Presented at The Association of Chiropractic Colleges and the Research Agenda Conference (ACC-RAC), March 12-14, 2009, Las Vegas

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Workshop Objectives

Morning Session

- Participants will understand …
  - Current State of Health Industry
  - Overview of NCQA organization and BPRP
  - Overview of the Clinical Measures and Structural Standards
  - Benefits of Participation
    - Patients, Providers, Payors, Policy Makers, Profession
- Q&A Session

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Workshop Objectives

Evening Session (6:30 – 8pm. TONIGHT!)

- Participants will obtain a detailed understanding of BPRP…
  - Clinical Measures
  - Structural Standards
  - Application Process
- Participants will make a preliminary assessment of their ability to meet BPRP benchmark
Panel Members

- Cynthia Martin, MHSA
  - NCQA Manager, Physician Recognition Programs
- John Ventura, DC, DACBO
  - Private practice, Rochester Chiropractic Group
  - Clinical instructor in family medicine, Univ of Rochester School of Med.
  - Asst. clinical professor, New York Chiropractic College
  - NCQA recognized status, BPRP

Panel Members

- Brian Justice, DC, DACBO
  - Private practice, Rochester Chiropractic
  - Director of chiropractic services, Unity Hospital Spine Center
  - NCQA recognized status, Back Pain Recognition Program
- Greg Snow, DC, CCSP
  - Dean of Clinics, Palmer West Campus
  - NCQA Recognized Site for Back Pain Recognition Program
Background Information

Health Care Economics

- Healthcare costs are far outpacing inflation and wage increases (1)
- Costs for spine related conditions rising at a faster pace than other conditions (2)
- Low back pain is the 3rd leading cause of disability in the workplace and 6th most costly condition (3)
- Estimated direct costs attributable to low back pain range from $12.2-90 billion (3)
References

3. Dagenais, S; Caro, J; Haldeman, S. A systematic review of low back pain cost of illness studies in the United States and internationally. The Spine Journal 2008, 8:8–20

Health Care Industry Response

- Improve outcomes and minimize costs by identifying physicians best suited to provide care for back pain patients
  - Pay-for-Performance
  - High-performance provider networks
    - E.g. Aetna, Blue Cross and Cigna
  - ICD 10
    - "provides the precision needed for … emerging uses such as pay-for-performance" (4)
- Bottom line: Incent providers and patients
References


ACA Stance(5)

- Recommends participation (or adherence) as the BPRP quality measures “could have a significant impact on Medicare reimbursement.”
- Notes that some managed care organizations may require BPRP participation for the treatment of certain conditions.
Currently there is no one profession seen as being the "go to" providers for back pain. Chiropractors appear well suited to fulfill this role. BPRP may represent one way to demonstrate:

- Emphasis on quality patient care
- Willingness to adopt EBP measures
- Willingness to submit to external scrutiny
- Willingness to be part of the bigger health care picture

Reference

5 ACA Website link: http://www.acatoday.org/content_css.cfm?CID=2298
Educational Perspectives

- "We can only obtain cultural authority when we have brought our educational programs up to the level that the public expects of an expert, learned profession." Wyatt et al
  - Patients seen in chiropractic college clinics found they were not representative of those seen by chiropractors in the field
  - Lacking sufficient volume and variety of patient exposures.
  - Found little evidence of teaching "evidenced based health-care" in chiropractic education.

