

XLHealth

Inform. Empower. Excel.

Caring for Members with Chronic Diseases: Diabetes

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CARE IMPROVEMENT PLUS

Specialized care for Medicare beneficiaries



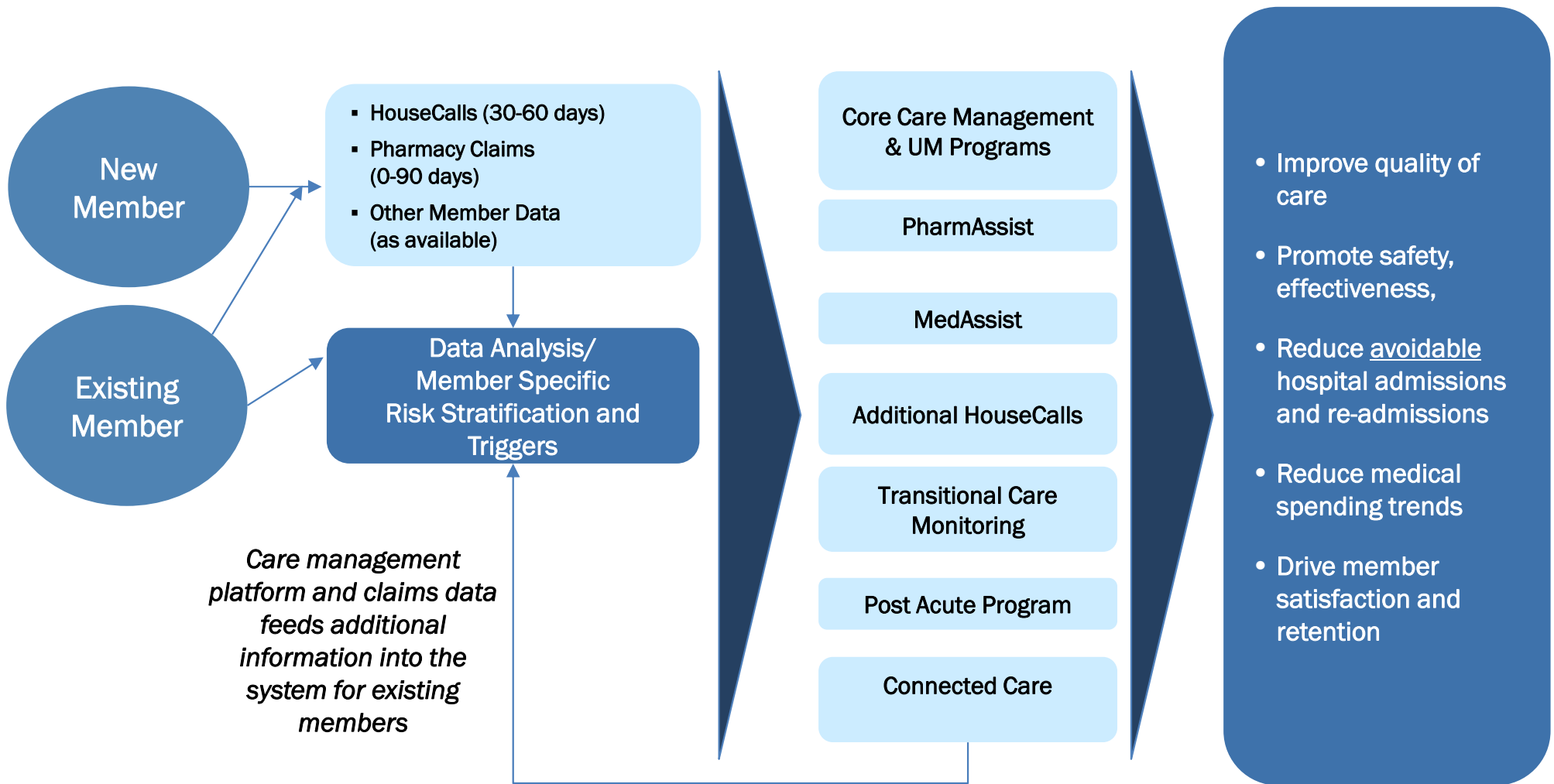
Key Facts

- **XLHEALTH operates the largest chronic condition special needs plan in the country.**
- Majority join from FFS Medicare
- **Membership of 115,000 (12/31/2011)**
- Plans include C-SNP (78%), D-SNP (11%), and MAPD
- **88% have diabetes, 54% have heart failure**
- 2011 States: AR, GA, MD, MO, SC, TX
- 2012 Expansion States: IL, IN, IA, NM, NY, WI
- **61% live near/below the poverty line**
- **53% of C-SNP enrollees are dual eligible**
- Membership (77%) in rural counties
- Majority live in medically underserved areas, not enough PCPs
- Low health literacy, 3 in 4 do not have a HS education
