



NCQA'S PCMH RECOGNITION AS A FRAMEWORK FOR PRACTICE TRANSFORMATION

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Initiative

OBJECTIVES

- 1) Participants will learn how practice facilitators can use the NCQA framework to initiate and scale practice transformation efforts so that they are successful and sustainable.
- 2) Participants will learn how to adapt their approach to practice transformation based on the size of the participating practices, their resources and transformation efforts to date and their decision to pursue NCQA recognition.
- 3) Participants will be able to identify barriers to practice transformation and recognize solutions for engaging staff and providers

Brown Primary Care Transformation Initiative (BPCTI)

- Began in 2010 as part of a 5-year federally-funded grant
- Provide facilitation to primary care practices to become Patient Centered Medical Homes (PCMH).
- Contract with the RI DOH for PF services
- Contract with Care Transformation Collaborative (CTC-RI) to provide facilitation services to 30 practices a year.



CARE TRANSFORMATION COLLABORATIVE OF RI

- Convened in 2008 by the Office of the Health Insurance Commissioner (OHIC) and the Executive Office of Health and Human Services (EOHHS)
- Funded largely by the health insurance companies
- 650,000 Rhode Islanders receive their care from CTC-RI practices
- Practices join CTC for 3-4 years
- Practices receive PMPM in return for meeting deliverables, including PCMH recognition

NATIONAL COMMITTEE FOR QUALITY ASSURANCE: NCQA

- Founded in 1990
- Independent, non-profit
- Programs include Patient Centered Medical Home recognition
- Over 13,000 practice sites have NCQA PCMH Recognition
- Focus on measurement, standardization and organization
- Looks at care delivery, efficiency, patient satisfaction

NCQA: 6 CONCEPT AREAS

1. Team-Based Care and Practice Organization:
2. Knowing and Managing Your Patients:
3. Patient-Centered Access and Continuity:
4. Care Management and Support:
5. Care Coordination and Care Transitions:
6. Performance Measurement and Quality Improvement:

CAN YOU USE NCQA AS A FRAMEWORK FOR CHANGE?

Yes: BUT...

Providence Community Health Centers v.
Barrington Family Medicine

PROVIDENCE COMMUNITY HEALTH CENTER:

- FQHC
- 8 sites
- more than 50,000 patients
- about 200 providers
- hundreds of other staff (MA, RN)
- 94% of their patients at 200% or below of poverty line

- BARRINGTON FAMILY MEDICINE

- 1 200 patients
- 2 providers
- No support staff
- Primarily serves commercially insured patients

STARTING PLACES FOR BOTH PRACTICES:

- 1. Team-Based Care and Practice Organization:**
2. Knowing and Managing Your Patients:
3. Patient-Centered Access and Continuity:
- 4. Care Management and Support:**
5. Care Coordination and Care Transitions:
- 6. Performance Measurement and Quality Improvement:**

PHCH

Team based care and practice organization:

STRONG LEADER

- Huddles
- Team meetings
- Focus on PDSA at team meetings
- Started small with off site meetings
- Then full staff kick off for engagement and buy in

BFM

Also started with team based care

Hired NCM

- no need to get buy in from staff or senior management
- no need for structured team meetings or formal huddles

STARTING PLACES FOR BOTH PRACTICES:

- 1. Team-Based Care and Practice Organization:**
2. Knowing and Managing Your Patients:
3. Patient-Centered Access and Continuity:
- 4. Care Management and Support:**
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- 6. Performance Measurement and Quality Improvement:**

WAS IT SUCCESSFUL?

How do you define success?

Did they receive NCQA recognition?


Did they improve care delivery?

PROVIDENCE COMMUNITY HEALTH CENTERS

Revolutionized their practice:

- staff communication
- efficiency – preparing for visits
- awareness of clinical quality measures and improvement

Has taken a long time and haven't addressed all aspects (patient experience)



The communication within the team has evolved tremendously. I think the staff feel that they are much more accountable for speaking their mind and giving opinions for what they think will work.

- Millie Diaz, Front Desk Supervisor

BARRINGTON FAMILY MEDICINE:

Major improvements in:

- Population management
- QI efforts
- Care management
- “She is improving our quality of care and everything else feels like a hoop to get her.”
Lisa Denny, MD

Didn't really need to address many areas of NCQA, such as documenting access.

Huge investment of time and resources for a practice that already functioned quite well

BARRIERS TO SUCCESS OF PROJECT

- No champion
- Not enough buy-in
- Not enough resources: time, money, personnel

TIPS FOR SUCCESS:

- Must have a champion
- Don't just dive in.
- Have clear expectations about extent of project
- Get regular clinical and staff engagement