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MEDICINE
US FAMILY HEALTH PLAN

JH US Family Health Plan

- 1981: US Public Health Service Hospitals designated to provide health care for uniformed services beneficiaries
- 1993: USTFs mandated to provide services through a fully at-risk managed health care plan
- 1996: Congress designates that the USTFs provide the TRICARE Prime benefit as “TRICARE Designated Providers” making them a permanent component of the MHS
- 1998: USFHP implements the TRICARE Prime benefit

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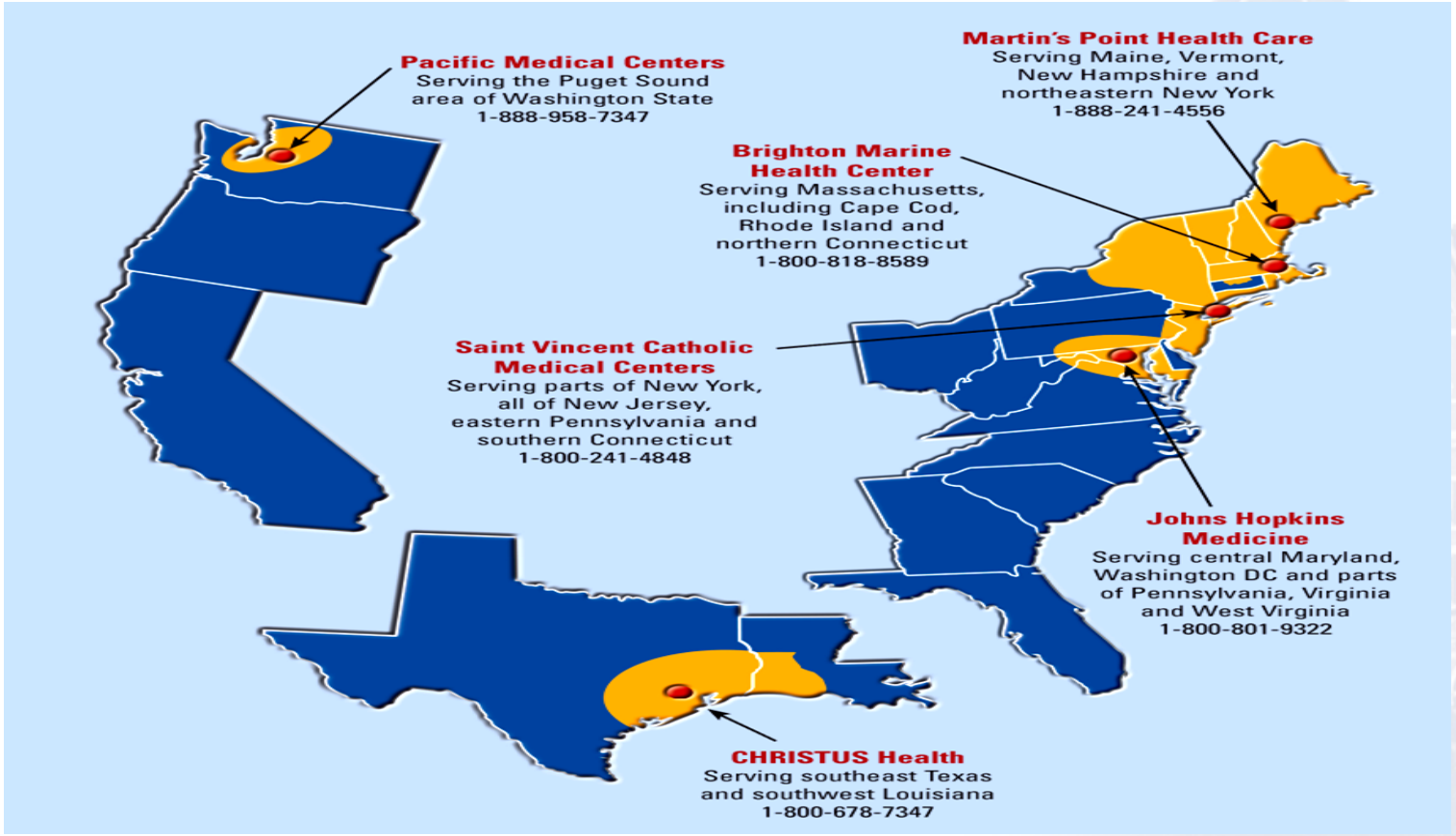
USFHP Alliance



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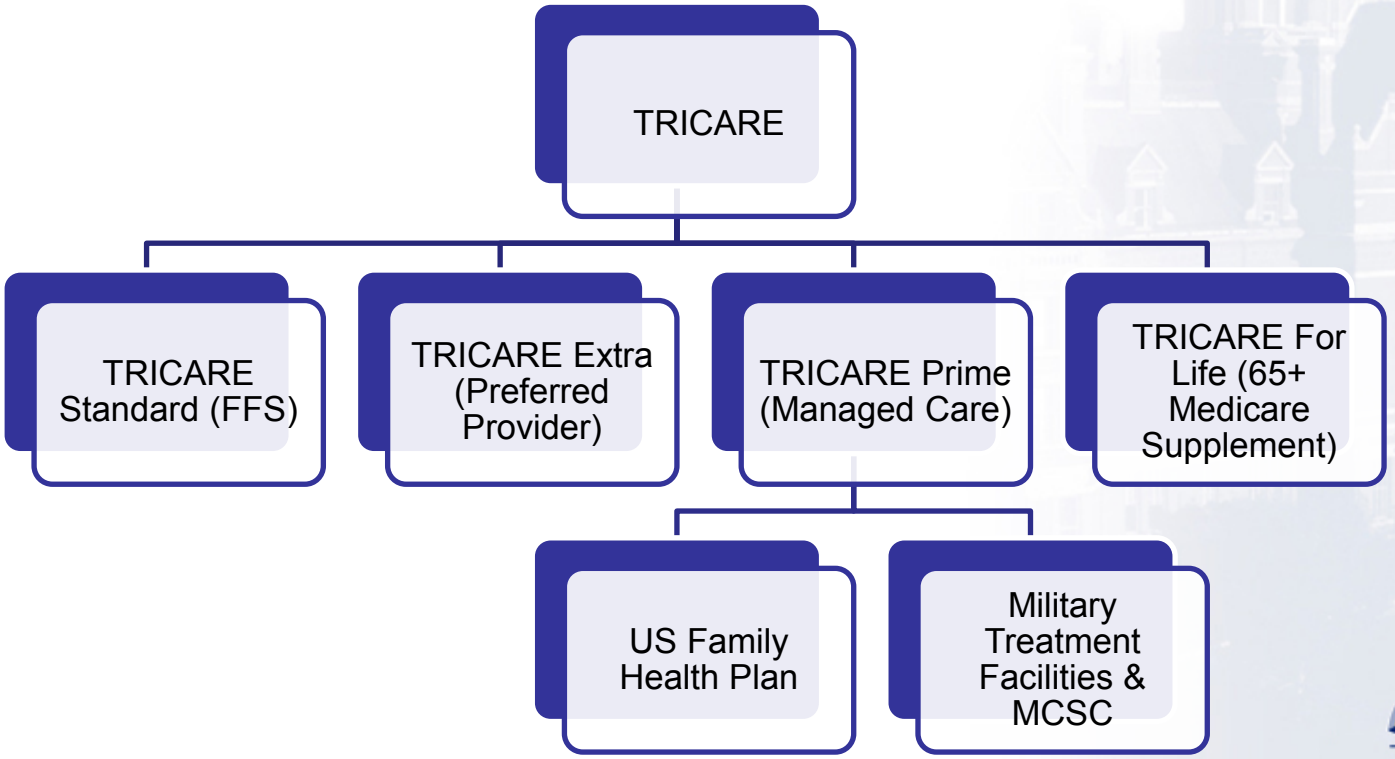
- **Fiscal Year 1997 National Defense Authorization Act "The health care delivery system of the uniformed services shall include the designated providers."**



