accenture

ACHIEVING THE PROMISE OF DATA EXCHANGE: THE RIGHT CARE FOR THE RIGHT POPULATION

March 8th, 2016

High performance. Delivered.

Strategy | Consulting | Digital | Technology | Operations

Objectives

At the end of this presentation, you should be able to:

- Identify the metrics for success in managing populations holistically

- Understand the promise of data in value-based care

- Understand the use of interoperability to enable data exchange

- Identify new strategies to engage those most at-risk

- Understand the value of an integrated care plan

Content

Value Based Care

Transforming Care

The Promise of Data Exchange

Case Summaries

Next Steps

Value Based Care is Inevitable

Healthcare reform and CMS-driven initiatives require Health systems to aggressively ramp up their capabilities to address value-based care

REGULATIONS

- Affordable Care Act has made Providers responsible for cost and quality of care

- CMMI initiatives like State Innovation Models (SIM)

- Incentives (DSRIP) and Penalties for avoidable readmissions

MARKET RESPONSE

- Launch of value-based care delivery models

- Increase in provider-led ACO/PCMH

- New collaboration models and integrated delivery systems

- Focus on data and analytics to manage patient populations
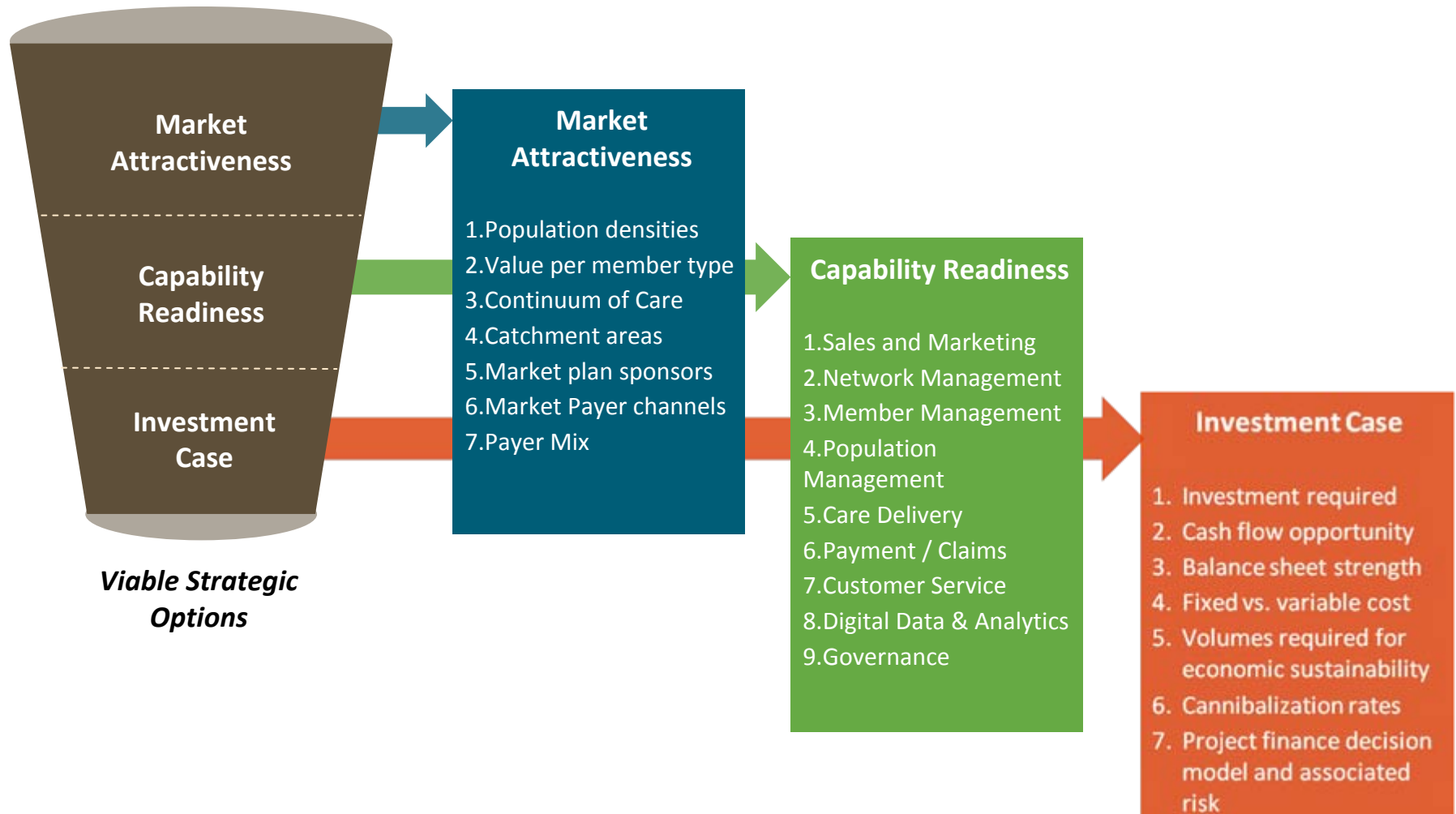
IMPACT ON HEALTH SYSTEMS

- Rapid transition to risk-based contracts

- Shortage of clinical workforce

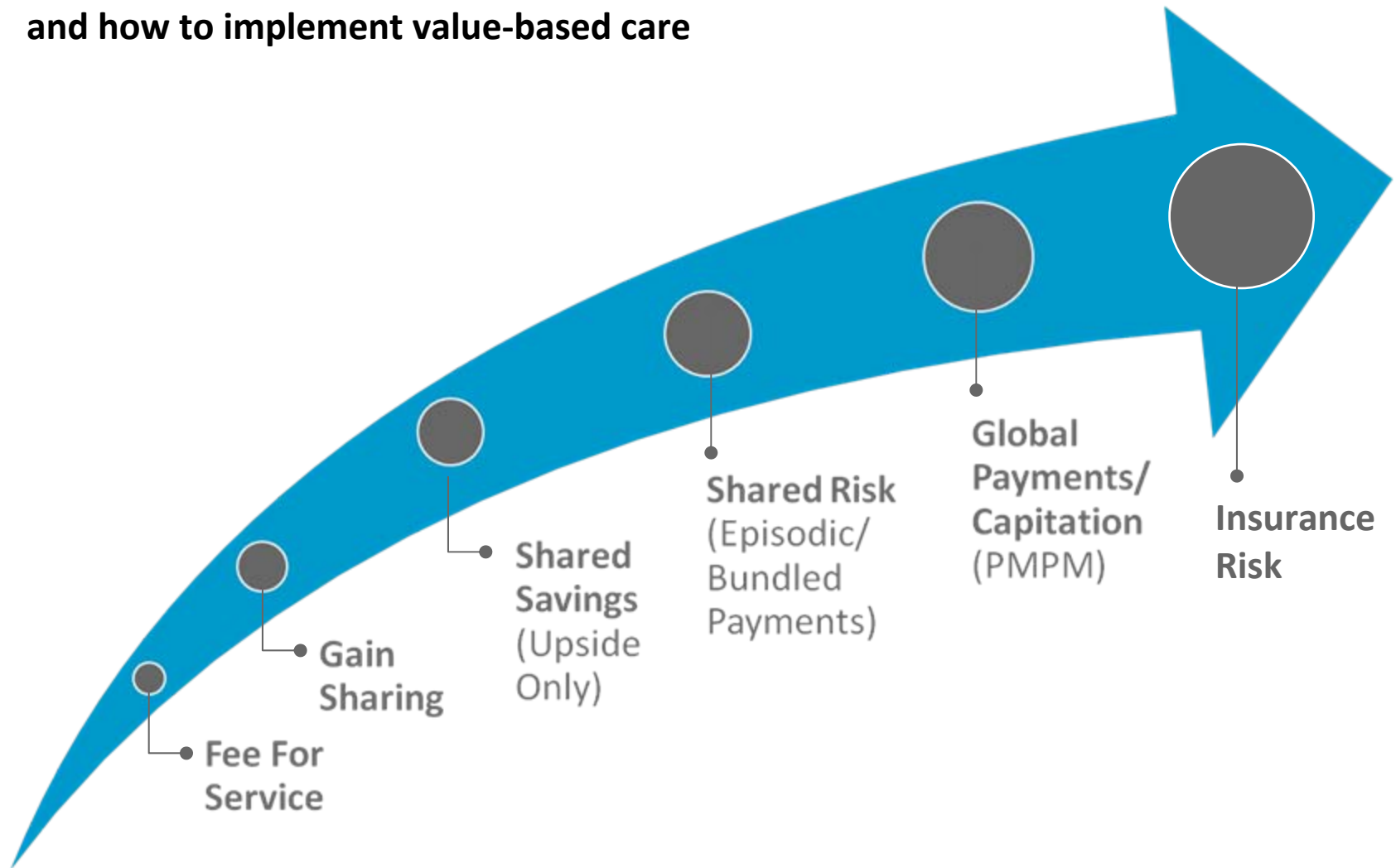- Limited data, analytics and technology infrastructure

