Enhanced Personal Health Care

A Better State of Health

Early Successes achieved in Anthem's PCMH and ACO Pilots

Anthem BlueCross BlueShield

COLORADO PCMH 2009

18% FEWER
HOSPITAL ADMISSIONS
15% FEWER
ER VISITS, IMPROVEMENT IN ALL DIABETES MEASURES

NEW HAMPSHIRE PCMH 2009

3.6% FEWER
HOSPITAL ADMISSIONS
6.1% FEWER
ER VISITS, IMPROVEMENT IN ALL DIABETES MEASURES

NEW YORK PCMH 2009

12-23% FEWER
HOSPITAL ADMISSIONS
11-17% FEWER
ER VISITS

DARTMOUTH-HITCHCOCK ACO 2012

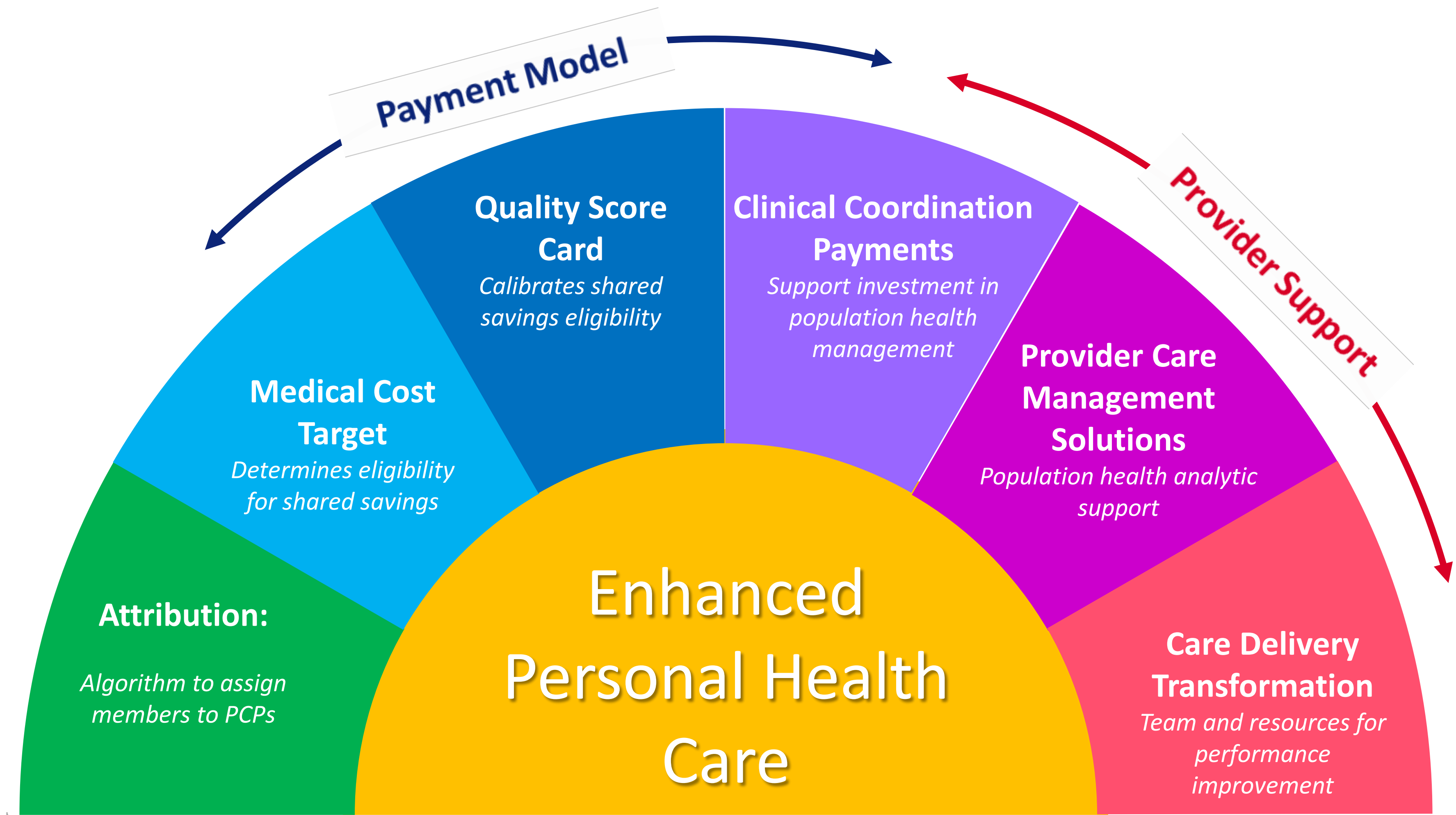
5.81% FEWER
HOSPITAL ADMISSIONS
10.6-18% FEWER
ER VISITS

CONNECTICUT PCMH 2012

18% FEWER
HOSPITAL ADMISSIONS
3% FEWER
AVOIDABLE ER VISITS
29% LOWER
READMISSION RATE

* Figures per 1,000 per

Understanding the EPHC Model



Enhanced Personal Healthcare: Aligning Anthem and Provider Incentives

Under the Shared Savings program, providers receive money when they:

- **Increase** the **amount of savings** by **reducing costs**
- **Increase** the **percent of savings** they can take home by meeting quality and utilization targets established in the program's scorecard
- Must meet minimum threshold

Accountable for Quality

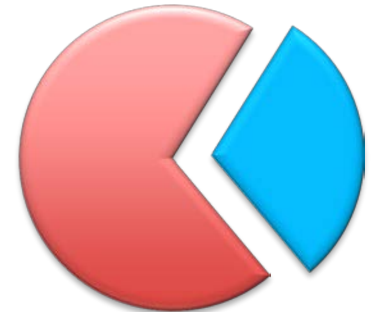
EPHC **Commercial** Scorecard Metrics and Weighting

