Technology and Data's Impact on Population Health

5 Steps to an Effective and Sustainable Population Health Management Program

NEXTGEN® HEALTHCARE

This eBook will share critical information about population health management and explain how providers can create an effective and sustainable population health program, step by step.

Why create a population health management program?

If you work in healthcare, you've been facing waves of changes over the last few years. One of the most significant was the passing of the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015. It has become a catalyst in changing how care is delivered, moving from volume to value, and adding more focus on population health management.

Why? Because today, ACOs, PCMHs, FQHCs, and other new value-based, shared risk, and merit-based incentive models are transforming healthcare and demanding that focus.

To succeed, healthcare providers now need to navigate this new paradigm.

The key to smooth sailing is a robust population health management program, which you'll need to fine-tune before you can succeed in the value-based care era.

What is population health management?

The primary goal of population health management is to improve health outcomes of groups or cohorts of people by improving care quality, providing better access to care, and increasing preventive care. It has the potential to not only improve the entire healthcare system, but can also help reduce the cost of care significantly. Because of the shift to value-based, shared risk, pay for performance reimbursement models – population health management is becoming increasingly important. At the most basic level, many characterize population health management as the organization and management of the healthcare delivery system in a way that makes it more clinically effective, more cost-effective, and safer for patients. In the end, the key to success for value-based care and payment models is managing and improving the health of a practice's entire patient population, not only those actively seeking care.

Effective population health management aims to improve and maintain a population's health at the lowest necessary cost.

Leveraging data within your smart population health management strategy

Effective population health management has the power to transform healthcare. But that won't happen without robust data and actionable analytics. To improve your population's health cost effectively, you need a smart, comprehensive population health management strategy that puts the collection and use of data at its core.

Many healthcare organizations struggle with this, particularly in light of emerging value-based care and regulatory requirements. While electronic health records (EHRs) can provide the raw data many healthcare providers need – making the data accessible and usable – reporting on the outcomes is still a struggle for most providers.

That's why – anchored by technology, aggregated data, and data analytics – you need a population health management strategy that helps you identify high-risk patients, drive patient engagement, expedite care management, and positively impact outcomes. All with the goals of improving community health and reducing healthcare costs.

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Healthcare leaders embrace population health

According to the 2015 HIMSS Leadership Survey:

38%

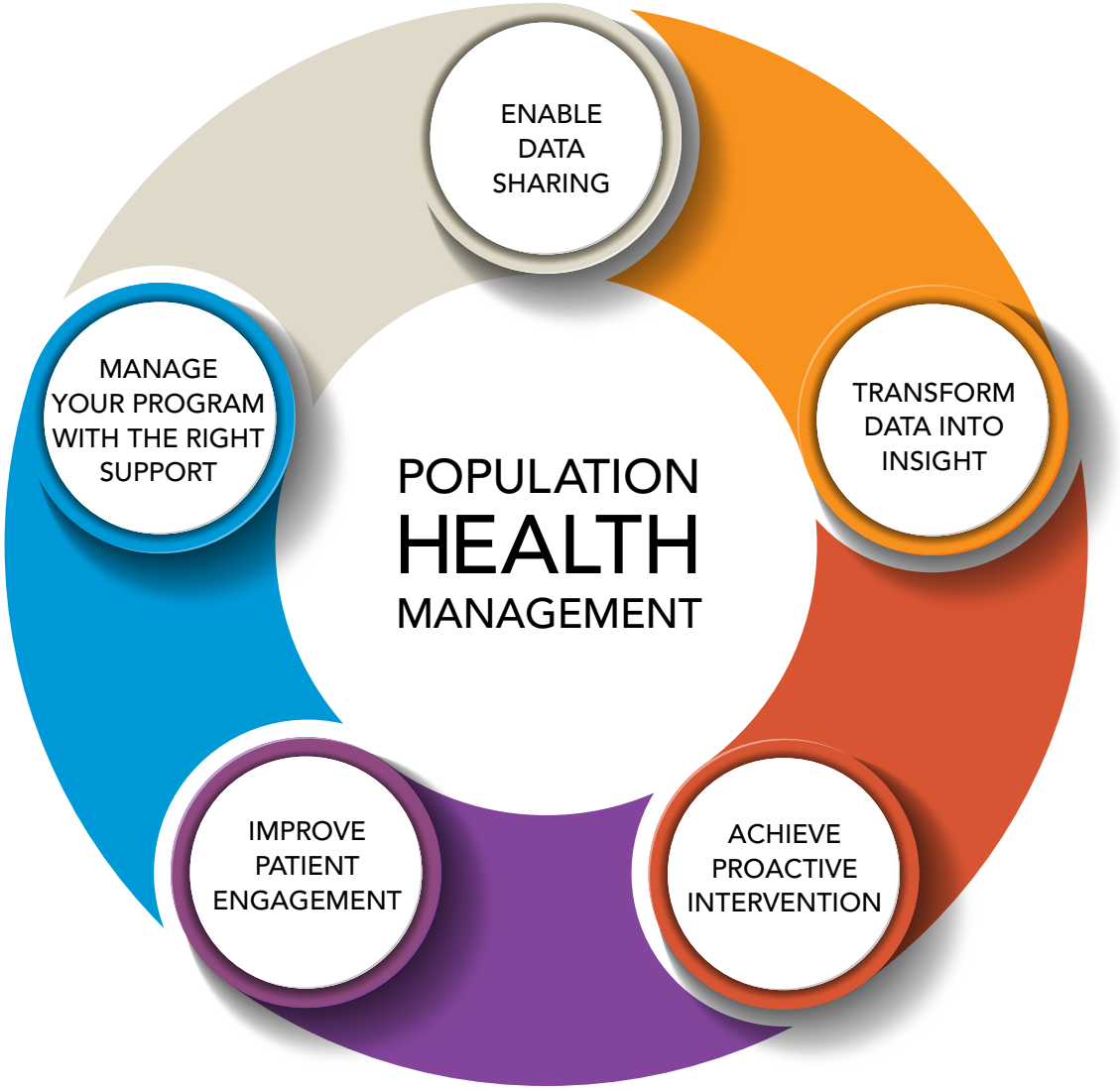
More than one-third of respondents indicated that population health management tools were in place at their organization

