Challenges and Opportunities for Improving Health and Healthcare in Ohio through Technology

Ohio Health IT Advocacy Day

Craig Brammer, CEO

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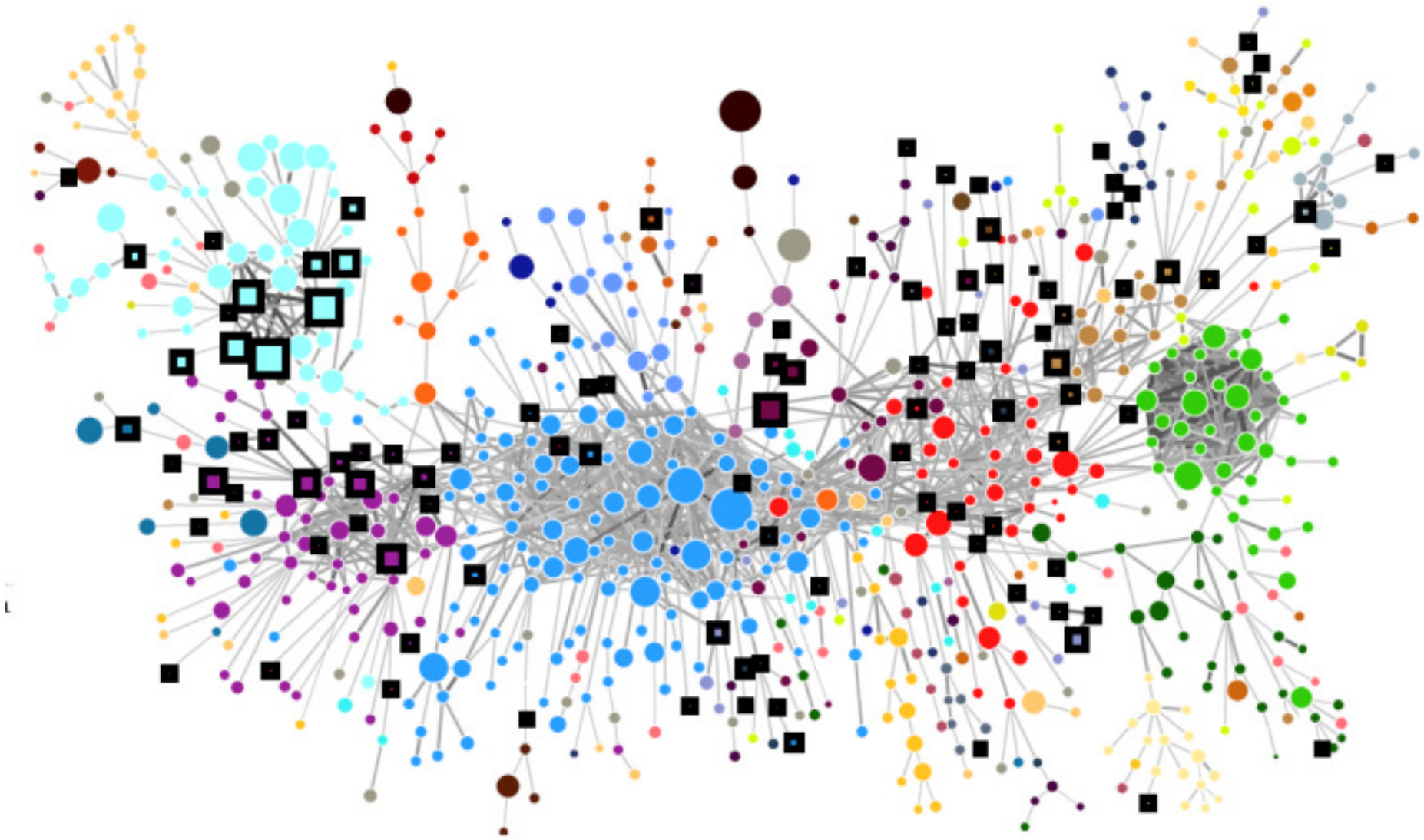
Challenge #1: Information Gap

A point of view can be a dangerous luxury when substituted for insight and understanding.

Challenge #2: Competition

GREATER CINCINNATI HEALTH COUNCIL
THE HEALTH COLLABORATIVE
HEALTH BRIDGE

Challenge #3: Complexity



The Feds: What are they up to?

The NEW ENGLAND JOURNAL of MEDICINE

Beyond a Traditional Payer — CMS's Role in Improving Population Health

William J. Kassler, M.D., M.P.H., Naomi Tomoyasu, Ph.D., and Patrick H. Conway, M.D.

There is an emerging consensus that to improve health as much as possible, we must adopt population health strategies addressing underlying causes of poor health.[1] The term "population health" has been used to describe both a clinical perspective focused on delivering care to groups enrolled in a health system and a broader perspective that focuses on the health of all people in a given geographic area and emphasizes multisector approaches and incorporation of nonclinical interventions to address social determi-

domains to encourage incremental progress toward population health.

For medical practices, which are structured around individual, face-to-face encounters, pursuing a population-based approach means considering what happens between visits; using patient registries and other tools to improve the use of preventive care services; addressing health disparities by considering social, economic, and cultural factors; and referring patients to a wider range of community services. Through our Innovation Center,

vide incentives for delivery systems to invest in efforts to improve health and reduce costs. Although accountable care organizations (ACOs) must initially invest in internal systems for coordinating care, mature ACOs are exploring opportunities to incorporate nonclinical members into care teams to help high-risk patients connect to practices and address social and community-based barriers to care.

For health plans, Medicaid and Medicare contracts afford greater flexibility than fee-for-service arrangements in paying

National Quality Strategy: How It Works

STAKEHOLDER TYPES

- States
- Federal and HHS
- Private Sector
- Multi Stakeholder Groups

PRIORITIES

Six quality concerns that affect most Americans.

- Patient Safety
- Person- and Family-Centered Care
- Effective Communication and Care Coordination
- Prevention and Treatment of Leading Causes of Mortality
- Health and Well-Being
- Affordable Care

LEVERS

Core business functions, resources, and/or actions that may serve as a means for achieving improved health and health care quality.

- Measurement and Feedback
- Public Reporting
- Learning and Technical Assistance
- Certification, Accreditation, and Regulation
- Consumer Incentives and Benefit Designs
- Payment
- Health Information Technology
- Innovation and Diffusion
- Workforce Development

THE THREE AIMS

The National Quality Strategy unites efforts to improve health and health care for all Americans. The above graphic provides a high-level view of how the National Quality Strategy works to provide better, more affordable care for the person and the community.

Who we are

Neutral forum for collective impact among stakeholders

Those ***providing*** health care

Those ***receiving*** health care

Those ***paying*** health care

VISION

To make health and healthcare a competitive advantage for Greater Cincinnati and the communities we serve.

Organizational Infrastructure

…Reorganized

What We'll Cover Today

PCMH

Transforming primary care to better serve wellness, prevention, and disease management

Payment Reform

Payment Reform to align payment to outcomes: The Comprehensive Primary Care Initiative

Transparency

Quality Rankings of Primary Care Physicians and Hospitals- almost 600 physicians reporting

Data Analysis

Aligning Data Collection and Analysis

With technology and data management powered by HealthBridge

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Transformation and the PCMH

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The PCMH Model

Source: American Academy of Family Medicine

The Promise of PCMH

COST REDUCTIONS

$26.37 PMPM
(Michigan)

ROI
2.5 to 1 to 4.5:1
for every dollar spent
(Colorado)

FEWER ED VISITS

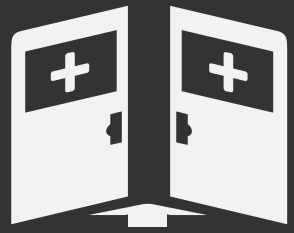
19%

Reduction in ED Visits (GE)

INPATIENT ADMISSIONS

31%

Decrease in Inpatient Admissions
(20 study average)



FEWER READMISSIONS

13%

Decrease in Readmissions
(20 study average)

The Promise of PCMH

IMPROVEMENT IN POPULATION HEALTH

Fewer complications in diabetes patients (GE)

Increases in screening and immunization rates

IMPROVED ACCESS

Same Day Appointments

After Hours Contact

INCREASE IN PREVENTIVE SERVICES

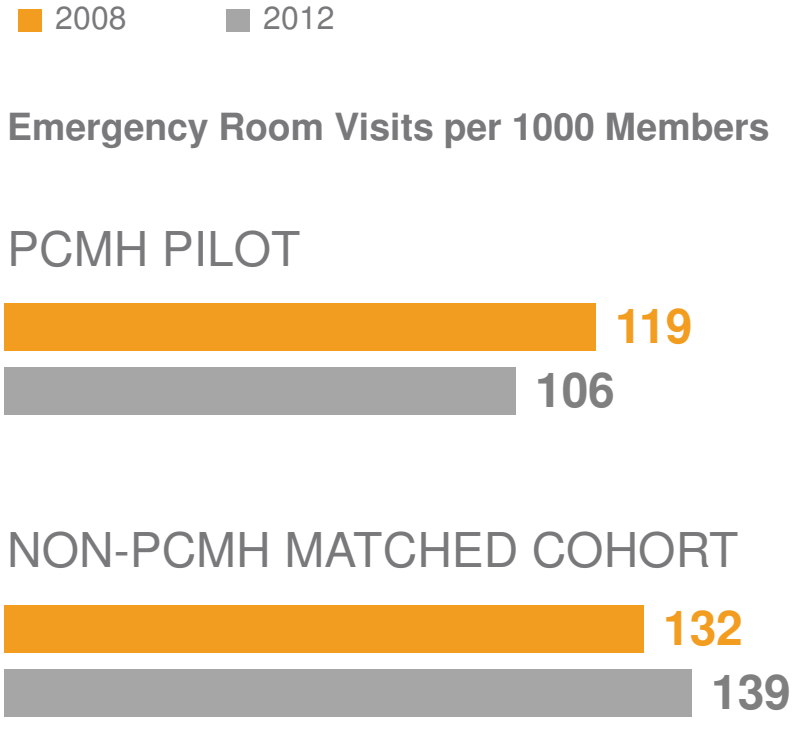
Nutrition Services

Medication Reconciliation

IMPROVEMENT IN SATISFACTION

Improved Patient Satisfaction

Early Local Results



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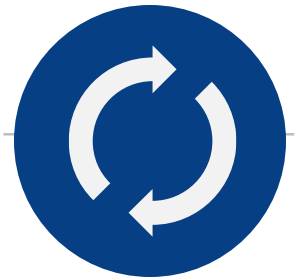
Paying for Value, Not Volume

Payment Models that…



SUPPORT TRANSFORMATION ACTIVITIES

ENCOURAGE CARE COORDINATION AND PREVENTION

REWARD OUTCOMES

CPC
Comprehensive Primary Care

PCMH + Payment Reform

- **75** practices and **261** providers
- **Multi- payer:** 9 health plans + Medicare
- **300,000** estimated commercial, Medicaid and Medicare enrollees

