Lessons Learned Implementing PCMH & PCSP Programs

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NCQA: What we do, and why

OUR MISSION

To improve the quality of health care

OUR METHOD

Measurement

We can't improve what we don't measure

Transparency

We show how we measure so measurement will be accepted

Accountability

Once we measure, we can expect and track progress

context

*Always design a thing by considering it in **its next larger context** – a chair in a room, a room in a house, a house in an environment, an environment in a city plan.*

--Eliel Saarinen
Architect, 1873-1950

Health care has it BACKWARDS. We design…

Payment models *without consideration of how incentives might harm patients and undermine quality of care.*

Technology *that cannot* ***capture a patient's story*** *or* ***support team-based care.***

Measures *without consideration of the unique needs of* ***individuals & the effects on those being measured.***

The Patient-Centered Neighborhood

NCQA Recognition Program

Patient-Centered Medical Home | Patient-Centered Specialty Practice | Patient-Centered Connected Care

Population Health Management

Transformed in the PCMH

Current View

30 Patients Per Day
14 have Chronic Conditions
Unknown Health Risks
Visits Too Short for Coaching

New Population View

2500 Patient Population
900 have Chronic Conditions
1100-1250 have Mod-High Health Risk
Care Teams Leveraged by HIT

Volume-Based/Episodic → **Value-Based/Continuous**

Evolution of the PCMH Standards

Continue to Move Practices Closer to Achieving the Triple Aim

2011

-Emphasizes relationship with/expectations of specialists

-Integrates behaviors affecting health, language, CLAS

-Enhances evaluation of patient experience

-Underscores importance of system cost-savings

-Enhances use of clinical performance measure results

2014

-Further incorporates behavioral health

Additional emphasis on team-based care

-Focuses on care management of high need populations

-Higher bar, alignment of QI activities with "triple aim"

2017

-Addition of Annual Reporting Requirements

-Further integrates social determinants & community connections

-Further integrates behavioral health

-Shift from focus on structure to focus on outcomes

Going Forward

-Add and retire relevant criteria

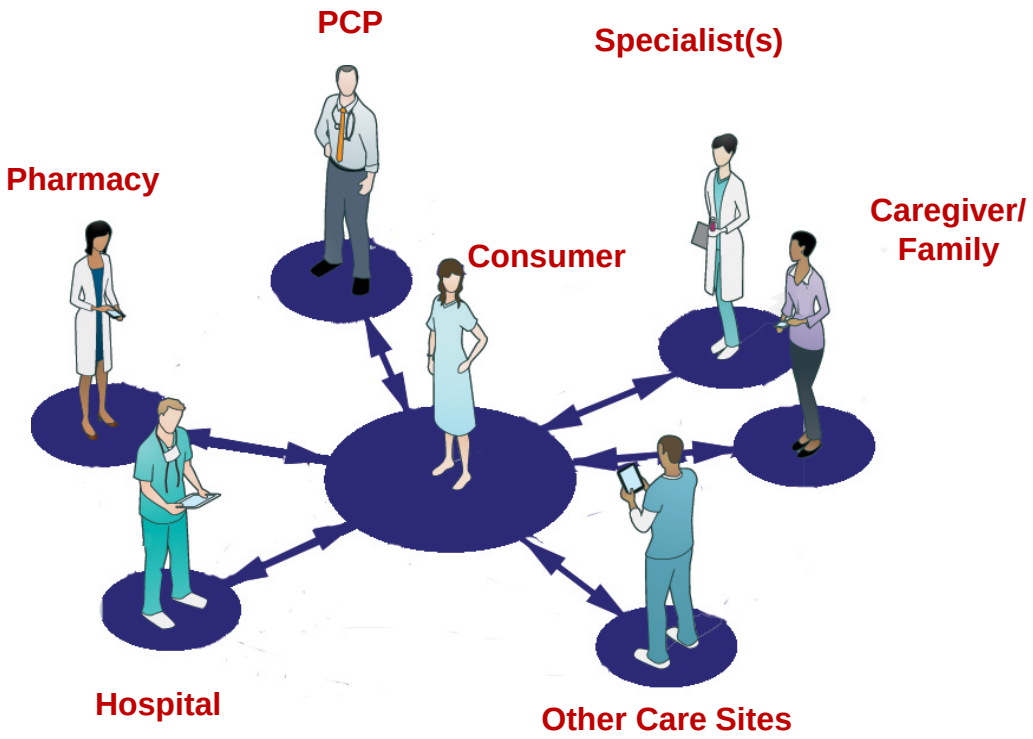
-Continue to evolve and update annual reporting requirements

-Further integrate other special topics

-Align with new programs and initiatives

Why Create a Program for Specialists?

