Super Utilizers: 
Developing Viable Payment Strategies 

Andrew Baskin, MD 
National Medical Director 
Aetna
The case for *improved patient engagement*

**70%** Adults who had difficulty making doctors’ appointments, getting phone advice, or receiving care after hours

**27%** Report that no one informed them of their test results or they had to call repeatedly to obtain them

**47%** Report at least one failure of coordination, e.g., communication between health care providers

**Only 50%** Say their provider asks about their goals and concerns

**Only 40%** Feel they work together with their provider as a team

*Improving Quality and Reducing Costs in Health Care: Engaging Consumers Using Electronic Tools*
Bipartisan Policy Center Health Information Technology Initiative, December 2012
Commercial/Medicare Health Plan Perspective

• Health Plan/Provider partnerships
  – Collaborations, P4P, PCMH, ACO

• Health Plan Programs
  – Super-utilizer/high cost claimant identification
  – Care management

• Data sharing

• Provider tools/support

• Member/Consumer tools
Incent & Enable Providers to Create Value - Goal: Move Up the Value Pyramid

- ACOs
- High Performance Networks
- Payment Alignment
- Local Market Rationalization
- Competition Based on Quality & Cost
- Managing Medical Costs
- Shared Savings
- Bundled Payments
- Pay for Performance
- IOEs/IOQs/Steerage
- Transparency
- P-Model
- Scoreables
- Discount Imp.

Transformative
Foundational
Quality – Medical Management Approach

Enabling effective care of seniors with multiple conditions and reducing preventable hospital admissions

### Elements

- All new members receive a Health Risk Assessment (80% completion rate) and monthly predictive modeling
- Those identified receive Comprehensive Screening and Management
- Enrolled 18% of members in Care Management
- New programs for Home Care Management and Institutionalized members piloted
- Nurses, Social Workers, Behavioral Health, Disease Management Specialists are all trained in Geriatrics and Change Management
- We provide specialized programs:
  - Advanced Illness
  - Transitional Care Management
  - Chronic Illness

### Impact

- Enables identification/management of all conditions and barriers to address the whole person
- Provides greatest impact will all comorbidities and issues managed concurrently
- Aetna preventable admissions in core markets are going down year over year
- Admissions are below the Medicare FFS level.
- Provides a uniform, effective and integrated strategy for members with multiple conditions and psychosocial barriers
- Expands successful medical management to more high risk and vulnerable populations. Disease Management is a component of a comprehensive Care Management program.
Collaborative Care Management

The Collaborative Care Management Model provides the following services for assigned Aetna Medicare members:

- Dedicated or Embedded Case Manager (available for groups with 1,000 or more Aetna Medicare assigned members)
  - Completes care assignments
  - Views all patients’ health care transactions and alerts you to issues (did not fill a prescription, etc.)
  - Delivers “Care Considerations and other valuable follow-up information and helps “close the loop”
  - Works closely with physicians and staff
- Captures and reports data on transactions and interventions
- Out of area management, transplant management, etc.
- Specialized Care Management programs: End of Life Care Management, Dementia, etc.
Shared Value Through Better Quality Management

• $ X pmpm for achieving all target measures. Exact measures to be mutually agreed upon. Some possible measures:
  • Diabetes Management: HbA1C at least each year
  • Follow-up visit within 30 days after a hospital discharge
  • 2x/year office visit for members with CHF, diabetes, or COPD
  • Management of avoidable inpatient admissions measured against a total acute days target per 1,000
  • Annual office visit with each assigned member
  • Enhanced reimbursement through better identification of chronic conditions.
Provider Collaboration Model: Impact to Date

• 75 physician groups have signed Collaboration contracts

• Results (beyond our already significant admission reductions):

• 15% Reduction in Acute Bed Days per 1000 versus Market Results: (in addition to our 34% reduction)
  • Incremental impact exclusive of denials overall
  • For some groups we see a reduction in acute days of 60% compared to the region for Medicare, and reduction in cost of > 25%
  • Days that do not happen - an intersection of quality and cost
  • All groups with > 200 members have met all quality criteria and exceeded targets for acute days
• High level of member and physician satisfaction with the program
Example of Specialized Care Management Program: Aetna Compassionate Care

- Care management by specialty trained nurse case managers to handle physical, emotional, spiritual and culturally-diverse needs of patients in advanced stages of disease

