

Critical Success Factors for
succeeding in Value Based Payment
Models:
Infrastructure for improving health
and reducing costs

David Kendrick, MD, MPH

Relevant Disclosure and Resolution

Under Accreditation Council for Continuing Medical Education guidelines disclosure must be made regarding relevant financial relationships with commercial interests within the last 12 months.

David Kendrick, MD, MPH

I am consulting manager of MyHealth through a contract between OU and MyHealth.

Learning Objectives

Upon completion of this session, participants will improve their competence and performance by being able to:

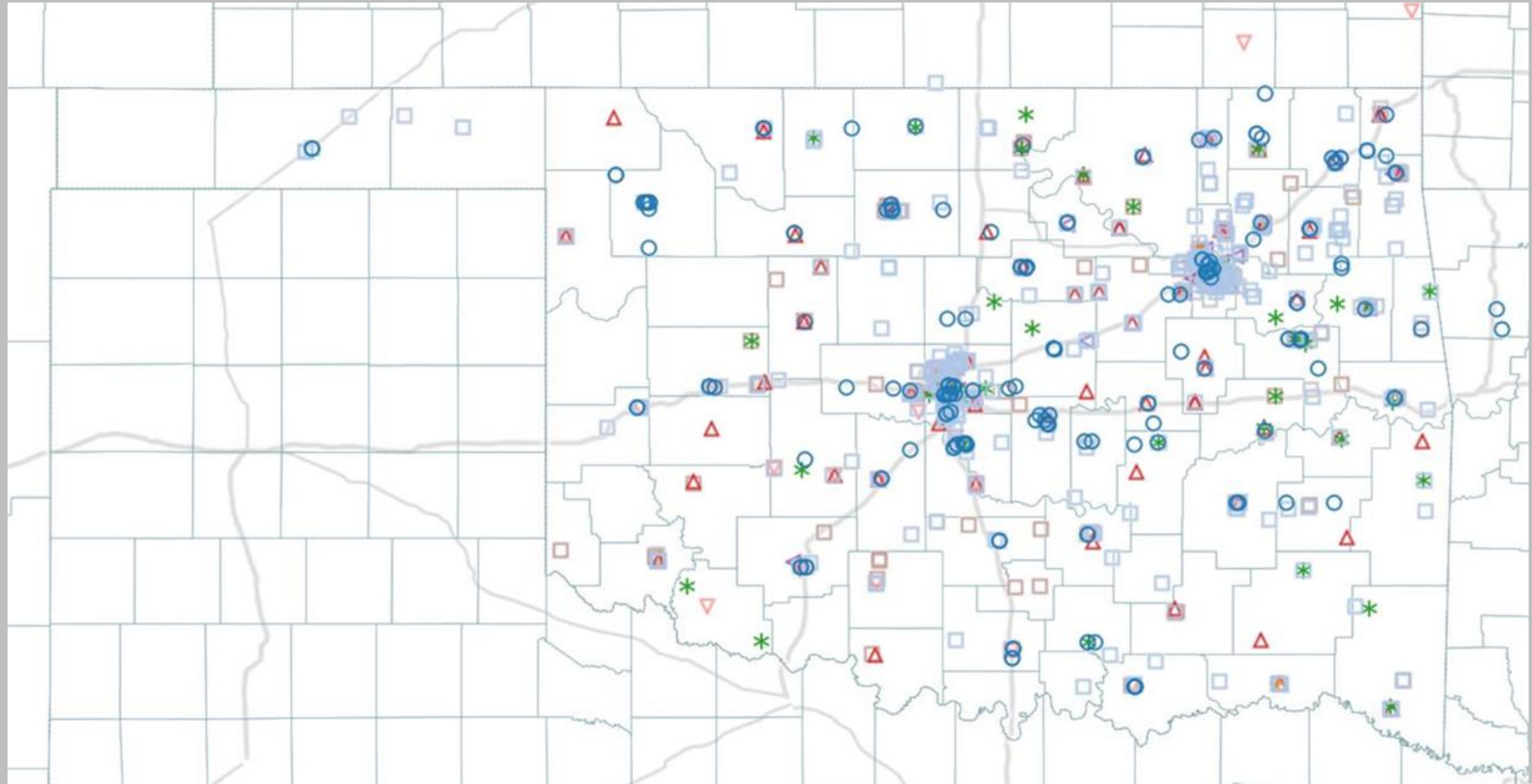
1. Describe the status of health information exchange in Oklahoma
2. Access and use the site and tools of the Health Information Exchange
3. Describe the ways that the tools and reports can be used to improve population health management, quality, and care gap closure



MyHealth[®]
ACCESS NETWORK

Locations

1072



Facility Type

Null	Emergency Services	Lab	Pharmacy
Behavioral Health...	FQHC	Long Term Care ...	Public Health
Clinic	Hospice	Ophthalmology/Op...	Urgent Care Facility
Community/Social...	Hospital	Payer	

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Behavioral Health...	FQHC	Long Term Care ...	Public Health
Clinic	Hospice	Ophthalmology/Op...	Urgent Care Facility
+ Community/Social...	Hospital	Payer	

VBPM's: Critical Success Factors for Providers and Payers

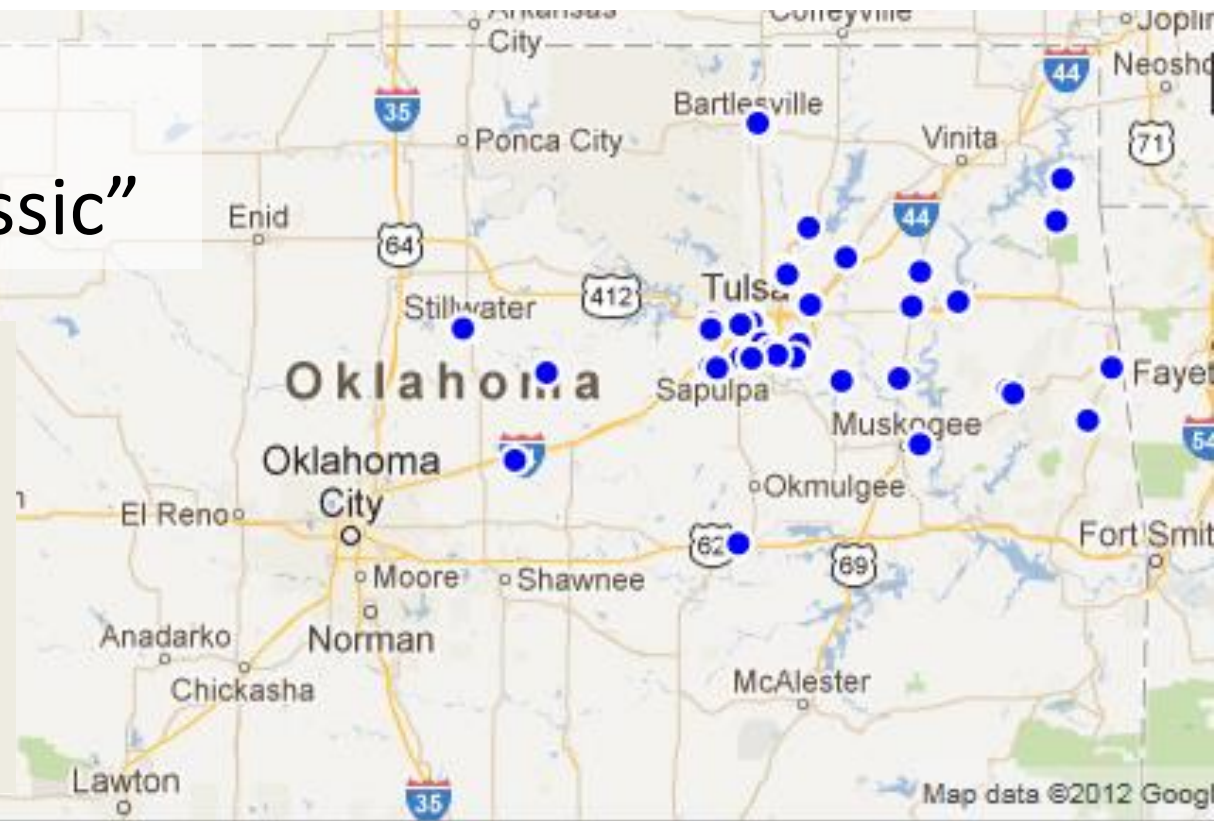
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Comprehensive Primary Care “Classic”

**\$100M in Care
Management
and Practice
Transformation
fees to PCPs**



- 68 practices, 265 docs
- OK Payers require MyHealth Participation
- >30 hospitals affiliated
- Four payers (BCBS, CCOK, Medicaid, Medicare)
- >90% of covered lives
- Shared savings Y3-4

CPC Medicare Advantage Cost Impact

- Cost impact over first 2 years of program:

Category	CPC 2 year cost savings
Admissions for COPD	-27.4%
Admissions for CHF	-13.7%
Lab Costs	-25.2%
Imaging Costs	-47.7%
High Tech Imaging	-46.6%
Outpatient Costs	-32.1%
Hospital Admissions	-10.4%
30-day Readmission Rate	-9.3%
Total Medical Allowable	-13.7%

Oklahoma Results

Comprehensive Primary Care

\$33 million in gross savings
\$25 million in net savings
\$12.5 million in potential shared savings
\$10.8 million shared with **52 of 61 practices**

