Data Analysis

March 22, 2021

Part II of Series:

Using Hospital Data in SHIP Value-Based Purchasing (VBP) and/or Accountable Care Organization (ACO)

Objectives

- Short review of Data Analysis
- Test knowledge of data mining available
- Review workplans for possible different solutions to data tracking, reporting and overall management

Data Analysis: The Prep

- Make sure data is accessible for preparation
- We recognize some electronic health record (EHR) systems are not data friendly
- Determine your descriptive stats…is it a count or average or percent?
- How will hospitals report the data
- Are you providing the template for data collection

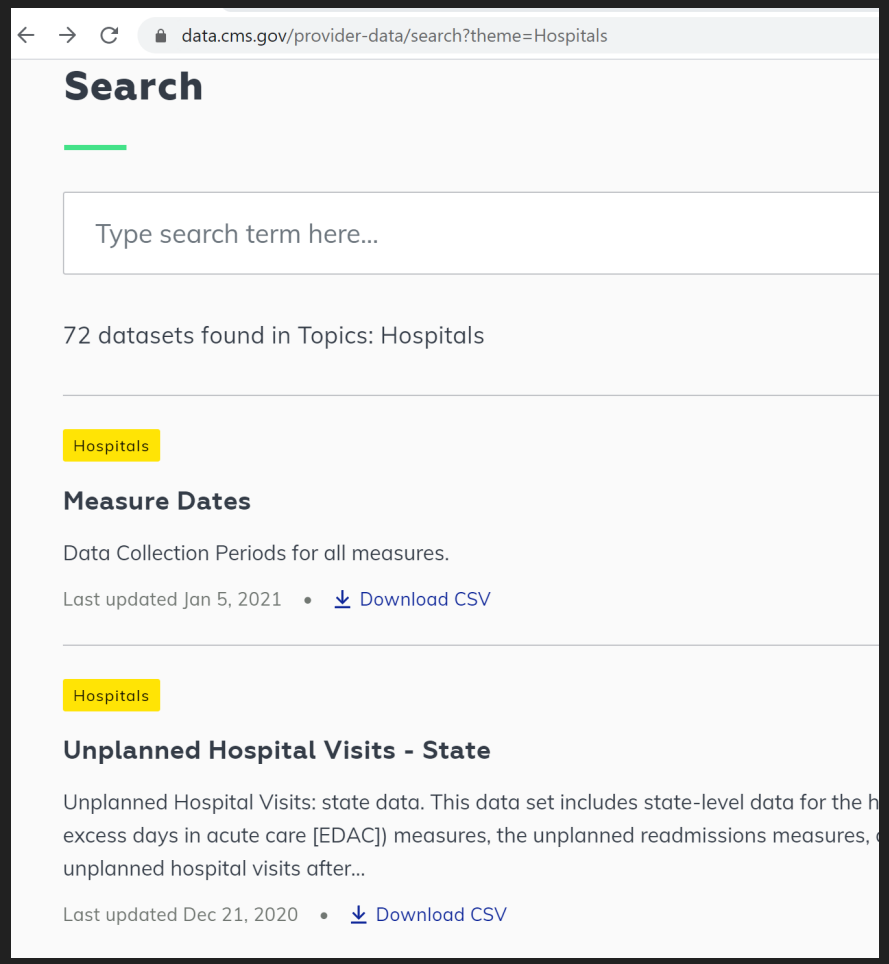
Evaluation: Data Mining

- Used to discover new information about your data
- May be used for describing data or predicting outcomes

Sources for data

Data Sources for 'Mining'

https://data.cms.gov/provider-data/search?theme=Hospitals



	A	B	C	D	E	F
1	Measure ID	Measure Name	Measure St	Start Date	Measure Er	End Date
2	ACS_REGISTRY	ACS Participation data	4Q2018	10/1/2018	3Q2019	9/30/2019
3	COMP_HIP_KNEE	Complication Rate Following	2Q2016	4/1/2016	1Q2019	3/31/2019
4	COMP_HIP_KNEE_HVBP_B	Complication Rate Following	2Q2011	4/1/2011	1Q2014	3/31/2014
5	COMP_HIP_KNEE_HVBP_P	Complication Rate Following	2Q2016	4/1/2016	1Q2019	3/31/2019
6	EDAC_30_AMI	Excess Days in Acute Care aft	3Q2016	7/1/2016	2Q2019	6/30/2019
7	EDAC_30_HF	Excess Days in Acute Care aft	3Q2016	7/1/2016	2Q2019	6/30/2019
8	EDAC_30_PN	Excess Days in Acute Care aft	3Q2016	7/1/2016	2Q2019	6/30/2019
9	EDV	Emergency Department Volur	1Q2019	1/1/2019	4Q2019	12/31/2019
10	FUH_30	Follow-up after Hospitalizatio	3Q2018	7/1/2018	2Q2019	6/30/2019
11	FUH_7	Follow-up after Hospitalizatio	3Q2018	7/1/2018	2Q2019	6/30/2019
12	HACRP_CAUTI	CAUTI_Score	1Q2018	1/1/2018	4Q2019	12/31/2019
13	HACRP_CDI	CDI_Score	1Q2018	1/1/2018	4Q2019	12/31/2019
14	HACRP_CLABSI	CLABSI_Score	1Q2018	1/1/2018	4Q2019	12/31/2019
15	HACRP_MRSA	MRSA_Score	1Q2018	1/1/2018	4Q2019	12/31/2019
16	HACRP_PSI90	CMS_PSI_90_Score	3Q2017	7/1/2017	2Q2019	6/30/2019
17	HACRP_SSI	SSI_Score	1Q2018	1/1/2018	4Q2019	12/31/2019
18	HACRP_Total	Total_HAC_Score	3Q2017	7/1/2017	4Q2019	12/31/2019
19	HAI_1	Central Line Associated Blood	1Q2019	1/1/2019	4Q2019	12/31/2019
20	HAI_1_HVBP_Baseline	Central Line Associated Blood	1Q2017	1/1/2017	4Q2017	12/31/2017
21	HAI_1_HVBP_Performance	Central Line Associated Blood	1Q2019	1/1/2019	4Q2019	12/31/2019
22	HAI_2	Catheter Associated Urinary T	1Q2019	1/1/2019	4Q2019	12/31/2019
23	HAI_2_HVBP_Baseline	Catheter Associated Urinary T	1Q2017	1/1/2017	4Q2017	12/31/2017
24	HAI_2_HVBP_Performance	Catheter Associated Urinary T	1Q2019	1/1/2019	4Q2019	12/31/2019

