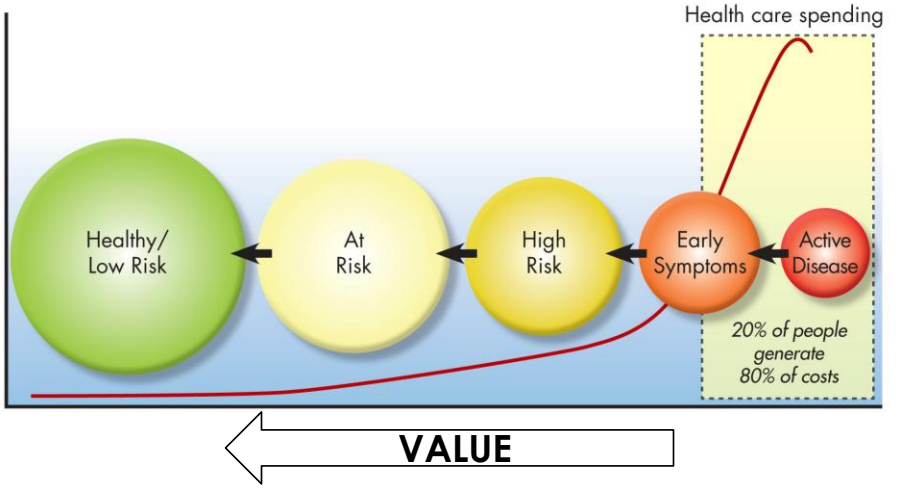
NCQA's Patient-Centered Medical Home PCMH 2011

Presentation to CalSIM Grantee Staff & Stakeholders

June 5, 2013

NCQA
Measuring quality.
Improving health care.

We work toward high-value health care



Measurement, transparency and accountability move health care toward greater value

What We Know

- All providers should be part of an accountable entity.
  - PCMHs can be aggregated up and benchmarked on cost and quality.
  - Specialists need to be part of the accountable entity too.
- NCQA uses a total population management approach.
  - Addressing healthcare needs on the front end will keep people out of the ER/ambulatory ICUs.

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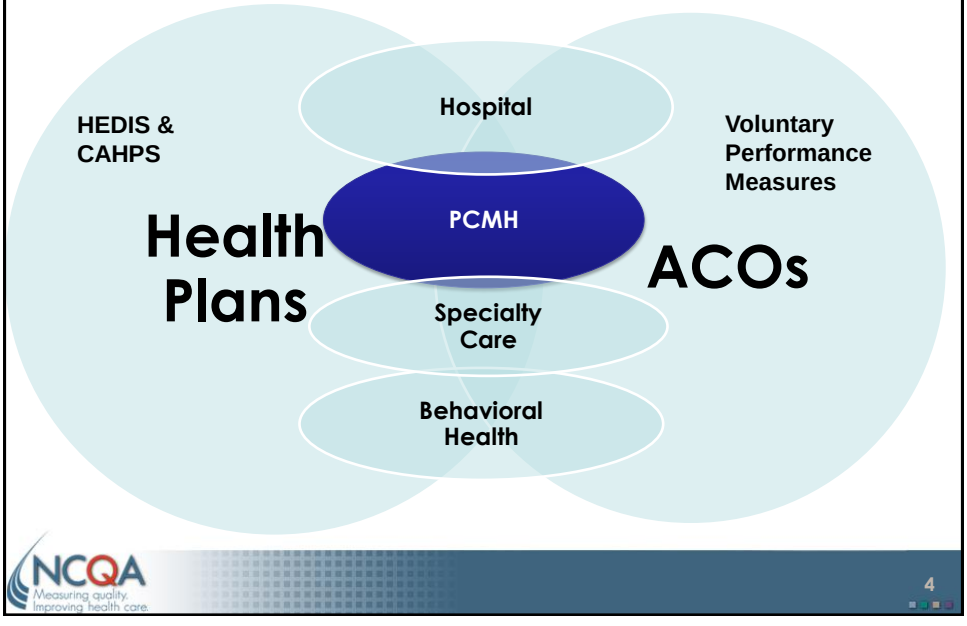
Evolving Delivery Landscape



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ACO Accreditation: What Early Adopters are Saying

- "Allowed us to better connect dots for all our departments to streamline work & improve." *Beth Waterman, HealthPartners:*
- "Subjecting ourselves to an outside checklist & review made us better." *Doug Carr, MD, Billings Clinic*
- "Ensured that we were implementing uniform standards across our four-state health system… helped embed the Triple Aim goals into the fabric of our organization." *John Smylie, Essentia Health*
- "Demonstrates to the marketplace that our organization offers better value." *Jonathan Crossette, The Children's Hospital of Philadelphia*

