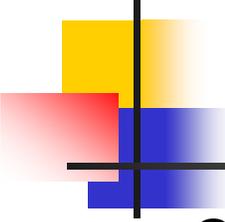


Pennsylvania's  
**Chronic Care Management,  
Reimbursement and Cost Reduction  
Commission**

---

*Transforming Primary Care Practice:  
The Southeast Pennsylvania Rollout*

**May 4, 2009  
Donald Liss, M.D.  
Richard Snyder, M.D.**

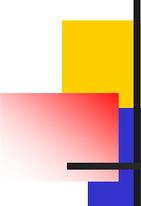


# Distinguishing Features

---

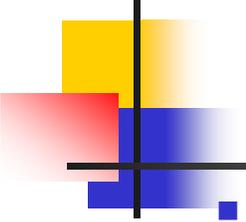
- State Government as *convener*
- *Multi-stakeholder participation* in design and implementation
- Transforming care for *all patients*
- Funding methodology *transparent and adequate*
- *Support* for practices
- *Scale* is sufficient to yield reliable results
- *Transferrable*

# The State of Primary Care in the USA



---

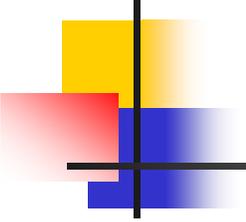
- Research shows patients with PCPs have lower costs, but...
- Primary care practitioners declining in numbers – failure to attract new graduates
  - Low reimbursement compared to non-PCP peers
  - Low satisfaction
- Current primary care practice is reactive, often responding to acute episodes, resulting from poor self-management by patients with chronic illness
  - Access is inadequate
  - Emphasis is on issuing referrals and not on coordinating care
  - Minimal focus on patient education and no support staff for patients
  - Slow to adopt evidence-based medicine
  - Generally lower level of sophistication (EMR, support staff, etc.)
  - Minimal communication between providers



# Chronic Care Commission

---

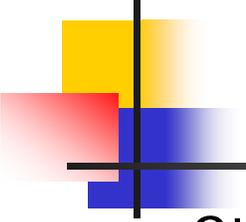
- Part of **Prescription for Pennsylvania**
- Created by Executive Order of Gov. Rendell, May 2007
  - Goal - Improve chronic care delivery in PA
    - \$1.7 billion in avoidable admissions
    - Missed opportunities noted in process/outcomes measures
- 45 Commission members
  - Provider, insurer, state government agency, organized labor, academic and consumer representatives
  - Five subcommittees
    - Practice Redesign
    - Incentive Alignment
    - Performance Measurement
    - Pooled Claims Database
    - Consumer Engagement
- Due diligence
  - Wagner Chronic Care Model
  - Patient Centered Medical Home Model



# Chronic Care Commission

---

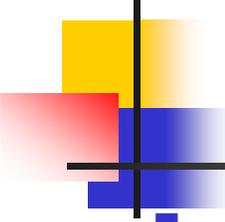
- The preferred model incorporates features of the **Chronic Care Model** and the **Patient-Centered Medical Home**
  - Regional “Learning Collaborative” rollouts
  - Practice coaches
  - Registry (or EMR), e-Prescribing, open access scheduling
  - Communication – telephonic, e-mail
  - Team – health educators, case managers, CRNPs, PCPs
  - Endorsement of NCQA PPC-PCMH recognition
  - Provider and consumer incentive alignment
  - Clinical, financial and satisfaction outcomes monitoring and reporting



# Chronic Care Commission

---

- Strategic plan to Governor and Legislature in February 2008
  - Framework to guide rollout activities in the Commonwealth's six regions
- A Steering Committee crafted a model with a 3 year commitment for:
  - The Governor's Office of Health Care Reform (GOHCR)
  - Participating Payers
  - Participating Providers
  - IPIP (Improving Performance in Practice)

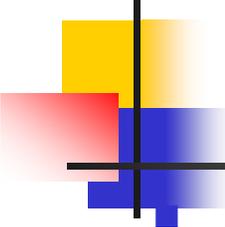


# Role of GOHCR

---

- Convener
- Staffing
- Funding
  - Consultants
  - Faculty / expenses for year-long learning collaborative
  - Data collection, aggregation, evaluation and reporting activities through a 3<sup>rd</sup> party, including surveys
- Coordinating
  - Flow of data between practices and payers
  - Flow of funds from payers to practices and IPIP
  - Baseline and subsequent satisfaction surveys

# Requirements of PCP Practices



---

- Attend “Learning Collaborative” meetings
  - Team(s) from each practice
  - Seven days in first year
  - Initial focus on diabetes and pediatric asthma
- Work with an assigned IPIP practice coach to transform practice
- Use a patient registry (or EMR) to track patients
- Report data from the patient registry and other sources required for evaluation purposes
- Achieve Level 1 NCQA PPC-PCMH Recognition within 12 months
- Reinvest funds into the practice site, including staff and technology

# Requirements of Payers

- Three year commitment to fund and support
- Methodology – payments proportionate to revenue from all sources as validated and coordinated through GOHCR
- Payment to IPIP for Practice Coaches
- Payment to PCP Practices are intended to offset costs
  - Infrastructure development
    - NCQA PPC-PCMH survey tool \$80/practice
    - Data entry to registry \$800/practice
    - Office assistant \$8,000/practice
    - NCQA application fee \$360/clinician
    - Registry license fee \$275/clinician
  - Time for practice team to attend learning collaborative
    - Seven days during 1<sup>st</sup> year \$11,655/team
    - Consist of quarterly 2 day learning and final outcome meetings

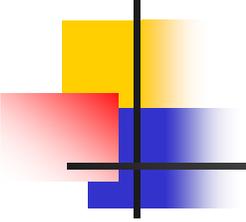
# Requirements of Payers

Enhancement to current payer contractual payments

- Annual lump sum payments upon NCQA PPC-PCMH recognition yield up to \$4PMPM
  - Prorated for portion of year at each level of recognition
  - Prorated based on PCP/CRNP FTEs in practice
  - Discounted by % of revenue from Medicare FFS and non-par payers

NCQA PCMH Recognition Level	Practice 1 FTE	Practice 2-4 FTEs	Practice 5-9 FTEs	Practice 10-20 FTEs
Level 1	\$40,000	\$36,000	\$32,000	\$28,000
Level 2	\$60,000	\$54,000	\$48,000	\$42,000
Level 3	\$95,000	\$85,500	\$76,000	\$66,500

