Data Analytics Platforms

NAACOS Summer 2021 Boot Camp

June 22, 2021

Aledade

NAACOS 2021

Kimberly Aswell
Vice President, Technical Product Management

For us, it was advantageous to **build our own** population health management tool

- **Why** did we decide to do it?
- **What** did we do?
- **How** does it work?

Several principles guided our build/buy decision-making process

BUILD

We want to build things that are unique to our approach to VBC.

We want to build most components of provider/user-facing technology because of the impact on driving outcomes.

Examples: Predictive Models; Patient Prioritization; End-user workflows

BUY/PARTER

We want to buy things that we consider to be commodities and can be the same for everyone.

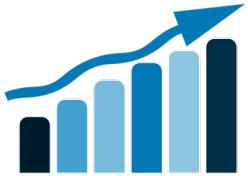
Examples: Risk Models; Medication History; Telehealth; Interfaces; Data Mappings

We have a diverse in-house team available to support our ACOs

Software Development

Software Engineers, Designers, Product Managers

Data Insights



Business & Data Analysts, Research Scientists

Coaching, Training & Workflow Optimization

Industrial Engineers, Educators, Industry & Policy Experts, Clinicians

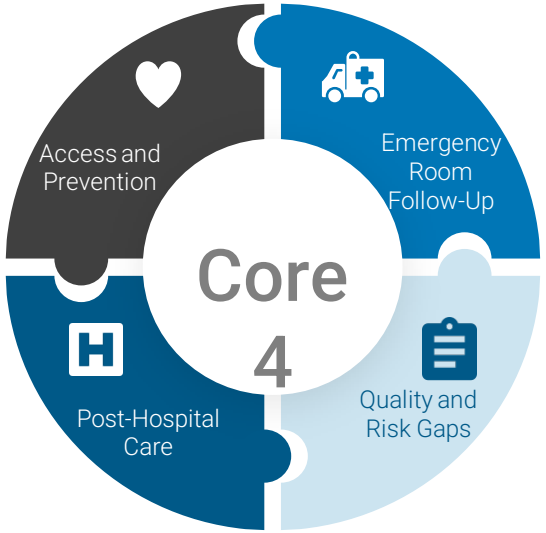
How does it all come together?

Invest in high-quality data sources

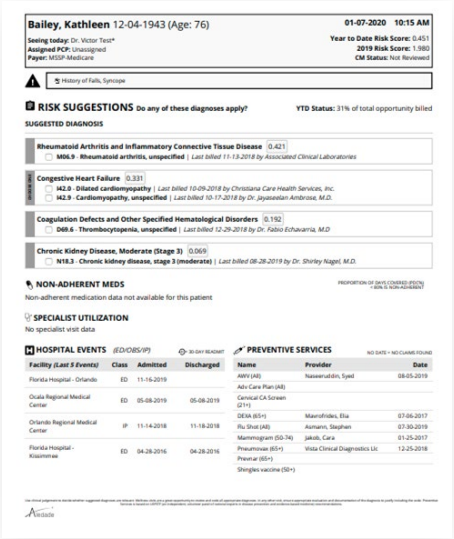
Purchase or Connect

- Risk Algorithms
- EHR Integration
- HIEs
- Claims (CCLF)
- Claims (Commercial)
- ADT
- Medication History

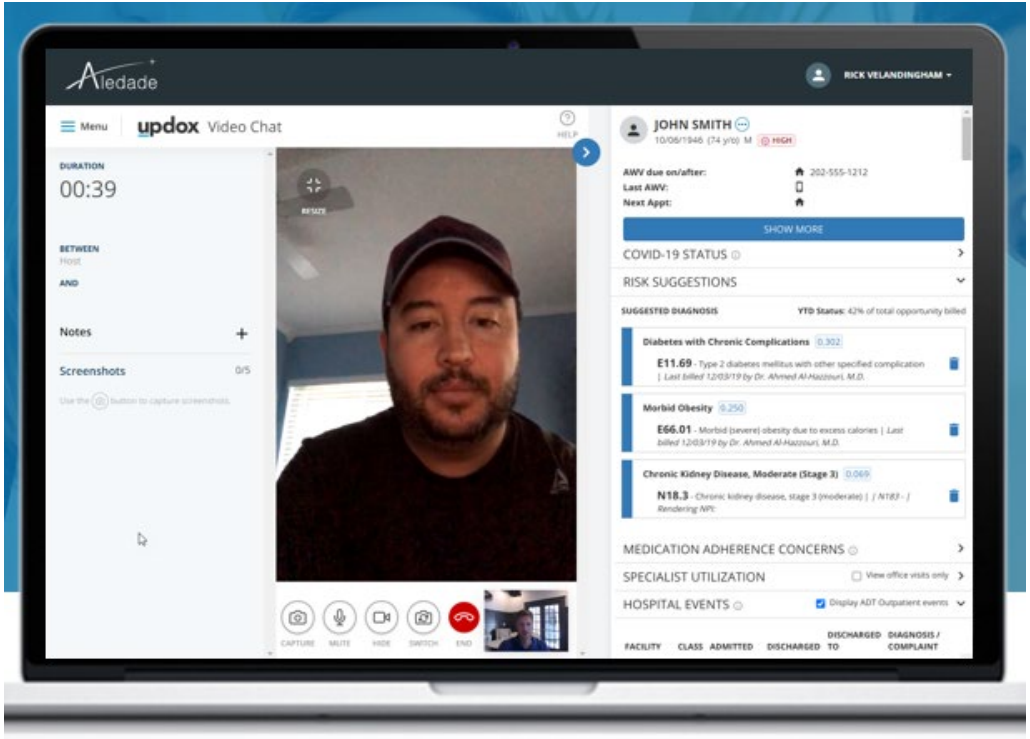
Use Data to prioritize initiatives unique to your ACO



Use Technology to drive user-level behavior change



We've found opportunities to partner without compromising our desire to control the end-user experience



Advice regarding Build/Buy

- If you build for yourself you can make a lot of simplifying assumptions
- Invest heavily in the right data sources
- Store your data
  - Store data that you don’t think you need
  - Store multiple versions of data
  - Store clicks/interactions to sharpen your tools over time
- Building allowed us to be **outcomes focused** vs. feature focused
- Avoid conference room design: Go out an observe and speak to the people who are going to use it

Building our own solution offered us **greater control**

Surveillance

- What's going on with my patients?
- Are practices doing the work?
- What opportunities are still open?

