Building Patient-Centered Medical Homes

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National Health Policy Forum

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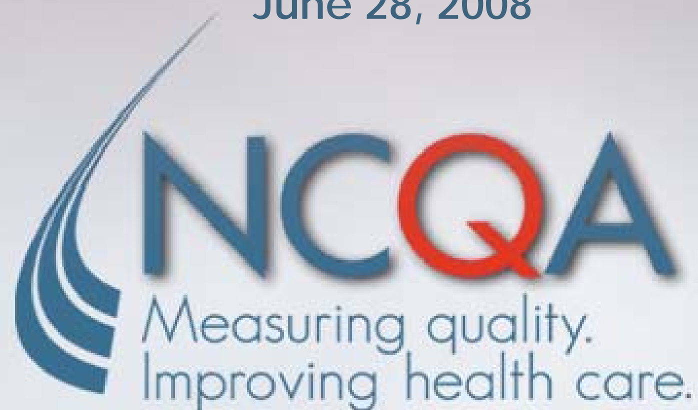


Agenda

- NCQA
- Development of PPC-PCMH
- What is needed for the medical home to succeed?

NCQA

Mission

To improve the quality of health care

Vision

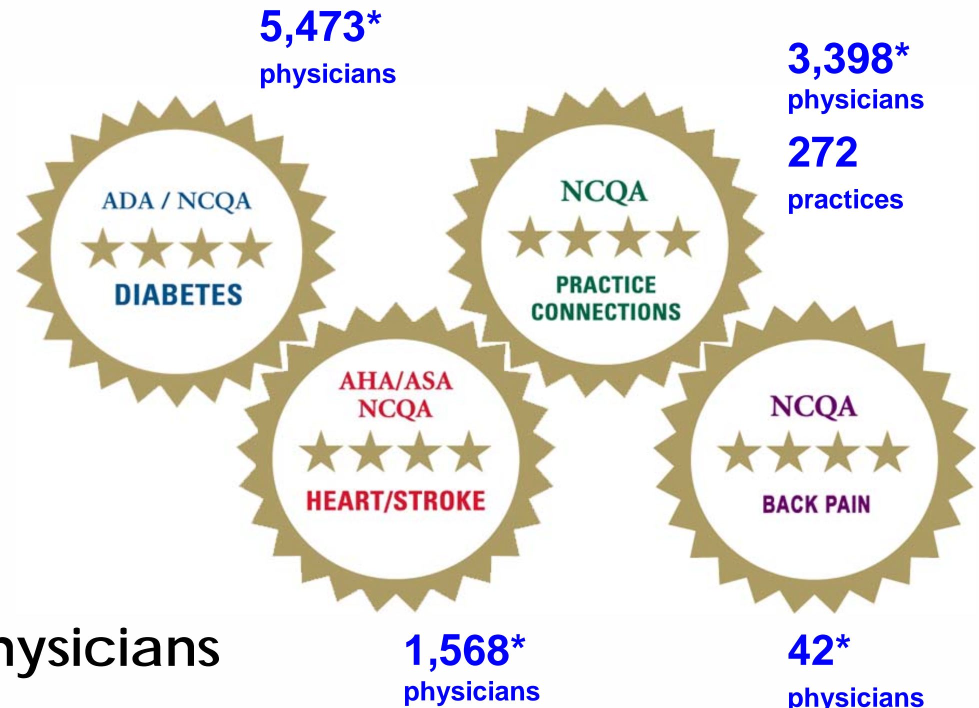
To transform health care through quality measurement, transparency, and accountability

A Brief Introduction

- Private, independent non-profit health care quality oversight organization founded in 1990
- Committed to measurement, transparency and accountability
- Unites diverse groups around common goal: improving health care quality

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 10,400* physicians Recognized



*As of May 31, 2007

Goals of PPC Development

- Develop tool for evaluating systematic approach to delivering preventive and chronic care (Wagner Chronic Care Model)
- IOM: 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

Correlation of Systems, Clinical Performance

- Published and in process research on PPC
  - 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, and some sub-scores have positive correlation with higher clinical performance on most measures (diabetes, CV)
  - Overall PPC score does NOT appear to correlate with overall patient experiences of care
  - Practice self report (without documentation or audit) does not produce reliable information

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

PPC-PCMH Development

- PPC 2006 developed with multi-stakeholder advisory committee
- Jan 2008: PPC-PCMH created with input from ACP, AAFP, AAP and AOA
  - Aligned standards with Joint Principles
  - Incorporated critical attributes of PCMH
  - Defined foundational elements ("must pass" requirements)

NQF Endorsement and AQA Approval in process; NCQA process for evolution in place

Need for a Standardized Tool

- 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-PCMH, Areas of Evaluation

- Access and Communication
- Patient Tracking and Registry Functions
- Care Management
- Patient Self-Management Support
- Electronic Prescribing
- Referral Tracking
- Test Tracking
- Performance Reporting and Improvement
- Advanced Electronic Communication

How PPC-PCMH Recognition Works

Physician/practice

- Self-assess, collect data using Web-based software
- Submit documentation to NCQA when ready
- May be asked to submit more data if needed

NCQA

- Evaluates and scores all applications
- Checks licensure of physician
- Audits a sample of applications
- Posts Recognized physicians on web
- Distributes list of Recognized physicians monthly to health plans and others
- Physicians sent media kit, press releases, letter & certificate

Myths About PPC-PCMH

- Small practices can't qualify **(>20% of qualified practices are solo physician sites/practices)**
- Passing (25 points) is too hard **(practices do not have to submit tool until they score above passing)**
- Passing (25 points) is too easy **(estimate fewer than 15% of practices could pass without making changes)**
- You have to have an EMR to pass **(can get nearly 50 points without)**
- All you need to pass is an EMR **(need to reengineer)**

What Will be Needed for PCMH to Succeed?

