Go (Primary Care) Team! Team-based Care in the Medical Home

C. Edwin Webb, American College of Clinical Pharmacy
Jennifer Baldwin, CareFirst
Lewis Levy, Best Doctors
Richard Ricciardi, AHRQ
Melissa Thomason, Patient, Family Advisor
John Weiss, ACICBL
PATIENT-CENTERED PRIMARY CARE COLLABORATIVE

Presented by Jennifer Baldwin, RN MPA
Senior Vice President, Patient-Centered Medical Home (PCMH)
CareFirst BlueCross BlueShield

November 13, 2014
Agenda

Background

- Focus on Chronic Conditions
- Differentiating Factors of CareFirst PCMH

PCMH Overview

- Total Global Budget
- Quality Score
- Outcome Incentive Award
- Program Strategies

Program Results
The Prevalence of Chronic Conditions is 46% and Rising

Number of People With Chronic Conditions (in millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Pop</th>
<th>% of Pop with Chronic Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>262.8M</td>
<td>44.9%</td>
</tr>
<tr>
<td>2000</td>
<td>276.1M</td>
<td>45.3%</td>
</tr>
<tr>
<td>2005</td>
<td>296.4M</td>
<td>44.9%</td>
</tr>
<tr>
<td>2010</td>
<td>309.3M</td>
<td>45.6%</td>
</tr>
<tr>
<td>2015</td>
<td>325.5M</td>
<td>45.8%</td>
</tr>
<tr>
<td>2020</td>
<td>341.4M</td>
<td>46.0%</td>
</tr>
<tr>
<td>2025</td>
<td>357.5M</td>
<td>45.9%</td>
</tr>
<tr>
<td>2030</td>
<td>373.5M</td>
<td>45.8%</td>
</tr>
</tbody>
</table>


Concentration of Costs in a Few

“A small percentage of CareFirst’s Members consume approximately half of all of the Company’s health care spending in the region. This mirrors the national experience.”
(Program Description & Guidelines, January 2014)

72% of admissions were for members in bands 1 and 2

Percent of Population | Percent Of Cost | Cost PMPM
--- | --- | ---
3.2% | 36.6% | $3,215
9.0% | 26.2% | $798
13.1% | 17.2% | $367
27.1% | 14.5% | $153
47.6% | 5.5% | $38

Advanced / Critical Illness Band 1

Multiple Chronic Illnesses Band 2

At Risk Band 3

Stable Band 4

Healthy Band 5

Source: CareFirst HealthCare Analytics – Commercial, Under 65 Population – 2013
Patient-Centered Medical Home Field Operations

- 1M Attributed Members
- 20 Regions spanning Maryland, the District of Columbia and Northern Virginia
- 4,000 enrolled PCPs and NPs
- 425 Medical Panels
- 300 Nurses
- 10,559 care coordination plans YTD
Total Cost of Care Initiative

All elements are tightly integrated and designed to work together, coordinated by the care team.
PCPs are Accountable for Care in All Settings

PCPs: Caring for the whole patient and influencing the entire medical dollar.

Source: CareFirst HealthCare Analytics – Medical spending is based on claims paid in 2012 for the CareFirst Book of Business Excluding Over 65. The Pharmacy % is adjusted to represent typical spend for members with CareFirst’s pharmacy benefit.
Differentiating Factors of the CareFirst PCMH Program

- Credible data and analytic support
- Significant, meaningful financial incentives
- High touch with superior technical support

- 22 Program Consultants
- 120 SearchLight Reports
- 300 Nurses
- iCentric
- Service Request Hub
- 12% Participation
- $200/100 Care Plan
- Outcome Incentive Award
- 120 SearchLight Reports
- 300 Nurses
- iCentric
- Service Request Hub
- 12% Participation
- $200/100 Care Plan
- Outcome Incentive Award
Overview of PCMH Program

- Total Global Budget
- Quality Score
- Outcome Incentive Award
- Program Strategies
Patient Care Account

A global budget is established for each Panel.

<table>
<thead>
<tr>
<th>Actual (Debits)</th>
<th>Expected (Credits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All services paid by CareFirst including member’s coinsurance, copay, and deductible (Allowed Amount*)</td>
<td>All global CareFirst expected care costs shown as Per Member Per Month (PMPM)</td>
</tr>
</tbody>
</table>

The global budget is adjusted to reflect Overall Medical Trend, or healthcare inflation, and the acuity of the members based upon the average Illness Burden.
## Patient Care Account - One Patient

