• Together 2 Goal® Updates
  – Webinar Reminders
  – 2017 Webinar Topics
  – Goal Post August Newsletter Highlights
  – IQL Conference: Nov. 14-17
• Use a Patient Registry & Publish Transparent Internal Reports (Lehigh Valley Health Network)
  – Sameera Ahmed, MS, RHIA, CHDA
  – Nina M. Taggart, MD, MBA
• Q&A
  – Use Q&A or chat feature
WEBINAR REMINDERS

• Webinar will be recorded today and available the week of September 19th
  – Together2Goal.org Website (Improve Patient Outcomes → Webinars)
  – Email distribution

• Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen
INPUT REQUESTED: 2017 WEBINAR TOPICS

- Beginning planning for 2017 monthly webinars
- Email topic and/or speaker recommendations to together2goal@amga.org
- Self-nominations accepted
National Day of Action

• **Twitter chat**
  - Nov. 3, 2-3pm Eastern
  - #T2Gchat

• **Online pledge**
  - Commit to different “actions” on Nov. 3
  - Select from our ideas or create your own!
GOAL POST SEPT. NEWSLETTER HIGHLIGHTS

Campaign Spotlight:

Resource of the Month

©2016 AMGA FOUNDATION
Conference Theme: Succeeding Under MACRA and Risk-Based Payment

To Register: www.amga.org/IQL2016
TOGETHER 2 GOAL® AT AMGA’S INSTITUTE FOR QUALITY LEADERSHIP (IQL)

• **Monday, November 14**
  – Pre-Conference Session*
    • Johnson & Johnson Health Care Systems, Inc. CORE Program

• **Tuesday, November 15**
  – Chief Quality Officer/Director Leadership Council
    • Improving Care Delivery: Assessing and Addressing CVD Risk
    • Team-Based Approach to Diabetes Care

• **Wednesday, November 16**
  – Peer-to-Peer Breakout Session
    • New Approach to Improving Diabetes Care with In-Person Professional Education Training Model

*SUBJECT TO CHANGE
TODAY’S SPEAKERS

• **Sameera Ahmed, MS, RHIA, CHDA**
  – Senior Healthcare Data Analyst, Lehigh Valley Health Network

• **Nina M. Taggart, MD, MBA**
  – Physician Administrator, Population Health, Lehigh Valley Health Network
Using Reports and Registries to Support the Management of Diabetes Patients

Nina M. Taggart, MD, MA, MBA, FAAO
Sameera Ahmed, MS, RHIA, CHDA
Today’s Discussion

• Introduction
• LVHN’s population health management strategy
• Development and deployment of patient registries using Optum One
Lehigh Valley Health Network

- Recognized by U.S. News & World Report, Fortune, Modern Healthcare, Leapfrog, others
- 5 hospital campuses, 12 Health Centers
- +10 ExpressCARE locations
- Approx. 1,161 acute care beds
- 1,340 physicians (700 network-employed)
- More than 13,000 employees
- Ancillary Services
- Physician Hospital Organization
- Revenues over $2 Billion
U.S. Healthcare Delivery System Evolution

### Acute Care System 1.0
- Episodic healthcare
- Lack of integrated care networks
- Lack of quality & cost performance transparency
- Poorly coordinated chronic care management

### Coordinated Seamless Healthcare System 2.0
- Patient/person centered
- Transparent cost and quality performance
- Accountable provider networks designed around the patient
- Shared financial risk

### Community Integrated Healthcare System 3.0
- Healthy population-centered, population health-focused strategies
- Population-based reimbursement
- Community health integrated
- Networks linked to community resources capable of addressing psycho-social/economic needs

Populytics

- Population health management and analytics firm
- Established December 2013
- Integrated services
  - Population Health Analytics
  - Clinical care coordination
- Expert professionals
  - Payer & provider informatics
  - Advanced analytics
  - Insurance and risk management
Integrated Care Management Model for a Healthier Community

- Community Care Teams (5%)
- Ambulatory Care Managers (25%)
- PCMH Initiatives (30%)
- Convenience, Access & Preventative Care (40%)
Population Health Management Executive Committee

• Clinically driven, includes key network leadership

• Programmatic focus leverages clinical integration and care alignment throughout LVHN

• Shared KPIs
  • Clinical pathways
  • Costs/spend
  • Utilization (Inpatient, ED, Readmissions)
  • Pharmacy costs

• Informs and facilitates concurrent work
Identifying Diabetes Care and Cost Opportunities

- Claims-based analytic tools used to identify cost drivers by clinical condition for attributed population
- Other measures of interest by clinical condition
  - Number of members
  - Inpatient & ER utilization
  - Comorbidities (CKD, CHF)
Using Clinical Data to Stimulate Discussion

