

Diabetes Integrated Practice Unit
Pilot Project
Collaboration of Michelin,
Bon Secours, United Healthcare,
Medco & Porter/Tiesberg/Wallace

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Bon Secours St. Francis Health System

Why Michelin and St Francis?

▶ Michelin

- ▶ Strategy of Health, Productivity & Engagement
- ▶ Financial risk if health of employees unaddressed
- ▶ High rate of chronic conditions in workforce
- ▶ High rate of diabetes in population and workforce

▶ St. Francis

- ▶ As employer - same incentives
 - ▶ As provider -
 - Pilot to test Accountable Care Organization Model
 - Chronic Disease Focus – Community health focus
 - Learning Lab – Michelin best practice, employer directed, test new model, community based
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Why Chronic Health?



Unhealthy and Growing

- ▶ Chronic disease is the leading cause of death
- ▶ Increasing rate in baby boomers and older
- ▶ About half of those with chronic disease have multiple chronic conditions

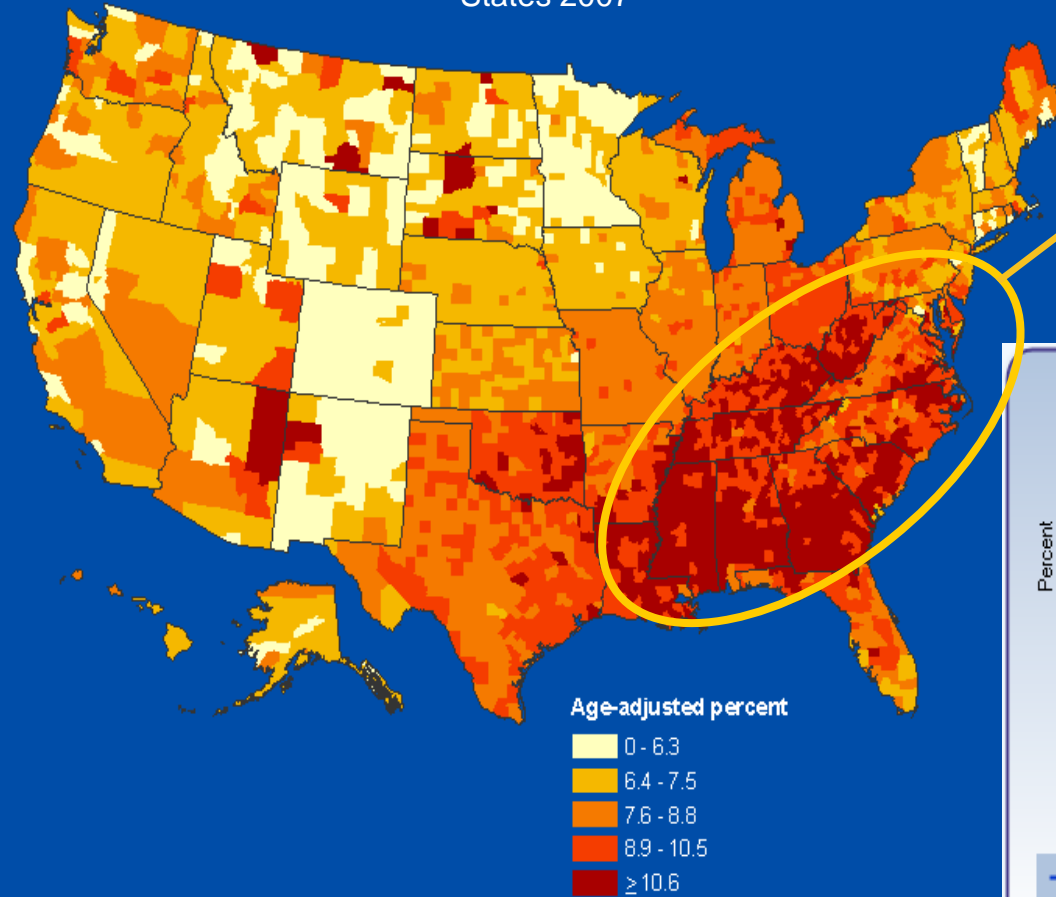
Expensive

- ▶ \$3 of \$4 spent on medication for adults is spent on chronic care
- ▶ \$1.5 *trillion* in annual U.S. health care spending is for chronic illness.

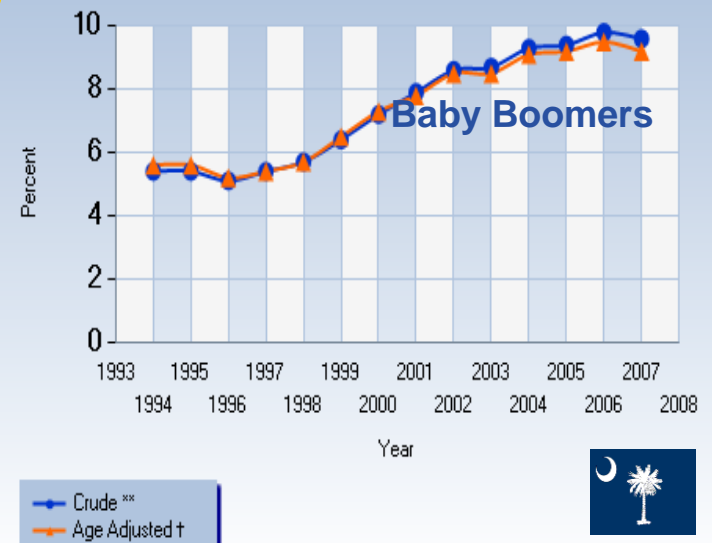


Why Diabetes?

