Medical Home: Progress Report and a Look Ahead

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President

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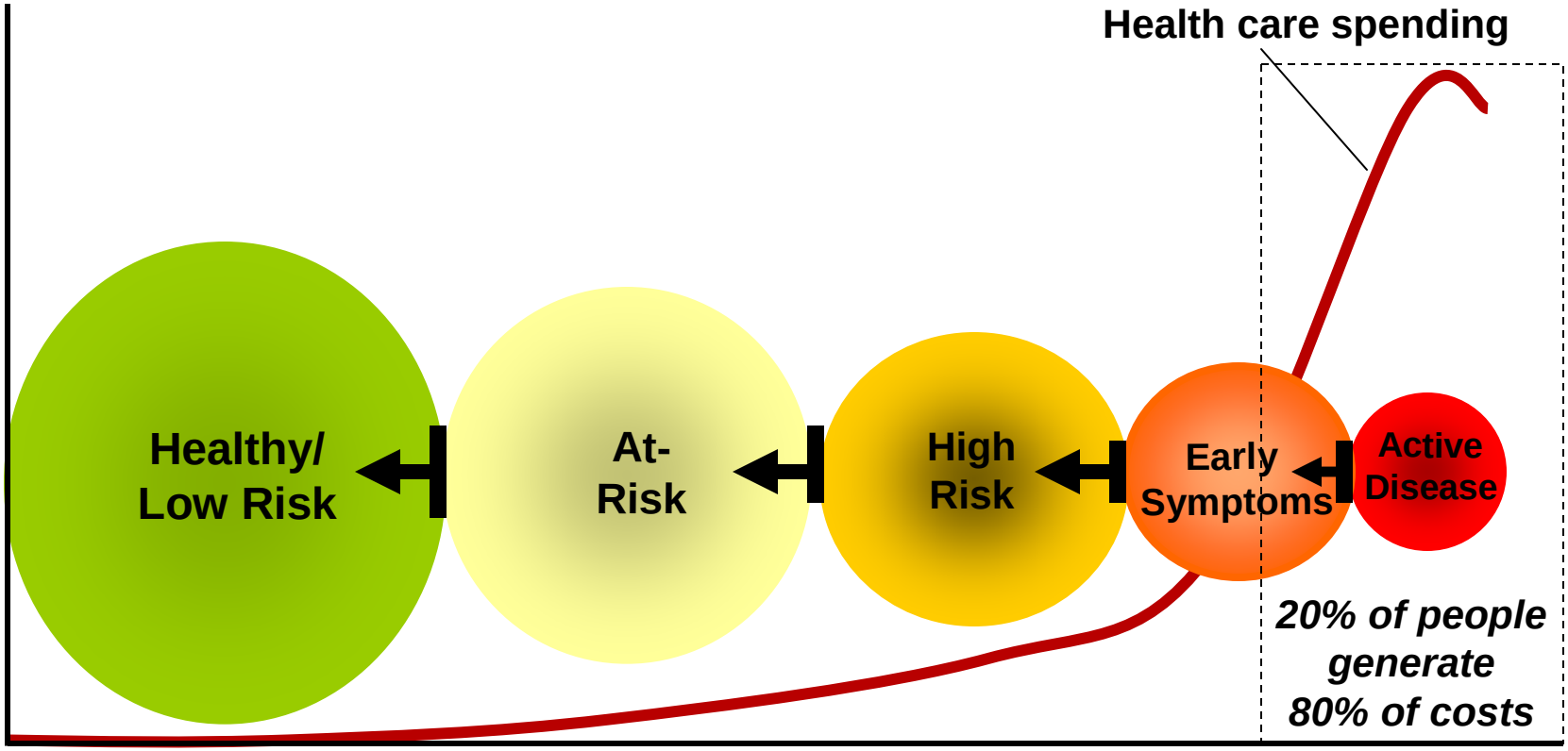
NCQA
Measuring quality.
Improving health care.

Today's Agenda

- How our health care system should work
- The state of health care today
- Measurement leads to improvement
- The Patient-Centered Medical Home

WHAT'S HEALTH CARE SUPPOSED TO DO?



