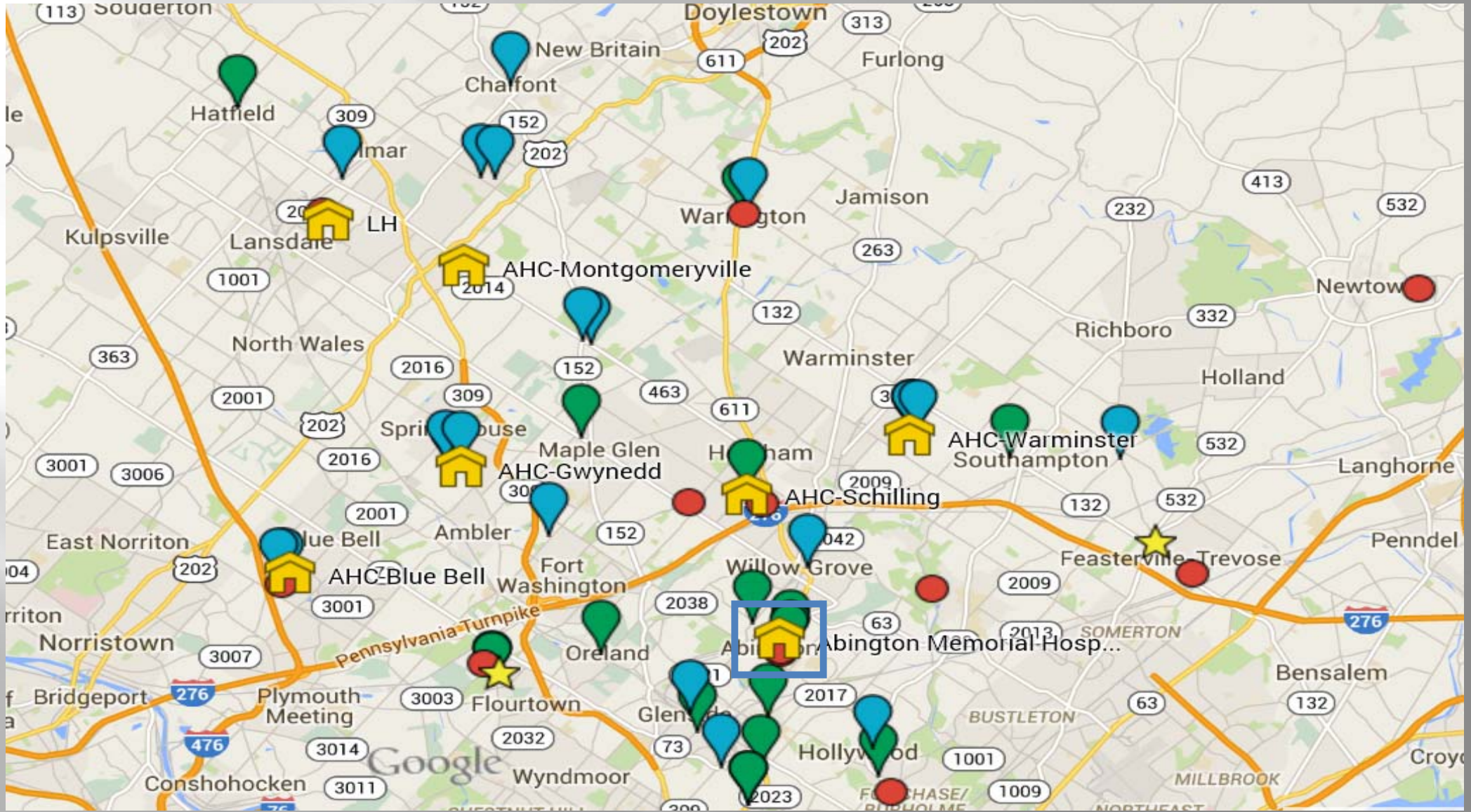
A PCMH JOURNEY
ABINGTON HEALTH PHYSICIANS

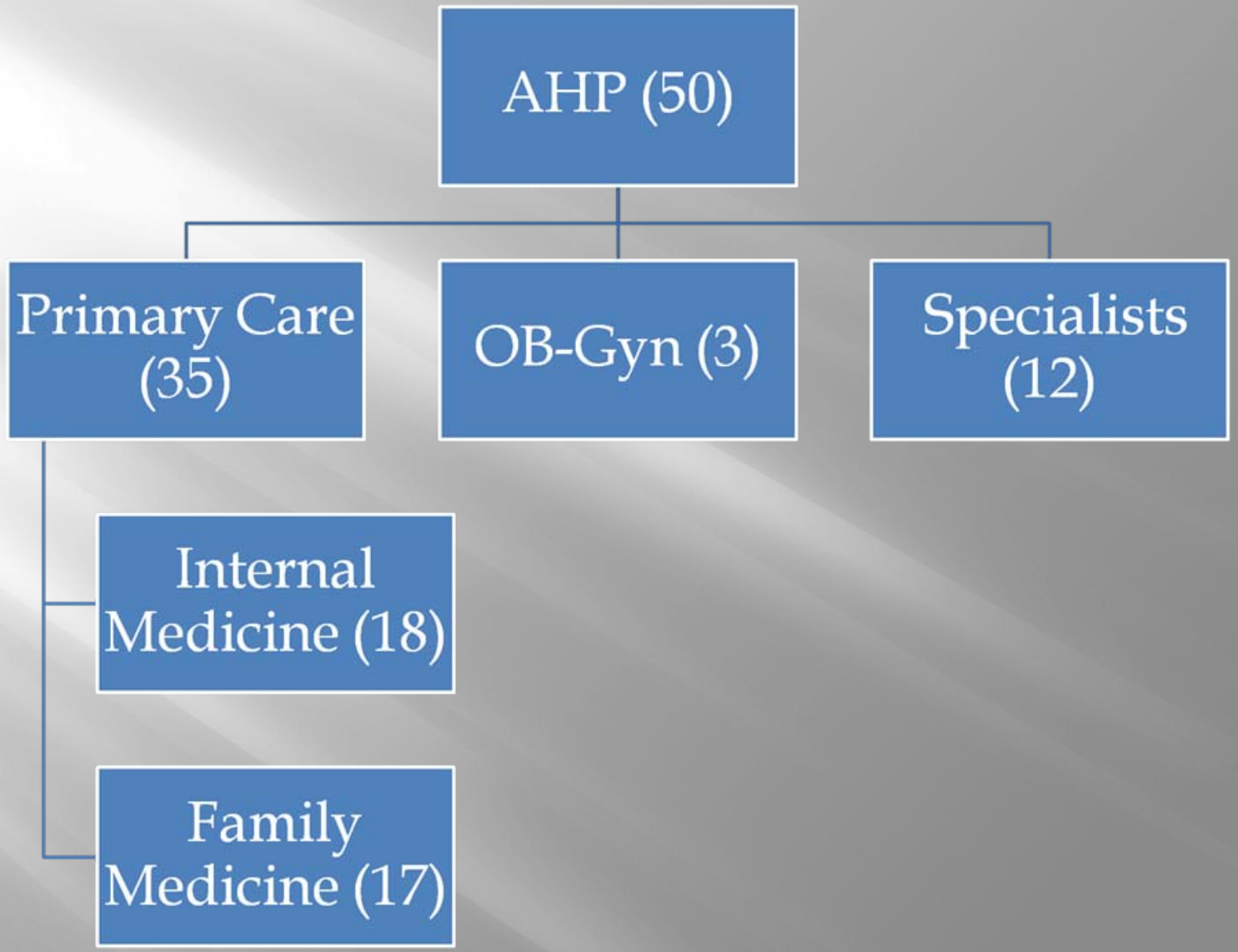
Steven Spencer, MD, MPH

Director of Population Management, Abington Health System

Abington Health System

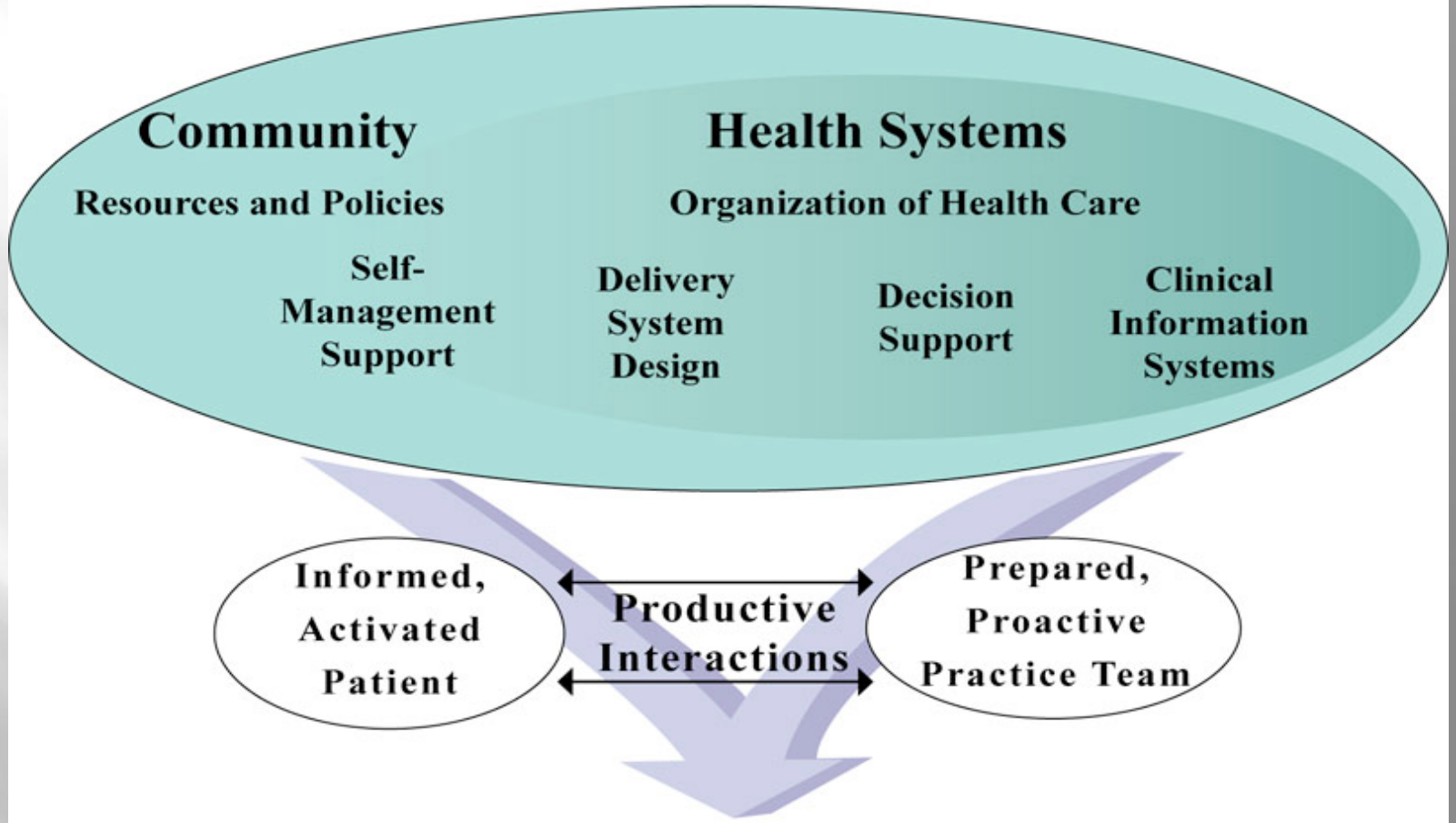
- Located in Philly suburbs
- Two acute care hospitals
- Two urgent care centers
- Multiple Medical Campuses
- Abington Health Physicians (AHP)


