

PGIP INITIATIVE UPDATES: EBCR, QOPI and Proposed New Initiatives on ED and Inpatient Utilization

PGIP Quarterly Meeting
September 5, 2008
Schoolcraft Community College

Tom Leyden, Health Care Manager



Agenda

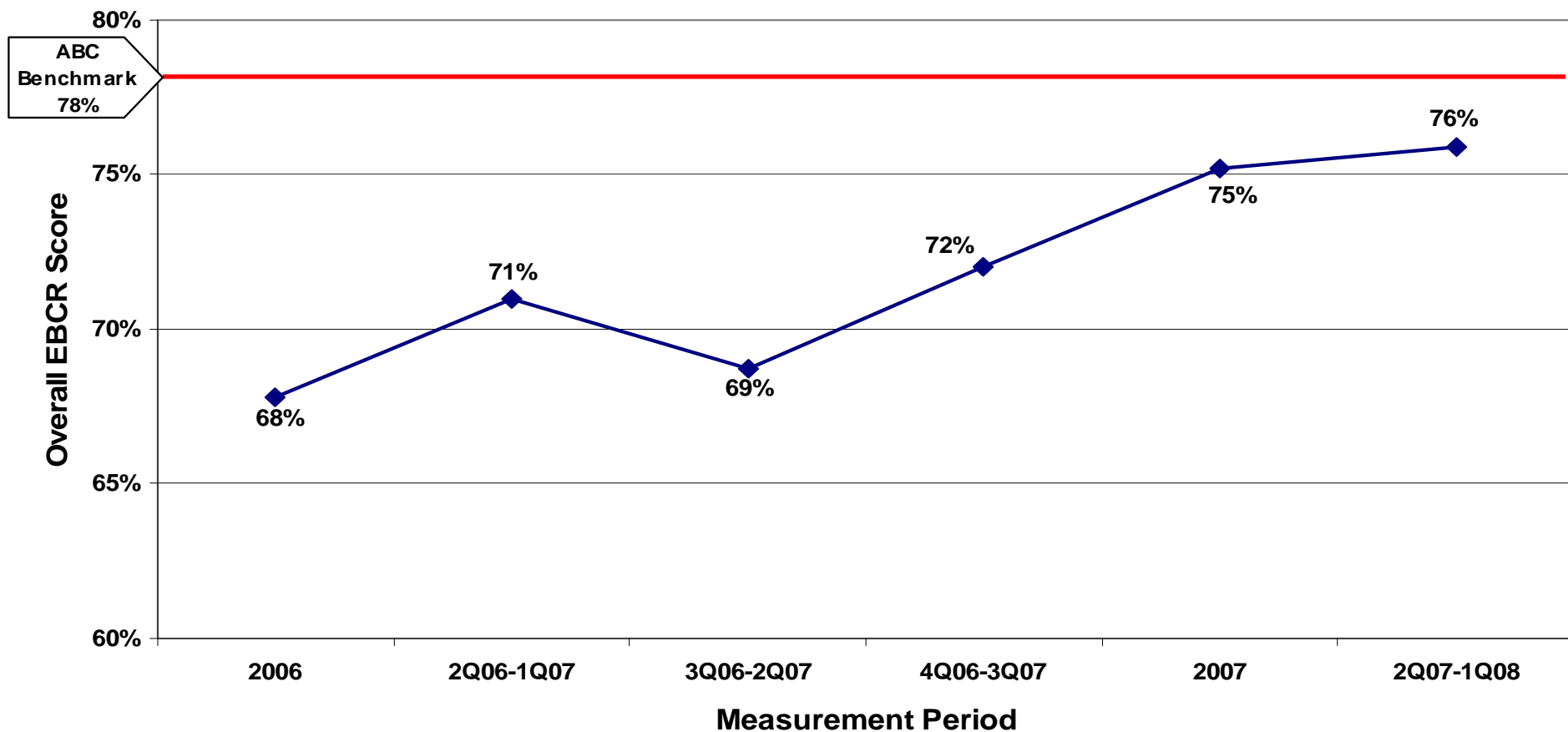


1. Evidence Based Care Report (EBCR) – Sept 2008 Update
2. ASCO QOPI Update
3. Proposed ED and Inpatient Utilization Initiatives for 2009

Overall EBCR Score



PGIP Improvement in Evidence Based Care Measures: PGIP Overall EBCR Score by Measurement Period



EBCR Improvements Realized



	Jun-07	Jun-08	...	Sep-08
PO's with Overall EBCR rates ≥ 80	0.0%	15.2%		15.2%
PO's with Overall EBCR rates > 75 , but < 80	9.7%	48.5%		60.6%
PO's with Overall EBCR rates > 70 , but < 75	22.6%	33.3%		24.2%
PO's with Overall EBCR rates in the 60's	67.7%	3.0%		0.0%
	<hr/>	<hr/>		<hr/>
	100%	100%		100.0%

- **75.8 % of POs have EBCR scores ≥ 75 compared to 10% 15 months prior**
- **3 of the 5 PO's with scores above 80 are within striking distance of 85%**

EBCR Improvements Realized



- **In the past 12 months...**

- Progress is being made across the board by all POs
 - Range of EBCR scores 1 year ago was 61 to 79
 - Today, score range is 70 to 84
- Overall EBCR Score for PGIP (Entire Program) increased 6%, from 70% to 76%
- 3 highest performing POs (Advantage Health, MMPC, U of M)
 - Have all-payor patient registries installed for all or the vast majority of their PCP offices
 - Patient registries address all 4 chronic diseases
 - Have increased their overall EBCR score each quarter for the last 5 quarters

Reminder: 11 New EBCR Measures



Beginning with the June 2008 EBCR, BCBSM began providing POs with their rates for the following measures:

- CAD: Persistence of Beta Blocker after AMI
- CHF: ACE/ARB Persistence (non-HEDIS)
- COPD: Use of Spirometry in Diagnosis
- Low Back Pain: % Receiving Appropriate Care
- Breast Cancer Screening
- Cervical Cancer Screening
- Adolescent Well Care Visit
- Adolescent Immunization Status
- Childhood Immunization Status
- Well Child Visit (first 15 months)
- Well Child Visits (years 3 – 6)



Question: What's going on with the new EBCR measures?

