NCQA PCMH Recognition

Tricia Barrett, Vice President, Product Development
Will Robinson, Manager, Public Policy

May 29, 2014

NCQA
Measuring quality.
Improving health care.

Key Points

- **NCQA PCMH Recognition helps turn primary care into what patients want it to be**
  - **Strong care coordination & care management**
  - **Improved access**
  - **Shared decisions**
- **The program has been improved over time: we are making small but important changes in 2014**
- **A growing body of evidence suggests PCMHs improve quality and lower costs**
- **Running a fair, accurate and cost-effective evaluation program is not easy and not cheap**

Background

- Goal is to evaluate practice transformation
- First version of the program launched in 2003; three versions have been launched since
  - 2008 / 2011 / 2014
- Continual process to review and incorporate latest evidence and best practices in primary care delivery
- Draw significantly on panel of national experts
- Patient-centeredness is the key

How is the program organized?

- **Providers evaluated based on their ability to meet 6 core standards**
- **Assessments are done at the practice level (not provider) – medicine is a team sport**
- **Supporting documentation is submitted through online portal**
- **NCQA reviews documentation and awards a recognition**

Scoring Levels

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

Level 1

Level 2

Level 3

Patient-Centered Medical Home 2014

(6 standards/27 elements)

1) **Patient-Centered Access (10)**
   - A) ***Patient-Centered Appointment Access (4.5)**
   - B) 24/7 Access to Clinical Advice (3.5)
   - C) Electronic Access (2)
2) **Team-Based Care (12)**
   - A) Continuity (3)
   - B) Medical Home Responsibilities (2.5)
   - C) Culturally and Linguistically Appropriate Services (2.5)
   - D) ***The Practice Team (4)**
3) **Population Health Management (20)**
   - 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)
4) **Care Management and Support (20)**
   - 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)
5) **Care Coordination and Care Transitions (18)**
   - A) Test Tracking and Follow-Up (6)
   - B) ***Referral Tracking and Follow-Up (6)**
   - C) Coordinate Care Transitions (6)
6) **Performance Measurement and Quality Improvement (20)**
   - 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)

