Population Health
Davies Site Visit

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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

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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

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

IMPROVED QUALITY	REDUCED COST	BETTER PATIENT EXPERIENCE

• Safety
• Disease Management/Clinical Programming
• Medication Management
• Behavioral Health
• Wellness/Prevention
	• Care Transitions/Post-Discharge Intervention
	  ▹ *ED, Admission/Readmission Avoidance*
	• Complex Care Management
	• Standardized Care Pathways
	• Referral Management
	• Community Partnerships/SNF
		• 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

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Governing Committees

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

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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

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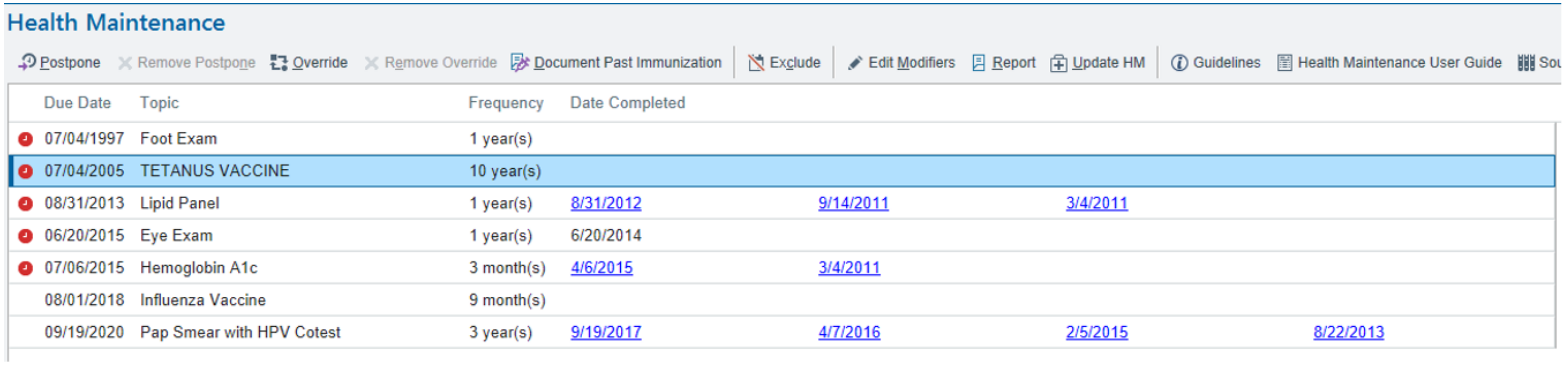
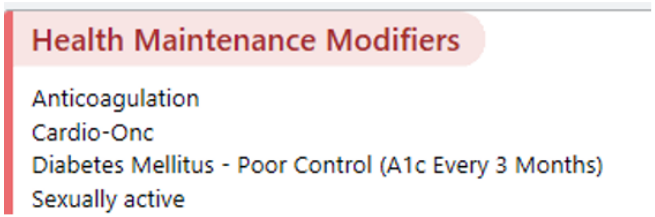
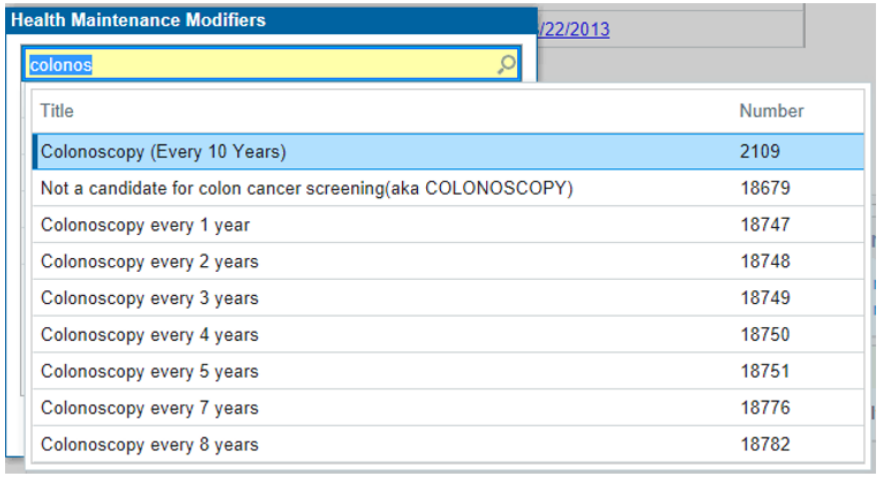
Health Maintenance

Expansion of Preventive Care to include Chronic Disease Management







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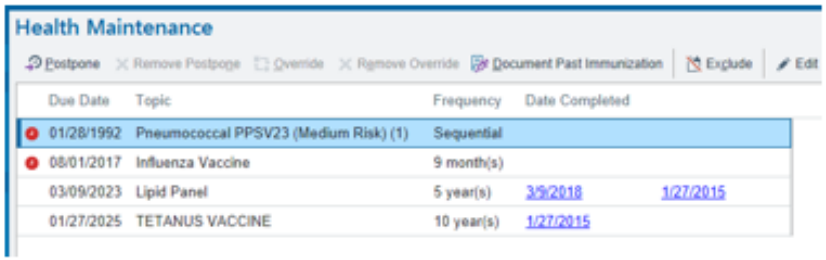
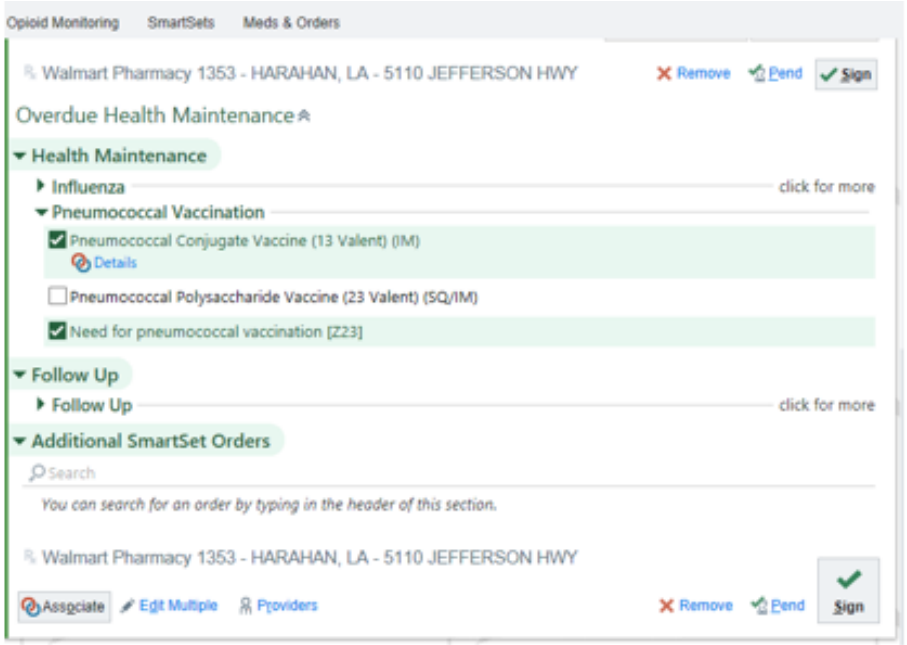
Health Maintenance Overdue Smart Set

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





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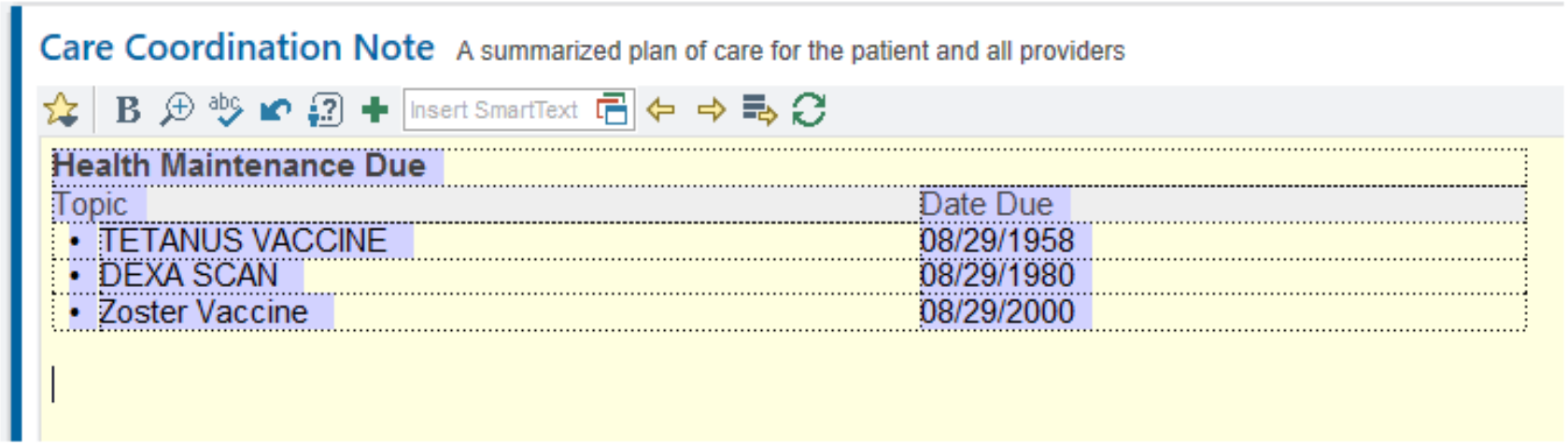
Use of Care Coordination Notes