Souderton
Doylestown
New Britain
Chalfont
Hatfield
Furlong
Jamison
Kulpsville
Lansdale
LH
AHC-Montgomeryville
Newtown
Richboro
North Wales
Warminster
Holland
Maple Glen
AHC-Gwynedd
AHC-Warminster
Southampton
AHC-Schilling
Langhorne
East Norriton
Ambler
Fort Washington
Willow Grove
Penndel
Feasterville-Trevose
AHC-Blue Bell
Norristown
Pennsylvania Turnpike
Oreland
Abington Memorial Hosp...
SOMERTON
Bensalem
Bridgeport
Plymouth Meeting
Flourtown
BUSTLETON
Conshohocken
Wyndmoor
MILLBROOK
Google

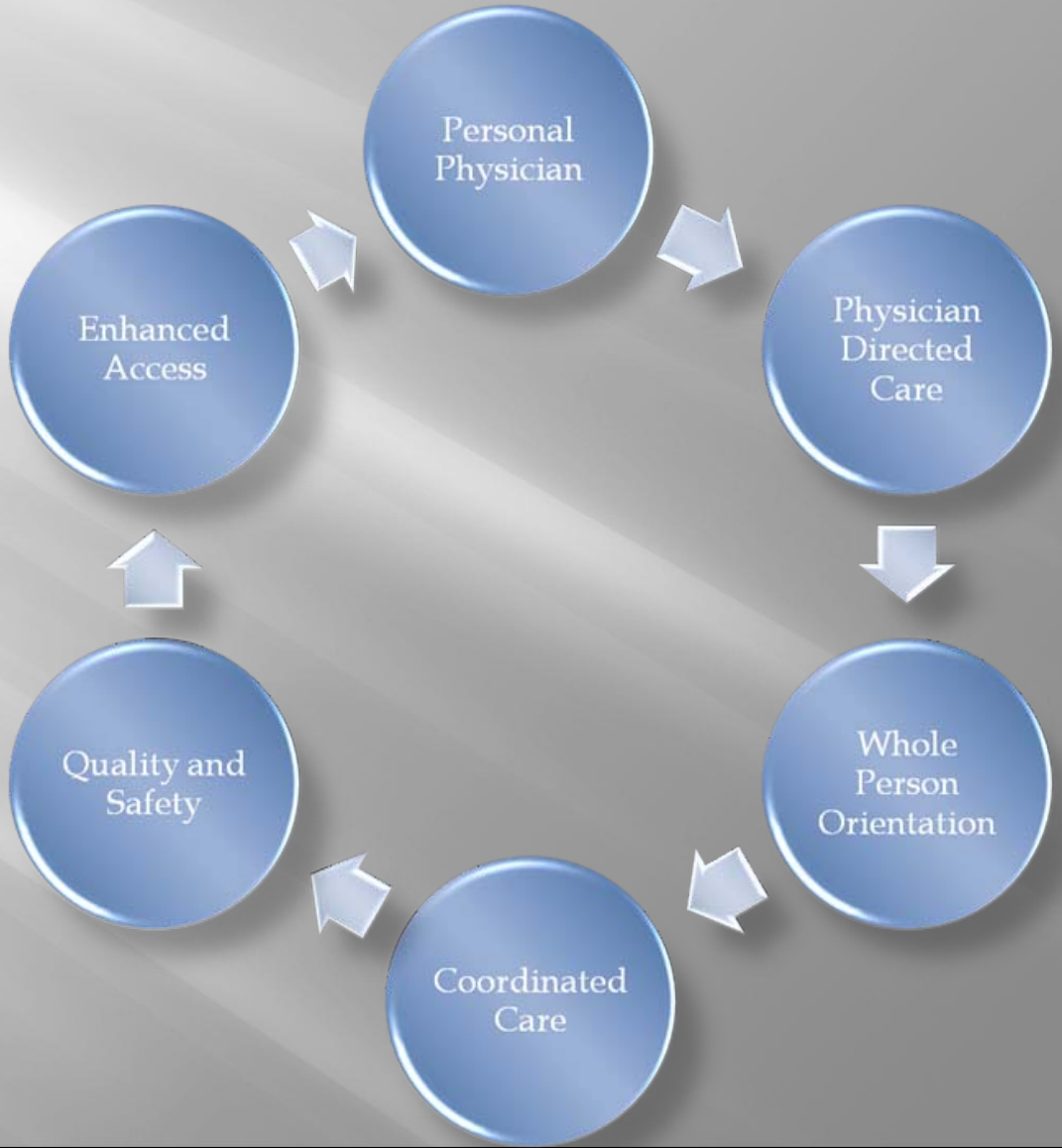

AHP (50)
Primary Care (35)
OB-Gyn (3)
Specialists (12)
Internal Medicine (18)
Family Medicine (17)

What is the Patient Centered Medical Home?

The Chronic Care Model

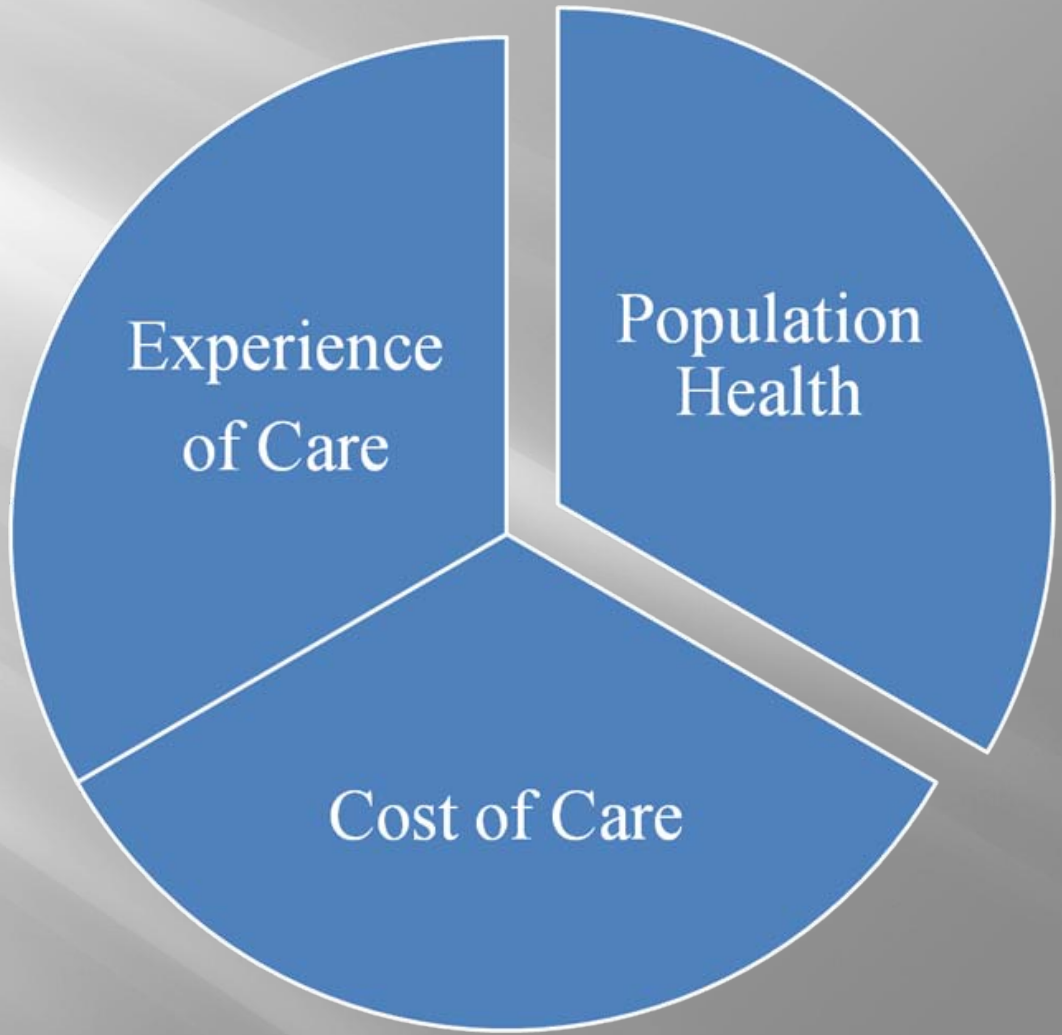


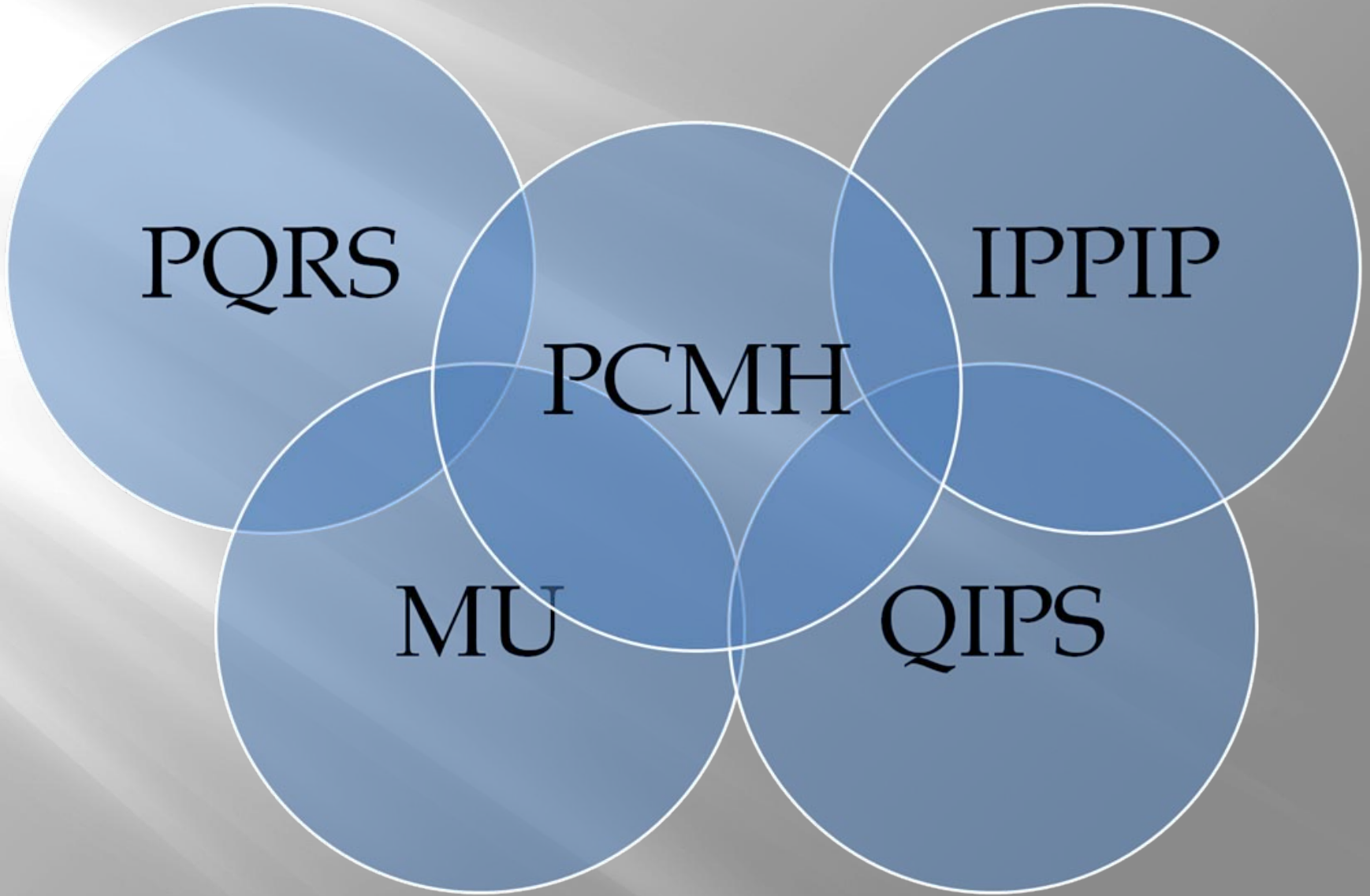
Improved Outcomes


Personal Physician
Physician Directed Care
Whole Person Orientation
Coordinated Care
Quality and Safety
Enhanced Access

What was the expected benefit of certifying our offices?

