The Next Generation of Care Collaboration

Building Your Business Case in a Value-Based Market

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Core Solutions, Inc.

Adam Bauer
Senior Manager
Deloitte Consulting
Outline

1. Journey To Care Collaboration
2. Collaborative Healthcare Ecosystem
3. Building Your Business Case in a Value-Based Market
4. History Of Exchanging Health Information
Journey To Care Collaboration
Maturity Continuum

Source: Seven Habits of Highly Effective People, Dr. Stephen R. Covey

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Industry Maturity

Sales Volume

<table>
<thead>
<tr>
<th>Fragmentation</th>
<th>Shakeout</th>
<th>Maturity</th>
<th>Decline</th>
</tr>
</thead>
</table>

Time

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## Industry Maturity

<table>
<thead>
<tr>
<th>Independence</th>
<th>Interdependence</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are different than physical health</td>
<td>“We need to work with the rest of the healthcare system to better serve our clients”</td>
</tr>
<tr>
<td>We are a small industry / agency/ organization</td>
<td>“We are an important part of the healthcare system”</td>
</tr>
<tr>
<td>It is difficult to measure what we do</td>
<td>“We need to adopt measurement based outcomes”</td>
</tr>
<tr>
<td>We have great stories about our services</td>
<td>“We have great data to prove the value we create in the healthcare system”</td>
</tr>
</tbody>
</table>
Organizational Maturity

Dependence
- Grant funding
- Narrow focus

Independence
- FFS Billing
- Interdisciplinary services
- Limited governance

Interdependence
- Value based
- Integrated care
- Strong governance
- Strong HIT foundation
- Data driven
- Strong board

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Collaborative Healthcare Ecosystem
Collaborative Health Ecosystem

- Regulators
- Investors
- Technology
- Data Science & Analytics
- Life Sciences
- Strategic Influencers
- Payers
- LTSS Providers
- Social Determinants of Health
- Person
- Behavioral Health Providers
- Medical Providers

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The Case for Change

- Unsustainable Costs
- Improper Incentives
- Treating the Symptom

2.5x
Per capita spending on health care compared to industrialized peers

5%
Portion of salary derived from quality

64%
Health portion of total U.S. health and social care spending

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Value-Based Care Drivers

Regulatory Pressure
Affordable Care Act
MACRA

Realigned Incentives
Shifted Targets
New Responsibilities

Reform Initiatives
BIP
DSRIP
Value-Based Care Models

Fee-for-Service (FFS)
- Volume-based model
- Low Risk

Shared Savings (P4P, P4Q, Medical Home)
- FFS until year-end reconciliation
- Incentives for achieving pre-defined cost and/or quality metrics
- No downside risk

Bundled Payments
- Arrangement with pre-determined reimbursement for clinically defined episodes
- Can include downside risk

Shared Risk
- FFS until reconciliation with upside and downside risk within a pre-determined corridor
- Members attributed to provider (typically by PCP)

Global Capitation
- Full-risk arrangement with provider bearing the full impact of any upside or downside risk
- Provider receives PMPM for attributed lives

Increasing Level of Risk and Capabilities Required

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Provider Positioning for Value-Based Care

- Provider Alignment
- Care Coordination
- Fee for Service
- Gain Sharing
- Pay for Performance
- Pay for Quality
- Medical Home
- Condition or Population-Focused ACO
- Global ACO
- Market-Balking – Hold the Line
- Optimize: Rate and Volume
- Optimize: Outcome and Value

Bubble Size = Savings Opportunity

Market Pressure – Dominant Provider
Market Pressure – Dominant Payer

Optimize: Outcome and Value

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Medi-Cal Whole Person Care pilot program initiated 2016

Texas announced plans to pilot Medicaid managed LTSS program in 2017

MassHealth design of Medicaid ACOs to incorporate Community Partnerships with LTSS providers

FIDA health plan targets the dual eligible population in NY State

CMS Accountable Health Communities attempts to address health-related social needs
Human Services Role in VBC

