The Triple Aim and Beyond
Partnering with Payers/Rethinking Partnerships

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Objectives

- Learn how Anthem successfully engaged and partnered with providers and the community to improve delivery of care and patient outcomes. While collaboratively improving patient care, quality and providing extensive data to reduce overall costs.
Enhanced Personal Health Care (EPhC)

- Allows practices to effectively transform to a patient-centered model

The following pillars were fundamental in our program development:

- **Pillar 1**: Payment redesign
- **Pillar 2**: Better access to care
- **Pillar 3**: Care management and coordination
- **Pillar 4**: Exchange of information
Understanding the EPHC Model

Enhanced Personal Health Care

Medical Cost Target
Determines eligibility for shared savings

Quality Score Card
Calibrates shared savings eligibility

Clinical Coordination Payments
Support investment in population health management

Provider Care Management Solutions
Population health analytic support

Care Delivery Transformation
Team and resources for performance improvement

Attribution
Algorithm to assign members to PCPs

Payment Model

Provider Support
Framework for Our Partnership: Characterized by Three Key Features

Primary Goal:
- Comprehensive understanding of an organization’s structure, culture and capabilities allowing the team to frame relevant, joint work together and operate from common ground

The assessment seeks to understand a provider’s:
- Vision, mission and organizational structure
- Primary Care Medical Home capabilities
- Use of HIT
- Member outreach and engagement process
- Care Management capabilities
- Risk stratification methodology
- Population health infrastructure
- Technical capabilities
- Measurement of success
Framework for Our Partnership: Characterized by Three Key Features

Use of the assessment information drives the development and dialogue around the Roadmap

The end product Roadmap incorporates:
- Baseline data analysis
- Summary of possible program opportunities based on shared story
- Proposed objectives, goals, targets to discuss and agree on
- Proposed action items/steps for Anthem and organization to carry out in order to achieve defined goals
Framework for Our Partnership: Characterized by Three Key Features

A forum for working together to assure program resources fit need, achieve desired outcome, and are being utilized effectively.

Typical Anthem team membership:
- Network Director
- Contract Lead
- Medical Director
- Patient-Centered Care Consultant
- Data Analytics representative (optional)

Frequent Organization team membership:
- Contract Lead
- Operations Lead/Finance
- Medical Director
- Physician Champion
- Quality/Transformation VP
- Care Management VP
- CIO or delegated Lead
A New Generation of Collaboration

- Today, multiple stakeholders must be involved in any effort to achieve system improvements in health care for better outcomes, better patient experience and lower costs
- They must also work collaboratively to improve patient care and quality, provide extensive data, and reduce overall costs
- Today, we have a collaborative goal between providers and payers with successful outcomes
Building the Program

- Many were hoping to work with us in a collaborative relationship and looking for a payer sponsored, value-based program.

- The health plan worked to lay the foundation for a partnership that providers would be excited to join.

- Leadership was able to create teams and resources quickly to support providers.
The Approach

- Anthem realized that a vital element in achieving successful patient-centered care was to maximize the strong relationship providers had already established with their patients.

- Anthem decided to invest a substantial amount of money and evolved the Enhanced Personal Health Care division.

- The program provides providers extensive support including streamlined data, clinical and practice tools, and field expertise.
Hurdles and Challenges

Providers seeing us as a collaborator rather than just a payer

Proving forward momentum

Getting the message out

Leadership buy-in

Data accuracy
Providers and Payer Working Together

- Our approach was to successfully engage with providers and communities to improve delivery of care and patient outcomes, and the keys to effective collaboration among stakeholders.

- We were very transparent with data and progress.
What helped different stakeholders work together effectively?

- Common goal of providing collaborative care to patient to achieve better health outcomes
Impact of Interventions - The Triple Aim

Components of the Triple Aim that can be achieved in partnerships of payers with providers and their staff

- **Quality of Care**
  - Increased with extensive data and resources

- **Better Patient Experience**
  - Better access to care
  - Enhanced patient engagement and care coordination
  - Defined care plans

- **Lower Health Costs**
  - Focus on health
  - Reducing avoidable emergency room utilization
Provide data to support the momentum that fosters patient-centered care and effectively implement intervention bundles
What are these Groups doing Differently with Data?

