The Pennsylvania Chronic Care Initiative

Appendix

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bailit health PURCHASING

Origins of CCM Initiative

- The Governor's Office of Health Care Reform (GOHCR) was the architect of Governor Rendell's Prescription for Pennsylvania, the Governor's comprehensive health care reform plan
- GOHCR is tasked with implementing the plan, including the Chronic Care Initiative
- The Pennsylvania Chronic Care Management, Reimbursement and Cost Reduction Commission was established by Governor Rendell's Executive Order in May 2007
- The purpose of the Commission is to design the informational, technological and reimbursement infrastructure needed to implement and support widespread dissemination of the Chronic Care Model throughout Pennsylvania

CCM Commission

- Organization:
  - 45 Commission members
    - Provider, insurer, state government agency, employer organized labor, academic and consumer representatives
  - Four subcommittees include Commission members, plus additional representatives from stakeholder organizations
    - Practice Redesign
    - Consumer Engagement
    - Incentive Alignment
    - Performance Measurement
  - Fifth subcommittee created in 7-08: Pooled Claims Database
  - Staffed and facilitated by the Governor's Office of Health Care Reform and Bailit Health Purchasing

Implementation Process

- Each of four state regions required to form a Rollout Steering Committee composed of key stakeholders, including providers, insurers, GOHCR, and consumers.
- Regional rollouts must adhere to the Commission's broad framework, but has room to vary its approach.
- Steering Committee holds biweekly meetings (telephonically) to develop its own financial model and to refine certain implementation parameters address only in general terms in the strategic plan.
- The Southeast PA Regional Rollout Steering Committee crafted the following specific model.

Requirement: Payers

- Derivation of infrastructure development payments:
  - Infrastructure Costs to Practice During the First Year
    - 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 to attend learning collab (7 days/year) $11,655/clinician

Requirements: Payers

- Derivation of enhancement of FFS/capitation:
  - Informed by analysis of limited available estimates of practice costs to implement CCM/PCMH ($4-$9PMPM range – excluding EMR) and of existing CCM/PCMH programs and pilots
  - Commission recognized that it is likely that costs would vary based on practice size and configuration. Some existing modeling assumes a solo PCP practice, while RI assumes a small group practice.
  - Southeast PA model provides up to approximately $4PMPM for NCQA PPC-PCMH recognition, less Medicare FFS share of practice
    - Per clinician amount decreases as practice size increases

Payment Triggered by NCQA PPC–PCMH Recognition

Annualized revenue per full-time-equivalent practitioner from all sources for implementing the features of the PCMH recognizes economies of scale and the incremental resources to achieve full transformation of the practice to include all features, *discounted by* the % of practice revenue derived by Medicare FFS and insurers with low market share.

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

Additional Regions

- Additional Regional Rollouts, each involving 20-30 practice sites are being planned for the South Central, Southwest and Northeast Pennsylvania for the winter and spring of 2009.
- The models differ in some ways. For example:
  - There is a higher bar for NCQA recognition-linked payment: “Level One Plus.”
  - There is separate payment for care management resources, role specifications, and reporting requirements on how care managers spend their time.
  - TransforMED is being used to provide additional assistance to practices with need for basic practice management assistance.

Consumer Engagement

- **Consumer Engagement Subcommittee developed following framework to encourage self-management:**
  - IPIP to develop partnerships with statewide organizations to identify community needs and develop programs to fill needs.
  - IPIP to develop vetted registry of community programs that support self-management goals.
  - IPIP and MacColl Institute to train practice coaches and practice self-management coaches in self-management skills
  - Include as practice incentive creation of community partnerships
  - Insurers to reimburse for diabetes and asthma educational programs in community sites, including practices, libraries, etc.
  - GOHCR to work with the PA DOH to develop Stanford Chronic Care Self Management Program (Lorig Model) throughout the state.
  - P4P programs to include collaborative action planning and goal setting
  - Rollouts to pilot a consumer incentive initiative

Consumer Engagement

- Framework continued
  - GOHCR to work with PA AHEC to develop a self-management training program for providers that includes CE credits.
  - GOHCR to work with accrediting organizations to require self-management skill training in all PA schools that graduate providers who interact with patients.
  - GOHCR to recommend to NCQA that its PCP-PCMH standards include requirements that providers participate in self-management skills training program and that practice designate an individual to be responsible for overseeing practice self-management education and support activities.

