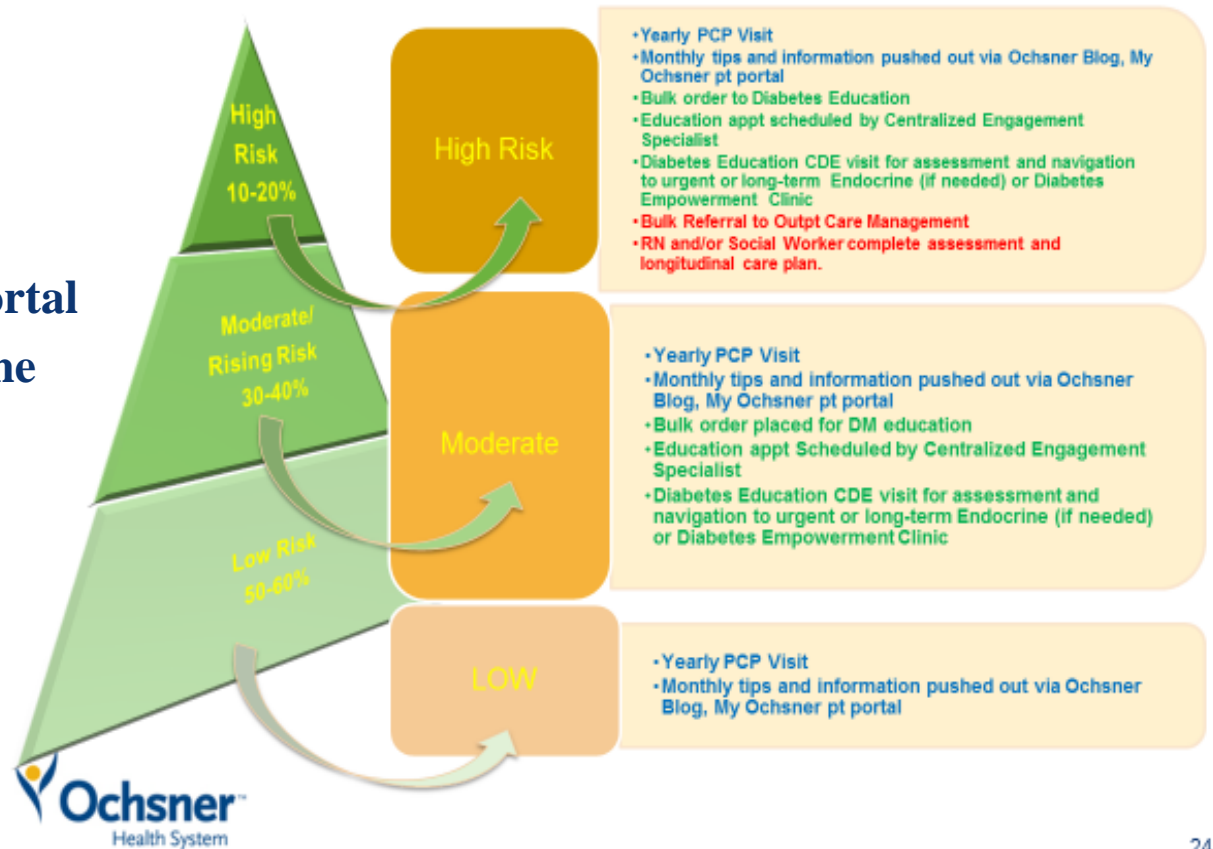
as of end of 2017, over 21,300 care gaps closed

	Mammogram	Fit Kit	A1c	Lipid Panel	Microalbumin
Ordered	11,864	13,855	15,342	9,580	8,677
Resulted	1,167	1,115	8,885	5,405	4,807

Diabetes Management Program

- Risk Stratification
- WOG Ordering
 - DM Education
 - Outpatient Case Management
- Push DM Education via Portal
- DM Education Telemedicine

Interventions



Pilot Data DM Education

- 60.9% of 218 referred patients attended diabetes education
- Results to date on A1c control: n=62 pts with f/u A1c

	# Patients	Entry A1c	Post-pilot A1c (2-6 mo)
Total	62	8.41%	7.6%
High Risk	12	11.57%	8.29%
Mod Risk	50	7.7%	7.3%

- *Increase: Slidell's diabetes educator overall total unique patient volume*

(across all payers)

