




ACCESS Plus:

*The Innovative Model for
Medicaid Primary Care Case
Management and Disease
Management in Pennsylvania*



Required Notification to Meet CME Guidelines

The target audience for “*ACCESS Plus: The Innovative Model for Medicaid Primary Care Case Management and Disease Management in Pennsylvania*” includes:

- Physicians
- State Medicaid Directors
- State Medicaid Program Executive Management Staff
- State Legislators
- Other Healthcare Policy Experts and ACCESS Plus Stakeholders

The Planning Committee members do not have any conflicts of interest to report:

- | | | |
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Required Notification to Meet CME Guidelines

*Continuing Medical Education Credits

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the Pennsylvania Medical Society, the Pennsylvania Department of Public Welfare and the Ash Institute. The Pennsylvania Medical Society is accredited by the ACCME to provide continuing medical education for physicians.

The Pennsylvania Medical Society designates this educational activity for a maximum of 1.00 *AMA PRA Category 1 Credit(s)*™. Physicians should only claim credit commensurate with the extent of their participation in the educational activity.

Learning Objectives

- Identify the essential elements of a Primary Care Case Management Program
- Provide examples of improved clinical outcomes resulting from disease management interventions for a chronic condition
- Identify the benefits of adopting Health Information Technology (HIT)

CME Disclosure – Presenters

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Innovations in American Government Awards Program
Ash Center for Democratic Governance and Innovation
- No one in a position to control the content of this activity has any relationships to disclose.



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**for Democratic Governance
and Innovation**

**The Ash Center seeks to foster
innovations in government around the
world in order to strengthen democratic
governance, institutions, and processes.**



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and Innovation**

What We Do

- Knowledge Building
- Asia Programs
- Democratic Governance Initiatives
- Global Network
- Government Innovators Network
- Innovations in American Government



Innovations in American Government

- Established in 1985 to highlight examples of government at its best
- Recognized innovation on the state and local level
- In 1995, began accepting applications from the Federal Government
- In 2001, became permanently endowed at the Kennedy School of Government
- In 2003, became a part of the Ash Institute for Democratic Governance and Innovation.



Goals of the Program

- Increase media coverage of innovative initiatives
- Encourage other government jurisdictions to replicate innovative initiatives
- Build a broader constituency for programs
- Capture the interest of an audience of legislatures and others with influence
- Aid programs in their ability to respond to external inquiries



Results

- Over 400 initiatives have been recognized
- Over \$20 million in grants have been disbursed
- Many recognized programs have been replicated throughout the United States and the world
- The Innovations Program itself has been replicated in nine other countries



Eligibility

- All levels of government in the United States are eligible to apply
- Programs from across all policy areas are encouraged



Eligibility (continued)

- Programs must be administered under the authority of one or more governmental entities
- Programs must have been implemented 12 months prior to the date of submission
- Nonprofit, private sector, and union initiatives are eligible with significant governmental involvement and oversight



Selection Criteria

- Novelty
- Effectiveness
- Significance
- Transferability



Selection Process

Five rounds of selection

- Round One: Short preliminary application
- Round Two: Secondary application
- Round Three: Secondary review
- Round Four: Site visit
- Round Five: Presentation to National Selection Committee



Innovations Award Grants

- Designed to promote replication and dissemination activities
- Past programs have held conferences, created videos, provided technical assistance and distributed brochures
- These materials have encouraged other jurisdictions to adopt the program



Government Innovators Network

www.innovations.harvard.edu

- On-line portal devoted to government innovation
- Serves as a one-stop shop for innovators to learn and share ideas
- Each program has an information page



ACCESS Plus

- 2008 Innovations in American Government Finalist
- Program underwent rigorous evaluation process
- Among 15 programs selected from a pool of nearly 1000 applicants
- Program is an innovative model for states and agencies to adopt



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ACCESS Plus Program Overview

Managed Care in Pennsylvania

- Began managed care in 1986
- Moved to mandatory Managed Care in 1997
- Implemented Mandatory Managed Care (HealthChoices) in 25 counties
 - Impacting approximately 1 million recipients

Pennsylvania Counties without Mandatory Managed Care

- 42 Counties in Pennsylvania remained under a traditional Fee-For-Service delivery system
- HealthChoices was determined not to be an ideal care delivery model for these counties due to:
 - Low voluntary penetration
 - Low participation from providers
 - Low Managed Care Organization (MCO) interest
- A program design was needed to ensure suitability for both rural and urban counties

What is ACCESS Plus?

