NCQA PCMH Recognition

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QUALIS HEALTH

THE COMMONWEALTH FUND

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Why create a Medical Home?

- Improved clinical outcomes
- Reduced health disparities
- Improved patient experience
- Improved staff satisfaction
- Improved operational efficiencies
- Reduced cost of healthcare overall

Why were standards developed?

- To evaluate a systematic approach to delivering preventive and chronic care
- To build on the IOM's recommendation to shift from "blaming" individual clinicians to improving systems of care
- To create measures that are actionable for clinical practices
- To validate measures by relating them to clinical performance and patient experience results

Why attain formal PCMH recognition ?

- Operating framework
- Potential for increased reimbursement
- Market advantage
- Pride
- Alignment with Meaningful Use and the Accountable Care Organization

Who else is doing this?

- NC QA PCMH recognition stats (NCQA, Dec 31 2010)
  - 7676 clinicians
  - 1506 sites
  - 44 states
- Pilots/demonstration projects in 39 states (NASHP, Feb 15 2011)
  - Health plans
  - State Medicaid agencies
  - State primary care associations
  - Private foundations
  - Public-private partnerships

What's new in 2011 ?

- 9 domains became 6
- Improvements
  - Eliminated duplication
  - Better alignment of elements with operations
  - Stronger focus on patient-centeredness
- 10 Must Pass elements collapsed to 6
  - Must achieve all 6 to gain any level of recognition

What's new in 2011 (cont'd)

- Eligible providers now include mid-levels
- Alignment with CMS Meaningful Use criteria
- New scoring algorithm
- Enhanced instructions @ www.ncqa.org

PCMH 1
Enhance Access and Continuity

Provide team-based care with access and advice during and after hours and patient/family information about the medical home

A. Access During Office Hours
B. After-Hours Access
C. Electronic Access
D. Continuity
E. Medical Home Responsibilities
F. Culturally and Linguistically Appropriate Services (CLAS)
G. Practice Team

PCMH 2
Identify and Manage Patient Populations

Acquire and use data for care of the practice's patient population

A. Patient Information
B. Clinical Data
C. Comprehensive Health Assessment
D. Use Data for Population Management

PCMH 3
Plan and Manage Care

Use evidence-based guidelines for preventive, acute and chronic care management for chronic, frequent and behavior-based conditions, including medication management

A. Implement Evidence-Based Guidelines
B. Identify High-Risk Patients
C. Care Management
D. Manage Medications
E. Use Electronic Prescribing

PCMH 4
Provide Self-Care Support and Community Resources

Support patient and family in self-care with information, tools and community resources

A. Support Self-Care Processes
B. Provide Referrals to Community Resources

PCMH 5
Track and Coordinate Care

Track and coordinate tests, referrals and transitions of care

A. Test Tracking and Follow-up
B. Referral Tracking and Follow-up
C. Coordinate with Facilities / Care Transitions

PCMH 6
Measure and Improve Performance

Use performance and patient experience data for continuous quality improvement

A. Measure Performance
B. Measure Patient/Family Experience
C. Implement Continuous Quality Improvement
D. Demonstrate Continuous Quality Improvement
E. Report Performance
F. Report Data Externally

6 Must Pass Elements

PCMH 1 A	**Access During Office Hours**
PCMH 2 D	**Use Data for Population Management**
PCMH 3 C	**Care Management**
PCMH 4 A	**Support Self-Care Processes**
PCMH 5 B	**Referral Tracking and Follow-up**
PCMH 6 C	**Implement Continuous Quality Improvement**
	Must Pass at 50%

Comparison of 2008 – 2011 Scoring

2008			2011		
Level	Points	Must Pass	Level	Points	Must Pass
1	25-49	5	1	35-59	6
2	50-74	10	2	60-84	6
3	75-100	10	3	85-100	6

SNMHI Participation in NCQA PCMH Recognition Progress

	CO	ID	MA	Pittsb	OR	Totals
1st Wave 2008 stds	8	1	7	5	0	21
2nd Wave 2008 stds	1	10	1	0	0	12
3rd Wave 2011 stds			6			6
Totals	9	11	14	5	0	39
% ppn	69%	85%	100%	50%	0%	60%

The SNMHI NCQA PCMH Journey

RCC	Org	Health Ctrs	In Progress	Completed
CO	4	8	3	5 @ Level 3
ID	1	1	1	
MA	4	7	2 * 2011	5 @ Level 3
PA	3	5	4	1 @ Level 3
OR	0	0	0	0
Totals	12	21	10	11

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