

# Measures for a New Model of Ambulatory Care

L. Gregory Pawlson MD, MPH  
Executive Vice President NCQA



Core Presentation



# Why Measure?

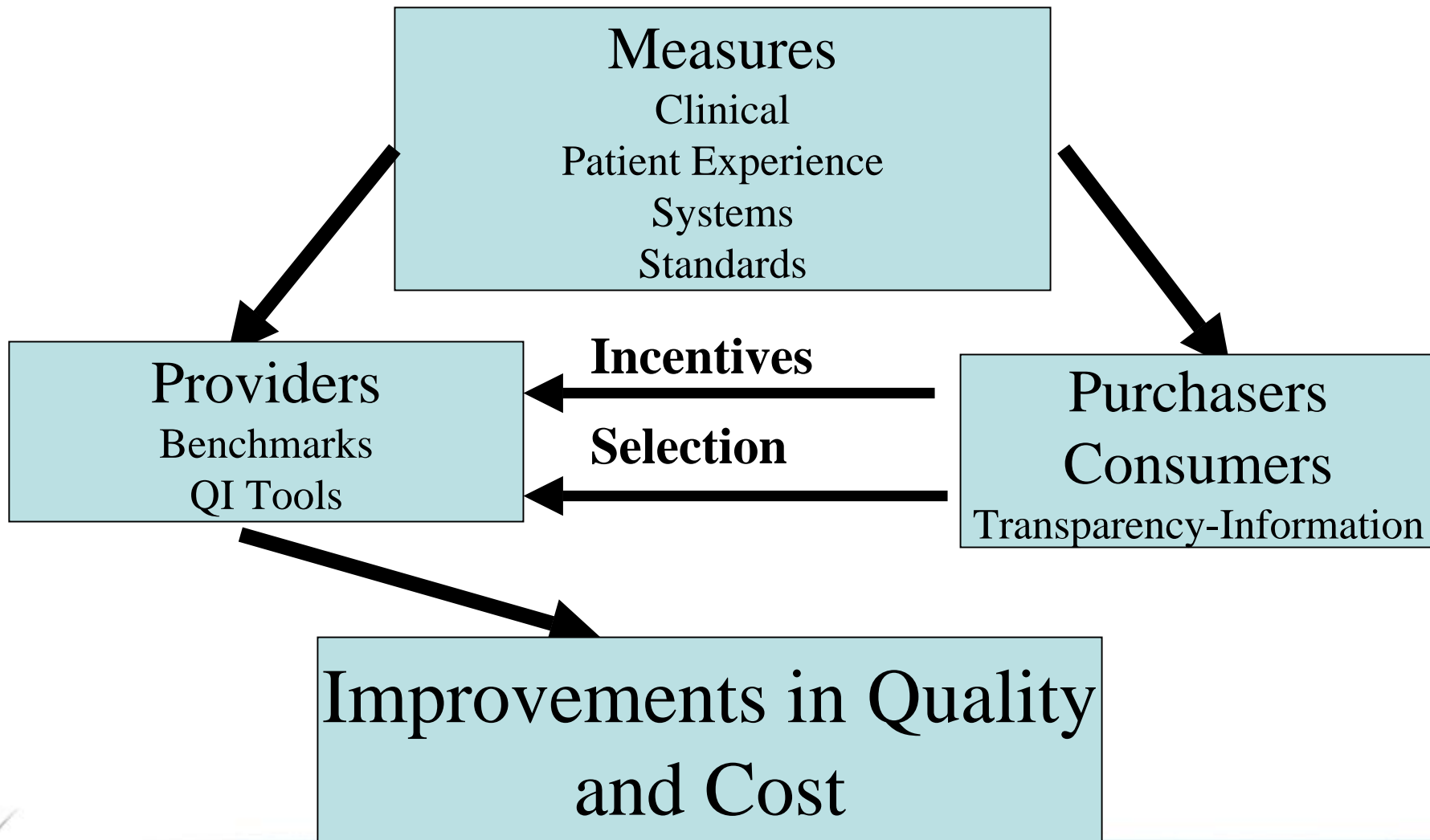
- **Internal: to further quality improvement through professionalism**
  - Guide to which areas to explore
  - Gauge of progress towards goals
  - Reward and encourage high performers
  - Identify and provide insights of under performance

