

# Using Technology and Data Infrastructure to Realize the Potential of SIM Reforms



The Office of the National Coordinator for  
Health Information Technology



# *Kentucky State Innovation Model (SIM) HIT Innovation Forum*

Patricia MacTaggart

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202-230-0987

- **Purpose of Health IT:**

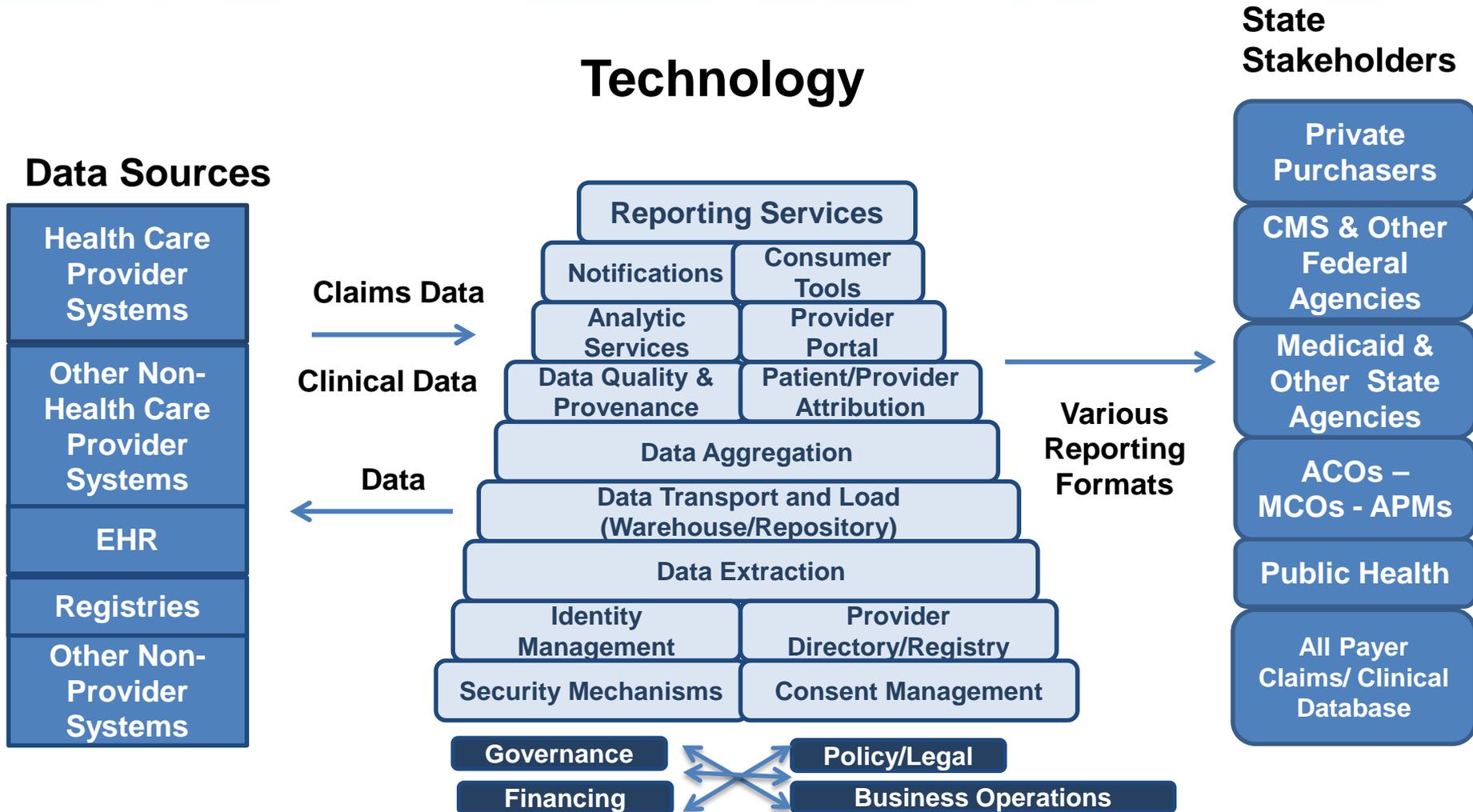
- Assist the state in implementing and utilizing health IT to support their SIM Model/Test Plans
  - Alternative Payment Methodologies - Bundles
  - Service Delivery Reform – PCMC, ACO, Modified Health Home

- **State Health IT SIM Deliverable:**

- Health IT components of the SIM Design State Health System Innovation Plan (SHSIP) or SIM Test State Operational Plan
  - Guidance, including checklists, templates and tables are the “output” documentation for discussion and validation
  - Focus is on the “input”: discussions and activities that need to happen to create the “output’ documentation

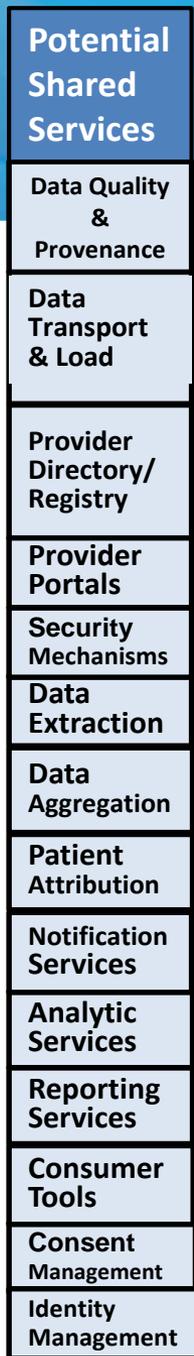
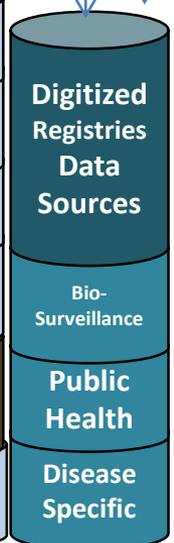
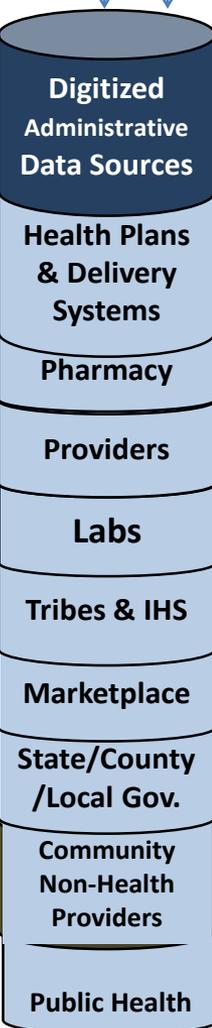
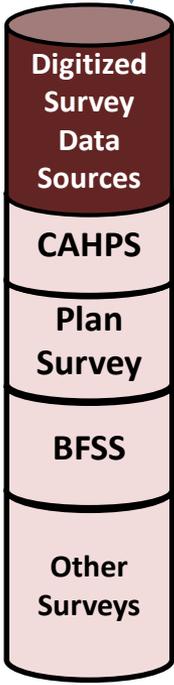
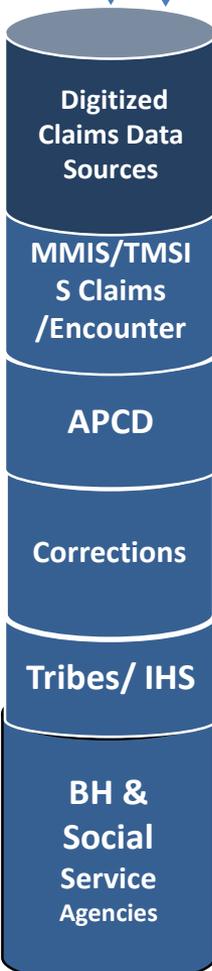
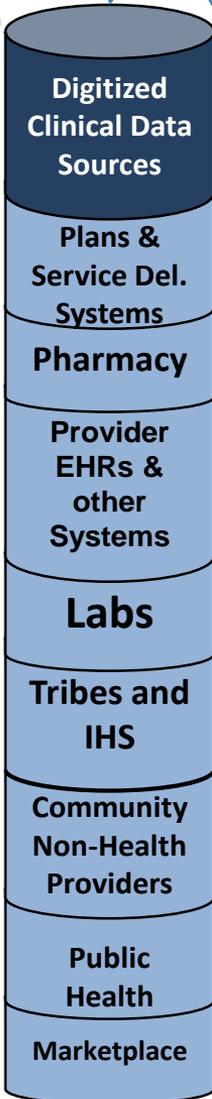
- **Focus:**
  - Where do you want to be in 5-7 years
  - Interim: foundational for 5-7 plan within current realities
- **Framework:**
  - Information needs - State, communities, providers, purchaser, consumers and “Impactable”
  - Data needs – quality, security, timeliness
  - Health IT infrastructure needs –leverage and plan to fill the “gaps”
- **Implementation of “Roadmap”**
  - Policy Levers
  - Leveraging: Medicaid and “Meaningful Use”

