

Leveraging the Patient Centered Medical Home Model to Improve Member Engagement

AHIP Medicare Conference 2014



THE NOLAN COMPANY

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Presented to:



America's Health
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Objectives

- Define the standards of the Patient Centered Medical Home (PCMH) model
- Align the PCMH model standards with health plan engagement goals
- Identify opportunities to optimize the PCMH model to meet health plan engagement goals

Agenda

- PCMH Evaluation Data and Outcomes
- Marketplace
- PCMH Model
- Success in Today's Market
 - Member Engagement
 - Provider Engagement
 - Role of Patient Centered Medical Home (PCMH)
- Partnership Opportunities

PCMH Evaluation Data and Outcomes

- Colorado Multi-Payer PCMH Pilot
 - 15% fewer emergency department visits compared to 4% fewer in control group
 - 18% fewer inpatient admissions compared to 18% increase in control group
 - Number of specialty visits remained flat versus 10% increase in control group
 - For every dollar WellPoint invested, estimated return ranged from \$2.5:\$1 to \$4.5:\$1
 - Data 2009-2012
- WellPoint's Single Health Plan Model New York PCMH
 - Compared to control group
 - 11% fewer emergency department visits for adults; 17% for children
 - 14.5% lower risk adjusted total PMPM costs for adults; 8.6% lower for children
 - Data 2007-2010

PCMH Evaluation Data and Outcomes

- University of Pennsylvania Medical Center Health Plan Medical Home Pilot
 - 5.1% fewer emergency department visits
 - 6.1% increase in inpatient admissions vs 8.1% for non-PCMHs
 - 12.5% fewer readmissions (2008-2009); 18.3% fewer hospital readmissions (2009-2010)
 - 160% return on investment for PCMHs
 - Data 2008-2010
- CareFirst BlueCross BlueShield
 - \$98 million in total costs savings
 - Panels earning incentives achieved average of 4.7% savings versus 3.6% higher costs for those not earning incentives
 - Data 2010-2012

PCMH Evaluation Data and Outcomes

- Oregon Coordinated Care Organizations Oregon Health Authority
 - 9% fewer emergency department visits
 - 18% reduction in emergency department spending
 - 12% fewer inpatient readmissions
 - 7% increase in primary care spending
 - Data 2012-2013
- Highmark PCMH Pilot
 - 9% fewer inpatient admissions
 - 13% fewer 30-day inpatient readmissions
 - 5% decrease in total PMPM costs for coronary artery disease patients
 - 3.5% decrease in total PMPM costs for diabetics
 - 2% decrease in overall health care costs
 - Data 2011-2012

PCMH Evaluation Data and Outcomes: Medicare

| Medicare Projects | Evaluation Data and Outcomes |
|---|---|
| Beacon, LLC CMS Pioneer ACO | <ul style="list-style-type: none"> • Savings of \$499/beneficiary/year • 5% shared savings for year one |
| Bellin-Thedacare Healthcare Partners CMS Pioneer ACO | <ul style="list-style-type: none"> • Reduced the cost of care by 4.6% for 20,000 Medicare beneficiaries |
| Beth Israel Deaconess Physician Organization (BIDPO) CMS Pioneer ACO | <p>In the 1st year of operation</p> <ul style="list-style-type: none"> • Saved 4.2% of its budget for patient care • Generated a return of \$7.79 million for BIDPO |
| Monarch Healthcare CMS Pioneer ACO | <ul style="list-style-type: none"> • Reduced medical costs by 5.4% in 2012 from its baseline, while national medical costs grew by 1.1% for a comparable population • Driven primarily by reductions in hospital admissions and skilled nursing facilities utilization and unit costs |
| Montefiore ACO CMS Pioneer ACO | <ul style="list-style-type: none"> • 7% savings in the first year • Gross savings of more than \$96 million in the second year, compared to \$87.6 million in 2012. • Improved quality performance in key areas, such as depression screening and screening for risk of future falls |
| Partners HealthCare CMS Pioneer ACO | <ul style="list-style-type: none"> • Rate of cost growth slowed by 3%, compared to Medicare reference trend • \$14.4 million in shared savings |