1. Enhanced Primary Care Case Management (EPCCM) medical home model
2. 325,000 Medicaid members, excludes dual eligibles but includes ABD, over 50,000 with chronic diseases covered by DM
3. Disease Management (DM) Program- done by vendor for CAD, CHF, Asthma, COPD, Diabetes
4. Complex Case Management- manages over 2,500 active cases
5. Vendor has guaranteed cost savings, is at risk for DM performance, and responsible for P4P implementation

ACCESS Plus Program Design Chronic Care Model

- The original program design was based on concepts from the Wagner Chronic Care Model
- Elements of model include:
 - Medical Home Concept
 - Delivery System Design
 - Self Management Support
 - Decision Support
 - Clinical Information Systems
 - Proactive Care Team

ACCESS Plus Program Design Chronic Care Model

- Modifications to the ACCESS Plus Program in 2007 consistent with the goals of Rx for PA (Prescription for Pennsylvania)
- Enhanced Primary Care Case Management (EPCCM) is a hybrid model of the Managed Care and traditional Fee-for-Service delivery systems

ACCESS Plus Program Goals

- **Improve access** to primary care and other appropriate health care services
- Provide a **medical home** for children and adults
- **Improve the quality** of health care available to Medical Assistance recipients
- Provide access to **disease management (DM)** and **care coordination**
- **Stabilize** Pennsylvania's Medical Assistance spending

Elements of the EPCCM ACCESS Plus Program

- Establishment of Medical Home
- Preventive Care for Children (EPSDT) and Adults
- Care Coordination; including Behavioral Health
- 24 Hour Nurse Triage Helpline
- Depression Screening
- Disease Management
- Medically Complex Case Management
- Maternity Care (Low and High Risk Pregnancies)
- Community Based Nurses

Cost Control Considerations

- Controlling costs remained a priority
- Began exploring cost savings opportunities
- Researched Disease Management

Program Enhancements For Enrollees

- Medical home for children and adults
- Enrollment Assistance Contractor to assist with enrollment
- Enrollee hotline
- Increased access to PCPs
- PCP directories
- Consumer empowerment/education
- Consumer input through Regional Advisory Committees
- Assessment of healthcare quality
- Assessment of consumer satisfaction
- Disease Management
- 24 hour nurse call line
- Complex Care Management
- Care Coordination- dental & specialty referral, transportation

Program Enhancements For Providers

- Access to community-based nurses
- Coordinated Disease and Case Management services
- Community-based nurses and provider service representatives
- Resources for coordination with BH and dental providers
- Access to consumer education and action plan materials
- Provider education and guideline based charting tools
- Access to consumer education and action plan materials
- Provider education and guideline based charting tools
- Care gap identification
- Provider Call Center
- Input through participation in Regional Advisory Committee
- Provider incentive opportunities
- Fees increased for primary care services (EPSDT, E&M codes)

Regional Advisory Committee (RAC)

- The ACCESS Plus program hosts a series of quarterly meetings to gather input from enrollees, providers and other stakeholders
- RACs are held in NE (Wilkes Barre), NC (State College), NW – (Erie) and SC (Johnstown)
- Issues and concerns are logged and solutions reported back at subsequent RAC meetings
- RACs include educational presentations of value to enrollees and providers



ACCESS Plus Disease Management

ACCESS Plus

Disease Management

- **5 Chronic Conditions**
 - Asthma
 - Coronary Artery Disease
 - Chronic Obstructive Pulmonary Disease
 - Diabetes
 - Heart Failure
- **Predictive Modeling**
- **Risk Stratification**
 - Level 1 (Low Risk)
 - Level 2 (Moderate Risk)
 - Level 3 (High Risk)

Disease Management State Regional Approach

North West (NW)	Implement Diabetes Collaborative Project based on the Institute of Healthcare Improvement (IHI) model
South Central (SC)	Promote group visits and support groups for patients with chronic conditions
North Central (NC)	Improve decision support mechanisms through the spread of best practices
North East (NE)	Implement hospital based nurses who focus on enrollees with high Emergency Room utilization and on enrollees admitted with chronic diseases