### Mary Smith – One Member for 2013

<table>
<thead>
<tr>
<th>Date</th>
<th>Service Description</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>1/4/2013</td>
<td>Primary Care Visit</td>
<td>$50</td>
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<tr>
<td>1/4/2013</td>
<td>Vaccination</td>
<td>$4</td>
</tr>
<tr>
<td>1/7/2013</td>
<td>Pharmacy Fill</td>
<td>$120</td>
</tr>
<tr>
<td>2/4/2013</td>
<td>ER Visit</td>
<td>$125</td>
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<tr>
<td>2/4/2013</td>
<td>ER Treatment</td>
<td>$300</td>
</tr>
<tr>
<td>3/6/2013</td>
<td>Ophthalmologist Visit</td>
<td>$127</td>
</tr>
<tr>
<td>4/22/2013</td>
<td>Orthopedic Visit</td>
<td>$257</td>
</tr>
<tr>
<td>4/25/2013</td>
<td>Pharmacy Fill</td>
<td>$120</td>
</tr>
<tr>
<td>4/25/2013</td>
<td>Physical Therapy</td>
<td>$22</td>
</tr>
<tr>
<td>5/5/2013</td>
<td>Physical Therapy</td>
<td>$22</td>
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<tr>
<td>7/10/2013</td>
<td>Pharmacy Fill</td>
<td>$120</td>
</tr>
<tr>
<td>8/4/2013</td>
<td>Primary Care Visit</td>
<td>$50</td>
</tr>
<tr>
<td>8/22/2013</td>
<td>Dermatologist Visit</td>
<td>$300</td>
</tr>
<tr>
<td>8/23/2013</td>
<td>Pathology Test</td>
<td>$50</td>
</tr>
<tr>
<td>9/22/2013</td>
<td>Dermatologist Visit</td>
<td>$100</td>
</tr>
<tr>
<td>9/22/2013</td>
<td>Cardiologist Visit</td>
<td>$554</td>
</tr>
<tr>
<td>10/15/2013</td>
<td>Outpatient Hospital Visit</td>
<td>$1,325</td>
</tr>
</tbody>
</table>

**Total Debits:** $3,646  
**Total Credits:** $4,500

---

**Base Year Average Member Cost, Adjusted for Risk and Medical Inflation**
# Patient Care Account - One Panel for One Year

**XYZ Family Practice Group (10 PCPs)**

<table>
<thead>
<tr>
<th>Actual (Debits)</th>
<th>Expected (Credits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>Mary Smith</td>
</tr>
<tr>
<td>$774,060</td>
<td>$4,500</td>
</tr>
<tr>
<td>Inpatient Care</td>
<td>John Doe</td>
</tr>
<tr>
<td>$2,967,230</td>
<td>$4,500</td>
</tr>
<tr>
<td>Outpatient Care</td>
<td>Jane Richards</td>
</tr>
<tr>
<td>$3,354,260</td>
<td>$4,500</td>
</tr>
<tr>
<td>Specialist Care</td>
<td>Bob Jones</td>
</tr>
<tr>
<td>$2,451,190</td>
<td>$4,500</td>
</tr>
<tr>
<td>Ancillary Care</td>
<td>Steve Patel</td>
</tr>
<tr>
<td>$1,290,100</td>
<td>$4,500</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
</tr>
<tr>
<td>$2,064,160</td>
<td></td>
</tr>
</tbody>
</table>

Total Debits: $12,901,000  
Total Credits: $13,500,000  

Savings From Expected Cost: $599,000
# Quality Measures/Quality Score Card

<table>
<thead>
<tr>
<th>Category</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP Engagement*</td>
<td>35</td>
</tr>
<tr>
<td>Appropriate Use of Services</td>
<td>20</td>
</tr>
<tr>
<td>Effectiveness of Care</td>
<td>20</td>
</tr>
<tr>
<td>Patient Access</td>
<td>15</td>
</tr>
<tr>
<td>Structural Capabilities</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total 100 Points</strong></td>
<td></td>
</tr>
</tbody>
</table>

*At least 20 of 35 points are needed for Outcome Incentive Award (OIA)*
# Quality Score Card

<table>
<thead>
<tr>
<th>PCP Engagement</th>
<th>Appropriate Use of Services</th>
<th>Effectiveness of Care</th>
<th>Patient Access</th>
<th>Structural Capabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>35 points</td>
<td>20 points</td>
<td>20 points</td>
<td>15 points</td>
<td>10 points</td>
</tr>
</tbody>
</table>

### PCP Engagement*
- PCP Engagement with the PCMH Program: 7.5 points
- PCP Engagement with Care Plans: 7.5 points
- Member Satisfaction Survey: 7.5 points
- Program Consultant Assessment: 10 points
- Program Representative Assessment: 2.5 points

### Appropriate Use of Services
- Admissions: 8 points
- Potentially Preventable Emergency Room Use: 4 points
- Ambulatory Services, Diagnostic Imaging and Antibiotics: 8 points

### Effectiveness of Care
- Chronic Care Maintenance: 10 points
- Population Health Maintenance: 10 points

### Patient Access
- Online Appointment Scheduling: 3 points
- Unified Communication Visits / Telemedicine: 3 points
- Office Hours Before 9:00am and After 5:00pm on Weeknights: 3 points
- Office Hours on Weekends: 3 points
- Overall Patient Experience: 3 points

### Structural Capabilities
- Use of E-Prescribing: 2 points
- Use of Electronic Medical Record (EMR): 2 points
- Meaningful Use Attestation: 2 points
- Medical Home Certification: 2 points
- Effective Use of Electronic Communication: 2 points

*At least 20 of 35 points are needed for Outcome Incentive Award (OIA)*
How does a Panel Earn an Outcome Incentive Award (OIA)?

