Improving Provider and Patient Engagement in Medicaid DM Programs

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HealthyTogether℠

APS Healthcare

Agenda

- APS Overview
- Best Practices in Community Health Engagement for Beneficiaries and Providers
- Constituents:
    (1) Consumers and families
    (2) Community Providers, Federally Qualified and Rural Health Centers, Health Systems
    (3) Community Health Departments
    (4) Volunteers and Community Supports

APS Overview

APS Healthcare – At a Glance

- Leading national specialty healthcare company
- Serve more than 20 million people
- Stand alone and integrated programs
- $200M revenue (2006 projected)
- Privately-Held
- Organized into three business units – APS Public Programs, APS Commercial Programs and APS Puerto Rico
- 7 URAC accreditations
- 2005 DMAA Best Government Disease Management Program Award recipient
- Two time EAPA Quality Award

APS Overview – Government Programs

APS in the Public Sector

Key Facts

- $130 million in revenue (2006 projected)
- 35 programs in 20 states
- Serve 30% of all Medicaid beneficiaries in the U.S.
- 100% client retention rate
- QIO-like designation from CMS
- 2005 DMAA Award recipient for Best Government DM Program
- Programs for disabled have earned "Promising Practices" designation from CMS

Product Offering

- Disease Management
- Enhanced Care Management
- Utilization Management/Review
- External Quality Review
- Behavioral Health Management
- Informatics Consulting
- Mental Retardation/ Developmental Disability Programs
- Indigent Care and Social Necessity programs
- Children's Health Services

Operating Model

- Locally-based staff leads and supports each program
- Each program has a dedicated Executive Director who provides leadership
- High degree of collaboration exists with state health agencies on product design and service delivery

"APS is unique in our breadth of services. Our success is due to collaborative care models; use of Internet-based electronic health records with evidence based guidelines; and a decentralized model for program leadership and operations."

— David Hunsaker,
President
APS Public Programs

APS Overview – Public Programs Services

	Health Management Services	Behavioral Health Services	Quality Improvement Services

Product Overview	• Disease Management services for Medicaid populations (both general Medicaid population and ABD population)
	• Utilization Management services for behavioral and medical
		• Stand-alone Behavioral Health, both at-risk and ASO
		  • Traditional approach
		  • Emerging population management approach
			• External Quality Review
			• Quality Improvement Organization (QIO)
			• Preadmission Screening and Resident Review
			• Informatics Consulting
			• ESPDT
			• Disability Programs for MR-DD

Core Capabilities	• Cover a wide variety of acute condition programs for the chronically ill Operate out of facilities based in state of contract award • Utilize proprietary CareConnection tool to share data with providers • Establish relationships with leading academic medical centers (e.g., Morehouse for the Georgia contract) • Have formal partnerships with Federally Qualified Health Centers to perform screenings and deliver services	• Maintain extensive provider network in states of operation • Operate out of facilities based in state of contract award • Pay claims through relationship with ACS (Maryland) and through internal resources (using Paradigm system in Puerto Rico) • Run call centers that match patient with appropriate providers and ensure all member questions are answered	• Utilize proprietary Care Connection tool to share data with providers • Certified as a QIO-Like (PRO) Organization
Differentiators	• Simultaneously manage behavioral and medical conditions • Excel at designing community-based programs • Winner of 2005 DMAA Best Public Sector DM Program Award	• Long-term relationships in key markets • Reputation for good value and outstanding service • Strong provider partnerships	• High level of subject matter expertise – viewed as one of the leaders • Sterling reputation-10 programs • Efficient operational platform – highly profitable

Transforming Disease Management into Person-Centered, Population Health Outcomes Management

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Serving the Medicaid Population

- Open-Panel, Non-System of Fragmented Care
- Messy Data
- Poverty / Socioeconomic Stressors
- Transient Addresses / Inconsistent Phone Number
- On Again / Off Again Eligibility
- Literacy Issues
- Cultural, Socioeconomic, Language Barriers
- Cultural Resiliency and Community Strengths *(Often Overlooked)*

One-size DM program does not fit all!

Transforming Disease Management

Intensive Management of One Disease

- Intensive case management for people with specific disease
  - Intensive care management for people with multiple co-morbidities
    - Person-centered population health outcomes management

