



SIM and ADT Alerts

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June 2015



SIM Round One: Design

- SIM = State Innovation Model
- Eight month design grant awarded February 2013
- Submitted design in December 2013
 - State Healthcare Innovation Plan (SHIP),
 - Five year visionary plan
- 19 required components, including:
 - Vision statement for system transformation
 - Well-defined “AS IS” and “TO BE” for transformed state
 - Barriers and opportunities
 - Population health status, social/economic impacts on health
 - Timeline

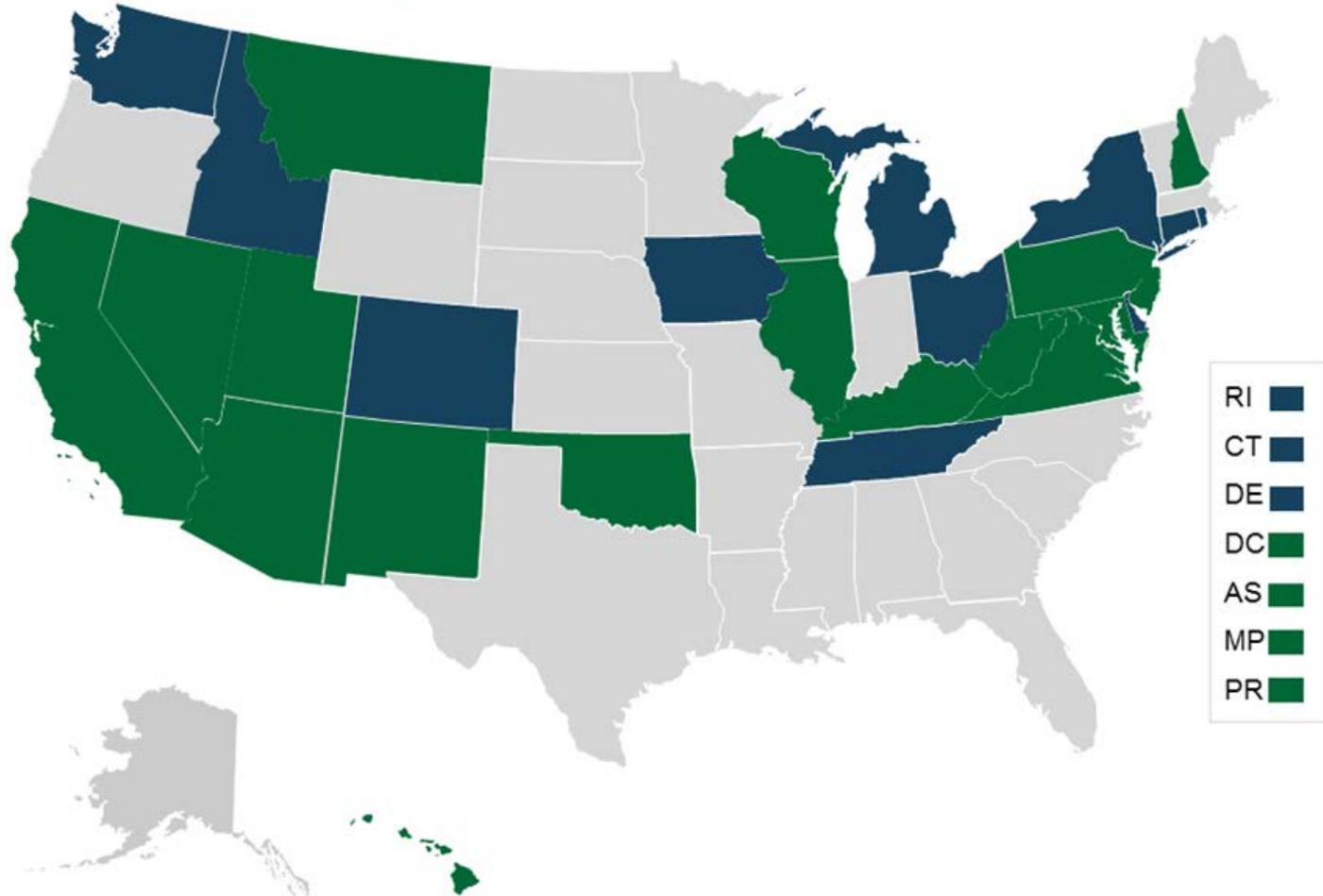
SIM Round Two: Test

- On December 16, 2014 CMS announced
 - 11 Test states (\$620m) **includes Iowa!**
 - 21 Design states (\$43m)
 - Iowa received approval for \$43.1m over 4yrs
 - Funds released 1 year at a time
 - One pre-implementation year & three test years
 - Each year the state requests a non-competing extension to draw down more funds

Round 2 SIM Awards

Model Test Awards

Model Design Awards



Source: Centers for Medicare & Medicaid Services



Model Testing Proposal

Iowa must apply policy and regulatory levers to address three focus areas:

1. Transform health care delivery systems
2. Improve population health
3. Decrease per capita total health care spending

Transform Health Care Delivery

Expand Value-based Payments to Full Medicaid

Expand PCP Assignment

Work with MCOs to promote value arrangements

Incrementally add LTC/BH Services

Care Coordination payments for chronics (aligned with HH)

Align with Other Payers

Use VIS

Develop VIS Star Rating

Include Medicaid HMO/CHIP Plans

Support Delivery System

Develop Community Care Teams

Develop Admission Discharge Transfer (ADT) system

Technical Assistance approach with IDPH

