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.

California Health Care Foundation

California Improvement Network
Better Ideas for Care Delivery

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

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CEO

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Total Cost of Care

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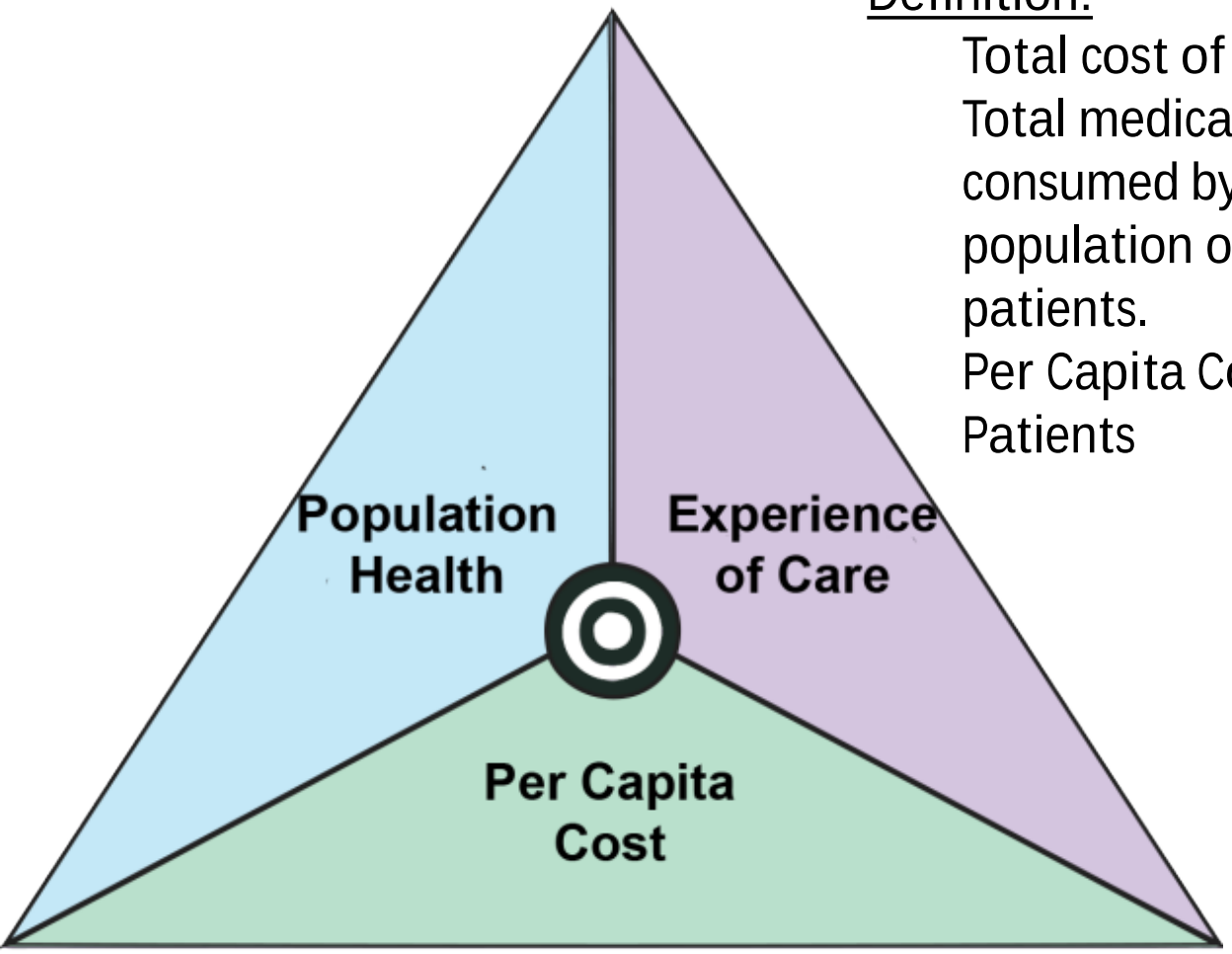
The Triple Aim



