Patient-Centered Medical Home 201

BD Advancing Community Health: Driving Quality Outcomes

Agenda

- ✓ *NCQA 2017 Standards*
- ✓ *NCQA Tools and Resources*
- ✓ *Americares Eligibility Criteria*
- ✓ *Americares Process and Timeline*

Key Differences Between 2014 and 2017 Standards

New Process

- ✓ To seek recognition, much more hands on approach with NCQA to include check-ins with NCQA staff
- ✓ There are no longer levels of recognition: you are recognized or you aren't
- ✓ Annual reporting to maintain recognition

New Standards

- ✓ Core criteria that must be met
- ✓ Elective criteria: certain number must be selected and met to reach recognition
- ✓ To receive recognition, you must meet the 40 core criteria and then an additional 25 elective credits from 5 of the 6 program concepts.
- ✓ New distinctions available: behavioral health integration, reporting of electronic quality measures, or patients experience reporting.

New NCQA Process

A More Hands-on Approach

- ✓ Readiness Assessment
- ✓ Enrollment in the Q-Pass, online recognition software (when you enroll, you will complete a questionnaire and pay an initial fee)
- ✓ Up to three virtual meetings with an NCQA representative
- ✓ Once recognition is received, annual reporting is required

NCQA PCMH 2017: Six Core Concepts

- **Team-Based Care and Practice Organization**
  The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.

- **Knowing and Managing Your Patients**
  The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers and organizes and trains staff to work to the top of their license and ability to provide effective team-based care.

- **Patient-Centered Access and Continuity**
  Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access.

NCQA PCMH 2017: Six Core Concepts

- **Care Management and Support**
  The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.

- **Care Coordination and Care Transitions**
  The practice tracks tests, referrals and care transitions to ensure comprehensive care coordination and communication with specialists and other providers in the medical neighborhood.

- **Performance Measurement and Quality Improvement**
  The practice collects, reports and uses performance data to identify opportunities for quality improvement, sets goals and acts to improve clinical quality, efficiency, patient experience and engages the staff and patients/families/caregivers in the quality improvement activities.

NCQA Standards 2017: Team Based Care and Practice Organization (TC)

Competency A: The practice is committed to transforming the practice into a sustainable medical home. Members of the care team serve specific roles as defined by the practices' organizational structure and are equipped with the knowledge and training necessary to perform those functions.

- ✓ TC 1 **(Core)**: Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.
- ✓ TC 2 **(Core)**: Defines practice organizational structure and staff responsibilities/skills to support key PCMH functions.
- ✓ TC 3 (1 credit):The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges).
- ✓ TC 4 (2 credits): Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees.
- ✓ TC 5 (2 credits): The practice uses an EHR system (or modules) that has been certified and issued on ONC Certification ID, conducts a security risk analysis, and implements security updates as necessary correcting identified security deficiencies.

NCQA Standards 2017: Team Based Care and Practice Organization (TC)

Competency B: Communication among staff is organized to ensure that patient care is coordinated, safe and effective.

- ✓ TC 6 **(Core)**: Has regular patient care team meetings or a structured communication process focused on individual patient care.
- ✓ TC 7 **(Core)**: Involves care team staff in the practice's performance evaluation and quality improvement activities.
- ✓ TC 8 (2 credit):Has at least one care manager qualified to identify and coordinate behavioral health needs.

NCQA Standards 2017: Team Based Care and Practice Organization (TC)

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

- ✓ TC 9 **(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.

NCQA Standards 2017: Knowing and Managing Your Patients (KM)

Competency A: Practice routinely collects comprehensive data on patients to understand background and health risks of patients. Practice uses information on the population to implement needed interventions, tools, and supports for the practice as a whole and for specific individuals.

- ✓ KM 1 **(Core)**: Documents an up-to-date problem list for each patient with current and active diagnoses.
- ✓ KM 2 **(Core)**: Comprehensive health assessment includes (all items required):
  - a. Medical history of patient and family.
  - b. Mental health/substance use history of patient and family.
  - c. Family/social/cultural characteristics
  - d. Communication needs
  - e. Behaviors affecting health
  - f. Social functioning
  - g. Social determinants of health
  - h. Developmental screening using a standardized tool (NA for practices with no pediatric population under 30 months of age)
  - i. Advance care planning

NCQA Standards 2017: Knowing and Managing Your Patients (KM)

Competency A: Practice routinely collects comprehensive data on patients to understand background and health risks of patients. Practice uses information on the population to implement needed interventions, tools, and supports for the practice as a whole and for specific individuals.