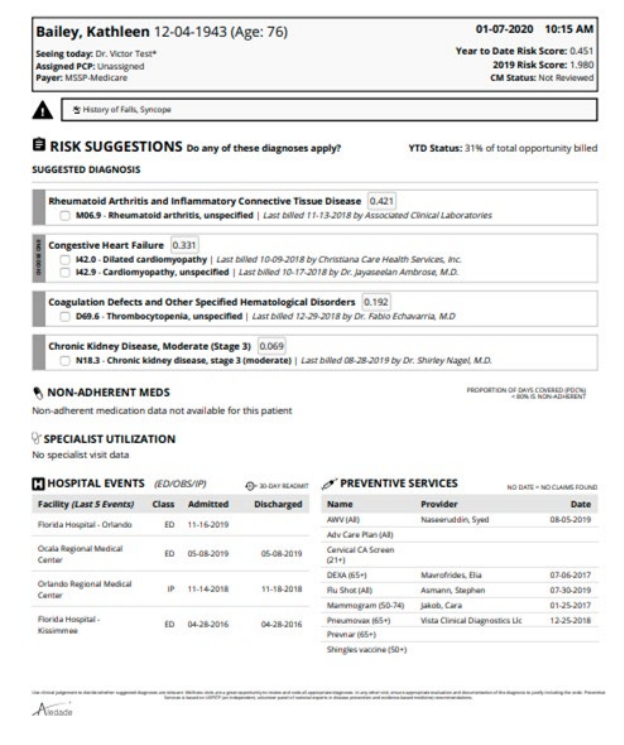
Workflow

- Can we help providers see and close coding gaps?
- How do we ensure each staff member is working at the top of their license?
- How can we optimize the EHR workflow?

Coaching/ Adoption

- Help users know how all of this work relates to clinical care
- Provide education and training

How do you get provider adoption of your tools?



Bailey, Kathleen 12-04-1943 (Age: 76) — 01-07-2020 10:15 AM

Seeing today: Dr. Victor Test*
Assigned PCP: Unassigned
Payer: MSSP-Medicare

Year to Date Risk Score: 0.451
2019 Risk Score: 1.980
CM Status: Not Reviewed

History of Falls, Syncope

RISK SUGGESTIONS Do any of these diagnoses apply? — **YTD Status:** 31% of total opportunity billed

SUGGESTED DIAGNOSIS

Rheumatoid Arthritis and Inflammatory Connective Tissue Disease 0.421
- M06.9 - Rheumatoid arthritis, unspecified | *Last billed 11-13-2018 by Associated Clinical Laboratories*

Congestive Heart Failure 0.331
- I42.0 - Dilated cardiomyopathy | *Last billed 10-09-2018 by Christiana Care Health Services, Inc.*
- I42.9 - Cardiomyopathy, unspecified | *Last billed 10-17-2018 by Dr. Jayaseelan Ambrose, M.D.*

Coagulation Defects and Other Specified Hematological Disorders 0.192
- D69.6 - Thrombocytopenia, unspecified | *Last billed 12-29-2018 by Dr. Fabio Echavarria, M.D*

Chronic Kidney Disease, Moderate (Stage 3) 0.069
- N18.3 - Chronic kidney disease, stage 3 (moderate) | *Last billed 08-28-2019 by Dr. Shirley Nagel, M.D.*

NON-ADHERENT MEDS

PROPORTION OF DAYS COVERED (PDC%) < 80% IS NON-ADHERENT

Non-adherent medication data not available for this patient

SPECIALIST UTILIZATION

No specialist visit data

HOSPITAL EVENTS *(ED/OBS/IP)* — 30-DAY READMIT

Facility (Last 5 Events)	Class	Admitted	Discharged
Florida Hospital - Orlando	ED	11-16-2019	
Ocala Regional Medical Center	ED	05-08-2019	05-08-2019
Orlando Regional Medical Center	IP	11-14-2018	11-18-2018
Florida Hospital - Kissimmee	ED	04-28-2016	04-28-2016

PREVENTIVE SERVICES — NO DATE = NO CLAIMS FOUND

Name	Provider	Date
AWV (All)	Naseeruddin, Syed	08-05-2019
Adv Care Plan (All)		
Cervical CA Screen (21+)		
DEXA (65+)	Mavrofrides, Elia	07-06-2017
Flu Shot (All)	Asmann, Stephen	07-30-2019
Mammogram (50-74)	Jakob, Cara	01-25-2017
Pneumovax (65+)	Vista Clinical Diagnostics Llc	12-25-2018
Prevnar (65+)		
Shingles vaccine (50+)		

- Meet Providers where they are
- The important thing is that providers engage with the data - it doesn't really matter *how* they do that

Community Care Partnership of Maine: Navigating Data Analytic Platforms and Services

Tuesday, June 22, 2021

COMMUNITY CARE
PARTNERSHIP OF MAINE
103 Maine Avenue | Bangor, Maine | www.CCPMaine.org

Community Care Partnership of Maine
by the numbers
June 2021

8
Aetna | Aetna Medicare Advantage | Anthem | Anthem Medicare Advantage | Cigna | Harvard Pilgrim Health Care | MaineCare Accountable Communities Program | Medicare Shared Savings Program
Payer Agreements

363
Miles between our northernmost & southernmost member organizations

3,750
Employees
Across Our Member Organizations

18
Member Organizations
15 FQHCs
3 Community Hospitals
Bucksport Regional Health Center | Cary Medical Center | DFD Russell Medical Center | Eastport Health Care, Inc. | Fish River Rural Health | Greater Portland Health | Harrington Family Health Center | Health Access Network | Hometown Health Center | Islands Community Medical Services, Inc. | Katahdin Valley Health Center | Millinocket Regional Hospital | Nasson Health Care | Penobscot Community Health Care | Pines Health Services | Sacopee Valley Health Center | St. Croix Regional Family Health Center | St. Joseph Healthcare

245,000
Patients Served Annually

$36.5 million
in savings generated under the Medicare Shared Savings Program to date with $16.4 million returned to CCPM and its member organizations