Evaluation

- The Commission has approved an evaluation design utilized matched pairs of practices as a control group.
- The initiative will be evaluated using the following measurement domains:
  1. engaged providers
  2. patient self-care knowledge and skills
  3. patient function and health status
  4. primary care practice satisfaction
  5. appropriate and efficient utilization of services
  6. clinical care quality
  7. Cost
- Currently finalizing RFP for evaluation services.
- Have sent out base line questionnaire to patients in participating and control group practices.

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

Asthma	Goal	Endorsements
Utilization		
ED visit	<0.3%	
Hospitalization	<0.1%	
Classification		
Severity classified	>90%	NQF, Physicians Consortium
Anti-inflammatory		
Persistent asthma on anti-inflammatory medication	>90%	AQA, NQF
Prevention		
Influenza vaccination	>90%	AQA, NQF
Composite Measure		
Receive all 3 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

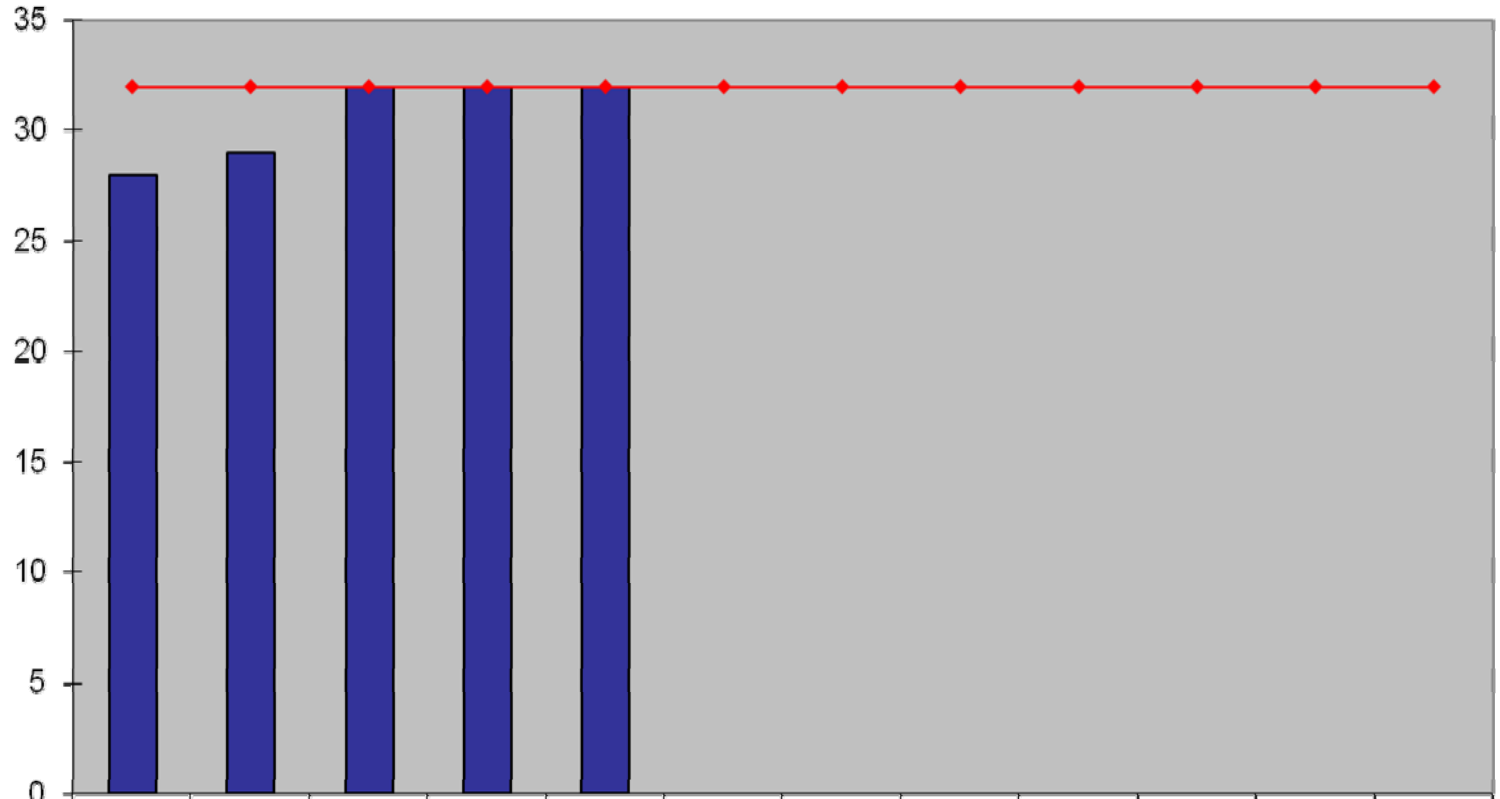
Performance Reporting System

- The Commission require practices to submit monthly performance data on these measures through IPIP.
- The measures apply to the entire practice population (e.g., population management).
- Easy to report data from Colorado registry system.

