Population Health: Managing Chronic Disease Patients Efficiently and Cost Effectively

Presenters: Shirley Garcia. Cheryl DeRosa, and Briana O'Malley

November 9, 2018

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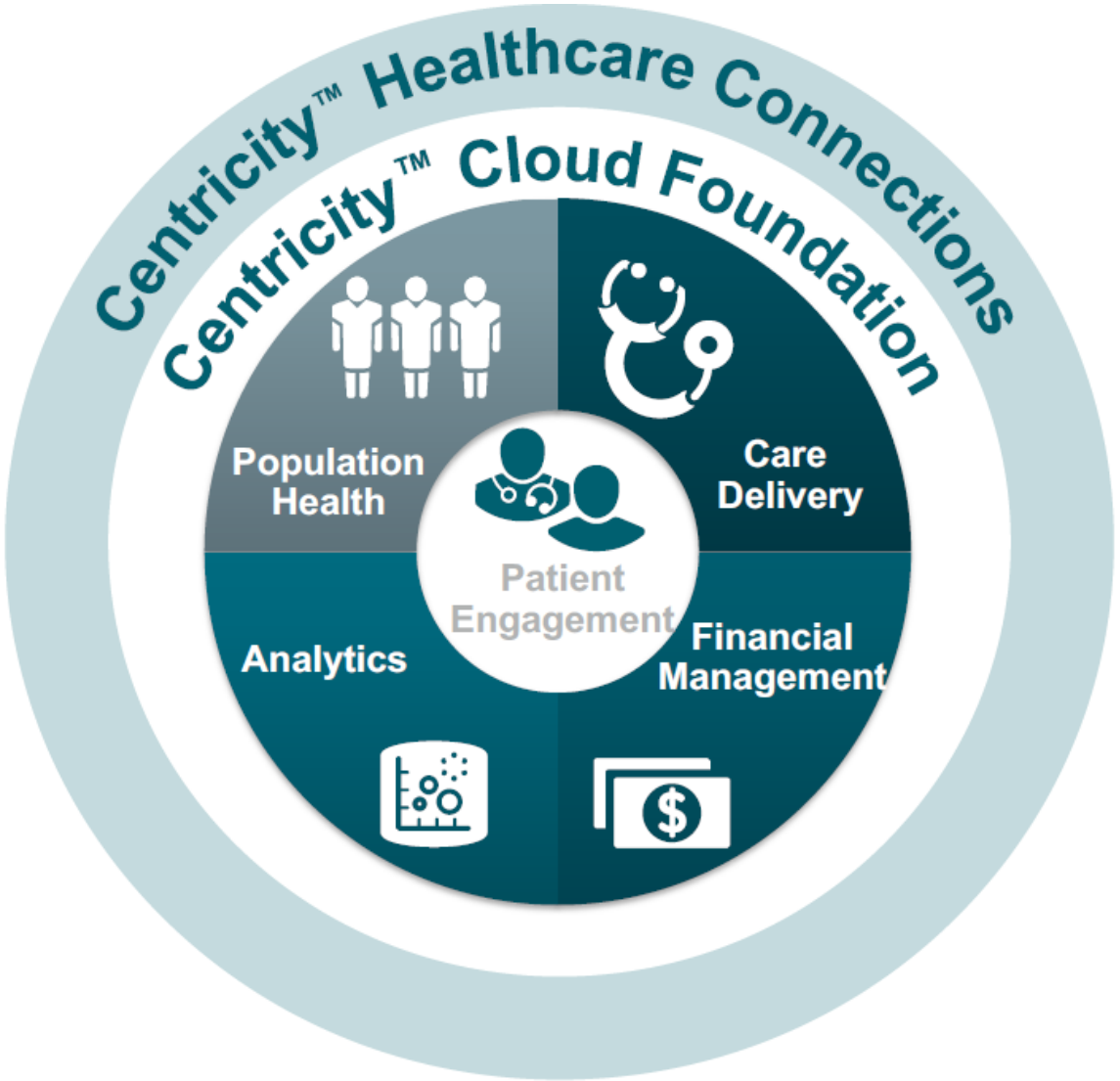
ACM Population Health Solutions



Increase Provider Efficiency

Enhance Care Quality

Strengthen Financial Performance

Population Health:
Managing Chronic Disease Patients Efficiently and Cost Effectively

Executive Summary

Key Issues

Issue/Challenge

As payers transition to value-based care, practice success will increasingly be dependent upon the ability to integrate care coordination into ambulatory care settings to improve outcomes and better control costs in chronic disease patient populations.

However, cultural, organizational, operational barriers and provider burnout make it challenging to implement a successful population health program.

This presentation will help you

- **Enhance care quality** with organizational transformation, advanced care coordination, and better visibility to where care is needed to more effectively manage populations
- **Increase provider efficiency** by balancing workloads, operating at top of licensure, and aligning patient data with evidence based guidelines at the point of care
- **Strengthen financial performance** in shared savings contracts with better cost control in chronic disease populations

Key outcomes impacted:

- Reduced provider and team burnout
- Improved disease control
- Reduced care gaps

Panel discussion

Shirley Garcia

Director Product Management

Virence Health Technologies

Cheryl DeRosa

RN, BSN, PMP-EMR Project Director

Preferred Primary Care Physicians

Briana O’Malley

Clinical Applications Manager

Preferred Primary Care Physicians

Population Health:
Managing Chronic Disease Patients Efficiently and Cost Effectively

Agenda

1. Research Results: Challenges in and Barriers to Population Health
2. Importance of Organizational Transformation in Population Health
3. Practical Application: Tackle One Area at a Time
4. Enabling Technology and Tools
5. Summary and Q&A

Research Results: Challenges in and Barriers to Population Health

Conducted by HIMSS Media Pulse Research on behalf of Virence Health Technologies, February 2018

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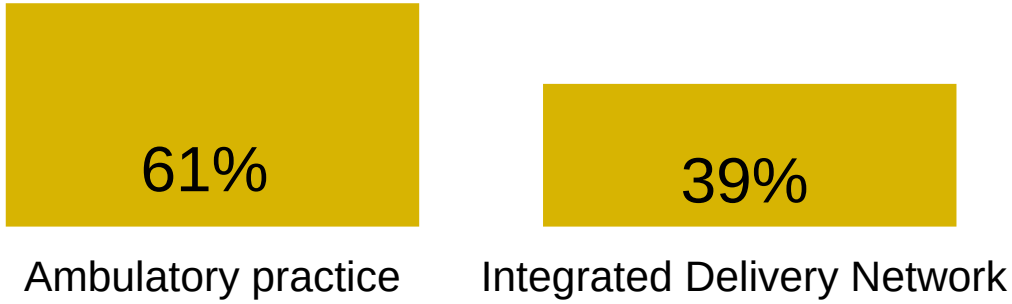
Research Overview: A large, diverse sample produced robust insights

HIMSS Media conducted this research in February 2018 on behalf of Virence Health to better understand how healthcare providers/practices are managing population health

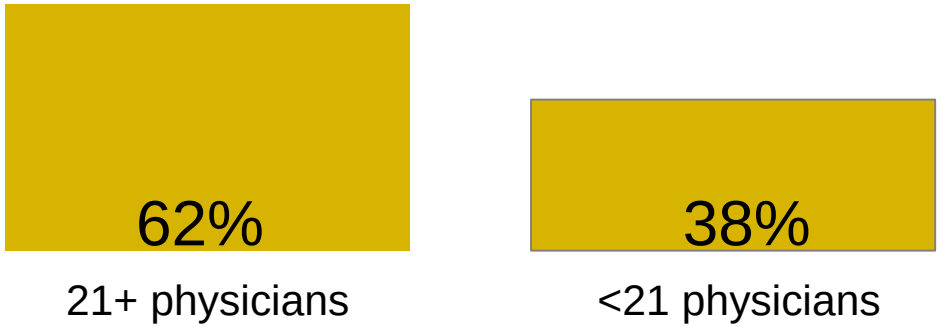
96
Respondents

- Mix of Business, Clinical, IT/Technology roles
- Mix of small and large ambulatory practices and IDNs

Organizational type

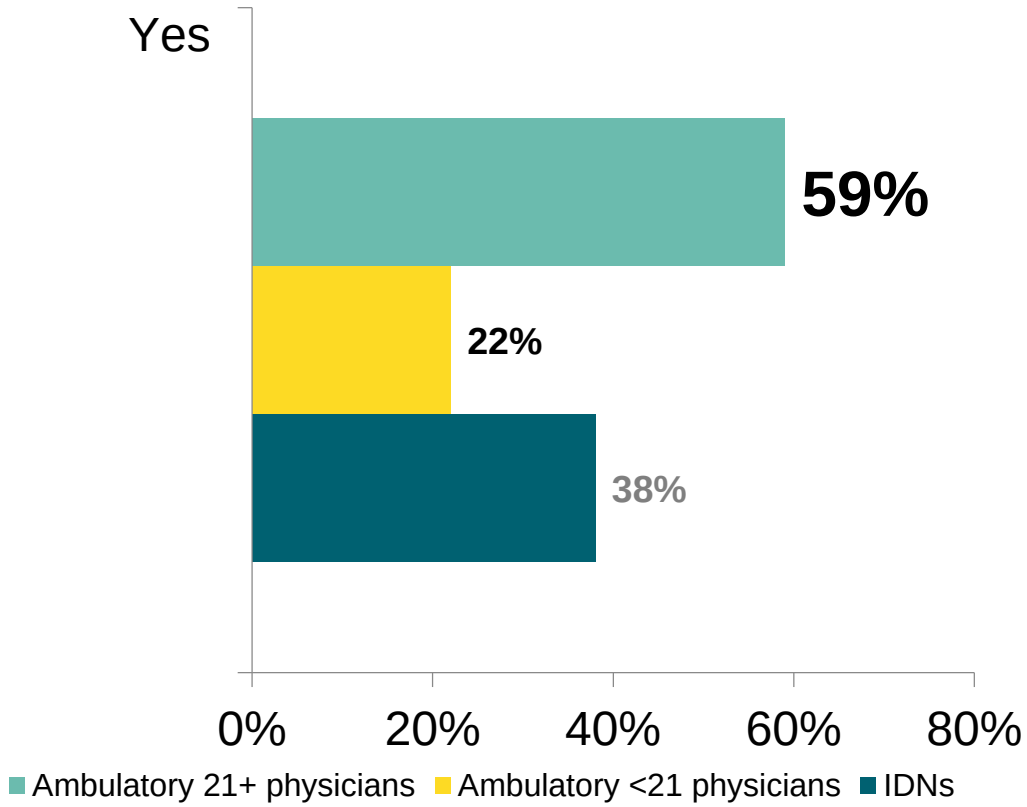


Organizational size

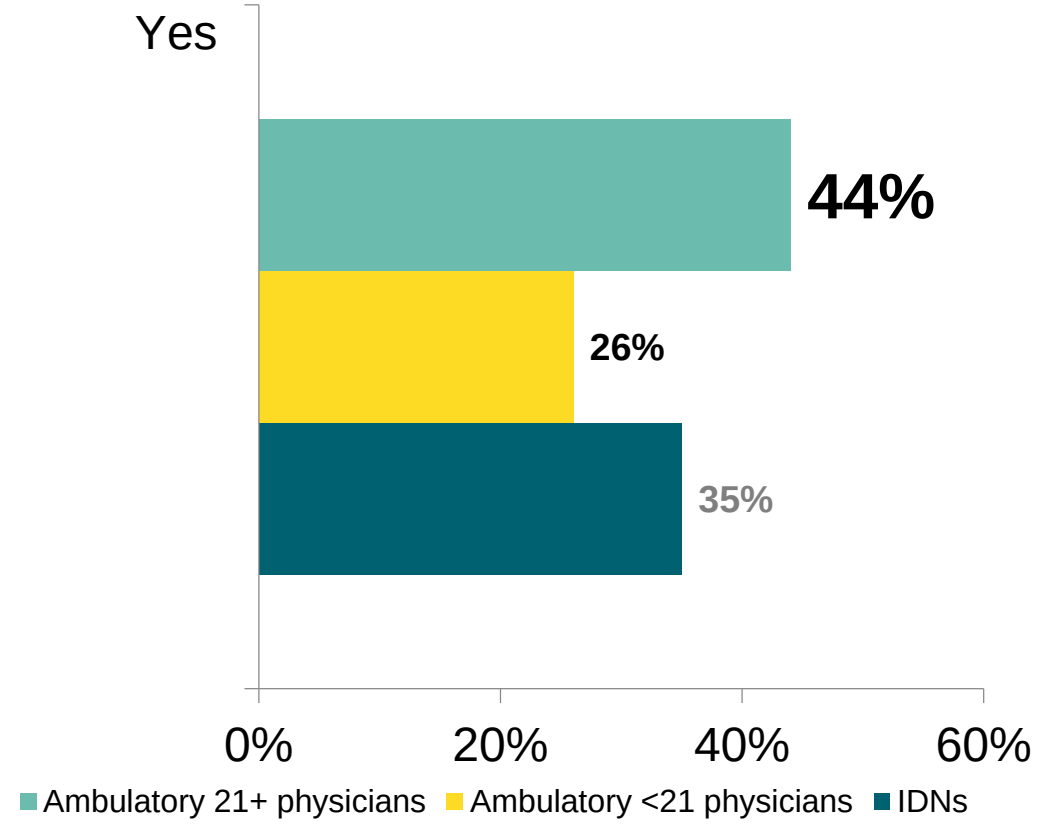


Large ambulatory practices most likely to be a PCMH / CPC+ have >10% of revenue tied to risk-based contracts

Practice is PCMH or Involved in CPC+ Program



>10% of Practice Revenue Tied to Risk-based Contracts



Q. Is your practice a patient centered medical home (PCMH) or involved in the Comprehensive Primary Care Plus (CPC+) program?
Q. Is a significant portion (>10%) of your practice revenue tied to risk-based contracts (i.e., payment based on outcomes and costs)?