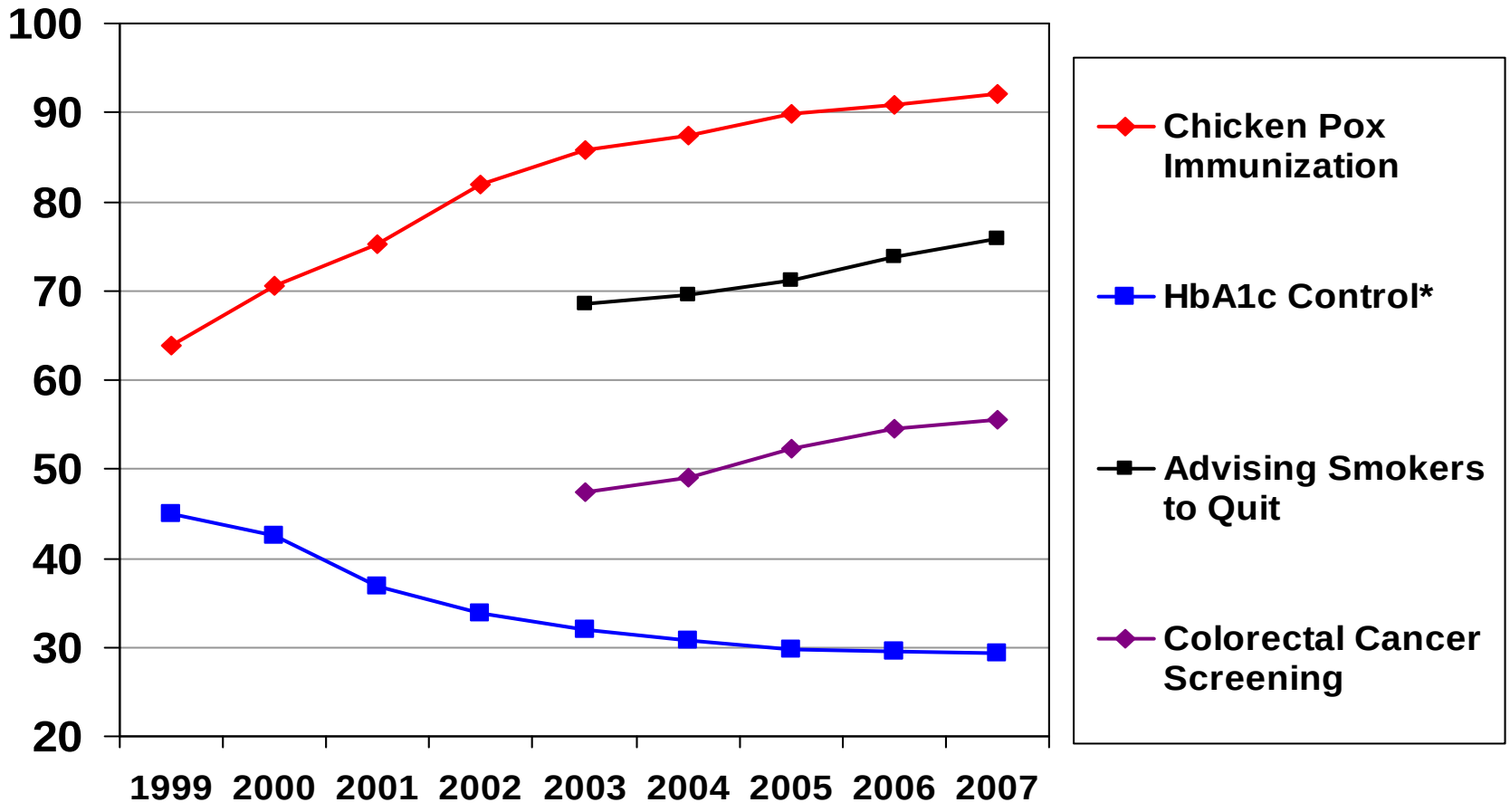
A *value-based* health care system

Source: HealthPartners

MEASUREMENT HAS LED TO QUALITY IMPROVEMENT

- **Eleven years of measuring data has shown that measurement leads to improvement!**
  - Children are nearly three times as likely to have had all recommended immunizations as in 1997
  - Diabetics are twice as likely to have cholesterol controlled (<130 mg/dL) as in 1998
  - More than 97% of cardiac patients prescribed beta-blockers after a heart attack (up from 62% in 1996)

SELECT IMPROVEMENTS: 1999 – 2007



*Lower is Better for this measure

THESE IMPROVEMENTS SAVE LIVES!