Triple Aim




PQRS
IPPIP
PCMH
MU
QIPS

Patient-Centered Medical Home incentive program

The Patient-Centered Medical Home (PCMH) incentive program rewards offices that have been recognized by the National Committee for Quality Assurance (NCQA) for achieving the Physician Practice Connections® (PPC)-PCMH standards of health care delivery. These standards, endorsed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, require enhanced access and communication, patient tracking, care management, patient self-management support, electronic prescribing, test tracking, performance reporting and improvement, and advanced electronic communication. More information on PCMH recognition and the PPC-PCMH standards are available on the NCQA website at *www.ncqa.org/tabid/631/default.aspx*.

Practice and member eligibility requirements for the PCMH incentive program

All practices that have met the QIPS prerequisites and quality performance requirements are eligible for the PCMH incentive program. There are *no* minimum membership thresholds.

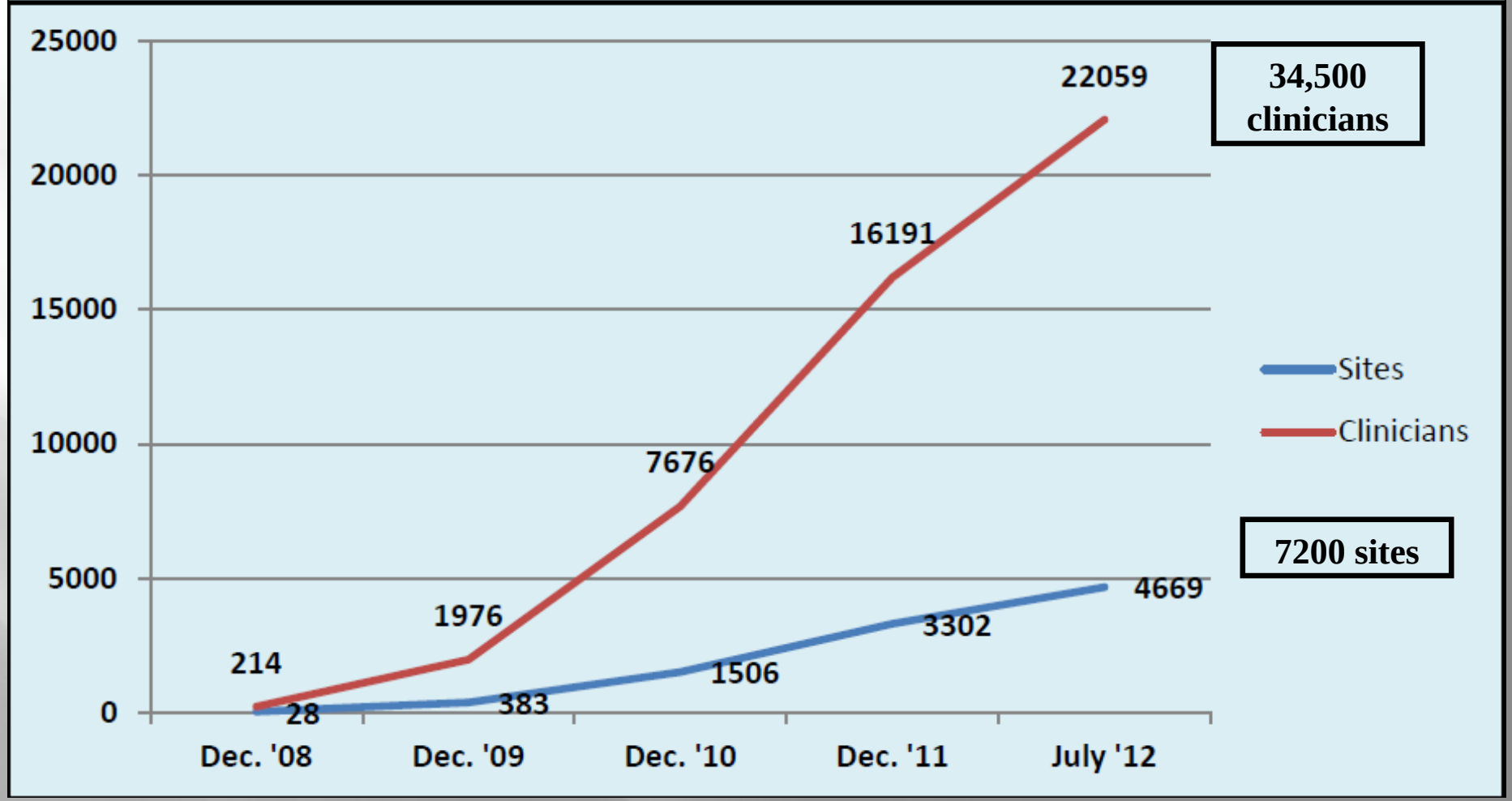
Payment of PCMH incentive

Once each month, KHPE will receive notification from NCQA of practices that have received PCMH recognition. Practices will be eligible for payment 30 days following KHPE's receipt of notification from NCQA, not the date on the certificate. This incentive is paid on a fixed PMPM basis, based on the membership on record as of the first day of the month during which the incentive is paid.

PCMH incentive payments*	
NCQA level of recognition	**Commercial HMO/POS and Medicare Advantage HMO PMPM**
Level III	$3.00
Level II	$2.00
Level I	$1.25

NCQA Patient-Centered Medical Home Recognition Growth Since 2008

22,059 Clinicians in 4,669 Recognized PCMH Practices as of July 31, 2012



What Did We Do, Part I?

PPC 1: Access and Communication — 9.00 points

The practice has standards for access to care and communication with patients, and monitors its performance to meet the standards.

Intent

The practice provides patient access during and after regular business hours, and communicates with patients effectively.

Element A: Access and Communication Processes — 4.00 points

The practice establishes in writing standards for the following processes to support patient access:	Yes	No	NA
1. Scheduling each patient with a personal clinician for continuity of care	☐	☐	
2. Coordinating visits with multiple clinicians and/or diagnostic tests during one trip	☐	☐	
3. Determining through triage how soon a patient needs to be seen	☐	☐	
4. Maintaining the capacity to schedule patients the same day they call	☐	☐	
5. Scheduling same day appointments based on practice's triage of patients' conditions	☐	☐	
6. Scheduling same day appointments based on patient's/family's requests	☐	☐	
7. Providing telephone advice on clinical issues during office hours by physician, nurse or other clinician within a specified time	☐	☐	
8. Providing urgent phone response within a specific time, with clinician support available 24 hours a day, 7 days a week	☐	☐	
9. Providing secure e-mail consultations with physician or other clinician on clinical issues, answering within a specified time	☐	☐	
10. Providing an interactive practice Web site	☐	☐	
11. Making language services available for patients with limited English proficiency	☐	☐	☐
12. Identifying health insurance resources for patients/families without insurance.	☐	☐	

Scoring

100%	75%	50%	25%	0%
Practice has written process for 9-12 items	Practice has written process for 7-8 items	Practice has written process for 4-6 items	Practice has written process for 2-3 items	Practice has written process for 0-1 items

Data source Documented process, Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Diabetes guidelines*

Internal Medicine Associates of Abington-Maple Glen

Abington Health Physicians

(Adopted March 2011, Revised September 2013)

- Screening for all patients
  - With 1 or more risk factors for CAD (e.g. hypertension, tobacco use, early family history of CAD, etc.)
  - Family history of diabetes in first degree relative
  - BMI>30
  - Clinical symptoms of diabetes (e.g. polyuria or polydipsia)
  - History of gestational diabetes or delivered child >9 pounds
- Diabetic diagnosis defined as
  - fasting blood sugar>126
  - HgbA1c> 6.5
  - Non-fasting blood sugar>200 with clinical symptoms of diabetes
- Diabetic labs
  - HgbA1c measured at least once every six months (Quarterly for hgbA1c>9)
  - Creatinine measured at least once every six months
  - Fasting lipid profile at least once a year
  - Urine microalbumin at least once a year
- Diabetic exams


Order Sets
Search for Order Sets
ORDER SET: CHF-PCMH
New
Update
Delete
MEASURE:
QUICK ORDER SET: YES
PRACTICE ADMINISTRATOR
DIAGNOSES (TRIGGER):
425.4 Congestive cardiomyopathy
428.0 Congestive heart disease, unspecified
428.20 Systolic heart failure, unspecified
428.30 DIASTOLC HRT FAILURE NOS
DIAGNOSES (LINKED): (SAME AS TRIGGER)
AGE (TRIGGER): All Age
GENDER (TRIGGER): Unknown
Rx
Browse
Name | Strength | Take | Freq | Duration | Refills | Route | Formulation | Dispense | Del
Metoprolol Tartrate | 25 MG | 1 tablet | Twice a day | 30 day(s) | | Orally | Tablet | 60
Furosemide | 20 MG | 1 tablet | Once a day | 30 day(s) | | Orally | Tablet | 30
Spironolactone | 25 MG | 1 tablet | Twice a day | 30 day(s) | | Orally | Tablet | 60
Losartan Potassium | 25 MG | 1 tablet | Once a day | 30 day(s) | | Orally | Tablet | 30
Carvedilol | 6.25 MG | 1 tablet with food | Twice a day | 30 day(s) | | Orally | Tablet | 60
Lisinopril | 10 MG | 1 tablet | Once a day | 30 day(s) | | Orally | Tablet | 30
Labs
Browse
Description | Delete
COMP METABOLIC PANEL - FASTING
B-Type Natriuretic Peptide
BASIC METABOLIC PANEL FASTING
LIPID PROFILE
Diagnostic Imaging
Browse
Description | Delete
Chest - 2 Views
ECHO CARDIOGRAM
Procedures
Browse
Description | Delete
ECG Recording

Patient: Test, PCMH **DOB:** 01/01/1960 **Age:** 51 Y **Sex:** Female
Phone: 215-481-2000 **Primary Insurance:**
Address: 1200 Old York Road, Abington, PA-19001
Encounter Date: 06/17/2011 **Provider:** Steven E. Spencer, M.D.
Appointment Facility: IMAA

Subjective:

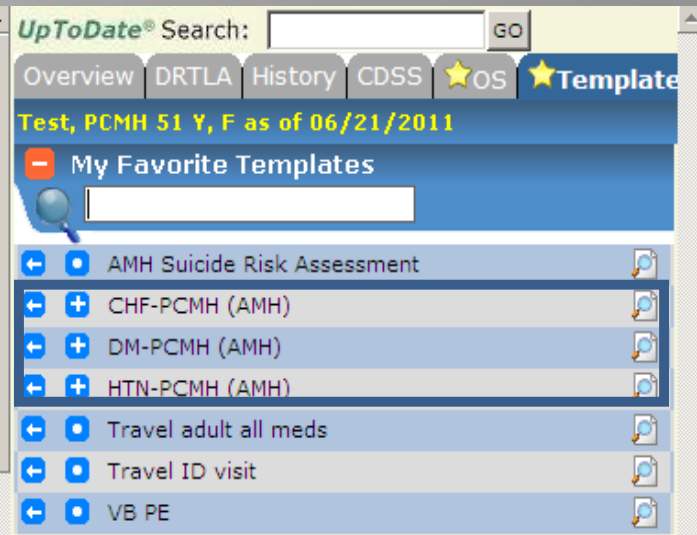
Chief Complaint(s):