51%

of respondents indicated that their organization has improved population health as a result of the IT tools in use at their organization

Your step-by-step population health management guide

How do you execute on a smart population health management strategy? The graphic below illustrates **the key "anatomy" of an effective, sustainable population health management program.** Let's take you through this step-by-step process and explain **what you need to know – and do –** to create and sustain population health management success.



1

Enable data sharing

Data access and exchange are critical, but challenging

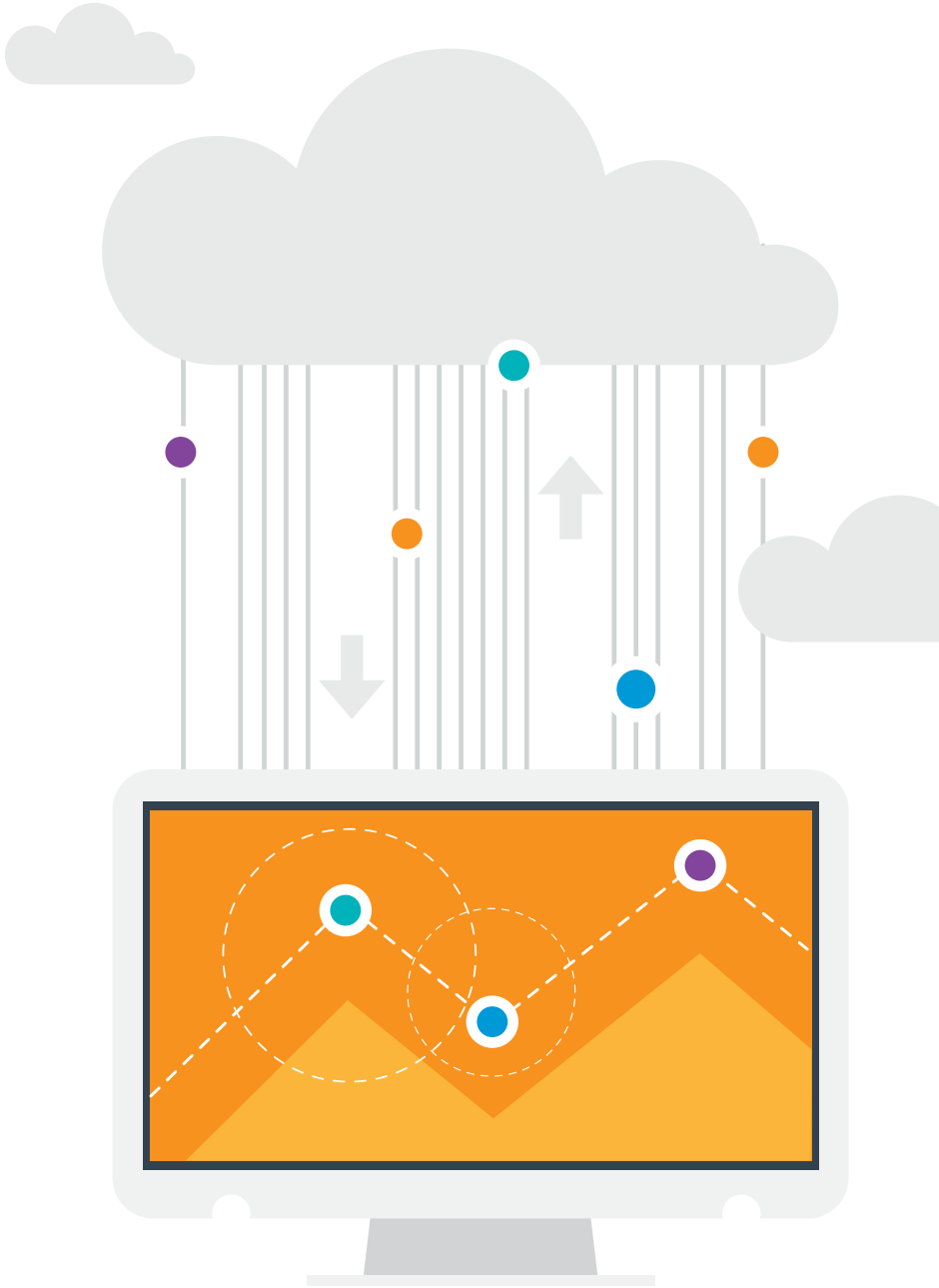
Today's reimbursement models require more patient data than ever before. To successfully adopt a population health model, you must acquire, aggregate, and leverage data in support of clinical integration.

