

# The New York State Adirondack Medical Home Demonstration

**REPORT TO THE LEGISLATURE  
JUNE 2014**

New York State Department of Health  
Office of Quality and Patient Safety  
Division of Performance Improvement and Patient Safety



**Department  
of Health**

## EXECUTIVE SUMMARY

A Patient Centered Medical Home (PCMH) is a model of care in which each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team is responsible for meeting the patient's primary care needs and coordinates appropriate care with other providers when needed. PCMH concepts were jointly developed by the American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association to modernize and transform primary care by improving access, quality, and care coordination as well as decrease unnecessary utilization and costs. This model incorporates advanced health information technology and revolves around evidence-based findings on preventive and chronic care coordination services provided by care teams.

From 2006 to 2007, the Adirondack region of upstate New York lost about 25 primary care physicians. Losing medical professionals had been an on-going issue for this region, with an already small base of primary care physicians. The community and the health care workforce in the Adirondacks viewed this not only as a crisis, but also as an opportunity to make a change. The PCMH model was selected as the best way to improve primary care for both professionals and patients in the region.

In an effort to better coordinate care through increased PCMH-recognized medical practices in New York State (NYS), the Governor signed legislation that allowed for the development of incentive programs. One such program authorized a multi-payer approach to assist the reform and modernization of the primary care system in the Adirondacks. This initiative, known as the Adirondack Medical Home Multi-payer Demonstration, or the 'ADK demonstration,' was also expected to result in long-term savings by promoting primary care services that help patients stay healthy, reduce the complications associated with chronic diseases, and avoid potentially preventable admissions.

Article 29, Title 2, Section 2959 of NYS Public Health Law provided the Commissioner of Health with the authority to establish a multi-payer medical home demonstration in the Adirondack region of NYS. Under the supervision of the New York State Department of Health (NYS DOH), NYS Medicaid, along with seven other payers, agreed to provide financial support to the majority of providers in six counties in the Adirondacks (Hamilton, Franklin, Clinton, Essex, Warren, and northern Saratoga) to become recognized by the National Committee for Quality Assurance (NCQA) as PCMHs and transform their practices, including introducing electronic health records (EHRs). Payers agreed to reimburse participating medical home providers an additional \$84 per member per year (PMPY) in enhanced payments. Medicare became the ninth payer in July 2011 through the Centers for Medicare and Medicaid Services (CMS) Multi-payer Advanced Primary Care Practice initiative.

Multiple evaluations have been performed on overall quality of care, patient satisfaction, provider experience, utilization, and total cost of care to evaluate the effectiveness of the

demonstration since the beginning of the pilot. These evaluations, carried out by the NYS DOH, participating payers, and private consultants, have generally shown improvements across all domains. For example, important preventive services such as childhood immunization rates for two-year-old children improved from 2012 to 2013 (hepatitis A, hepatitis B, influenza, measles, mumps and rubella, and varicella zoster virus). Analyses from independent evaluators show that the total cost of care per member per month (PMPM) decreased for all payers from 2012 to 2013 and overall patient satisfaction with their care improved from 76 percent to 81 percent. In 2011 and 2013 provider satisfaction surveys were distributed and providers rated their overall experience with the ADK demonstration highly for both surveys. The demonstration has also served to expand the primary care workforce in the region, attracting and retaining 16 more primary care physicians as well as allowing for practices to begin hiring care management staff. Additional analyses may be beneficial to further understand trends and findings presented in this report.

The ADK demonstration was scheduled to conclude at the end of 2014; however, legislation passed in 2012 authorizes the establishment of multi-payer demonstrations anywhere in the state which by extension permits the ADK to continue. At this time, Medicaid and Medicare have committed to continue participating through the end of 2016. All other payers have agreed to continue participation until the end of 2016, although some of the terms of participation may change based on discussions currently in progress.

## BACKGROUND

### *Patient-Centered Medical Home*

The American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, and the American Osteopathic Association, have jointly defined the PCMH as a model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team, which may include roles for nurse practitioners, registered nurses, physician assistants, social workers, and care managers, is responsible for providing for all the patient's health care needs and arranges for appropriate care with other qualified physicians and community resources when necessary.

A PCMH also emphasizes enhanced care through open scheduling, expanded hours, and communication between patients, providers, and staff. Care is also facilitated by disease registries, information technology, health information exchange among providers, and other means to ensure that patients obtain the proper care in a culturally and linguistically appropriate manner.

The NCQA designed a recognition program to objectively measure the degree to which a primary care practice meets the operational principles of a PCMH. NCQA's PPC-PCMH™ and PCMH 2011 programs assess whether practices are functioning as medical homes. Building on

the joint principles developed by the primary care specialty societies, the PPC-PCMH™ and PCMH 2011 standards emphasize the use of systematic, patient-centered, coordinated care management processes.

NCQA's PPC-PCMH's™ medical home standards were first released in 2008 with the second, strengthened version published in 2011 ("PCMH 2011"). A third set of standards was released in 2014 ("PCMH 2014"). Health Information Technology (HIT) implementation and behavioral health integration within primary care continue to remain areas of importance, as well as focusing on coordination with community resources and non-primary care specialists to ensure person-centered care.

For more information about NCQA's PCMH program please visit:

<http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx>

Additional information about the differences between 2008, 2011, and 2014 NCQA PCMH standards is available at:

<http://www.ncqa.org/portals/0/programs/recognition/ppc-pcmh%202008%20vs%20pcmh%202011crosswalk%20final.pdf>

<http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH/PCMH2011PCMH2014Crosswalk.aspx>

### ***Patient Centered Medical Home in New York State Medicaid***

There are two PCMH programs operating within New York's Medicaid program: the Statewide PCMH program and the ADK demonstration. Article 5, Title 11 of the New York State Social Services Law, section 364-m, enabled the Commissioner of Health to provide enhanced reimbursement to NCQA-recognized PCMH providers who participate in Medicaid fee-for-service (FFS) and Medicaid managed care (MMC), which is known as the Statewide PCMH program. The program was implemented in 2010 and is still operational. In October 2011, the NYS DOH expanded the program to include Child Health Plus (CHP) under a separate law: Article 29 AA, Section 2959. For more information on the Statewide PCMH program, please visit the NYS DOH Medicaid Redesign Team (MRT) website:

[http://www.health.ny.gov/health\\_care/medicaid/redesign/pcmh.htm](http://www.health.ny.gov/health_care/medicaid/redesign/pcmh.htm)

The authority to establish multi-payer demonstrations was afforded through Article 29, Title 2, Section 2959 of NYS Public Health Law. The most notable differences between the Statewide and ADK demonstration programs are: 1) ADK is a multi-payer program, while the Statewide program is specific to NYS Medicaid, 2) ADK operates in a specific geographic region, while the Statewide program provides financial incentives to providers throughout NYS, and 3) the payers involved and amounts of enhanced payments given to PCMH-recognized practices differs by PCMH program. Providers participating in ADK are excluded from the Statewide program initiative with respect to incentive payments. In 2014, the ADK was subsumed under Public

Health Law 2959A, giving the Commissioner of Health the authority to establish multi-payer demonstrations throughout NYS.

In 2009, the NYS DOH submitted a State Plan Amendment (SPA) for the ADK demonstration, seeking approval to provide enhanced payments to PCMH providers for providing primary care services to MMC and FFS Medicaid recipients in the Adirondacks. CMS approved the SPA in 2010 with a retroactive effective date of January 1, 2010, which was the official start date of the demonstration.

In 2011, CMS implemented the Multi-payer Advanced Primary Care Demonstration Program (MAPCP), a national project that allowed Medicare to join with other commercial and public payers to support the transformation of care in already-existing state multi-payer demonstrations in eight states, including New York's ADK demonstration. The other states CMS is participating in are: Maine, Vermont, Rhode Island, Pennsylvania, North Carolina, Michigan, and Minnesota. Medicare's participation in New York's multi-payer demonstration began on July 1, 2011. While originally planned to conclude after three years, CMS extended its participation twice, originally through 2014 and most recently to the end of 2016.

### *Inception of the Adirondack Medical Home Demonstration*

The ADK demonstration operates in a highly rural area, with a high proportion of older adults. With the exception of southwest Florida, the Adirondacks has a higher population density of people over the age of 65 than any other region in the country.<sup>1</sup> This results from younger people leaving the region, largely due to lack of job opportunities and an underdeveloped-business economy. Additionally, residents of this geographic area largely suffer from poverty and poor health. In comparison to other regions of NYS, individuals within this service area are more likely to have lower wage income, live in poverty, have a disability, and lack health insurance coverage.<sup>1</sup>

The health care system in this region is similar to others in rural areas with limited choices of providers and little competition. There are five hospitals in the region with fewer than 550 beds in total. Consequently, it is difficult to attract and retain physicians in this community and the Adirondack region is designated as a Federal Health Professional Shortage Area.<sup>1</sup> The region's inability to attract and retain a primary care workforce was the driving factor initiating the five-year ADK demonstration. The primary goals of the project are to strengthen the region's ability to attract and retain primary care physicians by improving quality of life, increasing income, and transforming primary care delivery system by improving continuity and quality of care.

In the Adirondack region, about half of the population is insured by public payers (Medicaid and Medicare) with the other half largely covered by the seven private insurance carriers that are participating in the ADK demonstration: Excellus, The Empire Plan (United Healthcare), Fidelis,

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<sup>1</sup> The LA Group, P.C. Adirondack Park Regional Assessment Project Executive Summary. Adirondack Association of Towns and Villages website. <http://aatvny.org/content/Generic/View/1:field=documents;/content/Documents/File/16.pdf>. May 2009. Accessed January 19, 2011.

Empire Blue Cross, Blue Shield of Northeastern New York, the Mohawk Valley Plan (MVP), and Capital District Physicians' Health Plan (CDPHP). Medicare joined the demonstration through MAPCP in July 2011. After several months of collaborative planning, Medicaid and the other commercial payers entered into an agreement to provide an additional \$7 PMPM to transform the health care system in this region. As part of that transformation, the providers were required to achieve NCQA's Level 2 or 3 recognition as PCMHs and implement EHRs in all practices, which would "populate" a clinical data warehouse. The payers are responsible for submitting their claims/encounter data to a data warehouse as well.

## DEMONSTRATION STRUCTURE AND GOVERNANCE

### *Pods & Practices*

In the ADK demonstration, physician practices are held to a series of performance benchmarks. This is to hold practices accountable for implementing medical home concepts and to ensure the funding given to the providers is used to achieve desired outcomes in patient care within three non-competitive sub-regional groups. These three groups follow the region's natural geographic alignments and are known as 'pods.'

Pod 1: Tri-Lakes Region - overseen by the Adirondack Health Institute

Pod 2: Lake George Region - overseen by Hudson Headwaters Health Network

Pod 3: Plattsburgh Region - overseen by Champlain Valley Physician's Hospital's medical services organization

These governance pods were created to support participating physicians, including many disparate and unaffiliated practices, throughout the project. Pods are responsible for providing local, physician-directed governance for the clinicians to help support and facilitate the transitions necessary to become and maintain recognition as a PCMH. Additionally, the pods provide assistance with EHR implementation, assist with care coordination projects, complex case management, and care transition management.