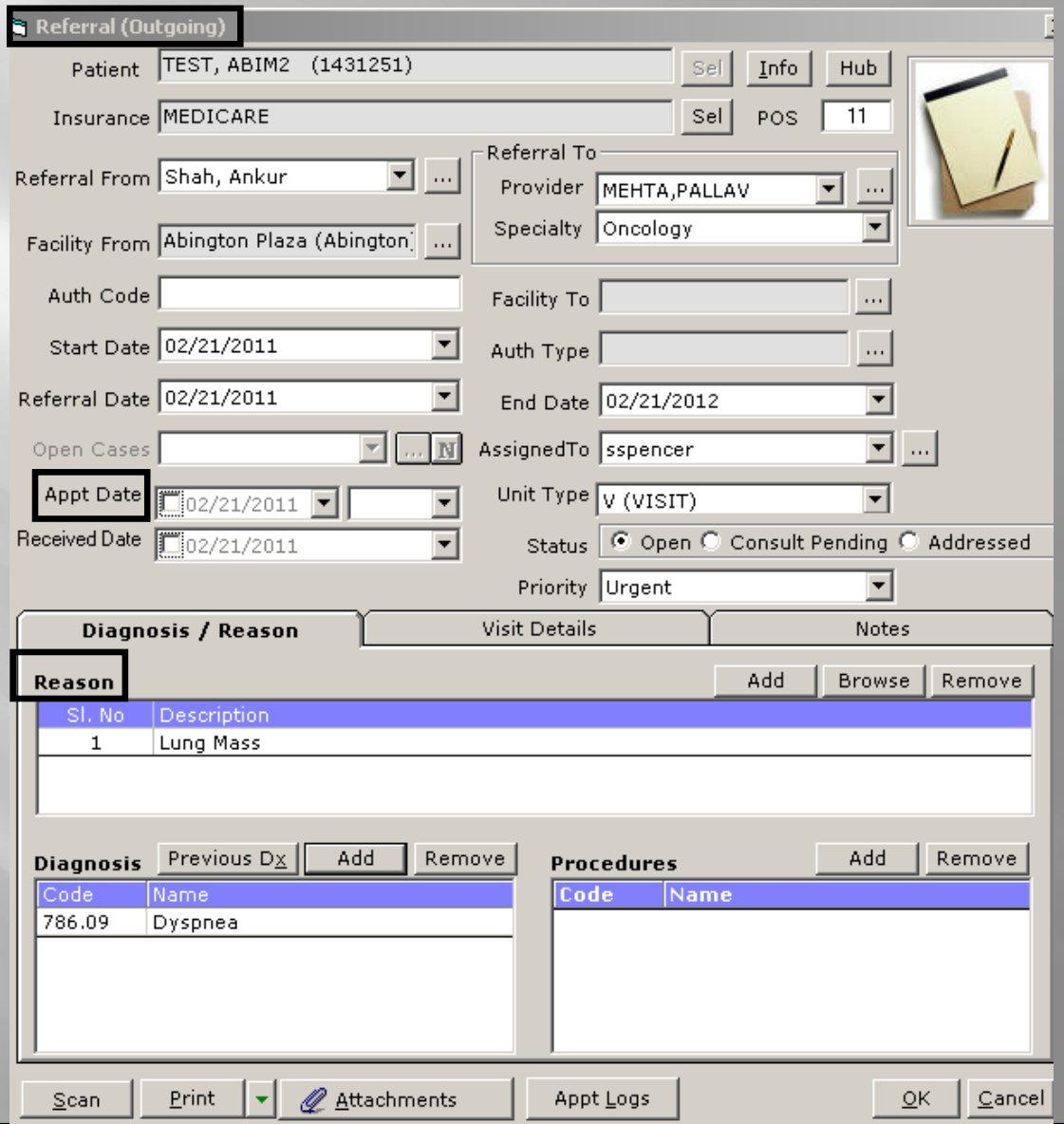
HPI:

Congestive Heart Failure

Patient with a history of congestive heart failure
Reviewed compliance with diet and exercise
Reviewed medication and any barriers to compliance
Reviewed today's weight and weight from home
Reviewed today's blood pressure and heart rate
Reviewed last BMP, fasting lipid profile
Reviewed immunizations including pneumovax and influenza

Current Medication:
Medical History:
Allergies/Intolerance:
Gyn History:
OB History:
Surgical History:
Hospitalization:
Family History:
Social History:
ROS:




Referral (Outgoing)
Patient
TEST, ABIM2 (1431251)
Sel
Info
Hub
Insurance
MEDICARE
Sel
POS
11
Referral From
Shah, Ankur
Referral To
Provider
MEHTA,PALLAV
Specialty
Oncology
Facility From
Abington Plaza (Abington)
Auth Code
Facility To
Start Date
02/21/2011
Auth Type
Referral Date
02/21/2011
End Date
02/21/2012
Open Cases
AssignedTo
sspencer
Appt Date
02/21/2011
Unit Type
V (VISIT)
Received Date
02/21/2011
Status
Open
Consult Pending
Addressed
Priority
Urgent
Diagnosis / Reason
Visit Details
Notes
Reason
Add
Browse
Remove
Sl. No
Description
1
Lung Mass
Diagnosis
Previous Dx
Add
Remove
Code
Name
786.09
Dyspnea
Procedures
Add
Remove
Code
Name
Scan
Print
Attachments
Appt Logs
OK
Cancel

Registry

Imm / T. Inj | Encounters | Structured Data | Saved Reports | Referrals | Reports | Allergies

Demographics | Vitals | **Labs / DI / Proc.** | ICD | CPT | Rx | Chief Complaints | Medical History

Imaging: Colonoscopy — Sel

Result: ...

Attribute	Lower Limit	Upper Limit

Results Date Range: 1 / 1 /2003 to 12/31/2012

Actual Fasting: Fasting — Ordered Fasting

Number of tests >= — Ignore Fasting Conditions

Query Attributes — Include tests with no results

Save Queries | Run Subset (NOT) | Run Subset | Run New

		Patient Name	DOB	Sex	Age	Tel. No	Acc #
☑	w		05/09/1947	f	67Y		
☑			08/12/1956	f	58Y		
☑	w		03/15/1955	f	60Y		
☑			11/19/1951	m	63Y		
☑	w		03/09/1954	f	61Y		
☑	w		08/01/1950	f	64Y		
☑	w		09/01/1955	m	59Y		
☑	w		04/10/1939	m	75Y		
☑			10/21/1962	M	52Y		
☑	w		11/03/1949	f	65Y		
☑	w		12/23/1955	f	59Y		
☑	w		05/05/1955	f	59Y		
☑	w		03/18/1940	m	74Y		
☑	w		06/14/1950	f	64Y		

Encounters :: From Date >= 01/01/2011 AND To Date <= 12/31/2011 AND Appt Providers = Spencer,Steven; Spencer,Steven AND Office Visits Only AND Mode=Facility AND Facility= IMAA AND VisitType=ALL

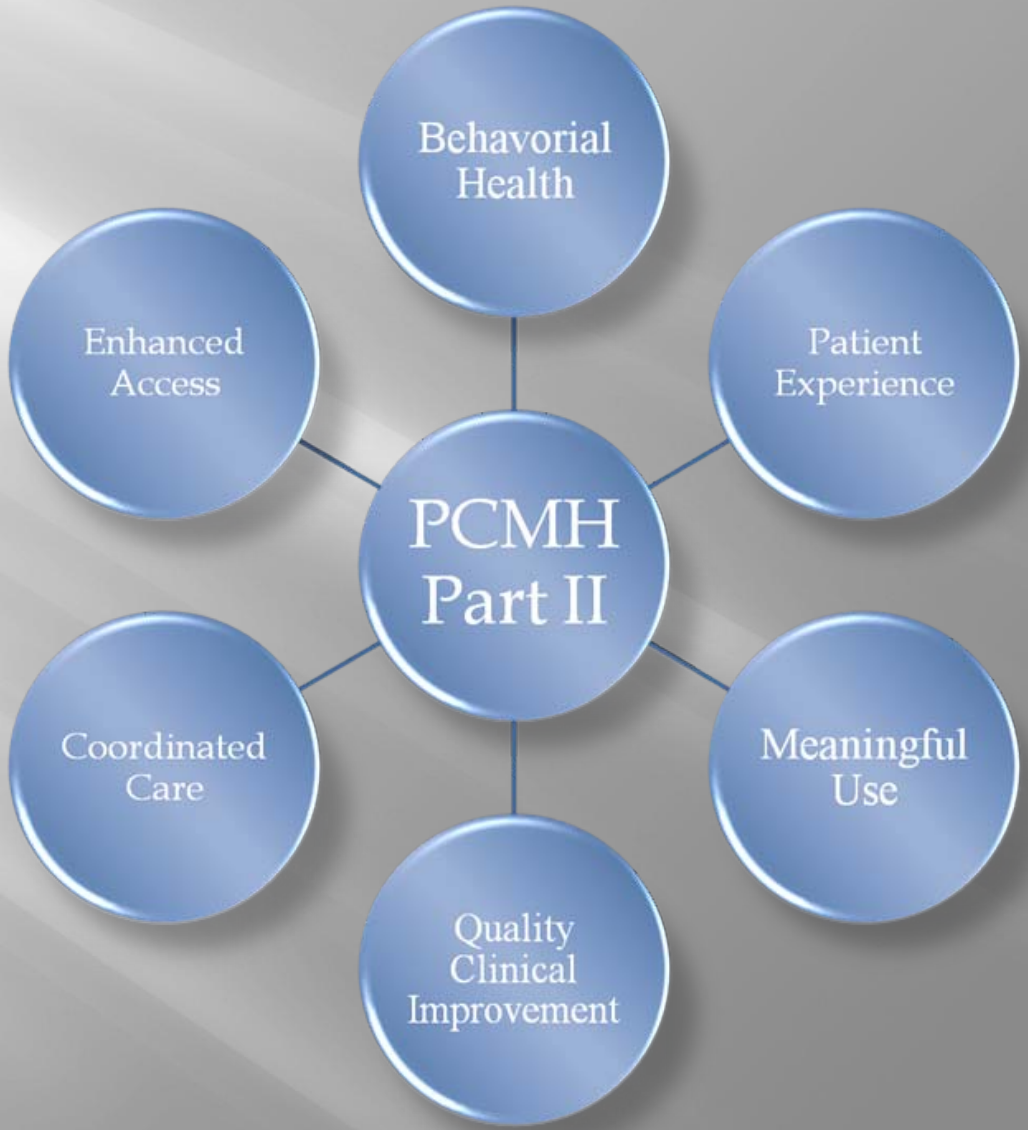
Demographics :: Age >=50 AND Age <=75 AND Sex=Both AND AND Show =All

