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!

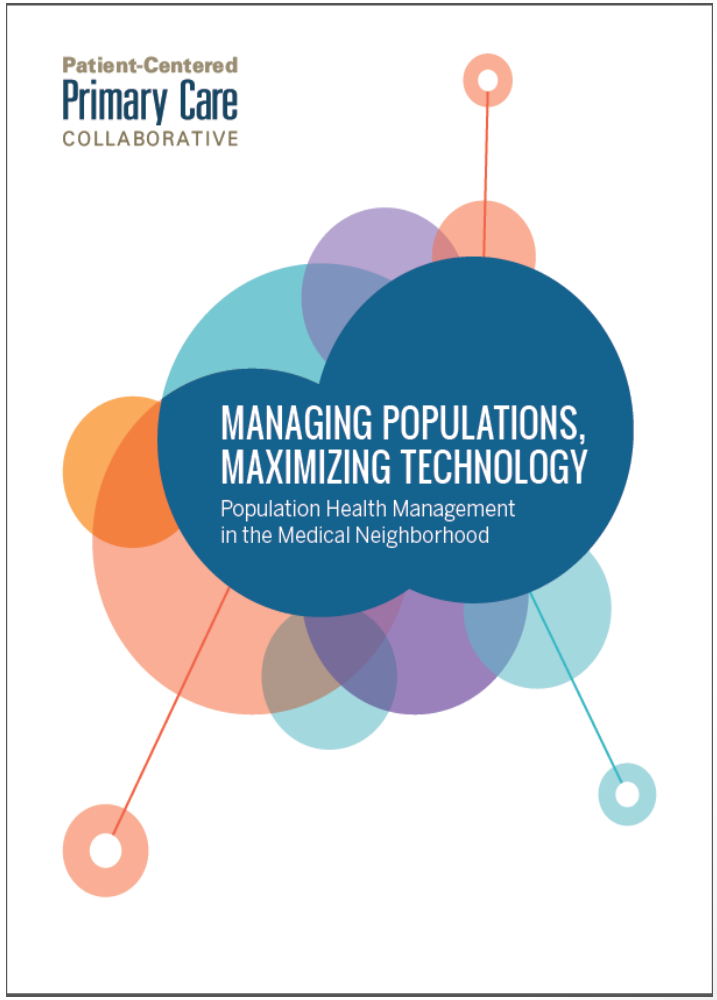
A Show of Hands

- 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?

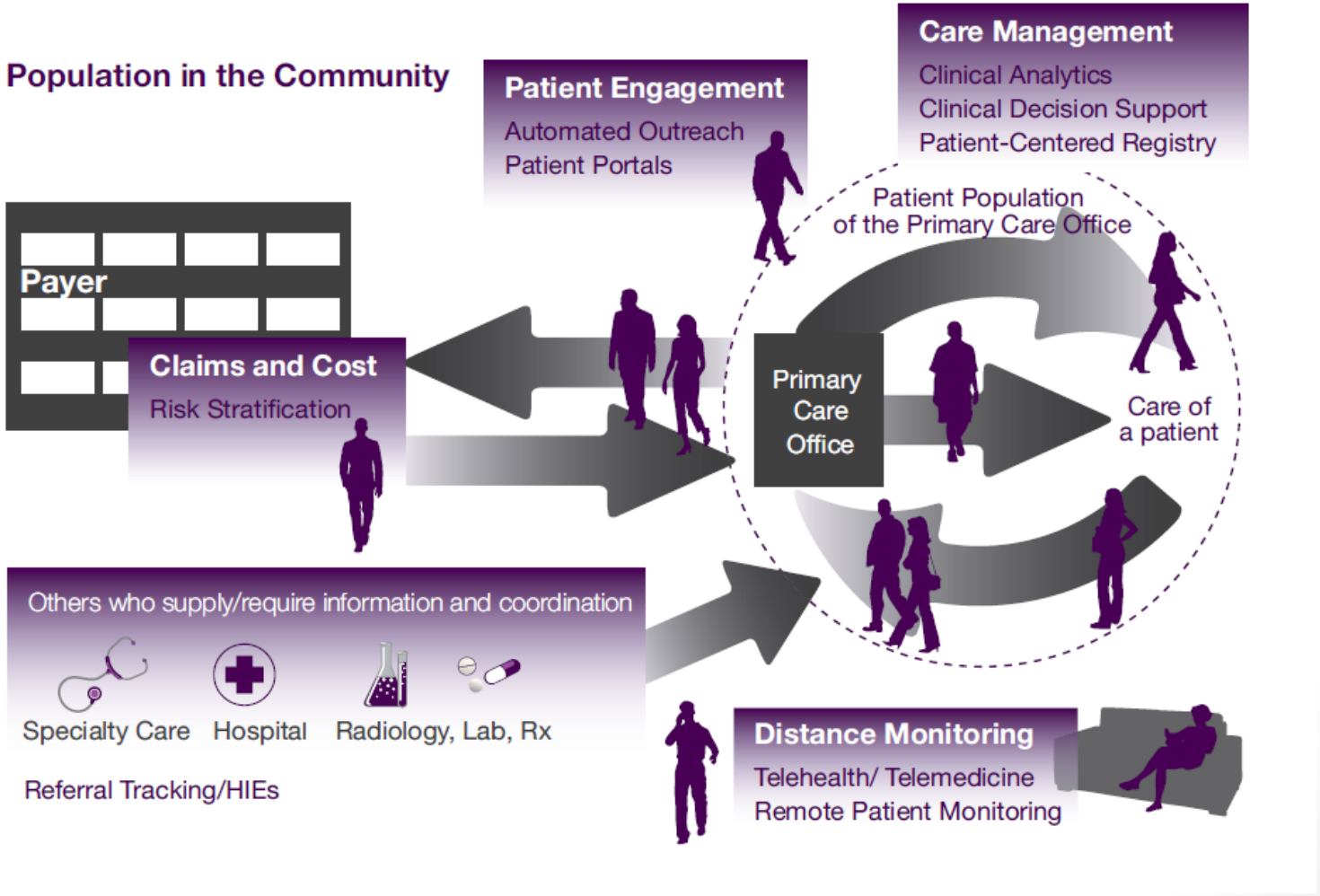
HIT Beyond EMR and Analytics: 2013 PCPCC Report

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

Beneficiaries

3.87M Total

Personnel

Total	163,630	78,191

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

Facilities

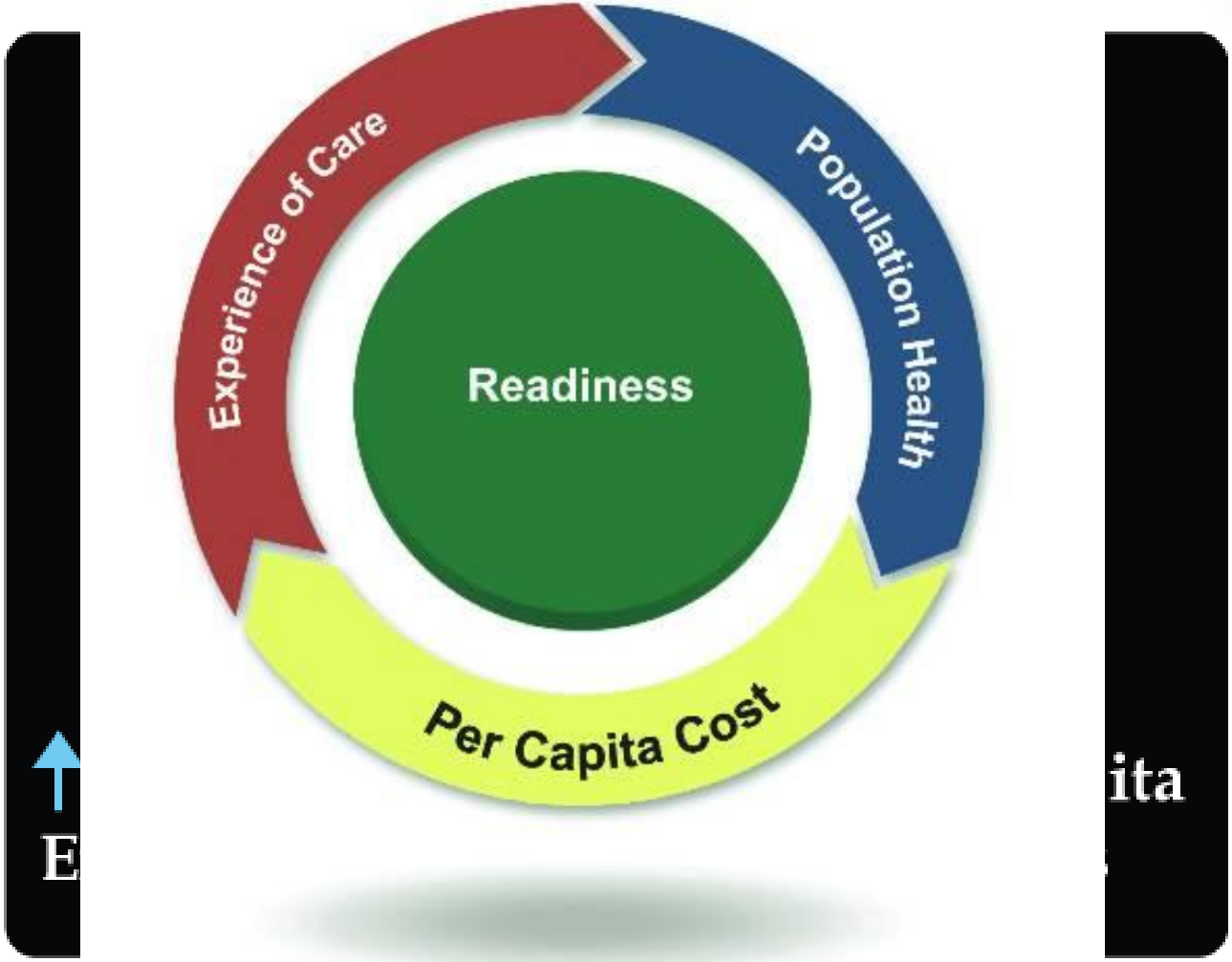
Active/Reserve

10 / 16	Combat Spt Hosp (CSH)
16 / 22	FWD Surg Tm (FSTs)
90 / 0	Other Active Units
0 / 52	Other Army NG Units
0 /134	Other Army AR Units

