Standards and Guidelines for Physician Practice Connections®—Patient-Centered Medical Home (PPC-PCMH™)

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Overview

The Physician Practice Connections®—Patient-Centered Medical Home (PPC-PCMH™) is a modification of 2006 Physician Practice Connections (PPC). The PPC-PCMH version of PPC reflects the input of primary care specialty societies and others on how to use the 2006 PPC to assess whether physician practices are functioning as medical homes.

Creating the PPC-PCMH as an approach to care is a response to the crisis in primary care, with far fewer physicians choosing careers in primary care (e.g., general internal medicine; family medicine; pediatrics; and in some formulations, obstetrics and gynecology). In addition, surveys indicate that physicians in primary care are disillusioned and considering early retirement or career change. Research by Barbara Starfield and others links higher ratios of primary care compared with specialties as having higher quality and lower costs (both in the United States and in international comparisons) of primary care.

Joint Principles of the PPC-PCMH

While early work on the medical home concept was done by pediatricians and focused on care of children with special needs, the concepts embedded in the Patient Centered Medical Home were further developed by a collaboration of the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP) and the American Osteopathic Association (AOA). NCQA provided input related to our work on the PPC and a Commonwealth Fund grant to define “patient-centeredness.” The joint principles, created and supported by ACP, AAFP, AAP and AOA, define the following key characteristics of the PCMH.

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 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.

Quality and safety are hallmarks of the medical home.

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients and the patient’s family.
- Evidence-based medicine and clinical decision-support tools guide decision making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision making and feedback is sought to ensure patients’ expectations are being met.
- Information technology (IT) is utilized appropriately to support optimal patient care, performance measurement, patient education and enhanced communication.

- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. While aspiring to improve patient care, the four primary care groups envision implementation of the PCMH as linked to more rational (and higher) payment for primary care, which is in very fragile status in the U.S. The four primary care groups, aided by others, have held discussions with employers, health plans and the federal government to encourage the development of PCMH implementation/demonstration programs. In concert with the joint principles, the PPC-PCMH standards emphasize the use of systematic, patient-centered, coordinated care management processes.

To achieve Recognition as a Patient-Centered Medical Home by meeting the NCQA PPC-PCMH standards, practices will attest to the 2007 Joint Principles of the Patient-Centered Medical Home of the AAFP, the AAP, the ACP and the AOA, as seen below. Practices apply for Recognition with the understanding that the PPC-PCMH standards assess many of the ways in which the practice functions as a patient-centered medical home. Functioning as a patient-centered medical home requires an approach beyond the areas assessed by the PPC-PCMH standards. The concept of the medical home and how to operationalize it is evolving and will result in future versions of the Joint Principles and PPC-PCMH.

NCQA developed the PPC-PCMH to evaluate the extent to which practices are Recognized as medical homes. During 2008, demonstration programs around the country will evaluate PCMHs to answer the following questions:

- How many practices can—and will—achieve Recognition?
- What quality and cost outcomes are associated with PCMHs?
- What are appropriate payment mechanisms for compensating PCMHs?

Demonstration practices will enhance and test PCMH care systems and submit documentation of their experience with the systems. NCQA will collect, analyze and report on PPC-PCMH results. Health plans, researchers, NCQA and others will evaluate the effectiveness of PPC-PCMH as tool for evaluating the quality and resource use of patient-centered medical homes. NCQA also will assess the need for changes in PPC 2006. We anticipate that recommended changes to PPC-PCMH and PPC 2006 will be merged into a single revision of PPC.

Why PPC-PCMH?

The Current Environment

In the private sector

A number of groups have formed to support and promote the concept of the PCMH, most notably the purchaser-led Patient-Centered Primary Care Collaborative (PCPCC), which has been active with federal legislators. In addition, most national insurers and some regional insurers have expressed interest in the concept and have been in discussions with the physician specialty societies and NCQA.

Given the shortage of primary care physicians in many areas of the country, health plans are interested in attracting and retaining primary care physicians and in supporting their ability to coordinate care for patients—*if* it improves quality and reduces costs. There is insufficient data on the impact of resource use of PCMH practices. If there is a commitment to greater reimbursement for PCMHs, plans and employers want to see improved quality of care and demonstrable cost savings.

