



moving to value-based care

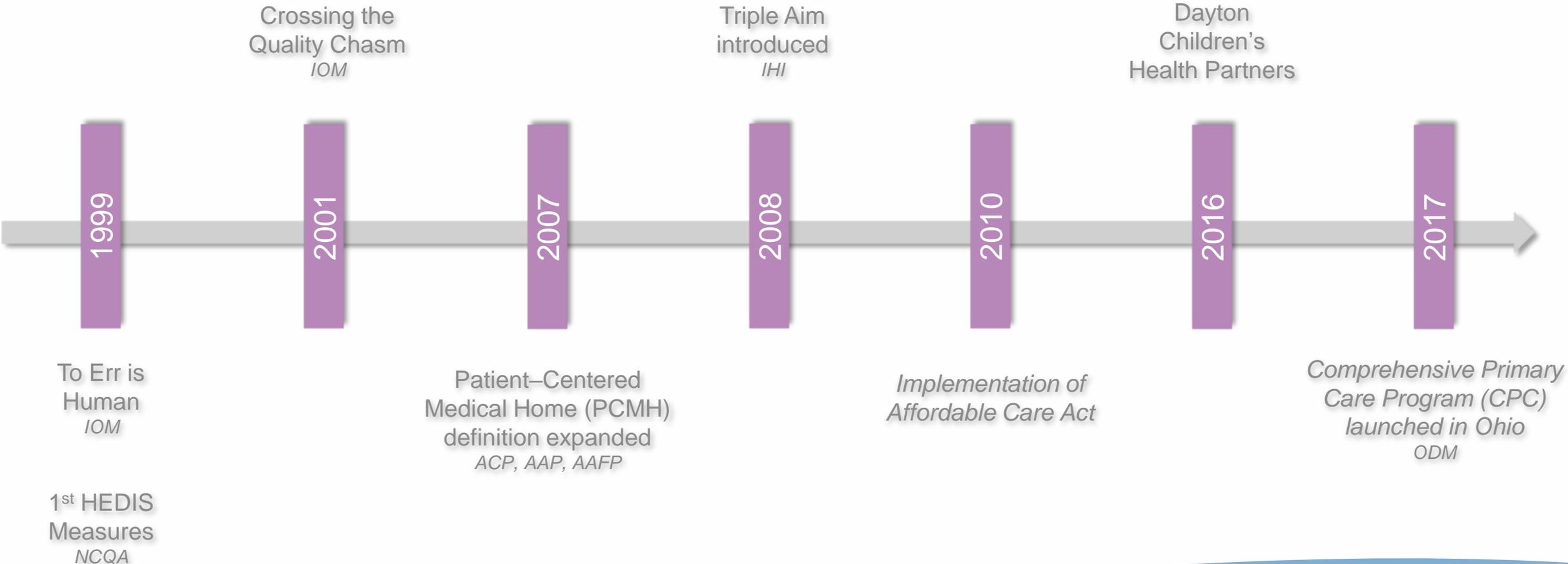
Angela Eberhart, DNP, APRN, FNP-C

september 13, 2019

objectives

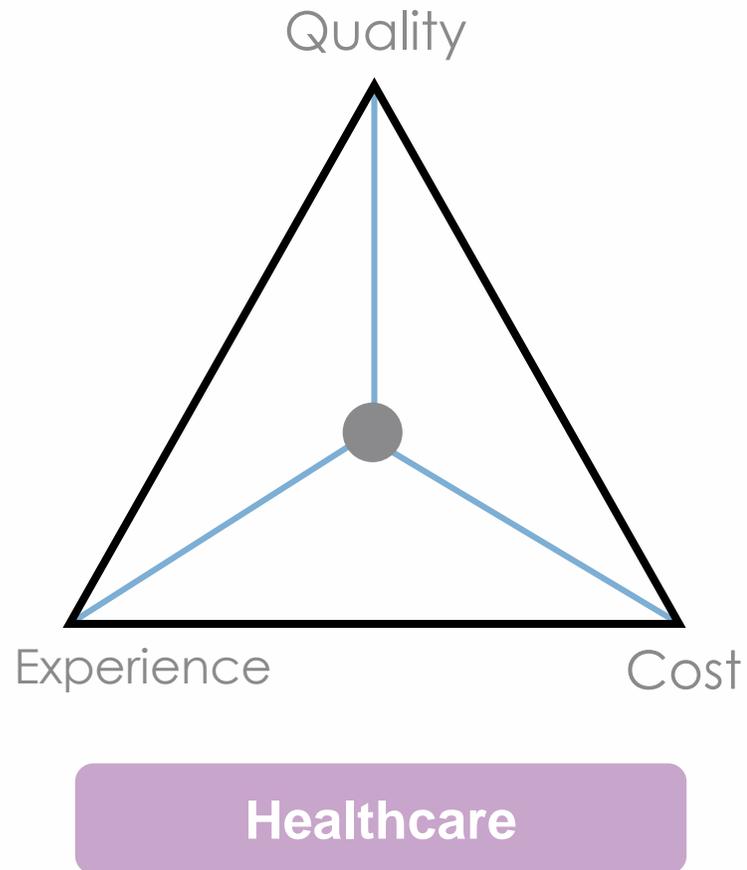
- Define the Triple Aim and the Quadruple Aim
- Describe population health
- Describe the difference between fee-for-service and value-based reimbursement
- Review 4 types of value-based payment models
- Discuss what this means for primary care:
 - ✓ Quality improvement tools
 - ✓ The data
 - ✓ The team

moving to value-based care timeline



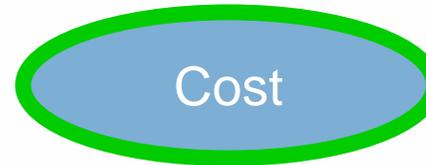
triple aim

the why



Health Outcomes

How do we improve health?
How do we address barriers?



Cost of Care

How are we using our resources?
How are we improving efficiency?



Patient & Provider Experience

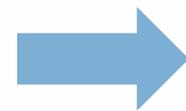
How do we engage patients?
How do we engage clinical teams?

quadruple aim

the why

Because of high costs and lower life expectancy, the U.S. is transitioning from ...

Volume-Based Care



Value-Based Care

Quadruple Aim





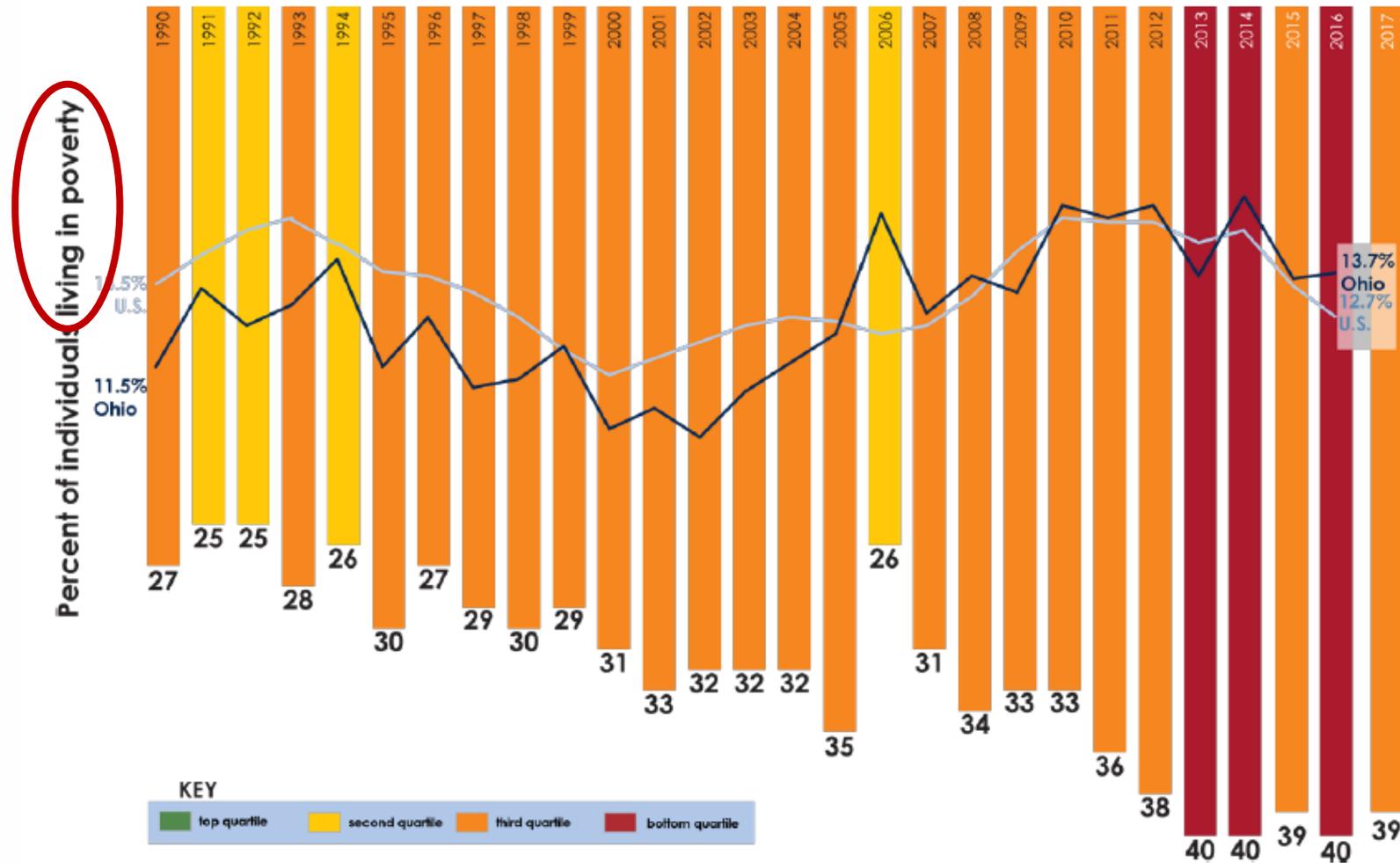
**population
health**

why do we need population health?

