Using cost of care data to achieve the Triple Aim

September 26, 2016

Welcome!
All lines are muted.
Please use chat to ask questions or to comment at any time.
Housekeeping

• This session will be recorded.
• Slides and recording will be posted on CIN website within a week.
  — www.chcf.org/cin

• To ask a question:
  — Logistical questions: Use CHAT to the Host
  — Questions for Speakers: Use CHAT to ALL

• Survey: Please look for quick online survey to let us know what you think.
Today’s Speakers

Diane Stewart
Senior director
Pacific Business Group on Health, California Quality Collaborative

Naomi Fuchs
CEO
Santa Rosa Community Health Centers
Total Cost of Care

Diane Stewart
dstewart@pbgh.org
The Triple Aim

Definition:

**Total cost of care** is defined as:

Total medical services consumed by a general population of attributed patients.

**Per Capita Cost** = Total Cost / # Patients
Per Capita Cost Varies

http://costatlas.iha.org/
## Total Cost of Care & Value Based Payment

<table>
<thead>
<tr>
<th></th>
<th>Medicare</th>
<th>Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FFS Patients</strong></td>
<td><strong>CMS</strong> contracts with accountable care organizations (ACOs) to participate in the Medicare Shared Savings Program (MSSP)</td>
<td><strong>Health Plans</strong> contract with providers, generally in “shared savings” arrangements</td>
</tr>
</tbody>
</table>
| **HMO Patients**         | **Medicare Advantage:** **Health plans** pay capitation to providers based on quality and cost performance | **Health Plans** pay capitation to providers either:  
  • “partial risk”- just professional costs or  
  • “global risk” – inpatient and outpatient costs |
So, What Do I Do??

- Summarizes Lessons from 15 Successful Organizations
- Managing Cost of Care for Medicare, Medicaid and Commercial populations

http://www.chcf.org/publications/2016/01/managing-cost-care
Measuring Progress

Important metrics to improve cost of care

- Acute Admits / 1000
- Readmit Rate
- Length of Stay (inpatient and SNF)
- ED Visits / 1000
- PMPM cost itemized to sufficient detail for comparison

Common external benchmarking sources

- Milliman (well, moderately or loosely managed comparison)
- Health Plan Reports (comparisons to others within the market)
Interview Findings

All reported the first priority was reducing hospital days

- Hospitalists: Managing intra-stay costs, reducing readmits, and ED redirection.
- “The Middle Layer”: Expanding the capability of post-acute care to a quality, safe alternative to hospitalization.
- Multi-disciplinary teams for complex patients to reduce admissions and readmissions.
- Transitions of care: Structured discharge to home to reduce readmits.
- Structured, consistent, replicable case review meetings (daily or weekly).
Important Foundations

- Leadership/Culture
- Data
- Multi-Disciplinary Care Teams
- Internal Alignment
## Benchmarks

<table>
<thead>
<tr>
<th>Measure</th>
<th>Medi-Cal Managed Care(^1)</th>
<th>Medicare Advantage(^2)</th>
<th>Commercial(^3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Bed Days (per thousand member years)</td>
<td>236</td>
<td>758.3</td>
<td>133</td>
</tr>
<tr>
<td>All-Cause Readmissions (% of Admissions)</td>
<td>16.4%</td>
<td>11.2%</td>
<td>8.1%</td>
</tr>
<tr>
<td>ED Visits (per thousand member years)</td>
<td>450</td>
<td>372.3</td>
<td>141</td>
</tr>
</tbody>
</table>

\(^1\) Integrated Healthcare Association, California Regional Health Care Cost & Quality Atlas, 2013 data  
\(^2\) Integrated Healthcare Association, Healthcare Hot Spotting: Variation in Quality and Resource Use in California, 2013 data  
\(^3\) Integrated Healthcare Association, Hospital Utilization Ranges for Commercially Insured Californians, 2013 data
Redwood Community Care Organization: Total Cost of Care Data and the Triple Aim

Naomi Fuchs, MBA
CEO
Redwood Community Care Organization
Santa Rosa Community Health Centers

Monday, September 26, 2015
Why Start an ACO?

The Head....

• Preparing for value-based care models and reimbursement

• Position RCHC health centers as a regional provider group

• Population health across health centers

• Potential to reinvest savings towards service

• Better care for patients!

The Heart....