Individual practice sites are primarily responsible for the implementation of their EHR systems, electronic prescribing, creating and maintaining registries, applying for and achieving PCMH recognition, improving access for patients, developing team-based care systems, tracking referrals, reengineering current practice workflow, and improving chronic disease management. To cover expenses of the shared responsibilities and services, parts of the enhanced payment providers receive from the participating payers are allocated to four different pools:

1. \$2.90 PMPM remains with the primary care practices as increased compensation
2. \$3.00 PMPM goes to the local pod to support shared services such as case management and the administration of the program
3. \$0.60 PMPM goes to the Adirondack Health Institute (described below) to support the overall project governance, management, data, and evaluation

4. \$0.50 PMPM goes towards a pay-for-performance initiative that is administered by the Adirondack Health Institute

### ***Adirondack Health Institute***

The Adirondack Health Institute (AHI) is a joint venture of Adirondack Health, Community Providers, Inc., Glens Falls Hospital, and Hudson Headwaters Health Network that covers the same service area as the ADK demonstration. AHI works with local providers and organizations through the coordination of planning, recruiting, clinical activities, outreach, and managing of grant-supported programs to help address challenges and changes in the health care industry. Additionally, AHI provides a variety of central services to support the ADK demonstration including governance and oversight of the pods in the project. Also, AHI oversees a number of ADK evaluations as well as the demonstration's pay-for-performance (P4P) program.

### ***Health Information Technology***

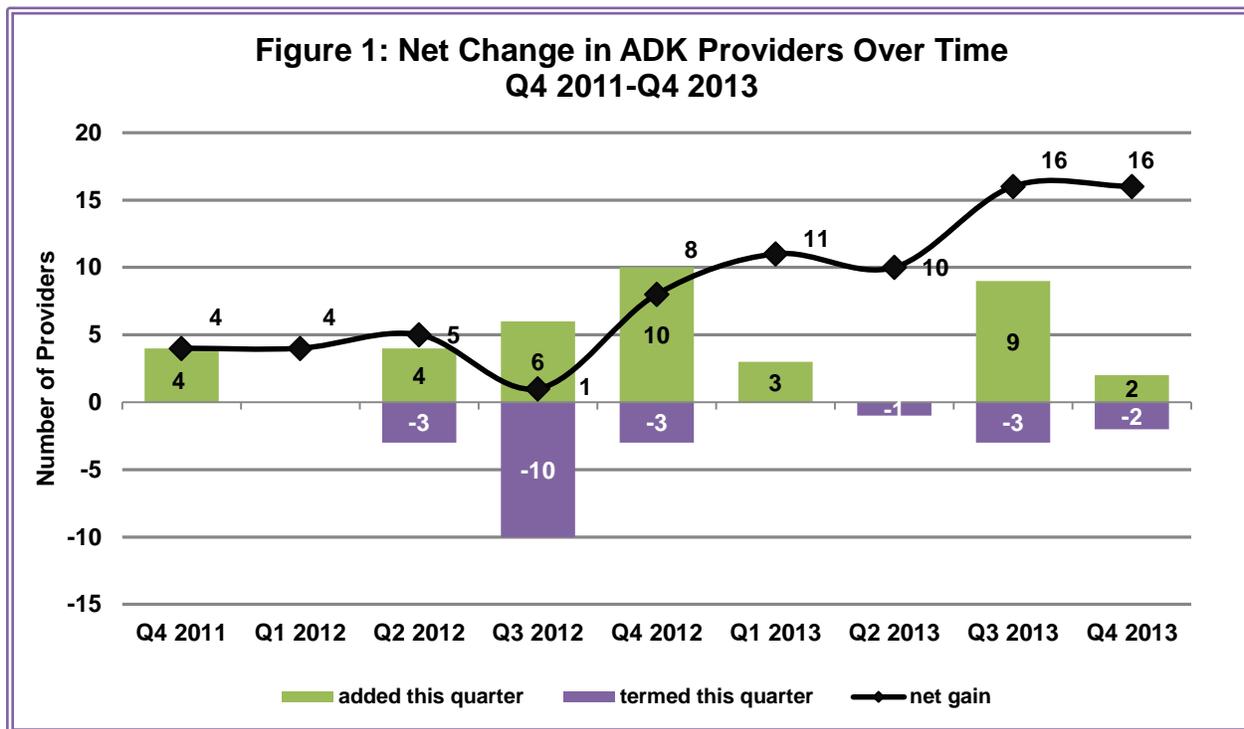
Achieving NCQA level 3 PCMH recognition requires practices to invest, implement, and utilize EHR systems in order to provide better care for patients. At the beginning of the ADK demonstration, only a handful of providers had EHR systems. Of those who had an EHR system installed, many were limited in functionality or the implementation process was incomplete. Due to limited resources, almost none of the practices participating in the ADK demonstration had developed patient registries, implemented electronic reminders, or had enabled automatic EHR features that were essential to create the PCMH model structure. In mid-2009, grant money was solicited from the Health Efficiency and Affordability Law for NY (HEAL-NY) Phase 10 (known as HEAL-10) to fund HIT purchases in support of the medical home project. In August of 2009, ADK was awarded \$7 million through the HEAL-10 grant program to support HIT for medical homes. A month later, ADK was awarded part of a \$2.7 million grant from the state, in conjunction with the Medical Society of the State of New York (MSSNY), to further support HIT and EHR implementation.

## **ENROLLMENT AND EXPENDITURES**

### ***Workforce Stabilization in ADK***

One of the driving factors for the creation of the ADK demonstration was to attract and retain a strong workforce. The number of providers in the area has slowly increased since the ADK demonstration was implemented. AHI tracks the number of providers leaving and entering the workforce on a quarterly basis. Providers include, but are not limited to, the following credentials: Medical Doctor (MD), Doctor of Osteopathy (DO), Nurse Practitioner (NP) Family Nurse Practitioner (FNP), Pediatric Nurse Practitioner (PNP) Licensed Clinical Social Worker (LCSW), and Physician Assistant (PA). From December 2011 to December 2013, the number of providers participating in the demonstration increased by 16. The number of providers joining

the demonstration, leaving the demonstration, and the net gain from 2011 to 2013 is shown in the following graph.

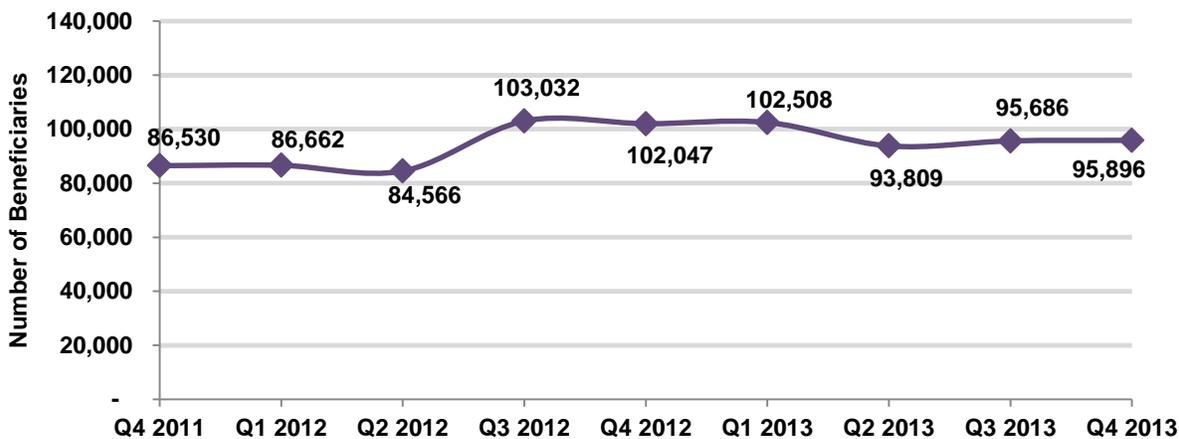


### **Beneficiaries and Attribution**

Attribution is believed to be the most effective way to establish a provider’s accountability for patients’ care coordination, enabling payers to provide additional reimbursement to the most appropriate providers. At the start of the demonstration, payers agreed upon a common attribution methodology, which has been continuously refined over the course of the demonstration. This attribution methodology, which incorporates the number and type of visits over a 24-month look-back period, is used by the majority of commercial payers. Other payers have used their own attribution methodology or provided additional payment for specific qualifying visits. Measuring the quality, satisfaction, and utilization of each physician’s attributed patients is essential to the operation of performance programs.

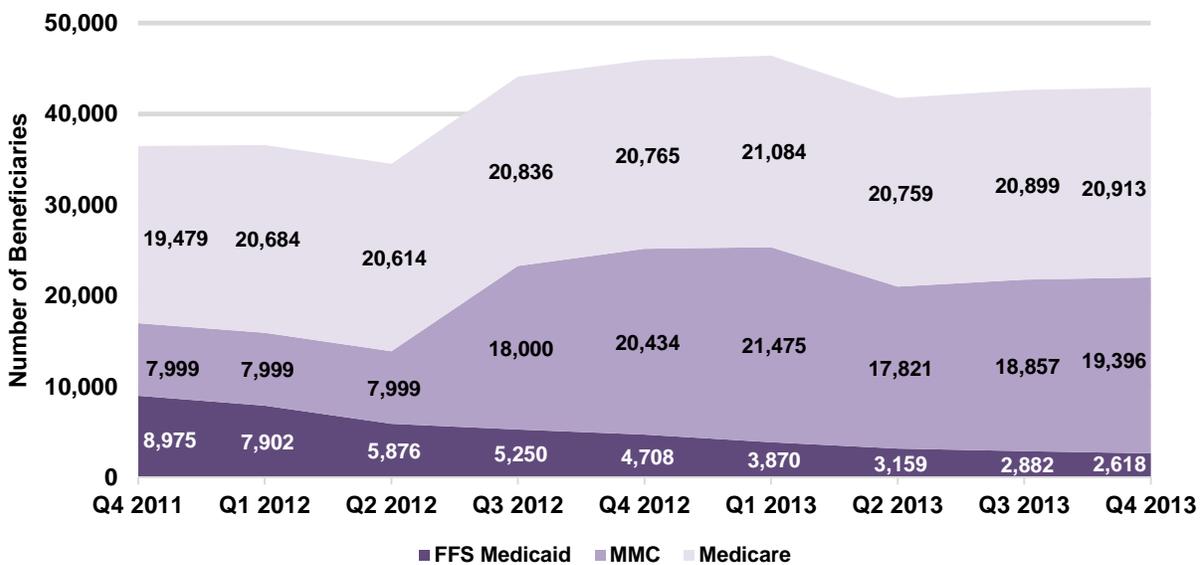
The number of attributed enrollees is based on quarterly data reported by the payers. Although patients may see an ADK provider, if they regularly see a non-ADK provider for primary care services they would not be attributed to the demonstration based on the attribution methodology chosen. Figure 2 shows nearly 96,000 attributed patients regularly receiving care from ADK providers at the end of 2013.

