Actionable Data and Physician Engagement Drive ACO Success

Session #100, February 21, 2017

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Speaker Introduction

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Conflict of Interest

Christy Cawthon, Manager, Decision Support
and
Sam Stearns, MS, MBA, Vice President, Analytic Consulting

Have no real or apparent conflicts of interest to report.
Agenda

• Overview of the UT Southwestern Accountable Care Network (UTSCAN)
• Launching UTSCAN: Three Key Challenges
• Pods: Scaling Accountable Care Through Physician Engagement
• Making Data Actionable Through Technology and Analytics
• Case Example: Home Health
• Results and Lessons Learned
Learning Objectives

• Classify steps used to develop the ACO technology platform and clinical infrastructure
• Design the components of the population management teams used to engage physicians
• Summarize the patient data and reporting metrics used to guide clinical interventions
• Describe continuous process improvement techniques to develop data-driven action plans
An Introduction of How Benefits Were Realized for the Value of Health IT

By enabling physician engagement with actionable data, Health IT has created several types of value at UTSW:

- **S** Increased Physician Satisfaction
- **T** Reduced Utilization
- **E** Enhanced Communication and Reporting
- **P** Improved Prevention and Chronic Care
- **S** Shared Savings
Overview of the UT Southwestern Accountable Care Network
UT Southwestern Accountable Care Network (UTSACN)

- Greater Dallas-Fort Worth Metroplex
- 3,000 Providers (400 PCPs)
- 27 Hospitals / 2 Health Systems
- Launched in 2014: Medicare Shared Savings Program (MSSP) Track 1

Source: UT Southwestern Accountable Care Network
Our Service Area: Dallas / Fort Worth
Launching UTSCAN: Three Key Challenges
UTSACN faced three challenges at launch

Physician Engagement
“What is Accountable Care?”

Technology Gaps
“How do we organize complex data?”

Patient Education
“How will I be impacted?”
Pods: Scaling Accountable Care Through Physician Engagement
Population Management Units: Pods

- 3,000 physicians organized in >45 Pods across the UTSW footprint
- Integrates multidisciplinary clinical team
- Drives physician leadership and strong care coordination
- Meets monthly to:
  - Share data
  - Review reports
  - Improve referral process
  - Discuss best practices

Source: UT Southwestern Accountable Care Network
Educating and Engaging Physicians

• Organized patient data
• Recruited strong physicians committed to accountable care
• Deployed analytics to identify patient needs and inform care
• Developed provider reports to support continuum of patient care
• Leveraged transparent provider scorecards for best practices
Making Data Actionable Through Technology and Analytics
# Three Complementary Data Sources

<table>
<thead>
<tr>
<th>Paid Claims Data</th>
<th>EMR Data</th>
<th>ADT Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Predictive modeling</td>
<td>• Gaps in care</td>
<td>• Transitions of care</td>
</tr>
<tr>
<td>• Risk scores</td>
<td>• 4 EMR vendors</td>
<td>• Compiled internally</td>
</tr>
<tr>
<td>• Spend by category</td>
<td>• 100 disparate systems</td>
<td></td>
</tr>
<tr>
<td>• Highest paid diagnosis</td>
<td>• Vendor support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Extraction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Standardization</td>
<td></td>
</tr>
</tbody>
</table>

- Extraction
- Standardization
Integrating data across the enterprise
### Actionable Data to Engage Providers: Pod Report

**Recommendations to drive action:**

- Share un-blinded performance data with providers
- Benchmark against practice, Pod, ACO, national
- Include both quality and cost efficiency