Public/Private Support for PCMH

22 states have Medicaid or multi-payer initiatives using NCQA's PCMH

- Pay for Performance
  - PCMH payments based on Recognition levels
- Encouraging enrollees to get PCMH care
  - Lower cost sharing for PCMHs
  - Educate enrollees on PCMH benefits
  - Feature PCMHs in provider directories
- Sponsoring practices to become PCMH
  - Cover Recognition costs/offer technical assistance
- ACA Sec. 2703 Health Home SPAs – 4 states list NCQA

Federal Support for PCMH

- **HRSA Patient-Centered Medical Health Home Initiative**
  - Focus on Community Health Centers - serve rural, underserved, often nurse-led practices
  - Covers Recognition costs and technical assistance
  - Up to 500 Community Health Centers per year; 5 year contract
  - 388 Recognized sites to date with 53 of those in CA. In CA we have issued 266 total tools
- **CMS Advanced Primary Care Practice Demonstration**
  - Federally Qualified Health Centers (FQHCs)
  - 500 FQHCs in 3-year project
  - Track progress toward being a Medical Home
  - CMS reimburses for managing Medicare beneficiaries
  - Goal: 90% achieve Level 3; 64 sites Recognized to date, 50 at Level 3.

PCMH Federal Support con'd

- **Military Health System - Military Treatment Facilities (MTF)**
  - Initially a PCMH self-assessment initially; then Recognition
  - Minimum 50 per year over 5 years.
  - 172 sites Recognized to date.
  - Includes: Internal Medicine, Family Practice, Pediatrics
- **HIT/MU – CMS pays practices who demonstrate Meaningful Use; PCMH increases value to practices to become recognized**
- **ACA Sec. 2703 Health Home – 8 quarters of 90% match**

Sampling of Initiatives in States Using NCQA PCMH

Colorado – HealthTeamWorks Multi-payer Pilot (CPCi); Multi-payer Advanced PCP Demo

Connecticut - Connecticut Primary Care "Glide Path" Program

Delaware – Medical Society of Delaware PCMH Initiative (Highmark)

Florida – Medicaid Medical Home Task Force (endorsing NCQA – still pending w/ current support: BCBSFL, MDVIP)

Georgia – Georgia AFP and Pediatric Health Improvement Coalition (PHIC)

Kansas – Kansas AFP PCMH Initiative (Kansas Health Foundation, Pfizer, Sunflower, BCBS of KS)

Kentucky – Greater Louisville Medical Society

Louisiana – DHH -Louisiana Health Care Quality Forum, LPCA

Maine – Patient Centered Medical Home Pilot

Maryland – Maryland Health Care Collaborative (MHCC) +1 Model

Massachusetts – State Medicaid PCMH Initiative/MassGen: Partners Healthcare

Missouri – Missouri Medical Home Collaborative (Wellpoint & UHC)

Montana - PCMH Montana Project

New Jersey – NJ Medicaid Medical Home Pilot (NJAFP)

New York – State Medicaid, PCIP; NYS Health Foundation; NYS Hospital Medical Home Demo

North Carolina – Community Care of North Carolina (N3CN)/BCBS of NC

Ohio – PCMH Education Pilot Project

Oregon – Patient Centered Primary Care Home (PCPCH) +1 Model

Pennsylvania – Chronic Care Initiative, Phase II includes Medicare

Rhode Island – Chronic Care Sustainability Initiative (CSI-RI)

South Carolina – South Carolina Department of HHS (BCBS of SC)

Texas - Texas Medicaid/CHIP in progress

Washington - State Medicaid Medical Home Initiatives **–** Reviewing NCQA PCMH Recognition Programs

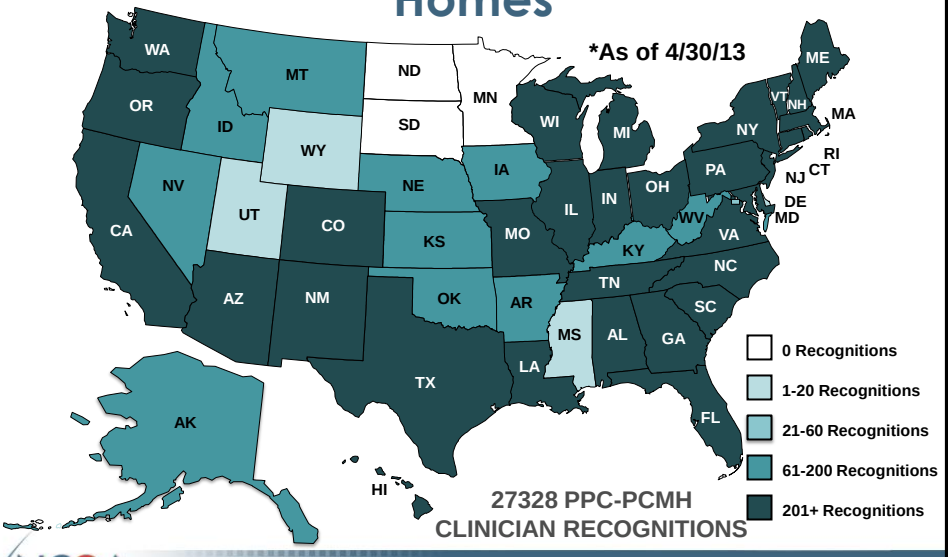
Vermont - "Blueprint for Health"

