



Advancing Primary Care and Changing Reimbursement

Blue Cross Blue Shield
North Dakota

June 11, 2008

Summary of a Provider Based Disease
Management and Advanced Medical Home
Concept

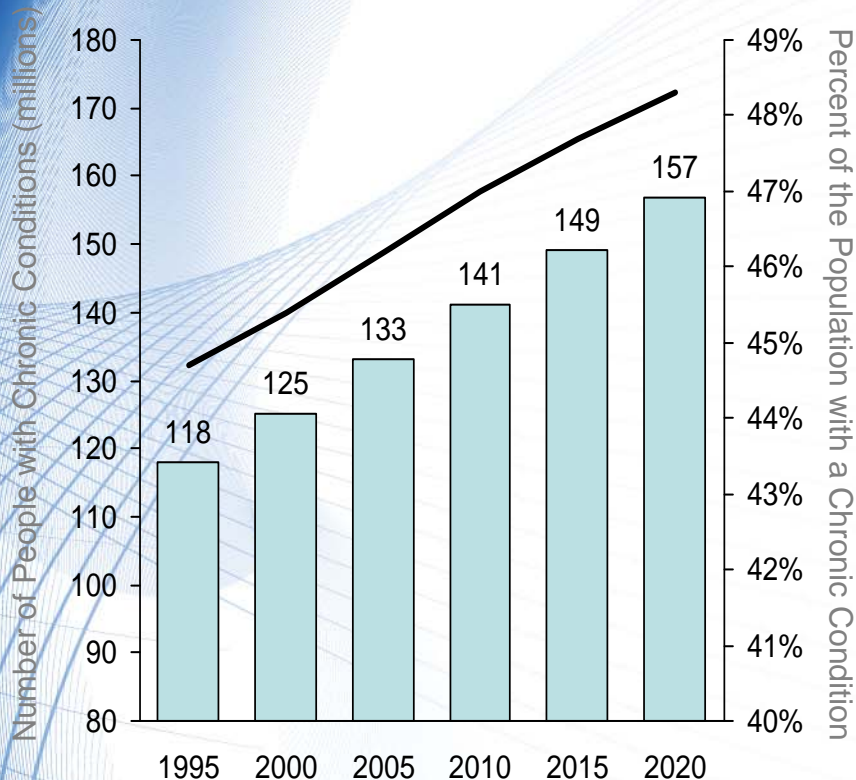


The Problem



More than 130 million Americans suffer from chronic conditions – this will increase in the future, further increasing costs

