2019 National Alliance Annual Forum

Employers driving innovation, health and value

November 11-13 | Washington, DC

#NatAllForum

eValue8 Showcase: Best Practices for Health Plans & PBMs

November 12| 3:30 - 4:25 PM ET

Jenifer Curry
Manager Clinical Programs
Regence BCBS

Allison Hess
Vice President, Health Innovations
Geisinger

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Vice President - Medical Affairs
Health Net - Centene

Allison Emery
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Kaiser Permanente Washington

A National Vision To Improve Diabetes Health Outcomes Using Food As Medicine

Fresh Food Farmacy™
Geisinger

GEISINGER:
An integrated health system

We care for patients

- 11 hospital campuses
- 253 clinic sites
- 3,000 providers

We provide quality, affordable healthcare coverage

- 578,000 members
- 55,000 contracted providers/facilities

We teach, research and innovate

- 523 MBS/MD students at GCSOM
- 48 GLH School of Nursing,
  2,000+ other nursing students
- 505 residents/fellows
- 1,000+ active research projects

Geisinger

Diabetes – A national call for help

Population Health Impacts

2018 → **2050**

1 in 10 Adults With Type II Diabetes

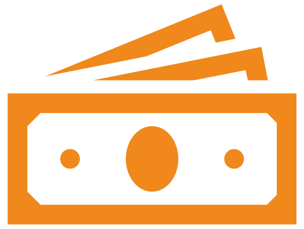
1 in 3 Adults With Type II Diabetes

HBA1c of 6.5-9
1 in 5 are food insecure[2]

HBA1c >9
1 in 4 are food insecure[2]

Financial Impacts

Diabetes has highest healthcare spend[4]



$327 billion / year
Diagnosed diabetes cost to America[3]

2.3 times greater
Cost of healthcare with diabetes compared to without diabetes[3]

[1]Diabetes Statistics Report, 2014
[2]Berkowitz SA, Baggett TP, Wexler DJ, Huskey KW, Wee CC. Food insecurity and metabolic control among U.S. adults with diabetes. Diabetes Care. 2013;36:3093-3099
[3]ADA Website
[4]US Spending on Personal Health Care and Public Health, 1996–2013," JAMA, 2016

Making Tough Choices That Affect Health

Feeding America's clients report that their household income is inadequate to cover their basic household expenses.

69%

HAVE HAD TO CHOOSE BETWEEN PAYING FOR UTILITIES AND FOOD

67%

HAVE HAD TO CHOOSE BETWEEN PAYING FOR TRANSPORTATION AND FOOD

66%

HAVE HAD TO CHOOSE BETWEEN PAYING FOR MEDICINE AND FOOD

57%

HAVE HAD TO CHOOSE BETWEEN PAYING FOR HOUSING AND FOOD

Sources: Map the Meal Gap (2014) and Hunger in America (2014)

CENTRAL PENNSYLVANIA FOOD BANK
No One Should Be Hungry

Innovative collaboration between clinical care and community based organizations – New processes driving impactful change

CENTRAL PENNSYLVANIA FOOD BANK

No One Should Be Hungry

+ Geisinger → Fresh Food Farmacy™

How did we rethink our processes

A new model with 5 basic elements.

1. Identification
2. Food as medicine
3. Education/Clinical support
4. Care beyond health
5. Community partnerships

The Current Patient Experience - Meet Rita

Rita

Age 55

Condition(s) Diabetes

About Rita
- Married
- Raising her 3 grandchildren
- Has been underinsured and uninsured over the last few years

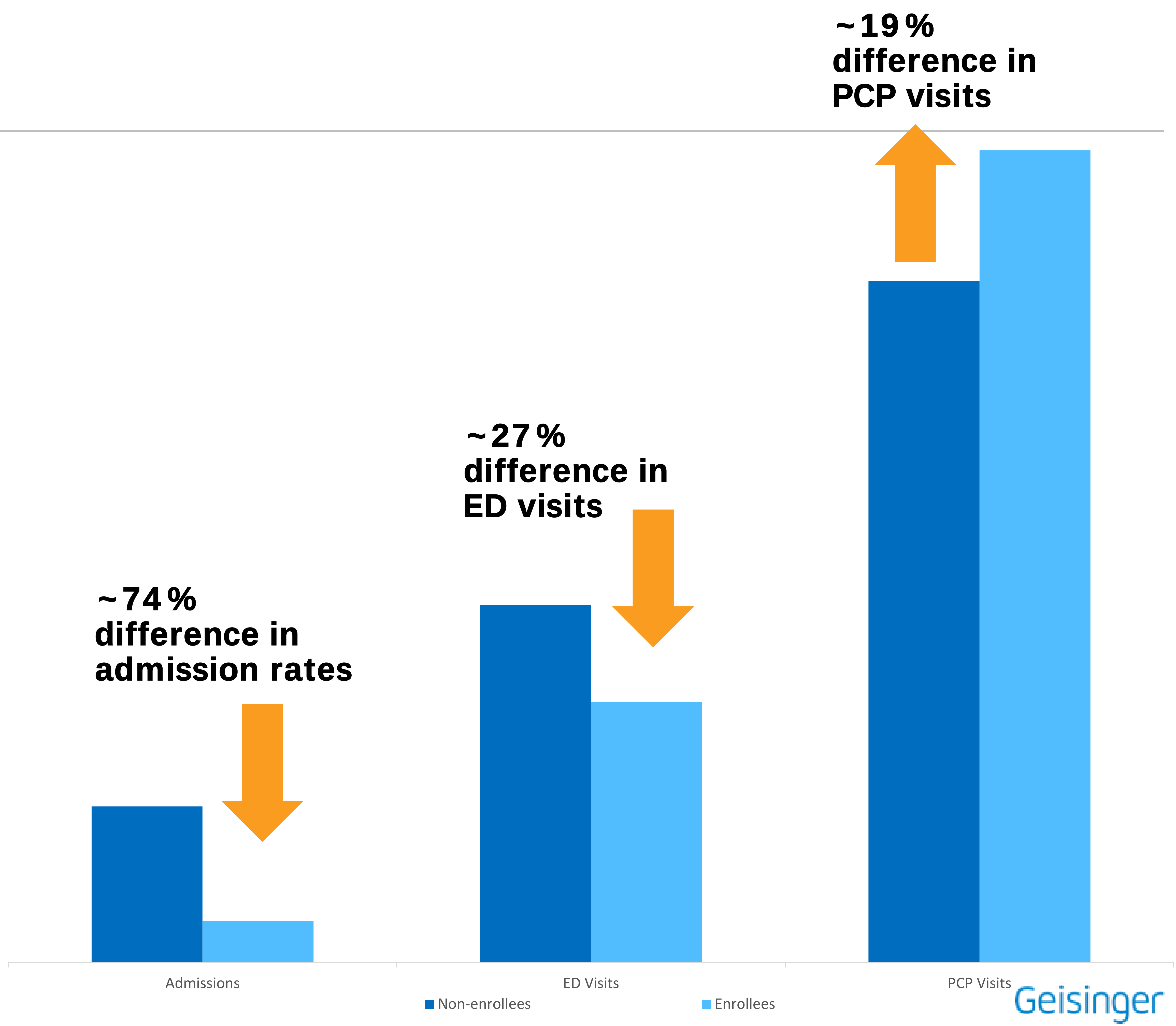
Enrolled in Fresh Food Farmacy → Worked with Case Manager on diet & exercise management → Began regularly checking sugars, watching diet, & walking for exercise

13.8 A1C
181 lbs.
209 LDL
312 Triglycerides

6.9 A1C
165 lbs.

5.4 A1C
135 lbs.
47 LDL
76 Triglycerides

FOOD AS MEDICINE IS HAVING A REAL FINANCIAL IMPACT



Geisinger

Fresh Food Farmacy- Patient reported outcomes

- **What is the most valuable part of the client-choice option?**
  - "One of the most valuable parts for me is the trust that is placed with you when choosing the appropriate number of items. You can also choose which food items you will use during the following week. I also like to try the recipes because they are very healthy and taste good too."
  - "It makes me feel more a part of the program"
  - "Being more involved with my food choices"
  - "That my family is eating healthier now"
  - "Being able to get my items myself, especially if is a busy day for the staff, makes for less wait times"

Fresh Food Farmacy- Patient reported outcomes

Overall health and mental / emotional health					
	Excellent	**Very good**	**Good**	**Fair**	**Poor**
Overall health **before** starting FFF (n = 106)	5.7%	5.7%	21.7%	50.0%	17.0%
Overall health **currently** in FFF (n = 106)	10.5%	30.5%	49.5%	8.6%	1.0%
Overall mental/emotional health **before** starting FFF (n = 106)	7.5%	9.4%	26.4%	46.2%	10.4%
Overall mental/emotional health **currently** in FFF (n = 105)	11.4%	43.8%	34.3%	10.5%	0.0%

Diet						
	More than once a day	**Once a day**	**Once every few days**	**Once a week**	**Less than once a week**	**I didn't eat fruits / vegetables**
Frequency of fruits or vegetables (not including juice) eaten **before** FFF (n = 106)	9.4%	17.9%	19.8%	20.8%	27.4%	4.7%
Frequency of fruits or vegetables (not including juice) eaten **currently** in FFF (n= 106)	47.2%	34.9%	11.3%	5.7%	0.9%	0.0%

