Mapping Performance To Manage Value: The Clinical Data You Need To Manage The Risk Of Value-Based Reimbursement

The 2018 OPEN MINDS Technology & Informatics Institute
October 23, 2018 | 2:30pm – 3:45pm

Joseph P. Naughton-Travers, EdM, Senior Associate, OPEN MINDS
Agenda

I. Mapping Performance In A Value-Based Market

II. Project Transition Case Study: Luke Crabtree, J.D., MBA, Chief Executive Officer, Project Transition

III. Centerstone Case Study: Jason Turi, Vice President of Population Health, Centerstone

IV. Questions & Discussion
Transition From Pay-For-Volume To Pay-For-Value – Across All Payers

About 40% of 2014 **commercial** health plan reimbursements to provider organizations linked to value-oriented initiatives; compared to 11% in 2013

**Medicare** is planning to shift 50% of FFS reimbursement from volume to value by December 2018

66% of all **Medicaid** beneficiaries were in some form of managed care in 2014, and as of June 2014, 1 million+ individuals enrolled in Medicaid health homes
More Value-Based Care = More Decision Support

- In a value-based market, the competitive edge will go to the organization that can provide “more” for the same amount of financial resources
- Meaning provider organizations must incorporate better, faster decision support tools into their operational processes
- Because “less than optimal” decisions about consumer care wastes precious resources – and will decrease the financial viability under these new value-based arrangements.

“In the next 10 years, data science and software will do more for medicine than all of the biological sciences together.”

– Vinod Kholsa
The federal Centers for Medicare & Medicaid Services notes that successful clinical decision support requires five elements:

1. **The right information** (evidence-based guidance, response to clinical need)
2. **To the right people** (entire care team – including the patient)
3. **Through the right channels** (e.g., EHR, mobile device, patient portal)
4. **In the right intervention formats** (e.g., order sets, flow-sheets, dashboards, patient lists)
5. **At the right points in workflow** (for decision making or action)
Population Health Management

- Identification
- Intervention
- Outcome Management
Leveraging Value-Based Reimbursement to Drive Best Practices

*OPEN MINDS* Technology and Informatics Institute

October 23, 2018
Project Transition Mission:

“To enable each person who has Serious Mental Illness, Dual Diagnosis Substance Use Disorder or an Intellectual Developmental disABILITY and Behavioral Health conditions to live a life that is meaningful to him/her in the community on terms he/she defines.”
About Us

• 36 years of demonstrated expertise in supporting a Member’s transition to independence to achieve sustainable community tenure
  • Work exclusively with the Top 3% of the State Medicaid Systems and Health Plans we serve
  • Over 4,000 members Served
• Passionately person-centered with built out tools to support, document, and report member progress
• Flexibility to work with diverse providers throughout the member’s transitions and milestones
• Early adopter of evidence-based best practices:
  • Dialectical Behavior Therapy (DBT) Skills System
  • Wellness Recovery Action Plans (WRAP)
  • Peer Support
  • Psychiatric Rehabilitation
  • Psychiatric and Clinical Services
Understanding Value-Based Reimbursement - Example

1. You already know what Value-Based Reimbursement is through lived experience.
2. Wrestling: when can he get back on the mat?
3. Gymnastics: when can he return to practice?
   • For example, take Cole:
4. Dirt Bike: when can he ride again?
5. Karate: Can he be ready for the next tournament?

Holly zeroed in on five key outcomes that aren’t measured by NCQA or HEDIS.