Prevalence of Chronic Conditions



Cost of Specific Chronic Conditions

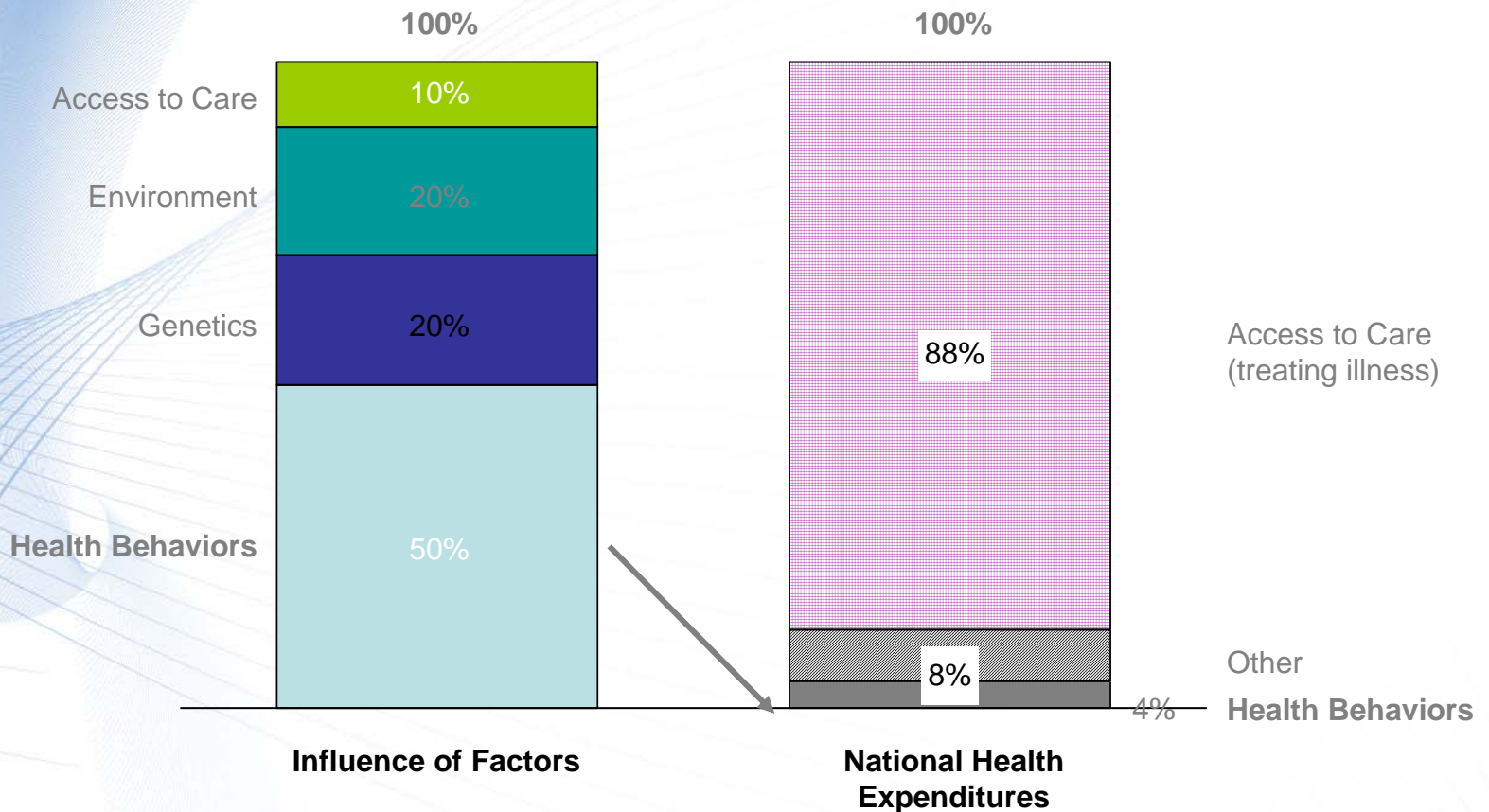
Chronic Condition	Prevalence	Annual Cost
Cardiovascular Disease	80MM	<ul style="list-style-type: none"> • \$283BN of direct healthcare costs • \$149BN in indirect costs/ lost productivity
Diabetes	18MM	<ul style="list-style-type: none"> • \$92BN of direct healthcare costs • \$40BN in indirect costs/ lost productivity
Asthma	~20MM	<ul style="list-style-type: none"> • \$20BN, including direct healthcare costs and indirect costs/ lost productivity (includes asthma and allergies)
Depression	~20MM	<ul style="list-style-type: none"> • ~\$100BN of direct healthcare costs (across all mental illnesses) • ~\$100BN in indirect costs/ lost productivity (across all mental illnesses)

Source: Wu, Shin-Yi, and Green, Anthony. *Projection of Chronic Illness Prevalence and Cost Inflation*. RAND Corporation, October 2000; American Heart Association, Centers for Disease Control (CDC), American Diabetes Association (ADA), Asthma and Allergy Foundation of America (AAFA), National Alliance on Mental Illness (NAMI); *Disease Prevalence and Economic Impact 2007* R. Miller, Booz Allen Hamilton analysis



There is a greater focus on factors that influence health, particularly on health behaviors where investment has traditionally been low

Factors that Influence Health Status Versus Health Spending



Sources: Centers for Diseases Control and Prevention, University of California at San Francisco, Institute for the Future. Reprinted from *Advances*, Robert Wood Johnson Quarterly Newsletter, 2000; 1:1