2015	178 Patients
2016	496 patients

Diabetes Education offered through Telemedicine Clinic

Key points

- Telemedicine in own primary care office
- Scheduled at the remote location and on the diabetes educator's regular schedule.
- Patient checks in at their normal primary care clinic.
- Computer with two monitors and 1 camera
- All education materials, demo pens, meters, etc... stored at the remote location
- Remote location has clinical staff to assist during teaching.
- Remote site weighs the patient
- Remote site does the diabetes distress scale
- Remote site sets up the call via Jabber.
- Remote site after the visit checks the patient out, provides additional materials and schedules follow up.
- Billable as we are an ADA recognized education program at \$79.00/30 min.
- Blood sugar logs and Bluetooth technology allows educator to see blood sugar trends between visits
- Linked Devices available via O-Bar

Comments

- "I had such a good time"
- "I can do this"
- "I can't wait to go home and try what I have learned"
- "So glad that this service is offered"
- "When can I see you again"

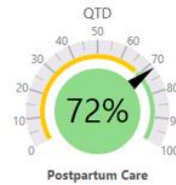
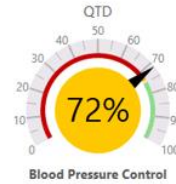
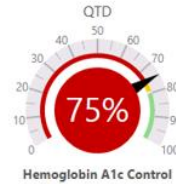
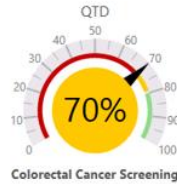
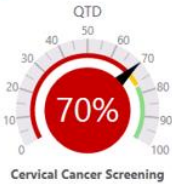
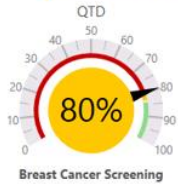


Overall Ambulatory Metrics - Dashboard

Service Area

Quality Measures OCHSNER SERVICE AREA

Service Area:



Provider

Quality Measures ⁵ Steven J. Granier, MD

PCP:

Breast Cancer Screening

This metric calculates the percentage of female patients in the primary care department in the last 2 years. To-date values were last processed on: 6/10/2018.

[View Graph](#)

[My Patients Missing Breast Cancer Screening](#)

[Click here for more information on this measure.](#)

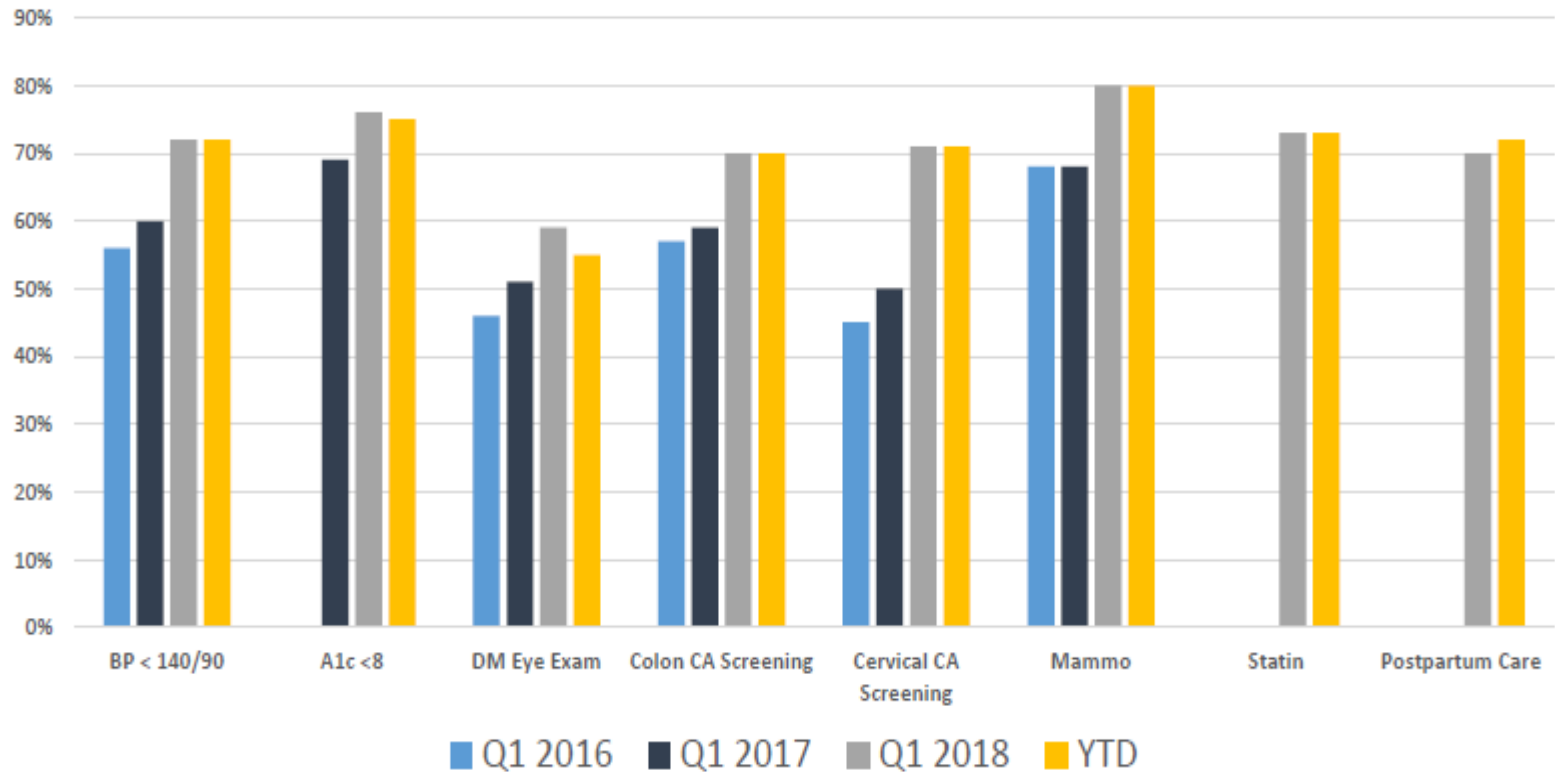
My Patients Missing Cervical Cancer Screening [33805816] as of Wed 6/13/2018 12:15 PM

