Tuesday, June 28, 2005

XLHealth

Inform. Empower. Excel.

# BIPA Case Study One Year Later: XLHealth

## Prepared For:
## Disease Management Colloquium

# Lessons Learned

- CMS is highly committed and excellent to work with
- "Contracting" process is flexible, yet rigorous, and should result in measurable and improved outcomes
- Obtaining data is not always as easy/quick as expected
- "There is a lot going on" for Medicare beneficiaries, which makes communication of new Program challenging, even when it appears to be highly favorable for those who qualify
  - We have been confused with Drug Cards, HMOs, other
  - Implication is that recruitment could be even harder if offering is less valuable (Drug Care enrollment is quite slow so far, even though "break even" is easy to achieve)
- Medicare is a big place, and that can cause confusion
  - 1800 Medicare not always able to confirm our existence
  - Providers confused re: eligibility and billing due to use of Group Health Plan systems
- Enrollment success requires an ongoing and multifaceted approach
- There will continue to be surprises…



2

# Next Steps

- Complete and then maintain full enrollment
- Utilize core clinical model to generate improved quality and reduced cost
- Continually evaluate opportunities for improvement
- Address surprises
- BIPA Demo health economics and outcomes research
- Use BIPA learning to improve CMS and other DM initiatives



3

# General Overview

- Started in late 90's as Diabetex, a diabetes DM Company with a primarily lower extremity focus

- Now focus on primarily seniors with complex diabetes and CHF, and the full range of co-morbid conditions
  - Changed name to XLHealth in late 2004
  - BIPA enrollment criteria includes 3 approximately equally sized categories: Complex Diabetes Without CHF; Complex Diabetes With CHF; CHF Without Diabetes

- BIPA Demo initial enrollment effective date is April 1, 2004
  - Award finalized in late 2003, and patient/provider recruiting started in Q1, 2003
  - While BIPA Demo is a "transforming event" for the Company from a revenue, number of lives and direct contracting with CMS perspective, the clinical model is the very similar to the existing business (pharmacy risk is new), and the Texas geography overlaps with existing business

# General Overview (cont.)

- High Touch: XLHealth's model relies heavily on market-based operations, and physical interaction with physicians, patients and their caregivers
  - Nurse Program manager and additional support in each of 6 metropolitan areas
- Physician Driven: XLHealth integrates deeply with patient's existing physicians and other caregivers, and uses existing physicians to drive the Care Team
- Lower Extremity Focus For Diabetes: XLHealth's Diabetes care management approach uses a Lower Extremity Focus to educate patients and monitor the need for intervention
- Best-of-Class Information System & Usage: XLHealth's internally developed information system effectively captures and prioritizes data, and allows us to assist in developing and following evidence-based medicine approaches
- Pharmacy Management & Pharmacist Interventions: Manage drug utilization through complete drug regimen reviews, and having nurse Program staff use physicians, as well as community-based and other pharmacists



5

# Program Goals & Objectives

- Prove that for Medicare Beneficiaries with Complex Diabetes and CHF, a Disease Management program that incorporates a pharmacy benefit can generate Medicare Part A/B savings sufficient to offset DM and pharmacy costs
  - "find better ways to improve the quality of life for people with diabetes and chronic heart disease"
  - "determine the benefits of disease management programs for chronically ill persons"
  - "find ways to make these services available to people with Medicare"
- Improved quality leads to increased satisfaction and decreased cost for these chronically ill beneficiaries
- Effectively Provide DM to Medicare beneficiaries, so that Medicare will continue to use DM for predictably high cost, manageable beneficiaries
  - DM in Capitated Setting: HCC risk adjustment system, Specialized Plan legislation, Capitated Disease Management Demonstration, etc.
  - DM in a FFS Setting: Voluntary Chronic Care Improvement Program, etc.
  - DM in Medicaid: CMS/Medicaid DM efforts are also rapidly expanding



6

# Program Goals & Objectives

XLHealth
Inform. Empower. Excel.

- **Where is this initiative leading?**
  - It leads toward a stronger focus on improving health outcomes for prospectively identified target populations who are not well served by the fragmented FFS health care delivery system.
  - It creates a new focus on setting measurable performance goals and tracking improvements in clinical quality, cost-effectiveness, and provider and beneficiary satisfaction in a regional, population-based framework.
  - It develops and tests the concept of tying contractor payment to results in achieving quality and cost targets and satisfaction levels.
  - It helps modernize Medicare by creating incentives for the private sector to harness advances in information technology and innovation in care management on behalf of FFS Medicare beneficiaries.
  - It addresses quality failings without changing beneficiary's benefits, providers, or access to care.
  - It is an approach that is regional, yet potentially replicable nationally.

