

Qualifying and Evaluating the Patient Centered Medical Home

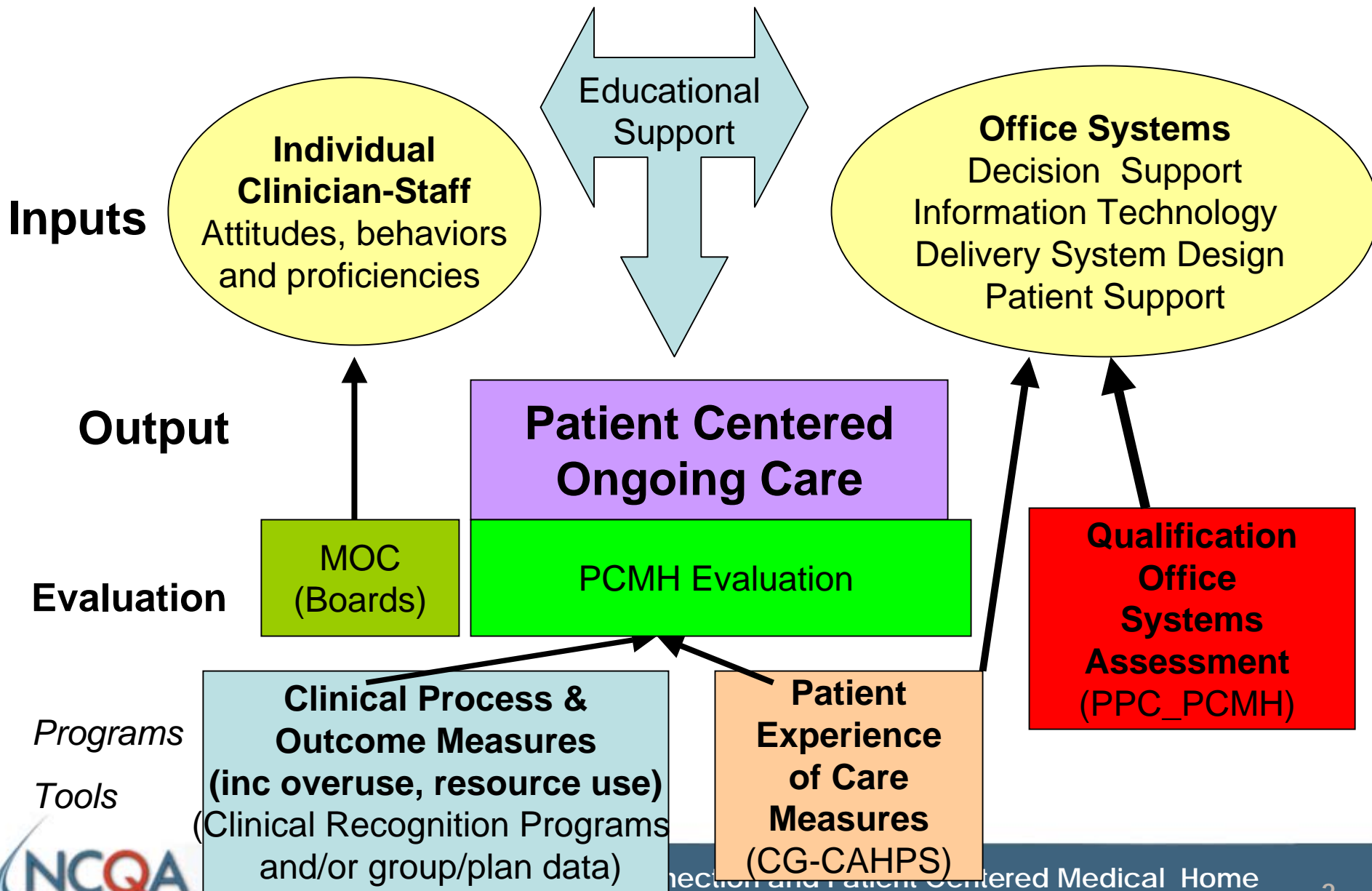
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Core Presentation



Implementing and Evaluating PCMH-Proposed Model



Need for a “Qualification” Tool

- If payors/plans are going to reimburse for being a PCMH- they need to be able to know what is-and is not a PCMH (especially for base payment)
- Critical for pilot/demonstration projects –if you can't define PMCH-how can you know if “it” works (multiple definitions)
- Creating/testing reliable-valid-practical tools usually takes years

Linkage of PCMH to Reimbursement for “ongoing” care

**Pay for Performance- Clinical and Patient Experience
(functioning of PCMH)**

Fee Schedule for Visits/Procedures

**Payment per patient per month (or year)
for level of “Patient Centered Medical Homeness”**

Modification and Use of the NCQA Physician Practice Connection Tool to Quality PCMH's



Goals of PPC Measure Development

- Develop measures for evaluating systems use (Wagner Chronic Care Model) in care of patients with prevention, and chronic illness needs
- 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**

