NCQA's 2014 Patient-Centered Medical Home Recognition

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NCQA role

Our mission

- **To improve the quality of health care**

Our method

- **Measurement**

We can't improve what we don't measure

- **Transparency**

We show how we measure so measurement will be accepted

- **Accountability**

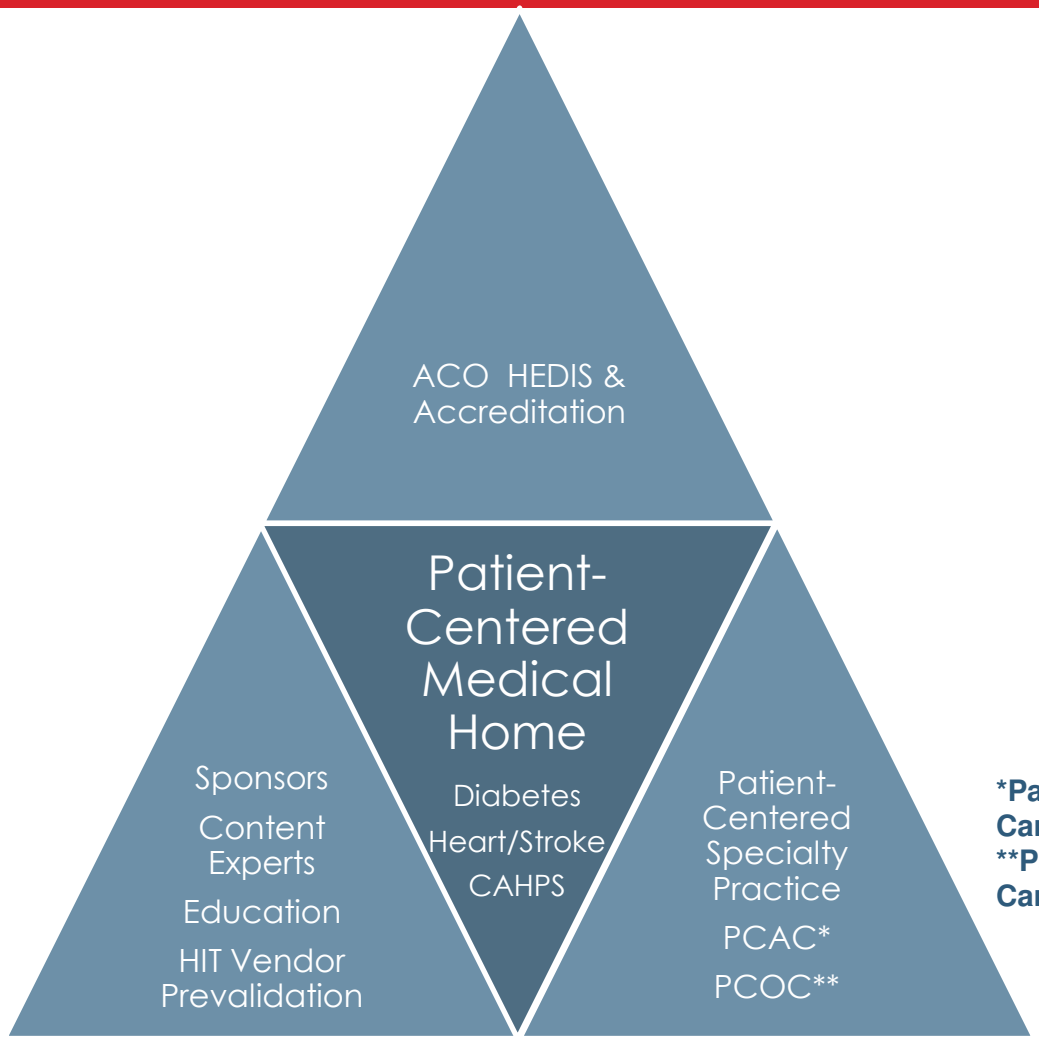
Once we measure, we can expect and track progress

Background

All providers should be part of accountable entities

- Health plans with exclusive networks (e.g., Kaiser)
- Medical groups/ACOs
- Integrated networks (including medical home "neighborhoods")
- Some specialties may need to stand alone (e.g., cancer)

