
Pennsylvania's **Chronic Care Initiative**

*Transforming Primary Care Practice
in an Era of Health Care Reform*



November 13, 2009
Richard L. Snyder, M.D.

Distinguishing Features

- Government as ***Convener***
- ***Multi-stakeholder participation***
- ***Transformational care for all***
- ***Transparent and adequate funding***
- ***Practice support***
- ***Scale*** to yield reliable outcomes
- ***Transferrable (regional and national)***

Chronic Care Commission

- Commission members (*provider, payer, consumer, labor, academic and State*)
- Goal - Improve chronic care delivery (*access, quality, cost*)
- Due diligence
 - Wagner Chronic Care Model
 - Patient Centered Medical Home Model
- Desired features of Pennsylvania model
 - Regional “Learning Collaborative” rollouts
 - Practice coach support
 - Technology – Registry/EMR, e-Rx, open access scheduling
 - Communication – telephonic, encrypted e-mail
 - Team – health educators, case managers, CRNPs, PCPs
 - Self-management skills
 - Provider and consumer incentive alignment
 - Third party assessment - NCQA PPC-PCMH
 - Clinical, financial and satisfaction outcomes reporting

3

Chronic Care Commission

- 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)
- First rollout in SE PA in May 2008

4

Role of GOHCR

- Convener
- Staffing
- Funding
 - Consultants
 - Faculty / expenses for year-long learning collaborative
 - Registry
 - Data collection, aggregation, evaluation and reporting activities through a 3rd 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

5

Requirements of PCP Practices

- Attend “Learning Collaborative” meetings
 - Team(s) from each practice
 - Seven days in year 1, then less frequently
 - Initial focus on diabetes and pediatric asthma
 - Testing
 - Implementing
 - Spreading
- Work with 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 L1 NCQA PPC-PCMH Recognition* in year 1
- Invest funds in staff and technology at practice site

* Later rollouts have not required recognition in year 1; focusing on care management

6

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 \$9,515/practice
 - NCQA PPC-PCMH survey tool
 - Data entry to registry
 - Office assistant
 - NCQA application fee
 - Registry license fee
 - Time for practice team to attend learning collaborative meetings
 - Seven days during 1st year \$11,655/team
 - Consist of quarterly 2 day learning meetings and final outcome meeting

Requirements of Payers

- Enhancement to current payer contractual payments
 - Annual payments upon NCQA PPC-PCMH recognition – per PCP FTE
 - 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

*The specific payment model varies somewhat in other regions of Pennsylvania to include PMPM payments for care management.

- Pay-for-performance – following year 3
- Behavioral health integration
- Consumer incentives

Requirements of IPIP

- Provide Practice Coaches to assist with
 - Transforming the practice
 - Data collection, aggregation, reporting and socializing
 - Linking practices to community resources
 - Completing the NCQA PPC-PCMH recognition process

9

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, academic and FQHC 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

10

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 and self-management support
- Setting goals with patients and following up on goals
- Producing patient report cards

11

How does Behavioral Health fit in?

- Clear connection of behavioral and physical health
 - 1 in 5 persons affected each year
 - Similar impact as other chronic disease on quality of life
 - Adverse impact on certain chronic illnesses
- Patient Centered Medical Homes have agreed to:
 - Periodic screening for depression in chronically ill
 - Provide or arrange for appropriate evidence-based care
 - Expand screening to other conditions at some point
- Payers have agreed to:
 - Elimination of referral/prior-authorization requirements
 - PCMHs to hire or co-locate behavioral health providers
 - MBHOs act as a resource to PCMHs
- Process / outcomes measures added to Evaluation

12

“We are empowering our patients to become more active participants with us and are providing self management support to assist them. We are seeing significant changes in patient behavior for many individuals who have been hard to reach in the past...”