# Disease Management Overview

- Makes the most sense for Medicare population
  - Disease prevalence
  - Link between chronically ill and percentage of expenditures
  - Predictability of expenditures
  - Medicare is long term payer
  - FFS side of Medicare needs to be better managed

# XLHealth Goals & Objectives

- Identify target population
- Generate physician/market awareness and support
- Obtain patient consents
- Create “registry”
- Collect and store data, and create initial Tiers
- Patient outreach, including face-to-face assessments, to improve data/tiers
- Generate patient specific Action Plan and Communications Track, incorporating the patient, physician and caregivers
- Obtain/Maintain physician buy-in by genuinely improving their ability to take care of their most difficult patients, including by improving the economics of taking care of those patients
- Obtain/Maintain patient and caregiver buy-in as a result of more coordinated and higher quality care



9

# XLHealth BIPA DM Demonstration

- BIPA “designed to demonstrate the impact on costs and health outcomes of applying disease management services, supplemented with coverage for prescription drugs, to specific Medicare beneficiaries with diagnosed advanced-stage congestive heart failure, diabetes, or coronary disease.” (www.cms.gov/researchers/demos/BIPADM.asp)
- 3 Sites awarded
- Patient Profile: HCC Score > 3.0
  - 2+ Hospital Admissions per Year
  - Beneficiaries with CHF and/or diabetes (32% of all FFS beneficiaries) account for 75% of Medicare expenditures
  - 38% Diabetes only, 28% Diabetes + CHF, 34% CHF Only (Bucket 1, 2, 3)
  - Discuss screening tool (see next page)
- Q3 2004, XLHealth reached full enrollment of 14,000 Medicare FFS beneficiaries with heart failure and complex diabetes
- 6 Major Metro areas in Texas, covering 46 counties (of appx 250), and 85% of population
- 30% medically homeless
- Approximately 20% of Medicare beneficiaries with 5 or more chronic conditions see an average of 13 physicians and spend 60% of Medicare dollars

# BIPA Screening Tool

- INCLUSION CRITERIA:
- Principle Inpatient Diagnosis of CHF in past 12 months ICD9 Dx: 428, 428.0, 428.1, 428.9, 398.91, 402.01, 402.11, 402.91, 404.01, 404.11, 404.91, 425, 425.0, 425.1, 425.2, 425.3, 425.4, 425.5, 425.7, 425.8, 425.9)
- OR
- At-least two carrier provider claims for Diabetes in past 12 months (ICD-9 Dx: 250.xx)
- AND
  - CAD/HTN admit (ICD-9 Dx: 401,411-414;DRG: 132, 133, 134, 140, 143)
- OR
  - CVD (ICD9 Dx: 430-438)
- AND Any two of the following conditions in the last 12 months:
  - Peripheral vascular disease (ICD9 Dx: 440.2, 440.3, 443.9);
- OR
  - Foot ulcer/wound (ICD9 Dx: 707.x, 892.x, 893.x, E920.8,440.2x, 440.3x, 443.9, 443.8, 443.89, 250.7;
- OR
  - Amputation (ICD9 Dx: 895.x, 896.x, 897.x, 785.4 or CPT: 28800, 28805, 28810, 28820, 28825, 27880, 27881, 27882, 27884, 27886, 27888, 27590, 27591, 27592, 27594, 27596, 27598);
- OR
  - Neuropathy (ICD9 Dx: 357.2, 356.9, 250.6);
- OR
  - Charcot Arthropathy (ICD9 Dx: 711, 713.5, 94);
- OR
  - Wound Debridement(CPT: 10060, 10061, 10120, 10121, 11040, 11041, 11042, 11043, 11044, 20000, 20005, 20103, 20245, 28001, 28002, 28003, 28005, 28008, 28020, 28022, 28024, 28120, 28122, 28124, 28140, 28153, 28190, 28192, 28193);
- OR
  - Revascularization (CPT: 35372, 35381, 35456, 25459, 35470, 35474, 25483, 25485, 35493, 35495, 35551, 35556, 35566, 35571, 35582, 35583, 35585, 35587, 35623, 35651, 35656, 35666, 35671, 35700, 35721, 35741, 35761, 35860, 35870, 35875, 35876, 35903, 36005, 36246, 36247, 36248)

Note: Discuss “refresh claims window” issue.