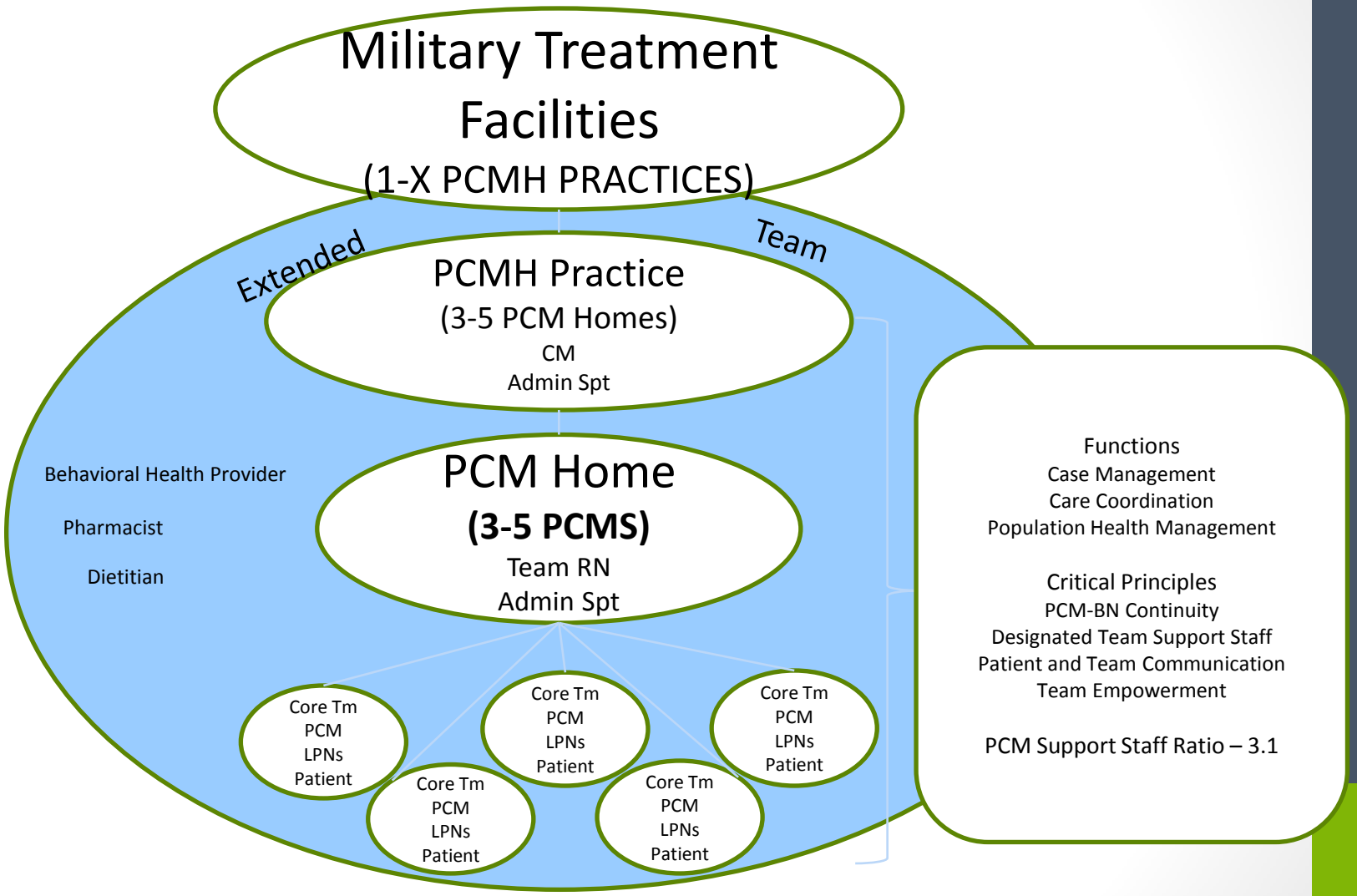
116/52/172 AC/NG/AR

340 Deployable Units

Over 600 direct and non-direct healthcare facilities


Experience of Care
Population Health
Readiness
Per Capita Cost

Army Patient Centered Medical Home



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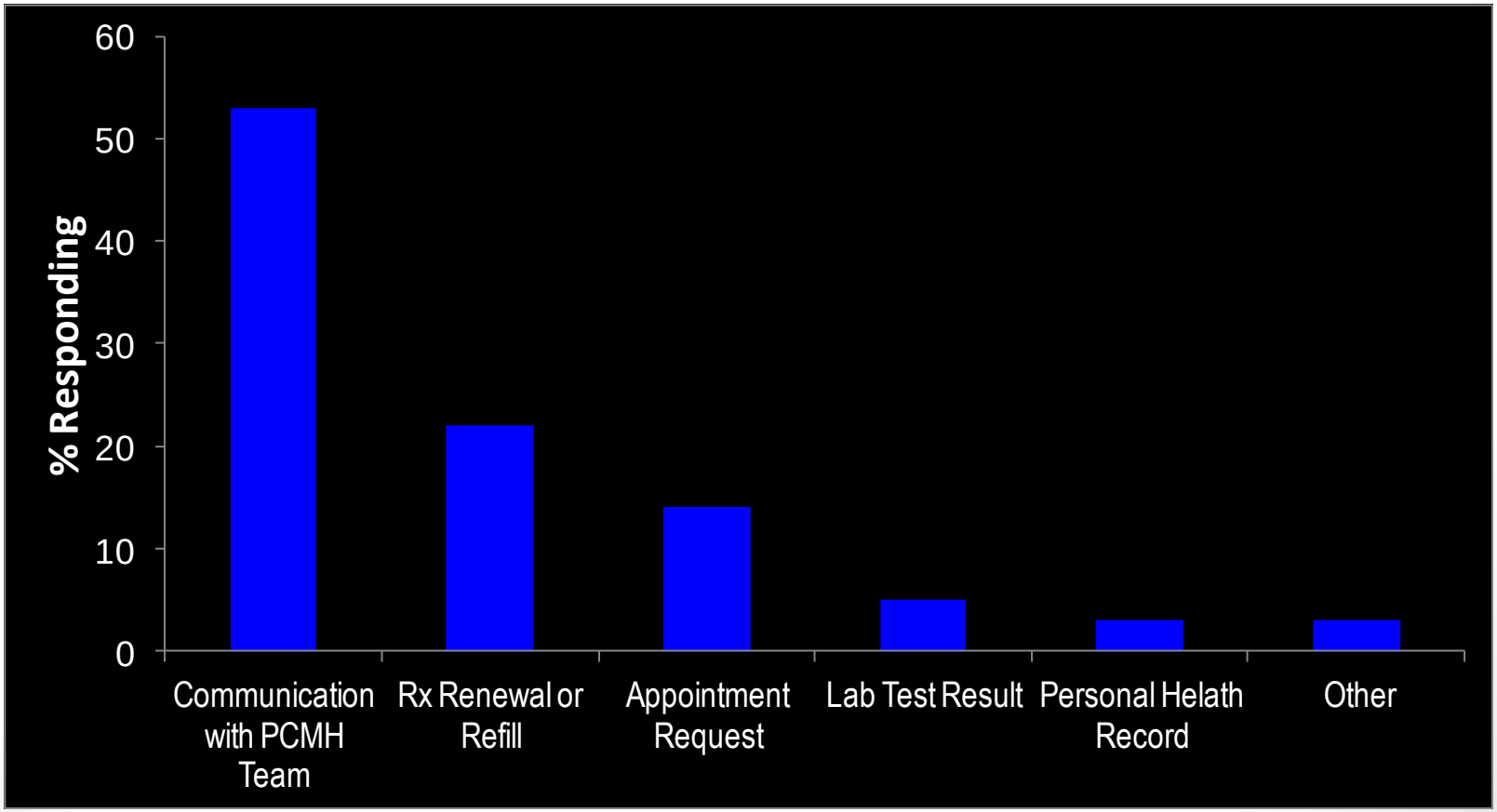
Where The Performance Triad Happens

Where Relationship Medicine Happens

Secure Messaging
Patient Satisfaction Results

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

Source: ICE DISA.mil



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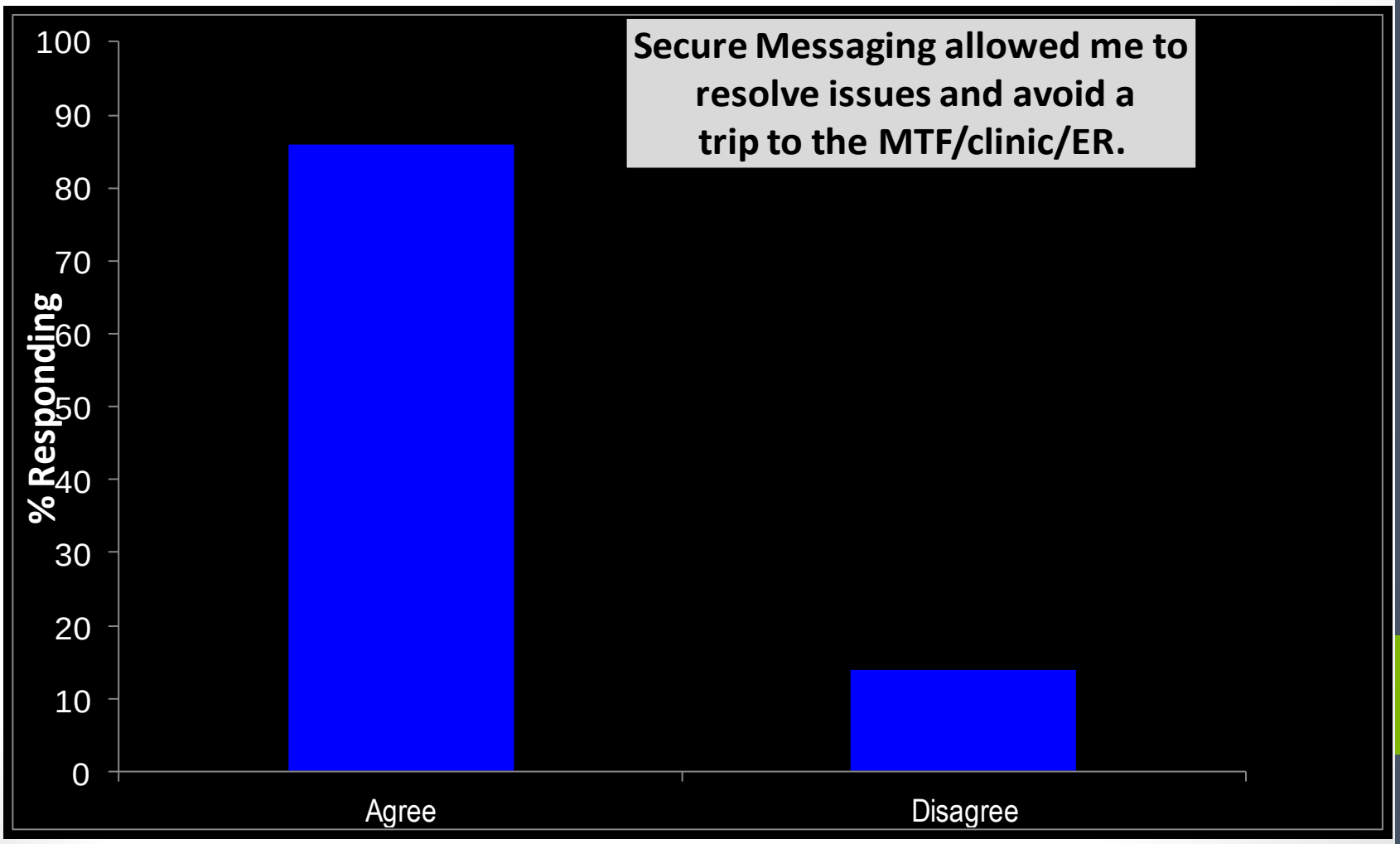

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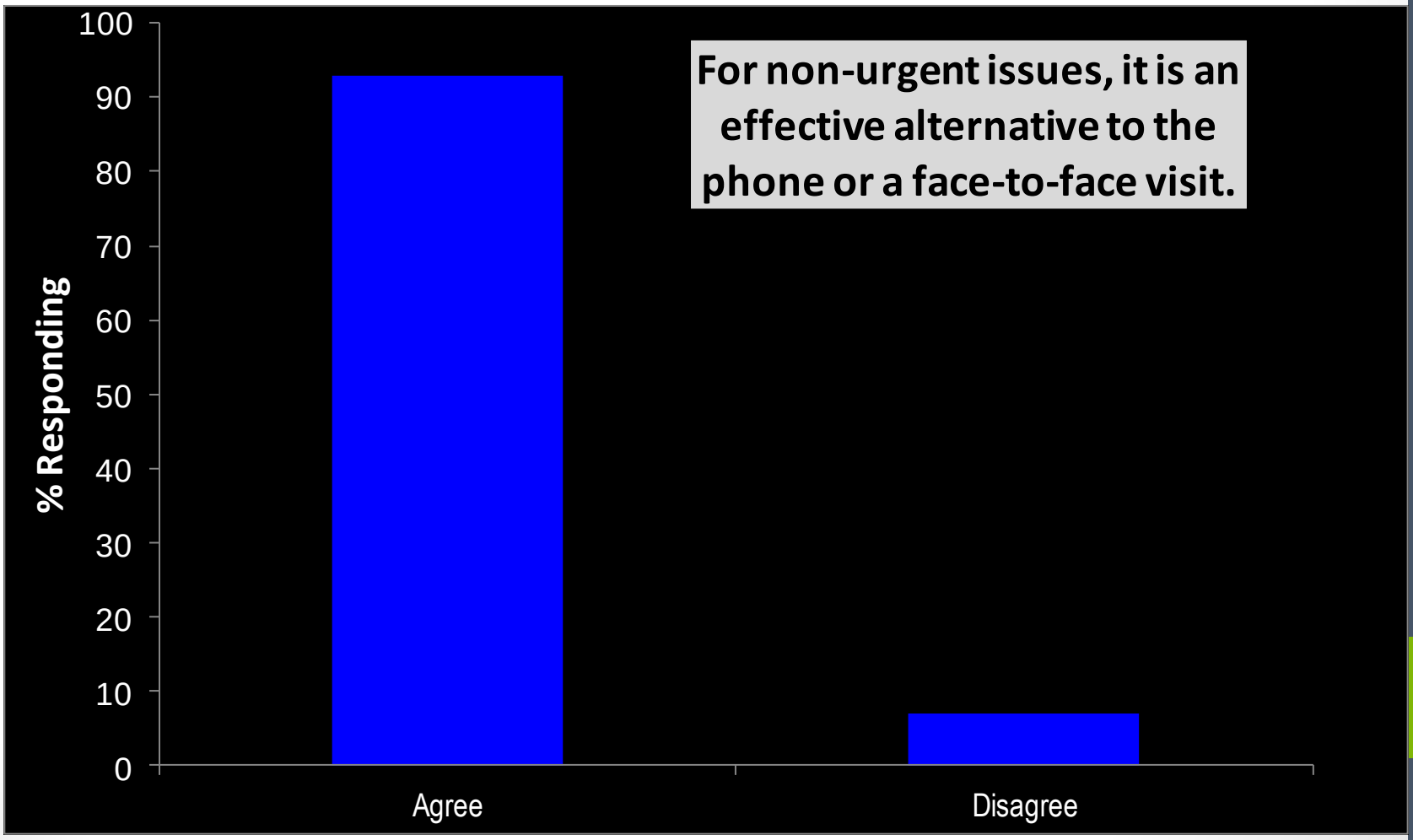

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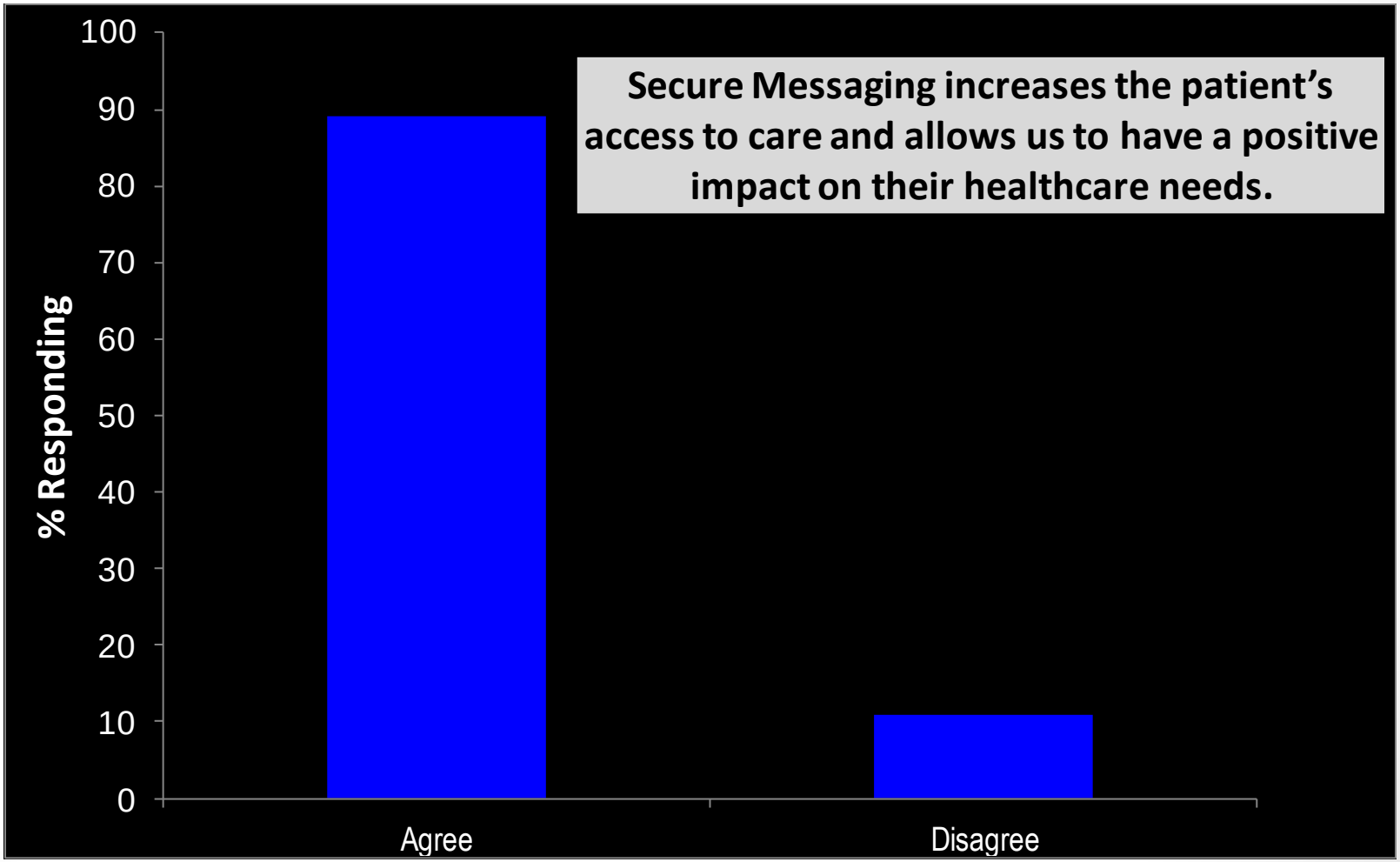

