Raising the Bar: NCQA Patient-Centered Medical Home 2014 Standards

Blueprint Semi-Annual Meeting
October 20, 2014

Objectives:

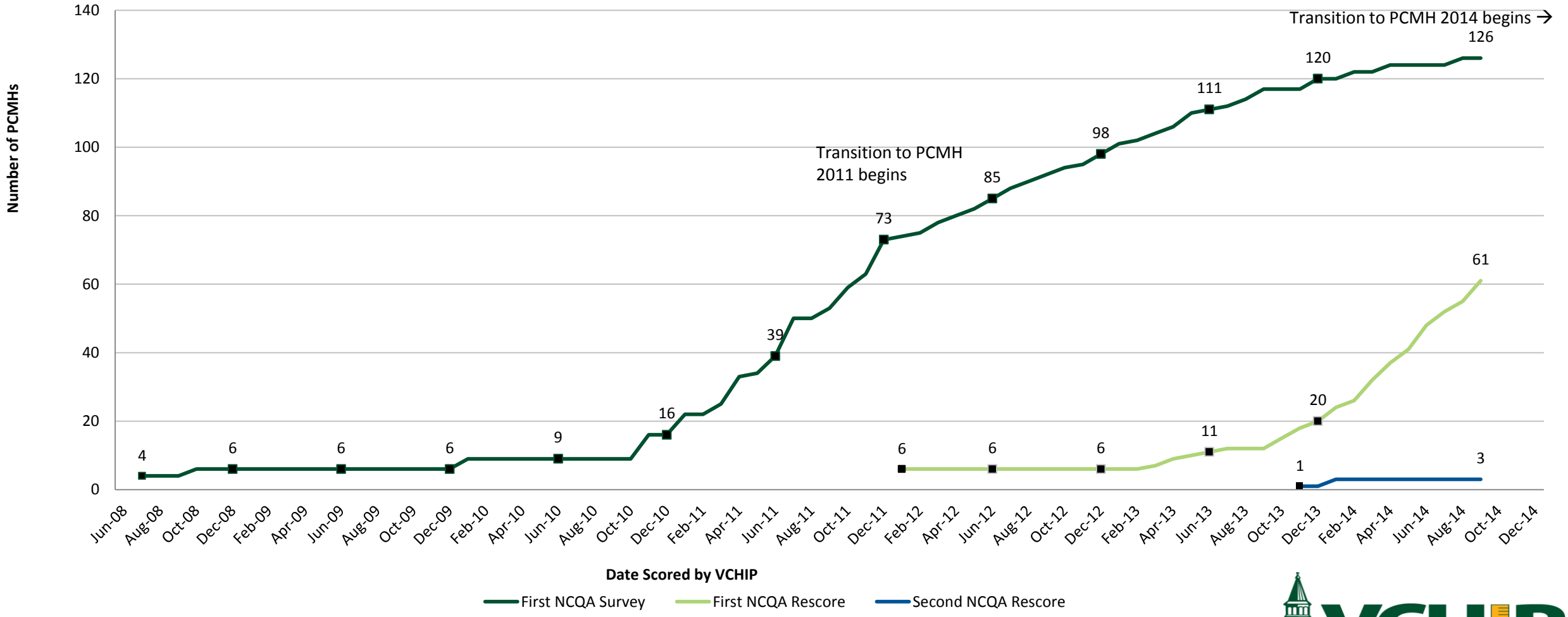
- Brief history and description of National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) Recognition Program
- Vermont's use of NCQA's PCMH Standards
- Overview of NCQA PCMH 2014 Standards
- Highlight NCQA's emphasis on team-based care
- Answer questions you have about integrating PCMH principles into your work and about how to demonstrate the patient-centered care delivered by your team to NCQA

NCQA PCMH Recognition Program

- Based on medical home concept first developed by the pediatric community to improve care for children with special health care needs & expanded into the 2007 “Joint Principles of the PCMH” through collaboration between primary care physician societies
- Developed by NCQA in conjunction with an advisory committee (people from practices, medical associations, physician groups, health plans and consumer and employer groups) to:
  - Help improve primary care
  - Provide a set of standards to measure practices against

Evolution of NCQA's PCMH Recognition Program

PCMH Timeline



*Excludes closed practices

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PCMHs in Vermont

- 126 PCMHs (independent practices, FQHCs & hospital-owned sites)
- Approximately 65% are family practices
- Includes 4 Naturopathic practices
- Almost 90% have electronic medical records