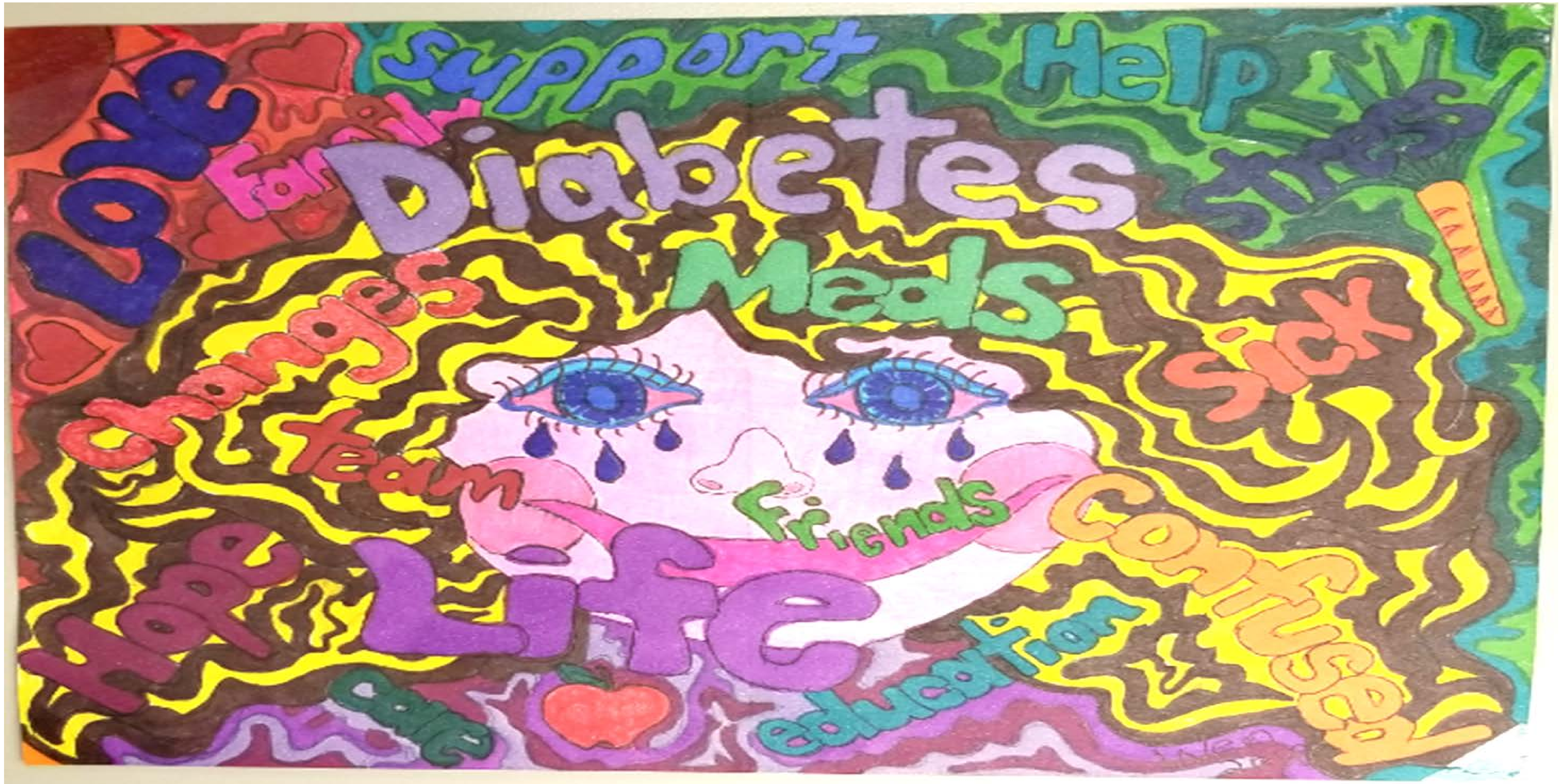
Geisinger

Fresh Food Farmacy- Patient reported outcomes

	Physical activity		
	Purposely exercise	**Housework / yardwork**	**Not active / sedentary**
Activity **before** FFF (n = 102)	12.7%	53.9%	33.3%
Activity **currently** in FFF (n = 95)	45.3%	48.4%	6.3%

Geisinger

Patient expression of impact



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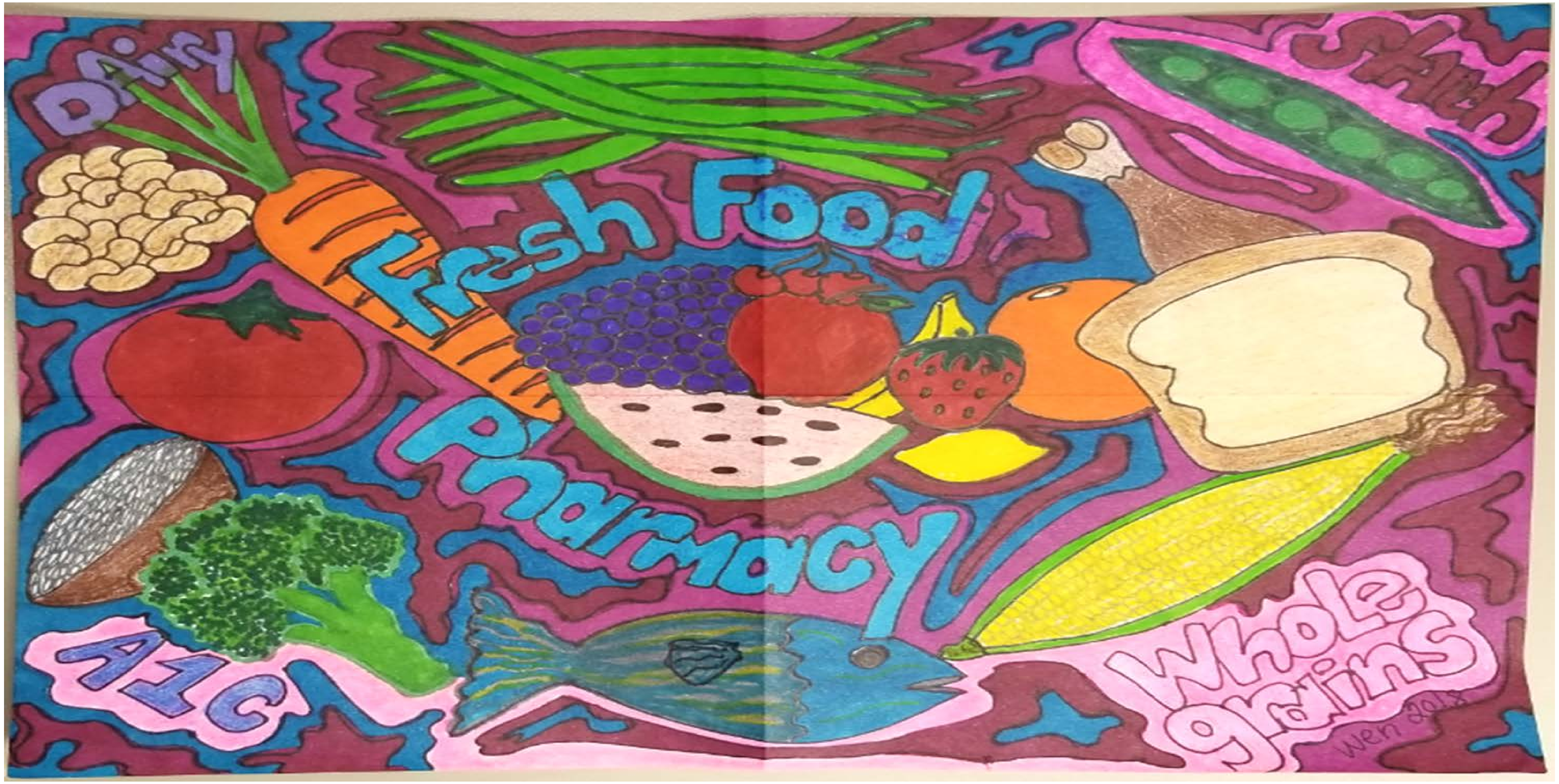
Patient expression of impact

