
# HL7 Partners Value Based Care Breakout

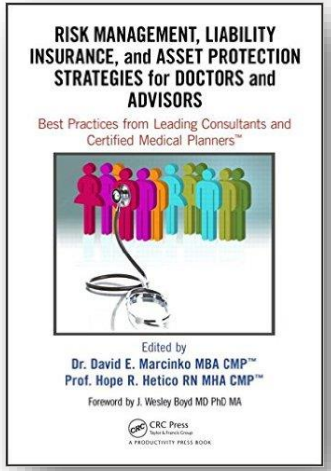

**Shahid N. Shah**
Entrepreneur-in-Residence
AHIP Innovation Lab

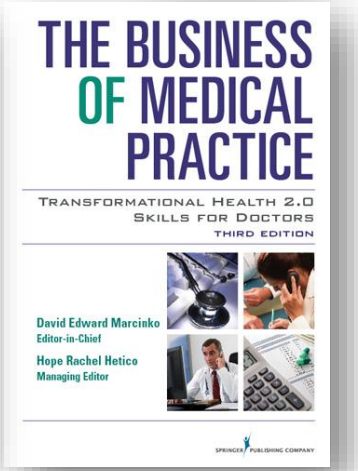
# Agenda

- Introductions
  - Facilitator
  - Participants
- Overview of breakout session purpose & goals
- Overview of AHIP IL approach to VBC innovation
- Value Based Care facilitated discussion
- Open discussions

# Meet Shahid, VBC breakout facilitator

- **Technology Strategist and Entrepreneur in Residence (EiR) for AHIP's Innovation Lab https://www.ahip.org/innovationlab/**
- Chairman of the Board at Netspective Communications and Citus Health; Publisher at Netspective Media and serial entrepreneur.
- Angel investor, board member, in several digital health and Internet startups.
- 25 years of software engineering and multi-site healthcare system deployment experience in Fortune 50 and public sector (Fed 100 winner).
- 15 years of healthcare IT and medical devices experience (blog at http://healthcareguy.com)
- 15 years of technology management experience (government, non-profit, commercial)




*Engineer, strategist, entrepreneur, investor, author, and journalist*

# The AHIP Innovation Lab ("IL") is a proven value-add/free service for AHIP Payers/IDN Members to help participants get real work done.

Rahul Dubey
AHIP SVP

Individual Members Bring Their Unique "Stated Needs"

IL Connects Innovators

IL Facilitates Innovation

AHIP Member

Explore multi-stakeholder multi-institution (MSMI) ecosystem challenges and "stated needs" one member at a time (or with their partners)

**First, IL is a "Think" Tank**

AHIP INNOVATION LAB
Collaborate. Create. Implement.

**Then, IL is a "Do" Tank using "Solution Working Groups" (SWGs)**

- Document PTBSs & JTBDs
- Discover Inflection Points
- Document Innovation Strategy
- Assist with Business Cases

**Ecosystem Partners**

accenture High performance. Delivered. · AMGEN · CHANGE HEALTHCARE · CONCENTRIX A Business Services Company · GE Healthcare · Healthcare Services & Solutions

Facilitate Implementation

AHIP INNOVATION LAB
Collaborate. Create. Implement.

**Consumer | Payer | Provider | Pharma | etc.**

# How the AHIP IL facilitates value based innovation

Understand management objectives based on desired outcomes

Consider using Objectives and Key Results (OKRs) framework for defining outcomes

Understand problems to be solved (PTBSs)

For each PTBS, understand Jobs to be Done (JTBDs) and journey mapping (JM)

Figure out how to model the PTBSs and JTBDs in simple spreadsheets or real simulations

Eliminate as many JTBDs as possible through policy or process redesign

For JTBDs remaining which cannot be removed (regulatory, statutory, business model, etc.) list remaining PTBSs

Find or create solutions, based on remaining PTBSs, JTBDs, and JMs

Test your hypotheses against the models and simulations and keep what's evidence driven

These are your "stated needs" (which you'll use to influence demand)

# There is no interoperability crisis in the healthcare industry.

**We do have a vendor management and accountable outcomes measurements management crisis.**

# What we've been asked to do by HL7

## Identify desired interoperability business outcomes

- How many of you think you already know the business outcomes?

## Define activities to accomplish the outcomes

- How many of you understand the outcomes enough to define activities?
- How comfortable do you feel with process measures?
- How comfortable do you feel with outcomes measures?

## Identifying barriers and challenges

- This is probably the easiest to do but we might get stuck here too long
- Is an Argonaut-style implementation guide necessary specifically for value based care or that

## Remove barriers and address challenges

- If we can pull this off, we'd never need to meet again! :-)

# Value based care breakout overview

## Background

Health care consumers' decision-making power is growing as individuals become responsible for more and more of their costs and they begin to increase participation in the care they receive. In order to meet these new demands, "value based" care is considered the best hope for the industry to come together and become more consumer-centric.

But this cannot be accomplished by focusing on one entity (the consumer) alone. It requires a new way of thinking about innovation across the ecosystem.

## Proposed takeaways and goals

We must develop multi-stakeholder, multi-institution (MSMI) engagement strategies to improve operational efficiencies and support a value-based design leveraging modern APIs and FHIR to:

- Create an accountable data sharing approach to understand the consumer's needs, how they are utilizing care, and their preferences for engagement
- Use data to engage stakeholders across the health care industry to improve personalization and deliver the right care management steps at the right time

# Are these the right areas for us to focus?

**Key questions**

- Can we re-engineer care delivery across multiple stakeholders and multiple institutions ("MSMI") to help control or lower costs and increase quality?
  - What should we target?
  - How will APIs (FHIR, REST, GraphQL) help?
- What financial rewards and incentives are available across MSMI?
  - Can APIs help improve the incentives and distribute those rewards?

**Potential deliverables**

- Identify a population and focus on the *most expensive* patients or the *most impactable* patients?
  - Proposal: pre-diabetics? Impactable?
- Value is derived from lower cost but costs cannot be lowered and quality cannot be improved if patients are not *impactable*.
  - Can FHIR help with risk identification, cohort preparation, and registries for *most impactable*?

# Information asymmetry is what FHIR reduces

Value based care will not work with the information asymmetry that exists today – when business interoperability and workforce interoperability across MSMI is properly managed, FHIR is the technology that will help solve information asymmetry across the ecosystem.