- The 11 new EBCR measures are considered to be in a “test” mode and aren't part of scoring and payment for 2008 PGIP
 - However these measures most likely will be included in the scoring/payment for 2009 PGIP
 - Additionally, these measures will be open to potential public reporting as of 1/1/09
- Overall, the new measures show some great opportunities for improvement and widespread variation among many of the measures
 - Beta Blocker persistence has a 25% to 82% spread
 - Use of Spirometry in diagnosis of COPD has a 25% to 61% spread
 - Appropriate Care for Low Back Pain has a 62% to 85% spread
 - Cervical Cancer Screening has a 75% to 84% spread
 - All of the Child/Adolescent measures have spreads of greater than 20%



Question: How am I being paid on the EBCR?

- On the Sept 2008 EBCR, the *Overall Evidence Based Care Score: OLD Measures* is the rate that PGIP utilizes to evaluate/ score and reward overall performance and improvement
- For Sept 2008 scoring/payment purposes, BCBSM is looking at overall performance, overall improvement and improvement within each clinical topic category
- The December 2008 payment will also look at how POs are faring compared to the ABC Benchmark. Those POs with Overall EBCR scores at or above the ABC benchmark will receive approximately 1/3rd of their payment tied to meeting the benchmark
 - 9 POs are presently eligible for this ABC-related payment

American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative (QOPI) – First Year Status Update



PGIP QOPI Initiative – Goals & Objectives



- Goal - Promote excellence in Michigan cancer care through participation in ASCO QOPI
- Objectives:
 - Participate in bi-annual data collection/ reporting
 - Conduct retrospective chart reviews at the member/practice
 - (1) Core measures, (2) Care at end-of-life module, and (3) One additional module from domain OR disease-specific modules
 - Review oncology practice reports, comparing practice results to National and Michigan aggregates in bi-annual data reports

Beginning in Fall 2008..

- Use QOPI performance data to identify practice unit and physician-specific opportunities for improvement
- Set performance improvement goals
- Share best practices