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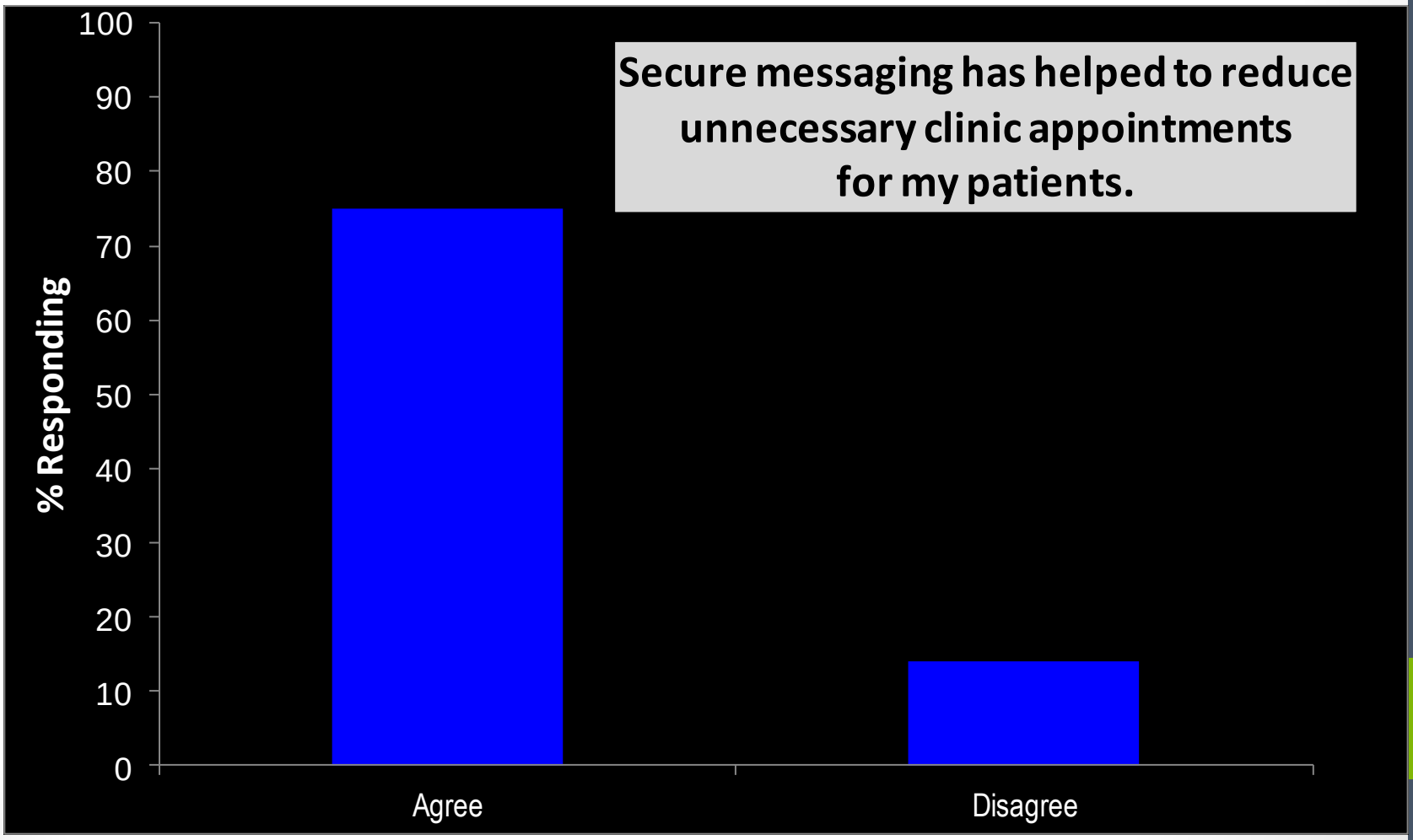
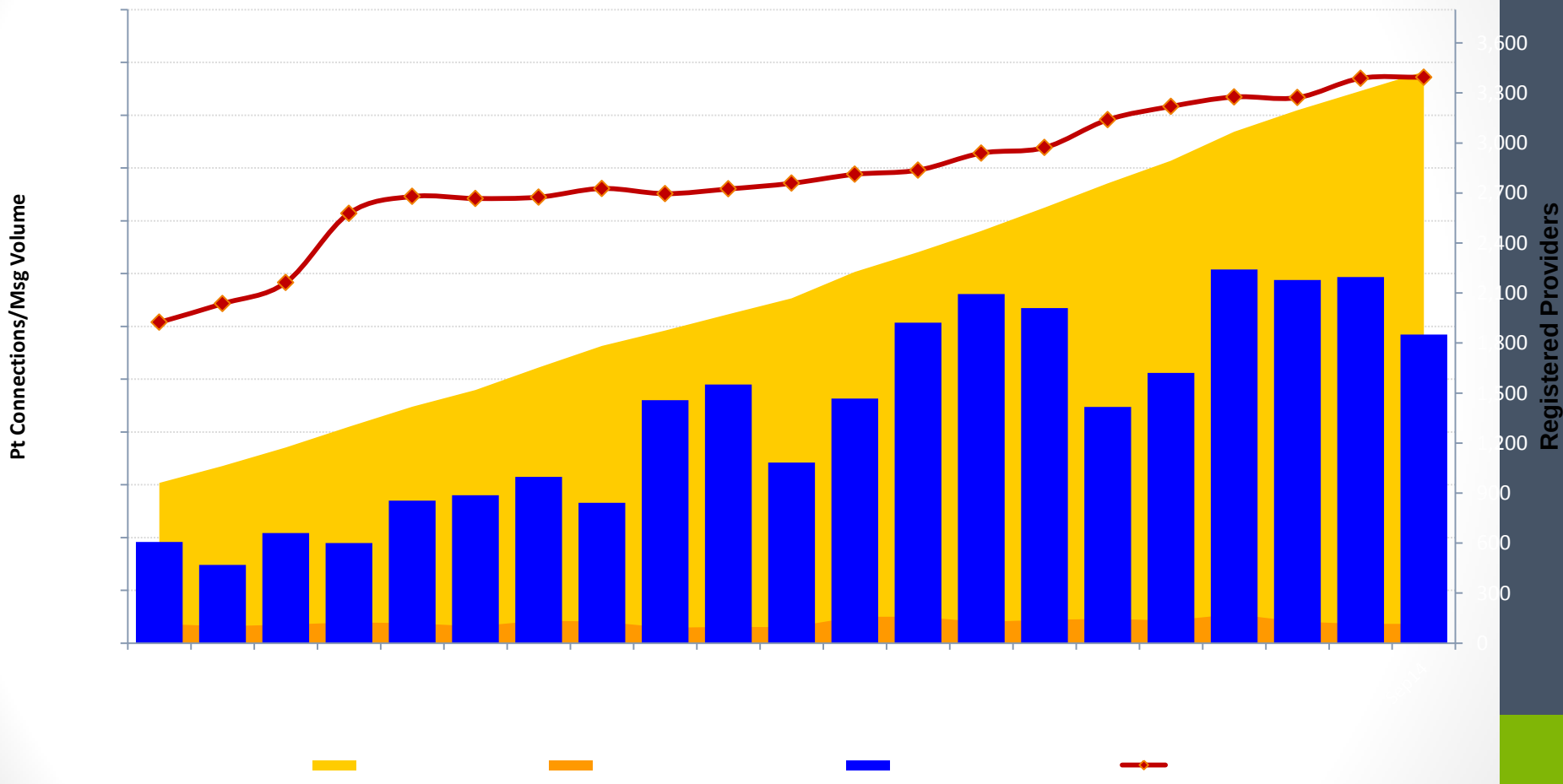
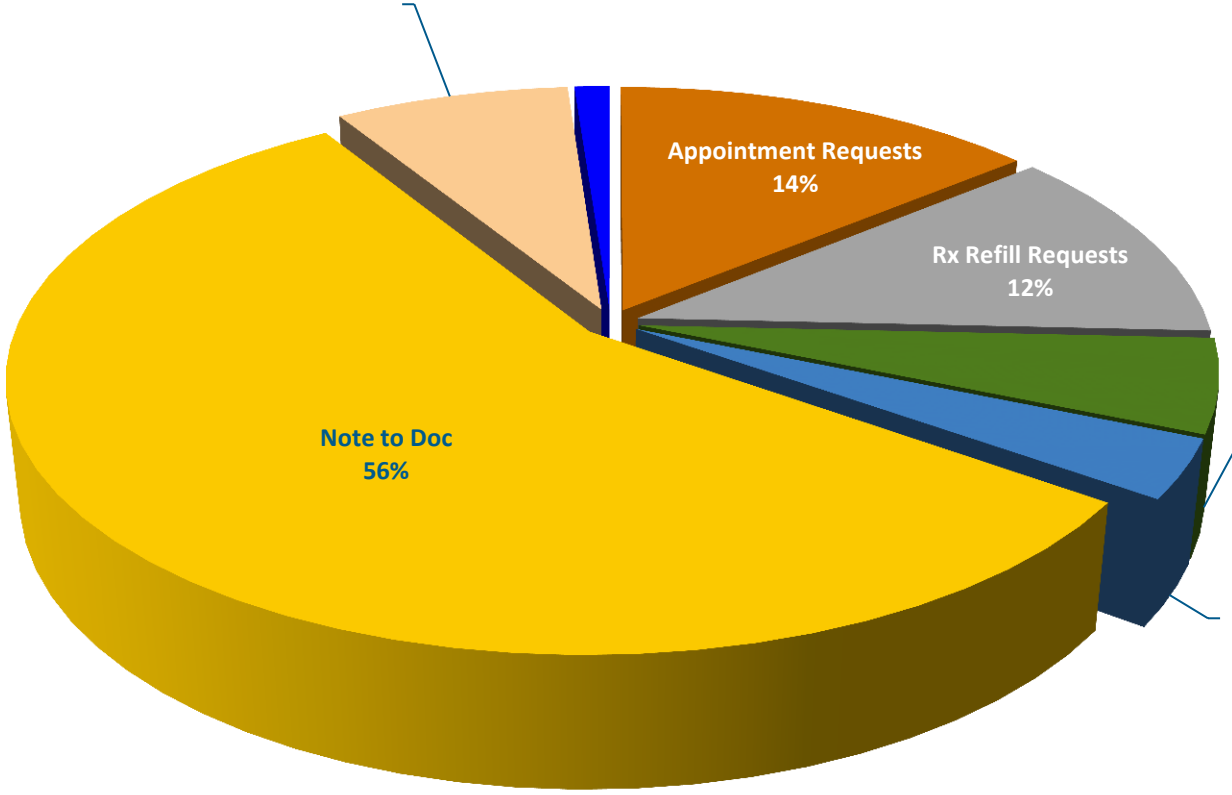


Source: ICE DISA.mil

Army Utilization Statistics through September 2014




Appointment Requests
14%
Rx Refill Requests
12%
Note to Doc
56%


Enrollment
Access
Engagement
Care Coordination
Enhanced referrals

Army Medical Homes
Refining Care Delivery

PCPCC Fall Conference, 2014

Two key focus areas:

Population Health

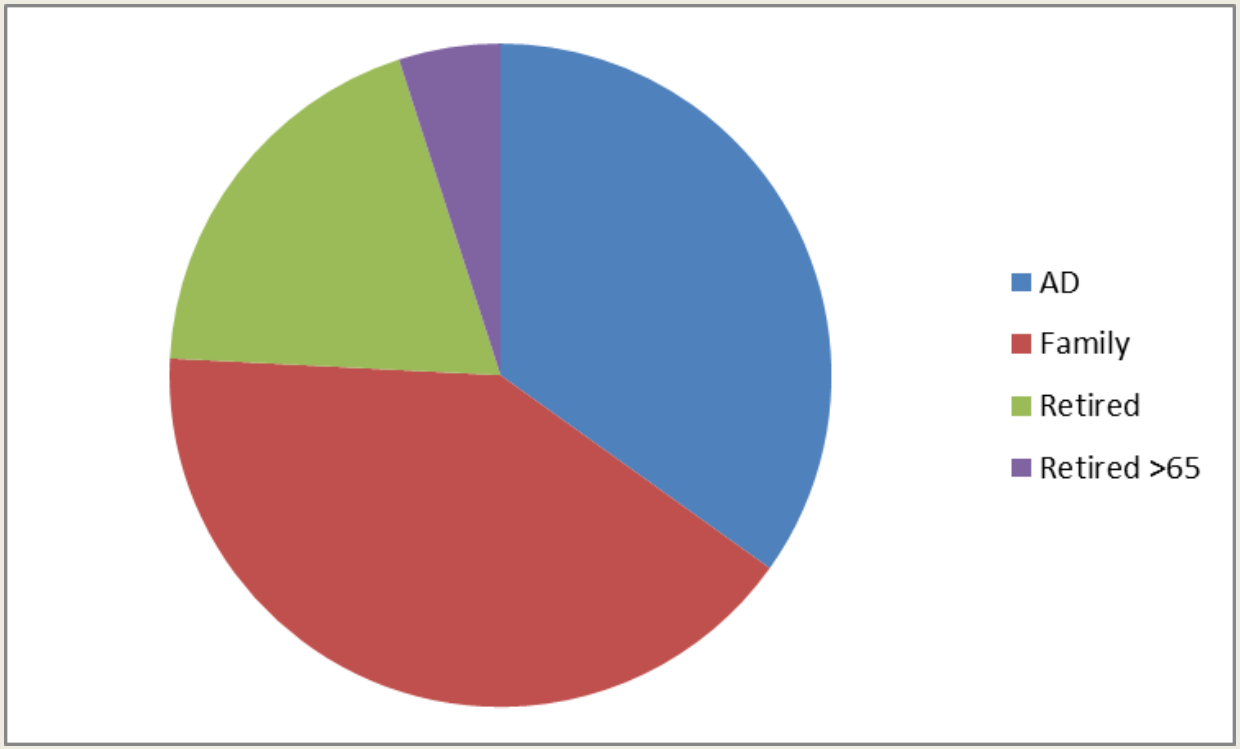
Medical Decisions

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

Population Health

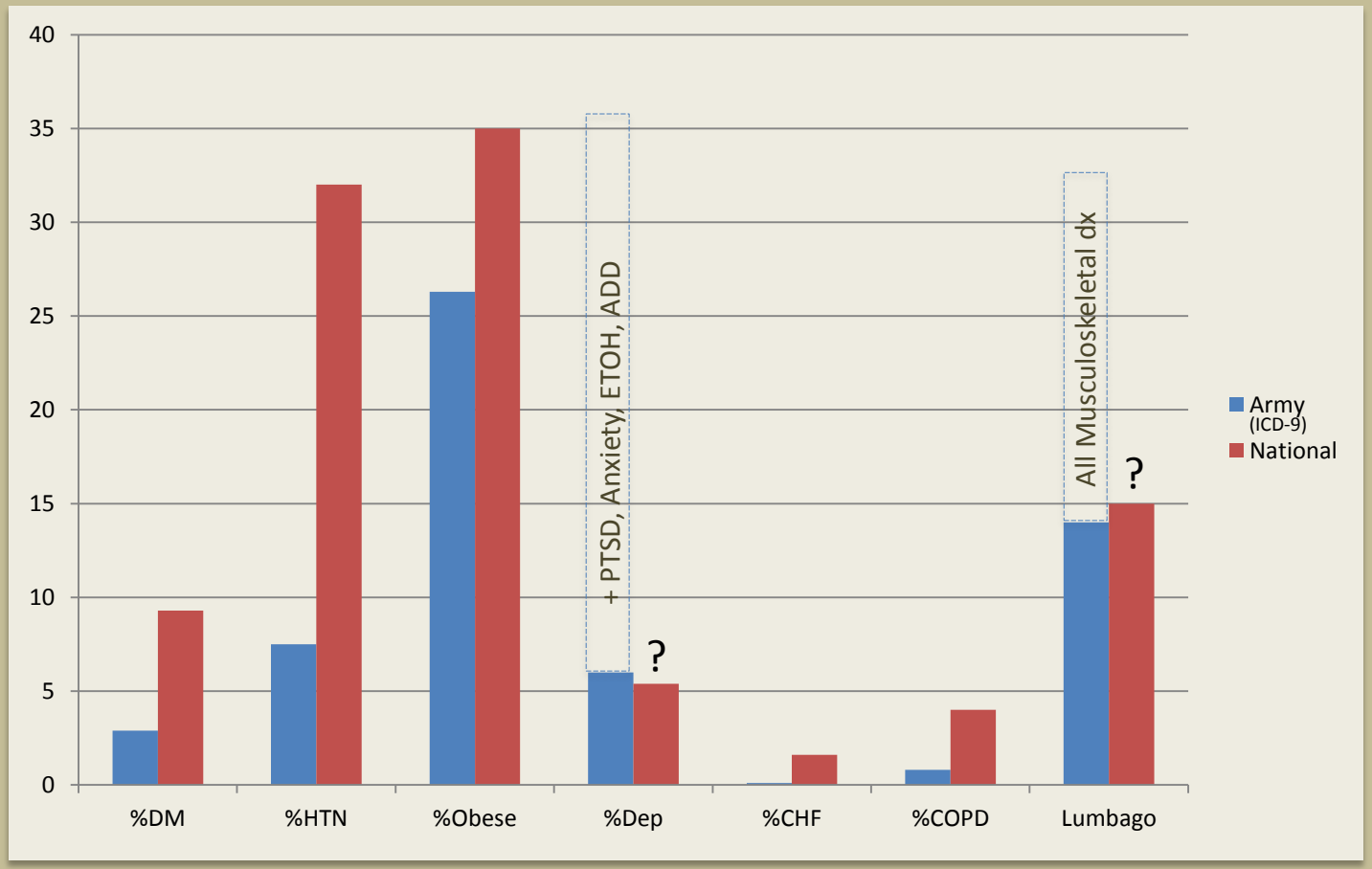
Understanding the Army Population

Total number enrolled to Army Facilities - 1,361,480



Population Health

Understanding the Army Population



National data – CDC population data 2012 and National Diabetes Statistics Report 2014
Army – includes all enrollees to direct care system