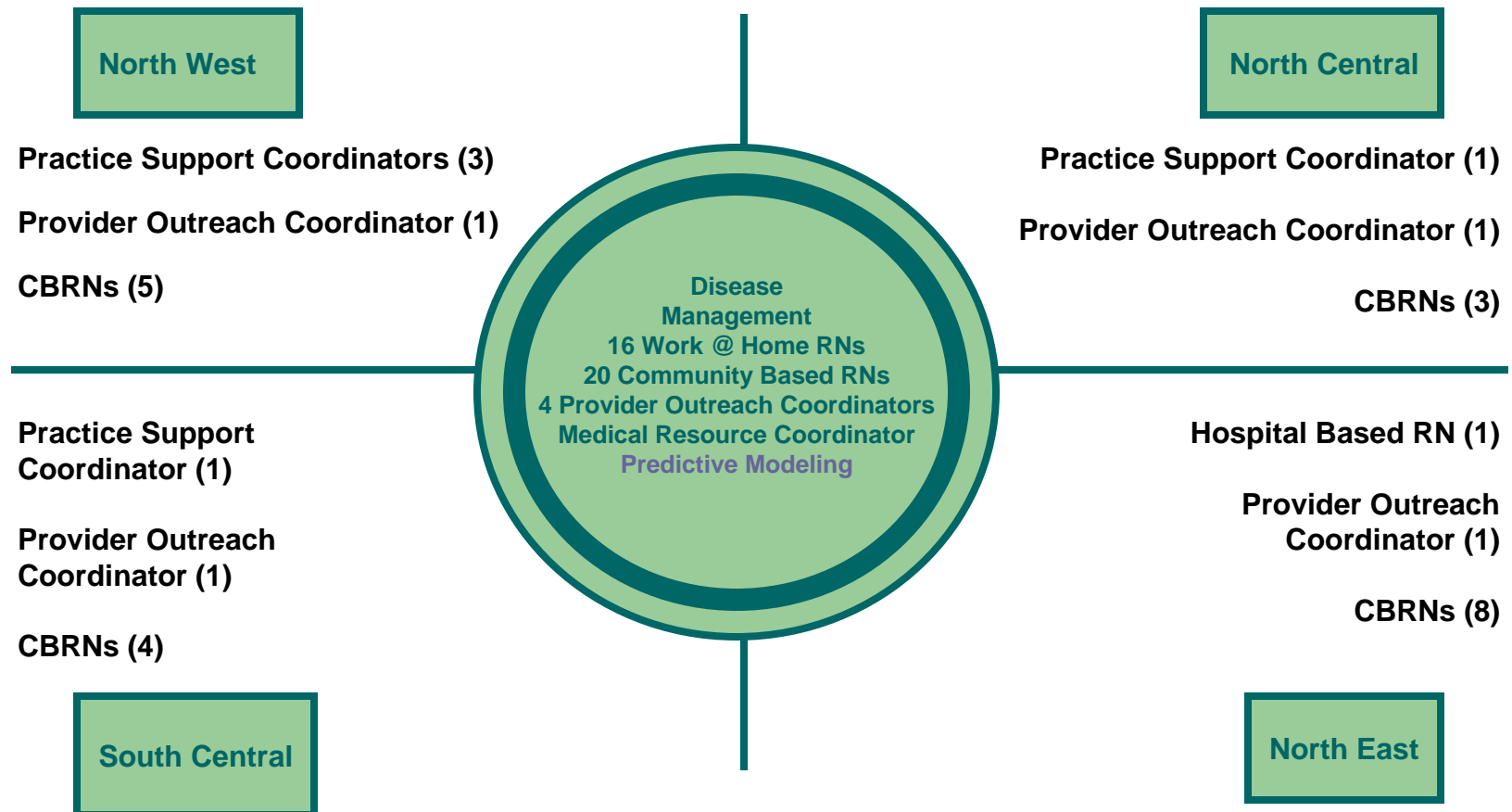
Disease Management Resources

- **CBRN - Community Based Registered Nurse (21)**
 - Visits enrollees, completes assessment, provides self-management education and resources
 - Visits providers to establish working relationship – POCs to introduce CBRNs to providers
- **POC - Provider Outreach Coordinator (4)**
 - Enrolls and assists providers with P4P Program
 - Facilitates provider/CBRN relationships
 - Helps with audits for performance measures based on HEDIS
- **Telephonic Nurses (16)**
 - Telephonic outreach to complete assessments and conduct educational sessions

Disease Management Resources (Cont.)