PCMH Evaluation Data and Outcomes: Medicare

| Medicaid Projects | Evaluation Data and Outcomes |
|--|---|
| Colorado Medicaid Accountable Care Collaborative | <ul style="list-style-type: none"> • 15-20% reduction for hospital admissions, relative to a comparison population prior to program implementation • 25% reduction in high cost imaging services, relative to a comparison population prior to program implementation • Emergency room utilization increased 1.9%, compared to 2.8% increase to those not enrolled • 5% lower rate of exacerbated hypertension, compared to non-enrollees • 9% lower rate of exacerbated diabetes, compared to non-enrollees • \$44 million gross and \$6 million net reduction in total cost of care for enrollees |
| Husky Health Person-Centered Medical Home | <ul style="list-style-type: none"> • 2% reduction in per person costs • Children receiving care at a PCMH were 10% more likely to received recommended EPSDT screenings |
| New York Health Homes | <ul style="list-style-type: none"> • 23% decrease in hospital admissions and emergency room visits • 14% increase in primary care visits |

PCMH Evaluation Data and Outcomes: Medicare

| Medicaid Projects | Evaluation Data and Outcomes |
|-------------------------------|--|
| Illinois Health Connect (IHC) | <ul style="list-style-type: none"> • Reduction of adjusted hospitalization rate by 18.1% between 2006 and 2010 • Reduction of bed-day rate by 15.6% between 2006 and 2010 • Decline of adjusted emergency department visit rate of 5% • Rate of estimated annual savings increased about 2% per year to 6.5% in 2010 <p>Per results of a 2012 physician satisfaction survey:</p> <ul style="list-style-type: none"> • 80.2% of physicians agreed or strongly agreed that the IHC Panel Roster helped them to manage patients' care (12.2% reported not using it) • 81.9% agreed or strongly agreed that the mailed Provider Profiles, which features physicians' quality measures, were useful for quality improvement (10.7% had not seen the profiles) • 75.2% agreed or strongly agreed that the bonus payment program stimulated quality improvement in their practice (10.6% were unaware of the bonus program) • 36.6% agreed or strongly agreed that the IHC Quality Assurance Nurse (academic detailing) service was helpful for understanding their Profile quality measures and how to achieve maximum bonus payments (61.8% had not used the Quality Assurance Nurse service) |

PCMH Evaluation Data and Outcomes: Medicare

| Medicaid Projects | Evaluation Data and Outcomes |
|---|---|
| Community Care of North Carolina (CCNC) | <ul style="list-style-type: none"> • Inpatient admission rates declined from 420 visits/1000 patients in 2007 to 384 visits/1000 patients in 2011 • Emergency department visits increased from 396 to 552 among non-participants from 2007 to 2011 • Statistically significant increase in access to ambulatory physician services • Statistically significant cost savings ranged from \$190.01 PMPM (2007) to \$63.74 PMPM (2011) • Estimated cost savings of \$382 million in 2010 • 11% reduction in pharmacy costs • 25% reduction in outpatient care costs |
| SoonerCare Choice | <ul style="list-style-type: none"> • Emergency room utilization decreased from 79.7 visits per 1000 members in 2009 to 73.5 in the first half of 2012 • Readmission rates fell by 26% between 2009 and 2012 • Patient satisfaction ratings on four different indicators (including getting needed care, getting care quickly, rating of personal doctor, and rating of specialist) grew between 2 and 7% • 90% of all age cohorts had access to PCP in 2012 • Access to preventive services improved for younger adults to greater than 83% in 2012 • Access to preventive services improved for older adults to 91% for older adults |