Ohio's rank in America's Health Rankings from 1990 to 2017

Living in Poverty

Health Policy Institute of Ohio
(HPIO)

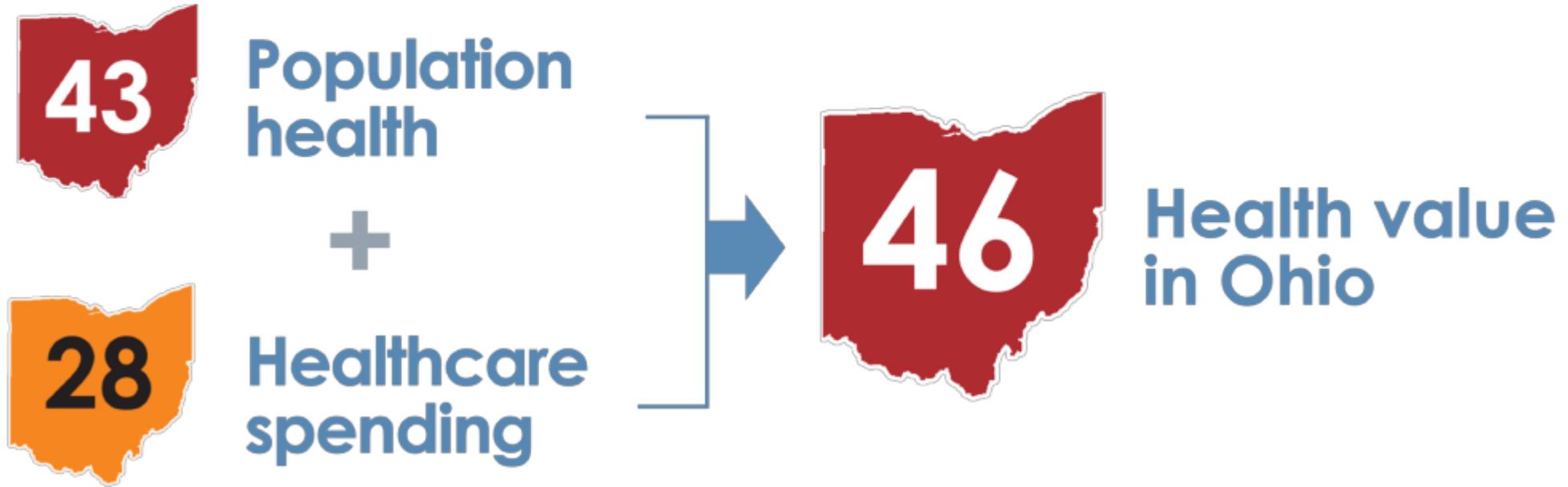


Source for poverty rate: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements, Historical Poverty Tables — People.

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Where does Ohio rank?

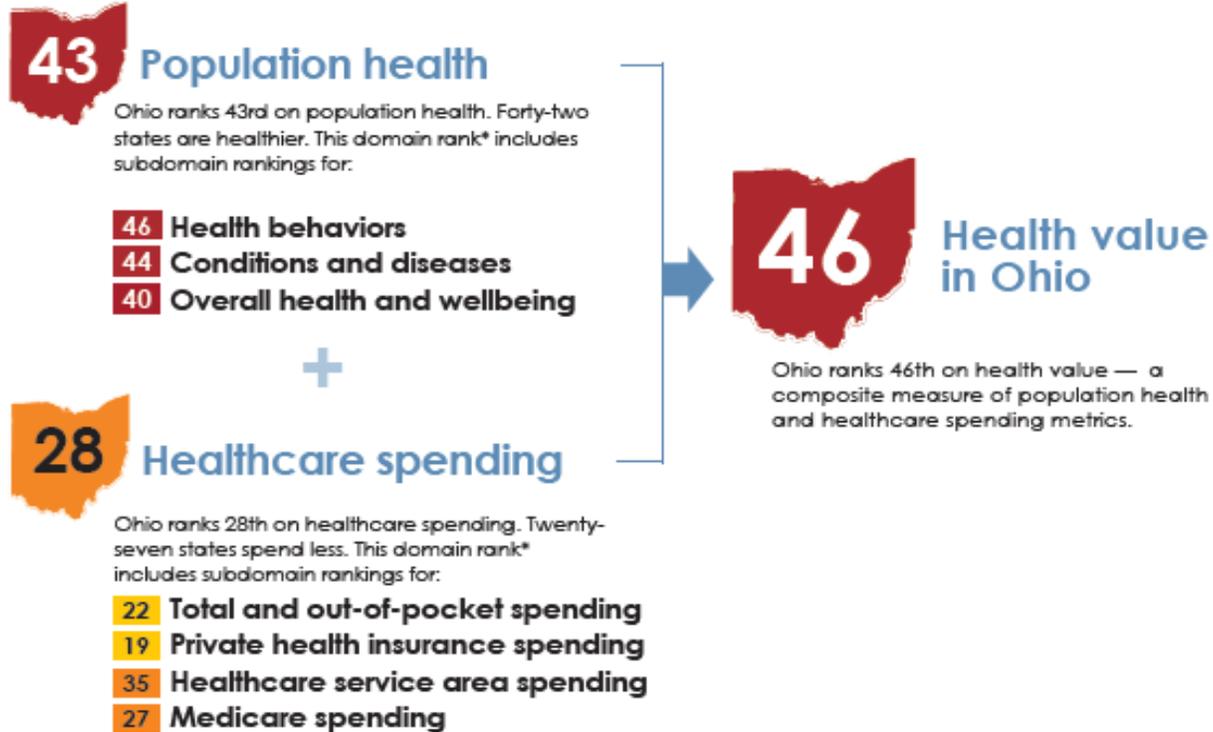
2018 Health Value Dashboard



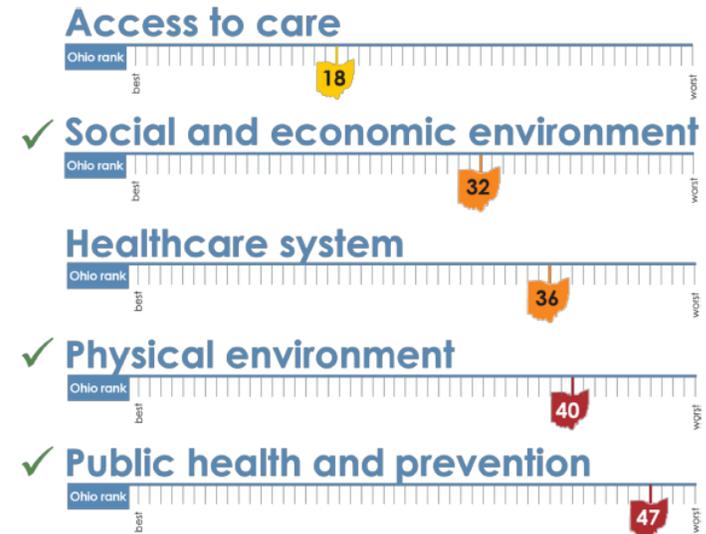
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Where does Ohio rank?

Ohioans are living less healthy lives and spending more on health care than people in most other states.



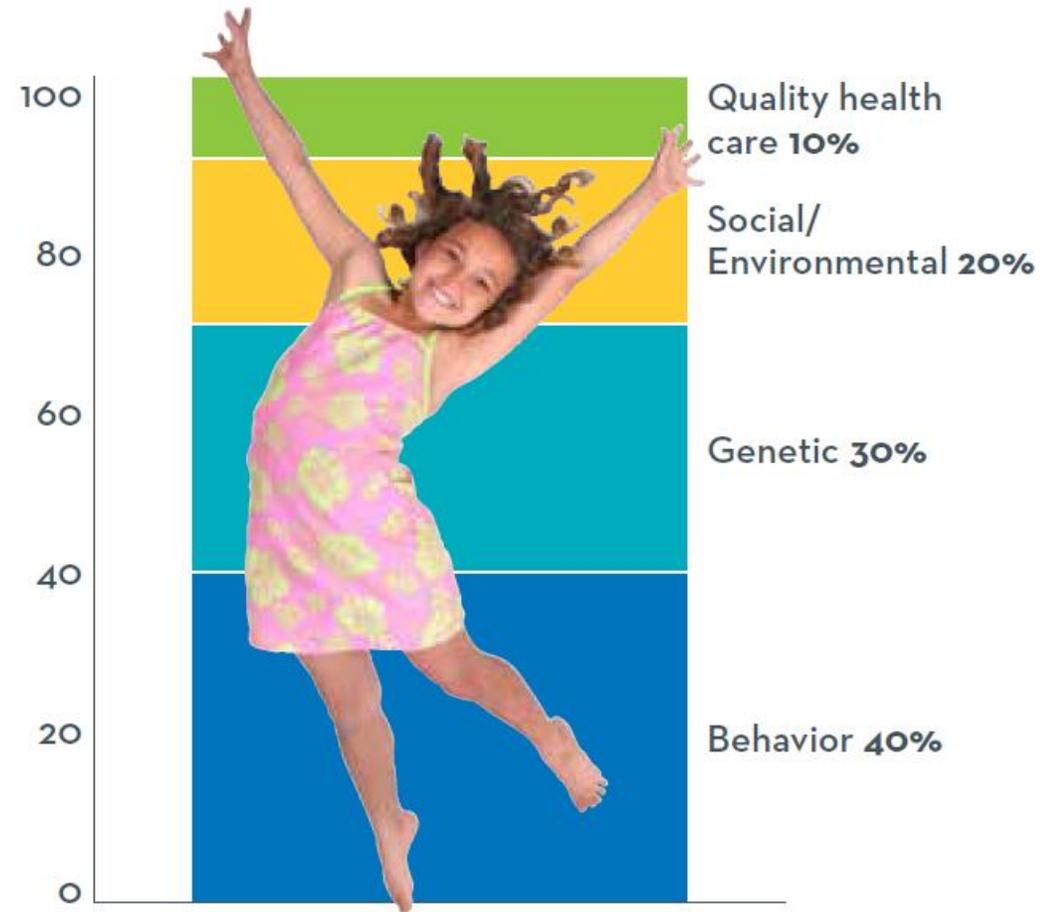
Why do we rank poorly?



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drivers of health

As CHA asserts, the “*science of disparity points us to where health happens for families; increasingly, that is outside of the hospital walls.*”



McGinnis, J.M. et al. Health Affairs 2002;21(2):78-93

what is population health?

