Orlando Health: Population Health Management in a Clinically Integrated Network

Automation of Population Health Management Aids Clinical Integration and Accountable Care Organization

Government and private insurers are moving away from encounter-based reimbursement and rapidly developing new payment models that reward coordination of care and population health management. Orlando Health, a seven-hospital, 1,780-bed Florida health system that is one of that state’s most comprehensive not-for-profit healthcare networks, saw the change coming and knew it must act. In standing with its size, the health system set an ambitious goal: to be the highest-quality, lowest-cost provider in central Florida.

“We like to be leaders, not followers,” explains Rick Schooler, Orlando Health Vice President and Chief Information Officer.

As a first step, in partnership with UF Health, the University of Florida’s healthcare system, Orlando Health’s leadership is working to form a clinically integrated network (CIN) that includes its 400 employed doctors, independent primary care and specialty physicians, and eventually practitioners employed by the University of Florida healthcare system. Clinical integration promises to coordinate patient interventions, manage quality across the continuum of care, drive population health management, and enable value-based contracting.

To get there, Schooler, a former CHIME/HIMSS CIO of the Year, realized the health system would need to significantly scale its care management and patient engagement efforts. Above all, it would need population health tools to help identify patients at risk of acute episodes, find the gaps in their care, engage them, and evaluate performance – all without spending large amounts of money on care coordination and care management.

“We knew that a key part of clinical integration and of surviving the future of health care is to manage the health of a population,” explains Schooler. “To do that, you need tools that are...
tailored to the individual level that allow you to intervene, interact, prompt, reach out, remind and analyze. You have to be able to take that individual information and aggregate it to the population level to detect trends, stratify patients based on clinical risk or other factors to really understand how you are doing on quality and cost utilization.”

Adds Jennifer Endicott, Orlando Health’s Vice President of Clinical Integration: “We had already recognized that an EMR would not get us where we needed to go. An EMR is a data repository that’s designed to allow healthcare providers to manage those patients who are in front of them, not those who are not in front of them. That task is just too cumbersome and difficult and frankly impossible for most EMRs.”

An Exhaustive Search

When evaluating solutions, Orlando Health felt it was vital to invest in a single platform for both clinical integration and population health management. Moreover, it needed a solution that would not put added stress on an already overloaded IT staff. Like all health systems, Orlando Health has many competing demands and not enough resources. The solution provider would need to do the heavy lifting, including data integration and workflow assessments, data mapping to protocols, system configuration, training and implementation.

A member of Schooler’s senior project management team led the vendor selection committee. After a systematic search of 12 different vendors that included multiple site visits, the health system ultimately chose Phytel for its easy-to-use provider interface, snapshots of patient care gaps, integrated patient outreach and education capabilities, and the proven ability to interface with Orlando Health’s multiple EHRs as well as integrate pharmacy and lab data.

Schooler confirms that Phytel has lived up to expectations. At Physician Associates, the health system’s employed group of 100 primary care physicians, Orlando Health has successfully interfaced Phytel with the group’s Allscripts EHR and implemented four modules—Phytel Outreach™ patient engagement tools, Phytel Remind™ appointment reminders, Phytel Insight™ reporting and dashboards, and Phytel Coordinate™ care management tools. A fifth module—Phytel Transition™ to enhance coordination of discharged patients—is planned for implementation by the end of the year. Phytel also is interfaced with Orlando Health’s Allscripts Sunrise inpatient EHR to capture information on patients discharged from the system’s hospitals.

“Phytel did an excellent job of getting us up in a very short time,” says Schooler. “Unlike other IT products I’ve experienced, Phytel met all of their commitments, all of their timelines. We were surprised by the ease with which we were able to get the data out of the source systems, so it didn’t put much stress on our team.”

Endicott says physicians also have been pleasantly surprised. “I’ve heard from physicians and staff that Phytel has enhanced their workflow and been a value-add as opposed to a detractor,” she says. “Most of the time when you implement a new technology tool, people complain that it has increased their workload, and often made things more cumbersome and difficult. This is the first time that I’ve heard that it is quickly considered to be a value-add.”

