Innovative Reimbursement Models
Value-Based Insurance Design and the Medical Home –
En Route to an ACO Model

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PCPCC Conference

March 14 , 2011

Integrated Health Partners
Calhoun County Pathways to Health

Community Collaboration to Transform Health Care (with a little help from our friends)

Calhoun County Pathways to Health (CCPTH)
2006–Opportunity Knocks

"Ability has nothing to do with opportunity."
–Napoleon Bonaparte

- Tom Simmer, MD, VPMA, CMO, Blue Cross Blue Shield of Michigan (BCBSM) – Challenge

1. Create a registry
2. Implement the Wagner Model
3. Creation of the framework for the Calhoun County Pathways to Health

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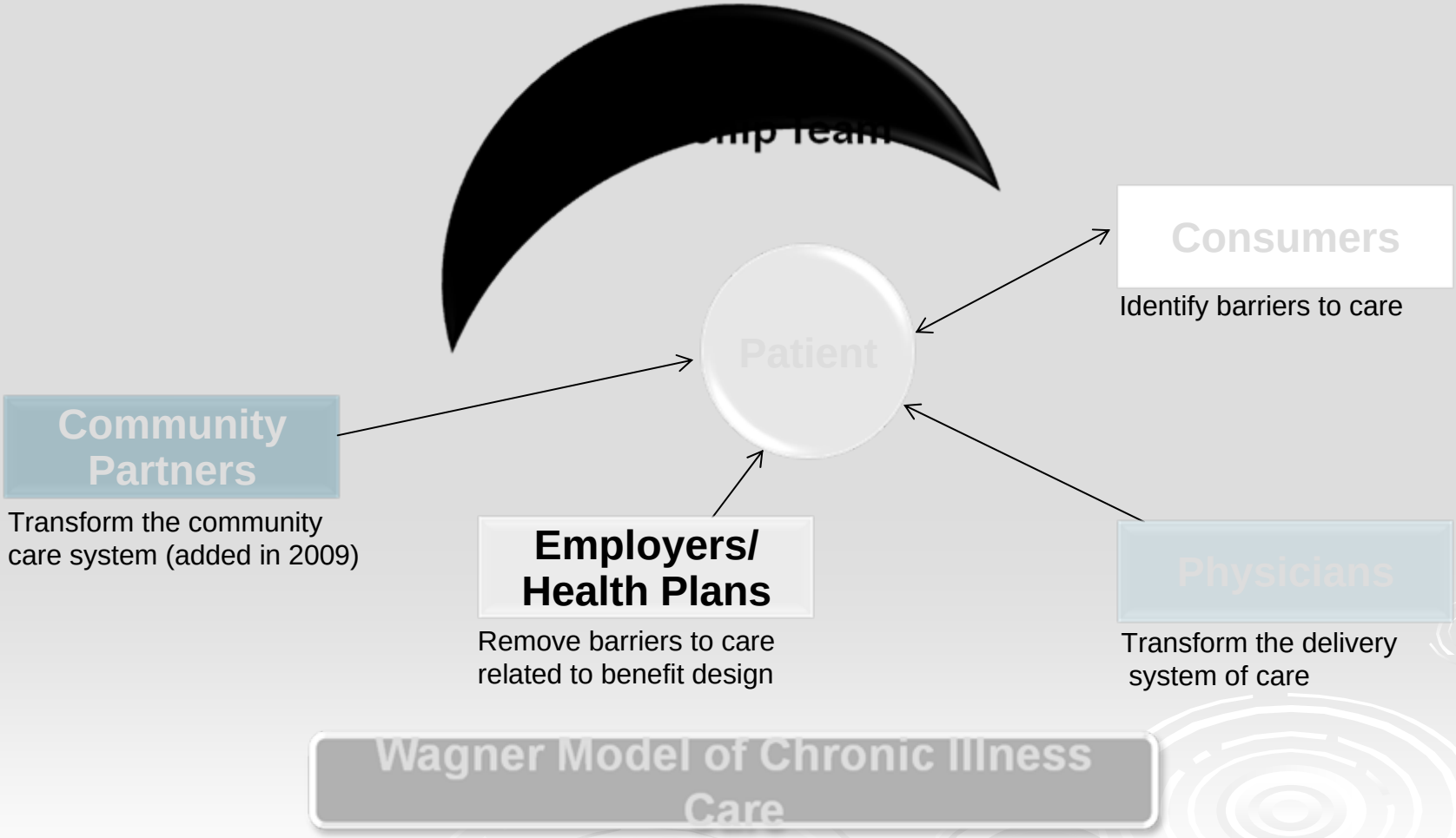
Calhoun County Pathways to Health Framework



Calhoun County Pathways to Health

Mission :

To improve the health of Calhoun County citizens by transforming the health care delivery system and health care experience

Vision:

To act as a change agent by gaining a better understanding of emerging health care needs and developing an integrated health care delivery system through the improved use of information technology

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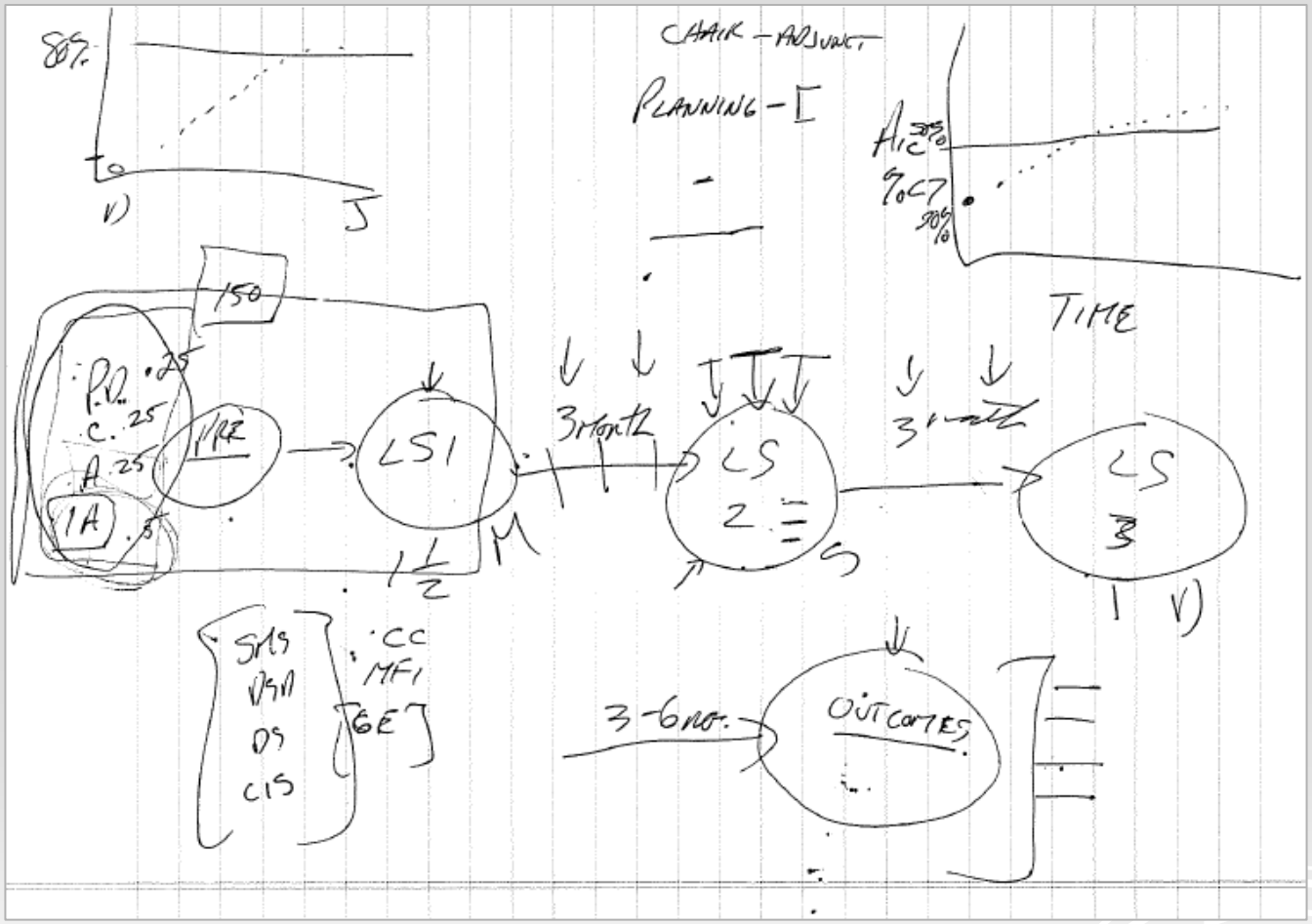
February 2007 – Evolutionary Jump