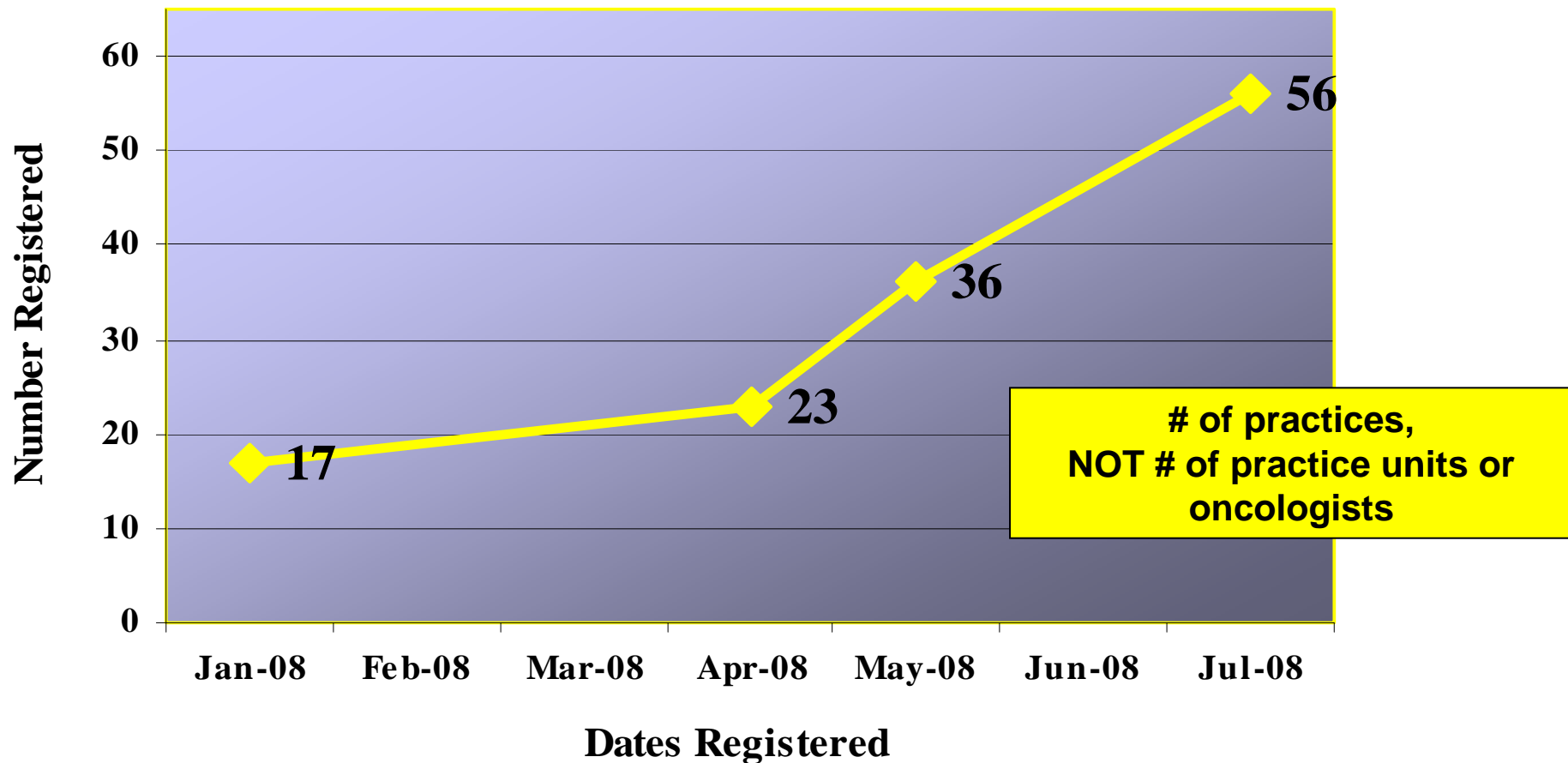
- Successes

- Michigan participation of oncology practice units has expanded tremendously
- Spring data collection results released to Michigan POs from ASCO
 - Michigan Aggregate (NEW)
 - National Aggregate
- BCBSM/ASCO partnership has received significant media attention

QOPI - Significant Registration Growth



Number of Michigan Practices Registered with QOPI



PGIP QOPI Initiative Makes News



- “Blues, cancer group unite to improve care, cut costs” (Detroit News – August 8, 2008)
- ASCO writing up BCBSM/ASCO partnership for their national peer reviewed journal - *Journal of Oncology Practice*. Article entitled “Blue Cross Blue Shield of Michigan - First Health Plan to Provide Reimbursement for Participation in QOPI” (Target publication date: November, 2008)



New Initiatives for 2009

Inpatient Utilization



Intent of the IP and ED Initiatives



- Reduce costs via reduction of inappropriate ED and IP utilization
- Improve quality for BCBSM members
- Provide an ongoing basis for assessing and rewarding the results of POs' PCMH efforts

Prevention Quality Indicators (PQIs)



- Agency for Healthcare Research and Quality (AHRQ) developed the Prevention Quality Indicators (PQIs) and released them in November 2001
- PQIs:
 - Can be used w/ hospital IP discharge data to ID quality of care for ambulatory care-sensitive conditions (ACSCs)
 - Assess quality of healthcare system as a whole; especially quality of amb. care, in preventing complications
 - Serve as a screening tool rather than as definitive measures of quality problems
- ACSCs are conditions for which effective outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease

Ambulatory Care Sensitive Conditions (ACSCs)



AHRQ's PQIs consist of 14 ACSCs, which are measured as rates of admission to hospital:

- Adult Asthma
- Angina w/o Procedure
- Bacterial Pneumonia
- COPD
- CHF
- Dehydration
- Diabetes (Short Term Comps)
- Diabetes (Uncontrolled)
- Diabetes (Long Term Comps)
- Hypertension
- Perforated Appendix*
- Rate of Lower-Extremity Amputation among people with Diabetes
- Urinary Tract Infection

* Denominator is based on adults (18-64 years) with a diagnosis code for appendicitis in any field (primary, secondary or tertiary diagnosis)

Percent of Total Admits for Adults (18-64) Attributed to a PGIP or Control Physician, 2005-2007



	% Total Admissions	Total Admissions (n)	Percent Admitted from ER (%)
PGIP-Attributed	53%	227,043	40%
Control-Attributed	28%	126,862	40%
Total PGIP & Control	81%	353,905	40%
<i>All Other Adult Members (Not Attributable)</i>	19%	68,425	36%

