Welcome

Health Information Exchange – Current State

Gary Ginter

System Vice President & CIO

Premier Health

CSOHIMSS HIE Liaison

Agenda
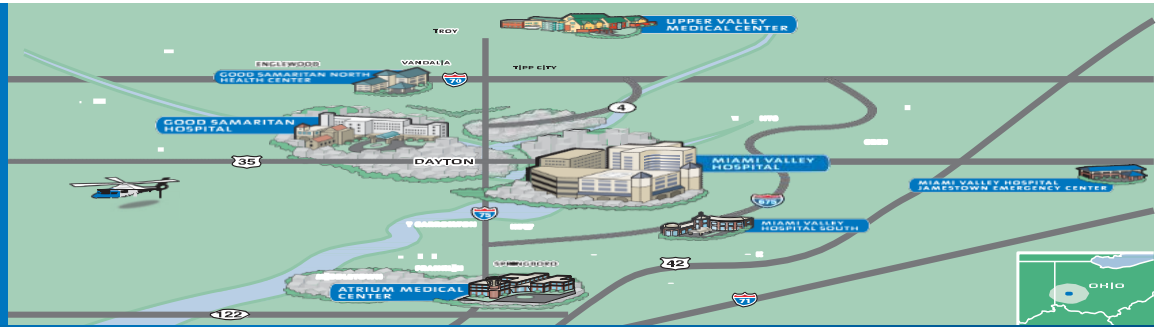
- About Premier Health
- Health Information Exchange
  - Results Routing
  - Direct Messaging
  - Care Everywhere
- Questions

Premier Health

Mission: We will build healthier communities with others who share our commitment to provide high-quality, cost-competitive health care services.

Premier Health is dedicated to improving the health throughout the communities we serve. A comprehensive health system and the largest in Southwest Ohio, Premier has four member hospitals along with affiliate members who provide service across the region.

Go to our website, **premierhealth.com** to learn more about Premier Health. Further explore the latest community involvement projects and health events we offer.

Member Organizations

- Atrium Medical Center
- CareFinders Physician Referral Program
- Dayton Heart & Vascular Hospital at Good Samaritan
- Fidelity Health Care
- Good Samaritan Hospital
- Good Samaritan North Health Center
- Miami Valley Hospital
- Miami Valley Hospital South
- Patient Information Partners
- Premier Community Health
- Premier Health Specialists
- Premier HealthNet
- Samaritan Behavioral Health, Inc.
- Upper Valley Medical Center
- Upper Valley Professional Corporation
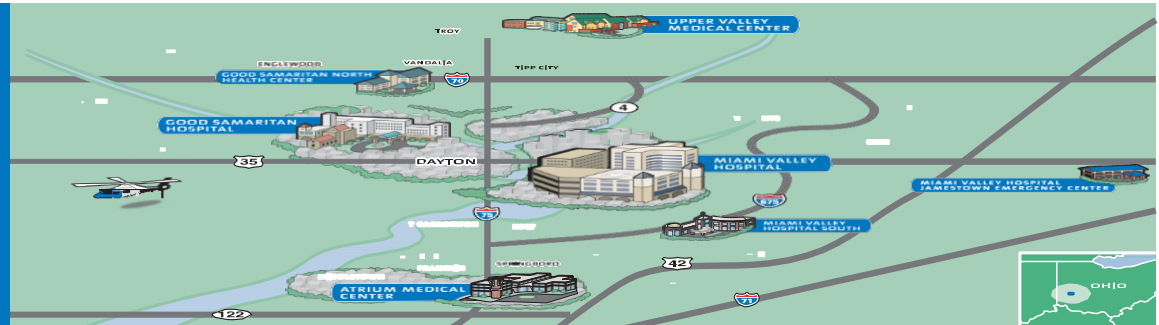
HiMSS
CENTRAL & SOUTHERN OHIO *Chapter*

Premier Health

Mission: We will build healthier communities with others who share our commitment to provide high-quality, cost-competitive health care services.

Key Facts
• Our hospitals have received quality rankings from U.S.News & World Report, HealthGrades, Consumer Choice, and others. Our facilities are accredited by The Joint Commission, American College of Surgeons Commission on Cancer, and others. Some have received Magnet® recognition.

• Premier Health is among the top hospital systems nationally in the Electronic Medical Records (EMR) Adoption Model, which benefits patients by providing seamless, accessible information for medical professionals.

• Premier offers area employees programs providing accessible, cost-effective health services and workplace wellness.

• Premier invested $128 million in 2011 for free care and other unpaid ser-vices to low-income families.

• Premier invested $29 million in 2011 for community projects and services which produces long-term benefits for a healthier population.

• Our school partnership programs address athletes' needs, expose students to health care careers and provide health education.

Key Facts (2012)

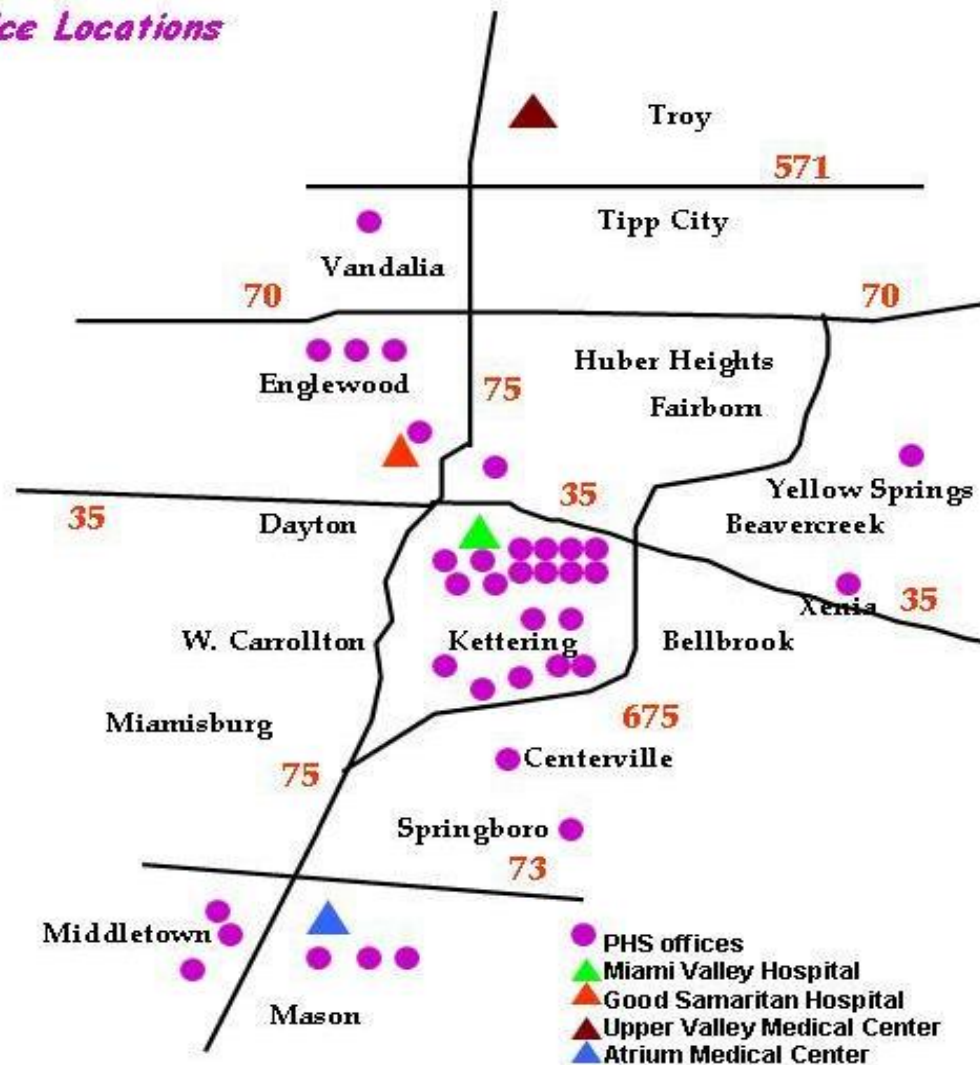|	
Licensed Beds	2,017
Physicians	2,333
Physician Specialties	70+
Employees	14,801
Volunteers	1,803
Inpatient Admissions	81,724
Outpatient Visits	895,030
ER Visits	288,437

