2017 National Committee on Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) Redesign: Mapping Changes from 2014 and 2011

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Speaker/Moderator: Jeanene Smith

Notes

Jeanene Smith:

Hello, I welcome you to our first webinar for the second year of work with clinics in Idaho. Just wanted to take a minute before we get into our conversation about PCMH standards. Each of your clinics should receive a welcome email from your assigned PCMH coach with information on getting ready for the first coaching sessions, which we anticipate would start in March. There will be six of these. This will be a combo effort between the PCMH coaches and the Public Health District Statewide Healthcare Innovation Plan (SHIP) Quality Improvement (QI) Staff that most of you are familiar with already and will try to work out mutually agreeable times that work for your clinic teams and us. All the clinics will be getting site visits, we are hopeful all will occur in April or May. Then we will all be gathering in Boise in June for the in-person Learning Collaborative.

Today we are going to go through the new world of Patient Centered Medical Home (PCMH) National Committee for Quality Assurance (NCQA) certification program because there is some significant changes coming with the start of the 2017 program. Trying to understand what might be the best for you and your clinics with the concept of the new 2017 changes. One of the emphases is that it is just moving from a lot of process which NCQA had heard a lot of concerns about to more performance improvement. Helping understand some of the key changes that we are anticipating that the redesign will have as opposed to what has been there for both the 2011 and 2014 PCMH standards, especially those clinics that may be operating under those currently. There are some key dates that we will be reviewing in order to be able to continue using the 2014 standards. Understanding how both the 2017 and 2014 programs will allow you to get credit for the new payment system that is coming out under Medicare Access and CHIP Reauthorization Act (MACRA) and its Merit Incentive Payment System (MIPS), which recognizes - going for this recognition it gives some credit towards that. I do want to caveat that what we are talking about today is based on the best available information that we could locate at this time. The final versions of 2017 do not come to be available until April. We are anticipating they will roll everything out more formally April 3. This is the best we could gather from what we could find on their web sites and information we could glean from folks in the know. With that, I will get started.

The National Council has had the PCMH Recognition Program for many years. It gets revised, usually in the past it was redone every three years. The last revision was 2014. Usually, when you went for the recognition with the status once you got recognized, you were good for three years. Then you renew under whatever the next version of standards was coming out as. However, 2017 is a little more complex as they went back and redesigned the overall structure of the program as well as updating some of the requirements to achieve the recognition. One of the key features of what will be launched this year is an ongoing sustained recognition status with annual check-ins on an ongoing basis with some calculated changes to make it less onerous for the clinics.

In order to make these changes, as I said, the NCQA reached out and got a lot of feedback from participants in the previous versions of the Recognition Program and other stakeholders as they went about to design and develop this redesign. They continue to try to prep further. I know I come from Oregon and having worked with our development in our state around Patient Centered Primary Care Home standards when we first looked at NCQA many years ago, I think it was the 2008 version, we wanted to be a little more outcomes and performance based, so we had created our own. I think NCQA has continued to hear that and over time has really started to align with where the industry is going in terms of the triple aim, population health management, talking about risk stratification, care transition, supporting patients in their self-management, and sort of a value based model. They are kind of making it

a little more challenging yet always trying to improve. Now they are in many ways very similar to what we designed in Oregon, for sure. You get credit towards the Oregon standards if you succeed at that NCQA one. They really were trying to be responsive to feedback because there needs to be less emphasis on process and paperwork and more emphasis on performance.

This is sort of the key aspects of this new design that is starting up. There is a lot more flexibility for practice because you and I will go through this a little later in the slide to where that flexibility takes place. Really trying to fit the pathway that clinics can undertake based on their strengths, schedule, and their goals. There is increased interaction with NCQA through this new approach with a consistent point of contact with NCQA representatives through your journey and through those annual renewals. Trying to make it more user-friendly, as I said. People find reporting and having some ways to align with other changes going on across public and private payers and trying to use what you already have to do for Meaningful Use (MU) and the upcoming, currently just starting MACRA payments. Then really continuous improvement: a lot of clinics will get certified and then things slide a little in terms of maintaining some of those processes, so coaching a little along the way to keep you on track to continue to improve how you are delivering care.

