Convergence and Standardization Needed for Financial and Clinical Data in Support of Value-based Care

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About the Presenters

- Margret Amatayakul is president of Margret\A Consulting, LLC and BIG consultant; adjunct faculty at the College of St. Scholastica and clinical associate professor at the University of Illinois at Chicago, College of Applied Health Sciences. She is a co-author with Steve Lazarus of the forthcoming CAQH CORE Report on Value-Based Payment, All Together Now: Applying the Lessons of Fee-for-Service to Streamline Adoption of Value-Based Payments*
- Steve Lazarus, PhD, is president of the Boundary Information Group (BIG), former chair of WEDI, HIPAA expert witness, and a founding co-chair of the HIPAA Summit. He is a co-author of the above named CAQH CORE Report on Valued-Based Payment.* BIG performs strategic planning, requirements analysis, system selection, contract negotiation, and implementation support for EHRs and other health IT; conducts HIPAA risk assessments for privacy, security, breach notification, and transactions compliance; and provides strategic planning for and implementation tools on value-based care programs

*This presentation reflects the opinions of the authors and is not a summary of the CAQH CORE Report on Value-Based Payment

Agenda

- Value-based care and its importance in managing healthcare quality and costs
- Achieving value through addressing communication issues: semantic, process, and policy interoperability
- Transitioning requires attention to:
  - Transactions and code sets (HIPAA and Other)
  - Privacy and security (HIPAA and Other)
  - Healthcare innovation (21st Century Cures and Other)

Value-based Care (VBC)

- VBC goes by many names (e.g., value-based payment, alternative payment models, value-based reimbursement); there are many federal and commercial programs; and a variety of delivery structures (e.g., ACO, PCMH, CIN)
- Whatever names or structures, the goal is to increase the value (quality and cost) and to reduce medical misadventures and waste in healthcare
- HHS vision* is to achieve:
  - High-quality care
  - At lower costs
  - To create a healthy population
  - With engaged people

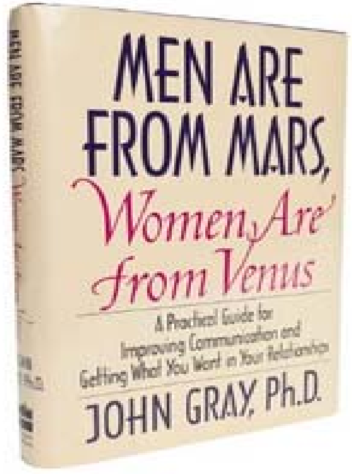
*Federal Health IT Strategic Plan: 2015-2020. Available at: https://www.healthit.gov/sites/default/files/9-5-federalhealthitstratplanfinal_0.pdf

Examples of Need to Address Value

- Multiple vials of medicine for a nebulizer wasted because of orders by two different physicians
- Patient required to pay hundreds of dollars for one dose of medicine because diagnosis code required on prescription for health plan reimbursement was not supplied by hospitalist who left employment and could not be readily found
- Prepped surgery suite contaminated as patient was wheeled in just minutes before a presumed UTI was identified by orthopedic surgeon on lab results available day prior to surgery
- Patient took antibiotics for two months as prescribed by orthopedic surgeon for presumed UTI, later found by PCP to be pancreatic cyst
- Medicare patient, whose kidney was removed due to localized cancer, was responsible for payment of two-day “observation admission”
- And the list goes on… with CMS projecting U.S. health spending to grow 5.5% annually over the next decade

