Shifting to Patient-Focused Value Care Creating a Win-Win-Win New Delivery and Incentives Toward Better Health: Analytics-as-a-Service and Personalized Affordable Value Evaluation Support (PAVES)

Healthcare affordability and value have been analyzed either by dividing the pieces of the healthcare cost pie that each viewpoint wants to fight for their share, or examining outcomes, readmissions and overall quality. There is a history of collecting quality outcome data by CMS. All the pieces are measured individually by the Center for Care and Service Quality (CCSQ) and by measures of individual pilot programs by the Center for Medicare and Medicaid Process. A few states, like Rhode Island in 2014 and Colorado, in a 2019 study, have tried to look at all State-healthcare-related costs; many other states have some form of all-payer data bases to gain insight into total costs.

As insurance commissioners, health secretaries, state legislatures and Governors /Lt. Governors are pressured by the community leaders for better value, a multi-tier approach is needed. This must connect the Macro Health Economics level not only to the Community Health Level, but also to the Personal and Practice-based Levels that address the whole person's concerns. In addition, the approach must put responsibility back into the hands of the professional primary-care practitioner. If we want to break out of just analyzing the problems and enter into state and local reform, we need a fresh approach, a new, three-level framework and integrated analytics program.

Macro-Health Economics:

Over the years, there have been many Macro Health studies, from the Dartmouth Health Atlas to those of the CommonWealth Fund, and most recently an ongoing effort by the Rand Corporation. Those and related small-scale studies have not created a solution beyond the Macro Health Economics level.

The May 2019 Rand Study reviewed the rising hospital costs and the great variations between the 25 states, with a focus on employee-based insurance costs, compared with Medicare payments made. This study, as well as others, highlighted that hospital costs are the largest, and continually rising, costs in healthcare. As a result, primary care is suffering. This established "us versus them" conflicts, e.g., the hospital versus the independent provider organizations or against the insurers/payers or the state. The analytics seem to have driven the arguments of each group to fight for "their share".

Analytics should provide some insights to help move toward real change, and new balanced alternatives. What are some of the possible alternatives?

- Moving one piece of the pie to another area without changing the delivery approach;
- Encouraging more mergers and acquisitions by the healthcare systems, where each community territory is staked out;
- Driving out the small providers;
- Focusing on the Key Patient-Primary Care Interface, where Delivery Reform and Patient Engagement on Treatment Adherence and Behavior Change can be made.

This last alternative is where the true interventions can be made. However, Primary Care needs help from empathetic and knowledgeable care coordinators, as specified by the Primary Care 1st CMS initiative. All delivery reform has to start with the basic step of placing the patient-caregivers-family into the center of the delivery models. By engaging the patient and having **all** value related to the delivery of value to the patients, all parties can be part of a win-win-win strategy. That alignment, however, will require an adjustable collaboration by all stakeholders.

Can the data coming from the federal government and the state-based, all-payer claims data be integrated together, not just for Macro-level analysis, but to create a data environment that can be used by the Patient-Provider Intervention?

We must define Middle-Level Community Health Economics. There needs to be a patient-personal health economics level that can allow for a person's health management and take personal responsibility. This will promote the patient to be part of a personal- and family-choice approach with the trusted primary care provider and empathetic care coordinator.