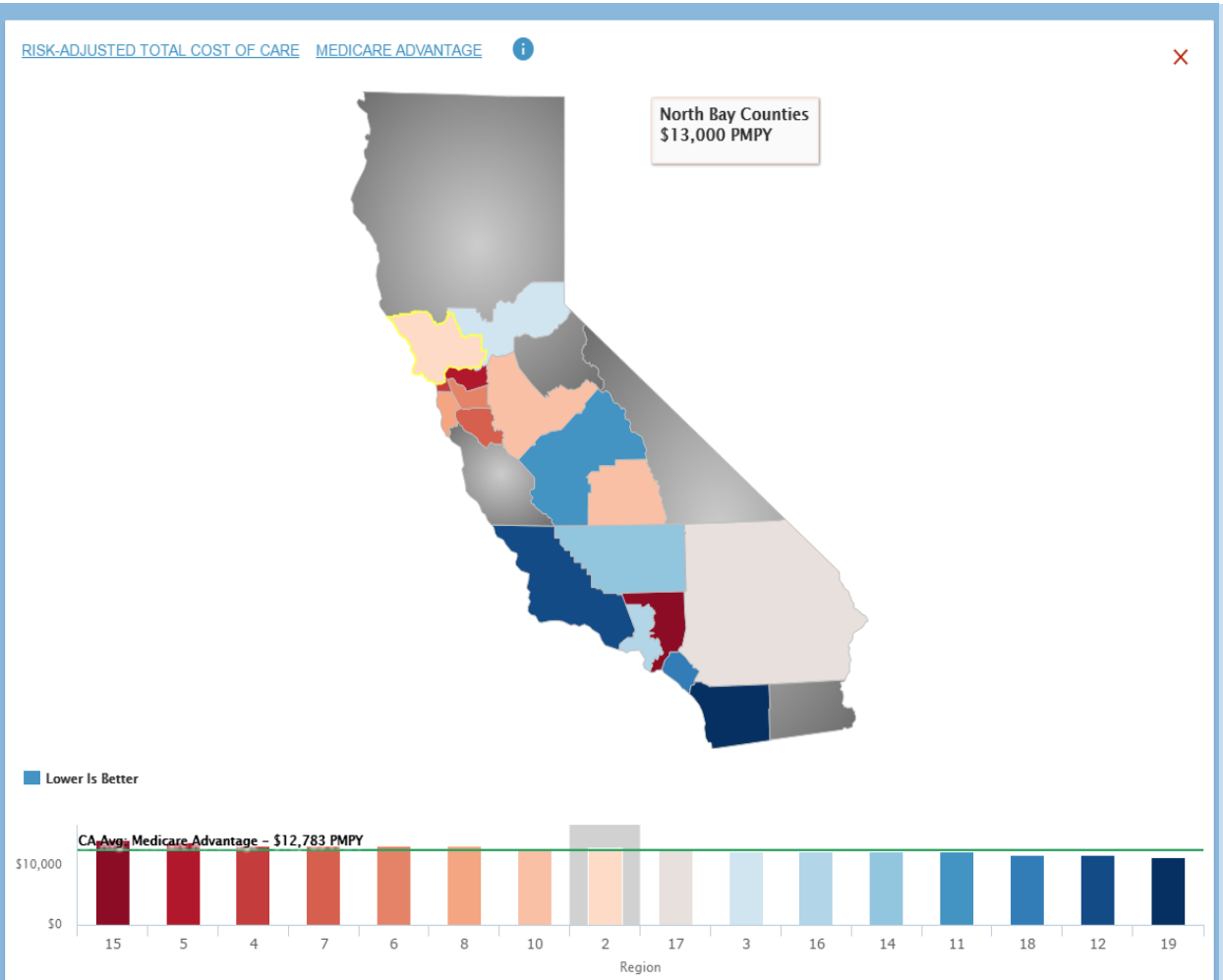
Definition:

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

Region	Name	Rate (PMPY)
1	Northern Counties	N/A
9	Central Coast - North	N/A
13	Eastern Region	N/A
15	Los Angeles - East	$14,500
5	Contra Costa County	$14,000
6	Alameda County	$13,500
8	San Mateo County	$13,500
4	San Francisco County	$13,500
7	Santa Clara County	$13,500
17	Inland Empire	$13,000
2	North Bay Counties	$13,000
10	Central Valley - North	$13,000
3	Greater Sacramento	$12,500
14	Kern County	$12,500
11	Greater Fresno Area	$12,500
16	Los Angeles - West	$12,500
12	Central Coast - South	$12,000
18	Orange County	$12,000
19	San Diego County	$11,500



http://costatlas.iha.org/

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Total Cost of Care & Value Based Payment

	Medicare	Commercial
FFS Patients	CMS contracts with accountable care organizations (ACOs) to participate in the Medicare Shared Savings Program (MSSP)	Health Plans contract with providers, generally in "shared savings" arrangements
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??

January 2016

Issue Brief

Managing Cost of Care:
Lessons from Successful Organizations

The influx of newly insured Californians through the public exchange and Medicaid expansion has renewed efforts by health care organizations to manage the cost and quality of patient care. In 2015, the California Quality Collaborative (CQC) decided to identify best practices for managing total cost of care, so as to encourage adoption more broadly across California's delivery system. The goal of the project was to identify replicable patient management strategies that effectively eliminate or modify unnecessary services while improving the quality of patient care. The project did not focus on strategies to address cost of care by reducing unit prices or altering contract arrangements.

To reveal the most effective strategies, CQC interviewed top-performing health care organizations around the country with demonstrated results in reducing the total cost of care. Organizations were identified through publicly reported data from Medicare and privately reported by the Integrated Healthcare Association (IHA), which collects and aggregates health plan data on commercial populations. Of the 20 organizations invited, 15 agreed to participate in separate 90-minute structured interviews.

Each interview included questions on the organization's:

- Experience with managing total cost of care
- Drivers for improving the cost of care
  - Cost categories addressed, in order of importance
  - Time to implementation
  - Key program elements
  - Results achieved
- Use of external performance benchmarks
- Challenges

Defining Total Cost of Care

Total cost of care refers to the cost of all medical services consumed by a population of patients in a year, and includes all covered professional, hospital, pharmacy, and ancillary care.

1

- 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)

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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).

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Important Foundations

Leadership/ Culture

Data

Multi-Disciplinary Care Teams

Internal Alignment

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Benchmarks

Measure	Medi-Cal Managed Care[1]	Medicare Advantage[2]	Commercial[3]
Inpatient Bed Days (per thousand member years)	236	758.3	133
All-Cause Readmissions (% of Admissions)	16.4%	11.2%	8.1%
ED Visits (per thousand member years)	450	372.3	141

[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

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REDWOOD
COMMUNITY
CARE
ORGANIZATION

