CHANGE CONCEPTS FOR PRACTICE TRANSFORMATION AND 2011 NCQA PCMH™ RECOGNITION STANDARDS: A CROSSWALK

May 2013

	Change Concept Element	2011 NCQA PCMH Standards
ENGAGED LEADERSHIP	1a. Provide visible and sustained leadership to lead overall cultural change as well as specific strategies to improve quality and spread and sustain change.	[none]
	1b. Ensure that the PCMH transformation effort has the time and resources needed to be successful.	PCMH 1: Enhance Access and Continuity, Element G: The Practice Team 2. Having regular team meetings or structured communication processes 4. Training and assigning care teams to coordinate care 5. Training and assigning care teams to support patients and families in self-management, self-efficacy and behavior change 6. Training and assigning care teams for patient population management 7. Training and designating care team members in communication skills
	1c. Ensure that providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model.	PCMH 1: Enhance Access and Continuity, Element G: The Practice Team 2. Having regular team meeting or a structured communication process
	1d. Build the practice's values on creating a medical home for patients into staff hiring and training processes.	PCMH 1: Enhance Access and Continuity, Element G: The Practice Team 4. Training and assigning care teams to coordinate care 5. Training and assigning care teams to support patients and families in self-management, self-efficacy and behavior change 6. Training and assigning care teams for patient population management 7. Training and designating care team members in communication skills

QUALITY IMPROVEMENT STRATEGY

Change Concept Element	2011 NCQA PCMH Standards
2a. Choose and use a formal model for quality improvement.	PCMH 6: Measure and Improvement Performance, Element C: Implement Continuous Quality Improvement (MUST PASS) 1. Sets goals and acts to improve performance on at least 3 preventive care, chronic/acute care, or utilization measures 2. Sets goals and acts to improve performance on at least one patient experience measures (access, communication, coordination, whole person care) 3. Sets goals and addresses at least one identified disparity in care or service for vulnerable population
2b. Establish and monitor metrics to evaluate routine improvement efforts and outcomes; ensure all staff members understand the metrics for success.	PCMH 6: Measure and Improvement Performance, Element A: Measure Performance The practice measures or receives data on the following: 1. At least 3 preventive care measures 2. At least 3 chronic or acute care clinical measures 3. At least 2 utilization measures affecting health care costs 4. Performance data strategies for vulnerable populations (to assess disparities in care).
2c. Ensure that patients, families, providers and care team members are involved in quality improvement activities.	PCMH 1: Enhance Access and Continuity, Element G: The Practice Team 8. Involving care team staff in the practice's performance evaluation and quality improvement activities PCMH 6: Measure and Improvement Performance, Element C: Implement Continuous Quality Improvement 4. Involve patients/families in quality improvement teams or on the practice's advisory council
2d. Optimize use of health information technology to meet Meaningful Use criteria.	[many of the 2011 NCQA PCMH standards contain meaningful use criteria]

	Change Concept Element	2011 NCQA PCMH Standards
EMPANELMENT	3a. Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis.	PCMH 1: Enhance Access & Continuity, Element D: Continuity 1. Expecting patients/families to select a personal clinician 2. Documenting the patient/families choice of clinician 3. Monitoring the percentage of patient visits with a selected clinician or team
	3b. Assess practice supply and demand, and balance patient load accordingly.	[none]
	3c. Use panel data and registries to proactively contact and track patients by disease status, risk status, self-management status, community and family need.	PCMH 2: Identify and Manage Patient Populations, Element A: Patient Information (All factors) PCMH 2: Identify and Manage Patient Populations, Element B: Clinical Data (All factors) PCMH 2: Identify and Manage Patient Populations, Element C: Comprehensive Health Assessment (All factors) PCMH 2: Identify and Manage Patient Populations, Element D: Use Data for Population Management (MUST PASS) (All factors)

