State Healthcare Innovation Plan (SHIP), Patient Centered Medical Home (PCMH): 2017 National Committee On Quality Assurance (NCQA) PCMH Standards: Moving From Process To Performance Improvement

Cohort 3: Webinar #1 Notes

February 21, 2018

Jeanene Smith: Good afternoon to everyone, and welcome to the start of the new year of clinic involved State Healthcare Innovation Plan (SHIP).

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

This is the first of six educational webinars that will be offered this year. We are going to focus on the National Committee on Quality Assurance (NCQA), the specific Patient Centered Medical Home Standards, and where they are today in the 2017 version.

Today's Learning Objectives

The next one will be in April, in Change Management. July 18 will be Care Transitions and Coordination Follow Up. In September one of my colleagues will be doing Oral Health Strategies. November 28, the relationships or the challenges and importance of it to really be successful in a medical home. Then we will go and outline some of the first steps. Some of you have already started to look at these, but we will make sure everyone is on the same page about them and walk through each of the standards, noting some of the key changes, for those of you who may have had 2011 or 2014 version of these. Then how the NCQA gets you ready for other value based payments, beyond things in your own state with your Medicaid program, but also with Medicare, on the federal level.

Poll Question #1:

First we are going to start off with a question for you all. We will have you answer on online. There it is. I wanted to get a feel for will your clinic be working on a recognition program, and which one? Are you not currently recognized and will be doing the 2017 this year? You are recognized under 2011 or 2014? Are moving towards 2017? Or you are looking at another recognition program?

I am from Oregon, and I know that many of the clinics on your western border often look to our Oregon Patient Centered Home Standards, and some of your other clinics often will look at other recognition programs specific to their particular program. Please go ahead and register your vote. Looks like the majority of you are not recognized and will be doing the 2017. Then there are a quarter of you that are moving transitioning. Then there is a few of you doing something else.

Oregon PCPCH Standards & NCQA's 2017 Standards

Since there are only three percent of you, we do have information in the slide deck.

NCQA PCMH Recognition Program - Major Changes in 2017

You did this huge application every three years. Then you were registered as a certain tier level. They changed all that last year. They mostly redesigned the structure of the program and not as much changed particularly around each of the standards. There is now an ongoing sustained recognition status is how they describe it, with an annual check in. If you get recognized during this year, then every year you will be updating your application and renewing things on an annual basis.

They will continue to tweak or adjust the standards, gradually, but not if they have a big overhaul every three years like they have had in the past.

2017 PCMH Recognition Redesign Overview

The focus was to try and be a little more flexible, so that you could take your path slowly. It is a little more personalized. You have calls directly with NCQA and there is usually about three of them to gradually get some of your standards done on one call, and then to another one, little bit later, and then a third as you are uploading your information.

They have tried to simplify the reporting and decrease the paperwork, which has always been somewhat of an issue with NCQA, but the direction has been steadily moving to less process and more outcome. The regular annual checkups, trying to keep everyone, including the clinics, focused on the models, and as an opportunity for continually improve your models. Try to think about expectations that might be facing you and your providers in terms of value based payment expectations. Next slide.

Participating in SHIP helps with NCQA scoring and costs

The State Health Innovation Project (SHIP) is a partner in quality with the NCQA. You get a discount, which is great, on the NCQA application fees using the state's code, the SHIP Quality Improvement (QI) folks and staff can make sure you get access to. You earn a point in the application because you are working under SHIP, which the state has received a large federal grant these last three years, and that allows you to get a point in your application. You can earn additional points on your application by participating in the patient engagement interviews with the team that is evaluating the overall efforts of Idaho, the SHIP State Evaluation Team.

2017 Recognition Process: Three Parts

There is three parts. You decide you are going to do this. The practice completes an online questionnaire in the commit stage. You sign up to use the new electronic system to upload your information. Then, you get assigned an NCQA liaison to help you work out your plan of action and get you those three calls scheduled. They also have some suggestions on what you might want to do at each of those calls, with a real focus on some of the core standard expectations, and then moving on to more the elective ones that are a little more challenging to accomplish or demonstrate.

