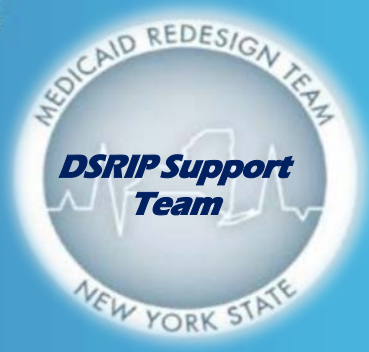
DST Webinar – Population Health Management



December, 2014

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DSRIP and Population Health

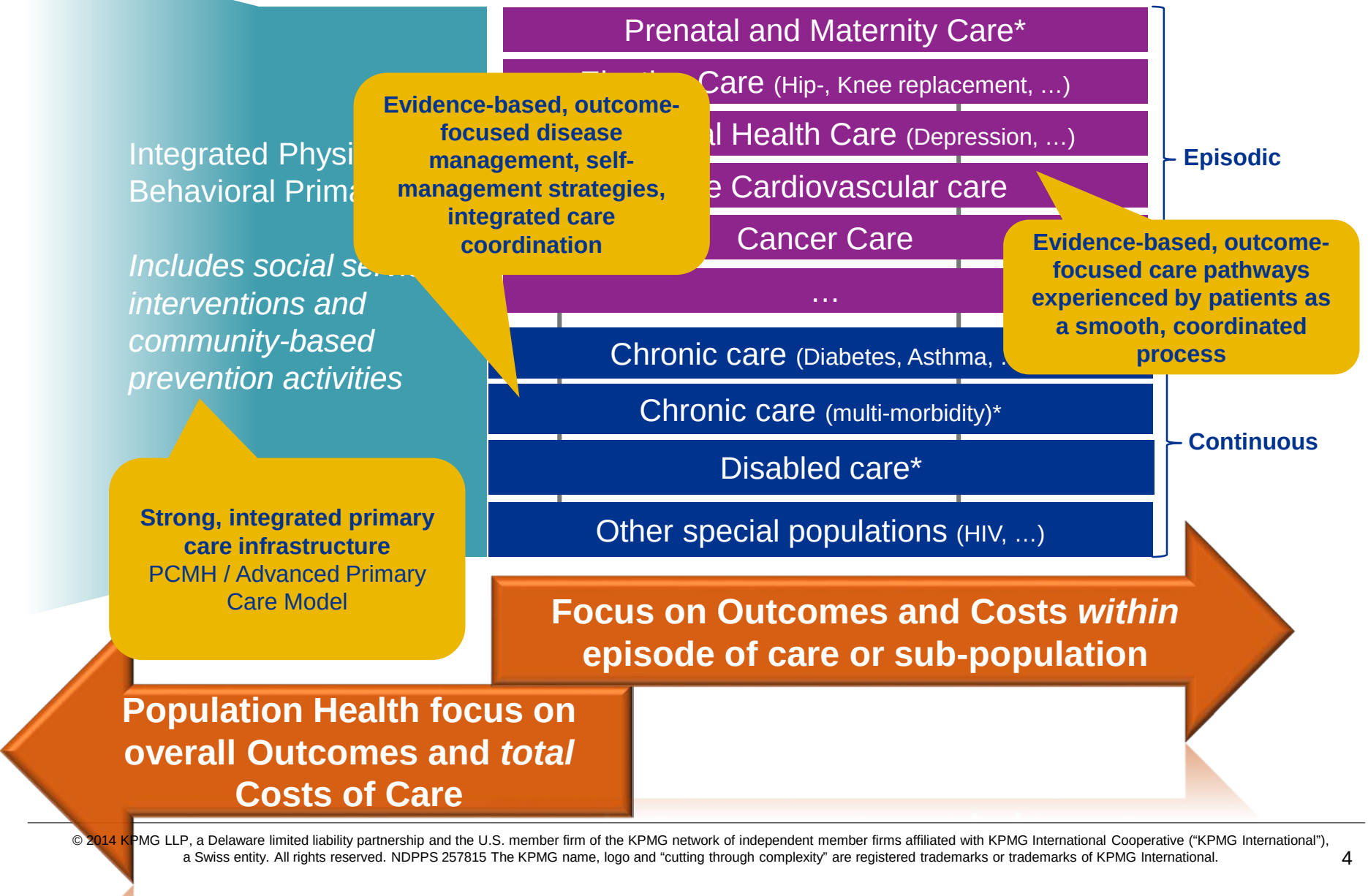
The DSRIP Challenge – Transforming the Delivery System

DSRIP is a major effort to collectively and thoroughly transform the New York State (NYS) Medicaid Healthcare Delivery System. There is a focus on transitioning:

- From fragmented and overly focused on inpatient care → integrated and focused on outpatient care
- From a re-active and siloed system → pro-active, community and patient-focused system

Building upon the success of the Medicaid Redesign Team (MRT), the goal is to reduce avoidable admissions and collectively create a future-proof, high-quality and financially sustainable care delivery system.

