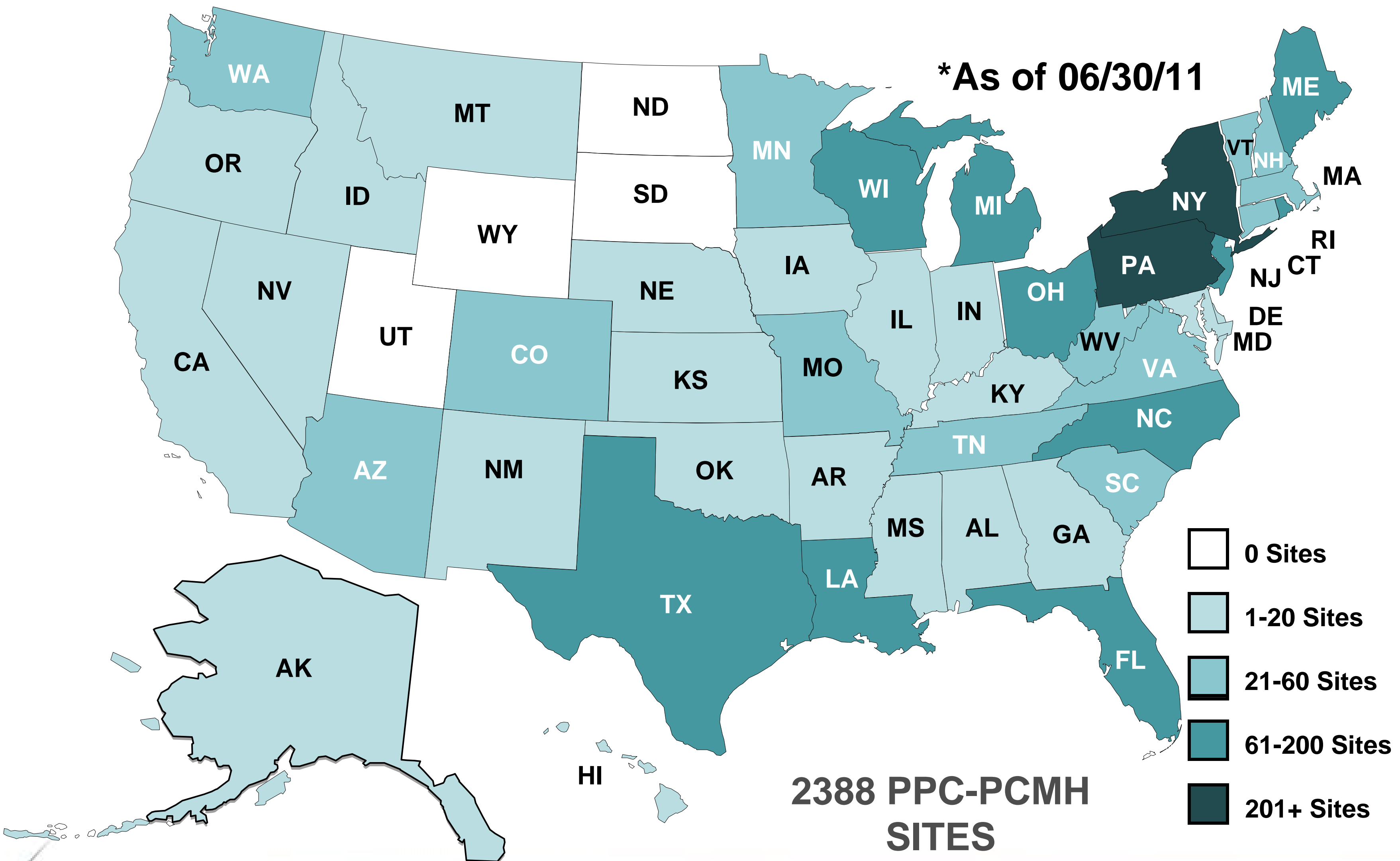
# NCQA's Patient-Centered Medical Home (PCMH) Program