BDC Takes A Patient Viewpoint at All Levels

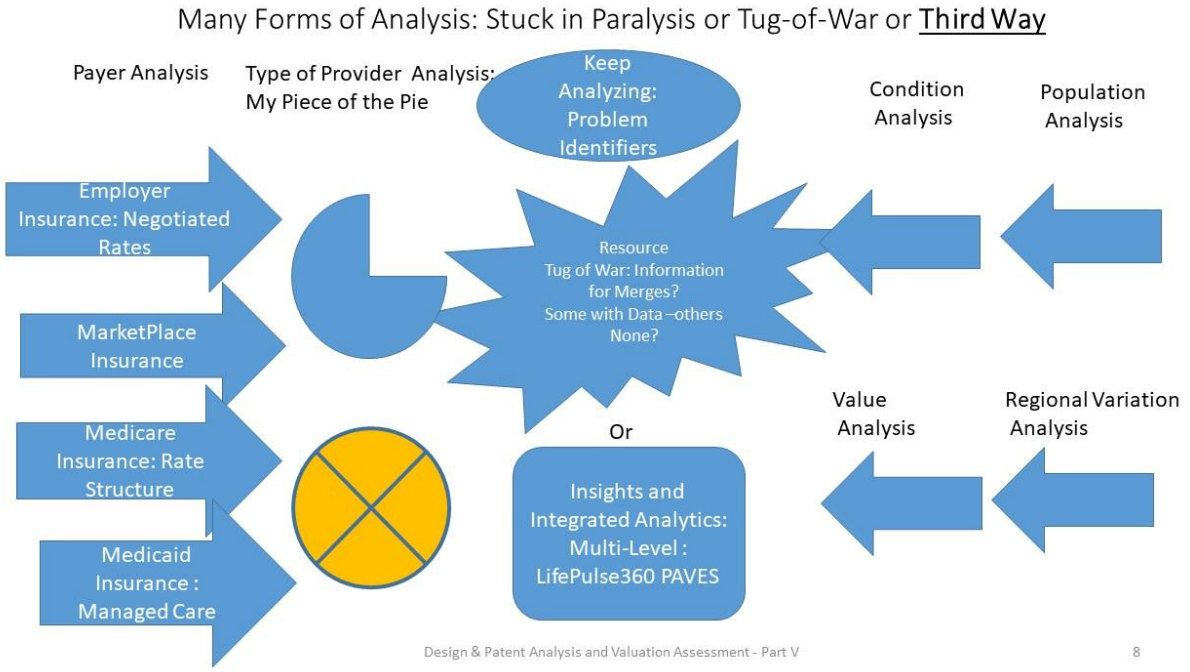
Most Health Economics and Improvement studies seem to want to take advantage of what can only be described as the first, complete, "facility-service"-focused measurements derived from the CMS Quality Metrics program.

As those data are released for further use, there can be many analytics-based studies, and different ways to say healthcare is not consistent, and not nearly as good, as Americans have believed. However, the macro-analysis by Health Economics perspective does not provide the analytics insights needed for delivery change and lacks detail needed for regulatory reform. The multi-levels of analysis must be aligned for consistency at the different levels: between the state, communities and the patient-provider delivery of care levels. This allows the communities to have the focus be on improving the care for high cost conditions. The next step is to fill the void of tools needed by the business analyses of provider practices that takes a patient perspective. Some of the payers have tried to provide a set of data for the practices to use and like CMS, there have been recommended new delivery models that do not provide choices by the provider practices. Today there is an information in-balance with most of the information going to the payer-insurer's hands. This data is often used by payers in their negotiation process. Others such as the big hospitals in their mergers and acquisition assessments also have a data advantage.

There is a way to shift the information power to the small practices by using their personal relationship with the patients that can understand their range of concerns, their conditions, what they value and what they can afford. The primary care practices and the patient can work together, aided with the right tools. They can take back the power with their "own information management and own analytics" with LifePulse360 and the Personalized Affordable Value Evaluation Support (PAVES) component. The primary care providers can get the information they need to manage their business with a patient-centric approach or they can feel like they have no choice but to become part of the profit first health networks. The power of patient relationship and information can provide choices and can drive delivery reform.

Unfortunately, patients and primary care or local specialists do not have the real data tools needed to benefit patients. Analytics are part of an add-on market for major vendors. They focus more on the big services to generate more revenue and are used as a higher profit driver, pushing for more profitable services that are claimed to be high value.

LifePulse360 PAVES addresses these issues and fits with providing meaningful data for quality Macro and Community Level support. LifePulse360 will work its way up to the top with well-grounded analytics that can drive new delivery models and incentive payments.