"I think you should have a collaborative."–Mike Hindmarsh

Learning Collaboratives

- Framework for quality improvement developed by the Institute for Healthcare Improvement (IHI)
- Year long commitment:
  - Quarterly 1-2 day sessions
  - Monthly conference calls
  - Importance to data and measurement
- Traditionally, applied to health care systems – CCPTH applies model across the community of stakeholders

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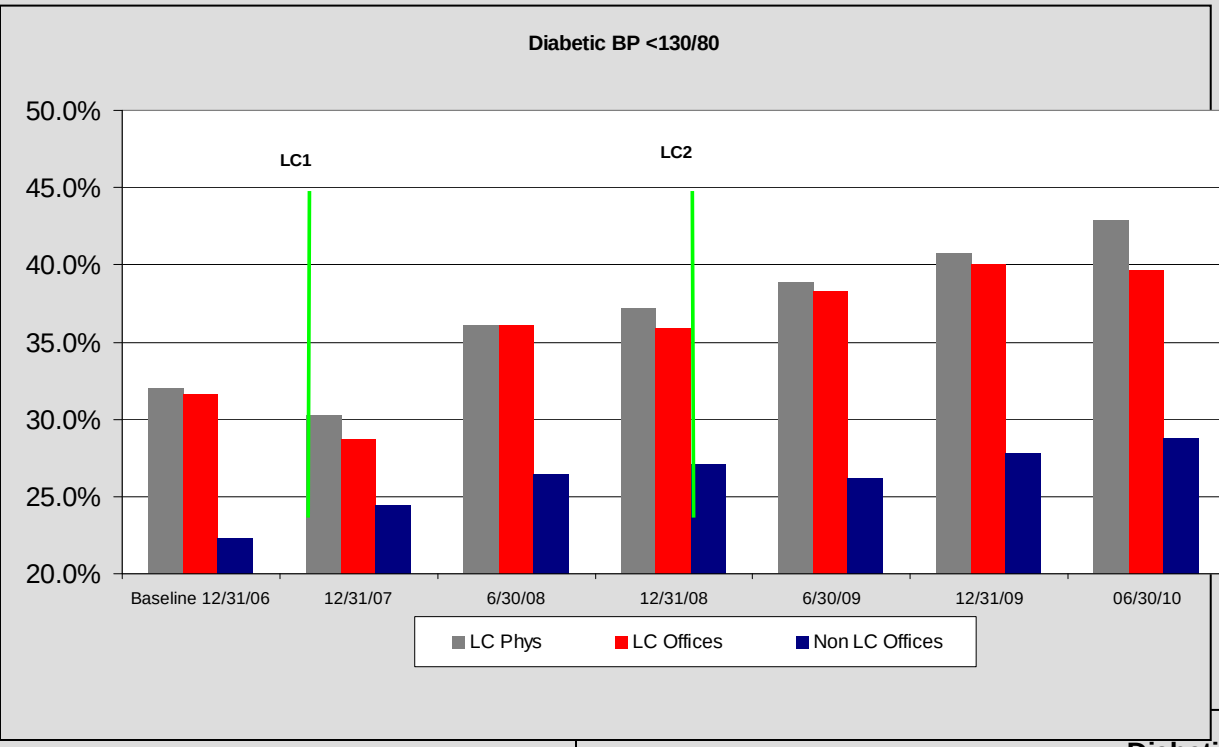
