Using Technology to Improve Population Health

PCPCC Annual Fall Conference
November 13, 2014
Objectives

• Describe ways in which TECHNOLOGY is expanding access for patients in the medical home
• Discuss how health plans and health systems are using TECHNOLOGY to assist practices to profile and prioritize the health needs of their patient population
• Identify TECHNOLOGY tools to assist the care team to implement standard PCMH workflows for risk stratification, cohort management, visit optimization and patient engagement
Your Panelists and Our Format

- **Steven Peskin**, MD, MBA, FACP, Senior Medical Director, Clinical Innovations, Horizon BCBS NJ
- **Deborah Redmond**, MBA, MHA, RPT, Vice President of Clinical Product Commercialization, UPMC
- **LTC Karl W. Brewer**, MD, Army Medical Home Operations, Office of the Surgeon General
- **Karen Handmaker**, MPP, PCMH CCE, VP Population Health Strategies, Phytel (Moderator)

**Format**
- 15 minute presentations
- Lots of questions and discussion!
A Show of Hands

- How many of you work in high-performing PCMH practices?
- How many of your care teams do manual activities that could/should be automated?
- Who uses a care coordination platform?
- Who uses mobile apps, remote monitoring or secure messaging?
- Who knows how many diabetics are in your population today?
TEN RECOMMENDED HEALTH IT TOOLS TO ACHIEVE PHM:

1. Electronic Health Records
2. Patient Registries
3. Health Information Exchange
4. Risk Stratification
5. Automated Outreach
6. Referral Tracking
7. Patient Portals
8. Telehealth / Telemedicine
9. Remote Patient Monitoring
10. Advanced Population Analytics
HIT-Enabled Population Health Vision

Source: Shifting to Value: Population Health Management Technologies for Accountable Care. www.phytel.com
Care in The Life Space

Terry Newton, M.D.
PCMH IM/IT Capability Manager
Office of The Surgeon General
PCPCC Fall Conference, 2014
ARMY MEDICINE
Serving To Heal...Honored To Serve
### Personnel

<table>
<thead>
<tr>
<th>Category</th>
<th>Active Duty</th>
<th>Reserve</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>163,630</td>
<td>78,191</td>
<td>241,821</td>
</tr>
</tbody>
</table>

*MEDCOM Appr Funds Only (No LN/NAF), OTSG CS-W00LAA, and All Army CP53 (as of EOM JAN13)*

### Beneficiaries

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Duty (AD)</td>
<td>805K</td>
</tr>
<tr>
<td>Family Members (AD)</td>
<td>232K</td>
</tr>
<tr>
<td>Dependent Survivor</td>
<td>119K</td>
</tr>
<tr>
<td>Eligible NG/RC</td>
<td>175K</td>
</tr>
<tr>
<td>Family Members of NG/RC</td>
<td>795K</td>
</tr>
<tr>
<td>Retired</td>
<td>952K</td>
</tr>
<tr>
<td>Family Members Retired</td>
<td>269K</td>
</tr>
<tr>
<td>Other</td>
<td>3.87M</td>
</tr>
</tbody>
</table>

### Facilities

- Medical Centers: 8
- Community Hospitals: 15
- Health Centers: 11
- Primary Care Clinics: 30
- Occupational Health Clinics: 147
- Dental Clinics: 169
- Veterinary Facilities: 15
- Research & Development Laboratories: 8
- Laboratory Support Activities: 22

Over 600 direct and non-direct healthcare facilities
Army Patient Centered Medical Home

Military Treatment Facilities
(1-X PCMH PRACTICES)

PCMH Practice
(3-5 PCM Homes)
CM
Admin Spt

PCM Home
(3-5 PCMS)
Team RN
Admin Spt

Extended Team

Functions
- Case Management
- Care Coordination
- Population Health Management
Critical Principles
- PCM-BN Continuity
- Designated Team Support Staff
- Patient and Team Communication
- Team Empowerment
PCM Support Staff Ratio – 3.1

Behavioral Health Provider
Pharmacist
Dietitian

Core Tm
PCM
LPNs
Patient
Core Tm
PCM
LPNs
Patient
Core Tm
PCM
LPNs
Patient
Core Tm
PCM
LPNs
Patient
Core Tm
PCM
LPNs
Patient
Where The Performance Triad Happens

Where Relationship Medicine Happens
Secure Messaging
Patient Satisfaction Results

ICE Survey 20 May – 9 Jun 13 (3 weeks)

Source: ICE DISA.mil
What Patients Value Most

- #1 – Ability to communicate with PCMH team – 53%
- #2 – Prescription renewal and/or refill – 22%

Source: ICE DISA.mil
Secure Messaging allowed me to resolve issues and avoid a trip to the MTF/clinic/ER.

