



Population Health: Managing Chronic Disease Patients Efficiently and Cost Effectively



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

November 9, 2018

virencehealth.com



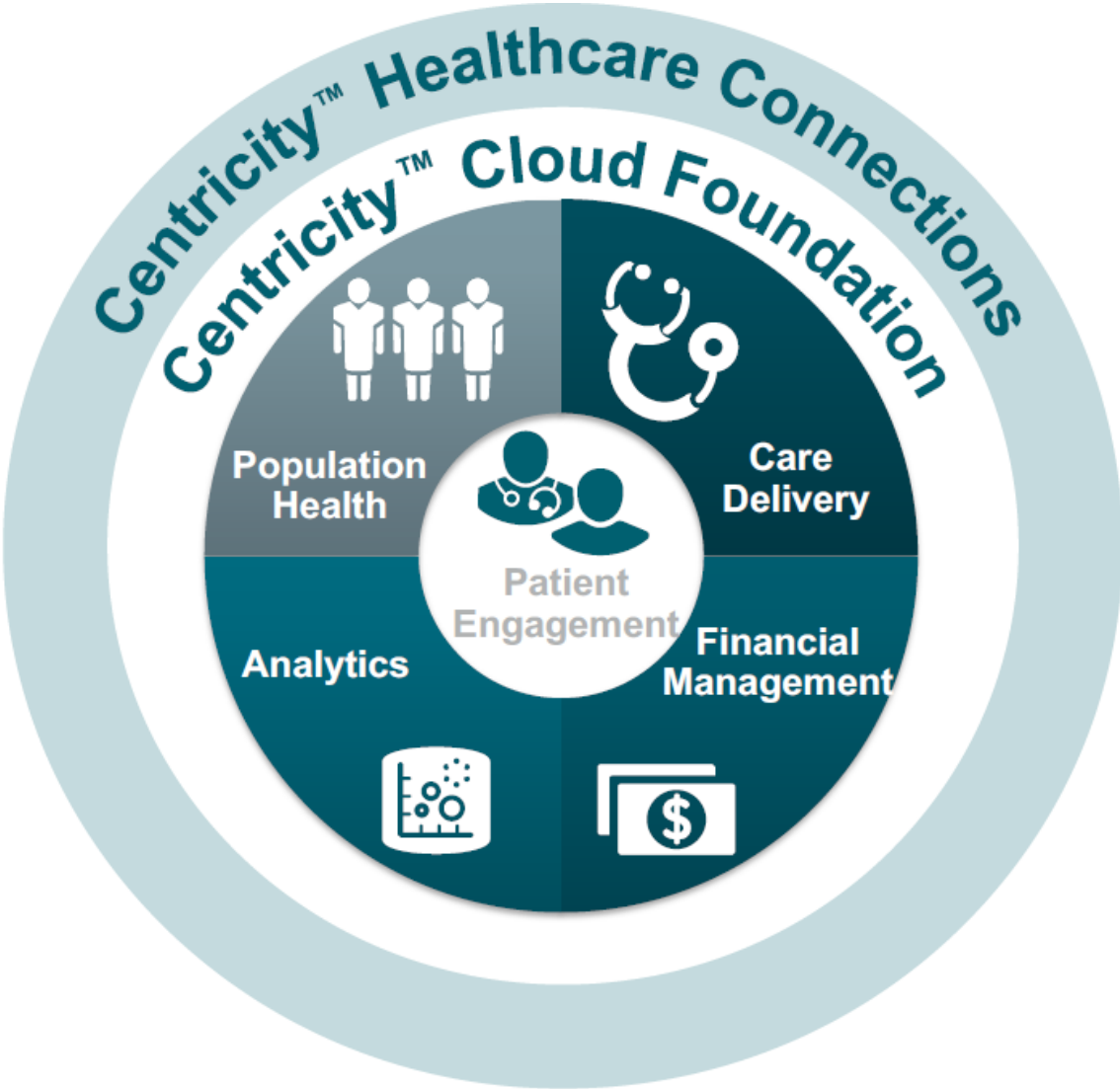
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ACM Population Health Solutions



**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



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

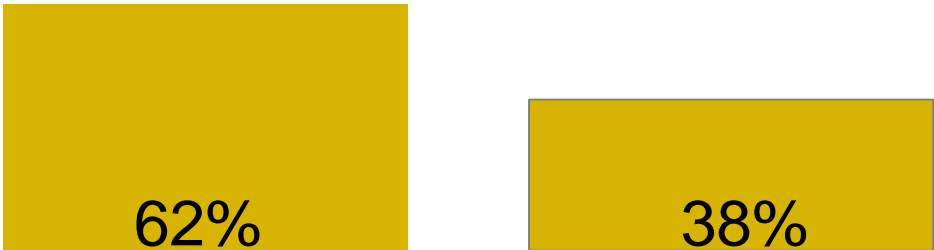
- Mix of Business, Clinical, IT/Technology roles
- Mix of small and large ambulatory practices and IDNs

