South Carolina Office of Rural Health

PCMH Development and NCQA Recognition Overview

May 2015
Overview

- Overview of PCMH
  - PCMH Features
  - Outcomes of Medical Home
  - Benefits of PCMH
  - Medical Homes in SC

- NCQA Recognition
  - Requirements
  - Application Process

- Building a PCMH – Practice Transformation
- SCORH Center for Practice Transformation
WHY PCMH?

- Quality Chasm
- Healthcare costs
- Declining physician and staff satisfaction
- Patient dissatisfaction
- Health information technology
- Performance measurement & reporting
- Changes in payment methodologies
Patient Centered Medical Home

- PCMH is an enhanced primary-care model that delivers comprehensive and timely care to patients, emphasizing the central role of teamwork and engagement between caregivers and patients.

- PCMH is a roadmap for transforming primary care.

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Enhancing Health and the Patient Experience

Medical Home Model

- Patient is the center of the Medical Home
- Team-Based Healthcare Delivery
- Access to Care
- Advanced IT Systems
- Decision Support Tools
- Patient & Physician Feedback
- Patient-Centered Care
- Refocused Medical Training
- Population Health

Model adapted from the NNMC Medical Home
Team-Based Care

Health Care Coordination

Advanced Access

Chronic Care Model

Better overall care
Three-Part Aim
Improved health
Lower per capita costs
PCMH Outcomes: Smarter Healthcare...

• Drop in hospital days - 36.3%
• Drop in ER use - 32.2%
• Reduction in total costs - 9.6%
• Reduction in outpatient specialty care - 15.0%
• Improvements in chronic disease and preventive care*
• Decreased staff burnout§
• Higher patient experience ratings§


§ Patient-centered medical home demonstration: a prospective, quasi-experimental, before and after evaluation. Reid RJ, Fishman PA, Yu O, Ross TR, Tufano JT, Soman MP, Larson EB. Am J Man Care, 2009 Sep 1;15(9):e71-87

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PCMH in South Carolina

• SC primary care practices are transforming their practices as medical homes
  o ~120 practices which include >520 providers have obtained NCQA recognition as a PCMH
  o 56 Nurse Practitioners are Recognized as practicing in a PCMH
  o 24 Physician Assistants are Recognized as practicing in a PCMH

• Organizations are working to support the development of medical homes in SC

• Growing alignment to support practice transformation and medical home development
  o Meaningful Use
  o EMR Implementation
  o SC Healthy Outcomes Plan

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Payment for PCMH

- SC Medicaid currently incentivizes practices to pursue PCMH recognition
  - $.50 PMPM for practices pursuing PCMH recognition
  - $1.00 PMPM for Level I recognition
  - $1.50 PMPM for Level II recognition
  - $2.00 PMPM for Level III recognition
- BCBSSC has a program for recognized practices
  - Application for participation can start 6-months before recognition is obtained
  - Three-component payment system
    - Traditional FFS
    - PMPM Care Management fee
    - Performance-based bonus
  - Focus on selected chronic diseases
- BCBSSC Rewarding Excellence program
- Cigna & Humana have PCMH/Accountable Care programs in SC
- CMS Health Innovations Award

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Why Now?

How can we work together to drive value-based care?

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NCQA RECOGNITION

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NCQA PCMH Recognition Process

• Set of standards to assess the extent to which health care organizations are functioning as medical home
• Obtaining recognition requires completing an application, which documents that specific medical home processes and policies are in place

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NCQA PCMH 2014

• Guides practices to
  o Organize care around patients
  o Work in teams
  o Coordinate and track care over time
• Provides a framework for transformation
• Used by payers & others as “stamp of approval”
• Aligns closely with Meaningful Use Stage 2
• 3 levels of Recognition
• Recognition lasts for 3 years

PPC-PCMH Standards and Guidelines are available free at www.ncqa.org/ppcpcmhh.aspx
Patient-Centered Medical Home 2014
(6 standards/27 elements)

1) Enhance Access and Continuity (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) Identify and Manage Patient Populations (20)
   A) Patient Information
   B) Clinical Data
   C) Comprehensive Health Assessment
   D) *Use Data for Population Management
   E) Implement Evidence-Based Decision Support

4) Plan and Manage Care (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 and Shared Decision Making

5) Track and Coordinate Care (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
   C) Measure Patient/Family Experience
   D) *Implement Continuous Quality Improvement
   E) Demonstrate Continuous Quality Improvement
   F) Report Performance
   G) Use Certified EHR Technology

*Indicates Must Pass Element

Scoring Levels
Level 1: 35-59 points.
Level 2: 60-84 points.
Level 3: 85-100 points.
# Point Requirements

<table>
<thead>
<tr>
<th>Level of Recognition</th>
<th>Points Required</th>
<th>Must Pass</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>35-59</td>
<td>6/6 must pass</td>
</tr>
<tr>
<td>Level 2</td>
<td>60-84</td>
<td>6/6 must pass</td>
</tr>
<tr>
<td>Level 3</td>
<td>85-100</td>
<td>6/6 must pass</td>
</tr>
</tbody>
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**NOTE:** Must Pass elements require a ≥50% performance level to pass
PCMH Transformation
Initial Steps