July 21, 2011

# Research Shows: Medical Homes *Work*

- Higher quality of care, reduced cost of care on some measures (Patient-Centered Primary Care Collaborative, 2010)
- Reduced hospitalization and ER visits, overall savings (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)

# NUMBER OF PPC-PCMH SITES BY STATE




2388 PPC-PCMH SITES

# PPC-PCMH Practices*

## *NUMBER OF PRACTICES IN EACH RECOGNITION LEVEL BY NUMBER OF CLINICIANS*

| | 1-2 | 3-7 | 8-9 | 10-19 | 20-50 | 50+ | Total |
|---|---|---|---|---|---|---|---|
| Level 1 | 334 | 300 | 35 | 47 | 9 | 0 | 725 |
| Level 2 | 39 | 46 | 2 | 5 | 3 | 0 | 95 |
| Level 3 | 513 | 708 | 127 | 163 | 53 | 4 | 1568 |
| Total | 886 | 1054 | 164 | 215 | 65 | 4 | 2388 |

*** As of 06/30/11**

# Recognized Practices in Connecticut

| Size of practice | Level 1 | Level 3 |
|---|---|---|
| 1-3 | 2 | 10 |
| 4-10 | 2 | 7 |
| 11 or more | 0 | 1 |
| Total | 4 | 18 |
| | | |
| Community health centers | 0 | 11 |

# PPC-PCMH Recognition

- NCQA has the most widely-adopted evaluation model
- States/practices can get on board with a  system that has a strong track record, Federal initiatives are expanding to military and FQHCs
- 2400 sites recognized, over 12,000 clinicians
- NCQA provides goals and guidelines for practice transformation based on evidence
  - Practices decide how best to reach goals based on their size, location, area conditions
- Gives clinicians a roadmap to improve quality with systematic approach to preventive and chronic care delivery
- Focuses on evidence-based requirements to improve quality and reduced costs

# Why Does the NCQA's Medical Home Program Succeed?

1. It's practical. Provides a plan for practice transformation, a definition of what is best about primary care
2. It's evidence based. Built on solid research
3. It's collaborative. Improves team-based interactions
4. It's flexible. Applicable to a spectrum of practices (basic to complex, small to large)
5. It addresses/solves a problem. Common solution for states and practices

# PCMH 2011: Evolution

- Raise expectations through scoring and new requirements; maintain a pathway for those just beginning to transform
- Streamline requirements/documentation with greater focus on areas with strongest link to desired outcomes
- Move toward performance reporting/benchmarking for clinical and patient experience measures
- Embed and report HIT Meaningful Use

# How NCQA Revised its PCMH Standards

1. Collected, analyzed stakeholder suggestions
2. Analyzed data from NCQA PCMH practices
3. Conducted patient experience research
4. Sought public comment
5. Interviewed NCQA PCMH practices
6. Worked closely with thoughtful, committed PCMH Advisory Committee

# What is different about the PCMH 2011 standards?

- Enhances patient-centeredness
- Emphasizes language, culturally sensitive aspects
- Integrates behaviors affecting health, substance abuse, mental health and risk factor assessment and management
- Enhances applicability to pediatric practices
- Aligns with CMS Meaningful Use requirements
- Emphasizes relationship with/expectations of subspecialists
- Enhances evaluation of patient experience
- Underscores the importance of system cost-savings
- Enhances use of clinical performance measure results

