Population Health 102

Feb 2017

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Our goals as we move into Population Health

- maximize best we can do for patients (even those who can't do what we ask)
- maximize reward for the hard work we do
- minimize impact to the actual doctors and nurses
- look good in the community of quality
- keep everyone doing work at the "top of their license/ ability"

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What Do I Need to Know

- There are $$$ for tracking patients' preventative health
- There are $$$ for providing lower cost care
- Medicare is changing!
  - Medicare= "MACRA", paying doctors will be "value-based" in **2019**
  - If we don't play their game = Our Fees drop
- Quality and cost performance measured collectively (all members of group).

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What Do I Need to Know

- Other Upside is:
  - Finding patients who “slip through the cracks”
  - Better public profile (data will be published)
  - Shared savings $$$
  - Attractiveness of group to others (insurers, referring partners, new recruits)

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What Do I Need to Do Now

- HCC Scoring
- Determines by Medicare “degree of illness”
- Higher severity of illness = sicker patient = likely to cost more
- Doctor’s care = cost of care
- Higher HCC score for patient = Doctor doing a better job at “value based” care
- If you treat or support their medical problem, get recognition for it = click the box

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Should you click the assessment ? Did you “CAT” it ?

- C = **Consider** the diagnosis in current plan of care, even how it affects other diagnoses, medications, and treatment plans
- A = **Assess / address** the diagnosis, through evaluation of whether it is getting better, worse, or stable = “remaining ***on the current regimen”***. A decision is effectively made whether to keep meds, diet, & restrictions the same, or change. Deciding to refer patients to another provider, or continue to rely on another provider/specialist to manage patient’s disease is included.
- T = **Treat** the diagnosis, addition of new therapy, OTC or prescription, physical therapy, or diet regimen, etc…

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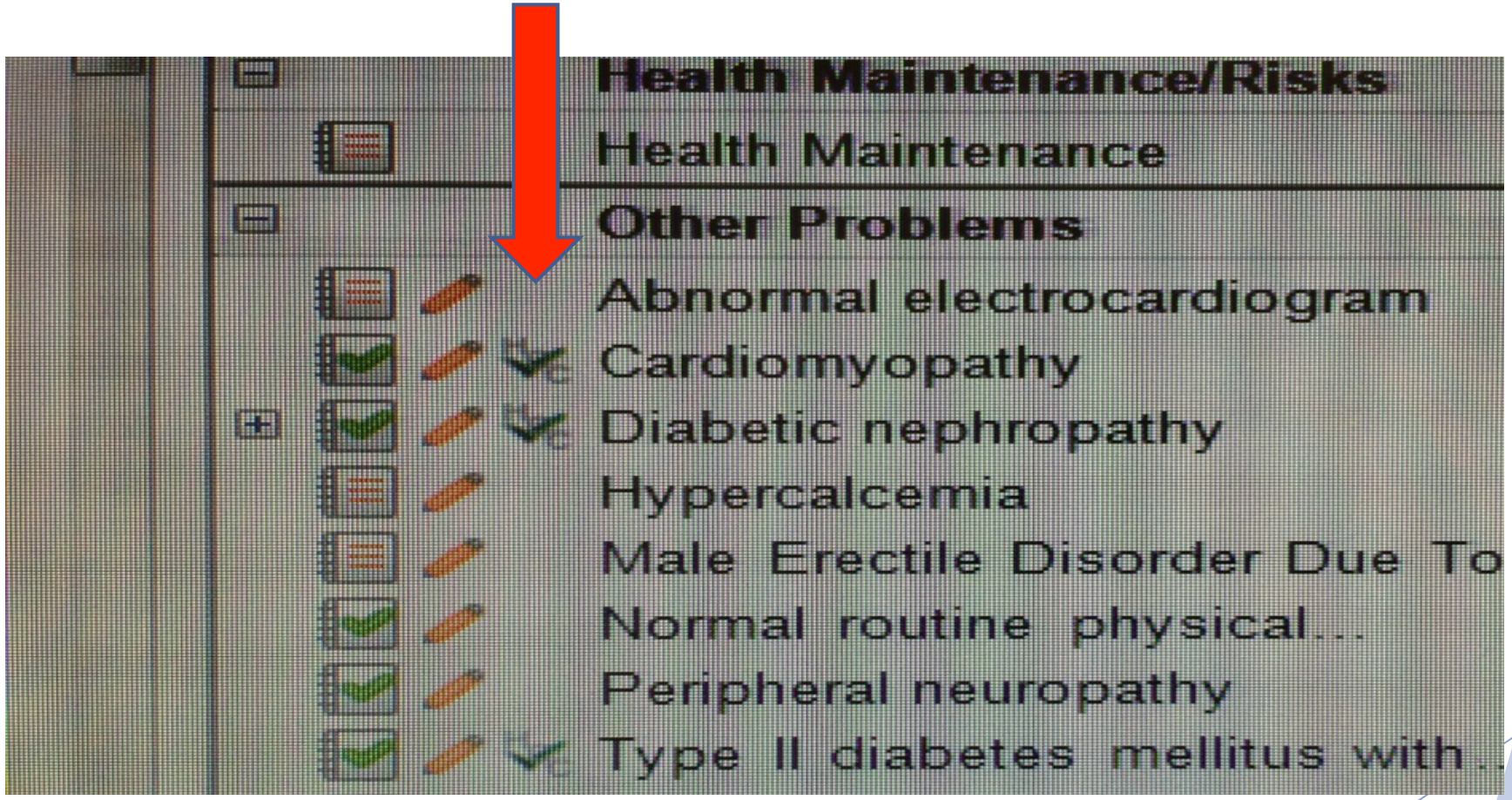
HCC Coding-if you see one of these on a diagnostic assessment list – consider clicking on it if you have dealt with the issue this visit