Doing the most good
for the most people
at the least amount of cost

Jack Friedman, CEO, Providence Health Plan



**value-based
reimbursement**

definitions

Value-Based Care a concept introduced in 2004 by Michael Porter and Elizabeth Teisberg. Payment should reflect value not volume

Value-Based Health Care is a framework for restructuring health care systems around the globe with the overarching goal of value for patients

Value-Based Health Care Reimbursement is a payment model that reimburses healthcare providers based on the quality they provide to patients rather than the number of patients they see

Value-Driven Health Care seeks to directly link quality health care to reimbursement. The four cornerstones of this movement are health information technology standards, quality standards, price standards and incentives

differences in payment models

Fee-for-Service

- **Traditional** payment model
- Providers are reimbursed by insurance companies and government agencies based on the **number of services** they provide
- Payments are **per person** per visit. Payments are unbundled and paid for separately
- Rewards **volume of services** and treating illnesses and injuries as they occur

Transition Period

Value-Based Reimbursement

- **New** payment model
- Intentional consideration of **quality of care** provided and overall outcomes of that care, in relation to cost-efficiency
- **Measurement** of outcomes and costs are used to validate choices, guide improvement, demonstrate the impact of innovation, learn from others, motivate collaboration and change and justify additional investments
- “**Best practices**” are used when treating patients
- Providers receive **incentive payments** for providing **better care** for individuals **at a lower cost** and are rewarded for **proactive** management of health

types of value-based payment models

- **Pay-for-Coordination:** Primary care provider leads and coordinates care between multiple providers and specialists to manage a unified care plan for patients and to ensure efficiency and quality; e.g., the Patient-centered Medical Homes (PCMH) model
- **Pay-for-Performance (P4P):** Providers are incentivized to meet certain quality and efficiency benchmark measures. Reimbursements are directly related to achieving these performance measures; e.g., the Hospital Readmission Reduction (HRR) program

types of value-based payment models

- **Bundled Payment or Episode-of-Care Payment:** Encourages quality and efficiency because healthcare providers are reimbursed with a set amount of money to pay for a specific episode of care, such as a hip replacement, and any complications. Providers keep any realized net savings; e.g., Bundled Payments for Care Improvement and the Comprehensive Care for Joint Replacement (CJR) model
- **Shared Savings Programs (Upside and Downside):** Providers form entity groups and provide population health management. Quality and efficiency are achieved through coordinated, team care and any realized net savings are given back to the provider: e.g., Accountable Care Organizations (ACOs)

How do we
improve quality
lower costs and
keep our focus
on the patient?

best strategies

- Identify subgroups of patients with similar needs, challenges, and ways to best access care
- Develop teams that are focused on care integration and improvement for each subgroup. The development of effective teams that are true drivers of care integration is the greatest departure from status quo
- Embed care coordinators in practices wherever possible to create close relationships with patients
- Who's on the team and how should team members work together? Make sure you have enough primary care providers and other clinicians to provide comprehensive preventive and chronic care
- How should office layout change? Design the space to facilitate the effectiveness of the teams

best strategies

- Measure outcomes and costs for each patient, by subgroup. The ultimate measures of success are outcomes that matter to patients
- Integrate primary care patient subgroup teams with relevant specialty care teams
- Create patient-centered medical homes or use existing PCMHs as building blocks
- Find ways to obtain timely information from hospitals and health plans about admissions, discharges, and procedures
- Automate as much population health management as you can while emphasizing human contact for high-risk patients

best strategies

- Don't try to manage population health with your EHR alone, but use applications built for population health to help accomplish your goals
- Integrate claims data with clinical data to provide breadth, timeliness, and adequate detail for analytic purposes
- Use predictive modeling to intervene with patients who are likely to get sick in the coming year
- Use registries to track patients' health status and make sure they get the services they need
- Apply financial analytics to budgeting, using historical data on costs and activity-based cost accounting
- Restructure compensation to align provider incentives with value-based care

a local solution

Dayton Children's Health Partners (DCHP)

- A clinically integrated network (CIN) started in 2016
- A framework for engaging independent pediatric primary care providers in planning and leading population health initiatives
- An opportunity to build capacity of private practices in quality improvement, data analysis, and value-based contracting in order to improve pediatric population health outcomes
- A catalyst for change and a grassroots effort fueled by comradery
- A safe place to ask questions, challenge old ways of thinking and trail blaze new paths
- All of this is sparking interest and gaining momentum



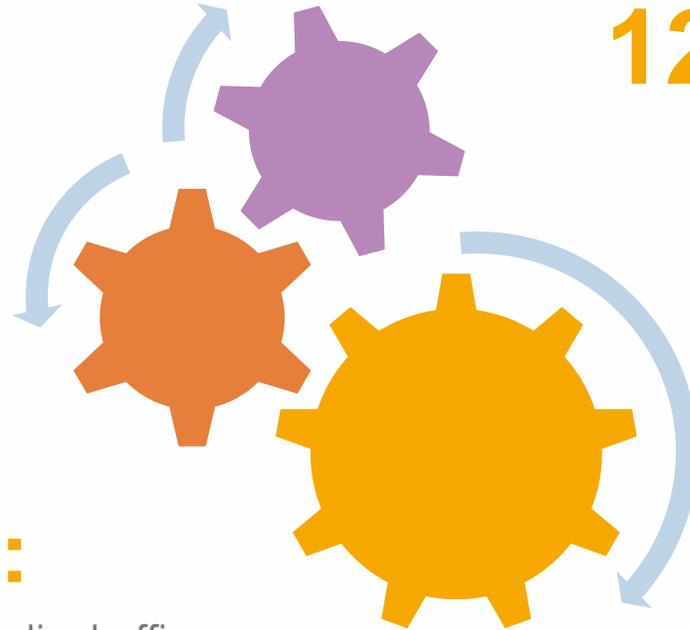
a clinically integrated network is a ...

**A collection of healthcare providers,
hospitals and payers that come
together to improve patient care and
reduce overall healthcare cost**

dayton children's health partners

clinically integrated network

150,000+
patients



5 team members:

- Shehzad Saeed, MD, chief medical officer
- Kim Grant, MS, interim executive director
- Angie Eberhart, DNP, clinical manager
- Sandy Spoltman, BS, senior data analyst
- Rachael Bell, LISW, behavioral health consultant

12 independent primary care practices

135+ primary care physicians

30 locations

155+ specialists

1 payer contract

2 co-management agreements



strategic plan 2019

collaborations in care

Develop and implement co-management agreements to facilitate alignment across the continuum of care.



financial vitality

Demonstrate performance on financial and quality indicators to tell our story to payers, employers and other potential partners.

Continue to develop payer and other relationships to support the work of the providers in the network.



right place, right care

Develop and implement education and a common language to encourage patients to utilize the best site of service for care.

Identify best practice in primary care for addressing potentially avoidable ED visits.



care transformations

Use data to develop a care management strategy to support the network's population health programs.

Utilize Wellcentive data to develop a comprehensive, pediatric risk stratification model.



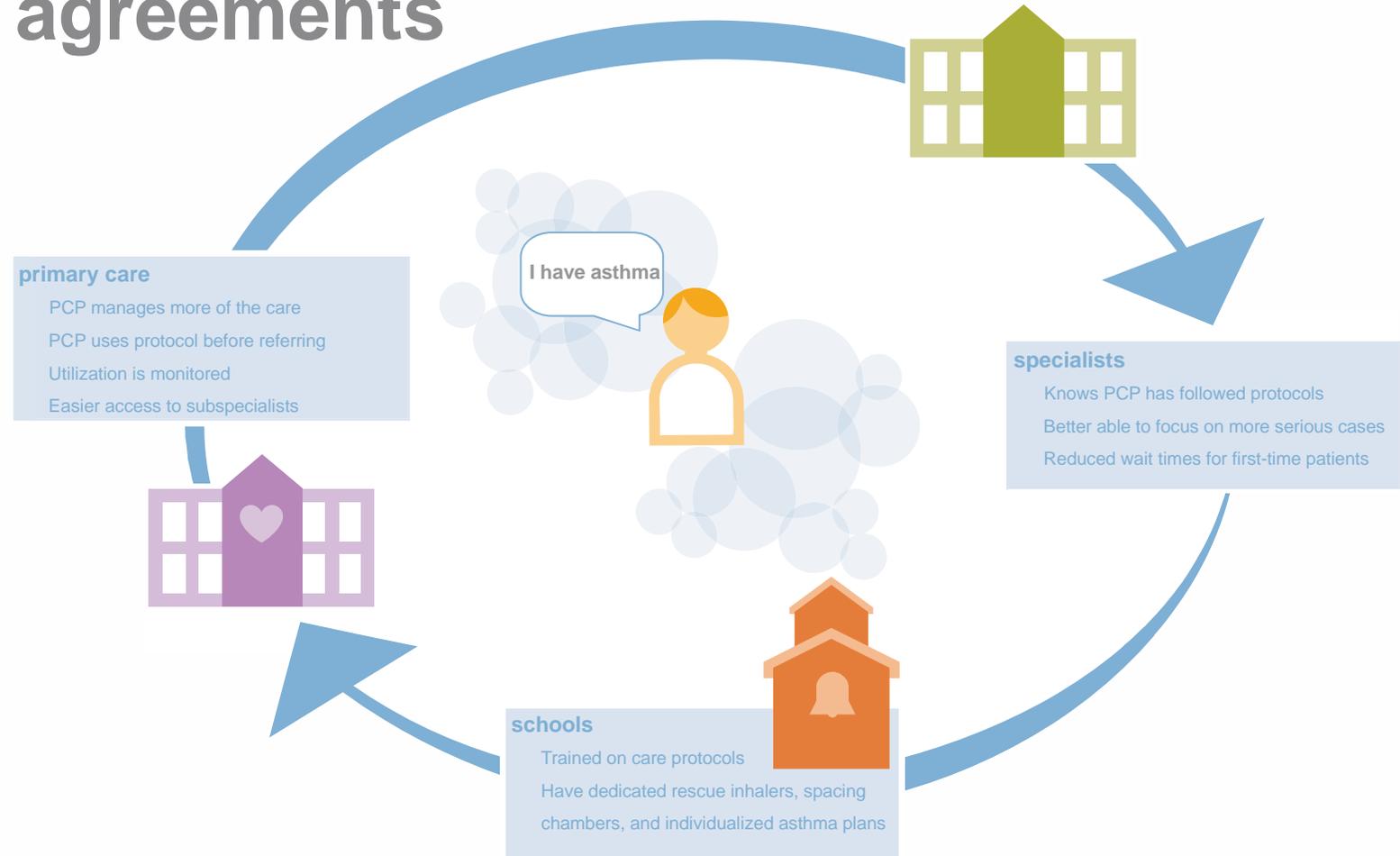
behavioral health in primary care

Develop a model for supporting the care of mental/behavioral health within primary care setting.