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THE HEALTH COLLABORATIVE
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CPC
Comprehensive Primary Care

- Care management
- 24/7 patient access
- Patient experience focus
- Quality improvement
- Care coordination
- Patient engagement
- Learning collaborative participation
- Health Information Technology

GREATER CINCINNATI HEALTH COUNCIL
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CPC
Comprehensive Primary Care

Sustainability = Meaningful incentives for investment in practice transformation

Risk = Not enough employer participation

Risk = Insufficient information for improvement and accountability

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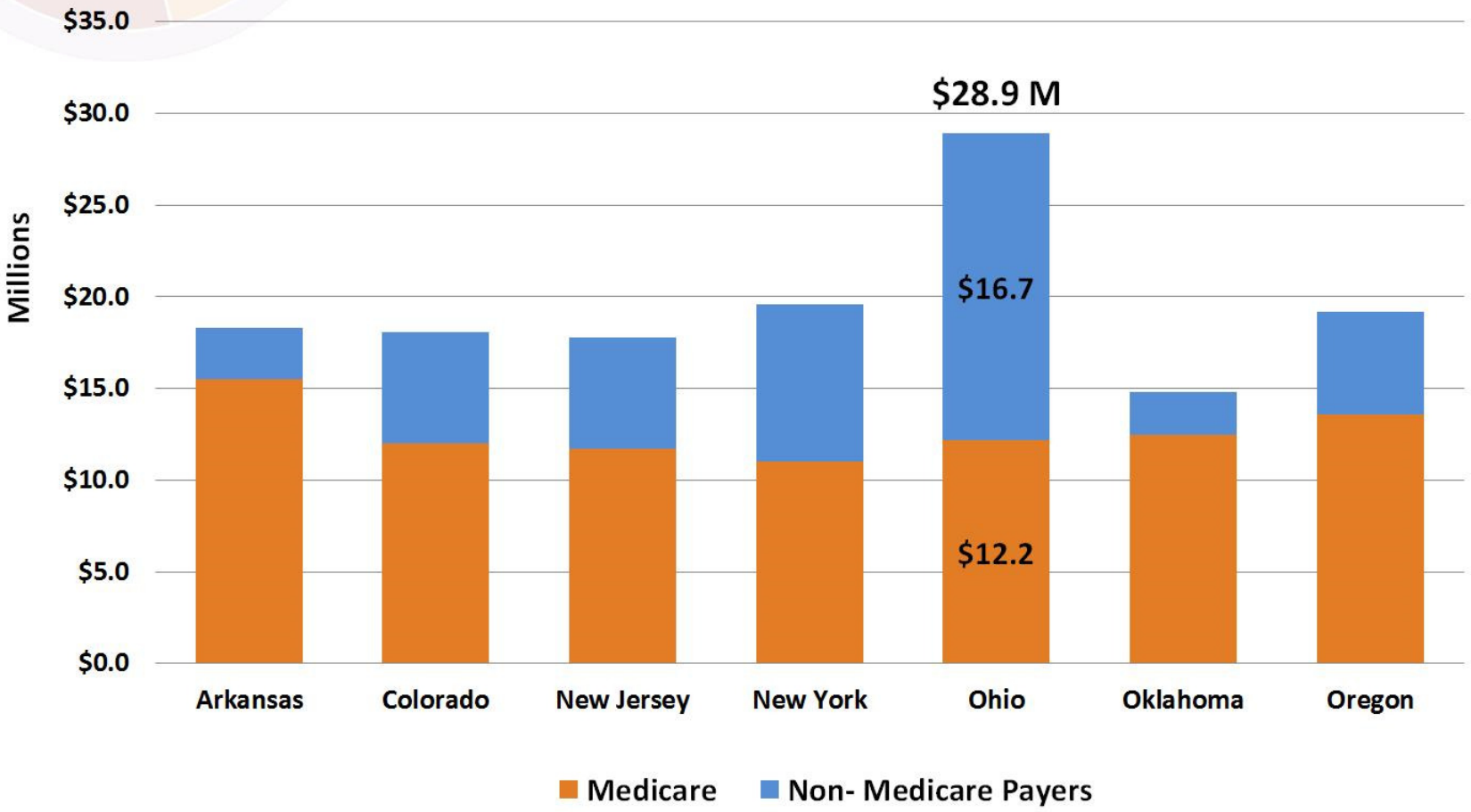
The CPC Investment

Care Management Payments

through 12/31/13



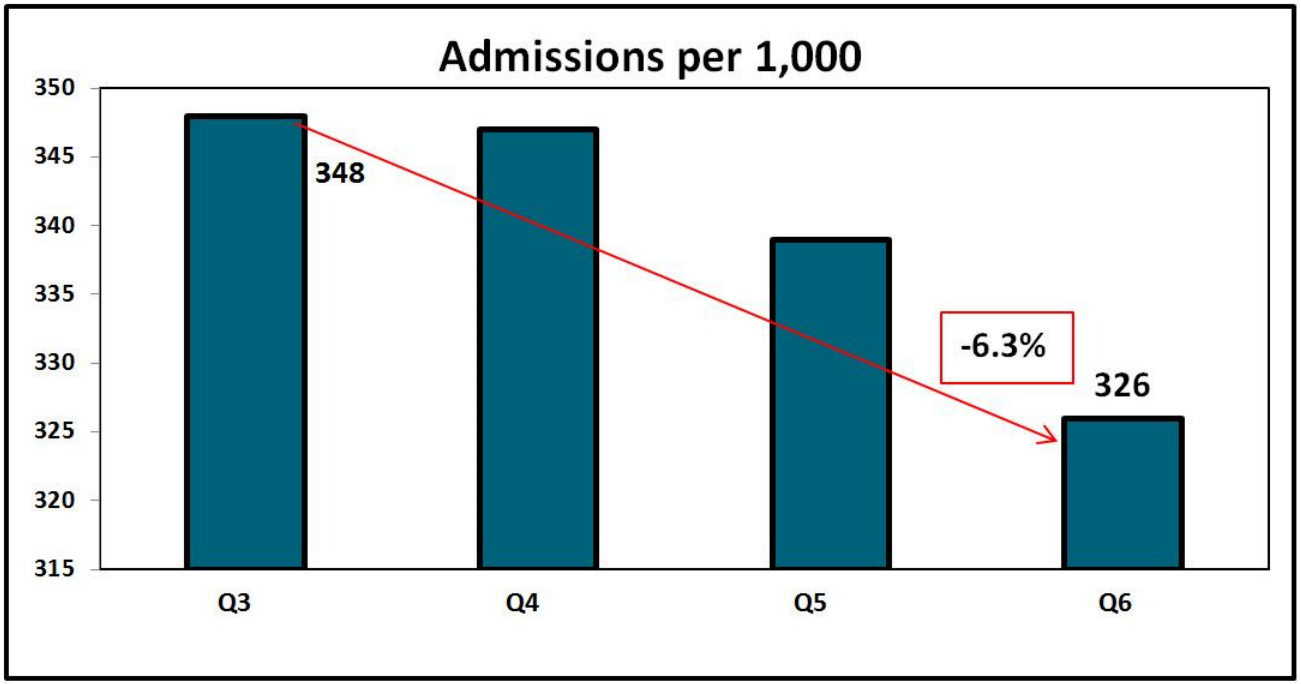
Source: Non-Medicare Payers: Self-reported Milestone 1 submissions from participating practices for PY 2013; Medicare: CMS Payment Data.

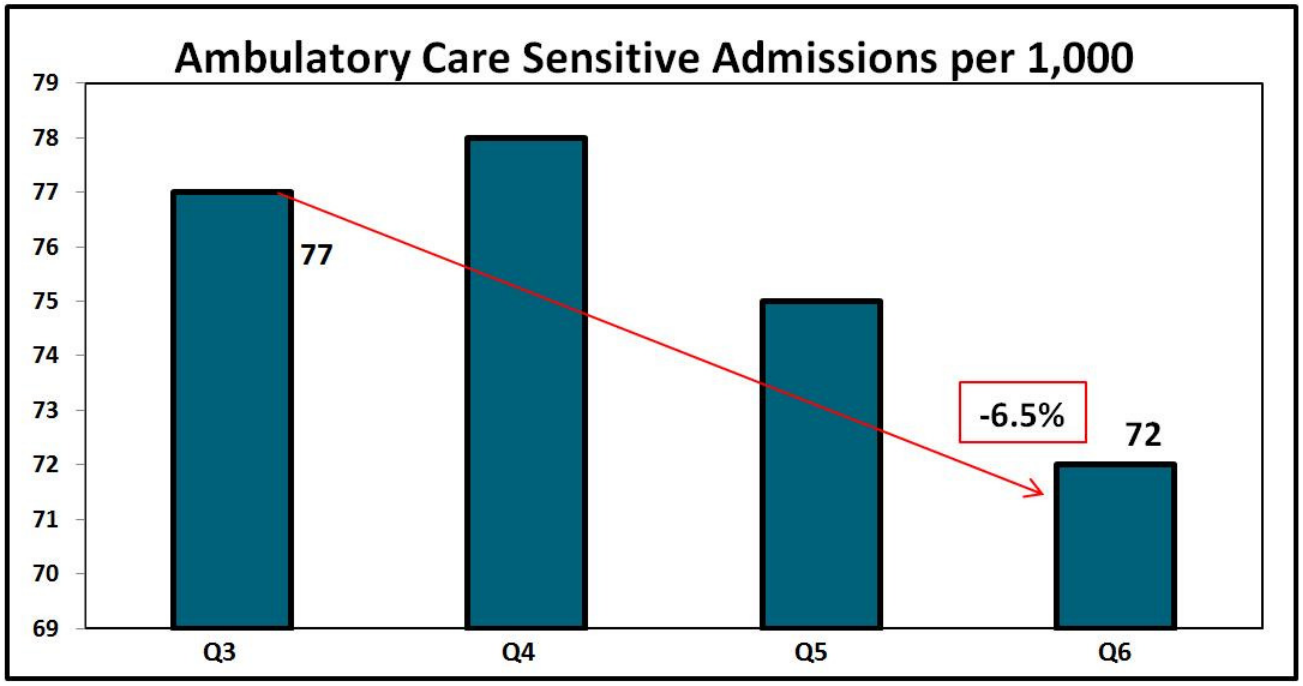
Notes: Practice-reported Medicare data was overwritten with CMS data. Medicare data were cleaned to remove information that appeared inaccurate of incomplete.

What do we learn from the data?