1. Determine Degree of Savings

2. Determine the Quality Score

3. Calculate Award Based on Intersection of Savings and Quality
Calculate Award as Intersection of Savings and Quality

OIA Awards: Degree of Savings

<table>
<thead>
<tr>
<th>QUALITY SCORE</th>
<th>SAVINGS LEVELS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10%</td>
</tr>
<tr>
<td>80</td>
<td>67</td>
</tr>
<tr>
<td>60</td>
<td>56</td>
</tr>
<tr>
<td>40</td>
<td>46</td>
</tr>
</tbody>
</table>

|               | 2   | 14 | 7  |

Outcome Incentive Award

- Percentage Points
- 12 Percentage Points

Participation Fee

Standard Fee

Base Fee

+ Persistency
Program Strategies

1. PCP Engagement and Panel Performance
2. Reduction in Gaps in Care and Population Management
3. Effectiveness of Medication Management
4. Cost Effective Referral Patterns
5. Care Coordination and TCCI programs
PCP Engagement and Panel Performance

Panel comparisons spur competition among providers toward higher levels of performance as teams.

One PCP or NP does not have enough Members to pool experience necessary to see patterns and trends of care costs.

Shared savings are calculated at the Panel level.

Difficult for solo PCPs to provide expanded office access and continuous coverage for their Members.

Panel provide a greater opportunity for peer consultation across and among practices.
Gaps in care for the portion of the population with chronic disease(s) are exceedingly common due to the fragmented nature of the health care system itself.

Studies have shown too few Americans receive the “appropriate” care they should get – according to well-documented and broadly endorsed clinical guidelines – for a range of common conditions.*

- Less than 50% of adults aged 65 years or older
- 25% of adults aged 50 to 65 years

PCMH Program leverages data resources to offer a streamlined approach to improve gaps in care.

Reduction in Gaps in Care and Population Health

- Gaps in care are exceedingly common due to the fragmented nature of the health care system.

- Studies have shown that Americans receive only about 50 percent of the “appropriate” care they should get – according to well-documented and broadly endorsed clinical guidelines – for a range of common conditions.*

- PCMH Program leverages data resources to offer a streamlined approach to improve gaps in care.

Effectiveness of Medication Management

• Medication complications are the **#1 cause** of readmissions.¹

• The average compliance rate is **25% or less**.²

• Poor compliance leads to poor outcomes and increased care costs.

• Medication reconciliation is conducted for all patients in care coordination.

• Comprehensive Medication Review is available for all members with high potential for drug interaction, overdose or side effects.


Cost Effective Referral Patterns
Consider Specialist Referral Patterns: “When” and “Where”

Primary Care Physician Refers to a Specialist

- Specialist A Uses Hospital X
  - $40,000

- Specialist B Uses Hospital Y
  - $25,000

- Specialist C Uses Hospital Z
  - $20,000
# Cost Effective Referral Patterns

## Search Results

### You Searched For:
- Zip Code:
- Distance:
- Specialty:

### Languages Spoken: English

**Note:** Click Provider link to return Specialist information to the Referral Form

<table>
<thead>
<tr>
<th>Cost Strata</th>
<th>Distance</th>
<th>Contact Information</th>
<th>Specialty</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW</td>
<td>1.5 miles</td>
<td></td>
<td>Emergency Medicine</td>
<td>Grad School: George Washington University Washington, DC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Residency: Intership: English</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Languages: Board Certified: Emergency Medicine - Board Certified</td>
</tr>
<tr>
<td>LOW</td>
<td>2.2 miles</td>
<td></td>
<td>Emergency Medicine</td>
<td>Grad School: George Washington University Washington, DC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Residency: Intership: English</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Languages: Board Certified: Emergency Medicine - Not Board Certified</td>
</tr>
<tr>
<td>MEDIUM</td>
<td>1.5 miles</td>
<td></td>
<td>Emergency Medicine</td>
<td>Grad School: Not Known</td>
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<td></td>
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<td>Residency: Intership: English</td>
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<td>Languages: Board Certified: Emergency Medicine - Not Board Certified</td>
</tr>
<tr>
<td>HIGH</td>
<td>1.5 miles</td>
<td></td>
<td>Emergency Medicine</td>
<td>Grad School: Geisinger Medical Center, Danville PA</td>
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<td>Residency: Intership: English</td>
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<td></td>
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<td>Languages: Board Certified: Emergency Medicine - Board Certified</td>
</tr>
</tbody>
</table>
Care Coordination

1. Hire, train and monitor nurses as local care coordinators

2. Select the right patient based on criteria:
   - Numerous hospitalizations or emergency room (ER) visits
   - Multiple specialists
   - Polypharmacy (10 or more medications)
   - Poor self-care conditions and are at a high risk for impending hospitalization
   - New diagnoses of conditions showing progressing health deterioration (For example, kidney impairment with a chronic diabetic)

