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Measurement Challenges for the Patient-Centered Medical Home (PCMH)

National Committee on Vital and Health Statistics
Populations/Quality:
Patient-Centered Medical Home Hearing

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BCBSMA – Putting our members' health first

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- Top-rated Health Plan
- 3M members nationally
  - 1.2M in national, self-insured accounts
  - 1 in 3 Massachusetts residents is a BCBSMA member
- 24,000 physicians in network, 8,800 primary care
- Commitment to quality and safety
  - Sponsored MA eRx and eHealth Collaboratives – MA is the #1 eRx state in the nation
  - Health Care Reform to achieve universal coverage of MA citizens
  - Health Care Excellence Award

Collaborating for improvement

For the past 10 years, BCBSMA has been engaging providers in conversations and iterative incentive programs aimed at accelerating improvements in quality and patient safety for our members.

- Performance-based contracts with nearly 100% of our network (PCPs, Specialists, Hospitals)
- Multi-faceted approach to “crossing the quality chasm” including payment reform, performance measurement and reporting, and public engagement

Primary Care Physician Incentive Program (PCPIP)

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- Since 2001, has awarded over $124 Million to individual PCPs based on their performance on a variety of quality, safety and infrastructure development measures
  - Represents up to 10-15% of total MD income from BCBSMA
  - Measures have included:
    - HEDIS and HEDIS-like process measures
    - e-technology adoption such as eRx, EHR, registry use
    - generic prescribing rates
    - New this year - submission of clinical outcome data such as A1C, BP and LDL levels

Guiding Principles in Selecting Performance Measures

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- Measures will be focused on safety, effectiveness, patient-centeredness and affordability
- Wherever possible, our measures should be drawn from nationally accepted standard measure sets
- The measure must reflect something that is broadly accepted as clinically important
- There must be empirical evidence that the measure provides stable and reliable information at the level at which it will be reported (i.e. individual, site, group, or institution) with available sample sizes and data sources
- There must be sufficient variability on the measure across providers (or at the level at which data will be reported) to merit attention
- There must be empirical evidence that the level of the system that will be held accountable (clinician, site, group, institution) accounts for a large portion of the system-level variance in the measure
- Providers should be exposed to information about the development and validation of the measures and given the opportunity to view their own performance, ideally for one measurement cycle, before the data are used for "high stakes" purposes

Seeking balance in difficult times…

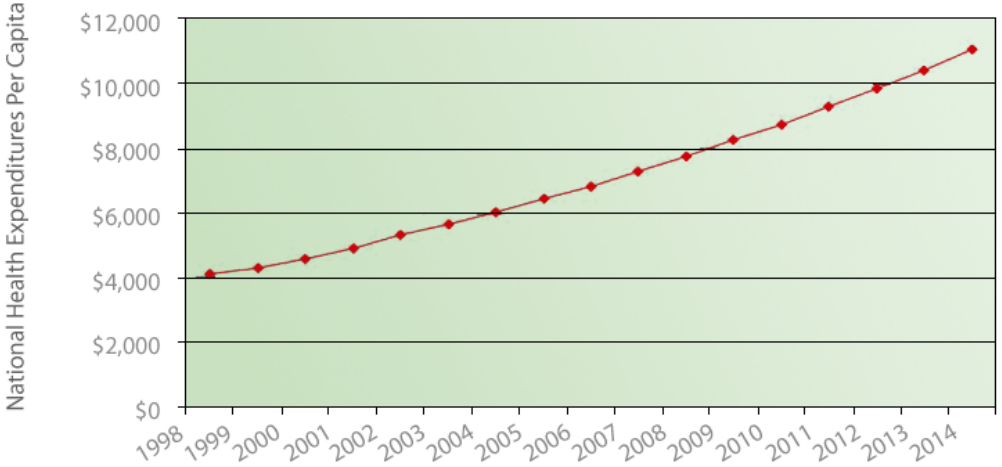
Primary care in peril

- Fewer doctors choose primary care
- Others leaving
- Limited access
- More demands on care
- Incomes lagging
- Low morale
- FFS payment system rewards volume over quality and reliability

- Increasing demands for measurement, improved safety and reliability of care, transparency and demonstrable value of care
- Expensive practice investments needed (EHR, practice redesign)