What We Know…

- Data reporting can be burdensome
- COVID has hit productivity for data reporting
- Where to get the data

- Work with Medicare Beneficiary Quality Improvement Project (MBQIP) data
- Some collaborative approaches
- No request for performance data

- Flex Monitoring Team (FMT)
- Care Compare
- Critical Access Hospital Measurement & Performance Assessment System (CAHMPAS)
- Hospitals self report data

Poll Question

- Do you provide a data tracking tool for your SHIP awardees?

Poll Question 2

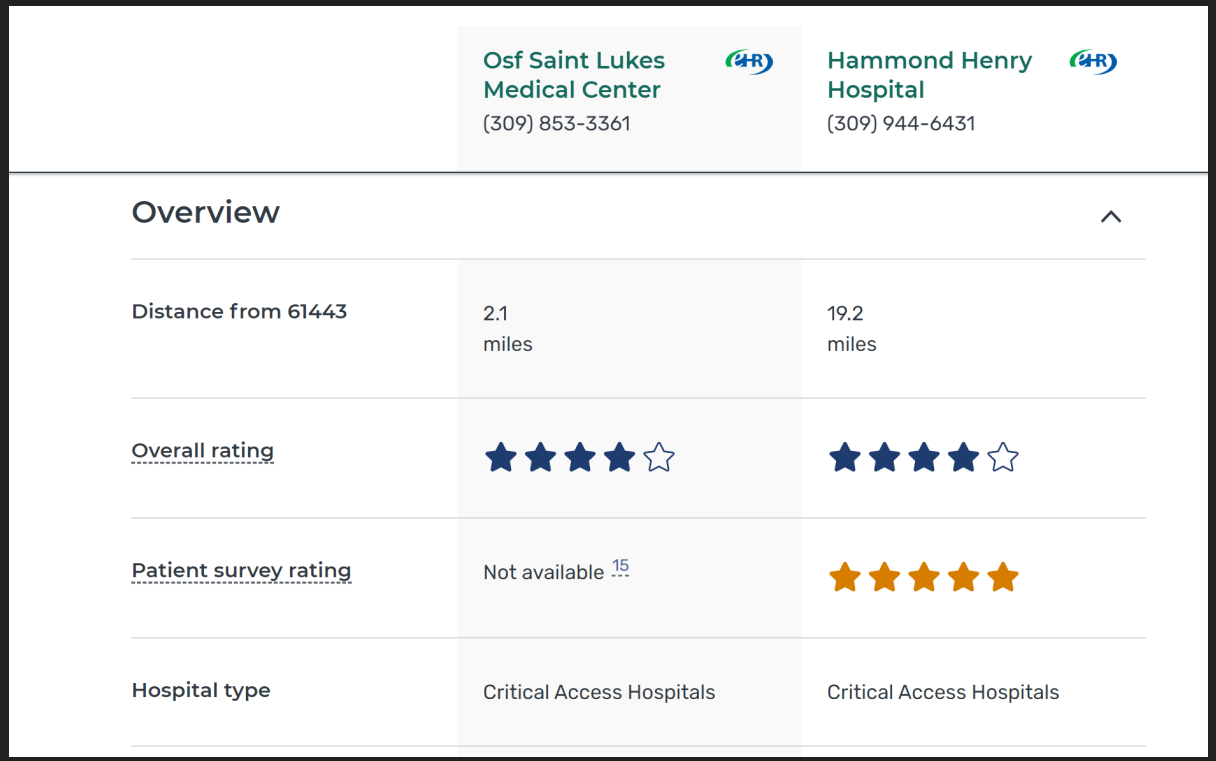
- Do you provide a platform for data reporting on quarterly intervals?

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): What Can Hospitals Report?