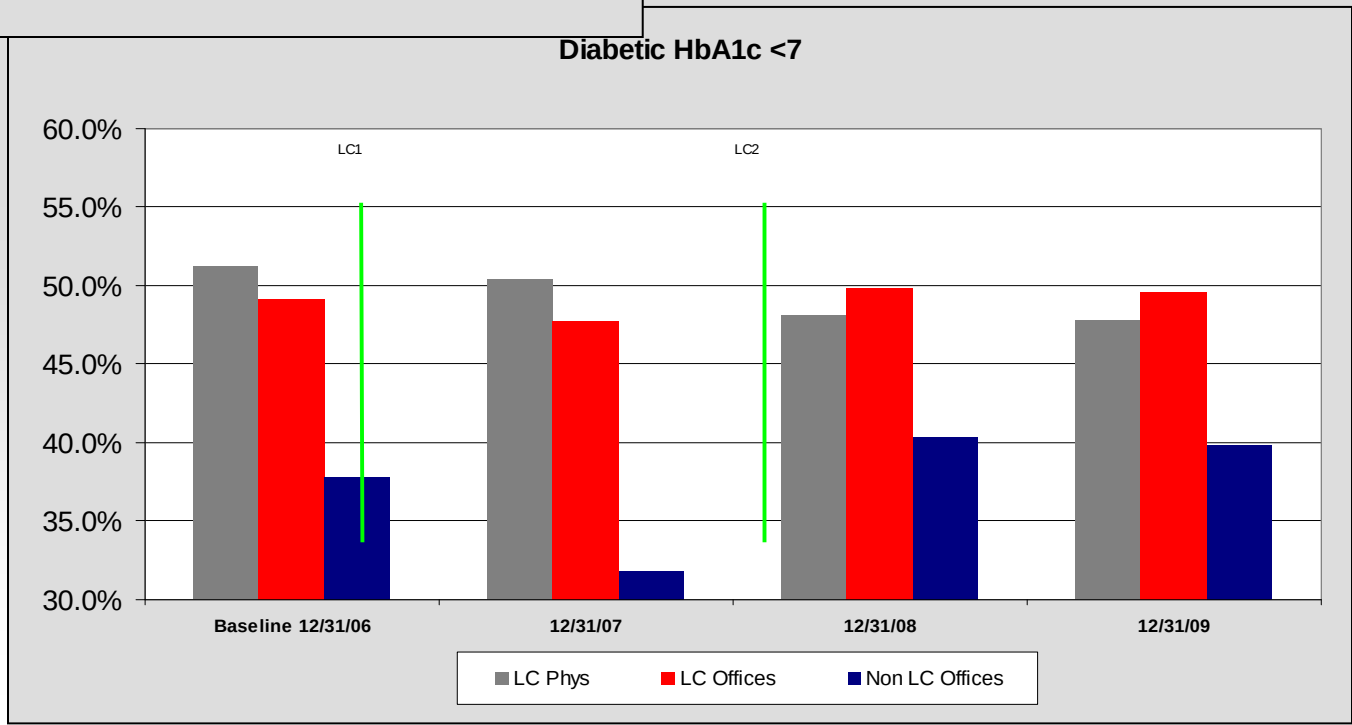
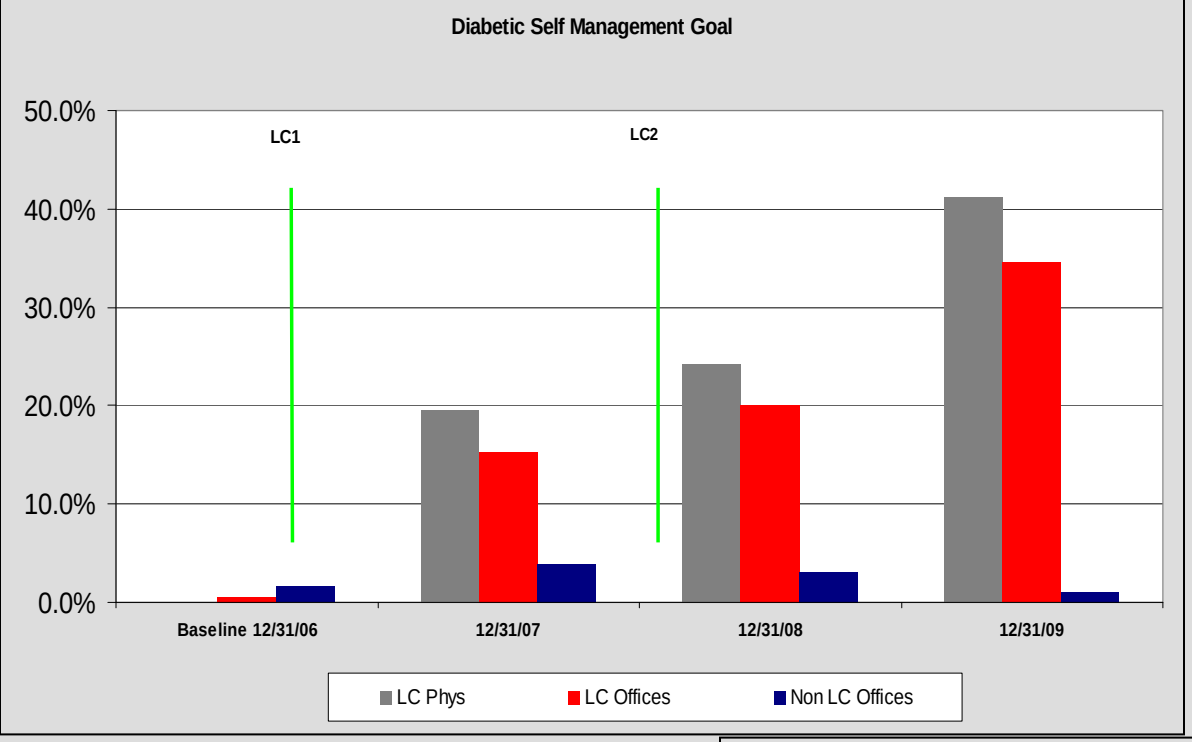
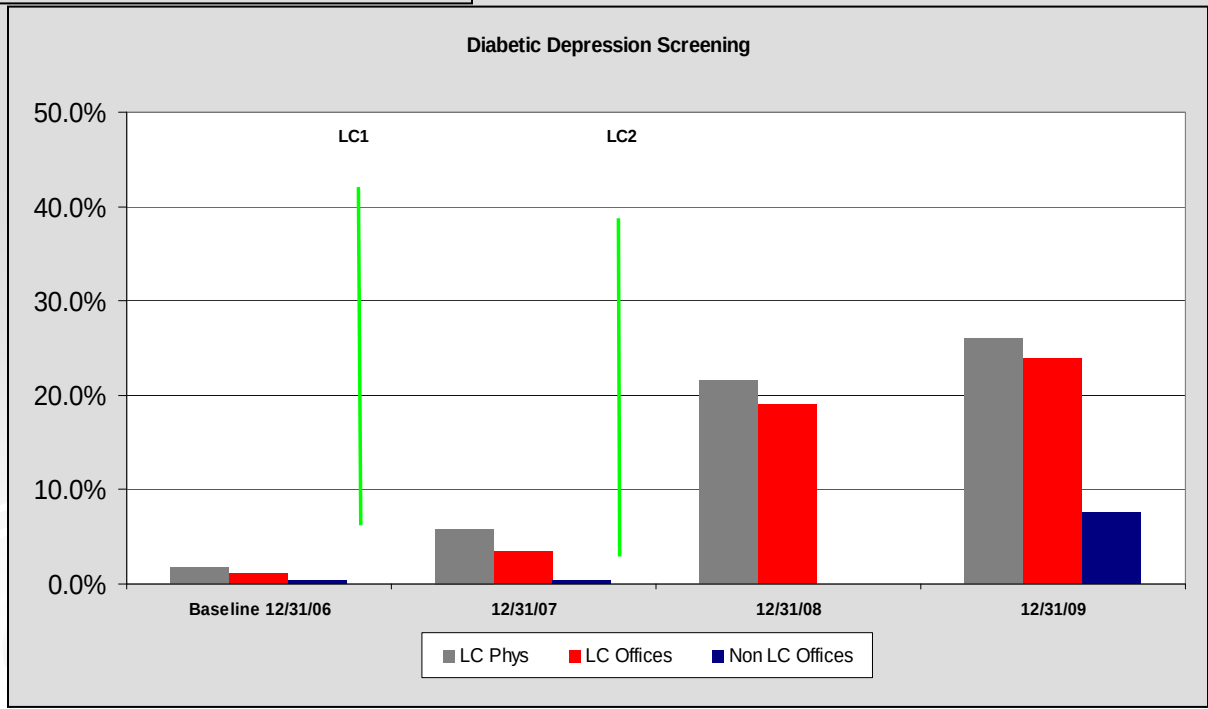
Physician Learning Collaboratives "changing the engine in mid flight "

- Learning Collaboratives as the basis for PCMH development
  - Completed three collaboratives with 60 teams
  - Expanded from diabetes focus alone to multiple chronic diseases, preventive measures, and efficiency measure