Geisinger

Patient expression of impact



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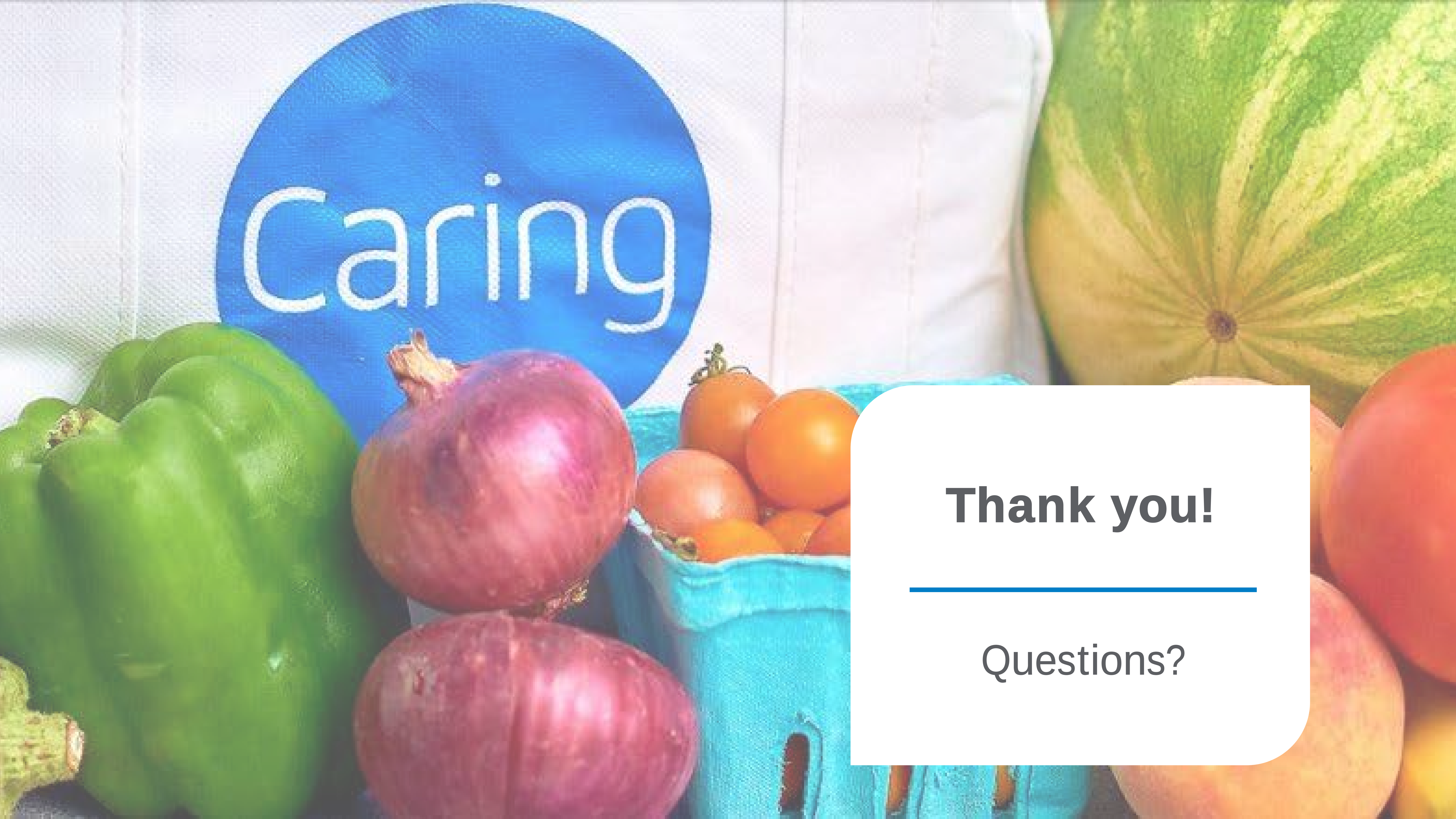


Thank you!

Questions?

SHAPE: Stroke and Heart Attack Prevention Every Day

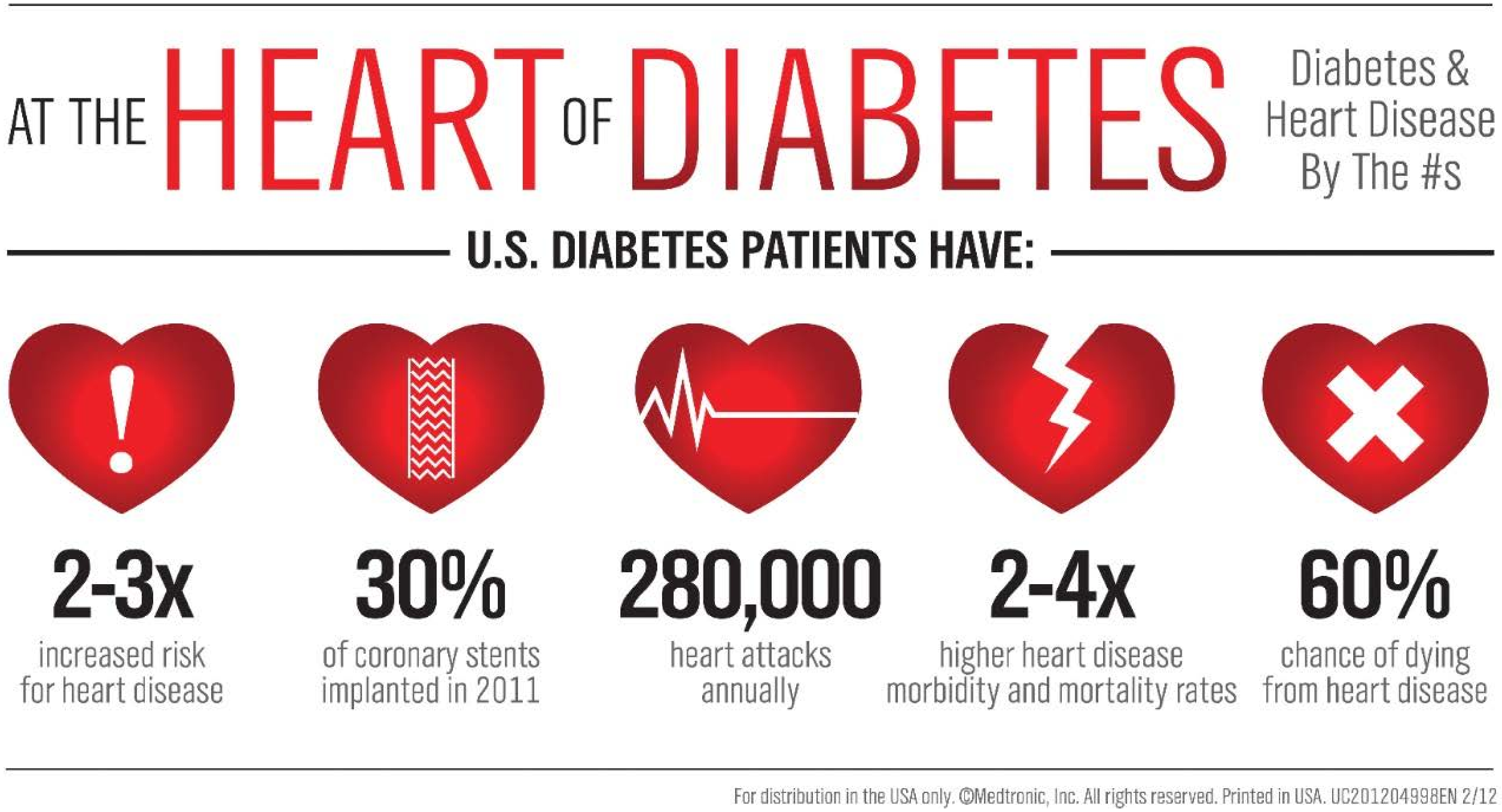
eValue8 Showcase: Best Practices for Health Plans and PBMs

for the National Alliance of Healthcare Purchaser Coalitions

Jean Shahdadpuri, MD, MBA
Health Net of California
November 12th 2019

Coverage for every stage of life™

Diabetes and Coronary Artery Disease



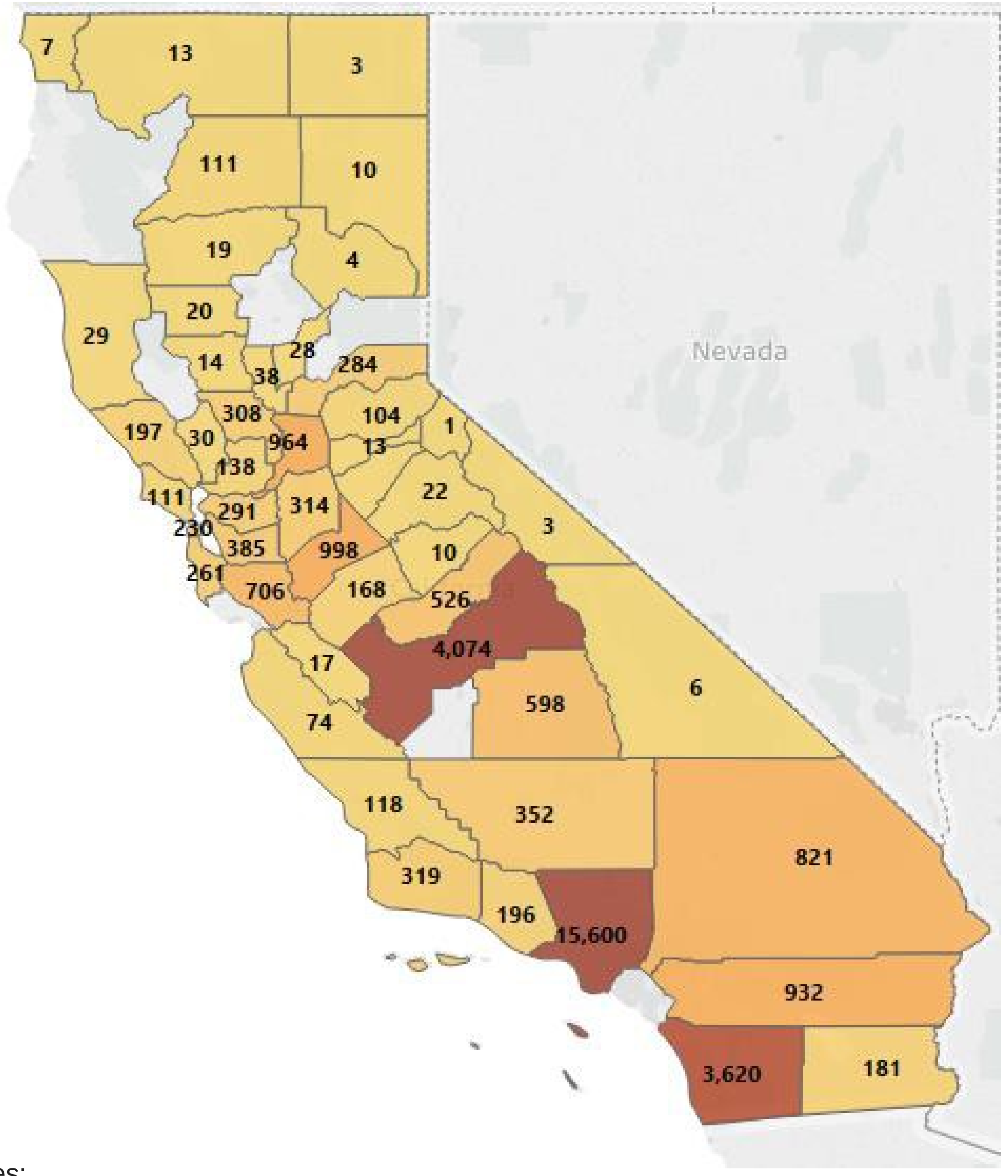
- Over 80% of all Diabetes-related coronary event spend is attributed to members with both Hypertension and/or Coronary Artery Disease.
- 183,000 members with DM with history of CAD and hypertension. The cardiovascular spend is about half of the total spend. Out of this population, only 27% was on the cardio-protective bundle.