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JH Enrollment

Active Duty Family/Members	11,119
<65 Retirees	20,799
65+ Retirees	8,279
Total	40,197

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JH Privileged to Serve Since 1981…

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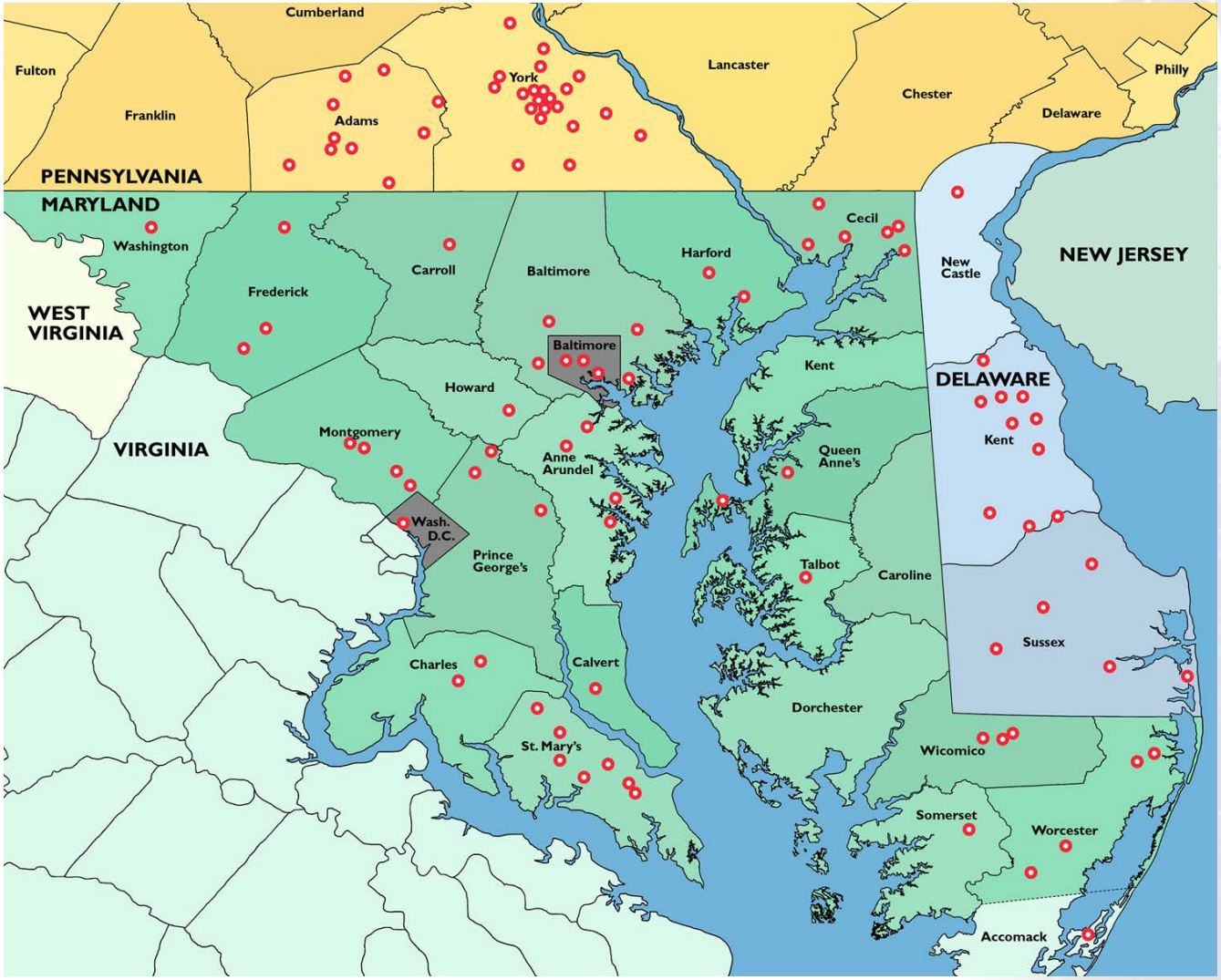
Johns Hopkins USFHP Network



