Center for Health Policy at BROOKINGS

Enhancing Care Delivery through Frontline Health Care Workers- Perspectives from Payers and Purchasers

Webinar

September 9, 2015

Housekeeping

- To minimize feedback, please confirm that the microphone on your telephone is muted.
- To mute your phone, press the mute button or *6. To un-mute, press *7.
- There will be several opportunities for questions and discussion throughout today's session. **Please use the chat window on the right of your screen to submit your questions into the queue at any point** and we will call upon you to state your question.
- Call the WebEx Help Desk at 1-866-229-3239 with technical problems.

AGENDA

- Introductions
  - Kavita K. Patel, Fellow and Managing Director
- Background of Work at the Hitachi Foundation
  - Mark Popovich, Vice President for Program
- Anthem
  - Karen Frederick Gallegos, Director of Community Transformation, Enhanced Personal Health Care
- National Business Group on Health
  - Shari Davidson, Vice President
- Questions/Closing Remarks

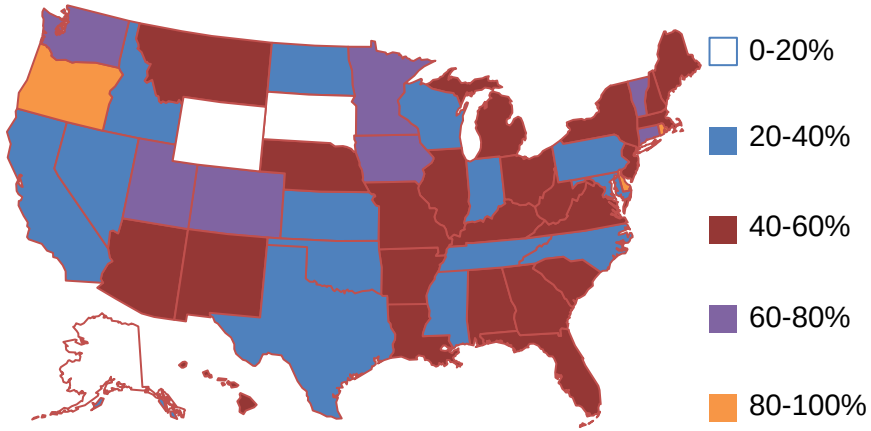
- Social Media: @brookingsmed @hitachifdn

Center for Health Policy at BROOKINGS

PCMH Prevalence and Experience Varies Widely

Proliferation of Medical Homes by State

(% of Practices Recognized as Medical Homes, as of March, 2014)



NCQA[1] Certification Elements

1. Access and Communication
2. Patient Tracking and Registry Functions
3. Care Management
4. Patient Self-Management and Support
5. Electronic Prescribing
6. Test Tracking
7. Referral Tracking
8. Performance Reporting and Improvement
9. Advanced Electronic Communication

!

- Many traditional medical homes struggling to control costs
- Practices will need to employ advanced medical features in order to improve quality while decreasing costs

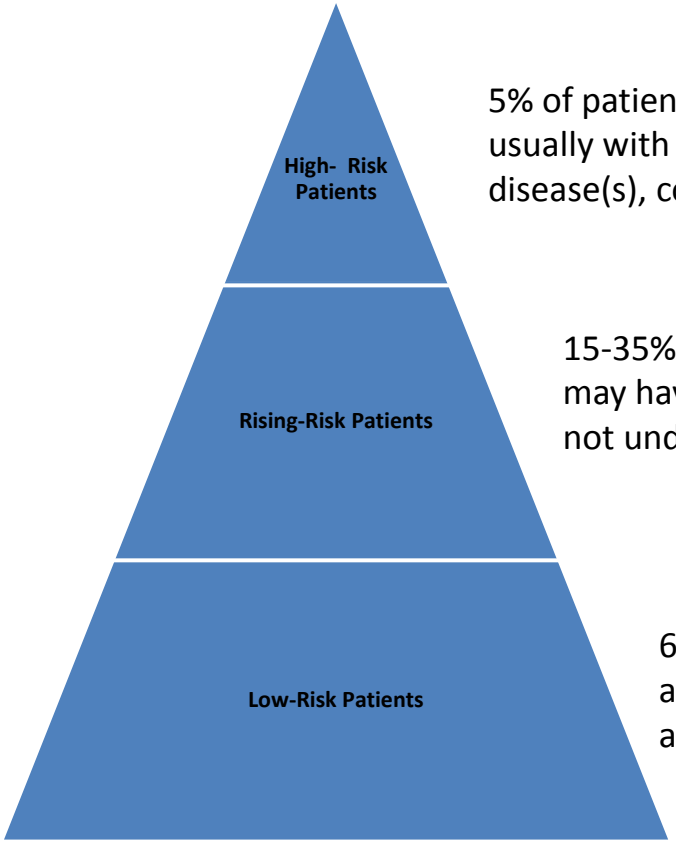
1) National Committee for Quality Assurance

Source: National Committee Quality Assurance, A New Model of Care Delivery; "Patient-Centered Medical/Health Home Initiative Update", Bureau of Primary Health Care – Health Resources Services Administration, June 16, 2014