- ✓ KM 3 **(Core**): Conducts depression screening for adults and adolescents using a standardized tool.
- ✓ KM 4 (1 Credit): Conducts behavioral health screenings and/or assessments using a standardized tool (implement two or more).
  - a. Anxiety
  - b. Alcohol use disorder
  - c. Substance use disorder
  - d. Pediatric behavioral health screening
  - e. Post-traumatic stress disorder
  - f. Attention deficit/hyperactivity disorder
  - g. Postpartum depression

NCQA Standards 2017: Knowing and Managing Your Patients (KM)

Competency A: Practice routinely collects comprehensive data on patients to understand background and health risks of patients. Practice uses information on the population to implement needed interventions, tools, and supports for the practice as a whole and for specific individuals.

- ✓ KM 5 **(Core)**: Assess oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners.
- ✓ KM 6 (1 Credit): Identifies the predominant conditions and health concerns of the patient population.
- ✓ KM 7 (2 Credits): Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data.
- ✓ KM 8 (1 Credit): Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials.

NCQA Standards 2017: Knowing and Managing Your Patients (KM)

Competency B: The practice seeks to meet the needs of a diverse patient population by understanding the population's unique characteristics and language needs. The practices uses this information to ensure linguistic and other patients needs are met.

- ✓ KM 9 **(Core)**: Assess the diversity (race, ethnicity, and one other aspect of diversity) of its population.
- ✓ KM 10 **(Core)**: Assesses the language needs of its population.
- ✓ KM 11 (1 Credit): Identifies and addresses population-level needs based on the diversity of the practice and the community (demonstrate at least two):
  a. Target population health management on disparities in care
  b. Address health literacy of the practice staff
  c. Educate practice staff in cultural competence

NCQA Standards 2017: Knowing and Managing Your Patients (KM)

Competency C: The practice proactively addresses the care needs of the patient population to ensure needs are met.

- ✓ KM 12 **(Core)**: Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (must report at least three categories):
  - a. Preventive care services
  - b. Immunizations
  - c. Chronic or acute care services
  - d. Patients not recently seen by the practice.
- ✓ KM 13 (2 Credits): Demonstrates excellence in a benchmarked/performance-based recognition program assessed using evidence-based care guidelines.

NCQA Standards 2017: Knowing and Managing Your Patients (KM)

Competency D: The practice addresses medication safety and adherence by providing information to the patient and establishing processes for medication documentation, reconciliation, and assessment of barriers.

- ✓ KM 14 **(Core)**: Reviews and reconciles medications for more than 80 percent of patients received from care transitions.
- ✓ KM 15 **(Core)**: Maintains an up-to-date list of medications for more than 80 percent of patients.
- ✓ KM 16 (1 Credit): Assesses understanding and provides education, as needed, on new prescriptions for more than 50 percent of patients/families/caregiver.
- ✓ KM 17 (1 Credit): Assesses and addresses patient response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment.
- ✓ KM 18 (1 Credit): Reviews controlled substance database when prescribing relevant medications.
- ✓ KM 19 (2 Credits): Systematically obtains prescription claims data in order to assess and address medication adherence.

NCQA Standards 2017: Knowing and Managing Your Patients (KM)

Competency E: The practice incorporates evidence-based clinical decision support across a variety of conditions to ensure effective and efficient care is provided to patients.

- ✓ KM 20 **(Core)**: Implements clinical decision support following evidence-based guidelines for care of (Practice must demonstrate at least four criteria):
  a. Mental health condition
  b. Substance use disorder
  c. A chronic medical condition
  d. An acute condition
  e. A condition related to unhealthy behaviors
  f. Well child or adult care
  g. Overuse/appropriateness issues

NCQA Standards 2017: Knowing and Managing Your Patients (KM)

Competency F: The practice identifies/considers and establishes connection to community resources to collaborate and direct patients to needed support.

