NJ DSRIP
Learning Collaborative

Data Accuracy and Measurement

New Jersey Department of Health (NJDOH)
September 10, 2015

Prepared by: Myers and Stauffer LC
New Jersey DSRIP Journey – signs of change

Setting the Goal
Moving toward the Goal
Early Signs of Meeting the Goal

Data
Information
Knowledge
Action

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DSRIP Program Aims

Program objectives include:
• Improved quality and access of care
• Improved delivery and consistency of care
• Expansion of primary care

Program goals include:
• Improve population health
• Reduce unnecessary admissions/ readmissions
• Reduce unnecessary emergency department visits
• Manage the trajectory of the cost of health care

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Information Challenges

- Understanding all the steps in the data information flow
- Understanding what the data represents
- Understanding how to make the data meaningful
What is the data life cycle?

End to End Information Flow

HOSPITAL
- Documentation of Service
- Electronic Health Record
- Charge Capture System
- Billing System

MCO / STATE
- Managed Care Organization Adjudication
- MMIS System Capture
- Data Warehouse Storage

DSRIP PROGRAM
- DSRIP Database
- Patient Roster
- Performance Measures
- Web Portal

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What are the Key Steps to Measurement?

- Attribution
- Patient Roster
- Matching
- Chart/EHR Performance Measure Calculation

Who is responsible? What is the logic? Why does this matter? Will the list change?

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Who is responsible? – The DSRIP Team runs the attribution algorithm on all Charity Care, Medicaid and CHIP patients to link accountability of care based on past treatment history.

- Links patients to hospitals based on two years of a patient’s utilization pattern

- Based on Evaluation and Management Visits on claims – code list is located in the Appendix B - Programming Assumptions document

- 30/70 Weighting – most current year’s utilization has higher weighting

- Minimum threshold of ten percent (10%) of utilization per category is included in the attribution approach
Attribution Model - hierarchical, with 10% threshold

✓ What is the logic?

**Category 1:** Visits to hospital-based clinics
A hospital-based clinic is defined as a clinic that is allowed to bill under the hospital’s provider identifier, is included on the hospital’s cost report, and bills on the Universal Bill (UB) claim form with specified revenue codes (510-519). (Refer to Programming Assumptions - Appendix B for further detail.)

**Category 2:** Visits to emergency departments

**Category 3:** Visits to community-based reporting partners

**Category 4:** All other visits to non-participating providers

If the patient has visited multiple providers within a category, the patient will be linked to the provider who had the plurality (i.e. simple majority) of visits.
**Attribution Model - hierarchical, with 10% threshold**

### Patient Smith - Attribution Example:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Visits (unweighted)</th>
<th>Weighted Visits</th>
<th>Attribution Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category 1: Hospital-based Clinics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital-based Clinic A</td>
<td>4</td>
<td>1.2</td>
<td>Hospital-based Clinic</td>
</tr>
<tr>
<td><strong>Category Total</strong></td>
<td>4</td>
<td>1.2</td>
<td>Hospital-based Clinic</td>
</tr>
<tr>
<td><strong>Category %</strong></td>
<td><strong>5.19%</strong></td>
<td><strong>2.57%</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Category 2: Emergency Departments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital ED A</td>
<td>31</td>
<td><strong>19.7</strong></td>
<td>ED</td>
</tr>
<tr>
<td>Hospital ED B</td>
<td>31</td>
<td>19.3</td>
<td>ED</td>
</tr>
<tr>
<td>Hospital ED C</td>
<td>8</td>
<td>4.4</td>
<td>ED</td>
</tr>
<tr>
<td><strong>Category Total</strong></td>
<td>70</td>
<td><strong>43.4</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Category %</strong></td>
<td><strong>90.91%</strong></td>
<td><strong>92.93%</strong></td>
<td>ED</td>
</tr>
<tr>
<td><strong>Category 3: Community-based Reporting Partners</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community-based Partner</td>
<td>0</td>
<td>0</td>
<td>Project Partner</td>
</tr>
<tr>
<td><strong>Category Total</strong></td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Category %</strong></td>
<td>0.00%</td>
<td>0.00%</td>
<td>Project Partner</td>
</tr>
<tr>
<td><strong>Category 4: All other providers; No attribution</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FQHC</td>
<td>2</td>
<td>1.4</td>
<td>Non-Hospital</td>
</tr>
<tr>
<td>Physician</td>
<td>1</td>
<td>0.7</td>
<td>Non-Hospital</td>
</tr>
<tr>
<td><strong>Category Total</strong></td>
<td>3</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td><strong>Category %</strong></td>
<td><strong>3.90%</strong></td>
<td><strong>4.50%</strong></td>
<td>Non-Hospital</td>
</tr>
<tr>
<td><strong>Overall Total</strong></td>
<td><strong>77</strong></td>
<td><strong>46.7</strong></td>
<td></td>
</tr>
</tbody>
</table>
Attribution Model - hierarchical, with 10% threshold

