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:
AT THE HEART OF VALUE AND QUALITY

PCMH
Patient-Centered Medical Home

CareFirst

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

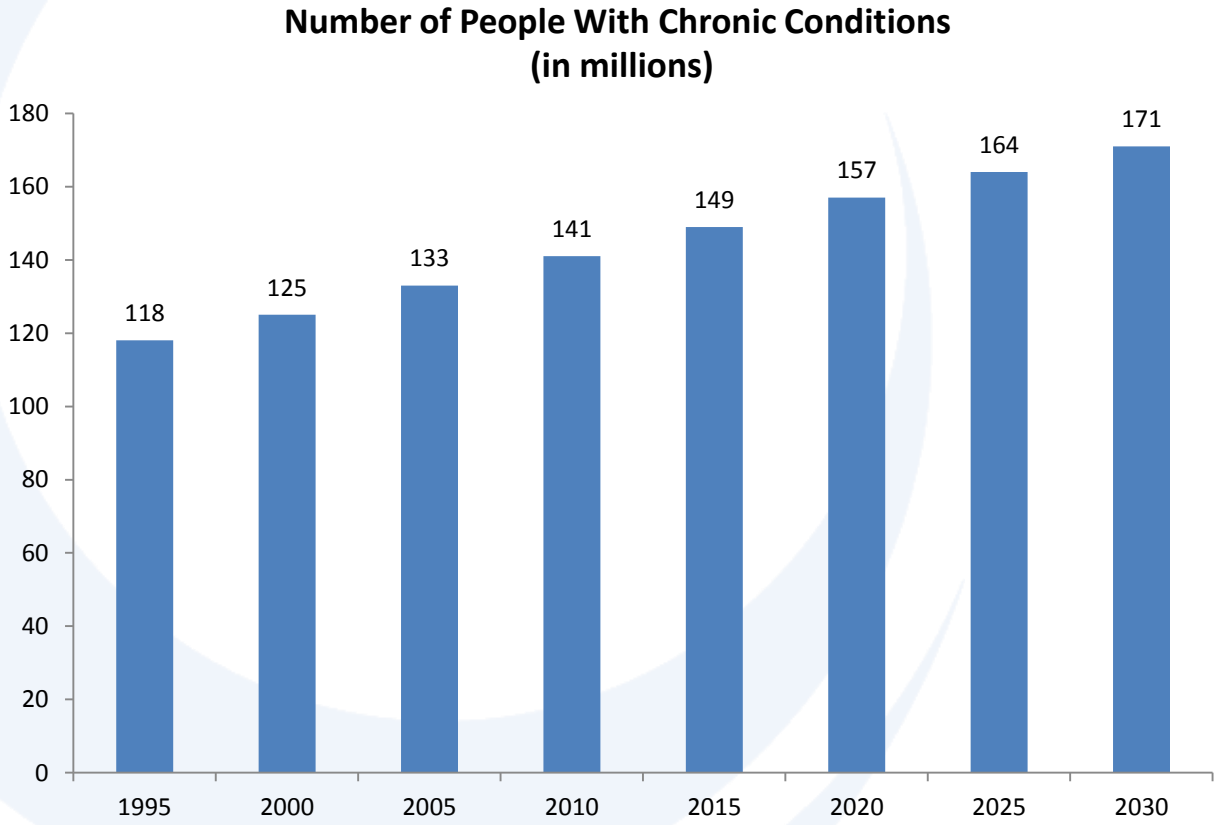
- Focus on Chronic Conditions
- Differentiating Factors of CareFirst PCMH

PCMH Overview

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

Program Results

The Prevalence of Chronic Conditions is 46% and Rising

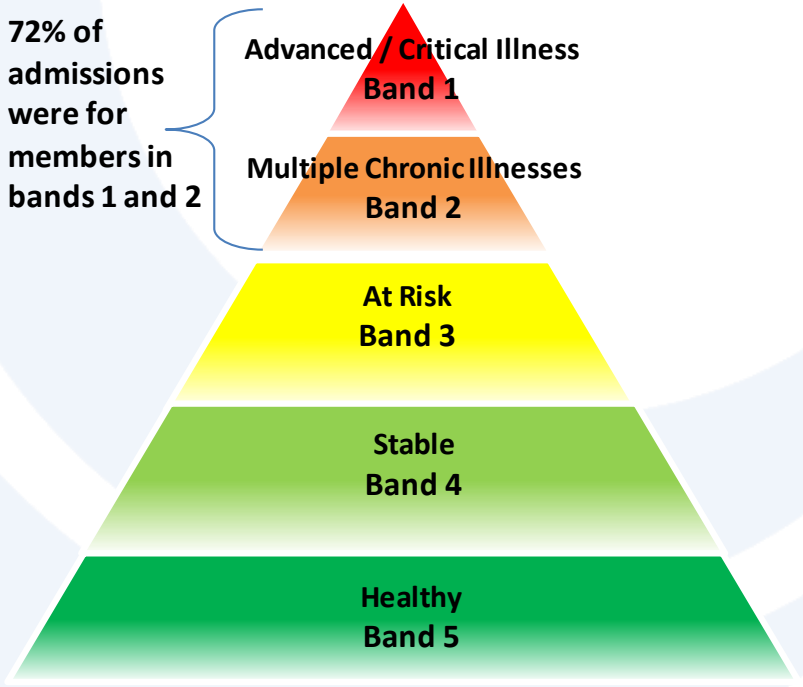


Total Pop	262.8M	276.1M	296.4M	309.3M	325.5M	341.4M	357.5M	373.5M
% of Pop with Chronic Condition	**44.9%**	**45.3%**	**44.9%**	**45.6%**	**45.8%**	**46.0%**	**45.9%**	**45.8%**

Robert Wood Johnson Foundation. Chronic Care: Making the Case for Ongoing Care, January, 2010. http://www.rwjf.org/en/research-publications/find-rwjf-research/2010/01/chronic-care.html.
US Census Bureau, US Population.

Concentration of Costs in a Few

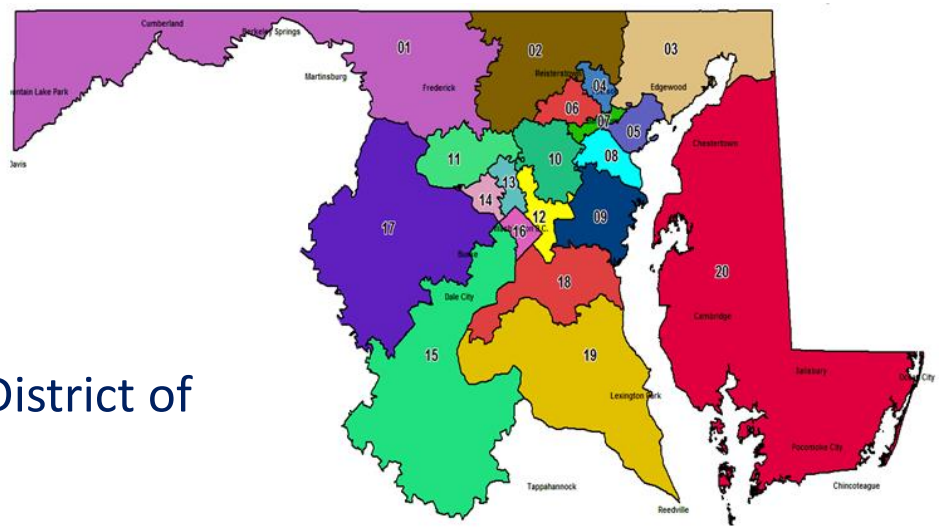
"A small percentage of CareFirst's Members consume approximately half of all of the Company's health care spending in the region. This mirrors the national experience. "
(Program Description & Guidelines, January 2014)



	Percent of Population	Percent Of Cost	Cost PMPM
Band 1	3.2%	36.6%	$3,215
Band 2	9.0%	26.2%	$798
Band 3	13.1%	17.2%	$367
Band 4	27.1%	14.5%	$153
Band 5	47.6%	5.5%	$38

Source: CareFirst HealthCare Analytics – Commercial, Under 65 Population – 2013

Patient-Centered Medical Home Field Operations

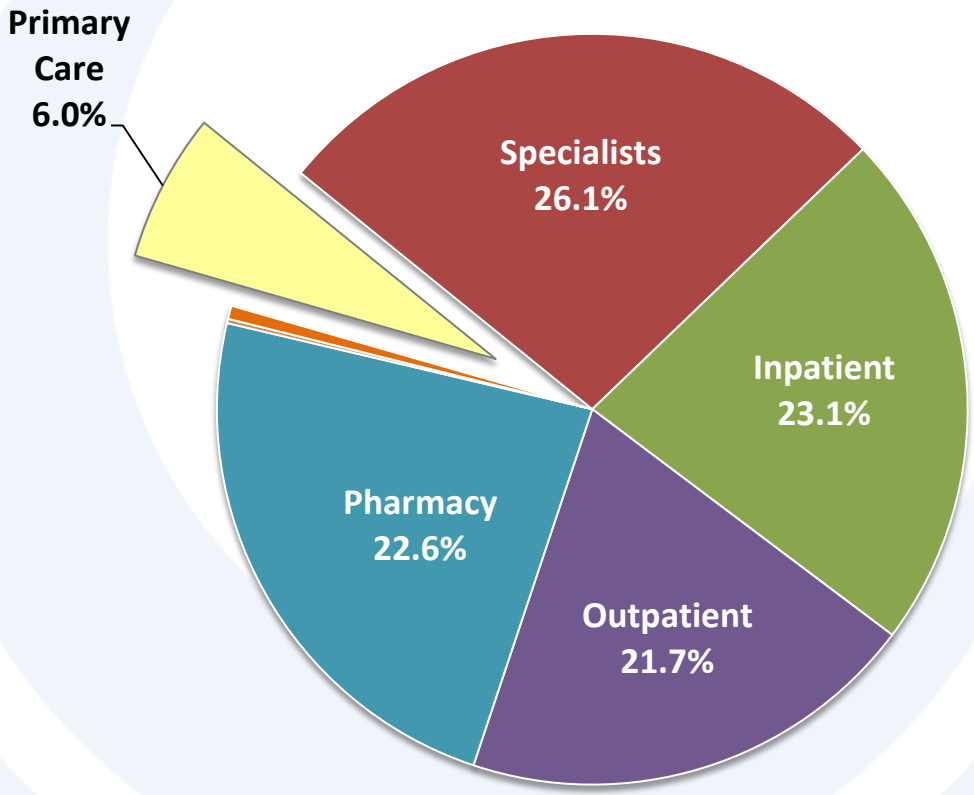


- 1M Attributed Members
- 20 Regions spanning Maryland, the District of Columbia and Northern Virginia
- 4,000 enrolled PCPs and NPs
- 425 Medical Panels
- 300 Nurses
- 10,559 care coordination plans YTD

Total Cost of Care Initiative

All elements are tightly integrated and designed to work together, coordinated by the care team.