Educational Trends

- Mentor Model replacing Supervisory
  - Faculty mentored and delivered care
  - Reflects "real world" more closely
- BPRP fits this change well
  - Validates level of care provided
  - Plug and play best practices program
  - Improve/Increase Pt volume and variety
  - Enhance Insurance credentialing
  - Enhance marketability
  - Enhance perception
Role of Health Care Education

- Educational institutions need to play a far greater role in development and implementation of health initiatives if they desire to lead in improvement of our nation's health. (Snyderman, MD7)
  - “Academic medicine must not lose sight of its core missions of innovating in research, patient care, and medical education.”
  - Must train “new doctors to be the best doctors.”
- Equally applicable to chiropractic education

References


About the NCQA
NCQA

- Founded in 1990
- Mission “To improve the quality of health care”
- Vision “To transform health care quality through measurement, transparency and accountability”
- NCQA offers Accreditation, Certification and Recognition Programs

NCQA Achieving The Mission

- Over 800 plans report HEDIS® data to NCQA (Commercial, Medicaid, Medicare, HMO/PPO)
- Over 250 commercial MCO plans are accredited by NCQA
- Over 75 Medicaid plans are accredited by NCQA
- Over 100 Medicare Advantage plans are accredited by NCQA (more than any other accrediting body)
- Over 85.9 million patients are impacted through the plans NCQA accredits
- Over 12,000 physicians are recognized nationally by NCQA programs
NCQA Recognition Programs

- Current programs: DPRP, HSRP, BPRP, 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

Number of Physician Recognitions by State

<table>
<thead>
<tr>
<th>State</th>
<th>Recognizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>WA</td>
<td>101+ Recognitions</td>
</tr>
<tr>
<td>OR</td>
<td>26-100 Recognitions</td>
</tr>
<tr>
<td>NV</td>
<td>1-25 Recognitions</td>
</tr>
<tr>
<td>CA</td>
<td>0 Recognitions</td>
</tr>
</tbody>
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Back Pain Recognition Program

- Released in 2007
- Seeks to “identify physicians and chiropractors who provide high-value, patient centered care for back pain.”
- A self-audit process
- Open to DCs, MDs, DOs (“physicians”)
- Other allied health care providers are not eligible

Major Focuses of Program

- Promotes a model of care that includes:
  - comprehensive patient assessment and reassessment,
  - judicious use of imaging,
  - patient education, and
  - shared decision making about surgery.
Designed to…

- “provide high-quality care from the outset of patient contact”
- “understand and consider previous treatment history to help avoid inappropriate treatment.”

Development Process

- NCQA developed the BPRP with significant input from employers, health plan medical directors and medical specialists through a variety of mechanisms:
  - Advisory Committee - expert panel
    - BPRP Measurement Evidence Review
  - Public Comment - user input
  - Beta-test - pilot sites
  - Early Adopters
What it IS about

- Program fits well within the paradigm of patient care delivery for most contemporary chiropractic practices
- A holistic approach that requires the provider to address the biopsychosocial factors found to increase incidence or chronicity of back pain

What it IS about

- Identifying individual physicians and chiropractors who provide patients with the care that best meets their needs, restores health and mobility and avoids unnecessary treatment and tests.
- Performance measurement = performance improvement
What it’s NOT about

- Restricting type or frequency of care
- Dictating treatment approaches
- Limiting chiropractic scope

NCQA BPRP Requirements

- 13 Clinical Measures, 11 apply to non-surgeons
- 3 Structural Standards, 2 apply to non-surgeons
- Thus, for non-surgeons, there are 13 relevant Measures and Standards
- Scores must be generated for at least 10
CMs Summarized

- Meaningful history components
  - Occ Hx, Smoking, Mental Health
- Appropriate physical exam
  - Radiating Pain
- Management advice
  - Avoid Bed Rest, Activity Levels
- Appropriate and timely reassessment
  - OATs