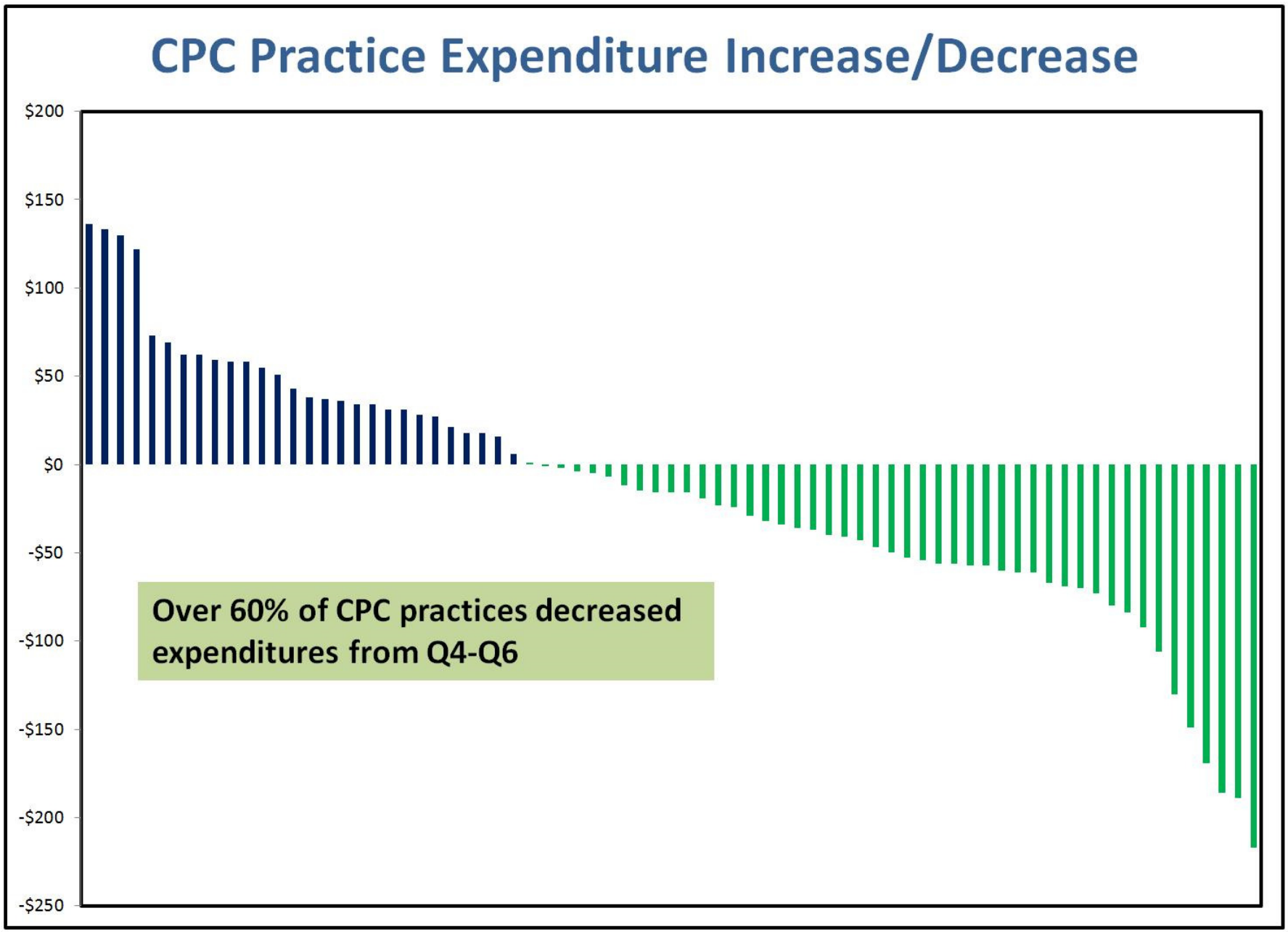
- **Region level and Practice level:**
  - What are the characteristics of our population?
  - Are we reducing expenditures?
  - How are we doing in key utilization areas?
  - How much variation is there amongst practices?
  - How is our quality?

Region View of Key Utilization Areas

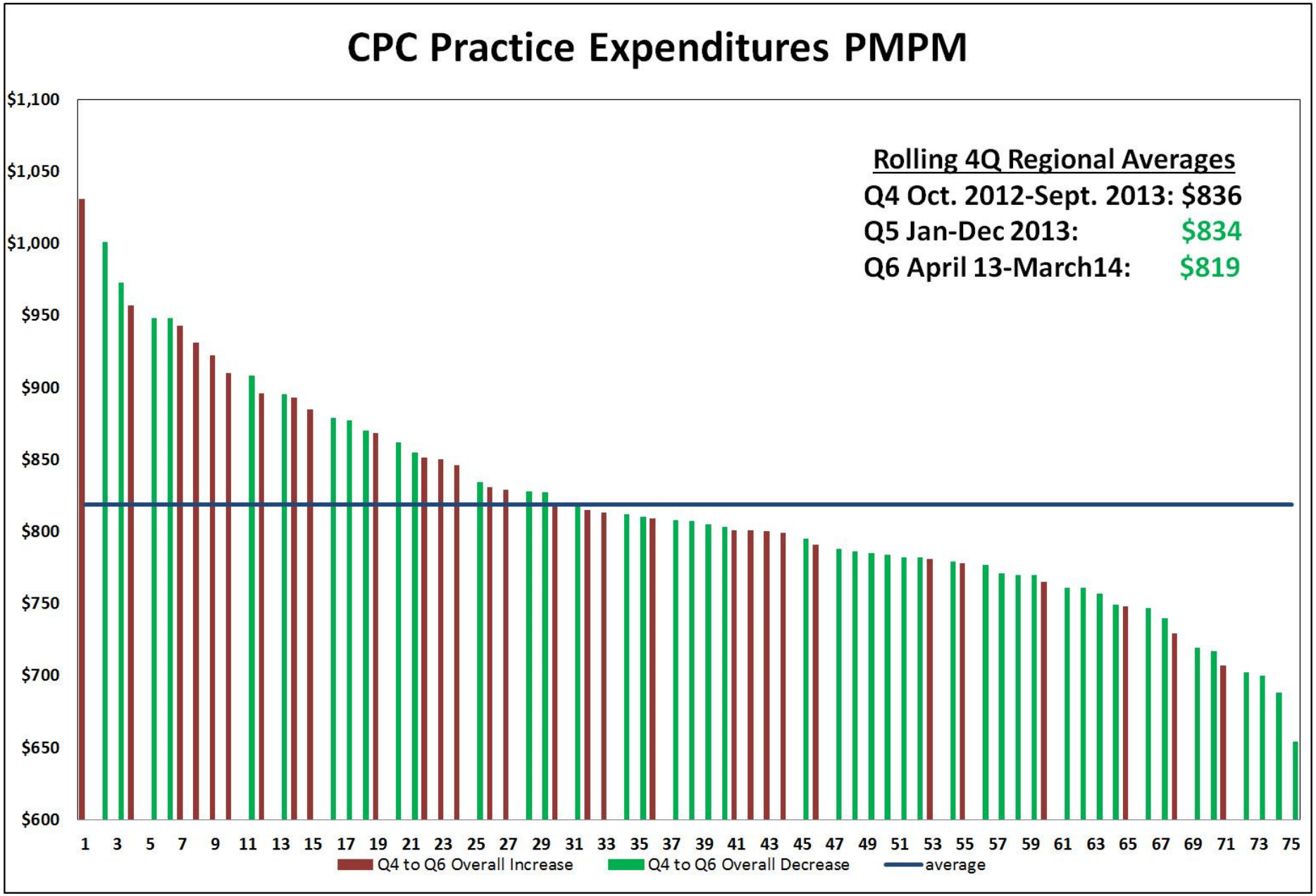




CPC Practice Expenditure Increase/Decrease



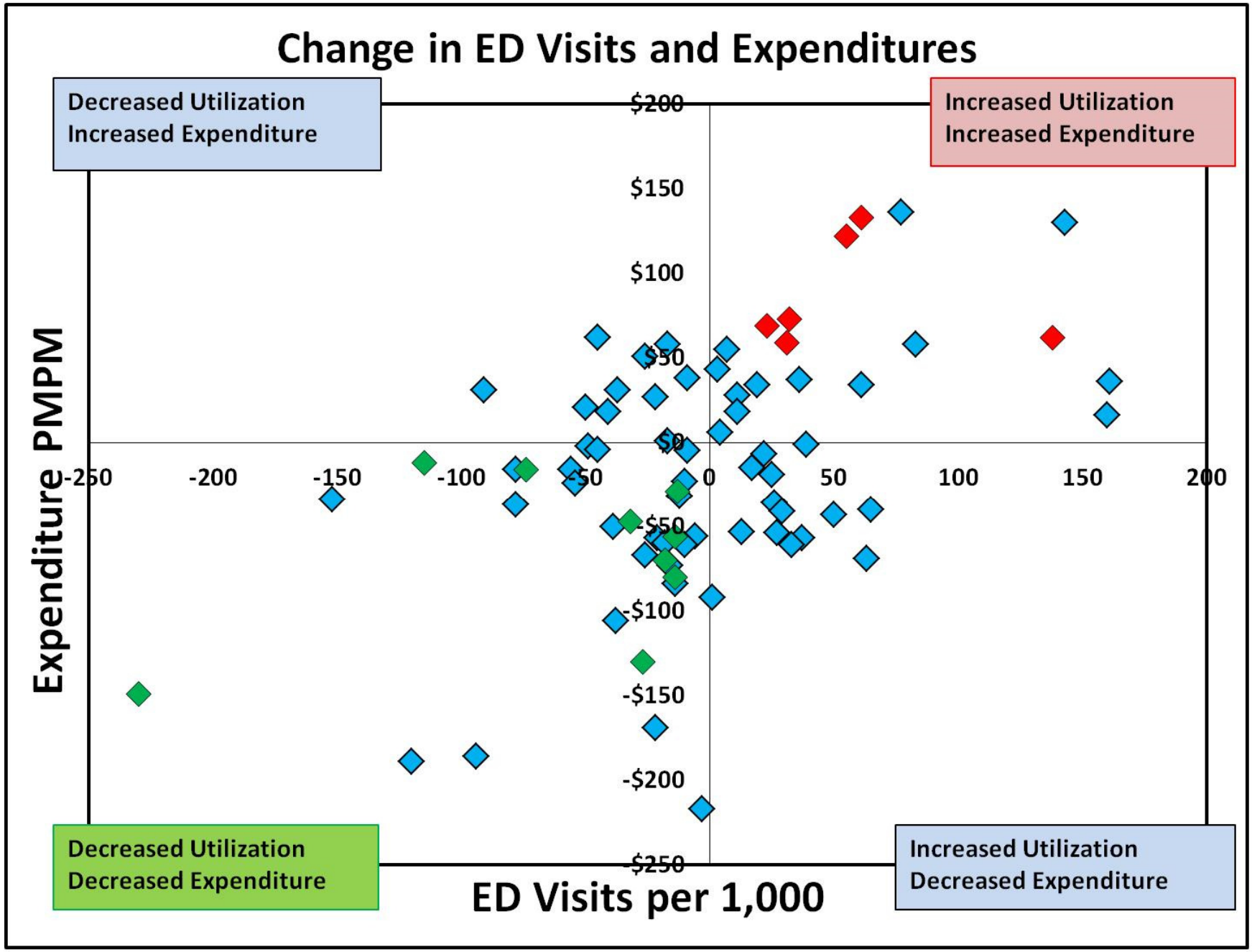
Practice Level Expenditure Variation



Practice-level Transparency

CPC
Comprehensive Primary Care

Practice Name	Expenditure Change Q4-Q6	ED Change Q4-Q6	ACSC Change Q4-Q6	30 Day Readmit Change Q4-Q6	Admission Change Q4-Q6
Practice A	$62.00	-45	-23	21	-28
Practice B	-$2.00	-49	6	-22	-31
Practice C	-$217.00	-3	-10	4	-15
Practice D	-$169.00	-22	-25	-59	-24
Practice E	-$149.00	-230	15	15	-124
Practice F	$62.00	138	4	17	22
Practice G	$28.00	11	11	28	-11
Practice H	$37.00	36	18	43	23
Practice I	-$19.00	25	8	16	-37