Source: ICE DISA.mil
For non-urgent issues, it is an effective alternative to the phone or a face-to-face visit.
Secure Messaging increases the patient’s access to care and allows us to have a positive impact on their healthcare needs.

Source: ICE DISA.mil
Secure messaging has helped to reduce unnecessary clinic appointments for my patients.

Source: ICE DISA.mil
Army Utilization Statistics
through September 2014
Note to Doc 56%

Appointment Requests 14%

Rx Refill Requests 12%

Referrals 3%

Admin (Note to Office & Billing Questions) 8%

Patient Initiated webVisits 1%
Enrollment
Access
Engagement
Care Coordination
Enhanced referrals
Army Medical Homes
Refining Care Delivery

PCPCC Fall Conference, 2014

Two key focus areas:

Population Health
Medical Decisions

LTC Karl W. Brewer, MD
Chief of Operations Army Medical Home
Defense Health Headquarters
Understanding the Army Population

Total number enrolled to Army Facilities - 1,361,480
Understanding the Army Population

Population Health

Army – includes all enrollees to direct care system

- %DM
- %HTN
- %Obese
- %Dep
- %CHF
- %COPD
- Lumbago

+ PTSD, Anxiety, ETOH, ADD

National data (ICD-9)
Army (ICD-9)
## Soldier compared to family member characteristics

### Family - Medical Home

<table>
<thead>
<tr>
<th>Clinic demographics</th>
<th>Disease Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>7K enrolled</td>
<td></td>
</tr>
<tr>
<td>63% female</td>
<td></td>
</tr>
<tr>
<td>0.3% Active Duty</td>
<td>6.8% HLD</td>
</tr>
<tr>
<td>38% - &lt; 18 years</td>
<td>5.8% Depression</td>
</tr>
<tr>
<td>33% - 10-39 years</td>
<td>3.5% HTN</td>
</tr>
<tr>
<td>17% - 0-4 years</td>
<td>2.8% Asthma</td>
</tr>
<tr>
<td></td>
<td>2.6% High utilizer</td>
</tr>
<tr>
<td></td>
<td>1.4% DM</td>
</tr>
<tr>
<td></td>
<td>0.32% COPD</td>
</tr>
<tr>
<td></td>
<td>0.32% CAD risk</td>
</tr>
<tr>
<td></td>
<td>0.28% LBP acute</td>
</tr>
</tbody>
</table>

| Inpatient hospitalization/enrolled | 254/6,876 |
| ER visit count/enrolled           | 1909/6,876 |
| Specialty count/enrolled          | 7,388/6,876 |

### Disease Prevalence

- HLD: 6.8%
- Depression: 5.8%
- HTN: 3.5%
- Asthma: 2.8%
- High utilizer: 2.6%
- DM: 1.4%
- COPD: 0.32%
- CAD risk: 0.32%
- LBP acute: 0.28%

### Visits per 100/year

- Inpatient hospitalization/enrolled: 3.6
- ER visit count/enrolled: 28
- Specialty count/enrolled: 107

### Adjusted Clinical Group (ACG)

- VHR & HR - patients: 565/6,876

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### Soldier – Medical Home

<table>
<thead>
<tr>
<th>Clinic demographics</th>
<th>Disease Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.5K enrolled</td>
<td></td>
</tr>
<tr>
<td>16% female</td>
<td></td>
</tr>
<tr>
<td>100% Active Duty</td>
<td></td>
</tr>
<tr>
<td>89% - 18-39 years</td>
<td>12% HLD</td>
</tr>
<tr>
<td>10% - 40-49 years</td>
<td>5.2% Depression</td>
</tr>
<tr>
<td>1% - 50-64 years</td>
<td>3.4% HTN</td>
</tr>
</tbody>
</table>

- High utilizer: 5.1%
- DM: 0.3%
- COPD: 0.2%
- CAD risk: 0.07%
- LBP acute: 7.7%
- Recurrent LBP: 5.0%

| Inpatient hospitalization/enrolled | 342/13,411 |
| ER visit count/enrolled           | 4,863/13,411 |
| Specialty count/enrolled          | 18,587/13,411 |