Percent of Total Inpatient Admits by ACSC

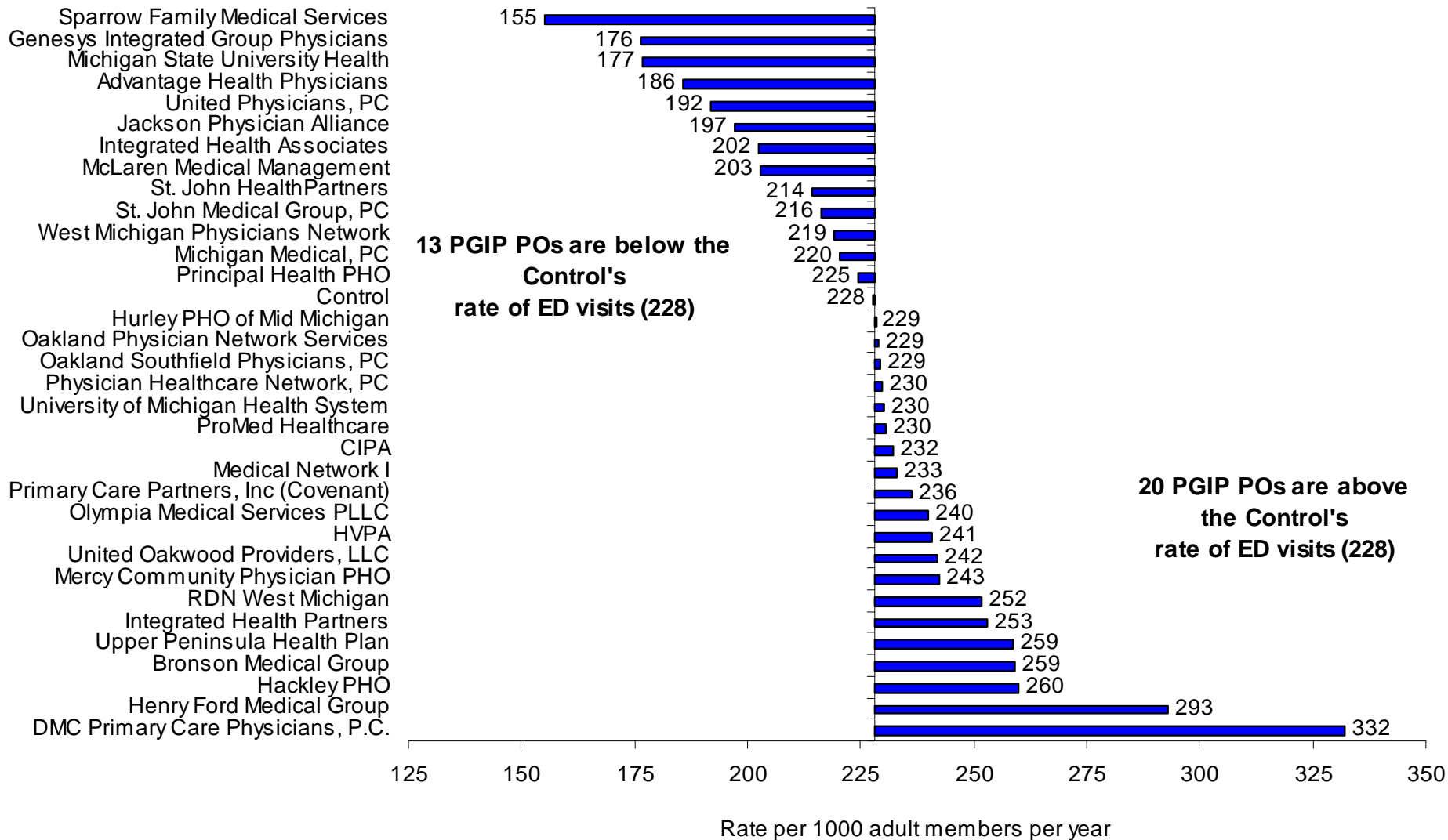


	2005	2006	2007
Lower-Extremity Amputations	2.9%	2.8%	2.7%
Bacterial Pneumonia	1.7	1.6	1.5
CHF	1.2	1.1	1.1
Adult Asthma	1.0	0.9	0.8
COPD	0.7	0.6	0.6
Urinary Tract Infection	0.5	0.6	0.5
Diabetes (STC or Uncontrolled)	0.5	0.4	0.5
Diabetes (LTC)	0.5	0.4	0.5
Dehydration	0.3	0.3	0.3
Perforated Appendix*	0.3	0.3	0.3
Angina w/o Procedure	0.3	0.2	0.2
Hypertension	0.2	0.2	0.3
TOTAL ACSC	10.2%	9.6%	9.5%

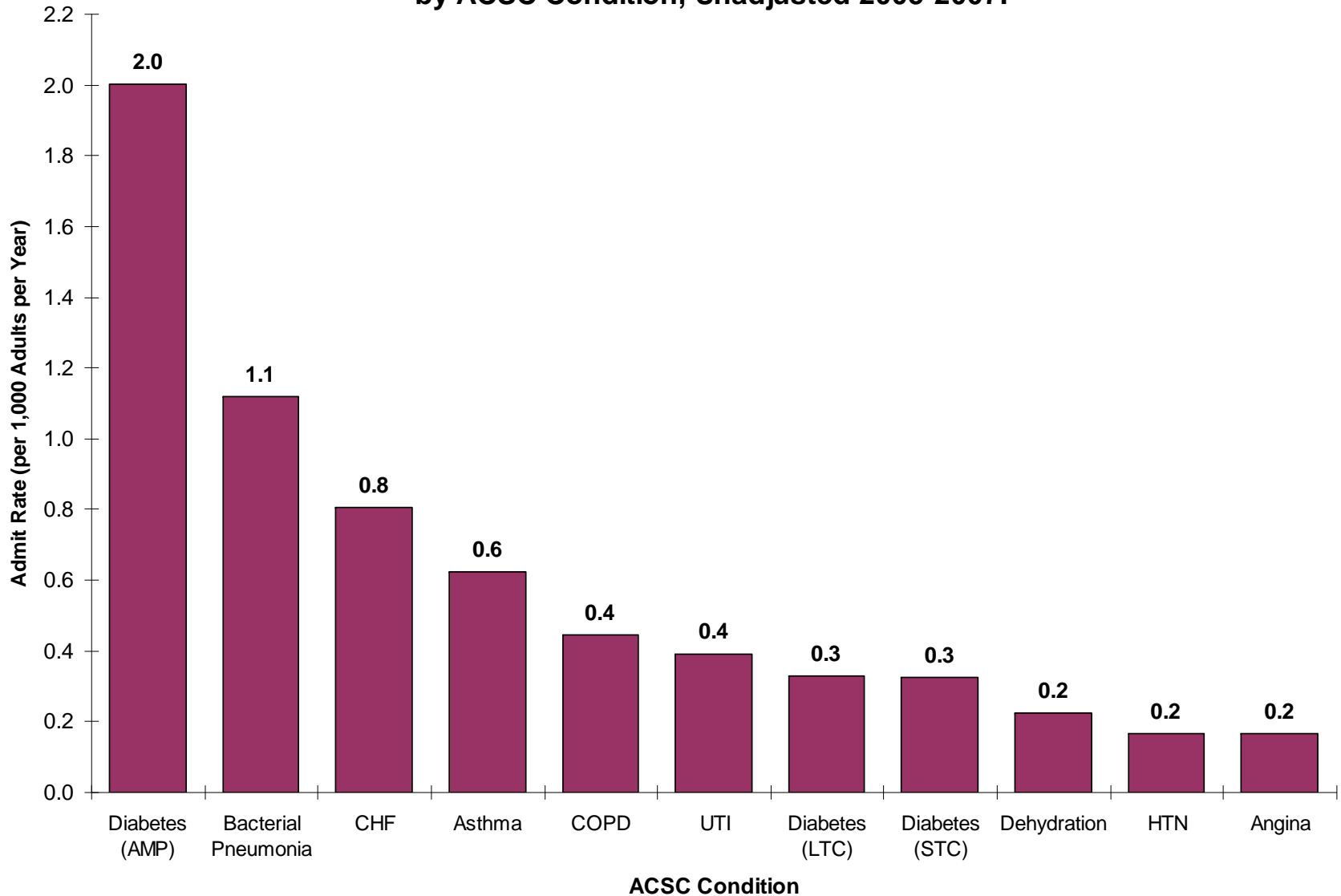
Note: Total may not add to the cumulative total of the individual conditions due to not being mutually exclusive.