Change in ED Visits and Expenditures
Decreased Utilization
Increased Expenditure
Increased Utilization
Increased Expenditure
Decreased Utilization
Decreased Expenditure
Increased Utilization
Decreased Expenditure
Expenditure PMPM
ED Visits per 1,000
$200
$150
$100
$50
$0
-$50
-$100
-$150
-$200
-$250
-250
-200
-150
-100
-50
0
50
100
150
200

CPC Serving as Model for Ohio

CPC
Comprehensive Primary Care

Key Driver for Expanding PCMH Statewide

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THE HEALTH COLLABORATIVE
HEALTH BRIDGE

Transparency

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Transparency is happening…

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YourHealthMatters

YourHealthMatters.org

Primary Care Providers Diabetes

- Cardiovascular Health
- Colon Cancer Screening Rates
- Patient Experience

Hospital

- Effectiveness
- Patient Experience
- Emergency Department

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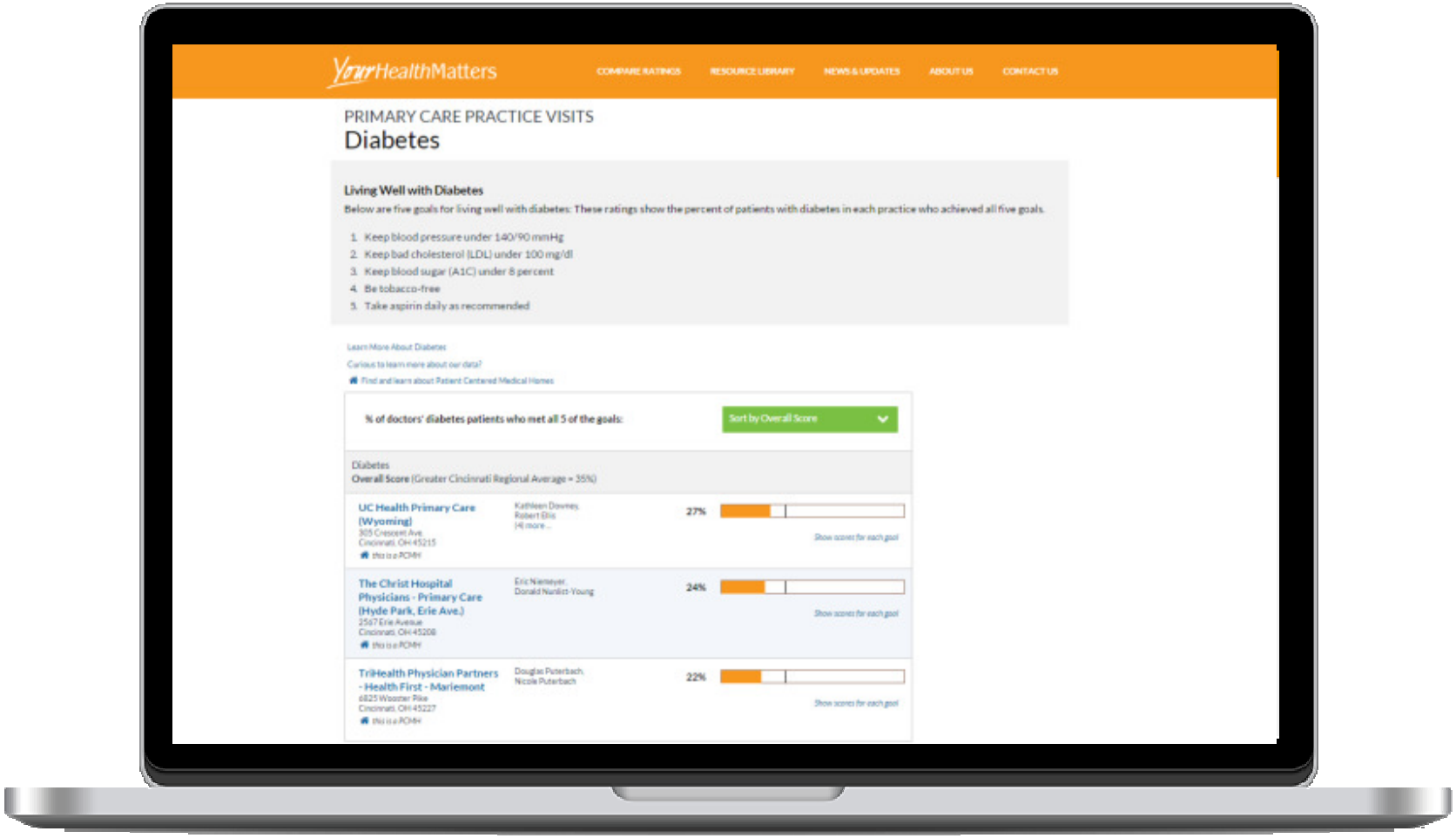
YourHealthMatters

YourHealthMatters.org



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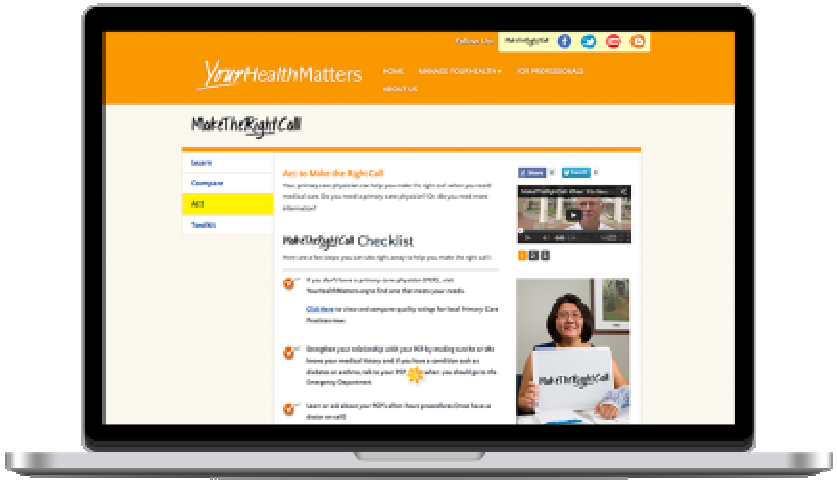
MakeTheRightCall

Goal:

Reduce unnecessary ED use by building a better relationship with a primary care doctor.



Campaign Videos

“Know the Difference”

Primary Care Physician? Or Emergency Room Physician?

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BENEFITS OF ALL-PAYER CLAIMS DATABASE

Need for a neutral, trusted, local source of truth

Community-wide view of cost and utilization for decision support and benchmarking

Transparency for consumers and payers seeking high quality care

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Better Data, Better Decisions

- 1 of 12 organization to receive qualified entity status
- Medicare data for analysis of cost and utilization to drive improvement
- Add Commercial claims data for a full and accurate picture

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Health Information Exchange and Data Management

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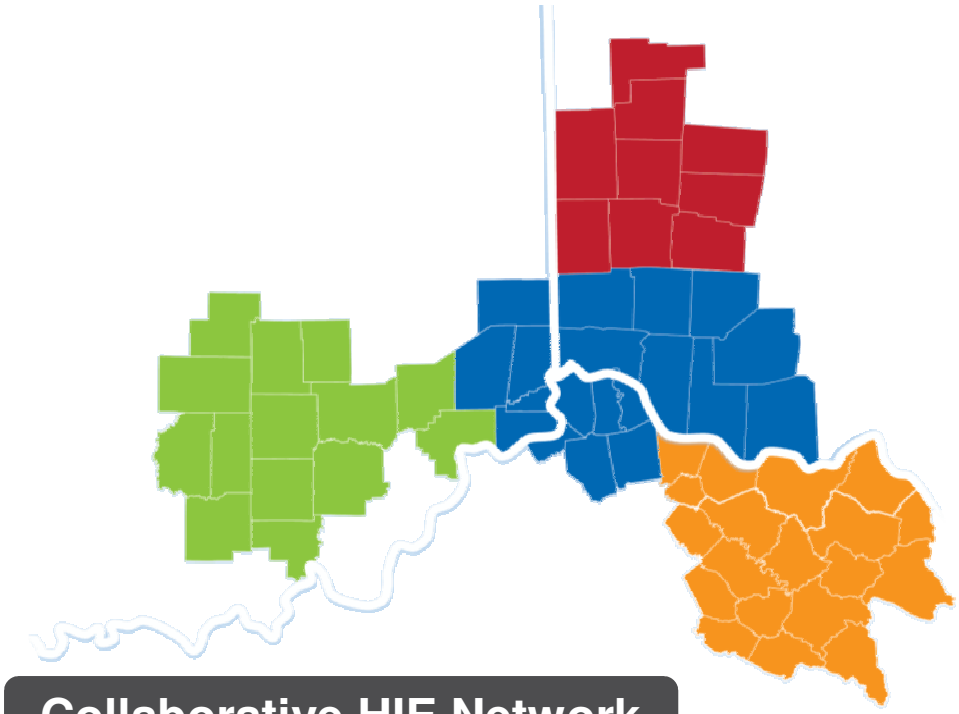
HealthBridge HIE Network