Cumulative Lives Saved Due to Commercial and Medicare Quality Improvement, 2000-2006

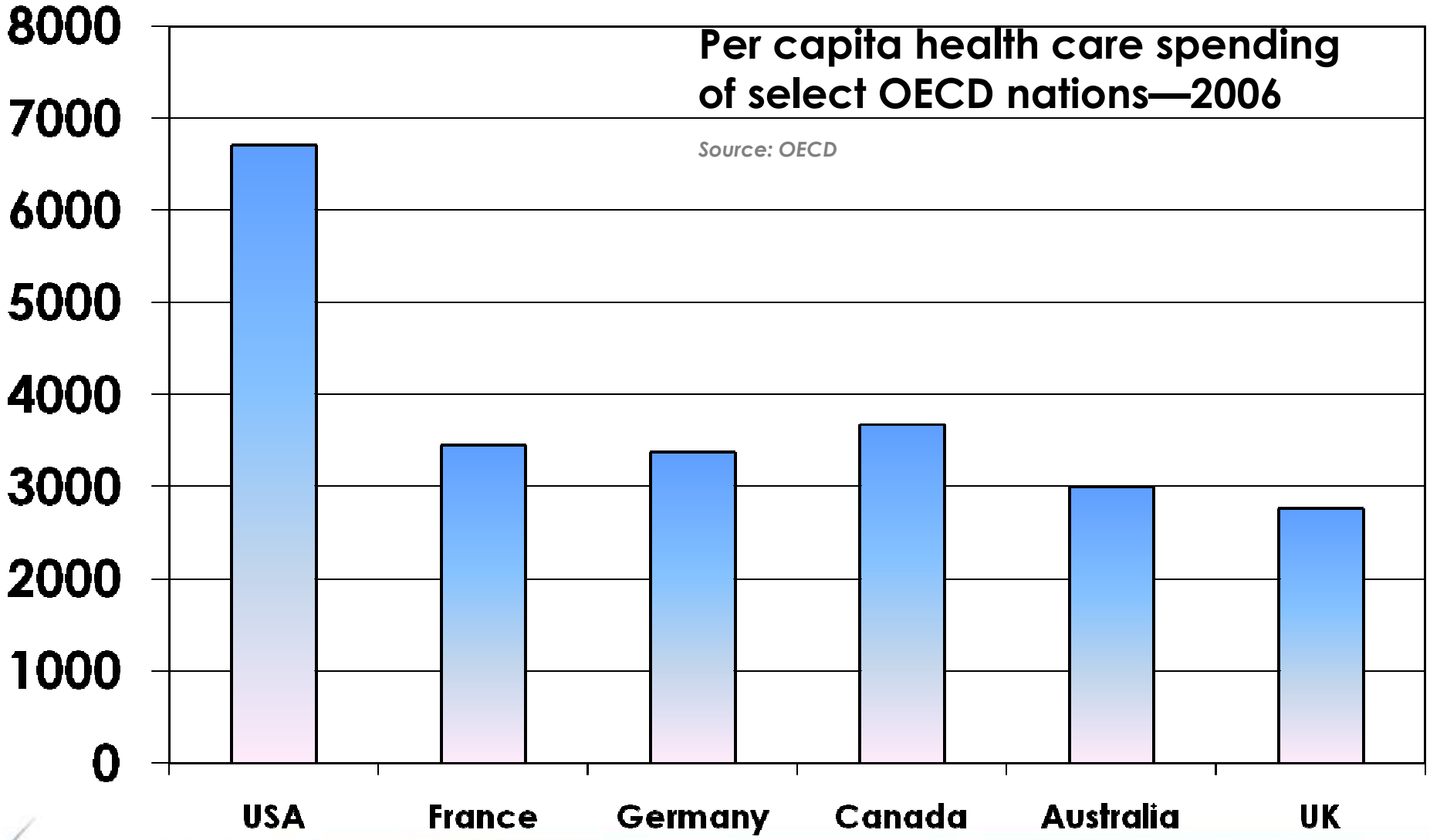
Measure	Lives Saved
Beta-Blocker Treatment	4,400 – 5,600
Cholesterol Management	10,100 – 17,000
Controlling High BP	56,800 – 98,600
Poor HbA1c Control	2,000 – 3,400
TOTAL	73,300 – 124,600