Age	PCP	Next Primary C	Last PCP visit	Last Pap Smear [ap Smear Due Date	Pt Comm Pref	Pt. Portal Status
25 y.o.	Todd L. Burstain, MD		12/07/2017		04/12/2014		Activated

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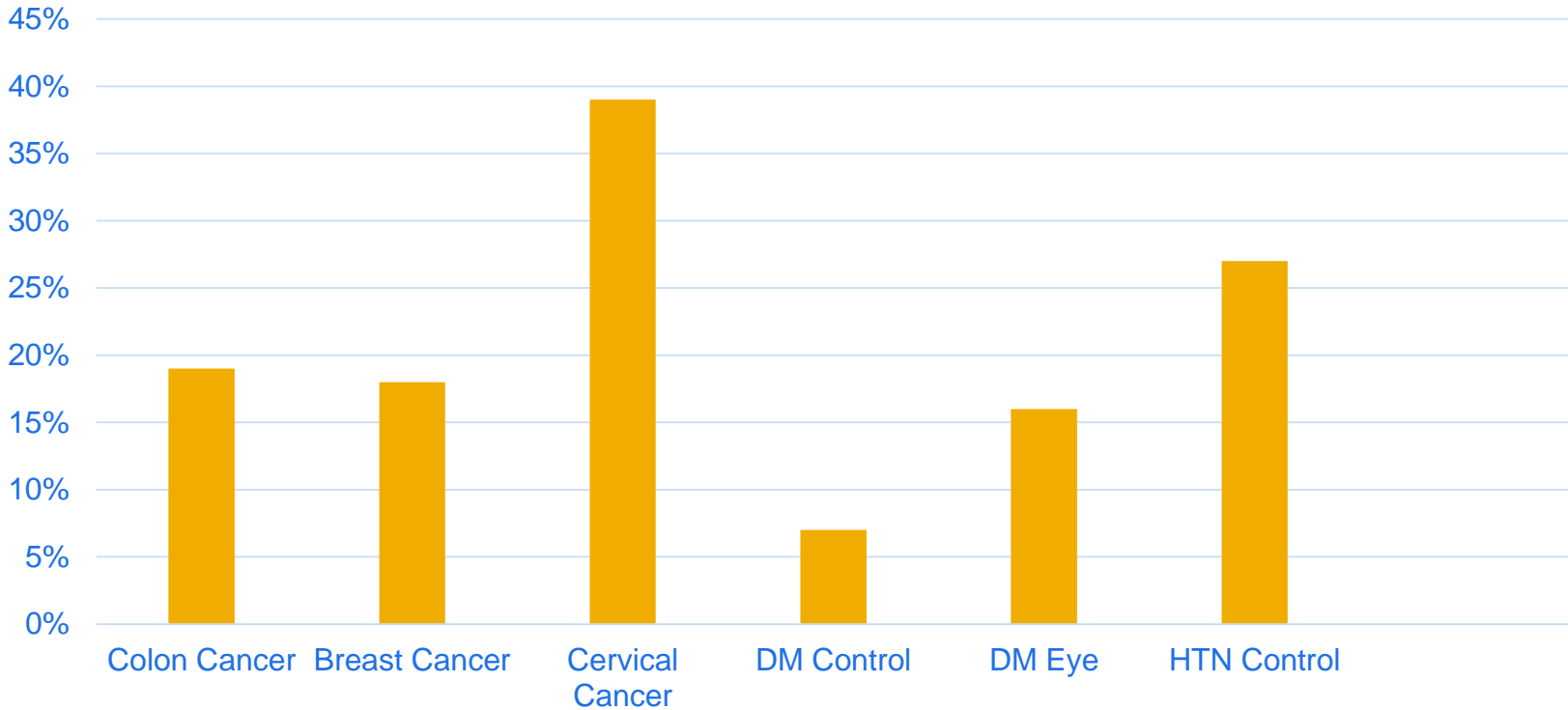
Maximizing Current Tools and Resources

