

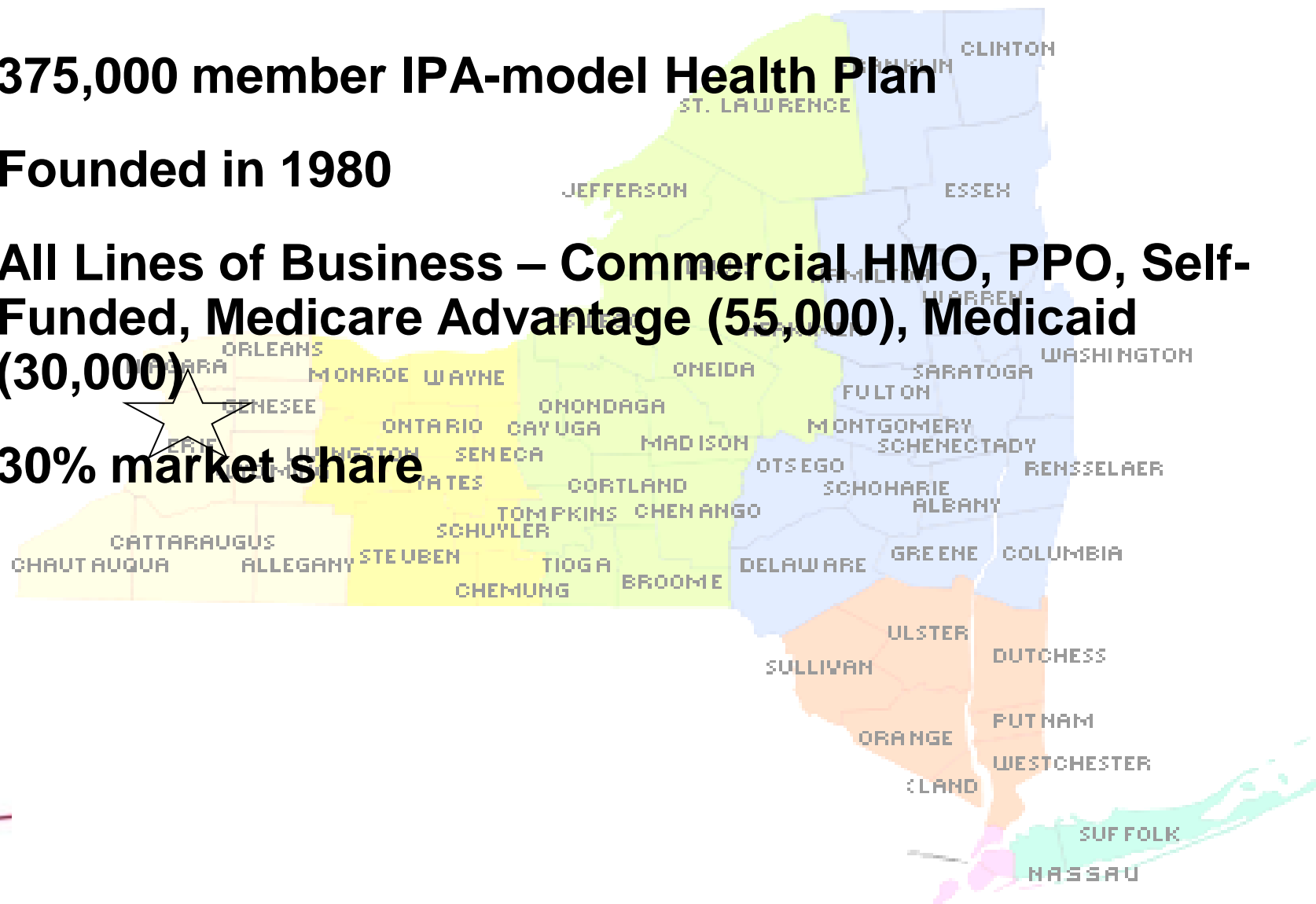
A close-up photograph of a hand holding a ripe red apple. The background is softly blurred, showing more of the hand and the apple's texture. The lighting is warm, highlighting the natural colors of the fruit and skin.

