Integrating Care Across Health & Humans Services

Vermont Blueprint for Health
Annual Conference

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CMO, Acupera

Aligning Measurement Across Health & Human Services

Objectives

This session will provide participants the opportunity to review and discuss:

1. State examples using data to guide health and human services
2. The key ingredients to aggregate reliable population data
3. Strategies for using data to meet long term health and near term cost goals

Introduction and Context

New Payment Models Drive Population Health

APM FRAMEWORK

At-a-Glance

The Framework is a critical first step toward the goal of better care, smarter spending, and healthier people.

- Serves as the foundation for generating evidence about what works and lessons learned
- Provides a road map for payment reform capable of supporting the delivery of person-centered care
- Acts as a "gauge" for measuring progress toward adoption of alternative payment models
- Establishes a common nomenclature and a set of conventions that will facilitate discussions within and across stakeholder communities

HCP LAN

Population-Based Accountability

Category 1	Category 2	Category 3	Category 4
Fee for Service – No Link to Quality & Value	Fee for Service – Link to Quality & Value	APMs Built on Fee-for-Service Architecture	Population-Based Payment
	A Foundational Payments for Infrastructure & Operations	A APMs with Upside Gainsharing	A Condition-Specific Population-Based Payment
	B Pay for Reporting	B APMs with Upside Gainsharing/Downside Risk	B Comprehensive Population-Based Payment
	C Rewards for Performance		
	D Rewards and Penalties for Performance		

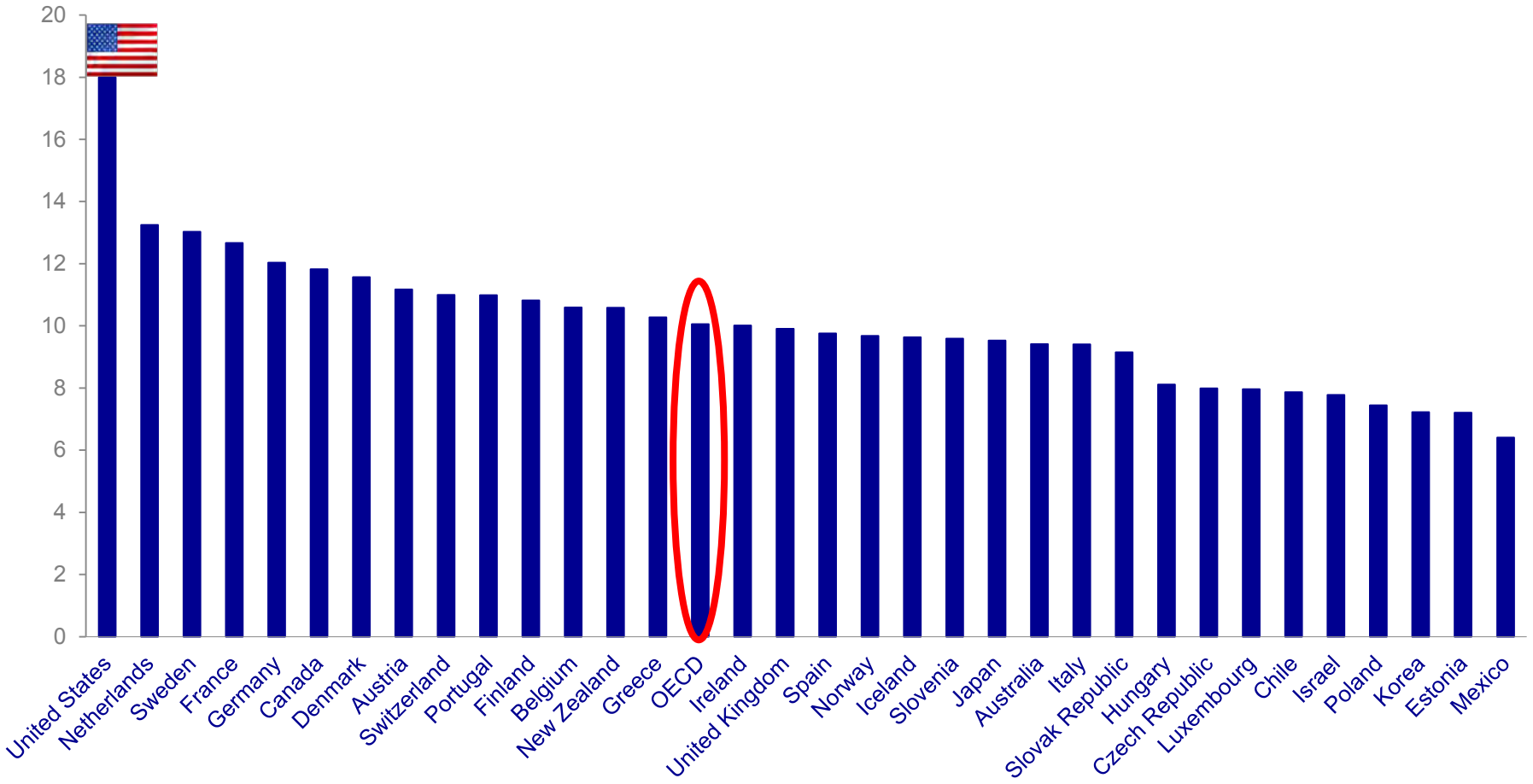
The framework situates existing and potential APMs into a series of categories.

