

# The Medical Neighborhood – Value of the Home-Neighbor Relationship

Robert Krebbs – Director of Payment Innovation

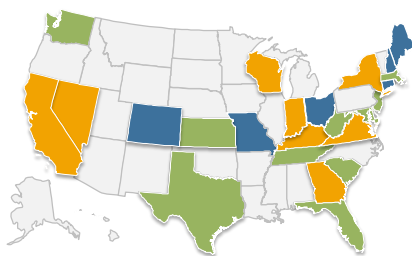
July 16th, 2015 – National Marrow Donor Program

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## A Health Benefits Leader

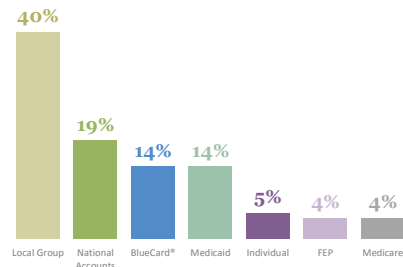
BC or BCBS plans in **14 states** and  
Medicaid presence in **19 states**

Increasingly diverse  
customer base



■ BC or BCBS licensed plans (6)  
■ BC or BCBS licensed plans + Medicaid presence (8)  
■ Medicaid presence (11)

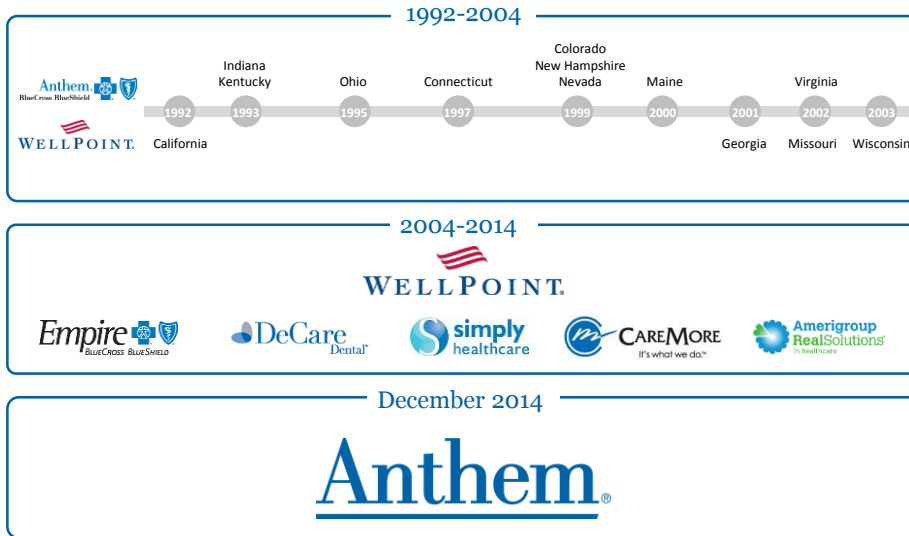
**1 in 9 Americans** **38.5 million**  
total medical members in  
affiliated health plans



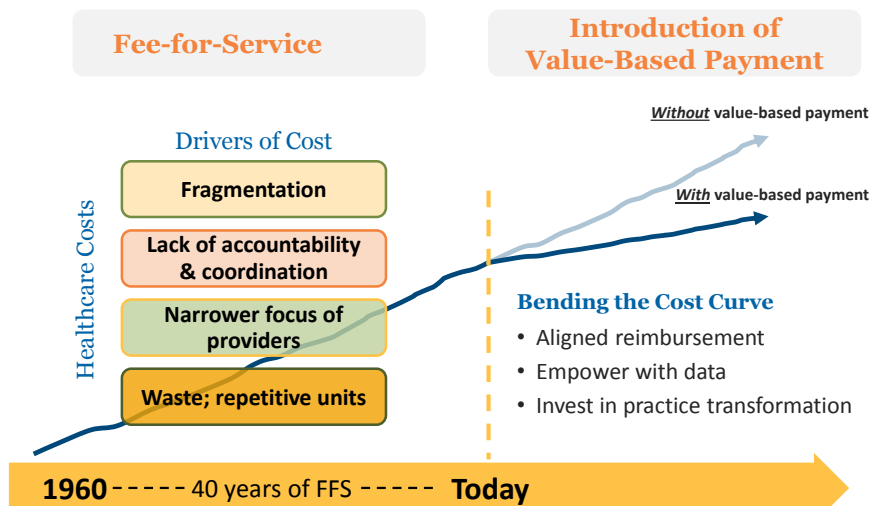
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## Evolution of Anthem, Inc.



