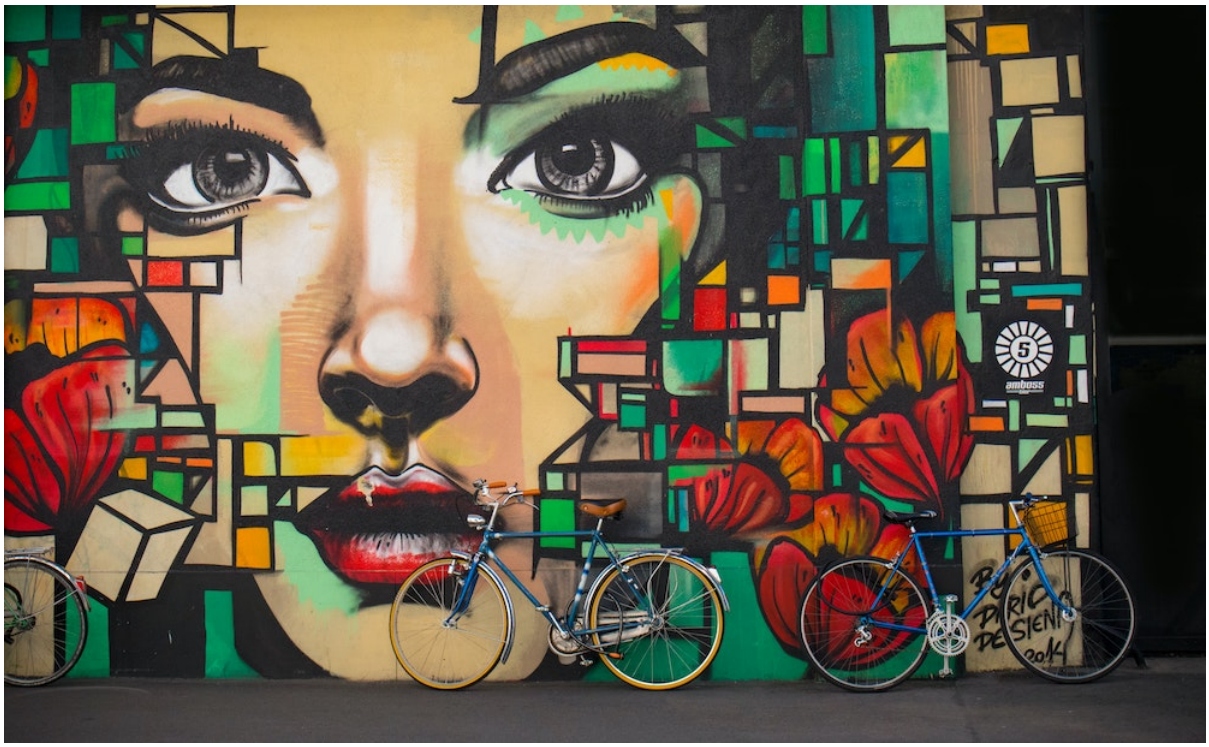
5 Imperatives for Your Value-Based Technology to Support APMs

written by Theresa Hush | June 23, 2022



After years spent transforming your health care technology, you may feel like you're almost done. But Value-Based Care Technology requires a different mindset. With reimbursement scaling to a tipping point for APM adoption, think "reboot"

instead. Your health system or group has a long way to go if your aggregated and integrated data cannot support person-centric care and data-directed population health, quality, and health equity strategies.

The Value-Based Care Technology game is no longer focused on implementing an EHR, or even population health. Those are basic ingredients that make it possible to do more. Now it's about bringing all the systems and data together to create value for your clinicians and your patients, a view that experts are beginning to advocate. Your ability to drive better performance in outcomes and costs will depend on radical improvements in data sufficiency and how that data lines up in your systems for use by stakeholders.

Consider this: for your clinicians to develop an optimal clinical plan with each patient under care in an APM, they must first understand the patient's long-term outcomes and events, plus the patient's own social needs and preferences and costs. Much of this is data clinicians never see now, even if they are using an EHR. Understanding and sharing this data makes it possible to help patients self-manage conditions and participate in prescribed therapies, and to feed information back to their clinicians. Across the organization, this is what drives better care and lower costs.

