Listening Session 1: *Best Practices for Measuring Quality and Outcomes Related to Caring for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models*

Presenters:

Subject Matter Experts

- **Brynn Bowman, MPA** – Chief Executive Officer, Center to Advance Palliative Care
- **Paul Mulhausen, MD, MHS** – Chief Medical Director, Iowa Total Care, a Centene health plan
- **Caroline Blaum, MD, MS** – Assistant Vice President, National Committee for Quality Assurance
- **David Kendrick, MD, MPH** – Chief Executive Officer, MyHealth Access Network

Listening Session 1: Best Practices for Measuring Quality and Outcomes Related to Caring for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models

Brynn Bowman, MPA

Chief Executive Officer, Center to Advance Palliative Care

Measuring Quality of Care for Patients During the Last Year of Life

Brynn Bowman
Chief Executive Officer
Center to Advance Palliative Care
June 10, 2024

Center to Advance Palliative Care™

capc

Defining the population

"Serious illness" is a health condition that carries a high risk of mortality AND either:

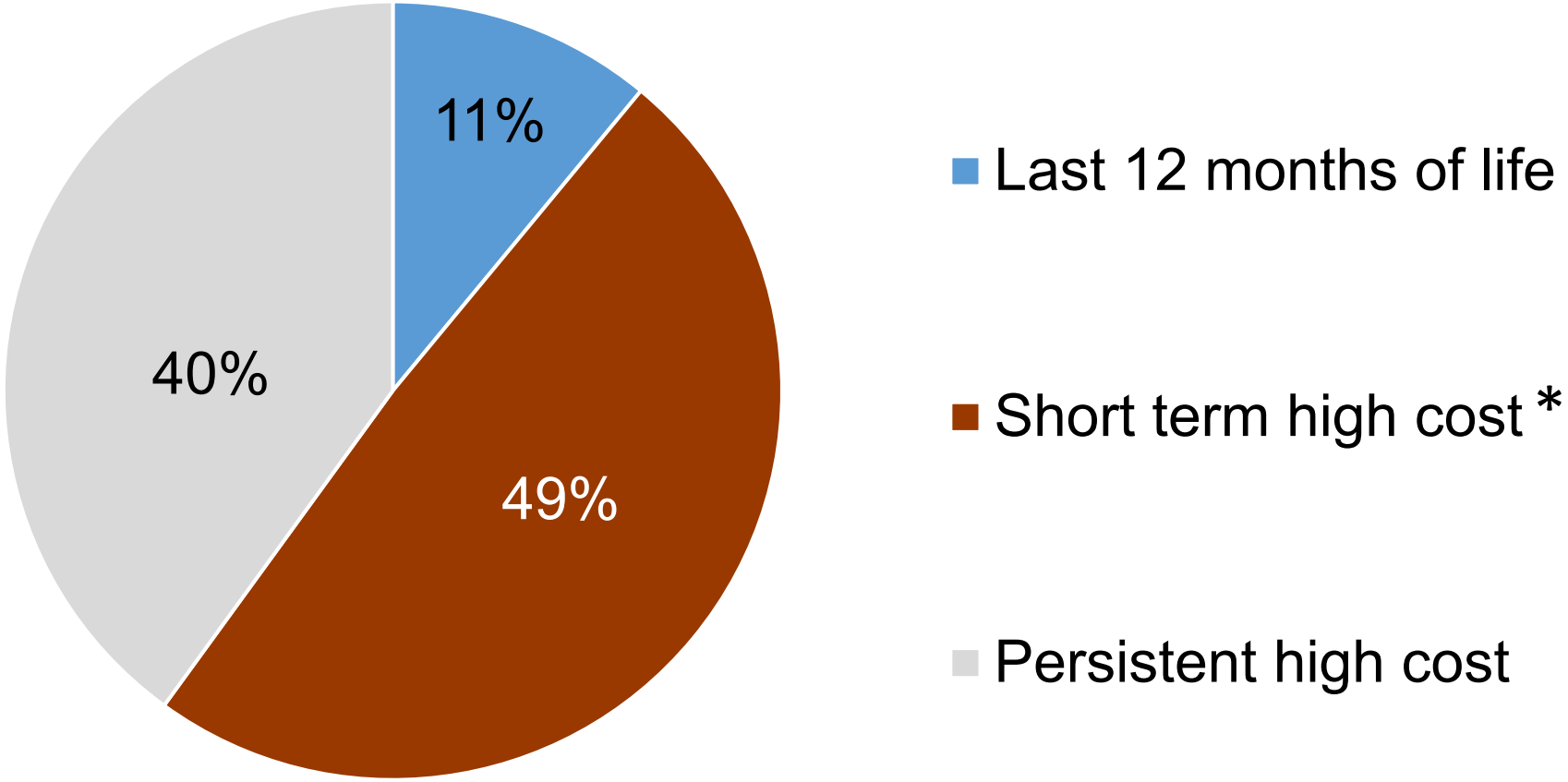
- Negatively impacts a person's daily function or quality of life

  OR

- Excessively strains their caregivers

Kelley AS, Bollens-Lund E. Identifying the Population with Serious Illness: The "Denominator" Challenge. J Palliat Med. 2018 Mar;21(S2):S7-S16. doi: 10.1089/jpm.2017.0548. Epub 2017 Nov 10. PMID: 29125784; PMCID: PMC5756466.

Serious Illness, Utilization Patterns, and Health Care Costs



Source: Institute of Medicine, *Dying in America*, 2015

capc Center to Advance Palliative Care™

*Short term high cost defined as “a discrete high-cost event in one year but who return to normal health and lower costs”

Palliative Care Improves Value

Hospital Palliative Care	Home-Based Palliative Care
• Improves patient & family satisfaction • Reduces readmissions, ICU utilization, length of stay, cost per day	• Saves up to $12k per enrollee to plans and ACOs • Reduces ED visits, admissions, readmissions, and hospital LOS

What can we learn from this about what is important to measure?

capc Center to Advance Palliative Care™

Sources: https://www.capc.org/the-case-for-palliative-care/

Palliative Care: Reducing Suffering, Reducing Costs

"Beneficial **at any stage of a serious illness**, palliative care is an interdisciplinary care delivery system designed to anticipate, prevent, and manage physical, psychological, social, and spiritual suffering to **optimize quality of life** for patients, their families and caregivers. Palliative care can be delivered in any care setting through the collaboration of many types of care providers. Through **early integration** into the care plan of seriously ill people, palliative care improves quality of life for both the patient and the family."

(National Consensus Project for Quality Palliative Care, 4th edition, 2018)

Quality Measurement Considerations for Patients with Serious Illness or Complex Chronic Conditions

- → We do not prognosticate accurately – and the majority of high-cost patients are not at the end of life
- → Need QMs applied across the trajectory of an illness
- → Few validated measures for this population

Recommended Quality Measures

“Feeling Heard & Understood” and “Experience of Receiving Desired Help for Pain”

- Developed by the American Academy of Hospice and Palliative Medicine and RAND, validated in outpatient palliative care population
- Patient-reported outcome performance measures (PRO-PMs)
- Endorsed by the National Quality Forum in 2021
- Not yet implemented in Medicare programs

Targeting Quality Measures at Existing Disparities

- Black patients and caregivers report poor-quality clinician relationships and communication
- Black and Hispanic patients receive poorer-quality pain management than White patients

Lee P, Le Saux M, Siegel R, Goyal M, Chen C, Ma Y, Meltzer AC. Racial and ethnic disparities in the management of acute pain in US emergency departments: Meta-analysis and systematic review. Am J Emerg Med. 2019 Sep;37(9):1770-1777. doi: 10.1016/j.ajem.2019.06.014.

Applying Hospice CAHPS Quality Measures to a Broader Population

Rationale

Validated measures that speak to the quality of communication, coordination/timeliness of care are important for a patient population that experiences crises and exacerbations

Items

- How often did you get the help you needed from the [hospice] team during evenings, weekends, or holidays?
- Did the [hospice] team give the training needed about [symptom management]?

https://hospicecahpssurvey.org/globalassets/hospice-cahps4/home-page/cahps_hospice_survey_fact_sheet_january-2024.pdf

ACO REACH QMs:

- Claims-based measures
- Risk-standardized, all-condition readmission
- All-cause unplanned admissions for patients with MCCs
- Days at home for complex, chronic patients (high needs ACOs)
- Timely follow-up after acute exacerbations (standard/new ACOs)
- CAHPS survey

ACO REACH CAHPS domains:

- **Getting timely care**
- **Communication**
- **Shared decision-making**
- How the patient rates the provider
- Care coordination
- Courteous/helpful office staff
- Health promotion and education
- Stewardship of beneficiary resources
- Access to specialists
- Activities of daily living

Need to apply quality measures specific to the population with complex chronic conditions or serious illness.

capc Center to Advance Palliative Care™

https://info.pressganey.com/press-ganey-blog-healthcare-experience-insights/guide-to-the-aco-reach-cahps-survey

Limitations of Claims-Based Measures: A Key Challenge for this Population

Cannot capture major drivers of utilization:

→ Food/housing insecurity

→ Cognitive impairment

→ Ill-equipped caregiver

→ Unsafe home

→ Health education needs

To know whether these needs are being identified and addressed, we have to ask – it's worth the cost.

capc Center to Advance Palliative Care™

Listening Session 1: Best Practices for Measuring Quality and Outcomes Related to Caring for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models

Paul Mulhausen, MD, MHS

Chief Medical Director, Iowa Total Care, a Centene health plan

Patient Reported Outcomes: Opportunities for Complex Populations

Paul Mulhausen, MD, MHS, FACP, AGSF
Chief Medical Officer
Iowa Total Care
June 10, 2024

Disclosure

I am a medical director for a health plan in Iowa.

I am speaking as a geriatrician and my views should not be construed as the formal position of my employer.

Why Patient Reported Outcomes?

- They amplify the voice of the patient in the assessment of value.
- They help stakeholders move beyond process measures.
- They promote patient-centeredness in care and performance measurement.

The Language of Patient-Reported Outcome

- Patient Reported Outcomes: an outcome reported by the patient.
  - “I feel depressed.”
- Patient Reported Outcome Measure (PROM): a method by which the reported outcome can be collected into a single-item measure.
  - “Scores 13 on the Patient Health Questionnaire – 9 (PHQ-9)”
- Patient Reported Outcome – Performance Measure (PRO-PM): an aggregate of the patient information into a valid and reliable measurement of performance.
  - “Percent of patients with major depression disorder and PHQ-9 score > 9 scoring < 5 after six months of treatment. “ (NQF 0711)

The Language of Population Complexity: The Five Ms

- **Multicomplexity:** multiple conditions, multiple providers, multiple locations of service, multiple caregivers, multiple medications.
- **Mobility:** maintaining balance, ability to walk, and avoid falls.
- **Medications:** adverse drug effects are amplified and drug interactions compound multicomplexity.
- **Mind:** maintaining mental activity, manage cognitive loss, managing mood disorders.
- **Matters Most:** person-centered goals of care; treatment plans that reflect goals of care.

Domains of Patient Reported Outcomes

- Health-Related Quality of Life
- Functional Status
- Symptoms and Symptom Burden
- Health Behaviors
- Motivation and Activation
- Patient Experience and Satisfaction (PREMs)

Inventory of PRO-PMs

- HealthMeasures: 615 Measures in English Language
- NQF: 52 Measures (30 endorsed by NQF)
- CMS Measures Inventory Tool (CMIT): 57 Measures (23 CBE Endorsed)
- Public Access FOTO measures (MIPS participants): 11
- Partnership for Quality Measurement: 56 Measures (31 CBE Endorsed)

PRO-PMs Opportunities in Total Cost of Care

- Reliable and Valid PRO-PMs that cut across Domains and Conditions may promote accountability in Total Cost of Care payment models.
- Cross-Cutting PRO-PMs may address both quality and accountability needs in complex populations with serious illness.
- PRO-PMs that capture the performance of care coordination across comorbid disease states and providers may be uniquely valuable.
- Total Cost of Care Model demonstrations create opportunities for measure development and translational research that ensures reliability, validity, acceptance, feasibility, and alignment across payers.

Barriers to PROM in Complex Populations

- Most PRO-PMs remain disease and episode specific
- Repeated Assessment for long term conditions
- Heterogeneity of measurement
    - Data source: patient vs. proxy
    - Mode of Collection: self-administration, survey
    - Method of Collection: paper and pencil, phone, digital platform
- Heterogeneity of engagement
    - Sensory changes
    - Cognitive loss
    - Health Literacy and Digital Dexterity
    - Disease Burden

Summary

- PRO-PMs present a high value opportunity to bring the voice of the patient into the accountability and the quality needs of Total Cost of Care payment models.
- Most PRO-PMs are disease based or based on episodes of care and may not be valid or reliable performance measures in medically complex populations.
- Opportunities exist for measure developers and payers to develop cross-cutting PRO-PMs that more effectively meet the accountability and quality improvement needs of seriously ill, medically-complex populations.

Listening Session 1: Best Practices for Measuring Quality and Outcomes Related to Caring for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models

Caroline Blaum, MD, MS
Assistant Vice President
National Committee for Quality Assurance

Developing and Standardizing Health Equity Measures for Patients with Complex Chronic Conditions or Serious Illness

Caroline Blaum, MD, MS
Assistant Vice President
National Committee for Quality Assurance (NCQA)
June 10, 2024

Agenda

CURRENT STATE: MEASURES IN USE

NCQA APPROACH

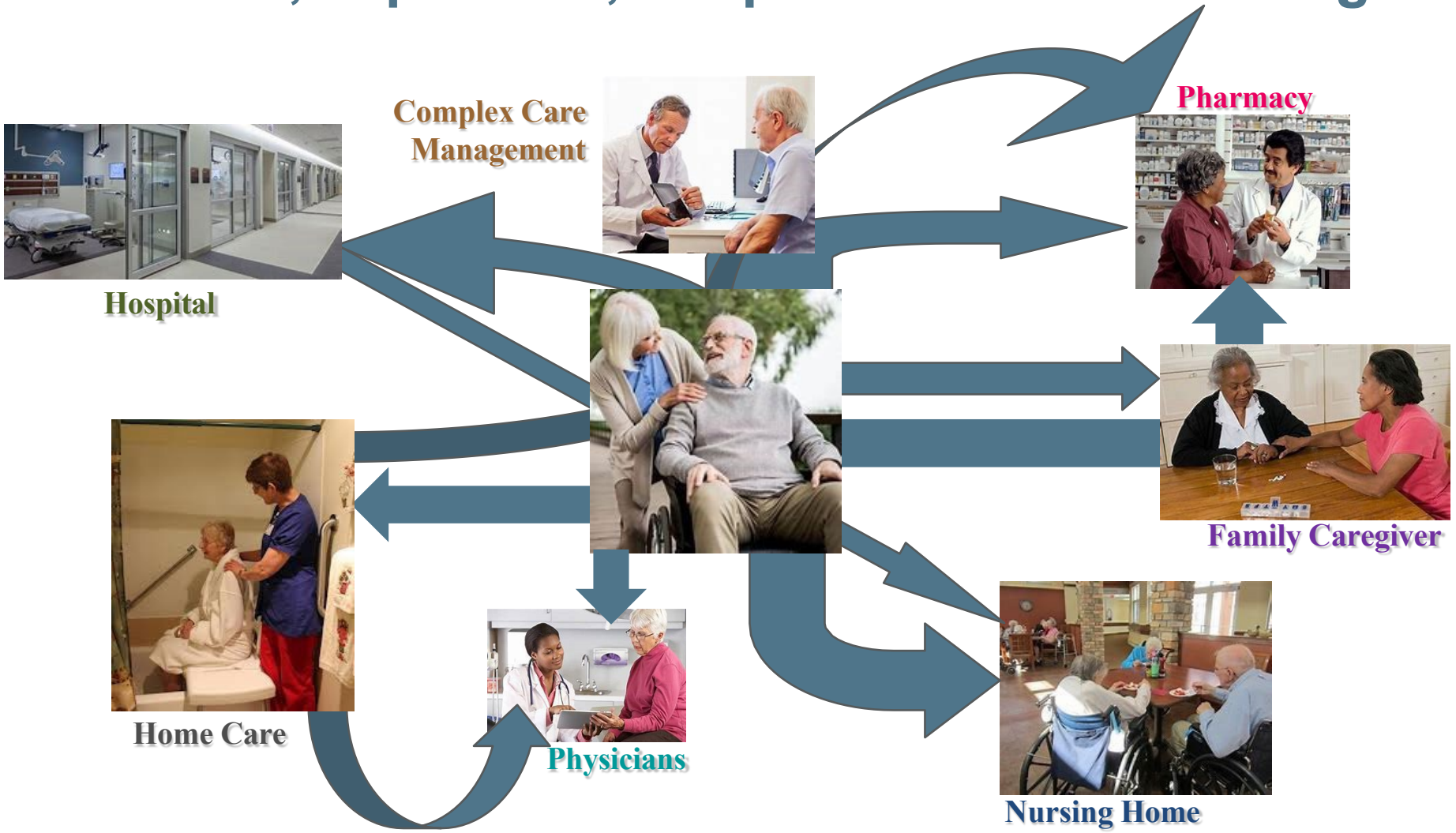
FUTURE MEASURES

USE CASE: PERSON-CENTERED OUTCOME MEASURES

BEST PRACTICES

Dr. Blaum has no disclosures.

Complex patients experience fragmented care that is often burdensome, expensive, inequitable and even dangerous



Care for seniors with complex health status is not based on evidence

- Major trials are disease specific and evaluate disease specific outcomes
  - People with multimorbidity, disability, or frailty are not usually in trials
  - Trials have minimal information on adverse events
  - Some areas (BH[1], SUD[2]) are poorly covered
- Need new and different evidence
  - Treatment effects on common goals (function, symptoms, survival) for persons with multimorbidity/frailty or serious illness
- Need to consider trade-offs, uncertainty, trajectory and complexity
- Need to infuse Equity throughout, using community engagement and best practices

[1] BH – Behavioral Health
[2] SUD – Substance Use Disorder

In order to provide quality care for complex patients, we need to keep three perspectives in mind – 1) Person, 2) Provider, 3) Payer

Current Measures:

- Often **not relevant** for or exclude complex patients
- Sometimes cover important activities but **can feel like "box checking"**
- **Don't clearly foster integration** of personal and medical care

Future measures need to…

- Address **equity** and **"what matters most"** to the person
- **Improve communication** between providers and with people and their families
- **Can be flexible and usable in many clinical settings** with different people and different clinician types, improving care integration

Populations with chronic conditions and/or serious illness

*Measure Types: How does **equity** fit in?*

Patient Populations	Process/Structure Measures	Outcome Measures:
• Multiple chronic conditions • Frail • Behavioral Health • Substance Use Disorder • Disabled • SOGI[3] • Socioeconomic challenges • End of Life	• Population Health – immunizations/screening • Structural/Operational • Effectiveness of Care • Patient Safety • Behavioral Health • Substance Use • Care Coordination • Social Needs • Social Connection	• Intermediate outcomes • Utilization – risk adjusted • Patient reported information • Patient reported outcomes • Patient engagement • Patient experience • Patient goal achievement • Burden – patient/ caregiver

[3] SOGI – Sexual Orientation and Gender Identity

Quality Care is Equitable Care

NCQA Approach

Existing measures

- Stratification by race, ethnicity and sociodemographic
- Inclusion of sexual orientation and gender identity (SOGI) – for relevant measures

New measures: Patient generated information, incorporating the patient voice

- Social Needs Screening; Social connection
- Patient experience; Patient-reported outcome
- Patient goals → Current care planning and advance care planning

Patient partners and patient/care partner engagement throughout measure development

Community engagement – lived experience and experts

Learning communities and collaboratives

Race & Ethnicity Stratification – Goals

Overall goal of this work:

Bring transparency to inequities in health care quality by race and ethnicity and **incentivize equity** with benchmarks and performance scoring.