## Transformation of the Healthcare Payment System Has Begun



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## Landscape of Anthem Payment Innovation

**787**  
hospitals  
75% of inpatient admissions  
hospital payment for quality and safety

**143**  
accountable care organizations  
Value-based contracts

**163,000**  
physicians  
physician pay for quality and clinical outcomes

**42,500**  
primary care physicians  
Enhanced Personal Health Care including Patient Centered Medical Homes and Comprehensive Primary Care Initiative

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## The Key to Success: Coordination and Communication within the Care Team

To create a truly high-value healthcare system, PCMH has to be the beginning of the transformation effort, not the end. A true medical neighborhood requires a “team” approach:

- Effective two-way communication between primary and secondary providers
- Appropriate and timely referrals and consultations with prompt feedback of findings / recommendations
- Effective co-management of patients when necessary
- A commitment to practice in a patient-centered fashion across all physicians delivering care to a patient

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## Why Do We Care About Coordination?

- Practice-to-practice care exchanges often produce frustration in the absence of care coordination structures:
  - **Primary care physicians** send patients for referral and hear nothing back from the specialist practice, sometimes only learning the visit actually occurred when the patient returns for a primary care visit
  - Patients arrive at **specialist physician** offices without needed pre-work, test results, etc., which lead to a wasted encounter and the need for visit rescheduling and delays in care OR numerous unneeded and avoidable tests are inappropriately ordered pre-consult, leading to healthcare spending waste and inefficiency

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## A Promising Solution: Care Coordination and the Care Compact

### What is it?

- An agreement that outlines the guidelines for providers to coordinate care in order to ensure the safe transition of care for members

### Why do we need it?

- Promotes mutual trust while improving communication by furthering the care exchange between providers

### How does it work?

- Outlines and defines the various types of care episodes in order to set expectations for roles, responsibilities and data exchange standards

### Why does it work?

- Provides a set of standardized processes for referrals and care coordination by outlining data requirements for status updates and patient profiles

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## Care Compact Adoption Impact

- Adoption of compact agreements transforms practice to practice exchanges by:
  - Providing **clarity** regarding roles and responsibilities among caregivers and delivering a clear picture of expectations from all involved in a patient's care
  - Providing clear lines of **accountability** regarding each patient's care so that lapses in agreed upon processes can be openly and fairly addressed

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## In 2014, Anthem began testing PCMH-N models

Patient Centered Specialty Care (PCSC) was launched as a small, limited pilot in 2014 (with expansion in 2015):

- Just over twenty enrolled practices in 2014, with good engagement from the majority of enrollees. We've doubled that amount in 2015, with continued expansion expected throughout the end of the year
- The practices cover multiple types of organizations, from large multi-specialty groups to small 2-physician independent practices
- The three target specialties are cardiology, endocrinology and OB/GYN

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## PCSC Scorecard – How it Works

Scorecard Section	Section Weight
Care Coordination	50%
Quality of Care	25%
Efficiency of Care	25%

- The scorecard is weighted to ensure each scorecard section maintains a static weight against the other sections
- If a measure within a section is deemed invalid for any reason, the associated points will re-weight within that section

- During the pilot stage of PCSC, the fee schedule enhancement opportunity is **locally determined** and driven
- This scale to the right is provided as an example only

PCSC Score	Potential FFS Enhancement
0 – 69 Points	0% Bump
70 – 90 Points	2% Bump
> 90 Points	4% Bump

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## PCMH-N

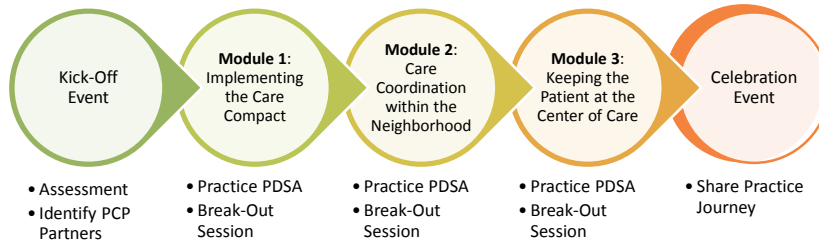
Engagement Model

Transforming  
Specialty Care in the  
Medical  
Neighborhood

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## PCSC – Learning Collaborative Approach



The curriculum is designed in a three part approach for each module:

1. Learning webinars to teach core skills and key concepts
2. Breakout sessions by specialty type, which focus on the practical application of the skill within the practice setting
3. Homework using small tests of change (such as PDSA cycles – Plan, Do, Study, Act) that build upon one another

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## Technical Assistance to Implement Care Compacts

The specialty practice is guided through this process with the support of dedicated associates trained in quality improvement and practice re-design to facilitate practices in the journey towards their “dream” referral process.