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Improvement Team

• Form a team
  o 3-6 members (2-3 if small practice)
  o Roles:
    • Provider champion
    • Day-to-Day leader
    • System leader
    • IT leader
    • Other (Front Desk Staff)
  o Meet 2x per month to get started – regular meetings
  o Review PCMH materials and develop game plan
  o Accountable for deliverables
  o **Practice transformation and medical home development CANNOT be done by one person**
Practice Assessment

• Assess your practice
  o Practice profile
    • Lists strengths and challenges
    • Identify opportunities for improvement
      o If you could change one thing about your day what would it be…
    • Increase your understanding of your patients - # of patients with selected chronic disease; average wait time for your patients…
  o PCMH Assessment
    • Complete PCMH Assessment tool - http://www.safetynetmedicalhome.org/sites/default/files/PCMH-A_0.pdf
    • Tool will identify strengths and gaps
    • Use PCMH Assessment to set priorities and develop game plan

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PCMH Assessment

**PART 2: CONTINUOUS TEAM-BASED HEALING RELATIONSHIPS**

<table>
<thead>
<tr>
<th>Components</th>
<th>Level D</th>
<th>Level C</th>
<th>Level B</th>
<th>Level A</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Patients are encouraged to see their panelled provider and practice team</td>
<td>only at the patient's request.</td>
<td>by the practice team, but is not a priority in appointment scheduling.</td>
<td>by the practice team and is a priority in appointment scheduling, but patients commonly see other providers because of limited availability or other issues</td>
<td>by the practice team, is a priority in appointment scheduling, and patients usually see their own provider or practice team</td>
</tr>
<tr>
<td>Score</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Non-physician practice team members</td>
<td>play a limited role in providing clinical care.</td>
<td>are primarily tasked with managing patient flow and triage</td>
<td>provide some clinical services such as assessment or self-management support</td>
<td>perform key clinical service roles that match their abilities and credentials</td>
</tr>
<tr>
<td>Score</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. The practice</td>
<td>...does not have an organized approach to identify or meet the training needs for providers and other staff.</td>
<td>...routinely assesses training needs and assures that staff are appropriately trained for their roles and responsibilities.</td>
<td>...routinely assesses training needs, assures that staff are appropriately trained for their roles and responsibilities, and provides some cross training to permit staffing flexibility.</td>
<td>...routinely assesses training needs, assures that staff are appropriately trained for their roles and responsibilities, and provides cross training to assure that patient needs are consistently met.</td>
</tr>
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<td>Score</td>
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**Total Health Care Organization Score** 0

**Average Score (Health Care Org. Score/3)** 0


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Why Me?

- Rural Health Clinics increasingly are expected to measure, report and improve quality measures and demonstrate clinical and operational improvements.
- SCORH Center for Practice Transformation created to support rural practices and providers in their improvement efforts and prepare them to operate under performance-based reimbursement models.
- Alignment with:
  - Meaningful Use
  - Performance reporting
  - EHR Implementation & Support
  - Workforce Management

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Center for Practice Transformation

- Provides experienced staff and resources in practice transformation
- Practice support is provided through
  - Practice coaching
  - Practice assessment & planning
  - Learning opportunities – monthly webinars, SharePoint site
  - Recognition support
- Practical & tactical
- Partner with practices and support services team as needed

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PCMH 1: Enhance Access and Continuity

• Same day appointments
• Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during and after office hours
• The practice provides electronic access
• Practice tracks and improves a measure of access

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PCMH 2: Team-Based Care

- Patients provides option to select a personal clinician
- Practice reports continuity
- Practice notifies patients of medical home responsibilities
- Practice trains staff in team-based care and
- Implements team-based care structure and activities

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PCMH 3: Identify and Manage Populations

- The practice collects demographic and clinical data for population management
- The practice assesses and documents patient risk factors
- The practice identifies patients for proactive and point-of-care reminders

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PCMH 4: Plan and Manage Care

• The practice identifies patients for case management
• Care management emphasizes:
  o Pre-visit planning
  o Assessing patient progress toward treatment goals
  o Addressing patient barriers to treatment goals
• The practice uses e-prescribing
• Assesses patient/family self-management abilities
• Works with patients to develop a self-care plan and provide tools and resources
• Clinicians counsel patients on healthy behaviors
• Assesses and provides or arranges for mental health/substance abuse treatments

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PCMH 5: Track & Coordinate Care

- Tracks, follow-up on and coordinates tests, referrals and care at other facilities
- Follows up with discharged patients
- Care coordination

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PCMH 6: Measure & Improve Performance

• Uses performance and patient experience data to continuously improve
• Identifies vulnerable patient populations
• Demonstrates improved performance

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