Today

- NCQA quality measurement
- Recognizing practices as patient-centered medical homes
- Evaluation tool: Physician Practice Connections®—Patient-Centered Medical Home (PPC-PCMH)
NCQA

Mission
To improve the quality of health care.

Vision
To transform health care through quality measurement, transparency, and accountability.
NCQA Physician Programs

- **Identify physicians who deliver superior care**
- **Measure against evidence-based standards**
- **Assess for diabetes, heart/stroke and back pain care, and evaluate office systems**
- **Publicly report Recognized physicians**
- **Encourage purchasers, plans and patients to reward Recognized physicians**
- **More than 9,750 physicians Recognized**
Physician Practice Connections® (PPC) Measurement

- Measures evaluate
  - Use of systems
  - Effectiveness in prevention
  - Management of chronic illness and patient safety

- Measures are “actionable” at physician practice level

- Measures are validated by relating them to performance
PPC Developed in Response to a Need

- **Response to IOM reports**
  - *To Err is Human* and *Crossing the Quality Chasm* provide evidence on critical importance of practice systems

- **Raise physician awareness of importance of systems in enhancing quality**

- **Link health services research on systems and clinical outcomes to practice**
PPC Development Process

• 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 Wagner chronic care model

Portions of this work supported by Robert Wood Johnson Foundation
## Content of PPC-PCMH-Wagner CCM

<table>
<thead>
<tr>
<th>Delivery System Design</th>
<th>Clinical Information Systems</th>
<th>Decision Support</th>
<th>Self-Management Support</th>
<th>Community Support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What’s Included?</strong></td>
<td><strong>How Much Used?</strong></td>
<td><strong>What Functions?</strong></td>
<td><strong>Evidence and Scoring</strong></td>
<td></td>
</tr>
<tr>
<td>(Infrastructure)</td>
<td>(Extent)</td>
<td>(Implementation)</td>
<td>(Verification)</td>
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**Patient-Centered Medical Home**

**Wagner CCM**
The Patient-Centered Medical Home Defined
ACP, AAFP, AAP, AOA joint statement - April 2007

- **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.
**PPC 2006 vs. PPC-PCMH**

**What’s the Same? What’s New?**

**2006 Version**
- Scoring structure
  - 9 standards = 100 points
  - Three Recognition levels
- **2 Must Pass** elements
  - Care management
  - Performance measures

**PPC-PC MH Version**
- Scoring structure - **SAME**
  - 9 standards = 100 points
  - Three levels
- **10 Must Pass** elements
  - Linked to Level
- Total points same; increased for some elements; decreased for others
- More universal to all primary care practices, e.g. pediatricians
- Changed standard on “Interoperability” to “Advanced Electronic Communication”
Additions to PPC-PCMH

- Patient-centered and care coordination components
  - Language preference
  - Patient experience data
  - Patients as partners in management of care
  - Written plan for patients transitioning to other care
- Family involvement in care where appropriate
- Broader spectrum of patients - infants to adult practices
- Comprehensive coordination of care with responsibility on medical home physician
- Electronic communication with patients/families
## PPC-PCMH Content and Scoring