Proactive Management of Whole Populations

Expanding Focus from High-Risk to Rising-Risk Patients

Managing Three Distinct Patient Populations



5% of patients; usually with complex disease(s), comorbidities

→ Trade high-cost services for low-cost management

15-35% of patients; may have conditions not under control

→ Avoid unnecessary higher-acuity, higher-cost spending

60-80% of patients; any minor conditions are easily managed

→ Keep patient healthy, loyal to the system

Building on the Critical Elements of the Traditional Medical Home

	Traditional Medical Home	Advanced Medical Home
Care Team	• PCP-centric → RN-centric	• RN → MA[1], non-clinical staff • Further prioritization of PCP time to complex primary care cases
Practice	• Team huddle	• Streamlined EMR workflows
Patient Experience	• Health coaching • Proactive outreach	• Reduced patient idle time • Improved access, virtual contact
Model Goal	• Stabilize primary care • Improve quality	• Increase capacity • Improve quality; decrease costs

1) Medical Assistant.

A Foundation at the Intersection of People & Profit

- **The Hitachi Foundation:** Independent foundation established by Hitachi, Ltd. in 1985

- **What we do:** Discover, demonstrate and expand business practices that improve economic opportunities for low-wealth individuals in the U.S. *and* enhance long term business value

- **How we do it:** Two signature programs

GOOD COMPANIES @WORK

ENTREPRENEURSHIP @WORK

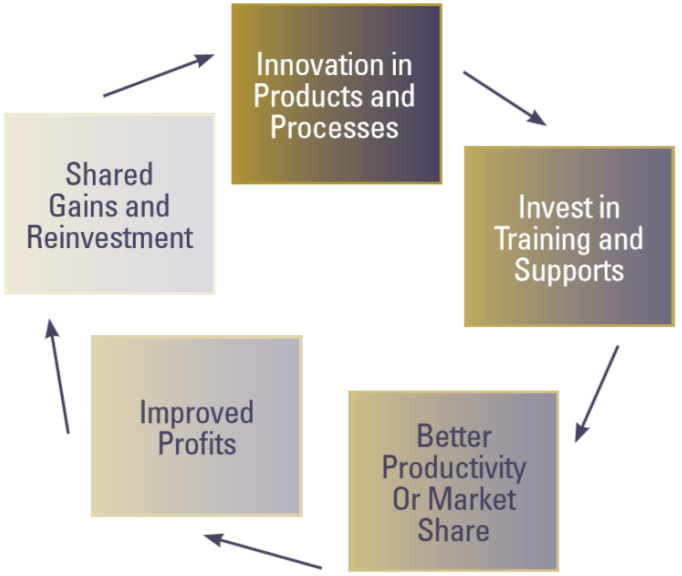
Good Companies @Work

- Corporations invest in people
  - $70 billion + annually on T&D
  - Largest share to leadership development

- We wanted to know:
  - Who invests in front-line, lower skilled workers?
  - Why and how do they invest and what's the payoff?

The Pioneer Employers Initiative

- 90 + case studies in healthcare and manufacturing;
- Showed impacts on turnover/retention, productivity, revenue, quality, and profitability;
- Higher earnings and career ladders for workers;
- Not “efficiency wages” – job redesign is key.



The Pioneers of Primary Care

2009-13: 19 case studies + toolkits and training resources by UCSF Center for the Health Professions and Brookings Center for Health Policy.

- New roles and responsibilities for Medical Assistants (MAs) within advanced medical home models
- Included standalone FQHCs, multispecialty clinics, and larger integrated systems/ACOs

Enhanced Personal Health Care

September 9, 2015

Enhancing Care Delivery through Front Line Health Care Workers: Perspectives from Payers and Purchasers

Karen Frederick Gallegos
Director of Community Transformation
Enhanced Personal Health Care

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Anthem Togetherworks Capabilities

Payment solutions	The programs we use to share risk and rewards with providers
Business solutions	The continuum of relationships that we engage in with providers
Data solutions	The data reporting and data implementation support we offer
Advisory solutions	The business know-how we share to support providers and employers
Experience solutions	The level of ease and seamlessness we enable for members

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Three Ways Enhanced Personal Health Care Promotes a Better Delivery System