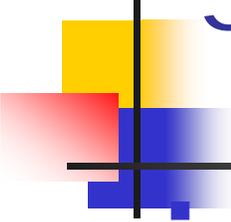
- Pay-for-performance – standard process post first 3 years based on clinical, utilization, satisfaction and financial outcomes



# Requirements of IPIP

---

- Provide Practice Coaches to assist
  - With transforming the practice
  - With data collection and reporting
  - Linking practices to community resources
  - With completing the NCQA PPC-PCMH recognition process

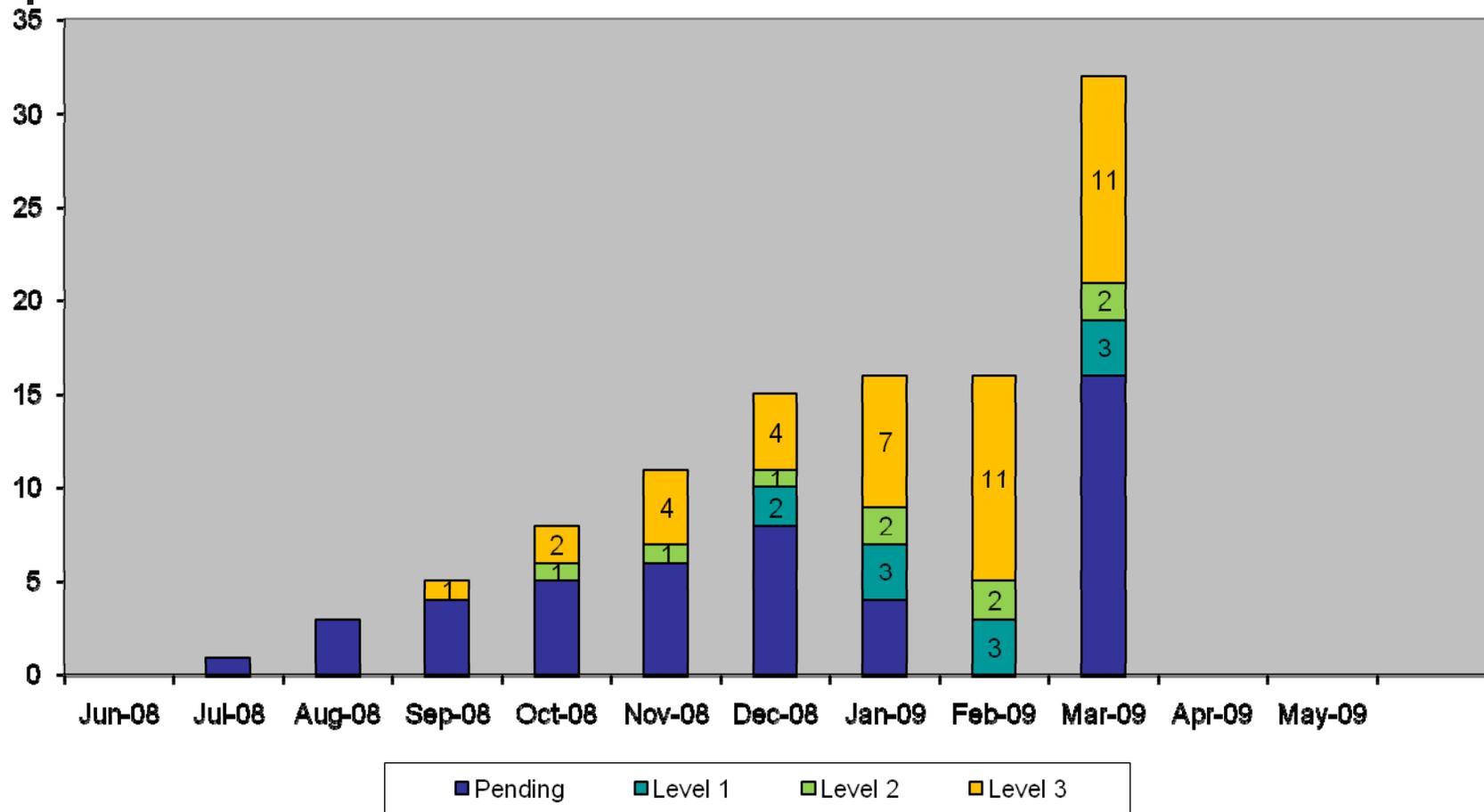


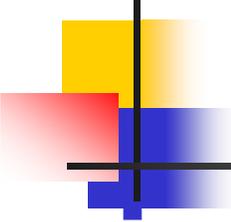
# Southeast Pennsylvania Rollout

---

- 6 Participating Payers
  - Independence Blue Cross, Keystone Mercy Health Plan, Aetna, Health Partners, AmeriChoice, CIGNA
  - Commercial, Medicare Advantage, Managed Medicaid
  - Account for 75-80% of revenue
- 32 Participating Practices
  - Pediatric, Family Practice, Internal Medicine, CRNP-led
  - 150 FTEs: 3 solo, 16 with 2-4 physicians, 10 with 5-8 physicians, and 3 practices of 10-20 physicians
  - Over 220,000 patients
  - Mix of independent and academic practices
  - Nearly half have EMR
- The Primary Care Coalition (the RWJF IPIP grantee in PA)
  - The PA Academy of Family Physicians
  - The PA Chapter, American Academy of Pediatrics
  - The PA Chapter, American College of Physicians

# NCQA PCMH Recognition

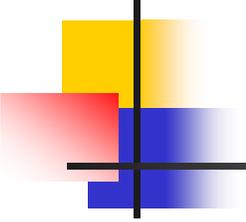




# Evaluation

---

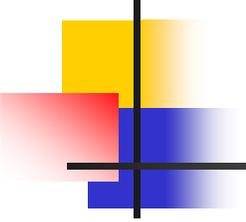
- The Commission has approved an evaluation methodology
  - Data from payers, providers, and surveys to be aggregated by 3<sup>rd</sup> party
  - Rollout “intervention” groups to be compared to control groups
  - Metrics are based on nationally endorsed measures where possible (NCQA, AQA, etc.)
- The initiative will be evaluated using the following measurement domains:
  - Engaged providers
  - Patient self-care knowledge and skills
  - Patient function and health status
  - Primary care practice satisfaction
  - Appropriate and efficient utilization of services
  - Clinical care quality
  - Cost



