



Sneak Preview: 2014 Patient-Centered Medical Home Recognition

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March 10, 2014

Overview

- **Background**
- **What's new**
- **Guest speakers**
- **Q&A**



Launch date



- **Mon. 3/24**
- **Order now at**
<http://bit.ly/1nj5ArS>
- **No charge**

More detailed version of today's webinar

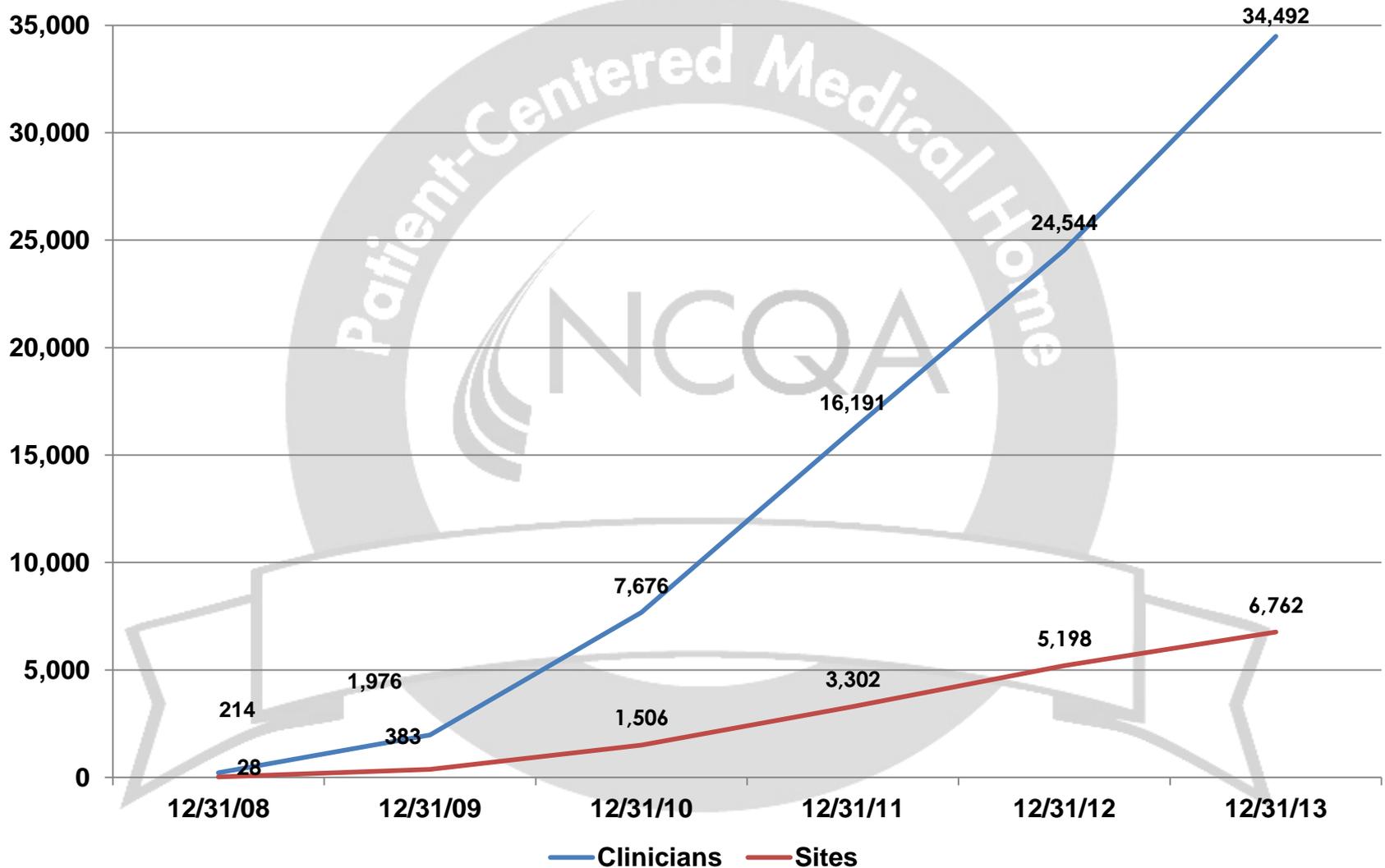


- **Wed. 4/23, 2:00 – 3:00 PM EDT**
- **For customers and others who use PCMH standards**
- **RSVP: www.ncqa.org/PCMH2014**

The background features a dark blue field with a horizontal red band across the middle. On the left side, there are several overlapping, curved, semi-transparent shapes in shades of blue and beige, creating a sense of depth and movement. The word "Background" is written in white, bold, sans-serif font on the right side of the red band.