Top Population Health Management Challenges Differ by Type of Practice

Ambulatory Challenges: Care Management / Coordination

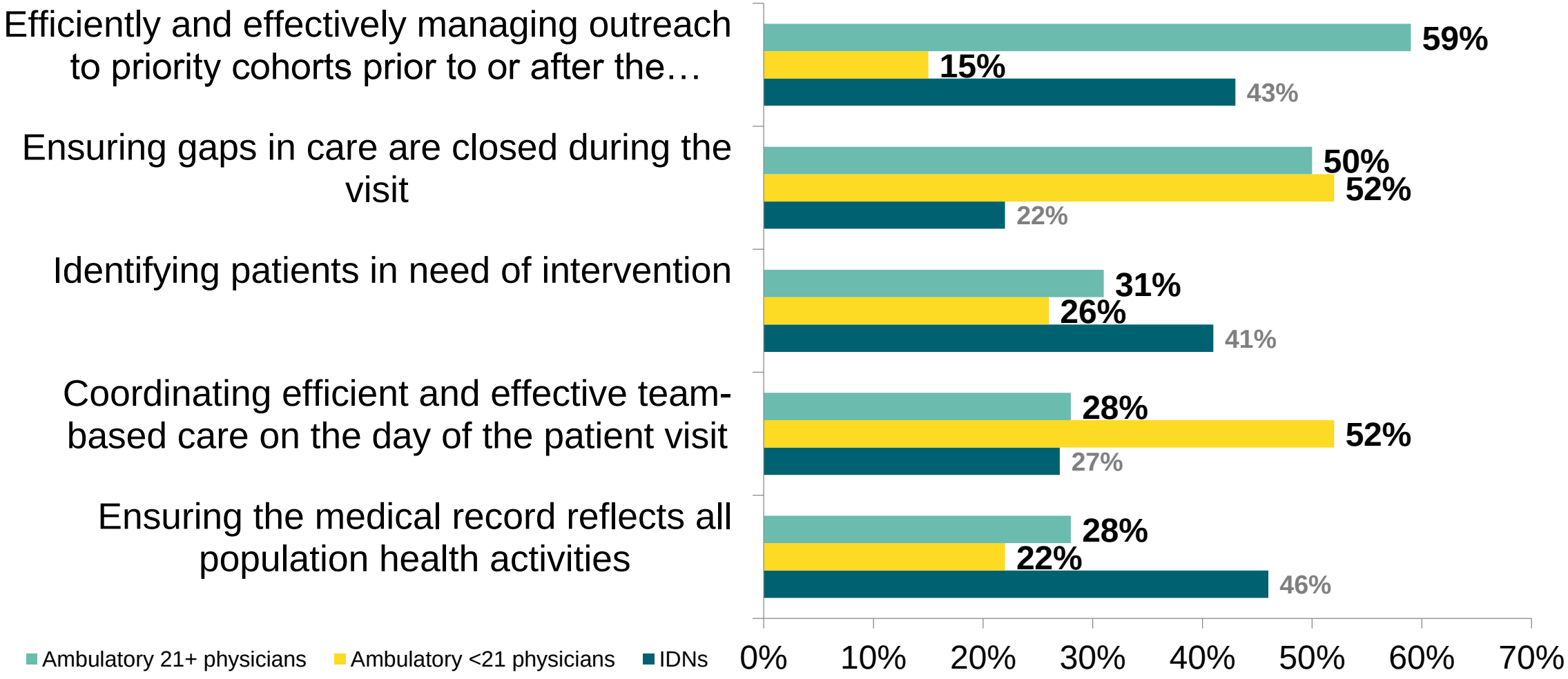
1. Ensuring gaps in care are closed during the visit (51%)
2. Efficiently and effectively managing outreach to priority cohorts prior to or after the patient visit (39%)
3. Coordinating efficient and effective team-based care on the day of the patient visit (39%)

IDN Challenges: Cohort Management / Identification

1. Ensuring the medical record reflects all population health activities (46%)
2. Efficiently and effectively managing outreach to priority cohorts prior to or after the patient visit (43%)
3. Identifying patients in need of intervention (41%)

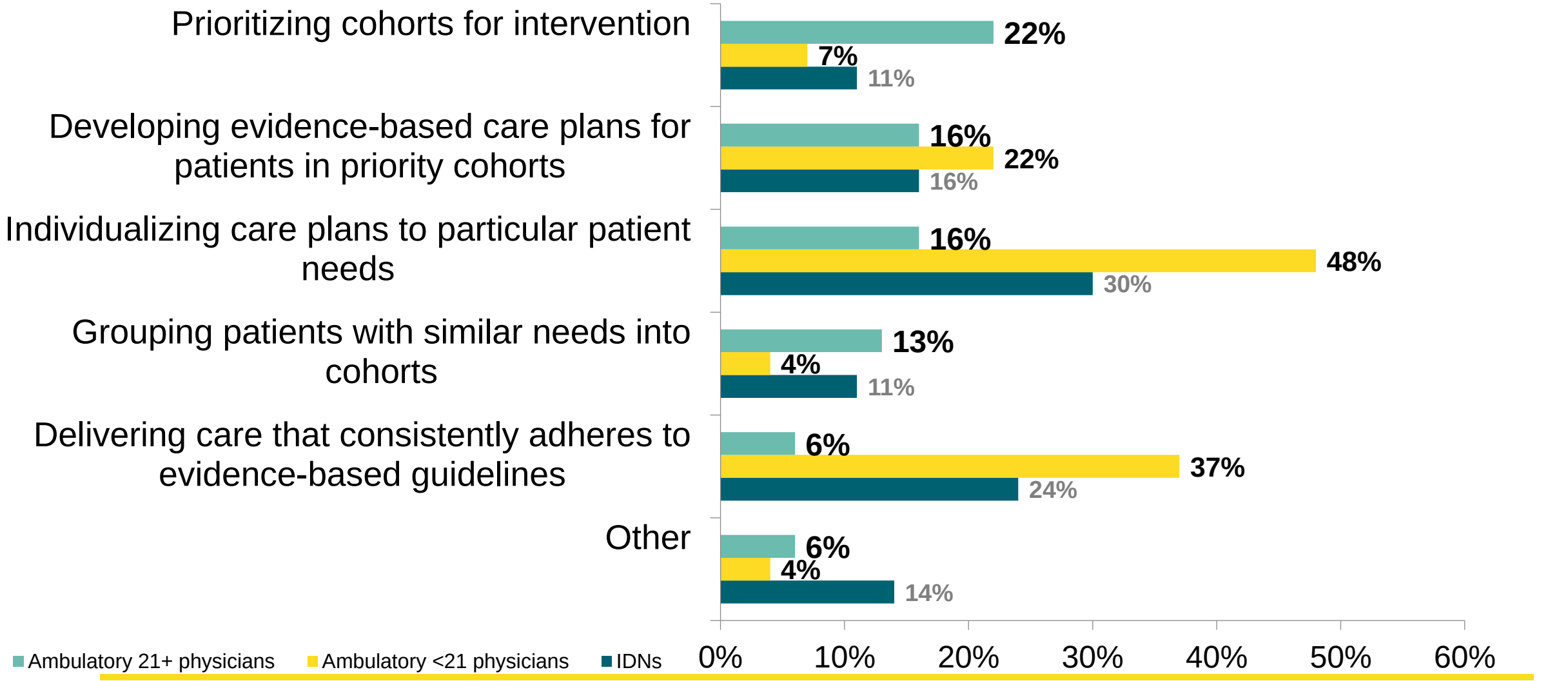
Top challenges vary by type / size of provider

Population Health Management Challenges



Q. What are your organization's top three challenges for managing population health?

Top challenges vary by type/size of provider (continued)



Q. What are your organization's top three challenges for managing population health?

What are the top challenges you face today?

- Identifying a Starting Point
- Risk Stratification – identifying your patients
- Getting paid for managing populations and their health
  - Transitional Care Management
  - Chronic Care management
  - VBC Programs: HCC / RAF
- The Change Process:
  - Shift to collaborative, team-based healthcare - Developing acceptance of New Workflows
  - Identifying/Hiring/reallocating Staff members
- Getting personal - empowering the patient, bolstering engagement
  - All stages of life
  - Wellness and health
- Coordinating Care across the continuum
  - collect, combine, analyze and share patient data and coordination activities
- Tracking Care quality and outcomes
- Using Best practices, communicating best practices and lessons learned

Importance of Organizational Transformation in Population Health

Preferred Primary Care Physicians Population Health Implementation

Cheryl DeRosa RN, BSN, PMP-EMR Project Director
Briana O'Malley-Clinical Applications Manager

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Preferred Primary Care Physicians

- 25 years of service-4 Physicians started PPCP based on Quality of Care
- 41 Physicians FP/IM, 20 NP/PA'S
- 22 Offices in 4 Counties in Southwestern Pa
- 85,000 Active patients (seen within 24 mos)
- Participate in Track 1 + ACO Keystone Clinical Partners
- One of 30% of the ACO's in the country to meet quality and cost benchmarks and share in savings with CMS for 2 years
- Very successful in pay for value programs (NOW DEPENDENT ON)

IT/Quality Resources

- 3 Full time Quality Nurses RN's Centrally based
  - 1 RN devoted to Intensive Case Management
  - Each with 20+ years in health care quality experience
- Office based care managers and quality advocates
- Central and office based EMR/quality training for MA's and RN's
- 10 Full time IT staff many with 10+ years in HIT
- PHI consulting division 2006, implementation, CDS, workflow
- EMR since 2002, same EMR vendor since 2004
- Had already built our own POC PH tool for chronic disease
  - Beta site for VBC Analytics with Virence
  - Crimson for ACO population

Preferred Primary Care Physician's Roadmap

- 2015 Started working with Ambulatory Care Management Population Health (ACM PH)-set up; decision making process
- 2016 Implemented First Practice with ACM PH POC Care Manager Dashboard
- 2017 Fully Implemented all practices to use of ACM PH Care Manager
- 2017 Central Worklist tracking for PCMH A1Cs greater than 9
  - Failure-practices not willing/able to do
- 2018 Central Worklist implemented for:
  - Transition of Care
  - Intensive Case Management
  - Dietitian Referral Tracking and Care Management

POPULATION HEALTH MANAGEMENT

Care Management / Care Coordination

Pathway to Success- “Reach out and Touch”

Supply proactive preventive and chronic care to **“ALL”** patients, both during and between encounters.

Maintain regular contact with patients and support their efforts to manage their own health. **IMPROVE ACCESS**

Care managers must **ENGAGE** high-risk patients to prevent them from becoming unhealthier and develop complications.

Use evidence-based protocols to diagnose and treat patients in a consistent, cost-effective manner. **SHARED DECISION MAKING**

Areas of Focus

- Tackle one area at a time
- Add areas of focus as your care managers develop skill

Preventative / Wellness	Diabetes	Asthma	COPD	Heart Failure	Cardiovascular Disease
Cancer	Headache	Pain Management	Transition of Care	Emergency / Urgent Care follow up	

Care Management 101

Began with diabetes	Care Manager	Assess
• Internal quality data • Payer Data • POC PH Tool • Define your DM PH registry	• Meet with your diabetics at every office visit • Follow up with your diabetics between office visits • Reach out to your patients who do not follow up.	• Are they taking their meds? • Are they checking their blood sugars? • Are they eating well? • Should they meet with a nutritionist?

Care Management 102

Aggregate the data at a higher level-prioritize YOUR efforts

Diabetics

- who did not have a pneumonia or flu vaccine
- who are not on an ACE inhibitor or an ARB
- who are not on a statin
- who did not have a urine microalbumin
- with repeated ER visits for hypo/hyperglycemia
- HOW DO YOU CLOSE THESE GAPS?

Multiple Methods of Outreach

- Portal Communications
- Personal Calls from practice based Care Managers
- Focused Mass Mailings
- Automated Telephonic Outreach-Clinical Algorithm based

POPULATION HEALTH MANAGEMENT

Data Management- Understanding your tools, what they can/can’t do

Reality Check

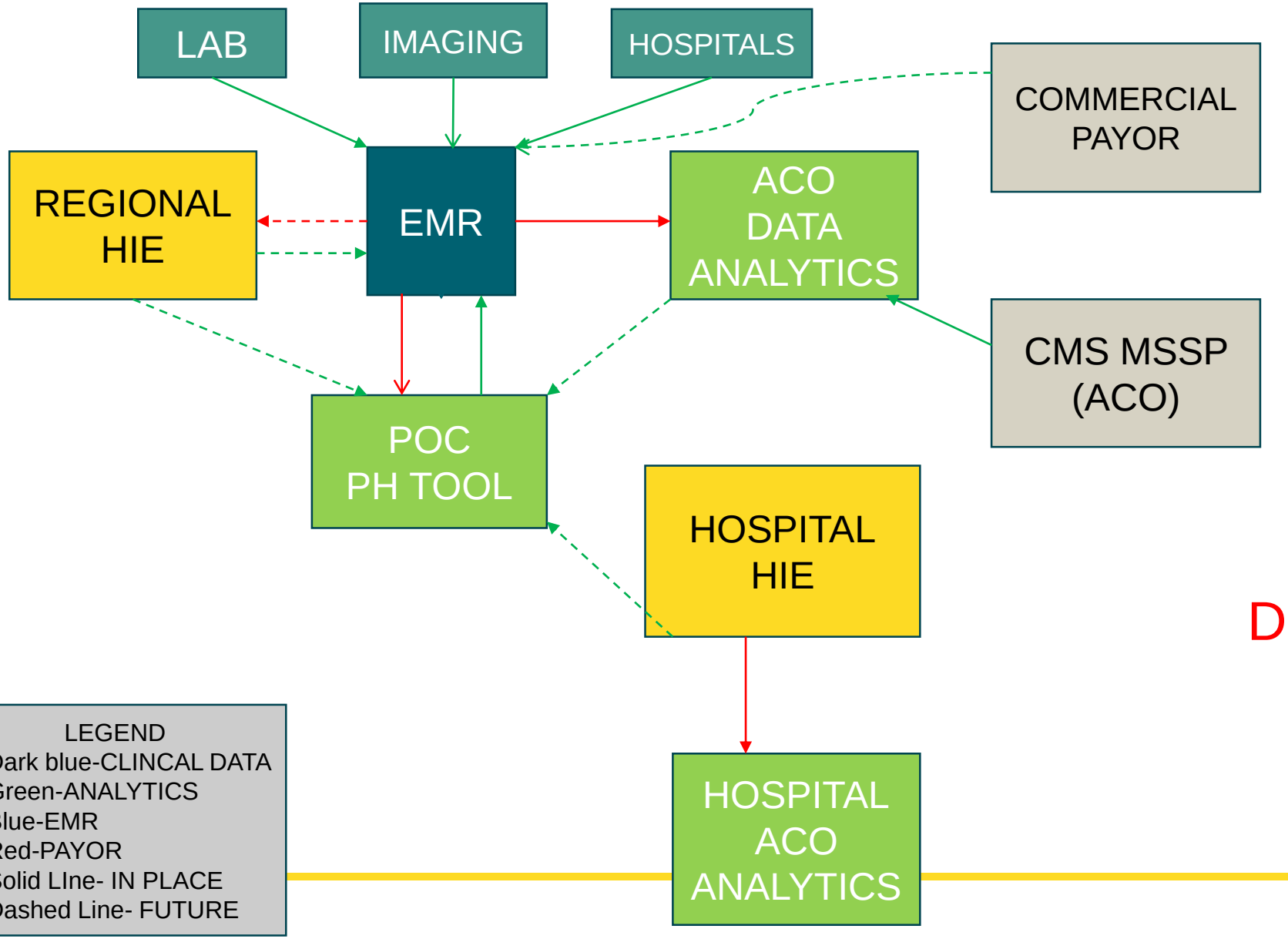
At this time,

no one is connected well enough

to aggregate and analyze

all of the data!