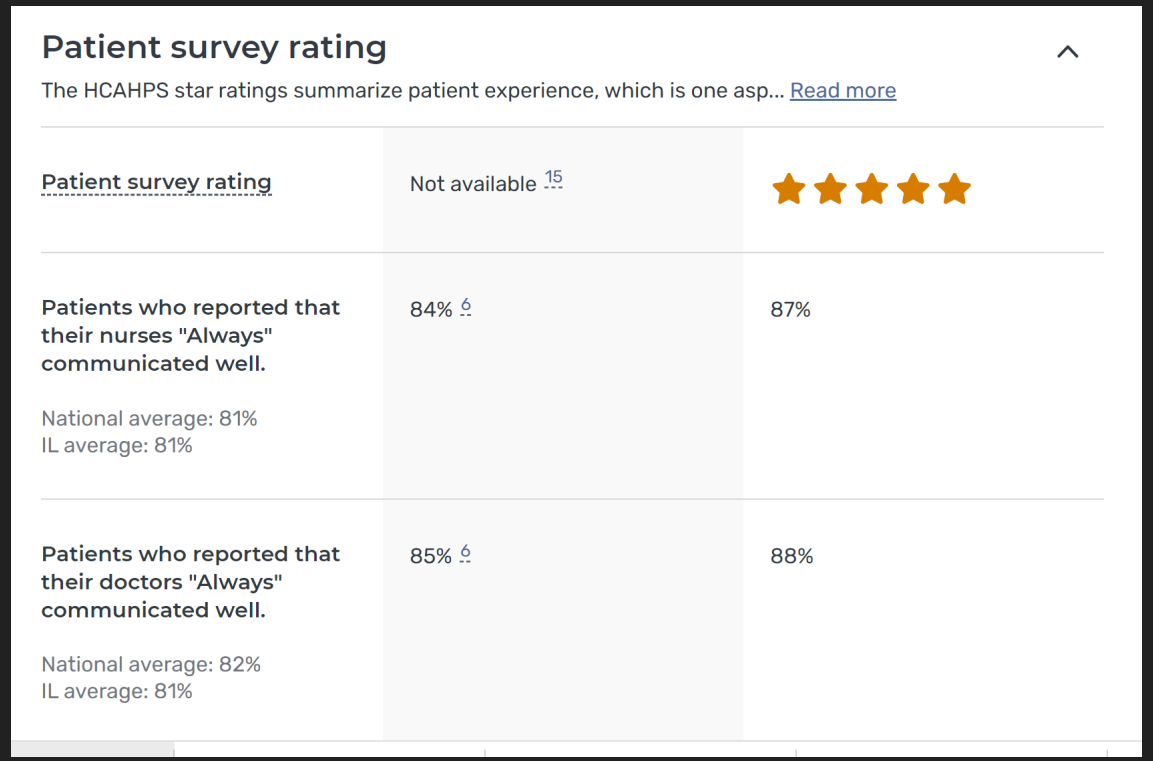
- Discussion time…what data are the hospitals able to provide to demonstrate outcomes?

HCAHPS

- Care Compare Data Portal
- Older data 4Q2019



	Osf Saint Lukes Medical Center (309) 853-3361	Hammond Henry Hospital (309) 944-6431
Overview		
Distance from 61443	2.1 miles	19.2 miles
Overall rating	★★★★☆	★★★★☆
Patient survey rating	Not available [15]	★★★★★
Hospital type	Critical Access Hospitals	Critical Access Hospitals



Patient survey rating

The HCAHPS star ratings summarize patient experience, which is one asp... Read more

Patient survey rating	Not available [15]	★★★★★
Patients who reported that their nurses "Always" communicated well. National average: 81% IL average: 81%	84% [6]	87%
Patients who reported that their doctors "Always" communicated well. National average: 82% IL average: 81%	85% [6]	88%

What are some challenges here:

Objective 2: Improve and support HCAHPS data collection process and related training				
Support rural hospitals' access to HCAHPS vendors and provide related training	Ongoing FY 2021	Director, Strategic Initiatives	Number and percent of SHIP hospitals reporting HCAHPS measures Number and percent of SHIP hospitals maintaining or improving their performance in HCAHPS data Percentage of survey completes for SHIP hospitals	Maintenance of 100% of SHIP hospitals publicly reporting HCAHPS measures 100% of SHIP hospitals that qualify for star ratings increase or maintain their star rating of 3 or above on patient experiences Increase in SHIP hospitals' survey completes rate

Complete training on Qualtrics Survey System for applications.	7/31/20	[redacted]	Number of trainings Completed; Number of surveys Created; Number of analysis reports created.	Number of trainings completed: 2 Number of surveys created: 2 Number of analysis reports created: 2

Another

- How could we measure This outcome differently?

Goal Three: Ensure SHIP funds are expended within the allowable scope and the impact of activities is reported.