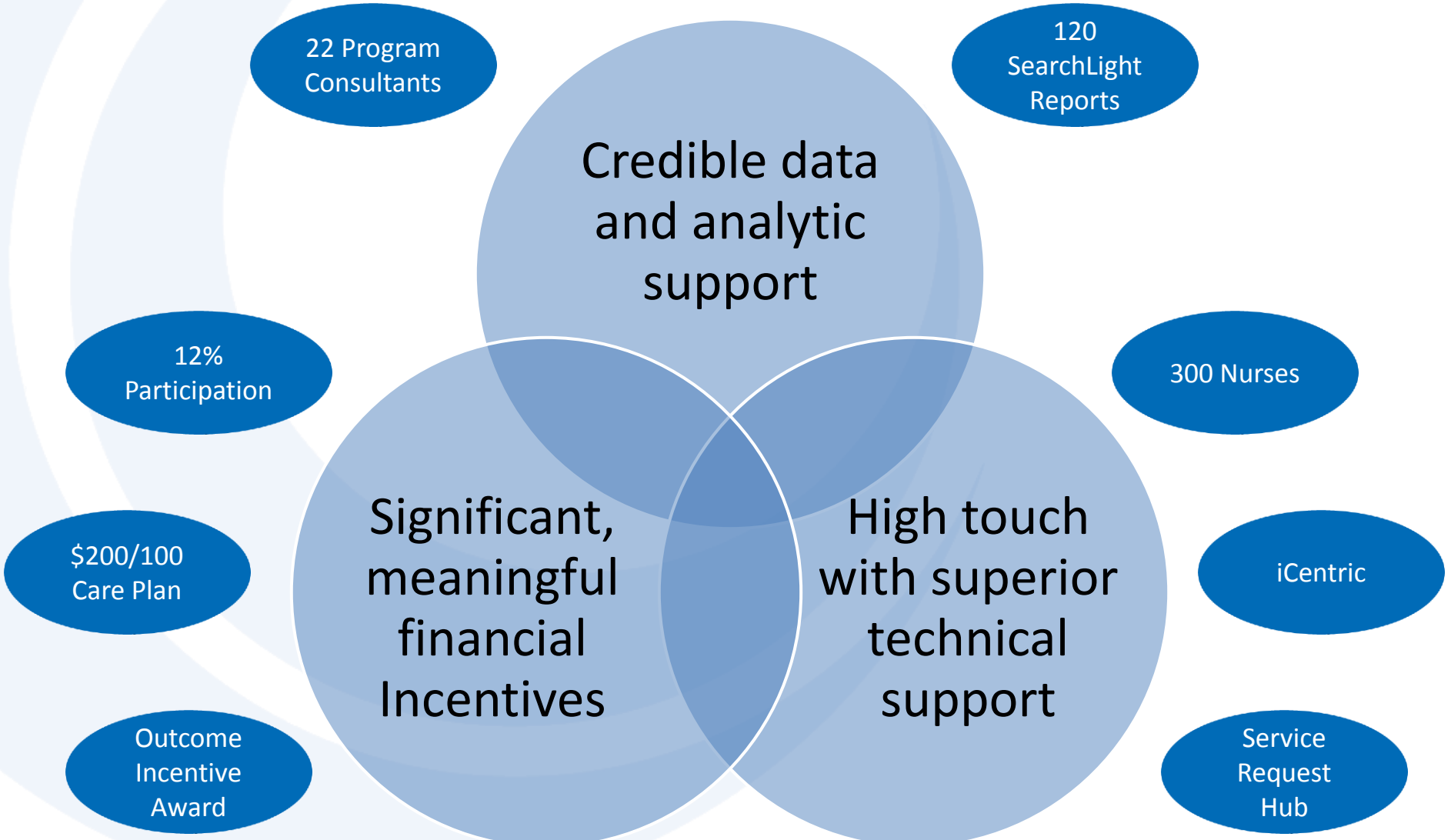
PCPs are Accountable for Care in All Settings



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



Overview of PCMH Program

Patient Care Account

A global budget is established for each Panel.

Patient Care Account

Actual (Debits)	Expected (Credits)
All services paid by CareFirst including member's coinsurance, copay, and deductible (Allowed Amount*)	All global CareFirst expected care costs shown as Per Member Per Month (PMPM)

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

Actual (Debits)			Expected (Credits)	
1/4/2013	Primary Care Visit	$50		
1/4/2013	Vaccination	$4		
1/7/2013	Pharmacy Fill	$120	January	$375
2/4/2013	ER Visit	$125	February	$375
2/4/2013	ER Treatment	$300	March	$375
3/6/2013	Ophthalmologist Visit	$127	April	$375
4/22/2013	Orthopedic Visit	$257	May	$375
4/25/2013	Pharmacy Fill	$120	June	$375
4/25/2013	Physical Therapy	$22	July	$375
5/5/2013	Physical Therapy	$22	August	$375
7/10/2013	Pharmacy Fill	$120	September	$375
8/4/2013	Primary Care Visit	$50	October	$375
8/22/2013	Dermatologist Visit	$300	November	$375
8/23/2013	Pathology Test	$50	December	$375
9/22/2013	Dermatologist Visit	$100		
9/22/2013	Cardiologist Visit	$554		
10/15/2013	Outpatient Hospital Visit	$1,325		

Base Year Average Member Cost, Adjusted for Risk and Medical Inflation

Total Debits: $3,646

Total Credits: $4,500

Patient Care Account - One Panel for One Year

XYZ Family Practice Group (10 PCPs)

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

… done for all patients in the Panel

Savings From Expected Cost: $599,000

Total Debits: $12,901,000

Total Credits: $13,500,000

Quality Measures/Quality Score Card

PCP Engagement*	35 points
Appropriate Use of Services	20 points
Effectiveness of Care	20 points
Patient Access	15 points
Structural Capabilities	10 points
Total 100 Points	

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

Quality Score Card

PCP Engagement	Appropriate Use of Services	Effectiveness of Care	Patient Access	Structural Capabilities
35 points	20 points	20 points	15 points	10 points

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

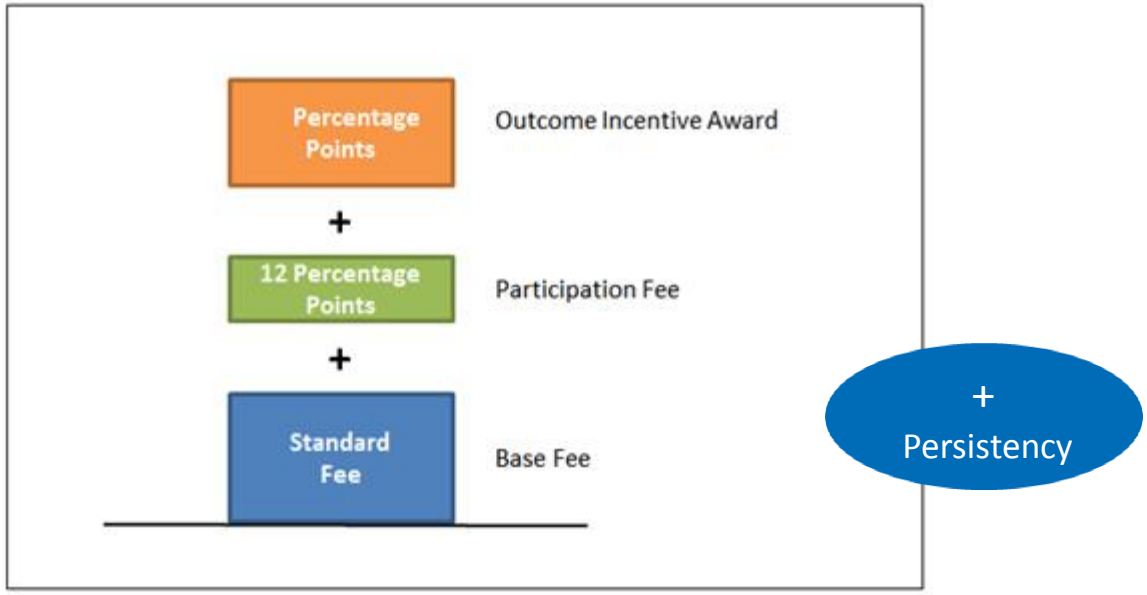
2. Determine the Quality Score

3. Calculate Award Based on Intersection of Savings and Quality

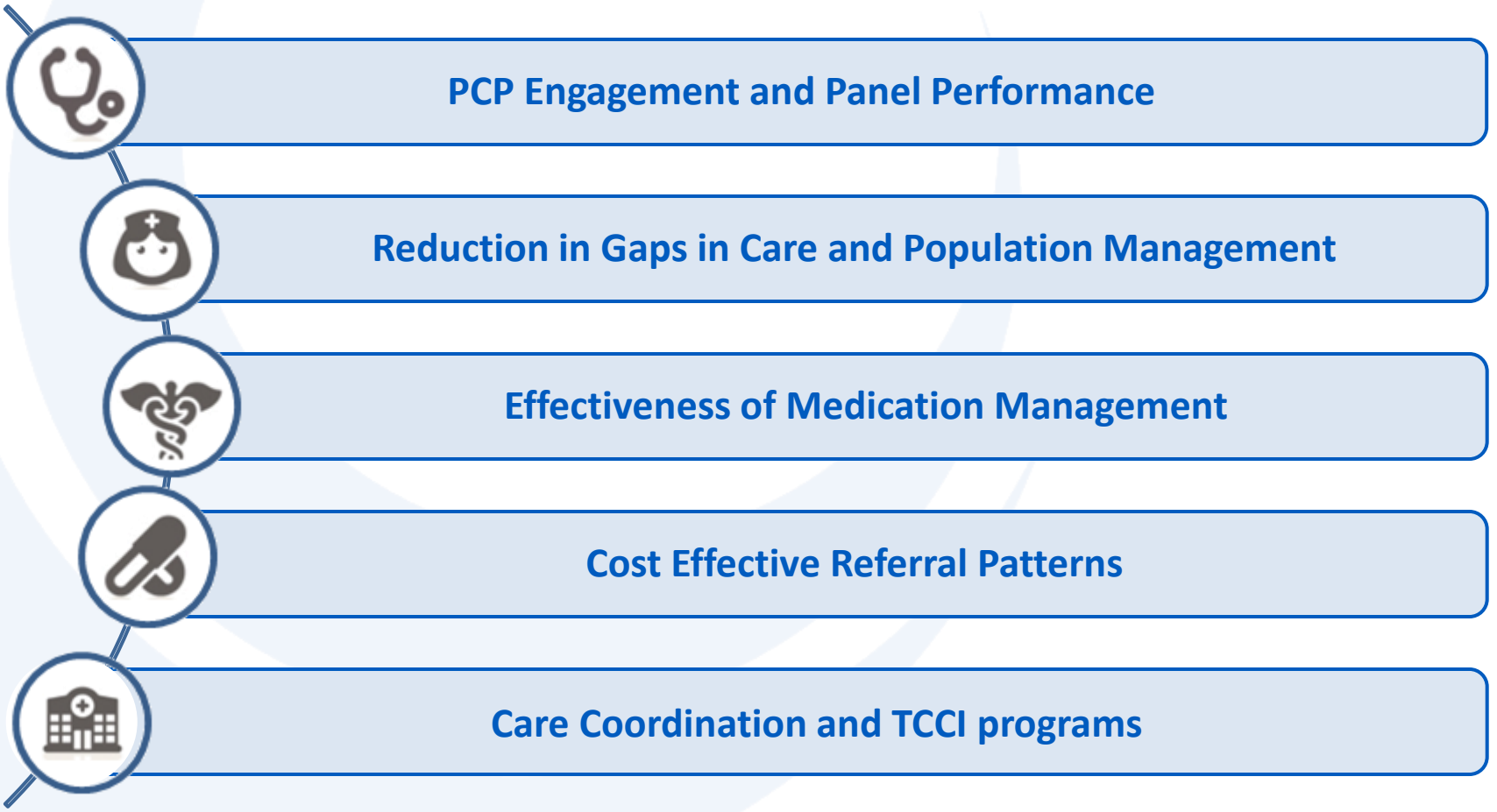
Calculate Award as Intersection of Savings and Quality