- Nearly 48% are permanently disabled, average age (non disabled) is 76
- Take 11-14 unique meds/month



XLHealth Coordinated Care Platform

Model of Care: Clinical Strategies





XLCare is Powered by Member Medical Data

- XLCare™ is XLHealth's proprietary integrated healthcare information workflow system
 - Used by all medical management programs and personnel
- Integrated across XLHealth's care management platform
- Physician medical record reviews (including HouseCalls) are captured in system
- Early identification of clinically frail members allows XLHealth to prioritize members and intervene in a timely fashion
- Integrated IT provides:
 - Medical cost and utilization trending data
 - Outcomes tracking analysis

Information Technology & Medical Management Tools



● XLHealth innovations

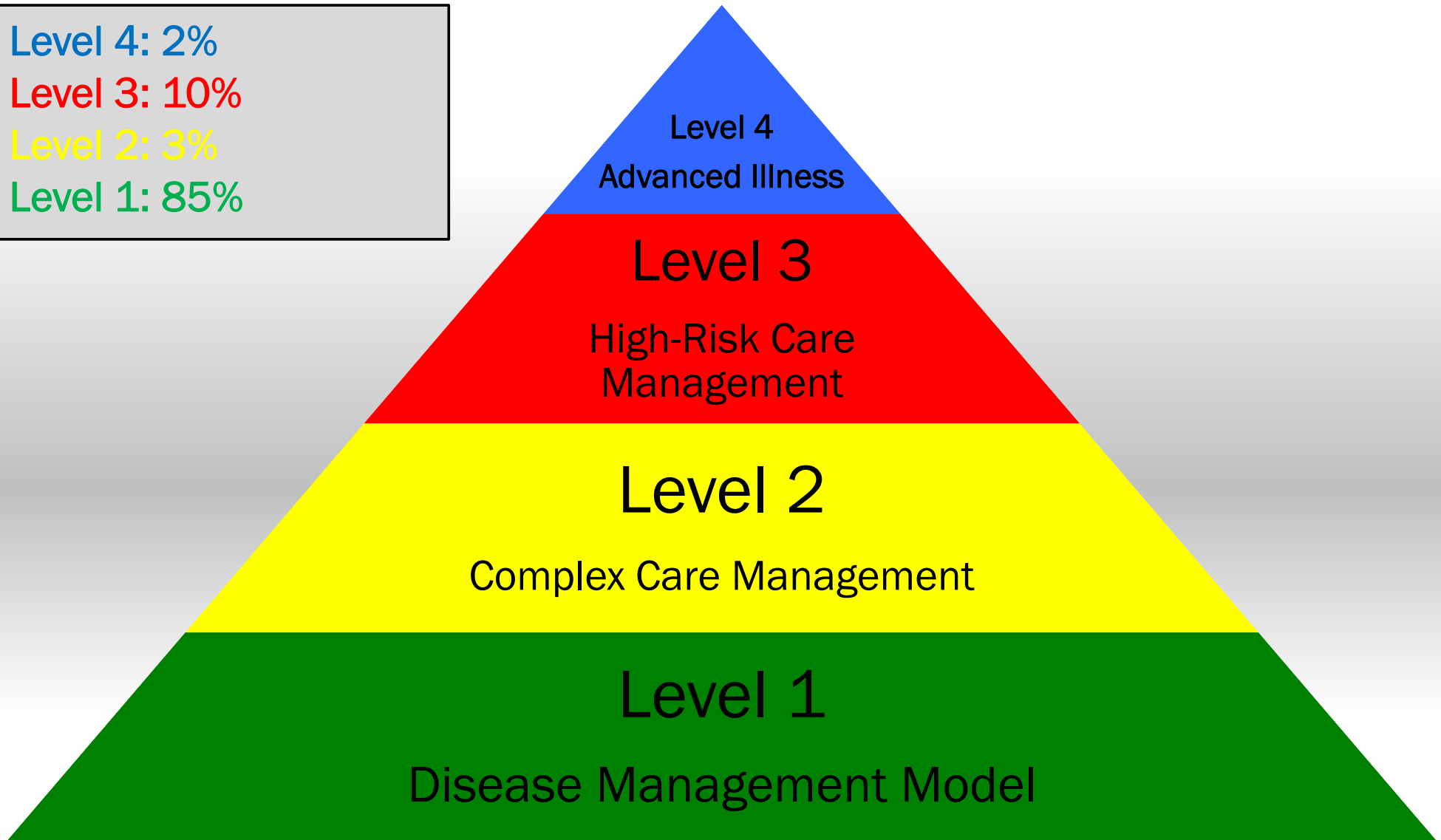
How Do We Focus On The Right Member?