# Why Measure?

- **External: To determine and drive value (cost and quality) through the market**
  - Public reporting: provides basis for those using an paying for care to chose wisely
  - Incentives
    - Pay for participation in QI
    - Pay for performance
    - Reimbursement for using systems
  - Tiering combines aspects of both public reporting and incentives

# Better Value in Health Care

## Professionalism      Market Place



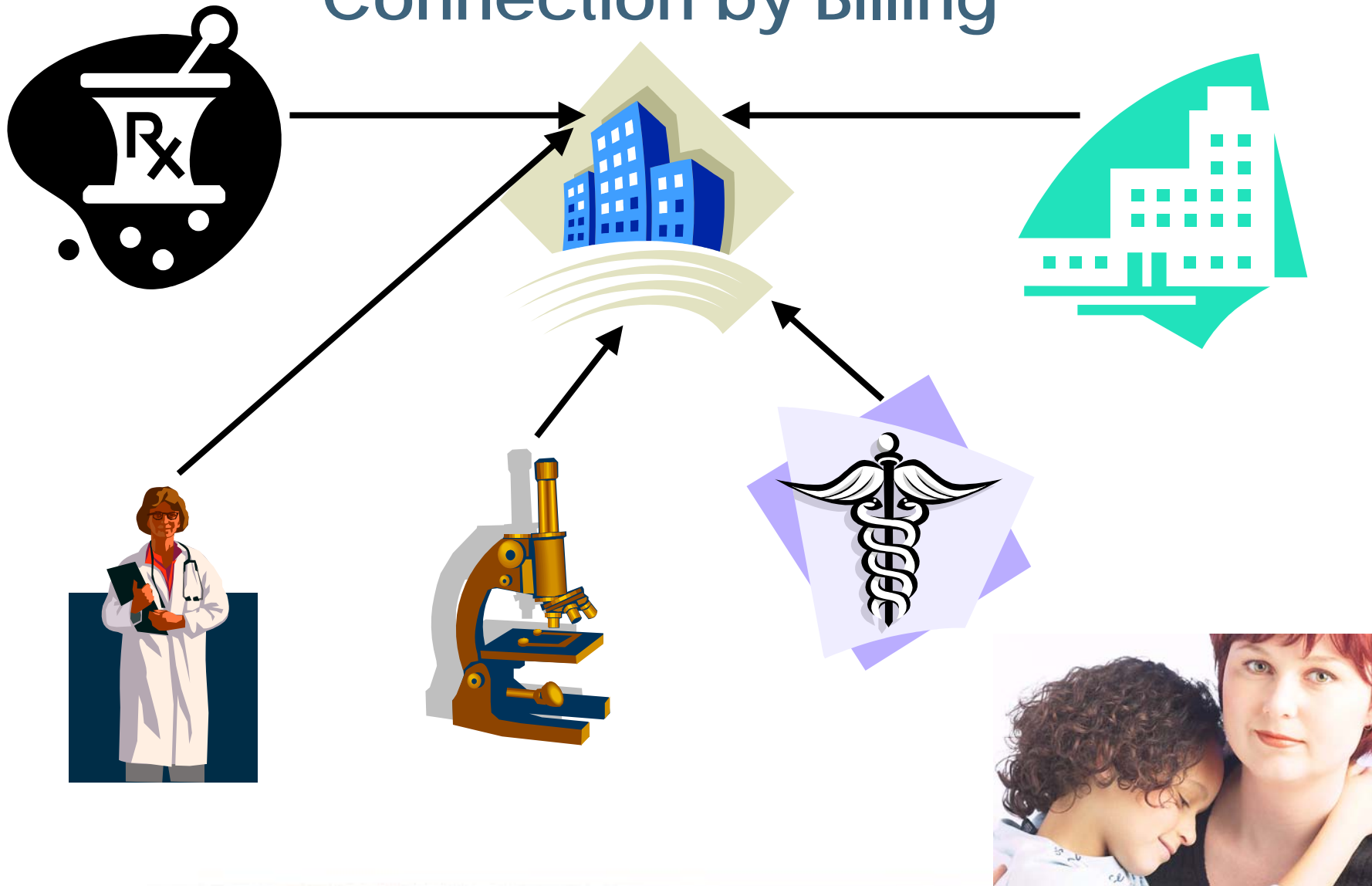
# Why do we need a “new” system

(some would say we don't have one now)

