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

- \textbf{>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) - \textit{Retired}

- Medical practice process and structural measures.
  - Physician Practice Connections - \textit{Retired}
  - Physician Practice Connections-Patient-Centered Medical Home (PPC-PCMH) 2008 - \textit{Retired}
  - Patient-Centered Medical Home (PCMH) 2011
  - Patient-Centered Medical Home (PCMH) 2014
  - Patient centered Specialty Practice (PCSP)

\begin{itemize}
  \item 10,520 clinicians
  \item 4,223 clinicians
  \item 270 Clinicians 52 Practices
  \item 44,057 Clinicians 9,359 Practices
  \item 573 Clinicians 62 Practice
\end{itemize}
NCQA PCMH SITES
As of 3/31/15

9,359 PCMH SITES
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 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
<table>
<thead>
<tr>
<th>1: Enhance Access and Continuity</th>
<th>Pts</th>
<th>4: Plan and Manage Care</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. *Patient-Centered Appointment Access</td>
<td>4.5</td>
<td>A. Identify Patients for Care Management</td>
<td>4</td>
</tr>
<tr>
<td>B. 24/7 Access to Clinical Advice</td>
<td>3.5</td>
<td>B. *Care Planning and Self-Care Support</td>
<td>4</td>
</tr>
<tr>
<td>C. Electronic Access</td>
<td>2</td>
<td>C. Medication Management</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>D. Use Electronic Prescribing</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>E. Support Self-Care and Shared Decision-Making</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2: Team-Based Care</th>
<th>Pts</th>
<th>5: Track and Coordinate Care</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Continuity</td>
<td>3</td>
<td>A. Test Tracking and Follow-Up</td>
<td>6</td>
</tr>
<tr>
<td>B. Medical Home Responsibilities</td>
<td>2.5</td>
<td>B. *Referral Tracking and Follow-Up</td>
<td>6</td>
</tr>
<tr>
<td>C. Culturally and Linguistically Appropriate Services (CLAS)</td>
<td>2.5</td>
<td>C. Coordinate Care Transitions</td>
<td>6</td>
</tr>
<tr>
<td>D. *The Practice Team</td>
<td>4</td>
<td></td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3: Population Health Management</th>
<th>Pts</th>
<th>6: Measure and Improve Performance</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Patient Information</td>
<td>3</td>
<td>A. Measure Clinical Quality Performance</td>
<td>3</td>
</tr>
<tr>
<td>B. Clinical Data</td>
<td>4</td>
<td>B. Measure Resource Use and Care Coordination</td>
<td>4</td>
</tr>
<tr>
<td>C. Comprehensive Health Assessment</td>
<td>4</td>
<td>C. Measure Patient/Family Experience</td>
<td>4</td>
</tr>
<tr>
<td>D. *Use Data for Population Management</td>
<td>5</td>
<td>D. *Implement Continuous Quality Improvement</td>
<td>3</td>
</tr>
<tr>
<td>E. Implement Evidence-Based Decision-Support</td>
<td>4</td>
<td>E. Demonstrate Continuous Quality Improvement</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>F. Report Performance</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>G. Use Certified EHR Technology</td>
<td>20</td>
</tr>
</tbody>
</table>

**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