Diabetic BP <130/80
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
LC1
LC2
Baseline 12/31/06
12/31/07
6/30/08
12/31/08
6/30/09
12/31/09
06/30/10
LC Phys
LC Offices
Non LC Offices


Diabetic HbA1c <7
60.0%
55.0%
50.0%
45.0%
40.0%
35.0%
30.0%
LC1
LC2
Baseline 12/31/06
12/31/07
12/31/08
12/31/09
LC Phys
LC Offices
Non LC Offices


Diabetic Self Management Goal
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
LC1
LC2
Baseline 12/31/06
12/31/07
12/31/08
12/31/09
LC Phys
LC Offices
Non LC Offices


Diabetic Depression Screening
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
LC1
LC2
Baseline 12/31/06
12/31/07
12/31/08
12/31/09
LC Phys
LC Offices
Non LC Offices

Improvement in Measures for Calhoun County Across Payors

Diabetic Foot Exams			Diabetic LDL-C* <100		
	12/31/06	6/30/10		12/31/06	6/30/10
Commercial (17.1%)	27.1%	44.2%	**Commercial (13.2%)**	30.1%	43.1%
Medicare (19 %)	28.5%	47.5%	**Medicare (15.7%)**	31.1%	46.8%
Medicaid/ Indigent (12.3%)	23.6%	35.9%	**Medicaid/ Indigent (13.4%)**	20.9%	34.3%
Uninsured (11.8%)	21.5%	33.3%	**Uninsured (16.3%)**	9.3%	28.2%

Care Management Collaborative #1 "herding cats"

- Engaged 12 different community partners with the traditional health care system to improve transitions of care
- "abysmal failure' lessons learned
  - Harder than imagined
  - Impacted individual patients but not the system

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Care Management Collaborative #2

- Increased engagement of vulnerable population
- Deeper involvement of physician practices
- Primary Focus
  - Assessing and meeting the needs of the patients
  - Communicating across care settings
  - Medication reconciliation
  - Referral processes
  - Transitions of care

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Care Management Metrics

Monthly data assessment on

- Medication Reconciliation
  - Medication listing 100% correct only
    20% of time (17/80)
- Confidence in Caring for themselves
  - 12% of patients lacked confidence related to managing their disease (6/51)
- Communication across the settings
  - Over 90% of patients (22/24) believe their providers communicated regularly
  - Redesigned the study tool for more chart review

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Employer Strategies

- Value Based Benefit Design
- Employer Collaborative – to address employee health and cost 2009- current
- Pilot for Provider Delivered Care Management (PDCM) with BCBSM 2010

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Employer Strategies

- Value Based Benefit Design
  - To remove barriers to care
  - Began creating the learning environment 2008-2009
  - Implementation with 3 employers 2009-2010
- Core Elements
  - Common diagnosis Diabetes
  - Employee engagement need to access health coach to get enhanced benefit
- Evaluation
  - RWJF grant Analyzing the impact of patient-centered medical homes, value-based insurance design and those initiatives together on clinical outcomes and cost

Diabetes	Rate	BCBSM Book of Business
HbA1C	84.9%	73.1%
Micoalbumin	50%	34.8%
Dilated Retinal Exam	41.9%	29.6%
Lipids testing	84%	70.4%
ACE/ARB	60%	69.5%
Lipid Lowering Agents	55.8%	61%

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Coronary Artery Disease (CAD)	Rate	BCBSM Book of Business Rate
Lipid Testing	56.4 %	72.3%
Lipid Lowering Agent	56.4 %	68%
Beta Blocker	51.3%	56.3%
ACE/ARB if appropriate	44%	63.7%
Beta Blocker after MI	60%	82.8%

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	Rate	BCBSM Book of Business Rate
Heart Failure (CHF)		
ACE/ARB	72.7%	64.5%
Lipid Testing	90.9%	62.2%
Asthma		
Asthma Controller Medication	84.4%	50.5%

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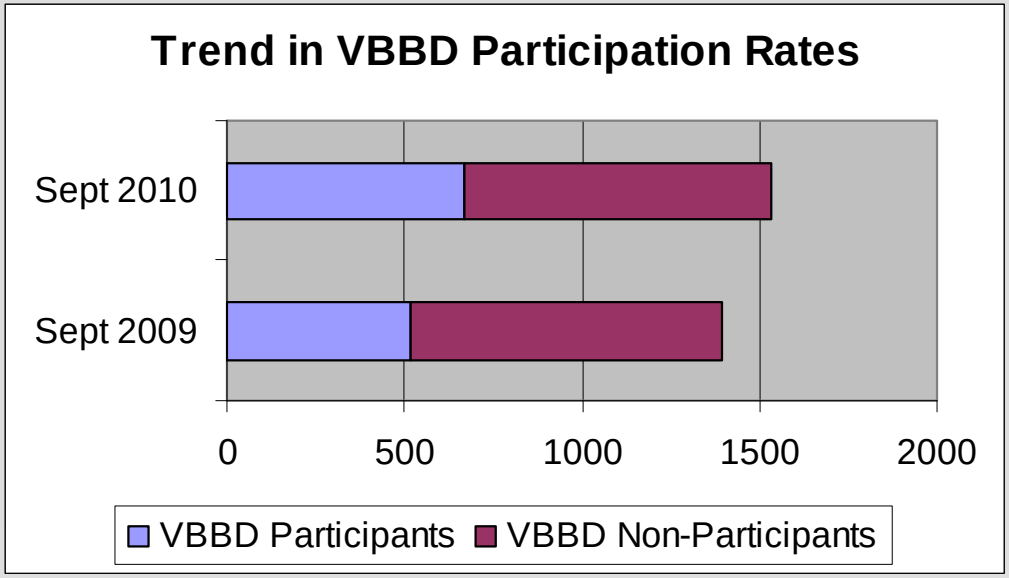
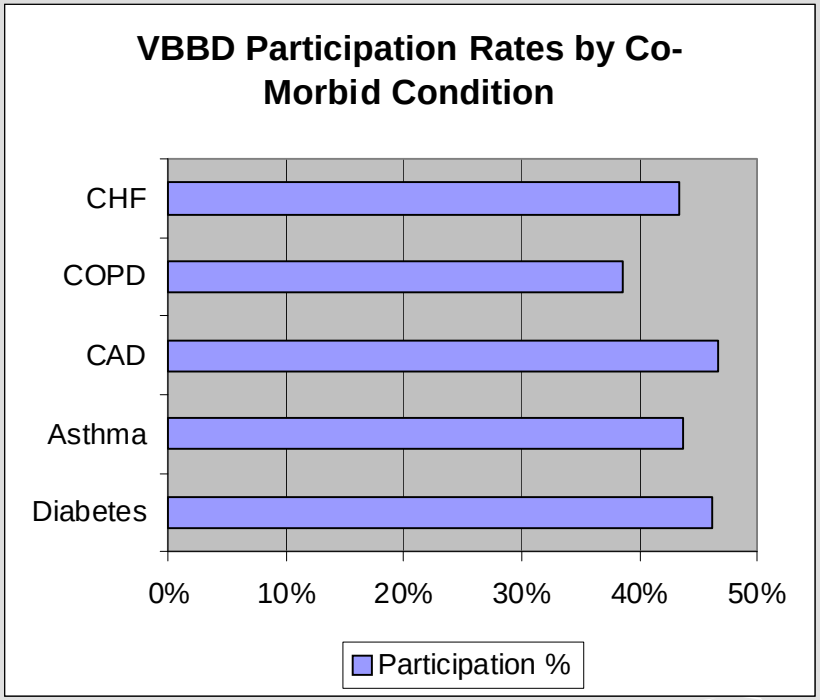
How has VBBD Participation grown in 2010 (Jan-Sep)?





