ONC 2023 ANNUAL MEETING

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ANNUAL MEETING

Exploring the Relationship between Payment Models and Documentation Burden

Andrew Gettinger, Dartmouth (moderator)
Nate C. Apathy, MedStar Health
A Jay Holmgren, UCSF
S. Trent Rosenbloom, Vanderbilt University Medical Center
Sarah Rossetti, Columbia University
Anna Taylor, MultiCare Connected Care

Exploring the Relationship between Payment Models and Documentation Burden

Andrew Gettinger, MD

Professor emeritus

Dartmouth GEISEL SCHOOL OF MEDICINE

Session Description

This session will explore how the use of EHRs outside of traditional Fee for Service environments may play a role in documentation burden experienced by clinicians. This session will review a summary of current knowledge on the variation in documentation burden within different payment environments. Presenters will also discuss how the Trusted Exchange Framework and Common Agreement can address EHR burden.

Agenda

- Brief Presentations

  Sarah Rossetti, Columbia University
  Nate C. Apathy, MedStar Health
  Anna Taylor, MultiCare Connected Care

- Reactor Panel

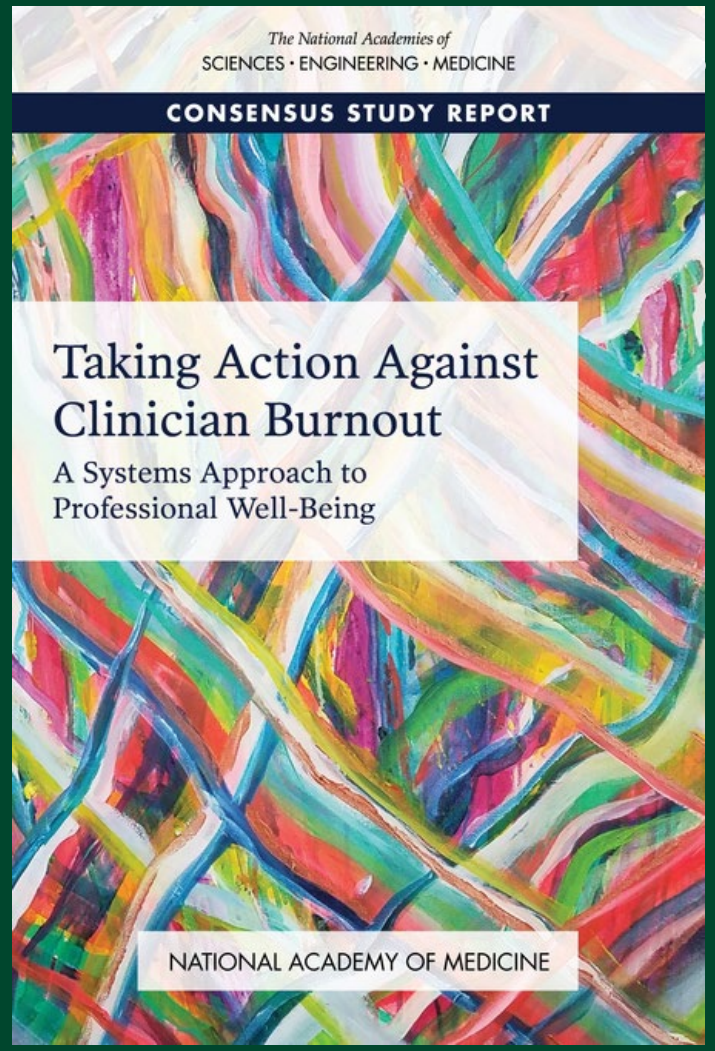
  A Jay Holmgren, UCSF
  Anna Taylor, MultiCare Connected Care
  S. Trent Rosenbloom, Vanderbilt

- Audience Questions

Context Setting

- ARA HITECH Act 2009
  - Federal incentives to digitize – "meaningful use"
  - ONC established in statute
- 21st Century Cures Act 2016
  - Information blocking prohibited
  - TEFCA to support interoperability
  - Clinician burden reduction report & efforts
- Priority to give patient's access to their data and to facilitate sharing among authorized parties

EHR's identified as a major contributor to burn-out



NAM Report 2019

Notes by US clinicians are 4 times longer than those in other countries

- Downing, N. L., D. W. Bates, and C. A. Longhurst. 2018. Physician burnout in the electronichealth record era: Are we ignoring the real cause? *Annals of Internal Medicine* 169(1):50–51.

Essential Electronic Health Record Reforms for This Decade

JAMA Viewpoint June 6, 2023

Don Eugene Detmer, MD, MA; Andrew Gettinger, MD

JAMA. 2023; 329(21):1825-1826. doi: 10.1001/jama.2023.3961

This Viewpoint posits suggestions to reform electronic health records (EHRs), including use of unique personal safety identifiers, reduction of administrative and regulatory content from clinical time, inclusion of patient-entered information into the EHR, and reinvention of the clinical note.

Transforming Landscape: Shift to Value Based Care

Fee-For-Service

- Providers paid for volume of services, not outcomes
- Patients must navigate the health system
- Siloed delivery of care
- **Limited information sharing and integration across settings (paper and electronic)**

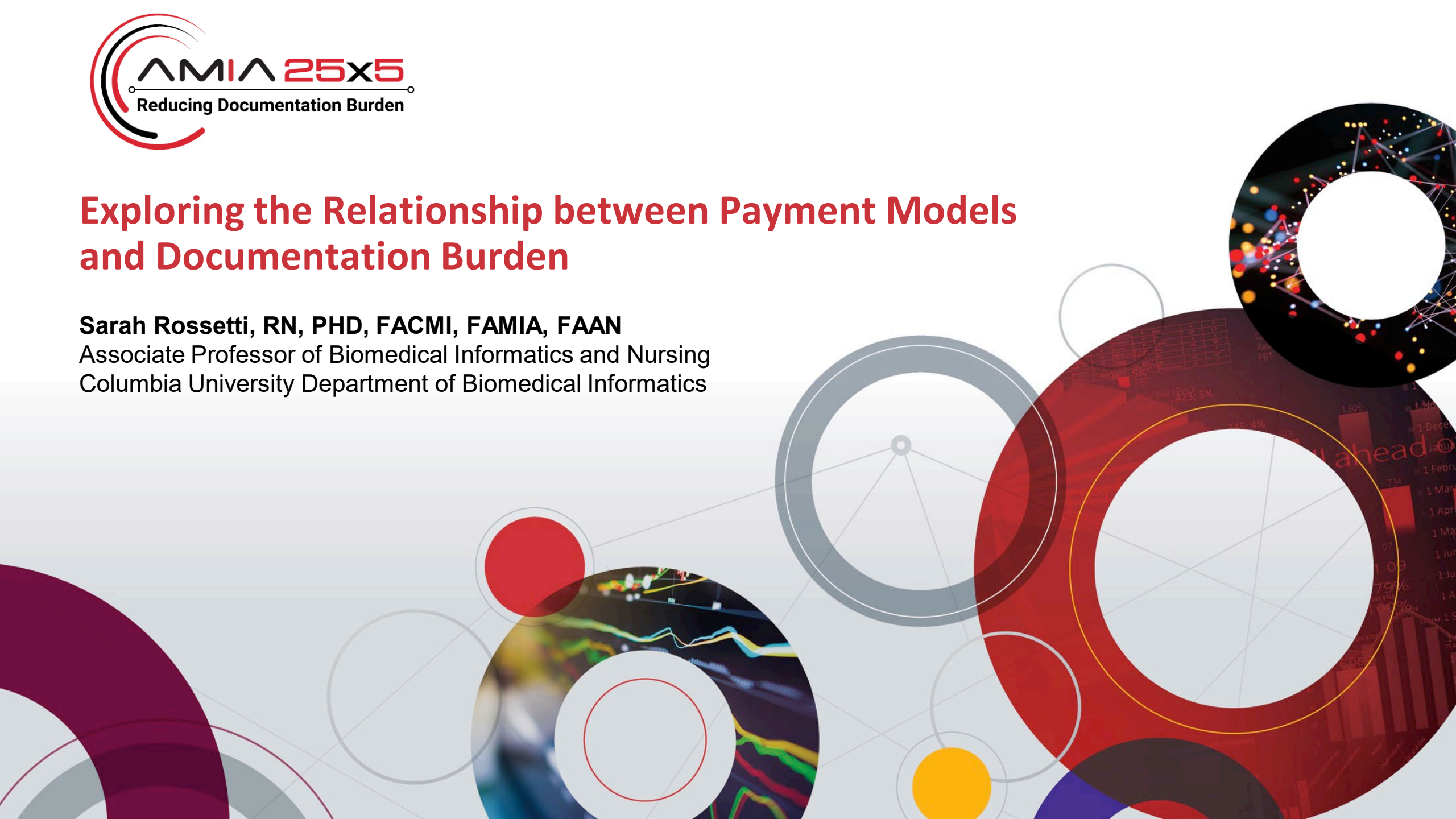
Emerging Value Based Care

- Providers paid for health outcomes, not volume of services
- Care team includes individual and all allied providers
- **Emphasis on use of technology to integrate care and share information**

AMIA 25x5
Reducing Documentation Burden

Exploring the Relationship between Payment Models and Documentation Burden

Sarah Rossetti, RN, PHD, FACMI, FAMIA, FAAN
Associate Professor of Biomedical Informatics and Nursing
Columbia University Department of Biomedical Informatics



AMIA's 25x5 Task Force

Mission

A U.S. healthcare workforce free of documentation burden and focused on patient care and improved patient outcomes.