Turning our attention toward the patients.

Healthcare spending is unsustainable at its current trend; change is needed. All of the existing Health Infrastructure systems are focused on the "stakeholder". These focus on tools with poor patient portal add-ons that don't actually engage the patient. LifePulse360 offers that new approach, which starts with the patient, gathering symptoms from their personal view, combined with gathering EHR data and utilization of community and human services for a holistic view.

One of the key problems in health economics is that the problem is looked at as a "balloon". For instance, according to the Network for Regional Health Improvement: Feb 2018 Report Health Affordability: Untangling the Cost Drivers:

> *"The idea of a healthcare cost balloon is well known and often cited. Squeeze the balloon to save in one part of the system and the balloon will expand elsewhere— leaving you with the same high healthcare costs." ….Affordability requires us to address all sides of the balloon. Despite intensive work by physicians to ensure appropriate utilization of resources, total cost of care may remain high as prices increase to make up for lost revenue."*

There are other fine studies, but they all leave out the patient and caregivers on the search for the solutions. For example, patients and caregivers, and extended family and friends, are very innovative in

caring for the disabled, taking loved ones for treatments, and putting much time and energy into "coping" with often major struggles, from autism, to addiction to aging. The confusing and complex healthcare system **must** address their broader needs in a personalized way. Those gaps are what LifePulse360 is designed to fill.

BDC Measures Value from the Patient Perspective and linked to Primary Care Whole-Conditions Cared for Perspective

Defining a three-level patient perspective that can foster changes at all levels, LifePulse360 is the platform that will provide the basis for bending the cost curve through capturing changes in regulation, care delivery and behavior. Three levels of data capture:

- **New Health Macro Health Level** - focused on rules and regulation of insurance design for a Value-Driven, Patient-Centric Culture: All the individual "facilities" will be linked to "ideal delivery models" for high cost chains of care that all take a patient perspective. The provider data will be aligned, somewhat imperfectly, from "their Niche" of service to a value chain that turns costs and "claims" to the value of the patient"

- **Middle Health Economics Level:** Each state or region will create a Community Health Assessment Model. It can start by turning current studies to the benefit of patients and maturing to a more Proactive Population Health Management approach. This intermediate level needs to provide States with analytics insights that can help them create actions and alignments with partner areas. LifePulse360 is an approach that bridges the rural and urban divide so that health care "service deserts" do not hurt the many citizens in underserved areas. The All-Payer Data Base and selective extraction of CMS data must create a State and Cross Over Zone Middle Health Economics model. Management has to go from the Macro-Level to the Micro-Level, where the new delivery models can be applied to patients and primary care providers as well as their care coordinators, and their related chains of care units.

- **Personal and Primary Care Provider Level**: LifePulse360 creates an environment and provides for feedback loops that enable sustained continuous improvement.

Cost and Price Transparency Must Not only help the Insurance Payers, but the Patients – they must be Personalized

How? - Answer some basic questions first, then establish some goals: Next, follow a Goal-Questions-Metrics-Trends cycle with engagement and feedback at all levels.

Simple New Macro-Level Health Economics:

What types of questions can Analytics at this level answer?

- Rural-Urban Bridging Issues
- Population Characteristics and trends
- Hospital "Areas" of Excellence- Claimed and Measured

- Hospital Catchment Areas where a region funnels the patients into one or a few competing University Driven Hospitals by following the Geographic Patterns and Gap in Treatment
- Questions needed for Medicaid and State Employees
- How is the Health of the State citizenry?
- What can we leverage from other states?
- What are common issues faced by all? and what is unique?
- Hospitals and their "catchment areas" and those areas that are 'crossover zones' where folks naturally cross-boundaries
- Plans for Cross-State Health Collaboration.