Data sufficiency is the number one issue most health systems and groups contemplating APMs must tackle. But it's not the only data issue you have. Let's unpack what your new APM world requires for getting and utilizing data.

Number One Mandate for APM Adoption: Data Sufficiency in Value-Based Care Technology

We've written before about how ACOs, especially those with multiple stakeholder groups and organizations, must develop a common data infrastructure. Data poverty limits your possibilities of rolling out even the most basic clinical interventions to improve outcomes and cost performance.

The bar for enough data, however, keeps getting higher. CMS has articulated a broader vision for quality and health equity, and has also recently outlined its vision for capturing and using specialty data between independent groups.

The recipe for creating the data you need to inform your APM starts with your own health system's or APM participating groups' data systems. But to gain a holistic view of your patients, eventually you must integrate outside data for services that you have referred to specialists or outside providers. Even if you have HIPAA-compliant data sharing agreements to get this far, there will still be gaps. Services provided to your patients that they selected or were outside your referral networks, as well as patient-held data that reflects outcomes and self-management (such as device data), will still be unknown, unless you have agreements to capture claims payment information from payers and arrangements to incorporate patient-held data.

How your own systems contribute to this scenario may go way beyond what you might have considered. EHRs in use by providers, transactional and financial information, managed care claims or insurance-negotiated rates many of which are not currently contributing to an APM data structure—are all

essential. The EHR feed should include as much clinical information as possible, especially diagnostic and lab values that are critical to staging or categorizing level of conditions, diagnoses, procedures, symptoms, outcomes, medications, and so on. To address health equity, collecting patient information on Social Determinants of Health is critical for inclusion in the EHR data. Ultimately, your goal is to provide a full view of each patient's clinical status and social barriers to improvement, along with patient risk and cost information.

In addition to data sources, data sufficiency also requires that all modes of care—outpatient setting or facility, emergency facility, urgent care, virtual appointments, and care-at home—can also eventually be included in the data. If this information is not currently being captured in your EHR, that is a required build so that it can be incorporated in your EHR feed.

It should already be obvious that the EHR is not the end point, but a source to the person-centric repository to facilitate data analytics, artificial intelligence, and performance improvement. In turn, data essential to the clinical experience should loop back into the EHR for action, be ported to population health for other interventions and into physician insights when activated.

Technology Build Differs from Historical Health Care Systems

You are most likely organizing your technology within organizational boundaries and then by functionality. But the result is that data cannot talk to each other from one entity

and system to the next, nor produce the needed information to stakeholders, such as person-centric outcomes, generalized data analytics that compare care teams in quality, and health-equity measure results.

The future will focus APM technology on person-centric results and demand that the entire care team is invested in the results and the path to reaching them—through data analytics and data-driven interventions, and the patient and patient's support group. In short, the future systems are upside down from where we are now.

While building this will take time as well as modifications in regulations and systems, and further developments of APMs that skirt current obstacles imposed by regulations, anti-trust, and competition between provider entities, you still need to set your sights toward data and technology that is very different from today.

Six Imperatives to Enable APMs with Value-Base Care Technology

Let's assume that you have already invested in aggregating sources of clinical and financial data into a repository. Where should you go from there?

First, let's examine what you need to manage the current environment. Your most immediate problem is identifying cost and helping to steer patient outcomes in a positive direction.

Your systems must aggregate the data and have analytics that tell you, by person, whether their clinical trajectory is on course or requires change. The data on what adjustments in the

patient’s plan are needed must be accessible at key decision points for every care team member, the patient, and the patient’s support network. Those decision points happen when you can engage both the clinician and the patient and/or patient’s support network. Clinical decisions are normally made iteratively over time in response to new information—and not always at a visit when a clinician is reviewing a patient’s EHR record with the patient.

With the need for time- and team-variation in mind, your technology needs to have these key attributes:

1. Build technology to be person-centric, with capture of longitudinal transactional data from all systems (clinical, financial, administrative), and the functionality to view patient episodes of care.

