BCBSM
Physician Group Incentive Program
2012 Program Year

Evidence Based Care Tracking

Initiative Plan

VALUE Partnerships
Improving Health Care in Michigan

I. Initiative Overview

The Blue Cross Blue Shield of Michigan (BCBSM) Evidence Based Care (EBC) Tracking Initiative is one of many initiatives of the Physician Group Incentive Program (PGIP). Since its inception in 2005, PGIP has supported and facilitated practice transformation using a wide variety of initiatives to reward physician organizations (POs) for improved performance in health care delivery. As of September 2011, PGIP includes 40 POs from across the state of Michigan, representing nearly 15,000 primary care and specialty physicians who are members of the BCBSM TRUST PPO and/or Traditional Networks. These physicians provide care to nearly two million BCBSM members.

BCBSM's Physician Group Incentive Program encourages all payer collaboration, catalyzing all payer system development, rather than payer-specific system development. Through PGIP, BCBSM is helping to improve the quality of care for all Michigan residents. Patients throughout the state, regardless of payer, benefit from the improved care processes developed through the PGIP provider community. Developing systems of care which are used for all patients helps assure that providers don't have to alter care processes based on whether patients have insurance, or which insurance they have. This is an important factor in ensuring that the best practices and care processes are reliably provided to all patients, all of the time. This all-payer approach to practice transformation is good for patients with coverage from BCBSM and BCN and helps further BCBSM's social mission of cultivating a healthier future for all Michigan residents.

Goals and Objectives

The Institute of Medicine's report on rewarding provider performance indicates there is benefit in aligning incentives to pay providers for higher-quality care measured by selected standards and procedures.[1] The EBC Tracking Initiative strives to induce best practices among PGIP physicians that result in effective care. This is achieved by increasing provider awareness and promoting the subsequent implementation of evidence-based medicine guidelines into daily practice.

The intention of the EBC Tracking Initiative is to align incentive payments by paying those physicians who provide a higher quality of care based on specified initiative performance metrics with the goal to:

- Encourage the most rapid, feasible performance improvement possible by PGIP physicians
- Induce best practice among PGIP physicians that results in effective care
- Support innovation and constructive change in processes for the delivery of care
- Promote better outcomes coordination of care across provider settings and over time

The EBC Initiative measures nine categories of cross-cutting care via a dashboard report with a focus on chronic disease categories where prevention of poor outcomes is possible with appropriate care. The dashboard report uses selected measurement criteria to compare evidence-based care across POs and against applicable benchmarks.

Summary of Results

In program year (PY) 2010, the overall rates for the thirty-nine physician organizations (POs) participating in the EBC Tracking Initiative ranged from a low of 62% to a high of 76.8% (excluding the asthma and statin measures). The overall EBC composite score for 2010 was 70.7% with a benchmark average of 75.4%. The overall score for each of the EBC Tracking categories of care (such as Antibiotic Use, Diabetes, etc.) for calendar year (CY) 2010 experienced positive and negative fluctuations in performance compared to CY 2009 rates. Five out of the nine categories of care exhibited an improvement in the overall rate, ranging from 0.2% to 3.8%, while four exhibited a decline in the rate.

The number of PO scores that fell in the ≥ 75% range decreased by 24.8% while the number of POs with scores in the 60-69% range increased 25% when compared to 2009. The most probable cause for this change was the retirement of the statin measure which has historically had very high rates. The elimination of the statin measure especially impacted the category of care for overall Coronary Artery Disease (CAD). After excluding statins, the CAD category experienced an average rate change of -4.9% with the range of rate changes falling between a negative 18.4% and a positive 9.9% across all physician organizations. Additional analysis including details and graphs are located in this initiative plan under Section V, Results.

II. Background

Health Problem and Significance

Effective care is the basis of the PGIP EBC Tracking Initiative. The Dartmouth Atlas Project's Center for the Evaluative Clinical Sciences provides a summary brief that serves to succinctly define effective care: "Services that are of proven value and have no significant tradeoffs – that is, the benefits of the services so far outweigh the risks that all patients with specific medical needs should receive them. These services, such as beta-blockers for heart attack patients, are backed by well-articulated medical theory and strong evidence of efficacy, determined by clinical trials or valid cohort studies".[2]

The Centers for Disease Control and Prevention (CDC) National Vital Statistics Report published April 24, 2008, examined descriptive tabulations of information reported on death certificates. The report cites the 15 leading causes of death in 2005 (Table 1) naming the top three causes as the most common, costly, and preventable among all health problems in the United States. The 15 leading causes of death in 2005 accounted for 82.3% of all deaths in the United States. Michigan's top three common causes of death in 2005 were comparable to the U.S. (e.g. heart disease, cancer, and stroke). The results are based on age-adjusted death rates and compare rates relative to 2004 rates.[3]

Table 1: Top 15 Leading Causes of Death in 2005* (relative to 2004)

Disease	Increase	Decrease
Heart Disease		2.7%
Cancer		1.1%
Cerebrovascular Diseases (Stroke)		6.8%
Chronic Lower Respiratory Diseases	5.1%	
Accidents (unintentional injuries)	3.7%	
Diabetes Mellitus	NS	
Alzheimer's Disease	5.0%	
Influenza and Pneumonia	2.5%	

Nephritis, Nephrotic Syndrome and Nephrosis (Kidney Disease)**	NS	NS
Septicemia**	NS	NS
Intentional self-harm (Suicide)**	NS	NS
Chronic Liver Disease and Cirrhosis**	NS	NS
Essential (primary) Hypertension and Hypertensive Renal Disease (Hypertension)	3.9%	
Parkinson's Disease	4.9%	
Assault (Homicide)	3.4%	

*Derived from CDC chronic disease burden statistics. Compares rates relative to 2004 and reported if significant change
**NS = Not Significant

Each year the National Committee for Quality Assurance (NCQA) examines the state of health care quality through data submitted by health plans across the country. NCQA's 2010 report on the State of Health Care Quality indicated that one of the most striking developments was the contrast in performance on childhood vaccination rates between commercial and Medicaid populations. Among commercial enrollees, the vaccination rates declined by almost four percentage points while the rate among the Medicaid plan members actually improved. Information obtained by NCQA from medical societies and Federal research agencies demonstrated similar shifts in the data.[4] As reported by NCQA in the 2011 State of Health Care Report, immunizations did not experience a full recovery for commercial health plans. Although a slight increase occurred for the Combination 2 Childhood Immunization Rate for commercial HMOs, the numbers were not statistically significant.[5] Some experts theorized that the decline in immunizations in the commercial population continues to be due, in part, to the public's perception of a link between immunizations and autism.

According to an October 2007 study entitled *An Unhealthy America: The Economic Burden of Chronic Disease* produced by the Milken Institute, the annual financial impact on the US economy for seven common chronic diseases is more than $482 billion in addition to billions of dollars in lost productivity.[6] The report indicates Michigan is in the third quartile nationally for its rates of seven common chronic diseases (i.e., Michigan experiences some of the highest rates of chronic disease in the country). High rates for variation in care demonstrate the continued need for implementation of evidence-based care or physician use of "best practice".[7]

Possible Solutions

As demonstrated in the EBC Tracking Initiative Cause and Effect Diagram on Appendix I, POs have a number of pathways available that serve to provide additional incentives and assist with implementation of EBC Tracking guidelines in the physician office setting. BCBSM supports the use of information technology for improving care, such patient registries, and recommends POs employ a variety of strategies to improve patient care and manage the health of patient populations.

Data Feedback: During the past ten years, methods for identification, critical appraisal, and synthesis of published evidence have become more formal, rigorous, quantitative, and sophisticated compared to earlier guidelines which tended to be strongly influenced by expert opinion.[8] Today's methods provide a strong foundation for measurement of guideline implementation. The EBC dashboard based on claims data has been produced by BCBSM since 2005 for the use of POs participating in PGIP. The dashboard, quarterly data sets, and monthly data feeds serve as tools to validate PO registry information and to provide feedback to assist providers in understanding where "gaps in care" exist. The EBC contains quality, cost, and effectiveness of care measures developed by synthesizing guidelines from:

- NCQA's HEDIS
- MQIC
- BCBSM developed medical guidelines
- American College of Cardiology
- American Heart Association

Vendor Solutions: Vendor solutions exist for data collection and reporting of HEDIS measures and are also available to physician practices for the implementation of electronic health records and/or registries. Examples of vendors include: Cerner, MedAssurant, Meditech, McKesson, and Siemens (see Appendix IV for the entire list). Some vendors, such as ZynxAmbulatory of Zynx Health Solutions, supply the evidence-based order sets and clinical decision support rules required by the American Recovery and Reinvestment Act of 2009 (ARRA), and help outpatient providers become meaningful users of electronic health records (EHRs) by incorporating quality measures from the Centers for Medicare & Medicaid Services into actionable clinical content.