Objective/Activities	Target Date	Responsible Party	Anticipated Results	Measurement of Results (Outcome)
Objective 1: Monitor CAH reimbursement requests. Activity: -Review CAH requests to confirm purchases are in line with proposed scope of work. -Review grant financial reports to monitor utilization of SHIP funds. -Contact CAHs that have not submitted for reimbursement. - Compile final report of SHIP activities.	• June 1-May 31 • Upon receipt. • Monthly • 6, 9, 12 months into funding period. • 12 months after funding.	• SHIP Project Coordinator	• All participating CAHs will utilize SHIP funds as proposed.	• 36 CAHs will use 100% of the SHIP funds. Full or partial award amounts will be used ~~toward the following:~~ **Value-Based Purchasing (VBP) Investment Activity:** • Four hospitals will use SHIP funds for quality reporting data collection/related training. *Reporting measure: Training related to quality data collection and reporting.* • Twelve hospitals will use SHIP funds for HCAHPS data collection and/or related training. *Reporting measure: Continued use of HCAHPS, reporting to Hospital Compare, and/or patient experience education.* • ~~Four hospitals will use SHIP~~ funds for efficiency or quality improvement training in support of VBP related initiatives. *Reporting measure: Completion of an efficiency or quality improvement training or project.* • One hospital will use SHIP funds to support Provider-Based Clinic quality

HCAHPS: Consortium

- What could we measure if doing consortium?
  - Not the quantity of employees trained…think demonstrated quality of care
  - How to capture the data?

HCAHPS continued

Objective 4: In Year-2, 9 hospitals will attend and complete all 4 of the HCAHPS improvement webinar and training.					
3	VBP Collaboration Session Webinars	December 2020 – January 2021	[redacted] Director SHIP Coordinator	December 17, 2020 – VBP Collaboration Session #1: HCAHPS Medicine Communications (15 Participants) January 28, 2021 – VBP Collaboration Session #2: HCAHPS Discharge Communications (28 Participants)	-Participants gained an understanding of the language and nuances of the HCAHPS Medicine Communication and HCAHPS Discharge Communication domain. -Participants shared their current process and investigated areas of opportunity through network collaboration to enhance performance.
3	HCAHPS Collection or Training	June 1, 2020 - May 31, 2021	SHIP Coordinator	Implementation of HCAHPS; Completion of HCAHPS training. -3 out of the 17 hospitals saw an improvement including a reduction in dollars at risk. The hospitals are reimbursed by CMS based on their ability to improve quality of care in a cost-effective manner or lower costs while maintaining standards of care. These improvements were determined by reviewing and comparing the 1st and 2nd quarter HCAHPS submissions for FY20.	Improve patient discharge processes with assistance from HCAHPS score; improve the number of new hospitals transmitting HCAHPS data and continued reporting to the Hospital Compare website offered by Medicare that gives information on how well hospitals provide recommended care to their patients with a 91% score on Patient Experience of Care for Communication about Discharge Information.

Last HCAHPS Example

Objective 1: ASSESS the current state of HCHAPS/Patient Experience scores and CAPACITY related to ongoing improvements within Patient and Family Experience activities.					
Activity	**Timeline**	**Responsible Party**	**Progress Measures**	**Outcome or Impact**	**Deliverable**
Conduct hospital-specific self-assessments of HCAHPS/patient experience processes and current results.	Aug 1 - Nov. 30	Participating hospitals and [redacted] team	Number of assessments completed	Identified hospital gaps to address targeted areas of improvement	Assessment reports
Objective 2: Support hospital staff in building capacity and planning for how they will improve the patient family experience through training and tools.					
Activity	**Timeline**	**Responsible Party**	**Progress Measures**	**Outcome or Impact**	**Deliverable**
Conduct 5 trainings, featuring such topics as addressing the changes in patient experience (including generational workforce difference and staff attitudes) and planning of strategies to support exhausted staff.	July 1 - May 31	[redacted] team	Number of webinars, number of hospital staff attendees, number of tools and intervention/strategies distributed	Increased hospital capacity via provision of resources and strategies, development of an action plan	Final report, comprehensive toolkit with resources to guide hospital improvements
Conduct 2 training meetings, one regionally and one statewide to build the SHARED resources and develop innovative implementation practices.	Aug. 1 - March 31	[redacted] team	Number of meetings, number of hospital staff attendees, post-event surveys, number of tools and interventions/strategies distributed-	Increased hospital capacity via networking and shared implementation lessons learned.	Final report, comprehensive toolkit with resources to guide hospital improvements
Conduct hospital consultative meetings to discuss implementation progress.	Aug. 1 - March 31	[redacted] team	Number of coaching encounters, number of action plan items implemented	Improved patient experience processes	Final report, comprehensive toolkit with resources to guide hospital improvements
Review allowable expenses for distribution	Apr. 1 - May 31	[redacted] team	Percentage of allowable expenses expended	Sustainable infrastructure and effort to continuously address PFE	Allowable expenses documentation

VBP…
Reporting Options and Data Capture

- Real-time data collection
- Challenges with current data
- Consider baseline data from national sites
  - A revisit to the toolkit
  - Why did hospital select the activity?

The purpose of this tool is to provide a web-based dashboard to educate state Medicare Rural Hospital Flexibility (Flex) Program Coordinators, state office of rural health staff, critical access hospitals, rural health networks, and other rural health stakeholders on population health data analytics.

