

Moving FORWARD

In the last issue of this Forum we made reference to the GRIPA Accountable Care Medical Program (ACMP) in relation to the Patient Outreach Report. In this issue we hope to provide more details to the ACMP “canvas”.

In this competitive market of health care contracting there is a distinct advantage to the provider network which can distinguish itself from the general provider population by demonstrating, using outcomes data, performance superior to the norm. GRIPA, using its proprietary analytics software and the practice management data submitted by all our member providers, coupled with lab and claims data where available, is able to graphically represent our/your network performance. Having developed this capability over the past few years, it is now time to refocus our efforts on distinguishing our outcomes performance.

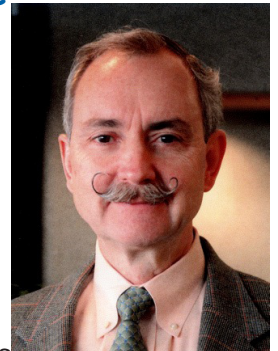
This is where the ACMP: Cardiac Risk Management, Chronic Condition Management, and Diabetes Prevention, comes to the fore. GRIPA administrative staff and Care Management Services, in collaboration with your Clinical Integration Committee, have identified a relevant, manageable, set of conditions judged most serviceable to:

1. Improve care for those patients representing the most immediate, greatest, risk for complications and consuming the most resources.
2. Enhance providers’ understanding and appreciation of the utility and potential of the GRIPA Connect portal: e.g. Patient Outreach Reports.
3. Sharpen our focus on those conditions whose improved management will best serve to distinguish our results in the current “performance” arena.
4. Create the necessary foundation for the providers to succeed in the pay for performance environment and allow GRIPA to sign additional contracts on behalf of our physician and hospital owners.

Accept it or not, the fact is that the medical payment model is rapidly migrating away from “fee for service” to pay for performance “P4P”. **Your Clinical Integration Program is well positioned to support and represent your performance. BUT... organization and collaboration are key. This is**

impossible without your active participation.

Towards this end: physician support, the Patient Outreach Report improves the quality of care by identifying to providers, those patients out of compliance with guideline-directed care: appropriate office visits or treatment goals. Accruing from this is a secondary benefit of adding to practice revenues by reaching out to these patients and filling “gaps in the schedule” most efficiently; as appropriate care indicates. To demonstrate, we ran a test sampling of one physician’s practice with the selection criteria focusing around just the ACMP conditions and associated measures.



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In this sample were identified 260 patients who did not meet the quality measure (s) established by the clinical guideline (s) addressing their condition(s). **This would indicate there is a significant population of patients in our community with, or progressing toward, a chronic illness who will benefit from seeing their physician and receiving appropriate care.** GRIPA Care Management Services, in conjunction with the PCP office staff, reach out to contracted members in need of care to successfully schedule them for visits or lab tests as necessary.

The ACMP, in order to most effectively produce the data to distinguish our performance from the rest of the community and avoid diluting effort over the entire population under our care, limits its focus to only those patients currently encompassed by contracts we have with: LiDestri Food and Beverage, RGHS, Paychex, Essence, and Wellcare. Once we have proven the model we will look toward broadening the patient pool.

We invite your opinions.

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