* Denominator is based on adults (18-64 years) with a diagnosis code for appendicitis in any field (primary, secondary or tertiary diagnosis)

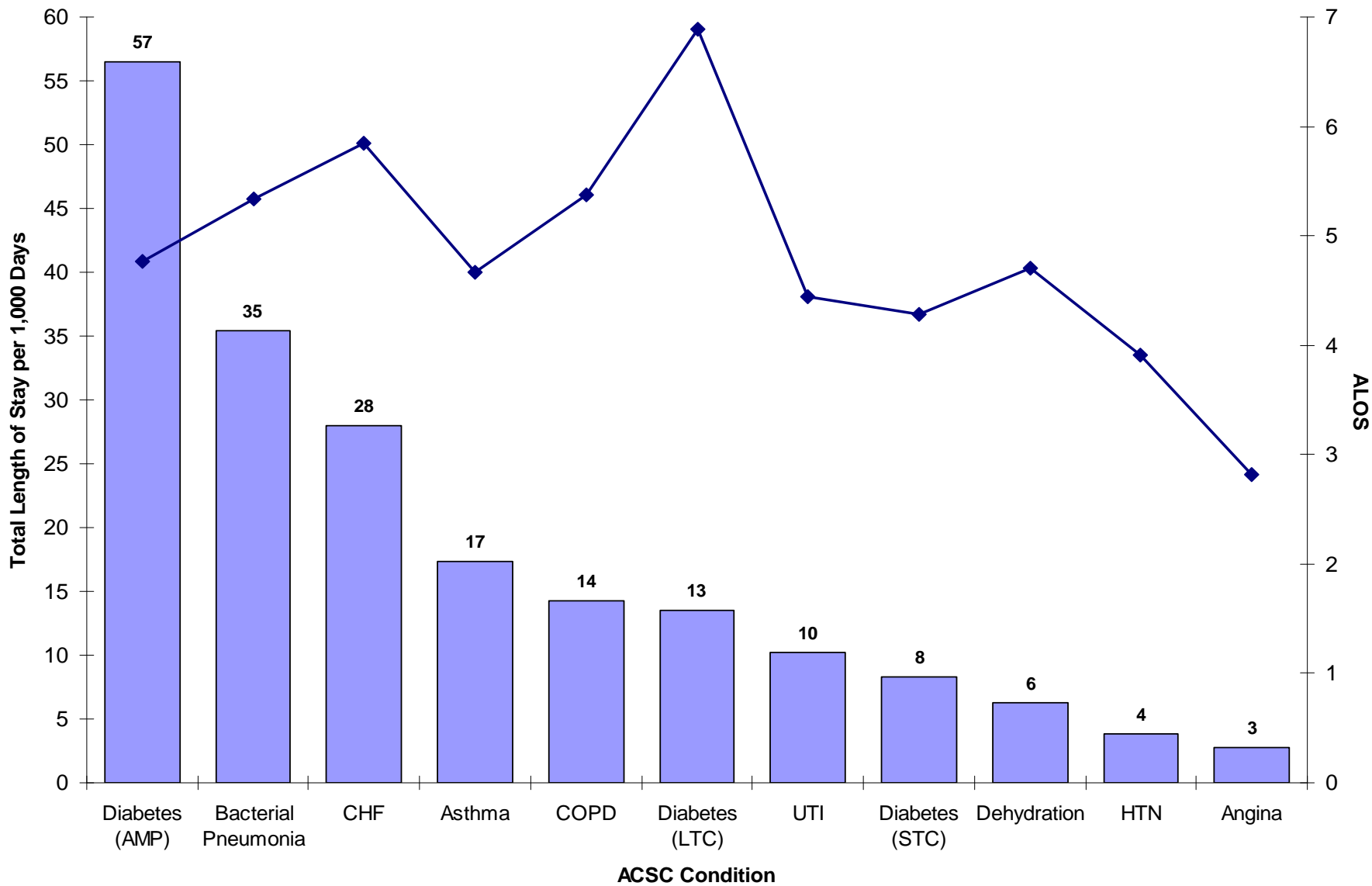
2007 overall rate of ED visits without hospitalization among PGIP attributed adult members, as compared to Control adult members



**Total ACSC-Related Inpatient Admit Rate (per 1,000 Adults per Year)
by ACSC Condition, Unadjusted 2005-2007.**



Total ACSC-Related Length of Stay and Average Length of Stay (ALOS) by ACSC Condition, Unadjusted 2005-2007.