Variation within a Population

Soldier compared to family member characteristics

Family - Medical Home

Clinic demographics
7K enrolled
63% female
0.3% Active Duty
38% - < 18 years
33% - 10-39 years
17% - 0-4 years

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 254/6,876	3.6
ER visit count/enrolled 1909/6,876	28
Specialty count/enrolled 7,388/6,876	107

Adjusted Clinical Group (ACG)
VHR & HR - patients – 565/6,876 **8.2%**

Soldier – Medical Home

Clinic demographics
13.5K enrolled
16% female
100% Active Duty
89% - 18-39 years
10% - 40-49 years
1% - 50-64 years

Disease Prevalence	
HLD	12%
Depression	5.2%
HTN	3.4%
Asthma	1.4%
High utilizer	5.1%
DM	0.3%
COPD	0.2%
CAD risk	0.07%
LBP acute	7.7%
Recurrent LBP	5.0%

Visits per 100/year	
Inpatient hospitalization/enrolled 342/13,411	2.6
ER visit count/enrolled 4,863/13,411	36
Specialty count/enrolled 18,587/13,411	138

Adjusted Clinical Group (ACG)
VHR & HR - patients – 1383/13,411 **10%**

ACG - Developed by Johns Hopkins Bloomberg School of Public health

Approach to Population Specific Guided Care

Areas of Focus

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**

Patient Centered Medical Home

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

Care Point	Linked to EMR Data		Clinic Level Analysis
		High frequency Individual diagnoses	Actionable PS-IM subgroups
ACG- RUB level 4 & 5 Patients High and Very High Risk patients	Aggregated Diagnostic Group Example - Musculoskeletal	Lumbago Chronic LBP Neck pain Sciatica Radicular pain	→ **Chronic Back Pain**
		Knee pain Shoulder pain Hip pain Elbow pain	→ **Overuse injuries**
		Rheumatoid Arthritis Osteoarthritis Gout Arthritis NEC Chronic Knee pain Chronic Shoulder pain	→ **Chronic Joint Pain**

ACG RUB	CHUP List	Total Encounters	23 - Other Contact for Heath Services	19 - Mental Diseases and Disorders	08 - Musculoskeletal System	03 - Ear, Nose, Mouth & Throat	01 - Nervous System	14 - Pregnancy & Childbirth	06 - Digestive System	10 - Endocrine, Nurtition & Metabosism)	09 - Skin & Breast	05 - Circulatory System	13 - Female Reproductive System	04 - Respiratory System	11 - Kidneys & Urinary Tract	02 - Eye	21 - Injuries	16
High	1	148	13	58	48	2	15	-	8	-	3	-	-	-	-	-	-	-
Very High	1	164	86	25	44	-	5	-	-	1	-	-	-	-	-	-	-	-
High	-	123	21	1	39	1	41	-	8	3	-	1	-	-	-	-	-	6
High	-	54	3	-	36	-	-	-	-	1	-	-	2	-	12	-	-	-
High	-	64	18	1	35	9	-	-	1	-	-	-	-	-	-	-	-	-
High	-	75	17	-	34	3	5	-	-	-	3	2	-	4	-	-	-	-
High	-	62	13	3	33	2	-	-	-	6	1	-	1	1	-	1	1	-
High	-	58	20	-	30	-	-	-	-	-	6	2	-	-	-	-	-	-
Very High	1	103	33	11	29	1	7	-	2	6	1	9	1	1	-	-	-	-
High	-	40	3	5	29	-	-	-	-	-	3	-	-	-	-	-	-	-
High	-	96	13	30	27	-	6	-	-	2	-	10	1	3	4	-	-	-
High	1	68	22	-	27	6	1	-	-	-	1	-	4	-	6	-	1	-
High	-	42	4	3	27	-	6	-	-	-	1	-	1	-	-	-	-	-
High	1	135	35	6	26	1	19	1	30	-	-	-	4	-	-	-	10	-
Very High	-	80	40	4	25	7	1	-	-	-	-	1	-	-	-	2	-	-
High	1	71	21	5	25	2	-	4	4	1	2	-	2	-	2	-	-	2
High	1	48	11	-	25	1	-	-	-	1	6	-	-	-	-	1	-	3
High	-	63	20	-	24	-	-	2	-	-	-	2	14	-	1	-	-	-
Very High	1	40	6	1	22	-	6	-	-	-	-	-	-	-	-	-	-	-
High	-	36	9	-	22	-	-	-	3	-	-	-	-	-	-	-	2	-
High	-	129	76	-	21	14	18	-	-	-	-	-	-	-	-	-	-	-
High	-	58	3	21	21	2	4	-	1	2	-	-	2	-	2	-	-	-
Very High	-	57	10	16	21	-	5	-	-	-	1	-	-	-	4	-	-	-
High	-	56	27	-	21	1	-	-	-	-	5	1	-	-	-	1	-	-
High	1	57	11	19	20	-	1	-	2	-	2	-	-	1	-	-	1	-
High	1	43	12	6	18	-	-	-	1	-	1	-	2	-	2	-	-	1
High	1	37	8	4	18	2	-	-	4	-	-	-	-	-	-	1	-	-
High	1	73	43	-	17	-	-	-	5	-	8	-	-	-	-	-	-	-
Very High	-	71	7	-	17	7	1	-	-	10	-	11	-	8	1	1	-	-
High	-	43	6	-	17	1	1	1	-	-	4	-	5	2	-	-	5	-
High	1	37	5	3	17	3	5	-	-	-	-	4	-	-	-	-	-	-
High	1	54	3	-	16	-	4	-	2	19	4	5	-	-	-	-	-	1
High	-	51	10	7	16	15	-	-	-	1	1	-	-	-	-	-	-	-
High	1	27	4	2	16	-	1	-	-	2	1	-	-	-	-	-	-	1
High	-	24	8	-	16	-	-	-	-	-	-	-	-	-	-	-	-	-
Very High	-	23	4	-	16	2	-	-	-	-	-	1	-	-	-	-	-	-
High	1	44	8	-	15	-	7	-	-	-	1	-	-	1	5	7	-	-
High	-	23	3	-	15	-	5	-	-	-	-	-	-	-	-	-	-	-
High	-	23	5	-	15	-	-	-	-	-	-	3	-	-	-	-	-	-

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

# of visits per Diagnosis	DC visits	PC visits	Total
V4989 3 - CASE MANAGEMENT CONTINUE	29		29
30981 - POSTTRAUMATIC STRESS DISORDER	15		15
7242 - LUMBAGO	12	3	15
V681 - ISSUE OF REPEAT PRESCRIPTIONS	12		12
V689 - ENCOUNTERS FOR UNSPECIFIED ADM	11		11
7244 - LUMBOSACRAL NEURITIS NOS	8	2	10
V5869 - LONG-TERM USE OF OTHER MEDICAT	8		8
7245 - BACKACHE NOS	6	2	8
311 - DEPRESSIVE DISORDER NEC	5		5
V6889 - ENCOUNTERS FOR OTHER SPECIFIED	5		5
V705 H - OTHER EXAM, DEFINED POPULATION	5		5
V571 - CARE INVOLVING OTHER PHYSICAL	3		3
33828 - OTH CHRONIC POSTOPERATIVE PAIN	2		2
V6540 - OTHER UNSPECIFIED COUNSELING	2		2
V705 2 - PERIODIC PREVENT EXAMINATION	2		2
3384 - CHRONIC PAIN SYNDROME	2		2
30400 - OPIOID TYPE DEPENDENCE UNSPEC	2		2
72283 - POSTLAMINECT SYND-LUMBAR		2	2
8472 - SPRAIN LUMBAR REGION		2	2
7231 - CERVICALGIA	1		1
V5849 - OTHER SPEC FOLLOWING SURG	1		1
V705 6 - POST-DEPLOYMENT EXAMINATION	1		1
2449 - HYPOTHYROIDISM NOS	1		1
33829 - OTHER CHRONIC PAIN		1	1
7248 - OTHER BACK SYMPTOMS	1		1
V701 - GENERAL PSYCHIATRIC EXAMINATIO	1		1
73382 - NONUNION OF FRACTURE	1		1
72210 - LUMBAR DISC DISPLACEMENT		1	1
V799 - SCREEN,UNSPEC MENTAL DISORDER	1		1
30789 - OTH,PAIN DISORDER,PSYCH FACTOR		1	1
3099 - ADJUSTMENT REACTION NOS	1		1
3079 - SPECIAL SYMPTOM NEC/NOS		1	1
30403 - OPIOID TYPE DEPENDENCE	1		1
29623 - DEPRESS PSYCHOSIS-SEVERE	1		1
V499 - UNSPECIFIED PROBLEMS WITH LIMB	1		1
30000 - ANXIETY STATE NOS	1		1
V549 - UNSPECIFIED ORTHOPEDIC AFTERCA	1		1
7243 - SCIATICA		1	1
72252 - LUMB/LUMBOSAC DISC DEGEN		1	1
V5721 - ENCTR FOR OCCUPATIONAL THERAPY	1		1
V4989 0 - OTHER SPECIFIED HEALTH IMPACT	1		1

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.

<u>Example – Low back pain</u>

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

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

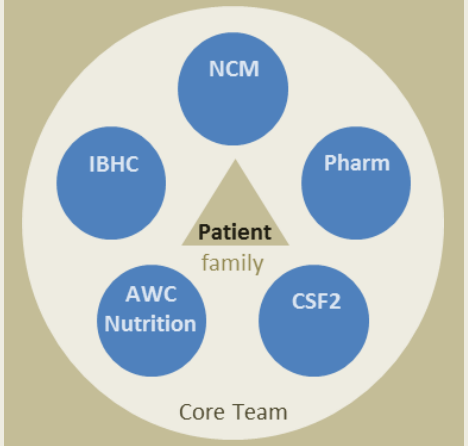
PS-IM Subgroups

- **Chronic Back Pain**
- **Overuse injuries**
- **Chronic Joint Pain**

Prioritize efforts on top 20 patients per PS-IM

PS-IM Team

PS-IM Core



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)

Musculoskeletal PS-IM Community

Secure Message Colleague to Colleague Messaging

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

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 back injury prevention

Pain class – setting appropriate expectation when living with pain

Field trip to post Fitness Center – Cross training techniques to reduce injury

Medical Decisions

Leveraging specialty knowledge

Specialty Care

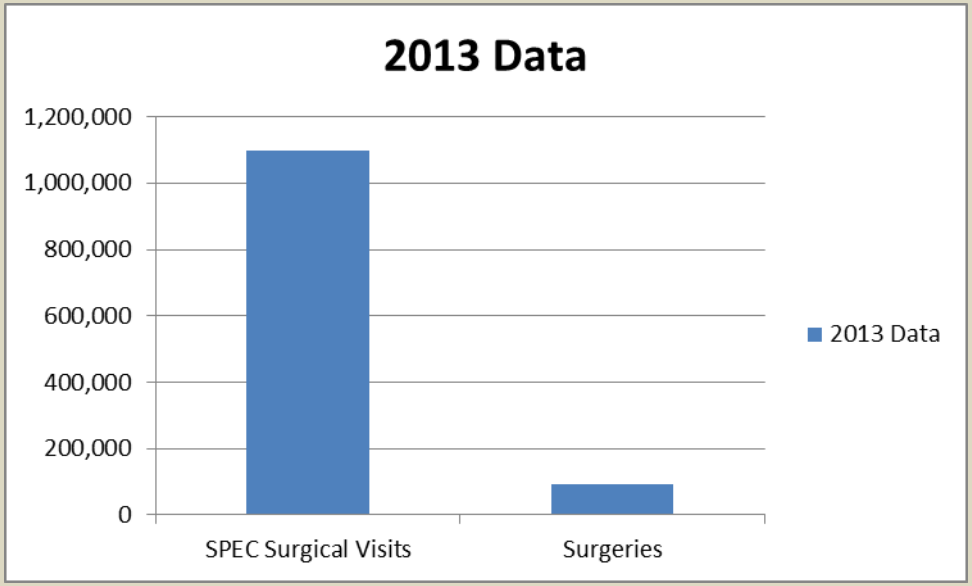
Unified with

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

Description of a Enhanced Referral

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

Referrals becomes a team process:

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

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

Enhanced Referral Process (ERP)