Vision

Reduce U.S. health professionals' documentation burden to 25% of current state within five years. Optimize and spread across health systems impactful solutions that decrease non-value-added documentation and leverage partnerships and advocacy with health systems, professional societies, and public/private sector organizations.

Organized into 4 Workstreams

1. Impact
2. Health Professionals/Systems
3. Policy/Advocacy
4. Technology Requirements

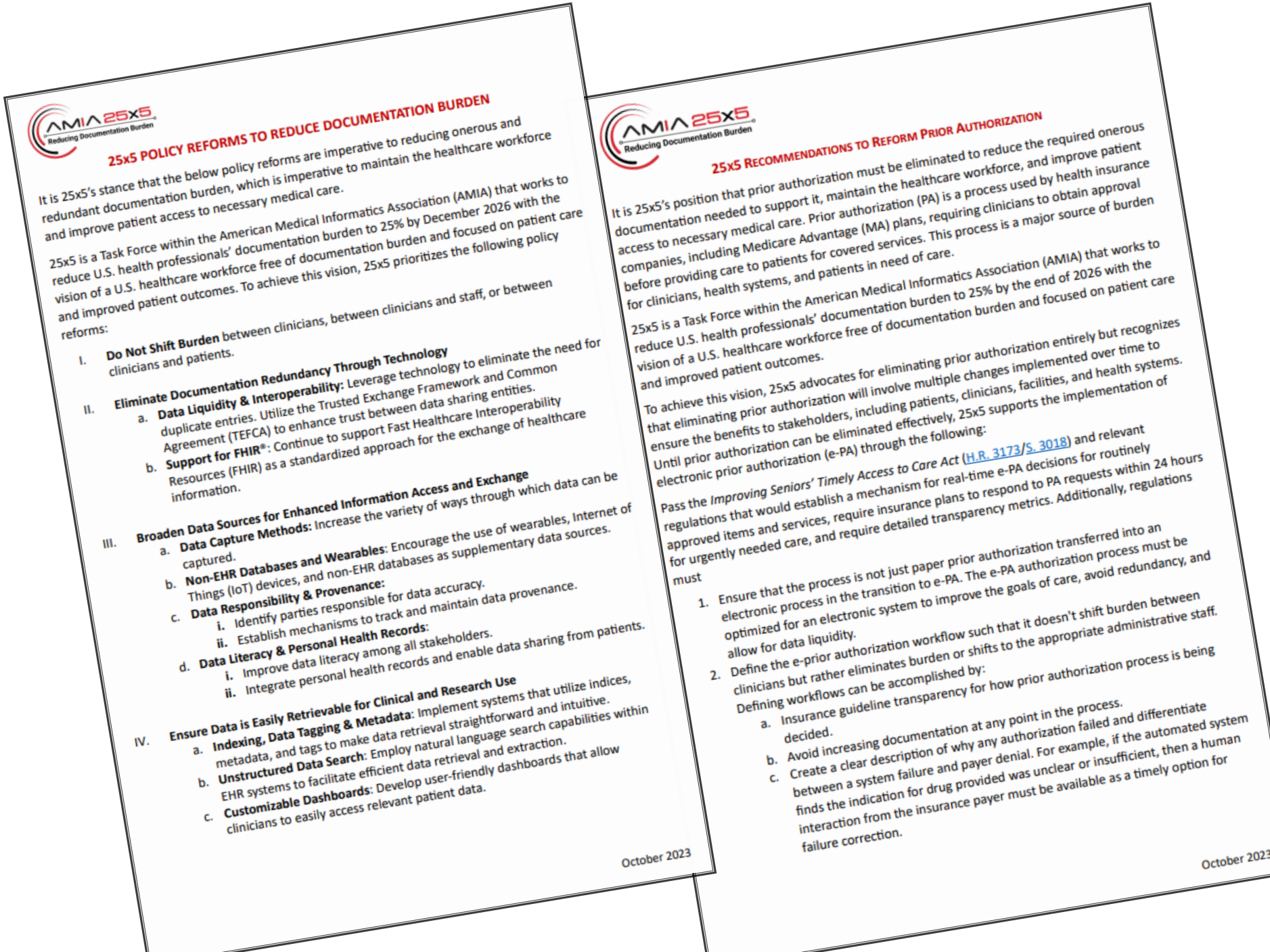
Principles of Engagement

- *No shifting of work to others*
- No erosion of care standards
- Leverage technology and existing data inputs where appropriate
- Maximize clarity of proposed rules to minimize misinterpretation by health systems and providers.

Policy Briefs

25x5 Policy Reforms to Reduce Documentation Burden

25x5 Recommendations to Reform Prior Authorization



25x5 POLICY REFORMS TO REDUCE DOCUMENTATION BURDEN

It is 25x5's stance that the below policy reforms are imperative to reducing onerous and redundant documentation burden, which is imperative to maintain the healthcare workforce and improve patient access to necessary medical care.

25x5 is a Task Force within the American Medical Informatics Association (AMIA) that works to reduce U.S. health professionals' documentation burden to 25% by December 2026 with the vision of a U.S. healthcare workforce free of documentation burden and focused on patient care and improved patient outcomes. To achieve this vision, 25x5 prioritizes the following policy reforms:

I. **Do Not Shift Burden** between clinicians, between clinicians and staff, or between clinicians and patients.

II. **Eliminate Documentation Redundancy Through Technology**
   a. **Data Liquidity & Interoperability:** Leverage technology to eliminate the need for duplicate entries. Utilize the Trusted Exchange Framework and Common Agreement (TEFCA) to enhance trust between data sharing entities.
   b. **Support for FHIR®**: Continue to support Fast Healthcare Interoperability Resources (FHIR) as a standardized approach for the exchange of healthcare information.

III. **Broaden Data Sources for Enhanced Information Access and Exchange**
   a. **Data Capture Methods:** Increase the variety of ways through which data can be captured.
   b. **Non-EHR Databases and Wearables**: Encourage the use of wearables, Internet of Things (IoT) devices, and non-EHR databases as supplementary data sources.
   c. **Data Responsibility & Provenance:**
      i. Identify parties responsible for data accuracy.
      ii. Establish mechanisms to track and maintain data provenance.
   d. **Data Literacy & Personal Health Records**:
      i. Improve data literacy among all stakeholders.
      ii. Integrate personal health records and enable data sharing from patients.

IV. **Ensure Data is Easily Retrievable for Clinical and Research Use**
   a. **Indexing, Data Tagging & Metadata**: Implement systems that utilize indices, metadata, and tags to make data retrieval straightforward and intuitive.
   b. **Unstructured Data Search**: Employ natural language search capabilities within EHR systems to facilitate efficient data retrieval and extraction.
   c. **Customizable Dashboards**: Develop user-friendly dashboards that allow clinicians to easily access relevant patient data.

October 2023

25x5 Recommendations to Reform Prior Authorization

It is 25x5's position that prior authorization must be eliminated to reduce the required onerous documentation needed to support it, maintain the healthcare workforce, and improve patient access to necessary medical care. Prior authorization (PA) is a process used by health insurance companies, including Medicare Advantage (MA) plans, requiring clinicians to obtain approval before providing care to patients for covered services. This process is a major source of burden for clinicians, health systems, and patients in need of care.

25x5 is a Task Force within the American Medical Informatics Association (AMIA) that works to reduce U.S. health professionals' documentation burden to 25% by the end of 2026 with the vision of a U.S. healthcare workforce free of documentation burden and focused on patient care and improved patient outcomes.