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



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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

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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				

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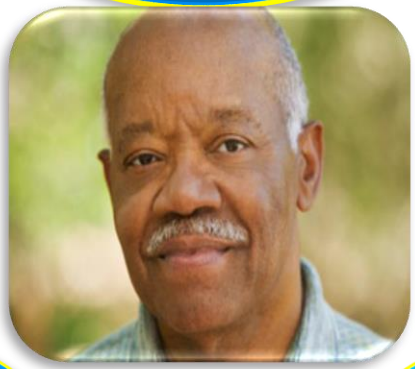
Population Health Cycle

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

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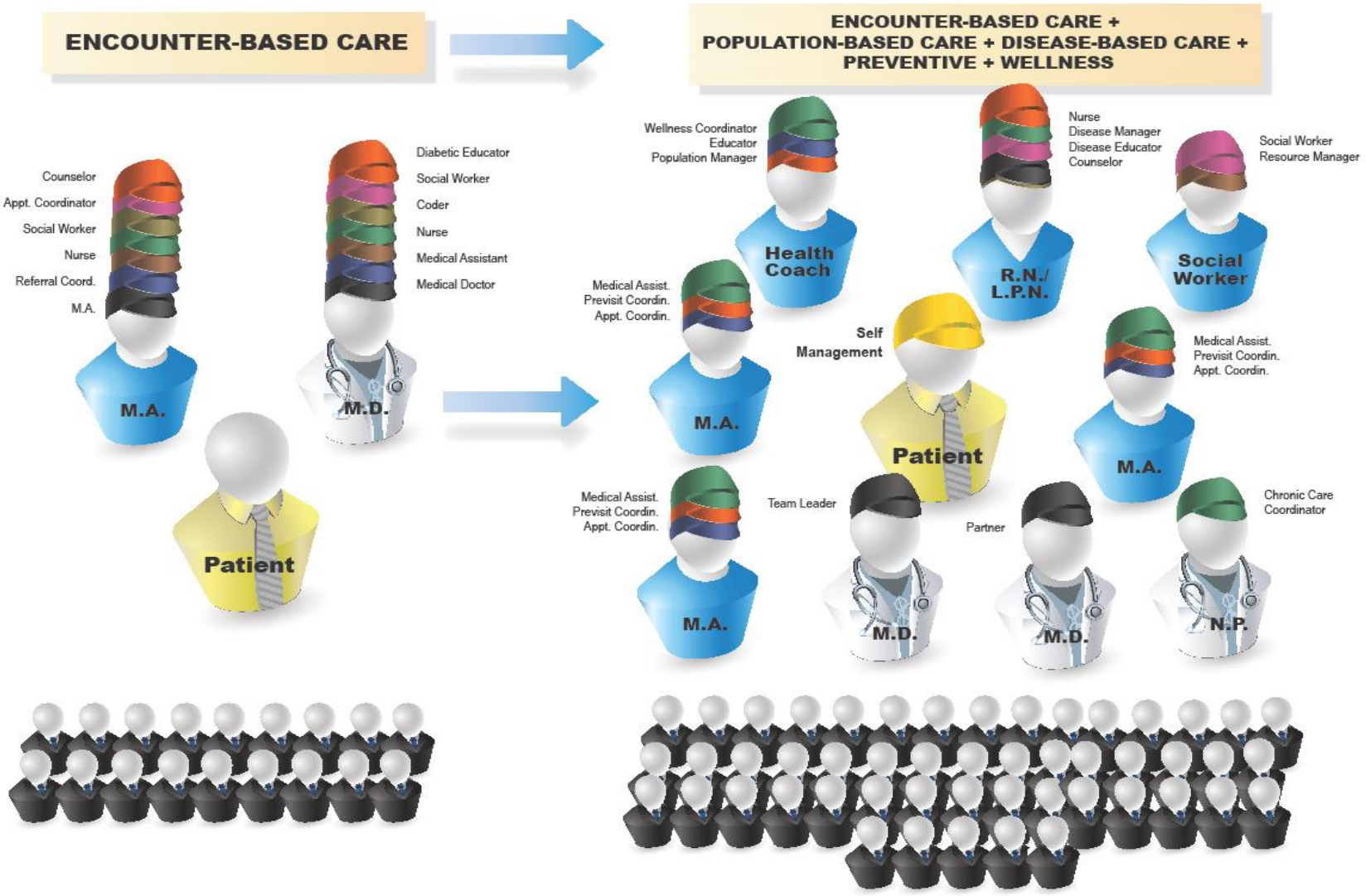
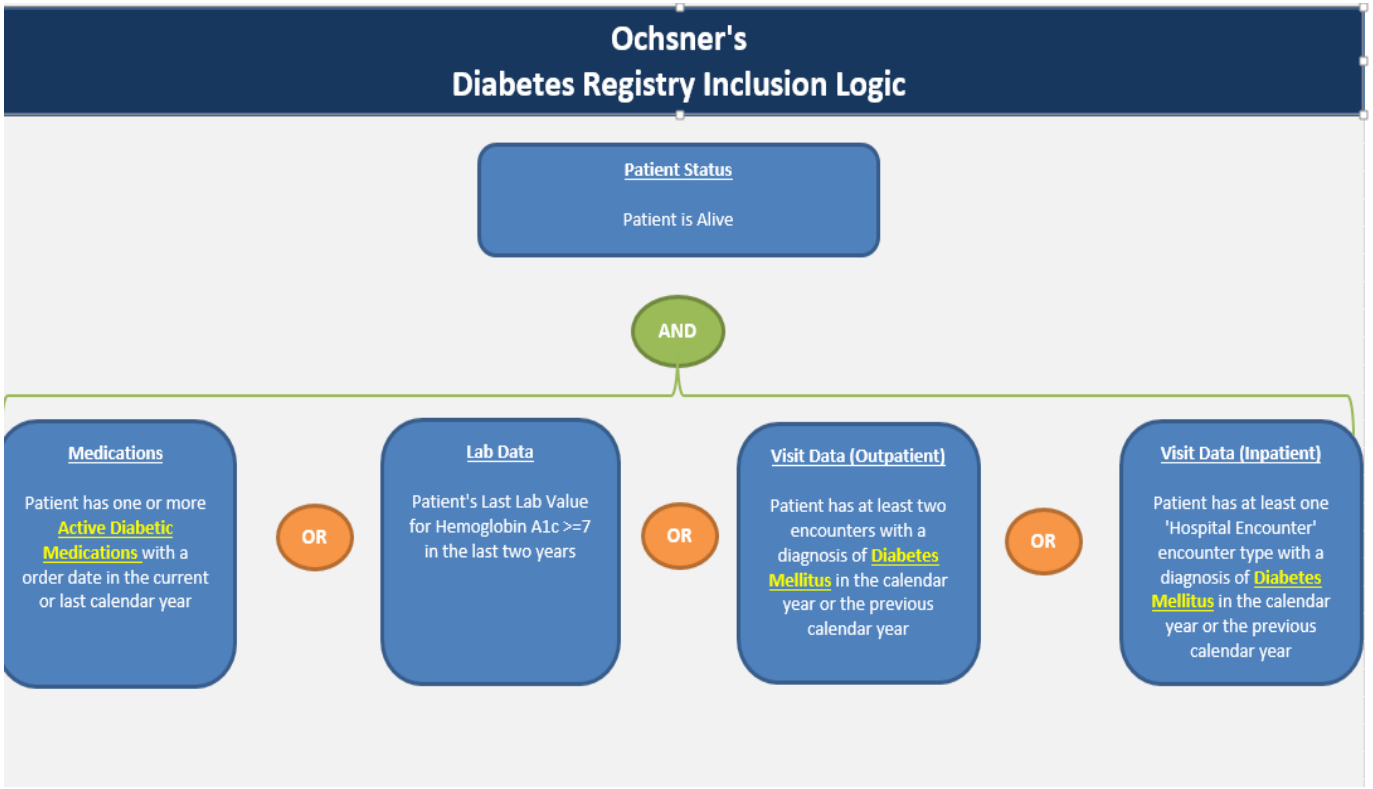
Evolution of Primary Care at Ochsner



Diabetic Registry: Inclusion Criteria



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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

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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