Middle Health Economic Level:

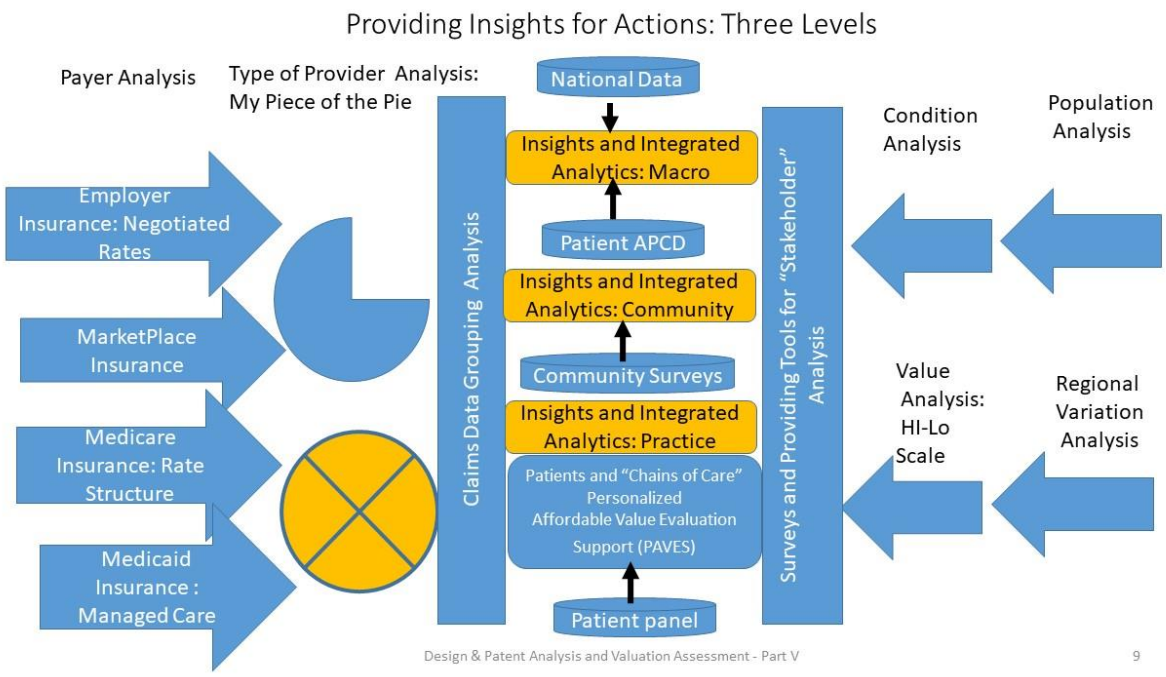
- Individual Hospitals create regular community assessment: types of questions?
- Make questions more community-related: Strengths-Weaknesses-Opportunities and Threats, including new "dangerous drugs"
- Which providers are missing? How large is the gap?
- Where do we go for experts?
- Patterns of Care and "Cross Over Zones"- ……bringing offices across state boundaries
- Medicare and Medicaid numbers
- Leveraging CMS Data

Personal and Primary Care Provider Level

- What is the highest value insurance for me?
- How much do I need to save so I can afford……(my conditions and family conditions)?
- What should I do to improve my immediate health costs and personal economic impact?
- Who should be my personal care provider and social support team? and what chains of care should I be focused on?

