April Lewis:

Everyone, this is April Lewis, the Director of Health Center Operations and HR Training with NACHC. Thank you so much for joining part one of our two-part business intelligence webinar series. We are thrilled that you took the time out of your busy schedules to be on this call as this is very important information. So on behalf of NACHC and on behalf of all the community health centers that we provide service to across the nation, we say thank you for your continued commitment to making America a healthier place. And one of the ways that we definitely are doing that is by focusing on our health information technology and business intelligence is critical to that.

April Lewis:

Without further ado, I want to briefly introduce who our three speakers are for this webinar today. We have Heather Budd, who is a trusted partner with NACHC. She is the VP of clinical transformation for Azara Healthcare, and she's also the point person that we use for our NextGen EHR youth group that meets monthly. And she'll be joined by her colleague LuAnn Kimker, who is the director of quality innovation. And we also have a special treat, we have an interview with one of our colleagues, Lisa Perry, who is the senior VP of quality and technology initiatives with CHCANYS in New York. So we do have a dream team lined up for you today. Please, I did put a note in the chat. If you have any questions that come up, please enter them in the chat box. And if time is on our side, we will get to those questions at the end of this webinar. If for whatever reason we don't have time today, we'll build them into part two. So without further ado, Heather, I'll pass it on to you.

Heather Budd:

Thank you so much, April, for that very kind introduction. We are all really excited to be with you today. For this really exciting topic, we're going to spend a little time on just a tiny bit more on introductions in a moment, then we're going to spend a moment talking about the shift from volume to value, which I know you guys are all acutely aware of, and then talking about what data we think is most needed from payers or health plans today. April alluded to a treat to get a time to talk to Lisa Perry from CHCANYS about their particular journey to get access to payer data in their environment. And then we'll talk about integrated payer data in action, what does some of these reports look like, what does CHCANYS have access to at its health centers and also at the PCA layer, and then talk about some lessons learned and some conclusions.

Heather Budd:

So I'll just take a moment to introduce myself. My name is Heather Budd. And as April said, I'm the VP of clinical transformation for Azara Healthcare. I have history of working at health center. I was a quality director and later a COO. And really, my job is all about making data work for health centers. I'm passionate about care team transformation and efficiency and use of data that really truly improve the experience of the staff and the patient and ultimately the outcomes that we achieve from all of this. So that's me. I'll give LuAnn a moment to introduce herself and then Lisa after that. Go ahead, LuAnn.

LuAnn Kimker:

Great. So I'm LuAnn Kimker, director of clinical innovation, and thank you, Heather. So my background really has been in quality improvement organizations as well as in large academic medical centers, where I focused on care team redesign, quality improvement, and really got bit by the bug for practice redesign and how we do that better. And so I spent most recently some time doing not only the quality and data informatics, but also really focusing on patient-centered medical home and helping practices

achieve a better place of something that's really transformed for medical home. And I'll pass over to Lisa.

Lisa Perry:

Hi, this is Lisa Perry from CHCANYS. I'm the senior VP for quality and technology initiatives at the New York State Primary Care Association. I've been here for 10 years. Prior to that, spent a good 20 years in other healthcare environments in New York State. And here at CHCANYS, I am responsible for the programs that promote performance improvement and clinical quality improvement. We brought live our data warehouse and reporting solution seven years ago. So it's been an interesting journey and our focus is on education, practice facilitation, and training, leveraging our data to improve performance.

Heather Budd:

Thank you so much Lisa. All right, so I think we'll transition here to the volume to value portion, and I'm going to give the ball to LuAnn so she can advance the slides.

LuAnn Kimker:

Thanks, Heather. So I'm just going to talk for a few minutes about the shift from volume to value. And over my time in healthcare, and I'm sure for many of you, we've seen a lot of transitions in what we're being expected to do, what your practices are being expected to do, and how they're expected to perform. And this really started when we started to think about things... at putting the patient at the center and not just all the things around it. And as you would expect, moving with that, that changes things. We're not just counting widgets anymore. We shouldn't necessarily be having conversations with our providers that are about, how do you increase your volume? Productivity still may be important, but I think in a very different way.

LuAnn Kimker:

And what we're looking for now is that we're looking for productivity from the entire care team. And we're moving from this crazy mode...and patients that are standing in front of us to looking at the larger population and being held accountable for the health and outcomes of that population versus just individual patients, which was very reactive and didn't often give us the outcomes that were desired. And I came across this graphic that was a part of a health catalyst article that was by Gary Kaplan and it was entitled Time to Sync the Two Canoe Argument. And if you look at this graphic, what you see on the left side is a real focus on performance. And we're trying to move away from where people were doing fee-for-service and move over to the right-hand side, the second curve as they're calling it, where it's really about value payment and the continuity of care that's required to do that, making sure that we've got the right IT systems in place and that care is not fragmented.

LuAnn Kimker:

And the real point of this is that for a long time we've been hearing people talk about moving to a value-based payment world. But as long as we're straddling both of those canoes, so to speak, and trying to make changes in a world that's still fee-for-service based and where our mindset is fee-for-service based, it's really hard to make that transition. And in that period, you might be expected to see revenue drops. And you're going to see your quality maybe not be as good, and your satisfaction, both your patients and your clients. So the sooner that you can make that transition and start to move over to the other side and get just in one boat, you're going to be a lot more stable.