Monthly Performance Reports

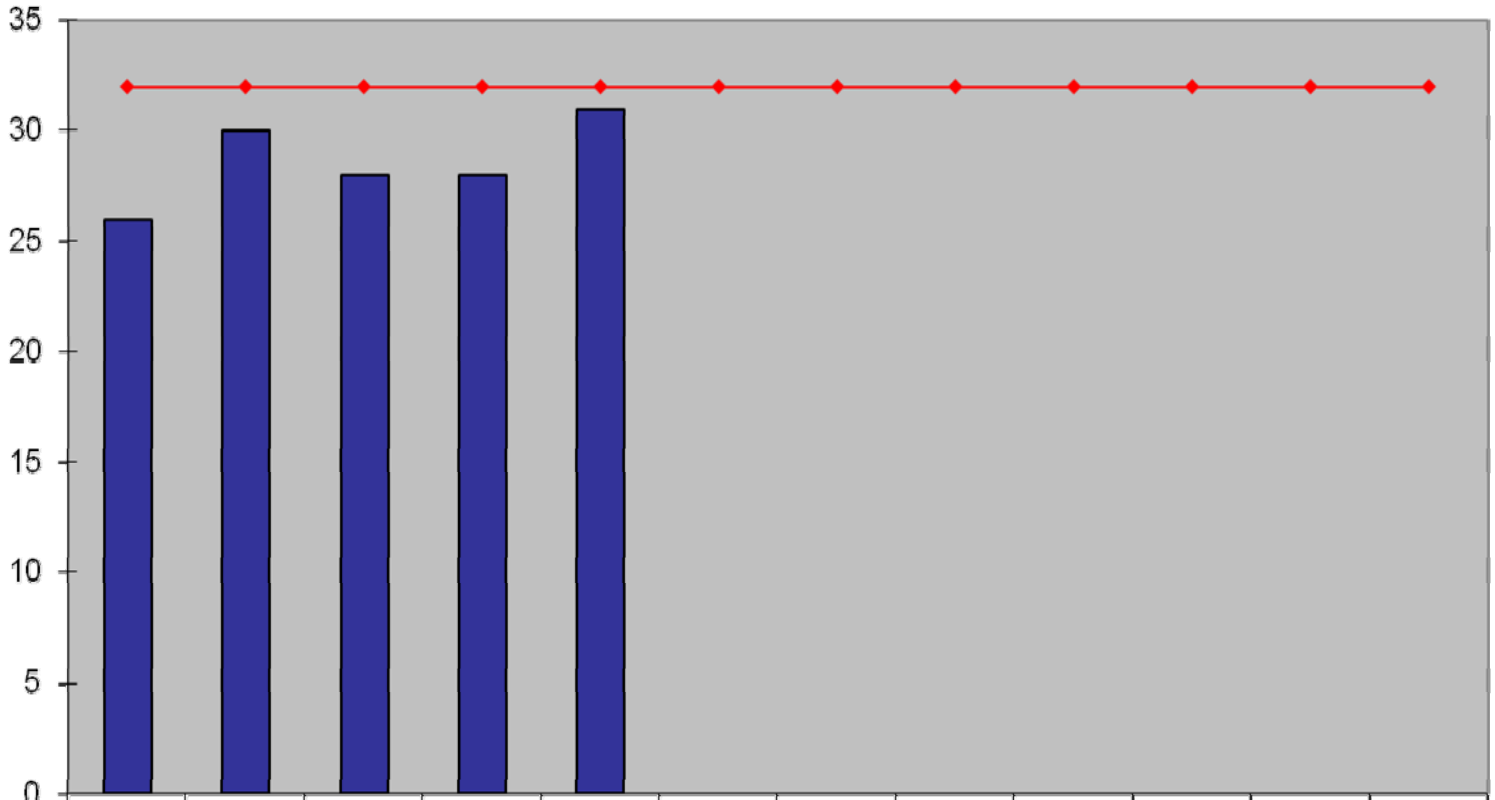
- 100% reporting since third month (90% first two months)
- Fifth monthly report (October) just coming in now
- Population of Focus, Total Population
- Practice assessment report by coach