Organizational type



Ambulatory practice Integrated Delivery Network

Organizational size



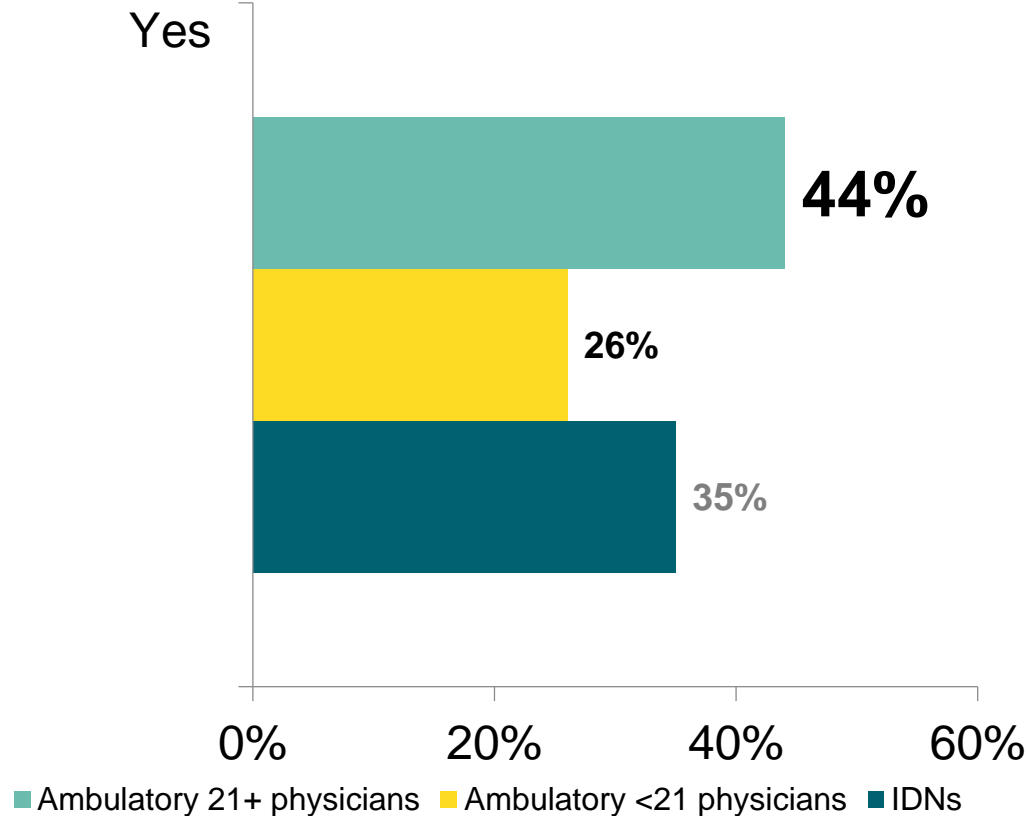
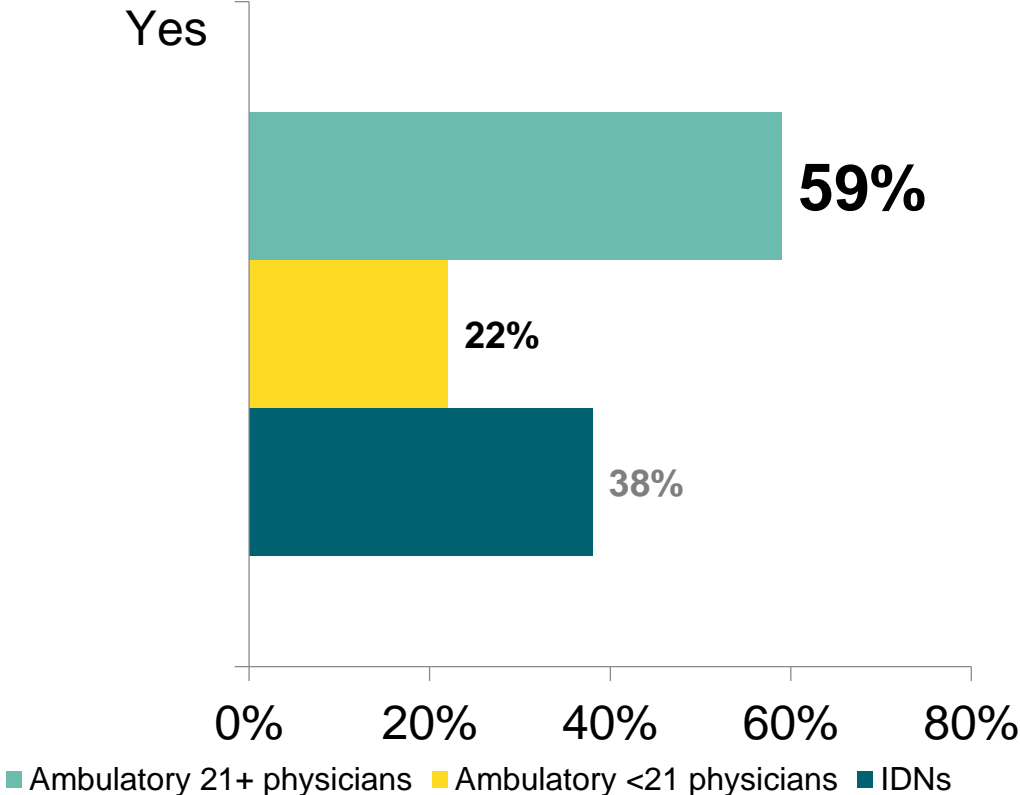
21+ physicians <21 physicians

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%)

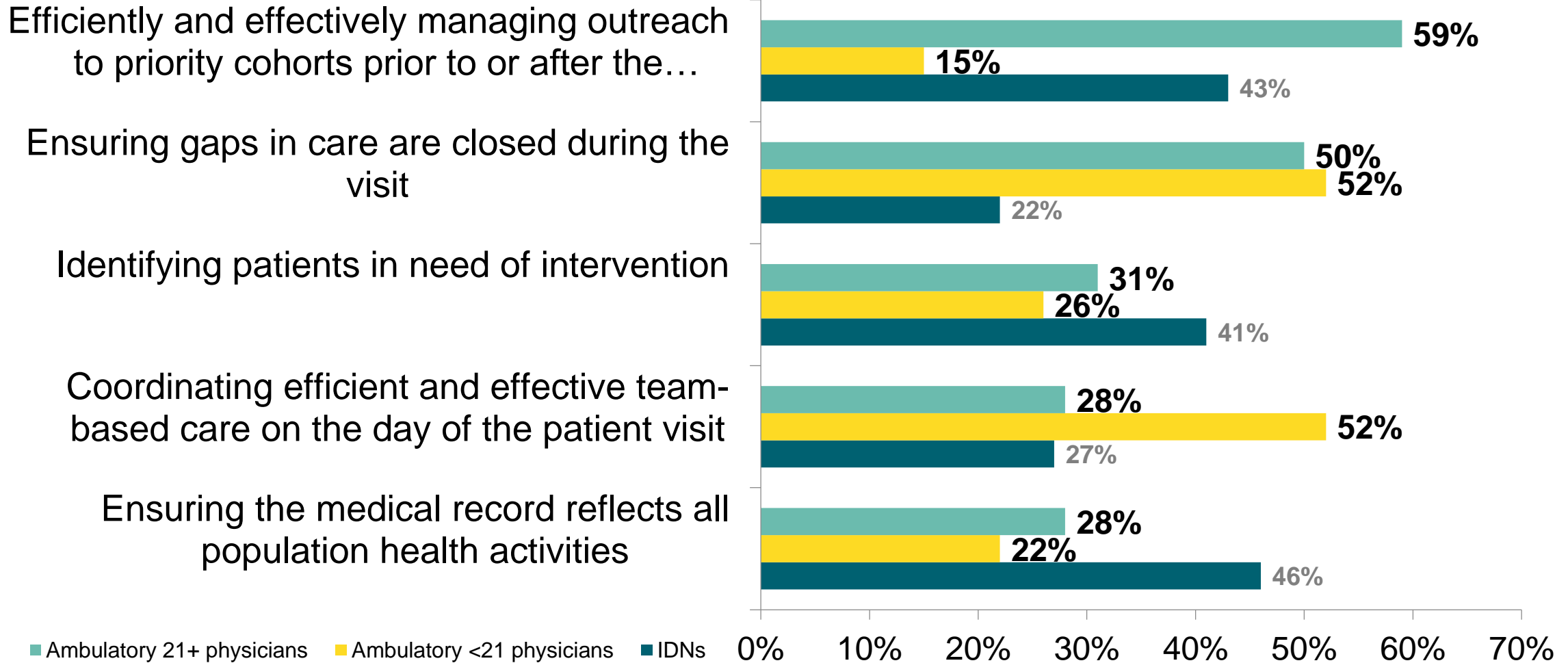
IDN Challenges: Cohort Management / Identification