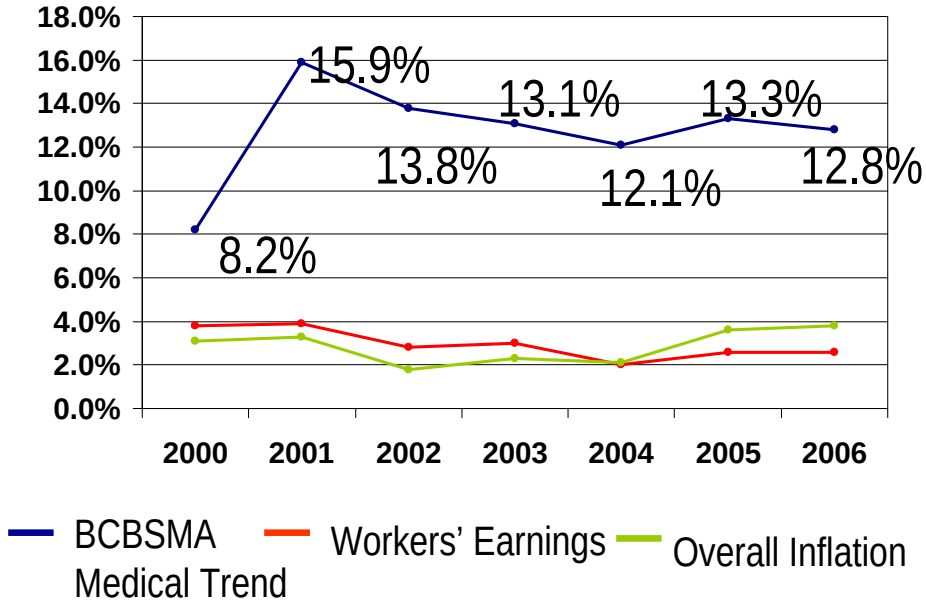
The Economic Imperative

Health care spending per capita is projected to nearly double over the next 10 years.



Source: CMS, Office of the Actuary, National Health Statistics Group

BCBSMA's medical cost trend is growing five times faster than workers' earnings, and nearly four times the rate of inflation.



Sources: BCBSMA, Bureau of Labor Statistics

What are we aiming for?

- Quality = Affordability
- Simply paying physicians more isn't the answer
- We have been challenged to build a new kind of measurement and payment model, an Alternative QUALITY Contract, that supports advanced care delivery systems to produce:
  - High performance on quality and safety metrics across the continuum of care
  - Efficiencies in managing to a global payment level
  - Predictable and controlled healthcare expenditure trends
- Looking for communities that are ready to work on this challenge…

The Patient-Centered Medical Home …
a critical stepping stone along the path

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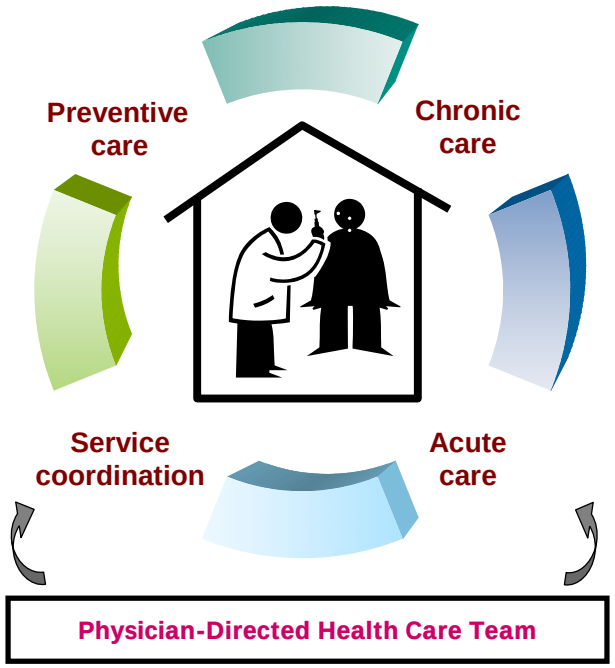
Vision -

The PCMH will provide an experience of care such that patients clearly view the Primary Care Practice as *the* place to start with any health care issue, not because it is required but because they perceive to be *the best way to get the safest, most coordinated, effective, affordable, efficient and satisfying care*