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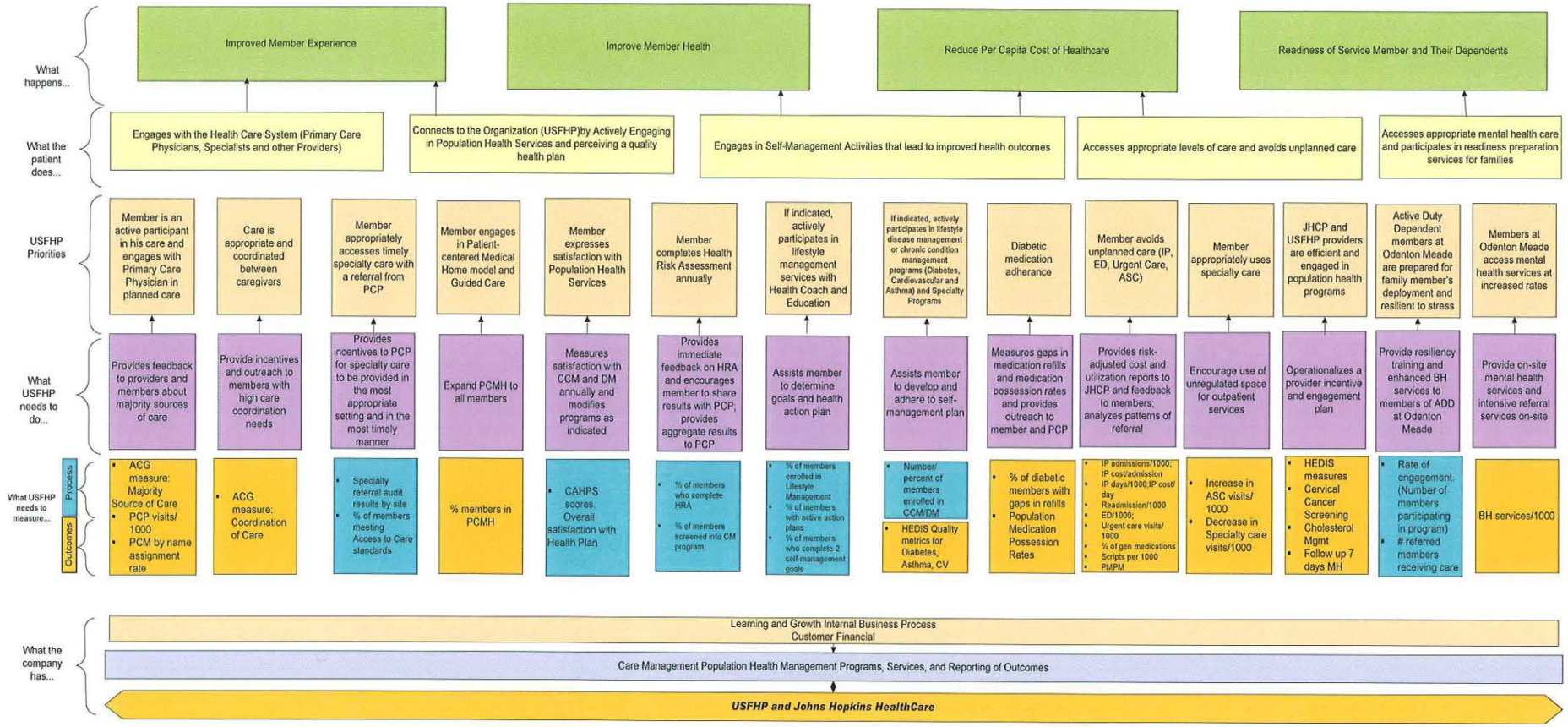
JH US Family Health Plan Quadruple Aim



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JH Member Health & Experience

2012 Accreditation Scoring	JH USFHP Points	Possible Points
Standards	53.0752	54.14
HEDIS Effectiveness of Care Measures Score	28.6025	32.86
CAHPS Measures Score	13.0000	13.00
Total & Status Level	94.6777 Excellent	100.00

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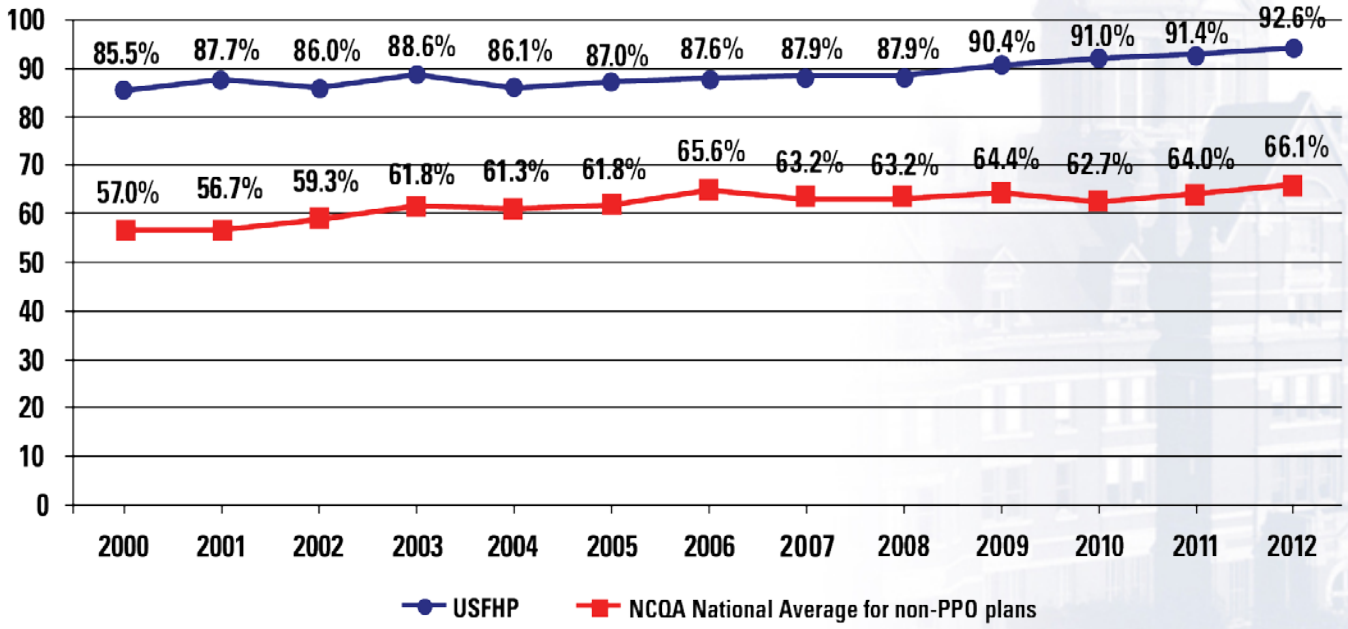
USFHP Alliance Member Experience

Among the Highest in America

Overall Satisfaction



Source: 2012 The Myers Group Survey and 2012 Public Report benchmark derived from NCQA Quality Compass Public Report and calculated by The Myers Group.

Comparison to national averages for member satisfaction with non-PPO plans (all percentages = proportion highly satisfied, rating plan 8 through 10 on a scale from 0 to 10, where 10 is the best possible plan). 2006–2012 surveys conducted by NCQA Certified vendor.