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

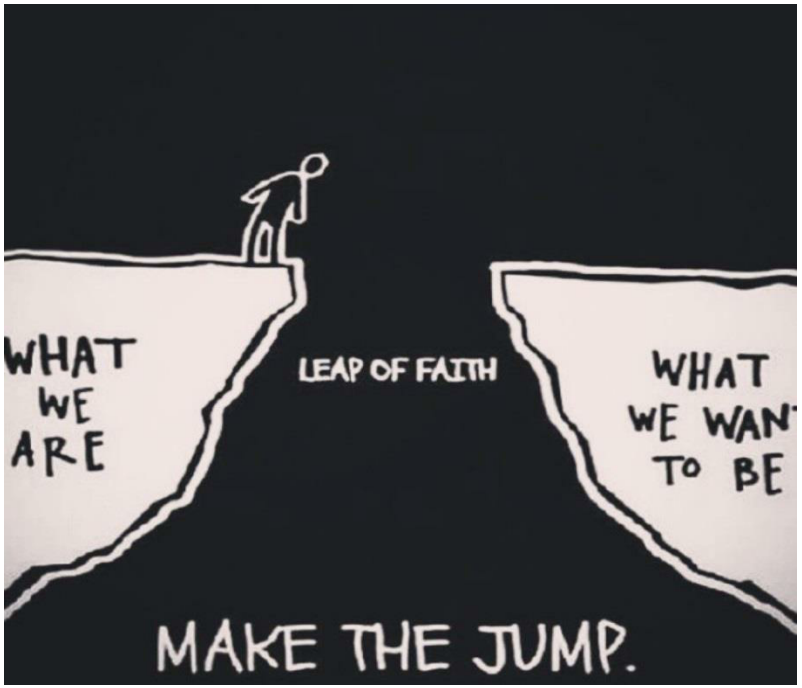
Monday, September 26, 2015

Why Start an ACO?

The Head….

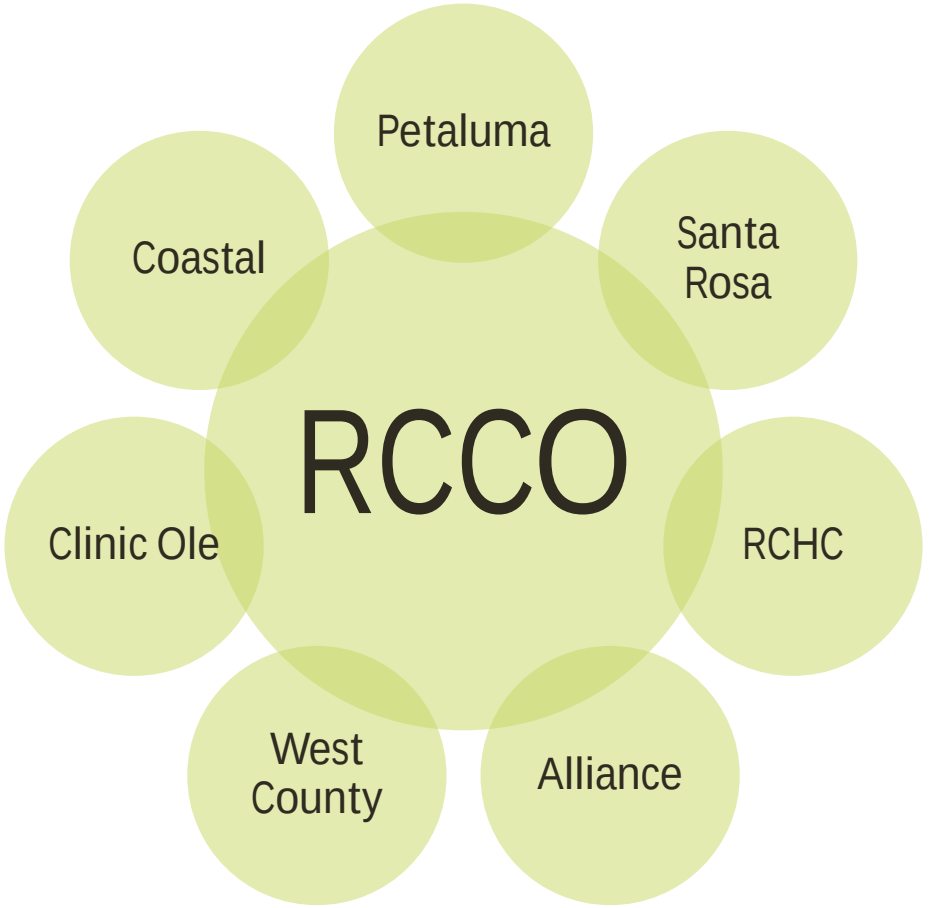
- Preparing for value-based care models and reimbursement
- Position RCHC health centers as a regional provider group
- Population health across health centers
- Potential to reinvest savings towards service
- Better care for patients!

The Heart….



