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
PCMH Prevalence and Experience Varies Widely

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

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

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

Source: National Committee for 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

- **High-Risk Patients**: 5% of patients; usually with complex disease(s), comorbidities
  - **Trade high-cost services for low-cost management**

- **Rising-Risk Patients**: 15-35% of patients; may have conditions not under control
  - **Avoid unnecessary higher-acuity, higher-cost spending**

- **Low-Risk Patients**: 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

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<tr>
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<th>Traditional Medical Home</th>
<th>Advanced Medical Home</th>
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<tbody>
<tr>
<td><strong>Care Team</strong></td>
<td>• PCP-centric → RN-centric</td>
<td>• RN → MA&lt;sup&gt;1&lt;/sup&gt;, non-clinical staff</td>
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<td></td>
<td></td>
<td>• Further prioritization of PCP time to complex primary care cases</td>
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<td><strong>Practice</strong></td>
<td>• Team huddle</td>
<td>• Streamlined EMR workflows</td>
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<td><strong>Patient Experience</strong></td>
<td>• Health coaching, Proactive outreach</td>
<td>• Reduced patient idle time</td>
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<td>• Improved access, virtual contact</td>
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<td><strong>Model Goal</strong></td>
<td>• Stabilize primary care, Improve quality</td>
<td>• Increase capacity</td>
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<td>• Improve quality; decrease costs</td>
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<sup>1</sup> 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

• 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

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Karen Frederick Gallegos
Director of Community Transformation
Enhanced Personal Health Care
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
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
Enhanced Personal Health Care

Value-Based Payment

Care Coordination Payments

Shared Savings
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.
Support for Patient-Centered Care
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
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
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.
Case Studies
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
## 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

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)
- Intended 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?”
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
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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Low-intensity Visits | Unavoidable ER Visits
61 | 52
90 | 91

Low-intensity Visits | Unavoidable ER Visits
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

Practice Demographics:

29 primary care providers

10,521 attributed members

35% Pediatric Readmission Rate
Education and Communication
Case Study: Medical Clinic

- 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
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Shari Davidson
Vice President
National Business Group on Health
**Employer Tools and Programs**

- Disease management: 81% (2016), 84% (2015)
- Nurse coaching for lifestyle management: 73% (2016), 73% (2015)
- Self-service decision support tools (e.g., online health content): 73% (2016), 71% (2015)
- Price transparency tools: 71% (2016), 71% (2015)
- Medical decision support/second opinion services*: 60% (2016)
- Employee advocacy tools/services for claims assistance (e.g., bill pay, claims resolution, etc.): 59% (2016), 52% (2015)
- High-touch health concierge services (e.g., program that helps employees navigate the health care system)*: 29% (2016)

* Denotes options that were not asked in last year’s survey.
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.
2016 Delivery Reform Initiatives

High Performance Networks: 26%
Centers of Excellence: 79%
Promoting ACOs: 21%
2016 Use of Centers of Excellence

- **Transplants**: 16% Yes, with incentives, 50% Yes, but no incentives, 15% No, but considering
- **Bariatric surgery**: 12% Yes, with incentives, 39% Yes, but no incentives, 19% No, but considering
- **Knees, hips or spine**: 18% Yes, with incentives, 19% Yes, but no incentives, 31% No, but considering
- **Cardiovascular/cardiac**: 9% Yes, with incentives, 22% Yes, but no incentives, 30% No, but considering
- **Cancer**: 6% Yes, with incentives, 26% Yes, but no incentives, 31% No, but considering
- **Fertility**: 11% Yes, with incentives, 22% No, but considering
- **Other procedures**: 11% No, but considering

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