PUBLIC COMMENT SUBMISSION FORM
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Physician Practice Connections™ Version 2 Draft Standards

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Standard/ Element	***Issue****	***Comment***
General Comment 1	The tool generally addresses issues relevant to primary care physicians' treatment of chronically ill patients. We encourage NCQA to consider, for each element, how the element is applicable to different specialties and across different treatments. In many cases, it is reasonable to consider prevalent procedures or treatments instead of chronic conditions. This notion is specifically addressed in detail below as it relates to itemized elements. Please consider that for some modules, it might be necessary to create specialty-specific documents. Each module should be evaluated for "fit" across specialties and treatments.	
General Comment 2	The scoring algorithms do not differentiate between physicians who meet 100% of the standards and those who meet some percentage adequate for full credit. Additionally, there is a subset of qualifiers within each element that are more valuable and should be weighted accordingly. NCQA is encouraged to weight scoring within each standard to appropriately identify those providers engaged in empirically-based systems that most impact quality and efficiency of care provided. Further, disclosure of practitioner compliance with specific elements, as opposed to the "batch" score now proposed, is necessary for consumers, payers, policy-makers, network developers, etc.	
General Comment 3	The standards, and elements contained therein, do not adequately describe comprehensive automated work flow platforms. In all cases, there should be easy recognition of the activity (as described in these standards), responsible party, timeframe, and systematic alerts when tasks are not completed as described and within the dictated timeframe. Obvious alerts are outlined in our comments. NCQA is encouraged to consider how alerts fit into all elements of each standard.	
General Comment 4	General EHR functionality that is overarching and/or is not explicitly evident in all the elements described are proposed below. Please consider adding a standard of general EHR functionality that includes such elements as: o Record emphasizes patient-specific actionable data, e.g. lab results, care reminders, self-management goals, etc. for easy follow up at point of care including alerts when care is not consistent with actions and timeframes as dictated (seem comment 3 above). o EHR enables trending and graphing so that it may be used as a patient education tool at point of care.	

	○ All data included within an EHR must be exportable for purposes of transmission to repository for population management, and for the potential of portability across practice sites. Innate in this is the use of nationally endorsed standards as outlined in section 8B, and technical capability to export data at the record (patient) level.	
1A	Information on patients tracked by practice's "basic" electronic system	Consider including: ○ HIPAA Privacy Release form(s) ○ Emergency Treatment Consent Form
1A	Explanation of Proposed Scoring, Method 3	Allowing attestation is not necessary here. Generating a denominator equal to the number of patients with at least one visit within the last 3 months is a feasible calculation for electronic or manual systems. Generating a numerator equal to the number of patients with these data elements should be a mandatory requirement of the system being assessed.
1B	Electronic System for Clinical Data	Consider including: ○ Organ donor status with advance directives Note timeliness quotient for risk factors. Because these factors are often modified by behavior and subject to change, they must be updated with routine frequency. Please consider defining adding a date-of-entry indicator on all risk factors.
1C	Registry input and output	Consider deleting this element. Registry input is well documented in: ○ 3A-Documenting Risk Factors ○ 8A-Integration of electronic data ○ 8C-Electronically receiving data Registry output is well documented in: ○ 2B-Using evidence-based guidelines (patient identification) ○ 2D-Population management ○ 2F-Conducting high-risk care management ○ 7A-Measurement and performance ○ 7B-Performance Reports ○ 7D-Reporting by linking electronic data ○ 7E-Electronic reporting-external entities ○ 8E-Using data for referral reports
2A	Identifying important chronic conditions	See general comment # 1 above. This standard well illustrates the inapplicability of this draft to specific specialties. Consider forcing the identification of high risk/prevalence treatment types as well as conditions. Consider developing standards around those conditions or procedures which cumulatively account for 75% of the practice's activity. Please ascertain in your scoring explanation that the conditions and treatments upon which these standards are based are identified as a function of frequency, cost, AND ability to be impacted both clinically and financially by systematic intervention.
2B	Using evidence-based guidelines, Explanation of scoring	In addition to use of evidence based guidelines, please consider adoption of nationally endorsed patient safety practices that are ambulatory care-relevant.

