HIT's 2020 Vision

Automating Population Health
Telemedicine: current and future
Preventing clinical data exhaust streams
HMT Dashboard: ICD-10
Population health management in a clinically integrated network

Automation yields a wealth of benefits for IT, administrators, clinicians and patients.

By Melanie Ezzell-Nelson

Government and private insurers are moving away from encounter-based reimbursement and rapidly developing new payment models that reward coordination of care and population health management. Orlando Health, a seven-hospital, 1,780-bed Florida health system that is one of that state’s most comprehensive not-for-profit healthcare networks, saw the change coming and knew it had to act. In standing with its size, the health system set an ambitious goal: be the highest-quality, lowest-cost provider in central Florida.

“We like to be leaders, not followers,” explains Rick Schooler, Orlando Health vice president and chief information officer. As a first step, in partnership with UF Health, the University of Florida’s healthcare system, Orlando Health’s leadership is working to form a clinically integrated network (CIN) that includes its 400 employed doctors, independent primary care and specialty physicians, and eventually practitioners employed by the University of Florida healthcare system. Clinical integration promises to coordinate patient interventions, manage quality across the continuum of care, drive population health management and enable value-based contracting.

To get there, Schooler, a former CHIME/HIMSS CIO of the Year, realized the health system would need to significantly scale its care management and patient engagement efforts. Above all, it would need population health tools to help identify patients at risk of acute episodes, find the gaps in their care, engage them and evaluate performance — all without spending large amounts of money on care coordination and care management.

“We knew that a key part of clinical integration and of surviving the future of healthcare is to manage the health of a population,” explains Schooler. “To do that, you need tools that are tailored to the individual level that allow you to intervene, intercede, prompt, reach out, remind and analyze. You have to be able to take that individual information and aggregate it to the population level to detect trends, stratify patients based on clinical risk or other factors to really understand how you are doing on quality and cost utilization.”

Adds Jennifer Endicott, Orlando Health’s vice president of clinical integration: “We had already recognized that an EMR would not get us where we needed to go. An EMR is a data repository that’s designed to allow healthcare providers to manage those patients who are in front of them, not those who are not in front of them. That task is just too cumbersome and difficult — and frankly impossible for most EMRs.”

An exhaustive search

When evaluating solutions, Orlando Health felt it was vital to invest in a single platform for both clinical integration and population health management. Moreover, it needed a solution that would not put added stress on an already overloaded IT staff. Like all health systems, Orlando Health has many competing demands and not enough resources. The solution provider would need to do the heavy lifting, including data integration and workflow assessments, data mapping to protocols, system configuration, training and implementation.

A member of Schooler’s senior project management team led the vendor selection committee. After a systematic search of 12 different vendors that included multiple site visits, the health system ultimately chose Phytel.

At Physician Associates, the health system’s employed group of 100 primary care physicians, Orlando Health has successfully interfaced Phytel with the group’s Allscripts EHR and implemented four modules: Phytel Outreach patient engagement tools, Phytel Remind appointment reminders, Phytel Insight reporting and dashboards, and Phytel Coordinate care management tools. A fifth module (Phytel Transition, to enhance coordination of discharged patients) is planned for implementation by the end of the year. Phytel also is interfaced with Orlando Health’s Allscripts Sunrise inpatient EHR to capture information on patients discharged from the system’s hospitals.
Medical homes, neighborhoods and beyond

The health system is moving forward on several fronts. Orlando Health is one of 15 health systems nationwide to participate in a CMS-funded Patient Centered Medical Neighborhood demonstration project. The initiative, which utilizes technology for population health management, is designed to connect acute-care hospitals with technology-empowered primary care, specialty and subspecialty practices to drive better quality, superior patient experience and population health at a more affordable cost.

Key to Orlando Health’s selection for the program was that a majority of its ambulatory care offices have been officially recognized by the National Committee for Quality Assurance (NCQA) as patient-centered medical homes (PCMH). The medical home model is widely embraced as a prerequisite for population health management.