# Health IT Stack for Value-based Payment Models and the Learning Health System



# Exchange of Health Information

Send, Receive, Find and Use Health IT Ecosystem



# Implementation Strategies for Health IT Infrastructure: Utilizing Policy Levers



- **State Government Direct Infrastructure/Activity**
- **State to Entities within the State: Non-State Government**
  - Direct Statutory/ Regulatory Authority
  - Contractual Requirement: Participation - Payment
  - Incentive/Penalty
  - Public Reporting
  - Message Bully Pulpit

# Lessons Learned – Learning from Other States

- **Avoid innovation fatigue - “project” syndrome**
- **Health IT discussions part of population health, payment & service delivery discussions – not isolated**
- **Governance is a challenge**
- **Foundational technology meets many needs**
- **Understand your current state of health IT**
- **Expanded care teams create different demands**
- **“Services that impact health” as well as health services require interoperability with different providers and services**
- **Sustainability benefits from alignment public and private and leveraging Medicaid**



Governor's Office of  
Health Transformation

# Ohio's Health Information Technology Strategy

Greg Moody, Director  
Governor's Office of Health Transformation

Kentucky State Innovation Model HIT Forum  
September 29, 2015

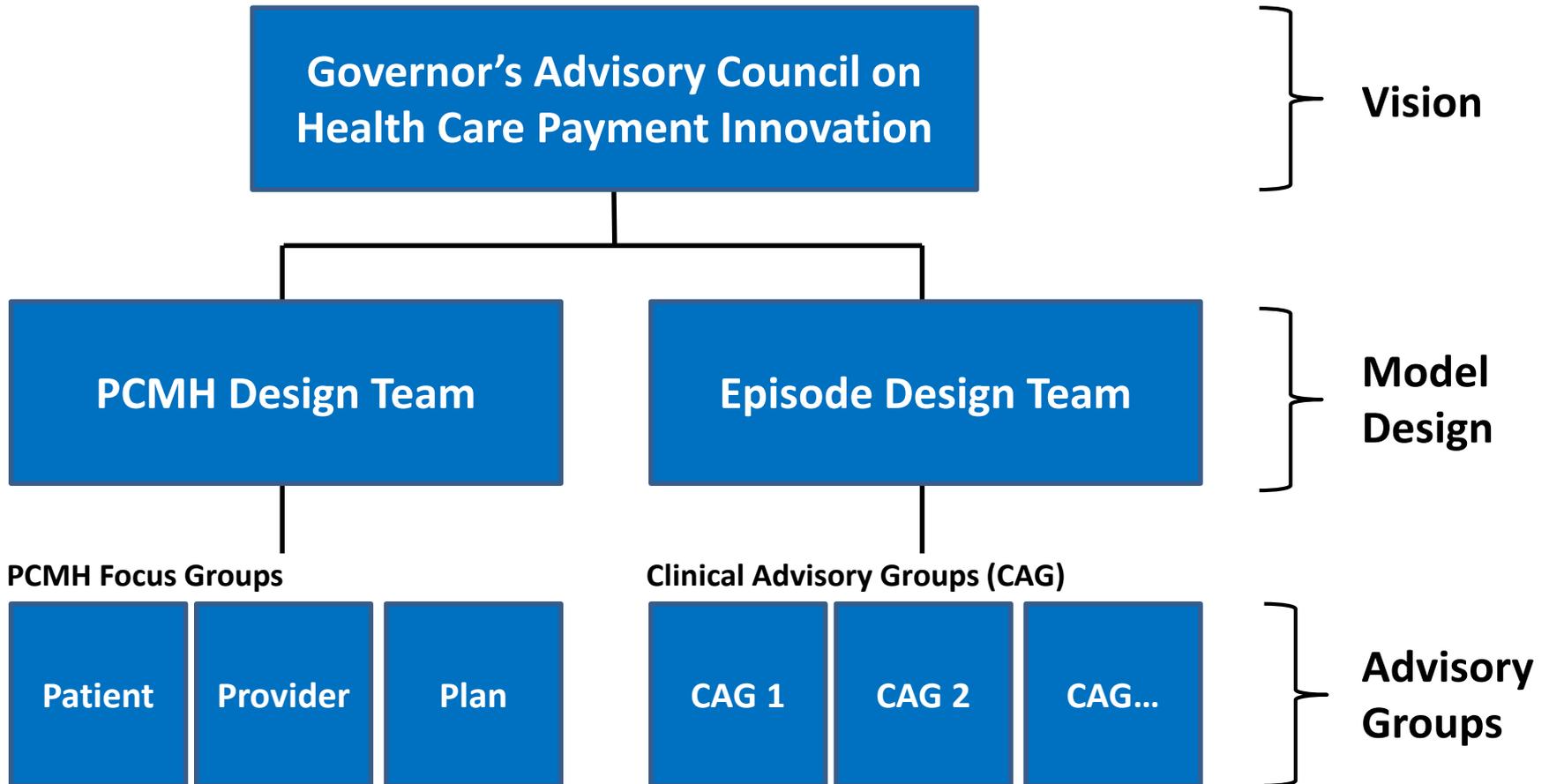
[www.HealthTransformation.Ohio.gov](http://www.HealthTransformation.Ohio.gov)



Modernize Medicaid	Streamline Health and Human Services	Pay for Value
<ul style="list-style-type: none"><li>• Extend Medicaid coverage to more low-income Ohioans</li><li>• Prioritize home and community based (HCBS) services</li><li>• Reform nursing facility reimbursement</li><li>• Integrate Medicare and Medicaid benefits</li><li>• Rebuild community behavioral health system capacity</li><li>• Enhance community developmental disabilities services</li><li>• Improve Medicaid managed care plan performance</li></ul>	<ul style="list-style-type: none"><li>• Support human services innovation</li><li>• Implement a new Medicaid claims payment system</li><li>• Create a cabinet-level Medicaid Department</li><li>• Consolidate mental health and addiction services</li><li>• Simplify and integrate eligibility determination</li><li>• Replace two disability determination systems with one</li><li>• Coordinate services for children</li><li>• Share services across local jurisdictions</li></ul>	<ul style="list-style-type: none"><li>• Engage partners to align payment innovation</li><li>• Provide access to medical homes for most Ohioans</li><li>• Implement episode-based payments</li><li>• Align population health planning and priorities</li><li>• Coordinate health information infrastructure</li><li>• Coordinate health sector workforce programs</li><li>• Support regional payment reform initiatives</li><li>• Federal Marketplace Exchange</li></ul>

**Many policy priorities are directly enabled by developments in technology, access to data, and sophisticated analytics**

# Ohio's payment innovation design team structure





# 5-Year Goal for Payment Innovation

## Goal

80-90 percent of Ohio's population in some value-based payment model (combination of episodes- and population-based payment) within five years

## State's Role

- Shift rapidly to PCMH and episode model in Medicaid fee-for-service
- Require Medicaid MCO partners to participate and implement
- Incorporate into contracts of MCOs for state employee benefit program

### Patient-centered medical homes

### Episode-based payments

## 2014

- In 2014 focus on Comprehensive Primary Care Initiative (CPCi)

- State leads design of six episodes: asthma acute exacerbation, COPD exacerbation, perinatal, acute and non-acute PCI, and joint replacement

## 2015

- Collaborate with payers on design decisions and prepare a roll-out strategy

- State leads design of seven new episodes: URI, UTI, cholecystectomy, appendectomy, GI hemorrhage, EGD, and colonoscopy