**Net Savings:
5.4%**

Overall Quality Performance

92% of practices successfully reported eQIMs

85% of practices met quality requirements

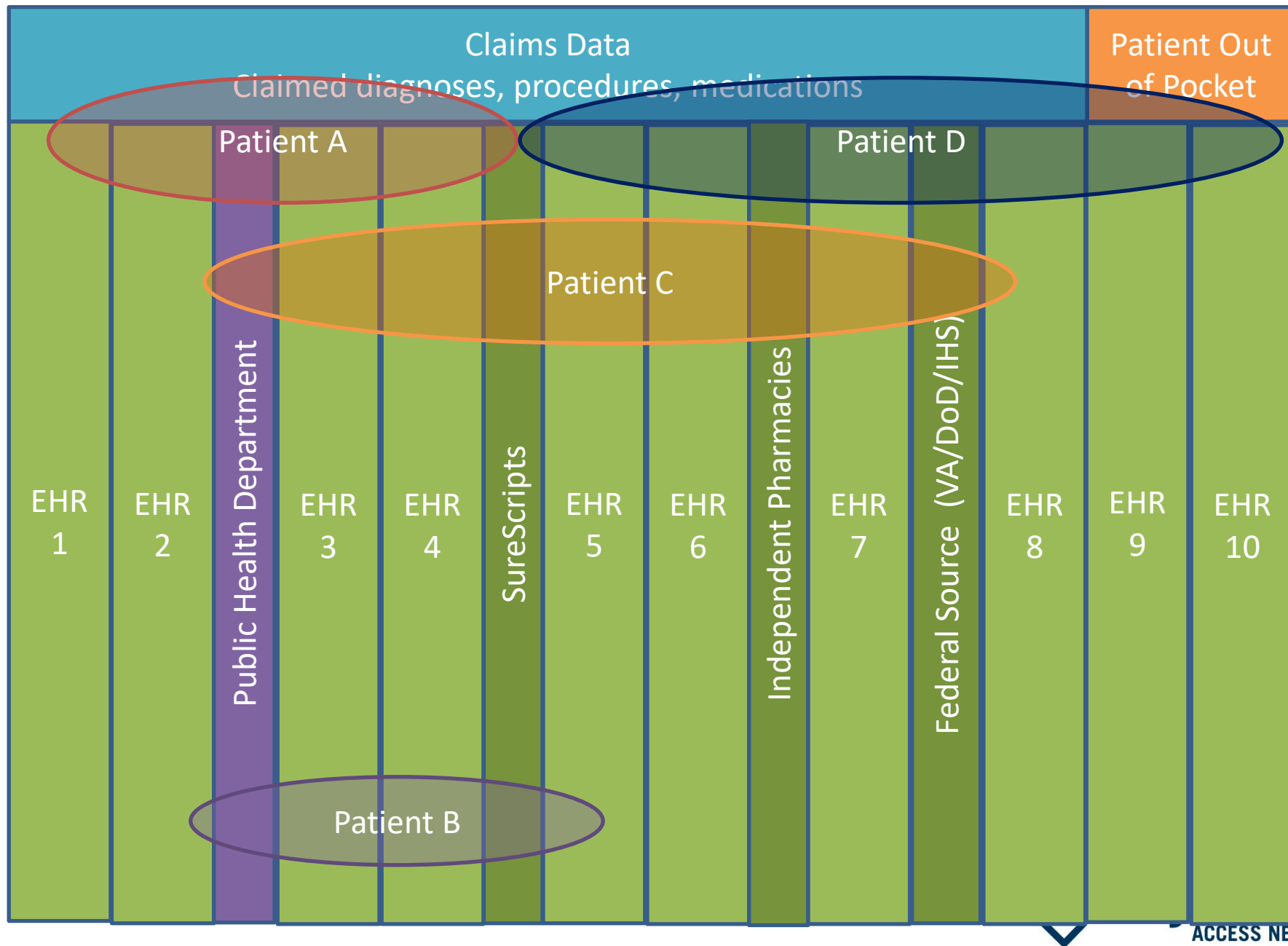
Claims-based Measures

Exceeded benchmarks for all 3 measures

- All-cause readmissions: 14.68% (highest benchmark)
- HF admissions: 0.97 (first benchmark)
- COPD admissions: 1.12 (first benchmark)

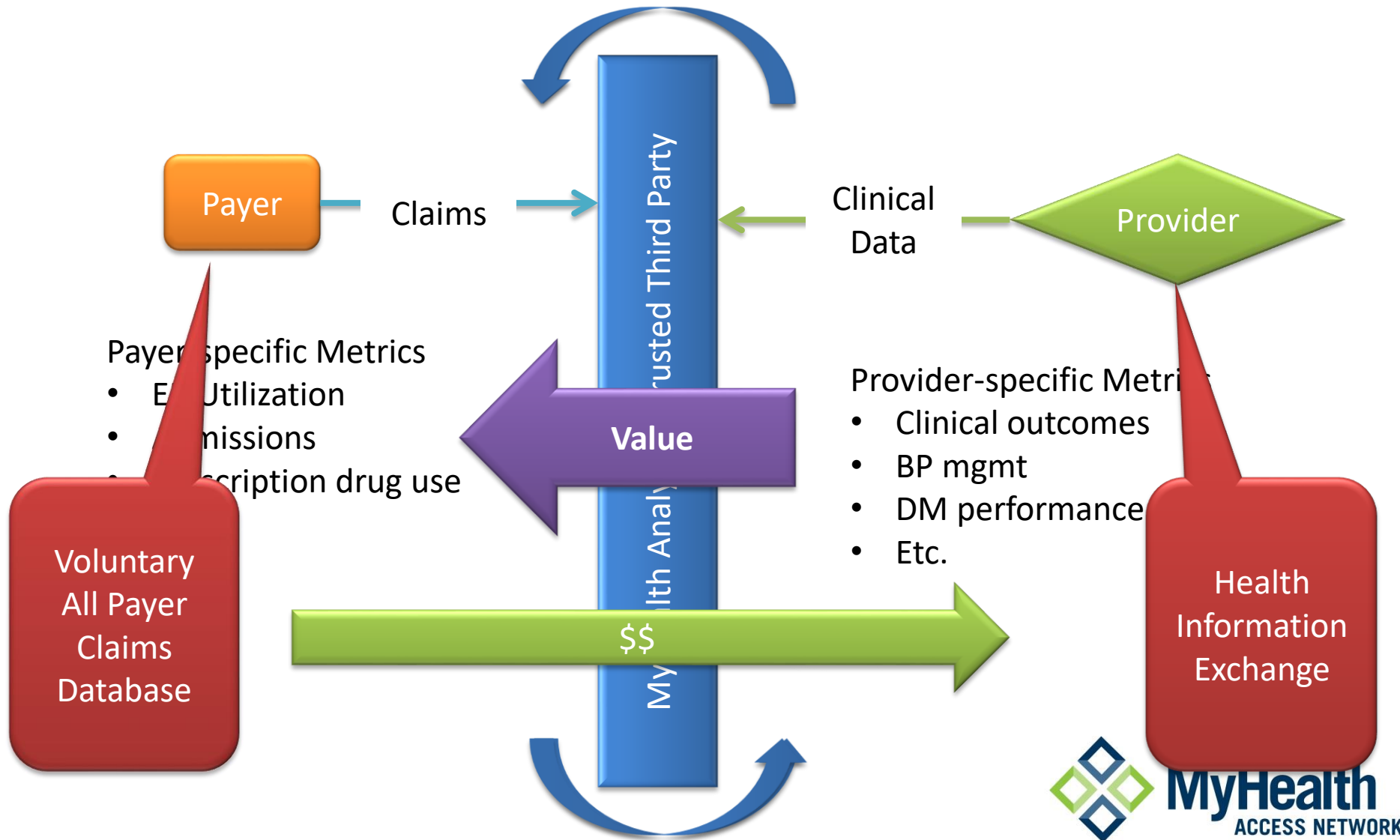
VBPM's: Critical Success Factors for Providers and Payers

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NETWORK

Pay for Value: Trusted 3rd Party



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Patient Name

DOB: Age: 44

Filter Data Sources Print

SUMMARY VITAL SIGNS MEDICATIONS PROBLEMS ALLERGIES LAB RESULTS ENCOUNTERS PROCEDURES IMMUNIZATIONS CLINICAL DOCUMENTS

Vital Signs (55)

Measurement Type	Value	Units
weight E&M - 3141-9	355	[lb_av]
respiratory rate E&M - 9279-1	18	/min
pulse rate E&M - 8867-4	70	/min
blood pressure, systolic - 8480-6	122	mm[Hg]
blood pressure, diastolic - 8462-4	78	mm[Hg]
temperature E&M	98.7	[degF]
weight E&M - 3141-9	356	[lb_av]
temperature E&M	97.1	[degF]
weight E&M - 3141-9	356	[lb_av]
pulse rate E&M - 8867-4	66	/min
blood pressure, systolic, left arm	133	mm[Hg]
blood pressure, diastolic, left arm	82	mm[Hg]
pulse rate E&M - 8867-4	64	/min
temperature E&M	98.5	[degF]
respiratory rate E&M - 9279-1	16	/min
blood pressure, systolic - 8480-6	120	mm[Hg]
blood pressure, diastolic - 8462-4	70	mm[Hg]

Medications (272)

Medication Name	Start	Active?	End D...
NYSTATIN 100000 UNIT/GM CREA	11/26/2013	Yes	
NYSTATIN 100000 UNIT/GM CREA	11/26/2013	Yes	
TRIAMCINOLONE ACETONIDE 0.1 % CREA	11/26/2013	Yes	
NYSTATIN 100000 UNIT/GM CREA	11/26/2013	Yes	
TRIAMCINOLONE ACETONIDE 0.1 % CREA	11/26/2013	Yes	
NYSTATIN 100000 UNIT/GM CREA	11/26/2013	Yes	

Allergies (45)

Allergen
PENICILLIN G POTASSIUM (PENICILLIN G POTASSIUM)
vancomycin
penicillins
Flagyl
Cleocin T
ACE inhibitors
LISINAPRIL
CLEOCIN (CLINDAMYCIN)
FLUCONAZOLE

Lab Results (51)

Observation Code
Clinical Lists Update: Imaging Report/Saint Francis
Lab Report: HEPATIC FUNCTION PANEL, BASIC MET...
Lab Report: LIPID PANEL, TSH
Extended Hours Office Visit: Diabetes Visit Room #4
Lab Report: LIPID PANEL, HEMOGLOBIN A1c
Lab Report: SUREPATH PAP
Lab Report: SUREPATH PAP
Lab Report: LIPID PANEL WITH REFLEX TO DIRECT L...
Office Visit: Office Visit Rm#02 - Bloody stools, hea...