**Figure 2: Estimated Number of Beneficiaries Assigned to All Payers in ADK**



The following graph tracks changes in the number of enrollees in public insurance programs that had a visit with an ADK provider. CHP members participating in the demonstration are included in the MMC total. The significant decrease in the Medicaid FFS population and large increase in MMC is mostly due to the mandatory transition of FFS populations into MMC in the ADK counties. As of December 2013, almost half (42,927) of the enrollees in the ADK demonstration were insured by one of the three public payers: Medicaid FFS, MMC, and Medicare as shown in Figure 3.

**Figure 3: Number of Beneficiaries with Public Insurance Q4 2011 - Q4 2013**



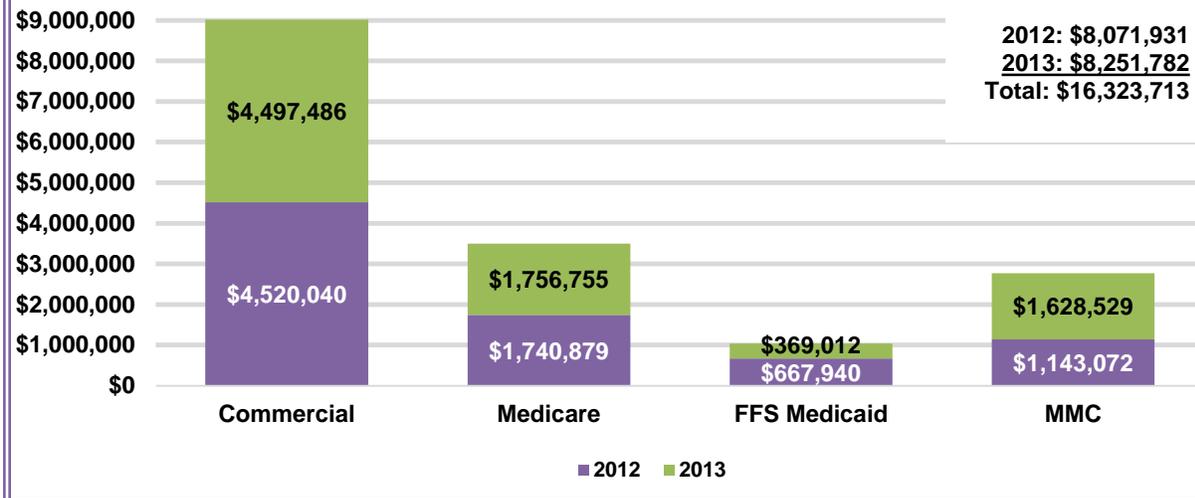
## Expenditures

All payers participating in the ADK demonstration provide an additional \$84.00 PMPY (\$7 PMPM for 12 months) to participating providers. In the FFS (claims-based) reimbursement system, an 'add-on' is given for qualifying visits (where eligible evaluation and management procedure codes are used). In a capitated system, \$7 per member is added to monthly capitation rates. In both payment systems, the total increased PCMH payments equals \$84 PMPY (detailed in the table below).

Table 1: ADK Demonstration Provider Reimbursement by Payer Type	
Payer Type	PCMH Payment to ADK Providers
Commercial, Medicaid managed care*, Child Health Plus and Medicare FFS	\$7 PMPM (totaling \$84 PMPY)
Medicaid FFS	\$28 or \$32** per qualifying visit (on average totaling \$84 per member per year)
* Medicaid providers participating in the ADK demonstration are not eligible for other PCMH payment programs, such as New York Medicaid's Statewide PCMH program, which provides increased payments based on provider's recognition level.	
** In early 2014 the Department of Health observed a downward trend in the number of visits patients have with their PCPs in ADK from 3 visits per year to approximately 2.6 visits per year. On January 1, 2014 the FFS add-on payment amount was increased from \$28 per visit to \$32 per visit in response to this trend.	

Figure 4 shows the amount spent by payer for add-ons and increased capitation payments in 2012 and 2013. Expenditures in capitated arrangements were calculated by multiplying the number of plan-reported enrollees attributed to that payer type for the given year by \$7 PMPM. CHP expenditures are included within the MMC total expenditures. Medicaid FFS expenditures were calculated by summing all add-on payments in the given year using claims data.

**Figure 4: Enhanced Payment Expenditures Across All Payers  
2012-2013**



As noted in the previous section, the public payers insure just under 45 percent of the insured population participating in the ADK demonstration. Among public payers, Medicare had the greatest expense (almost \$3.5 million for 2012 through 2013) due to their larger attributed population. Enhanced payments generated an expense of approximately \$4.5 million for the private payers each year. In 2012, the Medicaid program paid almost \$700,000 in FFS add-ons and \$1.1 million in MMC enhanced capitation payments. As the FFS Medicaid population continued to migrate into to MMC during 2013, the add-on expenditure for FFS Medicaid enrollees in ADK showed a four percent decrease from 2012, and a four percent increase in MMC capitation payments.

### ***Pay-for-Performance (P4P)***

Beginning in January 2013, a P4P component was established where by \$0.50 of each practice’s portion of the \$7PMPM is set aside in a separate fund, to be redistributed bi-annually based on practice performance in quality, patient satisfaction, and utilization. Select quality metrics are continuously collected from practices’ EHRs, patient satisfaction measures are obtained through the Consumer Assessment of Healthcare Providers & Systems Clinician and Group (CG-CHAPS) surveys (a satisfaction survey created by NCQA), and measures of emergency, inpatient, outpatient, and professional services utilization are available through the data warehouse. P4P funds that are not earned by low performers are placed in a performance improvement pool used to fund improvement initiatives across the ADK demonstration.

All of the practices participating in ADK began contributing \$0.50 PMPM toward the first payment cycle of the P4P initiative (January 1, 2013 through June 30, 2013). The funds collected were distributed to each practice for their performance rating in each of the areas they were evaluated: quality, patient satisfaction, and utilization. Almost \$287,000 was contributed to the overall P4P pool during the first payment cycle. The practices were awarded approximately

\$222,000 in May 2014 for meeting or exceeding performance standards established in each of the evaluation areas. Practices did not have to meet the standards for all three domains to be able to receive P4P funds. Awards were given separately for each domain at the end of the first year. Nearly \$64,000 of the funds remained because some practices did not meet the P4P benchmarks in all evaluation domains, and these funds were allocated to the performance improvement pool. All of the practices met the benchmark for the quality domain, more than half of the practices met the benchmark for the patient satisfaction domain, and most practices met the benchmark for the utilization domain.

## EVALUATION AND RESULTS

Evaluation related to quality, patient satisfaction, provider experience, cost and utilization across all payers is ongoing. Results are compared across payers and pods, and continuous evaluation has allowed stakeholders to trend results over time in each domain.

### *Quality*

The ADK demonstration is able to generate 30 adult and 18 pediatric National Quality Forum (NQF) quality measures using EHR data from the practices. The adult measures focus on management of coronary artery disease, diabetes, and hypertension. The pediatric measures focus on managing asthma and documenting and managing obesity. A full list of the 48 measures is available in Appendix 1 and Appendix 2.

An analysis of the overall quality of care received by patients in the demonstration was done using 2012 and 2013 EHR data. Changes in rates were not tested for statistical significance. Table 2 through Table 7 compare the results by year across the following domains: adult coronary artery disease, adult diabetes management, adult hypertension, pediatric asthma, pediatric obesity, and pediatric prevention. Please note that the participating providers' entire panel of patients is included in these results. Therefore, while the majority of the patients are insured by the nine participating payers, these rates include performance for non-participating payers as well, such as Medicare Advantage patients. In addition, there are multiple EHR systems throughout the demonstration with varying levels of capabilities for data capture and for some measures, data capture is more "robust" in claims data than medical records. As a result, there may be underreporting in EHR data.

From 2012 to 2013, four of five measures in the coronary artery disease domain showed improvement (Table 2). Cholesterol (LDL-C) screening rates improved, as well as an overall improvement in the percentage of patients with LDL-C with levels less than 100mg/dL. The only measure in the coronary artery disease domain that did not improve was the percent of patients with LDL-C levels greater than or equal to 130mg/dL.

<b>Table 2: Adult Coronary Artery Disease</b>		
<b>Measure</b>	<b>2012</b>	<b>2013</b>
Percent of patients receiving at least one LDL-C test	73.6%	74.9%
Percent of patients with LDL-C <100mg/dL	51.1%	52.7%
Percent of patients with LDL-C ≥130mg/dL*	7.0%	7.8%
Percent of patients with most recent BP<130/80 mmHg	41.5%	47.0%
Percent of patients with most recent systolic BP ≥140 OR diastolic BP ≥90mmHg*	21.1%	19.5%
* a lower rate means better performance		

From 2012 to 2013, both measures in the adult hypertension domain showed improvement (Table 3). Overall, blood pressure measurement improved by over three percent, while patients with high blood pressure decreased by almost five percent.

<b>Table 3: Adult Hypertension</b>		
<b>Measure</b>	<b>2012</b>	<b>2013</b>
Percent of patients with most recent BP<130/80 mmHg	32.9%	36.2%
Percent of patients with most recent systolic BP ≥140 or diastolic BP >90mmHg*	29.6%	24.7%
* a lower rate means better performance		

In the adult diabetes management domain, the majority of measures showed improvement from 2012 to 2013 (Table 4). Almost all screening and testing measures, such as foot exams, LDL-C testing, nephropathy assessments, and blood sugar (Hemoglobin A1c or HbA1c) tests, showed improvement for the adult diabetes management measures. The overall adult diabetes management population showed improvement in LDL-C results, HbA1c results, and blood pressure results. Measures that did not show improvement included: the percent of patients who received eye exams or evaluation of retinal photographs and the percent of patients with HbA1c test results above the recommended level.

Table 4: Adult Diabetes Management		
Measure	2012	2013
Percent of patients receiving at least one foot exam	2.6%	8.4%
Percent of patients receiving at least one LDL-C test	58.2%	63.6%
Percent of patients receiving at least one nephropathy assessment	69.2%	70.3%
Percent of patients receiving one or more HbA1c tests	65.0%	71.9%
Percent of patients who receive a dilated eye exam or evaluation of retinal photographs	7.1%	6.5%
Percent of patients with LDL-C <100mg/dL	35.3%	37.6%
Percent of patients with LDL-C $\geq$ 130mg/dL %*	8.0%	8.8%
Percent of patients with most recent BP <130/80mmHg	36.6%	35.7%
Percent of patients with most recent HbA1c $\leq$ 7.0%	33.5%	38.1%
Percent of patients with most recent HbA1c >9.0%*	8.7%	9.5%
Percent of patients with most recent HbA1c level <8.0%	47.1%	53.1%
Percent of patients with most recent systolic BP $\geq$ 140 or diastolic BP $\geq$ 90mmHg*	22.3%	21.1%
* a lower rate means better performance		

The measure in the pediatric asthma category showed improvement from 2012 to 2013 (Table 5).

