Patient Centered Medical Home

SORH Regional Partnership Meeting/Region B

Presented by Terri Gonzalez

North Carolina Medical Society FOUNDATION
Opening Doors to Quality Health Care

What is Patient Centered Medical Home?

- PCMH is an approach to provide comprehensive primary care to patients.
- PCMH create partnerships between patients and providers, while increasing access and overall value of care.
- PCMH is not a destination but rather an indicator that primary care practices are working intentionally to improve the value of their health care services.

Patient Centered Medical Home Raises the Bar

- More emphasis on team-based care
- Care management focus on high-need populations
- Alignment of quality improvement activities with the "triple aim"
- Further integration of behavioral health
- Sustained transformation

NCQA PCMH Model

- The National Committee for Quality Assurance is a private, not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda.

- NCQA's programs and services reflect a straightforward formula for improvement: Measure. Analyze. Improve. Repeat.

URAC PCMH Model

Originally named for Utilization Review Accreditation Commission, but was later changed to URAC when it broadened it's scope.

New Program to be released January 2016 allows for a more hands on review process and less documentation.

URAC Tier Structure

Tier 1 –

- Staff Training for PCMH team roles
- Active Patient Participation in their Care
- Beginning Population Health Management & Medical Neighborhood capabilities

Tier 2 –

- Effective workflows for collaboration & care coordination
- Enhanced access to services & referrals via the Medical Neighborhood

URAC

Tier 3 –

- Patient Engagement in Decision making and Self Care
- Promotion of Prevention, Wellness and Health Risk Management
- Care continuity, integration of behavioral health & Substance Use disorders
- Demonstrated performance improvement

URAC HIT Designation

- Basic & Advanced EHR
- Consumer Communications Portal
- Electronic Exchange of Information during Transitions of Care

- All done with the practice remotely and electronically!

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The Joint Commission Product for PCMH Compared to NCQA

Feature	The Joint Commission	NCQA
Length of Award	3 years	3 years
Scope of Evaluation	Entire organization/practice	Delivery site specific
Core Components	Patient Centered Care; Comprehensive Care, Coordinated Care; Superb Access to Care; Systems Approach to Quality & Safety	Patient Centered Access; Team Based Care; Population Health Management; Care Management and Support; Care Coordination & Care Transitions; Performance Measurement & Quality Improvement
Need to Submit Documentation of compliance	No	Yes
Onsite survey Conducted to evaluate compliance	Yes	No
Onsite consultation on approaches to compliance	Yes	No
Scoring Process	Must comply with all standards, with post-survey opportunity & support to comply	Points based with Must Pass elements & critical factors

Joint Commission Product for PCMH Compared to NCQA

Copy of preliminary report available on-site?	YES	No
Post Survey support	Yes	No
Continued Compliance Support	Yes	No

Above information from:
http://www.jointcommission.org/assets/1/18/PCMH_cross_ncqa.pdf

Details on NCQA Recognition

NCQA PCMH 2014 (6 standards/27 elements/100 points)

1) Patient-Centered Access (10)

A)*Patient-Centered Appointment Access

B)24/7 Access to Clinical Advice

C)Electronic Access

2) Team-Based Care (12)

A)Continuity

B)Medical Home Responsibilities

C)Culturally and Linguistically Appropriate Services

D)*The Practice Team

3) Population Health Management (20)

A)Patient Information

B)Clinical Data

C)Comprehensive Health Assessment

D)*Use Data for Population Management

E)Implement Evidence-Based Decision Support

4) Care Management and Support (20)

A)Identify Patients for Care Management

B)*Care Planning and Self-Care Support

C)Medication Management

D)Use Electronic Prescribing

E)Support Self-Care & Shared Decision Making

5) Care Coordination and Care Transitions (18)

A)Test Tracking and Follow-Up

B)*Referral Tracking and Follow-Up

C)Coordinate Care Transitions

6) Performance Measurement and Quality Improvement (20)