LuAnn Kimker:

And as you do that, there's a lot that you're going to have to look at. And this is just representative of the ecosystem. So as we've talked about business intelligence and the things in prior webinars and the things that you need to do, a really important part is looking at all the places that you have and get data from, and what you want to do with that, how you actually integrate those things and have tools that help you pull out the information that's necessary for your success. And that's what I want to move to next as we talk about what is the actual payer data that's needed?

LuAnn Kimker:

What we have right now, you'll see two boxes here. On the right-hand side, you've got your EHR data. And these are all your patients at the center. And on the left, you've got the payer rosters, the things that you're receiving monthly from multiple payers, all with their own system, all with their own Excel file or printed document, and all with their own websites that they're asking you to go to and portals to be able to get information about your patients. And what ends up happening is you've got a lot of time spent behind closed doors trying to figure it out and understand which patients are actually yours.

LuAnn Kimker:

So what we want to get to is where you actually push these two together and you can see that the areas that are muted here in-between, in the lighter green inside the bigger box, that's actually showing you the patients that are, what I would call, both unmatched members and matched patients and members. So on the left-hand side in the bars that are sticking out, these are the patients that the health center or that the health plan says are yours, but you've never seen. And all those that are inside the box are those patients that are yours and that the health center says are yours and that have actually been seen and cared for at your center.

LuAnn Kimker:

So what kind of data are we looking at? On the right-hand side, you've got all of your traditional information that you've been getting, the stuff that you get from the patient when they're there with you, problem list, EHR, their prescriptions, lab results. You may have a risk level that's calculated either within or outside of your EHR and put in there. You've got information about social determinants, and you're also probably getting some reports, so your clinical quality results. From a member perspective, though, the amount of data that can enhance what clinical data you have is not just your enrollment, which we mentioned before, but claims data, pharmacy data, a payer risk calculation, claims cost, and then care gap.

LuAnn Kimker:

I'm going to talk about those a little later on in the program. But the care gap's where the payer is telling you what's needed and what information they have about patients and who are not meeting certain preventive and quality measures. So really, being able to pull all of that information so that you end up with not a member and a patient, but a person, and that we can use all of this data together to help tell the story and to help actually provide interventions and care to those individual patients coming in to see you or conduct that outreach that's necessary to reach those patients.

LuAnn Kimker:

So what this ends up with is that when we're able to get all of that data, you're able to identify those patients who are high-cost, the ones that are your inpatient and ER utilizers, and identify those with care gaps so that eventually what you're able to do is reconcile what the payer identifies as a gap, what you've identified as a gap, and reconcile it so that you can actually close care gaps with your EHR data and be able to have less, or I should say more efficient conversations and interactions with the health plan and the data that you actually have on those patients.

LuAnn Kimker:

And I can't emphasize enough as you're getting all of this data, the importance of attribution. And while that seems like something you already have, waiting through it is complicated. But this little graph is designed to show you that if you start with attribution, which is the easiest piece of information for you to get from your health plans, having that is what's going to drive your quality and your risk and your cost and your ability to control that. Because without attribution to start, your quality drops and you're more at risk and have higher cost patients. But once you identify those patients, then you can actually start to act on it and get those patients into your health center. And I'm going to hand it back over to Heather.

Heather Budd:

Okay, great. So I'm actually going to ask for some help from April on this. We put together a little poll. And I think the first question we want to ask you all to comment on is how many of you are currently getting payer data? April, any instructions you want to give to participants about how to do-

April Lewis:

Nope, I'm going to open it up and you will have one minute to answer. So the poll is open now.

Heather Budd:

Okay, great. So the reason we're asking these series of questions is we just really want to get a handle on how many of you are actually getting some form of this right now. And I want to clarify, payer data could be as simple as the roster or attribution data that LuAnn was just talking about. We're going to get into the specifics of exactly what you're getting in the next question. So any form of it is really what we're asking about for question number one.

April Lewis:

All right. And we have about 25 seconds left for those who have not answered. Yes, they're slowly trickling in. All righty, and that's time. Perfect. So the response was, Heather, we have 41 people on the call, 41% that say yes, 10% say no. We have 10% that also is not sure and 39% did not answer.

Heather Budd:

Okay, great. No problem. So for question number two, I'm sure April's about to queue it up. We're interested in getting a sense from those of you who said, "Yes, we are receiving some form of payer data." Is it on paper still? So A or B are going to be your paper answers, and specifically, paper with just enrollment or roster data only, or paper with enrollment and claims data, which is probably less common, but we'll see what you guys have to say. And then the second set of answers are electronics. So maybe your payer or your health plan has asked you to log into a portal, and they're giving you just enrollment roster data, that way, or maybe they're having you login to a portal or sending something to

you electronically, encrypted I'm sure. And it's enrollment roster and some form of claims data. So we're curious to see that, yeah. And if you want to answer this and you are not receiving payer data at all, then you'll just choose option E.

April Lewis:

All right, we have about 30 seconds left for those that need to respond.