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Primary Care Physician
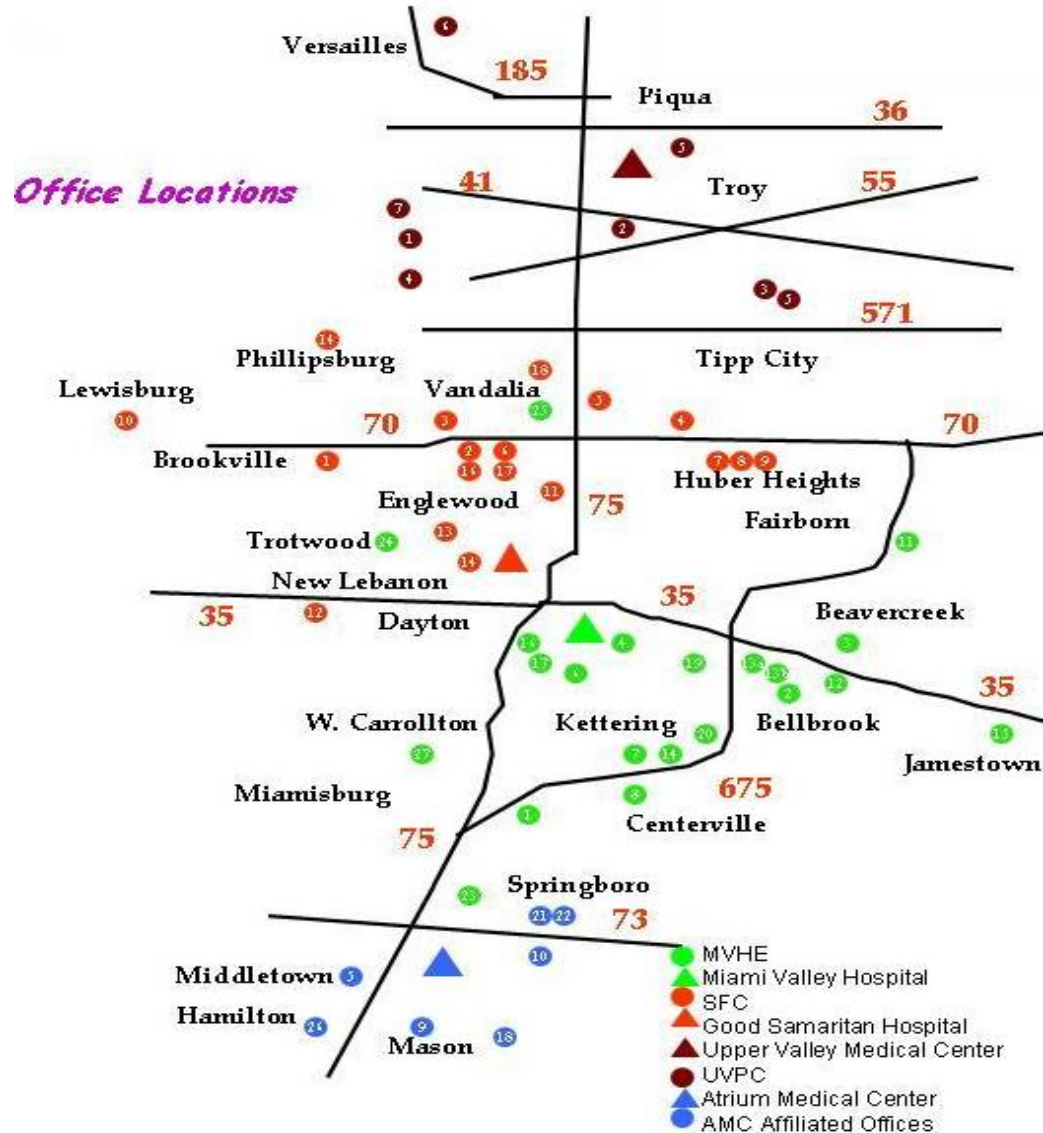
Specialist

Office Locations

Health Information Exchange

2012

Health Information Exchanges are like your gas station. It provides robust data that fuels your journey to Meaningful Use!

Depending on the exchange you choose, your quality performance may vary.

WELCOME
Please Insert Card

Credit
Debit
Yes Enter
Cancel

Sale $ 67.89
Gallons 12.345

Regular 4.82
Unleaded 4.97
Premium 5.06

GASOLINE

87 — **GDAHIN**
- Low performance
- Any physician practice or health organization can use, regardless of size or type of EHR.
- EHRs with proper interface software (purchased by practice) can upload/download here.
- Office with no EHR can download or fax out of this HIE.