PCMH Evaluation Data and Outcomes: Medicare

| Medicaid Projects | Evaluation Data and Outcomes |
|---|--|
| Oregon Coordinated Care Organizations (CCO) | <ul style="list-style-type: none"> • In 2013, emergency department visits served by CCO decreased 17% since 2011 baseline data • 12% fewer inpatient readmissions • 27% reduction in hospital admissions for patients with congestive heart failure • 32% reduction in hospital admissions for patients with chronic obstructive pulmonary disease • 18% reduction in hospital admissions for patients with adult asthma • Improved access: 18% increase in outpatient primary care visits • 19% reduction in emergency department visit spending |
| Missouri Health Homes Program | <ul style="list-style-type: none"> • 12.8% reduction in hospital admissions • 8.2% reduction in emergency department use • Decrease of \$127.55 PMPM in hospital and emergency department visit costs • Overall cost savings of approximately \$2.9 million • Total net cost savings to Medicaid, when including dual eligibles, was more than \$27 million after one year of enrollment |

The Market: Members

- Individuals vs. Anonymous Groups
 - Complex information
 - Coverage
 - Financial responsibilities
 - Medical conditions
 - Treatment options
 - Guidance
- Health Plans
 - Learn how to engage members better
 - Member guidance and empowerment
 - Affect outcomes and quality of life

The Market: Members

- Member Engagement
 - Not Customer Relationship Management (CRM)
 - All of the products, benefits, and services directed toward members that are coordinated, deployed, and focused on providing value to the customer experience measured by the customer's perspective.

Impact of Member Engagement

- Numerous studies show that consumers who are engaged least by their insurers represent the highest costs.
- Survey of 31,000 members
 - Members with the lowest level of engagements cost health plans 21% more than respondents reporting the highest engagement level.
- Insurers with clear strategies and thoughtful tactics can improve engagement over time.

The Market: Providers

- Increased accountability
 - Population Management
 - Quality
 - Outcomes

- Health Plans
 - Payment strategies to foster outcomes
 - Collaborative opportunities to address goals/objectives of health plan and provider

patient centered Medical Home (PCMH)



American Academy of Family Physicians

- Frequently the first point of contact for an individual
- Often follow patients over years
- Integration of behavioral healthcare and care management
- Patients involved in quality improvement

PCMH Model: NCQA Recognition Levels

- Three levels of recognition – 1, 2, and 3
- Level 3 indicates more mature operational processes than level 1.
- Duration: 3 years
- Health Plan Opportunities
 - Stratify providers based on recognition levels
 - Reimburse based on stratification
 - Some health plans have lower co-pays for members that utilize services at a Level 3 PCMH

PCMH Model: NCQA 2011 Standards

| Standard | Elements |
|--|---|
| 1: Enhance Access and Continuity | <p>A: Access during office hours (must pass)</p> <p>B: After hours access</p> <p>C: Electronic access</p> <p>D: Continuity</p> <p>E: Medical home responsibilities</p> <p>F: Culturally and linguistically appropriate services</p> <p>G: The practice team</p> |
| 2: Identify and Manage Patient Populations | <p>A: Patient information</p> <p>B: Clinical data</p> <p>C: Comprehensive health assessment</p> <p>D: Use data for population management (must pass)</p> |
| 3: Plan and Manage Care | <p>A: Implement evidence-based guidelines</p> <p>B: Identify high risk patients</p> <p>C: Care management (must pass)</p> <p>D: Medication management</p> <p>E: Electronic prescribing</p> |
| 4: Provide Self-Care Support and Community Resources | <p>A: Support Self-Care Process (must pass)</p> <p>B: Provide referrals to community resources</p> |
| 5: Track and Coordinate Care | <p>A: Test tracking and follow-up</p> <p>B: Referral tracking and follow-up (must pass)</p> <p>C: Coordinate with facilities and manage care transitions</p> |
| 6: Measure and Improve Performance | <p>A: Measure performance</p> <p>B: Measure patient/family experience</p> <p>C: Implement continuous quality improvement (must pass)</p> <p>D: Demonstrate continuous quality improvement</p> <p>E: Report performance</p> <p>F: Report data externally</p> <p>G: Use certified electronic health technology (for meaningful use only, not score for PCMH recognition decision)</p> |

