Identifying Advanced (or at least Advancing) Primary Care Practices

Covered California
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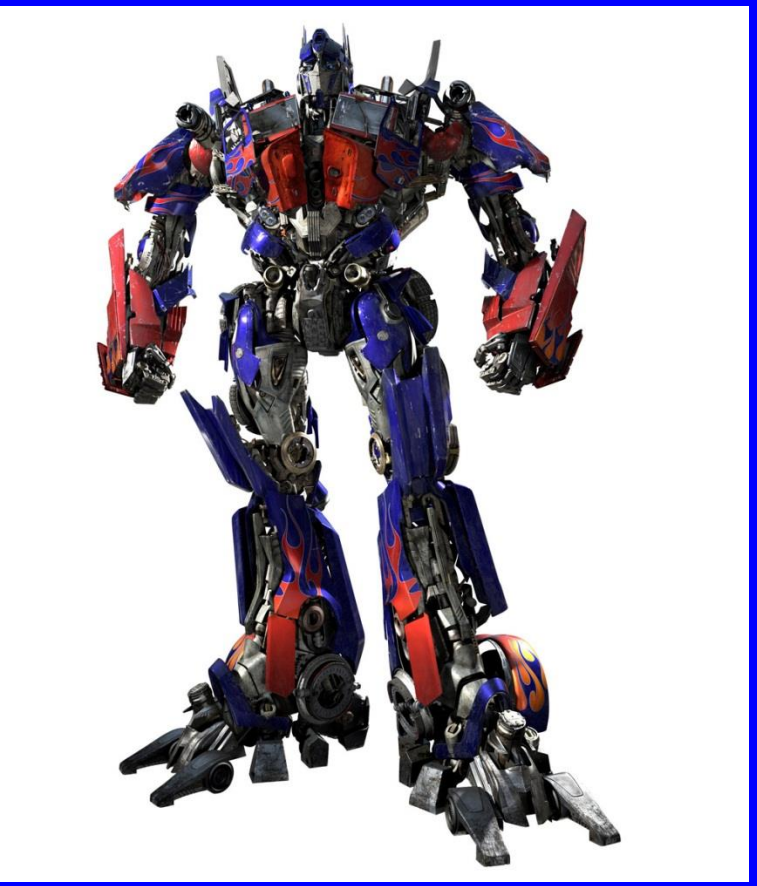
The Basic Question

- How do I know if this primary care practice is one where I, my loved one, or my fellow subscribers in my Covered CA health plan would want to get their care?

Primary Care Practice Transformation

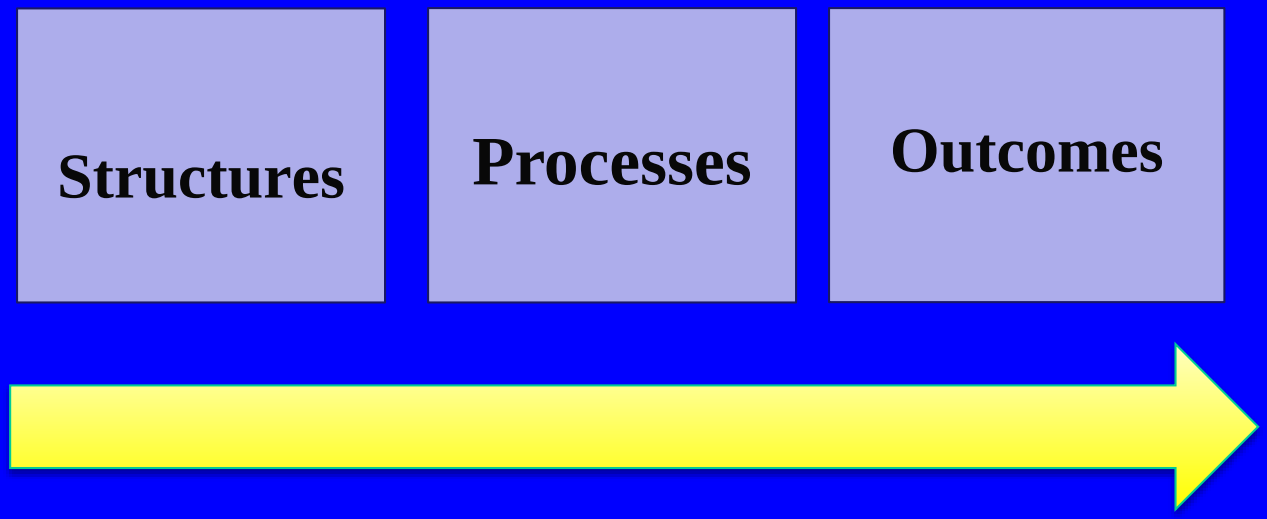


- Patient-Centered Medical Home (PCMH)
- Redesigned Primary Care
- Advanced Primary Care
- High Performing Primary Care