To achieve this vision, 25x5 advocates for eliminating prior authorization entirely but recognizes that eliminating prior authorization will involve multiple changes implemented over time to ensure the benefits to stakeholders, including patients, clinicians, facilities, and health systems. Until prior authorization can be eliminated effectively, 25x5 supports the implementation of electronic prior authorization (e-PA) through the following:

Pass the *Improving Seniors' Timely Access to Care Act* (H.R. 3173/S. 3018) and relevant regulations that would establish a mechanism for real-time e-PA decisions for routinely approved items and services, require insurance plans to respond to PA requests within 24 hours for urgently needed care, and require detailed transparency metrics. Additionally, regulations must

1. Ensure that the process is not just paper prior authorization transferred into an electronic process in the transition to e-PA. The e-PA authorization process must be optimized for an electronic system to improve the goals of care, avoid redundancy, and allow for data liquidity.
2. Define the e-prior authorization workflow such that it doesn't shift burden between clinicians but rather eliminates burden or shifts to the appropriate administrative staff. Defining workflows can be accomplished by:
   a. Insurance guideline transparency for how prior authorization process is being decided.
   b. Avoid increasing documentation at any point in the process.
   c. Create a clear description of why any authorization failed and differentiate between a system failure and payer denial. For example, if the automated system finds the indication for drug provided was unclear or insufficient, then a human interaction from the insurance payer must be available as a timely option for failure correction.

October 2023

25x5 Logic Model

Process & Impact Measures

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Item #	Process or Outcome	Impact	Measure(s)	Workstream Responsible (data collection and analysis)
19		Disseminate policy positions, responses, and summaries of activities	Count of policy responses, white papers, and peer-reviewed papers	Policy/Advocacy
20		Support existing policy/advocacy efforts that relate to burden reduction	Count of policy/advocacy efforts formally in support of	Policy/Advocacy
21		Convene external partners and stakeholders	Count of external partners and stakeholders engaged; descriptive statistics of roles, regions, and types of organizations engaged	Policy/Advocacy
22		Toolkit utilized by health systems/provider organizations facilitating documentation burden reduction planning and initiatives	Utilization rates stratified by setting type and geographical location; trending of utilization rates overtime	Health Professional/System
23		Best practices, pilots, challenges and exemplars shared via National Collaborative of health systems/provider organizations	Count of resources/assets shared across sites	Health Professional/System
24		...ority for external	Total dollars available for research funding	Policy/Advocacy
		...l strategic plans	Baseline percent of health systems/provider organizations sampled that have a burden reduction initiative in strategic plan	Impact
			Count of platforms posted on; Count of posts and re-posts; Count of engagement during Symposium Social Media Campaign, trends over time	AMIA staff
			Utilization rates stratified by user type/role; trending of utilization rates overtime	AMIA staff
		...nd integrated ...rden	The impact of the toolkit will be assessed using process, outcomes and satisfaction measures	Health Professional/System
		...reduction	Percent of health systems/provider organizations that downloaded toolkit with active burden reduction improvement programs (Evaluation survey)	Health Professional/System
			Count of policy changes with any linkage to 25x5 policy/advocacy efforts	Policy/Advocacy
		...nd meetings	Count of: internal FTEs available; external organizations providing resources; budget for education and meetings	Policy/Advocacy
		...f burden	Baseline rates of perceived burden among sampled population; Trend of rates of perceived burden among sampled population	Impact
		...c plans	Trended percent of health systems/provider organizations sampled that have a burden reduction initiative in strategic plan	Impact
		...keholders	Utilization rates stratified by user type/role; trending of utilization rates overtime	AMIA staff
			Count of number of publications citing 25x5	Impact

Burden as an organizational strategic initiative Perception of documentation burden

Process & Impact Outcomes

Inputs	Activities	Short	Medium	Long
Leveraging AMIA Resources • Member volunteers • Member expertise • Communications channels • Symposium/ Conferences • Research Findings • Collaboration tools • Board feedback • Staff *Collaborating with other organizations and networks* • e.g, NBRC, HIMSS, OSG, ONC *Stakeholders* • Health Professionals • Patients/consumers • Healthcare organizations • Technology vendors • Policy makers *Leveraging support from external sources* • e.g., funding from NLM, AHRQ	*Health Professional/System Workstream* • Conduct environmental scan of documentation burden efforts • Develop toolkit to guide health systems/provider organizations through documentation burden reduction • Foster inter-organizational collaboration across health systems/provider organizations *Technology Requirements Workstream* • Educate HIT users about existing functionality intended to reduce documentation burden • Develop HIT Industry Roadmap • Engage and incentivize knowledge sharing activities within the vendor community *Policy/Advocacy Workstream* • Information collection meetings with regulatory and accreditation groups to identify/promote validated solutions, avoid duplication of efforts, and identify gaps • Conduct environmental scan of existing efforts to reduce documentation burden • Advocate for vision of a streamlined provider note (codable/required) • Investigate the reduction/elimination of Prior Authorization • Facilitate a dedicated documentation burden policy event *Impact Workstream* • Establish standard definition of Documentation Burden • Identify valid and feasible approach to survey clinicians on perceived burden • Survey Hospitals regarding inclusion of burden in strategic plan *Cross-Workstreams* • Establish national online presence highlighting AMIA as thought leader and collaborator in documentation burden reduction • Sharing/information exchange with engaged community of stakeholders • Advocate to implement systematic interventions to support providers and health systems in reducing documentation burden	*Health Professional/System Workstream* • Literature review of documentation burden efforts accepted for publication • Publication of Health Systems/Provider Toolkit • National Collaborative of health systems/provider organizations established *Technology Requirements Workstream* • AMIA 25x5 Pitch Event • Clarified 25x5 priorities for vendors • HIT industry roadmap collaboratively defined *Policy/Advocacy Workstream* • Advocate for funding for documentation burden research • Disseminate policy positions, responses, and summaries of activities • Support existing policy/advocacy efforts that relate to burden reduction *Impact Workstream* • Peer-reviewed publication on Definition of Burden • Peer-reviewed publication on systematic reviews of surveys of clinician perceived burden • Establish plan to measure rate in which burden reduction initiatives are incorporated into hospital strategic plans *Cross-Workstreams* • 25x5 Initiative included at least one time per month in both AMIA planned social media posts across platforms and planned member email communication highlighting ongoing 25x5 work and/or empowering AMIA members and stakeholders. • Addition of 25x5 Initiative to AMIA's value proposition promoting and building the informatics field. • Articles related to documentation burden included in *Informatics SmartBrief* educating and empowering members. • Annual social media campaign hosted during AMIA Symposium educating members and public about the initiative and the informatics field. • Utilization of an online platform for communication and engagement optimizing infrastructure for member-driven impact. • Convene external partners and stakeholders	*Health Professional/System Workstream* • Toolkit utilized by health systems/provider organizations facilitating documentation burden reduction planning and initiatives • Best practices, case studies, challenges and exemplars shared via National Collaborative of health systems/provider organizations *Technology Requirements Workstream* • HIT industry roadmap circulated to advance documentation burden reduction across HIT *Policy/Advocacy Workstream* • Funding organization(s) initiate consideration of documentation burden as a strategic priority for external research funding • Disseminate policy positions, responses, and summaries of activities • Support existing policy/advocacy efforts that relate to burden reduction *Impact Workstream* • Broad dissemination and feedback on the definition of Documentation Burden • Development of a pulse survey on clinicians' perceptions of burden, ideally within an existing national survey • Establish baseline data of burden reduction initiatives incorporated into hospital strategic plans *Cross-Workstreams* • Increased digital footprint of online and social media presence • Measure and adapt to maintain and extend digital footprint • Users engaged with communication/engagement online platform • Partnerships established and duplication of efforts avoided	*Health Professional/System Workstream* • Burden reduction strategies disseminated in Toolkit are established, impactful, and integrated into health systems/provider organizations' efforts to reduce documentation burden • Processes in place at health systems/provider organizations for on-going burden reduction improvements and mitigation of new burden *Technology Requirements Workstream* • Technological advancements identified in HIT industry roadmap incorporated into products and/or included in HIT industry business strategic plans • Challenge executed focused on using artificial intelligence/machine learning to reduce documentation burden *Policy/Advocacy Workstream* • Funding organization(s) identify documentation burden as strategic priority for external research funding • Change in policy(s) to reduce or eliminate documentation burden • Increase in resources available for documentation burden advocacy, education, and meetings *Impact Workstream* • MESH terms created for documentation burden • Administration and validation of national pulse survey for clinician perceived burden • Annual trending of burden reduction initiatives incorporated into hospital strategic *Cross-Workstreams* • Recognition prog measurable posit • AMIA recognized resources on bur • AMIA 25x5 Task F efforts • Scholarship and r practices • AMIA/25x5 top r media searches r • Improved interna increased stakeh • Usage of commu external partners • Stakeholder perc past 5 years

Assumptions
- Available and validated measurements for burden are limited
- Science behind methods to measure documentation burden is evolving
- Quantifying value-add documentation versus non-value add documentation is essential but understanding how to do this is limited
- Goal is to eliminate burden, not shift burden between clinical roles
- There will be no erosion of care standards
- Task force publication pending defining clinical documentation burden and scope of 25x5 work
- Workstreams will approach documentation burden from different perspectives
- Summative evaluation will be conducted by triangulating 5 noted components to evaluate 25x5 Task Force goal to reduce burden to 25% of current state by 2026

External Factors (Barriers and Facilitators)