VIS – Value Index Score, PCP – Primary Care Provider, MCO- Managed Care Organization, HH – Health Home, LTC/BH – Long Term Care/Behavioral Health,

HHS Announces Goals in the Shift to Value-Based Payments

HHS Secretary Burwell announces move from Medicare traditional FFS payments to value using ACOs/ Medical Home programs

- 30% by end of 2016
- 50% by 2018
- 85% of payments tied to either quality or value by 2016

HHS has seen \$417million in savings due to existing ACO programs

“We believe these goals can drive transformative changes, help manage and track progress and create accountability for improvements”

How do you support the system during change?

Focus on the community

- Establish learning events, share best practices

Use technology to improve care coordination

- Real-time Admission/Discharge/Transfers data

Integrate Social Supports/Public Health into care delivery

- Develop Community Care Teams

Improve Population Health

Improve Population Health/ Healthiest State Initiatives

Tobacco Use

Diabetes

Obesity/Childhood
Obesity

Hospital Acquired
Infections

Obstetrics
Adverse Events

Engage Patients/Improve Health Literacy

Build from Healthy
Behavior Program

Use HRA to measure
Patient activation

Utilize Public
Partnerships for
education & outreach

Measure Member
Experience

Choosing Wisely
Campaign

Collect Social Determinants of Health

Impact Individual
patient care

Implement
Community SDH
Transformation
grants

Study potential
risk adjustment on
payment model

Decrease Per Capita Health Care Costs

Evaluation and Monitoring

Conduct Rapid
Cycle
Evaluations

Track Total Cost
of Care

Public Reporting
of Results

Achieve Scale within Delivery System

Align and partner
with Public Payers
(CHIP/M-HMO)