**Next to the patient, their families, and the MSMI workforces, data is the most important tangible asset that we all share in ecosystem.**

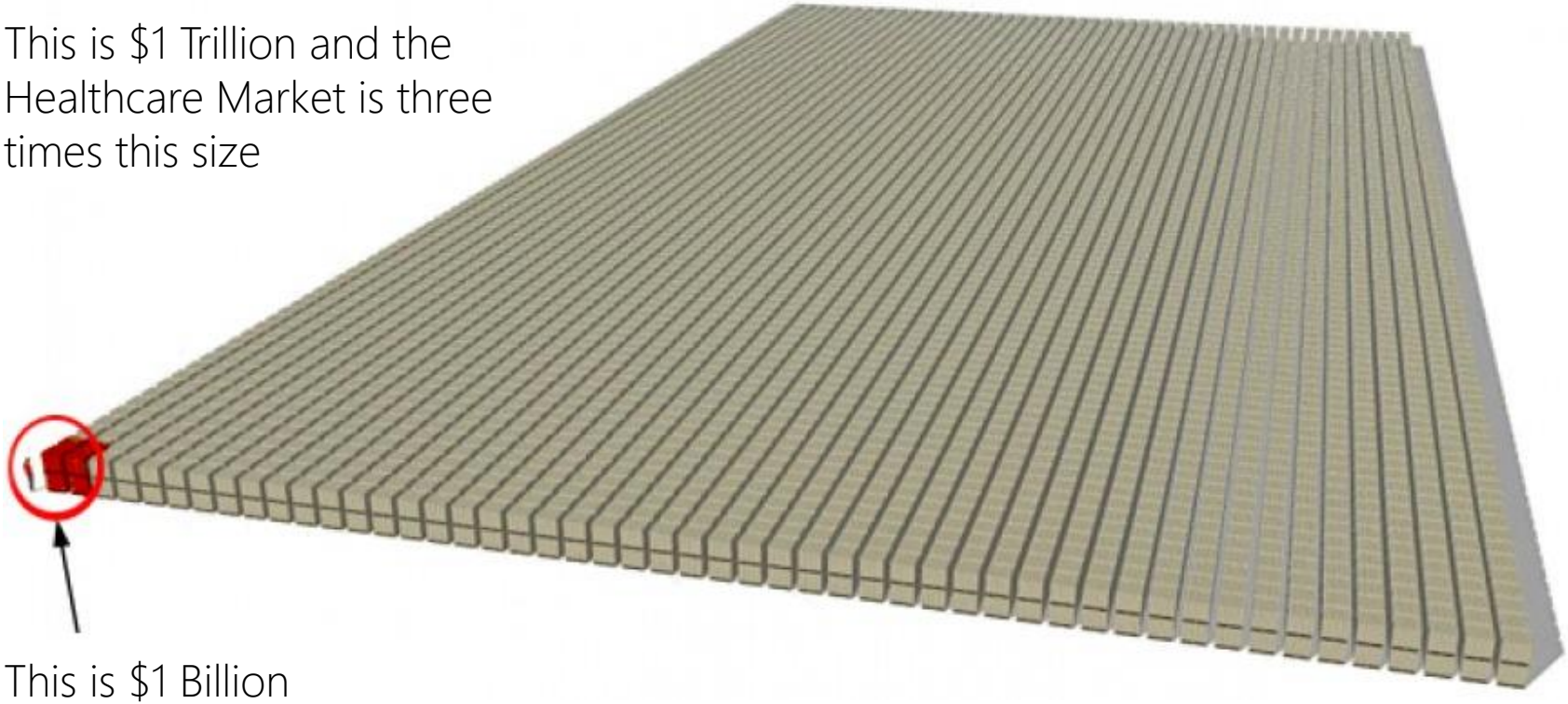
Each MSMI knows about data from a transactional perspective but the Partners in Interoperability Program will help identify data(through new or existing FHIR resources) required to manage shared risk contracts and manage incentive programs.


# No, value based care will not disrupt the healthcare “industry” any time soon.

But small portions can be impacted.
Positively.

# Why is disruption in healthcare so hard?

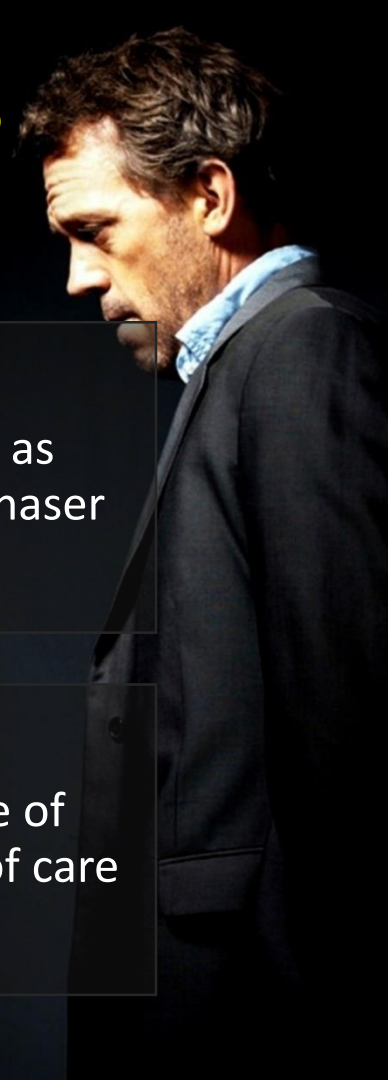
This is $1 Trillion and the Healthcare Market is three times this size