A)Measure Clinical Quality Performance

Measure Resource Use and Care Coordination

A)Measure Patient/Family Experience

B)*Implement Continuos Quality Improvement

C)Demonstrate Continuous Quality Improvement

D)Report Performance

E)Use Certified EHR Technology

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*Must Pass- If meet 100% of Must Pass Items = 27.5 points

PCMH 2014: Standards and Elements

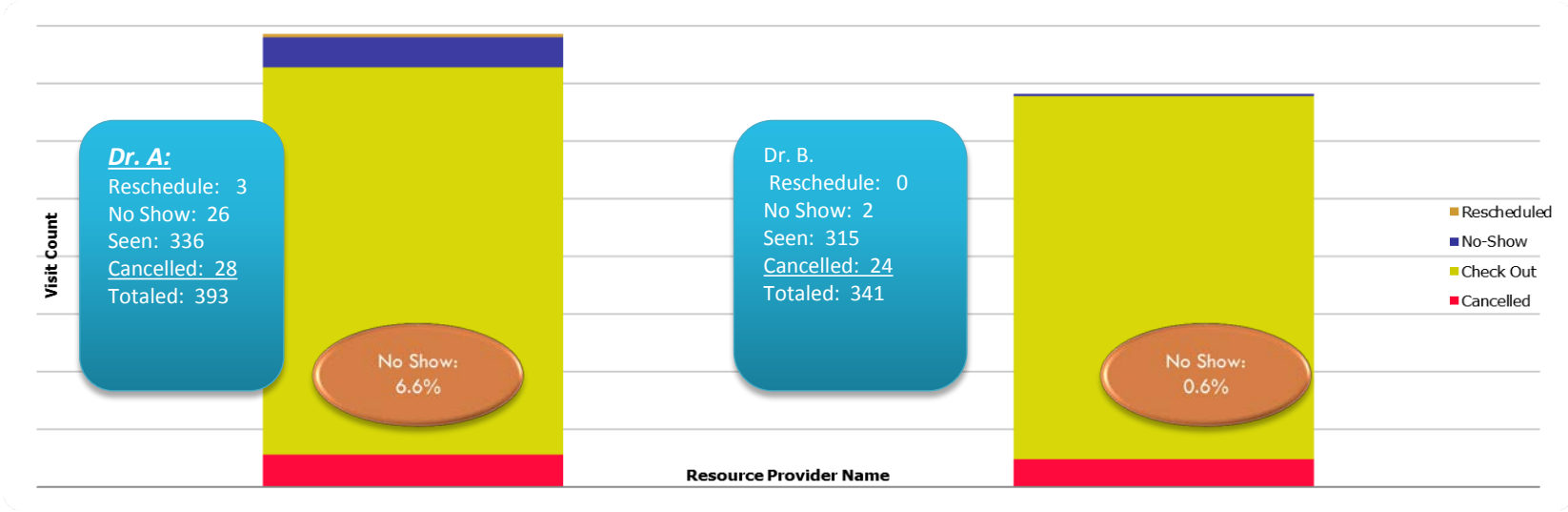
1A: Patient-Centered Appointment Access

MUST PASS 

The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:

1. Providing same-day appointments for routine and urgent care
2. Providing routine and urgent-care appointments outside regular business hours.
3. Providing alternative types of clinical encounters.
4. Availability of appointments.
5. Monitoring no-show rates.
6. Acting on identified opportunities to improve access.

No Show Reporting



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PCMH 2014: Standards and Elements

2D – The Practice Team

MUST PASS 

1. Defining roles for clinical and nonclinical team members
2. Identifying the team structure and the staff who lead and sustain team based care.
3. Holding scheduled patient team care team meetings or a structured communication process focused on individual patient care (CRITICAL FACTOR)
4. Using standing orders for services
5. Training and assigning members of the care team to coordinate care for individual patients
6. Training and assigning members of the care team to support patients/families in self-management, self-efficacy and behavior change.
7. Training and assigning member of the care team to manage the patient population
8. Holding scheduled team meetings to address practice functioning.
9. Involving care team staff in the practice's performance evaluation and quality improvement activities.
10. Involving patients/caregivers in quality improvement activities or on the practice's advisory council.