The Big Picture: NCQA's Delivery System Accountability Suite



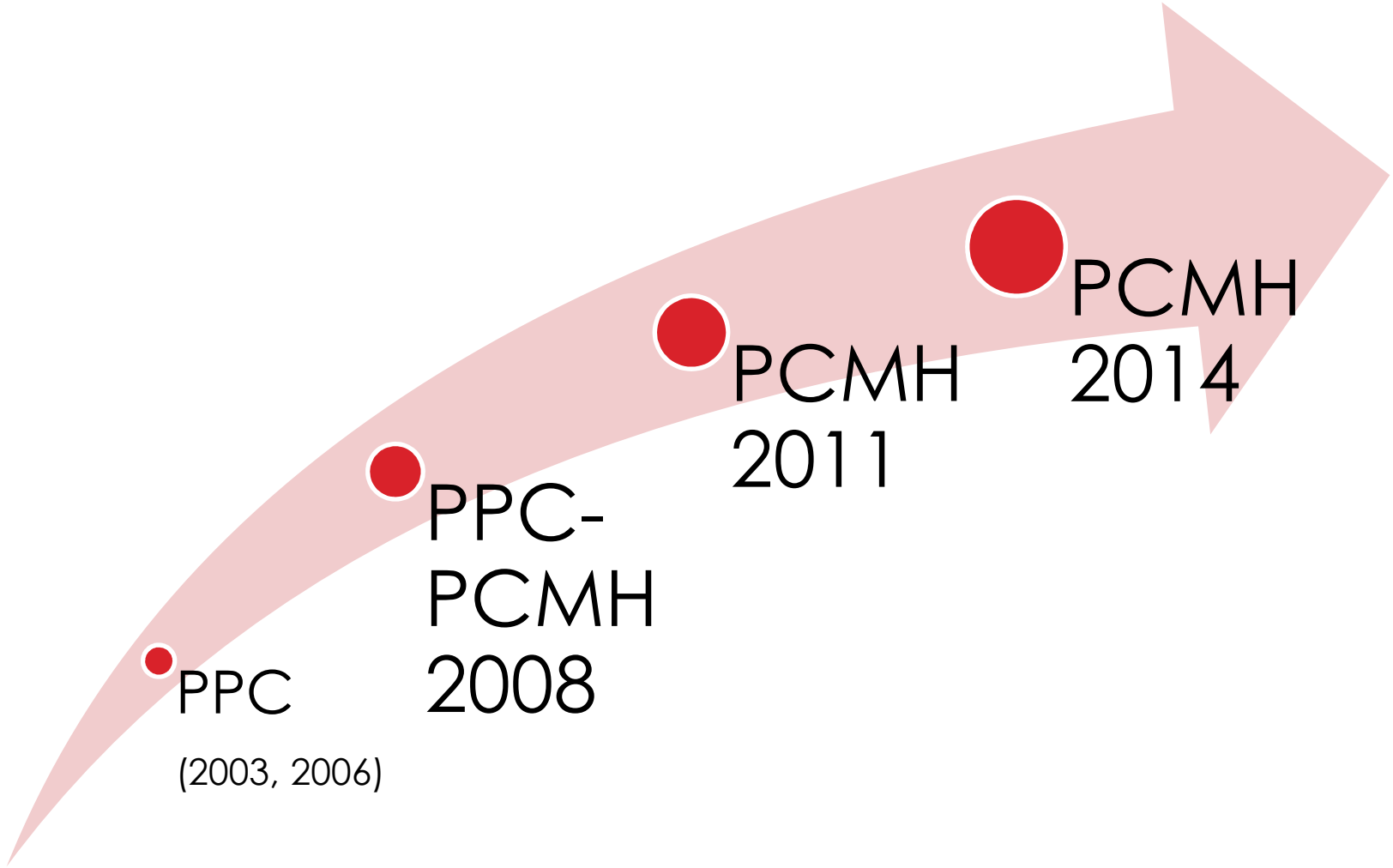
***Patient-Centered Ambulatory Care (working title)**
****Patient-Centered Oncology Care (PCORI contract)**

What is a PCMH?

