# What is the Path to Success?

## Steps to Establishing New Analytical Based Approaches and Evaluating System Changes Using Assessments of Uncoordinated Care

State and federal agencies and health plans are designing and testing new care delivery and payment models such as patient centered medical/health homes, accountable care organizations, integrated care coordination programs, provider performance incentives, interoperable health information exchanges, and electronic health records with clinical decision support systems. However, in order to truly create value and efficiency in the healthcare system, these approaches will have to be integrated and implemented with a better understanding of current delivery and access patterns that are not consistent with best practices, are inefficient and create unnecessary costs. This overview offers some suggested steps in establishing analytical based approaches, targeting specific patients, as well as evaluating changes to health care delivery systems using assessments of uncoordinated care. These approaches will provide the basis for identifying and reducing unnecessary costs and improving the quality of care in both fee-for-service and managed care delivery models.

### Defining the Problems and Solutions

**1. Increasing expenditures and inefficiency due to uncoordinated care**

Public and commercial plans are struggling with increasing healthcare budget growth and increasing patient enrollment while realizing that the system of care delivery is not functioning as efficiently or cost effectively as possible to achieve the best clinical outcomes.

**Solution:** Apply new methods to identify and target the specific patients who have unnecessary, duplicative and inappropriate services as well as those with opportunities for savings due to improved care coordination. According to Southeastern Consultants' recent findings published by the national Institute of Medicine, if health reform efforts aimed at uncoordinated care patients are developed and implemented in U.S. public and commercial health plans, the average savings that can be achieved are estimated at $240 billion per year or 9% of the total annual expenditures for direct care services.[1]

**2. Lack of resource coordination and patient targeting among management programs**

State Medicaid agencies and managed care health plans expend significant resources on silo based utilization and administrative management programs. Current utilization review programs, care management and audit/investigative programs are often not coordinated with each other in terms of common criteria applied, procedures for referrals and follow-up, and a shared focus and intervention

[1] ***The Healthcare Imperative: Lowering Costs and Improving Outcomes.*** **The Institute of Medicine. 2010. Washington, DC: The National Academies Press.** Publication Link: Owens, MK. Chapter 3: Inefficiently Delivered Services, Costs of Uncoordinated Care, pgs 131-138. http://books.nap.edu/openbook.php?record_id=12750&page=131

strategy specifically for an identified subset of patients that will generate the greatest return on investment.

**Solution:** Evaluate and retool existing systems and programs periodically which may include modifying current technology, system edits, and creating common and integrated criteria among existing utilization review and disease/care management programs to target the, same groups of patients, coordinate efforts and increase return on investment for these intervention and monitoring programs.

**3. Lack of integrated technologies to improve efficiency and patient outcomes**

Technologies that are currently being implemented in many plans, such as electronic health information exchange systems, e-prescribing, and other two-way provider monitoring and communication tools are not integrated among inpatient and outpatient settings nor with patients' claims and treatment histories so that there is actionable information available for medical home providers and others involved in care management.

**Solution:** Integrate various technologies that offer the best return on investment for patient and provider monitoring of service utilization, costs, and quality of care. Patients that are identified in the claims analysis as receiving uncoordinated care should be prioritized to receive focused interventions and their providers could be prioritized to receive allocations of new technologies and resources first, as part of a plan-wide effort or in regional pilot programs to expand medical and pharmacy home models of integrated care.

**4. Need for provider incentives and new payment models**

Providers lack incentives for reducing unnecessary services and facilitating the appropriate care specific to each individual patient. Managed care payment and delivery models do not automatically ensure that unnecessary services will be reduced or that care will always be better coordinated since individual providers are reimbursed primarily on a fee-for-service basis and are often not paid performance based fees to coordinate care delivery with care management intervention and monitoring programs and with other treating providers.

**Solution:** There must be a concerted effort to engage providers to be active participants in assisting patients with achieving coordinated care via new models such as medical/pharmacy homes and accountable care organizations. Engage stakeholders, such as hospitals, physician groups, pharmacists, patient advocates, and others to design care delivery and reimbursement models that create incentives for providers to assume enhanced patient management activities in a multidisciplinary team approach. Initially, resources should be focused on the identified, targeted uncoordinated care patients. Providers should be adequately compensated and encouraged to perform these added responsibilities, such as through increased care management fees, shared savings arrangements, medication therapy management fees, receiving enhanced practice management technology tools, pay for performance, and other appropriate incentives.

**5. Need for sophisticated analytics and deeper understanding of data**

Current approaches in analytics attempt to identify patients that are high cost, high utilizers, and those "at risk" for adverse events that result in hospitalizations or "at risk" for high cost services and procedures. This traditional approach mistakenly assumes that all of the identified patients are both cost and quality impactable which we know is not the case as many of these patients have complex, co-morbid

 

conditions that must be treated often at appropriate levels of high cost to the system. This risk stratification approach results from a very superficial understanding of the data and is best used to simply predict future costs for patients. Predicting future costs is useful for budgeting processes, but does nothing to identify unnecessary costs and services that are driving those predictive costs inappropriately.