Member Engagement Strategy

- Any good member engagement plan will address objectives, performance metrics, timelines, and budgets.
- Need focused goals
 - Identify the decision(s) you want to influence
 - Identify opportunities to engage members
 - Choose an effective channel
 - Evaluate existing engagement channels for effectiveness
 - Anticipate and create new channels for engagement
- Utilize the customer life cycle as a framework
 - Attract
 - Enroll
 - Manage
 - Retain

Member Engagement Strategy

- Customer Life Cycle & Key Member Decisions
 - Attract
 - Key Decision(s)
 - Choosing the best benefits at the right price based on individual circumstances
 - Engagement Opportunity/Channel associated with PCMH Model
 - Benefit package that fosters
 - » Use of preventive services, i.e. reduced or no co-pays for wellness visits
 - » Use of PCMH, i.e. reduced or no co-pays for declaring the PCMH as primary care provider and utilizing services

Member Engagement Strategy

- Customer Life Cycle & Key Member Decisions
 - Enroll
 - Key Decision(s)
 - Choose a primary care physician
 - Make decisions based on benefits package
 - Engagement Opportunity/Channel associated with PCMH Model
 - Provide information on PCMH model
 - Provide information on health costs and quality utilizing PCMH data
 - Previously mentioned benefits package influences enrollment
 - For members who have not had an initial preventive care visit, conduct a member health “fair” with the PCMH.
 - » Member has an appointment with primary care provider.
 - » Health plan staff on site for the purpose of engaging members.
 - » Suggest holding at a time best for the population, i.e. teenagers on a Saturday
 - » Addresses HEDIS for health plans

Member Engagement Strategy

- Customer Life Cycle & Key Member Decisions
 - Manage
 - Key Decision(s)
 - Make decisions about preventive care
 - Self-manage illness or chronic conditions
 - Choose and purchase medications
 - Pay member portion of claims
 - Engagement Opportunity/Channel associated with PCMH Model
 - Partner with the PCMH
 - » On population management to accomplish goals of both organizations
 - » To define a framework of care transitions, including specific expectations on two-directional communications
 - » To identify high-risk or complex patients and facilitate communication between PCMH and health plan for care management
 - Priority scheduling

Member Engagement Strategy

- Customer Life Cycle & Key Member Decisions
 - Retain
 - Key Decision(s)
 - Decide whether or not to continue with the health plan for another year
 - Engagement Opportunity/Channel associated with PCMH Model
 - Include members utilizing PCMH Model in member satisfaction surveys
 - » Is there a difference in the member satisfaction results between members utilizing PCMH and members utilizing non-PCMH providers?
 - Most important piece a plan can do to retain members is to engage them during the previous three phases.

Components of Provider Engagement

- Payment Reforms
 - Traditional FFS component coupled with an additional care management payment
 - Shared savings models
 - Bundled payments
 - Partial or full capitation
 - Can be tiered based on PCMH level of recognition, i.e. Level 1, 2, or 3 or only for a particular, more mature level of recognition, i.e. Level 3
 - Reimburse for end-to-end population health management workflow, instead of gaps in care
- Value-based purchasing and value-based insurance design
 - Incentivizes members to use higher-value services
 - Reduced or no co-pays for wellness visits or for receiving care in a recognized PCMH
 - Tiered pharmacy benefits to encourage the use of cost effective prescription drugs
 - Increased transparency on health costs and quality utilizing the PMCH data

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Appendix



PCMH Model: Eligibility

- Eligible outpatient primary care practices
 - Must provide primary care for all of the patients, not just selected patients
 - One or more clinicians who practice together and provide patient care at a single geographic location
 - The practice care team follows the same procedures and protocols
 - Medical records for all patients treated at the practice site, whether paper or electronic, are available to and shared by all clinicians
 - The same systems – electronic and paper-based – and procedures support both clinical and administrative functions
 - Hospital-based primary care practices and residency clinics are eligible.