3. Write a clear, concise effective care plan with quality review

4. Utilize the right resources (TCCI)
Selecting Patients for Care Coordination
SearchLight® Reports

IV. Key Use Patterns

- A. Admissions, Readmissions and ER Visits by Hospital
- B. Admission, Readmission and ER Visit Gross Debts by Hospital
- C. Hospital Admissions/Readmissions by Month
- D. Hospital Admission Gross Debts by Month
- E. ER Visits by Month
- F. ER Gross Debts by Month
- G. Hospital Admissions/Readmissions by Provider
- H. Members with Admissions/Readmissions - All Bands
- I. Members with ER Visits - All Bands
- J. Top 10 Procedures in Both ASC and Outpatient Hospital Settings
- K. Use of Urgent Care Backup (UCB) - Weekend/Weekday Visits by Illness Band
- L. Use of Urgent Care Backup (UCB) - Weekends/Weekday Visits by Provider
- M. Debts for Prescription Drugs by Source and Type
- N. Generic Dispensing Rate for Mail/Retail Pharmacy Drugs
- O. Generic Dispensing Rate - Max Potential Savings
- P. Generic Fill Rates for Mail/Retail Pharmacy Drugs - Provider Detail
- Q. Generic Cost Ratios for Mail/Retail Pharmacy Drugs - Provider Detail
- R. Mail Order Dispensing Rate for Mail/Retail Pharmacy Drugs
- S. Mail Order Dispensing Rate - Calculated Potential Savings
- T. Costliest Brand Drugs
- U. Members with Multiple Drugs
- V. Members with Multiple Maintenance Drugs
- W. Costliest Specialty Drugs

V. Top 10 to 50 Lists of High Cost/High Risk/Highly Unstable Members

- A. High Cost/High Risk Members with Multiple Indicators
- B. Overall PMPM $
- C. Pharmacy PMPM $
- D. Drug Volatility Score
- E. Specialty Drug PMPM $
- F. High Rx Utilization
- G. Hospital Use
- H. Multiple Comorbidities
- I. Gaps in Care
- J. Disease Instability
- K. Members with Adverse/High Risk Health Assessment Results (Release Coming Soon)
Selecting Patients for Care Coordination

SearchLight® Reports: Top 10-50 Lists of Members with High Cost/High Risk/High Instability

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### V. Top 10 to 50 Lists of High Cost/High Risk/High Instability Members

#### A. High Cost/High Risk Members with Multiple Indicators

The chart below displays the list of Members identified as high cost/high use/high risk. The chart is sorted to show Members with the most checked categories at the top. Check marks indicate potential High Cost/High Risk based on the following categories within the trailing 12 months as of September, 2013:

<table>
<thead>
<tr>
<th>#</th>
<th>Member Name</th>
<th>IB Score</th>
<th>Provider</th>
<th>Dominant Episode</th>
<th>Overall PMPM $</th>
<th>Pharmacy PMPM $</th>
<th>Drug Volatility Score</th>
<th>Specialty Drug PMPM $</th>
<th>High Rx Utilization</th>
<th>Hospital Use</th>
<th>Multiple Comorbidities</th>
<th>Gaps in Care</th>
<th>Disease Instability</th>
<th>Health Assessment</th>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Additional information on Member care coordination activities can be viewed through the care plan links on the Member roster.*
### Member Health Record - Timeline

**Period:** Oct 2013 - Sep 2014  
**Member Since:** December 2014

**Episode Duration**  
Click on the episode to see health details.

<table>
<thead>
<tr>
<th>Episode</th>
<th>% of Total $</th>
<th>Sep 14</th>
<th>Aug 14</th>
<th>Jul 14</th>
<th>Jun 14</th>
<th>May 14</th>
<th>Apr 14</th>
<th>Mar 14</th>
<th>Feb 14</th>
<th>Jan 14</th>
<th>Dec 13</th>
<th>Nov 13</th>
<th>Oct 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary Artery Disease</td>
<td>90%</td>
<td></td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Hypertension Essential</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevent/Admin Hlth Encount</td>
<td>2%</td>
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<td>1</td>
<td></td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>&lt; 1%</td>
<td></td>
<td>2</td>
<td>1</td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Lipid Abnormalities</td>
<td>&lt; 1%</td>
<td></td>
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</tbody>
</table>

**NOTE:** Shading indicates episode duration. Count indicates number of visits during the period.

### Prescription Drugs

Click on the supply link or colored block to see prescription details.

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>NITROSTAT</td>
<td>Antianginal - Coronary Vasodilators (Nitrates) and Combinations</td>
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<td></td>
<td></td>
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<td></td>
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<td></td>
<td>90d</td>
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<td>ALPRAZOLAM</td>
<td>Antianxiety Agent - Benzodiazepines</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>30d</td>
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<tr>
<td>ATORVASTATIN CALCIIUM</td>
<td>Antihyperlipidemic - HMG CoA Reductase Inhibitors (statins)</td>
<td>90d</td>
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<td>90d</td>
<td>90d</td>
<td>90d</td>
<td>90d</td>
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<td>90d</td>
<td>90d</td>
<td>30d</td>
<td></td>
</tr>
<tr>
<td>METOPROLOL TARTRATE</td>
<td>Beta Blockers Cardiac Selective, All</td>
<td>90d</td>
<td>90d</td>
<td>90d</td>
<td>90d</td>
<td>90d</td>
<td>90d</td>
<td>90d</td>
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<td>90d</td>
<td>90d</td>
<td>30d</td>
<td></td>
</tr>
<tr>
<td>AMLODIPINE BESYLA TE</td>
<td>Calcium Channel Blockers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>30d</td>
</tr>
</tbody>
</table>

**NOTE:** Products are grouped by therapeutic class. Not a complete list.

### MARTHA PHILLIPS’s Illness Band

- **Multiple Chronic Illnesses**
  - Year to Date: $4,397
  - Trailing 12 Months: $33,494

### Health Care Spend

- **Health Scores**
  - Drug Volatility Score:
  - Framingham Risk Score:
  - ACE Score:
  - LACE Score:

### Member Alert History

<table>
<thead>
<tr>
<th>Date</th>
<th>Type</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/24/2013</td>
<td>Inpatient</td>
<td>FREDERICK MEMORIAL HOSPITAL</td>
</tr>
</tbody>
</table>
Components of a Care Plan

- Patient Narrative
- Social and Family History
- Medications
- Allergies
- Diagnostics/Lab Results
- Vital Signs
- Encounter History
- Assessment and Plan
- Care Coordination Team information

- All care plans **must** have a compelling need, medication reconciliation and an actionable plan
- Dual sign off by PCP and Local Care Coordinator required to “activate” care plan
<table>
<thead>
<tr>
<th>Primary Care Provider</th>
<th>Care Coordination Team</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCP Name:</strong></td>
<td>DANIEL H COLLECTOR</td>
</tr>
<tr>
<td><strong>Practice Name:</strong></td>
<td>MARYLAND FAMILY CARE</td>
</tr>
<tr>
<td><strong>PCP Address:</strong></td>
<td>35 E PADONIA ROAD Timonium MD, 21093</td>
</tr>
<tr>
<td><strong>PCP Phone Number:</strong></td>
<td>4106833330</td>
</tr>
<tr>
<td><strong>Provider Id:</strong></td>
<td>S1900111</td>
</tr>
<tr>
<td><strong>Panel Id:</strong></td>
<td>MP11100123-L02</td>
</tr>
<tr>
<td><strong>Care Coordination Team</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Regional Care Coordinator:</strong></td>
<td>Carefirst RCC</td>
</tr>
<tr>
<td><strong>Local Care Coordinator:</strong></td>
<td>Lisa,Rose</td>
</tr>
<tr>
<td></td>
<td>4436025144</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:lisa.rose@healthways.com">lisa.rose@healthways.com</a></td>
</tr>
<tr>
<td><strong>National Care Coordinator:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Customer Service Rep:</strong></td>
<td>Krista Womack</td>
</tr>
<tr>
<td><strong>Case Manager:</strong></td>
<td>CheryllMonius</td>
</tr>
<tr>
<td></td>
<td>410-724-2573</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:cheryl.monius@carefirst.com">cheryl.monius@carefirst.com</a></td>
</tr>
<tr>
<td><strong>HTC:</strong></td>
<td>Sandra Schaech</td>
</tr>
<tr>
<td></td>
<td>410-528-7187</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:Sandra.Schaech@carefirst.com">Sandra.Schaech@carefirst.com</a></td>
</tr>
<tr>
<td><strong>Behavioral Health Case Manager:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Cardiologist:</strong></td>
<td>Peter Sabia</td>
</tr>
<tr>
<td></td>
<td>301-681-5700</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:psabia@associatesincardiology.com">psabia@associatesincardiology.com</a></td>
</tr>
<tr>
<td><strong>Hospice Clinical Contact:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>SNF Clinical Contact:</strong></td>
<td>Kim Jordan</td>
</tr>
<tr>
<td></td>
<td>443-204-4436</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:Kim.Peters@Genesishcc.com">Kim.Peters@Genesishcc.com</a></td>
</tr>
</tbody>
</table>
All elements are tightly integrated and designed to work together, coordinated by the care team.
PROGRAM RESULTS
2013 Outcome Incentive Award (OIA) Results

- Of the 291 PCMH Panels participating in 2013, 200 (69%) earned an OIA with an average award of 36 percent.
- Of the 230 panels participating in 2011-2013, 84 (37%) earned an OIA all three years.
- The “winning” panels in 2013 managed their populations’ cost to 5.2% below target.
- Based on these results for a third year in a row, the PCMH program is clearly demonstrating that it is contributing to a bend in the cost curve.
- Overall medical trend is projected to be 3.5% in 2014.

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>% of Panels Receiving OIA</th>
<th>Average Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>60%</td>
<td>25%</td>
</tr>
<tr>
<td>2012</td>
<td>66%</td>
<td>33%</td>
</tr>
<tr>
<td>2013</td>
<td>69%</td>
<td>36%</td>
</tr>
</tbody>
</table>
Actual Medical Trend Substantially Better than Target

5-year Average Overall Medical Trend 7.5%

- 2010: 7.5%
- 2011: 7.5%
- 2012: 7.1%
- 2013: 6.5%
- 2014P: 5.5%

- 2010: 4.9%
- 2011: 4.9%
- 2012: 3.5%
- 2013: 3.5%
- 2014P: 3.0%
Chronic Care Coordination Program Results

Experience of 11,957 Commercial Members in Care Plans

- 57% Reduction in ER Visits
- 61% Reduction in Admissions
- 48% Reduction in Readmissions

Average Age: 53
Average Illness Burden At Care Plan Start: 5.90
Source: CareFirst Health Care Analytics – PCMH population compared to attributed Non-PCMH PCP population.
Includes data through EOY 2013, paid through March 2014.
Exclusions: Medicare Primary, Catastrophic, TPA, and out of area.
Questions?
Go (Primary Care) Team!
Team-based Care in the Medical Home

C. Edwin Webb, American College of Clinical Pharmacy
Jennifer Baldwin, CareFirst
Lewis Levy, Best Doctors
Richard Ricciardi, AHRQ
Melissa Thomason, Patient, Family Advisor
John Weiss, ACICBL
Go (Primary Care) Team!
Team-based Care in the Medical Home

Lew Levy, MD, FACP
Senior Vice President of Medical Affairs
Chief Quality Officer
Best Doctors, Inc.