Notes:
Spend and member figures based on all members with spend at each respective facility from July 1, 2015 to March 31, 2016 (9 Months)
Coronary Artery event likelihoods assigned to Diagnosis Codes
Data source: http://media.corporate-ir.net/media_files/IROL/25/251324/1329501069178.high_resolution.jpg

Health Net
Population with Diabetes Overview

Member Distribution

Health Net Members with Diabetes



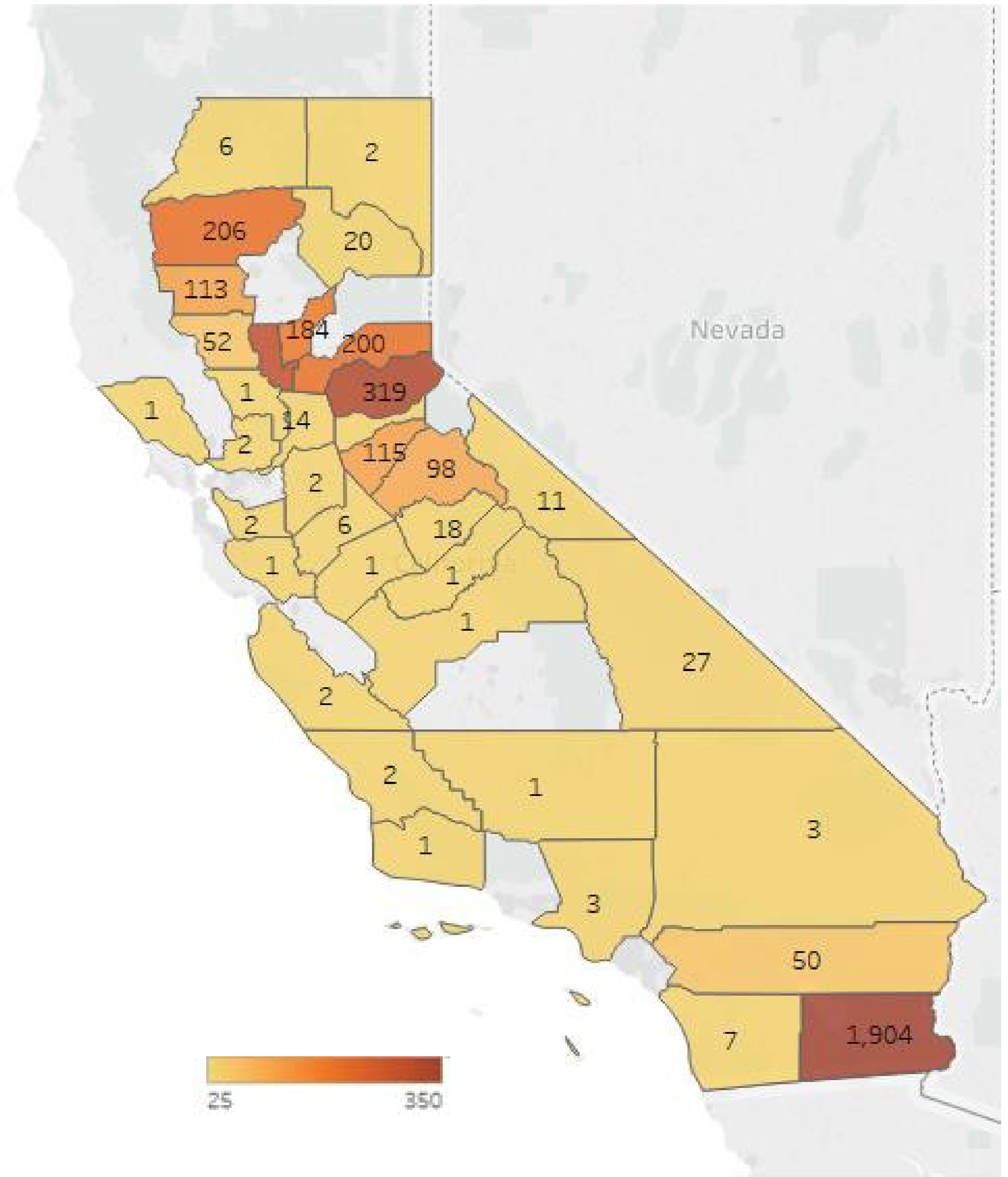
- High concentration of members with diabetes in higher populated counties such as Los Angeles, San Diego, and Fresno.
- Fewer members in Bay Area; more concentrated in Southern California and Sacramento areas.

Notes:
Spend and member figures based on all members with spend at each respective facility from July 1, 2015 to March 31, 2016 **(9 Months)**
Diabetes, Coronary Artery Disease, and Hypertension defined according to CMS guidelines

California Health & Wellness (CH&W) Population with Diabetes Overview

Member Distribution

CH&W Members with Diabetes by County



- Majority of members with diabetes (over 55 years of age) come from Imperial County.
- Higher population in Northern California.

Spend and member figures based on all members with spend at each respective facility from July 1, 2015 to March 31, 2016 **(9 Months)**
Diabetes, Coronary Artery Disease, and Hypertension defined according to CMS guidelines

SHAPE: Model and Population

Health Net®

SHAPE MODEL

CARDIO-PROTECTIVE BUNDLE

Daily dose of:

- Aspirin 75–235 mg
- Lovastatin 40 mg
- Lisinopril 20 mg

ALL ELIGIBLE PATIENTS

Diabetes (age > 55 year old)

and – Hypertension

and/or – Cardiovascular Disease (high risk and/or prior heart attack or stroke)

SUPPORT ACTIVITIES

To ensure compliance with cardio-protective bundle:

- Use of healthcare coaches such as diabetes educators, nutritionists, dieticians, etc. with follow up visits to patients via telephone.
- Frequency of engagement is determined by the coach as per the acuity and risk of patient, and the willingness of the patient to engage.
- Established a dedicated pharmacy program where pharmacists and technicians work to close medication related gaps via telephone outreach.

A variety of many other patient, provider, and provider group educational and outreach activities.

Target population

Region: California

All Health Net lines of business including Commercial, Exchanges, Medicaid, Medicare and related products.

SHAPE: Goals

Short-Term Goals

Partner with providers and provider groups.

Share best practices for care.

Introduce the cardio-protective medication bundle to members and monitor their compliance & adherence.

To educate members about their medication regimen and wellness.

Share education resources available to support providers and members.

Long-Term Goals

- Decrease and prevent cardiovascular events in this high risk population.
- Achieve the quadruple aim of improved population health, improved member experience, lowered costs, and improved provider experience.

SHAPE: Results to Date

Health Net®

Utilization rates around cardiovascular events decreased

Patient engagement increased

Increased cardio-protective medication bundle adherence rate

- By 43% for those members with diabetes that were not receiving the suggested cardio-protective medication bundle at the start of the SHAPE program.

PMPM cost decreased with costs savings

- Medicare LOB reduced by 60%.
- MediCal LOB reduced by 27%.
- Commercial LOB reduced by 17%.

Potential HEDIS® Measures Impacted

HEDIS® - Healthcare Effectiveness Data and Information Set

SHAPE: Supporting Activities

Data analytics support

Member list with DM, CAD and HTN

Medication history for these high risk members

Baseline utilization trends

Number of cardiovascular events in these members

MyStrength
Member online engagement tool on motivation, weight loss, wellness, exercise

Quality Improvement
Member/Provider interventions to close care gaps and improve related HEDIS® rates.

