

Supporting Small, High-Volume, High-Value Practices in Philadelphia

David Kelley MD, MPA, Chief Medical Officer
Office of Medical Assistance Programs
Pennsylvania Department of Public Welfare



**REDUCING
DISPARITIES**
AT THE PRACTICE SITE

ADVANCING CHRONIC CARE QUALITY

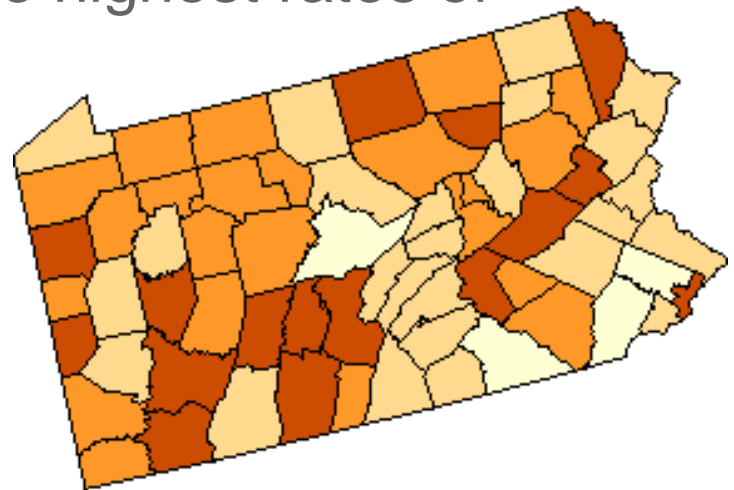
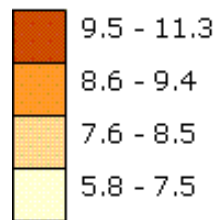
Why diabetes? Why Philadelphia?

Pennsylvania's prevalence of diabetes by race/ethnicity.

Hispanic	8.9%
Black, non-Hispanic	10.6%
White	7.6%

Philadelphia county has one of the highest rates of diabetes in Pennsylvania

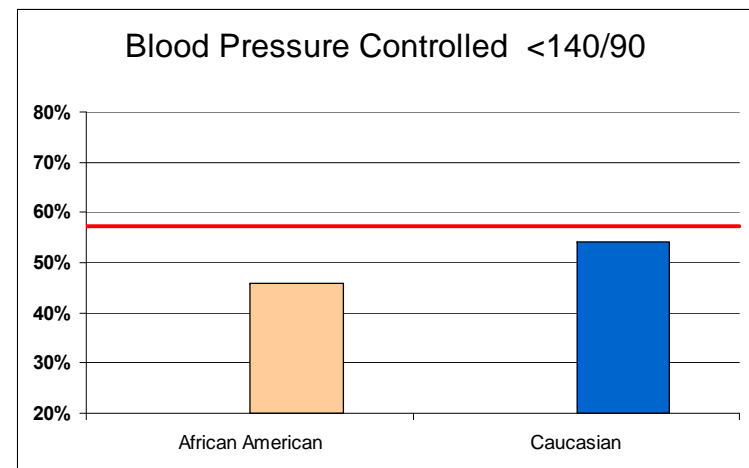
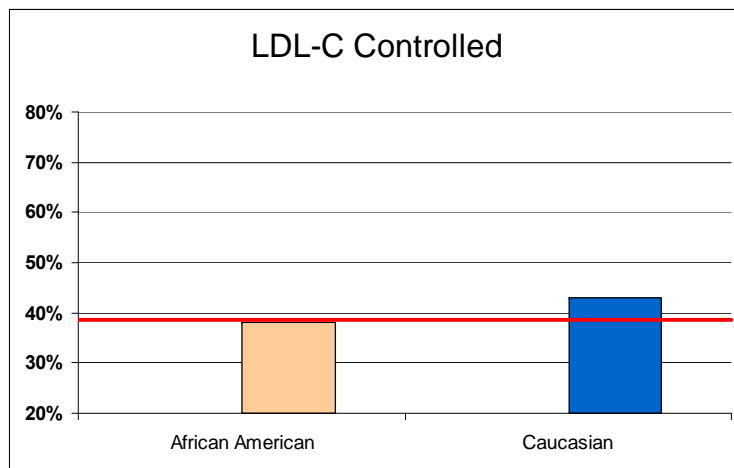
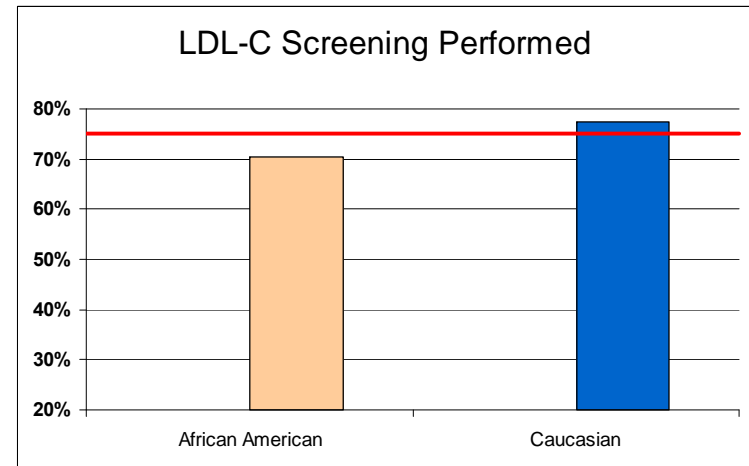
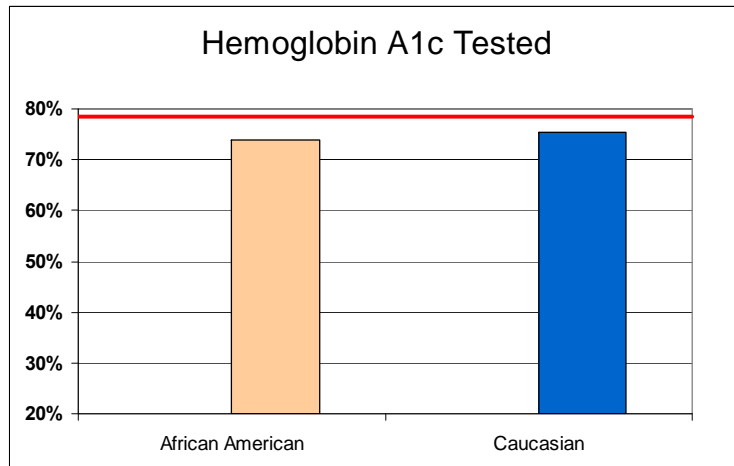
2005 Percentage of adults ≥ 20 years old with diabetes