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

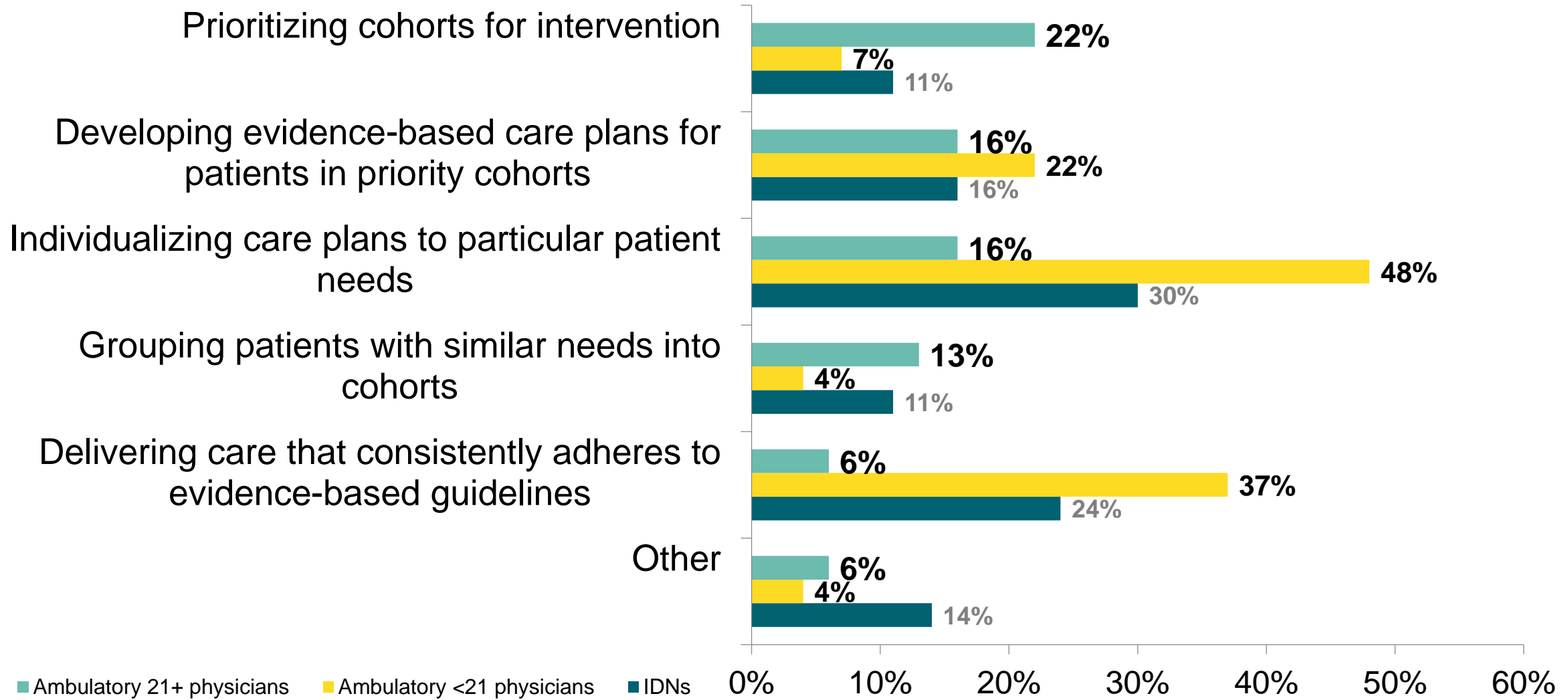


Population Health Management Challenges



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



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**

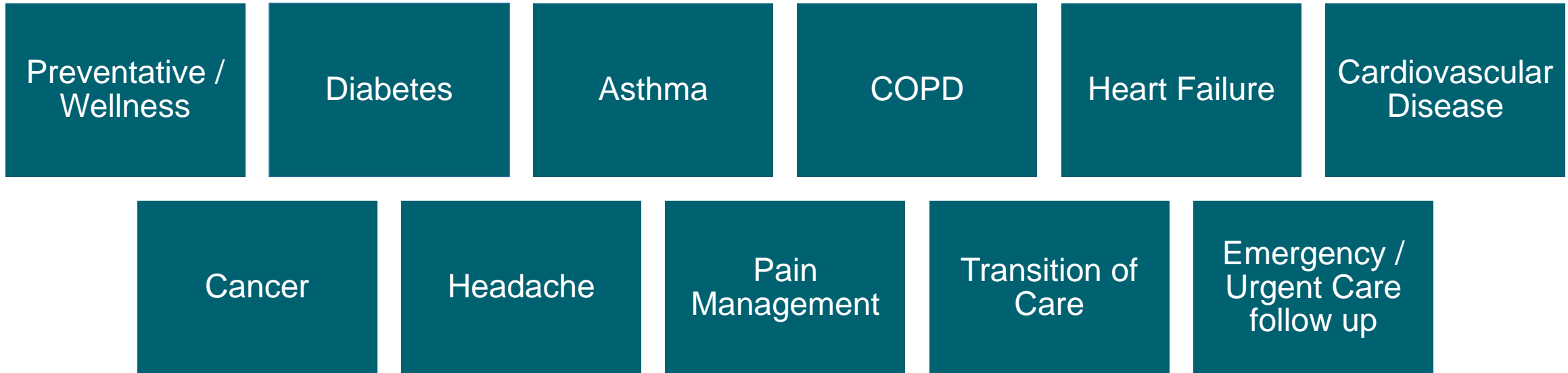
Care managers must **ENGAGE** high-risk patients to prevent them from becoming unhealthier and develop complications.

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



Care Management 101



Began with diabetes

- Internal quality data
- Payer Data
- POC PH Tool
- Define your DM PH registry

Care Manager

- 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.

Assess

- 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



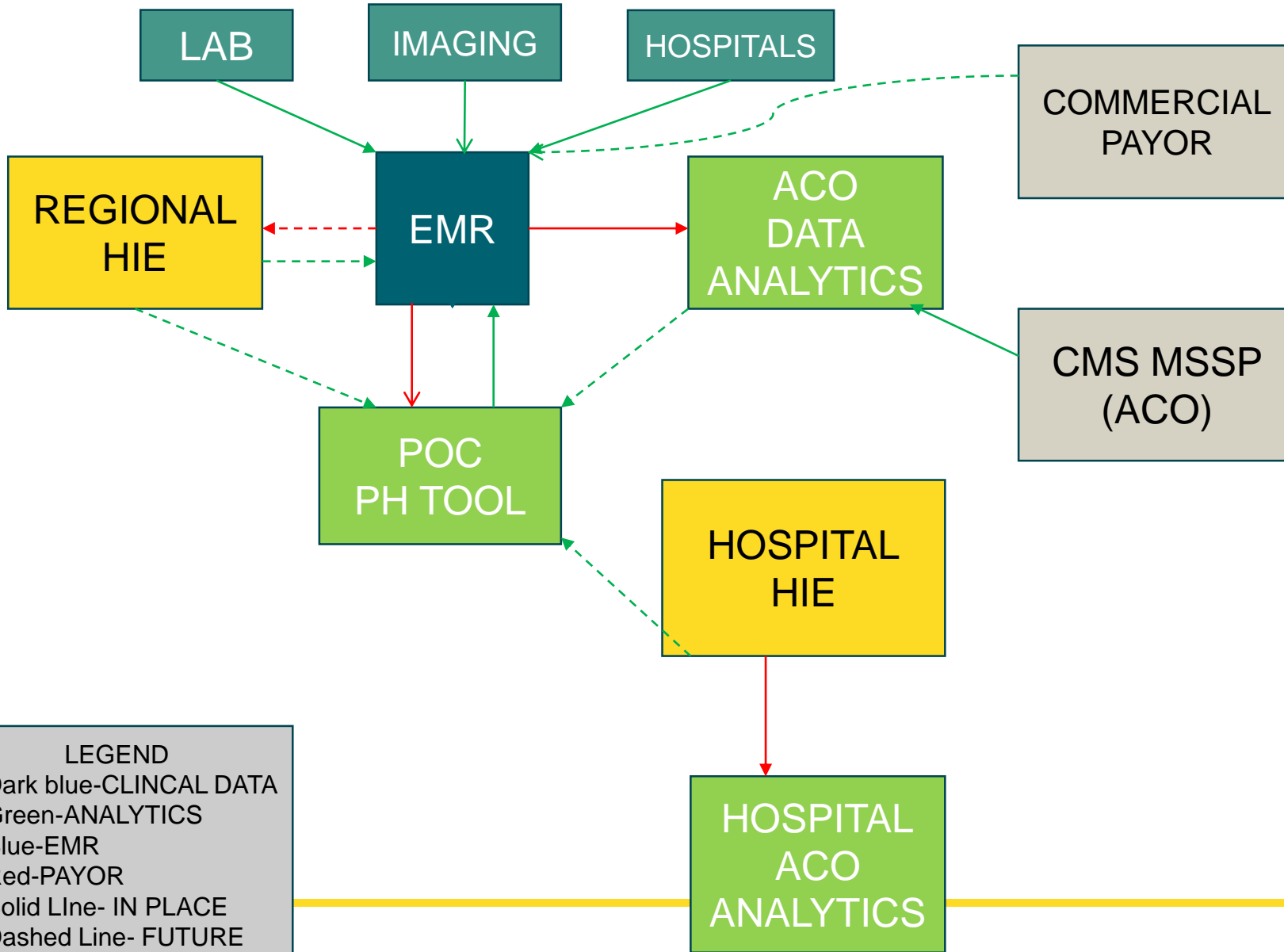
- Portal Communications
- Personal Calls from practice based Care Managers
- Focused Mass Mailings
- Automated Telephonic Outreach-Clinical Algorithm based