<table>
<thead>
<tr>
<th>Standard 1: Access and Communication</th>
<th>Pts</th>
</tr>
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<tbody>
<tr>
<td>A. Has written standards for patient access and communication**</td>
<td>4</td>
</tr>
<tr>
<td>B. Uses data to show it meets its standards for patient access and communication**</td>
<td>5</td>
</tr>
<tr>
<td><strong>Must Pass Elements</strong></td>
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<thead>
<tr>
<th>Standard 2: Patient Tracking and Registry Functions</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Uses data system for basic patient information (mostly non-clinical data)</td>
<td>2</td>
</tr>
<tr>
<td>B. Has clinical data system with clinical data in searchable data fields</td>
<td>3</td>
</tr>
<tr>
<td>C. Uses the clinical data system</td>
<td>3</td>
</tr>
<tr>
<td>D. Uses paper or electronic-based charting tools to organize clinical information**</td>
<td>6</td>
</tr>
<tr>
<td>E. Uses data to identify important diagnoses and conditions in practice**</td>
<td>4</td>
</tr>
<tr>
<td>F. Generates lists of patients and reminds patients and clinicians of services needed (population management)</td>
<td>21</td>
</tr>
</tbody>
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<tr>
<th>Standard 3: Care Management</th>
<th>Pts</th>
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<tbody>
<tr>
<td>A. Adopts and implements evidence-based guidelines for three conditions **</td>
<td>3</td>
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<tr>
<td>B. Generates reminders about preventive services for clinicians</td>
<td>4</td>
</tr>
<tr>
<td>C. Uses non-physician staff to manage patient care</td>
<td>3</td>
</tr>
<tr>
<td>D. Conducts care management, including care plans, assessing progress, addressing barriers</td>
<td>5</td>
</tr>
<tr>
<td>E. Coordinates care/follow-up for patients who receive care in inpatient and outpatient facilities</td>
<td>20</td>
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<tr>
<td>A. Assesses language preference and other communication barriers</td>
<td>2</td>
</tr>
<tr>
<td>B. Actively supports patient self-management**</td>
<td>4</td>
</tr>
<tr>
<td><strong>Must Pass Elements</strong></td>
<td></td>
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<thead>
<tr>
<th>Standard 5: Electronic Prescribing</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Uses electronic system to write prescriptions</td>
<td>3</td>
</tr>
<tr>
<td>B. Has electronic prescription writer with safety checks</td>
<td>3</td>
</tr>
<tr>
<td>C. Has electronic prescription writer with cost checks</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 6: Test Tracking</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Tracks tests and identifies abnormal results systematically**</td>
<td>7</td>
</tr>
<tr>
<td>B. Uses electronic systems to order and retrieve tests and flag duplicate tests</td>
<td>6</td>
</tr>
<tr>
<td><strong>Must Pass Elements</strong></td>
<td></td>
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<table>
<thead>
<tr>
<th>Standard 7: Referral Tracking</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Tracks referrals using paper-based or electronic system**</td>
<td>4</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Standard 8: Performance Reporting and Improvement</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Measures clinical and/or service performance by physician or across the practice**</td>
<td>3</td>
</tr>
<tr>
<td>B. Survey of patients’ care experience</td>
<td>3</td>
</tr>
<tr>
<td>C. Reports performance across the practice or by physician **</td>
<td>3</td>
</tr>
<tr>
<td>D. Sets goals and takes action to improve performance</td>
<td>3</td>
</tr>
<tr>
<td>E. Produces reports using standardized measures</td>
<td>2</td>
</tr>
<tr>
<td>F. Transmits reports with standardized measures electronically to external entities</td>
<td>15</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Standard 9: Advanced Electronic Communications</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Availability of Interactive Website</td>
<td>1</td>
</tr>
<tr>
<td>B. Electronic Patient Identification</td>
<td>2</td>
</tr>
<tr>
<td>C. Electronic Care Management Support</td>
<td>1</td>
</tr>
<tr>
<td><strong>Must Pass Elements</strong></td>
<td></td>
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## PPC-PCMH Scoring

<table>
<thead>
<tr>
<th>Level of Qualifying</th>
<th>Points</th>
<th>Must Pass Elements at 50% Performance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 3</td>
<td>75 - 100</td>
<td>10 of 10</td>
</tr>
<tr>
<td>Level 2</td>
<td>50 - 74</td>
<td>10 of 10</td>
</tr>
<tr>
<td>Level 1</td>
<td>25 - 49</td>
<td>5 of 10</td>
</tr>
<tr>
<td>Not Recognized</td>
<td>0 - 24</td>
<td>&lt;5</td>
</tr>
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**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.
PCMH “Must Pass” Elements

- Written standards for patient access and patient communication
- Use of data to show meeting this standard
- Use of paper or electronic-based charting tools to organize clinical information
- Use of data to identify important diagnoses and conditions in practice
- Adoption and implementation of evidence-based guidelines for three conditions
- Active support of patient self-management
- Tracking system to test and identify abnormal results
- Tracking referrals with paper-based or electronic system
- Measurement of clinical and/or service performance
- Performance reporting by physician or across the practice
PCMH Progress to Date

• Existing PPC 2006 tool modified with input from ACP, AAFP, AAP and AOA
  – Incorporated critical attributes of PCMH
  – Reviewed and modified PPC tool to Recognize practices as medical homes

• Engage practicing physicians, health plans, employers and consumers
  – Numerous presentations via Web-ex’s and at regional and national meetings
  – Participate in Patient-Centered Primary Care Collaborative (PCPCC), a purchaser sponsored group
  – Link NCQA’s technical support to CMS and RWJ Aligning Forces for Quality work
Linkage of PCMH to Reimbursement: One Model

- Pay for Performance
  - Quality, Resource Use and Patient Experience
- Fee Schedule for Visits/Procedures
- Payment per Patient for Qualified Medical Homes
  (services not normally reimbursed)
Implementation of PCMH