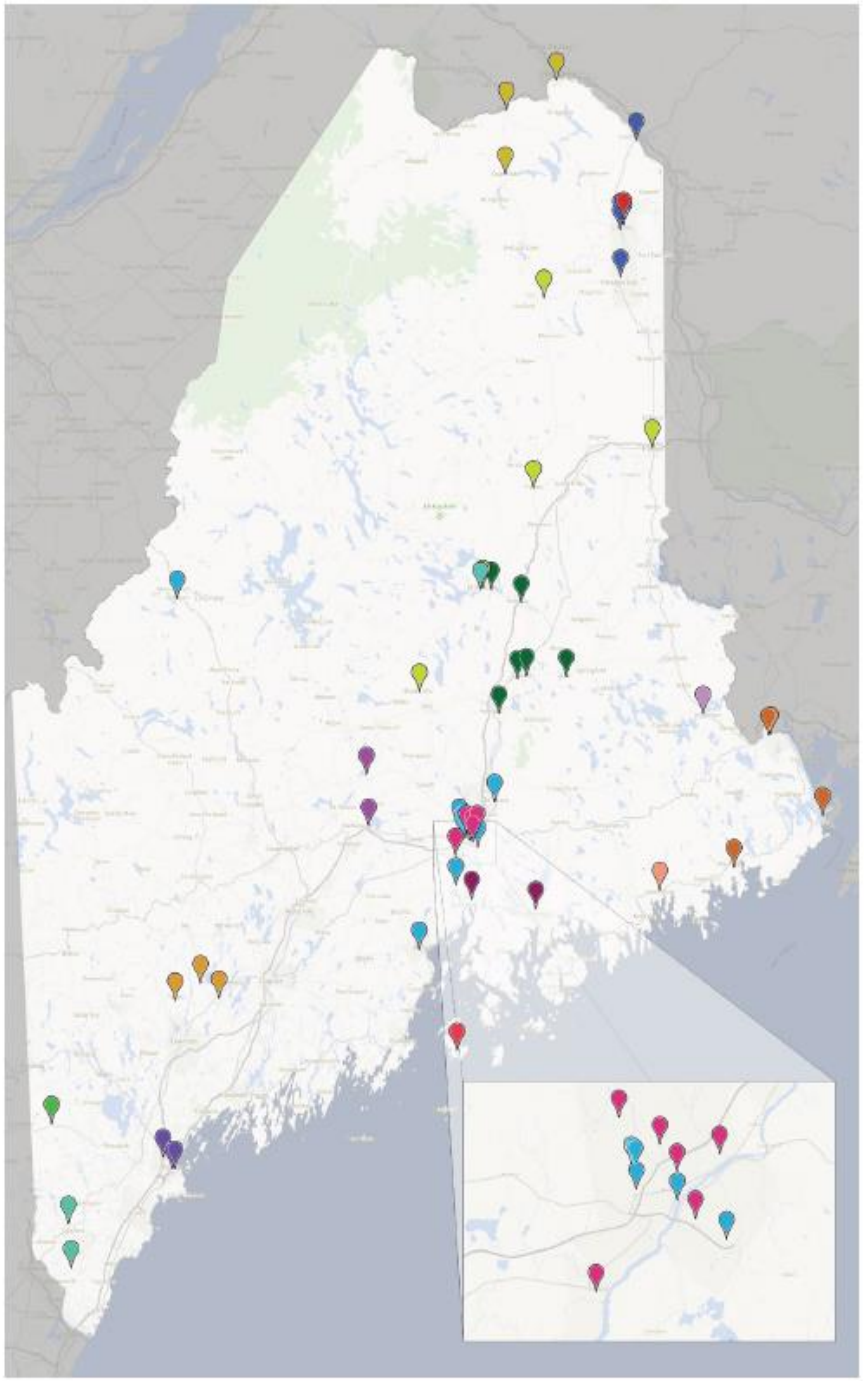
293
Primary Care Providers

80,000
Attributed Lives Overseen

Our Mission

Community Care Partnership of Maine (CCPM) is dedicated to improving the collective health of our communities through the **coordination of sustainable, innovative, and effective patient-centered care**.

CCPM member organizations are committed to **collaboration, resource sharing, and the implementation of best practices** for improving the patient and care team experience, achieving high-quality clinical outcomes, and managing costs.



- **Bucksport Regional Health Center**
  Bucksport • Ellsworth
- **Cary Medical Center**
  Caribou
- **DFD Russell Medical Center**
  Turner • Leeds • Monmouth
- **Eastport Health**
  Eastport • Machias • Calais
- **Fish River Rural Health**
  Eagle Lake • Fort Kent • Madawaska
- **Greater Portland Health**
  Portland • South Portland
- **Harrington Family Health Center**
  Harrington
- **Health Access Network**
  Lincoln • Lee • Medway
  Millinocket • W. Enfield
- **Hometown Health Center**
  Newport • Dexter
- **Islands Community Medical Services, Inc.**
  Vinalhaven
- **Katahdin Valley Health Center**
  Millinocket • Ashland • Houlton • Patten • Brownville
- **Millinocket Regional Hospital**
  Millinocket
- **Nasson Health Care**
  Springvale • North Berwick
- **Penobscot Community Health Care**
  Bangor • Brewer • Old Town
  Belfast • Winterport • Jackman
- **Pines Health Services**
  Caribou • Presque Isle • Van Buren
- **Sacopee Valley Health Center**
  Porter
- **St. Croix Regional Family Health Center**
  Princeton
- **St. Joseph Healthcare**
  Bangor • Brewer • Hampden

