Community Care Physicians Quality of Care Initiatives 2006

- Bridges to Excellence
- Performance Improvement Projects
- EMR Implementation

Bridges to Excellence Status Report

- 17 Practices representing 84 Physicians achieved recognition
- Improved patient outcome and response
- Quality branding
- Significant monetary reward: >$470,000 and counting from the collaborative
- An additional $188,000 anticipated by year's end
- ~ $500,000 received in related incentives (Healthplans)
- Corporate Application in progress with EMR implementation

BTE Related Activities

- Diabetes Care Initiative
- Diabetes Case Management Program
- Diabetes Self Management Education Program
- ProCare
- EMR

DCI
Diabetes Care Initiative

Diabetes Performance Measurement and Improvement

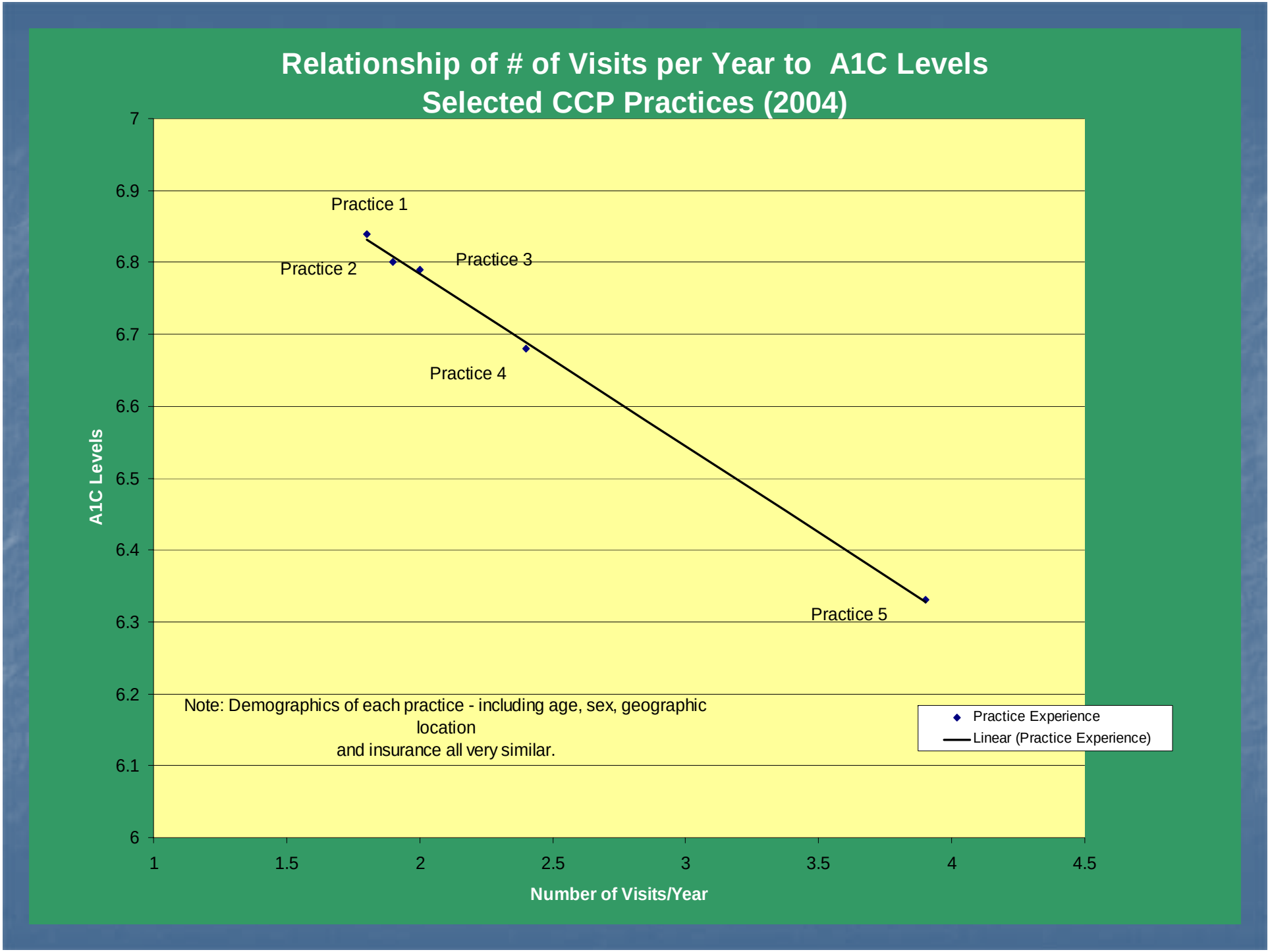
- Develop Diabetic registry
- Conduct process audit
- Provide benchmarking data
- Develop interventions and implement
- Re-measure