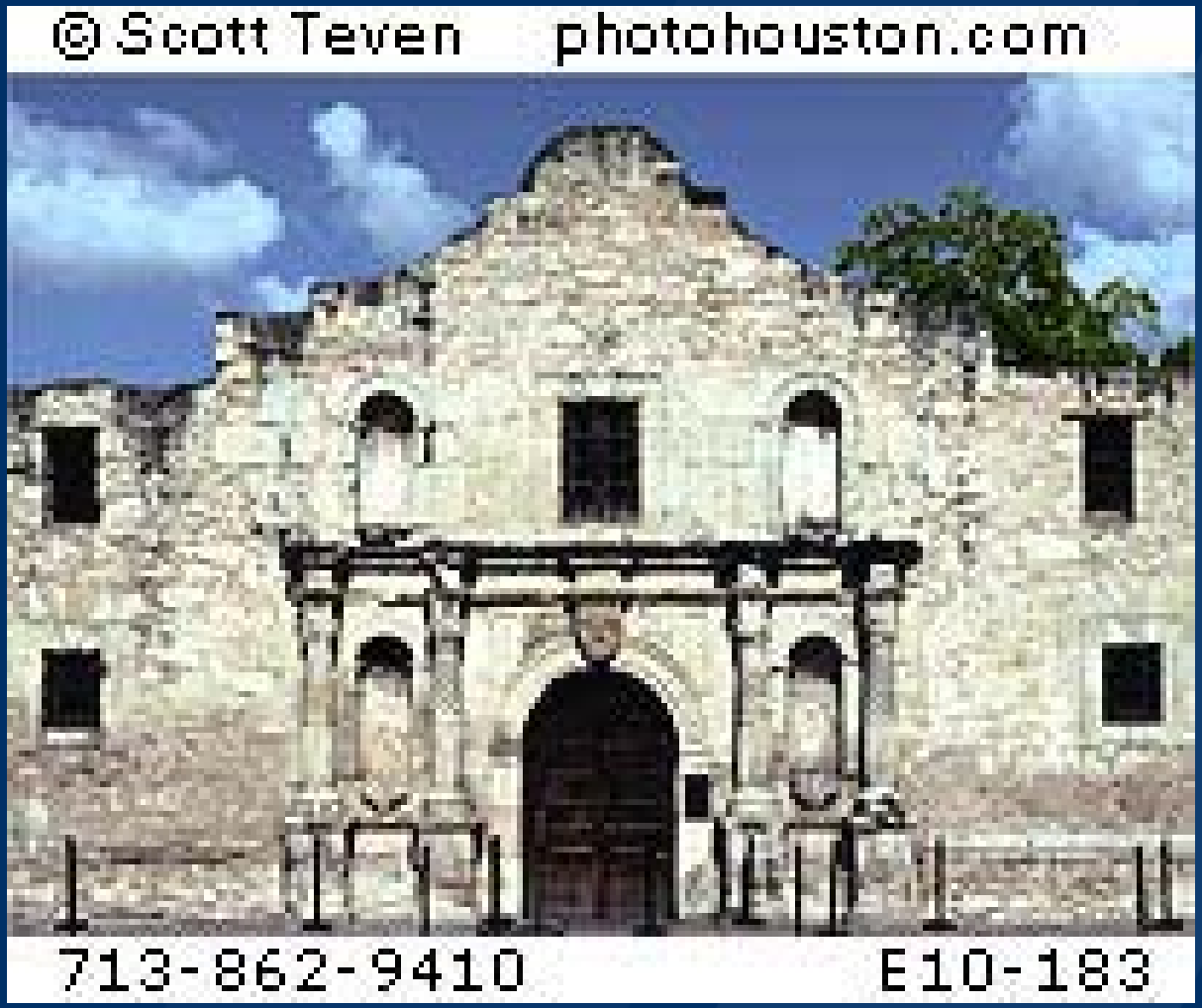
# Patient Engagement:
# A "Public Health" Approach

- TMA Endorsement in Texas
- TMF Endorsement in Texas
- 4 of 7 State Medical Association's Endorsed XLH's CCIP Applications
- 2 of 7 Associations were CCIP co-applicants
- Health Department / Medicaid
- Department Of Aging / Area Offices On Aging
- Etc., Etc., Etc.

# XLHealth BIPA DM Demonstration

- CMS provided target population of 49,939 at outset
  - Plus HHSC, physician identified (low HCCs), plus refresh
- 125,428 enrollment calls made
- 526,148 pieces of mail sent
- 19,569 recruited and consent form signed
  - 3700 not randomized (pre-HCC or doctor obtained)
- 10,161 net patients
- 7,121 actively managed (i.e., had Welcome Call)
- 6,074 (85%) had F-to-F Assessments (including BP)
- 2,107 physicians returned 8,187 quarterly reports with lab data (HbA1c, LDL): Next time, just do labs at F-to-F?