Every year, the average Medicare beneficiary…

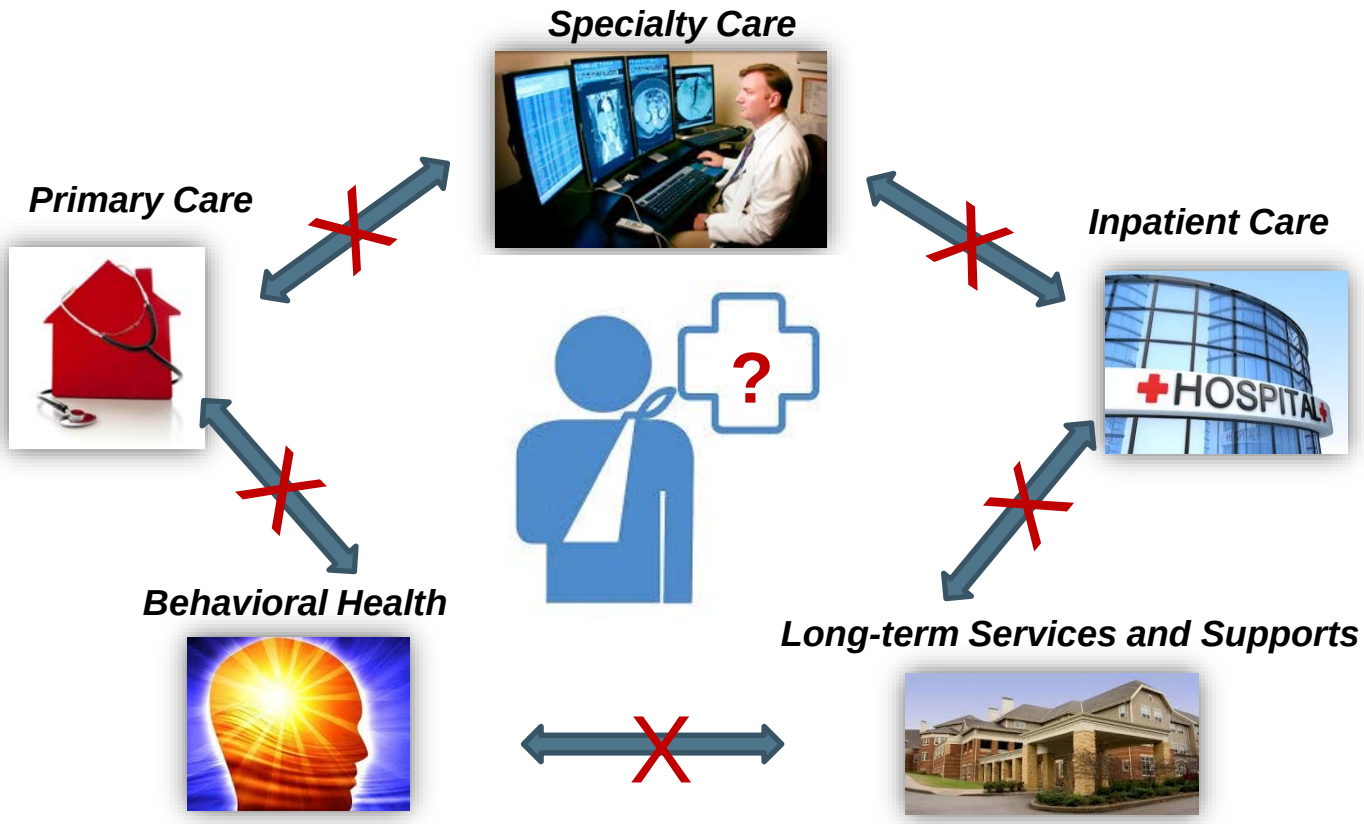


Sees 7 physicians

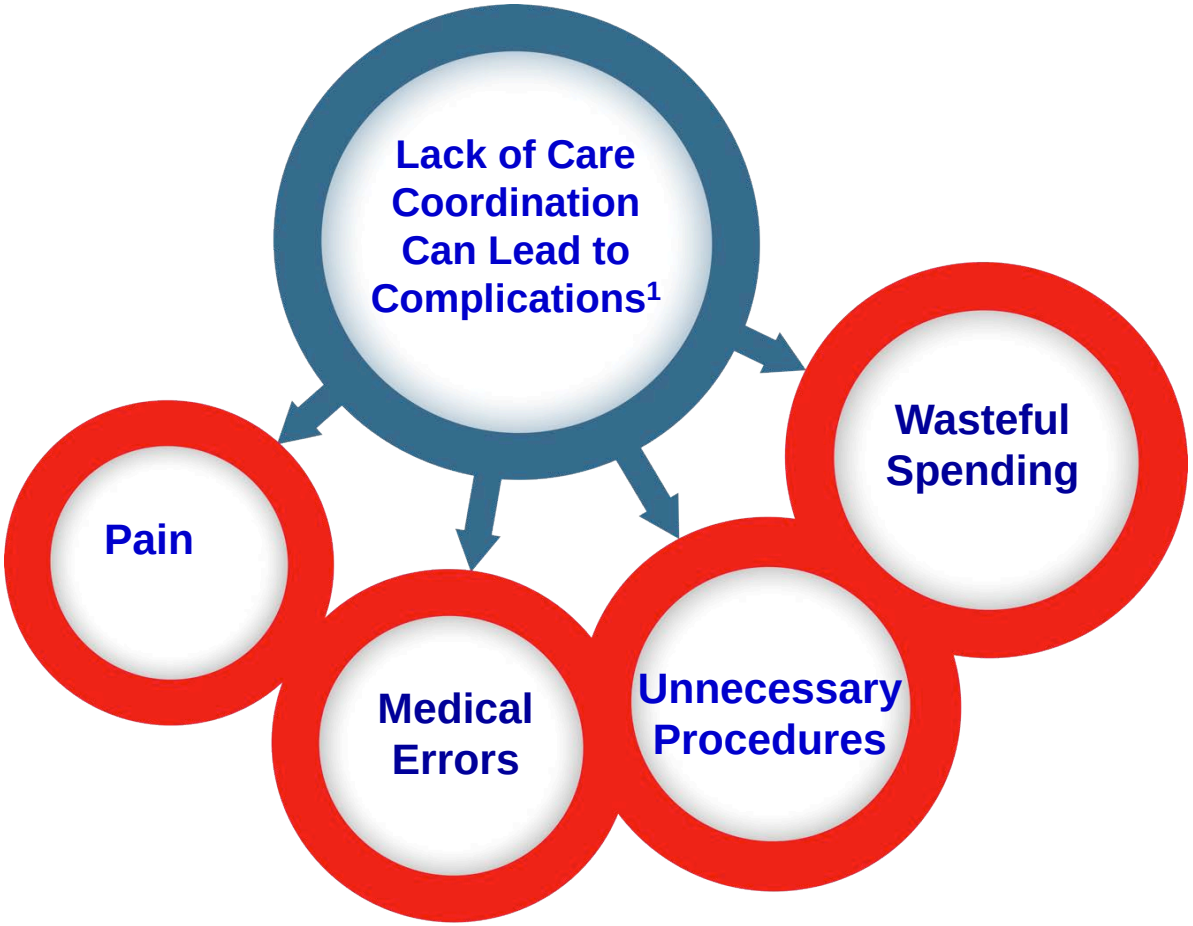
Fills 20+ prescriptions

Has 2 referrals

Even if individual organizations deliver high quality care, effective patient-centered *systems (neighborhoods) require coordination*…



The Burden of Uncoordinated Care



The National Academies Health and Medicine Division (aka IOM) has estimated that care coordination initiatives addressing these complications could result in $240 billion in healthcare savings.