Goals – ultimately improve outcomes

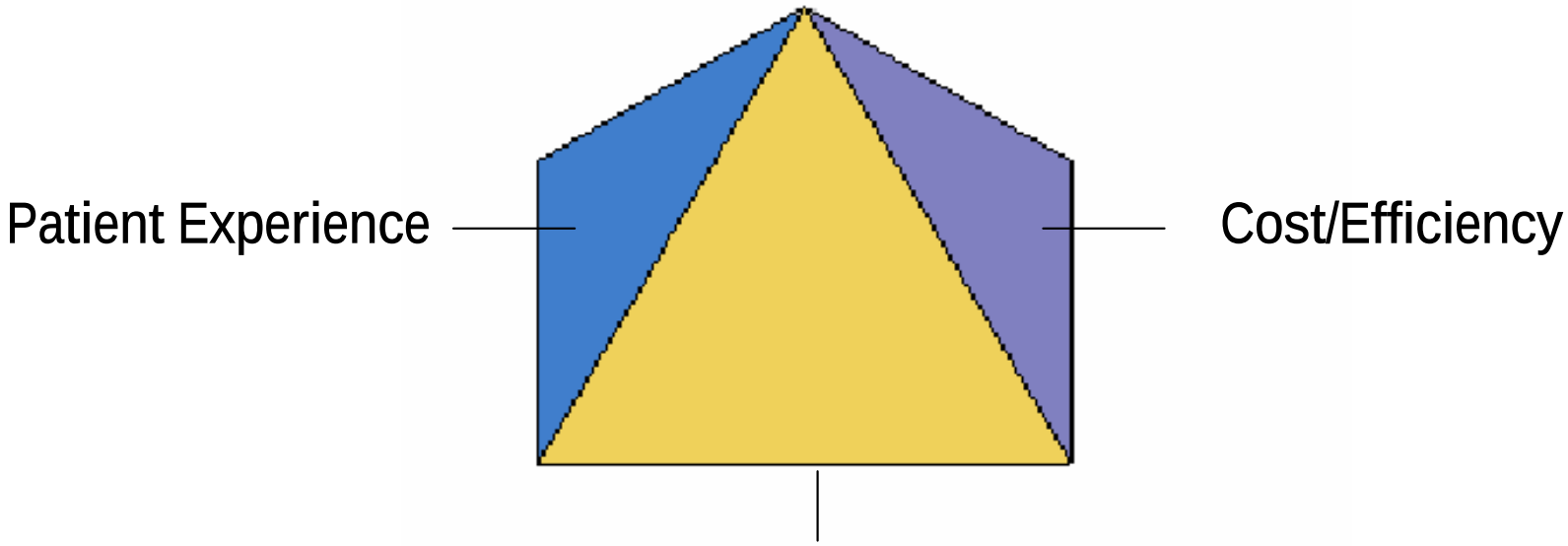
- Better health
- Better experience for both patients and health care professionals
- Sustainable, affordable health care; purchasers can readily appreciate the value



How do we get there?

- Addressing underuse
  - Deficiencies of care are frequently the easiest to identify and measure and therefore are the most commonly addressed
  - Existing national measures are heavily focused on underuse or insuring the reliable provision of evidence-based care
- But we also need to address overuse, preventable complications of care/misuse
  - Much harder to identify, measure and fix
- Many physicians and practices today don't have the resources and skill sets to establish, monitor, and continuously improve population-based care
  - Particularly true for physicians not associated with large practice organizations
  - PCMH offers a framework to build upon

Nationally Accepted Framework



What might this look like?

Desired practice capabilities	Measure domain		Potential Measure	Potential Measure and Data Source	Possible Payment Mechanism
access, coordination, effective communication and teaching management/prevention tracking, planned and prepared visits, coaching/motivational behavior change, asynchronous care where appropriate, involves patient in care decisions, multifunctional teams that optimize the physician's role in a way that is both efficient and enhances patient experience	**Patient Experience:**		Clinical Interaction Quality Integration of Care Access to Care	C/Q CAHPS/ACES (MHQP)	Traditional FFS plus Prospective pmpm
	Practice Functional Redesign:	Infrastructure	NCQA PPC-PCMH	NCQA	Prospective pmpm

Desired practice capabilities	Measure domain	Clinical Area	Potential Measure	Potential Measure and Data Source	Possible Payment Mechanism
Team-based, proactive prevention and chronic disease care in collaboration with patients; performance measurement and improvement at group level for quality, patient experience and cost/utilization efficiency	**Clinical Outcomes Measures:**	Diabetes	HbA1C & LDL-C in control	HEDIS	Quality-based incentive
		Hypertension	Blood Pressure Control		
		Cardiovascular Disease	LDL-C in control		
	Clinical Process:	Smoking cessation	Assistance to quit		Quality-based incentive
		Behavioral health	Depression screening, optimal contacts, acute & continuation phase Rx	HEDIS	
			Substance abuse screening		
			Pediatric BH screening		
		Obesity	BMI screening and advice	Anticipated HEDIS 09	
		Diabetes	HbA1c Testing, eye exams, nephropathy screening	HEDIS	
		Cholesterol Management	LDL-C screening in diabetes and CVD	HEDIS	
		Preventive Care	Screening for breast, cervical & colorectal cancer	HEDIS	
			Chlamydia screening and Rx	HEDIS	
		Pediatrics	Infant, preschool and adolescent well visits	HEDIS	
			Appropriate screening and Rx for URI & Pharyngitis	HEDIS	
	Cost/utilization Efficiency	Pharmacy	Generic prescribing rate	BCBSMA pharmacy data	Quality-based incentive
		Radiology	High Cost Imaging trend/utilization	BCBSMA claims	