# XLHealth BIPA DM Demonstration



# XLHealth BIPA DM Demonstration

# XLHealth BIPA DM Demonstration

# XLHealth BIPA DM Demonstration

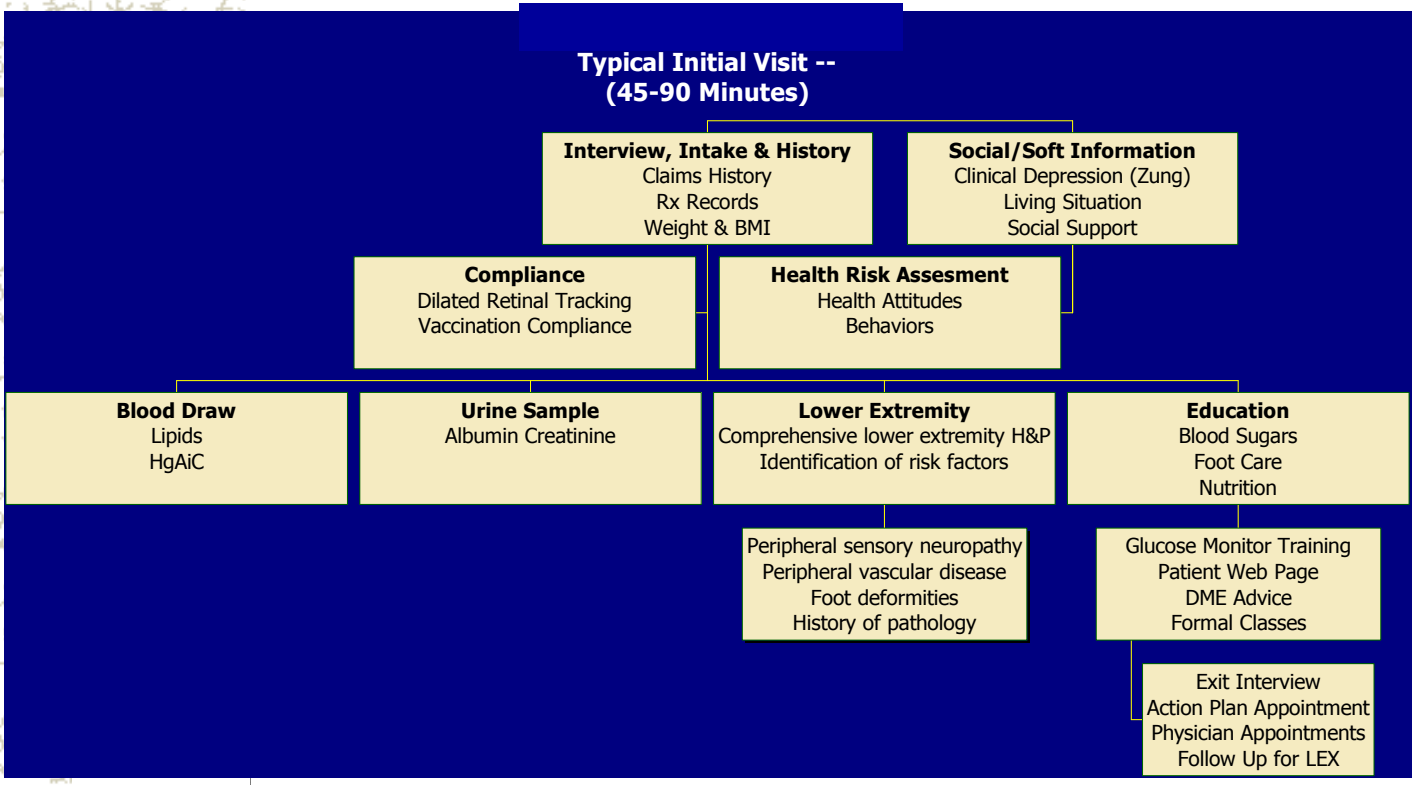
- 62% have secondary drug coverage
- Approximately 20% are dual eligible
- Patient distribution
  - Austin 721 (7.2%)
  - Corpus Christi 780 (7.8%)
  - Dallas / Fort Worth 2,899 (29.0%)
  - EL Paso 834 (8.3%)
  - Houston 3,310 (33.1%)
  - San Antonio 1,456 (14.6%)
- Houston to El Paso = 730 miles (East to West)
- Corpus Christi to Dallas = 377 miles (South to North)
- Austin to San Antonio = 79 miles (in the middle)
  - Combined area is about the size of Houston or Dallas/Fort Worth
- Texas is the only U.S. state that was once an independent nation. After declaring independence from Mexico on March 2nd, 1836, the Republic of Texas was in existence through 1845.
  - Even though the battle of the Alamo was lost on March 6th 1836

# XLH Disease Management Model

- Collect & Analyze Administrative Data (Claims, Rx Records, Lab Encounters)
- Collect Lab Values -- Electronic if Available, or from Doctors
- Patient Outreach & Assessment
  - Calls, Letters (all)
  - Face to Face Visits
  - Collect 500+ Clinical & Social Data Points
- Central Relational Database
  - Data & "Plans" accessible to Doctors at Point-of Care
  - Integrated with Pharmacy Partners, PBM, etc
- Create Custom Intervention Plan & Allocate Resources
  - Intensity: F2F, Call, Letter & length allocated
  - Frequency: Daily (home monitoring, calls), weekly, etc.
  - Participant:  Nurse, CRM, Pharmacist, etc.
  - Content: Clinical Goal of Intervention (missing Rx, foot exam, etc.)
- Reports to Doctor and Patient

# Assessment Process

## The Assessment Process



# Learning from Face-to-Face Assessments

- Significant lost opportunity, even in well-managed groups
  - 60% of all assessed patients high risk
  - 87% of these NOT ‘visible’ in claims data
  - 50% visible after comprehensive phone contacts
    - 50% still NOT visible (discuss visit to San Antonio)
  - Medication inventories require face to face
- Older patients learn & accept F2F
- Older patients respond to multiple party contacts
- Broad physician acceptance
- Need enhanced medication interventions