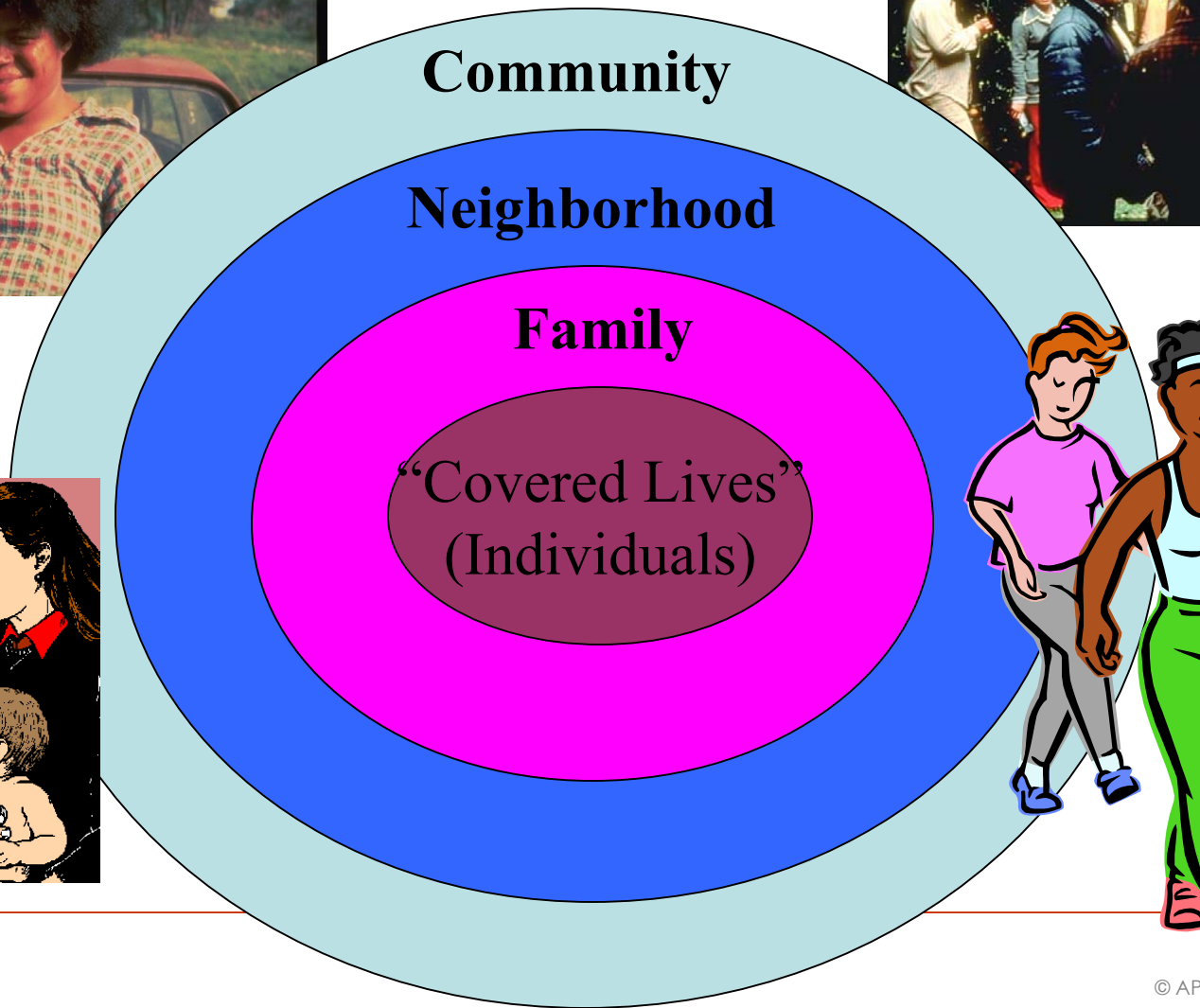
Person-Centered Outcomes Management

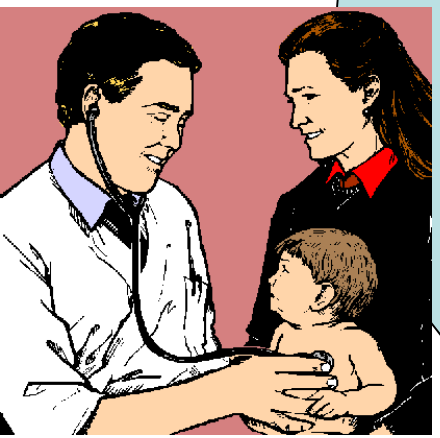
1. Focus on people, not diseases
2. Usual (Sub-Optimal) Care Abounds! Help people get the care they need; and notice when they don't *(Monitor for "intervenable deficits" in care)*
3. Co-morbidities abound! Stratify by co-morbidity clusters and "high-impact conditions"
4. Triangulate on best-practice / best outcomes *(patient + practitioner + systems level interventions each reinforcing the other)*
5. Act like a system of care, not a random bunch of silos!

1. People are not a Disease!

- Transportation
- Health Beliefs
- Economic Issues
- Trust *vs.* Disrespect
- Locus of Control
- Culture & Language
- Discontinuity of Care
- Health Literacy
- Strengths & Resiliency

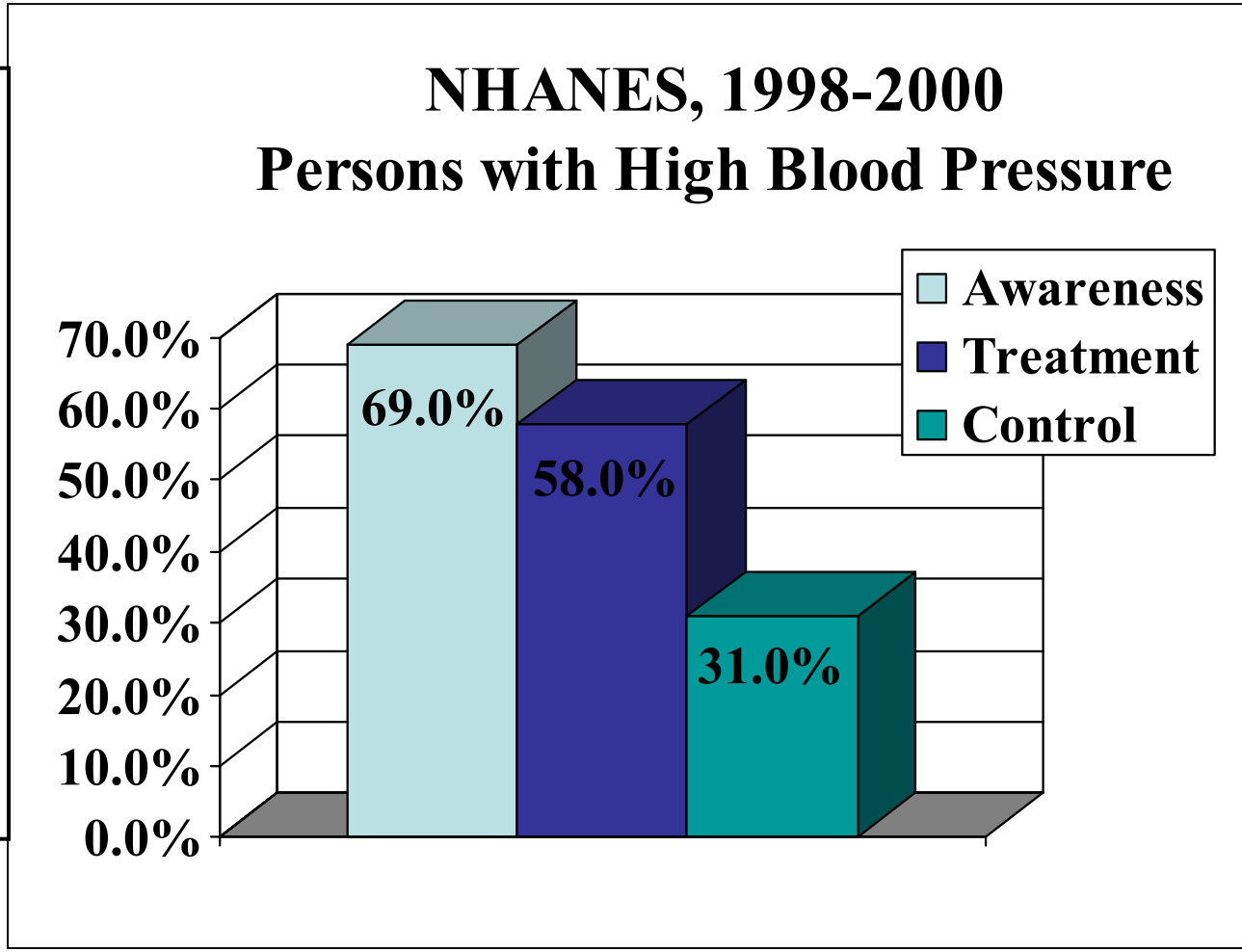
People Live in Families & Communities
(Move From Covered Lives to Community Context)





