Overview

- Background
- What’s new
- Guest speakers
- Q&A
Launch date

- Mon. 3/24
- Order now at [http://bit.ly/1nj5ArS](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](http://www.ncqa.org/PCMH2014)
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

As of 2/28/14
37 states have initiatives that use NCQA Recognition

- Private (13)
- Public (7)
- Both – Including Multi-Payer (17)

*Includes the District of Columbia*
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
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
   B) 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

* Must-pass
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
Thank you