- **PSC – Practice Support Coordinator/ Practice Coach (5)**
 - Roles vary by region – PSC is either aligned with specific practice or works with all practices in the region
 - Promote process improvements in provider offices
 - Focus on P4P measures
 - Coordinates handoffs to CBRNs
 - Attends patient appointments as necessary
- **HBRN – Hospital-Based Registered Nurse (1)**
 - Aligned with Geisinger Hospitals
 - Interfaces with DM patients seen in the ER to promote medical home and manage patient conditions
 - Works with discharge planners to ensure appropriate utilization and discharge planning with follow-up
 - Works with hospital case managers for appropriate referrals to Complex Care Management Unit

DM Staff Distribution





ACCESS Plus

Intense Medical Case Management

Overview

Intense Medical Case Management

- **Intense Medical Case Management services are available to enrollees who may need additional support**
 - Individuals with complex health needs; including co-morbidities
 - Individuals experiencing a catastrophic event
 - Individuals with chronic conditions other than any of the 5 disease managed diagnoses who are in need of one-on-one support by a Registered Nurse
 - Women identified as having a high risk pregnancy

Overview (Cont.)

Intense Medical Case Management

- 40 FTEs
- Managed by DPW
- Focus on complex special need children and adults
- Transplant, cancer, pain management, high risk Ob
- Referrals from providers, DM vendor, inpatient nurse reviewers, predictive modeling

Objectives

Intense Medical Case Management

- Assurance of the provision of continuity of care and follow up
- Provision of comprehensive assessment of medical, social and psychosocial needs
- Development of care plans addressing clinical care/services, social and psychosocial needs
- Provision of assistance in coordinating multidisciplinary health care services and referral activities, to minimize duplication of services

Objectives (Cont.)

Intense Medical Case Management

- Provision of ongoing follow-up activities to ensure delivery of needed health care and social services
- Provision of periodic reassessment and evaluation of recipient needs and case management activities
- Collaboration with physicians, specialists and other medical professionals to meet the recipient's needs



ACCESS Plus Pay For Performance (P4P)

ACCESS Plus Pay For Performance (P4P)

- Original P4P Program was implemented in November 2005 and focused more on “Pay for Participation”
- Focus was on clinical outcome measures related to the 5 Disease Management Programs:
 - Asthma
 - Coronary Artery Disease
 - Chronic Obstructive Pulmonary Disease
 - Diabetes
 - Heart Failure

ACCESS Plus P4P Expansion Design

- Built upon the foundation of the original program design
- Focus of the P4P Program was redirected from “Pay-for-Participation” to:
 - **Clinical** incentives for multiple conditions
 - **Administrative** incentives
- **Criteria used for the creation of the new clinical incentives include:**
 - Known deficits in compliance with standards/quality of care (HEDIS)
 - Known barriers to improving care
 - Relative ease of obtaining required data
- **Implemented November 2007**

PCP Incentives – Phases 1 and 2

- **Phase 1: Payment for participation (allowed for early rewards)**
 - Sign-up for P4P program – \$200
 - Encouraging consumer participation – \$30 per patient
 - Identification of candidates for DM – \$40 per patient
- **Phase 2: Payment for collaboration**
 - Care plan development – \$60 per care plan
 - Payment for 2 care plans per year

PCP Incentives – Phase 3

Phase 3: Quality of care process improvement

- **Year 1:**
 - CHF – Beta Blockers
 - DM & CAD – ASA
 - Asthma – “controller” medication
- **Year 2 :**
 - CHF – Beta Blockers
 - DM – LDL measured
 - CAD – statin use
 - Asthma – “controller” medication

Payment of \$17 per process accomplished for each patient

Positive Impact Clinical Outcome Measures (P4P)

- **Physician participation in P4P programs has been shown to increase:**
 - The average monthly rate of occurrence for a **blood test for cholesterol** within the **Diabetes** population
 - The average monthly rate of occurrence for a **prescription for controller medication** within the **Asthma** population
 - The average monthly rate of occurrence for a prescription for **cholesterol lowering medication** within the **CAD** population
 - The average monthly rate of occurrence for a **prescription for beta-blocker** within the **HF** population