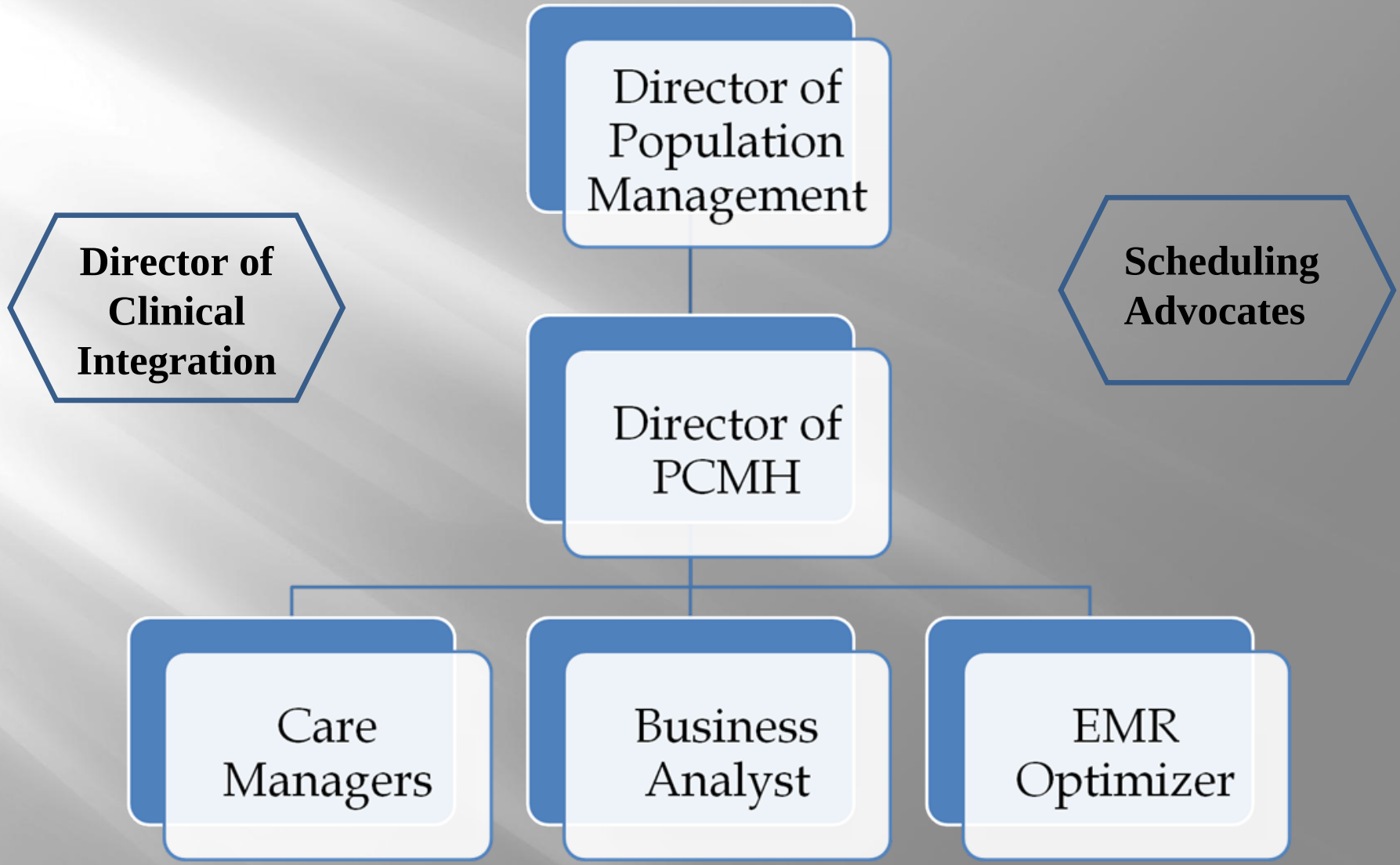
Labs :: Mode=Imaging AND Name=Colonoscopy AND Date >= 01/01/2003 AND Date <= 12/31/2012 AND Ignore Fasting Conditions

Letter ... | Run Letter | < Prev | Next > | 1-100 | of 156 records | Clear Search | Analyze Data

100 | Patient Hub | New Appointment | Copy | Flowsheet | Exclude from Search | Release Lock | Send eMessage

What Did We Do Part II?


Behavorial Health
Enhanced Access
Patient Experience
PCMH Part II
Coordinated Care
Meaningful Use
Quality Clinical Improvement


Director of Population Management
Director of Clinical Integration
Scheduling Advocates
Director of PCMH
Care Managers
Business Analyst
EMR Optimizer

Improvement Project Planning Form

Team: **NCQA Regulatory Team** Project: **PCMH 2011 Certification for New Practices**

Members: Dr. Spencer, Justin Kuprevich, Vickie Barrella, Marguerite Adelsberger,. Christine Matteo (excused)

Driver – list the drivers you'll be working on	Process measure	60-day Goal	Final Project Goal Fall 2013
1. Review Standards for compliance with existing and new Standards and Measures	2011 Standards	Have clear workflow of new 2011 processes to implement in non-certified practices	Practices meet all 2011 Standards

Standard	Change to Test	Tasks to Prepare for Tests	Data Needed to Evaluate Test	Person Responsible	TimeLine ('t' = test; 'i' = implement, 's' = spread) Week 1	2	3	4	5	6	7	8						
	Review current 2008 AHP Standards	Compare to 2011 Standards to identify gaps		VB & MA						X								
1E 1-4	Patient Info on PCMH Patient Brochure	Create with John Phillips	MA to provide JP with regulatory content in 1 week JP to brand	MA	X													
1E 1-4	Patient Info on PCMH for 2014 video	Innovation Circle Grant		SS														
1C 1	Patients requesting electronic copy of health info	Need clarification from Nancy Meisinger/Marjorie Miller	Hold to compile a clarification list	MA								X						
1C 2	% patients using web portal			JK (when needed)														
1C 3	Clinical summaries provided to patients	Also for MU	On MAC Dashboard	JK (when needed)														
1C 4	Provide printed material in languages of Pop.	Do a one time inventory of languages in the population from	eCW has English and Spanish patient teaching	JK														

Groupname	Expiration (due for re-cert)	2011 Submission Date	2011Certification Date	IBC payment Date	Expected 2011 Level	ISS User ID	License #	Submitted	Project #	outreach date
Ambler Medical Associates- Springhouse										7/31/2014
North Pann Family Medicine Assocoates						P10000113744	51152			
STEVEN I. COWAN		4/25/2014	5/25/2014	6/25/2014	3	PD18269922	48463	7/31/2014	233275	monthly
SEAVY and SESTITO INTERNAL MEDICINE		5/1/2014	6/1/2014	7/1/2014	3	P10000101546	51100	8/29/2014	234634	monthly
LAWNDALE INTERNAL MEDICINE	11/8/2014	8/1/2014	9/1/2014	10/1/2014	3	PD1891941	50505	8/11/2014	235517	5/20/2014
JERRY M ROTH MD FACP	11/27/2014	8/1/2014	9/1/2014	10/1/2014	3	PD1890140	50483			7/13/2014
BLUE BELL FAMILY PRACTICE	12/5/2014	9/1/2014	11/15/2014	12/1/2014	3	PD18914732	50485			7/31/2014
ELKINS PARK MEDICAL ASSOCIATES	12/8/2014	9/1/2014	10/15/2014	11/1/2014	3	PD1891941	50505			6/10/2014
ABINGTON GENERAL INTERNAL MEDICINE	1/3/2015	10/1/2014	11/15/2014	12/1/2014	3	P10000098745	51088			6/6/2014
MEDICAL CENTER AT GWYNEDD	1/10/2015	10/1/2014	11/15/2014	12/1/2014	3	P10000108642	51116			
ABINGTON PLAZA MEDICAL ASSOC	1/10/2015	10/1/2014	11/15/2014	12/1/2014	3	P10000108943	51119			4/30/2014
FAMILY PRACTICE OF WILLOW GROVE	1/10/2015	10/1/2014	11/15/2014	12/1/2014	3	P10000109343	51121			7/5/2014
AMBLER MEDICAL ASSOCIATES	1/12/2015	10/1/2014	11/15/2014	11/1/2104	3	P10000109545	51123			7/31/2014
SPRINGHOUSE INTERNAL MEDICINE	1/22/2015	10/1/2014	11/15/2014	12/1/2014	3	P10000109742	51124			
CHELTENHAM INTERNAL MEDICINE	1/25/2015	10/1/2014	11/15/2014	12/1/2014	3	P10000109944	51126			
GLENSIDE MEDICAL ASSOCIATES	1/27/2015	10/1/2014	11/15/2014	12/1/2014	3	P10000110146	51128			7/11/2014
GLENSIDE INTERNAL MEDICINE	1/27/2015	10/1/2014	11/15/2014	12/1/2014	3	P10000110551	51130			
HORSHAM MEDICAL ASSOCIATES	2/7/2015	11/1/2014	12/15/2014	1/1/2015	3	P10000110652	51131			
HORSHAM FAMILY PRACTICE	2/7/2015	11/1/2014	12/15/2014	1/1/2015	3	P10000110741	51132			
HARTSVILLE MEDICAL PRACTICE	2/16/2015	7/1/2014	8/15/2014	9/1/2014	3	P10000111142	51133			
UPPER DUBLIN INTERNAL MEDICINE	2/19/2015	11/1/2014	12/1/2014	1/1/2105	3	P10000111341	51135			
ABINGTON CEDARBROOK INTERNAL MEDICINE	2/22/2015	11/1/2014	12/15/2014	1/1/2015	3					

Sheet1 RRWB-Audit

READY

Provider PCMH Checklist 2013

Office Encounters

- Make daily **same day appointments** available for urgent appointments
- Make sure that there are off hour appointments and advice (nights, weekends)
- During your patient encounter make note of missing **patient registry information** such as:
  - Emergency contact
  - Pharmacy
  - Race/Ethnicity
  - Height/Weight/BMI
  - Presence of advanced directives
- Three Important Conditions (DM, HTN, Tobacco Cessation)
  - For patients with any the three important conditions document:
    - Document **Controlled** in the treatment section for patients who have met the definition of controlled specified in the guidelines
    - For uncontrolled patients please specify care management support
      - Document all the measures used to assess if patient is at goal
      - Specific wording can be found in each condition's template in ECW
    - For uncontrolled patients who are not at goal please specify self management support
      - Document the tools you have given to the patient to help them reach goal
      - Specifics can be found each condition's template in ECW

Urgent referrals, patients that need to be seen by specialist within two weeks

- Option to generate in treatment section
- Appropriate information completed by the provider and/or designated office staff
- Information faxed or printed by provider or designated office person and sent directly to the specialist prior to the initial office visit
- If no office person designated, office staff should followup on urgent referrals by ensuring that the office has received documentation of the patient's specialist visit
- Whenever possible the Provider or appropriate member of the office should talk to the specialist's office directly to alert them of reason for urgent appointment request

Document on call

- Enter directly into e clinical telephone encounter in real time using **on call** dropdown
- Send paper based document to staff member to enter into e clinical

Labs/Diagnostic Studies

- Close the loop on all tests and studies
- Call patient, forward result to a staff person to inform patient, generate a letter, or publish to the patient portal for all labs and diagnostic studies

Prescriptions

- All prescriptions must be generated through the EMR
- Scripts written when the EMR is not available should be scanned into the system
- Please document all over the counter medication using available structured templates

Hospital Discharge

- Your hospitalized patients should have follow up appointment scheduled within seven days of discharge
- Correspondence with patients after hospital discharge should be documented in e clinical

Quality Improvement

- Requirement to take part in these projects for quality improvement (e.g Influenza, mammograms)
- Requirement to take part in projects to improve service excellence

Abington Health Physicians

PCMH Provider Checklist

Chronic Conditions

- HT N
- Diabetes
- Smokers
- High Risk Patients

- *Document Care Management Support*
- *Document Self Management Support*
- *Use Scheduling Advocates for Referrals*
- *Document on call encounters in EMR*
- *Close loop on all diagnostic tests and labs*
- *Medication reconciliation at every visit*
- *Access for sick visits and TOC visits*