Significant Improvements in Ambulatory Quality 2016-2018

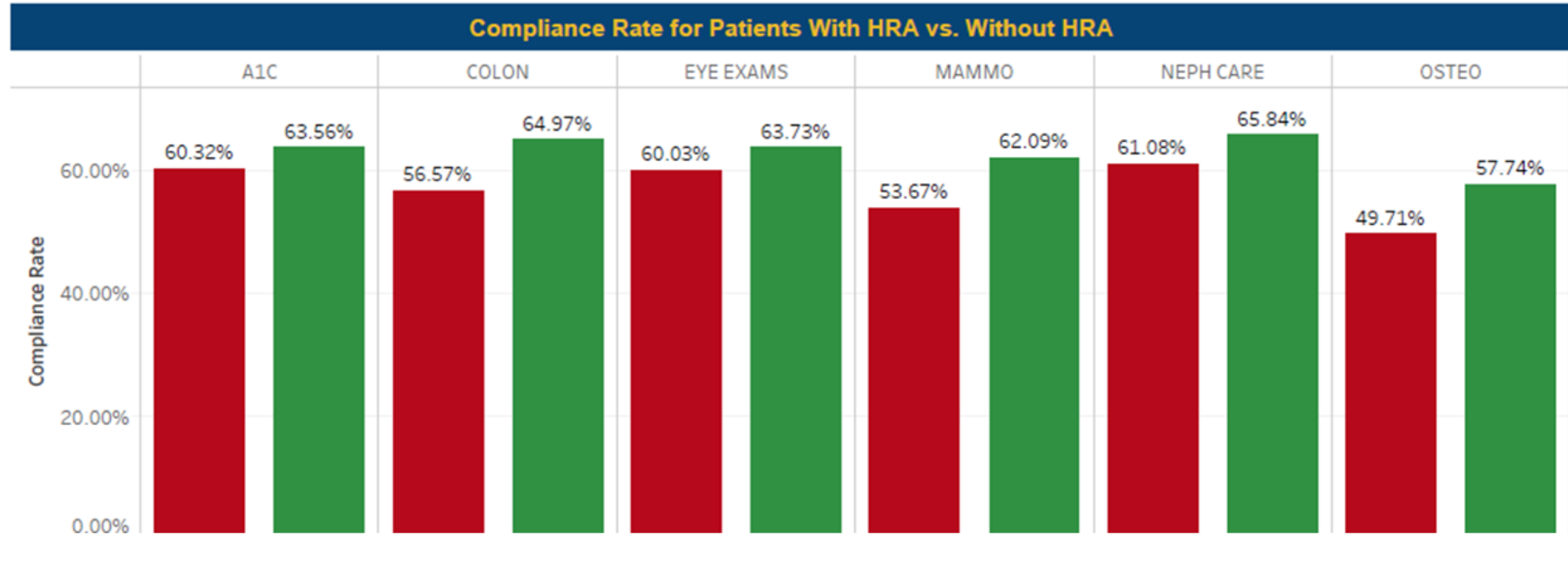


2017 Ambulatory Quality Improvements in Results


YoY Absolute % Increase 1/2017 vs 1/2018





Value of HRA Visit



Active Diagnosis Review

☰ Active Diagnosis Review (HCC) (Refresh to see most accurate data) 

