

## Transcript of PAC Track 2 (Operationalizing CPC+ Data Distribution and Aligning Quality Measure Sets and Reporting), Meeting 3

February 28, 2017

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### **[Charles Fazio]**

Uh, good afternoon, everybody. Uh, this is Charlie Fazio, uh, chair of our Action Collaborative. Welcome to this meeting of Track 2. Uh, couple things: one, we think we're set-up to have a wonderful conversation today, um, uh, some material that we think you'll find really interesting and an opportunity for conversation, uh, about that material and, uh, about what's going on in one of our regions. Uh, the other thing I'll mention before we start, uh, we have a request. Uh, we're working really hard to make adjustments as we go and to make sure that these sessions are meeting your needs. So, at the end of the session we have a couple of, uh, polling questions to try to get to some of that information. We have an open-ended question to try to get to that some of the information. Uh, what's working well, what do you need to have work differently, uh, so that this, um, even better meets your needs. Um, so we're glad you're here. Uh, we're looking forward to hearing some of that feedback after what promises to be a great session, and with that I'll turn it over to Lauren Icard.

### **[Lauren Icard]**

Hi, everyone, this is Lauren Icard. I'll just add my thing. So, I'm glad you're all able to join today. As Charlie said, we're expecting this to be a very robust conversation and interactive conversation. So, I just wanted to provide a couple of reminders. Um, in order to submit questions or to participate in the conversation you have two options: the first is the chat box feature. You'll find that on the left side of your screen if you're, um, connected to the online meeting. Um, the second way is to use your phone. So, if you're going to participate in the conversation verbally, you'll need to dial-in using your phone. Um, and just a couple of reminders about ReadyTalk, we hope that everyone is feeling comfortable with this new technology, but if you have any connectivity issues, um, first we ask that you try to refresh your browser, and if you have any additional questions, or, or can't seem to get it to work, feel free to contact Brian whose email and number are on the slide here or, um, any of the rest of us. We'll be happy to help you with that. Um, as I said, we want this to be an interactive and engaging conversation, so all the lines will be unmuted. Um, this means we need your help so please, um, mute your lines if you're not speaking and we ask that you, um, please don't put us on hold. Um, that would be great. Um, so, uh, without further ado, I'll turn over to Michael so we can get into the meat of the conversation.

### **[Michael Bailit]**

Thanks, Lauren. Hi, everybody. So, our agenda today is, um, really almost all Oklahoma all the time. We are focusing on, uh, um, uh, in-depth, um, uh, learning experience about what, um, Oklahoma has done on, uh, data aggregation. Uh, before we go there, um, our, uh, our every meeting reminder, uh, to please not share any financial information, uh, that is, uh, competitively sensitive during the course of our call today. Um, as a reminder, this, um, Pac Track 2 is about, um, uh, data support to practices. This is our third conversation that we've had on the topic, uh, and this aligns with, um, the sixth milestone in the CPC+ payer partner collaboration roadmap. Um, as I said this is, um, our third conversation on, um, on data aggregation and, uh, data alignment strategies. We will have one more on this topic, um, and, uh, then we will, uh, transition to talking about, uh, um, measure and measure set alignment. Uh, but, uh, today we're going to continue on, uh, the theme of data support to practices.

Um, during our first meeting, uh, we learned that there's, um, some real variation among the CPC+ regions with the respect to data strategies. Some regions have already aggregated, or in the process of aggregating paired data, for the purpose of distributing unified data and/or reports to practices, and sometimes that aggregated data includes clinical data; but for other regions, data aggregation might be a longer term possibility, but in the short-term, the regions are really going to focus upon aligning, um, separate reports that each pair will provide to practices to support their performance transformation and improvement effort.

Um, during our second meeting, we heard from Diane Marriott and Ellen Bunting who described Michigan's really impressive data aggregation reporting strategy. Um, for those of you who participated and those of you who didn't, um, Michigan's leveraging a state-wide multipayer claims and clinical database that was developed and is maintained by the Michigan Data Collaborative. And they're providing data reports and analytics to 37 provider organizations, over 300 primary care practices, serving, uh, 1.2 million covered lives. We also heard during our last meeting from Sarah Wang from Arkansas BlueCross BlueShield, um, they are not right now implementing a data aggregation strategy. Instead, um, Sarah described their report alignment strategy involving BlueCross and other Arkansas commercial insurer and Medicaid.

So, um, today, um, for our third meeting, as I said we're going to focus on learning about what, um, Oklahoma has done. We have three guests: Dr. Joseph Cunningham of BlueCross BlueShield, Dr. Jack Sommers of CommunityCare and Dr. David Kendrick of MyHealth, um, Access Network who are going to talk about their experience aggregating claim and clinical data for analysis and distribution to Oklahoma primary care practices. Uh, and as, uh, Lauren said, um, you can, uh, insert questions into the chat box. Um, you should feel free to speak up. Um, I will also, uh, be, um, sharing some questions with them, but unlike, um, our format the last time, they are going to share a, uh, PowerPoint presentation with some content, um, uh, to start us off. And so, um without any further delay, uh, David, uh, why don't I introduce you as our, uh, our, uh, initial speaker.

**[Joseph Cunningham]**

Ok, we're on. [Transition slide deck] All right, well, this isn't David this is Joe Cunningham, I'm with BCBS of OK, and I wanted to just kick us off. We're going to divide and conquer on this uh PowerPoint that Dr. Kendrick has created for us. So, um, I did want to start out and say while we're talking about CPC+ data distribution and aggregation, we felt like it was important to start where we came from so that you would have an idea of where we're heading. And uh with that one of the things that is unique uh in OK

and we've worked with some other regions and primarily the neighbors to our east um that are very good friends of ours and we have taken on the decision to always put the patient first. And so our organizations, uh we don't let our organizational baggage get in the way. I don't know how to say it, you know, less harsh, but that's just it. We put the patients first and we focus on what's best for the patient. And uh as such I think is people were able to recognize the results and OK's been able to achieve uh in CPC classic over the past several years um it has been a successful performance for us, and we'll talk about trust many times throughout this discussion. And that is the key to everything we do is trusting the participants uh it is not the technology it's the trust that we have for each other. So that being said I'd like to turn it over to Dr. Jack Sommers and uh he'll start us off.

