

**2017 National Committee on Quality Assurance
(NCQA) Patient Centered Medical Home (PCMH)
Redesign: Mapping changes from 2014 and 2011
Webinar #1: February 15, 2017**

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Welcome/Orientation

- Coaching Calls
 - Each clinic should have received a welcome email from its PCMH Coach with information on preparing for the first coaching session, including completing a self-assessment.
 - The first of six coaching calls will be in March. The clinic team, PCMH Coach and Public Health District (PHD) Statewide Healthcare Innovation Plan (SHIP) Quality Improvement (QI) Staff will find a mutually agreeable time for coaching calls.
- Site Visits will occur in April or May
- The Learning Collaborative will occur June 27-28 in Boise

Learning Objectives

- Review the key changes to the overall NCQA PCMH certification program starting April 2017
- Identify the emphasis in the 2017 PCMH redesign of moving from process to performance improvement
- Distinguish the key changes in the 2017 PCMH redesign from those of 2011 and 2014 PCMH Standards
- Understand the options and key dates for those previously certified under the 2011 and 2014 PCMH Standards, or considering application under the 2014 PCMH Standards
- Recognize how the 2017 redesigned program can help qualify for enhanced Medicare reimbursement under the new Medicare Access and CHIP Reauthorization Act (MACRA) of 2015's Merit Incentive Payment System (MIPS)

Discussion today is based on best available information released to date.

Full final details of the 2017 PCMH Program won't be available until NCQA officially launches the redesigned program April 3, 2017.

NCQA PCMH Recognition Program

- PCMH standards have been revised every three years to align with changes in the healthcare environment; last done in 2014
- In the past, practice recognition status lasted three years, after which the practice must renew their recognition under current NCQA standards

For 2017 PCMH recognition, however:

- NCQA is redesigning the overall structure of the program, as well as updating the requirements
- With the redesign, to be launched April 2017, there is ***ongoing, sustained recognition status*** with ***annual check-in*** and reporting instead of the 3-year cycle

Direction of PCMH Updates and Redesign: Move to Performance Improvement

- NCQA reached out to a variety of stakeholders for feedback as they updated and developed the 2017 PCMH redesign
- NCQA continues to raise the bar for practices to maintain their recognition to incent practices to continue their transformation
 - *Aim to align with industry standards:* Triple Aim, population health management, risk stratification in care management, integrated care across the health care/social service systems, care transitions and self-management support, movement toward a value-based model
- The 2017 PCMH Redesign responded to feedback that there needs to be less emphasis on process and paperwork, and more emphasis on performance

2017 PCMH Recognition Redesign Overview

- **Flexibility** – practices can take a path that suits their strengths, schedule and goals
- **Personalized Service** – increased interaction with NCQA; have a consistent point of contact
- **User-Friendly approach** – meaningful requirements, but simplified reporting and decreased paperwork
- **Continuous Improvement** – Moving to annual check-ins to help strengthen efforts and progress towards advanced medical homes
- **Alignment with changes in health care** – aligns with current public and private initiatives; adaptable to future changes

2017 PCMH Recognition Process has Three Parts

COMMIT

- Practice completes an online self-assessment
- Once ready to commit, practice works with assigned NCQA liaison to develop an evaluation plan and schedule

TRANSFORM

- Practice gradually initiated transformation efforts
- New online system to submit documentation and data
- Along the way, NCQA conducts virtual check-ins for immediate feedback towards recognition

SUCCEED

- Once recognized, practice continues transformation efforts
- Practice checks in with NCQA annually, with attestation to sustain recognition

2017 PCMH Program: Scoring and Recognition

- Eliminates Recognition Levels: no more Level 1, 2 or 3
 - Achieve recognition by meeting all core criteria and some of the credits of elective criteria
- Must complete all of the Core Criteria (40 credits)
- Elective/Additional Criteria: Need to achieve 25 credits
 - Two levels of optional activities; one level more advanced
 - Able to piece together any way wanted but at least touch each concept area
- Once recognized: annual check-in with NCQA
 - No more 3-year cycles once on the 2017 program
 - Virtual “check-in” by phone/web with data and documentation submission requirements using new on-line platform

2017 PCMH: Other Important Features

- Deliberatively been designed to align with MACRA's MIPS/Quality Payment Program (QPP)
 - The MIPS track includes a category: Clinical Practice Improvement Activities worth 15% of each provider's MIPS score
 - NCQA PCMH recognition (either 2014 or 2017) will automatically get the provider full credit for that category
- Whole person care: behavioral and oral health
 - Behavioral health credits integrated into the concepts and criteria with physical health, and starting to incorporate oral health connections
- Continued alliance with medical societies, boards and organizations:
 - Providers can get credit for PCMH recognition towards renewing board certifications, possibly some continuing medical education credits

