NATIONAL QUALITY FORUM

Patient Safety Quarterly Meeting Series

Public Agenda

The Power of Alignment: Engaging Purchasers and Payers to Accelerate Patient Safety Efforts
Thursday, April 24, 2014, 8:30am-2:45pm

Remote Participation Instructions - Streaming Audio Online

- Direct your web browser to: http://nqf.commpartners.com
- Under "Enter a Meeting" type in the meeting number **373393**
- In the "Display Name" field, type in your first and last name and click "Enter Meeting"

Objectives

(1) Identify the most effective best practices to mobilize purchasers and payers in meeting the Partnership for Patients goals.
(2) Identify concrete steps for achieving results through these best practices.
(3) Enable participants to take immediate action in their organizations and membership bases.

Audience

- Public and private sector healthcare purchasers and payers, from national and regional organizations.
- Patient advocates and patient advocacy organizations.

Agenda

8:30am **Light Breakfast** (provided by National Quality Forum)

9:00am **Introduction and Meeting Overview**
Louise Probst, MBA, RN, Meeting Chair, Member, National Quality Forum Board of Directors, and Executive Director, St. Louis Area Business Health Coalition

- Outline of meeting objectives
- Overview of the Partnership for Patients Meeting Series
- Welcome from Neal Comstock, Vice President, Member Relations, National Quality Forum
- Participant introduction activity

9:30am **Examples of Purchasers and Payers Achieving Results**
Brian DeVore, Director, Healthcare Strategy and Ecosystem, Intel Corporation
Alan Spielman, MBA, Assistant Director, Federal Employee Insurance Operations, US Office of Personnel Management

- Narrative presentation by each speaker, describing their success story and results (20 minutes per presentation)
- Audience question and answer period, moderated by Louise Probst(10 minutes per presentation)

10:30am **Break**

10:45am **Examples of Purchasers and Payers Achieving Results (continued)**
John O'Brien, MPH, PharmD, Vice President, Public Policy and Community Affairs, CareFirst with Jon Shematek, MD, Chief Medical Officer, CareFirst

- Narrative presentation, describing CareFirst's success story and results (20 minutes)
- Audience question and answer period, moderated by Louise Probst (10 minutes)

11:15am **The Partnership for Patients (PfP): Where Are We Now?**
Dennis Wagner, MPA and Paul McGann, MD, Partnership for Patients Co-Directors

- Overview of CMMI and the federal efforts supporting patient safety and quality, highlighting the importance of collaboration between hospitals and purchasers/payers in achieving results
- Q & A as a large group

12:15pm **Networking Lunch** (provided by National Quality Forum)

1:00pm **Small Group Breakout Session: Best Practices for Engaging Purchasers and Payers**
Small group facilitators:
Vicky Ducworth, Manager, Clinical Program and Delivery System Innovation, The Boeing Company
Bernie Rosof, MD, Chairman, Board of Directors, North Shore-Long Island Jewish Health System
Cristie Travis, MSHA, CEO, Memphis Business Group on Health
Missy Danforth, The Leapfrog Group, Senior Director, Hospital Ratings

- Participants break into four small groups for facilitated discussion around key questions:
  - Based on our experiences, what are each of our best practices to improve quality - specifically to reduce HACs and/or readmissions?
  - What will we do next – as individuals or a group - to spread these best practices?
- Group facilitators report back on action steps identified to mobilize purchasers and payers around best practices

2:00pm **On the Horizon: Transforming Clinical Practice**
LT Fred Butler Jr., MPH, Partnership for Patients Communications Lead, Quality Improvement and Innovation Models Testing Group, Center for Clinical Standards and Quality, CMS
Shaheen Halim, PhD, Quality Improvement Innovation Model Testing Group, Center for Clinical Standards and Quality, CMS

- Overview of a new initiative for private practice transformation to generate higher value through quality improvement and technical assistance for a large number of clinicians and their practices

2:30pm **Conclusion and Next Steps**
Louise Probst, Meeting Chair

2:45pm **Adjourn**

The Power of Alignment: Engaging Purchasers and Payers to Accelerate Patient Safety Efforts

2nd Meeting of the Patient Safety 2014 Quarterly Meeting Series

Supporting the Partnership for Patients

convened by the
NATIONAL QUALITY FORUM

April 24, 2014

9th Floor Conference Center
1030 15th Street NW, Washington, D.C. 20005

Welcome and Introductions

Louise Probst, MBA, RN
Executive Director, St. Louis Area Business Health Coalition
Member, Board of Directors, National Quality Forum

Table Introductions

Please take a moment to introduce your name, title and organization

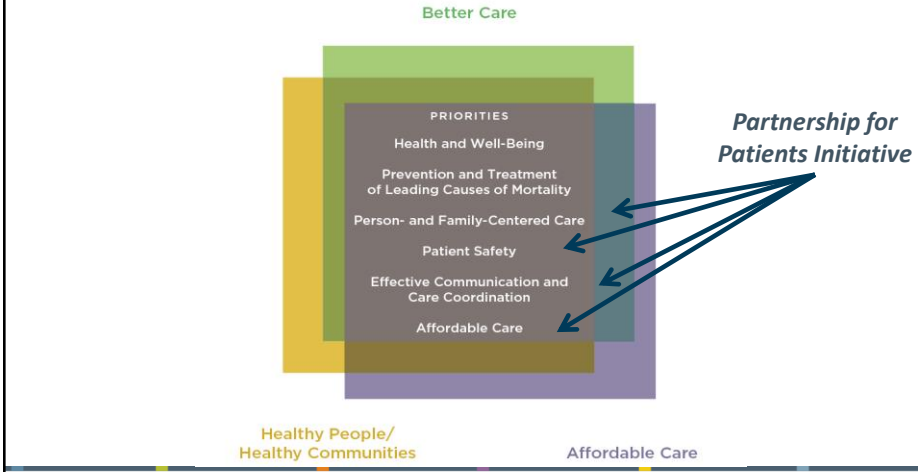
Welcome and Introductions

Neal Comstock
Vice President, Membership
National Quality Forum

The National Quality Strategy

NATIONAL QUALITY FORUM 5

The National Quality Strategy



NATIONAL QUALITY FORUM 6

Partnership for Patients

GOALS:

40% **Reduction in Preventable Hospital-Acquired Conditions**

1.8 Million Fewer Injuries | 60,000 Lives Saved

20% **Reduction in 30-Day Readmissions**

1.6 Million Patients Recover without Readmission

National Quality Forum and Patient Safety

Working together to implement the patient safety priority area of the National Quality Strategy

2014 National Quality Forum Meeting Series

A series of four meetings over the year. Topics include:

1. Engaging the workforce --
2. **Engaging purchasers and payers --**
3. Leveraging accreditation efforts --
4. Taking action in person-centered care --

-- To accelerate the Partnership for Patients goals of reducing hospital acquired conditions and readmissions.

Today's Meeting Objectives

- Identify the most effective best practices to mobilize purchasers and payers in meeting the Partnership for Patients goals.
- Identify concrete steps for achieving results through these best practices.
- Enable participants to take immediate action in their organizations and membership bases.

Today's Agenda

Introduction and Meeting Overview
Networking activity

Examples of Purchasers and Payers Achieving Results
Success stories from the field

The Partnership for Patients
Where are we now?

Breakout Session: Best Practices for Engaging Purchasers and Payers
Small group discussions to identify next steps

On the Horizon: Transforming Clinical Practice
Upcoming initiative for private practice transformation

Examples of best practices

St. Louis Area bhc BUSINESS HEALTH COALITION employer partners in healthcare

Highlights from the St. Louis Area Business Health Coalition

Louise Probst
Meeting Chair

BHC Mission and Approach

Mission: Support employers in their efforts to obtain better health and health care value

Strategic Objectives:
1. Improve Health
2. Achieve Transparency
3. Correct Misaligned Incentives

Health Care Reform Community by Community

Value-Based Purchasing

Community partnerships yield important progress

Align incentives toward greater quality and value

MIDWEST HEALTH INITIATIVE

Improving Health Care Through Shared Knowledge and Understanding

How St. Louis' RHIC Supports Partnership for Patients?

Mission

To provide a forum where trusted information and shared responsibility are used to improve health and the quality and affordability of health care.

Vision

A community that consistently leads the nation in health, care quality and affordability

A Shared Data Asset

Data warehouse of eligibility, medical, and pharmacy data for over 1 million lives

A Common Table

Bringing together those that provide, pay for, and use health care services to share information and responsibility for improving the region's health and health care

ACTIONS:

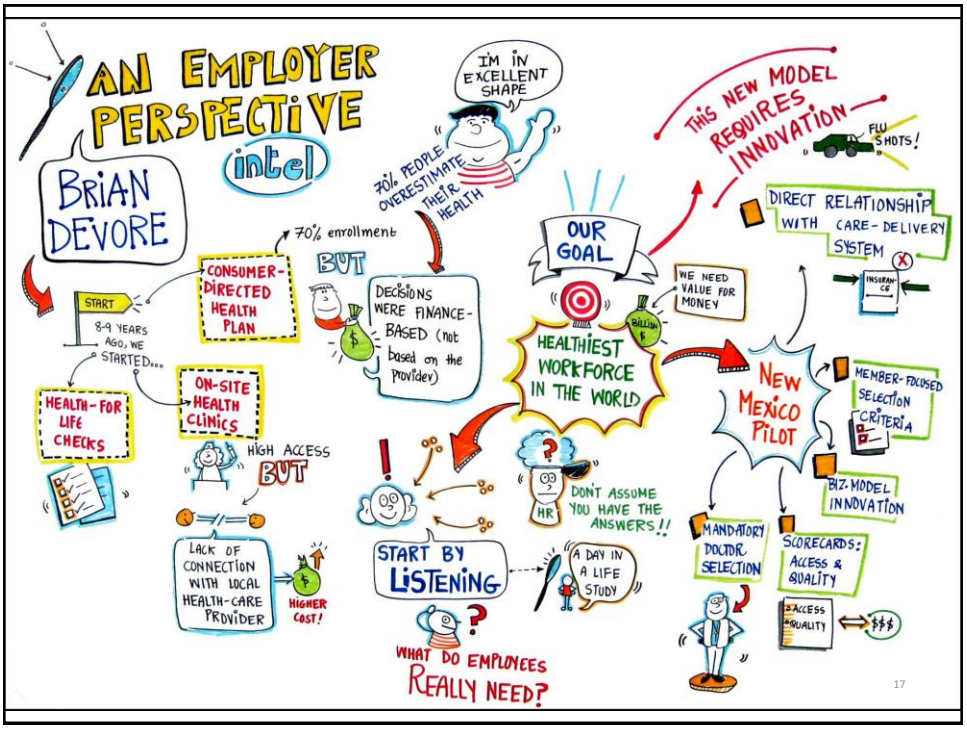
1. 2011 and 2012 ***Partnerships for Healthier Babies***
2. 2012 to present ***www.LiveWellSTL.org***
3. 2014 - ***Understanding and Encouraging Appropriate Utilization of Emergency Room Services***

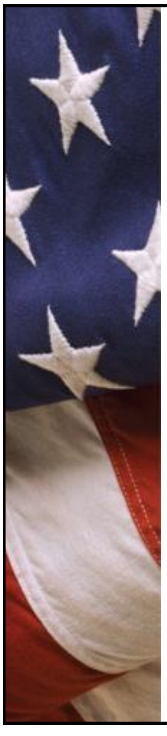
Table Introductions

- As a purchaser or payer, what is your organization doing to drive quality and lower costs?
- How do these current activities support the Partnership for Patients goals of reducing hospital readmissions and/or hospital acquired conditions (HACs)?
- What is your advice to other purchasers and payers, including CMS, who are trying to reduce readmissions and HACs?

Examples of Purchasers and Payers Achieving Results

Brian DeVore
Director, Healthcare Strategy and Ecosystem
Intel Corporation





Office of Personnel Management
Achieving Results in National Programs

Alan Spielman

Assistant Director

Federal Employee Insurance Operations

April 24, 2014

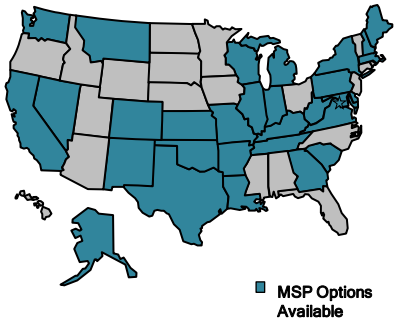
OPM Health Insurance Portfolio

Federal Employees Health Benefits Program

- 97 carriers, 256 plan options in 2014
- 8.2 million FEHB members
- Lifelong relationship

Multi-State Plan Program

- 150 plan options in 30 states and DC
- Expansion expected for 2015



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Healthier Americans Strategic Goal

- Sponsor **high quality**, consumer friendly, affordable insurance products
- Optimize insurance related business processes
- Improve **preventive services** delivery
- Develop **partnerships** in support of population health
- Enhance outreach and health literacy

Strategic Plan FY2014-2018
Available at www.opm.gov.

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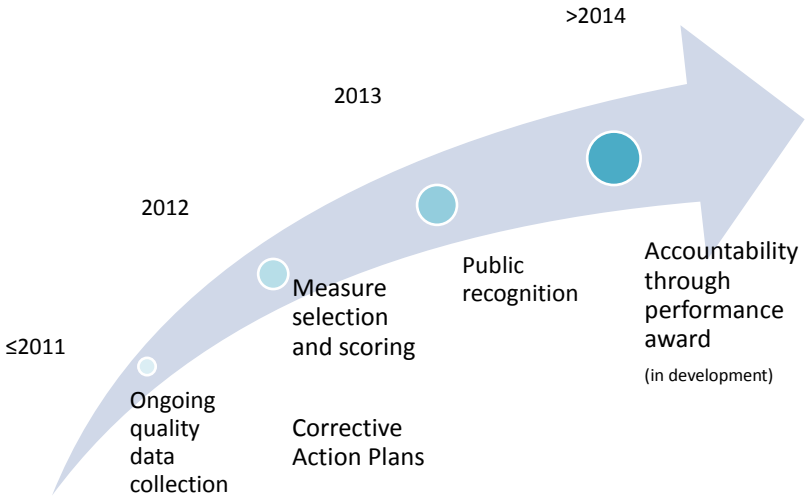
Advancing Quality



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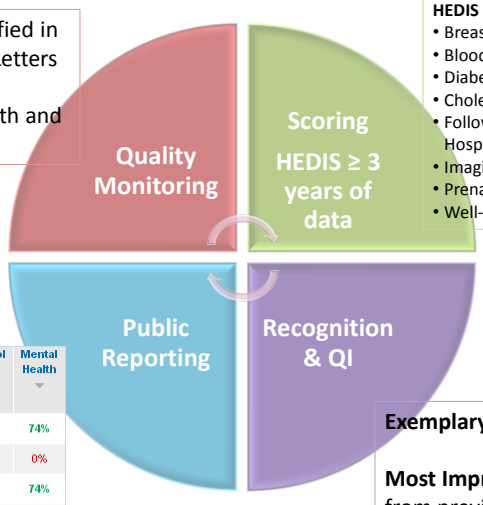
Quality Framework

- Measures specified in annual Carrier Letters
- Population health and policy priorities



HEDIS subset for 2014
- Breast cancer screening
- Blood pressure control
- Diabetes management
- Cholesterol screening
- Follow-up after Mental Health Hospitalization
- Imaging for Low Back Pain
- Prenatal Care
- Well-Child Visits

Diabetes Testing	Diabetes Screening	Cholesterol Testing	Mental Health
90%	88%	95%	74%
89%	87%	92%	0%
93%	91%	93%	74%
93%	89%	91%	0%
91%	88%	92%	54%

Exemplary: Top performers

Most Improved: Increase 20% from previous year

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Alignment with Partnership for Patients Goals

Making Care Safer

- Early Elective Delivery
- Hospital Acquired Conditions
- Appropriate Utilization
- Readmissions

Improving Care Transitions

- Patient Centered Medical Homes (PCMH)
- Accountable Care Organizations (ACO)

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Making Care Safer: Reducing Early Elective Delivery

- Plans chose focus for 2014
- Highlighted CMS metrics and TJC Perinatal Measures
- Include data in hospital contract renewals
- Progress update in June 2014

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Making Care Safer: Reducing Hospital Acquired Conditions

- Guidance on never events
- Plan consideration of hospital data in structuring networks

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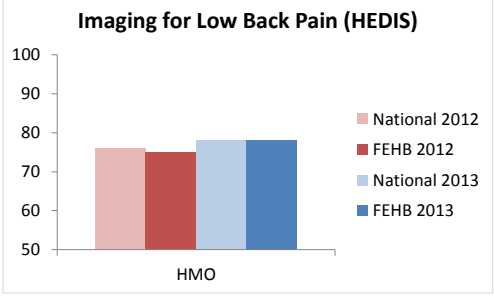
Making Care Safer: Appropriate Utilization