- Using Anthem’s data to identify practice improvement efforts and set practice goals, thereby impacting their entire patient population.
- Identifying patients who need additional intervention, based off of risk scoring, care gaps, utilization and burden of illness.
- Developing processes for planned visits, care planning, care coordination, and goal setting.
- Looking at their current costs and working to better manage utilization and increase condition stability.
Quality Measures and Performance Assessments

There are a total of 27 measures used to evaluate performance.

They are broken into two categories

- **Clinical quality measures**
  - Acute and chronic care measures
  - Preventive measures

- **Utilization measures**
## Utilization Measures

<table>
<thead>
<tr>
<th>Utilization Measures</th>
<th>Use Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potentially Avoidable ER Visits</td>
<td>This measure was developed using research regarding ER visits that may be treatable in an ambulatory care setting</td>
</tr>
<tr>
<td>Ambulatory Sensitive-Care Admissions</td>
<td>12 potentially avoidable hospitalizations for ambulatory care sensitive conditions as developed by AHRQ</td>
</tr>
<tr>
<td>Generic Prescriptions</td>
<td>5 classes of medications will be assessed for generic dispensing rate</td>
</tr>
</tbody>
</table>
Provider Care Management Solutions Reports

Reports available to care teams

<table>
<thead>
<tr>
<th>Patient Attribution Reports</th>
<th>Care Management Reports</th>
<th>Resource Utilization Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attribution list</td>
<td>Hot spotter report</td>
<td>ER view report</td>
</tr>
<tr>
<td>Detailed attribution list</td>
<td>Inpatient authorization report</td>
<td>Admission view report</td>
</tr>
<tr>
<td>No longer active list</td>
<td>Care opportunity report</td>
<td>Pharmacy report</td>
</tr>
</tbody>
</table>

Lists will support care team in tracking full panel of attributed members to identify patients who will be included in the practices attributed patient population.

Lists will support care team in managing high-risk members, identifying member gaps in care, and offering appropriate follow-up immediately post-acute discharge.

Lists will support care team in managing resource use, such as ER visits and admission reports. They can be used to identify opportunities to direct patients elsewhere.
Enhanced Personal Health Care Program
Performance Scorecard Overview

The Interim scorecard view does not represent the final scorecard used for performance evaluation for the measurement period. A final scorecard will be made available upon measurement period close-out.
### Scorecard Example

<table>
<thead>
<tr>
<th>Measures</th>
<th>My Organization</th>
<th></th>
<th>My Group</th>
<th></th>
<th>My Panel</th>
<th></th>
<th>Market</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adherent</td>
<td>Rate</td>
<td>Adherent</td>
<td>Rate</td>
<td>Adherent</td>
<td>Rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>223 / 315</td>
<td>70.79%</td>
<td>223 / 315</td>
<td>70.79%</td>
<td>865 / 1,216</td>
<td>71.14%</td>
<td>72.61%</td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>24 / 29</td>
<td>82.76%</td>
<td>24 / 29</td>
<td>82.76%</td>
<td>171 / 211</td>
<td>81.04%</td>
<td>80.37%</td>
<td></td>
</tr>
<tr>
<td>Medication Adherence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of Days Covered (PDC): for Hypertension (ACEI or ARB)</td>
<td>102 / 153</td>
<td>66.67%</td>
<td>102 / 153</td>
<td>66.67%</td>
<td>520 / 799</td>
<td>65.08%</td>
<td>65.18%</td>
<td></td>
</tr>
<tr>
<td>Proportion of Days Covered (PDC): Oral Diabetes</td>
<td>34 / 62</td>
<td>54.84%</td>
<td>34 / 62</td>
<td>54.84%</td>
<td>147 / 252</td>
<td>58.33%</td>
<td>59.68%</td>
<td></td>
</tr>
<tr>
<td>Proportion of Days Covered (PDC): for Cholesterol (Statins)</td>
<td>97 / 165</td>
<td>58.79%</td>
<td>97 / 165</td>
<td>58.79%</td>
<td>462 / 782</td>
<td>59.08%</td>
<td>60.52%</td>
<td></td>
</tr>
</tbody>
</table>
Tableau Example - Ambulatory Sensitive Admission Diagnoses

