Key Performance Indicators
From Data Collection to Improved Patient Care

Presented by
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Disclaimer

I cannot claim the content of this material as all mine. I’ve simply gathered information from geniuses, experts and a variety of resources to present this information to you today. Use caution to apply your own research prior to implementing any changes in your own organization.

Liability with regard to errors, omissions, misuse, or misinterpretation lies with you, the beneficiary of my scavenger hunt. The handout is provided as a reference tool only, and should not be construed as a legally binding opinion.
Agenda

- Why bother?
- PQRS Overview
- Successful Reporting?
  - CMS Reports
  - Internal Reports
- The Next Step
  - Medical Home Model
- Bottom Line Results
Why Bother?

• CMS now considers itself to be a “passive payer”
  – current Medicare Physician Fee Schedule based on quantity and resources consumed, NOT quality or value of services

• Value-Based Purchasing will transform CMS into an “active purchaser”
Value-Based Purchasing

Value = Quality / Cost

Using payment incentives to encourage higher quality and avoidance of unnecessary costs, to enhance the value of care
Value-Based Purchasing

What is the Physician Feedback Program?

- The Physician Feedback Program provides comparative performance information to physicians.
- It is one part of Medicare’s efforts to improve the quality and efficiency of medical care by:
  - Helping CMS provide meaningful and actionable information to physicians so they can improve the care they furnish.

- Changing physician reimbursement to reward value rather than volume.
MEDPAC MODEL

Bottom

Performance

Top

$
MEDPAC MODEL

Performance

Bottom

Top

$
Move Towards Value-Based Purchasing

2007
- TRHCA
- 74 measures
- Claims-based only

2008
- MMSEA
- 119 measures
- Claims
- 4 Measures Groups
- Registry

2009
- MIPPA
- 153 measures
- Claims
- 7 Measures Groups
- Registry
- EHR-testing
- eRx

2010
- MIPPA
- 175 individual measures
- Claims
- 13 Measures Groups
- Registry
- EHRs
- eRx
- PQRI GPRO

2011
- TBD through rule-making

VBP
Analysis and Payment

Each year, the Physician Quality Reporting System incentive payment and the Physician Quality Reporting System feedback report are issued through separate processes. Physician Quality Reporting System feedback report availability is not based on whether or not an incentive payment was earned. Feedback reports will be available for every TIN under which at least one eligible professional (identified by his or her National Provider Identifier, or NPI) submitting Medicare Part B PFS claims reported at least one valid Physician Quality Reporting System measure a minimum of once during the reporting period. Physician Quality Reporting System participants will not receive claim-level details in the feedback reports.

Incentive Payments

Eligible professionals who satisfactorily report quality-measures data for services furnished during a Physician Quality Reporting System reporting period are eligible to earn an incentive payment equal to a percentage of the eligible professionals estimated total allowed charges for covered Medicare Part B Physician Fee Schedule (PFS) services provided during the reporting period.

Below are the authorized incentive payment amounts for each program year:

- 2010 Physician Quality Reporting System – 2.0%
- 2009 Physician Quality Reporting System – 2.0%
- 2008 Physician Quality Reporting System – 1.5%
- 2007 Physician Quality Reporting System – 1.5% subject to a cap

The Affordable Care Act authorized incentive payment through 2014:

- 2011 Physician Quality Reporting System – 1.0%
- 2012 Physician Quality Reporting System – 0.5%
- 2013 Physician Quality Reporting System – 0.5%
- 2014 Physician Quality Reporting System – 0.5%
PQRS Overview

- PQRI is one step in CMS’ implementation of Value-Based Purchasing

- The 2006 Tax Relief and Health Care Act (TRHCA) (P.L. 109-432) required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period).

- CMS titled the statutory program the Physician Quality Reporting Initiative (PQRI).
PQRS Overview

- PQRI was further modified as a result of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (Pub. L. 110-275) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110-275).

- In 2011, the program name was changed to Physician Quality Reporting System (Physician Quality Reporting).