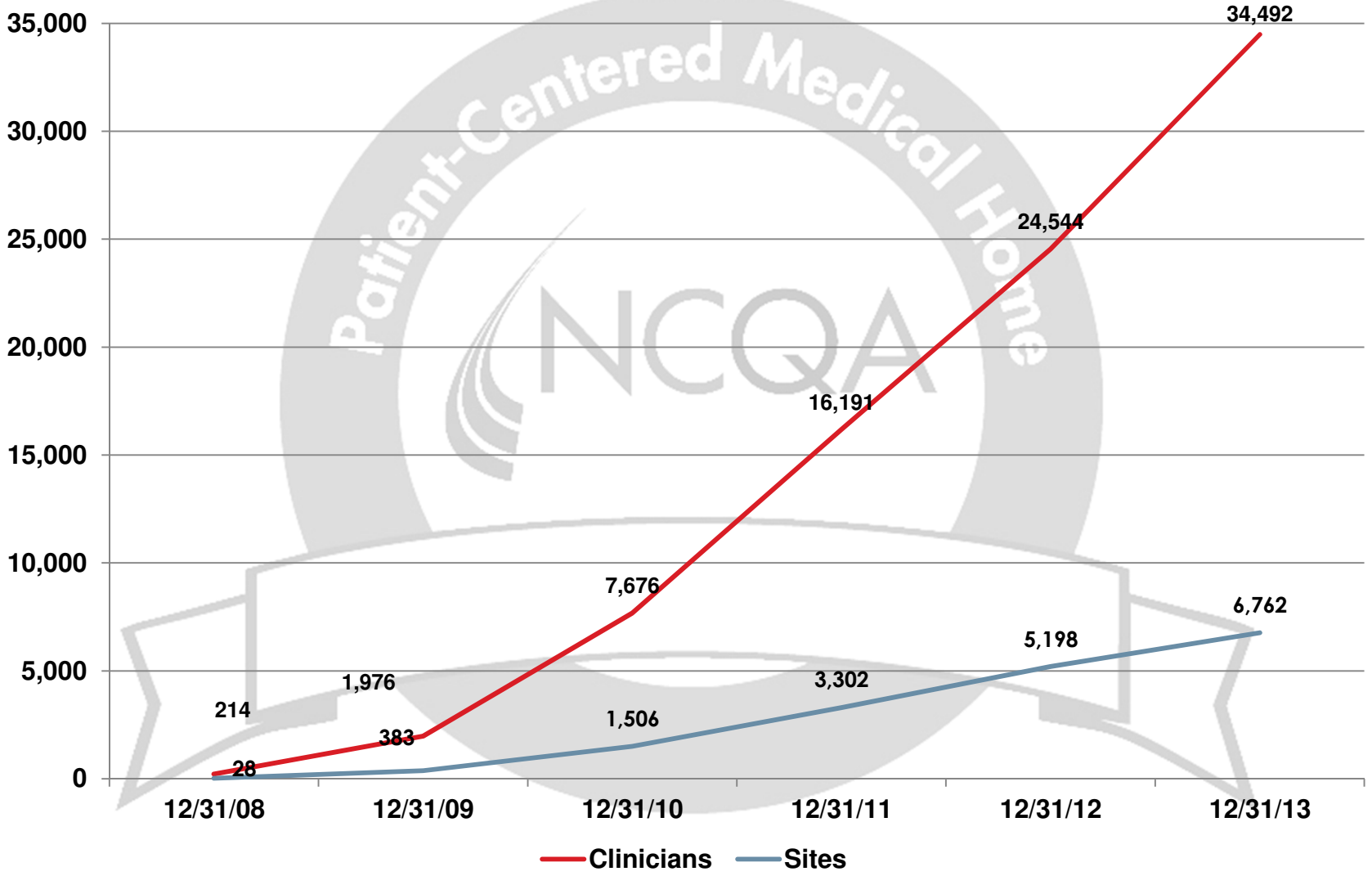
Patient-Centered Medical Home

- Emphasizes care coordination and whole-person care to transform primary care into "what patients want it to be"
- Prizes ongoing clinician-patient relationships (not disjointed visits) to keep patients healthy
- Teamwork frees providers to work to their level of training
- Information technology helps providers work to improve population health

