Measuring the Success of the Patient-Centered Medical Home: A Webinar

May 16, 2012

The Patient Centered Medical Home Evaluators' Collaborative

Agenda

3:00–3:07	Introduction Melinda Abrams, M.S.
3:07–3:14	Cost and Utilization Measures Meredith Rosenthal, Ph.D.
3:14–3:21	Clinical Quality Measures Asaf Bitton, M.D., M.P.H.
3:21–3:28	CMS Perspective Suzanne Goodwin, Ph.D.
3:28–4:00	Question and Answer Session Moderator: Melinda Abrams, M.S.

Melinda Abrams, M.S.
Vice President,
Patient-Centered Coordinated Care
The Commonwealth Fund

PCMH Spread Is Substantial

- 90+ commercial pilots
- 42 state Medicaid/CHIP programs
- 3 federal CMS initiatives
- Department of Defense
- Veterans Health Administration
- Bureau of Primary Health Care

Why Medical Home Evaluations Are Important

- Preliminary results suggests PCMH can result in better quality, increased efficiency, improved clinician/staff experience and patient experience
- However, gaps in the evidence exist. Need to evaluate the model as a whole.
- Need information that is useful to policymakers, purchasers, payers, clinicians, and patients
- **Standardization of outcome measures can increase comparability**
- Variation in demonstration contexts can increase generalizability

PCMH Evaluators' Collaborative

Goal:

- Align evaluation methods to the greatest extent possible, share best practices, and produce useful information to inform policy and practice

Specific Objectives:

1. Reach consensus on a core, standardized set of outcome measures and data collection instruments
2. Share the consensus with interested researchers across the country
3. Foster an ongoing and supportive exchange where evaluators share ideas that improve the design and interpretation of results

Open to researchers actively engaged in a PCMH evaluation (70+ evaluators engaged)

The Summary Statement: Our Approach

- Cost/utilization and clinical quality workgroups reached agreement (2009–2011)
  - Presented and/or published results
- PCMH Collaborative members identified core measures through an online survey
- PCMH Collaborative met June 2011 to discuss
- Follow-up survey administered September 2011
- Conference call December 2011 to review draft statement and final measures
- Consulted with national, outside experts

Source: The Commonwealth Fund PCMH Evaluators' Collaborative. M. Rosenthal, M. Abrams. and A. Bitton. Recommended Core Measures for Evaluating the Patient Centered Medical Home: Cost/Utilization and Clinical Quality. The Commonwealth Fund: New York, NY, May 2012.

Meredith Rosenthal, Ph.D.
Professor of Health Economics and Policy
Harvard School of Public Health

PCMH Evaluators Collaborative: Utilization and Cost Measure Recommendations

Meredith B. Rosenthal, Ph.D.

Harvard School of Public Health

Logical Connections Between the PCMH and Utilization/Cost

- PCMH will increase accessibility of primary care and thereby reduce utilization in more expensive sites of care
- PCMH will improve management of chronic illness, which will *increase* ambulatory care and Rx, *decrease* inpatient and emergency department care for preventable complications
- PCMH will improve care coordination and prevent readmissions, admissions due to dropped handoffs

Core Utilization Measures Recommended to Address Efficiency Questions

- Emergency department visits (all and/or ambulatory-care sensitive)
- Hospitalizations (all and/or ambulatory care–sensitive)
- Readmissions within 30 days

These have a moderate level of evidence to support PCMH impact and strong logical connections

Supplemental Utilization Measures to Address Efficiency Questions

- Primary care visits
- Specialist visits
- Laboratory and imaging tests
- Prescriptions

These measures could go up or down in a successful implementation of the PCMH—they will tell us about how the pilot changed care.

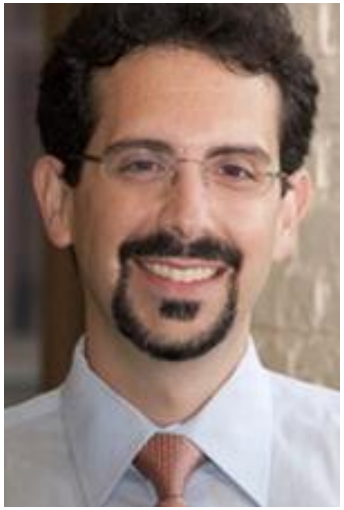
Source: Rosenthal MB, Beckman HB, Dauser Forrest D, Huang ES, Landon BE, Lewis S. Will the Patient-Centered Medical Home Improve Efficiency and Reduce Costs of Care? A Measurement and Research Agenda. *Medical Care Research and Review,* published online on June 2, 2010.