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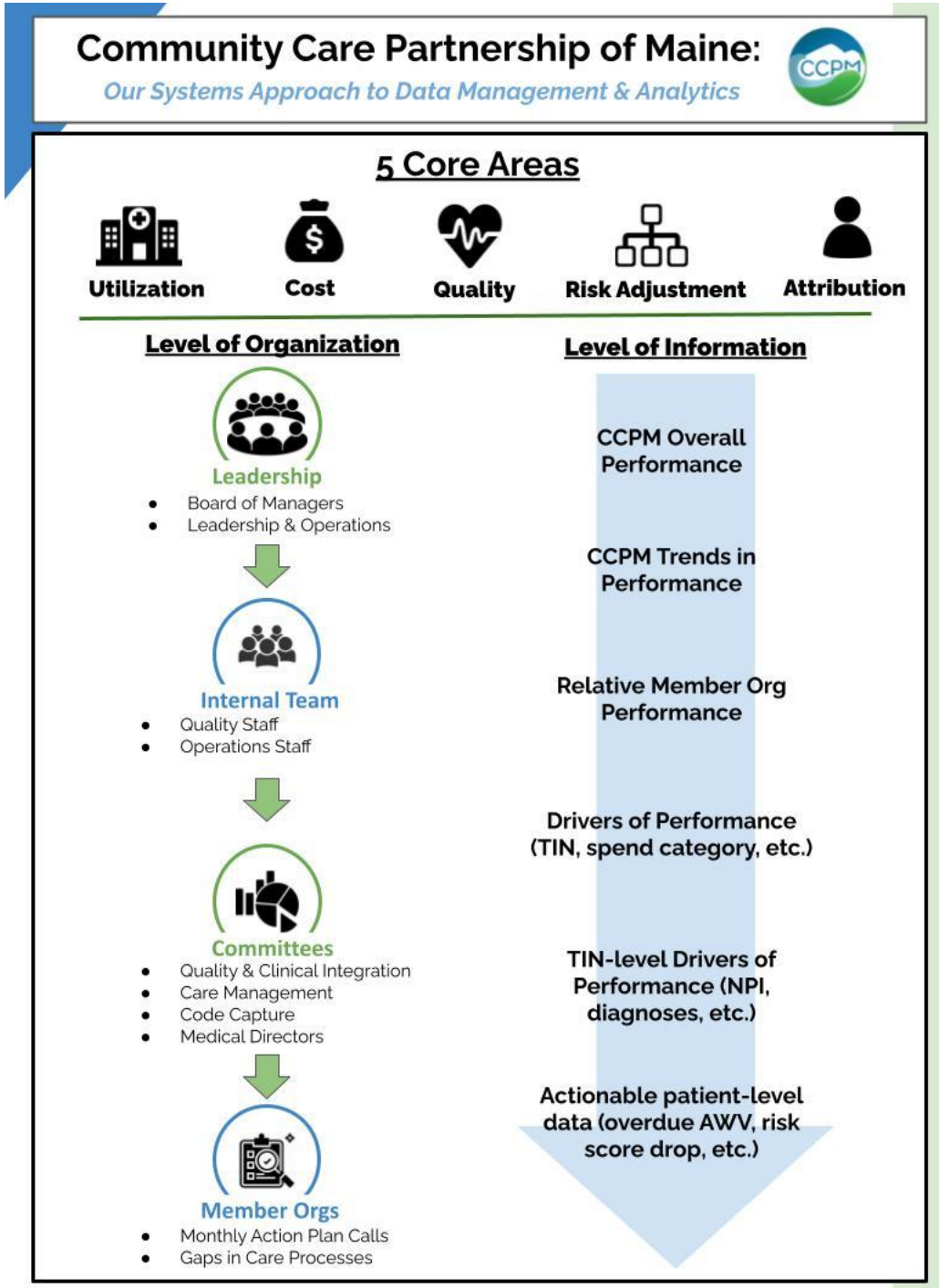
Differentiating Factors

- FQHC and small community hospital comprised and informed model
- Attribution agnostic approach
- Best practices valued over standardization
  - Commitment to keeping care local and informed by best practices

Our Process:

- Identified core areas of focus for data management and analytics
- Inventoried currently available for each of the 5 core areas
- Inventoried relevant stakeholders at all levels of the organization
- Created nested reports in each core area (ACO overall, TIN level, NPI level, actionable patient lists, etc.) - *Make or buy decision*
- Determined audience, frequency for each report



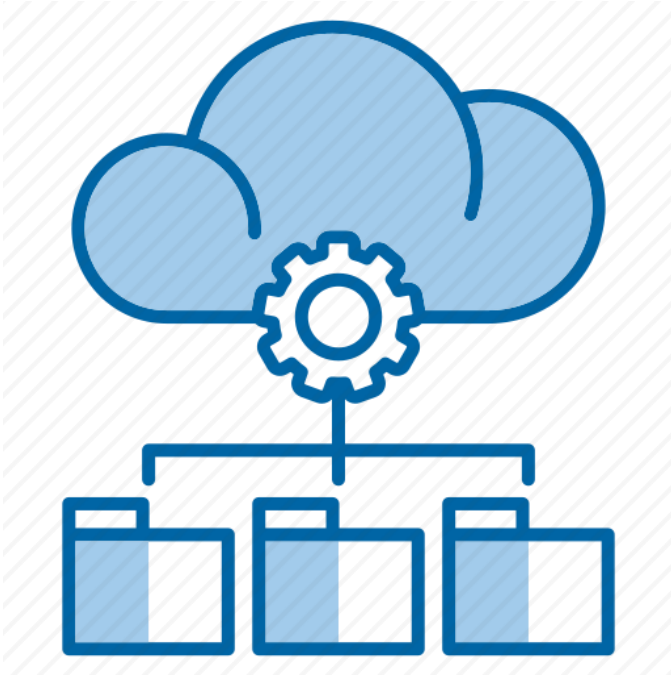
CCPM Resources for Data Management & Analytics

CCPM Self Service Data Center: Digital library for accessing clinical and quality reports; updated routinely

Transparent Performance Benchmarking: Establishment of ACO wide goals for 12 quality and utilization metrics with quarterly tracking of ACO average and TIN by TIN unblinded performance comparison

Actionanble Patient Lists: Routine delivery of list of patient opportunities (overdue AWV, risk-spend outliers, missed HCC-mapping diagnosis codes)

Targeted Performance Improvement Support: Each TIN works with CCPM team to identify 2-3 quality or utilization metrics to move the needle on, monthly touch bases



Key Data Management Vendors

HealthInfoNet

- **Hospital Performance:** Compare actual-to-target performance for key performance indicators (KPIs) using case-mix and severity-adjusted targets
- **Volume and Market Share:** Track and trend volume and market share by service area, disease, payer and patient demographics
- **Population Risk:** Identify populations and individuals most at risk for future high costs, inpatient admissions, and emergency room visits
- **30-Day Readmission Risk:** Identify inpatient encounters most at risk for readmissions
- **Variation Management:** Understand resource variation by disease and cost category

SALIENT HEALTHCARE
A Division of Salient Management Company

- **Control Risk:** Identify missed coding opportunities, develop strategies for follow-up, and measure impact of intervention.
- **Manage Quality of Care:** Create actionable, customized lists stratified by TIN or provider and monitor progress toward quality goals (AWV, etc.)
- **Control Utilization:** Evaluate patterns of ED utilization by beneficiary, TIN or NPI to inform intervention strategies.
- **Reduce Costs:** Evaluate TIN and NPI performance across all expenditure components and subcomponents and isolate beneficiaries that require further analysis.