Determining Where to Take Risk…

Organizations evaluating value based models need to understand their potential risks and assess readiness to deliver

Market Attractiveness

Capability Readiness

Investment Case

Viable Strategic Options

Market Attractiveness

1. Population densities
2. Value per member type
3. Continuum of Care
4. Catchment areas
5. Market plan sponsors
6. Market Payer channels
7. Payer Mix

Capability Readiness

1. Sales and Marketing
2. Network Management
3. Member Management
4. Population Management
5. Care Delivery
6. Payment / Claims
7. Customer Service
8. Digital Data & Analytics
9. Governance

Investment Case

1. Investment required
2. Cash flow opportunity
3. Balance sheet strength
4. Fixed vs. variable cost
5. Volumes required for economic sustainability
6. Cannibalization rates
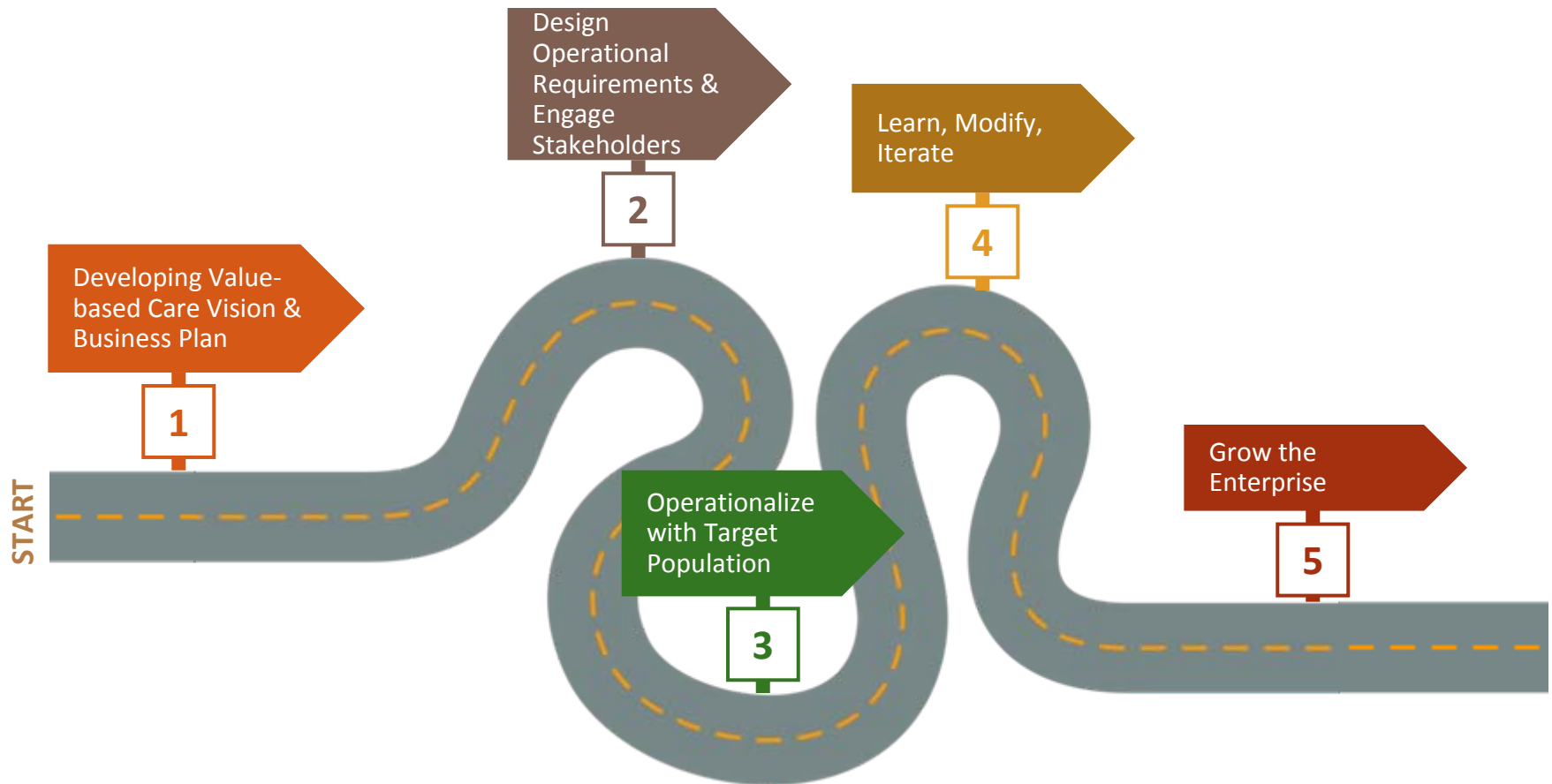7. Project finance decision model and associated risk

...Informs Where And How to Play

An assessment of readiness and risk tolerance should guide organizations as to were and how to implement value-based care

Fee For Service

Gain Sharing

Shared Savings (Upside Only)

Shared Risk (Episodic/ Bundled Payments)

Global Payments/ Capitation (PMPM)

Insurance Risk

The Roadmap to Value Based Care is Not Linear

Implementing Value Based Care is a learning experience for everyone and requires strategic and operating model changes

Design Operational Requirements & Engage Stakeholders

2

Learn, Modify, Iterate

4

Developing Value-based Care Vision & Business Plan

1

Grow the Enterprise

5

START

Operationalize with Target Population

3

Where would you put your organization on the value-based maturity curve?