Evolution of NCQA's PCMH Recognition



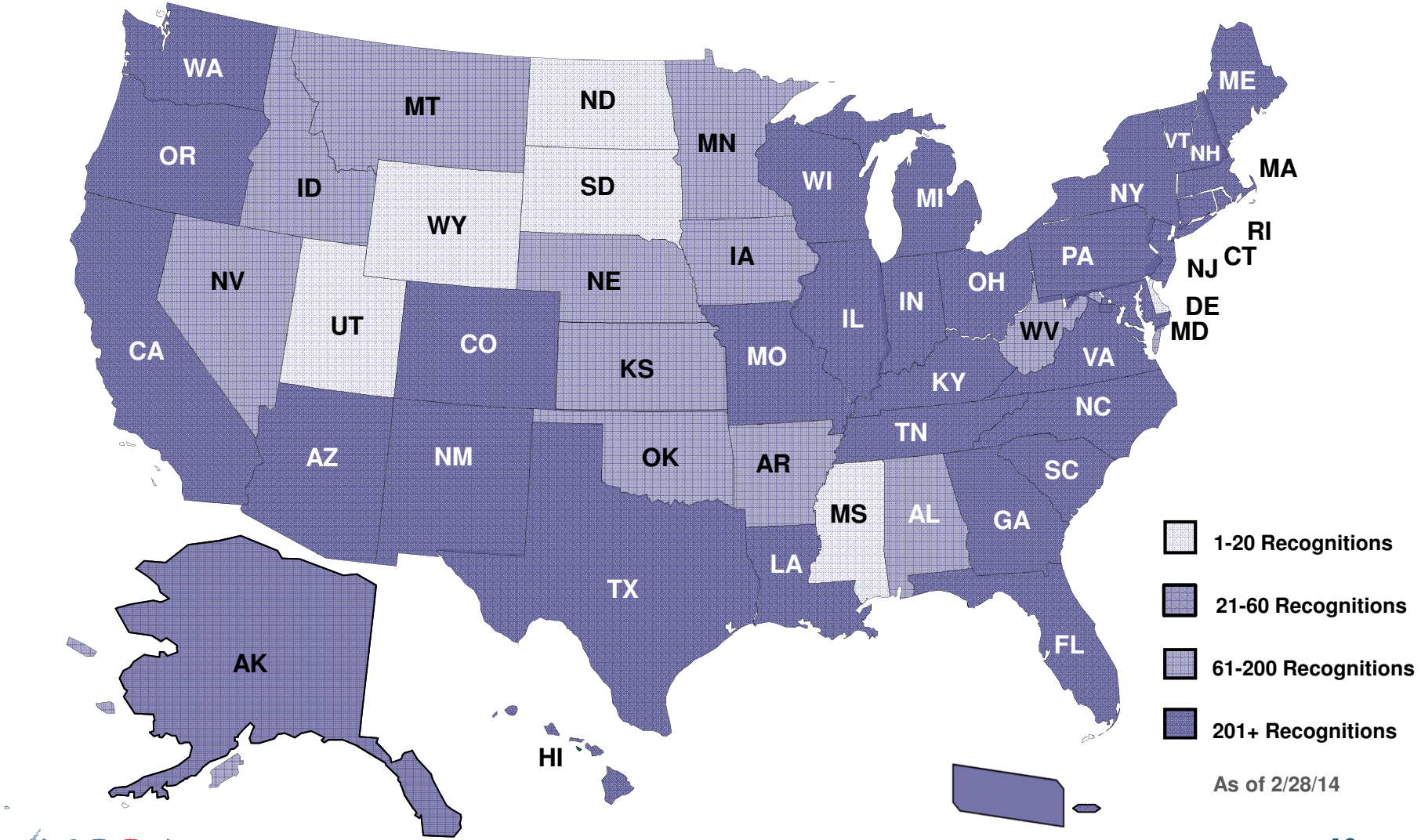
PCMH is the fastest-growing delivery system innovation