Using Population Data to Guide a Value Based Learning Health System

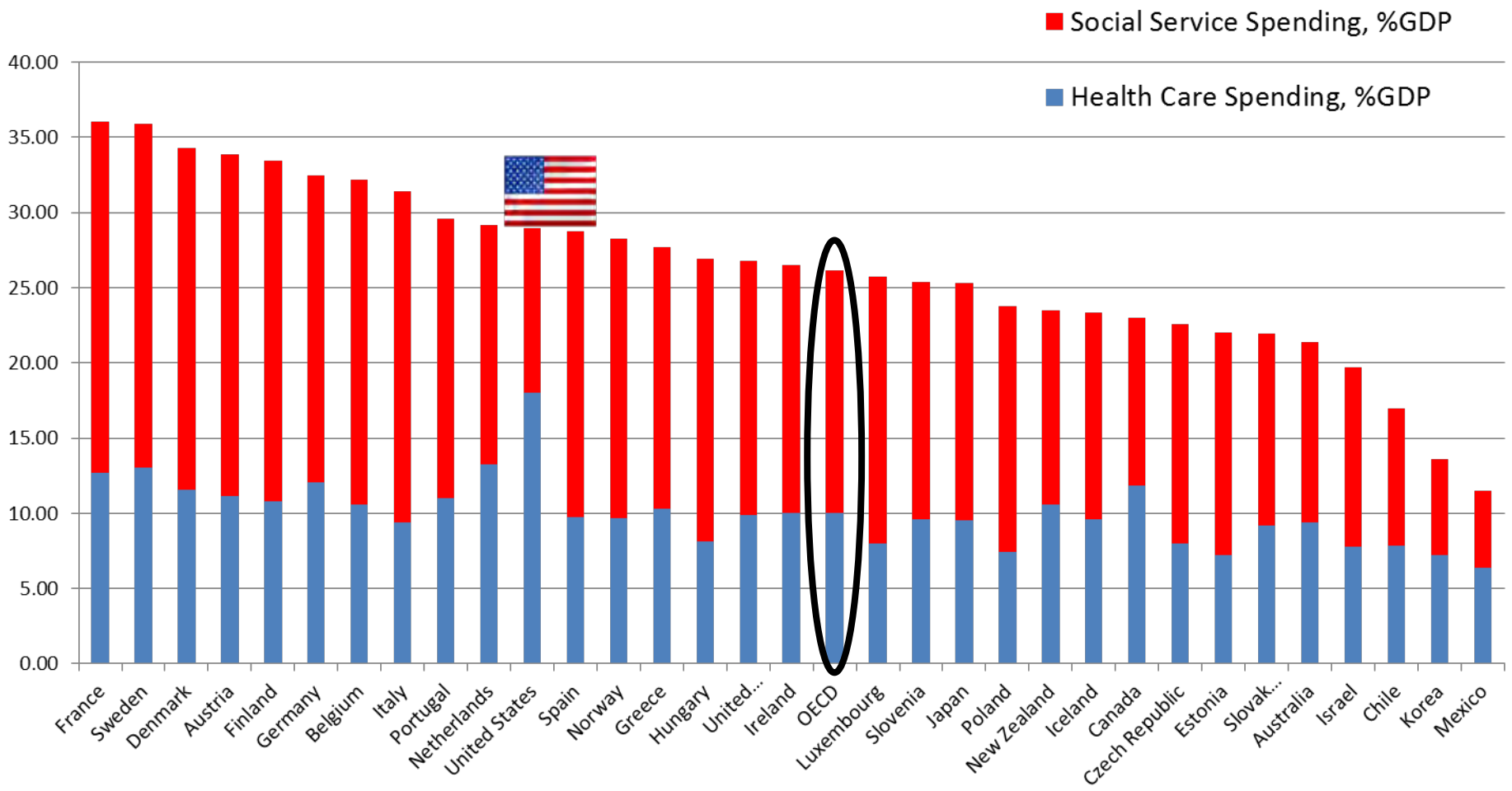
Use Cases

- Care management for people with complex needs
- Outreach and prevention for key populations
- Outcomes to evaluate program impact on core measures
- Comparative performance across settings (variation, drivers)
- Predictive models to meet health, quality, and cost goals