Monthly Report Submission



	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09
# Practices	28	29	32	32	32							
N	32	32	32	32	32	32	32	32	32	32	32	32

Monthly Conference Call Participation

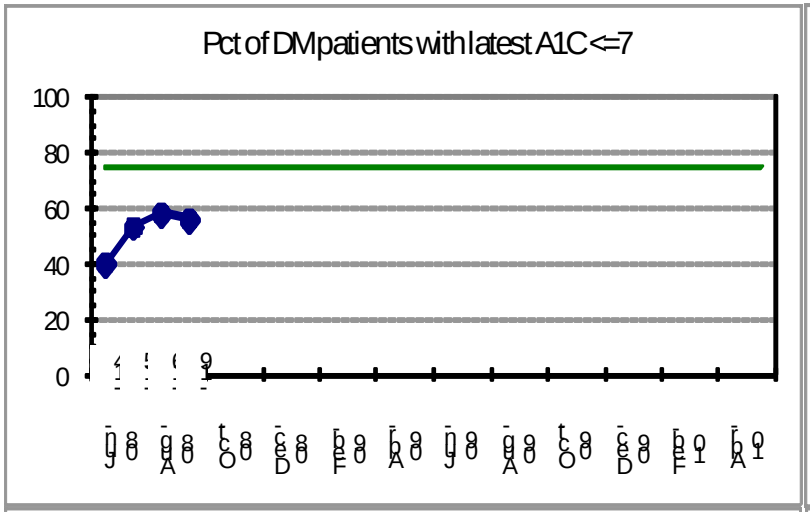


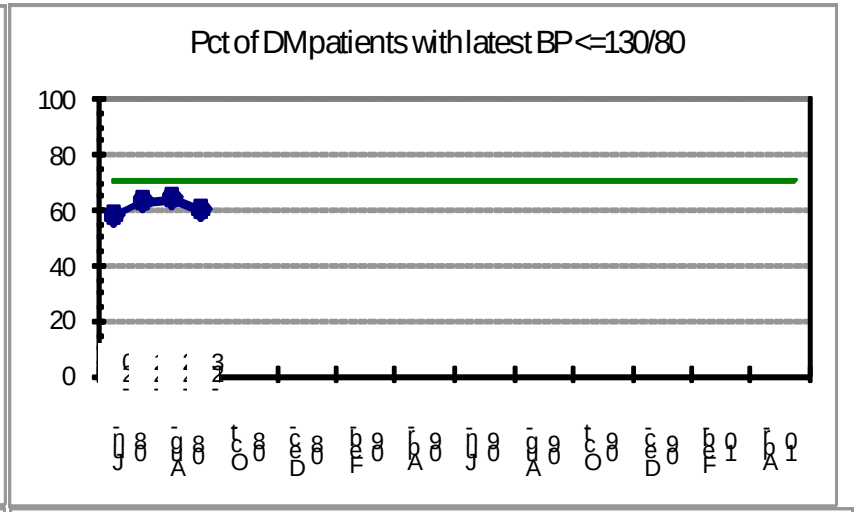
	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09
# Practices	26	30	28	28	31							
N	32	32	32	32	32	32	32	32	32	32	32	32

