Tomorrow’s Coordinated Health Care System – Today

Enabling the Future of Healthcare Outcomes and Practices – A National Perspective

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Surgeon General Vivek Murthy
U.S. Surgeon General Initiatives

Heroin use is part of a larger substance abuse problem.

Nearly all people who used heroin also used at least 1 other drug. Most used at least 3 other drugs.

Heroin is a highly addictive opioid drug with a high risk of overdose and death by wear.

People who are addicted to...

- Alcohol
- Marijuana
- Cocaine
- Opioid Painkillers

...more likely to be addicted to heroin.

STEP IT UP!
SURGEON GENERAL'S CALL TO ACTION TO PROMOTE WALKING AND WALKABLE COMMUNITIES
Changing the Culture

Building a culture of prevention so we are a Nation that is as good at preventing illness as we are at treating illness.
Pine Ridge Reservation (South Dakota)
Mt Kilimanjaro, Tanzania
19,341 feet
“It's the action, not the fruit of the action, that's important. It may not be in your power, may not be in your time, that there'll be any fruit. But that doesn't mean you stop doing the right thing. You may never know what results come from your action. But if you do nothing, there will be no result.”

Gandhi
On the horizon....

- Within the next 24 months - evolution of fee for service into alternative payment models fueled by MACRA.
- Need to improve outcomes in order to survive financially.
- Providers and vendors must innovate or die
- Population health, big data, interoperability, personalized medicine, telemedicine
Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)

Changes how Medicare pays providers

Ends the Sustainable Growth Rate (SGR) formula for determining payments for providers’ services.

New framework for rewarding health care providers for giving better care

Combine existing quality reporting programs into one system

Incentives – Pay for value and better care.

Quality Programs:

- Merit-based Incentive Payment System (MIPS)
- Alternate Payment Models (APMs)
Merit-Based Incentive Payment System (MIPS)

Combines parts of the:
- Physician Quality Reporting System (PQRS)
- Value-based Payment Modifier
- Electronic Health Record (EHR) Incentive program

Single program based on:
- Quality
- Resource use
- Clinical practice improvement
- Meaningful use of certified EHR technology

Begins in 2019
- Physicians can remain under fee-for-service (FFS) along with pay-for-performance.
Alternative Payment Models (APMs)

Accountable Care Organizations (ACOs)
Patient Centered Medical Homes (PCMHs)
Bundled Payment models
Other value-based platforms

From 2019-2024, qualified participants will receive an annual 5 percent lump-sum incentive payment based on costs from physician fee schedule. The fee schedule increases annual payments to those participants starting in 2016 at the 0.75 percent rate.

Can choose to be excluded from MIPS and instead participate in certain APM’s.

Project from 41 million ACO-covered lives to 177 million ACO-covered lives by 2020.
Proposed rule

Centers for Medicare & Medicaid Services

42 CFR Parts 414 and 495

[CMS-5517-P]

RIN 0938-AS69

Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repeals the Medicare sustainable growth rate (SGR) methodology for updates to the physician fee schedule (PFS) and replaces it with a new Merit-based Incentive Payment System (MIPS) for MIPS eligible clinicians or groups under the PFS. This proposed rule would establish the MIPS, a new program for certain Medicare-enrolled practitioners. MIPS would consolidate components of
MIPS: Quality Payment Program

Success in four performance categories:

**Quality (50 percent of total score in year 1):** For this category, clinicians would choose to report six measures from among a range of options that accommodate differences among specialties and practices.

**Advancing Care Information (25 percent of total score in year 1):** For this category, clinicians would choose to report customizable measures that reflect how they use technology in their day-to-day practice, with a particular emphasis on interoperability and information exchange. Unlike the existing reporting program, this category would not require all-or-nothing EHR measurement or redundant quality reporting.

**Clinical Practice Improvement Activities (15 percent of total score in year 1):** This category would reward clinical practice improvements, such as activities focused on care coordination, beneficiary engagement, and patient safety. Clinicians may select activities that match their practices’ goals from a list of more than 90 options.