A Solution



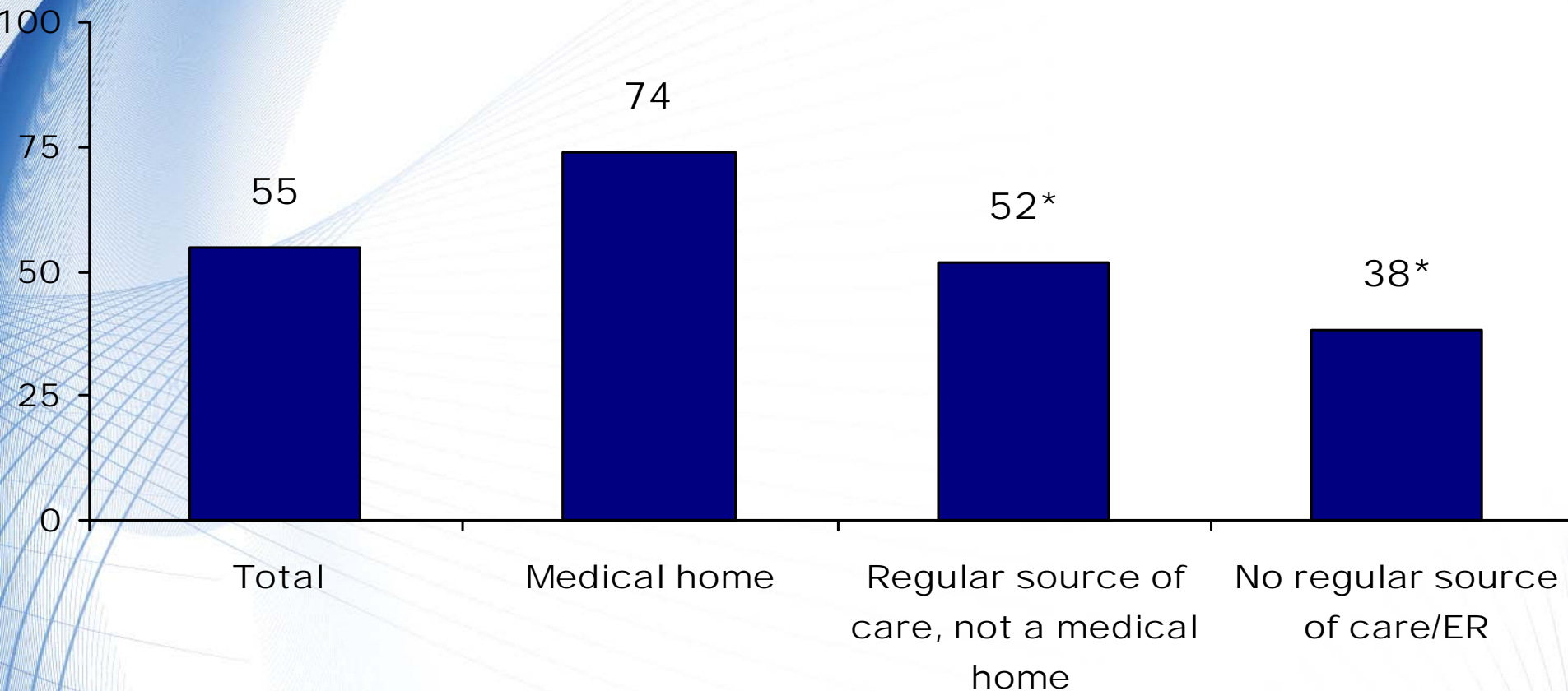
Advanced Medical Home

- Multiple, varied definitions. In essence:
 - A medical practice that is able to provide appropriate, evidenced-based medical care to a patient in a longitudinal fashion that meets the needs of all parties involved whilst providing high quality care and improved outcomes in a cost effective manner. This process is supported by a strong reliance on accurate, actionable data at the point of care, in order to deliver the desired outcomes.



The Majority of Adults with a Medical Home Always Get the Care They Need

Percent of adults 18-64 reporting always getting care they need when they need it



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.

* Compared with medical home, differences remain statistically significant after adjusting for income or insurance.