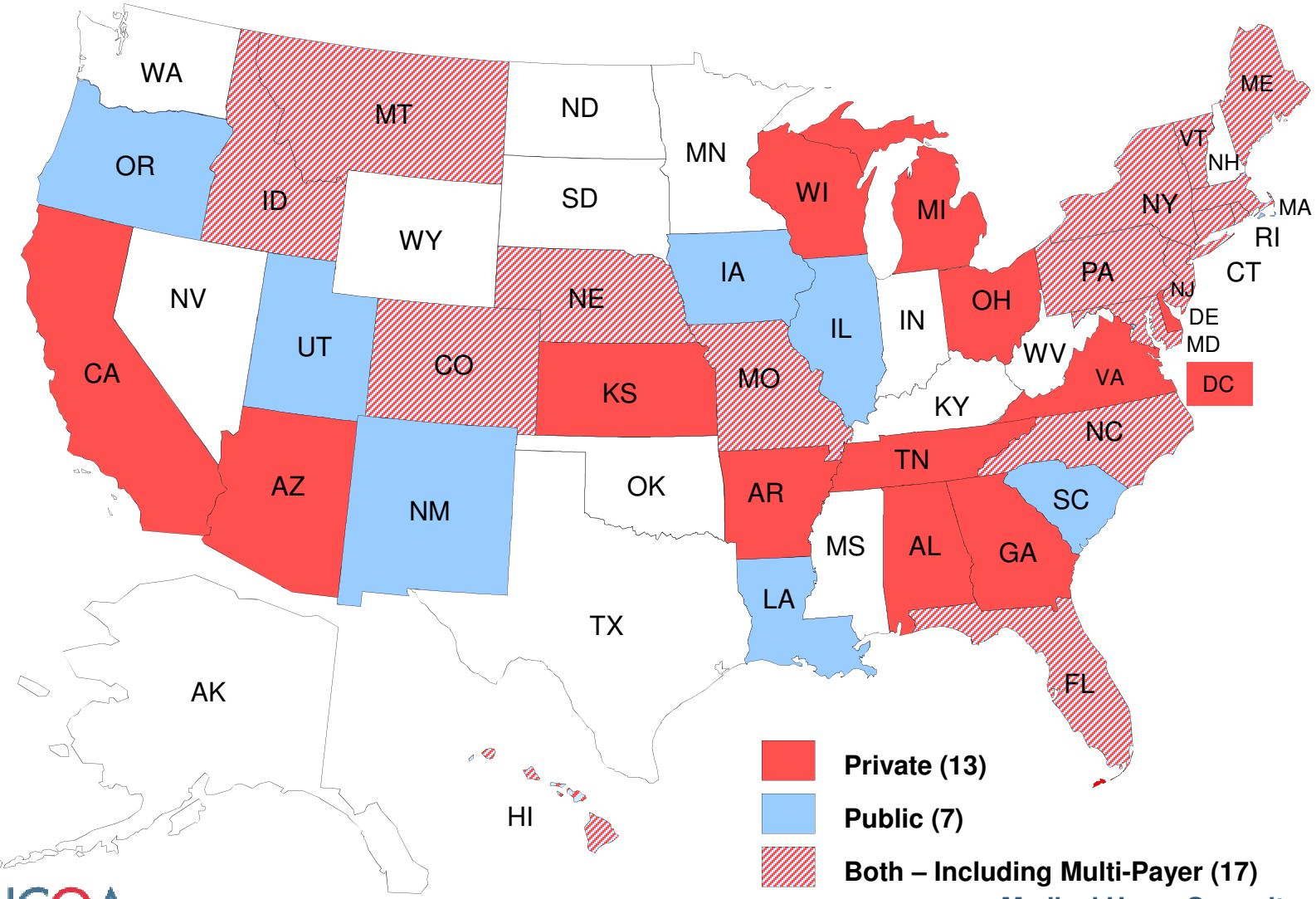
NCQA PCMH strengths

- Standardization
- Reach
- Flexibility
- Feasibility
- Continuous improvement
- Aligns with meaningful use

35,677 PCMH clinicians (7,066 sites) have earned NCQA Recognition



37 states have initiatives that use NCQA Recognition



Many studies support PCMH

- Improved patient experience
- Reduced clinician burnout
- Reduced hospitalization rates
- Reduced ER visits
- Increased savings per patient
- Higher quality of care
- Reduced cost of care

See journal citations in NCQA White Paper:

The Future of Patient-Centered Medical Homes

http://bit.ly/1dQQ9kn

What Makes a Successful PCMH?