Total HIE Network

- **50+ Hospitals**
- **9000 Doctors**
- **3+ Million patients**

Collaborative HIE Network

HB provides technology infrastructure for three other HIEs

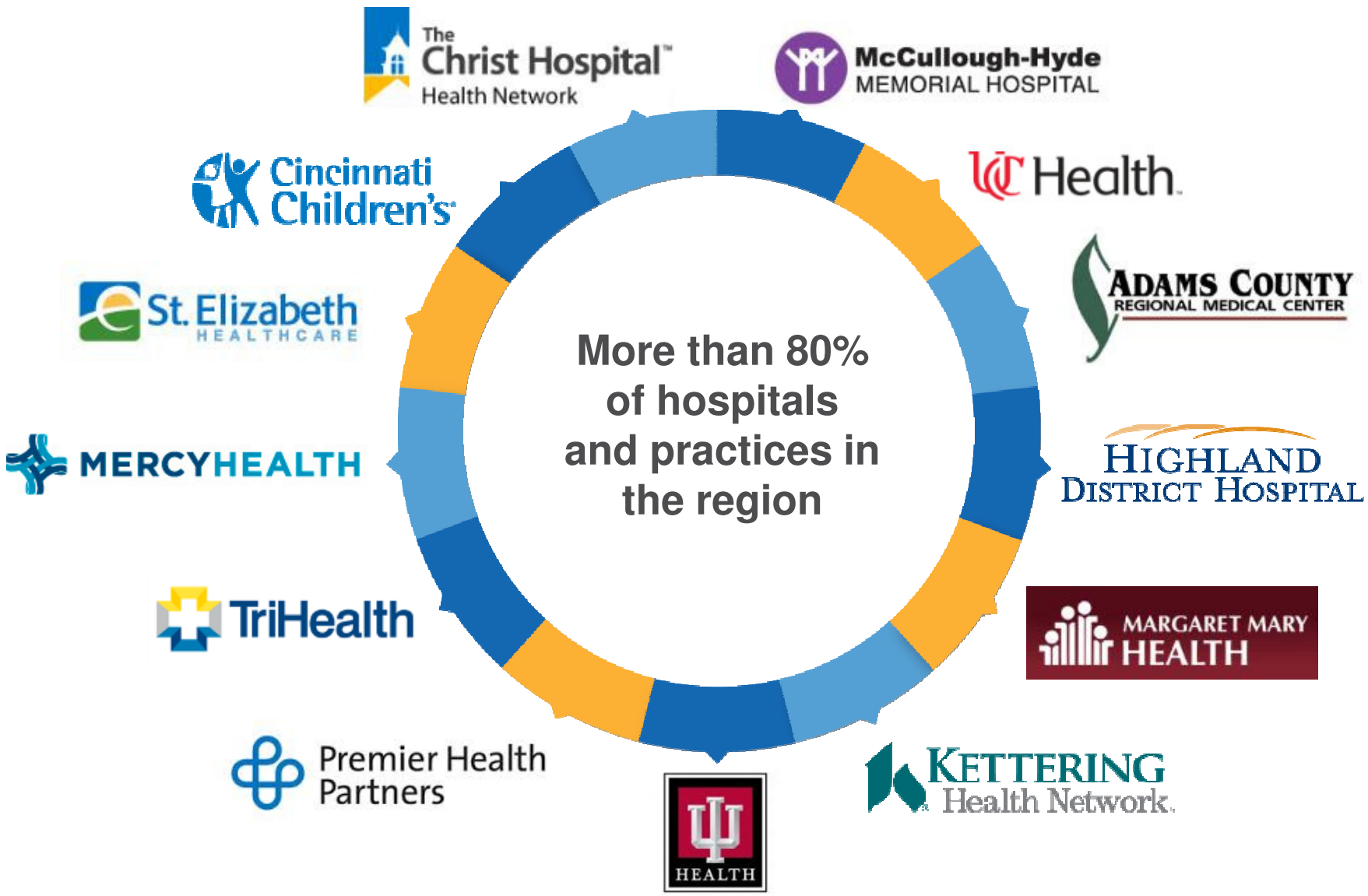
GDAHIN
GREATER DAYTON AREA HEALTH INFORMATION NETWORK
A Service of GDAHA

NeKY RHIO
NorthEast Kentucky Regional Health Information Organization

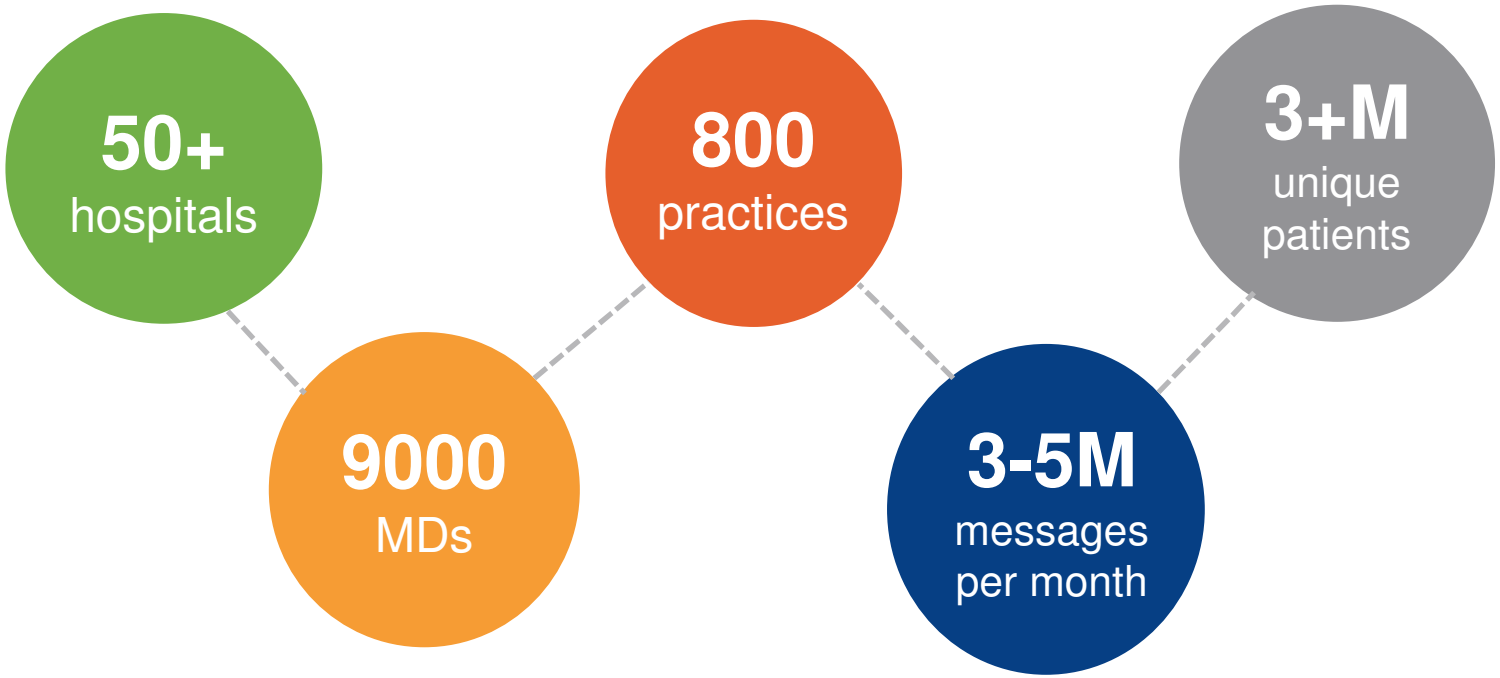
healthLINC
CONNECT. CARE. COLLABORATE.

HealthBridge

Health System Participation



Connection Statistics



>80% of physicians & hospitals exchanging data through HealthBridge

Architecture

Who We Get Data From

- Hospitals
- Physicians Practices & Clinics
- Lab Providers
- Imaging/Radiology Providers
- Health Plan Data

How We Handle Data
Core HIE Technologies

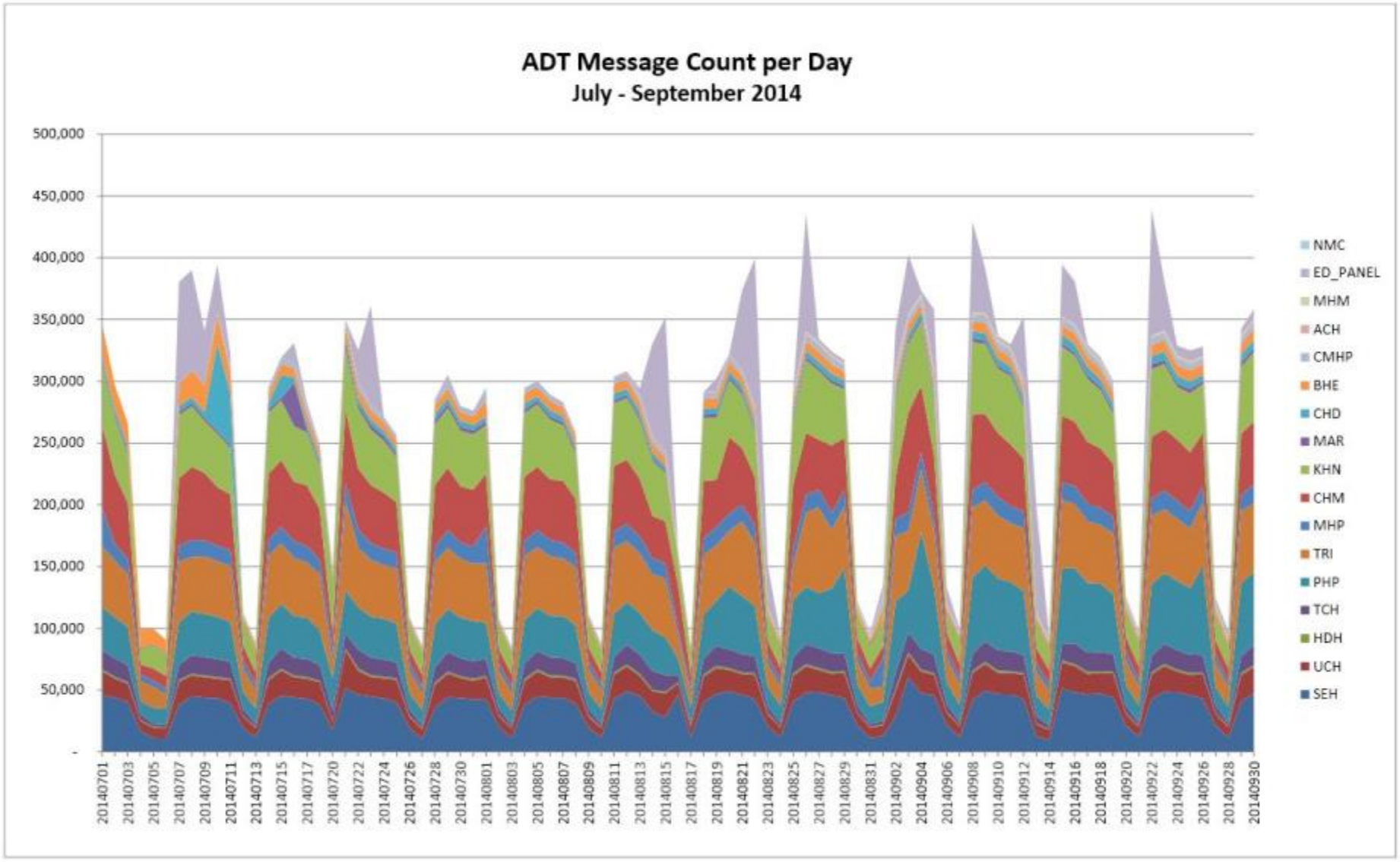
- Inbound Integration Engine
- Data Normalization
- Identity Management Solution
- Clinical Repository
- Routing Logic
- Outbound Integration Engine