While you are transforming magically to your new model, you are going to be having those three virtual check-ins, with some immediate feedback on how you are doing. There is an expectation you would upload ahead of those so that the reviewer could look at some of that information ahead of time, before the call. You are constantly submitting things up through that system. Then once you are recognized, you continue on your journey, and you would have the annual check-ins with some additional attestation to sustain that recognition.

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

For 25 percent of you that have had 2011 or 2014, there is not an option to renew under those anymore. There was last year, but there is not anymore. If you are still active, you enter at that transform step and you get some of the things you have done for 2011 or 2014 will automatically qualify you for many of the standards in 2017. As we go through these, you will see that there is some twists and turns, and we will go through what some of those are.

Annual renewal for 2017 PCMH: Check-in Process

For those of you who were wondering, what do I have to do every year once I get recognized? There is free access to a listing of what you will have to annually report on, so it is good to have that in your head as you are doing it the first time, to know what you are going to have to continually be doing to keep and maintain your status.

Renewals are not free however. You will have to pay again, but the reporting requirements are free. You would again do a self-assessment. You would try and meet all the requirements, and then you would continue to use the Quality Performance Assessment Support System (Q-Pass). Then NCQA reviews the submissions and notifies you of the sustained recognition status. They will randomly select practices for auditing, just to ensure that what you attest to is true, and that does have some consequences if not.

2017 PCMH Recognition Redesign Overview

Another quiz question for you guys. How many of you have downloaded or reviewed the 2017 PCMH standards already? We will do this fairly quickly. Well, looks like we are sort of leaning towards about a third of you have not yet, but two thirds of you have. I want to put up the results, so those are available. Those are free on the web site. I will point out there is a listing of links at the end of the slide deck, and I will point out which one you need to go to, to get those, but they are available for you to review and read through.

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

While they were restructuring things last year in the new 2017, they talked about a standard, and then underneath a standard was an element, and then underneath each of the elements, there were factors. Now they are called, the 2017 standards, and there are six concepts, key expectations, of meeting those standards to prove that you have associated competencies and criteria under each concept. The concepts are the foundation on which a practice builds a medical home. The competencies organize your way of showing that you are doing it.

The criteria are the individual structures, functions, and activities. Of the criteria, there are two kinds. There is the core, the ones you absolutely have to do to be considered a patient-centered home. If you are new to this, that you really want to look at, and see how you can meet those. There are credits sprinkled throughout each of the key concept areas, and some are worth one point, some are worth two points.

The ones that are worth more are the ones that are probably a little more challenging, especially if you are new to the model. We will go through these a little bit. That is part of your time with your coaching.

2017 PCMH Program: Scoring and Recognition

Must be [0:16:00] meeting all the core criteria, and there is an expectation of the number of elective credits. You have to have at least the 40 credits for the core, and then you have to get at least 25 of the elective. As I said, some are worth one, some are worth two, and they want to make sure you are doing electives inside at least five of the six areas. You cannot just do all your electives in one area, or two areas. You sprinkle your electives across. Then, as I said, you would have the annual check-in to maintain that and demonstrate that going forward.

2017 Competencies and Criteria Overview by Concept

As we go through and look at each of the competencies and the criteria, by the concept. I am not going to go into super low detail at this point, but try to give you some sort of high level overview of what those six concept areas contain.

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

The essence of the patient centered home is to be team based, and that the organization is behind this. This was new in 2014. Any of you are 2011, might not have quite seen this in its full force as it is today.

One of the key core criteria is the practices must have a designated PCMH clinician leader, and a lead staff, to manage activities. It cannot just be run by your office manager to do this. You have to engage the providers, and cannot just totally be run by the providers. It has to be engaging your office staff as well. You will have to identify. You are being asked to talk about the different care team. Who is the team? What are their roles? Are you training around those roles?

