

Supporting Patient-Centered Medical Homes



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Overview

- Patient-Centered Medical Home
- Supports for Adopting PCMH
- Keys to Success

NCQA's PCMH 2011 Standards

- Enhance Access and Continuity
- Identify and Manage Patient Populations
- Plan and Manage Care
- Provide Self-Care Support and Community Resources
- Track and Coordinate Care
- Measure and Improve Performance

2011 PCMH Content and Scoring

Standard 1: 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
Standard 2: 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
Standard 3: Plan and Manage Care	Pts
A. Implement Evidence-Based Guidelines	4
B. Identify High-Risk Patients	3
C. Care Management**	4
D. Medication Management	3
E. Use Electronic Prescribing	3
	17

Standard 4: Provide Self-Care Support and Community Resources	Pts
A. Support Self-Care Process**	6
B. Provide Referrals to Community Resources	3
	9
Standard 5: 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
Standard 6: 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
G. Use of Certified EHR Technology	0
	20

**** Must Pass Elements**

PCMH Scoring

6 standards = 100 points

6 Must Pass elements

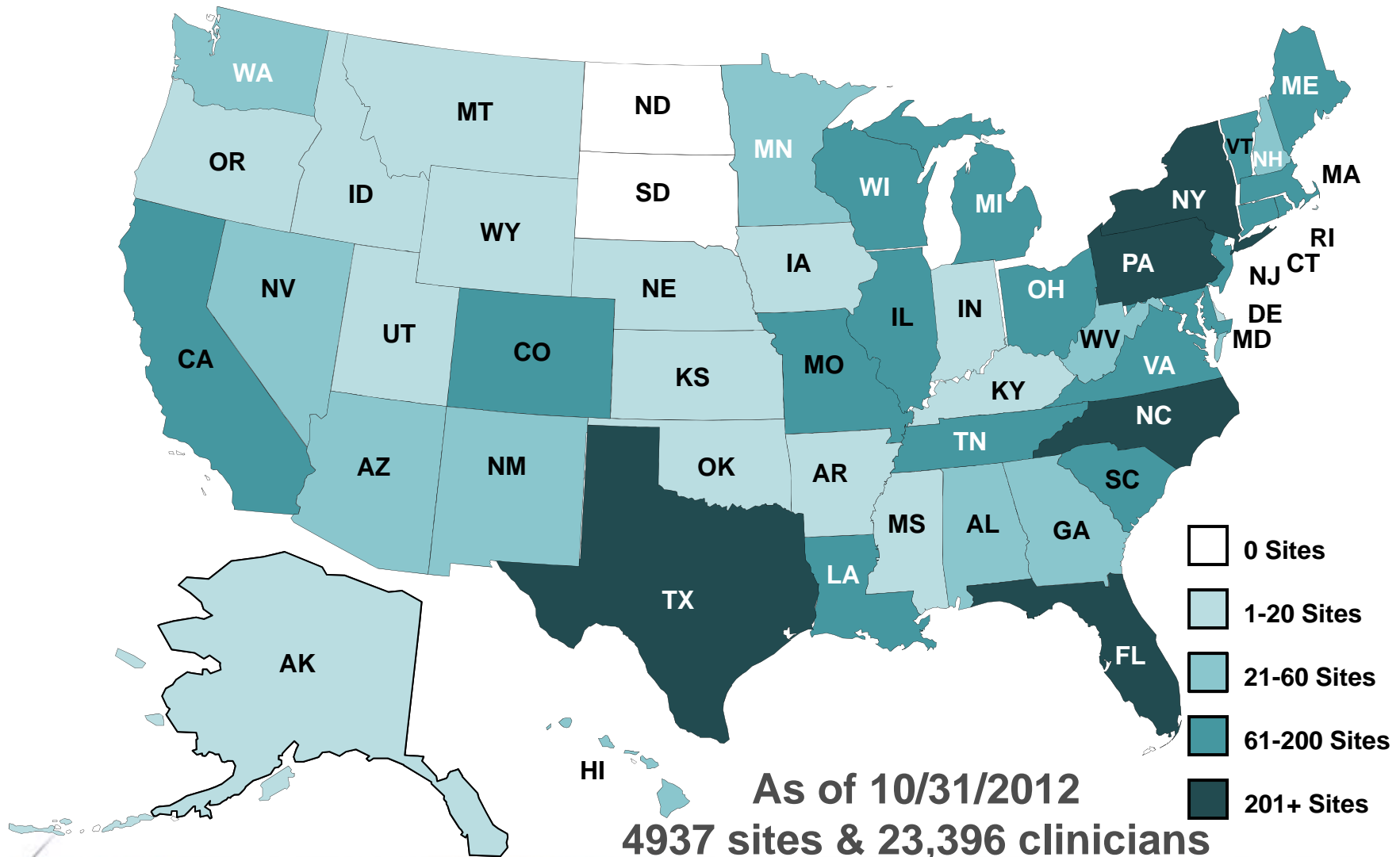
NOTE: Must Pass elements require a $\geq 50\%$ performance level to pass