Align and partner
with Private
Payers

Track VIS Improvement

Monitor VIS and TCOC
relationship

Identify sub populations needs
improvements

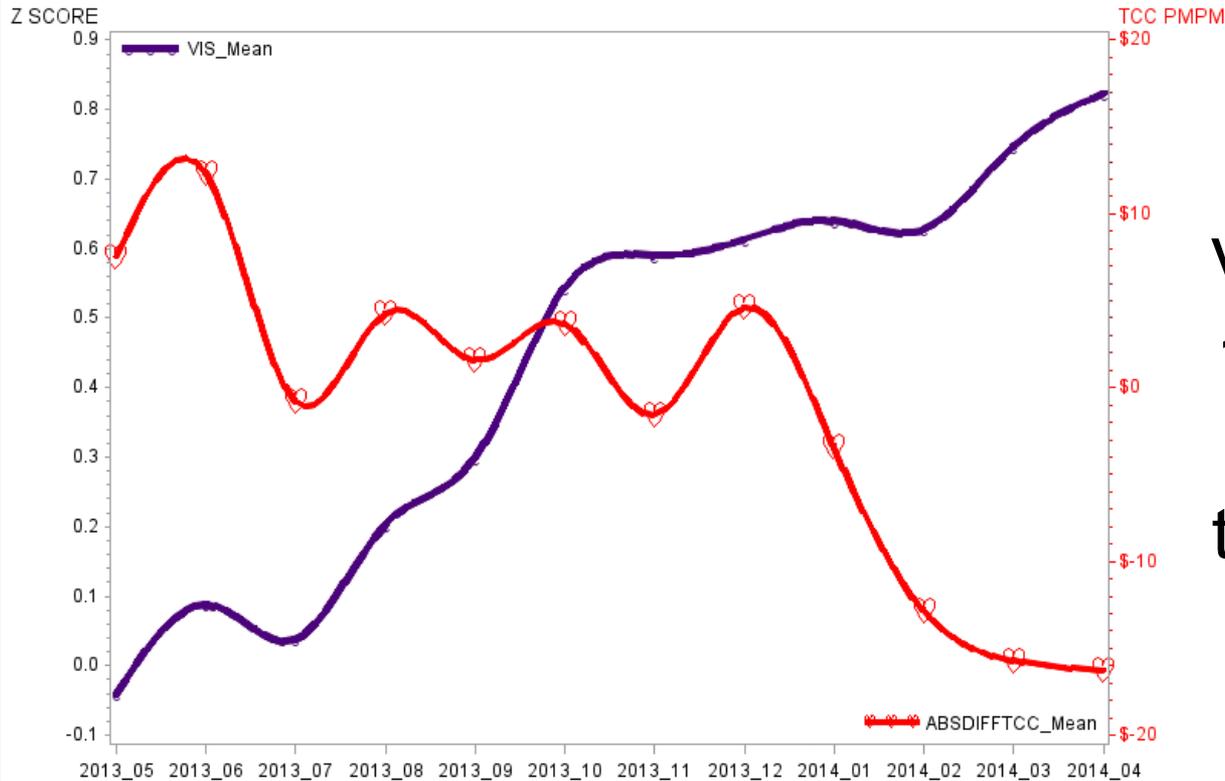


Achieve Scale and Track Improvements

- By developing value-based purchasing arrangements like other payers, providers and community partners can focus on changes that impact not only the whole person, but all people they serve
- Using VIS to track quality links better quality to lower expenses, as shown on next page