Cost Reduction
- Acute Care Needs
- System Utilization

Outcomes
- Personal Goals
- Adherence
- Behaviors

Experience
- Transparency
- Engagement
- Personalization

Social Determinants of Health

Person

LTSS Providers

Behavioral Health Providers

Medical Providers

Payers
Human Services Provider Maturity Model

<table>
<thead>
<tr>
<th>Enablers</th>
<th>Threshold</th>
<th>Status Quo</th>
<th>Raise the Bar</th>
<th>Change the Game</th>
<th>Transform</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy</strong></td>
<td>Meet day-to-day client needs</td>
<td>Sustain client service and operational viability</td>
<td>Achieve operational efficiency and service benefits</td>
<td>Broaden role of agency in client quality of life</td>
<td>Enable seamless healthcare as a community partner</td>
</tr>
<tr>
<td><strong>People</strong></td>
<td>Resistant to change</td>
<td>Adept at core functions; apply tools selectively</td>
<td>Competently apply a toolset to integrated workflows</td>
<td>Nimble across data sources, tools, and workflows</td>
<td>Embrace and apply technology for proactive care</td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td>Manual, disintegrated</td>
<td>Heavily manual, sub-optimal where automated</td>
<td>Core systems support essential process clusters</td>
<td>Automated tools and data integration to achieve efficiency</td>
<td>Tech-enabled workflows that re-define operations</td>
</tr>
<tr>
<td><strong>Technology</strong></td>
<td>Afterthought</td>
<td>Disparate back office and service program solutions</td>
<td>Integrated care delivery and revenue operations systems</td>
<td>EHR and integrated capabilities to manage health and quality</td>
<td>Ubiquitous mobile service and business management</td>
</tr>
</tbody>
</table>
Building Your Business Case in a Value-Based Market
What Can We Learn From CMS VBP?

- Core Measures
- Patient Experience
- Outcomes
- Efficiency (MSPB)
What Can We Learn From CMS VBP?

<table>
<thead>
<tr>
<th>FY</th>
<th>Applicable Domains &amp; Weights</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>Clinical Process of Care (10%)</td>
</tr>
<tr>
<td></td>
<td>Patient Experience of Care (25%)</td>
</tr>
<tr>
<td></td>
<td>Outcome (40%)</td>
</tr>
<tr>
<td></td>
<td>Efficiency (25%)</td>
</tr>
<tr>
<td>2017*</td>
<td>Patient and Caregiver-Centered Experience of Care/Care Coordination (25%)</td>
</tr>
<tr>
<td></td>
<td>Safety (20%)</td>
</tr>
<tr>
<td></td>
<td>Clinical Care (30%)</td>
</tr>
<tr>
<td></td>
<td>• Clinical Care – Outcomes (25%)</td>
</tr>
<tr>
<td></td>
<td>• Clinical Care – Process (5%)</td>
</tr>
<tr>
<td></td>
<td>Efficiency and Cost Reduction (25%)</td>
</tr>
<tr>
<td>2018</td>
<td>Patient and Caregiver-Centered Experience of Care/Care Coordination (25%)</td>
</tr>
<tr>
<td></td>
<td>Safety (25%)</td>
</tr>
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<td></td>
<td>Efficiency and Cost Reduction (25%)</td>
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What Can We Learn From CMS VBP?

![Image of data table and graph](http://www.qualityreportingcenter.com/wp-content/uploads/2015/02/IQR-FY2017_VBP-Domain-Weighting-Infographic.pdf)

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What Can We Learn From CMS VBP?


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What Can We Learn From MIPS

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Maximum Possible Points per Performance Category</th>
<th>Percentage of Overall MIPS Score (Performance Year 1 - 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality:</strong> Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-value measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.</td>
<td>80 to 90 points depending on group size</td>
<td>50 percent</td>
</tr>
<tr>
<td><strong>Advancing Care Information:</strong> Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.</td>
<td>100 points</td>
<td>25 percent</td>
</tr>
<tr>
<td><strong>Clinical Practice Improvement Activities:</strong> Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn &quot;full credit&quot; in this category, and those participating in Advanced APMs will earn at least half credit.</td>
<td>60 points</td>
<td>15 percent</td>
</tr>
<tr>
<td><strong>Cost:</strong> CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.</td>
<td>Average score of all cost measures that can be attributed</td>
<td>10 percent</td>
</tr>
</tbody>
</table>

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Key Takeaways

• Need to be able to measure and demonstrate improvements:
  • Quality/Outcomes
  • Consumer Experience
  • Cost
Our Biggest Challenge

Lack of Standardized Industry Outcomes
A National Call for Measurement-Based Care in the Delivery of Behavioral Health Services

All primary care and behavioral health providers treating mental health and substance use disorders should implement a system of measurement-based care whereby validated symptom rating scales are completed by patients and reviewed by clinicians during encounters. Measurement-based care will help providers determine whether the treatment is working and facilitate treatment adjustments, consultations, or referrals for higher intensity services