# PCMH 2011 Content and Scoring

| PCMH1: Enhance Access and Continuity | Pts |
|---|---|
| **A. Access During Office Hours**** | **4** |
| B. After-Hours Access | 4 |
| C. Electronic Access | 2 |
| D. Continuity | 2 |
| E. Medical Home Responsibilities | 2 |
| F. Culturally and Linguistically Appropriate Services | 2 |
| G. Practice Team | 4 |
| | 20 |

| PCMH2: Identify and Manage Patient Populations | Pts |
|---|---|
| A. Patient Information | 3 |
| B. Clinical Data | 4 |
| C. Comprehensive Health Assessment | 4 |
| **D. Use Data for Population Management**** | **5** |
| | 16 |

| PCMH3: Plan and Manage Care | Pts |
|---|---|
| A. Implement Evidence-Based Guidelines | 4 |
| B. Identify High-Risk Patients | 3 |
| **C. Care Management**** | **4** |
| D. Manage Medications | 3 |
| E. Use Electronic Prescribing | 3 |
| | 17 |

| PCMH4: Provide Self-Care Support and Community Resources | Pts |
|---|---|
| **A. Support Self-Care Process**** | **6** |
| B. Provide Referrals to Community Resources | 3 |
| | 9 |

| PCMH5: Track and Coordinate Care | Pts |
|---|---|
| A. Test Tracking and Follow-Up | 6 |
| **B. Referral Tracking and Follow-Up**** | **6** |
| C. Coordinate with Facilities/Care Transitions | 6 |
| | 18 |

| PCMH6: Measure and Improve Performance | Pts |
|---|---|
| A. Measure Performance | 4 |
| B. Measure Patient/Family Experience | 4 |
| **C. Implement Continuously Quality Improvement**** | **4** |
| D. Demonstrate Continuous Quality Improvement | 3 |
| E. Report Performance | 3 |
| F. Report Data Externally | 2 |
| | 20 |

****Must Pass Elements**

# PCMH Scoring

6 standards = 100 points

***6 Must Pass*** elements

**NOTE: Must Pass** elements require a **≥ 50%** performance level to pass

| Level of Qualifying | Points | Must Pass Elements at 50% Performance Level |
|---|---|---|
| Level 3 | 85 - 100 | 6 of 6 |
| Level 2 | 60 - 84 | 6 of 6 |
| Level 1 | 35 - 59 | 6 of 6 |
| Not Recognized | 0 - 34 | < 6 |

**Practices with a numeric score of 0 to 34 points and/or achieve less than 6 "Must Pass" Elements are not Recognized.**

# Must Pass Elements

## Rationale for Must Pass Elements

- Identifies critical concepts of PCMH
- Helps focus Level 1 practices on most important aspects of PCMH
- Guides practices in PCMH evolution and continuous quality improvement
- Standardizes "Recognition"

## Must Pass Elements

- 1A: Access During Office Hours
- 2D: Use Data for Population Management
- 3C: Manage Care
- 4A: Self-Care Process
- 5B: Referral Tracking and Follow-Up
- 6C: Implement Continuous Quality Improvement

# Emphasize Patient-Centered Care

Increasing patient-centeredness

PCMH 1: Enhance Access and Continuity

- Provide continuity of care with the same provider
- Provide information to the patient about medical home
- Provide access to care during and after office hours
- Provide patient materials and services meeting the language needs of patients

PCMH 4: Provide Self-Care and Community Support

- Provide resources to support patient/family self-management

PCMH 6: Measure and Improve Performance

- Involve patients/families in quality improvement
- Obtain performance data for key vulnerable populations

# Focus on Behavioral Health

Incorporating attention to behaviors affecting health, mental health and substance abuse

- PCMH 1: Enhance Access and Continuity
  - Comprehensive assessment includes depression screening, behaviors affecting health and patient and family mental health and substance abuse
- PCMH 3: Plan and Manage Care
  - One of three clinically important conditions identified by the practice must be a condition related to unhealthy behaviors (e.g. obesity) or a mental health or substance abuse condition
  - Practice must plan and manage care for the selected condition
- PCMH 4: Provide Self-Care and Community Resources
  - Self-care support includes educational and community resources and adopting healthy behaviors
- PCMH 5: Track and Coordinate Care
  - Tracks referrals and coordinates care with mental health and substance abuse services
- PCMH 6: Measure and Improve Performance
  - Preventive measures include depression screening

