Prevent Patients from Falling Through the Cracks in 10 Easy Steps
Proactive, automated patient engagement—anytime, anywhere.

Automate care management to improve population health.

**AUTOMATE**
Automatically reach out to, and manage, your entire patient community. Meet criteria for MU, PCMH, and ACOs.

**TRACK**
Track enhanced communications and improved outcomes with configurable reports and dashboards.

**IMPROVE**
See a significant return on investment from increased payer reimbursements and additional treatment opportunities.

[Watch an online demo](#) | Call us at 855-510-6398
Set it and forget it.

Providers today need an automated patient engagement solution that is fully integrated with their EHR and practice management systems. This integration enables providers to target high-risk patient and work more efficiently and collaboratively across the organization.

Targeted outreach—why it matters.

Providers need to deliver preventative care and the most appropriate intervention based on the individual’s condition, health risk, and severity of illness. Proactive Population Health management helps providers improve:

- Patient health
- Care quality
- Practice productivity
- Operational efficiency
- Revenue opportunities

Effective population health management drives collaborative care, which is at the heart of ACO, Meaningful Use (MU), and PCMH goals.
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Know population health goals.
Deliver better care in lower cost settings using population health tools

- Reduce avoidable ER visits and hospitalizations
- Lower hospital readmissions

Improve financial outcomes

- Maximize financial return for value-based care
- Earn preventative care incentives
- Better identify treatment opportunities
- Negotiate better risk/gain sharing terms with payers
Find root causes.
You need to manage your patient panel now more than ever.

The US healthcare system has been broken for decades—resulting in fragmented care delivery, unsustainable costs, and poor access to quality care. Although the reasons are complex, our changing demographics and patient non-compliance are root causes of the problem, fueled by many factors:

**Baby boomers (born between 1946 and 1964) are extremely high healthcare utilizers especially for “end of life” care**

- 40.3 million people age 65 or older in 2010; by 2050 projected 88.5 million; 8 in 10 seniors suffer from at least one chronic condition

  - About 25 percent of seniors are obese
  - 20 percent have diabetes
  - 70 percent have heart disease
  - Plus, there’s a projected physician shortage and issues of patient non-compliance with treatment

**Increasing chronic disease and comorbid conditions**

- Obesity
- Heart disease
- Diabetes

**We’re transitioning to coordinated, collaborative, integrated, value-based care**

**New diagnostic/treatments are now available to improve chronic conditions**

Grasp the impact of patient non-compliance.
Patient non-compliance accounts for:

- **11%** of all hospital admissions
- **41%** of nursing home admissions
- **20%** of prescriptions never filled
- **30%** of prescriptions never refilled

Contact with doctors and hospitals is sporadic and infrequent. Plus, health problems are often not addressed until the patient is in crisis.

By 2020, it’s projected that 25% of the American population will have multiple chronic conditions.

Get the “lifestyle lowdown” on your patients.
Providers can help prevent chronic illness by encouraging lifestyle and behavioral changes.

Modifiable behaviors that affect chronic diseases:

- Lack of Physical Activity
- Poor Nutrition
- Tobacco Use
- Excessive Alcohol Consumption

Even healthy patients tend to cut corners. Ask your patients:

- When is the last time you had a preventative screening on time?
- How many doctors’ appointments did you cancel this year because you were too busy?
- Do you always take your medications as prescribed?
- Do you stop taking medication when you start feeling better?
- Do you eat properly?
- Do you exercise regularly?
- Are you getting enough sleep?

Patient engagement tools enable patient participation in their own healthcare goals.
Tackle value-based payment models.
How you get paid is changing.

Shifting from volume-based to value-based care puts the burden on physicians, predominately primary care physicians, for managing, improving, and reporting clinical outcomes. This means that reporting on these outcomes will affect how, and how much, providers are paid.

This is true regardless of whether or not you are:
- Engaging in proactive patient engagement for preventative care
- Keeping patients from falling through the cracks
- Engaged in quality reporting for ever-increasing measures and mandates

It’s your patient—and your responsibility—whether the patient is:
- Compliant
- Non-compliant
- Chronically ill
- Sick short term
Maximize quality reporting channels.
If you don’t track it, you can’t report it!
Generate more revenue with quality reporting.