A. Fee for Service

B. Gain Sharing

C. Shared Savings

D. Shared Risk

E. Global Payments/ Capitation (PMPM)

0%	0%	0%	0%	0%
A.	B.	C.	D.	E.
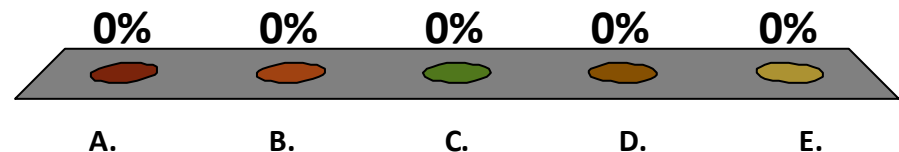
Multiple Drivers to Value-Based Care

Multiple drivers define organizational efforts around value-based care

ACCOUNTABLE CARE ORGANIZATION
404 Shared Savings Program ACOs serving **7.3 million** assigned beneficiaries.

CMMI DEMONSTRATION PROJECTS
Several initiatives around Primary Care Transformation & State Innovation Models.
11,300 sites have NCQA PCMH recognition.

MEDICAID DELIVERY SYSTEM REFORM
7 states have used Section 1115 Medicaid demonstration waivers (DSRIP).
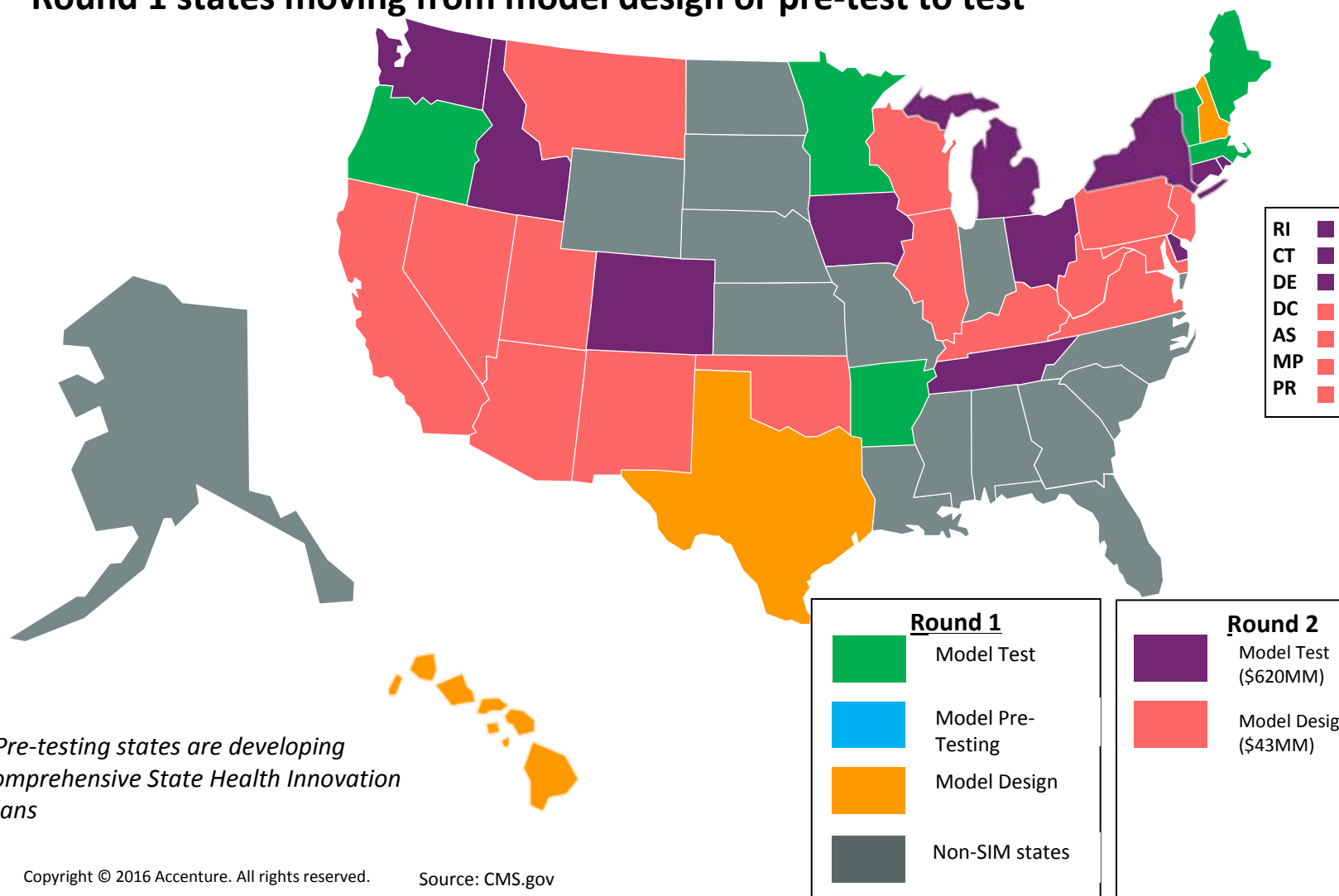
COLLABORATION MODELS
Numerous payer-provider or provider-provider collaboration models of care.

Source – CMS, NCQA & AHA (Implementing New Health Care Delivery System Models)

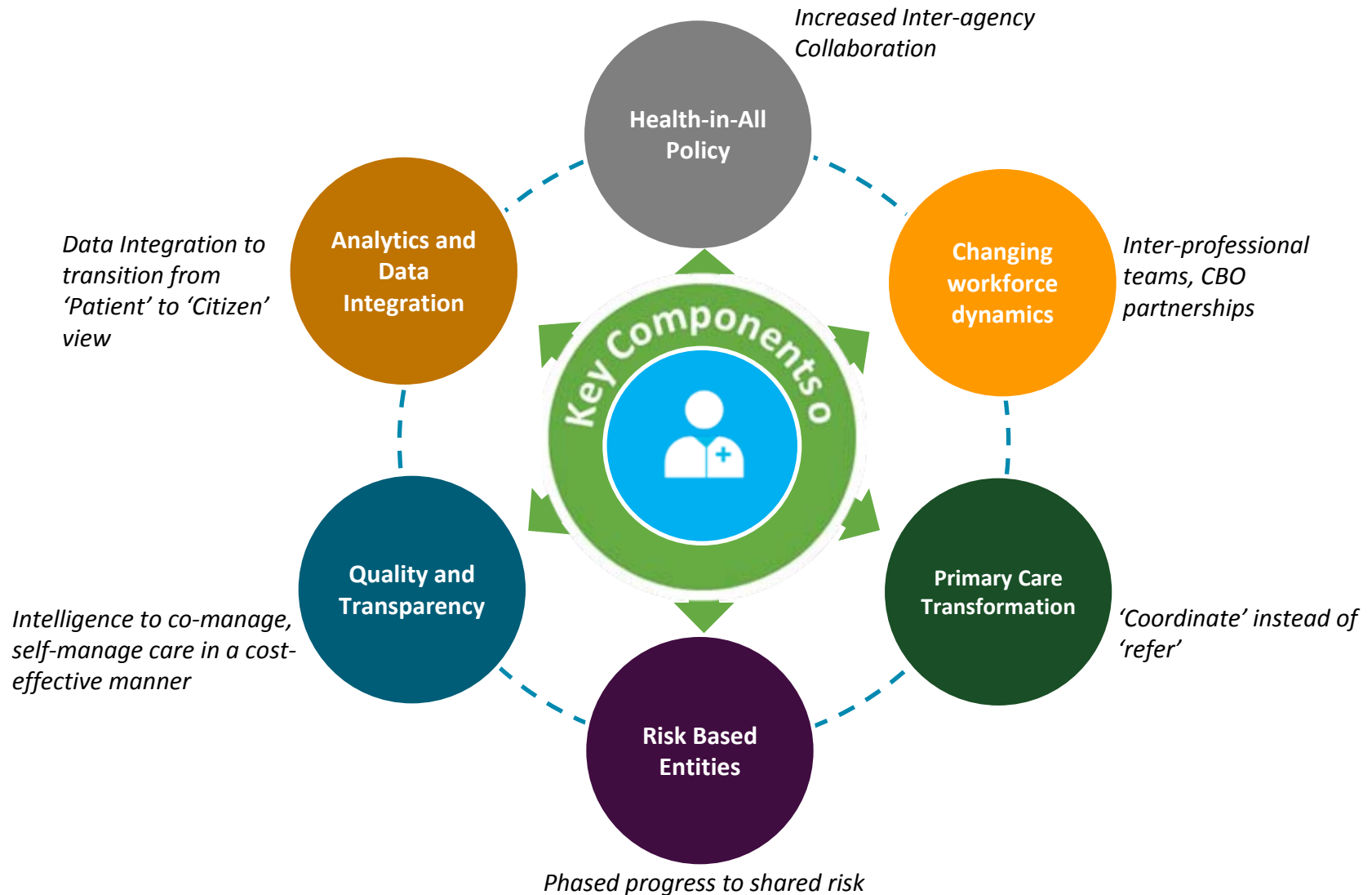# Collaboration Models and Integrated Delivery Networks

