POPOPULATION HEALTH:
Turning data into information, and information into transformation.

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Laura Spurr, MS, PMP
Objectives

- Organization description
- Change in industry landscape
- Population Health analytic tool
- How we started
- Preparing for pilot
- Developing a new model
- LIVE
- Measuring outcomes
- Results
- Patient impact
- Strategic Roadmap and Population Health
- System-wide roll out
Aurora Health Care is one of the largest not-for-profit, integrated health care systems in the United States.

- Wisconsin and northern Illinois.
- ~1.2 million patients
- 15 hospitals
- ~175 clinics
- 80 pharmacies
- 60 laboratories
- Home care services
- 1600 physicians
- 400 advanced practice providers
Where we spend our $$$

Acute Care /Advanced Illness
• Episodic
• Patient needs our services
• Utilize most resources
  (3% population/29% of cost)

Tertiary Prevention
  Manage chronic conditions
  (7% population/23% cost)

Secondary prevention
  Early detection screenings
  At Risk (10% population/19% cost)
  Stable (30% population/22% cost)

Primary Prevention
  Healthy (50% population/7% cost)

We spend the largest number of resources on the smallest percentage of the population

Statistics from NCQA: Continuing Care and Case Management for Population Health
Accounting for a Change in Landscape

CURRENT STATE
Volume-based/Episodic care

Results in:
• Healthcare costs expected to reach $4.4T in 2018
• Unnecessary services
• Inefficient delivery of care
• Missed prevention opportunities

FUTURE STATE
Value-based/Continuous Care

Results in:
• Proactive care management of patient populations
• Leveraged caregiver teams working at top of license
• Easy access to care
• Efficient delivery of quality care
How to account for change?

- Understand the world we live in is changing
- Account for the regulatory mandates
- Electronic Health Record impact.
- Managing data effectively to achieve integrity and quality information
  - Prevent “Garbage in Garbage out”
- Aggregating and analyzing the data
  - Showing a holistic view
  - Show patterns
  - Identify relationships
  - Highlight opportunities
Driving change through Population Health

• Industry buzz word, where definitions vary.

• Identifying what Population Health is for Aurora Health Care
  – Help patients live well.
  – Increase provider access to allow for expanded population based care models.
  – Providing a team approach to care.
  – Optimize our technology and practice to produce the best possible outcomes.
  – Instill a self-improving culture based on high quality data.
  – Use data as an asset to identify populations and make meaningful changes.
Getting from here to there

Data input

Everything in between

Meaningful Change
Selecting a Population Health Analytic Tool

- Humedica MinedShare® is a cloud-based solution built to serve as the analytic engine for population health management.

- Integrating clinical and claims data across continuum to give providers a complete view of their population and trends in health utilization and outcomes.

- Predicting patients at-risk and reducing preventable costs by identifying unmet needs and clinical risk factors.

- Making all clinical insights immediately actionable by combining a patient-centered view with multiple attribution models.

- Driving performance improvement through deep comparative benchmarks.
Beginning the Journey to Meaningful Change

• Understanding “Predictive” analytics
  – Moving beyond Risk Scoring
• Using enterprise data across the care continuum, to improve patient care by analyzing data to identify trends and patterns, and predict future behaviors and events, to a high degree of certainty.
• Analyze different populations to understand the opportunities.
• Identify where the largest number of resources are spending the most time.
Identifying Populations

Cohorts

Cohort Prevalence

Avg Charlson (Diff from Comp)