2017 PCMH Annual Check-in Process

- New online platform for submitting data and documentations
- Preliminary annual reporting requirements available (free online)
- Practices must:
 - Complete a self-assessment, verifying core features of medical home
 - Must meet minimum number of requirements for each category
- NCQA will:
 - Review submission and notify of their sustained recognition status
 - Will randomly select practices for audit to validate attested documentation and data
- If don't submit on time or fail to meet other requirements, can have recognition suspended/revoked

If my clinic has never been certified, do I work on 2017, 2014 or 2011 PCMH recognition?

- Take a self-assessment to assess readiness
- If part of a group of practices, may want to align with the version your other clinics are doing, if able, to enhance synergy and support across your group
- However, it is **not** an option to apply for 2011 Standards
- Work towards the new 2017 approach to make future renewals easier and requires less paperwork than in the past

So the options for clinics not yet certified at all:

- Can apply under 2014 PCMH Standards, only if practice can meet the deadlines before September 2017

OR

- Apply under the 2017 PCMH redesigned program, starting April 2017

What happens when the new 2017 PCMH program launches for those already recognized under 2014?

- Practices that achieved 2014 PCMH Level 3 recognition can move directly to the annual reporting process when their current PCMH recognition expires
- Practices that achieved Level 1 or Level 2 under 2014 PCMH get credit towards the 2017 PCMH recognition, which can streamline their evaluation under the new program structure
- Three options for Level 1 and Level 2 (2014 recognized) practices
 - Submit an Add-on Survey to earn Level 3 under 2014 PCMH, and move to the new 2017 PCMH program when your current recognition period expires
 - Enroll under 2017 PCMH starting April 2017, but must have at least 6 months left on your recognition to get credit for where you are so far
 - Renew under 2014 PCMH Standards, if can meet deadlines, for another 3-year period, and move to the new 2017 PCMH at the end of that time (but must be Level 3 by then to move **directly** to annual reporting process)

What if my practice is currently still certified under 2011 PCMH Standards?

1) Move to the 2017 PCMH redesigned process

If active status under 2011 PCMH, enter at the “Transform” step (second phase) beginning in April 2017

TRANSFORM

- *Continue transformation*
- *New on-line system to submit documentation and data*
- *Along the way, NCQA conducts virtual check-ins for immediate feedback towards fulfilling recognition expectations*

OR

2) **Convert** to 2014 PCMH Standards –

- If are active as a Level 3 under 2011 PCMH, can convert to 2014 PCMH and get an additional year of recognition
- If are a Level 1 or 2, can do an add-on survey to achieve Level 3, and then convert; need to request and do before deadlines

OR

3) **Renew** under 2014 PCMH Standards, if practice is able to request and complete application before Sept. 30, 2017

Moving from 2011 to 2014 PCMH?

For clinics currently certified under 2011, and considering moving to 2014 PCMH

- Similar structure: 100 total possible points; same point thresholds; 6 standards; most elements and factors remained the same
- There were some new areas of focus for 2014 PCMH; restructuring of some standards, some new elements and factors, and a different allocation of points in the 2014 Standards
- Group coaching call from Cohort 1 has detailed comparison from 2011 to 2014 (posted as a handout for download during this webinar)

However, time is limited to use 2014 PCMH!

Renewing or Moving to 2014 PCMH: Don't forget the key deadlines!

Last Day to purchase PCMH 2014 survey licenses	March 31, 2017
Last day to request Add-On surveys (to increase to higher level)	June 30, 2017
Last Day to submit PCMH corporate survey	May 31, 2017
Last day to request Corporate Add-on Tools (to increase to higher level)	July 31, 2017
Last day to submit <u>all</u> PCMH 2014 Site Surveys	September 30, 2017

Recognition Criteria for Credit Under 2017 PCMH: What do I have to demonstrate?