Problems (44)

Description	Start Date
SWELLING OF LEFT ANKLE	2/24/2015
DISORDER, TONGUE NOS	2/24/2015
CELLULITIS, LEG, LEFT	2/10/2015
CELLULITIS RIGHT FOOT	12/9/2014
	10/1/2014
SVT	10/1/2014
SKIN TAG	5/13/2014
	5/13/2014
VERRUCA VULGARIS	10/2/2013
UNSPECIFIED DISORDER OF RE...	10/2/2013
VISUAL CHANGES	10/2/2013
PLANTAR WART	5/28/2013
PAP SMEAR, ABNORMAL, ASCUS	5/28/2013
ABDOMINAL PAIN RIGHT LOW...	2/5/2013
MORBIDLY OBESE	1/30/2013
URI	9/4/2012
ANGULAR CHEILITIS	6/12/2012
ONYCHOMYCOSIS	6/12/2012
CANDIDIASIS OF SKIN	6/12/2012
SKIN LESIONS, MULTIPLE	3/13/2012
OSTEOARTHROS UNSPEC GEN/...	7/12/2011
DIARRHEA	7/12/2011

Encounters (22)

Patient C...	Visit N...	Admit Date	Attending Physician	Source
O - Outpatient	17404081...	2/24/2015 2:42:20 pm	David Kendrick MD MPH,	OU-Tulsa
O - Outpatient	17392154...	2/10/2015 7:24:05 pm	Mark Fox MD,	OU-Tulsa
O - Outpatient	17387489...	2/5/2015 9:48:32 am	Carmen Ruiz MD,	OU-Tulsa
O - Outpatient	17343548...	12/16/2014 1:13:33 pm	David Kendrick MD MPH,	OU-Tulsa
E - Emergency	327700531	12/9/2014 2:04:51 pm	KEVIN MARKOWSKI,MD	Saint Francis Hospitals
O - Outpatient	5277811	12/5/2014 8:02:00 am	GRETA WARTA,	St John Clinics
O - Outpatient	17289172...	10/14/2014 2:47:05 pm	Lucas Massoth MS,	OU-Tulsa

Procedures (1)

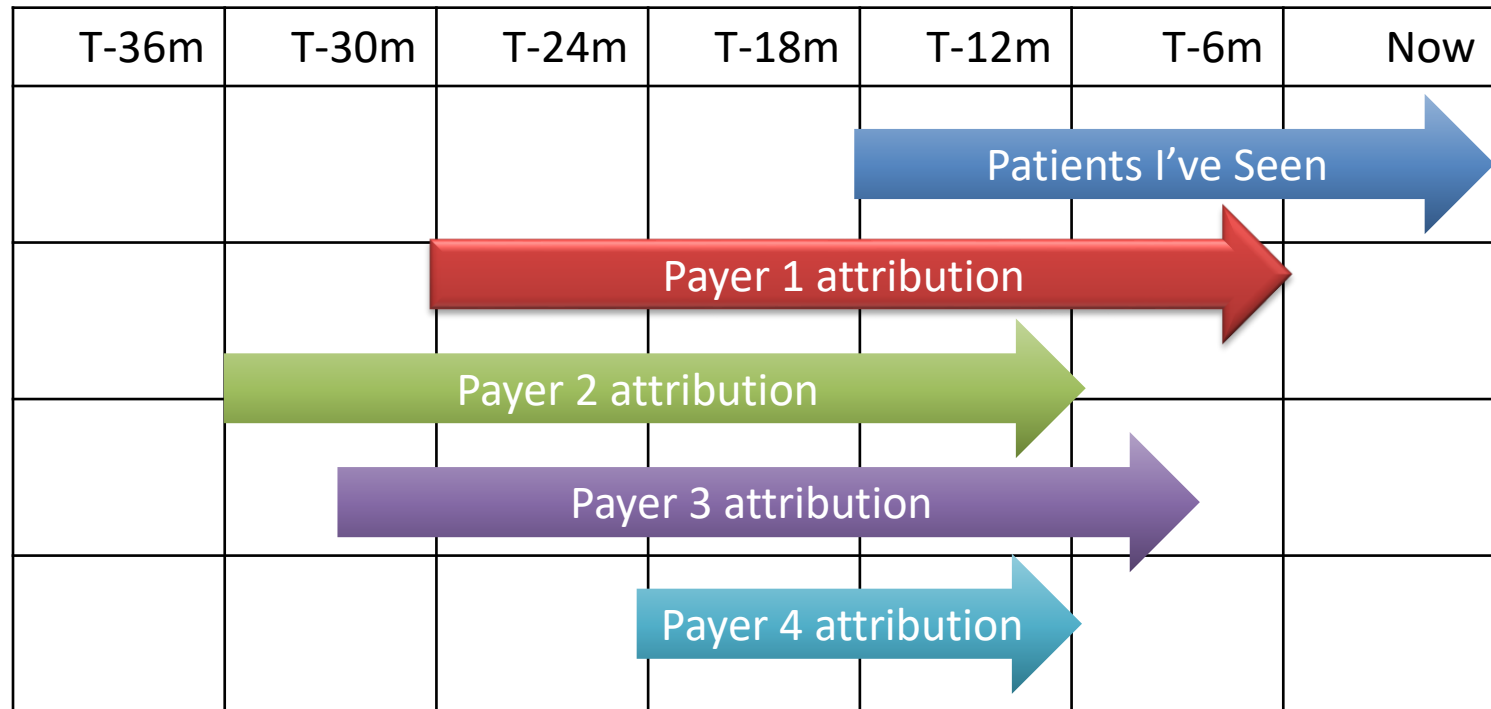
Description	Procedure Code
Colonoscopy - Diagnostic/Screening	45378

VBPM's: Critical Success Factors for Providers and Payers

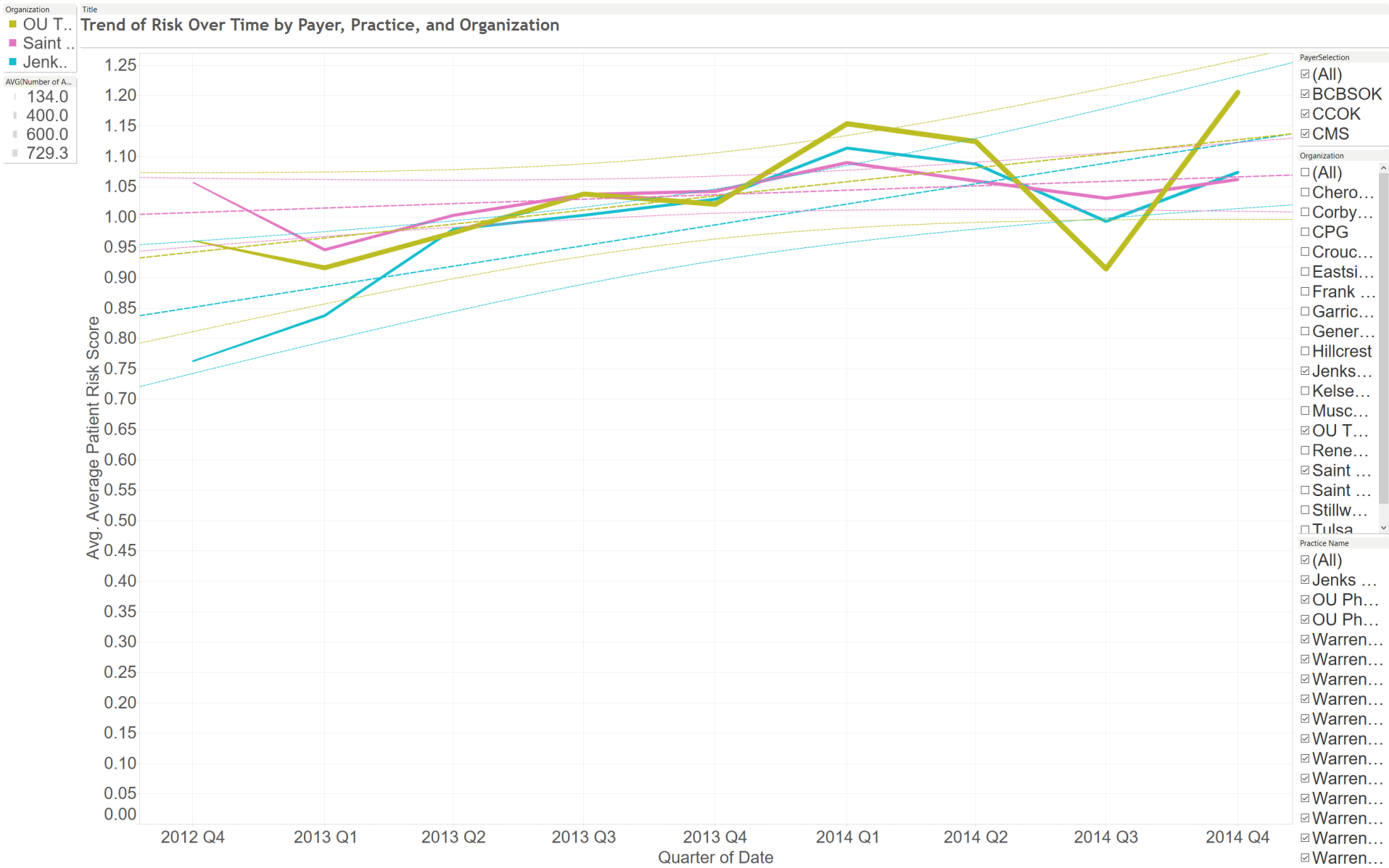
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Who are my patients?

Attribution can be confusing, but is critical to understand . . .



What is their risk?



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Active Panel Monitoring

[illegible]

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Example: HbA1c control– what is the correct answer for each provider? Patient? Payer?

Claims: Medicaid		Claims: Commercial 1		Claims: Commercial 2		Claims: Commercial 3		Claims: Commercial 4		Medicare Commercial	
EHR 1	12.1%	Patient A	9%	SureScripts	7.6%	8.5%	Patient D	8%	10%	8.6%	EHR 10
	Public Health Department	9.8%	10.5%		Patient C	8%	10%	7%			
		Patient B	6.9%		7.5%	Independent Pharmacies	Federal Source (VA/DoD/IHS)				
		EHR 3	EHR 4		EHR 5			EHR 6	EHR 7	EHR 8	

Take 3 diabetes measures: 1) Appropriate Testing, 2) Control <8, 3) Out of Control >9

Claims: Medicaid		Claims: Commercial 1		Claims: Commercial 2		Claims: Commercial 3		Claims: Commercial 4		Medicare Commercial				
	12.1%	Patient A	9%		7.6%	8.5%		Patient D	8%	10%	8.6%			
			9.8%	10.5%	Patient C	8%		10%	7%					
			Patient B	7.5%										
			6.9%											
EHR 1	EHR 2	Public Health Department	EHR 3	EHR 4	SureScripts	EHR 5	EHR 6	Independent Pharmacies	EHR 7	Federal Source (VA/DoD/IHS)	EHR 8	EHR 9	EHR 10	
0%	33%		66%	100%		33%	100%		50%		100%	50%	100%	0%
NA	0%		50%	33%		100%	50%		0%		50%	0%	0%	NA
NA	100%		50%	33%		0%	0%		100%		50%	100%	0%	NA

Take 3 Diabetes Measures:

Source	Appropriate HbA1c Testing	DM in control (A1c<8)	DM out of control (A1c>9)
EHR 1	0%	NA	NA
EHR 2	100%	0%	100%
EHR 3	66%	50%	50%
EHR 4	100%	33%	33%
EHR 5	33%	100%	0%
EHR 6	100%	50%	0%
EHR 7	50%	0%	100%
EHR 8	50%	0%	100%
EHR 9	100%	0%	0%
EHR 10	0%	NA	NA
VA/DoD/IHS	100%	50%	50%
Population:	?	?	?

Payers will get multiple scores on the same patient—what do they do with that?

Looking at populations, we cannot roll these up . . .