Displaying 7 / 7 cohorts

<table>
<thead>
<tr>
<th>Process</th>
<th>Result</th>
<th>Comp.</th>
<th># of Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pts w/ 1 or More BMI assessments (Last 12 Months)</td>
<td>89%</td>
<td>86%</td>
<td>879,352</td>
</tr>
<tr>
<td>Pts w/ 1 or More SEP &amp; DBP Tests (Last 24 Months)</td>
<td>90%</td>
<td>92%</td>
<td>879,352</td>
</tr>
<tr>
<td>Pts w/ 1 or More Lipid Panel Tests (Males Age 35+, Females Age 45+)</td>
<td>57%</td>
<td>60%</td>
<td>571,895</td>
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<tr>
<td>Pts w/ 1 or more colorectal cancer screenings (ages 50-75)</td>
<td>22%</td>
<td>24%</td>
<td>348,873</td>
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<tr>
<td>Pts w/ Smoking Status Recorded (Last 24 Months, Ages 18+)</td>
<td>21%</td>
<td>18%</td>
<td>673,352</td>
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<tr>
<td>Pts Who Ever Had a Pneumonia Vaccine (Ages 65+)</td>
<td>20%</td>
<td>25%</td>
<td>201,833</td>
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<tr>
<td>Females w/ 1 or More Bone Density Tests (Ages 65+)</td>
<td>16%</td>
<td>25%</td>
<td>116,269</td>
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<td>Females w/ 1 or More Mammograms (Last 24 Months, Ages 40-69)</td>
<td>53%</td>
<td>37%</td>
<td>242,963</td>
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</tbody>
</table>

*example screen shots are from Humedica MinedShare®
CHF-Related Admissions and ED Visits

Patients

Number of admissions + ED visits per patient

- $x \leq 1$
- $1 < x \leq 2$
- $2 < x \leq 3$
- $3 < x \leq 4$
- $4 < x \leq 5$
- $5 < x \leq 6$
- $6 < x \leq 7$
- $7 < x \leq 8$
- $8 < x$

4.2% of CHF pts.
18% of pts. w/ CHF-related hosp. admit or ED visit in next 6 mos.

Lift = 4.2

Admissions + ED Visits

4.2% of CHF pts.
24% of CHF-related hosp. admits and ED visits in next 6 mos.

Lift = 5.7

*screen shots are from Humedica MinedShare®
Predictive Analytic Risk Stratification

AAH HF Pilot Sites PCP CHF: % of Pts by Predictive Model Risk Category

Likelihood of CHF-related Hospitalization within 6 months Categorized

*screen shots are from Humedica MinedShare®
How to make the data actionable

✓ Leadership vision
✓ Assessing current state and regulations
✓ Formed strategic roadmap
✓ Selected the population health analytic tool
✓ Analyze the data to identify our opportunities

• Now lets make the magic happen!
The Reason Why

This **man has an EF 15%, DM, HF, CVA and multiple co-morbidities.** He started the HFCC pilot by **walking in with a cane with edema and severe SOB.** He stated that he was **SOB all the time.** Weight was up and down multiple admissions last 7/22/13. Since then and with HFCC he has now received all his medications covered for him through the VA (big cost savings for the patient). He qualified for Cardio/Pulmonary Rehab. He is understanding his HF and his medications. He is now on the treadmill with Cardio/Pulm rehab 25-30 min at 2.5% incline at 2.5 MPH 3 days/wk. He is back to working 9 hr days 2-3 days per week as a machine operator. He told me today that "**I feel like he did when I was 50**. Patient understands how to manage his weight and watch his symptoms and likes being kept in check with his disease process.

-Aurora Health Coach, RN

*note the term “Health Coach” and “PCMH RN” in this presentation are interchangeable.*
How we started

MARCH 2013

Governance:
• Formed a Steering Committee
• Selected a Physician Chair to drive change
• Identified a core project/develop team of experts

How we selected the Project & Pilot Group:
• Compared Humedica’s data analysis against Aurora’s strategic roadmap, to determine our focus:
  o Predictive Analytics
• Used national benchmarks to validate focus.
• Analyzed where the greatest opportunities presented
  o Heart Failure and COPD populations.
Heart Failure and COPD Projects

PHASE 1
Purpose: Use Predictive Analytics to identify the highest risk populations forecasted to admit within 6 months for Heart Failure. Institute a disease-specific action plan to improve outcomes for this population.

