Using Data to Improve the Community’s Health

November 15, 2018
Today’s objectives

1. Overview of trends in value based care that all providers and support organizations should know

2. Description of available community health improvement data

3. What is needed to illustrate your value

4. Premier’s Value Based Care (VBC) resources and white papers
“The health of the people is the foundation upon which all of their happiness and all of their powers as a community depend.”

~ Benjamin Disraeli
Key Definitions

Population Health Management

• …managing the care for a defined set of individuals with the goal of improving the quality, efficiency and patient satisfaction (the Triple Aim™) and lowering the cost trend for the overall group.

Value-Based care (VBC)

• …health care that is based on the value of a service provided rather than the volume of services.
• Using evidenced-based care while taking into account patient preferences.

Value-Based payment (VBP)

• …a fundamental shift from fee-for-service, which is volume based, to payments related to outcomes, or the value provided.
• It is a strategy used to promote quality and value of health care services with a goal to slow the total cost of care.
The journey to population health management

Changing reimbursement models:
- Reimbursement cuts
- Value-based reimbursement
- Pay for performance contracts
- Tiered networks / payments
- Bundled payments / gainsharing
- ACOs/shared savings
- Care management PMPMs
- Global or total cost of care payment

1. Preparatory
2. Transformational
3. Implementation
4. Expansion

Necessary capabilities evolve by stage:
- Manage costs to reimbursement
- Maximize performance
- Engage providers
- Develop network
- Capitalize on payment incentives
- Balance the service portfolio/ growth strategies
- Manage episodes longitudinally
- Address complex cases
- Initiate care coordination
- Employ data analytics
- Utilize provider alignment models
- Establish insurance risk capability
- Measure and monitor population health efforts
- Narrow the network
- Grow covered lives

Care redesign should not outpace reimbursement changes… new payment mechanisms must be secured to support the care model

ACO – accountable care organization; PMPM – per member per month
Value-based payment market segments

1. Employee Health Plan
2. Uninsured
3. Medicare ACO
4. Medicare Advantage
5. Medicaid
6. Commercial Health Plans
7. Direct to Employer
Value Based Payment Models

- Centers for Medicare and Medicaid (CMS)
  - Medicare Value Based Purchasing (VBP) program for hospitals focuses upon readmissions, Hospital-Acquired Conditions (HACs), and cost
  - CMS Bundled Payment (Bundled Payment for Care Improvement (BPCI), Oncology Care Model (OCM), Comprehensive Care for Joint Replacement Model (CJR), and BPCI-Advanced)
  - CMS Medicare Accountable Care Organization (ACO) Models (Pioneer, Medicare Shared Savings Program (MSSP), Next Generation ACO Model (NextGen)
  - Medicaid Value Based Payment Models (Consumer Driven Health Plan (CDHP), Delivery System Reform Incentive Payment Program (DSRIP), Medicaid Managed Care etc.)
  - Comprehensive Primary Care Plus (CPC+)
  - Medicare Advantage (MA)
- Commercial
  - HMO, PPO
  - Direct to Employers (e.g. Boeing, Booz Allen Hamilton, Whole Foods, etc.)
  - Federal, State Commercial Exchanges
  - Bundled Payment
1. Highly engaged leadership – Clinical partners, financial partners, managed care, at the highest levels.

2. Alignment of incentives with physicians and other providers.

3. **Payer/provider trust and collaboration is vital** – Developed through transparency around shared information, tools and resources.

4. Payer agnostic programs including, **analytics and performance improvement support teams**. Some payers are attempting to develop and sell these services to providers.

5. Active joint operating committees with both payer and provider representation.

6. **Focused action plans to improve performance** in key areas.

7. **Clinical performance data sharing** at the subgroup and individual provider level.

8. **Active management of clinical improvement plans as well as a well defined care management processes.**

Source: Premier’s Annual Value Based Commercial Payment Contracting Arrangements Meeting
As risk increases, so does the dependence on information.

<table>
<thead>
<tr>
<th>Fee for Service</th>
<th>Shared Savings</th>
<th>Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay for Reporting</td>
<td>Value-based Purchasing</td>
<td>MSSP</td>
</tr>
<tr>
<td>Lower risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Management</td>
<td>Manage volume</td>
<td>Manage <strong>Total Payer Cost of Care</strong> (Per Member Per Month)</td>
</tr>
<tr>
<td>Clinical Management</td>
<td>Manage care process</td>
<td>Coordinate care (Patient registries, predictive analytics)</td>
</tr>
<tr>
<td>Data Management</td>
<td>Manage silos of data</td>
<td>Integrate silos of data (acute, ambulatory, pharmacy)</td>
</tr>
<tr>
<td>Data Interpretation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MSSP – Medicare Shared Savings Program; NGACO – Next Generation ACO Model
In a VBC world, new metrics are more informatics intensive

Traditional FFS

“More is good”
- Number of admissions
- Number of procedures
- IP Case Mix Index (CMI)
- Net revenue per adjusted patient day
- Patient Census Report (PCR)

Population Health

“More is bad”
- IP admissions / 1,000
- OP visits / 1,000
- Ambulatory / preference sensitive admissions
- Total medical cost / svc
- Per member per month
- Re-admits / 1,000

FFS – fee for service, IP – inpatient, OP – outpatient, svc - service
What do you need to manage the health of populations?