# Anticipated Gains

---

- Improved quality of care within 1 year
- Reduced admissions and cost in 3 years
- Improved access to care and member satisfaction
- Support for the vulnerable and essential primary care professional community
- A robust demonstration of the impact of a far-reaching, multi-payer strategy to transform care delivery
- Lessons learned to hopefully apply to a broader system-wide model application

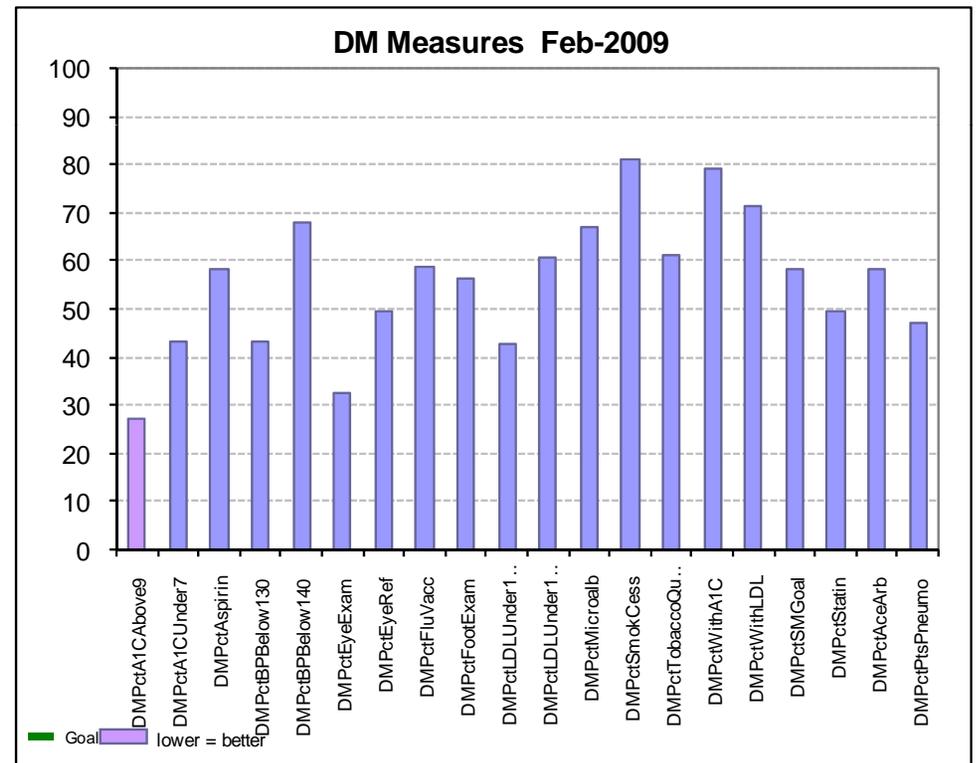
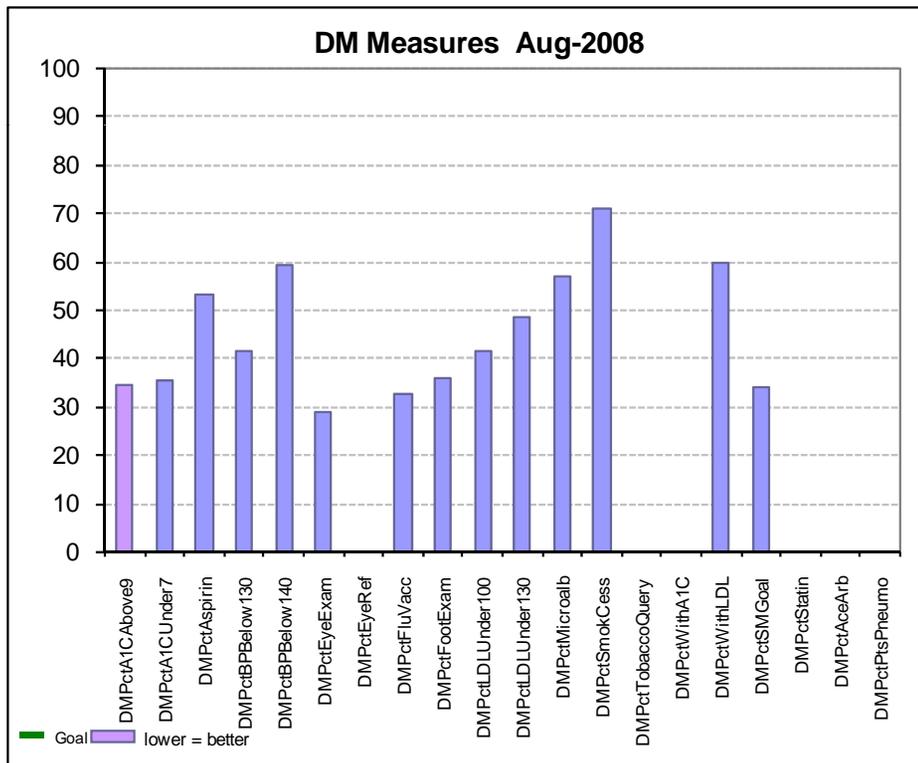
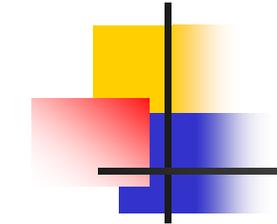


# What are the practices doing?

---

- Focusing on “planned visits” to ensure patients get all needed care at visits
- Bringing in patients overdue for services
- Providing team-based care
- Establishing standing orders
- Overcoming clinical inertia with clinical guidelines
- Holding group visits
- Stratifying patients for care management, self-management support
- Setting goals with patients and following up on goals