# List Of Indicators

- Operations
  - Enrolled patients
  - Participating patients (Welcome Calls, Initial Assessments, Goals Reports, Coaching Calls)
  - Barrier patients
  - FTEs per participating patient
- Lab data
  - % patients with Lab data
  - HbA1c (<8, 8-10, >10), SBP (<140, 140–160, >160), DBP (<80, 80–90, >90), LDL (<100, 100–130, >130)
- Monitoring
  - % Of CHF patients on scales
  - Alerts per patient & % of acted upon alerts
- Medication Management
  - CHF: % Of patients on ACE/ARB, Betablocker
  - Diabetic: % of patients on Statin, ACE/ARB
- Lower Extremity Management
  - Number of podiatry referrals, diabetic shoes, temperature probes
- Number of “case management” patients
- Hospitalizations (CHF, LEX, CAD, Total)

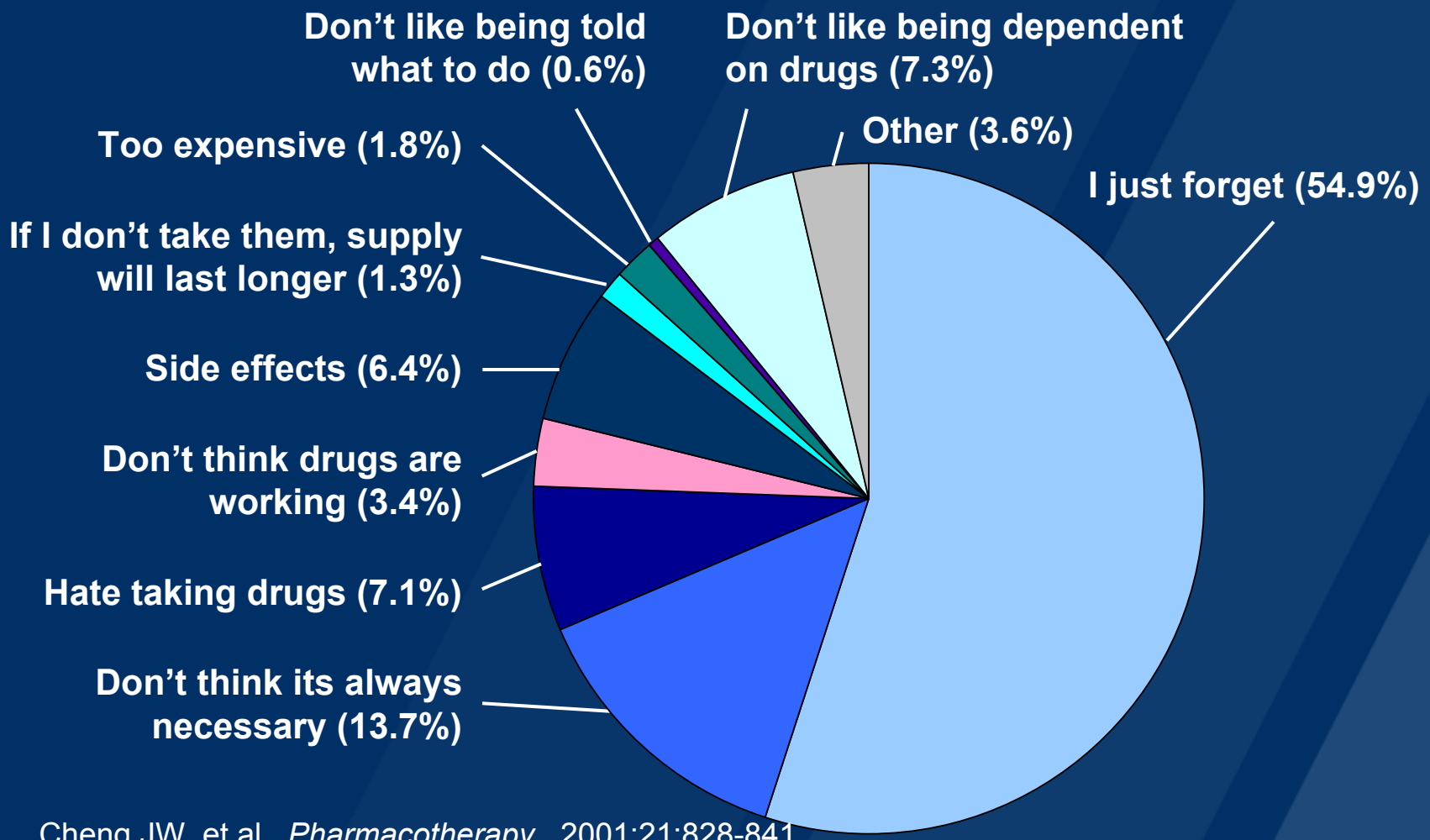
# Lost Promise of Medication Management

- 50% of patients do not follow regimens
- Noncompliance accounts for 10% of hospital admissions and >30% in chronically ill
- 20% of prescriptions are never filled
- 30% are never re-filled
- Medication misuse — estimated costs $177 billion a year
- Improper drug therapy — estimated 9.6 million hospitalizations per year