Patient and PCM decide to enter ERP

↓

Specialty team provides input

4 General Paths based on input

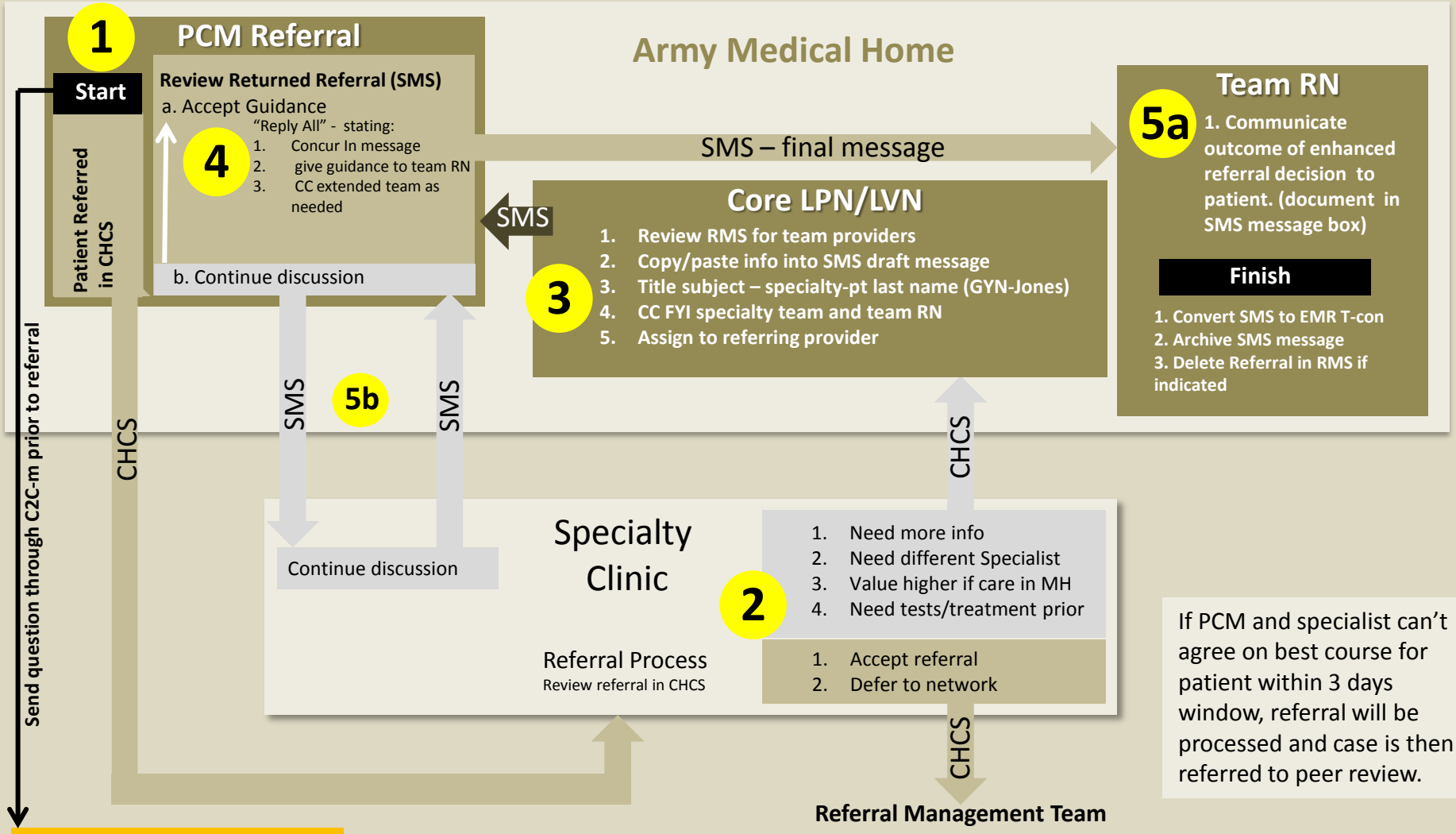
Additional evaluation, testing and treatment recommended	**Early intervention by PCM team recommended by specialist**
Routine referral for face to face visit	**Accelerated referral for face to face visit**

↓

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



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

UPMC | TECHNOLOGY DEVELOPMENT CENTER

PCPCC Annual Fall Conference 2014

Using Technology to Improve Population Health

Deborah Redmond, MBA MHA RPT
Vice President, Clinical Products | 11/12/2014

Who We Are

UPMC LIFE CHANGING MEDICINE

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

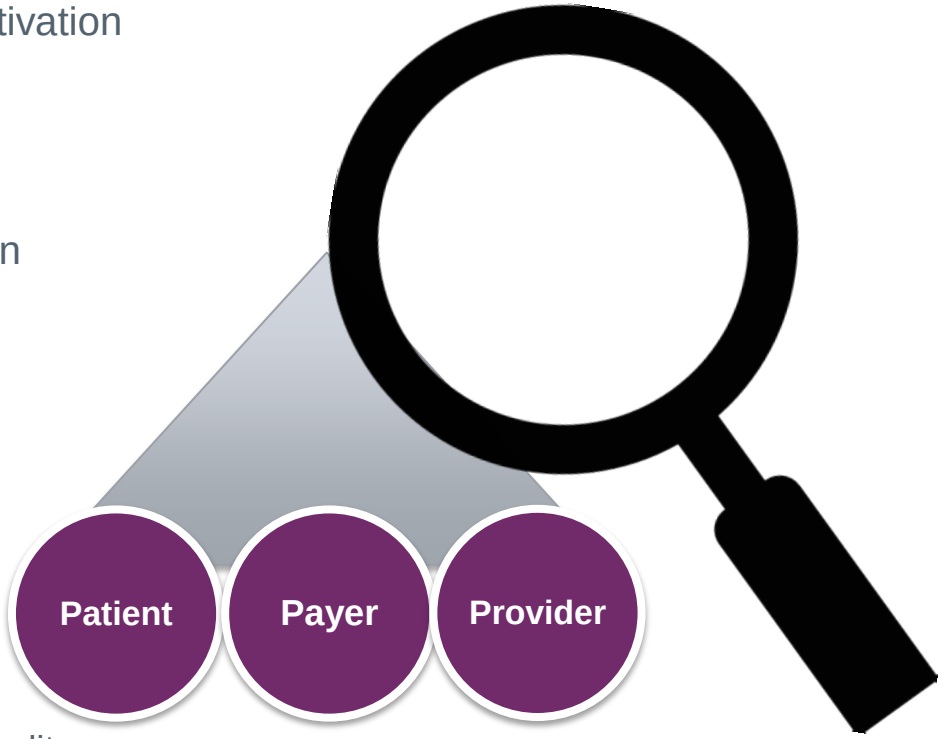
Our Goal

Align patient, payer, & provider to optimize population health

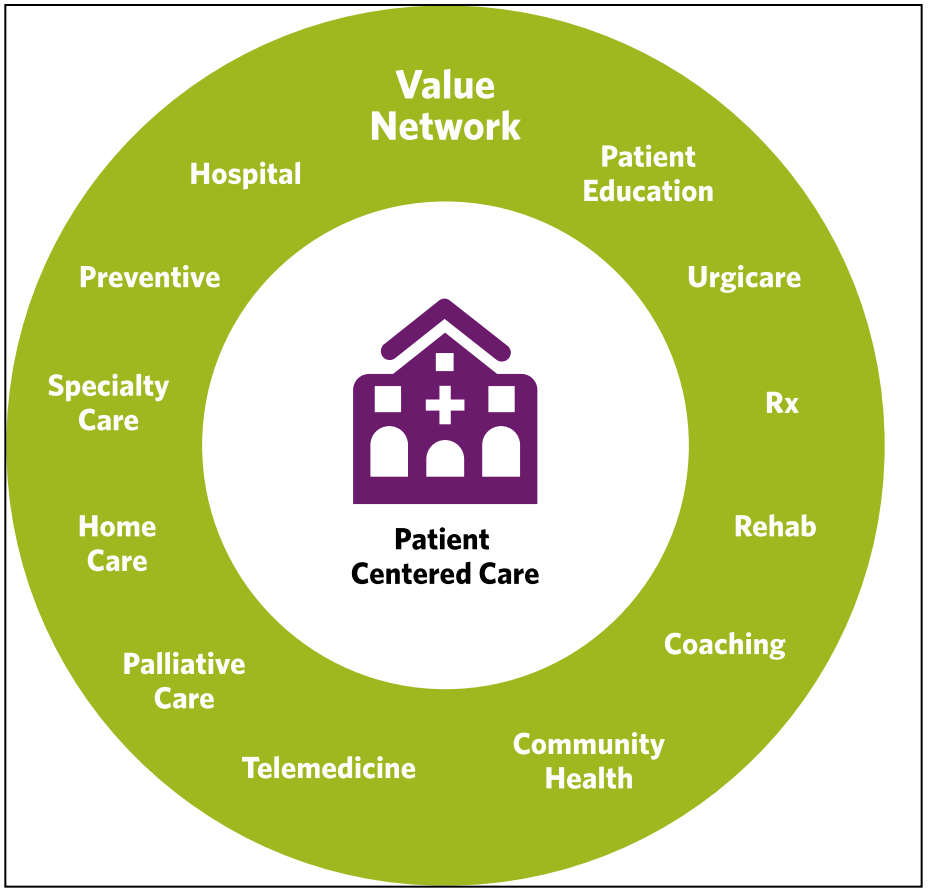
- Higher level of Engagement and Activation
- Increased Market Competitiveness
- Customer Retention and Satisfaction
- Better Outcomes at a Lower Cost

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

Risk Category & Example Conditions

Low Risk	Medium Risk	High Risk	Complex Risk
40% of total	30% of total	20% of total	10% of total
Episodic Factors	3-4 Factors	5+ Factors	multiple comorbidities
• Pregnancy	• Medication Reconciliation	• COPD	• Multiple Comorbidities
• Lifestyle Change	• New Diabetics	• CHF	• ESRD
• Healthy Eating	• Smokers	• Asthma	• Sickle Cell, Hemophilia
• Physical Activity	• Behavioral Health	• Morbid Obesity	• Complex Behavioral Health
• Stress		• CAD	

Workflow Platform

Care Management Operations

Team

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

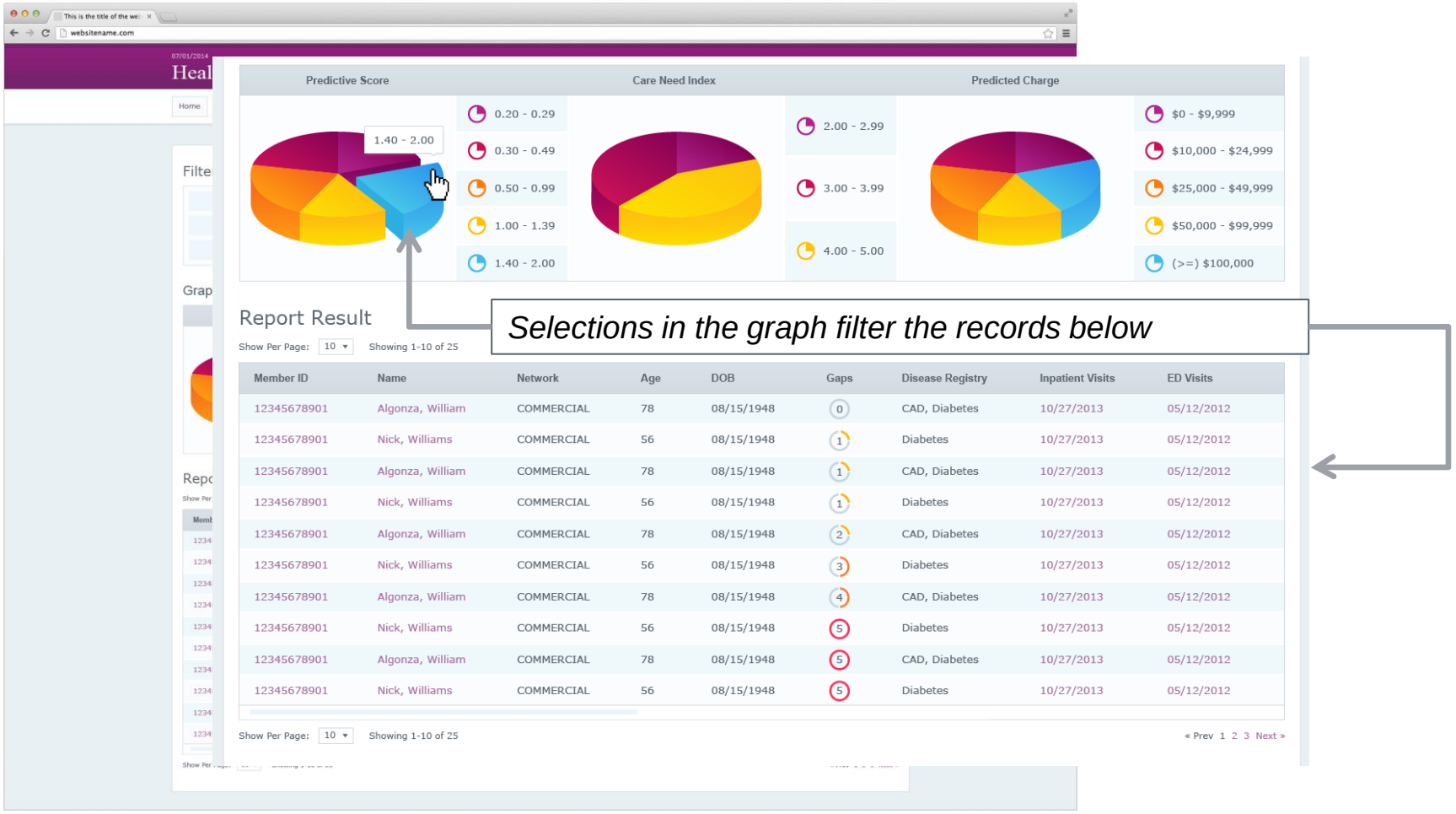
Patient-Centric Workflow | **Activity Suppression** | **Prioritized Outreach** | **700+ Proprietary Interventions**

>700 Interventions

- Patient Engagement: Lifestyle Management Programs
- Pharmacy Optimization
- Condition Coaching
- Patient Centered Medical Home
- High Cost/Complex Case Management

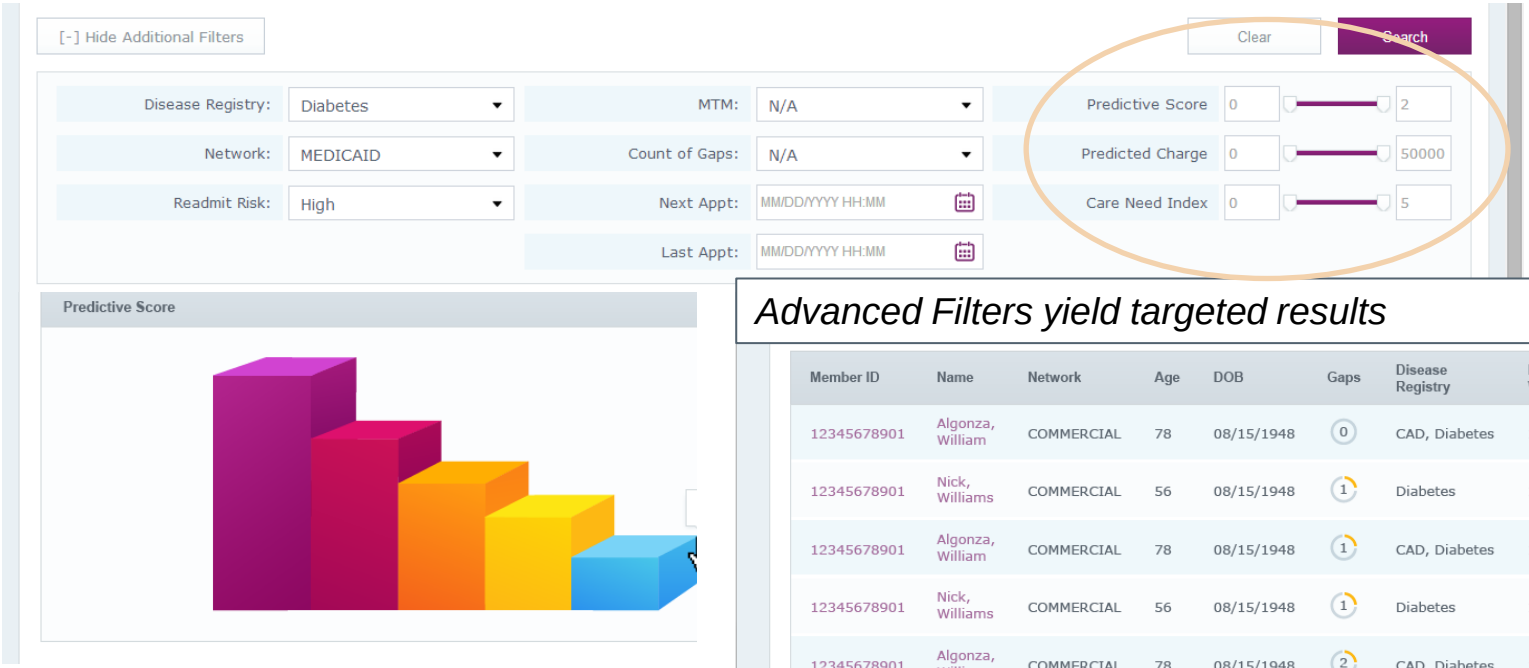
Confidential – Do Not Duplicate

Population Health Dashboard



UPMC TECHNOLOGY DEVELOPMENT CENTER

Population Health Dashboard



Advanced Filters yield targeted results

Member ID	Name	Network	Age	DOB	Gaps	Disease Registry	Inpatient Visits	ED Visits
12345678901	Algonza, William	COMMERCIAL	78	08/15/1948	0	CAD, Diabetes	10/27/2013	05/12/2012
12345678901	Nick, Williams	COMMERCIAL	56	08/15/1948	1	Diabetes	10/27/2013	05/12/2012
12345678901	Algonza, William	COMMERCIAL	78	08/15/1948	1	CAD, Diabetes	10/27/2013	05/12/2012
12345678901	Nick, Williams	COMMERCIAL	56	08/15/1948	1	Diabetes	10/27/2013	05/12/2012
12345678901	Algonza, William	COMMERCIAL	78	08/15/1948	2	CAD, Diabetes	10/27/2013	05/12/2012
12345678901	Nick, Williams	COMMERCIAL	56	08/15/1948	3	Diabetes	10/27/2013	05/12/2012
12345678901	Algonza, William	COMMERCIAL	78	08/15/1948	4	CAD, Diabetes	10/27/2013	05/12/2012
12345678901	Nick, Williams	COMMERCIAL	56	08/15/1948	5	Diabetes	10/27/2013	05/12/2012
12345678901	Algonza, William	COMMERCIAL	78	08/15/1948	5	CAD, Diabetes	10/27/2013	05/12/2012
12345678901	Nick, Williams	COMMERCIAL	56	08/15/1948	5	Diabetes	10/27/2013	05/12/2012