Some clinics even recruit based on the needs they need for their team, such as the care manager, but what is the role of the medical assistants, what is the role of if you have front desk engaged, if you have a pharmacist, for instance, or a behavioral health specialist? They just want to see evidence you are organized. You are having some regular meetings to talk about the model, and how you are doing on it. Then how are you engaging the patient? Does the patient know, or their family, that you are a patient centered home? To ensure that they understand what that means and how that might be different, which is a great marketing tool.

I have seen examples of where a health plan might give a lower copay for you if you are a patient centered. They are going to want to go to those patient centered homes to a lower copay. It is patient centered team based care, so some of the points in this concept are related to patients themselves continuing to be a key part of the care team.

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

The elective points there are a little more of a leap, and certainly private practices are not as used to having the patients, their families or caregivers be an advisory group, but our federally qualified health centers and community health centers are very used to that. We are starting to see this happen both private and community health centers, where they are really engaging those patients and their families to review their information about how they share information with patients.

Another elective in this one is if you have a care manager that identifies and coordinates behavioral health needs. There is a strong emphasis of the integration of care, particularly medical and behavioral health, which is mental health and substance abuse. There are some actual points you can get along the way, if you have oral health to be integrated closely with your practice.

Team-Based Care and Practice Organization: Competency C

This is just an example of what you are going to see in those standards when you download it. They give you guidance. This is TC 09, meaning it is the team-based care, it is the ninth of the core areas. You will see that over on the right-hand side. You not only have to document, you have a process, so giving information about the medical home, you could say our policy is that every new patient in the patient package has a description that we are a patient centered home, and what this means to them.

Then you also need evidence that you are implementing it. You need to somehow show you have given those out. You could also have a question on a patient satisfaction survey. “Do you know if this is a patient centered home?” There is different ways to get that evidence of implementation. Those of you that did 2011 and 2014, the difference is not just to document a process or show a policy. You have to show that you are doing the policy. You will see this scene throughout all of the 2017 standards.

2017 Concept: Knowing and Managing Your Patients (KM)

The second concept is called knowing and managing your patients. This is similar to those of you who have done 2011 and 2014. Thinking about population health, you are trying to think about everybody that comes overall that you are caring for. Traditionally, in practices, we often only think about the patient in front of us. This is really thinking about your whole practice, and starting to anticipate their needs. For the competencies here you are going to have to demonstrate you are collecting and analyze information to understand background and health risks of patients, commonly done through a health risk assessment, or via your electronic health record.

Understanding their characteristics and language needs of the patient population. In our charts, electronically, we know which language to anticipate. There are [0:23:24] different approaches you can do to know and manage your patients. We are going to design a care management program around our diabetics and hypertensives who have hemoglobin A1Cs over nine, or something like that. You know that because you have looked across your population. You are trying to proactively address their care needs, rather than waiting until they show up and you see that one patient after another with a hemoglobin A1C over nine and none of them are getting their screenings. If you set up a care management program for them, then you are addressing them as a population of diabetics and procedures for medication safety.

Processes for documenting, reconciliation, and assessment of barriers. I know some of the community health clinics including the one I work in, we often have the Doctor of Pharmacy (Pharm D) go through our charts and do some reconciliation, especially if they are coming out of the hospital. There are other processes that smaller clinics can also do to make sure that there is medication safety. Sometimes there are some automatic features in your electronic health record as well.

You are thinking about your population, how are all your patients on Coumadin. How are you managing them? How are you managing all everybody as they get out of the hospital? So you are thinking about them not as Mrs. Jones and Mr. Smith individually, you are thinking about all the Mrs. Jones and Mr. Smiths with this particular issue or problem.

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

Showing that you are using evidence based decision guidelines is really important as you are addressing the needs of that population. Some of these are loaded into your electronic health record, some are not. The practice has to get together, maybe over lunch, sit down and think about which set of standards. Many of our specialty organizations like the Academy of Family Practice, or for pediatrics, has these. How do you show and demonstrate NCQA that you are using them? Then identifying, prioritizing relevant community resources.

If you are looking across your population, you should have a lot of patients who are low literacy. How are you connecting them with some perhaps programs where they could improve that, or are you doing something that you can partner with a community agency to help a subset of your population? The elective points in this one are if you have a controlled substance database, I know Oregon has one of these. I think there is one in Idaho. Starting to use drug data to assess and address medication adherence, that is a little harder for a small practice out in the middle of rural Idaho to do.

