

2010 Initiatives PGIP Quarterly Meeting

September 11, 2009

Sandy Reoma, Healthcare Manager



Radiology Initiative

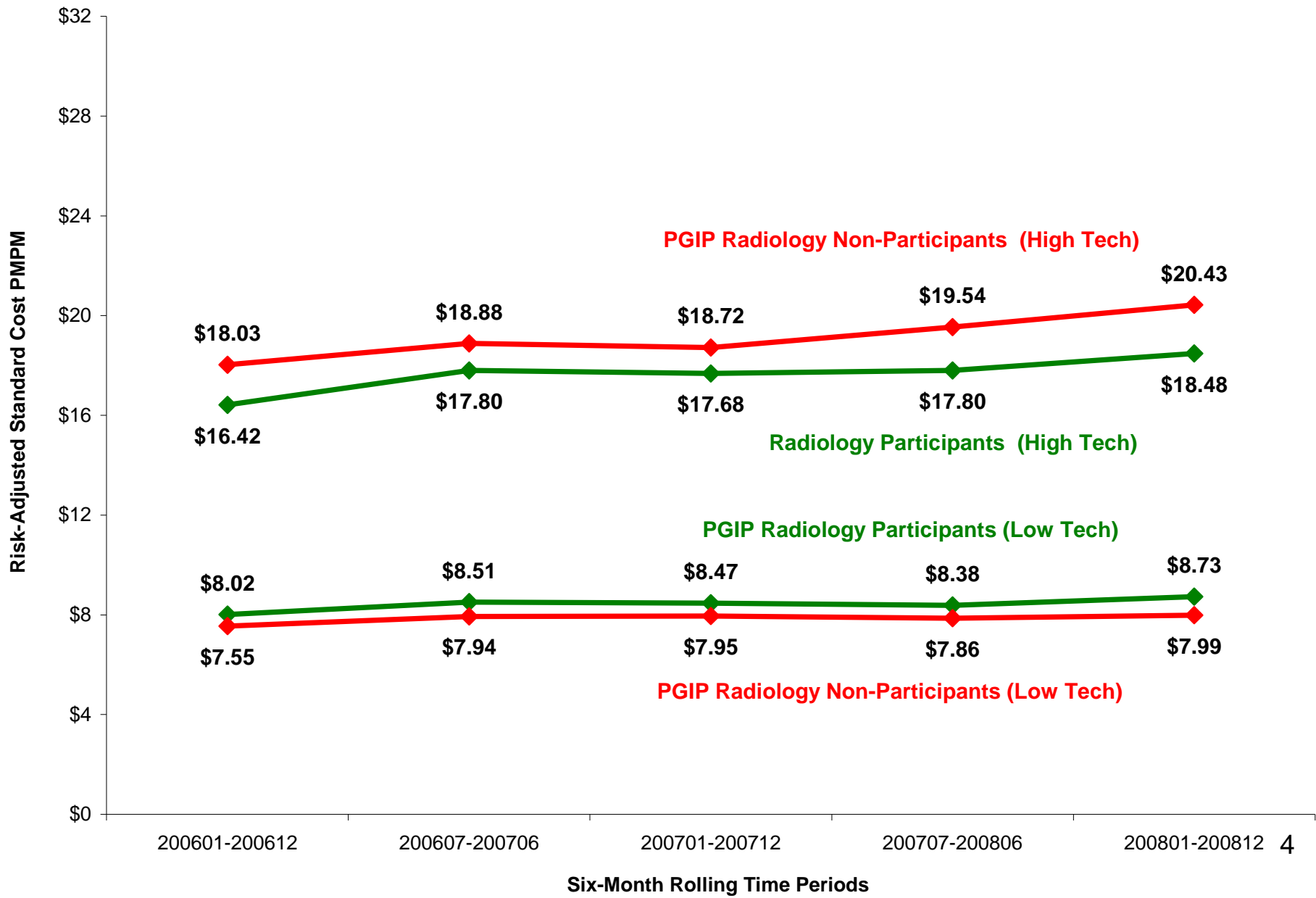
- Radiology use trends 2006-2008
- What's new with dashboard reports
- 2010 Strategy



Radiology Risk-Adjusted Standard Cost PMPM Trends for Total PGIP Physician Organizations vs. Control, 2006-2008.