Enhanced Personal Health Care

Value-Based Payment

Support for Patient-Centered Care

Exchanging Meaningful Information

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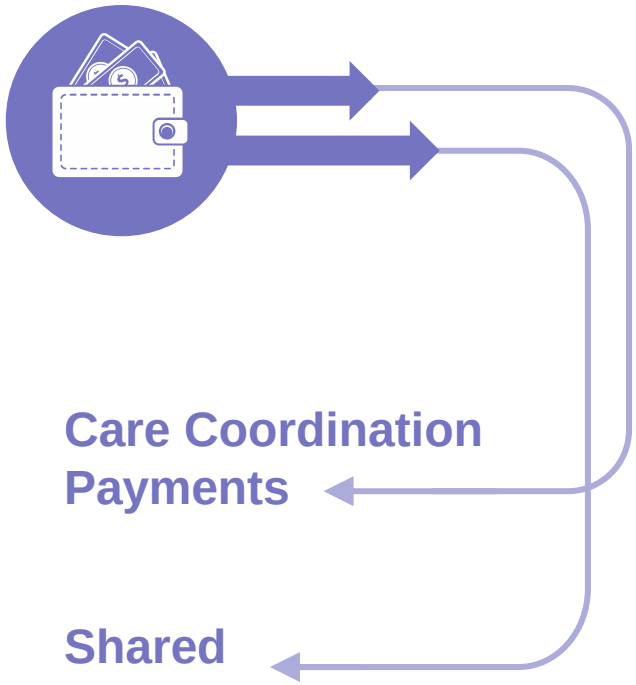
Enhanced Personal Health Care

Value-Based Payment



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Quality Improvement Measures

There are 27 Clinical Quality Measures that support the Provider Score Card broken into three categories:

Prevention Measures

Utilization Measures

Acute and Chronic measures

Quality gate

Providers must meet a minimum performance threshold on clinical quality measures before they are eligible to earn shared savings.

Overall determinant of proportion of shared savings

After the quality gate is satisfied, the proportion of shared savings the provider receives depends on scores in three categories, and the improvement score. The better the performance, the greater the shared savings earned.

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Support for Patient-Centered Care

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Deeper insights into how we get results:

Our team of Transformation Experts

Care Consultant

- Work flow and process improvement expert
- Identifies interventions that improve health outcomes
- Works collaboratively with providers to establish transformation action plans
- Develops learning collaborative content based on best practices from national experts. Creates peer-to-peer learning opportunities
- Identifies community resources to help practices manage population health

Provider Clinical Liaison

- Helps practices develop care management skills, interpret reports & ID high-risk patients
- Helps organizations manage Attributed Members with complex needs
- Fosters seamless coordination between the PCP and plan-sponsored programs

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Channels of Engagement:

Many roads to achieve quality and cost results

On-site consulting

- Joint Operating Committee structure that includes Network, Contracting and Transformation.
- Field team engages practice in understanding data, identifying opportunities, developing action plans and next steps
- QI principles, Intervention Bundles and CM Methodologies are used to drive improvement

Collaborative learning

- Learning Library Recordings shared monthly
- Monthly virtual “Office Hours”
- National and State- specific sessions
- Web and Action Series

Transformation tools

- Web Based Reporting and Member longitudinal record
- On-demand library of recorded presentations and resources
- Data-driven Transformation Action Plans
- Intervention Bundles address quality and cost of care
- Access to web-based ACP Practice Advisor® tool

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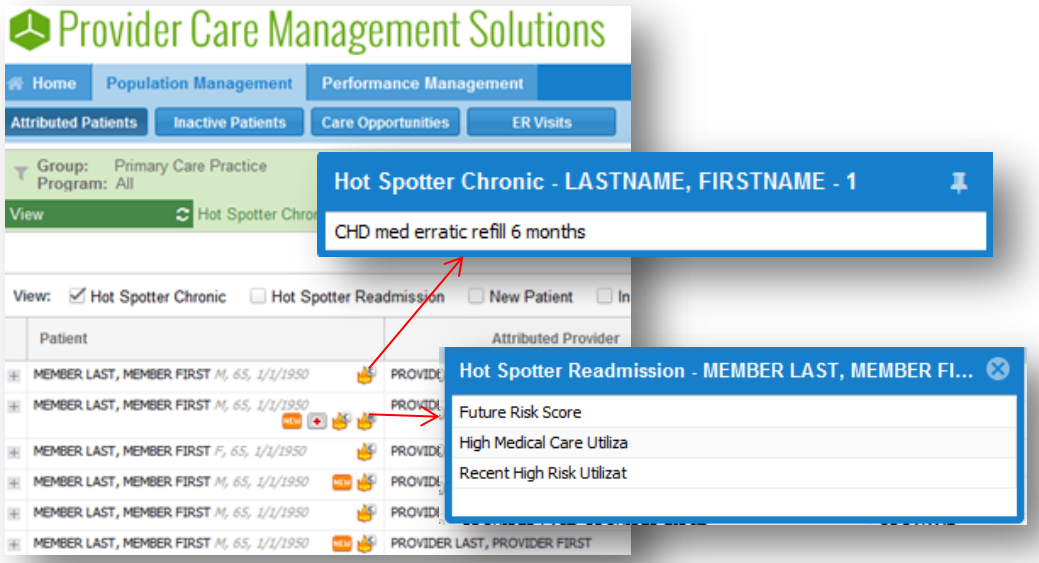
Exchange of information

We provide actionable analytic reports that offer insight into:

- Avoidable and unnecessary ER use
- Gaps in care
- Attributed high-risk/high-cost members
- Admission and Readmission Reports

We provide interpretive guidance

The data and the tools providers need to intervene, improving the health status of patients and reducing costs associated with avoidable ER visits, readmissions and other cost drivers.



