Using DATA Effectively in a World of Payment Reform

A Picture is Worth a Thousand Words
Data Driven

Driven (adjective)
1. having a compulsive or urgent quality <a driven sense of obligation>
2. propelled or motivated by something —used in combination <results-driven> (Noun. a thorough or dramatic change in form or appearance)

Let’s Talk about Your Data

- Pull out the data you brought today
- Facilitated Discussion
- Initial Exercise
Performance Measures in a Medical Home
Pulling together WHAT WE KNOW

Lencioni Addresses A Data-Driven Culture In The Book
- Three Signs of a Miserable Job by Patrick Lencioni
Performance Measures

- Provide a focused, clarifying snapshot of key data that communicates to all viewers—even a novice viewer—the status of efforts (performance) and what successes and failures the organization or project is having.

Why Should You Measure?

- Develops a common understanding
  - A basic point of reference to build on
- Is objective
  - It is devoid of personal feelings and value judgments
- Validates what some people “have been saying” and adds to your credibility
  - It demonstrates that you are in touch with what is going on in clinic
- Imposes the responsibility to act in a timely manner
  - “Call to Arms”
- Enables us to see trends that our perception may not notice
  - Challenges our optimism and often false sense of security
In this well known optical illusion, the ebbinghaus illusion, the orange dots are actually the same size, however, the surrounding information leads us to perceive something quite different ..... Measurement removes that bias.

In This World Of Payment Reform… What Should You Measure?
Think of your Dashboard: Importance, Urgency, & Simplicity

- **Speedometer**: Critical to safety, changes frequently, & is calculated in MPH.

- **Odometer** (Mileage): Affects service management, resale value, updates within minutes if following directions, & is calculated by measuring the distance traveled.

- **Fuel Gauge**: Essential to avoid breakdowns or excess gas stops and it’s variable based on the speed and length of your trip.

- **Oil Pressure Warning Light**: Gives advanced warning of potential mechanical failure because engine can breakdown with sudden drop in pressure.

Some Common Operational Measures

- Third Next Available Appointment (TNAA)
- No-Show
- Missed Opportunities (MO)
- Cycle Time (CT)
- Productivity
- Continuity
- Cash Collection
- Payer mix
- Dropped calls
- Telephone encounter/Voice Mails/messages
- QuickStart and SoftLanding
So.....What Should We Measure?

- What is important to our patients, our business, our future?
- Adherence to Mission Statement
- Impact on Business/Budget: Productivity & Payer Mix
- Efficiency: CT, MO, Productivity, Dropped Calls, telephone encounters (non face to face patient work)
- Customer Service: Cycle Time & Patient Survey data
- Access: TNAA, missed opportunities
- Staff Satisfaction/Development: Soft landings, charts completed at time of care
- Quality of Care: Any and all key Clinical Measures

In This Section

- Data requirements
- Data strategies VBP
- Overarching data strategies
1. Answer questions
2. Getting right data to answer questions
3. Reliable data
4. Timely data
5. Engaging & actionable data
6. Follow up system

What Questions Do We Want To Answer?

- Our clinical quality performance
  - Process
  - Outcome
- Our efficiency performance
- Patient retention
- How can we maximize payment *(to reinvest for resources for our patients)*

<table>
<thead>
<tr>
<th>Average cost of care</th>
<th>Efficiency (% improvement)</th>
<th>Maximum share of savings (25%)</th>
<th>Efficiency + quality (0 – 100%)</th>
<th>Member months</th>
</tr>
</thead>
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Patient Retention

- How attributed
  - Provider eligibility
  - Timing (visits & other parameters)
  - Adult, FP, or pediatric provider?
- Exclusions
- Process to identify & track

Attribution Lists

- Detail
- Format
- Tracking type
QI 04 (Core): Monitors patient experience through:
A. Quantitative data. Conducts a survey (using any instrument) to evaluate patient/family/caregiver experiences across at least three dimensions such as:
- Access.
- Communication.
- Coordination.
- Whole-person care, self-management support and comprehensiveness.
B. Qualitative data. Obtains feedback from patients/families/caregivers through qualitative means.
Patient Retention

- Outreach
  - How?
  - When?
- Tracking
- Relationship
- Patient engagement

Risk component of attributed members

Data are reliable
Clinical Quality

- Comprehensive diabetes management (2)
- BMI (adult & child)
- Asthma Rx management
- Immunization composite
- Antidepressant Rx management
- EPSDT (3)

Average cost of care ➤ Efficiency (% improvement) ➤ Maximum share of savings (25%) ➤ Efficiency + quality (0 – 100%) ➤ Member months

Clinical Quality

- Comp diab measure
- BMI (adult & child)
- Asthma Rx mgmt
- Immunization composite
- Antidepressant Rx mgmt
- EPSDT (3)