The 2017, they actually changed the names and they really call it, it is not necessarily standards; their nomenclature has changed. There is basically three parts. You do a self-assessment not too dissimilar from what many of you have done already for your own clinics to get started in this new year of clinic work. Then you commit, get assigned an NCQA liaison to develop an evaluation plan and schedule and how you will achieve recognition. Then you work to gradually initiate those efforts and there is an online system that will go live to submit that documentation and then there are these virtual check-ins for immediate feedback towards recognition. As opposed to past years where you had to fill out a big application, send it in, and wait to hear back on it, trying to be a little more timely. Then once you are recognized, as you continue along your transformation efforts you will check in with NCQA annually with some required attestation annually to sustain that recognition.

The new program really eliminates that recognition level. Many clinics might be a level one and want to move to a level three and that is kind of going to the wayside in the 2017. If you are needing to meet a set of core criteria, and then there are some elective criteria that the long list of that you get to choose from. You have to meet 40 credits of the core curriculum and then at least 25 and there are different levels within those elective criteria and you can kind of piece together what might work best for you in your clinic. Then, as I said, no more three cycles; you would need to do an annual check-in if you do the 2017 route. Having more virtual check-ins, I found information related to about three check-ins through the course of time and making sure that the data was submitted using the new online platform that they are going to roll out.

As I said earlier, it has deliberately been designed to align with the MACRA/MIPS quality program. Fifteen percent of your MIPS score includes a category called Clinical Practice Improvement Activities and getting recognized under a 2014 or 2017 recognition will automatically get the provider full credit for that category, which is nice. There is a place more increasing push towards behavioral health integrated into the concepts and criteria along with the expectations around physical health and there is even some reference to doing some things around oral health. We are really trying to get to that whole person care. Then providers can get credit for PCMH recognition towards helping them renew their Board Certifications and their continuing Medical Education credits, which is good for your practices in terms of getting buy-in from providers in helping them fulfill their obligation.

As I said there is a new online platform, we have not seen it yet. It will be rolled out with the new stuff in April. There are some reporting requirements and I have a link at the end of the slide deck to what you would be expecting to have to report on an annual basis. It is not the final, final, but it gives you an idea of what you need to be doing as you consider what root you are going to go here. The self-assessment, we do not know exactly what that will look like if it will look similar to the PCMH-A, or will it be slightly different, so we will have to wait and see on that one. It kind of verifies those core features that you would expect and have been part of the PCMH standards over the years. Then, as I said, you would have to meet a minimum number of requirements under each category. Some of the details are not out exactly to tell you today, but we will continue to keep everyone informed as more information rolls out and try to summarize it and make it easy for you. Then NCQA reviews your submission as they have been doing

over the years with the three-year cycle. They will randomly select practices for audit and if you do not submit on time or fail to meet other requirements they could pull a recognition.

What if I am working in a clinic just started this Cohort 2 group but my clinic has never been recognized? What should I do? Should I work on 2017 knowing more and more details will come out by April or should I think about the past options of 2014 or 2011? Really doing your self-assessment helps assess how ready you are and where you might think your clinic should be. If you are a group of practices a lot of times it is easier with many sites, you might want to align with where your clinics are, if possible, to kind of enhance the synergy across the organization and support each other. However, if everyone else is 2011, you will not have an option to apply for 2011 standards; those are basically closed. Your goal should be, if you do choose to go to 2014 like the other clinics in your groups then you would want to continue to consider how to get to that new 2017 approach. It is going to make future renewals easier and require less paperwork than the past. Basically, there are two options left at this point with the 2011 off the table. You could apply under the 2014 PCMH standards. There are, I will have a slide later showing the deadlines. Everything has to be done, signed, sealed, and submitted by September this year if that is what you choose to do. Or you start to apply under the 2017 recognized program thinking that that is kind of going to be the way of the future, and I think if you are a group practice, you then bring the rest of your clinics along at a later point. If you are a solo practice then you might want to just go for 2017. We will talk about the differences as we go along here today.

What happens if I am currently recognized under 2014 and this new 2017 thing comes on? Anybody who is a practice that is at a level three recognition, which I do not think many of the clinics in this Cohort are at this point, but some of your parts of your group might be. You can move directly to the annual reporting process in the 2017 when your current PCMH recognition expires. Practices that are, at the moment, a level one or a level two under 2014 get credit towards the 2017 recognition, which could streamline you getting certified under 2017. That kind of leaves those of you that are already at 2014 status, level one or level two, you could boost yourself up to level three if you need to get that in by September and move into a 2017 when your current cycle expires. You can enroll under 2017, so maybe you are certified level one, level two 2014 and you are going to be expiring, you have at least six months left on your recognition, you could use some of that towards credit on the 2017. Or you could renew under your 2014 standard if you can get in under all the deadlines for another three-year period and then move to the new 2017. You cannot move directly unless you are a level three. It is a little complicated, but thinking through where your clinic is at, if you are part of a group practice where your other group practices are at and looking at the deadline and thinking this through.