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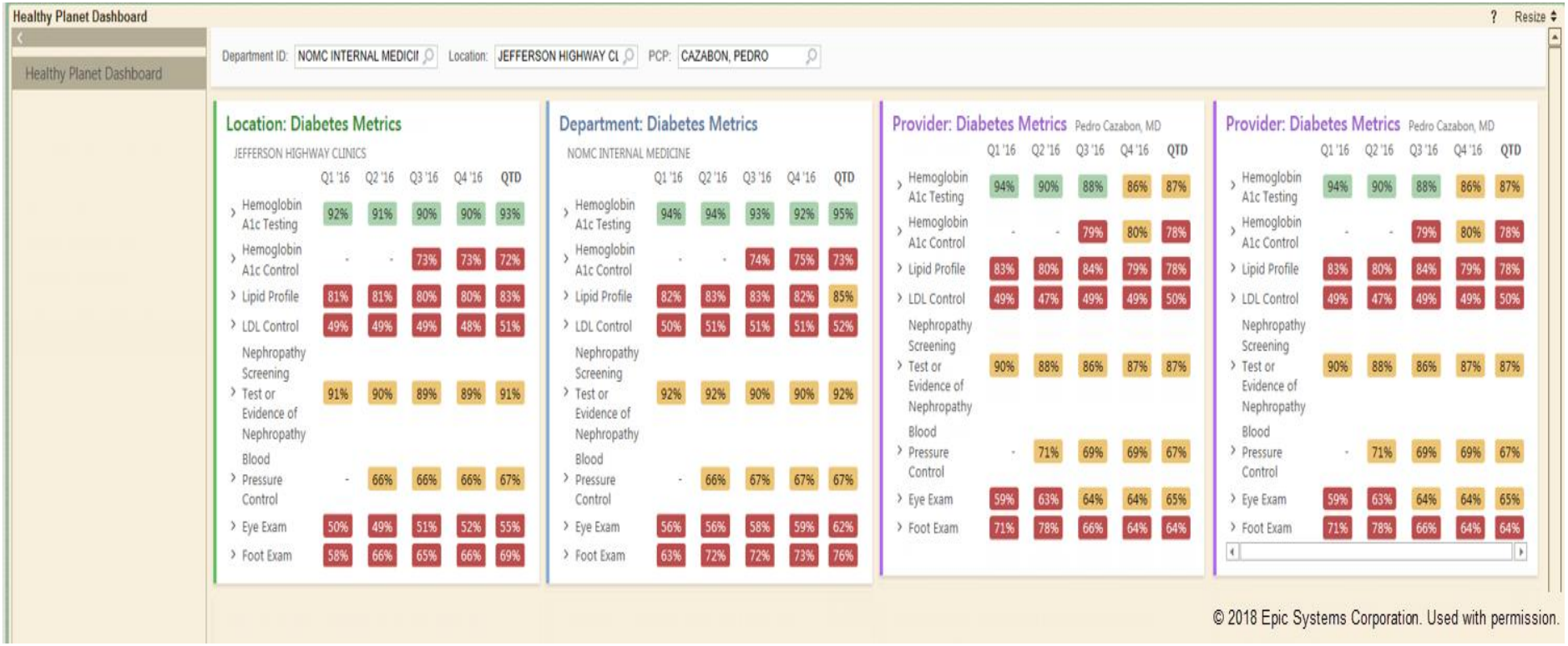
Analytics: Dashboards



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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%	92%	78%	71%	80%		70%	90%

St. Tammany West

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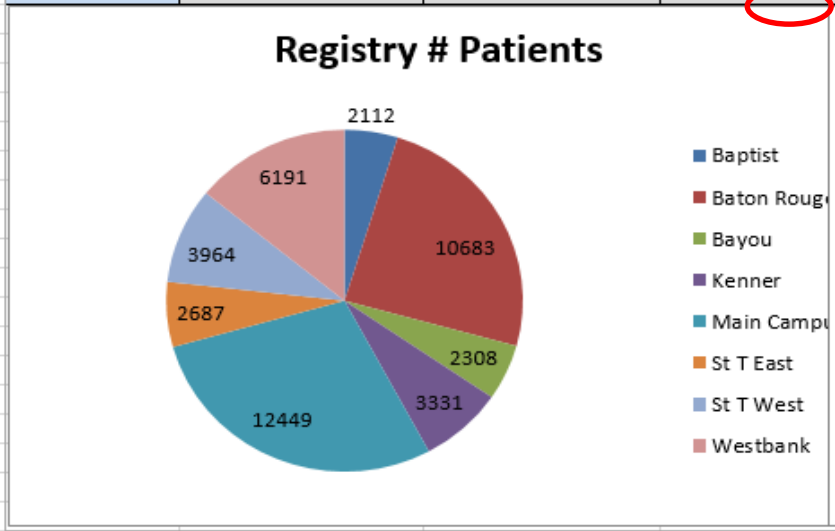
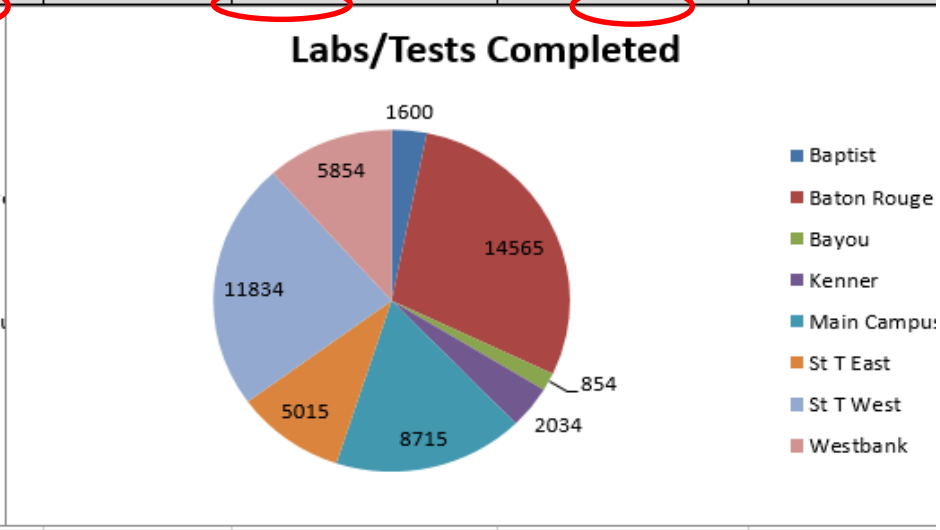
Diabetic Registry Outreach Outcomes

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 Lab
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%





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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

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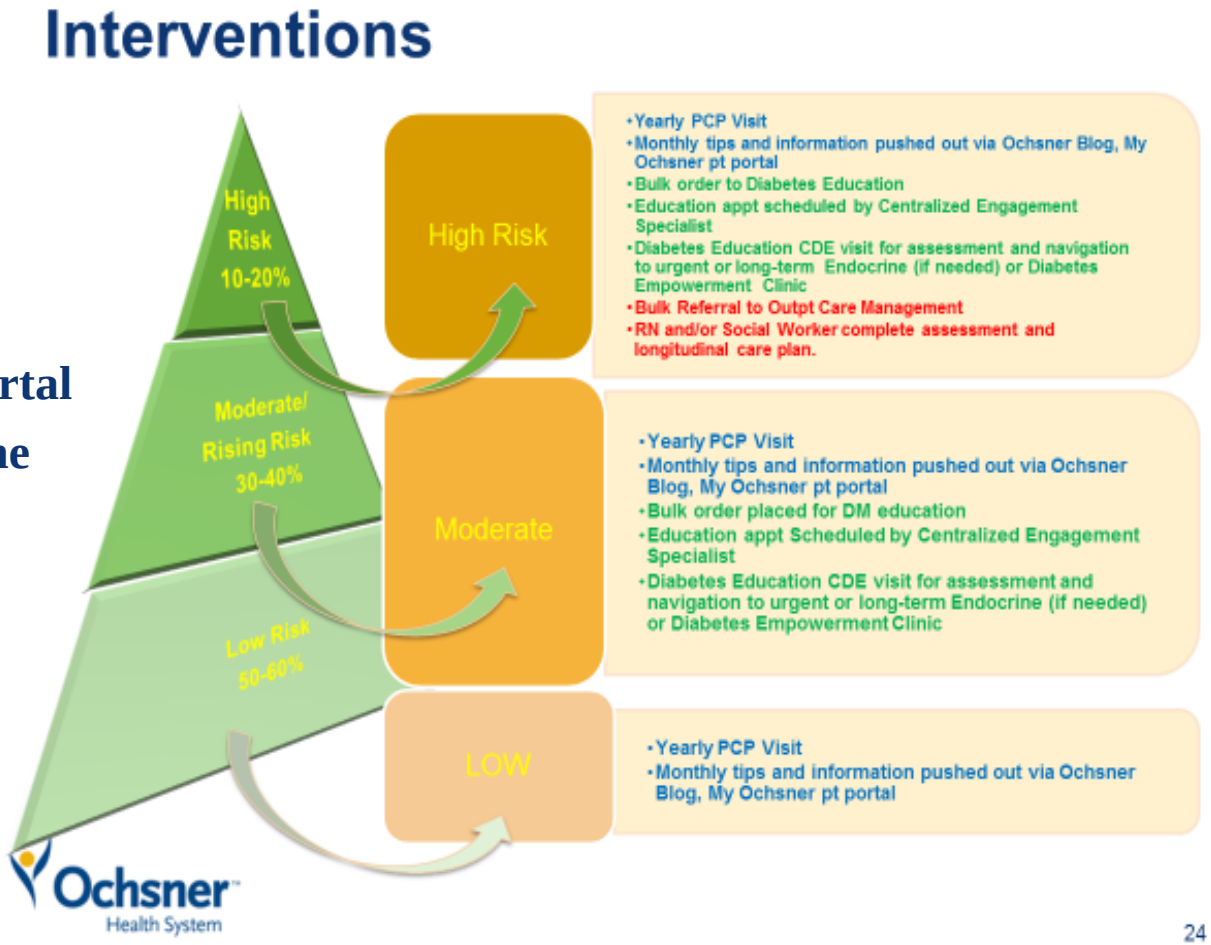
Diabetes Management Program

