Measures for a New Model of Ambulatory Care

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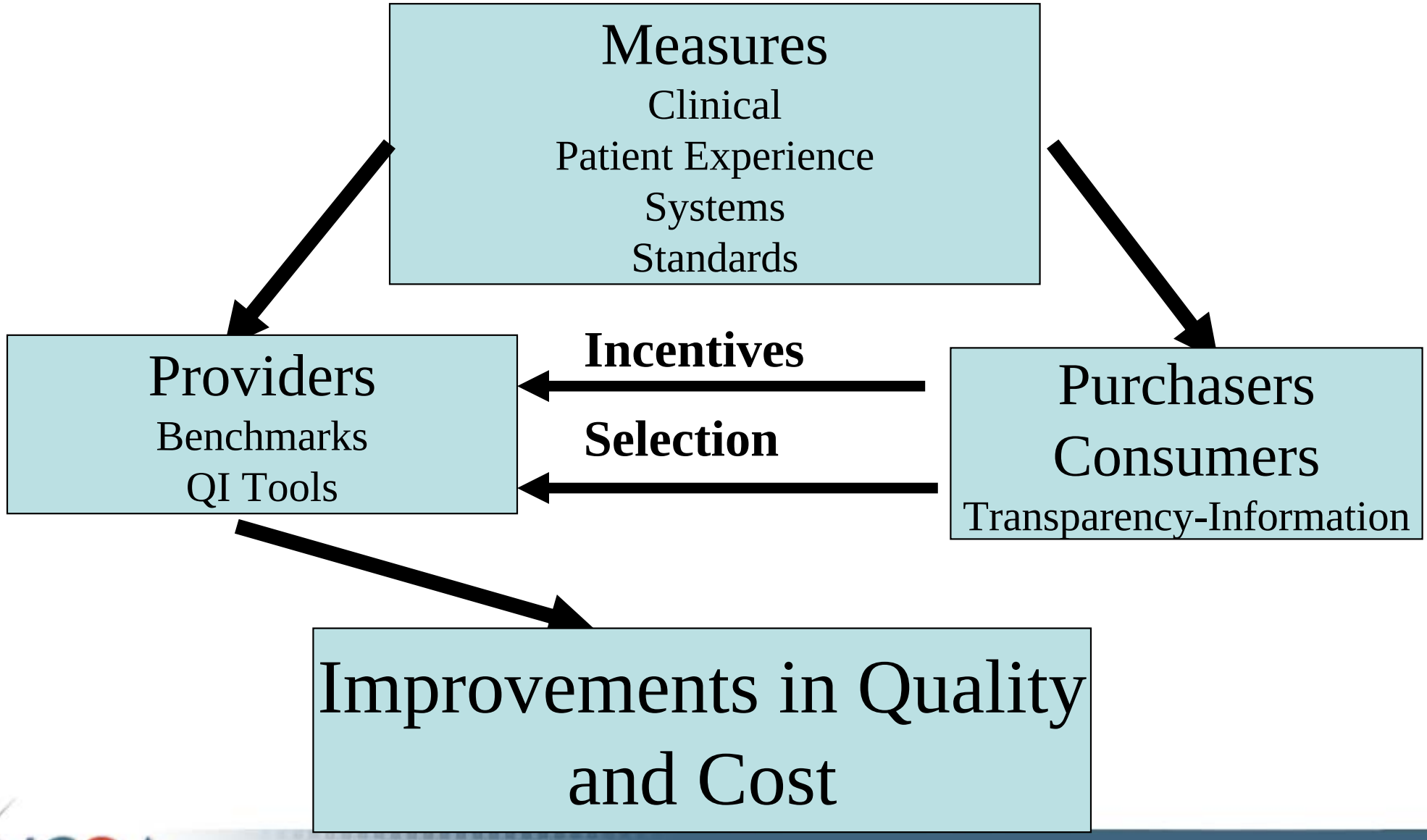
Core Presentation