### Visits per 100/year

- Inpatient hospitalization/enrolled: 2.6
- ER visit count/enrolled: 36
- Specialty count/enrolled: 138

### Adjusted Clinical Group (ACG)

- VHR & HR - patients: 1383/13,411

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ACG - Developed by Johns Hopkins Bloomberg School of Public Health
1. High risk patient identification and support
   - Can be low prevalence, but costly to the system

2. Conditions with a high prevalence
   - Catches larger numbers and prevents progression

3. Proactive Preventive Opportunities
   - Prevents disease
Population Specific Integrated Medicine (PS-IM)

**A Variation of the Integrated Practice Unit**

**Population Specific – Integrated Medicine (PS-IM) Identification**

1. Breakout RUB 4 (high risk), & 5 (very high risk) patients
2. Within RUB 4 & 5 stratify into aggregated diagnostic groups (ADG)
3. Define patients in ADGs with high utilization in that diagnostic group using M2 data
4. Of these patients assess specific diagnoses that are actionable by a PS-IM approach.

**Example of PS-IM Group development**

<table>
<thead>
<tr>
<th>Care Point</th>
<th>Linked to EMR Data</th>
<th>Clinic Level Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACG - RUB level 4 &amp; 5 Patients</td>
<td>High frequency Individual diagnoses</td>
<td>Actionable PS-IM subgroups</td>
</tr>
<tr>
<td>Aggregated Diagnostic Group Example - Musculoskeletal</td>
<td>Lumbago, Chronic LBP, Neck pain, Sciatica, Radicular pain</td>
<td>Chronic Back Pain</td>
</tr>
<tr>
<td></td>
<td>Knee pain, Shoulder pain, Hip pain, Elbow pain</td>
<td>Overuse injuries</td>
</tr>
<tr>
<td></td>
<td>Rheumatoid Arthritis, Osteoarthritis, Gout, Arthritis NEC, Chronic Knee pain, Chronic Shoulder pain</td>
<td>Chronic Joint Pain</td>
</tr>
</tbody>
</table>
1. Organizing patients into RUB very high and high risk.

2. Link to diagnostic groups from EMR data based on visit frequency

Example – Musculoskeletal System
1. Identify the patients with high utilization in particular diagnostic group.

2. Look at each visit diagnosis to further define diagnoses within the diagnostic group and associated visit frequency.

3. This helps determine the primary area of support which the patient would benefit.

**Example – Low back pain**
Population Specific Integrated Medicine (PS-IM)

**PS-IM Group Development**

**Population Specific Needs**
Within RUB 4&5 define population in high utilized specific diagnostic groups

**Musculoskeletal System**
Define Population Specific Diagnoses
NCM and Team RNs meet to review list of patients and further define within PS-IM Group

**PS-IM Group (example)**

**Musculoskeletal System**
Define Population Specific Diagnoses
NCM and Team RNs meet to review list of patients and further define within PS-IM Group

**PS-IM Subgroups**
- Chronic Back Pain
- Overuse injuries
- Chronic Joint Pain

Prioritize efforts on top 20 patients per PS-IM

**PS-IM Core**

**PS-IM Team**

**Musculoskeletal PS-IM Community**
- PT/OT
- Pain management (IPMC)
- Orthopedics/podiatry
- Rheumatology
- Radiology
- Chiropractic
- Fitness Center
- Nutrition Care
- Army Wellness Center
- Emergency Department/Inpt

**Secure Message**
Colleague to Colleague Messaging

**PCMH Team Education**
- Rheumatology – identifying cause of joint pain
- Orthopedics – when to order films
- IPMC – Differentiating types of pain and the appropriate treatment

**Group Appointment/classes**
- PT/OT – overuse injury reduction
- Pain class – setting appropriate expectation when living with pain
- Field trip to post Fitness Center – Cross training techniques to reduce injury

**Quarterly PS-IM Group Review**
1. Invite patients to participate
2. Inform Community teams of PS-IM patients via SMS
3. Review each patient and develop or evaluate CCP

12 month patient program

**m-Care**
Link patients to the m-Care platform (future)
Medical Decisions
Leveraging specialty knowledge

Specialty Care
Unified with
Primary Care

Increasing the Breadth of Care
Expanding Patient Focused Care
Surgical Efficiency

Opportunity to improve surgical capacity

8.5% of new patients result in surgery
12 new patient visits / surgery
**Enhanced Referral**

**Defining a new process for referring to specialty care**

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**Description of a Enhanced Referral**

Virtually bring specialists into the medical home to provide guidance early in the disease process.