Filter Population By:

- *Practice*
- *Disease Registry*
- *HEDIS Gaps in Care*
- *Readmission Risk*
- *Next Appointment*
- *Last Inpatient or ED Visit*

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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

UPMC TECHNOLOGY DEVELOPMENT CENTER

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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

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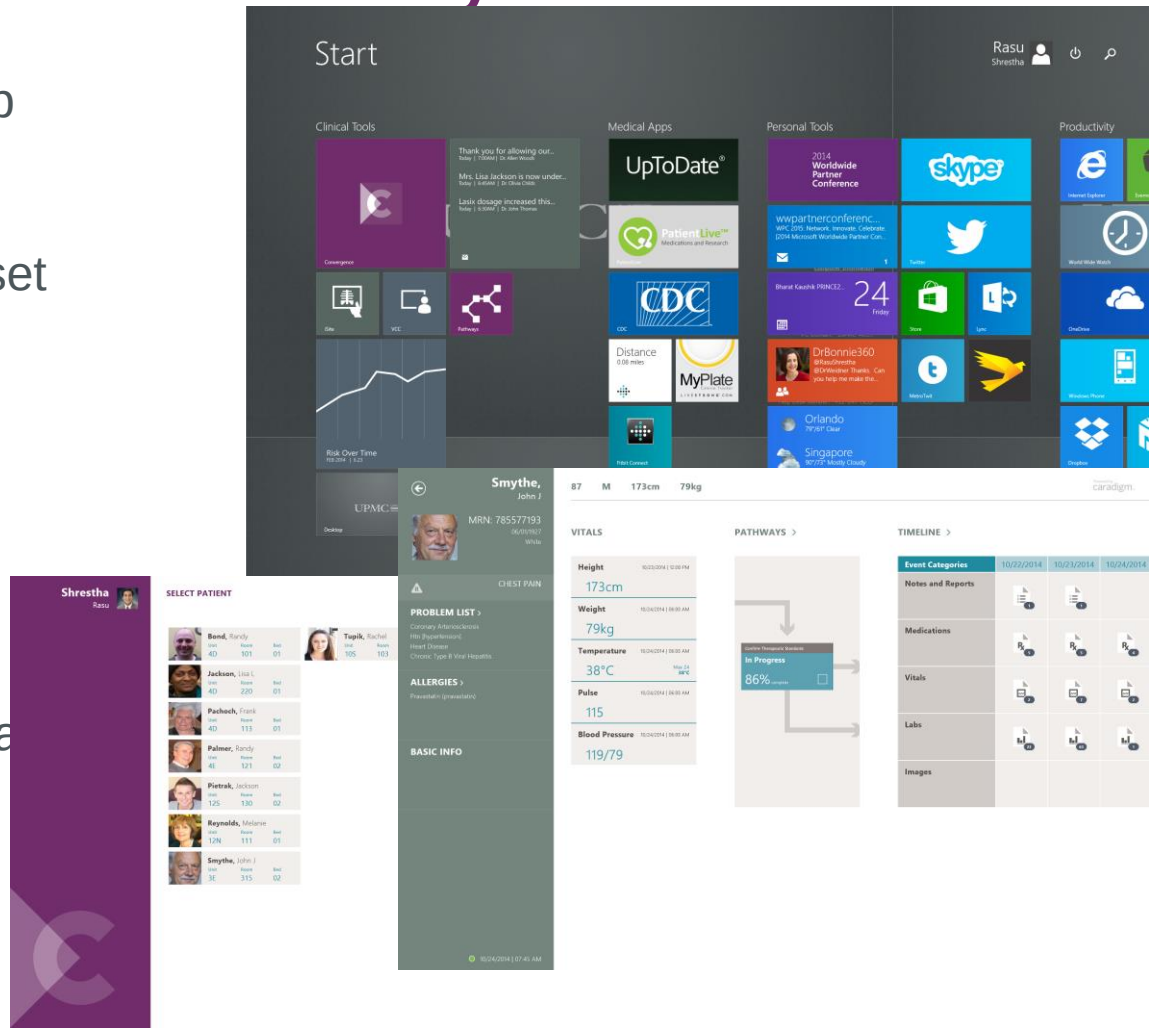
Fluence Platform
Health Visualization and Clinical Pathways

- 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 da



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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

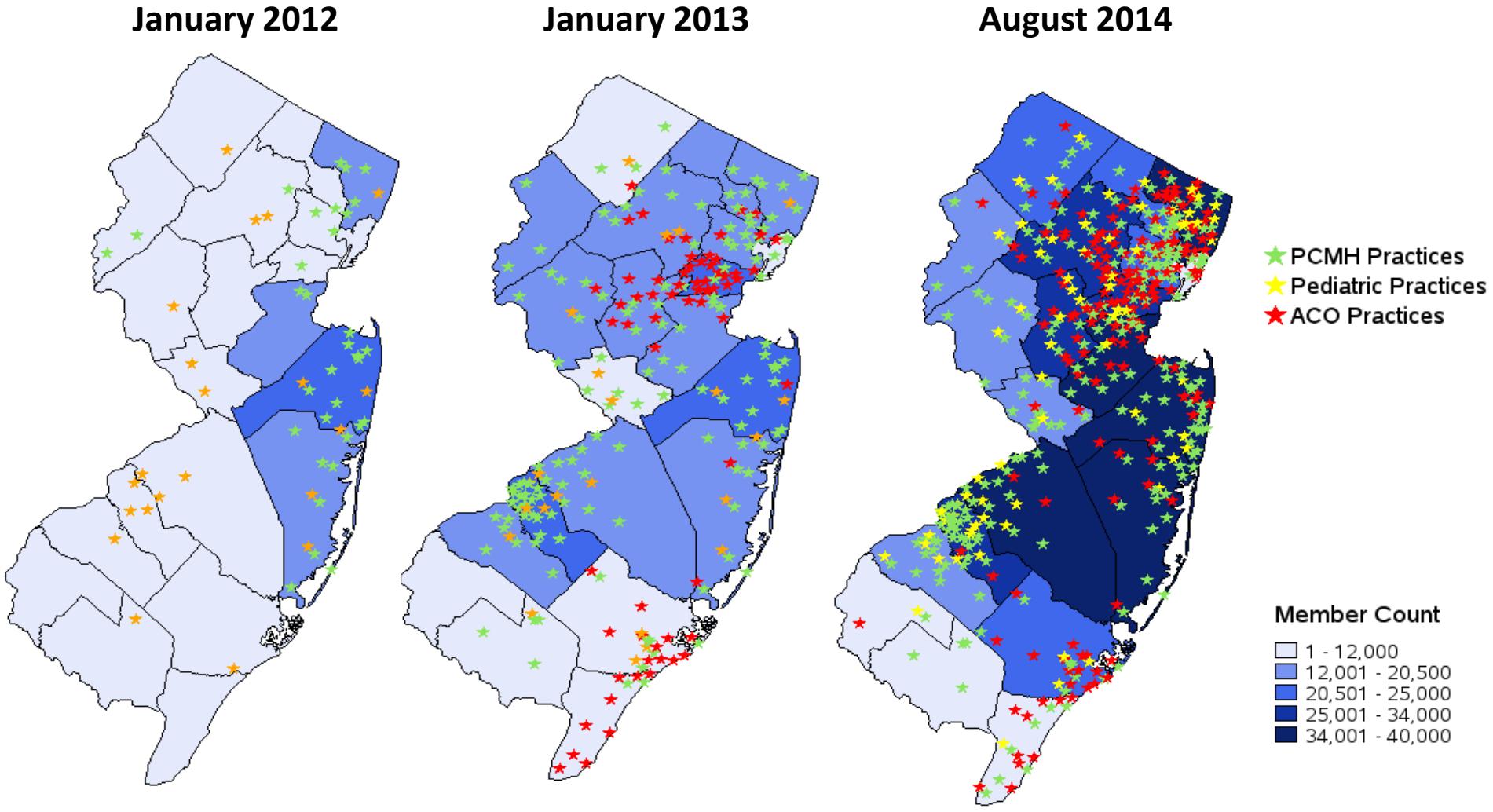
"Patient-Centered Primary Care; At the Heart of Value and Quality."

Using Technology to Improve Population Health

November 12, 2014

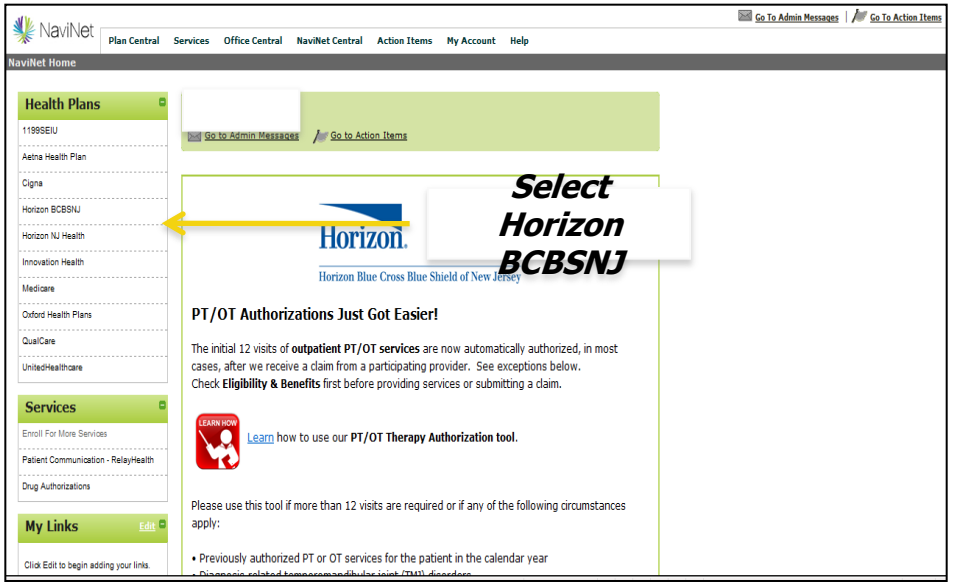
Steven R. Peskin, MD, MBA, FACP
Senior Medical Director Clinical Innovations
Horizon Healthcare Services, Inc.