- Provides:
  - Advanced planning, directives and support
  - Emotional support and pain management
  - Choices, alternatives, use of hospice care

Aetna Compassionate Care Results: Medicare

- Program transposes traditional acute and hospice numbers
  - 81% of Medicare members in Compassionate Care Program elected hospice care
  - 18% deaths in acute or sub-acute facilities
  - 82% reduction in acute days, 88% for intensive care days
  - High level of member and family satisfaction
Aetna Medicare Physician Collaboration: Summary

- Collaboration changes the nature of the relationship with participating physicians

- Embedded case managers enhance the collaborative care management process, the relationship with collaborating physician, and the impact of care management

- Demonstrable incremental positive impact

- High physician and member satisfaction

- Facilitates transition to accountable care
PCMH strategies

**Multi-Payor Collaboratives, CMS, and Comprehensive Primary Care Initiative (CPCI)**

- Region specific contracting pipeline
- Care Coordination Fee and Shared Savings
- Efficiency and Clinical Performance Monitoring

**Direct Contractual Relationship**

- Region specific contracting pipeline
- Care Coordination Fee and Shared Savings
- Efficiency and Clinical Performance Monitoring

**PCMH Recognition Model**

- Market based program
- Care Coordination Fee
- Efficiency and Clinical Performance Monitoring

- **Reduced hospitalizations and ambulatory care:** primary and readmissions, sensitive specialty/facility and other costs
- **Improved transition of care**
- **Shared decision making** and behavioral engagement
- **Increased patient engagement** in preventive health and wellness
- **Updated clinical decision-support tools** to improve care management, tracking and adherence to evidence-based guidelines
Aetna’s Industry-Leading Tools and Services

Our diverse suite of tools and services enable the ACO model and make Aetna a partner of choice
Data Sharing

• ACO, PCMH, P4P (primary care and specialty care)
• Monthly member level detail on all quality measures
e.g., readmission rates, Diabetes and CHF measures
• Monthly member level detail on all efficiency measures
e.g., ER visits, generic prescribing, non-participating utilization
• Daily inpatient census (including all hospital admissions, even outside of the local provider network, non-participating facilities, and distant locations)
Super utilizers/High Risk member identification

- High Cost Claimants (HCCs): dollar threshold (e.g., $75,000)
- Identification prior to becoming a HCC
- Predictive modeling: high likelihood of increased medical costs over the next 12 months
- Hospital predictor: high likelihood of hospitalization within 6-8 months
- Opportunity score: gaps in care
- Case and Disease management triggers: frequent ER visits (3 within 6 months), readmission within 30 days, trigger diagnoses for DM, UM nurse ID of potential HCCs
- Health Risk Assessment (HRA)
Medical Management

• Degree of collaboration, sharing of services/programs, and integration dependent on provider group capabilities

• Complex Case Management:
  • Does member have a PCP? If not, then connect them.
  • Address transportation and cost barriers, time barriers (e.g., not enough time), not understanding reasons for compliance with medications and visits, health literacy, seeing multiple physicians with perceived different recommendations from each, depression screening and refer as needed.
  • Educate member, refer to community resources, outreach to physician(s), EAP (employee assistance program) referral for issues like stress, minor depression, problem caring for parents, etc.

• Social workers

• Disease management: single or multiple conditions

• Behavioral Health integration

• Specialized programs, e.g., Compassionate Care Program
Aetna Compassionate Care℠ Program addresses barriers to optimal care

This program provides support to members with Advanced Illness and their families, and helps them to access optimal care.

1. Specialized Case Management Services
2. Enhanced Hospice Benefits*

*Does not include Medicare
Case Management Services

- **Helping members understand options, nurses were trained to:**

  - Assess and manage members’ care in a culturally sensitive manner
  - Identify resources to make members as comfortable as possible, addressing pain and other symptoms
  - Help coordinate medical care, benefits and community-based services
  - Inform the member about treatment options, continuity of care, and advanced care planning
  - Provide personal support
Results to date (2012) of program participants show:

- **Significant increase in hospice use**
  - The proportion of members using hospice increased dramatically -- to 71% for Commercial members and 81% for Medicare members. In addition, the average number of days in hospice nearly doubled.