• Regional sponsors (plan, coalition, employer group) to engage in demonstration projects

• Participating practices agree on core elements of PCMH
  - Sign attestation of core principle of PMCH (as defined by AAP, AAFP, AAP, AOA)
  - Tool to Recognize practices as PCMH’s using PPC-PCMH
  - Link to incentive payment for being a PCMH
  - Evaluate demonstration projects
Prospective Evaluation of PCMH Demonstration Projects

- Likely to be multiple evaluators—decisions will be made by plans and foundations.
- NCQA is working with Commonwealth Fund and medical organizations to create common evaluation elements:
  - Standard set of clinical performance measures (NQF endorsed, where possible, use of NCQA Recognition programs)
  - Resource use/cost measurement at group or “virtual group” level (PCMH vs. non-PCMH)
  - Patient experience of care measures (CG-CAHPS)
Key to Sustained Payment Reform for PCMH: Demonstrated Benefits

- Evaluation should focus on multiple endpoints: process and outcomes, patient experiences, and efficiency

- Standardized set of tools and metrics will allow for comparing results across settings and populations

- Evaluation design to focus on outcomes/care for patients served in PCMH vs. those not in PCMH; unlikely to have sufficient information at physician level to draw conclusions, particularly for resource use
Questions? Comments?
Additions to PPC-PCMH

• Added patient-centered and care coordination components
  - Language preference,
  - Patient experience data
  - Patients as partners in management of care
  - Written plan for patients transitioning to other care

• Based on input from primary care specialty societies

• Incorporated family in care where appropriate

• Applicable to spectrum of patients - infants to adult practices

• Emphasis on comprehensive coordination of care with responsibility resting on medical home physician

• Electronic communication with patients/families

• Scoring changes
  - 10 must pass
  - Levels
    • Level 1 - must pass 5 of 10
    • Levels 2&3 - must pass 10 of 10)
**PPC 2006 vs. PPC-PCMH**

What’s the Same?  What’s New?

### 2006 Version
- Scoring structure
  - 9 standards = 100 points
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  - Levels posted on Web
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### Standard 1: Access and Communication
- **A.** Has written standards for patient access and patient communication**
  - **Pts:** 4
- **B.** Uses data to show it meets its standards for patient access and communication**
  - **Pts:** 5
  - **Total:** 9

### 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
- **D.** Uses paper or electronic-based charting tools to organize clinical information**
  - **Pts:** 6
- **E.** Uses data to identify important diagnoses and conditions in practice**
  - **Pts:** 4
  - **Total:** 20

### Standard 3: Care Management
- **A.** Adopts and implements evidence-based guidelines for three conditions**
  - **Pts:** 3
- **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
  - **Total:** 20

### Standard 4: Patient Self-Management Support
- **A.** Assesses language preference and other communication barriers
  - **Pts:** 2
- **B.** Actively supports patient self-management**
  - **Pts:** 4
  - **Total:** 6

### Standard 5: Electronic Prescribing
- **A.** Uses electronic system to write prescriptions
  - **Pts:** 3
- **B.** Has electronic prescription writer with safety checks
  - **Pts:** 3
- **C.** Has electronic prescription writer with cost checks
  - **Pts:** 2
  - **Total:** 8

### Standard 6: Test Tracking
- **A.** Tracks tests and identifies abnormal results systematically**
  - **Pts:** 4
- **B.** Uses electronic systems to order and retrieve tests and flag duplicate tests
  - **Total:** 13

### Standard 7: Referral Tracking
- **A.** Tracks referrals using paper-based or electronic system**
  - **Pts:** 6

### Standard 8: Performance Reporting and Improvement
- **A.** Measures clinical and/or service performance by physician or across the practice**
  - **Pts:** 3
- **B.** Survey of patients’ care experience
  - **Pts:** 3
- **C.** Reports performance across the practice or by physician**
  - **Pts:** 3
- **D.** Sets goals and takes action to improve performance
  - **Pts:** 2
- **E.** Produces reports using standardized measures electronically to external entities
  - **Pts:** 1
  - **Total:** 15

### Standard 9: Advanced Electronic Communications
- **A.** Availability of Interactive Website
  - **Pts:** 1
- **B.** Electronic Patient Identification
  - **Pts:** 2
- **C.** Electronic Care Management Support
  - **Pts:** 4
  - **Total:** **12**

**Must Pass Elements**
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