PPCP IA



LEGEND
1. Dark blue-CLINCAL DATA
2. Green-ANALYTICS
3. Blue-EMR
4. Red-PAYOR
5. Solid LIne- IN PLACE
6. Dashed Line- FUTURE

DO YOUR OWN IA DIAGRAM !!

Data Input

Enter data correctly to optimize EHR utilization (Meaningful Use)

- Immunization Management Form
- Hand updating the flowsheet
- Interactive forms that prompt you and allow you to enter data at the point of care

Interface as many as health systems and providers as possible

- If set up correctly, will input structured, retrievable data
- The more information at hand, the better you can track your patients

IF YOUR DATA HOUSE IS NOT IN ORDER, YOU WILL STARVE!!!

- Poor data = poor quality scores
- Coders Rule- Sad but true , RAF impacts everything

PH Software- Vendors not born Equally

- Data Aggregation-Data Repository
- Risk Stratification-Clinical/Financial
- Care Coordination-Care Managers tool
- Patient Outreach-Portals, Social Media, Secure Text

Utilizing Data to Make Point of Care Decisions

Using your data and evidence-based guidelines to make decisions on patient care at the time of the office visit

Enables real-time decision making

Requires standardized data

Requires accurate clinical decision support

Update - Test -- Ofc Visit at O1 on 2/22/2018 12:18:21 PM by Katie Gargiulo RN [Doc ID: 1882]

Summary:

Interactions:

Forms | Text

Forms | Add...

- HPI - General
- UI/Falls Risk Assessment
- Vitals Extended PPCP
- Hx-Summary
- Risk Factors PPCP
- PPCP ROS Complete with Pr
- HM & Disease Management
- CareManager Control Panel
- Lab Review
- PPCP Physical Exam
- Problem A&P Single ICD-10
- Prescriptions
- Immunization Management
- Favorite Forms

Attachments | Add...

Favorites | Add

- Blank image
- Favorite Forms
- Risk Factors PPCP

Orders | Medications | Problems | + Medication | + Problem | End...

Patient Name: Test, "House" Patient ID: 1820123 DOB: 10/30/1944 73 Years Old Male Home: (412) 531-2902

ACO Patient

History of Present Illness

Since the patient's last office visit, has he/she been in the hospital or seen a specialist? yes no

Is the patient having any problems with their medications? yes no

History from:

Chief Complaint:

HPI:

brief (1-3 elements) **extended (4 or more elements)**

HPI elements: location, quality, severity, duration, timing, context, modifying factors, and associated signs/symptoms

Problems | New Problem | Allergies | Meds | Orders | Refill Rx | Flowsheet | nowledge Pre Visit Prep Informa

pt needs A1C (08/10/2016 9:38:54 AM)

Providers in the patient's care such as Consultants, Home Care, Physical Therapist, DME Providers, Psych, etc:

Dr. Test Cardiologist (412) 485-5843
Dr. Test B Oncologist (412) 475-4875

Include provider list in note

Preferred Healthcare Informatics: 20170808-01

Care Management Workflow definition

Help

GE Test | 73 Year Old Male | 10/30/1944

Add All Text

Care Team | Update Flowsheet | PROBLEMS | MEDICATIONS | ORDERS | ALLERGIES

Responsible Provider: Louis A Civitarese DO | Insurance Carrier: MEDICARE | Last Office Visit: 02/19/2014

CV Risk	Risk 10yr/30yr	Statin Intensity	LDL-Cholesterol	BP	MI B-Blocker	APT
	?	On statin	test patient mg/dL	122/82	On beta blocker	Warfarin
Diabetes	A1c	ACEI/ARB	Urine Alb	Eye Exam	Foot Exam	Diab Ed
	Due	On ACEI/ARB		Due	Due	Due
Prevention	BMI	Depr Screen	Diab Screen	Falls Risk	Tobacco	AAA
	Due			Due	Current	Due

Cancer Screening	Colon CA	Breast CA	Cervical CA
	High Risk		

Immunizations	Flu	Hep A	Hep B	HIB	HPV	Meningo	MMR	Pneumo	TD	Varicella	Zoster
*Clinical List	Due		?					Due (PCV13)			

Heart Failure	Diagnosis	LVEF	NYHA	Office Wt	Home Wt	ACEI,ARB,ARNI	HF BB	Aldo Blocker	Diuretic	Digoxin	ICD	CRT	Med CI
	NOS	Due	Due	456		ACEI, ARB	Yes	Yes	Yes	Yes			Yes

Stroke Prev / Warfarin Mgmt	AFib Dx	On Warfarin	Managed By	INR Target	Last INR	Next INR	TTR
	No	Yes			2.0	2 weeks	

Asthma	Last Control	Assessment	Controller Meds	Action Plan
		Due	ICS	Due

A - Allergy | ^ - Active Hold or Take Action | ? - Missing Value

Data Entry

Suspected Diagnosis

Depression	Diabetes	Heart Failure	Hypertension	Osteoporosis

Risk Factors

Problems-CCC

- Depression

CV Risk Reduction
Diabetes
Treatment
Identification
Services Due
Quality Assurance
Heart Failure
Prevention
Stroke Prevention
Patient Control Panel

Diabetes WIthout Statin | Add Filter | Export | Message | Print

Treatment

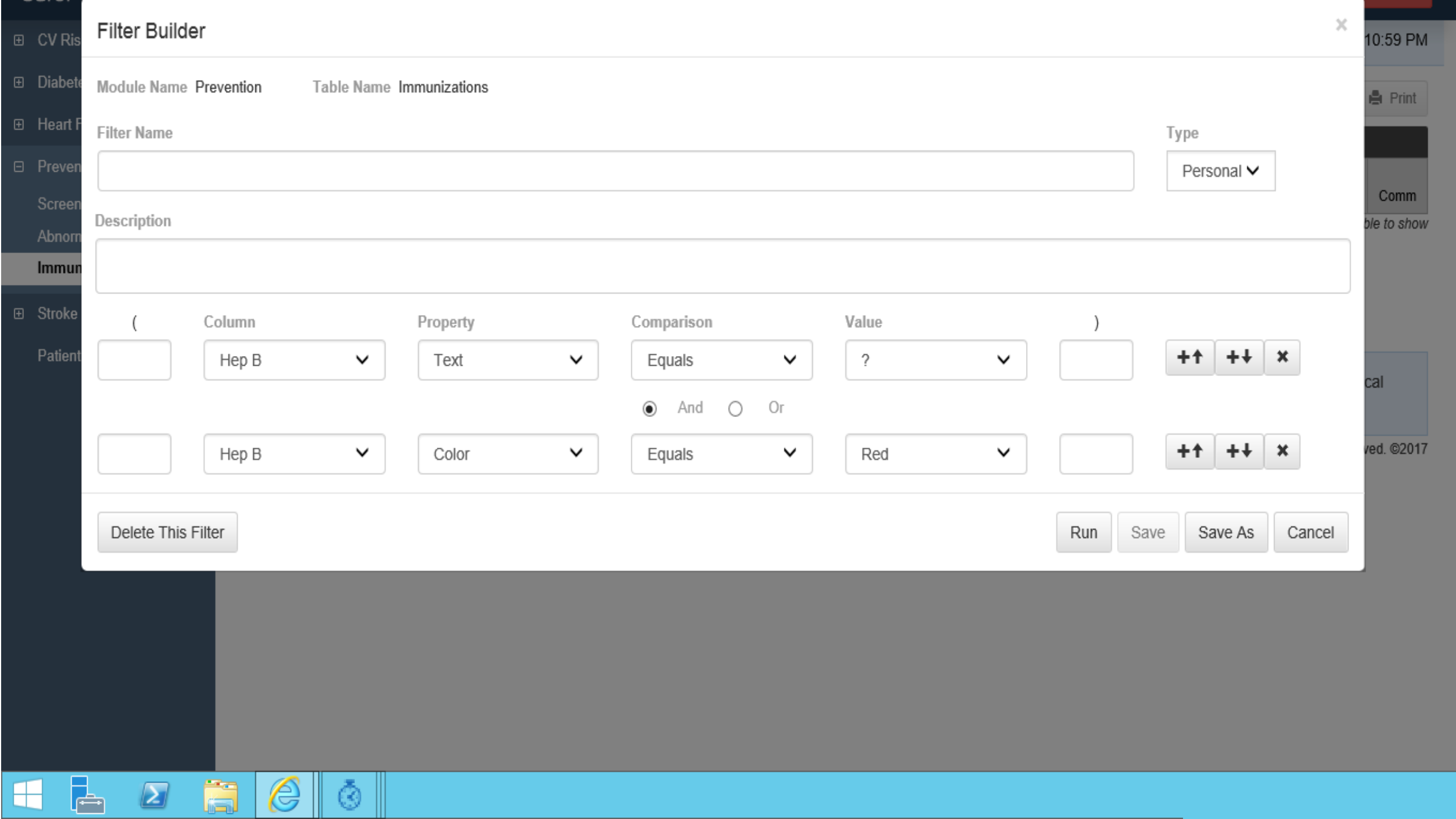
Patient	Age	Statin Intensity[1]	LDL	A1c	BP	ACEI /ARB	APT[2]	Diab Ed	Tob Use	BMI	Last Appt	Next Appt	PCP	Other Prov	Comm
	76	No statin	102	4.8	146/80		Yes	Due	Quit	27.3	12/28/2017		Louis Civitarese DO		
	76	No statin	135	Due	120/64	Yes	Yes	Due	Quit	35.1	1/29/2018	7/30/2018	Michael Speca DO		
	59	No statin	45	Due	Due			Due	Current	31.2	6/2/2016		Michael Speca DO		
	83	No statin	113	Due	140/80	Yes	Yes		Quit	27.8	1/17/2018		Jared Bovalino DO		
	58	No statin	90	Due	140/90			Due	Quit	33.3	1/12/2018	2/28/2018	Louis Civitarese DO		
	84	No statin	95	8.1	148/80		Warfarin	Due	Never	31	1/30/2018	3/9/2018	Louis Civitarese DO		
	69	No statin	118	5.5	138/90	Yes		Due	Quit	31.4	1/8/2018		Frank Civitarese DO		
	54	No statin	52	7.1	140/90	Yes		Due	Quit	41.6	11/24/2017		Frank Civitarese DO		
	49	No statin	88	Due	128/80	Yes	APT	Due	Never	70.8	1/30/2018	3/5/2018	Louis Civitarese DO		
	83	No statin	83	7.1	138/80		Yes	Due	Never	32.5	11/24/2017	3/28/2018	Frank Civitarese DO		
	58	No statin	86	9.9	130/86	Yes	APT	Due	Quit	40.6	2/6/2018		Jared Bovalino DO		
	88	No statin	94	9.4	122/78	Yes	APT	Due	Never	32.1	12/6/2017		Michael Speca DO		
	61	No statin	61	Due	120/80	Yes	APT	Due	Quit	50.4	8/16/2017		Michael Speca DO		
	54	No statin	99	Due	Due	Yes		Due	Quit	40	6/1/2016		Michael Speca DO		
	83	No statin	113	Due	110/78			Due	Never	19.2	11/7/2017	3/7/2018	Michael Speca DO		

CV Risk Reduction
Diabetes
Treatment
Identification
Services Due
Quality Assurance
Heart Failure
Prevention
Stroke Prevention
Patient Control Panel

A1c greater than 9 with no appt in past... | Add Filter | Export | Message | Print