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POPULATION HEALTH . AND THE TECHNOLOGY TO SUPPORT IT

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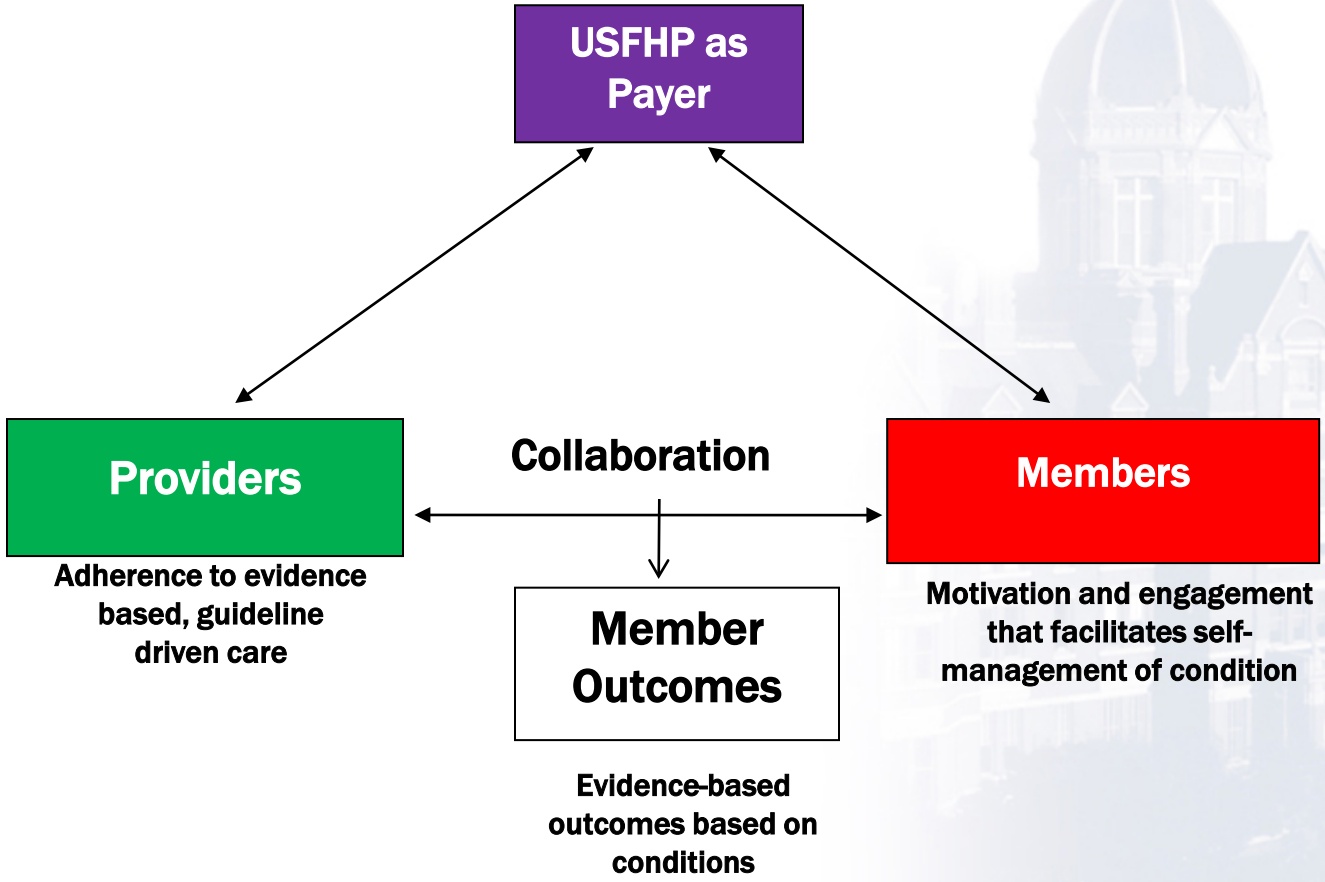
Johns Hopkins Medicine and Accountable Care

Johns Hopkins Medicine has all the necessary components to achieve a high-performance integrated delivery system.

A Model for an Accountable Care System: Provider and Member Engagement



Achieving the Quadruple Aim: A Population Health Approach

Identify and target beneficiaries in need of services

Assess Needs and Goals of beneficiary

Develop Patient Centered Action Plan

Intervene and carry out Action Plan with Patient

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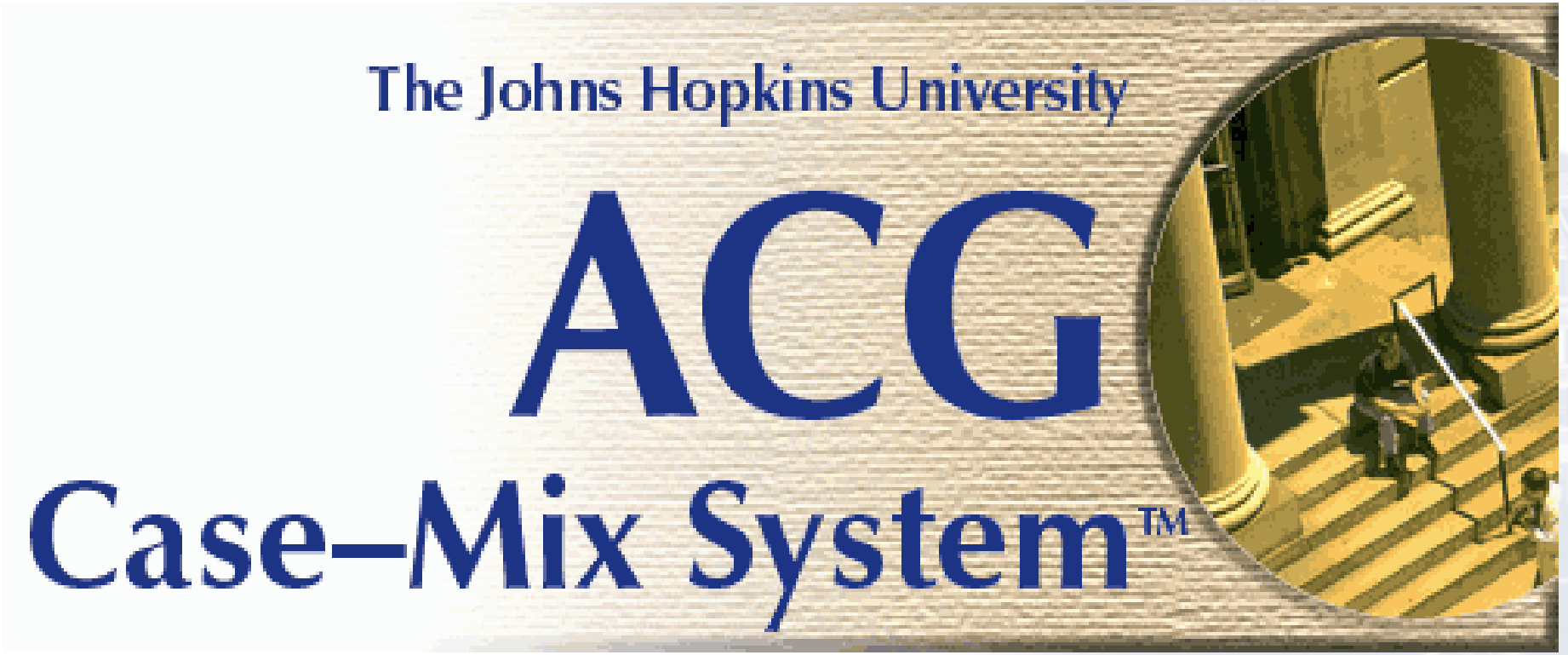
How do we identify and target those in need of services?