***Indicates Must Pass Element**

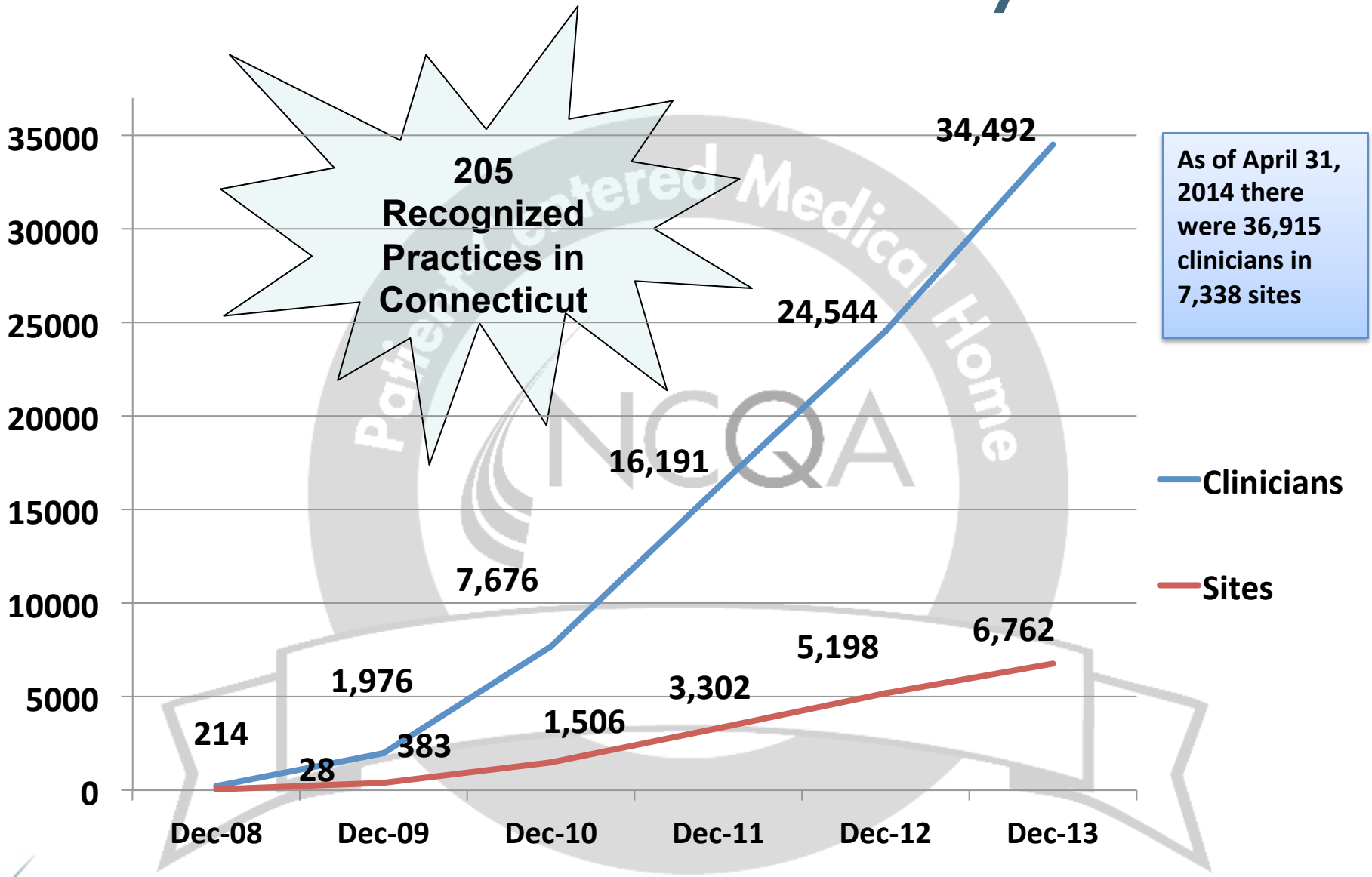
Key Changes to PCMH Recognition

- **Additional emphasis on team-based care.**
  - **Team-focused elements have been moved to their own standard (new PCMH 2: Team-Based Care).**
- **Focused care management on high-need populations.**
  - **Expect practices to identify patients who may benefit from care management and self-care support.**
  - **Criteria should consider social determinants of health, behavioral health, high cost/utilization, poorly controlled or complex conditions and patients 'referred'.**
- **Higher bar and alignment of Quality Improvement (QI) activities with the triple aim.**
- **Further Integration of Behavioral Health.**
- **Alignment with Meaningful Use Stage 2**

PCMH 2014 Advisory Committee Members

- Bruce Bagley, MD
  - TransforMED
- Michael S. Barr, MD, MBA, FACP
  - National Committee for Quality Assurance (previously with ACP)
- Randy T. Curnow, MD, MBA, FACP, FACHE, FACPE (Chair)
  - Vice President Medical Affairs at Mercy Health Physicians
- Susan Edgman-Levitan, PA
  - Stoeckle Center for Primary Care Innovation, Massachusetts General Hospital
- Foster Gesten, MD, FACP
  - New York State Department of Health
- Ralph Gonzales, MD, MSPH, MD, MSPH
  - University of California, San Francisco
- Marjie Harbrecht, MD
  - Health Team Works
- Kathleen Jaeger, JD
  - National Association of Chain Drug Stores
- Regina Julian, MHA, MBA, FACHE
  - Office of the Assistant Secretary of Defense for Health Affairs
- Donald Liss, MD
  - Vice President, Clinical Programs and Policy
- Sean Lyon, MSN, APRN, FNP-BC
  - Life Long Care, PLLC
- Daniel Miller, MD
  - Hudson River HealthCare, Inc
- Marci Nielsen, PhD, MPH
  - Patient-Centered Primary Care Collaborative
- Lee Partridge
  - National Partnership for Women and Families
- Jacob Reider, MD
  - Office of the National Coordinator for Health IT
- Kaitlyn B. Roe
  - Fuse Health Strategies, LLC
- Julie Schilz, BSN, MBA
  - WellPoint
- Xavier Sevilla, MD, MBA, FAAP
  - Catholic Health Initiatives
- Lisa Dulsky Watkins, MD
  - Principal, Granite Shore Consulting, LLC
- Audrey Whetsell, CPHIT, MA
  - Resource Partners
- Kimberly Williams, LMSW
  - The Center for Policy, Advocacy, and Education Mental Health Association of New York City

Where are we today?