1. **Leadership**
   - Motivation to change

2. **Practice Culture**
   - "Team" and "patient-centered" mentality
   - Change process capability
   - Resistance (barrier)

3. **Formal Approach to Quality improvement**
   - Quality of care indicators, patient experience
   - PDSA and other methods to make change
   - Feedback to providers

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What Makes a Successful PCMH?

4. Team-based care

Training
Delegation of responsibilities (e.g. standing orders)
Utilizing staff to the maximum potential of license

5. Health information technology

Functional and integrated EHR/registry
Inter-operability with local hospitals/other providers

6. Resources

Financial
Technical assistance for transformation

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What’s new

PCMH 2014 raises the bar

- More emphasis on team-based care
- Care management focus on high-need populations
- Alignment of quality improvement activities with the "triple aim"
- Further integration of behavioral health
- Sustained transformation

More emphasis on team-based care

- Is "must-pass" for any NCQA Recognition level
- Highlights specific roles and responsibilities for care team members
- Includes the patient as part of the care team

Care management focus on high-need populations

- Socioeconomic and personal factors
- High cost or utilization
- Poorly controlled or complex conditions
- Behavioral health needs

Alignment with triple aim

- Cost
- Quality
- Patient experience

Further integration of behavioral health

- Disclosing scope of behavioral health services to patients
- Establishing referral agreements with behavioral health providers

Sustained transformation

- PCMH is a process, not an event
- Practices show they follow PCMH standards over long periods

PCMH 2014
(6 standards/27 elements/100 points)

1) Patient-Centered Access (10)
- **A)***Patient-Centered Appointment Access
- B)24/7 Access to Clinical Advice
- C)Electronic Access

2) Team-Based Care (12)
- A)Continuity
- B)Medical Home Responsibilities
- C)Culturally and Linguistically Appropriate Services
- **D)***The Practice Team

3) Population Health Management (20)
- A)Patient Information
- B)Clinical Data
- C)Comprehensive Health Assessment
- **D)***Use Data for Population Management
- E)Implement Evidence-Based Decision Support

4) Care Management and Support (20)
- A)Identify Patients for Care Management
- **B)***Care Planning and Self-Care Support
- C)Medication Management
- D)Use Electronic Prescribing
- E)Support Self-Care & Shared Decision Making

5) Care Coordination and Care Transitions (18)
- A)Test Tracking and Follow-Up
- **B)***Referral Tracking and Follow-Up
- C)Coordinate Care Transitions

6) Performance Measurement and Quality Improvement (20)
- A)Measure Clinical Quality Performance
- B)Measure Resource Use and Care Coordination
- C)Measure Patient/Family Experience
- **D)***Implement Continuous Quality Improvement
- E)Demonstrate Continuous Quality Improvement
- F)Report Performance
- G)Use Certified EHR Technology