What has been done so far:

22 HEDIS measures stratified

Learning Network with health plans on collection and reporting of race and ethnicity data and sources to access those data

Race & Ethnicity Stratification – Learning Network

Pairing Quantitative and Qualitative Insights

Quantitative

Plans submitted population-level HEDIS data on measures stratified by R/E in MY2022

First look at performance in real-world settings.

Evaluate what patterns we might expect, inform questions we ask in first year analysis and in future maintenance.

**11 plans submitted data*

Qualitative

Plans interviewed with NCQA Equity in HEDIS Team to share insights

Gain an understanding of how plans are integrating the stratification into their work.

Learn about challenges and successes with the data, and how different organizations use it to inform quality improvement efforts.

**13 plans participated in interviews*

Social Need Screening and Intervention (SNS-E)

Measure Specification

Measure Description

The percentage of members who, during the measurement period, were screened at least once for unmet food, housing and transportation needs using a pre-specified screening instrument and, if screened positive, received a corresponding intervention.

Product Lines

Commercial, Medicaid, Medicare

Data Source

Electronic Clinical Data Systems

Exclusions

Hospice

I-SNP[4]

LTI[5]

Age Stratification

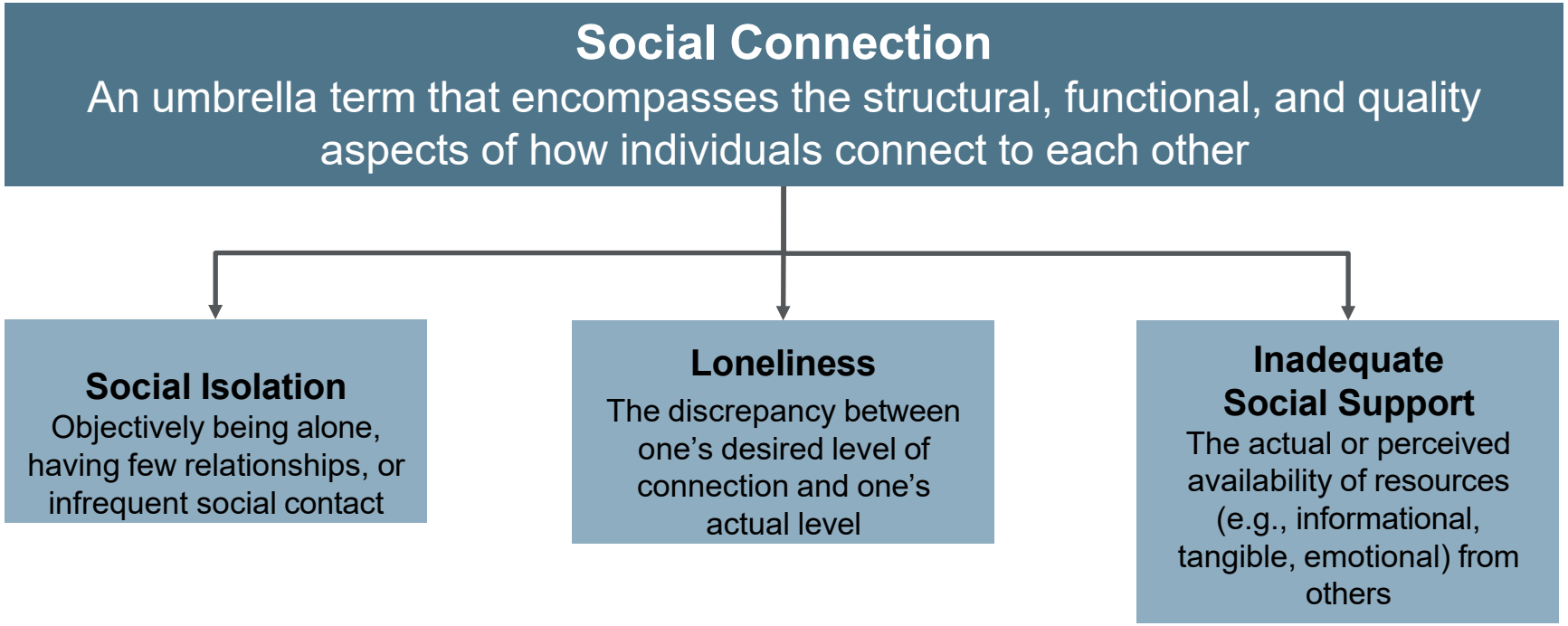
- ≤17
- 18-64
- 65+

[4] I-SNP – Institutional Special Needs Plan

[5] LTI – Long Term Institutional

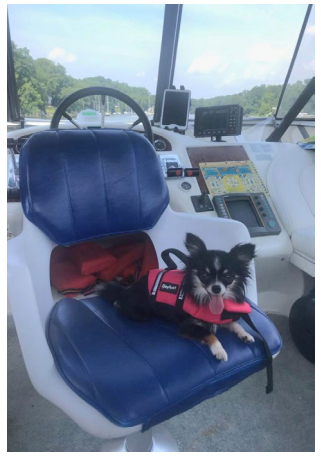
Social Connection

Evidence emerging



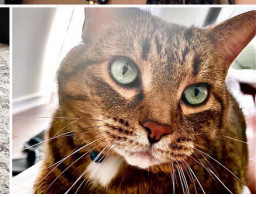
Measure will capture social connection screening and interventions for initial population.

What matters most?








Promoting health equity through measuring what matters most

Organizing a healthcare system around what matters to people, their families and their community

- For **individuals with complex care needs,** care should align with what matters to them, their health outcome goals
- **Measurement can be used to drive care that matters** and encourage clinicians to deliver care aligned with health outcome goals
- For quality measures, health outcome **goals must be measured and tracked in a standardized way**

Person-Centered Outcomes (PCO) Measures

Initial Population
Individuals 18+ years of age with a complex care need

Exclusions
Hospice
Long Term Care (institutional)
Died during measurement year

Reporting Method
Electronic Clinical Data Systems (ECDS)

Data Source
Administrative claims, EHR, case management, HIE

Measure Description

Measure 1 - Goal Identification: % of individuals 18 years of age and older with a complex care need who had a PCO goal identified resulting in completion of goal attainment scaling (GAS) or a Patient-Reported Outcome Measure (PROM) and development of an action plan.

Measure 2 - Goal Follow-up: % of individuals 18 years of age or older with a complex care need who received follow-up on their PCO goal within two weeks to six months of when the PCO goal and GAS or PROM were identified.

Measure 3 - Goal Achievement: % of individuals 18 years of age or older with a complex care need who achieved their PCO goal within two weeks to six months of when the PCO goal and GAS or PROM were identified.

2021 – 2024 Testing Efforts

Funded by The John A. Hartford Foundation and The SCAN Foundation

2018-2020 Testing	
Site Descriptions • Medicaid Case Management • Traditional Case Management • Geriatric and Serious Illness Programs	1300+ Individuals 100+ Clinicians 13 Sites
Clinician Types: RN, NP, SW, MD, Peer Navigator, Care Manager	
Location: California, Kansas, Maryland, Michigan, New York, North Carolina, Ohio, Oregon, Texas, Washington, Wisconsin	

2021-2024 Testing	
Site Descriptions • Area Agencies on Aging • Care Coordination Organization • Certified Community Behavioral Health Clinics • Home Based Primary Care	5000+ Individuals 180+ Clinicians 17 Sites
Clinician Types: RN, NP, SW, MD, Community Health Worker, Peer Navigator, Care Manager, Qualified Mental Health Professional, Counselors, Licensed Therapists	
Location: Arizona, California, New Jersey, Ohio, Tennessee, Texas	

Person-Centered Outcome Measures & Health Equity

High-quality care is equitable care.

***Investigate*:**

- Analysis of measure data included **comparison of race, ethnicity, preferred language, social needs, and payer.**
- This helped NCQA understand how these measures **impact different populations** and **if these measures would benefit from measure stratification.**

Identify:

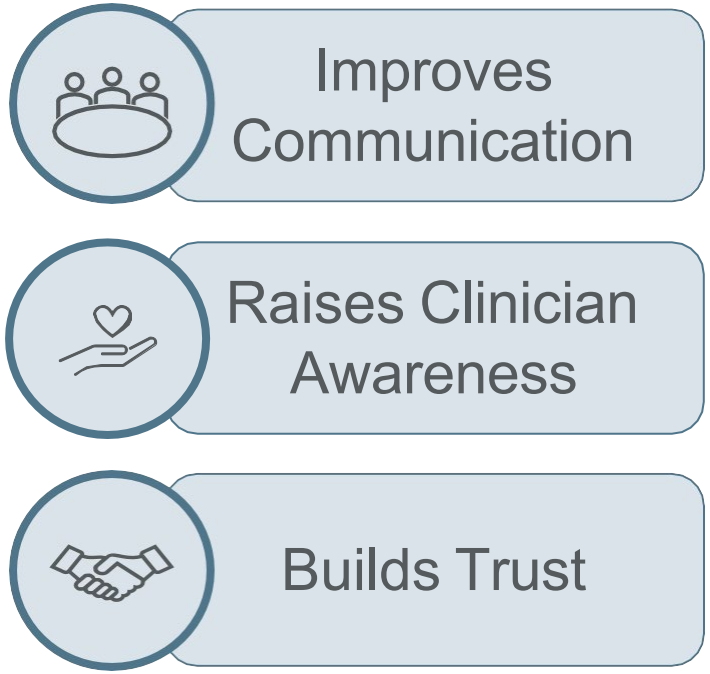
- Specific efforts were made during learning collaborative recruitment to **engage organizations serving diverse populations**. NCQA provided coordinated technical assistance and resources that addressed measurement, clinical workflow and clinical decision-making in diverse populations.
- To ensure patient-facing materials resonate with diverse populations, **measure resources are available in 7 languages** (Arabic, Chinese – Simplified and Traditional, English, Russian, Spanish, and Vietnamese) and Patient Partners reviewed all materials (including goal inventories) for clarity, direction, and appropriateness for use with patients and care partners.

Elevate:

- NCQA developed and disseminated messages about the measures **using information, data and stories that resonate with, and demonstrate value for, diverse populations and viewpoints**.
- **Patient partners and expert panels** that included people with lived experience and community partners as well as experts and other stakeholders were involved at all stages of measure development and testing.

What we've learned from testing

Qualitative Results



Quantitative Results

For a sub-group, we found 6-months post-intervention:

- Significant decrease in hospitalizations
- Non-significant decrease in ED use
- Improved patient experiences concerning care planning and patient activation

Best Practices

Consider all areas of social demographic risk and location to better target inequities

Race/Ethnicity stratification is important but only a component

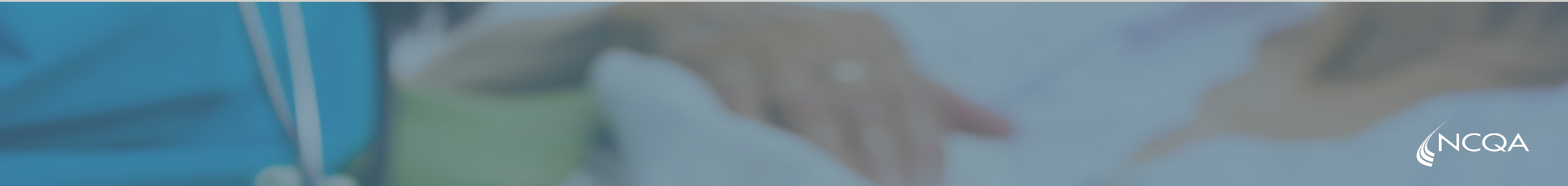
Link equity to whole person / person-centered care, and identify barriers to health and quality of life

Take perspectives not just from the healthcare industry but also our patients, families and communities

Think deeply about our process of measurement

- Do no harm and remove privilege from the process
- Have people at the focus of our work and not payment

Appendix



Portfolio of Stratified Measures: Measurement Year 2024

Domain	Measure
Prevention and Screening	Prenatal Immunization Status
	Childhood Immunization Status
	Immunizations for Adolescents
	Adult Immunization Status
	Breast Cancer Screening
	Cervical Cancer Screening
	Colorectal Cancer Screening
Behavioral Health	Initiation and Engagement of Substance Use Disorder Treatment
	Follow-Up After Hospitalization for Mental Illness
	Follow-Up After Emergency Department Visit for Mental Illness
	Follow-Up After Emergency Department Visit for Substance Use
	Pharmacotherapy for Opioid Use Disorder
	Prenatal Depression Screening and Follow-Up
	Postpartum Depression Screening and Follow-Up
Chronic Conditions	Asthma Medication Ratio
	Controlling High Blood Pressure
	Glycemic Status Assessment for Patients With Diabetes
	Eye Exam for Patients With Diabetes
	Kidney Health Evaluation for Patients With Diabetes
Perinatal and Well Visits	Prenatal and Postpartum Care
	Child and Adolescent Well Care Visits
	Well-Child Visits in the First 30 Months of Life

Geriatric Measures: Overview

Measures for people with complex health status. Varying sophistication

SNPs and What Matters

- Care of the Aged (COA)
- Advance Care Planning (ACP)
- Person Centered Outcome Measures (PCO Measures

Medications

- Use of high-risk medications in the elderly
- Potentially harmful drug-disease interactions in older adults
- Medication reconciliation post discharge
- Hypoglycemia leading to ED visit
- Deprescribing of benzodiazepines in older adults

Mentation

- Screening for depression and follow-up
- Depression remission at 12 months
- Follow-up after ED visit for mental illness
- Use of PHQ-9 to monitor depression symptoms

Health Outcomes Survey

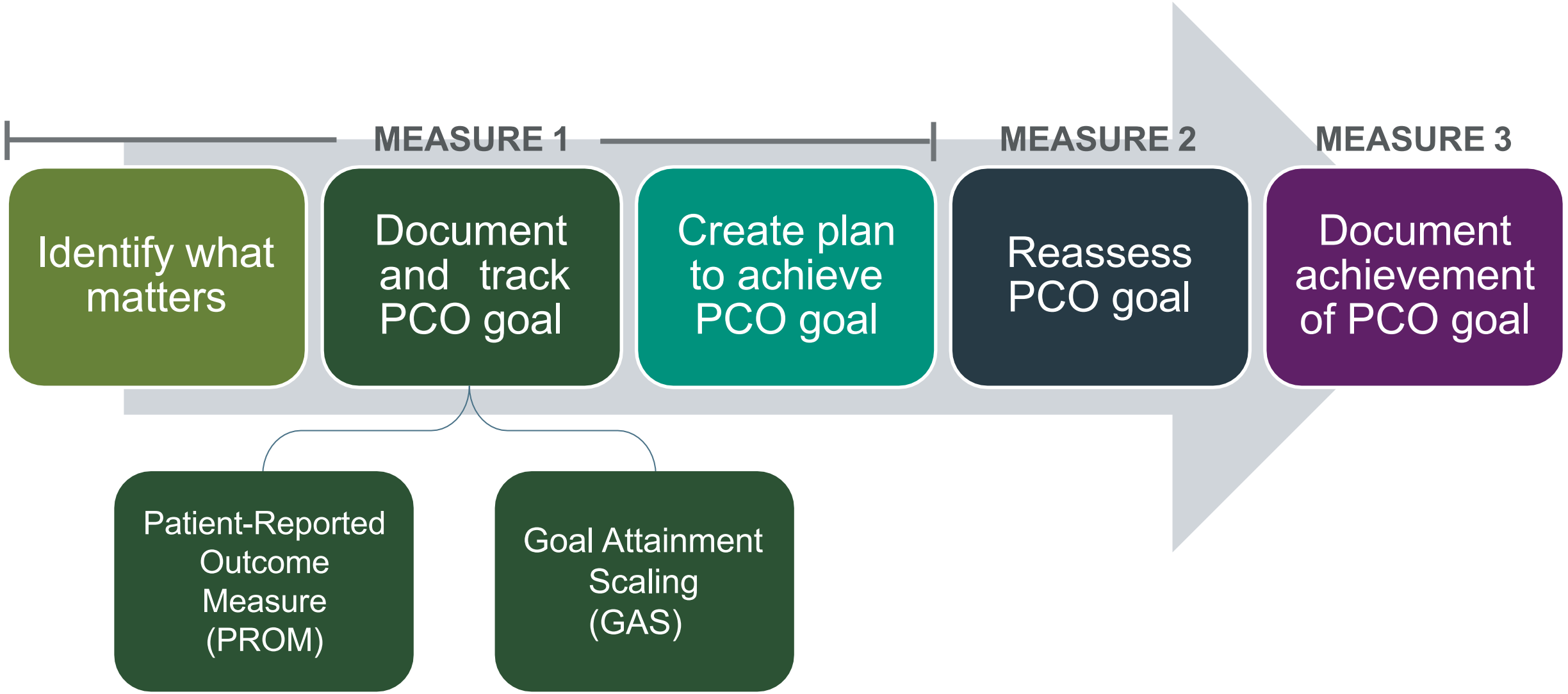
- Fall risk management
- Physical activity in older adults
- Urinary incontinence
- Improving or maintaining mental health
- Improving or maintaining physical health

Outcomes / Utilization

- All-cause readmissions
- Hospitalization after discharge from SNF
- Follow-up after ED visit for multiple chronic conditions
- Transitions of care

Person-Centered Outcomes Approach

Measuring what individuals say matters most to them



Goal Attainment Scaling

Example: 82-year-old person with mobility problem, depression, history of arthritis and heart failure

Goal: Walk her dog outside once a week for the next 2 months.