Disease Registries: BCBSM supports PO efforts to implement all-payer chronic disease registry systems at the physician office sites as important tools for accomplishing:

- Proactive population management (such as outreach to patients with identified gaps in care for essential services)
- Point of service use to customize care for facilitating planned care visits to ensure comprehensive efforts toward identifying patient goals and effectively engaging the patient in reaching those goals.

Registries provide the most recent information available patient population management and assists in standardizing care across the physician practice. Registries can also assist POs and PUs in adhering to major regulatory and quality initiatives for physician practices such as those endorsed by the Centers for Medicare & Medicaid Services, National Quality Forum, National Committee for Quality Assurance (NCQA), and the Joint Commission.

According to the Institute for Healthcare Improvement (IHI), a registry is an information system for recording relevant patient care information.[9] Registries allow health care providers to better manage the care for their patient populations. Providers can use registries to record critical elements of the care plan, produce care summaries at the time of a visit, and provide reminders to ensure proactive care. Registries are particularly important in managing the care of patients with chronic diseases, but can be also used to track preventive care.[10]

Creation of a registry (or list) of PU patient populations indicating which patients have a chronic disease condition is useful for tracking key measures and developing mechanisms that remind physicians automatically when patients need certain labs and preventive services. Such lists can be accessed and managed by a variety of physician office staff (such as nurses, medical assistants and administrative staff) with minimal training.

Reminder Systems: BCBSM supports the development of patient reminder systems (such as postcards, letters, emails, phone calls, etc.) whereby consumers receive reminders about necessary appointments, screenings, and other support that helps patients and their families manage chronic conditions such as diabetes and heart disease. Reminders coordinated with a patient's birthday as well as reminders sent during the spring and summer months have been shown to receive the most response. Studies demonstrate that reminders sent out in the fall and winter has a lower response rate whereas reminders sent in June or earlier seem to be a time of the year members are more willing to obtain health screenings.[11]

Patient-Center Medical Home (PCMH): Participation in the BCBSM Patient-Centered Medical Home (PCMH) Initiative began in 2008. This model of care delivery is embraced by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA). In this model, the traditional doctor's office is transformed into the central point for patients to organize and coordinate their health care, based on their needs and priorities.[12] At the core of the model is an ongoing partnership between each patient and a specially-trained primary care physician. This model incorporates modern conveniences, such as:

- Email communication and same-day appointments
- Quality ratings and pricing information
- On-line tools to help consumers manage their health information
- Review of the latest medical findings for making informed decisions

Online Education Resources: The internet provides many educational resources for healthcare professionals, patients, and consumers. For example, Michigan's Diabetes Outreach Network (http://www.diabetesinmichigan.org/) provides physician tools and patient resources to address best practice in diabetes care. Professional organizations and medical societies within Michigan often maintain web resources that also provide topic specific guidelines and links addressing the preventive measures on the EBC dashboard.

BCBSM Experience

Blue Care Network (BCN) has a broad-based incentive program designed exclusively on measures from the Healthcare Effectiveness and Data Information Sets (HEDIS). An annual payment is paid to providers with interim performance tracked through Health e-Blue (database) and the Quality Summary Reports. The measures for BCN are the same as the HEDIS measures used for EBC Tracking Initiative.

III. Initiative Description

Specific Area of Focus

The EBC Tracking Initiative provides incentive for POs to assist their physician members with implementing evidence-based care into their daily practice for the care of their patients. Incorporation of evidence-based care is expected to positively impact the delivery of care, quality of care, and health care outcomes while reducing unnecessary cost and services. Specific measures for this initiative were selected by BCBSM as indicators of specific evidence-based care provided by participating physicians. These indicators are also used to compare a PO's performance with their peers and against applicable measurement benchmarks.

Target Population

In general, this initiative targets BCBSM members, ages 0-64, attributed to a PCP that is member of a PGIP Physician Organization electing to participate in the EBC Tracking Initiative. The patient population may differ across specific EBC measures such as for childhood and adolescent measures.

Criteria for Participation

To participate in this initiative, physicians must meet the general criteria of being a member of a PO that has 1) joined the Physician Group Incentive Program as a whole, and 2) elected to participate in the EBC Tracking initiative. When this general criteria has been met, physicians must also be a primary care physician (PCP) defined for this initiative as one of the following specialties: Family Practice, General Practice, Internal Medicine, Geriatrics, and Pediatrics.

BSBCM Deliverables

Through the regular delivery of data, POs are provided the opportunity to identify and investigate variation in practices among their physician members in order to encourage both goal-setting and development of population-based interventions. Administrative claims data from BCBSM members are used to generate the biannual EBC dashboard report and quarterly EBC data sets. Data for all EBC measures are derived from the submission of professional, facility and pharmacy claims (including BCBSM business and external vendor data, when available). Three sources of data are provided to the POs as listed below.

EBC Dashboard Report: The EBC Dashboard is distributed to POs semi-annually in May and November. Appendix V lists the EBC measures for the 2012 PGIP program year. Detailed measure specifications describing how each individual measure is calculated are distributed to PGIP POs annually prior to the PGIP plan year. The semi-annual report compares PO performance to all POs, regardless of whether the PO has elected to participate in the EBC Tracking Initiative.

Claims data set and Monthly Data Feeds: The EBC quarterly data sets are distributed in February, May, August, and November. The datasets report the numerators and denominators for HEDIS-defined quality indicators at the member-level. This allows for the reporting of rates for all EBC measures at the PO-, practice unit- and individual physician levels. In addition, POs receive monthly-claims feeds for use in further identifying provider-level detail.

Note: Appendix II provides a table listing the EBC data delivery schedule and data parameters.

Data Education: Educational offerings will be provided as needed at the PO level during the program year to improve participating POs' understanding and adoption of the EBC measures and data reports. Education may occur in the form of Webinars, informational articles in newsletters, and written communications. Individual PO education about EBC data may occur upon the request of the PO or based on an educational need identified by BCBSM.

NOTE: BCBSM reserves the right to modify its evaluation and administrative processes related to the PGIP initiative.

PO Expectations/Deliverables

Physician organizations participating in the EBC Tracking Initiative are required to conduct the following activities:

Identify a clinical and analytic lead for the EBC Tracking Initiative: The clinical and analytic lead at each PO is responsible for receiving and reviewing data (dashboard reports and datasets) distributed by BCBSM and identifying measures and practice units that represent opportunity for improvement (i.e. significant increases/decreases in selected measures)

Review and analyze the biannual dashboard: Utilize the biannual dashboard reports and quarterly datasets (provided by BCBSM) to identify variation in practices. POs should develop and implement strategies and programs to disseminate data feedback and improve the use of evidence-based care at the practice unit and individual physician level.

Physician organizations must identify and address root causes for variations in care compared to best practice POs and physicians. Addressing variation will support the development of interventions specific to the problem areas resulting in maximizing the opportunity for improvement.

Review and analyze the biannual Normalized Impact Factor (NIF) Report: Utilize the NIF report (provided by BCBSM) to identify the specific EBC measures that demonstrate areas of opportunity for improvement and/or where the population can be impacted by the PO improvement strategies. The NIF report is intended to assist POs with their focused improvement efforts and replaces the "focus measures" used in previous program years. Please see Appendix VII for more information on the NIF Report.

Complete semi-annual progress reports: Progress reports must be completed semi-annually by all POs participating in the EBC Tracking Initiative. The progress reports are an opportunity to describe barriers to, and strategies for, success in improving the implementation and use of evidence-based care and should include major accomplishments such as the implementation of registries, data dissemination efforts, participation in PCMH, etc.

Data from the PO progress reports will be used to identify the existence and use of patient registries as well as other initiative implementation strategies. BCBSM will continue its work with the POs to further develop an understanding of which implementation strategies are used by physician organizations. Additionally, BCBSM will attempt to identify a correlation between initiative implementation strategies and the use of and improved use of evidence-based care and to what extent such strategies are crucial to success in achieving the goals of this initiative.

Attend monthly PGIP Data Users Workgroup meetings and periodic webinars: POs should designate a representative to attend the monthly PGIP Data Users Workgroup (DUW) meetings and webinars offered throughout the year. The DUW meetings are planned for and facilitated by PGIP POs to provide a forum for collaboration among POs, a hallmark of the PGIP program. Throughout the year, webinars are provided to discuss EBC data at PO, PU, and physician levels. In order for POs to develop expertise with data content and its practical uses, attendance by a PO is strongly advised.