Only through episodes can you evaluate the course of care individually and compare like events of care across people. Episodes can capture general conditions, specialty conditions and procedures, and multiple-condition episodes for conditions that are treated in combination, such as metabolic disease. Episodes can define discrete outcomes, cost profiles, quality measures, and interventions for improvement.

2. Support collaboration of care team members involved in a given episode based on shared data, regardless of whether or not they are in the same health care organization, and provide the mechanism for communication and input in the patient's outcomes and clinical interventions.

Value-Based Care Technology is the starting point for driving change in clinical results as a result of data and insights from data. A big change in culture for clinicians, the beginning stages of Value-Based Care adoption will consist of building trust, learning, and using data.

To be comprehensive, data from all venues of care—including, increasingly, the patient's home— should be captured. Primary and specialty, primary and behavioral health provider, and primary and community social service organization or home care provider are just a few of the permutations that will be involved with individual patients. Creating a plan that will involve multiple parties as well as the patient requires a common "system" in which every clinician (and the patient) can see outcomes and can contribute to the plan.

3. Provide the vehicle for patient engagement, patient-reported outcomes, patient self-management, and cost transparency.

Current systems are top-down and built for providers. Patients should be equal participants in new technology with a purpose of partnership. Along with many other changes to address health

care consumer needs, the hierarchy of systems and their data must change. The idea that provider data is superior and consumer data is suspect or of poorer quality prohibits you from seeing the full scope of your patients' health. In particular, prohibitions against inclusion of data from patient devices and patient-reported outcomes should be lifted and the data included in the technology so that they can inform members of the care team.

4. Provide the measures and tools to improve health status. Value-Based Care technology should measure health status improvement by positive changes in longitudinal outcomes and avoidance of low-value procedures, and by health equity measures.

The tools should ensure that findings loop back to views in all prominent technology—including but not limited to the EHR and population health—where data activates interventions for the care team and patient.

Note that while costs are not specifically noted for inclusion in technology, the APM is intended to meet that objective. The inclusion of cost information will be essential for providing patients with transparency and for giving physicians an understanding of downstream costs. We need to understand that, currently, comprehensive data is often unavailable. While all insurance agreements should be negotiated to obtain claims data to support cost analyses, you don't have the time to wait until cost data materializes to adopt Value-Based Care Technology for APMs.

There is another reason why costs can be treated separately and judiciously. Your care teams can achieve greater results if your path is clinical and patient-focused. You can prevent problems that cause the patient to need higher resource care by helping them manage risks or improve their condition- and age-risk management capabilities through data-driven population health programs tied to these risks. Clinical interventions are the most powerful tools for correcting the patient's cost trajectory and engaging them in sound medical decisions.

5. Manage downstream APM payments.

For APMs embarking on a full risk strategy that involves downstream payments not only to primaries but also to outside providers, Value-Based Care Technology must have the functionality of claims payments, contract management, and population and network management that is tied to various insurance contracts. At-risk contracts are expected to grow 9 percent annually from 2020 to 2025.

Even CMS is beginning to understand that until APMs such as ACOs can fully collaborate with specialty care through data sharing and reimbursement mechanisms, their ability to manage costs is limited, a perspective that we have frequently promoted as a means for ACOs to improve outcomes and better control costs. One of the advantages of the ACO Reach global payments options is that the payment mechanism facilitates collaboration with specialists, an advantage over the MSSP ACOs, which must rely on interest from the specialty group to generate engagement in collaborative sharing of data on outcomes and costs.

Data-driven strategies give you the ability to take on the

future of Alternative Payment Models. But today's current systems are still set up to support Fee-for-Service and cost distribution more than they are devised to redesign clinical care. Value-Based Care requires us to rethink how to organize the fundamental systems we use to create effective, accessible care to patients. And, this effort does more. While it starts with data sufficiency, the bigger challenge is to imagine how to redesign and reconstruct systems to highlight the value of our services: better outcomes, more access to care, and lower costs.

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.

Image: Timon Klauser