**Solution**: Use a validated analytical approach to identify uncoordinated care and create a corrective action plan for the targeted subpopulation and use this approach to design an effort to measure the effect of specific programmatic changes and interventions. Patient-level and population-level analysis of uncoordinated care is a set of measures which healthcare delivery systems can use for several purposes. For example, there may be interventions such as payment reforms, use of health information technology, use of medical homes and other changes in delivery systems and operations. Analysis of uncoordinated care can measure how much implemented changes reduced this important problem. This analysis identifies coordination of care problems, gaps in treatments, and cost variances between like patients resulting from their uncoordinated care. An important use of this analysis can also be to provide actionable information at the point of care to reduce uncoordinated care. This involves assessment, monitoring, communication, and corrective actions by providers and plan administrators.

## Steps in the path to success

1. **Obtain data sets of population to conduct initial assessment.**

   The assessment involves a 12 month baseline analysis using medical and pharmacy claims data from the payer/plan or claims processor. A payer/plan, whether fee for service or capitated managed care plan, could be providing services for Medicare, Medicaid, CHIP, state/federal employee, VA, commercial or group health enrollees. Other datasets that a payer or provider may make available, such as clinical repositories or electronic medical records data, can help enrich the basic claims data to provide for deeper analyses and monitoring.

2. **Ensure updates to data sets for review on a periodic basis for a reasonable time frame.**

   In addition to the baseline analysis, subsequent quarterly updates should be conducted for the given population. A single analysis over a shorter time window can itself provide valuable information for any delivery system. However, a demonstration of effectiveness in reducing uncoordinated care from any set of factors requires at least six months post interventional changes to accurately assess success rates and utilization and cost changes. Other more frequent updates may be helpful on a monthly basis such as for monitoring drug prescribing and appropriate use in the targeted population.

3. **Identify cost savings targets for the subset of patients with high levels of uncoordinated care.**

   Patients with high levels of uncoordinated care exhibit utilization patterns consistent with uncoordinated care based on clinically and statistically validated proprietary algorithms. Patient specific coordination of care risk scores are generated form a series of base criteria and secondary weighted criteria thresholds. The assessment is useful in both fee–for-service and managed care models and can provide aggregate risk scores or scores for any subpopulation for pre and post evaluation of improved care coordination.

   An in-depth claims analysis using the specified datasets is used to analyze and report defined measures on patient utilization and treatment patterns. This approach identifies and stratifies patients with coordination of care problems, evaluates gaps in treatment, and uses other utilization and quality

indicators to compare groups of patients to other like patients to determine inappropriate cost variances and differences in clinical and utilization measures. Some of the analytical measures may include:

- Medication use for duplicative and inappropriate dosing, prescribing and adherence
- Medical events such as avoidable hospitalizations and ER visits, duplicative or unnecessary office visits, labs and other services
- Provider pattern analysis to map prescribers/treating providers by specialty type, drug prescribing, and patient subtypes to evaluate provider access and treatment patterns including evaluation of assigned primary care provider usage and/or medical home compliance.

**4. Select the appropriate targeted subset of patients.**

A particular subset of patients can be selected on any number of factors. Generally, it is feasible to select the most extreme patients with uncoordinated care after reviewing matched subsets. One method is to select a subgroup with a particular threshold risk score such as the top 10% as measured by uncoordinated care indicators. Another option is to select the subgroup with the most per patient cost savings opportunities based on a matched comparison sample. These methods allow selection based on factors such as who may benefit most from targeted care coordination and enhanced management based on factors such as likely return on investment and overall program savings.

**5. Develop and apply corrective actions based on actionable information.**

Patient level information allows for a variety of corrective actions. At a minimum, this means providing actionable information to providers of those who have high scores and those at high risk for uncoordinated care. Payers/plans may create expectations regarding steps to reduce uncoordinated care. Providers will have access to treatment and utilization information they did not have previously. This may mean additional questions and engagement with patients. Corrective actions may also mean focusing care coordination resources such as case managers on the subset populations where such management can drive down uncoordinated care and resulting costs. Some patients may need medication reconciliation activities, comprehensive medication therapy management, or specialized care/case management interventions. Providers and payers must have continuous dialogue on the best means to improve the system and reduce the identified problems.

**6. Continuous assessment of system improvement.**

Assessment and analysis of uncoordinated care, including patient specific information, can provide great insights on healthcare delivery systems. Creating a measure of uncoordinated care in a population can provide a basis to advocate changes in payment policies, new models of delivery, and new incentive programs as well a method to evaluate improvements and changes that are implemented. An understanding of the data at a deeper level can change priorities regarding how to focus resources and determining which intervention and monitoring programs best address the needs of the population.

**Contact: Mary Kay Owens at mowens@ihis-health.org (850-668-8524) Author and primary developer of this analytical approach.**

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