Measurement Considerations

- Goal: Capability and/or Performance?
- Feasibility
  - Availability of data
  - Administrative simplicity
  - Expense
- Validity
- Equity
  - Does not unfairly disadvantage practices caring for disadvantaged populations

Donabedian Model of Quality



Why not just rely on measurement of performance on the triple aim outcomes?

- Challenges of feasibility, validity, equity
- Teach to the test
- Desire to assess commitment to and capability for process improvement
- Ask Bob Berenson

Assessing Structure and Process of Practice Redesign aka PCMH

- Conceptual models (e.g., UCSF CEPC 10 Building Blocks)
  - Largely used for guiding self-improvement work
- Formal recognition programs (e.g., NCQA)
  - Often used for eligibility for alternative PCMH payment models

10 Building Blocks of High-Performing Primary Care

T Bodenheimer et al AnnFamMed March 2014

UCSF Department of Family & Community Medicine
Center for Excellence in Primary Care

10 BB Logic Model

For each building block (e.g., population management) define measures for

1. Inputs: structures

   standing orders for immunizations, labs, etc

2. Outputs: short-term operational processes

   activity of non-clinician staff to close care gaps

3. Outcomes: intermediate performance/clinical processes

   % of patients up-to-date on immunizations, cancer screening, DM measures

4. Outcomes: long-term

   reduced late stage cancer, fewer preventable hospitalizations

Building Blocks LOGIC MODEL

INPUTS

OUTPUTS

OUTCOMES

Building Blocks	Structure	Short-Term Operational Processes	Intermediate Performance/ Clinical Processes	Long-Term Outcomes
6. Population Management	• **Panel Management** - Job descriptions for non-clinician staff roles include inreach and outreach to close care gaps - Standing orders exist for inreach/ outreach panel management - Staff trained in panel management • **Health Coaching** - Clinic has health coaches or staff assigned to do health coaching - Staff/ coaches trained in health-coaching • **Complex care management** -Care management staff/ structure exists -Protocols for identifying high-risk patients	• **Panel management** - Non-clinician staff use standing orders - Staff conduct inreach and outreach consistently • **Health coaching** - Patients receive health coaching and self-management • **Complex care management** - High-risk patients identified (quarterly) - 80% high risk patients receive care management - 100% care management patients have documented care plans	• % DM A1c/LDL check >80% •% Tdap/Pvax/Flu UTD >80% •% mammo/pap/CRC screen UTD >80% • % smoking assessed & counseled >80%	**Quadruple Aim** •Improve patient health • Improve patient experience •Improve staff experience • Reduce cost/ utilization - (ambulatory sensitive hospitalization and ED visits)
7. Continuity of care	• Documented workflows for appt scheduling with PCP or team • Team staff coverage system if PCP not available for urgent appt • Patients have direct contact to care team	•Staff consistently use workflows to prioritize appts with PCP • Patients consistently scheduled with team if PCP not available • Patients know practice team and who to contact	• % patient visits with PCP >70% • % patient visits with care team >90%	
8. Prompt access to care	• Confirmation call protocol developed • Data staff measure supply/ demand • Phone protocols for appointment and telephone advice • After hours phone access system in place • Electronic patient portal exists	• Confirmations calls conducted for 100% visits • >80% visits are voice confirmed • Appointment supply matches demand • Efficient processes to see patients at appointment time and reduce cycle time • Patients receive timely clinical advice by phone during and after hours	• No Show rate <10% • TNAA follow-up visit <5 days • TNAA new patient <10 days • Phone call wait time < 2 min • Phone dropped calls <10% • Cycle time < 60 min • Patients seen within 15 min of scheduled appt >90% • Patients using electronic portal> 30% • Patients report good appointment and phone access during and after hours/ weekends	
9. Coordination of care	•EHR allows test (lab/imaging) result tracking, abnormal results flagged •Workflows to track tests and follow-up on abnormals, and notify patients of results •EHR has system for electronic referrals •Electronic system notifies PCP and care team of ED visit or hospitalization • Workflows to follow-up with patients after care transitions	•Tests are tracked until completed and abnormal results followed up on in <1 day • Referrals are tracked and recommendations followed up on in timely manner • Team follows up with patients after ED visit or hospitalization	• % 90 patients receive phone call within 72 hrs after ED or hospitalization • % 90 patients have appointment within 14 days after ED visit/ hospitalization	
10. Template of the future	• Protocols, templates, and staff exist to conduct group visits, nurse visits, telephone visits, and electronic isits	• >30% visits are non-fact to face		