- Antibiotic Use
  - Added HEDIS measure to 2014 set (Avoidance of Antibiotics in Adults with Acute Bronchitis)
- Appropriate Use of Imaging



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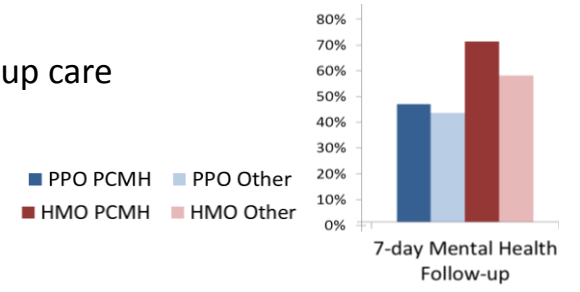
Making Care Safer: Readmissions

- Plan All-Cause Readmissions data pending
- Emphasize contracts with high performing hospitals
- Plans intervene to improve care coordination
- Ensure follow up care



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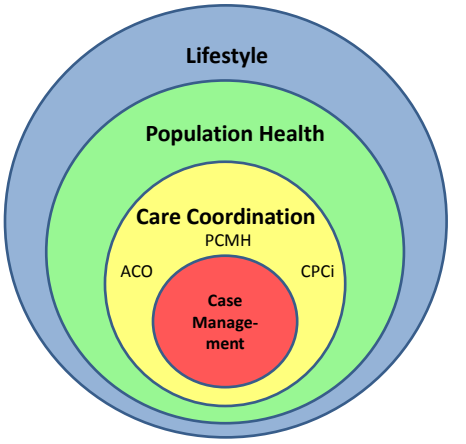
Improving Care Transitions

- Criteria for PCMH
- ACO products in 2014
- Comprehensive Primary Care Initiative



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Looking to the Future

Opportunities

- Lifelong relationship with members
- Improvement through accountability
- Building on work of partners
- Focus on drug utilization management
- Ability to advance care across settings

Challenges

- Consumer choice using quality data
- Dual coverage

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Heading Toward Health

Alan.Spielman@opm.gov

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Morning Break (15 minutes)

CareFirst

CareFirst's Total Care & Cost Improvement Initiative:

Data, Incentives & Partnerships to Change Behavior, Improve Care, and Achieve Results

Jon Shematek, M.D., Senior Vice President and Chief Medical Officer
John O'Brien, PharmD, MPH, Vice President of Public Policy

April 24, 2014

CareFirst

About CareFirst Blue Cross Blue Shield

- The largest insurer in the Mid-Atlantic region, serving 3.4 million members
- Employs about 5,000 associates and contractors in Maryland, Washington D.C., Northern Virginia, West Virginia, and North Carolina
- Has the largest provider network in the region, with more than 80 percent of the region's health care providers participating in one or more networks
- Keenly focused on lowering total medical costs by improving quality
- Launched the nation's largest Patient-Centered Medical Home (PCMH) program of its kind
- Awarded a Health Care Innovation Award from the CMS Innovation Center to include Medicare beneficiaries

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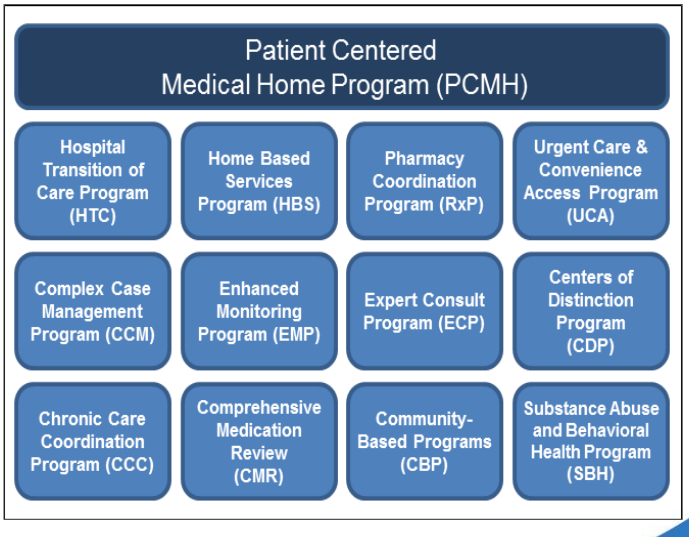
PCMH Program Supported by TCCI Elements



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TCCI Program
Total Care and Cost Improvement Program

TCCI Program Elements

1. **Hospital Transition of Care Program (HTC)**
2. **Complex Case Management Program (CCM)**
3. **Chronic Care Coordination Program (CCC)**
4. **Home-Based Service Program (HBS)**
5. **Enhanced Monitoring Program (EMP)**
6. **Comprehensive Medication Review Program (CMR)**
7. Pharmacy Coordination Program (RxP)
8. Expert Consult Program (ECP)
9. **Community-Based Programs (CBP)**
10. Urgent Care Access (UCA)
11. Centers of Distinction Program (CDP)
12. Substance Abuse and Behavioral Health Program (SBH)

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TCCI Program
Total Care and Cost Improvement Program

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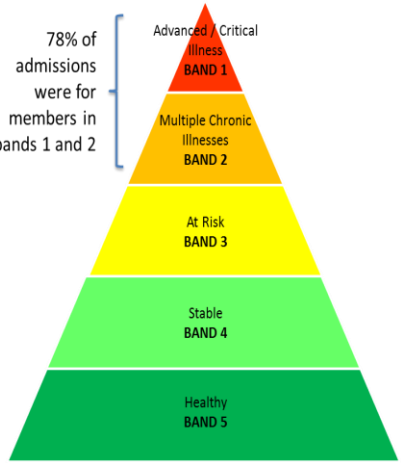
CareFirst Illness Burden Pyramid

78% of admissions were for members in bands 1 and 2



	Percent of Population	Percent of Cost	PMPM Cost	Illness Burden Range
Advanced / Critical Illness BAND 1	3%	29%	$4,436	≥ 5.0
Multiple Chronic Illnesses BAND 2	8%	23%	$1,160	2.00-4.99
At Risk BAND 3	12%	21%	$578	1.00-1.99
Stable BAND 4	27%	20%	$218	0.25-0.99
Healthy BAND 5	50%	7%	$49	0-0.24

Source: CareFirst HealthCare Analytics – 2012 Data

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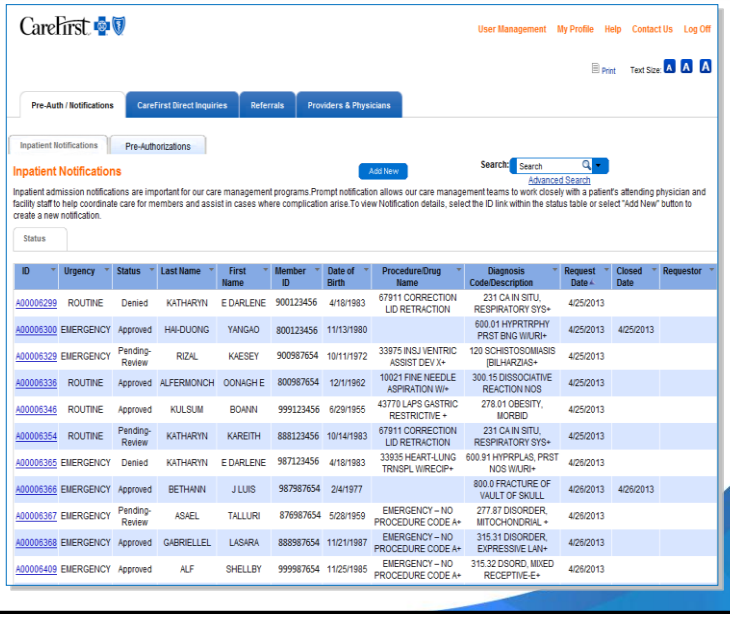
iCentric – HTC Roster of Members



CareFirst

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Pre-Auth / Notifications | CareFirst Direct Inquiries | Referrals | Providers & Physicians

Inpatient Notifications | Pre-Authorizations

Inpatient Notifications

Add New

Search: Search

Advanced Search

Inpatient admission notifications are important for our care management programs.Prompt notification allows our care management teams to work closely with a patient's attending physician and facility staff to help coordinate care for members and assist in cases where complication arise.To view Notification details, select the ID link within the status table or select "Add New" button to create a new notification.

Status

ID	Urgency	Status	Last Name	First Name	Member ID	Date of Birth	Procedure/Drug Name	Diagnosis Code/Description	Request Date	Closed Date	Requestor
A00006299	ROUTINE	Denied	KATHARYN	E DARLENE	900123456	4/18/1983	67911 CORRECTION LID RETRACTION	231 CA IN SITU, RESPIRATORY SYS+	4/25/2013		
A00006300	EMERGENCY	Approved	HAI-DUONG	YANGAO	800123456	11/13/1980		600.01 HYPRTRPHY PRST BNG W/URI+	4/25/2013	4/25/2013	
A00006329	EMERGENCY	Pending-Review	RIZAL	KAESEY	900987654	10/11/1972	33975 INSJ VENTRIC ASSIST DEV X+	120 SCHISTOSOMIASIS [BILHARZIAS+	4/25/2013		
A00006336	ROUTINE	Approved	ALFERMONCH	OONAGH E	800987654	12/1/1962	10021 FINE NEEDLE ASPIRATION W/+	300.15 DISSOCIATIVE REACTION NOS	4/25/2013		
A00006346	ROUTINE	Approved	KULSUM	BOANN	999123456	6/29/1955	43770 LAPS GASTRIC RESTRICTIVE +	278.01 OBESITY, MORBID	4/25/2013		
A00006354	ROUTINE	Pending-Review	KATHARYN	KAREITH	888123456	10/14/1983	67911 CORRECTION LID RETRACTION	231 CA IN SITU, RESPIRATORY SYS+	4/25/2013		
A00006365	EMERGENCY	Denied	KATHARYN	E DARLENE	987123456	4/18/1983	33935 HEART-LUNG TRNSPL W/RECIP+	600.91 HYPRPLAS, PRST NOS W/URI+	4/26/2013		
A00006366	EMERGENCY	Approved	BETHANN	J LUIS	987987654	2/4/1977		800.0 FRACTURE OF VAULT OF SKULL	4/26/2013	4/26/2013	
A00006367	EMERGENCY	Pending-Review	ASAEL	TALLURI	876987654	5/28/1959	EMERGENCY – NO PROCEDURE CODE A+	277.87 DISORDER, MITOCHONDRIAL +	4/26/2013		
A00006368	EMERGENCY	Approved	GABRIELLEL	LASARA	888987654	11/21/1987	EMERGENCY – NO PROCEDURE CODE A+	315.31 DISORDER, EXPRESSIVE LAN+	4/26/2013		
A00006409	EMERGENCY	Approved	ALF	SHELLBY	999987654	11/25/1985	EMERGENCY – NO PROCEDURE CODE A+	315.32 DSORD, MIXED RECEPTIVE-E+	4/26/2013		

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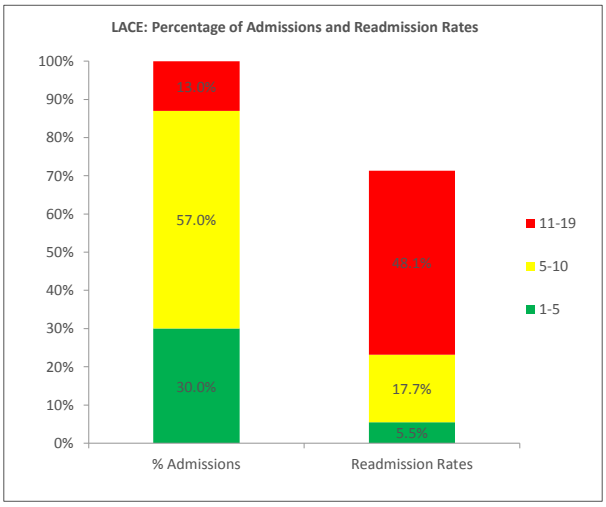
Hospital Transition of Care – LACE Scores



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TCCI Elements

1. Hospital Transition of Care Program (HTC)
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Complex Case Management Program – Specialty Areas

Case Management Specialty	Qualifications (in addition to multiple levels/ years of clinical experience in each discipline)	Percentage of Member Conditions/Illness in Specialty
Special Needs/High Risk Pediatrics	Certified Pediatric Nurse, Certified Neonatal Nurse, or Certified in Developmental Disabilities	20
Pediatric Oncology	Certified Pediatric Oncology Nurse, Certified Hospice/Palliative Nurse with concentration in Pediatrics, or Certified Pediatric Nurse	10
Adult Oncology	Certified Oncology Nurse, Certified Hospice/Palliative Care Nurse, or Certified Clinical Transplant Coordinator	20
High Risk Pregnancy	Certified Maternal Health Nurse or Certified Childbirth Educator/Nurse	10
Complex Medical Illnesses: Neurology, Cardiology, Pulmonology, Immunology, Gastroenterology, Endocrinology	Certified in Medical/Surgical Nursing or one of the specialty disciplines such as Neurology or Cardiology, Certified Case Manager, or Certified Geriatric Nurse	5
Palliative Care/Hospice	Certified Oncology Nurse, Certified Hospice/Palliative Care Nurse	5
Trauma/Rehabilitation	Certified Rehabilitation Nurse, Certified Orthopedic Nurse, Certified Neurology Nurse	30

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Complex Case Management Program Features

- The focus is on Band 1 of the Illness Burden pyramid – the most complex, catastrophic health care needs of the critically ill
- Better alignment with patients' needs and improved credibility with physician specialists
- Developed complex case management targeted capabilities for:
  - Adult Oncology
  - Pediatric Oncology
  - Complex Medical
  - Trauma/Rehabilitation
  - Special Needs/Complex Pediatrics
  - High Risk Obstetrics
  - Hospice/Palliative/End of Life Care
- Average caseload per Case Manager is 50 per month – average case is open for 3 months (longer for oncology and high-risk OB)

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TCCI Elements

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Program Goals

1. To provide PCPs with a complete view of their patients needs, to better understand their individual risks, keep patients healthier, and produce better outcomes
2. With PCP in the role of the central player, seeks to have PCP put a differential focus on patients with multiple chronic diseases at higher risk of breakdown and to manage that risk through Care Plans and closer oversight
3. To enable PCPs to see and understand the downstream costs and quality implications of their referrals and to feed continuous interest in the impact through informed specialist selection and collaboration

The goals of the PCMH program are to help PCPs produce better outcomes, assist PCPs as they quarterback care for patients with complex needs and help PCPs understand the cost-effectiveness of informed specialist selection and collaboration.

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The Structure – Credible Data

PCMH SearchLight

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

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PCMH SearchLight Report for Panel

A. High Cost/High Risk Members with Multiple Indicators

This view is a summarization of the Top 10 lists that follow. By default, the view shows the top 10 Members identified based on the total number of High Cost/High Risk factors categories in which they fall. These are checked below. Additional Members can be displayed in groups of 10 (up to 50). Options to filter on Members attributed to an individual physician and to filter by All Members or just those who are Care Plan Eligible are provided as well. This data includes Medicare Primary Members. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name.

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		24.51	MEZGEBE HAILE	Pneumonia, Bacterial	✔	✔			✔		✔			
2		2.56	CHIQUITIA ANDERSON	Pregnancy w Cesarean Section	✔	✔			✔					
3		4.24	AMY B PULLMAN	Hernia/Reflux Esophagitis	✔	✔		✔						
4		2.08	AMY B PULLMAN	Gastroint Disord, NEC	✔	✔			✔					
5		2.81	VIJAYALAKSHMI SUBRAMANIAN	Mental Hlth - Schizophrenia	✔					✔				
6		4.55	MEZGEBE HAILE	Arthropathies/Joint Disord NEC	✔					✔				
7		0.55	SITHANANDAM SADHASIVAM	Epilepsy	✔	✔								
8		3.64	AMY B PULLMAN	Respiratory Disord, NEC	✔	✔								
9		2.33	AMY B PULLMAN	Bursitis	✔						✔			
10		0.80	MILAGROS C ARIZA	Spinal/Back Disorders, Excl. Low	✔					✔				

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

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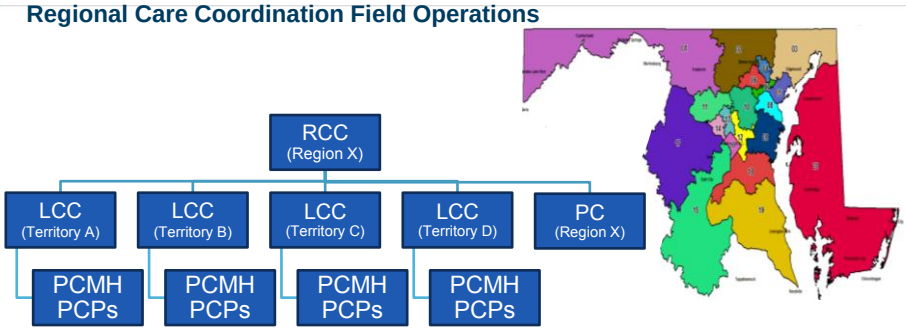
CareFirst

The Structure – High Personal Touch

Regional Care Coordination Field Operations



Care Coordination: Each of the 20 regions is assigned a Regional Care Coordinator. Each PCP in those regions is assigned a Local Care Coordinator.