## 2016

- Model rolled out to at least two major markets

- 20 episodes defined and launched across payers, including behavioral health

## 2017-2018

- Model rolled out to all markets
- 80% of patients are enrolled

- 50+ episodes defined and launched across payers, including behavioral health

# Significant progress implementing episode-based payment model ...

## Principles for selection:

- Leverage episodes in use elsewhere to **reduce time to launch**
- Prioritize meaningful **spend across payer populations**
- Look for opportunities with **clear sources of value** (e.g., high variance in care)
- Select episodes that incorporate a **diverse mix** of accountable **providers** (e.g., facility, specialists)
- Cover a **diverse set of “patient journeys”** (e.g., acute inpatient, acute procedural)
- Consider **alignment with current priorities** (e.g., perinatal for Medicaid, asthma acute exacerbation for youth)

## Ohio’s episode selection:

### *Episode*

### *Principal Accountable Provider*

#### **WAVE 1 (launched March 2015)**

- |                                    |                                     |
|------------------------------------|-------------------------------------|
| 1. Perinatal                       | Physician/group delivering the baby |
| 2. Asthma acute exacerbation       | Facility where trigger event occurs |
| 3. COPD exacerbation               | Facility where trigger event occurs |
| 4. Acute Percutaneous intervention | Facility where PCI performed        |
| 5. Non-acute PCI                   | Physician                           |
| 6. Total joint replacement         | Orthopedic surgeon                  |

#### **WAVE 2 (launch January 2016)**

- |                                |                                  |
|--------------------------------|----------------------------------|
| 7. Upper respiratory infection | PCP or ED                        |
| 8. Urinary tract infection     | PCP or ED                        |
| 9. Cholecystectomy             | General surgeon                  |
| 10. Appendectomy               | General surgeon                  |
| 11. Upper GI endoscopy         | Gastroenterologist               |
| 12. Colonoscopy                | Gastroenterologist               |
| 13. GI hemorrhage              | Facility where hemorrhage occurs |

#### **WAVE 3 (launch January 2018)**

- 14-19. Package of behavioral health episodes to be determined



*This is an example of the reports the plans listed above made available to providers beginning in March 2015*

# EPISODE of CARE PAYMENT REPORT

PERINATAL

Jul 1, 2013 to Jun 30, 2014

Reporting period covering episodes that ended between July 1, 2013 and June 30, 2014

PAYER NAME: Ohio - Medicaid FFS

PROVIDER CODE: 1234567

PROVIDER NAME: XYZ Women's Health Center

You would be eligible for gain or risk sharing of N/A<sup>1</sup>

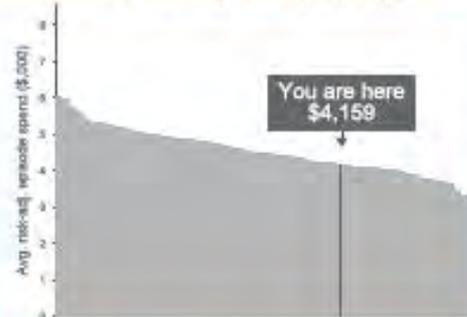
## Episodes inclusion and exclusion

Total episodes: 154



## Risk adjusted average spend per episode

Distribution of provider average episode spend (risk adj.)



## Episodes risk adjustment

**95%** of your episodes have been risk adjusted

## Quality metrics

Your performance on quality metrics that will be ultimately linked to gain sharing

HIV screening	53%
GBS screening	71%
C-section	31%
Follow-up visit	30%

## Potential gain/risk share

N/A<sup>1</sup>

<sup>1</sup> Not applicable during reporting-only period

## **Principles and Guidelines**

- First, do no harm by being overly prescriptive in data or infrastructure standards
- Assume the market's natural tendency is to solve several of these types of problems, although one way that markets fail is when incentives are not aligned for market participants
- Accelerate private sector innovation and adoption of innovative technologies
- Emphasize areas where the state already has assets and capabilities
- Deliver near term achievements that solidify the trajectory toward long-term goals

## Ohio's Preliminary HIT Strategy

# Landscape of Themes and Desired Outcomes

Rewarding Value	Performance Transparency	Care Coordination	Operational Efficiency	Non-Clinical Decisions	Clinical Decisions	Patient Engagement
Needed payer infrastructure, tools and data	Stakeholder alignment on metrics	Data formats enable sharing	Digitalization	Integration, curation of internal data	Researchers can access needed data	Infrastructure, tools, data to monitor patients
Channels to share data	Useable data captured	Needed data captured	Workflow automation	Access to external data	Researchers capable of analyzing data	Channels for patient/provider communication
Providers can accept payments	Providers have data to self-evaluate	Infrastructure to communicate	Automation of manual activities	Analytic infrastructure	Clinicians can access needed data	Consumers have control over medical record
Common use of capabilities across payers where needed	Payers have data to evaluate providers	Channels to access data	Technology spend optimized	Analytic tools and talent	Channels, tools to support clinical decisions	Consumers have access to health information to make decisions
	Consumers have data to evaluate providers	Data owners provide data	Intermediation cost reduced	Analytics for program assessment	Clinicians equipped to use tools, data	
	Sufficient analytic capacity	Providers use data				
	Channels to access data	Bi-directional communications				
		Transitions of care enabled				

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**State = Actor: actions that improve state run programs**

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**State = Catalyst: lead health care change for all Ohioans**

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**Priorities for State Action**

## Ohio's Preliminary HIT Strategy

# Market Progress

*The market is addressing many technology related outcomes ...*

### Selected Themes

### Selected examples of progress made in Ohio

#### Rewarding Value

- Payers and health IT innovators are developing the infrastructure and analytics to reward providers for value-based care

#### Performance Transparency

- Consumers are increasing demand for transparency as out-of-pocket costs grow, leading to innovative solutions for consumers

#### Care Coordination

- There is significant exchange of clinical data among providers when there is incentive to do so: CliniSync and HealthBridge (HIEs in Ohio) have made progress establishing data exchange capabilities covering nearly 90% of Ohioans; a large EHR vendor dropped fees for data-sharing outside of its EHR

#### Clinical Decisions

- The private sector is responding to demand for improved clinical-decision making and meeting the need to analyze large clinical data sets to identify care opportunities on an individual or system-wide basis

#### Patient Engagement

- Payers and employers recognize the need to engage patients and have been creating demand for innovative ways to do this, for example, companies that help consumers compare healthcare costs and quality

# Ohio's Preliminary HIT Strategy

## Market Challenges

*... the market has challenges where the State can focus*

Selected Themes	Technology-oriented outcome	Examples of challenges
<b>Rewarding Value</b>	<ul style="list-style-type: none"><li>Common use of capabilities across payers where needed</li></ul>	<ul style="list-style-type: none"><li>EHR vendors may create barriers to data sharing for cost or competitive purposes</li><li>Payers are reluctant to share cost data due to administrative burden and competitive concerns</li></ul>
<b>Performance Transparency</b>	<ul style="list-style-type: none"><li>Providers have data to self-evaluate</li><li>Consumers have data to evaluate providers</li></ul>	<ul style="list-style-type: none"><li>Private sector stakeholder have limited data and/or incentive to define and share performance information with providers using data from multiple payers</li><li>Data that may be useful for consumers to make better decisions about their care is either not accessible or not easy to interpret</li></ul>
<b>Care Coordination</b>	<ul style="list-style-type: none"><li>Data owners provide data</li><li>Transitions of care enabled</li></ul>	<ul style="list-style-type: none"><li>Data that may be useful to enable providers to improve their performance is either not easy to interpret or may face legal or competitive barriers</li></ul>
<b>Non-Clinical Decisions</b>	<ul style="list-style-type: none"><li>Analytic tools and talent</li></ul>	<ul style="list-style-type: none"><li>Accessing the right analytical skills to use diverse and complex data sets will be challenging and costly for the state as demand for these skills outstrips supply, resulting in potentially missed opportunities to make better decisions around program effectiveness and policy-making</li></ul>

## Ohio's Preliminary HIT Strategy

# Four Priorities for State Action

State Action	Description
<b>1. Share useful payer data to help providers improve</b>	<ul style="list-style-type: none"><li>▪ Design and deliver multi-payer (Medicaid, Medicare, commercial) data/reports to primary accountable providers (PAPs), Patient-Centered Medical Homes (PCMHs), and key participating providers, including actionable performance data and data about other providers that interact with patients; add commercial payer data as interested</li></ul>
<b>2. Reinforce and accelerate care coordination</b>	<ul style="list-style-type: none"><li>▪ Encourage/require PAPs and/or PCMH to develop stronger clinical (e.g., admission, discharge, transfer notifications) and administrative (e.g., appointment scheduling) linkages with other providers</li></ul>
<b>3. Improve usability and access to data</b>	<ul style="list-style-type: none"><li>▪ Continue/accelerate efforts to integrate data sets (e.g., Medicaid FFS, Medicaid encounter), expand access to data to internal and external stakeholders (e.g., researchers, providers, etc.) , and create potential for other parties (e.g., private health plans) to add data over time</li></ul>
<b>4. Use Big Data to improve programs and policy</b>	<ul style="list-style-type: none"><li>▪ Create (or repurpose) a public-private partnership to apply Big Data and Advanced Analytics to the state's most pressing policy issues</li></ul>