Worse (-2)	Current State (-1)	Realistic Goal (0)	Stretch Goal (+1)	Super Stretch Goal (+2)
Unable to let the dog outside.	Does not go outside to walk her dog	Walk her dog outside once a week for the next 2 months.	Walk her dog outside twice a week for the next 2 months.	Walk her dog outside three times a week for the next 2 months.

What could be worse | **Current State** | **Where they want to be**

Patient-Reported Outcome Measures (PROMs)

Selecting the best PROM to fit the goal

Examples		
Participant Goal	**PROM Selected to Measure Progress**	**Reason PROM Chosen**
Match PROM to goal topic		
Walk around the block 2 times per week	PROMIS Physical Function	PROM related to goal
Take medication regularly	PROMIS Self-Efficacy to Manage Medications/Treatment	Individual does not take daily medications regularly causing health condition to worsen
Match PROM to barrier		
Go out with friends 2 times per month	GAD-7	Individual has anxiety which is causing them to stay home
Be able to live at home	PROMIS Self-Efficacy to Manage Daily Symptoms	Individual has difficulty managing everyday activities
Apply to 5 jobs in the next 2 months.	PHQ-9	Individual is depressed, which has stopped them from looking for a job

Learning Collaborative Demographic Data

Primary Care/Long-Term Services and Supports (LTSS)

N=2,651

- Average Age = 65 years old
- Majority female (68.3%)
- **Majority of individuals either had Medicaid (50.7%) or were Dual Eligible (35.1%)**
- **49.8% of individuals were Black or another minority with 45.5% being White**
- 88% were not Hispanic, with 72.6% noting English as their preferred language
- Majority of individuals did not identify a social determinant of health need

Behavioral Health – Certified Community Behavioral Health Clinics

N=5,872

- Average Age = 41 years old
- Majority female (52.4%)
- **Majority of individuals were either uninsured (39.9%) or had Medicaid (34.9%)**
- **65.7% individuals who participated were White**
- **39.9% were Hispanic,** with 91% noting English as their preferred language
- Majority of individuals did not identify a social determinant of health need

PCO Measure Performance

Measure 1: Goal Identification

Measure 2: Goal Follow-up

Measure 3: Goal Achievement

	Primary Care/LTSS (N=5 sites)			Behavioral Health (N=8 sites)		
	Measure 1	Measure 2	Measure 3	Measure 1	Measure 2	Measure 3
Mean	51.8%	31.0%	13.9%	76.1%	13.2%	4.2%
Min	18.1%	11.8%	4.6%	6.9%	0.0%	0.0%
Median	40.1%	20.0%	9.7%	99.9%	9.7%	1.9%
Max	86.7%	60.6%	35.7%	100.0%	47.9%	12.1%

Measure Performance Stratification

Race, Ethnicity and Preferred Language

	Primary Care/LTSS			
	n	Measure 1	Measure 2	Measure 3
Race				
White	1205	64.8%	40.3%	23.9%
Black or African American	757	57.1%	29.7%	17.8%
Asian	331	29.6%	14.0%	8.4%
American Indian or Alaska Native	0	-	-	-
Native Hawaiian or Other Pacific Islander	0	-	-	-
Some Other Race	171	37.3%	17.3%	8%
Two or More Races	61	23.1%	11.5%	1.9%
Ethnicity				
Hispanic or Latino	216	27.4%	16.1%	5.6%
Not Hispanic or Latino	2338	55.6%	31.4%	18.1%
Preferred Language				
English	1925	65.6%	37.2%	19.8%
Spanish	107	31.3%	17.9%	10.4%
Other	530	34.5%	19.3%	14.0%

Listening Session 1: Best Practices for Measuring Quality and Outcomes Related to Caring for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models

David Kendrick, MD, MPH

Chief Executive Officer, MyHealth Access Network

Quality and Outcomes Achievement in Complex Conditions and Serious Illness

Technology, Data, and Continuous Improvement

David C. Kendrick, MD, MPH

MyHealth ACCESS NETWORK

Disclosures

David C. Kendrick, MD, MPH

- CEO, MyHealth Access Network
  - Oklahoma's Statewide Health Information Exchange
- Chair, Department of Informatics, OU School of Community Medicine
- Assistant Provost for Strategic Planning, OU Health Sciences Center
- Founder of MedUnison, LLC and developer of Doc2Doc
- Immediate Past Chair, Board of National Committee for Quality Assurance
- Board, CIVITAS Networks for Health
- Board, Patient Centered Data Home, nationwide interoperability model

MyHealth ACCESS NETWORK

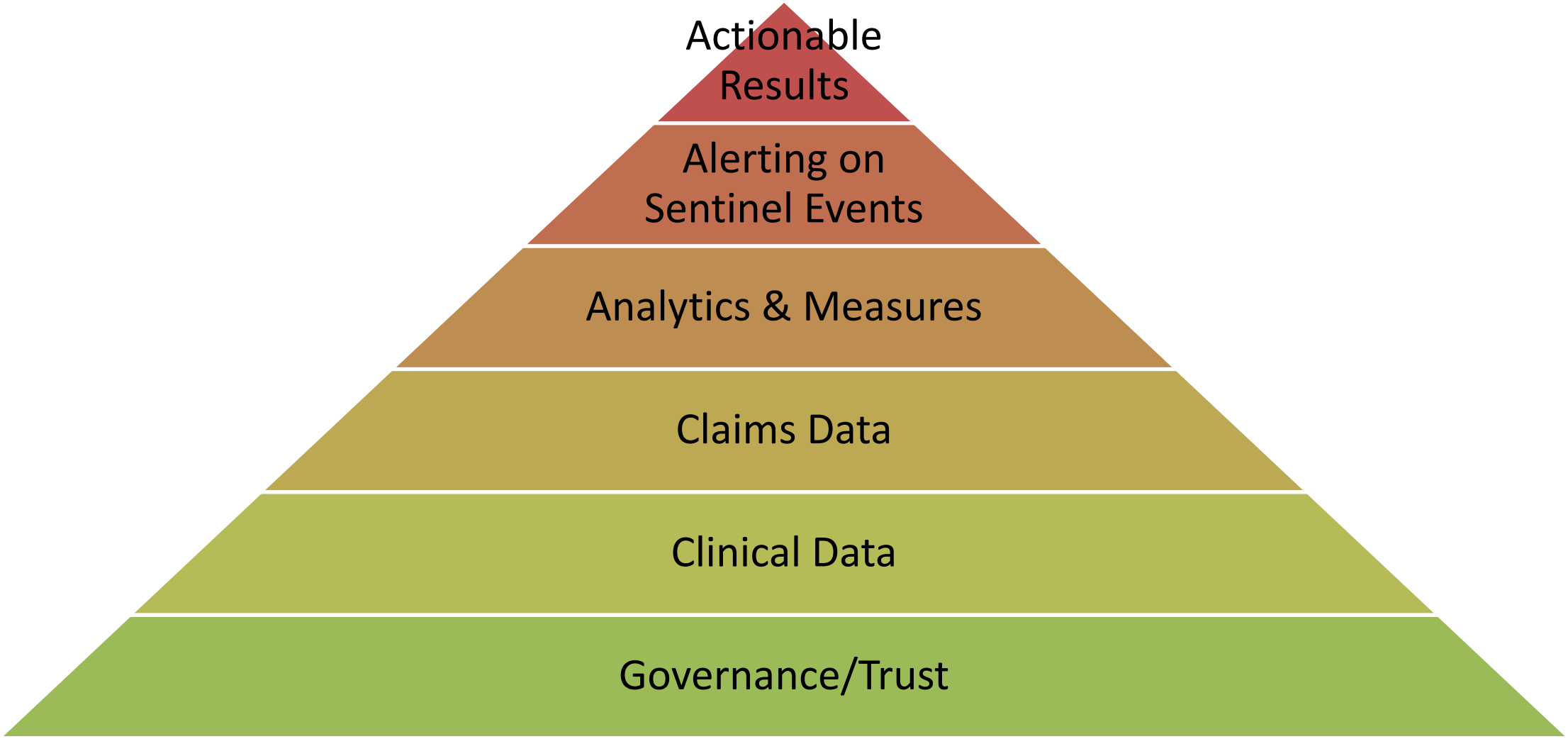
Experience with CMMI Models

Model	Roles	Timing
Comprehensive Primary Care Initiative (CPC Classic)	• Convener • National Faculty • Data Aggregator	2012-2016
CPC+	• Data Aggregator • National Faculty • Convener	2017-2021
Accountable Health Communities	• Principle Investigator • Bridging Organization	2016-2022

Primary Care First	• Event Alerting
	• Proposed:
	  • Data Aggregator
	  • Social Determinants of Health Screening
	  • Convener
		2022-?

MyHealth ACCESS NETWORK

Choosing Sites for Testing Innovation



MyHealth ACCESS NETWORK

Agenda

1. Is standardized patient data needed for multiple providers caring for patients with complex chronic conditions or serious illnesses in PB-TCOC models? If so, how?

2. Are there current examples of the collection and use of standardized patient assessment data and performance measures (e.g., post-acute care settings, other) for this patient population?

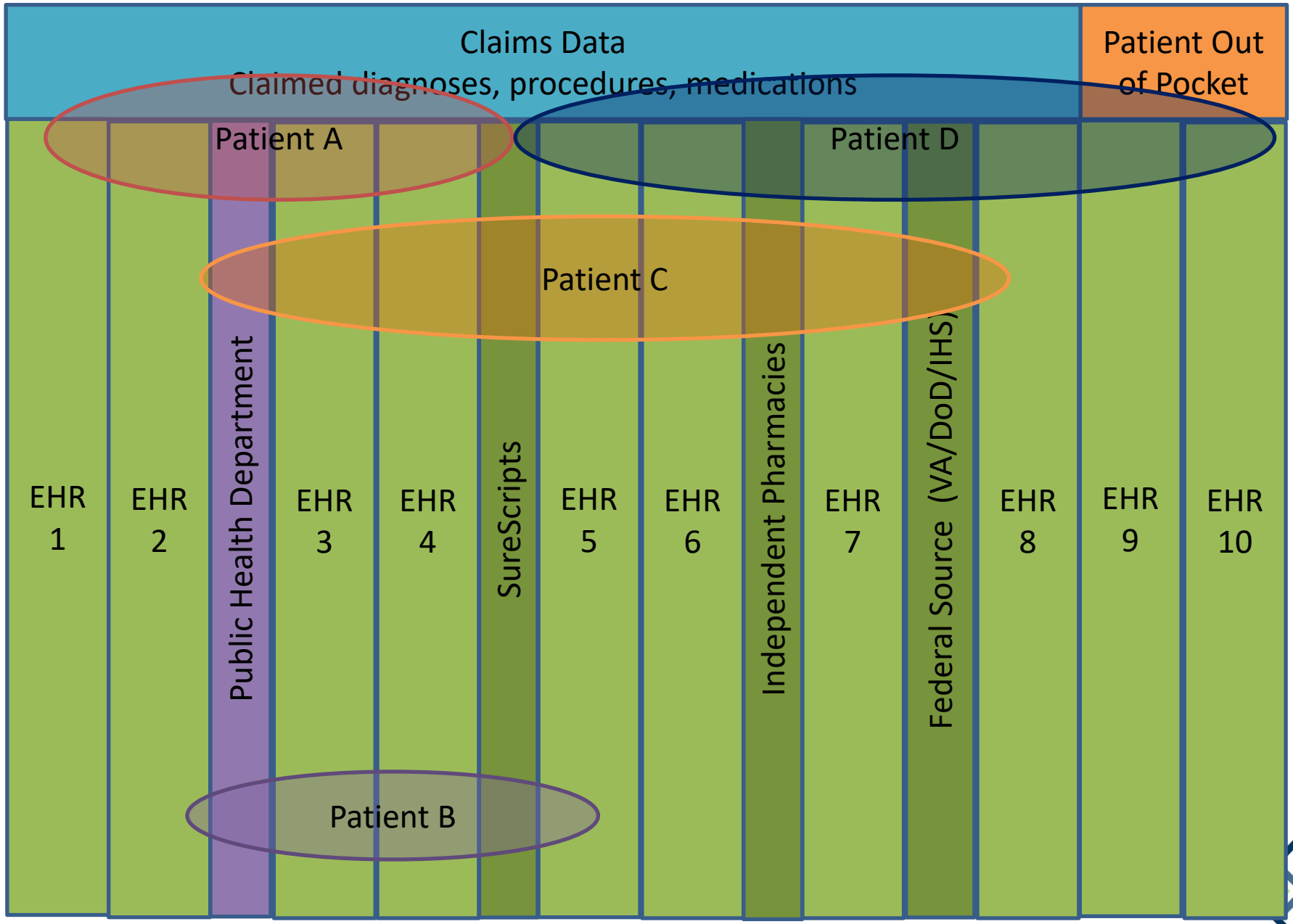
3. What strategies can be taken to improve the technology used to collect data from this patient population, the timeliness of data collection, and the sharing of resulting data with providers?

Agenda

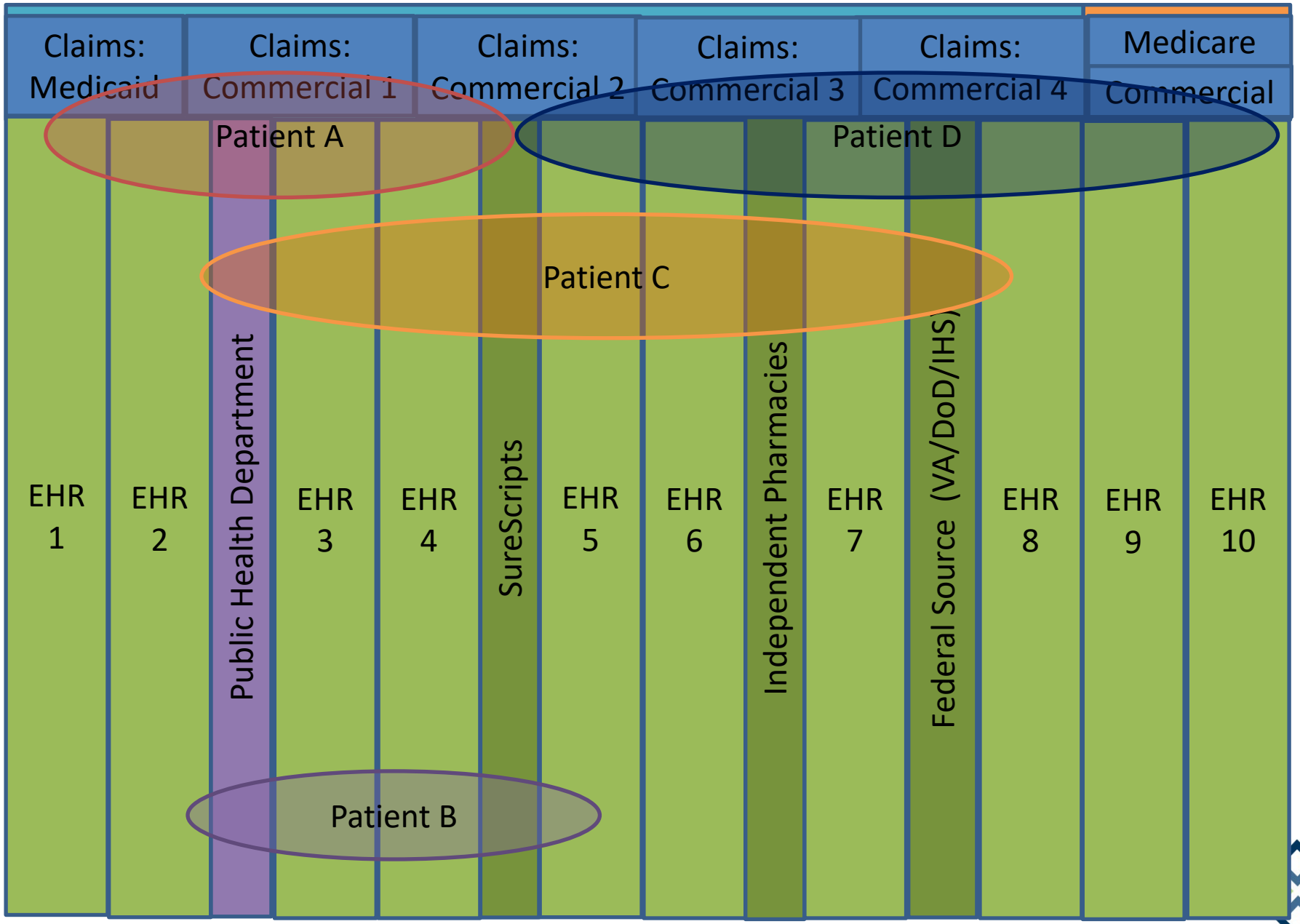
1. **Is standardized patient data needed for multiple providers caring for patients with complex chronic conditions or serious illnesses in PB-TCOC models? If so, how?**

2. Are there current examples of the collection and use of standardized patient assessment data and performance measures (e.g., post-acute care settings, other) for this patient population?

3. What strategies can be taken to improve the technology used to collect data from this patient population, the timeliness of data collection, and the sharing of resulting data with providers?