Consulting: Each practice is assigned a Program Rep and the entire panel is assigned a Program Consultant.

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CareFirst

Quality Scorecard (1 of 2)

Quality Scorecard Measures	
Category 1: PCP Engagement	**30 points**
PCP Engagement with the PCMH Program	
Supportive PCMH Office Environment	
LCC Collaboration	7.5 points
Care Plan Explanation	
Intra Panel Communication	
Overall Facilitation of PCMH Goals	
PCP Engagement with Care Plans	
Review Care Plan Documentation	
LCC Care Plan Consultation	7.5 points
Medication Review	
LCC Care Plan Collaboration	
Overall Facilitation of Care Plan	
Member Satisfaction Survey	
Understands the Care Plan	
Care Coordination is helpful	7.5 points
Sufficient Time with PCP or NP	
Access to Information needed to manage member's health	
Member's health has improved	
Program Consultant Assessment	
Presence at Panel Meetings	
Evidence of logging into SearchLight Reports	4.5 points
Active Participation in Panel Meetings	
Follow up with Program Consultants between Panel meetings	
Evidence of ongoing use of SearchLight Reports and a plan to follow up on SearchLight patterns	
Program Representative Assessment	
Participates in current webinars, monthly seminars and training	
Participates in scheduled meeting with Program Representative	
Active Portal access for all PCPs and NPs; current DPR; and Portal Administrator	3 points
Maintains current provider information and is knowledgeable of PCMH as evidenced by questions, comments and actions	
Files claims and appeals in accordance with CareFirst guidelines	

The program is assessed in several ways. PCPs are assessed on their engagement, Members are surveyed and the PCP's population health and care measurement are measured through claims activity.

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CareFirst

Quality Scorecard (2 of 2)

Quality Scorecard Measures Continued	
Category 2: Appropriate Use of Services	**20 points**
Admissions	
Preventable Admissions	8 points
Potentially Preventable Readmissions	
Potentially Preventable Emergency Room Use	4 points
Potentially Preventable Emergency Room Use	
Ambulatory Services, Diagnostic Imaging and Antibiotics	
Colonoscopy	
CT Scans	
MRI	8 points
Patients with Lower Back Pain	
Patients with Viral Upper Respiratory Infections	
Patients with Pharyngitis	
Category 3: Effectiveness of Care	**20 points**
Chronic Care Maintenance	
Diabetes	
Asthma	
ADHD	10 points
Coronary Artery Disease	
Coronary Artery Disease – Myocardial Infarction	
Major Depressive Disorder	
Population Health Maintenance	
Colon Cancer Screening	
Chlamydia Screening	
Cervical Cancer Screening	
Breast Cancer Screening	
Well-Child Exams (Ages 0-15 months)	10 points
Well-Child Exams (Ages 3-6 years)	
Well-Child Exams (Ages 12-21 years)	
Annual Dental Visit	
Childhood Immunizations	
Adolescent Immunizations	
HPV Vaccination	
Category 4: Member Access	**20 points**
Online Appointment Scheduling	4 points
Unified Communication Visits / Telemedicine	4 points
Office Hours Before 9:00am and After 5:00pm on Weeknights	4 points
Office Hours on Weekends	4 points
Overall Patient Experience	4 points
Category 5: Structural Capabilities	**10 points**
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
Total Potential Points	**100 points**

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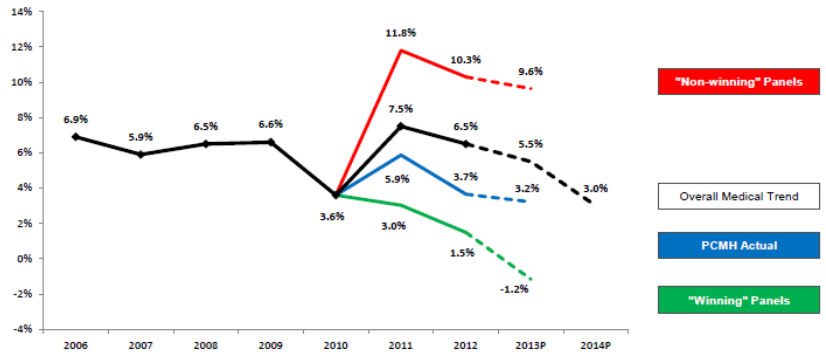
CareFirst

Program Results Have Been Encouraging

Program Impact on Overall Medical Trend

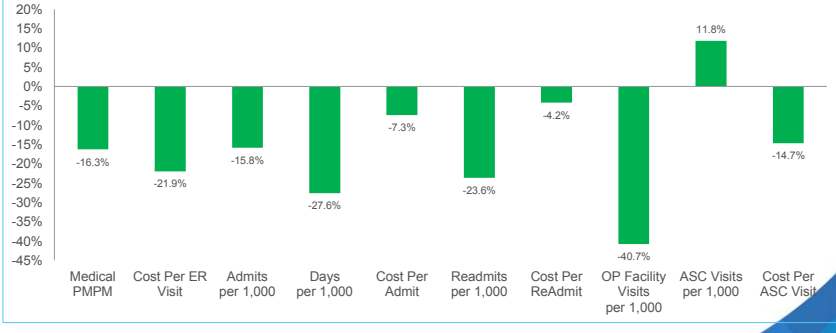


CareFirst

Key Measures – 24 Month Comparison of PCMH to Non-PCMH

- The PCMH population Medical PMPM shows a favorable variance of 16.3% compared to Non-PCMH in trailing 24 months ending December 31, 2012.
- PCMH ASC Visits per 1,000 shows a favorable variance of 11.8% compared to Non-PCMH along with a PCMH favorable variance in average cost per ASC visit of 14.7% compared to Non-PCMH in trailing 24 months ending December 31, 2012.

PCMH Favorable/Unfavorable to Non-PCMH 24 Months Ending December 31, 2012

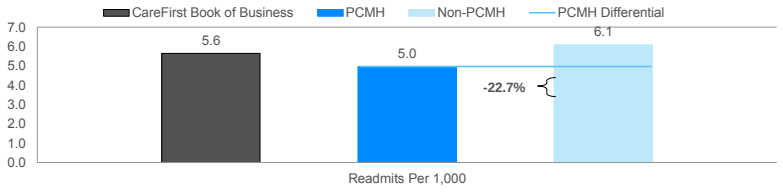


CareFirst

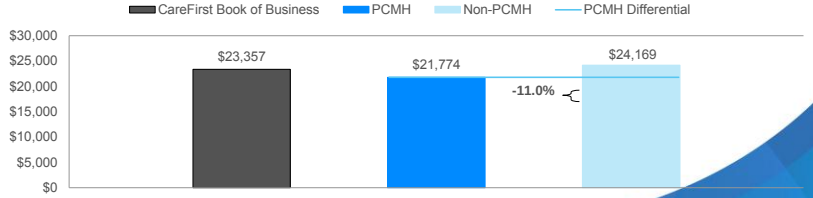
Key Use Measures – PCMH Compared to Non-PCMH

- PCMH Readmits per 1,000 shows a favorable variance of 22.7% compared to Non-PCMH, and a reduction in average cost per readmission of 11.0% compared to Non-PCMH in trailing 12 months ending December 31, 2012.

Readmits Per 1,000
12 Months Ending December 31, 2012



Cost Per Readmit
12 Months Ending December 31, 2012



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CareFirst

TCCI Elements

1. Hospital Transition of Care Program (HTC)
2. Complex Case Management Program (CCM)
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12. Substance Abuse and Behavioral Health Programs (SBH)

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CareFirst

Focus and Fundamental Change

- Members get confused at home
- Members get depressed at home
- Members become non-compliant at home

Yet,

- Homecare services have been episodic (irregular/occasional/lacking) – no focus
- Obstacles with benefit limits and cost sharing discourage use
- Poor management / oversight of providers and services offered by CareFirst
- Dozens of homecare agencies, DME's, & home infusion companies
- Hospital-based, county affiliates, "Mom and Pop" organizations

So,

- Properly focused, Home-Based Services are critical to reducing patterns of high hospital use

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CareFirst

Focus and Fundamental Change

- In the last year, the CareFirst team has evaluated the best home care providers
- Visited, interviewed and evaluated agencies throughout the region
  - Assessed the management team, technical ability, programmatic capabilities to stabilize people at home to reduce readmissions and ER visits
  - Selected 16 agencies to pilot new approach
  - Identified a "go to" primary and secondary agency for each sub-region
  - Now beginning a pilot to learn how to best work together

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CareFirst

Home-Based Services Plan – Comprehensive Assessment

Each home-based services plan must include and start with a comprehensive assessment that includes the following elements:

- **Environmental and Psychological Assessment**
- **Clinical Assessment**
- **Medications and Assessment**
- **Services Needed**
- **Overall Situation Analysis**
- **Community Resources / Needs Community Based Services**

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CareFirst

Home-Based Services

- **Highest Risk Members in Care Plans identified by CMs and LCCs – The Source of Select Referrals to "go to" Agencies**
- **Once referred, Home Assessment performed within 24-48 hours of request**
  - **In addition to assessing clinical status, this will address:**
    - **Safety; physical condition of home**
    - **Medications; review and reconciliation**
    - **Activities of daily living; capabilities/limits of patient**
    - **Availability of family, friends and neighbors to support**
    - **Available community-based services/resources**
      - **Faith-based and/or community groups/charities**
- **Based on the Assessment, a Home-Based plan will be created and agreed upon by Agency, CM/LCC and Physician**
- **Home-Based Plan will integrate into the existing care plan of the patient**
  - **Homecare agency implements plan in collaboration with CM/LCC and Physician**

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CareFirst

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CareFirst

Enhanced Monitoring Program – Creating the ADT of Health Care

- Two aspects of Enhanced Monitoring:
  - Monitoring patient's understanding/compliance
  - Biometric values
- Monitoring provides a continuous daily stream of data to a central monitoring center
- Enables detection of patterns and disruptions
- This is a simple idea: find out quickly when breakdowns are likely without having to be in the home
- Referrals are managed through the Service Request Hub
- iCentric users are able to view monitoring data and create charts to trend Member progress

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CareFirst

Enhanced Monitoring Program Initiated in Risk Business

Daily monitoring and educational content

Intensity of communication and education adjusts to Member need

- Symptoms
- Medication, Diet Habits & Activity Level
- Biometric measures
  - Weight
  - Blood Pressure
  - Pulse Ox
  - Glucose

Abnormal results or trends are reviewed by the monitoring center and physicians, LCCs, CMs are notified if necessary

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CareFirst

TCCI Elements

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CareFirst

Focus on Prescription Medications

- Medication complications are the #1 cause of readmissions
- Pharmacy claims are key source of valuable and timely clinical information
- Historically, no systems were available to allow PCPs and pharmacists to review all Members' medications
- We know average compliance rate is 50% or less
- Poor compliance leads to poor outcomes and increased care costs
- CareFirst's own studies show that non-compliant members with blood pressure medications generate 31% higher medical cost
- Referral for Comprehensive Medication Review:
  - Each Panel's Top 50 Members in # of Prescriptions
  - Each Panel's Top 50 Members in Spending on Prescriptions
  - Each Panel's Top 50 Members in Highest Drug Volatility Range
  - Referrals generated by PCPs, LCCs, CCMs, etc

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CareFirst

Focus on Prescription Medications

- Pharmacists and appropriate medication use essential to achieving quality outcomes and medical cost reduction
- Physicians need and appreciate the help as the number and complexity of medications increase
- The Member's medications are thoroughly reviewed, often by their local pharmacist
- Medications are reviewed for correctness of dosages, appropriateness, interactions, potential side effects and potential gaps in care
- As needed and in cooperation with the prescriber, the medication regimens are "tuned up"
- Follow-up is provided as needed to provide additional education and assure continued adherence

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CareFirst

Drug Volatility Index

Drug Volatility Continuum

Low / No Volatility — High Instability

1	2	3	4	5	6	7	8	9	10

1.0 Stable with little if any complications

10.0 Likely breakdowns

- **A CareFirst innovation**
- **Identify Members taking medications with a high level of side effects, drug interactions, or complex regimens that contribute to non-compliance.**
  - **HIV, mental health drugs, Hepatitis C, transplant drugs, blood thinners**
- **Drug Volatility Score is communicated to the PCP and pharmacist to help prioritize patients**
- **Drug Volatility Score is communicated to the physician on the MHR and in SearchLight reports for special attention**

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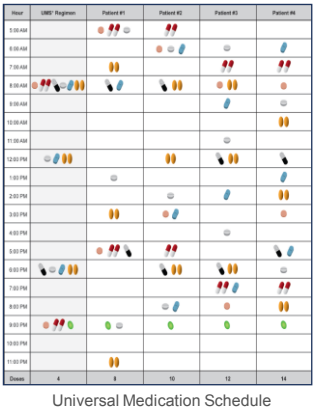
CareFirst

Medication Packaging

- **Members with very complex medication regimens may benefit from special packaging**
- **Comprehensive Medication Review must be completed first**
- **Universal Medication Schedule then developed to optimize dosing**
- **Then packaging can be customized and shipped to the Member**



Universal Medication Schedule

Medication Packaging

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CareFirst

Medication-related Results and Opportunities

- Nearly $5 million dollars in overall healthcare savings (estimated cost avoidance model) have been achieved through the MTM program in the first 3 quarters of 2013, with over $2 million in drug product costs saved
- Over 35,000 MTM services were provided in the first 9 months of 2013, with over 8,000 interventions focused on medication adherence issues
- Pharmacists and prescribers worked collaboratively to resolve over 5,000 drug therapy problems, resulting in significant changes in therapy to optimize medication regimens
- New/planned interventions will improve the identification and prevention of medication-related problems, and allow permit more discrete measurement of averted issues

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CareFirst

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Community-Based Programs – Overview

- Region rich in high quality programs of different types – managing congestive heart failure, diabetes, palliative care and many chronic conditions
- These programs are deeply imbedded in local communities – addressing cultural, linguistic and ethnic diversity
- When LCC and Case Managers identify patients who would benefit from such programs – goal is to connect the dots
- Responsibility of LCC or CM to assure follow-up and continued participation with a focus on outcomes
- This uses the region's greatest strengths – usually in partnership with local hospital system

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CareFirst

Community-Based Programs – 2014 Plan

- CareFirst will launch six (6) Community Based Programs in 2014:
  - Hospice & Palliative Care
  - Skilled Nursing
  - Diabetes Education
  - Congestive Heart Failure / Cardiac Rehab
  - Pain Management
  - Sleep Disorders

- Example: Congestive Heart Failure (CHF) @ Holy Cross (under development)
  - Multi-disciplinary team working with HTC, LCC and CM to focus on patients admitted for CHF
  - Physicians and advanced practice nurses and PCMH physicians ensuring prompt post-acute visits
  - Dieticians and exercise physiologists
  - Medication therapy management
  - Psychological and social support
  - Home-based services comprehensive assessment
  - Enhanced monitoring services

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CareFirst

Summary and Conclusion

- CareFirst has a system-wide culture of lowering total medical costs through quality improvement
- Our current innovations are lowering total medical costs by reducing readmissions and improving medication use (and other quality targets)
- The new Maryland Medicare Waiver will be an important lever to reduce HACs/readmissions. Our programs are an important lever to reduce costly preventable hospitalizations
- More innovations to be deployed in the near future
- We want to work with you!

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

National Quality Forum (NQF)

Patient Safety Quarterly Meeting Series:
The "Yin" and "Yang" of Current Results and
The Power of Alignment: Engaging Purchasers and Payers to Accelerate Patient Safety Efforts

April 24, 2014

Dennis Wagner & Paul McGann, M.D.
Co-Directors, Partnership for Patients

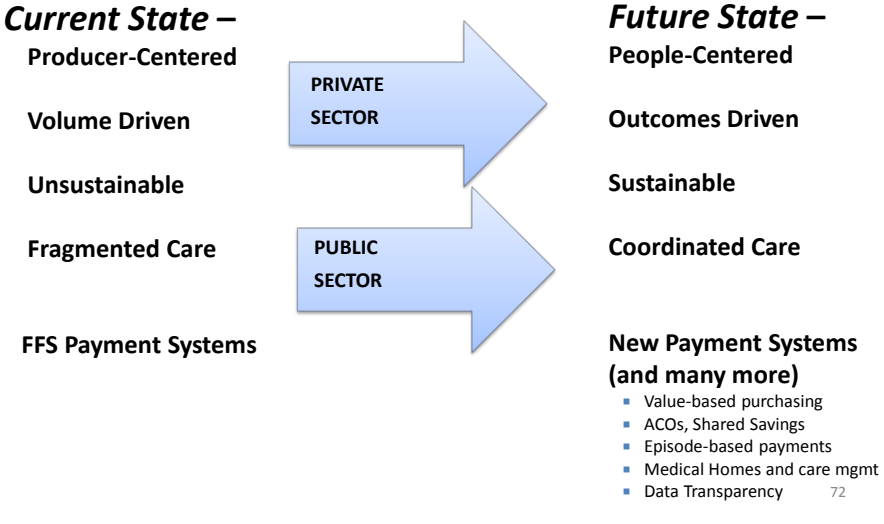
U.S. Department of Health & Human Services
CMS Center for Medicare & Medicaid Innovation

Thank You

- For the hard work you are doing to improve our nation's healthcare system.
- For your active commitment to improve the care of patients and clients.
- For your leadership and history of commitment and success on health care improvement, innovation and spread.