Governor's Office of  
Health Transformation

# Ohio's Health Information Technology Strategy: Detail on Four Priorities for State Action

[www.HealthTransformation.Ohio.gov](http://www.HealthTransformation.Ohio.gov)

# The Eight Fundamental Conundrums of the Health Reform Era

*Considerations for HIT Investment for State  
Innovations Models (SIM) Programs*

*Panelist: Troy Trygstad  
September 29, 2015*



**Conundrum #1:** Transition from Fee-For-Service to Fee-For-Value and Accountability is more than just measurement and Payment Reform, *it's about practice transformations to Population Management*

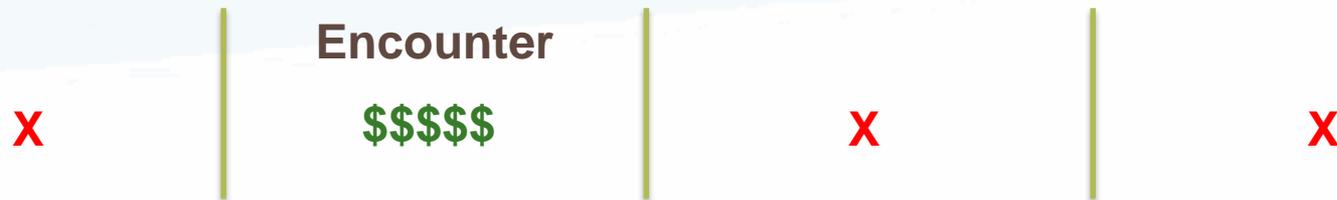


Community Care  
of North Carolina

# The 4 States of Patient Existence



- **Fee-For-Service**



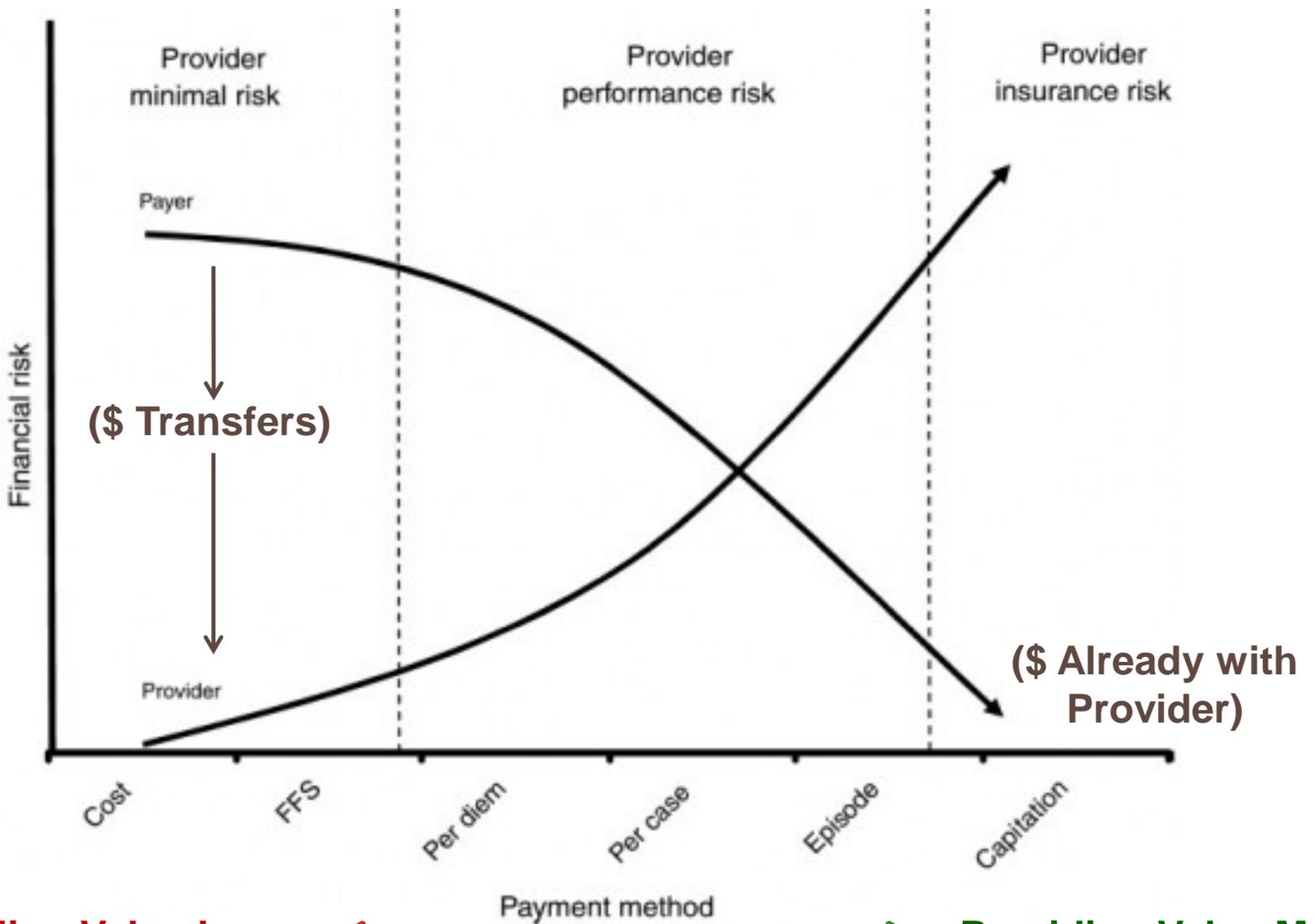
- **Population Management**



**Conundrum #2:** Transition from Fee-For-Service to Fee-For-Value— *how can Providers Live in Two Houses Simultaneously?*



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**Providing Value Less Important to Provider**