**[Jack Sommers]**

Um the only reason I'm kept around is for comic relief. I'd like to start the presentation with this slide. Um I think that you can see that we're different. Uh, we're different than the other participants in this. We've seen that we're different from the very first part of CPC classic. We we have started uh working together a a couple of years before cpc was even dreamed up in the mind of don burwick, so um we've we've had a head start but we're also we also think somewhat differently and we like to think that we're more nimble in how we respond to changes in the environment and so forth. Um so we might be adopted by by CMs but we think that we're still active participants.

The other thing is how we look at issues. Um sometimes the the phrase is used "thinking out of the box". Well this this is kind of a good example of that. Sometimes whethe rou're a physician or a care manager, what you see is in front of you uh and you don't see what's around you and when you see in front of you a barrier, that's a problem. Well, we have tried in ok not to look at the barrier in front of us. We look at the environment around us and we see there's a lot of ways out of this box. We just need to take advantage of the opportunity.

Um, in CPC Classic, ... [sigh]

**[David Kendrick]**

Nope. There it is.

**[Jack Sommers]**

There we go. [slide transitions] Um, our, our HIE, uh MyHealth, is located pretty profusely across the state of Oklahoma. These are the, the different, uh, private practices and facilities and so forth that we are able to contact, uh, contact. So, it's, it's very, a very rich, uh, data, um, structure. Um, one of the things that we want to talk about is we want the multipayer model to be available, if possible, and we really try to do that knowing with, with the major plans are here b- by really talking out CPC classic to the, uh, self-funded. Probably 60% of insured lives in Oklahoma are self-funded lives, and unless we bring those people to the table also and help them to see the promise that's available in PCMH, w- we're not going to make the progress that we need to do.

Um, this was our classic experience: we had 68 practices and 265 docs. Um, the payers in Oklahoma required participation in the MyHealth, health, health information exchange. Uh, we had the four payers at that point in time, um, and we're the only region that had actually achieved savings in every year of the CPC. Um, we did that through a lot of things. We, we lowered almost every aspect of care, uh, the,

the quality things as well by decreasing admissions for CHF COPD, decreasing the readmission rates, ED visits, and all the other types of things that we're really looking to do. This enabled us to really get a lot of savings and Oklahoma is responsible for about 80% of the total savings of the CPC classic, uh, program in the last year. So, we think that we're doing a good job. Um, and a lot of that is due to the, the working together we have with the health plans. Uh, we're, we're friends of one another and I, I, I think that there's few regions that can say that. I, I really enjoy meeting with Joe Cunningham. I really enjoy meeting with Dave Kendrick; I do that on a regular basis. Um, and by collaborating together, we really make this thing work.

**[Michael Bailit]**

Jack, can you explain what gave rise to you all coming together, um, and were you all friends before you started this? What was the impetus?

**[Jack Sommers]**

Uh, well, yes and no. Um, I think one of the things...

**[Joseph Cunningham]**

"No" to the friends part or what?

**[David Kendrick]**

[Laughter] Yeah, which part is "no"?

**[Joseph Cunningham]**

What are you saying, Jack?

**[Jack Sommers]**

[Laughter] See, I get no respect.

**[Joseph Cunningham]**

[Laughter] I tell you, I get no respect.

**[Jack Sommers]**

Um, I think part of the thing, uh, the two years even before CPC started was the birth of MyHealth. We were a beacon community, and we're able to start getting together, uh, at work, again, just like what Joe was talking about, the focus was around the patient and what's in the best interest of the patient. And when, when that was used as the core to build our HIE, that really made everything else possible. You know, that started our relationship where I was meeting on a monthly basis with Joe Cunningham and other people from Blue Cross and, and they with us, um, so that, that started...

**[David Kendrick]**

And the practices, too.

**[Jack Sommers]**

And the practices. Yeah, the practices were involved in the creation of it, of the exchange. The, when we started meeting together with the start of CPC, uh, we created a framework, uh, for doing the work in Oklahoma we called a "field team". And there were representatives from all the payers at the table, as well as representatives from the community, the community service counsel, the Oklahoma Center for Healthcare Improvement, our health information exchange, you know, and the, the um, local learning faculty from CMS. And, that, we, we met about every other week, and when you meet like that and you pray together and you meet together, you, you just establish a friendship that really is hard to beat. And the practices see that, so that when you go out to the practices and are, are talking to the practices about improvement, I'm not going out with my CommunityCare hat on, I'm going out with my, you know, MyHealth hat on, if you will, or the CPC hat on. I want the patient to get the best care possible. I don't really care whether it's a Blue Cross patient or a Medicaid patient or a United patient. I want the patient in Oklahoma to get the best care possible. That's, that's the key there. Any- Anything you want to add to it?

**[Joseph Cunningham]**

No, no. You said it all.

**[Jack Sommers]**

Ok. Um. This is...

**[Joseph Cunningham]**

Oh, sorry.

**[David Kendrick]**

Sorry.

**[Jack Sommers]**

This is the chart of the CPC+ practices that we have coming in now in 2017, and, I think that you can see that, compared to the chart we showed earlier of the MyHealth, it's pretty much exactly where MyHealth is. And this really gives us a leg up on making sure that we have the data we need available in the hands of the practitioners, you know, on the ground, in the field, so that they can get what they need at, at the point of care.

**[David Kendrick]**

It's also got Arkansas on there, too.

**[Joseph Cunningham]**

And it's got Arkansas on there, too. And Ms. Burkemeyer has been very helpful to us in working in Arkansas. [Laughter]

**[David Kendrick]**

[Laughter] That's right.

**[Michael Bailit]**

It looks like you're moving beyond, um, greater Tulsa now, is that so?

**[Jack Sommers]**

Yeah.