71

Delivery system and payment transformation



72

Our Challenge to Leaders in the Room

Use today to generate your "to do" list of items to accelerate progress in pursuit of reduced harm and 30 day readmissions:

1.
2.
3.
4.
5.

73

Questions to Run On

- Where are we with the Partnership for Patients (PfP) today?
  - What are our results so far?
  - What areas need increased action and attention?
- What actions can support this safety culture change, and improve patient care?
- ***What can purchasers and payers do to further accelerate patient safety efforts?***

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Partnership for Patients Focused on 2 Breakthrough Aims

GOALS:

40% **Reduction in Preventable Hospital-Acquired Conditions**

1.8 Million Fewer Injuries | 60,000 Lives Saved

20% **Reduction in 30-Day Readmissions**

1.6 Million Patients Recover without Readmission

partnershipforpatients.cms.gov

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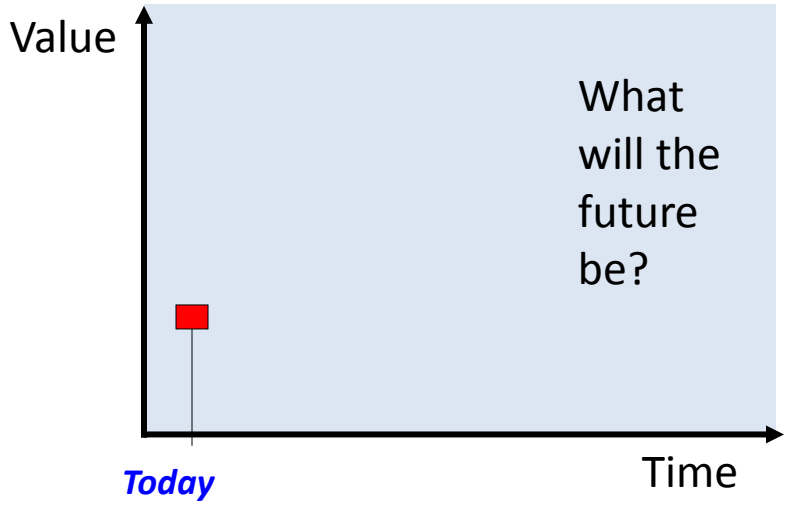
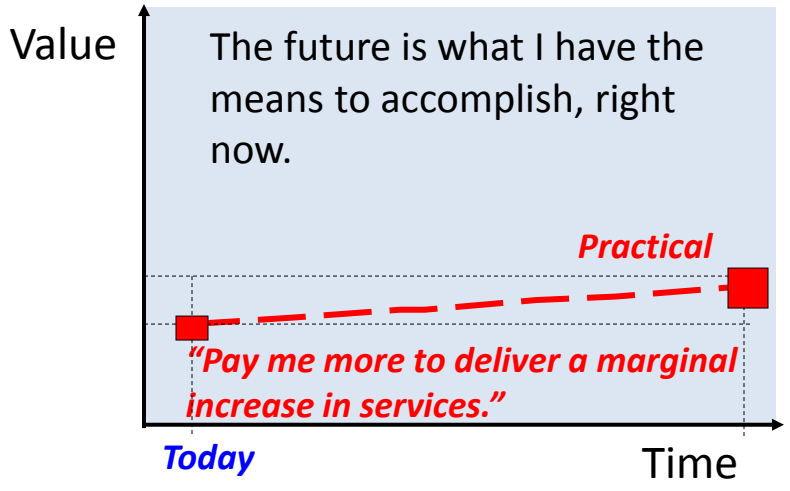
Join with us in standing for a compelling future beyond the current drift.

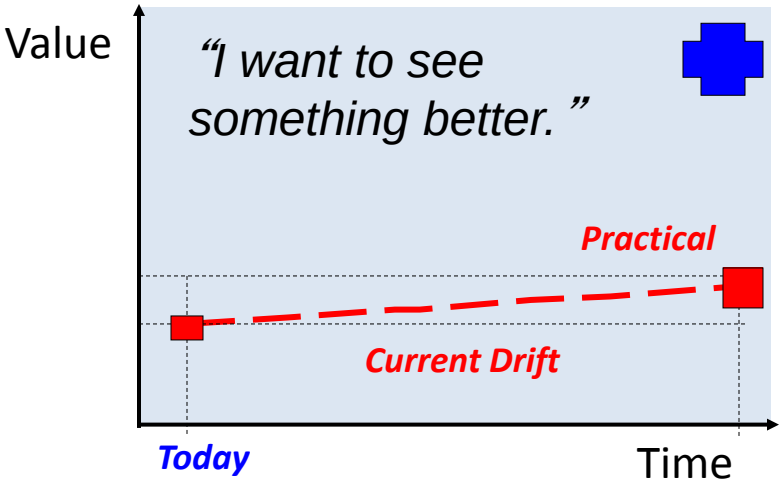
A choice we make every day



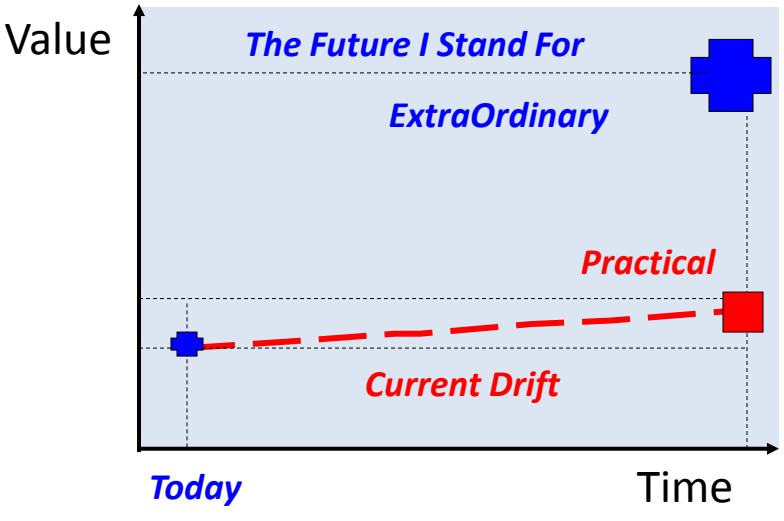
A practical choice



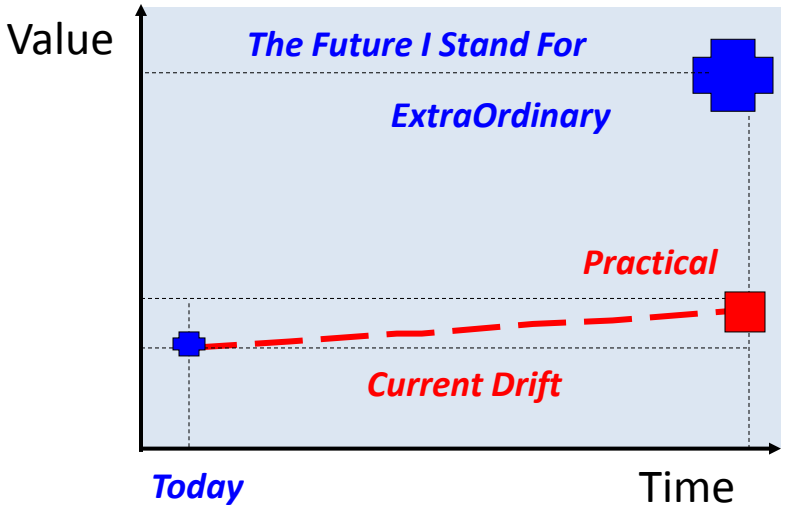
A leadership choice



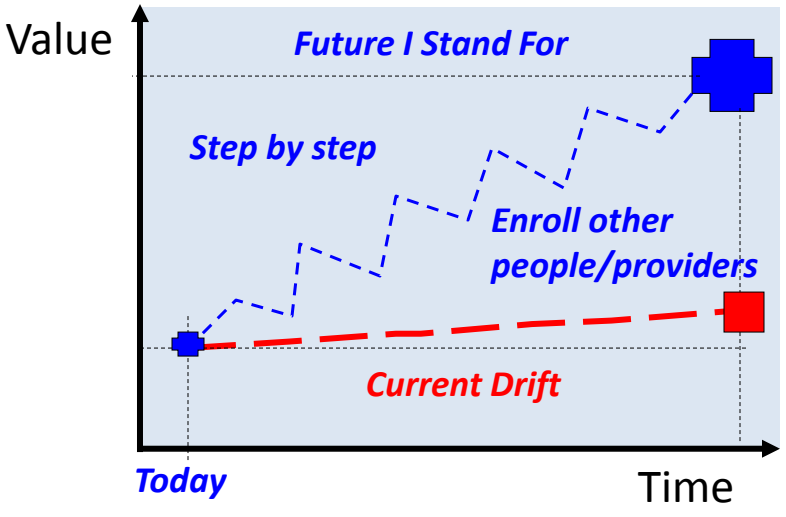
A leadership choice



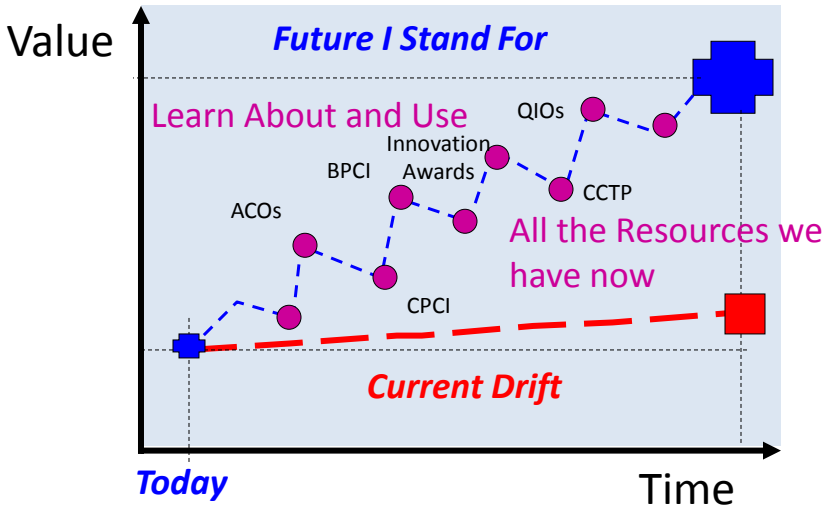
How do I get from here to there?



Leadership: Stand and enroll others



Leadership: Stand and enroll others

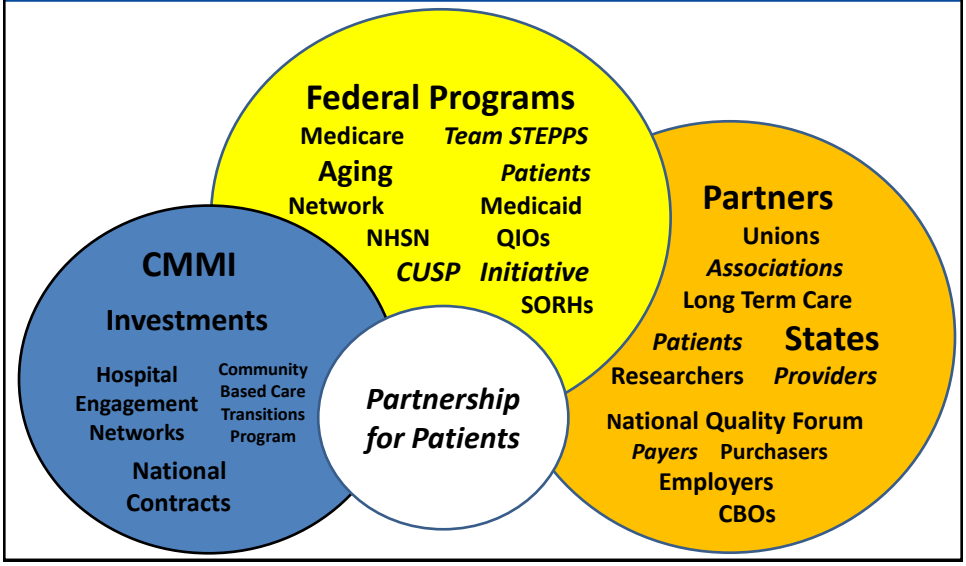


Our Requests to Each of You

- Choose to Stand for Better Care, Better Health at Lower Cost…for Our Patients, Your Profession, Our Nation
- Use Your Platforms to Make This Happen
- Do More of What is Already Working…Everywhere
- Lead in Enrolling Others
- Stand Together in Serving As Catalysts for Change

We can achieve our Bold Aims.

Partnership for Patients Achieves Results Through "3 Engines"



Exemplary Actions

- ***What are some of the examples of work by Partners to achieve action and results on the PfP aims?***
- ***What actions can we take to call attention to, celebrate, and spread these kinds of results?***

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Powerful Private & Federal Partners Have Aligned Their Work With the Partnership

A number of major partners from across the spectrum of health care stakeholders have made significant commitments aligned to our aims.

ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT

Transforming Healthcare Together
National Priorities Partnership
Convened by the National Quality Forum

march of dimes
working together for stronger, healthier babies

ANA
AMERICAN NURSES ASSOCIATION

Partners Contribute in Many Diverse & Significant Ways

- US OPM work to align Federal Employee Health Benefit plans with the Partnership for Patients Aims.
- "Buying Value" initiative to align purchasing with PfP Aims by large employers, unions, NBGH and many others.
- Johnson & Johnson incentives to employees discharged from hospitals who call for guidance on health care follow-up.
- Blue Cross Blue Shield Association set a corporate goal in 2012 to have all plans participate in one or more of – Surgical Safety Improvement, Eliminating HACs, Reducing Readmissions, Engage Hospital Boards – and has achieved 100% of this goal.
- NQF Maternity Action Team, March of Dimes, ACOG, LeapFrog and others team to achieve major national reductions in Early Elective Deliveries.

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11 Priority Areas of Focus

"No Patient wants a hospital that is only good at preventing 3 types of harm."

Hospital Engagement Networks are required to address ten areas of focus:

1. Adverse Drug Events
2. Catheter-Associated Urinary Tract Infections
3. Central Line Associated Blood Stream Infections
4. Injuries from Falls and Immobility
5. Obstetrical Adverse Events, including Eclampsia and Serious Maternal Hemorrhage
6. Reducing Early Elective Deliveries
7. Pressure Ulcers
8. Surgical Site Infections
9. Venous Thromboembolism
10. Ventilator-Associated Pneumonia
11. Reducing Readmissions

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Leading Edge Advanced Practice Topics (LEAPT) Program

- Severe Sepsis and Septic Shock (mandatory)
- Clostridium Difficile (c-diff), including antibiotic stewardship
- Hospital Acquired Acute Renal Failure
- Airway Safety
- Iatrogenic Delirium
- Procedural Harm (Pneumothorax, Bleed, etc.)
- Undue Exposure to Radiation
- Failure to Rescue
- Hospital Culture of Safety that fully integrates patient safety with worker safety
- Cost savings calculations for HACs (core and/or above), especially using "actual" cost and volume data (as compared with "projected")

Results Come From Many Contributors and Partnerships

- National Quality Strategy
- **National Priorities Partnership and Many Private Partners**
- American Nursing Association NDNQI
- NQF Maternity Action Team, American College of Obstetricians and Gynecologists, March of Dimes and Others Focused on Strong Start
- AHRQ Measurement Tools
- OASH HAI Action Plan
- HRSA Rural Health Programs
- Quality Improvement Organizations
- US OPM Federal Employee Health Benefit Plans
- ACL Aging Services Networks
- Reporting Programs
- Payment Penalties
- Hospital Engagement Networks
- Indian Health Service
- Community Based Care Transitions Program
- …and many others

Partnership for Patients Results: We Are Moving in the Right Direction!