County-level Estimates of Diagnosed Diabetes for Adults aged ≥ 20 years: United States 2007



**Michelin &
Bon Secours
Demographic**



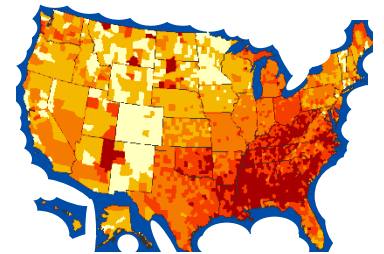
Impact and Opportunity of Diabetes

Pandemic

- ▶ ~ 24 million people with diabetes in US
- ▶ Another 57 million at increased risk

Productivity Impact

- ▶ 15 million work days missed due to diabetes
- ▶ 107 million unemployment disability days



Expensive

- ▶ Diabetes accounts for \$1 in \$5 spent on health care
- ▶ Total costs (direct and indirect): \$174 B
 - ▶ Indirect: (related to disability, work loss, premature death): \$58 B
 - ▶ Direct: \$116 B

South Carolina & Greenville

- ▶ South Carolina rated 47th in state health index rankings
- ▶ South Carolina ranks 5th in the country for obesity and 3rd for adult diabetes rate, 10.9% of population
- ▶ 58% of Greenvillians are overweight



8 % of Upstate SC Michelin Population has identified Diabetes

Facility	Location	% with Diabetes		
		EE	SP	CH
US0	Donaldson Center	6.86%	5.35%	0.00%
US1/US6	Donaldson Center	7.71%	6.48%	0.20%
US2	Anderson	7.45%	8.29%	0.42%
US3	Spartanburg	8.63%	9.18%	0.48%
US8	Starr	11.70%	9.68%	1.06%
DUN	Duncan	13.33%	2.27%	2.44%
MARC	Donaldson Center	7.02%	5.98%	0.14%
HNA	I-85 Pelham	5.79%	4.20%	0.11%
PRI	Donaldson Center	6.72%	5.61%	0.45%
LPG	Laurens	Members attended above Health Screenings		
MSTC	Donaldson Center			
TCI	Duncan			

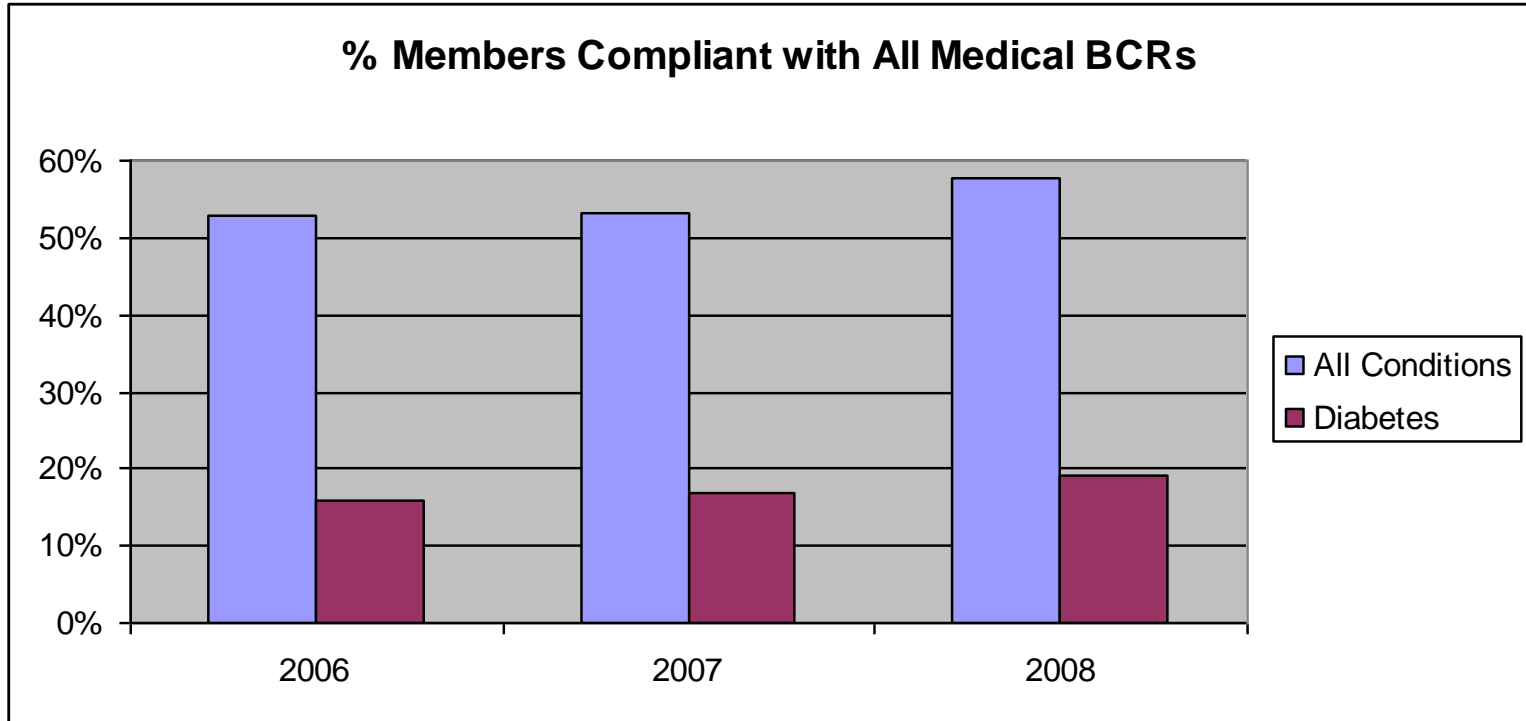


Michelin Condition Management Program

- ▶ 30% of covered lives have at least one chronic condition, 68% of costs are related to chronic members
- ▶ Chronic Condition Management program key element of new health and wellness strategy introduced in 2009
- ▶ Classic support program (stratification of risk and tiered telephonic clinical support)
- ▶ **Basic Care Requirements identified for all conditions**
- ▶ **Provided at no cost to employees and spouses that participate in program**
- ▶ Highest incidence and greatest potential for improvement in health and decrease in cost is in diabetic population