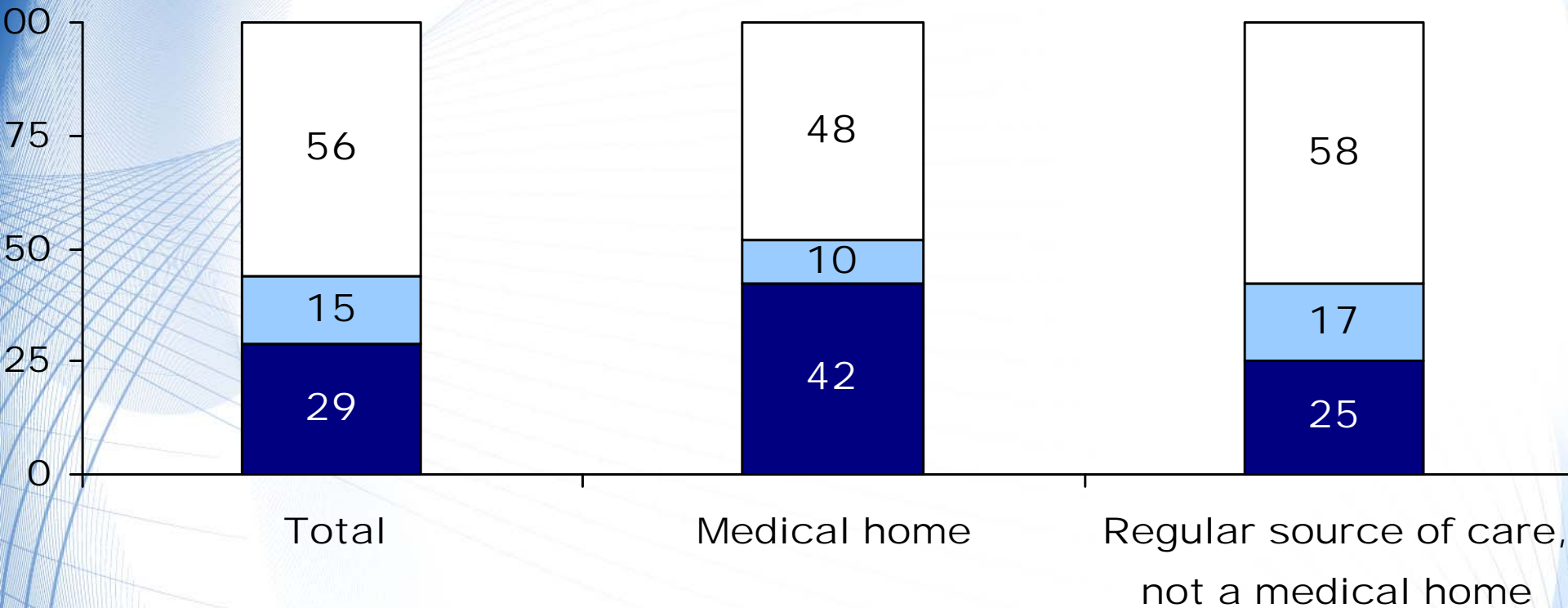
Source: Commonwealth Fund 2006 Health Care Quality Survey.



Adults with a Medical Home Are More Likely to Report Checking Their Blood Pressure Regularly and Keeping It in Control

Percent of adults 18-64 with high blood pressure

- Does not check BP
- ▒ Checks BP, not controlled
- Checks BP, controlled



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
Source: Commonwealth Fund 2006 Health Care Quality Survey.



Our Experience



Provider Community in North Dakota

- 50% of physicians are Primary Care Providers (PCP's)
- 80% of PCP's work for 6 large multi-specialty Group Practices in North Dakota.
- Physician turnover in State < 5% annually- thus stable, committed PCP Population.
- Much of state is rural and underserved.
- 1,600 Providers in North Dakota.
- 6 Large hospitals in 4 urban areas, rest smaller rural hospitals (20 beds or less)



MeritCare Health System

- Multi-specialty, fully integrated network of 37 clinics and two hospitals in South-eastern ND and NW Minnesota.
- Largest Group Practice in North Dakota.
- Employs 429 Physicians, 182 Mid-level Practitioners.
- Internal Medicine Division 58 physicians in Fargo/Moorhead- dedicated ambulatory IM Physicians.
- Dedicated Hospitalist Program (20 IM Physicians)



Diabetes Project

- IM Department Agrees to change paradigm of care from predominantly episodic to planned with use of Disease Management Nurse(DMN).
- BCBSND provided \$20,000 start-up funds to partially fund DMN at study site.
- Control site established with “care as usual”
- Agree on patient enrollment criteria, quality measures, and outcome measures.
- Project duration 12 months.
- Project initially conceptualized as a Physician Directed, PCP-based Diabetes Disease Management Program.