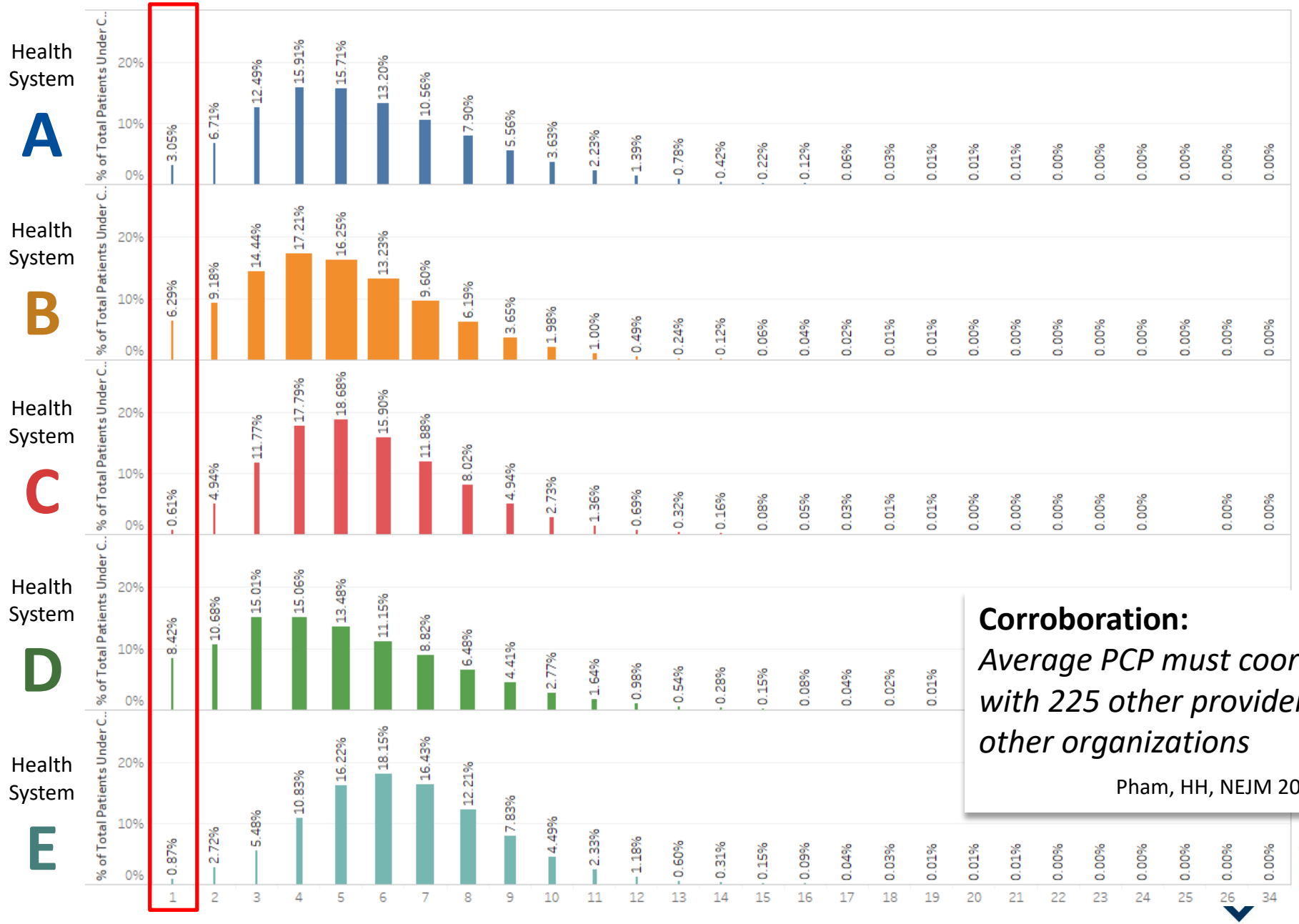


MyHealth ACCESS NETWORK



MyHealth ACCESS NETWORK

Data fragmentation by health system

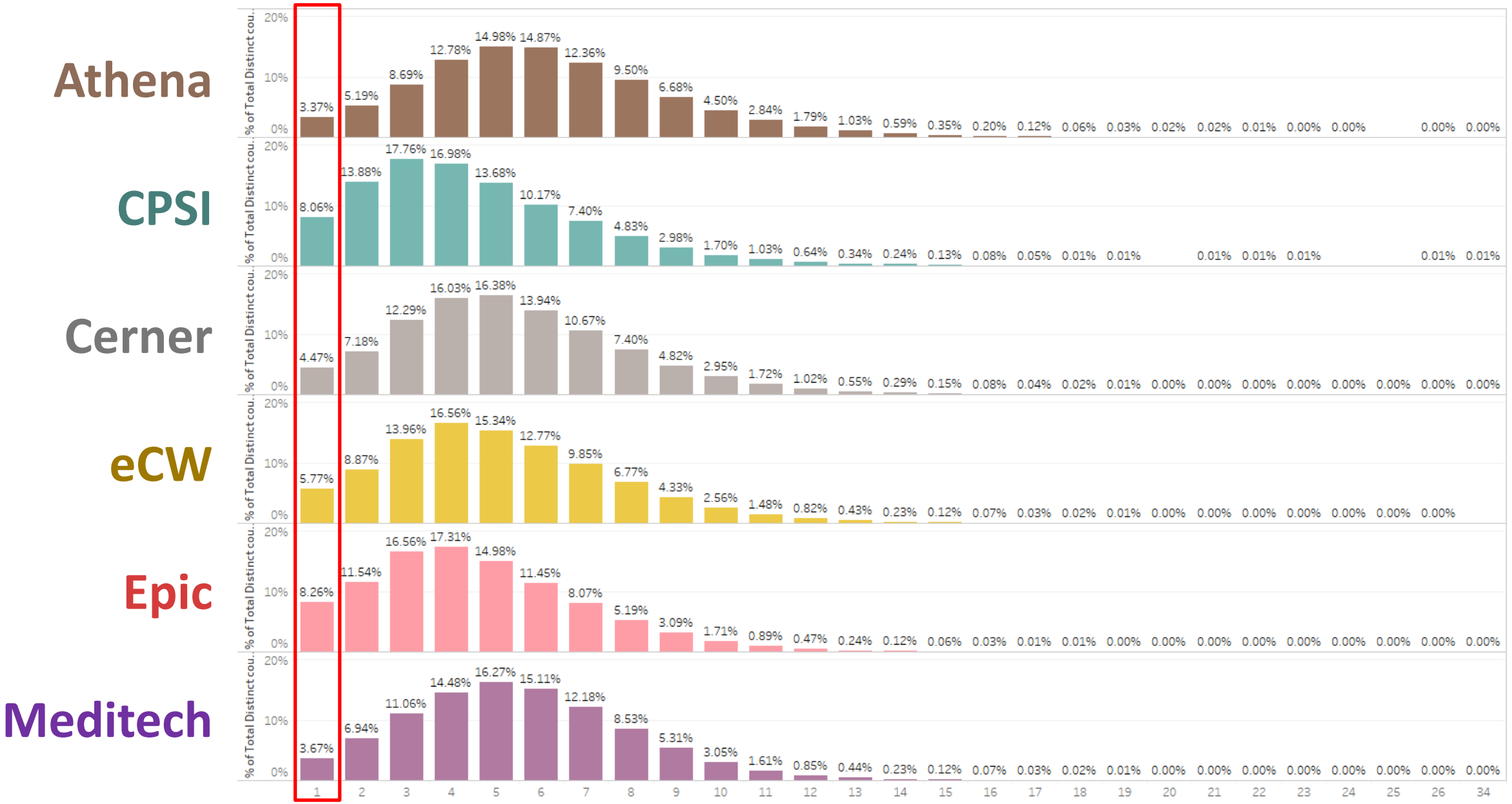


Corroboration:

Average PCP must coordinate care with 225 other providers in 117 other organizations

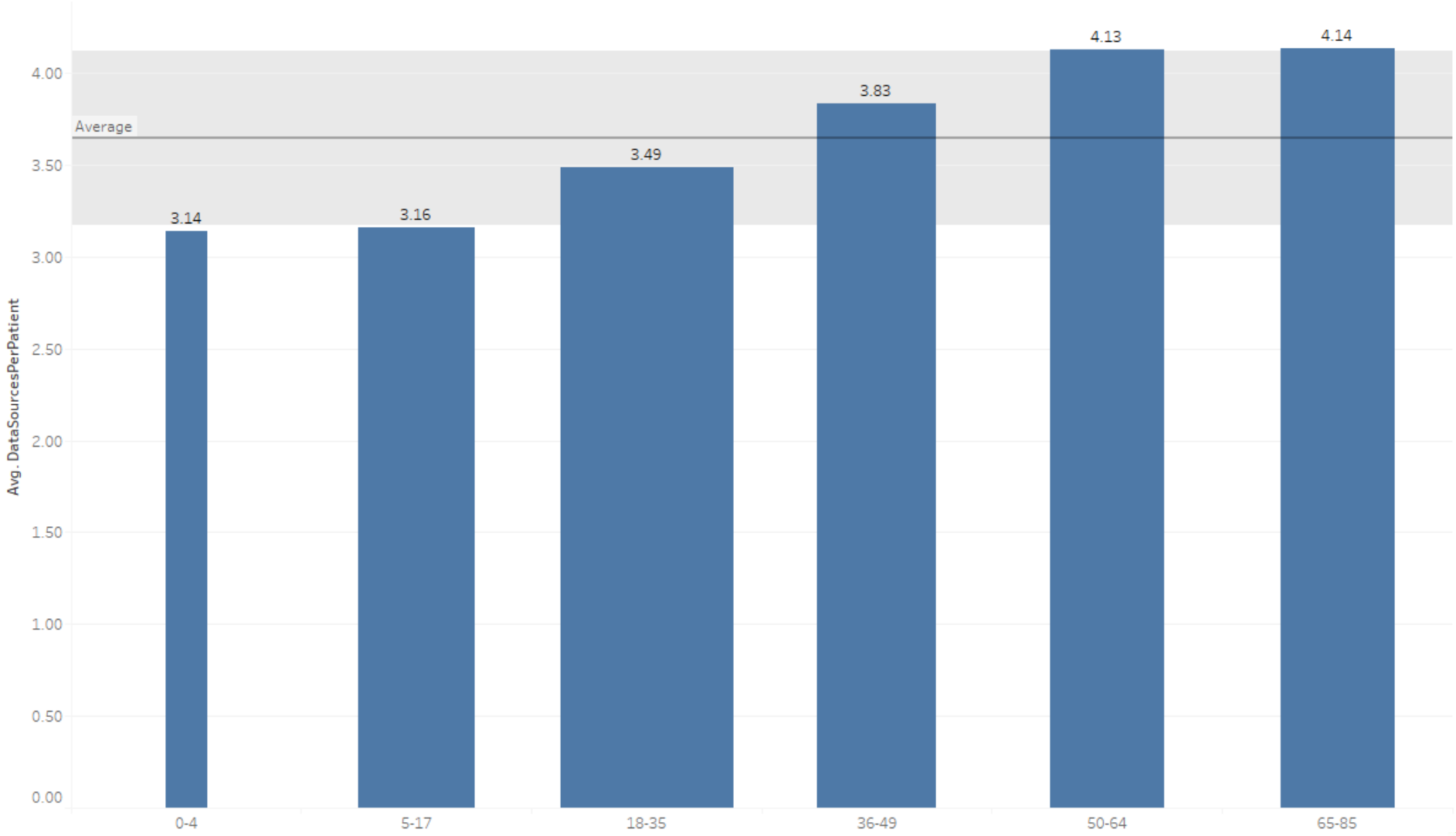
Pham, HH, NEJM 2007; 356: 1130-1139

MyHealth ACCESS NETWORK



MyHealth ACCESS NETWORK

Number of Data Sources by Age Grouping

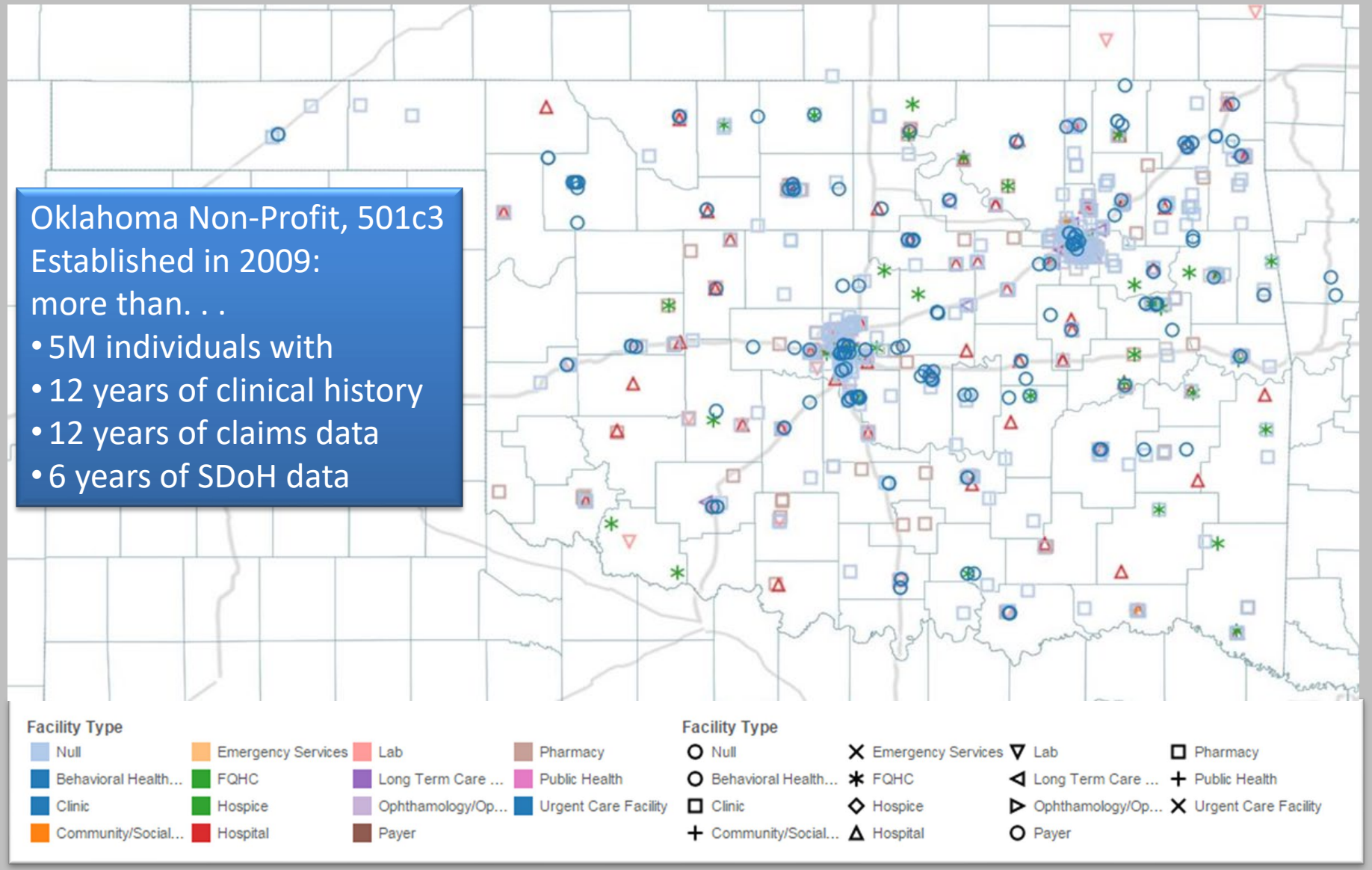


MyHealth ACCESS NETWORK

>2200 locations serving >130,000 patients daily

Oklahoma Non-Profit, 501c3
Established in 2009:
more than. . .

- 5M individuals with
- 12 years of clinical history
- 12 years of claims data
- 6 years of SDoH data

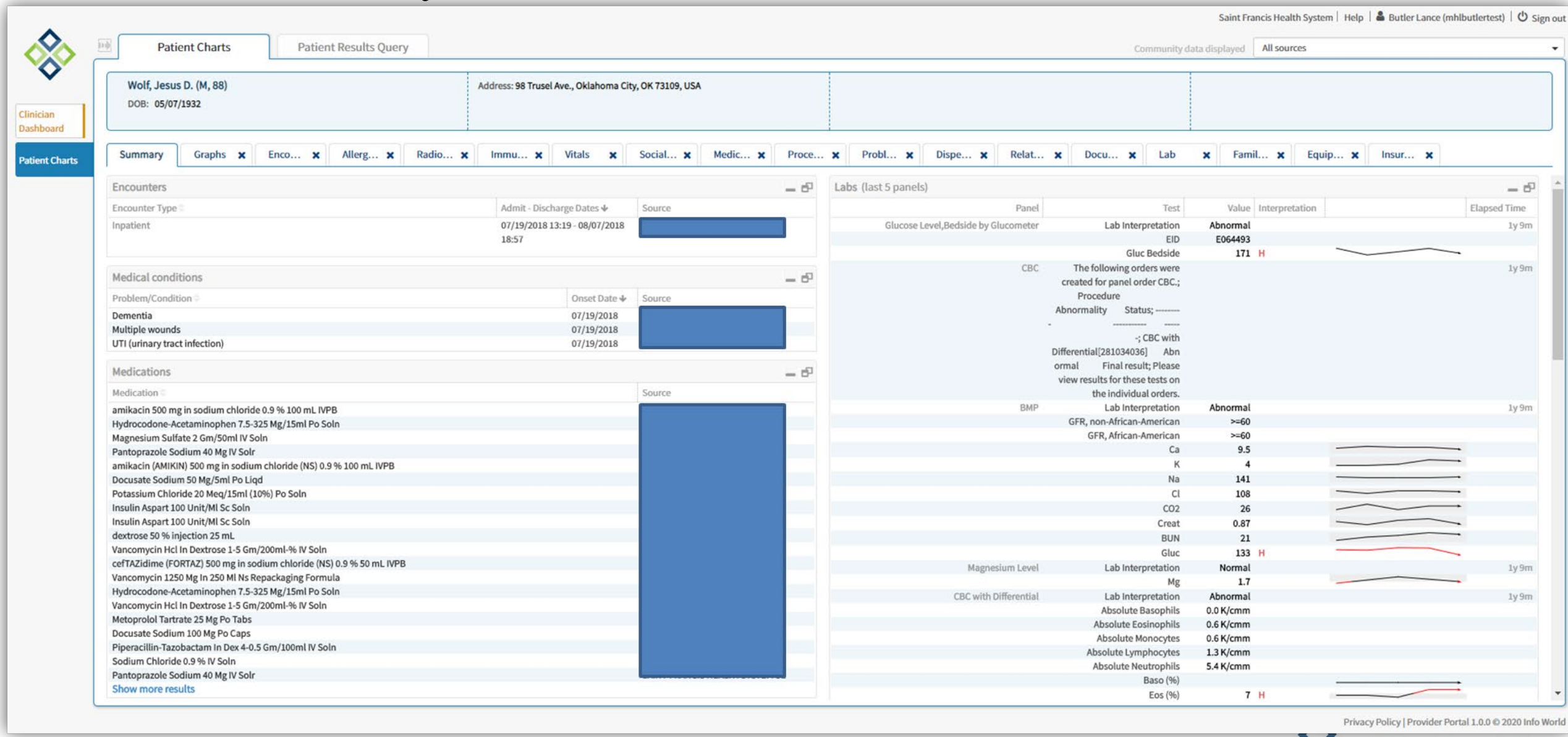


Health Data Utility: Rich Clinical, Claims, SDoH Data

- Diagnoses
- Medications
- Allergies
- Vital signs
- Clinical documents
  - H&P
  - D/C summary
  - Operative/Procedure notes
  - Progress notes
  - POLST/MOLST
  - Advanced Directives/Power of Attorneys for Health Care

- Labs/Observations/Assessments
- Insurance
- Dispensed Medications
- Equipment Devices
- Related Persons
- Social History
- Family History
- Radiology
- Care Team
- Goals of treatment

MyHealth Provider Portal + FHIR API



MyHealth ACCESS NETWORK

Health Data Utility vs. Health Information Exchange

HDU is more than a Health Information Exchange

- **Like an HIE:**
  - Governance with transparency, broad participation of stakeholders
  - Trust of stakeholders
  - Committed service to a specific geography (i.e. state or region)
  - Substantial if not 100% connectivity of health data within service area
  - Cleaning and organization of individual identities and data for secondary uses
- **A Health Data Utility that is more than an HIE:**
  - Like other utilities (electric, water, etc.), only 1 is needed, and provides infrastructure for all community needs
  - Use cases can be implemented within the HDU or through a range of partnerships
  - Integrate data from sources beyond healthcare (social services, education, crime, etc.)
  - Work with stakeholders beyond healthcare (state agencies, tribal governments, employers, policy-makers, homeless shelters, correctional systems, etc.)