Data Management Continuum:
Make or Buy Decision

Quality Data Gaps in Care Process

AWV Report Package

Customized Board Reporting Dashboard

Homegrown Solution: Quality Data Management

- CCPM staff manages audits, gaps in care processes for all payers
- Read-only EMR access, bi-directional HIE exchange enables CCPM staff to take the lift off of member organizations

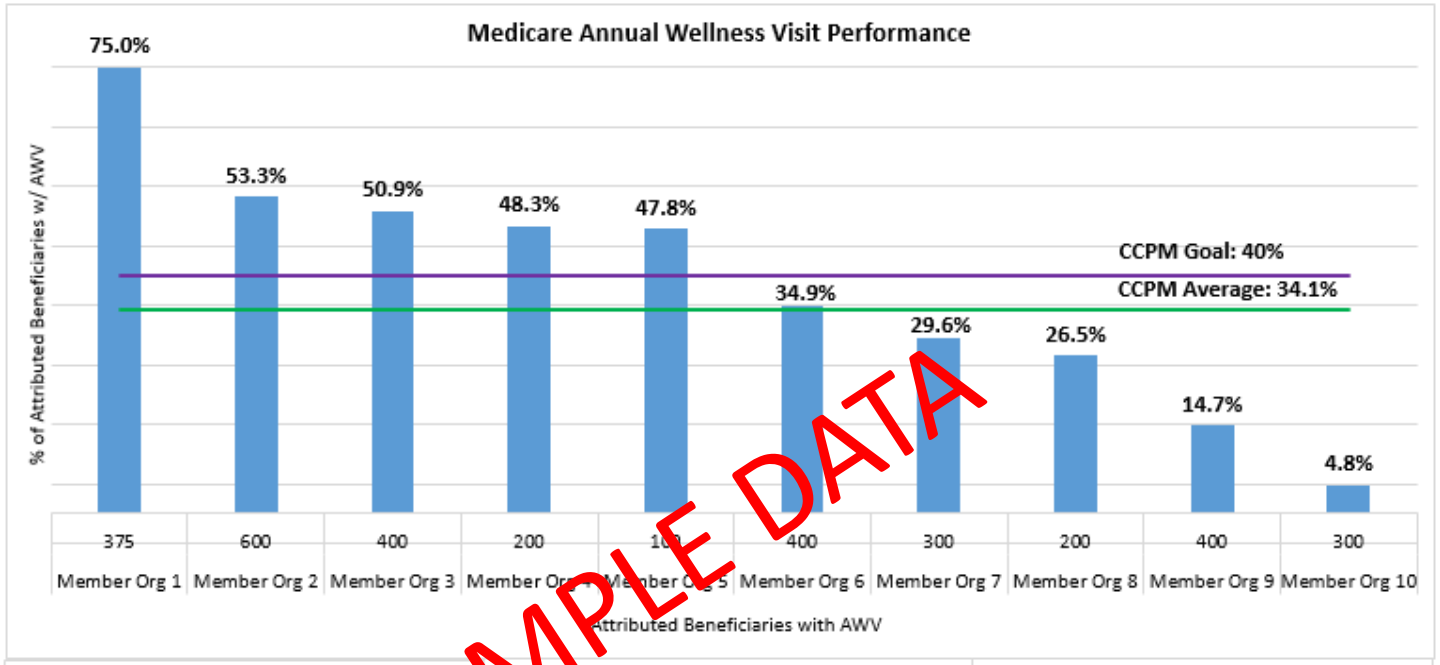
Announcements: October Deliverables and Upcoming Auditing

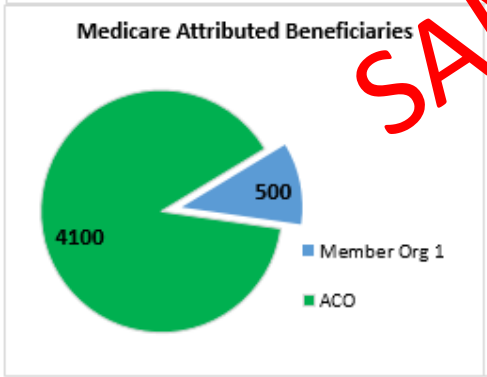
Deliverable:	Due by:	Submit to:	Excludes:
MaineCare PY4 HBa1c Audit (**see below**)	October 15th*	Upload audit to ShareFile	EHC, HAN, SVHC
Monthly Provider Roster Review	October 15th***	Erin Leighton via email	N/A
Cigna Monthly Gaps Audit	October 31st**	Upload forms to ShareFile	DFD, EHC, HAN, SVHC
Aetna Monthly Care Gaps	October 31st**	Upload forms to ShareFile	DFD, EHC, HAN
Harvard Pilgrim Care Gaps	October 31st**	Upload forms to ShareFile	DFD, EHC, HAN, SVHC

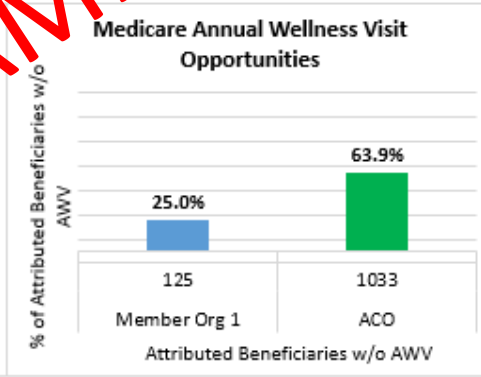
MaineCare recently requested that we self-report HBa1c results (i.e. percentage of members ages 18-75 with DM who have HBa1c < 8%) for the PY4 shared savings calculation slated for this fall. Accordingly, CCPM requests that our member organizations (excluding EHC, HAN and SVHC) review your EMRs to determine the result of each member's last HBa1c test for PY4 (8/1/17 - 7/31/18) and upload the report to ShareFile no later than October 15th for CCPM to submit to MaineCare. Note: CCPM is able to support the member organizations who have granted CCPM EMR access in completing this deliverable.

* Delivered to member organizations on October 7th.
** Delivered to member organizations between October 5th and October 15th.
*** Delivered to member organizations on October 1st.