Diabetes UDS ➤ BMI UDS ➤ Asthma UDS ➤ Immunization UDS ➤ Depression UDS

QI 08 (Core): Sets goals and acts to improve upon at least three measures across at least three of the four categories:
A. Immunization measures.
B. Other preventive care measures.
C. Chronic or acute care clinical measures.
D. Behavioral health measures.
Clinical Quality

Data are reliable

Clinical Quality

Right data

Diabetes Compliance and Financial Class

- Medicaid
- Medicare/Dual Elig.
- Private Insurance
- Self-Pay
- Slide
- Not Collected

Average cost of care
Efficiency (% improvement)
Maximum share of savings (25%)
Efficiency + quality (0 – 100%)
Member months

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Clinical Quality

Patients who Reported Barriers to Receiving Colorectal Cancer Screenings (n=58)

- Average cost of care
- Efficiency (% improvement)
- Maximum share of savings (25%)
- Efficiency + quality (0 – 100%)
- Member months

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Clinical Quality

To RIGHT people

- Paper plan
- Care coordination tool

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Benefits Of Data & Data Stewardship

- FTCA
- Understanding community and how to treat (JG)
- Better outcomes for patients
- More accurate information
- More satisfied patients
- Pay for performance (sustainability)
- Benefit brainstorm – bottom up, not a lecture

Managing & Aligning Data

- Start with what is required
- Identify “twofers”
- Add additional data collected (thorough inquiry)
- What is duplicated?
- What has been vetted?
- What are your missed (analytical) opportunities?
The Data Really Are Wrong

- Large fluctuations
- Reports measuring “same thing” differ
- Denominator is high or low
- Nonsense in audits
- Out of sync, redundant data
- Relying on old data
- Culture of transparency

Solutions To Integrate Into Your Data Strategy

1. Large fluctuations: Run different report, examine differences
2. Reports measuring “same thing” differently: Check & balance process
3. Denominator is high or low: Displaying n’s
4. Nonsense in audits: Documentation guides
5. Out of sync, redundant data: Report oversight
6. Relying on old data: Report calendars
The Data Dictionary & Documentation Guide

Data are reliable

Data Validation

Reports & Audits: hiteqcenter.org

Overview

Validating data from Health IT systems is the cornerstone of effective Health IT-enabled QI. Ensuring that Health IT-generated reports and data reflect an accurate picture of the care and outcomes of your population ensures that data is reliable for quality improvement, reporting, as well as many other purposes. This validation must be ongoing as systems, providers, workflow, and other change, and all impacts accuracy of data. This webinar provides understanding, QI tips, and guidance for validating data.

Data Accuracy Resources

Data Report Audit Tool

An Excel Template for Increasing Accuracy

Search HITETQ Content

Find HITETQ resources

Need Assistance?

Would you like more assistance regarding Health IT enabled QI strategies or support finding any of the included resources here?

Request Support

Upcoming Events

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Staff Engagement: Dashboards

Staff Engagement: Contests

When in doubt...ask the staff!
Staff Engagement: Dashboards

- Dissemination
  - Who
  - What
  - Where
  - When
  - Why
  - How

- Calendar & report instructions

DATA ACTIVITY
Having Data isn’t Enough, It has to be Used to Communicate Results?

- Publicly
- Transparently
- Simply—one page
- Understandable—even to a novice
- Not anonymously
- Up to date

MOST IMPORTANTLY…it Stirs to Action

….not responding is the same as accepting results
Data Activity

- On your table you have sticky notes...
- Utilizing a sticky note for each data point and without discussing. Each of you write out the top seven data points you and your team use to do your job everyday... Your job with the goal of moving your health center forward.
- Place the stickies on the table and discuss overlap. Where are you in agreement? Where do you disagree about priorities? How do your different sticky notes translate into different messages to staff?

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How We Use Data In The Patient Centered Health Home

The Hub Of The Patient Centered Health Home

What Patients Want
Let me in
Give me the best
Figure me out & fix me
Care about me more than I do
Don’t waste my time

PCMH Standard: 1A
PCMH Standards: 2, 4, 5

PCMH Standards: 2B&D, 4B, 5C, 6D,

PCMH Standards: 2, 4, 5

PCMH Standards: 4 & 5
Let Me In! The Access System

What Patients Want

Just say “YES”

Website Health Info

Patient Portal

Access

Visits

Texting

Phone

Email

PCMH Standard: 1A

“Don’t Waste My Time!”

What Patients Want

Don’t waste my time

Be on time

Orchestrate & synchronize

Teamwork

Same day appoints

Warm handoffs only

Multiple, integrated services per visit

PCMH Standards: 2B&D, 4B, 5C, 6D,
What Data Do You Use To Measure Patient Satisfaction?

- Look at Patient Satisfiers:
  - Access
  - Timeliness
  - Quality
  - Continuity

Words Of Wisdom

“Sometimes what counts can’t be counted, and what can be counted, doesn’t count.”

- Albert Einstein
How Does Your Culture Reflect Patient Centric Care?