Phase 1 conducted at 5 Practices involving 40 Practitioners and 3000 patients
Phase 2 expanded to total of 10 Practices, 60 Practitioners 4500 patients

Areas of Opportunity and Interventions

- Tobacco screening
  - Staff education on Diabetic patient prep and Tobacco screening
- Scheduling of follow-up visits
  - Process changes in the way we schedule patients
- Comprehensive foot care
  - Diabetes Tool Kits filled with tools for the provider and the patient – to facilitate foot exams
- Annual dilated retinal exam
  - Documentation Tools: flow sheets, standing order sets etc.
- Nephropathy testing
  - Educational information on nephropathy testing
- Self Management Education

  ADA Certified Diabetes Self Management Education Program


Relationship of # of Visits per Year to A1C Levels
Selected CCP Practices (2004)
A1C Levels
7
6.9
6.8
6.7
6.6
6.5
6.4
6.3
6.2
6.1
6
Practice 1
Practice 2
Practice 3
Practice 4
Practice 5
Note: Demographics of each practice - including age, sex, geographic location
and insurance all very similar.
Practice Experience
Linear (Practice Experience)
1
1.5
2
2.5
3
3.5
4
4.5
Number of Visits/Year

Diabetes Case Management Project

CDPHP Health Plan

and

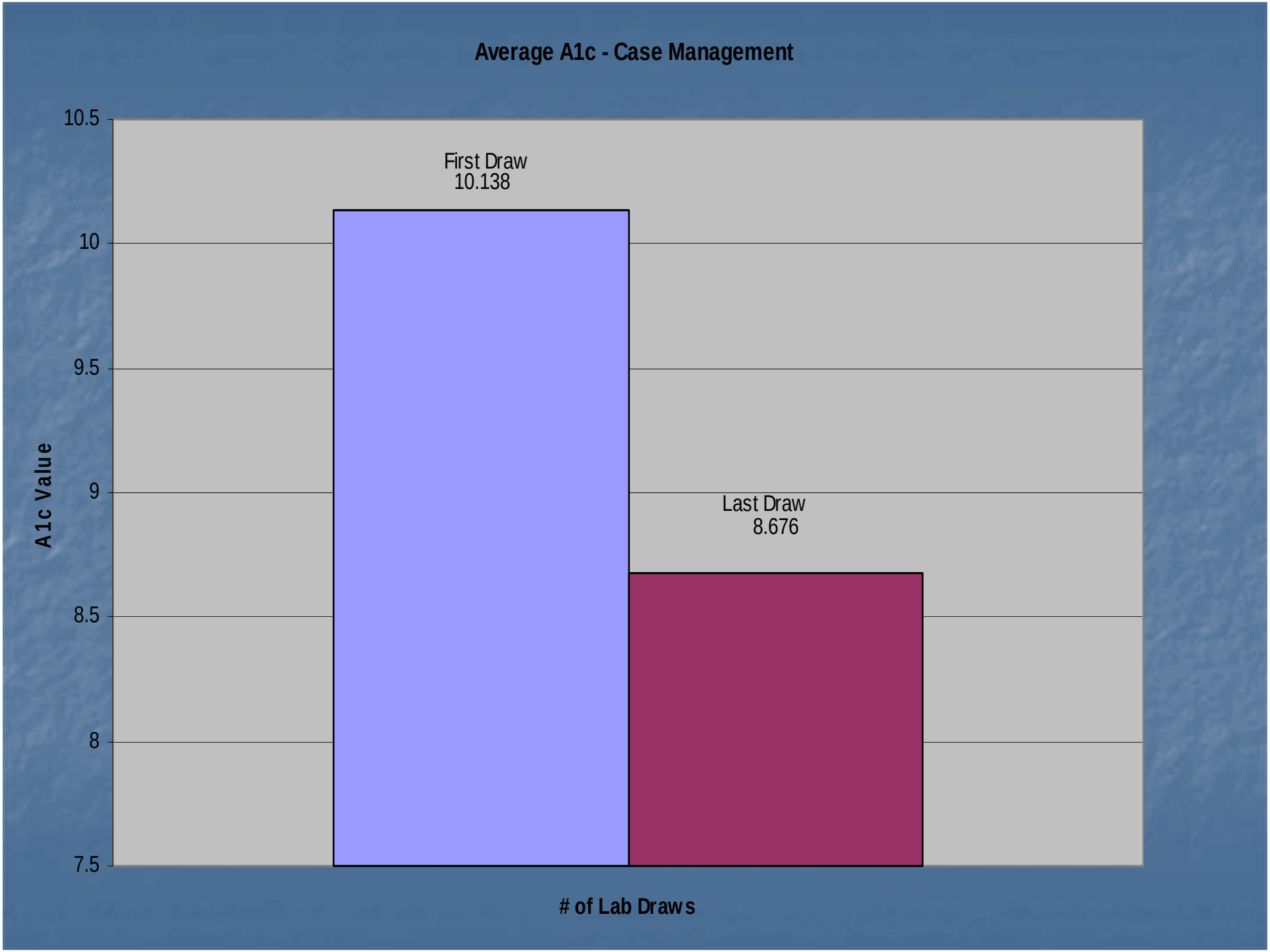
Community Care Physicians

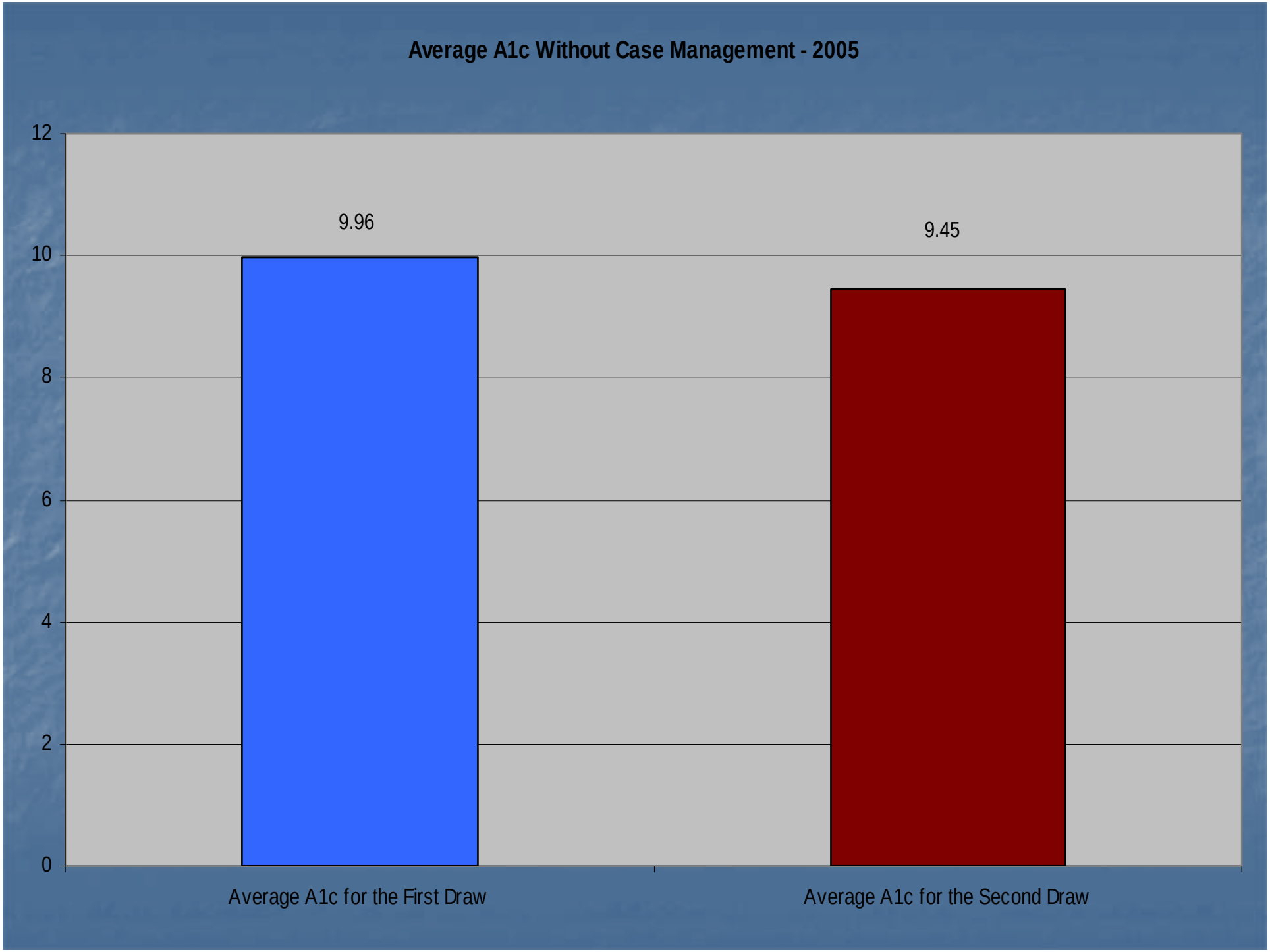
Diabetes Case Management

2004 - 2005

The Collaborative Project

- Patients were included in the project if their HbA1c was >9.0% (Case Management Trigger)
- CDPHP Case Managers worked with patients on lifestyle modifications, medication and diabetes management and provided general diabetes disease education.
- The Case Manager sent a follow-up report to the patient's physician documenting the intervention.
- The Provider incorporated the intervention into the plan of care thereby reinforcing the message.


Average A1c - Case Management
10.5
10
9.5
9
8.5
8
7.5
A1c Value
First Draw
10.138
Last Draw
8.676
# of Lab Draws


Average A1c Without Case Management - 2005
12
10
8
6
4
2
0
9.96
9.45
Average A1c for the First Draw
Average A1c for the Second Draw