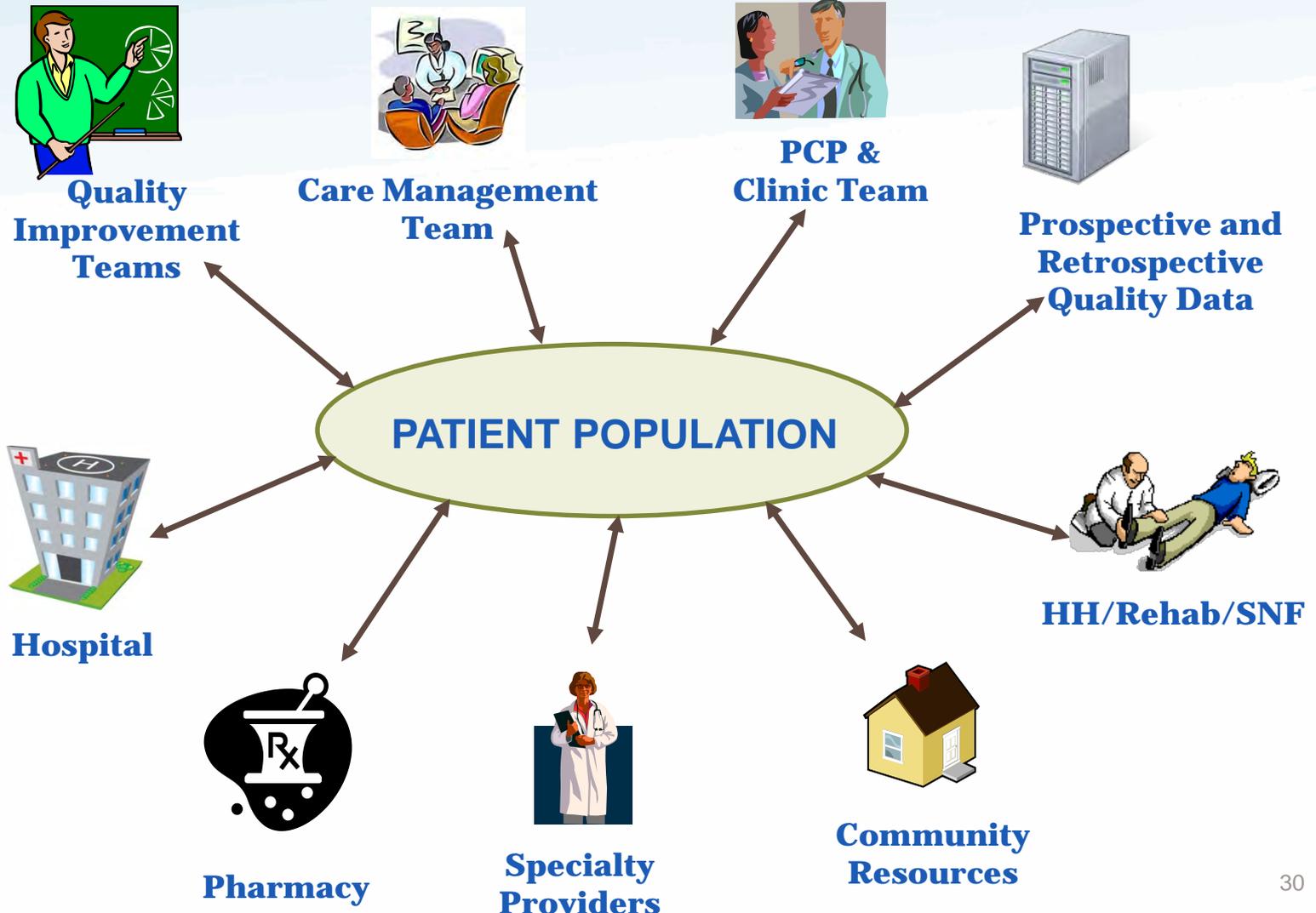


**Providing Value More Important to Provider**

**Conundrum #3: Coordinated Care =  
Shared Responsibilities = Shared  
Accountability = Shared Metrics = Shared  
Success**



# The Medical Neighborhood



# Conundrum #4: How to promote, measure and “score” the “Substitution Effect”



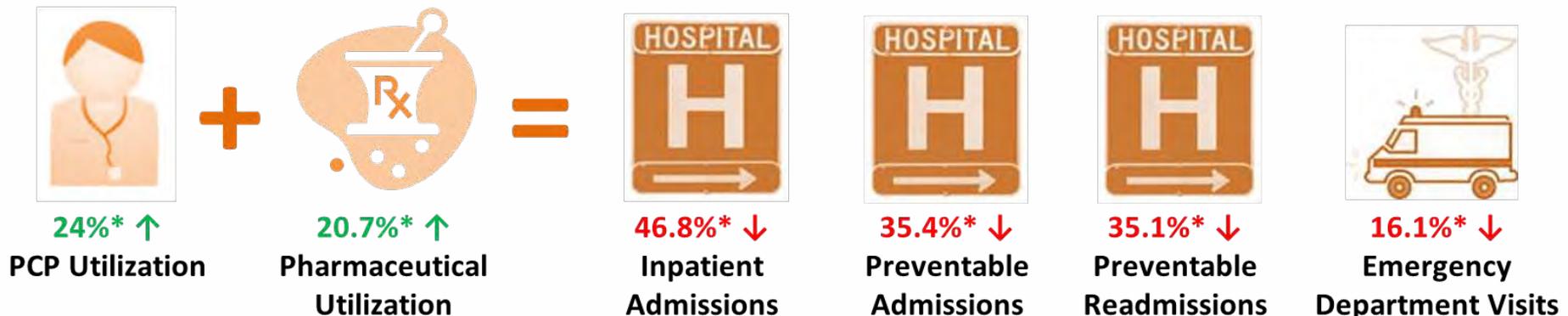
# Value-Based Payment Models have Offsets



What is the end goal?

What are patients, employers, taxpayers paying for?

Some expenditures are investments, others are the result of *lack* of investment



\*Absolute percentage difference between actual and expected rates for CCNC enrolled vs. unenrolled  
Treo Solutions Performance Analysis: Healthcare Utilization of CCNC-Enrolled Population - 2010 ABD Enrolled vs. ABD Unenrolled

# Conundrum #5: The Investment Model- Time Horizon matters

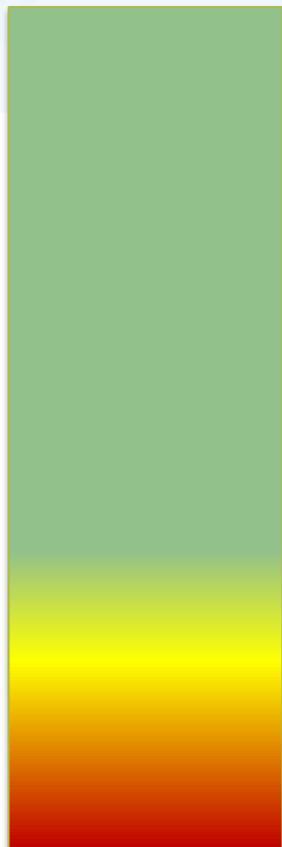


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# Fee For Value, Shared Savings and Capitation *Duality of Effort*



Population Risk



Return on Intervention Investment in Years 6-80  
(e.g. Vaccines, Well Child Visits)

Return on Intervention Investment in Year 2-5  
(e.g. Care Gaps)

Return on Intervention Investment in Year 1  
(e.g. Transitional Care)

Quality of Care Efforts

Cost Savings Efforts

**Conundrum #6: The Need for Sub-Population Specific Foci and the resulting Lack of Harmonization of Key Performance Metrics**



# ACO KPI Chaos



# Conundrum #7: Consumerism

*(Thank you Amy O' Donnell 😊 )*



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# The New Health Care Team Member.....

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- Can I take this if I am pregnant?
  - 281,000,000 hits
- What can I take to lose weight?
  - 153,000,000 hits

# Increasing cost share and price sensitivity.....



FierceHealthPayer

NEWS TOPICS ANALYSIS FEATURE

Topics: Financial Management | Legal / Regulatory / Risk Management | Operations & Business Management

## High-deductible plans, health savings accounts could repair the ACA

September 2, 2015 | By Leslie Small

## High Deductible Health Plans: Increasing in Popularity with Consumers and What That Means for Hospitals

Date 4/15/2015 Posted in April-May 2015, Hospitals

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### RELATED CONTENT

Patients' cost sensitivity worries some doctors

## High-deductible plans dominate next open enrollment

By Bob Herman | November 13, 2014

A single, 40-year-old nonemaker making \$35,000 a year in Terre Haute, Ind., can

# Conundrum #8: The chasm between Population Analytics and Practice



Community Care  
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# The Grand Canyon of Analytics

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**Population  
Management  
Analytics**

**Practice  
Workflow**

# High Level Recommendations



# High Level Recommendations

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- Design, build and support (or modify existing system) to **ensure a “continuity layer” exists** across payers, providers and consumers (*go with minimum viable product-don’t attempt to boil the ocean*)
- Consider **all types of credentials and care team members (including the patient)** when designing informatics to support SIM models (*but KISS on the capabilities offered-go for high value, not high complexity*)
- Design, build and support (or modify existing system) to **ensure a robust multi-payer claims database** with economic data is accessible by experts and organizations charged with mapping value, performance and trends (*over multiple time frames, short and long*)

# High Level Recommendations

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- Policy Makers should listen to:
  - ***Providers, Consumers and Payers*** when determining value proposition
  - ***CIOs, Technologists, and Vendors*** when determining feasibility and *which items should be on the “too hard” pile*

# Leaving you with this thought.....



.....which model is more likely to produce meaningful change?