Top N ASC Diagnoses Trend 2014

ASC Diagnoses

<table>
<thead>
<tr>
<th>ASC Diagnosis Code</th>
<th>ASC Diagnosis Name</th>
<th>Allowed Asc</th>
<th>ASC Count (Drilldown)</th>
</tr>
</thead>
<tbody>
<tr>
<td>19415</td>
<td>HF (ACSC)</td>
<td>$125,361</td>
<td>5</td>
</tr>
<tr>
<td>19417</td>
<td>Bacterial Pneumonia (ACSC)</td>
<td>$118,370</td>
<td>4</td>
</tr>
<tr>
<td>19414</td>
<td>Diabetes (ACSC)</td>
<td>$83,592</td>
<td>4</td>
</tr>
<tr>
<td>19419</td>
<td>Dehydration (ACSC)</td>
<td>$79,120</td>
<td>5</td>
</tr>
<tr>
<td>19412</td>
<td>Asthma &amp; Bronchitis (ACSC)</td>
<td>$73,893</td>
<td>6</td>
</tr>
<tr>
<td>19413</td>
<td>COPD (ACSC)</td>
<td>$37,095</td>
<td>4</td>
</tr>
<tr>
<td>19418</td>
<td>UTI (ACSC)</td>
<td>$32,061</td>
<td>5</td>
</tr>
<tr>
<td>19416</td>
<td>HTN (ACSC)</td>
<td>$18,124</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td><strong>Grand Total</strong></td>
<td><strong>$563,616</strong></td>
<td><strong>35</strong></td>
</tr>
</tbody>
</table>

Source: Claims Data Visit Counts Date Range: 12/01/2013-11/30/2014
Tableau Example – Potentially Avoidable ER

Top N Pot. Avoidable ER Diagnoses Trend

<table>
<thead>
<tr>
<th>Potentially Avoidable ER Top 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis Code</td>
</tr>
<tr>
<td>7694</td>
</tr>
<tr>
<td>5699</td>
</tr>
<tr>
<td>5990</td>
</tr>
<tr>
<td>7242</td>
</tr>
<tr>
<td>78652</td>
</tr>
<tr>
<td>462</td>
</tr>
<tr>
<td>6202</td>
</tr>
<tr>
<td>4659</td>
</tr>
<tr>
<td>7820</td>
</tr>
<tr>
<td>85500</td>
</tr>
<tr>
<td>842</td>
</tr>
<tr>
<td>30000</td>
</tr>
<tr>
<td>78703</td>
</tr>
<tr>
<td>0038</td>
</tr>
<tr>
<td>8226</td>
</tr>
<tr>
<td>56400</td>
</tr>
<tr>
<td>78791</td>
</tr>
<tr>
<td>4871</td>
</tr>
<tr>
<td>4660</td>
</tr>
<tr>
<td>4019</td>
</tr>
<tr>
<td>Grand Total</td>
</tr>
</tbody>
</table>

*Potentially avoidable ER calculated based on commercial EPHC attributed members in the most recent month.
Achieving the Triple Aim

Intervention Bundle: A structured way of improving the processes of care and patient outcomes. A small, straightforward set of evidence-based practices — generally three to five — that, when performed collectively and reliably, have been proven to improve patient outcomes.

- **Chronic Care**
  - Management of Diabetes
  - Management of Coronary Artery Disease
  - Management of Congestive Heart Failure
  - Management of Asthma
  - Low Back Pain
  - Medication management

- **Access to Care**
  - Enhanced Access
  - Reduction of Avoidable ER Visits
  - Reduction of Avoidable Hospital Readmission

- **Integration of Behavioral Health**
  - Building the Foundation and the Coordinated Care Model
  - Co-located Model of Care
  - Fully Integrated Model of Care
Innovative resources for population management and care coordination and tools to build community partnerships and relate success stories from providers engaged in value-based programs.
Executive Summary

Purpose
- The EPHC program would like to partner with your practice to impact the Triple Aim of increased patient satisfaction, improved quality and decreased cost of care

Approach
- Through analysis of data from the Provider Care Management Solutions (PCMS) system, EPHC Scorecard and claims data, our team has identified two areas of potential opportunity for quality improvement and increased shared savings (Avoidable ER Visits and Diabetes)

Findings
- Potentially Avoidable ER Visits and Diabetes were identified as key opportunities. These focus areas allow for potential to impact clinical as well as cost of care efforts.