Additional Support
HN Clinical Program Managers

Clinician Mentors
HN Regional Medical Directors

Case Management
Conductor of clinical experience, provides tailored program per acuity

Medication Adherence
Pharmacy initiatives and electronic pill box

HN Clinical Pharmacy
Telephonic member/ provider communications to optimize therapy and improve outcomes

Disease Management
Optum Commercial and Medicare; Omada online coaching program

Envolve Pharmacy Solutions
Medi-Cal OnDemand Program

Quality Improvement Outreach/Strategy

Health Net

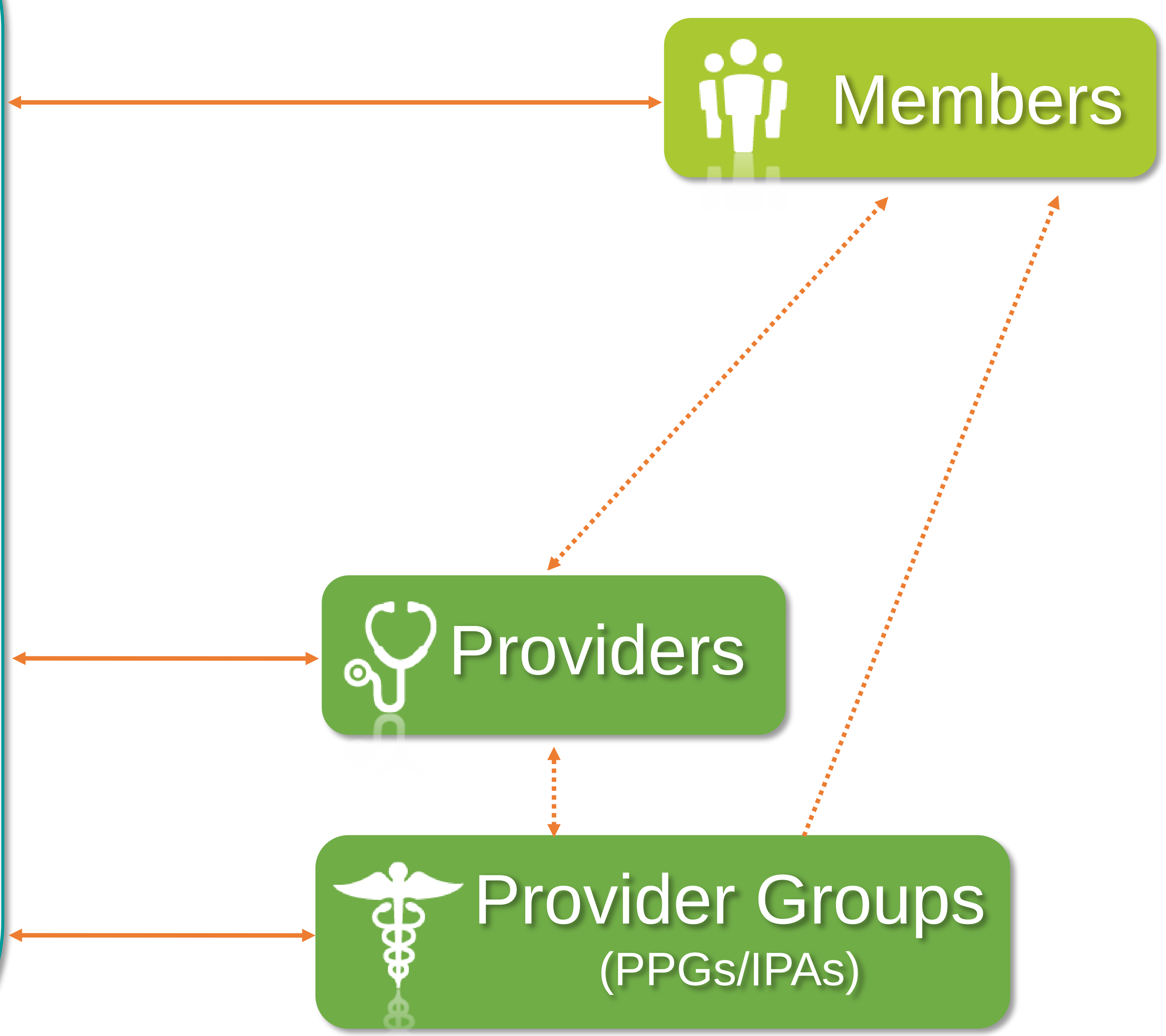
Health Net

Member Outreach:

- **Multimodal communications:** mail, interactive voice recordings (IVRs), text messaging, online newsletters, letters and/or emails
- **Live Calls** by clinical pharmacists trained in Motivational Interviewing
- **Incentive Programs**
- **In-home visits**
- **Health education** classes coordinated with clinics
- **Case Management and Disease Management**

Provider and Provider Groups Outreach:

- **Provider educational resources** including webinars
- **Care gap lists** and **HEDIS® report cards**
- **Provider Relations** and **Practice Transformation site visits**
- **PPG Joint Operation Meetings**



Statin Therapy Programs for Patients with Cardiovascular Disease (SPC)
Statin Therapy Programs for Patients with Diabetes (SPD)

- Encourage providers to prescribe a statin, ACE/ARB, aspirin (if appropriate) in patients with diabetes or cardiovascular disease.
- Multimodal outreach: letters and phone calls (Medicare).
- Follow-up: If provider agrees, verify paid prescription fill.
- Address barriers:
  - Educate for prescribers on statin re-challenge.
  - Provide education to members prescribed a statin who are reluctant to use/fill the medication.

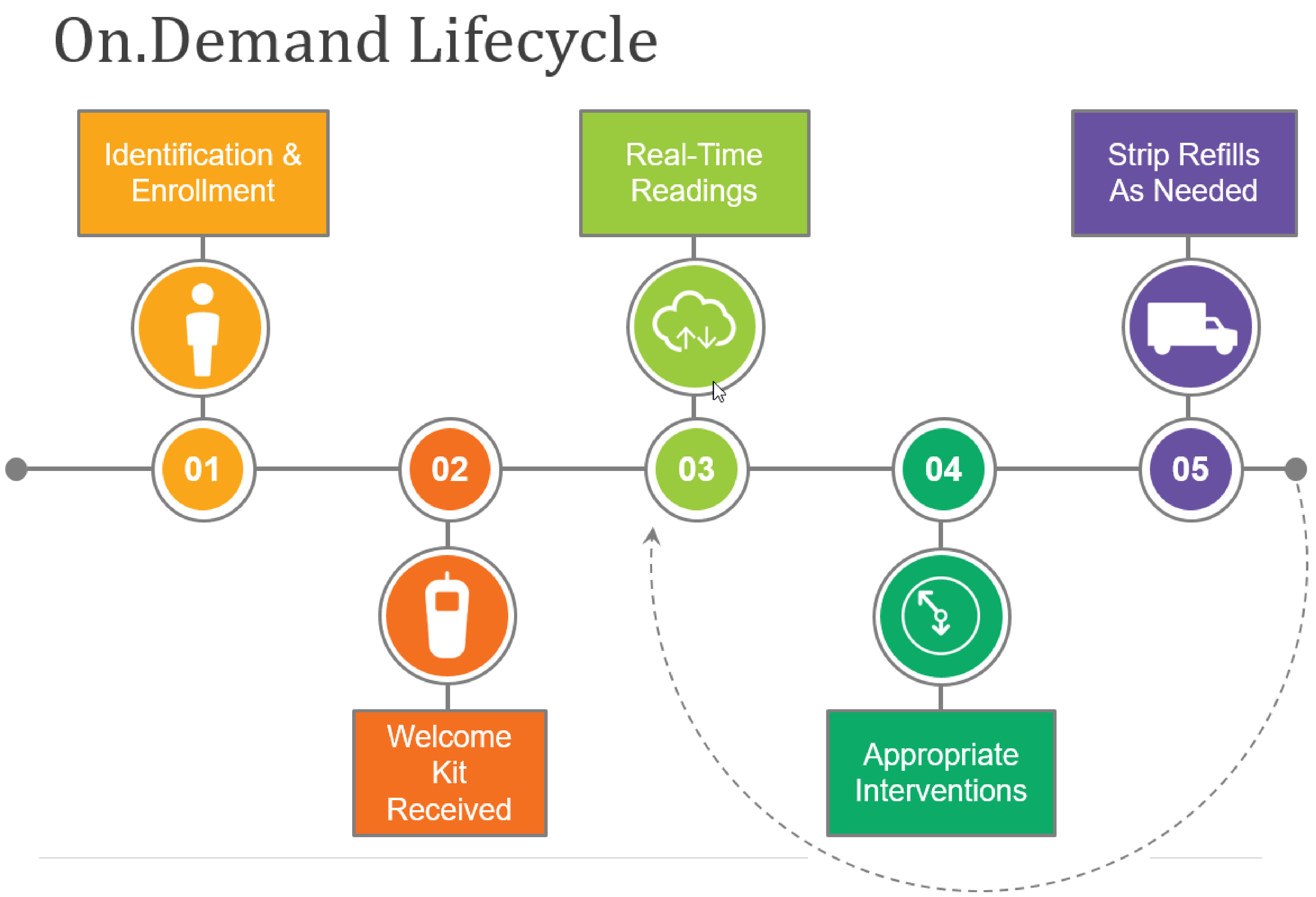
New designated Clinical Pharmacy Team:

- Focus is on members identified via Chronic Care Population Health Management .
- Goals are to improve medication adherence, clinical outcomes, member experience, and to reduce emergency room and inpatient utilization.
- Review pharmacy claims for members and outreach via telephone to non-compliant members and those not on the cardio-protective bundle. Can titrate.
- Utilizes motivational interviewing techniques.