Table 5: Pediatric Asthma		
Measure	2012	2013
Percent of patients ages 5-18 years with asthma who are on appropriate medication	41.9%	54.0%

In the pediatric obesity domain, the results were mixed (Table 6). The percent of patients with a calculated body mass index (BMI) increased. However, the percentage of patients who had a BMI result greater than the 95<sup>th</sup> percentile during the measurement period slightly increased.

Table 6: Pediatric Obesity		
Measure	2012	2013
Percent of patients ages 2-18 who had a BMI result >95th percentile during the measurement period*	18.4%	18.5%
Percent of patients who had height and weight taken with BMI calculated	89.8%	93.0%
* a lower rate means better performance		

Between 2012 and 2013, over half of pediatric prevention measures showed improvement (Table 7). Immunization rates improved for the following: Hepatitis A, Hepatitis B, Influenza, Varicella Zoster Virus (VZV) (also known as the chickenpox), and Measles, Mumps, and Rubella (MMR). Immunization rates did not improve for the following antigens: Diphtheria, Tetanus, and Pertussis (DTaP), Inactivated Polio vaccine (IPV), Haemophilus influenzae type b (HiB), pneumococcal, and rotavirus. All of the measures in the Table 7 include children two years of age that received the number of vaccines listed for each measure by the child's second birthday.

Table 7: Pediatric Prevention		
Measure	2012	2013
childhood immunization status – 4 DTaP vaccines	68.1%	60.8%
childhood immunization status – 3 IPV vaccines	80.1%	69.2%
childhood immunization status – 2 hepatitis A vaccine	20.6%	36.5%
childhood immunization status – 3 hepatitis B vaccines	25.7%	49.2%
childhood immunization status – 2 HiB vaccine	79.5%	73.4%
childhood immunization status – 2 influenza vaccines	44.3%	55.8%
childhood immunization status – 4 pneumococcal vaccines	74.9%	65.0%
childhood immunization status – 2 or 3 rotavirus vaccines	67.3%	65.7%
childhood immunization status – 1 VZV vaccine	78.2%	80.4%
childhood immunization status – 1 MMR vaccine	78.4%	79.4%

### **Patient Satisfaction**

In 2011 and 2013, AHI conducted surveys of patients to assess overall satisfaction with practices and physicians in the ADK demonstration using the Consumer Assessment of

Healthcare Providers & Systems Clinicians and Groups Survey (CG-CAHPS) instrument. Objectives of the survey were to:

- Measure patient perceptions of the participating providers
- Measure perceptions of the services provided by participating providers
- Compare results with established benchmarks based on national averages from the 2011 National CAHPS benchmarking database
- Analyze demonstration performance
- Determine key drivers of patients' overall ratings of ADK providers using a regression analysis
- Provide direction to improve the quality of care provided by the sites within the AHI network

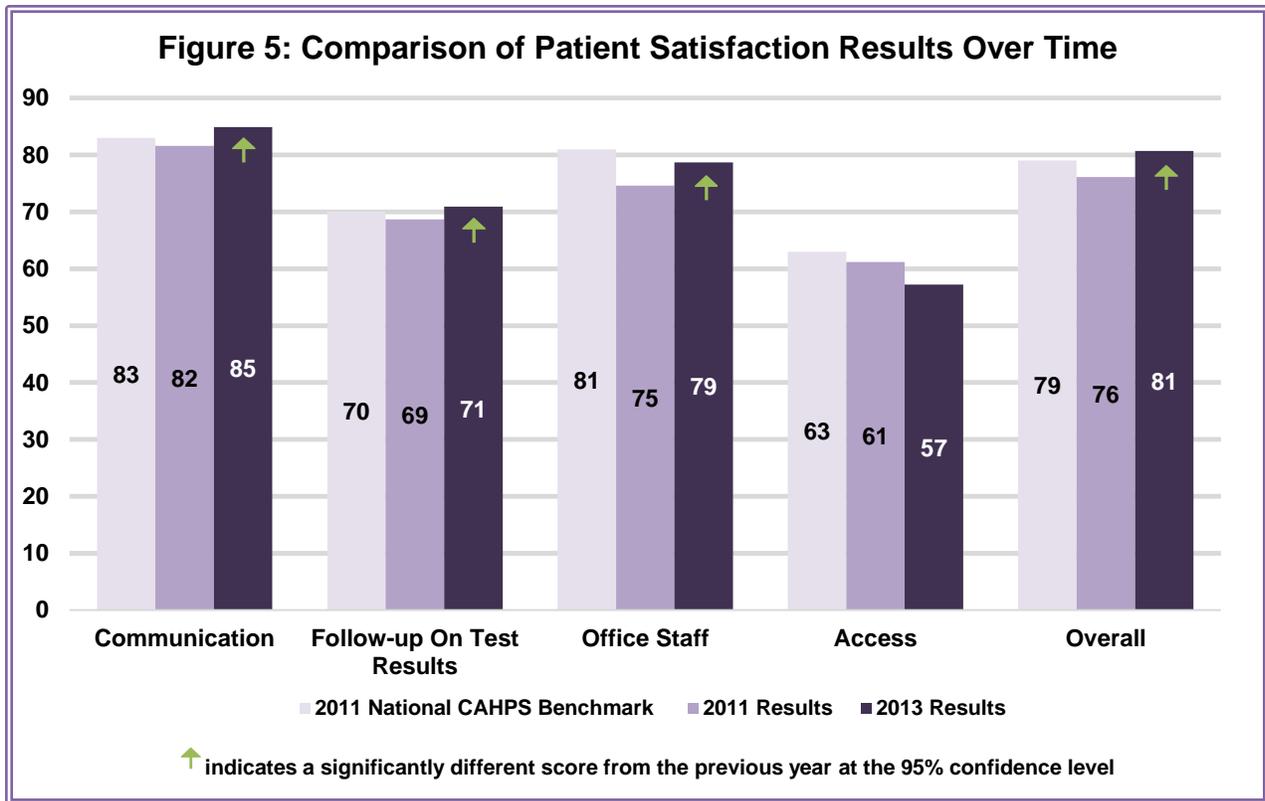
The CG-CAHPS survey instrument was used to assess overall patient satisfaction in 2011. The CG-CAHPS survey was mailed out in May 2011 to a random sample of 13,511 adult patients and parents of pediatric patients in the ADK demonstration who had a recent visit with their provider (in the previous 12 months). A follow-up mailing was sent to non-responders in June 2011. After adjusting for undeliverable mailings, the response rate was 41 percent.

Another version of the CAHPS survey tool, specific to PCMHs (PCMH CAHPS), was mailed out in February 2013 to a random sample of 14,239 adult patients or parents of pediatric patients in the demonstration that had a recent visit with their provider (in the previous 12 months). A follow-up mailing was sent to non-responders in March 2013. After adjusting for undeliverable mailings, the response rate was 38 percent.

The CG-CAHPS tool measures patient experience in the following domains: getting timely appointments, care, and information; how well providers communicate with patients; helpful, courteous, and respectful office staff; and patient ratings of the providers. PCMH CAHPS measures all areas that CG-CAHPS measures, as well as coordination of care, information about care and appointments, and three additional composite measures: how well providers pay attention to a patient's mental or emotional health; how well providers support a patient in taking care of their own health; and how well providers discuss medication decisions.

For additional information on the CAHPS surveys and to download the tools used in this evaluation, please visit: <http://cahpsdatabase.ahrq.gov/CGSurveyGuidance.aspx>

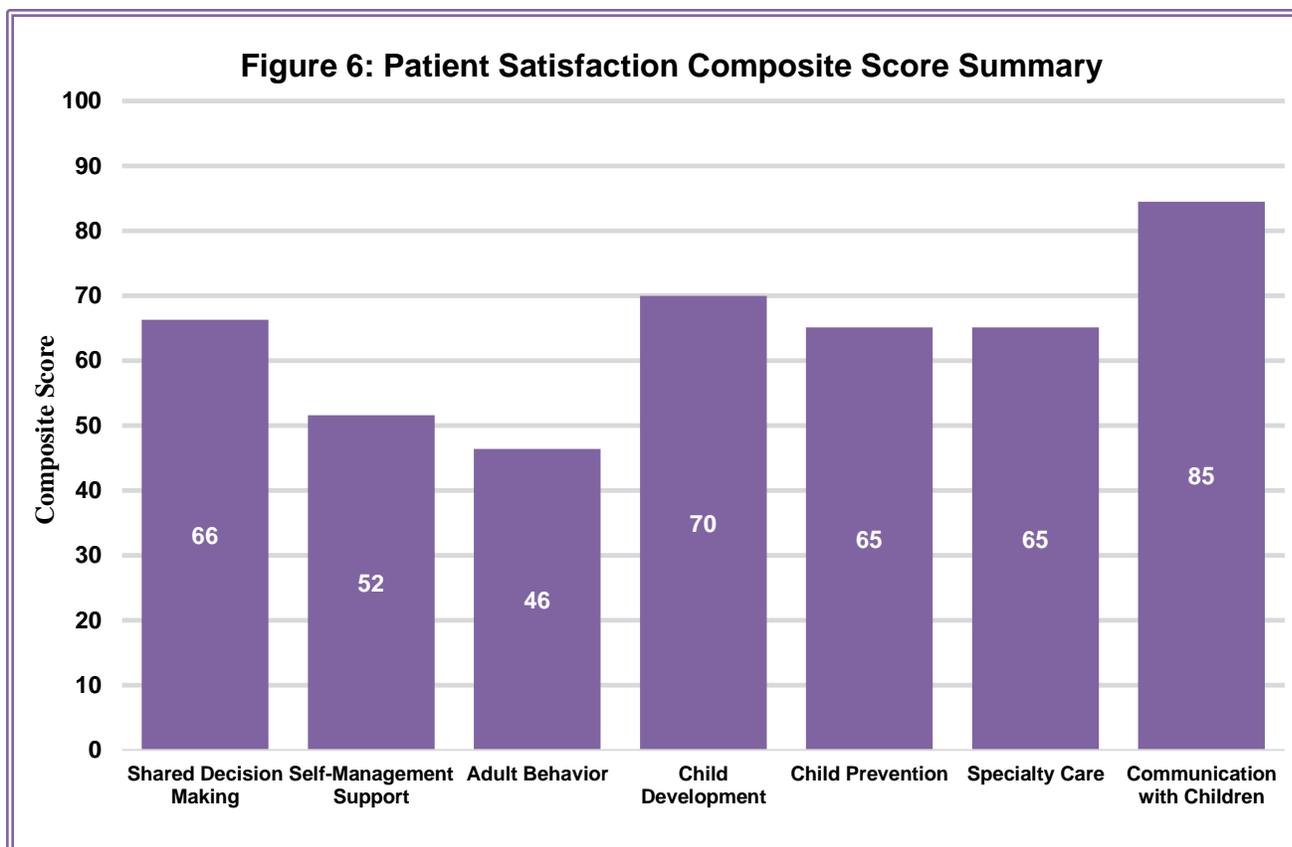
A comparison of the results of both surveys and the 2011 national CAHPS benchmark used in this analysis is displayed in Figure 5. In 2013, overall provider ratings increased for most measures: four out of five patients gave their provider a rating of nine or 10 (on a 0-to-10 scale where 10 was the best possible score). Composite scores were calculated for patient satisfaction in the following categories for, both 2011 and 2013: overall patient satisfaction, communication, follow-up on test results, office staff, and access to care. Survey questions for each composite can be found in Appendix 3.