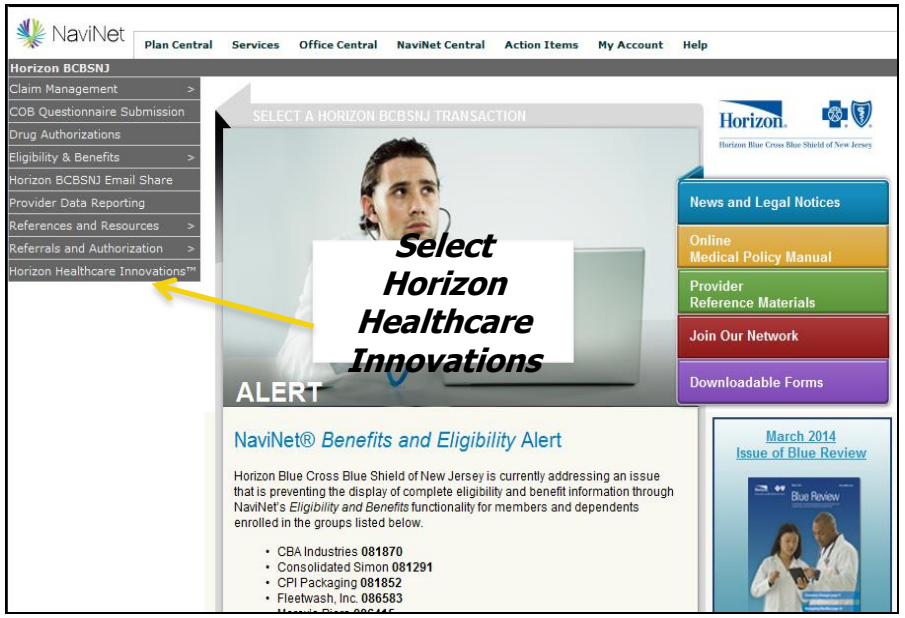
Coverage Trend

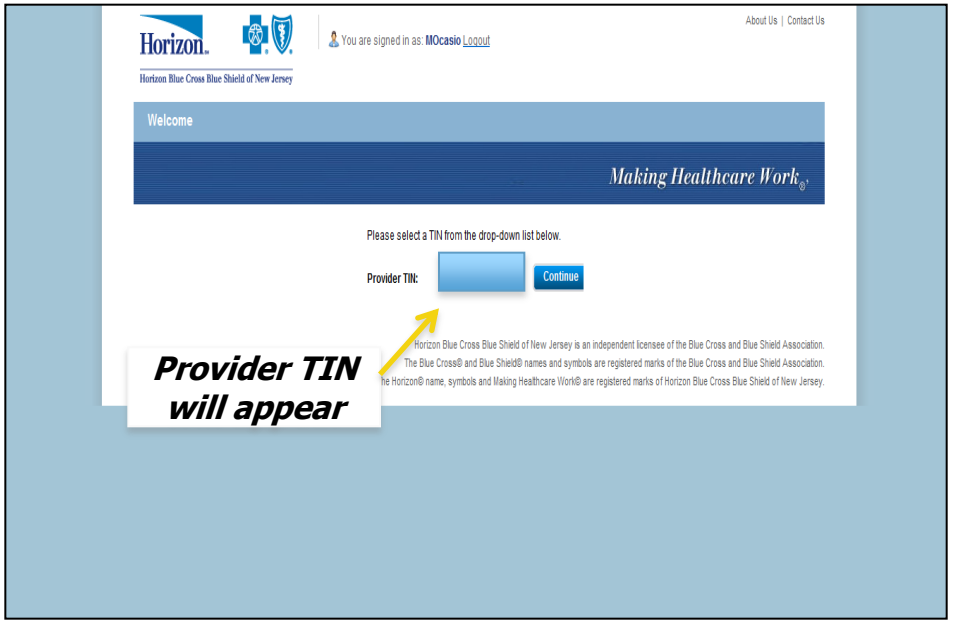


More than 900 locations, 3,700 Doctors currently in our innovative programs

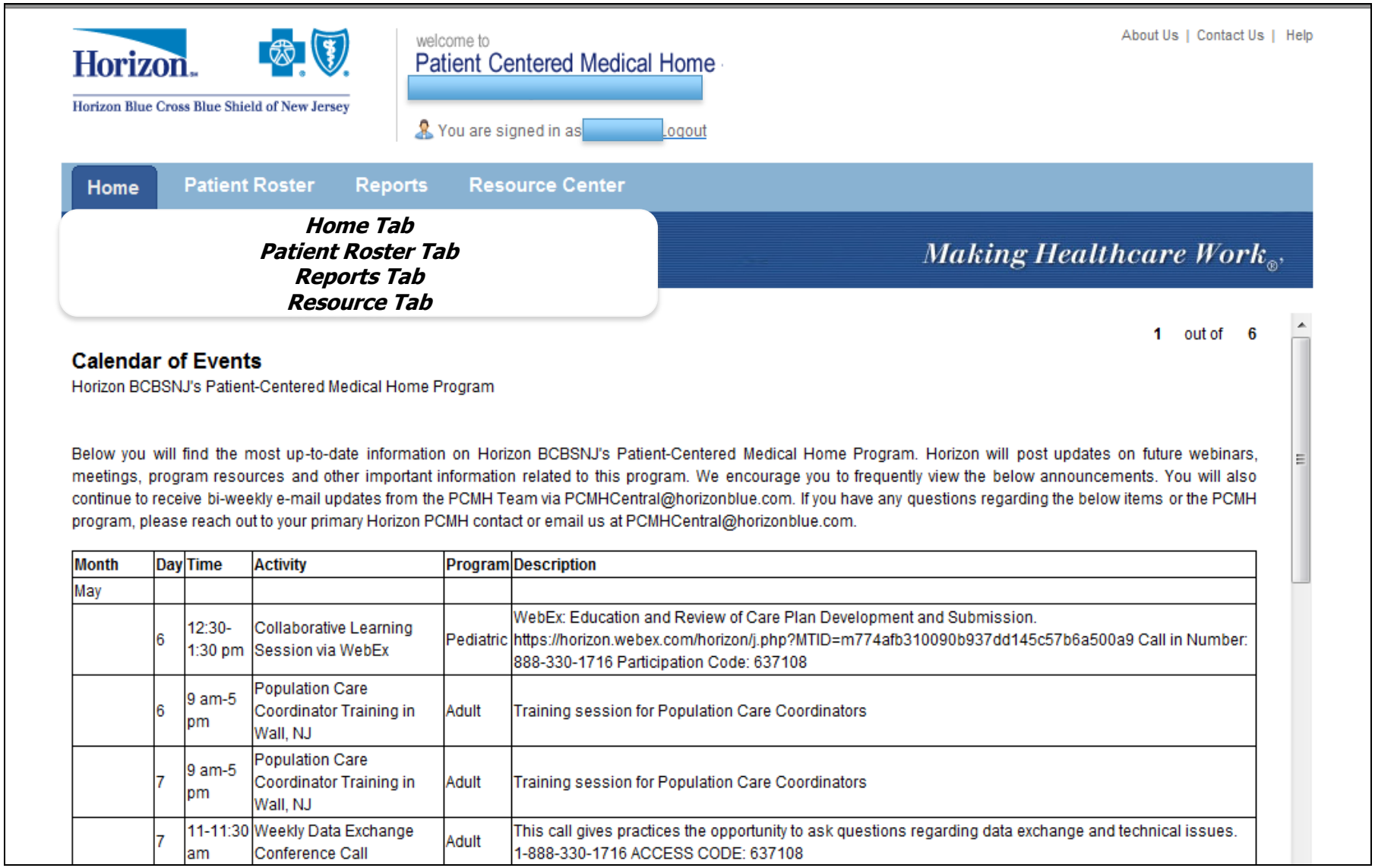
PCMH access Through NaviNet







Care Plan Tool –Home Page



Calendar of Events

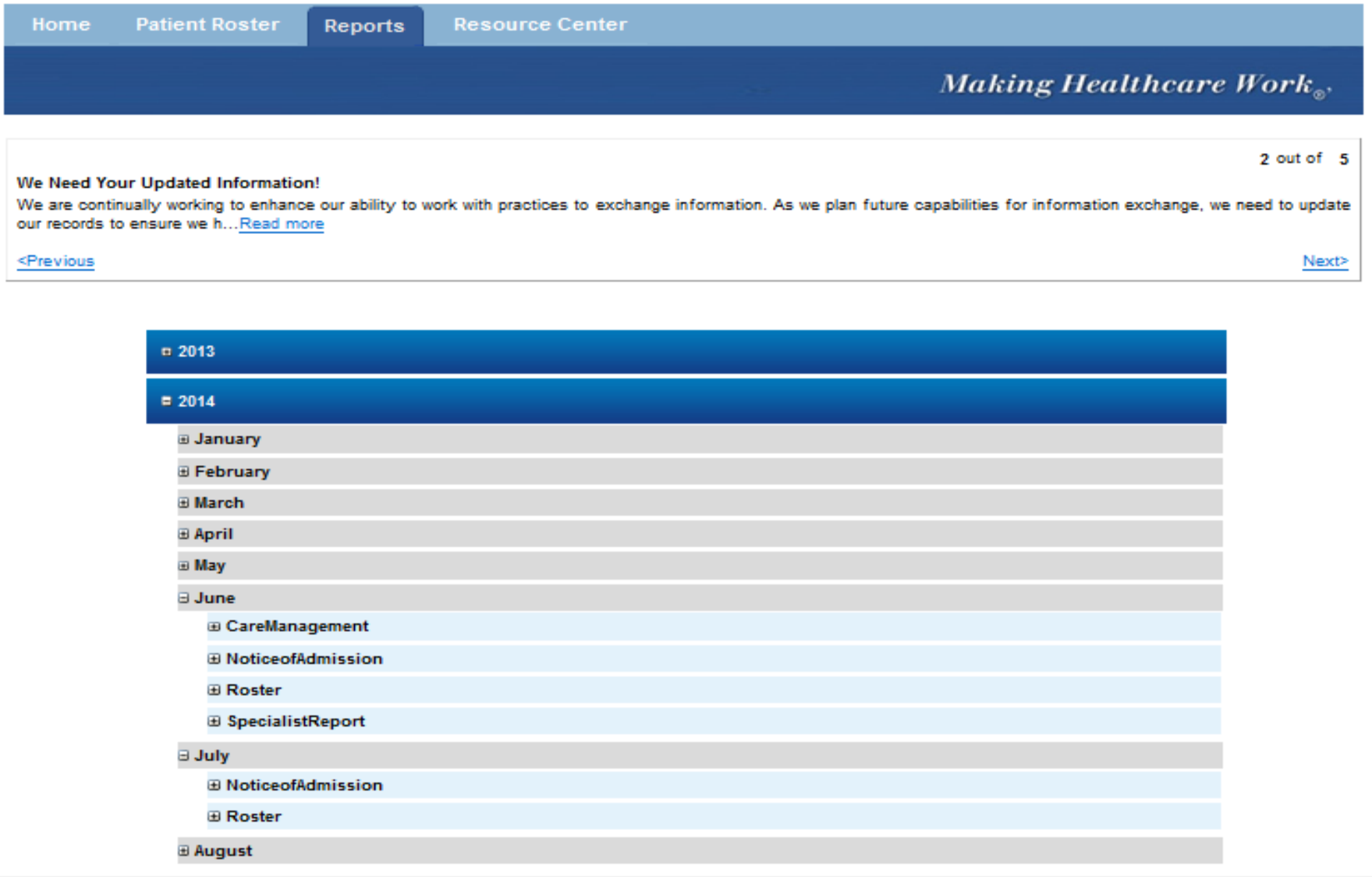
Horizon BCBSNJ's Patient-Centered Medical Home Program

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 PCMHCentral@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 PCMHCentral@horizonblue.com.

Month	Day	Time	Activity	Program	Description
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=m774afb310090b937dd145c57b6a500a9 Call in Number: 888-330-1716 Participation Code: 637108
	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 practices the opportunity to ask questions regarding data exchange and technical issues. 1-888-330-1716 ACCESS CODE: 637108

Horizon Blue Cross Blue Shield Confidential and Proprietary

Reports Tab on CPT Tool



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Sample Performance Report

Performance Overview

Clinical quality measures

Below 50th national percentile	50th to 75th national percentile	75th to 90th national percentile	Above 90th national percentile
• High BP control			
• Breast Cancer Screening			
• CRC screening			
• Diabetes: BP control			
• Diabetes: LDL Screening			
• Diabetes: HbA1C control			
• LDL Screening			
• Pneumonia vaccinations			
• Tobacco cessation			

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

~ Denominator less than 30 Excluded from evaluation

*Below Level I Target

Utilization metrics (Commercial)

ED visits	IP admissons	Specialist visits	GDR
net % change (lower is better)	net % change (lower is better)	net % change (lower is better)	net % change (higher is better)
9%	-42%	-4%	1%
Baseline Percentile vs Network Practices (higher is better):* 30%	Baseline Percentile vs Network Practices (higher is better):* 54%	Baseline Percentile vs Network Practices (higher is better):* 71%	Baseline Percentile vs Network Practices (higher is better):* 32%

BASELINE:
Weighted Performance Percentile at 47%

*See 'Release Notes' page

Sample Performance Report

Quality Measures - Detail

Quality Rate Key: Denominator < 30 | Not meeting target | Meeting Level 1 target | Meeting Level 2 target | Meeting Level 3 target

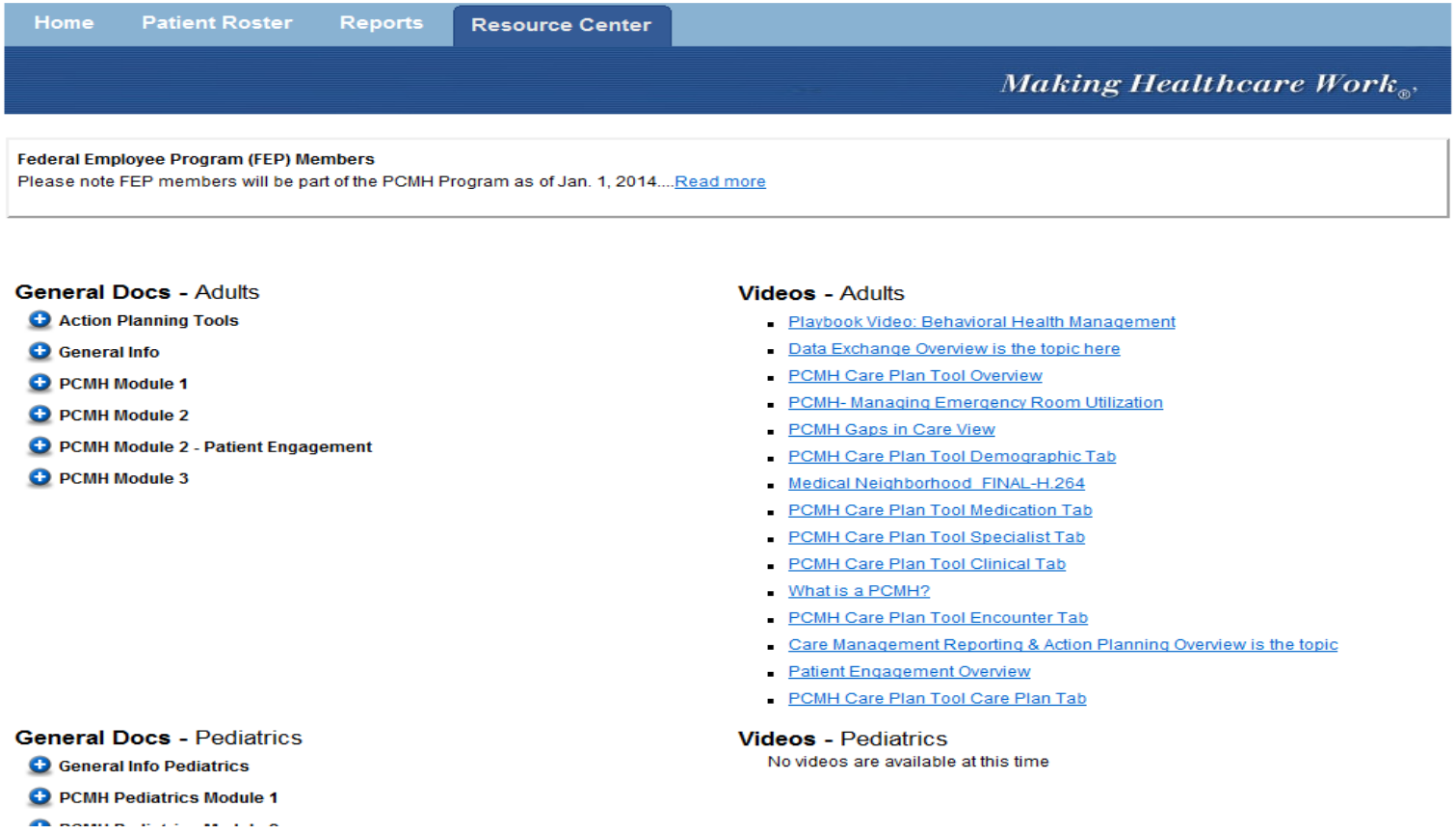
Clinical Data thru February 23, 2014
Claims Data thru January 2014

Measure	Numerator	Denominator	Quality Rate	Targeted Levels Level 1	Level 2	Level 3
High BP control	64	144	44.44%	64.37%	68.57%	74.00%
Breast Cancer Screening	174	312	55.77%	68.08%	71.97%	76.46%
CRC screening	151	333	45.35%	58.39%	65.76%	71.67%
Diabetes: BP control	25	53	47.17%	64.42%	70.41%	76.46%
Diabetes: LDL Screening	20	53	37.74%	45.99%	51.26%	55.84%
Diabetes: HbA1C control	22	53	41.51%	60.40%	65.45%	69.37%
LDL Screening	2	7	28.57%	57.96%	65.03%	71.35%
Pneumonia vaccinations	3	32	9.38%	73.00%	78.00%	82.00%
Tobacco cessation	77	172	44.77%	75.00%	80.58%	86.05%

*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.