- ***National Support and Management System*** **for Reducing HACs and Readmissions is in Place for 3700+ Hospitals**
- **Progress on *Patient and Family Engagement* is Accelerating**
- **Dramatic *Progress on EEDs* in Multiple Networks and Hundreds of Hospitals; Further Rapid Improvement Expected**
- **LEAPT is Launched and in the Field**
- **Initial Estimates Show Significant, Regular Decreases in Medicare 30-Day Readmissions through 2013**
- **2011 & Early 2012 AHRQ Independent National Scorecard Results Show Trends Are Positive and Moving in the Right Direction**

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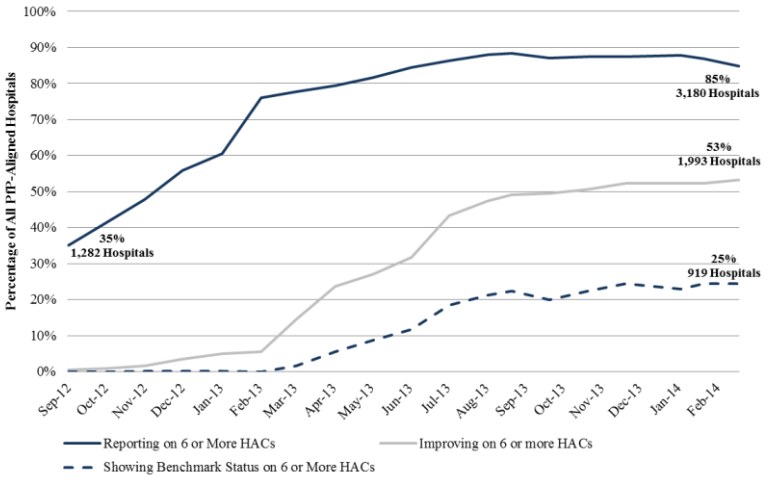
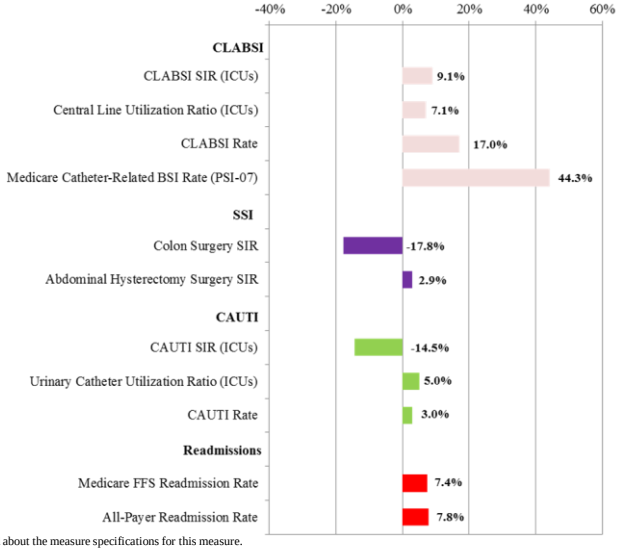
National Support & Management System Is Showing Increased Reporting, Improvement and Benchmark Status on 6+ HACs Over Time



Source: Monthly Z-5 Spreadsheets submitted by HENs.

Improvement from Baseline in Leading Indicators with at least 500 Hospitals Reporting

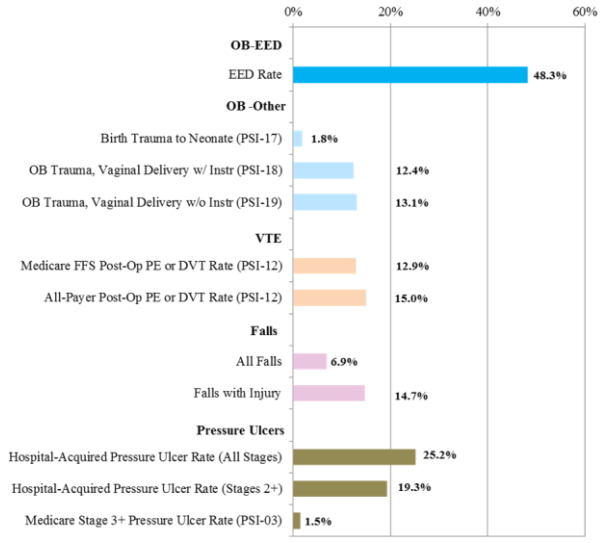


*Concerns have been raised about the measure specifications for this measure.

HSAG HEALTH SERVICES ADVISORY GROUP

MATHEMATICA Policy Research

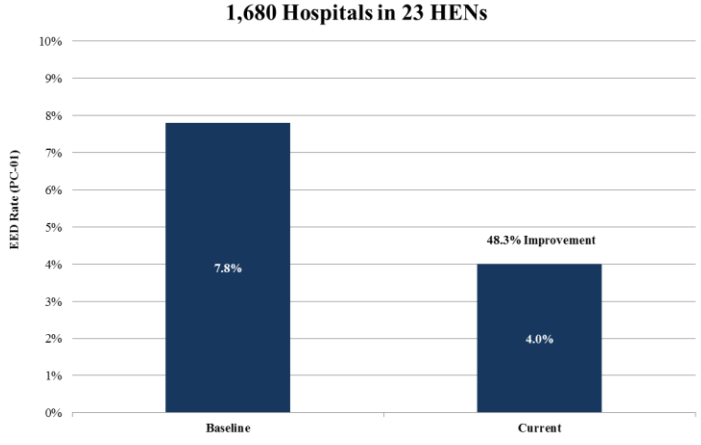
Improvement from Baseline in Leading Indicators with at least 500 Hospitals Reporting



HSAG HEALTH SERVICES ADVISORY GROUP

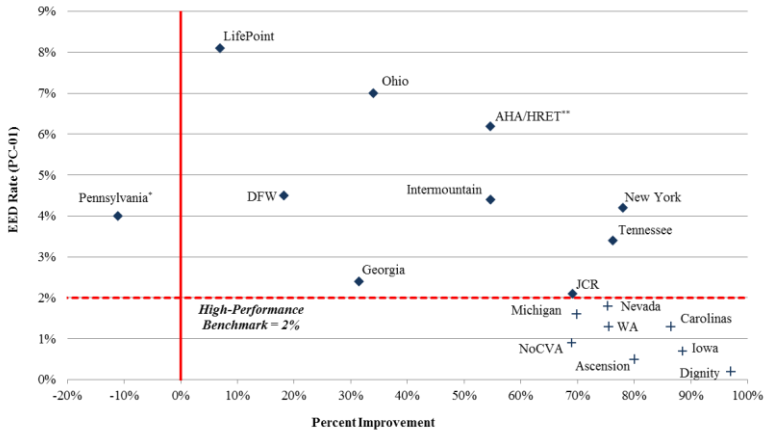
MATHEMATICA Policy Research

Dramatic Reductions in Early Elective Deliveries for 1300+ Hospitals Using PC-01 Measure



Source: HEN-reported data submitted March 2014.
Notes: Baseline and current periods vary by HEN. The HENs (and therefore number of hospitals) included in the run chart differ from those in this bar chart for two reasons: (1) quarterly data submitters were not included in the run chart, which shows the monthly trend, and (2) not having enough complete data during some of the months shown in the run chart. Baseline and current period rates are rounded for presentation, while the percent improvement is calculated using unrounded data.

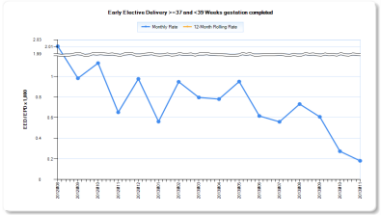
Early Elective Delivery (EED) (PC-01), Current Rate and Percent Improvement by HEN



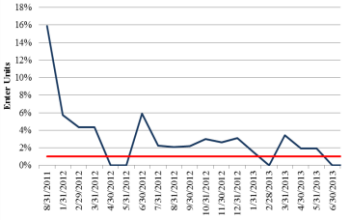
Source: HEN-reported data submitted March 2014.
Notes: Progress is seen as movement towards the bottom right corner of the figure, indicating both reduction in harm and low current event rate. The graph depicts measure improvement and levels only for those HENs that chose to report this measure, and at least 60 percent of their aligned hospitals are represented in the data. Baseline and current periods vary by HEN.
***Pennsylvania has a relatively late baseline, compared to other HENs (Q1 2013), so data showing worsening is based only on the two data points with sufficient data to date.**
****In March 2014, 24 of 28 states that report PC-01 are showing 30 percent or more improvement with at least 60 percent of their hospitals reporting.**
+ Indicates HEN met High-Performance Benchmark.

4 Examples of Many HEN-Wide Results in Reduction of Early Elective Deliveries

Ascension Health

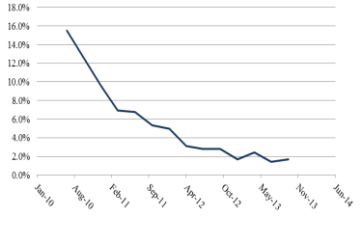


Dignity Health



Joint Commission Resources, Inc.

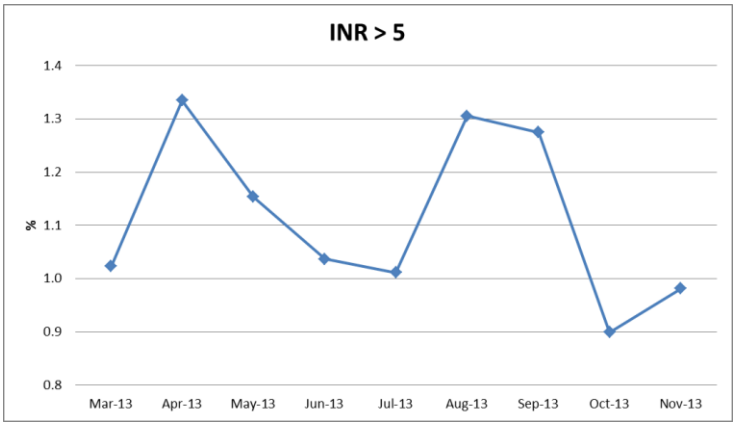
Washington State Hospital Association



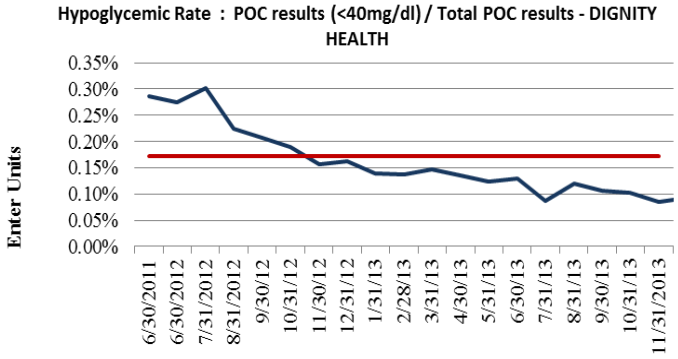
Hospital Engagement Networks Option Year 1 Scope of Work

- Option Year 1 Scope of Work started in December 2013 and ends December 2014
- Option Year Modification continued current work and also addressed a number of areas where special attention was needed
- Increased focus on highest risk Adverse Drug Events in 3 key areas:
  - Anti Coagulants
  - Opioids
  - Insulin and Hypoglycemic drugs

Ascension Health INR >5 Progress



Dignity Health: Progress in Reducing Rate of Hypoglycemia



Partnership for Patients Work on Patient & Family Engagement (PFE)

- **Authentically engage** patients in our work: model and create momentum
- **Identify** organizations that reflect best practices
- **Replicate** and spread effective practices
- **Track** progress on PFE across hospitals and increase transparency. Tracking on 5 PFE areas.
- **Team** with and support others involved in and leading this work

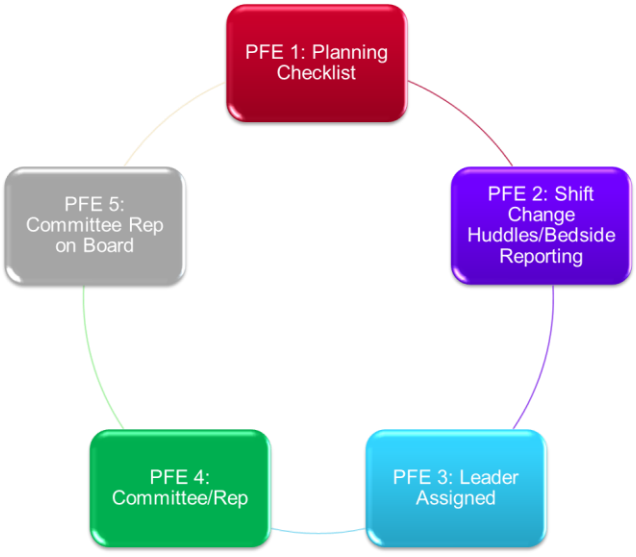
Helen Haskell is One of Thousands of Patient & Family Advocates Who Team on PfP Work

Helen Haskell is the President of Mothers Against Medical Error.

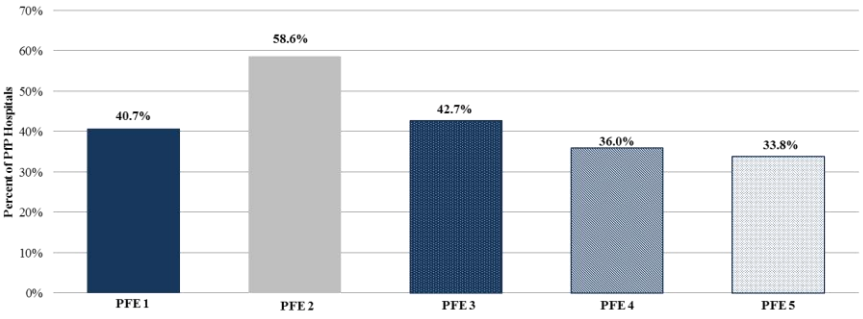
- Her healthy 15-year-old son, Lewis, developed severe upper abdominal pain while on NSAID and narcotic pain regimen following elective surgery
- Nurses and residents fail to act upon increasing signs of instability, including 24 hours with no urine output and four hours with no BP
- Four days post-op, Lewis died. Autopsy showed a giant duodenal ulcer and 2.8 liters of blood and gastric secretions in the peritoneal cavity

Since the medical error death of her young son in 2000, Ms. Haskell has been active in many areas of healthcare quality and safety.

Tracking on 5 Dimensions of Patient and Family Engagement



Hospitals Meeting PFE Criteria - March 2014



- PFE 1: Prior to admission, hospital staff provides and discusses a planning check list with every patient that has a scheduled admission – allowing for questions or comments from the patient or family - a planning check list that is similar to CMS's Disc
- PFE 2: Hospital conducts shift change huddles and do bedside reporting with patients and family members in all feasible cases.
- PFE 3: Hospital has a person or functional area, who may also operate within other roles in the hospital, that is dedicated and proactively responsible for Patient and Family Engagement and systematically evaluates Patient and Family Engagement activitie
- PFE 4: Hospital has an active Patient and Family Engagement Committee OR at least one former patient that serves on a patient safety or quality improvement committee or team.
- PFE 5: Hospital has at least one or more patient(s) who serve on a Governing and/or leadership board and serves as a patient representative.