The data included in this web-based tool are publicly available and consist of, but not limited to:

- Hospital Compare (data released July 2020)
- County Health Ranking (data released 2020)
- Dartmouth Health Atlas - Medicare Reimbursements/Enrollee (data released 2017)
- Area Health Resources File (data released 2019)
- U.S. Census, 2017 American Community Survey (data released 2019)

Note: Hospital Compare data in the Toolkit does not include data that has been suppressed due to small numbers. The Critical Access Hospital Measurement and Performance Assessment System (CAHMPAS), maintained by the Flex Monitoring Team, provides access to financial, quality, and community-benefit performance data of CAHs at the state and hospital level. Community and quality data in CAHMPAS are available to the public. Critical access hospitals (CAHs), state Flex Coordinators, and officials from the State offices of Rural Health may access detailed financial data through a password-protected site. State Flex Coordinators and CAHs already have access to their own Medicare Beneficiary Quality Improvement Project (MBQIP) data from quarterly reports created by the Flex Monitoring in support of FORHP.

Scenarios

The population health planning tool allows users to extract multiple data elements that are focused on specific scenarios. The scenarios focus on extracting information and analyzing the data in Microsoft Excel. The topics of the scenarios include, but are not limited to, the following:

- Diabetes Demographics
- Discharge Instructions
- Emergency Department Access
- Injury Demographics
- Patient Satisfaction
- Poverty, Preventable Stays, and Mental Health Shortage
- Social Determinants of Health
- Socioeconomic Status and Well-being
- Transportation and Health Status
- Understanding of Care and County Race
- Uninsured Rates, Behavior, and Mental Health
- Using Claims Data

Break It Down…

Objective 3: Provide efficiency and quality improvement training in support of Value-based Purchasing (VBP) related initiatives				
Support rural hospitals' access to an incident management system	Ongoing FY 2021	Director, Strategic Initiatives CIO	Number and percent of SHIP hospitals utilizing incident management data and software for quality improvement initiatives	Maintenance of 100% SHIP hospital utilization of incident management data and software to target specific quality improvement interventions

What measure(s) could be collected?
How does the grant support Quality Improvement (QI) interventions?

Discussion

- Four hospitals will use SHIP funds for efficiency or quality improvement training in support of VBP related initiatives.
  Reporting measure: Completion of an efficiency or quality improvement training or project.

Two Examples
Any initial thoughts/ideas/options to capture further data?

- One hospital will use SHIP funds to support Provider-Based Clinic quality measures training.
  Reporting measure: Completion of provider-based clinic quality measures training.

Consortium Example

Shared/Consortium/Network Hospital SHIP Funds

SHIP Grant FY		**Funding Amount**	
Contributing Hospital	ABC Community Hospital	**Contact Person**	Jane Doe
Selected Category	VBP Investment Activities		

Network Decision Tree

Per conversations with the Jane from ABC Hospital they have asked to use the SHIP funds for the network to provide Sepsis Certification training through The Joint Commission structure and platform. This will provide training to the network around performance and enhanced best practices in the following areas:

- Clinical care practices by standardized treatment of patients both sepsis and preventing sepsis
- Patient safety
- Reducing readmissions related to infectious disease
- Ensuring antibiotic stewardship practices

ICAHN will purchase The Joint Commission resources related to Sepsis Management and vet speakers for a minimum of two webinars and one face-to-face meeting for the network. These resources and tools will be available to the network regardless if using TJC as their accrediting vendor.

Objectives:

- Build the structure required for a systematic approach to clinical care
- Reduce variability and improve quality of patient care
- Provide objective assessment of clinical excellence
- Differentiate clinical care program in the marketplace and become provider of choice
- Have a minimum of 20 CAHs participate in training and sharing of best practices

Training	**Sepsis Certification**		
Dates	TBD	**Cost**	$9,000
Agenda/Details			

Goal 2: Improve data collection methods to facilitate quality reporting and improvement related to Value-Based Purchasing (VBP).					
Objective 1: Participating hospitals in Year-2 to report an increase in hospital index rank in their outcomes, safety, patient experience of care, and efficiency from Year-1					
3	Track SHIP VBP activities selected by facilities submitted on the Hospital Application.	December 2020 -January 2021	SHIP Coordinator and Staff Officer, I	-2 follow-up emails sent to each participating hospital that fails to submit their selected VBP activity by the initial due date. -5 follow-up phone calls to 3 hospitals	-VBP Investment Activities chosen by 31% of the participating hospitals. With 12 applicants selecting HCAHPS Collection/Training.
3	VBP program	June 1, 2020 - May 31, 2021	SHIP Coordinator & Consortium partner	Facilitated selection of a VBP "champion" at each facility this person will be the primary contact within the consortium. VBP Consortium sent 17 VBP Modeling Reports consistent with the CMS VBP Program to [redacted] PPS Hospitals	Identified where facilities should improve quality related outcomes. Hospitals will see a reduction and prevention of penalties under the VBP program with the assistance and training of the [redacted] Consortium.
3	VBP Consortium activity	June 1, 2020 - May 31, 2021	SHIP Coordinator & Consortium partner	- Identify hospital needs and align these needs with the SHIP VBP activity requirements. -Oversee Consortium PPS Hospital progress; and evaluate effectiveness of participating in VBP activities. -37% of SHIP Hospitals participated in the consortium.	Implemented activities will assist hospitals in bringing up the numbers of their overall quality performance including outcomes. safety, patient experience of care, and efficiency to the national benchmark. -Participating hospitals will meet at the end of the FY20 SHIP cycle for a peer sharing webinar to discuss improvements and to share best practice methods and ideas.
Objective 2: Increase the number of hospitals transmitting quality data, reporting improved quality outcomes and a reduction in re-admissions from previous year.					
3	Quality reporting activity	June 2020 – May 2021	SHIP Coordinator & Consortium partner	One-on-One data review sessions with 17 participating hospitals	4 of the 17 hospitals have had one on one deep dive training regarding quality performance outcomes
Objective 3: Each of the 17 hospitals for this activity will receive hospital specific HCAHPS reports by the end of Year-2.					
3	Follow up with facilities after Modeled VBP Performance Reports are sent to participating hospitals	November 2020-May 2021	SHIP Coordinator	Reviewed reports and provided 2 follow up TA's	-17 Hospitals received VBP Performance reports -24% of participating hospitals received direct assistance as of January 2021