<table>
<thead>
<tr>
<th>Clinical Measures/Structural Standards</th>
<th>Criteria</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Measures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Initial Visit</td>
<td>50% of patients in sample</td>
<td>8.0</td>
</tr>
<tr>
<td>2. Physical Exam</td>
<td>MUST PASS</td>
<td>9.5</td>
</tr>
<tr>
<td>3. Mental Health Assessment</td>
<td>72% of patients in sample</td>
<td>5.0</td>
</tr>
<tr>
<td>4. Appropriate Imaging for Acute Back Pain*</td>
<td>50% of patients in sample</td>
<td>7.5</td>
</tr>
<tr>
<td>5. Repeat Imaging Studies†</td>
<td>Data Collection Only – Will not be Scored</td>
<td>No Score</td>
</tr>
<tr>
<td>6. Medical Assistance with Smoking Cessation</td>
<td>76% of patients in sample</td>
<td>3.5</td>
</tr>
<tr>
<td>7. Advice for Normal Activities</td>
<td>48% of patients in sample</td>
<td>8.5</td>
</tr>
<tr>
<td>8. Advice Against Bed Rest</td>
<td>48% of patients in sample</td>
<td>7.5</td>
</tr>
<tr>
<td>9. Recommendation for Exercise</td>
<td>71% of patients in sample</td>
<td>5.5</td>
</tr>
<tr>
<td>10. Repeat Imaging Studies*</td>
<td>10% of patients in sample</td>
<td>6.5</td>
</tr>
<tr>
<td>11. Patient Reassessment</td>
<td>71% of patients in sample</td>
<td>6.5</td>
</tr>
<tr>
<td>12. Shared Decision Making**</td>
<td>50% of patients in sample</td>
<td>6.5</td>
</tr>
<tr>
<td>Structural Standards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Patient Education</td>
<td>Structural Standard</td>
<td>6.5</td>
</tr>
<tr>
<td>2. Post-Surgical Outcomes**</td>
<td>Structural Standard</td>
<td>8.5</td>
</tr>
<tr>
<td>3. Evaluation of Patient Experience</td>
<td>Structural Standard</td>
<td>3.5</td>
</tr>
<tr>
<td>Total Points</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Points Needed to Achieve Recognition</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Point Assignment

- Some clinical measures or structural standards are not required for non-surgeons.
- When a measure or standard is not required or not applicable because of small numbers, the points assigned to that requirement are proportionally reallocated to all of the other requirements.

BPRP

Application process
Step 1 - Purchase the BPRP Data Collection Tool (DCT)

- $80
  - Standards and Guidelines
  - Agreement
  - DCT Instructions
- Provides you with user name and password with which to enter
  - site information
  - clinician information
  - extracted file data

Step 2 - Preliminary Analysis

- Review NCQA Clinical Measures and Structural Standards against current clinic procedures
- Determine likelihood of meeting or exceeding benchmark
  - If meeting, move to next step
  - If failing to meet, implement changes to insure compliance and run for sufficient time to meet Standards
Step 3 - Extract Provider Data

- For individual doctors, 35 **eligible** cases
- For sites with 2 - 8 providers, 25 **eligible** patients per provider
- For sites with greater than 8 providers:
  - Submit 25 patients for at least 8 providers
  - NCQA will randomly select 8
  - If pass, ok
  - If fail, then must submit for all providers

Step 4 – Input Data into DCT

- Data can either be extracted and entered into the DCT patient by patient, or
- Data can be collected into a paper-based DCT, or
- Excel or other computer based DCT
Step 5 – Upload Structural Standard Evidence

- 2 Structural Standards
  - S1 – Patient Education
  - S3 – Evaluation of Patient Experience
- Link documents to first doctor only (not to all)

Step 6 – Preliminary Results

- Once DCT is completed (Measures and Standards data entered/uploaded), you can select “Preliminary Results” tab and you will receive a score for your site and for each clinician
- If not meeting benchmark, can then decide not to submit and make necessary changes.
**Step 7 – Upload DCT**

- If preliminary results look positive, then hit the “Submit” button to upload DCT
- Once DCT is uploaded, it cannot be accessed again.
- Adding future doctors/sites requires the purchase of another DCT and repeat of process

**Step 8 – Await Results**

- Submit fees for each site seeking approval ($450/doctor, up to $2700 max per site)
- Submit signed contract
- Once check and contract are received, applications are processed in 30 days
- Results are sent via email
Why Participate

Impact and Benefits of achieving Recognition

Employers.....
Insurers.....
Referral sources (primary care MDs).....
Patients.....

are all demanding Patient Centered,
Evidence Based
Health Care

NCQA BPRP provides clear demonstration of this
“The only purpose of the physician is to amuse the patient while nature cures the disease”

Voltaire
“The goal of science is not to reveal everlasting truth, but merely to erect a modest barrier to perpetual error. That’s all we’re trying to do, really, avoid perpetual error.”

