

# Defining the Patient-Centered Medical Home

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# Agenda

- What is a Patient-Centered Medical Home (PCMH)?
- How can you tell whether a practice is a PCMH?
- How does the Physician Practice Connections (PPC) PCMH version work?
- Lessons Learned and Future Development

# 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.

# 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)

# 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

# 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

# Content Overlap of Primary Care/PCMH/CCM

Comprehensive	<b>Primary Care</b>			
First Contact	<b>Patient-Centered Medical Home</b>			
Self-Management Support				
Decision Support				
Clinical Information Systems				
Community Linkages				
				<b>Wagner CCM</b>
	<b>What's Included? (Infrastructure)</b>	<b>How Much Used? (Extent)</b>	<b>What Functions? (Implementation)</b>	<b>Evidence</b>
			Patient-Centered Medical Home	11/12/08

# Adapting PPC for the Patient-Centered Medical Home

- Review and modification of the PPC tool for use in “qualification” of PCMH
- New PPC-PCMH version released in January 2008
- PPC-PCMH endorsed by ACP, AAFP, AAP, AOA, other specialties and PCPCC
- NQF endorsement received Sept 2008 (as “Medical Home System Survey”)

# 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

# PPC-PCMH Must Pass Elements

**PPC1A:** Written standards for patient access and patient communication

**PPC1B:** Use of data to show meeting this standard

**PPC2D:** Use of paper or electronic-based charting tools to organize clinical information

**PPC2E:** Use of data to identify important diagnoses and conditions in practice

**PPC3A:** Adoption and implementation of evidence-based guidelines for three conditions

**PPC4B:** Active support of patient self-management

**PPC6A:** Tracking system to test and identify abnormal results

**PPC7A:** Tracking referrals with paper-based or electronic system

**PPC8A:** Measurement of clinical and/or service performance

**PPC8C:** Performance reporting by physician or across the practice

# 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.

# 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
- Sign attestation to Joint Principles of PCMH

## 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)

# Potential New Content

- Access
  - Evening/weekend hours, agreement with facility for after-hours care
- Coordination of care
  - Information shared with specialists, information shared with patient, updating of care plan
- Team-based care
  - Defined roles and responsibilities, training, communication
- Role of medical home
  - Discussion of roles/expectations for medical home and for patients
- Community involvement
  - Assessment of community needs, matching services to needs, involvement of community organizations
- Addressing special population needs/risks
- Evaluating patient experiences

# PPC-PCMH

- Encourages practices to adopt evidence-based systems for improving care
- Uses systems evaluation to evaluate quality
- Provides mechanism for incentivizing investment in quality infrastructure and processes

## For More Information

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