**ACHP Board Symposium**  
**March 23, 2010**  
**Driving Affordable Quality Healthcare**  
**(in a community without integration)**

**Michael W. Cropp, MD**  
**President & CEO**  
**Independent Health**

# Independent Health

- **375,000 member IPA-model Health Plan**
- **Founded in 1980**
- **All Lines of Business – Commercial HMO, PPO, Self-Funded, Medicare Advantage (55,000), Medicaid (30,000)**
- **30% market share**



# Root Causes of the affordability / quality gaps

- **Flawed Payment Methodology**
- **Information Gaps at Point of Service and in Planning**
- **Diffuse or Lack of Accountability**
- **Minimal Individual Incentives and Engagement**
- **Underdeveloped Community Capacity for Change**

# Independent health strategy

- **Manage quality and cost by engaging providers and members to “rationalize” units of service with a focus on prevention and evidence-based medicine.**

# How Do We Move Forward

- **What has to be Done?**
- **What Can We do Alone?**
- **What Must be Done in Concert with Others?**
  - **Competitors**
  - **Providers – Physicians, Hospitals, others**
  - **Both of the Above**
  - **Community**

# Health Plan Initiatives

- **Primary Care Redesign**
- **Other Care Redesign for Quality and Efficiency**
- **Expanded Plan Services**
- **Benefit Redesign**
- **Payment Reform**
- **Integrated Technology Architecture and Platform**

# Primary Care Redesign

- **IDCOP Platform**
  - Access
  - Interaction
  - Reliability
  - Vitality
- **Integration with Plan & Specialists**
- **Predictive Modeling and Planning**

# Integrated Coordinated Care Model: Staging and Selection

- **Design Elements in Place**
  - **Alternative Access**
  - **Patient Monitoring/Engagement**
  - **Case Management**
  - **Patient Self-Management**

# Integrated Coordinated Care Model: Staging and Selection

- **E-prescribing**
- **Test Tracking**
- **Referral Preferences**
- **Performance Reporting/Cost Containment**
- **E-communication**
- **IT Infrastructure**
- **Data Exchange**

# “Second-Generation PCMH”...engaging SCP

- Use “activated” PCMH physicians to leverage high volume specialists to adopt similar criteria for care coordination, continuous quality improvement, cost and quality transparency, access, etc.
- Allow PCMH to either influence clinical practice patterns in SCP practices - or - shift referral patterns to more efficient, high-quality practices.
- Result is an immediate cost-quality shift across significant plan membership
- In essence, create “Advanced Specialty Care” practices as a ripple effect of the PCMH.

# Primary Care as a Natural Setting for Mental Health Care

- **Most frequent presentation of illness**
- **Setting for screening, prevention and care of chronic illness**
- **Behavioral health problems slow or halt prevention and treatment of chronic conditions (such as diabetes, heart failure and obesity)**
- **Preference for patients to receive care with PCP (especially for vulnerable populations)**
- **Specialty provider shortages**

# Behavioral Health Care in the PCMH – Goals for Integration

- **Improve quality through evidence-based screening, diagnosis and management**
- **Improve patient satisfaction by providing team-based behavioral health care in preferred setting**
- **Improve cost efficiencies by timely treatment and enhanced access to specialty providers in the community**

# Pilot Behavioral Health Integration Program

- **Novel initiative – first large pilot initiative to incorporate behavioral health integration with Medical Home implementation**
- **3 PCMH Pilot Sites with diverse patient populations**
- **Initial goal – Embed screening and management of depression within primary care sites**
  - **Primary Care site training in care management**
  - **Develop enhanced access to behavioral health providers in the community**
  - **Establish new role for out-patient psychiatric consultation with the PCMH site**
  - **Health Plan resource bank- Practice Care Coordinators and Behavioral Health Coaches**