OIA Awards: Degree of Savings

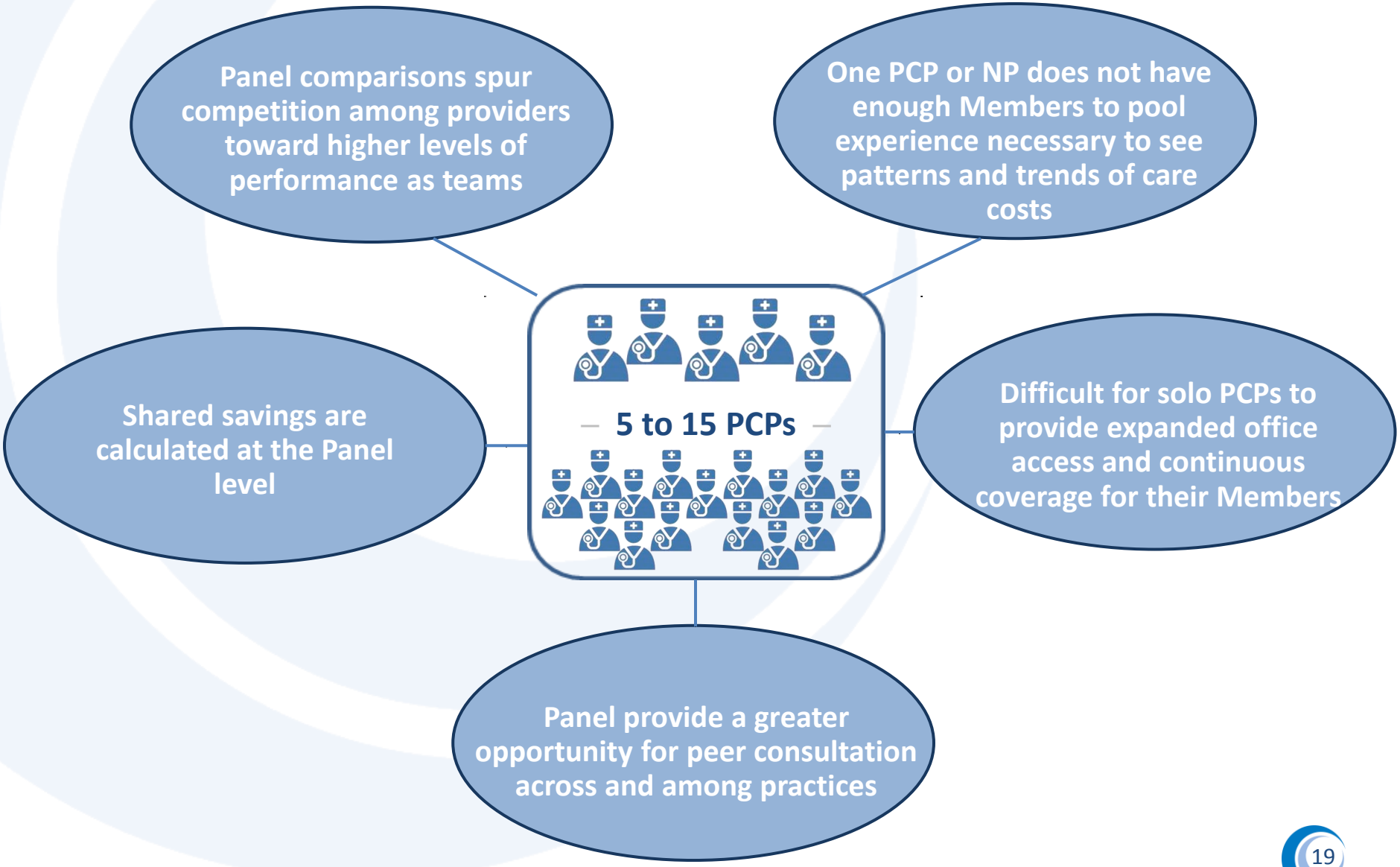
PCP PERCENTAGE POINT FEE INCREASE: YEAR 1					
QUALITY SCORE	SAVINGS LEVELS				
	10%	8%	6%	4%	2%
80	67	53	40	27	13
60	56	45	34	23	11
40	46	37	28	18	9
			2	14	7



Program Strategies



PCP Engagement and Panel Performance



Reduce Gaps in Care

- 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.

*CDC Focuses on Need for Older Adults to Receive Clinical Preventive Services (2012). Retrieved on October 30, 2014 from http://www.cdc.gov/aging/pdf/cps-clinical-preventive-services.pdf.

Reduction in Gaps in Care and Population Health

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

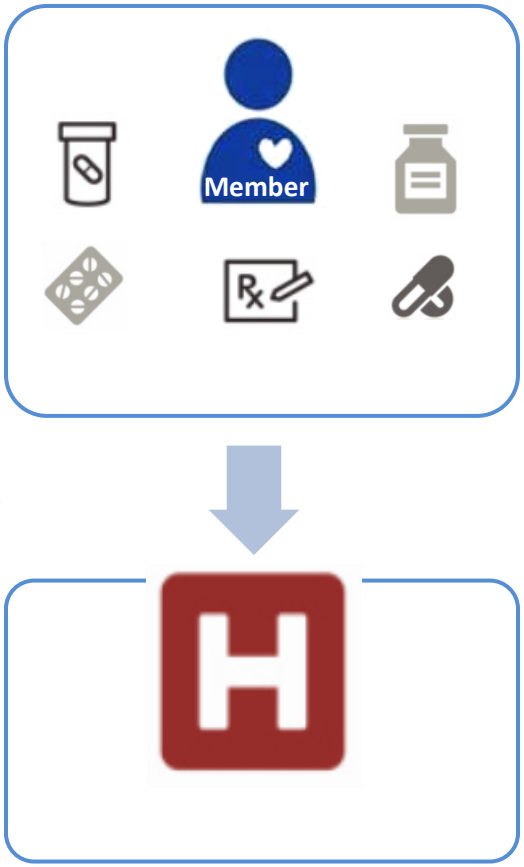
- Studies have shown that Americans receive only about 50 percent of the "appropriate" care they should get – according to well-documented and broadly endorsed clinical guidelines – for a range of common conditions.*

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

*Landmark Study Finds American Adults Often Fail to Get Recommended Care, Posing "Serious Threats" to Health, The RAND Corporation, 25 June 2003, http://www.rand.org/news/press/2003/06/25.html.

Effectiveness of Medication Management

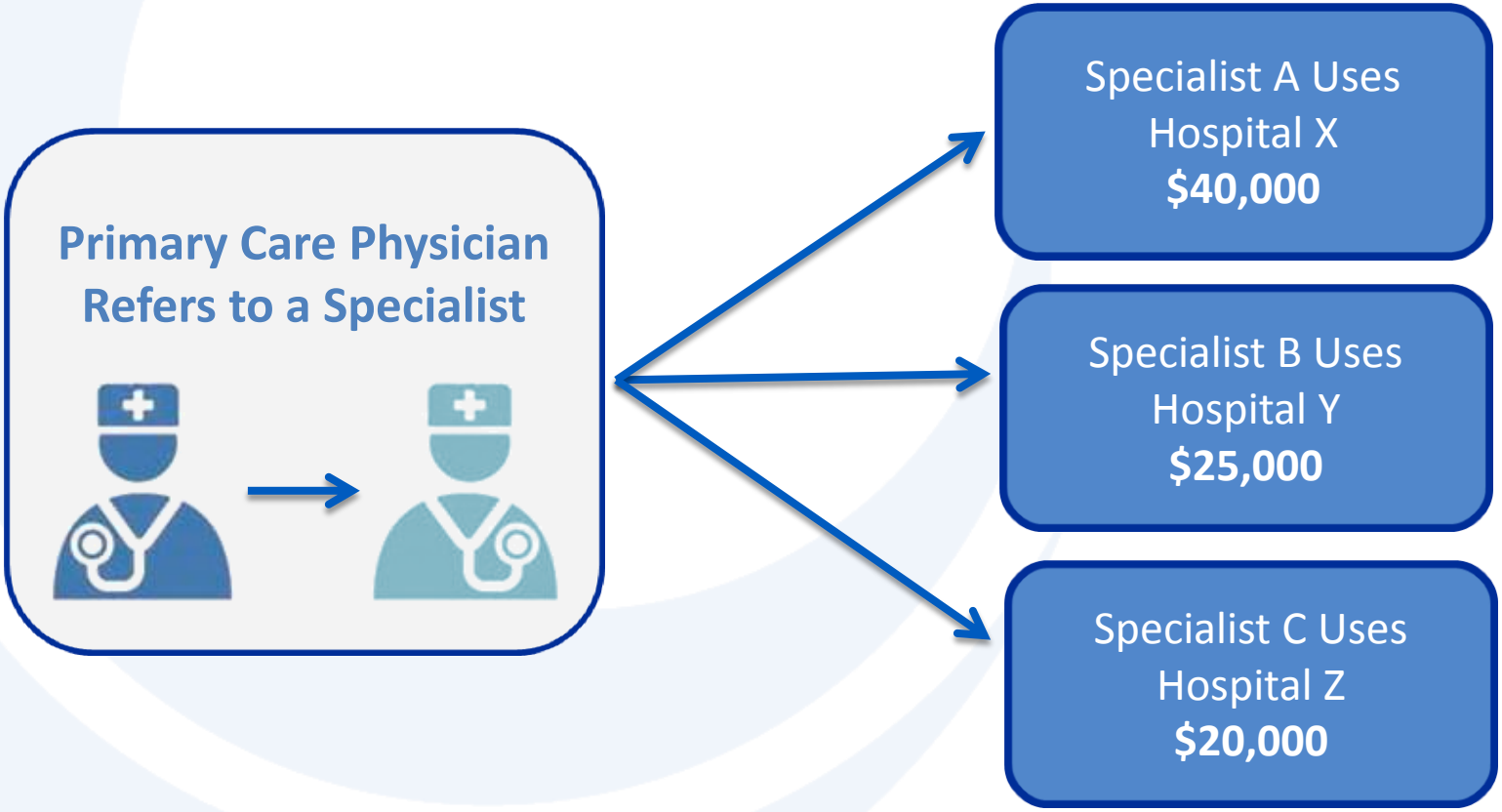
- Medication complications are the **#1 cause** of readmissions.[1]
- The average compliance rate is 25**% or less.**[2]
- Poor compliance leads to poor outcomes and increased care costs.
- Medication reconciliation is conducted for all patients in care coordination.
- Comprehensive Medication Review is available for all members with high potential for drug interaction, overdose or side effects.