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**Referrals becomes a team process:**

Enhanced Referral — A discussion between a PCM and specialist to determine the best course of care for the patient.

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**Patient benefits of new process**

Highlight patient benefits associated with process.

1. Specialty input early in the disease process
2. Patient seeing correct specialist
3. Maximize initial visit value to patient

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**Enhanced Referral Process (ERP)**

Patient and PCM decide to enter ERP

- Specialty team provides input

| 4 General Paths based on input |  
|-------------------------------|---|
| Additional evaluation, testing and treatment recommended | Early intervention by PCM team recommended by specialist |
| Routine referral for face to face visit | Accelerated referral for face to face visit |

Medical Home team communicates outcome of enhanced referral process to patient within 3 business days via SMS or phone.
Enhanced Referral Process (ERP)

Leveraging Secure Messaging within the Referral Process

**PCM Referral**

1. Review RMS for team providers
2. Copy/paste info into SMS draft message
3. Title subject – specialty-pt last name (GYN-Jones)
4. CC FYI specialty team and team RN
5. Assign to referring provider

**Core LPN/LVN**

- Need more info
- Need different Specialist
- Value higher if care in MH
- Need tests/treatment prior

**Specialty Clinic**

1. Accept referral
2. Defer to network

**Referral Process**

Review referral in CHCS

**Referral Management Team**

1. Communicate outcome of enhanced referral decision to patient. (document in SMS message box)
2. Convert SMS to EMR T-con
3. Archive SMS message
4. Delete Referral in RMS if indicated

**Team RN**

If PCM and specialist can’t agree on best course for patient within 3 days window, referral will be processed and case is then referred to peer review.

All responses should be as prompt as possible, but standard is to reply by the following ½ business day.

**Goal is for process to take < 3 business days**
Summary

Refining Care Delivery in Army Medicine

1. Population Focused Care
   - ACG data linked to diagnostic groups
   - Population Specific – Integrated Medicine Groups

2. Medical Decisions - Leverage Specialty Knowledge
   - Leverage specialty knowledge
   - Expanding breadth of care and patient focus
Questions
Using Technology to Improve Population Health

Deborah Redmond, MBA MHA RPT
Vice President, Clinical Products

11/12/2014
Who We Are

Highly integrated system with an academic medical center hub that is closely affiliated with the University of Pittsburgh Schools of Health Science

HEALTH SERVICES DIVISION
20 hospitals, 35 cancer centers, more than 400 outpatient locations, 5,500 affiliated physicians, 12,000 nurses $450+ million in NIH funding per year with University of Pittsburgh

INSURANCE SERVICES DIVISION
2.3 million lives enrolled in a portfolio of insurance products, including behavioral and workplace products. 10,000+ local employer groups

TECHNOLOGY DEVELOPMENT AND ENTERPRISE SERVICES
UPMC Innovation Center, Software Development Products HCC Scout, Convergence, Anywhere Care, NLP applications,

INTERNATIONAL SERVICES
International clinical operations and advisory services Ireland: hospital, cancer centers; Italy: hospital, outpatient diagnostics and research, Kazakhstan: cancer center
Our Goal

Align patient, payer, & provider to optimize population health

- Higher level of Engagement and Activation
- Increased Market Competitiveness
- Customer Retention and Satisfaction
- Better Outcomes at a Lower Cost

Initiatives

- Patient Centered Care
- Meaningful Use
- Always driving improvement in Quality
Integrated Seamless Systems of Care

Right Clinical Model
- Standardized protocols & registries
- Care transition programs
- Patient-centered medical homes
- Chronic care management models
- End of life palliative programs
- In-home treatment and support
- Telemedicine
- Lifestyle coaching & education

Consumer Support Tools
- Consumer incentives
- Transparency: Cost/Quality
- Shared decision support tools

Right Economic Incentives
- Shared Savings
- Capitation and bundled payments
- Care management payment
- Performance payment
- Benefit designs
Right Intervention
Broad portfolio of provider-developed protocols delivers targeted, high-value interventions through workflow platform