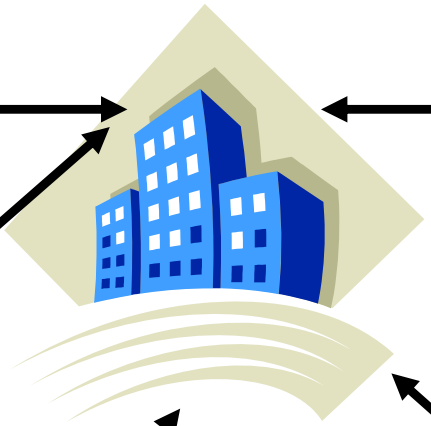
Better Value in Health Care
Professionalism Market Place

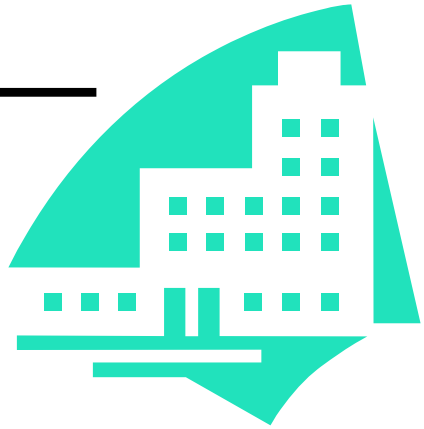


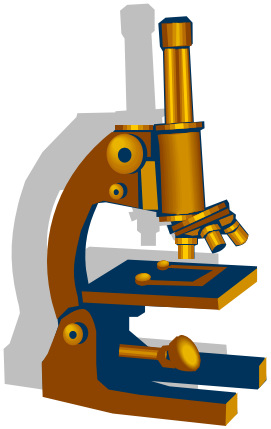
Why do we need a "new" system
(some would say we don't have one now)

- **Costs have (for 50 years), and continue to, rise faster than GDP**
  - **Uninsured, underinsured and related issues**
  - **Can't improve access without controlling costs**
  - **Major variation in costs WITHOUT relationship to quality (national/international)**
- **Major gaps in quality**
  - **Hospital deaths and readmissions**
  - **In ambulatory care-about 50/50 chance of getting needed services**