- **Costs have (for 50 years), and continue to, rise faster than GDP**
  - Uninsured, underinsured and related issues
  - Can't improve access without controlling costs
  - Major variation in costs WITHOUT relationship to quality (national/international)
- **Major gaps in quality**
  - Hospital deaths and readmissions
  - In ambulatory care-about 50/50 chance of getting needed services

# The current model of care

## Connection by Billing

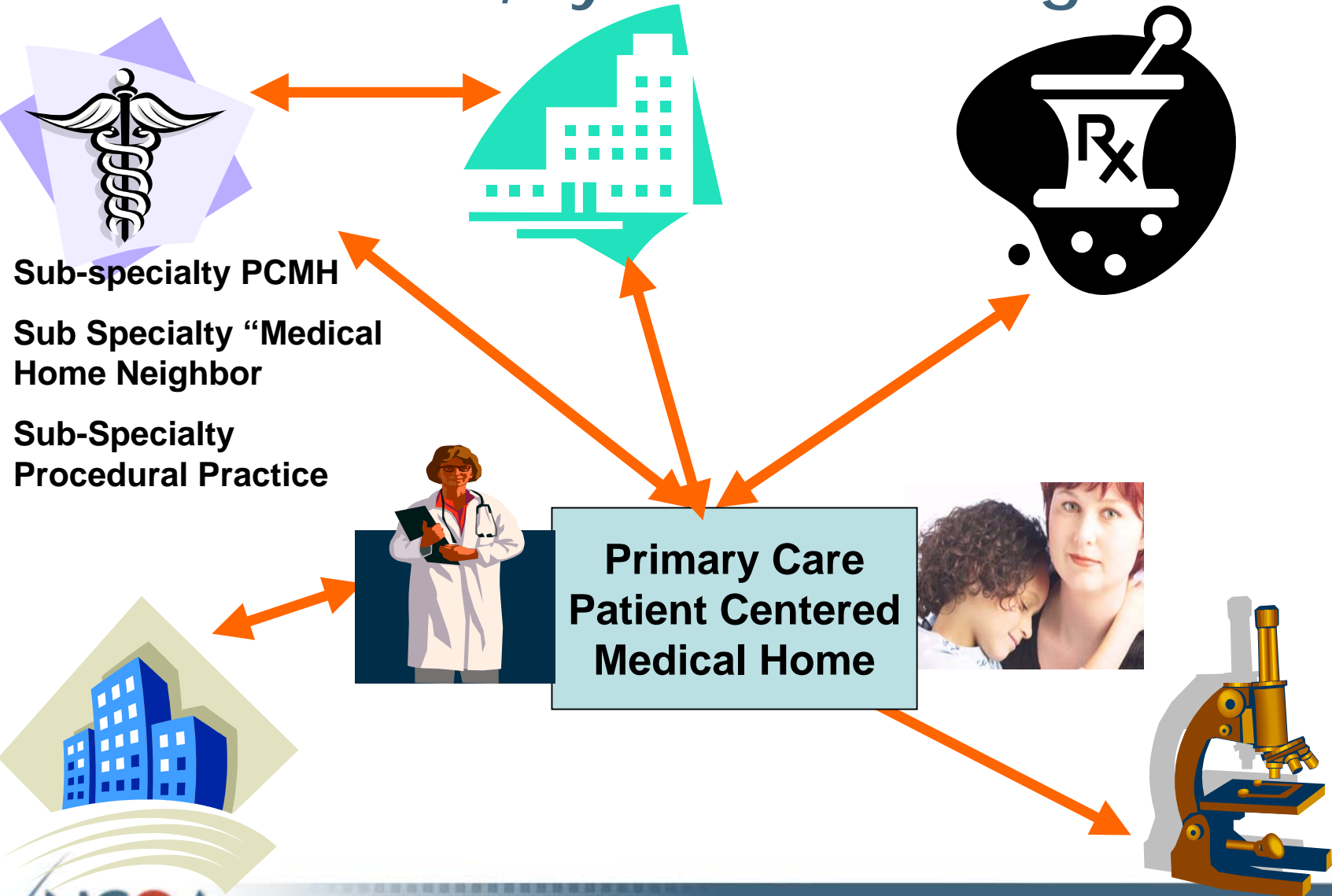




# A New Model for Ambulatory Care

- **Primary Care Patient Centered Medical Home**
  - Disease focused-specialty Patient Centered Medical Home
- **Sub-specialty: Consultative Evaluation-Management Practices**
- **Sub-specialty: Procedural Based**

# The future model of care-Integration by Information, Systems and Organization



# Empiric Basis for the core of a “new” Model

- Primary care based health care (international and within US) have lower costs and higher quality
- Use of systems within by Chronic Care-Planned Care Model leads to lower costs and higher quality ([www.improvingchroniccare.org](http://www.improvingchroniccare.org))
- Patients- and just about everyone else, are fed up with current “system” and lack of patient centeredness

