

PGIP Quarterly Meeting
June 13, 2008

Patient-Centered Medical Home Update

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Majority of POs, Practice Units, and Physicians Participating in PC-MH Initiatives



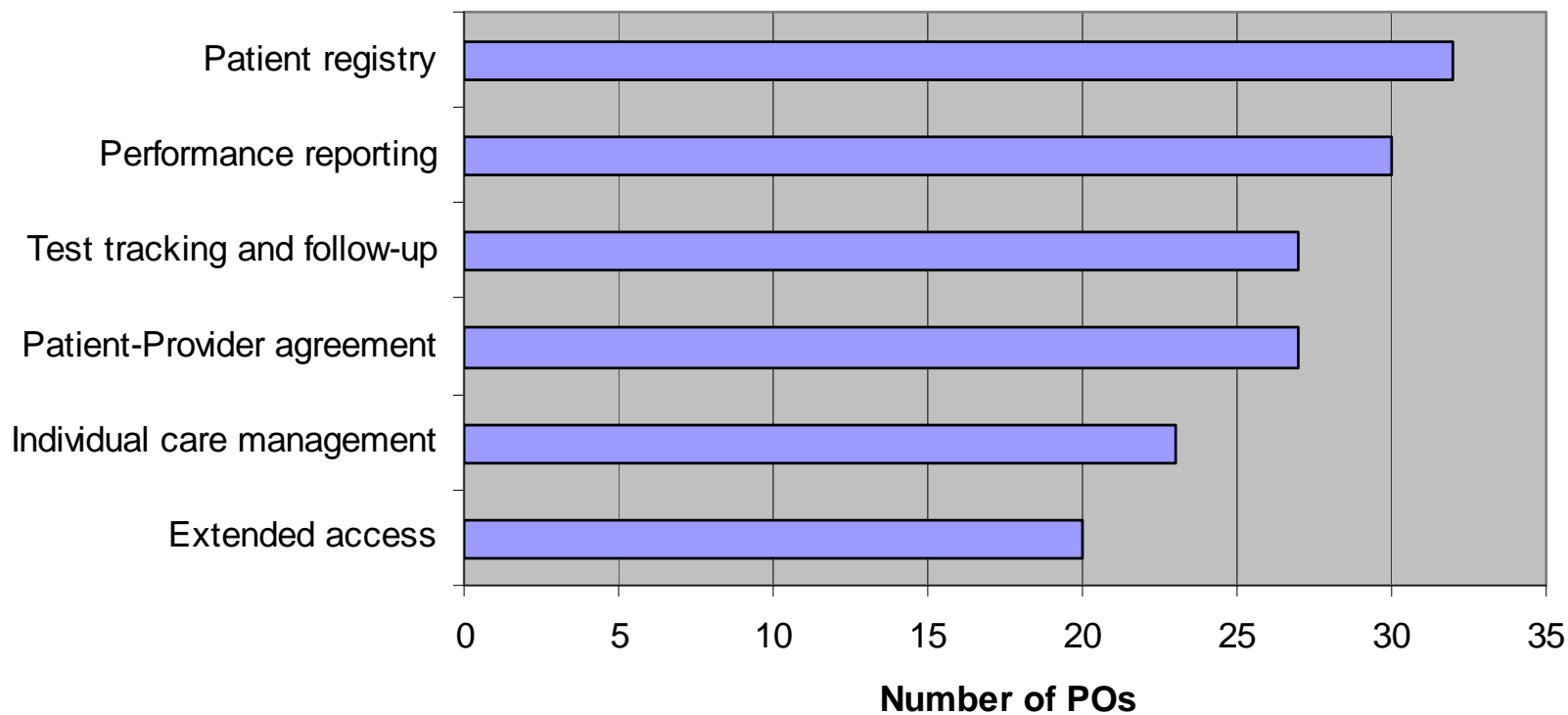
Participating in at least 1 Patient-Centered Medical Home (PC-MH) Initiative:

- 33 out of the 35 PGIP POs
- 75% of the 2500 Practice Units
- 81% of the 7000 surveyed physicians

Each of the PC-MH Initiatives was selected by at least 20 POs



Number of POs Selecting Each 2008 PC-MH Initiative



Most Practice Units have 1-10 physicians; larger Practice Units more likely to participate in PC-MH Initiatives