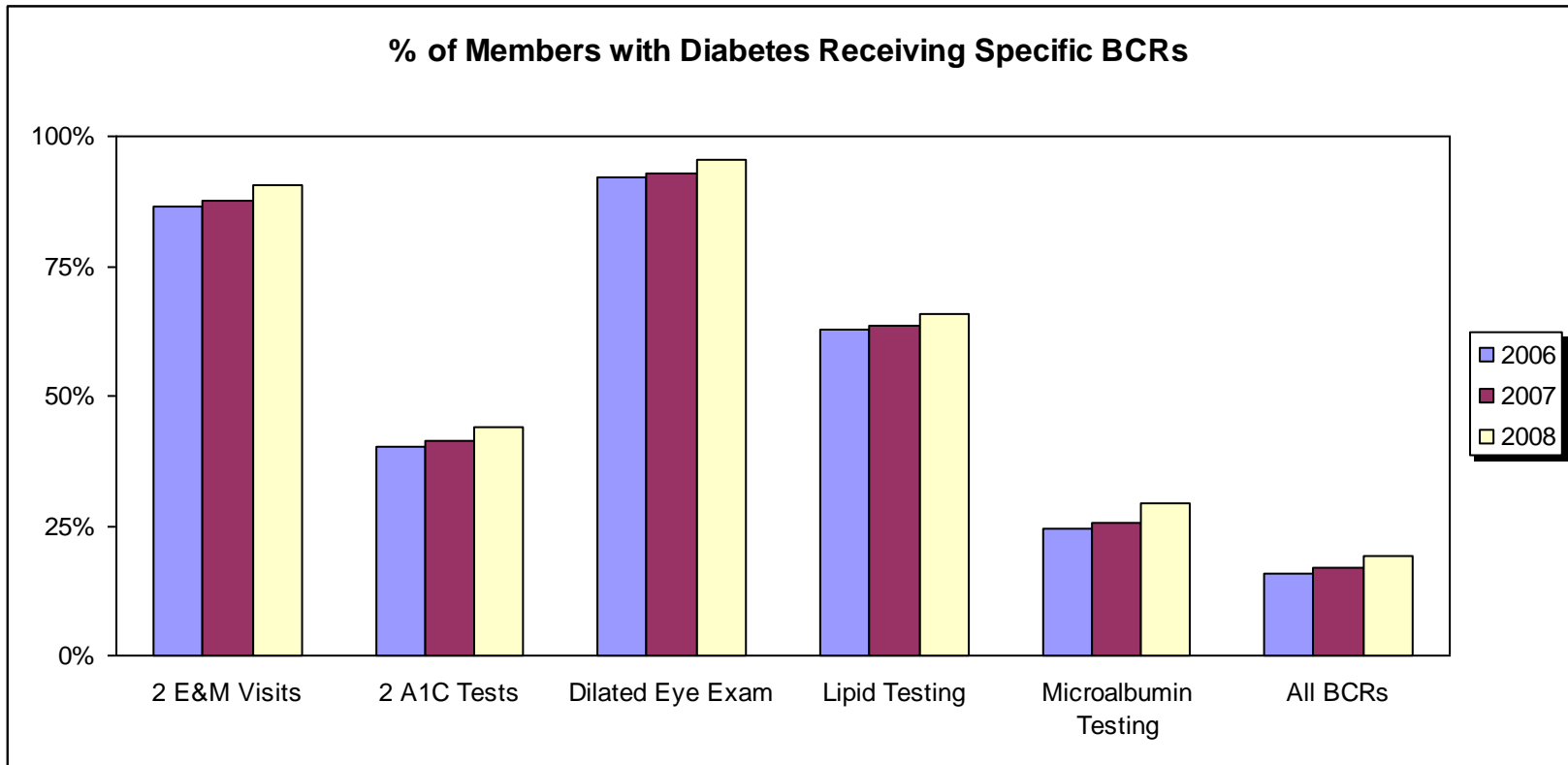
Condition Management



Further analysis showed that members with diabetes were doing a poor job as compared to members with the other conditions.



