National Medical Home Summit

Using Data for Knowledge

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Quality Counts

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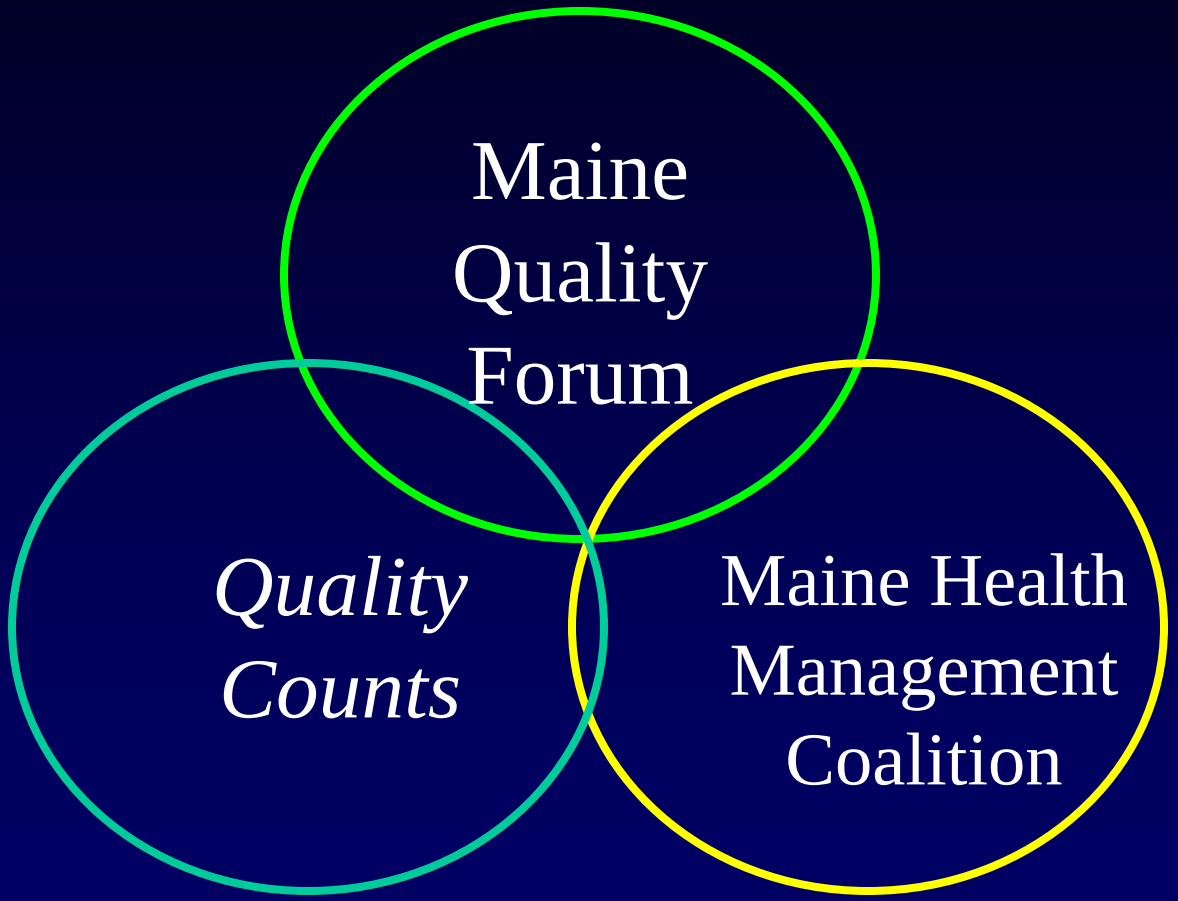
Objectives

- Review key aspects, goals for Maine PCMH Pilot
- Demonstrate ways that Maine Pilot provides practices with data feedback for improvement
- Encourage thinking about data available for your practices

Knowing Where You're Aiming

Maine PCMH Pilot Leadership



Maine PCMH Pilot

Key elements:

- 3-year multi-payer PCMH pilot
- Collaborative effort of key stakeholders, all major payers
- Adopted common mission & vision, guiding principles for Maine PCMH model
- Selected 22 adult / 4 pedi PCP practices across state
- Supporting practice transformation & shared learnings beyond pilot practices
- Committed to engaging consumers/ patients at all levels
- Planning rigorous outcomes evaluation (clinical, cost, patient experience of care)

MAINE
Patient Centered
Medical Home Pilot

Maine PCMH Pilot - Timeline

- Jan 2009: Call for practice applications
- May 2009: Practices notified – start of 6mo "ramp-up period"
- Sept-Dec 2009: practice NCQA PPC-PCMH applications, contracted with payers
- Jan 2010: Start date for PCMH payments
- Jan 2010 - Dec 2012: 3-year PCMH Pilot
- July 2011: Begin CMS MAPCP Demo

Maine PCMH Pilot
Practice "Core Expectations"

1. Demonstrated physician leadership
2. Team-based approach
3. Population risk-stratification and management
4. Practice-integrated care management
5. Same-day access
6. Behavioral-physical health integration
7. Inclusion of patients & families
8. Connection to community / local HMP
9. Commitment to waste reduction
10. Patient-centered HIT

PCMH Evaluation & Data for Improvement

- Practice changes
- Patient experience of care
  - CG-CAHPS patient surveys
- Clinical quality measures
  - Adult & pedi
- Cost & resource use (Health Dialog rpts)
  - Hosp's, readmissions, ED use, imaging