Health Expenditures as % of GDP, 2009



Total Investment in Health as % of GDP

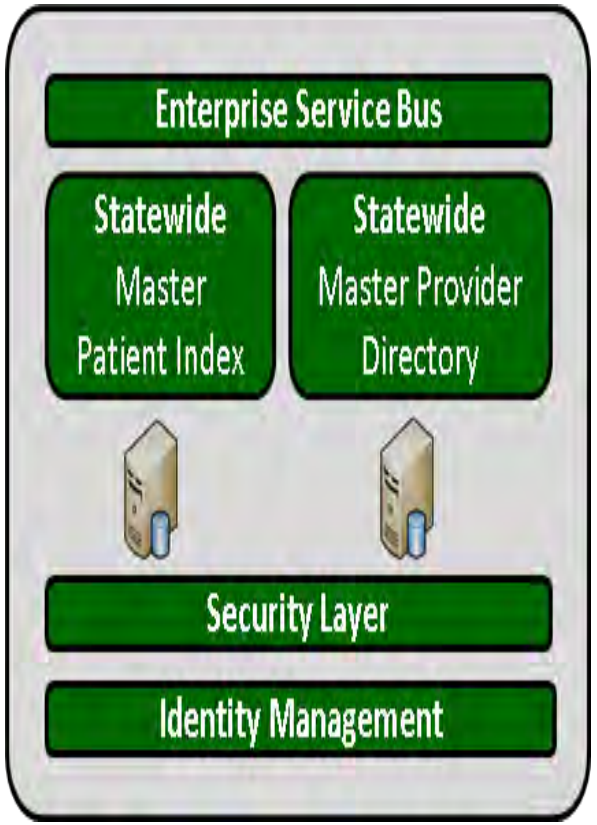


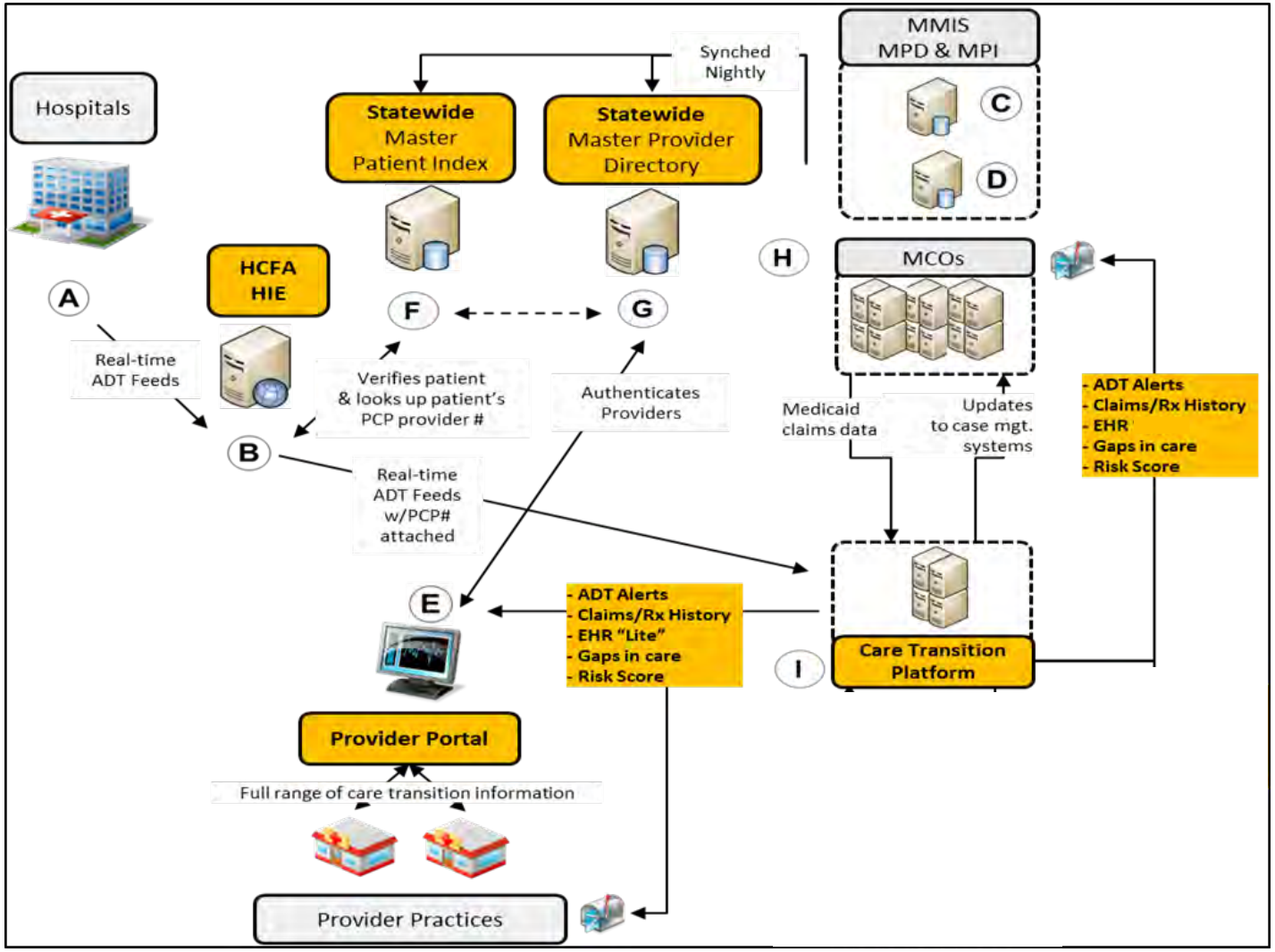
State examples using data to guide health and human services

Tennessee

- Primary care transformation
- Behavioral Health Integration
- Episodes of care
- Long-term services and supports
- Supportive Health Information Infrastructure
- Statewide Medicaid MCO
- Increasing participation of other payers
- CPC+ Program

Tennessee


Enterprise Service Bus
Statewide Master Patient Index
Statewide Master Provider Directory
Security Layer
Identity Management


Hospitals
Statewide Master Patient Index
Statewide Master Provider Directory
Synched Nightly
MMIS MPD & MPI
C
D
H
MCOs
HCFA HIE
A
F
G
Real-time ADT Feeds
Verifies patient & looks up patient's PCP provider #
Authenticates Providers
Medicaid claims data
Updates to case mgt. systems
- ADT Alerts
- Claims/Rx History
- EHR
- Gaps in care
- Risk Score
B
Real-time ADT Feeds w/PCP# attached
E
- ADT Alerts
- Claims/Rx History
- EHR "Lite"
- Gaps in care
- Risk Score
I
Care Transition Platform
Provider Portal
Full range of care transition information
Provider Practices

Maine

- Strengthen Primary Care
- Integrate Physical and Behavioral Health
- Develop New Workforce Models
- Support Development of New Payment Models
- Use Centralized Data and Analysis to Drive Change
- Engage People and Communities

Maine

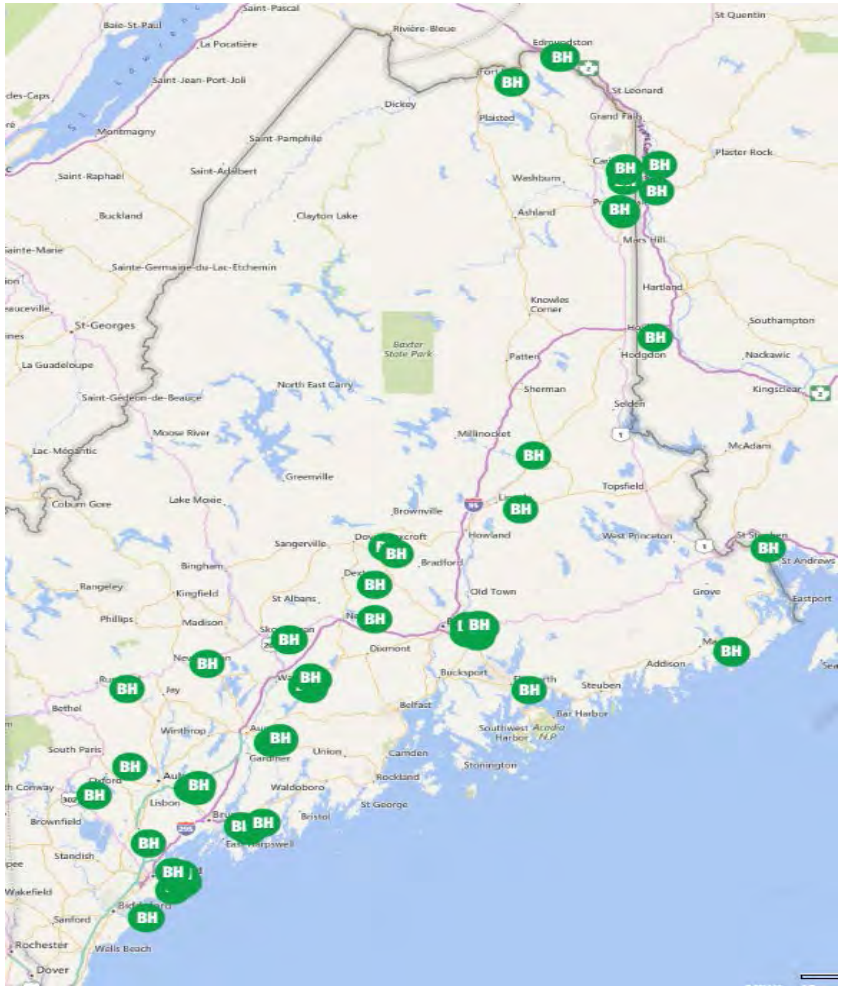
- Health Information Exchange (HIE) Scope and Infrastructure
  - (1) 100% of Maine's 36 hospitals are under contract with 35 currently connected; (2) 34 FQHC sites and over 400 ambulatory sites including physician practices, behavioral health, and long term care facilities are currently connected and participating in the HIE; (3) 1,474,238 Maine residents have clinical data in the exchange (97% of Maine's resident population).
- HIE Notifications
  - Real-time email notifications when patients arrive at the Emergency Department or Inpatient settings
- HIE Analytics Dashboard Tool
  - Provide MaineCare clinical risk data highlighting high-risk populations (utilization, outcome trends)
- HIE Blue Button Personal Health Record Pilot Project
  - patient community with access to their statewide HIE record leveraging "Blue Button" standards
- HIN Behavioral Health Projects
  - Inclusion of up to 25 behavioral health agencies in the HIE. In addition a meaningful use-like incentive program will be available to up to 20 behavioral health organizations to assist them in adopting EHRs, connecting to the HIE, and actively participating in quality measurement programs