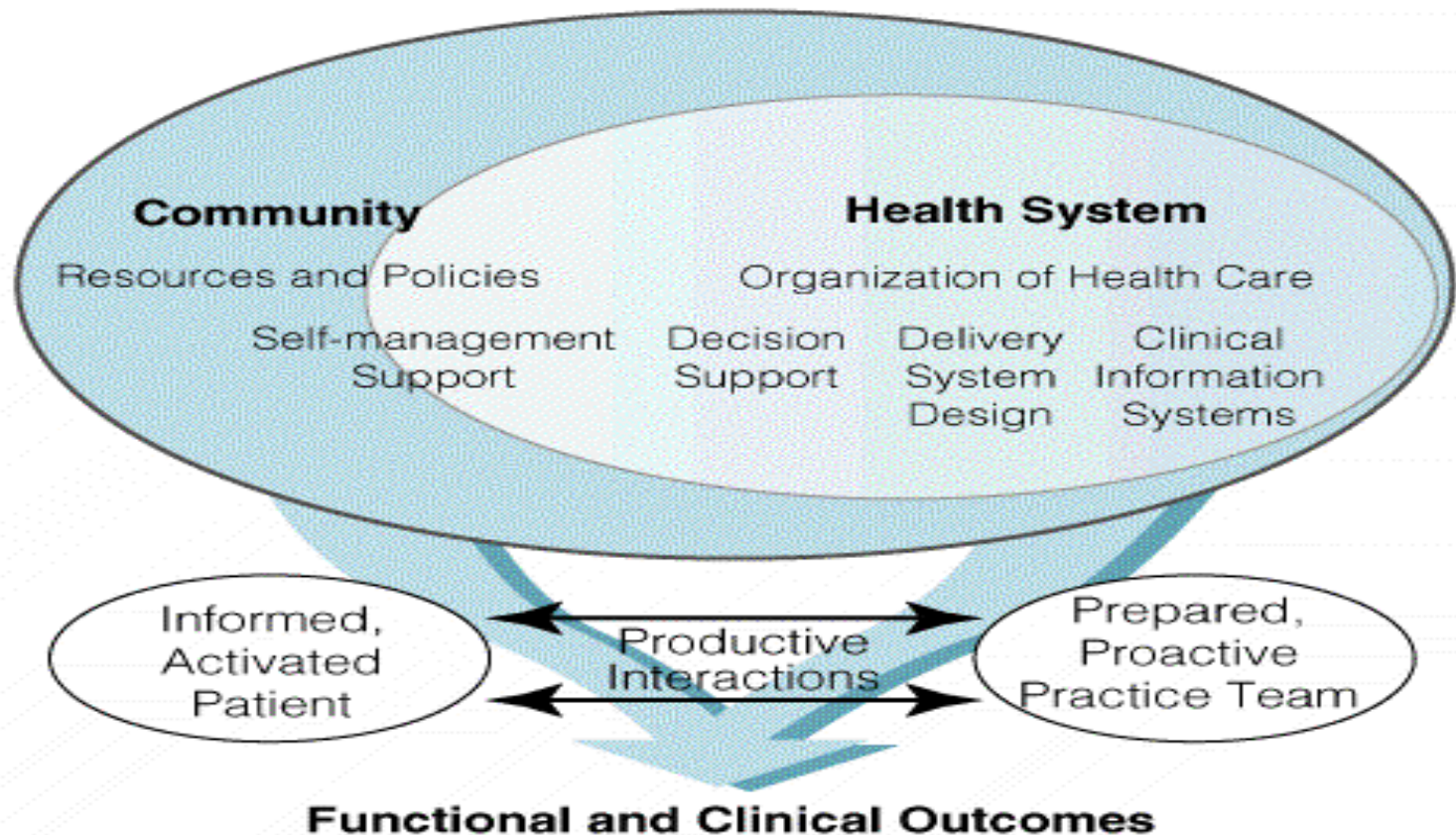
# Key Steps to a Health Care System

- Patient Centered Primary Care as core of health care system
- Implementation and use of health information technology and care systems at all levels of health care
- Integration of care (real or virtual)
- Reimbursement linked to desired process and outcomes of care (pay for what you want)
- Measurement and feedback to determine if you are getting where you want to be

# Primary Care

- **Definition**
  - First Contact
  - Comprehensive
  - Continuous
  - Coordinated
- **Some uncertain aspects**
  - Team versus individual practitioner
  - Degree of comprehensiveness needed
  - Types of linkages between primary care and other aspects of care (group, virtual group etc)