A 'key drivers' analysis revealed that the providers in this project perform well on measures such as provider communication with patients (listening carefully to patients, showing respect for what patients have to say, explaining necessary information in a way that is easy to understand, knowing medical history of the patient, and spending enough time with the patient) and having courteous and respectful office staff. However, it was found that there is still room for improvement in two areas: having helpful office staff and being up-to-date on specialty care.

Although the scores improved from the previous year, ADK providers fell short on the access composite benchmark in 2013. Less than one in five sites met or exceeded the benchmark for this composite. However, ratings for this composite significantly improved in four of five measures. The measure that did not improve was patients' access to speaking with a provider after hours or as soon as needed.

Figure 6 shows consumer satisfaction for the ADK demonstration in the areas of: shared decision making (66 percent), self-management support (52 percent), adult behavior (46 percent), child development (70 percent), child prevention (65 percent), specialty care coordination (65 percent), and communication with children (85 percent). Parents rated ADK providers highly in terms of communicating with children and over half of all patients indicated their provider seemed up-to-date on their care received from specialists.



In late 2013, the ADK governance committee began piloting a new platform for administering the PCMH-CAHPS survey, using a web-based tool called DocInsight. The trial was limited to only a few participating practices in the demonstration. DocInsight allows patients to rate their satisfaction in real-time, or shortly after their visit. Payers and providers decided, on the basis of pilot results and provider and payer enthusiasm, to measure patient satisfaction with DocInsight going forward and eliminate using paper survey tools that were used for previous evaluations.

### *Provider Experience*

AHI conducted a survey to assess physicians' overall satisfaction with their experience in this initiative in 2011 and 2013. The survey was developed by the American College of Physician's Center for Practice Innovation and distributed by mail in both years. The survey tool was comprised of 10 questions: one focused on identifying the provider's practice; one that focused on practice demographics; and eight consisted of ratings matrices in the following domains:

- Practice (accomplishing tasks at the practice, including, but not limited to, answering phones, reporting diagnostic test results, coordination of patient care)
- Patient Centeredness (managing patient concerns, meeting patient expectations, complaint resolution, using feedback to improve services, involving patients in care)
- Team Dynamics (staff teamwork, skills, knowledge, resources)

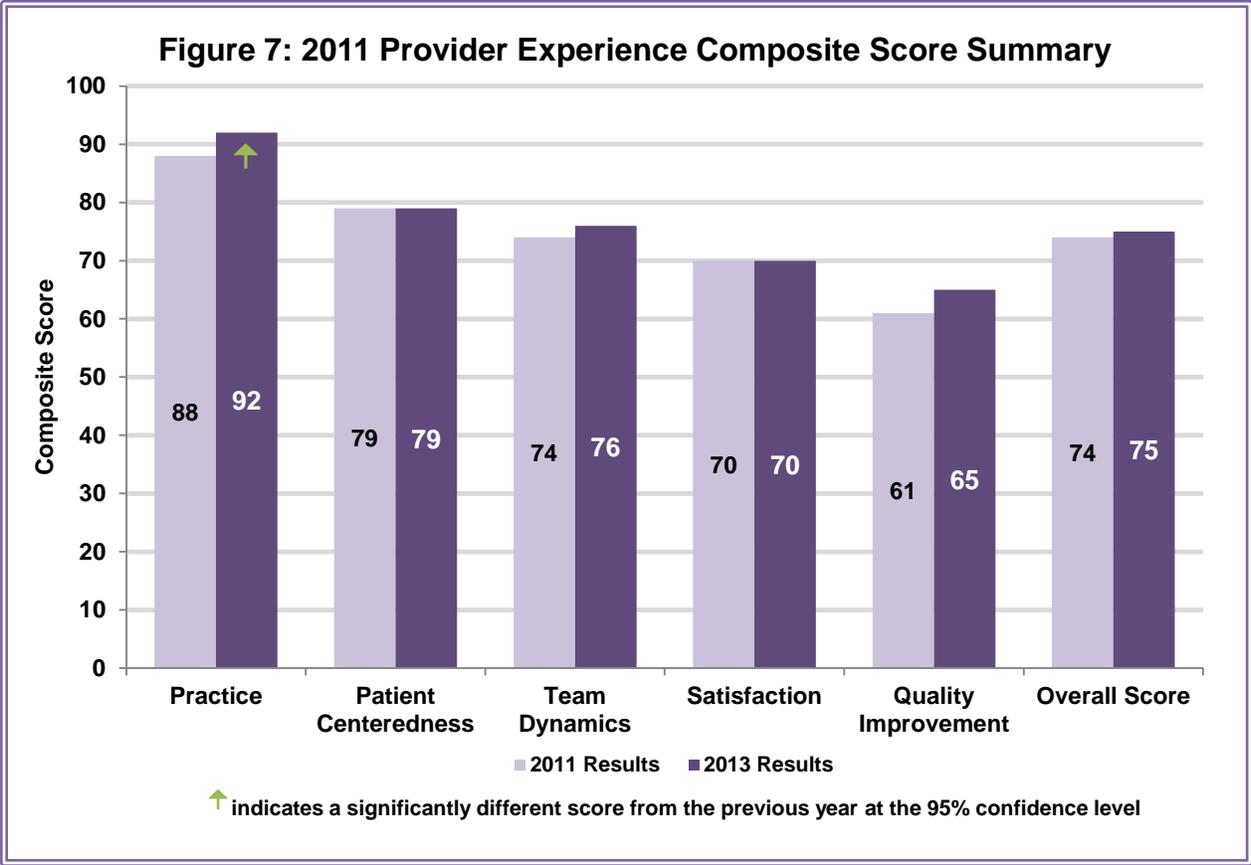
- Satisfaction (work environment, aspects of care for patients, morale/attitudes, and pace/stress)
- Quality Improvement (quality measurement, analysis, knowledge of practice's financial status, recognition for work)
- Provider Questions: factors that influenced schedule development (family, other interests, revenue, patient demands, local market); where to practice (proximity to training site, family, revenue, health professional shortage in area, lifestyle); and attitudes toward receiving payment for services (importance of prompt payment).

The list of survey questions for each composite score (practice, patient centeredness, team dynamics, satisfaction, and quality improvement) can be found in Appendix 4.

In 2011, 168 surveys were mailed and 55 were completed, and the response rate was 33 percent. In 2013, 175 surveys were mailed and 63 were completed, and the response rate was 35 percent.

The 2011 survey scores were the highest for the practice (88) and patient centeredness (79) composites while scores were the lowest for the satisfaction (70) and quality improvement composites (61) (Figure 7). The overall composite score calculated from ADK physician survey responses was 74. Results of this survey were not compared to external benchmarks.

The 2013 provider survey experience results were the highest for practice (92) and patient centeredness composites (79), similar to 2011, and showed a statistically significant improvement in the practice composite score from 2011 to 2013. Scores for the patient centeredness and satisfaction (70) composite remained the same across years. The team dynamics (76), quality improvement (65), and overall (75) composites all showed improvement in 2013 but were not statistically significant. Results of this survey were not compared to external benchmarks.



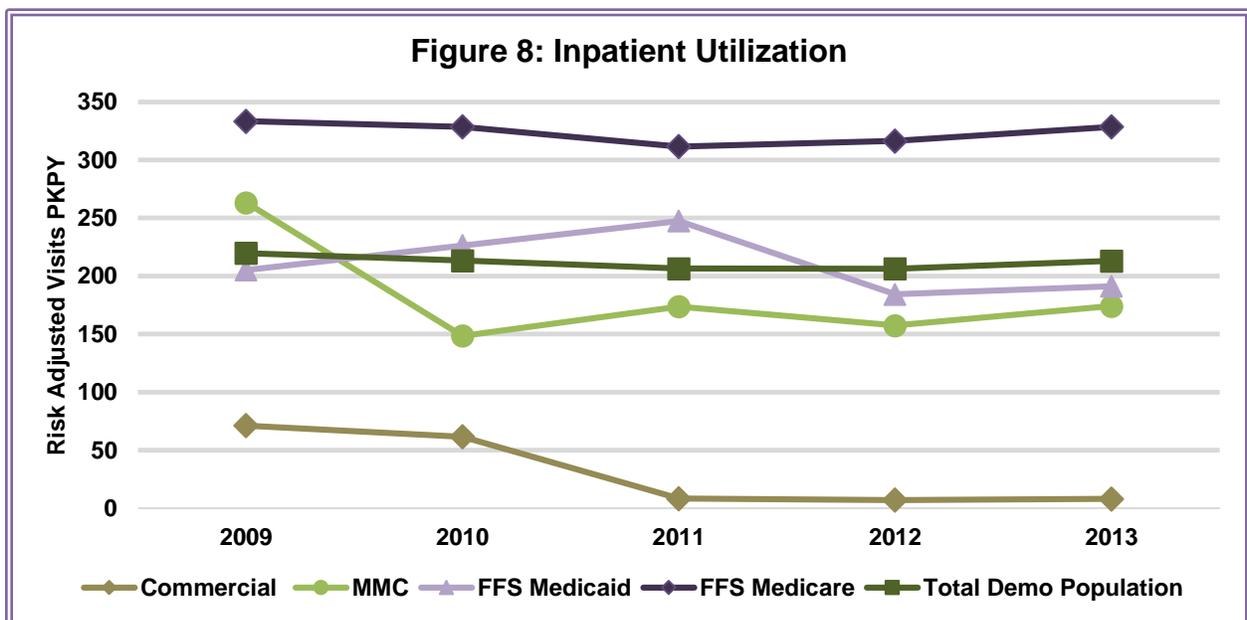
**Utilization and Cost**

The demonstration’s all-payer data warehouse consultant, 3M Health Information Systems, performed cost and utilization evaluations using claims data from all payers in the demonstration. The data in Figures 8, 9, 10, and 11 show inpatient, outpatient, and ER utilization rates, as well as the total cost of care PMPM using 2009 as a baseline. The data were risk adjusted by 3M’s Clinical Risk Groups (CRG), CRG severity, age, and gender to allow for a more accurate comparison across years and between payers. Risk adjustments were performed separately for each line of business using a separate weight set developed for the specific line of business (Medicare, Medicaid, and commercial). Relative weights were created and applied for each utilization and financial metric using 2010, 2011, 2012, and 2013 claims across all payers. For total cost of care, proxy pricing was used for commercial and managed care lines of business because payers did not provide actual costs to the data warehouse. Actual paid dollars were used for Medicare and Medicaid FFS. The proxy pricing was derived through the creation of All Patient Refined Diagnostic Related Groups (APR-DRG), and Enhanced Ambulatory Patient Grouping (EAPG) base rates and procedural rate codes from a benchmark data set. It should be noted that MMC rates include data for the CHP population in the demonstration for all cost and utilization figures in this section. The total demonstration trend contains data that are risk adjusted for line of business prior to summing for the total population. Note that these data only allow for comparison within the ADK demonstration over