- Eligible professionals who successfully report a designated set of quality measures on claims or via registries may earn a bonus payment based on their total allowed charges for covered Medicare physician fee schedule services. (2% in 2007)
PQRI Transition to P4P

- Payment incentive tied to how often a provider reports certain codes
- Overall value of service is not considered in this stage
- Will provide CMS with additional data needed to implement P4P
- Will transition providers into a quality reporting system
- Processes must be put in place to capture data
- Payment incentive for participation relatively small

- Payment incentive tied to quality/value of service provided
- Payment incentive much more significant
PQRS Measures

- CMS adopted 74 measures to be part of its PQRI program in 2007. This has grown to over 200 measures for 2012.

- Evidence-based

- Linked to quality of care

- Developed in conjunction with several national quality organizations
National Performance Measures
The CMS PQRI website has numerous educational materials, including Tip Sheets, Fact Sheets, FAQs, and materials from monthly PQRI National Provider Calls and other PQRI-related calls sponsored by CMS. You can also sign up for listservs here.
### Who Can Participate

<table>
<thead>
<tr>
<th>Doctor of Medicine</th>
<th>Doctor of Oral Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor of Osteopathy</td>
<td>Doctor of Dental Medicine</td>
</tr>
<tr>
<td>Doctor of Podiatric Medicine</td>
<td>Chiropractor</td>
</tr>
<tr>
<td>Doctor of Optometry</td>
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</table>

<table>
<thead>
<tr>
<th>Physician Assistant</th>
<th>Certified Nurse Midwife</th>
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</thead>
<tbody>
<tr>
<td>Nurse Practitioner</td>
<td>Clinical Social Worker</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>Clinical Psychologist</td>
</tr>
<tr>
<td>CRNA</td>
<td>Registered Dietician</td>
</tr>
<tr>
<td></td>
<td>Nutrition Professional</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Physical Therapist</th>
<th>Occupational Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Qualified Speech-Language Pathologist</td>
</tr>
</tbody>
</table>

All providers eligible to bill Medicare directly.
PQRS Measures

- Translate clinical actions so they can be captured in the administrative claims process

- Describe various aspects of care:
  - Prevention
  - Chronic Care Management
  - Acute Episode of Care Management
  - Procedural Related Care
  - Resource Utilization
  - Care Coordination
### 2012 Physician Quality Reporting System (Physician Quality Reporting) Measures List

The Physician Quality Reporting System (Physician Quality Reporting) measures were developed by various organizations for 2012. The following is a list of each measure, the measure developer, method of reporting available and contact information. Questions regarding the construct of a measure or its intent should be referred to the measure developer/contact as outlined in Appendix II (on page 33). Please note that gaps in measure numbering reflect retired 2007, 2008, 2009, 2010, and 2011 measures that are not included in 2012. This measure list is intended as a summary list to assist eligible professionals initially reviewing the measures and should not be used as a replacement for the measure specifications, which contain detailed reporting and coding instructions. A list of Physician Quality Reporting Measure Specifications where they can be found on the CMS website is listed in Appendix I (on page 32).

<table>
<thead>
<tr>
<th>#</th>
<th>NQF #</th>
<th>Measure Title &amp; Description</th>
<th>Measure Developer</th>
<th>Reporting Options/Methods</th>
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<tbody>
<tr>
<td>1</td>
<td>0059</td>
<td>Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus</td>
<td>NCQA</td>
<td>Claims, Registry*, EHR*, DM Measures Group (C/R), GPRO*</td>
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<td>0064</td>
<td>Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus</td>
<td>NCQA</td>
<td>Claims, Registry*, EHR*, DM Measures Group (C/R), GPRO*, Cardiovascular Prevention Measures Group (C/R)</td>
</tr>
<tr>
<td>3</td>
<td>0061</td>
<td>Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus</td>
<td>NCQA</td>
<td>Claims, Registry*, EHR*, DM Measures Group (C/R), GPRO*</td>
</tr>
<tr>
<td>5</td>
<td>0081</td>
<td>Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
<td>AMA-PCPI/ACCF/AHA</td>
<td>Registry*, EHR*, HF Measures Group (R), GPRO*</td>
</tr>
<tr>
<td>6</td>
<td>0007</td>
<td>Coronary Artery Disease (CAD): Antiplatelet Therapy</td>
<td>AMA-PCPI/ACCF/AHA</td>
<td>Claims, Registry*, EHR*, CAD Measures Group (R), GPRO*</td>
</tr>
<tr>
<td>7</td>
<td>0070</td>
<td>Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF &lt; 40%)</td>
<td>Registry*, EHR*</td>
<td></td>
</tr>
</tbody>
</table>
What Are PQRI Measures Groups?