# Wagner Model for Effective Prevention and Chronic Illness Care

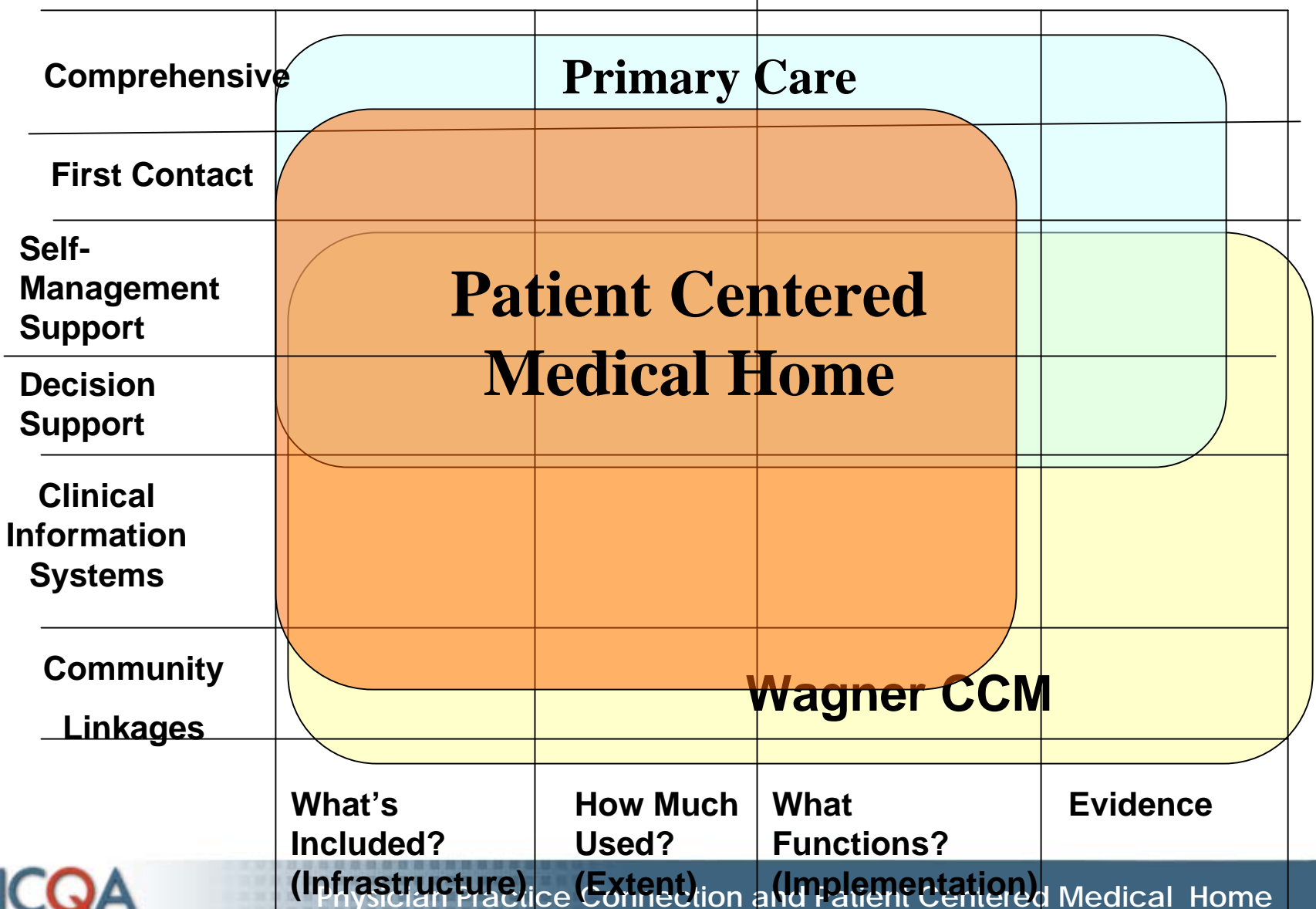


# The Patient Centered Medical Home Defined

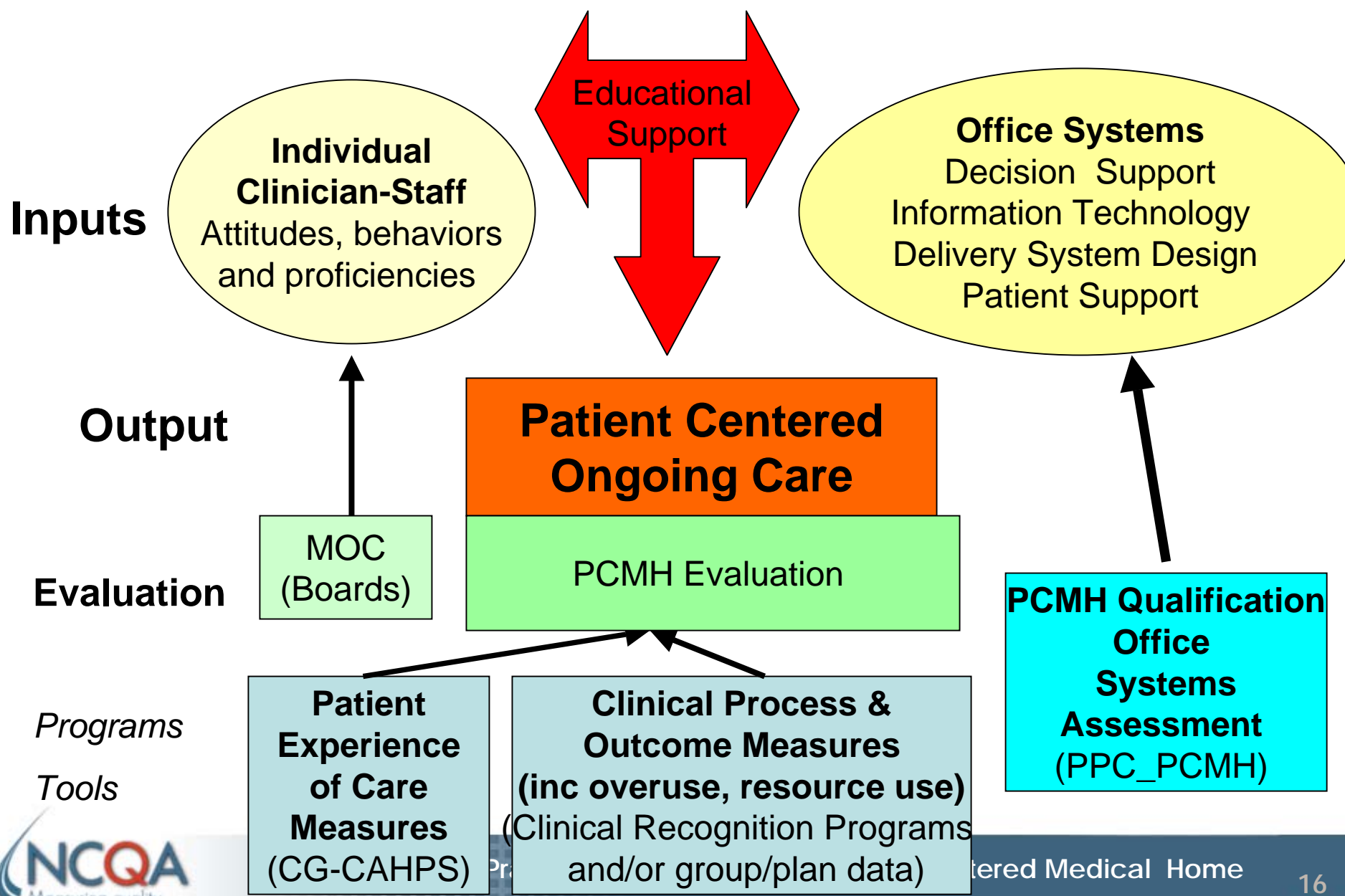
## ACP, AAFP, AAP, AOA

- ***Personal physician*** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- ***Physician directed medical practice*** - the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- ***Whole person orientation*** - the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- ***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

# Content Overlap of Primary Care -PCMH- CCM



# Implementing and Evaluating PCMH-Proposed Model



# Measures-for PCMH

(some differences between primary care and specialty PMCH)

- **Structural –systems presence and use measures**
  - PPC\_PCMH
- **Patient Experience of Care**
  - Clinician Group CAHPS survey
- **Clinical Performance (under, over, mis)**
  - **Process** (many)
  - **Intermediate outcomes** (a few)
  - **Outcomes** (very few useful-functional status promising)
- **Resource use-cost** (available but unproven)