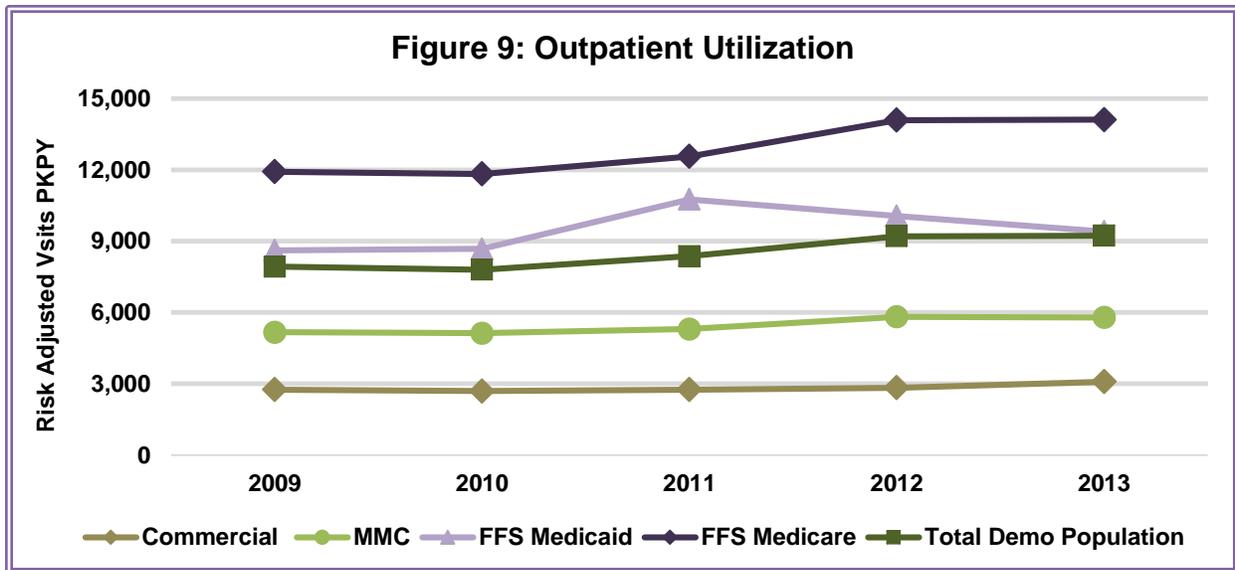
time and does not compare the demonstration to a control group of like providers over the same time period.

The total cost of care, as well as utilization related to inpatient admissions (all admissions including potentially preventable admissions), ER visits (all ER visits including potentially preventable visits), and outpatient services, are shown over time by payer in the figures below.

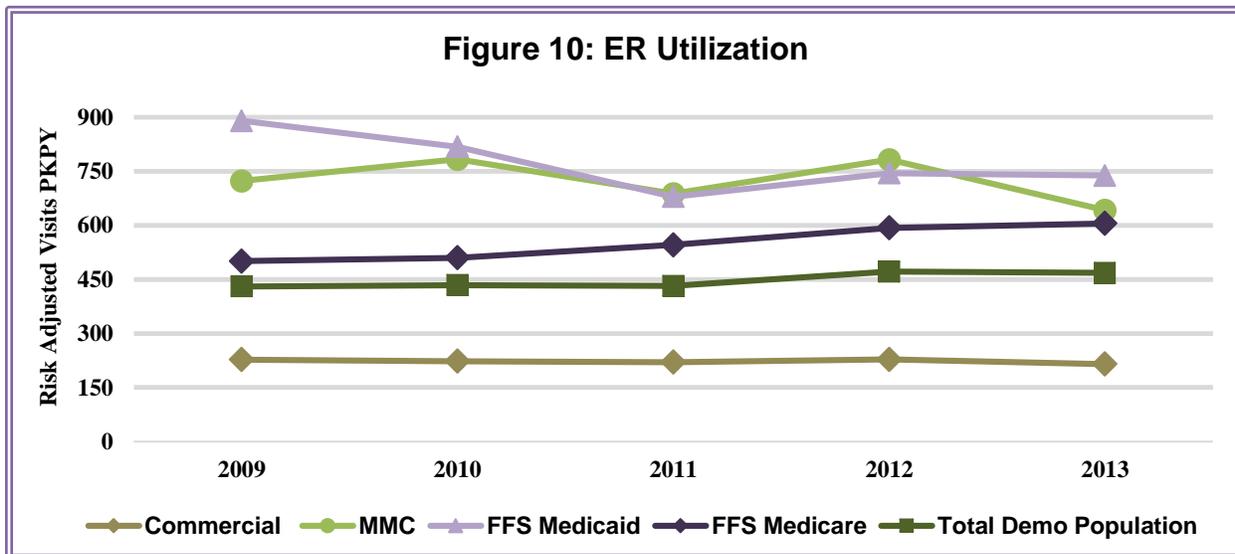
As seen in Figure 8, the Medicare population had the highest inpatient utilization rates per thousand per year (PKPY) and the commercial population had the lowest inpatient utilization rates for all five years of the evaluation period. FFS Medicaid rates increased slightly from 2009 through 2011, but decreased the last two years of the evaluation period and the MMC population rates show an overall decrease from 2009 to 2013.



The Medicare population showed the highest utilization rates for outpatient visits (outpatient services were defined as all visits excluding inpatient stays) as well, with an upward trend of increasing utilization rates from 2009 to 2013 (Figure 9). The Medicaid FFS population showed an increase in outpatient visits in 2011. The commercially insured population maintained the lowest outpatient utilization rates during the evaluation period and both the MMC and commercially-insured population utilization rates maintained relatively stable over time.

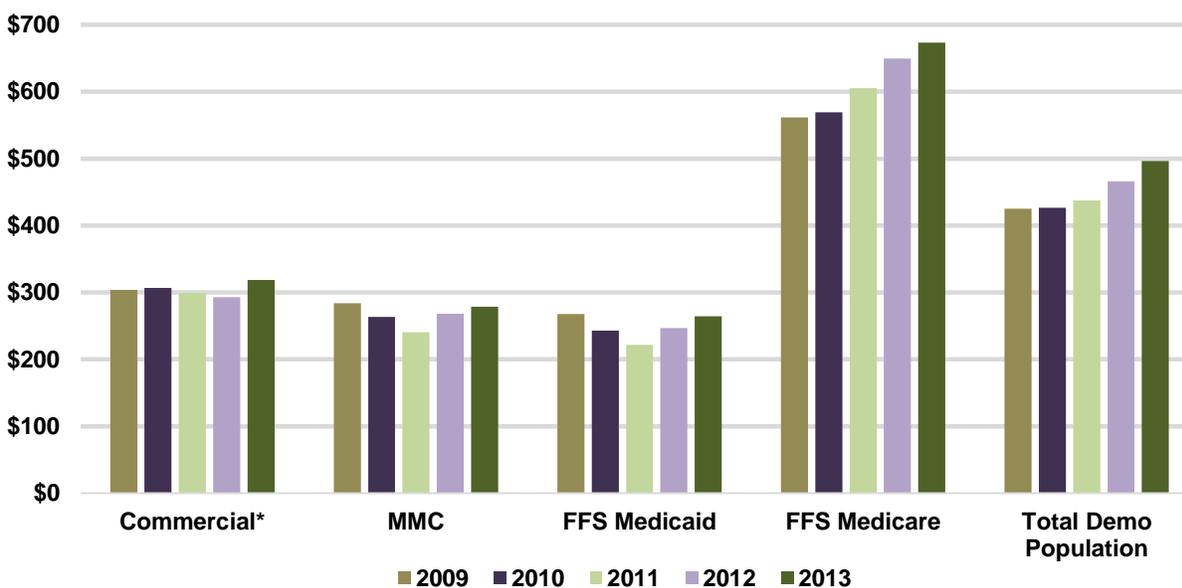


Unlike the inpatient and outpatient utilization rates, the Medicaid FFS and MMC population show the highest rates of ER utilization (Figure 10). Medicare ER utilization rates were less than both Medicaid groups' utilization rates but slightly increased over time. Similar to the other utilization rates shown in this section, the commercial population had the lowest ER utilization rate, which remained relatively stable over the evaluation period. All ER visits that did not result in an admission were included in this analysis.



In Figure 11, actual costs for public payers are shown while proxy prices are shown for commercial payers. From 2009 through 2013, the total cost of care PMPM was the highest among the Medicare population. Although the utilization rates for the commercial population were the lowest for inpatient, outpatient, and ER visits, the total cost was lowest for the FFS Medicaid population in all four years. The data show that the total cost of care for the total demonstration began to increase over time from 2011 to 2013.

**Figure 11: Risk Adjusted Total Cost of Care PMPM**



\*proxy prices were used for commercial payers while actual costs were used for public payers

### *Quality of Care and Utilization for Medicaid Managed Care Patients*

In addition to the all-payer analyses, the NYS DOH performed additional quality and utilization analyses on the MMC population participating in the ADK demonstration. MMC plans have been required to submit quality measurement data to the NYS DOH since 1994, known as the Quality Assurance Reporting Requirements (QARR). A recent requirement for plans to submit enrollee-specific data has allowed for the evaluation of quality for specific members, which therefore permits evaluation of quality for members seeing an ADK provider vs. those in non-PCMH practices. The following quality analyses use this member-level QARR data from 2012 to evaluate the quality of care provided by PCMH-recognized sites versus non-recognized sites. This study is not possible for the FFS Medicaid population because there are no quality-reporting requirements for individual providers in FFS Medicaid. Utilization data are based on MMC encounters, which are submitted to the NYS DOH monthly by the MMC plans.

### **Methodology**

Because certain enrollee characteristics, such as health status, may impact quality of care measurement and health care utilization, a matched comparison study of two subsets of MMC members (ADK group and non-PCMH group) was used to assess differences in clinical quality measures and utilization between the ADK and non-PCMH groups. PCMH status was determined by matching the patient to their assigned primary care provider (physician assignment is provided to the NYS DOH by MMC plans quarterly). The ADK and non-PCMH cohorts were further refined through a “one-to-one” match of socio-demographic characteristics such as: gender, age, race/ethnicity, Medicaid aid category, eligibility for cash assistance, and

length of MMC enrollment in months, region (NYC versus rest of state), and the member's health status as defined by CRGs. This matched comparison study increases the likelihood that any observed differences between ADK and non-PCMH are not influenced by patient characteristics which attempts to isolate the impact of PCMH.

Select QARR measures that assess the quality of preventive care and chronic disease management were chosen. To evaluate differences in preventable admissions, Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDIs), which identify hospitalizations that could have been potentially avoided through high-quality outpatient care, were examined but not presented in this report due to small numbers of events. For quality measures, group rates were compared to the combined overall rate to assess significance using a p-value of 0.05.