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Case Studies

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Medication Reconciliation: Education and Training

Practice: Ambulatory Care Clinic

Location: Maine

Intervention:

Training need identified during PCL and Pharmacist combined clinical review calls while discussing members gaps in care.

Presented Medication Reconciliation Education and Training to the clinical staff on Aug 11

Training Intent:

- How to conduct patient interview to inquire about patients current medications
- The thought process of critical thinking involved with performing the medication reconciliation

This organization develops learning objectives, Medical Assistant (MA) cards and presentation evaluations for each learning event

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Medication Reconciliation: Education and Training

MA Cards are laminated for the MA to keep on hand to support their clinical responsibilities

Medication Reconciliation

Step 1: Verification
Collecting medication history
Gather ALL medications from ALL sources:

- -Interview
- -Home med list
- -Meds brought in by the patient
- -Friends or family members
- -Medical records
- -Pharmacy
- -Rx claims in MMH+
- -Discharge instructions
- -Specialists

Review and compare ALL medications

Step 2: Clarification
Ensure medications and doses are appropriate
When clarifying the medications, looking for a "one to one" match!
Check for:

- -Changes in strength (12.5mg vs. 25mg)
- -Changes in dose (1 tablet vs. ½ tablet)
- -Changes in frequency (once a day vs. twice a day)
- -Validate the quantity and corresponding day supply
- -Drug Omissions (missing) and drug additions
- -Therapeutic duplications (this can occur if the patient doesn't keep an up-to-date med list)
- -Difference between what is prescribed and patient actual pattern of use
- -Drug-drug and drug-disease interactions, and contraindications

Medication Reconciliation

Step 2: Clarification
Critical Thinking Process to Identify and Clarify Discrepancies

- -"One-to-one match"
- -Intended discrepancy (purposeful)
- -Unintended discrepancy

Step 3: Reconciliation
Documentation of changes in the chart

- -Occurs after medication list is confirmed and discrepancies identified
- -Provider can make appropriate medication changes based on patients' clinical status
- -Document the medication changes clearly in the medical record for future review
- -Communication and share the reconciled list with patients, caregivers and all other providers involved in care
- -Share changes with the pharmacy to reduce potential for medication errors (automatic refills or refilling the wrong med)

Ask Probing Questions to Improve Medication Reconciliation:

- -Ask: "What medications are you currently taking?"
  "What medications do you take as needed?"
  "What medications do you take for your blood pressure?"

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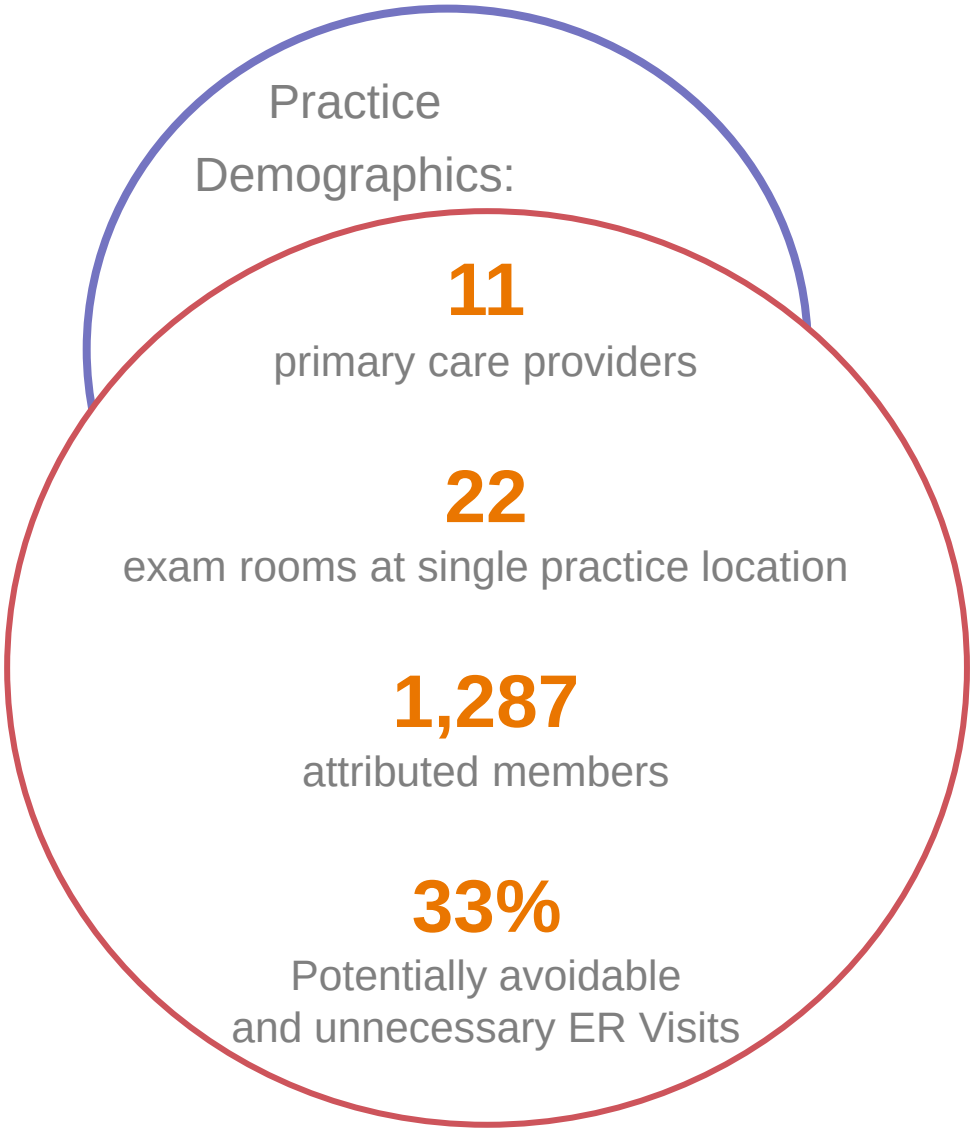
Transformation in Action:

Case Study:

Family Practice



Goal: Reduce potentially avoidable **and unnecessary** ER Visits by **10%** by Dec. 31, 2014

Technologically savvy

- Level III PCMH status by the NCQA
- Web-based Clinical Decision Support System to help ID high-risk patients
- Staff use eClinical Mobile to send telephone encounters, check schedules and messages, register new patients

Committed to enhanced access and patient-centered care

- Open access protocol: patients seen same-day without appointment
- Extended hours: 8:00 am – 8:00 pm Monday-Friday; urgent care on Saturday

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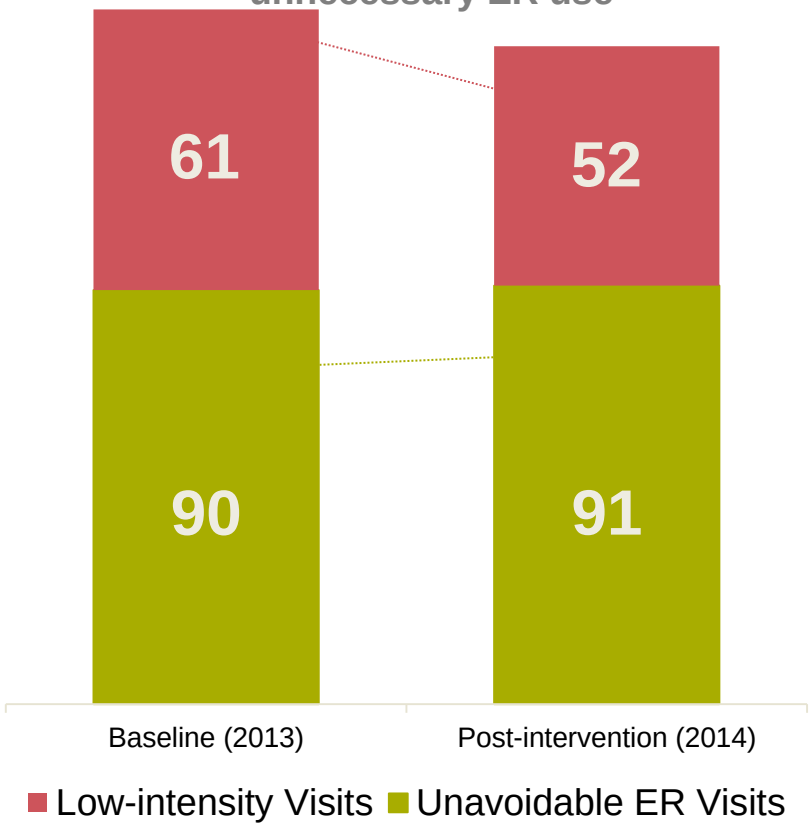
Education and Communication

Case Study:
Family Practice

- Educate providers on avoidable and unnecessary ER diagnoses
- Create posters to hang in all exam rooms
- Survey patients about ER usage
- Update website with extended office hours
- Email blast for patient outreach
- Create ER tracking registry