# PPC-PCMH Content and Scoring

Standard 1: Access and Communication <b>A. Has written standards for patient access and patient communication**</b> <b>B. Uses data to show it meets its standards for patient access and communication**</b>	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 <b>D. Uses paper or electronic-based charting tools to organize clinical information**</b> <b>E. Uses data to identify important diagnoses and conditions in practice**</b> 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 <b>A. Tracks tests and identifies abnormal results systematically**</b> B. Uses electronic systems to order and retrieve tests and flag duplicate tests	Pts 7 6 13
Standard 3: Care Management <b>A. Adopts and implements evidence-based guidelines for three conditions **</b> 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 <b>A. Tracks referrals using paper-based or electronic system**</b>	PT 4 4
Standard 4: Patient Self-Management Support A. Assesses language preference and other communication barriers <b>B. Actively supports patient self-management**</b>	Pts 2 4 6	Standard 8: Performance Reporting and Improvement <b>A. Measures clinical and/or service performance by physician or across the practice**</b> B. Survey of patients' care experience <b>C. Reports performance across the practice or by physician **</b> 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**

# Linkage of PCMH to Reimbursement

Pay for Performance- Clinical and Patient Experience  
Network (virtual or “real”)

Fee Schedule for Visits/Procedures

Payment per patient per month (or year)  
for qualification as “Patient Centered Medical Home”

# Evaluation Payment for Consultative Sub-specialty

- **Structural –systems presence and use measures (coordination, HIT, other)**
  - PPC-chronic care model
- **Patient Experience of Care**
  - Clinician-group CAHPS
- **Clinical Performance (under, over, mis)**
  - **Process** (many)
  - **Intermediate outcomes** (a few)
  - **Outcomes** (very few useful-functional status promising)
- **Resource use-cost** (available but unproven)

# Reimbursement in Consultative Care

Pay for Performance- **Coordination, Systems use**  
Clinical and Patient Experience (Network- real or virtual)

Fee Schedule for Visits/Procedures

# Evaluation-Procedural Sub-specialists

- **Structural –systems presence and use measures** (some but not tested-safety may be foundation)
- **Appropriateness** (few criteria- no measures)
- **Clinical Performance (under, over, mis)**
  - **Technical Process** (a few available)
  - **Intermediate outcomes** (few if any)
  - **Outcomes** (few if any)
- **Resource use-cost** (available but unproven)
- **? Patient Experience** (few if any available)