NOTE: Official finalized 2017 PCMH to be rolled out April 3, 2017

- **OLD:** Standards, Elements, Factors
- **NEW:** Concepts, Competencies, Criteria

Demonstrate ongoing alignment with recognition requirements by submitting data and documentation on these critical elements:

- Patient Centered Access
- Team-based Care
- Population health management
- Care management
- Care Coordination and Care Transitions
- Performance Measurement and Quality Improvement

Will also have the opportunity to submit on special topics, such as behavioral health

2017 PCMH Concepts vs. 2014 and 2011 Standards

<u>2017</u> PCMH CONCEPTS	2014 PCMH Standards	2011 PCMH Standards
Patient-Centered Access & Continuity	Patient-Centered Access	Enhance Access & Continuity
Team-Based Care and Practice Organization	Team-Based Care	Plan and Manage Care
Knowing and Managing Your Patients	Population Health Management	Identify and Manage Patient Populations
Care Management and Support	Care Management Support	Provide Self-Care Support and Community Resources
Care Coordination and Care Transitions	Care Coordination and Care Transitions	Track and Coordinate Care
Performance Measurement and Quality Improvement	Performance Measurement & Quality Improvement	Measure and Improve Performance

So, do the specific things practices need to do for credit points really differ that much in 2017 from 2014 PCMH, when you look deeper at the redesign?

Answer: Not that much.

2017 PCMH core competencies and criteria are not that much different from the required 2014 PCMH elements and factors.



2017 PCMH Criteria vs. 2014 PCMH Elements

2017 PCMH CONCEPTS	Focus of 2017 Criteria	2014 Elements/Must Passes
Patient-Centered Access & Continuity	<ul style="list-style-type: none"> • Access to practice and clinical advice • Care Continuity • Empanelment 	<ul style="list-style-type: none"> • Patient-centered Appointment Access* • 24/7 access to clinical advice • Electronic Access
Team-Based Care and Practice Organization	<ul style="list-style-type: none"> • Practice Leadership • Care Team responsibilities • Orientation of patients/families/caregivers 	<ul style="list-style-type: none"> • Continuity • Medical Home responsibilities • Cultural & linguistic appropriate services • The Practice team*

2017 PCMH Criteria vs. 2014 PCMH Elements

2017 PCMH CONCEPTS	Focus of 2017 Criteria	2014 Elements/Must Passes
Knowing and Managing Your Patients	<ul style="list-style-type: none"> • Data collection • Medication reconciliation • Evidenced-based clinical decision support • Connection with community resources 	<ul style="list-style-type: none"> • Patient Information • Clinical data • Use data for population management* • Implement evidence-based decision-support • Comprehensive Health assessment
Care Management and Support	<ul style="list-style-type: none"> • Identifying Patients for Care Management • Person-Centered Care Plan Development 	<ul style="list-style-type: none"> • Identifying patients for Care Management • Care planning and self-care support* • Medication management • Electronic Prescribing

2017 PCMH Criteria vs. 2014 PCMH Elements

2017 PCMH CONCEPTS	Focus of 2017 Criteria	2014 Elements/Must Passes
Care Coordination and Care Transitions	<ul style="list-style-type: none"> • Management of lab/imaging results • Tracking and managing patient referrals • Care Transitions 	<ul style="list-style-type: none"> • Test tracking and follow-up • Referral tracking and follow-up* • Coordinate care transitions
Performance Measurement and Quality Improvement	<ul style="list-style-type: none"> • Collecting and analyzing performance data • Setting goals • Improving practice performance • Sharing practice performance data, emphasis on electronic 	<ul style="list-style-type: none"> • Measure clinical quality performance, resource use and care coordination • Implement & demonstrate continuous quality improvement* • Report performance • Use certified EHR technology

2017 Concept: Team-Based Care

- New Standard in 2014
- Development of a strong care team is a Core Criteria
- Additions for 2017 PCMH:
 - Practices must have a designated PCMH clinician leader
 - Practices **must** have identified skills and resources to support team member roles, ensure skills maintained
 - Adds training and assigning members of the team for care management as one of the 3 of 5 options to demonstrate
- Patients themselves continue to be a key part of the care team
- 2017 Additional/Elective credit if patients are part of the governance or advisory council to the practice



2017 Concept: Knowing and Managing Your Patients

Similar to 2014 Population Health Management Standards

Overall Aim of this Core Criteria:

- Helps practices to capture and analyze information about the patients and the community it serves
- Helps practices to deliver evidence-based care that supports population needs, including cultural and linguistically appropriate services

NEW:

- Adds expectations in 2017 to **identify and prioritize relevant community resources** based on social determinants of health and common conditions
- 2017 Additional/Elective points, if:
 - Offer support materials that are on-line
 - Provide oral health resources to patients



2017 Concept: Patient-Centered Access and Continuity

Access, focused on the patient, has always been a critical part of the PCMH model

The 2017 Core Criteria are essentially the same as in 2014 PCMH Standards, but:

- Adds requirement for **both** documented process and reports/examples on some criteria
- Adds additional criteria to **assess the access needs and preferences** of the overall patient population
- 2017 Additional/Elective points added for:
 - Evaluation of clinicians' panel size and demonstrate a systematic approach for ongoing monitoring and balancing of the panels
 - Evaluation of health disparities across the patient population
 - Evaluate social determinants to assess access for individual patients



2017 PCMH Concept: Care Management and Support

- Core Criteria very similar to the 2014 Standard but folds in options for credit for use of electronic exchange with external entities and registries
- Aim: Set criteria for and identify patients who would benefit most from care management, especially those at highest risk:
 - Social determinants of health
 - Behavioral health
 - High cost/utilization
 - Poorly controlled or complex conditions
- 2017 Additional/Elective criteria
 - Follow-up on community referrals to determine impact on individual patients
 - Moves to not just documenting process but also provide examples of materials/logs or other demonstrated follow-up



2017 PCMH Concept: Care Coordination & Care Transitions

- This was new in 2014 and remains as a Core Criteria in 2017 aimed at improving coordination of care:
 - Coordinate care with specialists: track referrals, flagging and following up on specialist's reports
 - Close, proactive follow-up with patients/families after a hospital admission or emergency department visit.
- 2017 PCMH adds:
 - **Must** provide both documented processes *and* evidence showing how the process is met (reports, logs, electronic tracking system, etc.)
- 2017 PCMH Additional/Elective Points
 - Enhanced care coordination system such as evidence-based guidelines to determine need for referrals, closer alliances with usual specialty referrals with common expectations for info sharing
 - Points for advanced efforts in behavioral health such as monitoring of depression patients and integration of behavioral health providers



2017 PCMH Concept: Performance Measurement and Quality Improvement

- Expands on 2014 more focused, sustained improvement requirements
- Continued focus on patient experience
- Building a culture of quality improvement in the practice
- 2017 Additional/Elective points for:
 - Assessing & improving health disparities using performance data
 - Practice obtains feedback from a patient/family advisory council



2017 PCMH: Quality Measures

- Lots of feedback to NCQA to align with other quality measurement programs when developing the 2017 PCMH Redesign
- Have aligned with other quality programs: Centers for Medicare and Medicaid (CMS), Meaningful Use, and National Quality Forum (NQF)
- Practices will have the option to submit electronic clinical quality measures to NCQA in support of their recognition process
- Areas of Metrics: acute care; behavioral health; chronic disease; overuse of resources; immunization; preventive care; administrative
- NCQA's PCMH Quality Measures Crosswalk with other quality measurement programs available at:
http://www.ncqa.org/portals/0/Programs/Recognition/PCMH/Quality_Measures_Crosswalk.pdf
- Even if renewing with 2014 PCMH, good to align with these quality measures in your quality improvement efforts

Resource Links

PCMH-A Assessment Tool: <http://www.safetynetmedicalhome.org/resources-tools/assessment>

Start to Finish PCMH recognition (Not yet updated for 2017):
<http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/pcmh-walkthrough>

NCQA 2017 PCMH Recognition Redesign Overview:
<http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/pcmh-redesign>

NCQA 2017 PCMH Recognition Redesign Annual Reporting (preliminary):
<http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/pcmh-redesign/annual-reporting>

NCQA PCMH 2011–PCMH 2014 Standards Crosswalk:
<http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHome/PCMH/PCMH2011PCMH2014Crosswalk.aspx>

NCQA PCMH 2014 Conversion vs. Streamlined Renewal Requirements:
<http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHome/PCMH/DuringEarnItPCMH/OtherPCMHResources/PCMH2014ConversionvsStreamlinedRenewalRequirements.aspx>

Multi-site Streamlined Renewal Requirements

- Multi-site organizations with practices that have achieved PCMH 2014 Level 2 or 3 Recognition are eligible to renew by completing the entire survey, but it is only necessary to attach documentation for a limited number of elements.
- Remember the Level 3 2014 PCMH sites can transition to 2017 PCMH and annual reporting, but not all of your sites may be at the same level yet.
- Multi-site organization should refer to requirements for [PCMH 2014 renewal](http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/during-earn-it-pcmh/other-pcmh-resources/pcmh-2014-multisite-renewal-table) (but remember the deadlines for 2014 PCMH) (<http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/during-earn-it-pcmh/other-pcmh-resources/pcmh-2014-multisite-renewal-table>).

Stay tuned for the full final details of the 2017 PCMH Program once NCQA officially launches the redesigned program April 3, 2017.

Questions

Please enter your question in the Questions Pane of your Webinar Control Panel