And you need powerful, proven interoperability solutions to meet these challenges – your sustainability depends on it. This can be a challenge because healthcare data often resides in silos, spread across different systems in the care network. It often seems like no two organizations or systems speak the same "language." Information frequently lives in multiple disparate systems, making it hard to exchange data with colleagues, care teams, patients, and payers across organizations, locations, and communities.

It's no secret; communication with external providers is key

How can you meaningfully share data, aggregate information, meet health reform demands, and achieve value-based care if you can't securely connect and communicate? Enabling data sharing across care touch points is a required foundation for population health and to improve outcomes.

Set yourself up for success. You can start by simplifying interoperability using trusted communication tools within your network, as well as with external organizations.



Community Medical Center relied on its technology "anchor" to kick-start its program. Every organization engaged in population health management is doing it a little differently. In Falls City, Nebraska, a 25-bed Community Medical Center (CMC) with a five-provider clinic, relies on NextGen Healthcare as its anchor technology provider for population health management. The hospital has an active patient outreach analytics initiative and is assessing how accurate Medicare is with its quality determinations, which affect reimbursement rates.

You can't collaborate to improve outcomes if you're not sharing information

Data sharing is the key driver of collaborative, coordinated care. With stringent reporting requirements, you need a way to track your outreach efforts, results, and outcomes; and to provide that data to stakeholders outside of your organization.

Connect fragmented systems for value-based care

You need a single, longitudinal patient record for improved reporting and analysis as you work toward population health, collaborative care, improved outcomes, PCMH or ACO goals, and lower care costs.

2

Transform data into
actionable insight

Once connected, financial and clinical data must be turned into usable information. Transforming data into actionable insight can help improve care quality and reduce cost – such as when identifying high-risk patients for engagement and intervention. Using analytics, you can look for improvement opportunities at both the population and individual patient levels.

To transform data into actionable insight, you need the right analytic tools and expertise based on your business needs.

Choosing smart data analytics tools

The right data analytics tools provide access to critical information about your patients to help you identify and address problems, leverage resources effectively, and improve care and outcomes. To be effective, you need to slice and dice your information based on your predefined criteria – then take action.

For CMC, in the first month, 28 new thyroid disease cases were found. Plus, over the past year, a flu campaign resulted in 76 percent more patients coming in for vaccination.