Measure Number		Quality Metric Name
Medication Adherence		
1	CMS	Oral Diabetes
2	CMS	Hypertension (ACE or ARB)
3	CMS	Cholesterol (Statins)
Diabetes Care		
4	NCQA, HEDIS	Urine Protein Screening
5	NCQA, HEDIS	HbA1c Testing
6	NCQA, HEDIS	Eye Exam
Annual Monitoring of Persistent Medications		
7	NCQA, HEDIS	Digoxin
8	NCQA, HEDIS	ACE/ARB
9	NCQA, HEDIS	Diuretics
Other Acute and Chronic Care		
10	NCQA, HEDIS	Appropriate Testing for Children with Pharyngitis
11	NCQA, HEDIS	Appropriate Treatment for Children with Upper Respiratory Infection
12	NCQA, HEDIS	Osteoporosis Management in Women who had a Fracture
13	NCQA, HEDIS	Persistence of Beta-Blocker Treatment after a Heart Attack
14	NCQA, HEDIS	Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy in RA
15	NCQA, HEDIS	Use of Appropriate Medications for People with Asthma
16	NCQA, HEDIS	New Episode of Depression: Effective Acute Phase Treatment
17	NCQA, HEDIS	New Episode of Depression: Effective Continuation Phase Treatment
Adult Preventive		
18	NCQA, HEDIS	Breast Cancer Screening
19	NCQA, HEDIS	Cervical Cancer Screening
Pediatric Preventive		
20	NCQA, HEDIS	Childhood Immunization Status: MMR
21	NCQA, HEDIS	Childhood Immunization Status: VZV
22	NCQA, HEDIS	Well-Child Visits Ages 0-15 Months
23	NCQA, HEDIS	Well-Child Visits Ages 3-6 Years Old
24	NCQA, HEDIS	Well-Child Visits Ages 12-21 Years Old
Quality Improvement Measures		
1	NCQA, HEDIS	Breast Cancer Screening
2	NCQA, HEDIS	Medication Adherences: Statins
3	NCQA, HEDIS	Diabetes: HbA1c Testing
4	NCQA, HEDIS	Well Child Visits ages 3-6 Years Old
5	NCQA, HEDIS	Appropriate Testing for Children with Pharyngitis
Utilization Metric Name		
1		Avoidable ER Visits
2		Ambulatory Sensitive Inpatient Admissions
3		Generic Drug Dispensing Rate

60%

40%

Determines Eligibility for Shared Savings Proportion



Quality metrics are standard HEDIS measures

Accountable for Quality

EPHC **Medicare** Scorecard Metrics and Weighting

Category	Metric
Physician: Acute & Chronic Care Management	
Diabetes Care	Diabetes Care – Eye Exam
	Diabetes Care – Kidney Disease Monitoring
	Diabetes Care – Blood Sugar Controlled
Other Acute & Chronic	Osteoporosis Management in Women Who Had a Fracture
	Controlling Blood Pressure
	Rheumatoid Arthritis Management
Physician: Preventative	
Adult	Breast Cancer Screening
	Colorectal Cancer Screening
Medication Adherence	Diabetes Treatment
	High Risk Medication*
	Medication Adherence- Oral Diabetes
	Medication Adherence- Hypertension
	Medication Adherence- Cholesterol
Care of Older Adults	Adult BMI Assessment
	COA: Medication Review
	COA: Functional Status Assessment
	COA: Pain Screening

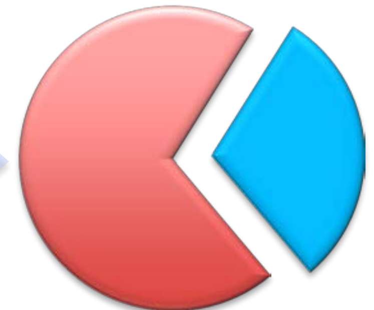
1 Calculate measure compliance rate

2 Compare to thresholds (4 or 5 Star Threshold)

3 Determine metric shared savings potential

4 Step 4: Calculate earned shared savings

Eligibility for Shared Savings Proportion



* Reverse Measure Lower is better. Compliant member count is non compliant members who need the gap closed.

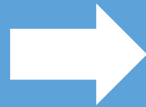
Non HEDIS Measures

Anthem.

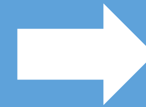
Case Study: Multi-Specialty Practice in the Southwest

Investments in Coordinated Care pay Dividends in Quality/Utilization

Multi-Specialty, multi-site practice of 40+ providers, 9,500 attributed members



Uses clinical coordination payments to fund "Nurse Navigators" for patient outreach, proactive care planning & transformation activities



Areas of focus include **closing gaps in care**, **proactive patient outreach, care transitions** and **care planning**

RESULTS

	2013	2014
Diabetes Management*	76%	79%
Adult Prevention**	74%	78%
Avoidable ER Visits/K	55.5	48.9