Level 4: 2%

Level 3: 10%

Level 2: 3%

Level 1: 85%



HouseCalls - Program Overview

■ HouseCalls are:

- 40- to 60-minute preventive care annual in-home visits with a nurse practitioner or doctor
- Comprehensive history and physical, brown bag review of medications, deep member education with administration of flu shots and performance of diagnostic tests
- In-home post hospital discharge visits on 15%-20% most “at risk”
- **Starting mid-2012, will serve as “medical home” for 20% highest risk members who do not have established relationships with PCPs**
- Focused follow-up visits beginning mid-2012

■ HouseCalls Practitioners

- Are independent professionals licensed in each state
- Specially trained, work-flow managed and credentialed by XLHealth
- Use proprietary tablet that is “pre-loaded” with all known clinical and care management data **before HouseCalls visits**
- Share all medical conditions, clinical findings and treatment recommendations with PCP and XLHealth staff (generally on same day of visit)

HouseCalls Key Facts

- 106,000 home visits in 2011
- 140,000 visits projected 2012
- ~85% of members accept and receive a HouseCalls annually
- Networks of 275-300 nurse practitioners and doctors

MedAssist – Background

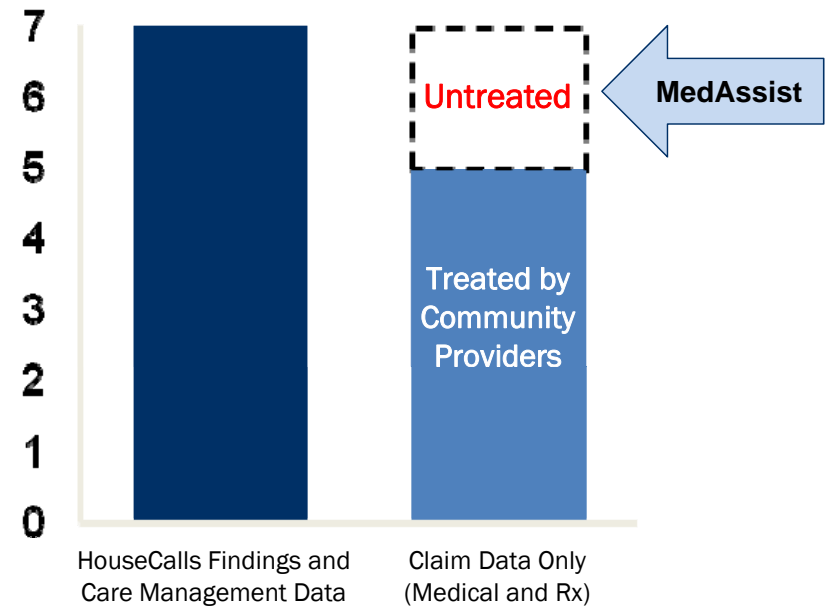
Findings

- HouseCalls data increase knowledge and timeliness of knowledge on patients' conditions
- Early action on data has huge potential for patient health, especially in chronic population

MedAssist Identifies New Treatment Needs

More than 200,000 potential areas of treatment identified

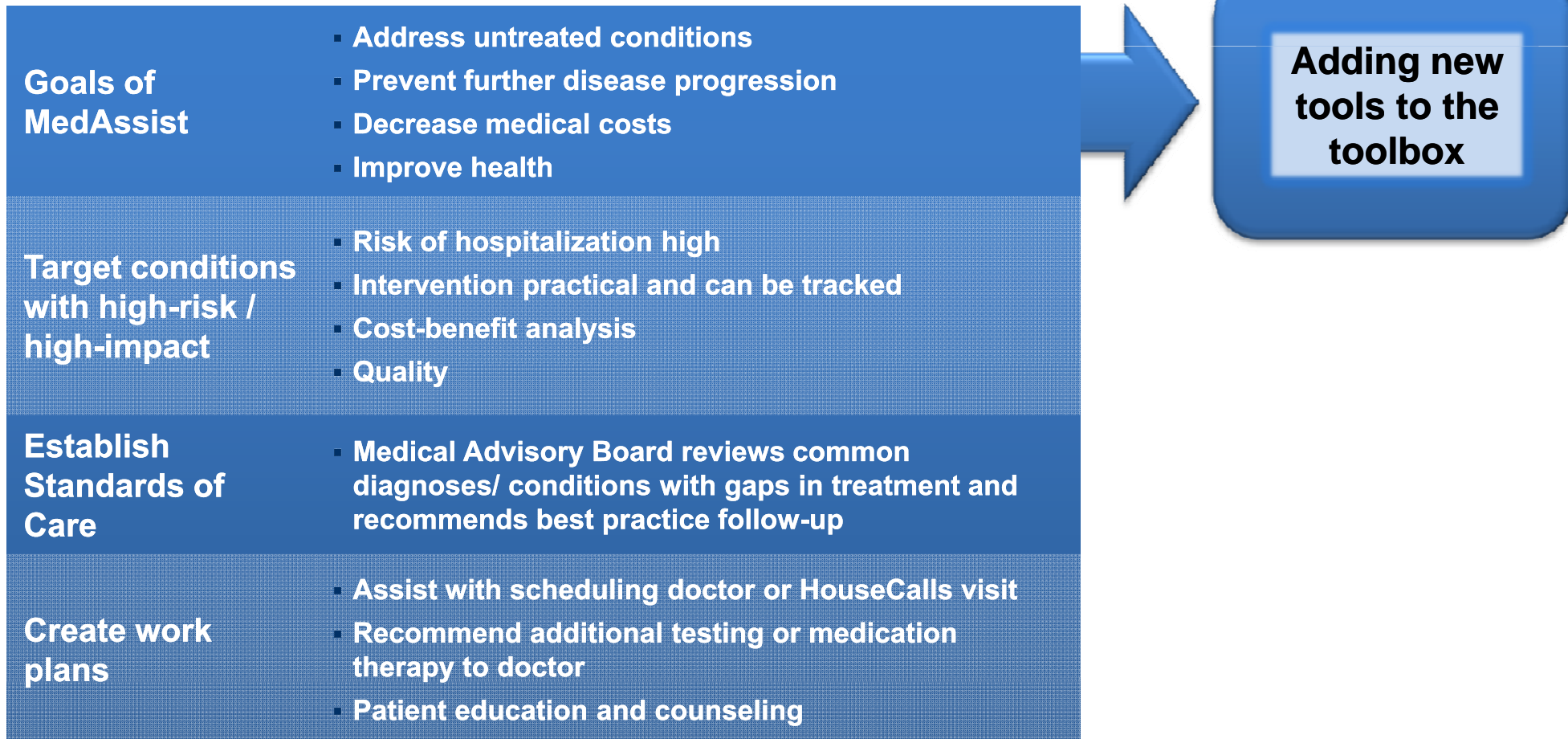
(# of diagnoses, not to scale)