Heather Budd:

Great.

April Lewis:

Okay, I think that is everyone.

Heather Budd:

Okay, great.

April Lewis:

Oh, wait, hold on. It won't let me.

Heather Budd:

Okay, so looks like from the bar graph, yeah, we're seeing about 8% of you are just getting paper enrollment data. Nobody's getting option B. So no one's getting paper enrollment and claims data, which is what I expected. And then we've got about 18% of you getting electronic portal enrollment roster only, and then another 20% are getting some form of enrollment electronically as well as some claims data, and then another 18% said not applicable. And of course, we had about 38% of you not answering because that corresponds to those that are not getting data. So that's interesting. So actually, our highest percentage is getting some form of electronic and claims data.

Heather Budd:

The last question we have for you is of those of you who are actually getting electronic data, how many of you are incorporating this into your EHR clinical business intelligence strategy now? So even if it's only enrollment data, how many of you are actually doing something with this, integrating it into the existing business intelligence, whether it's a reporting warehouse, data mart, some other clinical population health strategy tool? How many of you are actually integrating it and using it with that now?

April Lewis:

Okay, and I shortened the time on that one.

Heather Budd:

Yeah, great. Thank you.

April Lewis:

Let's wait on some participants to respond. About 10 seconds left.

Heather Budd:

Okay.

April Lewis:

Okay, perfect.

Heather Budd:

All right, let's see what we got.

April Lewis:

For those that are getting into that data, it's about 8%. For those who are not, 21%, 5% does not know, and 67% did not provide an answer, but they probably aren't getting the electronic data.

Heather Budd:

Right, exactly. Okay, so a small percentage who are actually starting to incorporate this into your business intelligence strategy, which is really encouraging to me because that is the direction that we are all hoping to go, and that's really why we're passionate about talking to you about the subject today. So I think without further ado, let's switch back to the main part of the presentation, and we are really excited to share with you our live interview with Lisa Perry, who already introduced herself, so she needs no further introduction. But really, our opportunity here is to hear about the journey that Lisa and her Primary Care Association went through in getting data for its members.

Heather Budd:

And just before we actually start to speak here, I just want to make sure that everybody understands that we know that there are Health Center Controlled Networks out there, or even just networks who are not necessarily affiliated with a PCA. And I'm hoping that you will all hear the same information as an equal opportunity to convene your members around getting access to health plan or payer data. This is not limited to just PCA. So even though Lisa represents that particular kind of organization, I'm hoping that you could see how this applies to all of you. So we'll be really working to address both the level of the health center and what it can get out of this as well as the Primary Care Association or network. Okay. So, Lisa, let's start with this first question. What were CHCANYS' or the Primary Care Associations goals in getting access to health plan data for the FQHCs?

Lisa Perry:

Sure. So, first, we'd just like to say that we are also an HCCN. And so we do this for our entire PCA network. But most of our HCCN members are also on our data warehouse platform, and we do this for them as well.

Heather Budd:

Great point.

Lisa Perry:

We've been a managed care state for quite a while in New York. So we knew seven, eight years ago that we wanted to be in a position to provide data and analytics to support our members, contract

negotiations, their contract management, population reconciliation to health plan rosters as well as to support analysis of costs and utilization and risk stratification. So we knew that it was very important for them to be able to do analytics with their EHR data, but we knew that that was not going to be enough. They needed to understand what their patients were doing outside their walls, they needed to see themselves as their health plans saw them.

Lisa Perry:

So we set out to achieve economies of scale for our members by building one connection each to as many plans as we could persuade to work with us on behalf of our centers, and then to incorporate this plan data into the data warehouse and analytics solution that we use, which is the drive data warehouse, but in New York State, we call it the Center for Primary Care Informatics or the CPCI. So you might hear me refer to it that way. So those were our goals, and our first step was to make sure we understood who the Medicaid managed care plans were with the most significant market share in New York State, and to work with our health centers to get introductions and possibly leverage with those plans. I would have to say that at the beginning of this effort, CHCANYS had no relationships with the plans. So we were really starting from scratch.

Heather Budd:

Right, okay. And what were the key moments that really happened over the course of your journey with really the first payer that you approached, given that you were starting out with no relationships, knowing that this was really important for your membership and your mission as a whole?

Lisa Perry:

Sure. Well, we were very encouraged that one of our nonprofit plans that has a pretty good market share in the New York City area was excited to work with us and we were very optimistic about that. We have members who are on the board of that plan, and we have members who were very interested in getting that data and worked with us in opening the door to that payer. But this particular journey was unusually difficult because we worked with three different CEOs over the course of two years. Unfortunately, there was huge leadership turnover at this plan. But I would say that the typical steps are the ones we followed with this plan to make contact, to educate the plan about why we're asking them to partner with us in this way, to come to an agreement about what we're going to share because there were some plans who would like us to share data back, but that's another story.

Lisa Perry:

And then once we come to that agreement, one of the most time-consuming steps of this process is when it gets turned over to legal. And the design and execution of contracts governing data use and protection is unbelievably varied and complex across the payers. And I'll talk a little more about that later. The technical work follows once those agreements are executed and is often the easiest part of the whole process. And then finally, we get to reap the fruit of all of our efforts and share payer data in meaningful formats with our health centers. So in this particular case, it did take two years, which is astonishing. I did at one point have to create a timeline to show the payer, "Yes, it has really taken this long, and here are all the points at which we've had to stop and start again." But you have to be patient and persistent to keep the momentum going.