Maine SIM Behavioral Health Project Goals

1. Implement connections between 20 BH organizations and the Health Information Exchange
   - Train BH staff to leverage EHR and HIE services
   - Document and share “Data Informed” workflows for patient care improvement
   - Build data interfaces and go live with initial data available from each BH organization

2. Support quality improvement aimed at reducing ED Utilization and measure impact (“Observational Analysis”)

Maine Behavioral Health Connections as of August 2016



- 13 of 20 Live with Data Sharing
- 75 Site Locations Accessing HIE
- BH Data Shared with HIE
  - Patient Identifiers and demographics
  - Encounter/Visit History
  - Adverse Reactions/Allergies
  - Medication History from Pharmacies & Medicaid Claims
  - Diagnosis (primary and secondary)
  - Procedure codes
  - Continuity of Care Documents (CCD)

Maine

HIN Data Informed" Workflows Documented

1. Targeted Care Management Services
2. Hospital Discharge Planning
3. Comprehensive Transitional Care; Post ED and Hospital Follow up
4. Identification and Coordination with Client's Care Team
5. Medication Reconciliation
6. Client Engagement and Education; Using the Client's HIE record
7. Intervention with Client Following a Medical Event while Waiting for Reports from Medical Providers
8. Assessment of Accuracy of SMI Diagnosis vs. Medical Diagnosis with Medical Provider
9. Identification of Gaps / Overuse of Medical Care
10. Location of Missing Clients

CHCS Center for Health Care Strategies, Inc.
Advancing innovations in health care delivery for low-income Americans

Measuring Social Determinants of Health among Low-Income Populations: Early Insights from State Initiatives

Funded by The Commonwealth Fund

Data Collection on Common SDOH Domains* by State

SDOH Domains	KS	MA	MI	NY	OR	TN	VT	WA
Housing	✔	✔	✔	✔	✔	✔	✔	✔
Family and Social Support	✔	✔	✔	✔		✔	✔	✔
Education and/or Literacy	✔	✔	✔		✔		✔	✔
Food Security		✔	✔		✔	✔	✔	✔
Employment	✔	✔	✔	✔	✔	✔	✔	✔
Transportation		✔	✔				✔	✔
Criminal Justice Involvement	✔	✔		✔	✔		✔	✔
Intimate Partner Violence		✔		✔	✔			

**Data collected from Medicaid beneficiaries at the individual and/or population levels; data not systematically collected from the entire Medicaid population*

State	Program/Agency	Purpose for SDOH Data Collection	Collection Mechanism/Tool
VT	Support and Services at Home/ Vermont Blueprint for Health	■ Develop person-centered care plans and care coordination strategies aimed at meeting individuals' goals	■ SASH assessment
	Integrated Communities Care Management Learning Collaborative (Collaborative effort among several agencies)	■ Develop person-centered care plans and care coordination strategies aimed at meeting individuals' goals	■ Shared Care plans and Care Coordinator Assessment ■ Eco Map ■ Camden Cards ■ Root Cause Analysis worksheet ■ Care Management Chart Review Tool