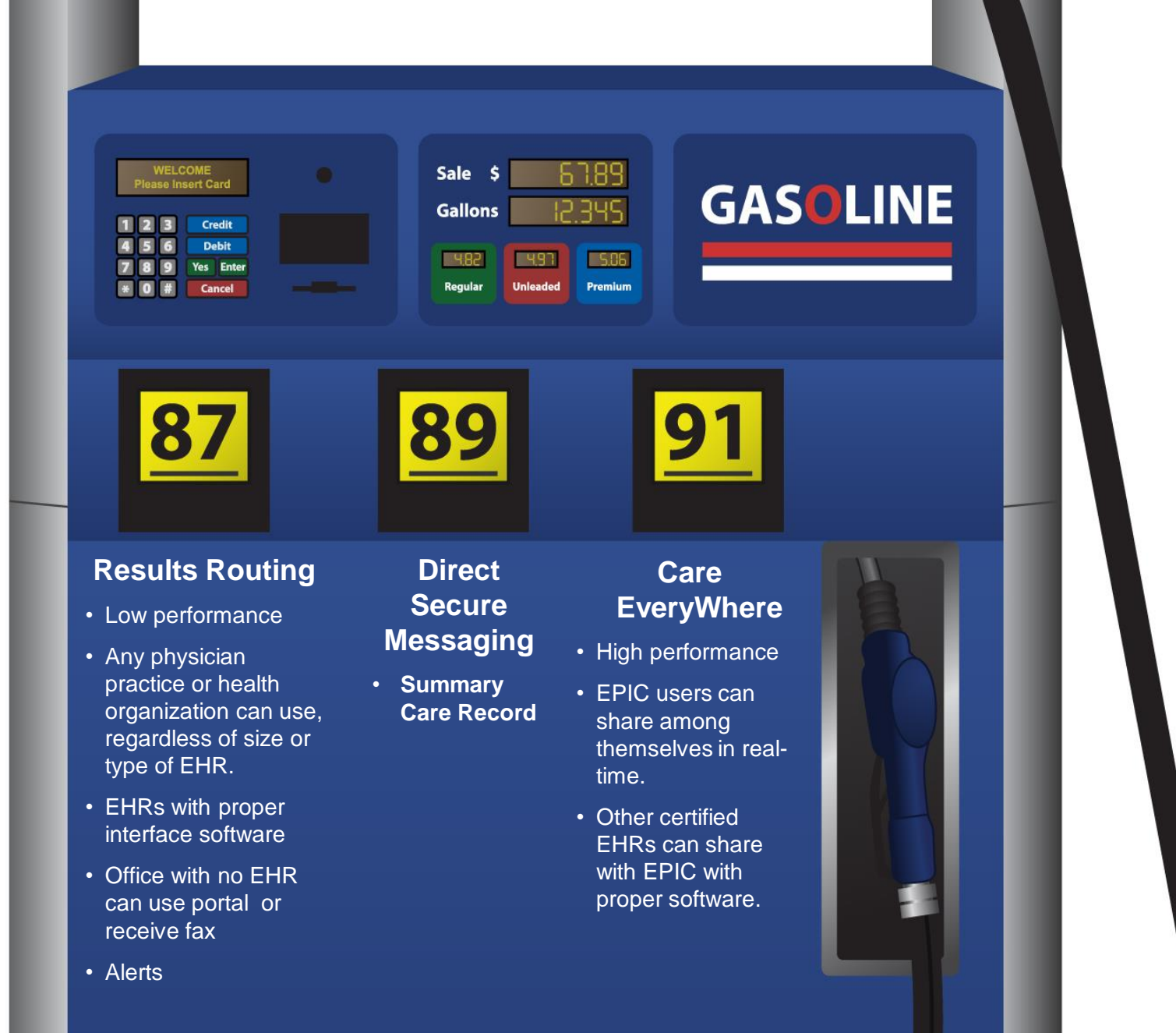**89** — **State Portal (TBD)**

91 — **EPIC**
- High performance
- EPIC users can share among themselves in real-time.
- Most certified EHRs can share with EPIC with extensions to their software.

2014

Health Information Exchanges are like your gas station. It provides robust data that fuels your journey to Meaningful Use!

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Yes Enter
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Sale $ 67.89
Gallons 12.345

4.82 4.97 5.06
Regular Unleaded Premium

GASOLINE

87

Results Routing

- Low performance
- Any physician practice or health organization can use, regardless of size or type of EHR.
- EHRs with proper interface software
- Office with no EHR can use portal or receive fax
- Alerts

89

Direct Secure Messaging

- **Summary Care Record**

91

Care EveryWhere

- High performance
- EPIC users can share among themselves in real-time.
- Other certified EHRs can share with EPIC with proper software.

Results Routing

- Health Information Exchange Options
  - HealthBridge
  - CliniSynch
- Options
  - ED/IP Alerting
  - Results
  - Syndromic Surveillance
  - Electronic Lab Reporting
  - Immunization
- Concerns
  - Preliminary vs Final Reports
  - Addendums
  - Physician not entered on patient record

Results Delivery - April 2014

CliniSync

    Delivered – 7,561   Utilized – 4,483

HealthBridge

    Results Sent – 113,082

Direct Secure Messaging (Summary of Care Record)

- HISP Vendors

  - HealthBridge

  - CliniSynch

  - Surescripts

- Epic to Epic through CareEverywhere

- Concerns

  - Struggling Across the Nation

  - Need HISP to HISP vendor communication

  - Format and volume of information

  - Not standardized across Healthcare Organizations

  - Competition

Care Everywhere

Point-to-point communication between Epic and non-Epic providers already in cooperative relationships.

- Configuration of non-Epic systems often a challenge

2,000,000 instances of exchanging data between Epic sites

- Ohio had 400,000 (20%) of those transactions

Premier Health's Care Everywhere Exchanges 2014

- Beaumont Health System
- Bon Secours Health System
- Catholic Health Partners
- Cincinnati Children's
- Cleveland Clinic
- Dayton Children's
- Dean Clinic, SSM Health Care of Wi
- Franciscan Alliance
- Grady Health System
- Hawaii Pacific Health
- Kettering Health Network
- Lexington Medical Center
- MetroHealth
- Monroe Clinic
- Nationwide Children's Hospital
- Noviant Health
- OCHIN

- Ohio State/Wexner
- OPRS (non Epic EMR)
- Park Nicollet Health Services
- Providence Health & Services Oregon & Calif.
- Reading Health System
- Salem Health
- St Elizabeth Health Care
- Stormont-Vail Healthcare
- Tampa General Hospital
- The Christ Hospital
- Tri Health
- UC Health
- Univ. of Pittsburgh Medical Ctr
- University of Virginia Medical Center
- West Virginia University Healthcare
- Yale New Haven Health System

Questions??