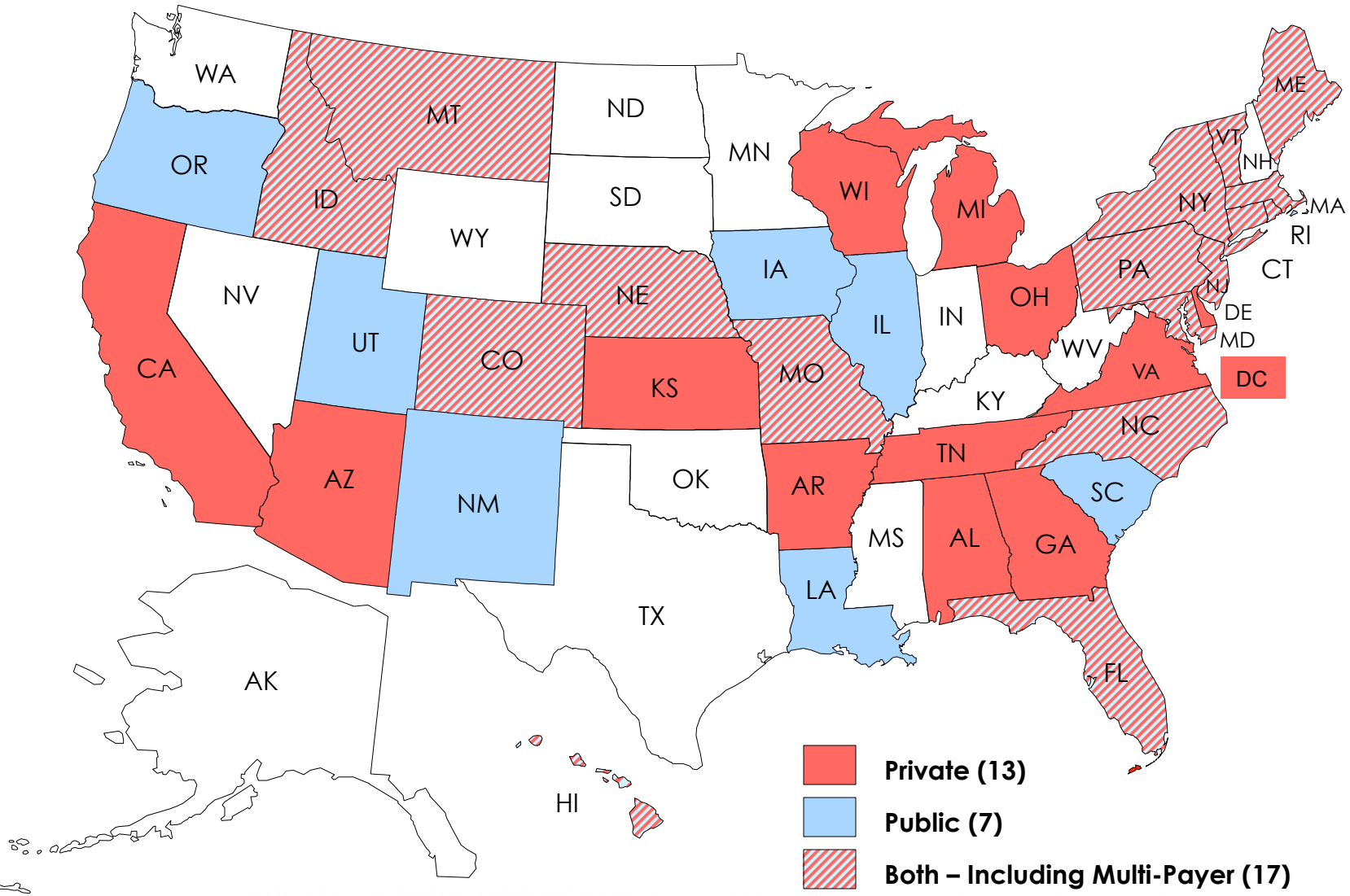
PCMH Practices: Both Big and Small

NUMBER OF CLINICIANS IN RECOGNIZED PRACTICES

	1-2	3-7	8-9	10-19	20-50	50+	Total
Level 1	271	257	28	34	4	0	**594**
Level 2	445	570	91	104	14	2	**1226**
Level 3	**1925**	**2579**	346	504	150	14	**5518**
Total	**2641**	**3406**	**465**	**642**	**168**	**16**	**7338**