The current model of care
Connection by Billing







The future model of care-Integration by Information, Systems and Organization

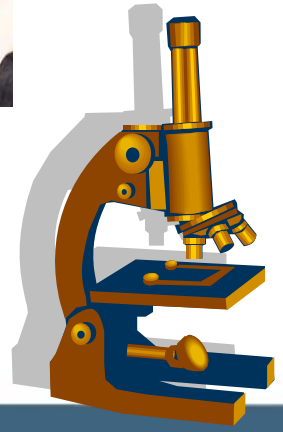
Sub-specialty PCMH

Coordinated Hospital and other facilities

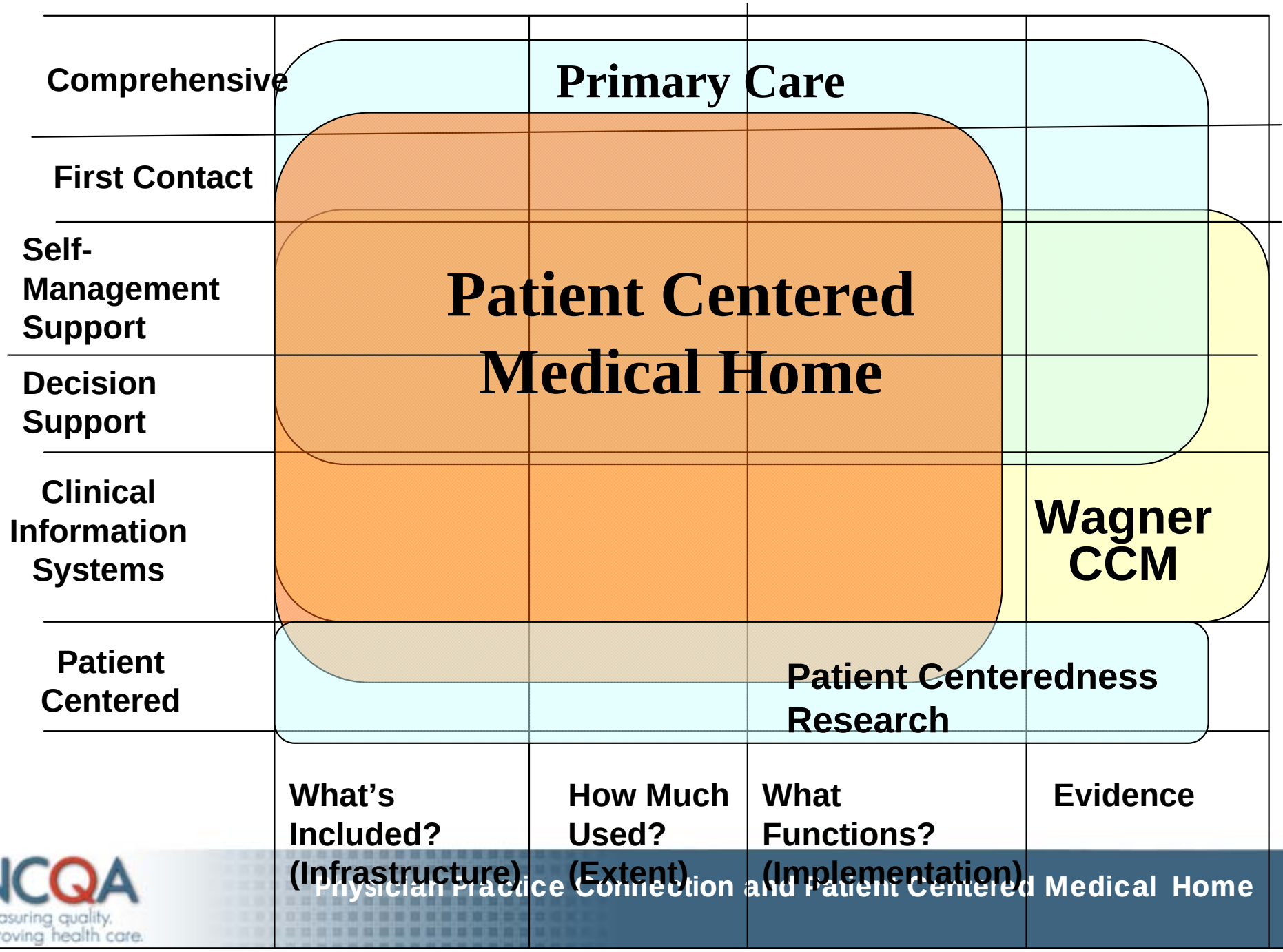
Sub Specialty "Medical Home Neighbor"