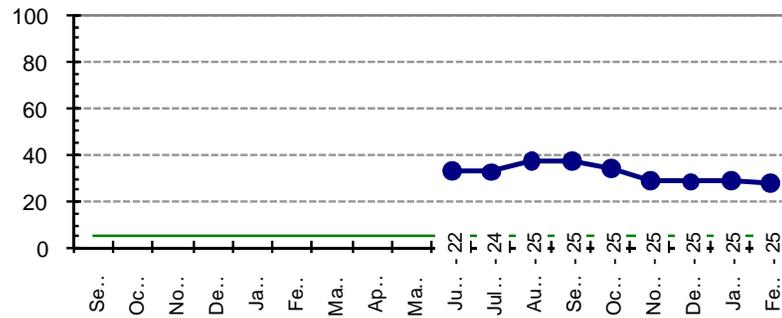
# All Diabetes Measures



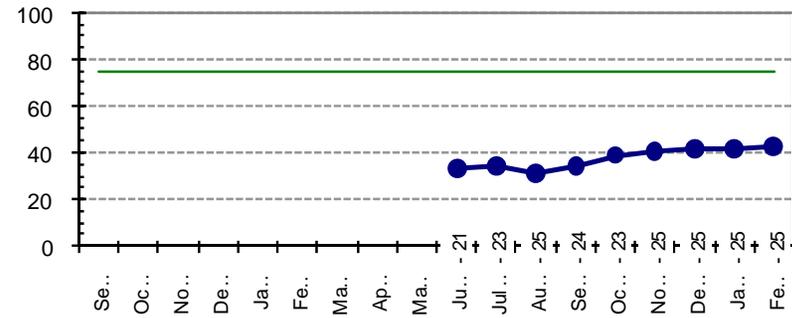
# Aggregate Total Pop Diabetes

(25 SE PA practices, average of 400 patients per practice)  
(10,000+ patients in total diabetes population)

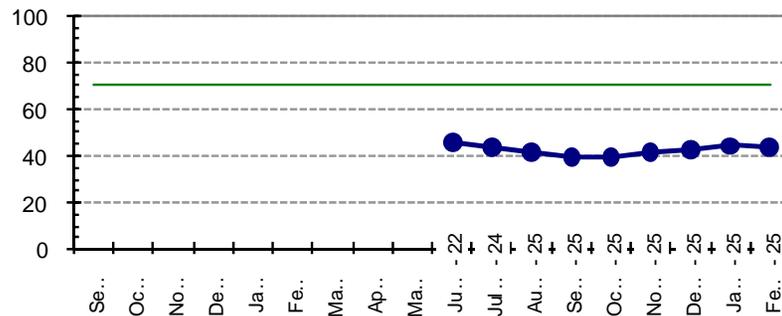
Pct of DM patients with latest A1C >9



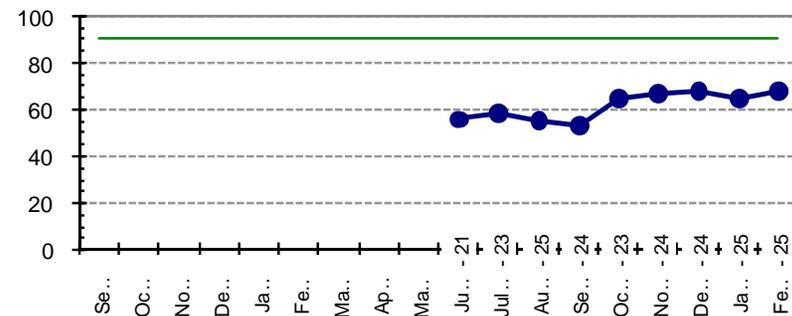
Pct of DM patients with latest A1C ≤7



Pct of DM patients with latest BP ≤130/80



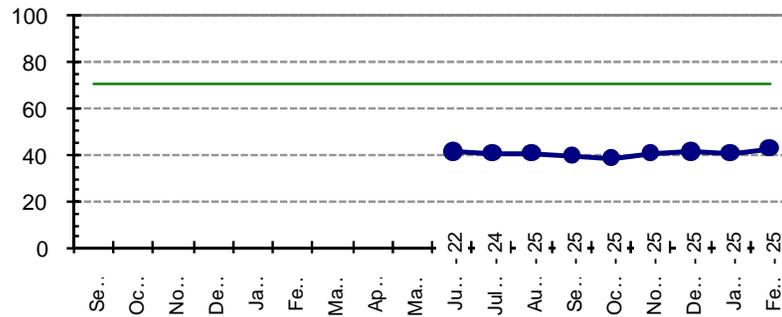
Pct of DM patients with latest BP ≤140/90



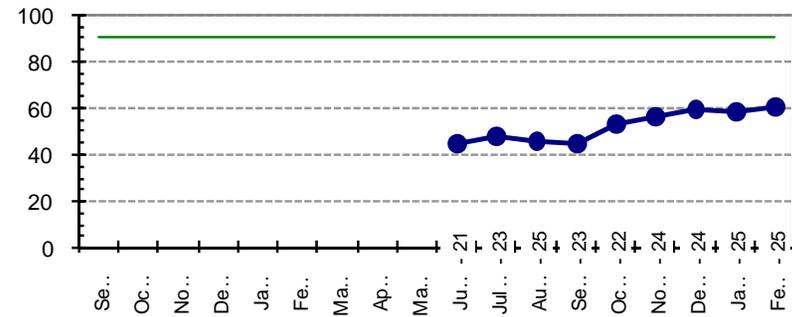
# Aggregate Total Pop Diabetes

(25 SE PA practices, average of 400 patients per practice)  
 (10,000+ patients in total diabetes population)

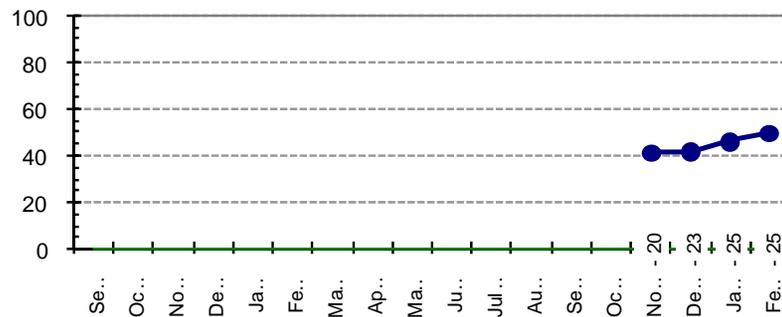
Pct of DM patients with latest LDL <=100