14.7%

decrease in low-intensity and unnecessary ER use



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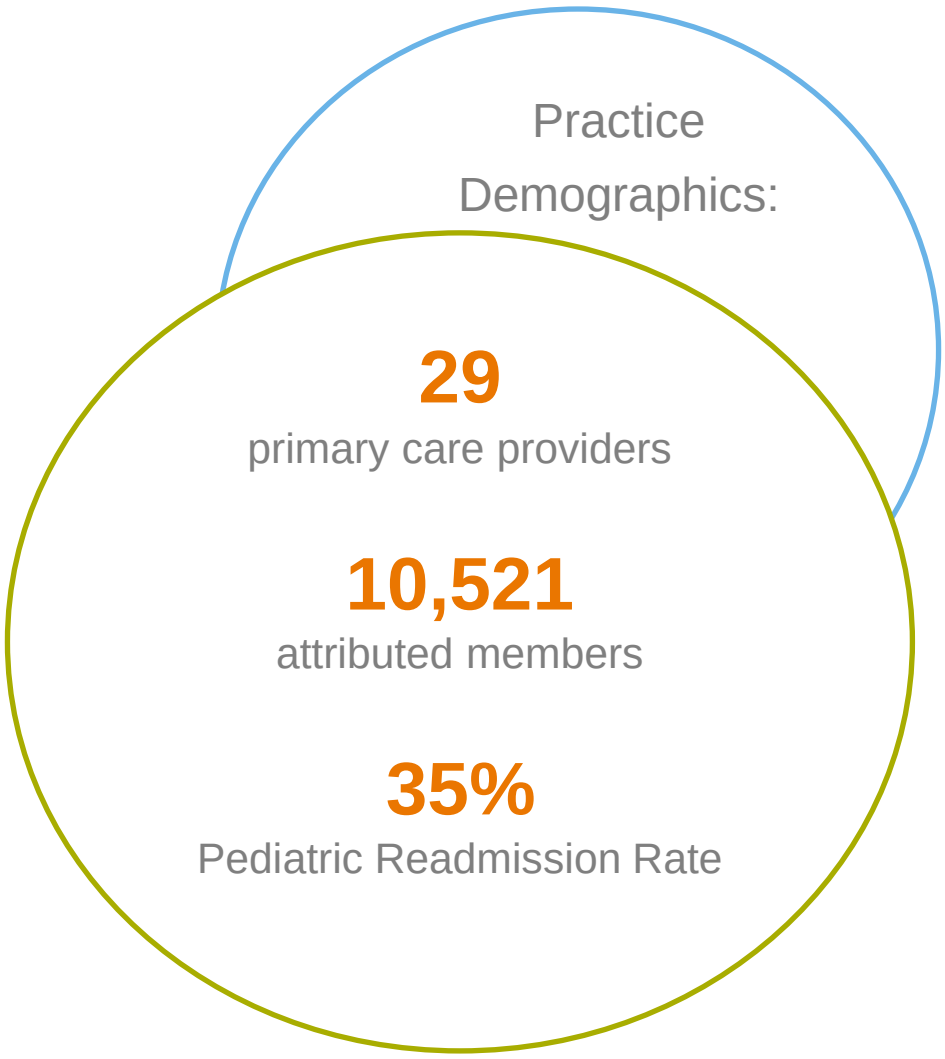
Transformation in Action:

Case Study:

Medical Clinic



Goal: Follow up on 100% of high risk Pediatric Patients identified on EPHC reports

Large Multi-specialty Provider

- Clinic runs a Quick Care Center
- Employs Diabetic RN Educator
- Offers a patient portal

Improve Care Planning for High Risk Pediatric Patients:

- Improve care coordination skills of staff
- Improve patient/family communication
- Improve medication reconciliation
- Educate staff and families about resources available

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Education and Communication

Case Study:

Medical Clinic

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- Payment solutions
- Business solutions
- Data solutions
- Advisory solutions
- Experience solutions

- Care coordinators trained on care planning and care coordination principles
- Identify patients that could benefit from enhanced care planning
- Review patient charts for gaps in care, missing clinical info from hospitals/specialists, reconcile meds
- Identified team leads to work with Anthem transformation and communicate with rest of team
- Outreach to families to assess needs and schedule follow up appt.
- Staff completed online training on Care Transition Planning through ACP Practice Advisor

Goal Met

Within 3 months, 100% of High Risk Pediatric Patients had proactive outreach

Questions?