#### Example: Monthly Cost and Utilization Report

<table>
<thead>
<tr>
<th>POD</th>
<th>PCP</th>
<th># of Individuals</th>
<th>Risk Adjusted Allowed PMPM</th>
<th>Top-Coded ($400K/yr) Allowed PMPM</th>
<th>ER Visits Per 1000</th>
<th>Admissions Per 1000</th>
<th>ACS Admissions Per 1000</th>
<th>Imaging RVU per 1000</th>
<th>Normalized RAS (Model 2) Medicare</th>
<th>Top-Coded ($400K) Yr Cost Efficiency Index</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>50%</td>
<td>50%</td>
<td>25%</td>
<td>50%</td>
<td>25%</td>
<td>75%</td>
<td>0%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
<td>$868</td>
<td>$856</td>
<td>491</td>
<td>239</td>
<td>109</td>
<td>1,207</td>
<td>0.76</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ACO</td>
<td>22,792</td>
<td>$771</td>
<td>$761</td>
<td>510</td>
<td>220</td>
<td>94</td>
<td>1,082</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Provider Group A</td>
<td>9,209</td>
<td>$868</td>
<td>$856</td>
<td>491</td>
<td>239</td>
<td>109</td>
<td>1,207</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Provider Group B</td>
<td>15,583</td>
<td>$730</td>
<td>$713</td>
<td>519</td>
<td>211</td>
<td>87</td>
<td>1,025</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>POD A</td>
<td>784</td>
<td>$828</td>
<td>$821</td>
<td>498</td>
<td>240</td>
<td>75</td>
<td>1,129</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Dr. A</td>
<td>112</td>
<td>$688</td>
<td>$694</td>
<td>860</td>
<td>259</td>
<td>54</td>
<td>1,250</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Dr. B</td>
<td>35</td>
<td>$568</td>
<td>$568</td>
<td>317</td>
<td>216</td>
<td>43</td>
<td>575</td>
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<td></td>
<td></td>
<td>Dr. C</td>
<td>73</td>
<td>$948</td>
<td>$929</td>
<td>445</td>
<td>191</td>
<td>162</td>
<td>1,273</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dr. D</td>
<td>564</td>
<td>$858</td>
<td>$840</td>
<td>422</td>
<td>241</td>
<td>69</td>
<td>1,055</td>
</tr>
</tbody>
</table>

Source: UT Southwestern Accountable Care Network, Verscend Technologies

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Actionable Data to Engage Providers: Quality Measurement

**Recommendations to drive action:**

- Extract and standardize EMR data
- Share drill-down reports on specific gaps in care with practices
- Group clinically-related measures and provide customized targets

**Example: Provider Dashboard**

- **Preventive**
  - BMI: ACO
  - Prev: ACO
  - Mammo
  - Colorectal
  - Falls
  - Htn Screening
  - Pneumo
  - Tobacco
  - Depression

- **Diabetes**
  - DM: ACO 27 - Hba1c Poor Control
  - DM: ACO 41 - Eye Exam
  - Composite

- **Other Quality Measures**
  - CAD: ACO 33 - ACE/ARB Thrpy
  - Depression: ACO 40 - Remission
  - HTN: ACO 28 - BP Control
  - IVD: ACO 30 - Anti-thrmb Thrpy
  - Prev: ACO 42 - Statin
  - HF: ACO 31 - Beta
  - Composite

Source: UT Southwestern Accountable Care Network © 2017 HIMSS
### Example: Patient-Level Care Gap Alerts