**[Joseph Cunningham]**

Right, the reason we focused, uh, for CPC classic around greater Tulsa is because, as Jack alluded to, that's where the, really, the footprint of the HIE MyHealth was. And, so, when we made applications to CMS for classic, we limited it to those 25 counties, I think, surrounding Tulsa because that's where the penetration of the utilization and participation of the HIE was the greatest. So, that's, and now as the HIE is expanded state-wide, we're able to expand this program to a state-wide effort.

**[David Kendrick]**

Right. All right, ok, thank you.

**[Joseph Cunningham]**

You know, Jack alluded to it, we talked about it earlier, everything we do has got to be patient-centric and community wide. And if you go to the next slide, you can see that as you look at the, uh, silos of data, if you'll move through that, David, you can see regardless of which patient it is, they will have data across numerous EHRs, uh, of which one treating physician or provider won't know what's going on with the others. And this became very key to us. As payers, we can see everything that we pay for on an individual patient, but it's difficult to relay that information, uh, to the practitioners. So, um, you might be going to want to move to the next slide. Um, so what we really have focused on is, is, um, well let me stop and say the reason we focus on this, [clears throat] excuse me, trusted third party entity was because, um, my organization had some experience, uh, in another state working with, uh, one of our sister Blue plans within the healthcare service corporation on, uh, uh, a giant, uh, ACL, the largest ACL. And when it came down to it, I had some participation in that, when it came down to it, we saw that some of the problems always occurs on how are you going to trust, or whose data are you going to trust, with what you're going to, uh, pay out, uh, quality b-, uh, supplemental payments. And so, it became clear to us that we needed a trusted third party. It shouldn't be the payer's data, it shouldn't be the provider's data, but we should aggregate our data in such a way that we can have a trusted third party, who'd actually do the analytics that we created and that we all agreed on to which we can pay to. And, so, that I think is one of the strong suits for us here, and, uh, so we have the HIE and David Kendrick as the trusted third party. And as you can see, uh, this is how we utilize it, um, and, um, as such, I think that is one of the keys to our success.

**[David Kendrick]**

Great.

**[Jack Sommers]**

David.

**[David Kendrick]**

So, I'll, I'll jump in now and talk about some of the technology, but I totally agree with what, uh, Dr. Cunningham was saying that, uh, this is not a technology project. This is all about, um, trust and relationships and governance and, and making sure that the, the, the both sides of any given contract are fair, and that, that the possibilities for people to succeed are equitable in both sides of any given contract. So, to that point, I'll talk mainly about this from the provider perspective, I guess, and what they see and experience. And, so, the first thing is about having that patient-centric data and showing it at the point of care. So, that, this is, uh, typical patient chart in MyHealth and it shows that aggregated across many clinics and many hospitals and, and payers. One picture of the patient's longitudinal record: all their vital signs, their labs, their meds, their allergies, and so on, their discharge, um, summaries, ADTs, and so on in this one view. And this view gets used, um, a fair amount by providers when they're taking care of patients, but I will tell you it is overwhelmingly used and loved by care managers who spend their whole day trying to track down records normally and figure out who to intervene with. And, as such, since the primary care initiative is that at its core, uh, initially at least the care management was primarily being brought to the table; this became a really important, uh, part of the toolset.

The next thing we observed...

**[Michael Bailit]**

David...

**[David Kendrick]**

Yes, sir?

**[Michael Bailit]**

I'm sorry, I just wanted to ask: So, can they pull that up through their EHR or do they have to go to a separate portal to access this?

**[David Kendrick]**

It depends on their EHR. In some EHRs, uh, well everybody can get to it through a webpage, I mean, of course, who has credentials. So, uh, if I get a call late at night, I don't go to my EHR. I log-in here cause it's just quicker and easier to do. But during clinic, during the day, my EHR has a, a, a button and it called MyHealth, and I push that button and I'm dropped right into the patient's chart from wherever I am in the EHR. Not all EHR vendors enable this, and that's, sort of, part of the pain that MyHealth is going through now, is figuring out ways to get the doctor's eyeballs quickly on the data they need to see, uh which, but that part- particular workflow issue is minimized in care managers, because they spend their whole day in this tool working through rather than just in the EHRs. So, that's a great question and, and really relevant one thing we would like to get improved if we can get EHR vendors to work with us a little better.

**[Michael Bailit]**

Thank you.

**[David Kendrick]**

Um, so the, the next item that, that, uh, really became clear, I think, in conversations with providers, to me, and I know that the payers on the call will recognize this as well is, the providers often don't understand who they're really responsible to take care of when they sign a contract. Um, and often in our EHRs, we look in reports and it shows the patients I've seen in the last 12 months and any care gap analysis or any quality report. But it turns out that when a payer is doing attribution, you guys on the phone know this, you're looking at claims data, so it's 3-6 months old by the time you can start to use it, and you often go back further in time than just one year to just make those attributions occur. And, so, patients attributed to this practice on the slide are coming from a bunch of different time ranges depending on which payer's attribution model comes to play. And, so, this we found was a really critical item to make clear to practices, and which one of the things MyHealth does, because when we receive that claims data, those 834 files, those roster files, we load them into the system and then all reports and alerting that we do back to providers, which I'll show in a minute, are in the context of that attributed patient population. And that's, uh, an important thing because, that, most clinicians that receive a report from an insurer that says, "You've done, you, you're performance is X on this measure," and then we look at the list of patients and don't even recognize a bunch of them and it's because of that attribution logic that, that, that happens.

So, we have an algorithm that I won't take you through in detail, but it basically honors the payer's attribution up at, up at the front. And then it allows the practices to say who they do take care of, who they think is their patients beyond that attribution. And then we do another thing in this algorithm, that I think has become important, and that is we don't just count billing events, which most payer-based attributions is triggered by, because we kind of think that's a self-fulfilling prophecy in terms of attributing patients to the doctors who wind up billing the most, and may not be the best thing for the future. So, we count touches, things like care management notes, um, prescriptions called in after-hours, that kind of thing, we're able to get that data in the HIE. And we, we grant, um, sort of, um, relationship points I guess, or attribution points, for those touches as well, which I think is important. So, attribution is one of those key foundational things for the doctors to get their heads around, and then risk modeling is also important and every payer provides a different, usually a different approach to risk stratification. Again, HCC is on the Medicare side, and probably Medicare Advantage, and then you've got all kinds of other things for different age groups, and so helping practices get one concept of risk for their practice is difficult to do. And, so, you can see here we've got three practices showing the trends of their risk, aggregated across different three different organizations, uh, three different payer organizations of risk models, and that's an important element for this.