Treatment

	Age	Statin Intensity[1]	LDL	A1c	BP	ACEI /ARB	APT[2]	Diab Ed	Tob Use	BMI	Last Appt	Next Appt	PCP	Other Prov	Comm
☐	48	On high	81	Due	Due	Yes	Yes	Due	Quit	45.8	1/4/2017		Louis Civitarese DO		
☐	44	On statin	59	10.2	130/80	Yes		Due	Current	42.7	8/10/2017	5/9/2018	Frank Civitarese DO		
☐	31		96	Due	120/70			Due	Never	45.1	8/21/2017		Michael Speca DO		
☐	30	No statin	176	Due	Due	Yes		Due	Quit	27.2	4/26/2016		Frank Civitarese DO		
☐	61	On high	187	Due	Due	Yes		Due	Quit	36	1/5/2017		Michael Speca DO		
☐	38	On statin	75	9.6	130/80	Yes		Due	Never	45.9	6/15/2017		Frank Civitarese DO		
☐	29			Due	118/70			Due	Quit	27	3/23/2017		Frank Civitarese DO		
☐	78	On statin	39	Due	Due	Yes		Due	Never	27.1	1/12/2017		Michael Speca DO		
☐	59	No statin	69	Due	Due		APT	Due	Quit	30	2/6/2017		Jared Bovalino DO		
☐	51	No statin	155	Due	Due	Yes		Due	Quit	37.3	1/26/2017		Michael Speca DO		
☐	58	No statin		Due	Due			Due	Never	37.4	6/30/2015		Frank Civitarese DO		
☐	59	No statin	99	Due	Due	Yes		Due	Quit	34.6	7/5/2016		Frank Civitarese DO		
☐	46	On statin	67	Due	Due	Yes		Due	Quit	51.2	1/12/2017		Michael Speca DO		
☐	60	On high	151	Due	136/82	Yes		Due	Never	22	6/29/2017	2/19/2018	Louis Civitarese DO		
☐	55	On mod-low	104	Due	Due	Yes		Due	Quit	41	10/24/2016		Louis Civitarese DO		


Filter Builder
Module Name Prevention
Table Name Immunizations
Filter Name
Type
Personal
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(Column Property Comparison Value)
Hep B
Text
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Hep B
Color
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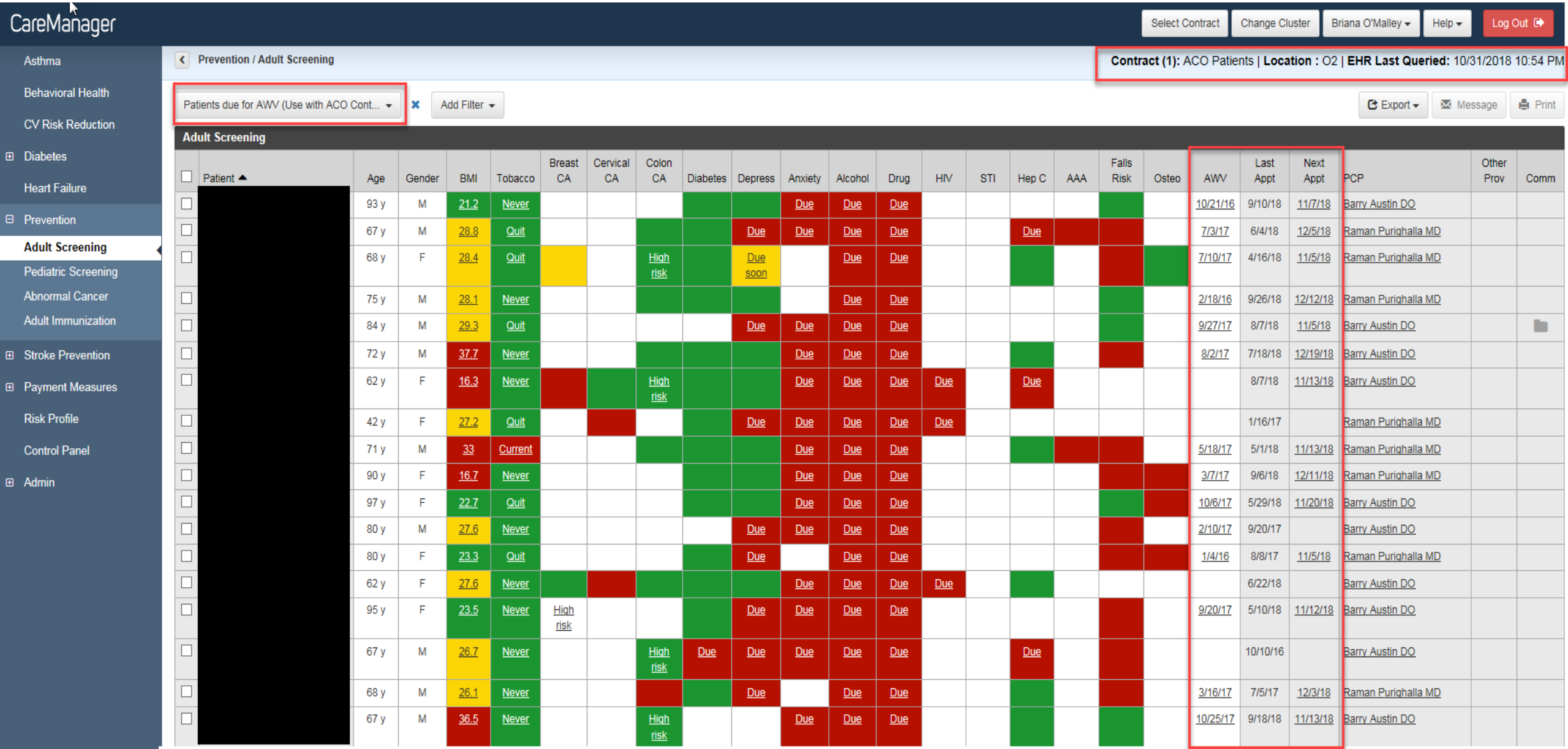
Red
Delete This Filter
Run
Save
Save As
Cancel

Preferred Primary Care Physicians
Annual Wellness visit



POPULATION HEALTH MANAGEMENT

Outcomes

ROI with Population Health Tool Financial

Hepatitis B Vaccine

Alerts in Pop Health tool based on Problem list and history of vaccines that Hep B Vaccine is indicated

ie: Diabetics; Fatty Liver Disease etc.

Office PH Tool Implementation	% Revenue Increase 6 Months Post Implementation
Office 01	435%
Office 15	764%

ROI with Population Health Tool Quality Scores

Diabetics on Statin-2017

Majority of Practices Implemented Pop Health Tool in Aug/Sept 2017	2017 1st Quarter	2017 4th Quarter
Payor 1	55% or 1 STAR	82% or 4 STARS
Payor 2	62% or 1 STAR	81% or 5 STARS

ROI with Population Health Tool
Good Patient Care

August 2016 – January 2018

FOBT Performed:	11,226
FOBT Positive:	1042
C-Scope Follow up:	489
C-Scope Abnormal:	324

Diagnosis Colon Cancer: 15

Transition of Care Improvement with Central Worklist Measured by Decreased Readmission Rate to Hospital

March 2018 through September 2018

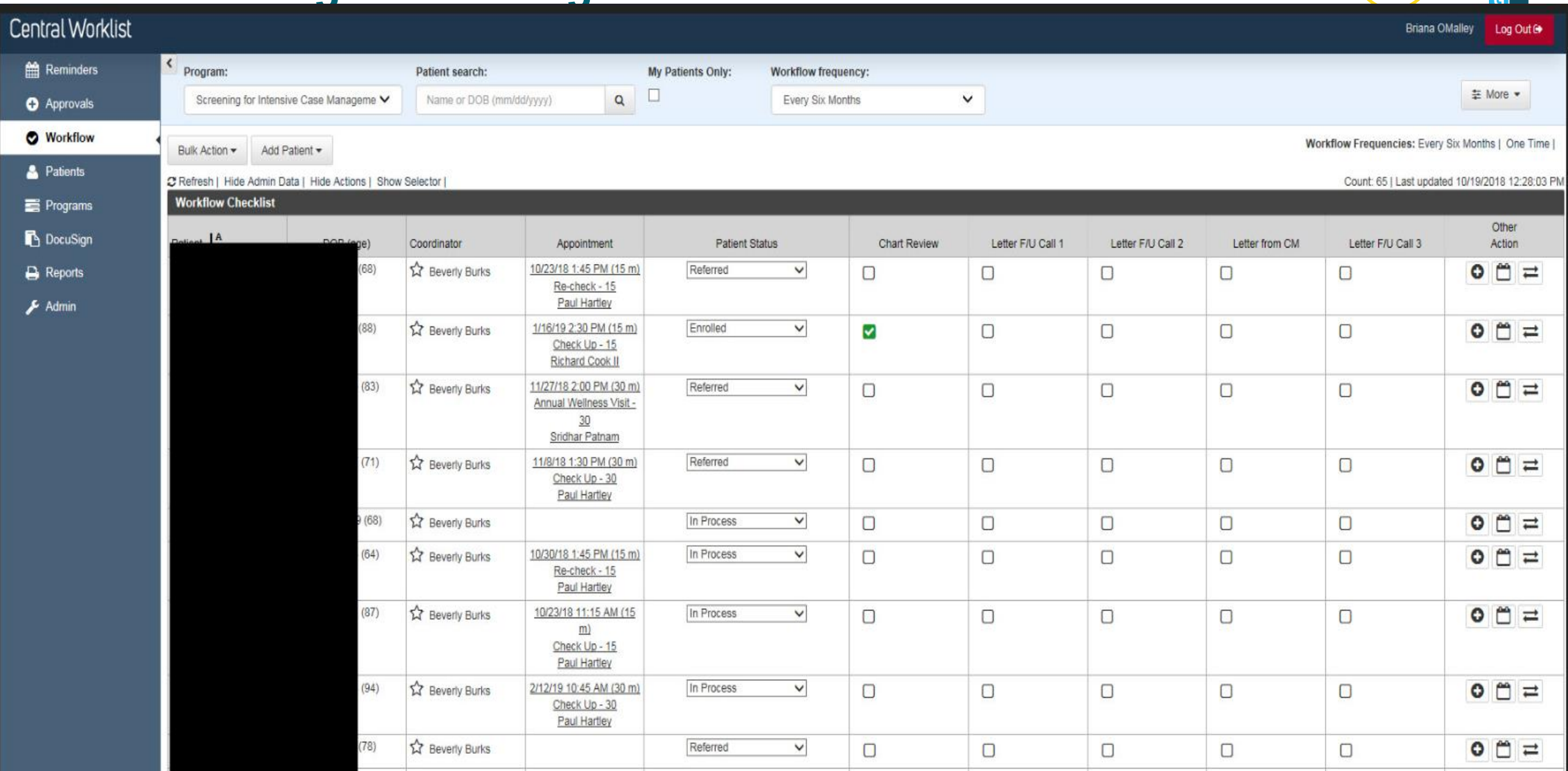
Piloted in 4 Practices since March Fully implemented Mid August	2017 4th Quarter	2018 3rd Quarter
Highmark BCBS (lower is better!)	.91 (Benchmark .46) 2 STAR	.64 (Benchmark .41) 4 STAR

Additional Wins:
Tracking TOCs for all lines of business-not just those paying
Increased revenue based on increased number of Office Visits and Increase level of service
Increased patient health through:
- Improved Medication Compliance
- Soft win of the patient appreciates the personalized care