POPULATION HEALTH MANAGEMENT

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

At this time,
no one is connected well enough
to aggregate and analyze
all of the data!

PPCP IA



DO YOUR OWN IA
DIAGRAM !!

LEGEND

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

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

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

Patient Name: Test, GE "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)

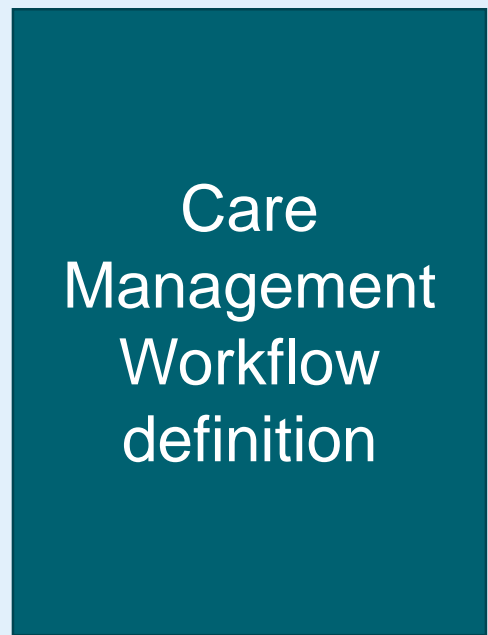
HPI elements: location, quality, severity, duration, timing, context, modifying factors, and associated signs/symptoms

Problems New Problem Allergies Meds Orders Refill Rx Flowsheet **Knowledge 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



Add All Text

Care Team Update Flowsheet PROBLEMS MEDICATIONS ORDERS ALLERGIES

Responsible Provider: Insurance Carrier: Last Office Visit:

CV Risk

Risk 10yr/30yr	Statin Intensity	LDL-Cholesterol	BP	MI B-Blocker	APT
<input type="text" value="?"/> ?	On statin	<input type="text" value="test patient mg/dL"/> 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
Due		?					Due (PCV13)			

**Clinical List*

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	<input type="text" value="456"/> 456	<input type="text" value=""/>	ACEI, ARB	Yes	Yes	Yes	Yes			Yes

Stroke Prev

AFib Dx	On Warfarin	Managed By	INR Target	Last INR	Next INR	TTR
Warfarin Mgmt	No	Yes	<input type="text" value=""/>	<input type="text" value="2.0"/> 2.0	2 weeks	<input type="text" value=""/>

Asthma

Last Control	Assessment	Controller Meds	Action Plan
	Due	ICS	Due

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

Suspected Diagnosis

<input type="text" value="Depression"/>	<input type="text" value="Diabetes"/>	<input type="text" value="Heart Failure"/>	<input type="text" value="Hypertension"/>	<input type="text" value="Osteoporosis"/>
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Problems-CCC

Depression

- Diabetes
- Treatment**
- Identification
- Services Due
- Quality Assurance
- Heart Failure
- Prevention
- Stroke Prevention
- Patient Control Panel

Diabetes Without Statin ✖ Add Filter

Export Message Print

Treatment																
<input type="checkbox"/>	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
<input type="checkbox"/>		76	No statin	<u>102</u>	<u>4.8</u>	<u>146/80</u>		Yes	Due	Quit	<u>27.3</u>	12/28/2017		<u>Louis Civitarese DO</u>		
<input type="checkbox"/>		76	No statin	<u>135</u>	Due	<u>120/64</u>	Yes	Yes	Due	Quit	<u>35.1</u>	1/29/2018	<u>7/30/2018</u>	<u>Michael Specca DO</u>		
<input type="checkbox"/>		59	No statin	<u>45</u>	Due	Due			Due	Current	<u>31.2</u>	6/2/2016		<u>Michael Specca DO</u>		
<input type="checkbox"/>		83	No statin	<u>113</u>	Due	<u>140/80</u>	Yes	Yes		Quit	<u>27.8</u>	1/17/2018		<u>Jared Bovalino DO</u>		
<input type="checkbox"/>		58	No statin	<u>90</u>	Due	<u>140/90</u>			Due	Quit	<u>33.3</u>	1/12/2018	<u>2/28/2018</u>	<u>Louis Civitarese DO</u>		
<input type="checkbox"/>		84	No statin	<u>95</u>	<u>8.1</u>	<u>148/80</u>		Warfarin	Due	Never	<u>31</u>	1/30/2018	<u>3/9/2018</u>	<u>Louis Civitarese DO</u>		
<input type="checkbox"/>		69	No statin	<u>118</u>	<u>5.5</u>	<u>138/90</u>	Yes		Due	Quit	<u>31.4</u>	1/8/2018		<u>Frank Civitarese DO</u>		
<input type="checkbox"/>		54	No statin	<u>52</u>	<u>7.1</u>	<u>140/90</u>	Yes		Due	Quit	<u>41.6</u>	11/24/2017		<u>Frank Civitarese DO</u>		
<input type="checkbox"/>		49	No statin	<u>88</u>	Due	<u>128/80</u>	Yes	APT	Due	Never	<u>70.8</u>	1/30/2018	<u>3/5/2018</u>	<u>Louis Civitarese DO</u>		
<input type="checkbox"/>		83	No statin	<u>83</u>	<u>7.1</u>	<u>138/80</u>		Yes	Due	Never	<u>32.5</u>	11/24/2017	<u>3/28/2018</u>	<u>Frank Civitarese DO</u>		
<input type="checkbox"/>		58	No statin	<u>86</u>	<u>9.9</u>	<u>130/86</u>	Yes	APT	Due	Quit	<u>40.6</u>	2/6/2018		<u>Jared Bovalino DO</u>		
<input type="checkbox"/>		88	No statin	<u>94</u>	<u>9.4</u>	<u>122/78</u>	Yes	APT	Due	Never	<u>32.1</u>	12/6/2017		<u>Michael Specca DO</u>		
<input type="checkbox"/>		61	No statin	<u>61</u>	Due	<u>120/80</u>	Yes	APT	Due	Quit	<u>50.4</u>	8/16/2017		<u>Michael Specca DO</u>		
<input type="checkbox"/>		54	No statin	<u>99</u>	Due	Due	Yes		Due	Quit	<u>40</u>	6/1/2016		<u>Michael Specca DO</u>		
<input type="checkbox"/>		83	No statin	<u>113</u>	Due	<u>110/78</u>			Due	Never	<u>19.2</u>	11/7/2017	<u>3/7/2018</u>	<u>Michael Specca DO</u>		