Live date: 06/2013
Focus Area: 5 clinics
1 hospital
Target Group: 129 Patients
Caregivers: 32 Providers
6 Health Coach RNs
Leadership: Cross functional
Cross organizational

PHASE 2
Purpose: Using Predictive Analytics to identify the highest risk populations forecasted to admit within 6 months for COPD. Institute a disease-specific action plan to improve outcomes for this population.

Live date: 01/2014
Focus Area: 5 clinics
1 hospital
Target Group: 263 Patients
Caregivers: 32 Providers
6 Health Coach RNs
2 Pharmacists
1 Home Care
1 Specialist
Leadership: Cross functional
Cross organizational
HEART FAILURE PILOT
POPULATION HEALTH
Planning

• Clinical validation of the data
• Performed Extensive Research to determine an optimal model
  – Industry
  – Internal
• Developed a plan based on the data and our gaps in care
  – Patient Engagement
  – Increased Care Coordination
  – Team based care model
• Identified the tools needed to support the model
  – Action Plans
  – Patient Management Plans
  – Order Sets and Documentation
  – Reports within our EHR
• Determined the Timeline
## High Level Pilot Timeline

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<tr>
<th>Project Milestones</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
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<td><strong>LIVE</strong></td>
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</table>
The Old Model

- Patient sees primary care provider in office
- Treatment Regimen
- Patient goes to ER
- Patient is admitted as Inpatient
- Patient is discharged from hospital
- Patient is scheduled to see PCP
- Patient has an episode
High Level Process Summary

✓ Use Health Coach RN as the conduit between provider and care team
✓ Institute a collaborative workflow
✓ Engage the patient in their care in an enhanced way
✓ Use heart failure protocols and quality-driven treatment plans to improve care.
✓ Develop electronic tools to allow for ease in utilization as well as comprehensive documentation.
The New Model

1. Patient arrives for visit
2. Patient sees Health Coach RN & Provider (co-visit)
3. Team develops tx plan and schedule
4. Report for target group
5. Validate pt. list with providers
6. Assign Health Coach RN
7. Health Coach RN performs regular f/u
8. Health Coach RN coordinates team members for the pt. (Pharmacy, Home Care...etc.)
9. Health Coach RN performs outreach call
Changing to a Team-based model

“A team is a group of people that do what I tell them to do”

You WILL listen to me!!

“A group of motivated people with complimentary skills, who are committed to a common purpose.”*

*definition by LEAN Six Sigma
Health Coach Outreach

Heart Failure Initial Intake

Hunter Ztest
9/13/2013

Patient Reported information:
What do you prefer to be called? ***
What is the best way for us to reach you? {CONTACT MANNER:130311}
Who do you live with? ***
Does anyone else help care for you? {yes:no:108347}
Is there anyone you would like to bring with you for your visits? {yes:no:108347}
Do you have a cardiologist you see for your heart care? {if yes, please update the care team yes:no:108347}
Do you follow a special diet? {yes:no:108347}
Do you follow a fluid restriction? {yes:no:108347}
Have you been hospitalized for your heart failure? {if yes, please note most recent hospital date yes:no:108347}
Do your heart symptoms interfere with your daily activities? {yes:no:108347}
How far can you walk before you become short of breath? ***
Please review and update the patients medication list with them.
Do you take over the counter medication that may not be on our medication list? {pay particular attention to medications such as ibuprofen, Aleve, etc. yes:no:108347}

