Recognizing Patient-Centered Medical Homes

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NCQA
Measuring quality.
Improving health care.

Agenda

- NCQA
- Development of Physician Practice Connections (PPC) and PPC-PCMH
- How the recognition program works
- Use of PPC-PCMH
- Future directions

NCQA

Mission

To improve the quality of health care

Vision

To transform health care through quality measurement, transparency, and accountability

NCQA Recognition Programs
Physician-Level Measurement

- Current programs: **DPRP, HSRP, BPRP, PPC, PPC-PCMH**
- What measures included: **Structure, process and outcomes of excellent care management**
- Where they come from: **partnership with leading national health organizations**
- Who rewards recognized physicians: **many health plans and coalitions of employers**
- Who is recognized: **more than 12,000 physicians nationally**

6500 physicians

1850 physicians

3450 physicians
270 practices

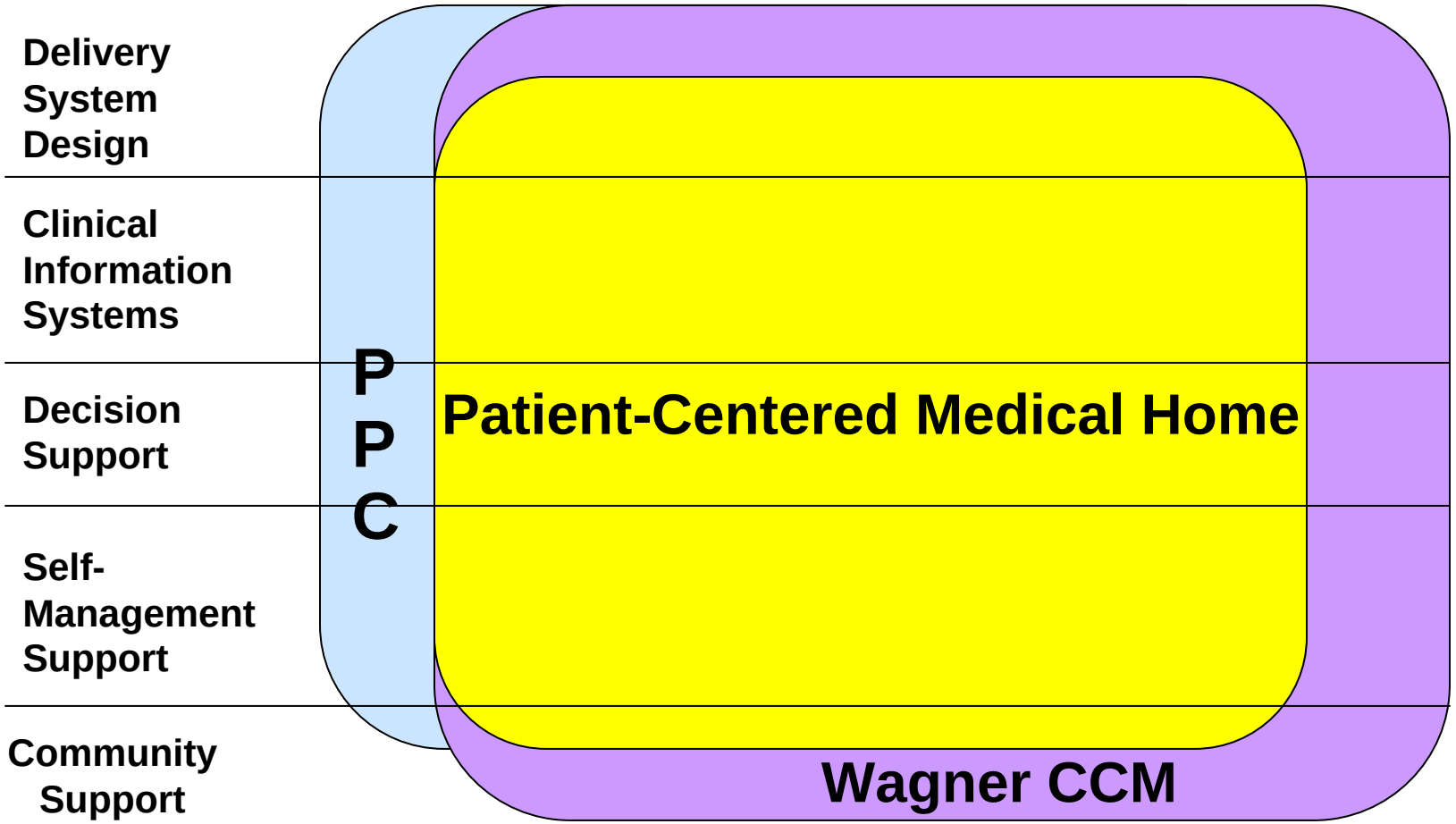
90 physicians
19 practices

272 physicians
40 practices

Goals for Physician Practice Connections (PPC)