15

Four Problems HDUs Solve

The Health Data Utility (HDU) is a public-private resource providing a source of robust clinical and non-clinical data.

1 The cost of U.S. health care continues to increase.

Health care spending hit almost 20% of total GDP in 2020. That's up from 5% of total U.S. GDP in 1960.

Source: Statista. https://www.statista.com/statistics/184688/us-national-health-expenditure-since-1960/

2 The quality of U.S. health care must improve.

Two results of improved health care quality are an increase in the proportion of adults who get recommended, evidence-based preventive health care and a reduction in the proportion of emergency department visits.

Source: Healthy People 2030.

3 The patient experience must improve.

Patients are continually surveyed about their experiences in the health care system; a poor experience can impact their health care provider's reimbursement.

4 The U.S. must prepare to respond to infectious disease outbreaks.

Evolving risk factors associated with external drivers such as globalization, displacement of people, and climate change reinforce the need for robust and sound public health infectious disease programs.

Contact us to learn more about the Health Data Utility Maturity Model

Visit thecsri.org/contact

Agenda

1. Is standardized patient data needed for multiple providers caring for patients with complex chronic conditions or serious illnesses in PB-TCOC models? If so, how?

2. **Are there current examples of the collection and use of standardized patient assessment data and performance measures (e.g., post-acute care settings, other) for this patient population?**

3. What strategies can be taken to improve the technology used to collect data from this patient population, the timeliness of data collection, and the sharing of resulting data with providers?

Examples of Standardized Patient Assessment and Performance Measures

- **Patient-centric:** How well is our patient (and their family) doing?
  - PHQ-9, GAD7, SBIRT, AHC SDoH, Edmonton, goals of care
- **System-centric:** How well is our team working to support
  - Achievement of POLST/MOLSTs and immediate availability to any new providers involved in care
  - Care-giver support and FUNDING where available
  - Family supports
  - Cultural sensitivity including communication in preferred language
  - Drug diversion protection

Resource: National Coalition for Hospice & Palliative Care

- Clinical Guidelines for Excellence in Palliative Care in 8 Domains
  1. Structures & Processes of Care
  2. Physical Aspects of Care
  3. Psychological and Psychiatric Aspects of Care
  4. Social Aspects of Care
  5. Spiritual, Religious, and Existential Aspects of Care
  6. Cultural Aspects of Care
  7. Care of the Patient Nearing End of Life
  8. Ethical and Legal Aspects of Care

Agenda

1. Is standardized patient data needed for multiple providers caring for patients with complex chronic conditions or serious illnesses in PB-TCOC models? If so, how?

2. Are there current examples of the collection and use of standardized patient assessment data and performance measures (e.g., post-acute care settings, other) for this patient population?

3. **What strategies can be taken to improve the technology used to collect data from this patient population, the timeliness of data collection, and the sharing of resulting data with providers?**

20

Strategies

What strategies can be taken to improve the technology used to collect data from this patient population, the timeliness of data collection, and the sharing of resulting data with providers?

1. Participation with Health Data Utility/HIE by all parties engaged in care of the patients
2. Connection of live data from as many sources as possible to the network
3. Unexpected or unintentional events: Subscribe to alerting services from HDU for all admissions, discharges and transfer events
4. Expected and Planned Events: Utilize referral coordination and management systems to plan and coordinate intentional care transitions
5. Utilize patient-centric standardized screening and referral systems for SDoH, depression, pain, happiness, and any number of patient reported outcomes
6. Leverage AI well– for example to communicate rapidly in the patient's preferred language and honor their cultural heritage and background

Strategies

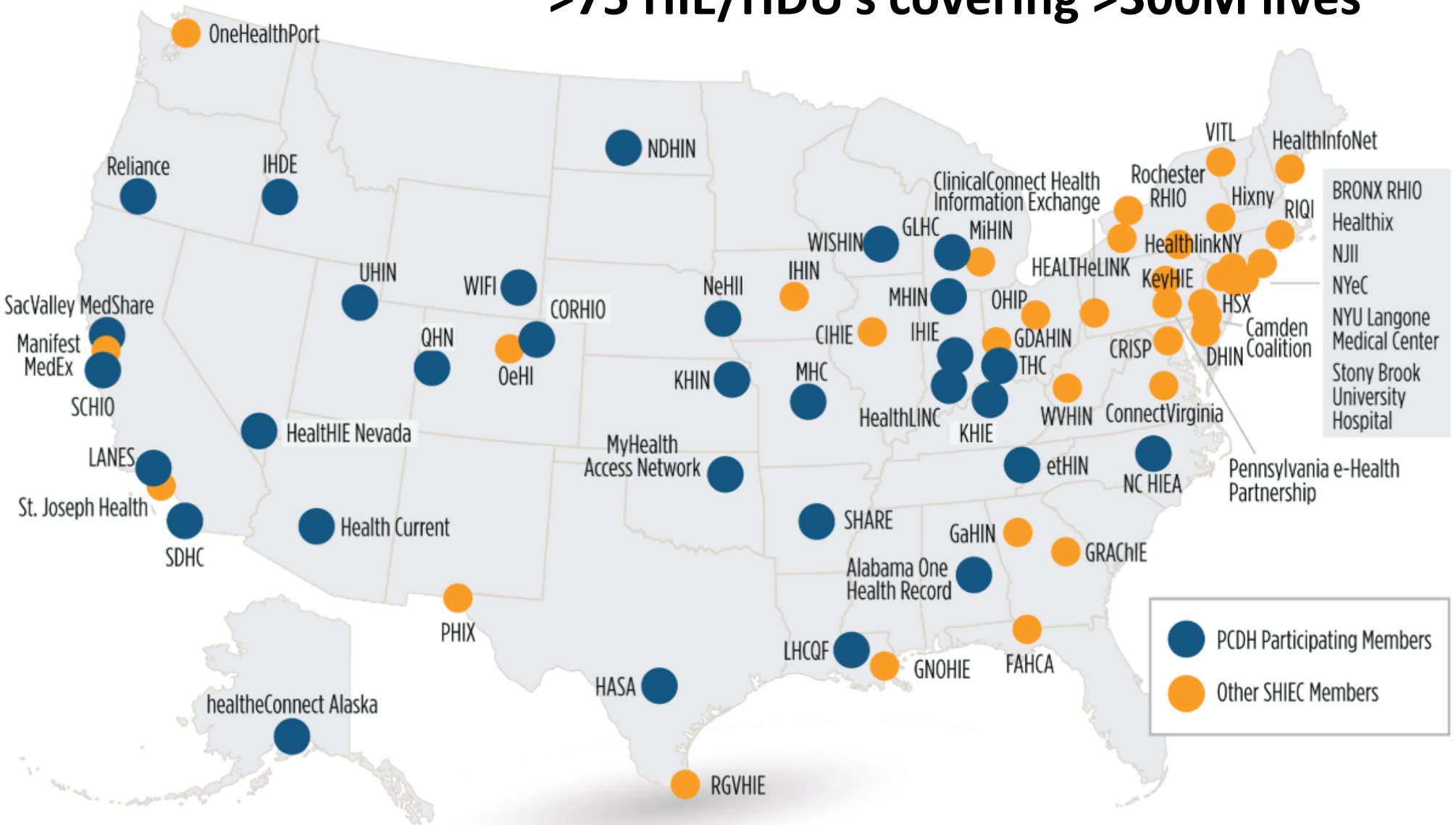
What strategies can be taken to improve the technology used to collect data from this patient population, the timeliness of data collection, and the sharing of resulting data with providers?

1. **Participation with Health Data Utility/HIE by all parties engaged in care of the patients**
2. Connection of live data from as many sources as possible to the network
3. Unexpected or unintentional events: Subscribe to alerting services from HDU for all admissions, discharges and transfer events
4. Expected and Planned Events: Utilize referral coordination and management systems to plan and coordinate intentional care transitions
5. Utilize patient-centric standardized screening and referral systems for SDoH, depression, pain, happiness, and any number of patient reported outcomes
6. Leverage AI well– for example to communicate rapidly in the patient's preferred language and honor their cultural heritage and background

CIVITAS
Networks for Health

Participation in a Health Data Utility

>75 HIE/HDU's covering >300M lives



23

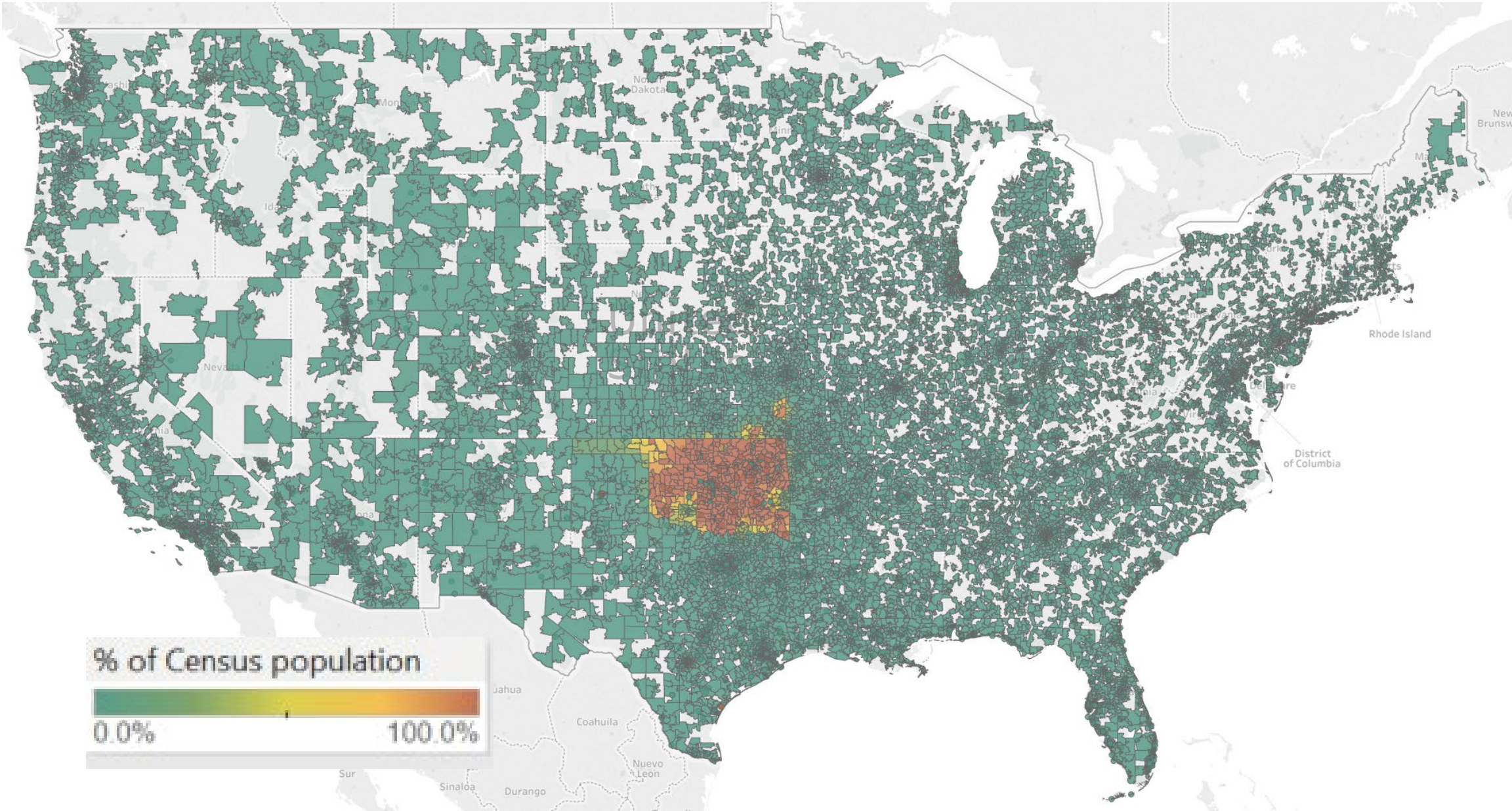
Strategies

What strategies can be taken to improve the technology used to collect data from this patient population, the timeliness of data collection, and the sharing of resulting data with providers?

1. Participation with Health Data Utility/HIE by all parties engaged in care of the patients
2. **Connection of live data from as many sources as possible to the network**
3. Unexpected or unintentional events: Subscribe to alerting services from HDU for all admissions, discharges and transfer events
4. Expected and Planned Events: Utilize referral coordination and management systems to plan and coordinate intentional care transitions
5. Utilize patient-centric standardized screening and referral systems for SDoH, depression, pain, happiness, and any number of patient reported outcomes
6. Leverage AI well– for example to communicate rapidly in the patient's preferred language and honor their cultural heritage and background