Sub-Specialty Procedural Practice

Primary Care Patient Centered Medical Home

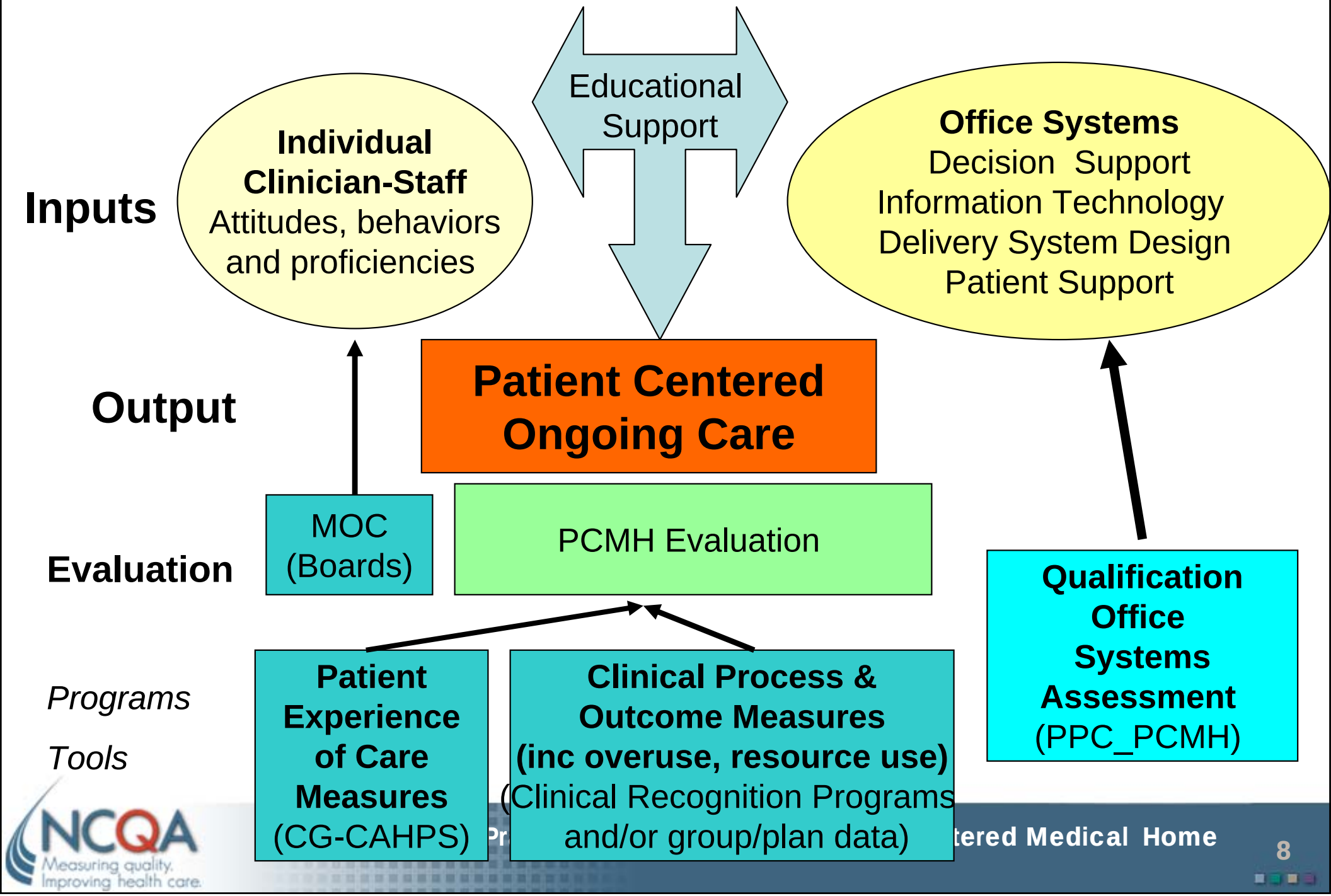


Patient Centered Medical Home: a Confluence of Concepts



So how will we “know” one when we see it- and how will we know if it enhances value?

Implementing and Evaluating PCMH-Proposed Model



Measures-for PCMH

(with some differences between primary care and specialty PMCH

- **Qualification of Practice**
  - **Structural –systems presence and use measures**
    - **PPC_PCMH**
  - **? Patient Experience of Care**
    - **Modified Clinician Group CAHPS survey**
- **Qualification of Clinicians (medical, nursing other)**
  - **Medical Boards- Maintenance of Certification (specific links to systems knowledge, patient interactions)-using PPC or related tools as training**
  - **Others-not aware of any current activity**

Measures-for PCMH

(some differences between primary care and specialty PMCH

- **Evaluation of impact of PCMH**
  - **Patient Experience of Care**
    - **Clinician Group CAHPS survey**
  - **Clinical Performance (under, over, mis)**
    - **Process** (many)
    - **Intermediate outcomes** (a few)
    - **Outcomes** (very few useful-functional status promising)
  - **Resource use-cost** (available but likely to require aggregate ?>5 MD practice size)
    - **Total cost over time (diabetes, CAD, Asthma)**
    - **Specific episodes (back pain)**

Linkage of PCMH to Reimbursement

Pay for Performance
Clinical and Patient Experience

Fee Schedule for Visits/Procedures

Payment per patient per month (or year)
for level of "Patient Centered Medical Homeness"

Qualification: The Physician Practice Connection survey tool

- **Physician Practice Connection (PPC) is a practice (site) on line survey tool**
  - **Developed and tested over past 7 years by NCQA to measure implementation of chronic care model**
  - **In widespread use by "Bridges to Excellence" and plans in reimbursement linked programs**
  - **Adapted and expanded in collaboration with four physician organizations and others as tool to use in demonstrations of PCMH**

Theoretical Framework of PCMH Informing Development of Physician Practice Connections

Chronic Care Model

- Clinical information Systems
- Decision Support
- Patient Self-Management
- Delivery System Redesign
- Community Linkages
- Health Systems

