Patient-Centered Medical Home: NCQA’s 2014 Update and Renewal Opportunities

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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
We should not lose sight of what is a PCMH?

**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.
The Triple Aim

- Improve the Experience of Care
- Reduce the Per Capita Costs of Healthcare
- Improve the Health of Populations
• Triple Aim: Improve Cost, Quality, Patient Experience
• Population health management.
• Integrated care.
• Care transitions and self-care support.
• Movement towards a value-based model.
PCMH is the fastest-growing delivery system innovation.
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
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

- 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
- 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

Practice MUST submit before expiration to avoid a lapse in Recognition!
Renewal Policy

- Practices submitting for renewal prior to their expiration date, have their expiration date extended until a decision on their renewal survey is completed.
- Stream-lined 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.
Streamlined Renewals

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

<table>
<thead>
<tr>
<th>Requirement</th>
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</thead>
<tbody>
<tr>
<td>Purchase and complete a new survey for each site</td>
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<tr>
<td>Submit current documentation for select Elements only; attest to the others</td>
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<tr>
<td>Pay current survey pricing</td>
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<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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</tbody>
</table>
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*

- For all the remaining elements, to receive credit for factors answered “Yes,” attest that you are eligible and have met the requirements for those factors:

  “ABC Family Practice previously achieved Level 2 or 3 Recognition as a Patient-Centered Medical Home and attests that the responses to the factors for this element reflect the current operations of the practice site and the documentation to support these responses can be provided on request.”

- The practice must be able to provide documentation for the elements that do not require documentation, if selected for audit.
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

• 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:

“Our 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.
## Patient-Centered Medical Home (PCMH) 2011 and Patient-Centered Medical Home (PCMH) 2014 Crosswalk

