National Committee for Quality Assurance

(NCQA)

Private, independent non-profit health care quality oversight organization founded in 1990

MISSION

To improve the quality of health care.

VISION

To transform health care through quality measurement, transparency, and accountability.

ILLUSTRATIVE PROGRAMS

*** Patient-Centered Medical Home * Patient-Centered Specialty Practice**

*** HEDIS® – Healthcare Effectiveness Data and Information Set**

*** Health Plan Accreditation * Clinician Recognition**

*** Disease Management Accreditation * Wellness & Health Promotion Accreditation**

NCQA Recognition Programs

Current as of 3/31/15

- **>59,643 Clinician Recognitions nationally across all Recognition programs.**
- **Clinical programs.**
  - **Diabetes Recognition Program (DRP)**
  - **Heart/Stroke Recognition Program (HSRP)**
  - **Back Pain Recognition Program (BPRP) - *Retired***
- **Medical practice process and structural measures.**
  - **Physician Practice Connections - *Retired***
  - **Physician Practice Connections-Patient-Centered Medical Home (PPC-PCMH) 2008 - *Retired***
  - **Patient-Centered Medical Home (PCMH) 2011**
  - **Patient-Centered Medical Home (PCMH) 2014**
  - **Patient centered Specialty Practice (PCSP)**

