

Intro to NCQA PCMH Recognition

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Background

- **Goal is to evaluate successful practice transformation**
- **First version of the program launched in 2003; three PCMH 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?

- Practice sites evaluated based on their ability to meet 6 core standards
- Assessments are done at the practice level (not clinician) – medicine is a team sport
- Supporting documentation (e.g., workflow forms, reports, records or files) are 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



Standards Layout

Standard – High Level Focus

Example: PCMH 1 Patient Centered Access

Element – Further Refined

Example: PCMH 1A Patient-Centered Appointment Access

Discussion today

Factor – Measurable Requirement

Example: PCMH 1A, Factor 1 – Providing same-day appointments for routine and urgent care

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)

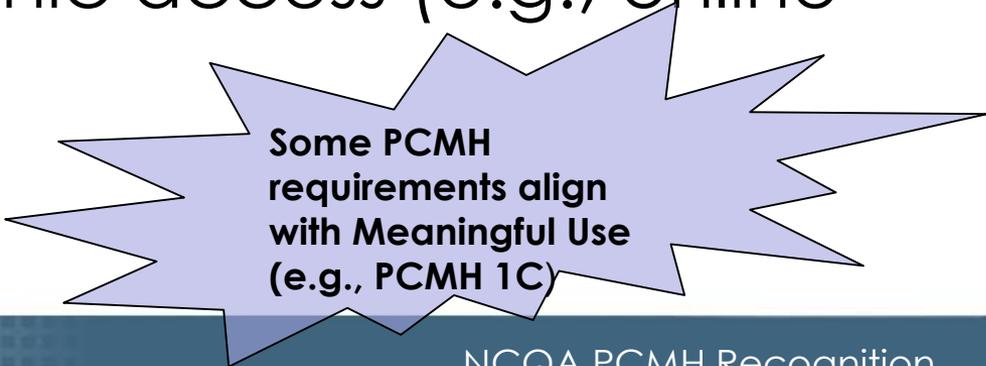
***Indicates Must Pass Element**

PCMH 1: Patient-Centered Access

Intent of Standard

The practice provides access to team-based care for both routine and urgent needs of patients, families & care-givers at all times

- Element A: Patient-centered appointment access **(MUST PASS)**
- Element B: 24/7 Access to clinical advice
- Element C: Electronic access (e.g., online portal, email)



Some PCMH requirements align with Meaningful Use (e.g., PCMH 1C)

PCMH 2: Team-Based Care

Intent of Standard

The practice provides continuity of care using culturally and linguistically appropriate, team-based approaches. The practice selects and trains team members to support patient self-management and care coordination.

- Element A: Continuity
- Element B: Medical Home Responsibilities
- Element C: CLAS
- Element D: The Practice Team **(MUST PASS)**

PCMH 3: Population Health Management

Intent of Standard

The practice uses a comprehensive health assessment and evidence-based decision support based on complete patient information and clinical data to manage the health of its entire patient population.

- Element A: Patient Information
- Element B: Clinical Data
- Element C: Comprehensive Health Assessment
- Element D: Use Data for Population Management (**MUST-PASS**)
- Element E: Implement Evidence-Based Decision Support

PCMH 4: Care Management and Support

Intent

The practice systematically identifies individual patients and plans, manages and coordinates care, based on need.

- Element A: Identify Patients for Care Management
- Element B: Care Planning and Self-Care Support (**MUST PASS**)
- Element C: Medication Management
- Element D: Use Electronic Prescribing
- Element E: Support Self-Care and Shared Decision-Making

PCMH 5: Care Coordination & Care Transitions

Intent

The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations.

- Element A: Test Tracking and Follow-Up
- Element B: Referral Tracking and Follow-Up
(MUST PASS)
- Element C: Coordinate Care Transitions

PCMH 6: Performance Measurement and Quality Improvement

Intent of Standard

The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.