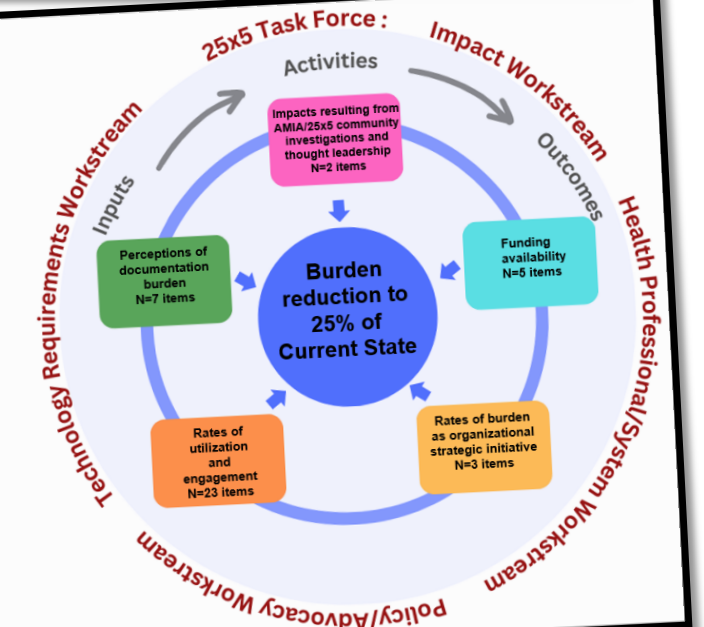
National
- *AMIA:* Measurement expertise; cross-organization collaborations; ACI community
- *Health Professional/System:* Infrastructures to share learnings
- *Technology Requirements:* Business needs; development timeline; culture; identification of customer
- *Policy/Advocacy Groups:* Alignment of priorities across groups
- The potential effects of artificial intelligence and machine learning technologies are continuously developing.
- Costs are unknown, particularly for innovative emerging technology like Artificial Intelligence and Machine Learning
- Conservative estimate of 161 task force volunteer hours per month

Local
- *Hea... and... stru... exp... pri...*

Five Components Triangulated to Evaluate Burden Reduction:

1. Perceptions of documentation
2. Impacts resulting AMIA/ 25x5 community investigations and thought leadership
3. Funding availability
4. Rates of burden as organizational strategic initiative
5. Rates of utilization and engagement

N = number of measured items from logic model that comprise each component



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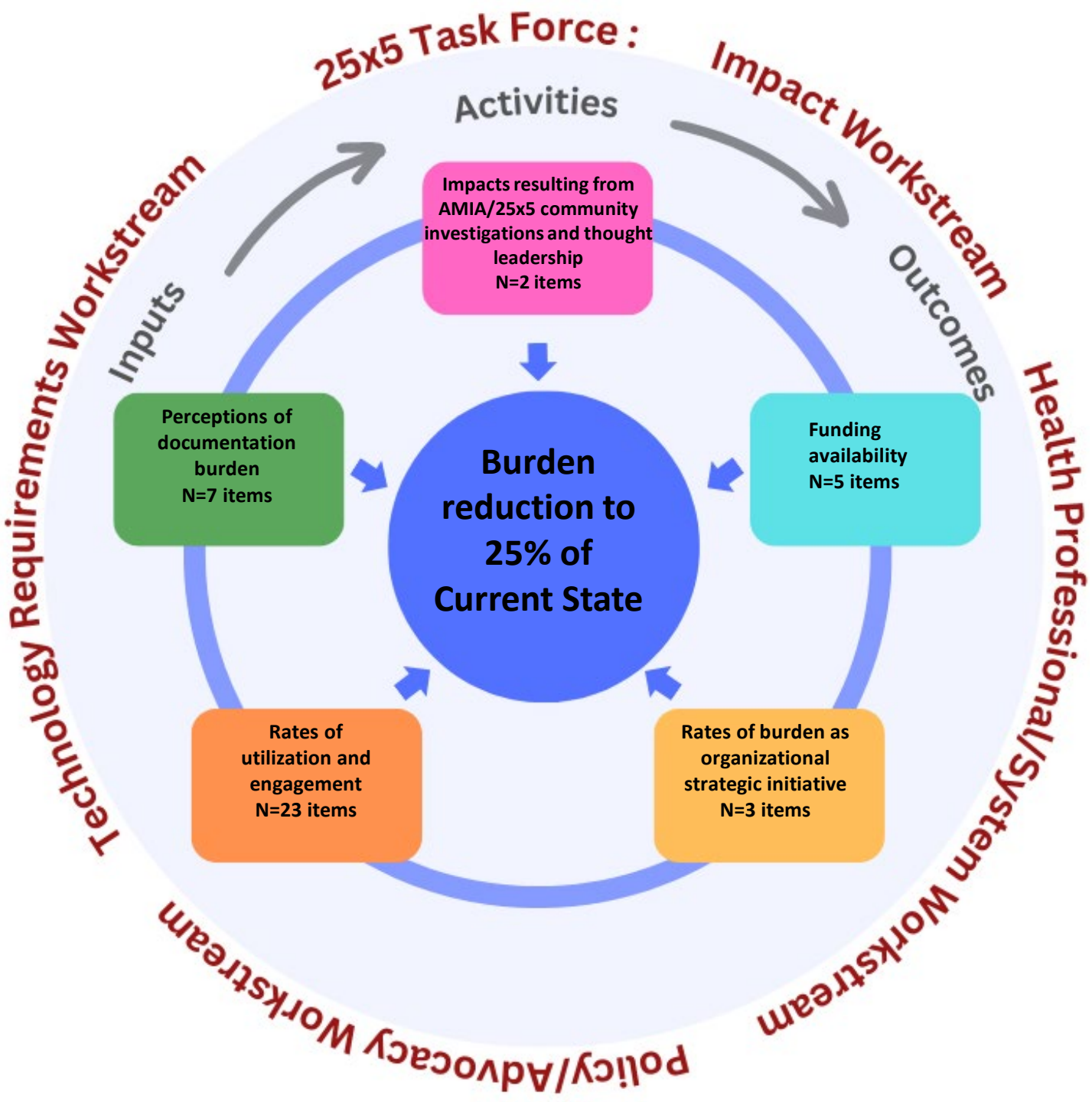

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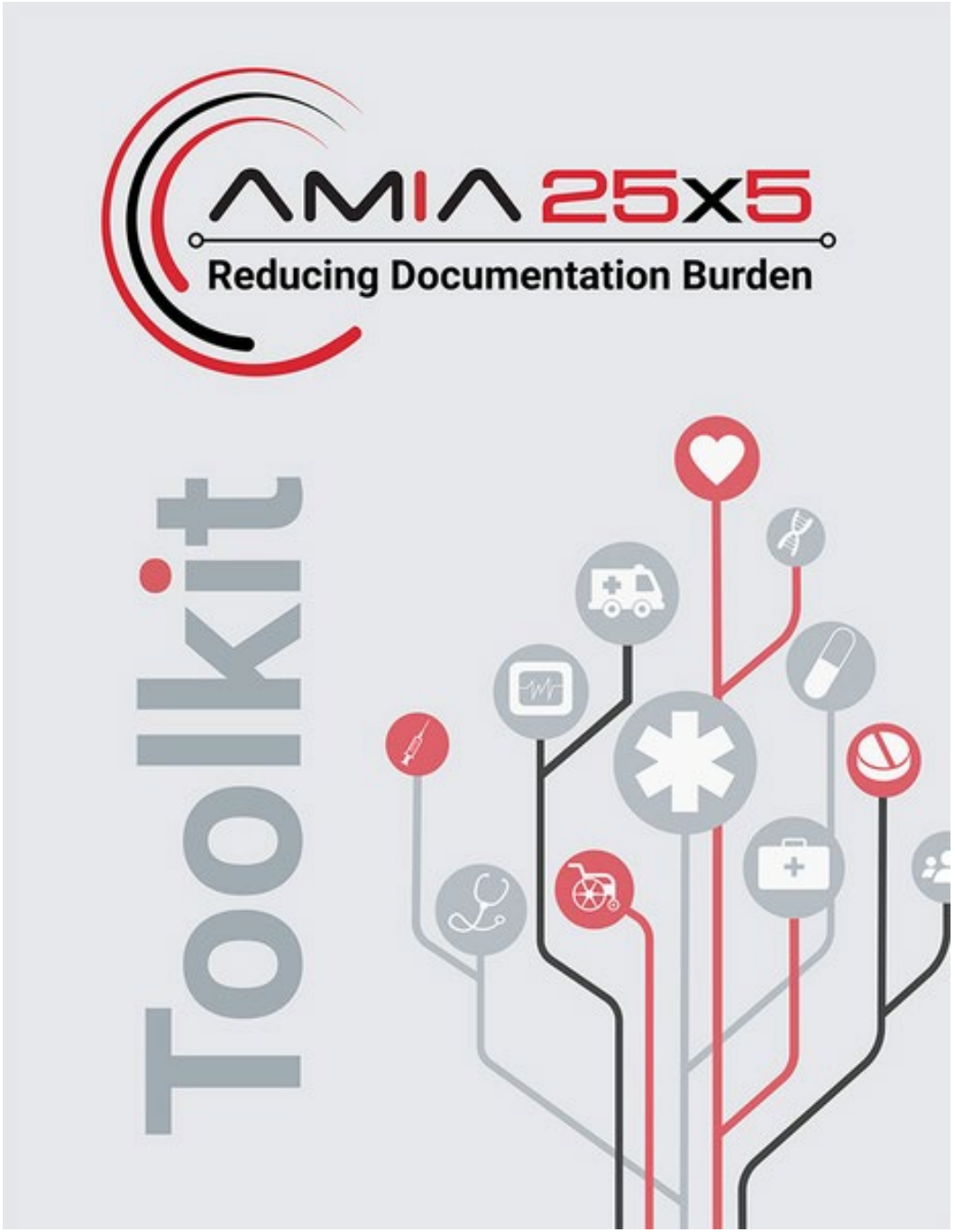
Measuring Perceived Documentation Burden & Trends Over Time