In the new value-based environment, providers will be responsible for documenting and reporting their patient outreach efforts across the practice. Tracking and monitoring the health status of the entire patient population is the first step in managing chronic conditions. Ultimately, providers will need to segment or “stratify” their population based on similar targeted health conditions.

If you don’t report it, you can’t get paid.

Quick glance – population health management benefits:

- Optimizes clinicians’ time
- Enables providers to focus more on patients in the office
- Helps providers to proactively address chronic and preventive care
- Is a building block for pay-for-performance initiatives like PCMH and ACO
- Helps improve operational efficiency and compliance with follow-up visits
- Increases revenue from timely preventative care visits
Get your “ACO game” on.
An ACO provides the actual framework for ongoing collaborative care across multiple patient touch points.

And an effective population health management program is fundamental to ACO success and payer population-based risk contracts.

To meet ACO goals such as improving collaborative care, care coordination, and patient engagement for better health outcomes, leverage your population health efforts to align with your accountable care goals. Proactively reach out to your patient population to schedule recommended care using tools such as NextGen® Population Health.

Ask your patients:

When your population health solution is integrated with your Patient Portal, you’re well on your way to better care coordination and improved outcomes.

- Keep healthcare providers more involved and connected to patients, and vice versa
- Improve disease management
- Ensure patients are up to date with treatments—and easily schedule maintenance visits by running quick reports by disease state
- Enable productivity improvements that save both time and money
- Lower the cost of healthcare through better care coordination and better quality outcomes
Leverage mid-level health practitioners.
Some interventions don’t require a physician.

Many treatments can be administered by eligible nurses, nurse practitioners, physician assistants, pharmacists, or other non-MD medical professionals. You can also see more patients with mid-level clinicians. Expand your time and resources for patient care, while increasing staff productivity and efficiency.

Use mid-level clinicians for preventative screenings such as:

- Breast Cancer
- Multiple Immunizations
- Cervical Cancer
- Chlamydia
- Prostate Cancer
- Colorectal Cancer
- Tobacco Cessation Intervention
Get the hang of data analytics.
Analyze patient data to identify potential treatment opportunities.

To minimize future costs, providers will need to predict which patients are likely to get sick. Motivating patients, especially your chronically ill population, to comply with recommended treatment and preventative care is a universal challenge for most providers.

Implementing Population Health into your practice is just the beginning of improving patient outcomes. Practices using patient engagement reporting and analytics set the stage for more advanced patient management capabilities. These include solutions such as risk stratification, risk scoring, predictive analytics, and improved value-based reimbursement opportunities.

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“We chose NextGen Population Health to help us provide the best care for our patients. The ability to effectively leverage our practice management and clinical data will help us identify treatment opportunities and improve quality outcomes.”

Dr. Thomas Huth
VP Medical Affairs
Reid Hospital & Health Care Services
Retool for patient “partnerships”
Elevate the patient/doctor relationship to new heights.

Because ACO delivery models are becoming more prevalent, providers are adopting new ways to connect, engage, motivate, and sustain meaningful patient engagement. As healthcare delivery evolves, (and designated caregiver) as a partner. This will require a major change in how patients, together with caregivers, use technology to better care for themselves, maintain their health, and/or manage chronic conditions.

Make population health management work for you:

- Maximize financial return during transition
- Reduce “avoidable” ED visits
- See fewer avoidable hospitalizations and readmissions
- Deliver better care in a lower cost setting
- Deliver improved quality care outcomes
- Leverage patient management tools
- Get reimbursement for screenings
- Get paid for “non-visit contacts”
- See shared savings opportunities
- Address chronic and preventive care proactively
- Use PH as a building block for quality initiatives (such as PCMH)
- Improve operational efficiency and compliance for follow-up visits
- Increase revenue due to fewer missed opportunities
- Increase volume of inbound calls
For more information, read our NextGen® Population Health brochure at www.nextgen.com/Products-and-Services/Ambulatory/Population-Health or watch an online demo at nextgen.com.