Develop and implement intervention plans to promote the use of evidence-based care guidelines related to the selected EBC Tracking Initiative measures: POs should actively review data received regarding their physicians' performance rates and develop formalized intervention plans that address gaps in care.

Quality Improvement Model

BCBSM began using an established benchmark of care methodology in 2008 to determine appropriate benchmarks for each of the quality measures addressed in the EBC. The benchmark methodology is a tool to facilitate the measurement, comparison and dissemination of benchmarks derived from the process of care practices already being achieved by best practice providers. Its approach is objective, easily updated and readily yields understandable feedback comparisons.

The benchmarks are typically used to measure the extent of use of processes of care widely accepted to improve outcomes. Therefore, providers achieving at or near benchmark levels should have better outcomes in terms of more effective and less costly care than providers who do not. BCBSM's use of the established benchmark of care methodology for the EBC Tracking Initiative will provide POs with benchmarks of best practices among their peer group - in this case, Michigan physicians that are part of the PGIP defined specialty population. Use of the methodology will ensure that:

- All PGIP providers contribute to the benchmark
- Providers with high performance but very low numbers of cases do not unduly influence benchmark levels
- BCBSM produces appropriate benchmarks for POs working in a PPO environment

The benchmark for each measure is calculated as the average score(s) of the top performing POs treating 10% of the attributed population. Benchmarks for each EBC measure, EBC clinical topic and overall EBC rate will be distributed in May and November of 2012 on the EBC dashboard.

The EBC Tracking incentive pays physicians for improving and providing a higher quality of care based on the specified performance metrics. A complete list of the 2012 EBC dashboard measures can be found in Appendix V. Two new measures - listed as "New for 2012"– are described below. These additions were based on identifying measures that address the EBC Tracking Initiative's key categories of clinical care and that are important for achieving better health outcomes in today's health care environment.

- Child/Adolescent Prevention: Appropriate Testing for Children with Pharyngitis
- Medication Management: Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

The child/adolescent prevention measure seeks to promote appropriate testing for children with pharyngitis in order to avoid the unnecessary use of antibiotics. The overuse of antibiotics has been linked to the emergence of antibiotics resistant bacteria. Guidelines for the appropriate use of antibiotics have been widely disseminated to health care professionals and, though new for EBC reporting, will be included for payment beginning July 2012.

The new DMARD measure seeks to encourage the appropriate and timely prescribing of medications for the treatment of Rheumatoid Arthritis. A cohort study published in 2011 concluded that care provided for RA is not consistent with current American College of Rheumatology guidelines.[13] The DMARD measure will be considered a test measure during the first year and will not be counted for incentive payment until January 2013.

The measures for the EBC Tracking Initiative undergo an annual review to identify whether care measures from the previous year are to be continued or retired. The criteria for each measure are also reviewed to identify changes in specifications, if any. When significant changes in criteria occur, POs are notified with the release of each EBC dashboard or sooner, if needed. A summary of changes in technical specifications for the existing EBC dashboard measures can be found in Appendix VI.

Incentive Model and Payment Methodology

In this initiative, incentive payments are based on PO performance, PO improvement over a prior measurement period, and the number of PO-attributed members. The payment methodology generates a single summary score for each PO that represents the weighted sum of the PO's normalized performance score and normalized improvement score. The normalized performance score is represented along a scale from 0-1, where 1 represents the best performance and 0 represents the worst performance. The normalized improvement score – the ratio of current improvement to the theoretical optimal improvement – is similarly represented along a scale from 0-1, where 1 represents the most improvement over the previous measurement period and 0 represents the least improvement over the previous period.

Each PO with a summary score above a certain percentile will receive an initiative incentive payment. The PO will receive a percentage of the initiative-specific incentive pool based on the PO's summary score, weighted by the PO's number of attributed members. POs with summary scores in the lowest percentiles will receive either no incentive payment or a negative incentive payment. The negative payment is based on the PO's summary score and the number of attributed members, factored by a negative 10% payment percentage.

The negative incentive payment is designed to a) encourage POs to become actively engaged in pursuing improvement in those initiatives in which they are enrolled, and b) encourage POs to carefully make their initiative selections and discourage them from enrolling in initiatives without engaging in activities to improve performance. A PO's poor performance on a specific initiative can result in a negative incentive payment that reduces the PO's overall reward payment for the scoring period. However, a PO's overall incentive payment (for all PGIP initiatives) for a scoring period will never be lower than zero.

BCBSM reserves the right to use discretion in making incentive payments based on the data and relative PO performance.

Normalized Impact Factor (NIF)

Beginning in July 2012, PGIP will implement an enhanced scoring method for the EBC Tracking Initiative. Physician Organizations will continue to be scored on their overall performance for this initiative, but BCBSM will begin incorporating a weighted improvement score for overall improvement as part of the payment calculation.

This weighted improvement scoring method provides for identifying improvement opportunities that are unique to the PO's patient population across all EBC measures. The weighted improvement score can be used by POs to identify outreach efforts that may produce the most significant improvements to their overall EBC score when applied to the POs existing population-based management approach.

In January 2012, each PO will receive their PO-specific NIF Report based on data from the November 2011 EBC dashboard. This report will be disseminated biannually based on the most recent dashboard available. The report will provide POs with the following information for each EBC measure:

- **Population Impact:** Percentage of PO population potentially affected for each measure
- **Improvement Opportunity:** The PO's opportunity for improvement for each measure

- **Normalized Impact Factor:** The NIF is calculated for each measure (obtained from multiplying the PO's population impact by the PO's improvement opportunity)

A higher NIF for a measure indicates greater population "impact" and/or potential for a large improvement in PO overall score if the performance on the measure improves. POs will be encouraged to use their Normalized Impact Factor Report as a guide for implementing population-based improvement strategies. Normalized impact factors will be included as part of scoring for improvement so that each measure is weighted according to its potential impact (i.e. a measure with a higher NIF will weigh heavier into the improvement score). As mentioned previously, the first payment using NIFs will occur in July 2012 (Please refer to Appendix VII for more detail).

Note: BCBSM reserves the right to modify focused measures, as well as program payment methods and processes related to focus measures, during the program year.

IV. Evaluation

Evaluation Overview

Evaluation of the EBC Tracking Initiative uses a model that compares participating physicians to non-participating physicians as this method provides better control for secular trends. This theory assumes that physicians not participating in PGIP may be a better source as an estimate for the secular trend in the time period following implementation rather than BCBSM observations prior to implementation of the EBC Tracking Initiative. A disadvantage of the model is the potential for selection bias. Examples of this would be physicians who self-select into the program compared to physicians who chose not to participate, and physicians who participate in other PGIP initiatives that may indirectly result in improved EBC performance.

The evaluation of the PGIP EBC Tracking Initiative will address evaluation of short-term and intermediate goals for both the initiative design and the effects theorized to result from incentive payments to POs to improve their EBC dashboard rates. These effects include short-term behavioral and knowledge-based changes as well as intermediate effects based on dashboard performance and improvement. Evaluation of long-term effects will be at a later time and based on factors such as cost savings and utilization of services.

Short-term Evaluation

The short-term evaluation will be accomplished via progress report questions as detailed in Appendix III.

Intermediate Evaluation

Intermediate evaluation will be determined based on EBC dashboard rates. Improvement trends in EBC rates over time will serve as an indicator that incentive payments made to POs for the purpose of implementation of evidence-base care at the PU level are resulting in the desired effect. When EBC rates improve, better health outcomes can be assumed based on literature demonstrating that implementation of evidence-based care improves the quality of care delivered and prevents or decreases the effects of chronic disease conditions.

Long-term Evaluation

The long-term evaluation plan is still under development and will most likely be based on factors related to appropriate utilization rates and cost-savings over time for the identified measures of care.

Progress Reporting

The EBC Tracking Initiative Progress Reports will be used to measure the process and intermediate outcomes measures. Examples of progress report question can be found in Appendix III.

V. Results

For the program year 2011, all of the 39 POs participated in the EBC Tracking Initiative including five Independent Associations (IPAs), 14 Physician Hospital Organizations (PHOs), and 20 physician organizations. The POs represented over 11,000 PCPs providing care for more than 1.8 million members. The number of PGIP POs participating in the EBC Tracking Initiative continues to increase since its inception in 2005 (Table 2, next page) and as new POs participate in PGIP.