November 13, 2014
# Diagnostic Error Rate Estimates

<table>
<thead>
<tr>
<th>Category</th>
<th>Estimation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expert estimate</strong></td>
<td>10-15% estimate by Arthur Elstein</td>
</tr>
<tr>
<td><strong>Second reviews</strong></td>
<td>2-5% of abnormalities are missed by radiology and pathology</td>
</tr>
<tr>
<td><strong>Standardized patients</strong></td>
<td>13% of patients presenting with common conditions to clinic (COPD, RA, others) are missed by internists</td>
</tr>
</tbody>
</table>
| **Look backs**      | Dissecting aneurysms: 39% delayed diagnosis  
                       Cervical cancer: 25-50% of last normal PAP are abnormal on review |
| **Autopsies**       | 10-20% of autopsies reveal major unexpected diagnoses that would have changed the management |

Diagnostic Error is Common

40,000 – 80,000 deaths per year in the US

Primary Care

1 in 20 primary care visits involve a preventable diagnostic error; half are potentially harmful

Healthcare Organizations

10 patients are harmed every day in clinics or ERs

1 death every month in healthcare organization

Leape et al.  JAMA  288:2405, 2002
Singh et al.  BMJ Qual Safety  2014
Patients are Seeing the Problem

Has a preventable medical error been made in your own care, or that of a family member?

- Yes: 34%
- No: 65%
- Don’t Know: 1%

Did the error have serious, minor or no health consequences?

- Serious health consequences: 21%
- Minor health consequences: 10%
- No health consequences: 3%

Kaiser Family Foundation – 2004 - National Survey on Consumers’ Experiences with Patient Safety and Quality Information
Initiatives Supporting Change

Patient-Centered Medical Homes

Accountable Care Organizations

Institute Of Medicine Report 2015 on Misdiagnosis
Institute of Medicine Project: Diagnostic Error in Health Care

Project Description

Evaluate the existing knowledge about diagnostic error as a quality of care challenge; current definitions of diagnostic error and illustrative examples; and areas where additional research is needed.

Examine topics such as the epidemiology of diagnostic error, the burden of harm and economic costs associated with diagnostic error, and current efforts to address the problem.

Propose solutions to the problem of diagnostic error.

Devise conclusions and recommendations that will propose action items for key stakeholders to achieve desired goals.
Collect Available Data

Leverages data across the Care Continuum to increase accuracy of patient profile

Health Data Hub

- EHR data
- Pharmacy Claims
- Prescription Data
- Patient Surveys And HRA
- Care Coordination Interactions
- External Lab data
- Practice Management Data
- Claim data-Professional & Facility
- Hospital Discharge
Local Care Coordinators & Care Managers Leverage Data

Best Doctors Process
Proven Approach with Actionable Treatment Recommendations

Collect all medical records
*For Critical Care, collected within 24-48 hours of initial contact

Create comprehensive clinical summary

Access world-class medical experts

Conduct expert review and develop report
*For Critical Care, delivered within 72 hours

Analyze clinical information

Review and QA expert response

Deliver results and recommendations to member and physician

Identify and refer member

START
INTERCONSULTATION® CASE STUDY – Homozygous Familial Hypercholesterolemia

Clinical History

- 22-year old male with homozygous familial hypercholesterolemia on four lipid-lowering medications, currently undergoing 50% lipid apheresis every two weeks
- Recommended increase in apheresis to 100% every two weeks
- Concerns regarding optimal medical management of hypercholesterolemia and overall lifestyle impact of increasing apheresis

Clinical Impact

- Expert confirmed the diagnosis of homozygous familial hypercholesterolemia
- Recommended a treatment change of replacing apheresis with increasing dosages of lomitapide
- Highly recommended the member stop smoking and meet with dietician/exercise specialist
- Recommended annual stress echocardiogram

Financial Impact

- $92,000 projected direct cost savings
- Cost avoidance for member discontinuing apheresis and starting medication

Member Testimonial

“I hated the apheresis as it got in the way of me feeling like a normal person. I am so psyched to be done with it!”

Physician Testimonial

“I appreciate this report and I believe it will have a huge impact on the life of my patient.”
Clinical History

- 13-year old boy with seizures, immune deficiency, chronic pain syndrome, frequent respiratory and sinus infections, recently diagnosed with Ehlers-Danlos Syndrome
- Currently on IVIg immunotherapy regimen; weaning off seizure medication
- Review of treatment plan requested for care optimization

Clinical Impact

- Expert confirmed the diagnosis of Ehlers-Danlos syndrome, complicated by chronic pain, fatigue, sleep disturbance and psychological distress
- Treatment plan change includes reconsideration of IVIg as clinically indicated
- Begin weekly subQ immunoglobulin injections, administered at home, which are better tolerated and maintain more constant immunoglobulin levels
- Consider physical therapy, non-narcotic medications and counseling to manage chronic pain

Financial Impact

- $9,900 projected direct cost savings
- Cost avoidance by eliminating IV immunotherapy and cost incurrence of immunoglobulin injections

Member Testimonial

"We really appreciated the opportunity to have Best Doctors review our son’s case. The report helped us understand what other options we have to help relieve his suffering."