Iowa Medicaid VIS Results

VIS and Risk Adjusted TCC Performance over Time for
PCPs who Improved

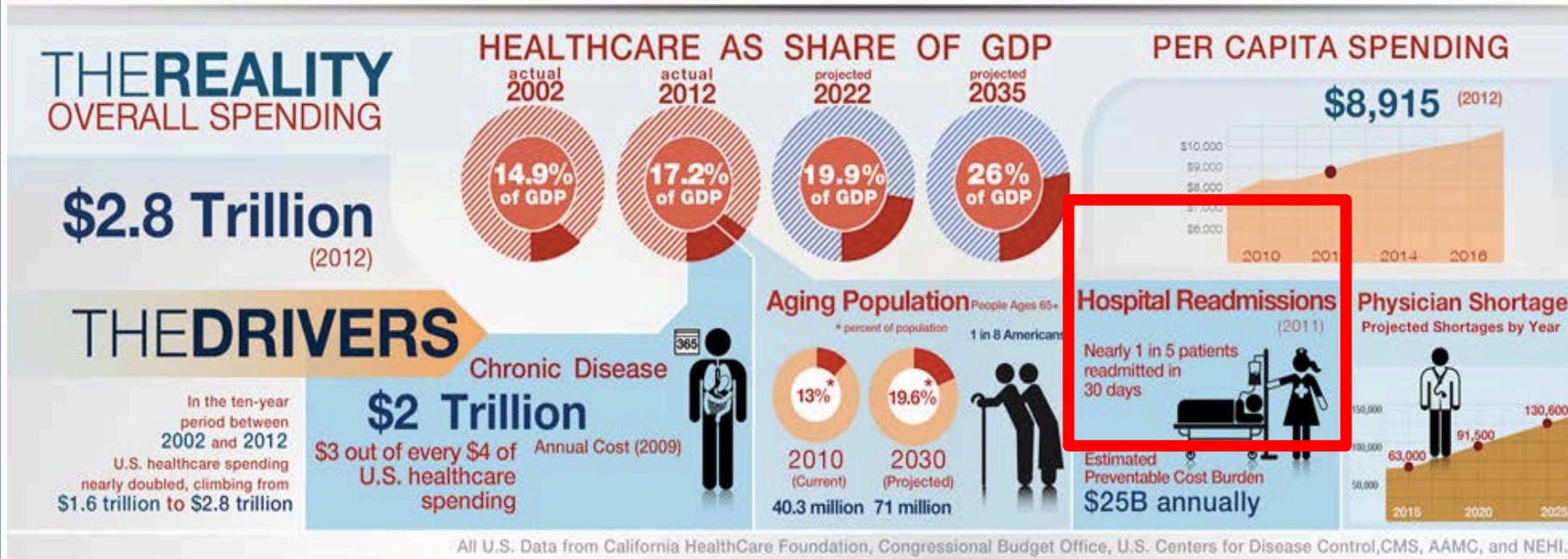


PCPs that improved their VIS score over a 12 month period also lowered their total cost of care during that same period

and own PCP visits to all PCP visit ratio was >.49

Using Health IT to improve health through SIM

Current State



Care Coordination

- Care teams are not aware of patient hospitalization or discharge for prompt follow up
- Cumbersome for care teams to exchange the information and monitor conformance
- Care teams span multiple organizations, systems, technical capabilities

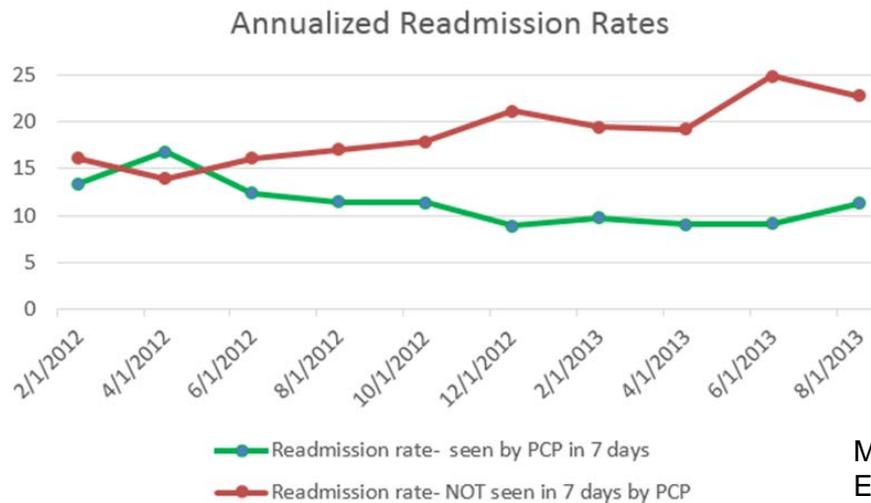
You don't know... what you don't know

How long does it take a care team to learn a high-risk patient was admitted for chest pain to another hospital in another city?