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HCC Coding

It looks like we have very healthy-easy to manage patients (lower than average)

We / you currently get this amount in shared savings

	HCC	Rev PMPM	MLR	Shared Savings
Starling Current	0.923	$ 803.67	97.5%	$0
Avg PC	0.932	$ 811.36	96.6%	$0
High PC	0.995	$ 863.25	90.8%	$0
Optimal Score - Average Population	1.100	$ 949.22	82.5%	$498,189
Optimal Score - Sicker Population	1.200	$ 1,031.26	76.0%	$1,232,119
Pick your Score Scenario	1.200	$ 1,031.26	76.0%	$1,232,119

we believe that we have sicker patients and should be here (average or higher)

We could get ½ this amount in shared savings

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What Do I Need to Do *Soon*…

For Medicare “Advantage” patients :

(listed in Allscripts for you as “Attributed patient”

- Paid Annual visits: Physical and or Wellness “interview” visit
- Visit Care Opportunities – “Gaps” in recommended care – ie: Patient never got mammogram or lab tests even though you ordered it
- Consider more Generics
- Help patients with medication Adherence

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Who Will Contact Me – the PCP

- Your practice manager
- Your practice staff
- Who will contact them:
  - Tracy King
  - Leann Davies

How much to do centrally vs at the offices ?