Pay for Performance Diabetes Measures

Item	Payment	Frequency (per year)	NCQA Bonus	Total
Eye Exam	\$15	1	\$2	\$ 17
HbA1c test	\$15	2	\$2	\$ 32
HbA1c <7	\$30	2	\$10	\$ 70
LDL test	\$15	1	\$2	\$ 17
LDL <100	\$30	1	\$10	\$ 40

Pay for Performance Diabetes Measures


Item	Payment	Frequency (per year)	NCQA Bonus	Total
BP Control	\$25	2	\$10	\$ 60
ACE/ARB	\$10	4	0	\$ 40
Aspirin	\$10	2	0	\$ 20
CCAT	\$40	2	0	\$ 80
Total				\$ 376

ACCESS Plus P4P Experience

- Over 1,600 providers participating
- Dental practices participating- 118
- Approx. \$3.2M in incentives to enrolled Providers (Program to date).
 - These dollars are over and above standard fees paid for services as determined by OMAP
- Participating offices care for >15,000 DM patients
 - >7,000 (50%) of the high risk patients

P4P Analysis

- Findings suggest that for patients who receive care from PCPs engaged in P4P:
 - Costs are lower
 - Utilization rates are lower
- \$823 annual savings per member.
- Reduction of 38 admissions per 1000 members.
- Analysis less clear on impact on ED visits during first year.



ACCESS Plus Program Evaluation Quality Improvement

Quality Program (QI)

- Accountable for setting goals and objectives for the ACCESS Plus program
- Reviews and approves clinical guidelines, reports and quality initiatives
- Makes recommendations to the Secretary of Welfare for any activities or interventions which would further the goals of the Quality Improvement Program

QI Program Description

- **The QI Program includes mechanisms for assessment, analysis and reporting of the quality of care provided through:**
 - Primary care
 - Preventive care
 - Acute and/or chronic conditions
 - Continuity of Care
 - Disease Management
- **The QI Program includes methodologies for assessment of the timely, accurate, complete collection and/or analysis of Enrollee and Provider Satisfaction Surveys**

QI Program Work Plan

- **Quality Improvement Activities (QIA)**

- Well Child Visits (3rd, 4th, 5th, 6th, years of life)
- Adolescent Well Child Visits
- Frequency of Ongoing Prenatal Care
- Cervical Cancer Screening
- ER Visit Rate

- **Surveys**

- Provider Satisfaction
- CAHPS (Adult and Child)
- Disease Management

- **Disease Management Clinical Outcomes**

- Blood Pressure control
- LDL-C control
- Hemoglobin A1c control
- Asthma Action Plans

- **Regional Projects**

- Diabetes Collaborative
- Spread of Best Practices
- Hospital Based Nursing

QI Program Evaluation

- **The annual QI Program Evaluation includes:**
 - Studies and activities undertaken
 - Rationales and methodologies for studies and activities
 - Outcomes / Results of studies and activities
 - Subsequent improvement actions
 - Analysis of claims data, enrollee demographic information, enrollee and provider surveys and other data as appropriate
 - Systematic analysis and re-measurement of barriers to care and the quality of care provided to enrollees

Clinical Quality Improvement Results

- **Asthma- controller medication use increased from 79.5% to 91.2%**
- **Diabetes**
 - HgA1C performed: 78.1% to 84.6%
 - HgA1C poor control: 43.3% to 34.1%
 - LDL<100: 25.3% to 37.5%
- **CAD**
 - Beta-blocker post MI: 78.7% to 94.2%
 - LDL performed: 64.2% to 82.5%
 - LDL<100: 18.7% to 45.9%
- **Controlling hypertension: 59.1% to 76.0%**
- **Dental ages 2-21: 41.2% to 48.9%**

DM Program Results

- **50% of DM recipients in the highest severity of illness (level 3) improved to a level 1 or 2**
- **Cost savings of DM program:**
 - \$27 million in Year 1
 - \$35 million in Year 2
- **Regression analysis – lower PMPM costs for individuals managed by P4P participating physicians**

Financial Performance Measures

- 5 Financial performance measures
- Based on HEDIS specifications
- Goals based on percentile of previous years Quality Compass data
- + / - 1% of PCCM premium available per measure



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Lessons Learned and Next Steps

ACCESS Plus Lessons Learned

- Help consumers find a medical home
- Help PCPs build a better medical home
- Consumer and provider involvement is essential
- Focus on measuring quality and satisfaction
- Contract risk requirements focused on quality
- Care management focused on the entire person, not specific diseases
- Move off the telephone and into the community

ACCESS Plus Lessons Learned (Cont.)