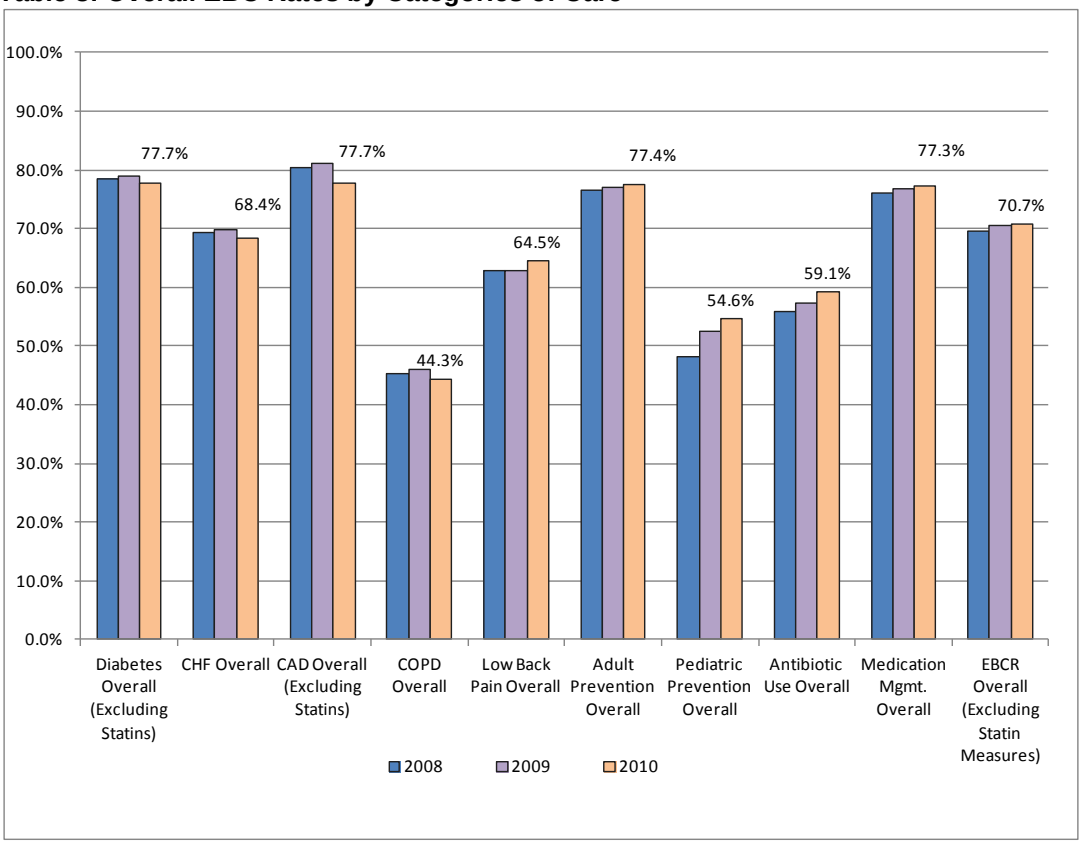
Table 2: PO participation in EBC Tracking Initiative

Program Year of Participation	Number of POs Participating in EBC Tracking Initiative
2008	31 out of 33
2009	32 out of 33
2010	33 out of 36
2011	39 out of 39

The 2011 EBC dashboard included 29 measures for payment with five measures selected for focused improvement. The EBC dashboard data was analyzed to determine if improvements occurred in calendar year (CY) 2010 compared to CY 2009. The overall rates for each of the thirty-nine POs participating in the EBC Tracking Initiative for CY 2010 ranged from a low of 62% to a high of 76.8% (excluding asthma and statin measures). The overall EBC composite score for 2010 was 70.7% with a benchmark average of 75.4%.

The CY 2010 composite scores for the nine categories of care experienced positive and negative fluctuations in performance compared to CY 2009 rates. Five of the nine specific categories of care exhibited an improvement in the overall rate, ranging from 0.2% to 3.8%, while four exhibited a decline in the rate (Table 3). The most probable cause for this change was the retirement of the statin use measure which historically, has had very high rates. The elimination of the statin measure especially impacted the category of care for overall Coronary Artery Disease (CAD). After excluding statins, the CAD category experienced an average rate change of -4.9% with the range of rate changes falling between a negative 18.4% and a positive 9.9% across all physician organizations.

Table 3: Overall EBC Rates by Categories of Care



The most commonly selected strategies for improving the EBC rates were the identification of physician outliers and aligning PO incentives with EBC indicators (Table 4 on next page) with most strategies being applicable for improvement across many of the PGIP initiatives. Over half of the POs selected the use of a registry as at least one of their strategies.

Table 4: Strategies Selected PY 2010

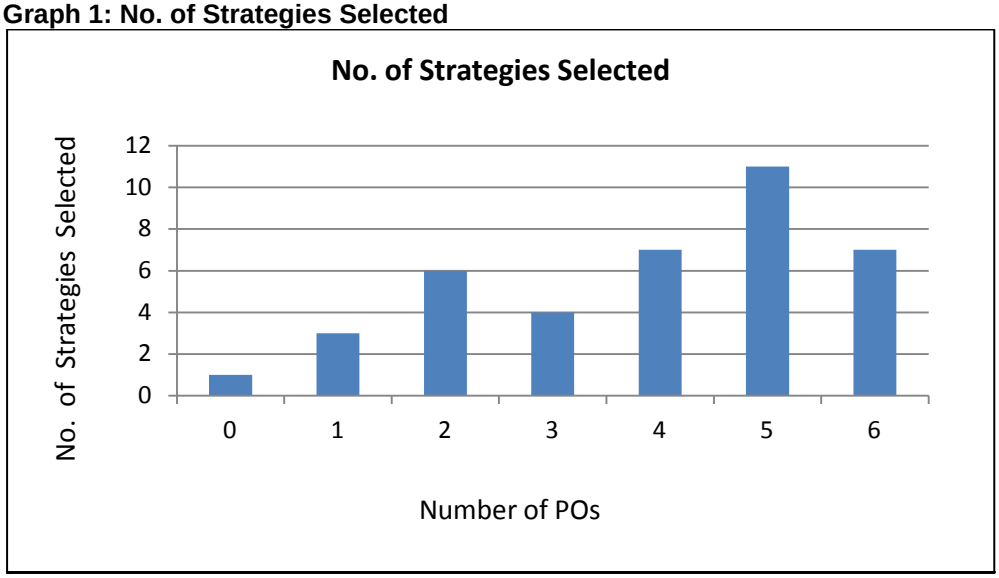
Strategies Selected	*No. POs*
Identify physician outliers	34
Align incentives with EBC	30
Flag patients with gaps in care	27
Web-based registry	24
Reminder system	21
Link EBC data with other payers	16

The EBC Tracking Initiative is designed to allow POs the opportunity to assist PUs with adjusting practice patterns to better incorporate evidence-based care for the identified EBC measures. The current use of the EBC dashboard appears to be best used by the PO as a reflection of improvements that were implemented during prior months or years. Physician Organizations' report using their own PO registry for "real time" assessment of patient care needs and sometimes use the monthly data feeds from BCBSM to validate their registry information. When in place, and effectively used, population management via a registry or similar technology is the most common source for actionable data while the EBC dashboard serves as a reflection of improvement trends resulting from interventions implemented in prior

time periods. In 2011, 26 of the 39 participating POs reported having a registry with the capability to identify gaps in care.

Of note is that more than half of the physician organizations used four or more strategies (Graph 1) to improve EBC rates. The majority (64%) of POs have also established a self-monitoring system to track and observe specific EBC measures.