• Two older brothers: when can he start rough housing with them?
• Wrestling: when can he get back on the mat?
• Gymnastics: when can he return to practice?
• Dirt Bike: when can he ride again?
• Karate: Can he be ready for the next tournament?
1. Agree upon outcomes that constitute value to your payor
Five Key Steps to Value-Based Reimbursement

• Your desired outcome and the payor’s desired outcome may not match.
• Find ways to compromise in order to be reimbursed without compromising your mission and core values

• Examples:

Self Manage Housing Stability
Self Manage Finances
Self Manage Personal Health & Wellness
Self Manage Medications
Engaged in Community Support (Healthy Natural Supports)
2. Define each outcome together very specifically

Examples:
- Data dictionary
- Nationally recognized normed instruments
3. Evaluate organizational readiness to take on the challenge of value-based reimbursement
Five Key Steps to Value-Based Reimbursement

CEO

VP of Clinical Services
VP of Finance
National Director of Marketing and Admissions
IT Director
State Director
State Operations Manager
Program Director

Clinician
Psychiatrist
Admissions Counselor
Outreach Manager
Billing

HR
VP of Quality and Ops

Psych Rehab Counselor
Residential Advisor
Peer Specialist
Office Manager
Social Worker
Direct Service Provider

MEMBER
Five Key Steps to Value-Based Reimbursement

MEMBER

Clinician  Psychiatrist  Admissions Counselor  Outreach Manager  Billing  IT Director  Psych Rehab Counselor  Residential Advisor  Peer Specialist  Office Manager  Social Worker  Direct Service Provider  HR

VP of Clinical Services  National Director of Marketing and Admissions  VP of Finance

Program Director

State Operations Manager

State Director

CEO
4. Optimize organization to achieve agreed upon outcomes
Five Key Steps to Value-Based Reimbursement

• To be successful in a VBR environment, you must be **person-centered** and **outcomes** driven
  • To do this you have to make the member’s **quality of life** paramount

• Turn the organization chart upside down and define what each team member needs to do to enable the member to achieve the desired outcomes
  • Utilize and/or upgrade technology
  • Change job descriptions
  • Inform process change
  • Operationalize work
5. Establish and maintain process to look at how you are doing and improve
Five Key Steps to Value-Based Reimbursement

- Incentivize staff to make the outcomes tangible
- Establish and leverage an employee bonus team
  - All employee call, monthly
  - Teams outcomes are measured and highest scoring teams share how/why they performed
  - No one team has the best performance across all measures. Shared learning is key for improvement!
• Future path toward quality of life
  • If a member is living the life they want—in the community, on terms they define—they are less likely to require higher levels of care.
  • Examples:
    • Increased Member level of distress tolerance and self-regulation [evident in increased periods between behavioral and emotional dysregulation]
    • Improved ability to interact effectively with peers, loved ones, and community supports
    • Increasing number of weeks without property damage
    • Increased tenure in the community (as opposed to an institutional setting)
    • Increased productivity (compared to baseline) which could include the following:
      • Involvement in the community
      • Religious/spiritual
      • Vocational
      • Educational
      • Social
  • Map to fiscal measures from claims data
  • There will always be some process measures
  • Human beings are people and we want transparency into the work being performed
Questions
Jason Turi, Vice President of Population Health, Centerstone
Agenda

- Centerstone Overview
- Why we do this work
- Population health essentials
- Acute care related performance measures
- What does the data tell us about cost and hospitalizations?
- Indiana case study
- Challenges and outcomes
CENTERSTONE at a Glance

Delivering care that changes people’s lives

- National, private, not-for-profit 501(c)(3) healthcare organization
- 60 years in operation - Specializing in behavioral healthcare
- Offering a comprehensive array of outpatient, inpatient, emergency, community-based and intensive in-home services
- Awarded 3 CCBHC Grants in 2018 for KY, IN, & IL

Nationally Recognized Service Lines:
- Integrated Primary Care
- Addictions Treatment including MAT
- Crisis Services – National Zero Suicide Model
- EAP
- Military and Veterans
- Intellectual and Developmental Disabilities
Centerstone Geography

Centerstone’s footprint is spread across the United States with concentration in five states: TN, KY, IN, IL and FL.

Centerstone's psychiatric inpatient hospital in Florida draws patients from across the nation.