Current Problems

✓ COPD (chronic obstructive pulmonary disease) [J44.9]	
✓ Diabetes mellitus [E11.9]	

[Mark as Reviewed](#)

Last reviewed by Todd L. Burstain, MD on 6/13/2018 12:04 PM

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Active Diagnosis Review Reporting

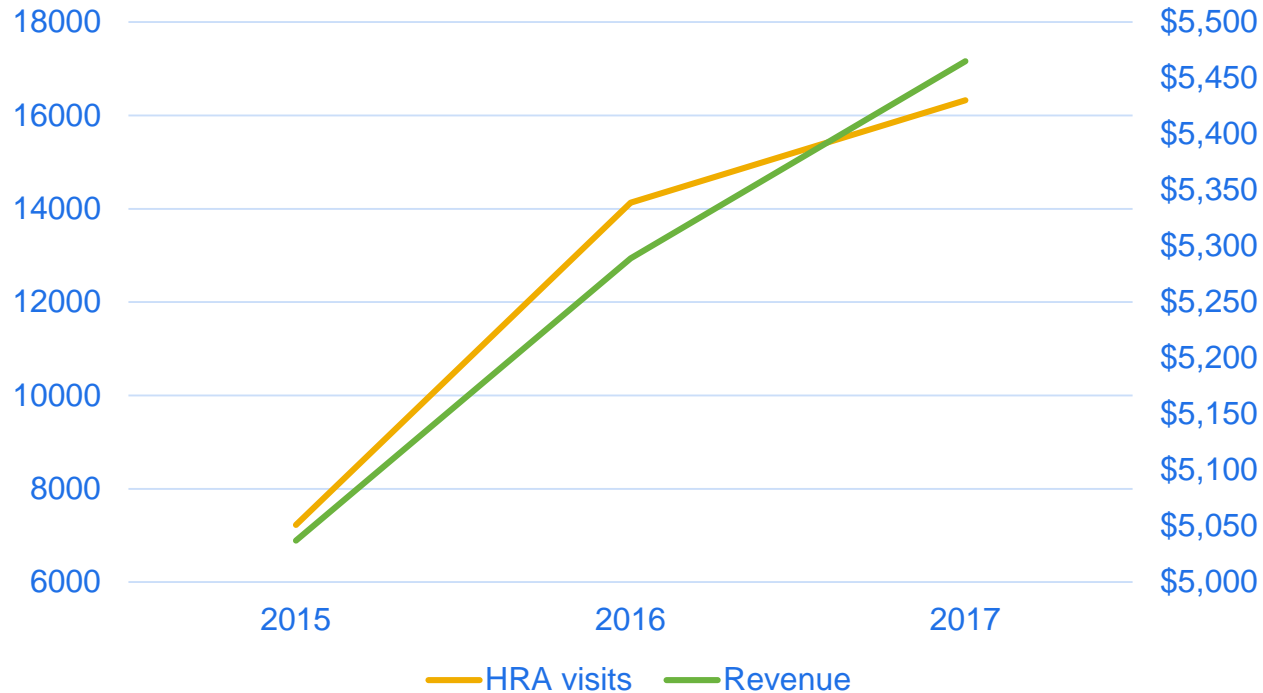
	<u>Percentile Rank (YTD)</u>	<u>Open HCC Capture (Last 14 Days)</u>
CARSTARPHEN, KATHY JO	99	100.00%
BRAGG, JAMES W. JR	98	100.00%
BLAKE, LESLIE A.	96	100.00%
BREAULT, JOSEPH L.	95	92.31%
CRUZ, BRIAN R.	91	100.00%
GRANIER, STEVEN J.	90	90.91%
MCQUEEN, MATTHEW A.	89	91.43%
LEARY, GLORIA M.	85	86.67%
CAZABON, PEDRO	83	93.33%
DENTON, GERALD D. II	83	100.00%
JOHNSON, KRISTIN S.	80	88.89%
IVESTER, ROBIN H.C.	77	0.00%
EPSTEIN, NONA K.	75	78.57%
DEGRANGE, CHRISTIE V.	70	80.00%
BRAATEN, JENNIFER N.	67	53.85%
BONNER, KIRK L.	62	30.00%
FERNANDEZ, SARA E.	62	
NGUYEN, LE	55	
YU, MARY	50	47.06%
MCCORMICK, MARY L.	48	78.57%
DVORIN, EVAN L.	38	83.33%