- **Costs can go up the longer you are unaware that a member was admitted to another ER or Inpatient while traveling out of town.**
- **It would be helpful if Care Coordinators were notified of this right away for specific members.**
- **While possible today it is not being done across organization boundaries.**



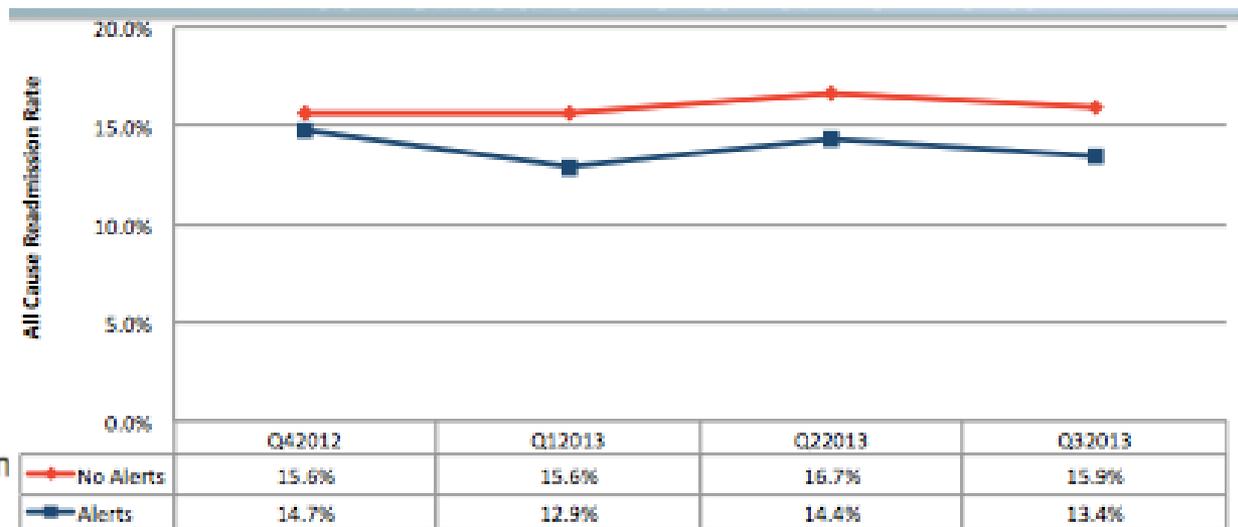
Examples of Reduction in Avoidable Readmission



Maryland Health Information Exchange /Johns Hopkins

30%

Reduction in readmissions
 A care transitions intervention reduced 30-day hospital readmissions by 30 percent



Moving beyond basic connections to interoperability and intelligence

SmartAlerts[®]



- **Start with ADT events**
- **ADT comes from a mature part of the hospital information system and has been available for some time.**
- **ADT connections are common within organizations but not statewide**
- **Start simple... build on it**

Start Simple

- Three Use Cases initially:
 - Emergency Department Discharge
 - Inpatient Admission
 - Inpatient Discharge
- Principles:
 - Alerts must have enough information to act
 - Must be timely
 - Must be used by care teams to improve outcomes

ADT Trigger Events

Possible if the data comes

- Admit/visit notification.
- Transfer a patient
- Discharge/end visit
- Register a patient
- Pre-admit a patient
- Change an inpatient to an outpatient
- Update patient information
- Cancel admit/visit notification
- Cancel discharge/ end visit
- Swap patients
- Merge patient information
- Add person information
- Update person information
- Merge patient information ID only
- Merge patient information account number only
- Merge visit – visit number

