Testimony of Jacquelyn Walsh

North Dakota Legislative Management

Interim Healthcare Reform Committee

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Mr. Chairman and Members of the Committee, my name is Jacquelyn Walsh. I am the Vice President of Clinical Excellence and Quality at Blue Cross Blue Shield of North Dakota (BCBSND). Thank you for the opportunity to speak with you today. I have been asked to speak about BCBSND's clinical and quality innovations and discuss the ongoing challenges of maintaining affordability for our fellow North Dakotans.

As a matter of introduction, I'd like to share a bit about my career in healthcare. I am a Registered Nurse and I have spent the majority of my career of 38 years working as a healthcare executive in the state of North Dakota. Up until 3 years ago when I came to BCBSND, I worked in small and large hospitals, small and large independent and integrated health systems both, and non-profit and for profit systems.

My first job as a newly graduated Registered Nurse was in a small community hospital in ND where my husband was attending college. Two of my mentors in this small hospital had been student nurses during World War ll where, due to limited nursing resources, they worked on the hospital units taking care of patients because there were not enough nurses due to the war effort. There also was not enough material supplies and equipment due to the war resource needs either. What a wonderful gift it was to work with these two ND nurses who continually reminded me that we must always be good stewards of our resources, human and material, as there are many times when they will be limited. In fact, one of the RN's said to me repeatedly

in a kind way, “Mark my words, the way things are going, healthcare is going to become too expensive to provide care for our patients if we aren’t more careful about our resources!” It established my thought process for patient care throughout my entire nursing career, be a good steward so that everyone has what they need to have the best outcome possible.

As you recall, my colleague Dr. Elizabeth Faust spoke to you in November about changes needed in the U.S. healthcare system. The reality is that healthcare in this country is so complicated and so expensive that we will be unable to sustain it much longer. The current healthcare spend is at 18% of the gross national product. Compare that to when I started my career in the late 70’s, when healthcare spend was closer to 4 – 8%, depending on the resource you use. For many of us, the hardest part is in knowing that although the US is #1 in spending, we are only #38 in terms of positive outcomes.

Today, I will share the areas of innovation and action that our work at BCBSND is producing to try and improve the health and wellbeing of our members. The center of this work is focused on care coordination, which is key to helping our members in partnership with their provider better manage their healthcare. Through designated and intimate case management, we are able to assist our members to make the best decision possible with regard to their ongoing healthcare. As so often happens, the Case Manager becomes involved after a healthcare episode has occurred, however, it is not too late. For example, the Case Manager makes sure the transfer to an appropriate level of care from hospitalization occurs, that post discharge follow up appointments are made and completed, that the post discharge medications are filled at the pharmacy and clearly understood by the member.

Once inpatient level of care is no longer needed, examples of lower levels of care could be: transitional care, subacute care, long term acute care or skilled nursing care. If there are issues identified on a post discharge phone call by the Case Manager, she will reach out to the provider directly on behalf of the member to clarify and assist with additional actions necessary to make sure the member has what they need at another facility or at home. Although transitional case management (hospital to lower level of care to home) is common, a longer term case management episode may be necessary when the medical condition is more complex over a longer period of time.

Several large employer groups in ND have designated Case Managers to assist with the members in order to have consistency with process and communication. The Case Manager is able to learn more about the employer group, its culture, the member's unique health risks and health needs. BCBSND has done this in order to enhance the personal touch of our Case Managers with large employer groups in order to specialize in managing their healthcare needs. Case Managers are able to concentrate on the acute health care needs of these members in a personal, high touch manner. We have found that this personalized care has made a difference for our members as proven in the recent case management member survey with a 73% satisfaction rate.

There has also been a considerable cost savings demonstrated with the case management activities. Through the third quarter of 2015, over $3M has been saved by coordinating our members care through transition from inpatient care into a lower level of care when medically appropriate, as well as ongoing follow up care to prevent potential complications which would necessitate readmission to inpatient care if untreated. And, in conjunction with our disease

management partner who assists us with care coordination of rare and complex disease management, we have saved over $4M by preventing admissions or readmissions due to potential complications related to these complex diseases.