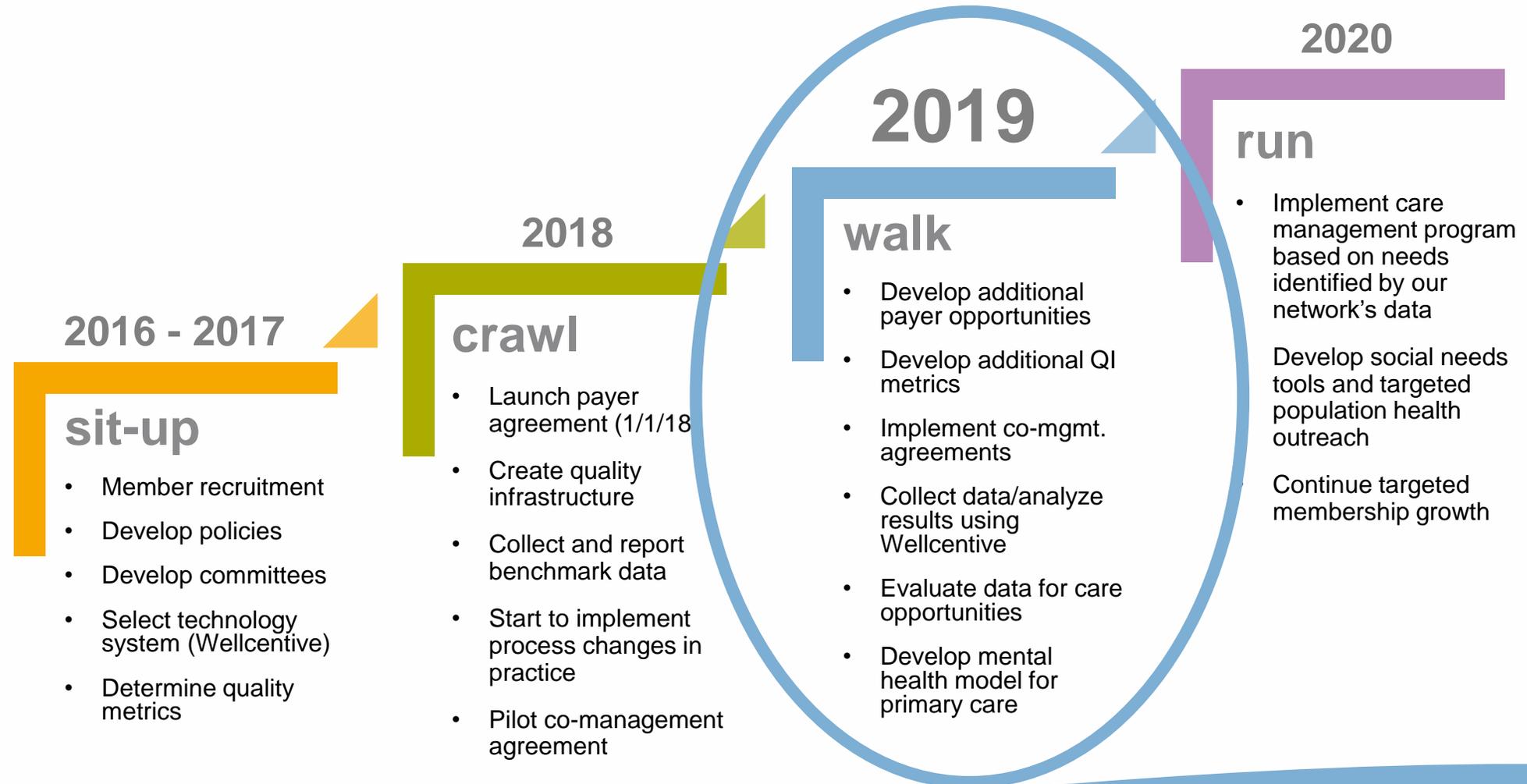


collaborations in care: co-management agreements

example: asthma



developmental milestones: “baby steps”





**quality
improvement
tools**

what is a CQM?

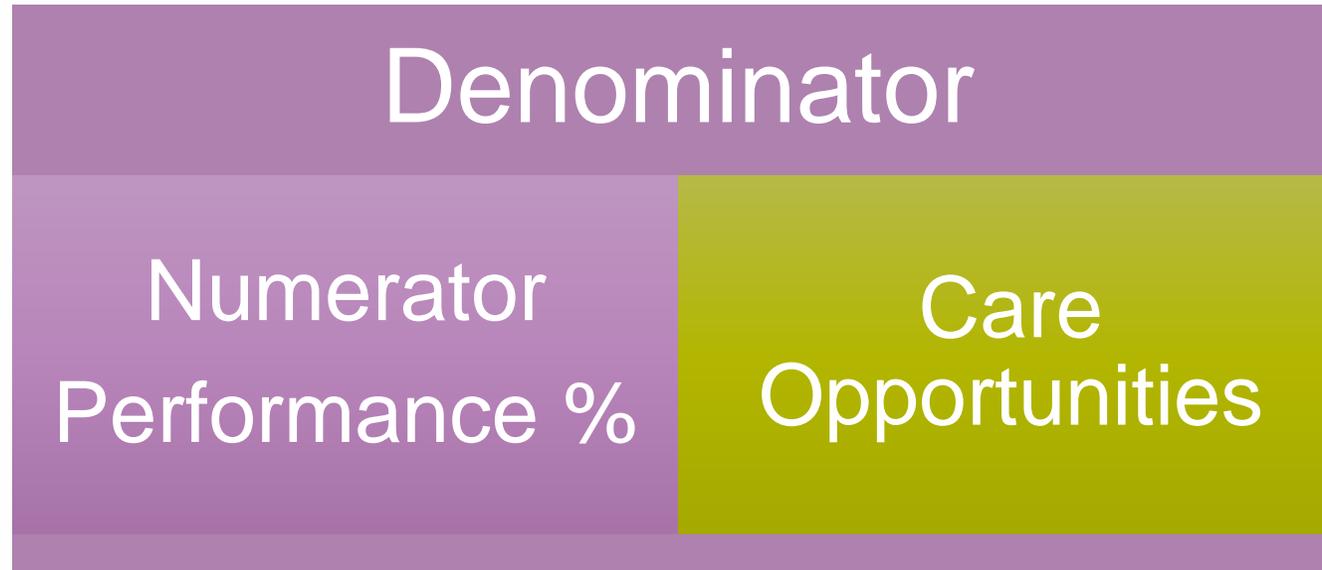
A tool that helps measure and track the quality of health care services provided by eligible professionals

CQMs measure many aspects of patient care:

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population/Public Health
- Efficient Use of Healthcare Resources
- Clinical Process/Effectiveness



all CQMs have a ...



Denominator = all the 3-6 year olds

Numerator = all the 3-6 year olds who had one well visit this calendar year

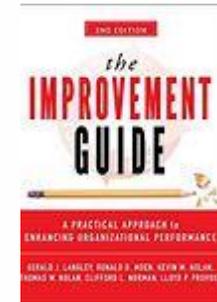
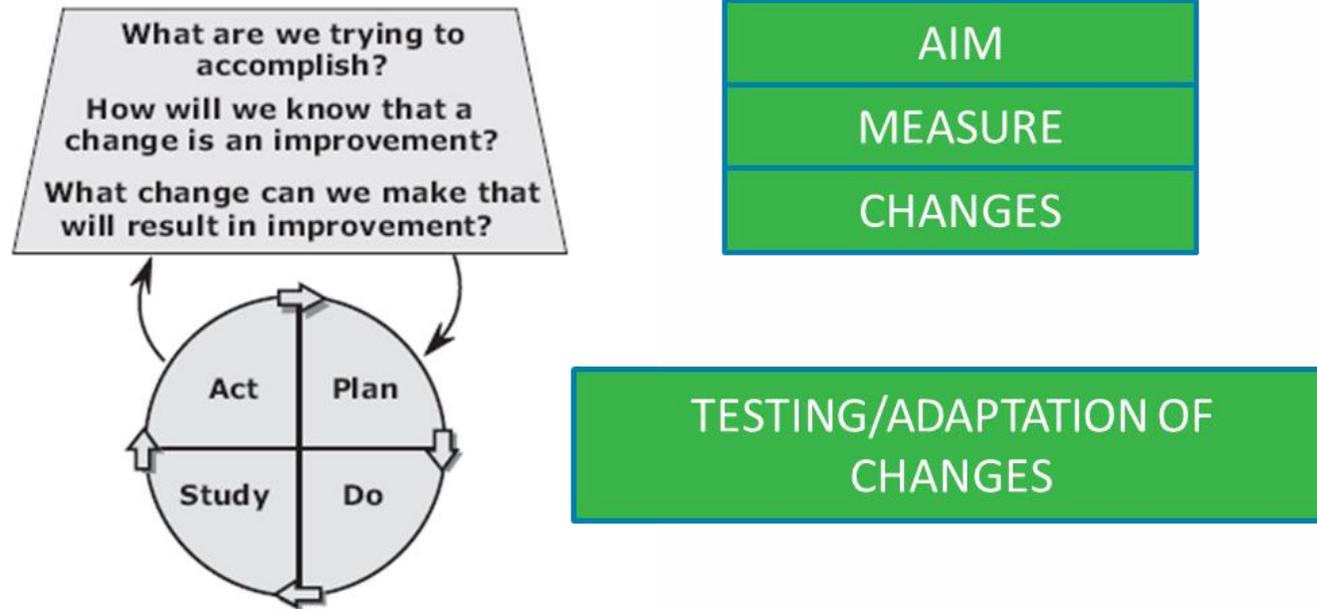
Care Opportunities = all the 3-6 year olds with no well visit this calendar year

who creates CQMs?