MedAssist – Goals of Program

Robust HouseCalls, pharmacy and other data are essential





MedAssist – Program Description

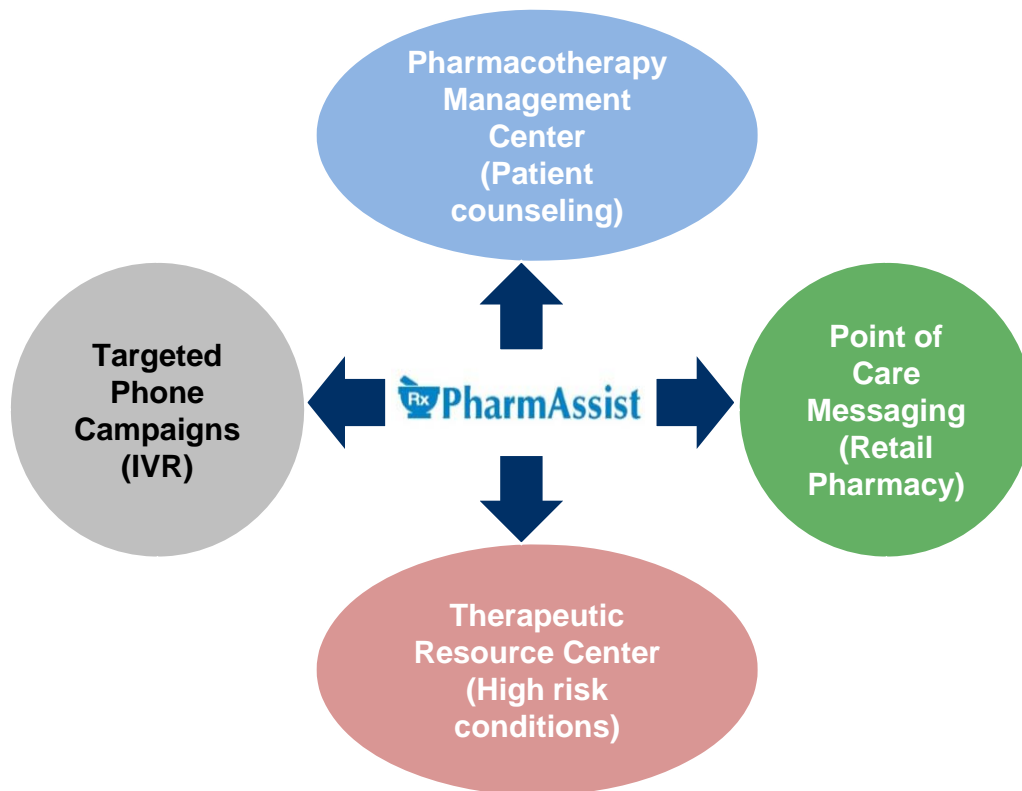
- Initial work :
 - Diabetic neuropathy
 - Malnutrition and morbid obesity
 - Chronic kidney disease
 - Retinopathy
 - Depression
 - Dementia
 - Osteoporosis
 - Acid Reflux
 - Uncontrolled Diabetes