Centerstone operates two inpatient Addiction Treatment Centers (Kentucky and Florida) as well as residential care centers.
“Every country in the world can be considered as a developing country when it comes to mental health” – Vikram Patel, Harvard School of Public Health, World Mental Health Day October 10th, 2018
It’s a statistic you’ve probably seen before – people with serious mental illness die an average of **15 to 30 years younger** than those without. This difference represents the largest health disparity in the U.S.; larger than gender, racial or socioeconomic differences. And unlike some of the other gaps that are slowly closing, it isn’t shrinking.
Population Health Essentials

- Identify attributed population
- Address social determinants
- Stratify by risk of adverse outcomes and tailor interventions as needed
- Meeting patients where they are
- Quality integrated primary and behavioral healthcare
- Using data to guide care delivery and change
Key acute care performance measures

- Acute Behavioral Health 30 day readmissions
- Emergency Department Utilization
- Follow up after Hospitalization for Mental Illness (FUH)

Who Cares?
- CCBHCs
- MIPS
- Medicaid
- Medicare
- Payers
- Clients
Normal distribution

Paranormal distribution
FIGURE 2–1 | Distribution of personal health care spending in the US civilian noninstitutionalized population, 2014.
SOURCE: Dzau et al., 2017.

Population rates of ED visits involving mental and substance use disorders, 2006-2013

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2006-2013
High-Need Adults Have More Emergency Department Visits and Hospital Stays

<table>
<thead>
<tr>
<th></th>
<th>Total adult population</th>
<th>Three or more chronic diseases, no functional limitations</th>
<th>Three or more chronic diseases, with functional limitations (high need)</th>
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<tr>
<td>Inpatient hospital discharges</td>
<td>107</td>
<td>147</td>
<td>535</td>
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Note: Noninstitutionalized civilian population age 18 and older.

FIGURE 3–2 | A framework for health with all of the factors that would go into an ideal taxonomy.

NOTE: SES = Socioeconomic status.

How do we impact complex populations within a fragmented healthcare system?

- Acute Behavioral Health 30 day readmissions
- Emergency Department Utilization
- Follow up after Hospitalization for Mental Illness (FUH)
Indiana Case Study
Multi-organization collaboration and data-sharing
Acute Utilization Data Flow

Hospital → HIE → CMHC
Key Opportunity

Engage clients and reinforce relationship

Address root causes - this event is a signal

Improve cross-continuum collaboration
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<th>First Name</th>
<th>Birth Date</th>
<th>Patient ID</th>
<th>Admit Date</th>
<th>Discharge Date</th>
<th>Facility</th>
<th>Visit Type</th>
<th>Chief Complaint</th>
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Ideal scenario

- Accountable Staff with time to respond
- Strong Relationships with Hospital staff
- Priority outpatient scheduling within 7 days
- Client keeps appointment & adheres to plan
Day to day struggles

- **9/24**
  - Z.M. d/c Psyche Unit

- **Hospital staff reluctant to share info b/c of 42CFR**

- **9/25**
  - Health Coach notified of f/u appt 10/3

- **10/3**
  - No show for f/u after repeated calls to reschedule

- **10/15**
  - Still unable to contact
Challenges

Engaging individuals with complex needs and busy lives

Integrating outside data into our E.H.R.

No “one” perfect software solution

Staff will resist parallel work flows and need to be co-designers
Moving the needle on key measures

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<th>Efficiency Indicators</th>
<th>Total Max Point Value</th>
<th>Desired Result</th>
<th>Baseline Result</th>
<th>Program Year Performance Targets</th>
<th>Q2 Interim Results</th>
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<td>Provider Baseline Results</td>
<td>Peer Group Baseline Period Avg. Rate</td>
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<td>Acute Behavioral Health (BH) Inpatient 30 Day Readmissions</td>
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<td>Lower is better</td>
<td>12.69%</td>
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2018 MIPS Outcomes

Follow-up after Hosp. for Mental Illness
(Within 7 days)

Follow-up after Hosp. for Mental Illness
(Within 30 days)
Questions & Discussion
Turning Market Intelligence Into Business Advantage

*OPEN MINDS* market intelligence and technical assistance helps over 550,000+ industry executives tackle business challenges, improve decision-making, and maximize organizational performance every day.