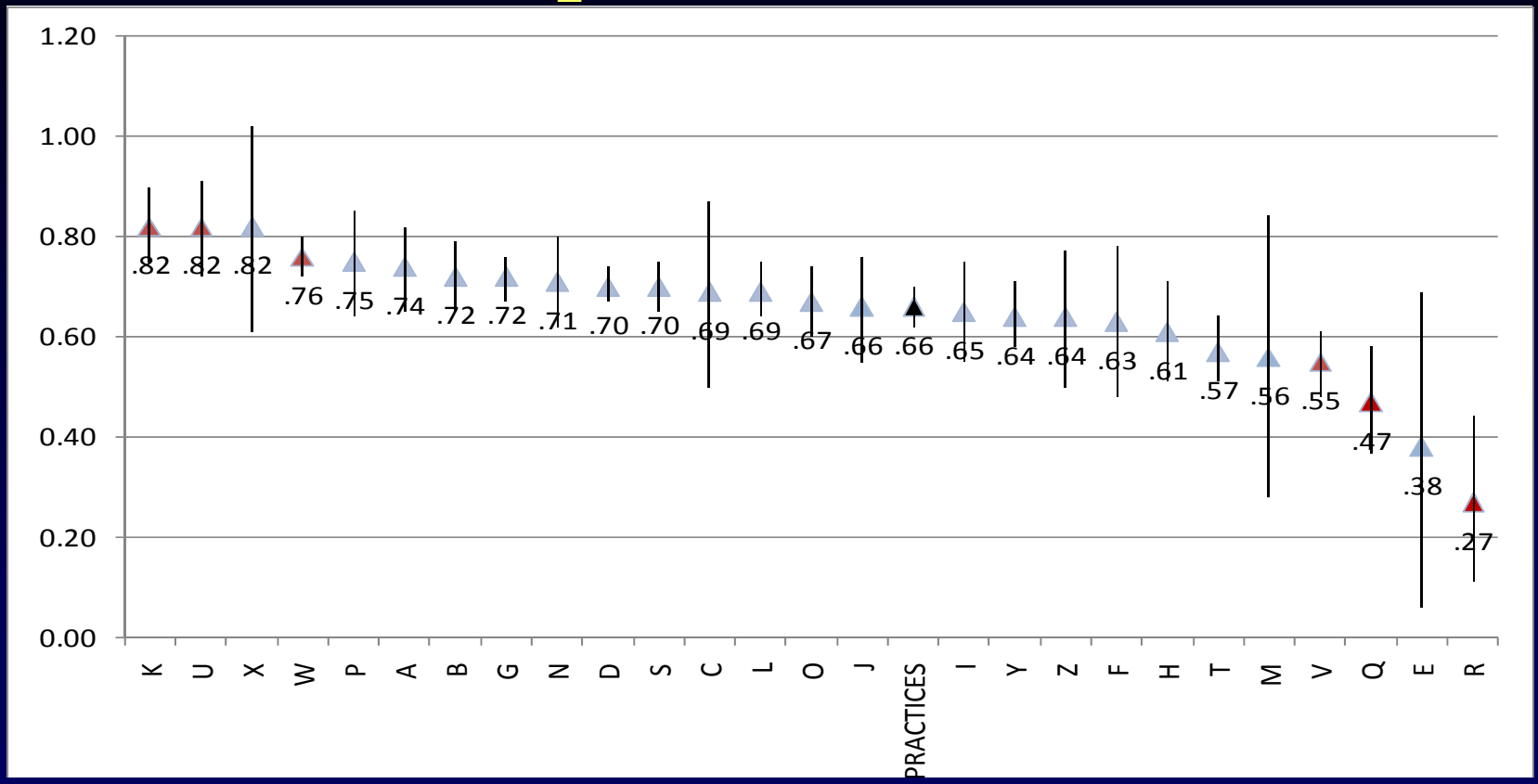
Assessing Practice Changes

- Baseline: Practice-workforce culture survey
- Ongoing – assessing adoption of PCMH Core Expectations:
  - Surveys of practice change
  - Bi-monthly practice self-reports
- Annual PCMH Dashboard

Workforce-Culture Surveys

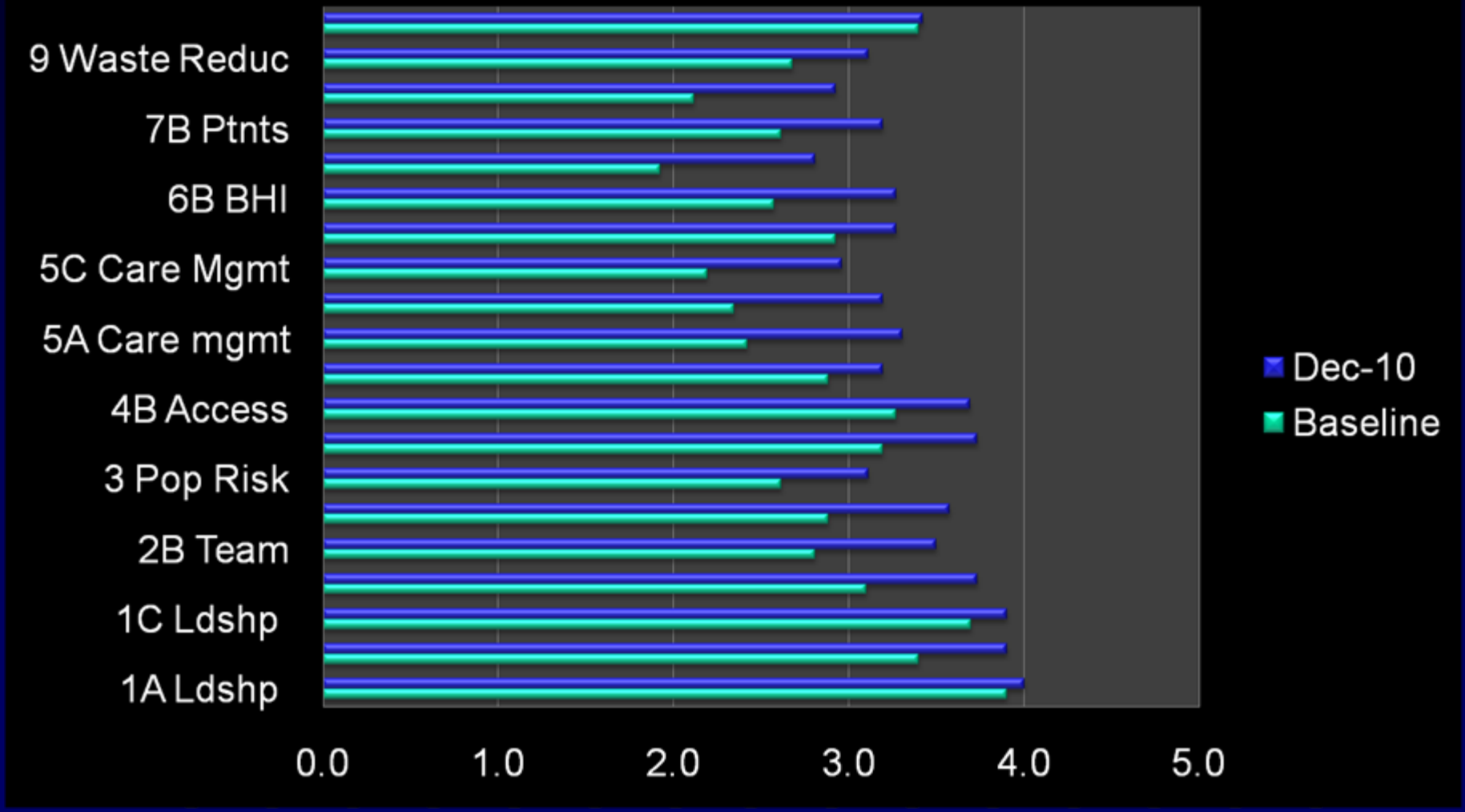
- Administered in late summer 2010
- 18 of 26 practices achieved ≥75% response rate
- Results to practices October-December, 2010
- Surveyed practices on six general dimensions:
  - adaptive reserve (AAFP/NDP), community knowledge, health information technology, patient safety culture, teamwork, staff burnout
- Using survey results to identify and feature high performing practices in various forums moving forward