**Cost (10 percent of total score in year 1):** For this category, the score would be based on Medicare claims, meaning no reporting requirements for clinicians. This category would use 40 episode-specific measures to account for differences among specialties.
Advancing Care Information

New program within MIPS – incorporates health information technology into the Merit-based Payment System (MIPS) to be more patient-centric, practice driven and focused on connectivity.

Three priorities:

- Improved interoperability and the ability of physicians and patients to easily move and receive information from other physician’s systems;
- Increased flexibility in the Meaningful Use program; and
- User-friendly technology designed around how a physician works and interacts with patients.
## New Measures

<table>
<thead>
<tr>
<th>Measure ID Number</th>
<th>CMS E-Measure ID</th>
<th>Data Submission Method</th>
<th>Measure Type</th>
<th>National Quality Strategy Domain</th>
<th>Measure Title and Description</th>
<th>Measure Steward</th>
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<tbody>
<tr>
<td>105/009</td>
<td>125v4</td>
<td>EHR</td>
<td>Process</td>
<td>Effective Clinical Care</td>
<td>Anti-Depressant Medication Management</td>
<td>National Committee for Quality Assurance/American Heart Association</td>
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<td>Two rates are reported a. Percentage of patients who remained on an antidepressant medication for at least 64 days (12 weeks) b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months)</td>
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<td>*</td>
<td>0418/134</td>
<td>N/A</td>
<td>Claims, Web Interface, Registry, EHR, Measure Groups</td>
<td>Process</td>
<td>Community/Population Health</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
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When and where to submit comments

- The proposed rule includes proposed changes not reviewed in this presentation. We will not consider feedback during the call as formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the 60-day comment period on June 27, 2016. When commenting refer to file code CMS-5517-P.

- Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
  - Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier

- For additional information, please go to:
  http://go.cms.gov/QualityPaymentProgram
Health plan/physician strategies

- Develop road map for business
- Financial and clinical improvements in all areas of healthcare delivery.
- Important for physicians to understand payment reform and have a plan to adapt.
- All the models are about sharing risk and sharing savings.
- Sicker patients require more resources – increases financial risk.
- Bundled payments or flat rates
Payment methods and benefit designs

Base – provider’s underlying compensation
  ◦ Fixed (salary)
  ◦ Activity-based (fee schedules or case rates)
  ◦ Population-based (capitation)

Incremental – layered on top of base payments
  ◦ Pay-for-performance
  ◦ Shared risk

Cost Sharing
  ◦ Copayments, co-insurance, deductibles – encourages consumers to use particular provider or services
  ◦ Contingent coverage – requires consumers to receive approval from payer or provider to utilize insurance coverage.
Payment methods & Benefit Design

**PAYMENT METHODS**

- Fee schedules
- Primary care capitation
- Bundled payments
- Shared savings
- Pay for Performance

**BENEFIT DESIGN**

- Narrow networks
- Tiered networks
- High deductible health plans
- Value-based design
- Centers of excellence
- Incentives to use alternative sites of care
Health care delivery models

Accountable Care Organizations (ACO’s)
- Take on risk in the form of shared risk and/or capitation
- Narrow network can drive consumers to ACO’s providers
- Broad network would not support risk-based payment method for ACO.

Patient-Centered medical homes (PCMHs)
- Value-based design
- Aligns interests of patient and practice; lowers consumer cost sharing
- Capitated payments to providers in PCMH support ability to make care more accessible, e.g. telehealth

Center of Excellence
- Delivers a limited set of high quality services efficiently
- Providers paid a package price for bundled episodes
- Consumers can compare prices
Guidance will allow Medicaid HITECH funds to support all Medicaid providers that Eligible Providers want to coordinate with.

Medicaid HITECH funds can support HIE onboarding and systems for behavioral health providers, long term care providers, substance abuse treatment providers correctional health, social workers, etc...

Will support HIE on-boarding of laboratory, pharmacy and public health providers.

90/10 Federal State match

Funding in place until 2021.

Funding must be cost allocated if other entities benefit.

For interoperability (not to provide EHRs). For implementation, not operational.

All providers or systems supported by the funding must connect to Medicaid Eligible Provider’s (EP’s)
Medicaid HITECH funds

All providers or systems supported by this funding must connect to Medicaid Eligible Providers (EPs).

