Initiatives Supporting NCQA Recognition Programs

- **Maine** - Patient Centered Medical Home Pilot
- **Vermont** - Vermont “Blueprint for Health”
- **North Carolina** - Community Care of North Carolina (N3CN)
- **Pennsylvania** - Chronic Care Commission, PAFP
- **Rhode Island** - Connect Care Choice Program
- **Minnesota** - Primary Care Coordination Program - Facilitated by Office of the Commissioner of Securities and Insurance
- **Maryland** - Maryland Health Care Collaborative (MHCC)
- **Michigan** - Priority Health, Health Plan of Michigan and Medicaid Health Plan
- **Massachusetts** - State Medicaid PCMH Initiative
- **New York** - Adirondack Medical Home Demonstration, State Medicaid
- **Ohio** - Cincinnati Health Improvement Collaborative
- **Colorado** - Colorado Clinical Guidelines Collaborative
- **Louisiana** - Through DHH the Louisiana Health Care Quality Forum
- **Washington State Medicaid Medical Home Initiatives** - Currently reviewing NCQA PCMH Recognition Programs
- **Connecticut** - Connecticut Primary Care Case Management (PCCM) Program - Currently reviewing NCQA PCMH Recognition Programs
How NCQA Revised its PCMH Standards

- Collected, analyzed stakeholder suggestions
- Analyzed data from NCQA PCMH practices
- Conducted patient experience research
- Sought public comment
- Interviewed NCQA PCMH practices
- Worked closely with thoughtful, committed PCMH Advisory Committee
Stakeholder Suggestions for PCMH 2011

- Underscore the importance of system cost-savings to employers
- Enhance patient-centeredness
- Emphasize language, culturally sensitive aspects
- Integrate behavioral health/risk factor assessment & management
- Include comprehensive care
- Consider relationship with/ expectations of subspecialists
- Evaluate patient experience
PCMH 2011 Development Goals

• Increase patient-centeredness
• Align requirements with processes that improve quality and eliminate waste
• Increase emphasis on patient experience
• Enhance use of clinical performance measure results
• Integrate: unhealthy behaviors, mental health and substance abuse
• Enhance coordination of care
• Enhance applicability to pediatric practices
PCMH 2011 Key Components

- **Access**
  - Evening/weekend hours, agreement with facility for after-hours care

- **Coordination of care**
  - Information to/from specialists/facilities/patient, update care plan

- **Team-based care**
  - Defined roles and responsibilities, training, communication

- **Role of medical home**
  - Discuss roles/expectations for medical home and for patients

- **Care management**
  - Pre-visit planning, care planning during visit, patient self-care, point of care reminders
  - Medication management
  - Include mental health/substance abuse/behaviors affecting health

- **Self-care management with community resources/referrals**

- **Identify/address population needs/risks**

- **Quality improvement**
  - Performance measurement
  - Patient experience
## Comparison of PPC-PCMH and PCMH 2011

### PPC-PCMH (9 standards/30 elements)

1. **Access and Communication**
   - Processes
   - Results
2. **Patient Tracking and Registry Function**
3. **Care Management**
   - Continuity Between Settings
4. **Self-Management Support**
5. **Electronic Prescribing**
6. **Test Tracking**
7. **Referral Tracking**
8. **Performance Reporting and Improvement**
   - Measure Performance
   - Measure Patient/Family Experience
9. **Advanced Electronic Communication**

### PCMH 2011 (6 standards/28 elements)

1. **Access/Continuity**
   - Access/Continuity
   - Medical Home Responsibilities
   - CLAS
   - Practice Team
2. **Identify/Manage Patient Populations**
3. **Plan/Manage Care**
   - Care Management (Incl. Behavioral Health)
   - Identify High Risk Patients
   - Medication Management/E-Prescribing
4. **Self-Care and Community Referrals**
5. **Track/Coordinate Care**
   - Test/Referral Tracking and Follow-Up
   - Coordinate with Facilities
6. **Performance Measurement/Quality Improvement**
   - Measure Performance/Patient Experience
   - Continuous Quality Improvement
   - Report Performance and Data
# 2011 PCMH Content and Scoring