Source: March 2014 HEN Z-5 spreadsheets

Safety Across the Board in the Dignity Hospital Engagement Network

Dignity 35 aligned hospitals, 100% of applicable hospitals are in each trend		**ADE**: 65% decrease in hypoglycemic rate (POC results<40 mg/dl)	**CAUTI**: 45.3% decrease in CAUTI per 1,000 catheter days (house-wide)
CLABSI: 34.5% decrease in CLABSI per 1,000 central line days	**Falls**: 35.8% decrease in falls with injury (NDNQI definition)	**EED**: 96.4% decrease in EED rate (PC-01); sustaining rate <1%	**PrU**: 50% decrease in rate of HAPU (all stages)
SSI: 35.7% decrease in SSI/100 targeted procedures	**VAP**: 60.4% decrease in VAP per 1,000 vent days	**VTE**: Sustaining low (benchmark)VTE rate (PSI-12)for the Medicare population	**Readm**: 9.6% reduction in Medicare FFS readmissions

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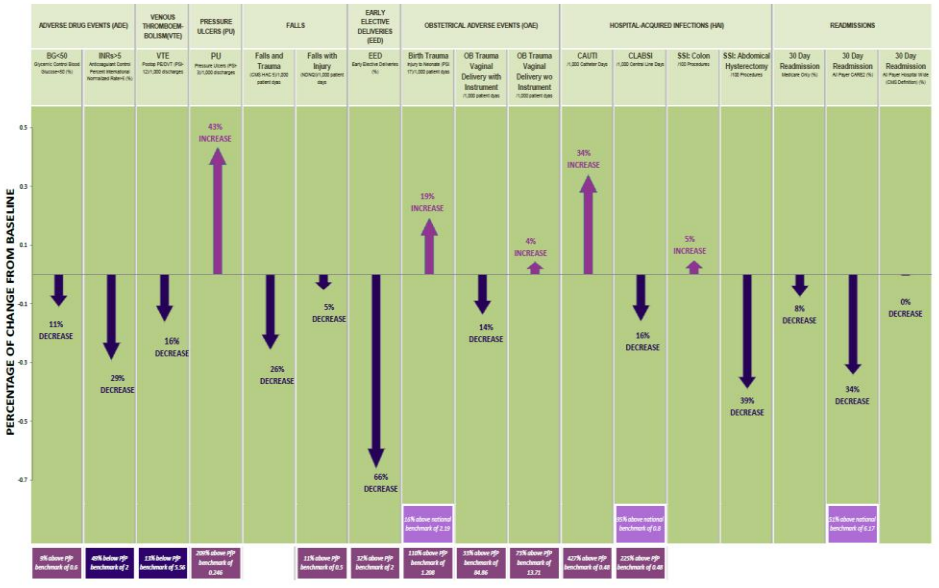
Georgia HEN Health
Harm Across the Board Progress Toward Goals



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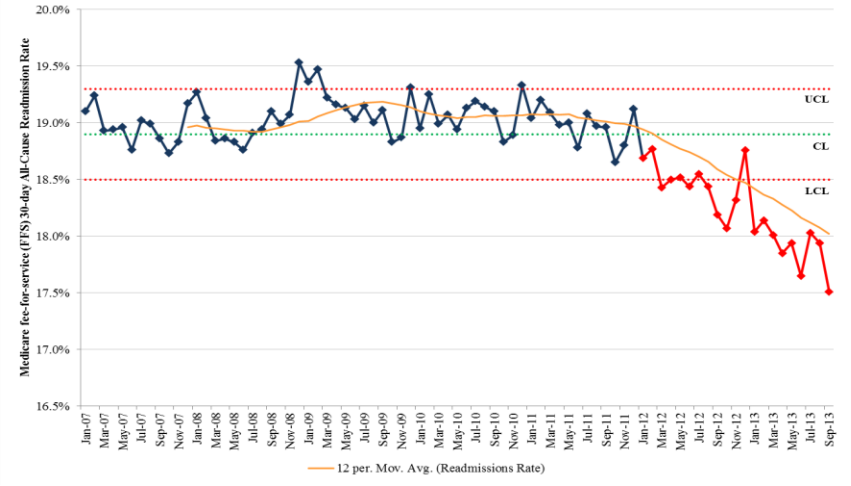
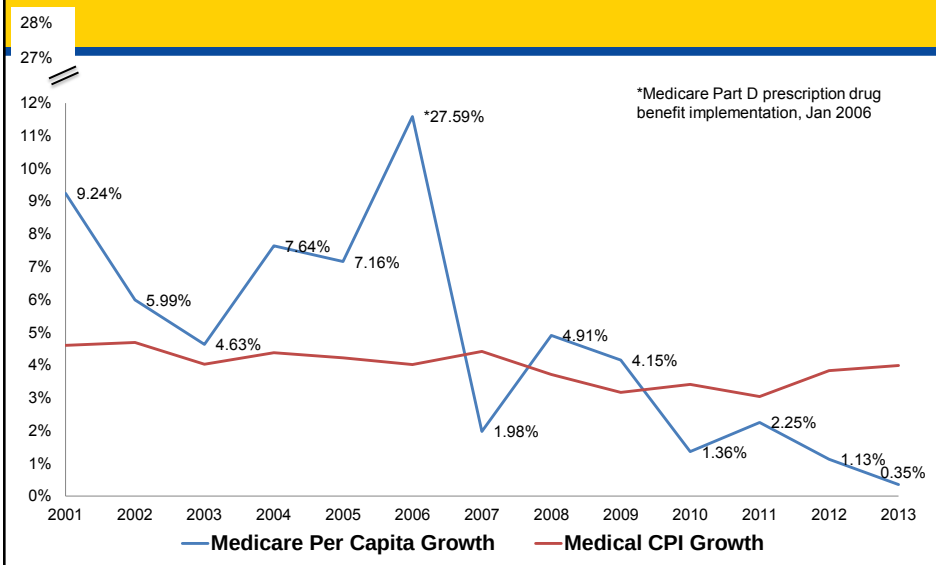
Unprecedented National Decreases
Medicare Fee-for-Service 30-day All-Cause Readmissions



Results: Medicare Per Capita Spending Growth at Historic Lows



Source: CMS Office of the Actuary

-- Lots of Progress --
And, We Can Do Better…

- Adverse Drug Events
- Pressure Ulcers
- Catheter Associated Urinary Tract Infections
- Safety Across the Board – in All Areas of Harm
- Sepsis and Other Advance Practice Topics

Patients and families -- like Helen Haskell -- are counting on all of us to do better…

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We Know How to Achieve the Results We Seek

- High performing hospitals…
- Entire systems of hospitals…
- And hospitals across entire states…

…have figured out how to achieve the results we seek.

The challenge is spread

If we always do what we've always done, we'll always get what we've always got.

- Partnership for Patients is About All of Us Doing Things Differently.
- We have unprecedented Federal action and coordination.
- We have an unprecedented CMMI Investment in taking proven practices to national scale.
- We have unprecedented action and alignment by community-based organizations, hospitals, clinicians, private partners and others.
- ***Join with us and with each other in making the most of this extraordinary opportunity for change and improvement.***

Our Challenge to Leaders in the Room

Use today to generate your "to do" list of items to accelerate progress in pursuit of reduced harm and 30 day readmissions:

- **What situations and opportunities are each of us presented with now?**
- **How do we embrace change with every challenge we face?**
- **What can each of us do to promote transparency, accountability and create a learning environment?**
- **What can each of us do in our work to create a culture of *safety across the board*?**

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Questions to Run On

- Where are we with the Partnership for Patients (PfP) today?
  - What are our results so far?
  - What areas need increased action and attention?
- What actions can support this safety culture change, and improve patient care?
- ***What can purchasers and payers do to further accelerate patient safety efforts?***

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Networking Lunch

Program resumes at 1pm

Small Group Breakout Session: Best Practices for Engaging Purchasers and Payers

Small group assignments

Table 1	Table 2	Table 3	Table 4
Missy Danforth, The Leapfrog Group	**Cristie Travis**, Memphis Business Group on Health	**Vicky Ducworth,** Boeing	**Bernie Rosof,** North Shore-Long Island Jewish Health System
John O'Brien, CareFirst	**George Andrews,** Humana	**Susan Fitzpatrick**, CIGNA	**Robert Krebbs**, Wellpoint
Gerry Shea, Buying Value	**Elizabeth Mitchell,** Network for Regional Healthcare Improvement	**Jacqueline Kreinik**, CMS	**Brian DeVore**, Intel
John Rother, National Coalition on Health Care	**Jeremy Nobel**, Northeast Business Group on Health	**Alan Spielman**, Office of Personnel Management	**Amy Moyer**, The Alliance
Brian Isetts, University of Minnesota	**Liz Gonzales**, National Content Developer	**Michelle Baker,** PFE Contractor	**Maureen Higgins,** Mathematica
Barbara Walters, Pioneer ACO	**Lisa Ann Morrise**, Patient Representative	**Chrissie Blackburn**, Patient Representative	**Alicia Cole,** Patient Representative
Jonathan Grau, National Quality Forum	**Shelly Coyle**, Partnership for Patients, CMS	**Rachel Weissburg**, National Quality Forum	**David Kelley**, Pennsylvania Medicaid

Small group discussion

1. Based on our experiences, what are each of our best practices to improve quality – specifically to reduce HACs and/or readmissions?

2. What will we do next– as individuals or a group – to spread this work?

Table Activity Report Out

Each table reports back on key insights

On the Horizon: Transforming Clinical Practice

LT Fred Butler Jr., MPH
Partnership for Patients Communications Lead
Quality Improvement and Innovation Models Testing Group
Center for Clinical Standards and Quality, CMS

Shaheen Halim, PhD
Quality Improvement Innovation Model Testing Group
Center for Clinical Standards and Quality, CMS

Slides will be available at the meeting

Conclusion and Next Steps

Louise Probst, Meeting Chair

Evaluation of the Day

Survey Monkey link will be sent to you after today's meeting

Please respond by **Friday, May 2**

Meeting Materials Available Online

Meeting materials will be available on www.qualityforum.org shortly, including:

- Today's presentation
- A recording of today's meeting
- A meeting summary

Thank You

WHITE PAPER
Connected Care
Healthcare

Employer-Led Innovation for Healthcare Delivery and Payment Reform: Intel Corporation and Presbyterian Healthcare Services

Can businesses increase employee satisfaction, create a healthier workforce, and control costs through disruptive innovation with the healthcare delivery system? Intel Corporation and Presbyterian Healthcare Services are betting they can, and have implemented a comprehensive redesign of health plan, delivery, and payment options for Intel's New Mexico employees.

Brian L. DeVore
Director, Healthcare Strategy and Ecosystem
Intel Corporation

Ben Wilson, MBA, MPH
Director of Global Healthcare Strategy
Intel Corporation

JJ Parsons
Vice President, Strategic Partnerships
Presbyterian Healthcare Services

Abstract/Introduction

As the Institute of Medicine noted in 2012[1], healthcare costs in the United States rose 88 percent in the past decade and now consume approximately 18 percent of the U.S. Gross Domestic Product (GDP). Yet waste and lack of coordination are pervasive throughout the system, and outcomes are significantly below those of other developed nations.

Employers are key stakeholders in the healthcare ecosystem. They hold the purse strings for much of the cost of employees' health insurance and often determine which benefits employees access. They can also be effective advocates for employees and their dependents in a complex healthcare system where care is often fragmented. To date, however, employers have largely limited their influence to wellness and disease management programs and contract negotiations with insurance companies.

After a decade of applying the usual levers to improve its employees' health and contain rising healthcare costs, Intel believes it is time for employers to work more directly to transform the payment and delivery systems for healthcare. In an innovative program with Presbyterian Healthcare Services (PHS), Intel has engaged directly and deeply in benefit design, plan design, and delivery optimization for employees and dependents at its Rio Rancho, New Mexico, facility. Intel and PHS have established a custom Integrated Delivery System (IDS) model of shared risks and rewards—essentially an employer-sponsored Accountable Care Organization (ACO) based on a patient-centered medical home (PCMH) model—that aims to give Intel employees more personalized, evidence-based, coordinated, and efficient care. This program, called Connected Care, moves beyond fee-for-service models to more effectively incent desired behaviors and results.

Connected Care is inspired by Intel's vision of having the healthiest workforce on the planet and making healthcare a strategic business and people advantage for the company. Intel and PHS believe Connected Care is also a demonstration of sustainable, system-wide changes that can improve access to high-quality, efficient, and affordable care.

Connected Care went live as an operational health plan and delivery system for Intel employees in New Mexico on January 1, 2013. In addition, Intel is establishing PCMH pilots with local providers in other regions to more fully engage members in managing their health and transforming system delivery.

Employers are in a great position to influence healthcare. Fee for service is broken. If you set things up so providers are paid for doing the right thing and you hold the system accountable, you can trust the system. Employees get the best care at the best time for the best price, and employers win too.

Tami L. Graham
Director, Global Benefits Design
Intel Corporation

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Intel's Journey

Intel is a global manufacturer of hardware and software building blocks that are "inside" many of the world's computers, servers, and networking and communications products. A majority of Intel's U.S. employees are located at six sites in California, Oregon, Arizona, and New Mexico. Intel is self-insured, and in Q4 2012 provided health insurance to approximately 48,000 U.S. employees and 79,000 dependents through several national plans.

Like most U.S. employers, Intel has worked to contain rising healthcare costs. A decade ago, Intel's healthcare cost trend was running above the national average and was projected to reach $1 billion by 2012. Intel undertook research to understand the issues driving the high costs, and committed to a comprehensive, long-term strategy to address them.

Intel set an overall objective of developing a culture where employees and their families are healthy, productive, and engaged in wellness-oriented lifestyles. The company increased its focus on consumer health plans, which give employees greater visibility to healthcare costs and provide financial incentives for them to be wise healthcare consumers. Nearly 70 percent of Intel employees migrated to consumer plans.

Intel also engaged employees and dependents in wellness and behavior change through on-site primary care clinics, disease management programs, health education, and a three-step wellness check that includes on-site biometric testing, an online health assessment, and in-person coaching. The wellness check and clinics achieved 70 percent participation, and more than 90 percent of participants were highly satisfied.

These efforts helped reset Intel's health cost trend line and reduced annual cost increases to better than the national average. But by 2010, the double-digit trend line had returned. Reflecting national trends, approximately 10 percent of Intel's employees or dependents are responsible for 70 percent of the company's healthcare spend, and another eight percent of Intel's covered lives are trending towards the highest-needs category. With an aging work force, further reductions will require improvements in population health and overall system efficiency.

Intel employees experience their own frustrations with healthcare. Many are overwhelmed by the broad choice of plans offered and the growing cost shift, particularly given the difficulties of gaining reliable data on cost and quality. Despite the best efforts of the individuals and organizations in the system, the highest-needs employees and dependents often receive disjointed, poorly coordinated care. A growing number struggle to manage multiple, complex chronic conditions. Physician shortages in some regions create barriers to timely care. Even employees who rarely deal with the healthcare system are frustrated by its inefficiencies when the need arises.

At the same time, Intel has become more involved in the healthcare industry. As a trusted technology advisor, Intel supports healthcare leaders around the world in using open standards-based information technology (IT) to increase healthcare's accessibility, quality, and efficiency. Intel's global health research teams conduct ethnographic studies to understand issues related to health, aging, and independent living, and work with the company's design teams to address them. In 2011, Intel and GE formed Intel-GE Care Innovations LLC, a healthcare joint venture to develop technologies that support healthy, independent living at home and in senior housing communities. Care Innovations builds on the assets, expertise, and operations of Intel's Digital Health Group and GE Healthcare's Home Health Division, and Intel continues to hold a 50 percent stake in the company.

Intel collaborates closely with its supply chain and with industry organizations. For example, Intel has been a major contributor to Dossia, an open-source framework developed by employers to provide lifelong personal health records for employees, dependents, and retirees; and the Continua Health Alliance to develop standards for connected telehealth devices.

Intel also has a tradition of disruptive innovation, informed risk-taking, and possibility thinking. Intel's co-founder, Robert N. Noyce, famously said, "Don't be encumbered by history. Go off and do something wonderful." As healthcare costs continued to climb, Intel's leadership began asking: Can we create a healthier workforce, give employees a better healthcare experience, and control costs through disruptive collaboration with the delivery system? Can we turn health into a competitive advantage?

Table 1. Status Quo and Next-Generation Healthcare

Stakeholders	Typical Status Quo	Next Generation
Employees and dependents	▪ Overwhelmed by broad choice and growing cost shift ▪ No visibility into reliable quality and cost data ▪ Need help navigating the complex healthcare system ▪ Unhappy with system inefficiencies: difficulty getting appointments, long office waits, duplicate paperwork, etc. ▪ Lack tools and support to manage personal health ▪ Lack incentives for proactive involvement in their own healthcare	▪ Unified, community-based model delivers comprehensive, evidence-based, coordinated care, with a heavy focus on prevention ▪ Focus on an efficient, high-quality healthcare experience ▪ Transparent data on cost and quality to guide member choices ▪ Optimal personal health is expected, supported, and rewarded ▪ Access to digital health tools, data, and communications for managing personal health ▪ Meaningful financial and health incentives ▪ Share proportionally in cost savings
Employers	▪ Double-digit trends in annual cost increases ▪ Highest-need members tend to be lost in the system ▪ Frustrated by antiquated, proprietary, and duplicative data systems across the healthcare system ▪ Frustrated by lack of influence in the healthcare value chain ▪ Limited data to fully understand improvements in employee health	▪ Compensation for value, with an intention to reduce overall costs while increasing quality of care and the health-care experience ▪ Patient-centered medical homes at the heart of care with network of qualified specialists ▪ Unified, real-time system of record for data, claims, and performance monitoring ▪ Data and information on health improvement of defined cohorts of the workforce ▪ Effective collaboration with providers to drive change
Providers	▪ Frustrated by bureaucracy ▪ Want to do the right thing, but incentives are misaligned ▪ Vary widely in their openness to change	▪ Creation of medical neighborhood and elimination of prior authorization reduce bureaucracy and empower providers; only willing providers participate ▪ Measurement and payment are aligned with value and innovation ▪ Effective collaboration with employers to drive change
Medical insurance plans	▪ Losing relevance beyond core claims processing; seeking ways to deliver value in a shifting landscape	▪ Deliver value by supporting new models for care and compensation

Core Tenets of a Next-Generation Strategy

By 2011, Intel had spelled out a holistic, next-generation healthcare model for Intel employees and dependents, and the company's leadership was ready to engage directly with the delivery system to implement it. In this model (Table 1, on previous page), evidence-based care is personalized to an individual's unique needs and coordinated around a patient-centered system. Care is delivered through multiple channels and makes optimal use of resources. A customized care-delivery system has a backbone of PCMHs backed by a network of specialty and hospital services that align clinically and financially.[2]

Reflecting what the Institute for Healthcare Improvement calls the Triple Aim[3], the next-generation model aims to increase population health, improve the member experience, and reduce costs. To encourage employee engagement with the healthcare system, the Intel model places a high priority on delivering an outstanding patient experience and removing barriers to care. The model also makes quality and costs transparent so employees can make informed decisions about when and where to seek care and which treatments to receive.