States Are Designing New Delivery and Payment Models...

32 states received Round 2 funding for State Health Innovation Models with many of the Round 1 states moving from model design or pre-test to test

RI
CT
DE
DC
AS
MP
PR

Round 1
- Model Test
- Model Pre-Testing
- Model Design
- Non-SIM states

Round 2
- Model Test ($620MM)
- Model Design ($43MM)

Pre-testing states are developing comprehensive State Health Innovation Plans

Source: CMS.gov

…and Consequently Developing an Ecosystem for Value Based Care

Increased Inter-agency Collaboration

Health-in-All Policy

Data Integration to transition from 'Patient' to 'Citizen' view

Analytics and Data Integration

Changing workforce dynamics

Inter-professional teams, CBO partnerships

Key Components o

Quality and Transparency

Primary Care Transformation

Intelligence to co-manage, self-manage care in a cost-effective manner

'Coordinate' instead of 'refer'

Risk Based Entities

Phased progress to shared risk

Source: Accenture Analysis

States are Also Leveraging Waivers to Institute New Care Models...

DSRIP requires rapid implementation of complex delivery system reforms and fundamental changes for the Medicaid population.

90% of Medicaid managed care provider payments will require value-based methodologies.

Performing Provider Systems (PPS) face increased demand for an integrated clinical and non-clinical infrastructure.
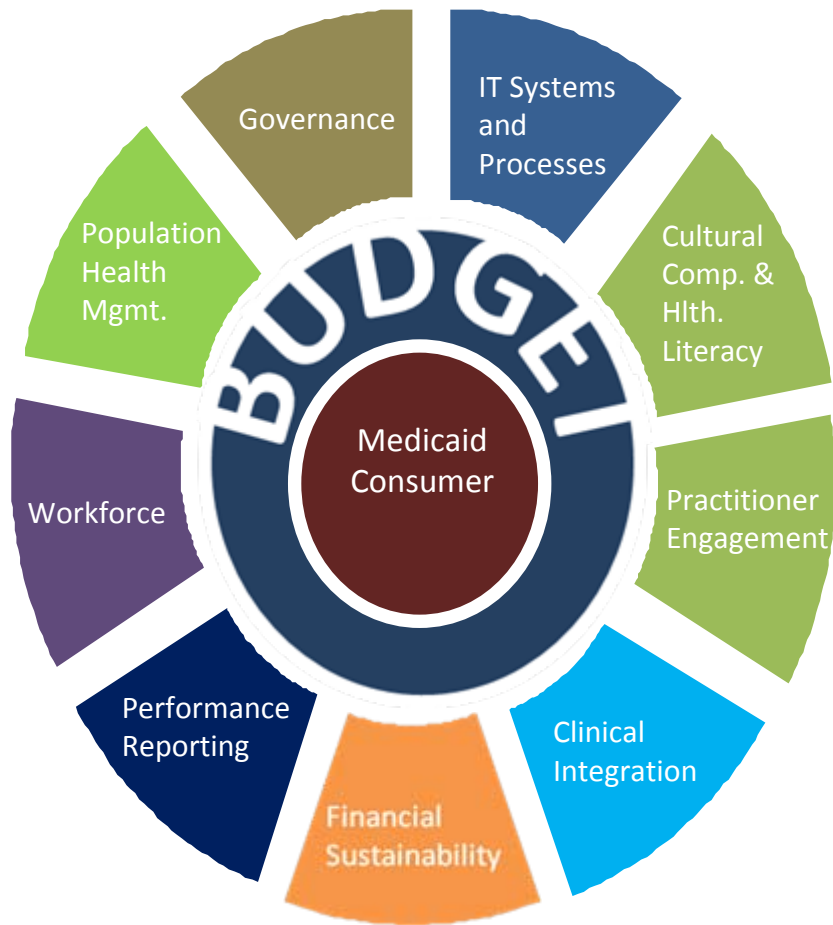
More than 40% of the funding is heavily tied to PPS' meeting the DSRIP performance metrics
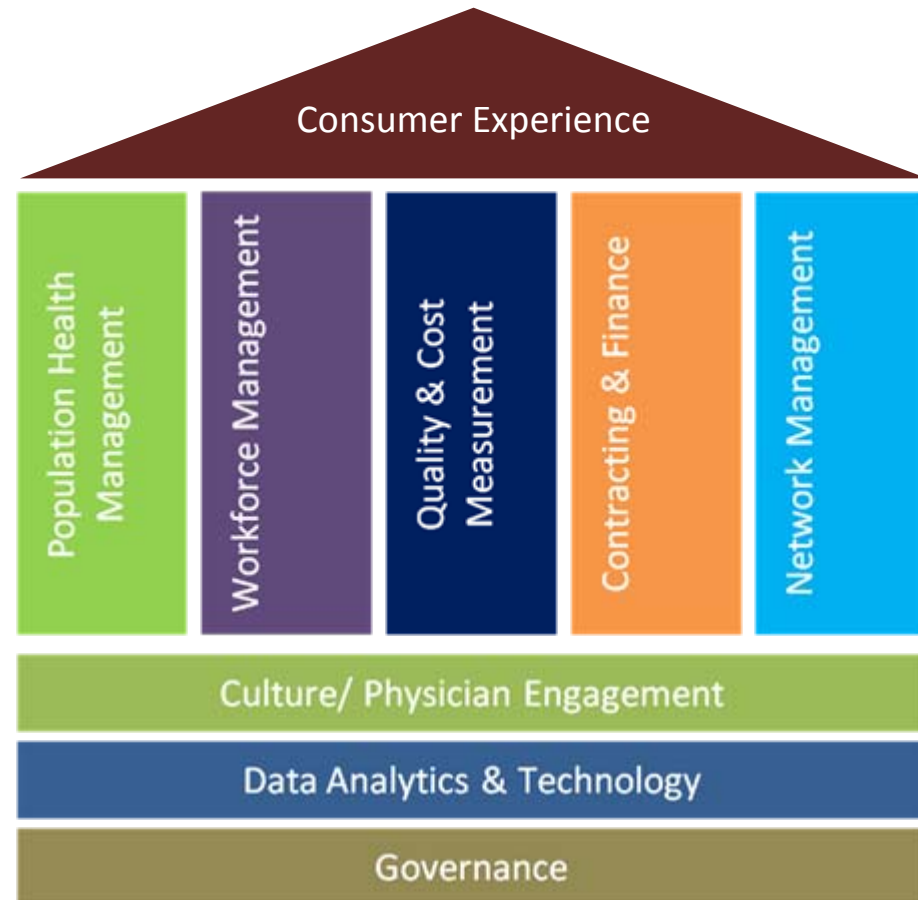
Overall DSRIP is a highly engineered program that demands collaboration and accountability by multiple stakeholders