Historical Clinical Information:
Is there an echocardiogram in the record? {yes:no:108347}
When was this performed? ***
What is the patient’s most recent ejection fraction? ***
Is the patient on an ACE inhibitor or ARB? {yes, no contraindication:130312}
Is the dose at target range? {yes, no contraindication:130312}
Is the patient on a beta blocker? {yes, no contraindication:130312}
Is the dose at target range? {yes, no contraindication:130312}
<table>
<thead>
<tr>
<th>Adv</th>
<th>Question</th>
<th>Answer</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Do you have any shortness of breath with activity?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do you have any shortness of breath at rest?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do you have problems sleeping due to your breathing?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are you able to lay in bed when you sleep? If yes, how many pillows do you use?</td>
<td>Yes</td>
<td></td>
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<tr>
<td></td>
<td>Has your weight changed in the last several days or week?</td>
<td>Yes</td>
<td>5 lb increase in one week</td>
</tr>
<tr>
<td></td>
<td>Do you have any swelling in your ankles, stomach or hands?</td>
<td>Yes</td>
<td>stomach</td>
</tr>
<tr>
<td></td>
<td>Do you have any chest pains?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are you having any problems taking your medications regularly?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are you having any side effects from your medications?</td>
<td>No</td>
<td></td>
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<tr>
<td></td>
<td>Do you have any questions about your medications?</td>
<td>No</td>
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</tr>
<tr>
<td></td>
<td>Yes/No (Shift+F5)</td>
<td></td>
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</tbody>
</table>
Evidence Based Order Set

MEDICATIONS

- **Diuretics, Andosterone Antagonists, Other**
  - 0 of 11 selected
- **Ace Inhibitors - ARB**
  - 0 of 39 selected
- **Beta Blockers**
  - Bisoprolol - Initial dose 2.5 mg daily; titrate to effective dose 10 mg daily
  - Carvedilol - Initial dose 3.125 mg bid; titrate to effective dose 25 mg bid
  - Metoprolol - Initial dose 12.5 - 25 mg daily; titrate to effective dose 200 mg daily

- bisoprolol (ZEBETA) 5 MG tablet
  - 1/2 tablet daily
  - 2.5 mg, Oral, DAILY, Disp-15 tablet, R-2
- bisoprolol (ZEBETA) 5 MG tablet
  - 1 tablet daily
  - 6 mg, Oral, DAILY, Disp-30 tablet, R-2
- bisoprolol (ZEBETA) 10 MG tablet
  - 10 mg, Oral, DAILY, Disp-30 tablet, R-5
- carvedilol (COREG) 3.125 MG tablet
  - 3.125 mg, Oral, 2 TIMES DAILY, Disp-60 tablet, R-2
- carvedilol (COREG) 6.25 MG tablet
  - 6.25 mg, Oral, 2 TIMES DAILY, Disp-60 tablet, R-2
- carvedilol (COREG) 12.5 MG tablet
  - 12.5 mg, Oral, 2 TIMES DAILY, Disp-60 tablet, R-2
- carvedilol (COREG) 25 MG tablet
  - 25 mg, Oral, 2 TIMES DAILY, Disp-60 tablet, R-5
- metoPROLOL (TOPROL-XL) 25 MG 24 hr tablet
  - 12.5 mg, Oral, DAILY, Disp-15 tablet, R-2
- metoPROLOL (TOPROL-XL) 25 MG 24 hr tablet
  - 25 mg, Oral, DAILY, Disp-30 tablet, R-2
- metoPROLOL (TOPROL-XL) 50 MG 24 hr tablet
  - 50 mg, Oral, DAILY, Disp-30 tablet, R-2
- metoPROLOL (TOPROL-XL) 100 MG 24 hr tablet
  - 100 mg, Oral, DAILY, Disp-30 tablet, R-2
- metoPROLOL (TOPROL-XL) 100 MG; 2 tabs daily
  - 200 mg, Oral, DAILY, Disp-30 tablet, R-5
Patient Management Plans

ED/Urgent Care Patient Management Plan

Reason for Plan: Reduction in the use of the Emergency Department.