2. Bad Care Abounds! Usual Care Hypertension Control

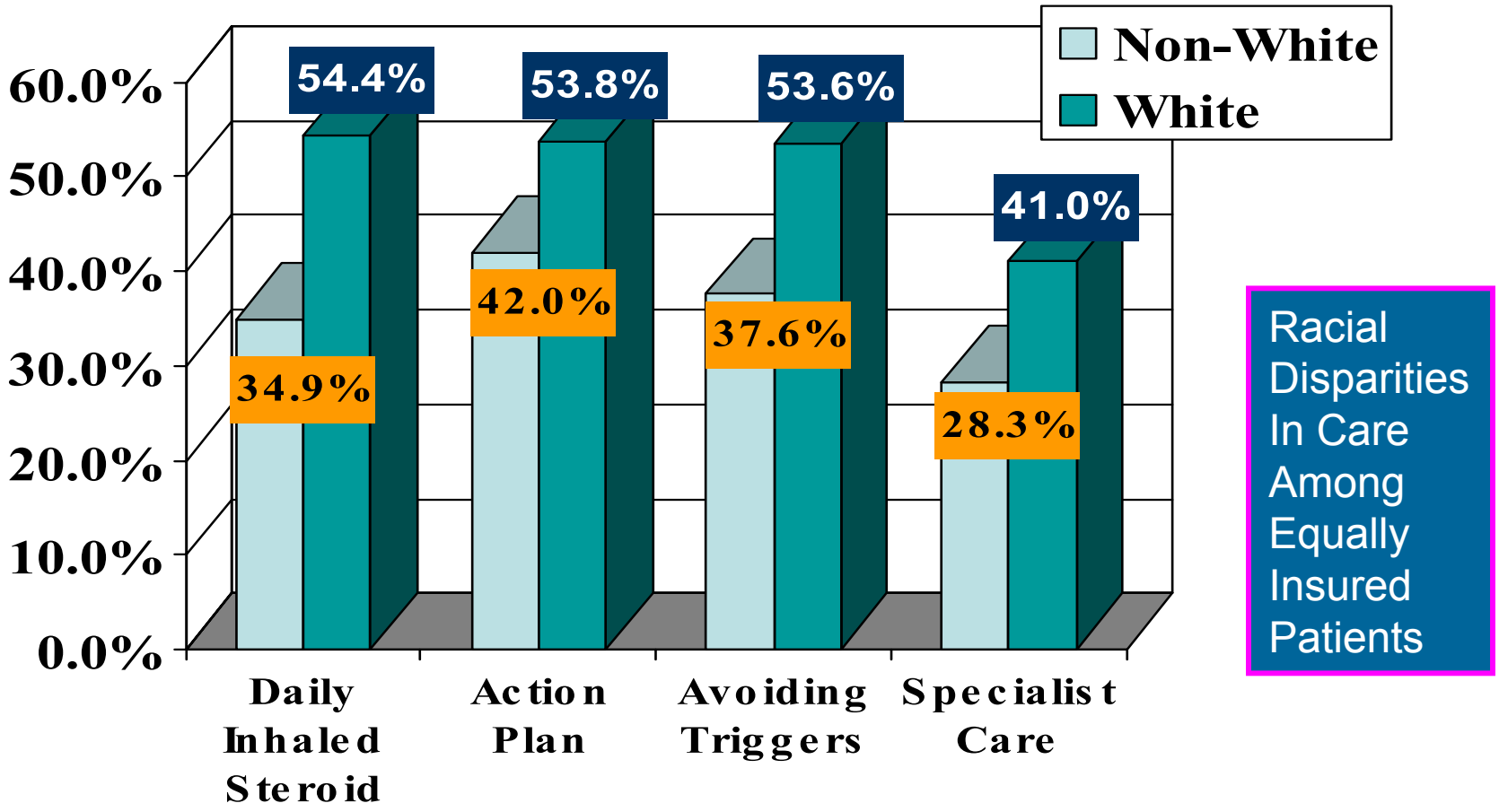
- According to NHANES data, only 31% of hypertensive individuals had adequate control of their blood pressure, and only 58% were receiving any treatment at all.