ggginter@premierhealth.com

Our Mission
We will build healthier communities

Our Commitment

- To **expand and better support** the relationship between care providers and patients by leveraging a connected team.
- To use technology to **transform patient data** into actionable information.
- To make **access to care** easier for the patient.
- To create a **simplified, better coordinated care** experience
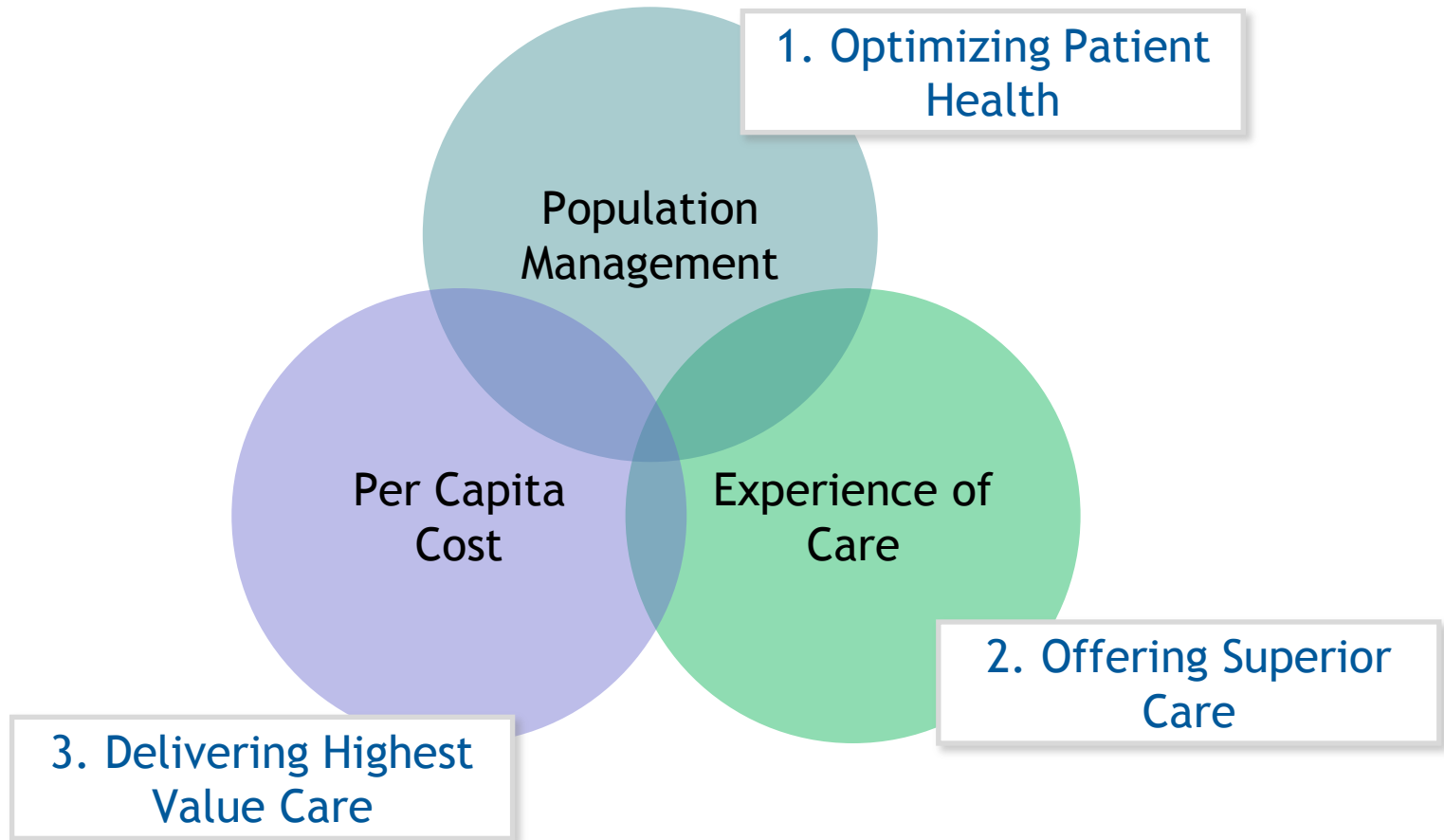- To **shift incentives** to rewarding better health.

Benefits of Population Health System Strategy

- Strategic
  - Establishes provider led, community-based entity to manage population health
  - Supports physician network and IDN relationship expansion

- Clinical
  - Uses proven strategies to improve health outcomes for patients
  - Creates funding stream for care management resources outside hospital/clinic walls
  - Enhances physician care model

- Financial
  - With superior execution, generates substantial physician compensation and health system margin opportunity
  - Appropriately leverages benefit design to enhance access to Premier
  - Minimizes financial risk with current generation 1) evidence-based care management strategies, 2) advanced IT/analytics, 3) established severity-based reimbursement methods and 4) provider reimbursement alignment

The Goal: The "Triple Aim"

Population Management

Per Capita Cost

Experience of Care

1. Optimizing Patient Health

2. Offering Superior Care

3. Delivering Highest Value Care

The Rationale: Shift to Payment Risk More Immediate Than Many Realize

Immediate and Imminent Forces Pushing Providers Toward Risk

Public Payers

Medicare Value-Based Payment

For both hospitals and physicians, CMS moving to incorporate value-based metrics into reimbursement

Here Today

↓

Penalty Avoidance

Private Payers

Changing Payer Expectations
Employers, payers more interested in contracts that reward directly for total cost of care reduction and improved Quality of Care

Potential Near-Term Threat

↓

Increased Revenue

Market Forces

Competitive Dynamics

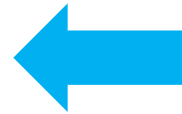Mature provider groups actively pushing for new contract models, forcing unready competitors to play catch-up

↓

First Mover Advantage

The Rationale: The Integration Imperative

Premier Health → **Creation of Premier Health Group** ← **Aligned Physicians**

Premier Health

Changing Market Demands
- Competing on value
- At risk for outcomes

Future Threats
- Expected reduction in volumes
- Proposed Medicare cuts
- Market share determined by value

Aligned Physicians

Shifting Workforce Demographics
- Premium on work-life balance
- Interest in team-based care

Worsening Financials
- New reimbursement cuts
- Rising practice costs

Reform Uncertainty
- Unable to cover investment in care management resources
- Fear of referral stream loss

Our Approach: Physician-led Clinical Care Redesign

- **Physicians leading Physicians**: A stronger integration and collaboration habit formed by physicians leading physicians

- **Organizational Alignment**: Physician leaders and their physician peers are better aligned with the organizational culture and strategic goals of the organization

- **Clinical decision making**: Physician led discussions and resulting clinical decisions related to evidence based guidelines and treatment pathways are more quickly agreed to and ultimately reduce competition or infighting among departments or disciplines

Our Approach: Premier Health Group Governance Structure – Physician Led

PHG Board Members

- 7 Physician Seats on PHG Board
- Independent majority : 4 of the 7 seats are Independent Physicians
- Primary care led: 4 of the 7 seats are Primary Care Physicians

- 4 seats are Premier Health Executives
- 2 seats are a Community Leaders

PHG Provider Network

- Over 3,100 providers, incl. over 2,100 physicians and mid-levels

- 9 county primary service areaa

- Premier IP Facilities – Miami Valley Hospital, Upper Valley Medical Center, Atrium Medical Center, Good Samaritan Hospital, Miami Valley South Hospital.