This is $1 Billion


“What's not going to change in the next 10 years?”
Jeff Bezos

# What's not going to change in healthcare?



Do no harm, safety first, and reliability effect on standard of care

Statutory cruft & regulatory burdens increase over time

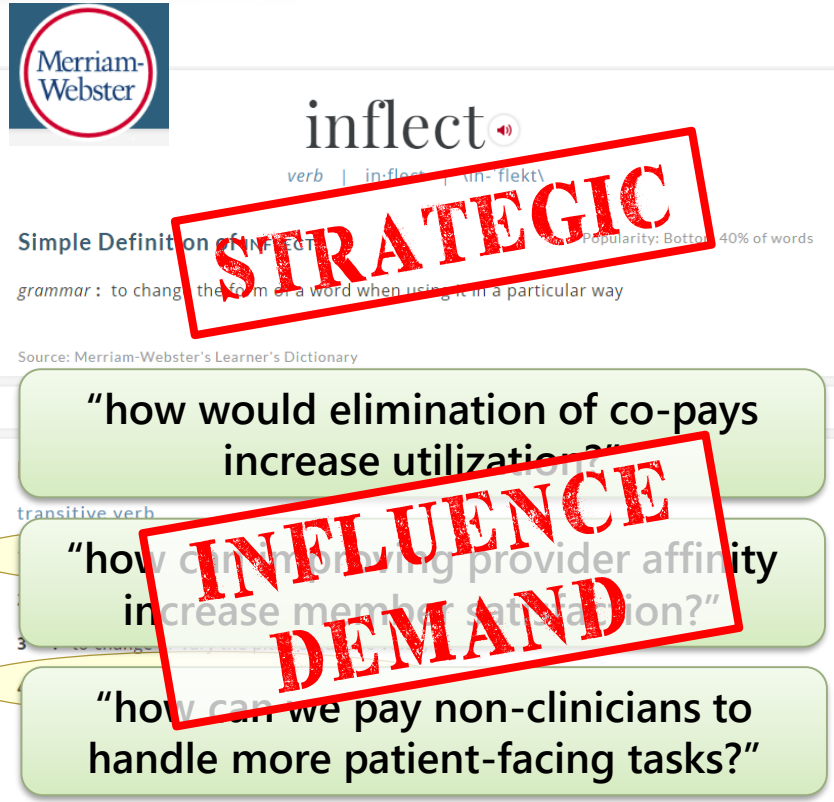
Government as dominant purchaser

Outcomes based payments intermediation & pricing pressure

Eminence & consensus driven decisions as collaboration increases

Increased use of alternate sites of care

# Inflective vs. Reflexive Innovation

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# VA: Nurse practitioners nationwide no longer need physician supervision


David Shulkin, undersecretary of health for the Department of Veterans Affairs, with VA Secretary Bob McDonald at a House hearing in February, 2016.
Joe Gromelski/Stars and Stripes

By NIKKI WENTLING | STARS AND STRIPES
Published: December 23, 2016

WASHINGTON — To address staffing shortages across the country, the Department of Veterans Affairs will allow thousands of advanced practice nurses nationwide to treat patients without physician supervision.

Starting Jan. 13, certified nurse practitioners, clinical nurse specialists and certified nurse-midwives at VA hospitals will be authorized to "practice to the full extent of their education … without the clinical supervision or mandatory collaboration of physicians," the rule states.

David Shulkin, the VA Undersecretary for Health, said the change would free up physicians, alleviating challenges the VA has with getting veterans quick access to medical treatment. But the physician-led American Medical Association said the rule would do away with the team-based care that's been adopted at the VA and revert it back to an "outdated model" of health care delivery.

The VA started a system-wide effort to hire additional health care providers and speed up veterans' access to treatment in 2014, when media reports and internal investigations revealed veterans had long waits for care and managers were manipulating wait-time data.

INFLECTIVE INNOVATION

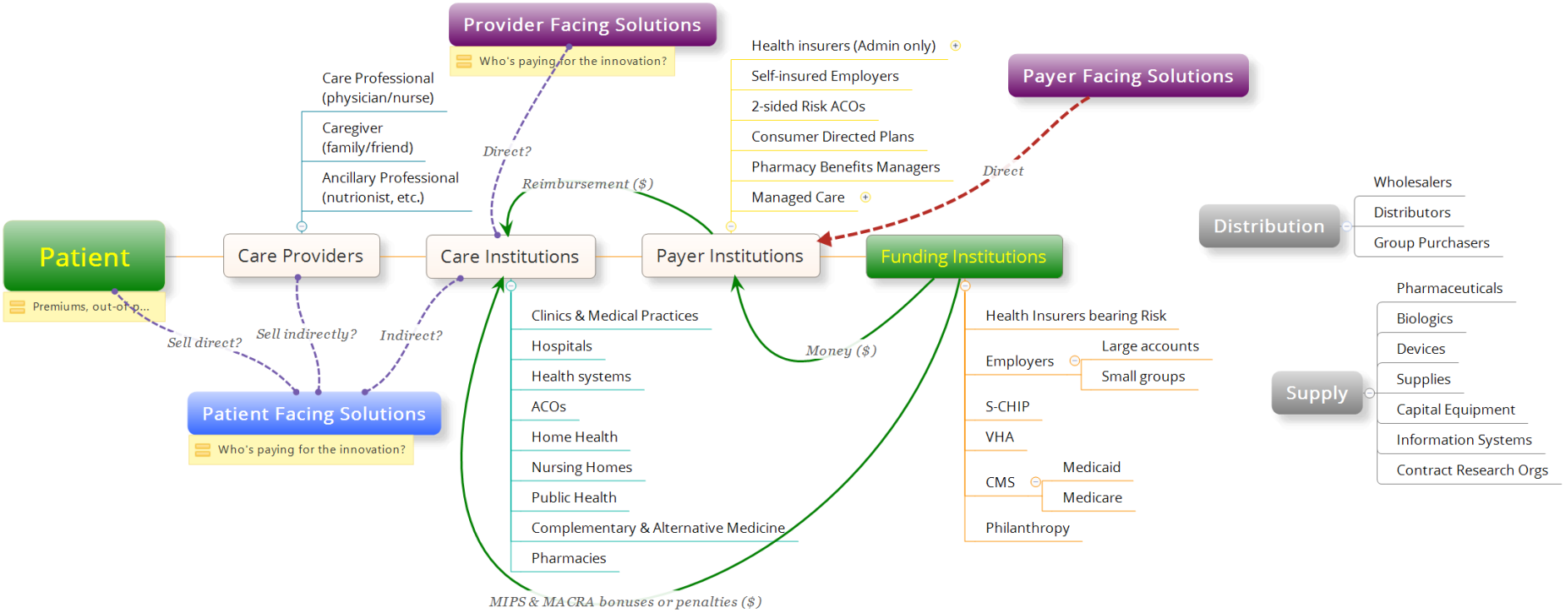
http://www.stripes.com/va-nurse-practitioners-nationwide-no-longer-need-physician-supervision-1.445862