THE STATE OF HEALTH CARE QUALITY

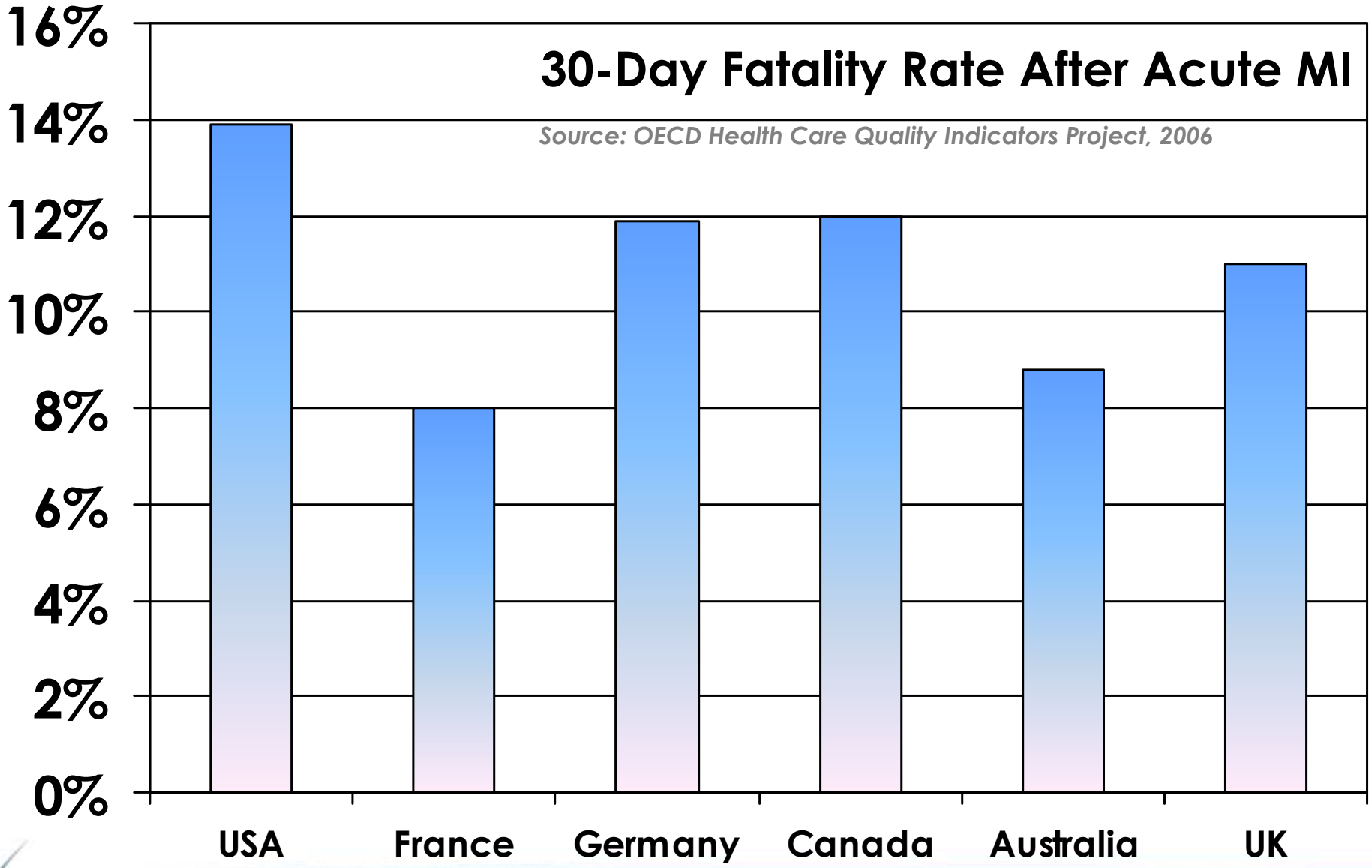
QUALITY? IT'S VARIABLE—AT *BEST*

- **RAND: Americans get evidence-based care only 55% of the time**
  - **Children receive such care only 47% of the time**
- **IOM: Up to 98,000 Americans die each year due to avoidable medical errors**
- **NCQA: Variations in care result in up to 89,000 deaths, $3.5 billion in avoidable costs**

WE SPEND ALMOST *DOUBLE* OTHER INDUSTRIALIZED NATIONS…



BUT OUR RESULTS ARE OFTEN WORSE



IT'S THE DELIVERY SYSTEM, STUPID!

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 14,000 physicians nationally**