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

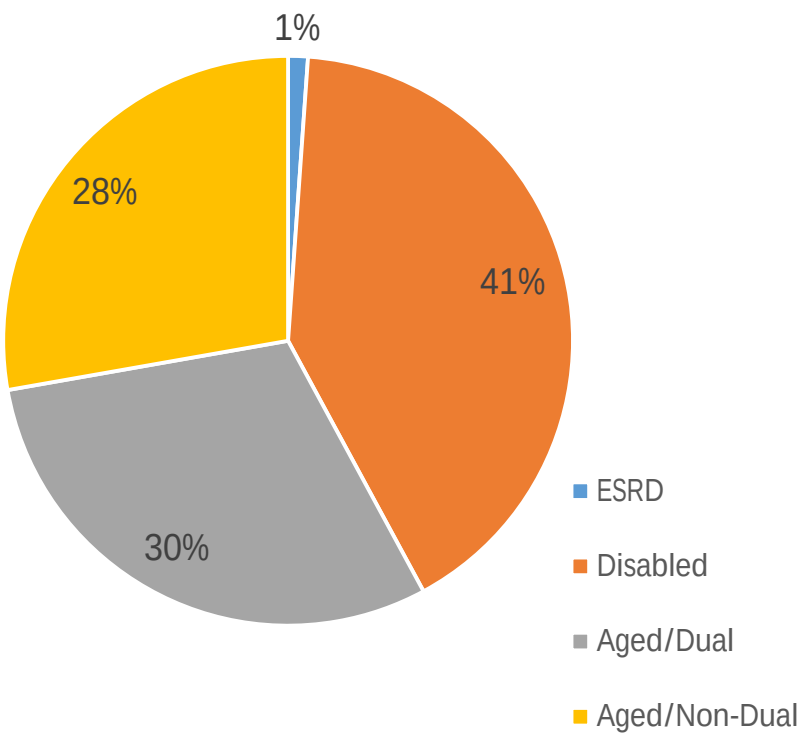
Data vs Analytics

- 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

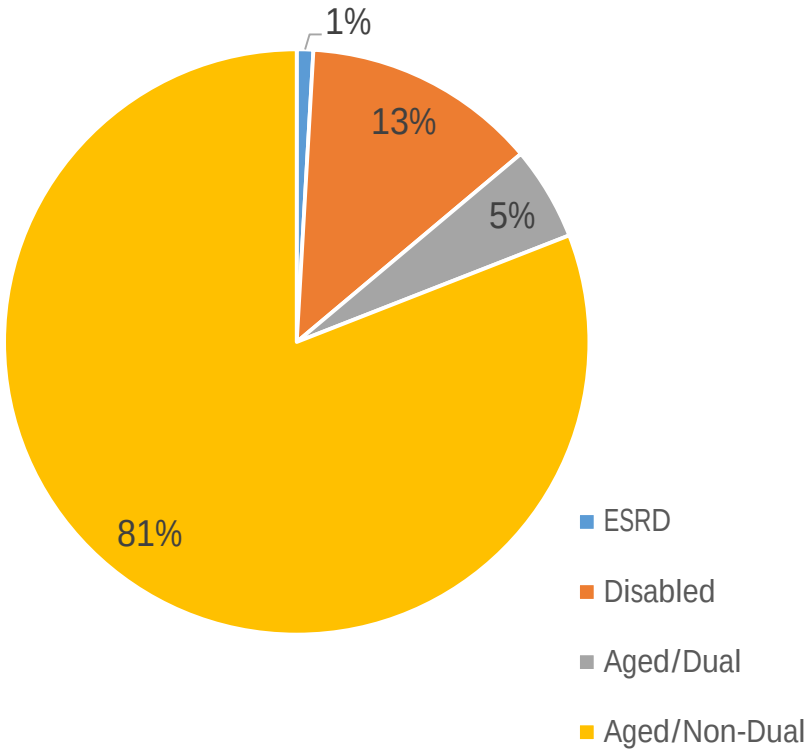
What We Learned - Patient Population