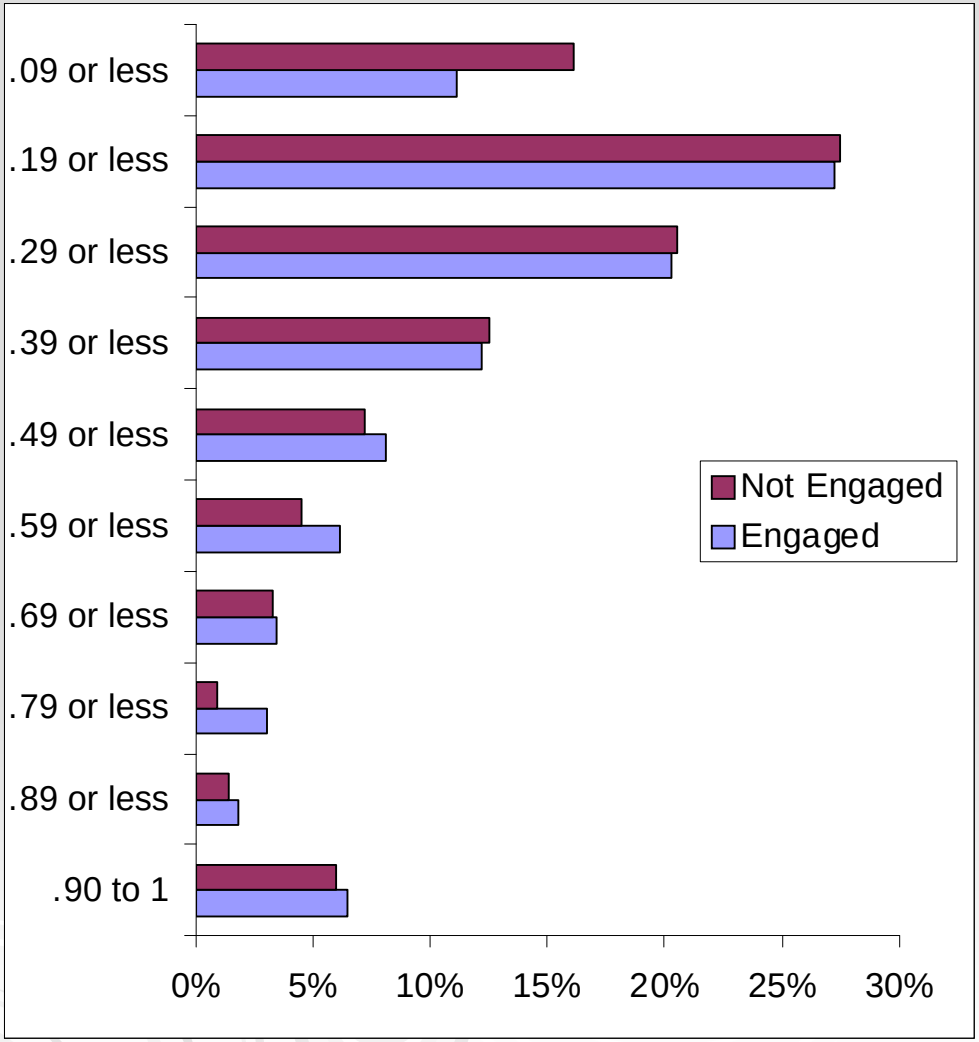
- 134 new members have been identified since 2009.
- VBBD participation has grown from 35% to almost 44%,

even as the number of diabetics identified has increased by 134.

- Compliance is higher among diabetics with more higher risk co-morbidities –

46% of diabetics with CHF, COPD and CAD.

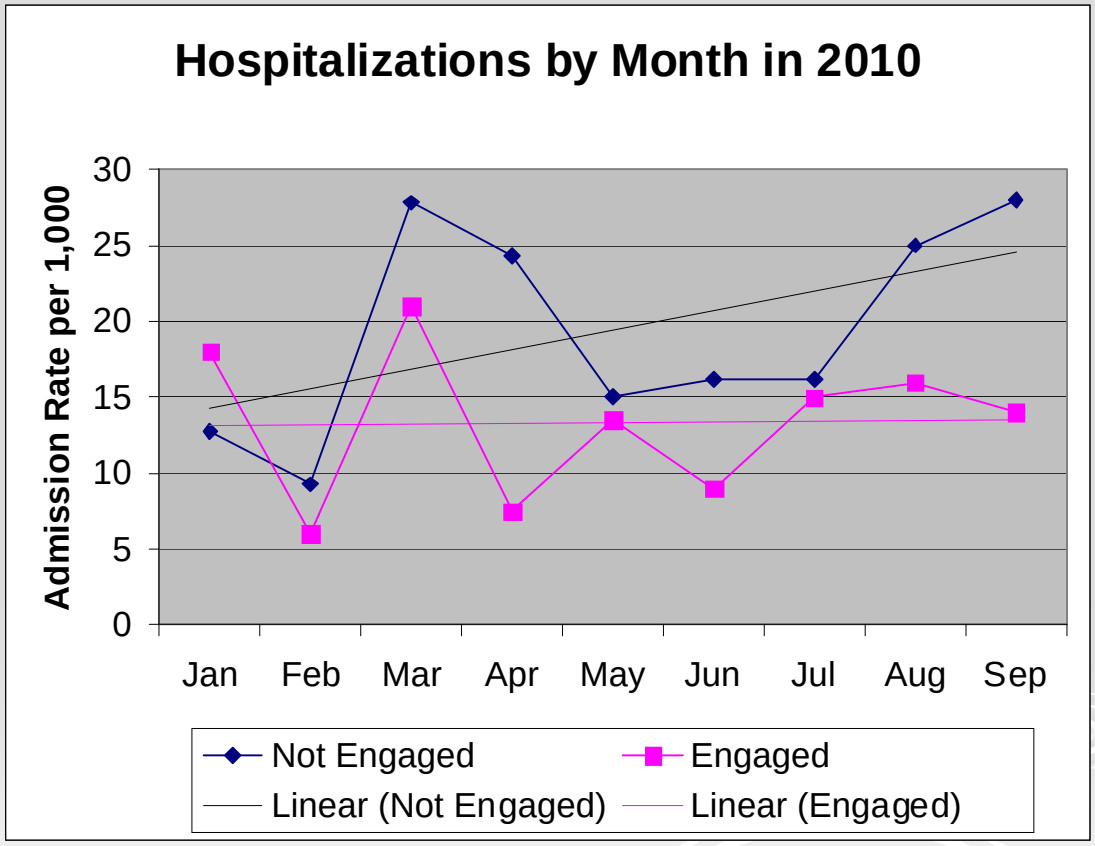
- VBID compliant members are likely to have higher risk scores. What does this mean?
  - The program is reaching those with the greatest need - a higher % of compliant members have high risk-scores
  - High risk members perceive the need to engage with nurse coaches to better manage their disease
  - High risk members will tend to be better managed with coaching and reduced barriers to medication, supplies, and necessary testing
  - Need to focus on compliance for lower risk members to avoid complications as disease progression occurs



This [illegible] non-Medicare members only since risk-score is based on claims, and BCBSM has only supplemental claims for Medicare members.