- **4 or more individual measures** related to a clinical topic that have a common patient population specified in the denominator that is defined by diagnosis and/or encounter codes.

- **Measures Groups Specifications** are not the same as those for individual measures. Use the correct manual.

  - 2012 measures groups:
    - Diabetes Mellitus
    - Chronic Kidney Disease
    - Preventive Care
    - Coronary Artery Bypass Graft (CABG)
    - Rheumatoid Arthritis
    - Perioperative Care
    - Back Pain
    - Hepatitis C
    - Heart Failure (HF)
    - Cataracts
    - Coronary Artery Disease (CAD)
    - Ischemic Vascular Disease (IVD)
    - HIV/AIDS
    - Community-Acquired Pneumonia (CAP)
    - Asthma
    - Chronic Obstructive Pulmonary Disease (COPD)
    - Inflammatory Bowel Disease (IBD)
    - Sleep Apnea
    - Dementia
    - Parkinson’s Disease
    - Hypertension
    - Cardiovascular Prevention
PQRS MEASURE REPORTING

- Choose from national measures list

- Ideally select at least 3 measures
  - Consider measure groups

- Select a reporting method
  - With reimbursement claim
  - Qualified* Registry
  - Qualified* EHR

*Registries and EHR vendors must successfully complete a vetting process in order to be considered ‘qualified’ for PQRS
Understanding the PQRI Measures:

NUMERATOR
(clinical action required for performance)
\[
\frac{\text{NUMERATOR}}{\text{DENOMINATOR}}
\]

DENOMINATOR
(Describes eligible cases for which a clinical action was performed: the eligible patient population as defined by denominator specification)

Reporting Rate =
Performance Met + Performance Exclusions + Performance Not Met
Eligible Population
Measure Specifications

Quality Data Codes that make up the Numerator relay that either:

- The measure requirement was met

- The measure requirement was not met due to documented allowable performance exclusions (i.e., using performance exclusion modifiers 1P, 2P, or 3P)

- The measure requirement was not met and the reason is not documented in the medical record (i.e., using the 8P reporting modifier)
Exclusion (1P, 2P, 3P) and Reporting Modifiers (8P)

NOTE!!

- One or more exclusions may be applicable for a given measure
- Certain measures have no applicable exclusion/reporting modifiers
- Must refer to the measure specifications to determine the appropriate exclusion modifiers
PQRS Claims-Based Process

Visit Documented in the Medical Record

Encounter Form

Coding & Billing

Critical Step

N-365

Analysis Contractor

National Claims History File

Carrier/MAC

Confidential FB Report

Incentive Payment
Claims Based Reporting

- Codes will have a “$0.00” charge
- Codes must be submitted with original claim

NO SECOND CHANCES!
### Example Claim – CMS 1500

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Place of Service</th>
<th>CPT Code</th>
<th>Procedure Description</th>
<th>Charges</th>
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<td>07.10.07</td>
<td>21</td>
<td>4047F</td>
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<td>1100.00</td>
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<tr>
<td>07.10.07</td>
<td>21</td>
<td>4041F 1P</td>
<td></td>
<td>0.00</td>
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<td>07.10.07</td>
<td>21</td>
<td>4049F</td>
<td></td>
<td>0.00</td>
</tr>
</tbody>
</table>

- **CPT II Code for Antibiotic Timing Measure**: 4047F
- **CPT II Code for Antibiotic Discontinuation Measure**: 4041F 1P
- **CPT II Code for Antibiotic Selection Measure (with Modifier)**: 4049F
Registry Submission

- **What is a registry?**
  - Captures and stores clinically related data submitted to the registry by the EP
  - Registry submits information on PQRI individual measures or measures groups to CMS on behalf of EPs

- **CMS selects “qualified” registries annually**
  - Current list of *Qualified Registries for 2010 PQRI Reporting* is available at: http://www.cms.hhs.gov/PQRI/Downloads/QualifiedRegistriesPhase1Rvsd120709_1.pdf