10 Areas of Documented "Sub-Optimal" Primary Care

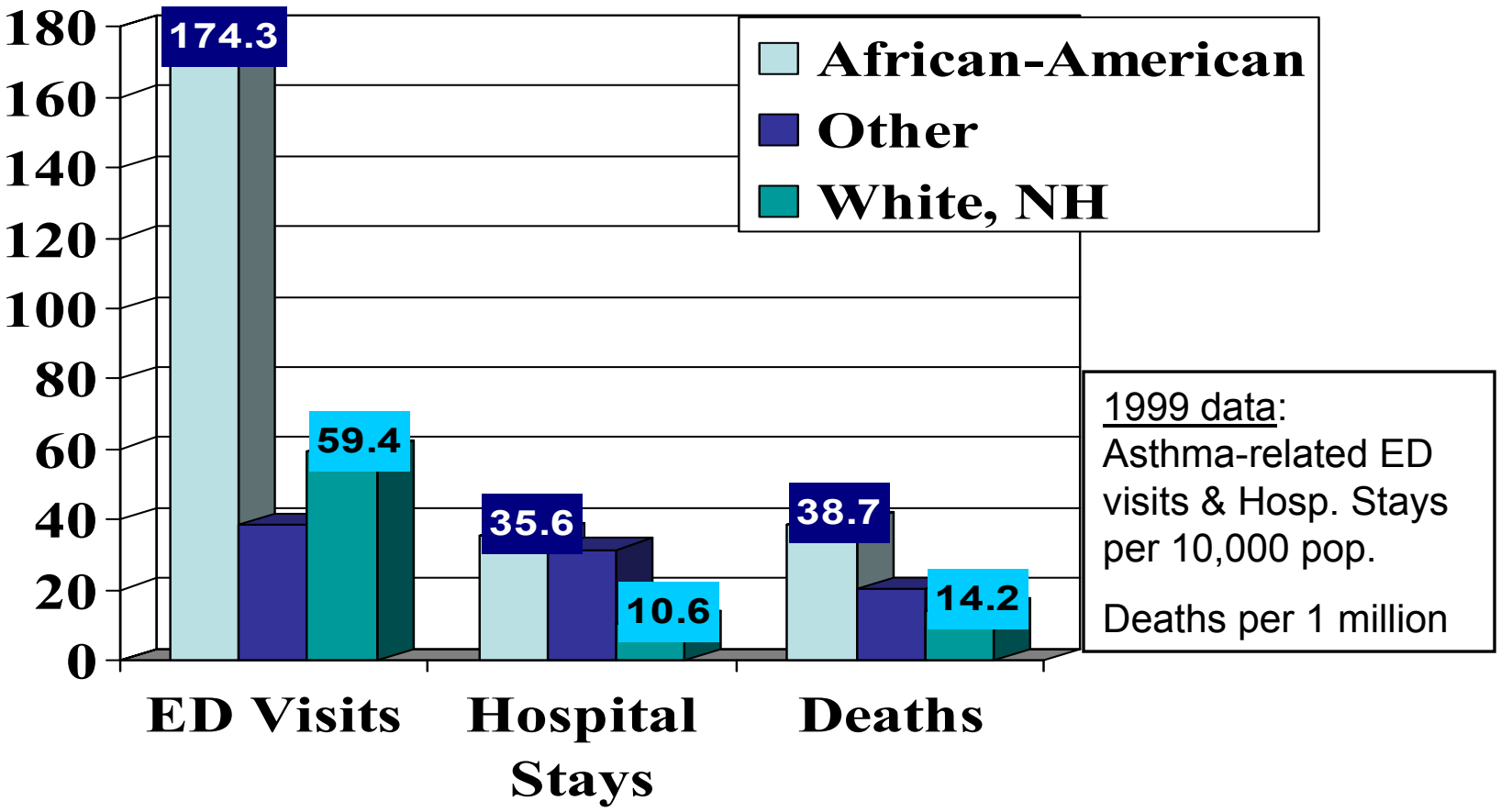
- Asthma
- Hypertension
- Heart Disease
- Diabetes
- Depression
- Cancer Screening
- Adult Immunizations
- Obesity / Diet
- Smoking / Tobacco
- Alcohol & Other Substance Abuse

From Bad Care to Worse Care High Variance ⇔ High Disparity



Krishnan JA, Diette GB, Skinner EA, Clark BD, Steinwachs D, Wu AW. Race and sex differences in consistency of care with national asthma guidelines in managed care organizations. Arch Intern Med 2001, July 9; 161(13):1660-8.

Unequally Bad Care = Unequally Bad Outcomes

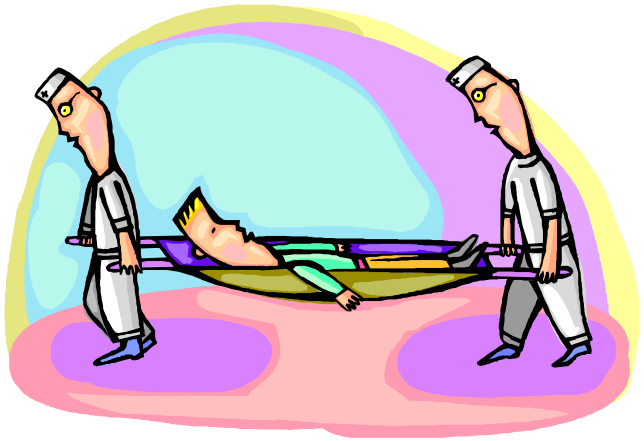


Surveillance Summary for Asthma -- United States, 1980-99. MMWR, 2002 Mar 29: 51(1):1-13.