Medical Homes, Neighborhoods and Beyond

Orlando Health’s due diligence has paid off as Phytel’s on-time and on-budget implementation and proven technology is helping it move from a focus purely on acute episodic illness to true population health management. The health system is moving forward on several fronts. Orlando Health is one of 15 health systems nationwide to participate in a CMS-funded Patient Centered Medical Neighborhood demonstration project. The initiative, which utilizes Phytel technology for population health management, is designed to connect acute-care hospitals with technology-empowered primary care, specialty and subspecialty practices to drive better quality, superior patient experience and population health at a more affordable cost.

Key to Orlando Health’s selection for the program was that a majority of its ambulatory care offices have been officially recognized by the National Committee for Quality Assurance (NCQA) as patient-centered medical homes (PCMH), thanks in part to their use of Phytel and its ability to deliver NCQA auto-credit toward PCMH certification. The medical home model is widely embraced as a prerequisite for population health management.

Chris Jordan, Orlando Health’s Chief Applications Officer for Ambulatory Systems, says Orlando Health struggled to achieve PCMH status before Phytel. “We were having a very hard time producing the kind of reports that are required for the medical home,” he recalls. “We were trying to create custom reports manually and hand them to case managers one at
Phytel is helping us change our care model, identify gaps in care for the patients in front of us, and, more importantly, the gaps in care for the people who aren’t in front of us, which is what we need to succeed as an ACO and under value-based care in general. That was just simply not going to happen with our existing systems.
to track and improve each of these performance measures. Phytel Insight delivers metrics and dashboard reporting that enables the health system to evaluate and measure its effectiveness across key quality initiatives. And Phytel Coordinate provides care teams with an advanced toolkit to risk-stratify patients and create personalized, automated interventions to better manage those populations and optimize each patient encounter.

The Orlando Health team in charge of the ACO reporting program has designed it to reduce physician work, minimize new clinical documentation steps, and have the same clinical documentation process address both the federal Meaningful Use program and ACO documentation, when feasible.

“Phytel is helping us change our care model, identify gaps in care for the patients in front of us, and, more importantly, the gaps in care for the people who aren’t in front of us, which is what we need to succeed as an ACO and under value-based care in general,” says Endicott, who is responsible for managing the operations of Orlando Health’s ACO. “That was just simply not going to happen with our existing systems.”

Right Tools, Right Partner

Moving forward, the second phase of Orlando Health’s Phytel deployment will make the platform available via health information exchange (HIE).

“We will tie our population health solution into our HIE so that our affiliated physicians in the field can get access to the Phytel reports on care gaps and other functionality,” explains Jordan. “We’re also going to be implementing a patient summary screen within our affiliated physicians’ EHRs to provide an at-a-glance summary view of the patient’s care gaps.”

The next step will be to integrate all of the Phytel tools with a single patient portal for the CIN.

Endicott says that Phytel so far is saving manpower at Orlando Health, where 15 care managers currently use the system. “And, now that we have access to timely data and are changing out clinical model, we’re getting closer to being able to accept risk contracting arrangements.”

She points out, “The most obvious positive result of our use of Phytel is the ability to have patients contacted through automated outreach. We have physicians saying that after years of trying to get patients to come in with their medications for medication reconciliation, they now have patients showing up with all of their medications in a bag. It sounds like a small thing but it’s essential and wasn’t happening prior to our use of Phytel.”

Schooler concludes: “There is no population health management without this technology. You just can’t manage populations without data and the ability to make that data actionable. Phytel delivers both.”

**Solution: Phytel Population Management System**

**PRODUCT DISTINCTIONS**

- Drives population health management
- Can be used to build medical homes and ACOs
- Generates demonstrable quality improvement
- Implementation is smooth and rapid
- Nationally recognized, evidence-based protocols are customizable
- Registry seamlessly integrates with EMR, PM and other systems
- Identifies gaps in care in a patient population
- Automated patient messaging can be repeated at preset intervals

**RESULTS**

- On-time, on-budget implementation of Outreach, Remind, Coordinate and Transition for 100 physicians
- Integrated data from Allscripts inpatient and ambulatory EHRs, capturing patient information across the continuum of care
- Sped NCQA PCMH certification for a majority of Orlando Health’s medical practices via Phytel NCQA autocredit
- Enabled management to determine physician quality bonuses by tracking compliance with quality measures
- Enabled Medicare Shared Savings ACO reporting, minimizing physician work and clinical documentation steps, providing dual documentation for ACO and Meaningful Use