PC-MH Designation will be based on PC-MH infrastructure and overall performance



- Categories of Performance:
 - Infrastructure (PC-MH domains of function)
 - Quality
 - Cost
 - Patient Experience/Satisfaction
- Criteria and relative weight for each category will be determined through collaborative assessment of various scenarios

Basic PC-MH Designation will require competency in a subset of PC-MH capabilities



Infrastructure

- PC-MH domains of function
 - First capability for each domain of function required
 - Plus X of Y capabilities (varies by domain of function)
 - Self-management goal established for each PC-MH patient [add to Patient-Provider Partnership Domain of Function?]
- E-Prescribing
 - E-Rx system with link to either EMR or pharmacy management hub (e.g., enabling access to prescribing history and other clinical decision support information) and with capability to print hard copy prescriptions

Quality

- Category
 - EBCR performance
- Measures
 - Absolute Performance (relative to other PGIP POs and compared to ABC)
 - Performance Improvement (relative to other PGIP POs and ABC)

Cost and Quality measures may be used to identify top performers or only to identify outliers



Cost (some categories may be aggregated)

- Categories
 - Generic Prescribing
 - ACSC IP Admits
 - ER use
 - Radiology
 - Cardiology
 - All Other IP Use
 - All Other Costs
- Measures
 - Absolute Performance (relative to other PGIP POs and compared to control)
 - Performance Improvement (relative to other PGIP POs and control)

Patient Quality/Satisfaction

- Survey to be conducted by strategic planning July-Dec 08
- Survey population: patients of top 50% of PCPs (furthest along PC-MH continuum/high performing on cost and quality measures)