- Do patients know you are medical home?
- Can they tell?
- Have they had a different experience?
- Are they healthier?

Now for the Tough Questions….

- What happens when a patient shows up late?
- What happens when a staff member shows up late?
- What happens when a manager shows up late?
- What happens when a doctor shows up late?
12. Identifying High Utilizers

The High Utilizer

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Efficiency

- Percent improvement
  - 0 – 20%
  - Average of 5 categories
- Stars
  - 0-5, 10% each
- Care coordination, proactive management, integrated, access

Efficiency

- All-cause hospital readmissions rate per 1,000 member months
- Avoidable ED visits per 1,000 member months
- Ambulatory care - ED visits per 1,000 member months
- Inpatient admissions per 1,000 member months – Total inpatient
- Mental health utilization per 1,000 member months - Inpatient
What Data Do You Need?

- External:
  - Claims
  - ADT
  - Hospital data sharing
- Internal:
  - TNAA
  - Self-reports hospitalization
  - At risk patients
  - Hospital discharge documents

Efficiency for VBP

- All-cause hospital readmissions rate per 1,000 member months
- Avoidable ED visits per 1,000 member months
- Ambulatory care - ED visits per 1,000 member months
- A inpatient admissions per 1,000 member months – Total inpatient
- Mental health utilization per 1,000 member months - Inpatient

QI09 (Core) Set goals & act to improve on at least one measure of resource stewardship (care coordination or health care costs)
Understanding Patient’s Primary Risk Factors

- Genetic conditions
- Risk factors and risky behavior
- Comorbidities
- Previous admissions
- SDH

Addressing Risk Factors With Patients

- Actionable reports at patient level
- What is the main barrier?
  - Rx adherence; safe, effective, and appropriate
  - Mental health
  - Health literacy
  - SDH
  - Lack of care coordination
- Assign a go to person
Addressing Risk Factors At Practice Level

- Data – dashboards and pertinent stratification
- Consistent, structured meetings and/or peer review
  - Including community partners
- Success stories – they are not just to make us feel good
- Journal club, project ECHO, focus on rare or new conditions

QI 05 (1 Credit): Assesses health disparities using performance data stratified for vulnerable populations (must choose one from each section):
A. Clinical quality.
B. Patient experience.

It Takes A Community

Don’t give up!!
HIGH UTILIZATION ACTIVITY

13. Care Coordination
Show Of Hands!

Before Care Coordination

- Case Management Outreach
- DME Coordinator
- Perinatal Staff
- Call Center
- Automated Reminder Calls
- Outside Agencies
- Referral Coordinators
- Care Management Outreach
Opportunities For Relationship Building

- Appointment confirmations
- Outreach for needed appointments, such as chronic care visits, immunizations, and preventive care
- New patients assigned by insurances
- Follow up from Outreach Events

Three Places to Start

1. Communication
2. Identifying Areas of Low Hanging Fruit
3. Care coordination is not a new department, it's a new approach to all patient care
Communication

- Communication with other venues.
  - ED is a great place to start because patients often come in to see us after this care is complete. And, payors are happy to work with us to reduce this expense and these “unnecessary visits.”
  - We have different EMRs and each “place” of care has its own challenges. Establishing relationships and coordination digitally is absolutely necessary. Where’s your next place to connect?

One Example From Adrienne
You Have To Start Somewhere

- Use the information managed care companies send you about utilization
- Connect with the Utilization Management division of one of your major insurances
- Call your neighboring hospital
Identify Your Area(s) To Start

- Diagnosis / Disease – (a model from Michigan) pediatric asthmatics, prenatal, adults with hypertension
- Demographic – children, prenatal
- Payor – managed care group
- Grant identified group – HIV+ patients, patients with food insecurities

Getting Started

- Get clear about your Starting Group
- Determine educational needs
- Look at your staffing and determine who can do these tasks
- Establish a process
- Communication out to patients (visit preparation, Robust Confirmation Calls, Referral follow up, text, home visits)
- Communication in from patients (portal, social media, events,
The Results

![Graph showing successful care management and outreach over time.]

The Results

![Graph showing confirmed appointments over time.]

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Care Coordinators vs. Care Coordination

- Consider care coordination as a more holistic approach to health care.
- Assembly line versus artisan creations.
- Since 1993, when *The Discipline of Teams* (Smith and Katzenbach) came out by Harvard Business Review. Coleman has been teaching that we need to create broader work roles... one person can do more for the patient.
- It leads to better job satisfaction of current staff to be more engaged in the patient.
**Who Does Care Coordination?**

- Everyone… call center
- Referrals
- MAs can ask questions when they do Visit Preparation, when they do Robust Confirmation Calls and when they do Robust Vitaling
- Care Coordination can be done by nurses tied to the team. They bring up about patients in the huddle and they talk about who is in the hospital, who went to the ED and who we have NOT heard from recently.

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**Final Planning Activity**

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