### Available Support

- **Dedicated staff to provide assistance**
- **Structured virtual Learning Collaboratives**
- **Individualized coaching and support**
- **Tools and Resources**
- **Free license to the ACP Practice Advisor<sup>SM</sup> – Specialty Practice Recognition**

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## Time Commitment Estimates

- CDT Learning Collaborative Activities

Estimated total hours: 14.5-17.5

Includes: Webinars, Breakout Sessions, Bi-Weekly Calls

Internal Practice Processes:

Estimated total hours: 12-26\*

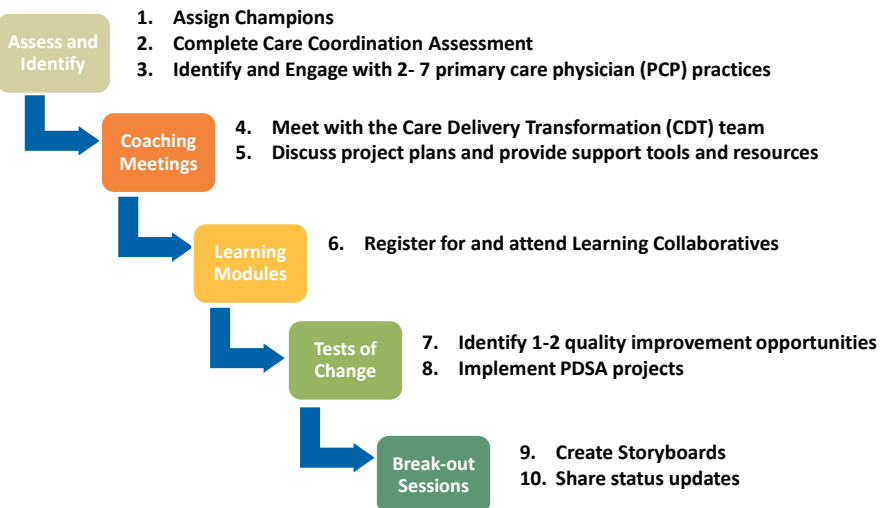
Includes: PCP Recruitment, PDSA Projects, Storyboard

\* Estimated practice time for work on internal processes is per clinic site and is dependent upon multiple variables (complexity of practice operations, number of compacts being implemented, electronic health record functionality, etc.). The initial ask is to establish the processes, then maintenance, spread and enhancements will likely take more time as we progress through the program pilot.

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## Implementing Care Compacts: 10 Steps to Success



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## PCSC Care 2014 Learning Collaboratives

### Module 1

#### Implementing Care Compacts

Featured Speaker: Neil Kirschner, PhD., American College of Physicians

*June 19, 2014 12 – 1:00 pm ET*

- Break-Out Sessions Week of July 14-18, 2014, 12-1:30 pm

### Module 2

#### Coordinating Care Across the Medical Neighborhood

Featured Speaker: Carol Greenlee, MD FACP FACE, Vice Chair, Council on Subspecialty Societies, American College of Physicians

*August 14, 2014, 12 – 1:00 pm ET*

- Break-Out Sessions- Week of September 8-12, 2014, 12-1:30 pm ET.

### Module 3

#### Keeping Patients at the Center of Care

Featured Speaker: Ben Matlock, MD, MPH, Assistant Professor of Medicine, University of Colorado School of Medicine

*October 2, 2014, 12 – 1:00 pm ET*

- Break-Out Sessions- Week of September 8-12, 2014, 12-1:30 pm ET

#### Self-Management Support

Featured Speaker: Kathy Reims, MD, CMO, CSI Solutions, LLC

*Recorded Webinar*

- Break-Out Sessions- Week of September 8-12, 2014, 12-1:30 pm ET

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## PCSC Virtual Breakout Sessions

- Each learning module included a specialty specific breakout session in which practice could connect to:
  - Learn about and share best practices, successes and challenges with industry professionals
  - Ask and answer questions to support the journey towards becoming a PCSC practice
  - Receive and provide feedback and direction on pilot activities

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# PCSC

## Year One Takeaways

## What We've Learned

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## Key Insights: Dr. Scott Hammond