Formal nominations of Practice Units for PC-MH Designation due 12-15-2008

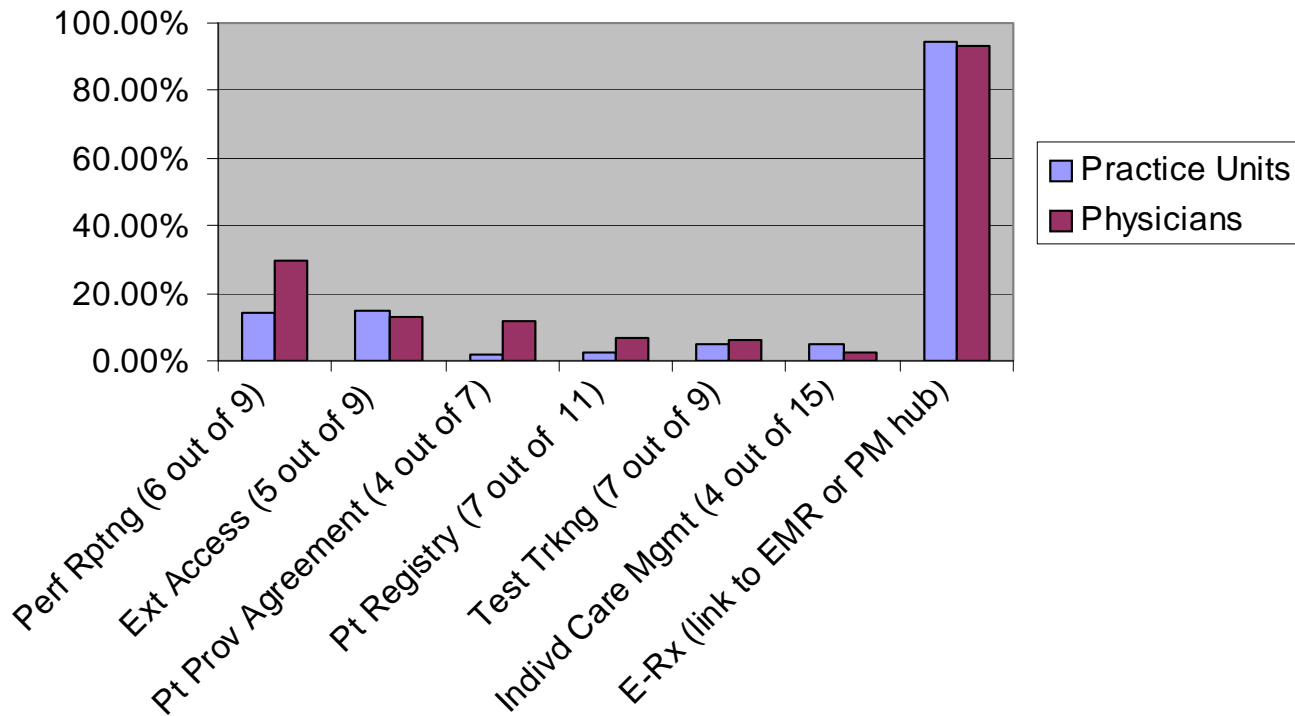


	ECD
BCBSM develops PC-MH Designation Tool and populates with self-assessment data and cost and use continuous variables at Practice Unit level to test various scenarios for determining designation status of practice units	9-9-08
BCBSM evaluate scenarios; develops recommendations for PC-MH Designation criteria	10-1-08
BCBSM collaborates with PCLC and PO leadership to finalize PC-MH Designation criteria	11-1-08
POs formally nominate Practice Units for PC-MH Designation	12-15-08
BCBSM assesses nominees, reports preliminary determinations to POs	2-1-09
POs provide feedback, discussion	3-1-09
BCBSM communicates final Basic PC-MH Designation decisions	4-1-09
BCBSM implements differential reimbursement	7-1-09

As of Feb-08, Basic PC-MH Designation criteria for Performance Reporting met by 30% of physicians; Extended Access by 12%



Percent of Practice Units and Physicians with Basic PC-MH Infrastructure in Place as of 2-29-08, by Domain of Function (based on self-reported data)



Note: For all PC-MH Domains of Function, task/capability x.1 is required

PGIP PC-MH Related Initiatives Under Development for 2009



Core Clinical Processes Initiatives

- Self-Management Training
- Patient Portal
- Linkage to Community Services
- Specialist Referral Tracking
- Coordination of Care
- Preventive Services

Service-Specific Initiatives

ED Use
ACSC Use

Additional Opportunity for PC-MH Designated Providers:

BlueHealthConnection Care Management delegated to office setting



Appendix

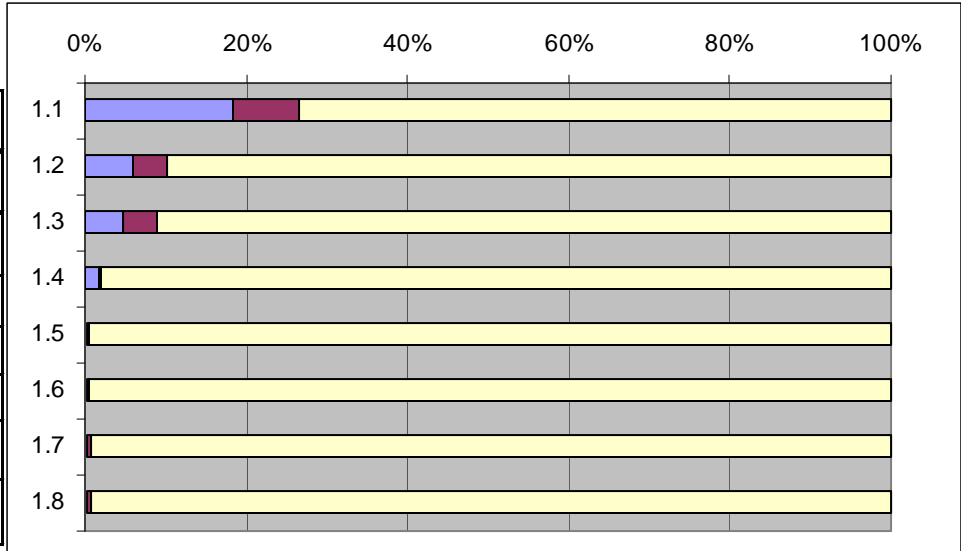
PC-MH Self-Assessment Data

PC-MH Capabilities in Place by Domain of Function as of 2-29-08

■ Percent of Total Reported PGIP Physicians w/Capability FULLY IN PLACE
 ■ Percent of Total Reported PGIP Physicians w/Capability PARTLY IN PLACE
 ■ Percent of Total Reported PGIP Physicians w/Capability NOT IN PLACE

PATIENT-PROVIDER PARTNERSHIP INITIATIVE (Basic Req: 4)

