

Physician Practice Connections®—Patient-Centered Medical Home (PPC-PCMH™)

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Today

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



Physician Practice Connections—Patient-Centered Medical Home (PPC-PCMH)

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NCQA

Mission

To improve the quality of health care.

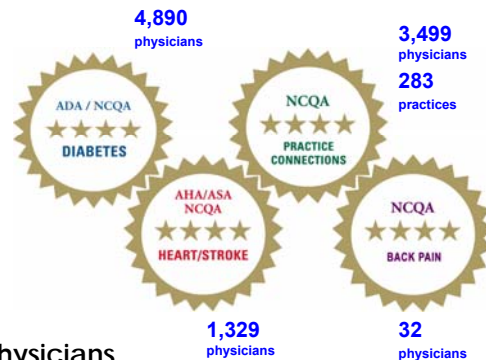
Vision

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

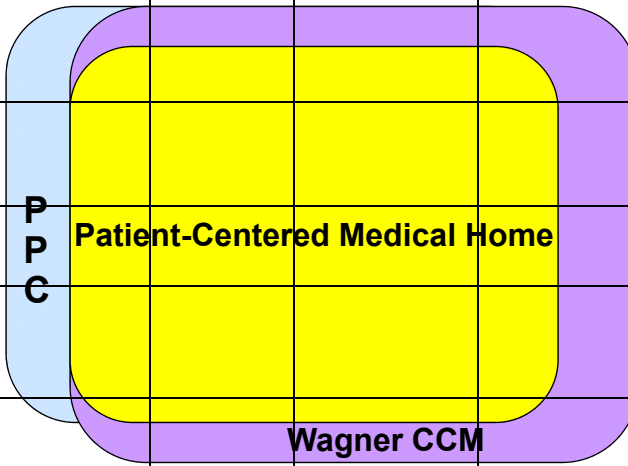


PPC Development Process

- 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

Delivery System Design				
Clinical Information Systems				
Decision Support				
Self-Management Support				
Community Support				
	What's Included? (Infrastructure)	How Much Used? (Extent)	What Functions? (Implementation)	Evidence and Scoring (Verification)

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.



Physician Practice Connections—Patient-Centered Medical Home (PPC-PCMH)

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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-PCMH 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"



Physician Practice Connections—Patient-Centered Medical Home (PPC-PCMH)

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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

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**Must Pass Elements



PPC-PCMH Scoring

Level of Qualifying	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.



PCMH “Must Pass” Elements

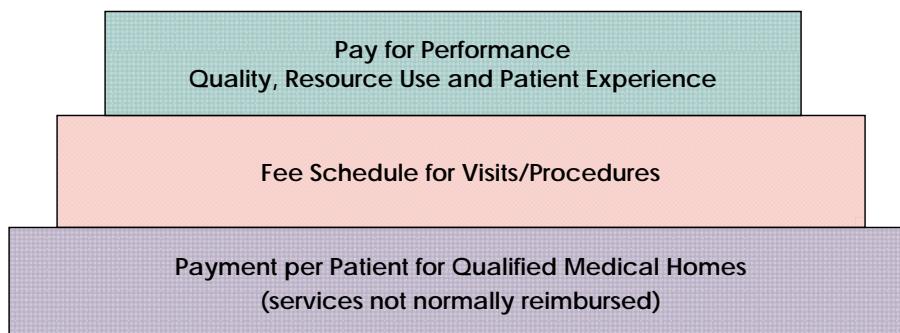
- Written standards for patient access and patient communication
- Use of data to show meeting this standard
- Use of paper or electronic-based charting tools to organize clinical information
- Use of data to identify important diagnoses and conditions in practice
- Adoption and implementation of evidence-based 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



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?