Treatment Plan: If patient has complaints of Chest Pain, I recommend the following:

1) Pt take nitroglycerin 0.4 mg tabs, one tab SL every 5 min x 3
Training

**Health Coach, RN**
- Disease specific education
- EHR functionality training
- Health coaching techniques
- Motivational interviewing
- Industry models
- Operational Flow
- Change Management

**Provider**
- Disease specific education
- EHR functionality training
- Population Health analytic tool education
- Operational Flow
- Change Management

**Clinical Caregivers**
- EHR functionality training
- Change Management
- Operational Flow

**Other Caregivers**
- Awareness
- Change Management
- Operational Flow
Example Disease Education

At Risk for Heart Failure

Stage A
At high risk for HF but without structural heart disease or symptoms of HF.

- Patients with:
  - Hypertension
  - Atherosclerotic disease
  - Diabetes
  - Metabolic syndrome

- or

- Using cardiotoxins
- with HFx CM

Therapy Goals
- Treat hypertension
- Encourage smoking cessation
- Treat lipid disorders
- Encourage regular exercise
- Discourage alcohol intake, illicit drug use
- Control metabolic syndrome

Drugs
- ACEI or ARB in appropriate patients
- (see text)

Stage B
Structural heart disease but without symptoms of HF.

- Patients with:
  - Previous MI
  - LV remodeling including LVH and low EF
  - Asymptomatic valvular disease

Therapy Goals
- All measures under stage A
- Drugs
  - ACEI or ARB in appropriate patients (see text)
  - Beta-blockers in appropriate patients (see text)

Devices in Selected Patients
- Implantable defibrillators

Stage C
Structural heart disease with prior or current symptoms of HF.

- Patients with:
  - Known structural heart disease
  - Shortness of breath and fatigue, reduced exercise tolerance

Therapy Goals
- All measures under stages A and B
- Dietary salt restriction
- Drugs for Routine Use
-Diuretic for fluid retention
- ACEI
- Beta-blockers

Drugs in Selected Patients
- Aldosterone antagonist
- ARBs
- Digitalis
- Hydralazine/nitrates

Devices in Selected Patients
- Biventricular pacing
- Implantable defibrillators

Stage D
Refractory HF requiring specialized interventions.

- Patients who have marked symptoms at rest despite maximal medical therapy (e.g., those who are recurrently hospitalized or cannot be safely discharged from the hospital without specialized interventions)

Therapy Goals
- Appropriate measures under stages A, B, C
- Decision re: appropriate level of care

Options
- Compassionate end-of-life care/hospice
- Extraordinary measures
- Heart transplant
- Chronic inotropes
- Permanent mechanical support
- Experimental surgery or drugs
Live and Support

- Local Provider Champion
- Health Coach RN Lead
- Daily check-in calls with core development team & local leaders
- Re-education sessions
- Weekly newsletters with lessons learned
- In-person rounding by local leads and core team
- Provider to Provider outreach for the struggling or reticent.
**Tracking Outcomes**

*Content is for illustrative purposing only and not real data*
Lessons Learned

- The positive impact of the combination visit
- Using APPs for coverage
- Changing clinic dynamic and the need for Change Management
- Health Coach RN role definition
- Provider Adversity
  - Local physician champions
- Patient Engagement
  - Using the right terminology with patients “Heart Failure”
Now for the Results

SUCCESS
Because you too can own this face of pure accomplishment
Clinical Successes

• Drop in Heart Failure rates:
  ➢ 65% reduction in admissions from 2012 to 2013!
• Decrease in ER utilization.
• Increase in Patient Wellness (moving to lower risk).
• Increase in Patient Satisfaction
• Enhanced Care Coordination model with expanded primary care delivery team.
Readmission Impact

• 30% decrease in all-cause readmissions from 2012 to 2013*!