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



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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

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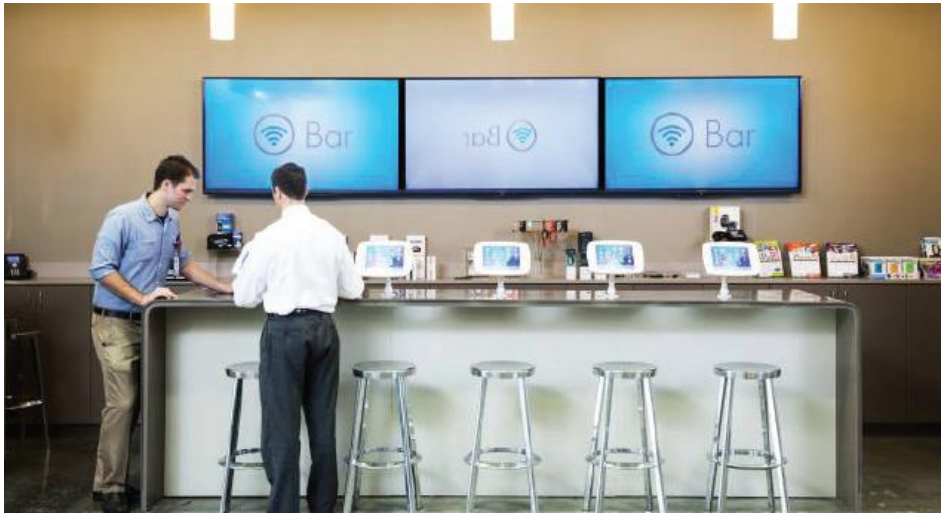
Diabetes Education offered through Telemedicine Clinic

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"



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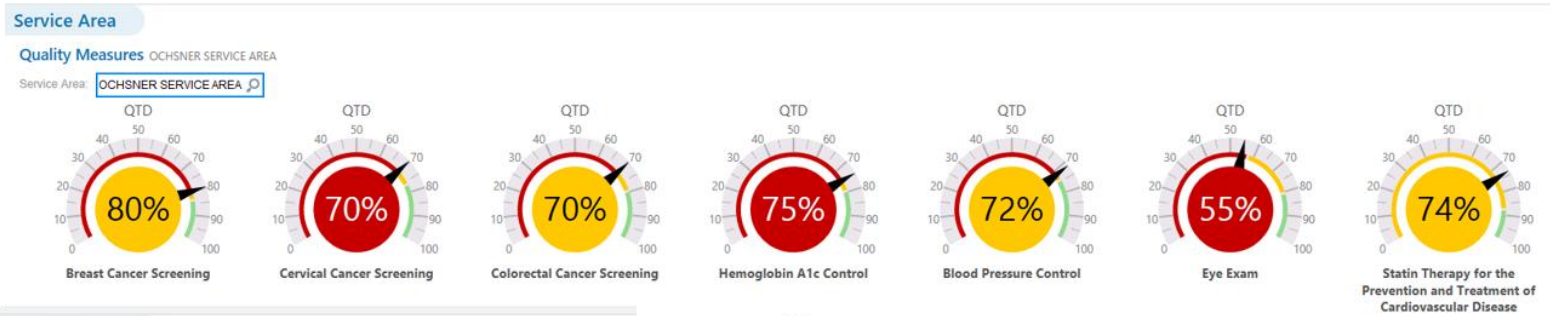
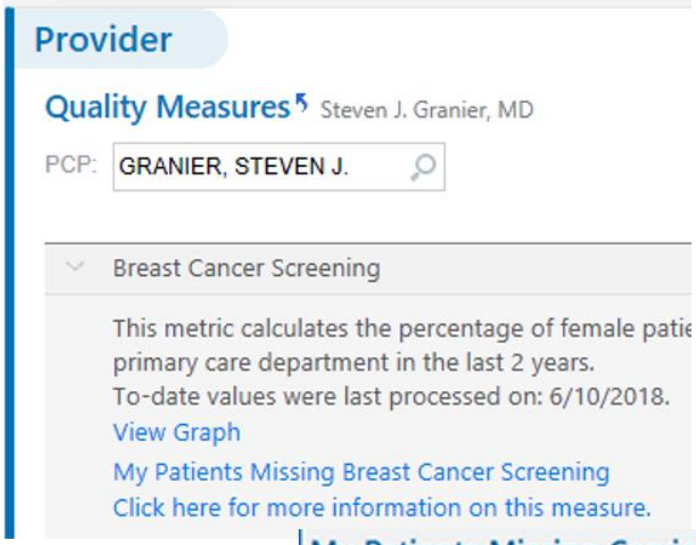
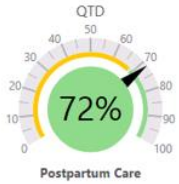
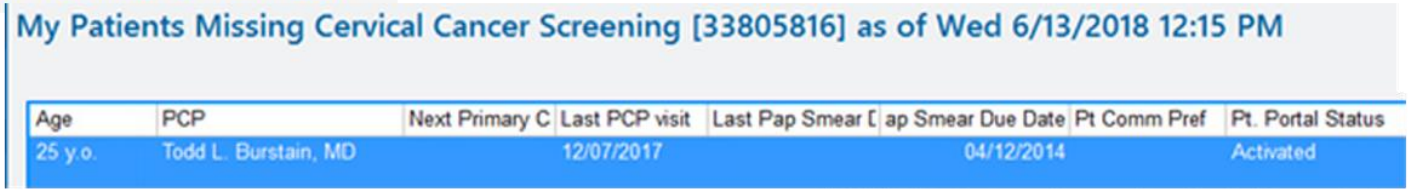
Overall Ambulatory Metrics - Dashboard









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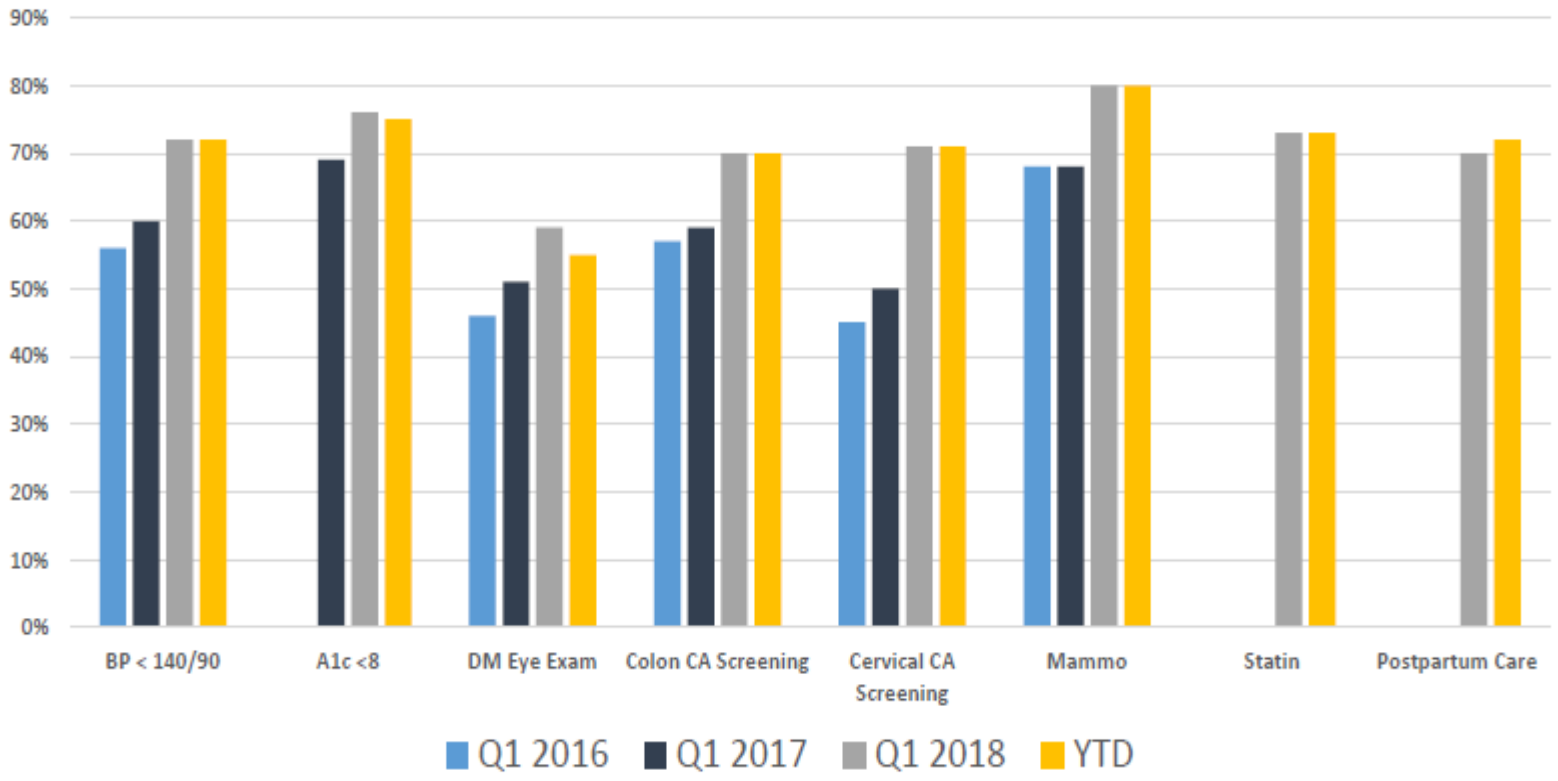
Maximizing Current Tools and Resources