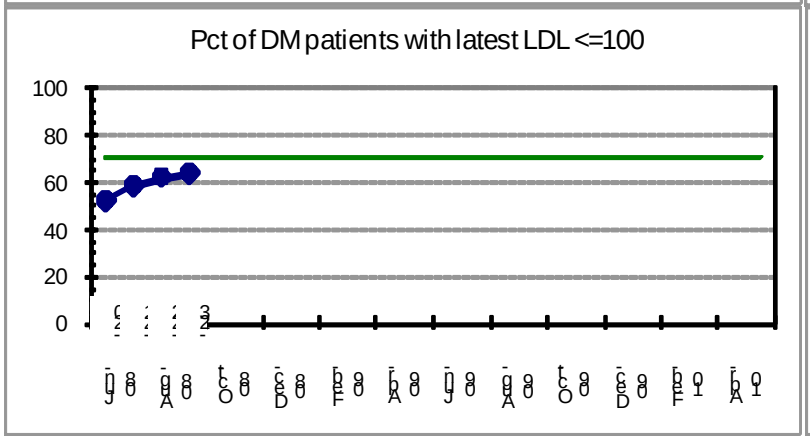
Diabetes Performance

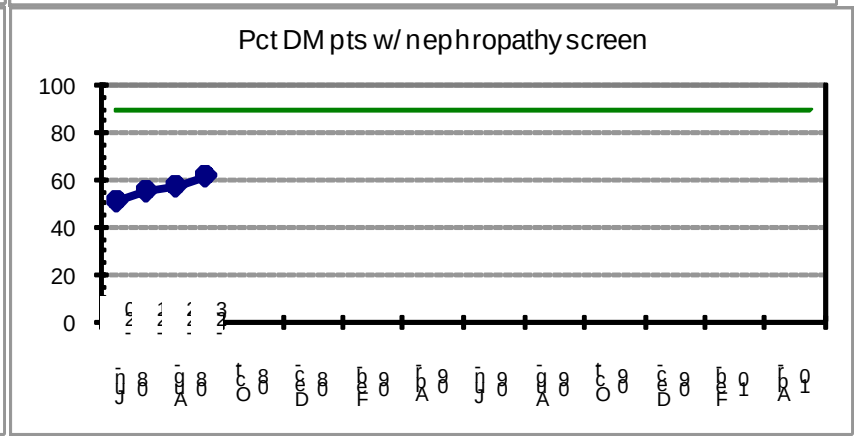
Population of Focus Sept Run Charts

(25 practices, 10,000+ patients in total population)