PCMH Model: Eligibility

- Eligible outpatient primary care practices (continued)
 - Primary care practice examples:
 - An incorporated group of three clinicians in an office site who use the same systems and staff, as described above
 - An individual clinician, whether sharing an office with other clinicians or not, who maintains his or her own system
 - A group of clinicians at one location that is part of a larger medical group with several locations
 - A practice within a multi-site group
 - A multi-site group has 3 or more practice sites using the same systems and processes including an electronic medical record system shared across all practice sites.
 - A subset of primary care clinicians within a multi-specialty practice.

PCMH Model: Eligibility

- Eligible primary care clinicians
 - Only clinicians that a patient/family can select as a personal clinician
 - Typically physicians, nurse practitioners and physician assistants who practice in the specialty of internal medicine, family medicine, or pediatrics
 - Nurse practitioners and physician assistants must have their own panel of patients
 - Specialty physicians are not usually eligible
 - Nurse practitioner practices without a physician lead can achieve recognition in the following circumstances:
 - It is allowed according to the scope of practice determined by state law
 - Practices are reviewed against the same requirements as a physician-led practices
 - Must have an active unrestricted license as a doctor of medicine, doctor of osteopathy, nurse practitioner, or physician assistant

PCMH Model*: Standard 1: Enhance Access and Continuity

| Elements | Factors |
|--|---|
| Element A Access During Office Hours (must pass) | <p>The practice has a written process & defined standards, & demonstrates that it monitors performance against the standards for:</p> <ul style="list-style-type: none"> • Providing same-day appointments • Providing timely clinical advice by telephone during office hours • Providing timely clinical advice by secure electronic messages during office hours • Documenting clinical advice in the medical record |
| Element B After Hours Access | <p>The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:</p> <ul style="list-style-type: none"> • Providing access to routine and urgent-care appointments outside regular business hours • Providing continuity of medical record information for care and advice when the office is not open • Providing timely clinical advice by telephone when the office is not open • Documenting after-hours clinical advice in patient records |
| Element C Electronic Access | <p>The practice provides the following information and services to patients and families through a secure electronic system:</p> <ul style="list-style-type: none"> • More than 50% of patients who request an electronic copy of their health information receive it within 3 business days • At least 10% of patients have electronic access to their current health information within 4 business days of when the information is available to the practice • Clinical summaries are provided to patients for more than 50% of offices visits within 3 business days • Two-way communication between patients/families and the practice • Request for appointments or prescription refills • Request for referrals or test results |
| Element D Continuity | <p>The practice provides continuity of care for patients/families by:</p> <ul style="list-style-type: none"> • Expecting patients/families to select a personal clinician • Documenting the patient's/family's choice of clinician • Monitoring the percentage of patients visits with a selected clinician or team |

*2011 Standards

PCMH Model*: Standard 1: Enhance Access and Continuity

| Elements | Factors |
|--|---|
| Element E Medical Home Responsibilities | The practice has a process and materials that it provides patients/families on the role of the medical home, which include the following: <ul style="list-style-type: none"> • The practice is responsible for coordinating patient care across multiple settings • Instructions on obtaining care and clinical advice during office hours and when the office is closed • The practice functions most effectively if patients/families provide a complete medical history and information about care obtained outside the practice • The care team gives the patient/family access to evidence-based care and self-management support |
| Element F Culturally and Linguistically Appropriate Services | The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by: <ul style="list-style-type: none"> • Assessing the racial and ethnic diversity of its population • Assessing the language needs of its population • Providing interpretation of bilingual services to meet the language needs of its population • Providing printed materials in the languages of its population |
| Element G The Practice Team | The practice uses a team to provide a range of patient care services by: <ul style="list-style-type: none"> • Defining roles for clinical and nonclinical team members • Having regular team meetings or a structured communication process • Using standing orders for services • Training and assigning care teams to coordinate care for individual patients • Training and assigning care teams to support patients and families in self-management, self-efficacy and behavior change • Training and assigning care teams for patient population management • Training and designating care team members in communication skills • Involving care team staff in the practice's performance evaluation and quality improvement activities |