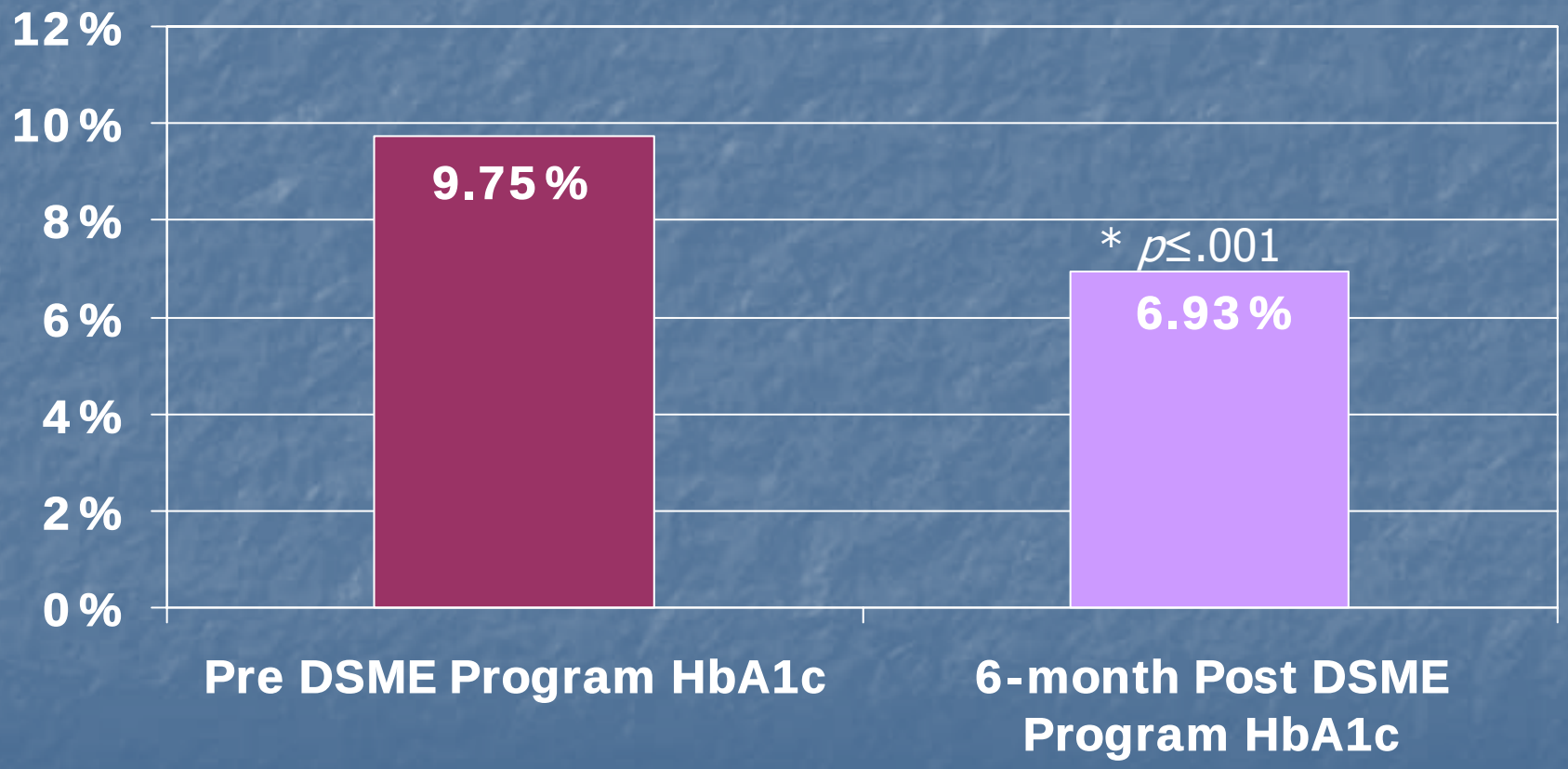
Case Management Results

Year	Average A1c Pre-Case Management	Average A1c Post-Case Management	N	Change
2004	10	8.2	98	1.8
2005	10.1	8.6	76	1.5
Combined 2004 2005	10.05	8.4	174	1.65

Diabetes Self Management Education Program