ACO Report Card

ACO Quarterly Measures Report Card

Things to keep in mind:

- ACO-17 only includes patients identified as tobacco users in the denominator of the calculation. Only patients identified as tobacco users, who also received cessation intervention, are included in the numerator of the calculation.
- ACO-18 is a two-part measure. If a positive depression screening result is found, a follow-up plan must be documented.
- ACO-18 measures the completion of depression screening for total population using a PHQ-2 tool. ACO-40 measures the completion of ongoing monitoring of depression diagnosed patients using a PHQ-9 tool.
- ACO-27 is an inverse measure. Lower scores indicate better performance. Patients with A1c values >9 are included in the numerator of the calculation.
- CMS pulls the year end GPRO reporting patient lists. Quarter 1-3 patient lists are pulled internally. The sample volume may differ significantly between the two

Care Coordination/Patient Safety

Measure Number	Measure Name	90% Percentile	ACO Aggregate YTD	YTD
ACO – 13	Screening for Future Fall Risk			

Preventive Health

Measure Number	Measure Name	90% Percentile	ACO Aggregate YTD	YTD
ACO – 14	Influenza Immunization			
ACO – 17	Tobacco Use: Screening and Cessation Intervention for users			
ACO – 18	Screening for Clinical Depression and Follow-up Plan			
ACO – 19	Colorectal Cancer Screening			
ACO – 20	Breast Cancer Screening			
ACO – 42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease			

At-Risk Population

Measure Number	Measure Name	90% Percentile	ACO Aggregate YTD	YTD
ACO – 40	Depression Remisssion (PHQ-9)			
ACO – 27	Hemoglobin A1c Poor Control (A1c value >9)			
ACO – 28	Hypertension (HTN): Controlling High Blood Pressure			
	Total Points Earned (see Key)			
	Total Percentage			

ACO's Have Data

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Metric Measured	October	November	December	January	February	March	April	May	June	July	August	September
MWV	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Post DC Calls/TCM Opportunities	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
TOC Follow Up	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
ER PCP Alignment	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
ER Telephone Follow Up	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Referral Tracking/Completion Process	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!

Skilled Care Tracker

# Patients to/back to Nursing Home												
# Patients to Swing Bed												

Recommended Disease Registries (add to the list if you have other implemented/actionalable disease registries in place)	Number of Patients	Number Actively followed by Care Management or Care Coordination
Diabetics		
COPD		
CHF		
Hypertensive Patients		

ACO Team Information | Action Items & Team Mtng Notes | Summary | MWVs | Post DC TCM Calls | ER Telephone Follow Up | Quarterly Quality ...

ACO Reporting

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Measure Number	Measure Name	Your ACO Performance Rate	Mean Performance Rate[a]	30th Percentile Benchmark	90th Percentile Benchmark
ACO-8	Risk-Standardized, All Condition Readmission	15.54	14.98	15.18	14.27
ACO-35	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	19.65	18.59	19.22	16.85
ACO-36	All-Cause Unplanned Admissions for Patients with Diabetes[b]	46.84	37.01	39.00	23.12
ACO-37	All-Cause Unplanned Admissions for Patients with Heart Failure	93.17	76.75	82.32	50.99
ACO-38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	70.69	59.00	65.99	41.39
ACO-43	Ambulatory Sensitive Condition Acute Composite (AHRQ Prevention Quality Indicator (PQI) #91)	2.67	1.98	N/A[c]	N/A[c]
ACO-44	Use of Imaging Studies for Low Back Pain	60.00	64.36	N/A[c]	N/A[c]

CMS Care Coordination/Utilization

Description	Quarter 1- 2018			Quarter 2 - 2018			Quarter 3 - 2018			Quarter 4 - 2018			Quarter 1- 2019		
	ACO	ALL MSSP ACOS	National Assignable FFS	ACO	ALL MSSP ACOS	National Assignable FFS	ACO	ALL MSSP ACOS	National Assignable FFS	ACO	ALL MSSP ACOS	National Assignable FFS	ACO	ALL MSSP ACOS	National Assignable FFS
30-Day Post-Discharge Provider Visits Per 1,000 Discharges	787	796	786	798	800	789	802	804	790	806	805	795	789	802	789
COPD/Asthma Discharge Rates per 1,000 Beneficiaries	13.80	10.21	10.76	13.39	9.43	9.92	12.18	8.76	9.15	11.14	8.16	8.63	10.58	7.72	8.22
CHF Discharge Rates per 1,000 Beneficiaries	17.00	15.93	16.74	16.91	16.12	16.81	17.09	16.09	16.85	16.65	15.84	16.72	16.361	16.12	16.69
Emergency Department Visits per 1,000 Beneficiaries	972	704	756	970	695	751	962	686	748	932	669	741	886	675	738