Does VBBD have a positive effect on Hospital Admissions?

- Initial higher admission rate for engaged members is associated with their higher risk scores and comorbidities
- After engagement, diabetics may better manage their condition, and improve compliance with their medication, avoiding complications

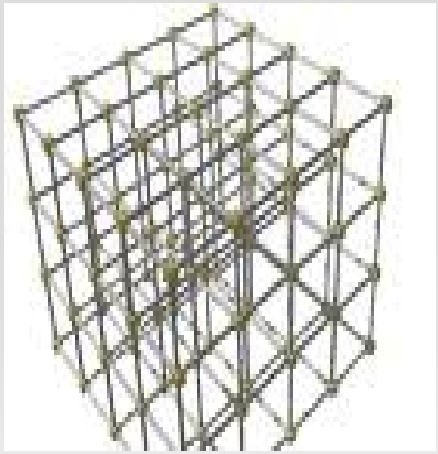


BCBSM – please note that formal evaluation is needed to validate observations in this report ,in order to control for bias and non-comparable populations

Note: Formal evaluation is needed to validate observations in this report, in order to control for bias and non-comparable populations

Employer Strategies

- Employer Collaborative – to address employee health and cost 2009- current
- Evidence based framework with metrics
  - Utilizes the framework of Dr. Edington's work "Zero Trends"



- Senior Leadership
- Operations Leadership
- Self Leadership
  The Calhoun County Challenge
- Rewards for Positive Actions
  VBBD
- Quality Assurance
  Developing metrics to continually reassess progress

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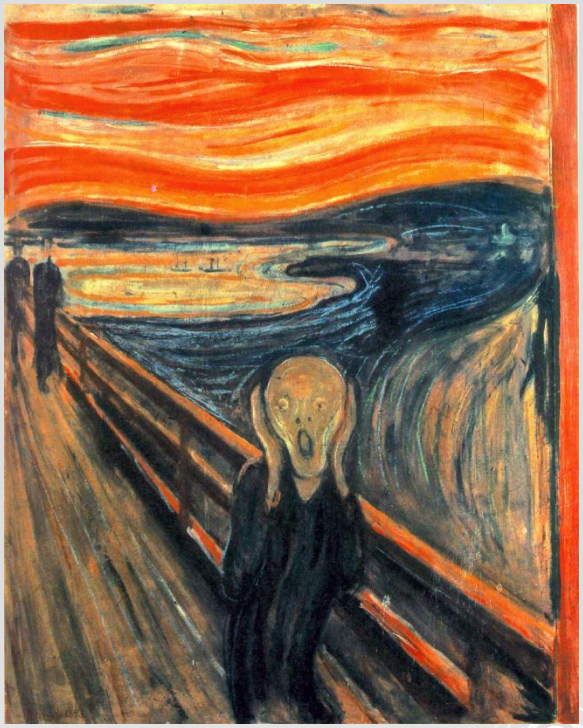
Employer Strategies

- Pilot for Provider Delivered Care Management (PDCM) with BCBSM 2010
  - Working with PCMH offices to move care management from vendor to primary care offices
  - Early measures of engagement of patients markedly higher
  - Data indicates practices increasing of patient contacts per month
  - " No one said it would be easy, but no said it would be this hard be this hard"
  - Great for patients – nightmare for everyone else
    - Data, metrics, reimbursement



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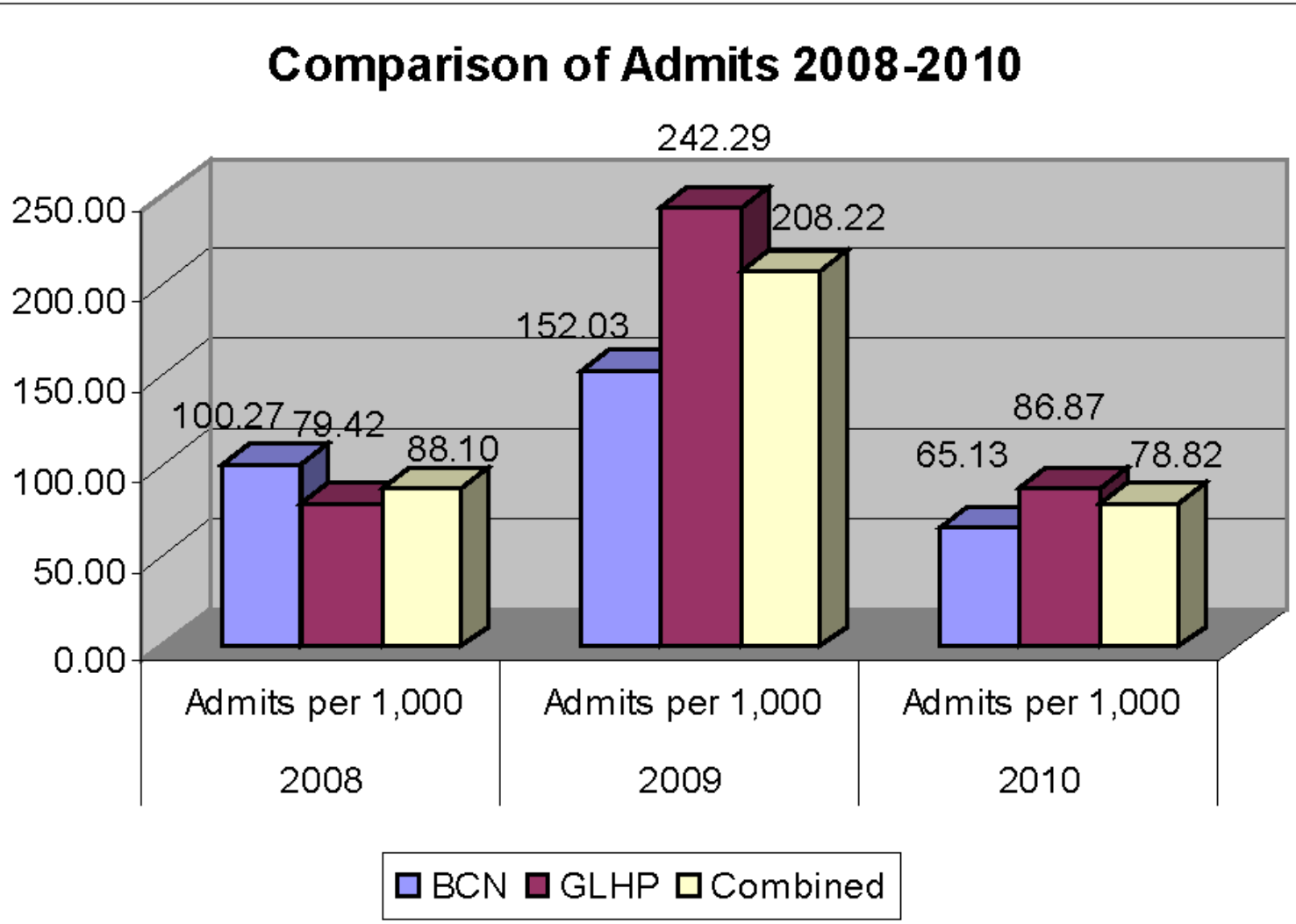
Information Technology