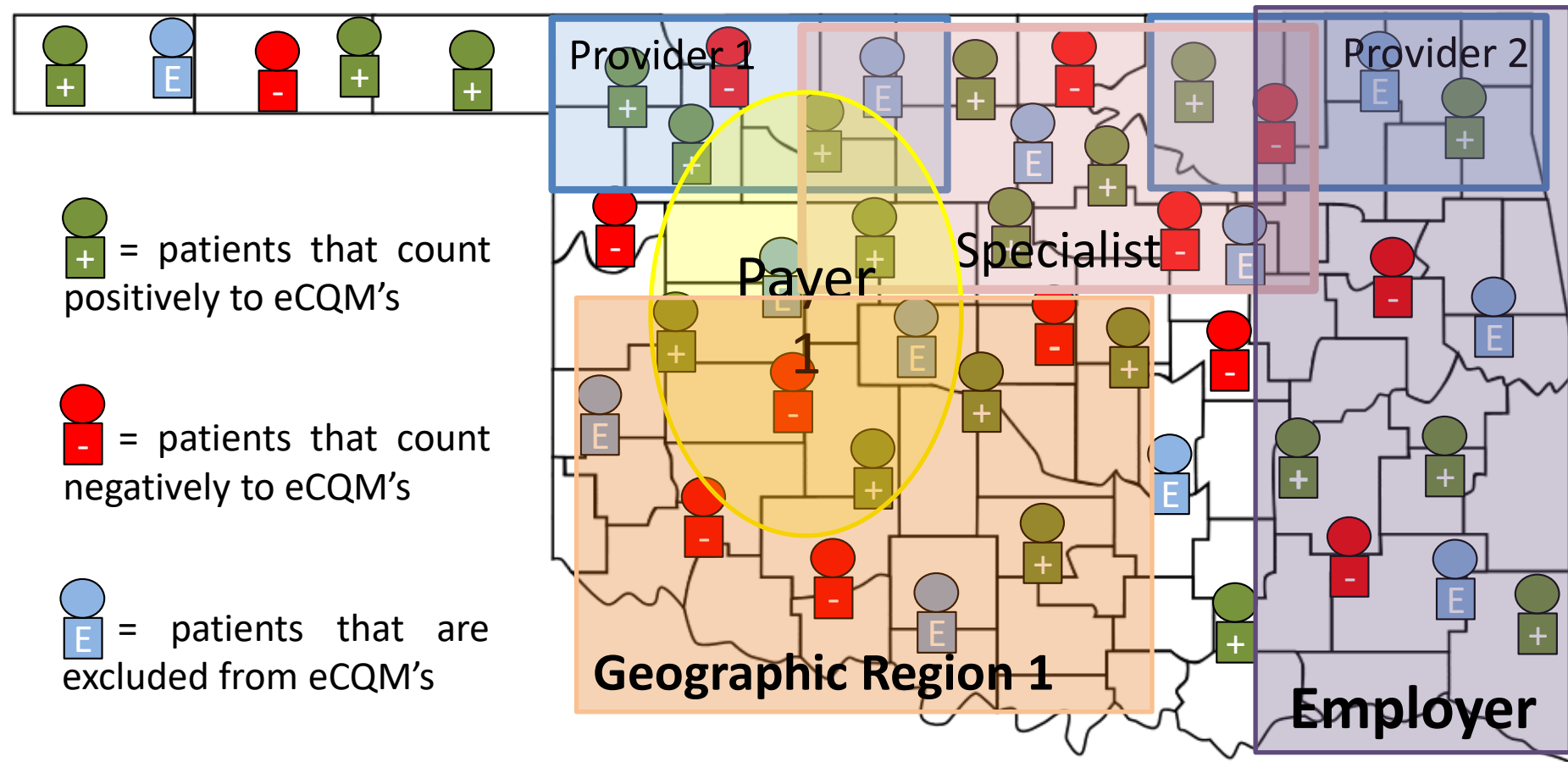
Isn't this what we *really* want to know?

Patient	Appropriate HbA1c Testing	DM in control (A1c<8)	DM out of control (A1c>9)
Patient A:	100%	0%	0%
Patient B:	100%	100%	0%
Patient C:	100%	100%	0%
Patient D:	100%	0%	0%
Population:	100%	50%	0%

Patient-centric measurement

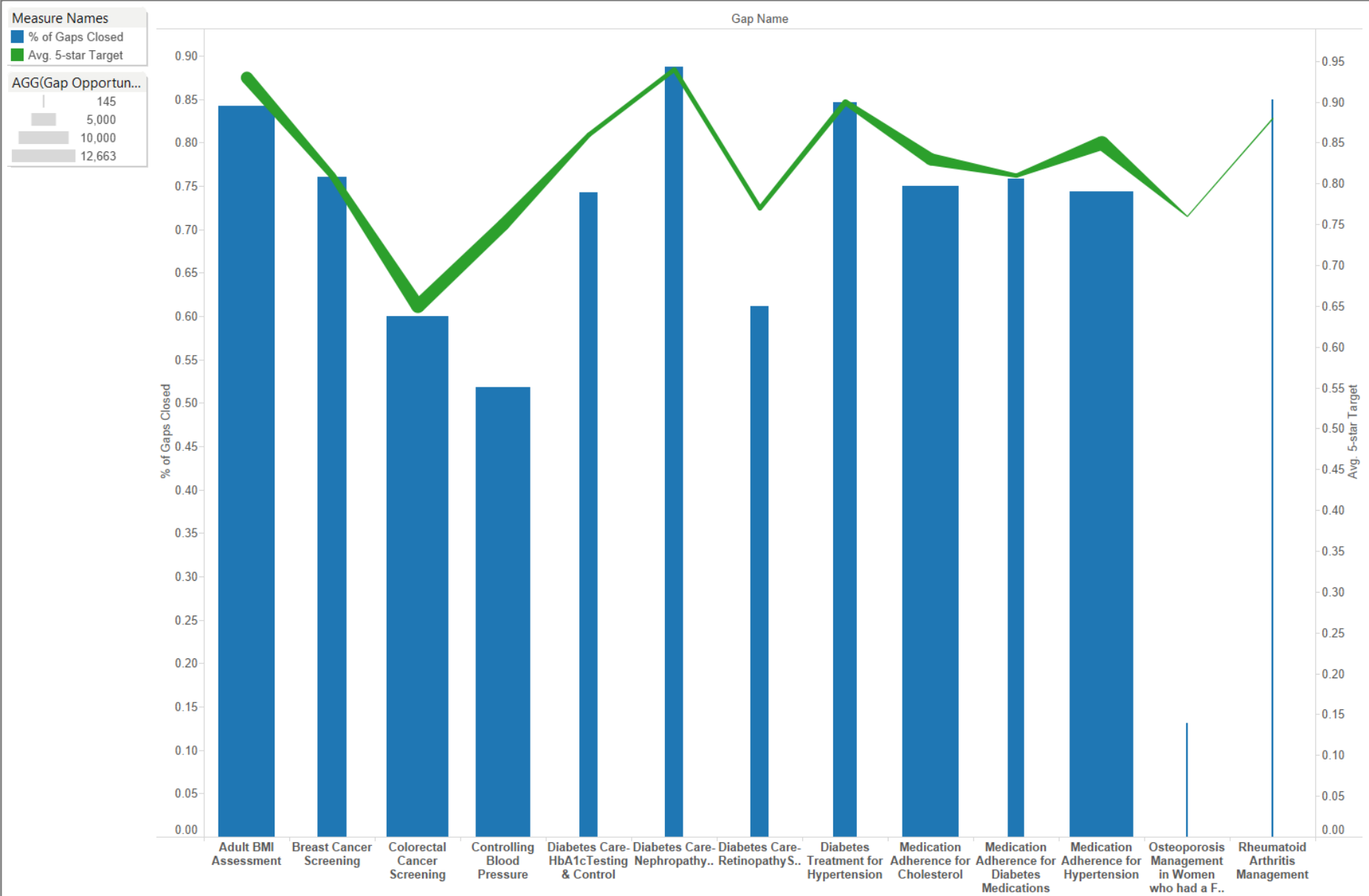
Measure once, reuse many times for many perspectives . . .

$$4+, 3-, 3E = 4/7 = 57\%$$



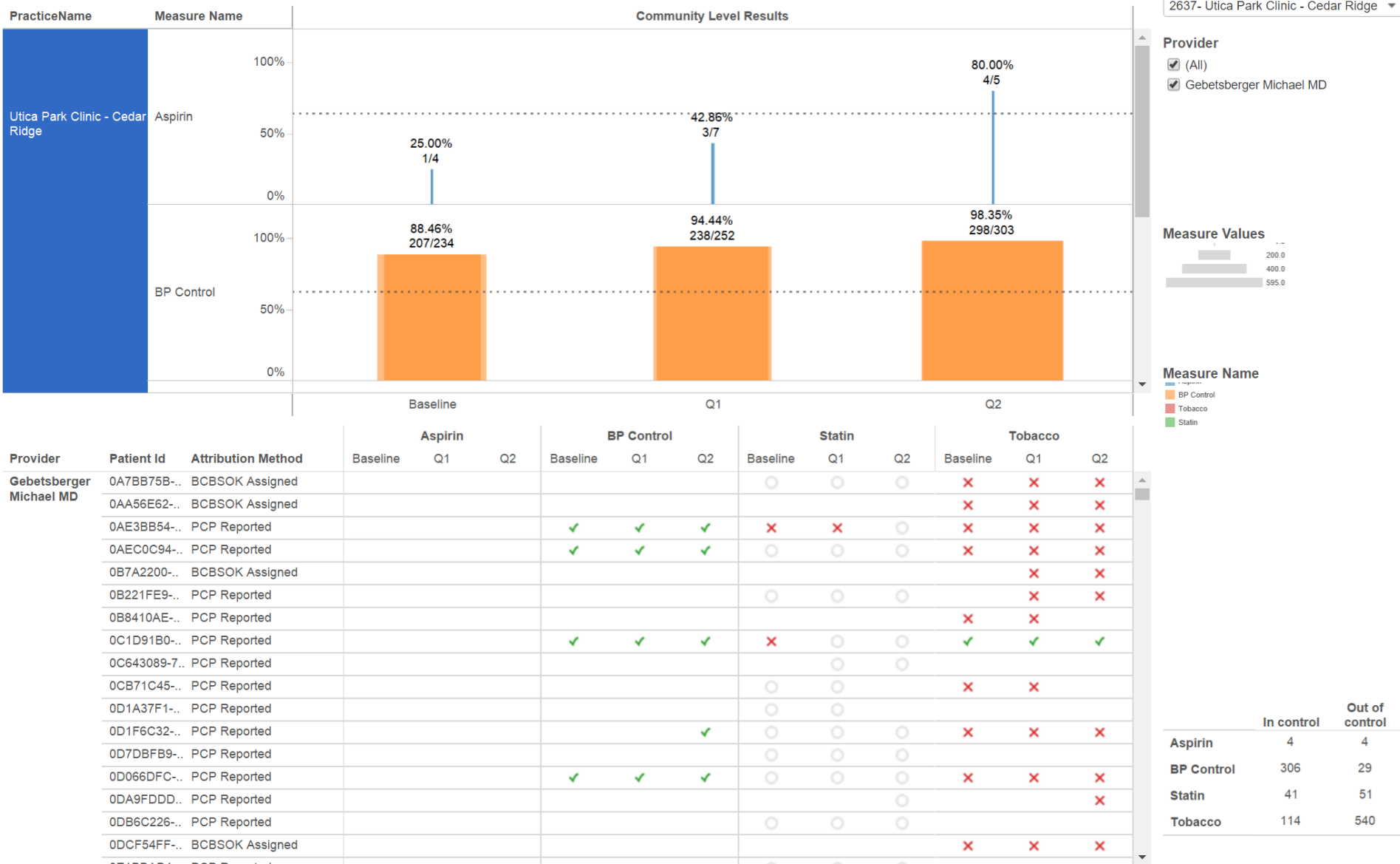
eCQM's calculated in real time based on changes in a patients cross-community data by placing a box around any portion of a population.