PCMH 2014: Standards and Elements

3D: Use Data for Population Management

MUST PASS 

At least annually the practice proactively identifies populations of patients and reminds them, or their families of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including:

1. At least two different preventative care services
2. At least two different immunizations
3. At least three different chronic or acute care services
4. Patients not recently seen by the practice
5. Medication monitoring or alert

6. practices must do this in a 12 month period of time.

PCMH 2014: Standards and Elements

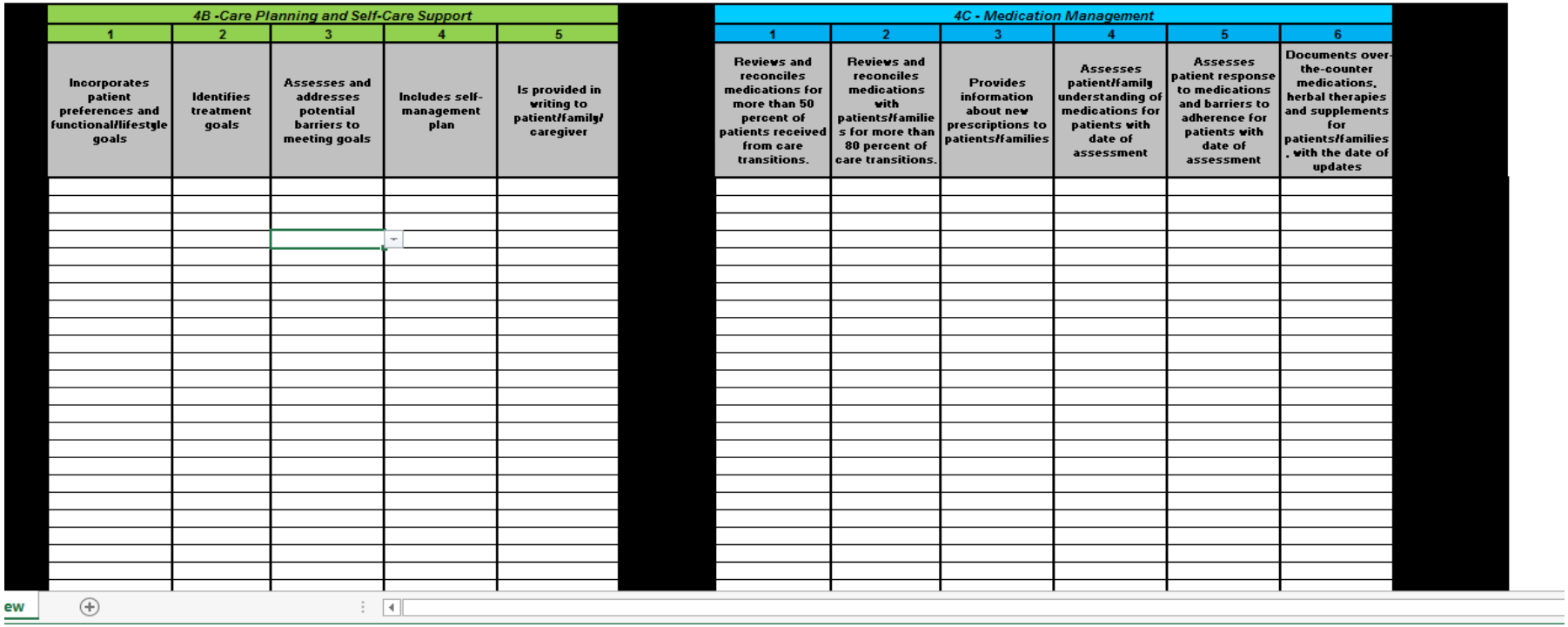
4B: Care Planning and Self Care Support

MUST PASS 

The Care Team and patient develop and update an individual care plan that includes the following features for at least 75% of patients identified in element 4A:

1. Incorporates patient preferences and functional/lifestyle goals
2. Identifies treatment goals
3. Assesses and addresses potential barriers to meeting goals
4. Includes a self-management plan
5. Is provided in writing to the patient/caregiver