## **Study Population**

For the 2012 measurement year, there were 13,684 MMC members in the final matched study population, of which 57 percent were 18 years or older, 57 percent female, 83 percent Caucasian, 60 percent were enrolled in Temporary Assistance for Needy Families (TANF), and 54 percent were continuously enrolled in MMC for 12 months or more.

## **Pediatric Quality of Care Results**

Pediatric MMC members assigned to ADK providers had a significantly higher rate of well-child and preventive care visits in third, fourth, fifth and sixth year of life (90 percent compared to 84 percent in the non-ADK group). There was not a significant difference detected for other quality measures, though children and adolescents assigned to ADK providers had slightly higher rates of appropriate testing for pharyngitis and appropriate treatment for upper respiratory infections (URI), and an equal rate of adolescent well-child visits. Pediatric enrollees assigned to ADK providers had slightly lower rates of well-child and preventive care visits in first 15 months of life and chlamydia screening (ages 16-20). Small sample sizes for five measures (medication management for people with asthma 50 percent days covered, medication management for people with asthma 75 percent days covered, follow-up care for children prescribed ADHD medication: initiation phase, follow-up care for children prescribed ADHD medication: continuation phase, and adolescent immunization-combination) did not allow for significance testing.

Table 8: ADK Medicaid Managed Care Sub-Analysis			
Pediatrics Quality Measures	2012		
Measure	ADK	Non ADK (Non PCMH)	Difference
Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits)	84.2	90.3	-6.1
Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life	83.5	77.1	6.4*
Adolescent Well-Care Visits	54.1	54.1	0.0
Appropriate Treatment for Upper Respiratory Infection (URI)	14.1	8.5	5.6
Appropriate Testing for Pharyngitis	86.7	85.0	1.7
Chlamydia Screening (Ages 16-20)	49.8	56.1	-6.3
*Relative differences between the ADK rate and combined rate are statistically significantly (p<0.05)			

## Adult Quality of Care Results

Adult MMC members assigned to ADK providers had significantly higher breast cancer screening rates (65 percent versus 55 percent) and cervical cancer screening rates (71 percent versus 65 percent). There was not a statistically significant difference detected for other quality measures, though adults assigned to ADK providers had slightly higher rates of: use of imaging studies for lower back pain and avoidance of antibiotics therapy in adults with acute bronchitis. Adults assigned to ADK providers had slightly lower rates of: annual monitoring for patients on persistent medication; medication management for people with asthma (50 percent days covered and 75 percent days covered); antidepressant medication management-effective acute phase treatment; antidepressant medication management-effective continuation phase treatment; follow-up after hospitalization for mental illness (within seven days and within 30 days); and chlamydia screening. Statistical significance is not only based on the difference between a rate and an average, but also, the size of the sample. As a result, differences in rates that appear to be large, but are not statistically significant due to small sample sizes and are not usually considered meaningful. Small sample sizes for two measures (adult BMI assessment and controlling high blood pressure) did not allow for significance testing.

Table 9: Medicaid Managed Care Sub-Analysis			
ADK Adult Quality Measures	2012		
Measure	ADK	Non ADK (Non PCMH)	Difference
Use of Imaging Studies for Low Back Pain	76.3	68.9	7.4
Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis	17.4	15.7	1.7
Annual Monitoring for Patients on Persistent Medications- Combined Rate	90.2	91.2	-1.0
Medication Management for People with Asthma 50 Percent Days Covered (Ages 19-64)	65.7	76.5	-10.8
Medication Management for People with Asthma 75 Percent Days Covered (Ages 19-64)	28.6	50.0	-21.4
Antidepressant Medication Management- Effective Acute Phase Treatment	59.3	63.5	-4.2
Antidepressant Medication Management- Effective Continuation Phase Treatment	37.0	42.3	-5.3
Follow-Up After Hospitalization for Mental Illness Within 7 Days	72.5	79.5	-7.0
Follow-Up After Hospitalization for Mental Illness Within 30 Days	72.5	76.9	-4.4
Breast Cancer Screening	64.9	54.6	10.3*
Cervical Cancer Screening	70.8	65.2	5.6*
Chlamydia Screening (Ages 21-24)	49.8	56.1	-6.3
*Relative differences between the ADK rate and combined rate are statistically significantly (p<0.05)			

## Medicaid Prevention Quality Indicators and Pediatric Quality Indicators

An additional analysis (not presented in this report) compared Medicaid Prevention Quality Indicator (PQI) and Pediatric Quality Indicator (PDI) rates for both children and adult populations in the ADK demonstration and for comparison groups of children and adult populations that do not have a provider that is recognized as a PCMH. While the analysis showed fewer PQI and PDI events in the ADK populations than in the comparison group (indicating positive ADK performance), the number of events for each group was too small from which to draw meaningful conclusions.

## DISCUSSION

These analyses show that overall, the ADK demonstration is generating overall positive results in almost all areas of evaluation, though not consistently across all domains or for all payers or providers. In the quality evaluation, the majority of measures showed improvement from 2012 through 2013 and in the MMC-specific quality evaluation, almost all measures with statistical significance showed higher results in the ADK group versus the comparison group.

The patient satisfaction evaluation also showed improvements over time in all rates and were statistically significant in all domains except for access to care. The provider experience survey results showed there is room for improvement in satisfaction with the work environment, as well as in quality improvement initiatives such as measurement and analysis.

While utilization rates did not decrease across the total population, the rates remained relatively stable from 2009 through 2012. The stable utilization (or in some cases, slight increase) of outpatient services over time was not necessarily unexpected. Enrollees may be receiving more primary and preventive care as a result of seeing PCMH-recognized providers, which may serve to stabilize or even reduce preventable utilization of ER and inpatient services.

The cost analysis showed the total cost of care increased for the combined population from 2009 through 2013. All payers showed an increase in the total cost of care PMPM between the last two years of the evaluation period (using 2009 data as a baseline and proxy priced data for commercial plans) which indicates that cost savings, as a result of a demonstration like this, may take time to appear. It should be noted that proxy costs may differ from internal evaluations using actual costs performed by the private payers. In addition, CMS evaluations of costs and utilization trends for Medicare FFS recipients comparing the demonstration providers to other provider comparison groups have not shown a positive impact for New York as of yet.

### *Caveats & Limitations*

Evaluation results should be considered with the following caveats and limitations for each analysis:

The quality of care analysis was performed using the quality data from each of the practices via their EHRs, though not all of the practices use the same EHR technology. This may have an effect on the quality data used for comparison in the overall analysis.

Furthermore, the 2013 patient satisfaction surveys had an adjusted response rate for qualifying respondents (includes adult and child populations) of 38 percent. Higher response rates would allow for more meaningful conclusions. Surveys were distributed randomly, but there is the possibility that there are inherent differences between responders and non-responders as the surveys were distributed via a mail-only method. Respondents' answers on satisfaction may

have been impacted based on how they remember the encounter if the time between the visit and completing the survey was a long period of time.

The provider experience surveys were sent out to all providers in 2011 and 2013 and the response rate was relatively low for both surveys, 33 percent in 2011 and 36 percent in 2013. Higher response rates may allow for more meaningful conclusions on overall provider experience within the ADK demonstration.

The data used for the utilization analysis was provided in quarter four of 2012 and quarter one of 2013 by each of the payers. Although the data were submitted during the same time frame the time period of the data may vary slightly by payer as they may have used different methodologies to account for their members during the quarters of interest. Enrollment numbers were much smaller in 2009 and 2010, which may have an impact on the trends displayed.

For the total cost of care PMPM analysis, actual pricing for FFS Medicaid and Medicare populations were available. However, the commercial and managed care payers did not share actual costs. As a result, a proxy pricing methodology was used to represent the total cost of care for some payers, while using real costs for other, making the comparison of total cost of care across all payer types difficult. Enrollment numbers were much smaller in years 2009 and 2010 which may have an impact on the trends displayed.

The matching methodology used in the MMC-specific quality and utilization evaluations matched enrollees in ADK with similar individuals that did not receive care from an ADK or PCMH practice, but other practice-level characteristics were not considered in the matching process. Matching on provider or practice characteristics is of high interest to the NYS DOH for future analyses. Also, given that Fidelis insures the majority of individuals in the MMC population, there is not much diversity in the payer mix for this analysis.

## NEXT STEPS

The NYS DOH will also compare the results of the statewide PCMH (Medicaid only) program to the results of ADK to isolate the effect of the ADK demonstration. In particular, the NYS DOH wants to analyze the impact of multi-payer collaboration on the positive results seen in the ADK demonstration. For MMC in particular, the NYS DOH plans to more closely analyze quality, utilization, and cost for subsets of members, such as enrollees with chronic conditions and enrollees who meet specific continuous enrollment criteria. Other payers will likely pursue similar analyses. RTI International (formerly Research Triangle Institute) is working as CMS' evaluation partner and is performing an analysis of the ADK demonstration for both Medicare and Medicaid. The analyses are currently in progress with a focus on cost, utilization, and experience in ADK practices compared to both PCMH practices not participating in ADK and to non-PCMH practices. It is expected that all of the private payers will continue to monitor trends over time for cost, utilization rates, and quality for their own members. Additionally,

implementation of DocInsight for member satisfaction will provide opportunities for continuous quality improvement.

An evaluation of the effects of P4P on quality, satisfaction, and utilization will be useful once providers begin to regularly receive payment for performance. Changes in quality, satisfaction, and utilization related to the amount providers receive can be considered in relation to important dates in the P4P initiative. For example, evaluators will explore if performance changed as a result of the demonstration (the start date for data collection) and if performance further changed as a result of funding being released to providers (the start date for P4P payment).

### *The Future of the ADK Demonstration*

Although the legislation allowing New York Medicaid to oversee the ADK demonstration has expired (New York Public Health Law §2959), the ADK is able to continue to operate under the New York Public Health Law §2959a-A Multipayer Patient Centered Medical Home Program. This new legislation allows for the continuation of the ADK demonstration and for the creation of additional PCMH multi-payer initiatives to operate in New York as well.

In September of 2014, CMS announced plans to extend the MAPCP demonstration for another two years, ending December 31, 2016. The remaining eight payers are currently engaged in meetings to discuss the structure of the demonstration going forward with plans to promote other payment reforms such as a shared savings program, on a voluntary basis. Satisfaction surveys will transition from a mail methodology to a web-based tool allowing for more timely results and the capability to make improvements quickly. The practices have also renewed their PCMH recognition under NCQA's 2011 standards.