Star ratings



Metrics to drive action . . .

Results Compared

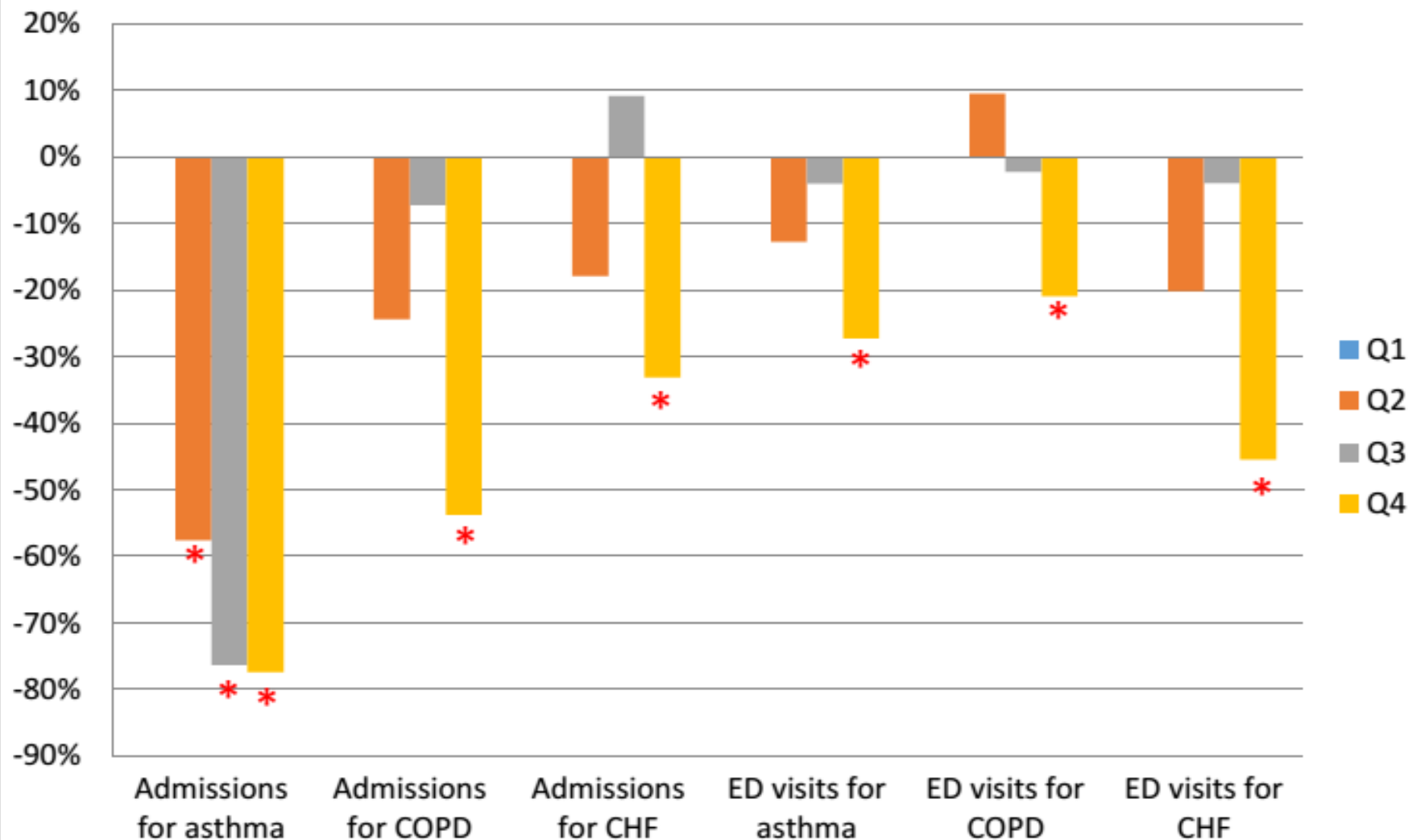


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Change in rates of ER Visits and Admissions from 2012 to 2013 same quarter

(* represents statistically significant change)



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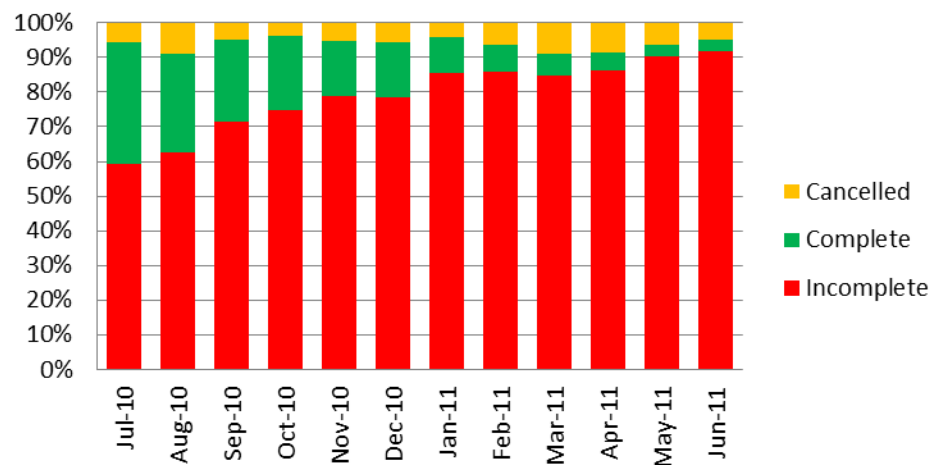
Managing and Closing Referral Loops

Clinic 1:

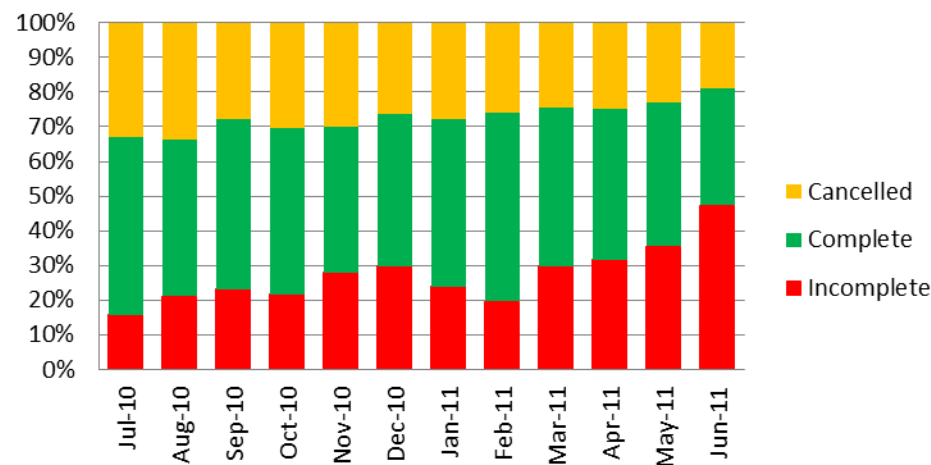
Visit Request Status as of August 31, 2011 by Month Initiated:

	JUL 2010		AUG 2010		SEP 2010		OCT 2010		NOV 2010		DEC 2010		JAN 2011		FEB 2011		MAR 2011		APR 2011		MAY 2011		JUN 2011		JUL 2011		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Total Number Initiated	409		361		442		363		362		324		325		285		438		426		433		457		392		5,017	
Pending Appointment	154	37.7%	172	47.6%	227	51.4%	210	57.9%	165	45.6%	171	52.8%	211	64.9%	199	69.8%	296	67.6%	272	63.8%	306	70.7%	314	68.7%	280	71.4%	2,977	59.3%
Scheduled	79	19.3%	49	13.6%	71	16.1%	55	15.2%	99	27.3%	65	20.1%	57	17.5%	37	13.0%	61	13.9%	75	17.6%	67	15.5%	90	19.7%	71	18.1%	876	17.5%
Consult in Progress	4	1.0%	2	0.6%	3	0.7%	3	0.8%	4	1.1%	4	1.2%	2	0.6%	0	0.0%	2	0.5%	8	1.9%	9	2.1%	10	2.2%	6	1.5%	57	1.1%
Visit Occurred: Report Pending	5	1.2%	3	0.8%	14	3.2%	4	1.1%	18	5.0%	14	4.3%	8	2.5%	9	3.2%	12	2.7%	13	3.1%	9	2.1%	5	1.1%	9	2.3%	123	2.5%