3. Co-morbidities Abound!

He's just one patient, how bad could it be???

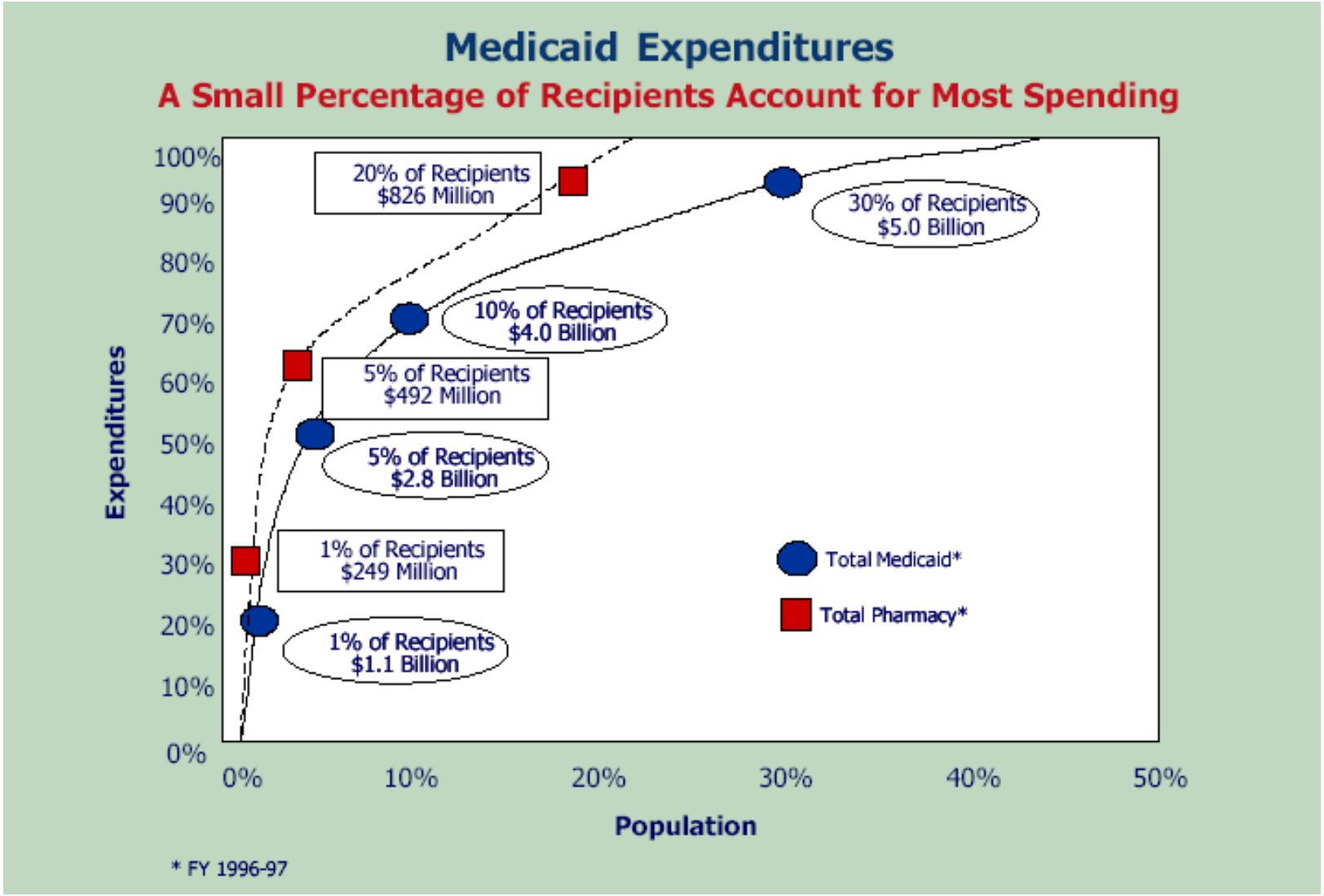
- Diabetes
- Arthritis
- COPD
- CHF
- Stroke
- Pneumonia
- Cancer
- Depression
- Alcohol / substance abuse



*** 21 ER Visits * 143 hospital bed-days**

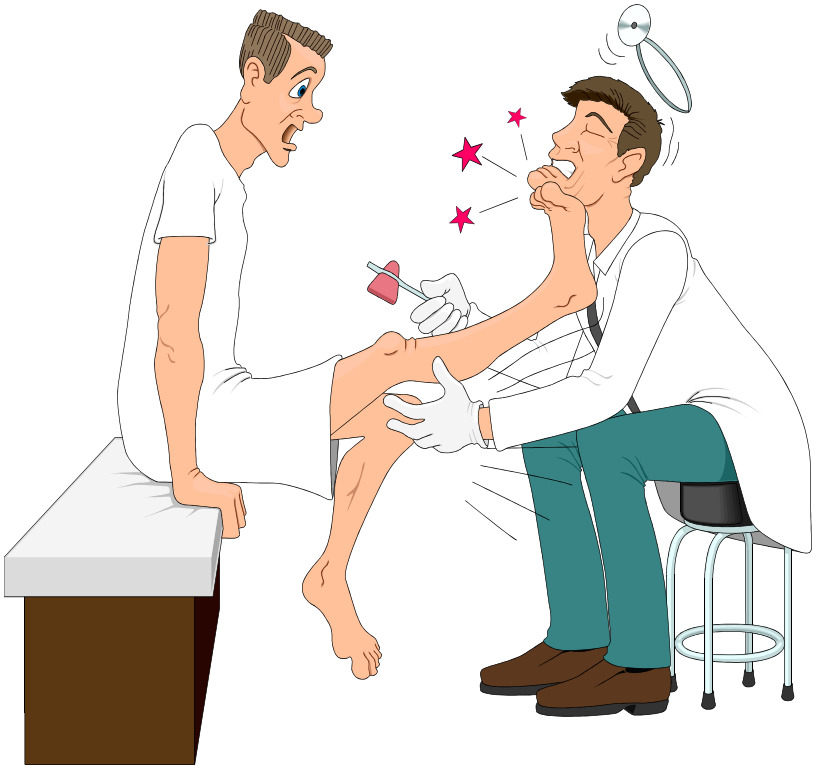
Inpatient	Outpatient	Physician	Other	Rx Drugs	Total
$217,657	$7,105	$29,756	$13,653	$12,182	$280,353