Wyoming – Wyoming Health Care Innovation Award (DOH, CMS, Transformed)

Commercial PCMH Pilots
Initiatives Strong, Some Expanding

- **WellPoint participating in NH, CO and NY multi-payer pilots demonstrated savings and improved quality, expanding PCMH nationwide**
- **Horizon Blue Cross Blue Shield of NJ – Lower admissions, readmissions, and ER visits, improved care for chronic disease (diabetes)**
- **Aetna launched PCMH initiatives in CT and NJ, also plans to expand PCMH nationwide**
- **Cigna's Collaborative Accountable Care program shows improved quality, lower Costs**

NCQA Patient-Centered Medical Homes



NCQA PCMH Activity in California

- **Plan & Provider Initiatives:**
  - **LA Care**, Pilot supporting practice transformation.
  - **California Primary Care Association** launched a Patient-Centered Health Home (PCHH) initiative in 2012.
- **Adoption in California:**

Model Type	Sites	# of Clinicians
Military	13	23
IPA	21	146
Medical Group	94	638
Total	128	807

PCMH 1: Enhance Access and Continuity

Intent of Standard

- Patients have access to routine/urgent care and clinical advice during/after hours that are culturally and linguistically appropriate
- Electronic access
- Clinician selected by patient
- Team-based care; trained staff

Elements

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

Access During Office Hours is a Must Pass Element

Critical Factors:

- Providing same-day appointments
- Providing timely advice when the office is closed
- The practice team has regular team meetings or a structured communication process

PCMH 2: Identify/Manage Patient Populations

Intent of Standard

- Collects demographic and clinical data for population management
- Assess/document risks
- Create lists; use for point of care reminders

Elements

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

Use of Data for Population Management is a Must Pass Element

The practice must identify patients in at least 2 of 4 areas of need and provide proactive outreach to remind patients/families about:

- Preventive services
- Chronic care services
- Being overlooked or not seen recently
- On specific medications

PCMH 3: Plan and Manage Care

Intent of Standard

- Identify patients with specific conditions including high-risk or complex, behavioral health
- Care management
  - Pre-visit planning
  - Progress toward goals
  - Barriers to treatment goals
- Reconcile medications
- E-prescribing

Elements

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

Care Management is a Must Pass Element

Critical Factors:

- Implement evidence-based guidelines for a condition related unhealthy behaviors or mental health or substance abuse
- Reviews and reconciles medications with families/families for more than 50% of care transitions
- Generate at least 75% of eligible prescriptions electronically

PCMH 4: Provide Self-Care/Community Resources

Intent of Standard

- Assess self-management abilities
- Document self-care plan; provide tools and resources
- Counsel on healthy behaviors
- Assess/provide/arrange for mental health/substance abuse treatment
- Provide community resources

Elements

A. Supports Self-Care Process
B. Provides Referrals to Community Resources

Supports Self-Care Process is a Must Pass Element

Critical Factor:

- Develops and documents self-management plans and goals in collaboration with at least 50 % of patient/families

PCMH 5: Track and Coordinate Care

Intent of Standard

- Tracks, follows-up on and coordinates tests, referrals and patient care in other facilities.
- Establish information exchange with facilities
- Follows up with discharged patients

Elements

A. Track Tests and Follow-Up
B. Track Referrals and Follow-Up
C. Coordinate with Facilities/ Care Transitions

Referral Tracking and Follow-Up is a Must Pass Element

Critical Factors:

- Tracks lab tests and imaging tests until results are available, flagging and following up on overdue results

PCMH 6: Measure and Improve Performance

Intent of Standard

- Practice uses performance and patient experience data to continuously improve
- Track utilization measures
- Identifies vulnerable populations

Elements

A. Measure Performance
B. Measure Patient/Family Experience
C. Implements Continuous Quality Improvement
D. Demonstrates Continuous Quality Improvement
E. Report Performance
F. Report Data Externally
G. Use of Certified EHR Technology

Implements Continuous Quality Improvement is a Must Pass Element

Practice can achieve Distinction by using CAHPS PCMH to collect and submit patient experience data