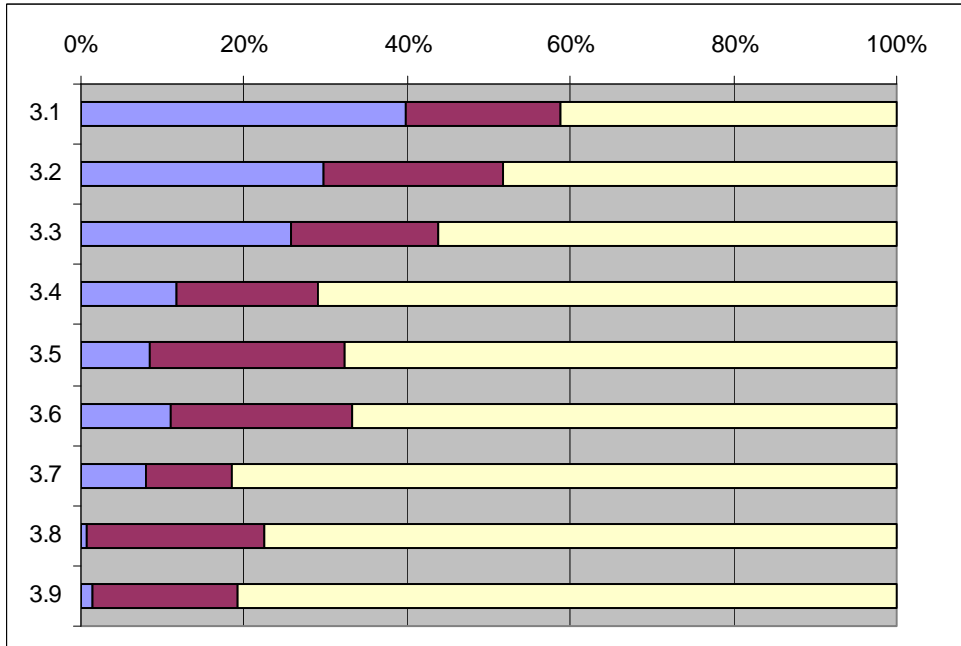
Practice unit is prepared to implement patient-provider agreement or other documented patient communication process
Practice unit is using a systematic approach to provide patient education and outreach on PC-MH
Patient-provider agreement or other documented patient communication process is implemented for at least 10% of patients
Implemented for at least 30% of patients
Implemented for at least 50% of patients
Implemented for at least 60% of patients
Implemented for at least 80% of patients
Implemented for at least 90% of patients



PERFORMANCE REPORTING INITIATIVE

Basic Req: 6

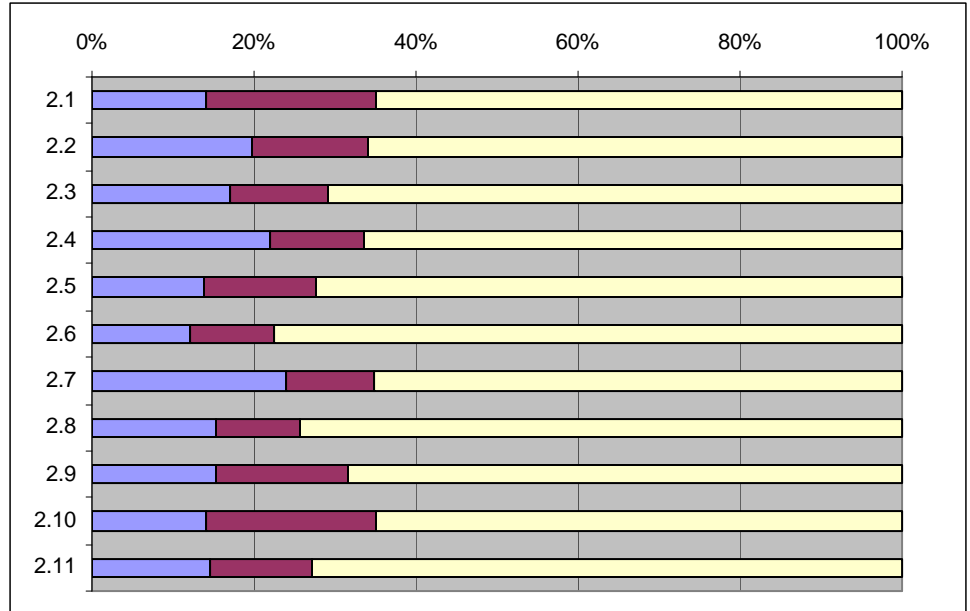
Key indicators have been established for the four major chronic conditions
Performance reports by indicator are generated at the PO, individual provider and clinic or Practice Unit level for each condition
Performance reports are generated for all chronic conditions
Data has been fully validated and reconciled to ensure accuracy
Summary and trend performance reports are generated
Performance reports are generated on pertinent quality indicators for both adult and pediatric patients
Performance reports are generated for all preventive services
Reports include additional clinical information: lab values, physiological parameters, medication history, ED, urgent care, inpatient hospitalizations
Interface is established enabling reports to include information on services provided by specialists