*** Must-pass**

Different levels of recognition for different levels of ability

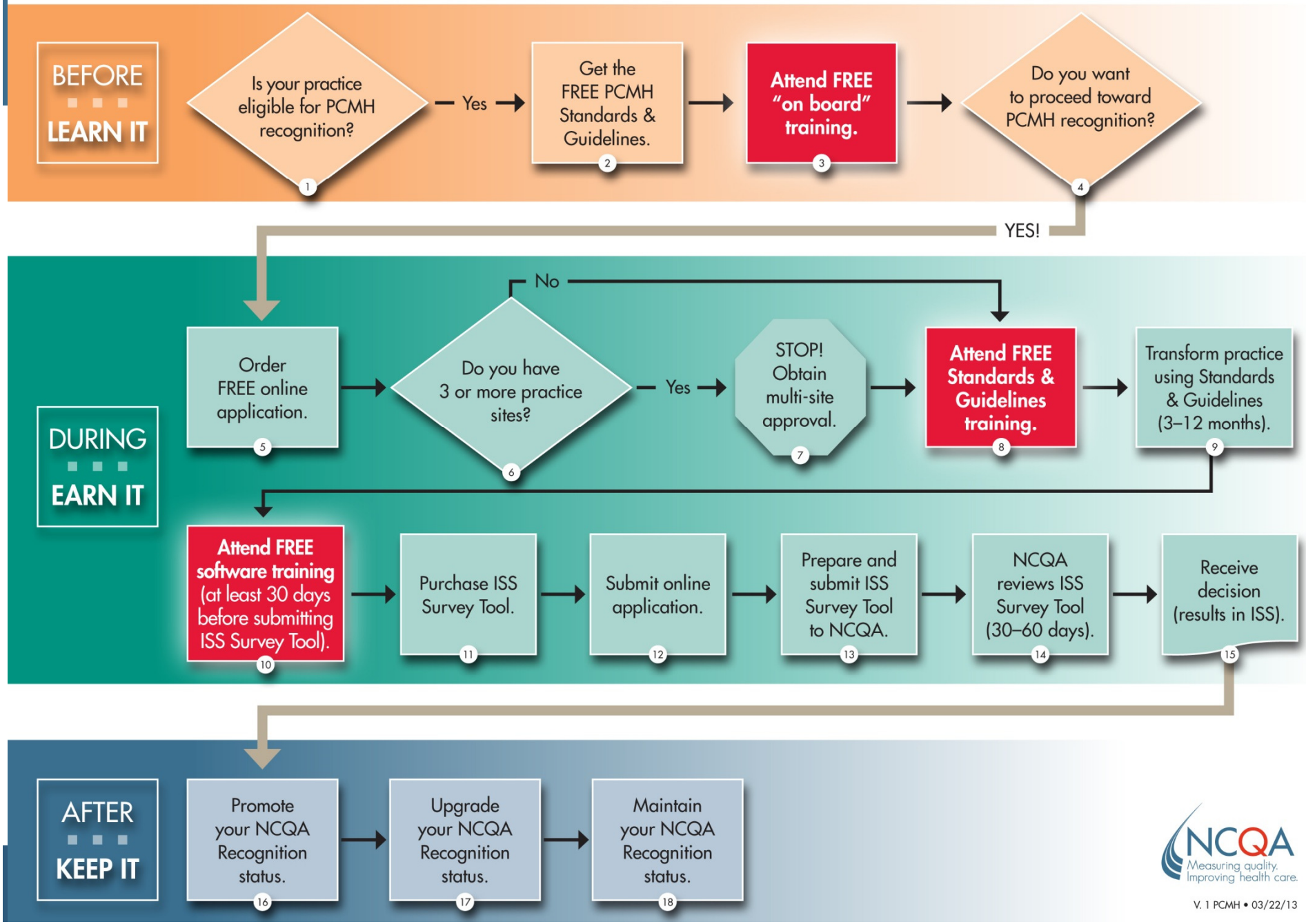
Level 1 **35-59 points**

Level 2 **60-84 points**

Level 3 **85-100 points**

6 must pass elements required for any level of recognition

Start to Finish: Patient-Centered Medical Home (PCMH) Recognition



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More details

- Mon. 3/24 Standards published
- Order now at http://bit.ly/1nj5ArS
- No charge

- Wed. 4/23, 2:00 – 3:00 PM EDT
- For customers and others who use PCMH standards
- RSVP: www.ncqa.org/PCMH2014

We still have big issues to solve

We believe in the art of the possible

Wanted & Needed

Health systems benchmarking

- **Build expectations for outcomes, sustained performance in PCMH**
- **Enable meaningful comparisons to support improvement**
- **Foster accountability across the triple aim**

NCQA Contact Information

Contact NCQA Customer Support at 1-888-275-7585 to:

- ✓Acquire standards documents, application account, and survey tools
- ✓Questions about your user ID, password, access

Visit NCQA Web Site at www.ncqa.org to:

- ✓Follow the Start-to-Finish Pathway
- ✓View Frequently Asked Questions
- ✓View Recognition Programs Training Schedule

For questions about interpretation of standards or elements submit a question to PCS (Policy/Program Clarification Support)

Free training each month
http://www.ncqa.org/tabid/109/Default.aspx

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