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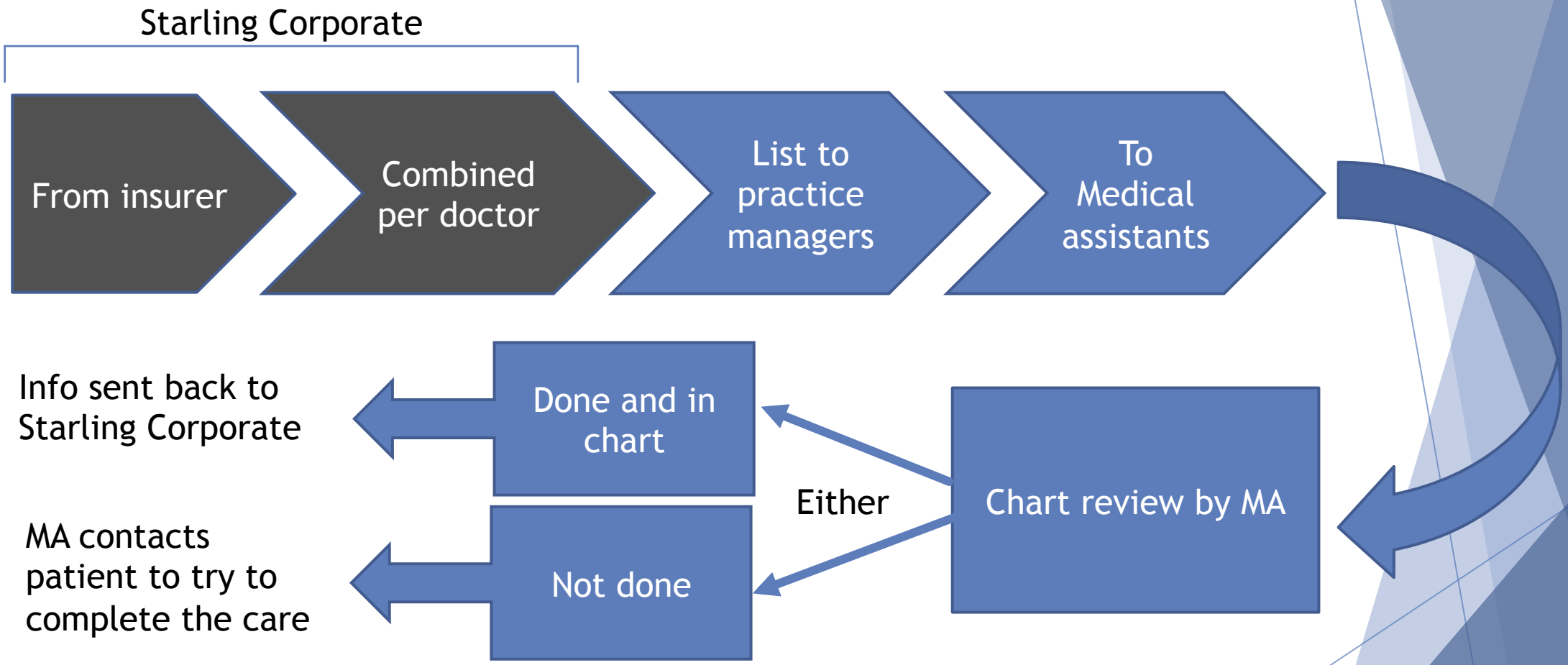
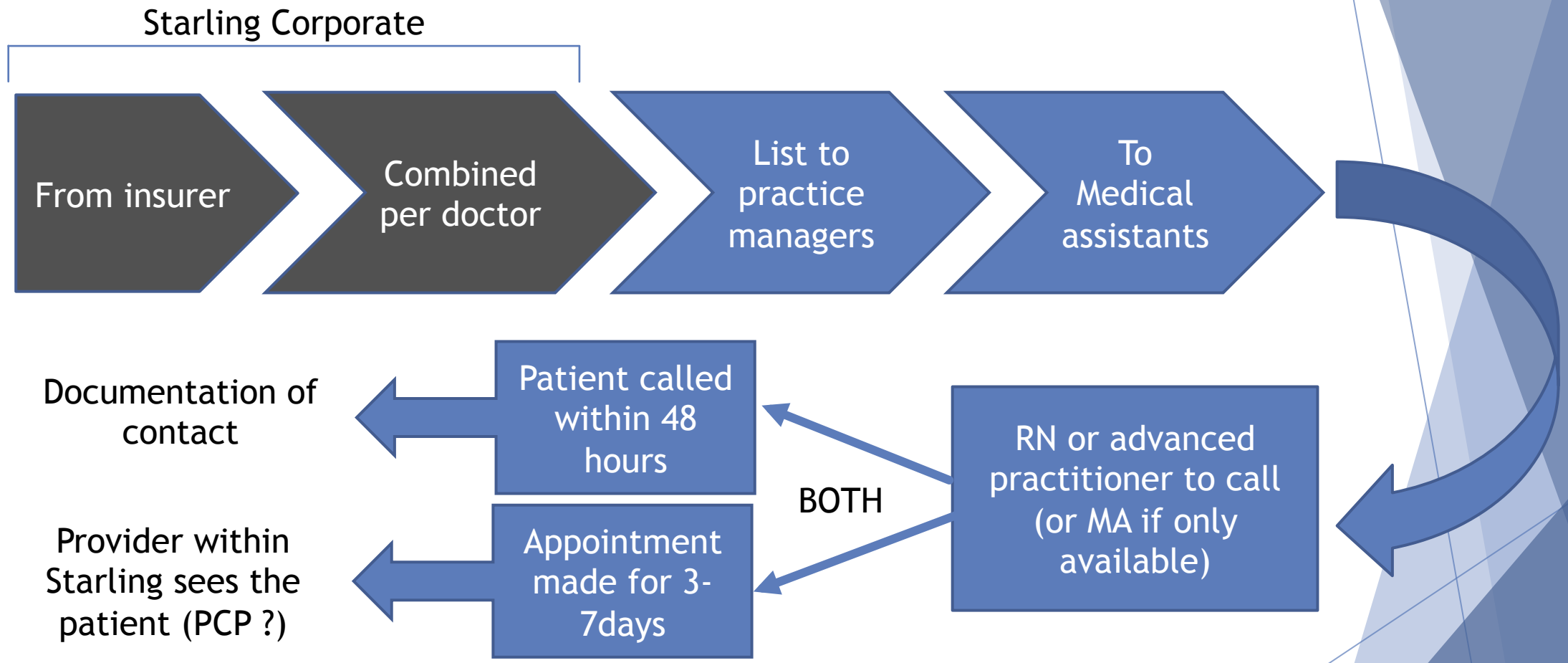
The flow of info : Gaps in Care



