
POPULATION HEALTH
Maximize Your Value-Based Care Bottom Line
nextgen healthcare

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The transition from traditional fee-for-service (FFS) payments to value-based reimbursement models is fundamental to the future of healthcare. Rather than rely on the number of tests or procedures to inform financial reimbursement, value-based care (VBC) models incentivize providers to deliver on three components: **improving the patient care experience, improving the health of populations, and reducing per capita cost.** By adhering to these incentives, scarce resources can be directed to patients who need care the most, costs can be reduced, and the health of at-risk populations can improve as a whole.

In this guide, we'll discuss structures of value-based care and how practices, both large and small, can support VBC delivery, along with the population health management tools necessary to do so.

IT'S ALL ABOUT OUTCOMES

Value-based care incentivizes providers to be cost and quality conscious by offering performance-based bonuses. Different quality measurement programs are often constructed from the same measurement standards (e.g. National Quality Forum (NQF) & Healthcare Effectiveness Data and Information Set (HEDIS) measures) and have subtle (and not so subtle) differences based on the reasons behind the data collection.

Types of Quality Measures

Structural Measures give consumers a sense of a healthcare provider's capacity, systems, and processes to provide high-quality care.

Process Measures indicate what providers do to maintain or improve health—for healthy people or for those diagnosed with a specific condition.

Outcome Measures reflect the impact of the healthcare service or intervention on the health status of patients.

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MEASURING QUALITY ISN'T SO EASY

Political Challenges

- Physician stakeholders wary about ultimate data usage
- A lack of consensus about what measures are appropriate
- Inability to secure consistent access to data

Technical Challenges

- Constructing measures to meet codified data requirements not aligned with real-world clinical workflow
- Data sources that are disparate or not comprehensive, and information systems that are not standardized

Individual vs. Group Measurement Challenges

- Quality measures often written to evaluate the performance of an individual physician for a full calendar year, not a group
- Specifications do not always easily scale/translate to evaluate groups or to evaluate smaller time frames

Measure Specification Variation Between Programs Challenges

- Formatting differences in specification documentation
- Codified data set requirements vs. narrative guidelines

VALUE-BASED CARE MODELS

Alternative Payment Models are emerging which require new approaches to managing payer-provider contracts. Accountable care organizations (ACOs), offer hospitals and patient care providers/organizations the opportunity to manage value-based care plans with network and governance flexibility. Typical contract models include:

Shared Savings (one-sided/upside risk) incentivizes providers/organizations to reduce healthcare spending on patient care to below the threshold (utilization budget) defined by the payer, returning a portion of savings achieved (bonuses) to providers, without any downside impact if threshold is exceeded.

Shared Risk (two-sided risk) offers a combination of performance-based incentives and limited threshold of risk shared with the payer. Providers share in savings but can be negatively impacted if care exceeds utilization threshold. Providers may be required to refund payment/cover a portion of the cost if utilization budgets are not met.