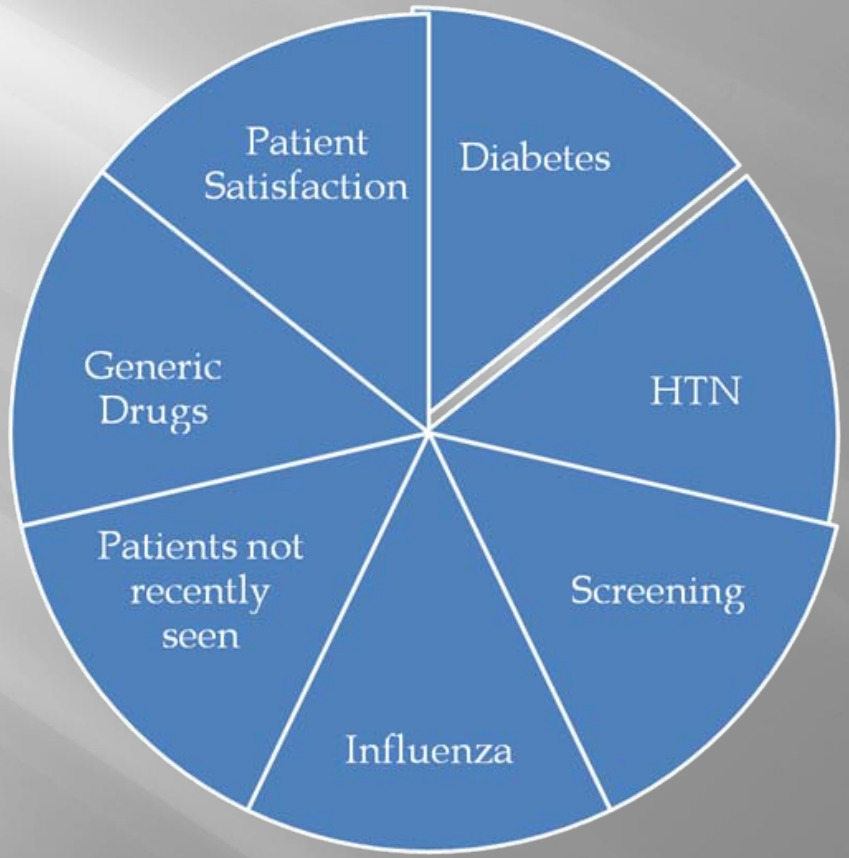
QI

- Diabetes
- HTN
- Mammography
- Colonoscopy
- Influenza
- Patients not seen
- Generic drugs
- Patient satisfaction

Tobacco Cessation guidelines
INSERT NAME OF PRACTICE -Abington Health Physicians

- Screening
  - All patients ≥13 years of age seen for an office encounter
  - Smoking status recorded at least once annually
  - Information recorded in the structured data in social history
  - Recorded as
    - Never smoker
    - Former Smoker
      - >1 year
      - Record date of last cigarette
    - Current Smokers
      - Office is encouraged to record:
        - Number of years smoked
        - Number of cigarettes smoked per day
        - Willingness to quit
  - Providers are encouraged to counsel all patients ≤18 years of age on the dangers of smoking and document counseling in the electronic medical record
- Practice Facilitates Care Management Support
  - Identified Current Smokers
    - Defined as anyone who is recorded as a current smoker in the electronic medical record
    - Smoker labs/vitals
      - Fasting blood sugar
      - Blood pressure checked at every office encounter
    - Smoker exams
      - Providers encouraged to perform a cardiovascular exam during every office encounter
      - Providers encouraged to perform a lung exam during every office encounter
    - Providers encouraged to palpate major pulses (carotid, radial, femoral) during every office encounter
    - Providers encouraged to order u/s of abdomen for male smokers 55-74 to rule out abdominal aortic aneurysm
    - Providers encouraged to use Smoking Cessation order set (see below)
- Practice Facilitates Self Management Support
  - Offered counseling
    - Behavioral Counseling by Providers during office encounters
    - The American Lung Association Freedom From Smoking Program offered by Abington Hospital
  - Providers encouraged to offer medication to patients who appropriate for this intervention
    - Nicotine replacement (i.e patches, gum)
    - Welbutrin
    - Chantix

Quality Initiatives



PPC-PCMH Quality Measurement and Improvement Worksheet

Bi-County-Abington Health Physicians

Process Improvement Projects-6C

(2)Measure: Influenza documentation in patients >65

Data Source: Chart Review/Audit/ eCW Registry Reports

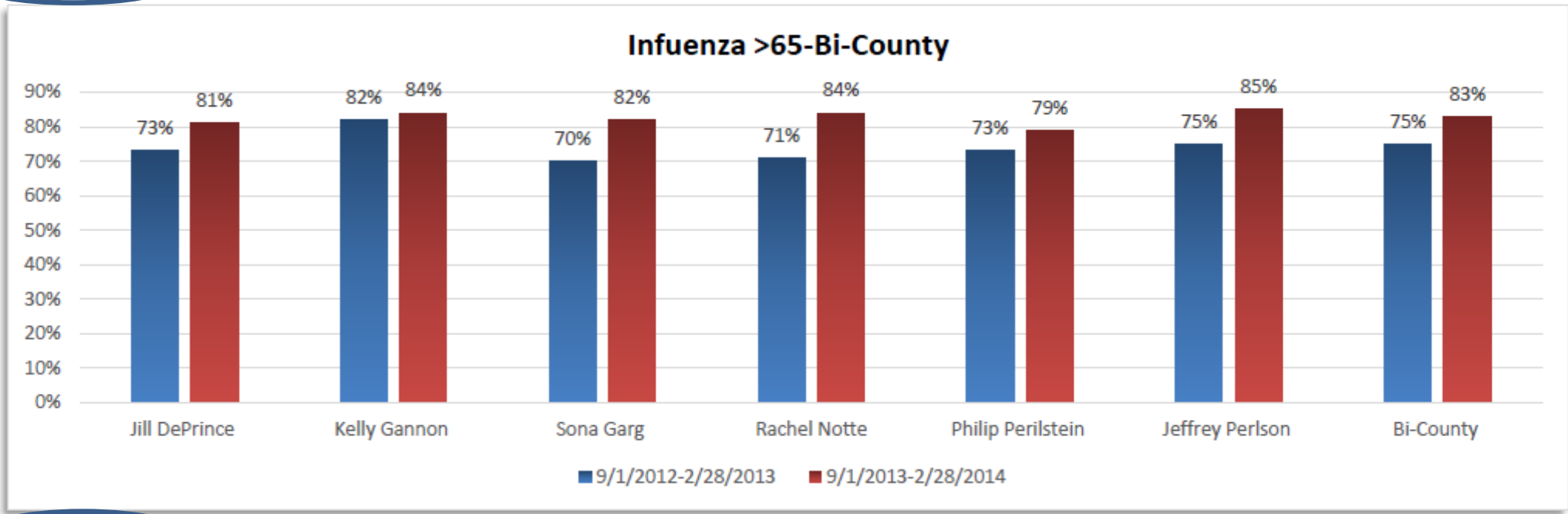
Opportunity Identified: The CDC has identified influenza vaccine adminstration as one of the most important public health initiatives in the US. Approximately 5-20% of the US population gets the flu annually. About 200,000 people are hospitalized with flu complications every year. Annual deaths from the flu range from 3,000 to 49,000 depending on the season. Increase compliance with administration of Influenza vaccine to patients >65.

Performance Goal: Increase compliance with administering Influenza vaccine to patients >65 by 10% for the 2012-2013 influenza season vs. the 2013-2014 influenza season

Action Taken:

- Influenza PI CME project developed and deployed (7/2013)
- Developed influenza administration protocol for medical assistance (8/2013)
- Updated practice website (8/2013)
- Flu posters placed in office (9/2013)
- Walk-in Days Available (9/2013)
- 10 Minute Education for practice staff conducted by PCMH care manager (9/2013)
- Influenza metrics presented monthly to practice (9-11/2013)
- *Ask every patient at every visit* campaign (9-11/2013)
- Addition of documentation choices in the EHR to capture vaccines administered outside the practice (10/2013)
- Telephone outreach to patients missing flu documentation (1-2/2014)

Performance:



Measure Criteria: Number of patients >65 seen in the office who had a documented influenza vaccine between 9/1/2012-2/28/2013 vs. 9/1/2013-2/28/2013

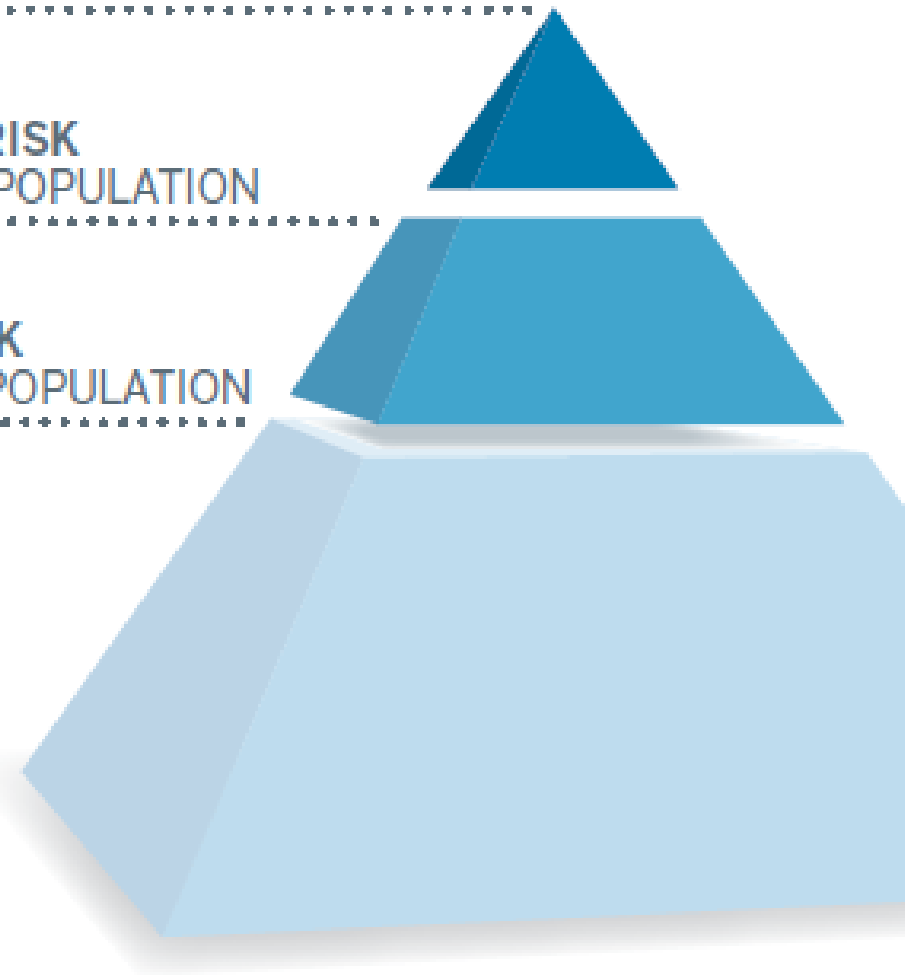
The practice rate increased from 75% (1234/1654) in the 2012-2013 season to 83% (1223/1475) in the 2013-2014 season.

Analysis: The results did not quite reach its goal of a 10% increase in the influenza documentation rates. The rates of the practice were already very high and it is also an accomplishment that the practice was able to maintain these rates. The practice will continue to update the physicians and the medical assistance about clinical updates to influenza administration. The practice will continue to provide monthly updates annually during the influenza season.