C Nelson, 2006

Haynes and Sackett, 1996
Best Practices Document/Process

- CCGPP, NCQA, Pay-For-Performance
- Incorporates best available evidence, clinical judgment and experience, patient values, co-morbidities, psychosocial, functional limitations, prior surgery, ergonomic issues, age of patient
- Goal is to improve quality, safety, cost, time, performance to best serve patient (patient centered and evidence based)

Triano, CCGPP 2005

Cost

<table>
<thead>
<tr>
<th>Industry Issue</th>
<th>Ask a CEO in the U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What business expense is your company’s biggest concern in 2006?</td>
<td></td>
</tr>
</tbody>
</table>

- Health Care: 43%
- Litigation: 26%
- Energy: 15%
- Materials: 11%
- Labor: 4%
- Premium: 4%

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Quality

Scope – The Quality Chasm
- A highly fragmented system that largely lacks even rudimentary clinical information capabilities results in poorly designed care processes characterized by unnecessary duplication of services and long waiting times and delays; substantial overuse of many services for which the potential risk of harm outweighs the potential benefits.

Value

QUALITY
COST
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**Cost & Quality**

- **Recommendation 1:**
  - DHHS and leading foundations should support *interdisciplinary* effort focused on developing a *common language* and *core set of competencies across professions*.

- **Recommendation 3:**
  - Accreditation bodies should move expeditiously to revise standards to educate students to deliver care using *core competencies*.

- **Recommendation 4:**
  - All health professions boards should require professionals to demonstrate periodically their ability to deliver care through *direct measures of*
    - Technical competence
    - Patient Assessment
    - Evaluation of Patient Outcomes, and
    - Other evidence-based assessment methods.
Cost & Quality

Recommendation 9:
AHRQ should work with a representative group of health care leaders to develop measures reflecting core set of competencies, set national goals and issue a report to the public evaluating progress toward these goals.

What is an MD looking for in a DC?

- Evidence influenced (rational approach)
- Patient centered
- Safe
- Effective communication (send reports)
- Clinically effective by valid/reliable outcome measures
- Cost effective

Don Levy, MD 2006
What does NCQA recognition give?

- Improved patient care
- Differentiates you to public, peers and payors that you provide high quality patient centered care
- Listing in NCQA promotional materials (goes to health plans across USA)
- Higher reimbursement and/or fewer documentation obstacles to reimbursement
- Clear demonstration of competency, which is first step in achieving cultural authority (legitimacy and competency)
- Demonstration to MDs that you deliver patient centered, evidence based care

Cultural Authority

- Cultural Authority is demonstrating competency and legitimacy
- We may not be able to do this as a profession, (though people like Greg Snow is working on this) but you can achieve local cultural authority by achieving recognition in the NCQA BPRP
Incentives/Disincentives

- Incentives for participating with NCQA
  - higher reimbursement
  - reduced administrative burden
  - marketing/promotion to payors, MDs

- Disincentives for not participating with NCQA
  - lower reimbursement
  - more administrative burden
  - closer scrutiny

Build a ‘community’ effort

- Use available resources
  FCER  www.fcer.org
  ACA   www.amerchiro.org
  WHG   www.westhartfordgroup.com

- Establish a local community
  L.E.G. example
“Go where there is no path and leave a trail”

-Ralph Waldo Emerson

NCQA BPRP
- Level playing field
- Evidence based, patient centered
- Process driven as metric for quality
- Develop regional and national cultural authority

Q&A Session

Brian Justice, DC (Provider)
Cynthia Martin (NCQA)
Greg Snow, DC (Education)
John Ventura, DC (Provider)
Evening Session

Workshop Objectives

Evening Session (6:30 – 8pm. TONIGHT!)