DSRIP – Delivery System Reform Incentive Payment Program

…Leading to Value-Based Care Adoption in Medicaid

DSRIP Components*

Governance · IT Systems and Processes · Cultural Comp. & Hlth. Literacy · Practitioner Engagement · Clinical Integration · Financial Sustainability · Performance Reporting · Workforce · Population Health Mgmt.

BUDGET

Medicaid Consumer

Value-based Care Components**

Consumer Experience

Population Health Management · Workforce Management · Quality & Cost Measurement · Contracting & Finance · Network Management

Culture/ Physician Engagement

Data Analytics & Technology

Governance

*Derived from Implementation Plan Application
**Accenture Analysis

Use Case Scenario : Delivering Coordinated Care

Emergency Department

- Attending ED Physicians creates referral request
- Care Manager reviews motivation intervention template

Patient Name: Chen (55)
Coverage : Medicaid
Condition: Obese, hypertensive, and has a 5 year history of insulin dependent uncontrolled type II diabetes.

External Entity Performs reporting

- Interface with RHIO community MPI
- Exchange with PPS partners and external collaborators
- Access to audit records

Behavioral Health Assessment Documented

- BH assessment performed before discharge
- Intervention and care protocol documented
- Care plan/treatment plan updated

Care Manager Reviews Reports
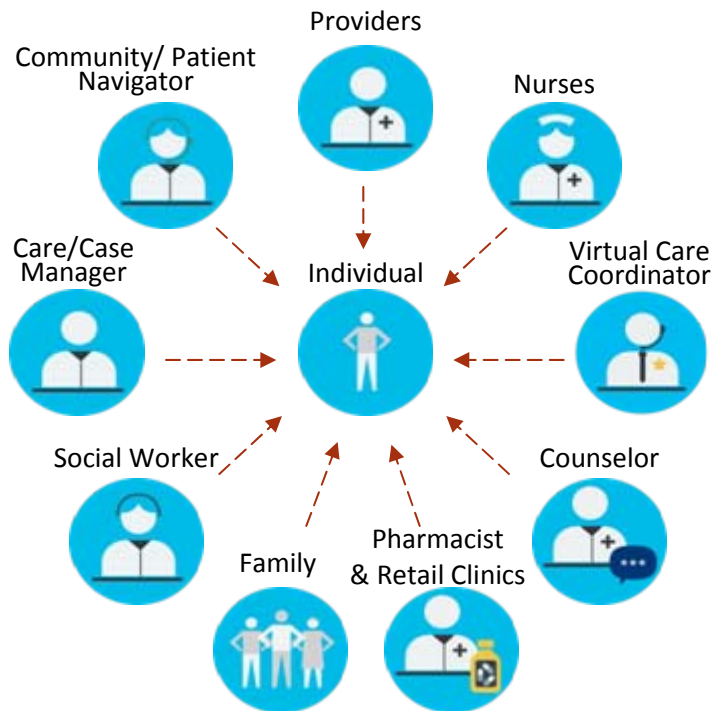
- Quality metrics, MU, NCQA, PCMH, and HEDIS
- Effectiveness of care protocols
- Risk stratification
- Near real-time reporting

Follow-Up

- Care Manager receives notification
- Care Manager reviews encounters and connects patient with required appointments
- Sets reminders and communication needs on behalf of patient
- Sends message to care team

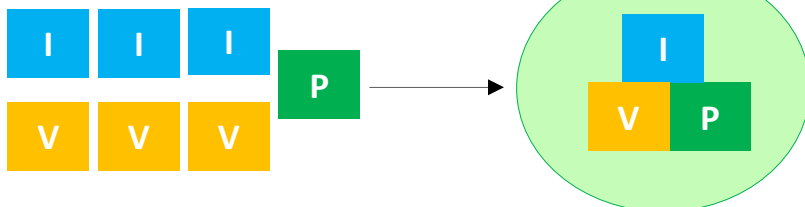**Patient Accesses Information and Receives Reminders**

- Patient reviews encounter information and receives reminders and notifications

The Value of an Integrated Care Plan

Multi-disciplinary team

Community/ Patient Navigator
Providers
Nurses
Care/Case Manager
Individual
Virtual Care Coordinator
Social Worker
Family
Pharmacist & Retail Clinics
Counselor

Current State

I	I	I
V	V	V

P →

Optimal State

I
V P

One Person One Care Plan Enables the…

✓Ability to have a 360 degree view

✓Ability to view/use comprehensive clinical and non-clinical data

✓Ability to use all data to forecast risk

✓Ability to view comprehensive benefits

✓Ability to integrate/coordinate care

✓Alignment of member contacts / outreach

✓Ability to deliver a consistent customer experience and have one call resolution

✓Claims paid accurately and on time

I-Insurer/Payer; V-Vendor; P-Provider

The Right Data to Manage Populations Holistically…

Social Determinants of Health contributes to 80% of the health outcomes

| Clinical Care	Healthy Behaviors	Social and Economic Factors	Physical Env.
• Claims, Lab, Pharmacy • Public Health	• Tobacco Use • Diet and Exercise • Alcohol and Drug Use • Sexual Activity	• Education • Employment • Income • Family and Social Support • Community Support	• Air and Water Quality • Housing and Transit

*County Health Ranking Model developed by the Robert Wood Johnson Foundation and the University of Wisconsin Population Institute
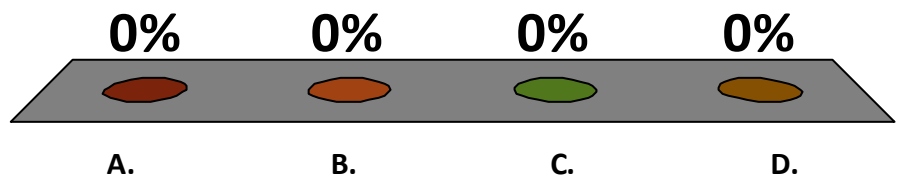
Survey: Which Payer type is the greatest driver of transformation in your organization?