I'd like to direct you to slide #1 in your packet which is a slide that Dr. Faust used when she gave her testimony. If you would look at the "at risk" bubble in the center of this slide, I'd like to point out this is the population of our membership that we really have the best opportunity to impact from a health outcome standpoint. The "at risk" member has not had a complex medical event as of yet but is at risk to do so and we are trying to prevent that from happening as I will explain below. The "simple chronic" and the "complex chronic" member have already had a health event and we are managing them through the case management and disease management staff.

Patient centered medical home, at BCBSND it is called MediQhome, is a care coordination philosophy utilized to manage members through primary care providers. BCBSND has had a patient centered medical home since 2008, one of the longest running medical homes among our Blue Cross family nationally.

BCBSND assists our MediQhome clinics with securing resources to manage their patients care more effectively by providing a "care management fee" to reimburse for such resources as well as recognizing certain clinical quality metrics required to be eligible for these fees. These resources include health coaches, additional nursing staff, support for health education for patients, support for nursing education, etc.

Medical homes have become the foundation for population health in a way that we never imagined but, doesn't it make sense to focus on primary care for managing health and save the specialty care for when it is really needed? And certainly in ND, we have a very strong primary care system who care for the majority of the folks in our state. We are very proud of MediQhome but we are equally proud to be moving into the next generation where the clinical quality metrics will move from a disease suite to a population health focus related to quality outcomes that validate positive care coordination at the primary care provider level.

BCBSND continues to strive to enhance and broaden our health management programs, including adding more data to inform our providers and groups, metrics and measurement tools, and financial incentives to motivate consumer engagement from each of our market segments and across the entire health continuum. Health contingent (outcomes based) programs for ND employer groups are key and include blood pressure management, tobacco cessation, weight management and primary care physician engagement. Additionally, BCBSND continues to invest in new technologies to meet the wellness needs of our diverse membership. For example, we now have the ability to integrate with the majority of "smart" devices to track and incentivize members for their physical activity. BYOD - Bring your Own Device Program - allows members to utilize the technology and/or application that they currently have and are familiar with to integrate into the BCBSND Wellness Platform. No longer is it just about reimbursing members for fitness club membership and for the last two years, BCBSND provides more incentives that are earned online for wellness activities than at a health club. Our wellness programs at BCBSND are where our members live and work every day. In addition, BCBSND is considering virtual fitness classes that can be completed at the members place of employment or at their home. Finally, BCBSND continues to explore innovative and collaborative ND solutions to improve the health and wellbeing of North Dakotans.

I would be remiss if I didn't not talk about BCBSND relationship with our participating providers. First of all, I want to tell you that I love working with providers – hospitals and clinics for sure, but even more importantly physicians! I have had the opportunity over the years to work with some of the best physicians in North Dakota! And, I can tell you that their primary focus is to do the best they can for their patient in order to have the best health outcome. It is how they are trained and it is what they want to do! And, it is very hard work! I have incredible empathy for physicians and I spent so much time on the provider side making sure they had the resources and support to take the very best care of patients possible. After all, I am a consumer of health care too and I want someone to help my physician in the same way so that I can have the same good outcome. At BCBSND, we have several initiatives working with our participating providers, physicians and hospitals alike, to provide access to the best care possible.

Accountable Care Organizations (ACO's) are broad provider based organizations that manage health care of a defined population, in this case BCBSND members, to strive to reduce costs and improve health care quality and patient experiences. ACO's align incentives and reduce fragmentation within health care delivery systems to meet the "triple aim". I believe Dr. Faust talked about this, the triple aim components are: improving health of populations (better health), improving experience of care (better care) and reducing per capita costs of health care (lower costs). BCBSND is working on an ACO model to take to our providers in order to improve the health care of our members, reward high quality care by providers, and reduce the total cost of care. By July of this year, we will have contracted with those providers in ND who are interested and have the capability and ability to be an ACO and we do have some! Patient