# Focus on Pediatrics

- Goal for PCMH 2011 to enhance applicability to pediatric practices
- AAP participated on the PCMH Advisory Committee
- Throughout the Standards
  - "Families" has been incorporated where appropriate
  - "NA for pediatric practices" has been used where appropriate
  - Pediatric examples and explanations have been added
  - References to Bright Futures have been included
- PCMH 1: Enhance Access and Continuity
  - Explanation addresses unique pediatric issues, such as teen privacy and guardianship
- PCMH 2: Identify and Manage Patient Populations
  - Includes pediatric clinical data and age appropriate screenings
- PCMH 3: Plan and Manage Care
  - Explanation specifies relevant pediatric clinical conditions, including well-child care and children/youth with special health care needs
- PCMH 4: Provide Self-Care and Community Support
  - Population specific referrals include parenting and respite care

# Focus on Patient Experience

Increasing the emphasis on patient feedback

PCMH 6: Measure and Improve Performance

- Expanded the survey categories (access, communication, coordination, self-management support, whole person orientation, comprehensiveness, shared decision-making) and the requirements for the practice.
- Use of patient survey results for quality improvement
- Involve patients/families in quality improvement
- Optional Recognition for reporting results using a standardized Patient Experiences survey & methodology

# Benefits of PCMH

- Clinician Burnout
  - 10% of PCMH staff reported high emotional exhaustion at 12 months compared with 30% of controls, despite similar rates at baseline
- Total Cost
  - 29 percent fewer emergency visits and 6 percent fewer hospitalizations.
  - Estimated total savings of $10.3 per patient per month
- Patient Experience
  - Improved access, coordination, goal-setting
- Quality
  - Improved HEDIS results

Reid RJ, Coleman K, Johnson EA, Fishman PA, Hsu C, Soman MP, Trescott CE, Erikson M, Larson EB. The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction, And Less Burnout For Providers. Health Affairs 29:5 (2010): 835-843.

# Practice Experiences

## Cleveland Clinic (a large multi-site submission)

- Established Rationale
  - Quality and Safety
  - Enhanced Access
  - Improved Satisfaction
  - Health Care Reform
  - Reimbursement
- Established Approach
  - Investigated cost, benefits and process
  - Performed gap analysis (self-assessment)
  - Focused on low hanging fruit and must pass elements first
  - Determined need for direct physician involvement
  - Attended NCQA trainings

*- presented at Better Health Greater Cleveland 2010*

# Practice Experiences (con't)

- Established Medical Home Recognition Team
  - Physician Champion
  - Team members adopted a standard to assess operational compliance
  - Standing meetings scheduled
  - Selected important conditions for evidence-based guidelines requirements
  - Established Clinical Practice Committee to develop guidelines
- Compliance Analysis
  - Recruited medical students to complete chart audits
  - Determined standards that could not be met with current processes
  - Identified deficiencies and focused on areas where compliance could be achieved
- Forging Ahead
  - Complex process to gather required examples and reports
  - Ballpark administrative time 0.5 FTE for six months

# Practice Experiences (con't)

## MetroHealth Systems

- Lessons Learned
  - Start early – it takes longer than you think
  - Evaluate where you are compared to criteria and be realistic
  - Answer the specific question asked in each element
  - It's okay if you don't meet every element
  - Watch the timeline, you don't have forever
  - Dedicate time away from general duties, difficult to do "piecemeal"
- Considerations
  - Include both clinical and technical savvy person on the application team
  - Implement any changes in practice with lead time, so that data will reflect the change in methods
  - You already do more than you think