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

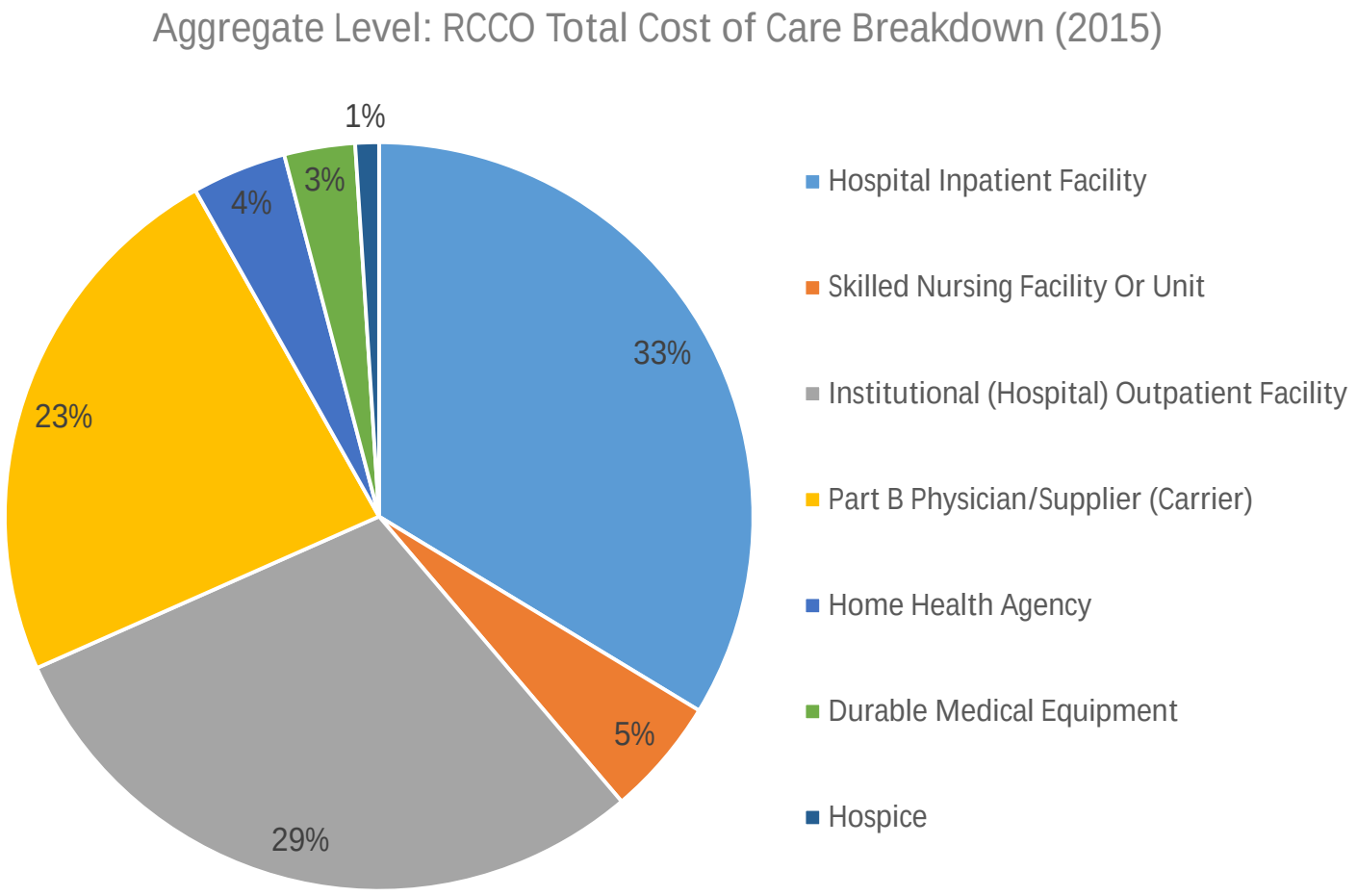
RCCO (2015)



All Other MSSP ACOs (2015 Median)



Total Cost of Care Data—How is it used?



Total Cost of Care Data—How is it used?