## APPENDIX 1 ADULT QUALITY MEASURES

Measure	Area	Description
Adult BMI Assessment	Prevention	The percentage of members, 18 to 74 years of age with an outpatient visit, who had their body mass index (BMI) documented during the measurement year or the year prior the measurement year.
Annual Monitoring for Patients on Persistent Medications- Combined Rate	Safety	The percentage of members 18 years and older who were taking certain medications for a minimum of six months and who received specific monitoring tests. The following rates specify categories of medications that are of interest: ACE Inhibitors or ARBs, Digoxin, Diuretics or Anticonvulsants.
Antidepressant Medication Management-Effective Acute Phase Treatment	Chronic Disease	The percentage of members ages 18 years and older who were diagnosed with depression and treated with an antidepressant medication who remained on antidepressant medication during the entire 12-week acute treatment phase.
Antidepressant Medication Management-Effective Continuation Phase Treatment	Chronic Disease	The percentage of members ages 18 years and older who were diagnosed with depression and treated with an antidepressant medication who remained on antidepressant medication for at least six months.
Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis	Acute Care	The percentage of adults, ages 18 to 64, with acute bronchitis who did NOT receive a prescription for antibiotics.
Breast Cancer Screening	Prevention	The percentage of women between the ages of 40 and 69 who had a mammogram during the measurement year or the year prior.
Cervical Cancer Screening	Prevention	The percentage of women between the ages of 24 and 64 who had a Pap test, within the measurement year.
Chlamydia Screening (Ages 21-24)	Prevention	The percentage of sexually active young women between the ages of 21 and 24 who had at least one test for Chlamydia during the measurement year.
Cholesterol Screening Test Cholesterol Level Controlled (<100mg/dL)	Chronic Disease	The percentage of members, ages 18 to 75 years, with a cardiovascular condition, who had at least one cholesterol screening test and whose cholesterol level was below the recommended level (100 mg/dL) during the measurement year.
Comprehensive Diabetes Care	Chronic Disease	This measure reports components of care for members, ages 18 to 75, with diabetes and the rate at which they received necessary components of diabetes care.
<i>Lipid Profile</i>	Chronic Disease	The percentage of members with diabetes who had at least one cholesterol screening test done during the past year.
<i>Dilated Eye Exam</i>	Chronic Disease	The percentage of members with diabetes who had a retinal eye screening exam during the last year or who had a negative retinal exam in the year prior.
<i>Nephropathy Monitoring</i>	Chronic Disease	The percentage of members with diabetes who had at least one nephropathy screening test or had evidence of nephropathy during the last year.
<i>Received All Tests</i>	Chronic Disease	The percentage of members with diabetes who had at least one of each of the following: HcA1c test, cholesterol screening test, dilated eye exam, and medical attention for nephropathy.

**APPENDIX 1 (Continued)**  
**ADULT QUALITY MEASURES**

Measure	Area	Description
<i>Poor HbA1c Control</i>	Chronic Disease	The percentage of members with diabetes whose most recent HbA1c level indicated poor control (>9.0 percent).
<i>HbA1C Control (&lt;8.0%)</i>	Chronic Disease	The percentage of members with diabetes whose most recent HbA1c level indicated poor control (>8.0 percent).
<i>HbA1C Control (&lt;7.0%)</i>	Chronic Disease	The percentage of members with diabetes whose most recent HbA1c level indicated poor control (>7.0 percent).
<i>Lipids Controlled (&lt;100 mg/dL)</i>	Chronic Disease	The percentage of members with diabetes whose most recent level of bad cholesterol was below the recommended level (LDL-C <100 mg/dL).
<i>Blood Pressure Controlled (&lt;140/90)</i>	Chronic Disease	The percentage of members with diabetes whose most recent blood pressure reading was below 140/90.
<i>HbA1c and Lipids Controlled</i>	Chronic Disease	The percentage of members with diabetes whose most recent HbA1c level was at or less than 9.0 percent and whose most recent level of bad cholesterol was below the recommended level (LDL-C <100 mg/dL).
Controlling High Blood Pressure	Chronic Disease	The percentage of members, ages 18 to 85 years, who have hypertension and whose blood pressure was adequately controlled (below 140/90).
Medical Management for People with Asthma 50% Covered (Ages 19-50)	Chronic Disease	The percentage of members between 19 and 64 years of age, who were identified as having persistent asthma and were dispensed appropriate medications and remained on an asthma controller medication for at least 50% of their treatment period.
Use of Imaging Studies for Low Back Pain	Overuse	The percentage of adults, ages 18 to 64, with acute bronchitis who did NOT receive a prescription for antibiotics.

## APPENDIX 2 PEDIATRIC QUALITY MEASURES

Measure	Area	Description
Adolescent Immunization-Combo	Prevention	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.
Adolescent Well-Care Visits	Prevention	The percentage of adolescents (ages 12-21) who had at least one comprehensive well-care visit with a primary care provider during the measurement year.
Appropriate Testing for Pharyngitis	Acute Care	The percentage of children, ages two to 18 years, who were diagnosed with pharyngitis, were prescribed an antibiotic, and who were given a group A streptococcus test.
Childhood Immunization Status (Combo 3: 4-3-1-3-3-1-4)	Prevention	The percentage of two-year olds who were fully immunized. The HEDIS specifications for fully immunized consist of the following vaccines: 4 Diphtheria/Tetanus/Pertussis, 3 Polio, 1 Measles/Mumps/Rubella, 3 H Influenza type B, 3 Hepatitis B, 1 Varicella, and 4 pneumococcal.
Chlamydia Screening (Ages 16-20)	Prevention	The percentage of sexually active young women between the ages of 21 and 24 who had at least one test for Chlamydia during the measurement year.
Counseling for Nutrition	Prevention	The percentage of children and adolescents ages 3-17 who had an outpatient visit with a PCP or OB/GYN practitioner during the measurement year, had counseling for nutrition.
Counseling for Physical Activity	Prevention	The percentage of children and adolescents ages 3-17 that had an outpatient visit with a PCP or OB/GYN practitioner during the measurement year, which had counseling for physical activity.
Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase	Chronic Disease	The percentage of children, ages 6 to 12 years, who remained on the medication for 7 months and who, in addition to the visit in the Initiation Phase, had at least 2 follow-up visits in the 9-month period after the initiation phase ended.
Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	Chronic Disease	The percentage of children, ages 6 to 12 years, who were newly prescribed ADHD medication and had one follow-up visit with a practitioner within the 30 days after starting the medication.
Medical Management for People with Asthma 50% Covered (Ages 5-18)	Chronic Disease	The percentage of members between 5 and 18 years of age, who were identified as having persistent asthma and were dispensed appropriate medications and remained on an asthma controller medication for at least 50% of their treatment period.
Weight Assessment - BMI Percentile	Prevention	The percentage of children and adolescents ages 3-17 who had an outpatient visit with a PCP or OB/GYN practitioner during the measurement year, who had their body mass index (BMI) calculated.
Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life	Prevention	The percentage of children between the ages of three and six years who had one or more well-child visits with a primary care provider during the measurement year.
Well-Child & Preventive Care Visits in First 15 Months of Life (5+Visits)	Prevention	The percentage of children who had five or more well-child visits with a primary care provider in their first 15 months of life.

## APPENDIX 3

### PATIENT SATISFACTION SURVEY QUESTIONS

#### **Overall Provider Rating:**

- Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?

#### **Communication Composite:**

- In the last 12 months, how often did this provider explain things (about your child's health) in a way that was easy to understand?
- In the last 12 months, how often did this provider give you easy to understand information about these health questions or concerns?
- In the last 12 months, how often did this provider seem to know the important information about your/your child's medical history?
- In the last 12 months, how often did this provider show respect for what you had to say?
- In the last 12 months, how often did this provider spend enough time with you/your child?

#### **Follow-up on Test Results:**

- In the last 12 months, when this provider ordered a blood test, x-ray or other test for you/your child, how often did someone from this provider's office follow up to give you those results?

#### **Office Staff Composite:**

- In the last 12 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?
- In the last 12 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?

#### **Access Composite:**

- In the last 12 months, when you phoned this provider's office to get an appointment for care you/your child needed right away, how often did you get an appointment as soon as you thought you/your child needed?
- In the last 12 months, when you made an appointment for a check-up or routine care (for your child) with this provider, how often did you get an appointment as soon as you thought you/your child needed?
- In the last 12 months, how often were you able to get the care you/your child needed from this provider's office during evenings, weekends, or holidays?
- In the last 12 months, when you phoned this provider's office after regular office hours, how often did you get an answer to your medical question as soon as you needed?
- Wait time includes time spent in the waiting room and exam room. In the past 12 months, how often did you/your child see this provider within 15 minutes of your/his or her appointment time?

## APPENDIX 4 PROVIDER EXPERIENCE SURVEY QUESTIONS

### **Practice Composite:**

Q2a. Indicate how well each of the following is currently accomplished at your practice:

1. Answering Phones
2. Appointment System
3. Messaging
4. Scheduling Procedures
5. Ordering Diagnostic Testing
6. Reporting Diagnostic Test Results
7. Prescription Renewals
8. Making Referrals
9. Pre-authorization for Services
10. Billing/Coding
11. Phone Advice
12. Orientation of Patients to Your Practice
13. New Patient Work-ups
14. Minor Procedures
15. Education for Patients/Families
16. Prevention Assessment/Activities
17. Chronic Disease Management
18. Coordination of Patient Care

### **Patient Centeredness Composite:**

Q6a. For each of the following, please indicate how much you agree or disagree with the statement:

1. This practice does a good job of managing patients concerns and suggestions
2. This practice does a good job of assessing current patients' needs and expectations
3. The staff promptly resolves patient complaints
4. Patients complaints are studied to identify patterns and prevent the same problems from recurring
5. This practice uses data from patient complaints to improve services

Q6b. Does your practice do the following:

1. Are patients asked for their ideas on their treatment plan?
2. Are patients asked to talk about any questions they are having with their medications?
3. Are patients asked about health habits in written or oral form?

### **Team Dynamics Composite:**

Q4a. For each of the following, please indicate how much you agree or disagree with the statement:

1. The entire staff of your practice works together like a team
2. Other staff have the skills and knowledge to back you up
3. Practice has enough people and resources to meet patients' needs
4. Each member of this practice contributes to the practice's success

5. Practice members are encouraged to express alternative viewpoints about service and clinical quality issues

**Satisfaction Composite:**

Q3a. Indicate how well each of the following is currently accomplished at your practice:

1. Opportunities for growth through education/additional training
2. Utilization of your abilities
3. Amount of time you are able to spend with each patient
4. Degree of responsibilities you have
5. Assistance and support for your coworkers

Q3b. How satisfied are you with each aspect of care, for patients in your practice:

1. Quality of health care
2. Stability of patient relationships
3. Ability to provide continuity of care for the patients
4. Your familiarity with the patients

Q3c. How would you rate the following:

1. Your morale and attitudes about working here
2. Other people's morale and attitudes about working here

Q4d: Over the last 12 month, how often have you felt:

1. Hurried or rushed
2. Stressed or overworked

**Quality Improvement Composite:**

Q5a. For each of the following, please indicate how much you agree or disagree with the statement:

1. You know how to measure to quality of your work
2. You collect data about the quality of your work
3. You know how to analyze (review) the quality of your work to see if changes are needed
4. You use these analyses for making decisions about your work
5. You know how well your practice is doing financially
6. You are recognized for your work