Impact of HRA Visits

Average HCC 1.04 to 1.22 (17.3% Increase)

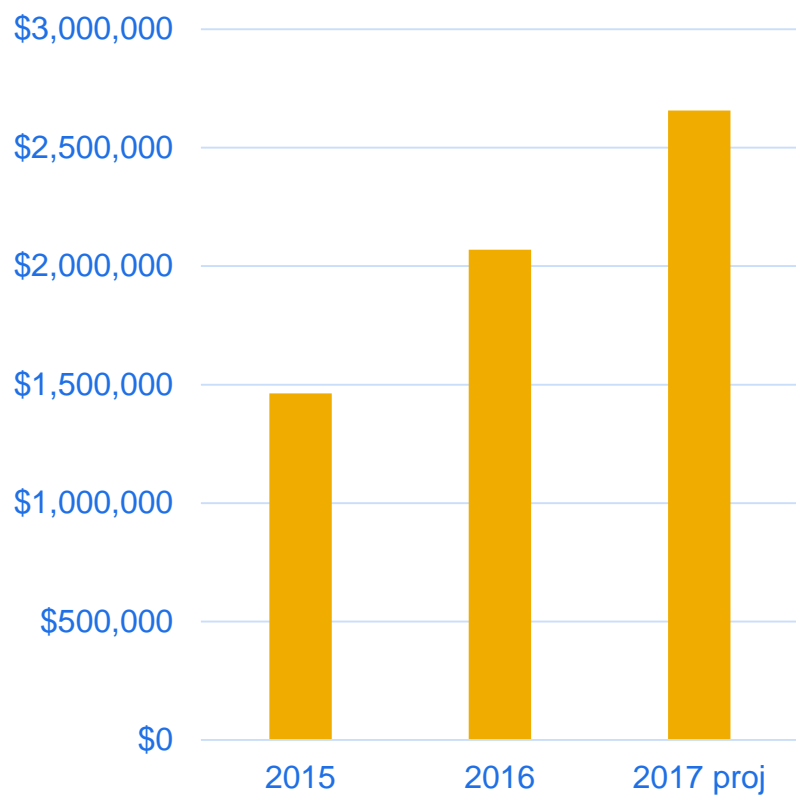
\$6.9 million/yr in pts with HRA visits

Total Improved Opportunity Gap over 3 years per Humana - \$22 million/yr

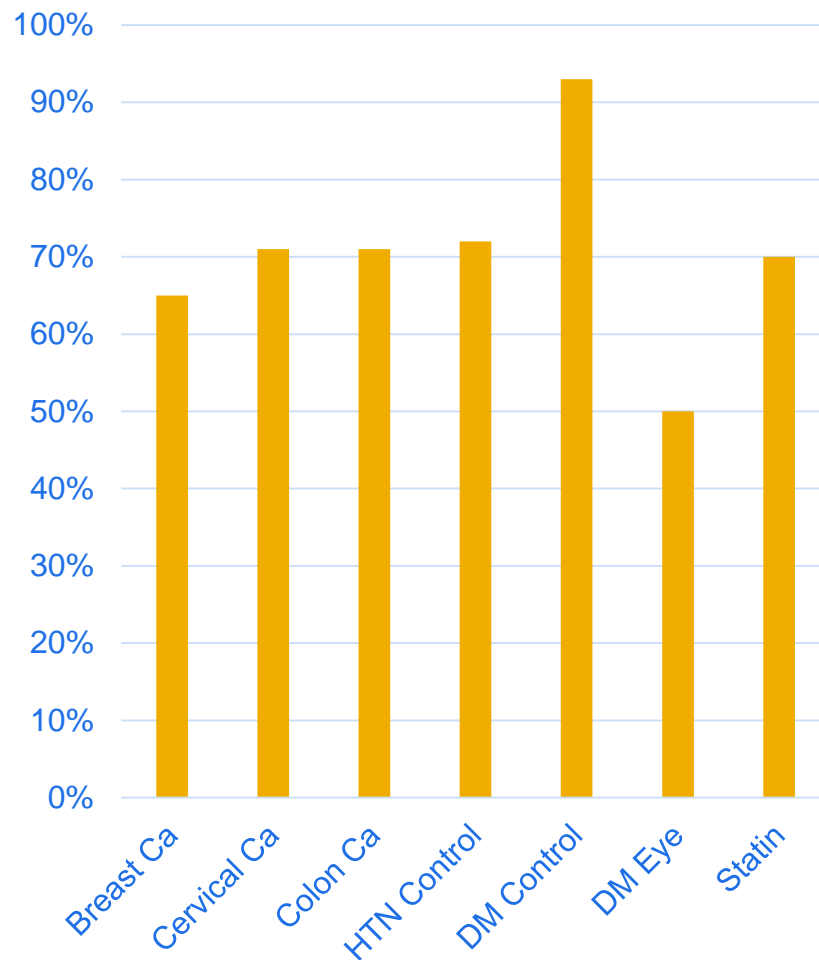


Financial Impact of Value Based Contracts (42,691 pts)

QBPC Payments



Current Data



Care Harmony Integration

Over 620 patients contacted

- Patients in MSSP Registry
 - 2 more chronic conditions
 - Demographics sent to Care Harmony platform
- Patients engaged in Care Harmony
 - Summary of care/recommendations sent to Epic media tab
 - Charges sent to Epic for submission for visit

Evolution of Medicine

- **19th century medicine – Treat symptoms**
- **20th century medicine – Treat diseases**
- **21st century medicine – Maintain health**
 - Predict
 - Prevent
 - Personalize
 - Precision
 - Pre-natal
 - Pediatrics
 - Policy
 - Patient centered
 - Participatory
 - Population Health

Capturing the Data

Financial Resource Strain

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

Food Insecurity

Within the past 12 months, you worried that your food would run out before you got money to buy more.

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

Transportation Needs

In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?

In the past 12 months, has lack of transportation kept you from meetings, work, or getting things needed for daily living?

Relationships

Social Connections

In a typical week, how many times do you talk on the phone with family, friends, or neighbors?

How often do you get together with friends or relatives?

How often do you attend church or religious services?

Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups?

How often do you attend meetings of the clubs or organizations you belong to?

Are you now married, widowed, divorced, separated, never married or living with a partner?

Intimate Partner Violence

Within the last year, have you been afraid of your partner or ex-partner?

Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?

Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?

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Capturing the Data

Financial Resource Strain

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

Not hard at all Not very hard Somewhat hard Hard Very hard Patient refused

Food Insecurity

Patient refused all

Within the past 12 months, you worried that your food would run out before you got money to buy more.

Never true Sometimes true Often true Patient refused

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

Never true Sometimes true Often true Patient refused

Transportation Needs

Patient refused all

In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?

Yes No Patient refused

In the past 12 months, has lack of transportation kept you from meetings, work, or getting things needed for daily living?

Yes No Patient refused

Relationships

Social Connections

Patient refused all

In a typical week, how many times do you talk on the phone with family, friends, or neighbors?

Never Once a week Twice a week Three times a week More than three times a week Patient refused

How often do you get together with friends or relatives?

Never Once a week Twice a week Three times a week More than three times a week Patient refused

How often do you attend church or religious services?

Never 1 to 4 times per year More than 4 times per year Patient refused

Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups?

Yes No Patient refused

How often do you attend meetings of the clubs or organizations you belong to?

Never 1 to 4 times per year More than 4 times per year Patient refused

Are you now married, widowed, divorced, separated, never married or living with a partner?

Married Widowed Divorced Separated Never married Living with partner Patient refused

Intimate Partner Violence

Patient refused all

Within the last year, have you been afraid of your partner or ex-partner?