- **Evaluate systematic approach to delivering preventive and chronic care (Wagner Chronic Care Model)**
- **Build on IOM's recommendation to shift from "blaming" individual clinicians to improving systems**
- **Create measures that are actionable for physician practices**
- **Validate measures by relating them to clinical performance and patient experience results**

Content of PPC-PCMH-Wagner CCM



PPC Advisory Council Members

- **Bruce Bagley, MD**
  American Academy of Family Physicians
- **Gifford Boyce-Smith, MD**
  Blue Shield of California
- **Suzanne Delbanco, PhD**
  Barbara Rudolph
  The Leapfrog Group
- **Charles Kilo, MD**
  GreenField Health System
- **Alan Muney, MD**
  Oxford Health Plans
- **Margaret See, RN, MBA**
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- **Michael S. Barr, MD, MBA, FACP**
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- **A. John Blair, MD**
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- **David Reuben, MD**
  UCLA
- **James Sorace, MD**
  CMS
- **Leif Solberg, M.D.**
  Health Partners Research Foundation
- **eHealth Initiative**
  - Dr. Amy Helwig
    Foundation for eHealth Initiative
  - Marc Overhage, MD, PhD
    Regenstrief Institiute, Inc.
- **CMS Contacts**
  - William Rollow, MD
  - Trent Haywood, MD
  - John Young

Adapting PPC for the Patient-Centered Medical Home

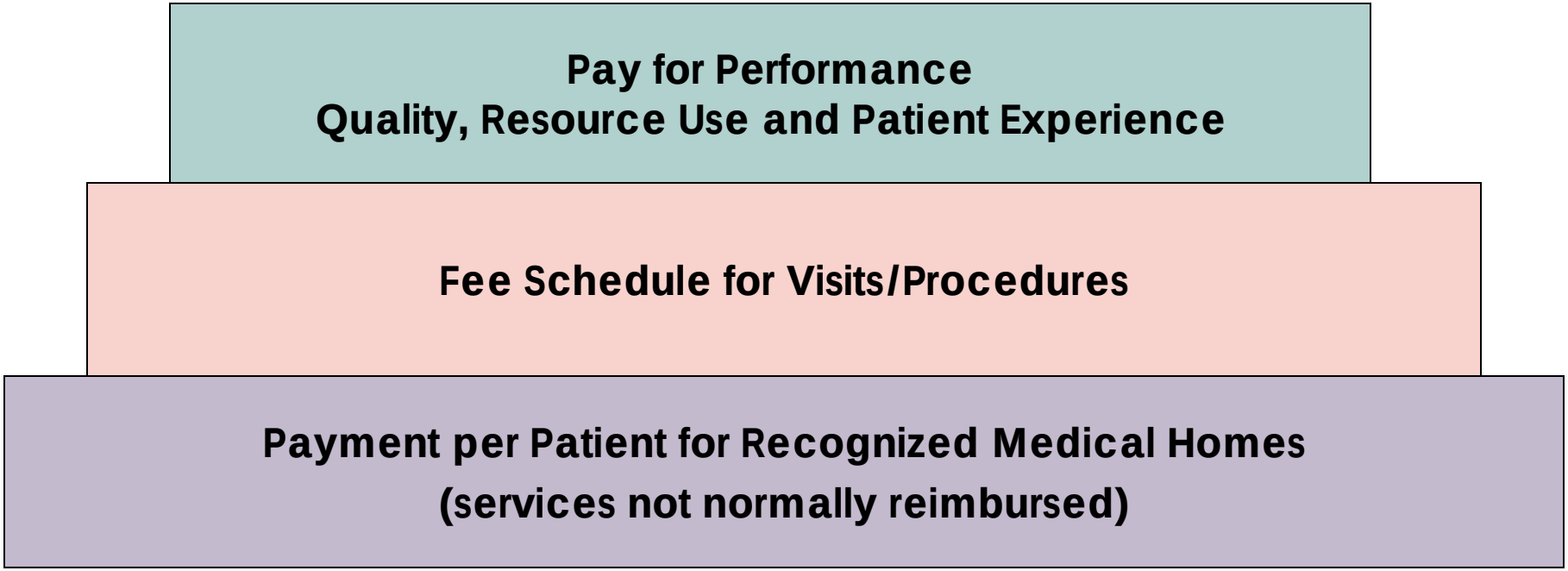
- **New PPC-PCMH version released in January 2008**
  - **Aligned standards with Joint Principles**
  - **Incorporated critical attributes of PCMH**
  - **Defined foundational elements ("must pass" requirements)**
- **PPC-PCMH endorsed by ACP, AAFP, AAP, AOA, other specialties and PCPCC for use in demos**

Endorsed by National Quality Forum Sept 2008 (as "Medical Home System Survey")

Need for a Standardized Tool

- **If payers are going to provide extra reimbursement, they need an objective determination**
- **Critical for evaluation across demonstration projects**
- **Critical for practices since practices may participate in projects for multiple payers**

