

Blue Shield of California Participation in the Right Care Initiative 2019 Annual Update

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Blue Shield of California and the Right Care Initiative Mandate

- In October 2015, Blue Shield of California (BSC) was required by the Department of Managed Health Care (DMHC) to:
 - Participate in the Right Care Initiative (RCI) University of Best Practices (UBP) and
 - To develop a plan with a goal of achieving the 90th percentile in RCI metrics by end MY 2018.



Why Participate in the Right Care Initiative?

- Evidence that RCI can save lives and money
- Provides care worthy of our family and friends that is sustainably affordable for all Californians

POPULATION HEALTH

By Allen Fremont, Alice Y. Kim, Katherine Bailey, Hattie Rees Hanley, Christine Thorne, R. James Dudl, Robert M. Kaplan, Stephen M. Shortell, and Anthony N. DeMaria

One In Five Fewer Heart Attacks: Impact, Savings, And Sustainability In San Diego County Collaborative

DOI: 10.1377/hlthaff.2018.0443
HEALTH AFFAIRS 37,
NO. 9 (2018): 1457-1465
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Foundation, Inc.



Blue Shield of California RCI Strategy

- Engage provider partners - developed provider engagement tool that speaks to the why should I care
- Enable providers to review their current capabilities and develop a quality improvement plan through the use of a Best Practices Self assessment tool
- Spread Best Practices
 - Encourage Providers to attend UBPs
 - Funded Bay Area Silicon Valley UBP
- Provide support through various means including
 - Quality Incentives for providers
 - Enabling Pharmacists as part of the care team either as funded staff or through community pharmacists
 - Internal corporate employee incentives tied to Hypertension and Diabetes control