Then, then, we have, um, to get into some specific tools that, that practices can use. Um, you know it's important to know if, if, if you're looking at claims data to see what, what to do about readmissions or what to do about, um, ER utilization, it's probably too late because that's 3-6 months ago. It's already happened. But because we have data in MyHealth that flows with about a minute to a minute and a half delay from the event occurring, we can let practices know about their patients registering in an emergency room or being admitted to the hospital or being discharged within enough time to do something about it. So, we call this our active alerting and panel monitoring. And what you see on the screen here is the, is the report that shows the clinic and then it shows all the patients that had any activity in the last 24 hours from outside that clinic, that outside activity – whether they were admitted to the hospital or discharged from it, or, or emergency room or, or, or admitted for delivery, whatever, um, it shows in this report. And they can use this, especially the care managers, but the, the, the team



basically, can use this report to stay on top of what's going on with their patients all the time. A similar report we provide is, is this 30-day readmission monitoring; again, not driven by claims, but driven by the actual flow of clinical data around the community. And you can see that this shows, looking back 30 days, this practice's patients who were discharged from hospitals in the community and what happened with whether they were in-patient or out-patient or emergency room visits that have happened in, in the interim during that 30-day risk window in each of those patients, so they can really, uh, make the care management interventions where and when they're needed.

**[Michael Bailit]**

David – can I...

**[David Kendrick]**

Yup?

**[Michael Bailit]**

I'm sorry to interrupt you, but, uh, but Greg inserted a question and I have a sense that some of the participants could use a little foundational knowledge about, um, what type of collaboration took place to identify, um, the data that had to be supplied by both the payers and by the practices that provide the input for you to be able to create these impressive outputs. So, can you just give a, a little bit of background on how the parties identified what data was to be aggregated and, um, and what funding helped support that occurring?

**[David Kendrick]**

Sure, um, let's see. Let me do that quickly. So, in 2009, when we started our meetings, we basically took the community through a pretty formal process that we've now been using in other communities as well where we said, clinicians, patients, those who are providers, basically, in a room, and said, "What are your priorities for data? What are those situations where you need better and more information?" And then we handed off to a team of quality officers whose, who added to that pile of data, that list of things they needed for reporting quality from a hospital perspective and from a, from an ambulatory perspective. And then they handed to a privacy and security team, who reviewed the laws and the policies to make sure we can actually share that data. They then handed to finance team to figure out how the heck we're going to pay for this for the community, and then last and least we invited technology people in the room to tell us how to build the thing we wanted. And, I can say that that process, the most important thing about that process was not that we wound up with a design that was inclusive of the, the data we needed, although that was one of the outcomes. The real important outcome was that it began the building of the relationships and, and sort of level set everyone's understanding about what was needed to succeed. So, then once we did that, we went about putting together the technology. We got the beacon award, which gave us a 12 million dollar grant to get going, and then from that we've been, uh, on our own nickel since about 2013, I guess, is when that funding ran out. And, um, and has been sustained by, by folks. Everybody pays, like a public utility model, almost, to be a member of MyHealth and to, to utilize the data that's in it. But, but essentially the...

**[Michael Bailit]**

To pay everybody, it's both the payers and the practices? Payers and providers, both?

**[David Kendrick]**

Yeah. Every- It's, it's, it's just like the power grid or the water supply. Everyone pays for what they use. So, um, but, but I will say that the data we exchange, to be sort of technical about it from our own, we get ADT messages that flow in real-t-, close to real-time, uh, we have CCDAs, which is the clinical summaries on each patient, and then we get, um, data-type specific things like lab fees, and medications, and immunizations and things from sources that can provide it. Not everybody can provide everything, but we get what they can, I mean, with it.

**[Michael Bailit]**

What, what, what percentage, uh, and I know it's separate for hospitals, primary care specialists, but what percentage of the practices are able to provide data to you?

**[David Kendrick]**

Um, everybody on...

**[Michael Bailit]**

Well what percentage of the covered lives, however you might define it?

**[David Kendrick]**

Well, well we have data on 3.5 million people. Um, but everybody who has a certified EHR has the capability to send us data. Uh, if there's a, if there's a reason, if they're not sending us the data and they have a certified EHR, it's down to one of two things: either the provider is not particularly comfortable with it, and the, or the, or the owner of the practice, whoever that is, and there's a bus-, there's some sort of a business reason or a political reason there...

**[Joseph Cunningham]**

Or fear.

**[David Kendrick]**

Or fear, right. And we always have the privacy and security conversations we take people through, for sure. Or the second that we encounter most often is that their EHR vendor is wanting to charge them too much money to get the data out. I'd say, I don't know, close to \$200,000 in what I call ransom fees, EHR vendors in the last, in the last year alone, to try to get them to, uh, allow the data to come out. It's one of the places we hope, we think payers can be most effective in, in, uh, breaking down barriers.

**[Michael Bailit]**

And, and so do you think you have most practices, a quarter, three-quarters?

**[David Kendrick]**

Oh, no. We have most people, uh, but we focused, but we focused, yeah, we have most patients, but we focused on the big health systems which are the biggest bang for the buck in getting the data in. And now we're working with smaller and smaller practices.

**[Jack Sommers]**

I'd say we have the bulk of the primary care, but specialties are a whole of another animal.

**[David Kendrick]**

Right, right. Uh, specialties has not had a need to come in until MIPS, of course, which brings up a real interesting point for the specialties to get onboard. And, um, you know, we, we know we have about 65% of the adjusted patient base from the hospital perspective in the state, uh, and I would say probably 40% of the practice activity, given that a lot of it's in the big health systems. But, there are a lot of little independent rural zones.

**[Michael Bailit]**

Ok, thanks.