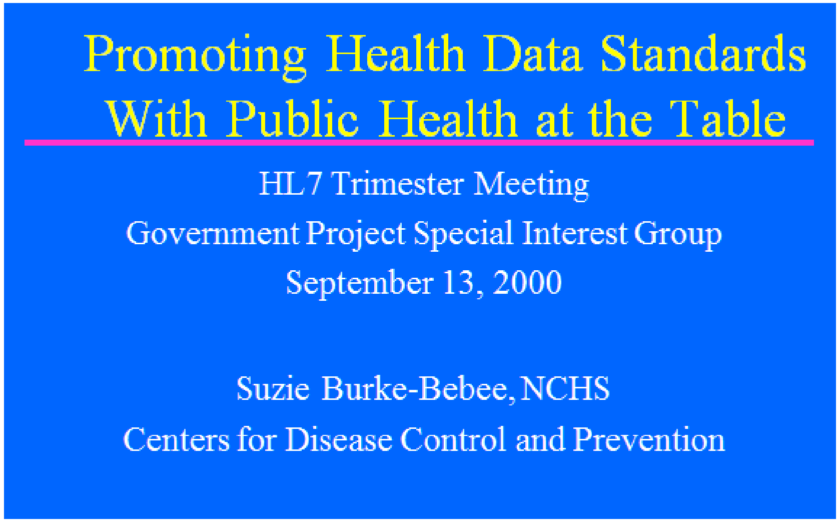
Achieving Value

- People often lament that if we could just get computers to talk to one another (**Technical Interoperability**), quality and cost issues would be resolved
- Unfortunately, interoperability issues today are largely related to communication, where clinical and financial data converge in new ways and for new purposes
- Convergence requires attention to: **Semantic (Data), Process (Workflow),** and **Policy (Cultural) Interoperability**; much like (on a lighter note):



Clinical & Financial

Data Issues Are Not New



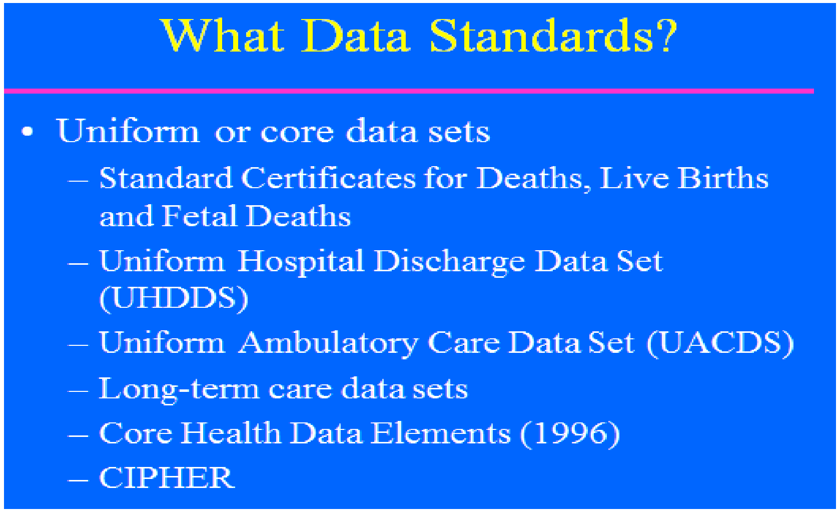
Promoting Health Data Standards With Public Health at the Table

HL7 Trimester Meeting
Government Project Special Interest Group
September 13, 2000

Suzie Burke-Bebee, NCHS
Centers for Disease Control and Prevention

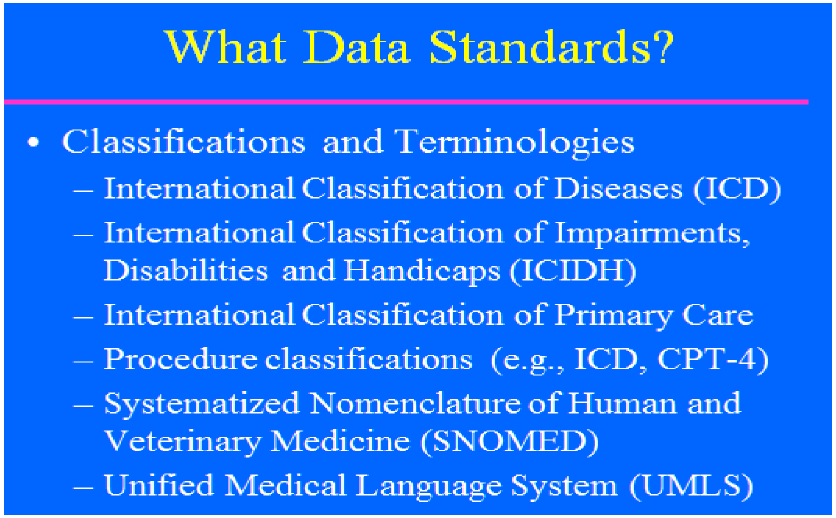
The Vision

- Enhancing the comparability, quality and integrity of health information from a wide variety of public and private sources - at the local, national and international levels - through more uniform data policies and standards



What Data Standards?

- Uniform or core data sets
  - Standard Certificates for Deaths, Live Births and Fetal Deaths
  - Uniform Hospital Discharge Data Set (UHDDS)
  - Uniform Ambulatory Care Data Set (UACDS)
  - Long-term care data sets
  - Core Health Data Elements (1996)
  - CIPHER



What Data Standards?