The flow of info: Transitions of care



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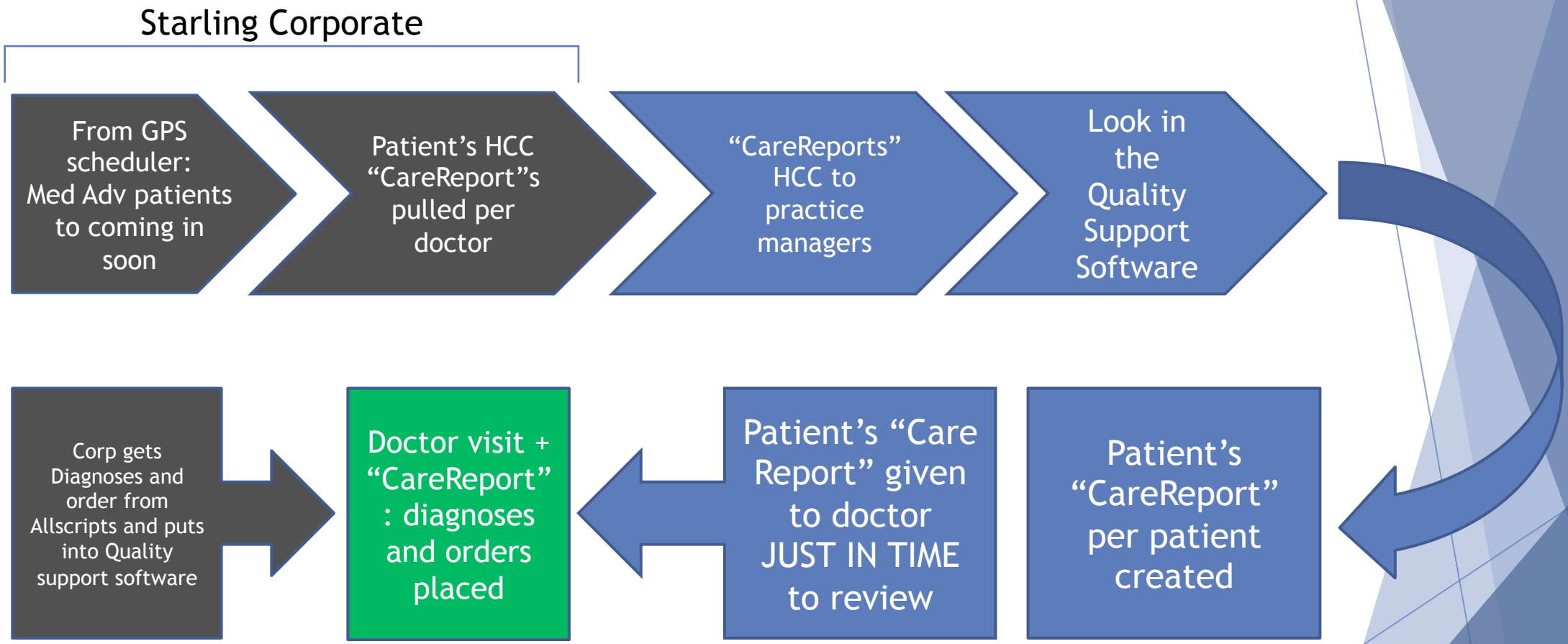
The flow of info: HCC = severity of illness



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What's Coming

- Transitions of care from hospital or SNF
  - Visit in 3 – 7 days
  - Increased revenue for the provider
  - If unable to do in your practice, offer this centrally ?
- After hours care, urgent care vs. ED
- Care management for high risk patients

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