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

Description

(Column	Property	Comparison	Value)	
<input type="text"/>	Hep B ▾	Text ▾	Equals ▾	? ▾	<input type="text"/>	<input type="button" value="++"/> <input type="button" value="+↓"/> <input type="button" value="x"/>
<input checked="" type="radio"/> And <input type="radio"/> Or						
<input type="text"/>	Hep B ▾	Color ▾	Equals ▾	Red ▾	<input type="text"/>	<input type="button" value="++"/> <input type="button" value="+↓"/> <input type="button" value="x"/>

Delete This Filter

Run

Save

Save As

Cancel



10:59 PM

Print

Comm

ble to show

cal

ved. ©2017

Preferred Primary Care Physicians Annual Wellness visit



CareManager

Select Contract Change Cluster Briana O'Malley Help Log Out

Prevention / Adult Screening

Contract (1): ACO Patients | Location : O2 | EHR Last Queried: 10/31/2018 10:54 PM

Patients due for AWW (Use with ACO Cont...)

Add Filter

Export Message Print

Adult Screening

<input type="checkbox"/>	Patient ▲	Age	Gender	BMI	Tobacco	Breast CA	Cervical CA	Colon CA	Diabetes	Depress	Anxiety	Alcohol	Drug	HIV	STI	Hep C	AAA	Falls Risk	Osteo	AWV	Last Appt	Next Appt	PCP	Other Prov	Comm	
<input type="checkbox"/>		93 y	M	21.2	Never						Due	Due	Due							10/21/16	9/10/18	11/7/18	Barry Austin DO			
<input type="checkbox"/>		67 y	M	28.8	Quit					Due	Due	Due	Due			Due				7/3/17	6/4/18	12/5/18	Raman Purighalla MD			
<input type="checkbox"/>		68 y	F	28.4	Quit			High risk		Due soon		Due	Due							7/10/17	4/16/18	11/5/18	Raman Purighalla MD			
<input type="checkbox"/>		75 y	M	28.1	Never							Due	Due							2/18/16	9/26/18	12/12/18	Raman Purighalla MD			
<input type="checkbox"/>		84 y	M	29.3	Quit					Due	Due	Due	Due							9/27/17	8/7/18	11/5/18	Barry Austin DO			
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<input type="checkbox"/>		62 y	F	16.3	Never			High risk			Due	Due	Due	Due		Due					8/7/18	11/13/18	Barry Austin DO			
<input type="checkbox"/>		42 y	F	27.2	Quit					Due	Due	Due	Due	Due							1/16/17			Raman Purighalla MD		
<input type="checkbox"/>		71 y	M	33	Current						Due	Due	Due							5/18/17	5/1/18	11/13/18	Raman Purighalla MD			
<input type="checkbox"/>		90 y	F	16.7	Never						Due	Due	Due							3/7/17	9/6/18	12/11/18	Raman Purighalla MD			
<input type="checkbox"/>		97 y	F	22.7	Quit						Due	Due	Due							10/6/17	5/29/18	11/20/18	Barry Austin DO			
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<input type="checkbox"/>		62 y	F	27.6	Never						Due	Due	Due	Due							6/22/18			Barry Austin DO		
<input type="checkbox"/>		95 y	F	23.5	Never	High risk				Due	Due	Due	Due							9/20/17	5/10/18	11/12/18	Barry Austin DO			
<input type="checkbox"/>		67 y	M	26.7	Never			High risk	Due	Due	Due	Due	Due			Due					10/10/16			Barry Austin DO		
<input type="checkbox"/>		68 y	M	26.1	Never					Due		Due	Due							3/16/17	7/5/17	12/3/18	Raman Purighalla MD			
<input type="checkbox"/>		67 y	M	36.5	Never			High risk			Due	Due	Due							10/25/17	9/18/18	11/13/18	Barry Austin DO			



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 1 st Quarter	2017 4 th 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 4 th Quarter	2018 3 rd 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



Central Worklist

Briana OMalley

Log Out

- Reminders
- Approvals
- Workflow**
- Patients
- Programs
- DocuSign
- Reports
- Admin

Program: Screening for Intensive Case Managem |
 Patient search: |
 My Patients Only: |
 Workflow frequency: Every Six Months

Bulk Action | Add Patient | Workflow Frequencies: Every Six Months | One Time |

[Refresh](#) | [Hide Admin Data](#) | [Hide Actions](#) | [Show Selector](#) | Count: 65 | Last updated 10/19/2018 12:28:03 PM

Patient ID	DOB (age)	Coordinator	Appointment	Patient Status	Chart Review	Letter F/U Call 1	Letter F/U Call 2	Letter from CM	Letter F/U Call 3	Other Action
(68)		☆ Beverly Burks	10/23/18 1:45 PM (15 m) Re-check - 15 Paul Hartley	Referred	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
(88)		☆ Beverly Burks	1/16/19 2:30 PM (15 m) Check Up - 15 Richard Cook II	Enrolled	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
(83)		☆ Beverly Burks	11/27/18 2:00 PM (30 m) Annual Wellness Visit - 30 Sridhar Patnam	Referred	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
(71)		☆ Beverly Burks	11/8/18 1:30 PM (30 m) Check Up - 30 Paul Hartley	Referred	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
9 (68)		☆ Beverly Burks		In Process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
(64)		☆ Beverly Burks	10/30/18 1:45 PM (15 m) Re-check - 15 Paul Hartley	In Process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
(87)		☆ Beverly Burks	10/23/18 11:15 AM (15 m) Check Up - 15 Paul Hartley	In Process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
(94)		☆ Beverly Burks	2/12/19 10:45 AM (30 m) Check Up - 30 Paul Hartley	In Process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
(78)		☆ Beverly Burks		Referred	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Preferred Primary Care Physicians Intensive Case Management Program



Central Worklist

- Reminders
- Approvals
- Workflow**
- Patients
- Programs
- DocuSign
- Reports
- Admin

Program: Intensive Case Management |
 Patient search: Name or DOB (mm/dd/yyyy) |
 My Patients Only: |
 Workflow frequency: Every Six Months

Bulk Action | Add Patient |
 Workflow Frequencies: Every 90 Days | Every Six Months | Every Year | One Time |
 Refresh | Hide Admin Data | Hide Clinical Data | Hide Actions | Show Selector |
 Count: 35 | Last updated 10/19/2018 12:29:26 PM