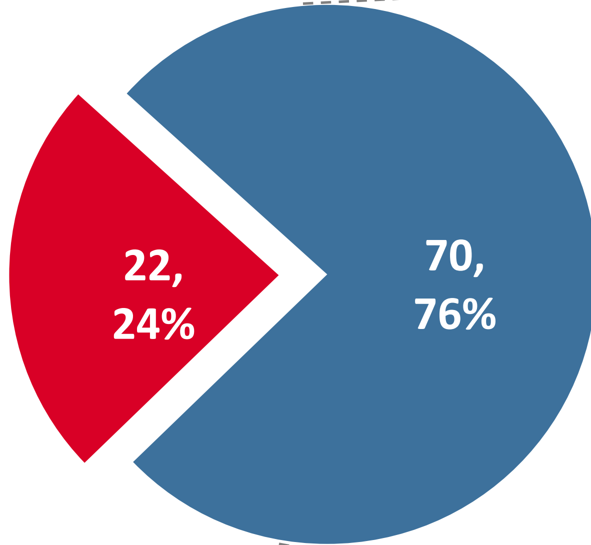
Market Benchmark

*Includes the following HEDIS measures: DM Eye Exam, DM Hemoglobin A1c Testing, DM LDL-Screening, DM Urine Protein Screening

**Includes the following HEDIS measures: Breast Cancer Screening, Cervical Cancer Screening

Shared Savings Results

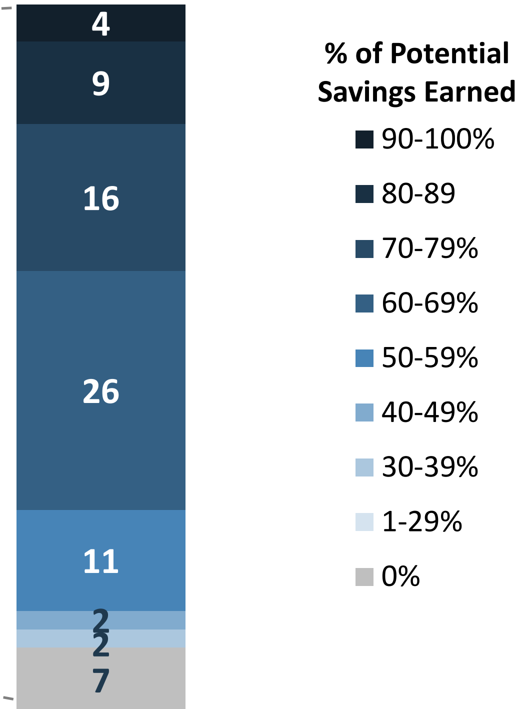
Panels who Earned Shared Savings



Did not earn Shared Savings

Earned Shared Savings

Distribution of Shared Savings Potential Achieved (# of Panels)



Deeper insights into how we get results:
Our team of Transformation Experts

Care Consultant

- Work flow and process improvement expert
- Identifies interventions that improve health outcomes
- Works collaboratively with providers to establish transformation action plans.

Provider Clinical Liaison

- Helps practices develop care management skills, interpret reports & ID high-risk patients
- Helps organizations manage Attributed Members with complex needs
- Fosters seamless coordination between the PCP and plan-sponsored programs

Other Resources

- **Pharmacist***:* Supports pharmacy management and RX reconciliation
- **Network Director**: Helps provider groups understand program contract and expectations
- **Contract Advisor***:* Manages onboarding process for participating providers

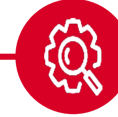
Channels of Engagement:
Many roads to achieve quality and cost results

On-site consulting

- Joint Operating Committee structure that includes Network, Contracting and Transformation.
- Field team engages practice in understanding data, identifying opportunities, developing action plans and next steps
- QI principles, Intervention Bundles and CM Methodologies are used to drive improvement

Collaborative learning

- Learning Library Recordings shared monthly
- Monthly virtual "Office Hours"
- National and State- specific sessions
- Web and Action Series

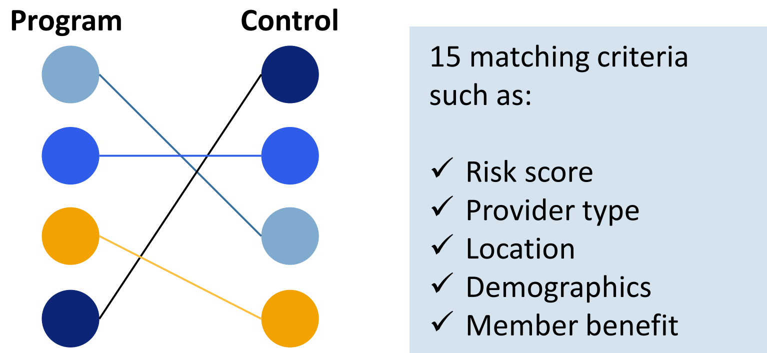


Transformation tools

- Web Based Reporting and Member longitudinal record
- On-demand library of recorded presentations and resources
- Data-driven Transformation Action Plans
- Intervention Bundles address quality and cost of care
- Access to web-based ACP Practice Advisor tool

EPHC Program Evaluation Overview

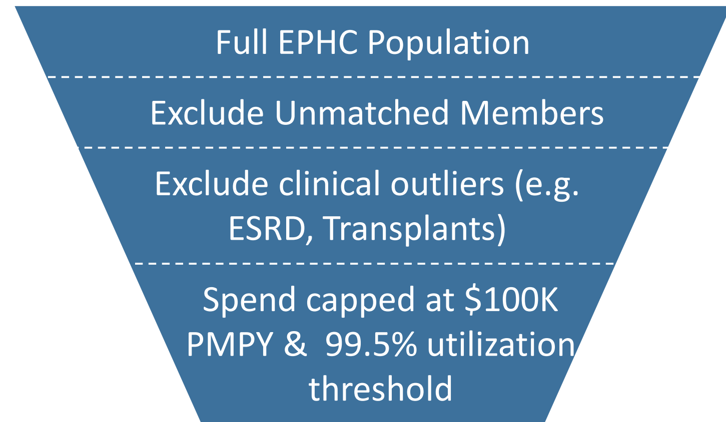
1. Match sample between EPHC attributed members (Program) and Non-EPHC affinity members (Control)