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

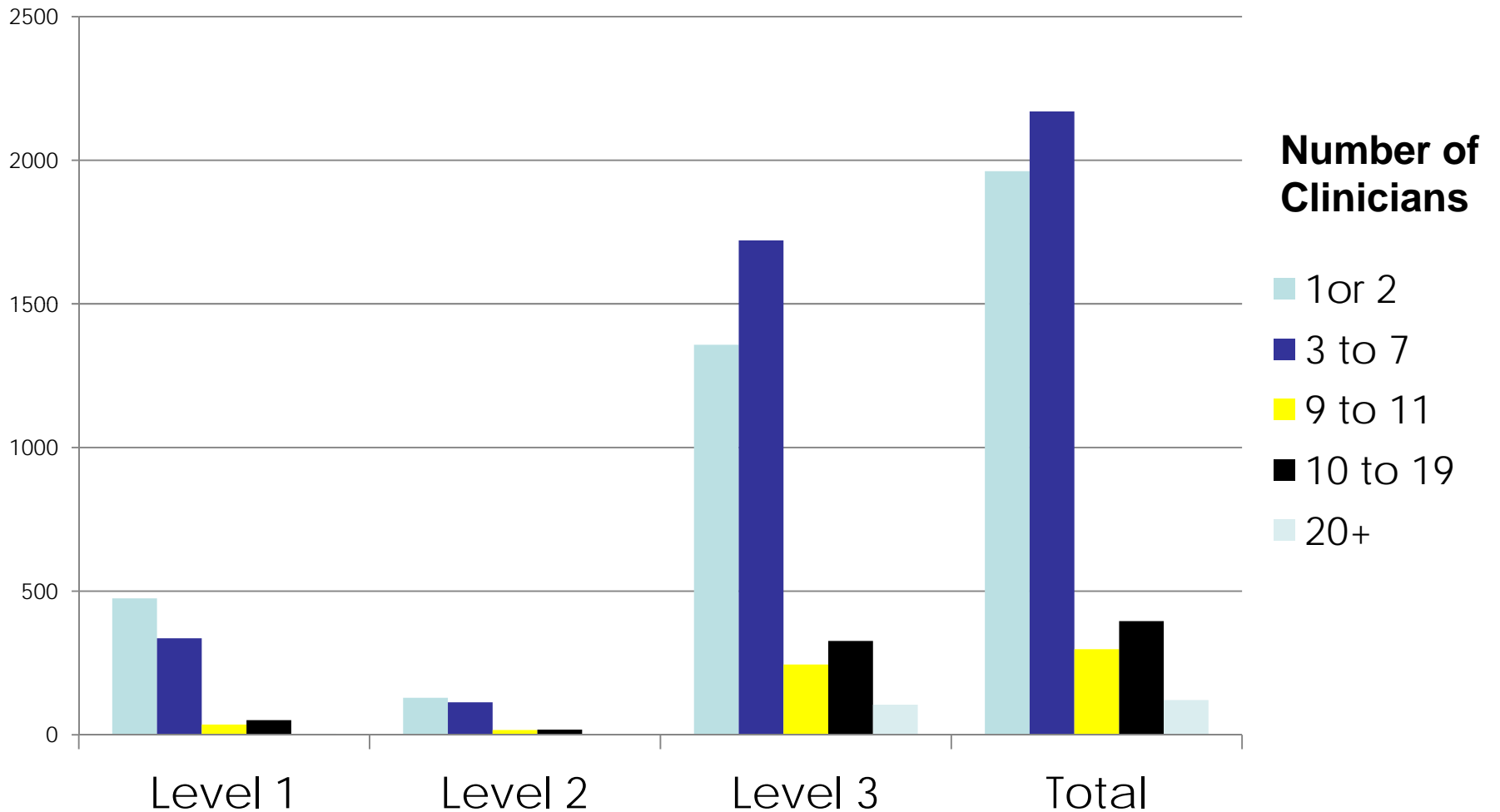
Practices with a numeric score of 0 to 34 points and/or achieve less than 6 “Must Pass” Elements are not Recognized.