# The BS of “patient centricity” and the reality of “my institution first” thinking is a major challenge.

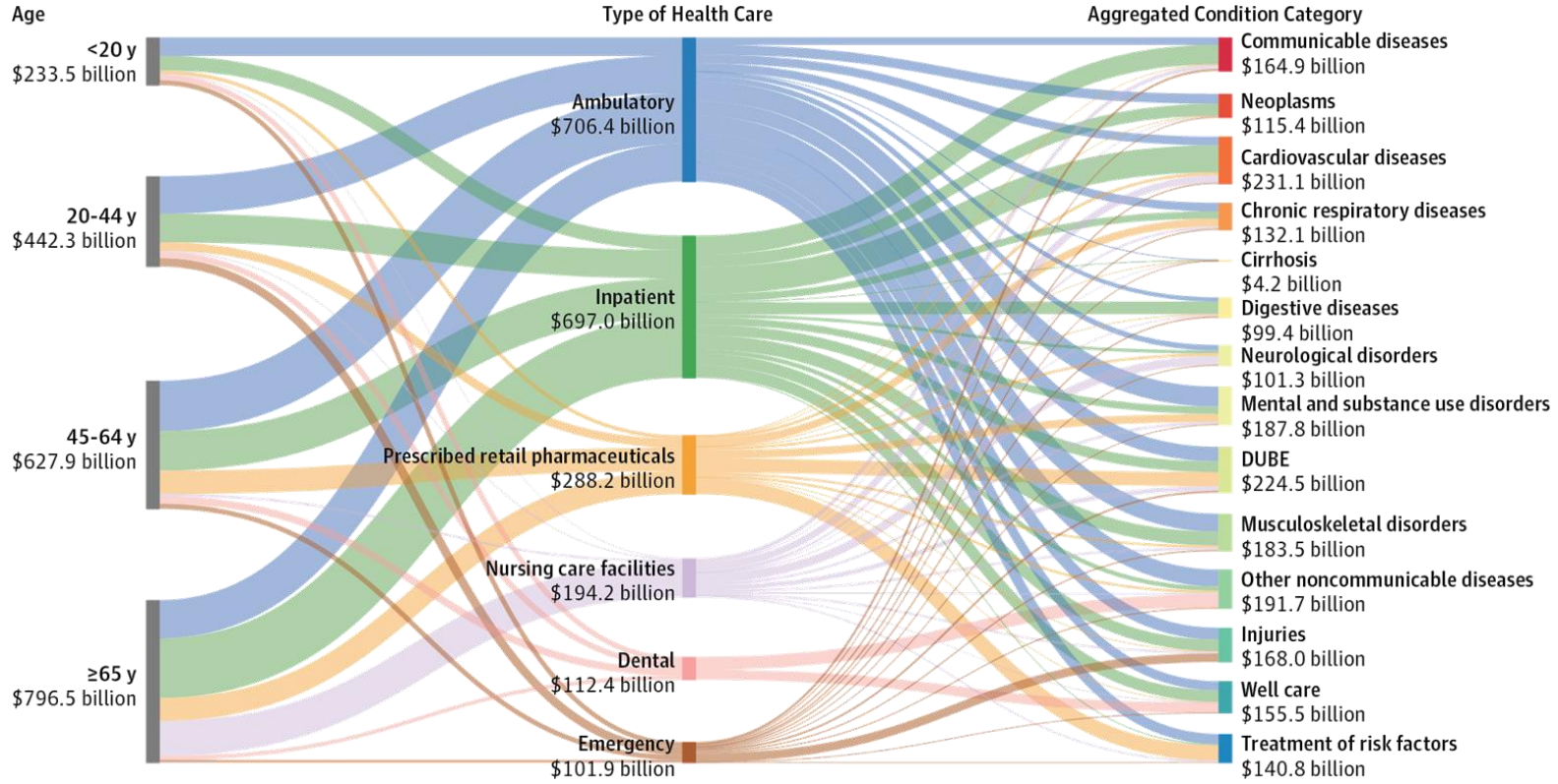
The reasons why are not any one ecosystem participant’s fault but will require leadership to solve. ☺

# If FHIR is so easy, why is interoperability so hard?

No single ecosystem participant is incentivized to change long term behaviors in patients so we're looking to do as little as possible with the most gain for our own institution.



# No one funding entity or insurer has beneficiary long enough to be accountable for long-term care even in a value based environment




http://jamanetwork.com/journals/jama/fullarticle/2594716

An innovator's primary job is to define desired outcomes tied to inflection points

# AHIP IL Value Based Care Solution Working Group ("SWG") Case Study

# Making it practical

## Defining the objectives

- Overview of Objectives and Key Results (OKRs) framework
- Overview of Problems to be Solved (PTBSs) framework
- Overview of Jobs to be Done (JTBD) framework

## Strategic Innovation Planning

- What innovations are pre-requisites to using FHIR in VB use cases?
  - Reimbursement innovation?
  - Relationship innovation (trust/alignment)?
  - Cost / price transparency?

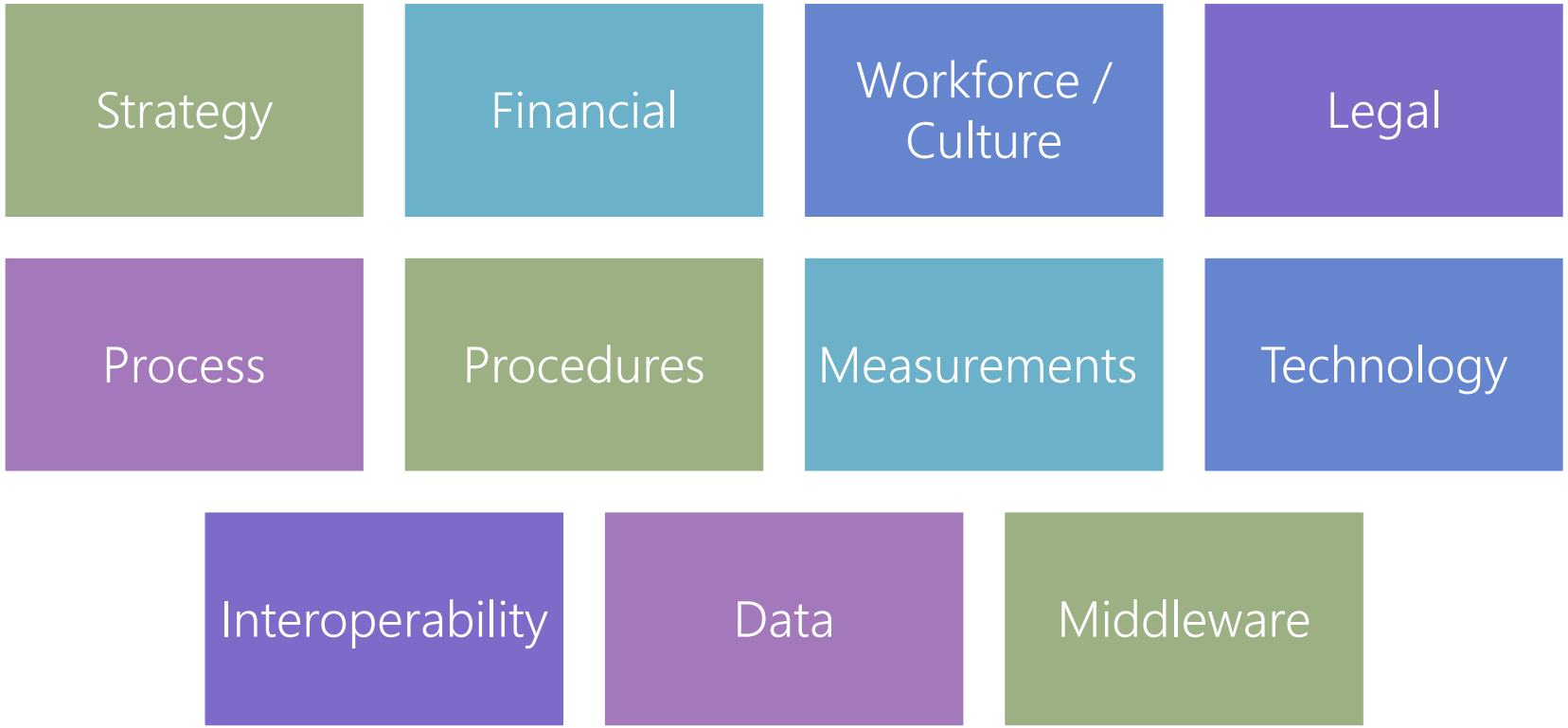
## Implementation Tactics

- What initial use cases do we target?
- Recommendation: Diabetes in Primary Care
- Patient journey map and how each touch point across MSMI can accommodate FHIR