Payment  
Innovation



Practice  
Transformation



Measurement  
Innovation

-or-

Measurement  
Transformation



Practice  
Transformation



Payment  
Innovation



# Follow-Up

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Troy Trygstad PharmD MBA PhD  
[troy@t2email.com](mailto:troy@t2email.com)

# Transforming Healthcare Through IT & Medical Home Support

**Trudi Matthews**  
Managing Director  
Kentucky REC

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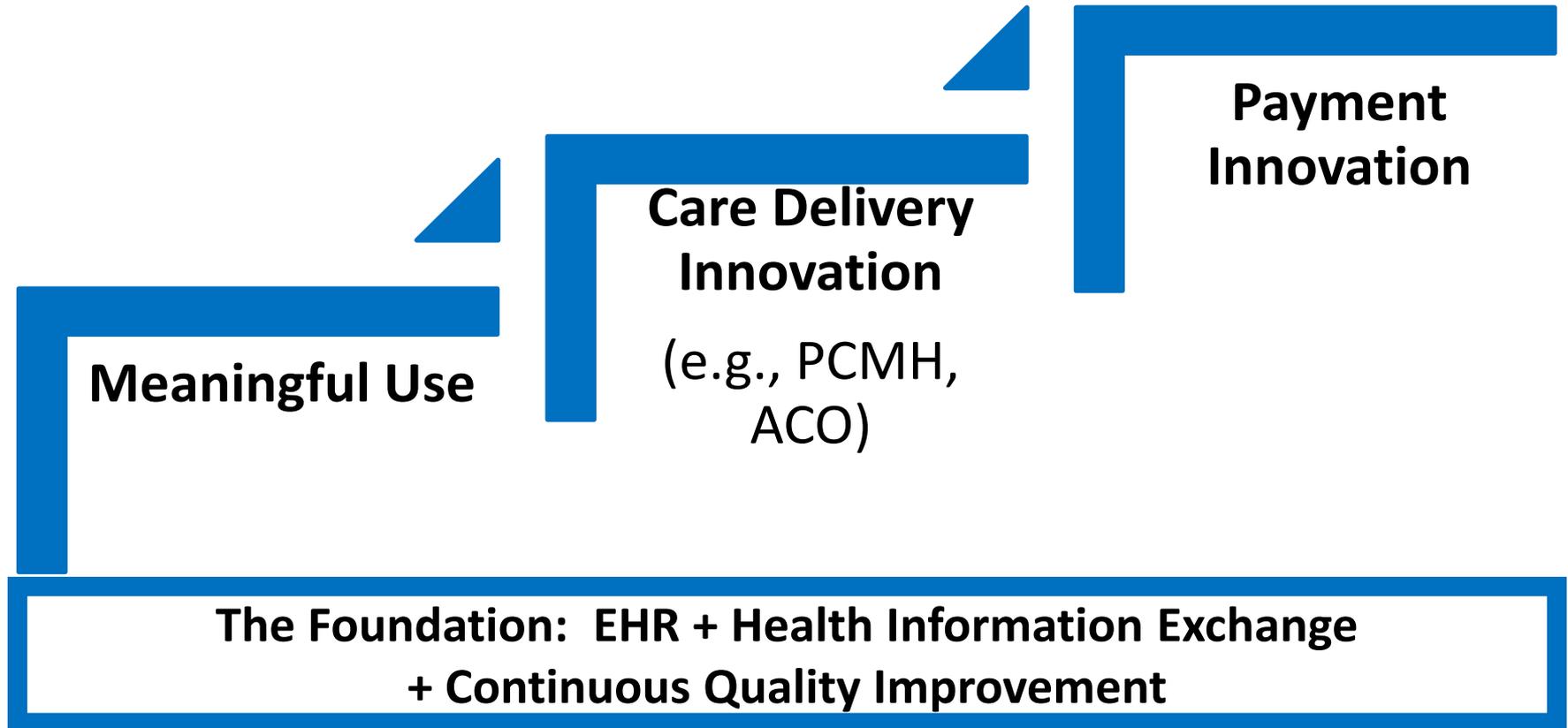


# Kentucky REC PCMH Support

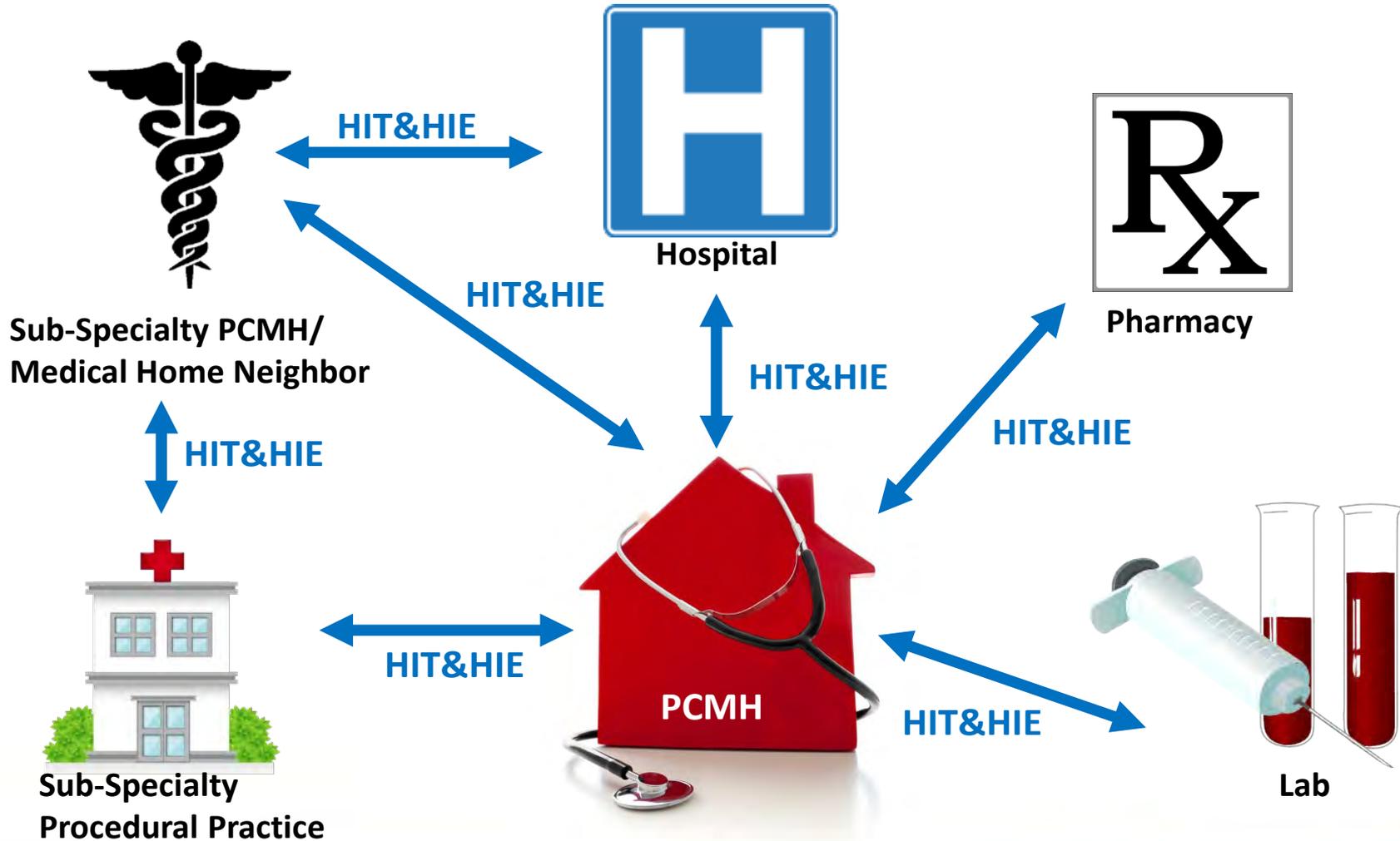
- Supporting practices since 2013; 3,000+ hours content and educational material development
- NCQA PCMH Recognition:
  - Level 3: 5 organizations/8 practice sites
  - Level 2: 2 organizations/4 practice sites
- Current PCMH Cohorts:
  - Started March 2015: 12 organizations/25 practice sites with 1 Specialty Practice
  - Kentucky Primary Care Association (KPCA) PCMH Cohort with 10 participants
  - Additional Fall/Winter 2015 Cohort Planned
- Additional enterprise support for health systems



# A journey of a thousand miles begins with a single step...



# Patient Centered Medical Homes are Just One Part of a Connected Medical Neighborhood



# Common Elements on the Payment Innovation Journey

- **Patient attribution**
- **Team Based Care and Empanelment**
- **Performance Measurement & Data Analysis**
- **High Risk Patient Identification & Care Management**
- **Care Coordination across the Medical Neighborhood**
- **Patient Engagement & Experience of Care**

