Pennsylvania Department of Public Welfare
DRAFT Chronic Care EQUIP

Focus Area	Lead Agency	2011 Objectives	Provider Goals
Chronic Care	**OMAP**	**Acceptance, Metric and Clinical Rates**	
Improve Quality, Cost Containment and Efficiency	1. Chronic Care Commission guidelines 2. Predictive Modeling/Risk Stratification 3. Disease management/IMCM for co-existing medical conditions 4. Pharmacy utilization rates (ability of Department to track medication usage, adherence and abuse) 5. Emergency room utilization rates/inpatient rates (including readmissions, PCP visits, encounter visits) (useful in all EQUIPS) 6. Track adverse events 7. Develops clinical decision support for providers 8. Physician access to pharmacy data	**Acceptance Rate:** 1. Twenty percent of ARRA participating providers are using a certified EHR/EMR **Metric Rates:** 1. Track HEDIS measures/ P4P for: a. Adult BMI measure b. HgA1C c. ACE/ARB d. Asthma medications e. LDL-C for diabetics and cardiovascular patients 2. Track disease specific measures for: a. Diabetes, including LDL and BP b. Asthma c. CHF, including ACE/ARB d. COPD e. Cardiovascular conditions, including Beta Blockers f. Monitor emergency room use **Clinical Rates:** 1. Track ASA/Anti-platelet use[1]	1. Completes Chronic Care Assessment Tool (ACCESS Plus) (electronic completion and submission) 2. Uses PDL (all EQUIPS) 3. Adheres to PDL (all EQUIPS) 4. E-prescribes (all EQUIPS) 5. Completes appropriate screening assessments and referrals and receives follow-up; uses validated tools and includes this information in electronic care plan to reflect integration of behavioral health and physical health 6. Uses emergency services effectively 7. Conducts medication reconciliation (all EQUIPS) 8. Conducts depression screening: uses and submits valid tool

[1] Develop alerts to assist providers with knowing if these are prescribed/ appropriate labs monitored.

Focus Area	Lead Agency	2011 Objectives	Provider Goals
Chronic Care	**OMAP**	**Acceptance, Metric and Clinical Rates**	
		2. Increase screening/ tracking for: a. Depression[2,3] b. BMI c. Developmental Delays/Autism d. Diabetic Measures(HgA1C, LDL-C, ASA) e. CV Measures (BP, LDL-C, ASA) f. Polypharmacy (8 drugs/ high end users) g. Use of narcotic/benzodiazepine medications, illicit drug use, suboxone or methadone h. Lab work	

[2] Conduct a two question screening: 1) Over the past two weeks have you ever felt down, depressed or hopeless? 2) Over the past two weeks, have you felt little interest or pleasure in doing things? If positive, complete a full assessment.
[3] Use of validated screening/assessment tools for depression, developmental delays and autism. Include in electronic care plan. This contributes to collaboration of behavioral health and physical health.

Pennsylvania Department of Public Welfare
DRAFT Chronic Care EQUIP

Focus Area	Lead Agency	2011 Objectives	Provider Goals
Chronic Care	**OMAP**	**Acceptance Ratio, Metric Ratio, Clinical Ratio**	
Engage Patients and Families	1. Develop pop-up alerts for providers to signify needed interventions (all EQUIPS) 2. Develop pop-up alerts for consumers that signify needed care (all EQUIPS) 3. Identify race/ethnicity for review of treatment disparities 4. Assign Case Managers, if necessary 5. Access to preventative care/health information on the website 6. Ability to send/receive text/email messages to providers (all EQUIPS) 7. Peer support/coaching (all EQUIPS)	**Clinical Ratio:** 1. HealthChoices MCOs and ACCESS Plus Member services to develop programs that allow consumers to access medical records and assist with creating an EHR, which could include scheduling, canceling and re-scheduling appointments (all EQUIPS) 2. Computer kiosks in FQHCs and RHCs for consumers to access their: a. Health information, including current medication list for reconciliation b. Current care plan c. Upcoming appointments d. Care gaps	1. Ability for providers to send/receive email/text messages to consumers (all EQUIPS) 2. Text messages to patients to remind them of needed appointments (all EQUIPS) 3. Availability of appointments (appointment standards) and ability to cancel or re-schedule appointments 4. Physicians and Case Managers educating patients on illness prevention, disease management and treatment options. 5. Comprehensive, patient-centered care plan, and provider collaboration with the consumer or caregiver in the development of electronic care plan (all EQUIPS) 6. Website health information (all EQUIPS)

Pennsylvania Department of Public Welfare
DRAFT Chronic Care EQUIP

Focus Area	Lead Agency	2011 Objectives	Provider Goals
Chronic Care	**SHOULD THIS BE OMAP? OR, TO BE DETERMINED?**	**Acceptance Ratio, Metric Ratio, Clinical Ratio**	
Improve Coordination of Care	1. IMCM referrals: Case Managers will focus on care gaps identified through algorithms - electronic pop-ups - and increase referrals for needed services (all EQUIPS) 2. Disease Management program referrals: Coordination of care between the Disease Management program and PCP - ability to view electronic care plan with capability to add and edit care plan only for specific discipline 3. Transitions of care between inpatient and home; emergency room and PCP; physical heath and behavioral health: Incorporate into electronic care plan 4. Transitions of care from child to adult (age-outs): Develop pop-up alerts for providers 12 months prior to a consumer turning 21 (all EQUIPS) 5. Equip providers and consumers with links to community resources and professional referral sources (all EQUIPS) a. Community resources (e.g., education classes, support	**Clinical Ratio:** 1. Medical/Dental home assignments 2. Enhance communication links to PCP from emergency room or inpatient care 3. Increase referrals to Dental home 4. Expand immunization registry to include BMI surveillance, vision, hearing and lead screenings 5. Use of electronic care plans 6. Depression screening	1. Referral to Medical/Dental home 2. Completes Chronic Care Assessment Tool and incorporates into EMR for electronic completion and submission 3. Comprehensive, patient-centered EHR with embedded HEDIS measures (all EQUIPS) 4. EHR identifies other specialists involved in patients care; one care plan incorporating all providers; ability for all providers to view but only add and edit capability for the specific discipline. Could be done by Provider portal 5. Depression screening: use of valid tool and submitted 6. Dental assessments and referrals 7. Link to immunization registry 8. Link to chronic care registry 9. Medication adherence and reconciliation: prescription and alternative medications (all EQUIPS) (Medication possession ratio)

Focus Area	Lead Agency	2011 Objectives	Provider Goals
Chronic Care	**SHOULD THIS BE OMAP? OR, TO BE DETERMINED?**	**Acceptance Ratio, Metric Ratio, Clinical Ratio**	
	groups, hyperlinks to national evidence-based websites) b. On line education and resources for providers and consumers c. Hyperlinks to MA Guidelines that are available via the ACCESS Plus website 6. Links to providers to patient specific data (all EQUIPS)		
Reduce Cycle Time between "New" Evidenced-based Healthcare and Community Practice	1. Provider education, training and support on the use of technology in the practice (all EQUIPS) 2. Hyperlinks to best practices related to the Disease Management programs 3. Long Term: Question ability to get a license for "Up-to-Date" (non-personal) and provide a link for providers to access; question cost (all EQUIPS)	**Clinical Rates:** 1. Create links to current treatment guidelines for providers 2. Integrate HEDIS measures into the certified her and patient care plan	1. Participation of providers in tracking trends and performance measures in clinical care (P4P, HEDIS)