National Pulse Survey

Economic Analysis



AMIA 25x5 Toolkit

- A tool to guide organizations through the process of reducing documentation burden
- Provides resources and a pragmatic approach to documentation burden reduction
- 1000 downloads to date

Convening & Partnering

New! 25x5 Community

Open to everyone

The 25x5 Community is now on Slack. Join to chat and collaborate on all things related to 25x5 and reducing documentation burden.

The 25x5 Toolkit channel is the space to connect with others using the Toolkit and share resources, information, and roadblocks.

Join the Slack community

Stay informed via email or provide feedback

AMIA convenes national leaders tackling burden reduction in clinical settings Pacesetters come together to discuss the future of AI to support burden reduction

November 16, 2023

Washington, DC – For a second year in a row, the American Medical Informatics Association (AMIA) hosted the National Burden Reduction Collaborative (NBRC), during the AMIA 2023 Annual Symposium, November 11-15, in collaboration with the Association of Medical Directors of Information Systems and the Alliance for Nursing Informatics. The NBRC spent Tuesday, November 14, sharing progress made over the last year across the Collaborative addressing key priorities. The Collaborative dedicated a majority of the agenda to discussing the potential of artificial intelligence (AI) technologies to significantly reduce clinician burnout and improve clinician wellbeing by addressing the documentation burden.

https://amia.org/about-amia/amia-25x5

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https://amia.org/about-amia/amia-25x5

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Literature Review of Electronic Health Record Documentation Burden Analysis in and Outside the Fee-For-Service Payment Model

Deliverable 4: Project Summary

Prepared for:
Office of the National Coordinator for Health Information Technology (ONC)
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330 C Street SW
Washington DC 20001

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Contract Number: GS35F0565T-140D0420F0486
Program Officials: Tricia Lee Rolle, PharmD, MS, PhD & Vaishali Patel, MPH PhD

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Burnout linked to documentation burden

COVID-19 has exacerbated clinician burnout (Shanafelt, et al 2022; Linzer, et al 2022)

Established link between EHR time and burnout (Adler-Milstein, et al 2020; Gardner, et al 2019; Hilliard, et al 2020; Tai-Seale, et al 2023)

Physicians rank “reduce time on documentation” as the most important intervention for improving wellbeing (Aiken 2023)

Reducing physician documentation burden has become a national policy priority and a focus for delivery organizations (Apathy, et al 2022; AMIA 25x5)

Why do we care?

Reimbursement & Payment Requirements

Documentation Burden

Burnout
Reduced FTE
Departure

In theory, value-based payment models should reduce documentation burden relative to traditional fee-for-service arrangements where clinical documentation is used for "justification" of billing

Narrative Review of Evidence

Little empirical evidence exists directly comparing documentation burden across payment environments. Burden exists in integrated payer-provider systems (e.g., Kaiser Permanente) and more homogenous payment environments (e.g., VA) in the US, but direct comparisons have not been done.

Summary of Findings 30 total articles

Overall, little evidence directly assessing the relationship between the payment environment and documentation burden.

Considerable speculation and hypotheses that payment-related demands drive documentation burden for US clinicians, but few directly compare burden in one environment vs. another.

Documentation & Payment in the US

International Comparison Studies

Proposals to Reduce Burden

New Evidence

from the National Electronic Health Records Survey (NEHRS)

Participation in accountable care organizations (ACOs) is uniquely associated with increased documentation burden among office-based physicians, compared to other value-based payment programs and incentive programs. Physician-owned practices report greater ease of documentation in the EHR, but other dimensions of burden do not meaningfully differ across practice ownership models.

Approach: Analysis of NEHRS 2019 & 2021

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

National Center for Health Statistics

National Electronic Health Records Survey

Nationally representative annual survey of non-federal US office-based physicians

Our sample: Only respondents who reported using an EHR

Survey Year	Response Rate	Raw N	Weighted N
2019	37.7%	1,372	271,177
2021	45.9%	1,694	355,420

Documentation Burden in NEHRS 2019 & 2021

Table 1. Office-Based Physician Sample Characteristics			
	Overall	No Program Participation	Any Program Participation
weighted n	626,598	225,751	400,847
Outcomes			
Time spent documenting in the EHR for clinical care is inappropriate (% agree or strongly agree)	60.0	54.7	62.9
Very or somewhat difficult to document clinical care in the EHR (% agree)	36.0	34.7	36.8
Spend more than 1 hour per day on average documenting outside of clinic hours (%)	76.1	70.9	79.0
Minutes spent per day documenting outside of clinic hours (mean, sd)	110.84 (69.58)	101.05 (69.56)	116.36 (69.00)