A. Medicaid

B. Medicare

C. Commercial

D. Employer

E. Equally Influential

0%	0%	0%	0%	0%
A.	B.	C.	D.	E.
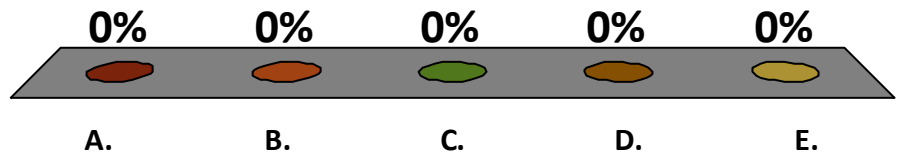
Survey: Which of these areas would be a higher priority to implement and/or optimize in your organization?

A. Community Health Workers/Patient Navigation (Modernizing Workforce)

B. Connected Health/HIE that enables care coordination and transitions of care

C. Care management capabilities that enable longitudinal care plans, alerts and full care team clinical decision support

D. Increasing the extension of care teams into the home

0%	0%	0%	0%
A.	B.	C.	D.

Interoperability is Fundamental to a Well-Functioning Value Based Care Model

Speed to Value

Access the Right Data | **Information Exchange at Scale** | **Improve Healthcare Value**

Clinical and Admin Data | Data Transport | Data Aggregation | Data Insights | Access and Usage

Hospital 1

Hospital 2

Dyads

Additional Providers

Additional Sources

EMR

HIF

Labs

HL7   X12

IHE   CDA

DIRECT

HL7 , CDA, & X12 provide data structure standards

Data In

Integrated Platform

Pharmacy | Lab | Outpatient | EMR | Radiology | ADT

Standardized Data

Insight Out

Rules Engine(s)

Other Gaps

Payer Data (e.g. claims, PBM)

EMR

EDW

Rules Engine

Other Portals

Clinical Viewer

Doctor/ Nurse

Health Plan Programs

Patient

Office Manager/ PCC

Administrator

Health Plan Exec

Interoperability (Done Right) Enables Next Generation Value Based Care

- Entire population (*not just a stratified cohort*) is care managed resulting in increased efficiency/effectiveness and savings

- Care coordination, patient and task lists are auto-assigned based on the client-defined program and real-time health status analysis

- Caregiver documentation such as HRAs, goals and interventions are auto-populated from already known information (e.g., test results)

- Documentation by all caregivers (*including patients*) becomes part of the single record for use by all rules and users

- On-demand quality and performance reports with improved accuracy in numerator/denominator and increased reimbursement

- Care management by exception: transforms reactive care managers into proactive care managers

The Benefits of Ontology

- Harmonizing terminologies, classifications and terminologies between organizations and systems is an important step in creating interoperability

- Knowing the clinical relationship and meanings between those terms creates actionable clinical knowledge

- Ontologies generate additional insights that are not present in static terminology usage

- Ontology usage supplements the Physician in making logical connections between disparate data

- Resolving all external terminologies to an internal ontological representation means that all connected systems benefit

- Ontology represents a larger set of clinical knowledge that can reasonably be accessed by a single, specialized, individual

Interoperability Challenges

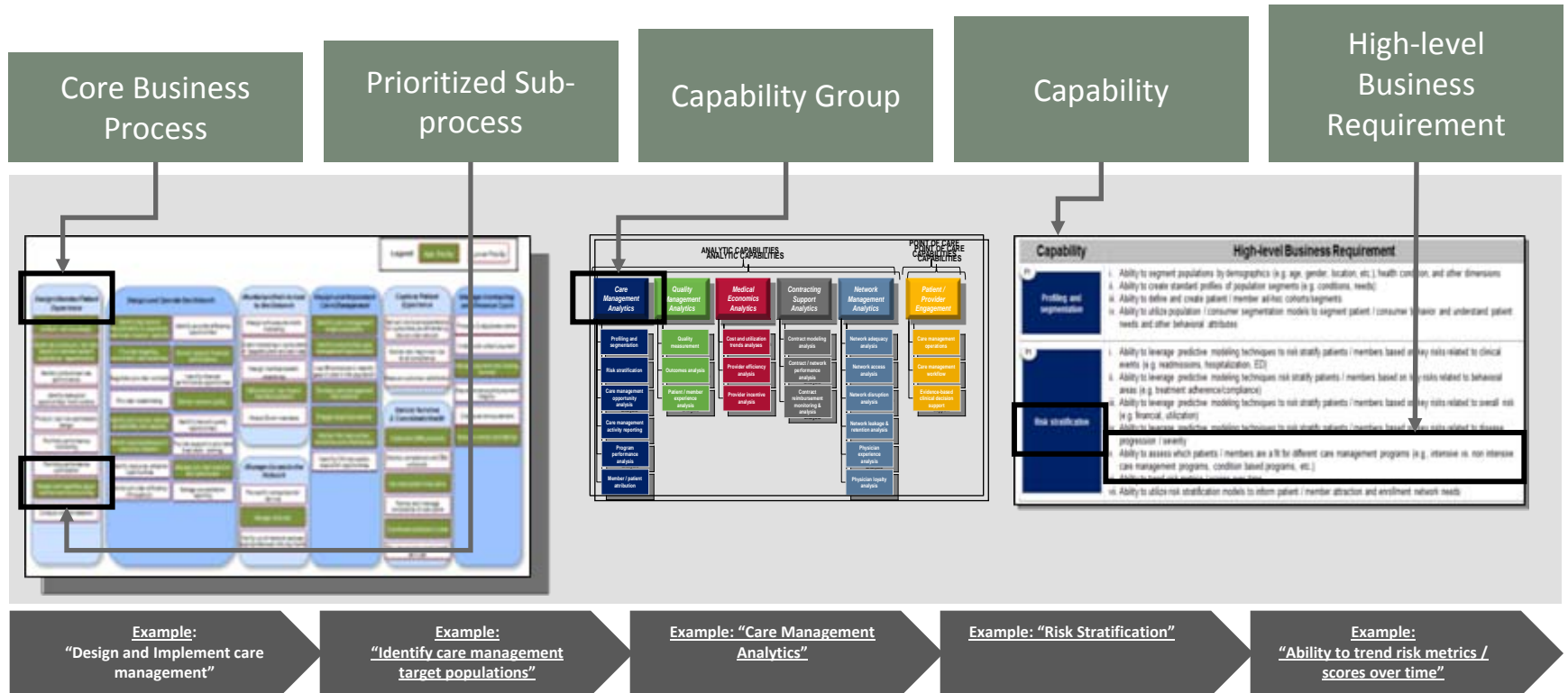| Data Silos	Prohibitive Costs	Change Management	Digitization	Governance
Inadequate access to external data is one of the most significant challenges for improving population health programs	Interoperability takes years to achieve. Most players must integrate between ten and fifty health information systems.	Patient consent and related processes will have to change. Difficult to secure stakeholder commitment to participate in new care models and workflows	Complex patient generated health data needs to be digitized and captured for everyone to realize the full potential and promise of interoperability	Determining the right data and aggregating data from multiple sources requires a strong governance structure to enable effective data exchange

Key Concept Relationship Mapping

A logical relationship framework shows the mapping between each key concept (i.e. from core business process to high-level business requirements).