10,520 clinicians

4,223 clinicians

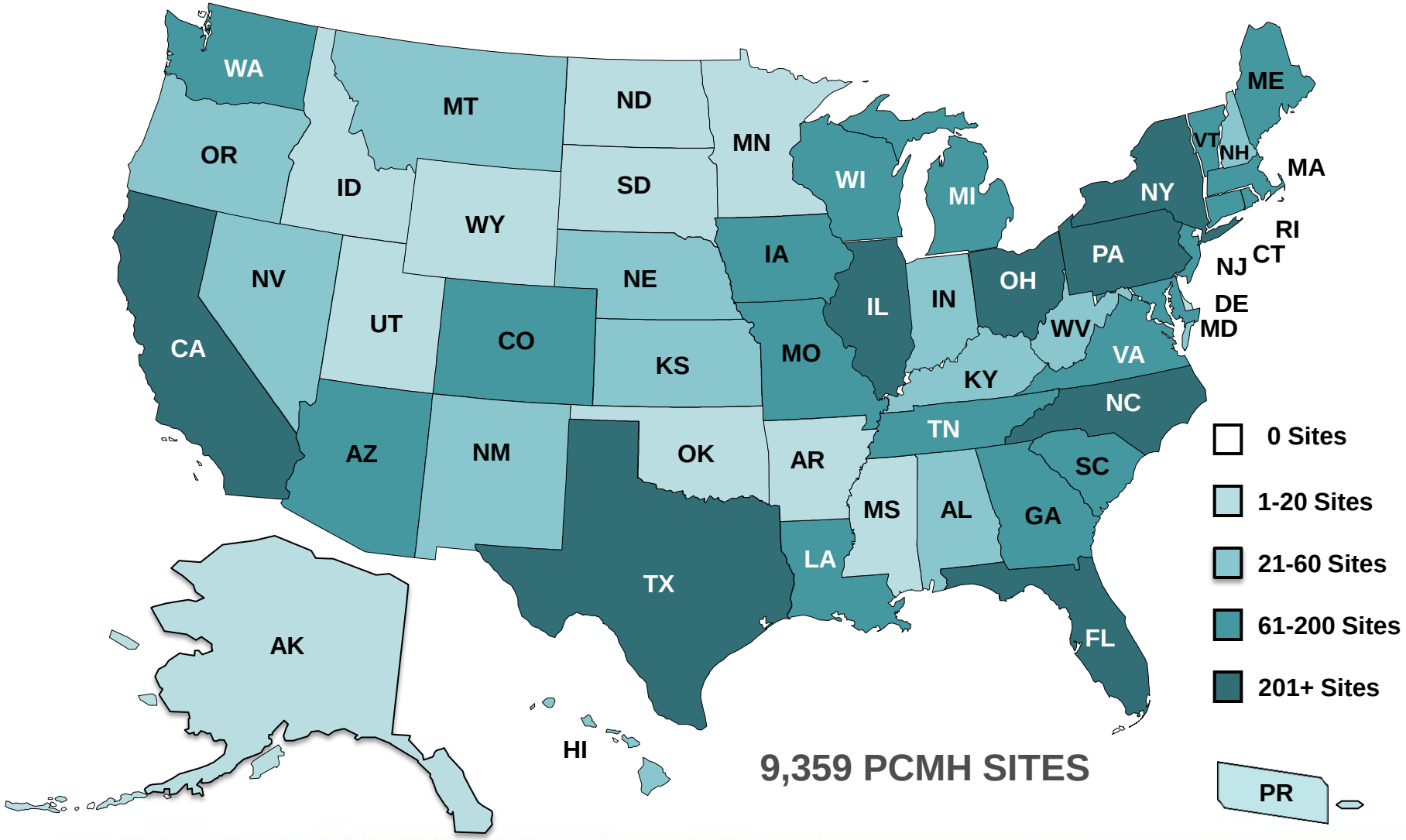
270 Clinicians
52 Practices

44,057 Clinicians
9,359 Practices

573 Clinicians
62 Practice

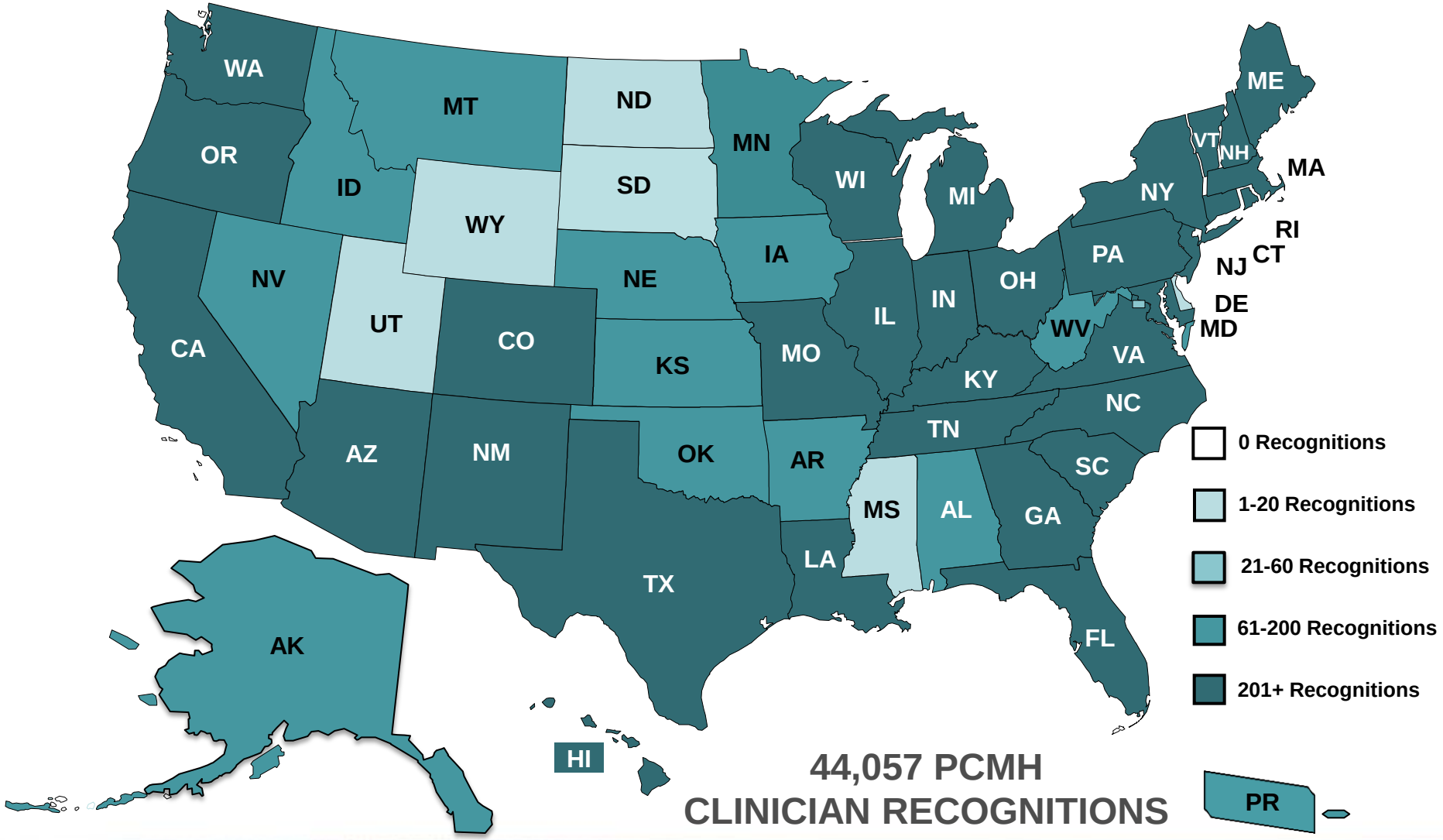
NCQA PCMH SITES

As of 3/31/15



NCQA PCMH CLINICIAN RECOGNITIONS

As of 12/31/14

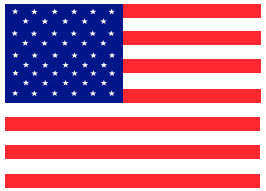


44,057 PCMH CLINICIAN RECOGNITIONS

Federal Initiatives with NCQA's PCMH

Defense Health Agency - Military Treatment Facilities (MTF)

- Initially a PCMH self-assessment; then Recognition
- 50 MTFs per year over 3 years
  - 328 MTFs achieved Recognition to date*
- Includes: Internal Medicine, Family Practice, Pediatrics

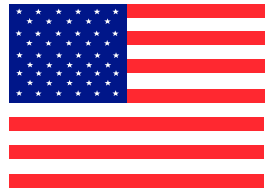


*As of 1/12/15

Federal Initiatives Continued

HRSA Patient-Centered Medical Health Home Initiative

- Community Health Centers – for rural, underserved, often nurse-led practices
- Recognition costs and technical assistance
- Up to 500 Community Health Centers per year; 5 year contract
- 2,610 sites currently enrolled
- 1,599 CHCs Recognized



Evolving PCMH and More

- **2003-2004:** Physician Practice Connections (PPC) - developed with Bridges to Excellence)
- **2006:** PPC standards updated
- **2008:** PPC–PCMH
- **2011:** PCMH 2011
- **2011:** ACO Accreditation
- **2013:** Patient-Centered Specialty Practice
- **2014:** PCMH 2014

PCMH 2014: Key Changes

1. **Additional emphasis on team-based care**
   - New element = Team-Based Care
     - Highlights patient as part of team, including QI
2. **Care management focused on high-risk patients**
   - Use evidence-based decision support
   - Identify patients who may benefit from care management and self-care support:
     - Social determinants of health
     - Behavioral health
     - High cost/utilization
     - Poorly controlled or complex conditions

PCMH 2014: Key Changes (cont.)

3. **More focused, sustained Quality Improvement (QI) on patient experience, utilization, clinical quality**
   - Annual QI activities; reports must show the practice re-measures at least annually