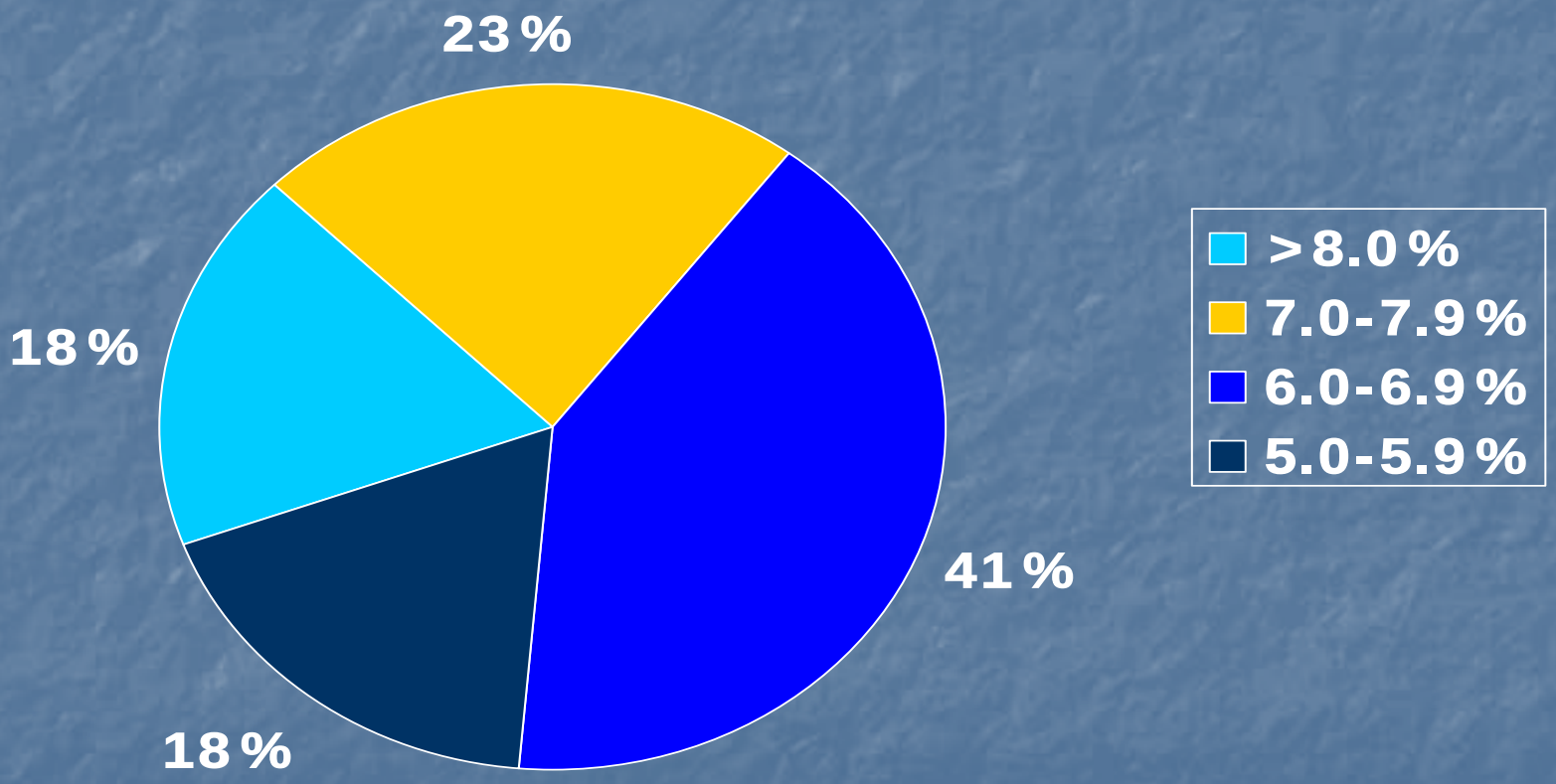
- ADA certified
- Multiple sites, times, group and individual classes - access
- Improve patient outcome by providing a previously un-reimbursable form of patient intervention.
- Promote continuum of care

