

AOA-CAP and OCC, PQRI, and PCMH

Making sense of the Acronyms

American Osteopathic Association Informatics

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AOA Clinical Assessment Program

Goals - Update on the AOA-CAP

- Background
 - Update on AOA-CAP
 - Residency program
 - Physician Program
- Making this meaningful to the practicing physician
 - Patient Centered Medical Home
- Physician Quality Reporting Initiative
 - Background and results from 2008-9
 - Participation 2010
 - Transition of PQRI to MOC
- AOA-CAP and Osteopathic Continuous Certification
 - Evolving models of OCC
 - Examples of Boards

Purpose of AOA-CAP

- Graduate Medical Education organizations developed core competencies - mid decade
 - Practice Based Learning and Improvement
 - Understanding how care is being delivered and how to improve the care.
 - Systems Base Practice
 - Understand how to use resources within and outside of their practice to improve the outcomes of the patients they care for
- AOA-CAP Success
 - Professionally supported improvement program in residency training since 2000
 - Results

Purpose of AOA-CAP

- Support practicing physicians in quality improvement
 - CME quality improvement launched in 2007
 - Physicians Quality Reporting Initiative launched in 2008
 - Discussions with boards to satisfy Osteopathic Continuous Certification
 - Currently having discussions with
 - ABOFP
 - AOBOS
 - AOBOS
 - AOBD
 - AOBP

Using CAP to Improve Care

Registry approach

Excerpts From Manuscript accepted by the JAOA

- Fifty-two osteopathic family practice residency programs entered data into the AOA-CAP diabetes registry between July 1, 2005 and December 31, 2007 for a total of 2565 patient cases. Twenty three programs entering data once during the time frame (n=989) versus 29 programs entering data repeatedly (n=1576). The rate of performance in a composite rate of process measures was significantly higher in the repeated AOA-CAP users ($p=0.0023$). This was largely driven by improvements in ACE/ARB use in patients with albuminuria ($p=0.0087$). The rate of performance in a composite intermediate outcomes in diabetes care was not statistically significant between the two groups ($p=0.72$).

The Patient Centered Medical Home Defined

Joint Principals AOA, AAFP, AAP

- **Physician directed medical practice** – the personal physician leads a team of individuals who engage the patient in collectively improving health
- **Whole person orientation**
- **Enhanced Access**
 - Open access, off hour service
- **Care is coordinated and/or integrated across the continuum of care**
 - Chronic disease management using internal and external resources

Background

- Payment Centered Medical Home is a practice transformation that when done correctly improves patient outcomes, satisfaction and provider satisfaction and practice efficiency.
- Center of redefining primary care
 - Moving from episodic acute care to chronic disease management
 - In response to an aging population and increasing tools to manage chronic disease

Using a study to define the difference

- The STENO-2 study was a randomized clinical trial that demonstrated when people with diabetes received intensified attention to get them to goals they had much better outcomes.
 - Quality of life
 - Cost of care
- Perfect example of what the Patient Centered Medical Home could achieve if deployed correctly
 - Practice redesign
 - Payment reform

The effect of co-ordinated care on diabetics

- 80 Type 2 diabetic patients with microalbuminuria randomized to:
 - Control
 - Regular care
 - Intensive intervention
 - Step-wise introduction of lifestyle and pharmacological interventions aimed at keeping:
 - glycated hemoglobin <6.5%
 - blood pressure <130/80mmHg
 - total cholesterol <175mg/dl
 - and triglycerides <150mg/dl.
 - reduction in intake dietary fat regular exercise and smoking cessation.

Results of the STENO study

- Intermediate Outcomes
- Event Rate
 - End Points
 - death from CVD, nonfatal MI, nonfatal stroke, revascularization, and amputation.

	Control Group (n=80)	Intensive Treatment Group (n=80)
Glycosylated Hemoglobin < 6.5	3%	15%
Diastolic < 80 mm Hg	60%	70%
Systolic < 130 mm Hg	18%	50%
Total Cholesterol < 175mg/dl	22%	72%

Results

- Endpoints after 7.8 years of follow-up
 - 44% of patients in the conventional care arm had events
 - 24% of patients in the intensive treatment arm had events (significantly lower)
- In addition to the 53% reduction in CVD events the intensive treatment group had a reduction of nephropathy, retinopathy, and autonomic neuropathy by 61, 58, and 63% respectively