   - Renewing practices will benefit from streamlined requirements, but must demonstrate re-measurement from at least two prior years
4. **Alignment with Meaningful Use Stage 2 (MU2)**
   - MU2 is not a requirement for recognition.
5. **Further Integration of Behavioral Health.**
   - Show capability to treat unhealthy behaviors, mental health or substance abuse
   - Communicate services related to behavioral health
   - Refer to behavioral health providers

PCMH 2014 Content and Scoring

(6 standards/27 elements)

1: Enhance Access and Continuity	Pts
A. *Patient-Centered Appointment Access	**4.5**
B. 24/7 Access to Clinical Advice	3.5
C. Electronic Access	2
	10

2: Team-Based Care	Pts
A. Continuity	3
B. Medical Home Responsibilities	2.5
C. Culturally and Linguistically Appropriate Services (CLAS)	2.5
D. *The Practice Team	**4**
	12

3: Population Health Management	Pts
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
	20

4: Plan and Manage Care	Pts
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
	20

5: Track and Coordinate Care	Pts
A. Test Tracking and Follow-Up	6
B. *Referral Tracking and Follow-Up	**6**
C. Coordinate Care Transitions	6
	18

6: Measure and Improve Performance	Pts
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
	20

Scoring Levels

Level 1: 35-59 points
Level 2: 60-84 points
Level 3: 85-100 points

*Must Pass Elements

Serving Homeless Populations: PCMH Challenges

- Low rates of telephonic and electronic interactions
- Patient pre-visit planning
- Continuity of care
- Patient outreach for needed care or referral follow-up
  - Notification of laboratory and imaging results
- Self-care planning and support

Meeting PCMH Challenges

- Practice should adopt processes that meet needs of their patient population
- Open access systems do meet same-day appointment requirements
- NCQA does not have minimum continuity rates
- Patient outreach must be attempted, as appropriate
  - No measure of "success rates"
  - Practices may inform patients of results at follow-up appointments