*2011 Standards

PCMH Model*: Standard 2: Identify & Manage Patient Populations

| Elements | Factors |
|--|--|
| <p>Element A Patient Information</p> | <p>The practice uses an electronic system that records the following as structured (searchable) data for more than 50% of its patients:</p> <ul style="list-style-type: none"> • Date of birth • Gender • Race • Ethnicity • Preferred language • Telephone numbers • E-mail address • Dates of previous clinical visits • Legal guardian/health care proxy • Primary caregiver • Presence of advance directives (except pediatric practices) • Health insurance information |
| <p>Element B Clinical Data</p> | <p>The practice uses an electronic system to record the following as structured (searchable) data:</p> <ul style="list-style-type: none"> • An up-to-date problem list with current and active diagnoses for more than 80% of patients • Allergies for more than 80% of patients • Blood pressure, with the date of update for more than 50% of patients 2 years and older • Height for more than 50% of patients 2 years and older • Weight for more than 50% of patients 2 years and older • System calculates and displays BMI (except pediatric practices) • System plots and displays growth charts and BMI percentile (except adult practices) • Status of tobacco use for patients 13 years and older for more than 50% of patients (except pediatric practices) • List of prescription medications with the date of updates for more than 80% of patients |

*2011 Standards

PCMH Model*: Standard 2: Identify & Manage Patient Populations

| Elements | Factors |
|--|---|
| Element C Comprehensive Health Assessment | To understand the health risks and information needs of patients/families, the practice conducts and documents a comprehensive health assessment that includes: <ul style="list-style-type: none"> • Documentation of age- and gender-appropriate immunizations and screenings • Family/social/ cultural characteristics • Communication needs • Medical history of patient and family • Advance care planning (except for pediatric practices) • Behaviors affecting health • Patient and family mental health/substance abuse • Developmental screening using a standardized tool (except for adult practices) • Depression screening for adults and adolescents using a standardized tool |
| Element D Use Data for Population Management (must pass) | The practice uses patient information, clinical data and evidence-based guidelines to generate lists of patients and to proactively remind patients/families and clinicians of services needed for: <ul style="list-style-type: none"> • At least 3 different preventive care services • At least 3 different chronic care services • Patient not recently seen by the practice • Specific medications |

*2011 Standards

PCMH Model*: Standard 3: Plan & Manage Care

| Elements | Factors |
|--|---|
| Element A Implement Evidence-Based Guidelines | The practice implements evidence-based guidelines through point-of-care reminders for patients with: <ul style="list-style-type: none"> • The first important condition • The second important condition • The third condition, related to unhealthy behaviors or mental health or substance abuse |
| Element B Identify High-Risk Patients | To identify high-risk or complex patients, the practice: <ul style="list-style-type: none"> • Establishes criteria and a systematic process to identify high-risk or complex patients • Determines the percentage of high-risk or complex patients in its population |
| Element C Care Management (must pass) | The care team performs the following for at least 75% of the patients identified in Elements A & B: <ul style="list-style-type: none"> • Conducts pre-visit preparations • Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit • Gives the patient/family a written plan of care • Assesses and addresses barriers when the patient has not met treatment goals • Gives the patient/family a clinical summary at each relevant visit • Identifies patients/families who might benefit from additional care management support • Follows up with patients/families who have not kept important appointments |