**[David Kendrick]**

Yeah, we're always working with them. So, uh, so the, the next thing is just to tell you a little bit about how we measure quality because we...this is, relevant.

**[Joseph Cunningham]**

Did you talk about the 30-day?

**[David Kendrick]**

Oh, I did talk about 30-day readmission, didn't I? Yeah, I did. Ok. So, the, the next thing is to just, to give you a little message about how we think about quality measures. And you remember the slide that, that Dr. Cunningham was talking about with the vertical bars that shows where the data is and how it's spread across multiple sources. So, we basically changed our perspective on measurement to say, "Look, while we want ultimately to know how a practice is performing or how a doctor is performing, we, we want it from different perspectives. And so we need to break everything down into the atoms." And the atom, in this case, is the patient, right? The belly button, so to speak, that is, and what its current status is on a measure. So, we realize that for any given quality measure, a patient is either in the numerator, or in the denominator, or excluded from the measure at any point in time, right? And so when we calculate quality measures using the MyHealth data, because it cuts across clinical and claims data sources and multiple practices and so on, um, we can simply determine who is in the numerator, who's in the denominator, and who is excluded. And so, rather than, um, getting one answer for a practice regardless of which payer's patients are taken care of, we get the individual patients. And then we use that attribution logic I was telling you about earlier to decide how the practice is performing. So, here's one provider, you see the five patients there, and their practice that are attributed to them, and you can see their performance is calculated at 75% based on the numerators and denominators. But perhaps more importantly, that practice can see who's the patient that is not in the numerator but needs to be, which becomes a care gap, right? It becomes something they can do something about. Same thing is

true. If you add another pra- provider, same approach. But one other thing about this method that I think is important is that it allows the specialist to have their performance, uh, accounted for and evaluated as payment models as well, because you can simply look at the patients they've touched over that period of time, or use whatever attribution logic you want to decide who their patients are. But, I think perhaps most importantly, from the payer perspective, when you look at quality measures, it's just your patients that you're looking at and the practices that are taking care of those patients. So, you can, you can see how a practice is doing for your members and not just an aggregate across it. And I think that's important because if you take a look at practices who have a high burden of say, dual eligibles or really sick people, their performance may not be where you might want it to be for your payer proportion but they might be doing perfectly well for your specific patients. And that's not really fair to practices or providers to judge them based only on their... on every other patient they take care of. In addition, incent people from taking sick patients, which is exactly the opposite, uh, from the incentive we want to create. So, anyway, this same approach lets us do public health reporting that's very specific to the geography, or even, dare I say, be able to report how a specific employer's patient populations they manage overtime, as well.

So, then we get to kind of a busy slide, if you can imagine one busier than the one I just showed you, and this slide shows how we have the conversation about measures with the practices. Um, there are, there's a situation that, that we're sort of in the thick of right now where practices go through the stages of grief once they see their performance. Uh, they get their calculated numbers and they're, they're almost always terrible because there's a lot of work to put in to get the data quality good. I'm not saying the practices are, are actually performing poorly, but the, the data mappings and the EHRs are not to the proper codes or the, or the, uh, they've been filling in the data in the wrong box, or failing to check a particular box. And so we build in a fair amount of time to go through that process with practices and make sure they, they can track down where the data's coming from. We obviously don't own their EHR or operate it, but we can see in the data they're sending us where there are gaps. And, so, what you see on this screen is a particular measure in the upper left, this is "Controlling High Blood Pressure", and you see a start and end date range that we're measuring for. And then down the left-hand side of the screen you can see a bunch of patients, individual people, deidentified, of course, and then the lower right hand corner, what you see is one selected patient. And you can see the value-sets of the variables that are important to this blood pressure measure, and you see a dot on this chart over time every time the patient has a piece of data relevant to that variable. And then you see the vertical dash lines, indicate the measure window, that timeframe I've chosen above, and then down below you see a pie chart. And so what this shows the practice is, they can mouse over any one of these dots and see the data behind it: what was the systolic blood pressure, what was the diastolic. But they can also see, and perhaps most importantly, can see how many other sources are taking care of their patient. How many people are on the team, uh, with air quotes around it, with them, because they often are not aware of this. And so it actually, to get this particular patient in the numerator for this measure, which is in control, it took what, six, six different sources of data to get this patient in the numerator. And I think this is something that most practices miss, most providers are unaware of, cause we all think our patients only come to see us, right?

**[Michael Bailit]**

We have, we have health systems that have paid a lot of money for their EMR, and they think, “Well, all I need, all the information I need is in my EMR.” And this shows, many times, that almost half of the data is not in their EMR. It’s in somebody else’s EMR.

**[David Kendrick]**

Right, or in the payer, or in the pharmacy, or any other place.

**[Jack Sommers]**

Um, we at CommunityCare, we have one of the larger Medicare Advance plans in the, in the state, um, probably the largest managed care. So, one of the things that we’re paid on is star measures, and this is something that we really push for, hard. Um, and I would say at the, at the beginning of the CPC classic program, we were at a 3.5 star level. Uh, for the last year, for our Part C measures, which are the clinical measures that physicians have control over, we were at 4.5 stars, and we attribute this pretty much solely to the impact of CPC+, uh, or CPC classic. The, the issue is that the, the providers have the information on care gaps they need at the point of care, so that they, at that point, their care managers or the physicians can fill those gaps at the time the patient presents for whatever kind of visit it is. They might be coming in for a cold, but when that information’s available at that point, “Oh, you have not had your mammogram in the last few years, we need to get that scheduled for you.” They can get that taken care of. Um, so it’s, it’s a proactive form of care rather than a reactive form of care. Uh, and you can...

**[Michael Bailit]**

Jack, Jack, can I ask you a question?

**[Jack Sommers]**

Sure.

**[Michael Bailit]**

Um, a- and actually it’s, it’s for all of you. Um, and, but you know, it relates to, um, Medicare and different payers, um, use multiple attribution methodologies and Patrick Gordon asked a question whether, um, payers, obviously, well, I would think not Medicare, but, but at least, um, um, uh, Blue Cross and CommunityCare, whether you are using the touches methodology for your attribution or are you using, um, a more traditional past utilization claims based approach?