ACO participation is reliably associated with greater documentation burden

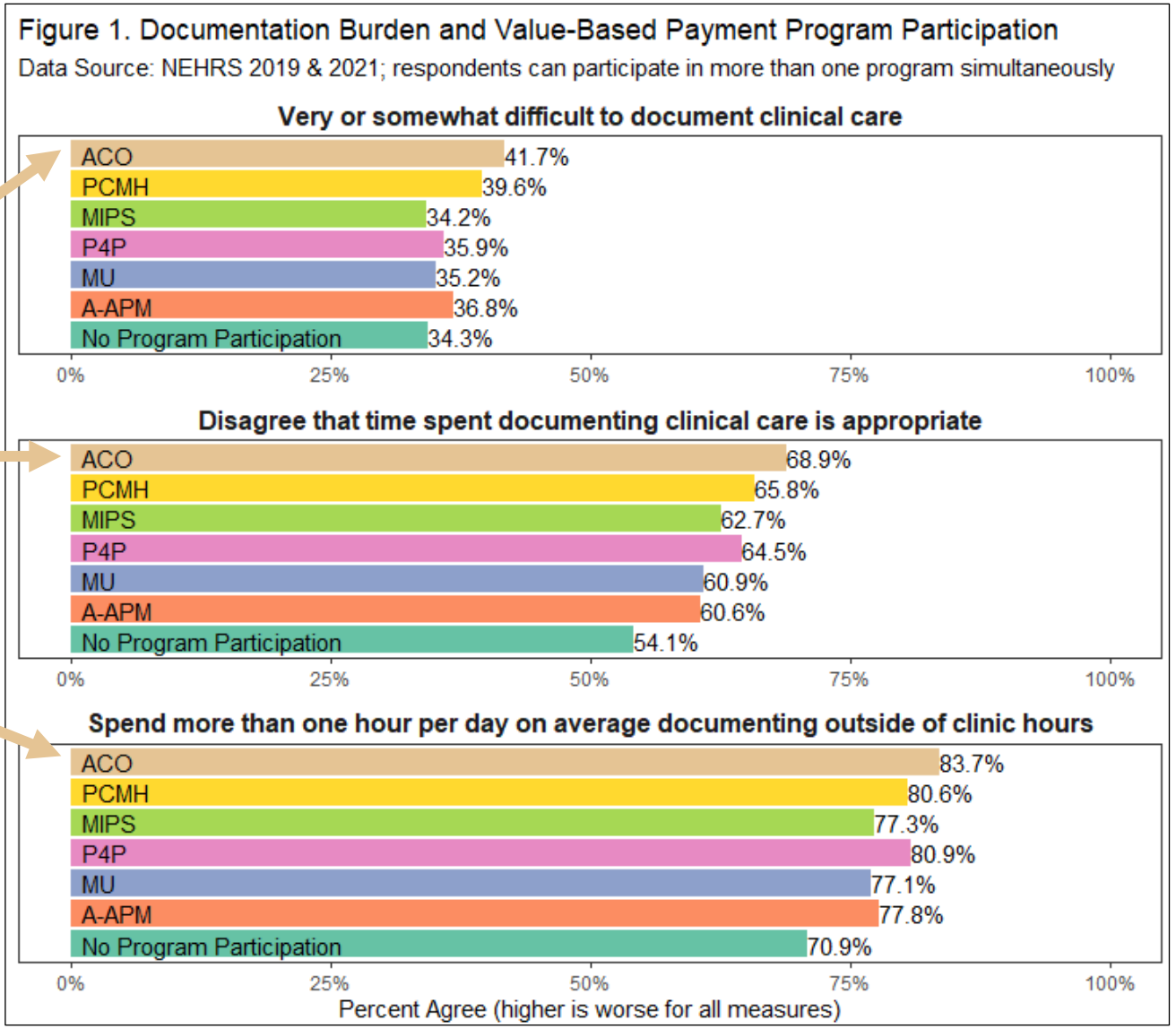


Table 2. Association between VBP program participation and EHR burden outcomes

	EHR Burden Outcomes			
	Time spent documenting in the EHR for clinical care is inappropriate	*Very or somewhat difficult to document clinical care in the EHR*	*Spend >1h per day documenting outside of clinic hours*	*Minutes spent per day documenting outside of clinic hours*
VBP Participation[a]	*B (se)*	*B (se)*	*B (se)*	*B (se)*
Any VBP Participation	0.06 (0.04)	0.01 (0.03)	**0.08* (0.03)**	**11.02* (4.95)**
Individual Program Participation[b]				
PCMH	0.00 (0.04)	0.01 (0.04)	0.01 (0.03)	0.70 (5.14)
ACO	**0.13*** (0.03)**	**0.11*** (0.03)**	**0.09** (0.03)**	**18.03*** (4.76)**
Pay for Performance	-0.02 (0.04)	-0.07 (0.04)	0.00 (0.03)	4.55 (5.69)
Meaningful Use	-0.04 (0.03)	-0.04 (0.03)	-0.01 (0.03)	-8.39 (4.78)
MIPS	0.01 (0.04)	-0.04 (0.03)	0.02 (0.03)	2.15 (5.31)
Advanced APM	-0.08 (0.06)	0.01 (0.06)	-0.06 (0.06)	-10.11 (8.44)
Practice Ownership[b]				
Physician or physician group	reference	reference	reference	reference
Ins co, health plan, or HMO	0.01 (0.11)	-0.07 (0.07)	-0.06 (0.10)	-15.67 (14.19)
Community Health Center	-0.02 (0.08)	0.16 (0.08)	-0.10 (0.07)	-13.46 (9.90)
Medical or Academic Health Center	0.05 (0.05)	**0.12** (0.05)**	-0.02 (0.04)	-2.63 (6.77)
Other	0.01 (0.04)	**0.09* (0.04)**	-0.05 (0.04)	-6.93 (5.71)
Staff Support for Documentation[b]				
No Support	reference	reference	reference	reference
Staff Support	**-0.11** (0.03)**	**-0.08** (0.03)**	-0.04 (0.03)	-2.41 (4.76)
Outcome Mean	0.60	0.36	0.76	110.84

[a]*VBP participation was defined as indication of any participation in any of the six available programs in both NEHRS 2019 and 2021. Estimates for this independent variable are from ordinary least squares regression models adjusting for practice ownership, practice size, treatment of Medicare and/or Medicaid patients, EHR vendor, staff support for documentation, physician sex, physician age, physician specialty, and survey year.*

[b]*Individual VBP program participation was not mutually exclusive. Estimates for individual program participation and practice ownership variables are from the same ordinary least squares regression models, which adjust for the same covariates noted above. *p<0.05; **p<0.01; ***p<0.001*

Discussion

Analyses of “value-based payment program participation” measured in aggregate are masking ACO-specific documentation burden

Relaxing *reimbursement-related* documentation needs may not eliminate documentation for other reasons (e.g., quality reporting, risk-adjustment)

Given “FFS chassis” that many ACOs still employ, clinicians in these arrangements may get the *worst of both worlds*

- Still have to document for reimbursement **plus** ACO documentation needs

MultiCare Connected Care™

MultiCare Journey

MCC

Population Based Care as a Strategic Pillar

Population Based Care

MultiCare Connected Care

Rising Cost of Healthcare

Rising cost of healthcare, and therefore employer and patient insurance premiums

Transition of Payment Models

Payment models shifting from fee for service to fee for value. All segments, government and commercial.

Changing Market Dynamics

Influx of venture capital funds. Investing in care continuum models with focus on primary care as center