In 2011, Intel summarized these objectives as the Five Requirements:

- Right care: use of evidence-based medicine
- Right time: same-day access to care
- Right price: material decrease in the cost of care
- Best life: rapid return to productivity for the member
- Best outcome: patient satisfaction 100 percent of the time

The next-generation model promotes an attitude of "expecting health," encouraging engagement and personal accountability by all members. Members are supported and encouraged to make the most of the medical home model and to actively manage their personal health.

The model promotes system-wide efficiency via payment reform, accountability, continuous process improvement, and waste reduction, all supported by patient-focused IT and using open information standards whenever possible. Value-based compensation is based on a global per-member per-month (PMPM) target with shared risks and rewards if results fall outside a buffer zone of expected results.

Benefits Design with the Employee at the Center

While designing its next-generation healthcare strategy, Intel was also taking a new, employee-centered approach to benefits design. Rather than developing programs and tools based on assumptions about what employees want and need, Intel conducted and commissioned research to find out.

Working with The Futures Company, a strategic consultancy with a focus on health and wellness, Intel undertook surveys, focus groups, and in-home, observational studies of Intel employees and their families to deeply understand how they feel about their health and the healthcare system. While guarding privacy, the research looked into what Intel's members think, feel, and value about their health and the healthcare system. The Futures Company mapped Intel employees into its LIVING Well framework, which identifies six segments based on an individual's health attitudes and behaviors (Table 2). It also showed what each segment sees as barriers to good health, what mindsets are associated with utilization, and how open members would be to new technologies and approaches.

Table 2. The Futures Company LIVING Well Segmentation Model

Segment	Description	US as a Whole	Intel Employees
Leading the Way	Highly motivated; actively managing their health; see few barriers to health	9%	17%
In It for Fun	High priority on living a healthy lifestyle; avid exercisers; few have serious health issues	18%	26%
Value Independence	Skeptical, do-it-yourselfers; want to manage their own care rather than engage with the healthcare system; may have a diagnosed health issue but are not necessarily treating it; tend to think they're healthier than they are	22%	16%
I Need a Plan	Want to be healthier but have a hard time taking action; many are older and are treating chronic conditions	19%	6%
Not Right Now	Younger; healthy but mainly due to their youth; may not feel in control of their health	22%	34%
Get Through the Day	In poorer health; feel their health is out of their control; many are treating chronic illnesses	10%	2%

> A lot of sophisticated employers understand the triangle of cost, quality, and access, but employers traditionally focus on cost at the level of the annual premium. What they need to do is design the benefit plan to incentivize the right behaviors, and improve cost by improving the system and optimizing health. They need a longer-term vision. Don't be so focused on short-term, one-year payment premiums.
>
> *Cheryl Mitchell*
> *Administrative Director*
> *Presbyterian Medical Group*

Among the significant findings were that health is a priority for most Intel members, and more than half are highly engaged in managing or maintaining their health. However, nearly all segments perceive a tension between the work environment and wellness, with sedentary jobs, stress, and lack of time as the biggest perceived barriers to better health.

Highlighting the need for personalization, the data showed that Intel members vary widely in their needs, desires, and attitudes across LIVING Well segments, job categories, and site locations. Members with chronic conditions struggle with lifestyle barriers at higher-than-average rates. Members see physicians as powerful change motivators, but say few exercise their influence. Quality, cost, and choice are employees' highest priorities for health plans and healthcare experiences.

The research led Intel to focus on three clusters of motives and desires:

- Higher needs. I have complex health conditions. I want clear direction and support for how to manage my health. I could use help navigating the health system.
- Convenience. I'm super busy. I want more time to take care of my health. I value easy, timely access to my healthcare providers.
- Low cost. I want the most value for my healthcare dollar and the security of knowing my out-of-pocket fixed costs.

Intel has used these research-driven insights to guide its plan design and engagement strategies, as well as to optimize the delivery system experience for its members.

Next-Generation Collaboration with an Innovative Delivery System

Because healthcare delivery is local, Intel sought IDS collaborators at locations where the company has a large concentration of employees rather than a nation-wide supplier. In August 2011, Intel issued a Request for Information and Proposal, and in December entered a relationship with Presbyterian Health Services to create a benefits plan and delivery system for Intel's Rio Rancho employees and their dependents. The Rio Rancho site has approximately 3,500 employees and is home to Intel's largest semiconductor manufacturing facility.

In selecting Presbyterian, Intel gains an innovative IDS collaborator that is widely recognized for clinical and organizational excellence. PHS is a not-for-profit system of eight hospitals across New Mexico, a health plan, the 600-provider Presbyterian Medical Group (PMG), and other entities. PHS is one of only 32 organizations selected by the Centers for Medicare and Medicaid Services (CMS) Innovation Center for the Pioneer ACO model. Presbyterian Hospital is a multi-year Consumer Choice Award winner and a 2011 Leapfrog Top Hospital. PHS won the American College of Cardiology Foundation's 2012 Platinum Performance Achievement Award for excellence in treating heart attack patients, and the cardiac critical care unit at Presbyterian Hospital received the 2010 Beacon Award for Critical Care Excellence from the American Association of Critical Care Nurses.

Other factors were important to Intel. PHS operates ten PCMHs, and all have achieved a Level 3 Recognition by the National Committee of Quality Assurance (NCQA). PHS works across the continuum of care and is experienced at population health management and high-risk case management. The Presbyterian Health Plan offers first-class claims processing, eliminating the need to seek external partnerships for that function. In addition, PHS focuses on Lean methodologies and data-centered improvement processes, and has used the Baldridge Criteria for Performance Excellence since 2002.

Healthcare IT is vital to the success of healthcare transformation, and PHS has made significant investments in healthcare IT. As of January 2013, all Presbyterian PCMHs have deployed Epic* Ambulatory, using electronic health records (EHRs) and other digital information tools to coordinate care and increase the use of evidence-based medicine. PHS hospitals are moving to Epic from a previous EHR platform over 2013-2014. PHS has deployed solutions that provide a basis for performance measurement, case management, and population health management.

For PHS, the collaboration with Intel is an opportunity to accelerate a transformation that is already well underway. Connected Care builds on much that PHS is already doing, and PHS is applying many Connected Care types of innovations across its system. PHS benefits from operating within an environment where the payment model provides incentives for "doing the right things right," and increases recognition of its leadership role in the industry.

Table 3. Connected Care at a Glance

Category	Capabilities
Plan design	▪ Patient centered medical homes with team-oriented care ▪ Medical "neighborhood" of selected local specialists ▪ High-value external network for special cases ▪ National in-network coverage when out of area ▪ 100 percent coverage of preventive services ▪ Comprehensive prescription drug coverage, including 100 percent coverage of specific medications for diabetes, hypertension, and other targeted conditions ▪ Elimination of nearly all prior authorizations ▪ Available as a high-deductible health plan (HDHP) or co-pay plan
Delivery system	▪ Same-day, 24/7 access, including secure messaging ▪ Nurse navigators for high-needs members
Compensation	▪ Per-member per-month cost baseline based on data validated through an underwriting analysis ▪ Shared risks and savings for results above and below a designated threshold ▪ Care is paid for by claim, but with risk and accountability built in ▪ Presbyterian Health Plan processes claims

Operationalizing the Model

With the framework established in December 2011, Intel and PHS had one year to design health plan offerings, establish pay-for-performance specifics, and map out the member experience. The new system would be offered at open enrollment in October 2012 and go live in January 2013.

After initial all-hands strategy sessions, the two enterprises worked in small, cross-organizational teams focusing on plan/benefit design, delivery system design, payment model and incentives, the employee/patient experience, technology infrastructure, employee engagement and communication, and other areas.

The project had top-level executive support and oversight from both enterprises. Both enterprises were experienced at disciplined collaboration and put their most experienced leaders on

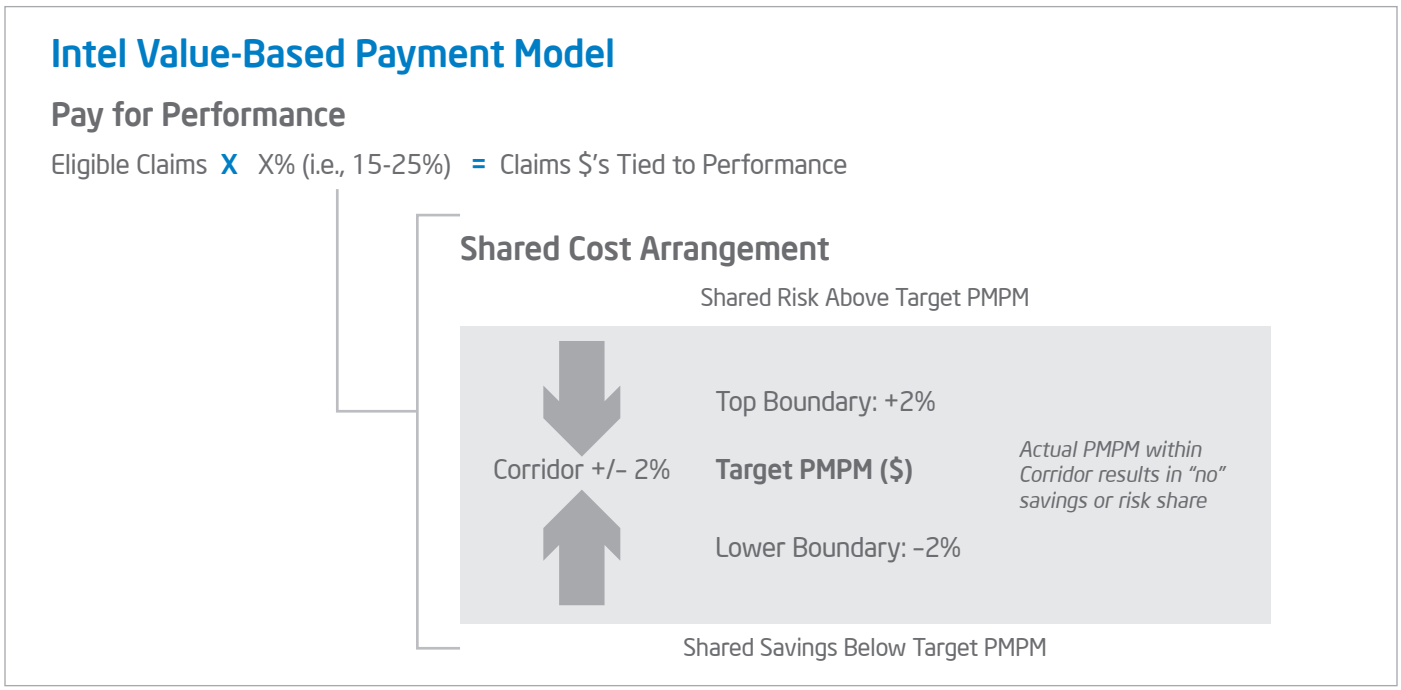

Figure 1. Value-Based Payment Model.

the project. Many team members brought valuable cross-functional backgrounds: HR professionals who had worked in the delivery system, delivery system leaders with a background in plan design, and so forth. The two organizations respected each other's cultures and expertise, and their commitment to the goal helped maintain a focus on removing roadblocks and finding the win/win.

The crux of the implementation was translating Intel's vision of the Five Requirements into practical, measurable specifics that provide a reasonable basis for accountability. Teams wrestled with the details of each requirement. How did Intel and PHS define access, for example? How would PHS meet Intel's objective of 24/7, same-day access? What level of access was appropriate—an appointment, an e-mail response, something in between? How would access be measured and what was an appropriate target? How would decisions on access impact other requirements? How would they contribute to the Triple Aim of improving outcomes, satisfaction, and costs? Intel and PHS were designing multiple systems with many moving, interlocking parts. Even the Five Requirements evolved during the year-long effort as the teams' understanding increased.

To better align risks and rewards with desired outcomes, Intel and PHS developed a value-based compensation structure that includes both shared costs and pay for performance and addresses both cost and qualitative factors. This compensation system is based on a global per-member per-month target, with a shared-savings "corridor" (see Figure 1). Intel and PHS share risks and rewards if results exceed or fall short of a designated target. Data for the cost baseline were validated through an underwriting analysis.

Synergies Among Plan Design, Delivery, and Compensation

The breadth of what Intel and PHS are tackling certainly presents challenges, but it also provides opportunities to have more of an impact. By addressing plan design, healthcare delivery, and compensation holistically, Intel and PHS gain significant synergies and enhance the likelihood of achieving the desired results. When trade-offs are necessary, implementation teams can balance them across all three elements. The system can be optimized for quality, efficiency, cost, and member satisfaction while focusing on Intel's specific objectives and those of its employees.

For example, instead of a typical plan design that takes a "plain vanilla" approach targeting low-volume healthcare users, Intel explicitly wants to ensure that highest-volume members get the highest-touch care. It is also important that all members receive evidence-based care. Intel and PHS designed the delivery system around PCMHs supported by a "medical neighborhood" of specialists, so members with complex needs have a team of health professionals providing coordinated care. This approach can increase quality and reduce wait times while contributing to lower costs. PHS established nurse navigators for high-needs members, so they get follow-up care without delays or confusion.

To promote evidence-based prevention and treatment of chronic conditions, Connected Care plans provide 100 percent coverage of preventive care, along with 100 percent coverage on a set of medications for asthma, hypertension, cholesterol, diabetes, and other conditions. Performance measures track a number of evidence-based screening procedures.

Intel wants all members to engage with the healthcare system and have a great experience. An outstanding experience is an intrinsic value since it helps generate higher patient engagement, which can improve health outcomes and contribute to cost savings. Delivery teams examined every phase of the member experience, looking for ways to optimize it for Intel's members without unduly disrupting PHS' ordinary processes. In addition to increasing convenience and satisfaction, these step-by-step process reviews led to changes that help reduce waste and optimize time with healthcare providers. This in turn promotes excellent care by giving providers more opportunity to identify and treat problems, strengthen their relationships with members, and positively influence behavior.

Although it wasn't part of Intel's initial plan, the company chose to turn its on-site clinic into a full PCMH with Presbyterian leading the design and implementation and providing overall management of the clinic. This step required remodeling and expanding the clinic and deploying Epic Ambulatory, but it adds convenience for Intel's members, enhances care coordination, and offers more meaningful ways to engage members than would otherwise have been possible.

Reflecting the technology expectations of the Intel workforce (and, indeed, of most Americans), the plan supports secure digital communications. Members can use Epic MyChart* to exchange secure electronic messages with providers, review lab results, and monitor their personal health trends. Measures of convenience and engagement are incorporated into the Connected Care performance metrics.

Intel and PHS took advantage of opportunities to optimize the delivery system to meet the specific needs of Intel's population. When anonymized analytics identified depression as a relevant health issue, Intel and PHS created a new depression screening process, incorporated it into the EHR, and integrated it into the provider's customary workflow.

By moving away from fee for service and aligning incentives around efficient, high-quality care, Connected Care helps eliminate traditional barriers that add waste, cost, delays, and frustration without adding value. For example, since provider incentives are aligned with appropriate care, Connected Care eliminates prior authorization for all but a handful of treatments. This removes a layer of bureaucracy (i.e., cost) and provides a better experience for patients and providers. Members, too, have a financial incentive to seek the most effective and cost-effective treatments. A treatment cost navigator calculator will make costs transparent and support members in finding high-quality, cost-effective care.

With the business model and the groundwork for care in place, PHS and Intel expect to begin working through an IT framework and tools to further improve care, increase member engagement, and reduce waste across the system year over year. Connected Care's value-based compensation model aligns with effective deployment of technology solutions, and this is an area with tremendous potential for innovation. Near-term options range from apps that engage members and support their health goals via their smartphones and tablets, to in-home telehealth monitoring for members with complex chronic conditions. Intel and PHS are also working toward the goal of a unified data warehouse for system performance analysis.

Data and Measurement: Critical Challenges

As data-driven enterprises, PHS and Intel recognized that solid data and detailed analytics would be critical to success. In addition to performance measures, the two organizations used data-driven assessments to better understand population health and attitudes, select specialists to invite into the medical neighborhood, develop a customized formulary, and establish the cost baseline of the PMPM target.

Table 4. Connected Care Sample Measures

Category	Measure	Description
Evidence-based medicine	Diabetes management	Percent of diabetic members attaining hemoglobin A1C level less than 8.0%, LDL level less than 100 mg/dL, and blood pressure less than 140/90 mmHg.
	Depression screening	Percent of adult members completing the depression screening when seen in a PCMH.
Right time, right setting	Nurse call response time	Percent of time nurses return symptom-related calls when requested within four business hours. Calls with urgent symptoms are transferred per protocol with a warm handoff immediately.
Member experience	Patient satisfaction with experience	Overall rating of PMG patient satisfaction using survey question: "Would you recommend?"

Data experts were an integral part of the program from the outset, working to identify analytics requirements, seek data sources and tools to meet them, and address gaps in the data. The implementation team is also collaborating with an independent healthcare analytics firm.