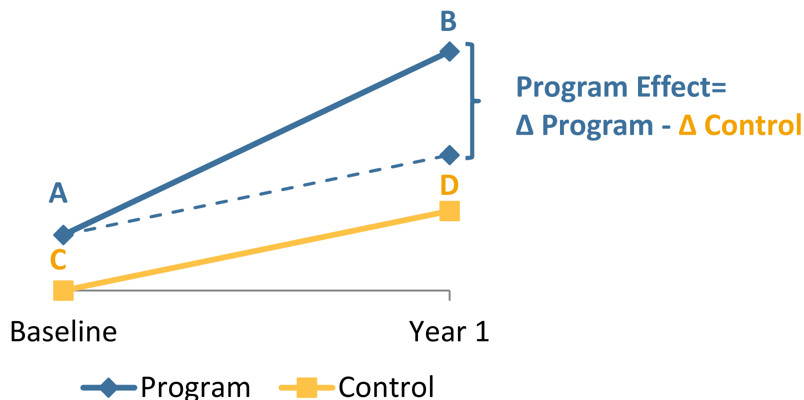
15 matching criteria such as:

- ✓ Risk score
- ✓ Provider type
- ✓ Location
- ✓ Demographics
- ✓ Member benefit

2. Pare sample to relevant population using inclusion/ exclusion criteria

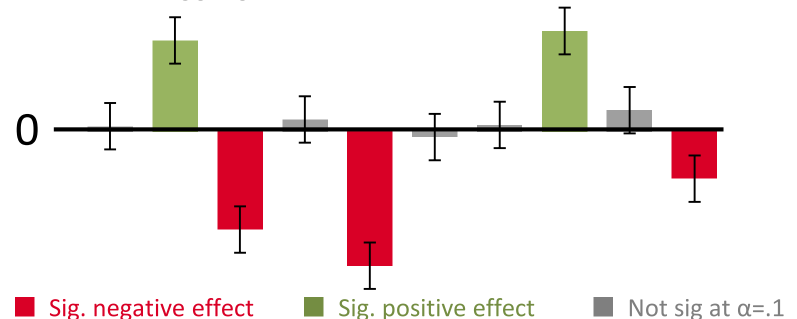


3. Difference in Difference Analysis between Baseline and Measurement Period isolates program effect from external influencing factors



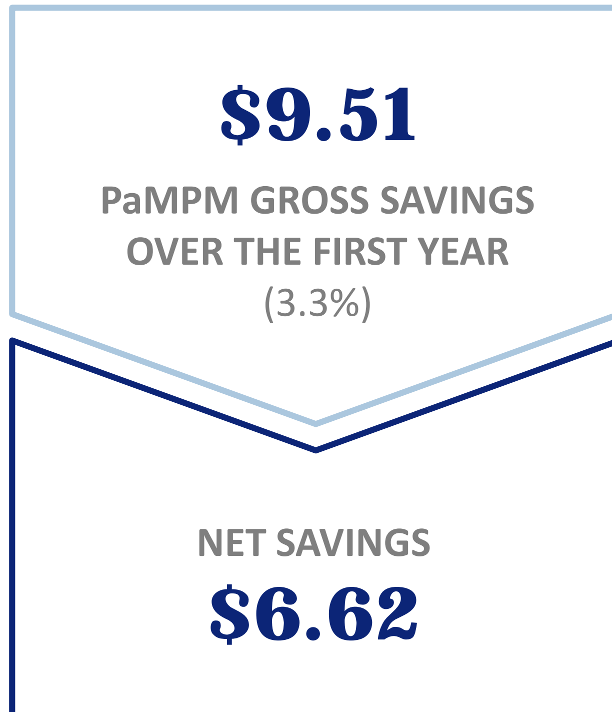
Program Effect= Δ Program - Δ Control

4. Statistical Significance Testing:
   - 90% confidence intervals generated at the member-measure Diff in Diff level
   - Confidence intervals linked to matching combinations of aggregate variables



Anthem's EPHC Program Delivers Cost of Care Savings

Anthem Year 1 Results



7.8% fewer
acute inpatient admits per 1,000

5.1% PMPM decrease
in outpatient surgery costs

5.7% fewer
inpatient days per 1,000

7.4% decrease
in acute admissions for high risk patients, and an **increase of 22.9 per 1,000** PCP visits for high risk patients

3.5% PMPM decrease
in ER visit costs and a **1.6% decrease** in ER utilization

Results from Anthem's EPHC Program year 1

Anthem CPCi – Summary of Progress to Date

Anthem participates in 3 of the 7 CPC markets (NY, OH/KY, and CO)