Adaptive Reserve



"A strong adaptive reserve includes such capabilities as a strong relationship system within the practice, shared leadership, protected group reflection time, and attention to the local environment. In the beginning of the NDP, practices varied considerably in their adaptive reserve, and that capability was a major determinant of a practice's initial progress" (NDP)

Maine Patient Centered Medical Home Pilot
Average Performance of 26 Practices in Core Expectations
Baseline-December 2010

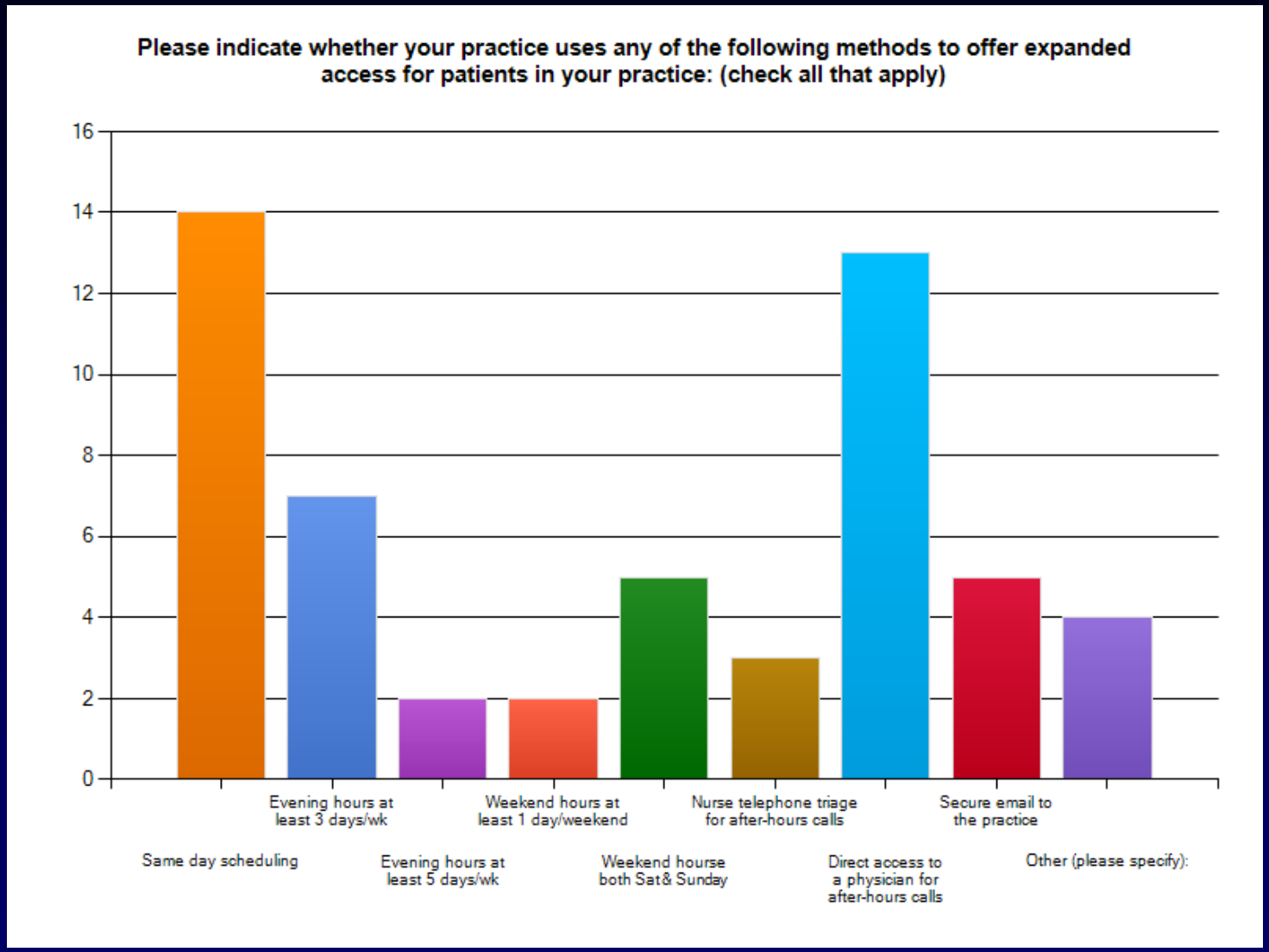


Maine PCMH Pilot Year 1 Dashboard

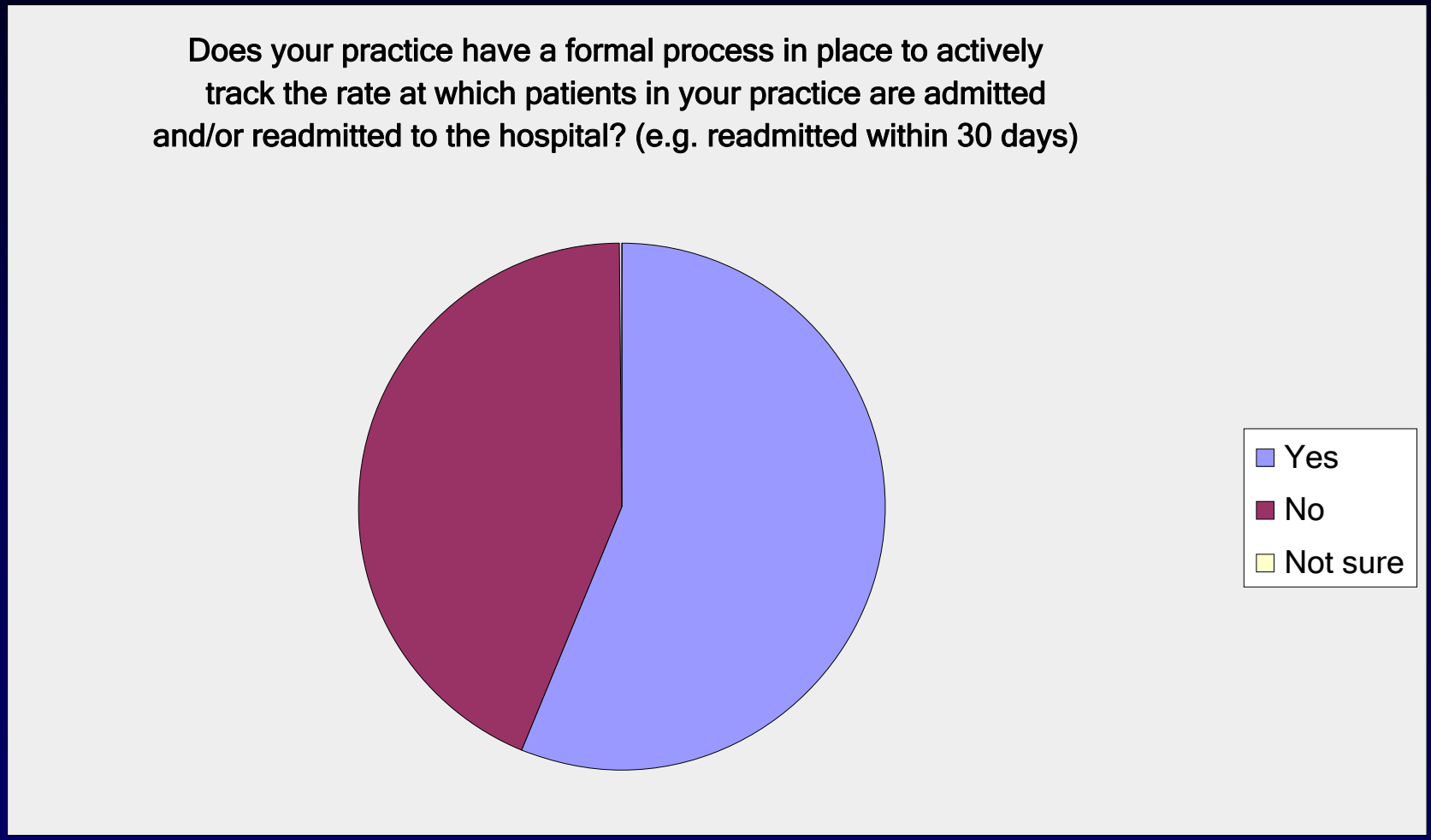
MAINE Patient Centered Medical Home Pilot

	A	B	C	D
5			* = Must Pass elemen	** Practice Self-Assessment per Practice's December
6	**Definitions**			
7	**1. Demonstrated Leadership**			
8	***Moderate progress***	***Fully Implemented***	***Year 1 Minimum Requirement***	***Practice Self-Assessment****
9	1a. The practice has identified at least one primary care physician or nurse practitioner as a leader within the practice. Leadership has made a commitment to improve care and implement the PCMH model known to some in the organization.	The practice had identified at least one primary care physician or nurse practitioner as a leader within the practice who visibly champions a commitment to improve care and implement the PCMH model.	Fully implemented* ***(Must Pass)***	Fully Implemented
10	1b. Some of the primary care leaders take an active role in working with other providers and staff in the practice to build a team-based approach to care. Individual providers, and occasional teams of providers, examine processes and structures to improve care, and review data on the performance of the practices.	All of the primary care leaders take an active role in working with other providers and staff in the practice to build a team-based approach to care, continually examine processes and structures to improve care, and review data on the performance of the practice.	Fully implemented* ***(Must Pass)***	Moderate Progress
11	1c. The primary care leader periodically participates as a member of the Leadership Team and participates in 50-75% of the PCMH Learning Collaboratives.	The primary care leader participates as a member of the practice Leadership Team and participates in all aspects of the PCMH Learning Collaborative	Fully implemented* ***(Must Pass)***	Fully Implemented
12				
13	**2. Team Based Approach to Care**			
14	***Moderate progress***	***Fully Implemented***	***Year 1***	***Practice Self-***