An early win for Orlando Health has been its use of Phytel Outreach, says Chris Jordan, Orlando Health’s chief applications officer for ambulatory systems. By creating ongoing automated messaging campaigns, Orlando Health has persuaded many patients who need preventive or chronic care to make appointments with their doctors.

But while Jordan says Phytel Remind and Phytel Outreach were essential to driving the group’s success with PCMH, it is Phytel’s reporting and care management tools that really empower users. Phytel Insight, the reporting module, excites Jordan “because it allows providers and case managers to look at our entire population and see how we’re doing,” he says. “Their favorite tool is the scatter plot that lets you look at all our diabetes or heart-failure patients or any other cohort across our 100 primary care providers and see where their vitals fall. On just one screen, they can see thousands of patients and see who the outliers are.”

Physician Associates’ care coordinators utilize the tool to focus their resources on the patients who need them most, Jordan says. Instead of having to search electronic charts and run reports, he says, the care coordinators can use Phytel Insight to spot “the 50 or 100 patients who are way outside of the control factor and concentrate on them first.” The practice also is using Phytel Insight to help determine physician quality bonuses, which track their compliance with quality measures, Jordan says.

“For instance, our doctors need to have 60 percent of their hypertension patients in control (with blood pressure 140 over 90 or less). Insight is really cool, because we can go in and say ‘Show me every doctor and their status on their entire population of hypertension patients.’ And we can immediately qualify them for their quarterly bonus. Without that tool, it would be really, really difficult for us to do that.”

ACO assistance

Orlando Health’s most ambitious population health effort yet is its accountable care organization (ACO), a Medicare Shared Savings Program participant. Under the program, Medicare rewards ACO participants for meeting certain thresholds of quality on 33 different population health measures. Orlando Health will be able to utilize the platform to track and improve each of these performance metrics. Phytel Insight delivers metrics and dashboard reporting that enable the health system to evaluate and measure its effectiveness across key quality initiatives. And Phytel Coordinate provides care teams with an advanced toolkit to risk-stratify patients and create personalized, automated interventions to better manage those populations and optimize each patient encounter.

The Orlando Health team in charge of the ACO reporting program has designed it to reduce physician work, minimize new clinical documentation steps and have the same clinical documentation process address both the federal meaningful-use program and ACO documentation, when feasible.

Right tools, right partner

Moving forward, the second phase of Orlando Health’s Phytel deployment will make the platform available via health information exchange (HIE).

“We will tie our population health solution into our HIE so that our affiliated physicians in the field can get access to the Phytel reports on care gaps and other functionality,” says Jordan. “We’re also going to be implementing a patient summary screen within our affiliated physicians’ EHRs to provide an at-a-glance summary view of the patient’s care gaps.”

For more on Phytel: www.releasewire.com/401hr-202

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For innovative patient encounters, WEDI recommends ...

The Workgroup for Electronic Data Interchange (WEDI) Foundation released the 2013 WEDI Report on Dec. 5, 2013. The report is the culmination of a nine-month public-private effort with more than 200 subject matter expert volunteers. It aims to provide a new roadmap for health IT over the next decade. According to the report, “innovative encounters” are touch points such as email, texting and telehealth used “to engage patients and providers without reference to location or time and allow non-emergent conditions to be evaluated and in many cases treated without the need for a physical visit.”

WEDI’s recommendations for innovative encounter models include:

- Identify use cases, conventions and operating standards for promoting consumer health and exchange of telehealth information in a mobile environment.
- Facilitate adoption and implementation of “best-in-class” approaches that promote growth and diffusion of innovative encounters across the marketplace and that demonstrate value for patients, providers and payers.
- Identify existing or proposed federal or state-based laws or regulations that create barriers to the implementation of innovative encounters (including licensure).

The full report is available at:
Source: WEDI