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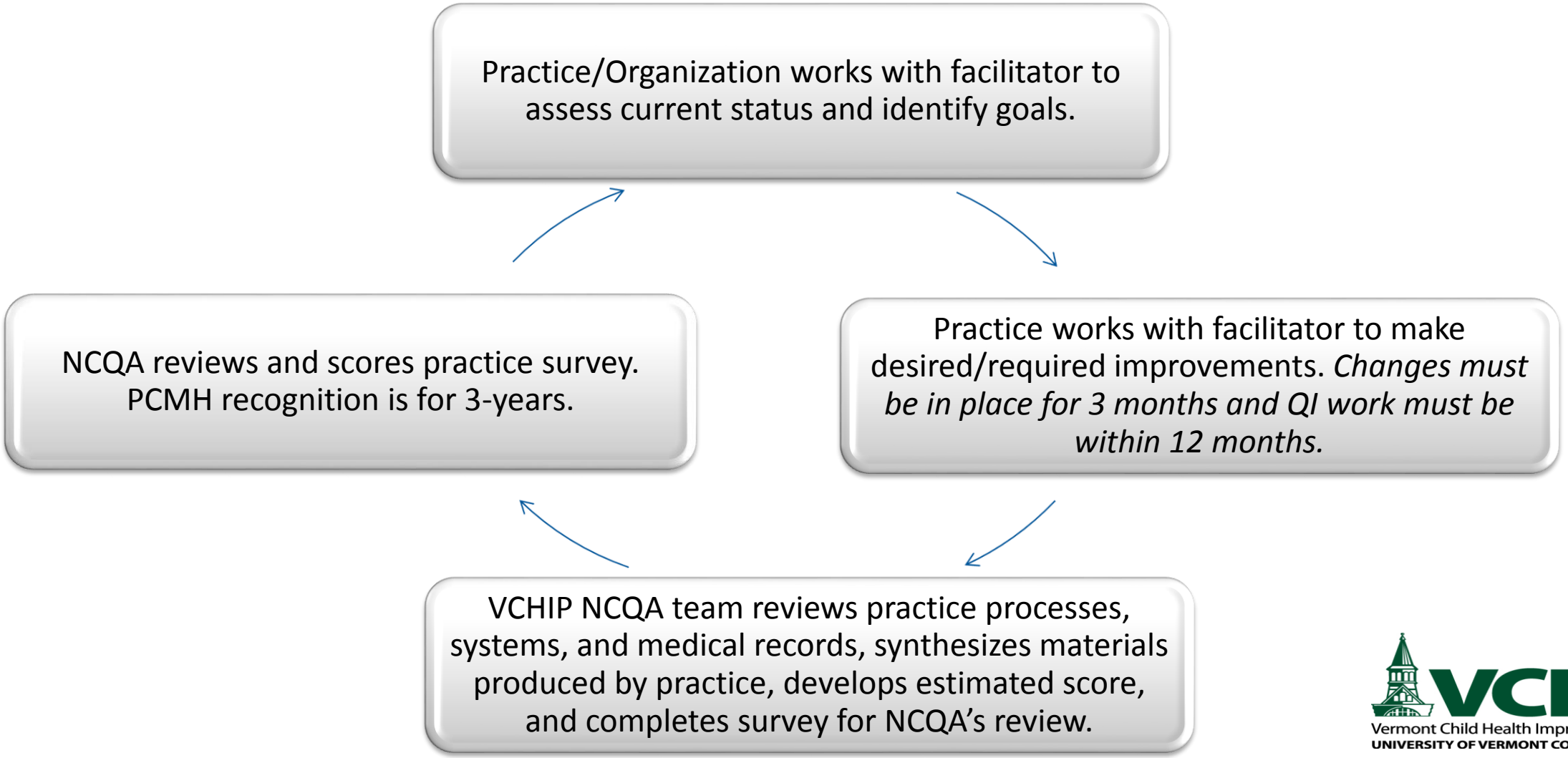
PCMH Process in Vermont



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NCQA's Goals for PCMH 2014

- More emphasis on:
  - Team-based care
  - Integration of behavioral health
- Focused attention on:
  - High-need populations
- And making improvements that are:
  - Sustainable
  - Aligned with the "Triple Aim"