Who – Patient

What – Admits and Discharges

When – Real Time

Where – Inpatient and ER,

Why – To inform immediately

How to make this happen

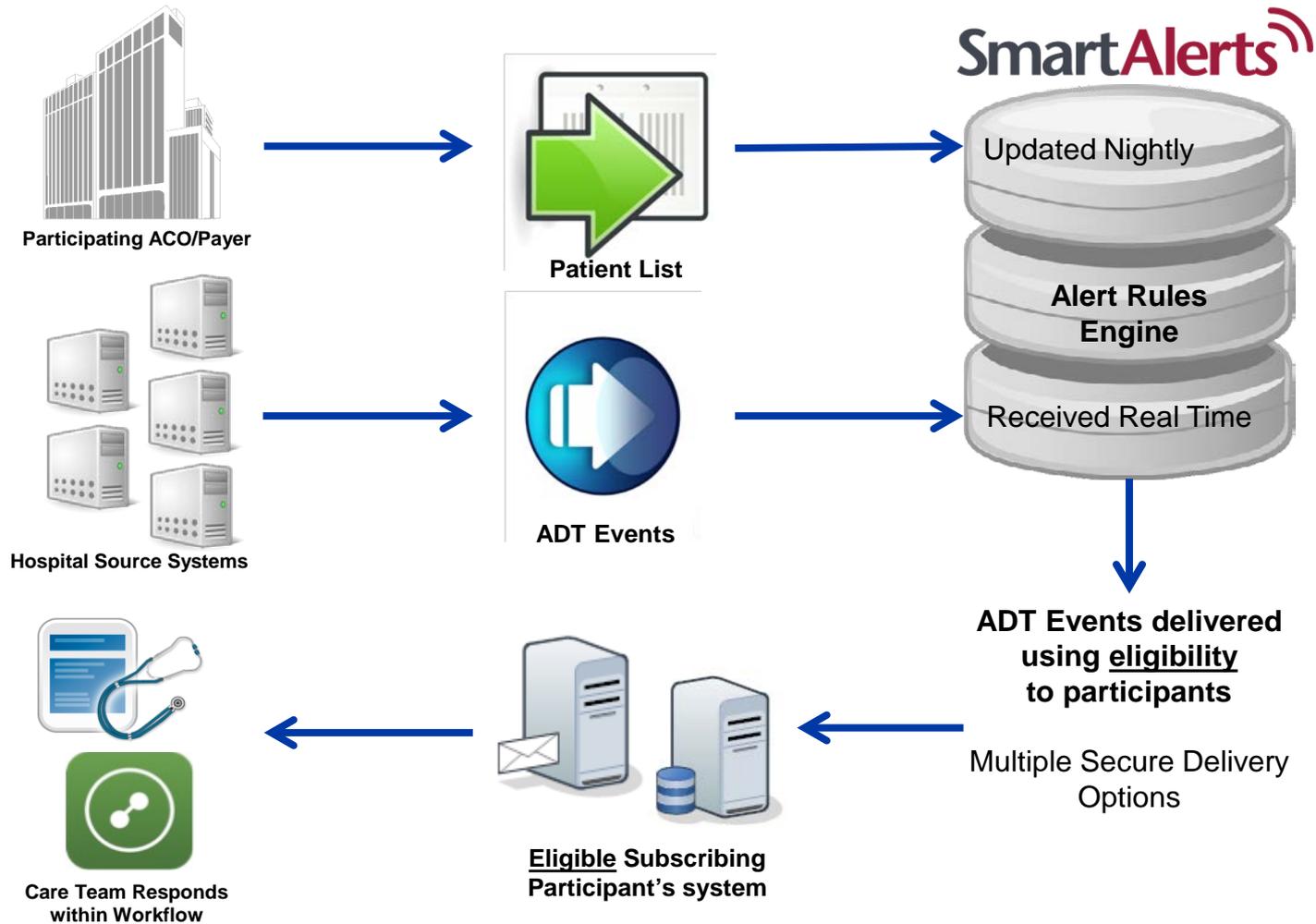
Build it:

- Connect all hospitals in Iowa to send ADT records to the Statewide Smart Alert engine.
- IME provides the patient lists for the system to use to route Event Alerts.

Use it:

- Care Coordinators set up to receive and use to improve outcomes.