Patient	DOB (age)	Coordinator	Appointment	Patient Status	Last Appt	Meds	HCC-Dx	Patient Education	Establish/Update Patient Goals	Other Action
[REDACTED]	[REDACTED]	☆ Beverly Burks	12/28/18 2:45 PM (15 m) Check Up - 15 Richard Cook II	Active (HF/COPD)	9/24/18	13	2.13	<input type="checkbox"/>	<input type="checkbox"/>	
[REDACTED]	[REDACTED]	☆ Beverly Burks	1/16/19 2:30 PM (15 m) Check Up - 15 Richard Cook II	Active (General)	10/10/18	8	1.03	<input type="checkbox"/>	<input type="checkbox"/>	
[REDACTED]	[REDACTED]	☆ Beverly Burks	1/28/19 3:45 PM (15 m) Check Up - 15 Richard Cook	Active (HF/COPD)	9/24/18	11	17.97	<input type="checkbox"/>	<input type="checkbox"/>	
[REDACTED]	[REDACTED]	☆ Beverly Burks	11/14/18 8:45 AM (15 m) Check Up - 15 Richard Cook	Active (General)	5/7/18	22	6.28	<input type="checkbox"/>	<input type="checkbox"/>	
[REDACTED]	[REDACTED]	☆ Beverly Burks	11/11/18 1:15 PM (30 m) Check Up - 30 Paul Hartley	Active (General)	10/8/18	26	6.15	<input type="checkbox"/>	<input type="checkbox"/>	
[REDACTED]	[REDACTED]	☆ Beverly Burks	1/11/19 1:00 PM (30 m) Routine/EXTENDED John Chalfant	Active (HF/COPD)	9/25/18	31	34.34	<input type="checkbox"/>	<input type="checkbox"/>	
[REDACTED]	[REDACTED]	☆ Beverly Burks	2/20/19 11:00 AM (15 m) Check Up - 15 Richard Cook II	Active (HF/COPD)	10/10/18	16	9.51	<input type="checkbox"/>	<input type="checkbox"/>	
[REDACTED]	[REDACTED]	☆ Beverly Burks	2/11/19 12:30 PM (15 m) Check Up - 15 Joseph Labuda	Active (General)	10/8/18	22	12.93	<input type="checkbox"/>	<input type="checkbox"/>	
[REDACTED]	[REDACTED]	☆ Beverly Burks	1/22/19 11:15 AM (30 m) Check Up - 30 Richard Cook II	Active (HF/COPD)	10/16/18	19	29.00	<input type="checkbox"/>	<input type="checkbox"/>	

Preferred Primary Care Physicians Transfer of Care Program



Briana O'Malley

Log Out

Central Worklist

- Reminders
- Approvals
- Workflow**
- Patients
- Programs
- DocuSign
- Reports
- Admin

Program: Transition of Care |
 Patient search: Name or DOB (mm/dd/yyyy) |
 My Patients Only: |
 Discharge Date From: 10/16/2018 |
 Discharge Date To: |
 Type of Discharge: All |
 Acuity: All |
 More

Bulk Action | Add Patient

Refresh | Hide Admin Data | Hide Clinical Data | Hide Actions | Show Selector | Count: 5 | Last updated 10/19/2018 12:12:44 PM

Patient	DOB (age)	Coordinator	Appointment	Discharge Date	Type of Discharge	Workflow State	Acuity	ACO Patient	Barriers to Care	DC Call 1 Completed	Med Reconciliation	Review DC Instruction	Office Visit Completed	DC Call 2	2nd Appt Completed	Other Action
[Redacted]	968	☆ Michele Sutton	10/22/18 3:00 PM (30 m) Hospital Follow Up - 30 Daniel Austin	10/16/2018	Hospital	Appt Scheduled	Moderate Complexity	-	-	✓	✓	✓	<input type="checkbox"/> 11 d	N/A	N/A	+ -
[Redacted]	(67)	☆ Michele Sutton	10/22/18 11:00 AM (30 m) Transition of Care Barry Austin	10/18/2018	Hospital	Pt. Due for Call	Moderate Complexity	-	-	<input type="checkbox"/> 3 d	<input type="checkbox"/> 13 d	<input type="checkbox"/> 13 d	<input type="checkbox"/> 13 d	N/A	N/A	+ -
[Redacted]	(90)	☆ Michele Sutton		10/16/2018	SNF to Home	Pt. Due for Call	Moderate Complexity	-	-	■ -1 d	<input type="checkbox"/> 11 d	<input type="checkbox"/> 11 d	<input type="checkbox"/> 11 d	N/A	N/A	+ -
[Redacted]	(75)	☆ Michele Sutton	1/7/19 9:00 AM (15 m) Check Up - 15 Barry Austin	10/17/2018	Hospital	Appt Scheduled	Moderate Complexity	-	-	✓	✓	✓	<input type="checkbox"/> 12 d	N/A	N/A	+ -
[Redacted]	(77)	☆ Michele Sutton	10/24/18 1:45 PM (15 m) Transition of Care Uma Punqhalla	10/16/2018	Hospital	Appt Scheduled	Moderate Complexity	-	-	✓	✓	✓	<input type="checkbox"/> 11 d	N/A	N/A	+ -

Preferred Primary Care Physicians Dietician Program



Briana OMalley [Log Out](#)

Central Worklist

- Reminders
- Approvals
- Workflow**
- Patients
- Programs
- DocuSign
- Reports
- Admin

Program: Dietitian Worklist
 Patient search: Name or DOB (mm/dd/yyyy)
 My Patients Only:
 Workflow frequency: Every Year
 More

Bulk Action Add Patient
Workflow Frequencies: Every Year |

[Refresh](#) | [Hide Admin Data](#) | [Hide Clinical Data](#) | [Hide Actions](#) | [Show Selector](#)
Count: 16 | Last updated 10/19/2018 12:31:31 PM

Patient	DOB (age)	Coordinator	Appointment	Workflow State	BMI	Height	Weight	A1c	Diab Ed	Reason for Referral	Education	Patient Contact	Charting Completed	Visit Billed	Attended 3 Week Group Class	Attended Office Group Class	Other Action
		☆ Kim Pierce	10/30/18 3:00 PM (5 m) Check Up - 5 Nicolette Chiesa	Active	25.2	70.00	175	11.50	Due	Diabetic	-	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		☆ Kim Pierce	11/5/18 9:45 AM (15 m) Re-check - 15 Crystal Connors	Active	33.6	73.00	254	10.30		Diabetic	-	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		☆ Kim Pierce	11/13/18 10:45 AM (15 m) Re-check - 15 Barry Austin	Scheduled	35.4	68.50	236	10.20	Due	Diabetic	-	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		☆ Kim Pierce	12/21/18 10:15 AM (15 m) Established Patient - 15 Joshua Goodrum 4mo tag	Active	32.8	71.75	240	12.90		Diabetic	-	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
		☆ Kim Pierce	3/22/19 11:00 AM (30 m) Check Up - 30 Joshua Goldman 6 month f/u MAD	New Patient (Default)	22.1	70.00	154	7.40		-	-	-	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Summary and Q&A



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.