This is a good start, but what is missing?

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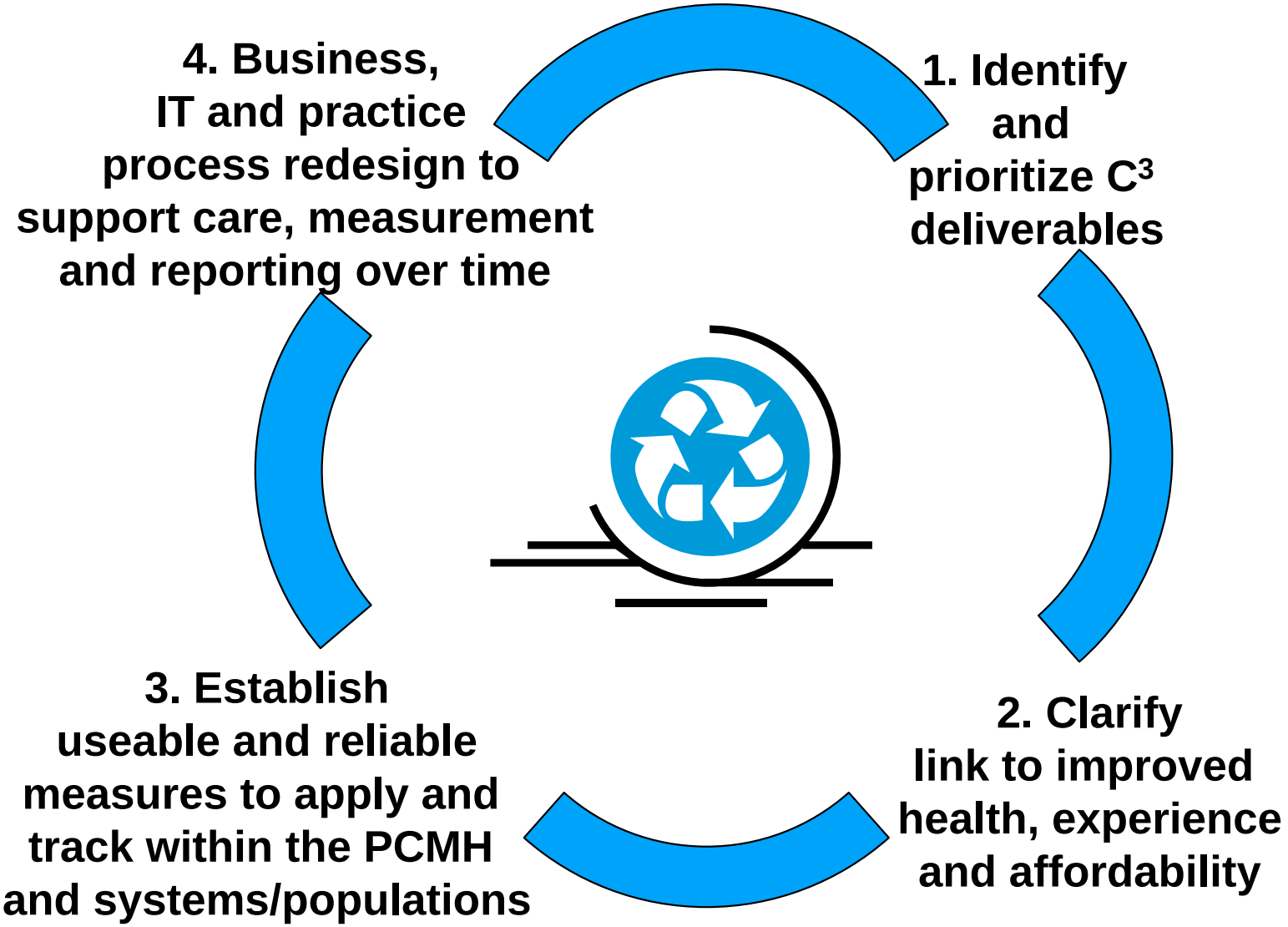
C^3 - collaboration, communication and coordination

- Sure, everyone knows we want these things – who wouldn't?
- But have we really identified what we're expecting?
- How would we know if day-to-day care is meeting the expectations?
- What if the care meets these expectations but is the wrong care?