<table>
<thead>
<tr>
<th>Standard 1: Enhance Access and Continuity</th>
<th>Pts</th>
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</thead>
<tbody>
<tr>
<td>A. <strong>Access During Office Hours</strong></td>
<td>4</td>
</tr>
<tr>
<td>B. After-Hours Access</td>
<td>4</td>
</tr>
<tr>
<td>C. Electronic Access</td>
<td>2</td>
</tr>
<tr>
<td>D. Continuity</td>
<td>2</td>
</tr>
<tr>
<td>E. Medical Home Responsibilities</td>
<td>2</td>
</tr>
<tr>
<td>F. Culturally and Linguistically Appropriate Services</td>
<td>2</td>
</tr>
<tr>
<td>G. Practice Team</td>
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<td><strong>Total</strong></td>
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<table>
<thead>
<tr>
<th>Standard 2: Identify and Manage Patient Populations</th>
<th>Pts</th>
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<tbody>
<tr>
<td>A. Patient Information</td>
<td>3</td>
</tr>
<tr>
<td>B. Clinical Data</td>
<td>4</td>
</tr>
<tr>
<td>C. Comprehensive Health Assessment</td>
<td>4</td>
</tr>
<tr>
<td>D. <strong>Use Data for Population Management</strong></td>
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<thead>
<tr>
<th>Standard 3: Plan and Manage Care</th>
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<tbody>
<tr>
<td>A. Implement Evidence-Based Guidelines</td>
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<tr>
<td>B. Identify High-Risk Patients</td>
<td>3</td>
</tr>
<tr>
<td>C. <strong>Care Management</strong></td>
<td>4</td>
</tr>
<tr>
<td>D. Medication Management</td>
<td>3</td>
</tr>
<tr>
<td>E. Use Electronic Prescribing</td>
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<table>
<thead>
<tr>
<th>Standard 4: Provide Self-Care Support and Community Resources</th>
<th>Pts</th>
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<tbody>
<tr>
<td>A. <strong>Support Self-Care Process</strong></td>
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<tr>
<td>B. Provide Referrals to Community Resources</td>
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<table>
<thead>
<tr>
<th>Standard 5: Track and Coordinate Care</th>
<th>Pts</th>
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</thead>
<tbody>
<tr>
<td>A. Test Tracking and Follow-Up</td>
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<tr>
<td>B. <strong>Referral Tracking and Follow-Up</strong></td>
<td>6</td>
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<tr>
<td>C. Coordinate with Facilities/Care Transitions</td>
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<table>
<thead>
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<th>Standard 6: Measure and Improve Performance</th>
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<td>A. Measure Performance</td>
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<tr>
<td>B. Measure Patient/Family Experience</td>
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<tr>
<td>C. <strong>Implement Continuously Quality Improvement</strong></td>
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</tr>
<tr>
<td>D. Demonstrate Continuous Quality Improvement</td>
<td>3</td>
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<tr>
<td>E. Report Performance</td>
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<tr>
<td>F. Report Data Externally</td>
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<tr>
<td>G. Use of Certified EHR Technology</td>
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**Must Pass Elements**
**PCMH Scoring**

6 standards = 100 points

6 *Must Pass* elements

**NOTE:** *Must Pass* elements require a $\geq 50\%$ performance level to pass

<table>
<thead>
<tr>
<th>Level of Qualifying</th>
<th>Points</th>
<th>Must Pass Elements at 50% Performance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 3</td>
<td>85 - 100</td>
<td>6 of 6</td>
</tr>
<tr>
<td>Level 2</td>
<td>60 - 84</td>
<td>6 of 6</td>
</tr>
<tr>
<td>Level 1</td>
<td>35 - 59</td>
<td>6 of 6</td>
</tr>
<tr>
<td>Not Recognized</td>
<td>0 - 34</td>
<td>&lt;6</td>
</tr>
</tbody>
</table>

Practices with a numeric score of 0 to 34 points and/or achieve less than 6 “Must Pass” Elements are not Recognized. Recognition is granted for three (3) years and is not transferable. A practice can submit an add-on survey during the three years to achieve a higher Level of recognition.
How Are We Doing?

- Medical homes have yielded promising results ...
  - 29% reduction in ED visits at Group Health
  - 20% reduction in hospitalizations at Geisinger
  - Achieve 94% of diabetes patients having ≥2 primary care visits per year for NC Medicaid
  - Over $400 million saved over 4 years for NC Medicaid
  - 3.8% total cost savings in Iowa
  - 11% expected cost savings in VT
  - $640/year saved per patient for the community at Intermountain

- ... and are being widely adopted across the country

- 45 states are involved in medical home pilot activity

Published and Ongoing Research on PCMH

• Key features of successful medical home pilots:
  – Use of non-physician care coordinators
  – Expanded access to health practitioners
  – Data-driven analytic tools
  – Use of payment to incentivize change (Fields, Leshen, Patel, 2010)

• Access to care through visits outside of regular hours and same day access shown to reduce emergency department use (Bodenheimer and Pham, 2010)

• A PCMH in integrated group practice showed significant improvements in patients’ and providers’ experiences in the quality of clinical care (Reid 2009).

