To Unlock ACO Access to Real Savings, Start with Trusted Data

written by Theresa Hush | August 22, 2024

Value-Based Care payment models are based on a clear CMS goal: lower Total Cost of Care and its counterpart, Total Per Capita Cost. But neither TCoC nor TPCC gives you the information you need to target your cost efforts. How to start? Begin by evaluating what initiatives you need to do in the five key areas:

Community Referrals
Avoid High-Risk Events
Cost Variation
Chronic Disease Intervention
Physician Episode Sharing

Your ACO may look at these five areas and think many of them are already underway through population health and other activities. But while population health efforts can help get patients services, they cannot change the course of treatments for patients who are not improving or evaluate variation in care. To make any clinical improvements in care, you will need to engage

your physicians. Those physicians must be equipped with data that they trust.

First, Examine What Data You Have

To examine your possibilities, look at these five key areas in connection with the type and quantity of your existing data. Your ability to improve patient health and manage costs is dependent on the amount and type of data you can harness. With small amounts of data that don't include all the necessary patient information, you can do some initiatives, but not a lot. The scale and efforts for your ACO will vary by volume of patients, payor mix and demographics, and the strategies you create in each area.

The Reality of a Low Data Approach

As we outlined in a previous article, you can start initiatives to improve outcomes and manage associated clinical costs with limited quality data that you are already collecting for your ACO.

Measure data for 2025 APP Reporting won't generate a lot of savings, because the numbers will be small. If you use a Medicare CQM method to report data to CMS, it will be further limited to avoiding hospital and ER events for patients based on clinical factors. The APP Measure values, to be most useful, should be gathered over a longer time period to identify the patient's trend, and be part of a multi-factor risk assessment.

Data will also depend on your data source. QRDA 1 data is generated to satisfy quality measures only, and therefore will not provide related outcomes, such as obesity for patients with high HgbA1C and uncontrolled blood pressure. For example, QRDA data would be insufficient to identify patients who are good candidates for continuous glucose monitoring or community social services.

Nevertheless, QRDA measures can provide a list of patients with high HgbA1C and uncontrolled blood pressure that could be matched with claims data on events and form a basic project for ensuring that patients have met visit requirements. It can also be used to form a base for importing other data for more focused initiatives, and thus provide valuable lessons about how to use data to engage physicians in improvements. Such data may also provide value on screening your population of patients with social factors preventing access to care. If you have no funds or ability to aggregate data from your participants' EHRs, you can at least start here.

Strategic Initiatives Need High Data Value

Each of the five key areas must be backed by a specific set of clinical data, which requires that your sources enable that data to be aggregated. Comparisons based on clinical data are

essential if you want to engage physicians in improvements. You should realize that all EHR data does not have equivalent value. Value varies based on data source, data extraction type, time, clinician documentation, and even implementation of the EHR itself.

Each aggregation methodology has pros and cons, and the cons don't apply just to QRDAs. Use of flat files to report data for aggregation are excellent for transactional data, but not always for some clinical data points that may be stored through EHR specialty-customized templates, and therefore require staff resources to produce. Flat files are not interoperable data, and although they can be a great source for a group that has no alternative methodology or database, they must be generated by Information Technology staff. FHIR connections, the highest standard for data aggregation and the source aligned with high-value continuous data feeds, are just now being accepted by some participating providers and their ACOs.

ACOs are often comprised of multiple groups on different systems. Some groups are still using paper records or are on old systems without data export capabilities. The acquisition of data for the purpose of all initiatives—cost as well as quality strategies—will depend on ACOs facilitating their practices' modernization and adoption of fewer, certified systems with FHIR application setups and sandboxes for analytics vendors.

Data Is Just the Starting Point—It Must be Energized by Analytics and Sharing

Your ACO will likely depend on a data aggregation and analytics vendor to aggregate, integrate, and energize your data. These vendors are, like Roji Health Intelligence, often in the business of meeting other business needs, such as quality reporting or clinical integration.

Minimal data aggregation involves claims, EHR transactional and clinical data, and disparate sources of clinical data. The target for this data is a database that is the center of your Value-Based Care platform, internal or vendor-created, and which fuels your strategies. It should be able to connect to other operational systems like EHRs and population health, and must share data with clinicians. Without information sharing and feedback loops for clinicians, your ACO cannot achieve trusted data.

The platform should have functionality for costs analysis, but should also involve the next step: to set up improvements via shared data among clinicians by specialty or collaborating groups, or clinical teams. The platform should also be able to break down the data into comparable units of measurement to identify costs. For example, an examination of costs for specialty services, divided into various specialties or even procedures, is not actionable. How much is not enough or too much? Your objective should be to calculate services provided to a patient, with

both outcomes and costs, in a way that is consistent with optimal clinical care over a time-delimited period. Patient Episodes allow you compare patient cases and examine for variations, complications, or other items that drive the cost higher (or lower).

Episodes of Care are the vehicle for comparison with others. Patient Episodes of Care are different from payment-driven episodes like Bundled Payments or other Episodic payments used by payors to cap reimbursement levels. The goal is to create episodes with clinical integrity that can serve as a vehicle for a true comparison of patient outcomes, services, and costs, for conditions and procedures that are defined by the same set of diagnosis or procedure codes.

Four of the five key areas are informed by Episodes of Care for either patients with chronic illness or patients undergoing treatments and procedures:

Avoid high-cost Events for high-risk individuals;
Narrow cost variation by identifying cost drivers and possible issues in clinical delivery;
Engage patients in change; and
Share data with physicians to guide clinical examination of costs.

The path to data-driven Value-Based Care is detailed and tolerates few shortcuts without compromising data that is trusted by clinicians. But the result of all that effort is well worth it: Clinicians who willingly use trusted cost and quality data to improve your patient care and manage costs, so that your ACO shines.

Founded in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.