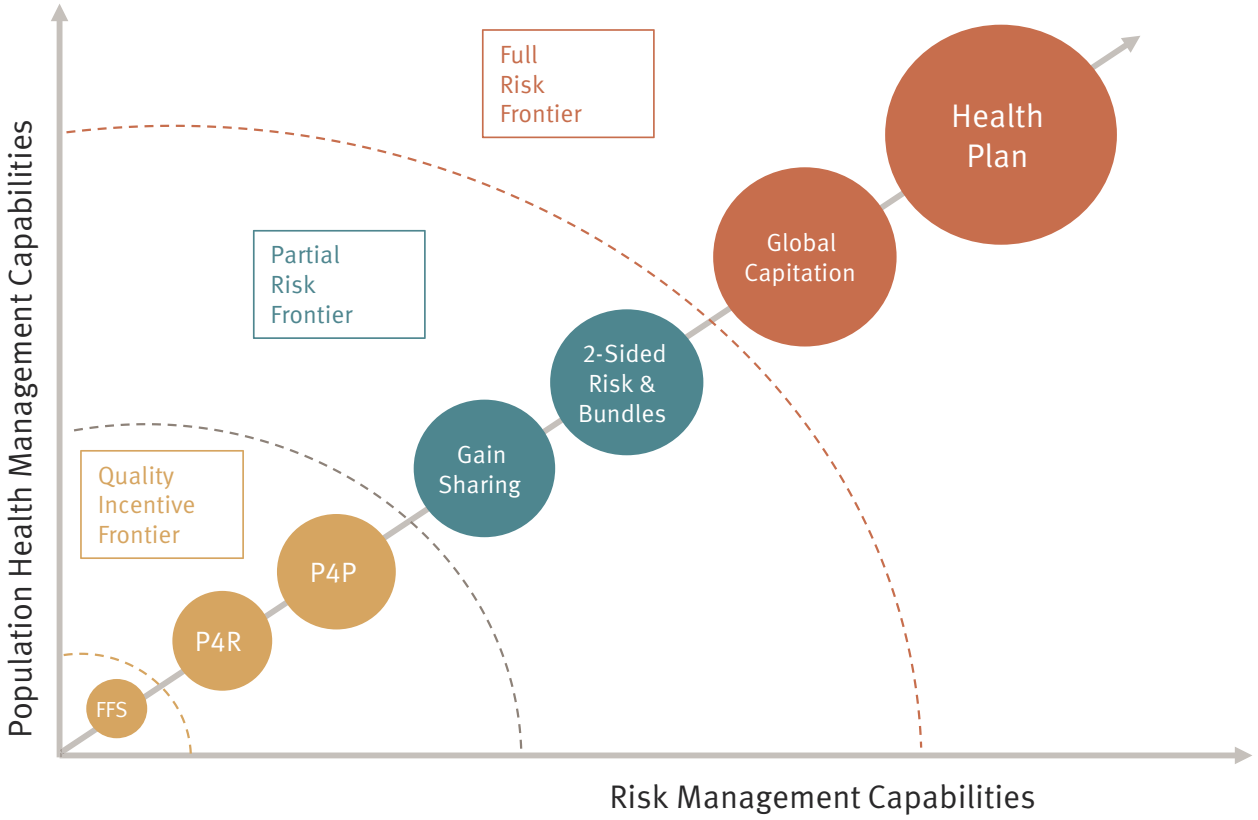
Full Risk (capitation model) pays providers on a per member per month (PMPM) basis to take on full risk of patient care and utilization cost—100% of insurance risk for covered services.

Two types of capitation models:

- **Global Capitation** offers providers a single, fixed payment across the care continuum for each patient.
- **Partial Capitation** offers a combination of fixed, monthly payments to providers for covered services, and FFS arrangements for non-covered services.

Value-Based Continuum

Robust Population Health Management capabilities enable risk management success



Key Capabilities to Enable Risk Management Success at Different Risk Frontiers

Full Risk

Partial Risk +

- Clinical Cost Drivers
- Practice Pattern Variations
- Patient Engagement
- High Cost Claimant Management
- Actuarial Services

Partial Risk

Quality Incentive +

- Pre-visit Planning
- Risk Stratification
- Predictive Analytics
- Patient Cohorts
- Resource Utilization
- Care Management
- Transitions of Care
- Network Design & Management

Quality Incentive

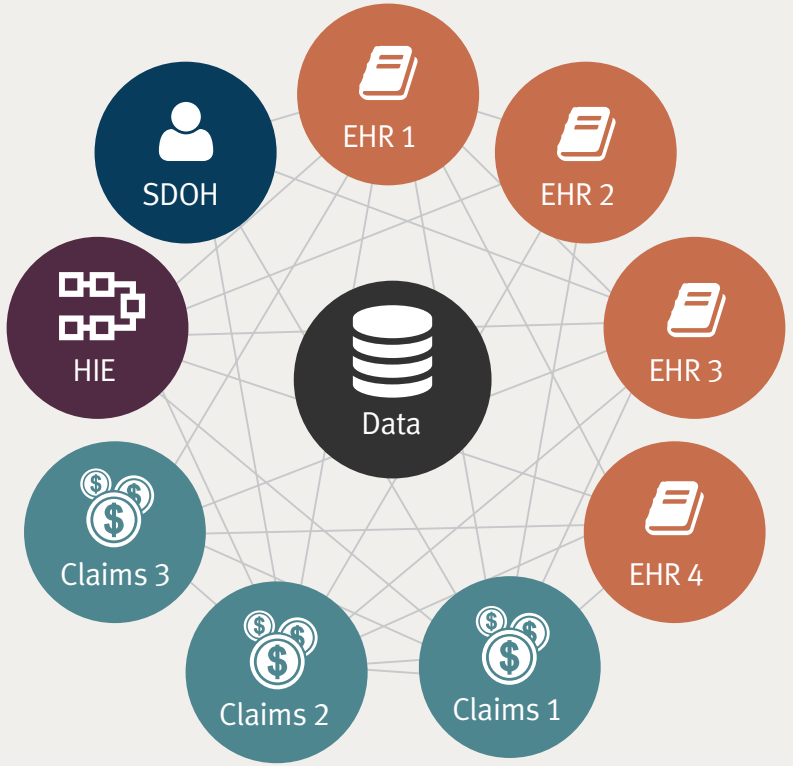
- Measures
- Performance to Targets
- Trending
- Gaps in Care
- Patients Not Seen