## Facilitating the Business Case

- How do we create the business cases that implementers can take to their bosses to get funding and resources?
- How do we identify bargaining chips for each decision-maker?

# Value Based Care is hard…we must be realistic



# Value is different for each population

## Prevention

### Well Patient

- Education
- Health Promotions
- Healthy Lifestyle Choices
- Health Risk Assessment

26 % of Population

4 % of Medical Costs

### At Risk

- Obesity Management
- Wellness Management
- Assessment – HRA
- Stratification
- Dietary
- Physical Activity
- Physician Coordination
- Social Network
- Behavior Modification

35 % of Population

22 % of Medical Costs

## Management

### Chronic Care

- Diabetes
- COPD
- CHF
- Stratification & Enrollment
- Disease Management
- Care Coordination
- MD Pay-for-Performance
- Patient Coaching

35 % of Population

37 % of Medical Costs

### Acute Treatment

- Physicians Office
- Hospital
- Other sites
- Pharmacology
- Catastrophic Case Management
- Utilization Management
- Care Coordination
- Co-morbidities

4% of Population

36 % of Medical Costs

Source: Amir Jafri, PrescribeWell

# What AHIP IL has seen as VBC challenges

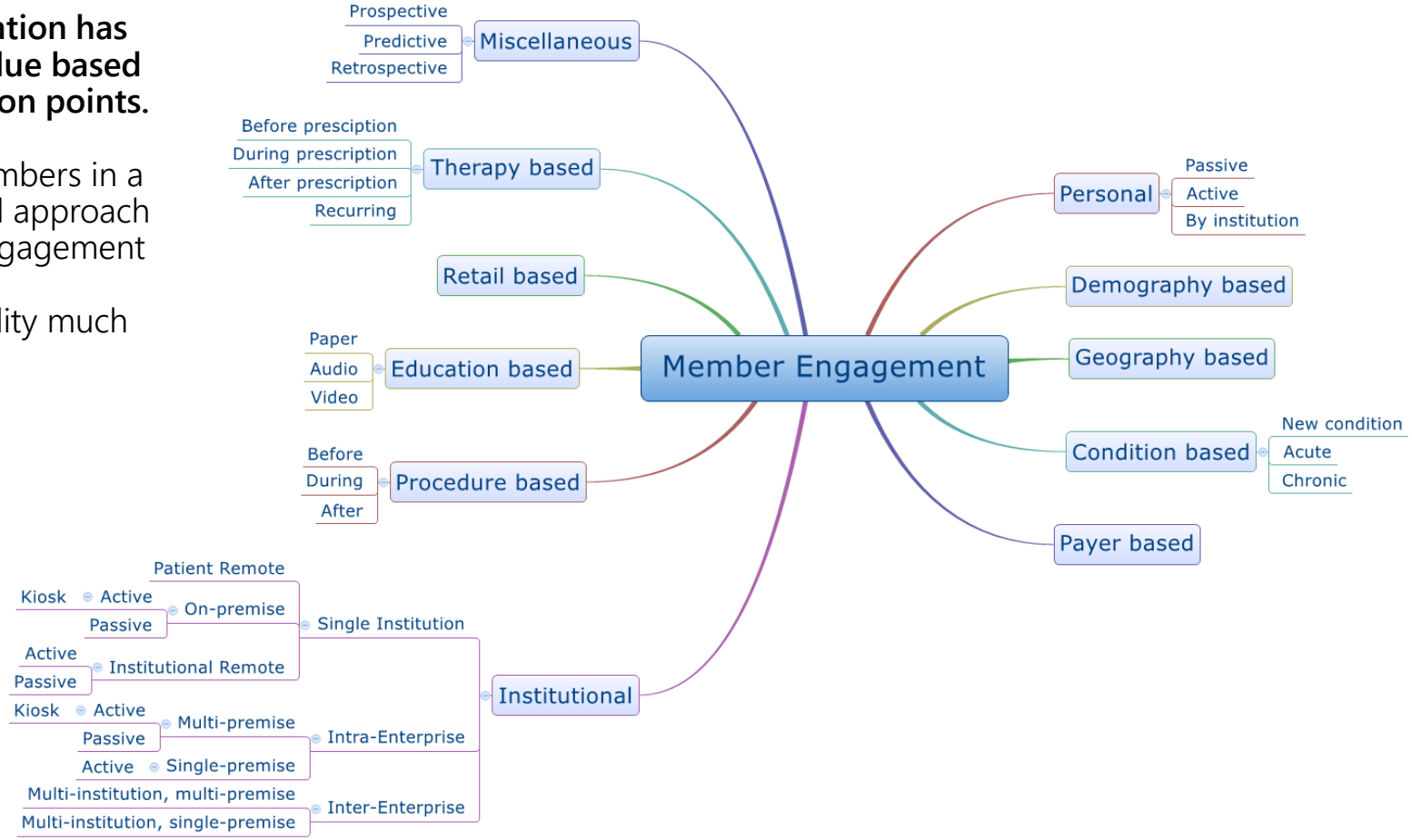
- Gaps in care
- Utilization management / over utilization
- Reimbursement innovation
- Relationship innovation (trust/alignment)
- Workflow / training of healthcare professionals / culture
- New administration and policies around healthcare; speculations vs. regulation

FHIR / Interop / APIs are enablers, not goals

Let's talk about what's important to you. This is a listening session.

**Each population has different value based care inflection points.**

Treating members in a personalized approach increases engagement but makes interoperability much harder.