Graph 1: No. of Strategies Selected

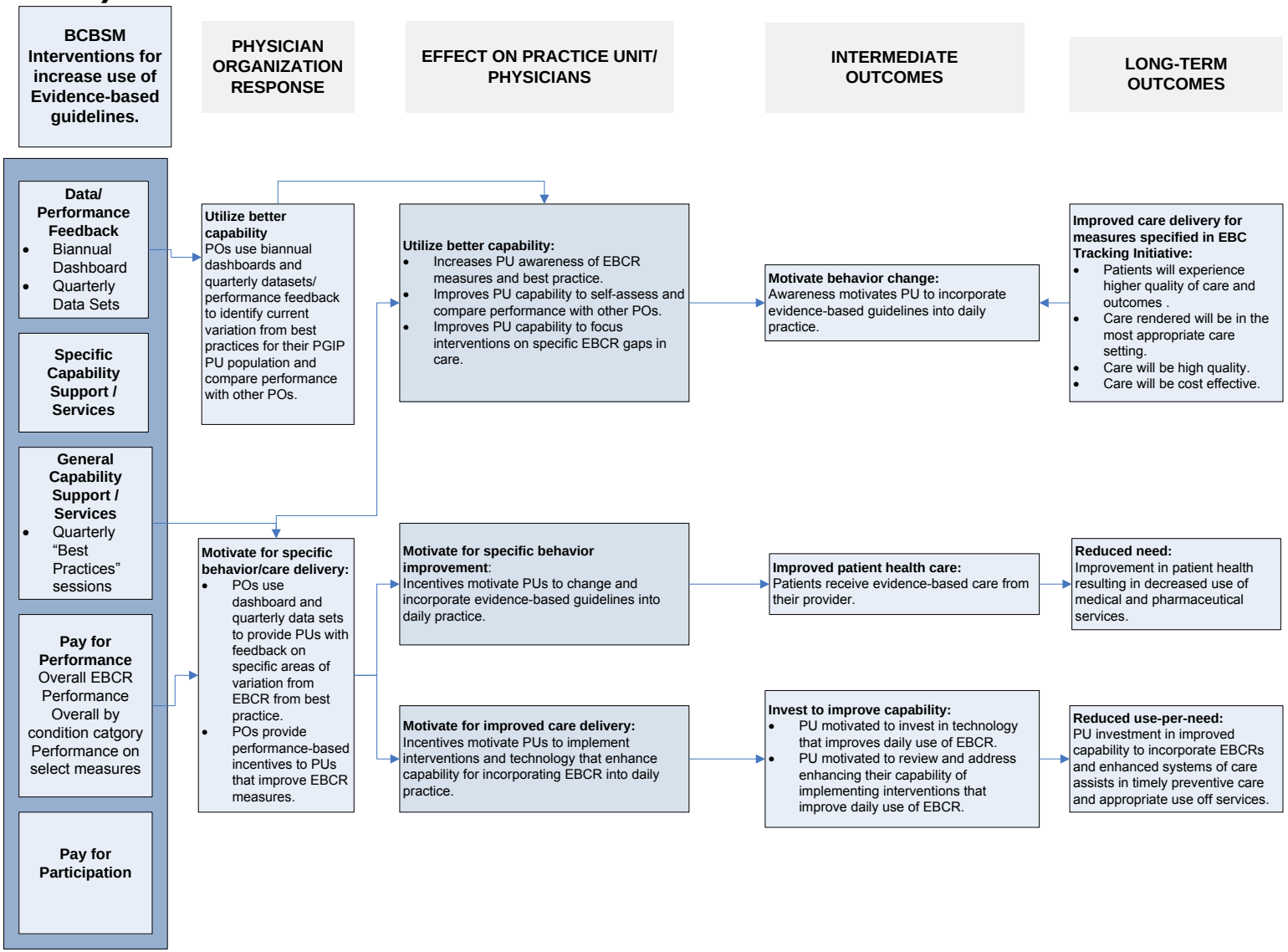


During the program year, BCBSM will continue to evaluate the EBC Dashboard Report for the relevancy of current EBC measures. Also, BCBSM will periodically examine the need for additional measures that reflect current clinical topics important to the health of BCBSM members.

Results of this initiative will be monitored for effectiveness and the outcomes shared with appropriate internal and external stakeholders such as executives, medical directors, PGIP POs and their partnering physicians, and PGIP leadership and staff. Evaluative reports will be tailored to the audience of interest with information pertaining to the decisions in which those stakeholders are involved.

Additionally, progress reports will be reviewed bi-annually to identify best practices for the purpose of spreading successful strategies to other participants in the initiative. Physician Organizations will be encouraged to share innovative approaches with their peers. Initiative progress and approaches used by POs will be disseminated to the PGIP leadership and summaries of results may be made available to other stakeholders as applicable.

Appendix I: PGIP EBC Tracking Initiative Cause and Effect Diagram (Intervention Model)



Appendix II: EBC Data Delivery Schedule

Report	*Distribution Date*	*Time Period of Claims*	*Data Specs Used*	*Physician List*	*Patient Attribution Period*
Quarterly Dataset	*02/28/2012*	*10/31/10-09/30/11*	*2011 EBCR*	*July 2011*	*07/01/09-06/30/11*
Semi-Annual Dashboard & Quarterly Dataset	*05/31/2012*	*01/01/11-12/31/11*	*2011 EBCR*	*January 2012*	*01/01/10-12/31/11*
Quarterly Dataset	*08/31/2012*	*04/01/11-03/31/12*	*2012 EBCR*	*January 2012*	*1/01/10-12/31/11*
Semi-Annual Dashboard & Quarterly Dataset	*11/30/2012*	*07/01/11-06/30/12*	*2012 EBCR*	*July 2012*	*07/01/10-06/30/12*

Appendix III: Evaluation Metrics

Process Measures

While long-term outcomes (such as improved patient outcomes and reduced overall medical and pharmacy costs) are goals of the EBC Tracking Initiative, the interventions are directed toward achieving short-term and intermediate goals that result in long-term outcomes. When short-term and intermediate goals are addressed, interventions may impact long-term goals by reducing the member's rate of use and/or likelihood of receiving inappropriate medical and pharmacy services. Demonstrated improvement in the short-term and intermediate goals for the EBC Tracking Initiative can theoretically then be attributed to long-term improvements related to better patient health outcomes, appropriate utilization of services, and cost savings.

The questions used to evaluate data use and resources required to implement interventions for this initiative are listed in Tables 1 and 2. This assessment is qualitative, but the responses to these questions may provide insight into what interventions elicit best practice by POs and PUs related to efficiency, staffing needs, and use of data. The questions are designed to evaluate processes and measures to best determine whether the EBC Tracking Initiative short-term and intermediate goals have been achieved.

Table 1: Evaluation of Short-term and Intermediate Goals

Category	Process	Data Source	Measurement	Outcome Measure
Initiative Team	Designated PO representative attends 90% of DUWG meetings.	Semi-annual Progress Report/DUWG attendance reports	1. How many POs attended the DUWG meetings? 2. How many meetings did the PO's designated DUWG attend?	1. Overall percent of PO attendance at DUWG meetings. 2. PO met/did not meet minimum attendance expectation.
Participation	PO Participation	PGIP Database	Number of POs that sign up for the EBC Tracking Initiative	Total number and percent of POs that sign up for participation in EBC Tracking Initiative
Potential Impact	PO BCBSM Member representation	CEB	How many BCBSM members are potentially impacted by PO participation in EBC Tracking Initiative?	Number and % of BCBSM members assigned a PCP relationship and the PCP's PO is participating in the EBC Tracking Initiative
Dataset Use	Data used to improve capability	Progress Report	Was the quarterly dataset opened by the PO? Y/N. If so: 1. Name and title of who opened dataset. 2. Date of dataset distribution i.e. Q110, Q210, Q310, and Q410.	Total number and percent of POs participating in EBC Tracking Initiative that opened their quarterly dataset.
Dataset Use	Data used to improve capability	Progress Report	Was the quarterly dataset opened by the PO shared? Y/N If so, who? 1. PO Leadership Y/N 2. PCPs Y/N	Total number and percent of POs that shared their datasets with: 1. PO Leadership 2. PCPs
Dataset Use	Data used to improve capability	Progress Report	For POs that shared their data, how was the data disseminated: PO: 1. Electronic 2. Verbal 3. Paper	Percent of POs that shared data via: PO: 1. Electronic 2. Verbal 3. Paper

Category	Process	Data Source	Measurement	Outcome Measure
			PCPs: 1. Electronic 2. Verbal 3. Paper	PCPs: 4. Electronic 5. Verbal 6. Paper
Dashboard Use	Data used to improve capability	Progress Report	Was the semi-annual dashboard report opened by the PO? Y/N. If yes: 1. Name and title of who opened dataset. 2. Date of dataset distribution i.e. May 2011 or Nov 2011.	Total number and percent of POs participating in EBC Tracking Initiative that opened their l dashboard report.
Dashboard Use	Data used to improve capability	Progress Report	Was the dashboard report opened by the PO shared? Y/N If so, who? 1. PO Leadership Y/N 2. PCPs Y/N	Total number and percent of POs that shared dashboard report with: 1. PO Leadership 2. PCPs
Dashboard Use	Data used to improve capability	Progress Report	For POs that shared dashboard report, how was the data disseminated? PO: 1. Electronic 2. Verbal 3. Paper PCPs: 1. Electronic 2. Verbal 3. Paper	Percent of POs that shared dashboard report with: PO: 1. Electronic 2. Verbal 3. Paper PCPs: 1. Electronic 2. Verbal 3. Paper
Dashboard Use	Data used to improve capability and Extent of PO assistance to PU	Progress Report	For POs that open the dashboard and dataset reports, select all that apply: • Our PO validates our registry data for accuracy • Identify clinical topics in need of focused improvement among our PUs • Identify improvement opportunities for individual PUs or physicians • Other (text field)	Number of POs using each strategy correlated with PO Overall EBC rates.
Dashboard Use	Data used to improve capability and Extent of PO assistance to PU	Progress Report	Based on improvement opportunities our PO identified from our EBC dashboard, our PO assisted specific practice units with implementing strategies for adopting evidence-based care into their practice in the following way (select all that apply): • identified strategies for the PU on how to adopt evidence-based care into their daily practice	Number of POs using each strategy correlated with PO Overall EBC rates.