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Preliminary Analysis

Eligibility
Clinical Measures
Structural Standards

Eligible Patients

- 18-80 years old
- LBP for at least 28 days without a break of more than 180 days (negative Dx)
- Treated 2 times over a period of at least 28 days
- Initial visit (exam for LBP) must have occurred within two years from the Index Date with no Neg Dx in between.
Important Eligibility Terms

- Start Date
- Index Visit Date
- Initial Visit Date
- Negative Diagnosis
- Last Visit Date

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Start Date

- *Start Date* – Date on which you *start* the review process
  - e.g. 2/12/09 (today)
- Once established, will NOT change
  - So if data is still being collected on 3/15, the “Start Date” remains 2/12/09
- Tip: do not pick until ready to extract data, do not change once extraction started
**Index Visit Date**

- The date applicants select to begin identifying eligible patients.
- Patients must be identified consecutively moving backward from the index date.
- The date is within last 24 months but at least 6 weeks prior to the Start Date.
  - Insures patients will meet eligibility minimum, e.g. reassessment

**Index Visit Date - cont**

- For example, if Feb 12, 2009, is the Start Date, the Index Date would be at least 42 days prior, e.g. 12/31/08.
- Starting on 12/31, we look for BP pts
  - Each one found will have a 12/31 Index date.
- Then check each day, going backward, from 12/31 to find additional unique eligible patients:
  - 12/30 Index dates
  - 12/29 Index dates
  - 12/28 Index dates
**Initial Visit Date**

- The earliest visit date, within two years from Index Visit Date (pt specific, NOT START DATE), that is preceded by a span of at least 180 days (6 months) with no visits to the physician for back pain.
- If there are no earlier visits, the Index Visit Date may be the Initial Visit Date.

**Last Visit Date**

- Date of the most recent visit the patient had with the physician
  - Cannot occur after the Start Date
  - Can be between the Start Date and Index Visit Date
  - If the patient has not had a visit since the Index Visit, the Index Visit Date may be the Last Visit Date.
Negative Diagnosis

- A period of 180 days or greater during which there were no visits for back pain complaint
  - E.g. Start Date/Index Visit date 1/31/09
  - Previous visits 1/14/09 - (neg dx) - 3/14/08, 3/12/08, 3/4/08, Initial visit 3/1/08.
  - Patient meets requirements; however, is ineligible due to Negative Diagnosis
    - If after a Neg Dx, a patient is seen 2x or more over a 28 day period, then they can be eligible if another examination is performed.
    - Cannot use info from prior to Neg Dx toward meeting the clinical measure

Example – Patient Visits

<table>
<thead>
<tr>
<th>Start Date</th>
<th>Last Visit</th>
<th>Index Visit</th>
<th>Initial Visit</th>
</tr>
</thead>
</table>
Clinical Measures

CM 1: Initial Visit
5 Factors Point Value = 8

50% of patients must have documentation of ALL of the following:
- Pain assessment
- Functional status
- History (red flags)
- Prior Tx and response
- Employment status – tasks, status, duration off work, Work Comp
CM1 – Common Requirements – All Factors

- Date
- Documented
- Occur on Initial Visit

Pain Assessment (CM1:F1)

- Assessment of pain and function informs about tx decisions and establishes baseline
  - Initial – cause and plan
  - F/U – effectiveness and modification

- % of Pts with pain assessment
  - Yes – if pain assessment is documented
  - No – if not documented
CM1:F1 Documentation

- Acceptable documentation examples:
  - Roland Morris, Oswestry,
  - SF-36, SIP, MPI
  - VAS, VRS, Faces
  - Clinical Measures docs\CM1 - F1.doc