Background

PCMH is the fastest-growing delivery system innovation

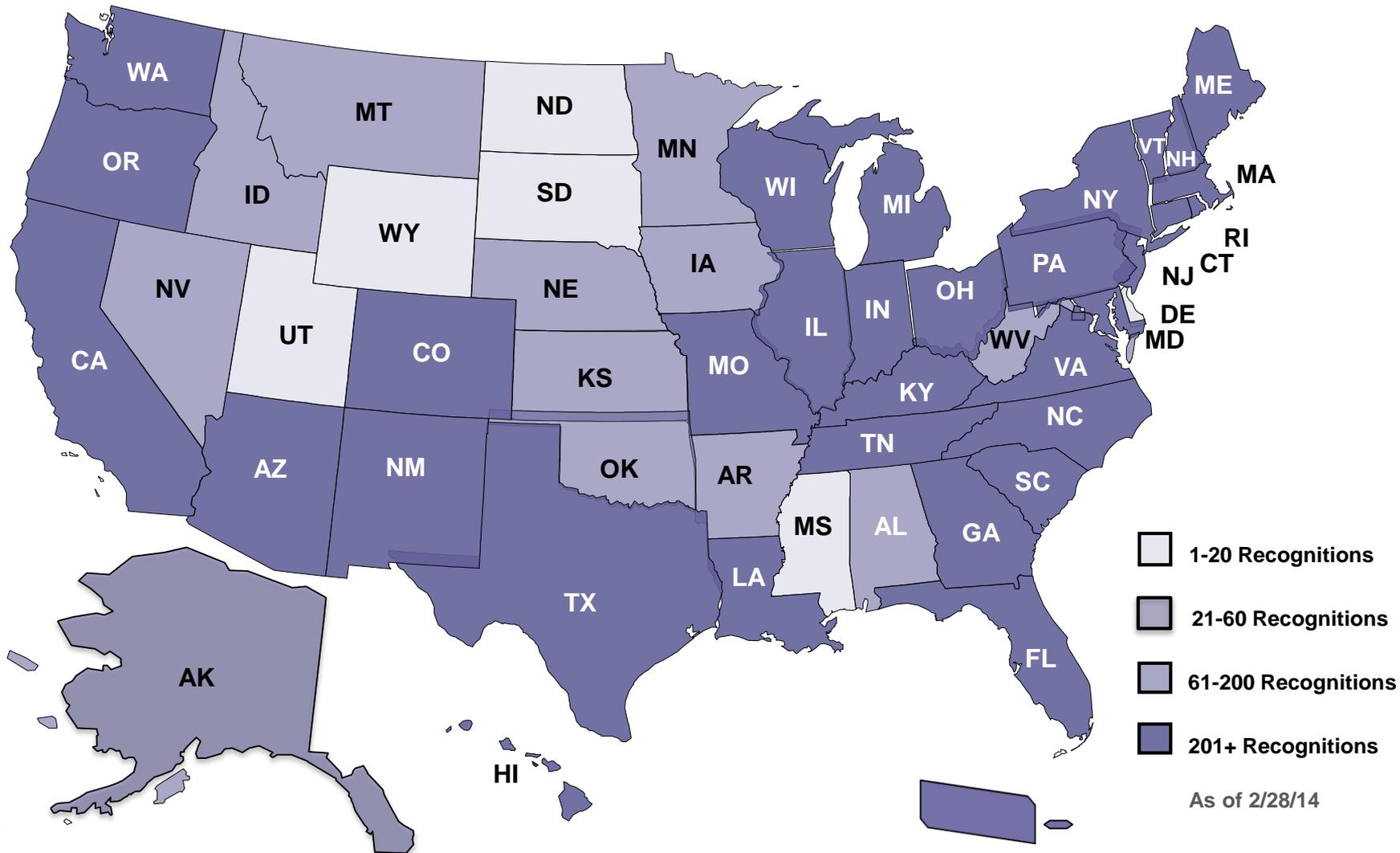


PCMH strengths

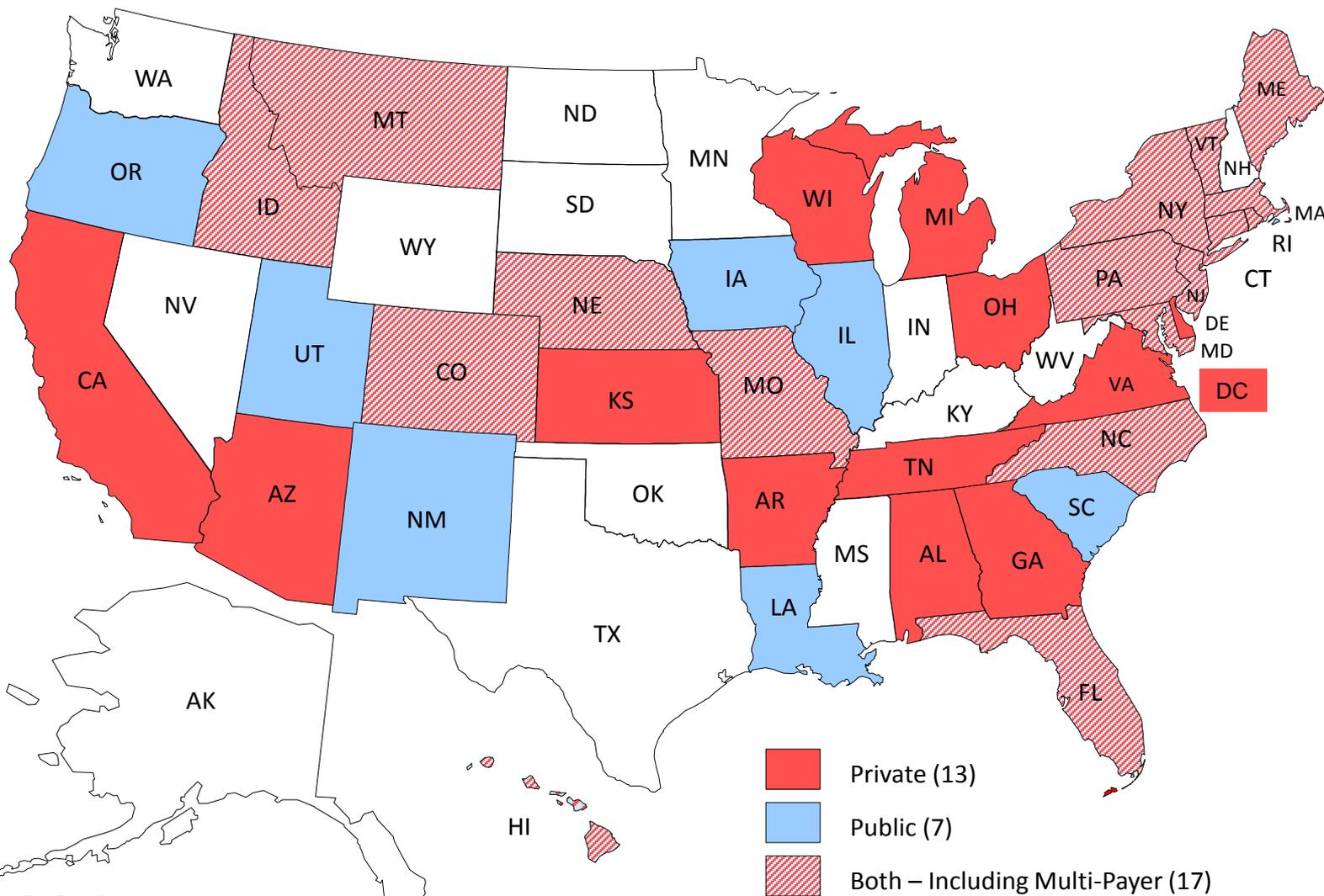


- **Standardization**
- **Reach**
- **Flexibility**
- **Feasibility**
- **Continuous improvement**
- **Aligns with meaningful use**