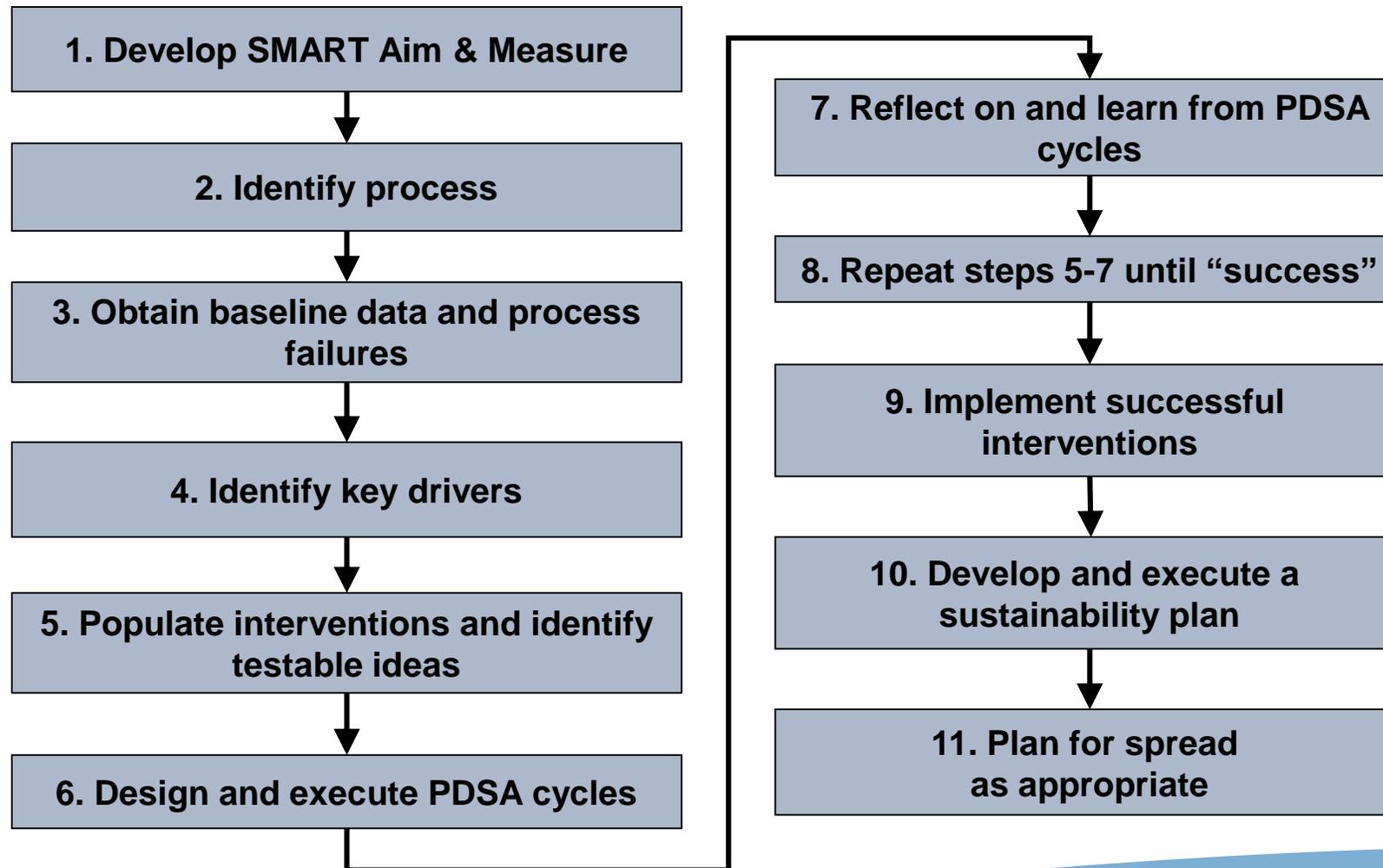
model for improvement

Fig 2. The Model for Improvement

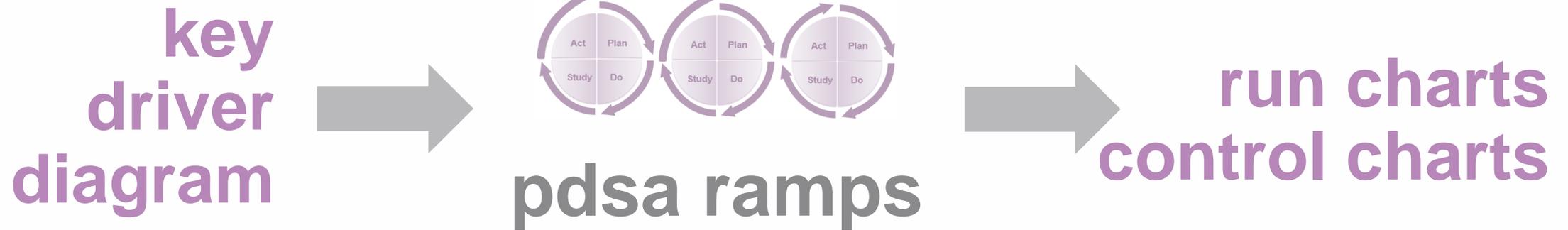


Source: Langley G et al. The improvement guide: a practical approach to enhancing organizational performance. San Francisco, Jossey-Bass Publishers, 1996.

quality improvement roadmap

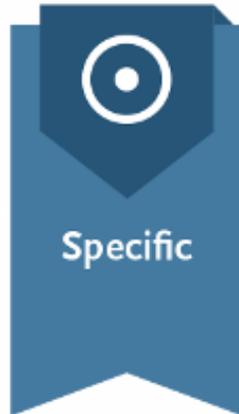


quality improvement roadmap



SMART aim

S



Specific

Definable
Clear

M



Measurable

Obtainable

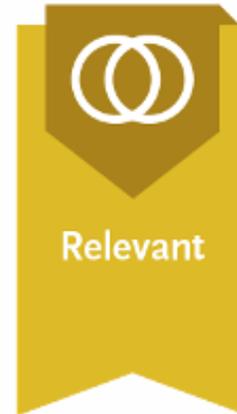
A



Attainable

Team Buy-In
Actionable

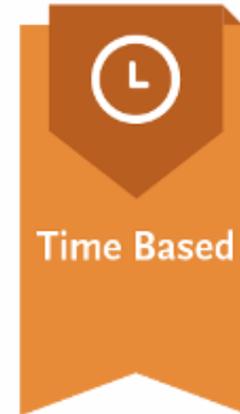
R



Relevant

Relevant to
Objective

T



Time Based

Exact Deadline

prevention SMART aims

Increase well visits for ages 0-15 months and 3-6 years

Increase fully immunized by age 2

Increase the percentage of well visits for ages 3-6 years in primary care from a monthly average of _____% to _____% by December 31, 2019.

Increase the percentage of well visits for 0-15 months of age in primary care from a monthly average of _____% to _____% by December 31, 2019.

Increase the percentage fully immunized 2-year olds in primary care from a monthly average of _____% to _____% by December 31, 2019.

utilization SMART aim

Decrease potentially avoidable emergency department (PAED) visits

Decrease the percentage of PAED visits for ages 3-17 in primary care for pharyngitis, strep, URI, cough and fever from a monthly average of _____% to _____% by December 31, 2019.

ICD-10 Codes:

Pharyngitis J02.0 & J02.9

Strep B95.0

URI J006.9

Cough R05

Fever R50.9

Simplified Failure Mode Effects Analysis (sFMEA) 2.20.19 v1

Project Name: Well Visits Age 5

Process Name: Scheduling and Reminders

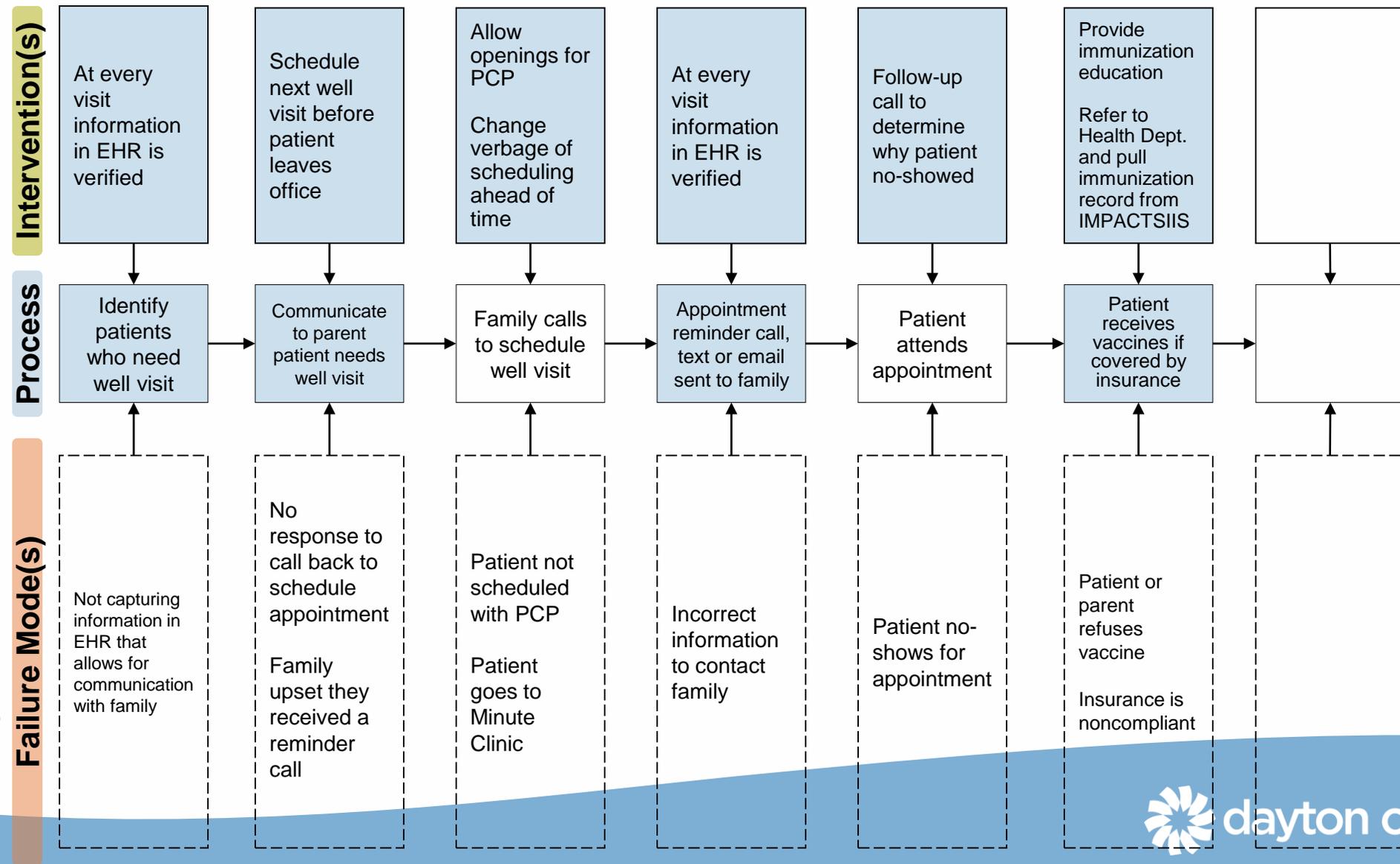


Move these to KDD

Picture of the current process

What could possibly go wrong

Informs interventions



Key Driver Diagram

Clear picture of the team's shared improvement roadmap

Project Name:

Project Leader:

Revision Date 2/20/19 v1:

Overall goal of QI project

SMART AIM

Goal of larger system affected by QI project

GLOBAL AIM

- The "what" needed to accomplish the aim
- Stated in the affirmative
- General statements
- Nouns

KEY DRIVERS

- The "how," the change that will occur
- Action oriented
- Very specific
- Verbs

INTERVENTIONS (LOR #)

increasing well visits age 5

key driver diagram (KDD)

project leader:
workgroup:
revision date: 3/20/19 v2

SMART aims

By December 2019, for children ages 5 years to 5 years 11 months and 30 days:

- Increase well child check from 63% to 93%
- Increase immunization compliance for DTaP from ___ % to ___ %
- Increase immunization compliance for MMR from ___ % to ___ %
- Increase immunization compliance for Varicella from ___ % to ___ %
- Increase immunization compliance for influenza from ___ % to ___ %

global aim

Support learning in school by improving preventative care for children entering kindergarten

key drivers

Correct patient demographics in EHR

Parent by-in and compliance

Provider availability

Consistent well child visit attendance

interventions

- **Educate** parent on importance of routine well child visits.
- **Educate** parent on the importance of vaccines.

- Create process for ongoing **verification** of patient demographics.
- Create process that will **encourage** parents to schedule appointments ahead of time or when they leave for the next well child visit.

- Create consistent **proactive review process** for appointments
- Create **follow up** process for No Show Appointments
- Create **No Show Compliance Report**
- Create process for staff to **schedule** chart reviews for well child visits.

the how

primary care PDSA cycle

- 1 pilot team
- Small test of change
- Pilot team makes recommendations before disseminating to other teams

P – Plan

Choose test or observation
Plan for collecting data
Make predictions
Write a SMART goal
Who? What? When? Where?

S – Study

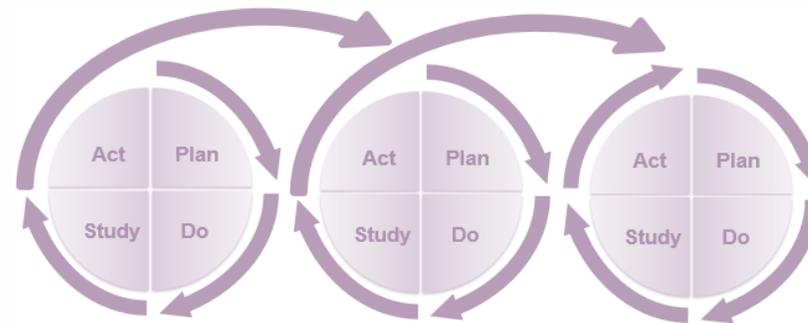
Set aside time to analyze data and study results
Compare data to predictions
Summarize and reflect on discoveries

D – Do

Try out the test on a small scale
Document what happened including unexpected observations

A – Act

Refine the change base on what was learned
Determine what modifications should be made
Prepare for next cycle
Recommend best practice



stepwise approach to intervention strategies





the data

whose patient is this anyway?

what is attribution?

The process of determining which provider is responsible for the care of a patient

per member per month (PMPM) payments

Prospective payments

Based on **level of risk**

- Low
- Medium
- High



shared savings payments

Retrospective payments

Based on **quality and costs**

differences in displaying data

Run Charts

1. Clear title (abbreviated SMART aim)
2. Label X-axis and Y-axis with appropriate descriptors
3. Include population size and description
4. Indicate goal line
5. Label desired direction of change (↑ or ↓)
6. Calculate and display a **median** line
7. Annotate chart with interventions and significant event

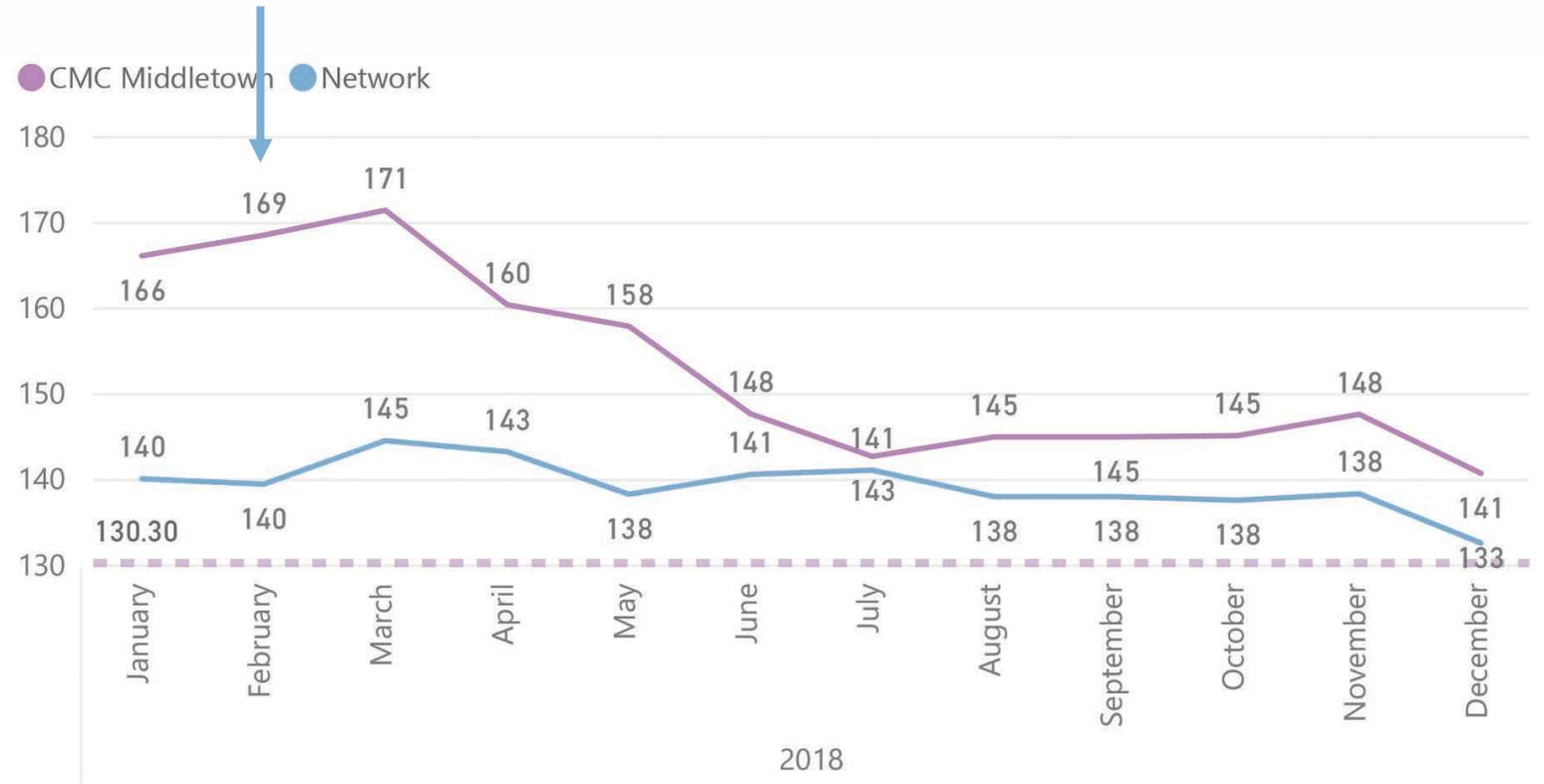
Control Charts

1. Clear title (abbreviated SMART aim)
2. Label X-axis and Y-axis with appropriate descriptors
3. Include population size and description
4. Indicate goal line
5. Label desired direction of change (↑ or ↓)
6. Calculate and display a **mean** line
- 7. Upper and lower control limits**
8. Annotate chart with interventions and significant events