Heather Budd:

Yeah, great point. So I'm curious what staff you typically met with at these various health plans, payers, and then how did they respond to your request?

Lisa Perry:

Sure. Well, it usually starts with the senior management, often with the CEO or other members of their C-suite, the CMO, the CIO, the COO. And most of them have already begun investing in their own portals and their own analytics. And so we heard over and over again, "We're already doing this for our health centers." And they would talk to us about the portals they've built to view data, or the hard copy reports they're sharing, and how they've invested in tools to benefit their health center members. And that's usually where it starts. Of course, later in the process, we begin to work with other staff as we actually begin to operationalize it.

Heather Budd:

Right, so of course then the question is how did you actually persuade them? How did you get them to operationalize it?

Lisa Perry:

Well, this is where the patients and persistence comes in. But we had to really explain that for resource-constrained healthcare providers who may have as many as five or six different health plans covering their patients, their Medicaid patients, that adoption of these multiple different tools, no matter how good they are, is a rather large challenge and a burden. And we basically tried to convince them that, "Let's make it easier for the health centers, let's bring them your data on a platform they're already using. They've already got staff that's adopted this platform. Let's put it in a place where they can view all their payers together. They will be more likely to be able to use the data." In any negotiation, there has to be value to both parties. And some of the plans got this immediately, that what's good for the health center is good for them. We all want to improve care and outcomes, we all want to lower costs. But for some plans, we had to be very explicit and make this clear that this is really going to benefit both parties.

Heather Budd:

Right, makes total sense. So, of course, there are going to be things that come up in these meetings that you weren't expecting. So I'm wondering if you'd share what surprised you in these meetings with payers and health plans.

Lisa Perry:

Sure. Well, probably shouldn't have been surprised. But because a lot of folks have no idea what a PCA is and how we relate to our members and how we relate to our vendors and technology partners, but there was a lot of misunderstanding about what the PCA could and could not do to change the way the data warehouse operated, to change the way the technology kept the data secure. And so we found that it was quite important upfront to explain the nature of these relationships and to explain what the PCA is accountable for, what the members are accountable for, and what the technology vendor is accountable for. We recently actually rewrote an agreement with that very first health plan that I just talked about, and we had to explain that all over again. And it could be because of turnover, but it was quite an eye opener that we had to explain our relationship to the health centers and the vendor again.

Heather Budd:

Right, right. So it's like there's really no institutional memory for the understanding of these different entities. And what I'm dramatically hearing from you, Lisa, is that it almost makes sense to come prepared with some clarifying documents that say, "Look, this is what these entities are that are coming to the table and how they relate to one another, maybe some diagrams." And the other one that I heard you talk about is just articulating the timeline so that people understood in that first payer example, given that they had three different CEOs, and probably other turnover underneath the C-level, that you really did have to show them, "This is a conversation that's been going on for X number of years, and here are all the points," just to help them understand the journey you've been on and to keep things moving. So I think those are key takeaways for listeners to the session.

Lisa Perry:

Yeah, I think that's absolutely right. I would love to have the time and the funding to do a little toolkit about this to share with everyone. And I think the idea of doing some diagrams or some explanations of PCA vendor, health center, what all those relationships are would be very helpful.

Heather Budd:

Right, and even some basics around some of the legal components because you mentioned how inconsistent they are, and of course, there's quite a bit of worry about the security, which is inappropriate way, and just giving some basics about what that should look like at the minimum might be helpful as well in terms of thinking about that toolkit that we're dreaming about.

Lisa Perry:

Yes, yes. So that takes us into other surprises. Basically, I felt that we were asking the health plans to do something that they had not been asked to do before. And so change is hard. People have to be convinced of the importance of it. They were dedicating resources to create electronic extracts for us. But it was something they had never been asked to do before. And I think it was fascinating how there was a complete lack of consensus across the plans on the legal documentation that was required, the security reviews that were required. The process was different at every single plan. And so that would for sure be part of the toolkit, like sample agreements that we executed with various plans with their names redacted.

Heather Budd:

Of course, yeah.

Lisa Perry:

The other surprise is that they don't all give you the same data. It got so complex. We actually have a chart, who is giving us cost data? Who's giving us utilization data? Who's giving us enrollment data? Who's giving us prescription data? Who's giving us care gap data, risk data? I will say this again at the end, but you take what you can get and work with it. Obviously, we prefer to have the same data from everyone. The average amount of time with our first four payers, given all of this complexity, was a little over two years. And the barriers varied, as I said, legal, leadership engagement, technical engagement staff turnover. The technical work was the "easy part." And then on the positive side, there were some surprises in the plans once they got the value of this, actually collaborating with us to do things that went beyond data sharing, actually helping us build new reports and tools, or helping us to promote adoption in their regular meetings with FQHCs.

Heather Budd:

Right. So we've already talked a little bit about some of the advice that you'd give your peers, but I think just recapping some of that and adding to it would be great to hear as well.