PATIENT REGISTRY INITIATIVE

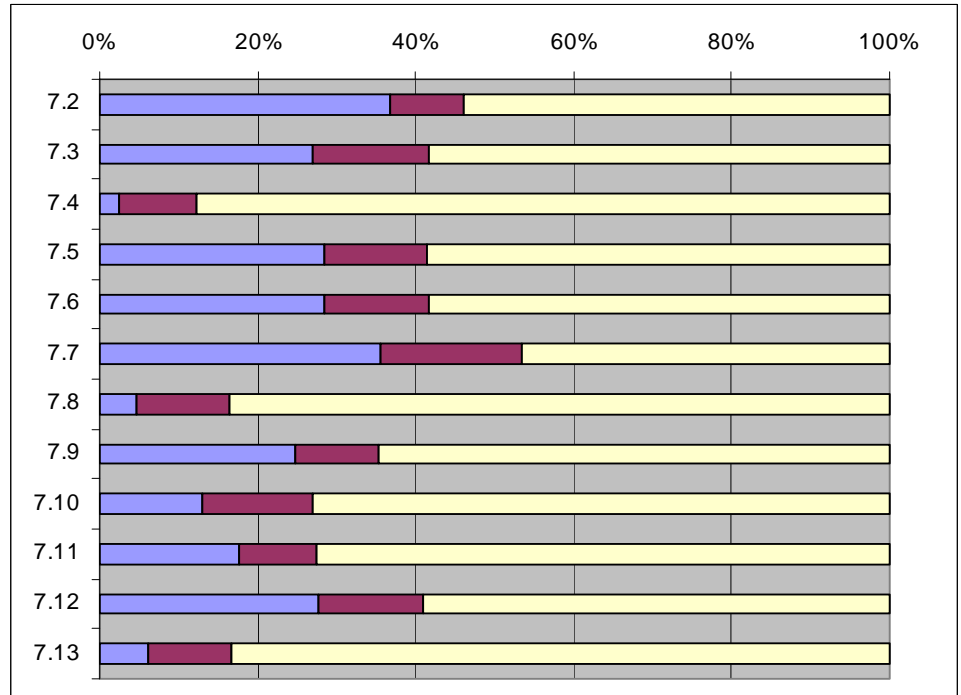
Basic Req: 7

All-payer registry (paper or electronic) in place for four major chronic illnesses
Registry incorporates comprehensive patient clinical information
Registry incorporates evidence-based care guidelines
Registry information is available at the point of care
Registry incorporates information on attributed physician for each patient
Registry can be used to generate automated communication
Registry incorporates information on chronic disease gaps in care
Registry incorporates information on physiological parameters
Registry can be used to generate trend reports for physicians
Registry is fully electronic
Registry includes patients with all chronic conditions



REGISTRY DETAILS (EBCR)

