

Consumer-Purchaser  
**DISCLOSURE**  
**PROJECT** Improving Health Care Quality through Public Reporting of Performance

July 2, 2010

Margaret E. O'Kane  
President  
NCQA  
1100 13th St., NW Suite 1000  
Washington, D.C. 20005

**RE: Comments on NCQA's Patient-Centered Medical Home 2011 Draft Standards**

Dear Ms. O'Kane,

The Consumer-Purchaser Disclosure Project is an initiative that is improving health care quality and affordability by advancing public reporting of provider performance information so it can be used for improvement, consumer choice, and payment. The Disclosure Project is a collaboration of leading national and local employer, consumer, and labor organizations. We appreciate the opportunity to comment on NCQA's Patient-Centered Medical Home 2011 Draft Standards. We are very supportive overall of NCQA's proposed standards and elements for medical homes, and we applaud NCQA's work in greatly strengthening its requirements around medical home capabilities, while at the same time recognizing the current limitations that practices face. The following are our thoughts on how the proposed standards can be further refined to better ensure that medical homes are truly patient-centered.

**Improvements that can be made across standards**

We believe that NCQA needs to amend or clarify some of the terms that it uses throughout its proposed standards. The proposed PCMH 2011 refers only to "patients/families," which does not reflect the fact that some caregivers are not family members. We recommend using "patient/caregiver" as the standard term instead. This is notable particularly in element 1E, on which we provide comments below. We support this element, but feel that the terminology should be changed from "family" to "caregiver." Along these lines, we also believe that practices should ask patients who they want to involve in their care, and this information should be recorded and respected. Also, the term "vulnerable populations" is used in the standards documents, but this may mean different things to different parties. We suggest that NCQA articulate what "vulnerable populations" means in the context of the PCMH 2011.

Currently, we feel that the scoring system is unclear, based on the information provided in the public comment documents. We hope that the scoring system achieves full transparency before the PCMH 2011 is finalized. On the same note, we encourage NCQA, as it considers how to score these various elements, to require that practices fulfill 100% achievement of the HIT and patient experience elements in order to receive certification.

**Specific Comments on Key Recognition Program Design Issues**

Below are our thoughts on how to strengthen specific proposed standards as well as responses to questions that NCQA has posed regarding its PCMH program.

#### Health Information Technology (HIT) and Alignment with Meaningful Use:

Consumers and purchasers strongly support NCQA's inclusion of HIT requirements that will align with what we hope will be the final CMS "meaningful use" requirements related to the PCMH. We strongly urge NCQA to require practices to meet these HIT requirements in order to receive the medical home certification. To be truly patient centered, medical homes must effectively adopt and use HIT. These technologies enable a medical team to provide the coordinated care that is a central benefit of the patient-centered medical home. We are very supportive of the HIT related elements including those listed in IC, 2A, 2B, 3D, 5A, and 5B.

Finally, we suggest NCQA look beyond the meaningful use criteria, and include other HIT-related elements that were not proposed in the CMS meaningful use definition, such as requiring the use of patient-specific educational materials as recommended by the HIT Policy Committee. Rather than viewing the meaningful use definition as an end point, we would recommend NCQA view it as a starting point, and explore other innovative ideas that were approved by the HIT Policy Committee for inclusion.

#### Optional Module for Use of Patient Standardized Patient Experience Survey:

We are encouraged that NCQA has incorporated patient experience into its medical home standards. However, we believe it is critical that the patient experience module should not be optional. NCQA should require practices to survey their patients using the core Clinician and Group CAHPS survey, so that the information collected can be compared across practice settings. This would allow for public reporting of patient experience immediately, both at the individual and practice level. We would also strongly suggest that NCQA add a qualitative component to the patient experience survey that would require practices to complete at least one qualitative feedback element, including focus groups, individual interviews, patient walk-throughs, or suggestion boxes, as described in element 6B, number 5. Another feedback method that we would suggest adding to that list is the development of patient/family advisory councils.

We understand that the expense of administering patient experience surveys may be prohibitive for some practices. NCQA could work with other organizations that have identified alternative lower cost models (e.g., Massachusetts Health Quality Partners, Consumers' CHECKBOOK, and the American Board of Internal Medicine) to help these practices overcome these cost barriers. Finally, as NCQA designs the scoring methodology for the recognition criteria, we strongly encourage that these particular elements be considered "must do/must pass."

#### 1A: Access During Office Hours

As currently written, NCQA allows practices to decide what is "timely" when it comes to the following standard, with the following statement: "Provides timely clinical advice by phone or email-during office hours." We strongly believe that NCQA, and not individual practices, should define what "timely" means. For example, the California's Department of Managed HealthCare's Timely Access Regulations requires that telephone calls to doctors' offices have to be returned within 30 minutes. Having a robust definition of timeliness will ensure that consumers get care from their primary providers, rather than being forced to go to an emergency room to get care quickly.