*American Pharmacists Association, www.aphanet.org*

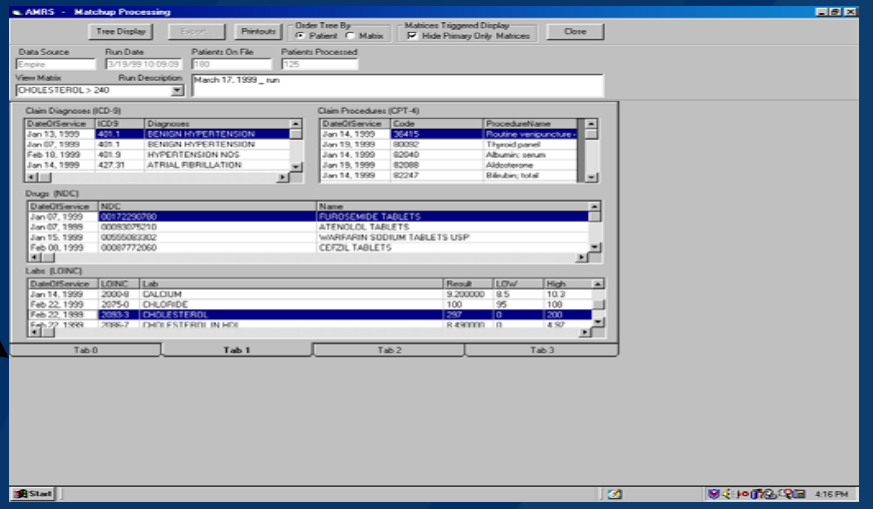
*Smith, DL, Medical Interface April 1993*

# Patient-Reported Reasons for Non-Compliance




Cheng JW, et al. *Pharmacotherapy*. 2001;21:828-841.

# Clinical Data Analyzed, Used To Create Useful Tools & Then Shared With Physicians




***Patient Summary Reports***

- **Risk Assessments**
- **Co-Morbidity Analysis**
- **Suggestions & Recommendations**
- **Best Practices Summary**
- **Follow-Up Recommendations**
- **Telemonitoring & Exception Contact**

# Sample Physician Report

XLHEALTH Physican Panel Detail Report (Physician Name: SMITH, ROBERT)



## Physician Panel Detail Report

XLHealth
Inform. Empower. Excel.

**Report Date : 03/28/2003**

| | |
|---|---|
| **Physician Name:** | **SMITH, ROBERT** |
| **Address:** | **123 MEDICAL AVENUE SPRINGFIELD TX-78123** |
| **Telephone:** | **(210) 555-1234** |
| **Client:** | **ANYCLIENT** |

| C A D Risk Factors | | | |
|---|---|---|---|
| A | Smoking | E | Family History |
| B | High LDL | F | Male >= 45 |
| C | HTN | G | Female >=55 |
| D | Low HDL | | |
| None Indicates no risk factors | | | |

| Lower Extremity Condition | | | |
|---|---|---|---|
| A | Ulcer | E | Edema |
| B | Infection/Cellulitis | F | PVD Symptoms |
| C | Gangrene | G | Neuropathy Symptoms |
| D | Charcot | | |
| None Indicates no LEX Conditions | | | |

### Patients Assessed

| Patient Name | Date Assessed<br>Initial(I), Recheck(R), Annual(A), Lab(L) Telephonic(T), Inpatient(IP) | HgA1C | Glucose Monitor | Blood Pressure (135/85) | Pt Reports Hx/Tx HTN | Proteinuria (Alb / Creat <30) | Patient Reports ACE / ARB | CAD Risk Factors | HDL / Total Cholesterol Non-Fasting Unless Indicated (**) (>40/<200) | Pt Reports Aspirin Therapy (Contra - C) | Eye Exam in Past 12 Months | Zung Score <50 | Lower Extremity Condition |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **DOE, JOHN** | **Summary** | See Trend | Yes | See Trend | **Yes** | 19.0 | Yes | A,C,D,E,G | **39/279** | **No** | **No** | **61** | G |
| | 7/20/2003(R) | **10.6** | Yes | **156**/70 | Yes | 19.0 | Yes | C,D,G | 39/279 | No | No | 61 | G |
| | 1/02/2003(I) | **5.8** | Yes | **168**/70 | Yes | 25.0 | Yes | C,E,F | 47/165** | Yes | No | - | F,G |
| **DOE, JANE** | **Summary** | See Trend | Yes | See Trend | **Yes** | **39.5** | **No** | B,G | 43/**224** | **No** | Yes | **59** | G |
| | 2/20/2003(I) | 6.9 | Yes | 132/80 | No | 296.0 | No | B,G | 43/224 | No | Yes | 59 | G |
| | 3/27/2002(L) | 6.5 | - | - | - | - | - | - | - | - | - | - | - |
| | 12/7/2001(L) | 6.7 | - | - | - | - | - | - | - | - | - | - | - |
| **SMITH, JOHN** | **Summary** | See Trend | Yes | See Trend | No | **79.0** | **No** | B,G | 42/**208**** | **No** | Yes | 36 | G |
| | 8/27/2002(I) | 6.7 | Yes | 130/82 | No | 79.0 | No | B,G | 42/208** | No | Yes | 36 | G |
| | 3/19/2002(L) | **7.5** | - | - | - | - | - | - | 42/- | - | - | - | - |
| **SMITH, JANE** | **Summary** | See Trend | Yes | See Trend | **Yes** | 18.0 | Yes | A,B,C,D,F | **38**/181** | Yes | Yes | - | G |
| | 5/21/2002(I) | 7.0 | Yes | **140**/70 | Yes | 18.0 | Yes | A,B,C,D,F | 38/181** | Yes | Yes | - | G |