Significant Improvements in Ambulatory Quality 2016-2018



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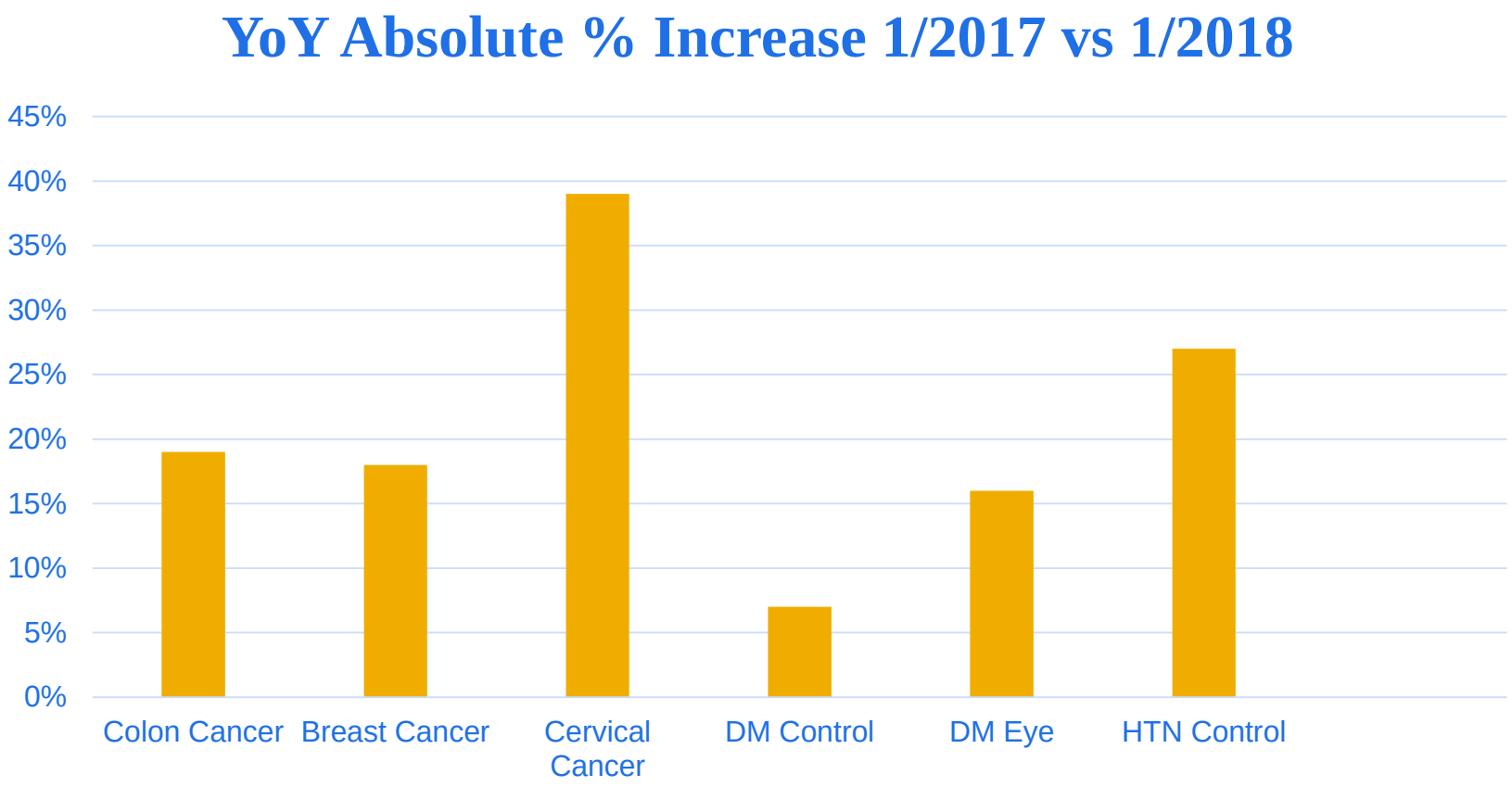
2017 Ambulatory Quality Improvements in Results



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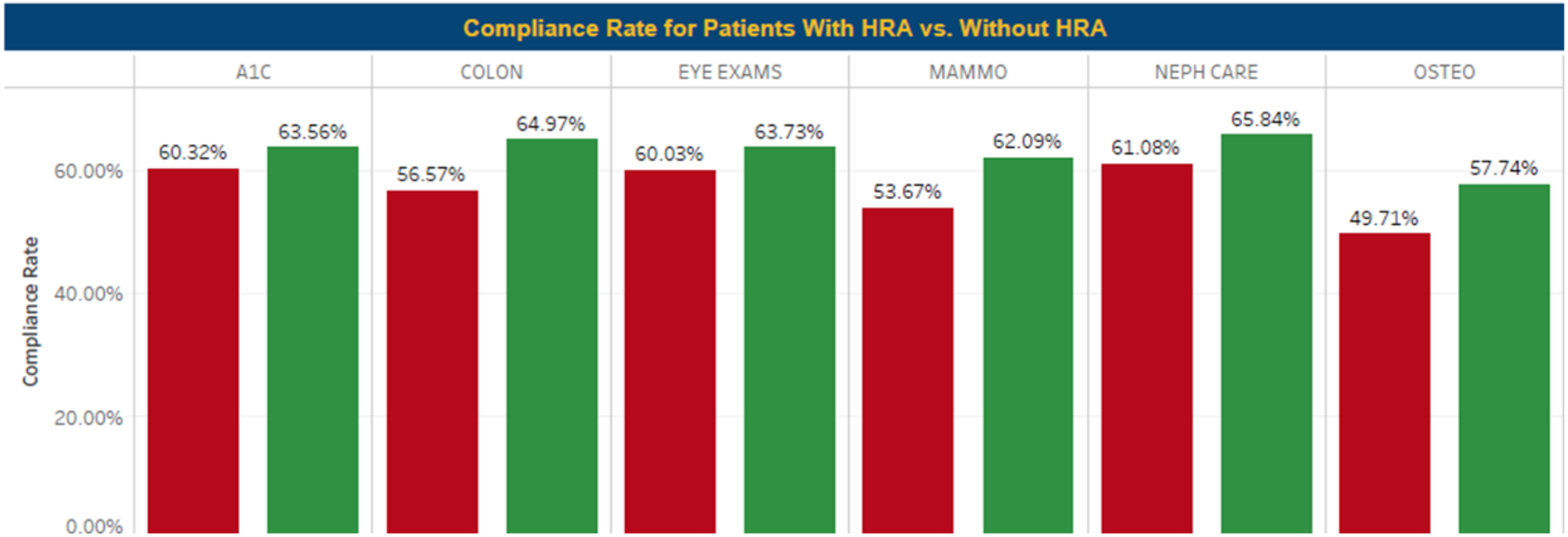
Value of HRA Visit