Clinic 1: 12 months of care transitions

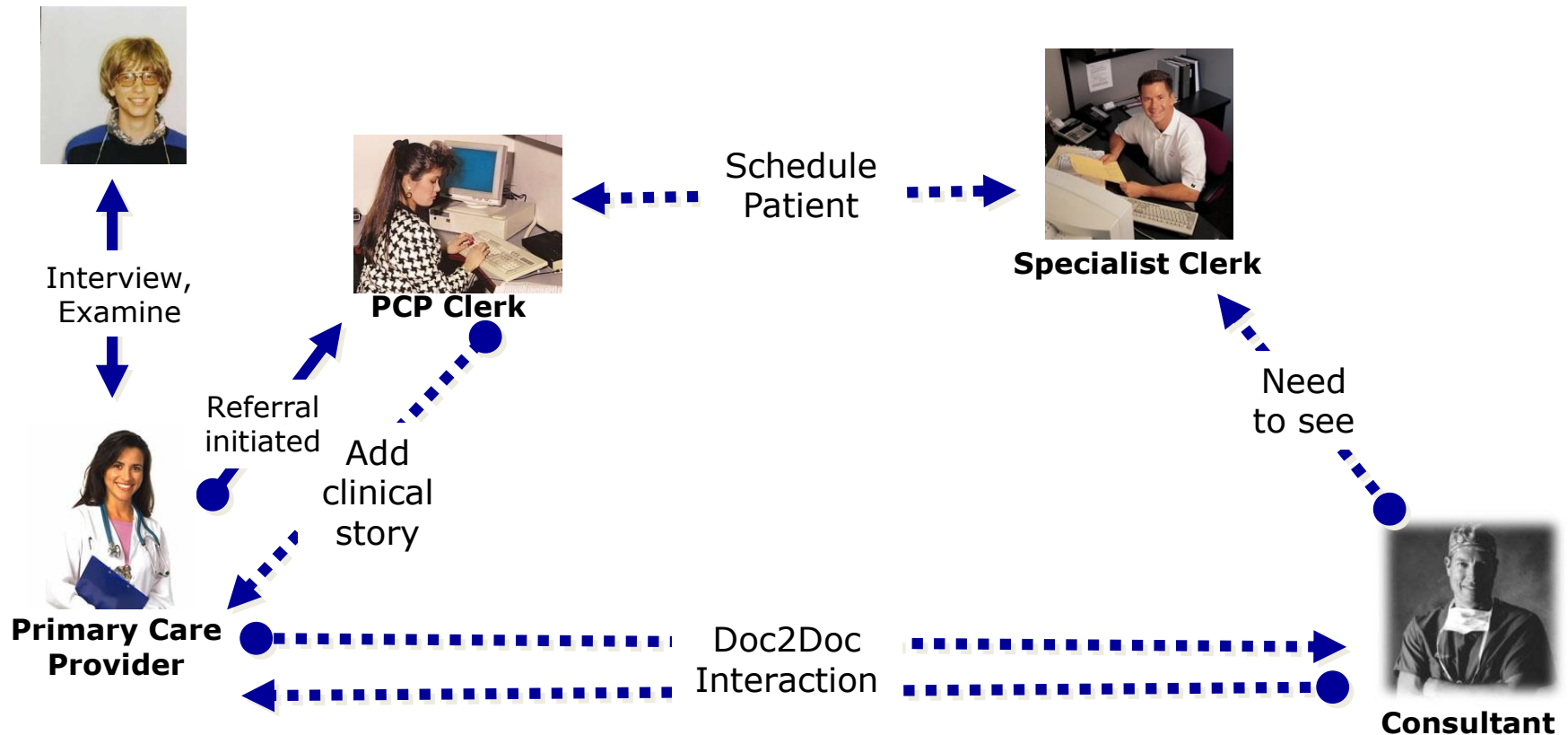


Clinic 2: 12 months of care transitions



Cancelled by Receiving Provider	31	3.8%	49	5.6%	34	3.7%	34	4.7%	30	3.6%	22	3.3%	18	3.0%	14	2.6%	32	3.4%	25	2.8%	42	5.1%	26	3.5%	14	1.6%	371	3.6%
Cancelled by Sending Provider	77	9.5%	77	8.7%	58	6.3%	44	6.1%	37	4.5%	32	4.9%	54	8.9%	46	8.7%	50	5.3%	56	6.3%	43	5.3%	36	4.8%	25	2.9%	635	6.2%
Failed Appointment	93	11.4%	96	10.9%	92	9.9%	82	11.4%	90	10.9%	70	10.7%	51	8.4%	28	5.3%	84	9.0%	76	8.5%	51	6.2%	37	4.9%	29	3.4%	879	8.6%
Rejected by Receiving Provider	10	1.2%	22	2.5%	24	2.6%	14	1.9%	23	2.8%	8	1.2%	11	1.8%	10	1.9%	9	1.0%	13	1.5%	15	1.8%	20	2.7%	33	3.9%	212	2.1%
Not Specified	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%

Doc2Doc Shared Care Plans

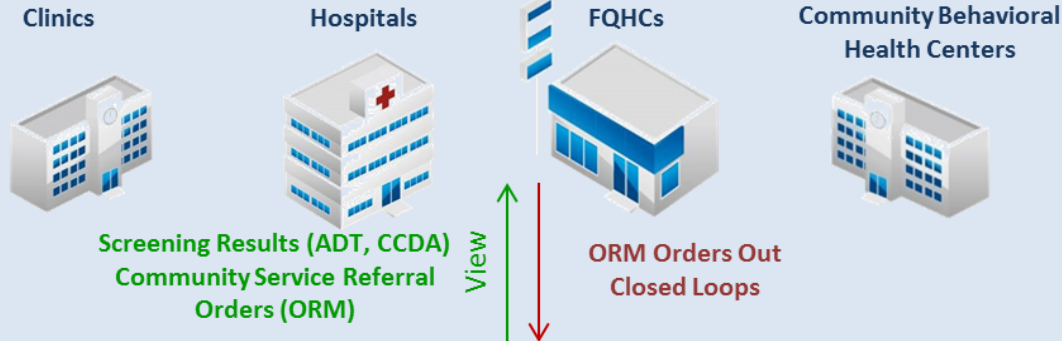


Results: eConsultations

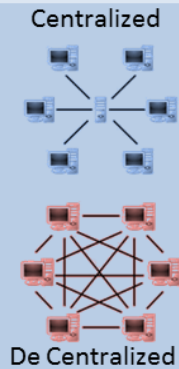
- Patients receiving an online consult had a significant reduction in PMPM cost of care when compared with themselves as historical controls:
 - *\$140.53 Pre Consult vs. \$78.16 Post Consult*
 - *Net savings of **\$62.37**, $p=0.021$*
- Compared with patients who received a referral but NOT a consult:

Cost Type	Mean PMPM Cost Change	Mean Percentage Change
Facility Costs (UB92)	-\$13.00	-20%
Professional Costs (HCFA 1500)	-\$108.04	-34%
Pharmacy Costs (PBM)	-\$9.14	-14%
Total Costs	-\$130.18	

Clinical Sites



Navigators



Dr's with screening results opting in

Community Service Referral Orders (ORM)



Reporting on Service Usage (Customer)

Claims Data (837) & Rosters (834)



ORM Order Statuses / Closed Loops
Iterative Referral & Care Coordination

Community Service Referral Orders (ORM)