Category

- Automate data and quality reporting for greater user access and expanded utilities
- **Population Health Analytics** - Back End (adjudicated claims, clinical data)
- Care Management Enabling Technology - Front End (clinical data, adjudicated claims)
- Quality / Utilization Reporting Requirements (contractual)
- Electronic Medical Record (administrative and clinical coordination)
- Health Information Exchanges (interoperability)

*Examples of Population Health Analytics:*

- Leverage new forms of analytics and reporting, population and provider levels
- Identify gaps in quality, utilization and efficiency across patients and providers real time and retrospectively segment populations by risk (using adjudicated claims and/or clinical data)
- Fully understand individuals’ risks through electronic data, social determinants, and lifestyle risk factors
Publicly available resources

• Geographies - nation, state, county, city, census tract
• Example indicators
  – Mortality
  – Health behaviors (smoking, drinking, obesity, etc.)
  – Access (providers, screening, services, etc.)
  – Social and economic (population, poverty level, education status, etc.)
  – Physical environment (air quality, water quality, housing and transit, etc.)
  – Chronic diseases
• Sources
  – RWJ County Health Rankings - www.countyhealthrankings.org
  – Community Commons - www.communitycommons.org/
  – State hospital discharge data (mandated vs voluntary)
  – Local Community Health Needs Assessments
Turning data into information

• Compare current performance to historical (internal benchmark)

• Benchmarking against risk-adjusted peer groups (external benchmark)
  - Inpatient utilization
  - Post-acute services utilization and cost
  - Outpatient services including use of medically unnecessary imaging screenings, rising costs of Part B drugs, overutilization of Emergency Department visits, or underutilization of Primary Care services/Urgent Care
  - End-of-life care and hospice utilization

• Benchmarks risk-adjusted to your own population
  - Include risk adjustments for age, gender, and demographics

Risk-Adjustment

• **Purpose:** to enable the accurate comparison of clinician or facility performance, accounting for populations that may be more or less ill/costly than the average

• **Example characteristics:** may include the patient’s age, past medical history, and other diseases or conditions (comorbidities) the patient had prior to the episode of care that are known to impact the health outcome

• **Common metrics:** measure outcomes that are commonly risk-adjusted include mortality, readmissions, complications or utilization
What should I pay attention to?

• Quality indicators:
  − Healthcare Effectiveness Data and Information Set (HEDIS)
  − Medicare Shared Savings Program (MSSP) Measures
  − Quality Payment Program (QPP, formerly MACRA) metrics
  − Anything specific to the contract

• Utilization indicators:
  − Admit or Discharge per 1,000 population
  − Length of Stay (LOS)
  − Emergency Department (ED) visits/1,000
  − Skilled Nursing Facility (SNF) days/1,000
  − Out of Network use
  − Pre-authorization rate
  − Other areas where there is high spend

• Primary care referrals to specialists (rate)
HEDIS® includes more than 90 measures across 6 domains of care:

1. Effectiveness of Care
2. Access/Availability of Care
3. Experience of Care
4. Utilization and Risk Adjusted Utilization
5. Health Plan Descriptive Information
6. Measures Collected Using Electronic Clinical Data Systems

The National Committee for Quality Assurance (NCQA) releases new technical specifications for HEDIS annually.

Source: https://www.ncqa.org/hedis/measures/
ACO PY2018* Quality 31 Measures

Patient/ Caregiver Experience Domain
(8 CAHPS measures)
- Eg. CAHPS: How Well Your Providers Communicate
- Eg. CAHPS: Patients’ Rating of Provider

Care Coordination/ Patient Safety Domain
(10 measures)
- Eg. Risk-Standardized, All Condition Readmission
- Eg. Falls: Screening for Future Fall Risk

Preventive Health (8 measures)
- Eg. Preventive Care and Screening: Influenza Immunization
- Eg. Colorectal Cancer Screening

At-Risk Population (5 measures)
- Eg. Diabetes: Hemoglobin A1c Poor Control
- Eg. Controlling High Blood Pressure

Quality (50 percentage points)
- CMS will use 11 of the 31 MSSP quality measures reported through the CMS Web Interface for the entire ACO
- P4R in ACO’s first performance year, thereafter P4P

Cost (0%)
- Not assessed for ACO

Improvement Activities (20%)
- MSSP ACOs automatically receive the full credit for this category.