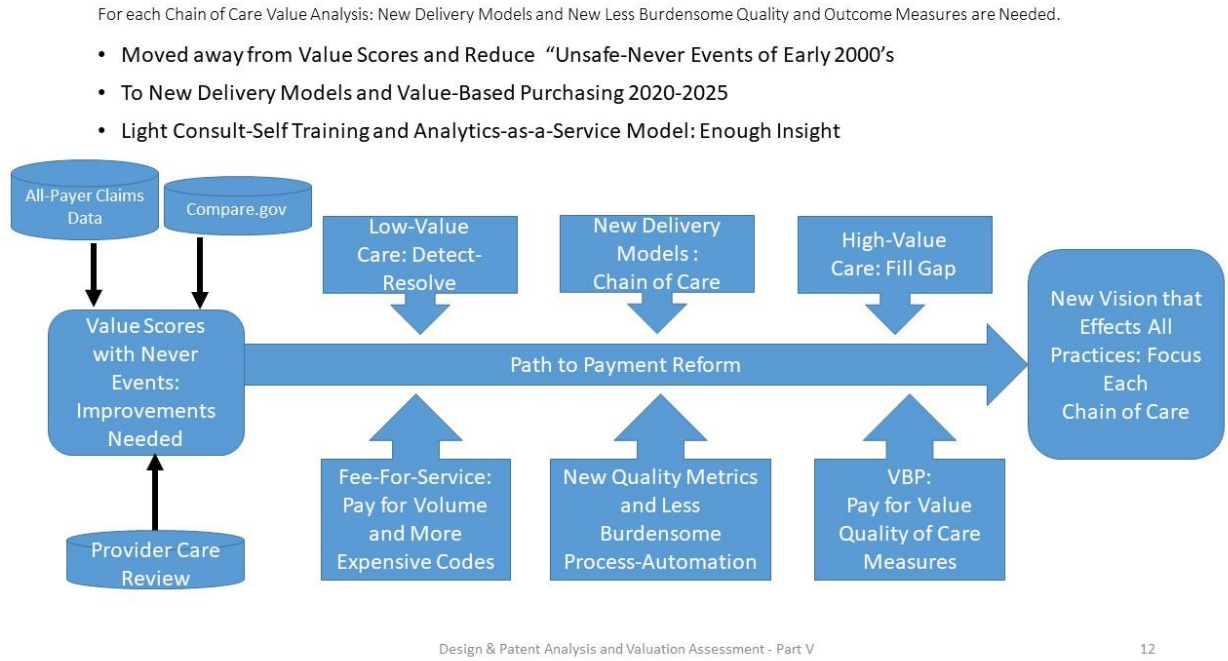
Strategic Approach:

1. Macro-Light level of Insights: Enough to understand the level of variations and opportunities for improvement: Shape a Medicaid Waiver plan
2. Each Community will follow a set of situational review steps and select a community focus area
3. Primary Care Providers will work with high risk-vulnerable- high cost subpopulation that can provide a natural fit for the providers panel and define a "focused" Chain of Care.



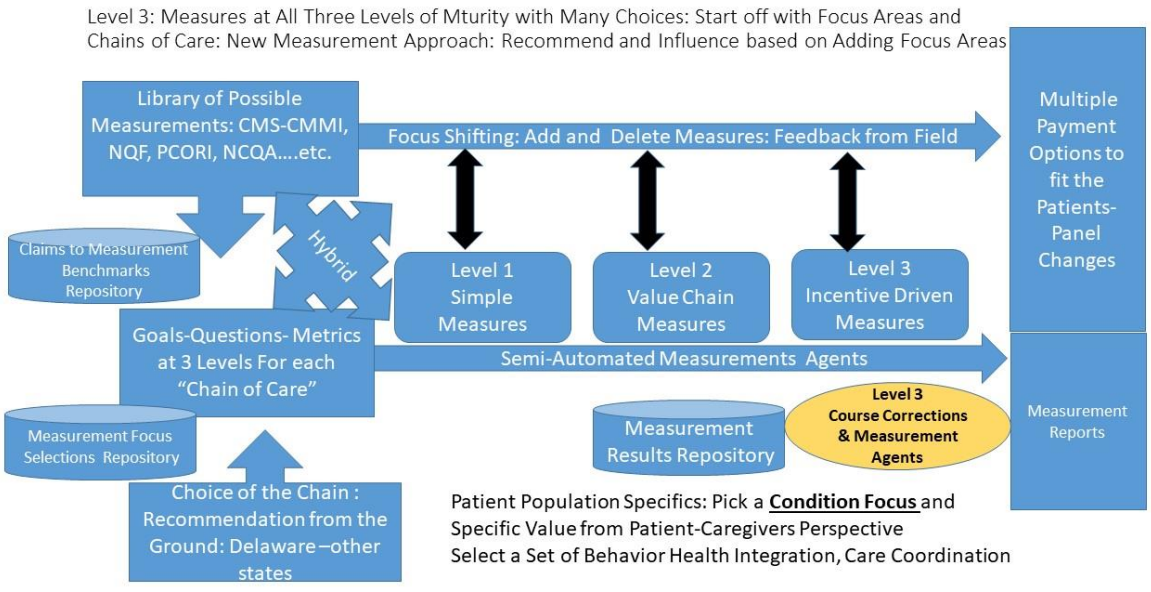
In every consumer market, except healthcare, there are many choices and decisions regarding price, quality, convenience, payment methods, etc. In healthcare, we often feel "stuck". Especially for those living in remote areas. LifePulse360, a personalized care coordination platform, recognizes that affordability and value have to be focused on the patient and adapt to their current projected cost and the path forward. This "new infrastructure" is needed to leap forward to a new win-win-win platform that can be used to project over the next one to three years.