POPULATION HEALTH MANAGEMENT (PHM)

A common goal of value-based care programs is improving the health of high-cost, high-risk populations. Achieving this goal requires individualized clinical insight in the context of a patient population. In order to support positive change, providers and healthcare organizations need solutions that help alleviate the operational and cognitive demands of delivering high-quality care and meeting burdensome reporting requirements.

A population health management solutions partner that can aggregate data from disparate sources, such as multiple EHR vendors on an agnostic basis, as well as assemble paid adjudicated claims data feeds from insurance plans, can help providers boost their ability to proactively manage care.

Data Optimization Drives Success



Your solutions provider needs to normalize, standardize, synchronize, and cleanse data so it is ready for the contemporary analytics required to be successful with value-based contracts.

Social Determinants of Health (SDoH) Matter

Social Determinants of Health (SDoH) is emerging as another valuable data source that needs to be aggregated. SDoH are the conditions in which people live, learn, work, and play that affect health and health outcomes. Examples of SDoH include income level, educational opportunities, occupation and workplace safety, gender and racial inequities, language and cultural norms, access to housing and utilities, and availability of healthy food sources.

It is evident that not all patients respond to care the same way. Variables such as geography and socioeconomic status contribute to how a patient engages in their care. Population health management models that account for social determinants can help providers mitigate root causes of health obstacles for patients.

A SOLUTION BUILT FOR YOUR SUCCESS

Risk Management

From the early days of HIT adoption through today's contemporary patient care models, NextGen Healthcare has provided clients the tools, data, and insights necessary to succeed. With predictive analytics you can better assess risk in your patient population, and proactively manage it.

Data Aggregation

Our tools provide a single source of truth by aggregating disparate sources of data into a trusted, clinically relevant, provider-focused solution.

Vendor Agnostic

Drawing on clinical, financial, and paid claims data, we are both data source and EHR vendor-agnostic.

ROI Visibility

Uncover gaps in care, monitor resource utilization, and proactively follow up with your patients to support revenue growth.

Key Components of Population Health

- Information must be available at the point of care
- Care management models must be sustainable
- Measurement of effective care management interventions is crucial