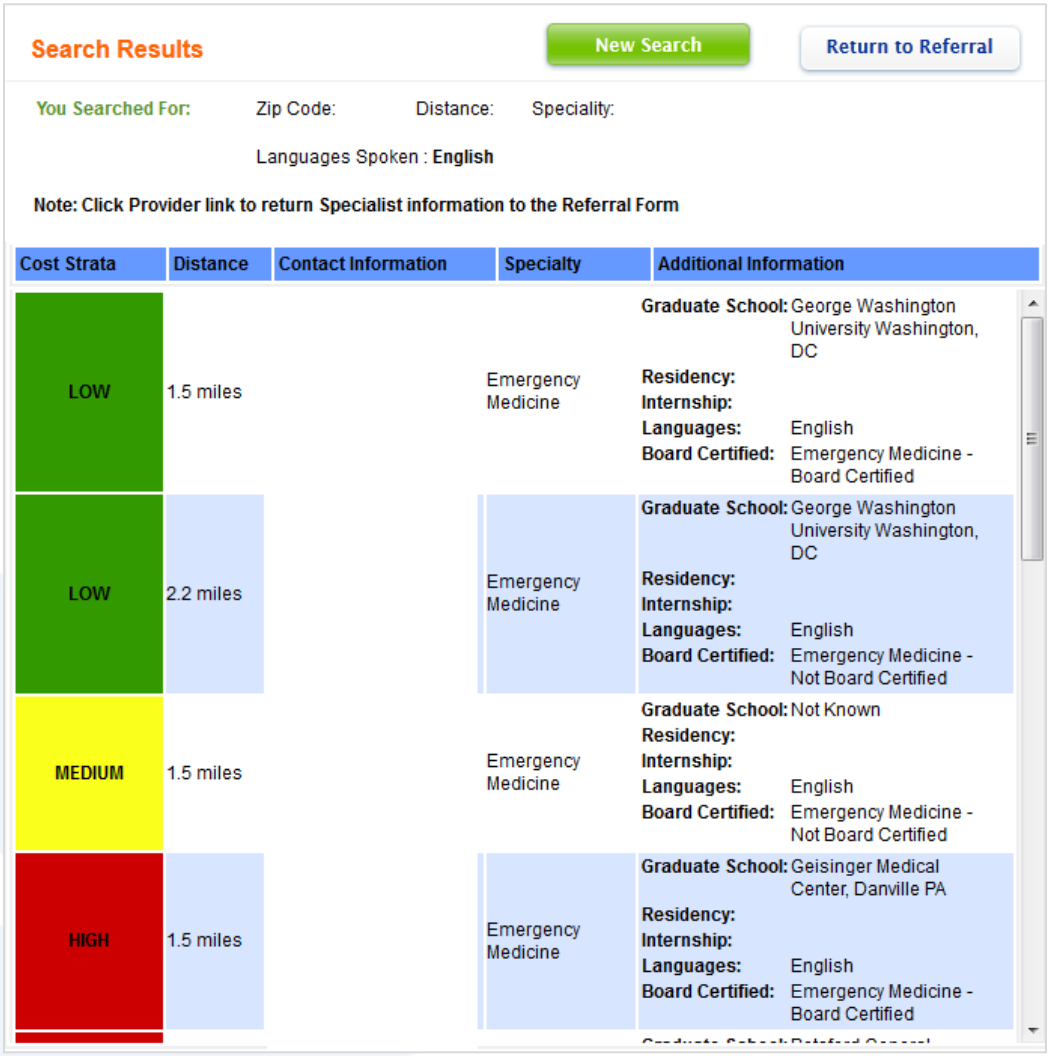
[1]Davies et al. Emergency re-admissions to hospital due to adverse drug reactions within 1 year of the index admission. Br J Clin Pharmacol. 2010;70(5):749-755.
[2]"Take as Directed: A Prescription Not Followed," Research conducted by The Polling Company. National Community Pharmacists Association December 16, 2006.

Cost Effective Referral Patterns

Consider Specialist Referral Patterns: "When" and "Where"



Cost Effective Referral Patterns



Search Results

New Search | Return to Referral

You Searched For: Zip Code: Distance: Speciality:

Languages Spoken : **English**

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

Cost Strata	Distance	Contact Information	Specialty	Additional Information
LOW	1.5 miles		Emergency Medicine	**Graduate School:** George Washington University Washington, DC **Residency:** **Internship:** **Languages:** English **Board Certified:** Emergency Medicine - Board Certified
LOW	2.2 miles		Emergency Medicine	**Graduate School:** George Washington University Washington, DC **Residency:** **Internship:** **Languages:** English **Board Certified:** Emergency Medicine - Not Board Certified
MEDIUM	1.5 miles		Emergency Medicine	**Graduate School:** Not Known **Residency:** **Internship:** **Languages:** English **Board Certified:** Emergency Medicine - Not Board Certified
HIGH	1.5 miles		Emergency Medicine	**Graduate School:** Geisinger Medical Center, Danville PA **Residency:** **Internship:** **Languages:** English **Board Certified:** Emergency Medicine - Board Certified

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

- Key Use Patterns - Section Overview
- A. Admissions, Readmissions and ER Visits by Hospital
- B. Admission, Readmission and ER Visit Gross Debits by Hospital
- C. Hospital Admissions/Readmissions by Month
- D. Hospital Admission Gross Debits by Month
- E. ER Visits by Month
- F. ER Gross Debits 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) - Weekend/Weekday Visits by Provider
- M. Debits 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

- Top 10 to 50 Lists of High Cost/High Risk/Highly Unstable Members - Section Overview
- 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

PCMH SearchLight

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

Return to Table of Contents

PCMH SearchLight Report for Panel

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:

Filter By: Members 1-10 | All Providers | All Members

#	Member Name	IB Score	Provider	Dominant Episode	Overall PMPM $	Pharmacy PMPM $	Drug Volatility Score	Specialty Drug PMPM $	High Rx Utilization	Hospital Use	Multiple Comorbidites	Gaps in Care	Disease Instability	Health Assessment
1		8.70		Cholecystitis/Cholelithiasis	✓		✓		✓	✓	✓		✓	
2		1.91		Diabetes	✓	✓	✓		✓		✓		✓	
3		14.10		Cancer - Breast	✓	✓		✓	✓		✓			
4		18.83		Cancer - Skin	✓	✓	✓		✓		✓			
5		3.21		Neurological Disorders, NEC	✓	✓			✓		✓		✓	
6		3.58		Mental Hlth - Bipolar Disorder	✓	✓	✓		✓		✓			
7		1.57		Mental Hlth - Bipolar Disorder	✓		✓		✓	✓				
8		1.36		Diabetes	✓	✓	✓		✓					
9		3.35		Osteoarthritis	✓	✓			✓		✓			
10		8.05		Pregnancy w Cesarean Section	✓				✓	✓	✓			

*Additional information on Member care coordination activities can be viewed through the care plan links on the Member roster.

Online Member Health Record

Member Health Record - Timeline

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

Episode Duration Click on the episode to see health details.

Episode	% of Total $	Sep 14	Aug 14	Jul 14	Jun 14	May 14	Apr 14	Mar 14	Feb 14	Jan 14	Dec 13	Nov 13	Oct 13
Coronary Artery Disease	90%					2	1		4		1	3	13
Hypertension, Essential	8%			1	1	1	2	1	1	1	1		2
Prevent/Admin Hlth Encounters	2%				1			2	1				
Diabetes	< 1%				2	1							
Lipid Abnormalities	< 1%						1		1				

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

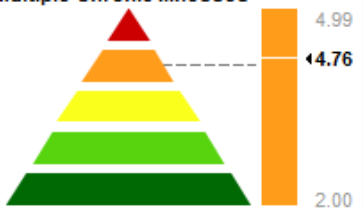
Prescription Drugs Click on the supply link or colored block to see prescription details.

Drug Name	Therapeutic Class	Sep 14	Aug 14	Jul 14	Jun 14	May 14	Apr 14	Mar 14	Feb 14	Jan 14	Dec 13	Nov 13	Oct 13
NITROSTAT	Antianginal - Coronary Vasodilators (Nitrates) and Combinations												9d
ALPRAZOLAM	Antianxiety Agent - B enzodiazepines												30d
ATORVASTATIN CALC IUM	Antihyperlipide mic - H MG CoA Reductase In hibitors (statins)		90d			90d			90d			90d	30d
METOPROLOL TARTR ATE	Beta Blockers Cardiac Selective, All				90d				90d			90d	30d
AMLODIPINE BESYLA TE	Calcium Channel Block ers												30d
	Platelet Aggregation In												

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

MARTHA PHILLIPS's Illness Band

Multiple Chronic Illnesses



Health Care Spend

- Year to Date: $4,397
- Trailing 12 Months: $33,494

Health Scores

- Drug Volatility Score: 9
- Framingham Risk Score: N/A
- ACE Score: N/A
- LACE Score: 5

Member Alert History

Date	Type	Facility
10/24/2013	Inpatient Aut horization	FREDERICK MEMO RIAL HOSPITAL

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

Care Coordination Team

Care Coordination Team

Last Updated: 10/28/2014 *By: MoniqueAdams , HT*

Primary Care Provider

PCP Name:	DANIEL H COLLECTOR
Practice Name:	MARYLAND FAMILY CARE
PCP Address:	35 E PADONIA ROAD Timonium MD, 21093
PCP Phone Number:	4106833330
Provider Id:	S1900111
Panel Id:	MP11100123-L02
E-mail Address:	

Care Coordination Team

Regional Care Coordinator:	Carefirst RCC
Local Care Coordinator:	Lisa,Rose 4436025144 lisa.rose@healthways.com
National Care Coordinator:	
Customer Service Rep:	Krista Womack
Case Manager: ***Responsible Lead as of 10/28/2014***	CherylMonius 410-724-2573 cheryl.monius@carefirst.com
HTC:	Sandra Schaech 410-528-7187 Sandra.Schaech@carefirst.com
Behavioral Health Case Manager:	
Cardiologist:	Peter Sabia 301-681-5700 psabia@associatesincardiology.com
Hospice Clinical Contact:	
SNF Clinical Contact:	Kim Jordan 443-204-4436 Kim.Peters@Genesishcc.com

Total Cost of Care Initiative

All elements are tightly integrated and designed to work together, coordinated by the care team.

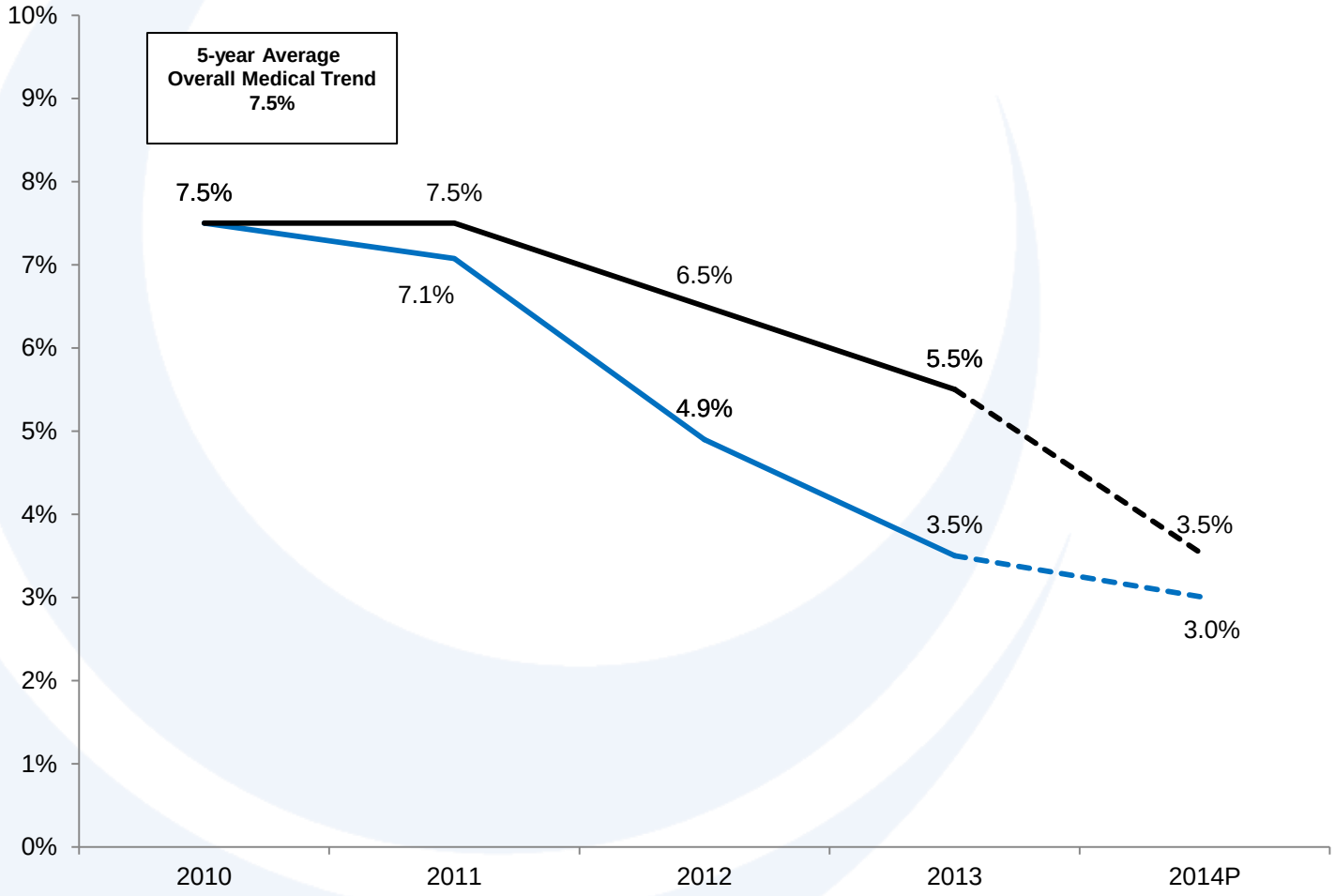
PROGRAM RESULTS

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.