Functional Status (CM1:F2)

- Spinal disorders involve a complex interaction of physiologic, psychological and social factors.
- Difficult to evaluate through traditional biomedical techniques.
- Evaluation of functional status is essential in the treatment of chronic disabling musculoskeletal conditions.
CM1:F2 Documentation

- % of Pts with assessment of functional status
  - Yes – if function assessed
  - No – if not performed or documented

- Required Documentation:
  - Roland Morris, Oswestry, SF-36, SIP, MPI
  - [Clinical Measures docs\CM1 - F2.doc](#)

- Intake/Review of Systems

History/Red Flags (CM1:F3)

- Determine if there are signs of serious underlying conditions

- % Pts with patient history (yes/no) that includes absence or presence of “red flags”
  - Yes – Red Flags present or absent
  - No – No documentation of Hx or Red Flags
CM1:F3 Documentation

- Documentation necessary to satisfy assessment for red flags can include the following:
  - Indication/notation of presence or absence of red flags
  - Notation of specific symptoms that may indicate the presence of red flags
  - Review of Systems

Prior Treatment and Response CM1:F4

- Important in the care of back problems.
- Variety of treatments may be appropriate.
- Failure to respond to treatment may indicate the need to try other approaches

- % of patients with documentation of assessment of prior back pain treatment and response
  - Yes – documentation of prior tx or no prior tx
  - No – no documentation
Prior Treatment and Response
CM1:F4
Clear notation, could include the following.
- No prior back pain (or prior tx)
- Dx/dates of episodes for last 2 yrs
- Report from referring physician
- Patient report of history and attempted treatments, including diagnostic tests (e.g., imaging)

☐ Intake Form or Hx questions

Employment Status (CM1:F5)
- Employment status and patient-perceived barriers (psychosocial, workplace, management issues) assists understanding of how to alter a patient’s back pain or disability trajectory and encourage return to work or full work status
CM1:F5 Documentation

☐ % patients with assessment of employment status
   ■ Yes – assessment performed
   ■ No – not performed

☐ Required Documentation

Scoring for CM1 – Pt History

☐ Do 50% or more have documentation on the date of the initial visit for each of the 5 factors?
   ■ Yes = 8 pts
   ■ No = 0 pts
CM 2: Physical Examination

**Must Pass**  Point Value = 9.5

- Integral component of identifying the source and mechanism of back pain
- Helpful in identifying signs of serious underlying diseases (fracture, tumor, infection or deformity)
- % of patients with documentation of P.E.

CM2 – Documentation

For Pts **WITH** radicular symptoms:
- SLR test
- Neurovascular exam including:
  - Ankle and knee DTRs
  - Quadriceps, ankle and great toe muscle strength, plantar flexion strength, motor testing, LE pulses, sensory exam
CM2 – Documentation

For patients **WITHOUT** radicular symptoms
- SLR
- Neurovascular exam or
- Clear notation of absence or presence of neurologic deficits

Scoring for CM2 – Physical Exam

- Do 50% or more have documentation of required PE on date of initial visit?
  - Yes = 9.5 pts
  - No = 0 pts, AND
    - No possibility of achieving Recognition
    - i.e. **Must Pass**
    - Institute changes before collecting data
CM 3: Mental Health Assessment
Point Value = 5

- Depression/psychological barriers to treatment are often encountered in BP patients.
- Need to determine if there are social or psychological distresses or barriers that may amplify or prolong the pain.
- Psychosocial factors strongly predict future disability and the use of health care services for low back pain.

Scoring for CM3 – Mental Health

**Documentation Examples:**
- SF 36, SIP or MPI; OR
- Notation of anxiety/stress/depression; OR
- Documentation of active depression Tx

- Do 72% of Pts with pain lasting longer than 6 weeks have a M.H. assessment?
  - Yes = 5 pts
  - No = 0 pts
CM 4: Appropriate Imaging
Point Value = 7.5

- % of pts for with imaging studies during the six weeks after pain onset
  - In the absence of “red flags” or progressive symptoms.
- Imaging not needed for acute BP <6 wks duration unless findings suggest systemic disease or progressive neurologic deficit.
- Imaging unlikely to reveal a specific cause and irrelevant findings are common.