annotated run chart

potentially avoidable ED visits

Added Afternoon
Walk-in Hours



annotated control chart

reducing ED constipation visits
Network Wellcentive data, 1/6/18 – 8/24/19

Desired direction
of change



P Chart

BASELINE



Note



Outlier



Note



Note



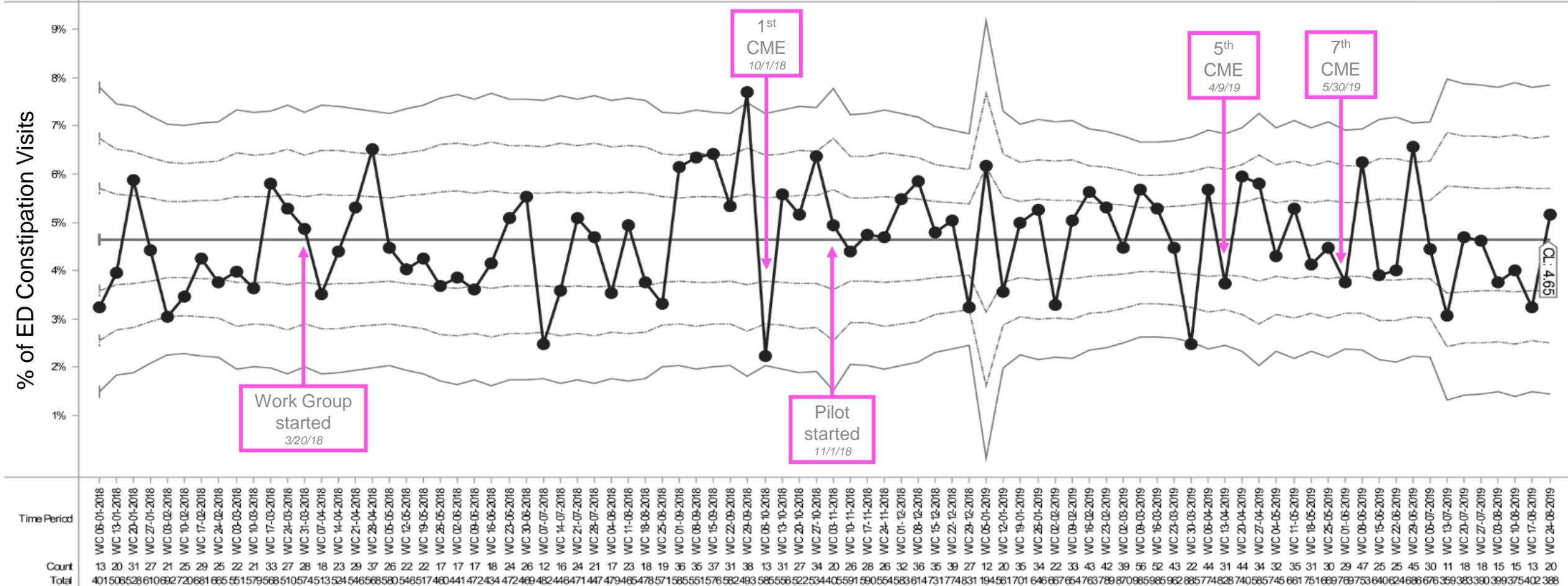
Outlier



Note



Note

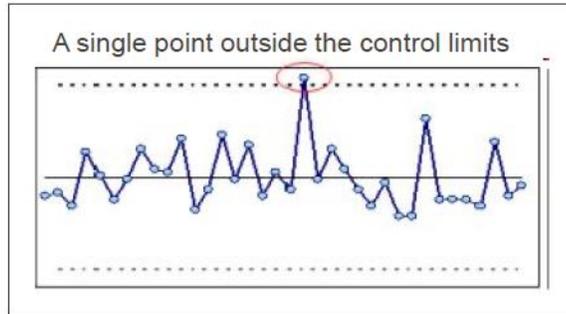


special cause variation

using control charts: rules for special causes

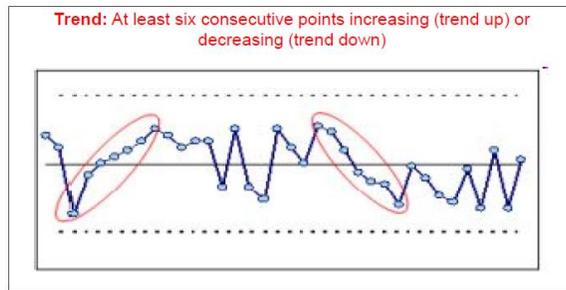
A control chart must show one of the following conditions to indicate sustained (statistically significant) improvement in the system.

single



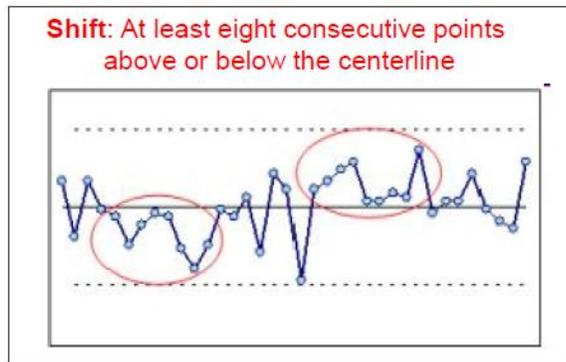
Single Point: A **single** point outside of the control limits.

trend



Trend: **Six (6)** consecutive points going up or down.
Two points of the same value within a trend count as one point.

shift



Shift: **Eight (8)** consecutive points either above or below the median.
Points on the mean within the shift do not count.

reporting tools

Tool	Description	Pros	Cons
Payer	<ul style="list-style-type: none"> • Electronic reporting tool used by a payer to capture performance of CQMs 	<ul style="list-style-type: none"> • Allows for tracking of costs and coding and billing habits 	<ul style="list-style-type: none"> • Based on claims data therefore treatment opportunities are 6 months old
Data Aggregation Software	<ul style="list-style-type: none"> • Electronic platform that aggregates data from PCPs, specialists, hospitals, labs, pharmacies & payers 	<ul style="list-style-type: none"> • Pulls data directly from multiple sources, including the EHR • Combined data allows for more comprehensive goal-setting around quality and costs • Treatment opportunities are nearly real time • Numerator, denominator and performance percentage easily available 	
Electronic Health Record (EHR)	<ul style="list-style-type: none"> • Digital record of a patient's health care 	<ul style="list-style-type: none"> • Timely data • Reporting capabilities 	<ul style="list-style-type: none"> • Cost data not available • Not all practices have an EHR

data aggregation

wellcentive

LifeQI

Availity™

Greenway Health™



athenahealth

Epic



Allscripts®

eClinicalWorks

wellcentive reporting

PHM Dashboard

DCHP ADT EVENTS NOTIFICATION

PHM DASHBOARD

WORKLIST	PATIENT COUNT	PERFORMANCE %
At-Risk Population		
★ Utilization: 2 or more PAED visits in Past 6 Months (DCHP)	1,870	2% ↓
Gaps in Care		
★ IMM: 15-18 month olds who need to catch up on 2 yr old immunization schedule (combo 10) - LMP	2,459	100% ↑
Risk Management		
★ JH RISK - RUB 5	25	0%

FAVORITE REPORTS	LAST REFRESH	REPORT TYPE
★ Asthma	01-15-2019 10:04 AM	Provider View
★ Constipation Co-Management	01-15-2019 9:13 AM	Provider View
★ Potentially Avoidable ED Visits (PAEDs)	01-15-2019 9:13 AM	Provider View
★ Potentially Avoidable Emergency Department (PAED) Visits		Patient Compliance View
★ Well Visits 0-15 Months		Patient Compliance View
★ Well Visits 3, 4, 5, 6 Years		Patient Compliance View

UTILIZATION: 2 OR MORE PAED VISITS IN PAST... Physician Organization:

No benchmark configured. [Click here to set a benchmark](#)

Size: Population, Shading: Performance %

The data is missing

Size: Top 10 Payers, Shading: Performance %

POPULATION OVERVIEW	NUMERATOR	POPULATION	PERFORMANCE %
CMC Middletown	29	7,466	0%
Child and Adolescent Specialty Care	112	10,464	1%
Cornerstone Pediatrics	60	8,056	1%
Dayton Hospital	1,137	47,761	2%
Ohio Pediatrics - North	145	6,224	2%
Ohio Pediatrics - South	338	10,460	3%
Pediatric Associates of Dayton - Beavercreek	0	0	0%
Pediatric Associates of Dayton - Englewood	0	0	0%
Pediatric Associates of Dayton - Kettering	0	0	0%

scorecard vs. dashboard

	Scorecard	Dashboard
Purpose	Managing performance	Performance at a glance
Timeliness of Data	Periodic (often monthly)	Current (often real time)
Users	Leaders	Point of service
Link to Systems	Sometimes	Almost always

- Scorecards and dashboards are analytical tools that allow you to focus on measurements that are important to your practice
- Scorecards and dashboards are not mutually exclusive
- The best analytical tools are often a combination of both
- Each user should use the tool or tools that are most appropriate to their function and responsibilities

scorecard

- Goal: create an easy to understand tool
- Highlight key measures selected by quality committee
- Gain insight on pediatric population: data is an asset

network
Anthem Performance Scorecard
2019 Baseline Data



▲ improvement from baseline
▼ decline from baseline
— no change from baseline

Acute and Chronic Care						
Measure	Eligible	Met	Not Met	# to 20th %	# to 80th %	Network Rate
Appropriate testing for Children with Pharyngitis	1,289	1,203	86	0	22	93.33%
Appropriate treatment for Children with URI	652	601	51	0	18.4	92.18%
★ Asthma Medication Ratio - Peds	108	98	10	0	2	90.74%

★

Preventive Care						
Measure	Eligible	Met	Not Met	# to 20th %	# to 80th %	Network Rate
★ Childhood Immunization Status: MMR	1,120	1,039	81	0	24	92.77%
★ Childhood Immunization Status: VZV	1,120	1,029	91	0	32	91.88%
★ Well Child Visits Ages 0-15 Months	962	850	112	0	46	88.36%
★ Well-Child Visits Ages 3-6 Years Old	3,498	3,166	332	0	83	90.51%
Chlamydia Screening: Peds	293	83	210	0	1	28.33%
Chlamydia Screening: 18+	390	152	238	0	49	38.97%

★

★

★

★

Utilization		Network Rate
★ Potentially Avoidable ER: Peds		69.17
Potentially Avoidable ER: 18+		54.95
Brand Formulary Compliance Rate: Peds		83.72%
Brand Formulary Compliance Rate: 18+		70.52%

★

Improvement					
Measure	Eligible	Met	Not Met	To Benchmark	Network Rate
★ Well-Child Visits Ages 3-6 Years Old	3,498	3,166	332	0	90.51%
Appropriate Testing for Children with Pharyngitis	1,289	1,203	86	0	93.33%

★

Benchmarks	
20th Percentile	80th Percentile
80.84%	95.00%
84.62%	95.00%
85.90%	92.25%

Benchmarks	
20th Percentile	80th Percentile
85.89%	94.92%
85.79%	94.69%
80.97%	93.13%
78.07%	92.89%
17.32%	28.57%
35.99%	51.49%