Patient-Centered Care

- Respect Patient Values
- Accessible
- Family-Centered
- Continuous
- Coordinated
- Community Linkages
- Compassionate
- Culturally Appropriate
- Emotional Support
- Information and Education
- Physical Comfort
- Quality Improvement

Cultural Competence

- Culturally competent interactions
- Language services
- Reducing disparities

Core Medical Home

- Personal physician
- Physician directed team
- Whole person orientation
- Care is coordinated and integrated
- Quality and safety
- Enhanced access

Foundation in Primary Care

First Contact | Coordination | Continuity | Comprehensive

PPC-PCMH Content and Scoring

Standard 1: Access and Communication	Pts
A. Has written standards for patient access and patient communication**	**4**
B. Uses data to show it meets its standards for patient access and communication**	**5**
	9

Standard 2: Patient Tracking and Registry Functions	Pts
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. Uses paper or electronic-based charting tools to organize clinical information**	**6**
E. Uses data to identify important diagnoses and conditions in practice**	**4**
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21

Standard 3: Care Management	Pts
A. Adopts and implements evidence-based guidelines for three conditions **	**3**
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pts
A. Assesses language preference and other communication barriers	2
B. Actively supports patient self-management**	**4**
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

Standard 6: Test Tracking	Pts
A. Tracks tests and identifies abnormal results systematically**	**7**
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13

Standard 7: Referral Tracking	PT
A. Tracks referrals using paper-based or electronic system**	**4**
	4

Standard 8: Performance Reporting and Improvement	Pts
A. Measures clinical and/or service performance by physician or across the practice**	**3**
B. Survey of patients' care experience	3
C. Reports performance across the practice or by physician **	**3**
D. Sets goals and takes action to improve performance	3
E. Produces reports using standardized measures	2
F. Transmits reports with standardized measures electronically to external entities	1
	15

Standard 9: Advanced Electronic Communications	Pts
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

**Must Pass Elements

Standard PPC Scoring

- **9 standards = 100 points**
- **Three levels of recognition (qualification) ,** based on total points achieved
  - **Recognized—Level 1**
    - 25 – 49 points
  - **Recognized—Level 2**
    - 50 – 74 points
  - **Recognized—Level 3**
    - 75 – 100 points
  - **Not Recognized (or reported)**
    - 0 – 24 points

In Summary

- **The primary care-patient centered medical home is THE cornerstone to health care system reform**
- **Measurement is critical for guiding improvement, evaluating impact and to support change in reimbursement**
- **We have a start of having the necessary measures and measurement BUT are a long way from where we need to be**

Appendix
Slides on PPC

NCQA
Measuring quality.
Improving health care.

Goals of PPC Measure Development

- **Develop measures for evaluating systems use and effectiveness in prevention, chronic illness and if possible patient safety**
- **Create measures that are "actionable" at level of physician office practice**
- **Validate measures by relating them to existing disease-specific performance measures and patient perceptions of care**

Need

- **Response to IOM reports**
  - To Err is Human and Crossing the Quality Chasm both provide evidence on critical importance of systems
- **Change from "blaming" individual clinicians for mistakes and shortfalls to improving systems so clinicians can succeed**
- **Raise awareness of physicians of importance of systems in enhancing quality**
- **Link health services research on systems and clinical outcomes to practice**

Development of PPC

- **Document evidence base linking specific system to clinical performance**
  - Medline Review
  - Cochrane Collaborative
  - Manuscripts in press
- **Convene expert panel to review evidence and suggest standards/measures**
- **Conduct analysis of practice defects using six sigma process (with GE in BTE project)**
- **Create standards**
- **Test survey tool incorporating standards developed related to chronic care model**

Study of Validity: Accuracy of Self-Report

- **Test accuracy of self-reports of practice systems using on site audit as "gold" standard**
  - **Varies by domain, by staff position, and by medical group**
  - **The predictive value of a positive report of a practice system is generally high.**
  - **Overall agreement with the on-site audit ranges from high (clinical information systems, quality improvement) to low (care management, population management).**
- **Several factors may explain lack of agreement**
  - **Variable implementation of systems across sites and conditions**
  - **Variations in staff members' exposure to systems**
  - **Lack of familiarity with systems**