15	2a. Practice has conducted education on the team-based approach to care and has staff buy-in to the concept of a team-based approach to care delivery and of expanding the roles of the non-physician providers to improve clinical workflows, but has not yet fully implemented team approach.	The practice uses a team-based approach to care delivery that includes expanding the roles of non-physician providers (e.g. nurse practitioners, physician assistants, nurses, medical assistants) to improve clinical workflows.	Fully implemented	Moderate Progress
16	2b. Practice has fundamental structures in place to meet this expectation and has done training but has not yet fully implemented. Leadership's vision is known to all within the organization and a few providers are involved in testing some of the work in this area.	The practice has committed to redesigning primary care practice in a way that utilizes non-physician staff to improve access and efficiency of the practice team in specific ways, such as through greater use of planned visits, integrating care management into clinical practice, delegating some types of patient testing or exams (e.g., ordering of routine screening tests, diabetic foot exams) to non-physicians; expanding patient education; and providing greater data support to physicians	Demonstrate Moderate Progress	Early Progress
17	2c. Some members of the practice team are bought into providing care as a team and specific roles and responsibilities have been assessed and developed for the team members.	Members of the practice team identify themselves as part of the practice team, and can identify their specific role and responsibilities within the team.	Demonstrate Moderate Progress	Moderate Progress
18				
19	**3. Population risk stratification and management**			
20	***Moderate progress***	***Fully Implemented***	***Year 1***	***Practice Self-***
21	3. The practice has a process in place for proactively identifying and stratifying patients across their population who are at risk for adverse outcomes and are starting to identify direct resources or care processes to help reduce those risks.	The practice has adopted a process for proactively identifying and stratifying patients across their population who are at risk for adverse outcomes, and direct resources or care processes to help reduce those risks.	Demonstrate Moderate Progress	Moderate Progress
22				
23	**4. Enhanced Access**			
24	***Moderate progress***	***Fully Implemented***	***Year 1***	***Practice Self-***
25	4a. Leadership's vision for preserving access to their patient populations is known by most in the organization.	The practice commits to preserving access to their population of patients.	Fully implemented* ***(Must Pass)***	Early Progress