*- presented at Better Health Greater Cleveland 2010*

# NCQA Recognition as a Patient-Centered Medical Home

- NCQA Recognizes outpatient primary care practices that meet the scoring criteria for Level 1, 2, or 3 as assessed against the Patient-Centered Medical Home requirements
- NCQA defines a practice as a clinician or clinicians practicing together at a single geographic location , includes nurse-led practices in states where state licensing designates NPs as independent practitioners
- PCMH Recognition identifies primary care clinicians practicing at the site, including nurse practitioners and physicians assistants, that can be designated as a patient's personal clinician
- Recognition is at the practice-site level , multi-site organizations can utilize a process that reduces duplication of documentation , but each site must complete a survey for Recognition

# Overview of Recognition Process

## NCQA

- Reviews submitted Survey Tool after all application information received: NCQA Agreement (contract with NCQA) and Business Associate Addendum (BAA), Application, Clinician information, Application fee
- Checks licensure of all clinicians
- Evaluates Survey Tool responses, documentation, and explanations
- Conducts 5% audit by email, teleconference, or on-site visit
- Executive reviewer conducts a secondary review
- Peer review by trained Recognition Program Oversight Committee (RP-ROC) member
- Issues final decision and status to the practice within 30 – 60 days
- Reports results
  - ✓ Recognition posted on NCQA Web site
  - ✓ Not passed - not reported
- Mails PCMH certificate and Recognition packet

# APPENDIX

# PCMH 1: Enhance Access and Continuity

## Standard

- Access
  - During/after office hours
  - Appointments and advice
- Electronic access
- Continuity of care with clinician/care team
- Information to patients about medical home
- Culturally and linguistically appropriate services (CLAS)
- Specific staff roles, responsibilities, training

## Meaningful Use Criteria

Patients provided electronic:

- Copy of health information
- Clinical summary of visit
- Access to health information

# PCMH 2: Identify and Manage Populations

## Standard

- Collects demographic and clinical data
- Searchable data: diagnoses, advance directives, immunizations, screenings, BMI, medications
- Assess/document risks
- Create lists; use for point of care reminders

## Meaningful Use Criteria

- Language, gender, race, ethnicity, DOB
- Problem list
- Medication list
- Medication allergy list
- Vital signs
- Growth chart (peds.)
- Smoking status
- Lists of patients with specific conditions for QI, decrease disparities
- Follow-up reminders for care

# PCMH 3: Plan and Manage Care

## Standard

- Identify patients with specific conditions including high-risk or complex, behavioral health
- Care management
  - Pre-visit planning
  - Progress toward goals
  - Barriers to treatment goals
- Reconcile medications
- E-prescribing

## Meaningful Use Criteria

- Clinical decision support
- Medication reconciliation with transitions of care
- E-prescribing
- Drug-drug, drug-allergy checks
- Transmit prescriptions using EHR
- Drug-formulary checks

# PCMH 4: Provide Self-Care Support and Community Resources

## Standard

- Assess self-management abilities
- Document self-care plan; provide tools and resources
- Counsel on healthy behaviors
- Assess/provide/arrange for mental health/substance abuse treatment
- Provide community resources

## Meaningful Use Criteria

Patient-specific education materials

# PCMH 5: Track and Coordinate Care

## Standard

- Track lab/imaging results; notify patients
- Integrate results into medical record
- Track referrals
- Coordinate with facilities
  - Hospitalized patients and ER
  - Establish information exchange with facilities
  - Follow up with discharged patients

## Meaningful Use Criteria

- Incorporate lab/test results
- Exchange patient information with other providers (meds/ allergies, tests)
- Provide summary care record for transitions and referrals

# PCMH 6: Measure and Improve Performance

## Standard

- Measure performance (preventive/chronic/acute care clinical measures)
- Track utilization measures
- Patient experience survey - identifies vulnerable populations
- Continuous quality Improvement
- Report performance
  - Clinical measures

## Meaningful Use Criteria

Report:

- Ambulatory clinical quality measures to CMS/ state
- Immunization data to registries
- Syndromic surveillance data to public health agencies