# Value Based Care Themes to Cover

| Strategy | Financial | Workforce / Culture | Legal | Processes & Procedures |
|---|---|---|---|---|
| •How are multiple stakeholders across multiple institutions ("MSMI") aligning their strategies around VBC? | •What financial incentives alignment exists between MSMIs? | •Are stakeholder workforces in each institution aware of their new roles, responsibilities, and RACI charts? Do they know the new patient journeys? Are MSMI trained around specific OKRs associated with their RACI? | •How can we move beyond simple agreements into more specification-oriented agreements that would memorialize data-specific expectations<br>•If something is not legally required, is it still important? | •Are MSMI processes well understood? Are the data exchange requirements defined and documented (with or without FHIR)?<br>•Are MSMI standard operating procedures for each process well documented, trackable, measurable, and shared? Are FHIR resources identified properly for each procedure? |

# Value Based Care Themes to Cover

## Measurements

- Have we properly delineated process measures vs. outcomes measures?
- Are quality measures defined well enough to put them into our contracts?
- How can we remove measurements over time instead of increase them?

## Technology

- Are each of the technologies necessary for exchanging FHIR data identified and procurable when necessary?

## Interoperability

- Has each MSMI participant's *business interoperability* documentation been approved and accepted? We'll assume technical interoperability will be easy but what about business and workforce interoperability?

## Data

- Assuming FHIR resources exist, where will data be stored and exchanged (what's canonical, what's transactional)?

## Middleware

- Does middleware for exchanging FHIR resource exist at each point where an exchange is necessary? How will endpoint discovery happen?

# Focus on insurers' VBC tasks or help providers?

## Providers' work

- Clinical services
- Patient registries
- Recruit patients
- Fill gaps in care
- Coding and sending claims for services
- Schedule and coordinate care clinically
- Engage patients during clinical services

## Payers' Work

- Pay claims
- Identify gaps in care
- Coordinate care administratively
- Engage consumers pre- and post-clinical services
- Risk scoring and registry identification
- Identify care variability across MSMI
- Understand utilization and engage network

# Aligning Multiple Roles and Responsibilities

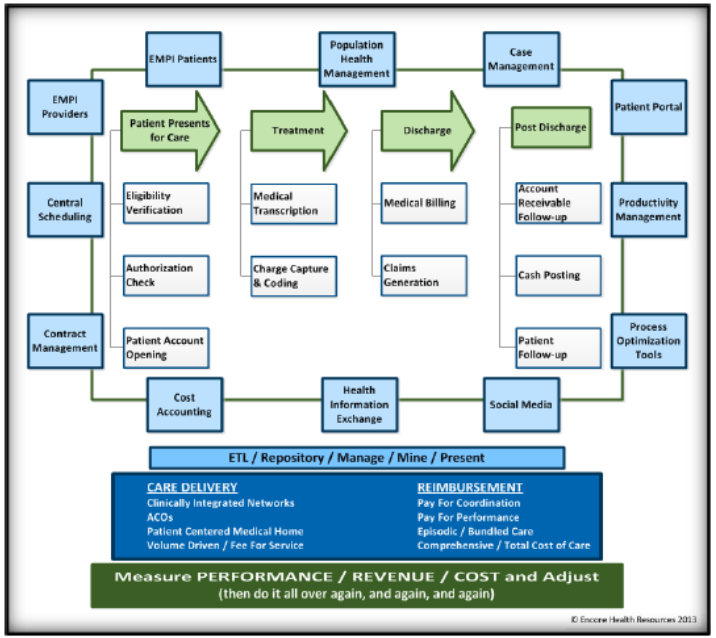



Figure 2. The Value-Based Revenue Cycle Impacts and Tools

| Business Administration | Risk Contracting | Population Health Management | Patient Care | Consumer Engagement |
|---|---|---|---|---|
| Marketing | Population Identification | Population identification and prioritization (risk level by need) | Care team collaboration, Shared clinical plans and work flow | Marketing/ enrollment |
| Population Identification | Needs Assessment/ Analytics | Care prioritization, including gaps in care | 360 patient/ consumer information | Multi-channel communication, clinical interaction and portal strategies |
| Enrollment, including insurance and basic demographic information | Utilization and cost modeling | Care team collaboration Shared clinical plans and common workflows | Best practice guidelines (treatment, costs, settings) | Clinical and health outreach, including social factors |
| Network Contracting and Management | Risk contract terms and incentives modeling | 360 patient/consumer information | 360 patient/ consumer information | 360 patient/ consumer information |
| Provider/Network Payments | Contract Payments/ Reimbursement Reconciliation | Best practice guidelines (treatment, cost, setting) | Aligned clinical and patient incentives | Goals, incentives and outcomes objectives and monitoring |
| AP/GL Services | Services/Bill Audit | Set and monitor individual and population health goals | Consumer mhealth technologies | Consumer technologies - mobile, social, consumer health technologies |
| Performance Incentives | Mandated Quality and outcomes measures/ Analytics | Patient clinical interactions (EHR and outreach | Patient clinical interactions | On-line health/ medical information, chat, groups |
| Cost Management Accounting | Contract analytics | Aligned clinical, patient and consumer incentives | Care management research and resources | Quality/ satisfaction assessments |

Table 1: Aligning Multiple Roles and Responsibilities

*Source: Value-Based Care – What Revenue Cycle Impacts should you worry about? Marhefka, et. al.*