*2011 Standards

PCMH Model*: Standard 3: Plan & Manage Care

| Elements | Factors |
|---|--|
| Element D Medication Management | <p>The practice manages medications in the following ways:</p> <ul style="list-style-type: none"> • Reviews and reconciles medications with patients/families for more than 50% of care transitions • Reviews and reconciles medications with patients/families for more than 80% of care transitions • Provides information about new prescriptions to more than 80% of patients/families • Assesses patient/family understanding of medications for more than 50% of patients with date of assessment • Assesses patient response to medications and barriers to adherence for more than 50% of patients with date of assessment • Documents over-the-counter medications, herbal therapies and supplements for more than 50% of patients/families, with the date of updates |
| Element E Use Electronic Prescribing | <p>The practice uses an electronic prescription system with the following capabilities:</p> <ul style="list-style-type: none"> • Generates and transmits at least 40% of eligible prescriptions to pharmacies • Generates at least 75% of eligible prescriptions • Enters electronic medication orders into the medical record for more than 30% of patients with at least one medication in their medication list • Performs patient-specific checks for drug-drug and drug-allergy interactions • Alerts prescribers to generic alternatives • Alerts prescribers to formulary status |

*2011 Standards

PCMH Model*: Standard 4: Provide Self-Care Support & Community Resources

| Elements | Factors |
|--|---|
| <p>Element A Support Self-Care Process (must pass)</p> | <p>The practice conducts activities to support patients/families in self-management:</p> <ul style="list-style-type: none"> • Provides educational resources or refers at least 50% of patients/families to educational resources to assist in self-management • Uses an electronic health record to identify patient-specific education resources and provide them to more than 10% of patients, if appropriate • Develops and documents self-management plans and goals in collaboration with at least 50% of patients/families • Documents self-management abilities for at least 50% of patients/families • Provides self-management tools to record self-care results for at least 50% of patients/families • Counsels at least 50% of patients/families to adopt health behaviors |
| <p>Element B Provide Referrals to Community Resources</p> | <p>The practice supports patients/families that need access to community resources:</p> <ul style="list-style-type: none"> • Maintains a current resource list on five topics or key community service areas of importance to the patient population • Tracks referrals provided to patients/families • Arranges or provides treatment for mental health and substance abuse disorders • Offers opportunities for health education programs (such as group classes and peer support) |

*2011 Standards

PCMH Model*: Standard 5: Track & Coordinate Care

| Elements | Factors |
|--|---|
| <p>Element A Test Tracking and Follow-Up</p> | <p>The practice has a documented process for and demonstrates that it:</p> <ul style="list-style-type: none"> • Tracks lab tests until results are available, flagging and following up on overdue results • Tracks imaging tests until results are available, flagging and following up on overdue results • Flags abnormal lab results, bringing them to the attention of the clinician • Flags abnormal imaging results, bringing them to the attention of the clinician • Notifies patients/families or normal and abnormal lab and imaging test results • Follows up with inpatient facilities on newborn hearing and blood-spot screening • Electronically communicates with labs to order tests and retrieve results • Electronically communicates with facilities to order tests and retrieve results • Electronically incorporates at least 40% of all clinical lab test results into structured fields in medical records • Electronically incorporates imaging test results into medical records |
| <p>Element B Referral Tracking and Follow-Up (must pass)</p> | <p>The practice coordinates referrals by:</p> <ul style="list-style-type: none"> • Giving the consultant or specialist the clinical reason for the referral and pertinent clinical information • Tracking the status of referrals, including required timing for receiving a specialist's report • Following up to obtain a specialist's report • Establishing and documenting agreements with specialists in the medical record if co-management is needed • Asking patients/families about self-referrals and requesting reports from clinicians • Demonstrating the capability for electronic exchange of key clinical information between clinicians • Providing an electronic summary of the care record to another provider for more than 50% of referrals |