- Madison County Hospital

The Approach: Start by Serving Premier's Employees 2014

- Premier Health -, one of the largest employers in the Dayton area, has over 17,000 enrolled employees and dependents
- We will demonstrate our results and then sell scale them across our primary service area

Care Coordinated by Physicians Can Improve Health and Control Costs
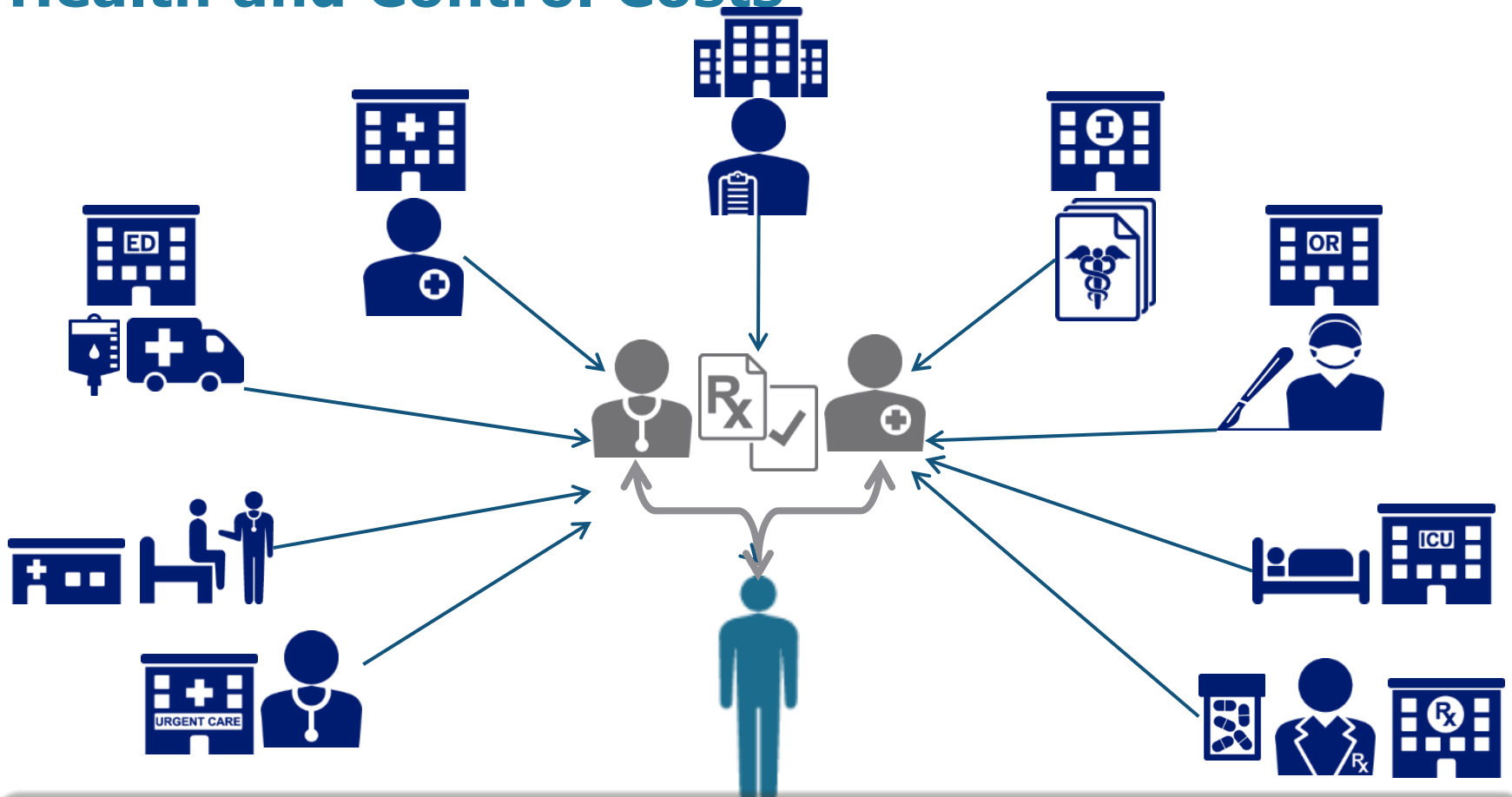
Patients' primary care doctors are the main point of contact for managing health.
Patient care is coordinated through an integrated care plan that tracks medical history, risk factors, and personal health goals