Yes No Patient refused

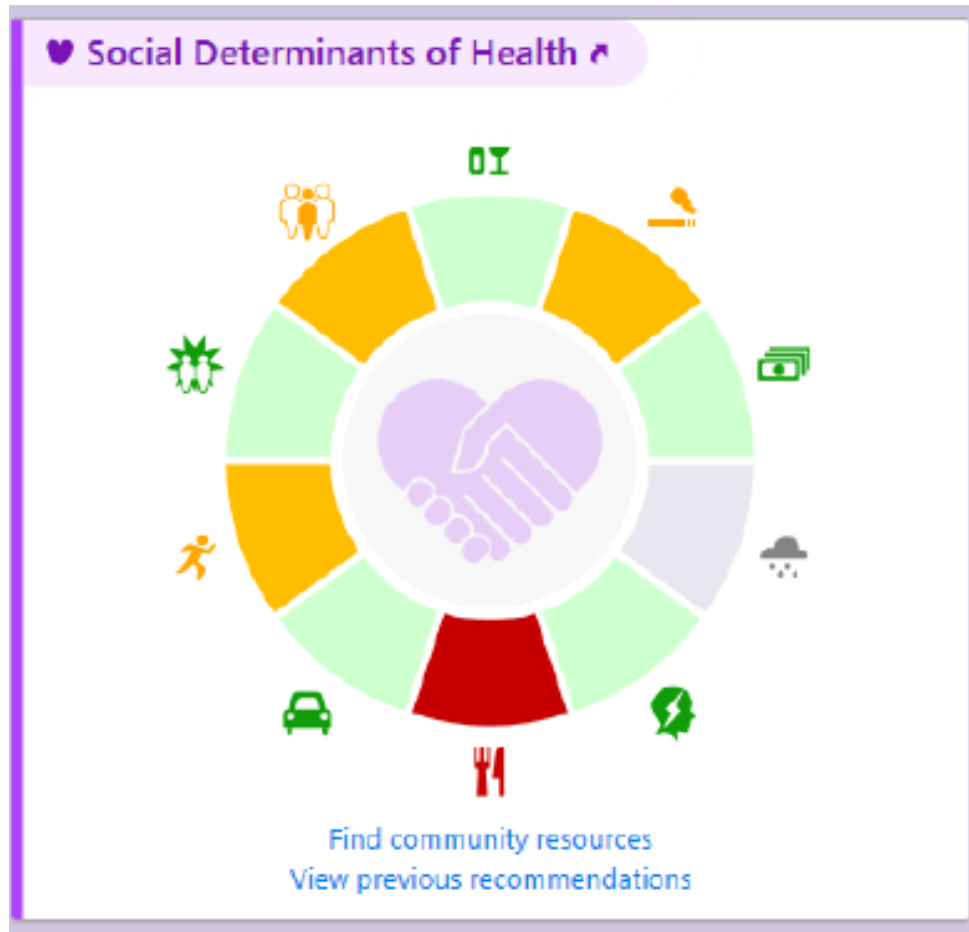
Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?

Yes No Patient refused

Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?

Yes No Patient refused

Social Determinants of Health



Social History

Social Determinants

- Substance and Sexuality
- Socioeconomic
- Lifestyle
- Relationships
- Social Documentation

- Alcohol
- Tobacco
- Financial
- Depression
- Stress
- Food Insecurity
- Transportation
- Mobility
- Family Conflict/Instability
- Social Connections/Resources

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Linking to Community Campaigns



Find food, health, housing and employment programs in seconds.

Zip

1446 programs
serve people in
New Orleans, LA (70118)

Type a search term, or pick a category

The screenshot shows the Ochsner Community Connection website interface. At the top, there is a search bar with the text "Zip or keyword or program name" and a search icon. Below the search bar is a navigation menu with icons for various categories: FOOD, HOUSING, GOODS, TRANSIT, HEALTH, MONEY, CARE, EDUCATION, WORK, and LEGAL. The current page is titled "New Orleans, LA (70118) / housing / help pay for utilities (15)". There are three filter tabs: "Program Filters", "Personal Filters", and "Income Eligibility". The "Program Filters" tab is active, showing a list of checkboxes for "Open Hours" (Open Now, Open Late, Open Early, Open Weekends, Open 24 Hours) and "Cost" (Free, Reduced Cost). A "Filter Search" button is located below the filters. On the left, there is a map showing the location of the program in New Orleans. On the right, there is a program listing for "Senior Services - Water Assistance" by Total Community Action, Inc. (TCA). The listing includes a "Details & Print" button, "Send to a Friend" and "Save to Favorites" buttons, and a location pin indicating it is 1.51 miles away at 1410 South Jefferson Davis Parkway, New Orleans, LA 70125. The program is marked as "Open Now" from 03:00 AM to 11:30 AM CDT. At the bottom, there is a footer with links for "Suggest Program", "Claim Programs", "Accessibility", "Terms", "Privacy", and "© 2012-2018. Powered by Aunt Bertha."