**EMR & Claims Care Gaps**

<table>
<thead>
<tr>
<th>Individual ID</th>
<th>IPP</th>
<th>Curr Attrib</th>
<th>Last Name</th>
<th>Chronic Conditions</th>
<th>All Measures Final Alert</th>
<th>Fair Priority</th>
<th>ACO 13 Falls Alert</th>
<th>ACO 14 Flu Alert</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXXXXXXXA</td>
<td>Provider A</td>
<td>2016 Q3 Bene List</td>
<td>Smith</td>
<td>1</td>
<td>1</td>
<td>Low</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXXXXXXXA</td>
<td>Provider B</td>
<td>2016 Q3 Bene List</td>
<td>Smith</td>
<td>0</td>
<td>5</td>
<td>Low</td>
<td>ACO 13 Falls Alert</td>
<td></td>
</tr>
<tr>
<td>XXXXXXXXA</td>
<td>Provider C</td>
<td>2016 Q3 Bene List</td>
<td>Smith</td>
<td>1</td>
<td>4</td>
<td>Low</td>
<td>ACO 13 Falls Alert</td>
<td></td>
</tr>
<tr>
<td>XXXXXXXXA</td>
<td>Provider D</td>
<td>2016 Q3 Bene List</td>
<td>Smith</td>
<td>0</td>
<td>7</td>
<td>Low</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXXXXXXXA</td>
<td>Provider E</td>
<td>2016 Q3 Bene List</td>
<td>Smith</td>
<td>2</td>
<td>2</td>
<td>Med</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXXXXXXXA</td>
<td>Provider F</td>
<td>2016 Q3 Bene List</td>
<td>Smith</td>
<td>3</td>
<td>2</td>
<td>Low</td>
<td></td>
<td>ACO 14 Flu Alert</td>
</tr>
<tr>
<td>XXXXXXXXA</td>
<td>Provider G</td>
<td>2016 Q3 Bene List</td>
<td>Smith</td>
<td>0</td>
<td>3</td>
<td>Low</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXXXXXXXA</td>
<td>Provider H</td>
<td>2016 Q3 Bene List</td>
<td>Smith</td>
<td>3</td>
<td>3</td>
<td>High</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Recommendations to drive action:**

- Quality improvement team stratifies patients based on both quality and risk to help meet goals.
**Recommendations to drive action:**

- Tell a story with multiple measures
- Compare risk-adjusted performance
- Calculate “Efficiency”: (Observed / Expected)
- Benchmark vs. market and national norm

---

**Example: PCP Cost Efficiency Summary**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Metrics</th>
<th>Your Performance</th>
<th>Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiaries</td>
<td># of Individuals</td>
<td>703</td>
<td>-</td>
</tr>
<tr>
<td>Risk &amp; Quality</td>
<td>RIS (Book of Business)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Risk Adjusted Allowed PMPM</td>
<td>$604</td>
<td>$537</td>
</tr>
<tr>
<td></td>
<td>Impact Dollars</td>
<td>$(591,626)</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Risk Adjusted Top-Coded ($400K/yr) Allowed PMPM</td>
<td>$585</td>
<td>$518</td>
</tr>
<tr>
<td></td>
<td>Top-Coded($400K/yr) Cost Efficiency Index</td>
<td>1.15</td>
<td>1.00</td>
</tr>
<tr>
<td>Admission Utilization Efficiency Index</td>
<td>Overall</td>
<td>1.09</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Due to Ambulatory Care Sensitive Conditions</td>
<td>1.73</td>
<td>1.00</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Outpatient ER Utilization Efficiency Index</td>
<td>0.83</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Outpatient Imaging Utilization Efficiency Index</td>
<td>1.02</td>
<td>1.00</td>
</tr>
<tr>
<td>Post Acute</td>
<td>SNF</td>
<td>0.49</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Home Health</td>
<td>0.86</td>
<td>1.00</td>
</tr>
<tr>
<td>% Generic Drugs</td>
<td>Overall</td>
<td>0.81</td>
<td>-</td>
</tr>
</tbody>
</table>

**Source:** UT Southwestern Accountable Care Network, Verscend Technologies

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**Recommendations to drive action:**

- In a fast growing population, calculate efficiency vs. national benchmarks:
  - Risk-adjustment measures relative performance
  - Provider efficiency is often stable over time
  - Population shifts can change benchmark substantially

**Efficiency** = \( \frac{\text{Observed Value}}{\text{Expected Value}} \)

**Expected** = Relative Risk \( \times \) Population Average

Example: Efficiency Trend - Clinic A

- Top Coded Cost
- Overall Admissions
- Outpatient ER
- Outpatient Imaging

Source: UT Southwestern Accountable Care Network, Verscend Technologies  © 2017 HIMSS
Leveraging Data to Engage Providers: Outreach to High Risk Patients