Pilot Practice Survey: Access Options



Pilot Practice Survey: Hospitalizations



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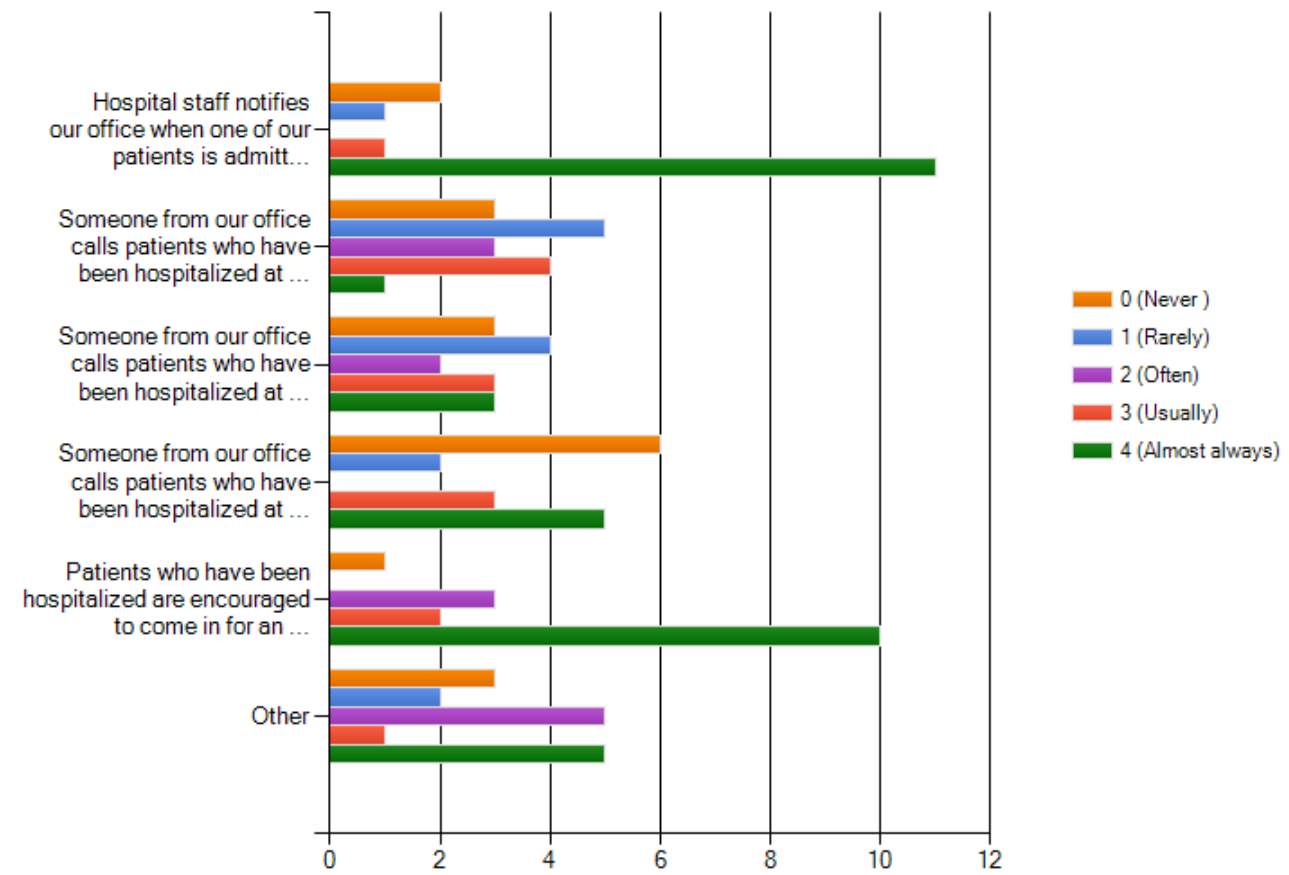


Patient Experience Surveys

- Used modified CG-CAHPS survey
- Surveys administered December 2009-May 2010 – paper & pencil, in office
- For many, first effort at formally assessing patient experience
- 25 of 26 practices collected 75% or more of their target number of surveys required (>300/practice)
- Practice-specific results reported back to all sites