ACO Reporting continued

Quality Performance Results, continued

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Table 2. Patient/Caregiver Experience

Measure Number	Measure Name	P4P or P4R	—	Nu S Co
ACO-1	CAHPS: Getting Timely Care, Appointments, and Information	P	—	
ACO-2	CAHPS: How Well Your Providers Communicate	P	—	
ACO-3	CAHPS: Patients' Rating of Provider	P	—	
ACO-4	CAHPS: Access to Specialists	P	—	
ACO-5	CAHPS: Health Promotion and Education	P	—	
ACO-6	CAHPS: Shared Decision Making	P	—	
ACO-7	CAHPS: Health Status/Functional Status	R	—	
ACO-34	CAHPS: Stewardship of Patient Resources	R	—	

Table 3. Care Coordination/Patient Safety

Measure Number	Measure Name
ACO-8	Risk Standardized, All Condition Readmission
ACO-35	Skilled Nursing Facility 30-day All-Cause Readmission measure (SNFRM)
ACO-36	All-Cause Unplanned Admissions for Patients with Diabetes
ACO-37	All-Cause Unplanned Admissions for Patients with Heart Failure
ACO-38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
ACO-9	Ambulatory Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults (AHRQ Prevention Quality Indicator (PQI) #5) [4]
ACO-10	Ambulatory Sensitive Conditions Admissions: Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8) [4]
ACO-11	Percent of PCPs who Successfully Meet Meaningful Use Requirements
ACO-39	Documentation of Current Medications in the Medical Record
ACO-13	Falls: Screening for Future Fall Risk

Starter Project: Consortium ACO

Each ACO member logs in and enters the following goal sections into a repository/portal somewhere

1. Goal 1: Improve quality scores to 90th percentile: We can enter this data based on quarterly quality reporting to Brian
2. Goal 2: SNF Management: # SNF and # Swing Bed patients in quarter
3. Goal 3: Specialty referral management: # patients in the CCM program versus # Medicare patients in past year (Dr. Davis do you remember why we picked past year versus the quarter?)
4. Goal 4: ED Utilization: ER Admit Rate ____%; # telephone follow up calls/# total visits per month to tally to a quarter
5. Goal 5: MWV: % of MWV completed in the month
6. Goal 6: Readmission management:
    a. # Readmits from SNF/LTC
    b. # Readmits from Swing
    c. # Readmits post-acute
    d. # RCAs completed
    e. # Preventable readmissions
7. # Admissions/month

Hospital & Contact Person			
Data Element	3Q2019	4Q2019	1Q2020
Total admissions this quarter to your facility			
Total number of readmissions this quarter			
Total number of preventable readmissions			
Total number transferred to SNF this quarter			
Total number in Swing Bed this quarter			
Current MWV rate			
Number patients in care management program			
Total number Medicare visits this quarter			
Total ER visits this quarter			
Total receiving post-discharge ED phone call			
ICAHN or if known by Hospital			
ED Avoidable percentage			
GPRO Quality Percentile Score			

Discussion

Objective 4: Provide efficiency and quality improvement training in support of Shared Savings Investment activities				
Provide shared consortium and program coordination, consultation, facilitation, and administration	Ongoing FY 2021	Director, Strategic Initiatives	Number and percent of SHIP hospitals assisted	Improvement in the effective and efficient allocation and use of SHIP grant funding in [redacted]
Provide contracted expertise, training, and resource development in quality improvement	Ongoing FY 2021	Director, Strategic Initiatives	Number and percent of SHIP hospitals assisted	Improvement in hospital staff expertise, understanding, and competency in the area of quality improvement
Objective 5: Provide Health Information Technology (HIT) training for value and ACOs				
Improve rural hospital health information technology expertise	Ongoing FY 2021	CIO	Number and percent of SHIP hospitals assisted	Improvement in hospital staff expertise, understanding and competencies in the area of health information technology
Provide external vulnerability scans and/or security awareness training	FY 2021	CIO	Number and percent of SHIP hospitals receiving their choice of external vulnerability scans and/or security awareness training	Decrease in hospital cybersecurity vulnerabilities Increase in hospital cybersecurity awareness

More Discussion

ACO Investment Activity:

- One hospital will use SHIP funds to support computerized provider order entry hardware/software and/or training.
  Reporting measure: Implementation or use of computerized provider order entry hardware/software and/or training.
- Six hospitals will use SHIP funds to support Pharmacy Services.
  Reporting measure: Implementation or use of pharmacy services.
- Two hospitals will use SHIP funds to support disease registry training and/or software/hardware.
  Reporting measure: Implementation or use of disease registry services, or related training.
- One hospital will use SHIP funds to support efficiency or quality improvement training or projects in support of ACO or shared savings related initiatives.
  Reporting measure: Completion of efficiency or quality improvement training or project related to ACO or shared savings initiatives.
- Twelve hospitals will use SHIP funds to support telemedicine or mobile health equipment installation or use.
  Reporting measure: Telemedicine implementation or use.
- Four hospitals will use SHIP funds to support cybersecurity services.
  Reporting measure: Implementation or utilization of cybersecurity services.