POPULATION HEALTH MANAGEMENT

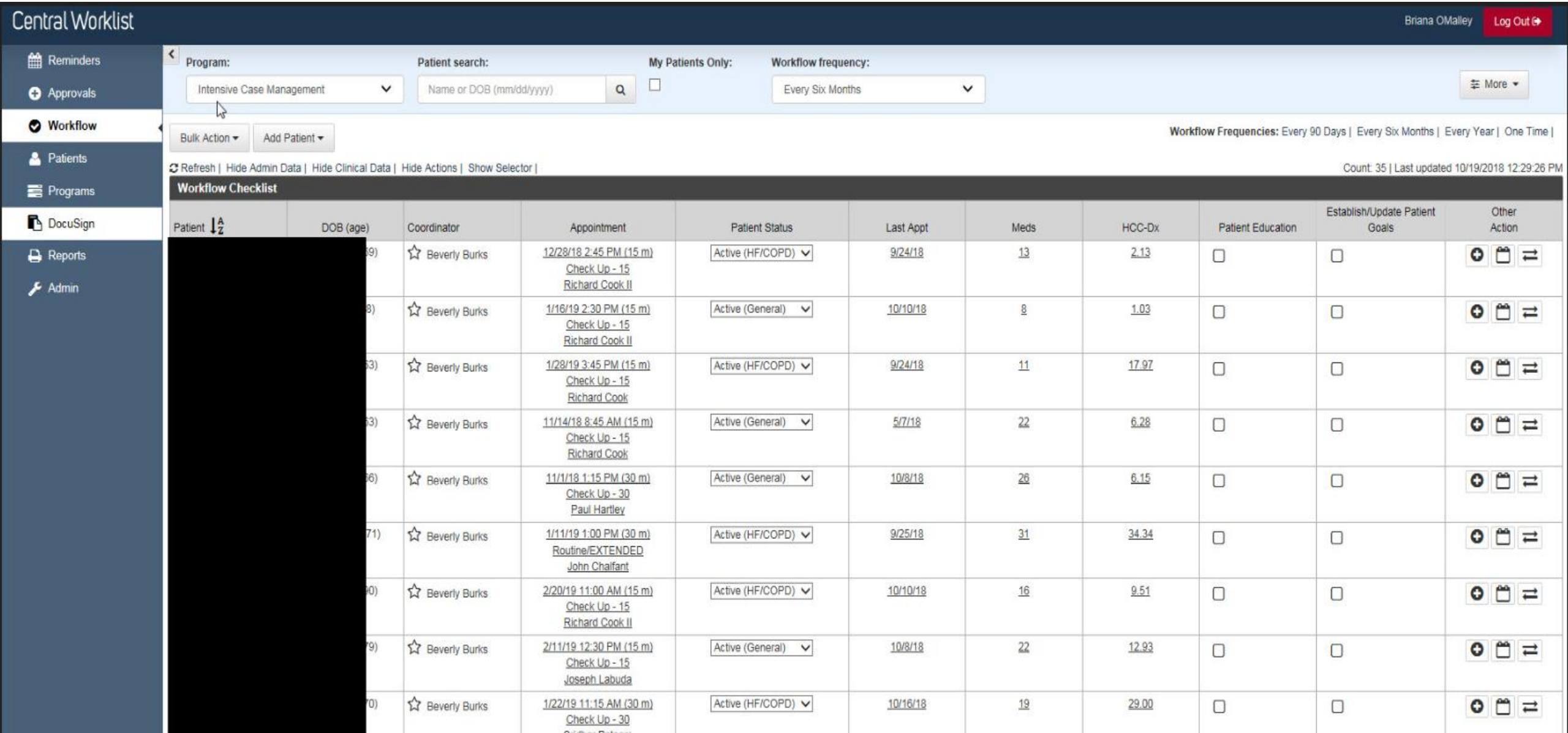
Using Central Worklist

Preferred Primary Care Physicians Case Management Program



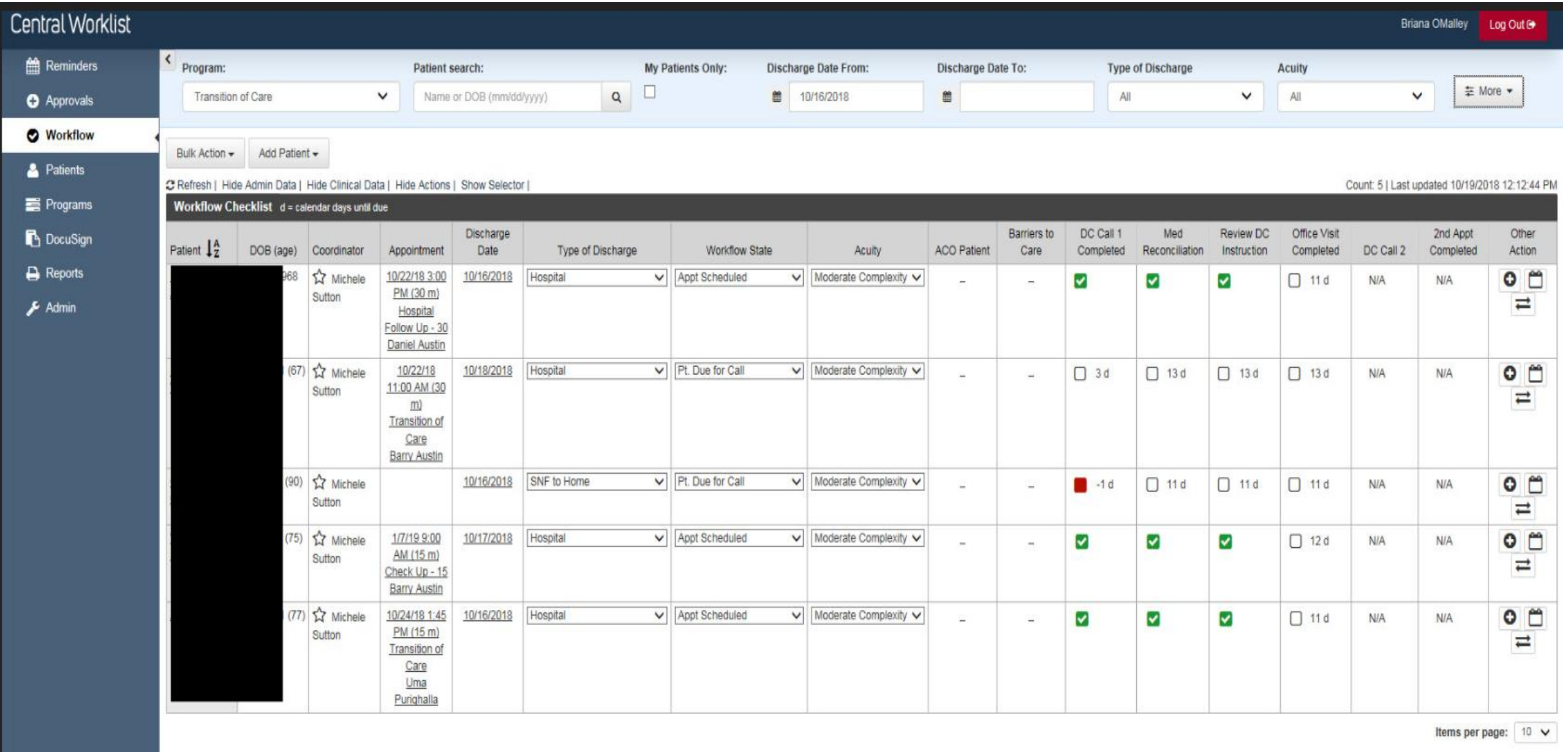
Preferred Primary Care Physicians

Intensive Case Management Program

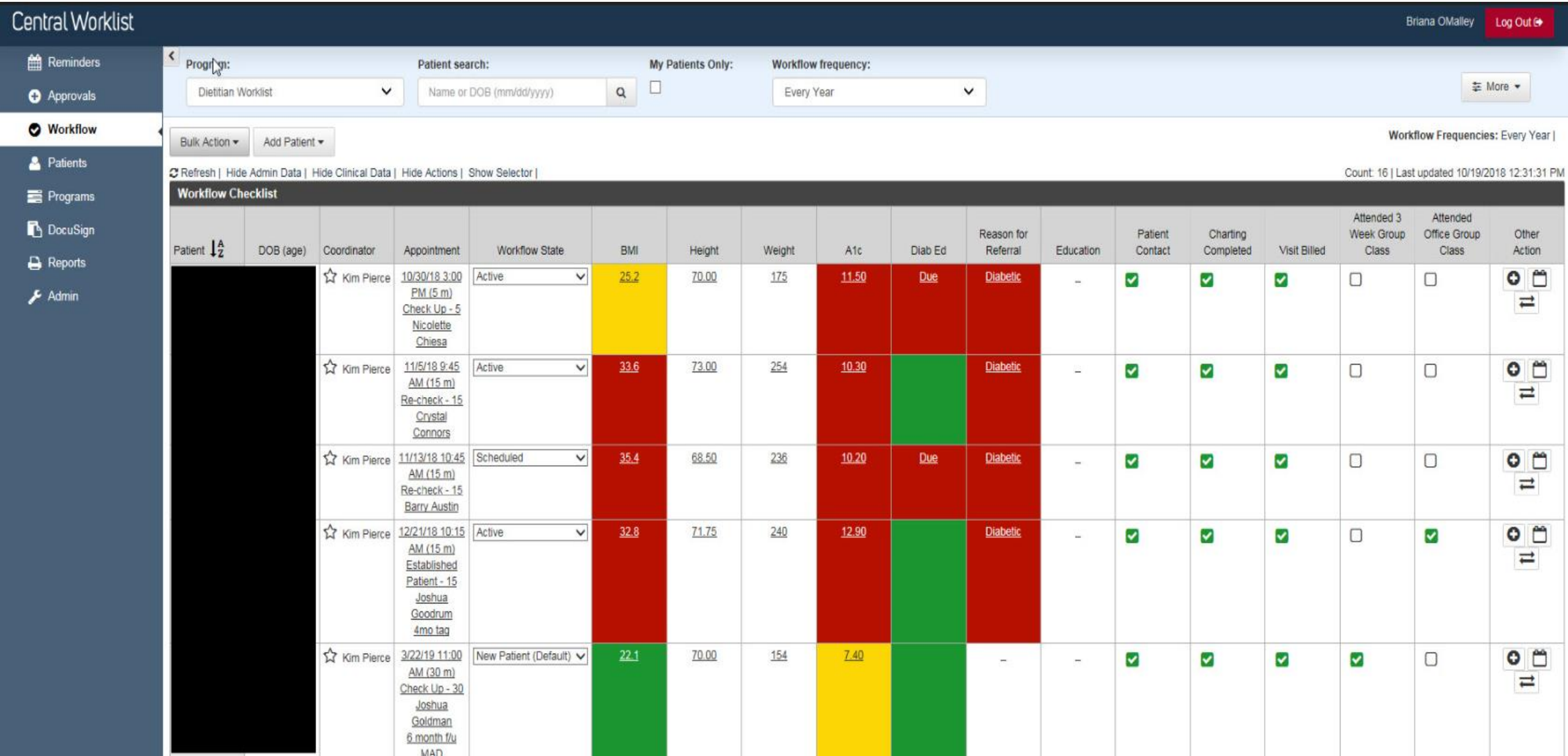


Preferred Primary Care Physicians

Transfer of Care Program



Preferred Primary Care Physicians
Dietician Program



Summary and Q&A

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Summary Success at PPCP

- **Enhance Care Quality**
- **Increase Provider Efficiency**
- **Strengthen Financial Performance**
- **Key outcomes achieved:**

  Improved disease control
  Reduced care gaps
  Reduced provider and team burnout

Helping you achieve the outcomes that matter most to you

Enhanced Care Quality

- Organization transformation
- Advanced Care Coordination
- Better visibility to where care is needed to effectively manage populations
- Help ensure consistent adherence to evidence-based guidelines from recent medical literature.
- Help reduce gaps in care with actionable insights from Care Plan dashboard.

Improved Provider Efficiency

- Balance workloads across Care Team
- Team operating at top of licensure
- Alignment of data with evidence based guidelines at point of care
- Reduction in clinician and Provider burnout. efficiency for provider or other identified role
- Actionable plans of care offer focus for conversation and interventions that matter most for the patient at the point of care.

Strengthened Financial Performance

- Better cost control in chronic disease populations can help strengthen financial performance in shared savings contracts.
- Strengthen performance under FFS and VBC models by helping practices ensure delivery of needed services and optimize value of care delivered across the team.
- Identify and take immediate action on gaps in care.
- Add-on Chronic Care Management tools offer focus and capture of time spent between face-to-face encounters.

Roadmap

Available
Today

- Cloud based integrated Care Management Platform
- Over 400 curated and codified evidence-based guidelines inform decision making
- Intelligent Patient-specific Care Plan automatically generated for the entire population
- Care Coordination Platform helps optimize revenue under both fee-for-service and VBR payment models
- Team-based care design helps ensure all team members practice at top of license, reduces physician burn-out, and reduces variation in care

Incubation
< 6 months

- Analytics driven Cohort identification – high risk, high cost, gaps in care
- Patient focused care - health concerns, advanced directives, social determinants
- Extended tools for patient outreach, engagement, and care coordination activities
- Threshold driven alerts prioritize care coordination
- Appointment-driven workflows support timely patient engagement

On the Horizon
> 12 months

- Care Team Communications
- Configurable Care Plan based on heterogeneous data sources
- Quality Insights at the Point of need: integrated analytics with clinical workflows

Sneak Peek !

December 2018 LA of CareManager 5.2

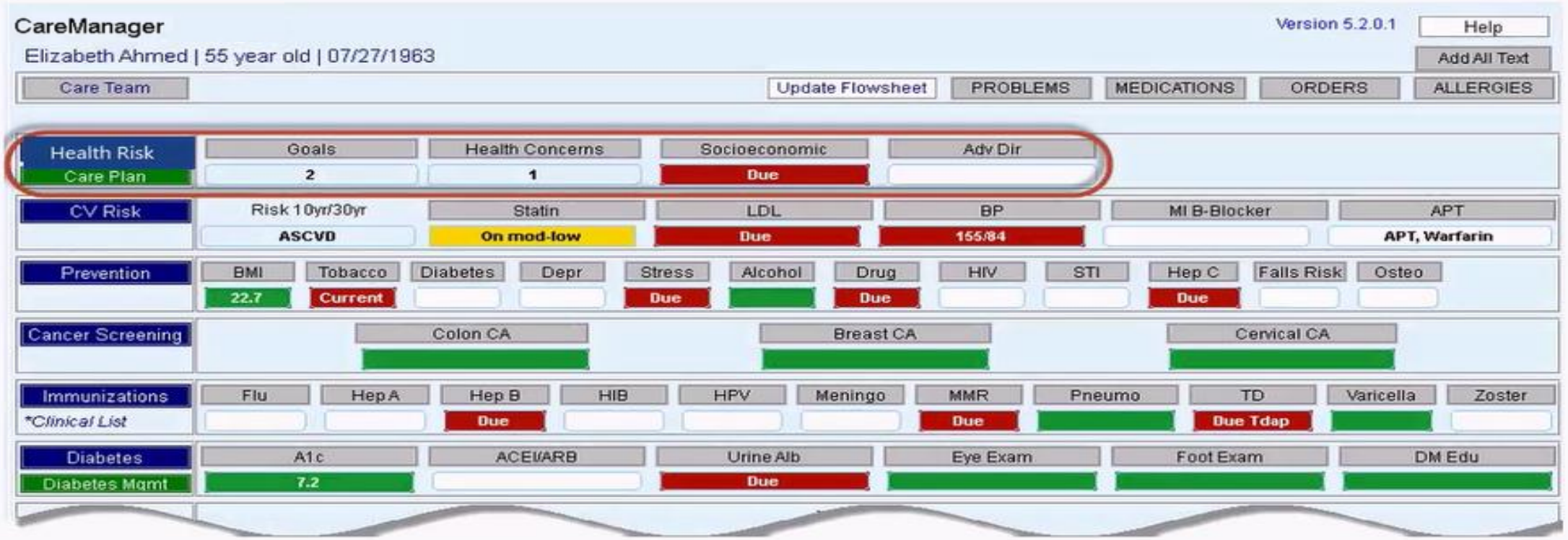
- Extended tools for patient outreach, engagement, and care coordination activities
  - Patient Health Concerns and Goals
  - Social Determinants of Health
  - Advanced Directives
- Immunizations
  - CDSi – Vaccine Schedule Recommendations
  - Jump button to Immunization Mgt HTML form

Central Worklist v4.2

- Threshold driven alerts prioritize care coordination
- Appointment-driven workflows support timely patient engagement