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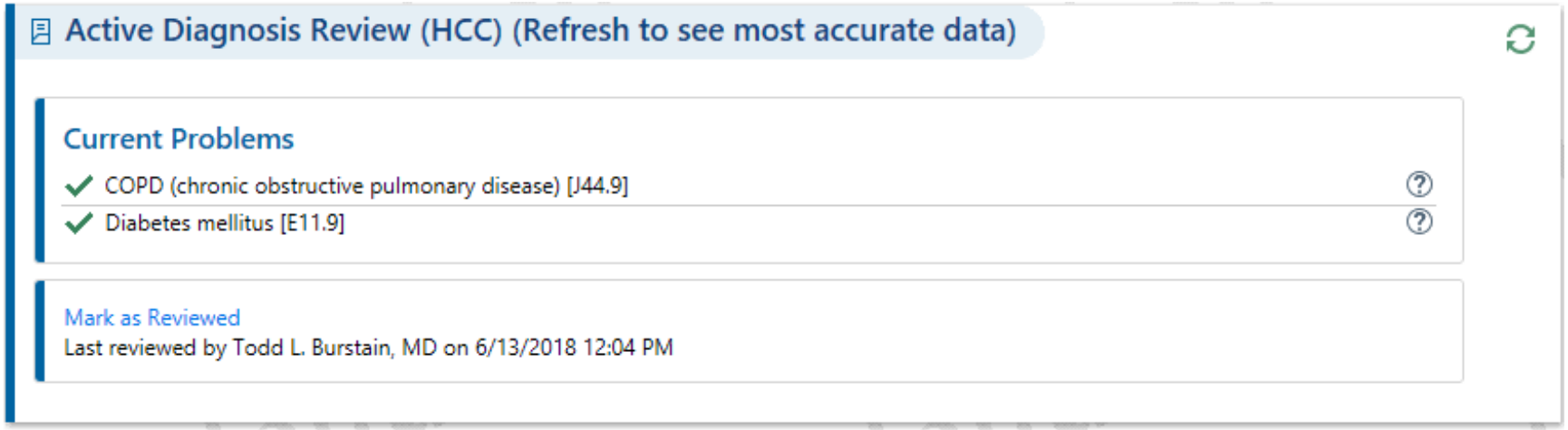
Active Diagnosis Review



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Active Diagnosis Review Reporting

	Percentile Rank (YTD)	Open HCC Capture (Last 14 Days)
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%

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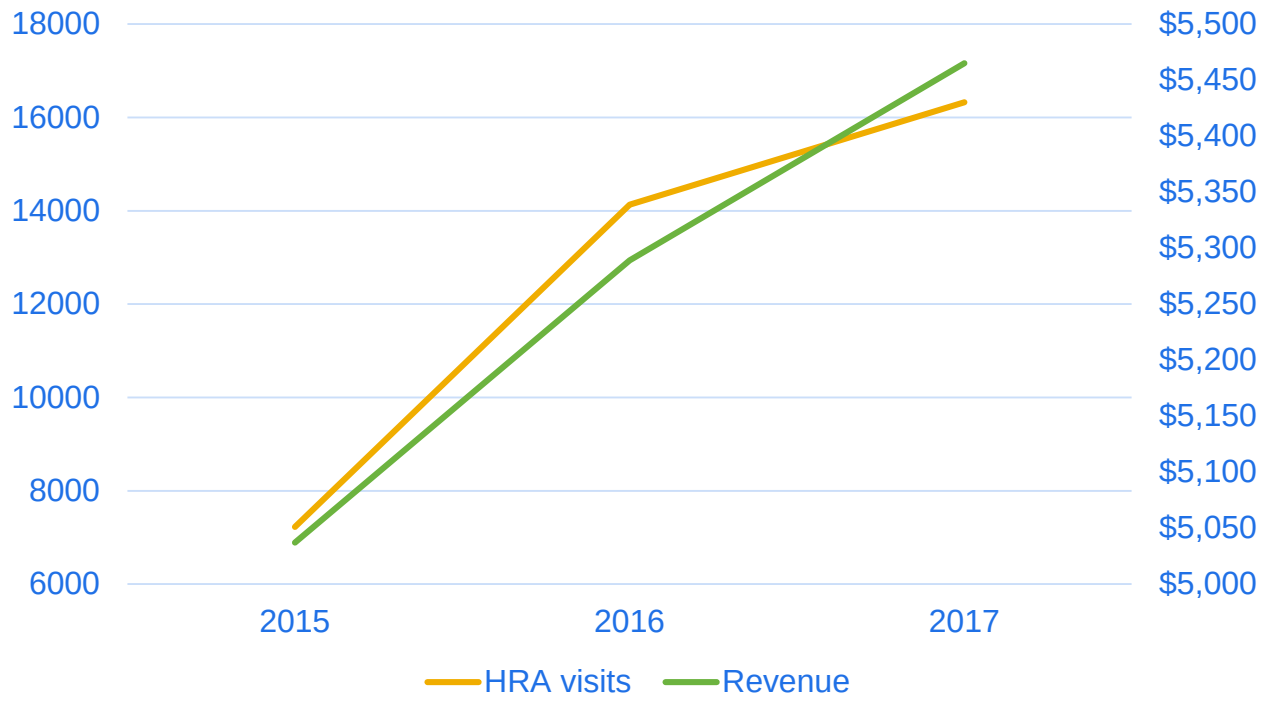
Impact of HRA Visits

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



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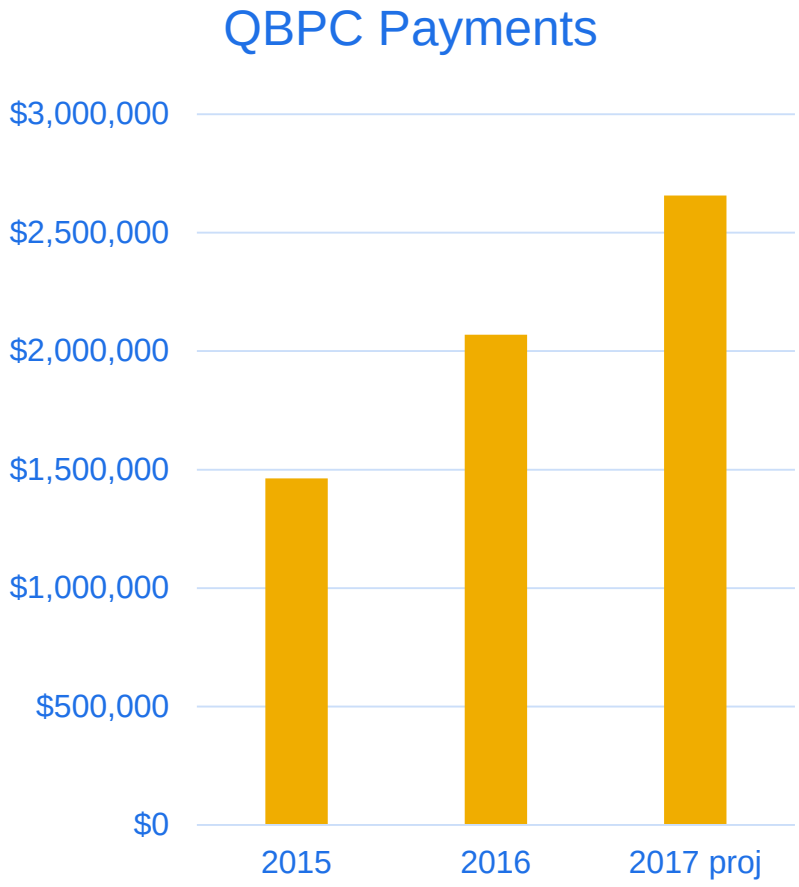
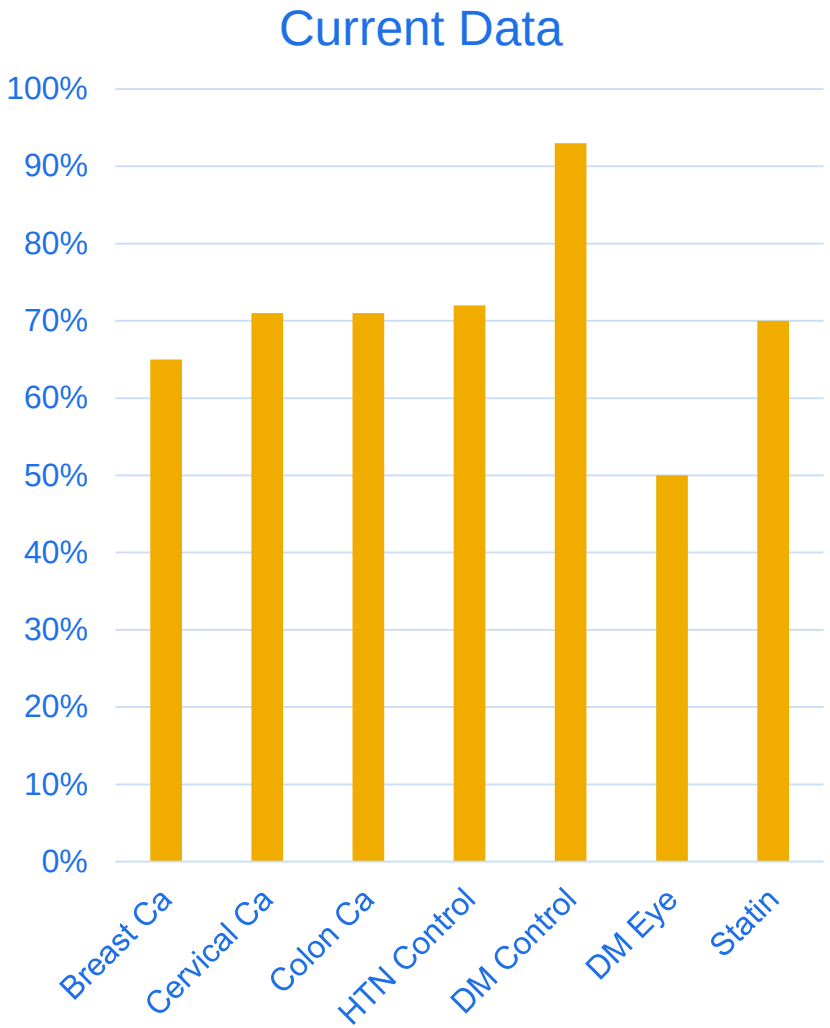
Financial Impact of Value Based Contracts (42,691 pts)