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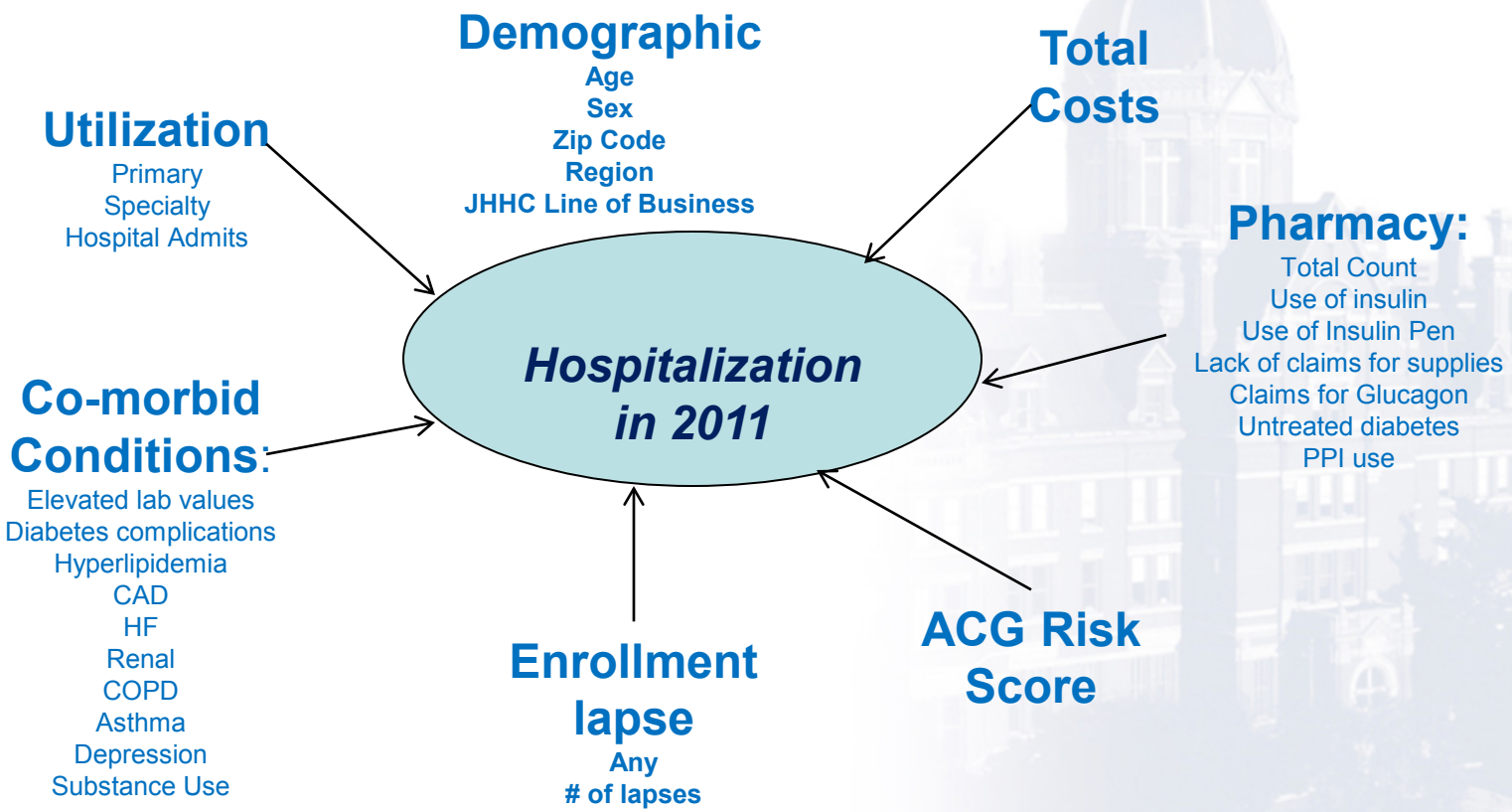
Variables in the Predictive Model