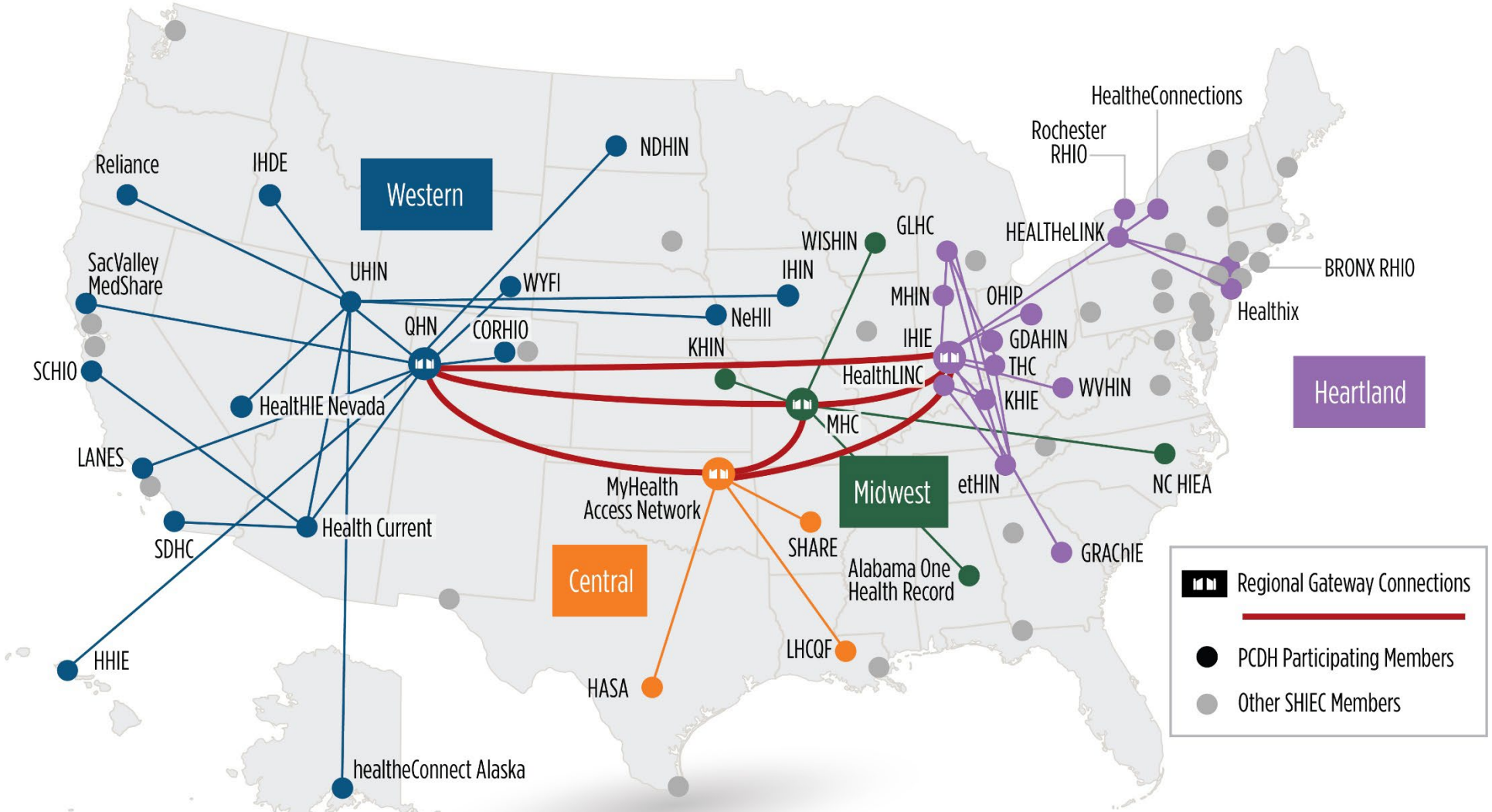
24

MyHealth Patient Population



CIVITAS
Networks for Health

Patient Centered Data Home™ Coverage



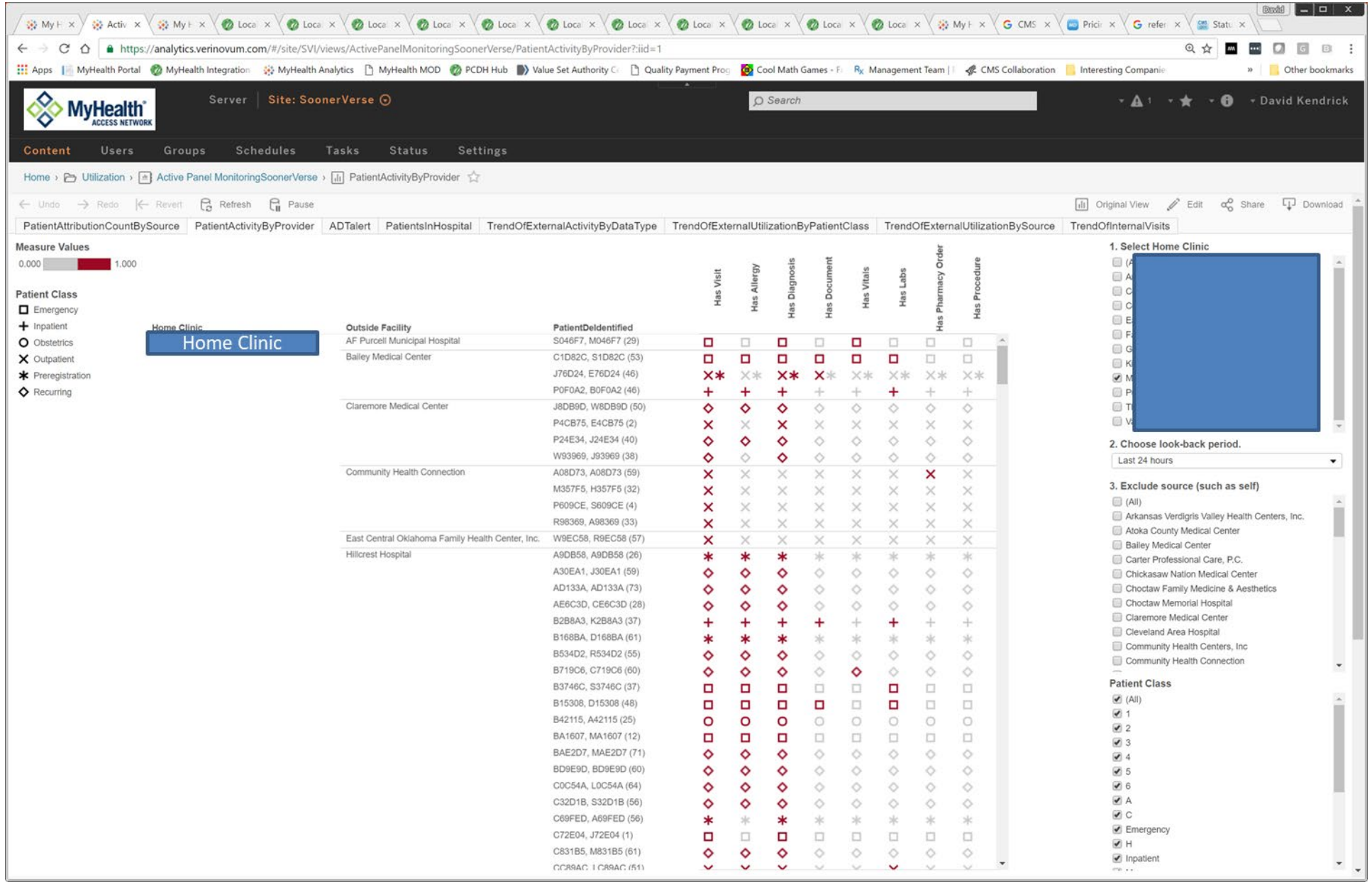
26

Strategies

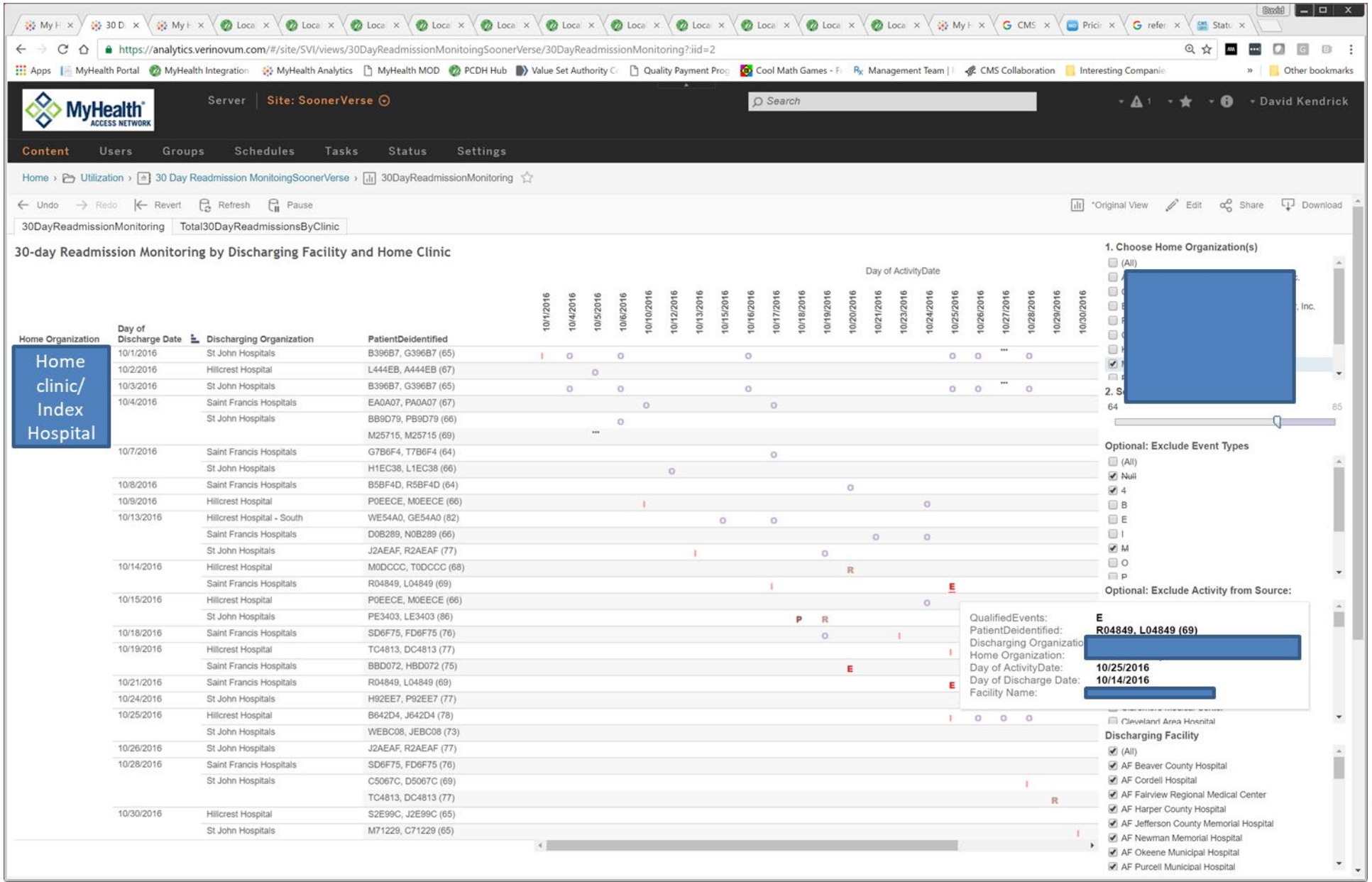
What strategies can be taken to improve the technology used to collect data from this patient population, the timeliness of data collection, and the sharing of resulting data with providers?

1. Participation with Health Data Utility/HIE by all parties engaged in care of the patients
2. Connection of live data from as many sources as possible to the network
3. **Unexpected or unintentional events: Subscribe to alerting services from HDU for all admissions, discharges and transfer events**
4. Expected and Planned Events: Utilize referral coordination and management systems to plan and coordinate intentional care transitions
5. Utilize patient-centric standardized screening and referral systems for SDoH, depression, pain, happiness, and any number of patient reported outcomes
6. Leverage AI well– for example to communicate rapidly in the patient's preferred language and honor their cultural heritage and background

Alerting to Unplanned Critical Events



30-day Readmission Monitoring



Strategies

What strategies can be taken to improve the technology used to collect data from this patient population, the timeliness of data collection, and the sharing of resulting data with providers?

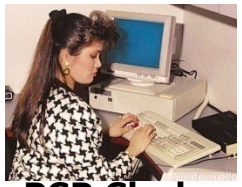
1. Participation with Health Data Utility/HIE by all parties engaged in care of the patients
2. Connection of live data from as many sources as possible to the network
3. Unexpected or unintentional events: Subscribe to alerting services from HDU for all admissions, discharges and transfer events
4. **Expected and Planned Events: Utilize referral coordination and management systems to plan and coordinate intentional care transitions**
5. Utilize patient-centric standardized screening and referral systems for SDoH, depression, pain, happiness, and any number of patient reported outcomes
6. Leverage AI well– for example to communicate rapidly in the patient's preferred language and honor their cultural heritage and background

Planned Events: Community-wide Care Transition Coordination Process

Interview, Examine

Primary Care Provider

Referral initiated



PCP Clerk

Schedule Patient

Specialist Clerk

- All communications electronic and logged
- Status of referral events clear to all involved parties
- No faxes, no printing: All records sent electronically to receiving provider
- Sending providers given the software, trained in 0.5 days
- Enables sending and receiving provider to meet meaningful use for care coordination, with or without an HIE

Specialist Physician

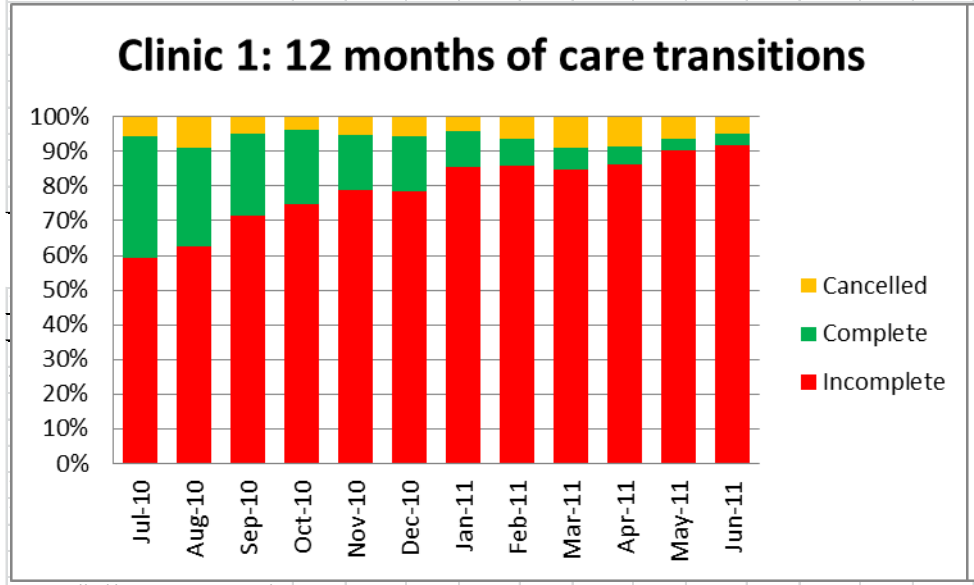
MyHealth ACCESS NETWORK

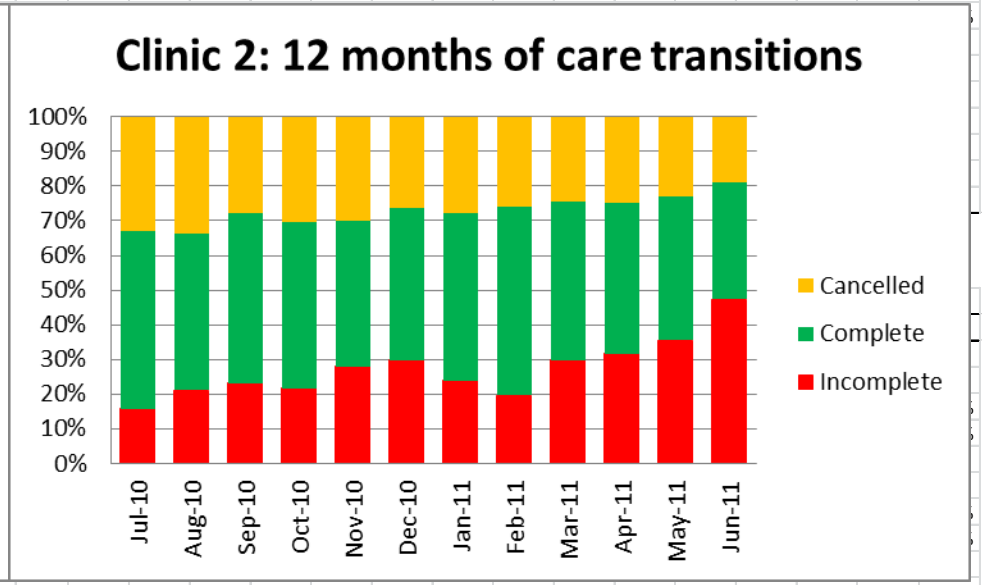
Electronic Referral Management

Clinic 1:

Visit Request Status as of August 31, 2011 by Month Initiated:

	JUL 2010		AUG 2010		SEP 2010		OCT 2010		NOV 2010		DEC 2010		JAN 2011		FEB 2011		MAR 2011		APR 2011		MAY 2011		JUN 2011		JUL 2011		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Total Number Initiated	**409**		**361**		**442**		**363**		**362**		**324**		**325**		**285**		**438**		**426**		**433**		**457**		**392**		**5,017**	
Pending Appointment	154	37.7%	172	47.6%	227	51.4%	210	57.9%	165	45.6%	171	52.8%	211	64.9%	199	69.8%	296	67.6%	272	63.8%	306	70.7%	314	68.7%	280	71.4%	2,977	59.3%
Scheduled	79	19.3%	49	13.6%	71	16.1%	55	15.2%	99	27.3%	65	20.1%	57	17.5%	37	13.0%	61	13.9%	75	17.6%	67	15.5%	90	19.7%	71	18.1%	876	17.5%
Consult in Progress	4	1.0%	2	0.6%	3	0.7%	3	0.8%	4	1.1%	4	1.2%	2	0.6%	0	0.0%	2	0.5%	8	1.9%	9	2.1%	10	2.2%	6	1.5%	57	1.1%
Visit Occurred: Report Pending	5	1.2%	3	0.8%	14	3.2%	4	1.1%	18	5.0%	14	4.3%	8	2.5%	9	3.2%	12	2.7%	13	3.1%	9	2.1%	5	1.1%	9	2.3%	123	2.5%

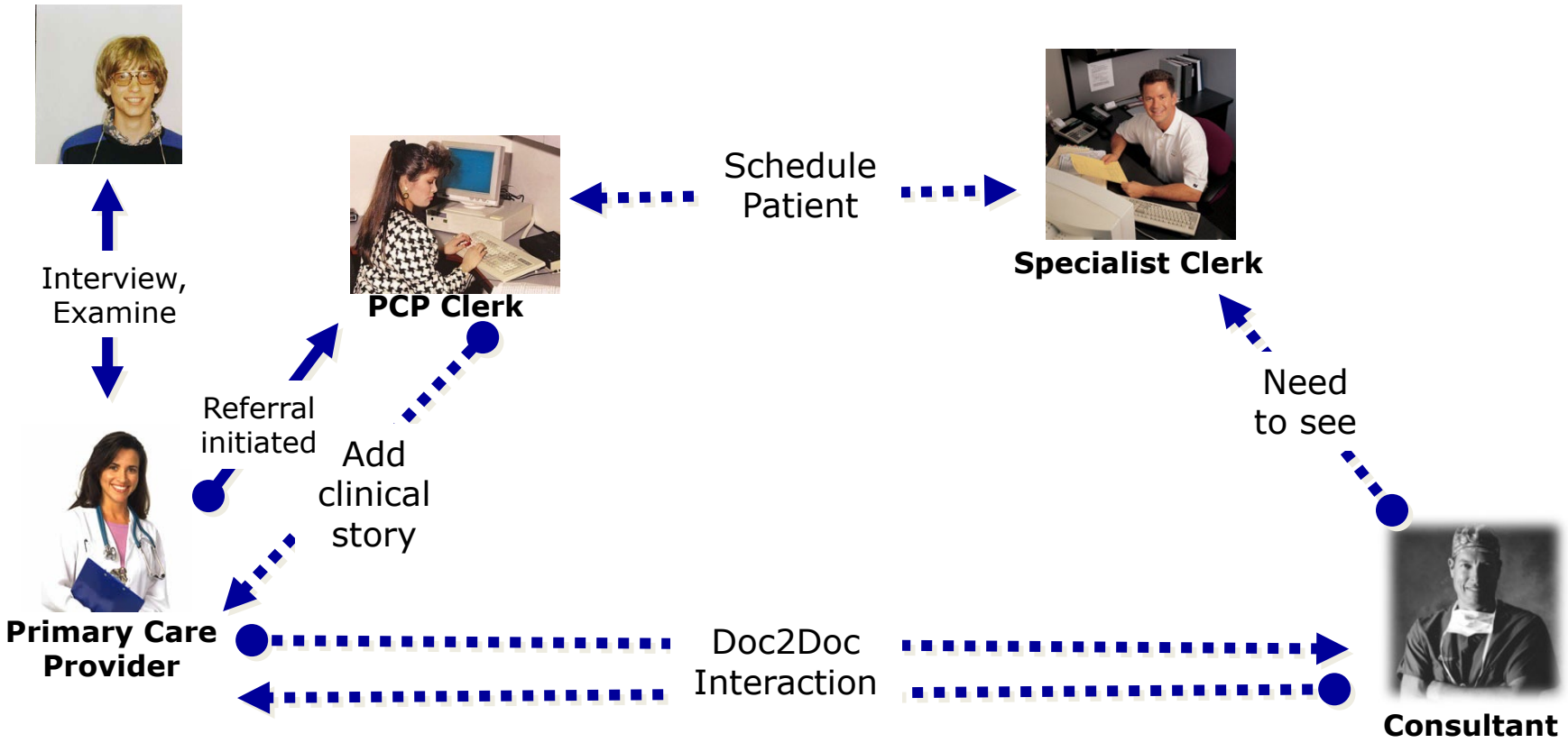




Cancelled by Receiving Provider	31	3.8%	49	5.6%	34	3.7%	34	4.7%	30	3.6%	22	3.3%	18	3.0%	14	2.6%	32	3.4%	25	2.8%	42	5.1%	26	3.5%	14	1.6%	371	3.6%
Cancelled by Sending Provider	77	9.5%	77	8.7%	58	6.3%	44	6.1%	37	4.5%	32	4.9%	54	8.9%	46	8.7%	50	5.3%	56	6.3%	43	5.3%	36	4.8%	25	2.9%	635	6.2%
Failed Appointment	93	11.4%	96	10.9%	92	9.9%	82	11.4%	90	10.9%	70	10.7%	51	8.4%	28	5.3%	84	9.0%	76	8.5%	51	6.2%	37	4.9%	29	3.4%	879	8.6%
Rejected by Receiving Provider	10	1.2%	22	2.5%	24	2.6%	14	1.9%	23	2.8%	8	1.2%	11	1.8%	10	1.9%	9	1.0%	13	1.5%	15	1.8%	20	2.7%	33	3.9%	212	2.1%
Not Specified	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%

MyHealth ACCESS NETWORK

eConsultations to Optimize Care Transitions



MyHealth ACCESS NETWORK

Results: eConsultations in Medicaid

- Patients receiving an online consult had a significant reduction in PMPM cost of care when compared with themselves as historical controls:
  - *$140.53 Pre Consult vs. $78.16 Post Consult*
  - *Net savings of **$62.37, p=0.021***
- Compared with patients who received a referral but NOT a consult:

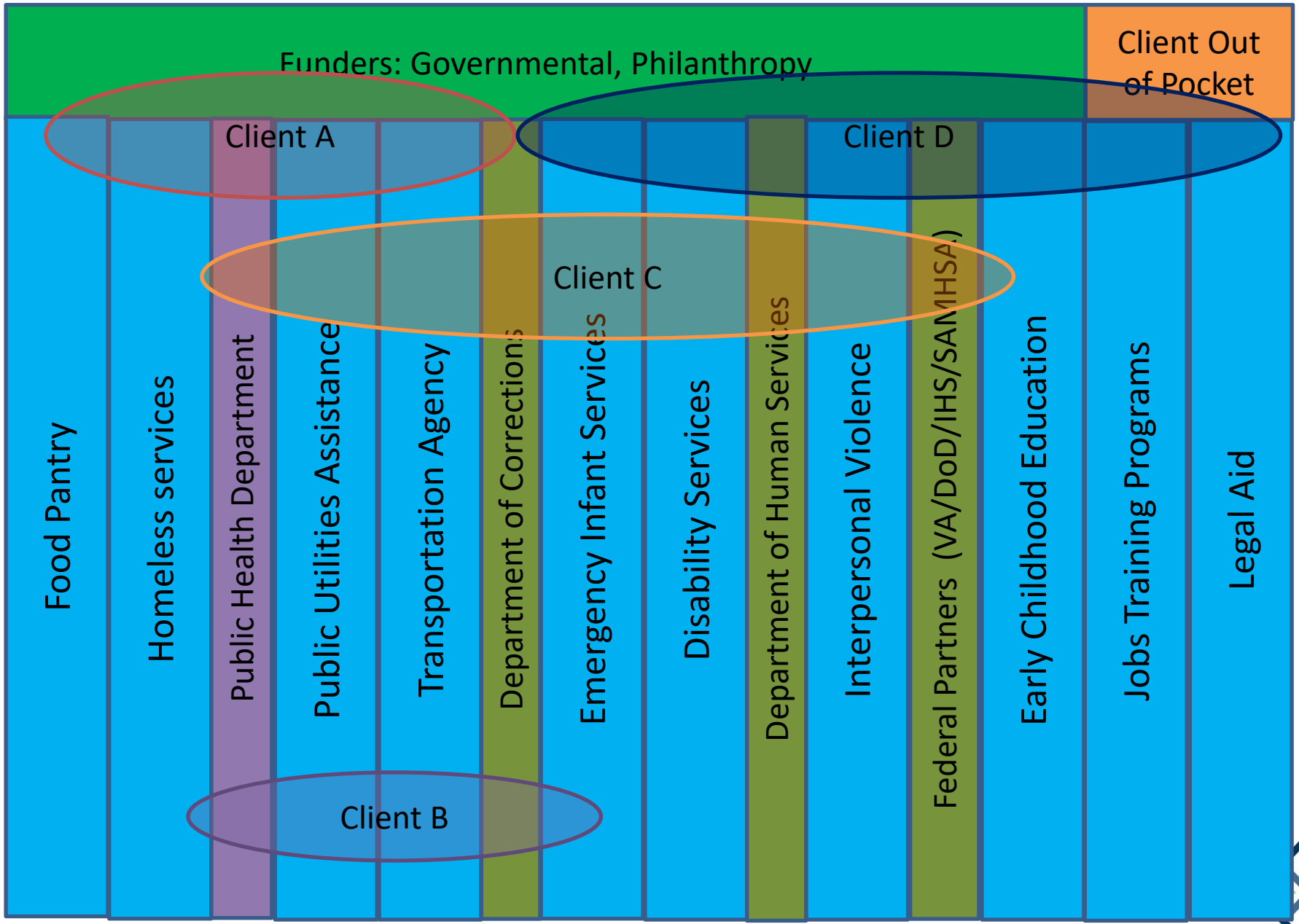
Cost Type	Mean PMPM Cost Change	Mean Percentage Change
Facility Costs (UB92)	-$13.00	-20%
Professional Costs (HCFA 1500)	-$108.04	-34%
Pharmacy Costs (PBM)	-$9.14	-14%
Total Costs	-$130.18	

Strategies

What strategies can be taken to improve the technology used to collect data from this patient population, the timeliness of data collection, and the sharing of resulting data with providers?

1. Participation with Health Data Utility/HIE by all parties engaged in care of the patients
2. Connection of live data from as many sources as possible to the network
3. Unexpected or unintentional events: Subscribe to alerting services from HDU for all admissions, discharges and transfer events
4. Expected and Planned Events: Utilize referral coordination and management systems to plan and coordinate intentional care transitions
5. **Utilize patient-centric standardized screening and referral systems for SDoH, depression, pain, happiness, and any number of patient reported outcomes**
6. Leverage AI well– for example to communicate rapidly in the patient's preferred language and honor their cultural heritage and background

Health Data Utilities Uniquely Support Addressing SDoH and Equity



MyHealth ACCESS NETWORK

SDOH Mobile Screening & Referral

1
Clinical Encounter

Patient checks into clinic.

2
SDoH Screening

SDoH Screening text from MyHealth is triggered to patient's cell phone while they are in the waiting room.

3
Process Results

MyHealth processes the results to determine social needs reported.

4
CRS Returned

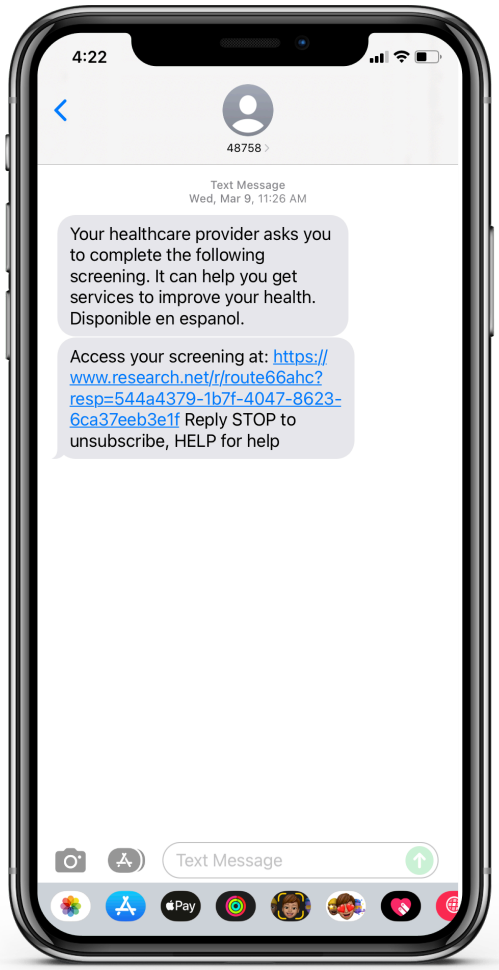
If a need is reported, a community resource summary is returned via text with information for 3 resources per need identified.

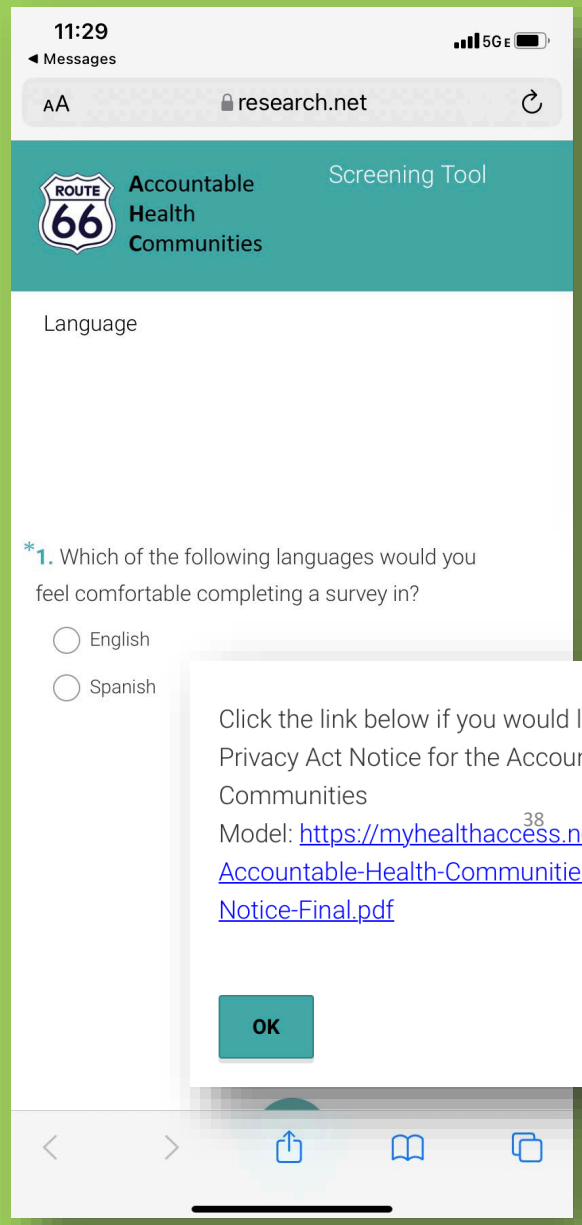
5
Closed Loop Referral Partner

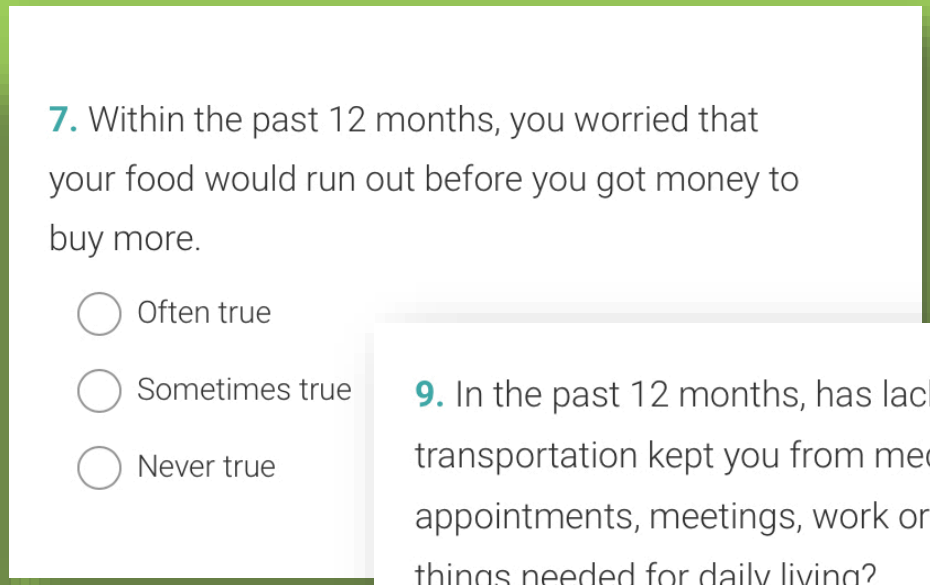
Referral sent to partner for closed loop coordination.

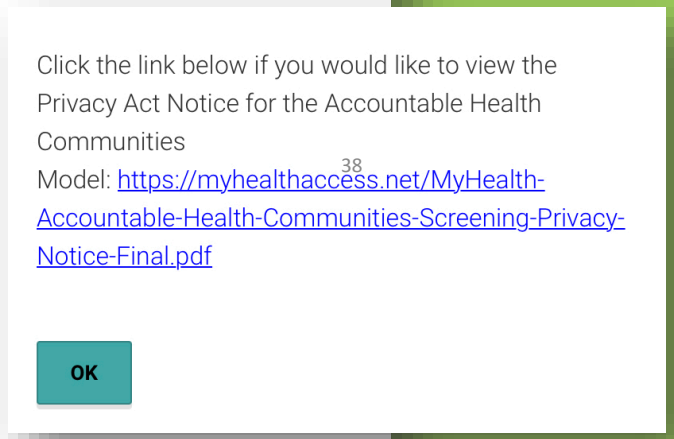
37

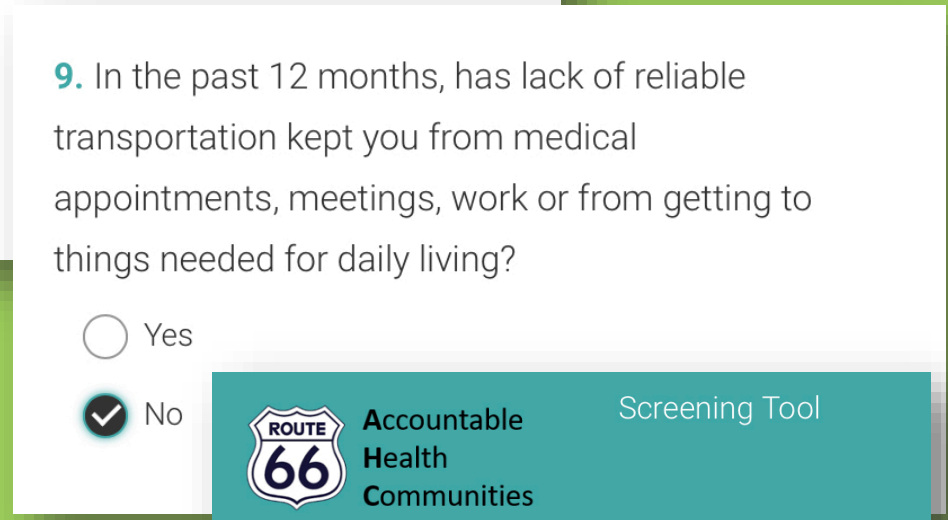
Mobile Screening

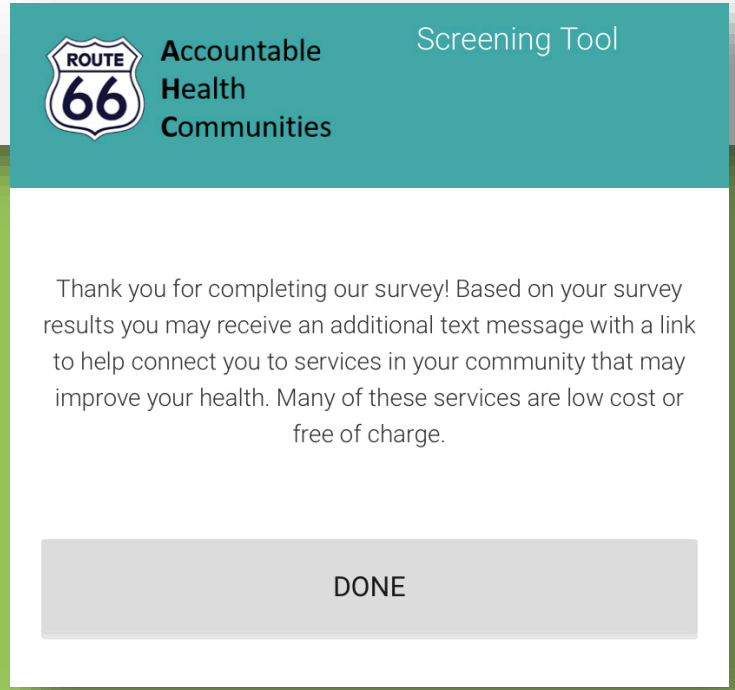




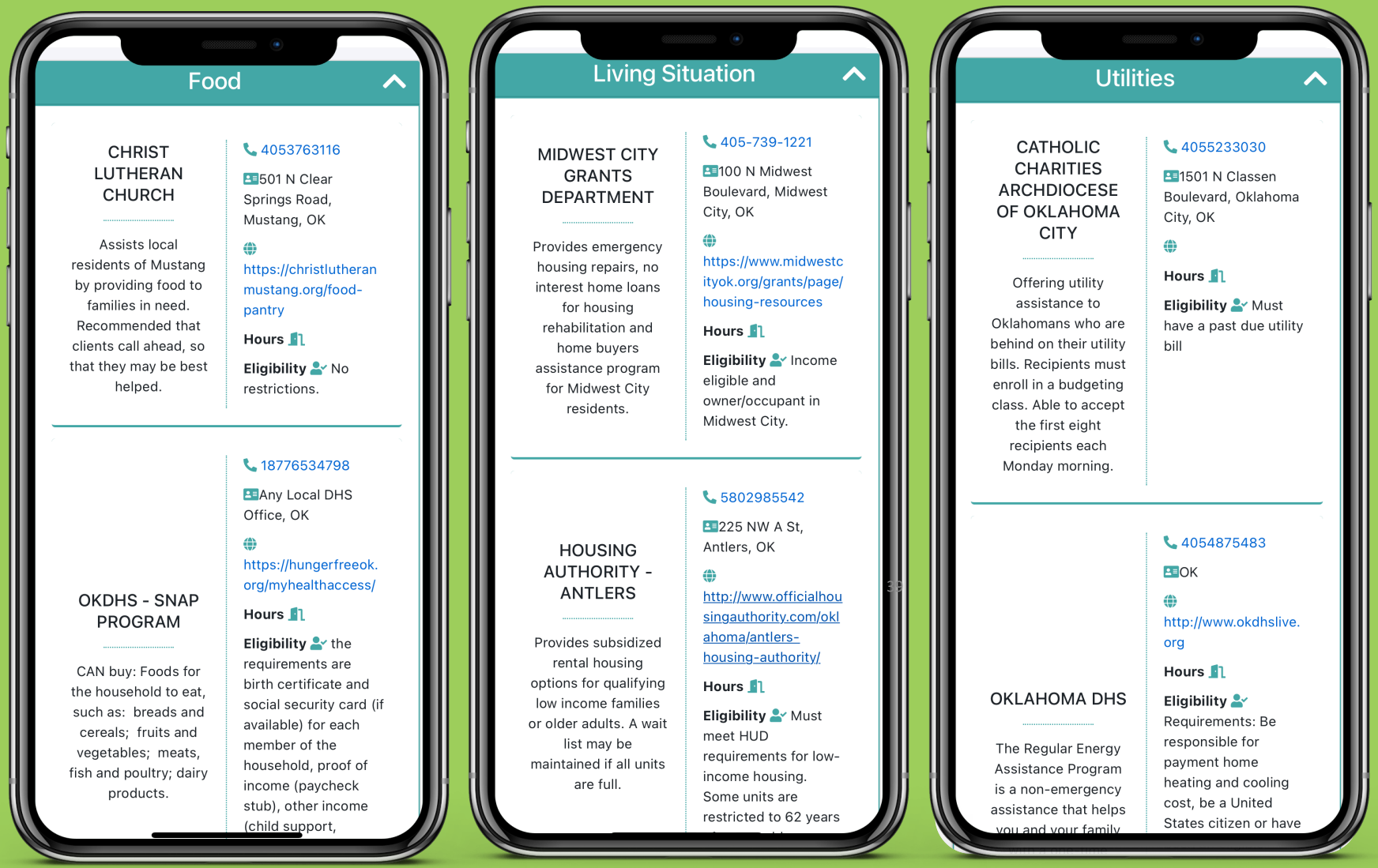








MyHealth® ACCESS NETWORK



Community Resource Summary

Texted back to patient after completion of the screening

MyHealth ACCESS NETWORK

Every community resource summary includes information for 211

SDOH Program Metrics

August 2018– May 30, 2024

By the numbers:

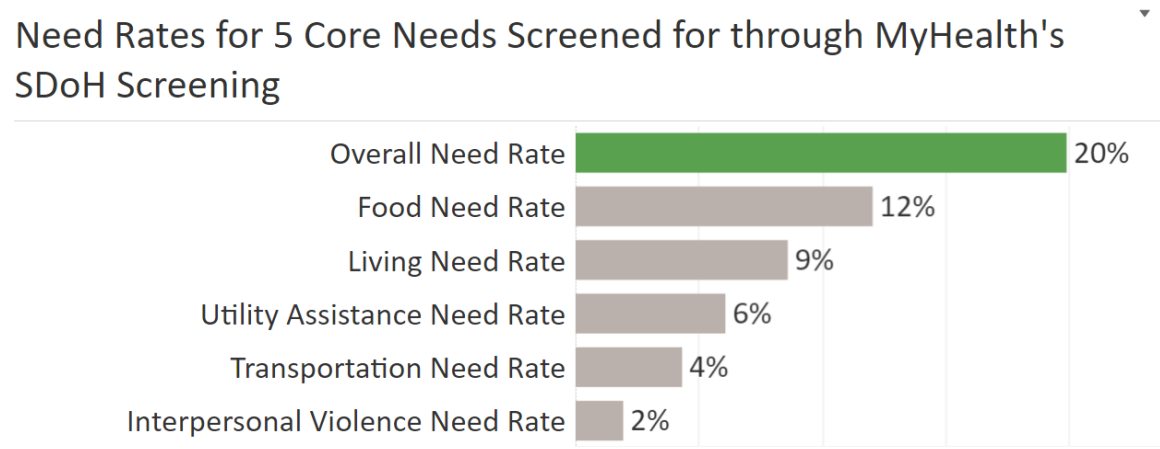
- ✓ **4.5+** million offers to screen
- ✓ **900,000+** responses
- ✓ **300,000+** responses with needs
- ✓ **400,000+** individual needs reported & addressed

Screening Delivery Rate

83%

Screening Response Rate

21%



24% of responses report 2+ needs

average of **1.7** needs are reported per need positive screening

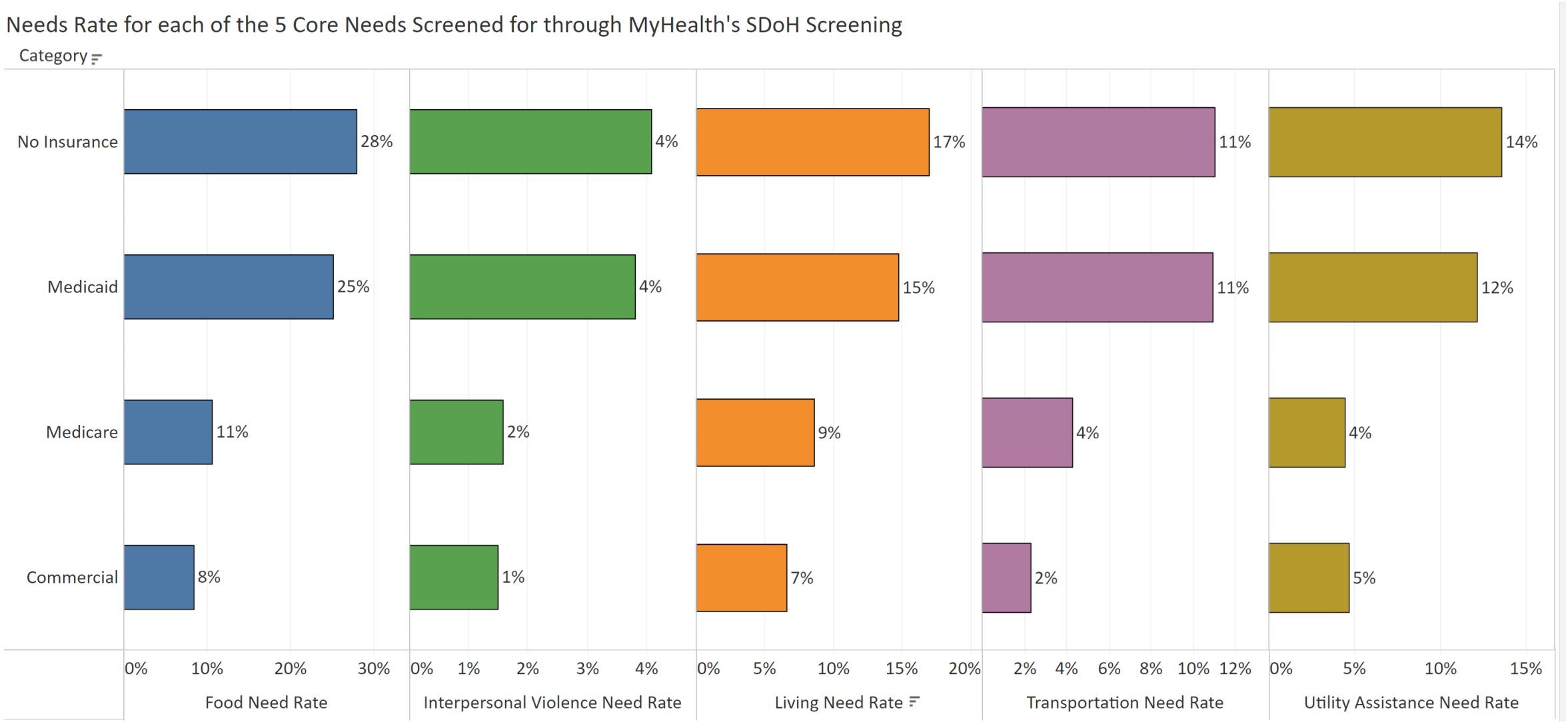
85% of responses with a living need is due to living conditions* rather having a place to stay

*Living condition issues include lack of heating, lead paint or pipes, mold, oven or stove not working, pests, missing or not working smoke detectors, and water leaks

40

SDOH Screening Metrics

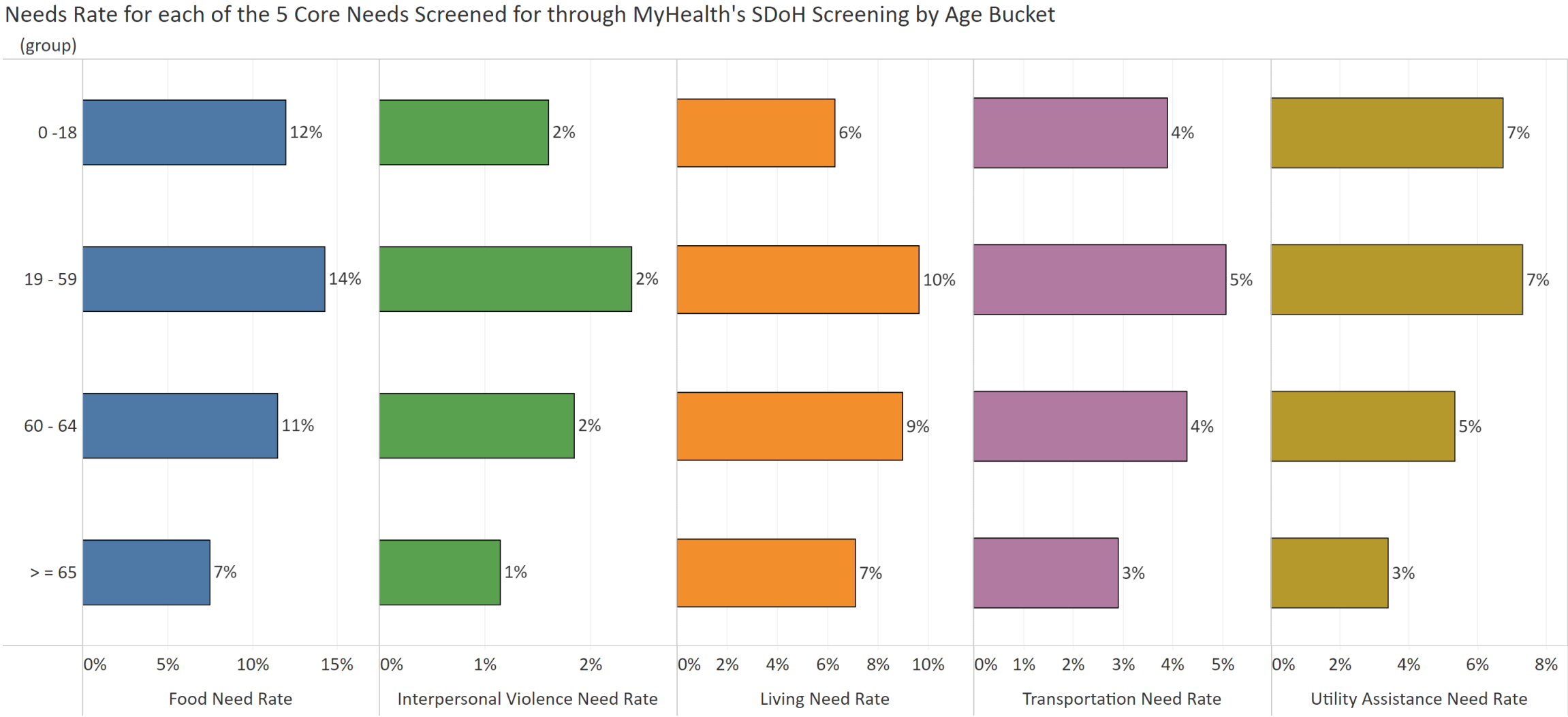
Year to Date



41

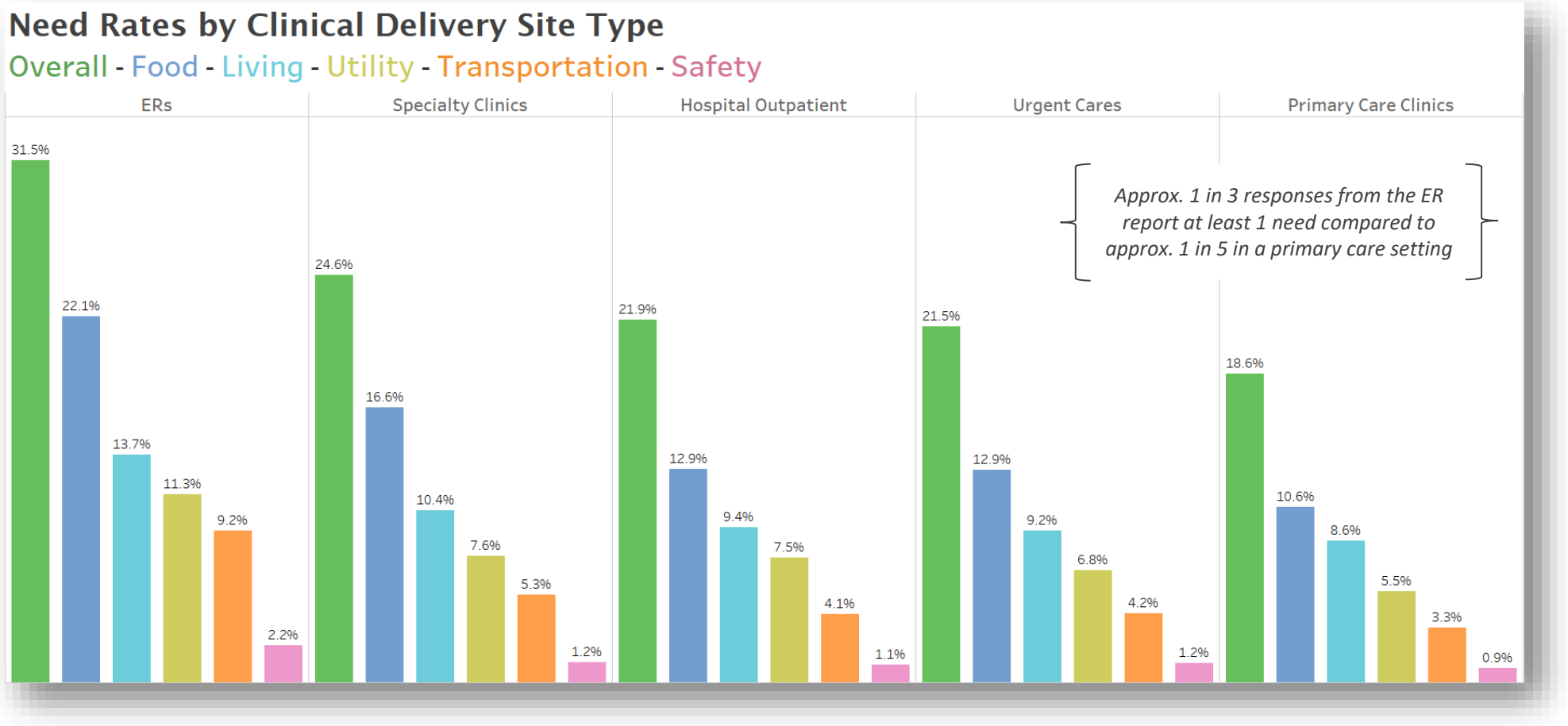
SDOH Screening Metrics

Year to Date



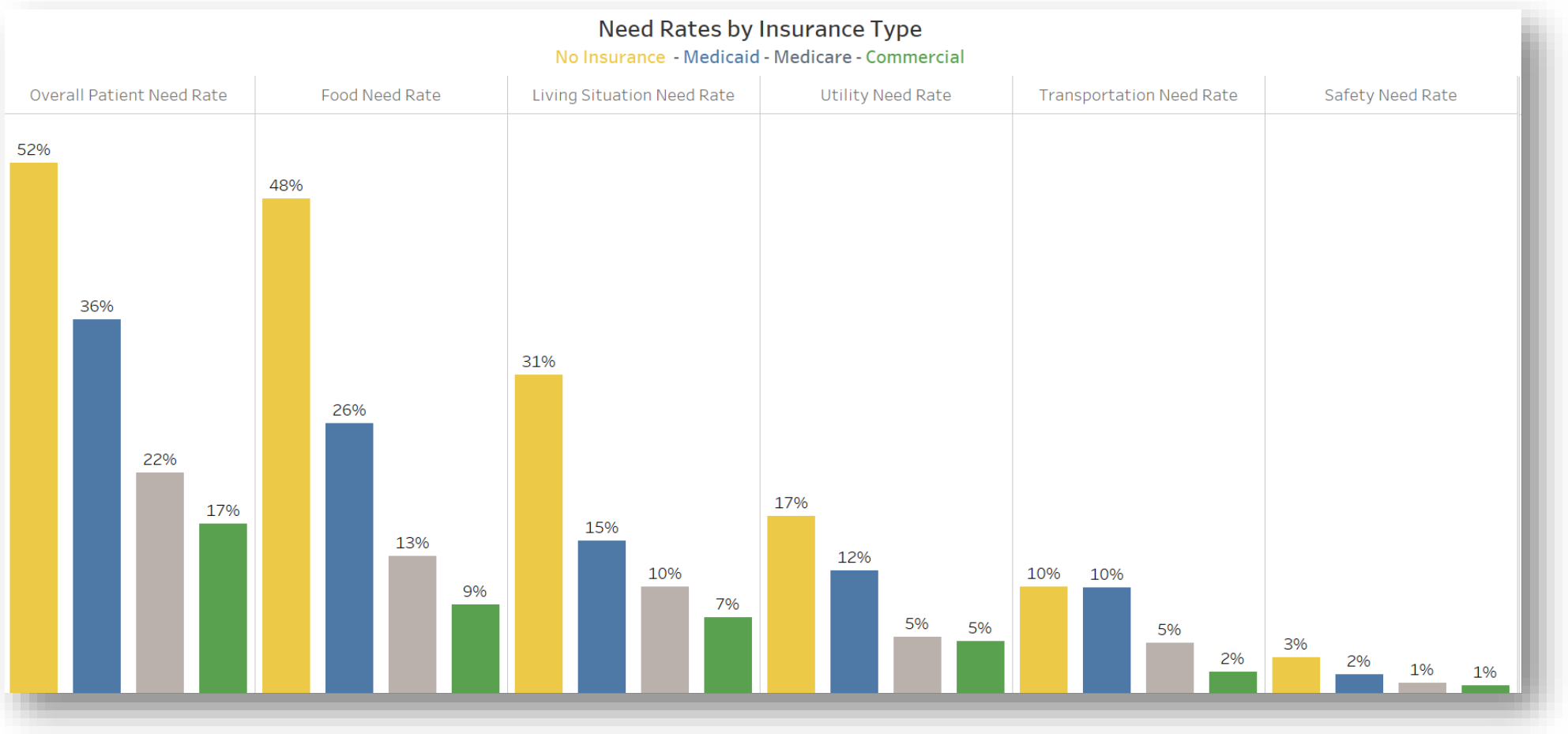
42

MyHealth AHC Need Rates by Clinical Site Type



MyHealth ACCESS NETWORK

MyHealth AHC Need Rates by Insurance Type



MyHealth ACCESS NETWORK

Strategies

What strategies can be taken to improve the technology used to collect data from this patient population, the timeliness of data collection, and the sharing of resulting data with providers?

1. Participation with Health Data Utility/HIE by all parties engaged in care of the patients
2. Connection of live data from as many sources as possible to the network
3. Unexpected or unintentional events: Subscribe to alerting services from HDU for all admissions, discharges and transfer events
4. Expected and Planned Events: Utilize referral coordination and management systems to plan and coordinate intentional care transitions
5. Utilize patient-centric standardized screening and referral systems for SDoH, depression, pain, happiness, and any number of patient reported outcomes
6. **Leverage AI well– for example to communicate rapidly in the patient's preferred language and honor their cultural heritage and background**

Smart Use of Artificial Intelligence

- **Basic:**
  - Cultural sensitivity
  - Live translation of ANY LANGUAGE
  - Rapid creation of written training materials in any language
- **Advanced:**
  - Leverage Health Data Utility data to train AI models for risk identification and treatment optimization
  - Live decision support based on model trained on each patients record
    - Tens of thousands of data points per patient incorporated

Discussion

David.Kendrick@MyHealthAccess.net

MyHealth@MyHealthAccess.net

www.MyHealthAccess.net

MyHealth ACCESS NETWORK