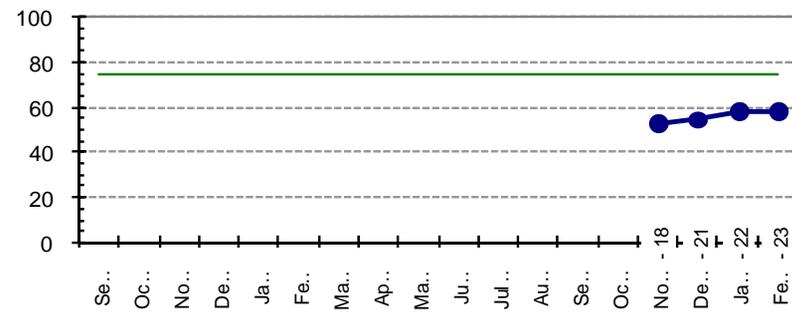
Pct of DM patients with latest LDL <=130



Pct of DM pts prescribed a statin



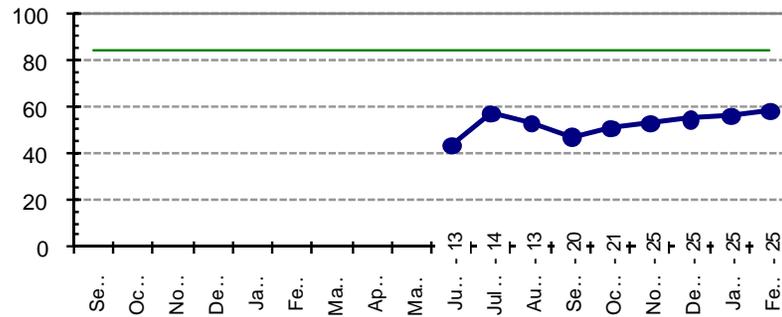
Pct of DM pts 55-75 taking ACE/ARB



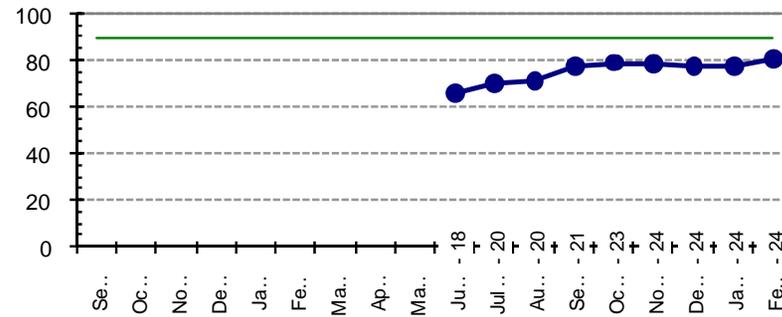
# Aggregate Total Pop Diabetes

(25 SE PA practices, average of 400 patients per practice)  
 (10,000+ patients in total diabetes population)

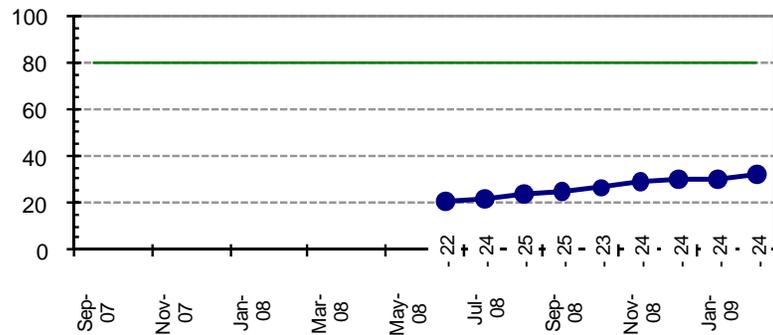
Pct of DM patients on aspirin



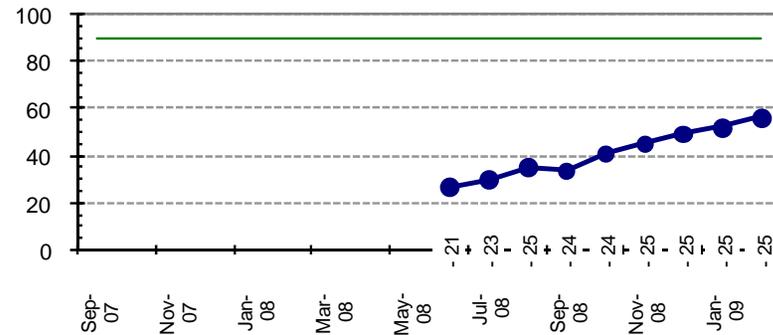
Pct DM pts w/ smoking cessation counseling



Pct of DM patients with eye exam



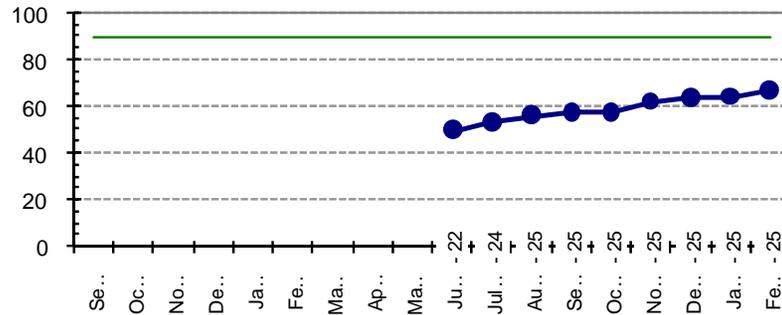
Pct of DM patients with foot exam



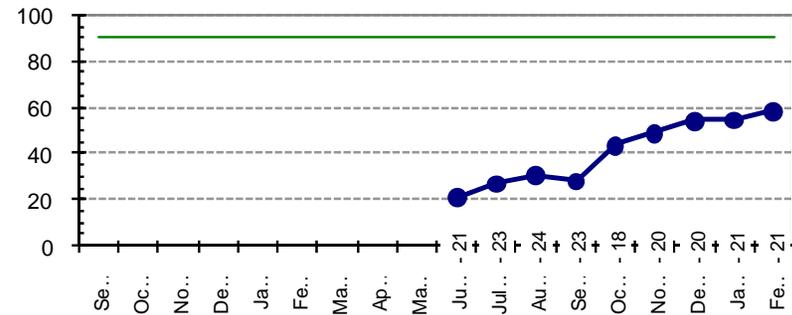
# Aggregate Total Pop Diabetes

(25 SE PA practices, average of 400 patients per practice)  
 (10,000+ patients in total diabetes population)