Patient Level: Patient Total Cost of Care

Utilization

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

Cost

HIC No	First	Last	DOB	Gender	Medicare Status	PCP	PCP Location	IP Hospital Expense	Outpatient Expense	SNF Expense	HHA Expense	ER Expense	PartB Expense	DME Expense	Hospice Expense	Part D Expense	Total Expense W/O Part D
00001	Mary	Smith	1/23/1972	Male	Aged without ESRD	SRCHC	Vista	$0	$262	$0	$0	$122	$701	$0	$0	$0	$4,430.05
00002	Jill	Baker	2/2/1980	Female	Disabled without ESRD	SRCHC	Vista	$33,507	$0	$0	$0	$0	$0	$0	$0	$10	$3,507.18
00003	Suzy	Jones	6/20/1968	Female	Disabled without ESRD	SRCHC	Lombardi	$0	$1,267	$0	$0	$0	$2,563	$0	$0	$20	$2,308.10

Total Cost of Care Data—How is it used?

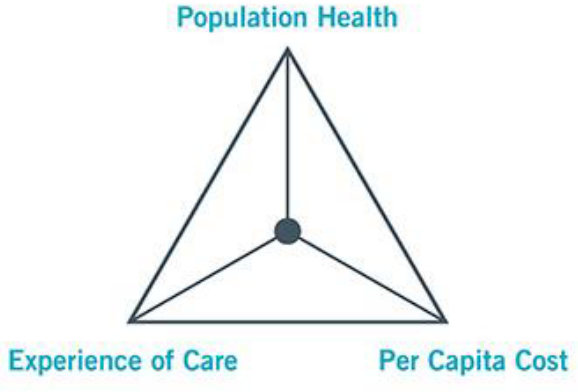
Claim Level: Individual Costs Associated with each Patient

Claim Level (claim type, duration, diagnosis, facility, cost)

Claim_ID	HIC No	First	Last	DOB	Type of Claim	ER Claim	Claim From	Claim Thru	Primary DX	Facility Name	Rendering Provider	Day	Cost
01234	00001	Mary	Smith	1/23/1972	Outpatient	ER-Claim	1/10/2015	1/10/2015	Urinary Tract Infection	Santa Rosa Facility	White, Betty	Sun	$317.80
02345	00001	Mary	Smith	1/23/1972	Outpatient	ER-Claim	3/16/2015	3/16/2015	Chest discomfort	Marin Facility	Jones, Bill	Mon	$2,214.76
02115	00001	Mary	Smith	1/23/1972	Outpatient	Non ER-Claim	05/12/2015	05/12/2015	Shortness of breath	Santa Rosa Facility	Merino, Julie	Tues	$139.88
03456	00001	Mary	Smith	1/23/1972	Outpatient	ER-Claim	08/08/2015	08/08/2015	ISSUE REPEAT PRESCRIPT	Santa Rosa Facility	White, Betty	Sat	$44.60
04567	00001	Mary	Smith	1/23/1972	Outpatient	ER-Claim	2/06/2016	2/06/2016	Urinary Tract Infection	Marin Facility	Gray, Regina	Sat	$510.99
05678	00001	Mary	Smith	1/23/1972	Outpatient	ER-Claim	05/07/2016	05/07/2016	Diarrhea	San Francisco Facility	Maple , Jeff	Sun	$1,202.02

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

REDWOOD COMMUNITY CARE ORGANIZATION

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

Measure	RCCO 2014	RCCO 2015	ALL MSSP 2015
Hospital Discharges, Total Rate	23.50%	22.80%	31.8%
Short-Term Stay Hospital Discharge Rate	20.90%	20.40%	29.3%
Long-Term Stay Hospital Discharge Rate	0.05%	0.08%	0.22%
Rehabilitation Hospital Discharge Rate	0.23%	0.23%	1.17%
30-Day All-Cause Readmission Rate	14.00%	14.40%	17.0%

Hospital Admit Strategy

Success and Failure

- Psychiatric admit rates 2014 and 2015

Measure	RCCO 2014	RCCO 2015	ALL MSSP 2015
Psychiatric Hospital Discharge Rate	2.40%	2.11%	0.90%

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?

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Upcoming CIN events

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