Recommendations
- Selection of an Intervention Bundle to support identified opportunities and impact the Triple Aim. Intervention Bundles are a structured way of improving the processes of care and patient outcomes: a small, straightforward set of evidence-based practices — generally three to five — that, when performed collectively and reliably, have been proven to improve patient outcomes
- Consider efforts to increase number of Care Management/Disease Management referrals to ensure patients are maximizing their benefits
- Identify and implement cost of care activities (site of service, generic dispensing) to maximize shared savings and decrease member financial burden
Executive Summary (continued)

Recommendations (continued)
- Monthly clinical review calls to include completion of Foundations curriculum, and review and focus of Hot Spotter patients with Diabetes, ER visits and inpatient admissions – to align with recommended intervention bundle
- Collaborate on a Learning Plan to support organizational goals and efforts

Implementation Considerations
- Fill-in Based on knowledge of practice

Next Steps
- Define shared goals for 2016 around improvement initiatives including selection of Intervention Bundle, Cost of Care opportunities and care management collaboration
- Determine frequency of transformation meetings with Care Consultant (CC)
- Schedule regular clinical meetings with Provider Clinical Liaison (PCL)
- Determine SMART goal for measuring efforts (How we will know if what we are doing is working?)
- Establish a forum to develop a learning plan to support area(s) of focus
## Patient Population: PCMS Summary

This table provides a high level snapshot of information patient population information in PCMS

<table>
<thead>
<tr>
<th>Condition</th>
<th>Overall Patient Count</th>
<th>Hot Spotter Chronic Patient Count</th>
<th>Percentage of Population on Hot Spotter</th>
<th>Risk driver count by condition</th>
<th>Average Gap Score</th>
<th>Patients with Inpatient admissions</th>
<th>Patients with 2 or more Inpatient admissions</th>
<th>Percentage of patient with inpatient admit with 2 or more</th>
<th>Patients with ER visits</th>
<th>Patients with 2 or more ER Visits</th>
<th>Patients with Urgent Care Visits</th>
<th>Patients with 2 or more Urgent Care Visits</th>
<th>Percentage of Patients with 2 or more Urgent Care</th>
<th>Patients with Care Opportunities</th>
<th>Percentage of Patients with Care Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>9271</td>
<td>356</td>
<td>4%</td>
<td>744</td>
<td>8.12</td>
<td>5214</td>
<td>5214</td>
<td>100%</td>
<td>7131</td>
<td>7131</td>
<td>100%</td>
<td>1393</td>
<td>353</td>
<td>25%</td>
<td>2405</td>
</tr>
<tr>
<td>Diabetes</td>
<td>828</td>
<td>179</td>
<td>22%</td>
<td>409</td>
<td>9.66</td>
<td>622</td>
<td>622</td>
<td>100%</td>
<td>794</td>
<td>794</td>
<td>100%</td>
<td>184</td>
<td>57</td>
<td>31%</td>
<td>551</td>
</tr>
<tr>
<td>Asthma</td>
<td>525</td>
<td>76</td>
<td>14%</td>
<td>52</td>
<td>7.22</td>
<td>382</td>
<td>382</td>
<td>100%</td>
<td>451</td>
<td>451</td>
<td>100%</td>
<td>137</td>
<td>59</td>
<td>43%</td>
<td>140</td>
</tr>
<tr>
<td>CHD</td>
<td>336</td>
<td>72</td>
<td>21%</td>
<td>47</td>
<td>7.70</td>
<td>286</td>
<td>286</td>
<td>100%</td>
<td>325</td>
<td>325</td>
<td>100%</td>
<td>96</td>
<td>32</td>
<td>33%</td>
<td>165</td>
</tr>
<tr>
<td>COPD</td>
<td>209</td>
<td>57</td>
<td>27%</td>
<td>17</td>
<td>6.43</td>
<td>170</td>
<td>170</td>
<td>100%</td>
<td>201</td>
<td>201</td>
<td>100%</td>
<td>84</td>
<td>43</td>
<td>51%</td>
<td>121</td>
</tr>
<tr>
<td>CHF</td>
<td>80</td>
<td>45</td>
<td>56%</td>
<td>13</td>
<td>7.79</td>
<td>73</td>
<td>73</td>
<td>100%</td>
<td>78</td>
<td>78</td>
<td>100%</td>
<td>36</td>
<td>16</td>
<td>44%</td>
<td>54</td>
</tr>
<tr>
<td>HTN</td>
<td>2395</td>
<td>277</td>
<td>12%</td>
<td>81</td>
<td>8.43</td>
<td>1704</td>
<td>1704</td>
<td>100%</td>
<td>2200</td>
<td>2200</td>
<td>100%</td>
<td>465</td>
<td>143</td>
<td>31%</td>
<td>956</td>
</tr>
<tr>
<td>Migraines</td>
<td>201</td>
<td>34</td>
<td>17%</td>
<td>0</td>
<td>4.64</td>
<td>161</td>
<td>161</td>
<td>100%</td>
<td>185</td>
<td>185</td>
<td>100%</td>
<td>77</td>
<td>29</td>
<td>38%</td>
<td>42</td>
</tr>
<tr>
<td>Obesity</td>
<td>456</td>
<td>66</td>
<td>14%</td>
<td>18</td>
<td>6.11</td>
<td>360</td>
<td>360</td>
<td>100%</td>
<td>432</td>
<td>432</td>
<td>100%</td>
<td>112</td>
<td>37</td>
<td>33%</td>
<td>131</td>
</tr>
</tbody>
</table>

