Practice Transformation Best Practices for PCMH Recognition (Last Modified: March 1, 2024)

This document serves as a comprehensive guide for primary care practices seeking to transform to the patient-centered medical home (PCMH) care delivery model, with a focus on achieving PCMH Recognition through the National Committee for Quality Assurance (NCQA). Widely regarded as the gold standard in the field, NCQA provides a benchmark for excellence in implementing the PCMH Recognition program. At the core of this transformative approach are **key characteristics** of the PCMH model include:

- A strong emphasis on **team-based**, coordinated care, exemplified by integrated care team (ICT) meetings,
- Considers **care transitions** to reduce fragmentation and allow for a more seamless patient experience,
- Care gap identification to effectively manage chronic conditions, and enhance overall patient outcomes,
- Integration of the **quality improvement (QI) cycle** ensures a continuous, systematic approach to improving care processes, and
- A shift in paradigm from volume to **value**, through resource stewardship, integrated care, in alignment with NCQA's PCMH recognition which offers a number of benefits.

Note: Learn more about NCQA's PCMH Recognition program by visiting www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/.

How to Transform Your Practice into a PCMH

Begin your practice's transformation into a Patient-Centered Medical Home (PCMH) by obtaining the NCQA PCMH standards from NCQA.org. Analyze operational requirements against your current state and assign patients to specific care teams. Prioritize communication, fostering awareness and disseminating information for effective planning and seamless implementation. Engage your team in open dialogue to ensure alignment with PCMH principles, creating a collaborative atmosphere crucial for successful transformation.

Operational considerations.

- **Maturity of documented processes**, such as policies and procedures (P&P), flow of patient visit, referrals to specialists, communicate lab test results,
- **Reporting** and monitoring Execution and monitoring of P&P--- P&P drive reporting, and committees for other evidence such as meeting minutes
- Shifting organizational **culture** (Quigley et al., 2021) Leaders need to be on board to help drive internal buy-in for meaningful changes to care delivery (Quigley et al., 2021)
- **Maintenance of standards/evidence**. Data source refers to the type of documentation NCQA expects your practice to provide when it comes time for auditing a particular standard/element, such as a (1) documented process, (2) report, (3) material, (4) records or files, and (5) other.
- **Staff** to support necessary functions including:

  - CM, Continuity and coordination of care (CoC)
  - QI
  - Admin/project management (PM) functions
- Interoperability such as the logistics of data stratification
- Embrace QI model and practices and evidence-based to drive changes … ***s***

Leverage patient experience data during practice transformation for continuous improvement via QI program interventions and to help drive committees/councils (i.e. the Consumer Assessment of Healthcare Providers and Systems (CAHPS) PCMH survey) to improve things like focused QI efforts on patient communication, shared decision-making (SDM), and care coordination (Quigley et al., 2021).

Investment/costs. The expenses associated with obtaining NCQA PCMH recognition can vary significantly due to factors such as the size, structure, and existing infrastructure of the primary care practice. Moreover, the extent to which the practice already aligns with PCMH principles and potential resource limitations further contribute to the variability in costs. Therefore, a clear understanding of the necessary steps is crucial. While I lack real-time cost data, I can offer a general overview of key elements that contribute to the overall cost:

1. **NCQA Application Fees:** The fees charged by NCQA for the PCMH Recognition application process depend on the practice's size and type (Milliman White Paper, 2019).
2. **Labor/Staffing:** PCMH transformation often needs dedicated individuals to spearhead and coordinate. This may involve the recruitment or training of staff for roles such as a PCMH coordinator, data analysts, and care coordinators.
3. **Training and Education:** Staff will need to be trained on how the PCMH transformation works, new processes, team-based care, and principles of the PCMH model.
4. **Technology and Data Analytics:** Embracing health information technology (HIT) solutions and data analytics tools may be essential to facilitate care coordination, monitor quality metrics, and effectively manage patient populations.
5. **Quality Improvement (QI) Cycle:** The integration of a continuous QI program incurs costs related to data collection, analysis, and execution of interventions based on analysis of the collected data.
6. **Practice Redesign:** Physical and operational changes within the practice, such as creating designated spaces for team meetings or adjusting workflows to enhance care coordination, may result in additional costs.
7. **Patient Engagement:** Strategies to involve patients in their care and communication efforts may necessitate additional resources, such as patient education materials and outreach programs.
8. **Consulting Services:** Some practices may choose to enlist external consultants with expertise in PCMH transformation to guide them through the process. For instance, CAHPS PCMH/patient survey administration may cost approximately $23,000, contributing to the overall expenses (Quigley et al., 2021).

Practices should thoroughly assess their current state, evaluate specific requirements for PCMH recognition, and formulate a budget that considers both one-time and ongoing costs. Additionally,

exploring potential financial incentives or support programs at the local, state, or federal levels may help offset some of the transformation costs.

Resources for Practice Transformation Support

Leveraging available resources is vital during practice transformation into an NCQA-recognized PCMH model, as it optimizes alignment with the accrediting body, efficiency, facilitates smoother integration of patient-centered care principles and practices. Examples include but are not limited to:

- Boddenheimer 10 building blocks of high-performing primary care: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3948764/
- NCQA PCMH standards are available via https://store.ncqa.org/.
- Take Action Plans back to your clinic NPM, TL, CS to get approval on implementation
- Put your Action Plans on your Visual Management board
- Keep working on your Annual Report Requirements (same day access, etc.)
- Keep working on your QI Worksheets – set a completion due date
- Primary Care Team Guide Assessment created by the MacColl Center for Health Care Innovation
- The implementation tool from AHRQ: https://archive.ahrq.gov/ncepcr/tools/pcmh/implement/index.html
- The empanelment tools from the Safety Net Medical Home Initiative: https://www.safetynetmedicalhome.org/change-concepts/empanelment
- The primary care team guide: https://www.improvingprimarycare.org/
- IHI QI toolkit: https://www.ihi.org/resources/tools/quality-improvement-essentials-toolkit

FAQ

What is NCQA's PCMH distinction in Behavioral Health Integration about? NCQA offers a PCMH Distinction in Behavioral Health Integration, which recognizes primary care practices adept at seamlessly incorporating behavioral health services into their overall healthcare delivery. This distinction aims to applaud practices that transcend traditional models by integrating mental health and substance use services, fostering improved coordination and continuity of care. Key components of NCQA's PCMH Distinction in Behavioral Health Integration typically encompass the assessment of a practice's capability to proactively screen and [early] identify patients with behavioral health needs.

Additional Resources and Materials

PCMH Requirements and 2024 Updates https://www.ncqa.org/videos/pcmh-office-hours-2023-pcmh-requirements/

If your practice is seeking assistance with your PCMH application, you may find a NCQA PCMH Content Expert helpful, resources are listed here: https://cce.ncqa.org/#/

Quigley, D. D., Slaughter, M., Qureshi, N., Elliott, M. N., & Hays, R. D. (2021). Practices and changes associated with patient-centered medical home transformation. The American Journal of Managed Care, 27(9), 386-393. https://doi.org/10.37765/ajmc.2021.88740

Quigley, D. D., Qureshi, N., AlMasarweh, L., & Hays, R. D. (2021). Using CAHPS patient experience data for patient-centered medical home transformation. The American Journal of Managed Care, 27(9), e322-e329. https://doi.org/10.37765/ajmc.2021.88745

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