DSRIP Vision- How Should an Integrated Delivery System Function?



Core Foundation for Population Health- Having the Right Information

The DSRIP program and the metrics focus on *improving population health*

This requires complete, longitudinal information on what happens to patients over time and across organizational boundaries

Such information is rarely systematically available for any given provider

The State's Medicaid Claims and Encounter data, completed with other datasources already available at State level form a strong basis to start with

- >90% of all DSRIP metrics are calculated by the State on the basis of these data

Core Foundation for Population Health- Having the Right Information

What information can PPSs expect to get from the State?

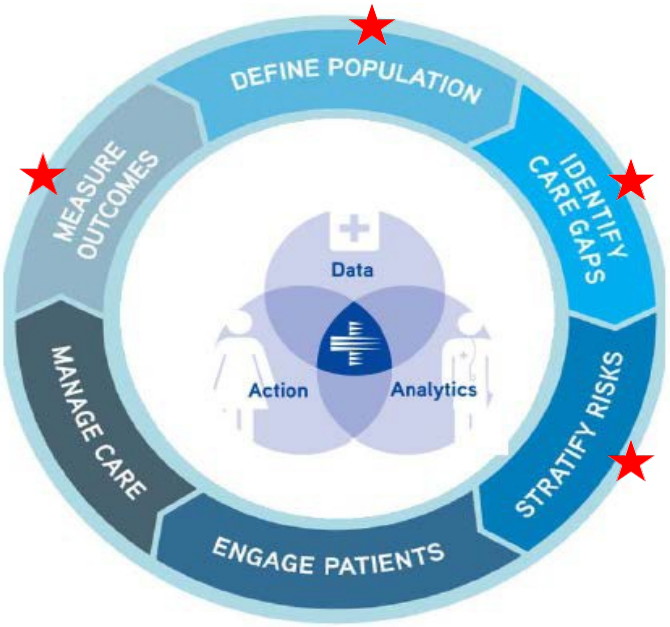
Until Dec. 2014	• The baseline information for the DSRIP measures as is available per county / zipcode • Further refined attribution information • Every PPS can get training in Salient Interactive Miner tool, which gives in-depth access to the State's Medicaid Claims & Encounter information (non-PHI)
In DY 1 (gradual build-out)	• Final attribution & network information • PPS-specific dashboards with outcomes information on 90% of DSRIP metrics (domain 2-3, including trends, yearly targets (gap to goal) • Dashboards showing comparative information between PPSs (trends, outcomes, benchmarks) • Access to enriched Salient Interactive Miner tool, which allows drill-down to provider & patient level in all measures for analysis of potential underlying drivers of poor/high performance, beneficiary-identification, options for improvement etc (PHI for analysis within PPS)
In DY 2 (gradual build-out)	• Revised attribution & network information (attribution for performance purposes is reset every year) • PPS-specific dashboards with outcomes information on 95% of DSRIP metrics (domain 2-3) total cost of care, and potential (risk-adjusted) shared savings, with drill-down capabilities to individual provider & subpopulation levels • Dashboards showing comparative information between PPSs (trends, outcomes, costs) • Access to enriched Salient Interactive Miner tool as above, now including risk-adjusted costs as well

Precise deadlines, scope and format of information may change

State Reports Will not Replace PPS Acquired Population Health Platform

DOH plans to provide claims-based reporting, but this may not be sufficient for real-time population health analytics and patient engagement needs for the PPSs due to the following constraints:

1. Claims based reports have a lag of 6 month and don't necessarily provide all clinical information like lab results
2. Report will not be real-time but retrospective in nature
3. Population management capabilities like Outreach to patients would not come from DOH reports



Legend:
Primary target for PPS provided population health platform. These may not provided by state in entirety

What you will receive from DOH will…

- Allow you to define and identify populations in your PPS to focus on
- Allow you to identify care gaps
- Allow you to stratify populations within your PPS based on clinical and financial risk
- Allow you to measure and monitor outcomes over time and attribute success/failure to partners within the PPS
- Allow you to benchmark your outcomes and trends with other PPSs in NYS and with national benchmarks
- Allow you to 'pipe' data streams into your own PPS specific PHM tools that can build upon this foundation
- Allow you to identify potential reductions in total cost of care per episode, subpopulation or at total Medicaid population level – crucial to start shared savings discussions with MCOs