In the public sector Legislation requires the Centers for Medicare & Medicaid Services (CMS) to implement and evaluate a Medicare PCMH demonstration. A number of state Medicaid programs are also considering some type of patient-centered medical home demonstration.

The Historical Perspective

The 2001 Institute of Medicine report*, Crossing the Quality Chasm: A New Health System for the 21st Century* (IOM, 2001), is a major source of inspiration for NCQA and for PPC in particular. Crossing the Quality Chasm examines the current state of health care quality and articulates a new vision for health care in the U.S. The report proposes six major aims for a quality health care system—specifically, health care should be safe, effective, patient-centered, timely, efficient and equitable. Improving the systems that support health care is key to achieving these aims. To drive health care to change in this direction, the report challenges employers and other purchasers to reward quality in the way that they purchase health care. Bridges to Excellence (BTE) and other reward programs are beginning to do that.

A follow-up report from the IOM, *Building a Better Delivery System: A New Engineering/ Health Care Partnership* (IOM, 2005) further describes the “underinvestment in information and communications technologies” that could help make health care more safe, efficient and effective. The report calls for greater collaboration between health care and engineering to solve these problems, and for public and private entities to accelerate the development of the National Health Information Infrastructure.

Crossing the Quality Chasm: 10 Simple Rules for the 21st Century Health Care System

Crossing the Quality Chasm put forth "10 Simple Rules for the 21st Century Health Care System" to guide the redesign of the health care system. These rules underlie PPC and describe a system different from most health care today.

1. *Care based on continuous healing relationships.* Patients should receive care whenever they need it and in many forms, not just face-to-face visits.
2. *Customization based on patient needs and values.* The system of care should meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.
3. *The patient as the source of control.* Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them.
4. *Shared knowledge and the free flow of information.* Patients should have unfettered access to their own medical information and to clinical knowledge.
5. *Evidence-based decision making.* Patients should receive care based on the best available scientific knowledge.
6. *Safety as a system property.* Patients should be safe from injury caused by the care system.
7. *The need for transparency.* The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice and patient satisfaction.
8. *Anticipation of needs.* The health system should anticipate patient needs, rather than simply reacting to events.
9. *Continuous decrease in waste.* The health system should not waste resources or patient time.
10. *Cooperation among clinicians.* Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

Crossing the Quality Chasm encourages focus on a finite number of chronic conditions that account for a large percentage of health care expenses in the U.S., and urges greater investment in and rewards for IT infrastructure to support evidence-based care. PPC brings together a focus on chronic care, with rewards for IT to support evidence-based care.

Specifically, the report cites an important body of work supporting the need for improved health care systems: the Model for Effective Chronic Illness Care, developed at HealthPartners in Minnesota and at Group Health Cooperative of Puget Sound (Bodenheimer, Wagner and Grumbach, 2002). Essential components of the model include clinical information systems that provide decision support for practitioners and prepared, proactive teams that offer self-management support to informed patients. Research shows that these systems produce effective, evidence-based care for people with chronic conditions. The Chronic Care Model spawned research done by NCQA funded by the Robert Wood Johnson Foundation, the development of survey-based measures to assess the presence of the elements of the model. These measures are incorporated into the PPC standards.

Other research shows that the components of the Chronic Care Model are not widely employed, despite compelling evidence of their usefulness. A major survey of large medical practices across the country assessed the presence of 16 care-management processes: 4 processes (disease registries, clinical guideline reminders, feedback to physicians and case management) used in treating each of four chronic conditions (diabetes, asthma, congestive heart failure and depression). Of the ideal 16 processes, the average number used was 5 (Casalino et al, 2002). This study also found that the more external incentives medical groups had, including financial incentives and public reporting, the more care processes they used.

The Consumer Perspective

At the same time that health services research is showing, ever more sharply, the importance of having systems in place to support quality health care, consumers seek to experience the benefits that follow from effective systems. Consumer research shows that consumers perceive many of the same shortcomings in the health care system. Moreover, patients value the kind of well-organized and coordinated experience with doctors that can result from good systems of care, and appreciate the value of evidence-based medicine.