Sometimes health plans can partner with you to help get you some of that information, and certainly across health systems they often have easier access. There are different kinds of electives that certain kinds of clinics might choose. Offering some support materials that are online might be an easier option to do for a small clinic that does not have access to big data sets. Then oral health, here you are seeing the integration of oral health.

Monitoring your diabetic population to make sure they are getting into the dentist, or coming up with options and community resources for that, would be a way to help meet some of the points in this concept.

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

This one is around patient centered access and continuity. This is really similar to the top standard of 2014, and access is a critical part of why there is even a patient centered medical home model. Providing appointments and clinical advice based trying to make sure what works, and paneling patients is part of this. You are trying to understand the access needs and preferences of the overall patient population. It is really critical. They are not going to get some of the services they need if you cannot get them in and start to think about how to make sure that there is some continuity of care with either a team of providers, or assigned providers, so you know what your population is.

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

The elective points in here are looking at your panel size, and developing an approach for monitoring and balancing of the panels. Sometimes everybody ends up wanting to see maybe their original provider in that clinic, and you get a new clinician in, and the is pretty off kilter, and so you try to adjust. I know it is challenging for some of the teaching programs in Idaho, where they got new residents coming through. It is all thinking about your panel size, and what you can do about it, and are you getting the whole family on one panel, and it is just showing you are at least looking at that.

Health disparities. Who is a real challenge with their finance, or access to food? Those, and social determinants. These are more advanced, and they are elective credit points, it is sometimes it is a matter of asking the questions. Then you need to be prepared for what kind of resources, where the SHIP QI specialists in the regions can help you with that access to community resources.

2017 PCMH Concept: Care Management and Support (CM)

This concept is care management and care support. They are pretty specific in here about that you would identify a set of patients who would most benefit from care management. We are not just talking care coordination, it is actually more than that. It is not just making sure they have their referrals and get there, but you are really going to take your high needs, high touch patients, and they need to come show you are thinking across these areas, which is either they have a behavioral health issue, they are your frequent fliers that are going in and out of the hospital and emergency room and causing high cost and high utilization.

They are the diabetic with the hemoglobin A1C of 11. There are social determinant issues that make it really challenging with lots of barriers for them to comply with treatment or make it to an appointment or they are being referred by an outside organization for you guys to help coordinate their care. You need to pick a subset of that larger population you are serving and think about how you could do some care management. A lot of clinics start with their diabetics in this situation, making sure they are screening for depression.

Then you start to develop Person Centered Care Plans, and those are not just what I would do as a doctor and a clinic and say, well, this is what we need to do next. It is really working with the patient and the care manager role is critical as to what is the patient willing to do next to help get to the right place. There be more instruction and opportunities to learn about care plans through your coaches, your SHIP QI manager folks, and our learning collaborative later in June.

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

Elective points here are a more detailed self-management plan in that individual care plan. Integrating the care plan and making sure it is accessible, because sometimes it is really hard for people to see where you have this care plan. Some of the electronic health records are not very friendly about this, but some of the newer ones are a little bit better. Then there are some for elective points here, you could do a risk stratification approach to your entire panel, and be even more detailed, to really pull out every patient. There are a lot of options here for elective credit points. Some that new clinics might not want to jump right into right away.

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

I think this is our fifth of six concepts. This one is care coordination and care transition. Slightly different than care management and this was new in 2014. You are really trying to improve that coordination of care. You send out things for a lab, an x-ray, MRI; are they getting back, are you informing the patient, and how can you prove that this is all happening? Coordinating care with specialists, making sure the referral and that key information is coming back from the specialists, so it can be acted on and applied to the patient's care.

Connecting with other facilities so if a patient goes to the emergency room, patient goes to the hospital, patient goes to the nursing home for a while, rehab from surgery, and things got changed and moved around and then they are coming back? How are you working with those transitions of care? That is the care coordination ,care transition concept and competencies.