NCQA PCMH Standards

1) **Patient-Centered Access (10)**
   - A) ***Patient-Centered Appointment Access (4.5)**
   - B) 24/7 Access to Clinical Advice (3.5)
   - C) Electronic Access (2)
2) **Team-Based Care (12)**
   - A) Continuity (3)
   - B) Medical Home Responsibilities (2.5)
   - C) Culturally & Linguistically Appropriate Services (2.5)
   - **D) *The Practice Team (4)**
3) **Population Health Management (20)**
   - A) Patient Information (3)
   - B) Clinical Data (4)
   - C) Comprehensive Health Assessment (4)
   - **D) *Use Data for Population Management (5)**
   - E) Implement Evidence-Based Decision Support (4)
4) **Care Management and Support (20)**
   - A) Identify Patients for Care Management (4)
   - **B) *Care Planning & Self-Care Support (4)**
   - C) Medication Management (4)
   - D) Use Electronic Prescribing (3)
   - E) Support Self-Care & Shared Decision Making (5)
5) **Care Coordination & Care Transitions (18)**
   - A) Test Tracking & Follow-Up (6)
   - **B) *Referral Tracking & Follow-Up (6)**
   - C) Coordinate Care Transitions (6)
6) **Performance Measurement and Quality Improvement (20)**
   - A) Measure Clinical Quality (3)
   - B) Measure Resource Use & Care Coordination (3)
   - C) Measure Patient/Family Experience (4)
   - **D) *Implement Continuous Quality Improvement (4)**
   - E) Demonstrate Continuous Quality Improvement (3)
   - F) Report Performance (3)
   - G) Use Certified EHR Technology (0)

Scoring Levels

Level 1: 35-59 points
Level 2: 60-84 points
Level 3: 85-100 points

*Must Pass Elements

NCQA
Measuring quality. Improving health care.

Concerns About Formal Recognition Programs

- Cumbersome application
- 100+ individual items
- Prescriptive “check box” approach
- Validity in predicting performance

Might there be a way to simplify and streamline the approach?

- Prioritize a few of the most essential building blocks
- Measure a stripped down set of items
- Minimize reporting burden

CMMI CPC+
Eligibility Criteria for Practices

Track 1

- Use of CEHRT
- Payer interest and coverage
- Existing care delivery activities must include: **assigning patients to provider panel, providing 24/7 access for patients, and supporting quality improvement activities.**

Track 2

- Use of CEHRT
- Payer interest and coverage
- Existing care delivery activities must include: **assigning patients to provider panel, providing 24/7 access for patients, and supporting quality improvement activities, while <u>also</u> developing and recording care plans, following up with patients after emergency department (ED) or hospital discharge, and implementing a process to link patients to community-based resources.**
- Letter of support from health IT vendor that outlines the vendor's commitment to support the practice in optimizing health IT.

My “straw man” suggestion for minimum set of measures

- Empanelment*
- Ability to measure and report performance metrics*
- Panel management: identifying and closing care gaps*
- Timely office access and after hours care plan*
- Coordination of post-ED and hospital visits*
- High risk patient management
- Behavioral health integration or referral coordination
- Assessment of patient experience
- Language access
- Team care/non-face-to-face visits

*CPC+ track 2 items

What can purchasers, health plans, and other stakeholders do to help practices deliver advanced primary care?

- Explicitly prioritize this as a goal
- Promote patient connection to primary care medical homes (empanelment)
  - Incentives and regulations
- Alternative payment models
  - Beyond pure fee-for-service: blended payment
  - Investing in shared resources (e.g., complex care coordinators)
- Support practice coaching for redesign
- Join multipayer initiatives (e.g., CPC+)

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http://cepc.ucsf.edu/