Key Areas for Improvement

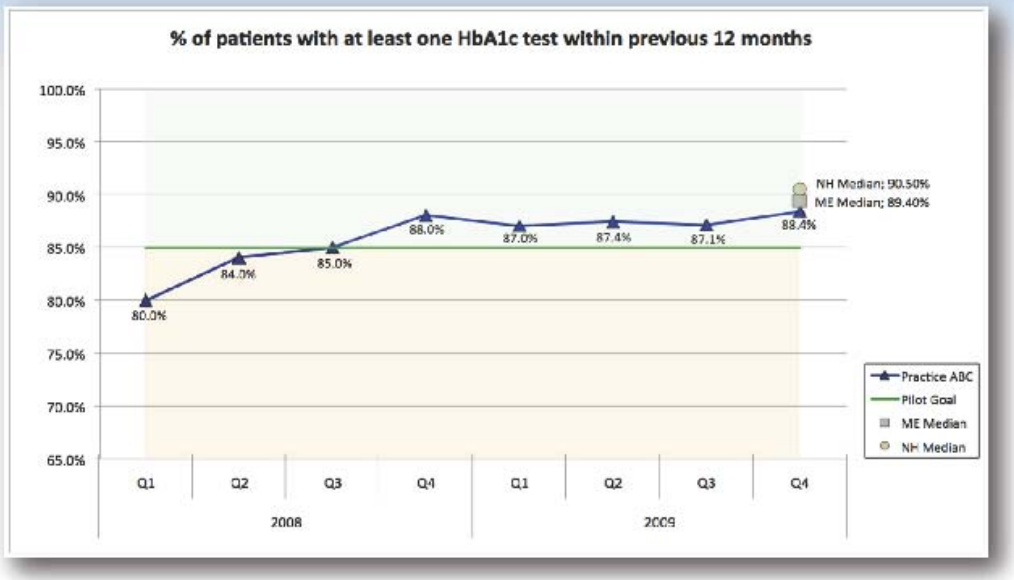
- CG-CAHPS questions (>40% “no”)
  - Between visit follow-up
  - Discussion of diet & exercise
  - Discussion of emotional concerns
  - Plan to manage care at home
- Practice-specific comments

Clinical Quality Improvement

- Practices asked to report quarterly on set of ~30 nationally-recognized clinical quality measures
  - Adult & pedi measures
  - Aligned with NCQA, PQRI, MU measures
  - Use online data reporting system
- Practices able to view their results compared to ME, NH median performance

Clinical Quality Improvement

Measure Chart (option 2)



Data Feedback: Cost & Resource Use

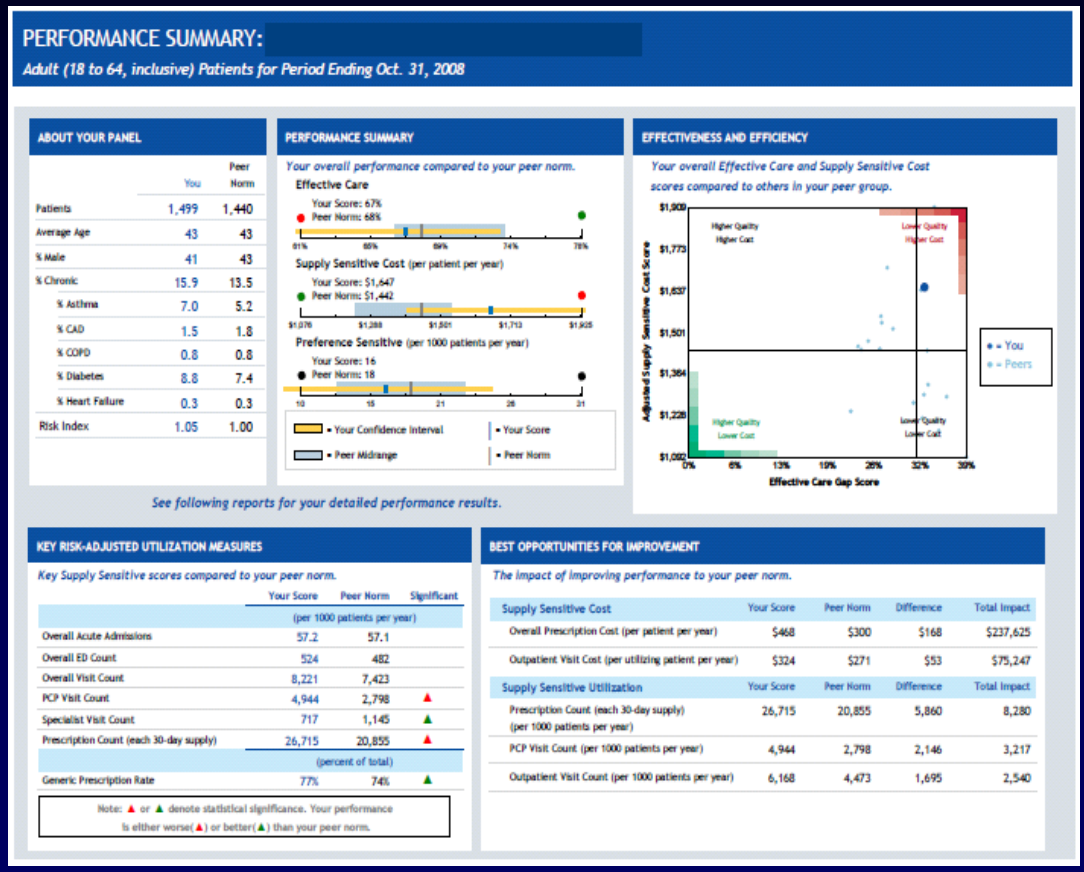
- Use claims from Maine All-Claims Paid Database, via MHDO
- MQF contracts with Health Dialog to produce reports
- First reports delivered to practices mid-August, using 2008 claims data
- Anticipate ongoing, q6mos reports

Health Dialog Provider Performance Measurement Reports

Performance Summary

Performance summary includes:

- Demographics about practice's panel
- Overall practice performance compared to peers in 3 areas of unwarranted variation
- Evaluation of overall effectiveness and efficiency
- Practice's score on 6 key utilization measures
- Best opportunities for improvement in the practice



PERFORMANCE SUMMARY:

Adult (18 to 64, inclusive) Patients for Period Ending Oct. 31, 2008

ABOUT YOUR PANEL

	You	Peer Norm
Patients	1,499	1,440
Average Age	43	43
% Male	41	43
% Chronic	15.9	13.5
% Asthma	7.0	5.2
% CAD	1.5	1.8
% COPD	0.8	0.8
% Diabetes	8.8	7.4
% Heart Failure	0.3	0.3
Risk Index	1.05	1.00

PERFORMANCE SUMMARY

Your overall performance compared to your peer norm.

Effective Care — Your Score: 67% · Peer Norm: 68%

Supply Sensitive Cost (per patient per year) — Your Score: $1,647 · Peer Norm: $1,442

Preference Sensitive (per 1000 patients per year) — Your Score: 16 · Peer Norm: 18

Your Confidence Interval · Your Score · Peer Midrange · Peer Norm

See following reports for your detailed performance results.