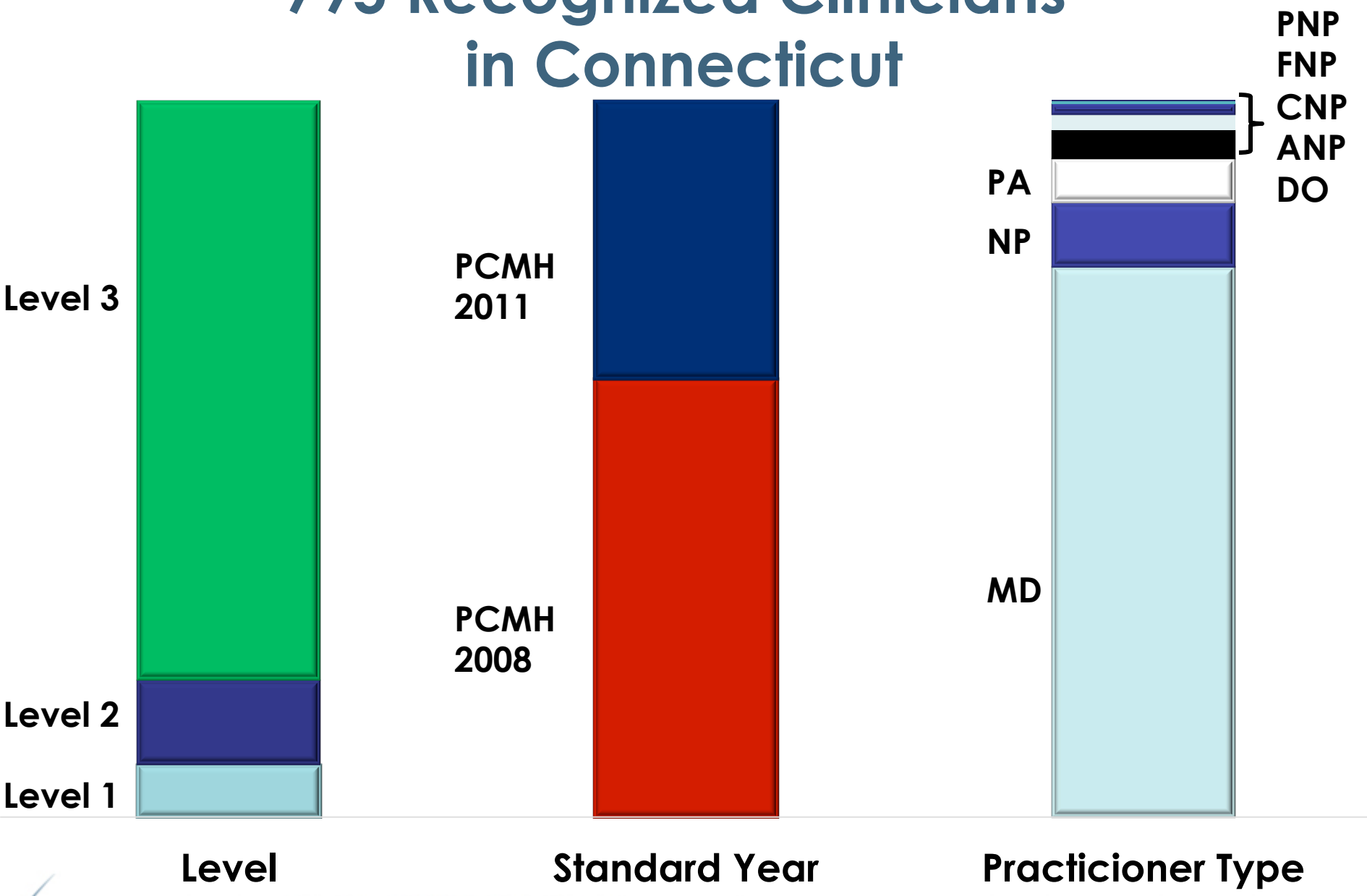
*** As of 4/30/14**

37 States* Have Public and Private Patient-Centered Medical Home (PCMH) Initiatives That Use NCQA Recognition



*Includes the District of Columbia

795 Recognized Clinicians in Connecticut



Evidence Supporting PCMH Model Continues to Grow

- ***Vermont Blueprint for Health 2013 Annual Report*: Lower inpatient admissions, higher use of primary care services, lower use of specialty care, higher use of non-medical services and supports**
- ***RTI Medicare Study*: PCMH recognition was associated with $1,099 lower average per-patient total Medicare spend**
- ***Empire Blue Cross*: Improved care for chronic conditions, lower ED use and hospitalizations**
- ***PCPCC Report*: Meta analysis found improvements across a range of categories, many of the individual studies were on pilots that used NCQA's program**

State Partnerships

- **States can augment recognition program requirements to meet their needs:**
  - **Add must-pass elements (e.g., PCMH 2E – Culturally and Linguistically Appropriate Services)**
  - **Allow pre-recognition evaluation (i.e., an 'on ramp')**
  - **Require specific clinical quality, patient experience, resource use & care coordination measures**
  - **Align incentives with either levels or point totals**
  - **Analyze practice performance on standards**
- **Most states provide transformation support, alternative payment arrangements**
- **We are open to discussing additional program modifications**

Program Administration

- **Administering consistent, fair and efficient evaluation program is not easy**
- **35 FTEs doing PCMH reviews**
- **Product development department continually updating program, providing clarifications and interpretations of standards**
- **Have invested close to $10 million on development and maintenance**

What's next for PCMH?

- **Streamlining process to be more efficient – goal is to make recognition largely a byproduct of transformation, reduce burden on providers**
- **Supporting more advanced practices through benchmarking clinical quality, patient experience and cost measures**

Questions?