Unlocking Success:
Creating a Team-Based Approach

Primary Care Practice

- PCPs
- Medical Assistants
- Nurse Practitioners
- Physician Assistants

+ Patient & Family

Care Manager

Patient & Family + Specialist

- Behavioral Specialists
- Social Workers
- Nurses
- Dieticians
- Pharmacist
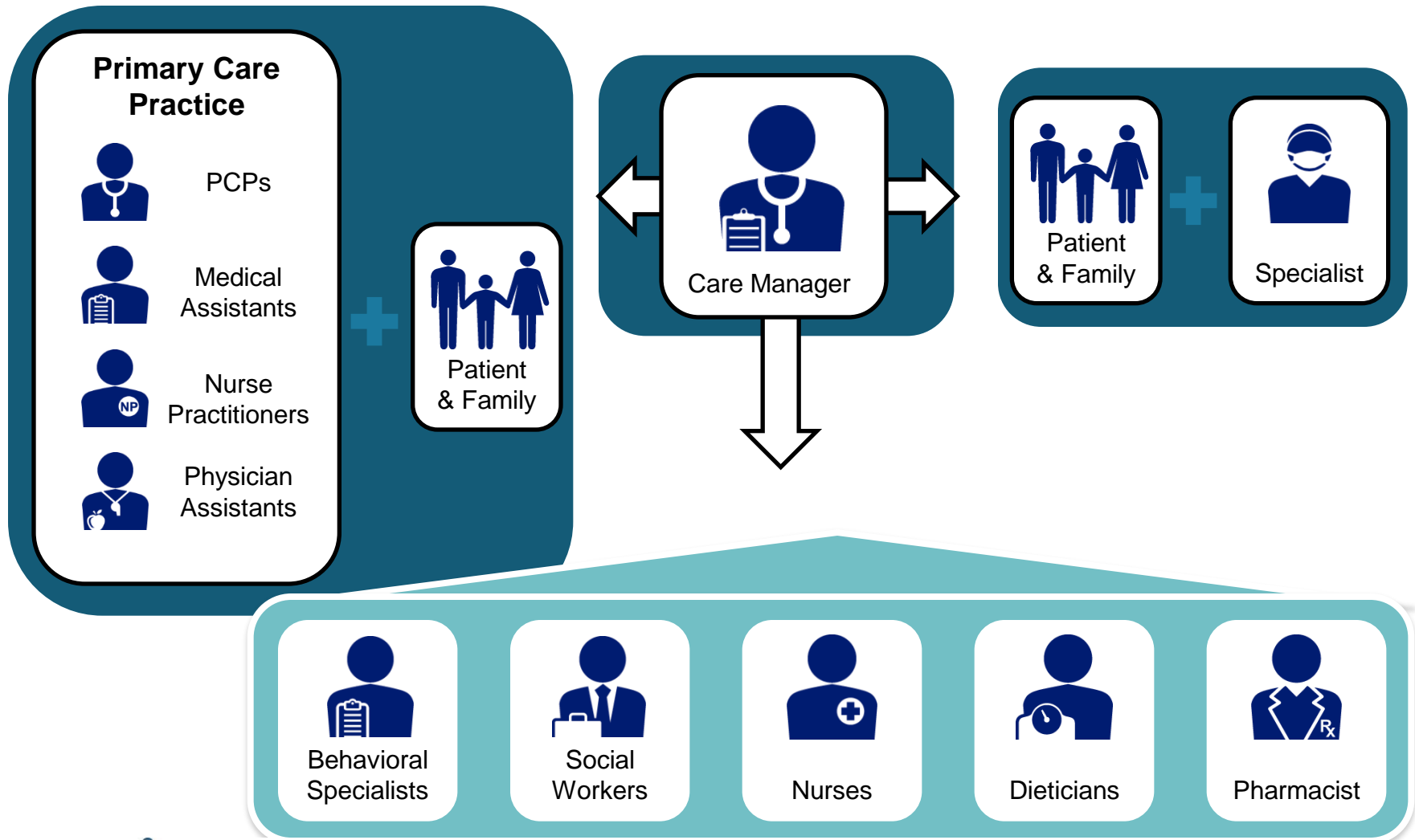
Meeting Members Where They Are
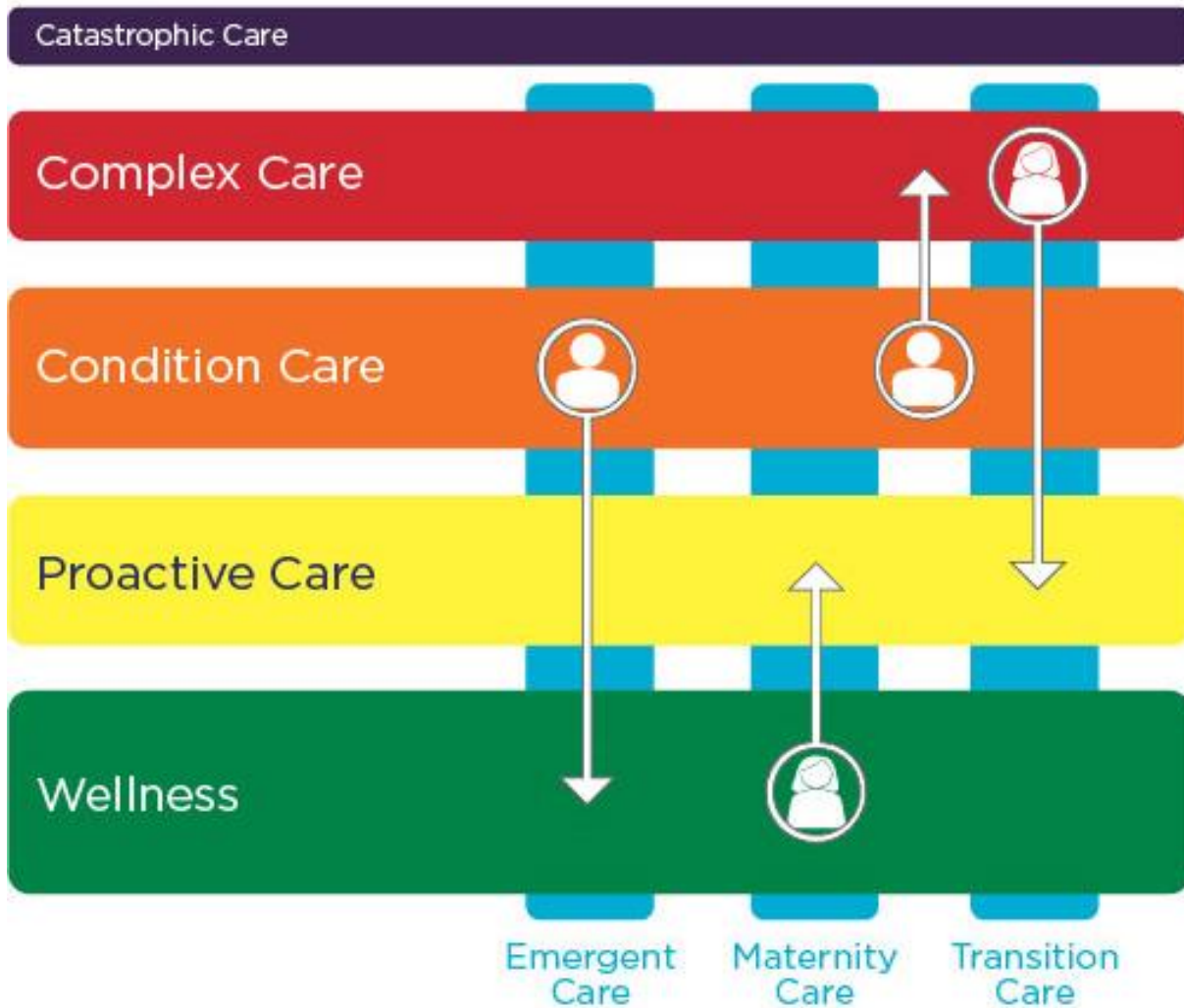
Health is dynamic.

Premier Health's population health platform is flexible and responsive to individuals' changing care needs.

Premier Health Plan's Model of Care

Physician Leadership: innovative models for compensation, governance and change management to support better physician and patient engagement.

Clinical Programs & Initiatives: evidence-based and financially viable interventions to better manage population health. Examples: Targeted Diabetes outreach, RAF support, UM Initiatives, Transition Care.

Care Delivery: method of execution for Clinical Programs based on the profile and risk population of specific practices. Also includes high value referral programs, designed to bolster in-system utilization.

Stratification: identification of individuals who are appropriate for specific care interventions, and who have the greatest potential opportunity for improvement.