• Clinical systems are associated with decreased use of inpatient and emergency care but not ambulatory care utilization in diabetes (Flottemesch, under review)
Positive Impact on Practices

- Better care management programs
- Greater attention to patient compliance
- Improved patient outreach (patient reminders, increased screenings, educational materials)
- Increased data collection and reporting
- Incentivizes investment in quality infrastructure and processes
Meaningful Use of Health Information Technology (HIT)

- NCQA emphasizes HIT because good primary care is information-intensive.
- PCMH 2011 reinforces incentives to use HIT to improve quality.
- Meaningful use language is embedded, often verbatim, in PCMH 2011 evaluation standards.
- Synergy/virtuous cycle: PCMH 2011 medical practices will be well prepared to qualify for meaningful use, and vice versa.
Distinction in Patient Experience Reporting

**Purpose:** Acknowledge practices that put in the extra effort to collect and report patient experience information in a standardized way

- NCQA developed the optional Distinction in Patient Experience Reporting to help practices capture patient and family feedback through the newly developed CAHPS PCMH Survey. Because consumer experience is a critical component of quality of care, more prominence on patient engagement is a crucial change to the PCMH program. The CAHPS PCMH Survey assesses several domains of care:
  - Access
  - Information
  - Communication
  - Coordination of care
  - Comprehensiveness
  - Self-management support and shared decision making.
Why Require CAHPS Patient-Centered Medical Home (PCMH)?

- Use of a standardized survey allows “apples to apples” comparison of patient experience across recognized practices.
- Non-proprietary survey and can be easily adopted by practices and vendors.
- Survey is specifically designed to evaluate patient experience with medical homes.
- Survey derived from the most widely used consumer experience survey.
- Rigor of the survey design and consumer testing process.
- Other entities and initiatives are likely to require use of CAHPS PCMH.
What is the PCMH application process?
Practice Tasks in Application Process

• Obtain a Survey Tool ($80) and online application package (Note the online application system is your account with NCQA and it is a separate system from the Interactive Survey System)
• Multi-site organizations should obtain application package first for specific instructions (free)
• Enter practice site and clinician information in online application
• Record survey tool license number in online application
• Complete electronic agreements in online application
• Submit online application
• Receive email confirmation that NCQA systems are linked and practice can submit Survey Tool
• Upload documents and submit survey tool when ready, with application fee (20% discount for residency clinics)
NCQA PCMH Evaluation Process

1. NCQA receives submitted Survey Tool
2. NCQA evaluates Survey Tool
   • Responses, documentation, and explanations
   • Practice may be contacted for clarifications
3. Audit - 5% of practices, consists of document requests, teleconference, and/or on-site review
4. Executive reviewer conducts a secondary review
5. Survey Tool is referred to a trained Review Oversight Committee (ROC) member for a peer review
6. Final decision and status determined
7. Report results with Level 1, 2, or 3
   • Recognition posted on NCQA Web site
   • Not passed - not reported
8. PCMH certificate and recognition packet
9. Practice achieving Level 1 or 2 can do add-on survey within the 3 year recognition time period
Renewal Requirements

• **Goal for PCMH 2011** to streamline documentation requirements for renewal submissions

• **Renewal Guidelines**
  - For practices Recognized at Level 2 or 3
  - Practice must always respond to all standards/elements
  - Practice only required to provide documentation for subset of elements (12)
    - PCMH 1C and PCMH 1G
    - PCMH 2C and PCMH 2D
    - PCMH 3A, PCMH 3B, PCMH 3C, and PCMH 3D
    - PCMH 4A
    - PCMH 5C
    - PCMH 6A (Factors 3 and 4) and PCMH 6C
Free Recognition Training Programs
PC MH 2011

1. Getting on Board with PC MH
2. PC MH 2011 Standards
4. The Online Application and How to Submit as a Multi-Site Practice

NCQA Contact Information

Contact NCQA Customer Support to:

• Acquire standards documents, obtain access to an online application, and purchase survey tools
• Questions about user ID, password, access
• 1-888-275-7585

Visit NCQA Web Site to:

• View Frequently Asked Questions
• View Recognition Programs Training Schedule

Submit to questions to pcmh@ncqa.org

Or direct questions to assigned team contacts:

• Ask about interpretation of standards or elements
• Request technical assistance with the application process