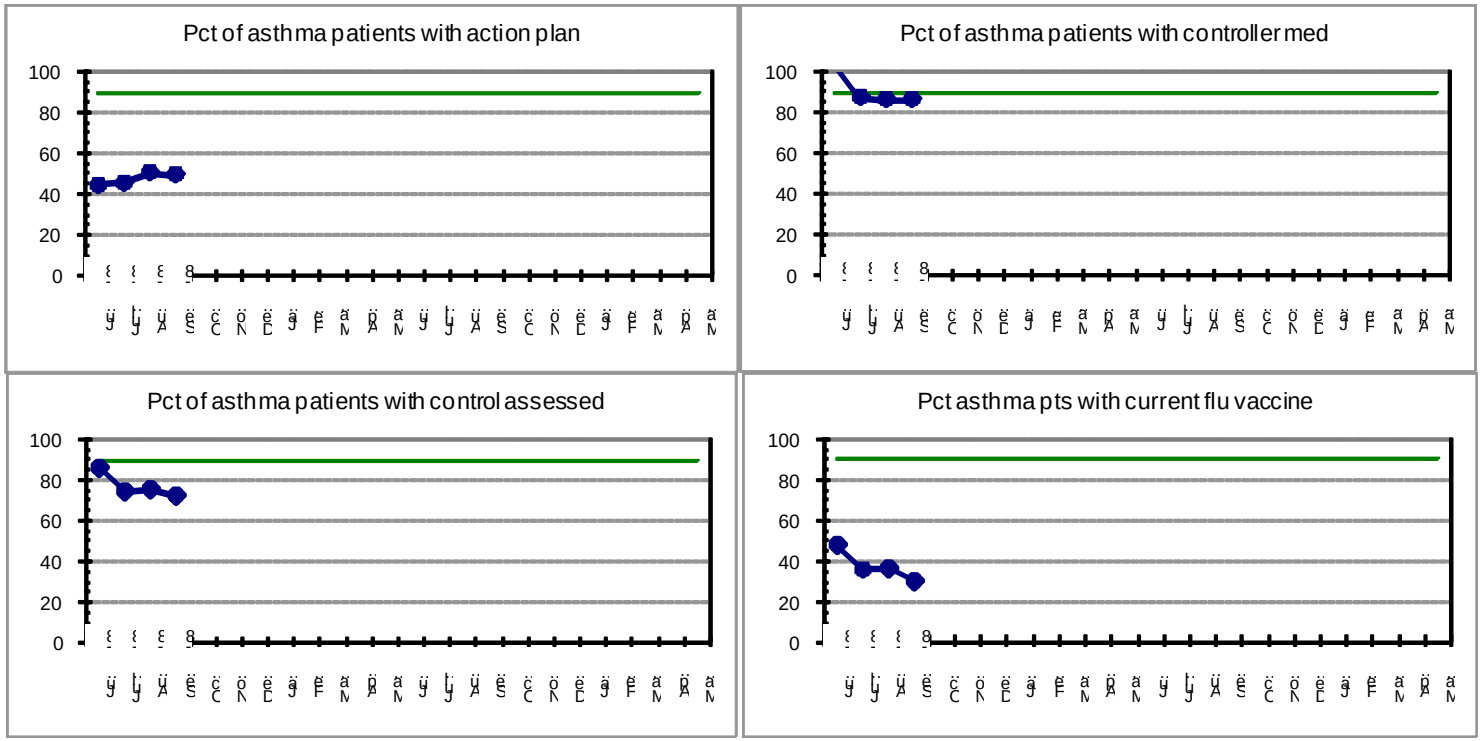




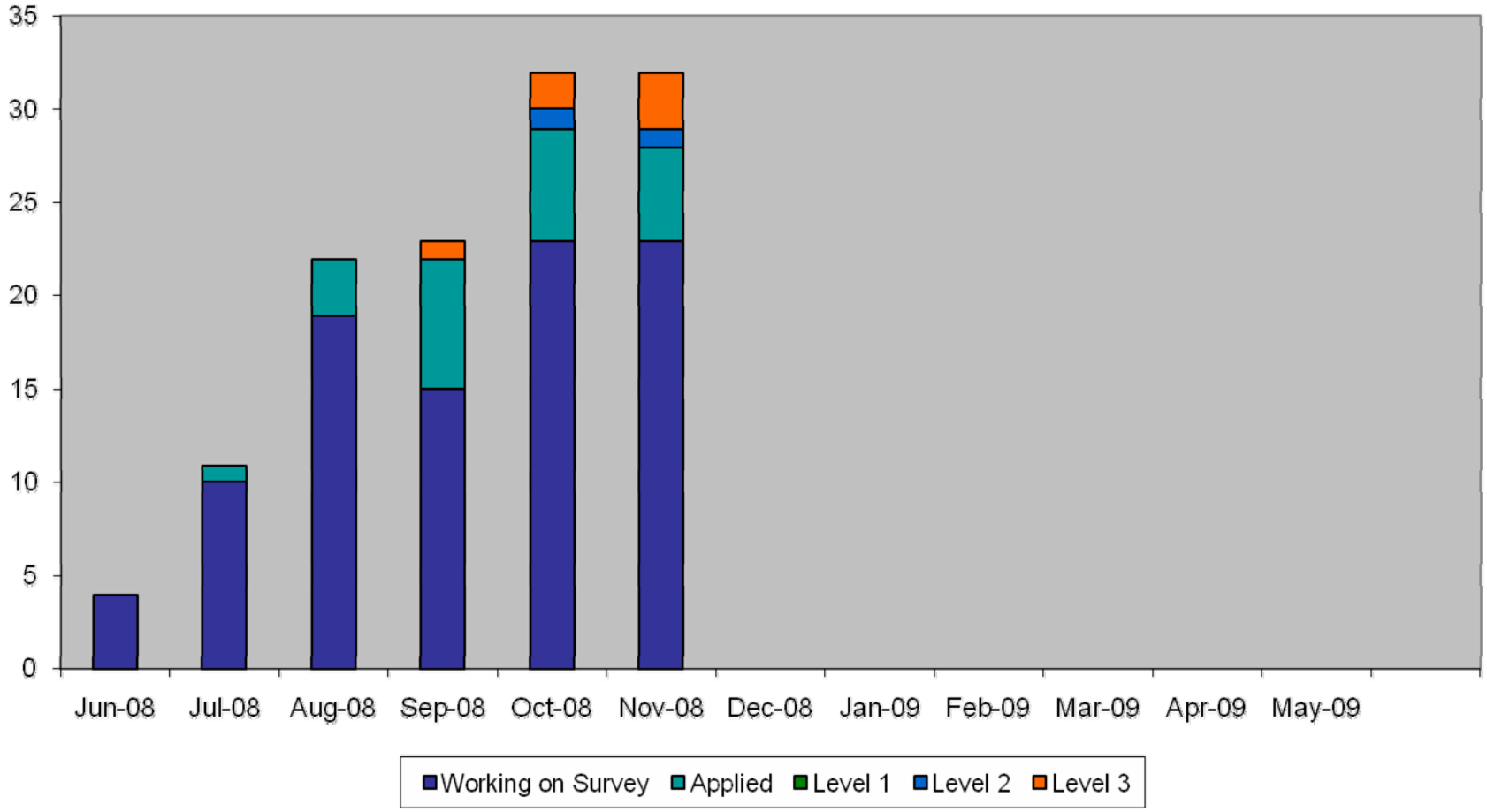
Asthma Performance

Population of Focus Sept Run Charts

(7 practices, 5,000+ patients in total population)