Physician Testimonial

“This is helpful. The member's mother is hesitant to change at this time, as he is doing okay. I will discuss this with her in another month."
Lew Levy, MD, FACP

Senior Vice President of Medical Affairs
Chief Quality Officer
Best Doctors
llevy@bestdoctors.com
Go (Primary Care) Team! Team-based Care in the Medical Home

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Team-Based Primary Care: Building High Functioning Teams & Measuring Outcomes

Richard Ricciardi, PhD, NP
Acknowledgements

Contributors:
• Kathleen Kerwin Fuda, PhD
• Sarah J. Shoemaker, PharmD, PhD
• Michael Parchman, MD, MPH
• Judith Schaefer, MPH
• Meaghan Hunt
• Jessica Levin

Expert Panel:
• Diane Cardwell, TransforMED
• Jody Hoffer Gittell, Brandeis Univ.
• Ben Miller, Univ. of Colorado
• Sally Okun, PatientsLikeMe, Inc.
• Ray Palmer, Univ. of Texas Health Science Center
• Eduardo Salas, Univ. of Central Florida
• Ron Stock, Oregon Health & Science Univ.
• Sheri ver Steeg, Mercy Clinics, Inc.
• Melissa Valentine, Stanford Univ.
• Elizabeth Yano, UCLA & VA HSR&D
Disclosures

• This research was conducted under contract to the Agency for Healthcare Research and Quality (AHRQ), Contract No. HHSA 290 2010 00004I, Task Order #5, “Developing a Foundation and Framework for Team-based Care Measures in Primary Care” Rockville, MD. The authors of this presentation are responsible for its content. No statement may be construed as the official position of the Agency for Healthcare Research and Quality of the U.S. Department of Health and Human Services.

• Financial support for this study was provided by AHRQ under contract No. HHSA 290 2010 00004I, Task Order #5.
Purpose: Provide an overview of research on team-based health care and instruments to measure high functioning teams
• Research on teams is available from other sectors
• Accumulating evidence that effective teams are associated with better patient outcomes
• Increasing recognition that successful primary care redesign efforts (e.g., medical home) will require a high-functioning primary care team
• Since research, evaluation and QI can help advance effective team-based care in primary care, instruments to support these activities are critical
• Growing agreement on attributes of effective team-based care
• Education has similarly been evolving towards interprofessional education
Methods

- Developed a conceptual model
  - 12 Constructs grouped into 3 main Domains, plus “Leadership”
- Conducted an environmental scan
  - Reviewed 3296 abstracts + 45 articles suggested by experts
    - Identified 221 potential sources, from which 129 full-text instruments were available
      - 64 instruments selected to map (related to teams and adaptable to primary care)
- “Mapped” the items in each instrument to the mediators or enablers of team care in the conceptual model
  - Two researchers systematically ‘mapped’ each item within an instrument to the mediator/enabler constructs in the model
  - Then reconciled by experts in team care
  - Each item could map to maximum of two constructs
- 48 instruments retained after mapping exercise
Conceptual Framework

- Developed and refined through a literature review and with input from the expert panel
- Framework uses an “Input-Mediator-Output-Input (IMOI)” configuration that is iterative and dynamic in nature
  - **Inputs:** precursors or pre-conditions for teams to exist
  - **Mediators:** processes that occur within the team, or enablers of effective teamwork; mediators were the focus of this project. There are 4 mediator domains in the framework:
    - Cognitive
    - Affective/relational
    - Behavioral
    - Leadership
  - **Outputs** are the results of effective teamwork in primary care
Conceptual Model of Team Care

Inputs:

Internal to Organization:
- Leadership:
  - inclusive
  - psychological safety
- Team composition:
  - size
  - diversity of ideas
  - diversity of skills
  - diversity of knowledge
  - prior training/experience
  - turnover/stability
- Patient population needs
  - (demand & workload)
- The “Built” environment
  (space and co-location)
- QI Infrastructure
  - Health IT capacity
  - Time for reflection & conversations
  - Internal expertise with a specific QI method
  - External expertise: QI consultants or practice facilitators

External to Organization:
- Local Context: job market, workforce
- Financing/Payment Models
- Health Policy Environment (e.g. licensure policies)

Mediators:

Teamwork

Cognitive:
- Sense-making
- Continuous learning
- Shared explicit goals and accountability
- Evolving mental models of roles

Affective/Relational:
- Trust
- Respectful interactions
- Heedful inter-relating
  - Commitment: “we v. me”

Leadership

Behavioral:
- Communication
  - Timely
  - Accurate/honest
  - Problem-solving
  - Multi-modal
- Adaptable to context and needs, improvisation
- Conflict Resolution

Outputs:

Team-Based Primary Care:
- Patient-Centric:
  - Inclusive of patient and accountable to them
- Defined, agreed upon roles:
  - Works at “top of education and experience”
- Measures processes and outcomes:
  - Accountable for evidence-based care
  - Continuous improvement
  - Proactive care that is a shared responsibility
  - Link to other teams/resources & coordinate care as needed
- Longitudinal continuity relationship