EFFECTIVENESS AND EFFICIENCY

Your overall Effective Care and Supply Sensitive Cost scores compared to others in your peer group.

Adjusted Supply Sensitive Cost Score — Effective Care Gap Score

Higher Quality Higher Cost · Lower Quality Higher Cost · Higher Quality Lower Cost · Lower Quality Lower Cost · You · Peers

KEY RISK-ADJUSTED UTILIZATION MEASURES

Key Supply Sensitive scores compared to your peer norm.

	Your Score	Peer Norm	Significant
	(per 1000 patients per year)		
Overall Acute Admissions	57.2	57.1	
Overall ED Count	524	482	
Overall Visit Count	8,221	7,423	
PCP Visit Count	4,944	2,798	▲
Specialist Visit Count	717	1,145	▲
Prescription Count (each 30-day supply)	26,715	20,855	▲
	(percent of total)		
Generic Prescription Rate	77%	74%	▲

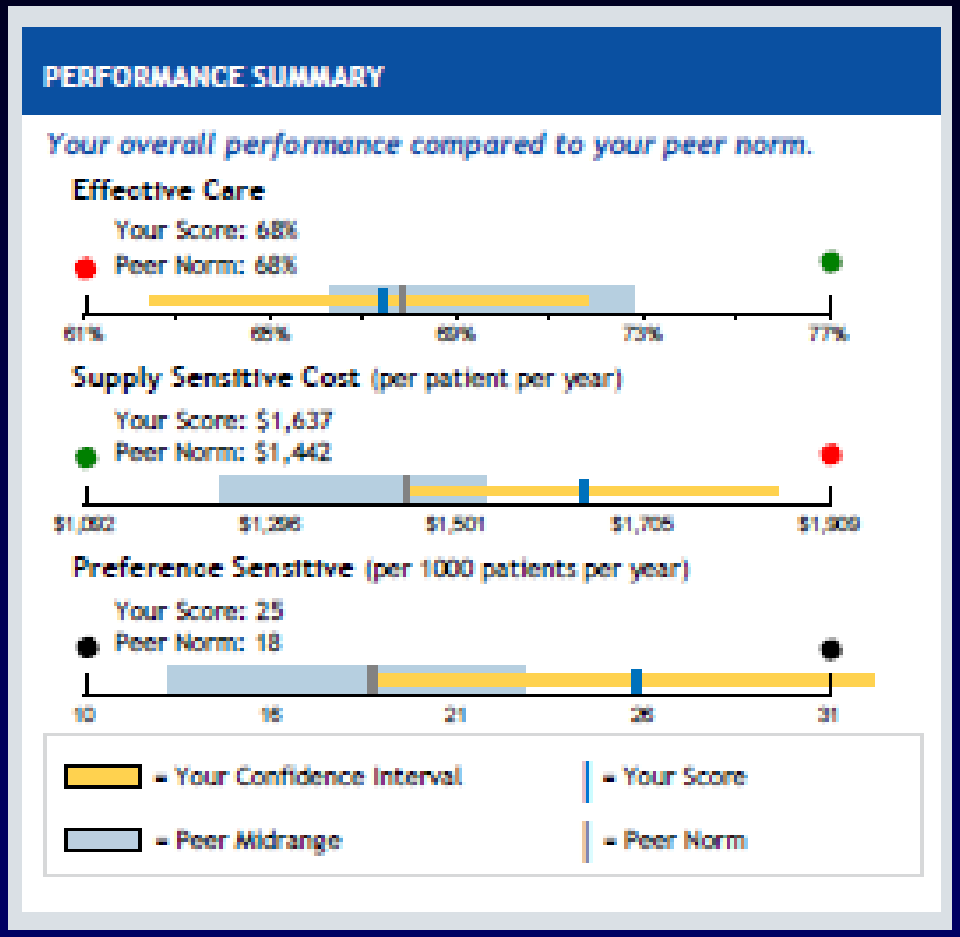
Note: ▲ or ▲ denote statistical significance. Your performance is either worse(▲) or better(▲) than your peer norm.

BEST OPPORTUNITIES FOR IMPROVEMENT

The impact of improving performance to your peer norm.

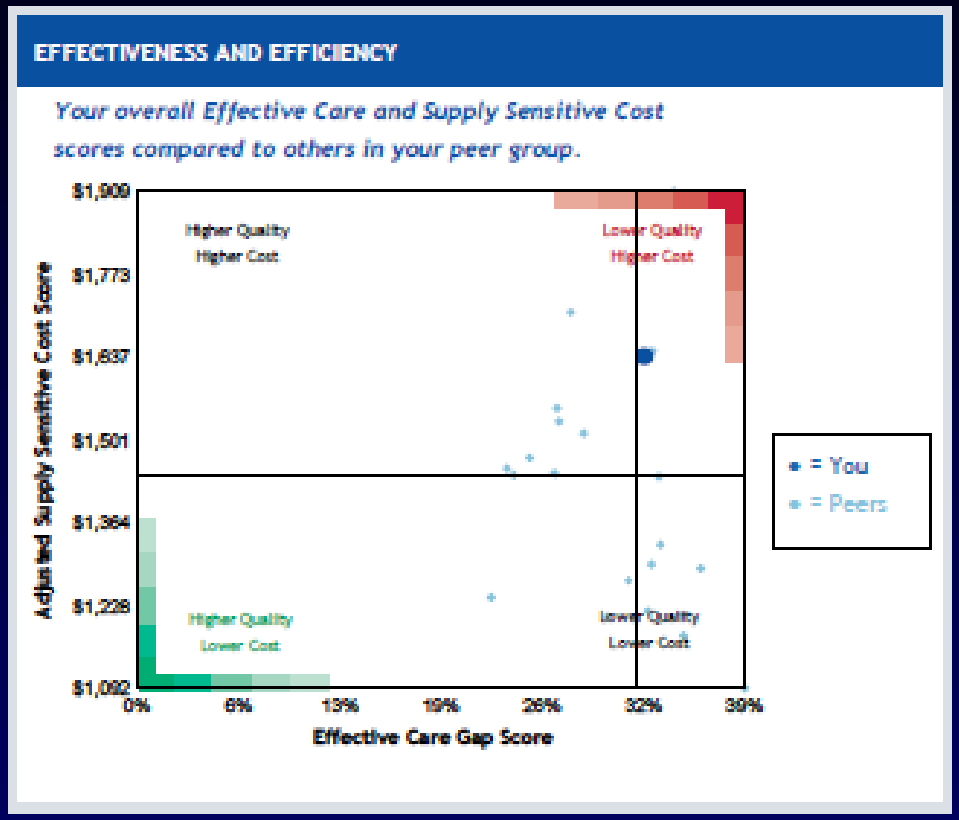
Supply Sensitive Cost	Your Score	Peer Norm	Difference	Total Impact
Overall Prescription Cost (per patient per year)	$468	$300	$168	$237,625
Outpatient Visit Cost (per utilizing patient per year)	$324	$271	$53	$75,247
Supply Sensitive Utilization	**Your Score**	**Peer Norm**	**Difference**	**Total Impact**
Prescription Count (each 30-day supply) (per 1000 patients per year)	26,715	20,855	5,860	8,280
PCP Visit Count (per 1000 patients per year)	4,944	2,798	2,146	3,217
Outpatient Visit Count (per 1000 patients per year)	6,168	4,473	1,695	2,540