Rationale for Medicaid Investments in Disease Management



-- Florida AHCA presentation, 1999

Co-Morbidities are Inter-Connected! The ABCD's of "Treat-to-Target"



"Treat-To-Target"

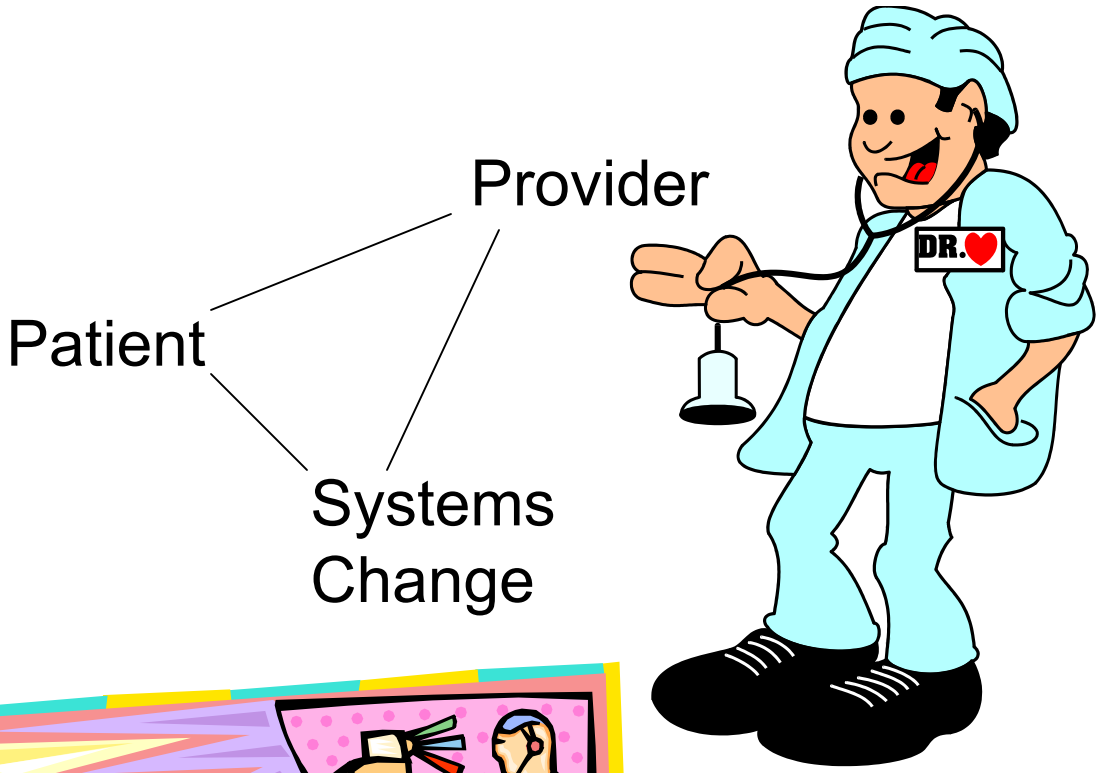
A. A1c
(tight glycemic control)