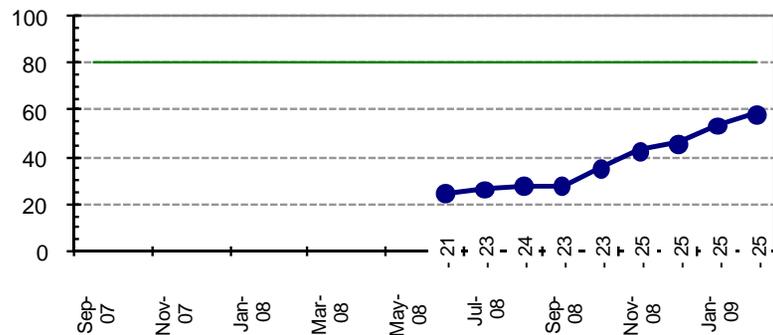
Pct DM pts w/ nephropathy screen



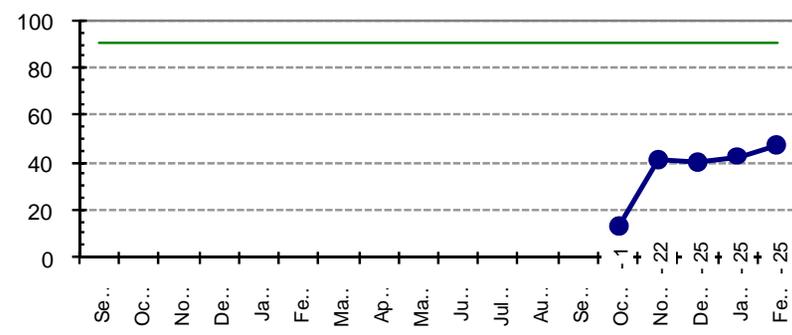
Pct of DM patients with SM Goal



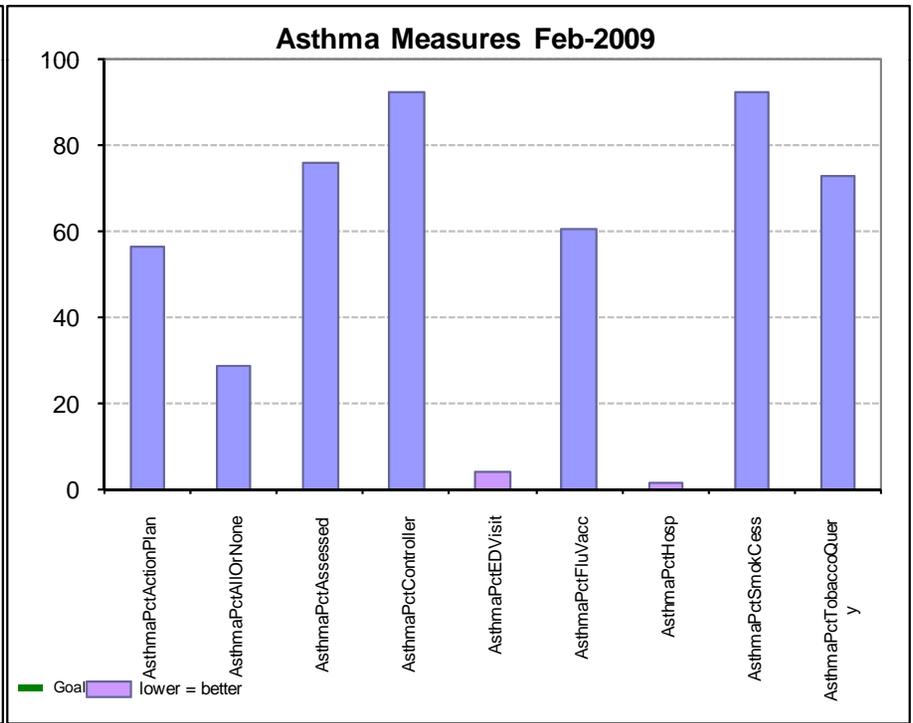
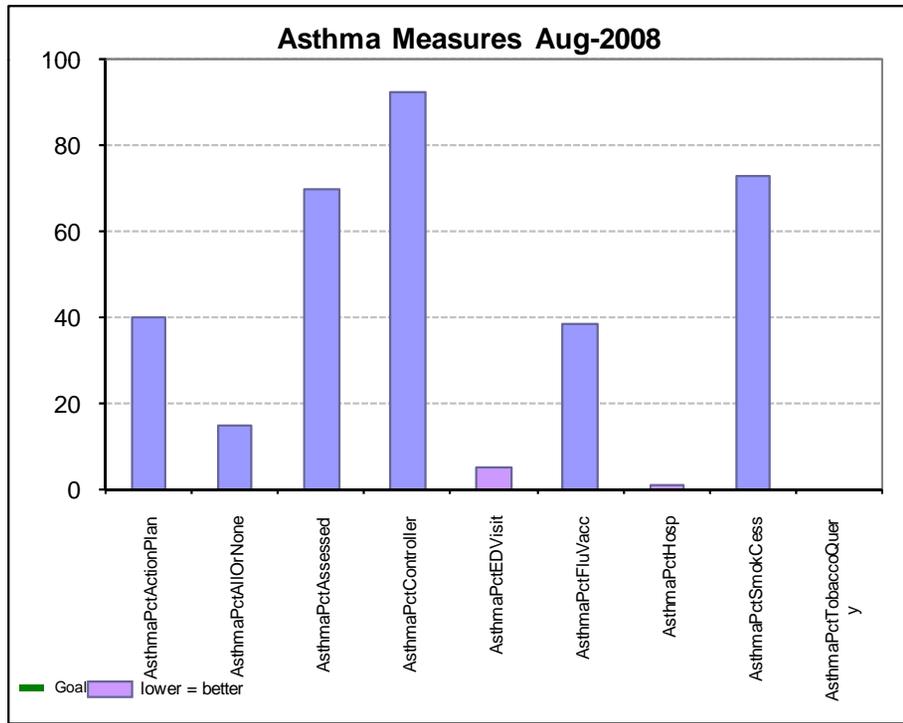
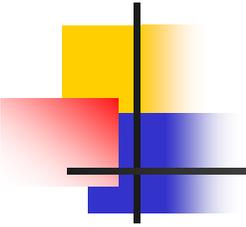
Pct of DM patients with current flu vaccination