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Additional Background

- PCMH Development
- PCMH Evidence of Success
- Meaningful Use and PCMH
- Patient-Centered Specialty Practice Recognition (PCSP)
- CLAS embedded in PCMH and PCSP

The Triple Aim

- A framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to health system performance
- The three dimensions are:
  - Improving the patient experience of care (including quality and satisfaction)
  - Improving the health of populations
  - Reducing the per capita cost of health care
- These three key concepts are embedded throughout the NCQA PCMH requirements

PCMH Development History

- Systematic approach to delivering preventive and chronic care (Wagner Chronic Care Model)
- Built on IOM's recommendation to shift from "blaming" individual clinicians to improving systems
- Measures actionable for practices
- Validate measures by relating them to clinical performance and patient experience results
- PPC-PCMH incorporated Joint Principles:
  - Whole-person focus
  - Coordinated, integrated, comprehensive care
  - Personal clinician, team-based care

Growing Evidence on PCMH

- **Significant improvement in ratings of access to care**
  L. M. Kern, R. V. Dhopeshwarkar, A. Edwards et al., American Journal of Managed Care, May 2013
- **Benefits of Implementing the PCMH – Improved Quality & Patient Satisfaction, Lower Costs**
  Patient Centered Primary Care Collaborative, September 2012
- **Colorado PCMH Multi-Payer Pilot Reduced Inpatient Admissions, ER Visits & Demonstrated Plan ROI**
  Harbrecht, Health Affairs, September 2012
- **PCMH Improves Low-income Access, Reduces Inequities**
  Berenson, Commonwealth Fund, May 2012
- **Better Preventive Health, Disease Management, Lower Resource Use & Costs**
  DeVries, American Journal of Managed Care, September 2012

Research Continued:

- **Patient-Centered medical home cost reductions for complex patients (Flottemesch TJ, Anderson LH, Solberg LI, Fontaine P, Asche SE., 2012)**
- **Medicaid Pilots: Improved access to care, reduced PMPM/PMPY costs, decreased ER and inpatient utilization, greater use of evidence-based primary care (Takach, 2011)**
- **Higher quality of care, reduced cost of care on some measures (Patient-Centered Primary Care Collaborative, 2010)**
- **Reduced hospitalization and ER visits, overall savings (Fields, Leshen, Patel, 2010)**
- **In integrated group practice, improvements in quality of clinical care, patient and provider experiences (Reid, 2009)**

Medicaid PCMH Pilots
Early Results Promising

- Oklahoma (Medicaid-wide): $29 reduced per patient per year costs, increased access, increased use of evidence-based primary care, increased patient satisfaction
- Colorado (Medicaid and CHIP): Large increase in access and patient satisfaction, decreased per patient per year costs
- Vermont (Blueprint for Health): Decreased inpatient and ER utilization, decreased PMPM costs
- North Carolina Medicaid (Community Care): Over $1 billion in total savings

Takach, *Health Affairs*, July 2011 (1325-1334) / Milliman Analysis

Meaningful Use of Health Information Technology (HIT)

- NCQA emphasizes HIT because good primary care is information-intensive
- PCMH 2011 reinforces incentives to use HIT to improve quality
- Meaningful Use language is embedded, often verbatim, in PCMH 2011 evaluation standards
- Synergy/virtuous cycle: PCMH 2011 medical practices will be well prepared to qualify for meaningful use, and vice versa

Patient-Centered Specialty Practice Recognition

- ***New*** **complimentary PCMH-like program for specialty practices meeting rigorous & practical standards for coordinating with primary care, such as:**
  - **Timely access to care**
  - **Consultation with primary care providers**
  - **Managing care for individuals and population**
  - **Coordination with facilities on care transitions and post-discharge follow-up**
- **Launched March 2013**
- **73 early adopter organizations across 28 states**

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Patient-Centered Specialty Practice (PCSP) Recognition Value & Uses

- **Activates American College of Physicians' "Medical Neighborhood"**
- **Distinguishes practices committed to coordinating care, reducing waste**
- **Shows readiness for PCP referrals & ACOs**
- **States can promote PCSP by:**
  - **Building in care coordination payments**
  - **Highlighting on provider directories**
  - **Using as a quality indicator in value-based purchasing (preferred tier" with lower copay)**

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CLAS Built into both Medical and Specialty Care Recognition Programs

- Provides CLAS appropriate services
- Trains the practice team to adequately support patients
- Maintains electronic tracking system to capture race, ethnicity and preferred language
- Conducts comprehensive assessment including cultural characteristics & communication needs
- Tracks key community resources
- Monitors performance to assess disparities in care & sets a QI goal
- Collects feedback on experience of vulnerable populations