Core Business Process	Prioritized Sub-process	Capability Group	Capability	High-level Business Requirement

Example: "Design and Implement care management"	Example: "Identify care management target populations"	Example: "Care Management Analytics"	Example: "Risk Stratification"	Example: "Ability to trend risk metrics / scores over time"
Processes and **sub-processes** required for Population Health are defined on the Logical Operating Model. The 8 core business processes align to 55 sub-processes, of which 22 were selected as business priorities for a client	The prioritized sub-processes drive core analytic and point of care capability groups, which represent system functionality and facilitate roadmap creation and vendor selection. 5 analytic and 1 point of care capability groups have been identified.	Within each capability group, capabilities defined tie directly to each prioritized sub-process and are to be executed to meet the priority. 24 capabilities have been defined i.e. 21 analytic capabilities and 3 point of care capabilities.	Each capability drives a set of high-level business requirements to be addressed by data and technology requirements, architecture, and vendor solutions. 136 business requirements have been identified.

Mapping Business Priorities to Capabilities and Requirements

Each of the prioritized business processes drive core analytic and point of care capability groups which in turn tie to unique capabilities and high-level business requirements that are necessary to develop long-term roadmap for Value Based Care.

Priority Business Sub-Process → *Capability Group* → *Capability* → *High-Level Business Requirement*

Identify care management target populations

Care Management Analytics
- **Risk Stratification** — Ability to leverage predictive modeling techniques to risk stratify patients / members based on key risks related to clinical events (e.g. readmissions, hospitalization, ED)
- *Profiling and segmentation* — Ability to leverage predictive modeling techniques risk stratify patients / members based on key risks related to behavioral areas (e.g. treatment adherence/compliance)
- *Member / patient attribution*

Medical Economics Analytics
- *Cost and utilization trends analysis* — Ability to leverage predictive modeling techniques to risk stratify patients / members based on key risks related to overall risk (e.g. financial, utilization)

Ability to leverage predictive modeling techniques to risk stratify patients / members based on key risks related to disease progression / severity

Quality Management Analytics
- *Quality measurement*
- *Outcomes analysis* — Ability to assess which patients / members are a fit for different care management programs (e.g., intensive vs. non intensive care management programs, condition based programs, etc.)

Patient-Provider Engagement
- *Care Management Operations* — Ability to trend risk metrics / scores over time
- *Care Management Workflow* — Ability to utilize risk stratification models to inform patient / member attraction and enrollment network needs

Case Summary 1:
New Payer/Provider Models Changing the Landscape

Who?	• Partnership between Anthem Blue Cross and 7 top hospital systems
What?	• Discounted HMO product, focused on enhanced care coordination and efficiency • Offers members an integrated delivery system experience
When?	• 1/1/2015 go-live
Where?	• California (LA and Orange Counties)
Why?	• Deliver seamless and unique **consumer experience** • **Clinical quality** to drive improved member outcomes • Provide easy access to **efficient referral network** of PCPs, specialists and urgent care • **Integrate care** through standardized clinical processes, data integration, and shared outcomes collaboration