Note: PHM programs take time to develop and mature

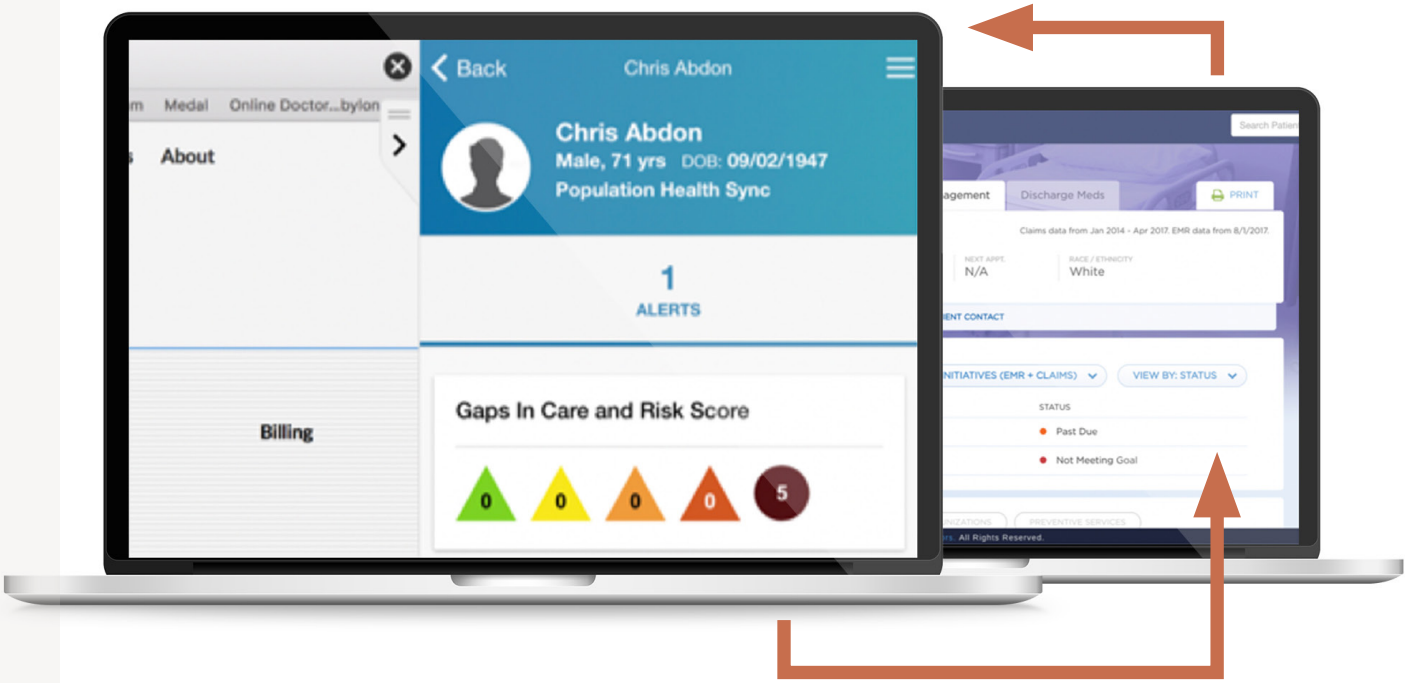
Whether clients are in a shared savings, shared risk, or full risk (capitation) VBC arrangement, they can leverage the full breadth of **NextGen® Population Health** analytics, tools, and dashboards to manage the cost (utilization) side of value-based care delivery.

Get analytic insight delivered directly into your workflow

Since so much time is spent in the EHR, insights need to show up directly in the chart. With NextGen Population Health, you can click on the summary icon (color-coded visual display), and with single sign-on view the full patient profile in the analytics application. The patient profile contains everything you need to know about that patient, including care gaps, risk status, care management progress, and more.