# Reimbursement in Procedural Care

Pay for Performance-Clinical and Patient Experience  
(Network-virtual or real)

Fee Schedule for Visits/Procedures  
**Adjusted for Appropriateness**

# Linkage of PCMH to Reimbursement

**Pay for Performance**  
Clinical and Patient Experience

**Fee Schedule for Visits/Procedures**

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

# In Summary

- The primary care-patient centered medical home is THE cornerstone to health care system reform
- Measurement is critical for guiding improvement, evaluating impact and to support change in reimbursement
- We have a start of having the necessary measures and measurement BUT are a long way from where we need to be

# Appendix

## Slides on PPC



# Goals of PPC Measure Development

- Develop measures for evaluating systems use and effectiveness in prevention, chronic illness and if possible patient safety
- 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**

# Development of PPC

- **Document evidence base linking specific system to clinical performance**
  - Medline Review
  - Cochrane Collaborative
  - Manuscripts in press
- **Convene expert panel to review evidence and suggest standards/measures**
- **Conduct analysis of practice defects using six sigma process (with GE in BTE project)**
- **Create standards**
- **Test survey tool incorporating standards developed related to chronic care model**

# 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

# Current PPC Initiatives

- 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***

# Use of PPC, DPRP and HRSP in BTE

- **Employers want to improve the quality of care their employees receive, and they want to increase the value of their health care spend:**
  - BTE Programs have actuarially validated savings and BTE recognized physicians deliver higher quality care
- **Employers want operational simplicity:**
  - BTE is now administered by licensed or certified administrators, mainly health plans
- **Physicians want to be measured by reliable and valid measures and independent third party organizations:**
  - BTE's Provider Performance Assessment Organizations and measurement systems are accepted by the physicians
- **Physicians need to know up front what performance is expected of them and what they will get for achieving it:**
  - BTE's Operations give physicians a market-wide view

# BTE Use of Recognition Programs

	National Measure set	Physician Activation	Consumer Activation
<b>Physician Office Link (POL)</b>	Physician Practice Connections (PPC)	Up to \$50 pmpy	Physician-level report card, and patient experience of care survey
<b>Diabetes Care Link (DCL)</b>	Diabetes Provider Recognition Program (DPRP)	Up to \$100 pdppy	Diabetes care management tool, and rewards for care compliance
<b>Cardiac Care Link (CCL)</b>	Heart Stroke Recognition Program (HSRP)	Up to \$160 pcppy	Cardiac care management tool, and rewards for care compliance

# PPC Recognition (Jan 2008 non 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><b>Standard PPC 1</b> <b>Access and Communication</b></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><b>Standard PPC 5</b> <b>Electronic Prescribing</b></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><b>Standard PPC 2</b> <b>Patient Tracking and Registry Functions</b></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><b>Standard PPC 6</b> <b>Test Tracking</b></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><b>Standard PPC 3</b> <b>Care Management</b></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><b>Standard PPC 7</b> <b>Referral Tracking</b></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><b>Standard PPC 4</b> <b>Patient Self-Management Support</b></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><b>Standard PPC 8</b> <b>Performance Reporting and Improvement</b></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><b>Standard PPC 9</b> <b>Interoperability</b></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



# 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 <b>A. Has written standards for patient access and patient communication**</b> <b>B. Uses data to show it meets its standards for patient access and communication**</b>	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 <b>D. Uses paper or electronic-based charting tools to organize clinical information**</b> <b>E. Uses data to identify important diagnoses and conditions in practice**</b> 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 <b>A. Tracks tests and identifies abnormal results systematically**</b> B. Uses electronic systems to order and retrieve tests and flag duplicate tests	Pts 7 6 13
Standard 3: Care Management <b>A. Adopts and implements evidence-based guidelines for three conditions **</b> 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 <b>A. Tracks referrals using paper-based or electronic system**</b>	PT 4 4
Standard 4: Patient Self-Management Support A. Assesses language preference and other communication barriers <b>B. Actively supports patient self-management**</b>	Pts 2 4 6	Standard 8: Performance Reporting and Improvement <b>A. Measures clinical and/or service performance by physician or across the practice**</b> B. Survey of patients' care experience <b>C. Reports performance across the practice or by physician **</b> 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