35,677 PCMH clinicians have earned NCQA Recognition



37 states have initiatives that use NCQA Recognition



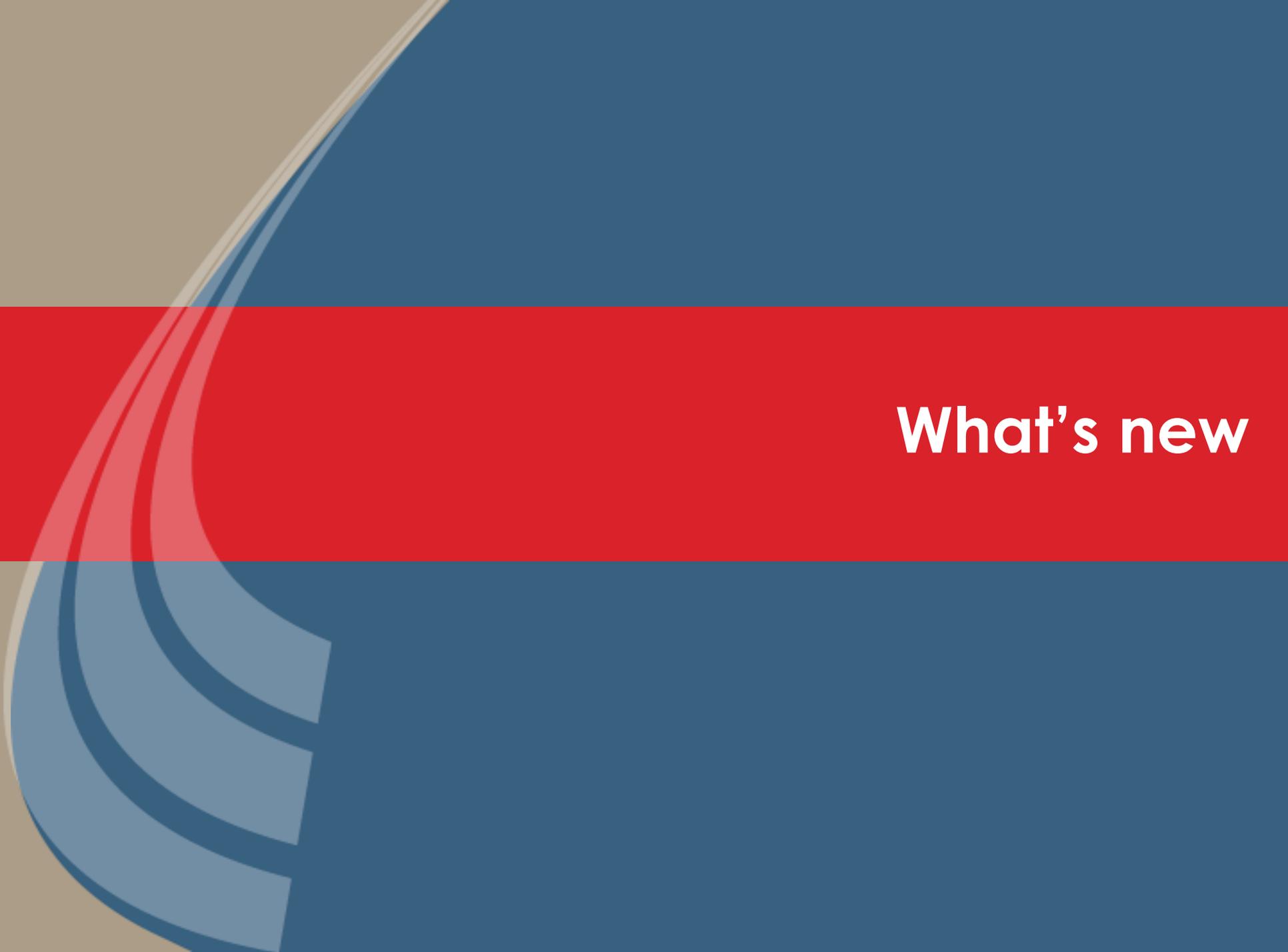
PCMH research

- **Improved patient experience**
- **Reduced clinician burnout**
- **Reduced hospitalization rates**
- **Reduced ER visits**
- **Increased savings per patient**
- **Higher quality of care**
- **Reduced cost of care**

See journal citations in
NCQA White Paper:

**The Future of
Patient-Centered
Medical Homes**

<http://bit.ly/1dQQ9kn>



What's new

PCMH 2014 raises the bar



PCMH 2014 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**



More emphasis on team-based care

- **Is “must-pass” for any NCQA Recognition level**
- **Highlights specific roles and responsibilities for care team members**
- **Includes the patient as part of the care team**



Care management focus on high-need populations

- Socioeconomic and personal factors
- High cost or utilization
- Poorly controlled or complex conditions
- Behavioral health needs



Alignment with triple aim

- **Cost**
- **Quality**
- **Patient experience**



Further integration of behavioral health

- **Disclosing scope of behavioral health services to patients**
- **Establishing referral agreements with behavioral health providers**



Sustained transformation

- **PCMH is a process, not an event**
- **Practices show they follow PCMH standards over long periods**



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

* Must-pass

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 Continuous Quality Improvement
- C) Demonstrate Continuous Quality Improvement
- D) Report Performance
- E) Use Certified EHR Technology

Different levels of recognition for different levels of ability

Level 1 35-59 points

Level 2 60-84 points

Level 3 85-100 points





Guest speakers

Guest speaker



**Randall Curnow, MD, MBA,
FACP, FACHE, FACPE**

**Vice President of Medical Affairs
Mercy Health Physicians**

e-mercy.com

Guest speaker



Kimberly Williams, LMSW

**Vice President, Center for
Policy, Advocacy and
Education**

**Mental Health Association of
New York City**

mha-nyc.org/CenterForPAE

Guest speaker



Lee Partridge

**Senior Health Policy Advisor
National Partnership for
Women & Families**

nationalpartnership.org

Questions and Answers





Thank you