Financial Arrangement

Calculate expected total health care costs per eligible member based on previous years health care cost + health care cost increase trend (9.5% 2005 vs. 2004)

- Measure total health care cost per eligible member in study for year preceding the study year as well as study year.
- Determine difference in expected vs. actual total health care costs during the study year (minus outliers – defined as total costs >\$50,000 per year)
- Compare actual costs of study group with costs of risk-adjusted control group during the study year and with inflation adjust prior year cost.
- Share 50% of difference in cost savings with Healthcare System.

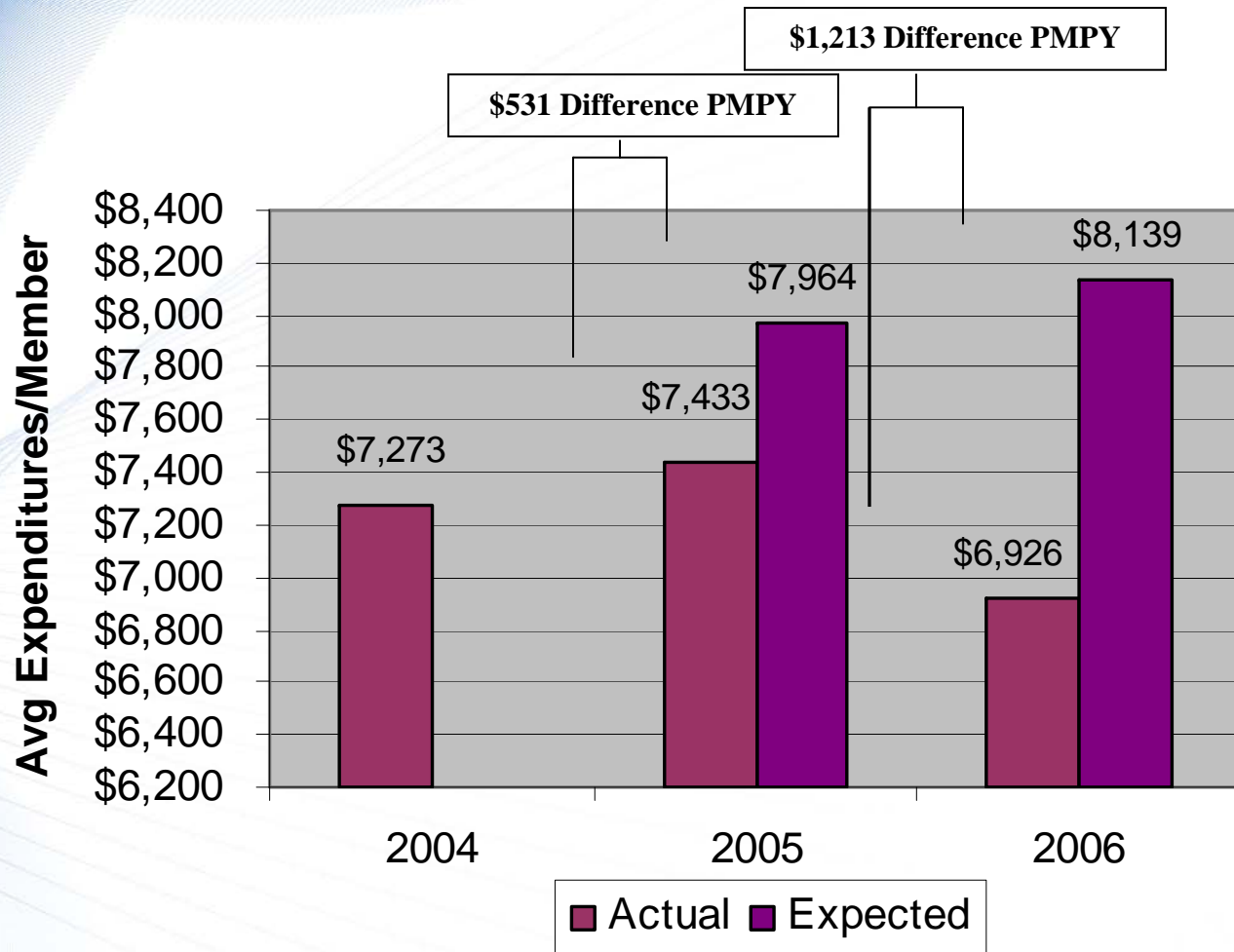


Results

- Diabetes care measures improved compared to prior year and control group
- Decrease in ER visits
- Decrease in inpatient claims
- Per member savings of \$500 PMPY



Study Population Average Savings per Member Calculation



Overall Savings:

2005: $\$531 \times 192 \text{ members} = \$101,940$

2006: $\$1,213 \times 192 \text{ members} = \$232,923$



Lessons Learned

- PCP's are able to provide longitudinal, patient-centered, evidence-based, cost-effective care with improved outcomes when the following conditions exist:
 - Paradigm shift from episodic to long-term longitudinal care.
 - Shift from individual to Team-based Care
 - Focus on evidence-based care vs. opinion/tradition.
 - Redesign of the Medical Practice
 - Total Practice Management
 - Strong Financial Support via reimbursement and incentives
 - Robust, relevant, actionable data at Point-of-Care.
 - PCP commitment to generate, trust, and utilize data to drive change
 - BCBSND Medical Policy change to support process.
 - Cost savings to health plan significant.



Phase Two



Expand Original Project

- Added 2 additional IM groups
- Added a Family Practice group
- Expanded disease focus
 - Diabetes
 - Coronary Artery Disease
 - Hypertension