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+



CareManager Version 5.2.0.1 Help

Elizabeth Ahmed | 55 year old | 07/27/1963 Add All Text

Care Team Update Flowsheet PROBLEMS MEDICATIONS ORDERS ALLERGIES

Health Risk Care Plan	Goals 2	Health Concerns 1	Socioeconomic Due	Adv Dir								
CV Risk	Risk 10yr/30yr ASCVD	Statin On mod-low	LDL Due	BP 155/84	MI B-Blocker	APT APT, Warfarin						
Prevention	BMI 22.7	Tobacco Current	Diabetes	Depr	Stress Due	Alcohol	Drug Due	HIV	STI	Hep C Due	Falls Risk	Osteo
Cancer Screening	Colon CA	Breast CA	Cervical CA									
Immunizations *Clinical List	Flu	Hep A	Hep B Due	HIB	HPV	Meningo	MMR Due	Pneumo	TD Due Tdap	Varicella	Zoster	
Diabetes Diabetes Mgmt	A1c 7.2	ACEI/ARB	Urine Alb Due	Eye Exam	Foot Exam	DM Edu						

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



CareManager Version 5.2.0.1 Help

Elizabeth Ahmed | 55 year old | 07/27/1963 Add All Text

Care Team Update Flowsheet PROBLEMS MEDICATIONS ORDERS ALLERGIES

Health Risk	Goals	Health Concerns	Socioeconomic	Adv Dir								
Care Plan	2	1	Due									
CV Risk	Risk 10yr/30yr	Statin	LDL	BP	MI B-Blocker	APT						
	AS-VD	On mod-low	Due	155/84		APT, Warfarin						
Prevention	BMI	Tobacco	Diabetes	Depr	Stress	Alcohol	Drug	HIV	STI	Hep C	Falls Risk	Osteo
	22.7	Current			Due		Due			Due		
Cancer Screening		Colon CA		Breast CA		Cervical CA						
Immunizations	Flu	Hep A										
*Clinical List												
Diabetes	A1c											
Diabetes Mgmt	7.2											

Elizabeth Ahmed

No Photo Available F 55 Years 27 July 1963 Sex Age

Active Problems

- HIV infection, acute retroviral syndrome (Z21)
- Complete traumatic amputation of right foot, level u...
- Depression, recurrent (F33.9)
- Other and unspecified alcohol dependence, unspecif...
- Acute myocardial infarction, of other anterior wall, e...
- DIABETES MELLITUS, NONINSULIN DEPENDENT (NIDD...
- Asthma

Health Concerns

- another health concern
- Independent add of a health concern

Patient Goals

Add Goal

View Goals by Status: All Active Completed On Hold Not Started

Get my viral load under control	Target: undetectable	Active	Start: 08/19/2018	End: 09/05/2018	
Get out of the house more often	Target: None	Active	Start: 08/14/2018	End: 09/06/2018	

Care Manager 5.2 Preview

Care Plan Extensions – Quick view of goals and health concerns



CareManager Version 5.2.0.1 Help

Cherrie Aalto | 85 year old | 10/23/1932 Add All Text

Care Team Update Flowsheet PROBLEMS MEDICATIONS ORDERS ALLERGIES

Health Risk	Goals	Health Concerns	Socioeconomic	Adv Dir								
	3	1	Due	Due								
CV Risk	Risk 10yr/30yr	Statin	LDL	BP	MI B-Blocker	APT						
	Age >79, No ASCVD		Due	Due								
Prevention	BMI	Tobacco	Diabetes	Depr	Stress	Alcohol	Drug	STI	Hep C	Falls Risk	Osteo	AWW
	Due	Due	Due	Due	Due	Due	Due			Due	Due	
Cancer Screening	Colon CA	Breast CA	Cervical CA	Lung CA								
Immunizations	Flu	Hep A	Hep B	HIB	Varicella	Zoster						
*Clinical List	Due				Due	Due RZV						
Diabetes												
Heart Failure												
Asthma												
Behavioral Health												

Patricity Practice Solution

Health Concerns
Lack of mobility Start Date: 08/14/2017
Comments: Sits around

Goals
Walking
Intervention: Excercise goal Status: Active Start Date: 08/13/2017
asdfsas
Hurt less Target Date: 09/03/2017
Intervention: Walk a lot Status: Active Start Date: 08/14/2017

OK

Care Manager 5.2 Preview

Socioeconomic Risk and Advanced Directives



CareManager Version 5.2.0.1 Help

Elizabeth Ahmed | 55 year old | 07/27/1963

Care Team Update Flowsheet PROBLEMS MEDICATIONS ORDERS ALLERGIES

Health Risk Care Plan 2

Goals 2 Health Concerns 1 Socioeconomic Due Adv Dir

CV Risk Risk 10yr/30yr ASCVD Statin On med low

Prevention BMI 22.7 Tobacco Current Diabetes Depr

Cancer Screening Colon CA

Immunizations Flu Hep A Hep B HIB Due

Diabetes A1c 7.2 ACE/ARB

Enli CareManager Version 5.2.0.1 Help

Elizabeth Ahmed | 55 year old | 07/27/1963

Care Team Update Flowsheet PROBLEMS MEDICATIONS ORDERS ALLERGIES

Risk Profile

Parameter	Last Value/Date	Current Status	Next Due	Plan	Entry
Education	11th grade (08/20/2018)	High			Education
Financial	Very hard (08/20/2018)	High			Financial
Social Isolation	0 (08/20/2018)	High			Social Isolation
Physical Activity	80 min/wk (08/20/2018)				Physical Activity
Intimate Partner Violence	0 (08/20/2018)				HARK
Advance Directives					Adv Dir

Include page details in note

Entry Orders Plan

Education What is the highest grade or level of school you have completed or the highest degree you have received? 11th grade

Financial How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Very hard

Social Isolation 1. Are you now married, widowed, divorced, separated, never married, living with a partner? Divorced

2. How many times per week do you talk on the telephone with family, friends, or neighbors? 2

3. How many times per week do you get together with friends or relatives? 2

4. How many times per year do you attend church or religious services? 0

5. Do you belong to any clubs or organizations such as church groups, fraternal or athletic groups, or school groups? Yes No

Calculate Score Social Isolation Score: 0

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



CareManager Version 5.2.0.1 [Help](#)

Ahikar Abarsha | 34 year old | 11/30/1983 [Add All Text](#)

[Care Team](#) [Update Flowsheet](#) [PROBLEMS](#) [MEDICATIONS](#) [ORDERS](#) [ALLERGIES](#)

Health Risk	Goals	Health Concerns	Socioeconomic	Adv Dir								
	0	0	Due									
CV Risk	Risk 10yr/30yr	Statin	LDL	BP	MI B-Blocker	APT						
	--/?		65	Due								
Prevention	BMI	Tobacco	Diabetes	Depr	Stress	Alcohol	Drug	HIV	STI	Hep C	Falls Risk	Osteo
	Due		?		Due	Due	Due	Due				
Cancer Screening	Colo	Centricity Practice Solution	Cervical CA	Lung CA								
			Due									
Immunizations	Flu	HIB	HPV	Meningo	MMR	Pneumo	TD	Varicella	Zoster			
<i>*Clinical List</i>	Due				Due		Due Tdap					
Diabetes		Not Applicable										
Heart Failure		Not Applicable										
Asthma		Not Applicable										

Socioeconomic
Risk Factor/Status
Education: Due
Financial: Due
Social Isolation: Due
Physical Activity: Due
Intimate Partner Violence: Due

OK

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

The screenshot shows a vertical navigation menu on the left with the following items: Health Risk, CV Risk, Prevention, Cancer Screening, Immunizations (with a red arrow pointing to it and a sub-label '*Clinical List'), Diabetes, Heart Failure, and Asthma. A yellow line connects the 'Asthma' item to the main content area. The main content area is titled 'Immunizations' and contains four vaccine categories: DTaP/Tdap/Td, Hib, Pneumococcal, and Polio. Each category has a green bar below it, indicating a recommendation. In the top right corner of the main content area, there are two buttons: 'Show All' and 'Show Plan'.