Technology: Diabetes OnDemand Program

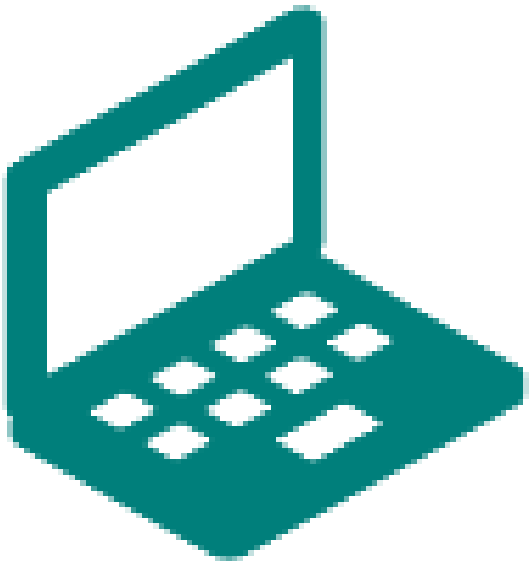
Targets high-risk testing adults with diabetes in the Medi-Cal population.

- Cellular-enabled glucometer provides real-time biometric data to program care managers.
- Care gaps or poor control trigger outbound telephonic disease management coaching.
- Analyzes each member's testing patterns to automatically replenish testing supplies via mail.
- Implemented Q4 2019.



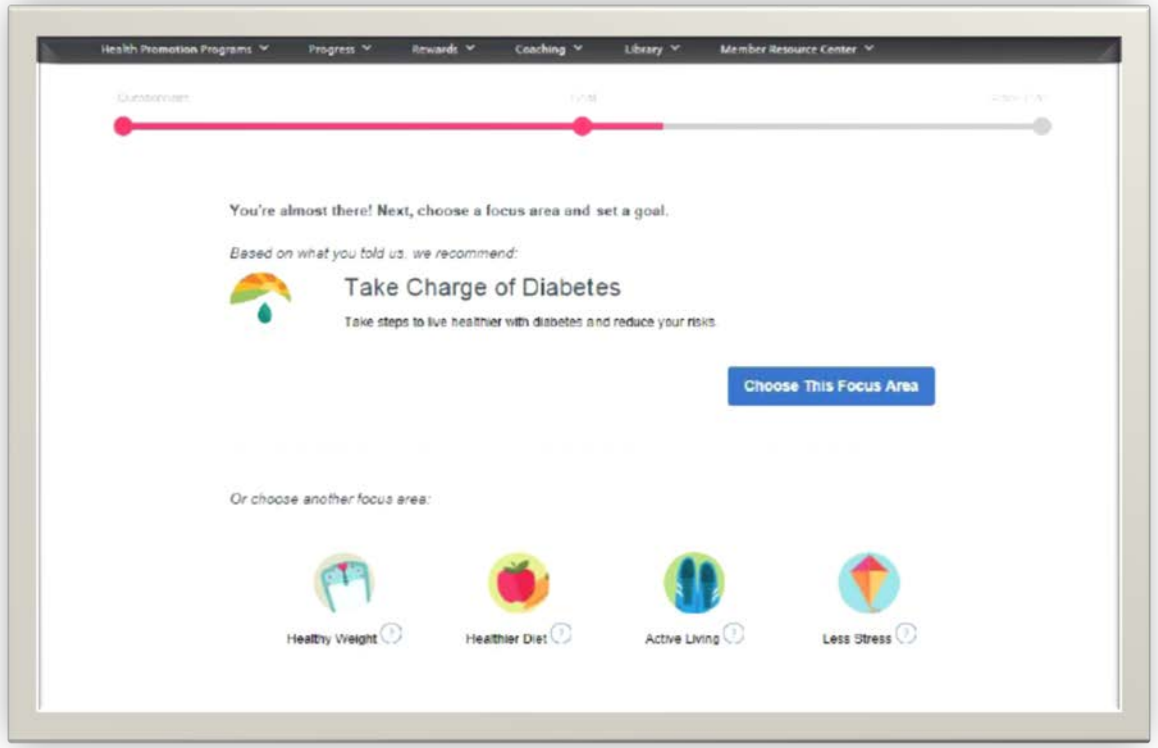
Take Charge of Your Health

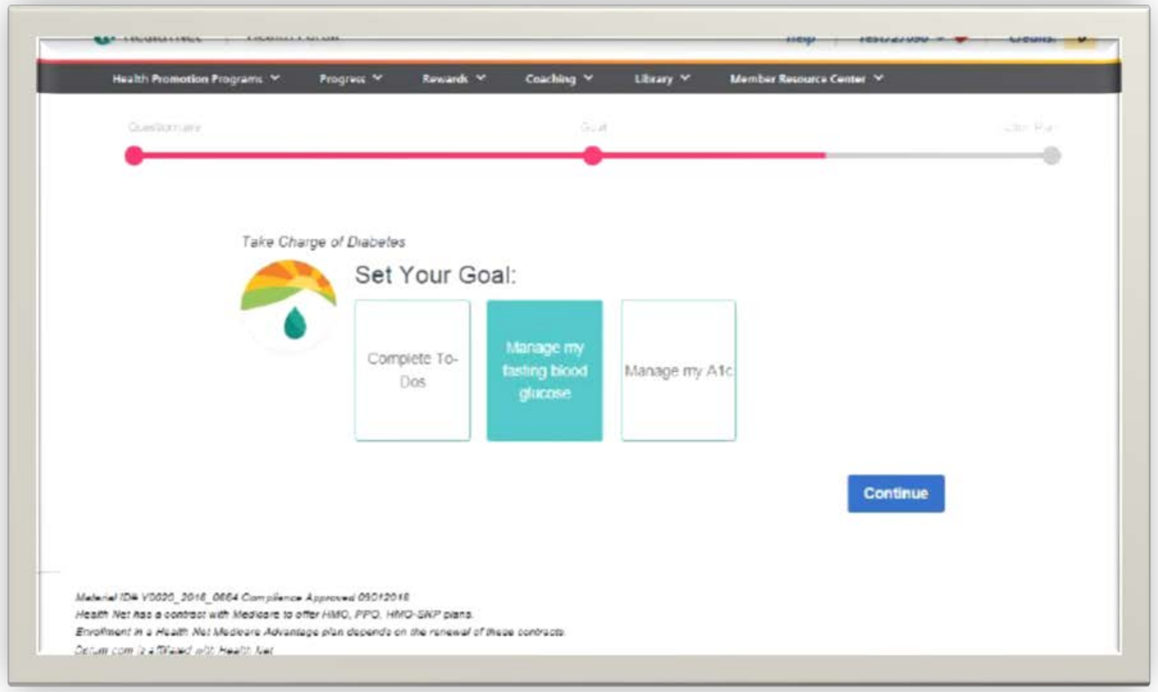
- This online program helps participants with chronic medical conditions better manage their well-being through adherence and personal wellness strategies.
- Complements the traditional approach of nurse-based disease management by offering a self-paced portal-based program that does not require the intervention of a telephonic coach or Disease Management nurse.



Offered for diabetes and hypertension, with upcoming modules on heart failure, asthma, and COPD.

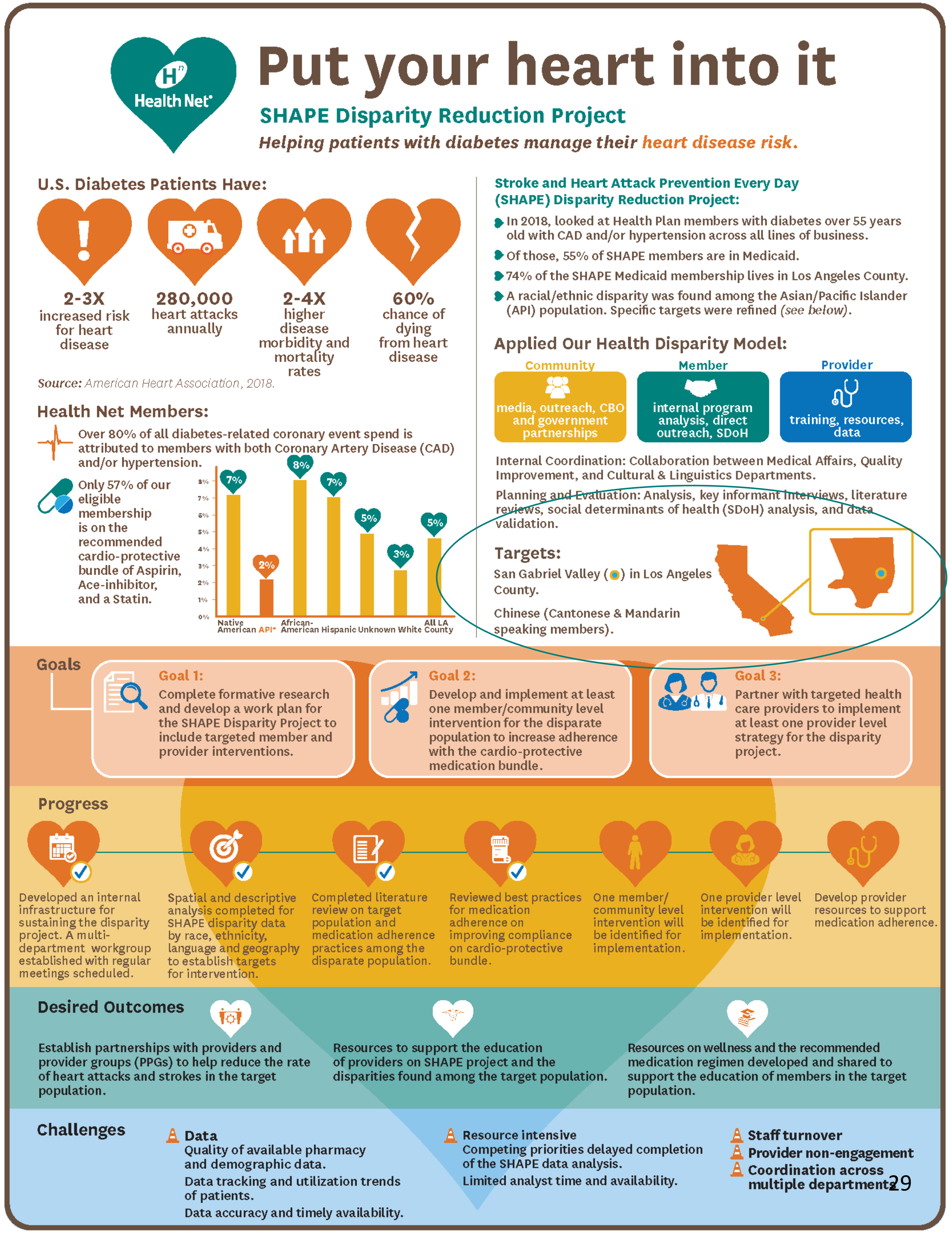
Available for Medicare and Commercial members.