Example: High Risk Patient Stratification

<table>
<thead>
<tr>
<th>Individual</th>
<th>Admissions</th>
<th>Total Paid</th>
<th>Re-admissions</th>
<th>Office Visits</th>
<th>ER Visits</th>
<th>LOH</th>
<th>LOED</th>
<th>RRS Normalized to Medicare</th>
<th>Predicted Allowed Amt</th>
<th>Prev RRS</th>
<th>Care Coord or CCM Activity</th>
<th>Risk Status</th>
<th>% Delta from Previous RRS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient A</td>
<td>1</td>
<td>$106,680</td>
<td>0</td>
<td>16</td>
<td>3</td>
<td>0.94</td>
<td>0.39</td>
<td>31.14</td>
<td>$129,963</td>
<td>28.85</td>
<td>CCM</td>
<td>2 - Moderate</td>
<td>8%</td>
</tr>
<tr>
<td>Patient B</td>
<td>2</td>
<td>$74,154</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>0.3</td>
<td>0.26</td>
<td>14.28</td>
<td>$59,605</td>
<td>15.79</td>
<td>NOS</td>
<td>1 - Impactful</td>
<td>-10%</td>
</tr>
<tr>
<td>Patient C</td>
<td>2</td>
<td>$49,888</td>
<td>0</td>
<td>18</td>
<td>4</td>
<td>0.46</td>
<td>0.75</td>
<td>8.21</td>
<td>$76,863</td>
<td>7.56</td>
<td>P</td>
<td>2 - Moderate</td>
<td>9%</td>
</tr>
<tr>
<td>Patient D</td>
<td>1</td>
<td>$43,886</td>
<td>0</td>
<td>6</td>
<td>1</td>
<td>0.36</td>
<td>0.36</td>
<td>6.63</td>
<td>$62,169</td>
<td>6.71</td>
<td>CCM</td>
<td>1 - Impactful</td>
<td>-1%</td>
</tr>
<tr>
<td>Patient E</td>
<td>0</td>
<td>$38,988</td>
<td>0</td>
<td>21</td>
<td>4</td>
<td>0.28</td>
<td>0.41</td>
<td>6.49</td>
<td>$60,913</td>
<td>6.74</td>
<td>NOS</td>
<td>1 - Impactful</td>
<td>-4%</td>
</tr>
<tr>
<td>Patient F</td>
<td>3</td>
<td>$42,059</td>
<td>1</td>
<td>28</td>
<td>7</td>
<td>0.7</td>
<td>0.92</td>
<td>5.76</td>
<td>$54,005</td>
<td>5.66</td>
<td>CC</td>
<td>3 - More Impactful</td>
<td>2%</td>
</tr>
<tr>
<td>Patient G</td>
<td>1</td>
<td>$51,307</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>0.54</td>
<td>0.25</td>
<td>3.92</td>
<td>$36,799</td>
<td>5.18</td>
<td>CC</td>
<td>2 - Moderate</td>
<td>-24%</td>
</tr>
</tbody>
</table>

Recommendations to drive action:
- Identify high utilization
- Identify high risk
- Identify Impactability

Engagement begins with provider awareness and allows for collaboration between our care coordination team and the patient

Source: UT Southwestern Accountable Care Network, Verscend Technologies

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Case Example: Home Health
Leveraging Data: Home Health Utilization

Opportunity

• Improve Home Health Utilization in MSSP population
  – MSSP Home Health Spend 2x national average, in Mid 2015
  – 1,200 home health agencies (HHAs) servicing our patients

Underlying Issue

• Physicians often sign CMS Home health certification form (485) without thinking twice:
  – Form is lengthy, complex, difficult to navigate
  – Fear of angering patient / family if home care removed
  – *Probably not doing any harm, right?*
Identifying High Value HHAs

ACO Analytics: Drill Down into Data

- Analyzed the data we had (Paid Claims)
- Created an efficiency score, based on actual paid claims, risk adjusted
- Narrowed the list to 44 HH agencies with >= 90% efficiency
- Cross-walked these to CMS STAR ratings
- Final network of 20 geographically dispersed, high efficiency, high quality HH agencies