Pct of DM pts with pnuemo vacc



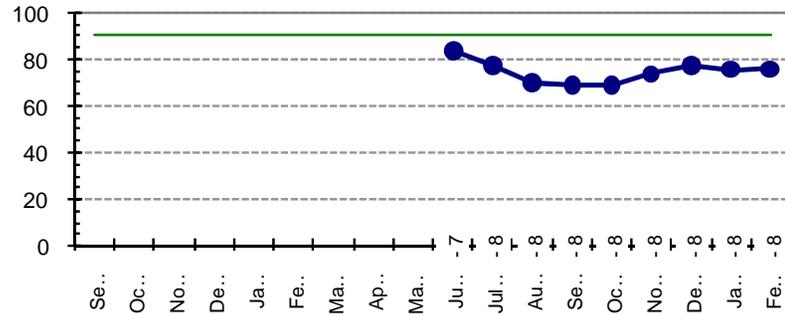
# All Asthma Measures



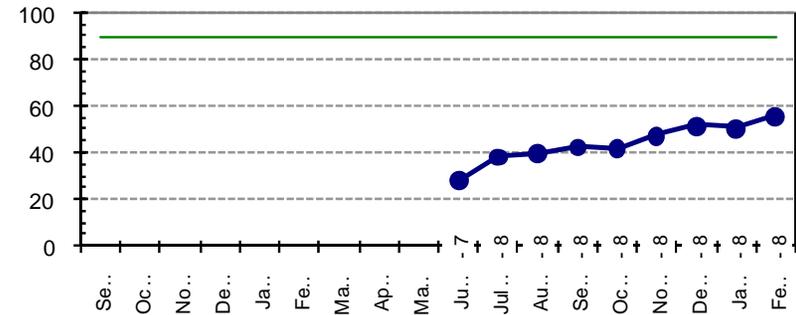
# Aggregate Total Pop Asthma

(8 SE PA practices, average of 600 patients per practice)  
 (5,000 patients in total asthma population)

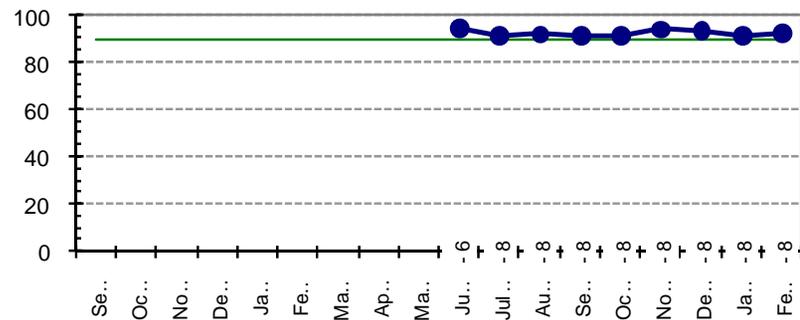
Pct of asthma patients with control assessed



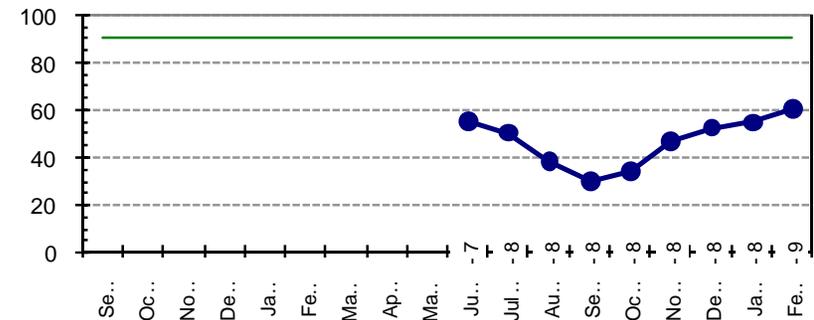
Pct of asthma patients with action plan

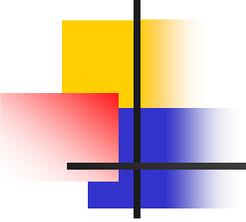


Pct of asthma patients with controller med



Pct asthma pts with current flu vaccine



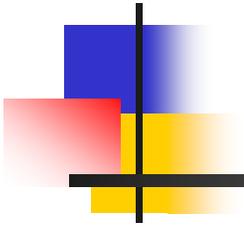


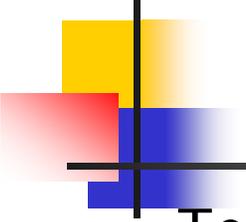
# Next Steps

---

- 2009 regional rollouts
  - South Central Pennsylvania – April 2009
  - Western Pennsylvania – May 2009
  - Northeast Pennsylvania – June 2009
  - Northwest Pennsylvania – September 2009
  - North-central Pennsylvania – November 2009
  - Southeast Pennsylvania – November 2009