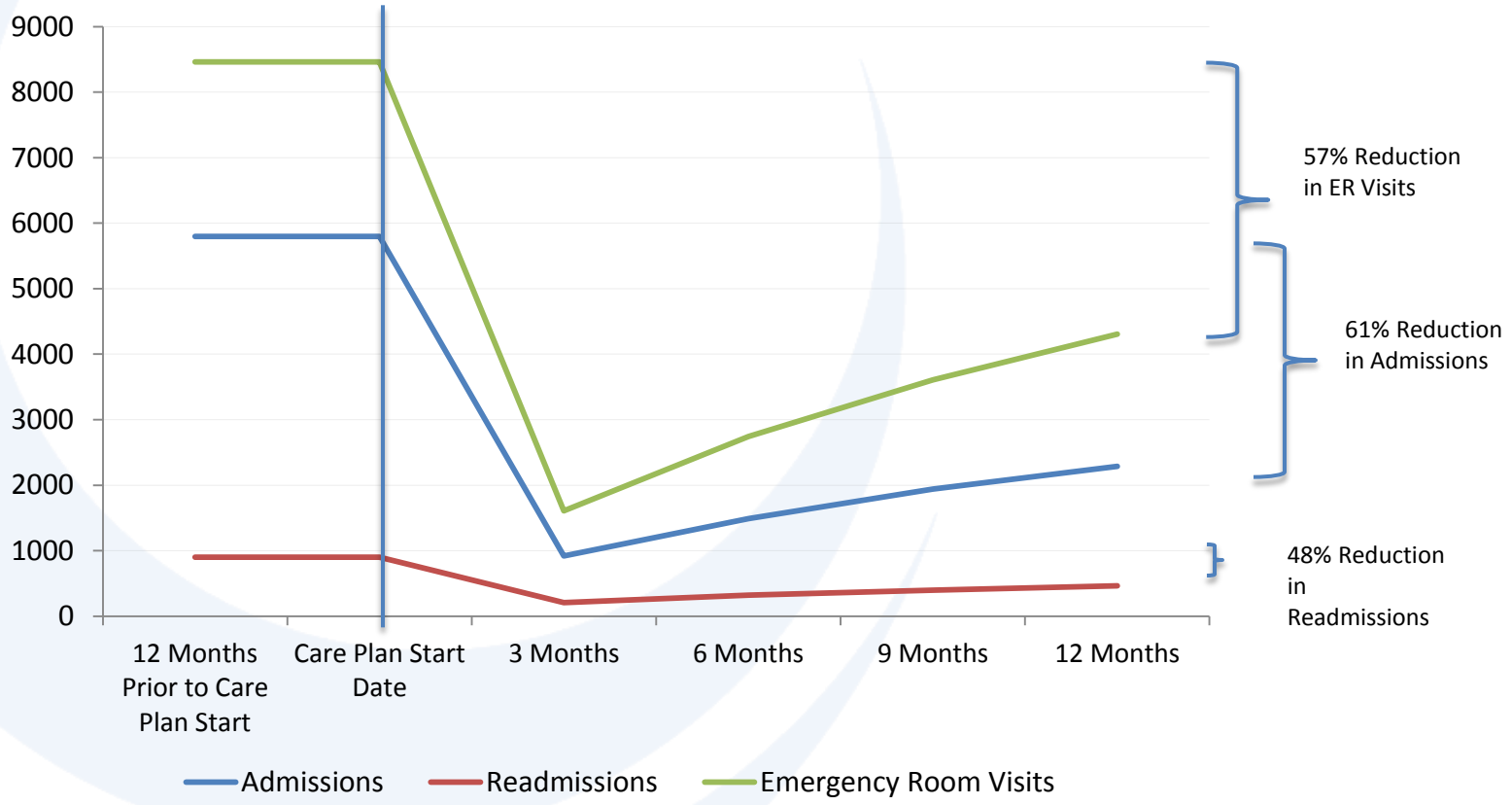
Performance Year	% of Panels Receiving OIA	Average Award
2011	60%	25%
2012	66%	33%
2013	69%	36%

Actual Medical Trend Substantially Better than Target



Chronic Care Coordination Program Results

Experience of 11,957 Commercial Members in Care Plans



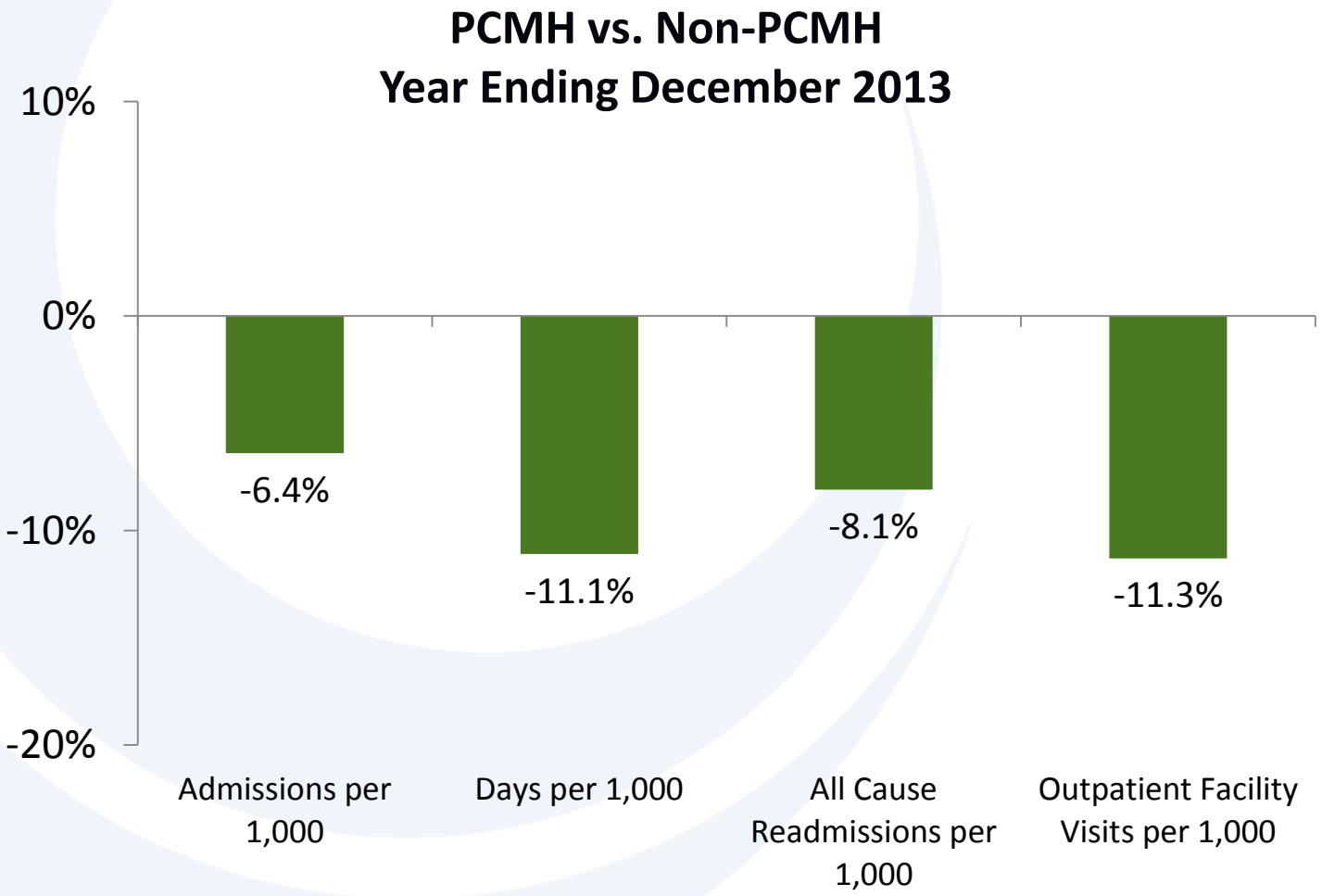
Average Age

53

Average Illness Burden At Care Plan Start

5.90

Measures That Matter



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

PATIENT-CENTERED PRIMARY CARE:
AT THE HEART OF VALUE AND QUALITY

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.

Best Doctors®

November 13, 2014

Diagnostic Error Rate Estimates

Expert estimate	10-15% estimate by Arthur Elstein
Second reviews	2-5% of abnormalities are missed by radiology and pathology
Standardized patients	13% of patients presenting with common conditions to clinic (COPD, RA, others) are missed by internists
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

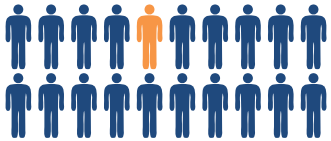
Mark L Graber, BMJ Quality & Safety, Vol 23:6

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

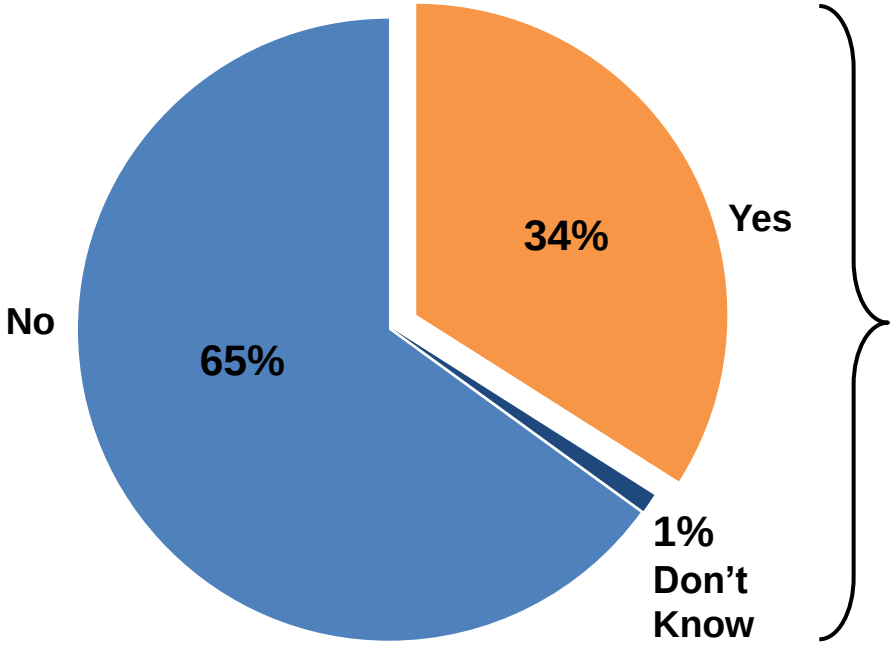
1 death every month in healthcare organization