 Bild: Leap of Faith - Make the jump.
RCCO Background

- Medicare Shared Savings Program (MSSP) ACO 2014-2016

- Health center-based primary care ACO *(one of 8 in the nation!)*

- Partnerships with local hospitals and multi-specialty groups
Medicare Shared Savings Program ACO

- Minimum of 5,000 Medicare patients
- Attribution of assigned patients by CMS
- Must reduce cost by a minimum of 2+% 
- Must be able to submit data on 34 quality measures
- No downside risk
- No funding from CMS
Triple Aim Strategy

1. Reduce Admissions
2. Reduce Re-admissions
3. Meet quality goals
Data vs Analytics

- Monthly claims-level files (includes TCOC) for each attributed patient
- Quarterly Aggregate Data Reports (includes data for other MSSP ACOs as comparison)
- Health center clinical data for quality metrics
- Use CCMR data analytics platform to manage and report data
What We Learned - Patient Population

- 8,500 beneficiaries (approx. 8,250 person-years)

**RCCO (2015)**

- ESRD: 41%
- Disabled: 28%
- Aged/Dual: 30%
- Aged/Non-Dual: 1%

**All Other MSSP ACOs (2015 Median)**

- ESRD: 81%
- Disabled: 13%
- Aged/Dual: 5%
- Aged/Non-Dual: 1%
Total Cost of Care Data—How is it used?

Aggregate Level: RCCO Total Cost of Care Breakdown (2015)

- Hospital Inpatient Facility: 33%
- Skilled Nursing Facility Or Unit: 4%
- Institutional (Hospital) Outpatient Facility: 29%
- Part B Physician/Supplier (Carrier): 5%
- Home Health Agency: 1%
- Durable Medical Equipment: 1%
- Hospice: 23%
## Total Cost of Care Data—How is it used?

### Patient Level: Patient Total Cost of Care

#### Utilization

<table>
<thead>
<tr>
<th>HIC No</th>
<th>First</th>
<th>Last</th>
<th>DOB</th>
<th>Gender</th>
<th>Medicare Status</th>
<th>PCP</th>
<th>PCP Location</th>
<th>Risk Score</th>
<th>OP Visits</th>
<th>E&amp;M Visits</th>
<th>IP Hospital Admits</th>
<th>SNF Claims</th>
<th>HHA Claims</th>
<th>ER Visits (NO Admit)</th>
<th>ER Admits</th>
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</thead>
<tbody>
<tr>
<td>00001</td>
<td>Mary</td>
<td>Smith</td>
<td>1/23/1972</td>
<td>Male</td>
<td>Aged without ESRD</td>
<td>SRCHC</td>
<td>Vista</td>
<td>0.63</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
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<tr>
<td>00002</td>
<td>Jill</td>
<td>Baker</td>
<td>2/2/1980</td>
<td>Female</td>
<td>Disabled without ESRD</td>
<td>SRCHC</td>
<td>Vista</td>
<td>2.35</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>00003</td>
<td>Suzy</td>
<td>Jones</td>
<td>6/20/1968</td>
<td>Female</td>
<td>Disabled without ESRD</td>
<td>SRCHC</td>
<td>Lombardi</td>
<td>1.55</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>0</td>
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#### Cost

<table>
<thead>
<tr>
<th>HIC No</th>
<th>First</th>
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<th>DOB</th>
<th>Gender</th>
<th>Medicare Status</th>
<th>PCP</th>
<th>PCP Location</th>
<th>IP Hospital Expense</th>
<th>Outpatient Expense</th>
<th>SNF Expense</th>
<th>HHA Expense</th>
<th>ER Expense</th>
<th>PartB Expense</th>
<th>DME Expense</th>
<th>Hospice Expense</th>
<th>Part D Expense</th>
<th>Total Expense W/O Part D</th>
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<tbody>
<tr>
<td>00001</td>
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<td>Smith</td>
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<td>$0</td>
<td>$262</td>
<td>$0</td>
<td>$0</td>
<td>$122</td>
<td>$701</td>
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<td>$4,430.05</td>
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<tr>
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<td>Baker</td>
<td>2/2/1980</td>
<td>Female</td>
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<td>Vista</td>
<td>$33,507</td>
<td>$0</td>
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<td>$0</td>
<td>$0</td>
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<td>$0</td>
<td>$3,507.18</td>
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<tr>
<td>00003</td>
<td>Suzy</td>
<td>Jones</td>
<td>6/20/1968</td>
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<td>SRCHC</td>
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<td>$0</td>
<td>$1,267</td>
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<td>$2,563</td>
<td>$0</td>
<td>$0</td>
<td>$20</td>
<td>$2,308.10</td>
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### Total Cost of Care Data—How is it used?