		Consider establishing "pass thresholds" on HEDIS process measures, as available, as evidence of meeting the standard. I.e., if diabetes is a top chronic condition, then report of the diabetes HEDIS process measures above the stated threshold would be adequate evidence of guideline compliance.
2C	Use of resources to assist patients	See general comment 2 above. The scoring algorithm here allows the same credit for a practice that does not institute follow-up when patients have not kept important appointments as it would for those practices that have. This well illustrates general comment 2 about awarding credit accordingly for 100% compliance, and for weighting element, recognizing a relative value to be gained by each element. Consider adding a requirement for the practice to demonstrate effective and efficient use of non-physician care-givers as appropriate.
2D	Population Management, Explanation of scoring: Data Source. "The practice must show that its clinicians review and use the paper-based system between patient appointments".	Population management should not be done with a paper-based system. It is highly inefficient and error-prone. This option should not be allowed for in scoring. The evidence cited does not demonstrate population management, but instead demonstrates use of resources to assist patients (in 2C, see 2-pre-visit planning and 2E-Decision Support at the Point of Care). Consider requiring evidence of population management that demonstrates true note of group prevalence, risk, and trends. Examples include those indicated for electronic systems as well as trending reports, targeted communications, and physician panel profiles.
2E	Decision support at point of care	Consider organizing reminders into categories, e.g. "Preventive" and "Chronic care". Consider adding the following point of care reminders: o Shared decision-making relative to preference-sensitive treatments o Readiness to change assessments Note general comments 3 and 4 above, and the desired use of systematic alerts as reminders and warnings at point of care (as well as for between visit patient-specific management).
2G	Care manager and physician communication	See general comment 1 above. This well illustrates inapplicability to certain specialties. Consider that for some hospital-oriented specialties, discharge planning and coordination would be an appropriate element.
3C and 3D	Educational resource topics and Connecting patients with self-management resources	The distinction between these two elements is unclear. As described, self-management resources may include classes, i.e. education. Consider combining these two elements with proposed scoring graduated based on number of options, e.g. classes, support groups,

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		interactive web-based programs, etc. Consider enhancing the element to include a systematic method for monitoring compliance. I.e. did patient follow through with class referral or is patient attending a 12-step program as referred?
3E	Self-management communication	This standard mixes alternative delivery systems, e.g. open access and group visits, with self management communications, e.g. interactive websites. Please clarify description of the standard, or consider splitting into two distinct standards. Consider emphasizing and continually advancing the science on those approaches to self-management that are based on empirically sound social science, e.g. Readiness to Change and Motivational Interviewing. Consider adding: o Health Coach
3F	Self management treatment plans	See general comment 3 above. A noted timeframe should be includes in all automated work flow platforms that systematically alert for follow-up or breach of compliance intervention. Consider adding: o Assessing readiness to change
4A	Electronic Prescribing Writing-Proposed Scoring	The proposed scoring awards 20% for a system capable of meeting the standard even if it does not. This is consistent with NCQA's approach throughout the document. However for this element, meeting the standard for less than 50% of the prescriptions written receives no credit (as does not having the capability at all). Therefore, having system capability with no implementation actually gains more credit than meeting the standard between 0%-50% of the time. Consider changing the scoring algorithm to award credit for meeting the standard less than 50% of the time (perhaps 20% credit).
4B	Electronic prescribing capability-connection to the pharmacy of the patient's choice	Consider rewording to allow use of a vendor for connection to pharmacy, e.g. Rx Hub. Use of this prevalent vendor would eliminate a practice's need to establish direct pharmacy connections.
4C	Prescribing decision support-safety. Proposed Scoring	Scoring for this standard combines patient-specific alerts and information with general alerts and information. Practitioners with access to patient-specific information at time of prescribing are hugely advantaged (and likely have far more systematic capability) than those who don't. The scoring algorithm should represent the critical distinction. This is important not only from a scoring/reporting perspective, but also for purposes of data collection and understanding the state of practice management. Consider splitting patient-specific