Percent of Adult ACSC Admissions from ER by Sex, 2005-2007

Primary Diagnosis	% (Female)*	% (Male)*
Pneumonia	19.6	19.7
Asthma	15.2	5.8
UTI	9.4	3.9
Diabetes w/ Complications	9.3	12.6
CHF (Non-HTN)	9.3	15.4
COPD	8.4	7.5
Appendicitis	3.9	4.6
Fluid Disorder (Dehydration)	3.7	3.1
Coronary Atherosclerosis	3.6	5.3
HTN w/ Complications	2.3	3.7
Chest Pain	1.1	1.2
Skin Infection	0.7	1.2

* Consists of 86-88% of Total ACSC Admissions

Drilling Down



- 3 of the 14 ACSCs account for approximately 55+% of ACSC inpatient admissions
 - Lower-Extremity Amputations
 - Bacterial Pneumonia
 - CHF
- 6,879 ACSC annual admissions for PGIP POs or approximately 132 admissions per week!

Further Drilling Down



- This translates into a significant number of hospital admissions per week for PGIP-attributed members, including:
 - 38 admissions for lower extremity amputations
 - 21 admissions for bacterial pneumonia
 - 15 admissions for CHF
 - 11 admissions for adult asthma
 - 8 admissions for COPD
 - 7 admissions each for Diabetes (LTC), Diabetes (STC), and UTIs
 - 4 admissions each for Dehydration, Perforated Appendix, and Hypertension
 - 3 Anginas w/o Procedures

Goal for PGIP POs ACSC Patients



- Access to timely and effective primary care with an emphasis on disease state management can prevent disease progression, complications, and avoid hospitalizations, ER visits, and even death for ACSC patients

What Can Be Done to Address ACSCs?



- Review your PO's data – look for opportunities for improvement
- Schedule workgroup meetings to address ACSCs and develop improvement plans
- Increase access to coordinated and continuous evidence-based health care services. Coordination of care by a provider with PCMH capabilities is important to reduce morbidity and mortality of patients with chronic conditions
- Promote Early Screening and Prevention
- Educate Patients and Parents of Children about how to Control a Chronic Condition
- Work your Disease Registries

New Initiatives for 2009

Emergency Department Utilization



ED visits and waiting time increasing nationally



- Between 1994 and 2004, total U.S. ED visits increased an estimated 18-26%, while the number of EDs decreased 9-12%
- Waiting times have increased
 - Waits increased 36% for all patients (from 22 minutes to 30 minutes, on average).
 - waits increased by 40% (from 10 to 14 minutes) for those classified as needing immediate attention
 - 150% increase in waiting time for ED patients suffering heart attacks
 - Waited 8 minutes in 1997; 20 minutes in 2004
 - 25% of heart attack victims in 2004 waited 50 minutes or more before seeing a doctor

As many as 50% of ED visits are for non-emergent problems



- Patients use the ED for non-emergent care for a variety of reasons:
 - Lack of access, or knowledge of access, to a PCP or lower intensity source of care
 - Lack of advice from physicians on how to handle sudden medical conditions
 - Patient familiarity and preference for treatment in ED settings
 - Attempt to shorten timeframe for diagnosis and avoid long waits for specialist appointments and testing
 - Inadequate management of chronic conditions by PCP (e.g., failure to provide self-management training, failure to address gaps in care)
 - Financial barriers to adequate self-management (e.g., prescription co-pays)
 - Prescription drug abuse
 - Other mental health issues