Integration in the EHR Workflow

Overlay with actionable multi-source data analytics



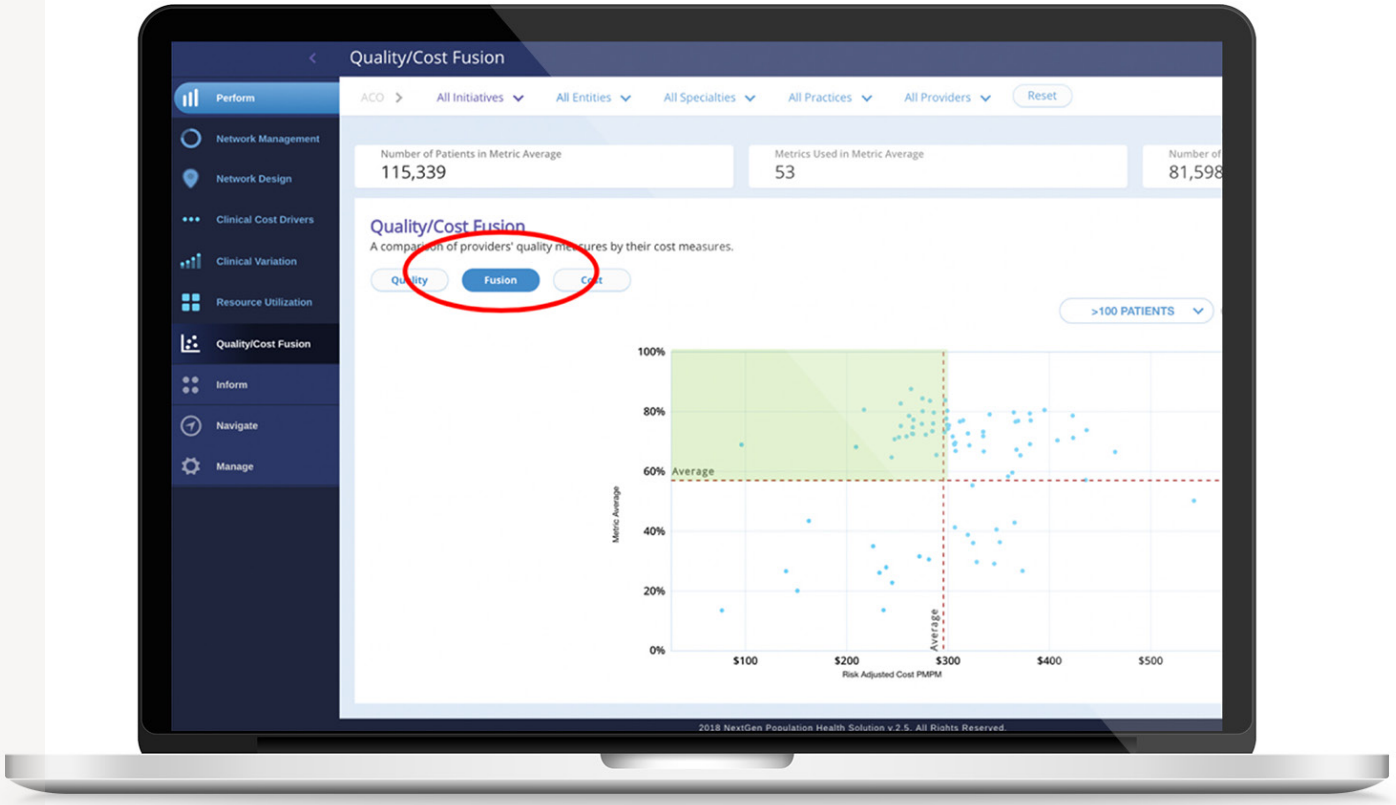
Click on overlay in EHR chart for single sign-on to full patient profile in the analytics application

Quality/Cost Fusion Dashboard: A true measure of healthcare value

y-axis = providers' weighted quality metric performance

x-axis = risk-adjusted cost per member per month (PMPM)

Providers who deliver high value show up in the upper left-hand quadrant—high average quality score and most cost effective (below the average cost of their fellow providers who deliver that care on a risk-adjusted basis [PMPM]).