NCQA Recognition Status



IPIP Coach Report

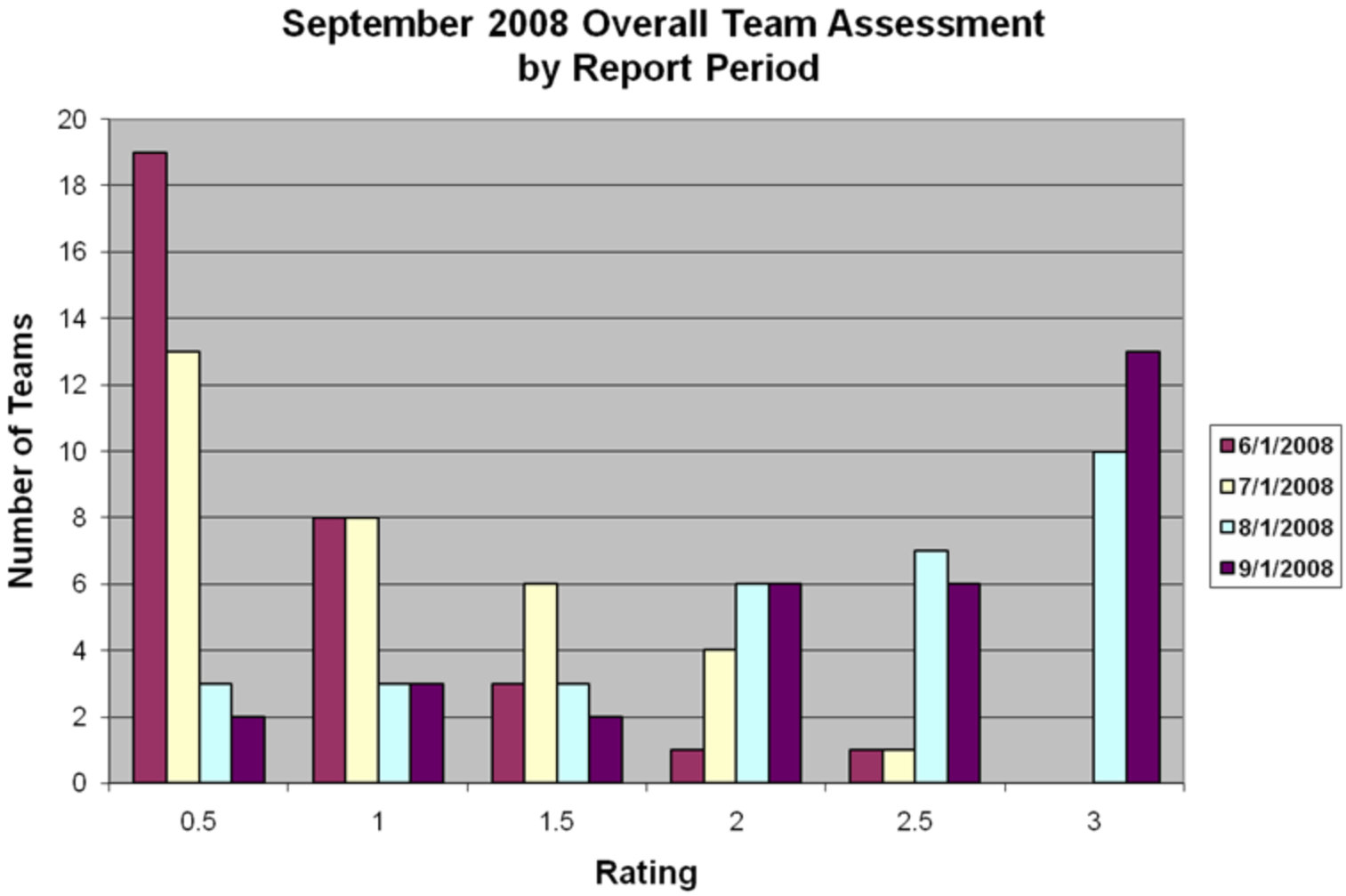
- Assesses teams on IPIP Change Package implementation and spread
  - Registry
  - Planned visits
  - Protocols
  - Self management support
- Also assesses Leadership and Team Engagement
- Plus Overall Team Assessment