Measure	Numerator needed for Level 1*	Level 2*	Level 3*	Difference Level 1*	Level 2*	Level 3*
High BP control	93	99	107	29	35	43
Breast Cancer Screening	213	225	239	39	51	65
CRC screening	195	219	239	44	68	88
Diabetes: BP control	35	38	41	10	13	16
Diabetes: LDL Screening	25	28	30	5	8	10
Diabetes: HbA1C control	33	35	37	11	13	15
LDL Screening	5	5	5	3	3	3
Pneumonia vaccinations	24	25	27	21	22	24
Tobacco cessation	129	139	149	52	62	72

Care Plan Tool – Resource Center



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

Horizon Blue Cross Blue Shields of NJ
Notice of Admission

View Report

Patient Roster

Member ID	First Name	Last Name	Date of Birth	Member Status	Risk	Issue Status	Date of Next Outreach	NOA Status	Create Patient Summary Report
[redacted]				Active	Not At Risk	New	02/24/2014	Outreach Attempted	
[redacted]				Active	At Risk	New	02/24/2014	Outreach Attempted	
[redacted]				Active				Active	
[redacted] Lucy Jones				Active	Medium	New		Active	

Care Management Reports

Tab	Section	Fields	Field Length	Description	Sample
At Risk and All Other Tab	Infromatics Genereated Reporting	KEY_1	50	HHI Patient Identifier	123456789ABCD9876
		LAST_NAME	30	Patient Last Name	DOE
		FIRST_NAME	20	Patient First Name	JOHN
		RISK_SCORE	5	Patient's latest risk score	23
		AGE	3	Patient's Age	51
		DOB	9	Patient's Date of Birth	4/16/1960
		GENDER	1	Patient's gender	M or F
		ER	3	Count of ER visits year to date (regardless of whether patient was actively participating in pilot at the time)	3
		IP	3	Count of IP Admits year to date (regardless of whether patient was actively participating in pilot at the time)	1
		PCP	3	Count of visits to the Medical Home year to date.	1
		LAST_VISIT	9	Date of last visit to the Medical Home	2/15/2011
		PRIMARY_RISK	50	Patient's primary condition	DIABETES
		SECONDARY_RISK	50	Patient's scondary condition	
		DX1	50	Top diagnosis by cost in the last 12 months.	DIABETES MELLITUS
		DX2	50	Secondary diagnosis by cost in the last 12 months.	SYMPTOMS INVOLVING RESPIRATORY SYSTEM
		DX3	50	Tertiary diagnosis by cost in the last 12 months.	HYPERTENSION
		OPEN_GAPS	2	Clinical quality measure eligible denominator count.	10
		TOTAL_GAPS	2	Clinical quality measure qualified numerator count.	5
		PRODUCT	5	Commercial or Medicare Advantage	COMMERCIAL
		LTM_COST	10	Total costs for care in the last 12 months.	14,256
	PCC Carry Over	PCC NAME	20	Population Care Coordinator's windows login (i.e. mhiggins)	jgantner1
		PCP_NAME	20	Primary Care Physician's name (Available through dropdown list)	Dr. Quinn
		CLINICAL_ASSESSMENT	10	Risk level determined by the Practice / PCC	High
		OUTCOMES_ACTIONS	15	Free text for user to input desired information on patient progress, outcomes, action items, etc.	i.e. Patient to see Dr. Jones (Endo) about bloodwork.
		NEXT_APPOINTMENT	9	Date of the patient's next scheduled visit to the medical home.	mm/dd/yyyy
		COMMENT1	250	Custom field to input whatever information you choose #1	i.e. Patient asked whether he could get a referral to Cardiologist - will confirm
		COMMENT2	250	Custom field to input whatever information you choose #2	i.e. Interested in smoking cessation programs
		COMMENT3	250	Custom field to input whatever information you choose #3	i.e. Patient's cell phone - 973-748-2568
	nent Reporting	EMR	2	Number of times the EMR has been updated during the month	2
		CPW	2	Number of times CPW has been updated during the month	2
		NEW_CARE_PLAN	2	Was a new care plan created for this patient (Y or N)	Y or N
		UPDATED_CARE_PLAN	1	Number of time the Care Plan was updated durning the month	1
		REF_CM	1	Was patient referred to Case Management (Y or N)	Y or N
		REF_CCP	1	Was patient referred to Complex Case Management (Y or N)	Y or N

Glossary | User guide | High_Risk | All_Other | FEP | ER_Visits | IP_Admits | Panel

Ready 85%

Care Management High Risk Report

Shaded for Privacy

RISK_SCORE	AGE	DOB	GENDER	ER	IP	PCP	LAST_VISIT	PRIMARY_RISK_FACTOR	SEC
3.53	60	7/14/1953	F			4	6/13/2013	Heart failure/cardiomyopathy	
4.96	63	3/22/1950	F		1	2	12/3/2013	Joint degeneration/inflammation	
4.49	75	9/20/1938	F					Diabetes	
2.65	55	8/1/1958	M	1		3	12/9/2013	Hypertension	
1.79	60	3/16/1953	M					Atrial fibrillation/flutter	
6.18	62	1/10/1952	M	1	1	6	8/13/2013	Acute and chronic renal failure	
4.92	56	7/5/1957	F			2	12/3/2013	Joint degeneration/inflammation	
4.32	59	5/21/1954	M			2	11/12/2013	Joint degeneration/inflammation	
3.29	54	12/13/1959	M			4	12/16/2013	Other cardiology	
2.96	50	6/1/1963	M	1				Diabetes	
8.94	53	8/28/1960	M	2		5	12/6/2013	Adult rheumatoid arthritis	
4.74	35	6/16/1978	F	2		5	11/13/2013	Mood disorder, depression	
1.83	71	4/8/1942	F					COPD, including asthma	
4.29	49	3/18/1964	F			2	9/18/2013	Orthopedic trauma, fracture or dislocation	
31.17	34	1/31/1980	F		4			Leukemia/neoplastic blood disease	
4.51	84	4/5/1929	F			2	11/11/2013	Joint degeneration/inflammation	
2.85	50	8/7/1963	F	2	1	8	11/8/2013	Ischemic heart disease	
4.13	49	7/15/1964	M		1	6	11/21/2013	Epilepsy	
4.18	24	10/5/1989	F	1	1	2	10/14/2013	Epilepsy	
4.91	61	7/6/1952	M			1	2/25/2013	Chronic skin ulcer	
6.74	56	7/21/1957	M		1	4	10/1/2013	Other hematology	
5.24	53	8/16/1960	F			5	12/9/2013	Other neurology	
2.71	56	4/1/1957	M			1	9/24/2013	Ischemic heart disease	
5.95	63	8/18/1950	F		1	4	7/16/2013	COPD, including asthma	
2.18	63	7/17/1950	F			5	10/21/2013	Mood disorder, depression	
1.97	59	7/25/1954	F			4	11/18/2013	Diabetes	
3.44	59	11/30/1954	F			2	5/14/2013	Diabetes	
6.31	55	6/14/1958	F	1		5	10/2/2013	Diabetes	
13.52	30	8/9/1983	F					Cystic fibrosis	
5.84	62	8/26/1951	F	1		4	11/11/2013	Joint degeneration/inflammation	

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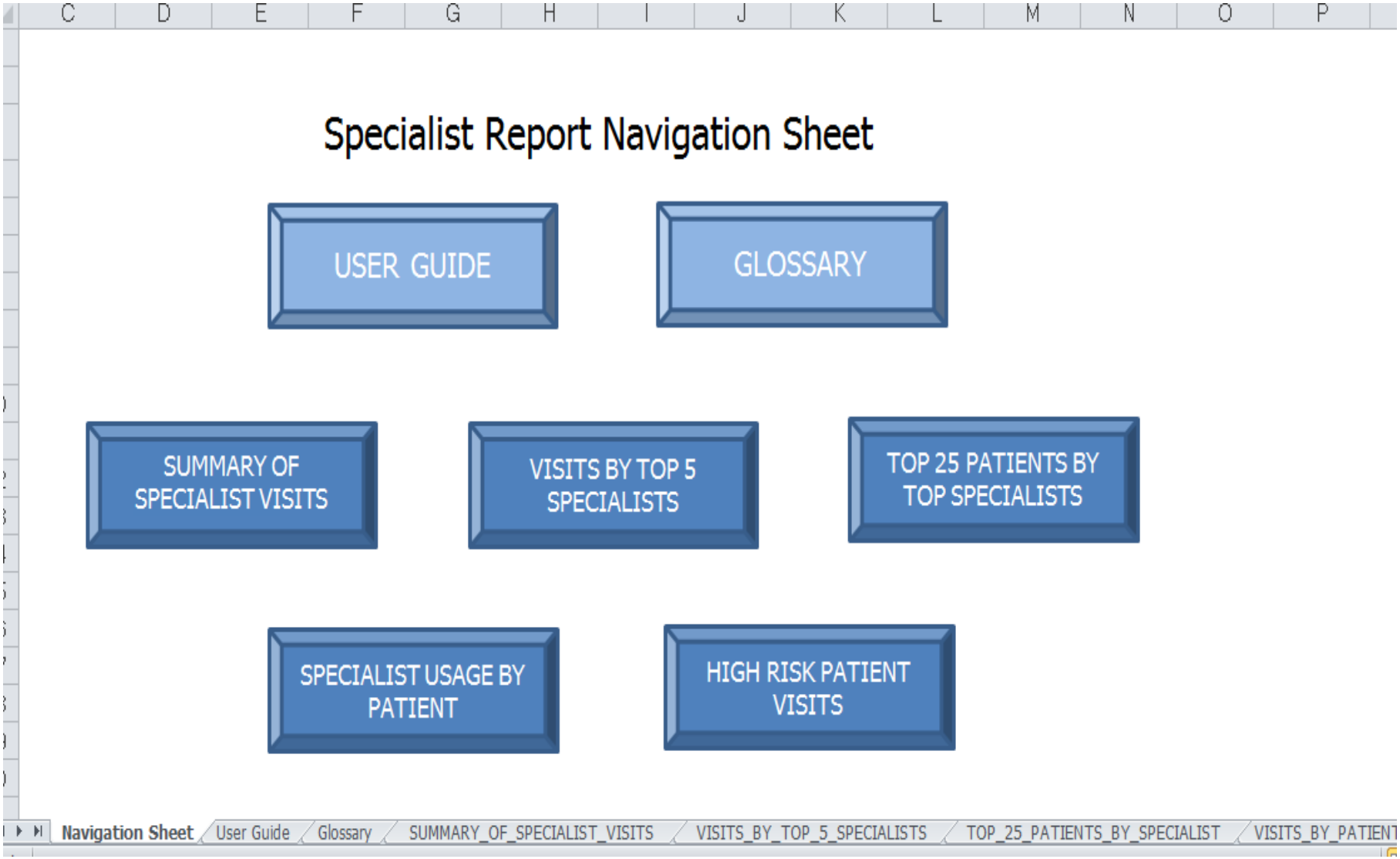
Specialist Report Overview



Horizon Blue Cross Blue Shield Confidential and Proprietary

Summary of Specialist Visit

A1 | SPECIALTY

	A	B	C	D	E
1	SPECIALTY	VISITS	UNIQUE_PATIENTS		
2	RADIOLOGY	163	138		
3	PODIATRY	112	66		
4	OPHTHALMOLOGY	110	86		
5	DERMATOLOGY	103	68		
6	HEMATOLOGY	72	19		
7	ALLERGY	67	21		
8	ORTHOPEDIC SURGERY	63	39		
9	CARDIOVASCULAR DISEASE	61	45		
10	UROLOGY	58	37		
11	GASTROENTEROLOGY	52	46		
12	OTOLARYNGOLOGY	36	24		
13	ENDOCRINOLOGY	29	24		
14	NEUROLOGY	22	18		
15	PULMONARY DISEASE	14	8		
16	PAIN MANAGEMENT	13	8		
17	RHEUMATOLOGY	9	7		
18	ORAL SURGEON	3	3		
19	INFECTIOUS DISEASE	2	2		
20	NEPHROLOGY	2	2		
21	HAND SURGERY	2	1		
22					
23					
24					
25					
26					
27					
28					
29					
30					

Glossary | SUMMARY_OF_SPECIALIST_VISITS | VISITS_BY_TOP_5_SPECIALISTS

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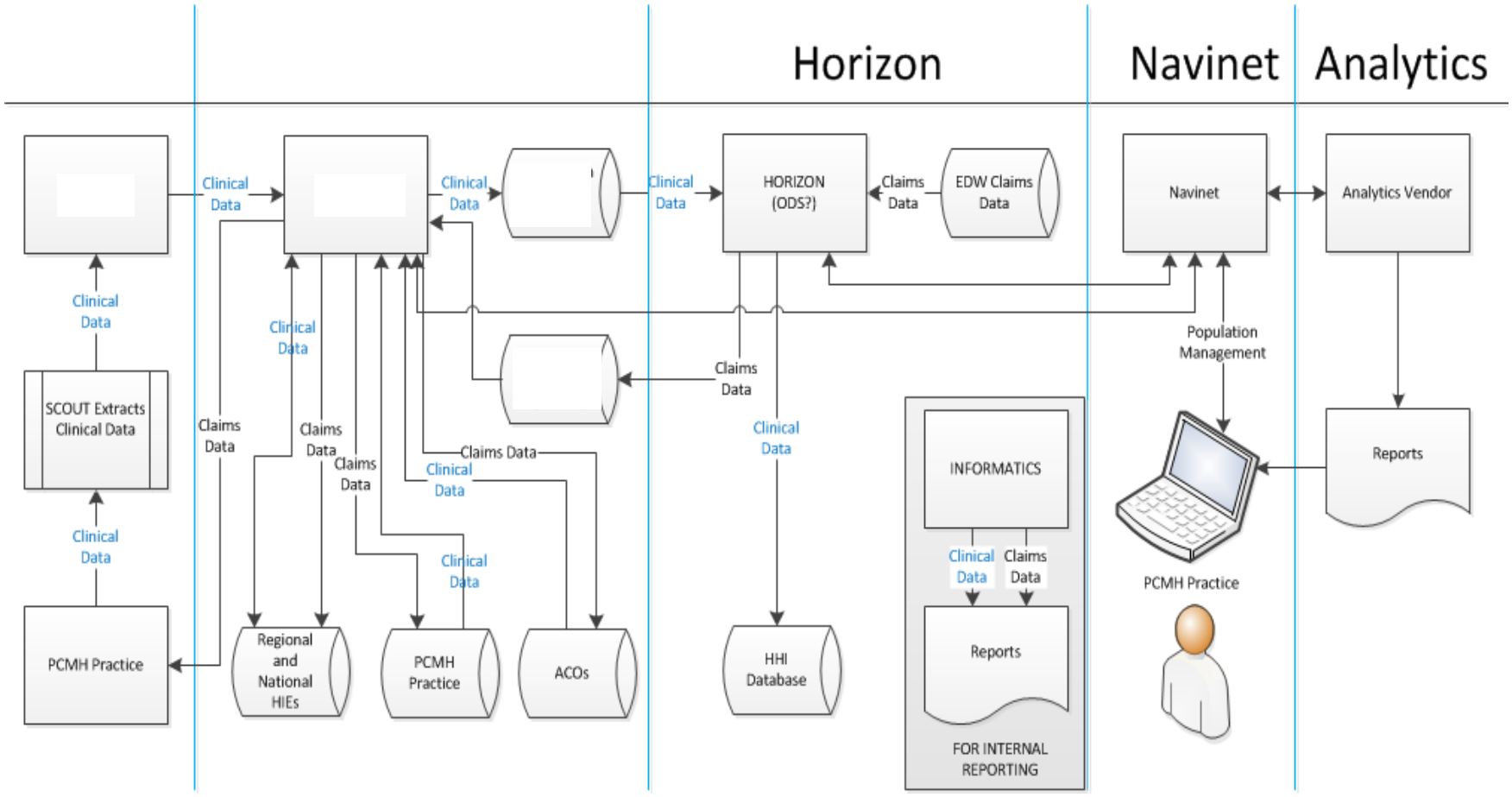
HIE Data Flow



Thank you

Questions