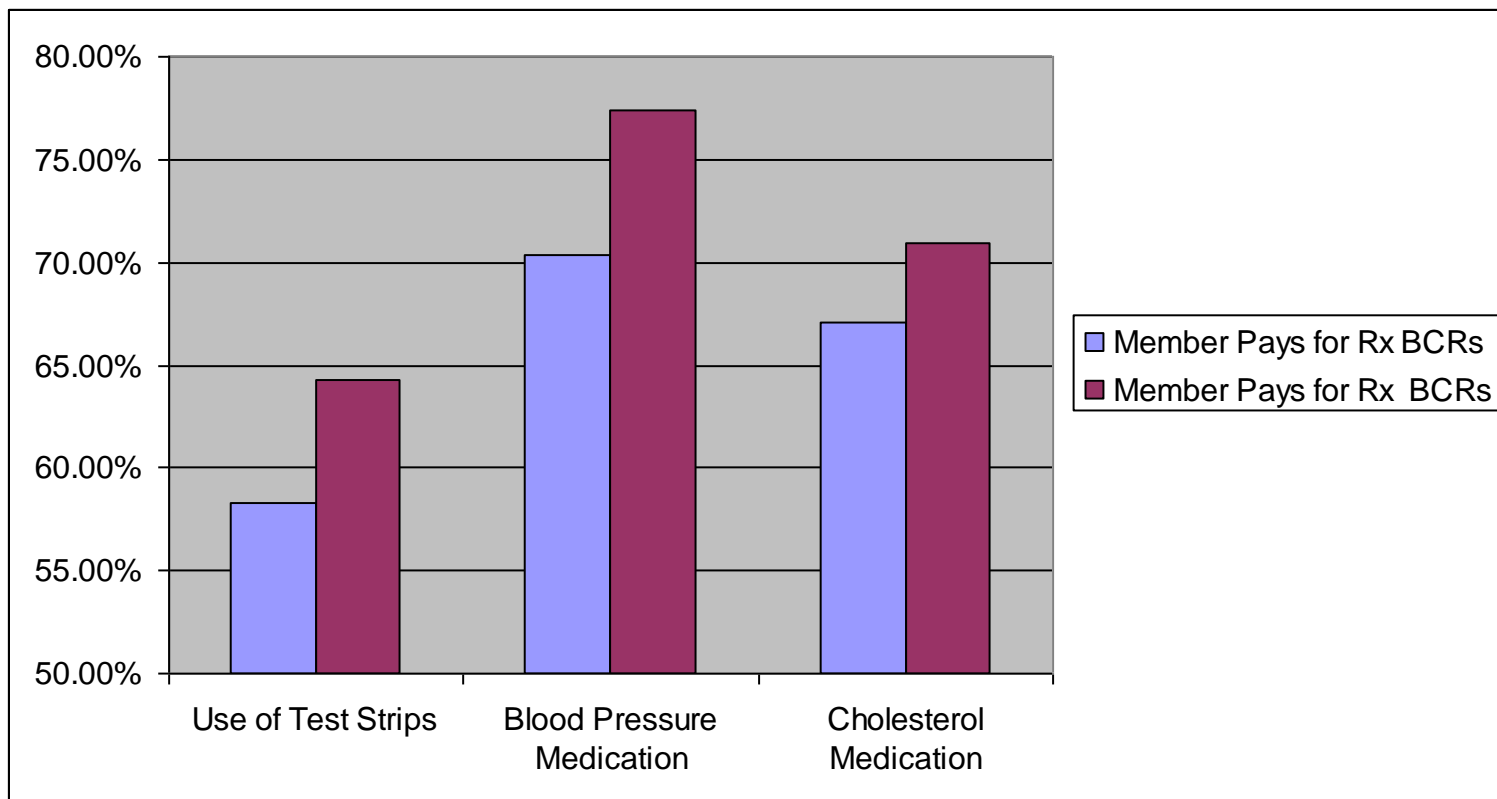
Condition Management Program



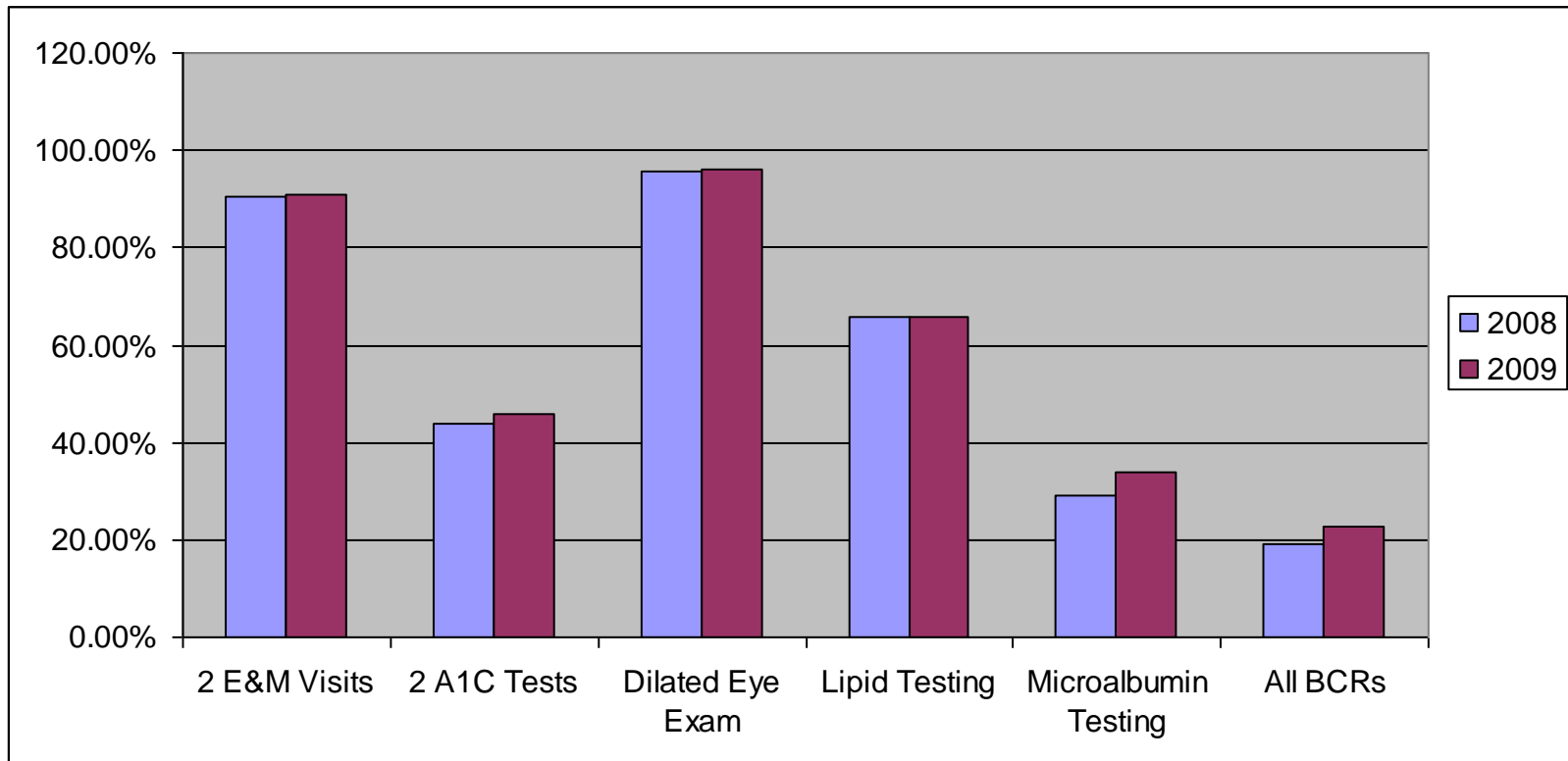
Members with diabetes were going to the doctor, but not receiving all the appropriate tests.