Program Outcomes 2011

- A significant number of XLHealth members have needs that are not treated by any provider.
- More than 200,000 potential gaps in care identified
- 87,000 treatment gaps in approximately 20 categories targeted for high-impact interventions
 - 90% of those contacted received some form of intervention
 - 30,000 members will begin treatment or follow-up for previously unknown or untreated condition
 - 30,000 appointments and clinical interventions
 - 43,000 members with follow-up, counseling, behavioral health or social assistance

PharmAssist Program Overview

PharmAssist identifies beneficiaries to maximize medication management, ensuring safe and effective drug therapy, and improving control of disease



GOALS

- Prolong life
- Decrease symptoms
- Prevent hospitalization
- Improve quality of life
- Save overall costs

RISKS

- Polypharmacy
- Side effects
- Wrong dose
- Wrong drug
- Drug interactions

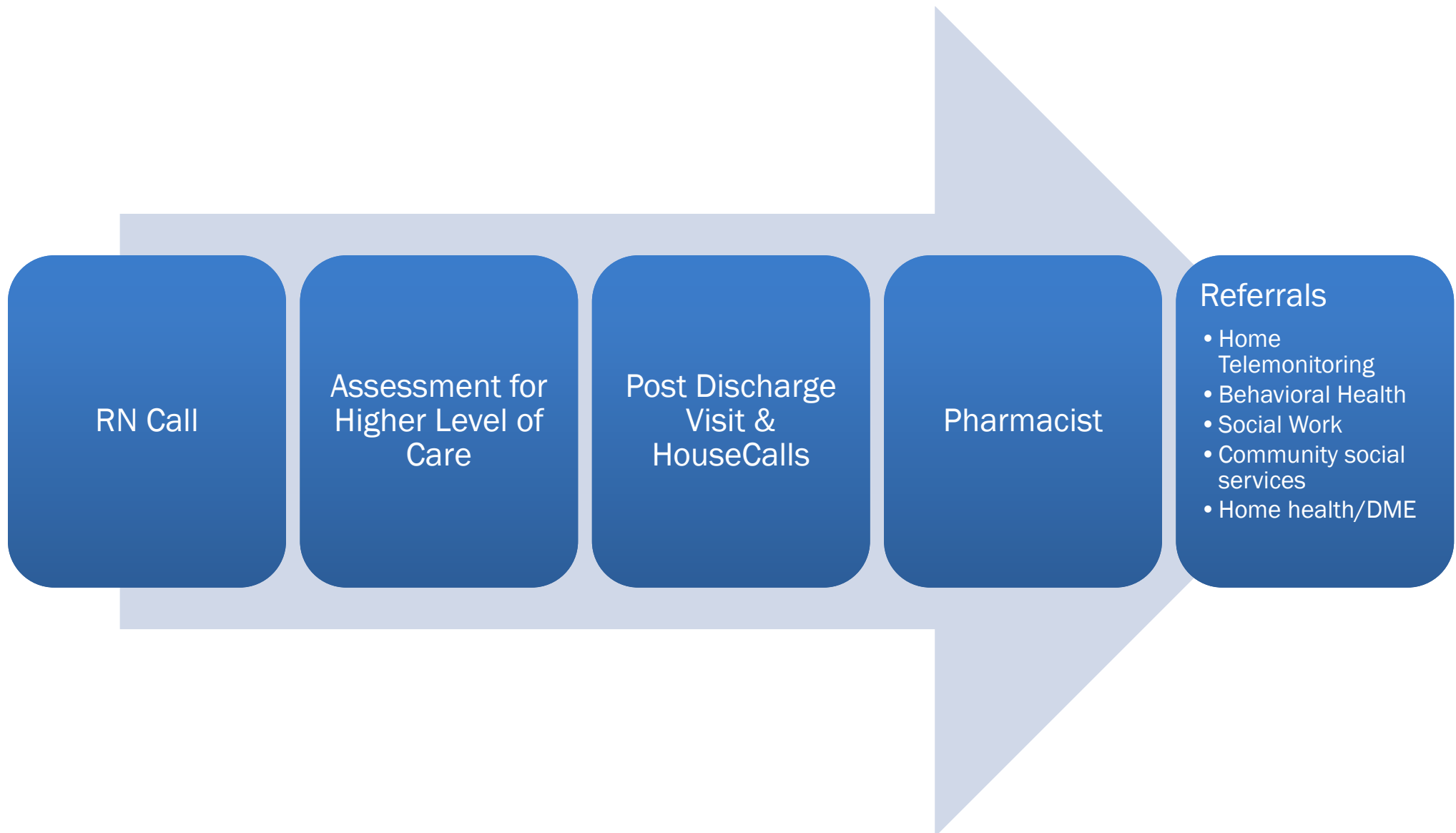
2011 Key Facts

- **3.3 million touches** to patients, pharmacists and physicians in 2011
 - Over 33,000 patient consults with a clinical pharmacist
 - >35,000 faxes to doctors alerting a potential patient problem
 - **>2,000 urgent calls placed to doctors**

- 2.9 million patient safety alerts at retail pharmacy before med dispensed



Transitions of Care Post Hospitalization



The logo for Connected Care features a blue heart shape formed by two hands cupping it from below.

Connected Care

- Educate on disease problem and options
- Support family and member in symptom management
- Facilitate family and member goals
- Earlier enrollment in hospice
- Avoid preventable hospitalizations and readmissions



XLHealth Versus FFS: Utilization Study

- XLHealth/AHIP study compares XLHealth versus Medicare FFS utilization rates, using XLHealth & Medicare 5% sample data
 - Study established comparable populations
 - 5% sample data matched to XLHealth geographies and age/sex/race demographics
 - Normalized for risk scores using claims data to ensure comparability
 - Criteria also included 12 months of enrollment and presence of a diabetes claim, for comparability to 5% sample
 - Focus of study is beneficiaries with diabetes; data set used XLHealth continuously enrolled 2010 enrollees