- Kennedy Forum


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BH Outcome Measures

Table 1: Adult Symptom Rating Scales for Core Outcome Measures

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>DOMAIN</th>
<th># OF ITEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9</td>
<td>Depression</td>
<td>9</td>
</tr>
<tr>
<td>Altman Scale</td>
<td>Mania</td>
<td>5</td>
</tr>
<tr>
<td>GAD-7</td>
<td>Anxiety</td>
<td>7</td>
</tr>
<tr>
<td>PCL</td>
<td>PTSD</td>
<td>20</td>
</tr>
<tr>
<td>PDSS_SR</td>
<td>Panic attacks</td>
<td>7</td>
</tr>
<tr>
<td>Audit-C</td>
<td>Alcohol</td>
<td>3</td>
</tr>
<tr>
<td>DAST-10</td>
<td>Drug abuse</td>
<td>10</td>
</tr>
<tr>
<td>PHQ-15</td>
<td>Somatization</td>
<td>15</td>
</tr>
</tbody>
</table>
BH Outcome Measures

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>DOMAIN</th>
<th># OF ITEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse Outcomes Module</td>
<td>Substance abuse</td>
<td>22</td>
</tr>
<tr>
<td>Brief Addiction Monitor (BAM)</td>
<td>Substance abuse</td>
<td>17</td>
</tr>
</tbody>
</table>
# BH Outcome Measures

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>DOMAIN</th>
<th># OF ITEMS</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional Outcomes Survey 20-Item Short Form (SF-20)</td>
<td>General medical and mental functional status</td>
<td>20</td>
<td>Scoring is relatively complex. Similar to the SF-36 and SF-12™</td>
</tr>
<tr>
<td>Daily Living Activities (DLA-20)</td>
<td>Functional outcomes</td>
<td>20</td>
<td>National Council for Behavioral Health</td>
</tr>
<tr>
<td>WHO Disability Assessment Schedule 2.0</td>
<td>Covers (6) domains of functioning (cognition, mobility, self-care, getting along, life activities, participation)</td>
<td>12- and 36-item version</td>
<td></td>
</tr>
</tbody>
</table>

*Note: These measures need to be administered on a frequent basis to assure their usefulness as a clinical support tool.*

## BH Outcome Measures

### Table 4: Child & Adolescent Rating Scales for Core Outcome Measures

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>DOMAIN</th>
<th>AGE VALIDATED AND # OF ITEMS</th>
<th>COMPLETED BY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Symptom Checklist (PSC)</td>
<td>Psychosocial dysfunction</td>
<td>35</td>
<td>Clinician</td>
</tr>
<tr>
<td>Modified Checklist for Autism in Toddlers (MCHAT)</td>
<td>Autism spectrum disorders</td>
<td>23</td>
<td>Clinician</td>
</tr>
<tr>
<td>CRAFFT</td>
<td>Substance abuse</td>
<td>9</td>
<td>Clinician</td>
</tr>
<tr>
<td>Mood and Feelings Questionnaire (MFQ)</td>
<td>Depression, dysthymia</td>
<td>7-17 yrs Long form (39 items) and short form (13 items)</td>
<td>Parent and youth</td>
</tr>
<tr>
<td>Patient Health Questionnaire Adolescent (PHQ-A)</td>
<td>Depression, dysthymia</td>
<td>12 – 19 yrs (9 items)</td>
<td>Youth</td>
</tr>
<tr>
<td>Vanderbilt ADHD Rating Scale-Parent</td>
<td>ADHD, scored for ADHD subscales, ODD, and conduct disorder, performance</td>
<td>6-17 yrs (55 items)</td>
<td>Parent</td>
</tr>
<tr>
<td>Vanderbilt ADHD Rating Scale-Teacher</td>
<td>As above</td>
<td>6-17 yrs (43 items)</td>
<td>Teacher</td>
</tr>
</tbody>
</table>
History Of Exchanging Health Information
A Difficult Patient
An Amazing Journey Towards Interoperability

2004
Creation of ONC

2006
CCHIT Certification

2006
HITEC ACT

2009
NHIN DIRECT

2011
S&I Framework

2013
Direct Trusted Agent Accreditation Program

2014
MU Stage 2

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Interoperability Options

- HIEs/RHIOs
- EHR – EHR Interoperability
- Direct Secure Messaging
Terms To Remember

• HISP
A Health Information Services Provider (HISP) is an organization that manages security and transport for health information exchange among health care entities or individuals using the Direct standard for transport.