Attributed Members	23,208	78,965	43,867
Participating Providers	27	17	41

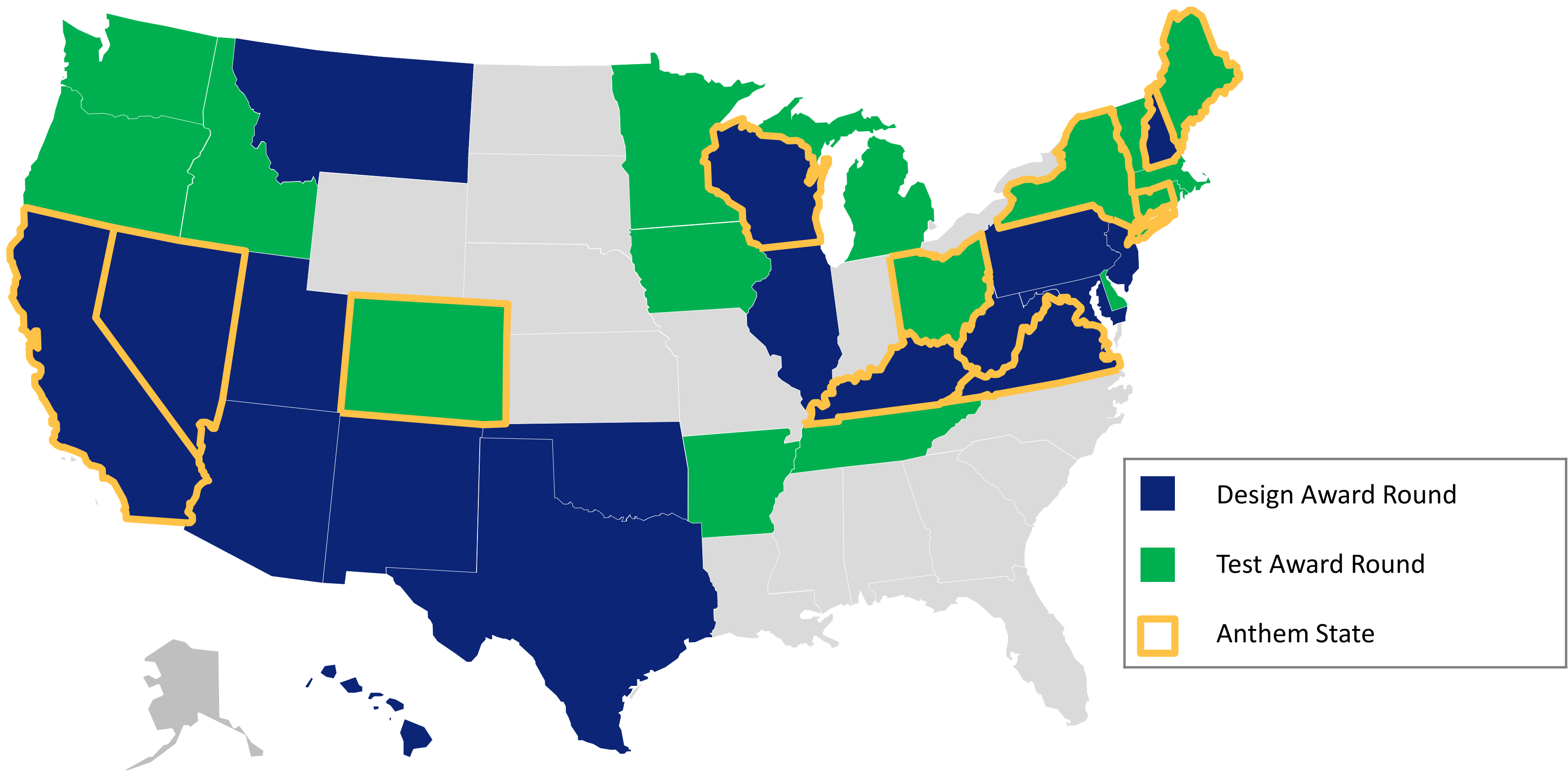
Early program results for New York and Ohio show early progress in quality and utilization:*

- Increase in follow-up visits post discharge in Colorado
- Increase in Saturday/Sunday visits in New York
- Decrease brand prescription spend and utilization in Ohio
- Decrease in ambulatory sensitive admits/1,000 and inpatient readmission rate in Ohio

Anthem

*CO results not yet available

Anthem Participation in CMS State Innovation Models (SIM) Initiative



Universe of Government VBP Programs

- **Centers for Medicare and Medicaid Services (CMS)**
  - Develops the tools necessary to create approaches to lessen healthcare cost growth and to identify and encourage high quality, cost-efficient care delivery patterns.
- **Centers for Medicare and Medicaid Innovation (CMMI)**
  - Innovation Model categories include- Accountable Care, Episode Based Payments, Primary Care Transformation, Medicaid and CHIP population initiatives, Medicare-Medicaid Population Initiatives, Best Practice Adoption Initiatives, and Initiatives that Accelerate the Development and Testing of New Payment and Service Delivery Models.
- **Medicare Access and CHIP Reauthorization Act (MACRA)**
  - Reforms Medicare payment policy for physician services, linking physician payment updates to quality, value measurements, and participation in alternative payment models.

- Sub-specialties within primary care (e.g. Pediatrics) need curriculum modifications tailored to their patient populations
- The community resources available to providers will vary from state to state
- Everyone wants standardization… until you try to standardize.
- How to create incentives for providers who are already highly successful in driving toward *The Triple Aim*
- Global cap should focus quality and access *as well as cost* - Beware of the cost only focus of the 90's
- Change is hard: groups will question whether transformation is really a necessary component of transformation

A Look Forward

Program Evolution and Expansion

2015
Increased market penetration of Value Based Contracting

2016
Groups moving to risk based contracts

2017
Broader launch of Specialty Program

Anthem
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Staff VP, Care Delivery Transformation
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Questions ?

Case Studies

CASE STUDY:

Transformation in Action

Forum Family Medicine

Aurora, Colorado

PRACTICE DEMOGRAPHICS

2 MD's 1 PA

primary care providers

9

Total exam rooms at one location

(2 Pediatric, 7 Adult)

1 of 65

part of a large loosely organized PHO

646

attributed members

Devoted to Improvement and Patient-Centered Care

- Identified a team member to take on care coordination and practice transformation efforts
- Care Coordinator worked hard for entire practice team to buy into the power of quality improvement, transformation, and patient centered care
- Completed Diabetes MOC Self-Evaluation of 10 charts within the Practice Advisor which identified significant gaps in their processes
- Listened to Learning Collaborative recording on *Diabetes Care – Key Essentials*
- Utilized Merck Conversation Map with newly formed diabetes group for patients
- Regular meetings with Anthem team
- Shared the practice success at the Colorado face to face learning collaborative and inspired others to implement small changes for big impacts

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CASE STUDY:

Managing Diabetes Care

Forum Family Medicine

Aurora, Colorado

The problem …

Poorly defined processes

Patients with little understanding of condition

Little knowledge of patient barriers

Resulting in….