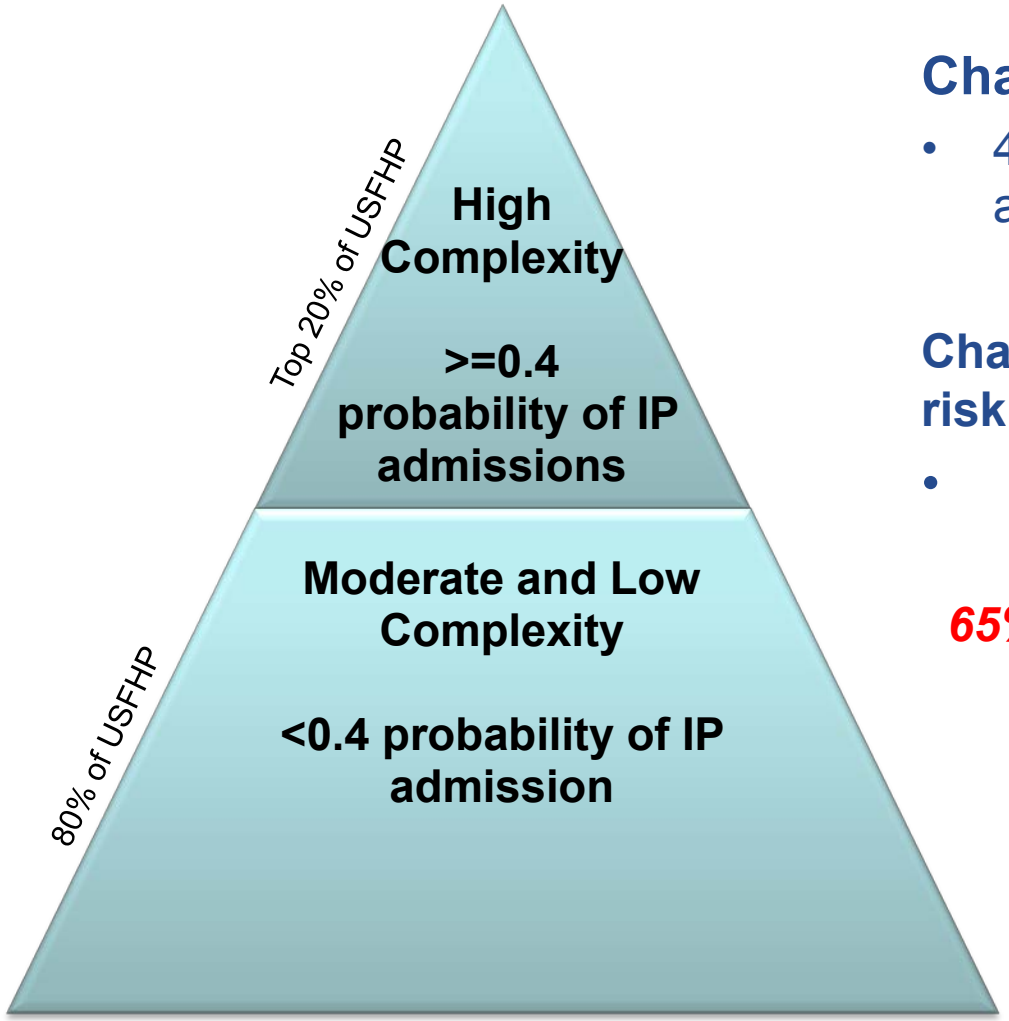
The ACG Predictive Model

- What the ACG-PM does:
  - Grounded in the **disease burden or co-morbidity perspective** unique to the ACG system
    - Focuses on commonly occurring patterns of morbidity and assessment of all types of medical needs
    - Holistic method has repeatedly proved to have many advantages over comparable case-mix approaches that include limited a set of diseases or episode categories.
  - Builds on facets of the ACG system and several years of **intensive research and development** at JHU
  - Uses statistical techniques to project the **impact of co-morbidity and other factors** on an individual's use of health care resources in a future time period

ACG-PM Outputs

- ACG-PM produces two types of predictive risk indicators:
  - **Probability Score**: represents the likelihood that a member will be among those persons using extraordinary health care resources
    - Scores range from 0 to 1. Score of 0.4 means the individual has a 40 out of 100 chance of being in the high-risk cohort next year
  - Predicted Resource Index: can be readily converted to a predicted dollar amount
    - Scores range from 0 to roughly 40 with a population mean of 1.0.

USFHP Population we serve



Characteristics of high-risk group:

- 46% have 1 or more hospital admissions in 2012

Characteristics of low and moderate risk Group:

- 16% have one admission

65% of all admissions are accounted for by the high risk group

Achieving the Triple Aim: A Population Health Approach

Identify and target members in need of services

Assess Needs and Goals of members

Develop Patient Centered Action Plan

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Case Management and Behavioral Assessment Completed in Database

- Health status
- **Medication Adherence**
- Life-planning Activities
- Cultural and Linguistic needs, preferences and limitations
- ADLs
- Caregiver resources
- **Nutrition**
- **Physical Activity**
- **Pain**
- **Stress**
- **Sleep**
- **Tobacco Use**
- **Alcohol Use**
- **Substance Use**
- **Emotional Status and Depression**
- Domestic violence and neglect
- Cognitive Function
- Patient Activation

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The Assessment of Needs

More comprehensive for high-risk patients
- ~150 questions for high risk patients
- ~50-60 questions for medium risk

About 20-30 mins.

Multiple assessment methods available, based on patient preference and need/usability
- Mailed, web-based, face-to-face interview in clinic, face-to-face interview in home conducted

Data scanned/direct entered into centralized USFHP database

Achieved high response rates from USFHP members

Sample Assessment Questions

Domain	Medium Risk	High Risk
Depression	PHQ-2 Over the past two weeks, how often have you been bothered by any of the following problems? • Had little interest or pleasure in doing things. • Felt own, depressed, or hopeless.	PHQ-8 Over the past two weeks, how often have you been bothered by any of the following problems? • Had little interest or pleasure in doing things • Felt down, depressed, or hopeless • Had trouble falling asleep or staying asleep or sleeping too much
Medication Adherence	Morisky 4-item	Morisky 8-item Do you ever forget to take your medicine? Are you careless at times about taking your dicine? you feel better do you sometimes stop your medicine? mes if you feel worse when you take the he, do you stop taking it? you travel or leave home, do you etimes forget to bring along your medications? Do you ever run out of your medicine?
Literacy	WRAT word list	WRAT word list

68% of the US population reads at a Basic or Below level. The literature shows direct associations between low literacy and poorer health outcomes.

Care Management System Produces Summary of Assessment

GENERAL HEALTH BEHAVIORS	
ASSESSMENT DOMAIN	**POSSIBLE INTERVENTIONS**
Weight Management BMI = 32.6 (height = 71 inches, weight = 234 lbs)	Care team for recommendations OR Behavioral Specialist for Weight Management Package OR Specialty clinic for dietitian, medical weight loss, or bariatric surgery referral OR Care team to rule out medical explanations and substance use with possible referral to Eating Disorders or other psychiatric specialty
Tobacco Use Current smoker Willing to try to quit	Case Manager for smoking cessation counseling or Motivational Interviewing and smoking cessation resources OR Behavioral Specialist for extended motivation interviewing
Alcohol Use of alcohol: monthly # alcoholic drinks on a typical day: X	Behavioral Specialist for full evaluation
Substance Use Use of illegal drugs: once or twice Use of prescription drugs for non-medical reasons: never AUDIT-C score = 7 History of diagnosis or treatment: yes Currently receiving treatment at: yes	Case Manager for reinforcement OR for testing for HIV, HCV, HBV OR Behavioral Specialist for full evaluation OR CHW to monitor or if referral to Behavioral Specialist declined
Nutrition In past week, eats fast food: 5 times Eating per day: 3 meals and 2 snacks Skips breakfast and lunch	Case Manager or Behavioral Specialist or CHW for Health Eating Package OR Case Manager for health team recommendations OR Nutrition/diabetes intervention
Physical Activity per week Light activity total (LAT) = 150 Moderate to vigorous physical activity (MVPA) = 100	If LAT < 180, refer to Case Manager, Behavioral Specialist, or CHW for Increasing Baseline Activity intervention. If MVPA < 150, refer to Case Manager or CHW for Increasing MVPA intervention.