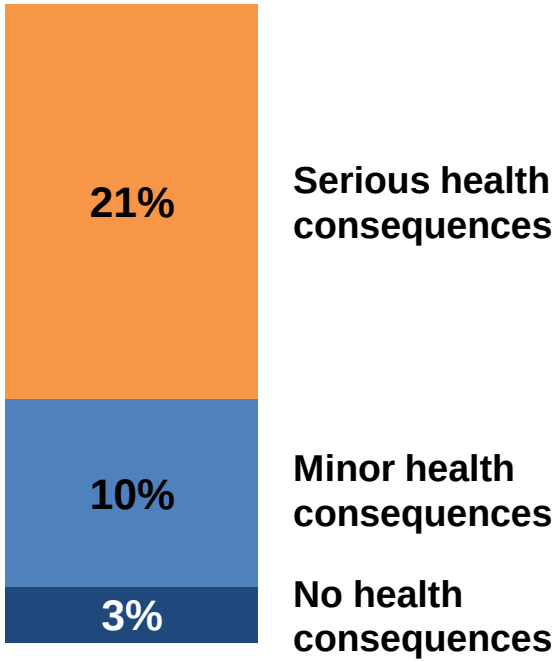
Leape et al. JAMA 288:2405, 2002
Singh et al. BMJ Qual Safety 2014

Patients are Seeing the Problem

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

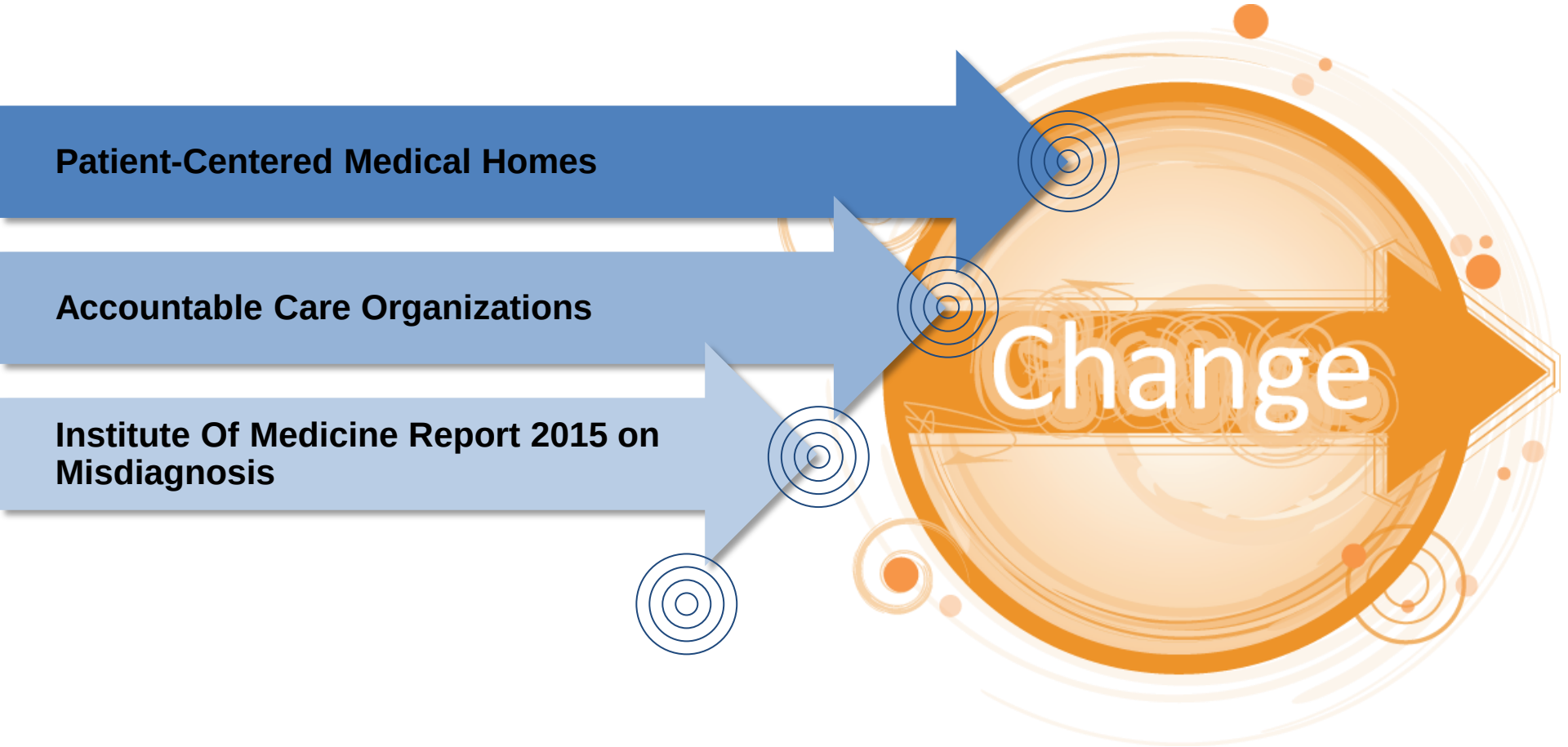
Did the error have serious, minor or no health consequences?





Kaiser Family Foundation – 2004 - National Survey on Consumers' Experiences with Patient Safety and Quality Information

Initiatives Supporting Change



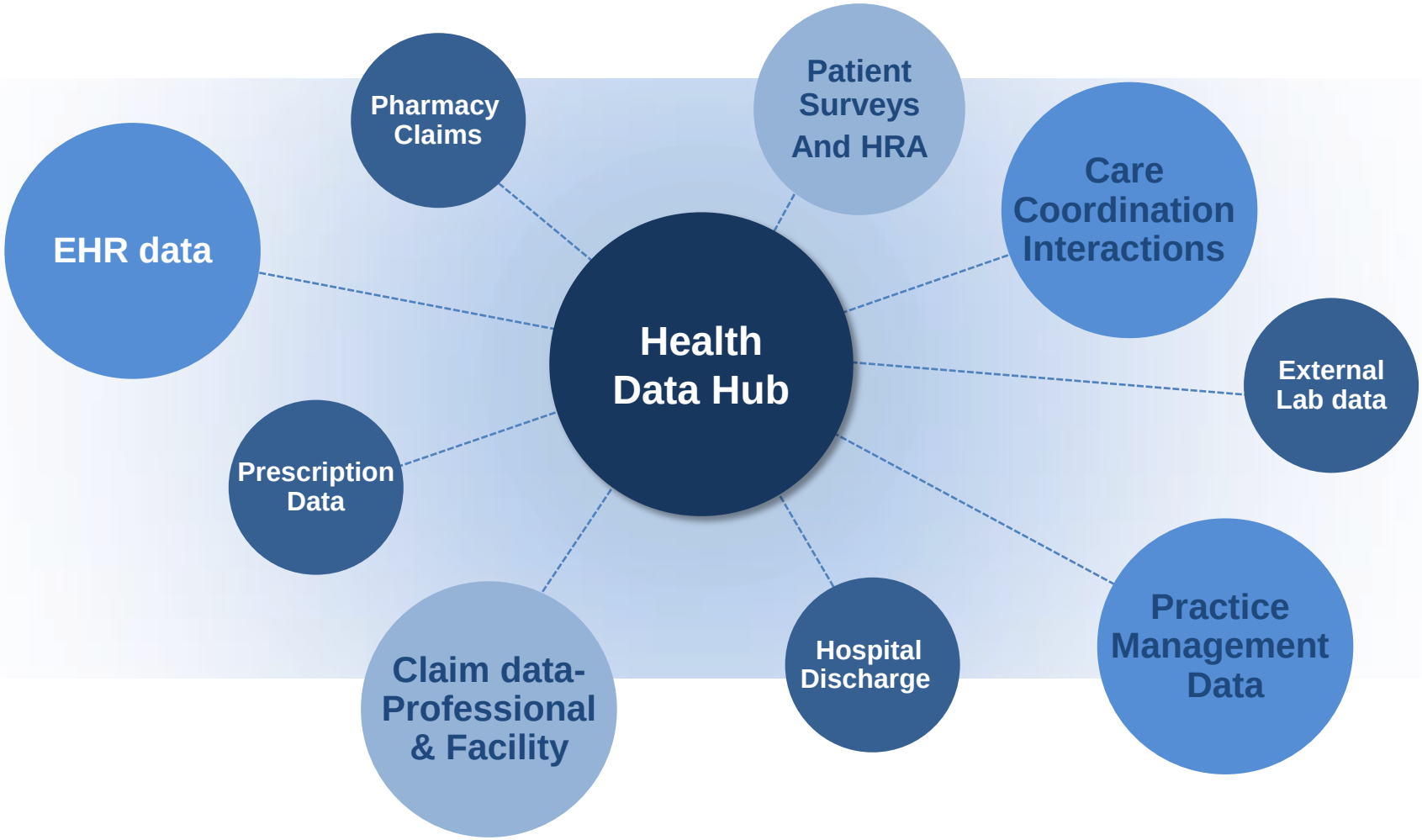
Institute of Medicine Project: Diagnostic Error in Health Care

Project Description

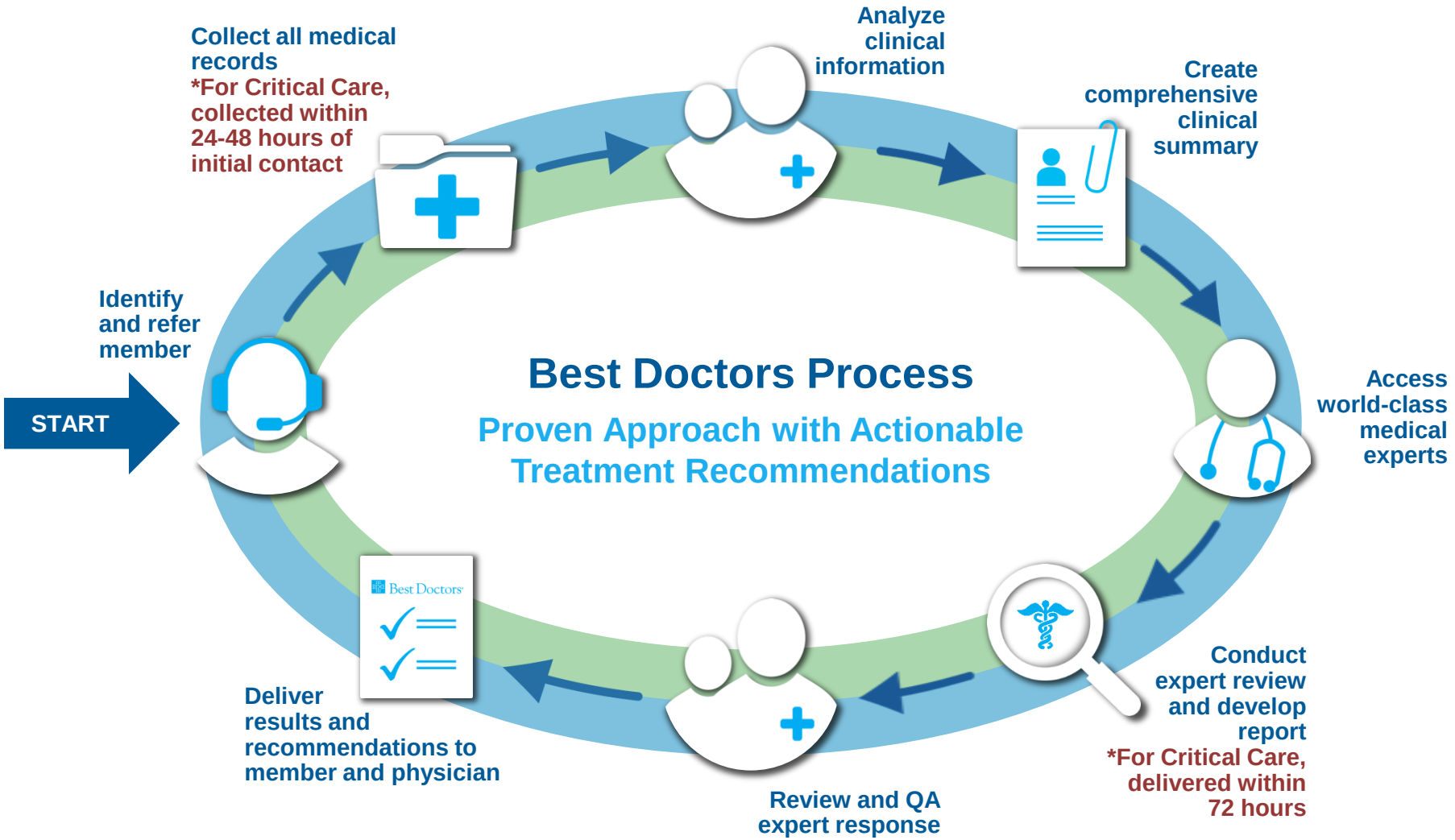
- **Evaluate** the existing knowledge about diagnostic error as a quality of care challenge; current definitions of diagnostic error and illustrative examples; and areas where additional research is needed
- **Examine** topics such as the epidemiology of diagnostic error, the burden of harm and economic 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