- **Registries provide CMS with EPs’ calculated reporting and performance rates at the end of the reporting period**
  - Data must be submitted to CMS via defined XML specifications
CMS selects “qualified” EHR vendors annually

- Current list of *Qualified EHR Vendors for the 2010 PQRI and Electronic Prescribing Incentive Programs* (including the specific product(s) and version(s) that are qualified) is available at: http://www.cms.hhs.gov/PQRI/Downloads/QualifiedEHRVendorsRvsd01042010Final.pdf

- Using a qualified EHR, EPs submit raw clinical data to CMS and measures are calculated by CMS
Successful Reporting

- If 4 or more measures are applicable to the practice, practitioner must report **at least 3** of them correctly for **80 percent of cases if reporting via registry** or **50 percent if reporting via claims** (visits or patients, depending on measure).
Successful Reporting

- If 4 or more measures are applicable to the practice, practitioner must report at least 3 of them correctly for 80 percent of cases if reporting via registry or 50 percent if reporting via claims (visits or patients, depending on measure).
Successful Reporting

- If 4 or more measures are applicable to the practice, practitioner must report **at least 3** of them correctly for **80 percent of cases** if reporting via registry or **50 percent** if reporting via claims (visits or patients, depending on measure).

Applicable measures

Provider reports 80%

- 85%
- 78%
- 95%
- 98%
Prior to encounter
Identify all Medicare patients eligible for denominator
Prepare Medicare charts (perhaps by placing quality worksheet in chart)

Day of encounter
Pull charts-verify pts. are eligible, ensure chart is prepared

Patient/clinician encounter
Denominator inclusion met? Verify Dx’s, meds, fill out WS
Document quality data in chart, fill out WS with quality codes

Patient checkout
Review medical record, PQRI WS, encounter form documented, confirm accurate coding

After encounter
PQRI quality codes entered on claim
Claims sent to MAC/carrier
MAC/carrier processes claim with quality codes

PQRI data stored in Medicare NCH file

ICD-9-CM DX?
CPT I?
CPT Cat. II?
CPT Cat. II?
Keys to Ensuring Successful Reporting

- Start reporting early to increase the probability of achieving the 80 percent rate
- Consider reporting on more than the minimum three measures to increase the likelihood of achieving successful reporting
- Report on as many eligible patients as you can to decrease the probability of being subject to the bonus cap
- Ensure that quality codes are reported on the same claim as the diagnosis or CPT-I codes
- CMS will make reports available – be sure you have access to IACS
Keys to Ensuring Successful Reporting

- ...but don’t wait for them – CMS reports typically arrive 10 months into the new reporting period!

<table>
<thead>
<tr>
<th>NPI</th>
<th>NPI Name</th>
<th>Department</th>
<th>Earned Incentive.</th>
<th>Measures Eligible</th>
<th>Measures Reported</th>
<th>Measures Satisfactorily Reported</th>
<th>NPI Total Earned Incentive Amount</th>
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<tbody>
<tr>
<td>XXXXXXXX</td>
<td>Doctor 1</td>
<td>Department 1</td>
<td>No</td>
<td>Not participating</td>
<td>1</td>
<td>0</td>
<td>0</td>
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<tr>
<td>XXXXXXXX</td>
<td>Doctor 2</td>
<td>Department 2</td>
<td>Yes</td>
<td>Reported Satisfactorily</td>
<td>7</td>
<td>2</td>
<td>2</td>
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<tr>
<td>XXXXXXXX</td>
<td>Doctor 3</td>
<td>Department 2</td>
<td>Yes</td>
<td>Reported Satisfactorily</td>
<td>8</td>
<td>3</td>
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<tr>
<td>XXXXXXXX</td>
<td>Doctor 4</td>
<td>Department 2</td>
<td>Yes</td>
<td>Reported Satisfactorily</td>
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<td>4</td>
<td>4</td>
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<tr>
<td>XXXXXXXX</td>
<td>Doctor 5</td>
<td>Department 2</td>
<td>Yes</td>
<td>Reported Satisfactorily</td>
<td>15</td>
<td>4</td>
<td>4</td>
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<tr>
<td>XXXXXXXX</td>
<td>Doctor 6</td>
<td>Department 2</td>
<td>Yes</td>
<td>Insufficient # measures reported at 80%</td>
<td>12</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>XXXXXXXX</td>
<td>Doctor 7</td>
<td>Department 2</td>
<td>Yes</td>
<td>Insufficient # measures reported at 80%</td>
<td>10</td>
<td>3</td>
<td>2</td>
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</tbody>
</table>
Keys to Ensuring Successful Reporting

- ...but don’t wait for them – CMS reports typically arrive 10 months into the new reporting period!