Developing C^3 or C^4 Measures to Supplement Patient Experience Measures



Mrs. Imenex Sample

51 year-old woman with uncomplicated type 2 diabetes

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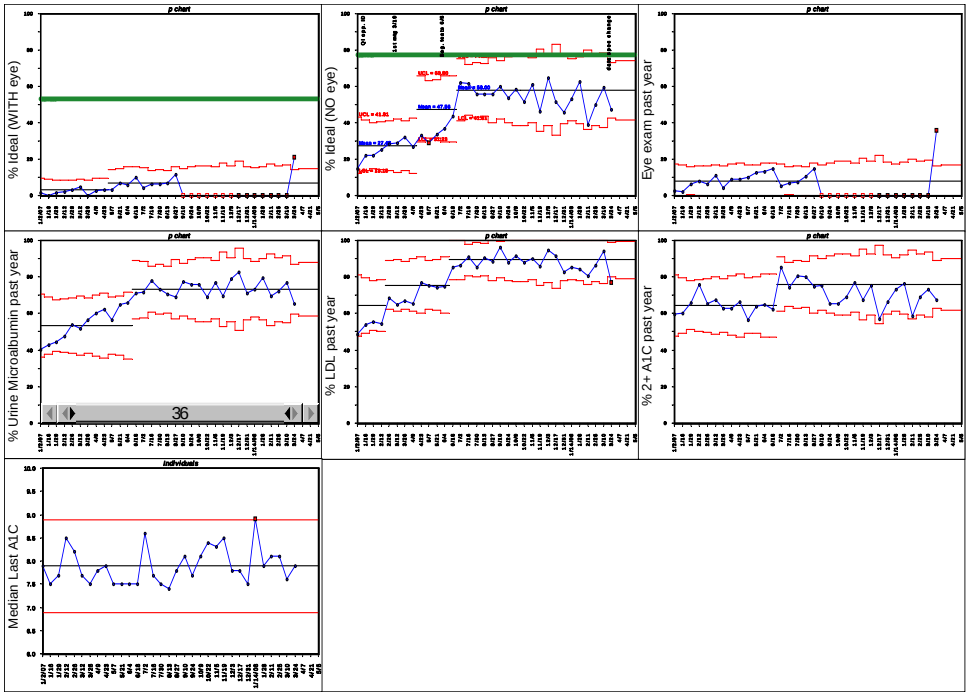
Today	In a mature PCMH
Episodic care initiated by the patient - Also caring for her elderly mother	Planned, team-based, care - in person and asynchronous Reminders automatically sent to patient Fully accessible data
Gaps in care are not routinely identified	Team tracks all chronic disease patients care needs and status, Team works with patients as needed to modify care plan; Patients understand care plan
Patient is uncomfortable speaking up about lack of understanding, or desire to change care plan	Mrs. Sample prepares for visits by using standardized information sharing Option to report progress and goals
Referral made to Dr. Heart based on lab results but without information transfer Tests are repeated, specialist time is not used efficiently	Team referral specialist sends all of the relevant information Dr. Heart collaborates with team such that unnecessary consultations can be avoided

How would we measure all of this?

- Mrs. Sample's ACES survey won't be done until the next annual cycle.
- PCMH will need reliable, real-time, accessible measures to monitor and improve their own performance, not just on the clinical processes and outcomes but on the related collaboration, coordination and communication elements.
- IT systems and EHRs will need to be able to easily report on standard and practice-specific clinical process, outcome, experience and C^4 measures.
- Plans will need to be able to demonstrate to employers and members that their provider networks are maintaining high levels of patient satisfaction, reliable clinical care and improving clinical outcomes.



Summary

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Patient-Centered Medical Homes:

- Meet the demands of an increasingly complex healthcare environment
- Provide patients and healthcare professionals with a more satisfying experience
- Need comprehensive, reliable and accessible measurement models

Next Steps:

- Articulate and prioritize the deliverables expected of the C^4 capabilities
- Develop effective, reliable measures
- Evolve to real-time measurement
- Refine technology tools to enable useful, reliable and consistent measurement at the practice, system and even national level