STENO Results

- When we develop a system that focuses on diabetic patients they:
 - Have less strokes, amputations, heart attacks and heart surgeries and death
 - Have higher quality of life
 - Less blindness, nerve loss, kidney loss
 - In this group of diabetics it halved the rate of these events
 - No new drug or treatment, just applying what we know works consistently and engaging the patient
 - Costs
- This is what the Patient Centered Medical Home can achieve
 - In DM and elsewhere

Implications of the Affordable Health Care for American Act

- 40 million Americans becoming insured
- Primary care enhanced payments
 - 10% payment increase
 - Focus on quality payments
 - Physician Quality Reporting Initiative
- Primary care training
- Key question
 - How to provide care for the marked increase in insured Americans
 - New practice model
 - Patient Centered Medical Home

Background

- Why the Patient Centered Medical Home
 - Current state of healthcare delivery
 - Shifting demographics
 - Episodic Care → Chronic Disease
 - Supportive Care → Active Management
 - Current state of primary care
 - History of investment
 - Resource-Based Relative Value Scale
 - Results of current model

Ohio PCMH Initiative

- Convened in Spring of 2009
- Developed a standard definition of the Patient Centered Medical Home
 - Consensus based process let by the State after concerns regarding adoption of the AOA, AAFP, ABIM, AAP definition
- Developed a list of objectives for the first year including
 - Defining PCMH through NCQA accreditation
 - Supporting and growing current projects
 - Incorporation of behavioral health focus
 - Information available at <http://www.healthcarereform.ohio.gov/Pages/default.aspx>

Ohio PCMH Initiative

- Current projects in Ohio
 - Cincinnati
 - Led by Bob Graham MD
 - Engaged 11 ‘pilots’ and 10 ‘copilots’ in transformation
 - » NCQA accreditation and Culture Change
 - Engaged payer commitment to cover 30,000 covered lives in a PMPM payment model when NCQA level 1 achieved
 - Columbus
 - Led by Access Health Columbus – Jeff Biehl
 - Convening payers and practices to launch a PCMH initiative in Columbus
 - » NCQA accreditation
 - Payers commence PMPM after practices achieve NCQA recognition

Cincinnati Practices, Insurers to Collaborate on Medical Home

Written by Leigh Page | September 07, 2010

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Three major insurers have agreed to pay 11 Cincinnati physician practices a set monthly amount to provide a patient-centered medical home in a pilot program for up to 10,000 patients, according to a report by the *Business Courier of Cincinnati*.

Anthem, UnitedHealthcare and Humana will pay \$5 to \$6 per patient per month in "care management" funds to the practices. The program, developed by Cincinnati's Health Improvement Collaborative, also gives the practices \$25,000 each to receive training in the medical home model.

The National Committee for Quality Assurance has accorded the practices Level III recognition as patient centered medical homes, the highest NCQA level. Several other Cincinnati practices are transitioning to the new model.

Under the medical home model, practices remind patients of services needed, measure clinical performance of physicians and set aside some appointments for same-day call-ins. They may also hire a care coordinator for patient outreach, following up after discharge from the hospital, for example.

Read the *Business Courier of Cincinnati* report on the [medical home](#).

What can you do now?

- Understand how your practice is performing
 - AOA-CAP of CME or PQRI
- Diabetes flow sheets
 - Checklists for preventive care
- Focus on treatment intensification (pharmacological)
 - Data from literature and CAP suggest that 30% of patients not at goal are due to 'physician inertia'
 - Rest are system or patient factors
- Engage your patients and the community in quality opportunities
 - Employers and patients

Physician Reporting Quality Initiative

- Update from Sharon McGill MPH
- Focus on regulatory language that enhances payment through MOC and provides an opportunity to have enhanced payment as well as certification

CMS' Physician Quality

Reporting Initiative

- Pay for reporting quality data through a claims-based or registry based system
- Beginning in 2011, an additional bonus payment of 0.5% will be added for physicians who participate in a MOC program required for board certification.

<u>Year</u>	<u>PQRI Bonus</u>	<u>+MOC</u>	<u>PQRI Penalty</u>
2008	1.5%		
2009	2.0%		
2010	2.0%		
2011	1.0%	1.5%	
2012-2014	0.5%	1.0%	
2015			1.5%
2016			2.0%



Osteopathic Continuous Certification

- Background
 - Use of practice performance assessment in continuous certification
 - Benefits
- Progress to date
- Expectations from boards
- Timelines

CAP and Osteopathic Continuous Certification

- Board certification and recertification process - *Practice Performance Assessment*
 - ABMS
 - ABIM
 - AAFP
 - ACS
 - AOA
 - Expectations by 2013
- State Licensure
 - Physicians not currently Board Certified