Care Manager 5.2 Preview

Care Plan Extensions – Comprehensive Care Plan for CPC+



Care Plan

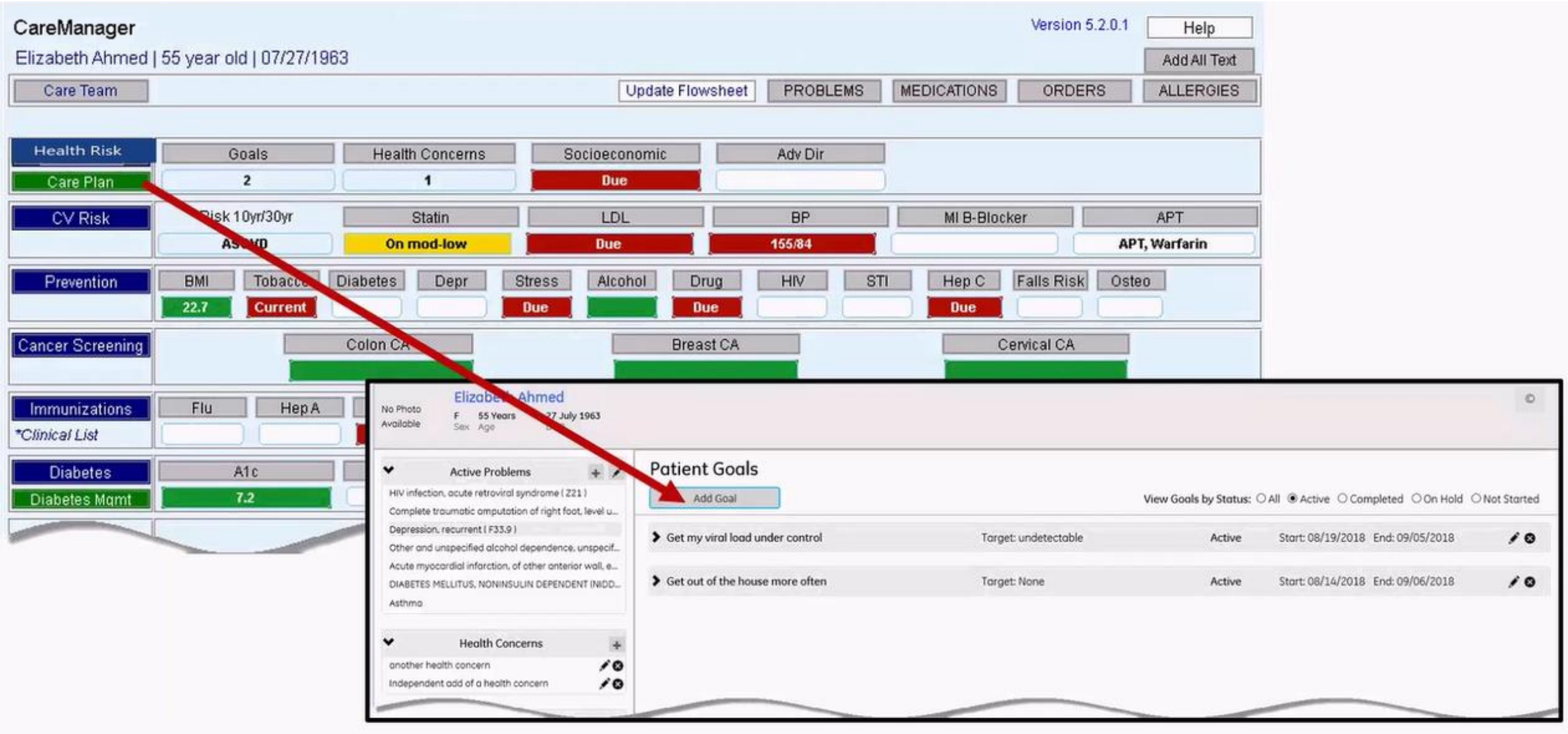
- ✓ Patient health concerns, goals and self-management plans.
- ✓ Care gaps
- ✓ Auto-population of data.
- ✓ Available to patient on paper and electronically.
- ✓ Available in electronic format to team members outside the practice.
- ✓ Interventions and health status evaluations and outcomes.
- ✓ Advance Directives and preferences for care.
- ✓ Action Plans for specific conditions.

Psychosocial and Behavioral

- ✓ Financial resource strain
- ✓ Education
- ✓ Stress
- ✓ Depression
- ✓ Physical activity
- ✓ Alcohol use
- ✓ Social connection and isolation
- ✓ Exposure to intimate partner violence