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

Past (current) use of PPC-RP

- 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

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 before 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)

PPC Scoring

- **9 standards = 100 points**
- **Three levels of recognition**, 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

Summary - PPC 2006 Content and Points

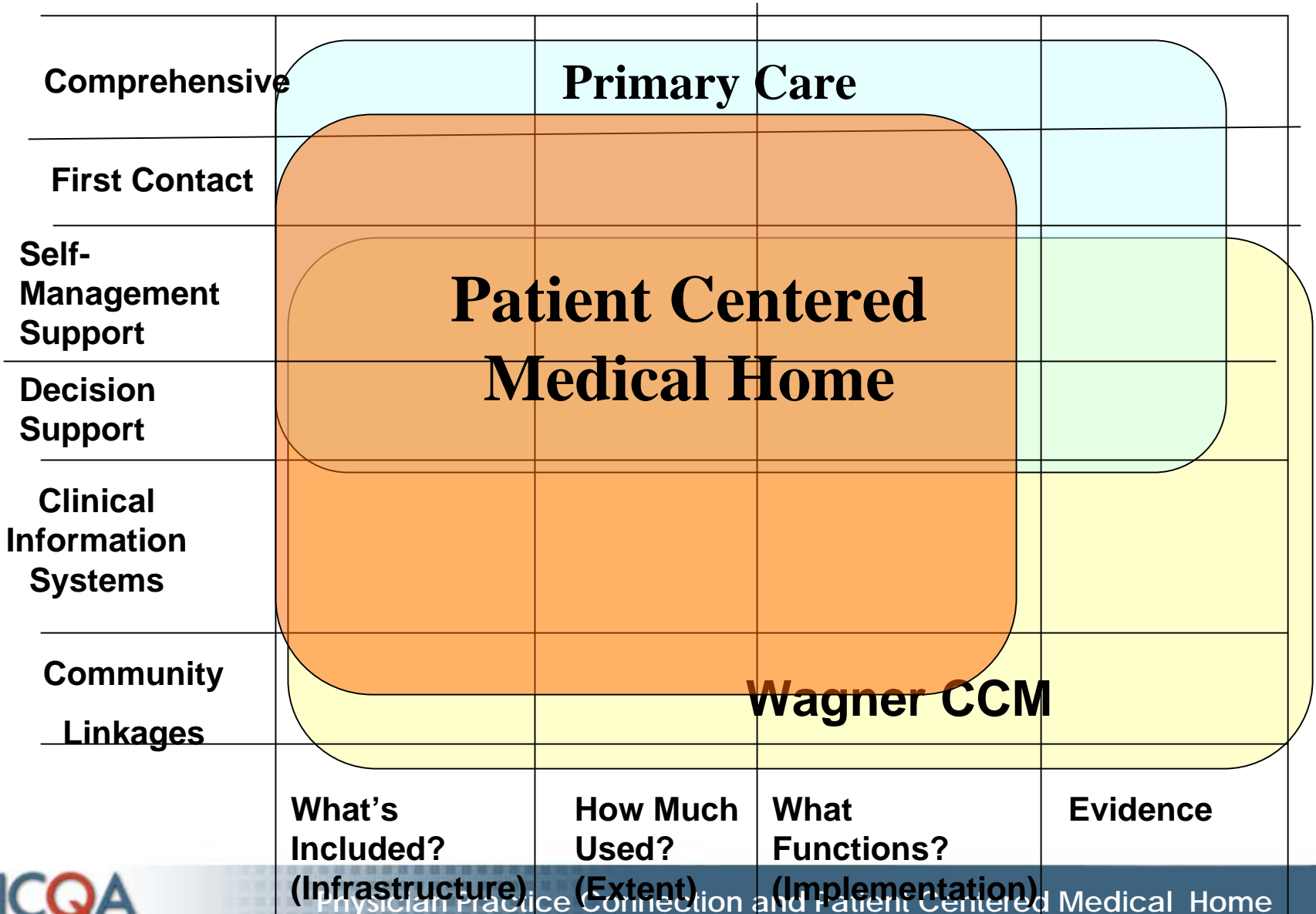
<p>Standard PPC 1 Access and Communication</p> <p>A. Has written standards for patient access and patient communication</p> <p>B. Uses data to show it meets its standards for patient access and communication</p>	<p><i>Pts</i></p> <p>4</p> <p>4</p> <p>8</p>	<p>Standard PPC 5 Electronic Prescribing</p> <p>A. Uses electronic system to write prescriptions</p> <p>B. Uses electronic prescription writer that connects to other systems</p> <p>C. Has electronic prescription writer with safety checks</p> <p>D. Has electronic prescription writer with cost checks</p>	<p><i>Pts</i></p> <p>3</p> <p>3</p> <p>3</p> <p>2</p> <p>11</p>
<p>Standard PPC 2 Patient Tracking and Registry Functions</p> <p>A. Uses data system for basic patient information (mostly non-clinical data)</p> <p>B. Has clinical data system with clinical data in searchable data fields</p> <p>C. Uses the clinical data system</p> <p>D. Uses paper or electronic-based charting tools to organize clinical information</p> <p>E. Uses data to identify important diagnoses and conditions in practice</p> <p>F. Generates lists of patients and reminds patients and clinicians of services needed (population management)</p>	<p><i>Pts</i></p> <p>2</p> <p>3</p> <p>3</p> <p>6</p> <p>4</p> <p>2</p> <p>20</p>	<p>Standard PPC 6 Test Tracking</p> <p>A. Tracks tests and identifies abnormal results systematically</p> <p>B. Uses electronic systems to order and retrieve tests and flag duplicate tests</p>	<p><i>Pts</i></p> <p>6</p> <p>6</p> <p>12</p>
<p>Standard PPC 3 Care Management</p> <p>A. Adopts and implements evidence-based guidelines for three conditions</p> <p>B. Generates reminders about preventive services for clinicians</p> <p>C. Uses non-physician staff to manage patient care</p> <p>D. Conducts care management, including care plans, assessing progress, addressing barriers*</p> <p>E. Coordinates care and follow-up for patients who receive care in inpatient and outpatient facilities</p>	<p><i>Pts</i></p> <p>3</p> <p>4</p> <p>3</p> <p>5</p> <p>5</p> <p>20</p>	<p>Standard PPC 7 Referral Tracking</p> <p>A. Tracks referrals using paper-based or electronic system</p> <p>B. Uses data to support referral decisions</p>	<p><i>Pts</i></p> <p>4</p> <p>3</p> <p>7</p>
<p>Standard PPC 4 Patient Self-Management Support</p> <p>A. Assesses language preference and other communication barriers</p> <p>B. Actively supports patient self-management</p>	<p><i>Pts</i></p> <p>2</p> <p>4</p> <p>6</p>	<p>Standard PPC 8 Performance Reporting and Improvement</p> <p>A. Measures clinical and/or service performance by physician or across the practice*</p> <p>B. Reports performance across the practice or by physician</p> <p>C. Sets goals and takes action to improve performance</p> <p>D. Produces reports using standardized measures</p> <p>E. Transmits reports with standardized measures electronically to external entities</p>	<p><i>Pts</i></p> <p>3</p> <p>3</p> <p>3</p> <p>2</p> <p>1</p> <p>12</p>
		<p>Standard PPC 9 Interoperability</p> <p>A. Stores electronic patient data using standardized code sets</p> <p>B. Receives specific types of healthcare data</p> <p>C. Has capability to transmit specific types of healthcare data</p> <p>D. Has capability to generate and/or capture information to make a referral report</p>	<p><i>Pts</i></p> <p>1</p> <p>1</p> <p>1</p> <p>1</p> <p>4</p>