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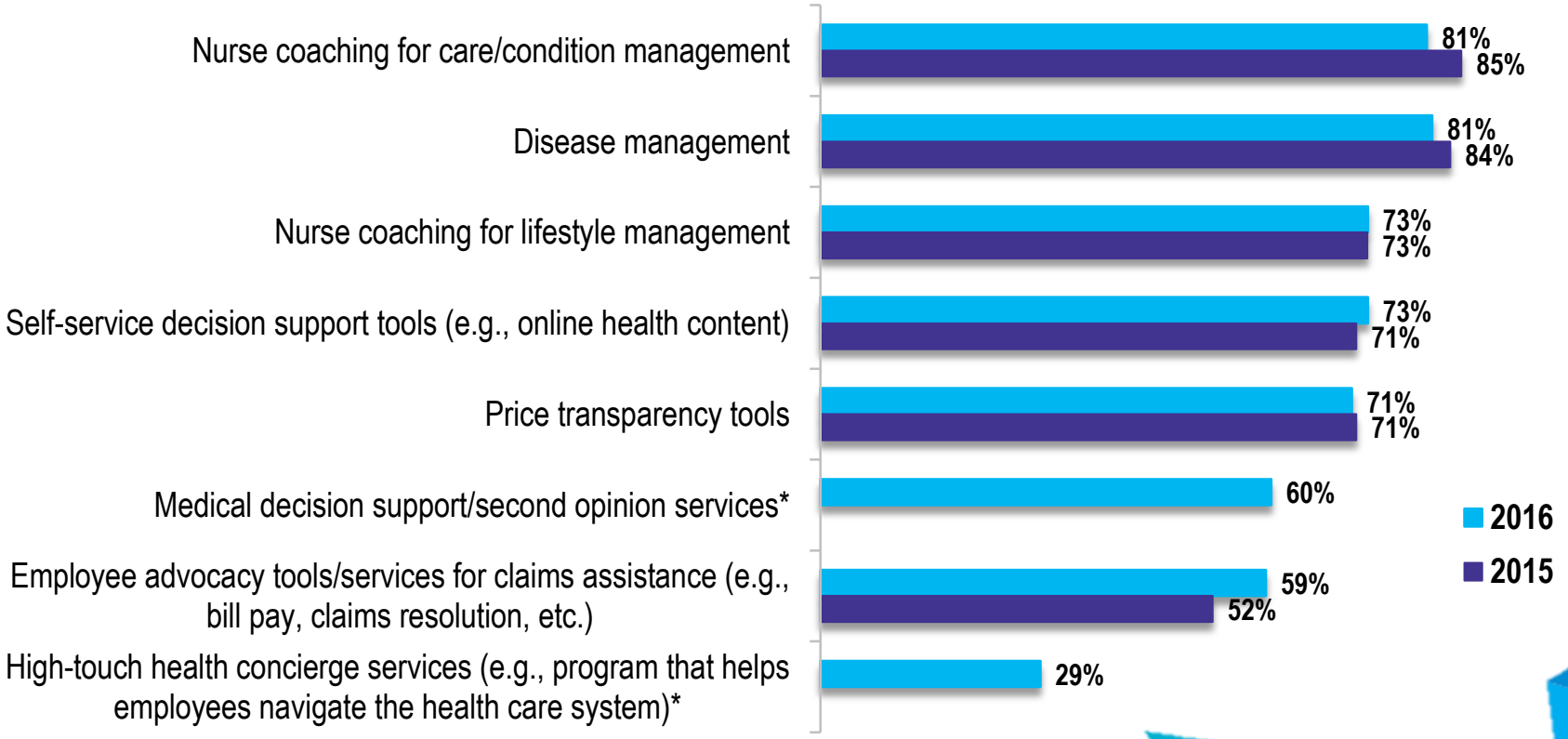
Shari Davidson

Vice President
National Business Group on Health

National Business Group on Health®

Members of the National Business Group on Health

Employer Tools and Programs



* Denotes options that were not asked in last year's survey.

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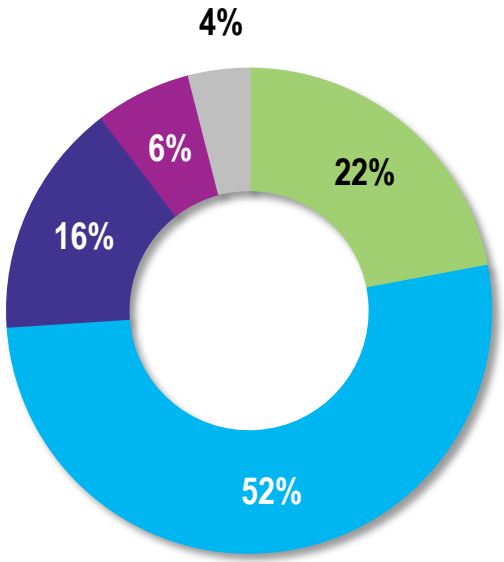
2016 Use of Telehealth



There has been considerable growth in employers offering telehealth. Next year, 74% of employers offer telehealth services to their employee, up from 48% this year