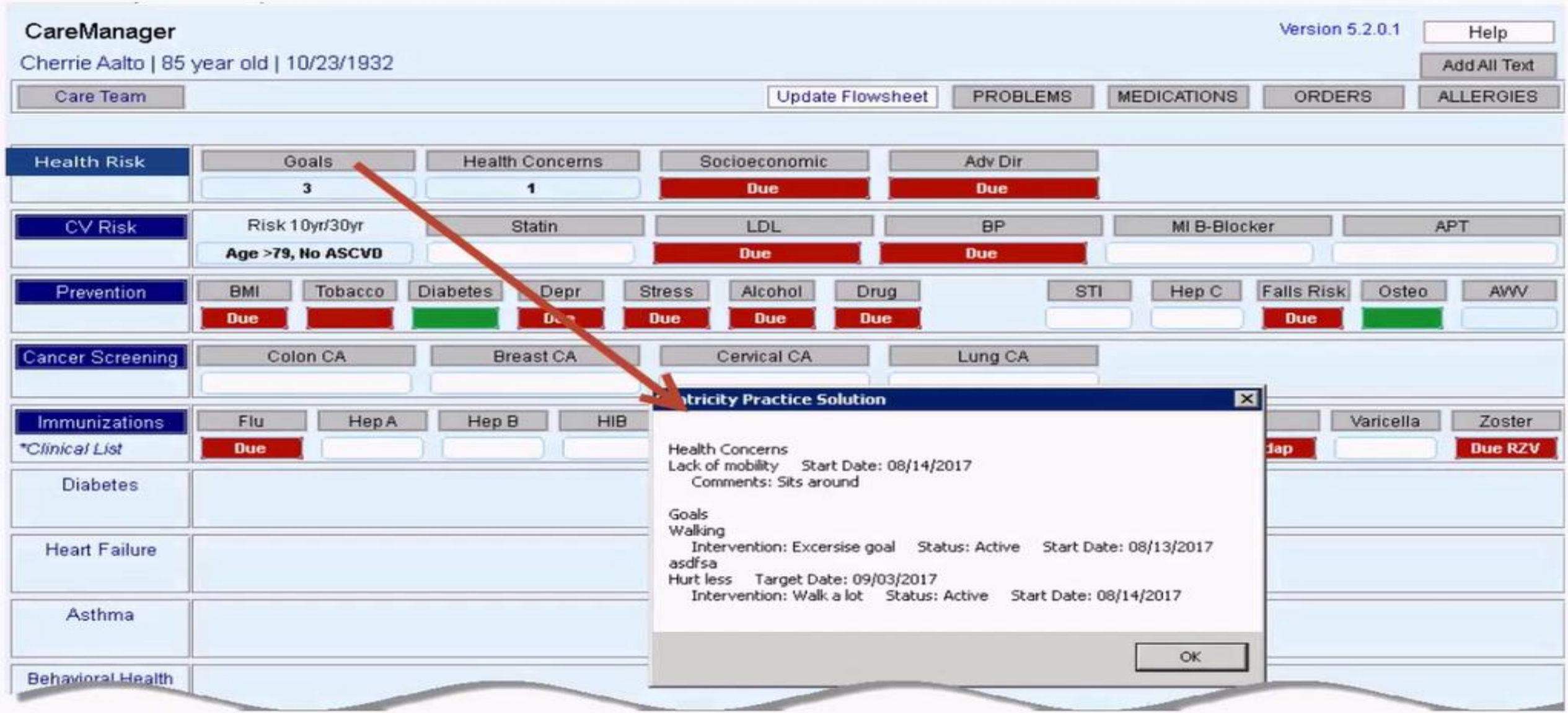
Care Manager 5.2 Preview

Care Plan Extensions – integration w/ Care Plan form



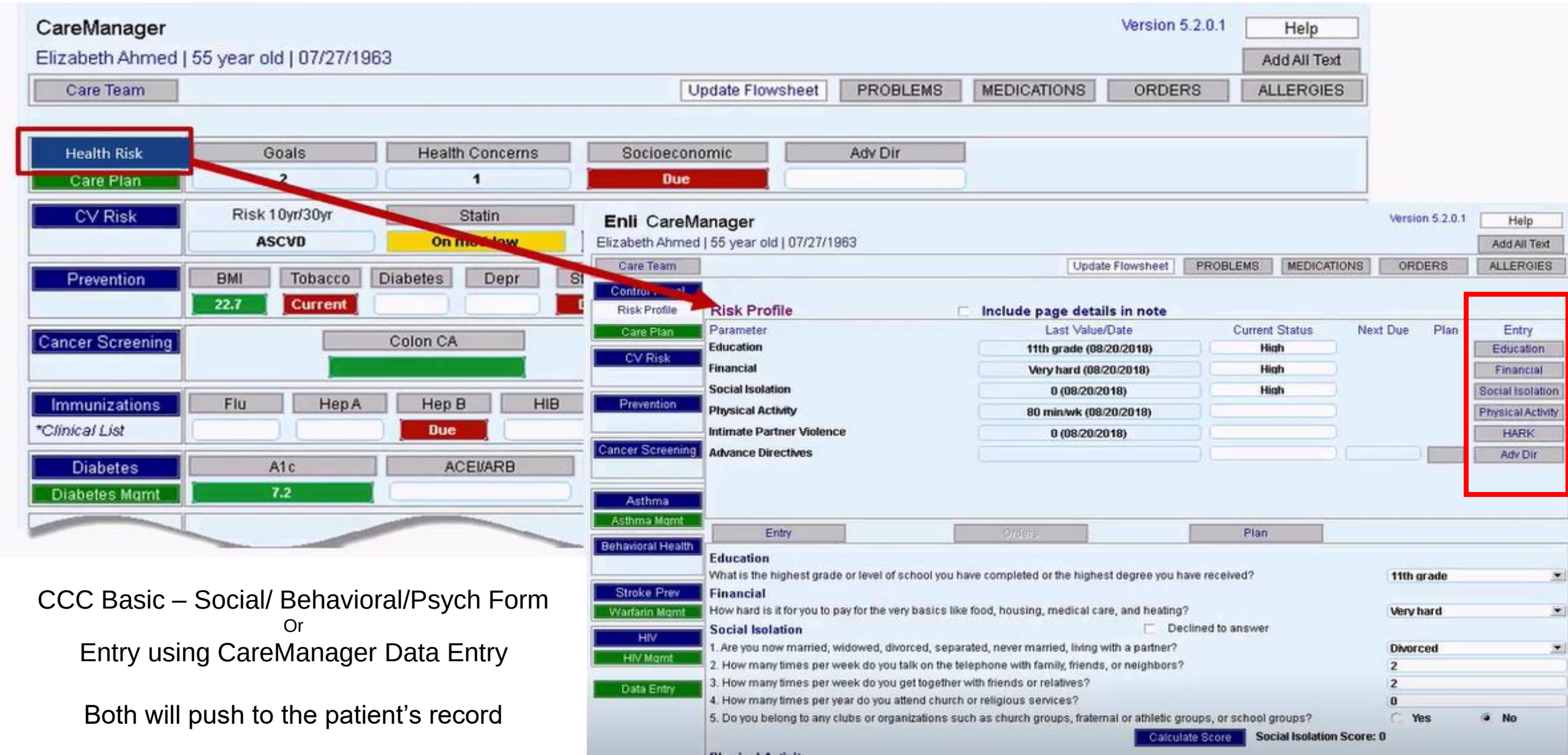
Care Manager 5.2 Preview

Care Plan Extensions – Quick view of goals and health concerns



Care Manager 5.2 Preview

Socioeconomic Risk and Advanced Directives



CCC Basic – Social/ Behavioral/Psych Form

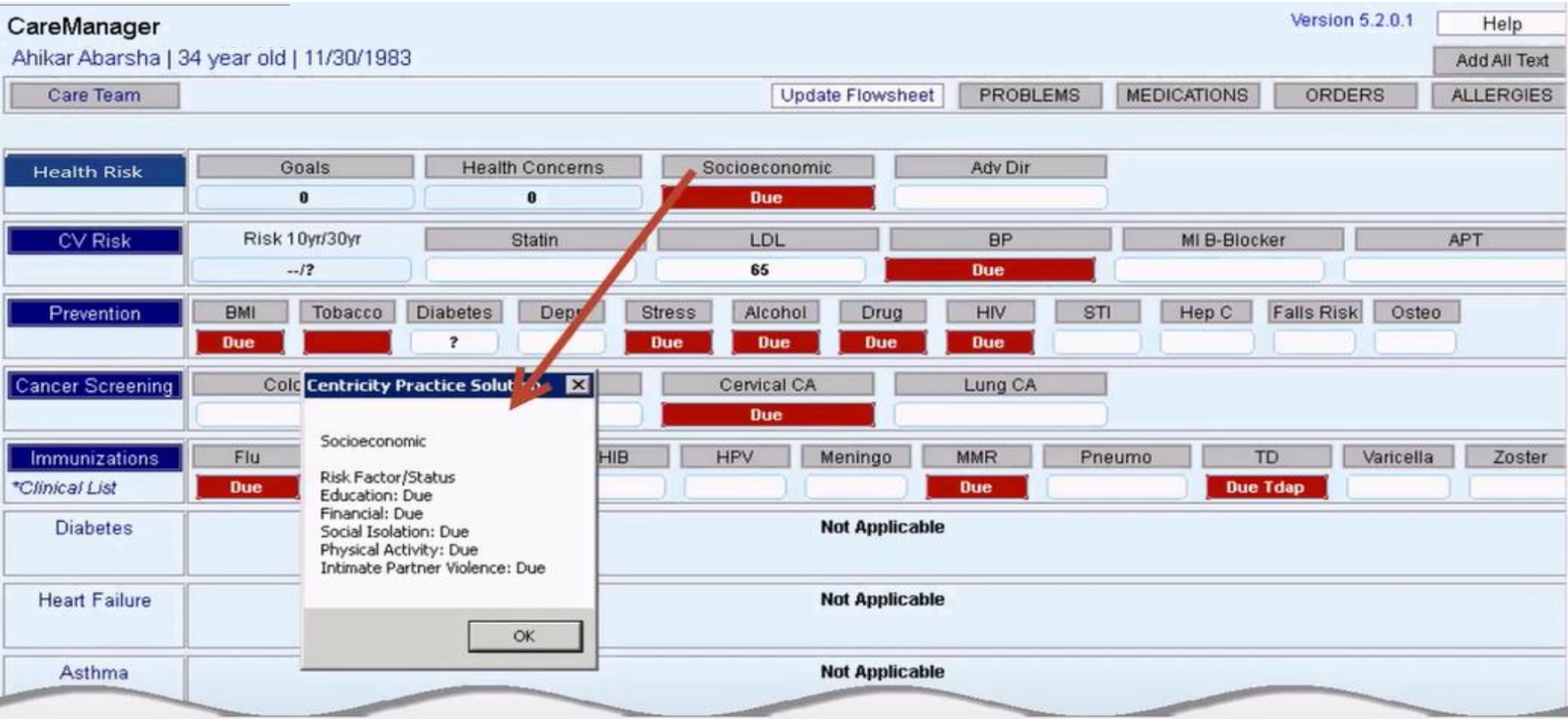
Or

Entry using CareManager Data Entry

Both will push to the patient's record

Care Manager 5.2 Preview

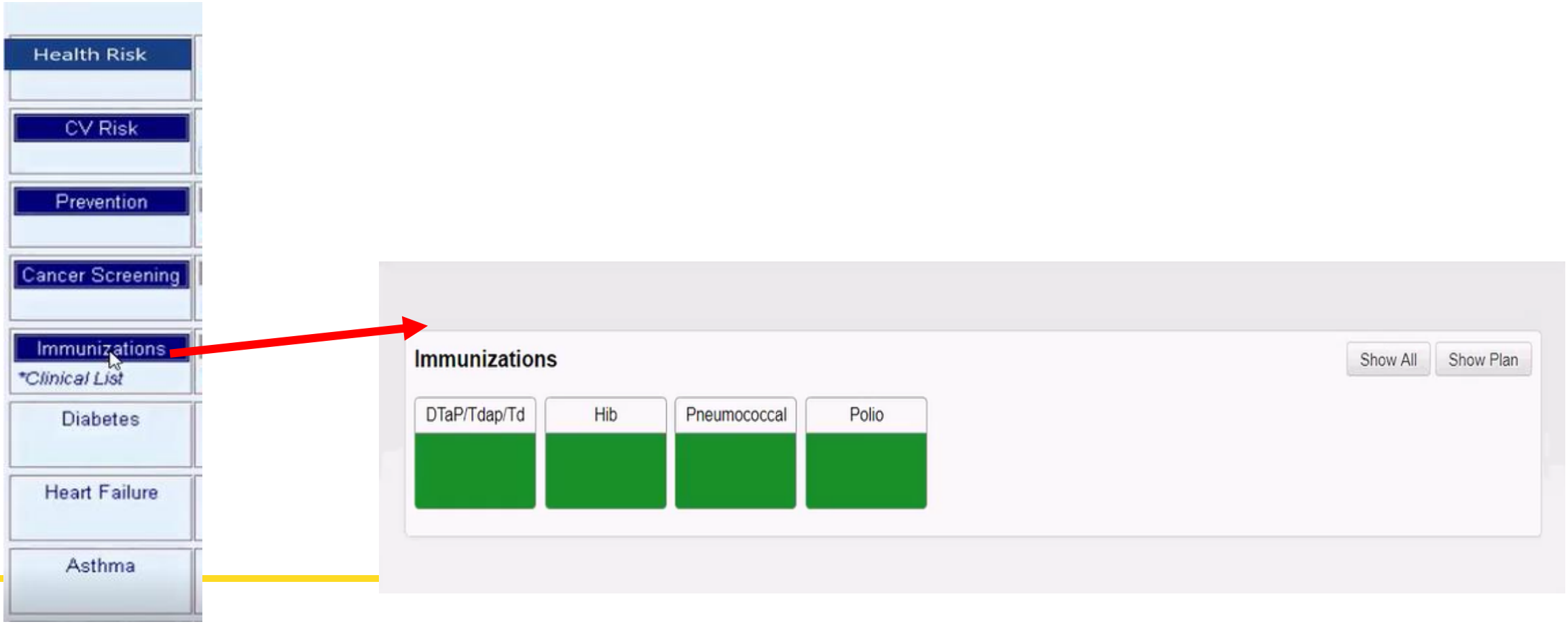
Socioeconomic Risk and Advanced Directives confirmation



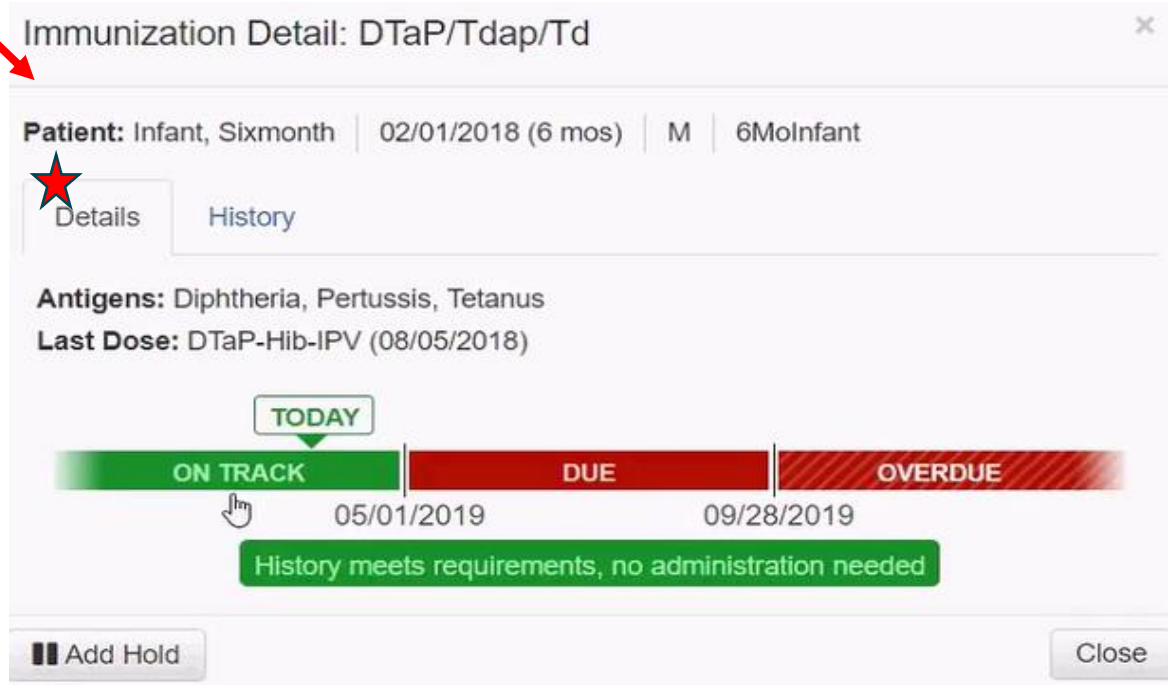
Care Manager 5.2 Preview

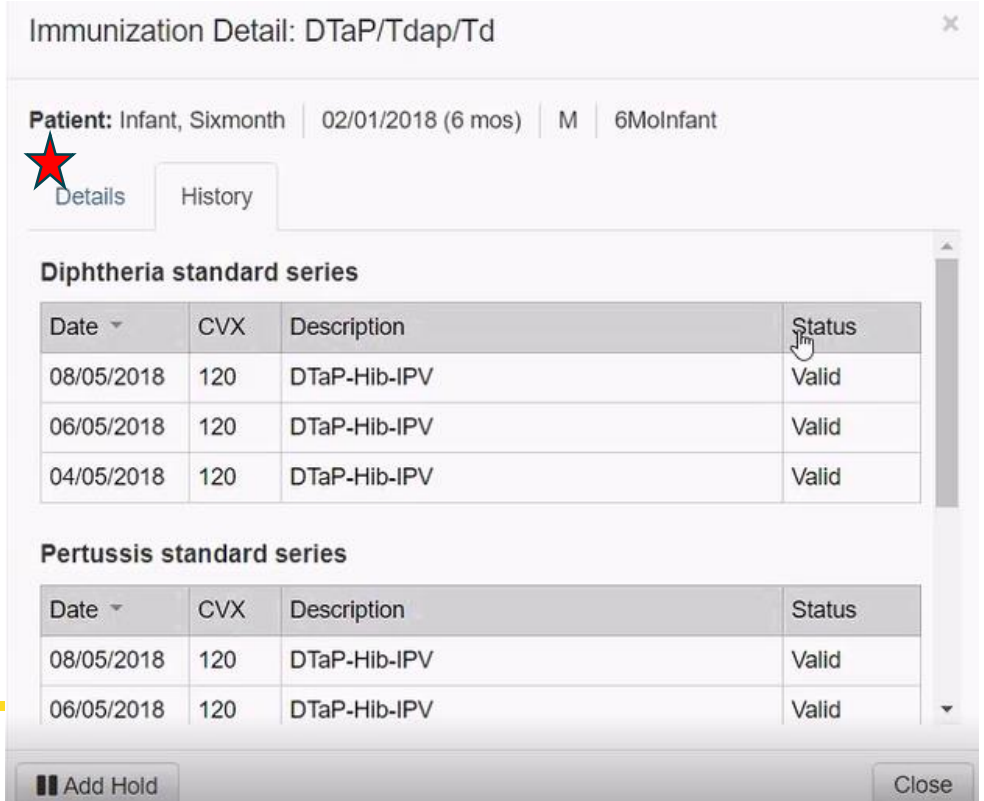
CareManager CDSi Immunization recommendations

- CDC CDSi: Foundation for the Solution
- Uses patient age, gender, conditions, and co-morbidities to recommend vaccines and their schedule
- Does require capturing vaccines using CVX codes – Obs terms not supported



Care Manager 5.2 Preview
Immunization, Next Due & History





Care Manager 5.2 Preview

Immunization – Patient Plan History

Immunizations

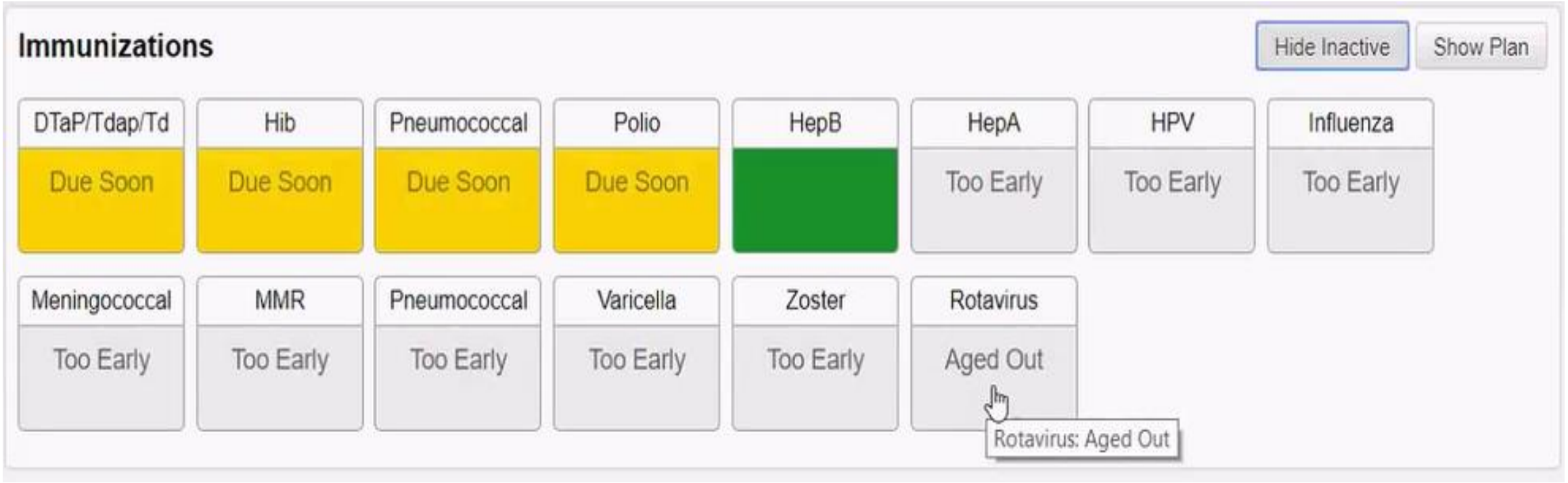
Show All | Show Plan

DTaP/Tdap/Td | Hib | Pneumococcal | Polio

Vaccine	Last Value	Current Status	Modify Status	Next Due
DTaP/Tdap/Td	DTaP-Hib-IPV (08/05/2018)	On Track	Hold	05/01/2019
HepA		Too Early	Hold	02/01/2019
HepB	Hep B, adolescent or pediatric (08/05/2018)	Complete		
Hib	DTaP-Hib-IPV (08/05/2018)	On Track	Hold	02/01/2019
HPV		Too Early	Hold	02/01/2029
Influenza		Too Early	Hold	
Meningococcal		Too Early	Hold	02/01/2029
MMR		Too Early	Hold	02/01/2019
Pneumococcal	Pneumococcal conjugate PCV 13 (08/05/2018)	On Track	Hold	02/01/2019
Polio	DTaP-Hib-IPV (08/05/2018)	On Track	Hold	02/01/2022
Rotavirus	rotavirus, monovalent (06/05/2018)	Complete		
Varicella		Too Early	Hold	02/01/2019

Care Manager 5.2 Preview

Immunizations Due & Aged Out.