Population Stratification

- **Low Risk (40% of total)**
  - Episodic Factors
  - Pregnancy
  - Lifestyle Change
  - Healthy Eating
  - Physical Activity
  - Stress

- **Medium Risk (30% of total)**
  - 3-4 Factors
  - Medication Reconciliation
  - New Diabetics
  - Smokers
  - Behavioral Health

- **High Risk (20% of total)**
  - 5+ Factors
  - COPD
  - CHF
  - Asthma
  - Morbid Obesity
  - CAD

- **Complex Risk (10% of total)**
  - multiple comorbidities
  - Multiple Comorbidities
  - ESRD
  - Sickle Cell, Hemophilia
  - Complex Behavioral Health

Care Management Operations

- **Team**
  - Comprised of RNs, social workers, health coaches, many with behavioral health experience

Workflow Platform

- **Patient-Centric Workflow**
- **Activity Suppression**
- **Prioritized Outreach**
- **700+ Proprietary Interventions**

>700 Interventions

- **Patient Engagement: Lifestyle Management Programs**
- **Pharmacy Optimization**
- **Condition Coaching**
- **Patient Centered Medical Home**
- **High Cost/Complex Case Management**
Selections in the graph filter the records below.
Population Health Dashboard

**Advanced Filters yield targeted results**

Filter Population By:
- Practice
- Disease Registry
- HEDIS Gaps in Care
- Readmission Risk
- Next Appointment
- Last Inpatient or ED Visit
MyUPMC Anywhere Care

• A virtual care application to enhance access and convenience while bridging geographic barriers.

• Allows the patient to select their symptoms rather than their condition (i.e. what they feel and know, rather than their medical diagnosis, which is how the eVisit used to work)

• Provides choices:
  – convenience care with guaranteed provider response time of 30 minutes or less.
  – continuity care visit with a doctor they know with a response time of 1 business day
  – ability to have the encounter via secure messaging or audio-visual consult

• Works on any device – desktop, tablet and mobile phone
HCC Scout – Hierarchical Condition Category

• Documentation, coding improvement and risk management application for leveraging improves in population health management.

• Assists the providers and coders in the identification of medical conditions

• Thru the use of natural language processing and clinical source documents provides:
  – indication of complex medical conditions to the providers which may otherwise have been difficult to find
  – augmentation to the traditional coding process
  – Improves productivity for providers and insurers

• Supports the incentives of patient centered medical home and shared savings
Fluence Platform
Health Visualization and Clinical Pathways

- Context-aware clinical desktop experience
- Mobility of the full clinical toolset
- Maintain traditional workflow
- Single view of the patient’s entire health story
- Meaningful visualization of a patient’s historic & real-time data
Fluence Platform
User Feedback

• “This is going to be big. This is going to be a game changer”
  - Josephine Chou MD

• “The concept is very good and very powerful. It is already useful.”
  - Joon Lee MD (day 3 of rollout)
Thank you
Redmonddk@upmc.edu
2014 PCPCC Annual Fall Conference

“Patient-Centered Primary Care; At the Heart of Value and Quality.”

Using Technology to Improve Population Health

November 12, 2014

Steven R. Peskin, MD, MBA, FACP
Senior Medical Director Clinical Innovations
Horizon Healthcare Services, Inc.
Coverage Trend

January 2012

January 2013

August 2014

More than 900 locations, 3,700 Doctors currently in our innovative programs
PCMH access Through NaviNet

Select Horizon BCBSNJ

Provider TIN will appear

Horizon Blue Cross Blue Shield of New Jersey is an independent licensee of the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association. Horizon care, symbols and Making Healthcare Work are registered marks of Horizon Blue Cross Blue Shield of New Jersey.

Horizon Blue Cross Blue Shield of New Jersey is currently addressing an issue that is preventing the display of complete eligibility and benefit information through NaviNet's Eligibility and Benefits functionality for members and dependents enrolled in the following groups:

- CBA/Industial 691870
- Consolidated Simon 081291
- CPI Packaging 081652
- Flashnet Inc. 080583
Calendar of Events

Horizon BCBSNJ’s Patient-Centered Medical Home Program

Below you will find the most up-to-date information on Horizon BCBSNJ’s Patient-Centered Medical Home Program. Horizon will post updates on future webinars, meetings, program resources, and other important information related to this program. We encourage you to frequently view the below announcements. You will also continue to receive bi-weekly e-mail updates from the PCMH Team via PMHCentral@horizonblue.com. If you have any questions regarding the below items or the PCMH program, please reach out to your primary Horizon PCMH contact or email us at PMHCentral@horizonblue.com.