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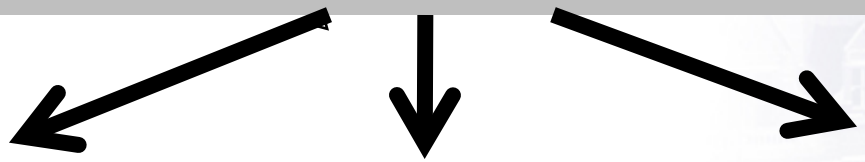
Individualized Patient-Centered Care: Specific behavioral and social interventions

Individualized intervention plan triggered by assessments, targeting specific behavior needs

Each assessment domain has recommended interventions for follow-up

Meet 2012 NCQA standard for evidence-based tools and approaches to patient counseling and intervention



Case Management Needs

- Care Coordination
- Case Management
- Assistive/Support Interventions
- Social and Economic Needs

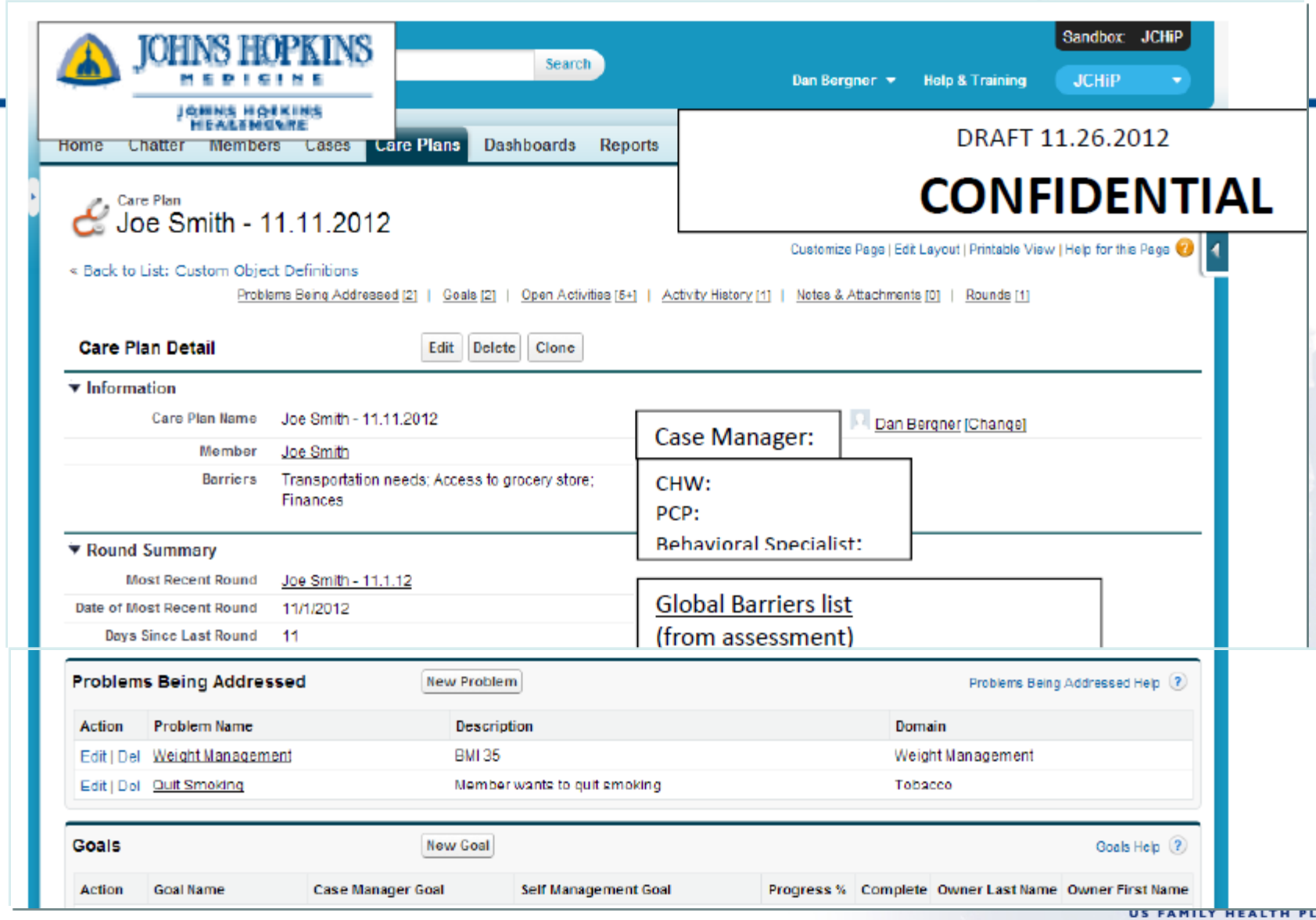
Health Behavior Risk Needs

- Counseling
- Lifestyle modification coaching
- Smoking cessation
- Weight management
- Specialist referrals (addiction, major depression, cardiac rehab, neuro/early dementia)

Disease-specific Self-Care Behavior Needs

- Behavior change counseling
- Health Coaching
- Family Training
- Social and instrumental support

Care Plan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Search
Sandbox: JCHiP
Dan Bergner
Help & Training
JCHiP
Home
Chatter
Members
Cases
Care Plans
Dashboards
Reports
DRAFT 11.26.2012
CONFIDENTIAL
Care Plan
Joe Smith - 11.11.2012
Customize Page | Edit Layout | Printable View | Help for this Page
« Back to List: Custom Object Definitions
Problems Being Addressed [2] | Goals [2] | Open Activities [5+] | Activity History [1] | Notes & Attachments [0] | Rounds [1]
Care Plan Detail
Edit
Delete
Clone
Information
Care Plan Name
Joe Smith - 11.11.2012
Member
Joe Smith
Barriers
Transportation needs; Access to grocery store; Finances
Case Manager:
Dan Bergner [Change]
CHW:
PCP:
Behavioral Specialist:
Round Summary
Most Recent Round
Joe Smith - 11.1.12
Date of Most Recent Round
11/1/2012
Days Since Last Round
11
Global Barriers list
(from assessment)
Problems Being Addressed
New Problem
Problems Being Addressed Help
Action
Problem Name
Description
Domain
Edit | Del
Weight Management
BMI 35
Weight Management
Edit | Del
Quit Smoking
Member wants to quit smoking
Tobacco
Goals
New Goal
Goals Help
Action
Goal Name
Case Manager Goal
Self Management Goal
Progress %
Complete
Owner Last Name
Owner First Name

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USFHP Medication Adherence:
Intervention to Address Needs