Performance Summary



- Practice's overall score is compared to peer norm in each of 3 categories of unwarranted variation:
  - Effective care (evidence based treatment or intervention to improve health status or quality of life)
  - Supply sensitive care (services that strongly correlate with resource supply)
  - Preference sensitive care (conditions that have multiple treatment options and the treatment decision should reflect the patient's preferences

Effectiveness and Efficiency



- Looks at overall supply sensitive cost score compared to the overall effective care gap score
- Practice is compared to other practices on a scatter plot with four quadrants based on the population medians

Utilization Measures

- Utilization measures look at overall admissions, emergency department visits, and PCP and specialist visits per 1000 patients per year
- Summary measures on prescription count per 1,000 patients and generic fill rate are included
- Colored triangles indicate where practice is significantly different from peers

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Best Opportunities for Improvement

BEST OPPORTUNITIES FOR IMPROVEMENT

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Shows where practice is significantly different from peers AND where the total impact of improving is highest

Practice Summary - Comparative Data

Panel Size	% Medicaid	Average Age	% Male	Risk Index	% Chronic	Overall SS Cost	Overall Effective Care	Overall Acute Admissions	Overall ED Count	PCP Visit Count	Specialist Visit Count	Overall Prescription Count	Generic Prescription Rate
400	30%	44.85	27.5%	1.08	16%	$1,531.35	73.1%	57.6	556	2,668	1,229	26,769	81.6%
1,844	38%	43.82	39.0%	0.98	11%	$1,178.60	65.2%	62.5	491	2,326	804	20,891	75.5%
676	16%	43.97	52.1%	0.94	10%	$1,211.26	65.4%	57.5	425	2,654	1,091	16,906	71.0%
648	4%	40.49	42.0%	1.01	9%	$1,209.27	70.1%	55.5	401	2,757	1,591	17,414	70.5%
628	59%	40.71	38.9%	1.05	15%	$1,710.20	72.4%	56.5	548	5,168	641	25,615	73.4%
2,621	38%	41.52	44.7%	0.98	13%	$1,328.60	66.7%	59.4	447	3,110	1,168	21,577	75.9%
1,196	34%	40.52	32.3%	1.07	13%	$1,268.90	68.7%	62.7	463	3,200	676	20,745	73.9%
1,838	16%	45.80	47.6%	1.04	15%	$1,453.65	76.5%	57.7	447	2,183	1,122	21,068	72.4%
871	46%	40.61	37.2%	1.04	13%	$1,440.21	66.8%	56.8	836	2,493	946	23,945	77.8%
343	8%	46.88	51.9%	1.05	13%	$1,552.45	73.3%	58.8	472	4,010	1,362	18,757	73.7%
1,505	4%	42.23	42.1%	0.98	10%	$1,241.21	77.5%	51.0	323	2,872	1,523	15,283	70.4%
1,502	22%	47.13	55.9%	0.97	16%	$1,510.93	71.6%	52.8	497	2,482	1,401	22,183	75.6%
713	13%	50.67	53.4%	0.97	15%	$1,443.03	76.0%	55.8	528	2,668	1,511	20,373	74.9%
1,499	42%	42.77	40.6%	1.05	16%	$1,647.15	67.2%	57.2	524	4,944	717	26,715	76.6%
2,617	45%	41.68	41.2%	1.03	15%	$1,637.47	67.7%	61.7	502	3,731	1,040	24,120	70.7%
1,947	56%	41.85	35.9%	1.05	18%	$1,908.98	65.8%	56.9	541	4,539	1,050	30,260	72.5%
1,380	44%	43.20	34.1%	0.99	13%	$1,218.97	67.5%	59.7	574	3,208	711	20,710	73.9%
2,502	9%	46.59	50.9%	0.99	17%	$1,471.21	75.0%	56.4	355	3,121	1,938	19,975	71.0%
491	15%	46.27	55.8%	0.93	10%	$1,092.12	61.3%	53.3	430	2,355	1,253	15,621	72.5%
1,768	53%	40.36	39.3%	0.96	15%	$1,289.39	64.1%	57.4	533	2,840	970	22,578	74.2%
2,841	22%	44.11	37.0%	1.02	12%	$1,445.69	73.4%	53.4	351	2,450	1,280	20,819	74.5%
859	2%	40.39	37.3%	0.96	11%	$1,295.87	67.3%	52.7	371	2,688	1,397	17,847	69.7%

Data Feedback - Lessons Learned Maine PCMH Pilot

- Change starts with effective leadership – aka, “Culture eats data for breakfast…”
- Data without a plan is just data
- Risk of data overload – need to parse, focus data for improvement
- Change happens through effective teams
- Recognize value of external & internal QI coaching

Where We're Aiming: Medical Home Is Where…

- Patients feel welcomed
- Staff takes pleasure in working
- Physicians feel energized every day

Getting Started – It's Time!

- Start where you are.
- Use what you have.
- Do what you can.

~ Arthur Ashe ~

www.mainequalitycounts.org

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    (See “Major Programs” → “PCMH Pilot”)