Each population group, from prenatal to the fragile elderly, face critical conditions and traumas that have to be reviewed in a systematic manner from the patient and their caregivers' perspective. A general approach for that type of analysis and the ability for a care coordination, integrated measurement and analytics platform, such as LifePulse360, must support the improvement consulting and include a configuration and adaptation process that does not require extensive programming (as shown below). It must also have the ability to adjust to new threats, such as new synthetic drugs that addict and kill, and new viruses. Building LifePulse360 to support change is critical differentiator.



The initial approach to value was focused on episodes, such as joint replacements; but new delivery models have refined the delivery and payment model. Today, providers are frustrated with the current measurement approaches and a new approach is needed. This is illustrated graphically below., where a set of measures can be chosen versus mandated by CMS. Choice is better, but a choice architecture, such as that shown below, offers providers and the condition-based, chain of care, value-delivery partners can utilize a three-stage measurement approach and include feedback and improvements as the delivery reforms evolve.

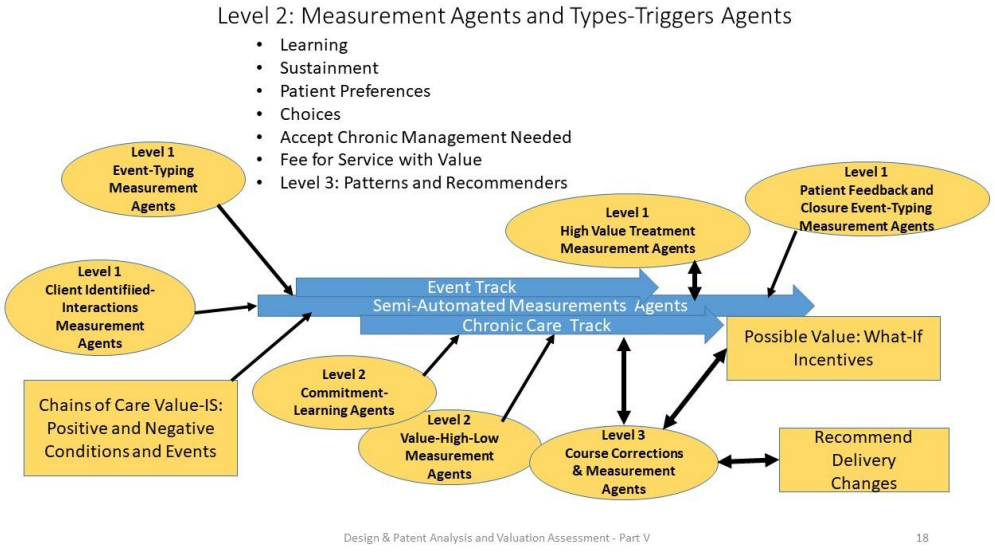
(what is our focus……) Info to be added?