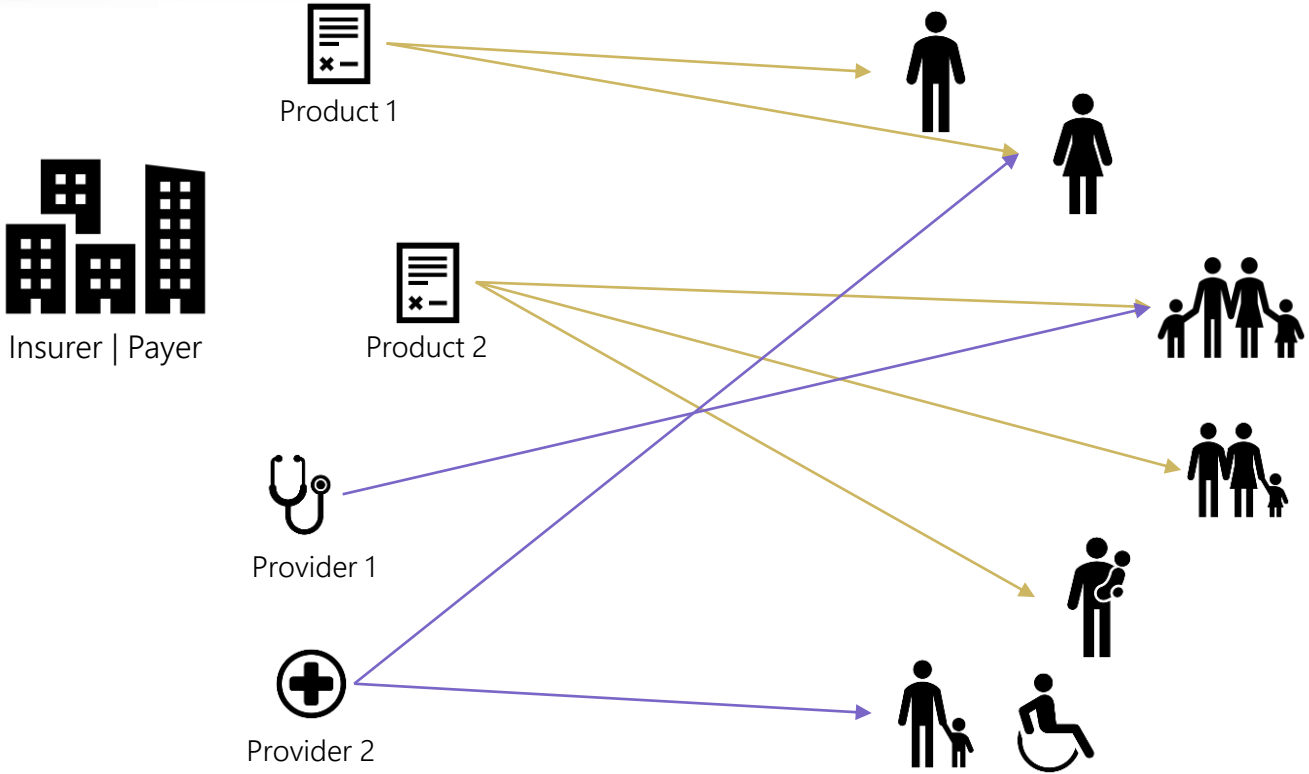
*Provider-Payer Collaboration – Shared Objectives, Blurring Roles & Vendors that Don't Get it; Janice Young Chilmark*

# Where can FHIR / technology intersect?

- Data tools – to pull (Extract, Transform, Load – ETL), house (repository), integrate–aggregate–normalize (manage), mine (analytics), present (reporting/dash-boarding) and push (Health Information Exchange – HIE) data.
- Process Optimization software – to enhance workflows.
- Patient Portals – to enhance communication with patients, better manage prevention, promote wellness and collect cash.
- Social Media tools – to manage patient, provider and business communication challenges now common for integrated care delivery networks.
- Marketing-to-the-Consumer tools – to market services based on price and quality.
- Population Health Management systems – to support care management of defined populations.
- Productivity Management systems – to manage the resource aspect of clinical processes.
- Cost Accounting systems (fortified) – to track costs across the continuum of care.
- Contract Management systems (also fortified) – to provide bilingual type management of traditional FFS based contracts as well as FFV based contracts.
- Enterprise Master Person Index (Patients) – to identify a population and tag patients who are "eligible" under alternative payment models.
- Enterprise Master Provider Index – to support centralized scheduling, referral management and overall patient care coordination.
- Scheduling systems that incorporate Referral Management – to manage patient care coordination.
- Case Management systems – to manage transitions of care.
- Health Information Exchanges – to capture and share patient data from multiple, disparate sites of care delivery.

*Source: Value-Based Care – What Revenue Cycle Impacts should you worry about? Marhefka, et. al.*

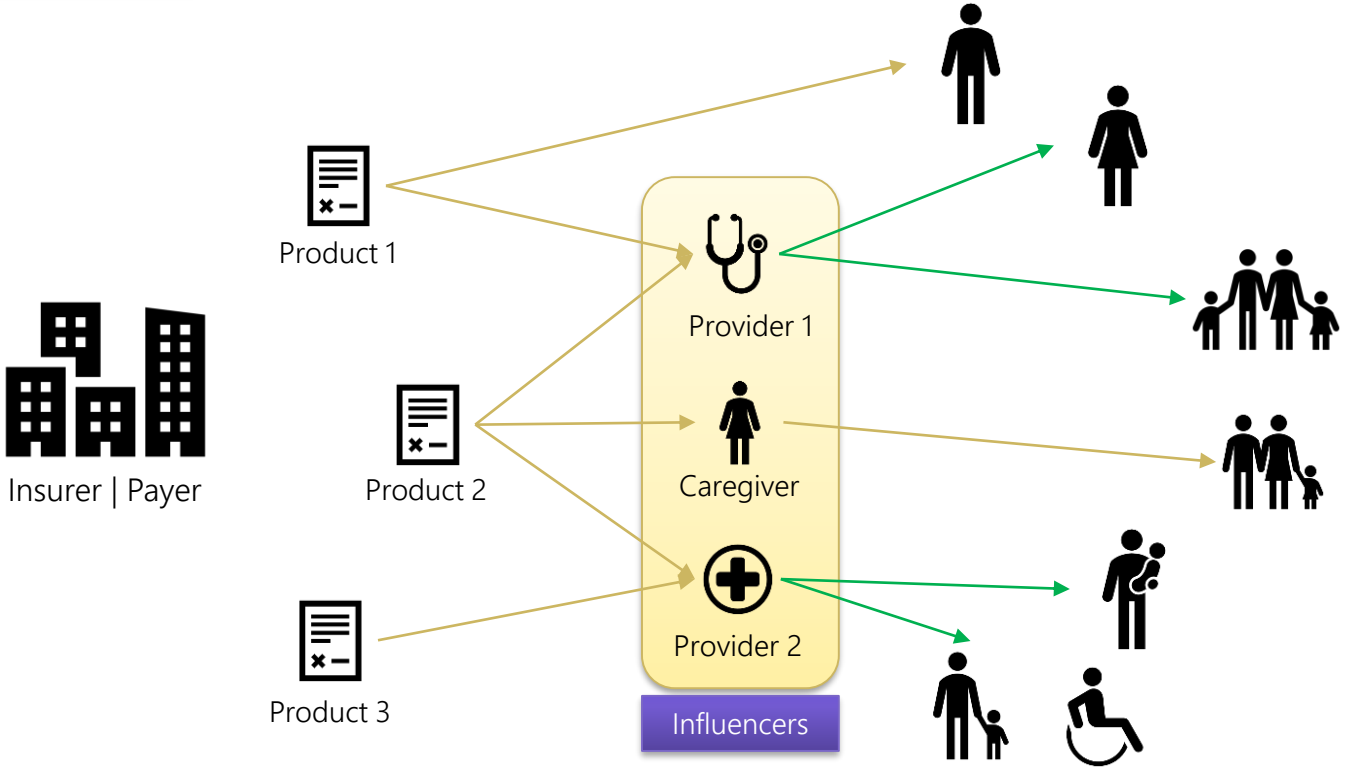
# "My institution first" approach to patient care




Each member population requires different engagement techniques at various times.