What if I am a practice? I am not sure there are many of you, if you are at 2011 I laid out what your options are here. You can move to 2017 and start up. Some of the stuff you are doing under 2011 might get you there faster. You could convert to 2014 if you can meet all the deadlines and get in everything and the same would go for renewing. If you are 2011 and want to renew but at the 2014, if you can get it all in before the application closes September 30, some different options there for 2011. These slides will be up on the portal for access after this.

For clinics that might be or have looked at the older standards of 2011, is it a big jump to go to 2014? We did a whole webinar for first year of clinics and we will have that available on the portal as well. It is pretty similar, 2011 to 2014. There are six standards, most of the elements and factors remain the same, they restructured a few things and it was 100 total possible points. Any clinic out there in 2011 wondering should I just go to 2014 and I might be able to do that, remember there is a time limitation on that. If you are a clinic that has never done any PCMH at all, do you go straight to 2017? If you are a 2011, do you go 2014 and then 2017? Those are the kind of decisions that you and your clinic will need to be making.

Here are the key dates to pay attention to and they are rapidly coming since it is already, amazingly already, halfway through February. If you want to go down the 2014 route, either renewing or going for your first-time recognition you need to get the survey licenses assigned by the end of next month, March. If you are a level one or a level two of 2014 and you want to go up to a higher level, level three, so you can easily move to 2017, that date is June 30. If you are a part of a large group you will need to do the corporate survey, which streamlines for those groups the amount of documentation they have to submit across multiple clinics, that deadline is May 31. If you are already a one or two there and you want to

bump up, your deadline is July 31. The last day to get everything in is the end of September this year. These are the key dates to weigh your decision on which way you are going to go.

So I decide I am going to go for credit under 2017, what do I have to do? The terminology has changed. Instead of saying you have PCMH standards they now call them concepts and the elements have been transposed into competencies and the factors have been renamed. I cannot tell you why they changed the names, but I think they were trying to make them more suitable as they were restructuring the design. If you look underneath, it is really similar in terms of the elements of stuff you have to do. It is still focused on patient centeredness, especially around access, the team-based approach, looking across your populations, sort of risk assessments, and tailoring your care management and other efforts to that, care coordination, care transitions and then performance measurements. Then, as I said, there are some opportunities for those clinics that have progressed further with Behavioral Health Innovation (BHI) there is opportunity to get credit for that.

Here, I tried to lay out what is different and what is the same. In many ways, as I said, the concepts are very similar to the standards that have been around in both the 2011 and the 2014. The names may change but the essence is pretty much the same. I am going to walk through these in more detail.

Does the view as a practice, if you had in your mindset - I have been considering doing this, I have been looking at the 2014 ones for a while, I think we can pull this off - could I really do 2017? If you look deeper at the redesign, is the actual stuff I have to do that much different? Really it is not that much, at least as far as we can tell at this point. Again, qualifies the final - final is out in a couple of months. They are really not that much different from what you are required. It is just kind of how it is organized and some other sort of structural changes in the program moving from three years to one, etcetera.

If you go through the concepts and look, it is very similar to if I take patient centered access and continuity, the new term. It is still about access to practice and clinical advice; it is care continuity and empaneling the patients with providers. The 2014 had elements that they said were must pass and then some were not. In this case, what 2017 does is - say you need 40 points of the core criteria to get away from that must pass option; what 2017 does is says these are the core criteria which you basically must pass and then the other ones become elective or additive. I will show some more examples of that in a minute. Team-based care and practice organization is about leadership across the practice, care team responsibilities, and then getting your families and patients to be aware that this is different and this is a team that you can reach out to any members of the team. Not too dissimilar from the must pass that was in the 2014 element; very similar when you look side by side.

Again, here I just highlighted out again knowing and managing your patients; a lot of it is population management, evidence-based clinical decision support, connecting with community resources and it is not too dissimilar from the must pass of using data for population management. The same words evidence-based decision support and trying to get thinking about the patient in terms of the context of their community and their needs individually as well. Care management and support is very similar; it is care plans, identifying which patients really need care management resources put towards them, very similar to 2014.

Care coordination, care transition is very similar. A lot of tracking of referrals. Not something I know many of clinics I worked with last year were spending a lot of time on. That is still there in the 2017, so those efforts are tracking lab and imaging results. Performance measurement and quality improvement, collecting and looking at your data to help you improve setting some goals, improving practice performance. Very similar to 2014 elements especially the must pass that 2014 clinics have had to do.