Hybrid: Merging Vendor Data with Homegrown Solutions





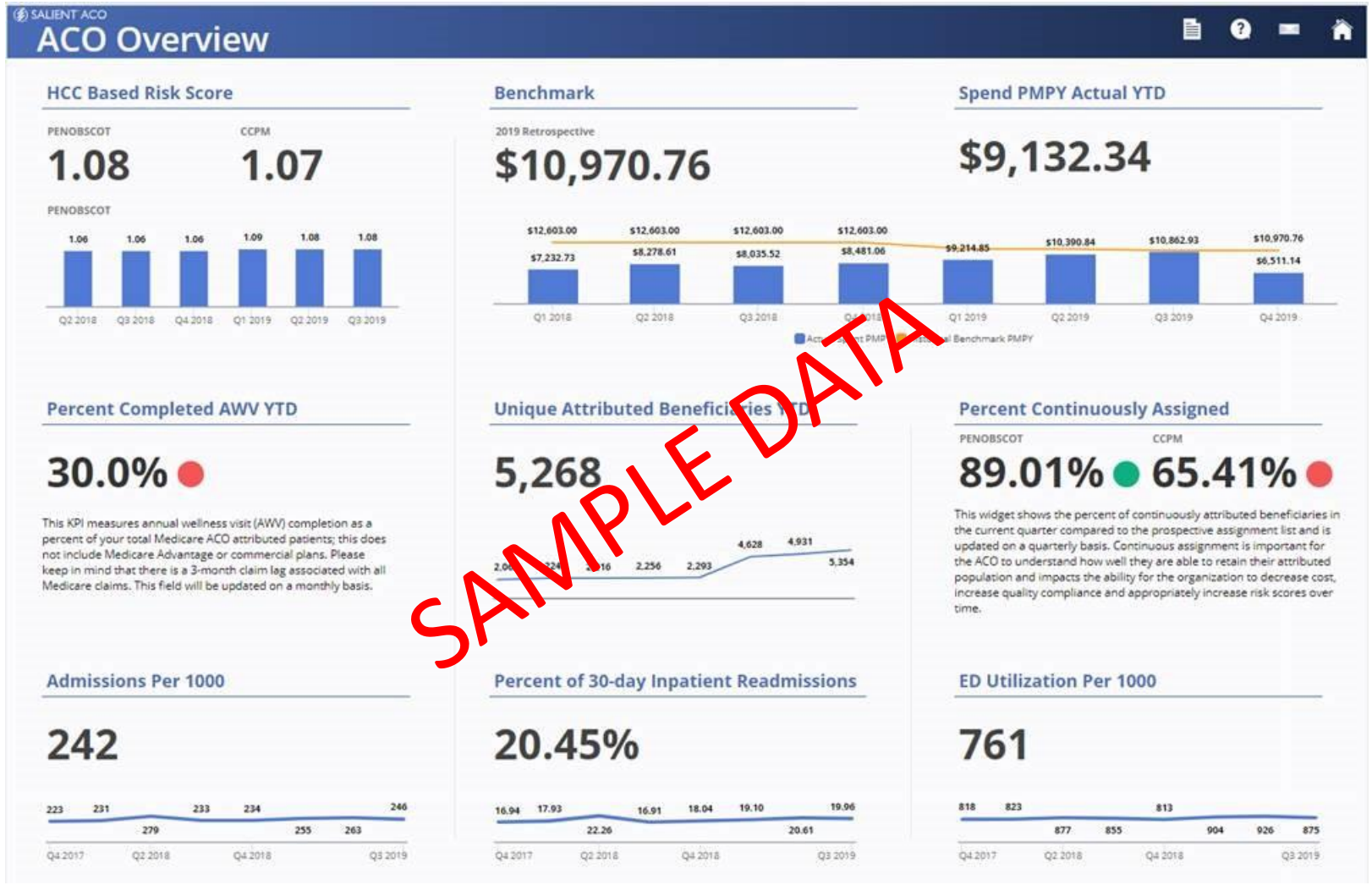


Medicare AWV - Dollars Left on the Table

$12,512.50

Formula: Total member-specific AWV opportunities multiplied by the CCPM Average Claim Payment Amount of $100.10.

Vendor-Led: Personalized Dashboard for Board Reporting



Key Considerations Informing Our Data Decision Points:

1. Align data management approach with mission.

2. Assume abundance, reduce waste.

Pop Health Data & Analytics

Anna Taylor, June 2021

MCC

Our Mission

Partnering for a healing and healthy future.

Our Vision

» ***MultiCare Connected Care will be leading catalyst of patient and population centered value in the Pacific Northwest.*** We will:

- collaborate to achieve unparalleled performance in how people experience healthcare by delivering exceptional quality, efficiency and value.
- be the preferred method to align with systems, patients, clinicians, payers and community stakeholders to address health and social needs across the continuum.
- empower, engage and support our clinicians to deliver patient and family-centered care in a model that thrives in value-based agreements.

