2017

# POPULATION HEALTH

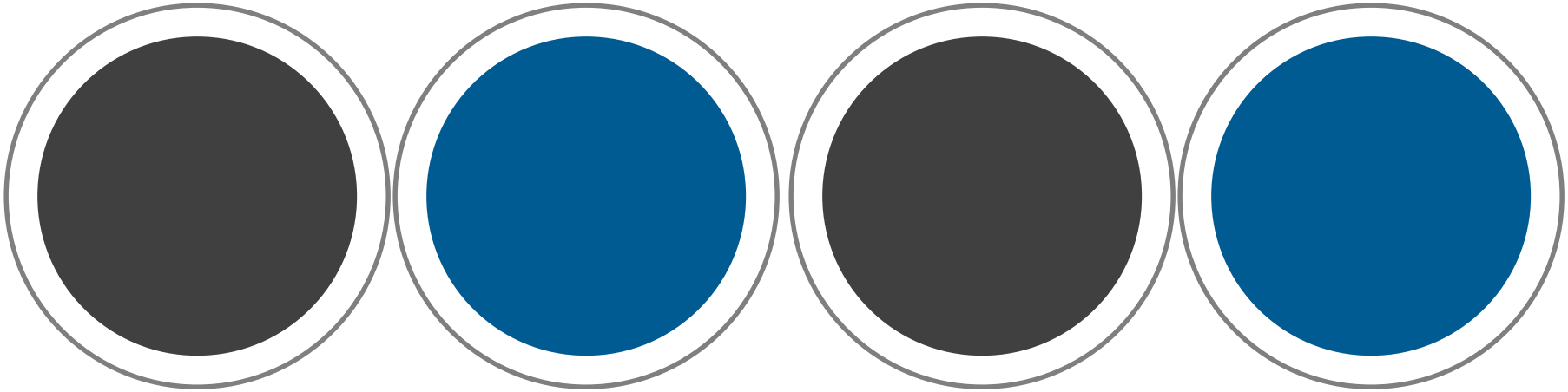
## Effectively Managing Complex Medicaid Populations

Rhonda L. Cox
Chief Population Health Officer
Vaya Health

- Increased knowledge of population health concepts and corresponding coordination strategies
- Increased knowledge of how HIT supports personalized care while ensuring appropriate interventions
- Identify strategies you can implement to prepare for NC transition to Tailored and Standard Plans

EXCITING LEARNING OBJECTIVES!

# BIG PICTURE & HOW IT TIES TO THE FUTURE



1

2

3

National Healthcare Direction

- Quadruple Aim
- Meaningful Use Certified HIT
- Value Based Contracting

1

## National Healthcare Direction

- Quadruple Aim
- Meaningful Use Certified HIT
- Value Based Contracting

2

## NC Healthcare Direction

- Quadruple Aim
- Value Based Contracting
- NC 1115 Waiver/RFI and RFP

3

1

National Healthcare Direction

- Quadruple Aim
- Meaningful Use Certified HIT
- Value Based Contracting

2

NC Healthcare Direction

- Quadruple Aim
- Value Based Contracting
- NC 1115 Waiver/RFI and RFP

3

Current Business Requirements/ QIPs/Etc.

1. What specific characteristics have you used to define member/patient cohorts?
2. For those distinct cohorts, what are your tailored preventive and acute care protocols to treat your members according to their risk profiles?
3. Questions 1 and 2 make no sense…must check out mentally…Rats! I forgot to get X a gift, what am I going to get them?

# POP QUIZ

# CHEAT SHEET 1:

## What's a Cohort?

A group of people experiencing similar symptoms monitored over a period of time. Such as:

- Procedure/encounter-based characteristics
- Member-centric or "people with" X, Y, Z characteristics
- Episode-centric or "conditions across X time"

How does this relate to Risk Profiles?

# CHEAT SHEET 2:

## What's a Risk Profile?

Risk Profiles look at known factors that individuals have that increase their "risk" of developing or hastening disease progression.

Risk stratification helps shape our preventive and reactive (acute) interventions based on clinical decision tools, work flows or other practice models.

# ESTABLISHING RISK PROFILES

Initial risk profiles are typically defined through some combo of data analysis on treatment services, pharmacy claims, hospital or acute care readmissions, etc.

Refined risk profiles come from a health risk assessment that looks holistically across the person's life and care continuums, including social influences (formerly known as SDoH)

Meaningful data elements that can be exchanged across systems support national, state and current business processes

- Using data to improve identification of individuals who need targeted interventions
- Reducing the burden of redundant assessment, services, etc.
- Reducing errors and cost inefficiencies
- Aligning and improving care planning and team response

LEARNING OBJECTIVE MOMENT

Secretary Cohen's Plan & 1115 Waiver is paving the way for Providers to play a key role in population health management in these ways:

- Managing health outcomes of groups of individuals AND
- Ensuring provision of standardized, high-quality care on a consistent basis to achieve optimal results

Both elements require the ability to capture/share/analyze data

LEARNING OBJECTIVE MOMENT

Medicare, Medicaid and Commercial Plans tie financial reimbursements through contracts between providers and payers

- “Pay for value”

LEARNING OBJECTIVE MOMENT

This arrangement makes healthcare providers accountable for what happens to individuals in the long run, no matter where they receive their care

Requires providers to communicate across systems to monitor, manage, and analyze data

**SAYING IT TWICE**

# THINGS YOU ALREADY KNEW, RIGHT?

Hospitals and licensed physicians, physician assistants and nurse practitioners who provide Medicaid services and who have an electronic health record system shall connect by June 1, 2018

**All other providers of Medicaid and state-funded services shall connect by June 1, 2019**

Clinical & demographic information pertaining to services paid for by Medicaid and other State-funded health care funds being sent to NC HealthConnex at least twice a day through:

- Direct connection to NC HealthConnex OR
- Via a hub

# WHAT DOES "CONNECTED" MEAN IN NC?

# NOT ALL SYSTEMS ARE EHRs & NOT ALL EHRs ARE MU CERTIFIED

Electronic Health Record = a real time digital version of a person's chart that makes information available instantly and securely to authorized users

https://www.healthit.gov/providers-professionals/faqs/what-electronic-health-record-ehr

# MEANINGFUL USE CERTIFIED EHR

## Stage 1 Criteria

- Electronically capturing health information in a standardized format
- Using that information to track key clinical conditions
- Communicating that information for care coordination processes
- Initiating the reporting of clinical quality measures and public health information
- Using information to engage patients and their families in their care

## Stage 2 Criteria

- More rigorous health information exchange (HIE)
- Increased requirements for e-prescribing and incorporating lab results
- Electronic transmission of patient care summaries across multiple settings
- More patient-controlled data

## Stage 3 Criteria

- Improving quality, safety, and efficiency, leading to improved health outcomes
- Decision support for national high-priority conditions
- Patient access to self-management tools
- Access to comprehensive patient data through patient-centered HIE
- Improving population health

# SOUNDS GREAT, BUT WHAT'S THE PLAN?

# VAYA TOTAL CARE

## Getting In Shape for the Value-Based Payment Ascent

VAYAHEALTH


**1 Basecamp**
Access provider resources and supports

**2 Begin Ascent**
Identify team to design and test workflows

**3 Development**
Create population health, info. sharing and referral workflows

**4 Testing**
Begin information and data exchange among providers

**5 Connection**
Use of health information tech. and connection with NC HIE by Feb. 2019

**6 Goal Reached**
Able to demonstrate impact, outcomes and readiness for pay for value

# QUESTIONS?