Linkage of PCMH to Reimbursement: One Model



Published and Ongoing Research on PPC

- **Practices can be systematic without an EMR, but practices with fully functional EMR's achieve highest scores on PPC (Solberg, 2005)**
- **Overall PPC score, and some sub-scores have positive correlation with higher clinical performance on most measures for diabetes, CVD (Solberg, 2008)**
- **Overall PPC score may not correlate with overall patient experiences of care (NCQA 2006)**
- **Practice self report (without documentation or audit) does not produce reliable information (Scholle 2008)**
- **Clinical practice systems are associated with decreased use of inpatient and emergency care but do not appear to affect ambulatory care utilization in diabetes (Flottemesch, in preparation)**

BTE Studies Show Better Quality can Cost Less

- **Compared to non-recognized physicians, physicians with PPC Recognition**
  - **significantly fewer episodes per patient (0.13; 95% CI = 0.13, 0.15)**
  - **lower resource use per episode ($130; 95% CI = $119, $140)**

Source: Rosenthal, AJMC, October 2008

Correlation of Systems, Cost

- **More research needed on relationship to cost; opportunities include:**
  - **Reduced ER visits**
  - **Reduced (unnecessary) tests**
  - **Reduced specialty care**
  - **Reduced drug interactions**
  - **Avoided hospitalizations**
  - **Reduced medical care at end-of-life**

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**

PPC-PCMH Scoring

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	75 - 100	10 of 10
Level 2	50 – 74	10 of 10
Level 1	25 – 49	5 of 10
Not Recognized	0 – 24	< 5

Levels: If there is a difference in Level achieved between the number of points and "Must Pass", the practice will be awarded the lesser level; for example, if a practice has 65 points but passes only 7 "Must Pass" Elements, the practice will achieve at Level 1.

Practices with a numeric score of 0 to 24 points or less than 5 "Must Pass" Elements are not Recognized.

How PPC-PCMH Recognition Works

Physician/practice

- Self-assess, collect data using Web-based software
- Submit documentation to NCQA when ready
- May be asked to submit more data if needed

NCQA

- Evaluates and scores all applications
- Checks licensure of physician
- Audits a sample of applications
- Posts Recognized physicians on web
- Distributes list of Recognized physicians monthly to health plans and others
- Physicians sent media kit, press releases, letter & certificate

Myths About PPC-PCMH

Myth

1. Small practices can't qualify
2. Passing (25 points) is too hard
3. Passing (25 points) is too easy
4. You have to have an EMR to pass
5. All you need to pass is an EMR

Reality

1. >20% of Recognized practices are solo physician practices
2. Practices do not have to submit tool until they score above passing
3. Estimate fewer than 15% of practices could pass without making changes
4. Can get nearly 50 points without EMR
5. Need to re-engineer

Use of PPC PCMH in Medical Home Demonstrations

- **CMS Medicare demo criteria are based on PPC-PCMH-CMS**
  - **Two tiers (instead of 3 levels)**
  - **Tier II requires EMR**
- **New elements**
  - **Comprehensive Health Assessment**
  - **Giving Patients Information on the Role of the Medical Home**
- **http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_PPC.pdf**

Examples of Initiatives Using PPC-PCMH

- **Multi-payer** - Colorado, Pennsylvania, Rhode Island
- **State-wide** – Pennsylvania, Vermont, Maine
- **Single payer** – EmblemHealth, Humana
- **Government** – Medicare, New York City, Louisiana

Promising Models

- **New York City**
  - Department of Health providing EHR to 2,100 MDs serving Medicaid population by 2010; implementation and QI support
  - Supporting practices to reach PPC-PCMH Level II within 2 years
- **Mid-Hudson Valley**
  - 300 practices participating in THINC RHIO with common EHR, interoperability and implementation support
  - Goal to reach PPC-PCMH Level II within 2 years
  - 6 health plans participating
- **North Carolina Medicaid**
  - Utility of 14 networks to support 3,500 MDs with care management services

Criticisms

- **Insufficient emphasis on access**
  - ***Looking at increasing in future versions***
- **Too much emphasis on HIT**
  - ***Strong support from public and private payors***
- **Doesn't get at issues beyond primary care**
  - ***Looking at medical home "neighbor"; multi-specialty environments***
- **Doesn't measure quality**
  - ***Studies have found relationship; can be combined with P4P***
- **Isn't patient-centered**
  - ***Looking at ways to further incorporate patient experience data***

Timeline/Next Steps

- Gather input from pilot testing
- Analyze data on currently Recognized practices
- Review results of ongoing PCMH demonstrations (including CMS)
- Consider testing “advanced” version
- Revise standards in 2010

PPC-PCMH

- **Encourages practices to adopt proven systems for improving care**
- **Provides mechanism for incentivizing investment in quality infrastructure and processes**
- **Complements evaluation of clinical effectiveness, patient experiences, and efficiency**