2009 Results - Impact of Michelin paying for BCRs for persons with diabetes

- ▶ Increase in insulin usage for those in CDH plan was 9%
- ▶ Impact of providing no cost RX BCRs was more significant



2009 Results – BCRs for Persons with Diabetes

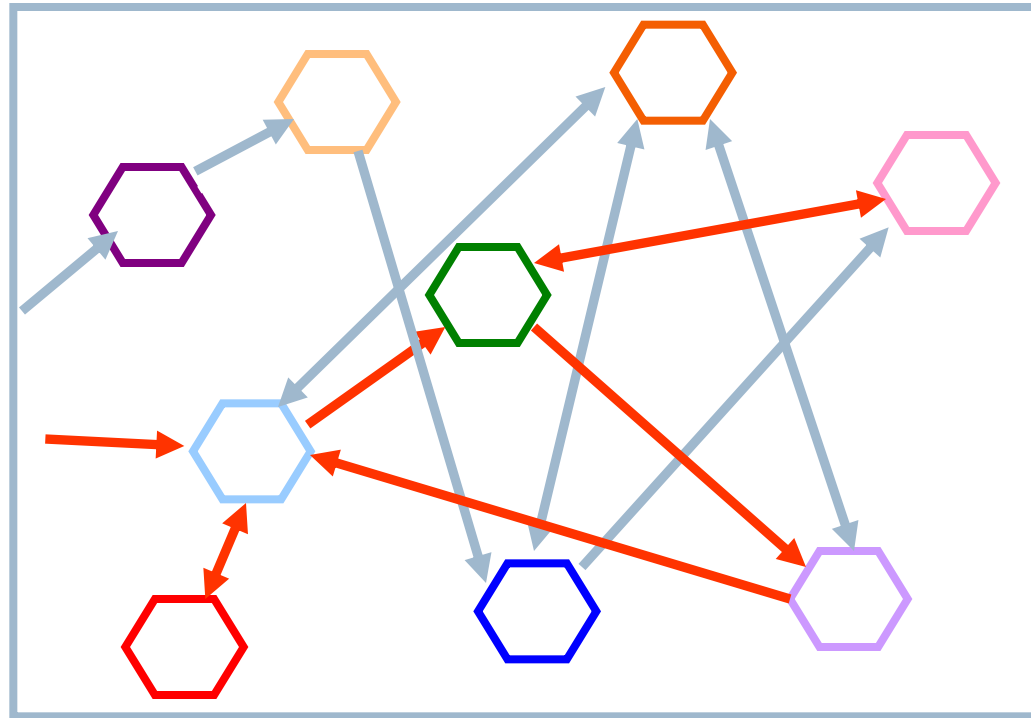


- Small improvements in all BCRs from 2008 to 2009, mainly in the area of testing.

Traditional Model: Obstacles for Patients

“Patient Pong”

Uncoordinated Care
Inappropriate Care
Self Navigation
Access Restricted
Care Restricted



Clinically Integrated Care Team or
Collection of Fragmented Services?