Technology Platform: Seamlessly integrated at the point of care, with best-in-class reporting functions to support improved patient outcomes

Executing Against the Model of Care

Five pillars of provider-led population management approach:

1

Right data
- Multiple sources
- Timely intelligence
- Detailed care notes

2

High-powered analytics
- Sophisticated rules engine
- Continually tuned risk models

3

Targeted interventions
- Broad portfolio of interventions
- Developed and vetted by UPMC providers

4

Right engagement
- Multiple modes of engagement
- Ranges from mailings to home engagement visit

5

Aligned network
- Integrated provider-driven approach
- Outstanding network services
- Innovative economic arrangements

Proprietary integrated delivery platform:

identifi SM

Integrated analytics and workflow engine

Scaled care management operations

Transformation from the Inside Out:

Better Outcomes & Member Engagement

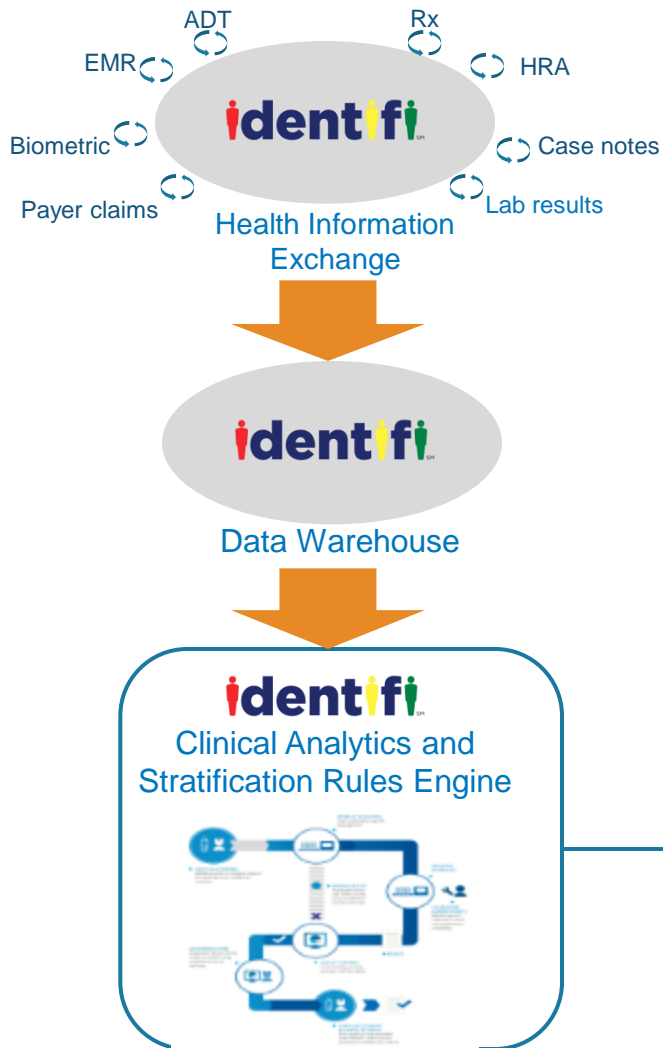**Shift to Medically Appropriate, Value-Based Care**

Reduce Unnecessary Care

Reduce Preventable Readmissions and ER Visits
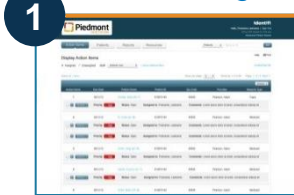
Drive Down Claim Costs

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Population Health Technology Platform

ADT   Rx

EMR   HRA

identifi

Biometric   Case notes

Payer claims   Lab results

Health Information Exchange

identifi

Data Warehouse

identifi

Clinical Analytics and Stratification Rules Engine

Care Management Workflow

1

- Configurable stratification and rules logic
- Prioritized, role-based work lists
- Track workflow across settings and care teams

Reporting and Insights

2

- Operational, clinical and financial KPI reports
- "Drill-Down" registry/dashboards
- View care gaps for populations and individuals
- Trigger workflow from dashboards

Health Plan 2.0

3

- Full integration with payer platform and features
- Designed to reduce provider friction and automate key functions e.g., UM, RAF
- Robust CRM and customer lifecycle management

Patient Engagement

4

- Physician-directed content delivery and multi-channel engagement
- Secure bi-directional messaging platform

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Multiple Sources of Data Integrated in a Individualized Stratification Approach

Primary Data

Patient Profile

Administrative Data

- Med/Rx Claims
- Eligibility
- Provider Files
- Consumer Data

Clinical Data
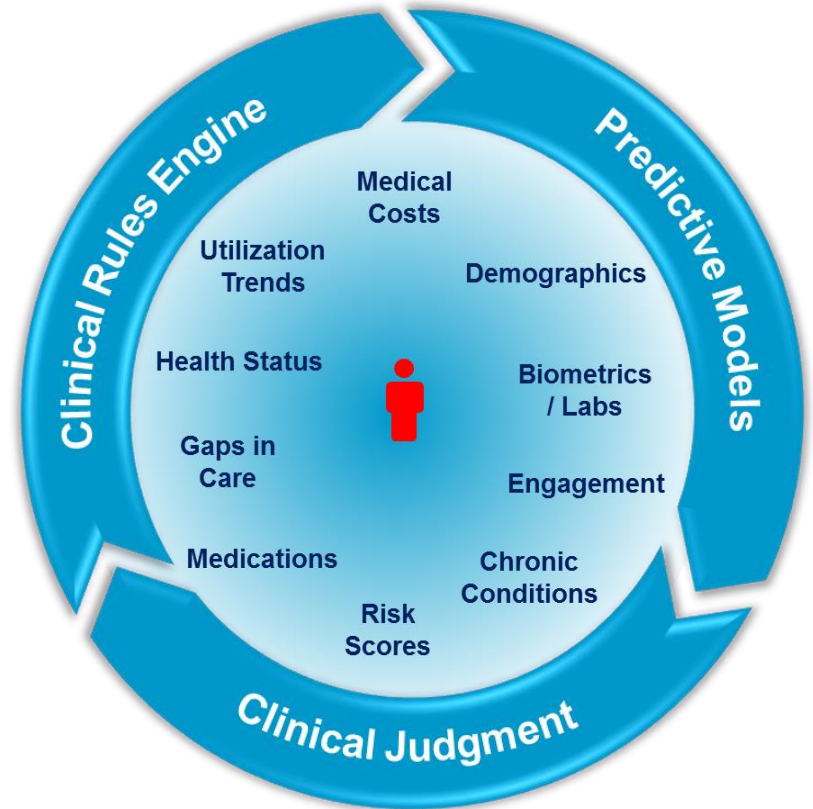
- Lab Values
- Biometric Screenings
- EHR Integration
- ADT Feeds

Survey Data

- Health Risk Assessments
- Patient Activation
- Patient Experience
- Physician Referral