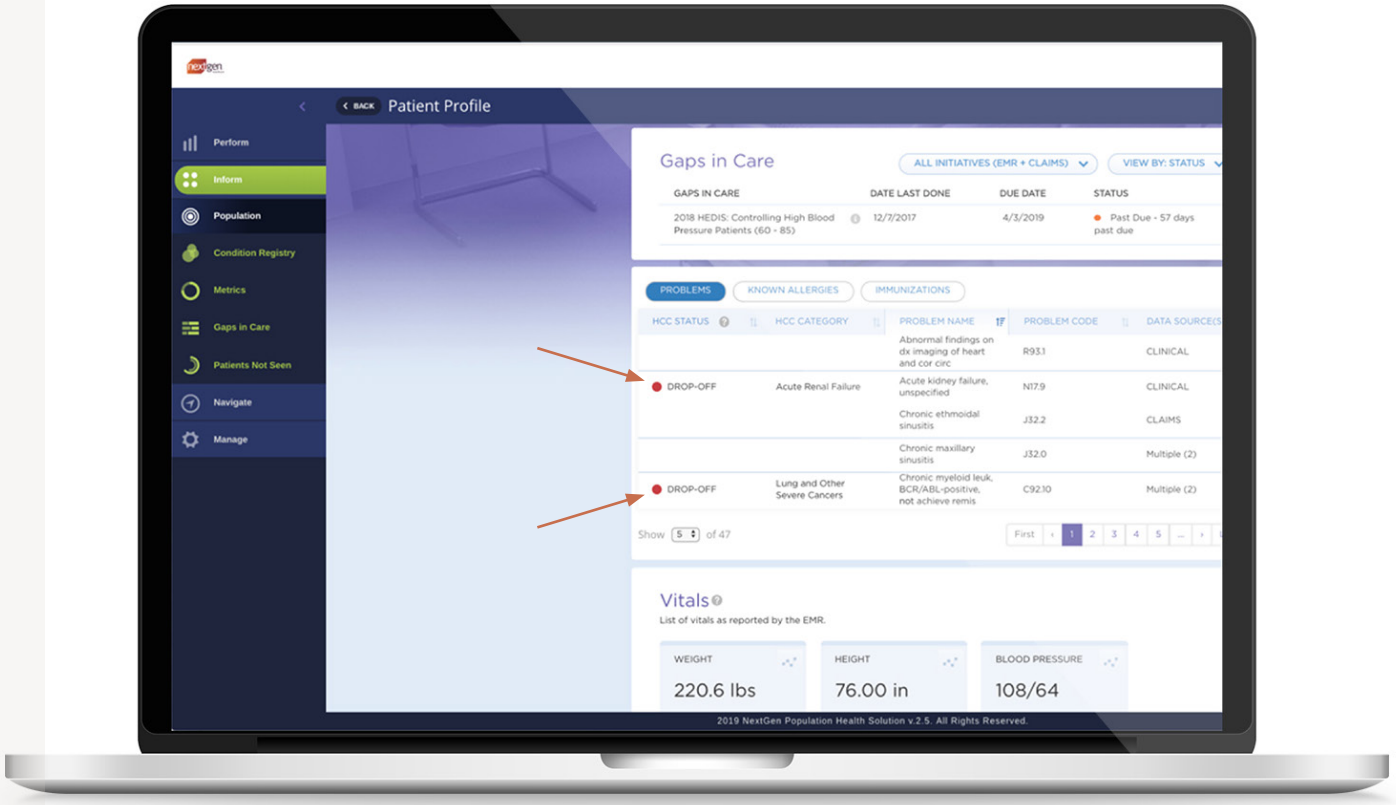


Hierarchical Condition Category (HCC) coding for risk adjustment potential

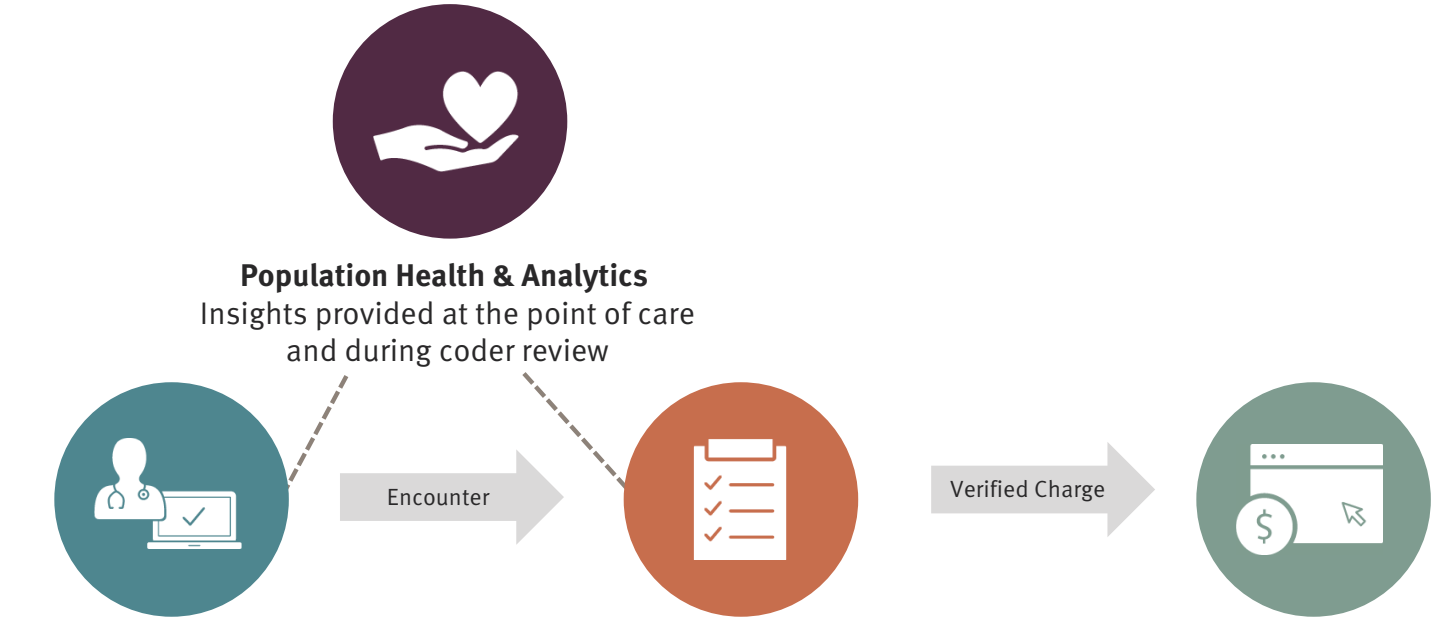
Patient health status in a baseline year that is used to predict costs in the following year requires annual recoding. HCCs are used to adjust capitated patient payments based on patient risk and complexity. Payment models that risk adjust modify reimbursement based on a patient's predicted level of risk.