Who We Send Data To

- Physicians Practices & Clinics
- Health Systems
- Post Acute & Social Services
- Patients & Families
- State HIE Connectivity

HealthBridge

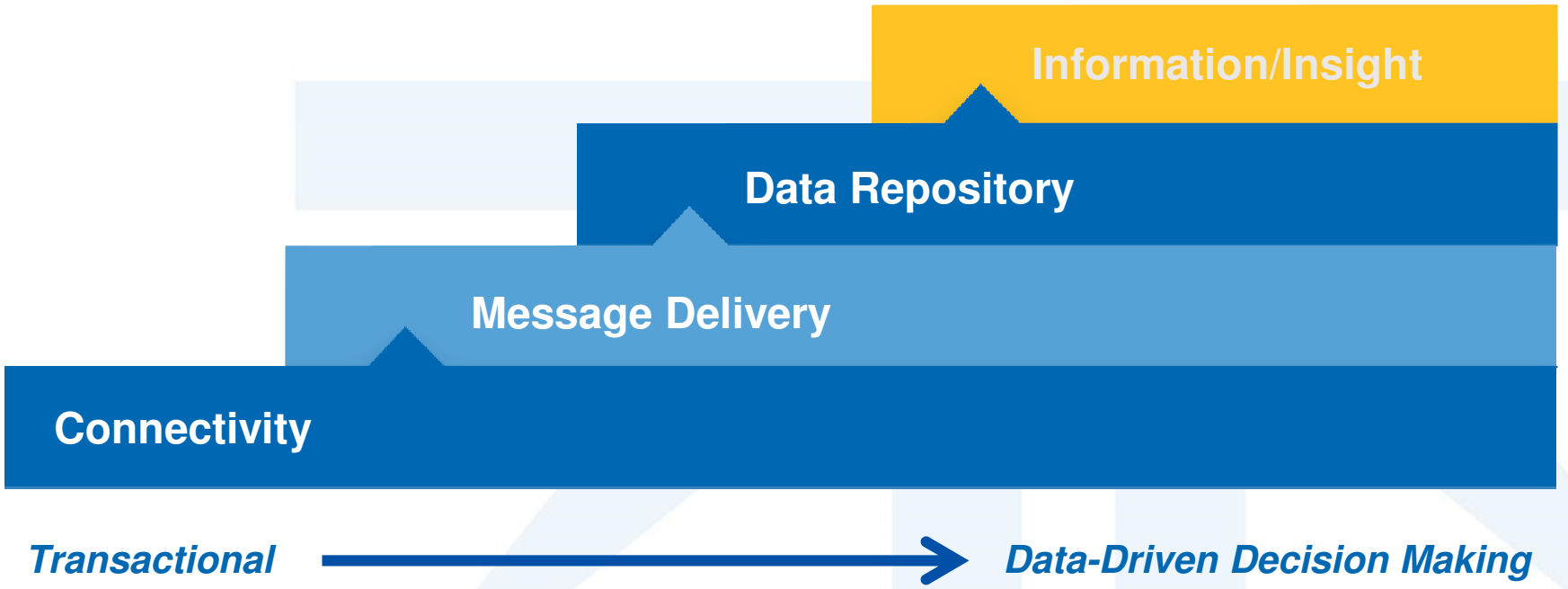
Identity Management



HIE Evolution

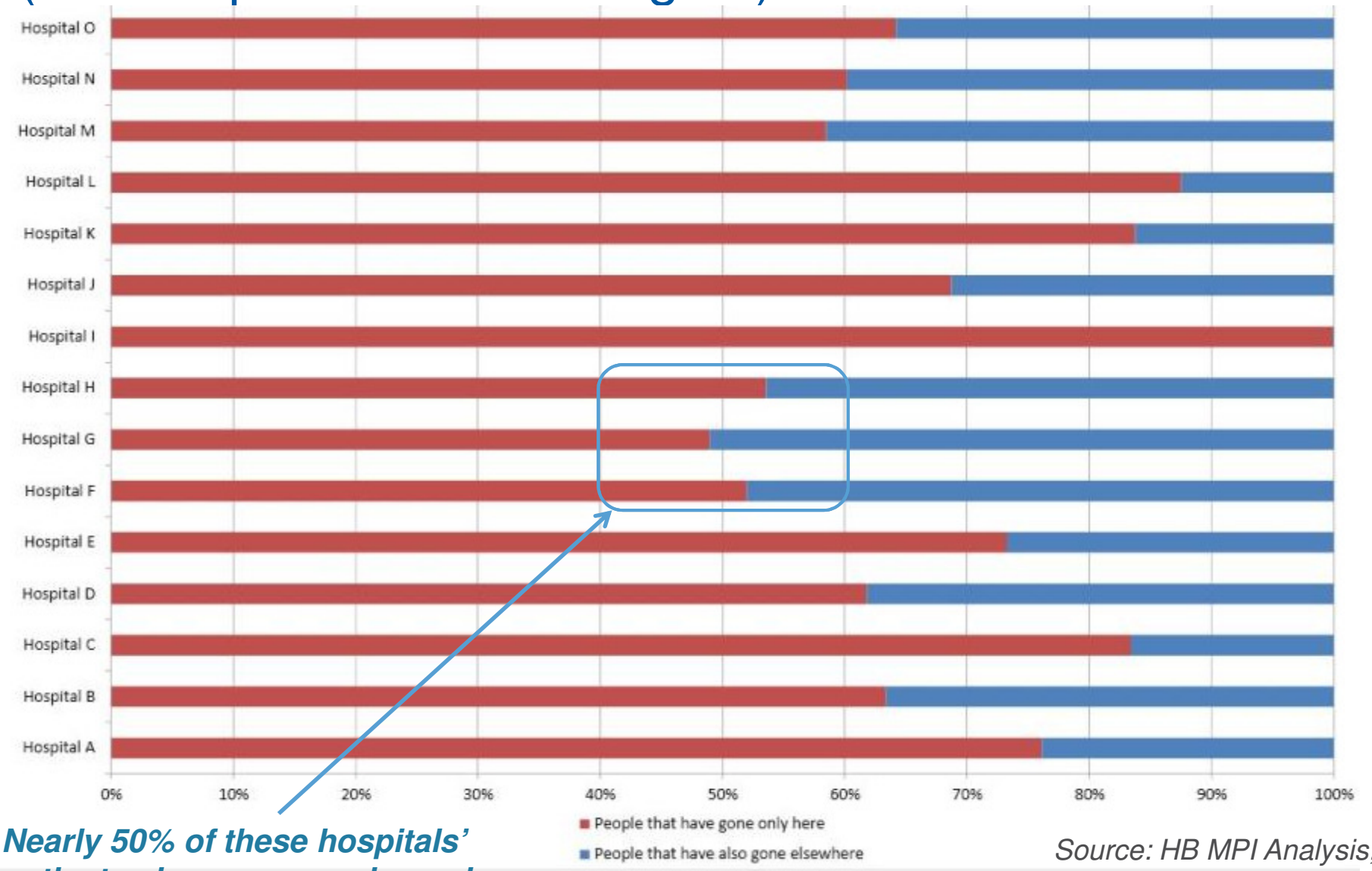
"The goal is to turn data into information, and information into insight."

- Carly Fiorina



HealthBridge

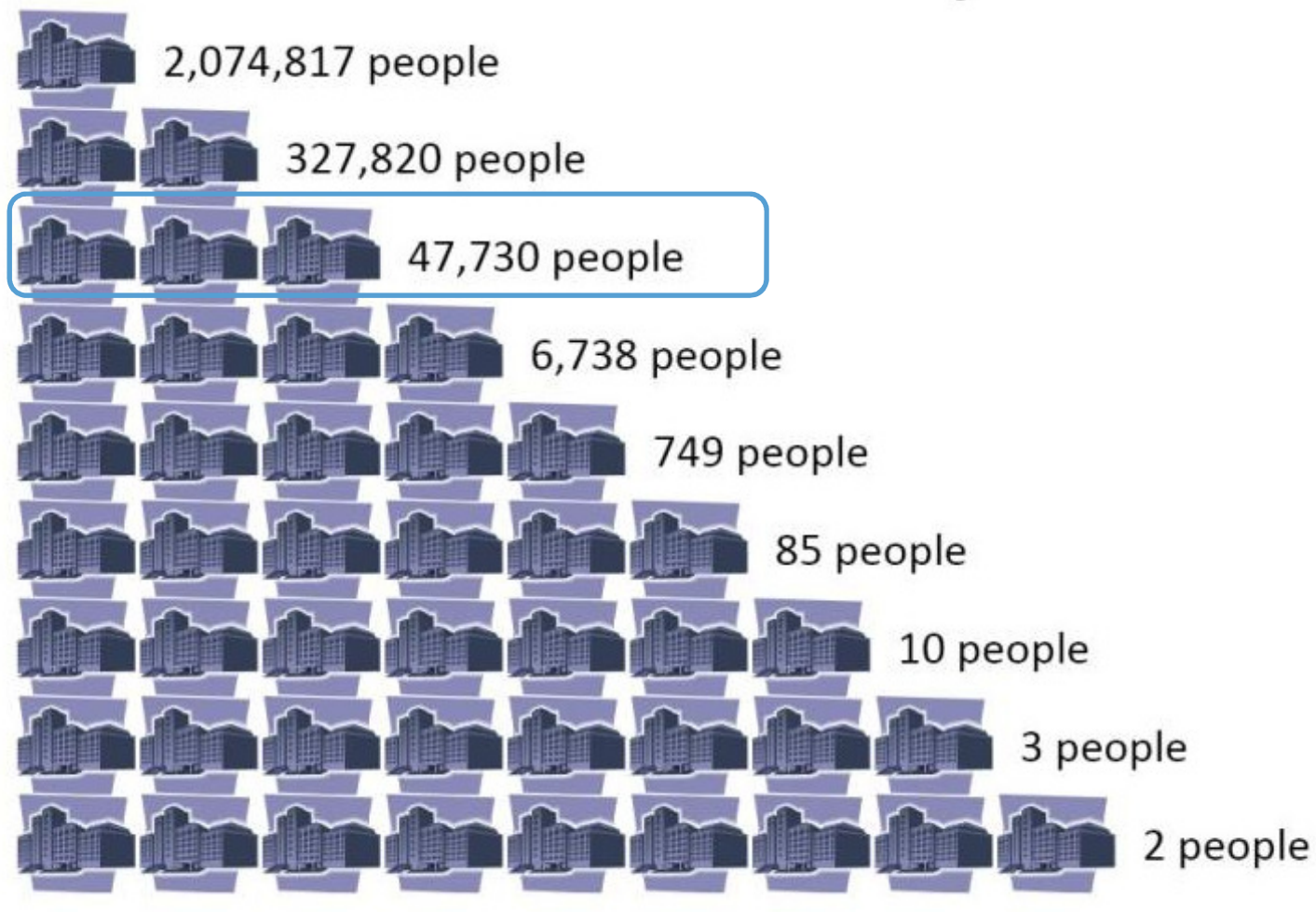
750K of 2.3M Use Multiple Health Systems (32% of patients in the region)



Nearly 50% of these hospitals' patients also go somewhere else.