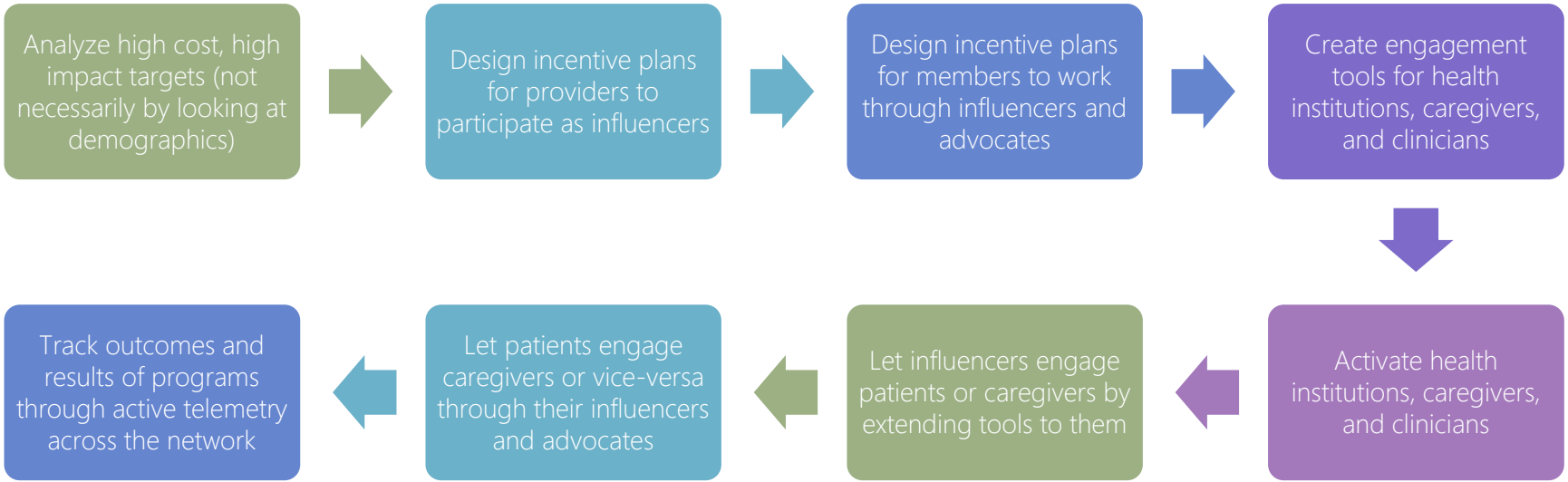
But ecosystem participants don't work together.

# Value Based Provider Affinity Approach (SWG)



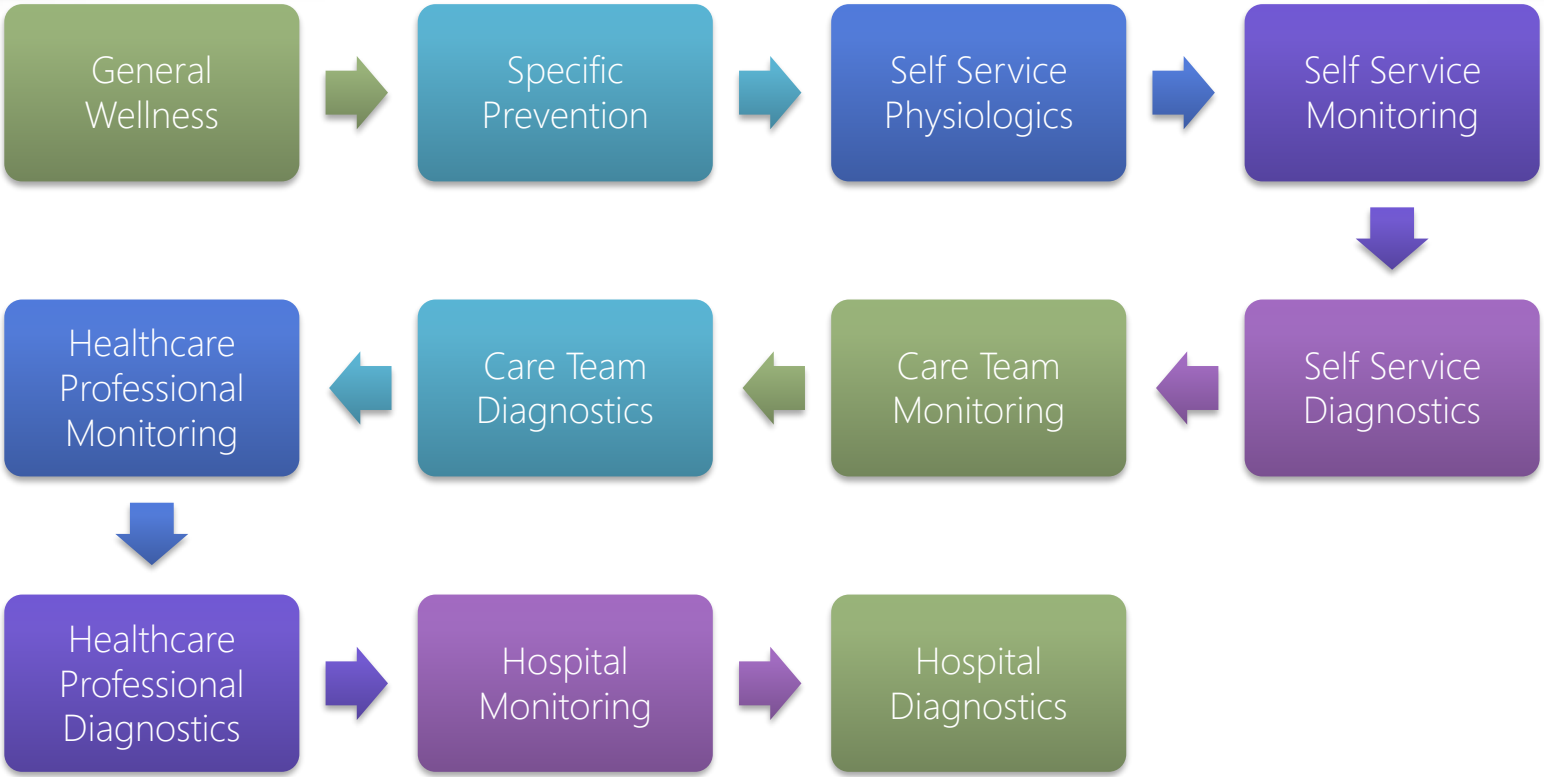

Each member population get personal care through their provider or other advocate, enabled by health insurer tools and support.

# How value based care via *provider affinity* works




**The AHIP Innovation Lab can work with you and your partners to develop specific programs and find solutions.**

# Interoperability opportunities with affinity



# Thank You!

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