NextGen Population Health helps providers HCC code accurately. HCC codes in the past that are no longer properly coded are identified with a red dot indicating "Drop Off" as identified by clinical or claims multi-sourced data aggregation.

The screen shot on the right illustrates the HCC Coding and Drop-off Remediation dashboard in the patient profile.



Population Health Analytics + HCC Coding Workflow

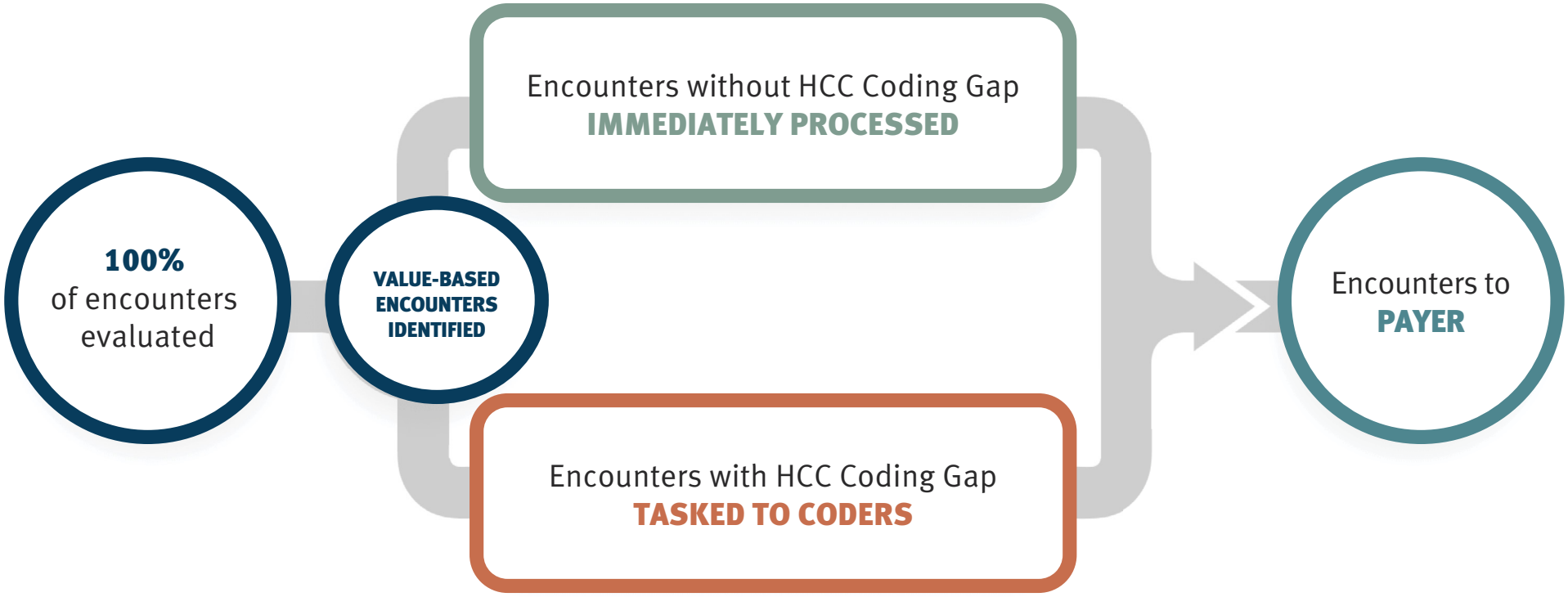


Partner Complementary Technology

Additionally, CareOptimize Coding Module—Analitico software—is an automated rules engine that identifies suspected conditions across comprehensive data sources.

- Uses natural language processing (NLP) to identify suspected conditions in unstructured data, documents, or un-coded text
- Reduces the coding burden on providers by auto-capturing conditions

Small Team Focused on HCC Coding Gaps



Providers should not be burdened or saddled with coding for HCC

This rules engine provides a level of automation so that all encounters are evaluated. It can specifically identify those that fall under value-based payment arrangements; and when the system is sure that there are no coding gaps in HCC, those are immediately processed and sent to a claims payer. In cases where exceptions are found through this automated technology, those are tasked to coders.

POPULATION HEALTH PROVIDES ROI AT ALL PHASES OF TRANSFORMATION

Fee-for-service: build fee-for-service revenue with preventative services through case-finding and closing gaps in care

Pay-for-performance: meet significant payment incentives and avoid penalties

Gain sharing: increase gains and success with enhanced quality performance and performance against budget

Full risk: achieve financial gains by managing cost, enhancing quality, and avoiding losses if exceeding budget

Impact of NextGen Population Health Management Solutions

- Data-driven identification of high-risk patient cohorts brings focus to clinical initiatives
- Quality and utilization measures track performance for risk-based contracts and drive transformation to value-based care
- Patient-clinician time and pre-visit planning optimization improves care management

CASE STUDIES—PHM IN ACTION

Murfreesboro Medical Clinic & SurgiCenter (MMC)