Why does this matter?

• Collectively, your attributed patients have sought services to your DSRIP network, at either your hospital or one of your reporting partners.

• Your DSRIP network has the greatest opportunity to impact the care of these patients.

• Your attributed population is the basis for all performance measures, including your pay for performance measures.

All of your patients – including commercial payers, Medicare, Medicaid, CHIP, Charity Care, self-pay

Attributed patients only – Medicaid, CHIP, Charity Care
Attribution Model - hierarchical, with 10% threshold

✓ Will this list change?
  • Based on input from the industry, attribution will only occur once per year.

  • This will allow greater consistency as to which patients will be included in performance measurement during the year.

  • Note – patients who frequently change providers, or move in a year may be included in your performance measure even when the patient no longer seeks care at your facility.
Attribution Results

- Confirms that the majority of patients are being attributed based on ED visits.
What are the Key Steps to Measurement?

- Attribution
- Patient Roster
- Matching
- Chart/EHR Performance Measure Calculation

Who is included on my roster?
Patient Roster Matching

✓ **Who is included on my roster?**
  
  Patients attributed to your hospital. The roster is segmented to only include patients who have received services at your facility. It is your responsibility to exchange that information based on your Data Use Agreement.

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**Attributed patients only** – Medicaid, CHIP, Charity Care

<table>
<thead>
<tr>
<th>Was there a Service?</th>
<th>Will it be on the Patient Roster?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospital</td>
</tr>
<tr>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>

In instances where the patient was seen by both providers, the patient will be included on BOTH rosters.
What are the Key Steps to Measurement?

1. Attribution
2. Patient Roster
3. Matching

How do I match these patients in my system?

Chart/EHR Performance Measure Calculation

Standard Reporting Workbook

Prepared by Myers and Stauffer LC
Patient Roster Matching

✓ How do I match these patients in my system?

• Ensure you understand the field definitions. Example:
  
  o **Original unique Medicaid ID** - is assigned to a Medicaid member.
    ▪ Because Charity Care patients do not enroll and receive a Medicaid ID, hospitals submit the patient's **social security number** in this field.

  o **Current Medicaid ID** - is a second Medicaid number that provides information on the member's current eligibility enrollment.
    ▪ This number changes as a member moves between programs, categories, counties and age groups. The maximum date of service (most recent date) in the attribution period with a claim will be used.
    ▪ Because Charity Care patients do not enroll and receive a Medicaid ID, this field is used to indicate the percentage of Charity Care coverage that the patient has. (e.g. 800000000000 = 80%)

• Look at all systems that may include patient information. This could be your billing system if you do not have EMR capabilities.
Patient Roster Matching

Step 1 - Match data through column “Recipient Medicaid ID (Current)” to your hospital's internal “Policy Number” field in your hospital’s information management systems/databases.

Step 2 - Match data using column “Recipient Medicaid ID (Original)” column to your hospital's internal “Policy Number” field in your hospital’s information management systems/databases.