B. BP Control
(tight BP control)

C. Cholesterol
(tight lipid control)

D. Depression
(treat to remission)

4. Triangulate Interventions to Achieve Best-Practice Outcomes



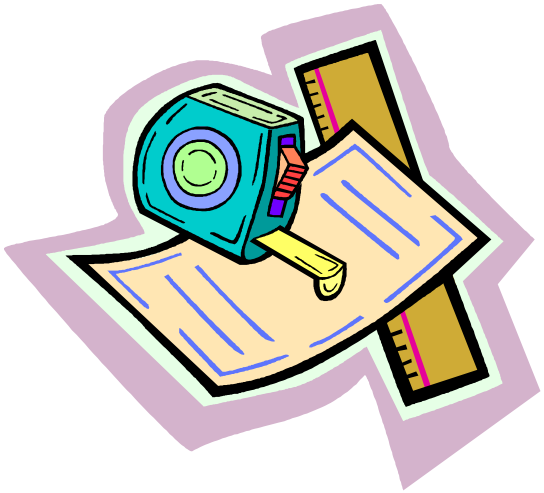
- Patient Self-Management Education

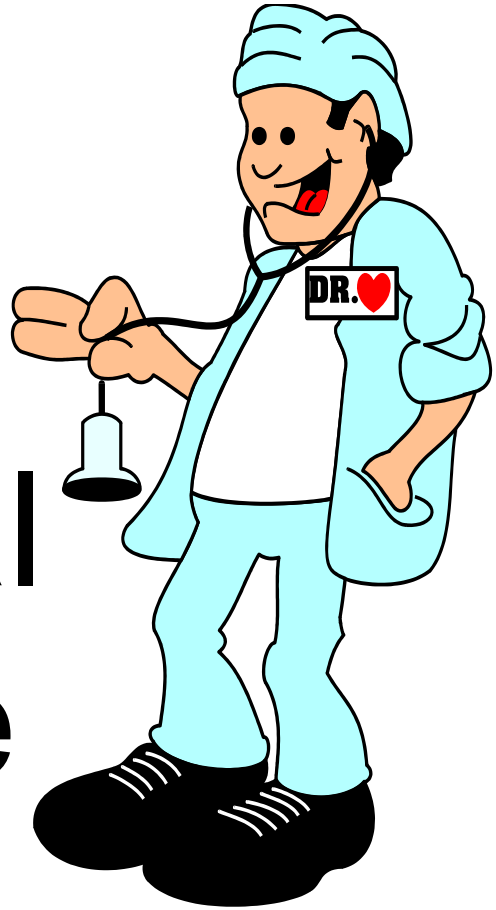
Cochrane Database Systematic Review (2003): ***Patient self-management education reduces relative risk of adverse outcomes:***

- **Hospitalizations RR = 0.64**
- **ED Visits** RR = 0.82
- Days off work or school RR = 0.79
- Nocturnal Asthma RR = 0.67
- *Caveat*: Little change in

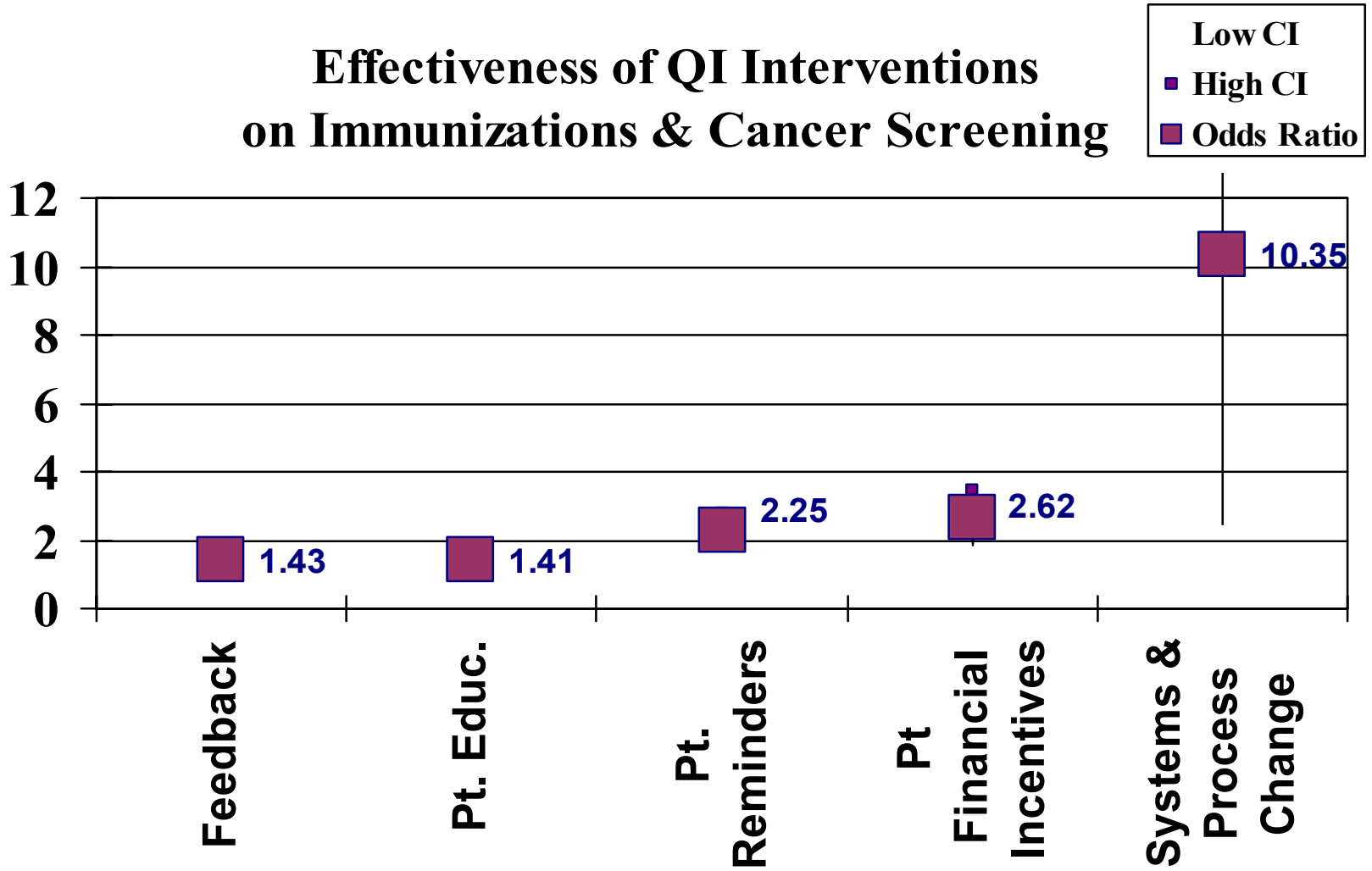
Triangulate on Best Outcomes – The Provider – Practice System

Usual Care = Sub-Optimal Care





Triangulate on Best Outcomes – Systems Change at the Provider – Practice Level



Interventions that increase use of adult immunization and cancer screening services: a meta-analysis. Ann Intern Med, 2002 May 7; 136(9):641-51. Stone EG, Morton SC, Hulscher ME, Maglione MA, Roth EA, Grimshaw JM, Mittman BS, Rubenstein LV, Rubenstein LZ, Shekelle PG.