Tell me about the Dollars

Quick Look at Financial Options/Considerations

- Lisa McFann MSN/ED, RN
- Kimberly Kicklighter BSN, RN

Successful Value Based Programs require providers and staff to be educated in the following :

1

Quality Program

- Process to capture quality measures
- Quality Measure Cheat Sheet
- Annual Wellness Visit (AWV)
- Day to day office visits

2

Patient Engagement

- Chronic Care Coaching
- Shared Decision making
- Motivational Interviewing

3

Coding

- Coding accuracy
- Highest level of specificity
- Risk Adjustment
- RADV Audit Compliance

4

Wellness & Prevention

- Annual Wellness Visit
- Chronic Care Management
- Transitional Care Management
- Advanced Care Planning
- Patient Health Coaching

Understanding Risk Adjustment

Risk adjustment: a predictive analytics tool utilizing actuarial data from claims submitted by health care providers, used to determine payments based on the relative health of at-risk populations.

How Risk Adjustment Works:

Submitted I-10 codes that risk adjust will be used by a payer to calculate each of your patients' Risk Adjustment Score (RAS)

The RAS will determine the projected 'spending budget' and prospective payments during the coming calendar year

Profitability or losses will depend on the net difference between Risk Adjusted payments and actual utilization costs for care rendered.

Risk Adjustment Education for Rural Health Systems is Critical

Accurate for Fee for Service Reimbursement

Accurate calculation of patient acuity

Accurate risk adjustment for cost and quality measures

Physician Compare website publishes data

Payers will continue to move towards risk adjusted contracts

Level the paying and playing field with payers

Risk adjustments impact for Value-Based Reimbursement

Medicare Advantage – **Capitated Payment**

Value Based Purchasing- **Pay-for-Performance**

Medicare ACO Shared Savings Program – **ACO Shared Savings/Risk**

MACRA- MIPS vs APMs- **Quality Payment Programs**

Hospital Quality Performance- **Clinical Care- (Mortality), Safety- (Infection/HAC Rates), Efficiency- (Spend per patient)**

Quality and Resource Use Report- report provides an overview of quality, cost and utilization for providers

Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Riskadjustment

Let's look at an example!

Name: John Doe
Gender: Male
DOB: 07/01/1950

Height: 64 inches
Weight: 240 pounds
BMI: 42

Chief Complaint & HPI: No symptoms, presents for AWV with known T2DM on Insulin x 7 yrs. Polyneuropathy, COPD & Major Depression
Past Medical History: T2DM, Polyneuropathy, COPD, Major Depression, Traumatic tow amputation (1996)
ROS: Per HPI, all other symptoms negative

Exam:
Unremarkable except for obesity, decreased breath sounds and expiratory wheezes, great right toe amputation and positive monofilament

Assessment/Plan:
(1) Preventative visit and findings discussed
(2) DM, Type 2 – stable, continue current treatment plan
(3) COPD – stable, continue Advair
(4) Neuropathy – stable, optimize BS control
(5) Major depression – stable, continue Lexapro
(6) Morbid obesity – IBT to lose weight

John Doe has an Annual Wellness Visit (AWV) with his primary care doctor. His AWV notes are in the report above.

Risk Adjustment Pays!

MODERATE SPECIFICITY Documentation & Coding				HIGH SPECIFICITY Documentation & Coding			
Condition	I-10	HCC	RAF weight	Condition	I-10	HCC	RAF weight
66-year-old, male	--	--	0.288	66-year-old, male	--		0.288
AWV	Z13.9	n/a	--	AWV	Z13.9	n/a	--
BMI =42.0	Z68.41	22	0.365	BMI =42.0	Z68.41	22	0.365
T2DM-uncomplicated	E11.9	19	0.118	T2DM with Neuropathy	E11.42	18	0.368
Neuropathy	G62.9	n/a	--	Neuropathy (buddy code)	G62.9	n/a	--
Long-term insulin use	Not coded	n/a	--	Long-term insulin use	Z79.4	19	0.118
Major depression, unsp.	F32.9	n/a	--	Major depression, mild	F32.0	58	0.330
Asthma, severe	J45.50	n/a	--	COPD, unsp.	J44.9	111	0.346
Great Toe Amputation	Not coded			Great Toe Amputation	Z89.419	189	0.779
No disease interaction				Disease interaction is T2DM-COPD	Disease interaction		0.182
Patient RAF Score			0.771	Patient RAF Score			2.776
PMPM Payment			$542	PMPM Payment			$1,943
Annual Payment			$6,493	Annual Payment			$23,333

As you can see, when John Doe's PCP codes more accurately the annual payment for providing care is significantly higher – over $16,000!

The 4 Keys to Improving Rural Healthcare Quality and Financial Outcomes:

1. Mastering Risk Adjustment Factor (RAF) recognition, documentation, and coding!
2. Mastering compliance with quality measure reporting
3. Eliminating inefficient spending and resource consumption
4. Delivering exceptional customer service to achieve outstanding patient experience

Questions – Comments - Thoughts

Open Mic Time

Next Week:

Schedule one-on-one calls
Deeper dive into what areas you may want assistance in
Further evaluate your current data