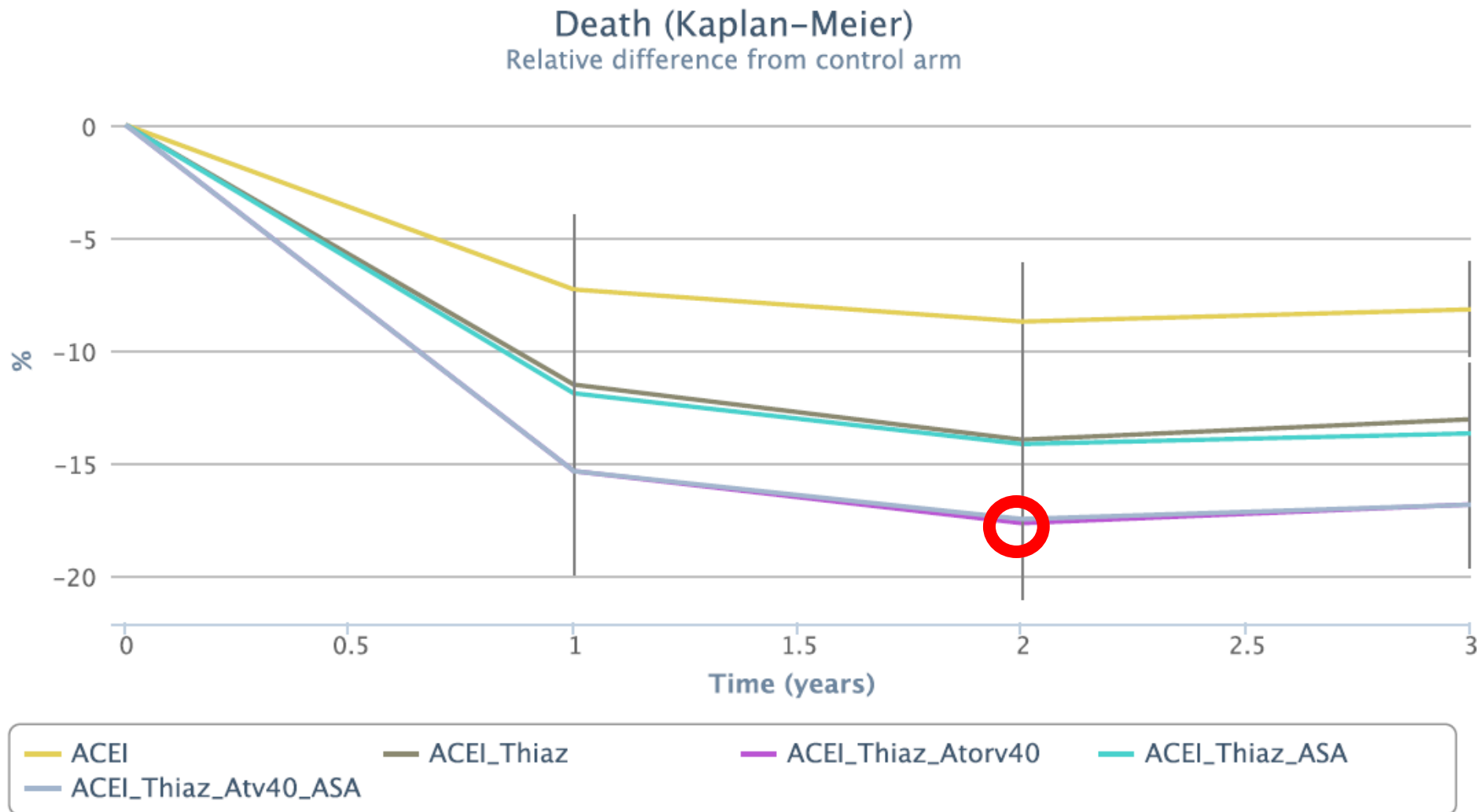


Provider Engagement Presentation

**How to Prevent One in Six of Your
High Risk Hypertensive Patients from
Dying from a Stroke or Heart Attack
in the next 3 years!**



Decrease Deaths in High Risk Patients* by 17% (1 in 6) in 2 years... Treat them NOW



*Uncontrolled Hypertensive over 55

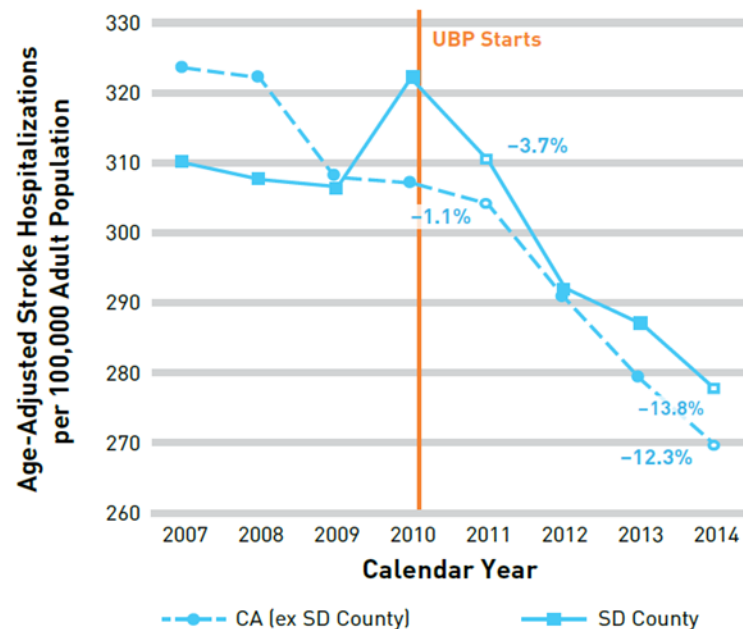
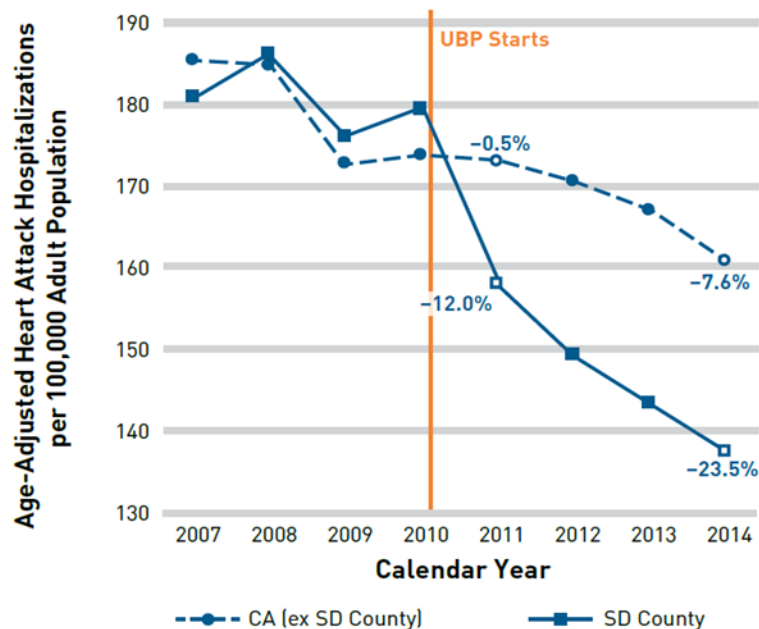
From Kaiser with permission



Experience in San Diego

Countywide Physician Organization Learning Collaborative

FIGURE 1. Age-Adjusted Hospitalizations per 100,000 Adult Population for Heart Attacks and Strokes in California, 2007 to 2014*



CA (ex SD County) indicates California excluding San Diego County; SD County, San Diego County; UBP, University of Best Practices.

*UBP started in February 2011, just after the 2010 data points. Percentages are percent changes since 2010. Principal discharge diagnosis codes from the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* were used for heart attacks (ICD-9-CM code 410) and strokes (ICD-9-CM codes 430-438).

Countywide Physician Organization Learning Collaborative and Changes in Hospitalization Rates

Brent D. Fulton, PhD, MBA; et al.