Radiology Risk-Adjusted High and Low Tech Standard Cost PMPM Trends for PGIP Physician Organizations, Radiology Initiative Participants vs. Non-Participants, 2006-2008.



What's new with Radiology Dashboard Reports

- Referral information
 - *Currently available on May 2009 dashboard report (reflecting data 2008Q1 – 2008Q4)*
- Other Radiology Category Metrics
 - *Echos*
 - *Breast imaging*
 - *Other associated procedures*
- Practice level details
 - *Available with next dashboard report (reflecting data 2008Q3 – 2009Q2)*



Radiology

2010 Strategy

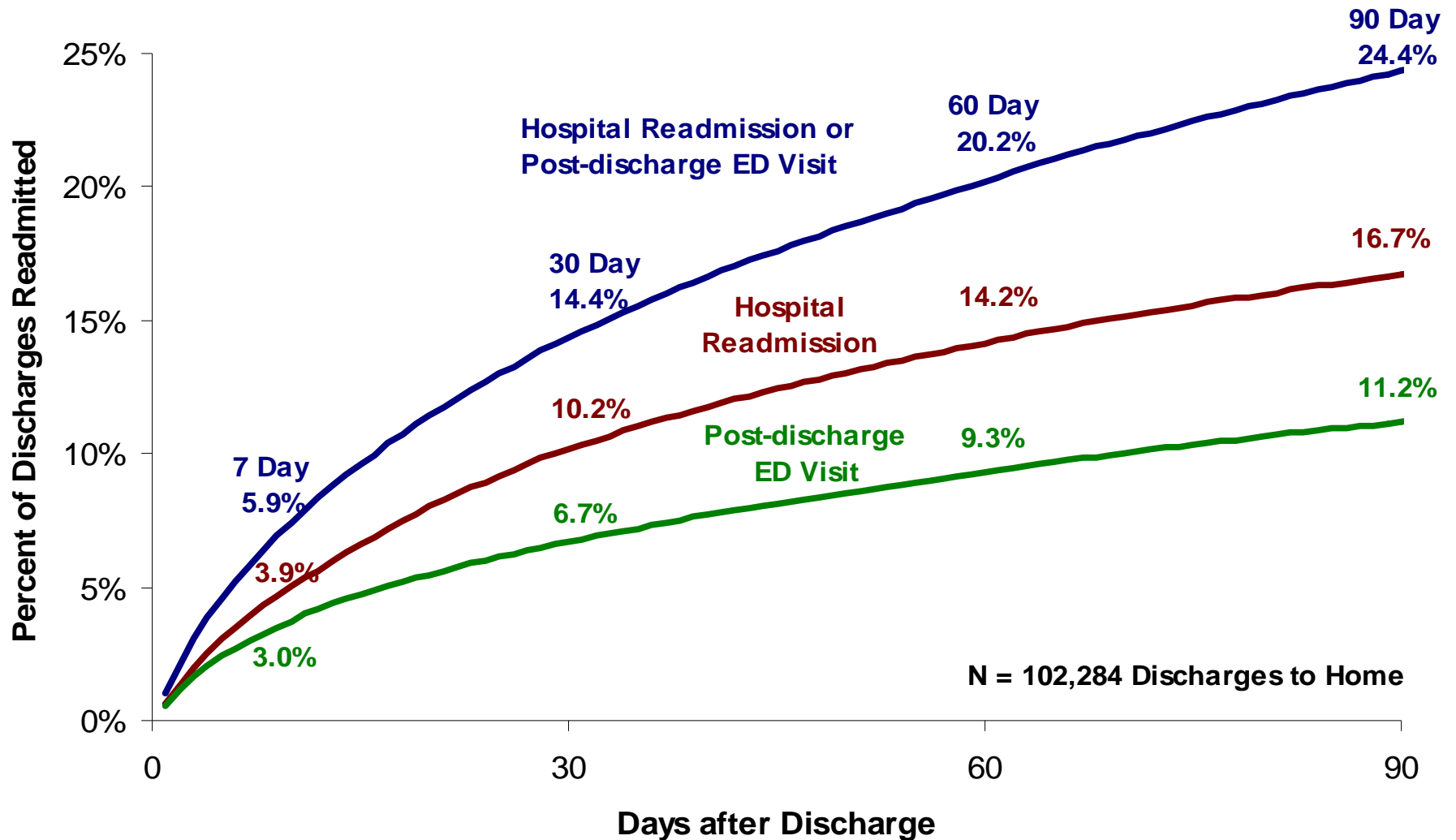
- Stay the course, with enhanced features:
 - Enhanced reports from BCBSM
 - Enhanced communication to facilitate sharing of best practices Modality specific strategy (through secured Web page)
 - Required involvement of radiologists as consultants