Linking the PPC to the Patient Centered Medical Home



Content Overlap of Primary Care -PCMH- CCM



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

PPC-PCMH Content and Scoring

Standard 1: Access and Communication A. Has written standards for patient access and patient communication** B. Uses data to show it meets its standards for patient access and communication**	Pts 4 5 9	Standard 5: Electronic Prescribing A. Uses electronic system to write prescriptions B. Has electronic prescription writer with safety checks C. Has electronic prescription writer with cost checks	Pts 3 3 2 8
Standard 2: Patient Tracking and Registry Functions A. Uses data system for basic patient information (mostly non-clinical data) B. Has clinical data system with clinical data in searchable data fields C. Uses the clinical data system D. Uses paper or electronic-based charting tools to organize clinical information** E. Uses data to identify important diagnoses and conditions in practice** F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	Pts 2 3 3 6 4 3 21	Standard 6: Test Tracking A. Tracks tests and identifies abnormal results systematically** B. Uses electronic systems to order and retrieve tests and flag duplicate tests	Pts 7 6 13
Standard 3: Care Management A. Adopts and implements evidence-based guidelines for three conditions ** B. Generates reminders about preventive services for clinicians C. Uses non-physician staff to manage patient care D. Conducts care management, including care plans, assessing progress, addressing barriers E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	Pts 3 4 3 5 5 20	Standard 7: Referral Tracking A. Tracks referrals using paper-based or electronic system**	PT 4 4
Standard 4: Patient Self-Management Support A. Assesses language preference and other communication barriers B. Actively supports patient self-management**	Pts 2 4 6	Standard 8: Performance Reporting and Improvement A. Measures clinical and/or service performance by physician or across the practice** B. Survey of patients' care experience C. Reports performance across the practice or by physician ** D. Sets goals and takes action to improve performance E. Produces reports using standardized measures F. Transmits reports with standardized measures electronically to external entities	Pts 3 3 3 3 2 1 15
Standard 9: Advanced Electronic Communications A. Availability of Interactive Website B. Electronic Patient Identification C. Electronic Care Management Support	Pts 1 2 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 Mathematica 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