- Ensure the Vendor provides integrated PCCM and DM services when possible
- Begin P4P initiatives by including a pay for participation component to encourage provider buy-in
- Explicitly state all program requirements in Vendor contracts
- Use collected data to proactively manage the program

ACCESS Plus DM Program Expansion

(Total of 21 DM Chronic Conditions – Effective July 2010)

- **Cardiovascular Disease**

- Coronary Artery Disease
- Heart Failure
- Hyperlipidemia
- Hypertension
- Peripheral Vascular Disease
- Stroke
- Transient Ischemic Attack

- **Respiratory Disease**

- Asthma
- Chronic Obstructive Pulmonary Disease
- Cystic Fibrosis

- **Gastrointestinal Disease**

- Gastroesophageal Reflux Disease
- Hepatitis
- Inflammatory Bowel Disease
- Peptic Ulcer Disease

- **Diabetes**

- **Rheumatologic Disorders**

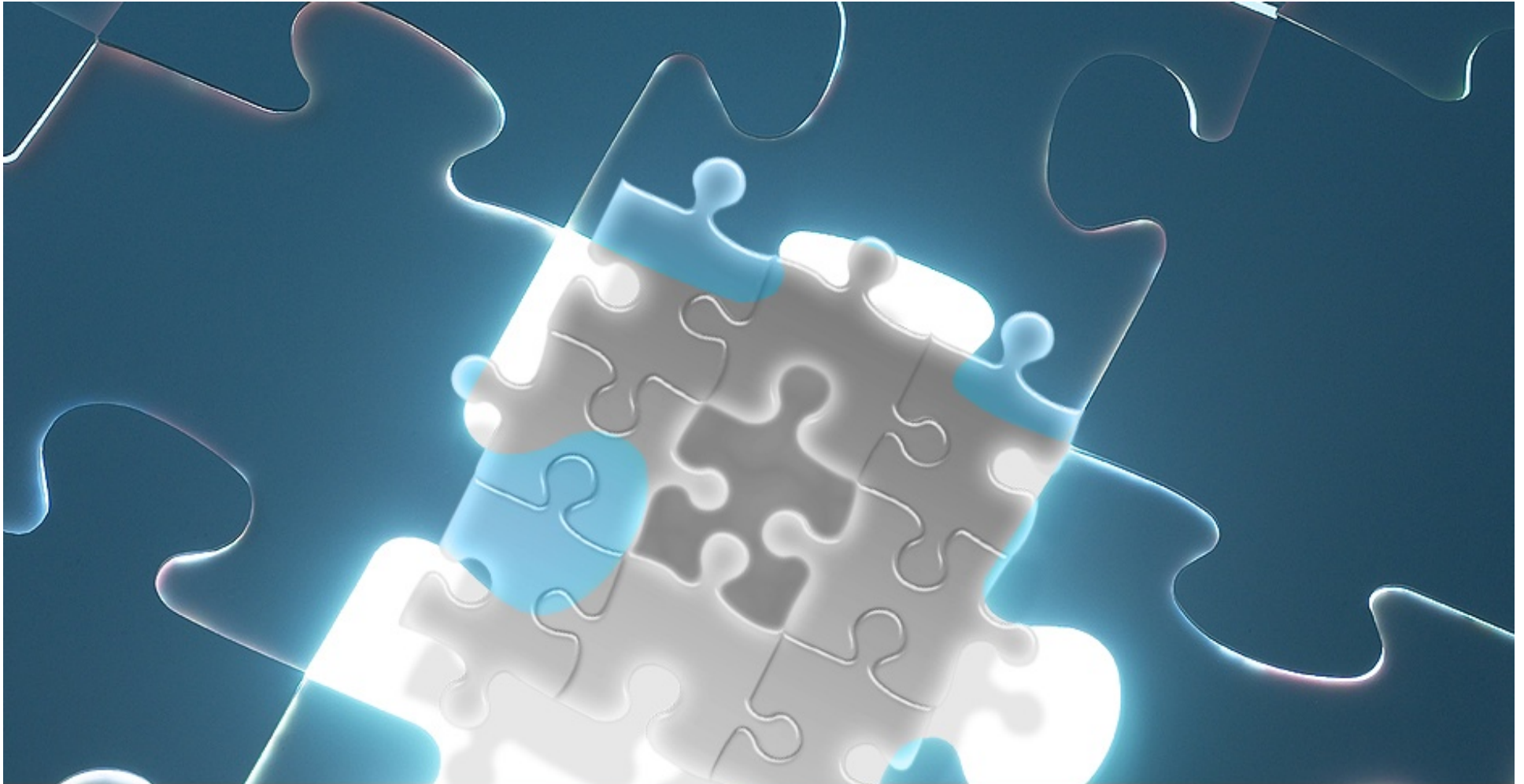
- Low Back Pain
- Rheumatoid Arthritis
- Systemic Lupus Erythematosus