The Diabetes IPU

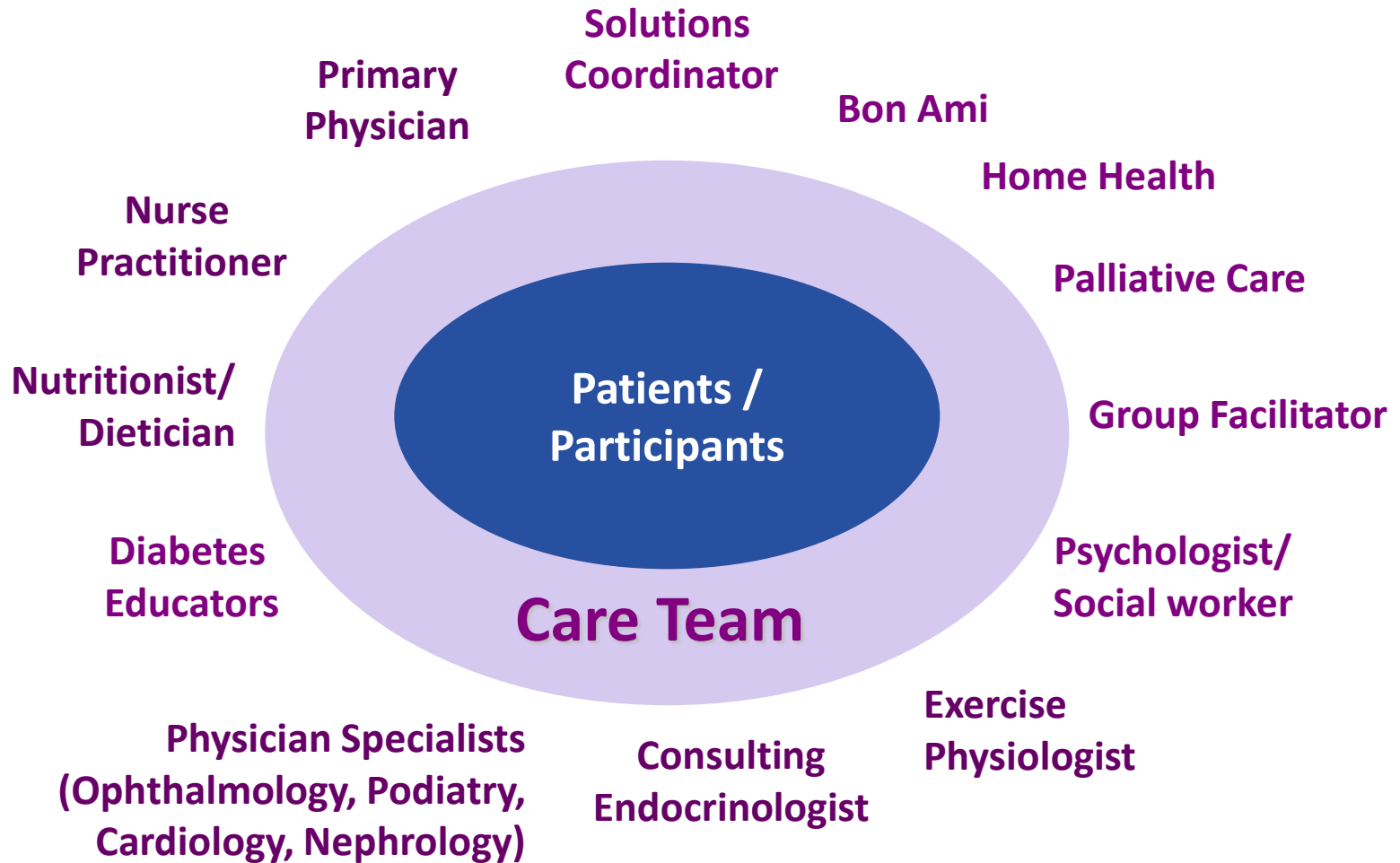
**Type 2 Diabetes
and Related
Health
Circumstances**