<table>
<thead>
<tr>
<th>Construct</th>
<th>Number of Instruments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sense-making</td>
<td>16</td>
</tr>
<tr>
<td>Continuous learning</td>
<td>31</td>
</tr>
<tr>
<td>Shared explicit goals</td>
<td>37</td>
</tr>
<tr>
<td>Evolving mental models of roles</td>
<td>12</td>
</tr>
<tr>
<td>Trust</td>
<td>26</td>
</tr>
<tr>
<td>Respectful interactions</td>
<td>40</td>
</tr>
<tr>
<td>Needful inter-relating</td>
<td>42</td>
</tr>
<tr>
<td>Commitment</td>
<td>42</td>
</tr>
<tr>
<td>Communication</td>
<td>26</td>
</tr>
<tr>
<td>Adaptable to context</td>
<td>26</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>21</td>
</tr>
<tr>
<td>Leadership (as mediator)</td>
<td>27</td>
</tr>
<tr>
<td>Conceptual Model Mediator Constructs</td>
<td></td>
</tr>
</tbody>
</table>
Number of Individual Items That Map to Each Construct

<table>
<thead>
<tr>
<th>Conceptual Model Mediator Constructs</th>
<th>Number of Items (n=1,647)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sense-making</td>
<td>58</td>
</tr>
<tr>
<td>Continuous Learning</td>
<td>177</td>
</tr>
<tr>
<td>Shared Explicit Goals</td>
<td>230</td>
</tr>
<tr>
<td>Evolving Mental Models</td>
<td>27</td>
</tr>
<tr>
<td>Trust</td>
<td>64</td>
</tr>
<tr>
<td>Respectful Interactions</td>
<td>199</td>
</tr>
<tr>
<td>Heedful Inter-relating</td>
<td>194</td>
</tr>
<tr>
<td>Commitment</td>
<td>144</td>
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<tr>
<td>Communication</td>
<td>251</td>
</tr>
<tr>
<td>Adaptable to Context</td>
<td>57</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>54</td>
</tr>
<tr>
<td>Leadership</td>
<td>192</td>
</tr>
</tbody>
</table>
Number of Instruments Measuring Each Mediator Domain

<table>
<thead>
<tr>
<th>Conceptual Model Mediator Domains</th>
<th>Number of Instruments (n=48)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive</td>
<td>44</td>
</tr>
<tr>
<td>Affective/Relational</td>
<td>47</td>
</tr>
<tr>
<td>Behavioral</td>
<td>45</td>
</tr>
<tr>
<td>Leadership (as a mediator)</td>
<td>26</td>
</tr>
</tbody>
</table>
Results: Item Level

Number of Items Measuring Each Mediator Domain

<table>
<thead>
<tr>
<th>Conceptual Model Mediator Domains</th>
<th>Number of Items (n=1,647)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive</td>
<td>492</td>
</tr>
<tr>
<td>Affective/Relational</td>
<td>601</td>
</tr>
<tr>
<td>Behavioral</td>
<td>362</td>
</tr>
<tr>
<td>Leadership</td>
<td>192</td>
</tr>
</tbody>
</table>
Discussion

• Majority of instruments were from health care, though some from other sectors may be useful to assess effective team-based primary care
• Some instruments will require some adaption (e.g., wording changes) in order to use in primary care setting
• Most instruments address multiple Conceptual Model constructs, but with differing degrees of emphasis
  ▶ None measured all of them
• Distribution of instruments and items across constructs and domains varied only slightly
Gaps in Measurement

- Highlights of Key Gaps:
  - Need to incorporate patient perspective into team-based primary care assessments, although more conceptual work is needed before instrument development occurs.
  - Address measurement challenges associated with aggregating at the unit-level from individual clinicians, particularly when there are few clinicians in a practice.
  - Support for non-researchers who wish to use the instruments by providing guidance and training (e.g., how to approach, use and interpret results).
Publish a Web-Based Atlas of Instruments

- A searchable database of 48 instruments to measure team-based primary care
  - Can search instruments on key characteristics
- A summary for each instrument is provided
- A resource to support measurement of attributes of effective teamwork to ultimately advance and improve team-based care primary care
- Coming soon to ahrq.gov (Spring 2015)
Thank You

AHRQ’s Mission:
To produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work with HHS and other partners to make sure that the evidence is understood and used.
SUPPLEMENTAL SLIDES
Building on Key Principles

- **Team Structure**
  - Multi-Team System For Patient Care

- **Leadership**
  - Effective Team Leaders
  - Team Events
  - Brief Checklist
  - Debrief Checklist

- **Situation Monitoring**
  - Situation Monitoring Process
  - Cross Monitoring
  - STEP
  - I’M SAFE Checklist

- **Mutual Support**
  - Task Assistance
  - Feedback
  - Advocacy and Assertion
  - Two-Challenge Rule
  - CUS
  - DESC Script
  - Collaboration

- **Communication**
  - SBAR
  - Call-Out
  - Check-Back
  - Handoff
  - “I PASS THE BATON”
Why Teamwork is Important in Primary Care

• The majority of medical errors are the result of health system failures rather than poor clinician performance

• Teamwork is essential in caring for patients with multiple comorbidities

• Teams of experts and support staff are necessary for coordination and applying 21st technologies to achieve patient-centered care
Go (Primary Care) Team!
Team-based Care in the Medical Home

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Jennifer Baldwin, CareFirst
Lewis Levy, Best Doctors
Richard Ricciardi, AHRQ
Melissa Thomason, Patient, Family Advisor
John Weiss, ACICBL