Four Key Uses of SDOH Data

Patient care management

Incentive and performance programs

Risk adjustment and rate-setting

Surveillance and program quality improvement

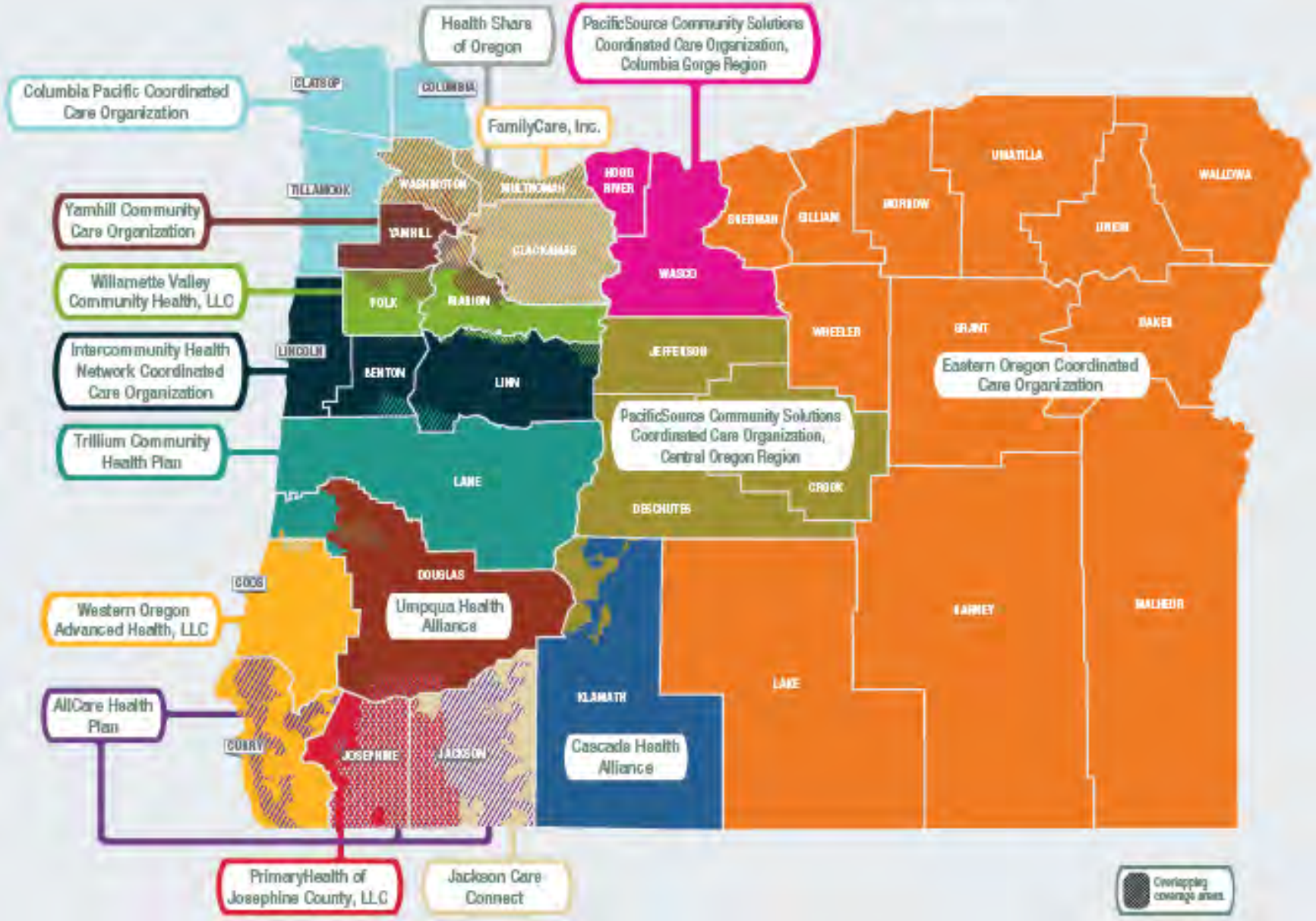
Incentive and Performance Programs

- Aggregating patient-level SDOH data for performance accountability
- Embedding SDOH domains into pay for performance measures
  - » KS basic performance measures:
    - % of beneficiaries who report being connected to social supports
    - % of beneficiaries who report they are doing what they want for work
  - » KS pay-for-performance measures:
    - # and % of beneficiaries with SUD whose employment increased
    - # and % of beneficiaries whose criminal involvement improved
- Performance Improvement Projects
  - » OR food security measure

Risk Adjustment and Rate-Setting

- Incorporating patient-level SDOH data in risk adjustment calculations to set reimbursement rates
- Provider payments
  - » NY Health Homes use functional adjustments for incarceration, homelessness, interpersonal violence
- MCO and future ACO rate setting
  - » MassHealth will use risk adjusters that capture homelessness, SUD, neighborhood stress score

Coordinated Care Organization Service Areas



Oregon Health Authority

CCO Incentive Measure Program

- Annual assessment of CCO performance on 18 measures selected by legislatively-established Committee.
- Compare annual performance against prior year (baseline) to see if CCO met an established benchmark, or demonstrated a certain amount of improvement.
- CCO performance tied to 'quality pool' (incentive payment); for CY 2016, 4 percent of annual capitation payments are at risk.

http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

Developing a Food Insecurity Measure

Conceptual Considerations

- Are we measuring providers (panel), or health plans (population)?
- Are we measuring screening (process) or results of screen (outcomes)?
- Food insecurity, or food insecurity + malnutrition?
- Community resource availability?