Conclusion: Need Audit or Documentation

Studies of Correlation of PPC with Clinical Performance and Patient Experience

- **Published** *and in prep research* **on PPC**
  - ***Overall PPC score, and some sub-scores have positive correlation with higher clinical performance on most measures (diabetes, CV, asthma)***
  - **Presence or absence of EMR per se, correlates ONLY WEAKLY with clinical measures**
  - **However, practices with fully functional EMR's achieve highest scores on PPC**
  - *Overall PPC score does NOT appear to correlate with overall patient experiences of care*
  - *Preliminary results indicate correlation between lower costs and PPC subscores (organizational, decision support)*

Conclusions

- Assessment of systems is feasible though challenging
- In pay-for-performance applications, review of documentation or on-site audit needed to verify some systems as well as implementation across practice sites
- Educating physicians and practice staff about systems is high priority
- More research on relationship of systems to quality and patient experiences is needed

Using the PPC in Practice

Overall Recognition Process

- **Recognition is based on:**
  - Responses in Web-based Survey Tool
  - Supporting documentation attached to Survey Tool
- **Each element specifies type of documentation**
- **Reports**
  - Reports from EHR, registry, practice management & billing systems
- **Documented processes**
  - Policies and procedures, protocols
- **Records or files**
  - Medical record review – documented in NCQA's workbook

Current PPC Initiatives

- BCBS NC
- CareFirst (BCBS plan-DC metropolitan area)
- BTE pilot markets – OH-KY, NY, New England
- Silicon Valley – Health Information Technology
- MVP Health Plan (New York)
- CHPHP (Health Plan, New York)
- Multiple new projects associated with PCMH

Most successful projects linked to pay for performance

Use of PPC, DPRP and HRSP in BTE

- **Employers want to improve the quality of care their employees receive, and they want to increase the value of their health care spend:**
  - BTE Programs have actuarially validated savings and BTE recognized physicians deliver higher quality care
- **Employers want operational simplicity:**
  - BTE is now administered by licensed or certified administrators, mainly health plans
- **Physicians want to be measured by reliable and valid measures and independent third party organizations:**
  - BTE's Provider Performance Assessment Organizations and measurement systems are accepted by the physicians
- **Physicians need to know up front what performance is expected of them and what they will get for achieving it:**
  - BTE's Operations give physicians a market-wide view

BTE Use of Recognition Programs

	National Measure set	Physician Activation	Consumer Activation
Physician Office Link (POL)	Physician Practice Connections (PPC)	Up to $50 pmpy	Physician-level report card, and patient experience of care survey
Diabetes Care Link (DCL)	Diabetes Provider Recognition Program (DPRP)	Up to $100 pdppy	Diabetes care management tool, and rewards for care compliance
Cardiac Care Link (CCL)	Heart Stroke Recognition Program (HSRP)	Up to $160 pcppy	Cardiac care management tool, and rewards for care compliance

PPC Recognition (Jan 2008 non PCMH)

- **Recognized practice sites – >300**
- **Physicians practicing at recognized sites – >3000**
- **Characteristics of recognized practices**
  - **Practice Size**
    - Median number of physicians – 6
    - Number of solo practitioner sites - >30 (10%)
  - **Practice Specialties**
    - 57% - Primary Care
    - 19% - Pediatrics
    - 9% - Cardiology
    - 2% - OB-GYN
    - 13% - Multi-specialty
- **Avg score 46/100** (note 25 points needed to pass)

Summary - PPC 2006 Content and Points

Standard PPC 1 **Access and Communication**	***Pts***
A. Has written standards for patient access and patient communication	4
B. Uses data to show it meets its standards for patient access and communication	4
	8

Standard PPC 2 **Patient Tracking and Registry Functions**	***Pts***
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. Uses paper or electronic-based charting tools to organize clinical information	6
E. Uses data to identify important diagnoses and conditions in practice	4
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	2
	20

Standard PPC 3 **Care Management**	***Pts***
A. Adopts and implements evidence-based guidelines for three conditions	3
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers*	5
E. Coordinates care and follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard PPC 4 **Patient Self-Management Support**	***Pts***
A. Assesses language preference and other communication barriers	2
B. Actively supports patient self-management	4
	6