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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

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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

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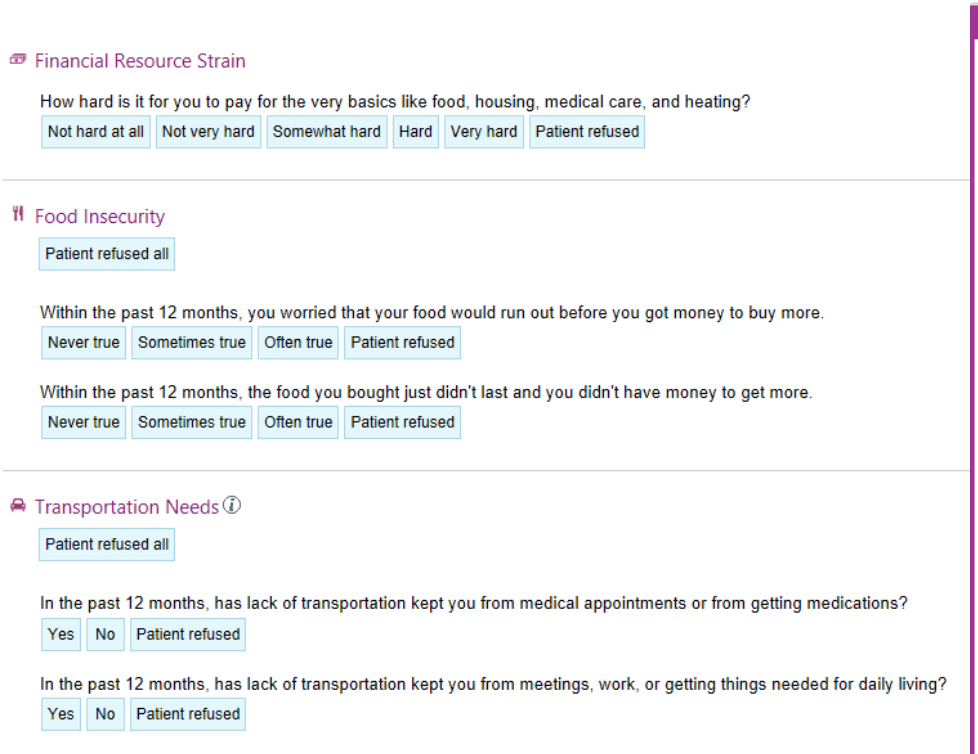
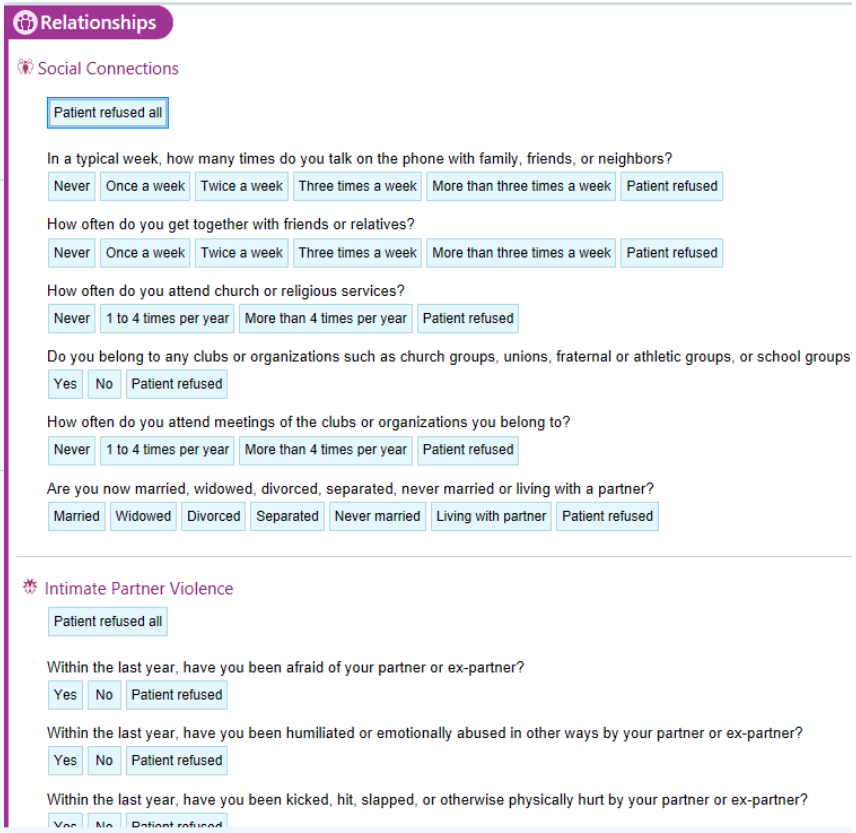
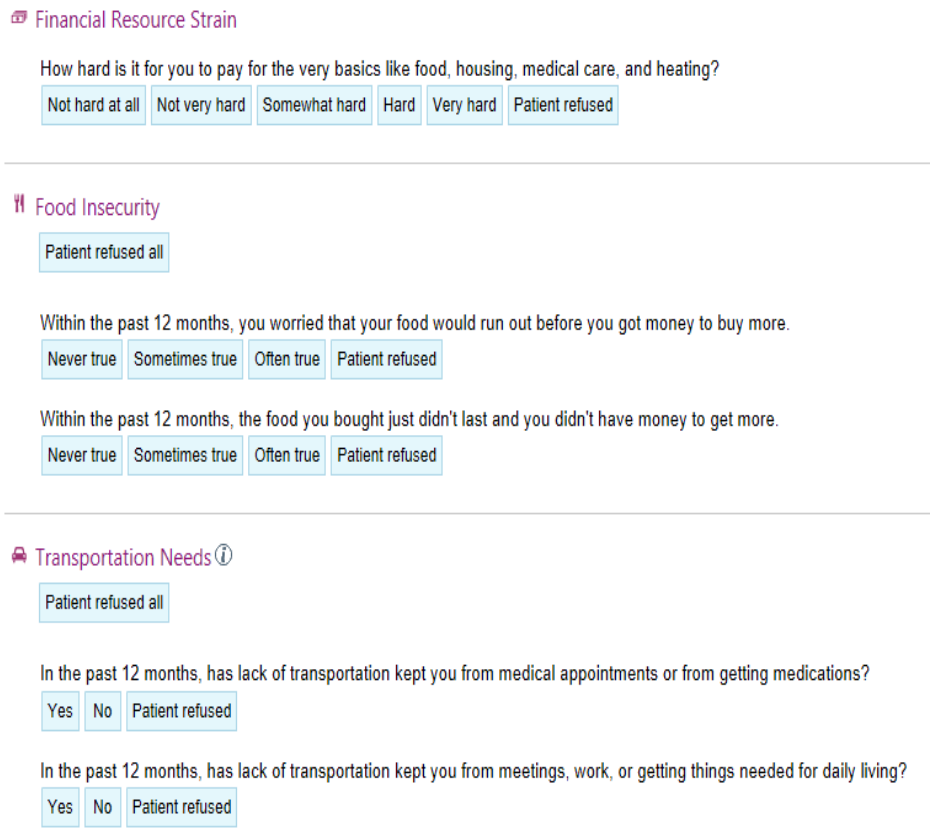
Capturing the Data