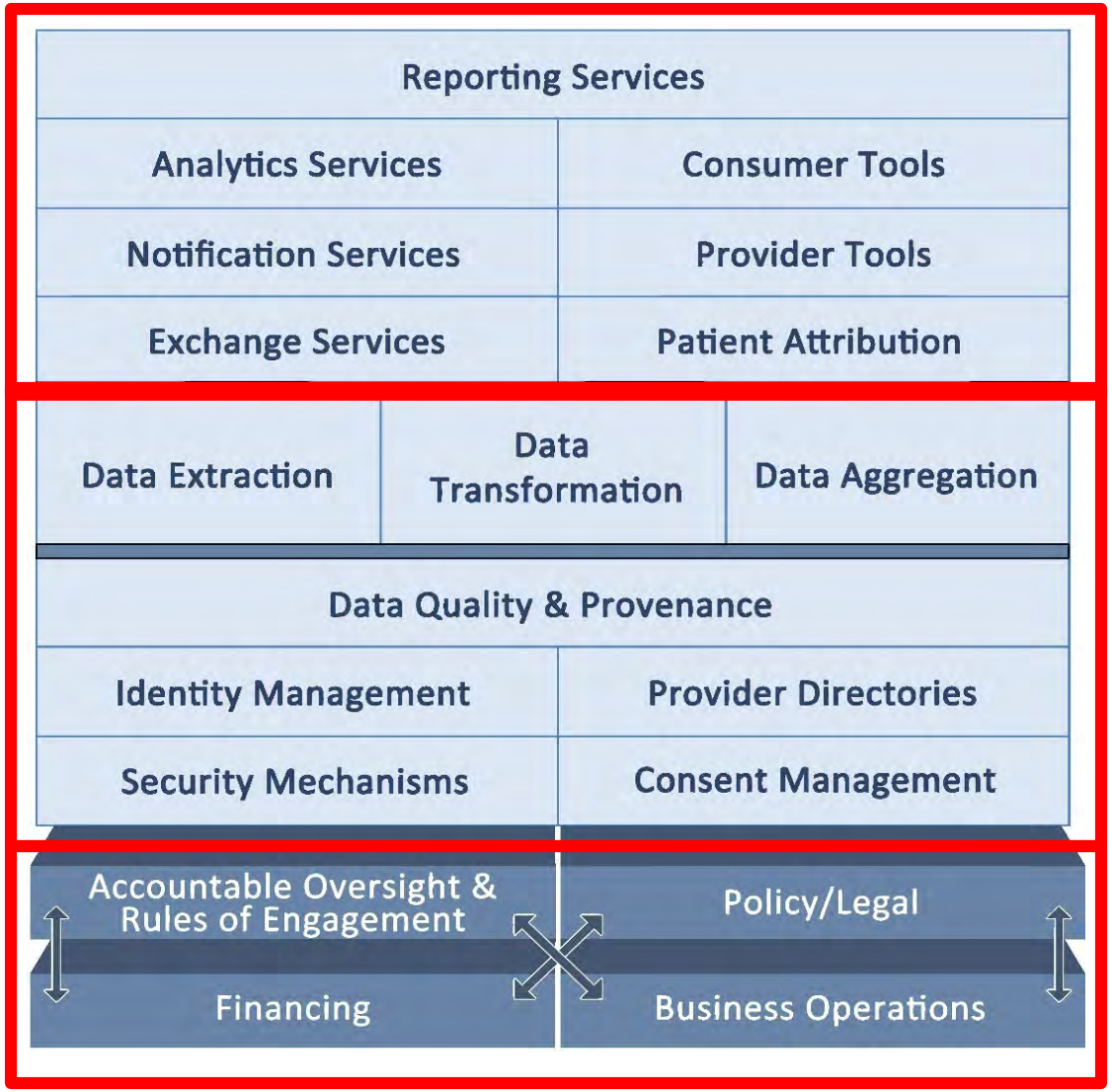
Technical Considerations

- Should the measure be:
  - Survey-based
  - Claims-based
  - EHR-based
- Who is included?
  - Ages
  - Continuous enrollment
  - Exclusions
- Standardized screening tools?

http://www.oregon.gov/oha/analytics/MetricsTAG/DRAFT%20Food%20Insecurity%20Screening%20Specifications%20v7.pdf

Key ingredients to aggregate reliable population data

Health IT Enabled Quality Measurement
ONC Strategic Implementation Guide



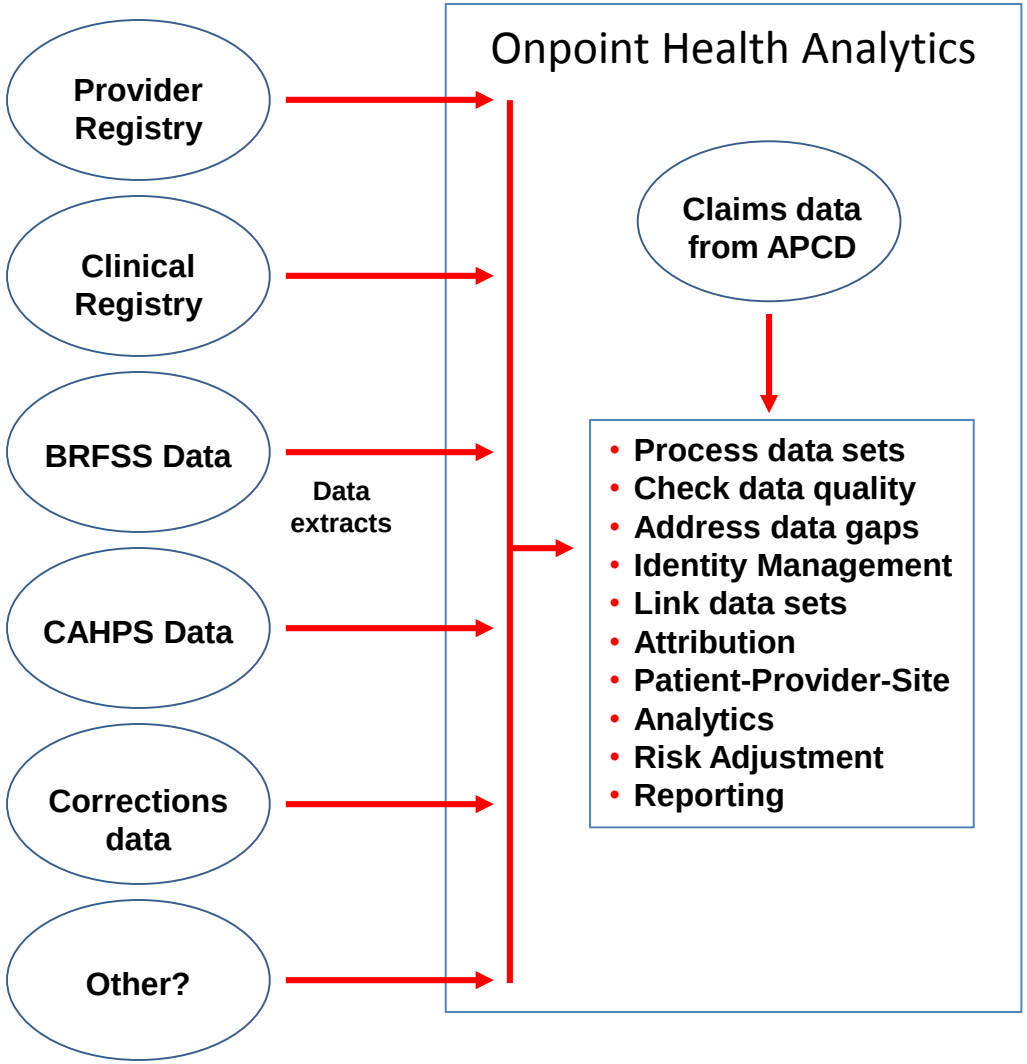
Data Use Capabilities

Core Technical Capabilities

Foundational Components

Vermont Blueprint for Health

Data & Measurement Capabilities



Measurement

- Quality
- Utilization
- Expenditures & Unit Costs
- Patient Experience
- Social, Economic, Behavioral
- Variation & Associations

Products

- Practice Profiles
- HSA Profiles
- Learning System Activities
- Performance Payments
- Outcomes & Impact
- Predictive Modeling

POPULATION HEALTH MANAGEMENT
Volume 0, Number 0, 2015
Mary Ann Liebert, Inc.
DOI: 10.1089/pop.2015.0055

Original Article

Vermont's Community-Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care

Craig Jones, MD[1], Karl Finison, MA[2], Katharine McGraves-Lloyd, MS[2], Timothy Tremblay, MS[1], Mary Kate Mohlman, PhD[2], Beth Tanzman, MSW[1], Miki Hazard, MA[1], Steven Maier, MSL[1], and Jenney Samuelson, MS[1]

Finison et al. BMC Health Services Research (2017) 17:58
DOI 10.1186/s12913-017-2010-0

BMC Health Services Research

RESEARCH ARTICLE — Open Access

Risk-adjustment methods for all-payer comparative performance reporting in Vermont

Karl Finison[1*], MaryKate Mohlman[2], Craig Jones[1], Melanie Pinette[1], David Jorgenson[1], Amy Kinner[1], Tim Tremblay[2] and Daniel Gottlieb[4]

Impact of Medication-Assisted Treatment for Opioid Addiction on Medicaid Expenditures and Health Services Utilization Rates in Vermont