Consists of over 80 physicians, 20 departments, 7 locations, and 700-plus staff

Their need

A population health solution to capture and analyze clinical data and measure quality

Solution capabilities

- Integrates into the EHR
- Provides care gap insight
- Combines analysis and reporting capabilities with actionable, point-of-care functionality

Results in less than six months

- Before only 9% of Medicare population had completed exam—after implementation, 19% had
- $180K generated from proactive engagement

"Using NextGen Healthcare population health solutions was crucial in enabling our organization to achieve the Level 3 Medical home certification."

Dr. Nicholas Coté, D.O.
MMC Family Medicine Physician and President

CASE STUDIES—PHM IN ACTION

Bridges Health Partners MSSP ACO

Consists of 4 independent health systems, 7 hospitals, 121 practices, and 1000-plus physicians

Their need

Improve patient care by bringing multiple data sources (from 20+ different EHRs) together to get a 360-degree view of patient population

Solution capabilities

- Value management analytics
- Pre-visit planning dashboard
- Actionable insights for allocating scarce care management resources

Results

- $8 million in savings in its first performance year in MSSP ACO
- 3.4% reduction in spending

"It is imperative that we as a healthcare industry get it right for our patients. NextGen Population Health is an important EHR-neutral enabler of this mission."

Tom Boggs
President of Bridges Health Partners

BELIEVE IN BETTER.

Contact us at 855-510-6398 or results@nextgen.com.

NextGen Population Health works with any EHR and is designed to help providers predict and prevent illness, manage care transitions, and treat the chronically ill—all while reducing cost.

1 Shared Savings Program, Centers For Medicare and Medicaid Services website, last modified Nov. 13 2019, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about **2** Social Determinants of Health: Know What Affects Health, Centers for Disease Control and Prevention website, last reviewed Jan. 29 2018, https://www.cdc.gov/socialdeterminants/index.htm **3** National Academies of Sciences, Engineering, and Medicine. Communities in Action: Pathways to Health Equity. Washington, DC: National Academies Press; 2017.

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