**[Jack Sommers]**

Um, I’ll let Dr. Cunningham speak for Blue Cross.

**[Joseph Cunningham]**

Oh, well, we d-, we do the traditional, uh, not touches, it’s a utilization metric, and it gets kind of muddy, as most of us know. But that’s what we like about what David said, Dr. Kendrick has done, with MyHealth, is we have the ability to attribute, uh, some but not all patients to a single provider. Uh, then we, uh, like to apply the MyHealth attribution logic. And with the final default, and this is one of the things that, that we really trust the, the practices and the physicians and, and care givers to really tell us

who it is they are taking care of, because they will know it much, in a much more timely fashion than we will.

**[Jack Sommers]**

Um, at CommunityCare, we're an HMO, so we assign the patient a primary care physician. So, we, we know it upfront what the attribution is. Now we always allow we the member to choose the PCP if they want to, but those who don't are assigned one based on a geographical algorithm. So, everybody knows, on the basis of looking at their card, who their primary care physician is. Now, that's, it's nice to say that. What actually happens in practice is a lot of times a little different. When we've gone to some of these practices, looking at the star ratings, and say, "You know, these five patients of yours haven't had their mammogram or their colorectal cancer screening." The physician will say, "You know, those aren't my patients." So, we'll, we still get some of that, and then we have to kind of go to the, the phys-, to the patient and say, you know, "Who are you actually seeing for your care?" But, by and large, we assign the PCP.

Um, and we, these kinds of things are provided on a, on a regular basis, you know, at least monthly. Uh, and they're updated really a lot more frequently than that, um, but, uh, it really does allow the, the physician to be able to go at, at the point of care. And, and sometimes, if they want to, for example, if it's coming up to the end of the year and our health plan knows that, you know, "By golly, we need 20 more mammograms to be done to, to hit that 5 star, uh, rating," we can go to the physicians and say, you know, "Can you give us five more mammograms?" And they can go to the list and say, "Ok, these are the lists of my patients who have not had mammograms and need them. Care manager, call these five people and get them scheduled." So, we can, we can really work it in a very distinct, kind of, direct basis to get the care done that we need to to meet, uh, CMS's requirements.

**[Joseph Cunningham]**

So, uh, point seven on our critical success factor has to be understanding what really our costs and utilization are. And many of us on this call are payers, and you know, I love to say that when we look at claims data to try to, to, uh look for actionable items, it's sort of like spray-painting your windshield black and using your rearview mirrors to drive to Vegas. It's, it's very difficult. And, so, what we have come to find out is that by this sharing of data, we have, we're able to share reports with practices in a much more timely fashion. And this is an example of that: this is our first year in CPC classic, and as you can see, we looked at, uh, quarter two through four. And you can see that we have statistically significant changes to the positive for us, uh, regarding several of these, uh, uh, quality measures, um, and we really attribute this to the fact that we were, as Dr. Sommers mentioned, we went out, we shared data with practices not, not Blue Cross data, not CommunityCare data, we shared CPC data with practices regardless of who went out to share it, in a way that gave them actionable information to some of the drivers of, uh, cost and utilization. So, I think that was one of the greatest things that we did.

The next thing, if you look at this, this is actually what happened. We have blinded the practices, but the point I want to make out is our practices all agreed to share where they land from a cost of care standpoint once the patient populations were risk-adjusted with each other. What this really did is this promoted synergies and collaboration between historically competitive practices that had never existed

before. And one practice might call another and say, “How did you solve for problem X?” or “How did you solve for problem Y?” This was the approach that we as payers, uh, and data sharers had, and we saw that translate down to the practices, and I think this is what has really driven us to, uh, the success that we’ve seen here before.

**[Michael Bailit]**

I know this is unadjusted, um, do you also give them risk-adjusted calculations of total cost?

**[Joseph Cunningham]**

Yes.

**[David Kendrick]**

Yeah, this, uh, this particular report comes from a whole, um, set of tools that they can look at, at from 100 different variables around costs, and uh, and the, and the way it’s being spent and then compare themselves to one another or to their history, as well.

**[Joseph Cunningham]**

So, we do give them unadjusted and risk-adjusted.

**[Michael Bailit]**

Hey message has come in...Um, do you also—this is a topic we’ve been talking about in this group in payer meetings—do you provide the practices with information on the cost of referral providers?

**[Joseph Cunningham]**

We are, you know that, we’re, not yet. That’s a nice way of saying it. Not yet. We want to. We’re a little bit concerned, uh, and we want to manage that message in our community very carefully. Um, we think that a lot of our practices have a fairly decent idea when it comes to specialty care, who are some of the bigger cost drivers. We have a, a group of clinicians that, uh, have a subcommittee within MyHealth called the Clinical Quality Committee, and we all gather. And many times they have said, “We know if we want to go straight to X, we send here. If we need this, we go there because somebody will step through many costly things to get to the same point.” And so, we’re not yet sh- sharing the true cost data cause we want to be careful how we do that and don’t incense a lot of our providers, um, but, I mean that’s, that’s where I’m coming from. That’s how we do it. Jack, do you have any comments?

**[Jack Sommers]**

No, I agree with that. The, the other issue is around, e- even among specialists, what the specialists have kind of limited themselves to do. Um, there are certain pediatricians, for example, that see really difficult children. That’s, that’s what they do. Or you’ll see an internist, and they really practice geriatrics. Well, they’re, they’re utilization, because they’re going to have a much higher risk, is going to be much higher, so it’s, it’s hard to compare apples to apples in that kind of scenario. Uh, even among an orthopedic group, you’ll have one guy who specializes on knees and another guy who does shoulders, and, so it’s really difficult to call.