• DIRECT
Direct is a technical standard for exchanging health information between health care entities in a trusted network.
Simple Use Case
Examples of Use Cases

• Primary care provider refers patient to specialist including summary care record
• Primary care provider refers patient to hospital including summary care record
• Specialist sends summary care information back to referring provider care record
• Hospital sends discharge information to referring provider
• Laboratory sends lab results to ordering provider
Electronic exchange of patient summary information among caregivers and other authorized parties via potentially disparate electronic health record (EHR) systems.
Creating “Value” from Interoperability

Individual with psychiatric issue is admitted to the ER

Notification to the BH Provider’s EHR

Automated text messages sent to Care team
Interoperability Adoption
Hospital Routine Electronic Notification

Percent of U.S. Hospitals that Routinely Electronically Notify Patient’s Primary Care Provider upon Emergency Room Entry

2015

- 2013 Routine Notification
- 2014 Routine Notification
- 2015 Routine Notification

- Routinely Notifies any Primary Care Provider
- Routinely Notifies Primary Care Providers Inside System
- Routinely Notifies Primary Care Providers Outside System

https://dashboard.healthit.gov/quickstats/quickstats.php

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Hospital Capability to Electronically Query

Percent of U.S. Hospitals’ with Capability to Electronically Query Patient Health Information from Outside Their Organization or System

2014

% of Hospital Providers Able to Electronically Query  % of Hospital Providers NOT Able or Capability Unknown

100%
75%
50%
25%
0

2012  2013  2014

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Evolving Nature of Accountable Care

• ACO Survey from Premier, Inc.
  
  • 79% of respondents indicated lack of interoperability with providers outside their ACO as their #1 challenge.
  
  • “Of all care settings, surveyed ACOs would most like to have greater interoperability with behavioral health and long-term/post-acute care (tied at 67%) to support operations,”


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Interoperability News

WHO

Stakeholders must have a way to identify each other and the patient. Stakeholders include: hospitals, physicians, offices, clinics, laboratories, pharmacies, payers (government and commercial), post-acute care, long-term care organizations, public health entities, researchers, and patients.

Essential Guidance
- Identify and identify stakeholders, including core entities, data partners, and affiliates.
- Use health care provider directories to identify and communicate with stakeholders.
- Use an EMR for patient matching using OCN-recommended data elements.

Advanced Guidance
- Incorporate both semantically exact and semantically similar data elements.

WHAT

Information can be pushed or pulled based on need, and privacy/confidentiality can be triggered by requests (e.g., for patient information) or events (e.g., transactions of care). Data can be used in real-time or stored for long-term retrospective uses (analytics and population health).

Essential Guidance
- Link data to relevant stakeholders based on event, condition, and content (e.g., hospitals should notify the patient during an admission or discharge).
- Ensure consent management capabilities based on national (ORR) and state laws (e.g., HIPAA, and state laws).
- Leverage FHIR's FHIR and MAML to access and administer data.
- Leverage FHIR's authentication, audit logs, and role-based access control to tightly control data and network access control. Export "data at rest" and use secure transport for "data in motion".

Advanced Guidance
- Conduct regular risk analyses and address weaknesses to comply with HIPAA regulations.

WHERE

Information transfer across the care continuum may be complicated by the need to cross local, regional, state, national, and even international boundaries.

Essential Guidance
- Data exchange mechanisms can include interface engines, firewalls, special-purpose networks, HIAs, HIPAA public and private at regional and state levels, and APIs.
- Exchange data across a range of applications and data, including IHE, EMR, big data, analytics, data warehousing, and various financial systems.

Advanced Guidance
- Connect to the national eHealth Exchange.
- Develop and implement dashboards to leverage data.
- Use standards such as IHE, XDS, and FHIR to bridge exchanges.

HOW

The strategy requirements for interoperability include: trust and mutual benefit among stakeholders; alignment with organizations’ and partners’ needs, standards, and clinical processes; and monitoring of progress.

Essential Guidance
- Ensure information and data exchange capabilities.
- Ensure data exchange between clinical and non-clinical data.
- Ensure data exchange with partners and vendors to support patient care processes.
- Ensure informatics data in patient-facing applications.

Advanced Guidance
- Implement a content management solution that supports privacy but does not affect patient medical care.
- Focus data governance efforts on PPS and other data exchange needs.
- Use the work of major interoperability initiatives such as Carequality and their trust framework, Confluent Health Alliance, and Project Argonaut.
- Target exchange to key beta testing and fully implementing regulations to achieve consumption accountability and accountable payment records.

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Next Generation Of Care Coordination
Exchange vs. Sharing

• Challenges with exchanging healthcare data
  • HIT Complexity
  • Lack of standardized data

• Sharing
  • Increased collaboration
  • Faster time to market
Exchanging Word Documents – Use Case

User A

Ver 1

User B

Ver 2
A More Efficient Way To Collaborate

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Applying Data Sharing To Healthcare
Open Discussions
Thank You