	Change Concept Element	2011 NCQA PCMH Standards
CONTINUOUS AND TEAM-BASED HEALING RELATIONSHIPS	4a. Establish and provide organizational support for care delivery teams that are accountable for the patient population/panel.	PCMH 1: Enhance Access and Continuity, Element G: The Practice Team 2. Regular team meetings and communication processes 4. Training and assigning care teams to coordinate care 5. Training and assigning care teams to support patients and families in self-management, self-efficacy, and behavior change 6. Training and assigning care teams for patient population management 7. Training and designating care team members in communication skills
	4b. Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care.	PCMH 1: Enhance Access and Continuity, Element D: Continuity 1. Expecting patients/families to select a personal clinician 2. Documenting the patient/families choice of clinician 3. Monitoring the percentage of patient visits with a selected clinician or team
	4c. Ensure that patients are able to see their provider or care team whenever possible.	PCMH 1: Enhance Access and Continuity, Element D: Continuity 3. Monitoring the percentage of patient visits with a selected clinician or care team
	4d. Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.	PCMH 1: Enhance Access and Continuity, Element G: The Practice Team 1. Defining roles of clinical/nonclinical team members 4. Training and assigning care teams to coordinate care 5. Training and assigning care teams to support patients and families in self-management, self-efficacy and behavior change 6. Training and assigning care teams for patient population management 7. Training and designating care team members in communication skills

ORGANIZED, EVIDENCE-BASED CARE

Change Concept Element	2011 NCQA PCMH Standards
5a. Use planned care according to patient need.	PCMH 3: Plan and Manage Care, Element A: Implement Evidence-Based Guidelines The practice systematically identifies individual patients and plans, manages and coordinates their care, baed on their condition and needs and on evidence-based guidelines. PCMH 3: Plan and Manage Care, Element C: Care Management 1. Conducts pre-visit preparations
5b. Identify high risk patients and ensure they are receiving appropriate care and case management services.	PCMH 3: Plan and Manage Care, Element B: Identify High Risk Patients 1. Establishes criteria and a systematic process to identify high-risk or complex patients PCMH 3: Plan and Manage Care, Element C: Care Management (All factors) PCMH 3: Plan and Manage Care, Element D: Medication Management (All factors)
5c. Use point-of-care reminders based on clinical guidelines.	PCMH 3: Plan and Manage Care, Element A: Implement Evidence-Based Guidelines The practice systematically identifies individual patients and plans, manages and coordinates their care, based on their condition and needs and on evidence-based guidelines.
5d. Enable planned interactions with patients by making up-to-date information available to providers and the care team at the time of the visit.	PCMH 1: Enhance Access and Continuity, Element G: The Practice Team 1. Defining roles for clinical and nonclinical team members 2. Using standing orders for services 4. Training and assigning care teams to coordinate care for individual patients PCMH 3: Plan and Manage Care, Element C: Care Management 1. Conducts pre-visit preparations 6. Identifies patients/families who might benefit from additional care management support

PATIENT-CENTERED INTERACTIONS

Change Concept Element	2011 NCQA PCMH Standards
6a. Respect patient and family values and expressed needs.	PCMH 1: Enhance Access and Continuity, Element F: The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families. PCMH 4: Provide Self-Care Support and Community Resources, Element A: Support Self-Care Process 3. Develops and documents self-management plans in collaboration with patients/families
6b. Encourage patients to expand their role in decision-making, health-related behaviors, and self-management.	PCMH 4: Provide Self-Care Support and Community Resources, Element A: Support Self-Care Process (MUST PASS) 3. Develops and documents self-management plans and goals in collaboration with patients/families
6c. Communicate with their patients in a culturally appropriate manner, in a language and at a level that the patient understands.	PCMH 1: Enhance Access and Continuity, Element F: Culturally and Linguistically Appropriate Services 2. Assessing the language needs of its population 3. Provides interpretation or bilingual services to meet the language needs of its population 4. Provides printed materials in the languages of its population
6d. Provide self-management support at every visit through collaborative goal setting and patient action planning.	PCMH 3: Plan and Manage Care, Element C: Care Management (MUST PASS) 2. Collaborates with patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit 4. Assess and address barriers when the patient has not met treatment goals PCMH 4: Provide Self-Care Support and Community Resources, Element A: Support Self-Care Process 6. Counsels at least 50% of patients/families to adopt healthy behaviors
6e. Obtain feedback from patients/families about their healthcare experience and use this information for quality improvement.	PCMH 6: Measure and Improvement Performance, Element B: Measure Patient/Family Experience 1. The practice conducts a survey to evaluate patient/family experience 3. The practice obtains feedback on the experiences of vulnerable patient groups 4. The practice obtains feedback from patients/families through qualitative means