Category	Process	Data Source	Measurement	Outcome Measure
			(give examples) • On-site visit to offices to discuss improvement strategies • Providing data reports that highlight the PU's opportunities the for improvement • Communicates with PUs via newsletters that provide information on data and evidence-based practices • Our PO sends patient reminders for preventive care on behalf of the PU • Our PO provides PUs with list of patients in need of or missing preventive services • Other (text field)	

Table 2: Evaluation of intermediate outcomes

Category	Process	Data Source	Measurement	Outcome Measure
Communication \Building Infrastructure	Communicates initiative objectives and EBC measures (all measures and the annual focus measures) to PUs	Progress Report	Question: Our PO communicates the initiative objectives and annual focus measures to PUs. • Yes • No	Number and % of participating PGIP POs that communicate the initiative objectives and focus measures to PUs
			Question: Our PO communicates the initiative objectives and annual focus measures in the following ways: 1. Distribute PGIP EBC document 3. Send a summary of the PGIP EBC document 4. Communicated via a PO newsletter to PU 3. Other. Please describe.	Number and % of for each type of method used for communication

Category	Process	Data Source	Measurement	Outcome Measure
Improve performance for EBC Tracking Initiative compared to previous 12-month period	Increase in percent of PGIP POs with overall EBC performance of 80% or greater	Semi-annual Dashboard Report	PGIP overall EBC performance score for all measures on which incentive payment is based	Percent for Overall PGIP
	Increase in percentage improvement for each category of care.	Semi-annual Dashboard Report	PGIP overall EBC performance score by each disease/condition/care category	Percentage improvement by disease/condition/ care category
	No decrease in performance by any PO for any individual EBC measure	Semi-annual Dashboard Report	PGIP EBC performance score by measure	Percent by measure for each PO
	Collaborate with other POs to adopt "Best Practices" for EBC performance improvement	Progress Report	Question #: Have you collaborated with another PGIP PO to adopt a "Best Practice" to improve EBC performance? • Yes • No	Number and % of participating PGIP POs that collaborated with another PGIP PO to adopt a "Best Practice"
			If yes, please describe "Best Practice" adopted and for which measure(s)	Description
	Communicate key performance rates to PUs	Dashboard	Question #: Do you communicate key performance rates to your PUs? • Yes • No	Number and % of participating PGIP POs that reported they communicated key performance rates to PUs
			If yes, how often?	Number and % by frequency
			If yes, what is the method of communication?	Number and % of participating PGIP POs that reported a method of communication by communication method

Category	Process	Data Source	Measurement	Outcome Measure
	Develop performance score targets based on actual performance rates	Progress Report	Question #: Do you develop and communicate to your PUs performance score targets based on actual current performance? • Yes • No	Number and % of participating PGIP POs that reported developing and communicating performance score targets
			If yes, how are these performance score targets established?	Number/percent of by method for POs responding "yes".
Increase overall PGIP performance on annual focus measures	Increase in each focus measure as compared to a prior 12-month period	Semi-annual Dashboard Report	Overall increase in the PGIP performance for each focus measure	Percent by focus measure
Increase number of PGIP POs that use a patient registry	Increase number of POs that report the use of a patient registry to meet the goals of the EBC Tracking Initiative	Semi-annual Dashboard Report	Question #: Do you have a patient registry in place? • Yes • No	Number and percent of POs with a patient registry in place
	Increase number of POs that identify a disease-specific registry	Semi-annual Dashboard Report	Question #: Do you have disease-specific registries? • Yes • No	Number and percent of POs with a disease-specific patient registry in place
			If yes, indicate the disease(s).	Number of disease-specific registries by disease
			How often are these updated? - annually - quarterly - other (describe frequency)	Number of responses by type of response?

Long-term Outcomes

Through implementation of the EBC Tracking Initiative, the intermediate steps in the causal pathway addressed by the intervention are expected to lead to a change in long-term distal outcomes. Table 3 provides examples of a potential long-term outcomes evaluation. These outcomes will be developed more fully in collaboration with CEB.

Study population: Data will be included for all members, ages 0 to 64 years, who are assigned a care relationship with a PGIP PCP that is part of a PO that elects to participate in the EBC Tracking Initiative. Physician panels established by the claims-based assignment of physician relationships will be an aggregated number by PO and PU. Analysis of specific populations within the EBC Tracking Initiative may vary by measure based on age category (i.e., adults versus pediatrics) and chronic condition (e.g., diabetes). Development of the long-term evaluation plan is yet to be determined.

Data Source: The PCP relationships that form the denominators of the indicators of interest will come from the claims-based PCP relationship assignment process, currently implemented semi-annually (March, September). Membership files will be linked to the PCP relationships file to provide demographic information and prospective risk information used for risk adjustment. The PGIP physician files contain information on relationships between physicians, PUs, and physician organizations. The PGIP physician file is updated semi-annually (January, July) with self-reported information from the respective physician organizations.

Main outcome: Improvement in quality indicators due to PGIP participation in the EBC Tracking Initiative.

Study Design: Evaluation of the EBC Tracking Initiative is still under development, but it will most likely incorporate a design consisting of a comparison in the rate of change among the EBC measures for PGIP participating physicians as compared to non-PGIP physicians. Historical performance data for the EBC measures will be used to form the basis of an existing secular trend in EBC Tracking Initiative services utilization prior to implementation of the Initiative in both participating and nonparticipating Physician organizations.

The limitation in developing an evaluation model is in identifying a method to determine whether specific financial incentives provided by BCBSM were the driving force behind improvements made by POs who participated in this specific initiative. Selection bias may skew evaluation findings in two ways:

- POs participating in the EBC Tracking Initiative may have been more likely to join this initiative because of existing efforts to include EBC guidelines in their practices
- POs physicians who participate in other PGIP initiatives that may indirectly result in improved EBC performance

Covariates:

Covariates are yet to be determined but most likely will include potential confounding variables in the relationship between PCPs participating in the EBC Tracking Initiative and overall services, cost, and trend in cost related to the services rendered in the Initiative:

- Age distribution of members assigned care relationships with PCPs
- Gender distribution of members assigned care relationships with PCPs
- Risk score distribution (as a proxy for general health) of members assigned care relationships with PCPs
- Disease severity of the population mix attributed to the PCPs based on the clinical information input
- Pre-existing knowledge of best practices related to the treatment of the members included in the EBC Tracking Initiative
- Participation in other PGIP initiatives where there is overlap between measures and/or goals

Table 3: Potential Indicator Measures of Long-term Outcomes

Objective	Type of Outcome	Outcome Measure	Description
Reduce overall healthcare costs by PGIP PO-attributed members represented by the EBC Initiative	Financial	- Reduce overall PMPM - Reduce PMPM for ED - Reduce PMPM for inpatient	Members included in the EBC attributed population exhibit a reduction in PMPM--overall, ED and inpatient
Reduce ED services use	Quality of Care	- Reduce the rate of ED visits	Members included in the EBC attributed population exhibit a reduction in ED rates
Reduce inpatient admission rate	Quality of Care	- Reduce the rate of inpatient admissions	Members included in the EBC attributed population exhibit a reduction in admission rates
Improve overall pharmacy use and reduce unnecessary costs	Financial	- Improve the rate of appropriate prescription use - Improve the PMPM for prescription cost	Members included in the EBC attributed population exhibit improvement in the appropriate use of pharmaceutical services

Appendix IV: Vendor Solutions

As of April 2010, NCQA has fully certified thirteen Healthcare Effectiveness and Data Information Sets (HEDIS) software vendors. Below is a sample with a description of the vendor's software solution.