- ✓ KM 21 **(Core)**: Uses information on the population served by the practice to prioritize needed community resources.
- ✓ KM 22 (1 Credit): Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.
- ✓ KM 23 (1 Credit): Provides oral health education resources to patients.
- ✓ KM 24 (1 Credit): Adopts shared decision-making aids for preference-sensitive conditions.
- ✓ KM 25 (1 Credit): Engages with schools or intervention agencies in the community.
- ✓ KM 26 (1 Credit): Routinely maintains a current community resource list based on the needs identified in KM 21.
- ✓ KM 27 (1 Credit): Assesses the usefulness of identified community support resources.
- ✓ KM 28 (2 Credits): Has regular “case conferences” involving parties outside the practice team (e.g. community support specialists)

NCQA Standards 2017: Patient-Centered Access and Continuity (AC)

Competency A: The practice seeks to enhance access by providing appointments and clinical advice based on patients' needs.

- ✓ AC 1 **(Core)**: Assesses the access needs and preferences of the patient population.
- ✓ AC 2 **(Core**): Provides same-day appointments for routine and urgent care to meet identified patient needs.
- ✓ AC 3 **(Core)**: Provides routine and urgent appointments outside regular business hours to meet identified patient needs.
- ✓ AC 4 **(Core)**: Provides timely clinical advice by telephone.
- ✓ AC 5 **(Core**): Documents clinical advice in patient records and confirms clinical advice and care provided after-hours does not conflict with patient medical record.

NCQA Standards 2017: Patient-Centered Access and Continuity (AC)

Competency A: The practice seeks to enhance access by providing appointments and clinical advice based on patients' needs.

- ✓ AC 6 (1 Credit): Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms.
- ✓ AC 7 (1 Credit): Has a secure electronic system for patient to request appointments, prescription refills, referrals, and test results.
- ✓ AC 8 (1 Credit): Has a secure electronic system for two-way communication to provide timely clinical advice.
- ✓ AC 9 (1 Credit): Uses information about the population served by the practice to assess equity of access that considers health disparities.

NCQA Standards 2017: Patient-Centered Access and Continuity (AC)

Competency B: Practices support continuity through empanelment and systematic access to the patient's medical record.

- ✓ AC 10 **(Core)**: Helps patients/families/caregivers select or change a personal clinician.
- ✓ AC 11 **(Core)**: Sets goals and monitors the percentage of patient visits with the selected clinician or team.
- ✓ AC 12 (2 Credits): Provides continuity of medical record information for care and advice when the office is closed.
- ✓ AC 13 (1 Credit): Reviews and actively manages panel sizes.
- ✓ AC 14 (1 Credit): Review and reconciles panels based on health plan or other outside patient assignments.

NCQA Standards 2017: Care Management and Support (CM)

Competency A: The practice systematically identifies patients who may benefit form care management.

- ✓ CM 1 **(Core)**: Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria):
  a. Behavioral health conditions
  b. High cost/high utilization
  c. Poorly controlled or complex conditions
  d. Social determinants of health
  e. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/family/caregiver
- ✓ CM 2 **(Core)**: Monitors the percentage of the total patient population identified through its process and criteria.
- ✓ CM 3 (2 Credits): Applies a comprehensive risk-stratification process for the entire patient panel in order to identify and direct resources appropriately.

NCQA Standards 2017: Care Management and Support (CM)

Competency B: For patients identified for care management, the practice uses patient information and collaborates with patients/families/caregivers to develop a care plan that addresses barriers and incorporate patient preferences and lifestyle goals documents in the patient's chart.

- ✓ CM 4 **(Core)**: Establishes a person-centered care plan for patients identified for care management.
- ✓ CM 5 **(Core)**: Provides a written care plan to the patient/family/caregiver for patients identified for care management.
- ✓ CM 6 (1 Credit): Documents patient preference and functional/lifestyle goals in individual care plans.
- ✓ CM 7 (1 Credit): Identifies and discusses potential barriers to meeting goals in individual care plan.
- ✓ CM 8 (1 Credit): Includes a self-management plan in individual care plans.
- ✓ CM 9 (1 Credit): Care plan is integrated and accessible across settings of care.

NCQA Standards 2017: Care Coordination and Care Transitions (CC)

Competency A: The practice effectively tracks and manages laboratory and imagining tests important for patient care and informs patients of the result.