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Time</th>
<th>Activity</th>
<th>Program</th>
<th>Description</th>
</tr>
</thead>
</table>
| May   | 6   | 12:30-1:30 pm   | Collaborative Learning Session via WebEx           | Pediatric| WebEx: Education and Review of Care Plan Development and Submission.
https://horizon.webex.com/horizon/j.php?MTID=m774af3b10090b937dd145c57b6a500a9 Call in Number: 888-330-1716 Participation Code: 837108 |
|       | 6   | 9 am-5 pm       | Population Care Coordinator Training in Wall, NJ   | Adult    | Training session for Population Care Coordinators                          |
|       | 7   | 9 am-5 pm       | Population Care Coordinator Training in Wall, NJ   | Adult    | Training session for Population Care Coordinators                          |
|       | 7   | 11-11:30 am     | Weekly Data Exchange Conference Call              | Adult    | This call gives participants the opportunity to ask questions regarding data exchange and technical issues. 1-888-330-1716 ACCESS CODE: 637108 |
Reports Tab on CPT Tool

We Need Your Updated Information!
We are continually working to enhance our ability to work with practices to exchange information. As we plan future capabilities for information exchange, we need to update our records to ensure we h...Read more

2013

2014

- January
- February
- March
- April
- May
- June
  - CareManagement
  - NoticeofAdmission
  - Roster
  - SpecialistReport

- July
  - NoticeofAdmission
  - Roster

- August
# Performance Overview

<table>
<thead>
<tr>
<th>Clinical quality measures</th>
<th>Below 50th national percentile</th>
<th>50th to 75th national percentile</th>
<th>75th to 90th national percentile</th>
<th>Above 90th national percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>High BP control</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Breast Cancer Screening</td>
<td></td>
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</tr>
<tr>
<td>CRC screening</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes: BP control</td>
<td></td>
<td></td>
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<tr>
<td>Diabetes: LDL Screening</td>
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<tr>
<td>Diabetes: HbA1C control</td>
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<tr>
<td>LDL Screening</td>
<td></td>
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<td></td>
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<tr>
<td>Pneumonia vaccinations</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Tobacco cessation</td>
<td></td>
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</tr>
</tbody>
</table>

~ Denominator less than 30
Excluded from evaluation

*Below Level 1 Target

*Metrics not captured: CAHPS: getting needed care, CAHPS: getting care quickly, and CAHPS: 9-10 rating of personal doctor

## Utilization metrics (Commercials)

<table>
<thead>
<tr>
<th>Metric</th>
<th>NET % Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED visits</td>
<td>9%</td>
</tr>
<tr>
<td>IP admissions</td>
<td>-42%</td>
</tr>
<tr>
<td>Specialist visits</td>
<td>-4%</td>
</tr>
<tr>
<td>GDR</td>
<td>1%</td>
</tr>
</tbody>
</table>

Baseline Percentile vs Network Practices (higher is better):

- ED visits: 30%
- IP admissions: 54%
- Specialist visits: 71%
- GDR: 32%

**BASELINE:**
Weighted Performance Percentile at 47%

*See 'Release Notes' page
## Sample Performance Report

### Quality Measures - Detail

<table>
<thead>
<tr>
<th>Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Quality Rate</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>High BP control</td>
<td>64</td>
<td>144</td>
<td>44.44%</td>
<td>64.37%</td>
<td>68.57%</td>
<td>74.00%</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>174</td>
<td>312</td>
<td>55.77%</td>
<td>68.08%</td>
<td>71.97%</td>
<td>76.46%</td>
</tr>
<tr>
<td>CRC screening</td>
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*Data presented is for informational use only, and should only be used as a guide. Numerators needed and differences are subject to change throughout the program year.*

### Numerator needed for

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### Difference

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Resource Center: A repository of resources available from Horizon to aide your practice in being a successful PCMH. Resources are housed under the following:

- General Documents
- Videos
- Tools
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*Horizon Blue Cross Blue Shield  Confidential and Proprietary*
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# Summary of Specialist Visit

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Thank you

Questions