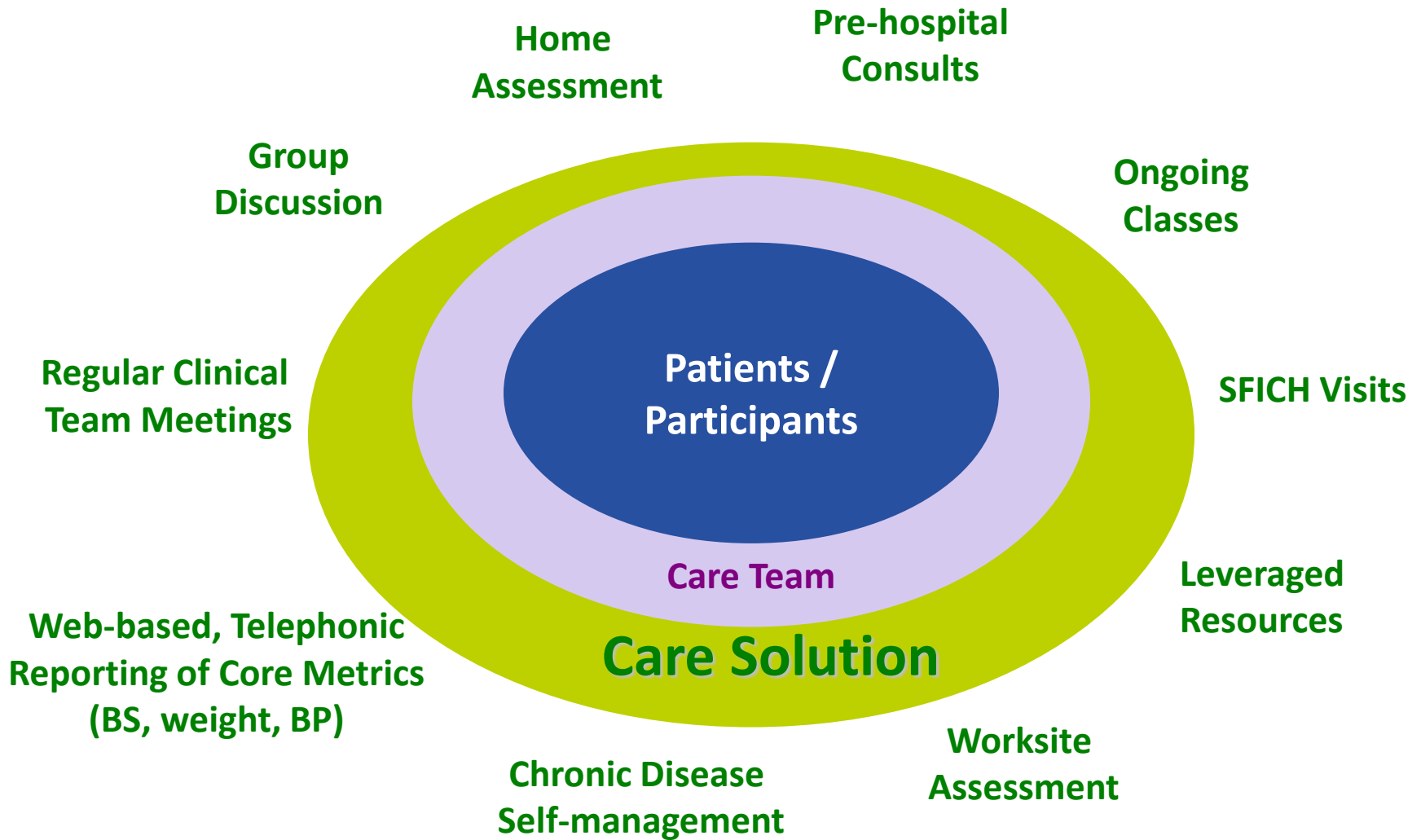
Employees and Families



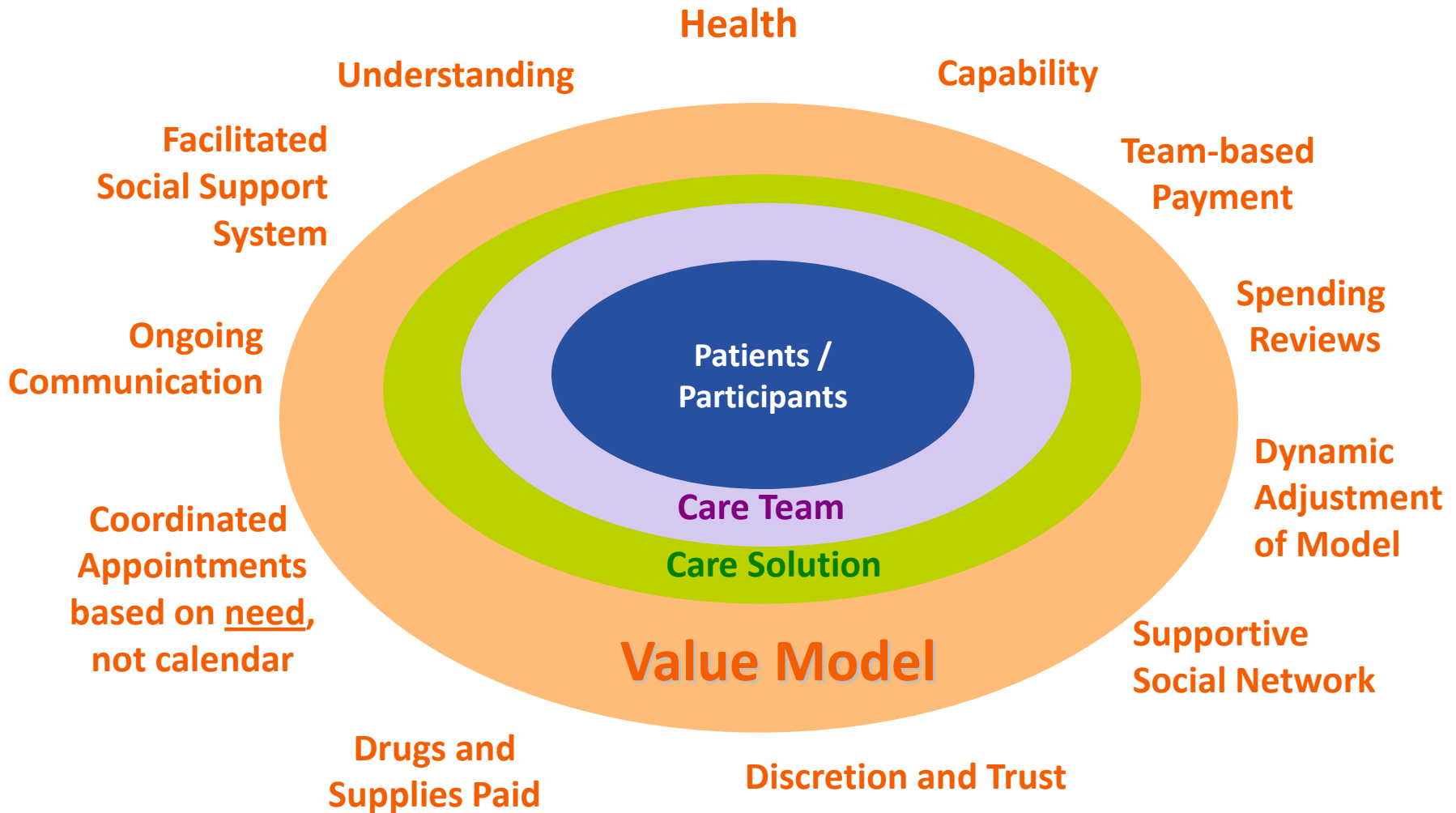
The Diabetes IPU




The Diabetes IPU



The Diabetes IPU



St Francis- Bon Secours/Michelin Integrated Practice Unit (IPU)

- ◆ Create an ongoing, personal relationship that **reduces the coordination burden on the patient** and raises odds of successful engagement.
 - ◆ **Coordination of care by a dedicated team of specialists**, coordinated by a lead PCP credentialed in diabetes related care.
 - ◆ **Individual treatment program** based on initial and on ongoing evaluations by IPU team.
 - ◆ Evaluations, counseling, and services prescribed in treatment program are **provided by IPU team and on site** at the St Francis Chronic Health center.
 - ◆ Special **offsite services coordinated by IPU team** (work site evaluations, grocery buying education, etc)
 - ◆ Services are coordinated to be delivered during the **same visit**.
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St Francis - Bon Secours / Michelin Integrated Practice Unit (IPU)