<table>
<thead>
<tr>
<th>PCMH 2011</th>
<th>Points</th>
<th>PCMH 2014</th>
<th>Points</th>
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<tr>
<td><strong>PCMH 1: Enhance Access and Continuity</strong></td>
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<td><strong>PCMH 1: Patient-Centered Access</strong></td>
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<tr>
<td><strong>Element 1A: Access During Office Hours</strong></td>
<td>4</td>
<td><strong>PCMH 1A: Patient-Centered Appointment Access</strong></td>
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<tr>
<td>MUST-PASS**</td>
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<td><strong>CRITICAL FACTOR = FACTOR 1</strong></td>
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<tr>
<td><strong>Element 1B: After-Hours Access</strong></td>
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<td><strong>PCMH 1B: 24/7 Access to Clinical Advice</strong></td>
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<tr>
<td><strong>CRITICAL FACTOR = FACTOR 2</strong></td>
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<tr>
<td><strong>Element 1C: Electronic Access</strong></td>
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<td><strong>PCMH 1C: Electronic Access</strong></td>
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<tr>
<td><strong>Element 1D: Continuity</strong></td>
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<td><strong>PCMH 2A: Continuity</strong></td>
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<tr>
<td><strong>Element 1E: Medical Home Responsibilities</strong></td>
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<td><strong>PCMH 2B: Medical Home Responsibilities</strong></td>
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<tr>
<td><strong>Element 1F: Culturally and Linguistically Appropriate Services (CLAS)</strong></td>
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<td><strong>PCMH 2C: Culturally and Linguistically Appropriate Services (CLAS)</strong></td>
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<td><strong>Element 1G: The Practice Team</strong></td>
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<td><strong>PCMH 2D: The Practice Team</strong></td>
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<tr>
<td><strong>CRITICAL FACTOR = FACTOR 2</strong></td>
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<td><strong>CRITICAL FACTOR = FACTOR 3</strong></td>
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<td><strong>PCMH 2: Identify and Manage Patient Populations</strong></td>
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<td><strong>PCMH 3: Identify and Manage Patient Populations</strong></td>
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<tr>
<td><strong>Element 2A: Patient Information</strong></td>
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<td><strong>PCMH 3A: Patient Information</strong></td>
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<tr>
<td><strong>Element 2B: Clinical Data</strong></td>
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<td><strong>PCMH 3B: Clinical Data</strong></td>
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<td><strong>Element 2C: Comprehensive Health Assessment</strong></td>
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<td><strong>PCMH 3C: Comprehensive Health Assessment</strong></td>
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<td><strong>Element 2D: Use Data for Population Management MUST-PASS</strong></td>
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<td><strong>Element 3D: Use Data for Population Management</strong></td>
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<td><strong>PCMH 3: Plan and Manage Care</strong></td>
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<td><strong>PCMH 3E: Implement Evidence-Based Decision Support</strong></td>
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<td><strong>CRITICAL FACTOR = FACTOR 1</strong></td>
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<td><strong>Element 3A: Implement Evidence-Based Guidelines</strong></td>
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<td><strong>PCMH 4: Plan and Manage Care</strong></td>
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<td><strong>CRITICAL FACTOR = FACTOR 3</strong></td>
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<td><strong>Element 3B: Identify High-Risk Patients</strong></td>
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<td><strong>PCMH 4A: Identify Patients for Care Management</strong></td>
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<td><strong>CRITICAL FACTOR = FACTOR 6</strong></td>
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<td><strong>Element 3C: Care Management MUST-PASS</strong></td>
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<td><strong>PCMH 4B: Care Planning and Self-Care Support</strong></td>
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<td><strong>Element 3D: Medication Management</strong></td>
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<td><strong>PCMH 4C: Medication Management</strong></td>
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<tr>
<th>Element 3D: Medication Management</th>
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<td>Element 3E: Use Electronic Prescribing</td>
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<td>PCMH 4D: Use Electronic Prescribing</td>
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<td>CRITICAL FACTOR = FACTOR 2</td>
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<td>PCMH 4: Provide Self-Care Support and Community Resources</td>
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<td>Element 4A: Support Self-Care Process</td>
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<td>PCMH 4E: Support Self-Care and Shared Decision Making</td>
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<td>CRITICAL FACTOR = FACTOR 3</td>
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<td>Element 4B: Provide Referrals to Community Resources</td>
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<td>PCMH 5: Track and Coordinate Care</td>
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<td>Element 5A: Test Tracking and Follow-Up</td>
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<tr>
<td>Element 5B: Referral Tracking and Follow-Up</td>
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<td>PCMH 5B: Referral Tracking and Follow-Up</td>
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<td>CRITICAL FACTORS = FACTOR 8</td>
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<td>Element 5C: Coordinate With Facilities and Care Transitions</td>
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<td>PCMH 5C: Coordinate Care Transitions</td>
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<tr>
<td>PCMH 6: Measure and Improve Performance</td>
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<tr>
<td>Element A: Measure Performance</td>
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<td>PCMH 6A: Measure Clinical Quality Performance</td>
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<td>Element 6B: Measure Patient/Family Experience 4 points</td>
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<td>PCMH 6B: Measure Resource Use and Care Coordination</td>
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<td>Element 6C: Implement Continuous Quality Improvement</td>
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<td>PCMH 6C: Measure Patient/Family Experience</td>
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<td>Element 6D: Demonstrate Continuous Quality Improvement</td>
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<td>PCMH 6D: Implement Continuous Quality Improvement</td>
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<td>Element 6E: Report Performance</td>
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<td>Element 6F: Report Data Externally</td>
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<td>PCMH 6F: Report Performance</td>
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<td>Element G: Use Certified EHR Technology</td>
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<td>PCMH 6G: Use Certified EHR Technology</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
Resources

- Web site: [www.ncqa.org/pcmh](http://www.ncqa.org/pcmh)
- Education Seminars: [www.ncqa.org/education](http://www.ncqa.org/education)
- Content Expert Certification: [www.ncqa.org/cec](http://www.ncqa.org/cec)
- Prevalidation
- Policy Clarification Support: [www.ncqa.org/pcs](http://www.ncqa.org/pcs)
- Recognition Notes newsletter
- Industry Research & Resources
Education

• [www.ncqa.org/learn](http://www.ncqa.org/learn)

FACILITATING PCMH RECOGNITION
• July 22-23 | Providence, RI
• September 30-October 1 | Charlotte, NC
• November 18-19 | San Francisco, CA

ADVANCED TOPICS IN PCMH
• July 24 | Providence, RI
• October 2 | Charlotte, NC
• November 20 | San Francisco, CA
Thank you