SHAPE
Disparity Reduction Project

- Analyzing data to measure and identify any potential disparities in medication adherence.
- SHAPE Disparity Reduction Project goal:
  - Increase adherence of the bundle among Chinese-



Health Net®

2019
Best Overall Project Cohort Award
Disparities Leadership Program
Massachusetts General Hospital
Disparities Solutions Center Boston

Q&A

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Thank you!

Appendix

Right Care Initiative
Kaiser Permanente ALL/Phase

Health Net®

Kaiser Permanente's medication bundle:

- **ALL: A**spirin, **L**isinopril (ACE-inhibitor), and **L**ipid lowering statin
- **PHASE: P**reventing **H**eart **A**ttacks and **S**trokes **E**veryday (ALL protocol with beta blocker therapy and lifestyle emphasis added)

Model of the Outcome Phase ALL	**To ensure they are offered daily dose of:**
Systematic implementation in all patients with: ▪ Diabetes (age ≥ 55 y/o) or ▪ Cardiovascular disease (prior heart attack or stroke)	▪ Aspirin 75-235 mg ▪ Lovastatin 40 mg ▪ Lisinopril 20 mg

A Kaiser Permanente QI study tracked 170k individuals over 2 years. Compared to those with no medication bundle exposure:

- Of 47,268 "**low exposure**" individuals who used the medication bundle ≤1 year, 726 fewer heart attacks and strokes occurred (**reduction in hospitalization for heart attack or stroke by 15 per 1,000 members**).

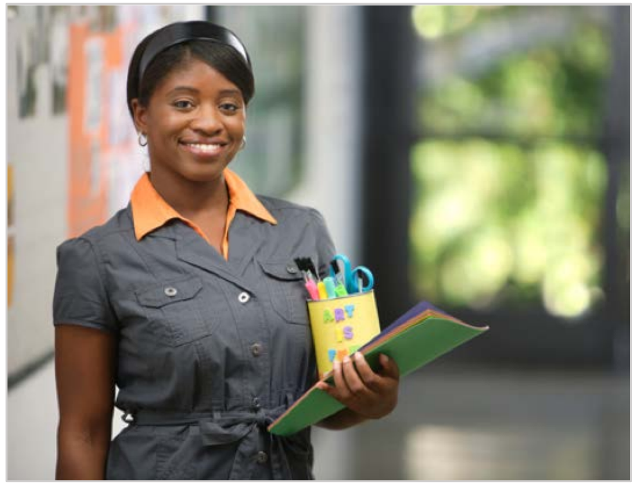
- Among the 21,292 "**high exposure**" individuals who used the medication bundle 1-2 year, 545 fewer heart attacks and strokes occurred (**reduction in hospitalization for heart attack or stroke by 26 per 1,000 members**).

Educational Theatre at Kaiser Permanente: *Above Between Below*

Allison Emery
Senior Workforce Health Consultant
Kaiser Permanente Washington

KAISER PERMANENTE®

Kaiser Permanente Thriving Schools



BUSINESS IMPERATIVE

One in five Kaiser Permanente members spends the majority of each weekday on a school campus.

LOCUS OF BEHAVIOR CHANGE

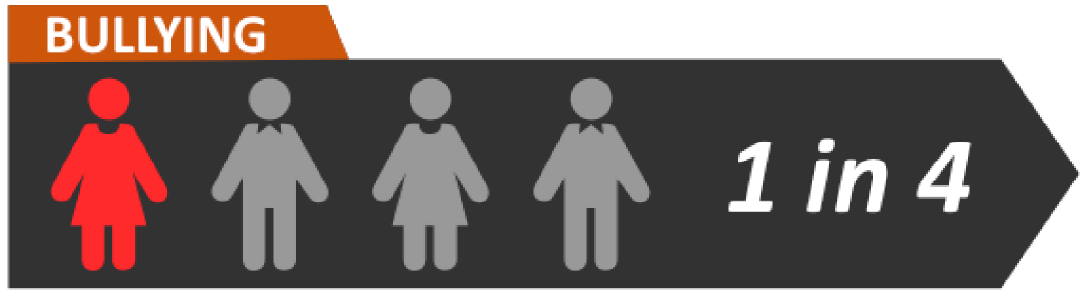
Health interventions in and around school settings can make significant impacts on health behaviors.

RECIPROCAL IMPACT

Health impacts educational attainment and education impacts life-long health.

Art has long been recognized for its power to connect individuals, heal communities and raise awareness of public health issues.

Educational Theatre focuses on building social & emotional skills, resiliency, and reducing stigma related to mental health.



- 16.5% of youth in the U.S. age 6 – 17 experience a mental health disorder each year.[1]
- Failing to address these mental health conditions has serious consequences.
- In the state of Washington, 1 in 4 middle and high school age youth report being the victim of bullying in the past 30 days.[2]

1. National Alliance on Mental Illness. (2019). By The Numbers. Retrieved from: https://www.nami.org/learn-more/mental-health-by-the-numbers
2. Washington State Healthy Youth Survey (2010-2016), Grades 6, 8, 10, and 12. Retrieved from: https://www.askhys.net/FactSheets.
   Infographic: Maike & Associates (2017). Exploring the landscape of mental health and wellness in Washington's K-12 education system.

“Above, Between, Below”

- Promotes community health through experiential learning and interactive engagement.
- Inspires healthy choices and the building of stronger communities.
- Educational theatre can improve students’ ability to take in and retain health information.[1]

1. Cheadle, Allen et al. (2012). Engaging Youth in Learning about Healthful Eating and Active Living: An Evaluation of Educational Theater Programs. *Journal of Nutrition Education and Behavior, Volume* 44(Issue 2), pp.160 – 165.

2017-18 school year

Students: 19,760

Educators: 1,211

Schools: 33

School Districts: 19

Average F/R Lunch %: 55.8%

Total Workshops: 134

Evaluation

- Preliminary data indicates **increases in students** who are almost always or always **standing up to bullying**

- Other lessons learned:
    - Adding teacher guides & post-play skill building workshops
    - Key strategy transition: from bullying to conflict resolution
    - Make time for conversation

ghosted

KAISER PERMANENTE®

Educational Theatre Program

In collaboration with

SCT SEATTLE CHILDREN'S THEATRE

What's next?