Lisa Perry:

Sure. Well, clearly, don't give up, and there will be barriers as I mentioned. And I think along with that, the corollary to that is take what you can get. Sometimes you're going to have to make noise. We had one health plan where they'd said, "Yes, we want to do this," but it just dragged on and on and on. And we finally blew the whistle and had one of our FQHC CEOs contact the plan CEO. And this put a little strain on our relationships with the team we were working with. But we got over it and the project got back on track. So sometimes you have to make a little noise.

Lisa Perry:

There may be other ways to get the data, and I'll talk about one example of that later, unexpected way to get the data. And then finally, really enjoy successes. It really is worth the effort when we see health centers, when we see the staff's eyes light up and they see that in 10 minutes, they can understand their enrollment in ways that used to take them days and be very labor intensive, or by looking at a registry, they can see patients with multiple hospitalizations, or they can identify their high-cost patients or their high-risk patients, just seeing people realize the power of the data makes it all worthwhile.

Heather Budd:

The other thing that I would add to this, Lisa, that I've seen you do so well is really amazing public praise for some of your health plan partners who've really gone the distance, and in some cases, gone beyond that, just data sharing and really turned into true collaborators with you. And I think anyone loves to be recognized, and it's just such a nice add to your partnership. And it also encourages other potential partners to want to join you. So I think that's another thing that I've seen you do with quite success.

Lisa Perry:

Yeah, and I'll talk a little bit about that later. We've integrated six payers. I just wanted to mention, and we have two in process. We have a lot of payers in Medicaid managed care payers in New York State, and many of them are regional. So we really have to put out our feelers all over the place. So we hope to have eight or nine within the next year. We have had a few just say no. And often after many months of conversation and meetings, it's very, very frustrating. We had three like that. And then we had one plan that said they were not interested. But later, we learned that members with value-based contracts with this payer were receiving data files, and we have been able to integrate those, or I should say Azara has been able to. And that's an example of a surprise where you may be able to access electronic data in other ways.

Heather Budd:

Right. So as part of that value-based engagement, they were supplying the data that you were essentially asking for so that it made it easier to go back and say, "Hey, let's do this electronically rather than in this more archaic way we've been doing it."

Lisa Perry:

Yes.

Heather Budd:

Great. Okay, so I'm sure many of you are wondering how did CHCANYS fund this project, and there's a number of different things that Lisa and her team did. So I want to ask her to share those things with you here.

Lisa Perry:

Sure. So we really didn't know what this was going to cost at the beginning. But we knew we had to do it. And so we went and began to look for money, and we were fortunate to find a family foundation that was forward-thinking enough to be interested in this and understand the value of it. And they have helped us, as it says here, with the integration of four of the plans, as well as three regional health information exchanges over a five-year period. Two of the integrations were funded by the FQHCs themselves, which was really remarkable, I think, that they saw the value and wanted to invest, really applaud them for that.

Lisa Perry:

And once an integration is created for plans data, it's reusable for every health center. So there's true economies of scale here. I would say also that we probably could have used some HCC on funding for this payer integration, we didn't. But we were able to use some funding from... We're part of the TCPI, Transforming Clinical Practice Initiative grant through CMS. And this is very compatible with the goals of the TCPI program, and we were able to use some funding from that grant.

Heather Budd:

That makes sense. So then the next layer of this is really once you're fortunate enough to get through all of those different barriers, all the frustrations and finally the technical integration piece of it, how do you actually get your members to use the data in a meaningful way?

Lisa Perry:

So as with any new technical functionality, adoption and use is an ongoing project. It never ends in part because there are many different levels, many ways of using the data. So people are going to adopt gradually. And we have the perpetual issue of turnover among our users. So people need to be brought on board and retrain. So it's an ongoing project. We have a wonderful team here at CHCANYS of practice coaches and other staff. And we have an help IT director, who really take on a lot of this adoption and use work in their site visits and in their conversations and meetings with health center leadership. So education of the health centers is critical to let them know what we have and how it can be used. We have collaborated with Azara on developing training, both remotely and in user groups at our annual conference. As I said, our coaches are doing individual health center visits, I'm doing individual health center visits. And whatever it takes, we will do.

Heather Budd:

Well, the other thing I would add to your list here is that I know you've got several health centers who've really modeled what it looks like to have engagement really from the beginning, all the way from the C-suite down to the folks who are doing the work with patients, right?

Lisa Perry:

Yes.

Heather Budd:

So health center who had a pretty visionary CFO and CEO and COO, who then said, "This is something we really want to do and helped even drive the process with you, with the payer, and then have really engaged their staff at the mid levels as well as, again, those that are seeing patients and doing the work on a daily basis to really make a difference with this data."

Lisa Perry:

It's very true.

Heather Budd:

Having that model-

Lisa Perry:

Yeah, we do showcase them when we can.

Heather Budd:

Exactly.

Lisa Perry:

Absolutely.

Heather Budd:

Yeah, exactly. Yeah, a lot of good things have come out of this. So I'm curious, what's next for you with using this payer data? How are you seeing this philosophically and where are you headed?