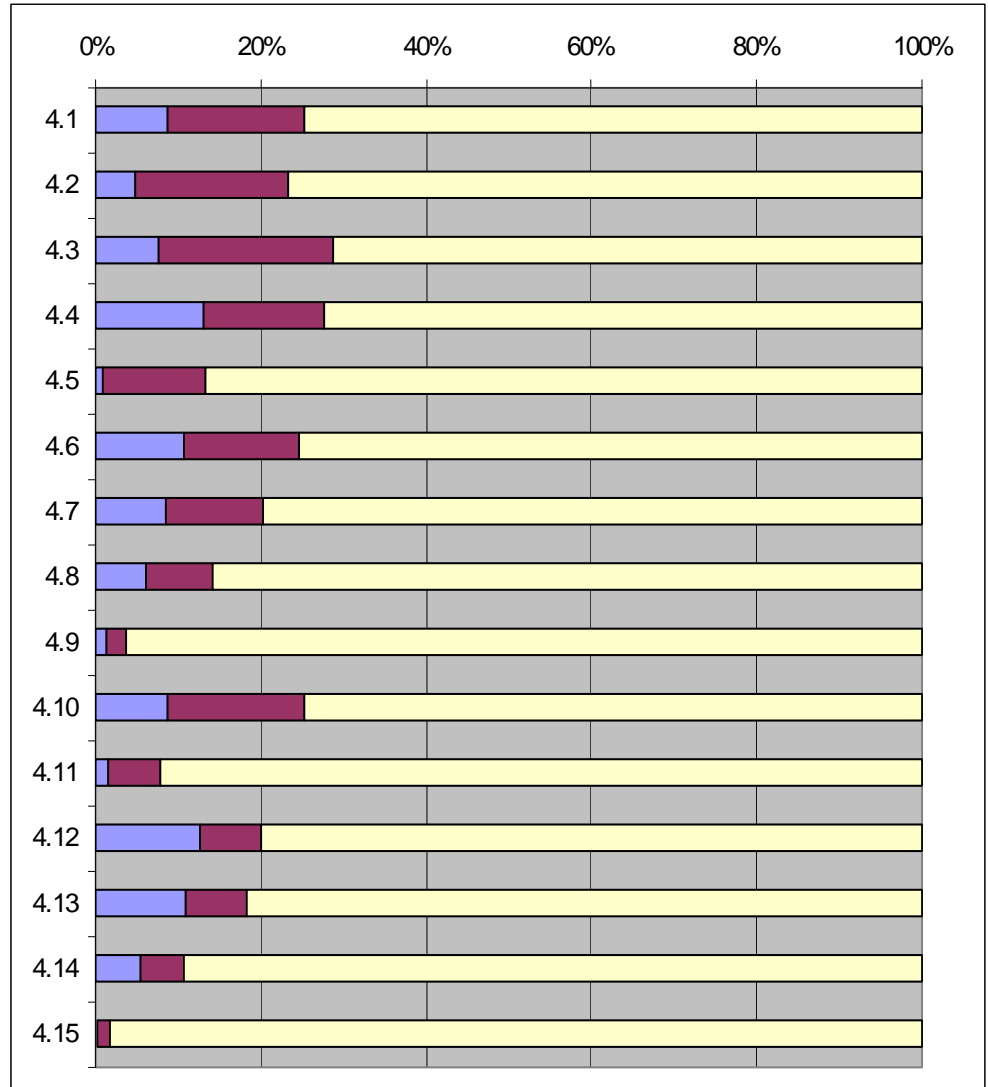
Practice unit slated to have all-payer patient registry implemented in 2008
Patient registry addresses asthma
Patient registry addresses chronic obstructive pulmonary disease
Patient registry addresses heart failure
Patient registry addresses coronary artery disease
Patient registry addresses diabetes
Patient registry addresses other disease(s)
Patient registry incorporates inpatient patient clinical information
Patient registry incorporates outpatient patient clinical information
Patient registry incorporates lab patient clinical information
Patient registry incorporates pharmacy patient clinical information
Patient registry incorporates imaging patient clinical information