"patients falling between the cracks…"

"high number of uncontrolled diabetic patients…"

"lower quality scores on EPHC program scorecard…"

GOAL:

*Implement a registry to track diabetic care and processes to improve care resulting in **10%** increase in EPHC Scorecard Diabetes Subcomposite by **Q3 2014***

400+ patients in population carried diabetes diagnosis

Patient Impact:

- Patient with A1c of 6.6 at last yearly visit
  - ✓ Care Coordinator outreached patient, who reported he was unaware he had diabetes
  - ✓ Scheduled for visit and screening - A1c was 11.2
  - ✓ Provided education, medication, Follow up plan in place
- Newly diagnosed patient with A1c of 6.5
  - ✓ Care Coordinator reviewed diabetes handout
  - ✓ Patient decided to use diet and exercise to decrease A1c and manage his diabetes.
  - ✓ After 2.5 months A1c dropped to 6.0

CASE STUDY:

Education and Workflow Processes

Forum Family Medicine

Aurora, Colorado

Created QI team with clinical leadership buy in

Built diabetes registry using Anthem provider toolkit

Created a educational handouts informing patients about diabetes and self care

Referred newly diagnosed patients to care coordinator

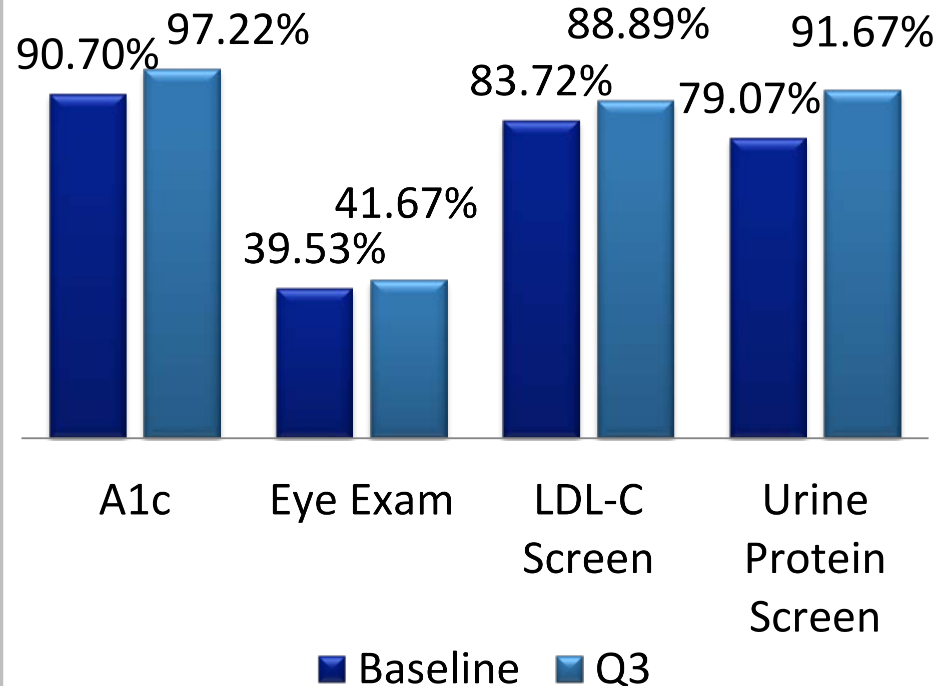
Update workflows to ensure screenings are completed prior to planned diabetic visits

Utilized mail, telephone and patient portal to outreach patients about needed screenings

Remove socks and shoes posters hung on doors in exam rooms

By Third Quarter, 2014:

- Overall Scorecard improved **14.34%**
- earned **100%** on Diabetes Sub-Composite
- **20%** improvement in Diabetes LDL Screening
- Reported completion of foot checks increased from 25% to **75%***



For Discussion –next steps with Forum Family….

1. Tracking patients with A1c of greater than 10 and creating action plans with potential referrals to Anthem DM/CM programs.
2. Developing an internal system for providing care management services to high risk diabetic patients
3. Continue to fine tune workflows for scheduling planned diabetic visits and ensuring patient screenings are completed according to evidence based guidelines.

CASE STUDY:

Transformation in Action

Riverdale Family Practice
Bronx, New York

PRACTICE DEMOGRAPHICS

11
primary care providers

22
exam rooms at single practice location

1,287
attributed members

Technologically savvy

- Level III PCMH status by the NCQA
- Clinical "HEALOW" app allows patients to review appointments, RX, provider messages, lab results
- Web-based Clinical Decision Support System to help ID high-risk patients
- Staff use eClinical Mobile to send telephone encounters, check schedules and messages, register new patients

Committed to access and patient-centered care

- Open access protocol: patients seen same-day without appointment
- Extended hours: 8:00 am – 8:00 pm Monday-Friday; urgent care on Saturday

CASE STUDY:

Emergency Room Visits

Riverdale Family Practice
Bronx, New York

The problem *isn't* access…

Riverdale offers **Extended Hours**

Practice offers **Open Scheduling**

…it's
Perception:

"The ER is **more convenient…**"

