The New Data Strategy Behind Population Health Has Nothing To Do With MACRA

With the ***final rule*** issued by CMS for the Medicare Access and CHIP Reauthorization Act, the landmark payment system for Medicare physician fees is officially the new game in town. Physician incentives for care improvement and adoption of value-based care models are firmly in place.

We're on our way to achieving the hallowed Triple Aim of healthcare — healthier populations, higher patient satisfaction, and lower cost. Right? The short answer is, "Well, kinda."

While response to the new MACRA rule has been largely ***positive***, truly moving to a value-based care system involves more than reduced bureaucratic red tape. It's about better data as becoming a data-driven organization is essential for improving care while still meeting revenue targets.

But what does data-driven healthcare look like? For starters, it's not just a fancy EMR. The ability to pull custom reports, data visualizations, and data sharing are just a few of the approaches needed to transform data into improved health. One Federally Qualified Health Center (FQHC) in Ohio, ***Community Health Centers of Greater Dayton*** (CHGDC), has adopted the data-driven mantra to produce real improvements in patient care.

Establishing A Foundation For Coordination Across The Continuum Of Care

FQHCs are part of the country's healthcare safety net. They provide care regardless of a person's health insurance status or ability to pay. CHCGD's clinical staff of 25 clinicians (doctors, dentists, nurse practitioners) serves 15,000 patients a year at six locations across Dayton.

Like most health organizations, CHCGD migrated to an EHR in the 2012, says Chava Sonnier, the Center's former patient manager and now clinical informatics lead. Soon after her arrival three years ago, Sonnier realized the limits of the EHR's ability to generate the data and reporting needed. The challenges were made even more apparent when the CHCGD decided to pursue certification as a Patient Centered Medical Home (PCMH), a care delivery model where patient treatment is coordinated through a primary care physician. The PCMH ***designation*** signifies the practice has undergone a transformation in quality and safety enhancement and has established a foundation for coordination across the continuum of care.

It quickly became apparent the extra reporting required for PCMH certification was going to be difficult if they just relied on their EMR. “It was challenging to do PHM-level reporting with the EMR,” says Sonnier. “There are limits to what you can get out of it, especially in the area of custom reporting. I was trying to build reports from scratch and had trouble trying to integrate multiple pieces into a single report.” But something else was bugging Sonnier: “I wanted PCMH to mean more to us than just maintaining certification. I wanted to make the data we generated via the PCMH measures to be part of our everyday life. I wanted the staff to know how effective they are being and where we need to make changes.”

The missing piece for true practice transformation was a population health management technology platform, which CHCGD implemented two years ago. FQHCs have been at the forefront of population health management, due in large part to their funding through government grants. That funding carries requirements to report on quality measures — a cornerstone of the journey to value-based care. The fully interoperable PHM packs a triple punch with data aggregation, risk stratification and analytics, and care coordination and management.

“Our PHM spits out information as a dashboard, and the clinical staff has that ‘aha’ moment,” says Sonnier. “While the platform turns out visualizations for the staff, I get details. It’s makes PHM real to the staff, because they realize they can go from reactive to proactive in terms of patient care.”

Improvements Borne Out By Better Use Of Data

Now, two years into PHM integration, CHCGD has racked up significant improvements:

- **Behavioral health integration.** Unlike private practices, FQHCs have the flexibility to access behavioral health services on a real-time basis. The PHM platform eases the addition of behavioral health services into a patient’s EHR to improve care coordination between primary care physician and therapist.

- **Near uniform compliance with smoking status assessment and education.** Smoking assessments were not in the intake template of the EHR. Medical assistants had to go to another template, which led to inconsistent compliance. The fallback was manual chart audits or taking stats by hand — again, not the most reliable form of data capture. With the PHM platform integrated into the EMR, smoking status assessment and education went from 70 percent of the intake population to 90 percent.
- **Colorectal screenings increased from 40 to 65 percent of eligible patients**. CHC received a grant from the American Cancer Society and Walgreens to do colorectal screenings. The baseline for screening had been 40 percent. With the PHM platform, they were able to run a dashboard to visualize how one provider’s screening rate matched up against their colleagues. This provider score card introduced an element of friendly competition to improve screening rates from 40 to 55 percent.
- **Easier compliance with grants**. Grants are a funding mainstay for FQHCs. Prior to the PHM platform, the center’s required grant reporting was ad hoc and time consuming. Today, CHC sets up the grant format once and selects the desired reporting time frame (quarterly, monthly) needed to fulfill the grant requirements.

Extreme Quality Improvement Measures Makeover: Data Edition

Better outcomes are one sign of better quality care. But most healthcare leaders know quality improvement is an ongoing task. At CHCGD, quality improvement got an especially rigorous data review and makeover. All quality metrics were migrated to the PHM platform, making that data easily accessible and quantifiable. “We’re able to set goals, establish a baseline, and set the frequency of reporting,” says Sonnier. “Every provider and every location gets the reporting they want, in the

format they want, and at the interval they need it." The same holds for patient outreach, where each of CHCGD's locations can measure the effectiveness of, for example, mail vs. phone.

MACRA And Medicaid Patients

Better data leads to better outcomes, as the above improvements show. But healthcare doesn't stand still. With the expansion of Medicaid in Ohio, CHC has more insured patients and those insurers need data. CHC's platform disaggregates patients by payer and gives each payer the data points they need building strong relationships between payer and provider and insuring that patients don't slip through the cracks.

According to Sonnier, the CHCGD staff takes the final MACRA rule in stride. "When big changes like MACRA come about, we are now data driven so it's not scary for us. We are prepared to track outcomes, provide the necessary reporting and in general be ready for whatever program changes come down the line."

A Truly Data Driven Organization

As data becomes more ingrained into CHCGD's workflow, clinicians and staff find new ways to harness data to help patients. Report requests are on the rise because data doesn't make them anxious, according to Sonnier. Whether it's changes in regulations, reimbursement and patient mix, or access to grants and alternative funding mechanisms, healthcare organizations that are data-driven have a sophisticated new set of tools they're not afraid to use.