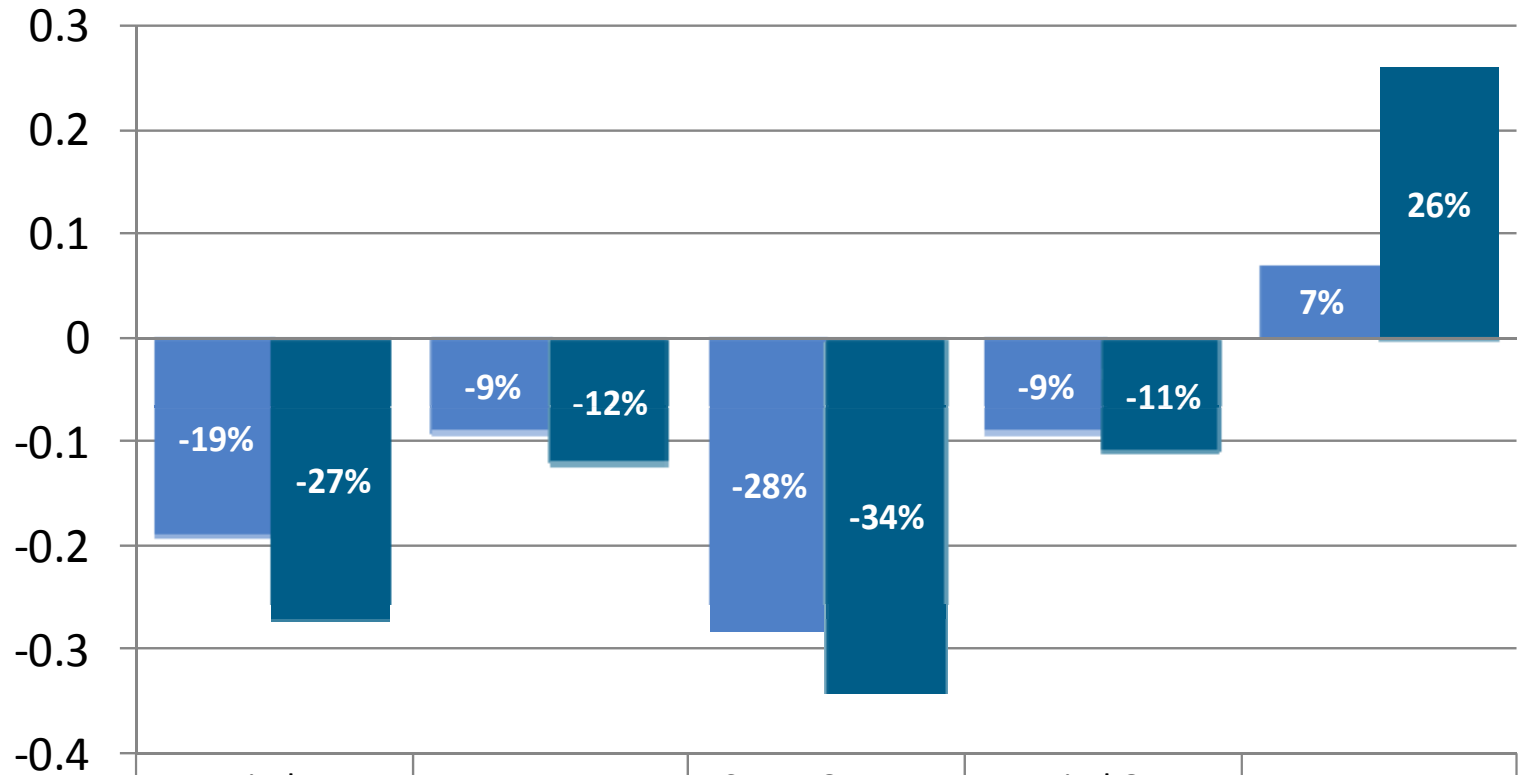
- Results published in the January 2012 edition of *Health Affairs* dedicated to “Confronting the Growing Diabetes Crisis”*

* Cohen R, Lemieux J, Schoenborn J, Mulligan T. Medicare Advantage Chronic Special Needs Plans boosted primary care, reduced hospital use among diabetes patients. *Health Aff.* 2012;31(1):10-119.



Comparison Results

XLHealth Versus FFS Utilization Results



	Hospital Inpat Days	Hospital Admits	Same-Quarter Readmits	Hospital Output Visits	Physician Visits*
All Diabetes Patients	-0.19	-0.09	-0.28	-0.09	0.07
Nonwhite Diabetes Patients	-0.27	-0.12	-0.34	-0.11	0.26

XLHealth Plan performance was markedly better than FFS in all key categories.

* Does not include HouseCall visits in XLHealth data



Authors' Conclusions

- Margins by which hospital admission and readmission rates were reduced in the XLHealth plan are “far too large to be explained by any issues with risk or geographic comparability.”
- Extra attention to in-home and direct patient care provided in the XLHealth program studied is associated with reduced hospitalization and readmission rates among enrollees.
- Diabetes patients in the XLHealth sample had lower hospitalization rates and readmissions than their peers in FFS, but many more physician office visits.
- Nonwhite diabetes patients in the FFS sample had **markedly** higher hospitalization and outpatient visit rates, and averaged nearly one fewer physician visit per year than all FFS patients.
- *“It is especially noteworthy that the XLHealth program appears to moderate the long-standing tendency for non-white patients to have higher rates of hospitalization and lower rates of physician visits than Medicare enrollees in general.”*