# Patient Case Study: Data Mining IDs Member #678910

- 66 Year old Female
- No HbA1c Results available
- Data Suggests *Probable* Treatment for CHF Within Past Year
- Member Receives Initial Risk Stratification as “T3 - At Risk”
- Becomes a Priority F2F Candidate & Actively Recruited to Spend Time at Assessment
- Visits with Assessment Nurse

# Meet Member #678910: Elizabeth

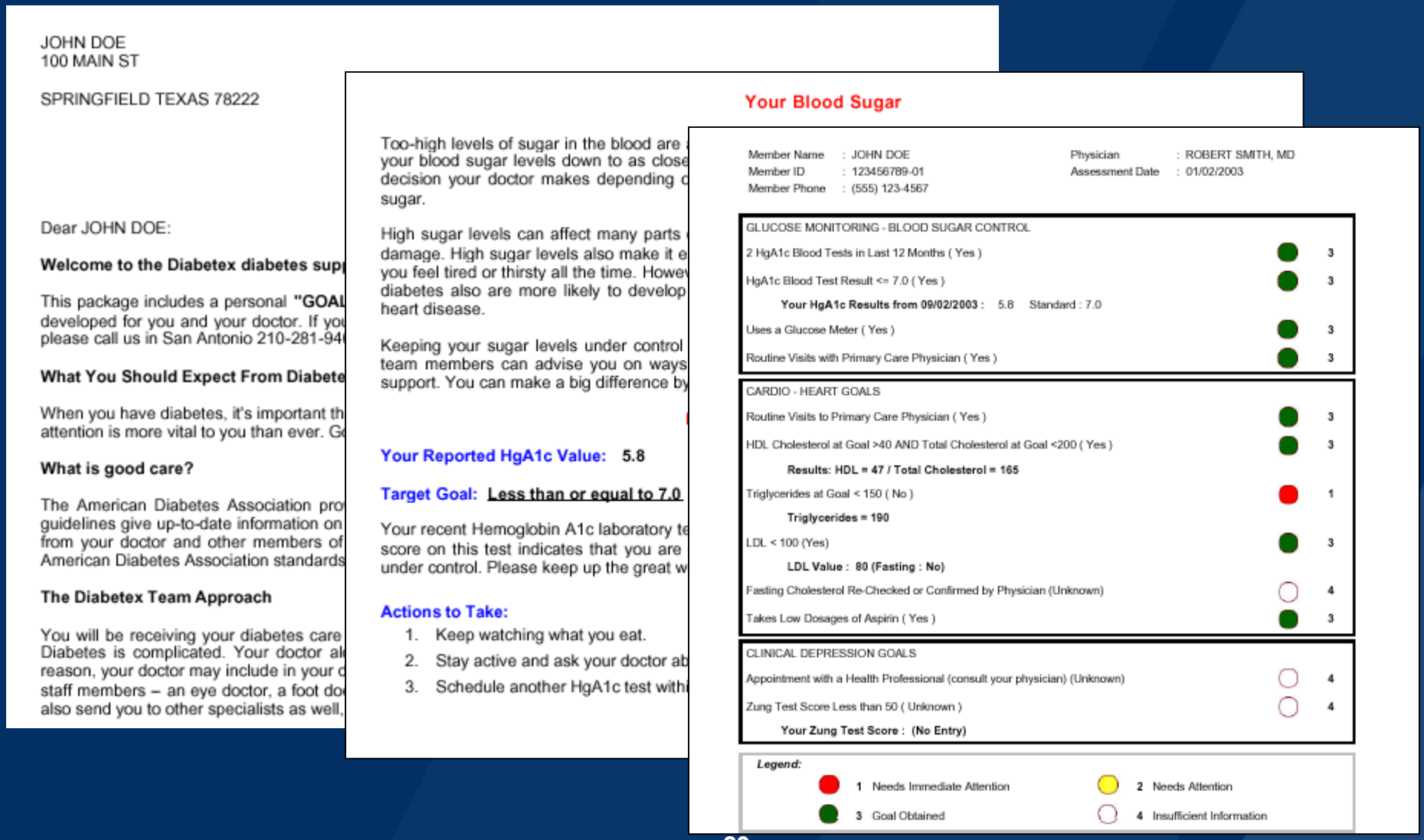
*At Screening XL Health Finds:*

- ✓ History of CHF
- ✓ Doesn't Drive – Lives Downtown with Grandchildren
- ✓ HbA1c of 8.6
- ✓ History of Hypertension
- ✓ BP 130/80
- ✓ Foot Ulcers & Severe Neuropathy in Both Feet