Source: HB MPI Analysis, Jan – Sept 2014

More than 50,000 Patients Went to 3 or More DIFFERENT Health Systems for Care



Replace text box with chapter logo

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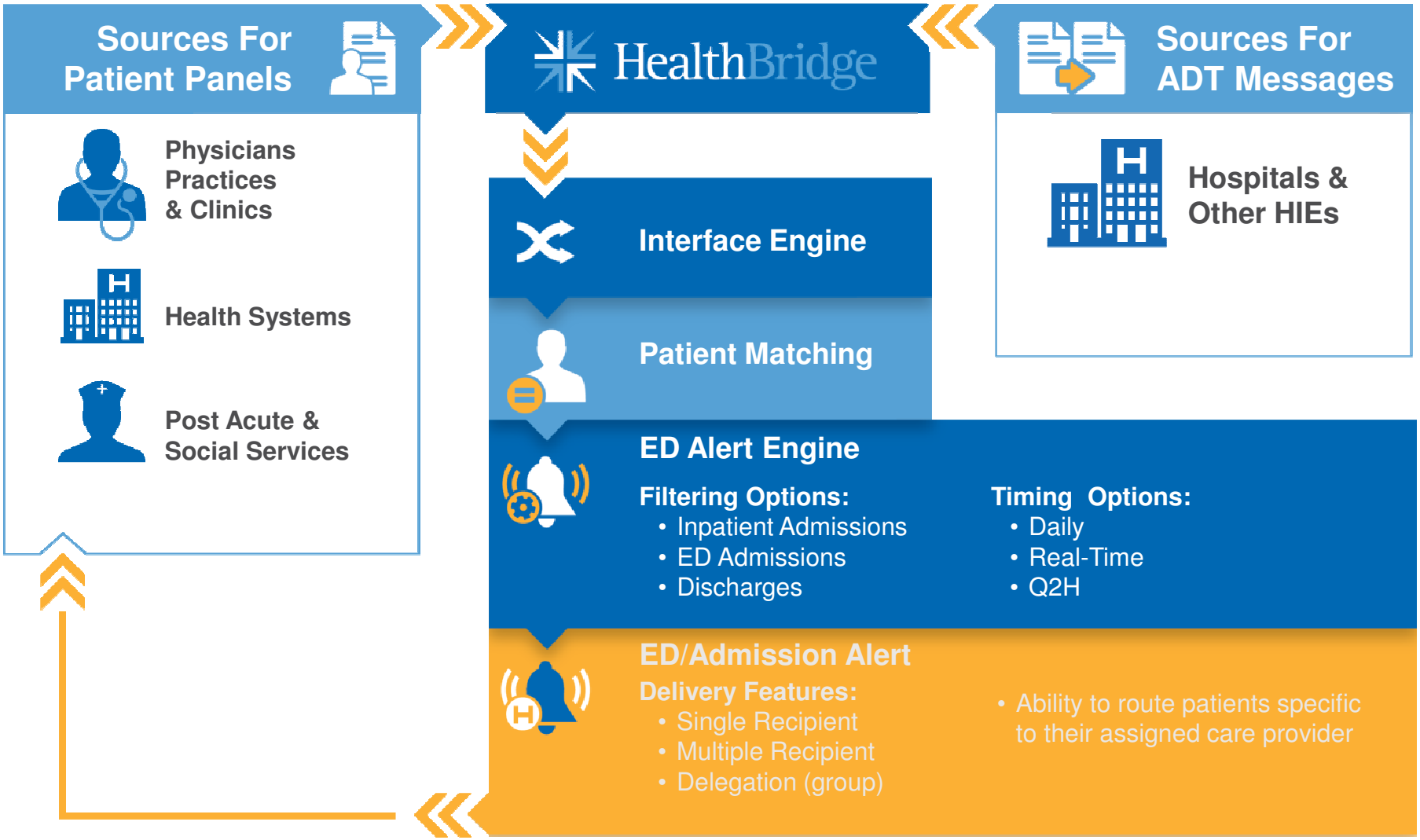
THE HEALTH COLLABORATIVE
HEALTH BRIDGE

Attacking Unhelpful ED Visits

A care coordination issue, particularly for chronically ill patients

- PCPs get little information about patient ED visits
- Unknown how many patients use ED for non-urgent illnesses
- Many follow up appointments after ED visit involve “data gathering”
- Processes for ED follow up inconsistent – risk for further ED use and hospitalizations
- Few off-the-shelf improvement tools and processes for ED visits

Event Notification



Event Notification

- Alerts System participating organizations include:
  - 21 hospitals
  - 87 primary care practices
  - 200+ Adult PCPs
  - 300+ Pediatricians
  - 35,000 patients with Diabetes
  - 30,000 patients with Pediatric Asthma
  - Visiting Nurses Association and Council on Aging
  - HealthLinc HIE network in Bloomington, IN

- **7,000 - 10,000 alerts sent per month currently**

Success!

- 5 yr old girl had visited the ED 5X in the previous year for uncontrolled asthma
- Alert notified practice that this patient was in crisis
- Medical Home followed up immediately
- Parent alerted to same day, open access scheduling – no need for the ED visit
- Great continued follow up and monitoring have kept her healthy

An Overarching Strategy

THE HEALTH COLLABORATIVE

COLLECTIVE IMPACT ON HEALTH

DATA-DRIVEN HEALTH IMPROVEMENT IN GREATER CINCINNATI

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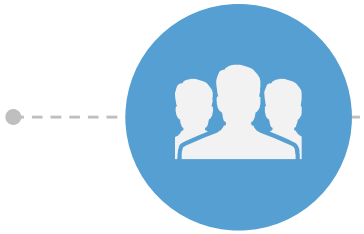
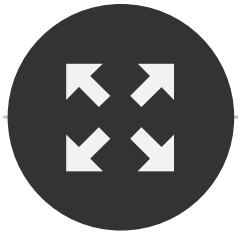
A Collective Vision and Strategy Informed by Data Can Drive Change



Opportunity

If we don't find local solutions, someone else's solutions will be forced upon us.



Drive Change

Communities and employers collectively need to drive improved health throughout the entire system.

Innovation

We have a unique collaboration in place in Greater Cincinnati foundational to leading health care innovation.

> *masters of our health destiny*

COLLECTIVE IMPACT ON HEALTH

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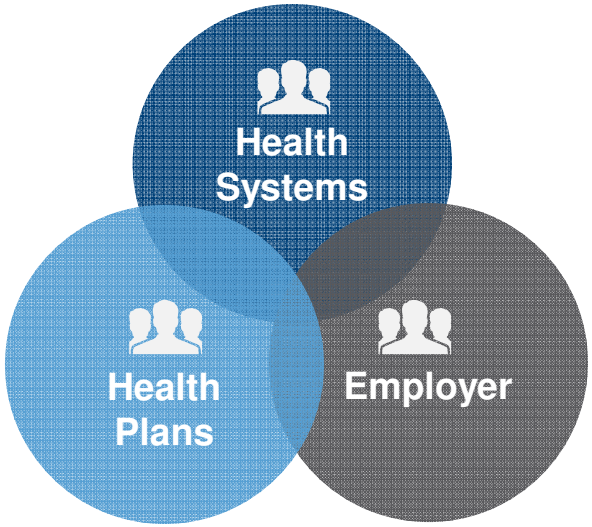
…By Working Collaboratively



Cooperation
Health systems, health plans and employers have a 21 year history of cooperation.

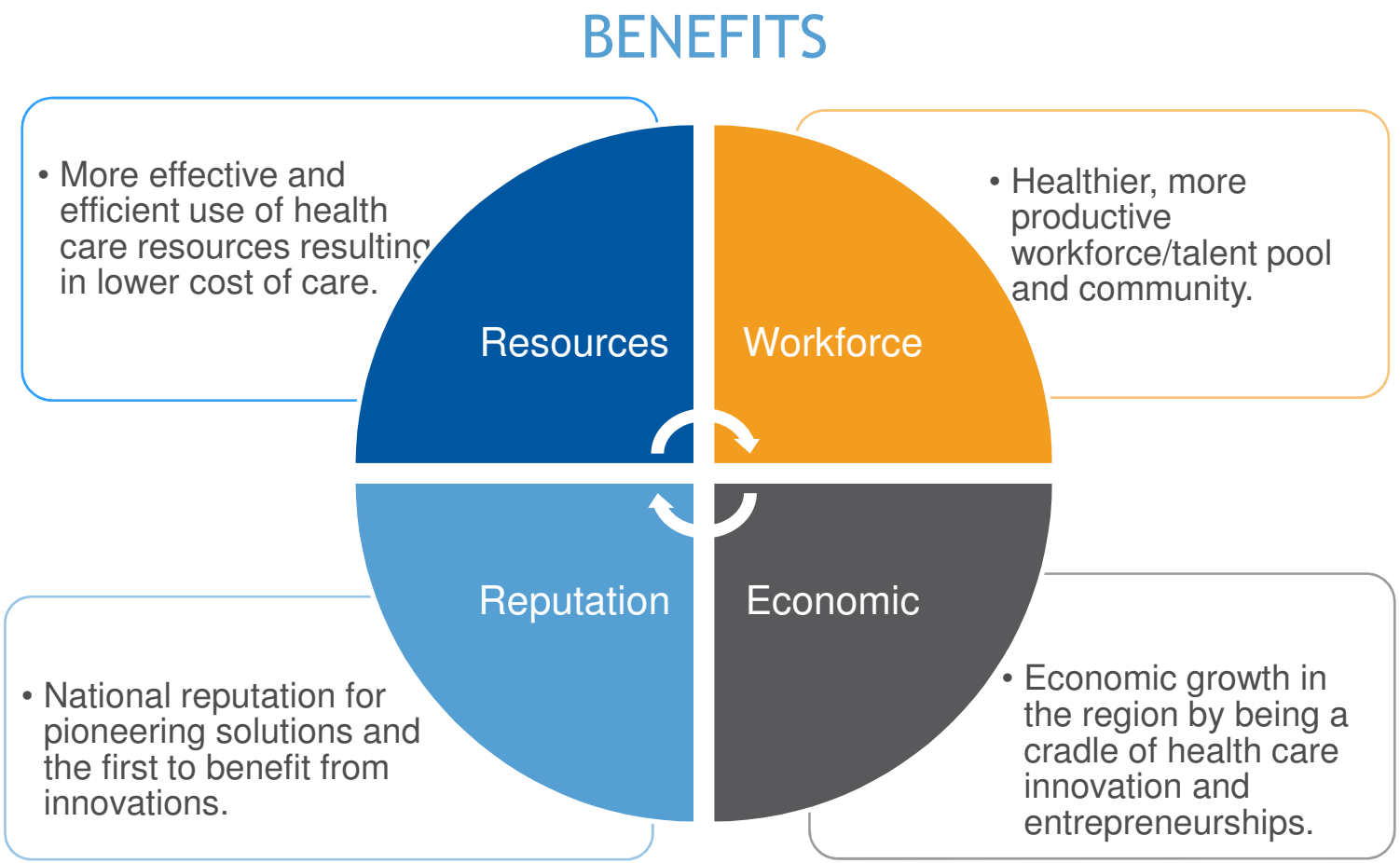
Quality
Currently leading successful QI initiatives in physician offices and in the hospital setting.