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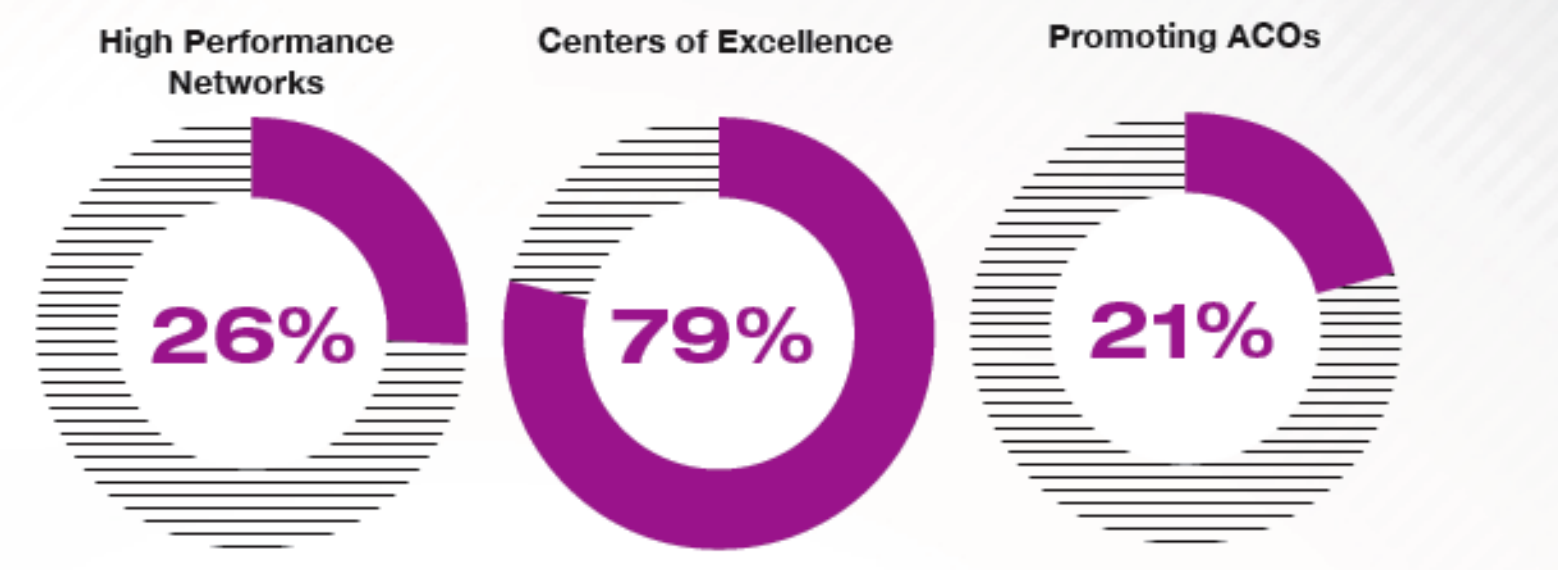
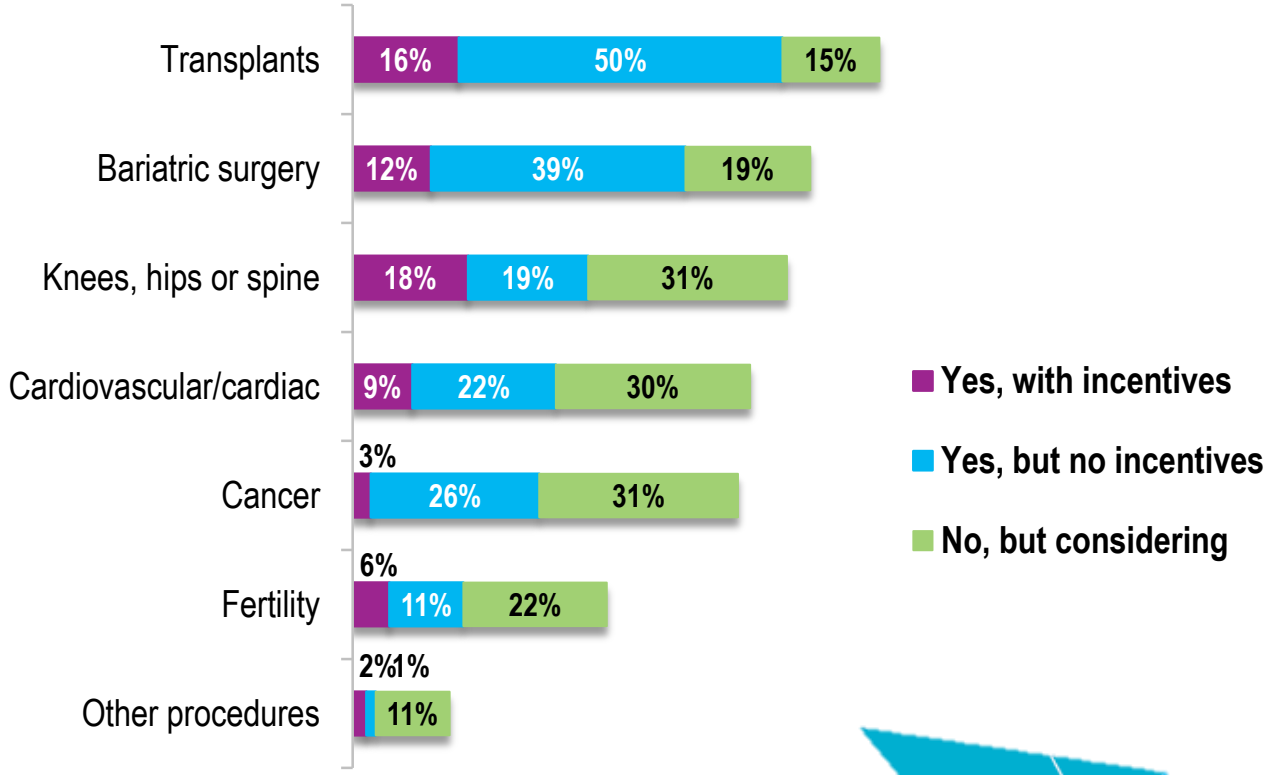
2016 Delivery Reform Initiatives



2016 Use of Centers of Excellence



Note: Other centers of excellence programs included: maternity; NICU; sleep apnea; pancreas; cornea; and kidney.

For More Information

- Email Kpatel@brookings.edu
- Visit our website for more information, case studies and blog posts related to this topic and more!

- http://www.brookings.edu/about/centers/health/focus-areas/delivery-system-reform/hitachi-care-team-initiative#recent_rr/

- Stay tuned for our final webinar at the end of September