**[David Kendrick]**

So, that's a good, that's a g- great segue to the next part of the conversation, I guess, which is, um, really actively starting to manage care transitions and closing loops. And I know the term "care transitions" in most people's minds refers to getting out of the hospital and into home or long-term care effectively and not bouncing back, but in our, in our community, we really, "care transitions" are any point A to any point B. And this is some work we started actually a long time before MyHealth came into existence and has been adopted here, as well. And we did a, a research study on this, and what we showed was when we, when we looked at how patients were moving around the community from one place to another, as they saw their primary care provider who initiated a referral, one of several things is happening: either the patient was told to go schedule their own visit, that they needed to see a dermatologist or cardiologist, or there was a mish-mash of phone calls and faxes going back and forth between a sending and receiving provider clerk with lots of, lots of information, but happening over a long period of time. And we found, in some cases, it was taking 60 days to get those referrals scheduled and have them, it, whether, not even to have the visit occur, just to have the initial contact done. And some practices were 3000 referrals behind when we studied this, just stacks and stacks of paper, uh, piled up on fax machines.

And so we studied that black box, and what realized was happening was that referrals and care transitions were actually a, a physician order. I mean, when I, when I refer someone to a cardiologist I'm writing an order, but unlike prescriptions, unlike lab tests, unlike surgeries, you know procedures, those, these orders weren't being tracked in any formal way according to any formal standards. And so we created 25 unique states that we thought referrals, uh, would go through and when we studied the paper process, this was the work flow: essentially, there was really no rhyme or reason to how a patient progressed through the community. And so we put into place, basically, a clearing house in the middle where we allowed, uh, where we routed the referrals from one party to another and imparted the statuses to them so that, uh, everything can be logged and managed electronically. And so rather than pieces of paper on fax machines, both the sending and receiving providers on both ends of the referral could see a worklist of all the referrals they've made, how many hours old it was, what the next step in the process was, and who owned the next step in the process, right down to who needed to call the patient, cause we found a number of patients just never got the call even though the visit was scheduled. So, the effect of that was to go from here, in which about 60% of referrals, even a year out, the sending clinic didn't know what happened to them, uh, down to, uh, only about, uh, 10-15% being unknown or, or about an 85% loop closure rate. And we, for the organizations that utilize this process, we managed to maintain an 85% loop closure rate since about 2010 for now. So pretty, uh, effective loop closure.

And then, one additional layer, which is really the reason we built all that in the first place, to this conversation was to say, "Well what happens when the sending provider and the receiving provider can have a conversation before the referral happened. Are all referrals really necessary?" And, of course, you know the, the nephrologist usually will tell you that they see about 40% of the patients for creatinine of two that they really didn't need to see anyway. And so, so we had a hunch that that might be the case and so, uh, if there is a specialist whose willing to triage the case, um, then, uh, you know, or to look at it electronically before they see it, then it goes through an electronic consultation process to the consultant and the, and the sending provider and the receiving provider can have an electronic



conversation. Uh, and if it needs to be seen, then, then it will go through the usual scheduling loop, but if it doesn't need to be seen, then several things have happened: one the, the, um, the visit didn't, an, an unnecessary visit didn't occur, and, and of course savings is there; two, unnecessary work-up didn't occur, because when that patient shows up in the specialist's office they're going to have to do the work-up all over again that the PCP did without a story; and three, the primary care provider got educated about how to manage this case, so it creates sort of a learning feedback system, where the primary care gets better and better at its job and the consultant gets a better sense of what the PCPs are needing help with. So, or the sending providers need help with. So, then we did a total cost of care analysis on the data from the electronic consultations, and we showed, now this is in a Medicaid population, we showed a \$130 PMPM savings for those who received the electronic consultation versus those who just got the referral, uh, without an electronic consultation. So that...

**[Michael Bailit]**

Karen Johnson just asked whether you are, whether the payers are compensating these e-consultations?

**[Joseph Cunningham]**

We are. Uh, well we, w- we, this is part of our track 2 for CPC+. We will be compensating them, uh, both the sending and receiving, because we believe it'll be, uh, uh, it'll be not only everything that Dr. Kendrick said, the patient, uh, will have much more satisfaction, there's an educational piece in there that really appeals to us from the primary care standpoint and, uh, so yes, we will be doing this.

**[Jack Sommers]**

Now, I, uh, C- CMS also just announced some new telehealth standards that allow for Medicare to reimburse under this scenario as well.

**[David Kendrick]**

Oh, I hadn't seen that.

**[Jack Sommers]**

Yeah, that just came out today. So, um...

**[David Kendrick]**

Very good. I'll take a look at that. Yeah, I mean, o- one of the things that, that hadn't come out in this conversation yet but I think has been an important factor in our CPC+ has been the simplification it provides. You know, providers are asked to look at different quality measures for every program they sign-up with, with every payer, um, and, they're l-, and they're, they're using different workflows, they're asking to transform in different ways. And CPC has allowed us to bring one set of transformation activities, and one set of quality measures, and, and through, with, I think through the stuff through MyHealth, one set of technology tools to use to, to do these activities. And so, it's music to my ears when another payer agrees to do something in the same way as others cause it really simplifies.

So, um, one of the things, is this me or you?

**[Joseph Cunningham]**

It's you.

**[David Kendrick]**

It's me, ok. Um, one of the things that, that has come about in this, and I can remember, um, hearing this from other folks when I was in Boston and other places, uh, is, is when we would talk about an innovation or a project that we had done, people would say, "Well, yeah, sure, that's Partner's healthcare. Nobody else is like that." And now, much to my amazement, people are saying sometimes, "Well, that's Oklahoma, but nobody else has that," right? So, what, we set pretty humble beginnings for this effort. And so, I want to point out to everyone on the call that almost no matter where you are, there are organizations who do what MyHealth does. They have not been necessarily engaged with by the payers... and, and they're not necessarily participating as an HIE, but you could do that. And I happen to know, these are, these are 49 different health information exchanges around the country that are partnered together in something called the Strategic Health Information Exchange Collaborative. And we have begun to work out data sharing agreements between us, so that when a patient from Oklahoma goes to Arkansas, for example, the Arkansas health information exchange organization sends us the alerts for these Oklahoma patients and likewise, Oklahoma sends back alerts on Arkansas patients. And what that creates is something we call the Patient Centered Data Home model where all data comes back home to rest wherever the patient's home address is. And we think that enables better decisions at the point of care, uh, because those alerts coming in from out of state enables me to take actions I need to as a PCP, um, but it also enables all of those analytics and quality measures to be more accurate because you're not missing, uh, critical events that may have occurred outside of, of the window of the rest of the state. So, this allows us, this Patient Centered Data Home model is, is an, an important strategy that MyHealth is engaging in with lots of our peers around the country that we hope will add a lot of value to this discussion about value based payment models and the ability of everyone to deploy some- some of the things that we have been able to deploy.