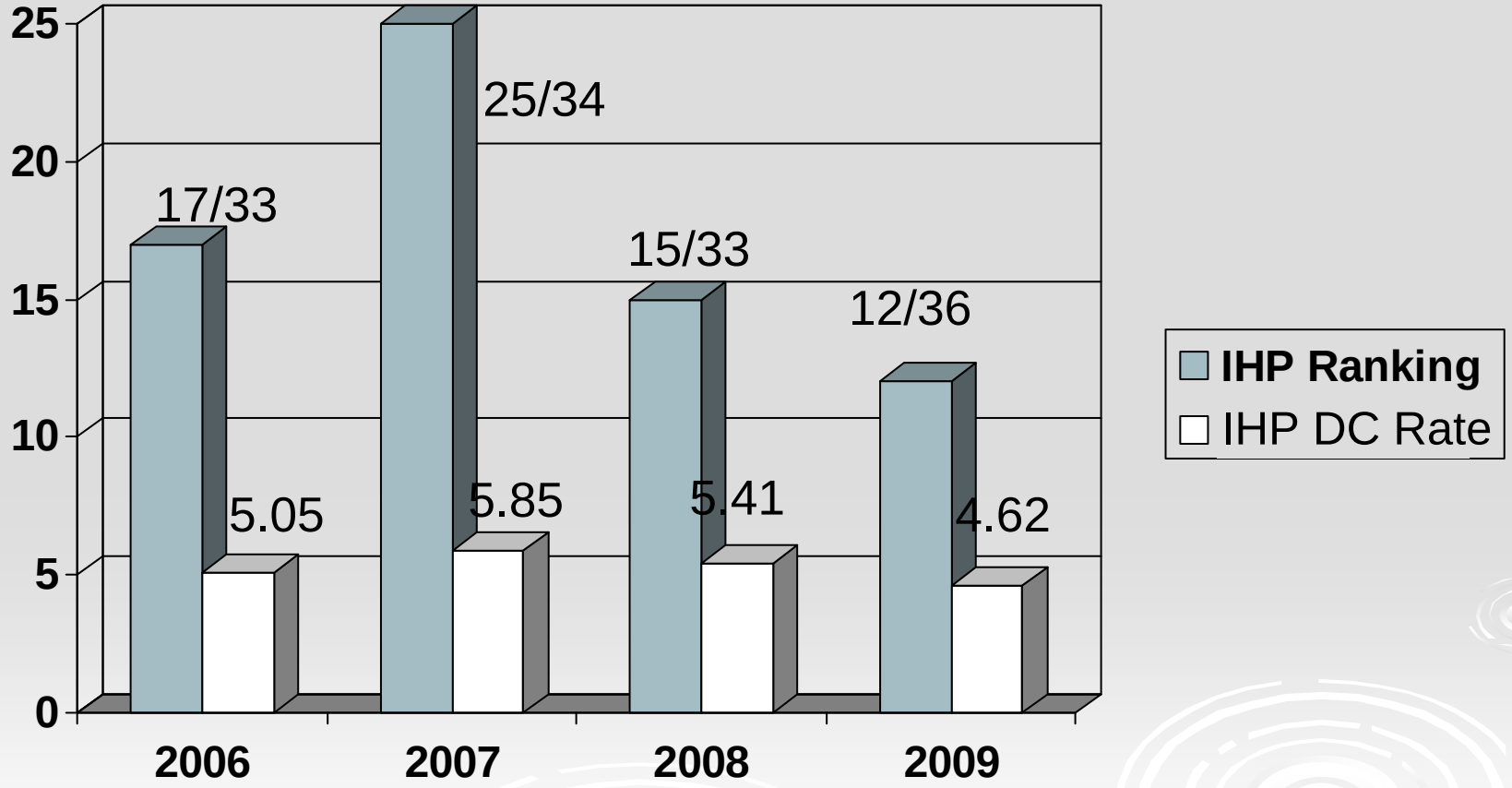
- It's a tool not an answer
- EMRs generally cannot do population health effectively
- Integration of the technology is key
  - Let function drive development
  - "black hole for dollars"

Money Makes the World Go Round

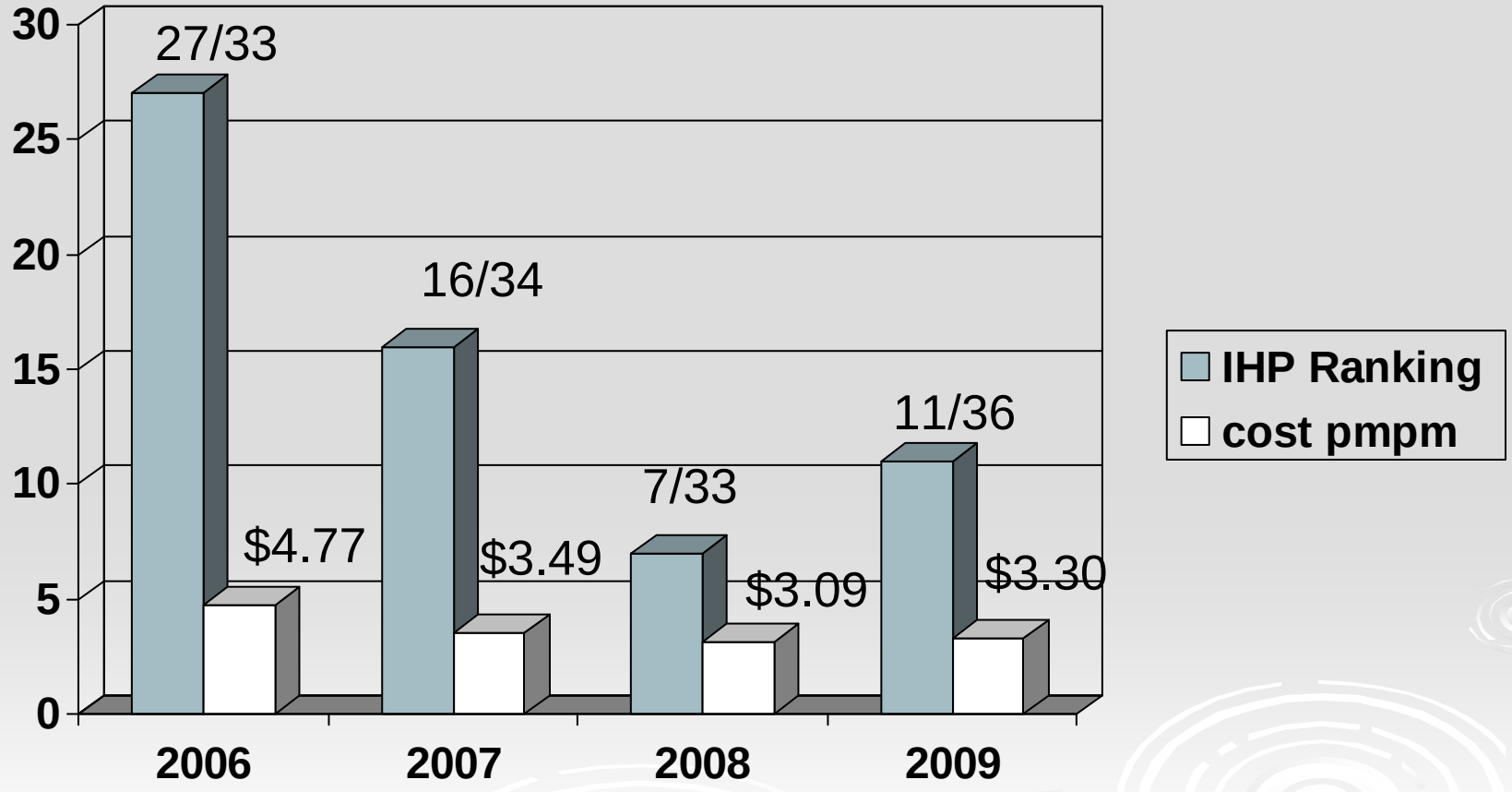
But are we saving money?