#### Claim Level: Individual Costs Associated with each Patient

<table>
<thead>
<tr>
<th>Claim_ID</th>
<th>HIC No</th>
<th>First</th>
<th>Last</th>
<th>DOB</th>
<th>Type of Claim</th>
<th>ER Claim</th>
<th>Claim From</th>
<th>Claim Thru</th>
<th>Primary DX</th>
<th>Facility Name</th>
<th>Rendering Provider</th>
<th>Day</th>
<th>Cost</th>
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</thead>
<tbody>
<tr>
<td>01234</td>
<td>00001</td>
<td>Mary</td>
<td>Smith</td>
<td>1/23/1972</td>
<td>Outpatient</td>
<td>ER-Claim</td>
<td>1/10/2015</td>
<td>1/10/2015</td>
<td>Urinary Tract Infection</td>
<td>Santa Rosa Facility</td>
<td>White, Betty</td>
<td>Sun</td>
<td>$317.80</td>
</tr>
<tr>
<td>02115</td>
<td>00001</td>
<td>Mary</td>
<td>Smith</td>
<td>1/23/1972</td>
<td>Outpatient</td>
<td>Non ER-Claim</td>
<td>05/12/2015</td>
<td>05/12/2015</td>
<td>Shortness of breath</td>
<td>Santa Rosa Facility</td>
<td>Merino, Julie</td>
<td>Tues</td>
<td>$139.88</td>
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<tr>
<td>03456</td>
<td>00001</td>
<td>Mary</td>
<td>Smith</td>
<td>1/23/1972</td>
<td>Outpatient</td>
<td>ER-Claim</td>
<td>08/08/2015</td>
<td>08/08/2015</td>
<td>ISSUE REPEAT PRESCRIPT</td>
<td>Santa Rosa Facility</td>
<td>White, Betty</td>
<td>Sat</td>
<td>$44.60</td>
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<tr>
<td>05678</td>
<td>00001</td>
<td>Mary</td>
<td>Smith</td>
<td>1/23/1972</td>
<td>Outpatient</td>
<td>ER-Claim</td>
<td>05/07/2016</td>
<td>05/07/2016</td>
<td>Diarrhea</td>
<td>San Francisco Facility</td>
<td>Maple, Jeff</td>
<td>Sun</td>
<td>$1,202.02</td>
</tr>
</tbody>
</table>
You need the claim... to achieve the Triple Aim!
Lessons Learned

Population Health Across a Shared Population

- Shift in level of collaboration: ACO responsible for outcomes across health centers
- Provider engagement and interventions across continuum of care
- Organizational alignment and consensus across participating centers
- Resources and expertise vary widely
- Clinical data reported differently across health centers
Lessons Learned

Data should drive strategy

- Reduce hospitalizations and re-admissions
- Collaboration across partners
- Predictive modeling – art vs. science
- Complex Care Management Programs
Hospital Admit Strategy

Success and Failure

Hospital discharge and re-admit rates 2014 and 2015

<table>
<thead>
<tr>
<th>Measure</th>
<th>RCCO 2014</th>
<th>RCCO 2015</th>
<th>ALL MSSP 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Discharges, Total Rate</td>
<td>23.50%</td>
<td>22.80%</td>
<td>31.8%</td>
</tr>
<tr>
<td>Short-Term Stay Hospital Discharge Rate</td>
<td>20.90%</td>
<td>20.40%</td>
<td>29.3%</td>
</tr>
<tr>
<td>Long-Term Stay Hospital Discharge Rate</td>
<td>0.05%</td>
<td>0.08%</td>
<td>0.22%</td>
</tr>
<tr>
<td>Rehabilitation Hospital Discharge Rate</td>
<td>0.23%</td>
<td>0.23%</td>
<td>1.17%</td>
</tr>
<tr>
<td>30-Day All-Cause Readmission Rate</td>
<td>14.00%</td>
<td>14.40%</td>
<td>17.0%</td>
</tr>
</tbody>
</table>
## Hospital Admit Strategy

### Success and Failure

- **Psychiatric admit rates 2014 and 2015**

<table>
<thead>
<tr>
<th>Measure</th>
<th>RCCO 2014</th>
<th>RCCO 2015</th>
<th>ALL MSSP 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Hospital Discharge Rate</td>
<td>2.40%</td>
<td>2.11%</td>
<td>0.90%</td>
</tr>
</tbody>
</table>
Successes & Challenges

• **Successes?**
  • Using the ACO as a “Learning Lab”
    • Significant improvement in performance on quality metrics from 2014-2015
    • Learning about claims analysis, predictive modeling and strategies specific to risk stratification. We still have A LOT of learning to do!
  • Developing new relationships with community partners to break down silos in the care continuum/improve care transitions

• **Challenges?**
  • Data & Limited Resources
    • Learning how to use claims data takes time.
    • Disseminating data to health centers in a digestible and actionable format also takes time.
      • In 2015 we did not hit our financial “benchmark”
    • Resources and expertise vary greatly across health centers (staff time, data expertise, QI expertise)
Questions?

Naomi Fuchs, MBA
Chief Executive Officer
Santa Rosa Community Health Clinics/RCCO
naomif@srhealthcenters.org
Upcoming CIN events

• Medication assisted therapy learning events
• Motivational Interviewing trainings
• Webinars in planning phases
• Join the network: www.chcf.org/cin