

Update: Patient-Centered Medical Home

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Agenda

- Update on PPC-PCMH
- Demonstrations, including CMS
- Health Reform
- Future Directions



Mission

To improve the quality of health care

Vision

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



Update



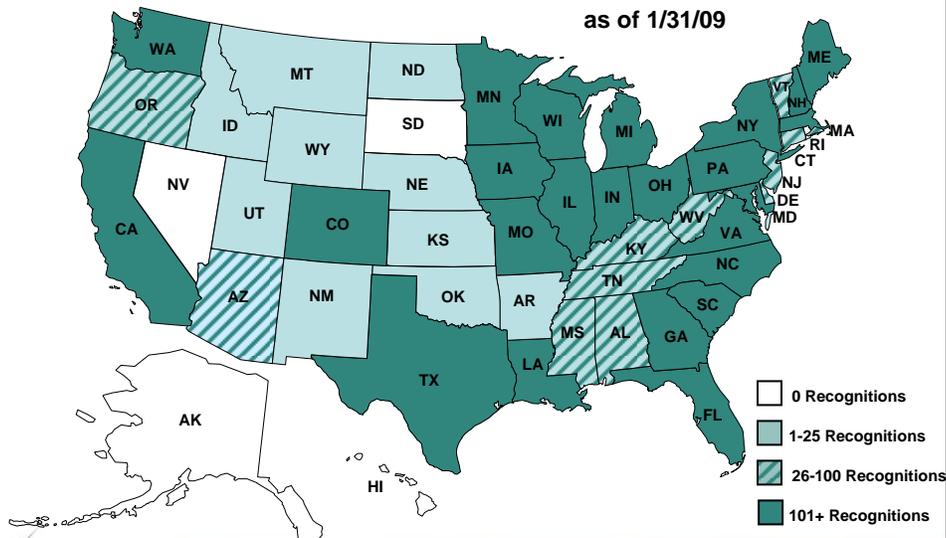
NCQA Recognition Programs Physician-Level Measurement

- 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**



* As of 2/6/09
Physician Practice Connections-Patient-Centered Medical Home
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Number of Physician Recognitions by State

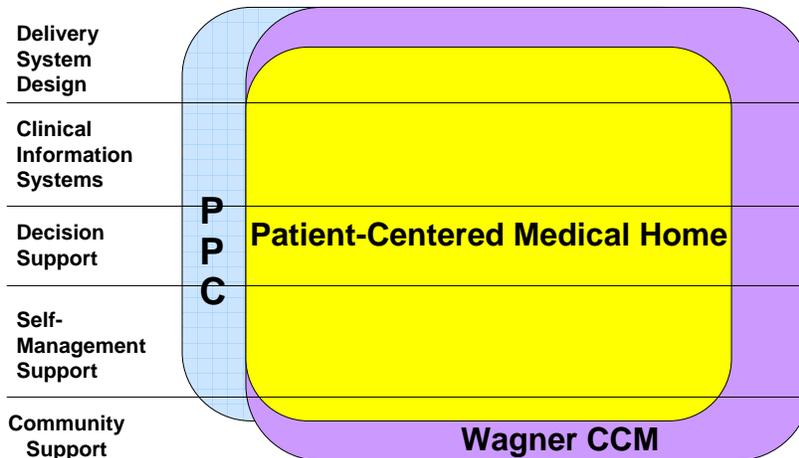


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Development Goals for Physician Practice Connections (PPC)

- 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



Standardized Measurement Needed for Medical Home

- 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

PPC Adapted for the Patient-Centered Medical Home

- 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”)*

PPC-PCMH Content and Scoring

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

**Must Pass Elements



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PPC-PCMH Scoring

Level of Recognition	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.



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PPC-PCMH Practices*

Activity To Date

Applications Received	Tools Submitted	Recognized Practices	Level 3	Level 2	Level 1
327	143	75	24	7	44

Location of Recognized Practices

IA	LA	MD	ME	MI	NH	NY	PA	VT
2	37	2	6	2	1	5	13	7

* As of 2/6/09



PPC-PCMH Practices*

Number of Physicians In Recognized Practices

	1-2	3-7	8-9	10-15	30-50	Total
Level 1	26	16	---	2	---	44
Level 2	2	3	2	---	---	7
Level 3	5	11	3	2	3	24
Total	33	30	5	4	3	75

* As of 2/6/09



Experience of Practices Recognized as a Medical Home

- 1. Practice uses EMR to track disease-specific goals for each patient and for physicians to provide condition-specific reminders to patients. Practice nurse serves as health coach working 1:1 with patients to improve health; improved data collection; developed and implemented standards; redefined workflow**

"The Medical Home design will revitalize primary care by improving the efficacy of our efforts while more fairly rewarding its inherent value."

Experience of Practices Recognized as a Medical Home (cont.)

- 2. Practice uses EHR and increased staff resources to enable office redesign and team-based care. Can now assess patients at population level.**

"The Medical Home allows physicians to do reliably and consistently the things they want to do anyway."

Experience of Practices Recognized as a Medical Home (cont.)

- 3. Practice has undergone a gradual transformation with a close nurse-physician partnership as central. Relief from administrative responsibilities leaves physician free to focus on patient care. Model includes 24 hour nurse care advice of nurse line.**

"Becoming a Medical Home is more about evolution than revolution."

Experience of Practices Recognized as a Medical Home (cont.)