Community Medical Center uses data insight to improve communication and care

CMC's goal has been to advance past canned reports and do deeper analyses of its population. It is marketing itself to the overall community. It has aggregated patient lists and has set up a rules-based hierarchy that governs an automated communications system. If a provider reaches out to a patient via CMC's NextGen® Patient Portal and the patient doesn't respond, then an email is sent. If that doesn't work, a postal letter is sent. Because of its rural population, traditional mail has proven more effective than email.

Get a 360-degree patient view

Using NextGen Care®, designed for population health management, CMC was able to see a 360-degree view of patients' chronic problems, allergies, medications, referrals, patient risk summaries, and a blend of clinical and financial data. This solution empowers providers to optimize predefined patient groups or create their own – then, save these groups and take action on them. From here, providers can make referrals, export a chart, create patient recalls, and much more.

A working population health program that's showing results

In addition to using NextGen® analytics to assess payer reimbursement, CMC uses it to identify patients with diabetes, high levels of lipids, high body mass index levels, hypertension, or thyroid disease, and get them in to see a doctor.

Changing provider mindsets at CMC

While the population health program at Community Medical Center is working, its start was a bit rocky. Educating patients on why they are being contacted, and the importance of that contact, worked better than expected, but the staff wasn't ready. So depending on your organizational dynamics, your population health management success may depend on changing the mindset of clinicians to be more proactive in providing care.

Identifying high-risk patients earlier.

CMC providers use NextGen Care to identify high-risk patients and fast-track them into care management with automated and expedited treatment intervention.

“Now we have a tool to make better point-of-care clinical decisions for improved outcomes, while maximizing payer reimbursements and incentives by improving our patient’s health. Additionally, the NextGen Healthcare template functionality is so rich we were able to configure our templates to accommodate the needs of all of our providers, enabling them to be more innovative and targeted with their outreach campaigns.”

Ryan Geiler, EHR Lead System Specialist
Community Medical Center

What is predictive analysis and why is it important?

Predictive analysis is the act of extracting information from existing data sets to determine patterns and predict potential future health trends and outcomes. Predictive analytics will not tell you what will happen in the future. But it can help you forecast what might happen and includes what-if scenarios and risk assessments.

Integrating predictive analytics into a healthcare delivery system

Prediction is most useful when that knowledge is conveyed into clinical action. Most importantly, it should carefully link to clinical priorities and measurable events, including cost effectiveness, clinical protocols, or patient outcomes. The first thing you want to know when jumping into predictive analytics (before anticipating your future) is very basic; what is happening in your population right now?

In the context of healthcare, predictive analytics systems are being used to understand which patients are at higher risk for hospital readmission, to reduce hospital stays after joint replacement, to anticipate staffing needs while reducing overtime, among other productive uses.

Smart organizations can use predictive analytics to make meaningful improvements on both the clinical and operational sides of the business.

The sooner you embrace it, the better: CMC's approach to predictive analytics

For those healthcare organizations looking to implement predictive analytics for population health management, CMC's Geiler says that figuring out the workflow and the process is much more difficult than implementing the technology. While predictive analytics is a relatively new field in healthcare, he believes the sooner healthcare organizations embrace it, the better.

"There is a fiscal incentive to do this now," Geiler says, referring to the fact that by 2018 over 50% of Medicare fee-for-service payments will be rewarding for quality and value and aligning Medicare Advantage and Medicaid to do the same. "If you don't start to do this now, next year you're going to be in complete panic mode."

Five important considerations when implementing analytics

1. Uniform, first-rate data is essential for results to be reliable
2. You must organize your processes and structures to allow disparate data integration
3. Stakeholders must buy in to using the data for predictive analytics for it to be effective
4. The right staff members (in leadership roles) must support and guide your strategic analytics efforts – many healthcare entities are now creating C-suite positions focused on analytics
5. Those who succeed at the highest level of advanced analytics put great emphasis on the use of data throughout the organization – and continually strive to improve on the effective use of data over time

3

Achieve proactive intervention

How CMC is engaging diabetic patients and improving outcomes

When CMC providers started using NextGen Care, CMC had a growing diabetic population. In July 2014, the organization began testing a population health tool embedded in its NextGen Healthcare electronic health record (EHR) with the hopes of better managing at-risk patients and enhancing health outcomes. More specifically, it wanted to identify patients who had not recently seen a physician, transition these individuals into care, provide evidence-based interventions as needed, and mitigate risk before the patients had a serious health episode.

