Patient-Centered Medical Home: NCQA’s 2014 Update

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Overview

- NCQA Overview
- 2014 Standards Updates
- Renewal Options
- Resources
- Questions
NCQA Provider-Based Quality Programs

Improve health care quality through transparency, measurement and accountability.

ACO Accreditation

DRP & HSRP Recognition

PCMH & PCSP Recognition
Industry Trends in Focus

• Triple Aim: Improve Cost, Quality, Patient Experience
• Population health management.
• Integrated care.
• Care transitions and self-care support.
• Movement towards a value-based model.
The Triple Aim

Improve the Experience of Care

Reduce the Per Capita Costs of Healthcare

Improve the Health of Populations
PCMH is the fastest-growing delivery system innovation
What makes a Patient-Centered Medical Home primary care practice different?

**Patient-Centered Medical Home**

- Delivers “whole-person” coordinated care to transform primary care into “what patients want it to be”
- Prizes clinician-patient relationships (not disjointed visits) to keep patients healthy between visits
- Supports “team-based care” that frees providers to work to their highest level of training
- Aligns use of information technology to help providers support the Triple Aim and improve population health.
Evolving PCMH and More

- **2003-2004:** Physician Practice Connections (PPC) - developed with Bridges to Excellence
- **2006:** PPC standards updated
- **2008:** PPC–PCMH
- **2011:** PCMH 2011
- **2011:** ACO Accreditation
- **2013:** Patient-Centered Specialty Practice
- **2014:** PCMH 2014
Growing Evidence on PCMH

• **PCMH Improves Low-Income Access, Reduces Inequities** Berenson, Commonwealth Fund, May 2012

• **PCMH Improves Quality And Patient Satisfaction, Lowers Costs** PCPCC, September 2012

• **Colorado PCMH Multi-Payer Pilot Reduced Inpatient Admissions, ER Visits & Demonstrated Plan ROI** Harbrecht, September 2012

• **The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction And Less Burnout For Providers** Soman, Health Affairs, May 2010

PCMHs Save Money
Better Access and Care Coordination Goes a Long Way

- **Lower overall per member per month costs** (Fields et al 2010, PCPCC 2012, Takach 2011, Patel 2012)
- **Health plans can have strong return on investment** (Raskas et al, 2012 / Harbrecht 2012)
- **Also see** the Patient-Centered Primary Care Collaborative’s Summary of Patient-Centered Medical Home Cost and Quality Results, 2010-2013 (PCPCC 2014)
1. Additional emphasis on team-based care
   - New element = Team-Based Care
     • Highlights patient as part of team, including QI

2. Care management focused on high-need patients
   - Use evidence-based decision support
   - Identify patients who may benefit from care management and self-care support:
     • Social determinants of health
     • Behavioral health
     • High cost/utilization
     • Poorly controlled or complex conditions
3. More focused, sustained Quality Improvement (QI) on patient experience, cost, clinical quality
   - Annual QI activities; reports must show the practice re-measures at least annually
   - Renewing practices will benefit from streamlined requirements, but must demonstrate re-measurement from at least two prior years

4. Align with Meaningful Use Stage 2 (MU2)
   - MU2 is not a requirement for recognition.

5. Further Integration of Behavioral Health.
   - Show capability to treat unhealthy behaviors, mental health or substance abuse
   - Communicate services related to behavioral health
   - Refer to behavioral health providers
## PCMH 2014 Content and Scoring

(6 standards/27 elements)