NYU ED Classification Algorithm



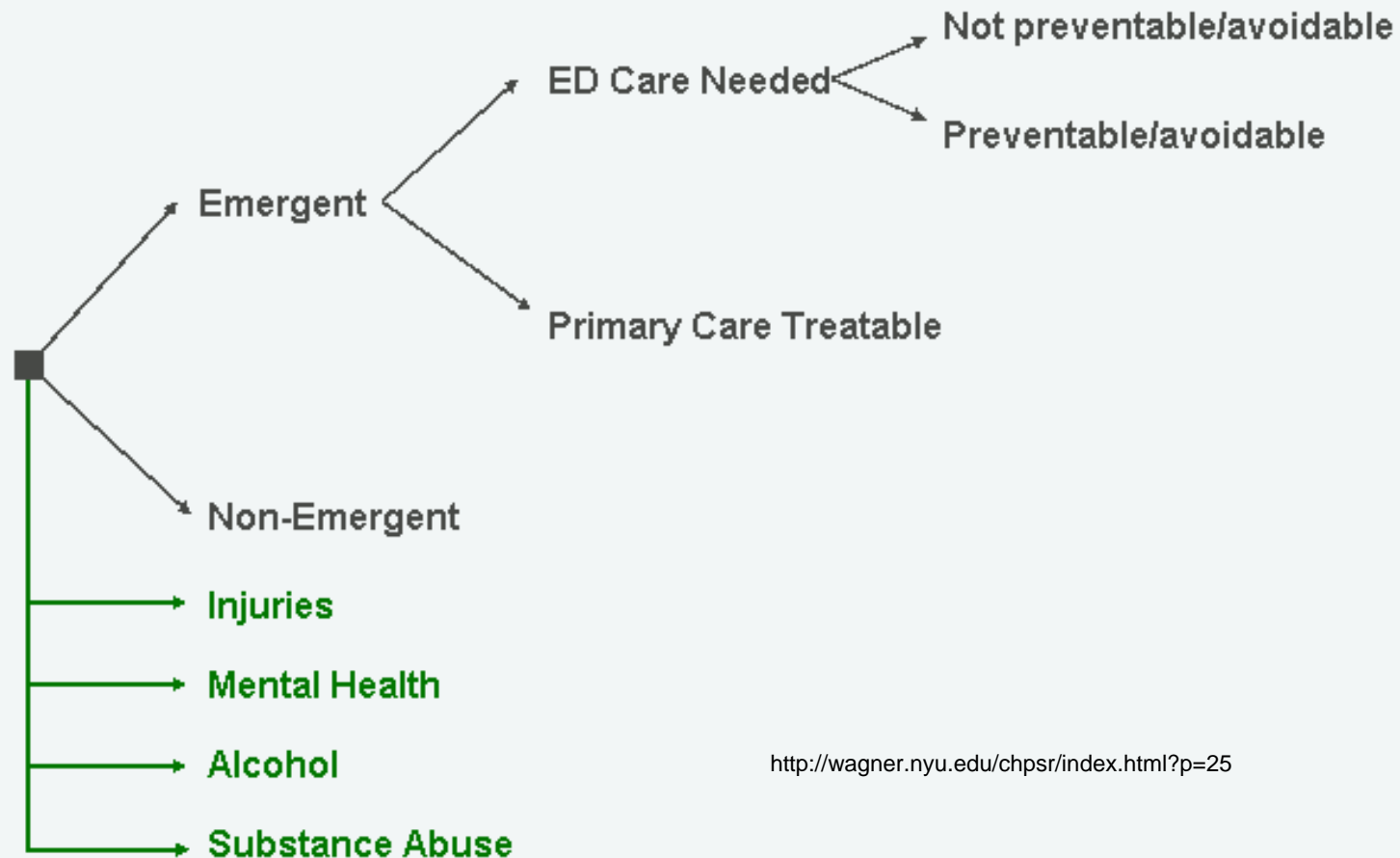
- ED classification algorithm developed by NYU Center for Health and Public Service Research, with advice from panel of emergency and primary care MDs
- Derived from research of sample of ~6000 full ED records from 6 Bronx hospitals (1994, 1999)
 - Included initial complaint, presenting symptoms, vital signs, medical history, age, gender, diagnoses, procedures performed, and resources used
- Classifies ED visits into 4 main emergent / non-emergent categories, and 4 additional categories of injury, mental health, alcohol and substance use
- Links the classified ED visits back to primary ICD-9 discharge diagnoses to calculate the proportion of ED visits in each category for every diagnosis

Four Main NYU ED Classification Categories



- Non-emergent - The patient's initial complaint, presenting symptoms, vital signs, medical history, and age indicated that immediate medical care was not required within 12 hours;
- Emergent/Primary Care Treatable - Based on information in the record, treatment was required within 12 hours, but care could have been provided effectively and safely in a primary care setting. The complaint did not require continuous observation, and no procedures were performed or resources used that are not available in a primary care setting (e.g., CAT scan or certain lab tests);
- Emergent - ED Care Needed - Preventable/Avoidable - Emergency department care was required based on the complaint or procedures performed/resources used, but the emergent nature of the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness (e.g., the flare-ups of asthma, diabetes, congestive heart failure, etc.); and
- Emergent - ED Care Needed - Not Preventable/Avoidable - Emergency department care was required and ambulatory care treatment could not have prevented the condition (e.g., trauma, appendicitis, myocardial infarction, etc.).