Progress to Date

- *AOA Board Certification programs with no interaction with AOA-CAP to date (some may be pursuing other programs (Surgery))*
 - *Anesthesiology – No activity*
 - *Neurology and Psychiatry – No activity*
 - *Neuromuskuloskeletal Medicine – No activity*
 - *Proctology - No activity*
 - *Surgery – No activity*

Progress to Date

- *Boards with discussions regarding type of support available from AOA-CAP and content expectations around OCC*
 - *Ophthalmology and Otolaryngology – Discussion*
 - *Pathology – Discussion*
 - *Internal Medicine - Discussion*
 - *Physical Medicine and Rehabilitation - Discussion*

Progress to Date

- *Boards with discussions regarding type of support available from AOA-CAP and content expectations around OCC – are evaluating other modules and methods of bringing in Practice Performance Assessment*
 - *Preventive Medicine – Discussion and initial plan for development – competing with allopathic*
 - *Nuclear Medicine – Discussion regarding potential modules – challenge of practice*
 - *Radiology – Discussion regarding potential modules*
 - *Emergency Medicine – Discussion regarding content and applicability – length of interaction*

Progress to Date

- *Boards which have made verbal commitment to AOA-CAP for OCC development and support*
 - *Dermatology – Preliminary measure selection, continued discussions*
 - *Orthopedic Surgery - Measure selection, discussions regarding scope of measure set, refinement of measure definitions*
 - *Family Practice - Content available, plan with AOBFP regarding roll out in initial and recertification*
 - *Pediatrics – Content available with 2 out of 3 measure sets vetted by clinical leadership groups, close to production at CECity*
 - *Obstetrics and Gynecology Surgery – Content develop by Board, reviewed with comments, close to production*

AOA-CAP and Boards LOA

- The Board would be responsible for the:
 - Nomination of clinical content areas and suggested measures within these areas.
 - Evaluation of structural, process and outcomes measures and determination of the proper mix for board certification - recertification
 - Setting the requirements for satisfaction for requirements for certification – re-certification relative to measure sets, volumes and other parameters. Development of timeline for roll out and integration of the PAM within the initial or recertification process.
 - Re-evaluation of clinical content and measure sets on an annual basis.

AOA-CAP and Boards LOA

- The American Osteopathic Association, through the Clinical Assessment Program, agrees to provide the Board services in the development of measure sets for clinician PAM including the following aspects:
 - Clinical focus of the PAM in terms of patient selection and project design including both retrospective and prospective approaches to completion of the PAM. Included would be the clinical homogeneity of the selected population.
 - Measure development and testing – Including
 - The assessment and characterization of evidence behind process of care measure (randomized clinical trials, observational studies / case studies, consensus opinion).
 - Synthesis of guidelines, if available, into measures
 - Development of risk stratification / risk adjustment for outcomes measures to provide a method of assessing practitioner performance after removal of the effect of patient factors on the outcome of interest.
 - Measure sensitivity and specificity in the relative to the attribute of performance the measure is designed to capture. This aspect may be sensitive to project design and anticipated strength of documentation.
 - Assessment of perceived opportunity gaps in current performance through literature, consensus development or pilot study.
 - Alignment of measure set with current national measurement projects including the CMS Physicians Quality Reporting Initiative, allopathic Board developed measure sets, National Quality Foundation, National Committee for Quality Assurance and other projects as identified by the Board or the AOA.
 - Measure reliability and validity within the context and science of quality improvement.

AOA-CAP and Boards LOA

- Development of a concise data dictionary providing practitioners instructions in patient selection, sampling techniques and data abstraction parameters for both types of project design.
- Abstraction tool development both hardcopy and electronic.
 - Testing of data dictionary and abstraction tool.
- Report development
 - Provide template of reports including measure construct and evidence base, comparative peer grouped data and, where available, benchmark information regarding performance.

AOA-CAP and Boards LOA

- Data Use and Confidentiality
 - The Board maintains ownership and authority for use of the data collected under the OCC program. This includes use for academic or commercial purposes. Requests for data use will be provided to the Board in a standard format from the AOA as received, information about the request will include requesting entity, stated purpose of use and assurance that data will be destroyed after purpose has been fulfilled. The identity of individual practitioners will be kept confidential through the use of an anonymous key within the database.

Summary

- A lot of activity in many area's impacting AOA-CAP
- Continued evaluation of membership value
- Activity and expectations of boards
 - Licensing boards
- Reimbursement
 - Value based purchasing and the patient centered medical home model