Our Values

Respect | Integrity | Stewardship | Excellence
Collaboration | Kindness

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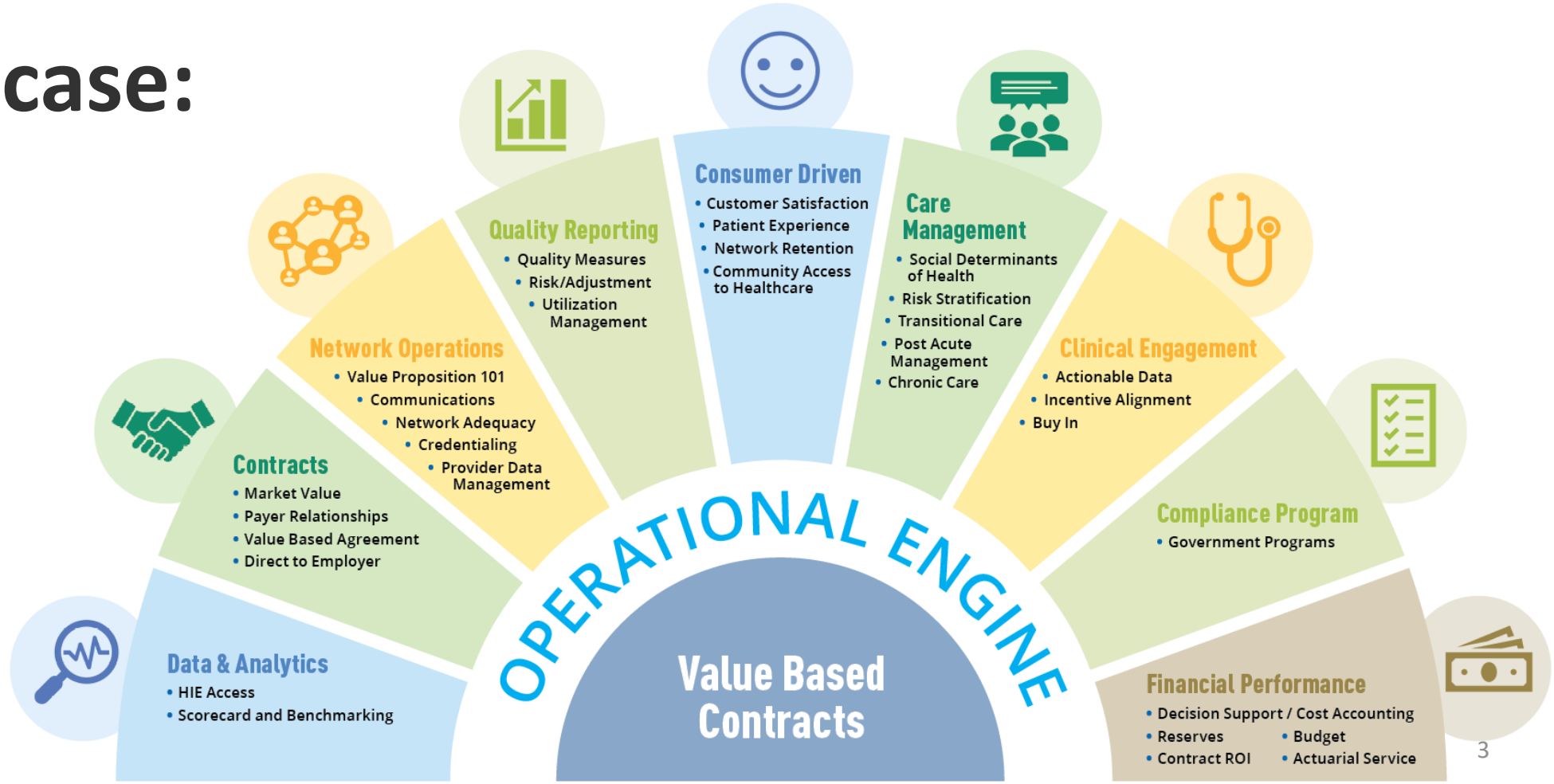
It starts with the business case:



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Board of Managers

Community Partnerships

MultiCare Connected Care
(population health engine)

Operations
Expanded Executive Leadership Team
(bi-weekly)

Special Projects
Executive Leadership Team
(bi-weekly)

Path to Value

- Strategy
- Operations

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Consistently Deliver on a Reporting Package

- Choose KPIs that measure success in performing under your VBC
  - Prioritize your measures
- Delivering measures to the governance structure
- Don’t get caught in the how: Operational leadership owns the “how,” you’re the subject matter expert

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Population Health Digital Ecosystem

Advanced Analytics & Business Intelligence

Predictive Analytics, Productivity Management, Medical Economics Performance, Clinical & Quality Risks Insights

Workflows & Operations

Population Health Platform (some Plug & Play**)**

Accomplishes 80% of Population Health Capabilities & Capacities – the driver

Acquisition & Aggregation

Data Lake & Interoperability

Sources

Foundation

- **Provider Data Management**
- **Member Eligibility**
- **All Claim Types**
- **Clinical – EMR Data**
- **Supplemental Data**
- **Publicly Reported Data**

"Without the foundational base, the additional layers cannot be built"

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Technology Guiding Principles

We strive to partner, listen, and enable business strategies through the adoption of these guiding principles.

- Systems will be operationally owned and projects will be operationally led.
- Existing integrated technology solutions are the preferred choice over functionality of a single system.
- We adopt leading practices & value the recommendations of our strategic technology partners.
- We are committed to keeping our systems current and secure.
- We embrace innovation and avoid ‘bleeding edge’ technology.

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How we resource the model:

» High-trust partnership with our internal Information Services & Technology, Performance Analytics & Digital Strategy

- Internal Client Executive: Program Manager

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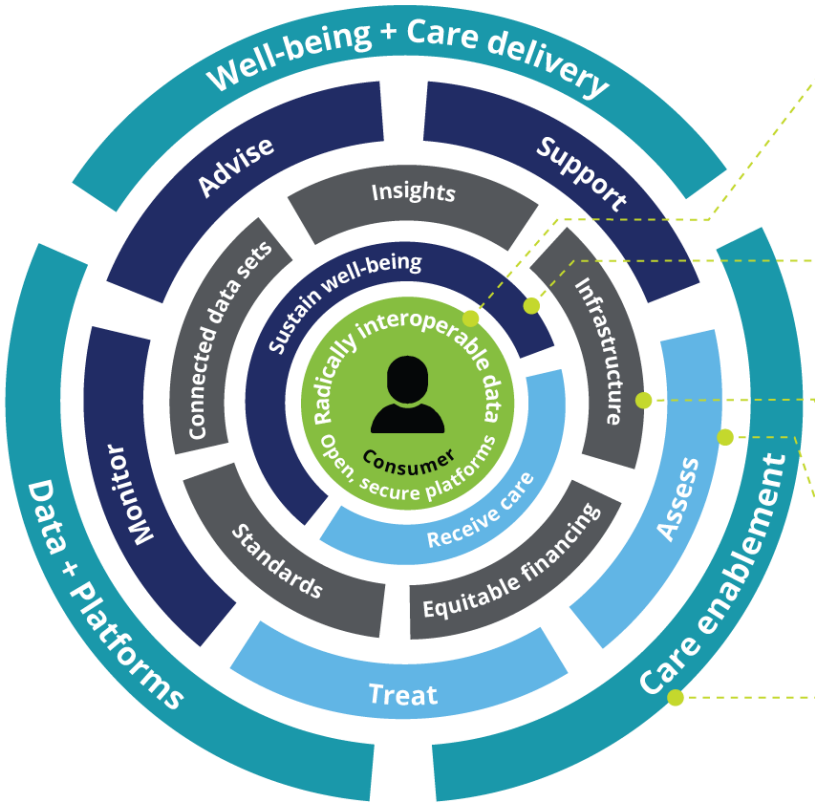
What makes it all work: Interoperability

- ***The mission***: Partnering for healing and a healthier future
- Data and information from partnering entities – disparate systems and operations
- Investment in capability and capacity for interoperability

The future of health will be driven by digital transformation enabled by radically interoperable data and open, secure platforms

Always-on sensors that capture data and platforms that aggregate, store, and derive insights from individual, institutional, population, and environmental data will catalyze the transformation.



The **catalyst for change:** Radically interoperable data will empower hyper-engaged consumers to sustain well-being and receive care only in the instances where well-being fails.