Company	Solution Description(s)
Austin Provider Solutions Website: www.austinps.com/hedis.cfm	• ***DUET - Data Upload Execution Tool*** is web-based software that maps, uploads and evaluates source data. It monitors data collection progress and produces automated data integrity reports for each data set. • ***HEDISLinx*** is an online portal with tools that provide real-time access to Measures, Metrics, Rates and comparisons. Reports HEDIS results for each product line (Medicare, Medicare Special Needs Plans, Medicaid, Commercial HMO and PPO, etc.) • ***RISE – Rate Improvement System and Evaluation -*** optional **RISE** module is a specialized intervention process for systematically implementing rate improvement strategies. RISE targets opportunities to proactively improve your rates, and features HEDIS rate reporting over different time periods, including rolling monthly and quarterly reports.
Catalyst Technologies, A MedAssurant solution Website: www.medassurant.com/catalyst-quality-spectrum.aspx	• **Quality Spectrum Insight ("QSI"):** SQL-based HEDIS reporting. Using a fixed data model, QSI software allows client programmers to quickly define native data sources into the formats required by the system. • **Quality Spectrum Focused Insight ("QSFI"):** (Restricted feature HEDIS reporting software –defined data set) • **Quality Spectrum Pay for Performance ("QSP4P"):** Physician quality measurement for both MCO and MMG clients. For health plans, Catalyst offers provider-specific measure sets that can be run within QS and add-on modules to QSI that allow MCOs to define complex logic to attribute member-level outcomes to specific physicians. For physician groups, Catalyst provides physician quality measures within the QSFI framework to allow MMGs to monitor their own performance and maximize incentive payouts. • **Physician Quality Measurement:** Module designed to report and compare rates for provider groups, employers, individual PCPs, geographic regions, and other small member groups.

Q Mark, Inc.
 	
Website:
www.qmarkinc.com
	• **HEDISHelp**
	  o Offers a flexible, robust importing process, including code mapping, data integrity checks, and the ability to append data
	  o Allows for reporting of administrative and hybrid rates in many ways, including product type, payer type, contract, eligibility type, and provider organization
	  o Produces NCQA standard and custom samples for hybrid medical record review
	  o Provides trending and benchmarking comparisons
	  o Exports member-level data at the click of a button
	• **HYBRIDHelp**
	  o Full bi-directional data synchronization, including replication to and from computers
	  o Seamless integration with HEDIS software
	  o Supports multiple provider locations to support desired chase parameters
	  o Search capabilities to any record by member, provider, location, and measure
	  o On-line edits to increase accuracy and completeness
	  o Automatically calculates HEDIS measure compliancy

	o Extensive on-line help including HEDIS measurement guidance Integrated o Inter-Rater Reliability auditing capabilities and reporting
TransUnion Healthcare Solutions Website: www.managedcare.com	• ManagedCare.com HEDIS reporting services fully-integrated with general reporting, physician profiling, and Program Management Tool. • Supports pay-for-performance and State-level reporting requirements, including non-claims administrative measures. These tools include customized dashboard presentations, organizational outcomes tracking, and comparative reporting to contrast plan-specific quality data with national norms from client database of over 100 MCOs and 10 million enrolled lives. • Provides a wide range of non-HEDIS quality reporting to dozens of MCOs across the Country. • Contracting model allows managed care organizations to conserve critical resources and out-source any or all elements of the annual HEDIS reporting process.
Top Physician Office EHR Vendors*	• Epic • Allscripts • EClinicalWorks • NexGen • SOAPWare • Other Vendors • GE Centricity • Practice Fusion ***Based on market share analysis from May 2010 survey of 512,000 office-based physicians at SoftwareadviceWare.com. Limitations are that survey excludes VA and Indian Health Services.*** http://www.softwareadvice.com/articles/medical/ehr-software-market-share-analysis-1051410/
Verisk Health Website: www.veriskhealth.com/products/verisk-health-hedis-solutions	• Analyze claims data, enter medical record data and submit data to NCQA • View, query, analyze and measure HEDIS data using standard or custom specifications, filters or drills • Calculate HEDIS measures • Collect HEDIS administrative and hybrid medical record data • Develop custom measures for individual clinical reporting initiatives • Export measures into Sightlines™ Enterprise Analytics and Sightlines™ Medical Intelligence platforms to support integrated quality measures across the care management continuum • Chart Review Tools • Quality Reporter • Web Portal
ZynxAmbulatory - Zynx Health	ZynxAmbulatory supplies the evidence-based order sets and clinical decision support rules required by the American Recovery and Reinvestment Act of 2009 (ARRA), and helps outpatient providers become meaningful users of electronic health records (EHRs) by incorporating quality measures from the Centers for Medicare & Medicaid Services into actionable clinical content. ZynxAmbulatory provides clinical decision support for more than 100 diseases and conditions most frequently seen in a primary care setting. http://www.zynxhealth.com/Solutions/ZynxAmbulatory.aspx

Appendix V: 2012 Dashboard Measures

Evidenced Based Care Tracking Initiative	
Current EBC Dashboard Measures	**Measure Source**
Adult Prevention	
1 Breast Cancer Screening *(50-64 years of age)*	HEDIS (modified)
2 Cervical Cancer Screening	HEDIS
Antibiotic Use	
3 Appropriate Treatment for Children with an Upper Respiratory Infection	HEDIS
4 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	HEDIS
Child/Adolescent Prevention	
5 Adolescent Well Care Visits	HEDIS
6 Adolescent Immunizations	HEDIS
7 Childhood Immunization Status	HEDIS
8 Well Child Visits in the First 15 Months of Life	HEDIS
9 Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	HEDIS
10 Appropriate Testing for Children with Pharyngitis ***NEW 2012***	HEDIS
Chronic Obstructive Pulmonary Disease (COPD)	
11 Use of Spirometry Testing in the Assessment and Diagnosis of COPD	HEDIS
Congestive Heart Failure (CHF)	
12 Rate of ACE/ARB	BCBSM
13 ACE/ARB Continuation and Persistence	BCBSM
Coronary Artery Disease (CAD)	
14 Persistence of Beta-Blocker Treatment After a Heart Attack	HEDIS
15 LDL-C Screening	BCBSM
16 Lipid Lowering Drug Rate	BCBSM
17 Atrial Fibrillation/Atrial Flutter: Chronic Anticoagulation Therapy	ACC/AHA
18 INR Monthly Testing for Patients with Atrial Fibrillation on Warfarin	ACC/AHA
19 Participation in Cardiac Rehabilitation Following a Qualifying Cardiac Event	ACC/AHA
Diabetes	
20 HbA1c Testing	HEDIS
21 LDL-C Screening Test	HEDIS
22 Monitor for Nephropathy	HEDIS
23 Lipid Lowering Drug Rate	BCBSM
24 ACE/ARB Use with Comorbid CHF	BCBSM
25 ACE/ARB Use with Comorbid Nephropathy	BCBSM
26 ACE/ARB Use with Comorbid Hypertension	BCBSM
Low Back Pain	
27 Use of Imaging Studies for Low Back Pain	HEDIS
Medication Management	
28 Antidepressant Medication Management	HEDIS
29 Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis ***NEW 2012***	HEDIS
30 Medication Management: Annual Monitoring for Patients on Persistent Medications	HEDIS
31 Follow-Up Care for Children Prescribed ADHD Medication	HEDIS (modified)

Appendix VI: Summary of Changes 2012

Measure	Changes to 2012 EBCR Measures
General Changes	
	• Allowable enrollment gap in coverage increased to 45 days • Upper age limit for applicable measures lowered to 64 to reflect PGIP attributed population
Adult Prevention	
Breast Cancer Screening	• Please refer to "Summary of Measures, Product Lines, and Changes" for HEDIS 2012 available at ncqa.org*
Cervical Cancer Screening	• Please refer to "Summary of Measures, Product Lines, and Changes" for HEDIS 2012 available at ncqa.org* • Lower age limit modified to reflect HEDIS specification
Antibiotic Use	
Appropriate Use for URI in Children	• Please refer to "Summary of Measures, Product Lines, and Changes" for HEDIS 2012 available at ncqa.org*
Appropriate Use for Bronchitis in Adults	• Please refer to "Summary of Measures, Product Lines, and Changes" for HEDIS 2012 available at ncqa.org*
	•Eligible population modified to reflect HEDIS specification
Child/Adolescent Prevention	
Adolescent Immunization	• Please refer to "Summary of Measures, Product Lines, and Changes" for HEDIS 2012 available at ncqa.org*
Childhood Immunization Status	• Please refer to "Summary of Measures, Product Lines, and Changes" for HEDIS 2012 available at ncqa.org*
	•Requirements for Hepatitis B vaccinations modified to reflect HEDIS specification
Well Child Visits (all three cohorts)	• Please refer to "Summary of Measures, Product Lines, and Changes" for HEDIS 2012 available at ncqa.org*
Appropriate Testing for Children with Pharyngitis	• New for 2012**
COPD	
Use of Spirometry in Assessment & Diagnosis of COPD	• Please refer to "Summary of Measures, Product Lines, and Changes" for HEDIS 2012 available at ncqa.org*
Congestive Heart Failure	
Rate of ACE/ARB	• Deleted UB Revenue codes 022x, 077x • Exclusion criteria revised • Identified contraindications • Drug list updated
ACE/ARB Continuation and Persistence	• Deleted UB Revenue codes 022x, 077x • Contraindications modified to reflect relative and absolute contraindications • Evidence of Outpatient visits, ED visits, and pharmacy removed from Eligible population • Drug list updated