7023 physicians

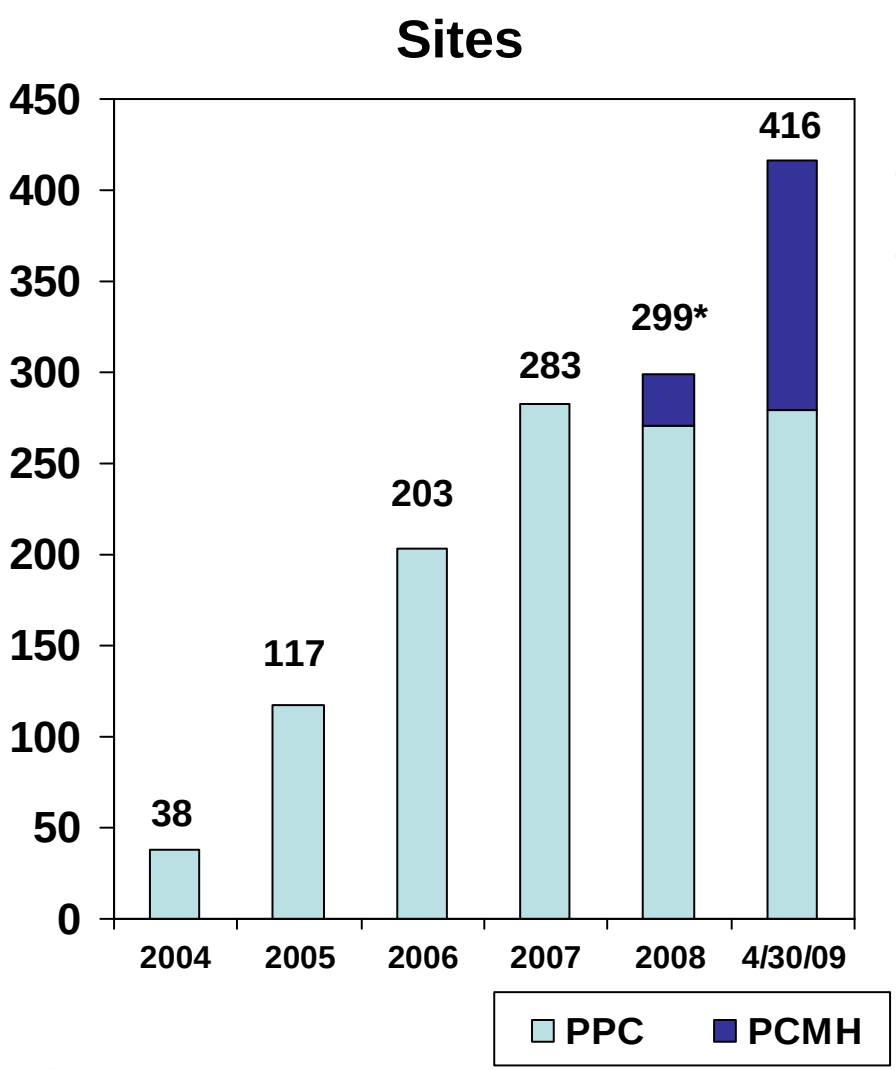
2032 physicians

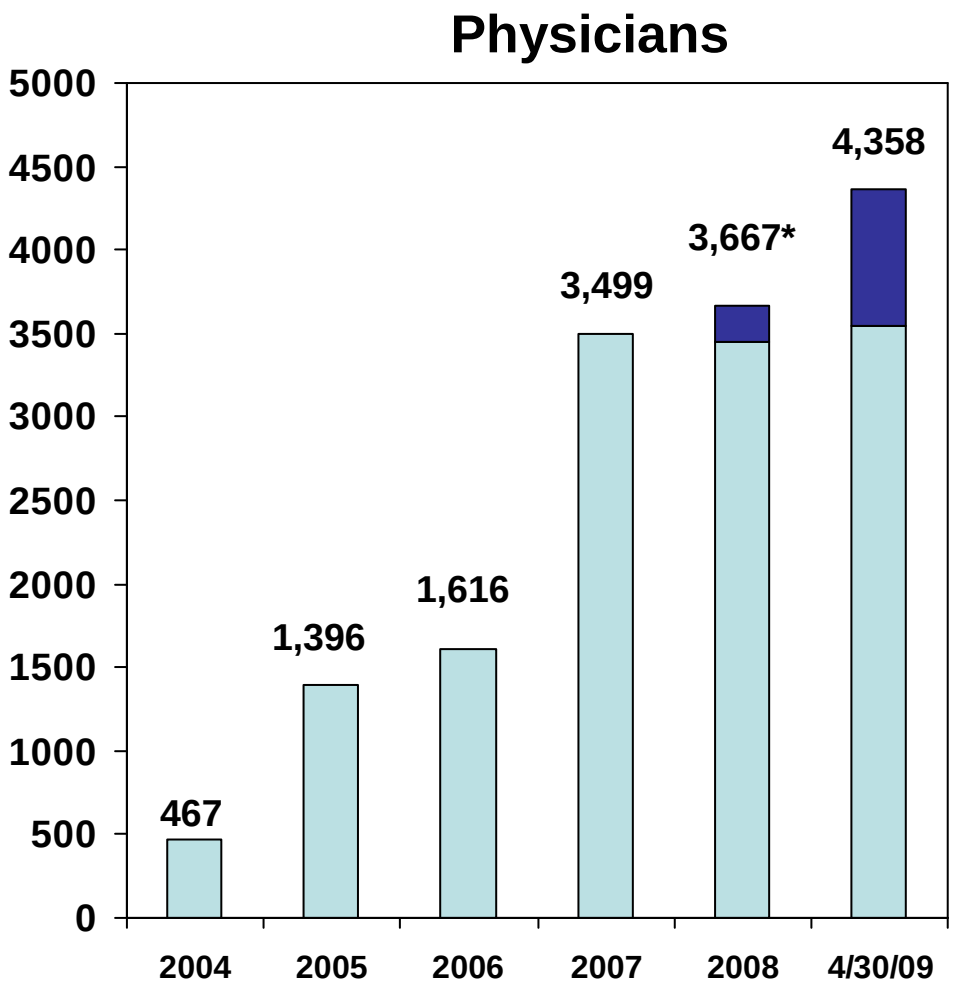
3443 physicians
279 practices

105 physicians

815 physicians
137 practices

Growth of PPC & PPC-PCMH





*PPC-PCMH released in 2008

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

Adapting PPC for the Patient-Centered Medical Home

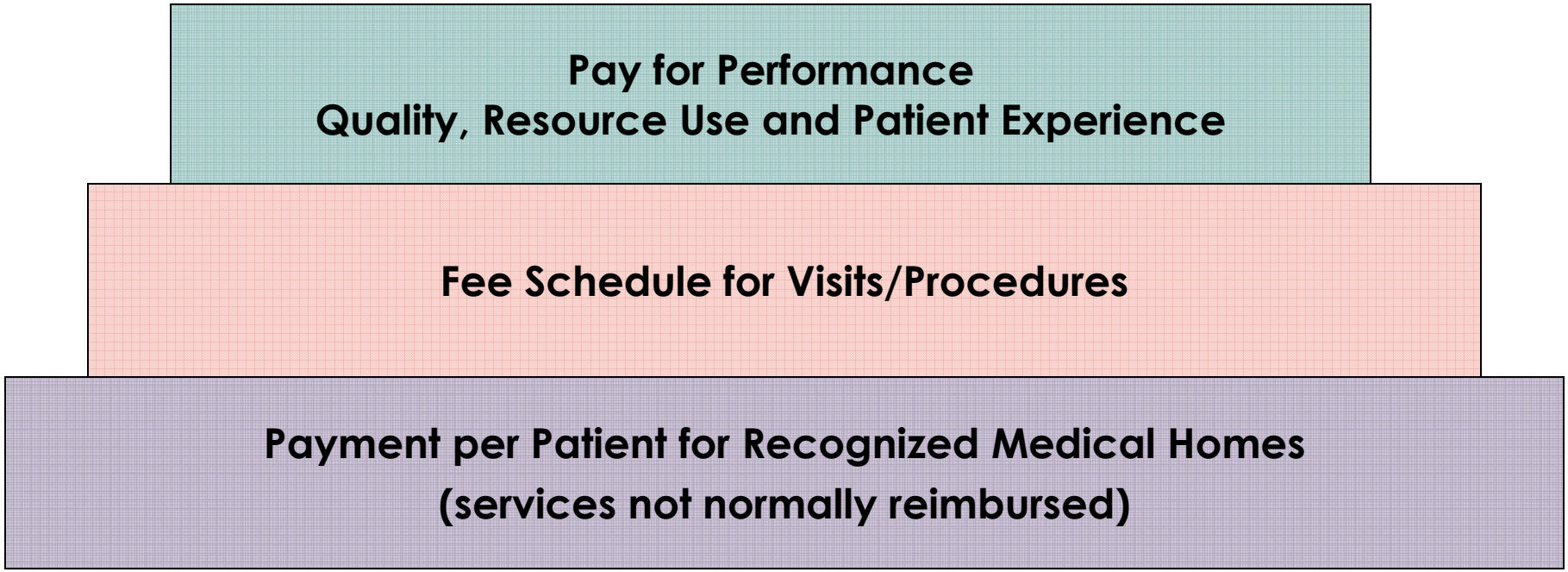
- **New PPC-PCMH version released in January 2008**
  - **Aligned standards with Joint Principles**
  - **Incorporated critical attributes of PCMH**
  - **Defined foundational elements ("must pass" requirements)**
- **PPC-PCMH endorsed by ACP, AAFP, AAP, AOA, other specialties and PCPCC for use in demos**

Endorsed by National Quality Forum Sept 2008 (as "Medical Home System Survey")

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