Clinical Rules Engine

Predictive Models

Clinical Judgment

Medical Costs

Utilization Trends

Demographics

Health Status

Biometrics / Labs

Gaps in Care

Engagement

Medications

Chronic Conditions

Risk Scores

Industry Case Study:
Risk and Cost Analysis

Distribution of Risk Level

■ 2007   2010

Compounding Effect of Lowering Trend
PMPM Trend: UPMC vs. Industry

— Industry Average

$65,732,231
5-year savings

	2007	2008	2009	2010	2011
Savings by Year	$4.5M	$6.9M	$3.3M	$15.4M	$35.6M

77.0% 79.0%

Low Risk Industry Average = **60%**

Moderate Risk Industry Avg = **25%**

High Risk Industry Avg = **15%**

19.0% 18.0%

4.4% 3.6%

Low Risk   Moderate Risk   High Risk
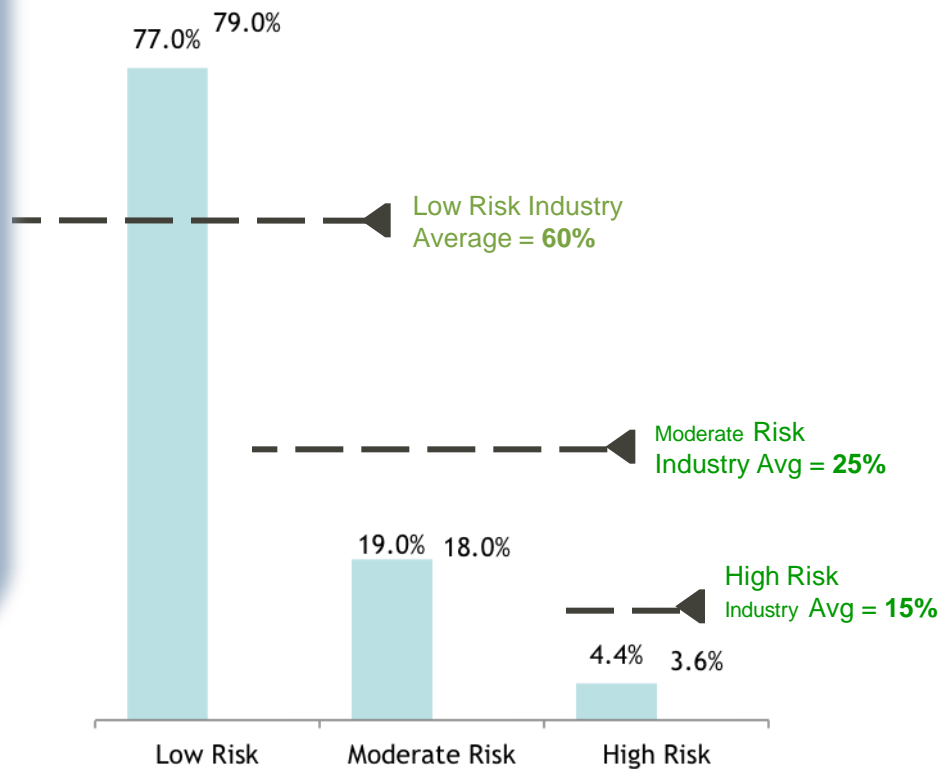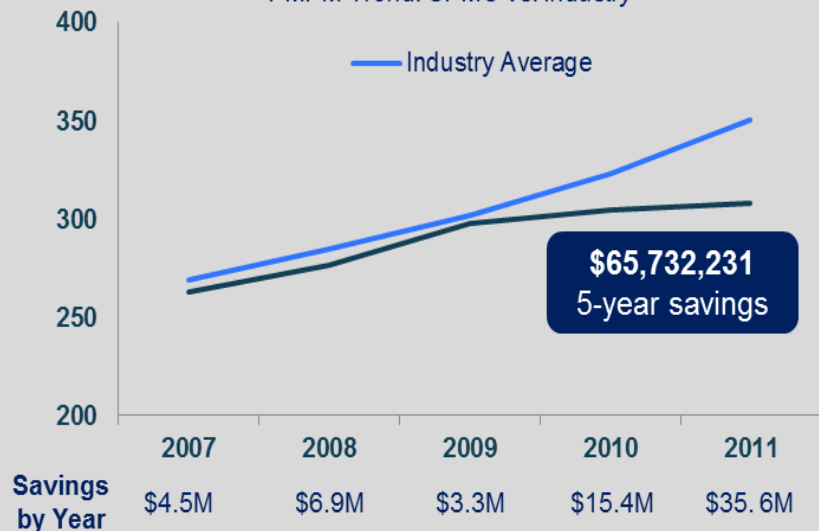
Source: UPMC employee cohort analysis. Self reported HRA data.

Overview of Complex Care Management Program

✓ **Identify patients with complex chronic illness (stratification process)**
Sources used to identify complex patients
  Claims date (Medical & Rx)
  Available ancillary data (e.g. lab data)
  Health Risk Assessment

✓ **Identify physicians to engage in complex care management**
Determine physicians/practices with density of complex patients (attribution process)
Engage "leading edge" physicians from the pool with density of complex patients

✓ **Vet complex patient list with physicians**
Create and share roster of complex patients identified through stratification
Review roster with physician to confirm, remove or add complex patients

✓ **Engage patients into complex care model**
Physician introduces program to patient
Care manager engage patient to determine their health goals

✓ **Deploy the "planned visit" for engaged complex patients**

✓ **Perform ongoing monitoring of program effectiveness and continuous quality improvement efforts**

Unplanned Care Program

✅ **<u>Identify patients</u>**

Potential Inclusion Criteria:

Any emergency room visit for an ambulatory sensitive condition

OR

Two or more ED visits in the last 12 months for any cause without a primary care visit in between

OR

Three or more ED visits in the last 12 months for any cause even with primary care in between

OR

Four or more of the combination of urgent care and ED visits in the last 12 months

AND

No primary care visit since the most recent ER or urgent care visit

✅ **<u>Determine the reasons for unplanned care</u>**

Engage the patient to discuss their unplanned care

Identify their needs

Educate them on their options

Connect them to a PCP

✅ **<u>Resolve the patient's immediate needs as able</u>**

✅ **<u>Refer patient to Care Management when complex needs identified</u>**

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Population Health Initiative: Transition Care

Admission
Patient introduced to Transition Coach and My PATH Home

Hospital

Discharge
My PATH Home guide completed, follow-up appointments scheduled

Home

First 48 Hours
For high-need patients, in-home visit

48-72 Hours
For moderate-need patients, phone call follow-up

Each Week
Phone call follow-up to discuss progress towards goals

Day 28
Progress assessed, moved to PATH Visit schedule if needed

Stable Health