ENHANCED ACCESS

Change Concept Element	2011 NCQA PCMH Standards
7a. Promote and expand access by ensuring that established patients have 24/7 continuous access to their care teams via phone, email or in-person visits.	PCMH 1: Enhance Access and Continuity, Element A: Access During Office Hours (MUST PASS) 1. Providing same-day appointments. 2. Providing timely clinical advice by telephone during office hours 3. Providing timely clinical advice by secure electronic messages PCMH 1: Enhance Access & Continuity, Element B: After-Hours Access 1. Providing access to routine and urgent care appointments outside regular business hours 2. Providing continuity of medical record information for care and advice when the office is not open 3. Providing timely clinical advice by telephone when the office is not open 4. Providing timely clinical advice using a secure, interactive electronic system when the office is not open PCMH 1: Enhance Access and Continuity, Element C: Electronic Access 2. At least 10% of patients have electronic access to their current health information (including lab results, problem lists, medication lists and allergies) within 4 business days of when the information is available to the practice 4. Two-way communication between patients/families and the practice 5. Request for appointments or prescription refills 6. Request for referrals or test results
7b. Provide scheduling options that are patient- and family centered and accessible to all patients.	PCMH 1: Enhance Access and Continuity, Element A: Access During Office Hours 1. Providing same-day appointments. PCMH 1: Enhance Access & Continuity, Element B: After-Hours Access 1. Providing access to routine and urgent care appointments outside regular business hours
7c. Help patients attain and understand health insurance coverage.	[none]

	Change Concept Element	2011 NCQA PCMH Standards
CARE COORDINATION	8a. Link patients with community resources to facilitate referrals and respond to social service needs.	PCMH 4: Provide Self-Care Support and Community Resources, Element B: Provide Referrals to Community Resources 1. Maintains a current resource list on five topics or key community service areas of importance to the patient population 2. Tracks referrals provided to patients/families 3. Arranges or provides treatment for mental health and substance abuse disorders 4. Offers opportunities for for health education and programs (such as group classes and peer support)
	8b. Integrate behavioral health and specialty care into care delivery through co-location or referral protocols.	PCMH 4: Provide Self-Care Support and Community Resources, Element B: Provide Referrals to Community Resources 3. Arranges or provides treatment for mental health and substance abuse disorders PCMH 5: Track and Coordinate Care, Element B: Referral Tracking and Follow-up (MUST PASS) 4. Establishing and documenting agreements with specialists in the medical record if co-management is needed
	8c. Track and support patients when they obtain services outside the practice.	PCMH 5: Track and Coordinate Care, Element B: Referral Tracking and Follow-up (MUST PASS) 1. Tracking the status of referrals, including required timing for receiving specialist's report 5. Asking patients/families about self-referrals and requesting reports from clinicians
	8d. Follow-up with patients within a few days of an emergency room visit or hospital discharge.	PCMH 5: Track and Coordinate Care, Element C: Coordinates with Facilities and Care Transitions 1. Demonstrates its process for identifying patients with hospital admission or ED visit 3. Demonstrates its process for consistently obtaining patient discharge summaries from the hospital and other facilities 4. Demonstrates its process for contacting patients/families for appropriate follow-up care within an appropriate period following hospital admission or ED visit
	8e. Communicate test results and care plans to patients/families.	PCMH 5: Track and Coordinate Care, Element A: Test Tracking and Follow-up 5. Notifies patients/families of normal and abnormal lab and imaging test results PCMH 3: Plan and Manage Care, Element C: Care Management 3. Gives the patient/family a written plan of care 5. Gives the patient/family a clinical summary at each relevant visit

Sources: Safety Net Medical Home Initiative. Change Concepts for Practice Transformation. 3rd ed. Seattle, WA: Qualis Health and the MacColl Center for Health Care Innovation; May 2013.
NCQA PCMH 2011 Recognition Program. Washington, DC: NCQA; 2011. For more information, refer to: www.ncqa.org.

Safety Net Medical Home Initiative

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The objective of the Safety Net Medical Home Initiative was to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative was administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.safetynetmedicalhome.org.

MacColl Center for Health Care Innovation