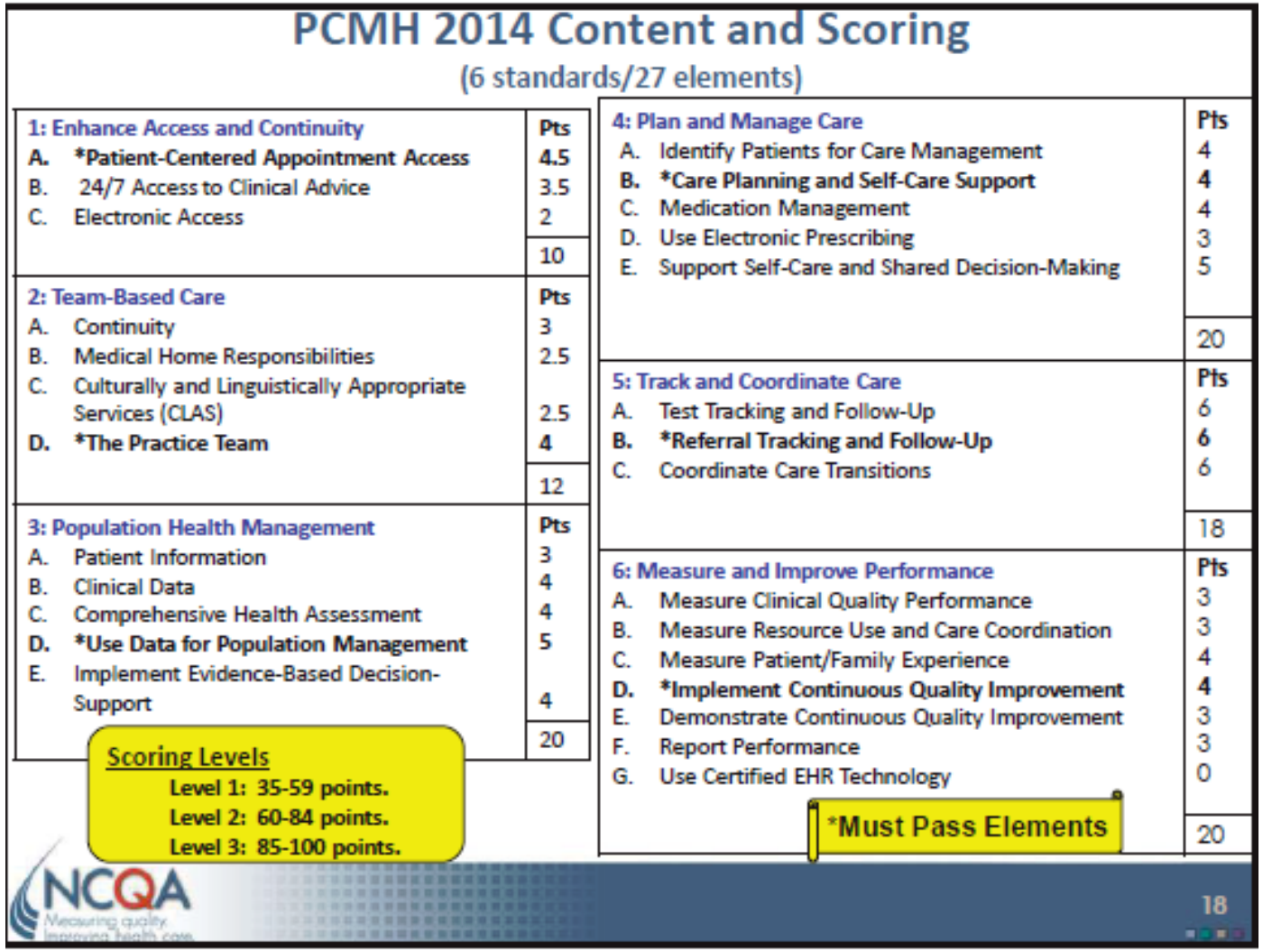
Important Updates to the Standards

- Standards align with Meaningful Use Stage 2 requirements
- Behavioral health has become a medical home responsibility
- Requirement that existing PCMHs demonstrate ongoing panel management, data collection, and continuous quality improvement
- Added expectation that practices are improving access to care and care coordination

Important Updates to the Standards

- Added expectation that caregivers, in addition to patient and family, are included in information-sharing
- Expanded use of evidence-based decision support tool
- Shift from focus on patients with specific conditions to focus on patients practice has identified as needing care management
- Addition of shared decision-making concept