**[Michael Bailit]**

We're nearing the end of our time. And, I'm sorry. W- We're nearing the end of our time, and I have some other slides I need to cover with the group before we close. So, I'd like to ask one last question. Um, and that, this has to do with really practice use. Um, we've talked in prior meetings about the fact that providing information to practices doesn't mean that they know how to use it, um, or that they do use it, or that they find it useful. So, can you share with the group, um, what you've done to educate practices on how to make use of these resources and how you assess whether they are helpful and, and actually actively used by them?

**[Jack Sommers]**

Yeah, I'll start with that. Um, one of the focuses of the field team for CPC classic was to make sure that David had, uh, frequent access to our podium. Uh, we also had times when during the all day face-to-face there were break-out times when the practice could go off and have one-on-one time with either David or a trainer to go over how to use the, the tools that MyHealth offers. So, um, both, all the payers in CPC classic have strongly supported and, and, uh, encouraged practices to work with David.

**[Joseph Cunningham]**

Yep.

**[David Kendrick]**

So, and, and I would say, speaking from the side of the person who's on the hook to get people using it correctly, it is, it is the biggest challenge we face. I mean, data quality is hard and, and running quality measures is hard, but getting into people's workflow is the most difficult thing. The good news is these practices are, are, are, um, they've had the benefit of sometime of panic, let's say, where they realize they don't know what they need to know. So, they're willing customers for this kind of data. Uh, when, and when we get it to them, they tend to be willing to use it. I will say though, we're about, of all the things we've got in terms of scales of progress, I'd say we're only 10% of the way there with getting the kind of utilization we need for the...

**[Joseph Cunningham]**

And so, I like saying that I think we're kind of a, a generation off of where we want to be, where we need to be. Uh, when I look at younger physicians, and both my children are physicians, you know they grew up through the university system and they saw these tools and technologies, and they can't hardly practice without them. It's difficult. As you take older, uh, dogs like us, you know, uh, it, it is a more difficult lift for us to learn these new technologies. Now, it doesn't mean we don't try to push that and we do, uh, but we are not letting perfect be the enemy, enemy of success here. We're, keep trudging forward. And actually, in some of our face-to-faces, we've seen some of the older doctors, once they adopt these technologies, they are the most staunch advocates of their use. So, that's really where we're at.

**[Michael Bailit]**

Well, this has been a fantastic, uh, presentation, and I think that, um, all 34 for us, uh, participating are really appreciative of you sharing this. Uh, I'm assuming the answer is yes, but can we distribute a copy of your PowerPoint presentation to the group?

**[David Kendrick]**

Yeah, we'll get you a PDF of it you can send around.

**[Michael Bailit]**

Great. Thank you. All right. Um, well, on behalf of the whole group, thanks. Um, I also have found that we tend to get the group asking a few questions right at the end of the meeting, so, um, can Lauren forward any questions that come in to us that might come in right at the end of the meeting?

**[Joseph Cunningham]**

Please do.

**[Michael Bailit]**

Ok. Great. Thank you. Yeah, I see Charlotte's entered one and no doubt others will have it. Ok, so, those of you participating, please type into the chat box if you have any other questions and we can follow-up with Joe, David, and Jack subsequently.

So, um, in the three minutes we have remaining, uh, we will distribute a summary of this meeting and, um, a PDF of the presentation. Um, um, and, uh, we will begin to, uh, prep for our upcoming, uh, meetings. Um, we'd like to ask you, uh, a few questions, um, a quick poll. Um, so, if you would, those of you online, um, respond to this poll and how you would rate the meeting: four choices. Um, so, if you just, uh, indicate the letter, which one, uh, is your assessment. Five responses thus far.

**[David Kendrick]**

Oh, are we going to get a score right here?

**[Michael Bailit]**

Yeah, you're going to get a grade. You could have left, but you're going to have to find out what your grade is. Um. [Silence] All right, so we've had, uh, twelve respondents. Um, I'm going to go on to, uh, the next question even though there may be others coming in. So, uh, you got a good grade, um, so feel good about that. Um, thank you for responding, the twelve of you who did.

Um, for our next meeting, what might be more valuable to you. Um, here are some options. If you would indicate, uh, what we might do that you would find helpful. [Silence] Uh, just one response. [Silence] Ok. [Silence]. All right, so we've had, um, seven responses, t- ten responses. So, um, I'm going to go, uh, eleven responses, so go to the results here: um, so more Q&A time. Obviously, we didn't have a lot for that, um, but that was in part because we wanted to hear everything, um, that we heard today. Um, and not surprisingly, some of you for whom this, what you just heard in Oklahoma, is not something you can do any time soon. Um, you'd like to hear more about aligned reporting models, and I think we need to bring that to you. Um, so that if you're in a region where that's a more appropriate focus, um, we can get to that. So, thank you for that feedback.

Ok, um, I'm going to skip this because we only have a minute left. And just, um, note, um, that right now, and, and we may modify this based on our feedback, but right now, um, we're going to hear, um, about efforts in Ohio and Colorado, uh, on what they've done on alignment and data aggregation. Um, but I think we'll make sure that we've got enough, uh, or some data alignment focus, uh, to respond to those of you who would like to hear more of that. And then for meetings five and six, we're going to turn towards talking about, uh, measures sets and, uh, CPC+ measure sets, and aligning those measures with perhaps other measures and how you get to an aligned measure set. So, uh, that's what's coming. Thank you everyone for participating. Um, and, uh, thank you once more to our, uh, three guests, to David, Joe, and Jack. Uh, and, uh, everyone, we will talk again in a few weeks. Thanks.