Scoring for CM4 - Imaging

- Did 50% or less of Pts without “red flag” received imaging in the 6 week period from the onset of pain
  - Yes – 50% or less rec’d films
    - Earn 7.5 pts
  - No – more than 50% imaged
    - 0 pts
CM 5: Repeat Imaging
Point Value = 0

- Only for patients who were imaged, or had previous films (from CM 4)
  - Excludes patients with “red flag” indicators or worsening symptoms
- Patients who receive repeat imaging in the 6 weeks period from the onset of pain; OR
- Patients with a single series who were not queried about prior films
- Currently collected for data purposes only

CM 6: Assistance with Smoking Cessation
Point Value = 3.5

- Health status of smokers with back pain is significantly lower than non-smokers
- Smokers who undergo spinal surgery have significantly poorer outcomes than non-smokers
- % of Pts who were assessed for their smoking status;
Scoring for CM 6

- Score 3.5 pts if
- 76% of patients have documentation that they were assessed for smoking, AND
- If smoker,
  - Recommendation to quit, and
  - Assist with medication or alternative; or,
  - Referral to smoking cessation program

California No-Butts Program

- Smoking Cessation Program
- Tax dollar paid
- Free Brochures, etc
- http://www.caldiabetes.org/content_display.cfm?ContentID=497
- http://www.californiasmokershelpline.org/Order.php
CM 7: Advice for Normal Activities
Point Value = 8.5

- % of Pts advised to maintain or resume normal activities
- best recommendation - rapid return to normal activities as tolerated and encouraged ambulation.
  - tempered by consideration of the patient’s usual job or life demands.
  - Heavy lifting, trunk twisting and bodily vibrations should be avoided when acute

Scoring for CM 7 – Activity Advice

- 48% of pts have documentation of advice to maintain or resume normal activities or ADLs
- Yes = 8.5 pts
- No = 0 pts
CM 8: Advice Against Bed Rest
Point Value = 7.5

☐ % of Pts advised against bed rest lasting four days or longer
☐ Same rationale
☐ 48% of pts have clear notation that they were advised against bed rest for 4 days or longer
  ■ Yes = 7.5 pts
  ■ No = 0 pts

CM 9: Recommendation for Exercise
Point Value = 7.5

☐ % of Pts with pain lasting > 12 wks for whom:
  ■ supervised exercise was recommended, Or
  ■ instructions for therapeutic exercises were provided, AND
  ■ that provider follow-up to ensure correct form and duration of exercise occurred.
CM 9 - Rationale

- Strong evidence that exercise is effective for chronic back pain and helps pts return to normal daily activities and work.
- In addition, clinically important benefit has been shown for therapeutic exercise across subacute, chronic and postoperative low back pain.

Scoring for CM9 - Exercise

- 71% of patients have documentation of recommendation for supervised exercise or were provided exercises (home) and had documented follow-up visit.
  - Yes = 7.5 pts
  - No = 0 pts
Note on Advices

- BPRP low hanging fruit
  - 3.5 pts - Smoking
  - 8.5 pts - Maintain/Resume Activities
  - 7.5 pts - Avoid bed rest
  - 7.5 pts - Exercise with follow up
- 27 pts total (23.5 w/o smoking)
- More than ½ the necessary points
- Must Pass P.E. = 9.5 pts

CM 10, 11 – Not Applicable

- CM 10: Appropriate Use of Epidural Steroid Injections
  - Point Value = 6.5
- CM 11: Surgical Timing (not applicable)
  - Point Value = 8.5
CM 12: Patient Reassessment
Point Value = 5