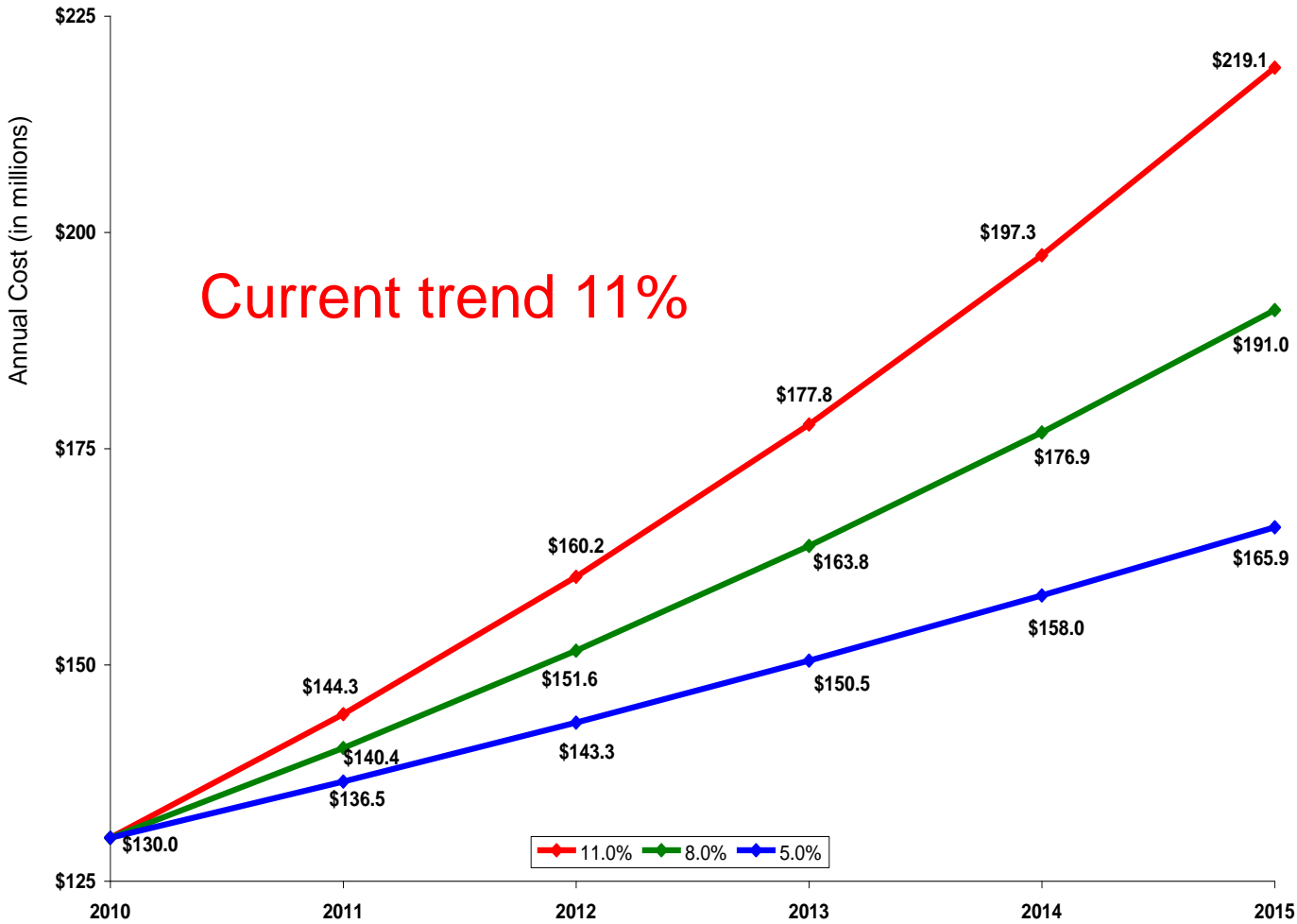
- ◆ **Individual outcome based measures** are gathered and tracked by the team
- ◆ Keep the **patient experience central** to the treatment and include the patient as part of the treatment team.
- ◆ Clinicians and overall team committed to **true health results**, not process measures.
- ◆ Doctors are salaried as part of the team, **not paid by services rendered or volume**.
- ◆ Plan pays a **fixed risk tiered rate** with improvements in risk scoring rewarded financially.
- ◆ Member receives all diabetes related care at **no cost**
- ◆ Objective is to treat the **whole patient**, not just diabetes.



Bon Secours Current Trend is 11%

Potential Reduction: \$144M Savings over 5 Years

Every 1% reduction in trend saves avg \$5M / year



OPPORTUNITIES

- Value-Based Design
- Patient-Centered Medical Home
- Behavioral Economics
- Total Health Management
- Integrated Health and Disability
- Best in Class Vendors
- Decision Support/Data Warehouse



Bon Secours Results

- ▶ 17 initially enrolled
- ▶ 140 pounds lost (among 14) in 6 months
- ▶ Group Appointments, Education
- ▶ HgA1C
 - ▶ Average: 7.3 reduced to 6.63
 - ▶ 10 above 7.0 reduced to 3 above 7.0
- ▶ 4 participants HTN, Rx free
- ▶ Quality of Life / Well-Being
 - ▶ Measurement
 - ▶ Observations
 - ▶ Groups / Individuals



The Model