<table>
<thead>
<tr>
<th>Month</th>
<th>Readmission Rate 2012</th>
<th>Readmission Rate 2013</th>
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</thead>
<tbody>
<tr>
<td>June</td>
<td>12.1%</td>
<td>11.6%</td>
</tr>
<tr>
<td>July</td>
<td>10.7%</td>
<td>6.4%</td>
</tr>
<tr>
<td>August</td>
<td>12.9%</td>
<td>8.8%</td>
</tr>
<tr>
<td>September</td>
<td>11.9%</td>
<td>7.4%</td>
</tr>
<tr>
<td>October</td>
<td>13.73%</td>
<td>6.41%</td>
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<tr>
<td>November</td>
<td>11.25%</td>
<td>8.16%</td>
</tr>
<tr>
<td>December</td>
<td>8.90%</td>
<td>7.26%</td>
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</tbody>
</table>

average ~11.64% ~8.0%
Now for something AMAZING...

<table>
<thead>
<tr>
<th>Heart Failure Readmission rate</th>
<th>2012</th>
<th>2013</th>
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<tbody>
<tr>
<td>September</td>
<td>28.57%</td>
<td>9%</td>
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<tr>
<td>October</td>
<td>12.5%</td>
<td>0</td>
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<tr>
<td>November</td>
<td>16.7%</td>
<td>0</td>
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<tr>
<td>December</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>average of 4 months</strong></td>
<td><strong>14.44%</strong></td>
<td><strong>2%</strong></td>
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</table>
Show me the Money!

- Avoiding readmission penalties
- Avoiding diversion - opportunity costs!
- Improved access for new patients
- Increase in clinic efficiencies
- Ability to care for larger panel size
- Efficient resource allocation for caregivers

In a world where your organization takes 100% of the risk...

- 6 months of data
- 29 providers
- cost savings = $444,720*

Aurora Health Care has ~600 FP/IM providers

cost savings = ~ $32,348,400*

*based on 100% risk model
*pilot data annualized
The Patient Rewards

Non-Compliant patient:
“I have done a lot of work for this patient with the VA to get all his medications covered. I have done a lot of listening to him vent, about his health and his physician. I voiced to him that I was going on vacation. He stated that he will change his appointment so that he can meet with me because he appreciates all the hard work I have done to help him with his care. **He stated that he felt no one has ever put this much time into helping him get healthy and helping him with his care coordination.**”

Health Coach Patient:
“She was one of my first patients after taking on this role as the Health Coach RN*. The whole family is familiar with the Health Coach and the collaborative effort we have provided as a team in Kewaskum. **This family and patient know they can call anytime with questions or concerns. They view me as an extension of the physician.** We now have a Patient management plan in place for her as well.”

Hospice Patient:
“She has recently gone on Hospice. I was able to help her by setting this up and making sure she had her WI DNR bracelet on. **She asked if I can still call her even while she is on hospice because she enjoys my weekly calls. The impact I am having means so much.**”
Next steps post Pilot
Strategic Roadmap: where population health fits

- Care Redesign
- Patient Experience
- Informatics
- Caregiver Engagement
- Cost Efficient Care
- Operational Improvement
- ACO
- Patient Experience
- Operational Improvement
- Informatics
- Cost Efficient Care
Integrating with Primary Care Redesign

As a program, Aurora’s Primary Care Redesign strategy uses a patient-centric approach to strengthen our foundation; optimally transform our operations; and communicate our vision.

Primary Care Redesign aims to:
• help patients live well
• improve caregiver experience
• improve provider access
• foster caregivers working to top of licensure
• increase our population base
• optimize outcomes in relevance to cost and spending

✓ POPULATION HEALTH FITS!!!
Making the Triple Aim Happen
• Build population health into the primary care redesign charter
• Messaging from the top (CEO and Medical Group Presidents)
• Fine-tune our marketing strategy
• Engage local leaders
• Onboard physicians through collaborative groups
• Expand Change Management
• Spread awareness to instigate adoption
• Create deployment plan
Our Next Stop

Excellence
Just Ahead
Questions