Lisa Perry:

Well, I think as our health centers in New York State, we have a value-based payment roadmap that really requires that providers in the Medicaid program enter in two different levels of value-based payment, whether it's upside risk, which is the first level, or upside/downside risk. So the need for the sharing of payer data is going to become more intense over time. And we need the payers to share more data, more details. We aren't getting the level of detail that we ultimately would like to have, and the members have begun to ask us to advocate for access to greater detail in the planned data. So I definitely see this in our future.

Lisa Perry:

Azara has already begun integrating line item claims detail when they have it or utilization detail when they have it. So that is going to be part of our push in the next couple of years. And then the other push is really on the adoption side because we don't have everything that we want. But there is no health center that is making exhaustive use of all the tools yet. So there are still many gains to be had by promoting greater adoption of the things we have.

Heather Budd:

Great. And I'm curious if you want to just share with us some examples of how you hope to operationalize the data further.

Lisa Perry:

Sure. Well, this is my opportunity to showcase the report that the one health plan helped us create. There was a lot of interest from both the plan and the centers in enhancing the tools and developing a care gap report, because the plans have historically been all about care gaps and how do we fill those gaps to improve our HEDIS measures and improve our premium dollars and be able to offer incentives to our providers. So one of our plans, HealthFirst, funded the development of a report that helps health centers identify true care gaps versus gaps that are really just data gaps. And I'll get into that in my last slide.

Lisa Perry:

So this is the care gap report. It's very colorful. It's a great new tool. For giving quality measure. Here, we're looking at colorectal cancer screening. It first identifies the matched versus the unmatched members. The matched being those we know about because they're in our EHR, and the unmatched being those we've never seen. It groups the matched members into those who've had a visit in the past year and those who've not, which is useful for outreach and follow up because all of these numbers are controlled down into all these numbers to get patient level detail. But I think the most interesting and unusual part of this tool is that it identifies patients where there's agreement between the plan and the health center. Either the patient does have a gap, or doesn't have a gap, and those are the red and the green boxes.

Lisa Perry:

So, for instance, for the matched members who had a visit in the past year, we agree with the plan on over 2,000 of them that they either do or don't have gaps. But it's the one in the orange boxes that are interesting because those are the patients where we don't have agreement. For instance, the plan thinks the gap is closed, but the health center does not, or the health center thinks the gap is closed, but the plan does not. This offers a great opportunity to actually close gaps by exchanging documentation with the plan. And it doesn't involve bringing a patient back in, it involves exchanging documentation. So our next steps on this are to develop a process plan that's sustainable for that exchange of documentation to make that as smooth as possible for both parties.

Heather Budd:

Great. And the other thing I would just want to point out about that particular piece of the exchange is that unlike care gap reconciliation that requires bringing in a patient and convincing them to have an appointment or perhaps get a service that they need, the exchange of documentations doesn't require someone who's clinically trained. So this is a much more administrative function. It's still a shift in the way the health center operates, but it's a different kind of staff person than you might be thinking would be required for care gap reconciliation.

Lisa Perry:

Yeah, absolutely. And if you think about it, closing those gaps, it's good for the health centers in terms of their UDS quality awards. So if they can document that a service was provided elsewhere, then they can count that gap as closed. And similarly, providing documentation to the plan will be hopefully revenue generating for the health center in terms of improving performance on the HEDIS measures.

Heather Budd:

Exactly. So I'm going to turn things over to LuAnn to talk for a few minutes about just some reports that show payer data in action. So I'll let her speak from here.

LuAnn Kimker:

Great. Thanks, Heather. And I think the one that Lisa just reviewed can be a really powerful tool. And I'm going to step it back a little bit from there in terms of understanding getting a handle on the data that you are getting and how it interacts with your EHR data. So this first slide here is one example of how you can understand your population better. And I think the nice part about this is that this can be readily available to a lot of different folks on your team. So one of the first things that you're noticing here is that you've got the total members who are eligible during the period, you're also able to see right below that those members that are unmatched. And you'll see a couple of different views here.

LuAnn Kimker:

But primarily, the other things that you can see on this slide are you can see a distribution of your members, and by age range, which are matched, the percent of matched members to patients. I always like to highlight this is demonstration type data, so not real. But I like to think about you can use this in terms of what are your age groups that you might want to try different outreach initiatives with, that teen population that's getting into the early 20s and 30s, where they may not be coming in as frequently as others who are older or who are younger in the pediatric range.

LuAnn Kimker:

I can also see that I get data from three different plans, and so I've got that information here. And then I can see it by encounter information. And the interesting piece about encounter information is this lets me see that I've got roughly 500 patients here, 2% of the matched members who are in my system, but really haven't been seen at all. They were probably just registered at some point. And I can also identify how are we doing on those that are matched. So on the opposite end, I've got 2% of the patients who haven't been seen in over two years. So if I've got somebody doing outreach, I can really focus on where I want to put my efforts.