Algorithm for Classifying Emergency Department Utilization



<http://wagner.nyu.edu/chpsr/index.html?p=25>

PGIP-Attributed Members Had Over 200,000 ED Visits w/out Hospitalization

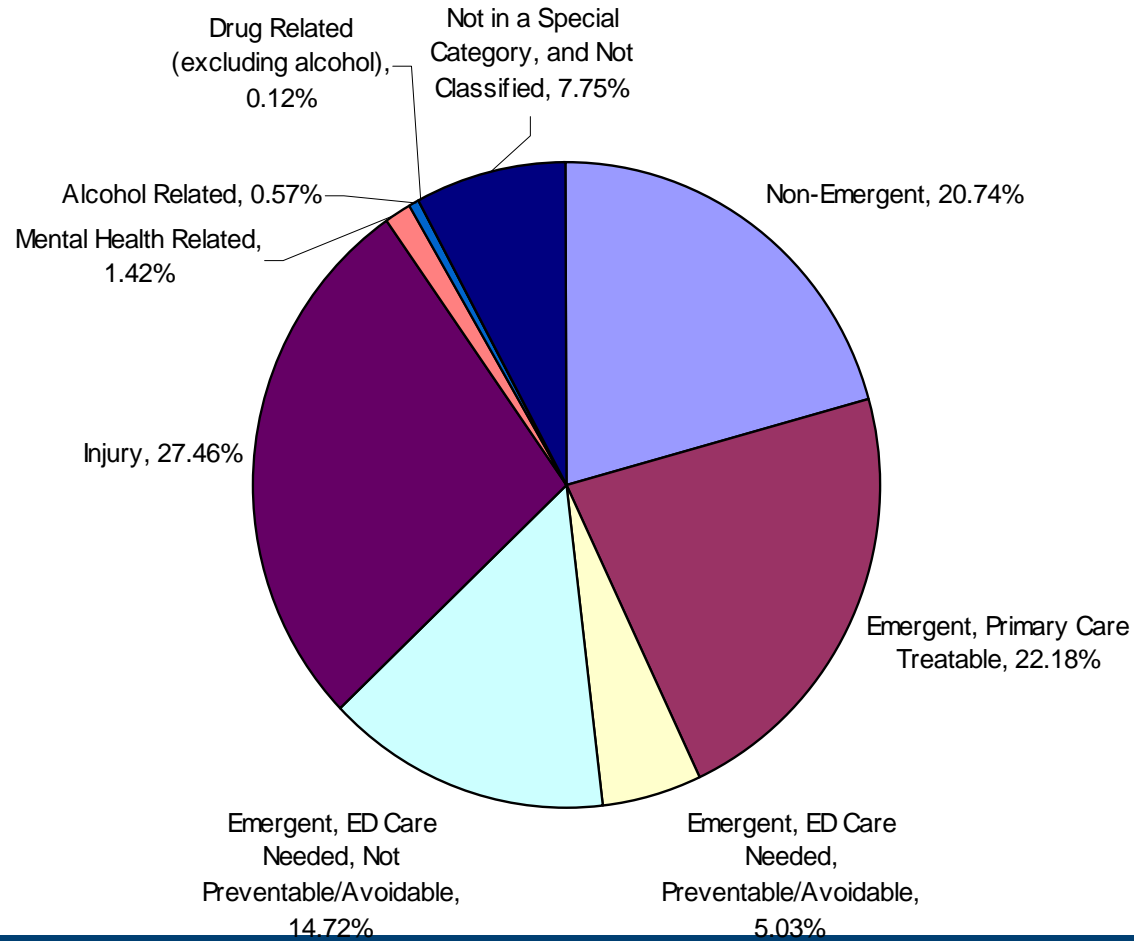


	2007	
	Total Attributed Members	Total Number ED Visits w/out Hospitalization
PGIP	917,285	206,982
Control	453,551	107,163

Over 45% of Adult PGIP ED Visits w/out Hospitalization Classified as “Avoidable”



Classification of ED Visits without hospitalization among PGIP attributed adult members aged 18-64 years, 2005-2007



PGIP ED Use Rates in All Categories Were Higher than Control in 2005, but Equal by 2007



		<u>Adjusted Rate/1000 Members</u>			<u>% Change in Adj Rate</u>
		2005	2006	2007	
Overall	PGIP	251	246	228	-8.97%
	Control	244	244	228	-6.70%
Non-Emergent	PGIP	53	52	47	-10.21%
	Control	51	52	48	-7.58%
Emergent-PCP Treatable	PGIP	56	56	51	-10.35%
	Control	54	53	49	-7.97%
Emergent-ED-Avoidable	PGIP	14	12	11	-16.48%
	Control	13	12	11	-15.72%
Emergent-ED-Not Avoidable	PGIP	37	37	34	-6.54%
	Control	34	34	33	-3.85%

What can be done to reduce ED use?



- Extended Access
- Individual Care Management and Self-Management Support
- Physician outreach & education to repeat ED users

Extended Access Can Reduce ED Visits



- Patients from practices with more than 12 evening hours per week used the ED 20 percent less often than patients from practices without evening hours.
- Patients from practices that had weekend hours also used the ED less, but the trend was not as significant.
- Patients also used the ED less often when their providers had a greater number of hours to address patients needs.

Source: "Association between primary care practice characteristics and emergency department use in a Medicaid managed care organization" Dr. Lowe, A. Russell Localio, J.D., M.S., Donald F. Schwarz, M.D., M.P.H., M.B.A., August 2005 *Medical Care* 43(8).

Self-management training can reduce ED visits



- In 32 studies of pediatric asthma patients, self-management training, in particular those using a peak-flow based educational strategy, was associated with a 21% decrease in ED use
- A Cochrane review of 36 trials found that adult patients who were educated about their asthma, visited their doctor regularly, and used a written action plan consistently had fewer visits to the emergency room
- In a 1999 Quebec randomized clinical trial, emergency department visits were reduced by 41.0% for COPD patients who received self-mgmt training

Sources: Wolf FM, Guevara JP, Grum CM, Clark NM, Cates CJ. Educational interventions for asthma in children. *Cochrane Database of Systematic Reviews* 2002, Issue 4. Art. No.: CD000326. DOI: 10.1002/14651858.CD000326.

[Gibson PG, Powell H, Coughlan J, Wilson AJ, Abramson M, Haywood P, Bauman A, Hensley MJ, Walters EH. Self-management education and regular practitioner review for adults with asthma. *Cochrane Database of Systematic Reviews* 2002, Issue 3. Art. No.: CD001117. DOI: 10.1002/14651858.CD001117.

Bourbeau J, Julien M, Maltais F, et al. Reduction of hospital utilization in patients with chronic obstructive pulmonary disease: a disease-specific self-management intervention. *Arch Intern Med* 2003;163:585-91

Physician outreach and intervention can reduce ED visits



- California ED Initiative in 2000
 - Physicians provided with lists of patients using ED
 - Physicians conducted patient outreach/education
 - Extended access implemented
 - 59% decrease in ED rates among targeted members