DSME Outcomes



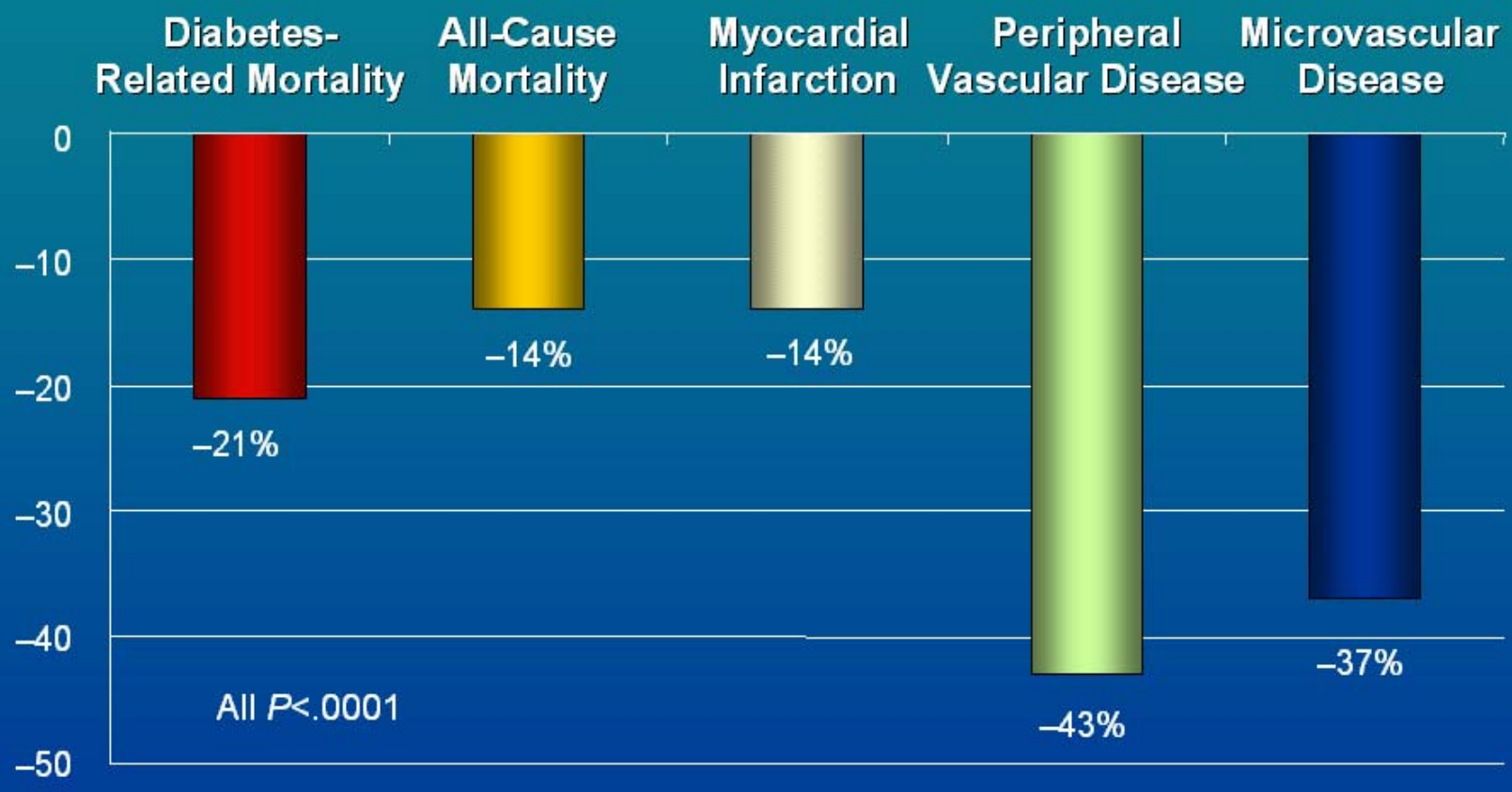
*Mean difference between HbA1c pre and post DSME Program was -2.8% (95% CI -2.09 to -3.55)