IPIP Assessment Scales

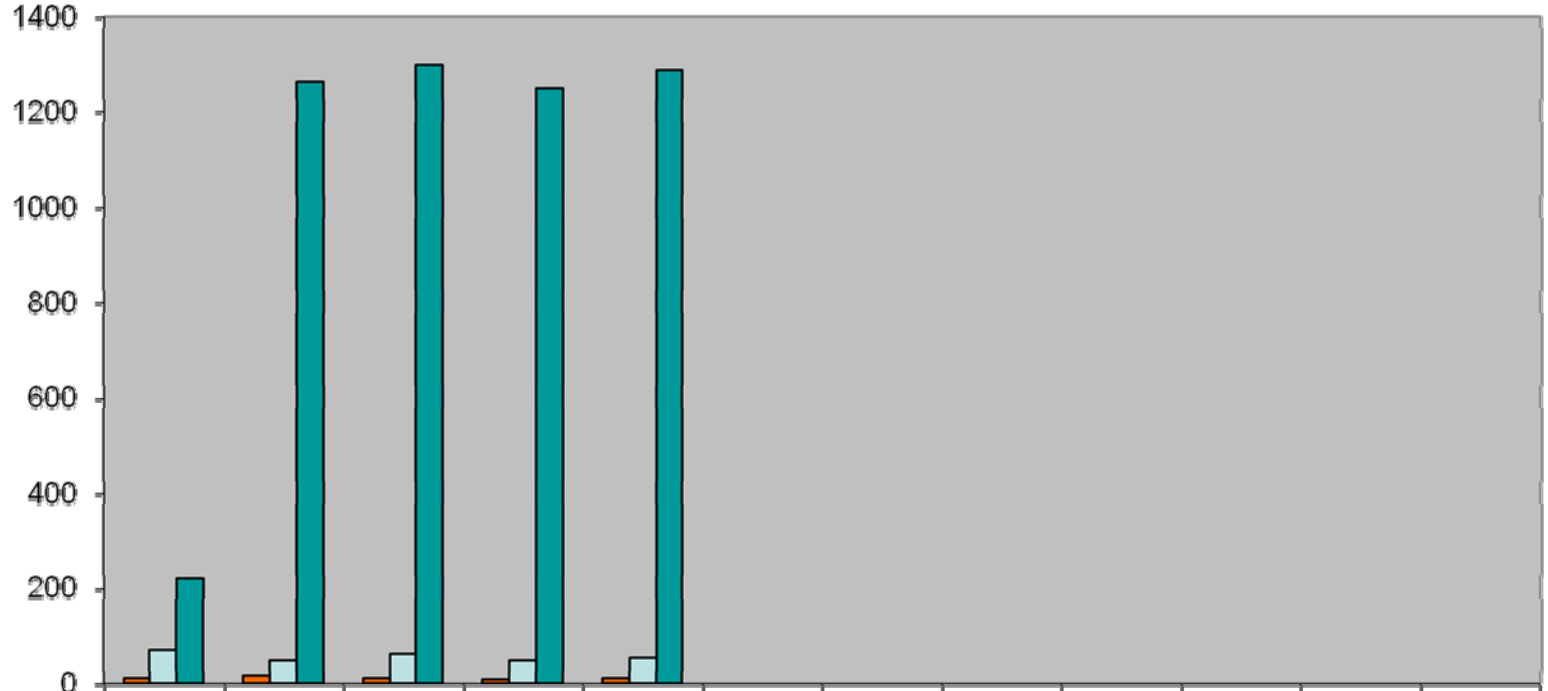
Example: Overall Team Assessment scale:

- 0.5 Intent to Participate
- 1.0 Forming Team
- 1.5 Planning for the Project Has Begun
- 2.0 Activity, But No Changes
- 2.5 Changes Tested, But No Improvement
- 3.0 Modest Improvement in Two Areas
- 3.5 Improvement in Three Areas
- 4.0 Significant Improvement Practice Wide
- 4.5 Sustainable Improvement Practice Wide
- 5.0 Outstanding Sustainable Results

IPIP Assessment of Practice Teams



QI Coach Activity with Practices



	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09
# Visits	11	17	12	8	11							
# Phone Calls	75	55	68	53	60							
# Emails	220	1268	1304	1254	1292							