- **Neurological Disorders**

- Migraine Headaches
- Multiple Sclerosis
- Seizure Disorders

ACCESS Plus Next Steps

- DPW is increasing the Vendor's responsibility for developing and maintaining PCP and Specialist provider networks.
- DPW is providing more specific requirements for Dental Outreach Services.
- DPW will also work with local, state and national policy organizations to identify and implement improvements in physical health and behavioral health coordination.
- DPW will continue to evaluate the P4P program and is considering conducting a comprehensive analysis to identify potential program enhancements.



Medical Assistance

Health Information Technology Initiative

June 24, 2010



Background

The American Recovery and Reinvestment Act of 2009 (ARRA) establishes a program for payment to eligible providers and hospitals who adopt and become "*meaningful users*" of certified electronic health record (EHR) technology.

Approximately \$45 billion in funding available for health information technology (HIT)



Office or Local Level

- EMR - Electronic Medical Record
- Transfers paper medical record files into an electronic file that is maintained in a secure database.



Sharing Information

- EHR - Electronic Health Record
- Links the information in the EMRs together between and among providers.
- Provides a comprehensive clinical picture that enables a provider to make the most accurate evaluation of the patient's care needs.



Regional and Statewide Linking

- HIE - Health Information Exchange
- Created when two or more healthcare organizations begin to share their EMRs
- A system that allows the exchange of both clinical and administrative data contained in an EHR across the boundaries of health care institutions and providers.



Why Focus on EHR? The Medicaid Top Ten

10. Funds could be available as early as January 2011
9. It's stimulus money
8. EHR is tied to improving care for patients through objectives such as care coordination



And...

7. It has a measurable return on investment for providers
6. System purchase and upgrade can be attained with 100% federal match for net allowable costs.
5. EHR adoption and HIE can be a collection and reporting tool for providers to participate in Medicaid programs



And...

4. EHRs and HIT can support program integrity activities
3. Significant Federal and State technical assistance is available, as well as peer support
2. Other stakeholders in your State are working on promoting EHR adoption and HIE and so time, resources and teamwork will be lost if efforts are not aligned



And the Number One Reason

1. Health Information Technology is not going to go away if you simply ignore it.



EHR Incentive Program

- Encourage the “adoption” and “meaningful use” of “certified” electronic health records (EHR).
- Provide education and outreach to make sure the purchase of certified EHR technology is not an end in and of itself.



Medicaid Funding – Two Types of Payments

- EHR Incentive Payments - 100% FFP
 - Hospitals
 - Eligible professionals
- Medicaid Administrative Payments - 90% FFP
 - Administer the incentive payments
 - Conduct oversight including the tracking of meaningful use, attestation and reporting
 - Pursue initiatives to encourage the adoption of EHR technology to promote quality and exchange data



Incentive Payments

100% FFP

Be an “*eligible*” provider

Use “*certified*” EHR technology as defined by the ONC

Meet the “*meaningful use*” criteria in the employment of certified EHR technology as defined by CMS.



Adoption of Certified EHR Medicaid

- An eligible provider or hospital can show adoption, implementation or upgrade to qualify for an incentive payment
- Demonstrating Meaningful Use also qualifies a provider for an incentive payment
- A “certified system” is being decided by the Office of the national Coordinator
- Meaningful use is being determined by CMS working with ONC and the HIT Policy Committee.



Eligible Professionals

Medicaid Provider	Eligibility Requirement
Physician	30% patient volume from MA individuals
Nurse Practitioner	30% patient volume from MA individuals
Certified Nurse Midwife	30% patient volume from MA individuals
Dentist	30% patient volume from MA individuals
FQHC/RHC	30% patient volume of needy individuals
Pediatrician	At a minimum 20% patient volume from MA individuals



Patient Volume

- EP's - Minimum 30% MA encounters except for pediatricians with a minimum 20% MA encounters
- FQHC or RHC – Same percentages for EP's but based on encounters with “needy individuals”
- Formula - the numerator is total number of Medicaid patient encounters in any continuous 90-day period in the preceding calendar year and the denominator is all patient encounters for the same period.