I wanted to run through these again and it was based on looking at the proposed changes and highlighting that the 2017 approach is not that much dissimilar than the 2014. Team-based care for instance was a new standard in 2014 and the essence in the 2017, the core criteria is that you would develop a strong care team. The addition specificity is added to that in 2017; you must have a designated PCMH clinical leader. The essence of that is to make sure that the providers are engaged and it is not just something that the back office and the administration is doing but there is buy-in from providers and you have a clinician that can work with the clinic across the team and the various providers. The practices must, this is an addition for 2017, have identified skills and resources to help support the team member role so that the medical assistance, nurses, and providers all know what their roles are in the team and

dealing with the populations that they are focused on and doing some trainings. Making sure that is very explicit is the new thing for 2017. It adds some training and assigning members to the team for care management as one of the three of five options to demonstrate that. Patients still continue to be a key part of the key team as was seen in the past versions of PCMH. The elective or additional credits are an option if you want to do something under this particular concept; is that engaging patients is part of the governance or advisory council to the practice. This is very commonly done in Federally Qualified Health Centers (FQHCs) and Community Health Centers and it is a little less commonly done in private practices. It is something that some private practices are moving towards. It is an optional elective credit that you can choose to do.

Under the concept, knowing and managing your patients is very similar to the population health management requirements. It helps you capture the information and understand your practice and some of the needs of the practice. The new for 2017 has added some expectations to show that you have identified and prioritized relevant community resources based on the needs of your population. If you are serving a very low income population with not much access to oral health resources; that you really are understanding what those are and are readily, easily provided to the patient is one. They put oral health in here as an additional, on top of things. I think for the core competencies, things like understanding how to get access to food stamps and other things for the high need, low income population by understanding that the social determinants are really going to drive the ability of the patient and the family to stay healthy and manage their diseases.

This one, patient centered access and continuity, is very common across the many years of PCMH. It is essentially the same. The distinction is that you essentially have to write out your process of how you are going to document that you are addressing access but that you actually need to provide to NCQA that you practiced and is it working. Not just writing down policies and procedures, but did you actually have a report that you run or a means or methodology to see if you are really doing what you are saying you are supposed to be doing. The other key component for 2017 is to assess the needs and preferences of the patient population. I think we will need to look at what the final language is here and I think the coaching team will continue to look at this one to help the clinics understand what this one means. If you need to have more help with your population to make sure that they can get access this would be something that you need to identify here. In the elective points under this one is starting to look at your clinician's panel size, demonstrate a systemic approach to monitoring and balancing those panels, looking across the health disparities across the patient population and looking at the social determinants. Again, a common theme that we talked about in the last concept, this is the way they are sort of augmenting. These are elective for these latter three points but ones that you could choose to get 25 of those points that you are required to do.

Care management support very similar again to 2014. In this one they folded in some options for credit for using electronic exchange with any of your external entities and registries. There is criteria rules that you are setting, it helps you set criteria and identify patients that would most benefit from care management. I think this is not going to be that much different from what others have done under 2014. The additional bonus points, additional elective points so to speak were even tracking community referrals beyond just the specialists and following up on labs. If you are sending someone out for some community resources making sure that that is happening, that they are able to get there and any feedback back and forth. It is starting to connect you with the medical neighborhood. It is moving to not just documenting processes, but trying to demonstrate that you really are following up and monitoring how well you are doing in these areas.

Care coordination and care transition, very similar to past. This is the tracking of referrals, following up after hospital stays or Emergency Department (ED) visits. Again the main change here for 2017 is not just documenting how you are going to do it, but are you really doing it and showing evidence of that through reports, logs, electronic tracking systems, etcetera. There are some additional elective options so that you can tie your evidence-based guidelines to the need for a referral working closely. Some clinics do this, where they work very closely with a specialist, especially if you are going to send someone to a GI provider you are always going to send these things with your patient and they are always going to do this so you have these close relationships. Again, medical neighborhood here as well. Then there are some big opportunities here; you have integrated behavioral health in your clinical setting, how you are

monitoring your more severely depressed patients and integration of your behavioral health providers? This is one to watch for those clinics that have that already in place, for sure.