- **Significant decreases in acute/critical care utilization**
  - There were 82% fewer acute hospitalization days (Medicare) and considerable reductions in emergency room visits for all program participants. ICU stays also showed dramatic (88% - Medicare) reductions.

- **High Satisfaction and savings**
Provider tools

- Data sharing: quality and efficiency measures, detailed patient level data
- Embedded or designated case managers
- Practice IQ (for independent PCMHs)
- Care Engine: Care considerations shared with providers (and members)
- Active Care Team suite (software platform to manage information)
- iNexx (virtual information sharing environment including PCP, Specialists, and Patients)
Practice iQ helps primary care physicians **thrive** – and **remain independent** – in the new value driven market place.

**Note:** Most physician organizations lack the experience, or knowhow, to be successful in a value-based model, and they lack the capital required to build the needed capabilities. Practice iQ aims to solve both of these problems.
Our intelligent solution is comprehensive and end-to-end...

Medicity provides the technology for healthcare data access.

CareEngine combines clinical and claims data for sophisticated analytics.

Care Team Suite and MyActiveHealth provide best in class applications for reporting, care management workflow, and patient engagement.

Embedded care coordinators add much needed clinical capacity to the physician practice.

Field based Practice iQ staff works with the physician organization to ensure clinical and financial performance.

Patient Specific Alerts, Gaps in Care, and Care Plans

Quality Measure Reporting and Benchmarking, Contract Performance Reporting

Care Management Workflow Application, Advanced Registry, and Population Health Tools

Patient Engagement Platform

Evidence Based Standards

Scalable & Skilled Clinical Resources

- Scaled to patient population risk and volume
- Staff is local and represents a combined approach:
  - Embedded
  - Telephonic
- Population health experts:
  - Disease Management
  - Case management
  - Wellness
  - Senior Programs

Dedicated Operational Support

- Account Management Executive
- Implementation Manager(s)
- Program Operations Manager(s)
- Practice Marketing Manager
- Informatics Manager
- Performance-Based Contracting Manager
- Customer Service Representative
Consumer engagement and tools

- Care Engine: Care considerations shared with members (and providers)
- iTriage
- Welvie decision support
- Member payment estimator: virtual claim with member cost share based on the benefit plan
- Mindfulness at Work: Mind-Body stress reduction group program
- Patients Like Me: online support group for patients with similar conditions; social networking; with monitor/facilitator
Aetna Mobile functionality

Available via mobile web, iOS and Android

- Search for doctors in Aetna's network by name, location or specialty
- Easily locate urgent Care Centers and Walk-In Clinics near you
- See the status of your recent claims
- View your coverage and benefits information
- Stay up-to-date with your PHR
- View ID card info
- Get a drug cost estimate before you fill a prescription
iTriage® – connecting consumers to information and care on the go

• One of health care’s leading mobile platforms to empower people to make better health care decisions, and improve health care delivery

• The iTriage app provides a Symptom-to-Provider pathway, connecting patients who are actively looking for health care with providers who have the capability and capacity to deliver that care

• iTriage can even help a consumer book an appointment with a physician or pre-register with an Emergency Department

• iTriage is a top 5 free health care and fitness app with a 4+ (out of 5) user star rating in the Google Play™ media store and the App Store
A special pilot

What it is>> PatientsLikeMe (PLM) is a social network where people can:
  • Learn about living with and treating their disease
  • Connect with others just like them
  • Monitor their health

Our collaboration >> A 12-month pilot that began in January 2013
  • We promote PatientsLikeMe via our Aetna Navigator® secure member website and the Personal Health Record (PHR)*
  • We do not share any Personal Health Information (PHI) with PatientsLikeMe as part of this program, nor does PLM share PHI with us

Our two-fold goal >>
  • Give our members new tools for decision support and informed decision making
  • Test members’ interest in online communities and understand active user behavior through their usage patterns

*PHR link scheduled for June 2013

- 175,000+ members
- Over 1,000 conditions
Why do members engage on PatientsLikeMe?

This network helps members engage by empowering them to use valid shared health data with their health care providers to improve care and outcomes.

*Step 1:* Create/update your patient profile and share it with others

*Step 2:* Find support from and compare experiences with other patients like you who understand

*Step 3:* Learn from aggregate community Treatment and Symptom Reports

*Step 4:* Take your patient profile to your provider appointments for an improved dialogue

*Step 5:* Play an integral and participatory role in your health care & outcomes