Research has found that consumers are interested in systematic care and follow-up, when given the opportunity to evaluate them. In 2001, NCQA completed a review of the literature on consumer preferences around quality of physician care (NCQA, 2001) for a series of focus groups. A number of studies have shown that when asked what is important in a doctor, consumers first mention the physician's ability to communicate and show a caring attitude (Robinson and Brodie, 1997). When information on quality of care is put in a proper context, additional aspects come out.

A specific study of consumers' needs as ambulatory patients was done by the Picker Institute, and found a wider range of consumer needs than is customarily expected. The study queried consumers in focus groups on their views about what constitutes quality care, what types of information they need to make health care choices and what some of the obstacles were that they faced in obtaining useful information. It identified access and coordination of care, information, communication, appropriate education, support and alleviation of fear and anxiety as needs of ambulatory patients. Additional needs included patient experiences with specific procedures of care, such as assistance with tests and follow-up information (Edgman-Levitan and Cleary, 1996).

Consumers also perceive the gap between the ideal and the actual in medical practice. The Procter & Gamble Healthcare Consumer Institute conducted a Consumer Satisfaction and Loyalty Study (Walker, 2001; Procter & Gamble, 2002; Proctor & Gamble, 2005), involving over 10,000 respondents across ages, geographic areas, income levels, ethnic backgrounds, genders and self-reported health status levels. The study measured characteristics that were most important to patients about doctors, how their doctors performed on those characteristics and gaps between values and performance.

Proctor & Gamble's analysis indicated 12 "Big Opportunities": gaps between importance and performance. Among them are areas covered in the PPC standards.

- Staff/doctor returns calls in a timely manner
- Staff/doctor follows up with a phone call
- The doctor is familiar with the patient's medical history.
- The doctor is good at diagnosing and treating any problem (Procter & Gamble, 2005).

Consumers thus expressed unmet needs that, in the future, physicians could fulfill with better systems, information and processes to make knowledge more readily available.

PPC-PCMH Development

Development process

NCQA staff worked closely with leaders of the four specialty societies (ACP, AAFP, AAP, AOA) and other interested stakeholders to develop PPC-PCMH. Each organization supports this version as the tool to use to Recognize practices as medical homes in PCMH demonstrations.

Content changes

Refer to Appendix 2 for the standards and elements, with the associated points. The crosswalk below highlights the differences between PPC 2006 and PPC-PCMH.

Must Pass elements

There are 10 must-pass elements. At a minimum (Level 1) practices must-pass 5 of these elements by performing at the 50 percent scoring level (earning half the points for the element).

- **PPC 1: Access and Communication**
  - Element A: Access and Communication Processes
  - Element B: Access and Communication Results
- **PPC 2: Patient Tracking and Registry Functions**
  - Element D: Organizing Clinical Data
  - Element E: Identifying Important Conditions
- **PPC 3: Care Management**
  - Element A: Guidelines for Important Conditions
- **PPC 4: Patient Self-Management Support**
  - Element B: Self-Management Support
- **PPC 6: Test Tracking**
  - Element A: Test Tracking and Follow Up
- **PPC 7: Referral Tracking**
  - Element A: Referral Tracking
- **PPC 8: Performance Reporting and Improvement**
  - Element A: Measures of Performance
  - Element C: Reporting to Physicians

New element

The following element is new.

- **PPC 8: Performance Reporting and Improvement**
  - Element A: Patient Experience Data

Changed standard

The following standard replaces the previous PPC 9.