1 **HIGH-RISK**
5% OF POPULATION

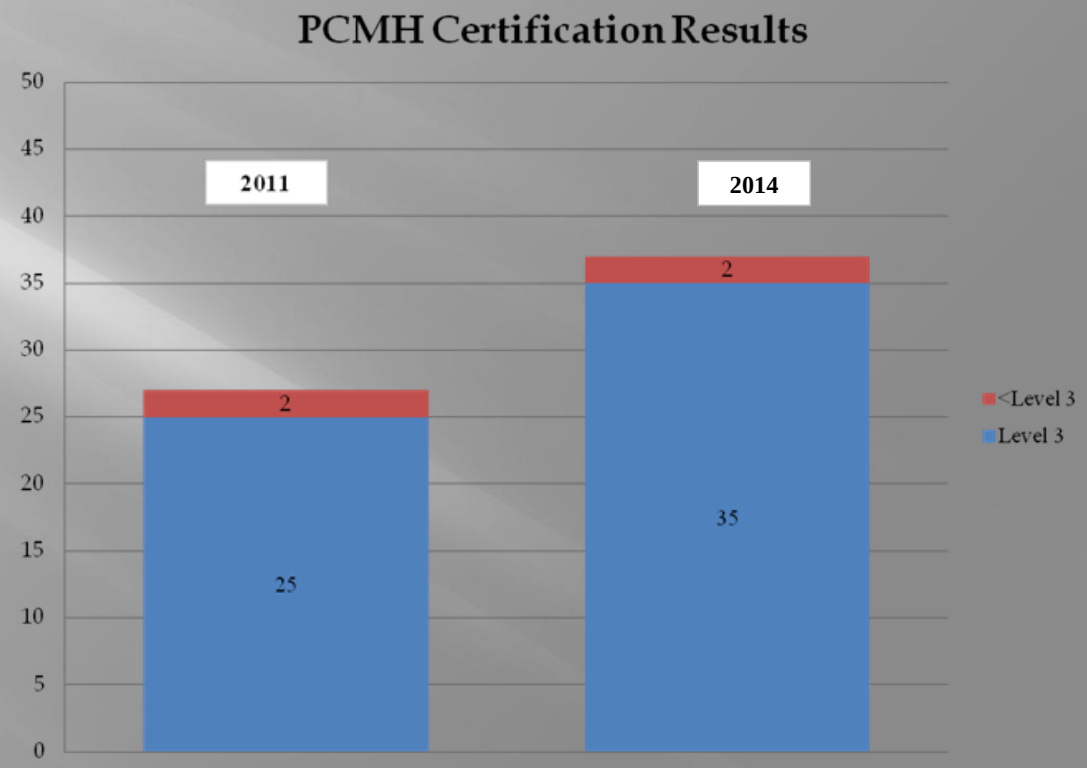
2 **RISING-RISK**
20% OF POPULATION

3 **LOW-RISK**
75% OF POPULATION



Results

- Part I (2011)
  - 27 Practice Sites Certified
    - 25 Level Three
    - 1 Level Two
    - 1 Level One
- Part II (2014)
  - 37 Practice Sites Submitted
    - 35 Practice Sites Certified Level Three
    - 2 Pending Certification



Original Investigation

Association Between Participation in a Multipayer Medical Home Intervention and Changes in Quality, Utilization, and Costs of Care

Mark W. Friedberg, MD, MPP; Eric C. Schneider, MD, MSc; Meredith B. Rosenthal, PhD; Kevin G. Volpp, MD, PhD; Rachel M. Werner, MD, PhD

IMPORTANCE Interventions to transform primary care practices into medical homes are increasingly common, but their effectiveness in improving quality and containing costs is unclear.

OBJECTIVE To measure associations between participation in the Southeastern Pennsylvania Chronic Care Initiative, one of the earliest and largest multipayer medical home pilots conducted in the United States, and changes in the quality, utilization, and costs of care.

DESIGN, SETTING, AND PARTICIPANTS Thirty-two volunteering primary care practices participated in the pilot (conducted from June 1, 2008, to May 31, 2011). We surveyed pilot practices to compare their structural capabilities at the pilot's beginning and end. Using claims data from 4 participating health plans, we compared changes (in each year, relative to before the intervention) in the quality, utilization, and costs of care delivered to 64 243 patients who were attributed to pilot practices and 55 959 patients attributed to 29 comparison practices (selected for size, specialty, and location similar to pilot practices) using a difference-in-differences design.

EXPOSURES Pilot practices received disease registries and technical assistance and could earn bonus payments for achieving patient-centered medical home recognition by the National Committee for Quality Assurance (NCQA).

MAIN OUTCOMES AND MEASURES Practice structural capabilities; performance on 11 quality measures for diabetes, asthma, and preventive care; utilization of hospital, emergency department, and ambulatory care; standardized costs of care.

RESULTS Pilot practices successfully achieved NCQA recognition and adopted new structural capabilities such as registries to identify patients overdue for chronic disease services. Pilot participation was associated with statistically significantly greater performance improvement, relative to comparison practices, on 1 of 11 investigated quality measures: nephropathy screening in diabetes (adjusted performance of 82.7% vs 71.7% by year 3, $P < .001$). Pilot participation was not associated with statistically significant changes in utilization or costs of care. Pilot practices accumulated average bonuses of $92 000 per primary care physician during the 3-year intervention.

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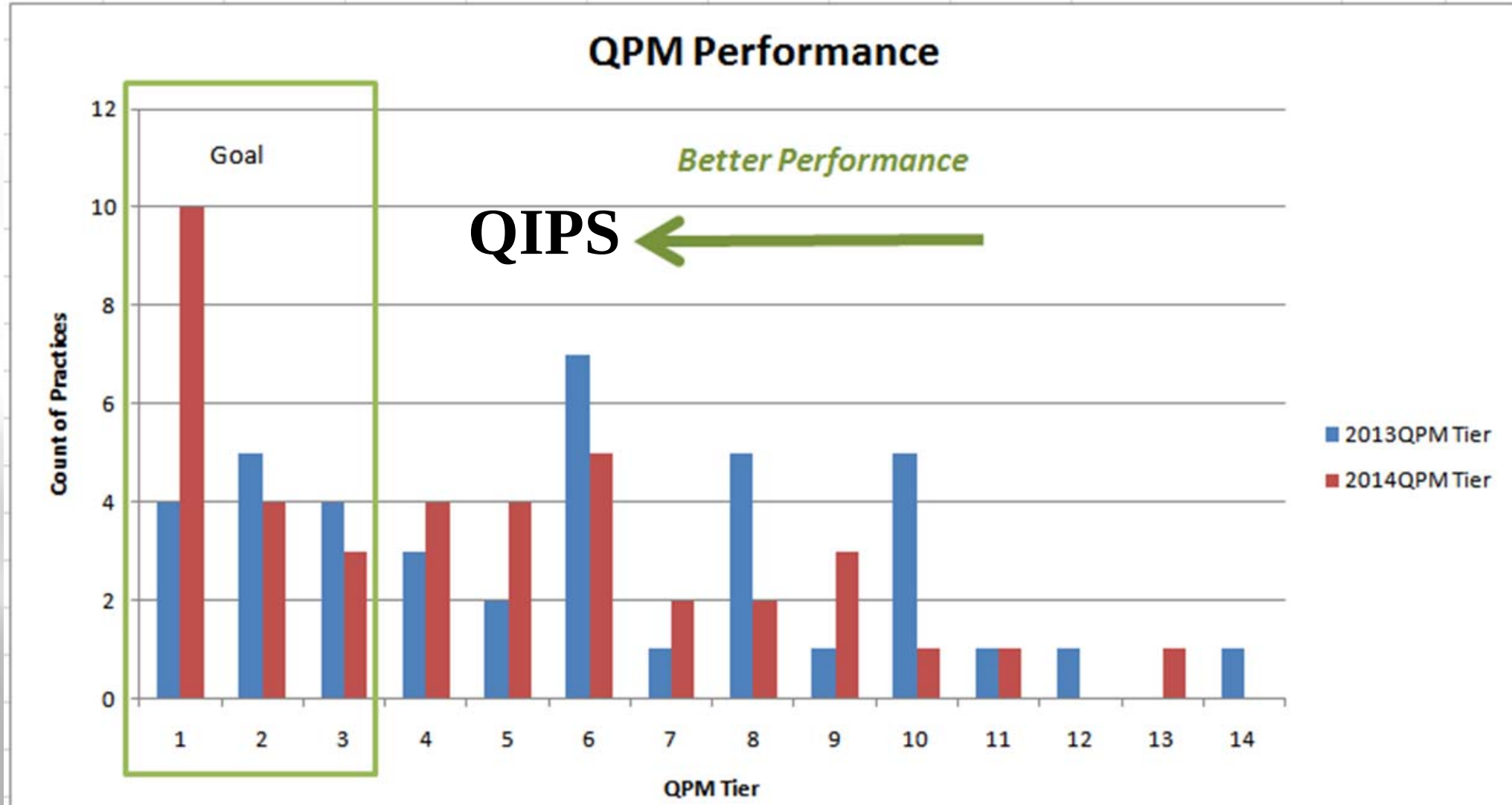
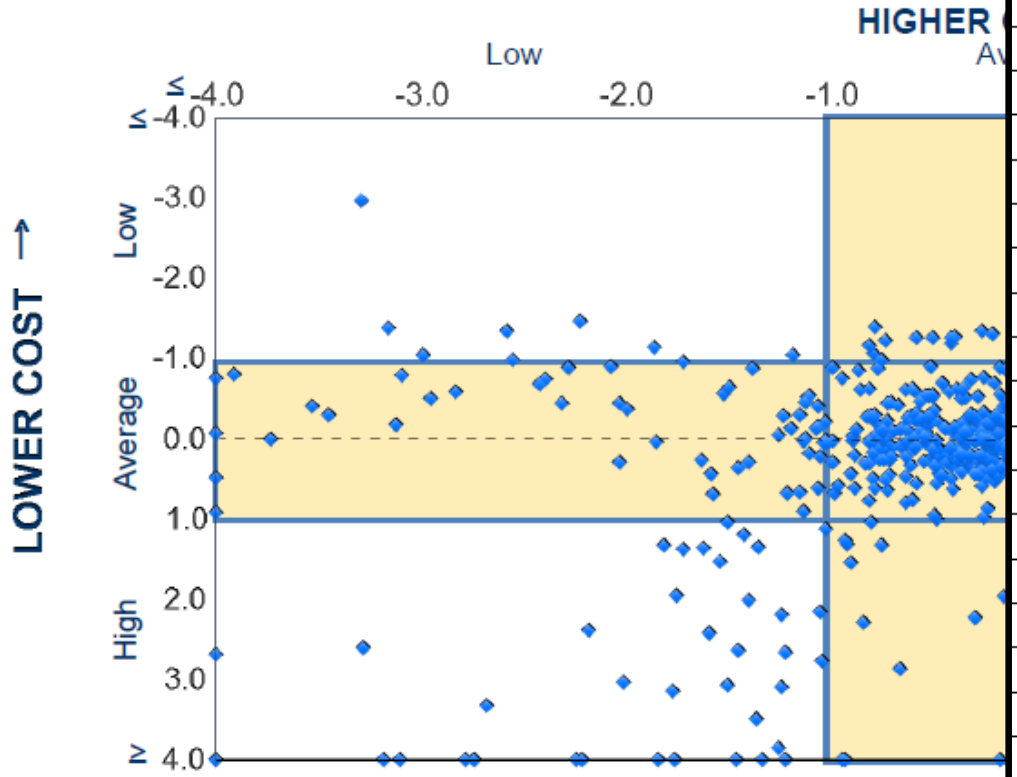
Author Video Interview at jama.com