20 Recommended HHAs

~1,200 HHAs in use

Source: UT Southwestern Accountable Care Network
## Home Health Agency Efficiency Scoring, Risk Adjusted

### Providers over the 80th Percentile in Risk adjusted Days

<table>
<thead>
<tr>
<th>Home Health Agency</th>
<th>Unique Patients</th>
<th>Avg RRS</th>
<th>HHA Total Spend</th>
<th>Risk Adj Avg Day</th>
<th>Risk Adj Spend Per Patient</th>
<th>Risk Adj Spend Per Day</th>
<th>Percentile for Risk Adj Days</th>
<th>Percentile for Risk Adj Spend</th>
<th>Blended Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand Total</td>
<td>13,686</td>
<td>3.05</td>
<td>$88,067,148</td>
<td>35.40</td>
<td>$2,111</td>
<td>$20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HHA A</td>
<td>657</td>
<td>2.87</td>
<td>$2,376,036</td>
<td>16.81</td>
<td>$1,259</td>
<td>$26</td>
<td>92.5%</td>
<td>86.9%</td>
<td>89.7%</td>
</tr>
<tr>
<td>HHA B</td>
<td>441</td>
<td>3.27</td>
<td>$2,255,963</td>
<td>21.57</td>
<td>$1,564</td>
<td>$22</td>
<td>79.3%</td>
<td>76.3%</td>
<td>77.8%</td>
</tr>
<tr>
<td>HHA C</td>
<td>424</td>
<td>2.48</td>
<td>$1,572,273</td>
<td>12.41</td>
<td>$1,496</td>
<td>$49</td>
<td>98.5%</td>
<td>77.3%</td>
<td>87.9%</td>
</tr>
<tr>
<td>HHA D</td>
<td>397</td>
<td>3.48</td>
<td>$1,482,162</td>
<td>13.67</td>
<td>$1,072</td>
<td>$23</td>
<td>97.5%</td>
<td>93.5%</td>
<td>95.5%</td>
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<tr>
<td>HHA E</td>
<td>395</td>
<td>2.98</td>
<td>$2,059,461</td>
<td>20.45</td>
<td>$1,749</td>
<td>$29</td>
<td>83.4%</td>
<td>65.2%</td>
<td>74.3%</td>
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<tr>
<td>HHA F</td>
<td>362</td>
<td>3.21</td>
<td>$1,721,269</td>
<td>16.45</td>
<td>$1,480</td>
<td>$28</td>
<td>93.5%</td>
<td>78.8%</td>
<td>86.2%</td>
</tr>
<tr>
<td>HHA G</td>
<td>360</td>
<td>3.00</td>
<td>$1,697,858</td>
<td>18.31</td>
<td>$1,573</td>
<td>$29</td>
<td>89.9%</td>
<td>75.8%</td>
<td>82.9%</td>
</tr>
<tr>
<td>HHA H</td>
<td>307</td>
<td>3.14</td>
<td>$1,594,931</td>
<td>19.31</td>
<td>$1,656</td>
<td>$27</td>
<td>85.9%</td>
<td>71.3%</td>
<td>78.6%</td>
</tr>
</tbody>
</table>

Source: UT Southwestern Accountable Care Network, Verscend Technologies
Engaging Providers: Home Health Utilization

• Create PCP Buy-In
  – Education on CMS requirements for Home Health
  – ACO has fiscal responsibility to use CMS $$ wisely
  – As PCP within the ACO, have a clinical responsibility to know why services are being utilized, and a fiscal responsibility to ensure $$ are used appropriately

• Develop Provider Specific Reports
  – Pod Meeting presentations (by Physician Reps)
  – Faculty leadership / buy-in
  – Provider notification of Care Coordination outreach related to HH utilization, the presumptive “close”
**Provider Specific Home Health Utilization Report (1/3)**

**Home Health Panel Performance Report 10/2015**
Jason Fish

<table>
<thead>
<tr>
<th>Action Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Suggested Action:</strong> This report contains the list of patients attributed to you that have had a home health claim in the prior 120 days. These are patients that are likely still receiving home health services that we have the potential to impact by reviewing for future home health needs. The Care Coordination team is available to help you evaluate these patients for appropriateness and eligibility for home health, and to identify appropriate alternative services to home health when applicable.</td>
</tr>
</tbody>
</table>

Please consider the following Action Steps in your review of this information:

1. Review the list noting the length of time the patient has been receiving continuous home health services (see Recerts). Each recert equals a separate 60 day certification. e.g. 4 Recerts indicate 240 days on continuous home health service, which should closely correlate with the Service (Svr) Days in the next column.