<table>
<thead>
<tr>
<th>Measure</th>
<th>N</th>
<th>Y</th>
<th>Grand Total</th>
<th>Percent Reported</th>
<th>Measure Description</th>
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<tr>
<td>1</td>
<td>41</td>
<td>3147</td>
<td>3188</td>
<td>98.71%</td>
<td>1A - Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus</td>
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<tr>
<td>2</td>
<td>48</td>
<td>3144</td>
<td>3192</td>
<td>98.50%</td>
<td>2A - Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus</td>
</tr>
<tr>
<td>3</td>
<td>43</td>
<td>3149</td>
<td>3192</td>
<td>98.65%</td>
<td>3A - High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus</td>
</tr>
</tbody>
</table>

| Grand Total | 132 | 9440 | 9572 | 98.62% |
Blue Cross & Blue Shield rolls out new home program

Blue Cross & Blue Shield of Florida Inc. is rolling out a new patient-centered medical home program to provide comprehensive primary care partnerships between patients, their doctors and their families.

The new program initially will target chronic medical conditions with major health implications, such as diabetes, obstructive pulmonary disease, coronary artery disease, asthma and congestive heart failure.

“Health care reform has helped renew the focus on the quality and affordability of care,” said Dr. Jonathan Gavras, chief medical officer and senior vice president at Blue Cross & Blue Shield of Florida. “Our focus with [the program] is to establish collaborative relationships with physicians to improve the delivery of quality care for members throughout the state.”

To date, more than 1,500 primary care providers have enrolled in the program.
United Healthcare Ties Physician Payments to Quality

Last week, United Healthcare announced a new plan to incentivize physicians to reduce readmissions and encourage patients’ recommended screenings. New provider contracts are being rolled out nationally that include financial rewards for care they determine to be high-quality and efficient. In the documents sent to their employer clients in January, United outlined the changes it will make to its reimbursement system. United indicated it will increase the number of “value-based” contracts over the next few years so that between 50 to 70 percent of their commercially insured members could be affected by 2015. United stated that they plan to use a variety of approaches in their new contracts, using either a withhold or a bonus approach. Among the measures that could be tied to pay are readmissions, hospital-acquired infection rates, mortality rates for certain conditions, use of radiology services and patient satisfaction. These areas (in bold) are focus areas for FHA’s quality initiatives. United indicated it would be targeting higher volume hospitals and medical groups over the next couple of years. (Wall Street Journal, 2/10/12)
"This is their new big carrot and stick method."
The Medical Home Model
DIABETES RAPID ACCESS PROGRAM
D-RAP
THE DISEASE MANAGEMENT PROTOTYPE
### Diabetic Registry Patient Information

<table>
<thead>
<tr>
<th>Name</th>
<th>MRN</th>
<th>DOB</th>
<th>Sex</th>
<th>HBA1C At Start</th>
<th>1st A1C After Start</th>
<th>2nd A1C</th>
<th>3rd A1C</th>
<th>4th A1C</th>
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<tbody>
<tr>
<td>Aguilar, Denise</td>
<td>19112462</td>
<td>05/23/1953</td>
<td>F</td>
<td>8.5</td>
<td>8.2</td>
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<td>Allen, Augusta</td>
<td>16344965</td>
<td>05/2007</td>
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<td>8.8</td>
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<td>355739</td>
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<td>10.2</td>
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<td></td>
<td>11.9</td>
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<td>10.0</td>
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<td>658545</td>
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<td>F</td>
<td>12.1</td>
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<td>7.0</td>
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<td>12527365</td>
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<td>M</td>
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<td>6.5</td>
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<td>15.3</td>
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<td>10.5</td>
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<td>Base, Sandy</td>
<td>2228564</td>
<td>10/06/1943</td>
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<td>10.6</td>
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<td>Beatty, Camilla</td>
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<td>8.2</td>
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</tbody>
</table>