- ✓ CC 1 **(Core)**: The practice systematically manages lab and imaging tests by:
  a. Tracking lab texts until results are available, flagging and following up on overdue results.
  b. Tracking imaging tests until results are available, flagging and following up on overdue results.
  c. Flagging abnormal lab results, bringing them to the attention of the clinician.
  d. Flagging abnormal imaging results, bringing them to the attention of the clinician.
  e. Notifying patients/families/caregivers of normal lab and imaging test results.
  f. Notifying patients/families/caregivers of abnormal lab and imaging test results.
- ✓ CC 2 (1 Credit): Follows up with inpatient facility about newborn hearing and blood-spot screening.
- ✓ CC 3 (2 Credits): Uses clinical protocols to determine when imaging and lab tests are necessary.

NCQA Standards 2017: Care Coordination and Care Transitions (CC)

Competency B: The practice provides important information in referrals to specialists and tracks referrals until the report is received.

- ✓ CC 4 **(Core)**: The practice systematically manages referrals by:
  - a. Giving the consultant or specialist the clinical question, the required timing and the type of referral.
  - b. Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.
  - c. Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports.
- ✓ CC 5 (2 Credits): Uses clinical protocols to determine when a referral to a specialist is necessary.
- ✓ CC 6 (1 Credit): Identifies the specialists/specialty types frequently used by the practice.
- ✓ CC 7 (2 Credits): Considers available performance information on consultants/specialists when making referrals.
- ✓ CC 8 (1 Credit): Works with nonbehavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care.

NCQA Standards 2017: Care Coordination and Care Transitions (CC)

Competency B: The practice provides important information in referrals to specialists and tracks referrals until the report is received.

- ✓ CC 9 (2 Credits): Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care.
- ✓ CC 10 (2 Credits): Integrates behavioral healthcare providers into the care delivery system of the practice site.
- ✓ CC 11 (1 Credit): Monitors the timeliness and quality of the referral response.
- ✓ CC 12 (1 Credit): Documents co-management arrangements in the patient's medical record.
- ✓ CC 13 (2 Credits): Engages with patients regarding cost implications of treatment options.

NCQA Standards 2017: Care Coordination and Care Transitions (CC)

Competency C: The practice connects with health care facilities to support patient safety throughout care transitions. The practice receives and shares necessary patient treatment information to coordinate comprehensive patient care.

- ✓ CC 14 **(Core)**: Systematically identifies patients with unplanned hospital admissions and emergency department visits.
- ✓ CC 15 **(Core):** Shares clinical information with admitting hospitals and emergency departments.
- ✓ CC 16 **(Core):** Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit.
- ✓ CC 17 (1 Credit): Systematic ability to coordinate with acute care settings after office hours through access to current patient information.
- ✓ CC 18 (1 Credit): Exchanges patient information with the hospital during a patient's hospitalization.
- ✓ CC 19 (1 Credit): Implements a process to consistently obtain patient discharge summaries from the hospital and other facilities.

NCQA Standards 2017: Care Coordination and Care Transitions (CC)

Competency C: The practice connects with health care facilities to support patient safety throughout care transitions. The practice receives and shares necessary patient treatment information to coordinate comprehensive patient care.

- ✓ CC 20 (1 Credit): Collaborates with the patient/family/caregiver to develop/implement a written care pan for complex patients transitioning into/out of the practice (e.g. pediatric care to adult care).
- ✓ CC 21 (Maximum 3 Credits): Demonstrates electronic exchange of information with external entities, agencies and registries (May select one or more):
  a. Regional health information organization or other health information exchange source that enhances the practice's ability to manage complex patients (1 credit).
  b. Immunization registries or immunization information systems (1 credit).
  c. Summary of care record to another provider or care facility for care transition (1 credit).

NCQA Standards 2017: Performance Measurement and Quality Improvement (QI)

Competency A: The practice measures to understand current performance and to identify opportunities for improvement.

- ✓ QI 1 **(Core):** Monitors at least give clinical quality measures across the four categories (must monitor at least one measure of each type):
  a. Immunization measures
  b. Other preventive care measures.
  c. Chronic or acute care clinical measures.
  d. Behavioral health measures.
- ✓ QI 2 **(Core):** Monitors at least two measures of resource stewardship (must monitor at least 1 measure of each type):
  a. Measures related to care coordination.
  b. Measures affecting health care costs.
- ✓ QI 3 **(Core):** Assesses performance on availability of major appointment types to meet patient needs and preferences for access.