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

Elective here is much more advanced. Using your guidelines in terms of when you send for referral. Maybe some arrangements with certain specialists, like you would always send this kind of information to your gastroenterologist (GI) doctor before you would send a patient, they would agree to always send this back. Their care managers talk to each other across clinics, so there are common expectations, sort of memorandums of understanding between you and your referral providers.

The monitoring of depression patients, and integrating your behavioral health providers, is another potential elective credit point in this rea. Behavioral health integration efforts are really critical. That does not always need to be on site. They are not specific to that, but how do you work, even if you have telehealth coming into your area. How are you working with those providers that are providing advice to those patients, or working with those patients, how is that information getting back to you as the care provider, so you are all working together on the same care plan for that patient?

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

The last of the concepts is the performance measurement and quality improvement. This is pretty similar to 2011, 2014 particularly. It just starts to build it out a little bit further, but you are starting to measure your performance and identify areas to improve. These are the plan, do, study, and act (PDSA). You are saying, “Oh my gosh; how could we improve our no-show rate, what are some steps we do? we do them, and then we re-evaluate.” Or how can we improve our developmental screenings on our little kids, certain ages, how are we going to fold that into the course of our work? Then evaluate it later to see if it is working and maybe not but tweak it and keep doing it.

You are trying to show that you are doing quality improvement and measuring that over time. This does not have to be big scientific research studies, just you do small changes, study it, see if it works, what did not, and what can we do to improve it. Then share that data. There are dashboards in many clinics now in Idaho showing how well they are doing on quality metrics, and how they are getting those developmental streams in. Getting those foot checks and diabetic retinopathy screens done, red, yellow, and green, to show how they are doing.

2017 PCMH: Other Important Features

If you are reporting quality data to the state, for Medicaid, or you are participating in Medicare Access and CHIP Reauthorization Act (MACRA) and other Medicare related programs, that gets you some points here. Getting feedback from some of your patients about how you are doing, those interviews I talked about probably could get you some points here. Then if you are doing a value based contract with the payers, they are paying you some sort of shared savings arrangement, or it is based on your quality performance, that would get you some points here.

There is really was an effort since they were developing MACRA about the time that this NCQA was being restructured. They really tried to align the two programs. If you are in the Merit Incentive Program, or effectually called Merit-based Incentive Payment System (MIPS) inside of MACRA, and MACRA is the nickname for the large change to Medicare that was a reauthorization of certain things, but in the midst of it is this Quality Payment Program (QPP). The MIPS track includes a category called clinical practice improvement activities that are worth 15 percent through your provider for your score.

If you get recognized by NCQA you automatically get the provider's full credit for that category. It is another incentive for doing the NCQA certification. I said earlier, there is a lot of focus, and I would anticipate going forward more and more focus, because we are seeing this nationally in what states and health plans are starting to ask for, is integrating whole person care. The mouth and the head are connected to the rest of the body. Behavioral health credits are integrated into the concepts, and I think I pointed out the oral health elective credit point there.

Then continuing to align with your medical society boards and organizations, you can get credit for PCMH recognition towards renewing board certifications, some continuing medical education credits. Important for your providers to incentivize them to engage in this model.

Resource Links for 2017 Recognition

Audience: Hi, this is Zack in Pocatello. I was just wondering if our Electronic Medical Record (EMR) will not integrate with Idaho Health Data Exchange (IHDE), is view only access adequate?

Jeanene Smith: I think if you are demonstrating to NCQA that you are at least looking, I believe so. There is a lot of workarounds on some of these. Because they realize that not all clinics are part of some massive big system that easily connects with those types of exchanges. It is a matter of describing and demonstrating how frequently you look at it in your policies and procedures so you can have something to show them it was looked at this many times. Because they do want evidence you looked, or how you applied the information.

Jeanene Smith: Okay, Sherry is asking do you recommend that we make the first call to NCQA even if we have not met the core points for 90 days? Or should we wait until we have net all and then call? You could connect with them, and start to make a plan. Because you could put the first call out far enough when you think you would be pretty close. It is important to have those core points. If you are getting pretty close, you could call and start to make a plan with them. There is sort of an initial call, and then the three formal review of your materials call. I would not make the first official call.