Example of Record Review Workbook



4B -Care Planning and Self-Care Support				
1	2	3	4	5
Incorporates patient preferences and functional/lifestyle goals	Identifies treatment goals	Assesses and addresses potential barriers to meeting goals	Includes self-management plan	Is provided in writing to patient/family/ caregiver

4C - Medication Management					
1	2	3	4	5	6
Reviews and reconciles medications for more than 50 percent of patients received from care transitions.	Reviews and reconciles medications with patients/families for more than 80 percent of care transitions.	Provides information about new prescriptions to patients/families	Assesses patient/family understanding of medications for patients with date of assessment	Assesses patient response to medications and barriers to adherence for patients with date of assessment	Documents over-the-counter medications, herbal therapies and supplements for patients/families, with the date of updates

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PCMH 2014: Standards and Elements

5B: Referral Tracking and Follow-Up

MUST PASS 

The practice coordinates referrals by:

1. Considers available performance information on consultants/specialists when making referral recommendations
2. Maintains formal and informal agreements with a subset of specialists based on established criteria.
3. Maintains agreements with behavioral healthcare providers.
4. Integrates behavioral healthcare providers with the practice site.
5. Give the consultant or specialist the clinical questions, the required timing and the type of referral.
6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.
7. Has the capacity for electronic exchange of key clinical information and provides an electronic summary of care record to another provider for more than 50% of referrals
8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports (critical factor)
9. Documents co-management agreements in the patient's medical record
10. Asks patients/families about self-referrals and requesting reports from clinicians.

PCMH 2014: Standards and Elements

11. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.
12. Has the capacity for electronic exchange of key clinical information and provides an electronic summary of care record to another provider for more than 50% of referrals
13. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports (critical factor)
14. Documents co-management agreements in the patient's medical record
15. Asks patients/families about self-referrals and requesting reports from clinicians.

PCMH 2014: Standards and Elements

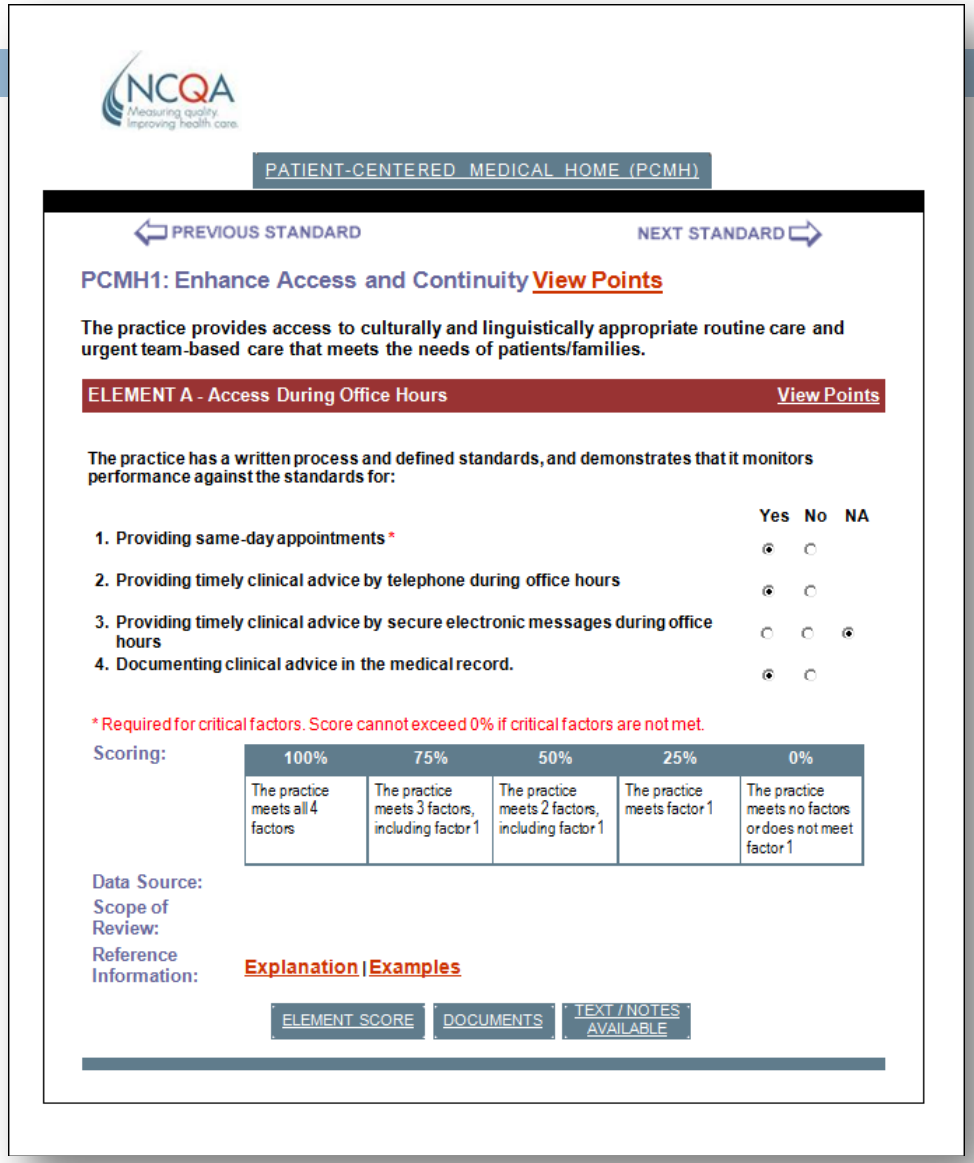
6D: Implement Continuous Quality Improvement