Am J Manag Care. 2017;23(10):596-603



Best Practices Self Evaluation Tool

- HTN and DM tabs
- 4 categories – Leadership, Processes, Patient Engagement, resources
- 23 items for HTN, 19 for DM
- 3 ratings –yes, no, sort of
- Resource links embedded
- Key parts highlighted

BSC HTN Best Practices Worklist		Group Name:			
		Date Evaluation Completed:			
	Hypertension "Best Practices" Worklist Item	Group's Status	Notes	Resource	Action Item
Leadership	Multidisciplinary team that includes clinical champion(s)		Should include Clinical Champions	Best Practice: Zufall Health "Building a Team"	
	Engaged all providers and clinical staff through education		Engage Providers and direct support staff in importance of controlling BP - can reduce strokes and heart attacks in high risk individuals 17% in two years. Synergy with Million Hearts, AMGF Measure up Pressure Down, AHA and AMA Target: BP	RCI Template Presentation	
	Internal public reporting of HTN control by provider		Peer Collaboration		
Processes	Recognition of providers with excellent performance		public recognition, financial incentives through quality program		
	Process map of clinic visit flow to evaluate delivery of care pre-visit, visit and post-visit				
	Hypertension is addressed at every primary care visit		Sample Chart Audit		
	Consistent Process to ensure HTN measurement part of every visit		Ensure every visit includes a BP reading; include specialty, and a process for routing back to primary care when reading is elevated >140/90		
	Staff trained to take accurate BP		Guidelines on patient posture, wait time, caffeine and smoking; retest all BP >140/90 after 5 minute rest. Co-assess with staff and providers initial and annual refresher. Sign at eye level from patient instructions, such as uncrossing feet	AMGF measure up pressure down	
	BP rechecks done on all patients not in BP control prior to leaving office, and documented in chart			7 Simple steps to ensure ACCURATE reading	
	Point of Care reminders in EHR				
	Adopt Hypertension Algorithm			template from SD RCI	
	Intensify treatment every 2-4 weeks until goal reached		No co-pay return visit with MA / RN to repeat BP		
	Monitor use of Algorithm		Pharmacy statistics: Number of medications per patient		
	Patient registry for Hypertension		Chart Review		
	Medical group participates in programs to improve HTN medication adherence		Leverage pharmacists/ pharmacy techs to improve adherence	AMGA Best Practice in HTN Registry Case Study for use of Pharmacist on team	
	Medical group reviews drug gap reports identifying members needing beta-blocker therapy after MI				
	Collaborative Practice Agreement with Pharmacist			Pharmacist help through Collaborative Practice Agreements greatly facilitates outcome	Template available
	Adopted Standing Orders			JCSF Example: Center for Excellence in Primary Care	
Specialists refer high BP to PCP		sample chart audit			



Key Best Practices

- Build a team with Clinical Champion Leader
- Public reporting of results by provider
- Adopt an algorithm
- Use of a registry
- Pharmacist as part of a care team



HMO Results to date – MY2016 to MY2018

RCI Measures	MY 2016	Benchmark	MY 2017	Benchmark	MY2018	Benchmark
CBP – Controlling High Blood Pressure	57.66	50 th	53.28	25 th	60.83	50 th
CDC 9 – Hypertension Controlled	66.97	50 th	64.23	50 th	65.55	50 th
CDC 3 – Eye Exams	45.07	25 th	51.09	50 th	52.17	25 th
CDC 11- HbA1c Control (<8.0%)	59.31	50 th	63.87	75 th	61.04	50 th
CDC 1 – HbA1c Testing	90.33	50 th	90.33	50 th	88.96	<25 th
CDC 7 – Monitoring Diabetic Nephropathy	89.78	25 th	91.42	75 th	90.47	25 th
CDC 2 – Poor HbA1c Control (>9%)	30.47	50 th	26.28	75 th	30.27	<25 th
PBH – Persistence of Beta-Blocker Treatment After a Heart Attack	81.35	25 th	79.95	<25 th	81.05	<25 th

HMO – BSC Commercial HMO/POS population

HMO ACO - Subset of Commercial HMO/POS population that are attributed to a HMO ACO



BSC RCI Future Strategy

- Continue to participate in UBP and various leadership roles
- Continue to expansion of provider partner participation
- Continue improvement of Supplemental Data submissions.
- Continue work with San Diego Accountable Community for Health work on Social Determinants
- Continue ACO clinical Best Practices forums
- Participate in raising awareness through national and regional partnerships including work with the office of the US Surgeon General, the American Heart Association, and the CDC National Hypertension Control Roundtable Organizing Committee



Future State

- We can achieve 80% hypertension control by incorporating Right Care Initiative Best Practices into practice.
- We can achieve much better Diabetes control using RCI Best Practices.
- We can eliminate strokes and heart attacks by attacking the 3 modifiable risk factors of Diabetes, Hypertension and Lipid Control
- We can provide care worthy of our family and friends that is sustainably affordable for all Californians.



blue  of california

An independent member of the Blue Shield Association