BCBSM Clinical Leader:	Tom Ruane, MD
Initiative Manager:	Sandy Reoma, MHSA, FACHE
Analytic Support:	Amanda Harrier, MPH
PGIP Representatives:	Steve Thiry, IHA Steve Yuill, MD, IHP



Transitions of Care

Post-discharge Event Rates following Discharge to Home, 2008



Transitions of Care

Opportunities for Improvement

<i>Type of 30 Day Readmission</i>	<i>Rate</i>	<i>Total Spend</i>	<i>\$/Readmit</i>
Total	10.2%	\$134.1 million	\$12,880
Foreseen Readmissions	1.7%	\$32.7 million	\$19,272
Readmissions for New Condition	2.1%	\$26.5 million	\$12,067
Potentially Preventable Readmissions*	6.4%	\$74.9 million	\$11,490

30 Day Readmissions following Discharge to Home, 2008

*Potentially avoidable = readmission time 30 days or less with previously known diagnosis



Transitions of Care - Goals

- Promote enhanced care coordination at transition from inpatient care to outpatient settings
- Promote collaboration among POs, with hospitals and with hospitalist groups
- Promote in-hospital patient experience and efficiency
- Generate measurable savings and reward clinicians for their improvements in care transitions



Transitions of Care - Strategy

Launch Society of Hospital Medicine's BOOST Project as a Michigan wide collaborative

- Create resources to implement best practices
 - Clinical toolkit to include discharge planning tools and risk stratification tools
 - Assessment of current care process and intervention development
- Provide technical support
 - Day long training of Transition Teams
 - Year-long coaching/mentoring program

BCBSM Clinical Leader:	David Share, MD
Initiative Manager:	Sandy Reoma, MHSA, FACHE
Analytic Support:	Michael Paustian, MS
Leadership Committee: (Chair)	Scott Flanders, MD, UMHS



Chronic Kidney Disease - Opportunity

- Growing burden of CKD
- Issues in identifying CKD patients
- Quality Improvement Opportunities
 - Collaboration between primary care physicians and nephrologists in managing concurrent conditions and complications
 - Timely consultation by nephrologists for CKD patients promotes better clinical outcomes
 - Active treatment can delay onset of ESRD



Chronic Kidney Disease - Goals

- Improve patient safety and treatment effectiveness
- Improve quality of care through better care management of CKD patients
- Reduce benefit costs

Chronic Kidney Disease - Strategy

- Reward POs to develop/implement registry of patients with CKD and patients at high risk of CKD
- Optimal management of CKD and at risk patients
- Timely referral to nephrologists

BCBSM Clinical Leader:	Tom Ruane, MD
Initiative Manager:	Sandy Reoma, MHSA, FACHE
Analytic Support:	Ann Annis-Emeott, RN, MPH
PGIP Representatives:	Keith Deans, PharmD, WMPN Lori Roark, PharmD, LHN Jon Segal, MD, UMHS Jerry Yee, MD, HFHS

