2017 National Committee on Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) Standards:

Moving From Process To Performance Improvement

Webinar #1: February 21, 2018

Jeanene Smith MD, MPH

PCMH Coach

Statewide Healthcare Innovation Plan

PCMH TRANSFORMATION TEAM

Today's webinar is one of six educational webinars over the SHIP Cohort Year 3

Date	Topic
February 21, 2018 (Today)	2017 National Committee on Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) Standards: Moving from Process to Performance Improvement
April 18, 2018	Change Management
July 18, 2018	Care Transitions and Coordination Follow-Up
September 19, 2018	Oral Health Strategies
November 28, 2018	The Relationship-Centered Medical Home: Building Relationships to Build a Better Home
January 16, 2019	Medicare Access and Childrens Health Insurance Plan (CHIP) Reauthorization Act of 2015 (MACRA) and Value-Based Care

Today's Learning Objectives

- Review the key changes to the overall NCQA PCMH certification program in 2017 and the emphasis of moving from process to performance improvement
- Identify the first steps to take in order to be recognized under the 2017 program.
- An appreciation of the specific 2017 Standard's Concepts, Competencies and Criteria, including the key changes from those of previous year's PCMH Standards (2011 & 2014)
- Recognize how the 2017 redesigned PCMH program can help qualify for enhanced Medicare reimbursement under the new MACRA of 2015's Merit Incentive Payment System (MIPS)

Poll Question #1:

Which recognition program will your clinic be working on during SHIP Cohort Year 3?

- Not currently recognized, will be doing 2017 NCQA
- Previously recognized under 2011 or 2014, moving to 2017 NCQA
- Looking at working on another recognition program other than NCQA (such as Oregon's Patient-Centered Primary Care Home Program [PCPCH], Joint Commission, others)

Oregon PCPCH Standards & NCQA's 2017 Standards

Oregon's Patient Centered Primary Care Home Program:

http://www.oregon.gov/oha/hpa/csi-pcpch/pages/index.aspx

- There are areas of similarity between Oregon's and NCQA's Standards.
- The Oregon Health Authority will recognize Patient Centered Medical Home sites at the level that the NCQA has recognized the site, with submission of additional information.
- Contact PCPCH program staff to discuss your options at PCPCH@state.or.us.; they have a crosswalk comparing Oregon's PCPCH and NCQA Standards

NCQA PCMH Recognition Program - Major Changes in 2017

- 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:

- They redesigned the overall structure of the program as well as updating the requirements.
- Now there is ***ongoing, sustained recognition status*** with ***annual check-in*** and reporting instead of the 3-year cycle.
- No more updates every 3 years; NCQA will do small adjustments annually.

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

Participating in SHIP helps with NCQA scoring and costs

- Idaho's SHIP is a Partner in Quality (PIQ) with NCQA
- Participating SHIP clinics can:
  - Receive a 20% discount on their NCQA application fees with the state's PIQ code.
  - Earn a point in their NCQA application because SHIP is a federal State Innovation Model (SIM) initiative.
  - Earn points on their NCQA application by participating in the patient engagement interviews with the SHIP State Evaluation Team.

2017 Recognition Process: Three Parts

1- COMMIT

- Practice completes an on-line questionnaire (http://pcmhquestionnaire.ncqa.org/)
- Sign up to use the new NCQA Q-PASS on-line system
- Once ready to commit, practice works with assigned NCQA liaison to develop an evaluation plan and schedule.

2 - TRANSFORM

- NCQA conducts 3 virtual check-ins with the practice for immediate feedback towards recognition.
- Use the Q-PASS on-line system to submit documentation and data along the way.

3 - SUCCEED

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

What if my practice previously certified under 2011 or 2014 PCMH Standards?

Move to the 2017 PCMH redesigned process

You can't renew under the older 2011 or 2014 Standards

If still have active status under 2011 or 2014 PCMH, enter at the "Transform" step (second phase)

TRANSFORM

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

Annual renewal for 2017 PCMH: Check-in Process

- Annual reporting requirements available on line (free to access)
- Practices must:
  - Complete a self-assessment, verifying core features of medical home
  - Must meet minimum number of requirements for each category
  - Continue to use the Q-Pass platform for submitting data and documentation
- 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

2017 PCMH Recognition Redesign Overview

Poll Question #2:

How many of you have downloaded and/or reviewed the 2017 PCMH Standards already?

- Yes
- No

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

- **OLD NCQA Standards**: Standards, Elements, Factors
- **NEW 2017 Standards** : Overall called the "2017 Standards" with 6 Concepts, and associated Competencies and Criteria under each Concept

Concepts are the foundation on which a practice builds a medical home.

- ***Competencies*** organize the criteria in each concept area
  - ***Criteria*** are the individual structures, functions and activities that indicate the practice is operating a medical home
    - **CORE**= must pass criteria

      and

    - **CREDIT**= Elective options; some worth 1 points; others worth 2 points

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 Competencies and Criteria Overview by Concept

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2017 Concept:
Team-Based Care and Practice Organization (TC)

This was new in 2014: PCMH Standard 2

Competencies

- Commitment to PCMH, with care team member roles specified, and each equipped with knowledge and training needed towards the new model.
    - **Practices must have a designated PCMH clinician leader *and* a lead staff to manage activities.**
- Communication among staff is organized to ensure care is coordinated, safe and effective.
- Communication with patient to engage them on expectations and their role in the model of care.
- Patients themselves continue to be a key part of the care team.

2017 Concept: Team-Based Care and Practice Organization (TC) *(continued)*

Elective credit points include:

- Patients/families/caregivers are part of the governance or advisory council to the practice.
- At least one care manager qualified to identify and coordinate behavioral health needs.