Cost Measure Recommendations

- Total medical claims cost per member per month
- Cost per case (episode)—calculated using standard episode grouper software—for targeted conditions
- Cost impact should be calculated for entire enrolled population *but also* subsets of patients who are likely to benefit more from the PCMH

Some Technical Specifications

- Ambulatory care sensitive versions of emergency department visits and inpatient admissions should be considered (either/or)
- Risk adjustment: necessary for cost and utilization analyses; use a validated, standard approach
- Pricing: transparency about pricing yardstick, standardization to publicly available fee schedule might be desirable



Asaf Bitton, M.D., M.P.H., F.A.C.P
Division of General Medicine
Brigham and Women's Hospital

Measuring Clinical Quality in the Patient-Centered Medical Home

Asaf Bitton M.D., M.P.H., F.A.C.P.

Division of General Medicine, Brigham and Women's Hospital
Department of Health Care Policy, Harvard Medical School
Commonwealth Fund PCMH Evaluators' Collaborative
May 16th, 2012

Conceptual Framework

- **Many** ways to conceptualize quality in PCMH
- PCMH →  → Improved Quality
- Developing a logic model
  - Started with the PCMH Joint Principles
  - Rittenhouse and Shortell, *JAMA*, 2009
  - Literature review and iterative workgroup meetings

PCMH Quality Logic Model

Domain	Specific Elements	Processes	Outcomes
Enhanced Primary Care	• First Contact Access • Continuity • Comprehensiveness • Coordination and Integration	• Prevention/ Screening • Disease Monitoring/Tx • Overuse	• Intermediate Chronic Dz • Pt Experience of Care • Utilization
Patient Centeredness	• Whole Person Orientation • Patient–Provider Communication	• Screening/ Dz Monitor & Tx • Pt Enablement & Trust • Decision-making	• Intermediate Chronic Dz • Pt Experience of Care
New Models of Practice	• Team-Based Care • Improved Care Facilitation • Clinical Information Systems • Payment Reform	• Prevention/ Screening • Disease Monitoring/Tx • Med mgmt	• Intermediate Chronic Dz • Medical Errors • Pt Experience • Utilization

Source: The Commonwealth Fund PCMH Evaluators' Collaborative. May 2012.

Important Considerations

- Measurement Scope
  - Adult and Pediatrics
- Sample Size
  - Reasonable measures with adequate numbers of pts
- Evaluation Burden
  - Core set vs supplemental measures
  - Claims-based and chart-based measures

Principles for Assessing Clinical Quality

1. Evaluators should use standardized, validated, nationally endorsed measures.
2. Evaluators should select measures from the following areas of primary care: prevention, chronic disease management, acute care, overuse, and safety.
3. Evaluators should apply a validated approach to data collection, especially if using measures from medical or electronic health records.
4. Evaluators should use consistent measures across practices within a demonstration.

Source: The Commonwealth Fund PCMH Evaluators' Collaborative. M. Rosenthal, M. Abrams. and A. Bitton. Recommended Core Measures for Evaluating the Patient Centered Medical Home: Cost/Utilization and Clinical Quality. The Commonwealth Fund: New York, NY, May 2012.

Core Adult Clinical Quality Measures

Measure (HEDIS Acronym)
Adult weight screening and follow-up
Breast cancer screening (BCS)
Cervical cancer screening (CCS)
Chlamydia screening in women (CHL)
Colorectal cancer screening (COL)
Tobacco use assessment and intervention
Pneumonia vaccination status for older adults (PNU)
Cholesterol management for patients with CV conditions (CMC)
Antidepressant medication management (AMM)
Medication management for people with Asthma (MMA)
Comprehensive diabetes care: Hemoglobin A1c testing

Prevention	Chronic Disease	Acute Care	Overuse	Safety

Source: The Commonwealth Fund PCMH Evaluators' Collaborative. M. Rosenthal, M. Abrams. and A. Bitton. Recommended Core Measures for Evaluating the Patient Centered Medical Home: Cost/Utilization and Clinical Quality. The Commonwealth Fund: New York, NY, May 2012.

Core Adult Clinical Quality Measures

Measure (HEDIS Acronym)
Comprehensive diabetes care: HbA1c poor control >9.0%
Comprehensive diabetes care: BP control <140/80 mm Hg
Comprehensive diabetes care: Eye exam (retinal) performed
Comprehensive diabetes care: LDL–C screening
Comprehensive diabetes care: LDL–C <100 mg/dL
Comprehensive diabetes care: Medical attention for nephropathy
Comprehensive diabetes care: all or none composite
Controlling high blood pressure (CBP)
Avoidance of antibiotic treatment in adults w/ acute bronchitis (AAB)
Use of imaging studies for low back pain (LBP)
Annual monitoring for patients on persistent medications (MPM)

Prevention	Chronic Disease	Acute Care	Overuse	Safety

Source: The Commonwealth Fund PCMH Evaluators' Collaborative. M. Rosenthal, M. Abrams. and A. Bitton. Recommended Core Measures for Evaluating the Patient Centered Medical Home: Cost/Utilization and Clinical Quality. The Commonwealth Fund: New York, NY, May 2012.