Mary Kate Mohlman, Ph.D. [a,*], Beth Tanzman, M.S.W. [a], Karl Finison, M.A. [b], Melanie Pinette, M.E.M. [b], Craig Jones, M.D. [a]

[a] Vermont Blueprint for Health, NOB 1 South, 280 State Drive, Waterbury, VT 05671, USA
[b] Onpoint Health Data, 254 Commercial Street, Suite 257, Portland, ME 04101, USA

Statewide Data Infrastructure Supports Population Health Management: Diabetes Case Study

Craig Jones, MD[1] Mary Kate Mohlman, PhD[1] David Jorgenson, MS[2] Karl Finison, MA[2] Katie McGee, MS[3] Hans Kastensmith[3]

Data Infrastructure for Population Health in a Waiver World

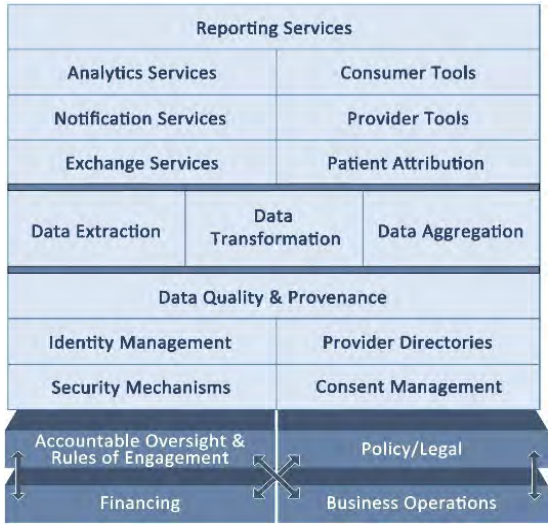
Opportunity in Vermont

Data Sources

Clinical Data **EHRs & HIE**	**Claims Data** **APCD**
Social Data **State/Community**	**Economic Data** **State**

Data Services

Foundational Components | **Technical Capabilities**



Data Users

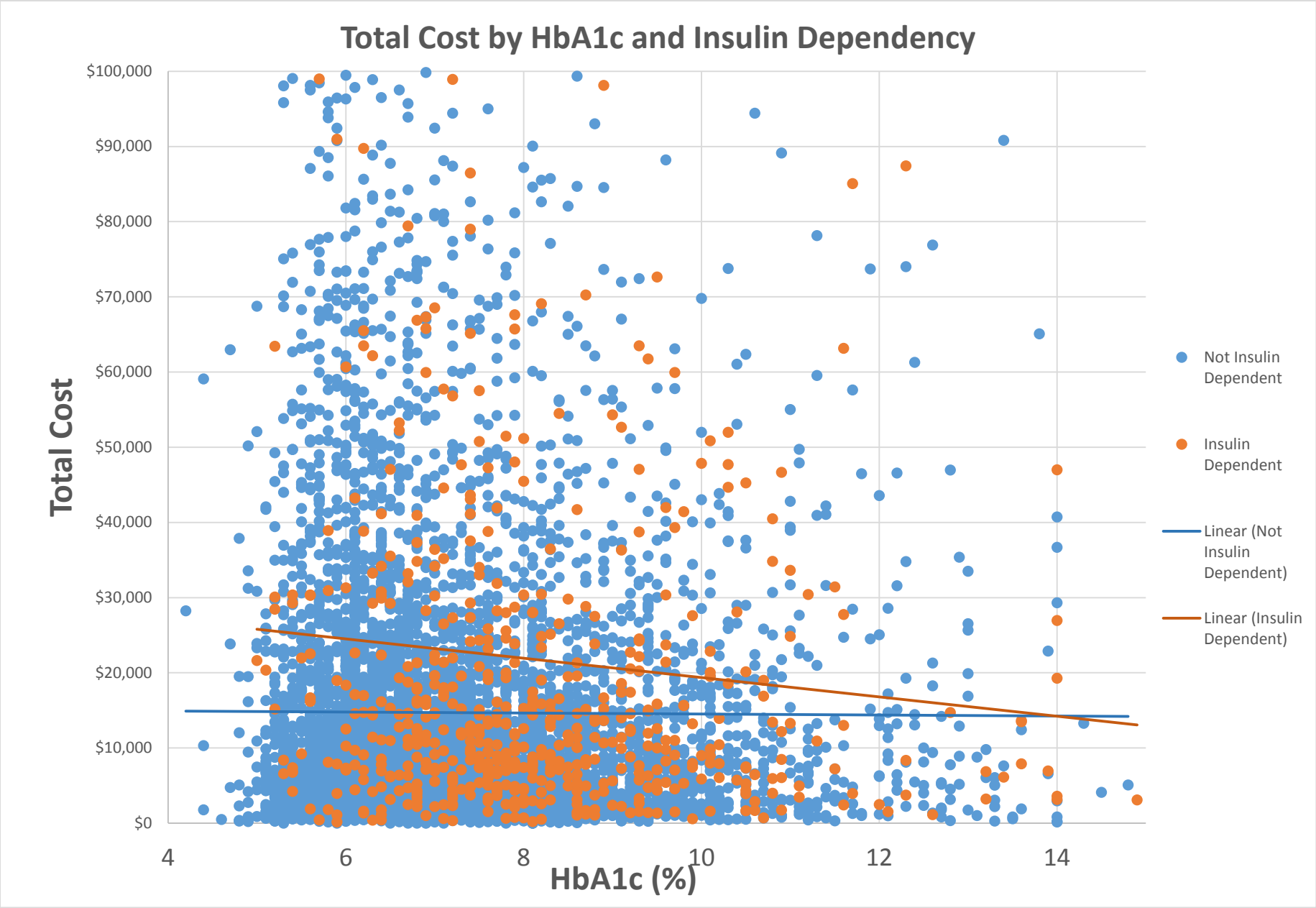
VCO / ACOs | **Other Providers** | **Payers** | **AHS** | **GMCB**

Data Uses

- Care management
- Outreach & prevention
- Outcomes & impact
- Comparison & variation
- Predictive models