Southside Medical Center Point of Service HbA1c Testing Results

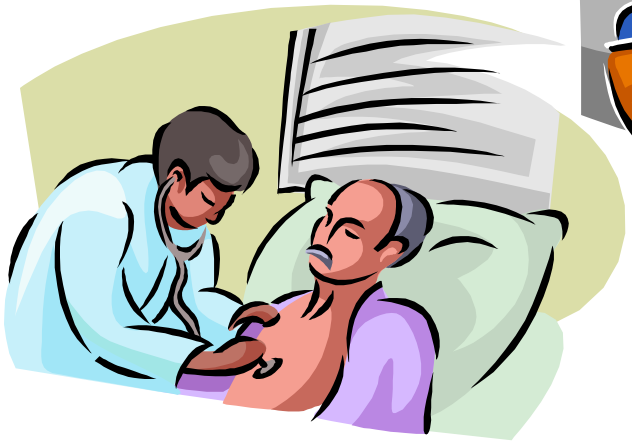
Measures	Before	After	p -value
HbA1c Test Performed	78/106 (73.6%)	92/106 (86.8%)	p = 0.397
Mean HbA1c Values	8.55	7.84	p = 0.004*
Provider counseling " opportunity to intensify" when HbA1c elevated	24/35 (68.6%)	39/39 (100%)	p = 0.028*
Regimen intensified in 90 days post HbA1c elevated (system)	10/35 (28.6%)	21/39 (53.8%)	p = 0.028*
Regimen intensified post HbA1c elevated & F/U with PCP	10/24 (41.7%)	21/39 (53.8%)	p = 0.001*

* Statistically significant $p < 0.05$

Good Care + Good Outcomes = Lower Costs!

- Compared to a diabetic individual with Hgb A1C < 6% , health care costs are this much higher if:
  - IF Hgb A1C = 8%,
    Health Care Costs ⇧ **10%**
  - IF Hgb A1C = 9%,
    Health Care Costs ⇧ **20%**
  - IF Hgb A1C ≥ 10%,
    Health Care Costs ⇧ **30%**

5. Help Break Down Silos – Act Like A Real *System* of Care



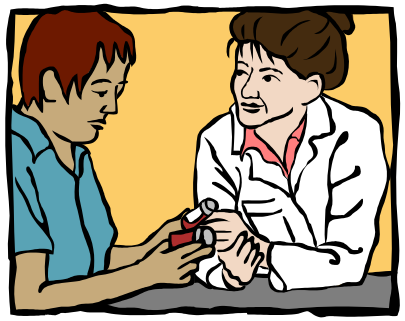
Teamwork!

- Community Health Workers (*Promotoras*)
- Medical Assistants
- Nurses / Nurse Practitioners
- Pharmacists
- Social Workers
- Health Educators
- Respiratory Therapists
- Physical Therapists
- Primary Care Practitioners
- Psychologists
- Behaviorists
- Sub-Specialists

Teamwork!

Enhanced Asthma Education via Community Pharmacists:

- Symptom scores ↓
- PEFR values ↑ **11%**
- Beta-Agonist Use ↓ **50%**
- Days off school / work ↓ **0.6 days/month**
- ED Visits ↓ **75%**
- Medical Office Visits ↓ **75%**
- Quality of Life Scores ↑ **19%**



McLean W, Gillis J, Waller R. The BC Community Pharmacy Asthma Study: A study of clinical, economic and holistic outcomes influenced by an asthma care protocol provided by specially trained community pharmacists in British Columbia. Can Respir J. 2003 May-Jun;10(4):195-202.

From Collaboration to Integration

Cherokee Health Systems "Integrated Care" Model:

- Biopsychosocial approach
- Addresses the whole person by integrating behavioral services into primary care.
- Combines the best traditions of primary care and mental health services in an integrated health care team to treat the whole person
- Services include education, behavioral management, assessments, brief interventions, as well as treatment for mental health disorders.

Community-Level Teamwork – A Real *System* of Care

Hospital

Mental Health

Emergency Room

Primary Care

Engaged, Community-Centered Health Management Programming

Best Practices for Community Health Engagement

- Increased technology integration and better data
- Increased community DM collaboration in both Program Design and Health Care Delivery
- Increased Focus / Integration of Mental Health into DM
- Performance Initiatives that reinforce outcome
- Participation in Grants for Collaboration
- Volunteers, Lay educators, Health Coaches as medical home extenders — ”Glue between the office visit”
- Targeting diseases specific to local / state communities
- Beneficiary Incentives for Self-Directed Care

Electronic Community Health Records

Transparent but secure Internet-based health records that:

- Are designed to conform to business and care management needs
- Elevate level of 360 degree information available on claims, medication, health alerts, guidelines, demographics and other issues
- Engage Providers and Consumers, facilitate “doing the right thing, first time, every time” systematic basis
- Adaptable to changing circumstances, reporting, linguistic, literacy, personal and other goals
- Use push technology opportunities for improvement
- Let all members of the health care team drive and benefit from the systems

Best Practices for Community Health Engagement

- EBM pathways for clinical support, Community Resource Directories for quality of life supports
- Information Sharing databases for Best Practices / Lessons Learned Systemic Improvement
- Increased focus on provider participation in day to day chronic care supports: build *value* and they will come
- Systematic Provider and Consumer involvement for design and use of educational tools: Advisory Groups
- Increased focus on outcomes and consumer / family education -- Teach rather than do when possible

Key Engagement Strategies – Summary

- Design Health Management Systems to assist / augment / add value, rather than duplicate services or perform them independently of the existing health care systems
- Facilitate collaboration with local PCPs, Specialists, Hospitals, Mental Health and Community Agencies
- Develop multiple methods of communication with consumers, providers and community interests
- Emphasize commitment to community-centered approach, integrating behavioral health and daily living education/supports as early as possible