		functionality from general information. See general comment 2 above. This standard well illustrates the distorted perception now enabled with batch scoring. Please consider scoring based on actual number of elements achieved.
4D	Prescribing decision support-efficiency. Proposed Scoring.	Current scoring algorithm implies an "all or nothing" strategy that rewards more credit for "capability but no implementation" than it does for "adoption of one tool". Consider graduating the scoring to reward partial completion of the standard. Universally, PBGH supports scoring based on number of elements accomplished vs. batch scoring as well as the incorporation of weighting. Specifically, element 4D2 would provide patient specific/formulary specific information and would be considered more "valuable".
	Prescribing decision support-efficiency. Element description.	Consider adding: o In addition to generics, recognize alternative cost effective brands (this can be an addition to 1 and 2 now in place). o Electronic prescription writer that alerts provider when dose optimization opportunities exist (i.e. when multiple pills per day prescriptions can be replaced with one pill per day prescriptions).
5A	System for tracking tests	Please define "tracking". I.e., is system expected to alert for outlier results, monitor if a result has been assessed by a clinician, and/or check for patient compliance with the order?
5B	Proposed scoring	Proposed scoring rewards partial credit (50%) for evidence of follow-up for abnormal test results with clinician OR patient. It is recommended that this element clarifies that a clinician should provide evidence of review (customary today is via initial) of all tests prior to communication with the patient.
5D	Decision support for tests 1. abnormal laboratory test results received 2. abnormal radiology test results received 3. duplicate tests ordered	It appears that parts 1 and 2 of this element are duplicative to 5B-Follow-up for abnormal test results and potentially duplicative to 5A-System for tracking tests (as described in an earlier comment, it is unclear if "tracking" here includes follow up after abnormal results). Consider deleting 5A, and fleshing out 5B to represent the standard for physician and patient follow up after abnormal test results. Note that in accordance with 1B-Electronic system for clinical data, it has already been established that lab and radiology results will be in the patient record for reference at point of care or between visits. 5D-Decision support for tests can include alerts for duplicate test ordering, as well as safety alerts, e.g. x-rays for pregnant women, efficiency alerts e.g. appropriate cat scan vs. MRI alerts, etc.

6A	Tracking referrals-In the past 12 months the practice has used a system that includes the following information o Origination o Documentation o Tracking status o Clinical and administrative details	Other standards have a 3 month lifespan requirement. This standard requires 12 months. Because these systems are new and evolving, a 12 month requirement may disqualify effective practices from compliance with this standard. Consider adopting a 3 month timeframe consistent with the other standards. Please include a definition of the four types of information required. I.e., it is unclear what is meant by "documentation" considering that clinical and administrative details are listed as a unique item. See general comment 3 and 4. Does "tracking status" include an alert for patients not in compliance with referrals? Please be explicit and recognize each specific element in scoring. Consider adding elements relative to physician consideration of performance-based quality and efficiency information as available to better inform referral decisions. Scoring algorithm should recognize the availability of this information from payers and the integration of the information into point of care decision support for referrals. Consider adding elements relative to patient-physician interaction and evidence of physician consideration of patient preferences with regard to quality, cost, and geography of referral recommendation.
7A	Measurement of performance	Recognizing the inefficiencies associated with data collection, consider requiring use of administrative data for producing measures. Consider adding measures of efficiency (note standard intent as stated in the document references efficiency but no measure of efficiency is included in the standard).
7B	Performance Reports	Consider application of measures to non-physicians with patient interaction. This includes administrative support responsible for responding to alerts, reminders, etc.
7D	Reporting by linking electronic data-Proposed Scoring	Consider adjusting scoring algorithm to score based on actual elements met instead of batching elements. See general comment 2 above.
8A	Integration of electronic data 1. uses accurate procedures for integrating all patient-level data showing rendering provider and clinical histories to a repository 4. has procedures to consolidate information from multiple sources 5. uses appropriate mechanisms to link data across sources	The distinction between items 1, 4, and 5 is not clear. Consider consolidating these three as follows: Uses accurate procedures for integrating all patient-level data from multiple sources with rendering provider and clinical histories to a repository

	3. maintains a repository that is valid and complete Proposed Scoring	Consider rewording item number 3 to acknowledge that the practice may utilize an external repository or outsource data integration to a vendor. Proposed scoring indicates full credit for compliance with items 2 and 6. Neither of those elements indicates that a repository of comprehensive patient data is maintained. Data "stuck" in an EHR may not be optimally usable. Consider moving away from batch scoring to an algorithm that recognizes compliance with individual elements.
8C	Electronically receiving data	Consider adding performance information where it is available. Consider that practice sites have access to practitioner and facility performance information from payers that supports comparative information at time of referral. Add the integration of these data as a scoring requirement.
8D	Electronically exchanging data	The need for 8D, given 8A and 8C is unclear. 8A and 8C are about integrating data, and the specific data types respectively. Please clarify the elements critical to exchange that are not receiving or integrating (possibly this standard is referring specifically to transmission, or possibly to auto correction or edit features, but intent of 8D is not evident. Please clarify.
8E	Using data for referral reports	Consider relocating this element to the referral section 6. Recommend clarifying that items in 1A and 1B are also included in a referral report.

*Issue may address a global comment, a specific standard or scoring element, data sources, explanations or examples.

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