The organization started by targeting its large diabetic patient population. CMC ran a report that showed those patients who had not had an HbA1c test—a key diabetes monitor —in the past three months. It then applied a scoring algorithm, which was based on several diabetic risk factors, including body mass index, lipids over 200, and a family history of diabetes. This generated a ranked report of more than 300 patients in need of care, with the most urgent cases listed at the top.

With the right information at hand, healthcare providers can better manage care transitions, such as through improved discharge planning or post-acute outreach. This improves care and helps prevent costly hospital readmissions.

The right type of targeted analysis identifies members of the population who require intervention—whether that means closing preventive or chronic care gaps, generating a care plan, or addressing what keeps a person from filling and taking prescriptions.

Getting diabetic patients in the CMC clinic door

The clinic then sent electronic communications to the identified patients, dispatching emails and reminders through its patient portal; however, this did not elicit the response the organization had expected. Trying a different approach, the clinic sent letters in the mail and made phone calls, having nurses reach out personally to those patients at highest risk. This tactic worked much better with its particular population, as mentioned previously, bringing a good portion of the 300 patients into the facility for care.

Once a patient arrived at CMC, the provider performed a thorough evaluation, using diagnosis-specific care guidelines provided through the EHR to facilitate comprehensive chronic condition management. These guidelines ensured the provider ordered the appropriate laboratory tests, created an effective and personalized care plan, scheduled follow-up appointments, and made any necessary referrals. By using these guidelines, the clinic was able to deliver consistent care for all diabetic patients coming to the facility and to continue to see them for follow-up care.

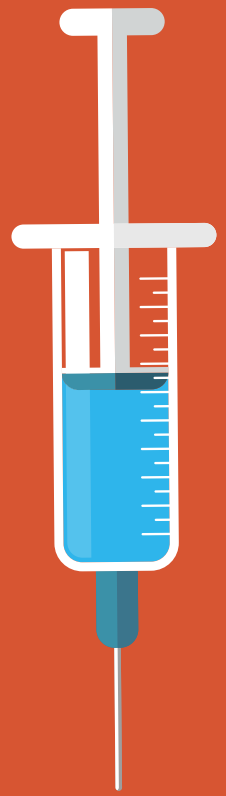
As a result of its diabetic population health management initiative, Community Medical Center discovered and responded to multiple patients with A1c levels at 12 or higher.

Boosting CMC's immunization rates using patient profiling

CMC knows it's important for its patients to get flu vaccines at its clinic so it can ensure documentation in the patient's record. "If flu immunizations are administered elsewhere, we may not be able to capture this important piece of information until we engage the patient. This is particularly important as we transition to value-based care," says Geiler.

Using the patient profiler application within the NextGen® Population Health solution, CMC segments its patient database for targeted outreach. It schedules patient alerts in stages so the office is not flooded with calls for appointments at the same time and patient flow is manageable for staff.

As Geiler explains, "We're tracking patient response to determine the overall increase in immunizations compared to last year and the results are in! We've seen a 76% increase in the number of influenza immunizations administered as a result of using population health solutions from NextGen Healthcare. During this time, we've added no new physicians, no new flu clinic dates, or no new businesses. The increase has been significant compared to 2014, prior to our population health solution being in full swing for influenza outreach."



"We've seen a 76% increase in the number of influenza immunizations administered as a result of using population health solutions from NextGen Healthcare."

"I've worked on multiple EHR systems, and one of the strengths of NextGen is that it has real-time SQL information available, so, at any given time, I can go into the database and see whatever I want to on any of our patients, even if they were seen five minutes ago. It sounds like something every EHR should be able to do, but I can tell you that every EHR cannot do that. A lot of them act as a data repository, where you might have to wait two days before you get live data."

Ryan Geiler, EHR Lead System Specialist
Community Medical Center

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Improve patient engagement

You can optimize patient engagement when you combine the delivery of information and expert advice with your patient's own requirements, preferences, and capabilities.

This enables the best, customized healthcare decisions possible – and allows patients to be partners in their own care.

What's more, to engage physicians well, you need their buy-in, in advance. Clinicians also care about streamlined, easy workflows – so be sure you can demonstrate that your technology is easy to use. Finally, make sure your providers are all aligned with your organizational goals.

How CMC engages patients

CMC providers have embraced NextGen Population Health because they are getting people in the door and employing their expertise to improve the quality of their patients' lives. Initially, there was some apprehension about dedicating time and resources to a new initiative, given the fast pace of this busy practice. However, after seeing how well its population health tool pinpointed at-risk diabetic patients, CMC's providers are eager to tackle other chronic conditions.