Examples of Use Cases that HITECH funds can support:
- Provider Directories
- Secure messaging
  - May support transitions of care
- Encounter alerting
  - Admission, Discharge and Transfer (ADT) messages
- Health Information Service Providers (HISP)
- Care Plan Exchange
  - Summary of care
- Query Exchange
- Public Health Systems (Immunization registries, PDMP)
Care Plan Exchange

Scenario 1: Unidirectional Exchange of a Care Plan during a complete handoff of care form the sending Care Team (e.g. Hospital setting) to a receiving Care Team (e.g. Home Health Agency and PCP)

Scenario 2: Exchanging a Care Plan between Care Team Members and a Patient

• Setting 1: Hospital or ED where Patient is discharged from sends Care Plan to Care Team in non-acute care setting

• Setting 2: Care Team including Patient in Acute Care Setting creates harmonized Care Plan for exchange with a second Care Team in a non-acute care setting

• Setting 3: Patient receives Care Plan in their personal health record application or patient system.
The public health systems that support Eligible Providers in achieving Meaningful Use may now be supported:

- Immunization Registries
- Syndromic Surveillance Registries
- Specialty Registries
  - Prescription Drug Monitoring Programs (non-MMIS)
  - Other diseases/conditions that are state priorities (homelessness, lead exposure, etc.)
- Architecture for the registries can now be supported, not just connections
Disparities in Health and Health Care

Social determinants and health outcomes

- Extensive evidence demonstrates a clear relationship between a variety of social determinants and health outcomes.
- States with higher ratios of social to health spending had better health outcomes one and two years later, compared to states with lower ratios.
- Social Services spending: Public Health, education, income support, transportation, environment, public safety, housing

Disadvantaged neighborhoods

Area Deprivation Index (ADI) – a validated census-based measure at the neighborhood level.

◦ Correlated with multiple health outcomes
◦ Recognized widely in research, census based indicators

Powerful Predictor

◦ Living in a severely disadvantages neighborhood predicts re-hospitalization as powerfully as the presence of illness, such as pulmonary disease; stronger predictor than diabetes
Patient Segmentation Analysis

Crucial to understand differences across patients and their needs.

Uses big data to help divide the population into distinct groups, which can then be targeted with care models and intervention programs tailored to their needs.

- Whole populations
- Sub populations
- High-risk populations
Patient segmentation in integrated care

1. Understanding variation in needs within the population
2. Identifying sub-populations with homogeneous needs
3. Understanding variation in needs within the subpopulation
4. Identifying high-risk groups within the population
5. Understanding variation in needs within high-risk groups

Examples:
1. Better Health for London
2. Delaware's State Health Care Innovation Plan
3. Kaiser Permanente's Senior Segmentation Algorithm
4. ValQronic
5. Counties Manukau
Drug-related morbidity

59 percent of drug-related emergency room visits are preventable. The most common reasons include:

- Adverse drug reactions – 39.3%
- Nonadherence – 27.9%
- Wrong or suboptimal dose – 11.5%

A Way of Life

“Good teams incorporate teamwork into their culture, creating the building blocks for success.”

Ted Sundquist, American football player, manager and commentator
Community-based Care transition programs

Improve transition from inpatient hospitals to home or other care setting.

Nursing, social workers, mental health workers, community health workers, pharmacists. Develop strategy to address patients at risk

Need champions!
Change: Kotter’s 8 Stage Process

1. Compelling reason to embrace change
2. Guiding Coalition of staff and students who support change
3. Vision and Strategy for direction and motivation
4. Communicate Vision to students — must “walk the talk”
5. Empower students to act by removing perceived barriers
6. Plan for and acknowledge a few short term wins to demonstrate progress
7. Consolidate gains using credibility to encourage more change
8. Integrate into Culture

Leading Change in Learning using Kotter’s Eight-stage Process
Working as a team – changing the culture

Be aware of group dynamics
  ◦ Different ages, values, ethnic/cultural

Everyone participates, feels valued

Informal leader/champion – support on the side

Help people visualize
  ◦ Hear/read about other best practices
  ◦ Listen to naysayers

Encourage creativity, empower
  ◦ Be open-minded, adaptable

Keep moving every week (or two)

Cheerleader/feedback
Supporting change
New care delivery models – new measures

As new care delivery models evolve to focus on value, accountability, and team-based care, new measure development opportunities exist to address care gaps and to support team-based care delivery systems and care transitions.