Local Care Coordinators & Care Managers Leverage Data



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."

INTERCONSULTATION® CASE STUDY – Treatment of Ehlers-Danlos

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

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:
AT THE HEART OF VALUE AND QUALITY

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

Richard Ricciardi, PhD, NP

Patient-Centered Primary Care Collaborative
2014 Annual Fall Conference, Washington DC

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 and Objectives

Purpose: Provide an overview of research on team-based health care and instruments to measure high functioning teams

Background

- 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

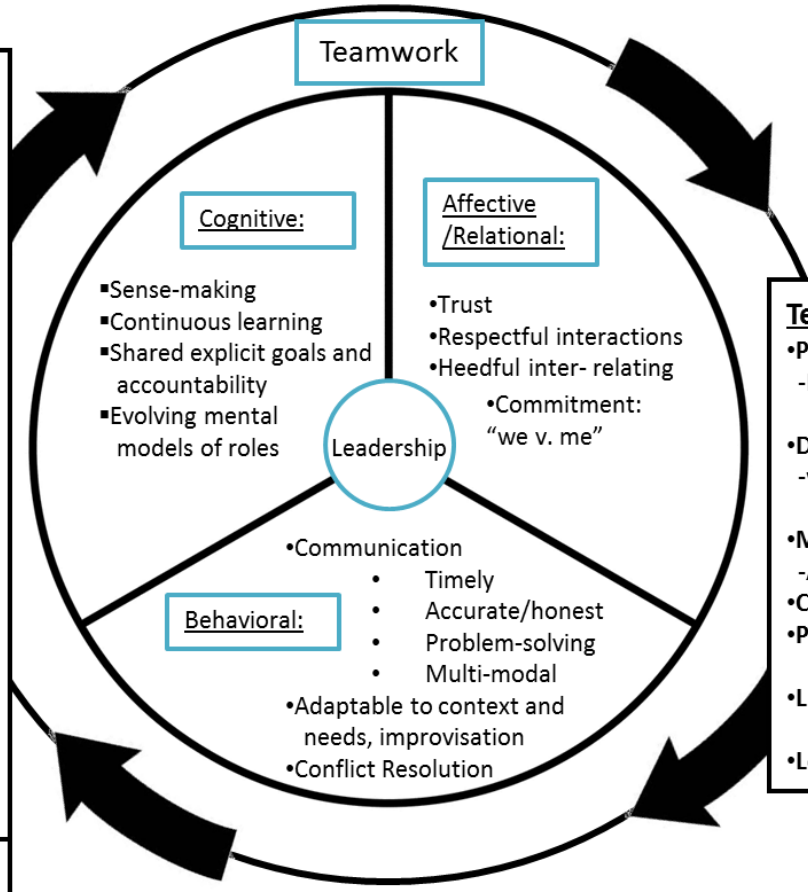
•Patient population needs
- -(demand & workload)

•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:



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

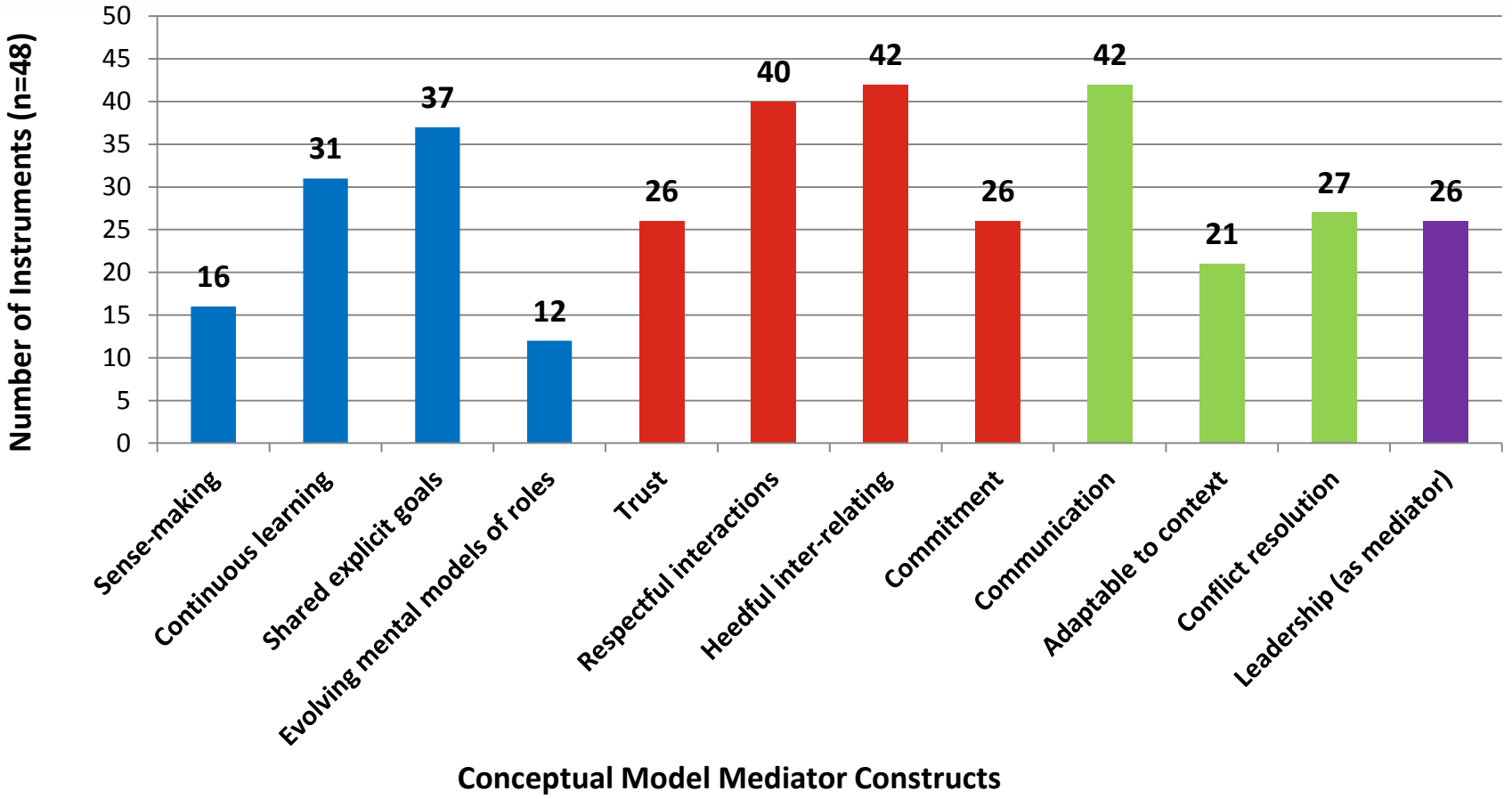
•Proactive care that is a shared responsibility

•Link to other teams/resources & coordinate care as needed

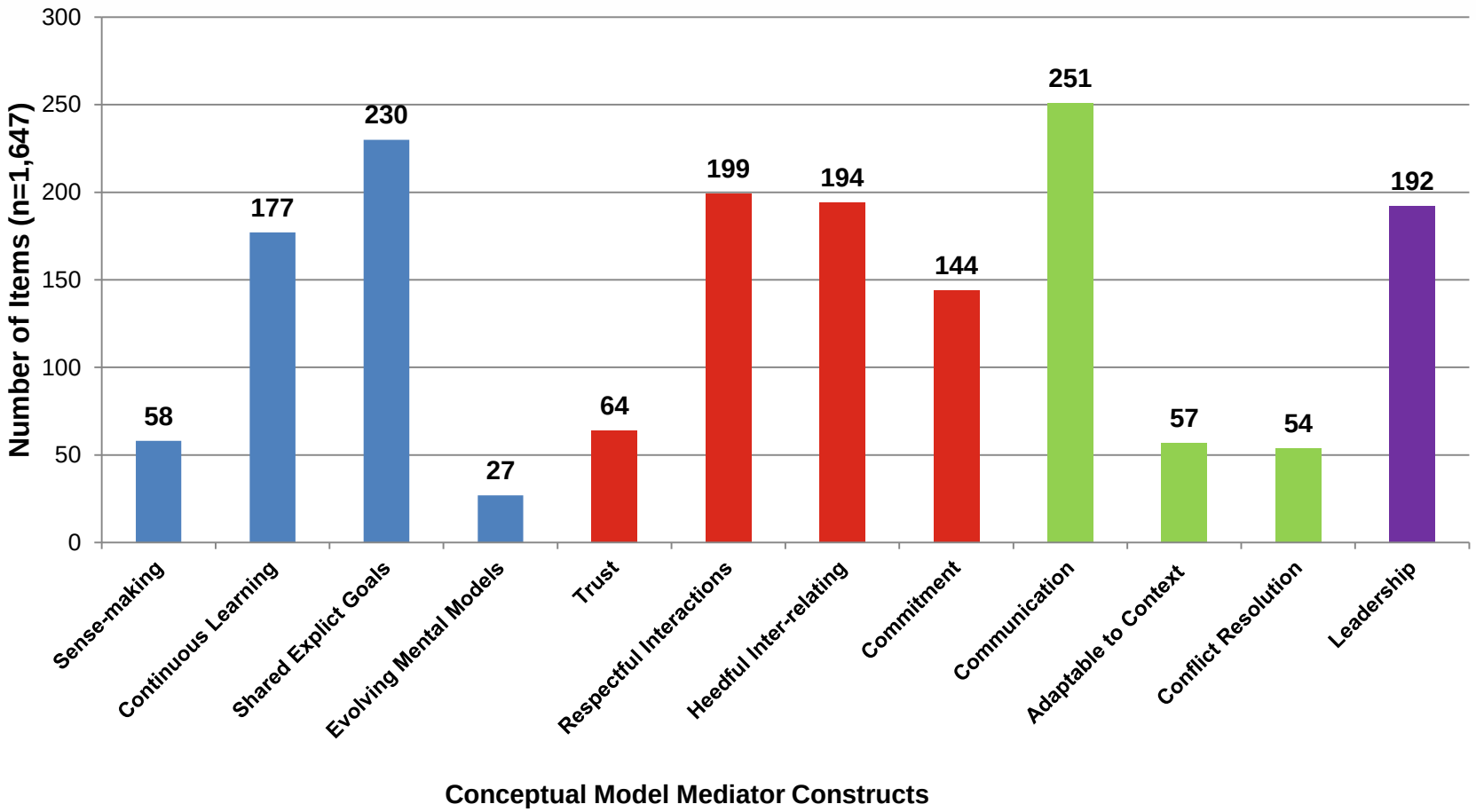
•Longitudinal continuity relationship

Shoemaker SJ, Fuda K, Parchman M, Schaefer J, Ricciardi R. A Review of Instruments to Measure Communication in Team-Based Care. Podium Presentation. International Conference on Communication in HealthCare. Montreal, Quebec, Canada. October 1, 2013.