Contact:

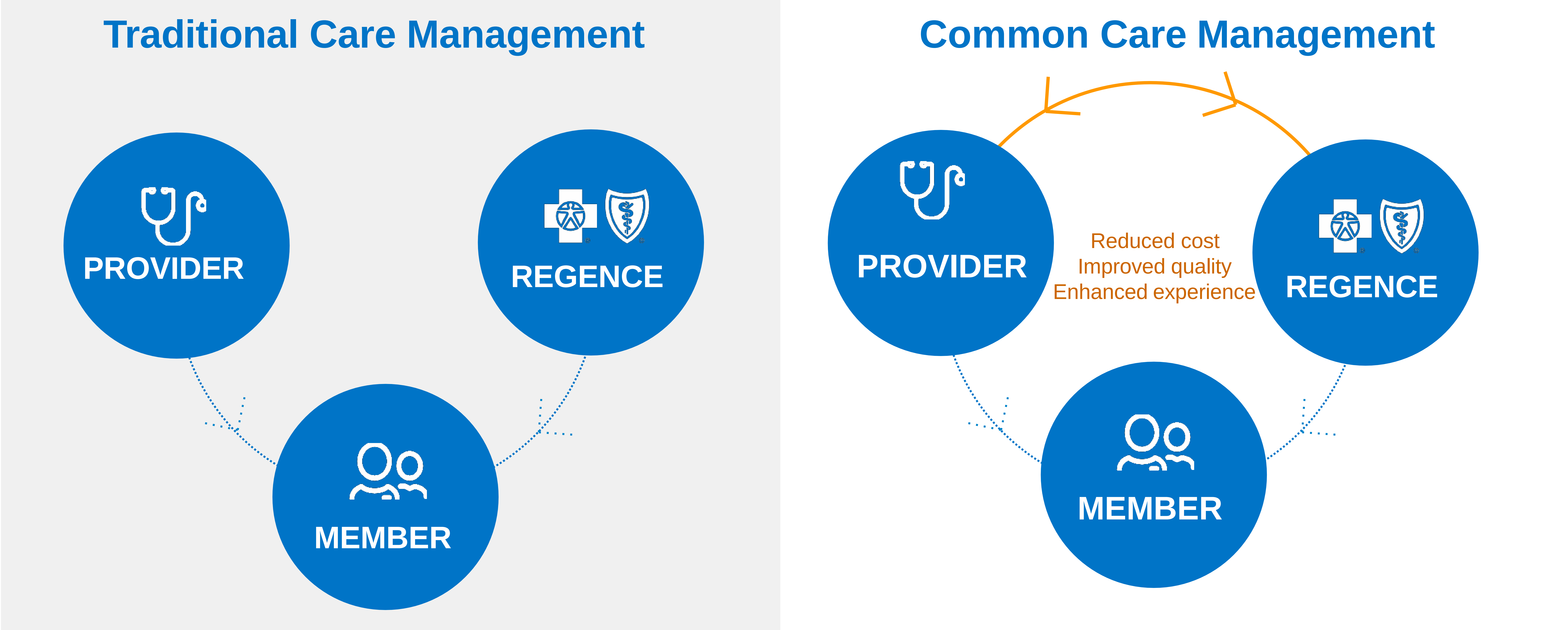
Jill Patnode – KPWA Thriving Schools jill.x.patnode@kp.org

Haley Ballenger – KPWA Educational Theatre Program: haley.x.ballenger@kp.org

Clinical Collaboration with Providers

Common Care, Provider Partnerships

The Common Care Approach



Common Care Objectives: Provider & Member

- Reduce cost and improve quality
- Enhance member experience
- Drive engagement with strategic provider partners
- Develop and drive innovation to improve communication between payer, provider and member
- Assist and guide providers as they build resources and capabilities to manage Regence members

Regence

Clinical Support Model

CURRENT TOOLS AND TECHNOLOGY

- Patient Priority Manager
- CGMA (Medicare only)
- Patient Risk Assessment
- HI Reporting
  - Member Risk Profile Report (Impact Pro)
  - Quality reporting
  - Member Utilization

FUTURE TOOLS AND TECHNOLOGY

- Patient Priority Manager
- MedSavvy

Common Care supports Provider Partners by offering a clinical support model that aims to influence outcomes related to:

- ED and inpatient admissions
- Care gaps
- Members with rising risk
- Complex / Chronic members
- Hospital discharges

Regence

Scope of Services & Activities

- Patient Identification
  - Through data, technology and tools, Regence identifies and shares high-risk member targets with Providers
- Clinical Collaboration Workgroups
  - Once members have been identified, Regence's Clinical Transformation Advisors and Common Care team meet with Providers to review members and discuss plan of care
- Case Management
  - Regence and Provider co-manage members through coordinated activities and interventions

Common Care Results to Date

Partnering with providers since 2016 to assist and engage members who need extra help managing their health

Targeted Patient Identification & Intervention + Clinical Collaboration

↓

Pairing Cambia's claims data and analytics, along with our providers' clinical insights, results in a comprehensive 360° view enabling us to identify members who would most benefit from care management

ED Utilization

↓ **5.4%** Commercial

↓ **8.3%** MA

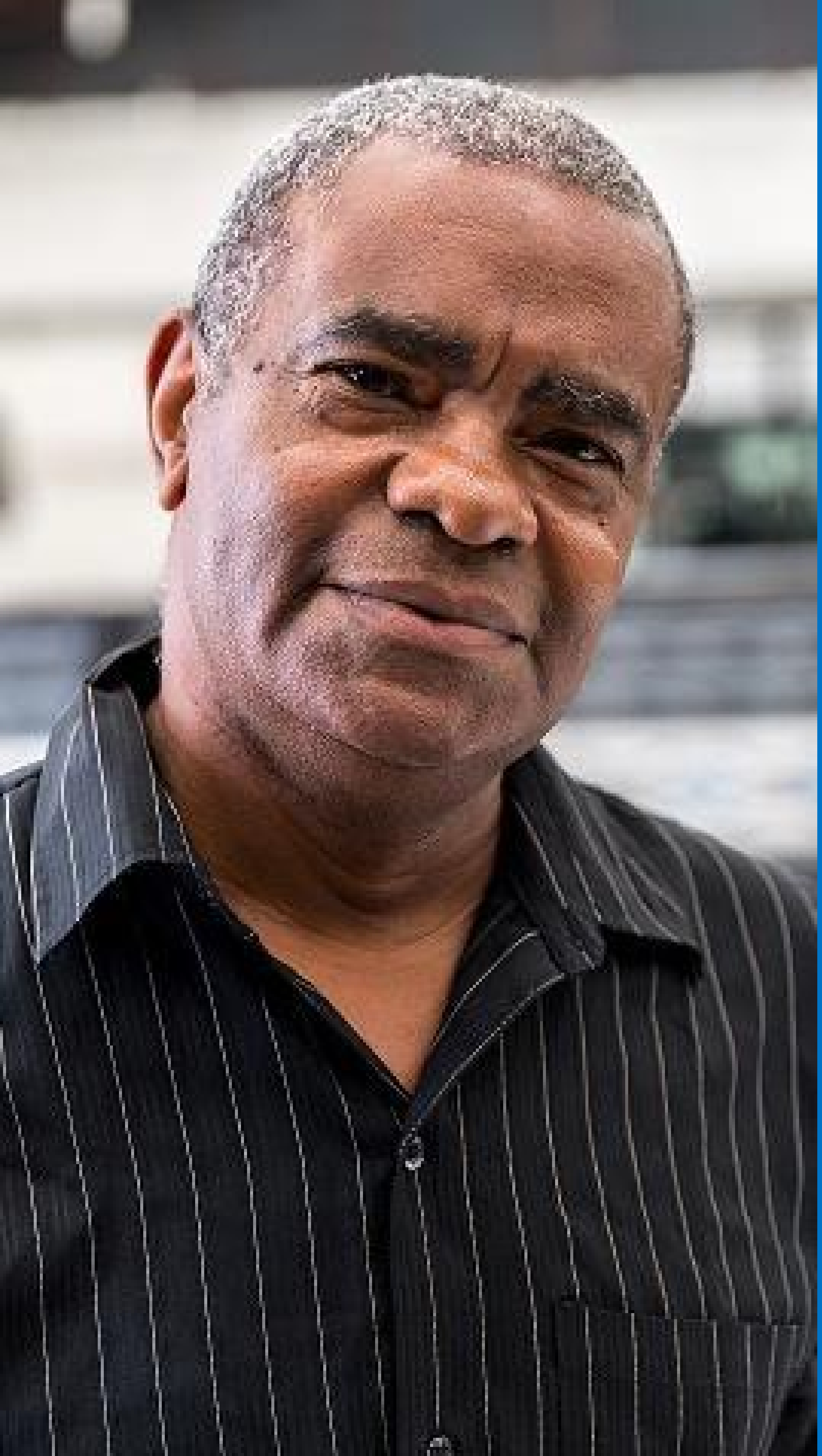
Quality Performance

↑ **4.9%** compliance

Providers Engaged

24

Regence



Meet Kenny

- 56-year-old male
- Diabetes and poorly controlled blood sugars
- Recently admitted to the ER for flu-like symptoms associated with high blood sugars

Opportunity

Care Management identified that Kenny was noncompliant with monitoring blood sugar and taking medication

Kenny relied on his wife to administer medication and check blood sugar but she works full-time and is unable to assist with care during the day

Intervention

Provided care-giver support to Kenny's wife to allay her concerns

Case Manager and Clinical Pharmacist at provider clinic reviewed the case and Pharmacist looped in PCP

Recommended a continuous Blood Glucose monitor for convenient readings so he could more easily manage his diabetes

Outcome

Coordinated coverage and benefits for continuous glucose monitoring system

Kenny has had no ER visits since case management collaboration

Continued Case Management and Clinical Pharmacist collaboration for treatment plan

What People are Saying

"By having access to an EMR's, the connection I have had with members is so much better. They truly know that I'm working closely with their PCP and that we do these calls because we care. Having access to members EMR also has helped with not calling members when it's not necessary (seeing they have upcoming appointments, labs, etc.)." - Regence Care Advocate

"Not only can I get up to date medical/Rx records on the member and see the interactions that have been going on with their PCP clinic, but I can see their risk level and whether they already have a CM working with them. This is extremely helpful to ensure we don't duplicate work or step on each other's toes, and it really enables collaboration with the clinic CM." – Regence Care Manager

"The collaborative case management program has been extremely successful, and we'd like to replicate your work within our own clinic." – Physician Leader @ provider pilot site

"It's really nice to know that my doctor and my insurance company are working together to give me the best care." – Regence Member

Regence

Thank you!

- Questions?