Core Pediatric Clinical Quality Measures

Measure (HEDIS Acronym)
Well child visits in the first 15 months of life (W15)
Well child visits in years 3-6 (W34)
Childhood immunization status (CIS)
Weight assessment and counseling (WCC)
Adolescent well-care visits (AWC)
Immunizations for adolescents (IMA)
Chlamydia screening in young women (CHL)
Follow-up care for children prescribed ADHD medications (ADD)
Follow-up after hospitalization for mental illness (FUH)
Medication management for people with asthma (MMA)
Appropriate testing for children with pharyngitis (CWP)

Prevention	Chronic Disease	Acute Care	Overuse	Safety

Source: The Commonwealth Fund PCMH Evaluators' Collaborative. M. Rosenthal, M. Abrams. and A. Bitton. Recommended Core Measures for Evaluating the Patient Centered Medical Home: Cost/Utilization and Clinical Quality. The Commonwealth Fund: New York, NY, May 2012.

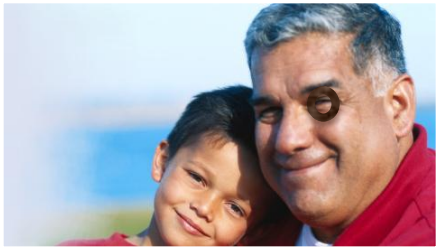
Supplemental Adult Clinical Quality Measures

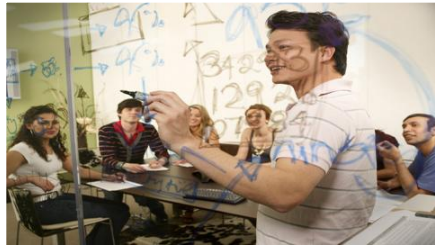
Measure (HEDIS Acronym)
Fall risk management (FRM)
Flu shots for adults ages 50–64 (FSA) and flu shots for older adults (FSO)
Medical assistance with smoking and tobacco use cessation (MSC)
Osteoporosis testing in older women (OTO)
Management of urinary incontinence in older adults (MUI)
Medication reconciliation post-discharge (MRP)
Use of high-risk medications in the elderly (DAE)

Source: The Commonwealth Fund PCMH Evaluators' Collaborative. M. Rosenthal, M. Abrams. and A. Bitton. Recommended Core Measures for Evaluating the Patient Centered Medical Home: Cost/Utilization and Clinical Quality. The Commonwealth Fund: New York, NY, May 2012.

Suzanne M. Goodwin, Ph.D.
Research Analyst
The Centers for Medicare and Medicaid Services

Measuring the Success of the Patient-Centered Medical Home: CMS Perspective





Suzanne M. Goodwin, Ph.D.
Rapid-Cycle Evaluation Group
Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services

May 16, 2012

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicare & Medicaid
INNOVATION

CMS PCMH Initiatives

- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice (APCP) Demonstration
- Comprehensive Primary Care (CPC) Initiative
- Medicaid Health Homes for Enrollees with Chronic Conditions

Center for Medicare & Medicaid INNOVATION

Evaluation Purposes

- All PCMH demonstrations and initiatives include a comprehensive evaluation
  - Study the process and challenges involved in transforming primary care practices into PCMHs
  - Assess the effects of the PCMH model on Medicare and Medicaid beneficiaries served by PCMHs

Mixed Methods Approach

- Qualitative and quantitative data
  - Site visits, interviews, focus groups
  - Patient and provider surveys
  - Claims data analysis
    - Quality of care measures
    - Cost and utilization measures

Salient Questions

- What data collection instruments should we use? Should we develop our own?
- What measures should we include? How should the measures be calculated?

Guiding Principles in Measure Selection

- Consistency in measures and measure specifications as much as possible
  - Tailoring to specific initiative when necessary

Measurement Alignment

- CMMI evaluation alignment activities
- CMS agency-wide alignment activities
- External alignment activities
  - PCMH Evaluators Collaborative

Importance of Measurement Alignment

- Using rigorous evaluation study designs and common metrics in PCMH evaluations is critical!
  - Results used to inform initiative planning and policy making
  - Cross-initiative comparisons
  - Contribute to meta-analyses and evidence base

CMS Alignment with PCMH Evaluators Collaborative

- CMS is committed to contributing to the PCMH evidence base and using common metrics
- Work of PCMH Evaluators Collaborative has been instrumental
  - CMS Statements of Work: "The Contractor shall use whenever possible common metrics endorsed by groups such as the PCMH Evaluators Collaborative"
- Encourage other public and private entities to support and participate in these efforts

Center for Medicare & Medicaid INNOVATION

Measuring the Success of the Patient-Centered Medical Home Q & A

Thank you for participating!

To read the recommendations and download the webinar slides, visit commonwealthfund.org.