- 4. Practice redesign was motivated by desire to improve patient outcomes. Change includes redistribution of patient care responsibilities among all staff which led to a team approach to care. Nurses triage patient calls and coordinate care of patients by phone.**

"The Medical Home....it's just better care, helping patients and staff."

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)

Needed for Medical Home Transformation to Succeed

- Support for practices in implementing medical home changes
- Data exchange strategy for practices, e.g. with hospitals, labs, other physicians
- Use of defined performance measures
- Payment reform

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

Myths About PPC-PCMH

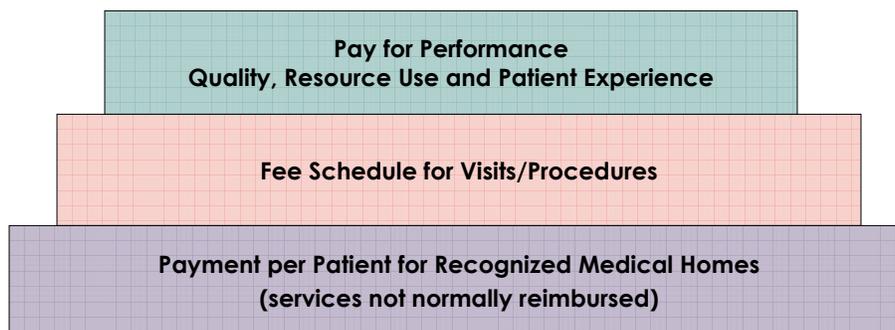
Myth

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

Reimbursement for PCMH: One Model



Demonstrations

Medical Home Initiatives Using PPC-PCMH

- **Multi-payer** - Colorado, Pennsylvania, New York, Rhode Island
- **State-wide** – Maine, Pennsylvania, Vermont,
- **Single payer** – EmblemHealth, Humana, CIGNA, United HealthCare
- **Government** – CMS (Medicare), New York City, Louisiana, Medicaid (Colorado, New Hampshire, Rhode Island, Vermont)

Promising Medical Home 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 2 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 2 within 2 years
 - 6 health plans participating
- **North Carolina Medicaid**
 - Launched by Medicaid and Office of Rural Health to serve Medicaid population
 - Utility of 14 networks to support 3,500 MDs with care management services



Medicare Medical Home Demonstration

- “... to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high need populations.”
- **Timeline**
 - Announce 8 geographic areas: Early 2009
 - Recruitment & application process: Spring 2009
 - Practices qualify: Spring/Summer 2009
 - Practices enroll beneficiaries: Early 2010
- **ThomsonReuters/NCQA have implementation contract**



Medicare Demonstration

- **CMS Medicare demo criteria are based on PPC-PCMH (PPC-PCMH CMS Version)**
 - 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

CMS Medical Home Payments

Medical Home Tier	Per Member Per Month Payments	Patients with HCC Score <1.6	Patients with HCC Score ≥1.6
Tier I	\$40.40	\$27.12	\$80.25
Tier II	\$51.70	\$35.48	\$100.35

HCC = hierarchical clinical conditions

Broad Interest in Patient-Centered Medical Home

- **Federal, private payers, states, physician groups**
- **Employers and business groups**
 - IBM helped found Patient Centered Primary Care Collaborative (PCPCC), a coalition of employers, consumer groups, patient quality organizations, health plans, labor unions, hospitals, physicians to develop/advance (PCMH)
 - Memphis Business Group on Health, National Business Group on Health, St. Louis Business Group on Health

Health Reform

Federal Health Reform Proposals and PCMH

- **President Obama: focus on health care cost, coverage and quality, including care coordination**
- **Stimulus package includes \$20 billion for HIT**
- **Health Reform 2009: Senator Max Baucus (D-Montana)**
 - **Focus on coverage, cost and delivery system reforms (including quality)**
 - **Increased payments for primary care and medical homes**
 - **NCQA ".....developed an assessment tool that tiers medical homes based on the implementation of particular capacities and patient services."**
- **Karen Davis, President, The Commonwealth Fund: included medical home in testimony before Senate Committee on Health, Education, Labor and Pensions**
- **ACP and AOA: asked Congress for improvements in patient-centered primary care and medical homes in stimulus package**

Future Directions

Criticisms of PPC-PCMH

- **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



Potential Future Directions for PPC-PCMH

- **Access**
 - Evening/weekend hours, agreement with facility for after-hours care
- **Coordination of care**
 - Information shared with specialists, information shared with patient, updating of care plan
- **Team-based care**
 - Defined roles and responsibilities, training, communication
- **Role of medical home**
 - Discussion of roles/expectations for medical home and for patients
- **Community involvement**
 - Assessment of community needs, matching services to needs, involvement of community organizations
- **Addressing special population needs/risks**
- **Evaluating patient experiences**



Other Suggested Changes

- **Revise weighting**
- **Revise must pass elements**
- **Consider options for addressing poor and disadvantaged populations, complex patients**
- **Consider options for addressing role of specialists as “medical home neighbor”**
- **Develop pathway for considering patient experiences results in PCMH Recognition**



NCQA Timeline/Next Steps for PPC Evaluation and Revision

- **Analyze data on currently Recognized practices**
- **Evaluate data from 2008 pilot test**
- **Review results of ongoing PCMH demonstrations (including CMS)**
- **Relate to health reform opportunities**
- **Revise standards in 2010**



Conclusions—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

Questions?