Benchmarks	
20th Percentile	80th Percentile
84.04	35.20
69.27	34.34
74.36%	91.86%
68.94%	89.63%

Benchmarks	
20th Percentile	80th Percentile
	90.00%
	90.00%

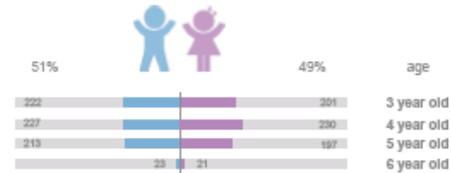
dashboard: practice or provider level

well-child visits ages 3-6 years old

practice a
claims paid through 03/31/2018
claims incurred through 12/31/2017

practice stats

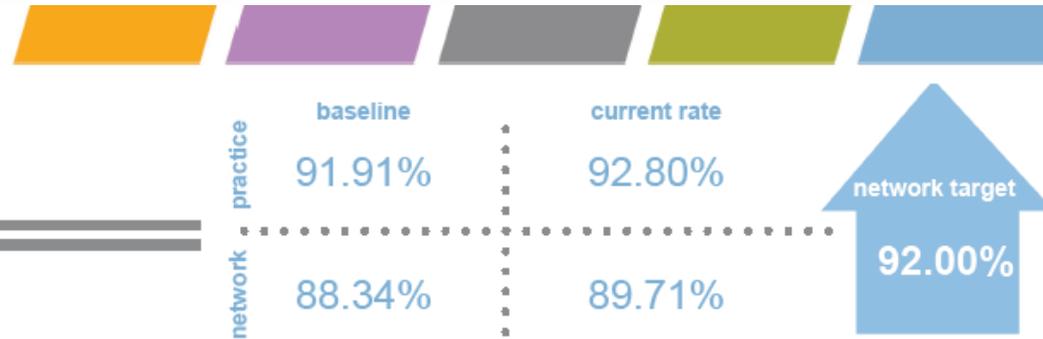
attribution



care opportunities



monthly performance



69 = services to network target

path to best practices

- Pull care opportunity reports from Availity showing patients who are coming due for their well-child visit within the nex 30-60 days.
- Practices will take action to call those patients to schedule appointments

Acute & Chronic Care	Baseline Network Rate 11/30/18	Current Network Rate 7/31/19	Network Goals	Program Benchmarks	Program
Pharyngitis ↑	93.33%	93.83%		95%	Anthem
URI ↑	92.18%	95.28%		95% --	Anthem Episodes of Care
Asthma ↑	90.74% --	88.71% --		92.25% --	Anthem Episodes of Care Co-Management
★ Constipation					Co-Management
Prevention					
Immunizations ↑ <i>(fully immunized by age 2)</i>	92.77% 91.88%	93.11% 92.76%		94.92% 94.69%	Anthem MMR Anthem Varicella DCHP
Well Visits 0-15 Months ↑	88.36%	86.10%		93.13% 48.80%	Anthem CPC
★ Well Visits 3-6 ↑	90.51%	90.89%		92.89% 59.49%	Anthem CPC
Utilization					
★ PAED Visits ↓	69.17/1000	69.23/1000		35.20/1000	Anthem

network goals 2019



be data-savvy

data-literate

curious

action-oriented

communicative

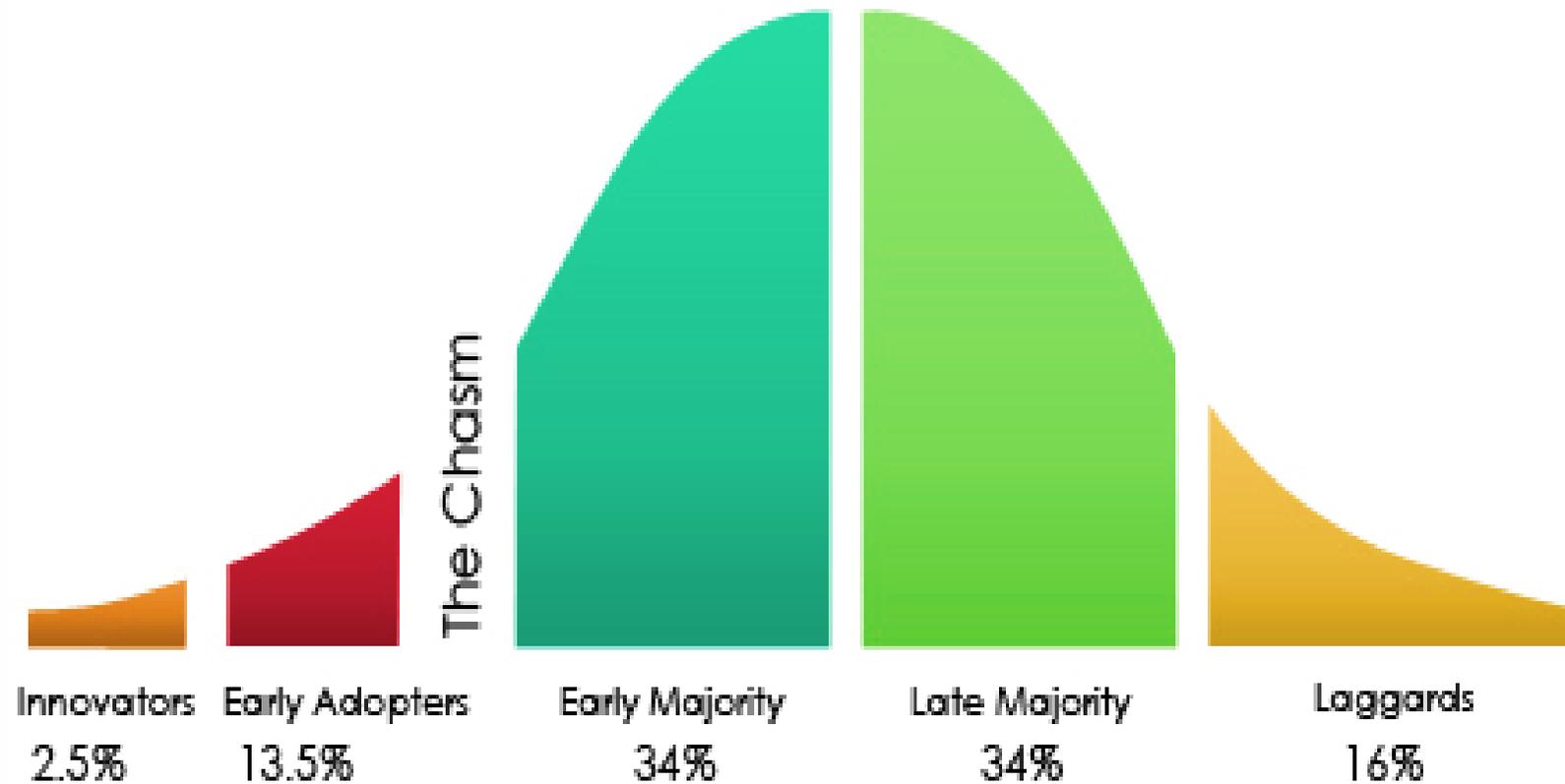
skeptical



the team

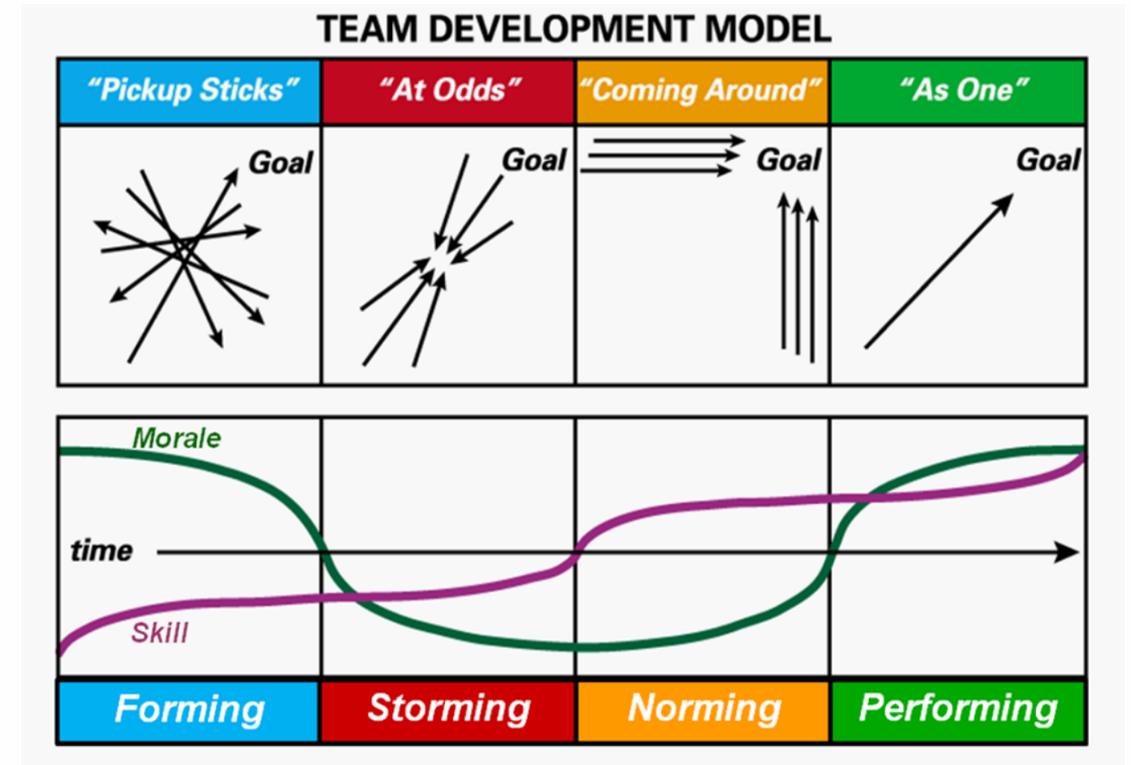
Diffusion of Innovation Model

Everett Rogers, 1962



stages of team development

- Developed by Bruce Tuckman, psychologist
- In his 1965 article, he describes the path that most teams follow on their way to high performance
- High performing teams equal high impact at the point of care



paradigm shifters



questions

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