2. Consider the following questions:
   - ? Who is ordering home care and why?
   - ? Does the patient meet home health eligibility criteria?
   - ? Would it be helpful to have UTSACN Care Coordination evaluate the need / rationale for continuing home health services?

3. If Care Coordination review needed:
   - Submit Care Coordination Referral
   - Fax: 214-645-0024
   - EPIC Referral Order for UTSCAP Care Coordination

**Reports Attached**

- [✓] Active HHA Patients- Patients that are likely still receiving services with a home health agency.
- [✓] Top 50 Home Health Companies - Comparison of your utilization of agencies compared to the network.
**Active Home Health Patients**

**Dr X**

**Executive Summary:** The report below displays your patients who are likely actively receiving home health care services based upon our data. For comparison purposes in 2010 only <13% of the total Medicare home health population required two or more consecutive 60 day home health care episodes.

**Action Needed:** UTSACN is here to help providers to review recertification requests. Providers can access this help by submitting a Care Coordination Referral for Home Health Evaluation. Fax to: XXX-XXX-XXXX or submit a UTSCAP Care Coordination Referral through EMR. UTSCAP care coordination can help you evaluate the need and eligibility for home health care, and provide alternatives to home health when appropriate. Please also consider having the patient come to see you in your office to specifically review whether they still qualify for home health care.

<table>
<thead>
<tr>
<th>Person Name</th>
<th>Risk Score</th>
<th>Highest Paid Primary Dx</th>
<th>Last Admission Date</th>
<th>IP Admits</th>
<th>HHA Spend</th>
<th>Recerts</th>
<th>Svc Days</th>
<th>Current HHA</th>
<th>Current Ordering Provider</th>
<th>Last Date Recerted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith</td>
<td>4.26</td>
<td>Osteoarthritis</td>
<td>7/18/2016</td>
<td>3</td>
<td>$21,715</td>
<td>6</td>
<td>295</td>
<td>HHA A</td>
<td>Internal Medicine</td>
<td>7/14/2016</td>
</tr>
<tr>
<td>Smith</td>
<td>3.36</td>
<td>Congestive Heart Fai</td>
<td>7/28/2016</td>
<td>5</td>
<td>$9,282</td>
<td>6</td>
<td>236</td>
<td>HHA A</td>
<td>Internal Medicine</td>
<td>6/30/2016</td>
</tr>
<tr>
<td>Smith</td>
<td>2.25</td>
<td>Rehabilitation Thera</td>
<td>9/10/2015</td>
<td>1</td>
<td>$16,910</td>
<td>6</td>
<td>295</td>
<td>HHA A</td>
<td>Internal Medicine</td>
<td>7/21/2016</td>
</tr>
<tr>
<td>Smith</td>
<td>3.89</td>
<td>Peripheral Vascular</td>
<td>-</td>
<td>-</td>
<td>$13,187</td>
<td>6</td>
<td>295</td>
<td>HHA B</td>
<td>Surgery</td>
<td>7/24/2016</td>
</tr>
</tbody>
</table>
### Executive Summary
The home health agencies below have been utilized within the past twelve months by your attributed patient population. The current UTSACN standard for home health agency has been established at 80th percentile or above for risk adjusted days, spend, and recertification.