Basic Req: 4

INDIVIDUAL CARE MANAGEMENT INITIATIVE

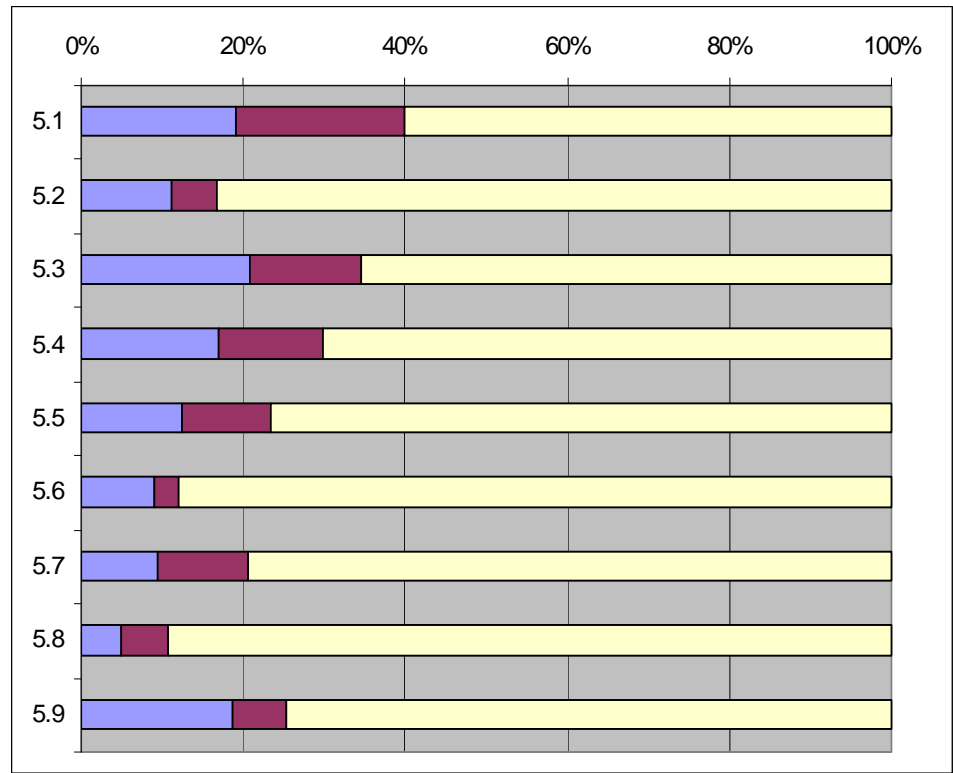
Practice Unit leaders and staff have comprehensive knowledge of the Patient Centered-Medical Home model & the Chronic Care model
Practice has teams of multi-disciplinary providers and a systematic approach is in place to deliver comprehensive care
Systematic approach is in place to ensure that established care guidelines (e.g., MQIC Guidelines) are followed by all members of the Practice Unit
At least one chronic condition has been identified for initial focus
Action plan development and goal-setting is systematically offered to all patients with the chronic condition selected for initial focus
A systematic approach is in place for appointment tracking & reminders for all patients with the chronic condition selected for initial focus
A systematic approach is in place to ensure that follow-up for needed services is provided for all patients with the chronic condition selected for initial focus
Planned visits are offered to all patients with the chronic condition selected for initial focus
Group visit option is available for all patients with the chronic condition selected for initial focus
Medication review and management is provided at every visit for all patients with chronic conditions
Action plan development and goal-setting is systematically offered to all patients with chronic conditions or other complex health care needs.
A systematic approach is in place for appointment tracking and generation of reminders for all patients
A systematic approach is in place to ensure follow-up for needed services for all patients
Planned visits are offered to all patients with chronic conditions
Group visit option is available to all patients with chronic conditions (may be done in collaboration with other Practice Units)



EXTENDED ACCESS INITIATIVE

Basic Req: 5

Patients have 24-hour access to a clinical decision-maker by phone, and clinical decision-maker has a feedback loop to the patient's PC-MH
24-hour patient access to clinical decision-maker is enhanced by enabling clinical decision-maker to access and update patient's EMR or registry info within 24 hours of the interaction
Patients have access to non-ED after-hours urgent care provider during at least 8 after-hours per week; urgent care provider has feedback loop to PC-MH
A systematic approach is in place to ensure that all patients are fully informed about after-hours urgent care availability and location
Patients have access to non-ED after-hours urgent care provider during at least 12 after-hours per week; urgent care provider has feedback loop to PC-MH
Patient access to after-hours urgent care provider is enhanced by enabling after-hours urgent care provider to access and update the patient's EMR or patient's registry record.
Advanced access scheduling is in place reserving at least 30% of appointments for same-day appointment for routine and/or urgent care
Advanced access scheduling is in place reserving at least 50% of appointments for same-day appointment for routine and urgent care
Practice unit has telephonic or other access to translator(s) for all languages common to practice.



TEST TRACKING INITIATIVE

Basic Req: 7

Practice has policy in place requiring tracking and follow-up for all test results which require follow-up, with identified timeframes for notifying patients of results
Systematic approach and identified timeframes are in place for tracking tests until the results have been received
Process is in place for ensuring patient contact details are kept up to date
Mechanism is in place for patients to obtain information about normal tests
Systematic approach is used to inform patients about abnormal test results
Systematic approach is used to ensure that patients with abnormal results receive the recommended follow-up care within defined timeframes
Systematic approach is used to document all test tracking steps (phone calls, letters, etc.) in the patient's medical record
All physicians and office staff are trained to ensure adherence to the test-tracking policy; all training is documented in each staff member's personnel file
Practice has automated test tracking system with Computerized Order Entry