- PPC 9: Advanced Electronic Communications *(PPC 2006: Interoperability)*
  - Element A: Availability of Interactive Web site *(PPC 2006: Use of Prescribed Standardized Codes)*
  - Element B: Electronic Patient Identification *(PPC 2006: Electronically Receiving Data)*
  - Element C: Electronic Care Management Support *(PPC 2006: Electronically Transmitting Data)*

Scoring

- The number of overall points is the same, but in some cases the distribution has changed
  - The number of points increased for some elements
  - As indicated below, some standards and elements have been added and others have been deleted
- One scoring option at the element level changed
  - Increased from 20% to 25%
- The number of factors increased in some elements, but this did not change scoring for those elements

Table 1: PPC 2006 to PPC-PCMH
Crosswalk

SCORING IN PPC-PCMH:

1. The number of overall points is the same but in some cases the distribution has changed:
   - The number of points increased for some elements.
   - As indicated below, some standards and elements have been added and others have been deleted.
2. One of the scoring options at the element level changed:
   - Increased from 20%–25%.
3. The number of factors increased in some elements but this did not change the scoring for those elements.

PPC 2006 and PPC-PCMH Standards	PPC 2006 and PPC-PCMH Element Titles	PPC 2006 Points	PPC-PCMH Points	Description of Change	PPC-PCMH Changes, Additions or Deletions				
					Standards	Elements	Factors	Explanation	Examples
PPC 1: Access and Communication	PPC 1A : Access and communication processes	4	4 Must-Pass	Added factor: Identifying health insurance resources for patients without insurance.			✓		
	PPC 1B: Access and communication results	4	5 Must-Pass	None					
PPC 2: Patient Tracking and Registry Functions	PPC 2A: Basic system for managing patient data	2	2	Added factors: Legal guardian, health insurance coverage and preferred method of communication			✓		
	PPC 2B: Electronic system for clinical data	3	3	Added factor: Head circumference for patients ≤2 years			✓	✓	
	PPC 2C: Use of electronic clinical data	3	3	None					
	PPC 2D: Organizing clinical data	6	6 Must-Pass	Added factor: Screening tool for developmental testing and growth charts.			✓	✓	
	PPC 2E: Identifying important conditions	4	4 Must-Pass	Added explanation for risk factors associated with practice's demographics.				✓	
	PPC 2F: Use of system for population management	2	3	Added factor: Patients who might benefit from care management. Added explanation for pediatrics.			✓	✓	

PPC 2006 and PPC-PCMH Standards	PPC 2006 and PPC-PCMH Element Titles	PPC 2006 Points	PPC-PCMH Points	Description of Change	PPC-PCMH Changes, Additions or Deletions				
					Standards	Elements	Factors	Explanation	Examples
PPC 3: Care Management	PPC 3A: Guidelines for important conditions	3	3 Must-Pass	Added to element: …evidence-based *diagnosis and* treatment guidelines…		✓			
	PPC 3B: Preventive service clinician reminders	4	4	Added examples for pediatric practices.				✓	
	PPC 3C: Practice organization	3	3	Expanded explanation of team of physicians and staff related to handling patient care responsibilities.			✓	✓	
	PPC 3D: Care management of important conditions	5 Must-Pass	5	Changed factors from setting to *writing* individualized care plans and treatment goals.			✓	✓	
	PPC 3E: Continuity of care	5	5	Added to element: …patients transitioning to other care. Added factors: written transition plan and help identifying new PCP or specialist.		✓	✓	✓	
PPC 4: Patient Self-Management Support	PPC 4A: Documenting communication needs	2	2	None					
	PPC 4B: Self-management support	4	4 Must-Pass	Added factor: provides written care plan to patient/family. Added to explanation: written materials appropriate for patients. Added to examples: referrals to community resources.			✓	✓	✓
PPC 5: Electronic Prescribing	PPC 5A: Electronic prescription writing	3	3	None					
	Electronic prescribing interoperability	3	Deleted	Deleted					
	PPC 5C (B): Prescribing decision support—safety	3	3	None					
	PPC 5D (C): Prescribing decision support—efficiency	2	2	None					