# Selected Examples of 2014 PCMH Standards & Meaningful Use Crossover

**Care Management Element 3E: Implement Evidence-Base Decision Support (Clinical Decision Support)**

**Care Management Element 4A: Identify Patients for Care Management**

**Care Coordination Element 5A: Test Tracking and Follow-Up**

**Care Coordination Element 5B: Referral Tracking and Follow-Up**

**Care Coordination Element 5C: Coordinate Care Transitions**

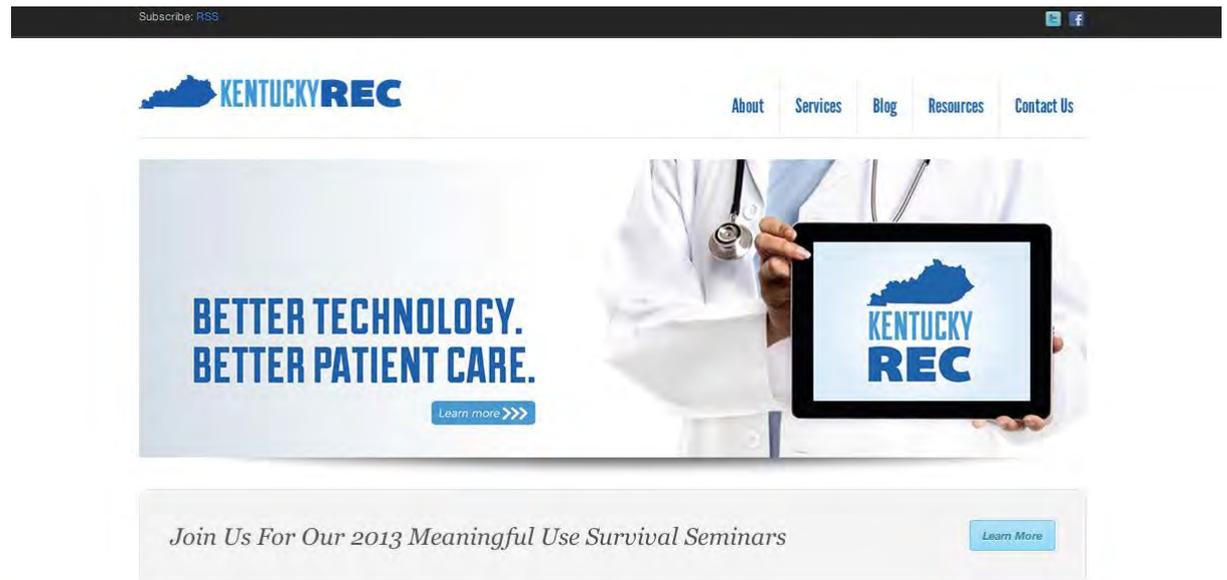
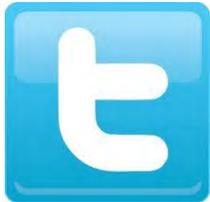
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# The Role of Technology in Providing Care Through a Physician-Led ACO

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Southern KY Healthcare Alliance ACO

# The Premise of ACOs

- ▶ Increase patient engagement to take more accountability for their health
- ▶ Improve patient outcomes
- ▶ Control or decrease medical costs

# Overview of ACO Technologies 1

## ▶ Analytics

- ▶ Understand patient attribution
- ▶ Understand patient's clinical needs
- ▶ Identifying opportunities to improve care quality
- ▶ Understanding cost of care

## ▶ Event Monitoring

- ▶ Admit / discharge notification
- ▶ Facilitate response / management of care transitions

## Overview of ACO Technologies 2

- ▶ Patient Outreach Capabilities
  - ▶ Call, txt, print, web, scheduling, etc.
  - ▶ Increase dialogue regarding patient's care and quality / preventive measures
- ▶ EMR / Care Platform
  - ▶ Support for health promotion / quality measure attainment (e.g., annual wellness visits)
  - ▶ Support for care coordination (e.g., shared care plans for complex patients)
  - ▶ Support for quality measure reporting, etc.

# ACO Success Factors

- ▶ Engaged physician leadership
- ▶ Ability to engage patients in care
- ▶ High value referral networks (working effectively with specialists, facilities, home health, etc.)
- ▶ Practice management buy-in
- ▶ Ability to address both planned and unplanned care

## Buy versus Source (technology)

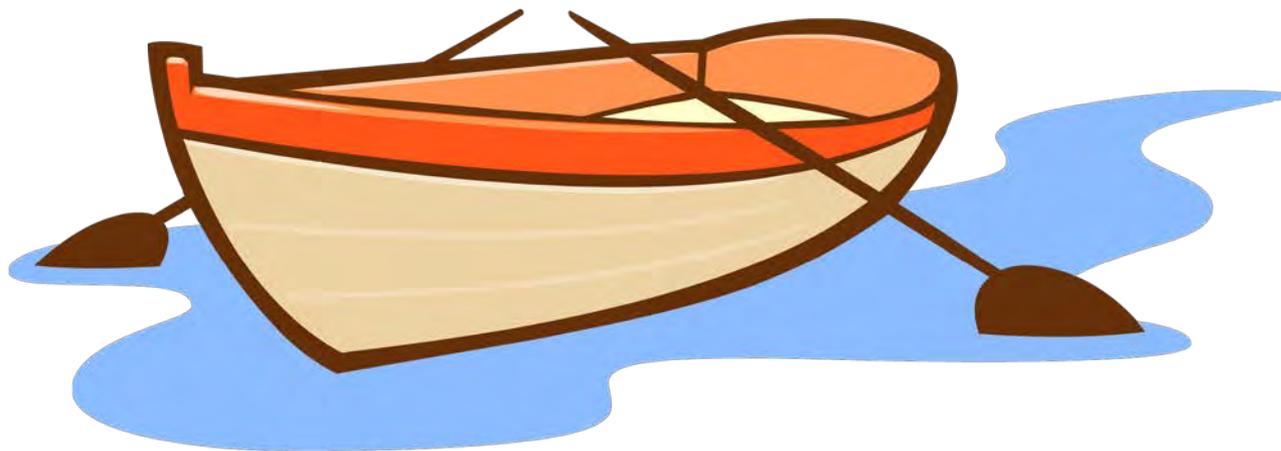
- ▶ ACOs have a tough decision when deciding to buy versus outsource these capabilities
- ▶ ACOs can take on different technology approaches based on the level of need and technology savviness of the ACO
- ▶ ACOs can find companies to partner with to fill technology gaps



**EY Entrepreneur  
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*2015 Award Winner*

# RowdMap



## Payer-Provider Risk-Readiness<sup>sm</sup>

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# In a nutshell...



Get to know gov data especially variation & risk

Rank your markets and docs by Risk-Readiness

Match your docs & markets w/ the right arrangements

Build your business & negotiate around this



# New Powerful Data on Every Provider, Market and Health Plan in the US



HEALTH POLICY  
**Medicare to Publish Physician-Payment Data Yearly**  
Move Gives Public Access to How Tens of Billions Are Spent Annually

**HHS.gov**  
U.S. Department of Health & Human Services

FOR IMMEDIATE RELEASE  
January 26, 2015

**Better, Smarter, Healthier:** In historic announcement timeline for shifting Medicare reimbursements from  
In a meeting with nearly two dozen leaders representing consumer Health and Human Services Secretary Sylvia M. Burwell today announced the move the Medicare program, and the health care system at large, rather than the quantity of care they get

## CMS: 50% of FFS will be gone by 2018

THE WALL STREET JOURNAL. | U.S.

*Current payment models aren't changing provider behavior. Providers need help.*  
Effects of Health Care Payment Models on Physician Practice in the United States, May 2015.



**CMS is releasing new, powerful data to support their goals of transitioning providers in to Pay for Value**

RowdMap



# Providers often Perform Better against These Metrics than Traditional Payer Evaluations



At the core of Risk-Readiness<sup>SM</sup> is

## Unwarranted Variation:

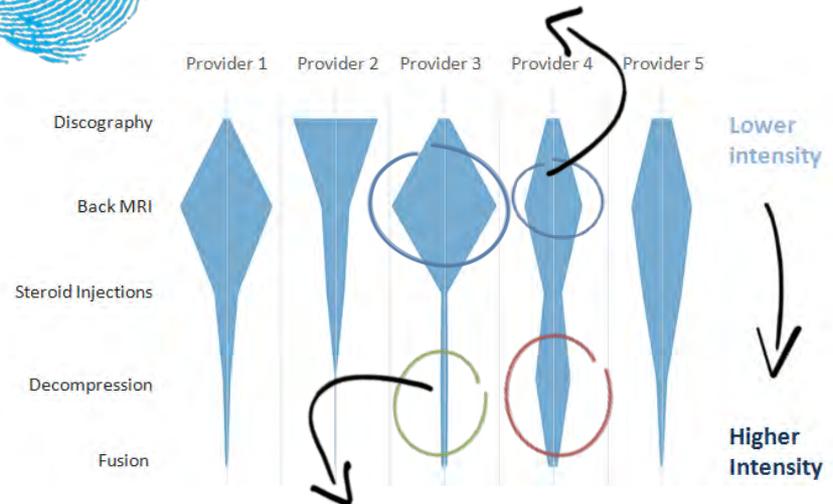
Every provider has a unique practice pattern that informs Risk-Readiness<sup>SM</sup>



Apply the Dartmouth Atlas for Unwarranted Variation methodologies to the newly released CMS data. This research has been repeatedly validated over the last 30 years and we now have a national data set to apply the methodologies at a large scale.