# Redefine Elizabeth as T1 HIGH RISK

- XLH – Care Managers contact her PCP & make an Immediate Appointment With Network Podiatrist for Wound Healing, Pedorthic Assessment & Prevention of Amputation
- XLH - Care Manager Identifies Elizabeth as a Level III CHF Patient
- Telemonitoring Equipment Installed in her home for Daily Monitoring of her CHF/Diabetes and Exception Reporting to her Physician
- XLH – Nurse Makes 2-3 Home Visits For Further Foot Assessment & Education
- Elizabeth Receives 4-6 Calls From XLH – Coach to Check on Her Progress and Goals Achievement
- XLH - Care Managers encourage Elizabeth to See Her Physician to Discuss Ways to Better Control Her Blood Sugars
- In Three Months XLH - Care Managers Remind Elizabeth to Have Her HbA1c Checked

# Sample Patient Reports



JOHN DOE
100 MAIN ST

SPRINGFIELD TEXAS 78222

Dear JOHN DOE:

**Welcome to the Diabetex diabetes sup**

This package includes a personal **"GOAL**
developed for you and your doctor. If yo
please call us in San Antonio 210-281-94

**What You Should Expect From Diabete**

When you have diabetes, it's important th
attention is more vital to you than ever. G

**What is good care?**

The American Diabetes Association pro
guidelines give up-to-date information on
from your doctor and other members of
American Diabetes Association standards

**The Diabetex Team Approach**

You will be receiving your diabetes care
Diabetes is complicated. Your doctor al
reason, your doctor may include in your c
staff members – an eye doctor, a foot do
also send you to other specialists as well,

**Your Blood Sugar**

Too-high levels of sugar in the blood are
your blood sugar levels down to as close
decision your doctor makes depending c
sugar.

High sugar levels can affect many parts
damage. High sugar levels also make it e
you feel tired or thirsty all the time. Howe
diabetes also are more likely to develop
heart disease.

Keeping your sugar levels under control
team members can advise you on ways
support. You can make a big difference by

**Your Reported HgA1c Value:** 5.8

**Target Goal:** **Less than or equal to 7.0**

Your recent Hemoglobin A1c laboratory te
score on this test indicates that you are
under control. Please keep up the great w

**Actions to Take:**

1. Keep watching what you eat.
2. Stay active and ask your doctor ab
3. Schedule another HgA1c test with

| | | | |
|---|---|---|---|
| Member Name | : JOHN DOE | Physician | : ROBERT SMITH, MD |
| Member ID | : 123456789-01 | Assessment Date | : 01/02/2003 |
| Member Phone | : (555) 123-4567 | | |

| GLUCOSE MONITORING - BLOOD SUGAR CONTROL | |
|---|---|
| 2 HgA1c Blood Tests in Last 12 Months ( Yes ) | 3 |
| HgA1c Blood Test Result <= 7.0 ( Yes ) | 3 |
| **Your HgA1c Results from 09/02/2003 :** 5.8 Standard : 7.0 | |
| Uses a Glucose Meter ( Yes ) | 3 |
| Routine Visits with Primary Care Physician ( Yes ) | 3 |

| CARDIO - HEART GOALS | |
|---|---|
| Routine Visits to Primary Care Physician ( Yes ) | 3 |
| HDL Cholesterol at Goal >40 AND Total Cholesterol at Goal <200 ( Yes ) | 3 |
| **Results: HDL = 47 / Total Cholesterol = 165** | |
| Triglycerides at Goal < 150 ( No ) | 1 |
| **Triglycerides = 190** | |
| LDL < 100 (Yes) | 3 |
| **LDL Value : 80 (Fasting : No)** | |
| Fasting Cholesterol Re-Checked or Confirmed by Physician (Unknown) | 4 |
| Takes Low Dosages of Aspirin ( Yes ) | 3 |

| CLINICAL DEPRESSION GOALS | |
|---|---|
| Appointment with a Health Professional (consult your physician) (Unknown) | 4 |
| Zung Test Score Less than 50 ( Unknown ) | 4 |
| **Your Zung Test Score : (No Entry)** | |

***Legend:***

1 Needs Immediate Attention
2 Needs Attention
3 Goal Obtained
4 Insufficient Information

# Summary

- Collect & Analyze Administrative Data (Claims, Rx Records, Lab Encounters)
- Collect Lab Values -- Electronic if Available, or from Doctors
- Patient Outreach & Assessment
- Central Relational Database
- Create Custom Intervention Plan & Allocate Resources
- Reports to Doctor and Patient

Tuesday, June 28, 2005

XLHealth

Inform. Empower. Excel.