- % of Pts that receive a follow-up assessment of both pain and function
- To determine whether current treatment is working, or other options should be tried
- Rationale: overwhelming majority of patients will have a favorable response in a relatively short period of time

Scoring for CM 12 - Reassessment

- 25% of Pts have re-assessment of their Pain (same criteria) and their Function (same criteria), AND
- the reassessment occurs within four to six weeks of their initial visit.
  - Yes = 5 pts
  - No = 0 pts
CM 13: Shared Decision Making
Point Value = 6.5

☐ Not applicable to non-surgeons

SS 1: Patient Education
Point Value = 6.5

The practice provides educational materials (e.g. brochures, pamphlets, web-based info, videos, etc.) in lay language that includes:

- Natural Hx of back pain
- Tx options, including alternatives to surgery
- Risks and benefits of Tx
- Evidence base for different Txs
SS 3: Evaluation of Patient Experiences  Point Value 3.5

- Evidence of an ongoing system for obtaining feedback about patient experience with care, AND
- A process for analyzing the data and a plan for improving the patient experience
- Pt. Sat. Survey must include: access to care; quality of physician communication with the patient; confidence in self-care; satisfaction with care

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How Did You Do?

- How many points scored?
  - >40 generally meets benchmark
  - <40 needs procedural adjustment
- Must Pass criteria (CM2 – Physical Exam)
- Scores on 10 measures (score can be 0)
Obtaining Recognition

Tips for Success

- Perform preliminary analysis first
- Pick a Start Date, then stick with it
  - If changed, need to redo eligibility data (dates) from cases previously entered
- Implementing changes?
  - Track new cases (paper DCT)
  - Select Start Date when 35+ cases done
Tips – Implementing Changes

- Implement Structural Standards ASAP
  - Qualify for points once in place
- Patient Exam (Must Pass CM2) should be focus of initial care pathway changes
- Advice CMs are easy to implement and/or document
- Assess forms/processes for easiest mechanism to implement, document and track.

Tips - Data Extraction Methods

- Computer extraction?
  - Can LB cases be culled out?
    - Reliability/accuracy of Dx code input (colleges)
  - Can Pt ages, visits, etc be culled out?
- Data Compilation
  - Using DCT (best for single office)
    - Online or Paper-based
  - Manually using Excel process
    - Is physical file required?
Tips - uploading DCT info

- Can either upload to DCT doctor by doctor or all doctors at once
- Once uploaded - do Preliminary Assessment as you go along
  - Must have sufficient # of cases
- Structural Standards
  - Uploaded once – append to first doctor entered
- Multiple locations within same organization can use a single “agreement”

BPRP Insurance Affiliations
NCQA Provider Listing

☐ Online Provider Link

Add Recognition seals to provider directories

For example:
- Aetna
- Blue Cross Blue Shield Association
- BlueCross BlueShield of Western New York
- BlueShield of Northeastern New York
- CIGNA
- GeoAccess
- Highmark Blue Cross Blue Shield
- Humana
- Medical Mutual (Ohio)
- MVP Health Plan, Inc.
- United
Helped physicians by supporting data collection efforts

- Blue Care Network (Michigan)
- Highmark Blue Cross Blue Shield
- MVP Health Plan (New York)
- Oxford (New York)
- United (4 areas)

Paid rewards for achieving Recognition or supplement application fees

- Anthem (Virginia)
- Bridges to Excellence
- Blue Cross Blue Shield of South Carolina/Companion
- CareFirst (DC-Maryland and Georgia)
- ConnectiCare
- HealthAmerica (Pennsylvania)
- Health First (Florida)
- Highmark Blue Cross Blue Shield
- MVP Health Plan (New York)
- Oxford (New York)
- Silicon Valley HIT
Requires Recognition for entry into high-performance networks

- Aetna
- CIGNA
- United

NCQA recognition
- high-quality physician
- leading edge of quality care delivery