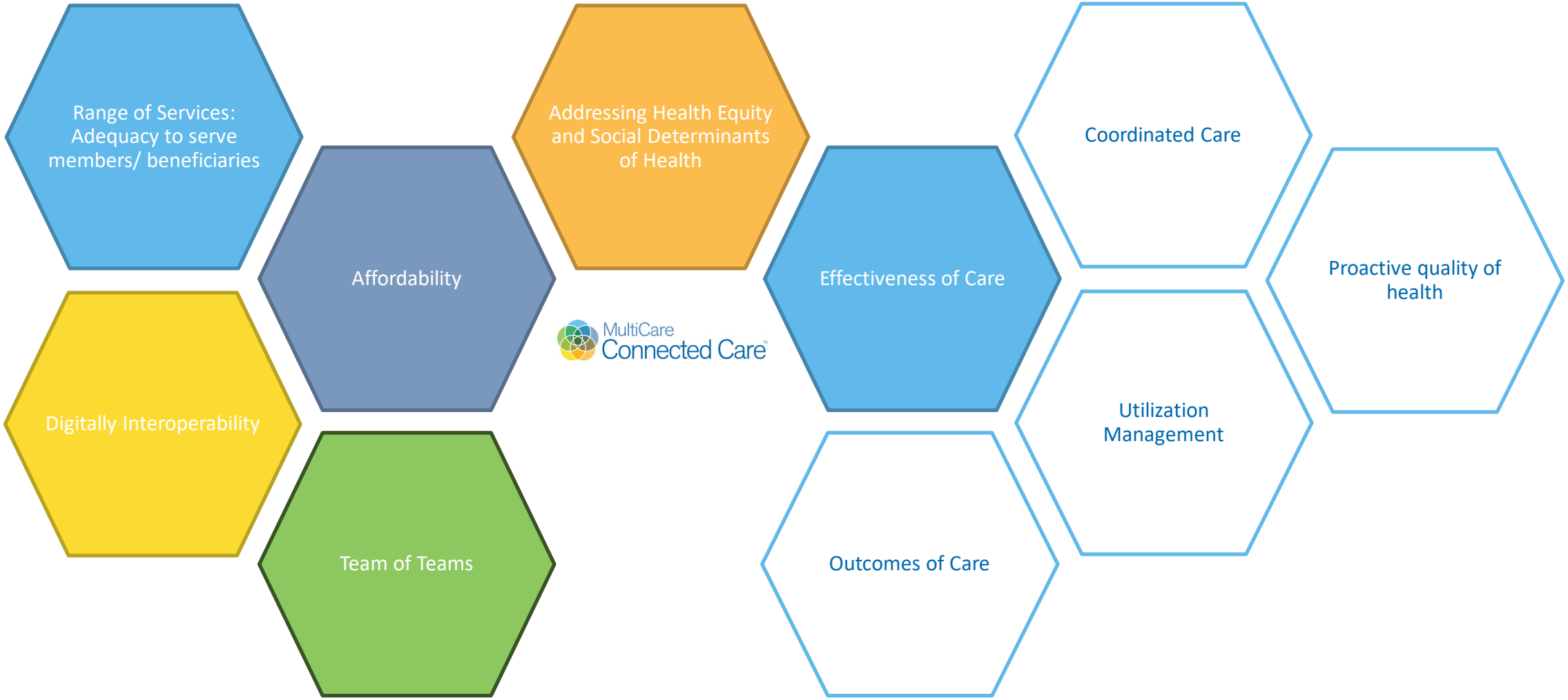
Changing Local & Federal Policy

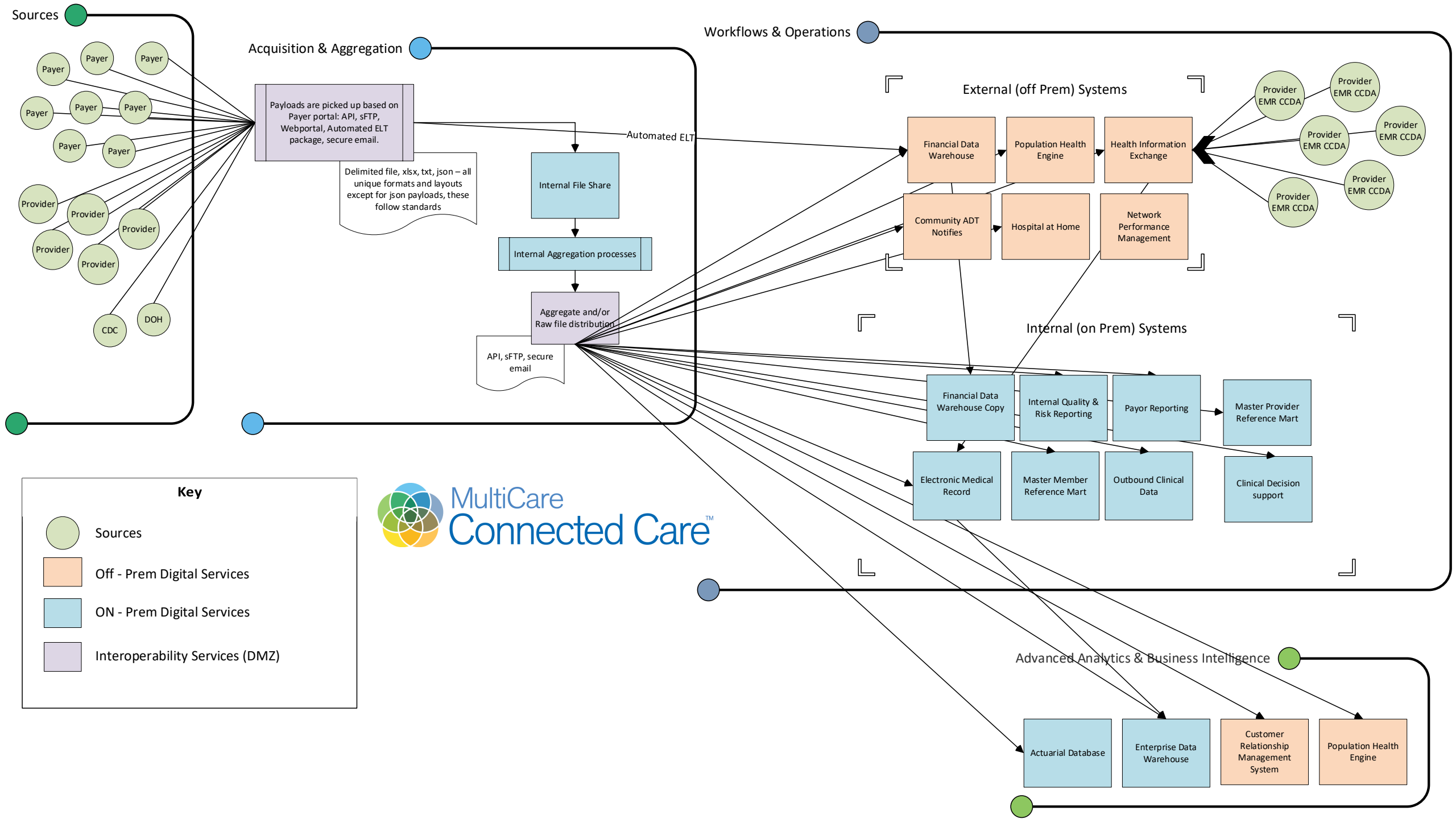
"All Medicare fee-for-service beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030" ~ CMS

Healthcare in the Digital Age

Technology is enhancing our capabilities to share business practices including care and finances across entities.

Value Creation




Sources
Payer
Payer
Payer
Payer
Payer
Payer
Payer
Payer
Payer
Provider
Provider
Provider
Provider
Provider
CDC
DOH
Acquisition & Aggregation
Payloads are picked up based on Payer portal: API, sFTP, Webportal, Automated ELT package, secure email.
Delimited file, xlsx, txt, json – all unique formats and layouts except for json payloads, these follow standards
Automated ELT
Internal File Share
Internal Aggregation processes
Aggregate and/or Raw file distribution
API, sFTP, secure email
Workflows & Operations
External (off Prem) Systems
Financial Data Warehouse
Population Health Engine
Health Information Exchange
Community ADT Notifies
Hospital at Home
Network Performance Management
Provider EMR CCDA
Provider EMR CCDA
Provider EMR CCDA
Provider EMR CCDA
Provider EMR CCDA
Provider EMR CCDA
Internal (on Prem) Systems
Financial Data Warehouse Copy
Internal Quality & Risk Reporting
Payor Reporting
Master Provider Reference Mart
Electronic Medical Record
Master Member Reference Mart
Outbound Clinical Data
Clinical Decision support
Key
Sources
Off - Prem Digital Services
ON - Prem Digital Services
Interoperability Services (DMZ)
MultiCare Connected Care™
Advanced Analytics & Business Intelligence
Actuarial Database
Enterprise Data Warehouse
Customer Relationship Management System
Population Health Engine

MCC

HL7® FHIR®

MultiCare's FHIR & API Adoption Journey

- **2018 –** Joined DaVinci with sponsorship through Cambia
- **2019 –** Proof of concept for quality measures reporting – MHS internal development, returns development investment in year 1.
- **2020 –** Proof of concept for eligibility
- **2021 –** Prior Authorization Trading Agreements
- **2022**
  - April: Formal approval from CMS for Waiver Exception to utilize FHIR for Prior Authorization
  - Oct: Go Live for Smart Authorization and proof of concept for scalable FHIR services
  - DaVinci Steering Committee representation
  - Dec: scalable FHIR ecosystem
- **2023**
  - FHIR Services
  - Eligibility scaled to multiple payers, creating 97% or higher match rates
  - Scaling Data Exchange for Quality Measures to multiple payers
  - Full scale API Management ecosystem

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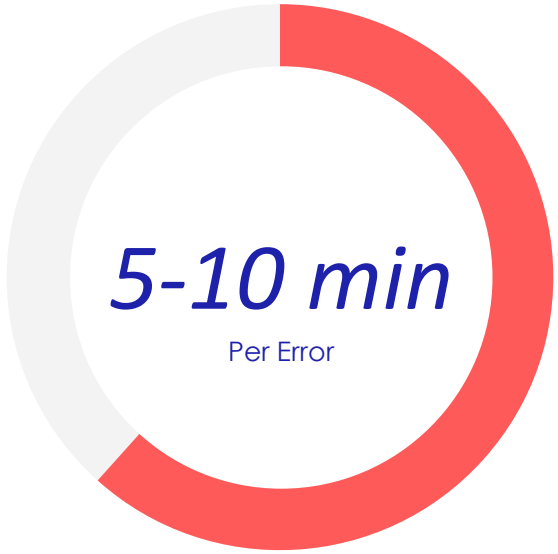
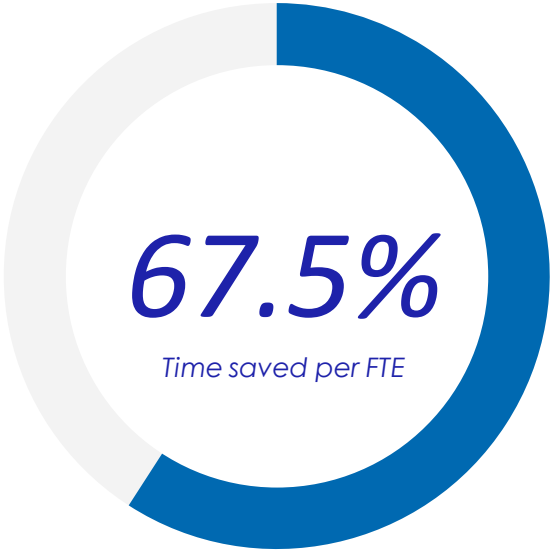
Measuring the Value – Risked Based Membership (ATR)

Decrease in Patient Matching Error Rates



Burden reduction from processing matching errors



Efficiency gains to be redirected to other activities

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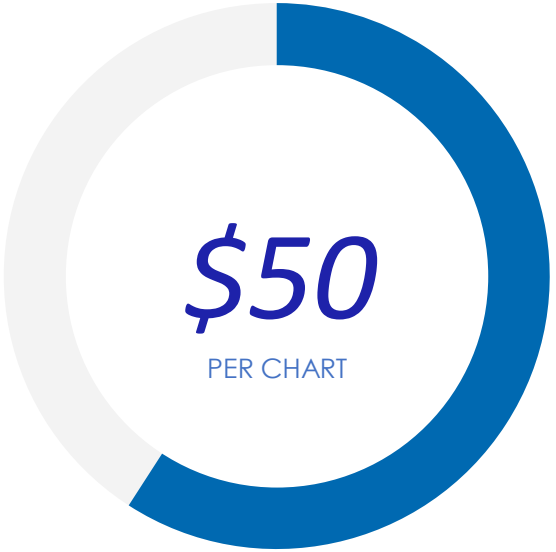
Measuring the Value – Quality Reporting (Data Exchange for Quality Measures - DEQM)