Population Health Management Criteria

The following criteria are key to selecting a robust population health management platform:

1 Patient Registries

Evidence-based definitions of patients to include in population health registries

2 Patient-Provider Assignment

Strategies and algorithms to assign patients to accountable physicians or clinicians

3 Precise Metrics in Registries

Discrete, evidence-based methods for flagging the patients in the registries that are difficult to manage or should be excluded

4 Clinical and Cost Metrics

Monitoring clinical effectiveness and cost of care to the system and patient

5 Basic Clinical Practice Guidelines

Evidence-based triage and clinical protocols for single disease states

6 Risk Management Outreach

Stratified work queues that feed care management teams and processes

7 Acquiring External Data

laboratory test results, and pharmacy data outside the core healthcare delivery organization

8 Communication with Patients

Engaging patients and establishing a communication system about their care

9 Educating and Engaging Patients

Patient education material and distribution system, tailored to the patient's status and protocol

10 Complex Clinical Practice Guidelines

Evidence-based triage and clinical protocols for comorbid patients

Source: Health Catalyst

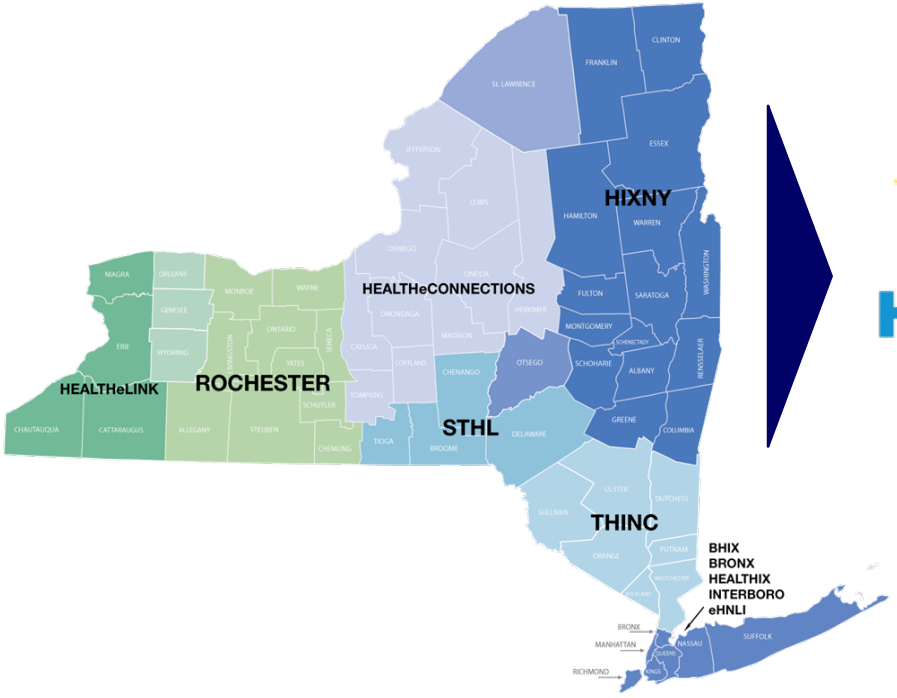
Challenges/ Issues Faced in Implementing Population Health Management

1	2	3
Complexity of data consolidation and normalization	**Access to real-time data for performance management**	**Care intervention for a patient**
• Receive claims feeds from payers • Combine claims, clinical, and admin data • Enterprise data warehouse vs. PHM-dedicated aggregation/analytics tool • Semantic interoperability	• Unilateral interfaces will delay useful data • Integrate with existing systems • Extensive business rules to help identify gaps in care • Meaningful alerts to trigger intervention	• Consider lead practices for care management • Available clinical team to review and act on information • Methods and timings of contacting patients • Cross community communication

Population Health Management Vendor Current Landscape

The marketplace for Health Information Exchange (HIE) vendors includes Regional Health Information Organizations (RHIOs), NY State HIE vendors, as well as commercial HIE vendors. Current RHIOS are utilizing one of four NY State HIE vendors. Additional vendors in the marketplace may be able to provide population health functionality.