Team-Based Care and Practice Organization: Competency C

The practice communicates and engages patients on expectations and their role in the medical home model of care.

TC 09 (Core): Has a process for informing patients/families/caregivers about the role of the medical home and provides patients/families/caregivers materials that contain the information.

GUIDANCE	EVIDENCE
The documented process includes providing patients/families/caregivers with information about the role and responsibilities of the medical home. The practice is encouraged to provide the information in multiple formats, to accommodate patient preference and language needs. The information that the practice provides should at minimum include information on after-hours access, practice scope of services, evidence-based care, availability of education and self-management support and practice points of contact. As a medical home, the practice helps patients understand the importance of having comprehensive information about all their healthcare activity and how and where to access the care they need coordinated by their personal clinician and care team.	**Documented process** ***AND*** **Evidence of implementation**

2017 Concept:
Knowing and Managing Your Patients (KM)

This is similar to 2014 Standard 3 – Population Health

Competencies:

- Collect and analyze information to understand background and health risks of patient (Adds social functioning and social determinants)
- Understand the unique characteristics and language needs of its patient population; ensure linguistic and other needs are met.
- Proactively address the care needs of the patient population.
- Establish procedures for Medication Safety: processes for documentation, reconciliation, and assessment of barriers.

2017 Concept:
Knowing and Managing Your Patients (KM) *(continued)*

Competencies continued:

- Create evidence-based decision guidelines to ensure effective and efficient care is provided.

- Adds expectations to identify and prioritize relevant community resources based on information on the population served by the practice

Elective credit points include:

- Review controlled substance database before prescribing.
- Use prescription drug data to assess and address medication adherence.
- Offer support materials that are on-line.
- Provide oral health resources to patients.

2017 Concept: Patient-Centered Access and Continuity (AC)

Similar to 2014 PCMH Standard 1.

Access has always been a critical part of the PCMH model.

Competencies:

- Enhance access by providing appointments and clinical advice based on patient's needs.
- Support continuity through empanelment and systematic access to the patient's medical record.

Adds additional core criteria to **assess the access needs and preferences** of the overall patient population.

2017 Concept: Patient-Centered Access and Continuity (AC) *(continued)*

Elective credit points include:

- 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.
- Evaluation of social determinants to assess access for individual patients.

2017 PCMH Concept: Care Management and Support (CM)

Core Criteria very similar to the 2014 PCMH Standard 4

Competencies:

- Systematically sets criteria and identifies patients who would benefit most from care management, with at least 3 from the following high risk groups:
  - Behavioral health
  - High cost/utilization
  - Poorly controlled or complex conditions
  - Social determinants of health
  - Referrals by outside organizations
- Demonstrate the use of data and collaboration with patient/family/caregiver to deliver person-centered care plans

2017 PCMH Concept: Care Management and Support (CM) *(continued)*

Elective credits points include:

- Include a self-management plan in individual care plans.
- Integrate care plan and ensure it is accessible across settings of care.
- (NEW) Apply comprehensive risk-stratification process to entire patient panel in order to identify and direct resources appropriately.

2017 PCMH Concept: Care Coordination and Care Transitions (CC)

This was new in 2014, remains in 2017 aimed at improving coordination of care:

Competencies:

- Tracks and manages lab and imaging tests; informs patients of results systematically.
- Coordinate care with specialists, track referrals until reports received.
- Connects with other facilities to support patient safety through care transitions; receives and shares information to coordinate comprehensive care.

2017 PCMH Concept: Care Coordination and Care Transitions (CC) *(Continued)*

Elective credit points include:

- Enhanced care coordination system such as evidence-based guidelines to determine need for referrals; closer alliances with usual specialty referrals with common expectations for information 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 (QI)

Expands on 2014's Standard 6 with continued focus on measuring patient experience and building a culture of quality improvement in the practice.

Competencies:

- Measure to assess current performance and identify areas to improve, including patient experience.
- Compare performance to goals and use the results to focus and implement changes.
- Accountable for performance: shares data with practice, patients.

2017 PCMH Concept: Performance Measurement and Quality Improvement (QI) *(continued)*

Elective credit points include:

- Assessing and improving health disparities using performance data or/and achieves performance in disparity measure.
- Reports results publicly; reports clinical quality measures to Medicare or Medicaid.
- Obtains feedback on experience of vulnerable patient groups.
- Engaged in a Value-Based Contract with a payer.

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 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

Questions

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

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RESOURCES

Resource Links for 2017 Recognition

NCQA PCMH Main page: http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh

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

NCQA PCMH Recognition: Getting Started:
http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/getting-recognized/get-started

Toolkit for 2017: Free Download; Includes Details on Concepts and Scoring
http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/toolkit

PCMH Recognition Process: Step-wise Overview of What to Expect:
http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/getting-recognized/get-started/process-becoming-a-pcmh

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

2017 PCMH Quality Measures

- Have aligned with other quality programs: Center for Medicare and Medicaid (CMS), Meaningful Use (MU), 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/QualityMeasures_Crosswalk.pdf

PCMH Portal – Portal User Guides & YouTube Videos!

Portal User Guides

- ✓ *Cohort 3 Clinics*
- ✓ *Cohort 1 & 2 Clinics*

YouTube Videos

Video walk-throughs of PCMH Portal sections

PCMH Portal User Guides and You Tube videos support efficient and effective PCMH Portal use.

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PCMH Portal – Toolkits Are Now Posted!

Toolkits

- ✓ New Clinic Onboarding
- ✓ Onboarding New Employees
- ✓ Mentoring Toolkit *(Coming soon… in development)*

Three new PCMH Toolkits help provide supportive information when starting, progressing through, and sustaining PCMH Transformation.