Step 3 - Match data using column “Patient Account Number” to your hospital's internal patient account number in your hospital's information management systems/databases.

Step 4 - Match data using demographic information including name, social security number, gender, date of birth to your hospital's information management systems/databases.
What are the Key Steps to Measurement?

What population is included?
What is the included and excluded criteria?
What role does my reporting partner play? How do I ensure my results are accurate?

Attribution

Patient Roster

Matching

Chart/EHR Performance Measure Calculation

Standard Reporting Workbook

Prepared by Myers and Stauffer LC
Performance Measure Calculation

➢ What population is included in the chart measures?

Inpatient Measures

NJ DSRIP Hospital-specific Attributed Patient Population

- Denominator eligible patients
- Numerator eligible patients

Your attributed patients are your defined population for both inpatient and outpatient performance measures.

Outpatient Measures

Reporting Partner
NJ DSRIP Hospital-specific Attributed Patient Population

- Denominator eligible patients
- Numerator eligible patients

Hospital-Based Clinic
NJ DSRIP Hospital-specific Attributed Patient Population

- Denominator eligible patients
- Numerator eligible patients

Your attributed patients are your defined population for both inpatient and outpatient performance measures.
Performance Measure Calculation

- **What population is included in the chart measures?**
  - If you are sampling data, the Initial Patient Total is the initial sub-set of patients.

![Diagram](image)

Reporting Partner
NJ DSRIP Hospital-specific Attributed Patient Population

Initial Patient Total
Denominator Eligible Patients
Numerator Eligible Patients

Prepared by Myers and Stauffer LC
Performance Measure Calculation

➢ What is the included and excluded criteria?

• Numerator and denominator criteria for each measure is provided in the databook. Detailed information can be found through the measure steward. Some measures have been adapted from the measure steward to more closely align with the goals and population of the New Jersey DSRIP program.

  o The denominator population is identified as:
    1. The NJ DSRIP Low income population attributed to each hospital within the specified performance period.
    2. The measure steward denominator specifications.
       • inclusion examples: diagnosis, age
       • exclusion examples: patients with limited coverage duration

  o The numerator is identified as:
    1. Denominator patients that meet numerator criteria.
       • inclusion examples: patients who have received defined treatment protocols or services
Performance Measure Calculation

What role does my reporting partner play?

- Supports hospital reporting requirements to receive full Stage 3 and Stage 4 incentive awards, including pay for performance achievement.
- Fulfills all performance measure obligations per the databook.
- Downloads patient roster from secure site and matches to internal systems.
- Abstracts, computes and submits outpatient measure data to hospital, or allows hospital, or third-party staff to fulfill these requirements.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Community-based Reporting Partner</th>
<th>Enhanced Reporting Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does NOT bill under the hospital’s provider identifier with specified revenue codes 510 – 519</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Is a Medicaid-enrolled clinic, facility or physician practice group that can/ will comply with reporting outpatient data</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Has a Data Use Agreement, or other formal data sharing arrangement in place by</td>
<td>October 2014</td>
<td>July 2015</td>
</tr>
<tr>
<td>Employment relationship or ownership with the hospital/ hospital system</td>
<td>May have an existing relationship</td>
<td>May Not have an existing relationship</td>
</tr>
<tr>
<td>Eligible for an incentive adjustment from 10% to 8% Gap Reduction</td>
<td>If patient volume ≥ 1000 Low Income</td>
<td>✓</td>
</tr>
</tbody>
</table>
Performance Measure Calculation

- How do I ensure my results are accurate and show improvement?

"That, detective, is the right question."

"Program terminated."
Performance Measure Calculation

How do I ensure my results are accurate and show improvement?