The array of measurements as represented below must be integrated into the delivery process and use patient feedback and outcomes as their key measures. The event driven nature of LifePulse360 will allow the automated collection of health events as shown below and their integration into the improved practice management. The semi-automated measurement and pick-and choose of measures from the array will allow the small practice to have analytics without the heavy consulting costs with their own PAVES configuration approach. The LifePulse360-PAVES capabilities builds-in events and measurement capture with a configuration to their delivery approach, chain of care and the value-based purchasing model that fits their patient panel and their target delivery approach. It is configured to your practice, in your community and with your mix of patients. The patient and providers set up the plan and both are incentivized, first with better care and health, and also to save money without sacrificing quality.

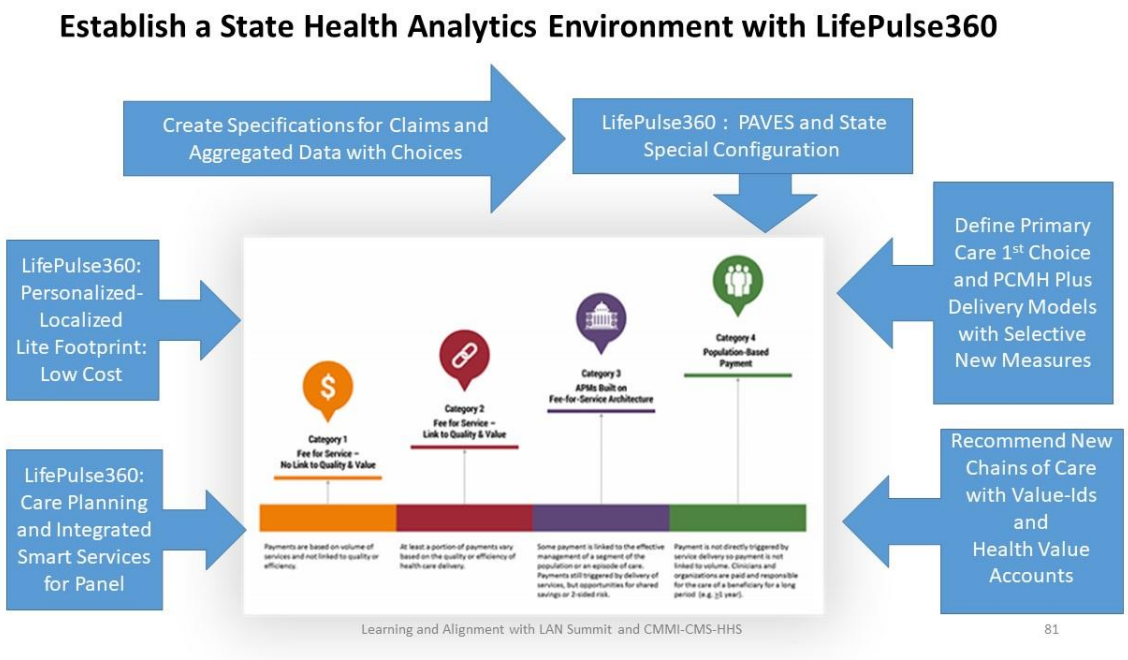
The tools are put into the hands of the Primary Care providers and Coordinators with the engagement and commitment of the patients.

The three levels of measures are shown in the representation below. The personal health events and the connection of a patient to one or more chains of care are automatically collected as LifePulse360 posts and logs events. The automatic collections of health events, appointments, tracking treatments and use of feedback from the patients and providers-care coordinators creates a personal scorecard for Level 1 simple measurements. These measures are from the point of view of the patients and primary care provider and gathering claims and quality reports from state or payers claims data. Level 1 data will be simple measures from LifePulse360 without gathering outside claims data. Level 2 and 3 will get claims data and compare the patients against other practice and similar populations. This will provide a practice benchmark against the value and pricing transparency measures. This will require outside information sources. Those sources must be provided by the state, regional collaborative efforts and the federal levels. The LifePulse360: PAVES capabilities allows measures to be done at the pratice and patient level now and not depend on the slow progress from the topdown data collaboration that is needed. The three phased approach gives the power back to the patient and the provider practices while allowing local collaboration within a specific "chain of care". LifePulse360: PAVES empowers the patients and providers with their own analytics to create their own insights. This can allow the patient centric delivery changes to begin immediately. It allows improved value to be delivered now.