Table. Factors Impacting Care Delivery and Adherence to Care			
FACTOR	**DATA SOURCE**	**STRATEGY**	**MODALITY**
Patients' Capacity			
Lack of clear education re: medical conditions	Case studies EBMC experience Literature	Care coordination Education Simplify treatment Build capacity CCC becomes a point of contact	NCM, CCC
Incomplete understanding of severity of condition or consequences of non-compliance			
Lack of knowledge about health and social service systems			
Health literacy			
Difficulty discerning when to seek care or professional health advice			
Inability to navigate health and social service systems			
Difficulty overcoming barriers without assistance			
Treatment complexity			
Patients' Attitudes/Beliefs			
Belief that medical care is not important	Case studies EBMC experience ICHABOD	Informal counseling & social support Organize health buddies	NCM, CCC
Unwillingness to face severity of health condition			
Mistrust of health system			
Fear of medical procedures and side effects			
Lack of confidence that patient's actions can improve health			
Social and Economic Environment			
Transportation	Case studies EBMC experience	Care coordination Social stabilization	CCC
Unstable and/or unsuitable housing			
Finance and resource insufficiency			
Lack of social support for healthy behaviors			
Household members' engagement in behaviors harmful to patient			
Health System			
Patient-provider communication	Case studies EBMC experience	Care coordination	NCM + CCC
Inefficiencies in processes			
Complexity of referral processes			
Inadequate follow-up or discharge planning			
Cost of medication, copayment, or both			

Integrated, Team-based Primary Care

Integrated Primary Care combines medical and behavioral health services to more fully address the spectrum of problems that patients bring to primary medical care.

- Integrate a new discipline – Behavioral Team – into the Primary Care Team
- Community based health workers extending services into the patients home and neighborhood
- Lift some burden from the primary care team
- Adjust the workflow

What Do Successful PCMH Interventions Have in Common?

- Target high risk patients
- Strong transitional care
- Medication management
- Ongoing assessments and monitoring of patients with chronic conditions
- Focused, streamlined care plans
- Close communication between care managers, patients, primary care doctors, and specialists
- Personal face to face contact between care coordinator and patient

Clinic Based Team: Behavioral Specialist, Case Manager, and Primary Care Physician

Nurse Case Managers embedded in primary care clinics are responsible for

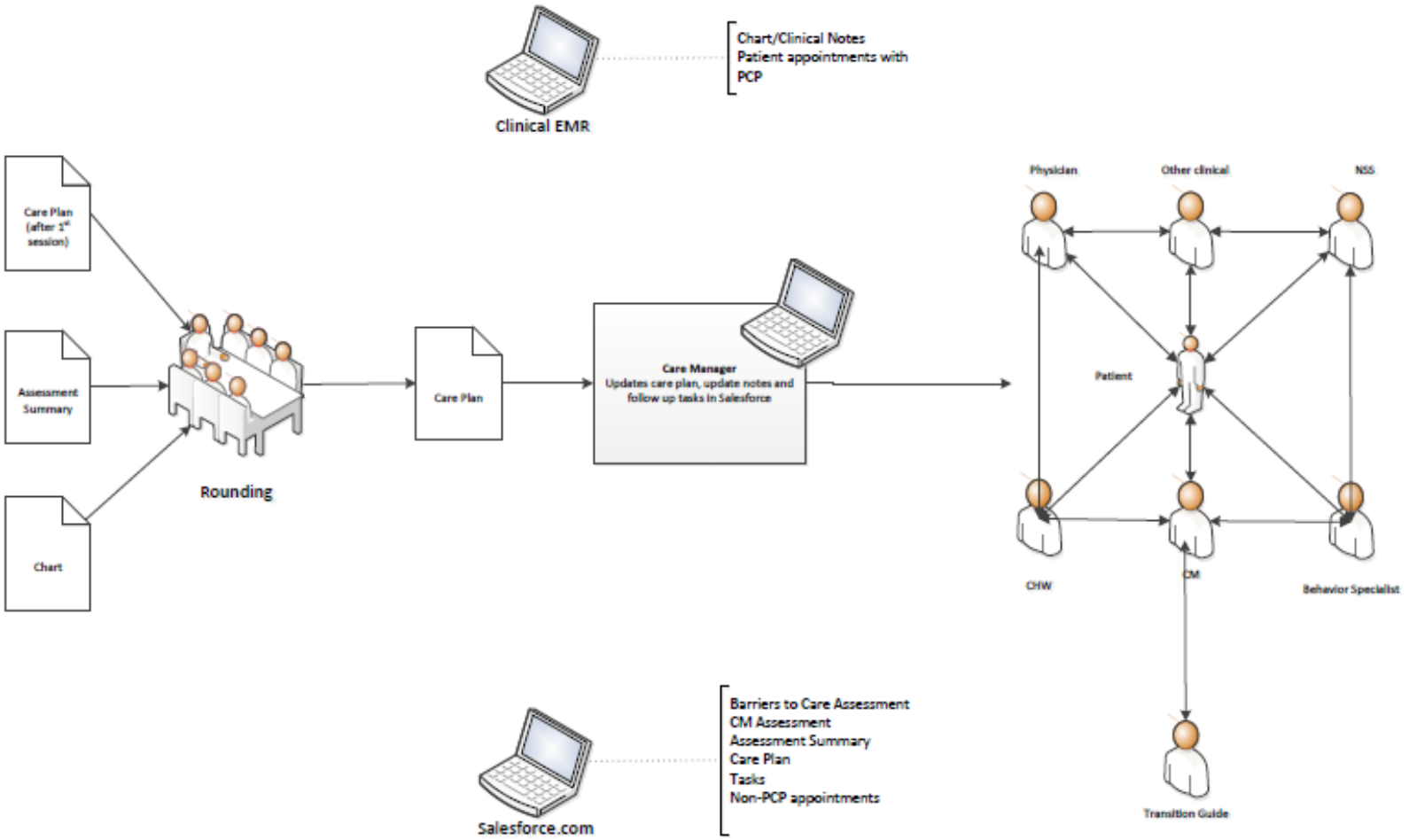
- Initial Assessment and Survey
- Ongoing Self-management support
- Develops and Communicates Care Plan with member and clinic team

Clinic Based Team: Behavioral Specialist, Case Manager, and Primary Care Physician

Primary Care Physician leads each team

- Oversees the care
- Has electronic and periodic in-person interactions with the care team
- Regular appointments with each patient

The Interdisciplinary Team Process



In Summary .. Population Health Approach

- Technology to support our approach
  - Data architecture to join multiple data sources at a patient-centric level (claims, EMR, pharmacy, self-reported surveys and symptoms)
  - Predictive models (sophisticated biostatistics software)
  - Systems that support collection of data that leads to summaries of needs/problems, creates care plan, tracks interventions and coordination amongst team members
  - Outcomes and data reporting (intelligence and decision support)
  - Portal for patients and caregivers (view, write to medical records, communicate with care team)

DISCUSSION, Q&A

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