- DM Cohort Demographic Profile
Using Clinical Data to Stimulate Discussion

- DM Cohort Clinical Profile
Using Clinical Data to Stimulate Discussion

- DM Care Gap Overview
Using Clinical Data to Stimulate Discussion

- DM Predictive Risk Overview
Turning Data into Actionable Information

• Engage care teams
• Identify clinical opportunities for improved care
• Determine strategy for targeted interventions
• Develop patient registries for population health and practice team
Practice Team Information Needs

- Predictive analytics
- Meaningful clinical indicators
- High utilizers (IP admits, ED Visits)
- Behavioral health information
- Social determinants
Predictive Analytics

• Prompts proactive outreach

• Predictive models assessing the likelihood of chronic-disease related admission and disease progression
  • DM
  • DM to CKD
Meaningful Clinical Indicators

- DM
  - Last A1c
  - SBP/DBP
  - LDL
  - BMI
  - ACE/ARB
  - eGFR
  - Endocrinologist
  - Eye exam
Other pertinent patient information

- Frequency of ED Visits, IP admits, readmits
- Behavioral health
  - Dx of depression
  - Rx for depression
- Need for social services
  - Patient is self pay
Collaboration with users

• Review other available variables with practice team members
  • DCSI Score
  • Charlson Score
  • HCC-RAF Score
  • # Primary Care Visits
  • Has a Next Visit/Date of Next Visit
  • Clinic of Provider for Next Visit
  • Total Charges
Final List of Registry Variables

• 60+ different variables covering:
  • Patient Demographics
  • Providers
  • Utilization
  • Upcoming appointments
  • Risk Scores
  • Predictive Analytics
  • Behavioral Health
  • Costs
  • Medications
  • Clinical Observations/Labs
## Registry View

<table>
<thead>
<tr>
<th>Date Added</th>
<th>DCIS Score</th>
<th>Curr...</th>
<th>DM Pt Probability of Developing CKD within ...</th>
<th>Likelihood of DM...</th>
<th>HCC-RAF [Last 1...</th>
<th>Last A1c 03/01/2...</th>
<th>Date of next visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>07-20-2016</td>
<td>1</td>
<td>08</td>
<td>80</td>
<td>0.810</td>
<td>6.0</td>
<td>12-08-2016</td>
<td></td>
</tr>
<tr>
<td>08-13-2016</td>
<td>1</td>
<td>08</td>
<td>82</td>
<td>1.202</td>
<td>6.3</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>07-20-2016</td>
<td>0</td>
<td>08</td>
<td>83</td>
<td>1.050</td>
<td>10.1</td>
<td>09-20-2016</td>
<td></td>
</tr>
<tr>
<td>07-20-2016</td>
<td>5</td>
<td>08</td>
<td>76</td>
<td>1.015</td>
<td>9.4</td>
<td>10-27-2016</td>
<td></td>
</tr>
<tr>
<td>07-20-2016</td>
<td>2</td>
<td>08</td>
<td>83</td>
<td>1.342</td>
<td>8.0</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>08-11-2016</td>
<td>1</td>
<td>08</td>
<td>86</td>
<td>0.437</td>
<td>6.8</td>
<td>07-20-2017</td>
<td></td>
</tr>
<tr>
<td>07-20-2016</td>
<td>1</td>
<td>08</td>
<td>74</td>
<td>0.629</td>
<td>7.7</td>
<td>11-16-2015</td>
<td></td>
</tr>
<tr>
<td>07-20-2016</td>
<td>0</td>
<td>08</td>
<td>46</td>
<td>0.429</td>
<td>8.0</td>
<td>09-27-2016</td>
<td></td>
</tr>
<tr>
<td>07-20-2016</td>
<td>1</td>
<td>08</td>
<td>79</td>
<td>0.771</td>
<td>---</td>
<td>12-01-2016</td>
<td></td>
</tr>
<tr>
<td>07-20-2016</td>
<td>3</td>
<td>08</td>
<td>94</td>
<td>4.019</td>
<td>6.2</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>07-20-2016</td>
<td>2</td>
<td>08</td>
<td>94</td>
<td>1.420</td>
<td>8.6</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>07-20-2016</td>
<td>0</td>
<td>08</td>
<td>80</td>
<td>0.907</td>
<td>7.9</td>
<td>09-28-2016</td>
<td></td>
</tr>
</tbody>
</table>
Defining Standard Work

• Set standard filters to guide outreach efforts and care gap closure for DM patients

• High Likelihood of DM Related Hospitalization
  • Likelihood >= 80%

• High Utilizers
  • ED Visits >= 2, Hosp Admits >= 3 in 12 months

• High Risk, Low Spend
  • HCC-RAF in high risk range, Total Charges <= $15,000
Coordinating Patient Care

- Identify patients with comorbidities or complications
- Identify barriers to seeking care and assist in resolutions
- Connect patient to resources across settings and episodes of care
- Engage patients in ongoing plan of care with PCP/Endocrinologist
Next Steps

• Integration of tool set with Epic
  • Risk scores
  • Predictive models
  • Registries

• Include more social determinants of health in standard workflow

• Submitting data to payers to support enhanced scoring on quality measures for incentive programs
Questions?