Field Notes

North Dakota MediQHome of BlueCross BlueShield

Problem:

North Dakota identified a need to enhance the delivery, efficiency, and quality of health care to combat chronic conditions, including hypertension.

Project:

MediQHome, based on the patient-centered medical home model, is designed to improve quality of care through collaborative decision-making, coordination of patient care, and use of a clinical information management system.

For more information please contact

Centers for Disease Control and Prevention
1600 Clifton Road NE
Atlanta, GA 30333
Telephone: 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348
Email: cdcinfo@cdc.gov
Web: http://www.cdc.gov

Overview

MediQHome was created in 2007 to improve quality of care and blood pressure control for patients with hypertension. The program grew out of the Diabetes Provider Report Card, an initiative that led to significant improvements in the quality of care delivered to patients with diabetes. Through the combined efforts of the North Dakota Heart Disease and Stroke Prevention Program, BlueCross BlueShield of North Dakota (BCBSND), and the North Dakota Diabetes Prevention and Control Program, MediQHome encourages providers to implement a patient-centered medical home model and to use MDInsight, a tool designed to measure the quality of clinical care. MDInsight uses a set of clinical measures and benchmarks for patients with chronic conditions and allows providers to monitor the delivery of care to their patients.

Key elements of the MediQHome program include

- Insurance provider sponsorship and buy-in.
- Providers who participate in a patient-centered medical home.
- A clinical information management system.
- Inclusive patient participation (regardless of payer or illness).
- Quality-based incentives.

BCBSND provides funding for key program areas that include monetary incentives for providers, training, implementation support, and a portion of the chronic disease management position. BCBSND also delivers case management services, which are handled by a team of care coordinators and health coaches. This team provides quality improvement coaching to each clinical site by reviewing the clinic's blood pressure data, identifying opportunities for improvement, and providing tools and resources to improve care. BCBSND proactively identifies the most at-risk patients and helps providers avoid adverse events, such as heart attacks and strokes.

Field Notes (cont.)

Goals and Expected Outcomes

The principal goal of MediQHome is to improve patient health outcomes in all disease areas, with a specific focus on increasing hypertension control to 70% or more among adults who have the condition. Expected outcomes of the program include lower health care costs, better access to care, more appropriate and efficient use of the health care system, improved quality of care by providers, and healthier behaviors among patients.

Intended Participants

The primary intended participants of MediQHome are providers that opt-in to the BCBSND insurance plan and participate in the patient-centered medical home. The intended program beneficiaries are all patients tracked in MDInsight that belong to a medical home.

Progress Toward Implementation

MediQHome progressed from a pilot program in 2007 to a statewide initiative in 2009. As of June 2012, approximately 75% of providers in North Dakota participate in MediQHome. BCBSND continues its efforts to market the program and recruit providers who do not currently participate.

Reach and Impact

More than 76% of BCBSND patients are assigned to a patient-centered medical home. A unique aspect of MediQHome is that MDInsight includes data from a participating provider's entire patient population, regardless of each patient's insurance provider. Therefore, providers can monitor delivery of care not only among BCBSND-insured patients, but also among those who receive Medicare or Medicaid benefits or who have any form of payment.

When the program expanded to include patients with coronary artery disease, cost savings from fewer emergency room visits and unplanned admissions increased from $500 to $1,200 per patient per year from 2005 to 2007. The savings in health care costs allowed BCBSND to shift resources to other program activities.

Other program outcomes are similarly promising. Quality of care scores for cardiovascular disease care measures have steadily improved from 14.7% in 2009 to 27.9% in 2012. During the same time period, the proportion of adults with their blood pressure controlled improved from 63% to 67.4%.

Lessons Learned

- **Provider engagement:** A critical element of success was the active involve-ment of providers in developing quality measures for assessing clinical care improvements. Representatives from the North Dakota Department of Health, state legislators, and a BCBSND member worked together to establish goals that fostered buy-in and ownership.
- **Data use:** Providers wanted to better understand how the clinical data were being used. Eventually, providers also wanted to be more transparent and compare notes with top-scoring clinics to identify best practices.
- **In-person trainings:** BCBSND discovered that remote training was not an effective way to show providers how to interpret and use their data. BCBSND now orients providers with a site visit using a detailed "advance-boarding" process.

Providers have started changing the way they deliver care and now have funds to do things they couldn't before.

MediQHome has changed the way BCBSND works. Case management was retrospective; now BCBSND can identify and manage the most at-risk patients before an adverse event occurs.