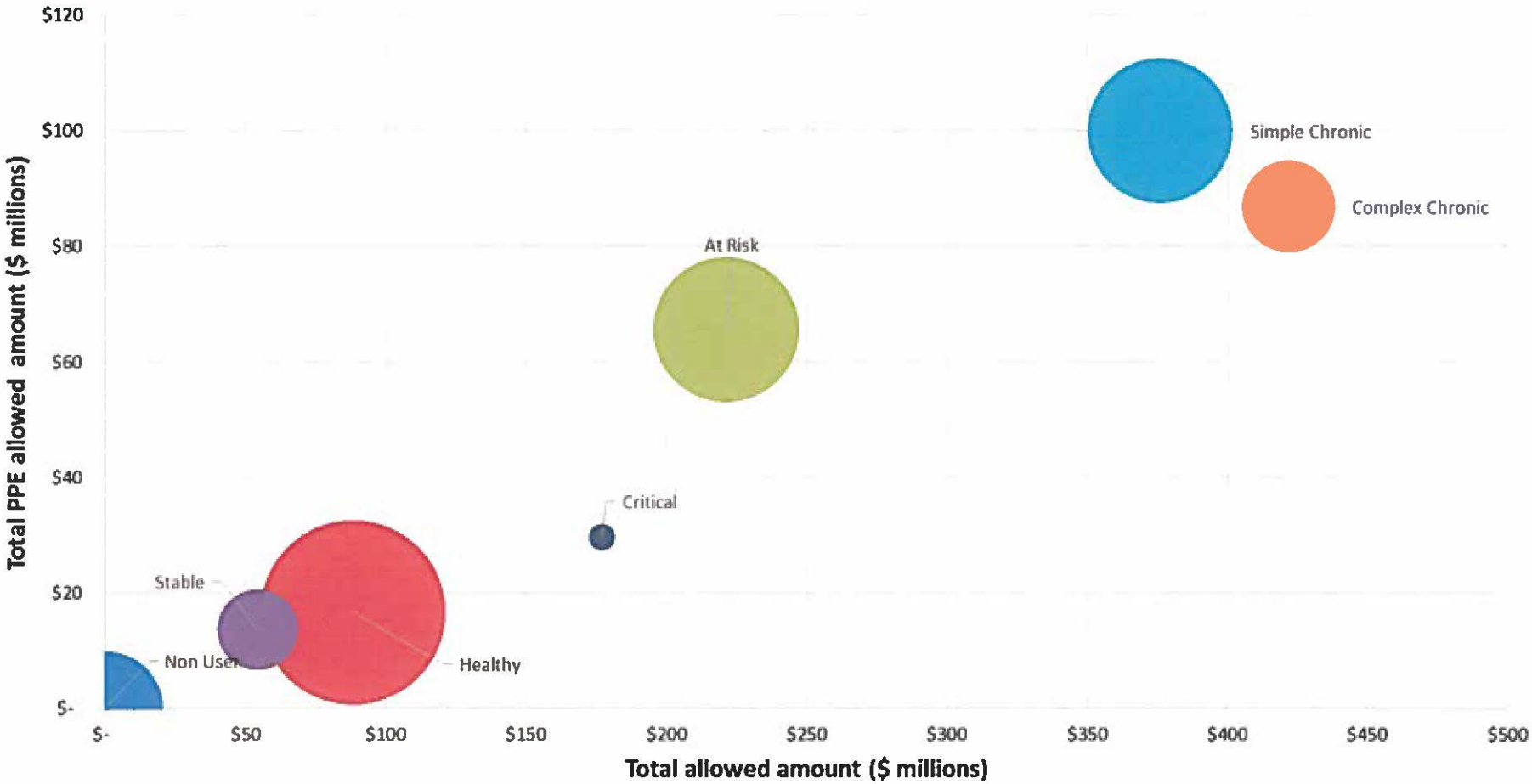
Centered Medical Homes are the foundation of an ACO arrangement between a payer and a provider.

Another component of provider partnership will be the new Value Based Program which will also be launched for our partnership with providers in July of this year. Value Based Programs (VBP) include patient centered medical homes, care coordination, disease management, incentivizing performance for quality metrics on behalf of populations, etc. at all levels of care – primary, tertiary, community and home based. I'd like to ask you to look at slide #2 in your packet. It demonstrates that again, medical homes are the foundation of VBP and it allows the provider to build up to an ACO by qualifying for a performance based reimbursement program based on quality metric accomplishments. A key component of VBP and ACO's will be data resources. BCBSND will work with providers to supply and analyze the appropriate data to determine the provider's performance, therefore the incentive for the performance, as a way of recognizing the highest quality care possible on behalf of the members of BCBNSD.