### Average HBA1C Results
- **At Start**: Average 10.9
- **1st A1C After Start**: Average 8.6
- **2nd A1C**: Average 8.7
- **3rd A1C**: Average 8.5
- **4th A1C**: Average 8.2
## Diabetes Registry

### Standard 2: **Patient Tracking and Registry Functions**

- **A.** Uses data system for basic patient information (mostly non-clinical data)
- **B.** Has clinical data system with clinical data in searchable data fields
- **C.** Uses the clinical data system
- **D.** Uses paper or electronic-based charting tools to organize clinical information**
- **E.** Uses data to identify important diagnoses and conditions in practice**
- **F.** Generates lists of patients and reminds patients and clinicians of services needed (population management)

<table>
<thead>
<tr>
<th>Patient name</th>
<th>Date of Birth</th>
<th>SEX</th>
<th>MRN</th>
<th>Date A1C</th>
<th>LDL</th>
<th>CK</th>
<th>Date A1C</th>
<th>LDL</th>
<th>CK</th>
<th>Date A1C</th>
<th>LDL</th>
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<td>N/D</td>
<td>12/20/07</td>
<td>6.4</td>
<td>N/D</td>
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</tbody>
</table>

**Averages:**
- 9.2 ± 138
- 8.2 ± 125
- 7.8 ± 118
National A1c Average – 7.7

**Standard 8: Performance Reporting and Improvement**

A. Measures clinical and/or service performance by physician or across the practice**

B. Survey of patients’ care experience

C. Reports performance across the practice or by physician**

D. Sets goals and takes action to improve performance

E. Produces reports using standardized measures

F. Transmits reports with standardized measures electronically to external entities

Diabetes Results

![Average A1C Result Per Office Chart]
Diabetes Results

**Graph 1:** Overall baseline characteristics of participants and data analysis by gender.

Number of Participants – 457; Males – 157, Females - 300
Graph 2: Changes in Hemoglobin A1c by Clinic Location.

Number of Participants – 457;
Brentwood – 64, College Park – 49, Commonwealth – 50,
Eastside – 126, Murray Hill – 141, Soutel – 27
Diabetes Results

Graph 3: Race-related differences in Hemoglobin A1c levels.

Number of Participants – 457;
African American – 280, Caucasian – 162, Other – 15
The Medical Home Model

A primary care practice that provides patients with care that is:

1. Accessible
2. Continuous
3. Coordinated
4. Patient-centered
5. Physician-guided
6. Cost efficient
7. Longitudinal
# NCQA Medical Home Recognition

<table>
<thead>
<tr>
<th>Standard 1: <strong>Access and Communication</strong></th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Has written standards for patient access and patient communication**</td>
<td>4</td>
</tr>
<tr>
<td>B. Uses data to show it meets its standards for patient access and communication**</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 2: <strong>Patient Tracking and Registry Functions</strong></th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Uses data system for basic patient information (mostly non-clinical data)</td>
<td>2</td>
</tr>
<tr>
<td>B. Has clinical data system with clinical data in searchable data fields</td>
<td>3</td>
</tr>
<tr>
<td>C. Uses the clinical data system</td>
<td>3</td>
</tr>
<tr>
<td>D. Uses paper or electronic-based charting tools to organize clinical information**</td>
<td>6</td>
</tr>
<tr>
<td>E. Uses data to identify important diagnoses and conditions in practice**</td>
<td>4</td>
</tr>
<tr>
<td>F. Generates lists of patients and reminds patients and clinicians of services needed (population management)</td>
<td>3</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Standard 3: <strong>Care Management</strong></th>
<th>Pts</th>
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</thead>
<tbody>
<tr>
<td>A. Adopts and implements evidence-based guidelines for three conditions **</td>
<td>3</td>
</tr>
<tr>
<td>B. Generates reminders about preventive services for clinicians</td>
<td>4</td>
</tr>
<tr>
<td>C. Uses non-physician staff to manage patient care</td>
<td>3</td>
</tr>
<tr>
<td>D. Conducts care management, including care plans, assessing progress, addressing barriers</td>
<td>5</td>
</tr>
<tr>
<td>E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities</td>
<td>5</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Standard 4: <strong>Patient Self-Management Support</strong></th>
<th>Pts</th>
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</thead>
<tbody>
<tr>
<td>A. Assesses language preference and other communication barriers</td>
<td>2</td>
</tr>
<tr>
<td>B. Actively supports patient self-management**</td>
<td>4</td>
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</table>