- Condition specific and Hot Spotter patients counts identify the number of patients within the attributed population which have a history of that diagnosis. Patients may overlap into categories due to comorbidities.
- Hot Spotter patients counts identify the number of patients on the Hot Spotter report which have a history of that diagnosis. Patients may overlap into categories due to comorbidities.
- Percentage of Hot Spotter Percentage identifies the percentage of patients of particular condition which are one the Hot Spotter report
- Percentage of patients with 2 or more admits identifies patients with an inpatient visit who had 2 or more inpatient stays within the calendar year
- Percentage of patients with 2 or more ER visits identifies patients with an ER visit who had 2 or more ER visits within the calendar year
- Patients with Care Opportunities include patients with past due, due in 30, due in 60 and due within the calendar year

**Please note:** Presently, we do not offer intervention bundles for migraine or obesity at this time. This information is included in this table as these conditions are included within the Hot Spotter report
Summary of Potential Opportunities – Area of Focus - ER Reduction

These suggestions represent an excellent opportunity to improve quality and impact medical costs, scorecard measures and overall patient and population health.

<table>
<thead>
<tr>
<th>Data Highlights</th>
<th>Clinical/Process Interventions</th>
<th>Cost of Care Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 2710 patients accounted for 3639 visits</td>
<td>• Transitions of Care</td>
<td>• Maximizing Site of Service Opportunities</td>
</tr>
<tr>
<td>• 35% of total ER visits are potentially avoidable</td>
<td>• Patient Education for ER alternatives</td>
<td></td>
</tr>
<tr>
<td>o Pediatric ER visits accounted for 26% of all visits with 42% of pediatric visits being identified as potentially avoidable</td>
<td>• Self-Management Support Structures</td>
<td></td>
</tr>
<tr>
<td>o Adult ER visits accounted for 73% of all visits with 32% of adult visits being identified as potentially avoidable</td>
<td>• Expanded office hours/24 hour on call</td>
<td></td>
</tr>
<tr>
<td>o Senior ER visits accounted for 1% of all visits with 28% of pediatric visits being identified as potentially avoidable</td>
<td>• Care Compacts with Specialists/Facilities</td>
<td></td>
</tr>
<tr>
<td>• Sunday was identified as highest utilization day (633) followed by Saturday (591).</td>
<td>• BH/SA screening</td>
<td></td>
</tr>
<tr>
<td>o Visits on these days account for 33.6% of all ER visits and 34.8% of all potentially avoidable visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Upon Review of ER visit Diagnosis Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o The top 15 potentially avoidable diagnoses for pediatrics (n=232) accounted for 59.4% of total visits (n=390) identified as potentially avoidable for pediatric population.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o The top 15 potentially avoidable diagnoses for adults (n=405) accounted for 47% of total visits (n=868) identified as potentially avoidable for adult/senior population</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o 249 ER visits were identified with an Ambulatory Sensitive Condition Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 78% of ER visits occurred at one of the identified top 10 Facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Claims data (04/01/2014-03/31/2015) indicates ER utilization trending upward</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Potentially Avoidable Visits/1000 (RA) has increased from 65.9 to 77.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o ER Visits/1000 (RA) has increased from 182.4 to 196.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Top 20 Potentially Avoidable ER visits for the claims period account for 1201 visits with a cost of $826,795.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o 28 inpatient admissions identified with an ambulatory sensitive diagnosis accounted for claim cost of $326,047.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Next Steps