Statewide Event Notifications



Statewide Services

Today:

- Direct Messaging – secure message from one participant to another
- Patient Query – for Treatment, Payment and Operations

New:

- Event Notification System, sending real-time alerts to registered care teams
 - Participants cannot query for an ADT record



2015 Initial Roll-out

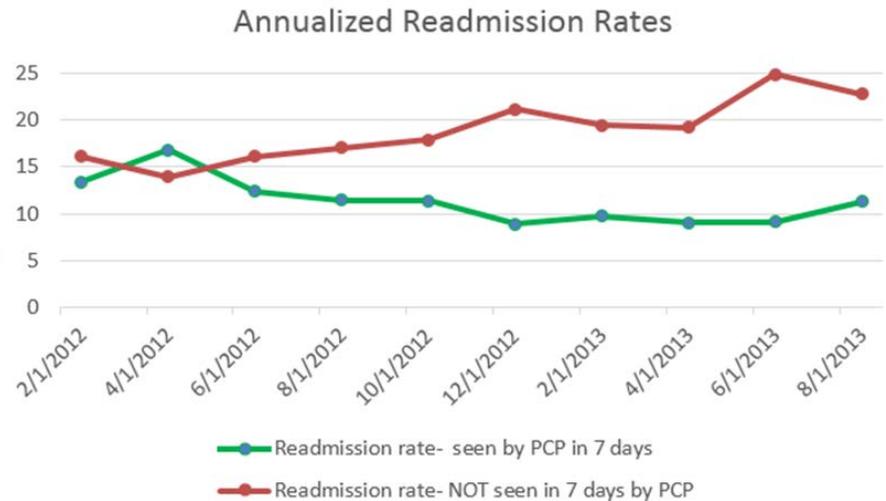
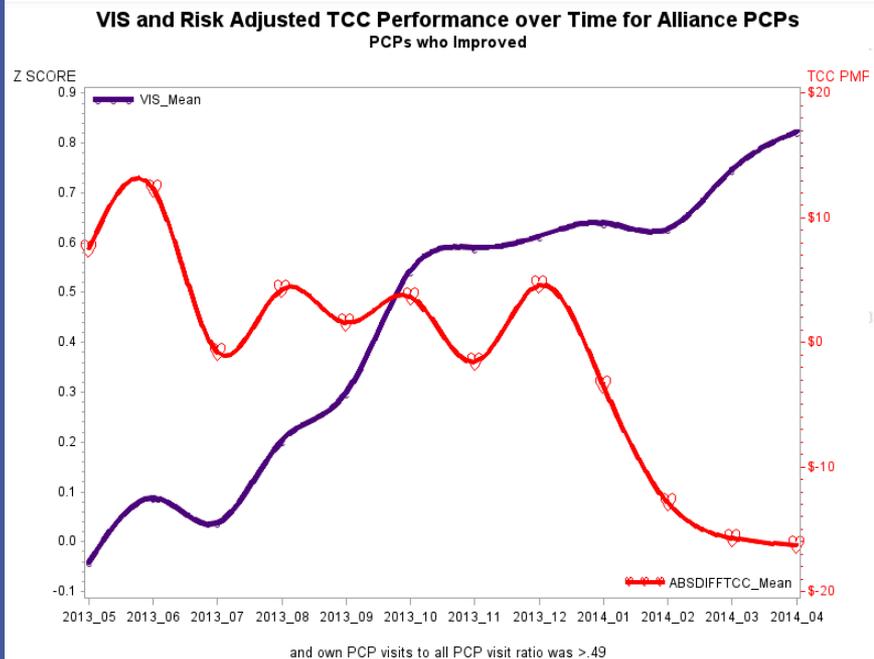
- Three identified Use Cases:
 - ED Discharge
 - Inpatient Admission
 - Inpatient Discharge
- Must have participation from hospitals in each ACO
- Limit alerts to direct feeds at the ACO level only
- Medicaid members with PCP assignments

Expansion Opportunities

- More Use Cases (pharmacy, urgent care, LTC, etc...)
- More payers (Medicaid MCOs, Private payers, etc..)
- Alerts to clinics and care teams using both direct feeds and direct messaging options

ADT Data impacts VIS Measures

- Chronic and Follow-Up Care Measures:
 - 30 day Potentially Preventable Readmissions
 - PCP Visit 30 Days Post Discharge



Resources

Website:

<http://dhs.iowa.gov/ime/about/state-innovation-models>

Emails:

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