# Appendix



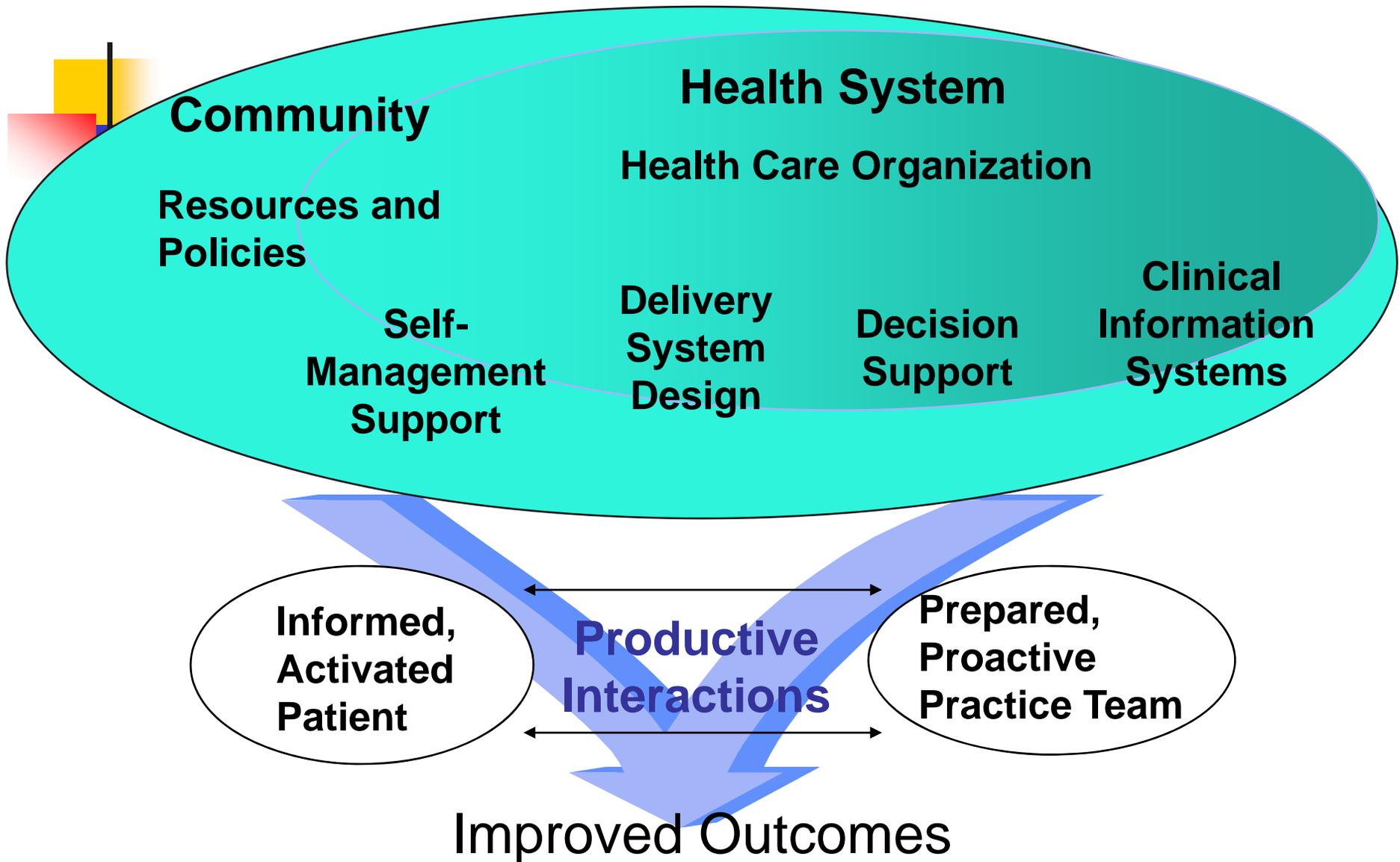


# “The Chronic Care Model”

---

- Team-based coordinated care, with a focus on patients with chronic illness
- Origin: Ed Wagner, McColl Institute for Healthcare Innovation, Group Health Cooperative of Puget Sound
  - Improved care coordination
  - Cost reductions from averted admissions
  - Improved quality of care
- Several existing state and national collaboratives, e.g.,
  - Vermont’s “Blueprint for Health”
  - WA state - based on the IHI Breakthrough Series Model
  - HRSA implementation through Federally Qualified Health Centers across the U.S., including 16 in PA

# What is the Chronic Care Model?



# “The Patient-Centered Medical Home” (PCMH)

## ■ Origin: American Academy of Pediatrics

- Now embraced by American Academy of Family Physicians, American College of Physicians and American Osteopathic Association
- Several pilots in place and emerging around the country (NY, CO)

## ■ Features

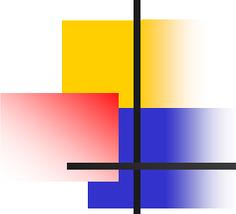
- Open access scheduling
- Use of a registry or EMR to manage a population
- Use of a team: Physician, CRNPs, case managers, health educators
- Improved communication (telephonic, e-mail)
- Decision support



<b>Diabetes</b>	<b>Goal</b>	<b>Endorsements</b>
<b>A1C</b>		
A1C documented	>90%	AQA, NCQA, NQF
Most recent A1C level greater than 9.0%	<20%	AQA, NCQA, NQF
Most recent A1C level less than 7.0%	>40	NCQA
<b>Blood Pressure</b>		
BP documented in the last year <140/90	>65%	AQA, NCQA, NQF
BP documented in the last year <130/80	>35%	NCQA
<b>Cholesterol</b>		
At least one LDL	>85%	AQA, NCQA, NQF
LDL Control <130 mg/dl	>63%	NCQA, NQF
LDL Control <100 mg/dl	>36%	NCQA, NQF
<b>Eye Exam</b>		
Received a dilated eye exam	>60%	AQA, NCQA, NQF
<b>Foot Exam</b>		
Foot exam	>80%	NCQA, NQF
<b>Smoking Status</b>		
Counseled to stop tobacco use	>80	AQA, NCQA, NQF
<b>Nephropathy</b>		
Tested for nephropathy or already under treatment	>80%	NCQA, NQF
<b>Prevention</b>		
Influenza vaccination	>60%	AQA, NCQA, NQF



<b>Asthma</b>	<b>Goal</b>	<b>Endorsements</b>
<b>Utilization</b>		
ED visit	<0.3%	
Hospitalization	<0.1%	
<b>Classification</b>		
Severity classified	>90%	NQF, Physicians Consortium
<b>Anti-inflammatory</b>		
Persistent asthma on anti-inflammatory medication	>90%	AQA, NQF
<b>Prevention</b>		
Influenza vaccination	>90%	AQA, NQF
<b>Composite Measure</b>		
Receive <u>all 3</u> key strategies for asthma care (classification, anti-inflammatory, influenza vaccination)	>75%	



---

---

**Hypertension (still under development)****Goal****Endorsements**

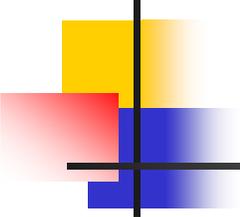
---

Blood Pressure

Most recent blood pressure below 140/90

NCQA, CMS, NQF

---



# Additional Information

---

Link to the Chronic Care Commission's Strategic Plan

<http://www.rxforpa.com/assets/pdfs/ChronicCareCommissionReport.pdf>

## Contact Information:

Governor's Office of Health Care Reform

Philip Magistro

717-214-8174

[pmagistro@state.pa.us](mailto:pmagistro@state.pa.us)