Select an area of Focus based on highest opportunities prevalent in the data and then select the appropriate supporting Intervention Bundle

- Bundles are small, straightforward sets of evidence based practice, that when performed collectively and reliably, have been proven to improve patient outcomes and cost. ~ IHI

Set a SMART goal

- A SMART goal is a way to guide and quantify objectives and outcome measures
  - Specific, Measureable, Actionable, Realistic, Time-bound
  - Example: Our goal is to reduce avoidable ER visits by 10% over the next 18 months for the full Anthem population.

Establish ongoing meeting plan (frequency, attendees, next date)

- Determine frequency of transformation meetings with the transformation team
- Meeting agendas may include development of PDSA Cycles, care management action plan review, tools/resource review, workflow reviews, or quality improvement activities review

Creation of PDSA Cycle

- Assist the practices with evaluation of the current workflows and look for opportunities for change through the data

Collaborate on a Learning Plan

- A learning plan documents the specific education, tools and resources needed to drive an intervention in order to achieve a stated outcome.
Sharing Meaningful Information

- Using the trends identified in Anthem’s data to identify practice improvement efforts and set practice goals
- Determining ways to obtain similar information using their Health Information Technology thereby impacting their entire patient population
- Identifying patients who need additional intervention, based off of risk scoring, care gaps, utilization and burden of illness. Proactively monitoring and engaging patients in care.
- Developing processes for planned visits, care planning, goal setting
- Providing care coordination services, patient self-management support as key aspects of care
- Looking at their current costs, the target they are shooting to fall below and working to better manage utilization and increase condition stability
Identify innovative resources for population management and care coordination and tools to build community partnerships and relate success stories from providers engaged in value-based programs.
Coordinated Model of Care

Understand the basic strategies of the Coordinated Care model

- Identify and engage patients
- Initiate and provide treatment and/or referrals
- Track treatment outcomes/referral outcomes
- Proactively adjust treatment if patients are not responding
Program Success
Successes

- Provided dedicated team members to help practices create new workflows and resources
- Shared extensive resources and hands-on support, eliminated obstacles
- Worked towards provider collaboration, sharing data and increasing transparency
- Worked through tough conversations toward our mutual goal of transformation
- Create a dedicated time to discuss roadblocks, issues, questions, and share success stories
Successes

- Sought continuous feedback from practices
- Maximized hiring and training our field team to best support practice teams
- Emphasized ways practices could implement value-based care with all patients
- Provided Collaborative Learning
Enhanced Personal Health Care Delivers Results

$9.51
PMPM gross savings over the first year (3.3%)

$6.62 PMPM
Net savings

Reduced Costs

Improved Patient Experience

Improved Population Health/Quality
Enhanced Personal Health Care Delivers Results

- **5.7% fewer** inpatient days per 1,000
- **5.1% PMPM decrease** in outpatient surgery costs
- **7.8% fewer** acute inpatient admits per 1,000
- **3.5% PMPM decrease** in ER visit costs and a **1.6% decrease** in ER utilization
- **7.4% decrease** in acute admissions for high-risk patients, and an **increase of 22.9 per 1,000 PCP visits for high-risk patients**

*Results from Anthem’s EPHC Program year 1
Enhanced Personal Health Care Delivers Results

Participating providers performed better than non-participating peers:

- **9.6% better** in pediatric prevention
- **4.8% better** in annual monitoring of persistent medications
- **4.3% better** in diabetes care
- **4.3% better** in cervical and breast cancer screening
- **3.9% better** in other acute and chronic care measures

*Results from Anthem’s EPHC Program year 1*
Enhanced Personal Health Care Delivers Results

Members who saw participating providers reported:

- Better access to urgent care
- Felt providers “always listened to them with respect”
- Their providers addressed addiction and mental health problems – an 11 percentage point improvement from a year earlier
Questions?

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