<table>
<thead>
<tr>
<th>Standard 5: <strong>Electronic Prescribing</strong></th>
<th>Pts</th>
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</thead>
<tbody>
<tr>
<td>A. Uses electronic system to write prescriptions</td>
<td>3</td>
</tr>
<tr>
<td>B. Has electronic prescription writer with safety checks</td>
<td>3</td>
</tr>
<tr>
<td>C. Has electronic prescription writer with cost checks</td>
<td>2</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 6: <strong>Test Tracking</strong></th>
<th>Pts</th>
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</thead>
<tbody>
<tr>
<td>A. Tracks tests and identifies abnormal results systematically**</td>
<td>7</td>
</tr>
<tr>
<td>B. Uses electronic systems to order and retrieve tests and flag duplicate tests</td>
<td>6</td>
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</table>

<table>
<thead>
<tr>
<th>Standard 7: <strong>Referral Tracking</strong></th>
<th>PT</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Tracks referrals using paper-based or electronic system**</td>
<td>4</td>
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<table>
<thead>
<tr>
<th>Standard 8: <strong>Performance Reporting and Improvement</strong></th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Measures clinical and/or service performance by physician or across the practice**</td>
<td>3</td>
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<tr>
<td>B. Survey of patients' care experience</td>
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<tr>
<td>C. Reports performance across the practice or by physician **</td>
<td>3</td>
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<tr>
<td>D. Sets goals and takes action to improve performance</td>
<td>3</td>
</tr>
<tr>
<td>E. Produces reports using standardized measures</td>
<td>2</td>
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<tr>
<td>F. Transmits reports with standardized measures electronically to external entities</td>
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<thead>
<tr>
<th>Standard 9: <strong>Advanced Electronic Communications</strong></th>
<th>Pts</th>
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<tr>
<td>A. Availability of Interactive Website</td>
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<tr>
<td>B. Electronic Patient Identification</td>
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<tr>
<td>C. Electronic Care Management Support</td>
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</table>

**Must Pass Elements**
The Patient-Centered Primary Care Collaborative

Providers
- ACP
- AAFP
- ABIM
- ACOI
- AAP
- AOA
- ACC
- AHI

Purchasers
- IBM
- General Motors
- FedEx
- General Electric
- Pfizer
- Microsoft
- Business Coalitions
- Merck

Payers
- BCBSA
- United
- CIGNA
- WellPoint
- Aetna
- Humana
- HCSC

Patients
- NCQA
- AFL-CIO
- National Partnership for Women and Families
- Foundation for Informed Decision Making
- SEIU
Resources Used:

- Dr. Fred Edwards - Professor and Chief, Cardiothoracic Surgery
  University of Florida / Shands Jacksonville
  Chairman, The Society of Thoracic Surgeons National Database
- http://www.cms.hhs.gov/PQRI/
- PQRI National Provider Calls presented by CMS Medicare Learning
  Network
- Dr. Kenyatta Lee – Clinical Director, Community Clinics Department
  University of Florida / Shands Jacksonville

Credentials:

- Melissa holds a Bachelor of Science degree in Health Information Management from the Medical College of Georgia and a Masters degree in Business Administration. She passed the American Health Information Management Association’s standardized exam to earn the credentials of Registered Health Information Administrator. She has also successfully passed the AAPC’s exam and selection process to earn recognition as a Certified Professional Coder, Certified Family Practice Coder and an Approved Physician Medical Coding Curriculum Instructor. To maintain her credentials, Melissa completes courses and research to earn continuing education units annually. Melissa currently serves on the AAPC Chapter Association Board of Directors. She has 19 years experience in interpreting Medicare and other regulatory guidelines and applying the rules to coding and billing situations.
Questions...?