<table>
<thead>
<tr>
<th>1: Enhance Access and Continuity</th>
<th>Pts</th>
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<tbody>
<tr>
<td>A. <strong>Patient-Centered Appointment Access</strong></td>
<td>4.5</td>
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<tr>
<td>B. 24/7 Access to Clinical Advice</td>
<td>3.5</td>
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<tr>
<td>C. Electronic Access</td>
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<table>
<thead>
<tr>
<th>2: Team-Based Care</th>
<th>Pts</th>
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<tbody>
<tr>
<td>A. Continuity</td>
<td>3</td>
</tr>
<tr>
<td>B. Medical Home Responsibilities</td>
<td>2.5</td>
</tr>
<tr>
<td>C. Culturally and Linguistically Appropriate Services (CLAS)</td>
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<tr>
<td>D. <strong>The Practice Team</strong></td>
<td><strong>4</strong></td>
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<tr>
<td><strong>Total</strong></td>
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<table>
<thead>
<tr>
<th>3: Population Health Management</th>
<th>Pts</th>
</tr>
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<tbody>
<tr>
<td>A. Patient Information</td>
<td>3</td>
</tr>
<tr>
<td>B. Clinical Data</td>
<td>4</td>
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<tr>
<td>C. Comprehensive Health Assessment</td>
<td>4</td>
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<tr>
<td>D. <strong>Use Data for Population Management</strong></td>
<td><strong>5</strong></td>
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<tr>
<td>E. Implement Evidence-Based Decision-Support</td>
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<td><strong>Total</strong></td>
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<tr>
<th>4: Plan and Manage Care</th>
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<tr>
<td>A. Identify Patients for Care Management</td>
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<tr>
<td>B. <strong>Care Planning and Self-Care Support</strong></td>
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</tr>
<tr>
<td>C. Medication Management</td>
<td>4</td>
</tr>
<tr>
<td>D. Use Electronic Prescribing</td>
<td>3</td>
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<tr>
<td>E. Support Self-Care and Shared Decision-Making</td>
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<tr>
<td><strong>Total</strong></td>
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<tr>
<th>5: Track and Coordinate Care</th>
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<tbody>
<tr>
<td>A. Test Tracking and Follow-Up</td>
<td>6</td>
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<tr>
<td>B. <strong>Referral Tracking and Follow-Up</strong></td>
<td><strong>6</strong></td>
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<tr>
<td>C. Coordinate Care Transitions</td>
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<tr>
<th>6: Measure and Improve Performance</th>
<th>Pts</th>
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<tr>
<td>A. Measure Clinical Quality Performance</td>
<td>3</td>
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<tr>
<td>B. Measure Resource Use and Care Coordination</td>
<td>3</td>
</tr>
<tr>
<td>C. Measure Patient/Family Experience</td>
<td>4</td>
</tr>
<tr>
<td>D. <strong>Implement Continuous Quality Improvement</strong></td>
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</tr>
<tr>
<td>E. Demonstrate Continuous Quality Improvement</td>
<td>3</td>
</tr>
<tr>
<td>F. Report Performance</td>
<td>3</td>
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<tr>
<td>G. Use Certified EHR Technology</td>
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<td><strong>Total</strong></td>
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**Must Pass Elements**

<table>
<thead>
<tr>
<th>Scoring Levels</th>
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<tbody>
<tr>
<td>Level 1: 35-59 points.</td>
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<tr>
<td>Level 2: 60-84 points.</td>
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<td>Level 3: 85-100 points.</td>
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PCMH Update Timeline

PCMH 2011

• June 30, 2014 last date to purchase PCMH 2011 survey tools
• March 31, 2015 last date to submit PCMH 2011 survey tools

PCMH 2014

• March 31, 2014 first day to purchase survey tools for the updated standards

March 31, 2014 - March 31, 2015
• May submit PCMH 2011 or PCMH 2014
2014 Standards Updates: Major Enhancements

- Team-based care
- Behavioral and mental health integration
- Measuring health care costs
- Referral tracking and follow-up coordination
- Annual reporting requirements
- “Meaningful Use” Alignment
• Now its own standard.

• Patient part of the care team.

• Development of strong care team a must-pass element.
PCMH 2: Team-Based Care

Element Overview

- Element A  Continuity
- Element B  Medical Home Responsibilities
- Element C  CLAS
- Element D  The Practice Team **Must-Pass**
Patients/families should be:
- Involved in QI opportunities
- Educated in expected care and their role in shared decision making.

Care team should demonstrate excellence in:
- Care management
- Care planning
- Self-care support
“The PCMH is a model of primary care in which a team of clinicians offers accessible first-contact care that is personalized, coordinated and comprehensive and meets most or all of a person's health care needs, including behavioral health”

-American Academy of Family Physicians, 2014
2014 Standards Updates: Behavioral Health

- Additional enhancements added:
  - More specific in comprehensive health assessment requirements.
  - Score for practices that integrate care within primary care setting.
  - Use of decision support tools.
“The measurement of price, cost, and spending is a key ingredient in building an accountable health care system.”

-Robert Wood Johnson Foundation¹

“By identifying and eliminating wasteful practices that do not improve health, physicians can provide the best possible care to their patients while reducing unnecessary costs to the health care system at the same time.”

-Steven E. Weinberger, MD, FACP, Chief Executive Officer and EVP, American College of Physicians
2014 Standards Updates: Measuring Costs

- Track overuse and appropriateness.

- High cost/high utilization to be considered in care management.

