Making Health IT Patient Centered
Session # 18, February 20, 2017
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Advocate Health Care
Speaker Introduction

Tina Esposito, MBA, RHIA, FACHE
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Advocate Health Care
Conflict of Interest

Tina Esposito, MBA, RHIA, FACHE

Has no real or apparent conflicts of interest to report.
Agenda

• About Advocate

• Payment shifts and the impact on data, analytics, and Health IT

• Making Health IT patient-centered

• Next steps in engaging patients
Learning Objectives

• Demonstrate an understanding of value-based payment as context for a more patient-centered approach in healthcare IT

• Illustrate specific approaches in making healthcare IT more patient focused

• Assess the current state of healthcare IT patient-centeredness within your own organization
STEPS™ Alignment

REALIZING THE VALUE OF HEALTH IT

- S: SATISFACTION
- T: TREATMENT/CLINICAL
- E: ELECTRONIC SECURE DATA
- P: PATIENT ENGAGEMENT AND POPULATION MANAGEMENT
- S: SAVINGS

PATIENT ENGAGEMENT AND POPULATION MANAGEMENT
Advocate Health Care

Hospitals (12)
4 teaching
1 children's (2 campuses)
1 critical access
5 level 1 trauma centers

Physicians
1,500 employed
5,000 Advocate Physician Partners
6,300 medical staff

Post-acute
Home health, hospice, long-term acute care hospital and palliative care

35,000 associates
$5.5 billion total revenue
17.9% market share
858,000 attributable lives
The Accountable Care Mind Shift

<table>
<thead>
<tr>
<th>FROM…</th>
<th>TO…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Siloed care management</td>
<td>Population/enterprise care management</td>
</tr>
<tr>
<td>Episodes of care</td>
<td>Value-driven coordinated care</td>
</tr>
<tr>
<td>Discharges</td>
<td>Transitions</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>Right care at the right place at the right time</td>
</tr>
<tr>
<td>Caring for the sick</td>
<td>Improving health status</td>
</tr>
<tr>
<td>Production (volume)</td>
<td>Performance (value/lower cost)</td>
</tr>
</tbody>
</table>
Data Driven
Health IT Before and After

[Image of a cartoon with one character asking, "what the hell is that?" and the other replying, "oh, just my mind"]

Key Data and Information Needs

• Create a platform for understanding patient needs
• Leverage data for analytics to predict needs and inform actions
• Expand use as a platform to engage
Step 1 – Connect Data
Step 2 – Link Sources to a Patient

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Records</td>
<td>3,400,000</td>
<td>379,000</td>
<td>94,000</td>
<td>44,000</td>
</tr>
<tr>
<td>Patients</td>
<td>10M</td>
<td>7.9M</td>
<td>8.6M</td>
<td>11.9M</td>
</tr>
<tr>
<td>Linked (%)</td>
<td>66%</td>
<td>95.3%</td>
<td>99%</td>
<td>99.5%</td>
</tr>
</tbody>
</table>

- 66% of all records linked
- 95.3% of all records linked
- 99% of all records linked
- 99.5% of all records linked

98% reduction in tasks with a possible “linkage” to an existing patient
Creating a Longitudinal View

Pre-hospital

Post-hospital
Filter on the high readmission risk inpatients for the timing and site of the first re-hospitalization and ED visit.

What does this show?
Longest bars are 31-90 days post discharge; SNF with highest 0-7 re-hospitalization. How do we best manage high risk patients past 30 days?
Step 3 – Leverage data analytically

• Can we predict patient needs?
• Can we more precisely tailor patient outreach?

*How can we target the right patients with the right interventions?*
Care Management Case Study

Roles: NP, RN, NA, SW, CHW

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Target Population</th>
<th>ROI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Case Management</td>
<td>Hospital</td>
<td>&lt; 1 year</td>
</tr>
<tr>
<td>Episodic Care Management</td>
<td>Risk of acute hospitalization</td>
<td>&lt; 1 year</td>
</tr>
<tr>
<td>Chronic Disease Management</td>
<td>Chronic disease management, e.g., Diabetes, Heart Failure</td>
<td>2-5 years</td>
</tr>
<tr>
<td>Complex Care Management</td>
<td>Multi disease, multi complication, renal failure, transplant, cancer, etc.</td>
<td>2-5 years</td>
</tr>
</tbody>
</table>

Barriers:
- Behavior
- Social
- Adherence
- Education

Enablers:
- Readmission Prevention
- Patient Portal
- OPCM
Guiding Principles

• An effective outpatient care management program is:
  – Short term (90-120 days total)
  – Focused on potentially preventable events
  – Evidence based
  – Measurable
Targeting the ‘right’ patients

• Potentially preventable patients are:
  – Clinician identified events most appropriate for care management
  – Events where OPCM intervention can reduce utilization within a 90-120 day time period
  – Impactable in a measurable way; with defined outcomes
## What is impactable?

<table>
<thead>
<tr>
<th>Condition</th>
<th>What is preventable</th>
<th>How can we prevent?</th>
</tr>
</thead>
</table>
| **Asthma** | Acute attack  
Exacerbations  
ER visits  
Non-adherence to medications  
Worsening of symptoms | Education: Asthma Action plan, understanding triggers, having a prevention plan, knowing when and how to use medications, understanding consequences of non-adherence  
Adhering to medication treatment plans  
Self-management with education and resources  
Steroids if symptoms are worsening |
Managing Care for an Episode

• Ensure optimal preparation and adherence

• Monitor, detect, and triage post-hospital complications

• Facilitate continuous collaboration among physician, hospital, and post-acute teams

• Capture and measure outcomes
Health IT Enablement

• Ensure high-touch follow-up for **ALL** patients

• Reinforce education and plan in-between visits

• Monitor adherence and status to identify and treat patients ‘at risk’
HealthLoop Pilot to Date

14 of 17 physicians live
705 enrolled patients
10,420 check-ins online

82% activation rate
8,000 virtual patient touches/month (no staff required)
77% PROM capture

30 Day-Readmission
Total Cost of Care
Likelihood to Recommend
Step 4 – Engage Patients
Moving from Patient to Person

- Genetics: 30%
- Behavior: 40%
- Socioeconomic: 15%
- Environment: 5%
- Healthcare: 10%

Source: McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Aff (Millwood) 2002;21:78-93
Going Digital
A Summary of How Benefits Were Realized for the Value of Health IT

- Loyalty Savings
  - Percent of patients likely to recommend services
  - Shared savings dollar achievement

- Spend Cost
  - Reduction in total cost of care
Questions

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Advocate Health Care

Take a few minutes to complete online session evaluation