PPC 2006 and PPC-PCMH Standards	PPC 2006 and PPC-PCMH Element Titles	PPC 2006 Points	PPC-PCMH Points	Description of Change	PPC-PCMH Changes, Additions or Deletions				
					Standards	Elements	Factors	Explanation	Examples
PPC 6: Test Tracking	PPC 6A: Test tracking and follow-up	6	7 Must-Pass	Added factor: follow-up to get results on in-patient pediatric screening tests.			✓		
	PPC 6B: Electronic system for managing tests	6	6	None					
PPC 7: Referral Tracking	PPC 7A: Referral tracking	4	4 Must-Pass	Added to element: *Specialist or* consultant report. Added to explanation: clinical details to include in referral.		✓		✓	
	PPC 7B: Referral decision support	3	Deleted	Deleted					
PPC 8: Performance Reporting and Improvement	PPC 8A: Measures of performance	3 Must-Pass	3 Must-Pass	Added to factor: examples for pediatric practices.			✓		
	PPC 8B: Patient experience data		3	New	✓	✓	✓	✓	✓
	PPC 8C (8B): Reporting to physicians	3	3 Must-Pass	Added to explanation: staff meetings.				✓	
	PPC 8D (8C): Setting goals and taking action	3	3	Added family involvement.				✓	
	PPC 8E (8D): Reporting standardized measures	2	2	None					
	PPC 8F (8E): Electronic reporting—external entities	1	1	None					
PPC 9: Advanced Electronic Communications	PPC 9A: Availability of interactive Web site		1	New	✓	✓	✓	✓	✓
	PPC 9B: Electronic patient identification		2	New	✓	✓	✓	✓	✓
	PPC 9C: Electronic care management support		1	New	✓	✓	✓	✓	✓

PPC 2006 and PPC-PCMH Standards	PPC 2006 and PPC-PCMH Element Titles	PPC 2006 Points	PPC-PCMH Points	Description of Change	PPC-PCMH Changes, Additions or Deletions				
					Standards	Elements	Factors	Explanation	Examples
PPC 9: Interoperability	PPC 9A: Use of prescribed standardized codes	1	Deleted	Deleted					
	PPC 9B: Electronically receiving data	1	Deleted	Deleted					
	PPC 9C: Electronically transmitting data	1	Deleted	Deleted					
	PPC 9D: Using data for referral reports	1	Deleted	Deleted					

PPC-PCMH Structure

Achievement levels

In PPC-PCMH, there are three levels of achievement. Practices can gauge their ability to achieve these levels by assessing whether they perform the functions required in each element of each standard. Each element indicates the extent of information technology required for that element.

Level 1 25 points–49 points.

Must-pass elements = 5 of 10, with a performance level of at least 50%.

Level 2 50 points–74 points.

Must-pass elements = 10 of 10, with a performance level of at least 50%.

Level 3 75 points or more.

Must-pass elements = 10 of 10, with a performance level of at least 50%.

Must-pass elements

These are elements that a practice must-pass at a 50% or greater score in order to achieve Recognition.

IT requirements

Basic *Requires an electronic practice management system.* Basic elements represent 60 percent of the elements in PPC v.2.

Intermediate *Requires further IT within the practice,* such as an electronic health report (EHR) or e-prescribing capability. Intermediate elements represent 33 percent of the elements in PPC 2006.

Advanced *Requires interoperable IT capabilities,* such as the ability to electronically transmit and receive data between the practice and other entities. Advanced elements represent 7 percent of the total elements.

PPC-PCMH Recognition Evaluation Process

NCQA uses the same evaluation process for all of its Physician Recognition Programs. The process to be Recognized is as follows.

1. The practice conducts a self-scoring readiness assessment using NCQA's Web-based Survey Tool, responding to questions and attaching supporting documentation to verify responses.
2. The practice uses the Survey Tool to submit its data for NCQA evaluation.
3. NCQA evaluates all data and documents submitted by the practice against the standards, and then scores the practice.
4. For at least 5 percent of practices, NCQA conducts an *additional, onsite audit*. During the audit, staff review source data, including medical records, to validate documentation and responses previously provided to NCQA.
5. NCQA provides final information to the practice.
6. NCQA reports information on the practice, its physicians and its level of performance to the NCQA Web site and to data users, including health plans and physician directory publishers.
7. NCQA does not report information on practices that do not pass at any level.

For additional information on NCQA's PPC-PCMH survey process, contact Customer Support at 888-275-7585 or go to NCQA's Web site at www.ncqa.org/ppc-pcmh.

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