Payment and the Switch Hitter Rule

- Cannot exceed \$63,750 over 6 years
- First Year for Adoption, Implementation or Upgrade – up to \$21,250
- Second through Sixth Year is for costs associated with licensing, support, training, and maintenance – up to \$8,500 each year
- One time switch between programs



Proposed Medicaid Provider Payments

Year	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total
2011	\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	-----					\$63,750*
2012	-----	\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	-----				\$63,750*
2013	-----	-----	\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	-----			\$63,750*
2014	-----	-----	-----	\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	-----		\$63,750*
2015	-----	-----	-----	-----	\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	-----	\$63,750*
2016	-----	-----	-----	-----	-----	\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$63,750*

*Maximum available amount. Amount may vary based on provider's net allowable cost



What Institutions are Eligible for Incentive Payments?

- Hospitals:
 - Acute care with at least 10% MA patient volume
 - Children's hospitals - no MA patient volume requirement
- Other "entities" designated by the State and approved by the US DHHS Secretary
- Eligibility is determined by CCN and payment is through a formula using MA inpatient discharge



Focus on Meaningful Use

- Incentive Payments are solely from the adoption of certified technology itself
 - It is the exchange and use of health information to better inform clinical decisions at the point of care
 - It is the ability to generate reports on a patient or groups of patients to evaluate the effectiveness and quality of care
 - Defined by CMS with help from ONC, HIT Policy and Standards Committees and others



The National Level Repository (NLR)

- The “Front Door” for the Program.
- Collects the following information:
 - Name, NPI, business address and business phone of each EP or eligible hospital.
 - Taxpayer Identification Number (TIN) to which the EP or eligible hospital wants the incentive payment made.
 - For EPs, whether they elect to participate in the Medicare or Medicaid EHR incentive program.
 - For eligible hospitals, their CCN.



Meaningful Use Quality Measures

- 90 proposed quality measures
- Core Measures for all EP's
- 15 clinical categories/specialties with specific core measures
- Pediatrics- 9 measures with 4 overlapping with the CHIPRA measures



Future Quality Strategy

- EQUIP's - Electronic Quality Improvement Projects - Links meaningful use from a provider's qualified electronic health record to Medicaid quality outcomes.
- Continues current with focus on electronic extraction of quality processes and outcomes in:
 - Pediatrics,
 - Ob/Gyn,
 - Screening,
 - Chronic Care Coordination,
 - Transitions of Care



Medical Assistance EQUIP's

Areas	Clinical Data (EHR only)	Admin data or EHR
Ob/Gyn	Race/ethnicity OB Needs Assessment form Depression screening, Live birth weight, ACOG recommended lab results	>80% Ob visits, 1st Trimester access Post-partum visit C-section rate low -risk first birth Hysterectomy rates
Pediatrics	Race/ethnicity Smoking status if >13/referral Ht, Wt, BMI, BMI%/referral Developmental screening/referral	Asthma medication, Well child visits, Access to care visits, Dental access, Lead screening, ADHD medication follow-up, Immunizations
Chronic Care	Race/ethnicity Smoking status/referral HgA1C value LDL value for diabetics and cardiovascular Blood pressure for diabetics and hypertension Aspirin use in diabetes and cardiovascular conditions	HgA1C and LDL done Asthma medication Immunizations
Screening	Race/ethnicity, depression, SBIRT, adult BMI referral	Colorectal, Breast , Cervical cancer screening , Chlamydia screening
ED utilization	Medical home referral Medication reconciliation Diagnostic test results	Name, MAID, DOB, DOS, facility, Dx 1-5, new meds
Hospital Discharge	Medical home referral Medication reconciliation Diagnostic test results 30 day readmissions rate	Name, MAID, DOB, DOS, facility, Dx 1-5, CPT 1-5 attending physician, discharge code,



Additional Resources

MA Documents and information can be found at:

<http://www.dpw.state.pa.us/PartnersProviders/MedicalAssistance/MAHITI/>

Comments on the ARRA and the Medicaid Health IT vision document: ra-mahealthit@state.pa.us