Foy, R., Hempel, S., Rubenstein, L., Suttorp, M., Seelig, M., Shanman, R., Shekelle, P.G. (2010). Meta-analysis: effect of interactive communication between collaborating primary care physicians and specialists. *Annals of Internal Medicine, 152 (4), 247-258*

The PCSP Design

Accommodates the range of relationships between PCP and specialist

Based on a typology developed by Dr. Christopher Forrest (2009)

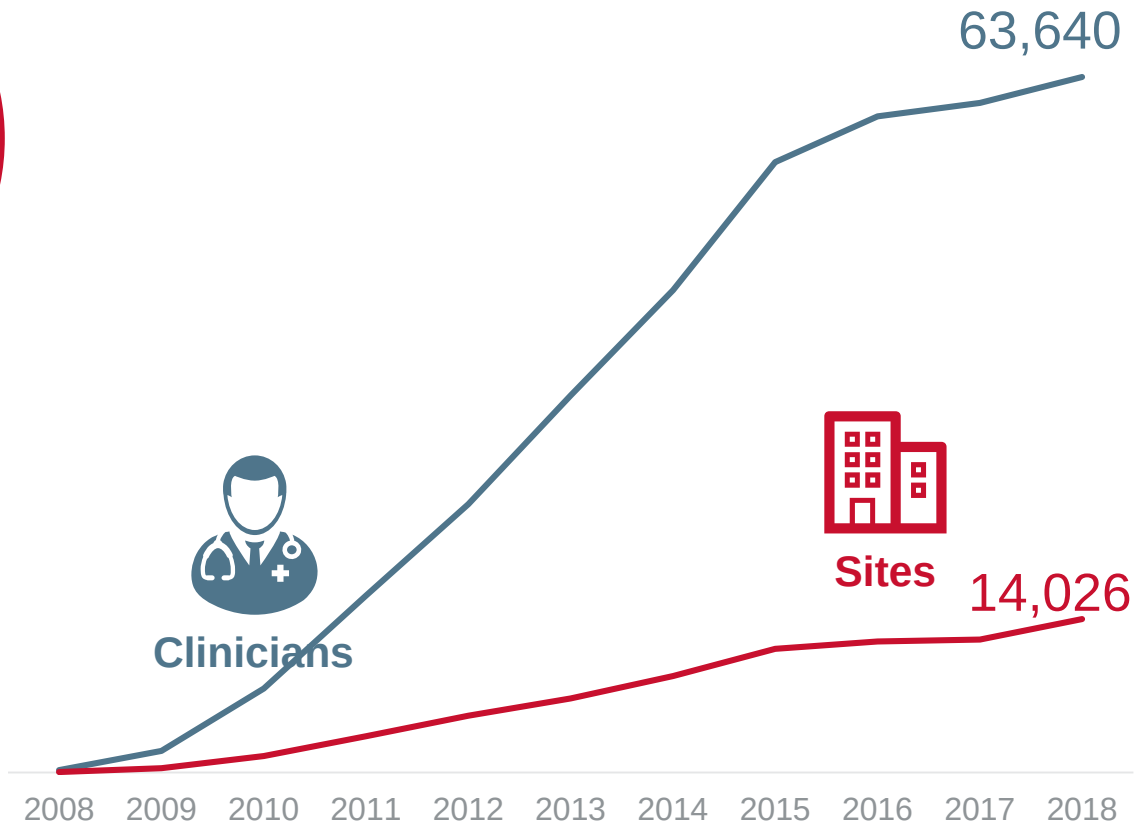
- Consulting on patients
- Evaluating and treating patients
- Co-managing patients
- Providing temporary/permanent care management for some patients

Practices are likely to have patients in each relationship category

Archives of Internal Med, June 2009

The fastest-growing delivery system reform:

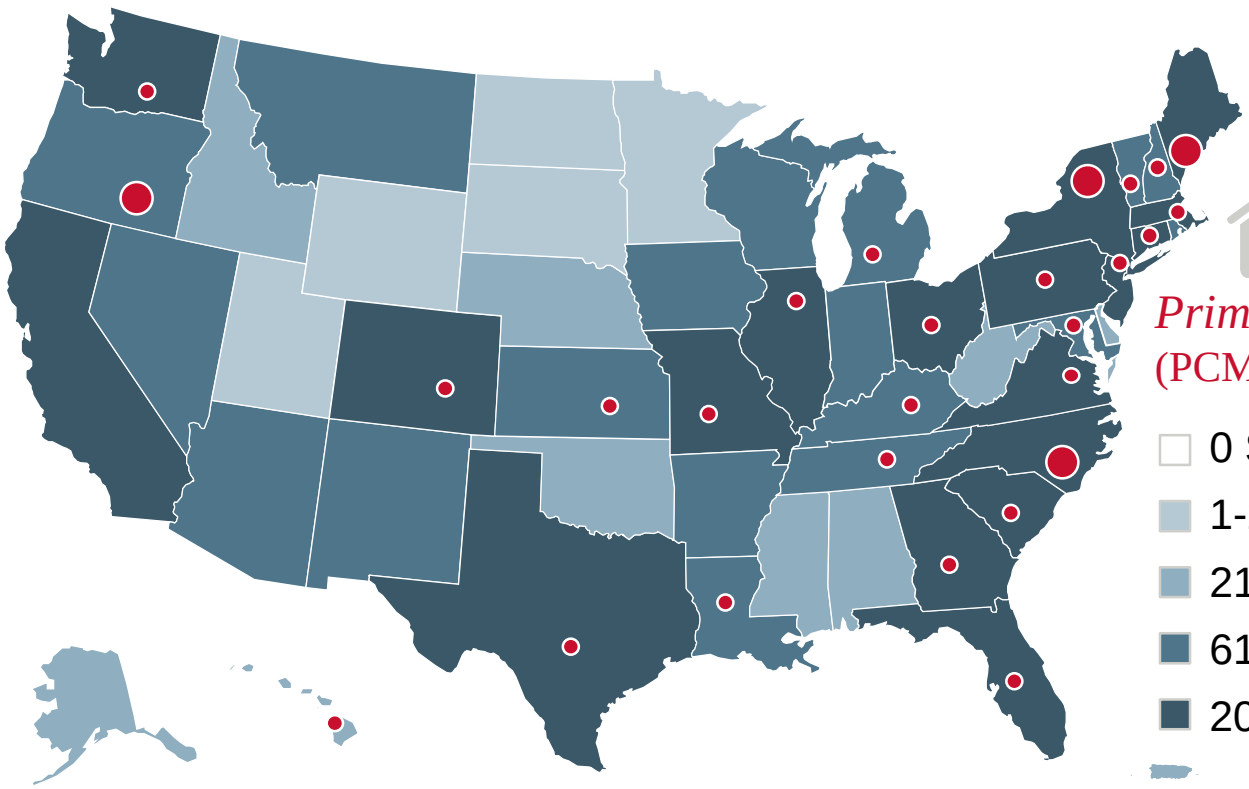
Patient-centered medical home (PCMH)



NCQA medical neighborhood recognitions

Closing the Loop Between Primary & Specialty Care

Over *14,468* Total Sites Recognized
PCMH & PCSP



PCMH

Primary Care (PCMH) SITES

- 0 Sites
- 1-20 Sites
- 21-60 Sites
- 61-200 Sites
- 201+ Sites

Specialty (PCSP) SITES

- 1-9 Sites
- 10+ Sites

PCMH Standards

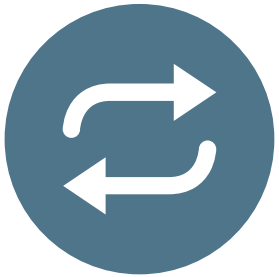
Concepts

Team-Based Care and Practice Organization (TC)

Knowing and Managing Your Patients (KM)

Patient-Centered Access and Continuity (AC)

Care Management and Support (CM)



Care Coordination and Care Transitions (CC)

Performance Measurement & Quality Improvement (QI)

PCSP Standards

Concepts

Team-Based Care and Practice Organization (TC)

Initial Referral Management (RM)

Knowing and Managing Your Patients (KM)