- Are all the steps in the process:
  - CLEAR
  - DOCUMENTED
  - VALIDATED
  - REPLICABLE
Performance Measure Calculation

Can your hospital’s DSRIP team answer the following questions?:

1. Who is responsible for running our data queries?
2. Have all of our applicable systems been considered for capturing inclusion and exclusion criteria?
3. Do all our measures start from our attributed population?
4. Are our data queries documented for all reportable measures?
5. Are these procedures saved to a shared location?
6. If a team member is on vacation, or leaves, do we have clear backup plans in order to report timely to achieve full incentive payment?
7. Do we have documented timelines?
Performance Measure Calculation

- Can your hospital’s DSRIP team answer the following questions?:

  8. Have we entered all data correctly on the Standard Reporting Workbook?

  9. Have we confirmed this by reviewing our results on the Measure Results page of the DSRIP web portal?

  10. Who is responsible for managing our relationship with our reporting partner(s) to support fulfillment of DSRIP goals?

  11. Can we confirm that our reporting partner/third-party vendor understands all performance measure requirements? Can our reporting partner/vendor answer these same questions?

  12. Are we tracking our performance over time?

  13. Are we sharing our results with key stakeholders and leadership?
What are the Key Steps to Measurement?

1. Attribution
2. Patient Roster
3. Matching
4. Chart/EHR Performance Measure Calculation

Standard Reporting Workbook
Performance Measure Calculation

Confirm data is submitted correctly.

If a hospital has three hospital sites reporting data, 3 columns should be filled out for inpatient measures.

<table>
<thead>
<tr>
<th>Measure - Format</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Name</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[Name of Measure is Pre-populated]</td>
<td>[Enter the operating name of the reporting entity.]</td>
<td>[Enter the operating name of the reporting entity.]</td>
<td>[Enter the operating name of the reporting entity.]</td>
<td>[Enter the operating name of the reporting entity.]</td>
<td>[Enter the operating name of the reporting entity.]</td>
</tr>
<tr>
<td>DSRIP #</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[DSRIP Number is Pre-populated]</td>
<td>[Enter the NJ Medicaid ID that is related to the reporting entity.]</td>
<td>[Enter the NJ Medicaid ID that is related to the reporting entity.]</td>
<td>[Enter the NJ Medicaid ID that is related to the reporting entity.]</td>
<td>[Enter the NJ Medicaid ID that is related to the reporting entity.]</td>
<td>[Enter the NJ Medicaid ID that is related to the reporting entity.]</td>
</tr>
<tr>
<td>Initial Patient Total</td>
<td>[Enter the total number of patients that meet the denominator criteria.]</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Denominator</td>
<td>[Enter the total number of records that are required to be]</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Prepared by Myers and Stauffer LC
Performance Measure Calculation

Confirm data is reported correctly.
Best practice –

- Track your performance over time.
- Continue to assess your project interventions. Make work flow adjustments and insert evidence-based practices.
- Monitor your DSRIP project patients and attributed patients.
Information to Knowledge - Early Results

- Identification and tracking of attributed patients.
- Determining whether the patient is connected to a PCP.
Information to Knowledge - Early Results

- Identification and tracking of attributed patients.
- Determining what happens when an attributed patient seeks service through the ED.
Information to Knowledge - Early Results

- Identification and tracking of patients with the applicable project diagnosis.
- Determining what information is collected, traceable and impacts metrics.
Overall decline in 2013 suspected result of transition from Charity Care to Managed Medicaid.
Suspect that the Unattributed Patients’ low ED rate per 1,000 members indicates managed patients that were unattributed because they are seeking preventive services from non-participating primary care providers.
Learning Collaborative Discussion

- What do we know now?
- What questions remain unanswered or unclear?
Learning Collaborative Discussion

1. What was a challenge that you encountered matching patients from the patient roster and how did you overcome it?

2. What was a coordination issue between your team and a vendor or reporting partner’s team? How will it be solved in the future?

3. Was information required from a measure that was only available from chart pulls? How is this data being added to an electronic system for easier retrieval?

4. What impact will the ICD-10 conversion have on your existing process?
Q & A