MUST PASS 

The practice uses an ongoing quality improvement process to:

1. Set goals and analyze at least three clinical quality measures from element A.
2. Act to improve on at least three clinical quality measures from Element A
3. Set goals and analyze at least one measure from element B
4. Act to improve quality on at least one measure from Element B
5. Set goals and analyze at least one patient experience measure from element C.
6. Act to improve at least one patient experience measure from element C.
7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations..

Example of Standard/Elements



NCQA
Measuring quality. Improving health care.

PATIENT-CENTERED MEDICAL HOME (PCMH)

PREVIOUS STANDARD NEXT STANDARD

PCMH1: Enhance Access and Continuity View Points

The practice provides access to culturally and linguistically appropriate routine care and urgent team-based care that meets the needs of patients/families.

ELEMENT A - Access During Office Hours View Points

The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:

	Yes	No	NA
1. Providing same-day appointments *	◉	○	
2. Providing timely clinical advice by telephone during office hours	◉	○	
3. Providing timely clinical advice by secure electronic messages during office hours	○	○	◉
4. Documenting clinical advice in the medical record.	◉	○	

* Required for critical factors. Score cannot exceed 0% if critical factors are not met.

Scoring:

100%	75%	50%	25%	0%
The practice meets all 4 factors	The practice meets 3 factors, including factor 1	The practice meets 2 factors, including factor 1	The practice meets factor 1	The practice meets no factors or does not meet factor 1

Data Source:

Scope of Review:

Reference Information: Explanation | Examples

ELEMENT SCORE | DOCUMENTS | TEXT / NOTES AVAILABLE

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Scoring Information:

4 Points Scoring

4 factors= 100%
3 factors (including factor 1) = 75%
2 factors (including factor 1)50%
1 factor = 25%
0 factors or missing factor 1 = 0%

1. Provide Same-Day Appointments-CRITICAL FACTOR MUST BE MET IN ORDER TO RECEIVE ANY SCORE ON THE ELEMENT
2. Providing Timely Clinical Advice by Telephone during office hours
3. Providing timely clinical advice by secure electronic messages during office hours (can select n/a on this)
4. Documenting clinical advice in the medical record

The North Carolina Medical Society and PractEssentials can offer you:

- We have assisted well over 50 practice on PCMH and PCSP in the state
- Several levels of assistance that are custom designed for your needs

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Resources:

http://www.ncqa.org/

http://www.jointcommission.org/assets/1/18/PCMH_cross_ncqa.pdf

https://www.urac.org/

Any Questions:

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