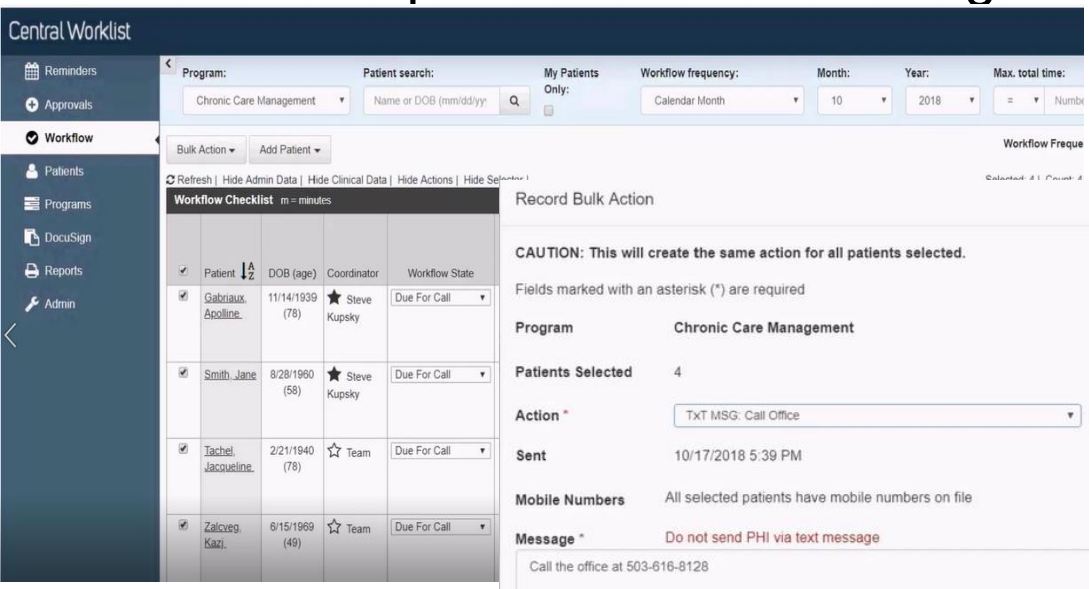
Central Worklist v 4.0 & 4.1 currently available

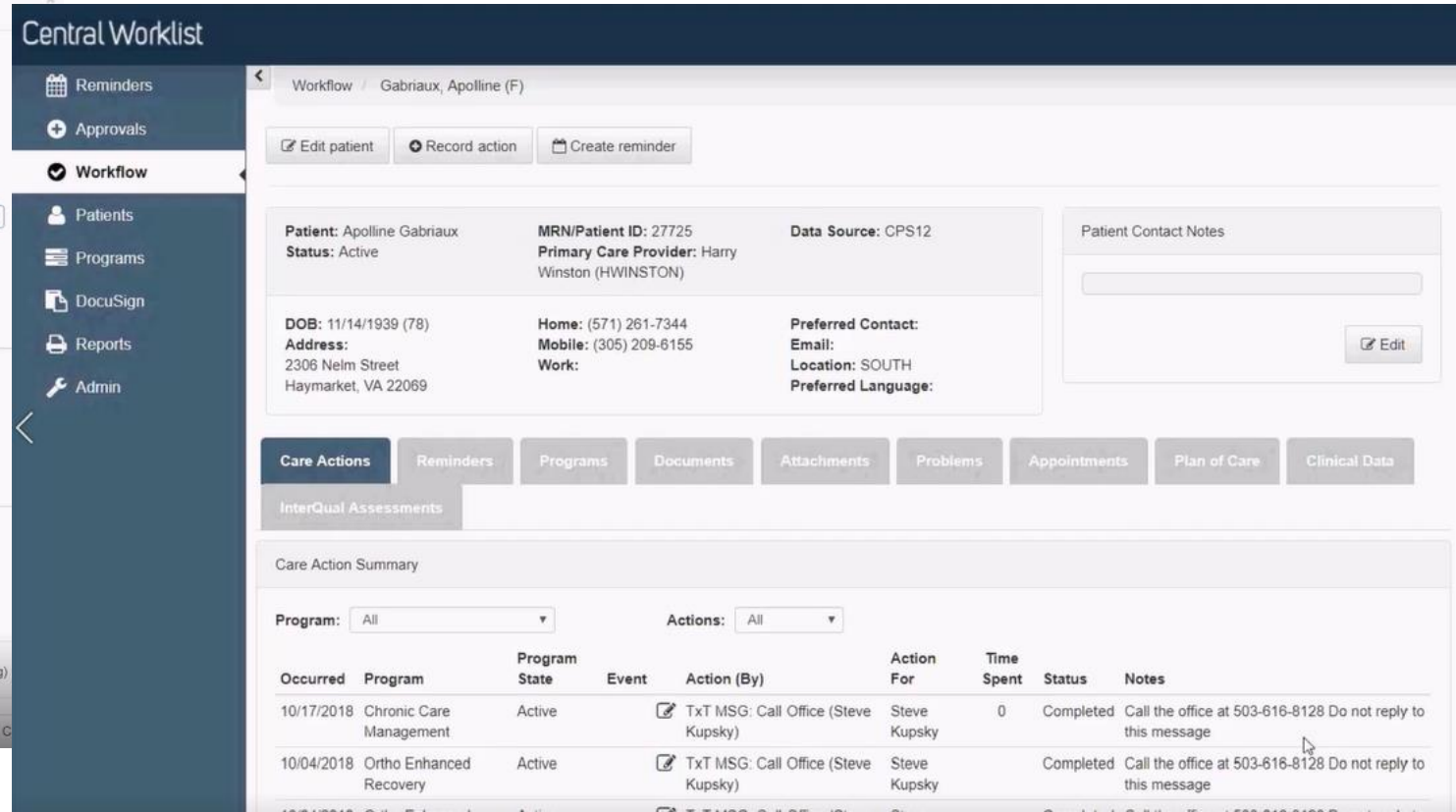
- Text Messaging integration – Twillio
  - Separate contract / license key with Twillio required
  - One-way communication – from Care Manager to patient
- Configurable Threshold driven alerts
  - Prioritization Care Coordination
    - Guides Care Manager tracking patients for follow-up and management
    - Example: Result values change, completion / in-completion of care Plan activities
- Appointment driven workflows
  - Pre-visit outreach
  - Chart-prep
  - Daily Huddle

Central Worklist

v4.1 Ad-hoc Text Messaging integration - Twillio

- Writes a copy of the message within Central Worklist
- Individual patient or bulk message Text





https://www.twilio.com/sms/pricing/

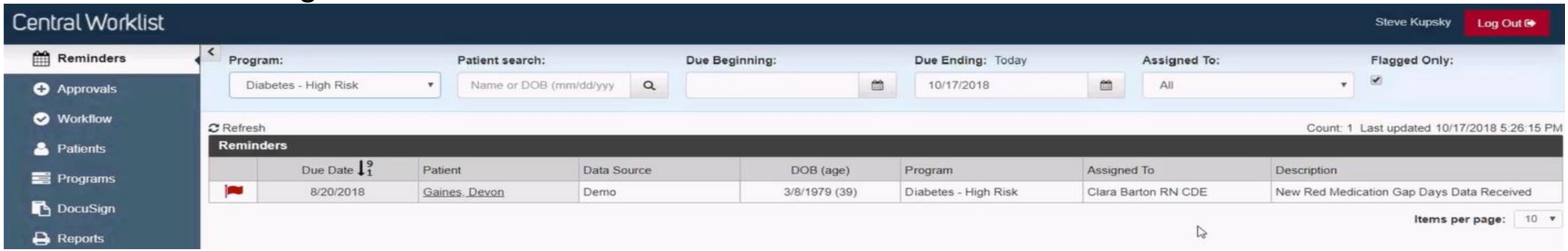
Central Worklist v4.1

Threshold driven alerts

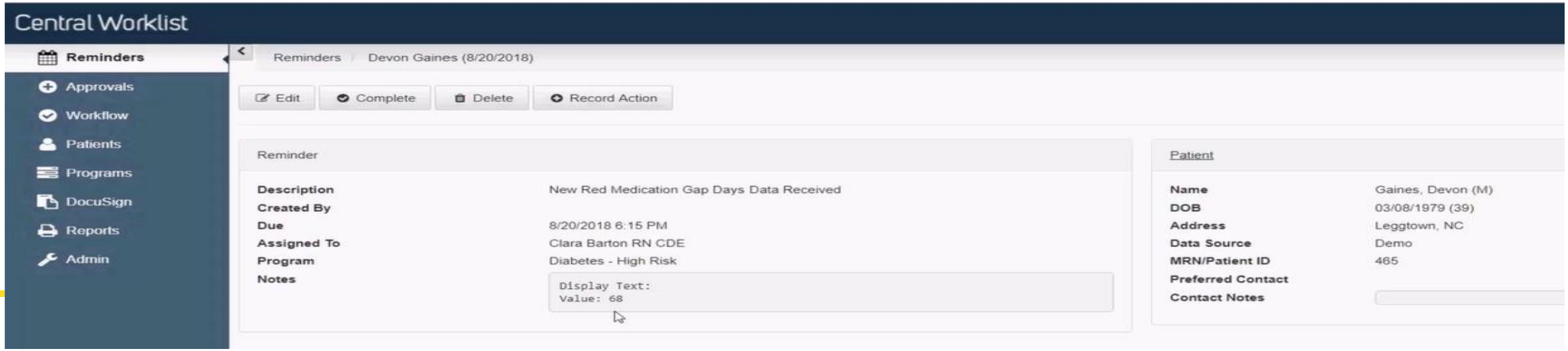
- Data element tracked in central worklist – based on threshold

  Re-interpret results – based on the change of a data element

  Care Manager informed for Care Coordination activities



View detail

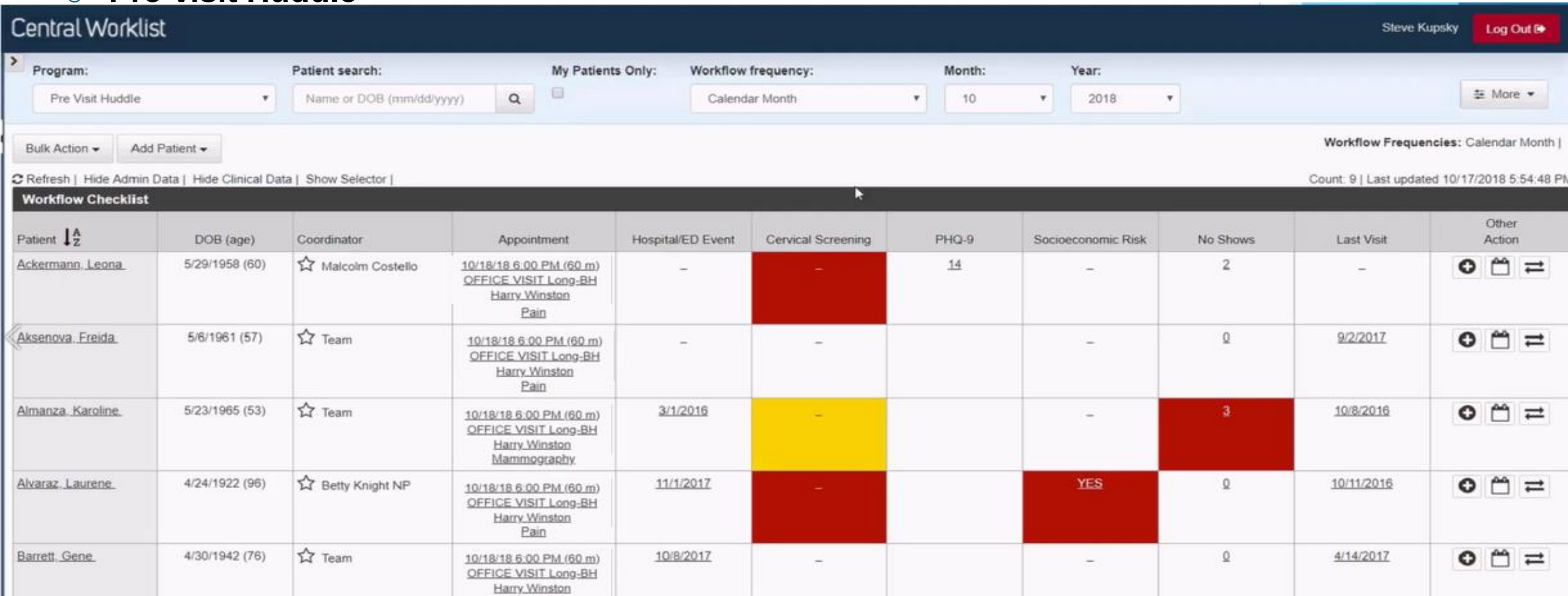


Appointment driven workflows

Using appointment data from Centricity

Identify the days ahead of the visit to create the list of patients

- Pre-visit outreach
- Pre-visit chart prep
- **Pre-visit Huddle**



Ambulatory Product Roadmap

Cloud

DenialsIQ™

CQR

Collaboration Framework

On premise

VBC Analytics - Quality

Ambulatory Population Health

VBC Analytics - Advanced

TODAY

Hospital Connect 2.0

Intelligent Orders

Landing Page

Medication Management

2018

2019

SP 1
- 32 Usability fixes
- 10 Performance fixes
- 31 Stability fixes
- 10 Compliance fixes

SP 2
- Rx renewal workflow fix
- Duplicate medication fix
- Bulk approvals of patient refills
- Visibility into inactive meds
- Additional measure support

SP 3
- Patient Access Measures – API Support

EPCS - DigiCert

CPS 19
CEMR 19
- AUC
- Cloud Data Services
- Centricity Now

CPS 20
CEMR 20

Action items

Attendees:

- Share the presentation with your care team(s)

Quality Leaders, Providers, Healthcare Executives

- Are your care managers and care team working with the same list of cohorts that you are?
  - Improve on 400+ quality measures with intuitive dashboards.

Care managers, and coordinators

- Does your current population health offering automatically assign plans based on patient's problems and conditions.
- Document care manager notes and task follow-ups to other members of the care team and push notes bidirectionally back to the EHR for workflow efficiency.

Learn More:

- Stop by the GE Booth this conference, or
- Account Manager
- Email Inside Sales at: EMRInsideSales@ge.com
- Email Presenter: Shirley.j.Garcia@ge.com

Thank you!

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Other sessions to consider

Saving Time and Improving Community Collaboration

Hospital Connect

Geoff Lay

Saturday 10:45 – 11:45
Cumberland 3&4

Stay Current to Optimize

Integrating the latest CPS and CEMR Functionality into your workflows

Rhea Davis

Saturday 1:30 – 2:30
Cumberland 3&4

Simple Chart Function Builder

New ways to save time, reduce clicks, and keep your Sanity

Katie Drennan & Sharie Frye

Saturday 2:45- 3:45
Cumberland 5

Get Social!

@VirenceHealth