Housing

Transportation

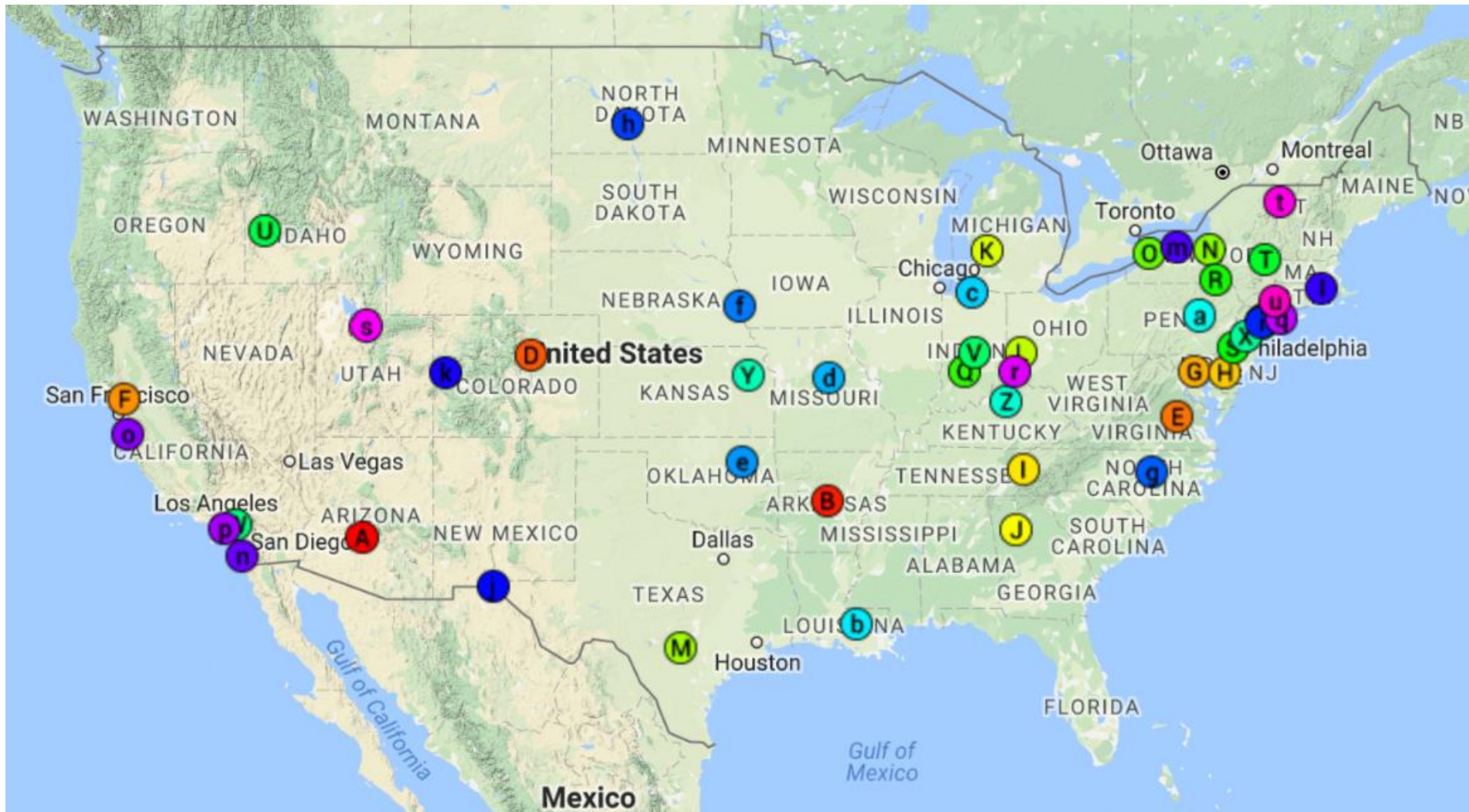
Food

Interpersonal Violence

Utilities

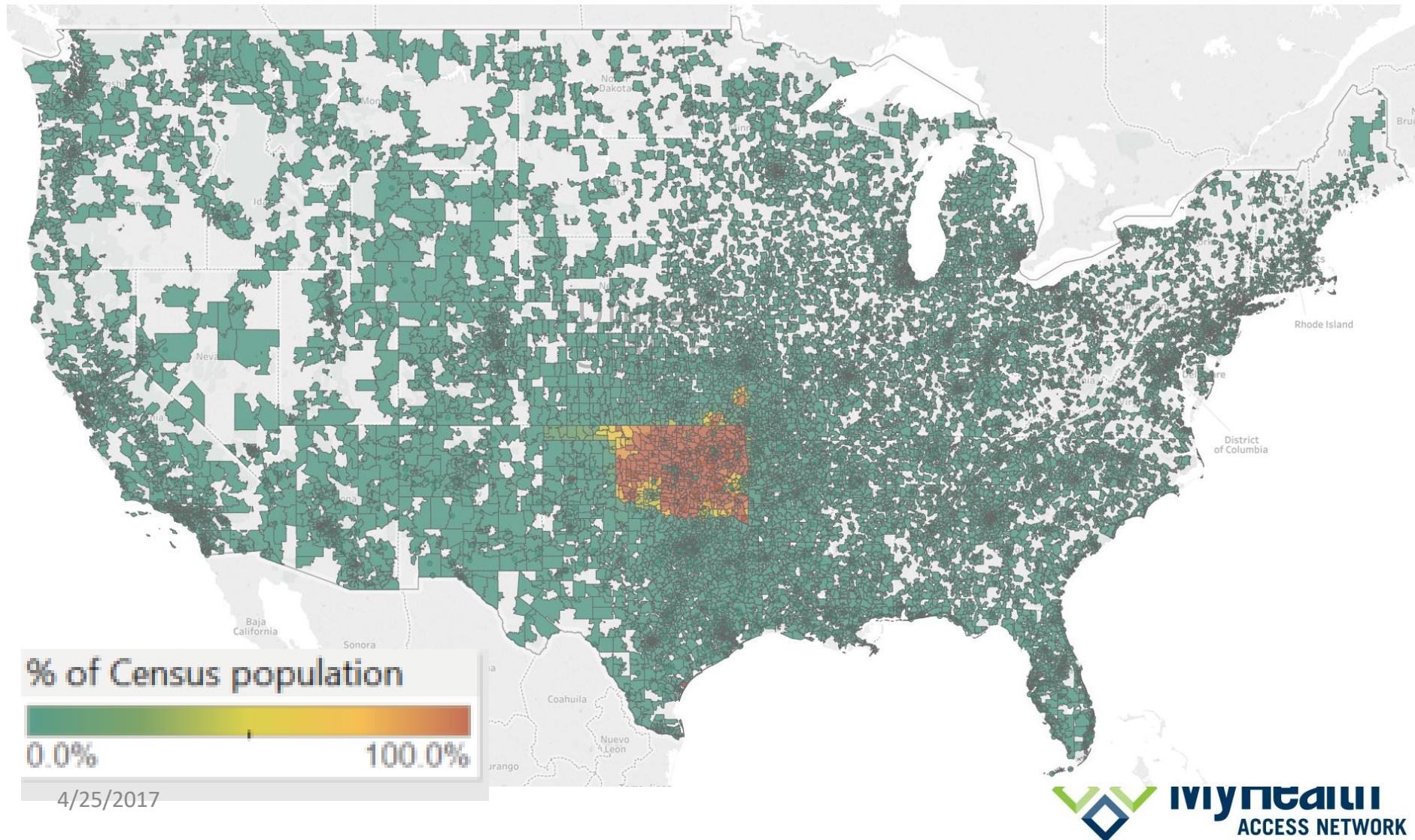
Community Services

How does this scale nationwide?

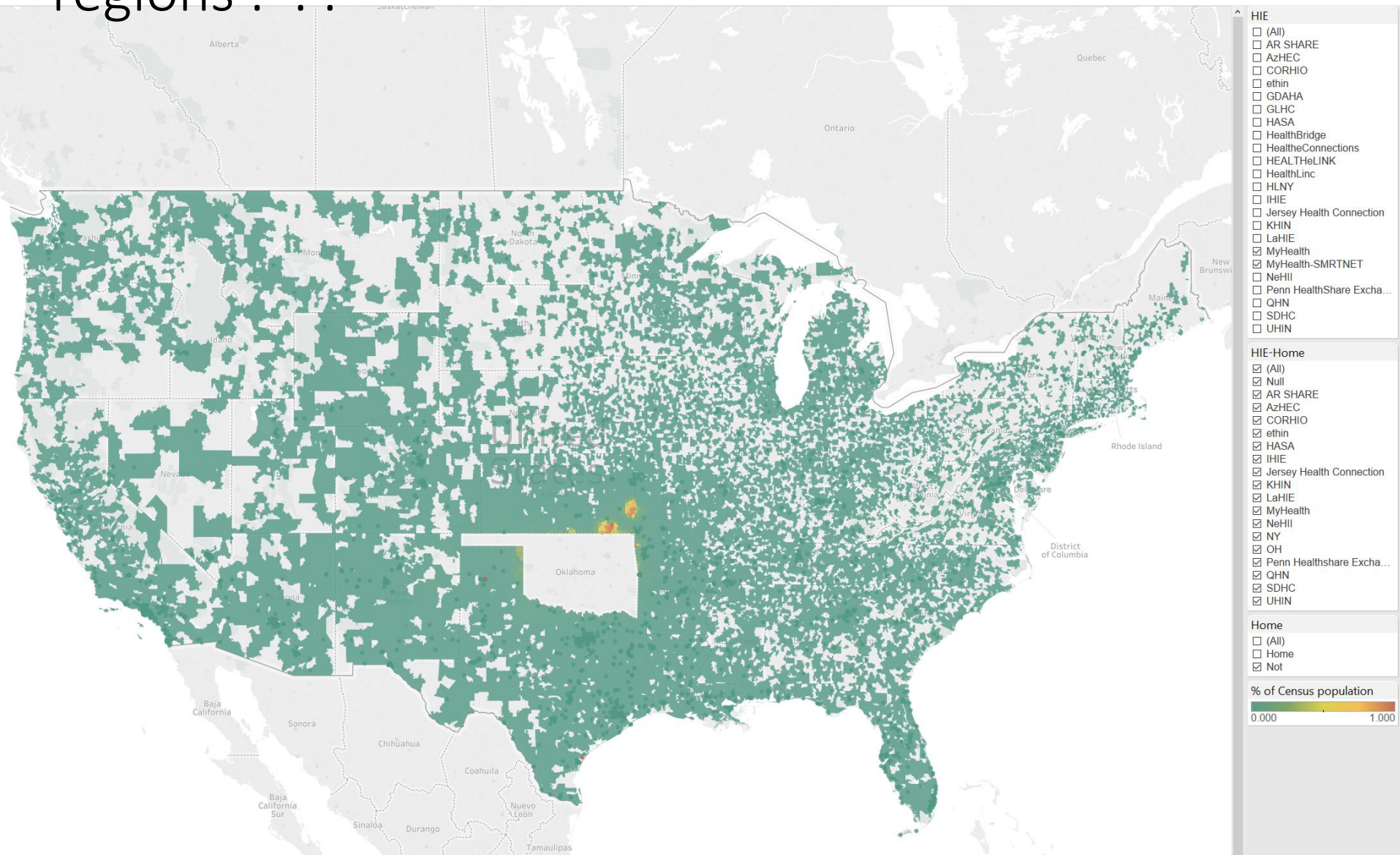


~190M lives from 49 HIE's

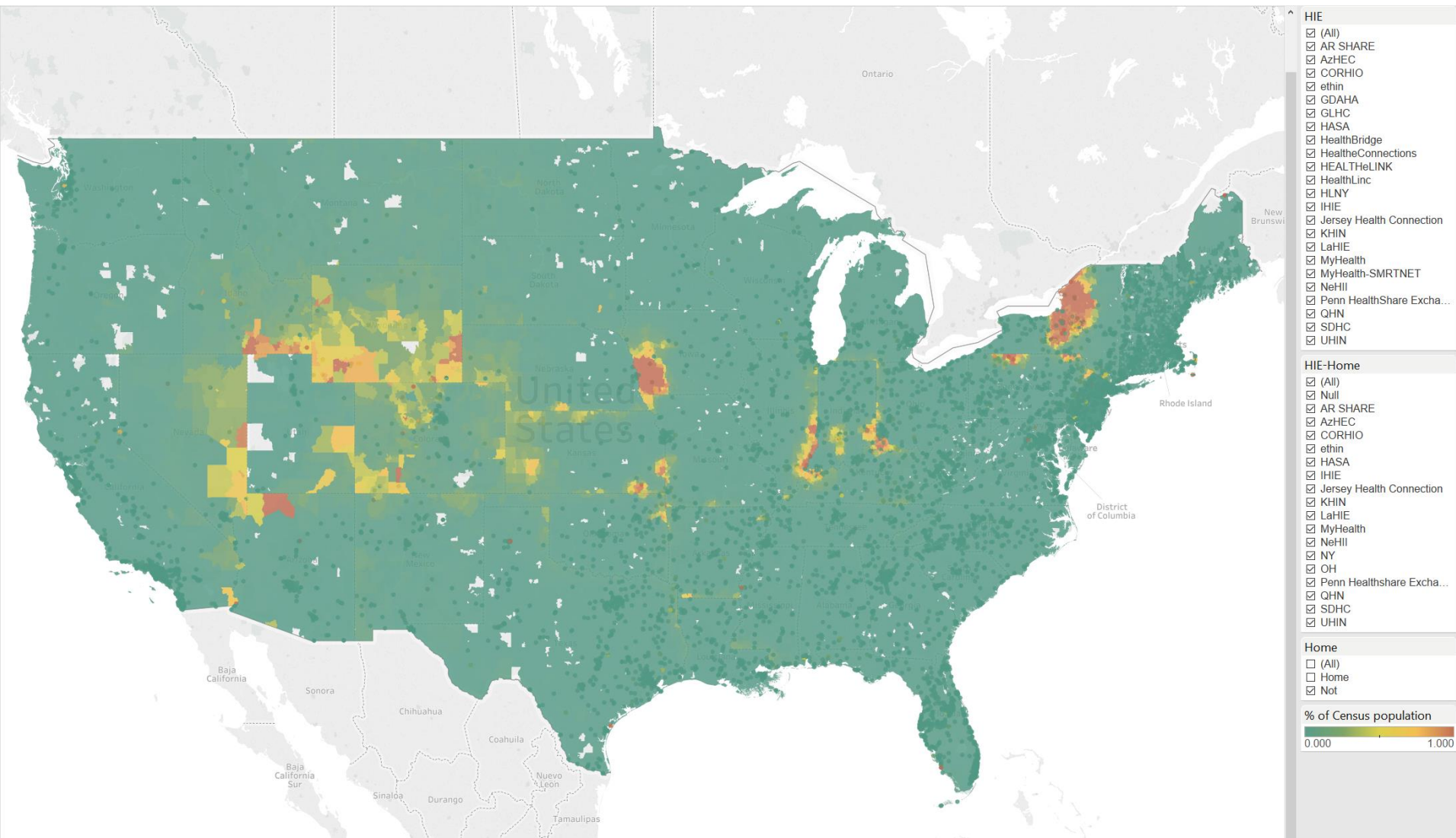
MyHealth Patient Population



Example: Oklahoma needs to push data to other regions . . .