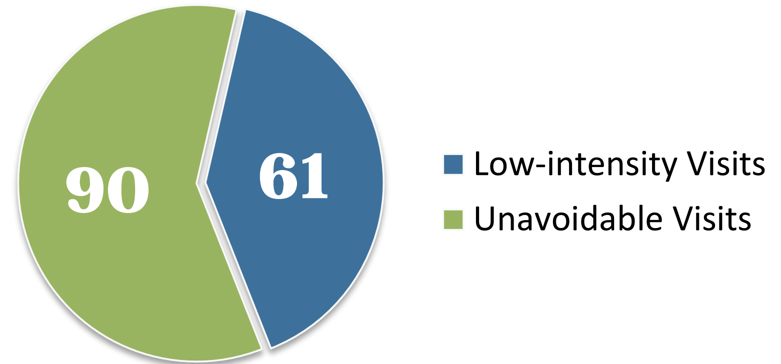
"There **won't be a doctor** available…"

"The ER is **faster**; the **care is better…**"

GOAL:

Reduce potentially avoidable ER Visits
10% by December 31, 2014

Despite Expanded Access, patients still misuse and overuse Emergency Room



Riverdale patients ED visits; n=151 October 2012-September 2013

Examples of Low-Intensity Dx

Code	Description
7820	DISTURBANCE OF SKIN SENSATION
7245	UNSPECIFIED BACKACHE
7840	HEADACHE
7862	COUGH
0340	STREPTOCOCCAL SORE THROAT
7821	RASH&OTH NONSPECIFIC SKIN ERUPTION

CASE STUDY:

Education and Communication

Riverdale Family Practice

Bronx, New York

Educate providers on avoidable ER diagnoses

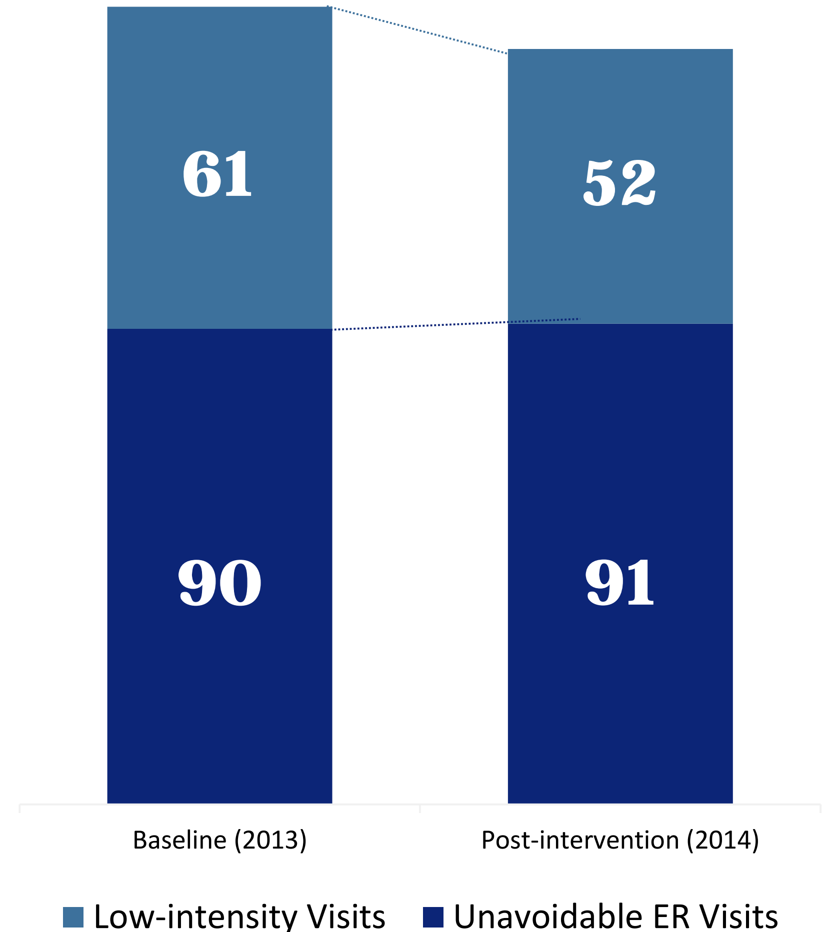
Create posters to hang in all exam rooms

Survey patients about ER usage

Update website with extended office hours

Email blast for patient outreach

Create ER tracking registry



Diabetes Management

Southern New Hampshire Internal Medicine
Londonderry, NH

Practice Demographics	Where Do We Begin?
Independent Internal Medicine Practice	Diabetes top chronic condition in practice
2 practice locations	Diabetes top chronic condition on hot spotter
15 primary care providers	Limited understanding of PCMH model
34 clinical staff	No care management of high risk members
2, 132 attributed members	No chronic condition registries
	In transition to EMR integration (75% integrated)

Medical Record Review: 10 Hot Spotter Diabetic Patients-April 2013

Patient Care Findings

- 8 of 10 had an AIc > 7, 3 of these > 9
- 9 of 10 had past due DRE
- 5 of 10 with uncontrolled b/p's (>140/90)
- 6 of 10 had BMI > 25 and 3 of these > 30
- 2 had not had a routine care visit in over a year

Care Workflow Findings

- No standardized comprehensive assessment in care visit template for: diet, weight, medication management, smoking, behavioral/mental health screening, self-management, symptom recognition.
- Gaps in scheduling routine follow up
- No consistent referral tracking process