Supplemental content at jama.com

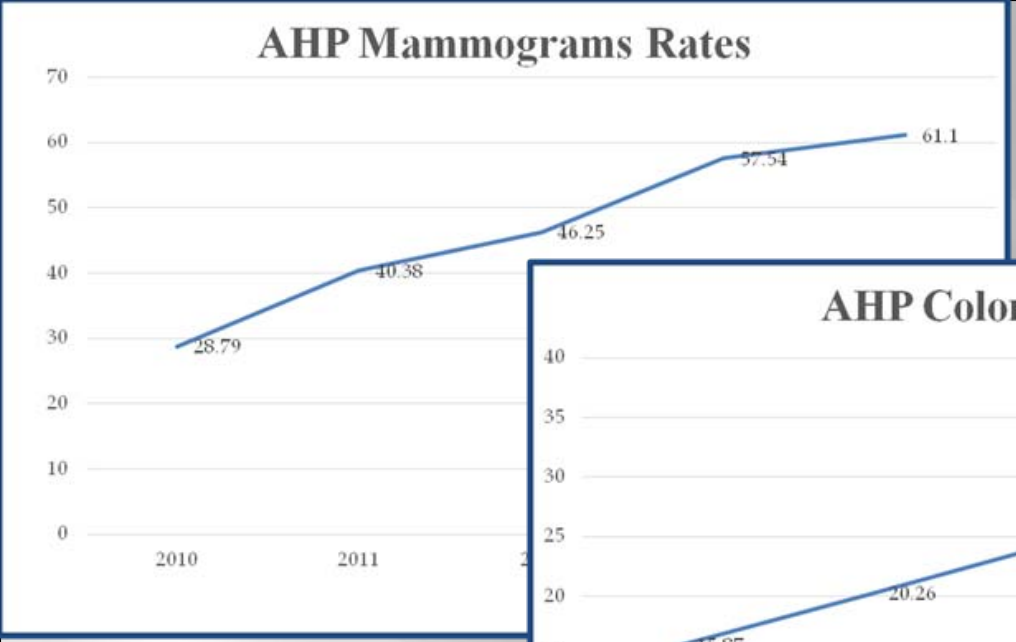

QPM Performance
Goal
Better Performance
QIPS
Count of Practices
QPM Tier
2013QPM Tier
2014QPM Tier
0
2
4
6
8
10
12
1
2
3
4
5
6
7
8
9
10
11
12
13
14

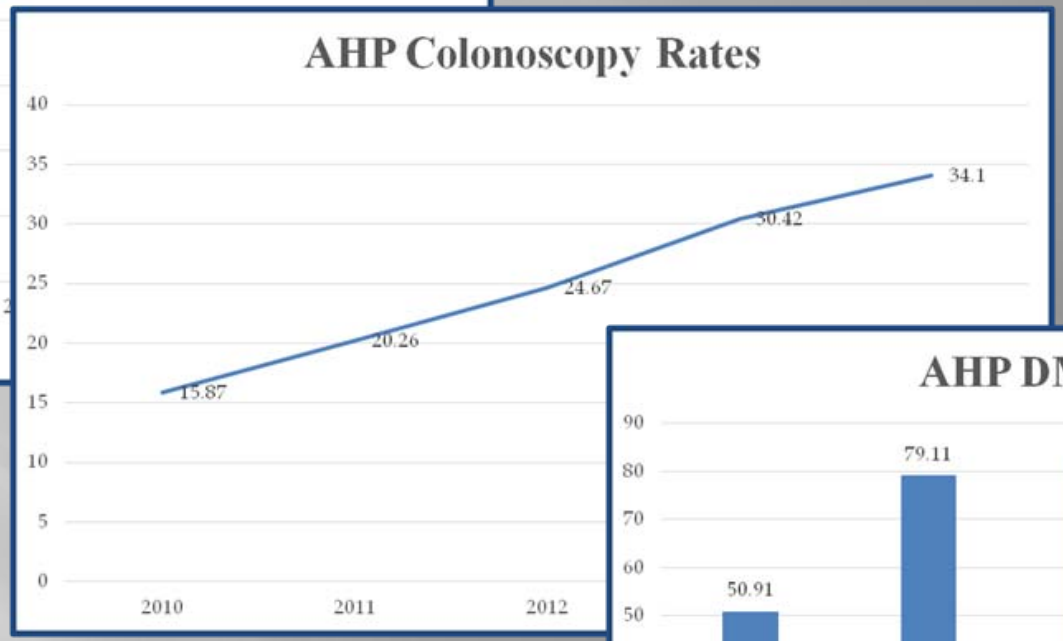
YOUR QUALITY TIERING PERFORMANCE: AVER

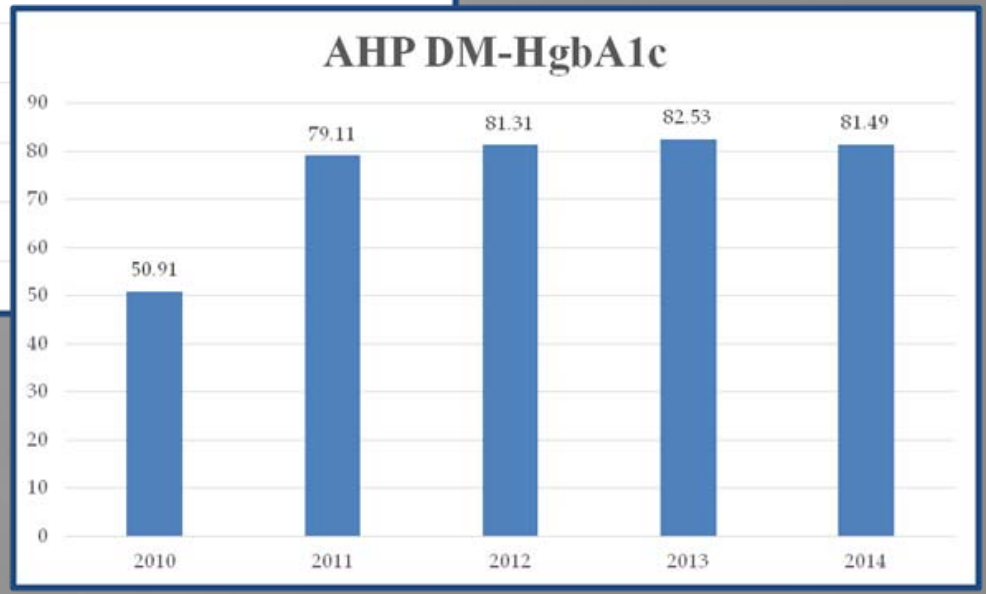


Modules	Numerator	Denominator	Percentage	Benchmark 2013*
Care 1	284	433	65.59	81.63
Care 2	96	528	18.18	42.09
CAD Composite	331	412	80.34	68.09
CAD-2	*347*	*412*	*84.22*	51.65
CAD-7	*292*	*312*	*93.59*	66.65
DM-2**	60	412	14.56	20.47
DM Composite	19	412	30.1	25.2
DM-13	*312*	*412*	*75.73*	*70.68*
DM-14	*241*	*412*	*58.5*	*57.17*
DM-15	*311*	*412*	*75.49*	*70.54*
DM-16	*213*	*233*	*91.42*	*80.21*
DM-17	*71*	*412*	*83.98*	*71*
HF	256	264	96.97	80.55
HTN	293	416	70.43	73.96
IVD 1	236	418	56.46	46.99
IVD 2	361	418	86.36	70.77
Prev 5	304	411	73.97	45.72
Prev 6	244	416	58.65	46
Prev 7	380	548	69.34	40.57
Prev 8	307	527	58.25	44.89
Prev 9	348	554	62.82	54.41
Prev 10	504	566	89.05	83.18
Prev 11	401	412	97.33	61.41
Prev 12	107	460	36.96	46.27

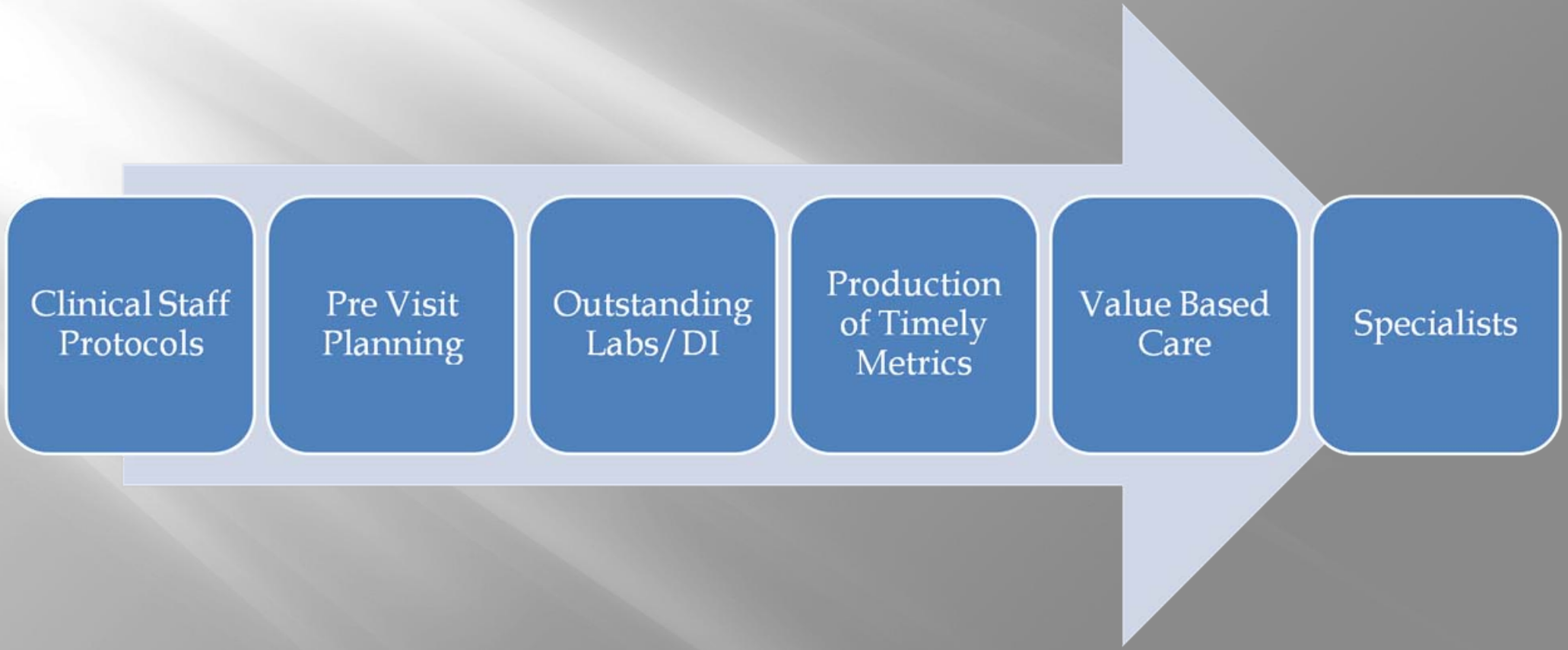
PQRS


AHP Mammograms Rates
70
60
50
40
30
20
10
0
28.79
40.38
46.25
57.54
61.1
2010
2011


AHP Colonoscopy Rates
40
35
30
25
20
15
10
5
0
15.87
20.26
24.67
30.42
34.1
2010
2011
2012


AHP DM-HgbA1c
90
80
70
60
50
40
30
20
10
0
50.91
79.11
81.31
82.53
81.49
2010
2011
2012
2013
2014

Future Focus



Thank You

- David Nash
- Laurence Merlis
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- Jack Kelly
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- Barbara Hartnett
- Marguerite Adelsberger

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