#### Top 50 Home Health Companies

<table>
<thead>
<tr>
<th>Home Health Agency</th>
<th>Patients</th>
<th>RRS</th>
<th>HHA Spend</th>
<th>Recerts</th>
<th>Svc Days</th>
<th>Risk Adjusted Avg Spend Per Patient</th>
<th>Risk Adjusted Avg Certs Per Patient</th>
<th>Risk Adjusted Avg Days Per Patient</th>
<th>Network Percentile Ranking*</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHA A</td>
<td>2</td>
<td>11.6</td>
<td>$122</td>
<td>1</td>
<td>10</td>
<td>$5</td>
<td>0.04</td>
<td>0.43</td>
<td>96%</td>
</tr>
<tr>
<td>HHA B</td>
<td>5</td>
<td>4.44</td>
<td>$15,705</td>
<td>10</td>
<td>409</td>
<td>$707</td>
<td>0.45</td>
<td>18.42</td>
<td>94%</td>
</tr>
<tr>
<td>HHA C</td>
<td>1</td>
<td>9.07</td>
<td>$669</td>
<td>1</td>
<td>7</td>
<td>$74</td>
<td>0.11</td>
<td>0.77</td>
<td>87%</td>
</tr>
<tr>
<td>HHA D</td>
<td>1</td>
<td>0.69</td>
<td>$3,818</td>
<td>1</td>
<td>21</td>
<td>$5,534</td>
<td>1.45</td>
<td>30.43</td>
<td>87%</td>
</tr>
<tr>
<td>HHA E</td>
<td>1</td>
<td>3.46</td>
<td>$5,526</td>
<td>1</td>
<td>55</td>
<td>$1,597</td>
<td>0.29</td>
<td>15.90</td>
<td>84%</td>
</tr>
<tr>
<td>HHA F</td>
<td>1</td>
<td>4.34</td>
<td>$2,698</td>
<td>1</td>
<td>0</td>
<td>$622</td>
<td>0.23</td>
<td>0.00</td>
<td>84%</td>
</tr>
<tr>
<td>HHA G</td>
<td>1</td>
<td>4.34</td>
<td>$4,226</td>
<td>2</td>
<td>79</td>
<td>$974</td>
<td>0.46</td>
<td>18.20</td>
<td>76%</td>
</tr>
<tr>
<td>HHA H</td>
<td>1</td>
<td>3.78</td>
<td>$4,171</td>
<td>1</td>
<td>22</td>
<td>$1,103</td>
<td>0.26</td>
<td>5.82</td>
<td>74%</td>
</tr>
<tr>
<td>HHA I</td>
<td>1</td>
<td>11.6</td>
<td>$2,764</td>
<td>1</td>
<td>16</td>
<td>$239</td>
<td>0.09</td>
<td>1.38</td>
<td>67%</td>
</tr>
<tr>
<td>HHA J</td>
<td>1</td>
<td>5.03</td>
<td>$1,988</td>
<td>1</td>
<td>0</td>
<td>$395</td>
<td>0.20</td>
<td>0.00</td>
<td>65%</td>
</tr>
<tr>
<td>HHA K</td>
<td>2</td>
<td>3.08</td>
<td>$10,100</td>
<td>6</td>
<td>317</td>
<td>$1,640</td>
<td>0.97</td>
<td>51.46</td>
<td>55%</td>
</tr>
<tr>
<td>HHA L</td>
<td>1</td>
<td>11.6</td>
<td>$4,562</td>
<td>2</td>
<td>98</td>
<td>$394</td>
<td>0.17</td>
<td>8.46</td>
<td>23%</td>
</tr>
<tr>
<td>HHA M</td>
<td>1</td>
<td>6.16</td>
<td>$1,390</td>
<td>1</td>
<td>0</td>
<td>$226</td>
<td>0.16</td>
<td>0.00</td>
<td>7%</td>
</tr>
<tr>
<td>HHA N</td>
<td>1</td>
<td>4.34</td>
<td>$409</td>
<td>1</td>
<td>15</td>
<td>$94</td>
<td>0.23</td>
<td>3.46</td>
<td>N/A</td>
</tr>
<tr>
<td>HHA O</td>
<td>1</td>
<td>2.55</td>
<td>$4,491</td>
<td>3</td>
<td>122</td>
<td>$1,761</td>
<td>1.18</td>
<td>47.84</td>
<td>N/A</td>
</tr>
<tr>
<td>HHA P</td>
<td>1</td>
<td>2.69</td>
<td>$4,761</td>
<td>2</td>
<td>55</td>
<td>$1,770</td>
<td>0.74</td>
<td>20.45</td>
<td>N/A</td>
</tr>
</tbody>
</table>