- **The cultural schism between PCP and specialists is profound and needs specific attention.**
  - It will not change quickly and is specific to each practice so quite varied and challenging.
- **Find reasonable and reliable measures of teamwork/care coordination and the clinical measures will follow.**
  - Concentrating on clinical and cost measures w/o establishing truly effective and sustainable teams will lead to disappointing outcomes.
  - Building teams takes time so double or triple your timeline expectations.
  - Teamwork requires educating, modeling and supporting change. This takes money and resources. The PCP-Patient-Specialist team is a new concept and needs **to be created, defined and standardized.**
- **Specialists will not engage unless the practice manager is engaged and has the autonomy to make change.**
  - Do not expect all specialists in a group to participate.
  - Must allow for and measure individual specialists.
    - Will make it difficult with data collection.
    - Transparency critically important and helpful if coupled with improvement coaching..
- **If you do not carve out breathing space for practice change, you will have a difficult time.**
  - Regular PCP-Specialist collaboratives are essential. "Got to date first to ensure a happy marriage".

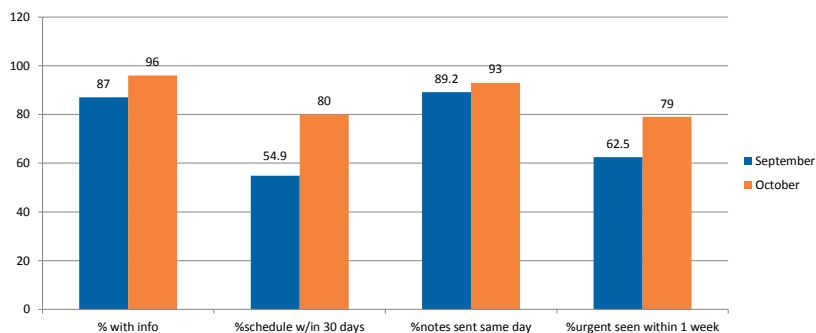


R. Scott Hammond, MD, FAAFP  
Associate Clinical Professor, University of Colorado  
School of Medicine  
Medical Director, Westminster Medical Clinic,  
Westminster, CO

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## Pilot Endocrine Practice – Examples of Success



### Increases noted in the amount of:

- referrals with complete information
- appointments scheduled within 30 days
- notes sent same day
- patients with urgent appointments seen within 1 week

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## Indicators of Success – Cont.

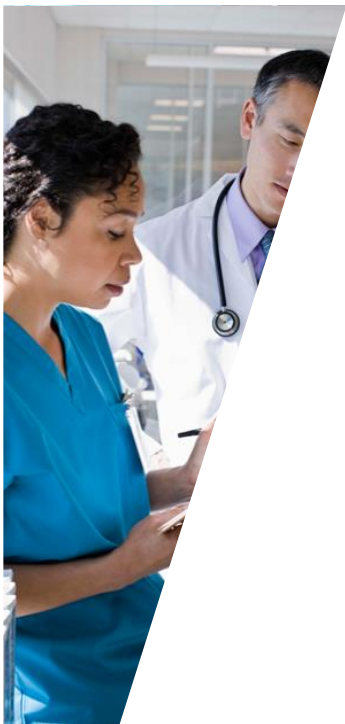
### Feedback received from an Endocrinology practice:

**“The use of the collaborative agreements and new referral forms has shown a dramatic increase in the number of complete referrals received, including reason for referral, complete demographic information, most recent chart notes, and pertinent labs and/or imaging completed.**

**These tools have also improved our utilization waste, by minimizing duplicity of testing.** In certain instances, we were able to notify primary care providers of unnecessary testing that would have been ordered and performed on behalf of the PCP, reducing healthcare expenditures.”

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## Next Steps for Pilot Year 2014 Provider Groups

- Function as a champion for the PCSC approach
- Participate in focus groups on specified topics
  - i.e. evaluate how the use of care compacts can impact cost of care
- Review curriculum and provide additional feedback on core program elements
- Speak at upcoming PCSC events to share best practices and lessons learned

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## The Neighborhood and HCT

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## Key Considerations

- While early efforts in Care Coordination improvement are focusing on PCP-to-Specialist interaction, ultimately team-wide interaction is the key:
  - Optimal Specialist-to-Specialist handoffs are just as critical for certain conditions as PCP-to-Specialist referrals
  - Specialists have an opportunity to define appropriate/inappropriate referral criteria and educate their Neighborhood partners
  - For HCT programs in particular, focused Care Compact approaches with community oncologists / hematologists can provide a firm foundation for improving referral timeliness and appropriateness

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