Promoting Interoperability (formerly Advancing Care Information) (30%)
- ACI performance assessed as a group through ACO Participant TINs

* Note: In the proposed CY 2019 Medicare Physician Fee Schedule Rule, CMS proposes to reduce the total number of measures in the MSSP quality measure set from 31 to 24 and focus the measure set on outcome measures including patient experience of care
Example: Success under risk requires attention to leakage, utilization, and outcomes...in that order of priority.
Example: Successful ACOs identify opportunities and monitor initiative outcomes

ACOs are groups of health care providers who voluntarily work with payers to offer high quality service and care at the right time in the right setting, and accept accountability for population outcomes

- **Post-Acute Care Utilization**
  - Skilled Nursing admission rate, length of stay, and paid per day averages
  - Post-acute Rehab utilization
  - Home Health services

- **Emergency Department Utilization**
  - Seek balance of ED visits, Urgent Care utilization, and PCP utilization

- **Inpatient Utilization**
  - Avoid unnecessary admissions of Ambulatory Care Sensitive Admissions and unnecessary surgeries
  - Unplanned, all-cause hospital-wide readmissions

- **High Cost / Rising Cost of outpatient services**
  - Measure avoidable high-tech (PET, MRI, CT) imaging
  - Part B Drug cost by specialty

- **End-of-Life Care and timing of hospice**
Demonstrating your value: Steps

1. DEFINE VALUE
Understand the targets towards which you are working

2. CORE SERVICES
Identify your core services that contribute to value to providers

3. MEASURE PERFORMANCE
Measure contribution and performance improvement; use process measures or outcomes measures or both

4. DOCUMENT SUCCESS & COMMUNICATE
Health systems and payers are both seeking information by which to elevate certain providers and exclude others, ensure they know your areas of contribution and success
How to illustrate your value: define value

- Improve patient experience of care (including quality and satisfaction)
  - Clinician Group CAHPS
  - Shared Decision Making
  - Reduction of wait times

- Reduce per capita cost of healthcare
  - Avoidable...
    - Acute readmissions per 1,000
    - SNF readmissions per 1,000
    - ED visits per 1,000

- Improve the health of populations
  - Preventive Care - Influenza Immunization
  - Preventive Screening - Colorectal cancer
  - Adult BMI Assessment

The Institute for Healthcare Improvement Triple Aim®
Community support can contribute to improved outcomes!
Which patient is at higher risk?

Patient A
- ESRD
- CHF
- A-fib
- Obesity
- ED Visits year to date: 10
- Admissions year to date: 6

Patient B
- Type II Diabetes
- COPD
- HTN
- ED visits year to date: 5
- Admissions year to date: 5

Example from DMH presentation at Premier’s Fall PHMC Meeting
Which patient is at higher risk?

Patient A
- ESRD
- CHF
- A-fib
- Obesity
- ED Visits year to date: 10
- Admissions year to date: 6

Patient B
- Type II Diabetes
- COPD
- HTN
- ED visits year to date: 5
- Admissions year to date: 5

The impact of Social Determinants of Health...

- Receiving home health
- Available transportation
- Receiving dialysis
- Age 60-65 and not eligible for public program assistance
- No transportation
- Not adhering to medications because of cost
Checklist: Keys to Value Based Care success

- Become familiar with general concepts and common terminology
- Develop a data analytic roadmap for your Value Based Contract (VBC) contract that is tightly aligned with the business and clinical roadmaps
- Promote/support sophisticated data analytics capabilities
- Utilize publicly available resources to supplement any gaps in information
- Understand the performance targets upon which you are or will be measured
- Identify your contributions
- Commit to measuring your own performance
- Document and communicate successes
Examples of Premier’s VBP Advisory Services

VBP Strategy & Roadmap

- Contract Review
- Performance Assessment
- Bench-marking
- Provider Alignment
- Care Management Design
- Metric Selection
- Contract Design
Ready, Risk, Reward

1. Aligning for Success with the Second Generation of CINs
2. Keys to Success in Bundled Payments
3. Building Successful Two-Sided Risk Models
   - Support the clinical and administrative aspects of care, with the goal of improving health outcomes
   - Use strategically selected actionable, predictable and comparable health information technology capabilities
   - Integrate measures across contracts to focus efforts; evaluate and benchmark the effectiveness and return on investment (ROI) of clinical interventions
   - Establish interoperability between providers to exchange clinical data and to manage and prevent leakage
   - Integrate electronic health record (EHR) clinical data with payer claims information
   - Negotiate with payers to ensure the payer shares robust adjudicated claims data for the population attributed in a risk arrangement in a timely manner

Source: https://learn.premierinc.com/white-papers
QUESTIONS

Sonia Greer, MSHP, FACHE
Director, Population Health
sonia_greer@premierinc.com
Contact Us

NewYork-Presbyterian Queens

http://www.nyhq.org/dsrippps

Amanda Simmons
(713) 859-9683
ams9014@nyp.org

Sarah Schauman
(505) 231-5591
sak2047@nyp.org

NewYork-Presbyterian Performing Provider System

http://www.nyp.org/pps

Paula N. Richter
(646) 317-2092
par9110@nyp.org

Rachel Naiukow
(347) 880-1707
ran9031@nyp.org
Sonia Greer, MSHP, FACHE

Director, Population Health, Premier

Ms. Greer is a Director on the Premier Population Health advisory services team and leads Premier’s Community Health Needs Assessment services. She has years of healthcare experience in the development and implementation of customized strategic and operational population health management solutions. Her specialty is strategic planning, financial modeling, physician alignment and clinical integration with the focus upon community health improvement.