Infrastructure
Capacity to securely collect and manage health data files. Soon be receiving Medicare Data

7,500 CONNECTED PHYSICIANS

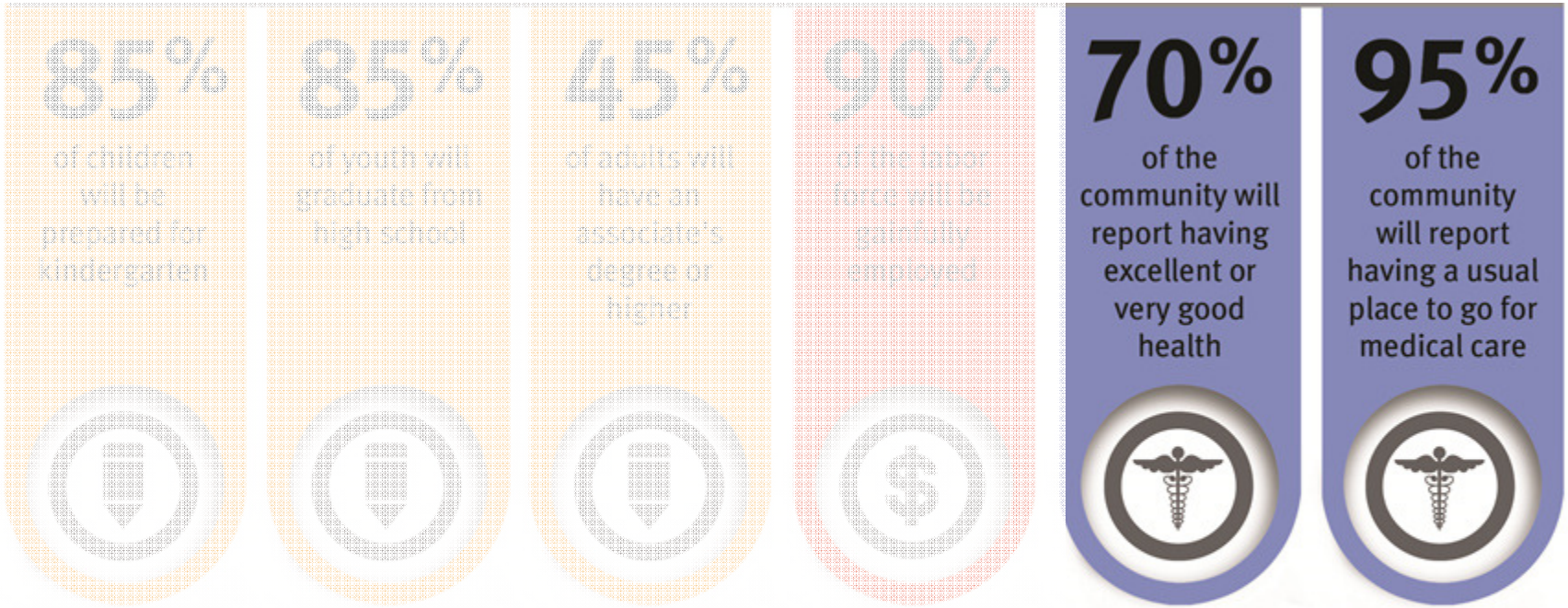
Greater Cincinnati is one of the nation's most connected health care communities with 7,500 connected physicians and a high adoption of electronic medical records. We are ahead of most other US cities in this regard.

…To Drive Value



Bold Goals

LIVE UNITED® United Way



The year the Bold Goals were created

2011 ▶ **2020**

Target year for the Bold Goals to be achieved

COLLECTIVE IMPACT ON HEALTH

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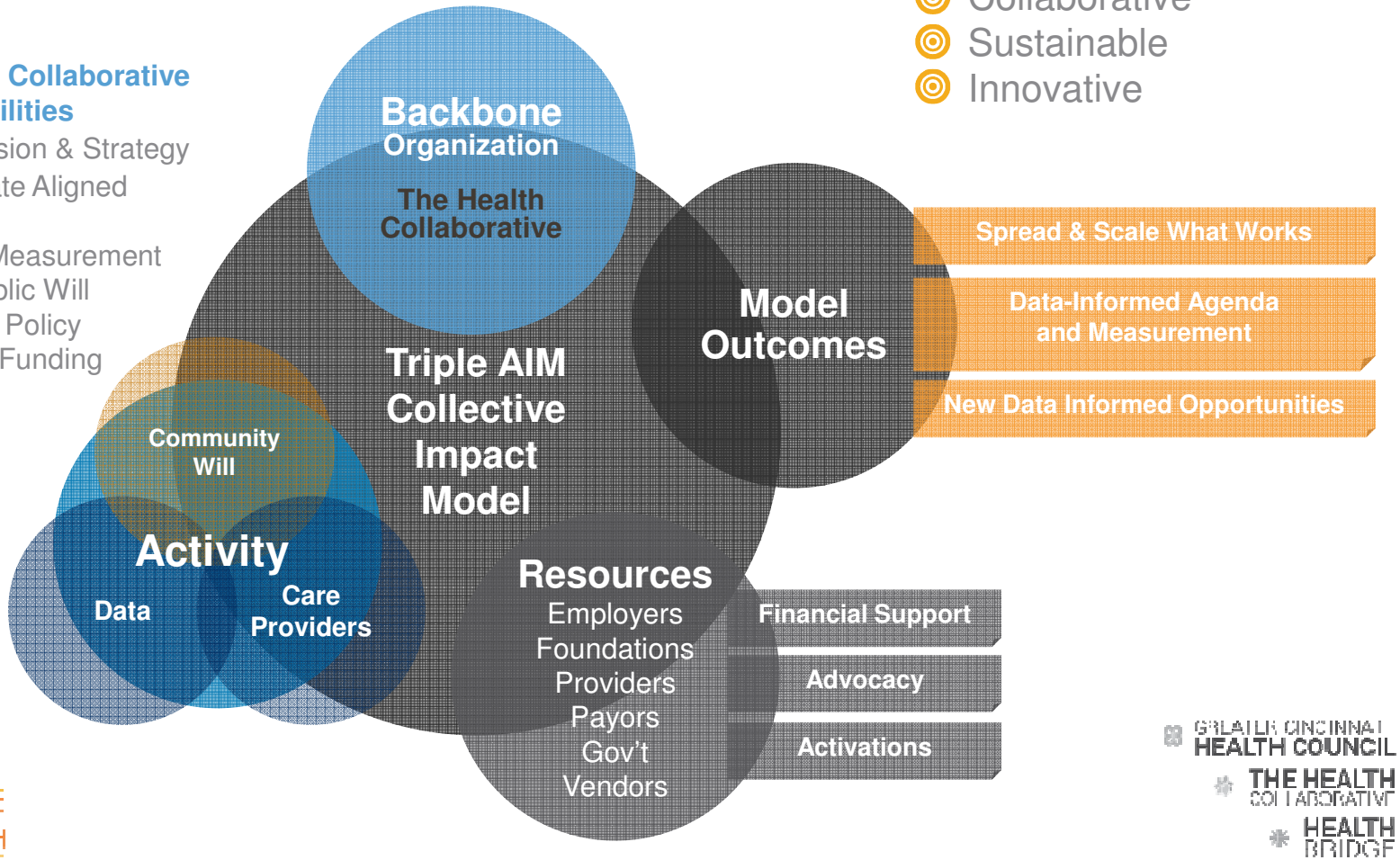
Impacting Change with Better Aim

Create an informed community-wide shared agenda for better health, better health care, and lower costs.

- Data-Driven
- Collaborative
- Sustainable
- Innovative

The Health Collaborative Responsibilities

- Guide Vision & Strategy
- Coordinate Aligned Activities
- Shared Measurement
- Build Public Will
- Advance Policy
- Mobilize Funding



COLLECTIVE IMPACT ON HEALTH

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With Everyone Involved

UNITED WAY

The United Way has entrusted the Health Collaborative to lead it's Bold Goals for Health.

HOSPITAL SYSTEMS

Hospitals and foundations contributing over $650,000/year x 2-years.

INTERACT FOR HEALTH

Interact for Health is a major supporter.

Employers

Health Plans and the business community.

COLLECTIVE IMPACT ON HEALTH

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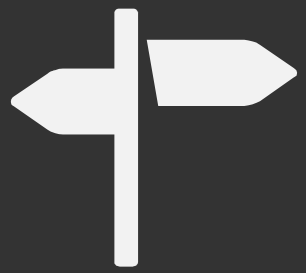
Charting a Path Together

EXPERIENCE
Nationally recognized organization with a 21 year history of bringing health care providers, payers and consumers together.

LEADING THE WAY
Leading a ***Collective Impact on Health***; a well-documented approach to large-scale social change.



TRIPLE AIM PLAN
Community-wide aligned goals and strategy for better health, better care and lower cost; "***The Triple AIM***".

COLLECTIVE IMPACT ON HEALTH

GREATER CINCINNATI HEALTH COUNCIL
THE HEALTH COLLABORATIVE
HEALTH BRIDGE

SUMMARY

- Models like PCMH are changing the way care is delivered and paid for
- We have an opportunity to use data to guide and inform health care decision making
- We provide tools for stakeholders to drive affordable, high quality care and improve health
- Our region’s Collective Impact strategy on Health unites the community

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