# Goal for “Whole Person” Care

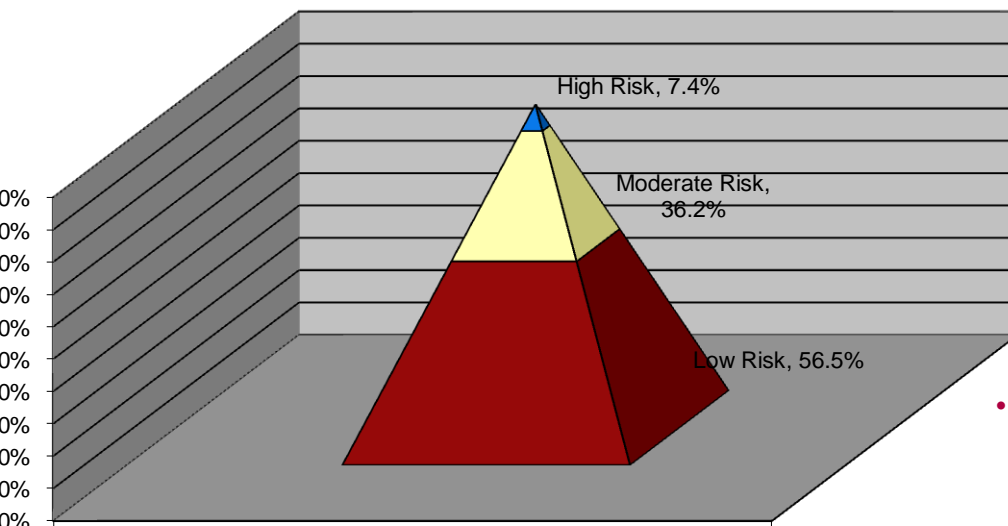
- **Support behavioral health management as integral to the sustainable transformation of primary care**
- **Improve access, affordability and quality of care by:**
  - decreasing stigma
  - improving care coordination and team collaboration
- **Decrease cost and improve health outcomes by:**
  - Managing co-morbidities
  - Diagnosing and treating behavioral health problems at earlier stages of presentation
  - Supporting families through education and community resources

# Other Redesign

- **Centers of Excellence**
  - **Cardiac**
  - **Prostate Cancer**
  - **Orthopedics**
  - **Stroke**
  - **Orthopedic Urgent Care**

# Expanded Plan Services Risk Pyramid – Program Availability

Health Risk Pyramid



65+ Current Risk 2008

- **High Risk**
  - Disease management
  - Case management
  - Palliative care (Home Connections)
  - Frail Elders (Care Partners)
  - Family Choice (SNP)
- **Moderate Risk**
  - Health Coach
  - Living Healthy
  - MIC Center
- **Low Risk**
  - Silver Sneakers
  - Warm Health IVR (Interactive Voice Response)
  - 24/7 Nurse Helpline

# Benefit Redesign

- **Transformational Benefit to Incentivize Engagement**
- **Lower Out-of-Pocket Expenses for Self Activation**

# Payment Reform

- **Primary Care**
  - **Base Payment – Prospective, Risk Adjusted**
  - **Fee for Service – Preventive & Routine Services**
  - **Bonus Payment – Retrospective, Risk Adjusted**

# Community Collaborative

- **Western New York Health-e-Link (RH10)**
- **P<sup>2</sup> Collaborative of Western New York**

# WNY Health-e-Link

- **3 Health Plan, 4 Health System “Owners”**
- **Information Highway**
  - **Electronic Prescribing**
  - **Results Reporting**
- **Electronic Medical Record Adoption**

# P<sup>2</sup> Collaborative of WNY

- **501-c-3 Community Organization**
- **Health Leaders**
- **Business Leaders**
- **Community Leaders**
- **Building Sustainable Capacity for Health Related Behavior Change Across the Community**

# P<sup>2</sup> Collaborative of WNY

- **Early Initiatives**
  - **Moving in Faith**
  - **Power Eaters**
- **Recent Work**
  - **RWJ Aligning Forces for Quality**
  - **Consumer Engagement**
  - **Public Reporting of Physician Performance**
  - **Quality Improvement Capacity Development**

# Next Steps

- **Scale Up – Chronic Disease Self Management**
- **Transitioning Additional Programming to the Community**

# Scale-up For Chronic Disease Self-Management (Living Healthy)

## Moving Beyond Competitive Advantage to Community Asset

Number of Individuals Affected	Steps Required to Achieve Broad Success
5	Train 3 group leaders, recruit for first class
25	Run 10 classes – utilized Independent Health employees (RedShirts) volunteer group leaders
125	Run group leader training session, participate in P2 collaborative with Kate Lorig, RN, Dr. P.H.
625	Run Living Healthy sessions with new leaders in multiple sites - success demonstrated with the inception of a volunteer program
<i>3,125</i>	<i>Expand to community with P2 offering sessions</i>
<i>15,625</i>	<i>Continue to train new leaders and send additional leaders to trainer education</i>

Independent Health Members

Future: NY State Interested in expanding beyond WNY