The organization is just beginning to expand its work to different disease states, as well as women's health, pediatric wellness, cardiac issues, and asthma. As the clinic broadens its population health program, it also plans to onboard a care manager who can take charge of reaching out and following up, thereby reducing reliance on existing nursing staff and helping boost outreach efforts to smoothly transition patients into care.

While Community Medical Center's use of population health technology will help the clinic prepare for changing care dynamics and emerging payment models, the real benefit of the program will always remain enhancing patient care and saving lives.

“After about four months of using NextGen Care, we generated roughly $64,000 in additional revenue. So in addition to all of the clinical quality measures that we’re starting to meet and the quality of life that we’re improving for our patients, we’ve seen a very good ROI.”

Ryan Geiler, EHR Lead System Specialist
Community Medical Center

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Manage your ongoing population health program **with the right support**

Support services can help organizations implement and manage a population health program with new care models, processes, and care teams. Plus, good support can help providers optimize their ability to implement actionable analytics, accurate patient care registries, and care management programs so they can exceed both clinical and financial goals.

The right partner will deliver the support you need to achieve interoperability and can empower you to:

- Securely exchange private health information to collaborate, aggregate, and act on health information to make better decisions for better care and outcomes
- Create a community-wide view of patients across disparate systems, manage care transitions, and deliver critical patient information at the point of care
- Measure and report the health of your population for value-based reimbursements
- Make the most of your existing IT resources and investments

Evolving to a value-based population health model requires a substantial commitment and investment. Choose a health IT partner who can help you lay the right foundation – from both an infrastructure and support perspective.

Avoiding mistakes – key lessons learned

Managing care better using new technology is both exciting and challenging, as Community Medical Center (CMC) learned along its path to population health management. Lessons learned include:

1

Begin at a realistic pace

You may want to jump right into population health management, using technology to recognize and respond to many diverse conditions simultaneously. However, unless you have staff available to turn data into patient care visits, it is not helpful to take a broad approach—and you may even limit your success.

2

Keep resource availability top of mind

Be intentional about timing your outreach efforts. If a few staff members are going to be out of the office, or there is already a high patient census due to flu season or other illness, CMC has delayed letters and phone calls to make sure that when patients respond, the practice can see them in the office using currently available resources.

3

Choose a tool with careful consideration

Cautiously consider what technology to use. It's important to have a population health solution that seamlessly interfaces with your EHR and is interoperable. This way, providers can access both risk stratification information and care guidelines at the point of care.

4

Keep report generation straightforward

Your population health management tool should use a structured database with discreet data and real-time analytics. Organizations wanting to achieve PCMH recognition or participate in various state or federal programs would likely want to invest in an EHR module specifically for population health to achieve this, as CMC has done.

About NextGen Population Health

NextGen Healthcare is the right health IT partner to help you achieve interoperability across silos. Our solutions –including our EHR and practice management systems – are fully integrated with the NextGen® product suite, so there are no APIs or third-party interfaces.

Using our single care management screen, care management team members can take actions in very few clicks (everything you need in one place) – without leaving their workflow. Users benefit from a 360° view of patients' chronic problems, allergies, medications, referrals, and patient risk summary, as well as a blend of clinical and financial data. And you can easily score your patients' risk level — high, medium, low — then take action based on risk level to address gaps in care. Plus, we offer point-of-care alerts to help you fast-track patient intervention.

By using our interoperable population health solution, your care team can access, share, and aggregate actionable data from multiple sources (via NextGen® Share) to optimize care to put patients back on track. Plus, with our patient portal you can engage with patients anytime, anywhere through improved, streamlined communications.

With our ROI calculator, you can track treatment opportunities and associated revenue by chronic condition and preventive outreach.

Get up and running with a team approach

NextGen Healthcare's team approach to implementation can get you up and running quickly and help with validating campaign results. Like Community Medical Center, you can rely on NextGen Healthcare as a proven technology "anchor" to kick-start your population health management program.

NextGen Healthcare is helping clients transition to value-based care by empowering them to nurture measurably healthier patient communities at a lower cost. Our solutions, optimized by physicians, developed with input from our 90,000 providers, and based on almost 25 years of ambulatory expertise, help ease the burdens of health IT, enable practices to improve individual outcomes, and nurture a healthier population.

Next Steps

We're ready to help you grow and thrive — and to improve your clinical and financial outcomes.

Learn more.

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