Standard PPC 5 **Electronic Prescribing**	***Pts***
A. Uses electronic system to write prescriptions	3
B. Uses electronic prescription writer that connects to other systems	3
C. Has electronic prescription writer with safety checks	3
D. Has electronic prescription writer with cost checks	2
	11

Standard PPC 6 **Test Tracking**	***Pts***
A. Tracks tests and identifies abnormal results systematically	6
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	12

Standard PPC 7 **Referral Tracking**	***Pts***
A. Tracks referrals using paper-based or electronic system	4
B. Uses data to support referral decisions	3
	7

Standard PPC 8 **Performance Reporting and Improvement**	***Pts***
A. Measures clinical and/or service performance by physician or across the practice*	3
B. Reports performance across the practice or by physician	3
C. Sets goals and takes action to improve performance	3
D. Produces reports using standardized measures	2
E. Transmits reports with standardized measures electronically to external entities	1
	12

Standard PPC 9 **Interoperability**	***Pts***
A. Stores electronic patient data using standardized code sets	1
B. Receives specific types of healthcare data	1
C. Has capability to transmit specific types of healthcare data	1
D. Has capability to generate and/or capture information to make a referral report	1
	4

Linking the PPC to the Patient Centered Medical Home

Progress to Date

- **Modification of PPC with input from ACP, AAFP,AAP and AOA**
  - Review and modification of current PPC tool for use in "qualification" of PCMH endorsed by ACP, AAFP, AAP, AOA
  - NQF endorsement and AQA approval in process
  - New PPC_PCMH version released in January 2008 (old PPC-2006 still available and in use for BTE and other areas)
- **Engagement of practicing physicians, health plans, employers and consumers**
  - Phone calls and web-ex's on PPC_PCMH
  - Patient Centered Primary Care Coalition (PC-PCC) led by ERISA Employers group engaged in PCMH
  - Educational programs planned and/or implemented by ACP, AAFP, AAP and AOA

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B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. Uses paper or electronic-based charting tools to organize clinical information**	**6**
E. Uses data to identify important diagnoses and conditions in practice**	**4**
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
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Standard 3: Care Management	Pts
A. Adopts and implements evidence-based guidelines for three conditions **	**3**
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pts
A. Assesses language preference and other communication barriers	2
B. Actively supports patient self-management**	**4**
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

Standard 6: Test Tracking	Pts
A. Tracks tests and identifies abnormal results systematically**	**7**
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Standard 7: Referral Tracking	PT
A. Tracks referrals using paper-based or electronic system**	**4**
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Standard 9: Advanced Electronic Communications	Pts
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

****Must Pass Elements**

What is happening now?

- **Identification and implementation of "a number" of private sector pilot projects**
  - Aetna, Cigna, Humana, United, BCBSA and Wellpoint Anthem have committed to regional multi-payer demonstration projects- Association of Community Health Plans has indicated interest
  - Patient Centered Primary Care coalition led by employers and consumer groups lobbying Congress and encouraging health plan participation in pilots
- **NCQA, along with Mathmatica and Center for Health Systems Strategies awarded contract to assist CMS in defining Medicare demonstration project**
- **Major push for CMS and states to explore implementation in Medicaid programs-several state mandates passed (Wa, La, NY)- others in process**

GREAT-BUT increasing confusion over what constitutes a "medical home"

Proposed approach to "standard" PMCH private sector demonstration projects

- **Defined sponsorship of project (plan, purchaser, regional coalition)**
- **Practice does attestation that they deliver primary care and adhere to overall principles of PCMH (developed by ACP, AAFP etc)**
- **Qualification of the practice as a PCMH using the Physician Practice Connection-PCMH tool**
  - **Based on 100 points for use of systems (see standards)**
  - **Practice must get at least 25 and pass 5 of 10 "must pass" standards to qualify (can be waived first year)**
  - **Can include assessment of three or more "levels" of PMCH (25-49, 50-74, 75-100)**

Proposed approach to "standard" PMCH private sector demonstration projects

- **Evaluation using one or more of the following**
  - **Clinical measures (administrative or chart review data-NQF endorsed measures)**
  - **Patient experience of care (Clinician-group CAHPS)**
  - **Resource use/cost measures (to be defined)**
- **Revised/enhanced reimbursement linked to PCMH practice**
  - **Base payment per patient per month based on qualification level as medical home**