Appendix VI: Summary of Changes 2012 (continued)

Measure	Changes to 2012 EBCR Measures
Coronary Artery Disease	
Persistence of Beta Blocker Treatment after an AMI	• Please refer to "Summary of Measures, Product Lines, and Changes" for HEDIS 2012 available at ncqa.org*
LDL-C Screening	• Deleted UB Revenue codes 022x, 077x • ICD-9 Diagnosis Codes aligned across all CAD measures • Numerator criteria modified • Removed 33410 from "Codes to Identify PTCA" • Diagnosis criteria modified
Lipid Lowering Drug Rate	• Deleted UB Revenue codes 022x, 077x • ICD-9 Diagnosis Codes aligned across all CAD measures • Lipid Lowering Drug List updated
Warfarin (brand name Coumadin) Use with Atrial Fibrillation	• No changes to this measure
INR Monthly Testing for Patients with Atrial Fibrillation on Warfarin	• No changes to this measure
Participation in Cardiac Rehabilitation Following a Qualifying Cardiac Event	• Denominator criteria modified • Numerator criteria modified
Diabetes	
HbA1c Testing	• Please refer to "Summary of Measures, Product Lines, and Changes" for HEDIS 2012 available at ncqa.org*
LDL-C Screening	• Please refer to "Summary of Measures, Product Lines, and Changes" for HEDIS 2012 available at ncqa.org*
Monitor for Nephropathy	• Please refer to "Summary of Measures, Product Lines, and Changes" for HEDIS 2012 available at ncqa.org*
Lipid Lowering Drug Rate	• No changes to this measure
ACE/ARB Use with Comorbid CHF	• Exclusion criteria revised
ACE/ARB Use with Comorbid Nephropathy	• Exclusion criteria revised
ACE/ARB Use with Comorbid Hypertension	• Exclusion criteria revised
Low Back Pain	
Use of Imaging Studies	• Please refer to "Summary of Measures, Product Lines, and Changes" for HEDIS 2012 available at ncqa.org*
	• Age range for eligible population modified to reflect HEDIS specification
Medication Management	
Antidepressants	• Please refer to "Summary of Measures, Product Lines, and Changes" for HEDIS 2012 available at ncqa.org*
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	• New for 2012**
Annual Monitoring for Patients on Persistent Medications	• Please refer to "Summary of Measures, Product Lines, and Changes" for HEDIS 2012 available at ncqa.org*
Follow-Up Care for Children Prescribed ADHD Medication	• Please refer to "Summary of Measures, Product Lines, and Changes" for HEDIS 2012 available at ncqa.org*

BCBSM reserves the right to reinstate retired and/or deleted measures should there be noticeable changes in performance. In addition, BCBSM reserves the right to add or change current EBC measures should significant changes in health care guidelines occur.

Appendix VII: EBC Tracking Initiative Enhanced Scoring Method

Introduction

The Blue Cross Blue Shield of Michigan (BCBSM) Evidence Based Care (EBC) Tracking Initiative is part of the Physician Group Incentive Program (PGIP). With the inception of the EBC initiative in 2005, PGIP began providing encouragement and financial incentives for physicians to more effectively manage populations of patients and build an infrastructure to more robustly measure and monitor the quality of care. In 2008, it was determined that PO improvement on the EBC Initiative had become notably slow-moving. To maximize overall EBCR improvement, PGIP began indentifying five "focus measures" for additional outreach efforts. Focus measures were identified on the basis of low overall scores and/or large variance across PO participants. With the introduction of "focus measures", POs have shown additional improvement. However, the improvement still remains less-than-optimal and inconsistent across all initiative participants.

To address all the above concerns, PGIP has examined various approaches to improve the existing scoring model for the EBC Initiative. After a thorough review, an enhanced initiative scoring model has been developed on the basis of the principles listed below:

1. Provide POs with a framework to identify significant improvement opportunities that are unique to their patient population.
2. Incent PO improvement on measures that make significant impact on POs' overall score and population health.
3. Score POs on both overall performance and improvement on EBC measures.
4. Supplement POs' outreach efforts and population health management strategies.

Beginning January 2012, every PO participating in the EBC Initiative will receive a biannual "Normalized Impact Factor" (NIF) Report. The NIFs are specific for every PO and are calculated for each EBC measure excluding the new measure for Medication Management: Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis. Using NIFs as a guide, POs can focus their outreach efforts to achieve maximum impact on their population. PGIP will incorporate the NIFs into the calculation of EBC scores. A description of the NIF and the EBC Composite Score calculation is provided below.

Normalized Impact Factor (NIF)

The 2012 EBC Initiative will have 31 measures. A NIF is calculated for every PO and each EBC measure as follows:

1. **Calculate the Population Impact for each EBC measure.** For example, in the case of the "Adolescent Well Care" measure, if PO_A has 32,000 total attributed patients, and 3,000 of those patients are eligible for the care as specified by the criteria for that measure, the percentage of total PO population affected by "Adolescent Well Care" would be:

Population Impact: 3,000/32,000 = 9.375%

2. **Determine the Percent Difference between PO's performance and PGIP average benchmark.** For example, the percent difference between PO_A's current performance on "Adolescent Well Care" and the PGIP average benchmark score is determined as follows: If PO_A scored 50% on "Adolescent Well Care" measure, and the current PGIP benchmark for this measure is 65%, then the absolute percent difference would be:

   Percent Difference: (65% - 50 %) / 65% = 0.23 or 23%

3. **Calculate the Raw impact factor.** The *raw impact factor* is a product of the *Population Impact* for each measure multiplied by the *Percent Difference* between PO performance and the PGIP average benchmark for that particular measure. So in the above example,

   *Raw Impact Factor for PO_A: = 9.375 * 23 =* ***215.625***

   (Note: For any measure where POs performance is greater than the average benchmark, the Raw Impact factor is set to zero. The percentages are excluded for simplicity in the above calculation.)

4. **NIF calculation.** After the raw impact factor is calculated for every EBC measure for PO_A, the NIF for each EBC measure is determined by calculating the ratio of raw impact factor for the measure and the sum of all the raw impact factors for PO_A. In the above example, if the sum of all raw impact factors for PO_A = 480, then:

   Normalized Impact Factor: "Adolescent Well Care" = (215.625/480) *100 = **44.9**

How to use NIFs

The sum of all NIFs will always be 100. The NIFs will vary by EBC measure and PO, based on the unique opportunity of each population.

- A high NIF implies that either a significant portion of the PO's population is affected by that measure and/or there is a significant opportunity for improvement on that measure.
- A low or zero NIF implies that the PO's current performance is at or above the PGIP benchmark for that measure and/or the measure affects an insignificant portion of the PO's population.

This is the type of information that each PO will biannually receive based on their PO specific NIF report. By using NIFs, a PO can determine the areas where they have significant opportunity for population impact if notable improvement occurs. So, using the above example with Adolescent Well Care, PO_A, through use of the NIF report, can more easily determine that there is a notable opportunity to make outreach efforts to make sure their adolescent members

are getting into the office, and once in the office, their disease registry will provide the clinical staff all the information they need to address gaps in care. The first step is therefore, understanding where there may be opportunities that would most positively impact the overall healthcare delivery to the PO's attributed population, and ultimately the PO's overall EBC score.

Calculation of EBC Composite Score

The EBC Composite Score (total 100 points) for every PO will contain two components:

1. The Overall Performance Score (50 total points)
2. The Overall Improvement Score (50 total points)

The Overall Performance Score for a PO is the average of all the performance scores on all the EBC measures. The Overall Improvement Score for a PO is the weighted average of all the individual improvement scores on all EBC measures. The NIFs for the PO will be used as the weights for the Overall Improvement Score. Therefore, improvement on a measure with a higher NIF will be weighted more heavily in the Overall Improvement Score and vice versa.

Additional information about the NIF report, including guidelines to interpret and implement the NIFs, will be made available to POs in January 2012. Additionally, PGIP will conduct a webinar in January 2012 to educate the PO community and address questions about the payment model.

Appendix VIII: PGIP Initiative Contacts

For additional information on the EBC Tracking Initiative, please contact one of the following individuals:

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Endnotes

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