*2011 Standards

PCMH Model*: Standard 5: Track & Coordinate Care

| Elements | Factors |
|---|--|
| <p>Element C Coordinate with Facilities and Manage Care Transitions</p> | <p>On its own or in conjunction with an external organization, the practice systemically:</p> <ul style="list-style-type: none"> • Demonstrates its process for identifying patients with a hospital admission and patients with an emergency department visit • Demonstrates its process for sharing clinical information with admitting hospitals and emergency departments • Demonstrates its process for consistently obtaining patient discharge summaries from the hospital and other facilities • Demonstrates its process for contacting patient/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit • Demonstrates its process for exchanging patient information with the hospital during a patient's hospitalization • Collaborates with the patient/family to develop a written care plan for patients transitioning from pediatric care to adult care, except for adult-only or family medicine practices • Demonstrates the capability for electronic exchange of key clinical information with facilities • Provides an electronic summary-of-care record to another care facility for more than 50% of transitions of care |

*2011 Standards

PCMH Model*: Standard 6: Measure & Improve Performance

| Elements | Factors |
|---|--|
| Element A Measure Performance | <p>The practice measures or receives data on the following:</p> <ul style="list-style-type: none"> • At least three preventive care measures • At least three chronic or acute care clinical measures • At least two utilization measures affecting health care costs • Performance data stratified for vulnerable populations (to assess disparities in care) |
| Element B Measure Patient/Family Experience | <p>The practice obtains feedback from patients/families on their experiences with the practice and their care. The practice:</p> <ul style="list-style-type: none"> • Conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories: <ul style="list-style-type: none"> • Access • Communication • Coordination • Whole-person care/self-management support • Uses the CAHPS patient centered Medical Home survey tool • Obtains feedback on the experiences of vulnerable patient groups • Obtains feedback from patients/families through qualitative means |
| Element C Implement Continuous Quality Improvement (must pass) | <p>The practice uses an ongoing quality improvement process to:</p> <ul style="list-style-type: none"> • Set goals and act to improve performance on at least three measures from Element A • Set goals and act to improve performance on at least one measure from Element B • Set goals and address at least one identified disparity in care or service for vulnerable populations • Involve patients/families in quality improvement teams or on the practice's advisory council |
| Element D Demonstrate Continuous Quality Improvement | <p>The practice demonstrates ongoing monitoring of the effectiveness of its improvement process by:</p> <ul style="list-style-type: none"> • Tracking results over time • Assessing the effect of its actions • Achieving improved performance on one measure • Achieving improved performance on a second measure |

*2011 Standards

PCMH Model*: Standard 6: Measure & Improve Performance

| Elements | Factors |
|--|---|
| Element E Report Performance | <p>The practice shares performance data from Element A and Element B:</p> <ul style="list-style-type: none"> • Within the practice, results by individual clinician • Within the practice, results across the practice • Outside the practice to patients or publicly, results across the practice or by clinician |
| Element F Report Data Externally | <p>The practice electronically reports:</p> <ul style="list-style-type: none"> • Ambulatory clinical quality measures to CMS or states • Ambulatory clinical quality measures to other external entities • Data to immunization registries or systems • Syndromic surveillance data to public health agencies |
| Element G Use Certified EHR Technology** | <p>To meet the federal Core and Menu Meaningful Use requirements:</p> <ul style="list-style-type: none"> • The practice uses an EHR system (or modules) that has been certified and issued a Certified HIT Products List Number(s) under the Office of the National Coordinator for Health Information Technology HIT certification program • The practice attests to conducting a security risk analysis of its EHR system (or modules) and implementing security updates as necessary and correcting identified security deficiencies |

*2011 Standards

**For Meaningful Use report only; not scored for PCMH Recognition decision

PCMH 2014

NCQA PCMH 2014 Standards

- Released March 2014
- Further integration of behavioral health
- Additional emphasis on team-based care
- Care management for high-need populations
- Encourage involvement of patients and families in practice management
- Alignment of Quality Improvement activities with the “triple aim” of improved quality, cost and experience of care
- Alignment with health information technology Meaningful Use Stage 2



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