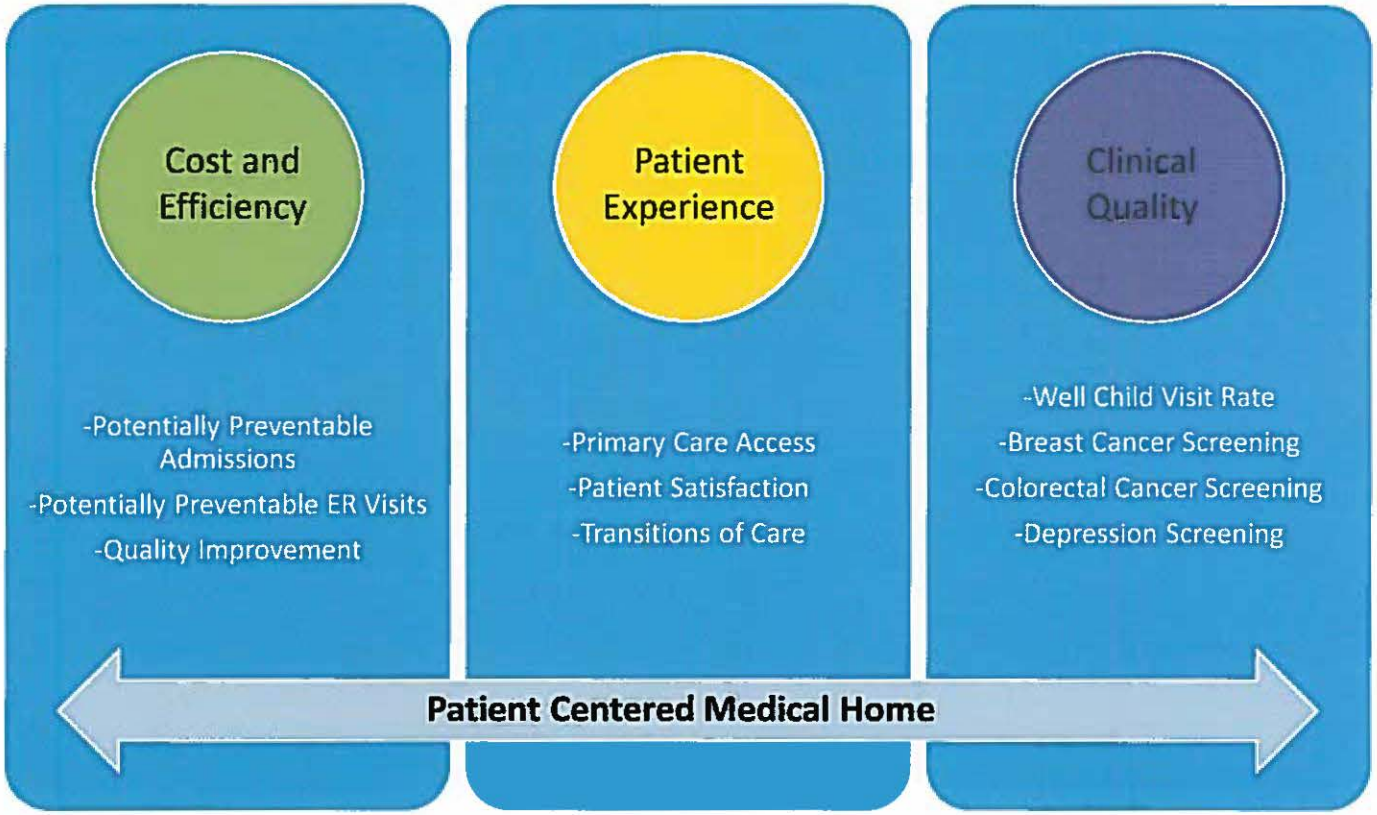
The ACO and VBP at BCBSND is transforming healthcare delivery in North Dakota by partnering with our providers. We have a 4 part strategy to do this: 1) Change the way doctors and hospitals are paid, 2) Work with doctors and hospitals to provide the tools and data they need to do so, 3) help our members be active partners in their own healthcare, 4) promote savings. As a result, we expect to see; fewer unnecessary emergency department visits, fewer hospital admissions and readmissions, reduced hospital infection rates, and better outcomes in key quality measures including breast cancer screening, improved cholesterol control, and adherence to best practices for treating diabetes. This has set BCBSND and our participating providers on a pathway to affordable, high quality healthcare in America.

Thank you for your gracious attention today and for the honor of speaking with you on this very important topic that I am very passionate about as a long time healthcare executive in the proud state of North Dakota!

Population Health



Value Based Program Quality Metrics



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