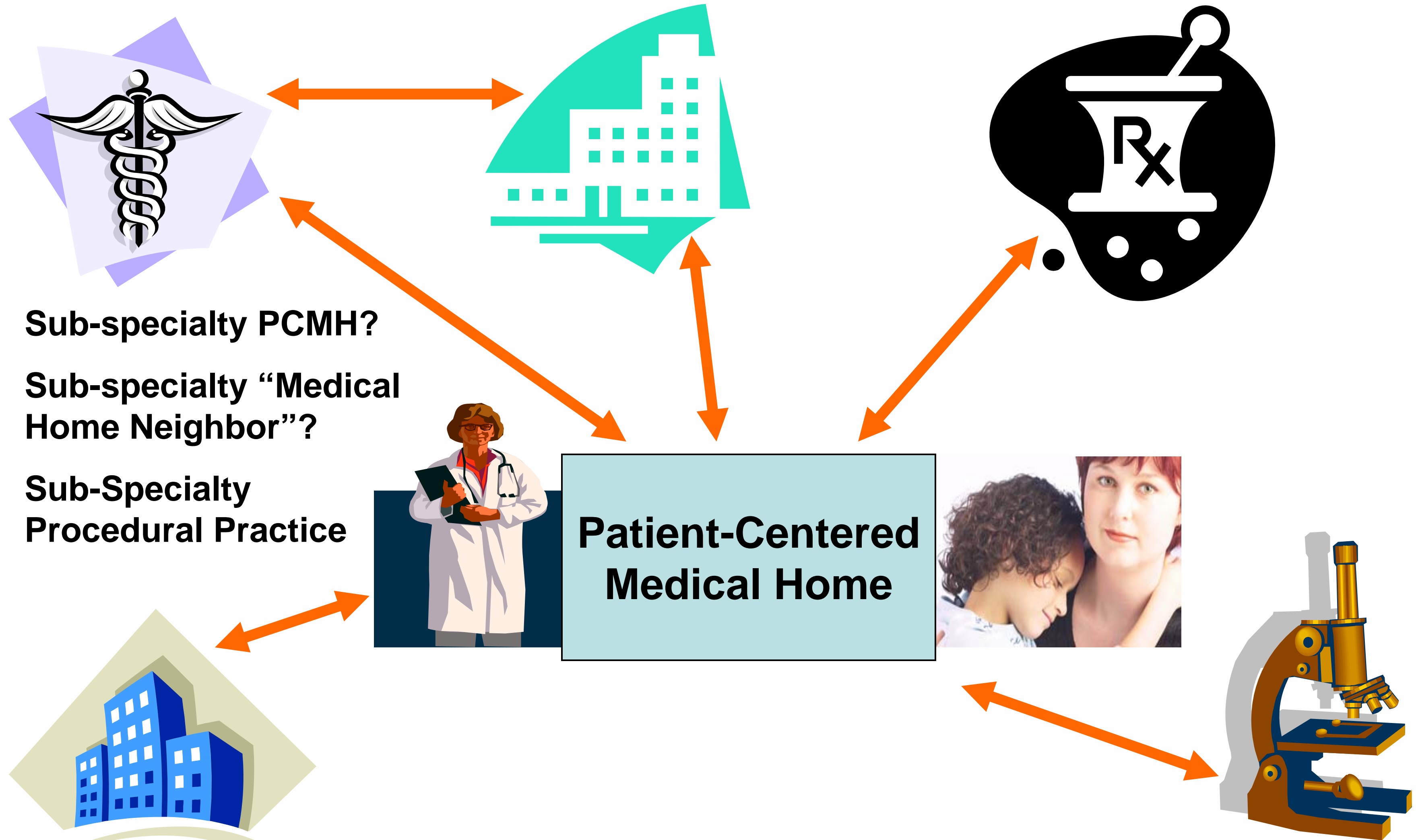
Why Do We Need a Different Model?

- Costs have for 50 years, and continue to, rise faster than GDP
  - Uninsured, underinsured and related care issues
  - Can't improve access without controlling costs
  - Major variation in costs WITHOUT relationship to quality (national/international)
  - Shortage of primary care MDs is leading to overuse of specialists
- Major gaps in quality
  - Avoidable ER visits
  - Avoidable hospital admissions, readmissions and deaths
  - In ambulatory care 50/50 chance of getting needed services

Key Steps to a Different Model

- Patient-Centered Primary Care as key building block
- 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

The Future Model of Care: Virtual Integration by Information



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 Recognized Medical Homes
(services not normally reimbursed)

Needed to Succeed

- Support for practices (utility)
- Data exchange strategy
- Performance measures
- Payment reform

Some Promising 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 II 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 II within 2 years
  - 6 health plans participating
- North Carolina Medicaid
  - Utility of 14 networks to support 3,500 MDs with care management services

Issues for the Future

- PCMH is not *the* answer to our cost and quality problems, but a vital building block
- How can we build on the PCMH to foster virtual, multi-specialty accountable entities?
- What is the role of specialists with regard to the PCMH?
  - Some specialties, e.g. cardiology, oncology, may serve as medical homes for some patients
  - Other specialties can support medical homes through information exchange