- Annually measure or receive quantitative data affecting health care costs.
2014 Standards Updates: Meaningful Use

Stage 1: Data Capture and Sharing

Stage 2: Advanced Clinical Processes

Stage 3: Improved Outcomes
2014 Standards Updates: Care Coordination

- Updates on how to work with specialists:
  - Greater specificity in agreements between providers.
  - Engage patients, families on self-referrals.
  - Coordinate reports with referred specialists.
The Practice:

1. Considers available performance info on consultant/specialists for referral recommendations
2. Maintains formal and informal agreements with subset of specialists based on established criteria
3. Maintains agreements with behavioral healthcare providers
4. Integrates behavioral healthcare providers within the practice site
5. Gives the consultant/specialist the clinical question, required timing and type of referral

*Meaningful Use Requirement*
6. Gives the consultant/specialist pertinent demographic and clinical data, including test results and current care plan

7. Has capacity for electronic exchange of key clinical information* and provides electronic summary of care record to another provider for >50% of referrals

8. Tracks referrals until consultant/specialist report is available, flagging and following up on overdue reports (Critical Factor)

9. Documents co-management arrangements in patient’s medical record

10. Asks patients/families about self-referrals and requests reports from clinicians
Summary

- PCMH is a process, not an event.
- 2014 updates reflect evidence-based trends.
- Standards work to achieve Triple Aim.
- Practices show they follow PCMH standards over long periods.
Expiring Recognitions

• Expired practices:
  – Lose eligibility for streamlined renewal option
  – Are no longer included in data feed to P4P sponsors
  – No longer displayed on NCQA’s Recognition Directory
• NCQA e-mails reminder to practice primary contact 6 months before expiration
• Keep NCQA updated on primary contact changes so that the practice does not miss the notification
• Practices can access their previous application account that retains their practice sites and clinicians
• Practices submitting for renewal prior to their expiration date, have their expiration date extended until a decision on their renewal survey is completed.

Practice MUST submit before expiration to avoid a lapse in Recognition!
**Streamlined Renewals**

*A streamlined process for renewals of Level 2 or 3 practice sites*

<table>
<thead>
<tr>
<th>Step</th>
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<tbody>
<tr>
<td>Purchase and complete a new survey for each site</td>
<td>✔</td>
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<tr>
<td>Submit current documentation for select Elements only; attest to the others</td>
<td>✔</td>
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<tr>
<td>Pay current survey pricing</td>
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<tr>
<td>New 3-year Recognition period</td>
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<tr>
<td>Multi-Site organizations need to be reapproved</td>
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Streamlined Renewal Policy

- Eligible for streamlined renewal with the PCMH 2011 survey:
  - PPC-PCMH 2008
  - PCMH 2011

- Eligible for streamlined renewal with the PCMH 2014 survey:
  - PPC-PCMH 2008
  - PCMH 2011
  - PCMH 2014
What Surveys are Eligible?

Single site surveys
Corporate surveys
Practice site surveys in a multi-site submission

• Streamlined renewal processes apply to both single and multi-site applicants
• Renewals and new sites may be included in a multi-site submission, but only renewing sites may attest to continuing performance
Attestation for Streamlined Renewals

- For the elements chosen, to receive credit for factors answered “Yes,” attest that the practice is eligible and has met the requirements for those factors:
  “ABC Family Practice achieved Level 2 (or Level 3) Recognition as a patient-centered medical home and attests that the responses to the factors of this element reflect the current operation of the organization/practice sites. Documentation to support these responses can be provided upon request.”

- If selected for audit, the practice must be able to provide documentation for the elements that do not require documentation.
Documenting Attestation

- **Until August 2014**, practices enter the attestation statement in the comment/text box of each element that will not be documented in that survey.
- **After August 2014**, practices complete a form in the organization background section of the survey to attest once for all the elements that will not be documented in that survey.
Streamlined Renewal Requirements for PCMH 2014

Level II and III sites must submit documentation for the following Elements for Renewals through PCMH 2014 Standards:

1A* 2D* 3C 3D* 4A 4B* 4C 5B* 6B 6D* 6E * Must Pass Corporate element

Includes all Must Pass Elements
Level II and III sites must submit documentation for the following Elements for Renewals through PCMH 2011 Standards:

- 1C
- 1G
- 2C
- 2D*
- 3A
- 3B
- 3C*
- 3D
- 4A*
- 5C
- 6A
- 6C*

* Must Pass

Corporate element
Resources

• Web site: www.ncqa.org/pcmh
• Education Seminars: www.ncqa.org/education
• Content Expert Certification: www.ncqa.org/cec
• Policy Clarification Support: www.ncqa.org/pcs
• Prevalidation program: http://goo.gl/uu3Q0T
• Recognition Notes newsletter: http://goo.gl/231OHE
• Industry research & resources: http://goo.gl/FXkSHw