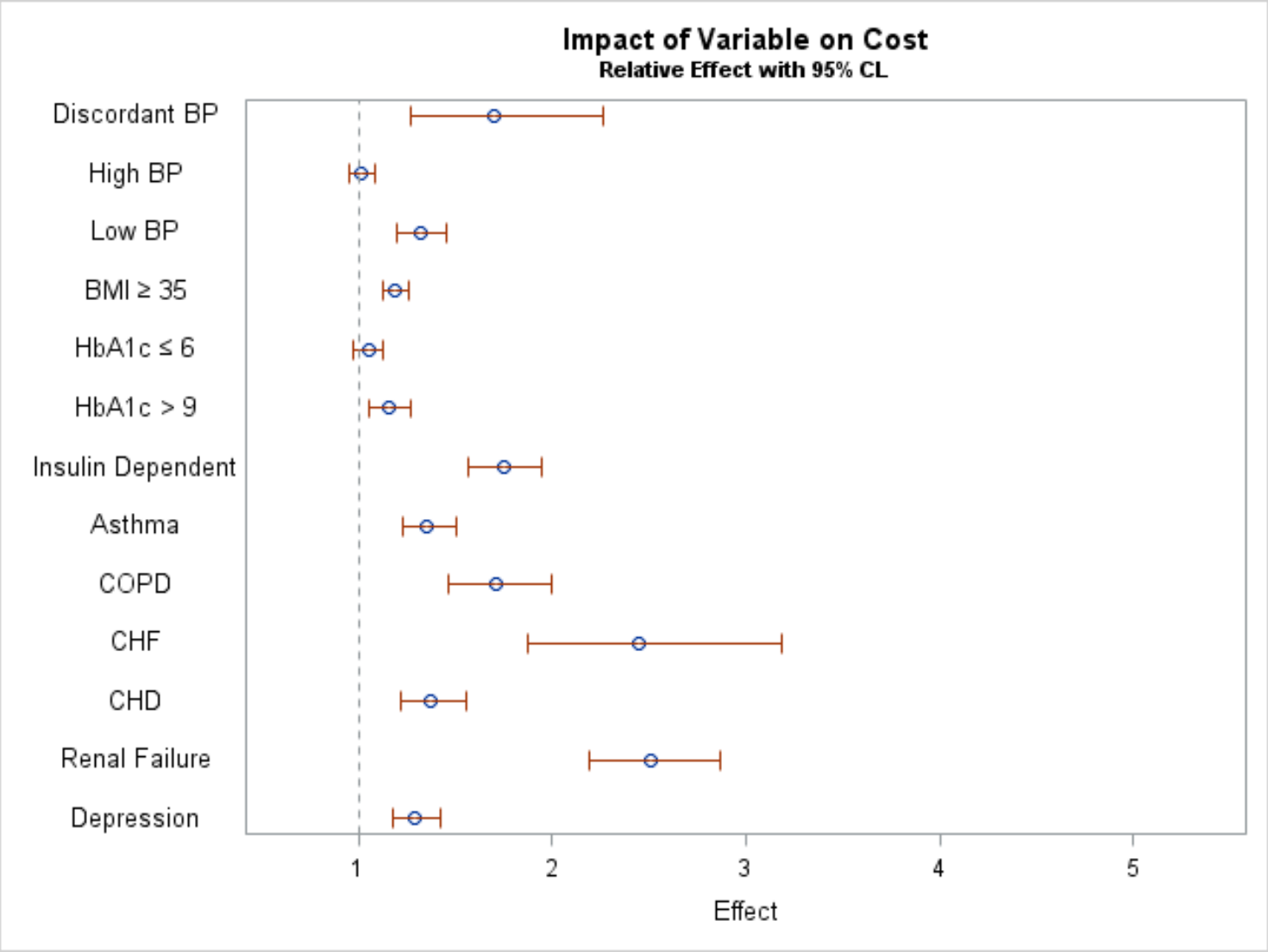
- Outcomes & impact
- Comparison & variation
- Predictive models
- Policy & legal Levers
- Governance & funding

Strategies for using data to meet long term health and near term cost goals



In press, Craig Jones, MD[1] Mary Kate Mohlman, PhD[1] David Jorgenson, MS[2] Karl Finison, MA[2] Katie McGee, MS[3] Hans Kastensmith[3] AJMC

Outreach to Reduce Avoidable Hospital Admissions



Outreach Criteria

- Diabetes + BP ≥ 140/90 mm/Hg
- Diabetes + BP ≤ 90/60 mm/Hg
- Diabetes + BMI > 35
- Diabetes + HbA1c ≤ 6%
- Diabetes + HbA1c > 9%
- Diabetes + Insulin
- Diabetes + Asthma
- Diabetes + COPD
- Diabetes + CHF
- Diabetes + CHD
- Diabetes + Renal Failure
- Diabetes + Depression

In press, Craig Jones, MD[1] Mary Kate Mohlman, PhD[1] David Jorgenson, MS[2] Karl Finison, MA[2] Katie McGee, MS[3] Hans Kastensmith[3] AJMC

Scaling Health IT for MACRA

Using Core Measures & Regional Data Services to Guide a Value Based Learning Health System

AIMs	Use of Measurement for a Value Based Learning Health System	Measurement & Modeling	Regional Data Services to Facilitate Measurement	Data Sources for Core Measures	Core Measures
• Better Quality • Better Health • Cost Control	• Incentives for providers to work together to improve outcomes • Initiatives to improve proactive outreach & preventive services • Initiatives to improve coordination & quality of services • Initiatives to improve integration of medical, social, behavioral services • Initiatives to reduce variation, unnecessary, & harmful services • Shared governance structure to oversee & improve data utility	Payer measurement & reporting needs	• Data sent in native formats • Most complete longitudinal patient record • Link patients-services-providers-sites • Apply attribution algorithms • Create data extracts & access for users • Analytic & reporting services • Data quality process & assistance	Payers, APCD, Claims Curators	• Quality • Health Status • Utilization • Expenditures • Medical Error • Social • Economic • Behavioral
		Provider measurement & reporting needs		EHR Systems	
		Populate value based payment models		HIE Networks	
		Evaluate outcomes & impact of programs		Specialty Registries	
		Comparative performance & variation analyses		Public Health Registries	
		Predictive models, machine learning		State Data Systems	

Using Population Data to Guide a Value Based Learning Health System

Key Learnings

- There is a national imperative for data sharing and measurement to support population health and a value based health system
- The importance of more complete predictive information using data from an array of sources (health, healthcare, social, economic, behavioral)
- Essential ingredients include foundational components, core technical capabilities, and strategies to drive a data use culture that supports a learning system
- The need for data aggregation that occurs as part of routine daily operations and minimizes administrative burden on providers, payers, and other stakeholders

Questions & Discussion