A. Crimm, M.D.
Ninth Street Internal Medicine Associates



Evaluation

- IPIP reporting at practice and Collaborative level to support day to day practice level management
- Evaluation methodology
 - Payer, provider, and survey data to be aggregated
 - Collaborative practices to be compared to control practices both at a regional and a State-wide level
 - Quality Metrics are based on nationally endorsed measures where possible (NCQA, AQA, etc.)
 - 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

“...the very process of identifying three conditions to focus on opened our eyes by quantifying what our most common diagnoses were, and enabling us to see where care improvement processes would be best focused.”

T. Lyon, M.D.

Mt. Airy Family Practice



Southeast Pennsylvania Achievements

- NCQA PPC-PCMH Recognition
 - Level 3: 14 Practices
 - Level 2: 4 Practices
 - Level 1: 14 Practices
- Process and Outcomes Measure Improvement (%)
 - HgbA1c < 9: 23%
 - HgbA1c < 7: 33%
 - BP ≤ 140/90: 25%
 - LDL < 130: 43%
 - % diabetics with eye exam: 71%
 - % diabetics with foot exam: 142%
 - % diabetics with SM goal: 195%
 - Nephropathy screening: 36%
 - Asthma “Action Plan”: 104%

“The practice has undergone quite a transformation. We are collecting data on process and outcome metrics by physician and across the practice, which has spurred all of us on to continue to refine what we do to improve patient outcomes.”

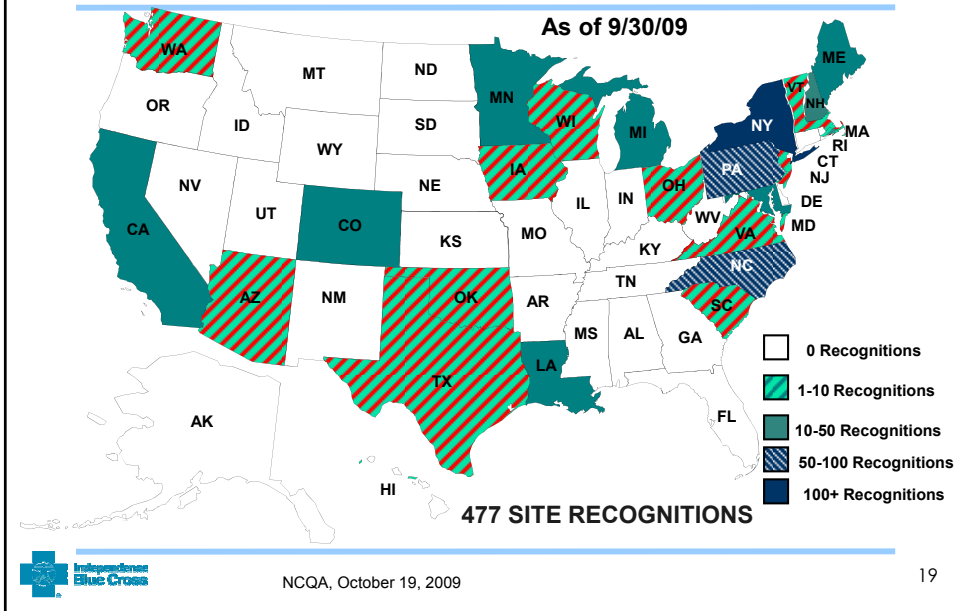
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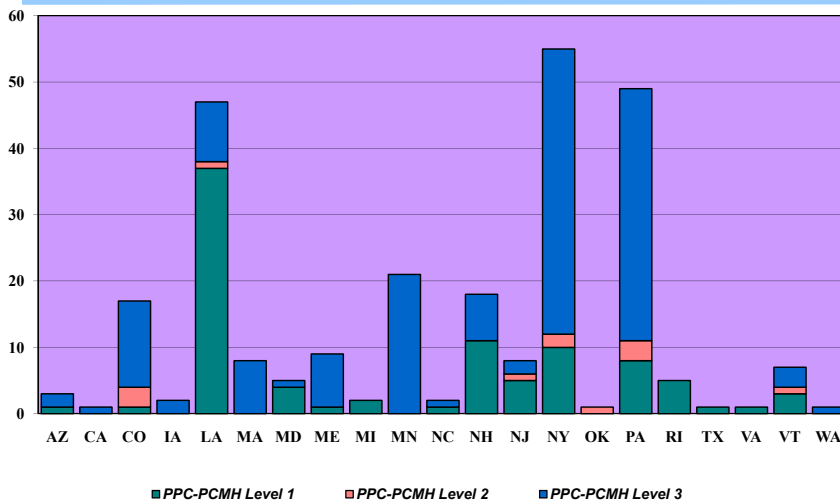
Statewide Implementation