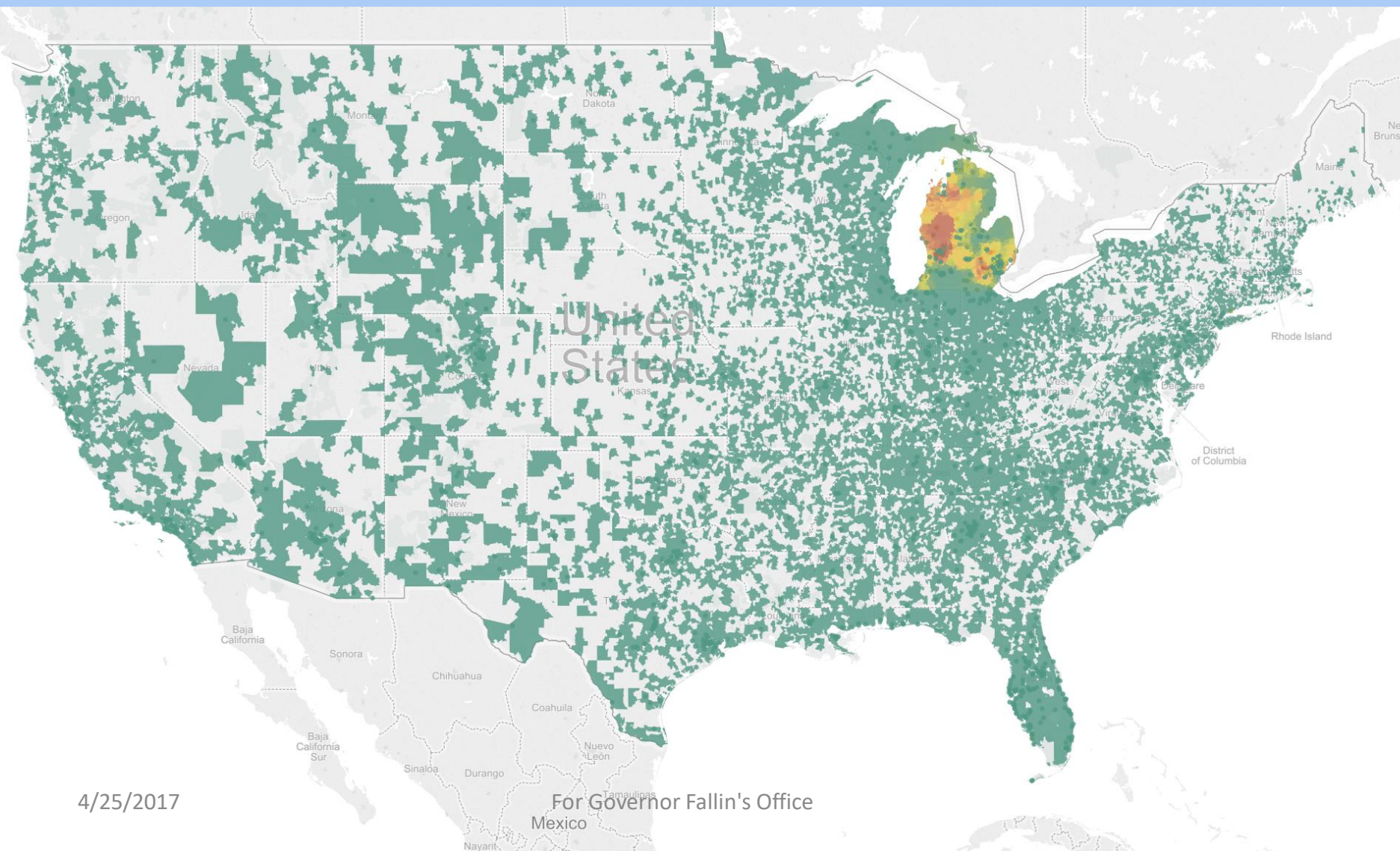


Care outside the PCDH: 20M patients





Member Population: Great Lakes Health Connect

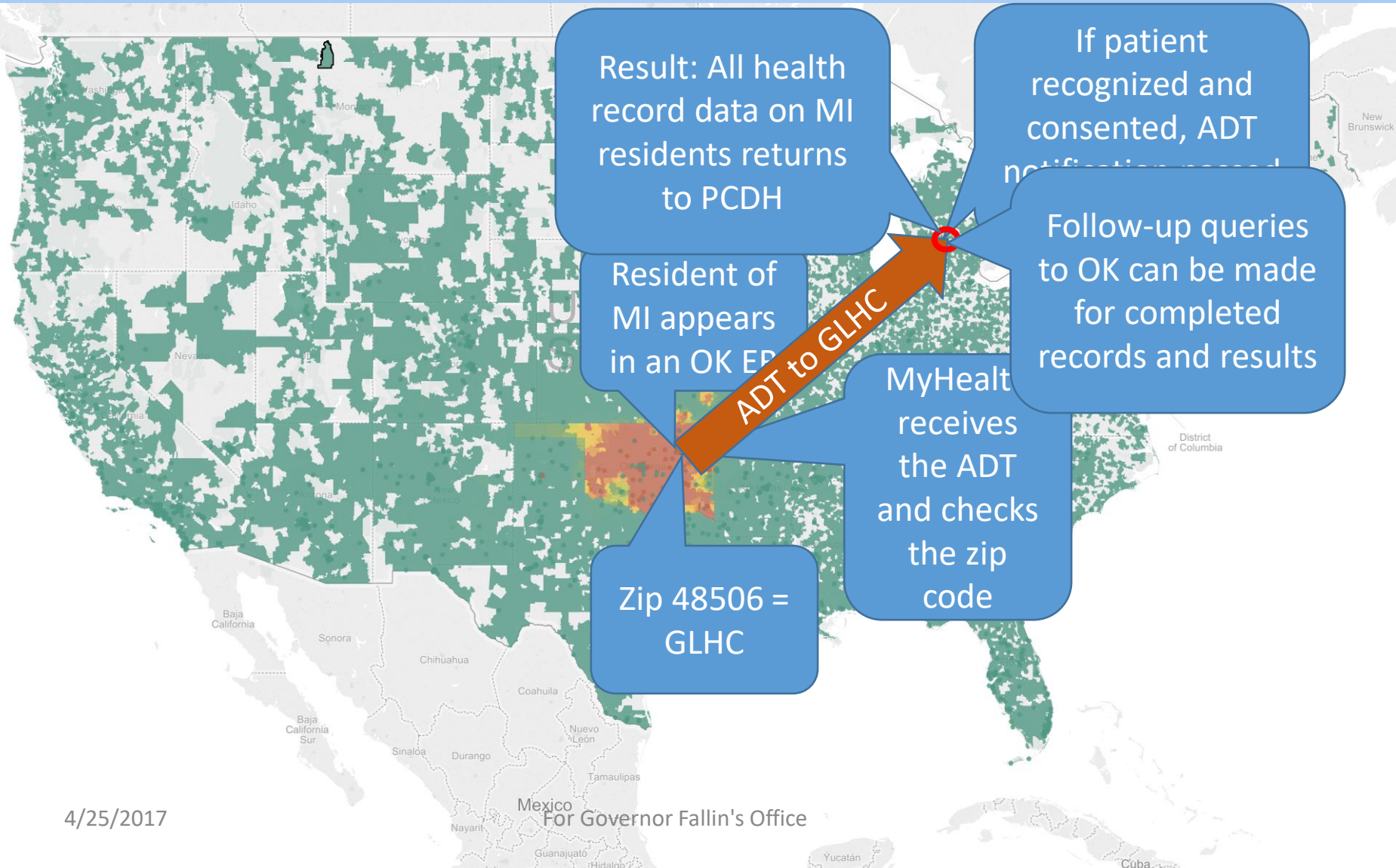


4/25/2017

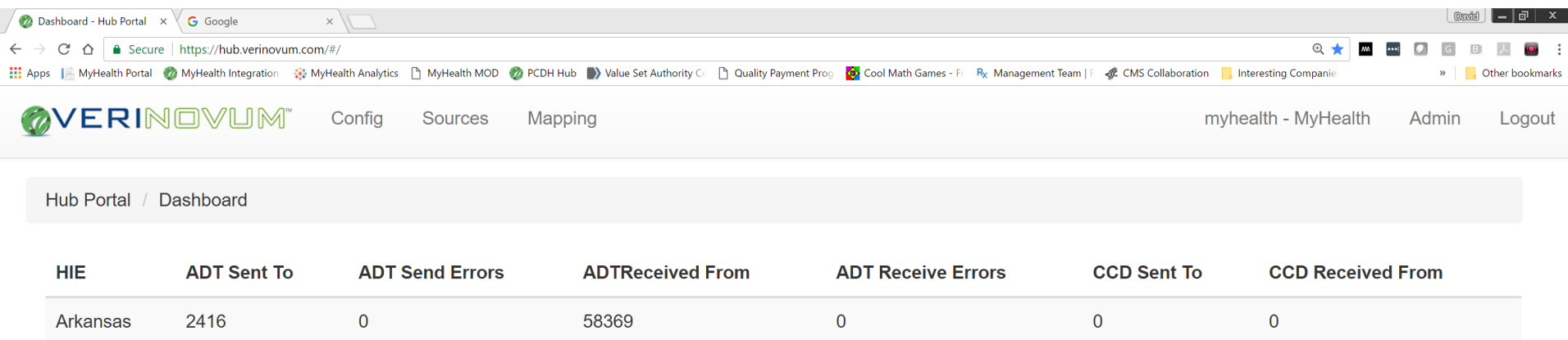
For Governor Fallin's Office
Mexico



Patient Centered Data Home



Live ADT alerts from Arkansas . . .



The screenshot shows a web browser window with the Verinovum Hub Portal. The browser's address bar shows the URL <https://hub.verinovum.com/#/>. The page has a navigation bar with links for Config, Sources, and Mapping. The main content area is titled 'Hub Portal / Dashboard' and contains a table with ADT and CCD data for Arkansas.

HIE	ADT Sent To	ADT Send Errors	ADTReceived From	ADT Receive Errors	CCD Sent To	CCD Received From
Arkansas	2416	0	58369	0	0	0

Conclusions

- MyHealth portal has data on >3M patients
- Use of the portal by care managers is growing significantly
- MyHealth Analytics provide
 - Utilization monitoring
 - eQMs & care gaps
- Accountable Health Community program will link providers and social services
- Patient Centered Data Home™ helps keep the whole patient record intact

Discussion

David.Kendrick@MyHealthAccess.net

www.MyHealthAccess.net