- Classifications and Terminologies
  - International Classification of Diseases (ICD)
  - International Classification of Impairments, Disabilities and Handicaps (ICIDH)
  - International Classification of Primary Care
  - Procedure classifications (e.g., ICD, CPT-4)
  - Systematized Nomenclature of Human and Veterinary Medicine (SNOMED)
  - Unified Medical Language System (UMLS)

Used with permission, Suzie Burke-Bebee, February 15, 2018)

Partial List of Current Data Issues

- Value-based ___Care vs. Payment/Reimbursement?__ (Value is not a new treatment or payment mechanism; rather it is the convergence of processes to improve quality and share risk related to outcomes
- Total cost of care: What do we include/exclude?
  - o Bundle o Episode o Encounter o Visit
  - o Provider cost o Health plan payment o Patient responsibility
- Admission: To hospital? To ED? To observation unit?
- Primary care provider and/or care manager/care coordinator (roles and responsibilities)
- Health information exchange vs. accurate and timely data sharing
  - o EHR o Data registry
- Standards for use of standard code sets (e.g., LOINC code truncation)
- Population health vs. public health
- Metric vs. Measure

Examples of Process/Workflow Issues

- Provider/patient attribution – often a combination of:
  - Prospective vs. retrospective use of providers assigned to patients
  - Single provider vs. multiple providers assigned to patients
  - Majority (more than 50%) vs. plurality (“most”) care among providers
- Patient risk stratification/Member risk adjustment
  - Different purposes; different models can impact care focus and payment
  - Inclusion of social determinants of health
- Provider identification and real time maintenance
- Patient identification
- Process vs. outcome measurement
- Definition of minimum necessary
- Variation in security controls
- Notifications: ADT, lab results, prescription fill
- Payment in risk contracts

Cultural Issues

- Patient engagement and shared decision-making
- The administrative burden of “many (health plans) to one (provider)”
- Standards vs. business rules vs. best practices
- Proprietary information with the need for transparency

Transitioning to VBC: Transactions & Code Sets

- Providers are paid under VBC for keeping people healthy, not for volume of services as in fee-for-service:
  - Payment shifts to incentives and risk sharing, and moving toward:
    - Payments across care providers for an episode of care for one patient
    - Payments based on outcomes with regard to the population of patients served; so eventually claims will go away, although at least in the interim the encounter purpose of the “837” will increase in importance
  - Care delivery shifts from treating illness/injury to wellness/prevention
    - Medical coding must reflect wellness/prevention services – not to pay directly for them (or to pay for specific treatment services), but to enable study of outcomes and to effect continuous improvement
  - Other transactions may be needed to communicate other and additional information
    - Examples: Social determinants of health (SDOH), ADT information, data on quality of care and outcomes

Transitioning to VBC: Privacy & Security

- Data needs shift from a focus on individual patients and their EHRs within a given provider setting to:
  - Evidence-based analysis of patient data presented to provider at the point of care for clinical decision support
    - Requires "big data" that preserves privacy while ensuring accuracy
  - Longitudinal views of patients across provider settings
    - Tests our understanding of "uses and disclosures for treatment, payment, and healthcare operations"
  - Enhanced sharing of data between providers, between providers and health plans, and with patients
    - Necessitates a shift in thinking about privacy and security from "you can't have" to "we need all applicable information in a timely, accurate, protected, and secure manner"
    - Requires patients to be at the center of decisions associated with sharing health information

Transitioning to VBC: Innovation

- In VBC, everyone should have a primary care provider (i.e., “general contractor”) who manages care across the continuum
- Social determinants of health must be understood and addressed
  - This focuses on actions needed by health plans, social services, public health, and local government programs
- Analytics are required to:
  - Identify people with emergent health risk so they can be treated aggressively to reduce moving into least healthy/most costly status
  - Understand cost of care to shift to health maintenance
  - Identify best medical practices, improve workflows, and engage consumers in shared decision making
  - Actuate precision medicine and personalized care
  - Ensure cost transparency for consumers as a more retail focus emerges

Future of VBC

- Many new needs are arising:
  - Interoperability, though not a new issue, must be addressed for:
    - Technical exchange of data across *all* platforms
    - Semantic consistency where data have common meaning; and variation for different purposes includes transparency
    - Processes that are streamlined and purposeful
    - Policy that supports quality in an economically sound manner
  - New sources of data must relieve the burden of data collection and sharing:
    - HIEs, registries, vMR, APIs for patient-generated/mobile health data
    - Data exchange must be enabled with easier-to-use tools, protections, and security
  - New alliances and partnerships must reduce barriers
- General consensus is that VBC:
  - Is an emerging model and will undergo continuous improvement

Questions?

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