Post DMSE HbA1c Distribution



*__68.18 %__ of patients who participated in the DMSE Program achieved a HbA1c≤7.0%

Reduction in Risk of Diabetic Complications with 1% Decline in Updated A1C (UKPDS)



A1C = glycosylated hemoglobin; UKPDS = United Kingdom Prospective Diabetes Study.
Adapted from Stratton IM et al. *BMJ*. 2000;321:405-412.

Disease Management
"Pro-Care"

- Systematic method of identifying patients in need of care and contacting them for follow up
- Evidenced based management of chronic illness
- Utilizes data mining of internal and external information sources
- Improves Provider payor profiles by "cleaning" claims data

ProCare ROI - 5 Practices
Pilot Project 2nd half 2005
Using "3 Most Prevalent Conditions"

# of Pts Identified ----------	2351
# of Visits scheduled ----------	677
Success rate ----------	28%
Total charges ----------	$151,367
Expenses ----------	$4,158

EMR ROI

- COST SAVINGS
  - CHARTS – SUPPLIES, PAPER, FORMS, SUPERBILLS, FOLDERS, SCRIPT PADS
  - CHART AVAILABILITY – ALL THE TIME IN MULTIPLE PLACES
  - CHART PULLS – TIME
  - CHART PREP – TIME
  - TRANSCRIPTION – COSTS (50 – 90%)
  - SCANNED EOBs
  - DIRECT CHARGE ENTRY
  - REDUCED CALL BACKS
  - STREAMLINED ePRESCRIBING
  - DECREASE OVERTIME
- REVENUE ENHANCEMENTS
  - PAY FOR PERFORMANCE – e.g. Bridges to Excellence
  - BETTER CODING – BETTER DOCUMENTATION (5 – 15 %)
  - CLINICAL RESEARCH CAPABILITIES
  - ENHANCED INCENTIVES FROM PAYERS
- REDUCED MEDICAL ERROR
- ENHANCED SPACE UTILIZATION
- IMPROVED QUAILTY CARE
  - LEGIBILITY
  - DISEASE MANAGEMENT
  - REFERRAL TRACKING
  - HIGH RISK TRACKING
  - PREVENTIVE MANAGEMENT
  - DECISION SUPPORT TOOLS

EMR Improvement on Documentation of Care