9 RHIOs/ QEs (Qualified Entities)



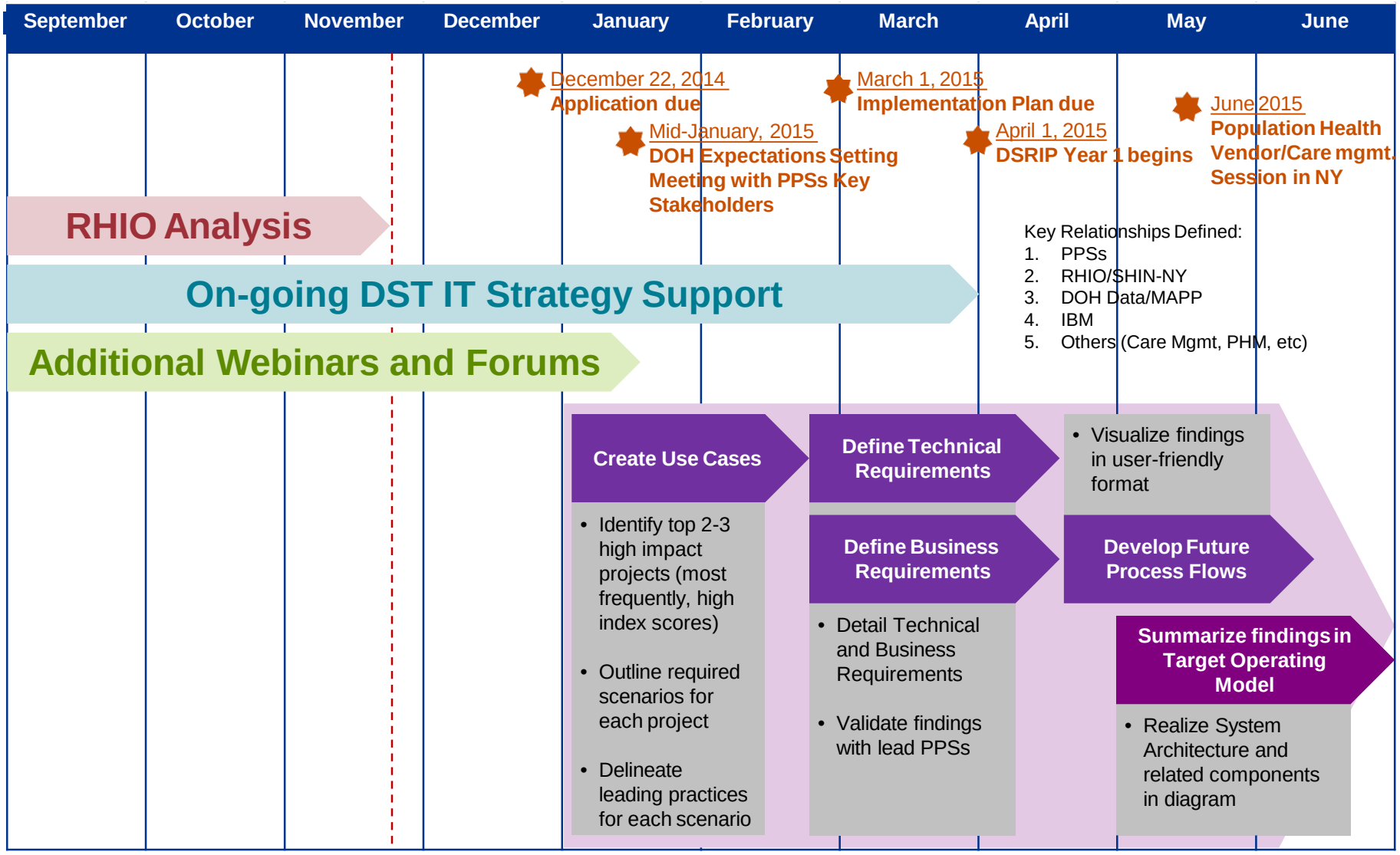
4 NY State HIE Vendors with PH Capabilities

InterSystems
OPTUM
HealthUnity
mirth

Vendors with PH Capabilities

- Covisint
- DBMotion
- eClinicalWorks
- Explorys
- GSI
- Kryptiq
- Lumeris
- McKesson
- Medecision
- The Advisory Board Company
- Wellcentive
- HIS Vendors

The DOH and PPS Support Activities: Proposed Support



Summary

Performing Provider Systems (PPSs) should take the necessary steps to ensure they have functional population health management tools in place help identify, monitor, and report on patient populations.

Population health management tools will help contribute to overall DSRIP goals of reducing avoidable hospital use and improving other health and public health measures, as well as by creating a cost efficient Medicaid program with improved outcomes.

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Disclaimers

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