LuAnn Kimker:

This is a similar slide and view of that data. This is focusing a little bit on cost. So now, I can also see my matched members and what cost category they're falling into, whether it's in the 50 to 100K, or whether it's in a very small area like 5 to 10. And then I can also see what is my matched member trend line look like? Is it staying pretty stable or is it going up and down? This dashboard actually shows you a little bit more information about cost. And you can see you've got your per member per month average cost assigned to the member per month. You can trend whether that per member per month is going up or down. You can see your membership growth. And you can also down in the bottom right here, you're able to look at the performance measures for a particular... You could do this for a particular plan, or for all your plans, and get a sense of how you're performing on those measures, whether you're in in target or not in target.

LuAnn Kimker:

One of the great pieces of information that we've seen people use also is around ER utilization rate. So you're able to see how many ER visits you have for the number of members that you have. And if I were to drill down into this measure a little bit further, I would be able to see who those patients were and where their visit occurred and the primary diagnoses. So even though I may be getting this a little later

than I might get HIE or ADT data, it's still valuable in terms of helping me understand who are the people with multiple visits to the ER. And this slide just represents a little bit of that quality measure performance as compared from member measure to a patient measure.

LuAnn Kimker:

And so usually, what you will see in this case is that you're performing better on a patient-based measure. In this case, for your well visits, three to six years old, you've got a 61% performance rate. And for your member-based, you're at 68%. Now, as I said, normally, you would see that reversed where your patient-based spent measure was doing better than your member-based because it has a lot more people in the denominator. But it's a hard mix to understand completely depending on what kind of data you're actually capturing and how many of your patients have been in recently.

LuAnn Kimker:

And then I think this is the last one that I want to show you here, which is really around that distribution around average cost per member per month. And interesting here is that when you're working with your care managers or your managed care team, you're able to identify the cost groups that have the highest total cost incurred, and then the average cost per member per month. So you would easily be able to target those patients in the detail that have really high pharmaceutical or behavioral health costs and think about the different interventions and approaches that you might want to deploy to address those populations. And I'm going to hand it back for lessons learned and questions and answers.

Heather Budd:

Thanks, LuAnn. Do you want to just advance the slides? Oh, you've already given me. Great. Thank you. All right. So we do want to leave a few minutes for questions. So I'm going to not spend a ton of time on this. But we really wanted to conclude with is there are some new staff members that are needed to make payer integration work. And really, from a PCA or a network staff perspective, as you've heard, and of course, you could do this as a CHC as well if you want to go directly to a payer to cultivate the relationship and do all the things that we're talking about a PCA and a network doing. But if you happen to be a PCA or a network, of course, your role is really convening those CHC members with the goal of getting greater leverage and truly developing and maintaining that relationship with payers that you heard Lisa speak so eloquently about.

Heather Budd:

And then also she mentioned the incredibly important value of a program staff lead. And we talked a lot about what should we call this person because what they're doing is really they're promoting adoption and usage, but their role is really communicating with the C-suite, keeping them engaged, and cultivating continuous understanding of the value of this data and the need to continue pushing their own staff to really use the tools that they have. And then CHCANYS also have a suite of practice coaches as many PCAs do, who are really on working at the ground level with practices and the teams that are actually using the data. And this is really where that continuous validation and engagement and adoption is happening. And you also heard Lisa mentioned that some of the more forward thinking and progressive health plans also really continue to emphasize the importance of adoption as well.

Heather Budd:

At the CHC level, there's also new staff that's required to make some of this work. And so really thinking about staff, and here's where I'm talking about administrative staff who are really helping to manage

enrollment and matching and then doing outreach that's not as clinical in nature. Of course, you could do this however you want to. And health centers have various different ways of doing this as with so many programs. There's a need for care management and care coordination resources to take action on some of the information that you receive and begin to address the needs of the population by priority. So this is where risk comes into play, assessing and prioritizing, considering that you're probably not going to be able to provide this level of service to every single patient.

Heather Budd:

And then also we mentioned earlier that the finance team/managed care team really begins to think about reviewing cost data from claims to improve contract management. This is where as health plans begin to share more data and become more transparent about cost, that you start to get a much more fairer negotiating platform as you think of those upside and and later downside risk contracts you may embark on. We also put together a few steps that just identify what you could actually do to get started today. So regardless of whether you're a PCA, a health center control network, a network, or a CHC, you can begin to identify who your highest priority payers are.

Heather Budd:

If you can, even if you're a health center, you might want to band together with some of your local CHCs that share this payer that you've identified as high priority to get some greater leverage, initiate those conversations, be really clear about what data you need and what are you planning to do with that data. Just like you ask anyone who asks for your data what they're planning on doing with it, you can imagine a payer would be having the same thoughts. Also, make sure you articulate the value that the payer will get out of it, walk before you run, be willing to consider just receiving enrollments before claims data, but also be willing to take more than that if they're willing to give it. And once you get the data, start using it and ideally show value quickly so that the payer stays engaged and is willing to consider giving you more.

Heather Budd:

And in terms of the future vision of BI value, in this particular area, we're hoping to really build a culture of transparency among the CHDs and the payers or health plans. We want this to be a more collaborative process where it's a fair negotiating field. And to really put all that into action, you need tools that incorporate payer data with your EHR data, you need an efficient, sustainable process for using that data, and the right staff members for both the administrative and the clinical tasks. And finally, we're really hoping to achieve significant improvement in the ability to deliver that higher quality of care to patients and address both their medical and nonmedical needs. So I know we're right at time, but I'm wondering, April, if there are any questions that anyone who's listening has for any of our speakers today.