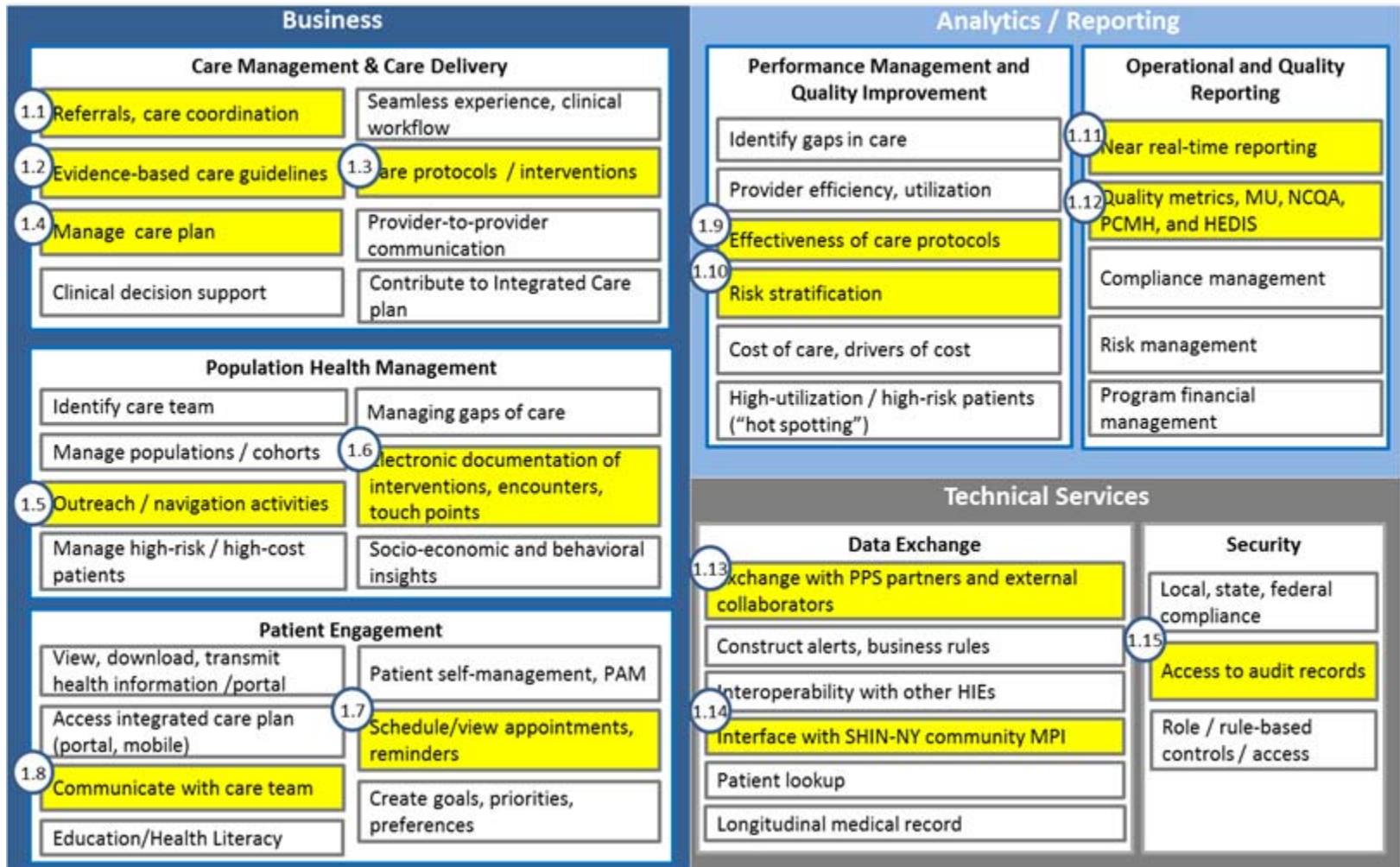CEDARS-SINAI

Good Samaritan Hospital

Huntington Hospital

MEMORIALCARE HEALTH SYSTEM

PIH HEALTH

TORRANCE MEMORIAL

UCLA Health

Case Summary 2:
State-driven Initiative Spurring Clinical Integration

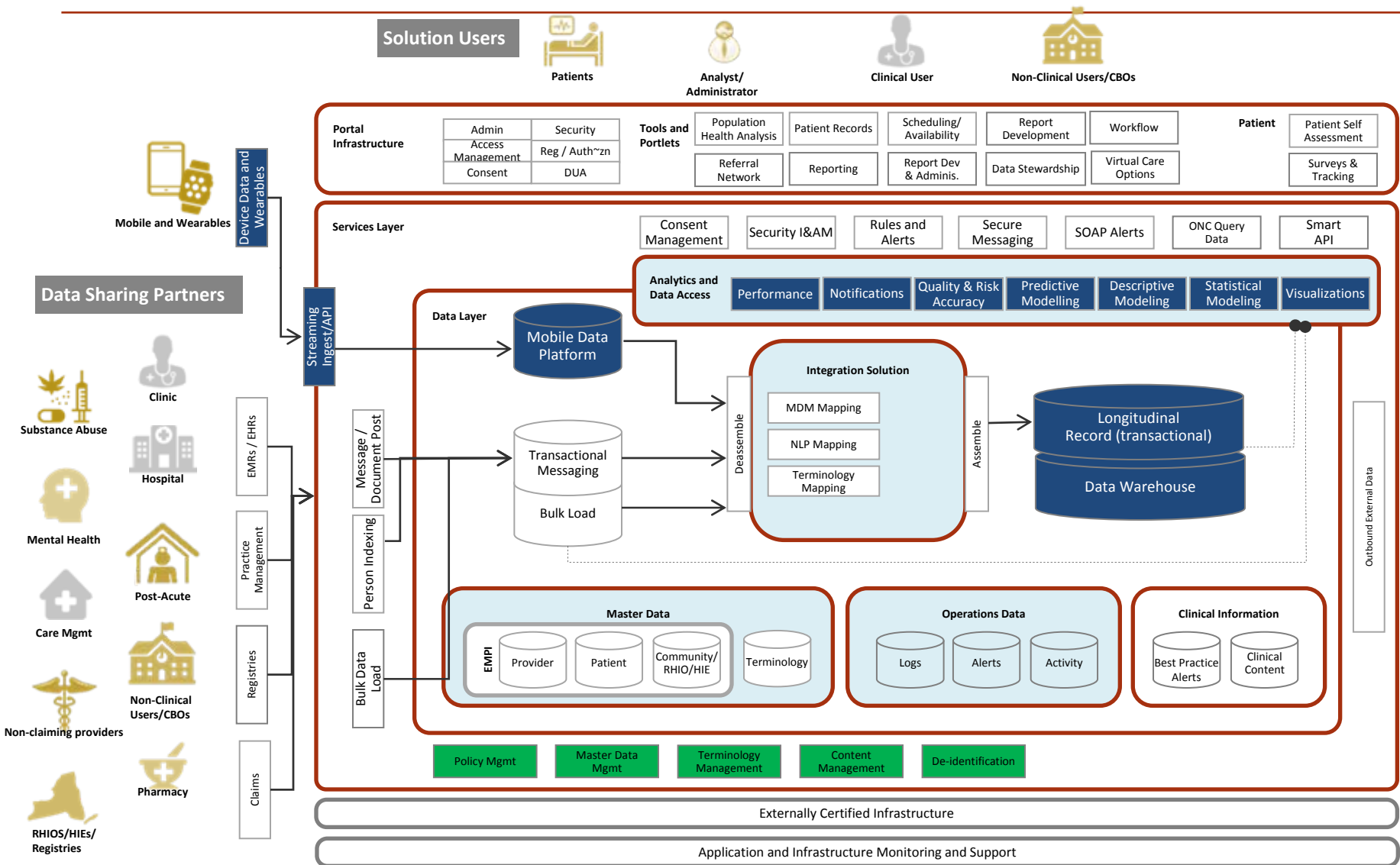|	
Who?	• Large Academic Health Center acting as a Lead Entity for an integrated network comprising of more than 150 organizational providers
What?	• State-driven Delivery System Reform Incentive Program (DSRIP) with the objective of reducing avoidable hospital use by 25% for Medicaid populations • Developing a clinically integrated system that can facilitate care coordination and population health management
Where?	• New York
Why?	• Design **clinically integrated structures** • Facilitate **population health vendor selection** for DSRIP • Supported organization in **assessing readiness to meet DSRIP milestones** (Project/Clinical/Organizational) programmed to serve attributed **Medicaid populations** • Position organization to **increase financial rewards and reduce exposure to penalties** associated with DSRIP • **Increasing financial visibility** over the DSRIP program period

NEW YORK STATE

DSRIP

Business Architecture and Vendor Demonstrations

Business Architecture capabilities can be mapped to user scenarios for the purpose of vendor demonstration and scoring

Technical Architecture

Solution Users

Patients · Analyst/Administrator · Clinical User · Non-Clinical Users/CBOs

Device Data and Wearables

Mobile and Wearables

Data Sharing Partners

Substance Abuse · Clinic · Mental Health · Hospital · Care Mgmt · Post-Acute · Non-claiming providers · Non-Clinical Users/CBOs · Pharmacy · RHIOS/HIEs/Registries

Portal Infrastructure

Admin	Security
Access Management	Reg / Auth~zn
Consent	DUA

Tools and Portlets

| Population Health Analysis | Patient Records | Scheduling/ Availability | Report Development | Workflow |
| Referral Network | Reporting | Report Dev & Adminis. | Data Stewardship | Virtual Care Options |

Patient

Patient Self Assessment · Surveys & Tracking

Services Layer

Consent Management · Security I&AM · Rules and Alerts · Secure Messaging · SOAP Alerts · ONC Query Data · Smart API

Analytics and Data Access

Performance · Notifications · Quality & Risk Accuracy · Predictive Modelling · Descriptive Modeling · Statistical Modeling · Visualizations

Data Layer

Streaming Ingest/API

EMRs / EHRs · Practice Management · Registries · Claims

Message / Document Post · Person Indexing · Bulk Data Load

Mobile Data Platform

Transactional Messaging · **Bulk Load**

Deassemble

Integration Solution
- MDM Mapping
- NLP Mapping
- Terminology Mapping

Assemble

Longitudinal Record (transactional)

Data Warehouse

Outbound External Data

Master Data

EMPI: Provider · Patient · Community/ RHIO/HIE · Terminology

Operations Data

Logs · Alerts · Activity

Clinical Information

Best Practice Alerts · Clinical Content

Policy Mgmt · Master Data Mgmt · Terminology Management · Content Management · De-identification

Externally Certified Infrastructure

Application and Infrastructure Monitoring and Support

Survey : What is the biggest knowledge gap in your organization relative to value-based care ?

A. Care Management Solutions

B. Patient Engagement

C. Provider Engagement

D. Interoperability

E. Integrating Social

F. Determinants of Health Data

G. Other

0%	0%	0%	0%	0%	0%	0%
A.	B.	C.	D.	E.	F.	G.
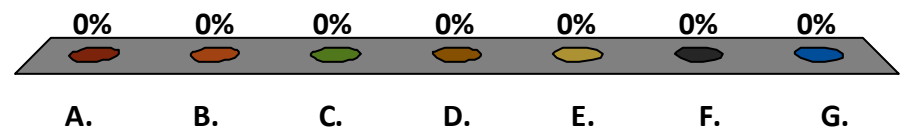
Key Takeaways

| Strategy & Governance | Data | Data Exchange | Care Management |

Sustainability
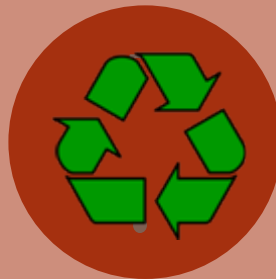
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