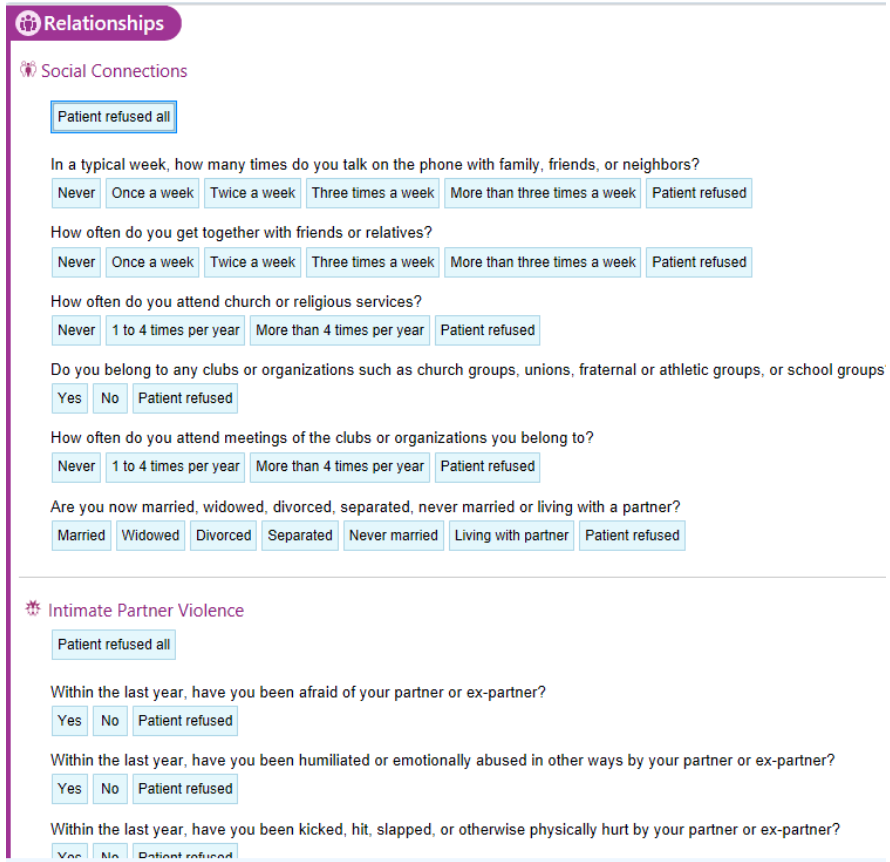




Ochsner Health System

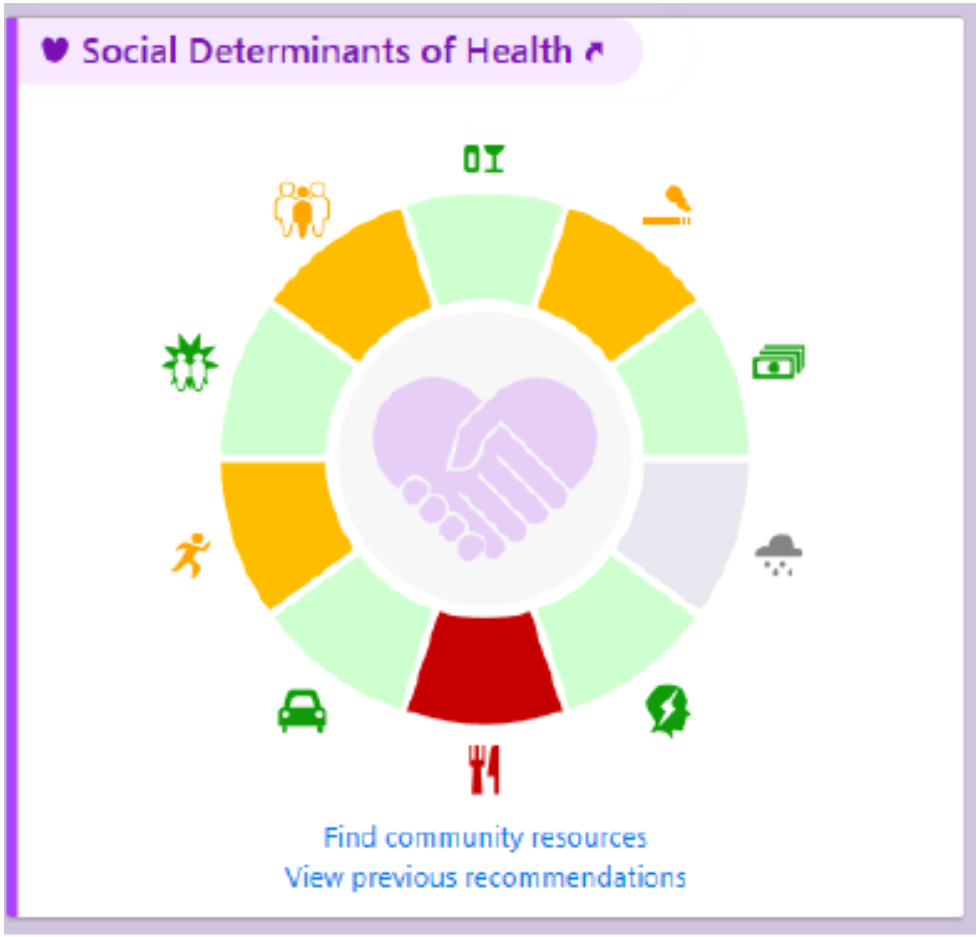
Capturing the Data





Ochsner Health System

Social Determinants of Health



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

Ochsner Health System

Linking to Community Campaigns

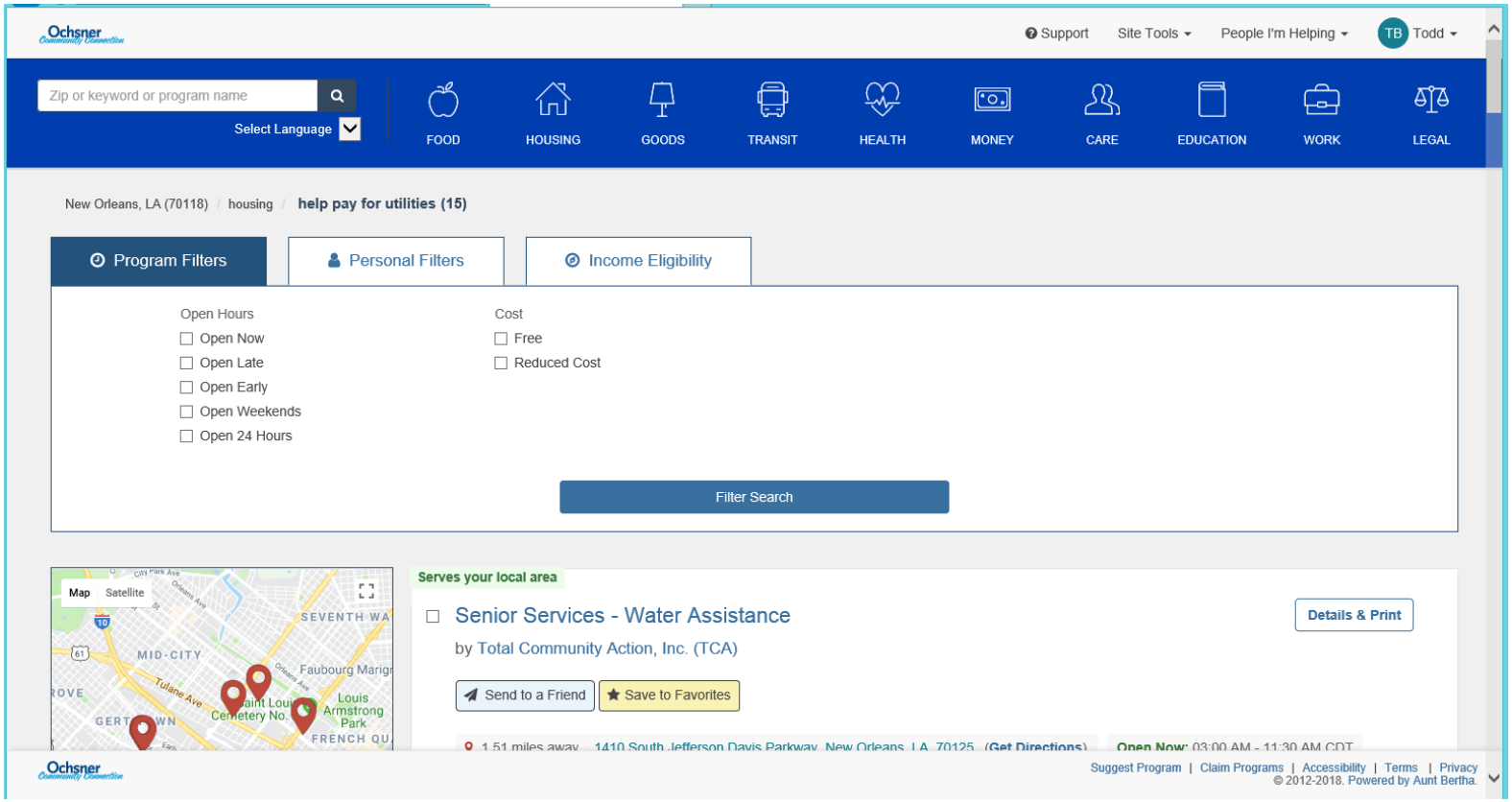
Ochsner Community Connection

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

Zip 70118 Search

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

Type a search term, or pick a category



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