- Element A: Measure Clinical Quality Performance
- Element B: Measure Resource Use and Care Coordination
- Element C: Measure Patient/Family Experience
- Element D: Implement Continuous Quality Improvement (**MUST PASS**)
- Element E: Demonstrate Continuous Quality Improvement
- Element F: Report Performance
- Element G: Use Certified EHR Technology

Documentation Types

1. **Documented process** Written procedures, protocols, processes for staff, workflow forms (not explanations); must include practice name and date of implementation.
2. **Reports** Aggregated data showing evidence
3. **Records or files** Patient files or registry entries documenting action taken; data from medical records for care management.
4. **Materials** Information for patients or clinicians, e.g. clinical guidelines, self-management and educational resources

NOTE: Screen shots or electronic “copy” may be used as examples (EHR capability), materials (Web site resources), reports (logs) or records (advice documentation)

Example: Documented Process – PCMH 1B

ABCD Family Medicine Clinical Advice Policy

Effective 6/30/2012

Patients have 24/7 telephonic access to a clinician (MD, RN, NP or PA) to provide clinical advice. Calls during office hours are to be responded to within one hour and are to be recorded as a noted patient interaction in the EMR at the time of the call. The on-call provider has computer access by logging onto the EMR remotely while on-call, which enables that care provider access to patient records, to view and search patient records, and also record after hours activity for a patient. After hours calls from patients are to be responded to by the on-call provider within one hour and are to be recorded as a noted patient interaction in the EMR in within 24 hours of communication with the patient.

Example: Report – Response Times to Calls for PCMH 1B

Shows:

- ✓ Call date/time
- ✓ Response date/time
- ✓ If time meets policy

Response times to meet standards for timely telephone response:

(A telephone call audit was conducted for our practice for two weeks. Below are the results. The encounter number refers to the unique tracking ID our EMR assigns. It has been provided instead of confidential patient information, for tracking purposes. policy for telephone response time is 24 hours.)

Encounter Number	Date we received phone request	Time of request	Date we responded to patient	Time of response	Elapsed Time	Response time meets policies?
	3/20/09	11:26	3/20/09	17:02	6 hours	yes
	3/19/09	11:21	3/19/09	13:10	2 hours	yes
	3/18/09	13:53	3/20/09	17:19	4 hours	yes
	3/17/09	15:02	3/18/09	9:31	18 hours	yes
	3/17/09	14:13	3/18/09	10:00	20 hours	yes
	3/19/09	15:14	3/20/09	9:09	18 hours	yes
	3/16/09	10:30	3/16/09	10:41	.25 hours	yes
	3/20/09	9:28	3/20/09	12:55	3 hours	Yes
	3/17/09	13:53	3/17/09	16:19	3 hours	yes
	3/18/09	14:35	3/19/09	14:34	24 hours	Yes
	3/19/09	11:16	3/19/09	11:32	0.25 hours	Yes

Example: Screenshot PCMH 5A Flagging Abnormal Labs

Lab Results Work List

Filters | Previous Set | Next Set | Review | Add Order ▾ | Add QCL | Open Patient | Refresh (0.5m ago)

[-] For Gullo John J., Bingham Marcel D., Alpert Tracy E.; Date Range: Previous 4 Weeks; Status In:Unreviewed

PatID	Date / Time	# Results	Criticality	Ordering Physician
A120050	1/10/2013 1:59:00 PM	1	Panic	Warning
A122927	1/14/2013 10:47:05 AM	20	Panic	Panic
A124297	1/21/2013 2:00:34 PM	20	Panic	(Custom)
A110376	1/8/2013 10:28:24 AM	16	Panic	(Blanks)
A090737	1/10/2013 9:50:23 AM	20	Warning	(Non blanks)
A130200	1/18/2013 4:43:00 PM	1	Warning	Panic
A062552	1/7/2013 11:06:54 AM	7	Warning	Warning
A089222	1/9/2013 8:55:00 AM	20	Warning	...
A092600	1/22/2013 1:44:25 PM	16	Warning	Bi
A002553	1/10/2013 11:25:00 AM	16	Warning	Gt
A111093	1/29/2013 9:53:48 AM	16	Warning	Bi
A124587	1/18/2013 8:45:55 AM	20	Warning	Gt

Questions?



APPENDIX

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**