#### Key Findings
- Your attributed patients have used 16 agencies in the past twelve months. Of those 6 are over the 80th percentile.
- Please note 50% of the agencies utilized are not meeting the UTSACN Standard.
- UTSACN goal is 75% of patients being serviced by agency performing at standard established by UTSACN (80th percentile).

#### Legend
- **80% or Greater**
- **Between 60% and 80%**
- **Less than 60%**

### Source
JT Southwestern Accountable Care Network, Verscend Technologies

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Engaging Providers: Home Health Utilization: *Provide a Process*

- **Make it EASY for Providers / Practice Engagement**
  - Created Care Coordination Referral for Home Health Evaluation
    - Process was a Standing Order, unless otherwise requested by PCP
  - Care Coordination Outreach to Home Health agency:
    - “If you anticipate recertifying patient again, please explain rationale”
      - “Who is ordering physician, if not PCP? What is the clinical rationale for home care?”
    - Notification that Care Coordination will provide oversight on behalf of PCP
  - **OPTION**: Add PCP to Care Team for future 485 recerts (medical decision)

*Requires Minimal Effort by PCP or PCP staff*
Engaging Patients: Home Health Utilization: *Provide a Process*

- **Outreach to Patients / Caregivers**
  - “What does HH staff do for you?”
  - “Is it helpful?”
  - “Are you seeing improvement?”
  - “What is your level of mobility?”

- **Facilitate transition, as applicable and appropriate**
  - Other sources of support (transportation, companion services, custodial care)

**Goal is NOT to eliminate Home Health Utilization**

**Goal is to make sure Home Health is being utilized appropriately and with oversight**
An Ongoing Process: Home Health Utilization: Next Steps

• Actively engage HH agencies in narrow network
  – Active and frequent communication
  – Regular meetings
  – Bi-directional support (ACO – HHA, HHA – ACO)

• Continue to monitor agency efficiency and quality, along with communication and engagement, to remain in Narrow Network

• Evolution of reports

• Leverage additional data sources

• Continual provider education / engagement
Results and Lessons Learned
### Summary: Value Realized from Health IT

<table>
<thead>
<tr>
<th>Health IT Value STEPS™</th>
<th>UTSCAN Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Satisfaction</strong></td>
<td>• Pod structure improved physician buy-in and reduced effort on PCP and staff</td>
</tr>
<tr>
<td><strong>Treatment / Clinical</strong></td>
<td>• Achieved a 15% reduction in home healthcare costs</td>
</tr>
<tr>
<td><strong>Electronic Secure Data</strong></td>
<td>• Monthly reports and Pod structure increased data sharing and communication across 3,000 PCPs</td>
</tr>
<tr>
<td><strong>Population Management</strong></td>
<td>• Improved ACO/HEDIS measures by 20% across all populations</td>
</tr>
<tr>
<td><strong>Savings</strong></td>
<td>• Generated $6M savings in year 1 and $30M in year two</td>
</tr>
</tbody>
</table>

Source: UT Southwestern Accountable Care Network
Lessons Learned

• Do not go in blind
• Implement technology analytics to understand metrics, and arm your physicians
• Define your strategy, and execute on it
• Build a partnership with your physicians
• Stay focused. Accountable care is a marathon, not a sprint
Questions

Christy Cawthon
Manager, Decision Support
University of Texas Southwestern Medical Center

Sam Stearns, MS, MBA
Vice President, Analytic Consulting
Verscend Technologies

UT Southwestern
Accountable Care Network

verscend