Recognition is granted for three (3) years and is not transferable. A practice can submit an add-on survey during the three years to achieve a higher Level of recognition.

Recognized Practices Across the USA



Small Practices Achieve Recognition



Initiatives Rely on NCQA's Recognition

- **Federal Initiatives**
 - HRSA Patient-Centered Health Home Initiative
 - CMS Advanced Primary Care Practice Demonstration
 - Military Health System - Military Treatment Facilities
- **State Public Initiatives**
 - ME, VT, NC, PA, RI, MN, MD, MI, MA, NY, OH, CO, LA
- **Health Plans**
 - Blue Cross/Blue Shield plans in 12 states
 - Aetna, Cigna, Centene, Group Health, Amerigroup and others

SUPPORTS FOR ADOPTING PCMH

Why get recognized? What gets in the way?

Motivations

- To improve quality of patient care
- To improve patient experiences of care
- To function more efficiently
- To become eligible for financial incentives

Barriers

- Time
- Money and other resources to invest in staff, training or equipment
- Information systems
- Knowledge and experience

Incentives Matter

***Nearly 80% of Small Practices (<5 physicians)
participated in demonstration or incentive programs***

Participated in demonstration or pilot	9.0%
Received payment for PCMH only	24.5%
Both demonstration/pilot and PCMH payment	45.7%

Practices Value Tangible Help

	Practices that Had Help	Help was Very Useful
Training for staff	85.5%	43.5%
Training for clinicians	84.2%	41.1%
Training for consumer advocates	31.4%	31.6%
Consultation/Coaching/facilitation specific to practice	63.9%	47.4%
Access to a learning collaborative	59.3%	43.4%
Training on how to meet requirements for NCQA's recognition requirements	81.3%	52.5%
Assistance with preparing documentation of application requirements for NCQA's recognition program	81.0%	67.4%

KEYS TO SUCCESS

Four Common Themes of Success

1. **Emphasis on Quality Improvement**
 - Test, evaluate changes; feedback to teams
2. **Enhanced Team**
 - “top of license” within scope of practice
3. **New roles and responsibilities**
 - Reminders, tracking referrals, medication reconciliation
4. **Effective Use of Information Technology**
 - Population management, care management and QI

Common Areas of Weakness

1. Patient experiences data
2. Referrals to community resources
3. After hours access
4. Electronic access

Testimonial

“First, there is the recognition both internally and externally that you provide state-of-the-art primary healthcare. **Second** is the way the criteria force your delivery system to think about routes of communication between the various parts of the healthcare system. We know that those points of transition of patients and their information are dangerous opportunities for medical errors to occur. **Third**, we anticipate that the recognition will bring increased reimbursement at some time down the line and improving reimbursement is always a major goal.”



*--Institute for Family Health (IFH), The Bronx,
Manhattan and in the Mid-Hudson Valley*

Key Points

- Adoption of the Patient-Centered Medical Home is increasing, even in small and underserved practices/clinics
- Practices need practical support and financial incentives
- PCMH builds on systematic approach, expanded role of staff and effective use of health IT

For More Information

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