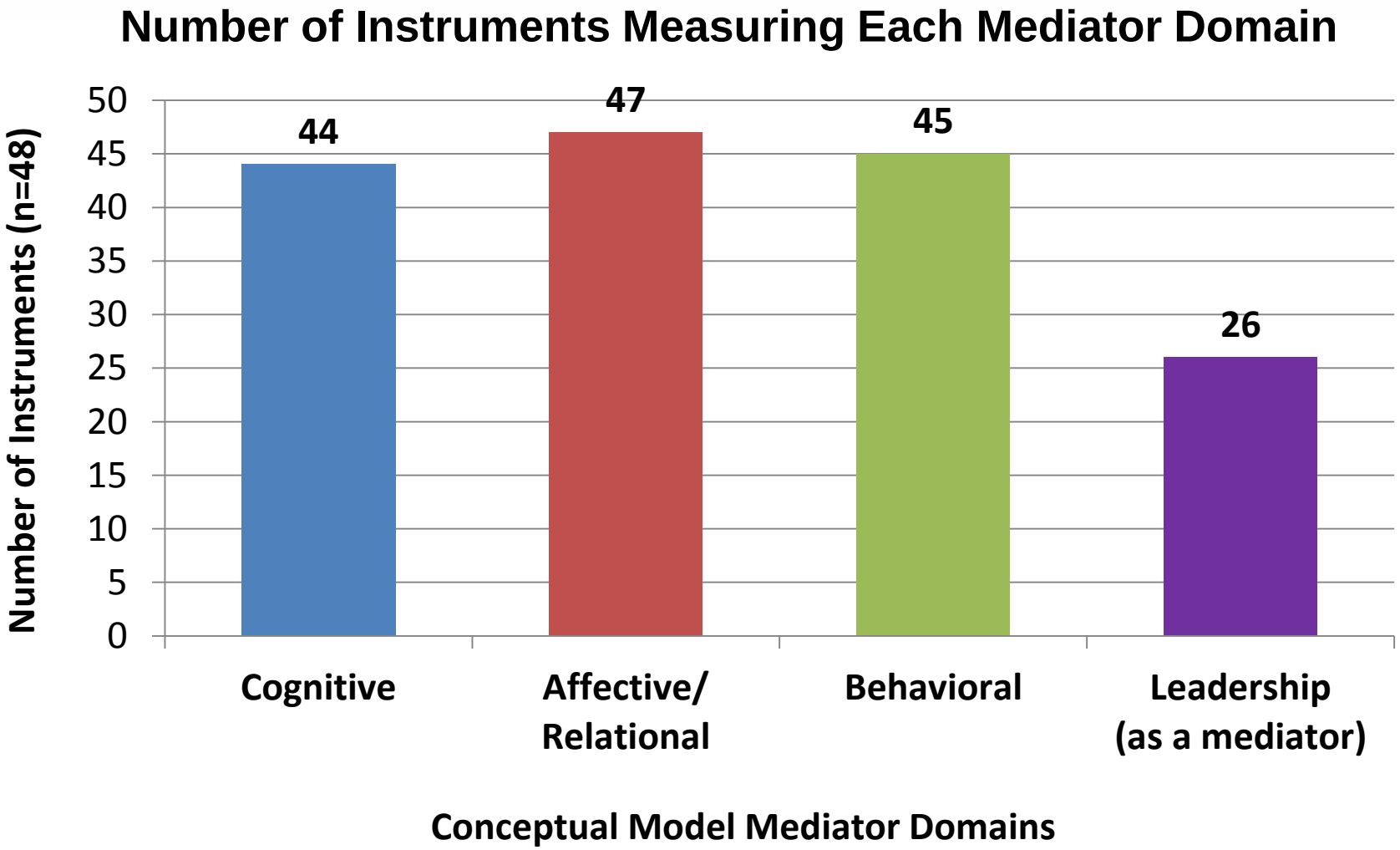
Number of Instruments That Map to Each Construct



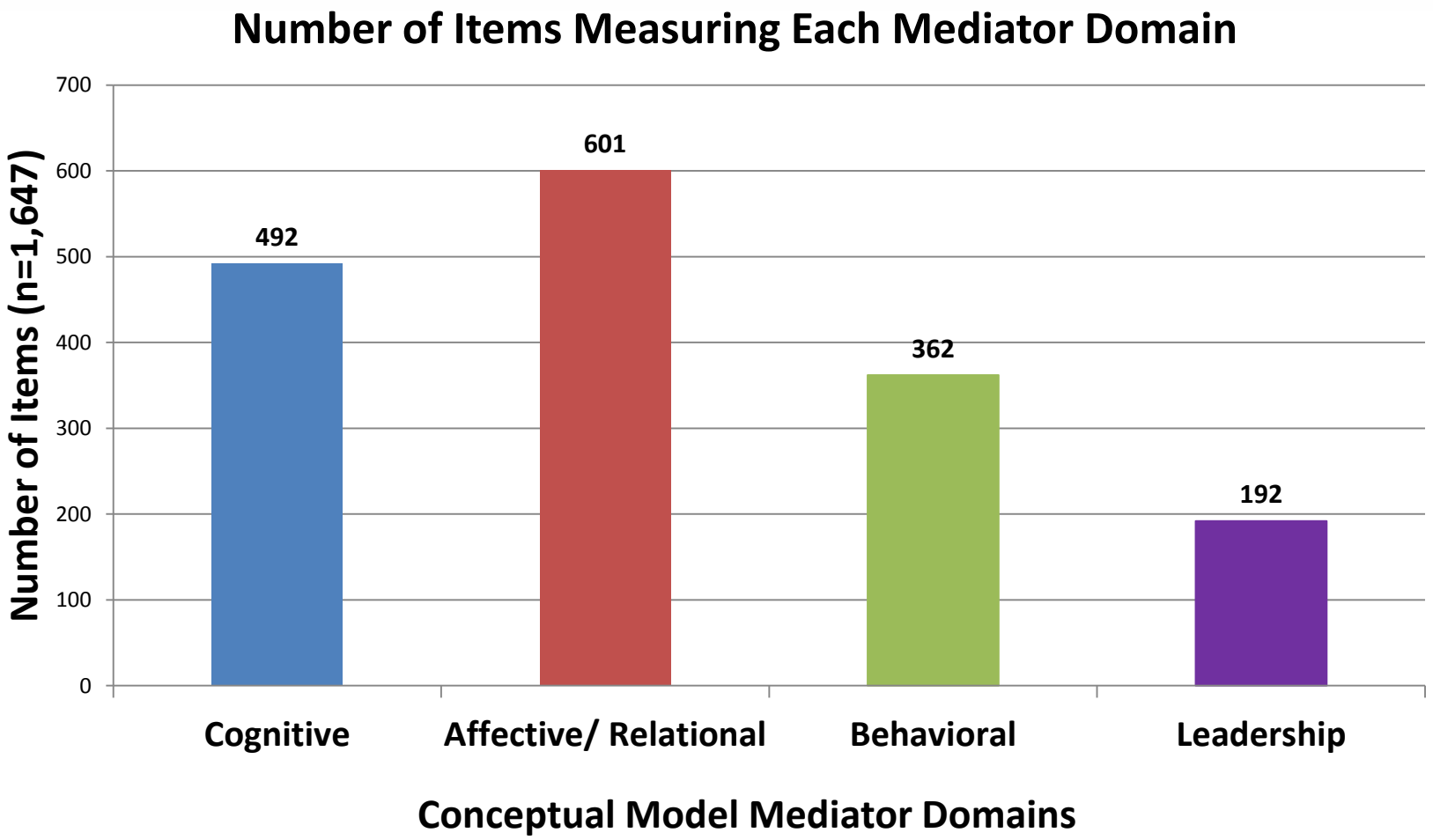
Number of Individual Items That Map to Each Construct



Results: Instrument Level



Results: Item Level



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

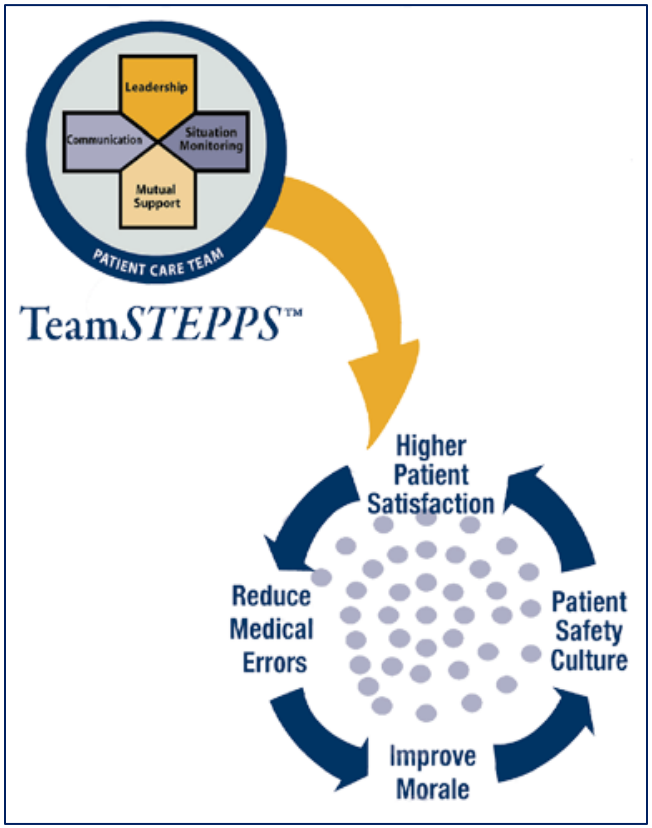
Gaps in Measurement

- 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

Primary Care TeamSTEPPS®

Building on Key Principles

Team Structure
Delineates fundamentals such as team size, membership, leadership, composition, identification and distribution

Leadership
Ability to coordinate the activities of team members by ensuring team actions are understood, changes in information are shared, and that team members have the necessary resources

Situation Monitoring
Process of actively scanning and assessing situational elements to gain information, understanding, or maintain awareness to support functioning of the team

Mutual Support
Ability to anticipate and support other team members' needs through accurate knowledge about their responsibilities and workload

Communication
Process by which information is clearly and accurately exchanged among team members

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

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

PATIENT-CENTERED PRIMARY CARE:
AT THE HEART OF VALUE AND QUALITY

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:
AT THE HEART OF VALUE AND QUALITY