MultiCare MRP performance improvement

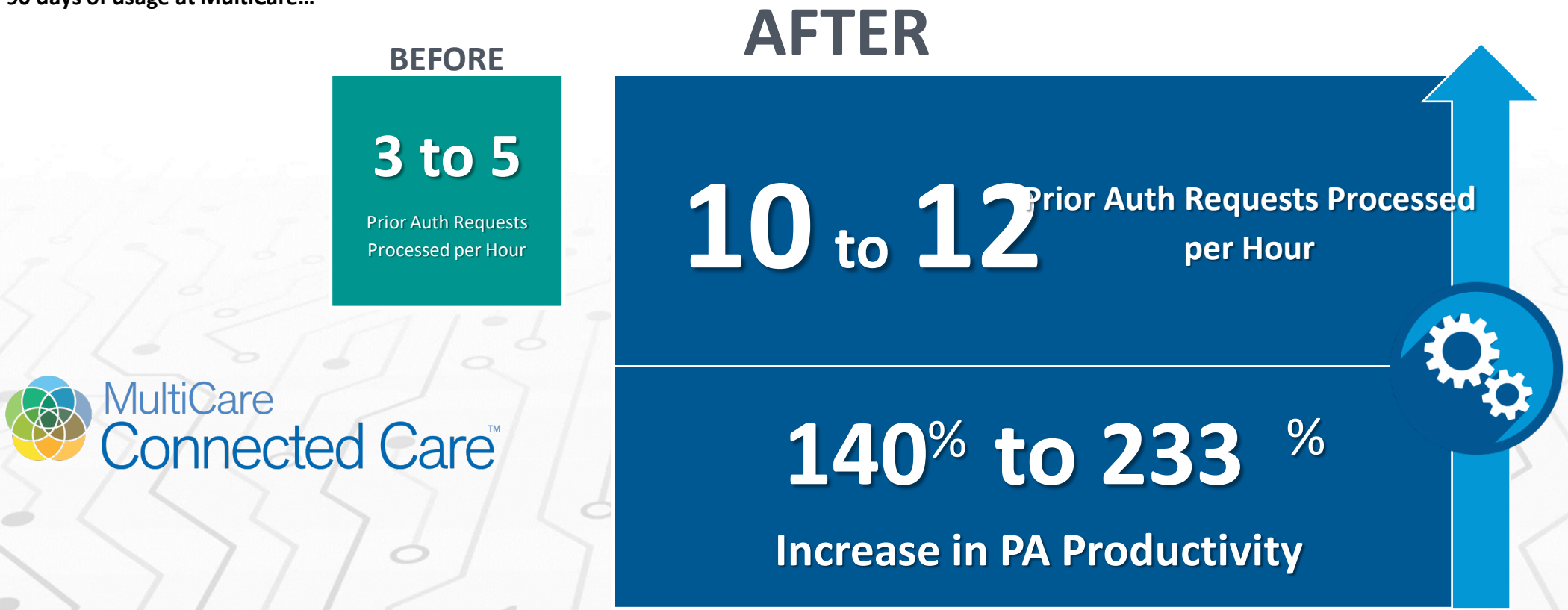
Additional Gaps Closed



Reduction in Chart Chasing

Automating Prior Authorization with Standard Interoperability

After 90 days of usage at MultiCare…



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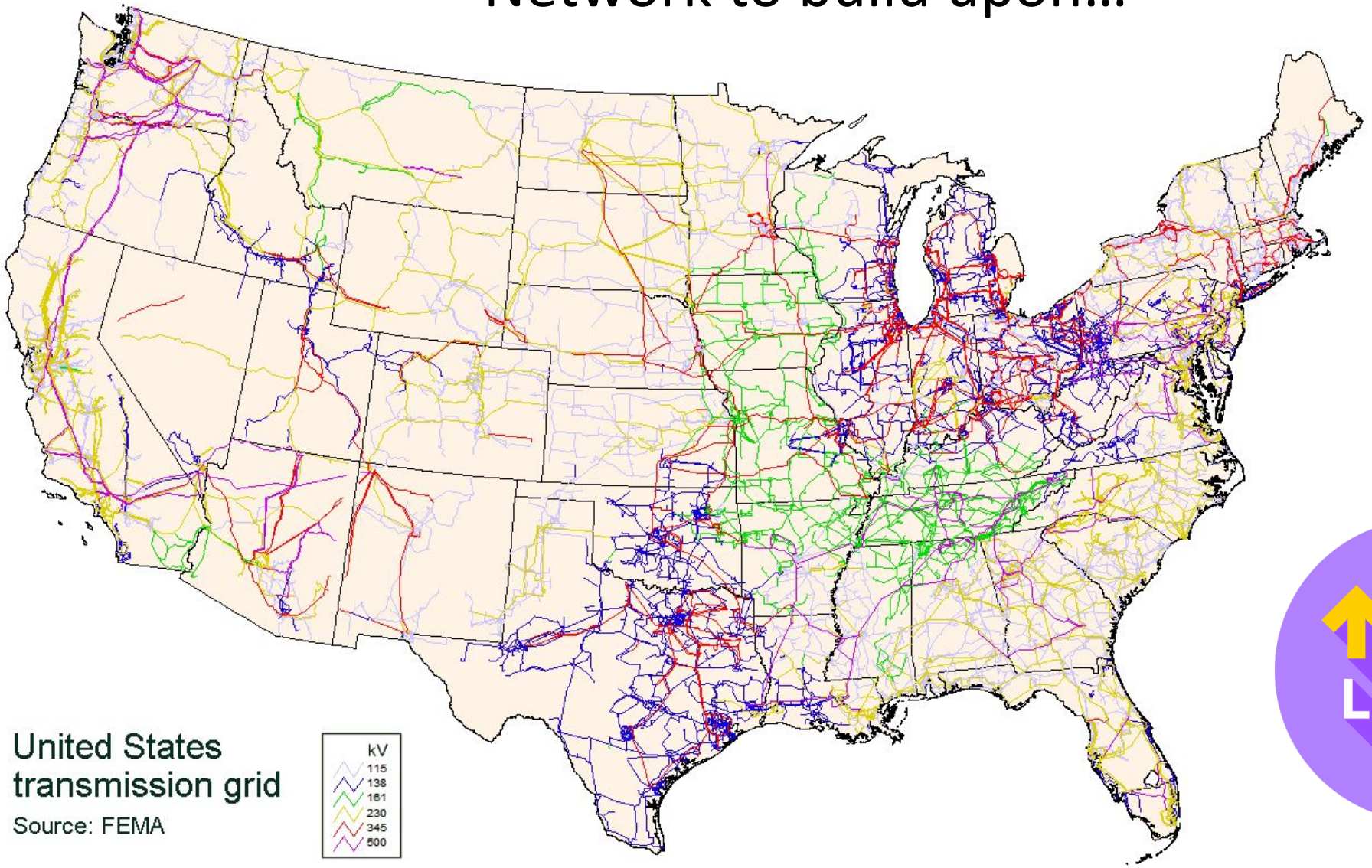
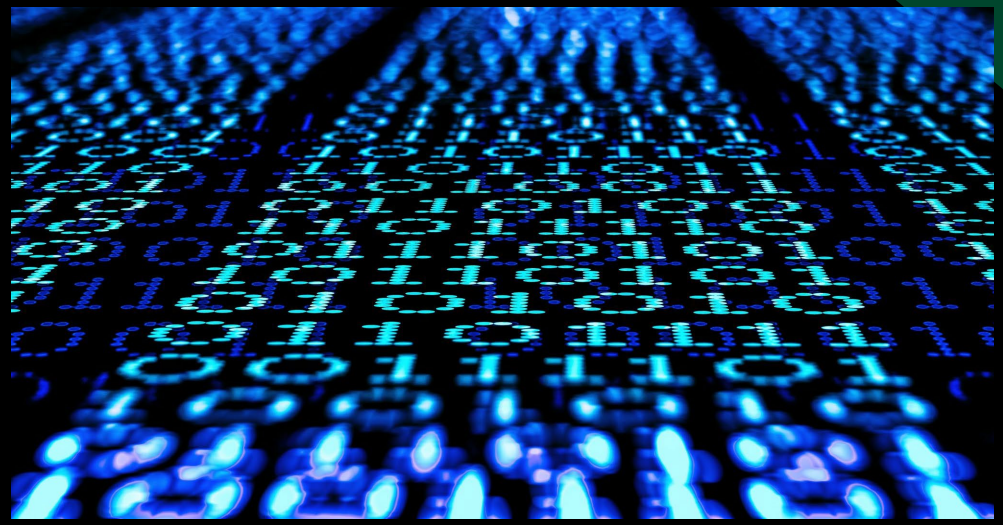
Network to build upon…



MultiCare

Discussion



Thank You for joining us today

Please email if you have further questions or comments:

Andy Gettinger (andrew.gettinger@dartmouth.edu)

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