- Additional regional rollouts planned
 - South-central Pennsylvania – Spring 2009
 - Southwest Pennsylvania – Summer 2009
 - Northeast Pennsylvania – Fall 2009
 - Northwest Pennsylvania – Fall 2009
 - North-central Pennsylvania – Fall 2009
 - Southeast Pennsylvania – Fall 2009
- } State Funding Only
- Currently over 750 physicians are participating across the Commonwealth
 - Over 1 million citizens seek care from these physicians

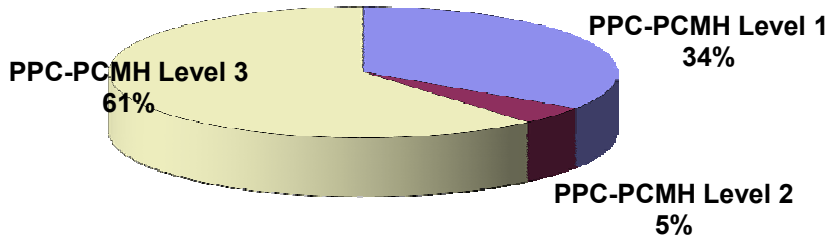
National Distribution of Recognized PPC & PPC-PCMH Sites



NCQA PPC-PCMH RECOGNIZED PRACTICES BY STATE (As of 9/30/09)



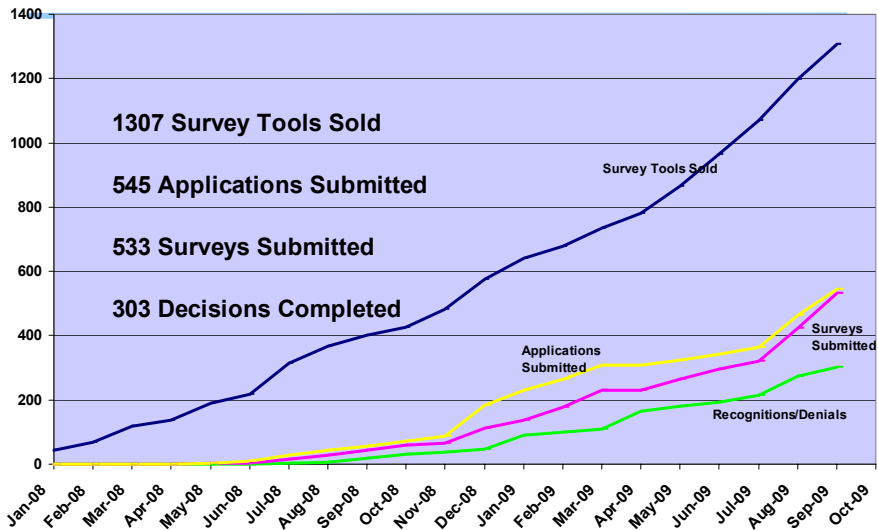
PERCENTAGE OF RECOGNITIONS BY PPC-PCMH LEVELS



NCQA, October 19, 2009

21

PPC-PCMH Accumulated Totals 9/30/09



NCQA, October 19, 2009

22

The PCMH in Health Care Reform

- Where does the PCMH fit into Reform?
 - Pilot to Mainstream transformation
 - Vertical integration
 - Accountable Care
- Opportunities
 - Federal
 - CMS
 - HHS
 - State
 - Local

23

Questions?