Source: Pennsylvania BRFSS 2005

Disparities for Diabetics in the SE Zone 2007

Compared to HealthChoices Average



Disparities for Medicaid Diabetics in South Eastern Pennsylvania: HEDIS Results for 2009

- African-Americans compared to Caucasians:
 - Lower rate of HgA1c testing
 - Higher rate of HgA1c poor control > 9%
 - Lower rate of LDL testing
 - Lower rate of LDL control <100
 - Lower rate of blood pressure control <140/90 and <130/80

Pennsylvania's Vision for *RDPS* Pilot

- Targets



Population: adult Medicaid members



Provider sites: providers with 500+ diverse Medicaid members



Condition: diabetes



Region: Philadelphia area

- Delivery system: Medicaid Managed Care

Overview of *RDPS* Pilot

- A collaborative of all three Medicaid Managed Care plans – AmeriChoice, Health Partners, and Keystone Mercy – in the Philadelphia region.



Improved health for engaged members

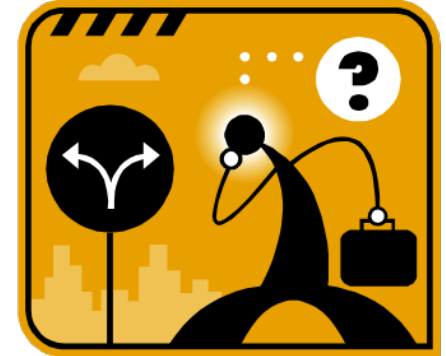


Measurable interventions



Statistically significant improvement in HEDIS measures






State/Plan Support



Actions:

- Aligning provider incentives around diabetes
- Shared practice coach
- Participation in an electronic registry

Practice-Level Interventions

-  Utilization of a shared practice coach
-  Increased/improved patient tracking
-  Increased utilization of community resources
-  Guideline-based diabetes education materials for members
-  Provider support to implement evidence-based practice guidelines & tools

Requirements of Participating Practices



Collaborative learning group meetings



Sharing of experiences, opportunities for improvements



Commitment to use an electronic registry



Commitment to measure quality and to improve diabetes outcomes

Progress to Date

- Practice coach/care manager actively engaged;
- Electronic registry populated and updated by care manager;
- Care manager identifying care gaps and reaching out to patients;
- Practices implemented guideline-based diabetes flow sheet;
- Guideline-based patient education materials available;
- Practices educated about enhanced revenue from diabetes P4P program; and
- Practice assessment completed.

Challenges

- Lack of practice “excess capacity”
 - Staffing, physical building, phone lines
 - IT hardware, software, training
- Adoption of direct use of registry
- Underdeveloped business and quality model
- Nurse focused on practice redesign versus care management
- Difficulty holding collaborative meetings

Next Steps

- Develop incentive payments specific to “becoming” a medical home
- Quarterly learning groups
- Integrate practice redesign activity with Pennsylvania’s Chronic Care Commission
- Monthly quality reports
- Integrate HITECH incentive payments