Two **jobs to be done** for consumers to holistically address their health (overall state of well-being encompassing mental, social, emotional, physical, and spiritual health).

Five **enablers** for consumers to accomplish their jobs to be done.

Five **tasks** that ecosystem players will perform on behalf of consumers.

Three categories of **business archetypes** in the future of health environment.

Source: Deloitte analysis.

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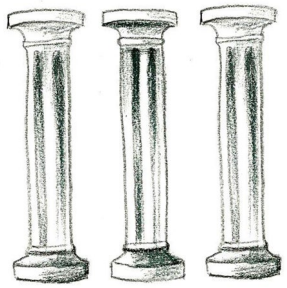
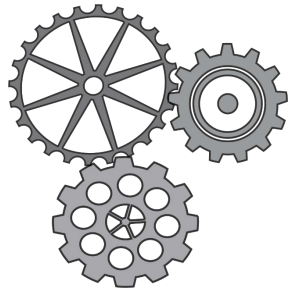
Standardized Interoperability

Internal tipping points driving the transition from traditional methods of interoperability to an advanced standardized solution



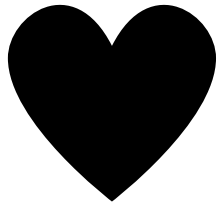
Strategic Alignment



Operational Engine

Business Case (Requirements)

Federal Rulings & Compliance



Partnership

Funding

DA VINCI HL7 FHIR

To ensure the success of the industry's shift to Value Based Care:

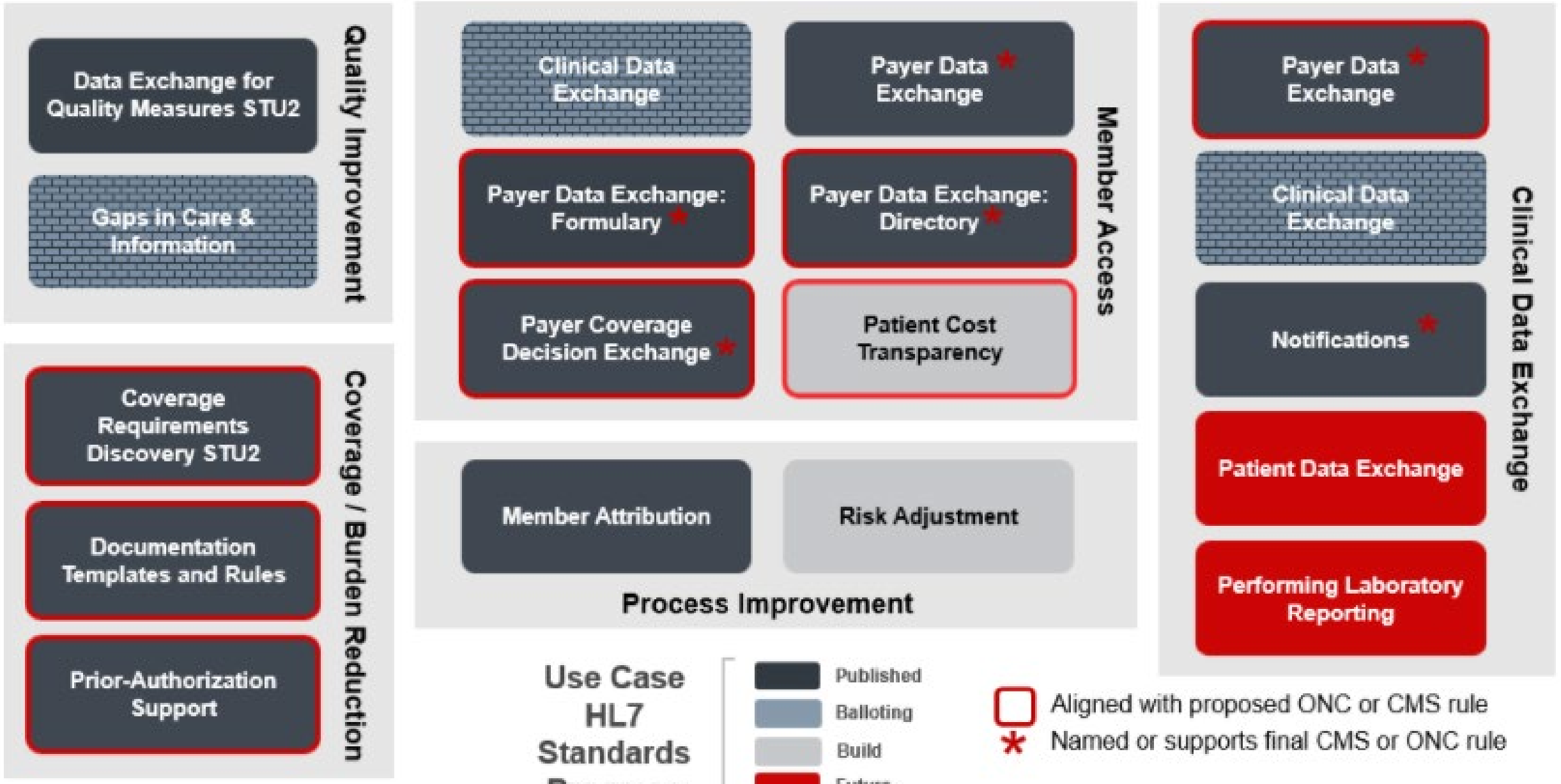
Pre-Collaboration / Controlled Chaos:
Develop ***rapid multi-stakeholder*** process to identify, exercise and implement initial use cases.

Collaboration:
Minimize the development and deployment of ***unique solutions.*** ***Promote*** industry wide ***standards*** and adoption.

Success Measures:
Use of FHIR®, implementation guides and pilot projects.

http://www.hl7.org/about/davinci/

Use Case Focus Areas



How to address technological innovation in a buy model?

- Partner
- Embrace innovation
- Pilot small and iterate

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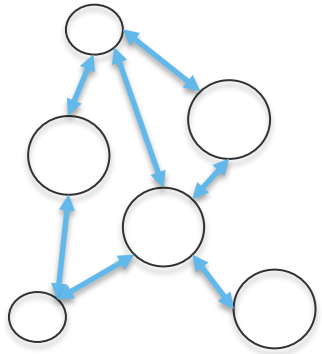
Challenges and Hiccups

Provider Alignment



EHR & Interoperability

Big $ Investment

Thank you!

Anna Taylor
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