Linkage of PCMH to Reimbursement: One Model



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)

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

PPC-PCMH Standards

1. Access and Communication
2. Patient Tracking and Registry Functions
3. Care Management
4. Patient Self-Management Support
5. Electronic Prescribing
6. Test Tracking
7. Referral Tracking
8. Performance Reporting and Improvement
9. Advanced Electronic Communications

Examples of Initiatives Using PPC-PCMH

- **Multi-payer** - Colorado, Pennsylvania, Rhode Island
- **State-wide** – Pennsylvania, Vermont, Maine
- **Single payer** – EmblemHealth, Humana
- **Government** – Medicare, New York City, Louisiana

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

Potential of Regional Extension Centers

- ARRA (stimulus act) includes $2 billion for a National Health Information Technology Research Center and "regional extension centers"
- Building on NYC, Mid-Hudson, NC, other experience
- Proposed goals (Federal Register RFI, 5/28/09)
  - Encourage adoption of EHRs
  - Assist clinicians with becoming meaningful users
  - Increase the probability that adopters will become meaningful users
- RFP for FY 2010 imminent

Significant PPC-PCMH Issues for Future

- How to further assess patient-centeredness, including patient survey results?
  - How to engage patients?
  - How to make name resonate positively?
- When should performance results be part of scoring?
- How to adapt to promote quality and cost gains across settings?
  - Primary care—subspecialty
  - Physician—hospital, other facilities
- How to streamline requirements, documentation?
  - For all practices
  - For practices renewing