We are just about through. In this one, again performance measurement and quality expands on the continuous quality improvement requirements that were in the past versions of 2014. It really tries to build a culture of quality improvement across the teams and the practice. There is some additional elective points under this one regarding tracking health disparities, which is one we are challenging to document. That is why it is elective. Then how you are getting feedback back and forth if you instituted a patient or family advisory council? Doing quality improvement with your input process.

As far as the quality measures, there was a lot of feedback to NCQA before this redesign that they needed to align with other quality measurement programs so they have purposefully aligned with the Centers for Medicaid and Medicare (CMS) meaningful use (MU) and National Quality Forum (NQF). The practices will have the option to submit these electronic in support of their recognition process. The areas are very similar to the past. Acute care, behavioral health, chronic disease, monitoring resources, immunizations - and then there are some administrative metrics. There is a PCMH quality measures crosswalk with these other programs that is available online. You might want to take a look at these. Even if you are going to go down the route of 2014. Knowing that 2017 is out there you probably want to make sure that you align your quality measures that you might want to focus on to the ones that you eventually need to be continuing monitoring in this. Something to think about is that the ones you chose are things that you would anticipate you need to do anyways if you are doing them under 2017 looking towards the future or if you are trying to decide what your next ones were going to be.

This is a lot of length but I thought they were useful. I think most of you are very familiar with the PCMH assessment tool. I would guess that it would be somewhat similar to what 2017 will be picking, but we will have to wait and see. For those that are totally new to PCMH there is the start to finish PCMH recognition process. When I last looked at it last week they had not yet updated it for the 2017 steps, but it does help you for those going 2014. That will probably be updated by April. There is a nice overview, pretty much tried to summarize it in the slides about the redesign. The preliminary, what you anticipate you will have to do for annual reporting. There is a crosswalk between the 2011 and 2014 standards for those clinics that may be more familiar with 2011 and want to go 2014 .I am anticipating there will be a more formal one of these with the 2017 concepts eventually. For those that want to decide whether to convert versus streamline your renewal requirements, you may want to take a look at the last one on that page.

For multi-site groups, they are pretty familiar - I am sure most of them are. This kind of lays out what we know so far about streamlining your renewal requirements as a large group. If you get all of your clinics to level three, you can transition fairly smoothly into 2017. You can get credit, as I mentioned before, as you move into 2017, but there is some more details there over what you have to submit. These will be updated as well as we get the final 2017 requirements in April. The essence is that we really want to stay tuned for those full final details of 2017, but I tried to pull out here across all the slide sets the sort of decision points that you, as a clinic, will need to decide on where you are going to be headed. There is certainly a lot of similarities over what you actually have to do. It is just how it gets reported, how frequently it gets reported, in many ways, it is the key differences between 2017 and 2014.

They can enter a question at this point, right?

Laurence Brown:

At this time, if you do have a question, go ahead and enter that into the question pane on your control panel. You can also use the raise-your-hand feature to do so. If you want to access copies of today's slides you can do so in the handout section of your control panel. It does not look like any questions have come in at this time.

Jeanene Smith:

It is all clear as mud, I am sure. I think it is important to think through where your clinic is at in terms of, will I do the 2014 or the 2017 knowing that you have a pre-compressed time zone for the 2014. Ideally, the 2017 should be less paperwork and burden with the tradeoff of having to check in every year but having close contact with NCQA throughout.

Kym Schreiber:

Jeanene, I think you did a great job. As we start Cohort 2 and working with your clinics and coaches working together to really sit down and assess the many, multiple options that are available to the clinics there might be more questions down the road and throughout the year. This is a great first step. I really appreciate your time gathering all of this info.

Jeanene Smith:

The coaches will be able to help individually answer questions as they start to work with you all. If we need to run down answers to your questions, we will; so your resources will really be your SHIP QI coordinator and your PCMH coach will be there to help you make your decisions over which direction you will be going.

Kym Schreiber:

I forgot to include this before. The Department of Health and Welfare (IDHW) and SHIP is a partner in quality with NCQA. We have a sponsorship code that will help clinics with the cost of that application fee. I will be sure to get that information to the coaches and all of our clinics soon so that they have that access and can provide that when they do their applications, if they choose to do NCQA.

Jeanene Smith:

That is true. There are some clinics that will not be choosing to go this route. I think the pricing structure for 2017 was not yet available when I looked.

Kym Schreiber:

With that, we will conclude this webinar today. Look forward to meeting many of you in person as we start the coaching and in June at the learning collaborative. There will be another webinar upcoming, the March one.

Laurence Brown:

The March 29 Group Coaching Call.

Kym Schreiber:

Thank you, and I hope everyone has a good rest of the day.