As is often the case in healthcare, the immaturity of information standards and tools often forced the implementation teams to extrapolate from multiple sources and reconcile different definitions of terms. Major data sources include claims data, health risk and biometric data from Intel's wellness program, self-report risk assessments, disability data, and electronic health records. All data is managed in accordance with HIPAA requirements.

As with other aspects of the program, Intel and PHS collaborated closely to identify targeted metrics aligned with the Five Requirements and with the needs of Intel's members. In some cases Intel and PHS wanted to track measures for which they had no baseline data; these were added as learning measures but will not factor into the first year's compensation calculations. Table 4 lists sample metrics.

For example, to measure the program's success in following evidence-based best practices and improving the health of diabetic members, Intel and PHS created a bundled metric that measures the percent of patients with diabetes mellitus who achieve hemoglobin A1C level less than 8.0 percent, LDL level less than 100 mg/dL, and blood pressure less than 140/90 mmHg. Since member participation in the healthcare system is an Intel objective, Intel and PHS are tracking system utilization by measuring the percent of employees and spouses who accessed a PCMH or nurse navigator to complete MyChart or complete two steps of Intel's three-step wellness program; Intel and PHS share responsibility for achieving targets for this metric.

Managing Change

No employer wants to undertake significant change for its workforce without good reasons and careful planning. Intel used its Employee at the Center model to optimize the Connected Care design, engagement and communication strategy, and rollout to members. Intel tested its messaging and vocabulary in focus groups, and discussed Connected Care benefits in relationship to employee priorities such as convenience, cost, and coordination. A phased engagement strategy presented information in digestible chunks through a series of events, in a variety of formats, starting well before open enrollment.

Intel provided clear information to help employees determine the plan that would best meet their needs, and attempted to be clear and transparent about trade-offs. Employees who did not sign up for a plan defaulted into the Connected Care plan most similar to their previous plan (either HDHP or co-pay). Intel also created videos and other communications to enable members to understand and benefit from the PCMH model, and to encourage their participation in the system.

Due to ecosystem changes and Intel's requirements, the Connected Care rollout occurred in tandem with other changes in the plans Intel offered. Some plans were being dropped, and as a result some members would need to find new providers. Intel worked systematically to minimize these changes, even negotiating a special, short-term contract with one plan to spare the plan's members from having to change providers before Connected Care's start date.

Intel's Rio Rancho site management was heavily involved in Connected Care planning and rollout, and the site manager's enthusiastic support was influential. PHS representatives were part of Intel's open enrollment presentations, and PHS established a high-touch customer service team to ensure a smooth go-live. Connected Care enrollment exceeded the target.

Next Steps and Conclusions

With Connected Care in full operation for Intel's Rio Rancho employees, Intel and PHS are monitoring activities, gathering data, and planning ways to incorporate new learnings. Both Intel and PHS are applying key learnings from the partnership throughout their organizations. Intel is also working to adapt and scale the model in other Intel locations in the U.S. Intel aims to replicate as much as possible while taking advantage of innovation and excellence in the healthcare ecosystem at each location. Intel is also looking at creative ways to influence healthy choices and help busy employees take better care of themselves.

The experiences of Intel and PHS show that employers and providers can be effective partners in advancing healthcare's transformation. Providers can gain enthusiastic partners who share their commitment to efficient, high-quality healthcare delivery and will align payment incentives to achieve it. Employers can support innovation in healthcare delivery and bring the employee/consumer voice into the healthcare system.

Employers and delivery systems can combine their unique perspectives toward the shared goals of improving member health, increasing satisfaction with the healthcare system, and reducing costs. Although it is daunting to tackle payment reform, delivery system design, and plan design together, this approach creates exciting opportunities to have a significant impact. Putting healthcare costs on a more sustainable basis can strengthen U.S. competitiveness in a global economy. Improvements in the health and healthcare experiences of employees can increase job satisfaction, loyalty, and quality of life.

Forward-looking health plans can support these collaborations by focusing on innovation and added value. Healthcare solutions providers and platform providers can help by committing to open information standards and rapid innovation.

Intel and PHS encourage employers and delivery services to engage in hands-on collaboration focused on a more sustainable, high-quality healthcare system. We have much to teach each other—and American workers have much to gain.

For More Information

Intel plans to publish other white papers on this experiment to share results, technology blueprints, and best practices.

Visit us on the web:

- http://www.intel.com/about/companyinfo/healthcare/index.htm
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The authors appreciate the participation of many individuals who play important roles in Connected Care and provided input for this paper. From Intel: James Dickey, Kevin Farr, Lukas Forney (including the payment model), Tami Graham, Cherizza Lundy, Prashant Shah, Julee Weller, Christy Wood. From PHS: Janice Beene, Jana Burdick, Donna Garcia, Cesar Goulart, and Cheryl Mitchell.

[1] Margaret O'Kane et al, Demanding Value from Our Healthcare: Motivating Patient Action to Reduce Waste in Health Care, Institute of Medicine, July 2012. Download the full discussion paper at **http://www.iom.edu/Global/Perspectives/2012/DemandingValue.aspx**.

[2] For a recent review of PCMH results, see Nielsen et al, Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results, 2012. **http://www.pcpcc.net/files/benefits_of_implementing_the_primary_care_pcmh_0.pdf**

[3] For resources on IHI's Triple Aim Initiative, see **http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx**.

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NATIONAL QUALITY FORUM

Patient Safety Quarterly Meeting Series

The Power of Alignment: Engaging Purchasers and Payers to Accelerate Patient Safety Efforts - Thursday, April 24, 2014
Speaker Biographies

Brian DeVore
Director of Strategy and Healthcare Ecosystem, Intel Corporation

Brian DeVore is the Director of Strategy and Healthcare Ecosystem and provides strategic guidance and oversees the national and local partnership efforts of Intel necessary to provide innovative healthcare to its employees. He works with senior executives in the healthcare and technology industries as well as business and government leaders to drive care, payment, data and organizational changes necessary to deliver improved quality at a repeatedly lower cost.

Mr. DeVore currently serves in advisory and board positions on the Oregon Health Policy Board, The Pacific Business Group on Health, The Oregon Coalition of Healthcare Purchasers and Dossia. He is a former alternate member of the American Health Information Community (AHIC) and was an advisor to the National Governor's Association State Alliance for eHealth, The Texas e-Health Alliance and the Oregon Health Information Technology Oversight Council (HITOC).

Prior to joining Intel, Brian formed and led Kryptiq Corporation's Government Affairs/Initiatives as well as an original principle with Myhealthbank, an early entry into the consumer driven health space. Brian holds a degree from Evangel University and has additional executive training from Stanford's Graduate School of Business.

Paul McGann, MD
Co-Director, Partnership for Patients, Deputy Chief Medical Officer for Campaign Leadership, Innovation Center, CMS

In 2002, Dr. McGann joined the full-time staff of CMS, initially in the Quality Improvement Group in the Office of Clinical Standards and Quality (now the Center for Clinical Standards and Quality). His first projects at CMS were to lead the introduction of quality improvement work in nursing homes and home health agencies into the Quality Improvement Organization contracts, beginning with their 8th contract cycle. The results of this work were published in the Annals of Internal Medicine in September 2006.

In July 2007 he was promoted to Deputy Chief Medical Officer for CMS. His responsibilities in that position included leading the re-design and clearance team for the QIO 9th Statement of Work. The procurement of this $1.1B contract was completed successfully in August 2008, and represented the start of CMS work to improve care transitions and reduce hospital re-admission rates for Medicare

beneficiaries. He also contributed to the development of the QIO 10th Statement of Work, which was awarded in August 2011. He has also contributed to the ongoing re-design of the ESRD Network Program, identification and reduction of health care disparities, and introduction of the principles of geriatric medicine into numerous CMS programs including measure development, survey and certification, coverage, and value-based purchasing. From February to May, 2011, Dr. McGann served as the Acting Chief Medical Officer for CMS, reporting to the CMS Administrator. In August 2011, at the request of the Administrator, Dr. McGann relocated to the CMS Innovation Center to become Co-Director of the Partnership for Patients, together with Dennis Wagner.

Dr. McGann received a Bachelor's Degree in Chemistry and a Master's in Biology from MIT. He graduated from the McGill Faculty of Medicine in Montreal, and completed both internal medicine and geriatric medicine training in Canada, where he practiced geriatric medicine for 14 years. He is board-certified in both internal medicine and geriatric medicine in both the United States and in Canada. He returned to the US in 1995 to become the founding Clinical Director of the J. Paul Sticht Center on Aging of Wake Forest University in North Carolina. He was named the first AGS-HCFA Health Policy Scholar in 1999. He relocated to Baltimore to join the full-time staff of CMS in 2002.

The Partnership for Patients is an unprecedented public-private program of work which commits to achieving two bold, national aims in health care quality improvement by the end of 2014: a 40% reduction in all-cause patient harm in US hospitals, and a 20% reduction in all-payer 30-day readmission rates. The Partnership for Patients has signed up 3,700 of the nation's hospitals, and more than 8,000 general partners in its three-year effort dramatically to improve patient safety in the nation's hospitals, across all public and private payors. It involves all Operating Divisions within the Department of Health and Human Services, including CMS, ACL (formerly AoA), AHRQ, CDC, HRSA, ONC, OASH, and many others. The two operational components of the Partnership for Patients are ACA Section 3026 Community Based Care Transitions Program (CCTP), and the "Hospital Engagement Networks", a program of competitive federal contracts which was awarded to 26 leading hospital organizations on December 9th, 2011. (More information at www.healthcare.gov.)

John Michael O'Brien, PharmD, MPH
Vice President, Public Policy, CareFirst

John Michael O'Brien is vice president of public policy at CareFirst BlueCross BlueShield, and leads federal government and regulatory affairs related to the implementation of the Affordable Care Act.

Dr. O'Brien joined CareFirst from the Centers for Medicare and Medicaid Services, where he served as the Director of the Strategic Partnerships Division. His other posts at the agency included senior adviser with the CMS Innovation Center – where he served on the Partnership for Patients and Million Hearts teams - and policy coordinator in the Office of Strategic Operations and Regulatory Affairs.

Before joining CMS, Dr. O'Brien was a professor of clinical and administrative sciences at the Notre Dame of Maryland University College of Pharmacy, and a Senior Policy Director at the Pharmaceutical Research and Manufacturers of America (PhRMA). He has a master's degree in public health from the Johns Hopkins Bloomberg School of Public Health, and a doctor of pharmacy degree from Nova Southeastern University. He also studied pharmacy and public policy at the University of Florida.

Louise Probst
Executive Director, St. Louis Area Business Health Coalition

Louise Probst is Executive Director of the St. Louis Area Business Health Coalition (BHC). The coalition represents St. Louis employers in their efforts to improve the health of their employees and the quality and affordability of health care.

BHC employers seek a transparent health care market where physicians, consumers, and others have information about quality and cost differences and actively use this information to improve health care. Ms. Probst also serves as the Executive Director of the Midwest Health Initiative (MHI). The MHI brings together health care stakeholders such as hospitals, health care providers, purchasers and consumers who share a belief in the power of information and collaboration to improve health and create a high-value health care system.

Ms. Probst began her career in health care as a critical care nurse. She has experience as a clinician, an educator, a hospital administrator, and a purchaser advocate. She has a Master's Degree in Business Administration from the University of Denver.

Ms. Probst serves on the board of directors of the National Quality Forum and is Co-Chair of its Consumer-Purchaser Council. She is also a member of the National Quality Forum's MAP Hospital Workgroup. Ms. Probst serves on the National Committee for Quality Assurance's (NCQA) Clinical Programs Committee. In past years, she has served on the Commonwealth Fund's Commission on a High Performance Health System, the NCQA's Standards Committee, various National Quality Forum (NQF) Steering Committees, and other initiatives to enhance the quality and affordability of health care. She is also a past Chairperson of the National Business Coalition on Health (NBCH).

Jon Shematek, M.D.
Sr. Vice President and Chief Medical Officer, CareFirst

Jon Shematek, MD is a graduate of Boston University, earned his medical degree at the University of Pittsburgh School of Medicine, and completed residency training at the Children's Hospital of Pittsburgh and the Johns Hopkins Hospital. He is board-certified in Pediatrics and Pediatric Cardiology. Following 25 years of medical practice and as medical director with the Columbia Medical Plan, he has served in a variety of administrative roles with CareFirst, currently as Senior Vice President and Chief Medical Officer. In that position he provides the strategic clinical leadership for CareFirst's quality improvement activities and care management programs. He has been responsible for the implementation of dozens of community-based innovative programs focused on improving public health and reducing health care disparities. He has led CareFirst's Patient Centered Medical Home program and is currently developing programs for effective Care Transitions for high-risk hospitalized patients. Dr. Shematek was appointed by the Governor to the Maryland Healthcare Quality and Cost Council and is also member of the Maryland Health Reform Coordinating Council's Health Care Delivery Reform Subcommittee.

Dr. Shematek has also served as member of NCQA's Review Oversight Committee and the Maryland Patient Safety Center's Board of Directors.

Alan P. Spielman
Assistant Director, Federal Employee Insurance Operations for the U.S. Office of Personnel Management (OPM)

In this capacity, he is responsible for managing the negotiation and administration of contracts providing insurance benefits for over 8 million active Federal employees, retirees and family members. Health insurance programs include the Federal Employees Health Benefits (FEHB) Program, health insurance coverage for tribal organizations, and the health insurance program for Members of Congress & congressional staff. Mr. Spielman is also responsible for administering the Federal Employees Group Life Insurance (FEGLI), the Federal Flexible Spending Account Program (FSAFEDS), the Federal Long Term Care Insurance Program (FLTCIP), and the Federal Employees Dental &Vision Insurance Program (FEDVIP).

Prior to joining OPM in 2013, Mr. Spielman was President and CEO of URAC, an independent nonprofit organization that is well-known as a leader in promoting health care quality through its accreditation, education and measurement programs. In this capacity, Mr. Spielman provided leadership and executive management of an organization responsible for accrediting over 600 organizations, including health plans, health websites, PBMs, specialty pharmacies, case management and other health care management entities.

Mr. Spielman came to URAC from Covington & Burling, a global law firm specializing in regulatory matters, where he was a senior advisor for health care reimbursement policy. Prior to that, he was with Medco Health Solutions, Inc., a leading pharmacy benefits management company, as vice president and general manager for federal programs. Spielman also held a variety of senior executive positions at the Blue Cross Blue Shield Association, including leadership of the Federal Employee Program.

Spielman began his career in government, including key roles with the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services, or CMS) and the Congressional Research Service. He holds an MBA degree, with a concentration in health care marketing/management from Loyola College and a Bachelor of Arts degree from the Johns Hopkins University, where he also continued graduate study in health economics. Beyond his master's degree, he has attained the Managed Care Professional designation.

Dennis C. Wagner, Co-Director, Partnership for Patients, CMS

Dennis Wagner is a national and international leader in the fields of healthcare quality improvement, the environment and social marketing. He is an enthusiastic, thoughtful and strategic person who believes in committing to and delivering on bold aims in work and life. Dennis currently works in the U.S. Department of Health and Human Services as Co-Director of the Partnership for Patients Initiative and as Associate Director for Campaign Leadership in the CMS Innovation Center.

Prior to his current CMS postings, Dennis served as the Associate Deputy Director and then Acting Director of the CMS Office of Clinical Standards and Quality (OCSQ). Dennis worked for 12 years at the Health Resources and Services Administration, including a final stint as Acting Director of HRSA's Office of Health Information Technology and Quality. While at HRSA, Dennis led a major national effort to increase the donation and transplantation of organs. Dennis was the Director and Co-Director for a series of three large, national Organ Donation & Transplantation Breakthrough Collaboratives and related initiatives. After years of relatively flat national organ donation levels, this work generated an unprecedented increase in organ donation of nearly 25% over a four-year period.

In his 20+ years of service with the U.S. government, Dennis has led and helped to support a series of national and international campaigns to:

- Improve health outcomes and drug safety through increased clinical pharmacy services;
- Increase access to health care and reduce disparities for underserved populations;
- Create integrated systems of health care in communities across the nation;
- Reduce exposure to second-hand smoke in the US;
- Reduce the public health risks of indoor radon gas;
- Increase organ donation in Australia;
- Clean up the Tha Chin River in Thailand;
- Get the lead out of gasoline in Vietnam;
- Improve air quality in Bangkok and Chiang Mai, Thailand; and
- Promote use of improved cookstoves by the world's poorest people.

Dennis attended a one-room country school in rural Montana for grades K-8. He has a Masters in Public Administration from Montana State University, and joined the Federal service with the US Environmental Protection Agency as a Presidential Management Intern in 1986.

Dennis was a Council for Excellence in Government Fellow in 1991-92. Dennis and HRSA colleagues were recipients of Government Executive magazine's prestigious Business Solutions in the Public Interest award in 2000. He and his organ donation team were among three 2005 Finalists for the prestigious Service to America Medal for Social Services (SAMMIEs) given by the Partnership for Public Service.

Dennis is married to the lovely and talented Diane M. Hill, also a Montana native. They have three children: Tess (17), Grant (14) and Margo (12).