

Partners In Care

Summary Highlights of the PIC Horizon SHBP Pilot program.

The Goal: To improve the health of patients with chronic conditions and lower health care cost trends through active Care Coordination guided by the patient's physician while facilitating the development of that capability in transforming Patient-Centered Medical Homes.

- Annual costs for the initial and expansion Phases of the Pilot Program continue trending downward – inclusive of program costs; and at a rate greater than the comparative SHBP Population.
- Bill Marino, President and CEO of Horizon BlueCross BlueShield of New Jersey, quoted these metric improvements and endorsed the program in a speech at the National Press Club in April, 2009:

"Preliminary results for the select metrics were eye-opening...Clearly had a dramatic effect on clinical metrics compliance."

Initial Pilot	Jan '07	Jan '08
HbA1c Testing Compliance	60%	92%
LDL Testing Compliance	33%	88%

Expanded Pilot	Jan '08	Dec '09
HbA1c Testing Compliance	48%	73%
LDL Testing Compliance	48%	72%

"A reduction in health care costs of 12% even when including the increased reimbursement"

"The result for patient compliance [in the expanded pilot] was almost as impressive as the initial population" "Overall health care costs for all patients had decreased almost 10% over the course of the year."

"The sample was relatively small but valid and it is clear that the Patient-Centered Medical Home shows great promise for improving patient's health and dramatically saving health care costs."

- An opportunity is emerging to impact those patients with more than 25 providers. It is extremely difficult for PCMH alone to coordinate care for a patient with between 25 and 80 providers.

Phase 1 Diabetics with 25+ providers: Costs of Care Down Clinical Metrics Up
Statewide Diabetics with 25+ providers: Costs of Care Up Clinical Metrics Down

- Statewide, there are over **28,000 Diabetics with more than 25 providers** over four years and their Clinical Compliance Rates are less than half of PIC's Pilot:

HbA1c process: 35% vs 89% LDL Process: 43% vs 79%

- Managing these 28,000 Diabetics at the rate of savings of the PIC Pilot Program could yield an annual savings of \$65,000,000 after program costs.

- HYPERTENSION: 20% of the people in the United States has the diagnosis:
 - In the NJSHBP over 40% are hypertensive – DOUBLE the national average

- Total overall costs, inclusive of Care Coordination charges, of the Hypertensives in the PIC Horizon CCE program are \$950,000 less than expected (or \$19 per participant per month) when compared to the overall SHBP population (\$850,000 for the two years of Phase 1 and \$100,000 for the first year of Phase 2).

- The rate of Inpatient Admissions is 2.4% lower than expected:
- The rate of Strokes is 10.8% lower than expected:
- The Heart Failure rate is 15.2% lower than expected:

Partners In Care

- The rate of Kidney Transplants is 100% lower than expected:
- The rate of Amputations is 23.1% lower than expected:

- Clearly, while financial savings are necessary and positive, the avoidance of suffering and pain associated with 859 fewer strokes, 997 fewer cases of Heart Failure, 52 fewer Kidney Transplants, and 39 fewer limb amputations far exceed the value derived in pure financial terms.

- Nationally, 29% of hypertensive patients have their blood pressure under control:
 - 47% of the Phase 1 patients are under control
 - 45% of the Phase 2 patients are under control
 - 60% - 65% of the patients in the top two CCE medical homes are under control.

- If the full savings achieved by the Phase 1 and Phase 2 programs are extrapolated successfully to the entire population of 225,147 Hypertensives in the SHBP, the annual savings could reach \$25-\$50 million per year on this disease alone. These savings estimates are based upon actual performance of the pilot.

- Many of the diabetics are hypertensive – adding to the need for active Care Coordination, however it makes accurately forecasting overall savings numbers difficult. For these purposes we are not considering the \$65 million for the diabetics with more than 25 providers and the \$25 - \$50 million for the Hypertensives to be additive.

- PIC's CCE Program has served over 8,000 Members of the Horizon SHBP population since inception. Participants include 5 PIC Medical Directors, 15 PIC Clinical and Administrative Staff and Physicians and Staff of over 524 PCMHs who generated the following:
 - 61,480 Contacts by PIC with over 12,535 hours invested
 - 32,013 Contacts by Providers with over 4,698 hours invested
 - \$524,521 Paid to Providers (through March 2009)
 - 5,701 Patients Touched (99% of the current members for Phase 01 and 02)
 - 524 PCMHs Involved

- PIC has implemented a full scale certification process for practice transformation via the Patient Centered Medical Home (PCMH).
 - PIC staff is assisting practices with Applications, Survey Tool completion and submission. PCMH Application Fees will be paid from CCE proceeds
 - The Center For Family Medicine (4 physicians) was the first PIC practice achieve NCQA certification. Several more are in process. Some are also in the NJAFP pilot.

- PIC has gained a great deal of knowledge from its Pilot, key factors include;
 - Lack of existing infrastructure within the physician practices prompted a greater interim role for PIC in data collection and chart review
 - Data intake, processing, and actionable information delivery to the PCMHs proved crucial to the program's success
 - Practices have been slow to make changes in workflow/processes unless there is critical mass within a PCMH, but are more likely to respond to collaborative care coordination outreach by physician organizations.
 - The program is most effective when clinical metrics, based upon national guidelines, are frequently reported back to PCMH