Measuring what matters

Differentiate provider performance: clinical processes, effectiveness, and diagnostic/treatment accuracy

Identify patient safety improvements and all-cause harm causes Close identified gaps in care

Track care coordination and transitions

Monitor practice transformation progress

Define high-performing teams

Document trusted patient-provider relationships.

# Caring Health Care Providers

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Caring</th>
<th>Non-Caring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voice</td>
<td>Talks at same level as patient; concerned voice</td>
<td>Talks down</td>
</tr>
<tr>
<td>Availability</td>
<td>Is available when needed</td>
<td>Limited availability</td>
</tr>
<tr>
<td>Presence</td>
<td>Listens, spends time with patient</td>
<td>Is in a hurry, rushes in and out.</td>
</tr>
<tr>
<td>Attitude</td>
<td>Shows patience when waiting for patient to make a decision</td>
<td>Lectures patient, is pushy.</td>
</tr>
<tr>
<td>Touch</td>
<td>Shakes hand, gentle touch</td>
<td>Afraid to touch</td>
</tr>
<tr>
<td>Respect</td>
<td>Respectful to elders</td>
<td>Criticizes or shames elder or family</td>
</tr>
<tr>
<td>Visit</td>
<td>Connects with patient; shares something about themselves.</td>
<td>All business; no connection.</td>
</tr>
</tbody>
</table>
Disruptive Technology
Connected Health

- Technology enabled care (TEC) is the collective term for telehealth, telemedicine, mHealth, etc.
- Wearables
Patient reported outcomes

- Opportunities for using patient-reported outcomes to enhance care delivery
- Play a role in successful shared decision making
- Provides insights into patients’ experiences of symptoms, quality of life, and functioning; values and preferences; and goals for health care.
- Patient survey - 80 percent of the respondents agreed that they would be willing to share their data for improved care.
- Challenges - logistical concerns, measurement challenges, technological barriers

Smart Medication Monitoring and Management

Smart Injector
- Dose taken
- Date/time log
- Temperature
- Expiration date
- Wireless data transfer

Smart Inhaler
- Dose taken
- Date/time log
- Temperature
- Expiration date
- Wireless data transfer

Data flowing back from “Smart” medications are presented in exception management dashboards for review by Pharmacists and other Care Team members.
Smart Medication Monitoring and Management

Smart Patch
- Date/time applied
- Duplicate patch?
- Temperature
- Expiration date
- Wireless data transfer

Smart Package
- Pill removed
- Date/time log
- Temperature
- Expiration date
- Wireless data transfer

Data flowing back from “Smart” medications are presented in exception management dashboards for review by Pharmacists and other Care Team members.
Synchronous vs Asynchronous Health Communication
**Synchronous vs. Asynchronous (Exception-Based)**

### Case Management and Care Coordination

<table>
<thead>
<tr>
<th></th>
<th>Synchronous</th>
<th>Asynchronous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounter or Call time (mins)</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Encounters or Calls / day</td>
<td>20</td>
<td>500</td>
</tr>
<tr>
<td>Encounters or Calls / week / FTE</td>
<td>100</td>
<td>2500</td>
</tr>
<tr>
<td>Health Concern Detection</td>
<td>5%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Exception-Based Asynchronous Communication and wireless remote monitoring offers better care, to more patients, at a fraction of the cost of traditional synchronous-based care.
“Take the first step in faith. You don't have to see the whole staircase, just take the first step.”

Dr. Martin Luther King Jr.
Sunrise from the top of Mt Kilimanjaro
Closing
Medical Reserve Corps

★ National “Network of Networks”
★ Mission: Engage volunteers to strengthen public health, reduce vulnerability and disaster risk, build resiliency, and improve community preparedness, response and recovery capabilities
★ Keys to success:
  ★ Dedicated volunteers and leaders
  ★ Supportive housing organizations
  ★ Strong partnerships

http://www.naccho.org/topics/emergency/MRC/networkprofile