This doctor has lower utilization and unit costs



But this doctor is making money for whoever owns the risk

Often, physicians with practice patterns that create value for whoever owns risk do not receive the right compensation from traditional payer utilization review and actuarial analysis

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# Win Is a Virtuous Cycle where Providers with Less Unnecessary Spend Have More Membership

Unnecessary Spend in Louisville  
By condition across hospitals,  
groups and physicians



**Hospital Marketshare**  
by Major Clinical Categories



**Provider Group Marketshare**  
by Major Clinical Categories



**Physician Marketshare**  
by Major Clinical Categories



Decrease market share of this group for ortho

Increase market share of this group for ortho

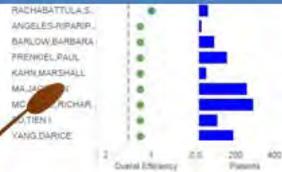
System goal is virtuous cycle where providers with lower rates of unnecessary care have higher market share. Fastest path may come from payers, employers and new network design and optimization.



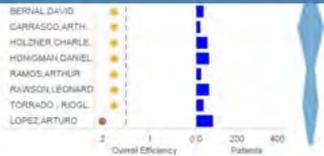
# Market Is Consolidating around Narrow Networks often Using This Data



What if you knew which providers would drive your success?



What if you knew which providers would sink you?



**CMS: 50% of FFS will be gone by 2018**

THE WALL STREET JOURNAL | U.S.

Here's who will win and who will lose



Payers buying providers who mitigate unnecessary spending and private equity groups accelerating groups to this. The newly released data can identify hidden value in providers.



# New Public Data Shows Risk-Readiness <sup>SM</sup> and Drivers for Groups, Individual Physicians

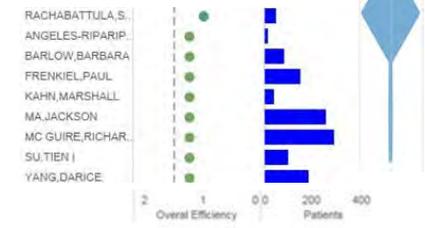


Match **appropriate risk arrangements** based on **provider practice patterns** and **Population characteristics** within a geography

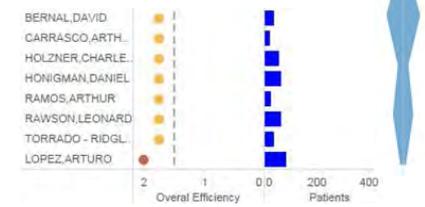
**PROVIDER RISK CONTINUUM**

	FFS Only	P4P Bonus	Upside Only	Partial Risk	Bundled Payments	Shared Savings/ Risk	Total Cap (PMPM)	Other (MA Plan, etc.)
	<b>Increasing Risk</b>							
Current Weighting	%	%	%	%	%	%	%	%
Conservative Scenario Target	%	%	%	%	%	%	%	%
Moderate Scenario Target	%	%	%	%	%	%	%	%
Aggressive Scenario Target	%	%	%	%	%	%	%	%

Great profile for aggressive risk



Tread carefully on path to risk

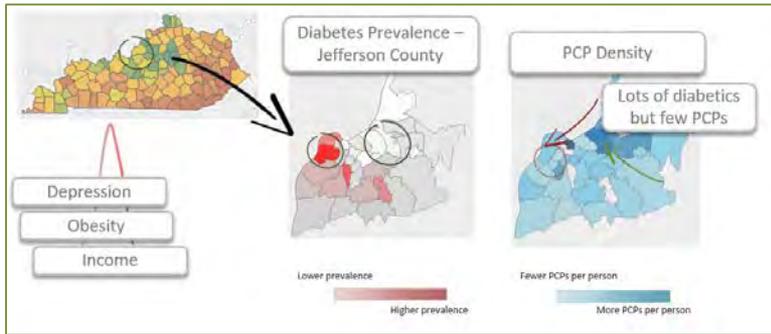


Practice patterns for unnecessary spending and no-value care benchmarked nationally and regionally inform government programs and payer-based risk arrangements

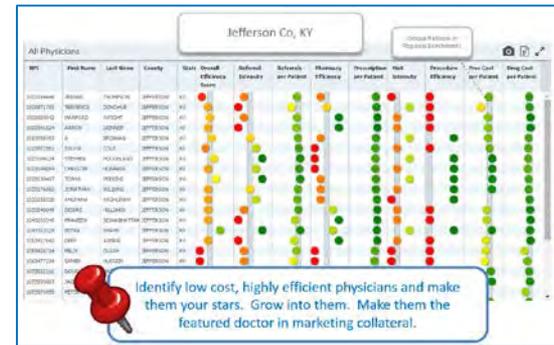




### 1 Population Health Reporting Plan from prevalence & physician supply

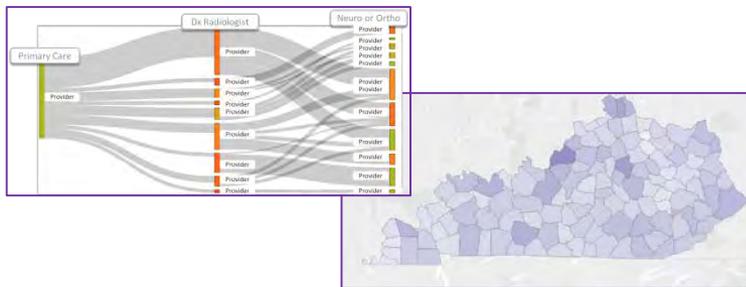


### 2 Risk-Readiness SM Reporting Match your performance to the right arrangements



Every group, physicians, hospital and post-acute center in KY

### 3 Unnecessary Costs Reporting Manage clinical care and costs

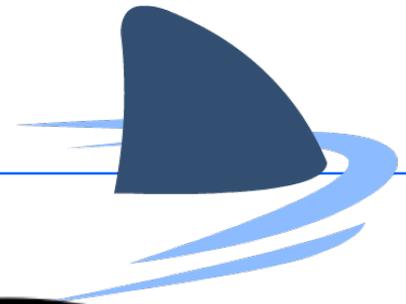


### 4 Payer Report Cards Negotiate with insurers using government benchmarks



# SIM TRENDS

## Risk-Readiness <sup>SM</sup>



This Is Real, a National Trend

Payers are using public data for risk and design

Risk-bearing providers are getting in the game



US CTO on using this public data: "Visionary Genius"



The government has the data and the private sector has the innovators. How can the two join forces to make us healthier and reform the nation's health care system? Tech Tuesday explores open data, public-private partnerships and how they could improve your health as Kojo broadcasts live from this week's Health Datapalooza in Washington, D.C.



Guests



**Todd Park** | Chief Technology Officer, The White House



**Josh Rosenthal, PhD** | Co-Founder & CSO, RowdMap



**Bryan Sivak** | Chief Technology Officer, US Department of Health & Human Services (HHS)



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### Everything you need to Belly Up

[Referrals: <http://1.usa.gov/1FzoEOV>]

[Variation: <http://go.cms.gov/1D8j7LE>]

[Shared Savings: <http://go.cms.gov/1Hh8vx0>]

[Medicare FFS Part B: <http://go.cms.gov/OCmyoy>]

[Medicare FFS Part D: <http://bit.ly/1mGyBxk>]

[Medicaid: <http://go.cms.gov/1z7b5ic>]

[Dartmouth: <http://bit.ly/1GXvIJp>]

[Behaviors: <http://1.usa.gov/1PzciST>]

[Health Data All Stars: <http://bit.ly/1GAsVC3>]