NCQA PCMH 2014



PCMH 2014 Content and Scoring

(6 standards/27 elements)

1: Enhance Access and Continuity	Pts
A. ***Patient-Centered Appointment Access**	**4.5**
B. 24/7 Access to Clinical Advice	3.5
C. Electronic Access	2
	10

2: Team-Based Care	Pts
A. Continuity	3
B. Medical Home Responsibilities	2.5
C. Culturally and Linguistically Appropriate Services (CLAS)	2.5
D. *The Practice Team	**4**
	12

3: Population Health Management	Pts
A. Patient Information	3
B. Clinical Data	4
C. Comprehensive Health Assessment	4
D. *Use Data for Population Management	**5**
E. Implement Evidence-Based Decision-Support	4
	20

4: Plan and Manage Care	Pts
A. Identify Patients for Care Management	4
B. *Care Planning and Self-Care Support	**4**
C. Medication Management	4
D. Use Electronic Prescribing	3
E. Support Self-Care and Shared Decision-Making	5
	20

5: Track and Coordinate Care	Pts
A. Test Tracking and Follow-Up	6
B. *Referral Tracking and Follow-Up	**6**
C. Coordinate Care Transitions	6
	18

6: Measure and Improve Performance	Pts
A. Measure Clinical Quality Performance	3
B. Measure Resource Use and Care Coordination	3
C. Measure Patient/Family Experience	4
D. *Implement Continuous Quality Improvement	**4**
E. Demonstrate Continuous Quality Improvement	3
F. Report Performance	3
G. Use Certified EHR Technology	0
	20

Scoring Levels
Level 1: 35-59 points.
Level 2: 60-84 points.
Level 3: 85-100 points.

*Must Pass Elements

NCQA Measuring quality. Improving health care.

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- Per-Person, Per-Month (PPPM) Payments are based on score
- Currently, payments range from $1.36 PPPM for a score of 35 to $2.39 PPPM for a score of 100

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The Care Team

- Medical Home Responsibilities include (PCMH 2B):
  - Coordinating patient care across settings
  - Getting medical history and explanation of care received elsewhere from patients
  - Making sure patients know how to access care during and after hours
  - Providing access to evidence-based care, education, and self-management support
  - Informing patients about the scope of services available (including behavioral health)
  - Providing equal access to all patients, regardless of payment source
  - Giving insurance information to uninsured patients
  - Giving patients instructions needed to get records transferred to the practice

The Care Team

- Practice Team is expected to (PCMH 2D & 3C):
  - Have defined roles for clinical and nonclinical team members
  - Hold scheduled patient care team meetings/have structured communication process to discuss individual patient care
  - Use standing orders
  - Train and assign members of the care team to coordinate care for individual patients, support patients/families/caregivers in self-management, self-efficacy, and behavior change, manage the patient population (i.e., panel/population management)
  - Hold scheduled team meetings to address practice functioning
  - Involve care team staff in performance evaluation and quality improvement
  - Involve patients/families/caregivers in quality improvement/include them on an advisory council
  - Regularly conduct comprehensive health assessments

The Care Team

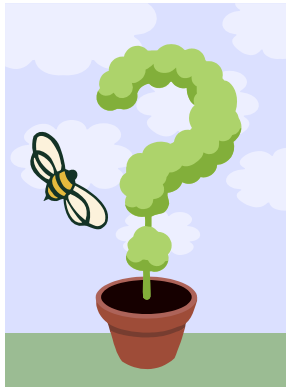
- Identify patients for care management (PCMH 4A)

- Provide care planning, self-care support, and shared decision-making (PCMH 4B & 4E)
  - Incorporate patient preferences and functional/lifestyle goals
  - Identify treatment goals
  - Assess and address potential barriers to meeting goals
  - Create self-management plan with patient/family/caregiver
  - Share care plan with patient/family/caregiver
  - Provide educational resources to patients
  - Provide self-management tools
  - Use shared decision-making aids
  - Offer or refer patients to structured health education programs
  - Maintain list of community resources (and assess usefulness of identified resources)

The Care Team

- Provide care coordination and facilitate care transitions (PCMH 5A, 5B & 5C)
  - Track and follow-up on tests
  - Work with specialists to treat and co-manage patients
  - Coordinate and/or provide behavioral health
  - Ask patients about self-referrals
  - Coordinate with hospitals
  - Provide follow-up care after hospital visits

Questions?



Additional Questions?

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