#### 1C: Electronic Access:

We strongly believe that patients should have full access to their health information in an electronic and timely manner. To strengthen this section, NCQA should require that practices demonstrate that patients have electronic access to their lab results; information is portable for patients and their caregivers; and patients receive an electronic copy of health information within 48 hours of request (which would align with proposed meaningful use requirements).

### 1E: Patient/Family Partnership

We applaud the requirement that practices will need to inform their patients about what a patient-centered medical home is. When explaining the role of the patient in the medical home, practices should share that the patient is a part of the care team. Practices should also share with patients what the patient's care team is responsible for (e.g., coordinated care, providing the patient with timely and electronic access to health information, whole person care, etc.). Also, as noted in our general comments above, the term "family" should be changed to "caregiver," so as to be inclusive of any person the patient wants involved in shared decision-making.

### 1F: Practice Organization

A proposed requirement in this section is "care team staff assigned and trained in communication skills with vulnerable populations." We believe that care team staff should be trained to communicate with all patient populations, although training for vulnerable populations may require additional elements (e.g., motivational interviewing and health coaching, training in cultural competency, etc.).

### 2A: Basic Data

We applaud NCQA's requirements that practices collect race, ethnicity, language, and gender data. When data are stratified by these considerations they should be used to address disparities, as NCQA recognizes in 6A: Measures of Performance.

### 2C: Comprehensive Health Assessment

In this section, practices importantly must complete assessments of various care areas. To strengthen this section, we suggest that NCQA require the use of a standardized tool in every care area – where there is a preponderant use of a validated tool – to facilitate comparisons across providers. For example, the PHQ-9 is typically used for screening for depression. This should also apply to the assessment tools listed in 4A: Self-Care Process. We are encouraged that NCQA includes "functional status" as part of the comprehensive health assessment, but this could be strengthened by requiring practices to also assess and document "change in functional status" to better understand whether the care provided is making a difference for patients.

### 3C: Medication Management

We strongly support the need for medication management. We believe that this section can be improved by requiring a practice to do more than monitor patient fill and refill data. The practice should capture whether patients are filling their prescriptions as well as whether necessary follow-up by practice staff is occurring in cases where prescriptions are going unfilled.

### 5A: Test Tracking and Follow-up

We question why NCQA is planning to delete "generates alerts for appropriateness of tests order." This appears to be an important element of patient-centered care, but there is no supporting information for why removal is being considered.

### 6A: Measures of Performance

We are concerned that practices are only required to monitor performance results for one measure of overuse, when there are multiple measures available on which practices can be evaluated. Overuse not only results in poor value of care but can be potentially harmful to patients (e.g., radiation from unnecessary MRIs). We would strongly recommend that there be at least three measures of overuse.

We suggest that practices also be required to monitor re-admissions and medication errors, both of which reflect patient safety as well as quality of care.

#### 6B: Patient/Family Feedback

In response to the requirement that the “practice conduct a survey to evaluate patient experiences,” we believe that patient experience surveys should be conducted at the level of the individual provider (e.g., each physician). Patient experience should capture how well individual providers care for their patients, based on research which shows that physicians account for the largest proportion of explainable system-level variation across all patient experience measures, as well as the most variation for measures assessing the quality of physician-patient interactions (see Rodriguez et al, *Attributing Sources of Variation in Patients’ Experiences of Ambulatory Care, Medical Care*, Vol. 47, No. 8, August 2009). Also, having data at the individual provider level facilitates patient choice; while physicians in a medical home may operate as a team, patients will still be selecting physicians on an individual basis to be a part of their care team. As always, all feedback data should be stratified by race, ethnicity, language, gender.

As we noted above in our comments regarding the use of the patient experience survey, we believe NCQA should require use of a standardized survey (i.e., CAHPS Clinician & Group Survey) to facilitate comparisons across providers. In addition to making it a requirement, we strongly urge that it be mandatory that practices obtain feedback from patient through qualitative means, as well as quantitative measures.

#### 6D: Electronic Reporting Performance Measures

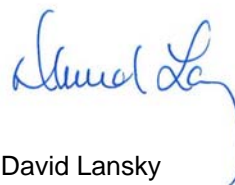
We strongly support having a practice be “transparent about its results on nationally approved performance measures.” Results should be electronically transmitted to the public sector, health plan, or others, as well as available to consumers and patients, and information shared with consumers and patients should be displayed in a format that is understandable and digestible by consumers. As noted several times in our comments, we believe NCQA should require that data be available at not just the practice level but the individual provider level (e.g., physician). Patients need information on individual provider performance. Physicians in a medical home may operate as a team, but patients will still need to select physicians on an individual basis to be a part of their care team.

On behalf of consumers and purchasers across the country, thank you for your consideration of our comments. If you have any questions, please don’t hesitate to contact either of the Disclosure Project’s co-chairs.

Sincerely,



Debra L. Ness  
President  
National Partnership for Women & Families



David Lansky  
President & CEO  
Pacific Business Group on Health