April Lewis:

Yes, thank you, Heather, Lisa, and LuAnn for the great presentation. And to everyone that joined, we are at the official end. So if you need to hop off, I totally understand. And thank you again. And as soon as the webinar closes, you will get a survey. So we do ask that you complete that brief survey so we can be sure to include your feedback as we develop future webinars and training moving forward. The one question we do have in a chat room says, "The data warehouse appears to be high value. How did the Health Center Controlled Network adopt a single platform such as Azara to have members use, or health centers required to purchase a full license?

Heather Budd:

Great. So, Lisa, that sounds like a question for you.

Lisa Perry:

Sure. Can you hear me?

Heather Budd:

Yes.

Lisa Perry:

Okay. Yeah, so that takes a lot of effort. Nobody was required to do anything. It really rested on convincing the health centers that this was a worthwhile investment. We raised a lot of funding to connect anyone who wanted to be connected to the data warehouse. I will say that no health center paid for their own connection. And that's a custom interface. So it's quite a bit of work. So we did have a variety of funding sources over the years than we've connected 52 of our health centers at this point. They do all pay their own annual subscriptions. We do provide some subscriptions subsidy through grants. But we subsidize 25%, they pay 75%. And that is their decision. We license the product and then we sub-license it to the health centers that choose to join. We definitely encourage it because all of our performance improvement work on the clinical side rests on it. But we do not require it.

Heather Budd:

Thank you, Lisa. Anything else, April?

April Lewis:

Nope, that was all. Well, we have another one. We have looked at products that would bring in payer data and aggregate it. But the sticking point has always been who does the work of bringing into the payer data, the software vendor or the CAC? Do you work with your payers and download the data then import?

Heather Budd:

Yes, that was great question.

Lisa Perry:

So I think that's for me too.

Heather Budd:

Go for it.

Lisa Perry:

So, yeah, that is the sticky point. A lot of vendors will say, "We can do this and we can do that and we can do this." And I'm always thinking, "Yeah, but who gets you the data?" And that is the responsibility of the PCA team here at CHCANYS. Nobody does that for us. That's our responsibility, working with the members to access that data. Then how it's ingested technically is a discussion between the plans, technology staff, and Azara's engineers. And we participate in those conversations if we can be helpful.

But those are really the two sides of the task. And generally, I'd say the more difficult side is just getting access to the data.

Heather Budd:

Mm-hmm (affirmative), yeah. And if I can, I just want to add a little bit to that, Lisa. That was a great answer. In terms of the CHC doing any of the technical work, generally speaking, there's really no burden on the CHC other than just being present and sometimes providing a landing place for the data that we will then pull it from. But really, we do most of the heavy lifting and that's a big part of the benefit of having a central data warehouse like what CHCANYS has so that you've got a place where everything can come through, especially using, like Lisa said, the one interface that's built for the plan that can then be reused for all of the subsequent health centers who would like to use it. It makes it much more streamlined. And the whole conversation about security and how it's going to be done becomes much, much smoother and easier as well. Would you agree with that, Lisa?

Lisa Perry:

Yeah. To have a single interface?

Heather Budd:

Yes.

Lisa Perry:

Yeah. And our objective is not to require technical work by the health centers.

Heather Budd:

Right. So hopefully, that answered that question. Anything else you're seeing, April?

April Lewis:

No, let me do one last scroll, but I think that was it. That's it. We have all the questions answered. And for anyone on the call, if anything comes up after the fact, you have my contact information, alewis@nachc.com. And I'll be sure to get it over to the team for part two, and we will be back on on next Tuesday, may the 29th, at one o'clock, where we'll be discussing business intelligence and disruptive technology. So you don't want to miss that one. And you still have time to register. If you have any technical issues, please reach out to me personally. And our often presented contact information is on the screen if you want to jot that down and follow up accordingly. So, Heather, LuAnn... Oh, go ahead, Heather, of course.

Heather Budd:

No, that's okay, April. So these slides will be available on mynachc.com. Is that right, in case folks want to access them later?

April Lewis:

Yes, I'm sorry. So what happens is I put the request in for the recording, and it takes no more than two weeks to get everything synced and uploaded to your MyNACHC accounts. If for whatever reason it's not there, please reach out, let me know. If you don't have access to MyNACHC when you go to nachc.org in the top-right corner, and go to the login tab, you'll be able to create an account there.

Heather Budd:
Okay, great. Well, thank you.

April Lewis:
Thank you.

Heather Budd:
It was a pleasure to be here and I'm especially grateful to Lisa Perry for being here today. We really appreciate it.

April Lewis:
Yes, Lisa-

Lisa Perry:
Thanks.

April Lewis:
... thank you so much, and LuAnn, thank you both. And to everyone that's still on the call, thank you. And we will talk to you on next Tuesday. Have a good day.

Lisa Perry:
Thank you.

Heather Budd:
Right, that's all.

April Lewis:
Bye-bye.

Heather Budd:
Bye-bye.

LuAnn Kimker:
Bye-bye.