The questions are, who pays for setting up an analytics environment? States have created all-payer data bases and much data can be captured from CMS and Federal sources, but very expensive tools with many highly paid analysts put the small practice at a tremendous disadvantage. The leadership in the state: Governor, Lt. Gov., key state senators and legislators, with the secretary of health, and the insurance commission need to create a "Commission or Board" to include the payers, and leading stakeholders have to come together around improving care to the patients and citizens of the state. For level 2 and 3 access to the CMS Health Care Quality Information System data should continue to follow the Open Federal Data mandate. While current health research groups, such as Rand and JHU, have leveraged the CMS open shared data model, the data alone are not a complete enough solution to drive reform. An Open Analytics environment is needed that can be used for state and community reform. A common State Analytics Reference Architecture can be tailored to the state goals, communities and key focus areas. The Reference Architecture should be configurable to the specific state. It should also allow the local community focused improvement, and individual practices, to use integrated measurements that can align with the HCP-LAN level 2 and 3 measurements. It is recommended that States, as part of a Health Reform Effort, use all payer claims data, along with gathered, open compare data, and create a State Analytics Environment that is shown in the diagram below. The State Analytics Environment can support reform across the many state communities. States should request a Medicaid Analytics waiver and also provide state funding, along with usage fees, for the "health community". This open analytics environment should provide common answers from many viewpoints. The viewpoints would address changes at all levels, reform will involve a combination of the federal changes to Medicare, Medicaid, and Insurance Markets, but the actions will also have to be at the state level. The alignment and connection of these changes can be simulated, projected and the impacts tracked forward as the cost curves are slowed and bent with improved delivery changes. The LifePulse360 PAVES analytic framework can align with the Health Care Payment -Learning Action Network (HCP-LAN) and will support great a leap forward to what they designate as level 3 and 4. Today only the few very profit driven organizations have moved forward with HCP-LAN steps and now efforts by States to create State Health Analytics Environment (as shown below) are a critical step to health delivery reform.

Each state should provide a health analytics environment and work on the many aspects of affordability and value that are at the state level, such as Medicaid, State Employees and their marketplace, and provide an "affordability benchmark and transparency environment" that can move a state, and the regional hospital catchment areas that cross boundaries of states.



Conclusion:

While the high-level, state or region specific macro health economics may tell the story of why health reform is so necessary, it does not help the changes in the delivery models and payment incentives that are needed for local and practice reform. The forced re-dividing of the pie, or all or nothing fights, will not work. A three level analytics approach has to focus on intervention at the personal and primary care point of care and the condition-related chains of care. Any of the three levels can be worked concurrently, and actually the bottom level, the pragmatic approach, can be linked to the personal concerns and be put into a personalized affordable path to better health and improved outcome with the primary care-care coordination engagement, and a focused panel of high-risk patients that are managed more closely. A new delivery approach will touch many who need to work on their overreliance on emergency rooms, failure to take healthy behaviors, and not detecting or taking preventive actions earlier. The form of insurance will not change the behavior of the patients and their health, but their engagement and enablers by LifePulse360 with PAVES can shift the cost curve and make cost transparency and affordability and your plan forward to be visible. Affordable and high value health care will take a shift in delivery and engagement by patients with their primary care provider and care coordinators and other members of their provider and social capabilities team. Healthy Engagement for ALL….requires acceptance and commitment with smart technology support.

LifePulse360 A Personalized Care Coordination Platform
John C. Dodd
President and Lead Consultant
John.Dodd@BDC-healthit.com
410-598-7266 / www.BDC-healthit.com
BDC IT HEALTH Transforming Healthcare