Goals

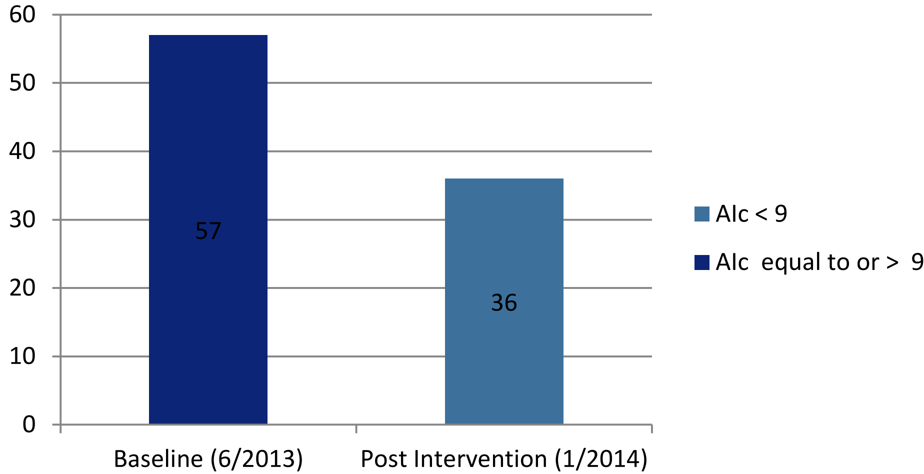
Reduce AIc for 50% of our patients with AIc $\geq$ 9 in 6 months

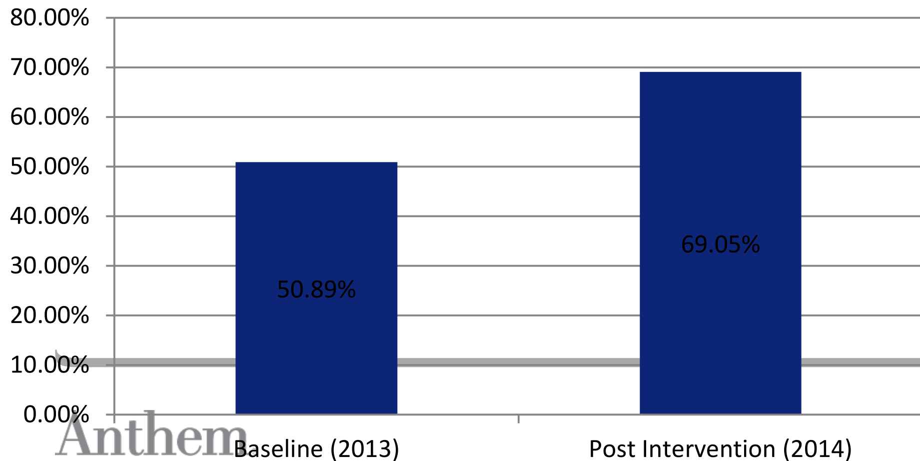
Increase DRE rate 15% by March 31, 2014

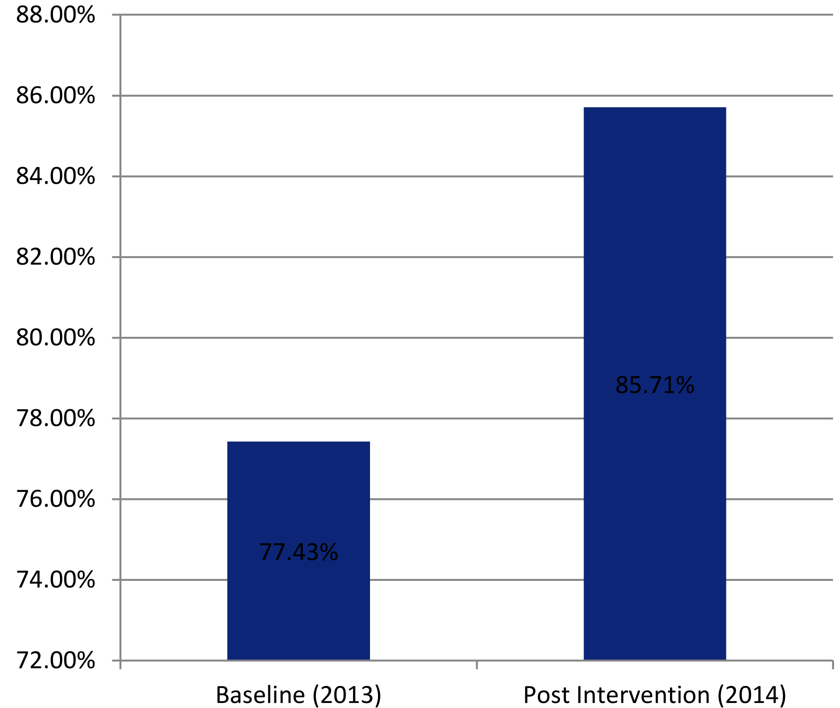
Increase diabetes care rate to meet level 4 by March 31, 2014

What We Did

- Create diabetes registry
- Develop Focused Diabetes Intervention Program to target: (high intensity care management)
  - Hgb AIc > or equal to 9.0
  - Hot spotter patients
  - Direct Referral by provider
  - Patient/Family request
- Develop diabetes care plan
- Develop diabetes patient education/self-management care sheet
- Created care compact with primary referring eye care provider
- Developed referral tracking protocol
- Active outreach to all diabetic patients with open past due gaps per care op report- focus DRE







Level 3 market benchmark = 74.87% Level 4 market benchmark = 79.20%

Performance scorecards set market benchmarks for practice performance measure targets. These benchmarks are represented by levels 1-4 and indicate a percentage achieved for a composite measure.
Level 1 = 30% achievement Level 2 = 50% achievement
Level 3 = 70% achievement Level 4= 100% achievement

Note: Practice baseline performance in diabetes care composite measure is **86.03%** (level 3) for this measurement period (4/1/15-3/31/16). Level 4 is set at 87.35%

Anthem