There is sort of a step wise overview of what to expect. On the NCQA web site, they say the things that you would want to have ready for that first call. Because you have the majority of those you could do that first call knowing that you are going to have a few hanger-overs that will need to be put to the second call with them. The slide that is up right now has your links to NCQA. The overview I talked about earlier, how to get started. The toolkit. Then there is that recognition redesign annual reporting requirements are there, so you can anticipate what you are going to have to do as you go forward.

2017 PCMH Quality Measures

The toolkit I think has all the standards in it. We will go back to that one. In the toolkit there are links out to the actual standards, so you can look. They did try to crosswalk their quality measures with the older meaningful use programs, the national National Quality Forum (NQF). The areas are as you would expect in acute care, behavioral health, chronic disease.

There is a crosswalk across the programs. If you are more familiar with what you are doing for meaningful use, you can see how one of those measures might work for your PCMH.

PCMH Portal – Portal User Guides & YouTube Videos!

Grace Chandler: We want to point out that on the PCMH portal there are some portal user guides and a YouTube video that walks you through the portal. If you go to the getting started page on the portal, you will see the portal user guide for cohort three clinics, and then there is also one for cohort one and two clinics. Then there is YouTube videos that will walk you through pieces of PCMH portal. There is a little dropdown, and each of the little YouTube videos is about a minute to three minutes long.

PCMH Portal – Toolkits Are Now Posted!

Then there are also some new toolkits that we just put on the portal. One is for new clinics that are onboarding as new PCMH clinics. It walks you through various aspects of PCMH, NCQA, and other entities that do recognition. Also what is PCMH. It goes through a lot of different features about Patient Centered Medical Homes. If you have new staff that are just coming onto your clinic, there is an onboarding of new employees toolkit, and that will walk that individual through various aspects of PCMH, helps them reach out to people in your organization or in your clinic, and lets them get oriented to PCMH.

There is also a mentoring toolkit that will be coming soon. It is in development. Please do turn to the portal, and if you have questions, there is a contact us feature on the portal that will help you contact us, and we will get back to you as soon as we can. Thank you.

Jeanene Smith: If your clinic is new to this whole concept of patient centered homes, it is a challenge to then start having to work through all the nitty-gritty details about the standards. Then if you have turnover, and you get new employees that come in, and they are not used to it either, then that can slow down your process. Onboarding new employees, starting to fold that into how you hire, how you orientate. This is the way we do it now in our clinic it is really important.

It can be a little overwhelming at first when you get all these standards thrown at you, but if you really start to break them down, and there is an assessment that you are starting to do, that is a tool to see where you are at today, and where you need to get to, and those gaps are what the coaching calls are all about to help focus on those areas, and work with your local regional SHIP QI folks to break through what do you need to do, and while you may seem like you will never get there, you will, and there are a lot of clinics that have been in the same boat as you and very successfully have gotten recognition.

It is really just a shift, like you are flying the plane while rebuilding it, but it can be very successful. There has to be evidence to show not only are you maybe improving access to care for the patients and lowering costs for unnecessary care in very expensive places, but it has actually been shown to have a lot of staff satisfaction, as well as patient satisfaction. You meet that quadruple aim by adopting this model of care. Uploading enough on Q-Pass so they give you the recognition standards that you deserve for all the hard work you do.

Grace Chandler: I just wanted to reinforce with everyone the recording and the transcription and the PowerPoint presentation will be posted on the portal in the next couple weeks. If you have staff that you want to listen to this recording and to this presentation, you can definitely have them get on the portal. If they do not have a login, they can send us a login request through the Contact Us on the portal as well, and we will set them up as portal users.

Jeanene Smith: Especially if you are the lead person across multiple clinics, some of these webinars, and we will have some mentorship webinars starting as well. The logins are through the portal, so any help we can to help you get key staff to listen to some of these areas. Whatever we can do to help you and your team learn about the model and success at getting achieving recognition.