Care Manager 5.2 Preview

Immunization, Next Due & History



Immunizations Show All Show Plan

DTaP/Tdap/Td Hib Pneumococcal Polio

Immunization Detail: DTaP/Tdap/Td

Patient: Infant, Sixmonth | 02/01/2018 (6 mos) | M | 6MoInfant

★ [Details](#) [History](#)

Antigens: Diphtheria, Pertussis, Tetanus
Last Dose: DTaP-Hib-IPV (08/05/2018)

Timeline:

- ON TRACK (05/01/2019 - TODAY)
- DUE (TODAY - 09/28/2019)
- OVERDUE (09/28/2019 -)

History meets requirements, no administration needed

Add Hold Close

Immunization Detail: DTaP/Tdap/Td

Patient: Infant, Sixmonth | 02/01/2018 (6 mos) | M | 6MoInfant

★ [Details](#) [History](#)

Diphtheria standard series

Date	CVX	Description	Status
08/05/2018	120	DTaP-Hib-IPV	Valid
06/05/2018	120	DTaP-Hib-IPV	Valid
04/05/2018	120	DTaP-Hib-IPV	Valid

Pertussis standard series

Date	CVX	Description	Status
08/05/2018	120	DTaP-Hib-IPV	Valid
06/05/2018	120	DTaP-Hib-IPV	Valid

Add Hold Close

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.



Immunizations Hide Inactive Show Plan

DTaP/Tdap/Td Due Soon	Hib Due Soon	Pneumococcal Due Soon	Polio Due Soon	HepB [Green Box]	HepA Too Early	HPV Too Early	Influenza Too Early
Meningococcal Too Early	MMR Too Early	Pneumococcal Too Early	Varicella Too Early	Zoster Too Early	Rotavirus Aged Out		

Rotavirus: 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

The screenshot shows the 'Central Worklist' interface. On the left is a navigation menu with options: Reminders, Approvals, Workflow, Patients, Programs, DocuSign, Reports, and Admin. The main area is titled 'Workflow Checklist' and shows a table of patients with columns for Patient, DOB (age), Coordinator, and Workflow State. Below the table is a 'Record Bulk Action' form with a warning: 'CAUTION: This will create the same action for all patients selected.' The form includes fields for Program (Chronic Care Management), Patients Selected (4), Action (TxT MSG: Call Office), Sent (10/17/2018 5:39 PM), Mobile Numbers (All selected patients have mobile numbers on file), and Message (Do not send PHI via text message). At the bottom, there is a 'Process' button and a confirmation message: 'Confirm you want to create 4 bulk actions'.

The screenshot shows the 'Central Worklist' interface for a specific patient, 'Gabriaux, Apolline (F)'. The patient details include: Patient: Apolline Gabriaux, Status: Active, MRN/Patient ID: 27725, Primary Care Provider: Harry Winston (HWINSTON), Data Source: CPS12, DOB: 11/14/1939 (78), Address: 2306 Neim Street, Haymarket, VA 22069, Home: (571) 261-7344, Mobile: (305) 209-6155, Preferred Contact: Email, Location: SOUTH, Preferred Language: . Below the patient details is a 'Care Action Summary' table with columns: Occurred, Program, Program State, Event, Action (By), Action For, Time Spent, Status, and Notes. The table shows two rows of actions: one on 10/17/2018 for 'Chronic Care Management' and one on 10/04/2018 for 'Ortho Enhanced Recovery'. Both actions are 'Completed' and involve 'TxT MSG: Call Office (Steve Kupsky)'. The notes for both actions are 'Call the office at 503-616-8128 Do not reply to this message'.

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

Central Worklist interface showing a list of reminders. The header includes filters for Program (Diabetes - High Risk), Patient search (Name or DOB), Due Beginning, Due Ending (Today), Assigned To, and Flagged Only. A table lists reminders with columns for Due Date, Patient, Data Source, DOB (age), Program, Assigned To, and Description. The first entry is for patient Gaines, Devon with a due date of 8/20/2018 and description 'New Red Medication Gap Days Data Received'. The interface also shows a sidebar with navigation options like Approvals, Workflow, Patients, Programs, DocuSign, and Reports.

View detail

Central Worklist interface showing the 'View detail' screen for a reminder. The breadcrumb path is 'Reminders / Devon Gaines (8/20/2018)'. Action buttons include Edit, Complete, Delete, and Record Action. The main content area displays details for the reminder: Description (New Red Medication Gap Days Data Received), Created By, Due (8/20/2018 6:15 PM), Assigned To (Clara Barton RN CDE), Program (Diabetes - High Risk), and Notes (Display Text: Value: 68). A sidebar on the left contains navigation options like Approvals, Workflow, Patients, Programs, DocuSign, Reports, and Admin. A 'Patient' section on the right shows details for Devon Gaines (M), including DOB (03/08/1979), Address (Leggtown, NC), Data Source (Demo), MRN/Patient ID (465), Preferred Contact, and Contact Notes.

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**

Central Worklist Steve Kupsky [Log Out](#)

Program: Pre Visit Huddle Patient search: Name or DOB (mm/dd/yyyy) My Patients Only: Workflow frequency: Calendar Month Month: 10 Year: 2018 [More](#)

Bulk Action Add Patient Workflow Frequencies: Calendar Month

Refresh | Hide Admin Data | Hide Clinical Data | Show Selector | Count: 9 | Last updated 10/17/2018 5:54:48 PM

Patient	DOB (age)	Coordinator	Appointment	Hospital/ED Event	Cervical Screening	PHQ-9	Socioeconomic Risk	No Shows	Last Visit	Other Action
Ackermann, Leona	5/29/1958 (60)	☆ Malcolm Costello	10/18/18 6:00 PM (60 m) OFFICE VISIT Long-BH Harry Winston Pain	-	-	14	-	2	-	+ 📅 ⇄
Aksenova, Freida	5/6/1961 (57)	☆ Team	10/18/18 6:00 PM (60 m) OFFICE VISIT Long-BH Harry Winston Pain	-	-		-	0	9/2/2017	+ 📅 ⇄
Almanza, Karoline	5/23/1965 (53)	☆ Team	10/18/18 6:00 PM (60 m) OFFICE VISIT Long-BH Harry Winston Mammography	3/1/2016	-		-	3	10/8/2016	+ 📅 ⇄
Alvaraz, Laurene	4/24/1922 (96)	☆ Betty Knight NP	10/18/18 6:00 PM (60 m) OFFICE VISIT Long-BH Harry Winston Pain	11/1/2017	-		YES	0	10/11/2016	+ 📅 ⇄
Barrett, Gene	4/30/1942 (76)	☆ Team	10/18/18 6:00 PM (60 m) OFFICE VISIT Long-BH Harry Winston	10/8/2017	-		-	0	4/14/2017	+ 📅 ⇄

Ambulatory Product Roadmap



Cloud

DenialsIQ™

CQR

Collaboration Framework

VBC Analytics - Quality

Ambulatory Population Health

VBC Analytics - Advanced



Hospital Connect 2.0

Intelligent Orders

Landing Page

Medication Management

2018

2019

On premise

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