Patient-Centered Access and Continuity (AC)

Plan and Manage Care (PM)

Coordinating Care and Care Transitions (CC)

Performance Measurement & Quality Improvement (QI)

Patient-Centered Care

Benefits

62%

of total lower spending per NCQA PCMH Medicare beneficiary was attributable to reductions in payments to acute care hospitals

$265

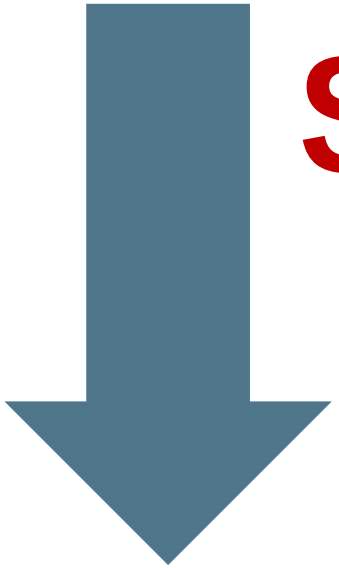
Lower average annual total Medicare spend per beneficiary for patients in NCQA recognized practices

Van Hasselt, M., McCall, N., Keyes, V., Wensky, S. G., & Smith, K. W. (2014). Total Cost of Care Lower among Medicare Fee-for-Service Beneficiaries Receiving Care from Patient-Centered Medical Homes. Health Services Research.

Patient-Centered Care

Lowering total cost of care

NCQA PCMHs lower costs through better chronic care management, preventive medicine, and coordination across care settings and transitions.



$482.40

Lower per capita spending for patients in NCQA PCMH[1]

$5m

Annual savings for 100,000 patients in NCQA PCMH pilot[2]

[1] - Department of Vermont Health Access / Vermont Blueprint for Health

[2] - Rosenthal MB, et al. (2016). A Difference-in-Difference Analysis of Changes in Quality, Utilization and Cost Following the Colorado Multi-Payer Patient-Centered Medical Home Pilot. *Journal of General Internal Medicine*.

Patient-Centered Care

Improving quality, reducing costly utilization

NCQA PCMH patients have high-quality disease management, better medication adherence, an emphasis on self-care and community support, and thus experience fewer acute incidents.

39%

Higher rate of self-care planning & community support[3]

5%

Better performance on a 5-measure diabetes care bundle[3]

6.3%

Higher rate of optimal medication adherence[4]

22%

Lower risk-adjusted use of ED services[5]

3 - Reiss-Brennan B, Brunisholz KD, Dredge C, et al. (2016). Association of Integrated Team-Based Care With Health Care Quality, Utilization, and Cost. *JAMA*.
4 - Lauffenburger JC, et al. (2017). Association Between Patient-Centered Medical Homes and Adherence to Chronic Disease Medications. *Annals of Internal Medicine*..
5 - DeVries, A, Chia-Hsuan W, Sridhar G, Hummel J, Breidbart S., Barron J. (2012) Impact of Medical Homes on Quality Healthcare Utilization and Costs. *AJMC*.

Patient-Centered Care

Improving Staff Experience & Burnout

Staff working in a PCMH experience:

- Reduced emotional exhaustion[6]
- Lower staff burnout[7]
- Higher motivation, enthusiasm, morale[8,9]

6 – Reid RJ, et al (2010). The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout For Providers. *Health Affairs*
7 – Nelson KM, et al (2014). Implementation of the Patient-Centered Medical Home in the Veterans Health Administration. *JAMA Internal Medicine.*
8 – Adewale V, et al (2015). Mixed-Method Patient-Centered Medical Home Evaluation: Outcomes of the Brown University Primary Care Transformation Initiative. *Conference: North American Primary Care Research Group.*
9 – Lewis SE, et al (2012). Patient-centered medical home characteristics and staff morale in safety net clinics. *Arch Intern Med.*

Get in touch

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For more information on PCMH & PCSP:
http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh

https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-specialty-practice-recognition-pcsp/

To access the PCMH Evidence Report:
http://www.ncqa.org/programs/recognition/practices/pcmh-evidence

For any other questions:
https://my.ncqa.org/


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Thank you