- Up-front Disease Management Fee plus savings sharing



Current Project

- Two year study
- Started October 1, 2007
- Anticipated enrollment 2,000 chronic disease patients
- Enrollment to date – 942 patients with 29 different providers



Phase Three



Statewide Advanced Medical Home

- Invite all Primary Care providers
- Provide a Quality Summary tool for the providers
- Providers to share Quality Data
- Allow a Disease Management Fee
- Target Chronic Disease and Prevention



What is required for an AMH to function?

- Cooperative relationship between the health care team and the patient.
- Longitudinal care as opposed to episodic care.
- Absolute focus on primary prevention.
- Competency in secondary prevention.
- Active management of referrals to specialists.
- Commitment to acting as the patient advocate in navigating the complexities of the health care system.
- Commitment to medical quality processes and data sharing in order to continually improve the care process.
- Financial and policy support of AMH functionality development and maintenance.



Clinical Suite Exam

Data is analyzed against evidence-based guidelines, and the reports are accessed via the Care Center web portal.

Diabetes:

A1C
LDL
Microalbumin
Retinal Exam
Blood Pressure

Asthma:

Daytime Symptoms
Nighttime Symptoms
Mild Intermittent
Mild Persistent
Moderate Persistent
Severe Persistent
Asthma Medications

Childhood Immunizations:

Diphtheria, Tetanus, Pertussis (DTaP)
Inactivated Poliovirus (IPV)
Measles, Mumps, Rubella (MMR)
Haemophilus influenzae type b (HIB)
Hepatitis B (HEP-B)
Varicella-Zoster Virus (VZV)
pneumococcal conjugate

Cancer Screenings:

Breast Cancer Screening:
Mammogram
Cervical Cancer Screening:
Pap test
Colorectal Cancer:
Fecal occult blood test (FOBT)
Flexible sigmoidoscopy
Double contrast barium enema (DCBE)
Colonoscopy

Hypertension:

Blood Pressure



- Comprehensive
- Longitudinal
- Efficient
- Better Care
- Supports and Encourages Primary Care