Comparison of Admits 2008-2010
250.00
200.00
150.00
100.00
50.00
0.00
100.27
79.42
88.10
152.03
242.29
208.22
65.13
86.87
78.82
Admits per 1,000
2008
Admits per 1,000
2009
Admits per 1,000
2010
BCN
GLHP
Combined

BCBSM PGIP
Ambulatory Care Sensitive Conditions
Inpatient Discharges /1000



BCBSM PGIP Ambulatory Care Sensitive Discharge Rate PMPM



Required Organizational Competencies
AHA ACO Research Synthesis Report

	Health Reform (2010)	Shortell/ Casalino (2010)	McClellan/ Fisher (2010)	Miller (2009)	Fisher/ McClellan (2009)	MedPAC (2009)
1. Leadership	**x**	**x**	**N/A**	**x**	**N/A**	**N/A**
2. Organizational culture of teamwork	**N/A**	**x**	**N/A**	**x**	**N/A**	**x**
3. Relationships with other providers	**x**	**x**	**x**	**x**	**x**	**x**
4. IT infrastructure for population management and care coordination	x	x	x	x	x	x
5. Infrastructure for monitoring, managing, and reporting quality	**x**	**x**	**x**	**x**	**x**	**x**
6. Ability to manage financial risk	**N/A**	**x**	**x**	**x**	**x**	**x**
7. Ability to receive and distribute payments or savings	x	x	x	x	x	x
8. Resources for patient education and support	x	x	N/A	x	N/A	N/A

Collaborative Partnerships?

Thank you!

Contacts:

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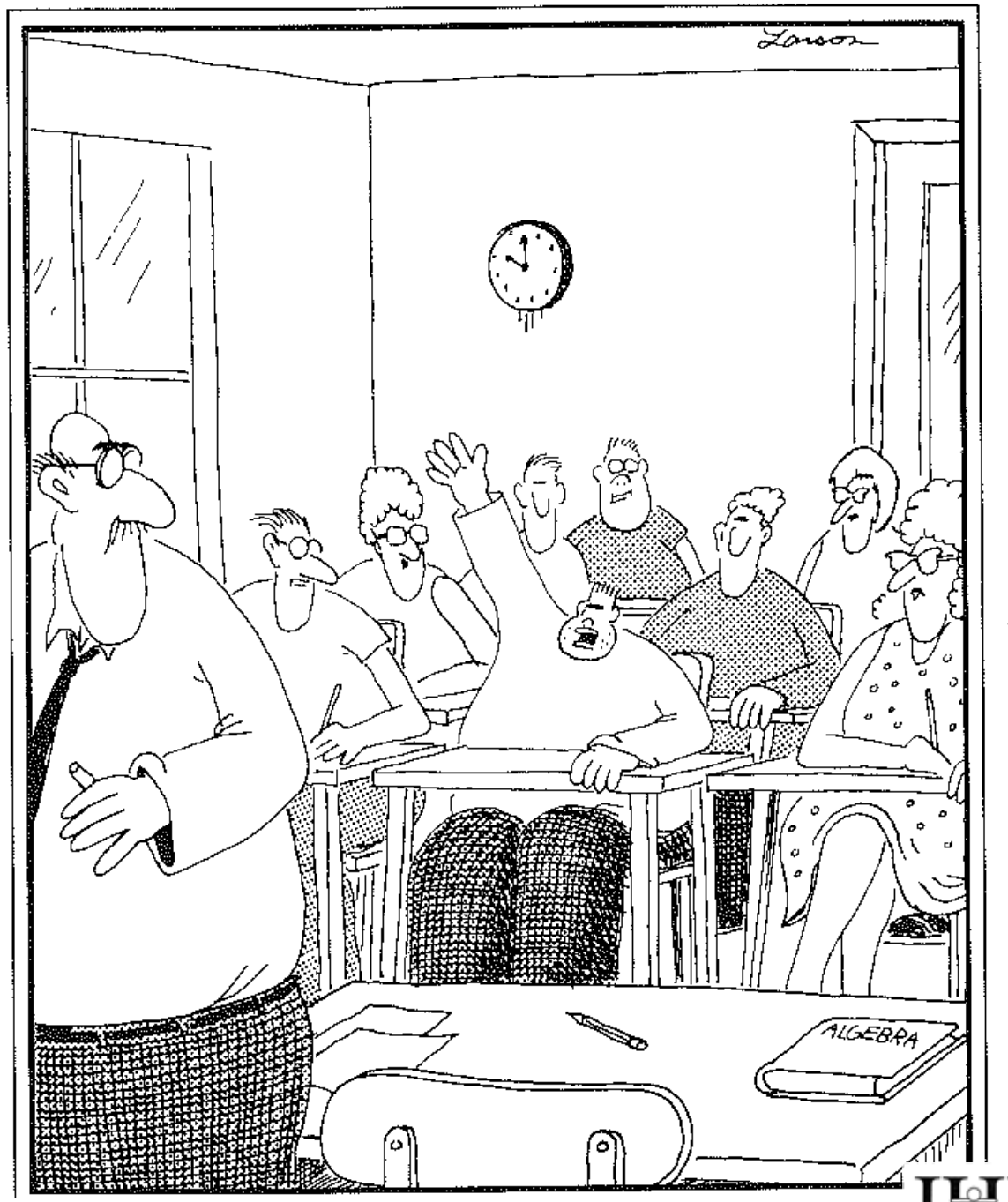

"Mr. Osborne, may I be excused? My brain is full."