NCQA Standards 2017: Performance Measurement and Quality Improvement (QI)

Competency A: The practice measures to understand current performance and to identify opportunities for improvement.

- ✓ QI 4 **(Core):** Monitors patient experience through:
  a. Quantitative data. Conducts a survey (using any instrument) to evaluate patient/family/caregiver experiences across at least three dimensions such as:
     - Access
     - Communication
     - Coordination
     - Whole-person care, self-management support and comprehensiveness
  b. Qualitative data. Obtains feedback from patients/families/caregivers through qualitative means.

NCQA Standards 2017: Performance Measurement and Quality Improvement (QI)

Competency A: The practice measures to understand current performance and to identify opportunities for improvement.

- ✓ QI 5 (1 Credit): Assesses health disparities using performance data stratified for vulnerable populations (must choose one from each section):
  a. Clinical quality
  b. Patient experience
- ✓ QI 6 (1 Credit): The practice uses a standardized, validated patient experience survey tool with benchmarking data available.
- ✓ QI 7 (2 Credits): The practice obtains feedback on experience of vulnerable patient groups.

NCQA Standards 2017: Performance Measurement and Quality Improvement (QI)

Competency B: The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies.

- ✓ QI 8 **(Core):** Sets goals and acts to improve upon at least three measures across at least three of the four categories:
  a. Immunization measures.
  b. Other preventative care measures.
  c. Chronic or acute care clinical measures.
  d. Behavioral health measures.
- ✓ QI 9 **(Core):** Sets goals and acts to improve performance on at least one measure of resource stewardship:
  a. Measures related to care coordination.
  b. Measures affecting health care costs.

NCQA Standards 2017: Performance Measurement and Quality Improvement (QI)

Competency B: The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies.

- ✓ QI 10 **(Core)**: Sets goals and acts to improve on availability of major appointment types to meet patient needs and preferences.
- ✓ QI 11 **(Core):** Sets goals and acts to improve performance on at least one patient experience measure.
- ✓ QI 12 (2 Credits): Achieves improved performance on at least two performance measures.
- ✓ QI 13 (1 Credit): Sets goals and acts to improve disparities in care or services on at least one measure.
- ✓ QI 14 (2 Credits): Achieves improved performance on at least one measure of disparities in care or service.

NCQA Standards 2017: Performance Measurement and Quality Improvement (QI)

Competency C: The practice is accountable for performance. The practice shares performance data with the practice, patients and/or publicly for the measures and patient populations identified in the previous section.

- ✓ QI 15 **(Core):** Reports practice-level or individual clinician performance results within the practice for measures reported by the practice.
- ✓ QI 16 (1 Credit): Reports practice-level or individual clinician performance results publicly or with patients for measures reported by the practice.
- ✓ QI 17 (2 Credits): Involves patient/family/caregiver in quality improvement activities.
- ✓ QI 18 (2 Credits): Reports clinical quality measures to Medicare or Medicaid agency.
- ✓ QI 19 (Maximum 2 Credits): Is engaged in Value-Based Agreement.
  a. Practice engages in upside risk contract (1 Credit).
  b. Practice engages in two-sided risk contract (2 Credits).

NCQA Tools and Resources

Online Tools

- ✓ Here is a copy of the standards and guidelines document
- ✓ This shows you steps you need to take in the recognition process
- ✓ Here is a link to a toolbox which will show you more about NCQA recognition and what tools are available
- ✓ Readiness assessment to determine if clinic is eligible and ready
- ✓ Here is a link to access online and in person trainings

Americares Program Process

Between Now and the PCMH 301 Webinar

- ✓ Complete post-webinar survey
- ✓ In-depth review NCQA standards and documents
- ✓ Sign up to receive NCQA announcements for webinars/ information
- ✓ Review Americares Clinic Eligibility Requirements for BD PCMH Program

Welcome

Thank you for your interest in NCQA Patient-Centered Medical Home (PCMH) Recognition. This brief questionnaire will help you determine if you are eligible and ready to begin the PCMH Recognition process. This questionnaire is for practices looking to come through recognition using the 2017 concepts and criteria.

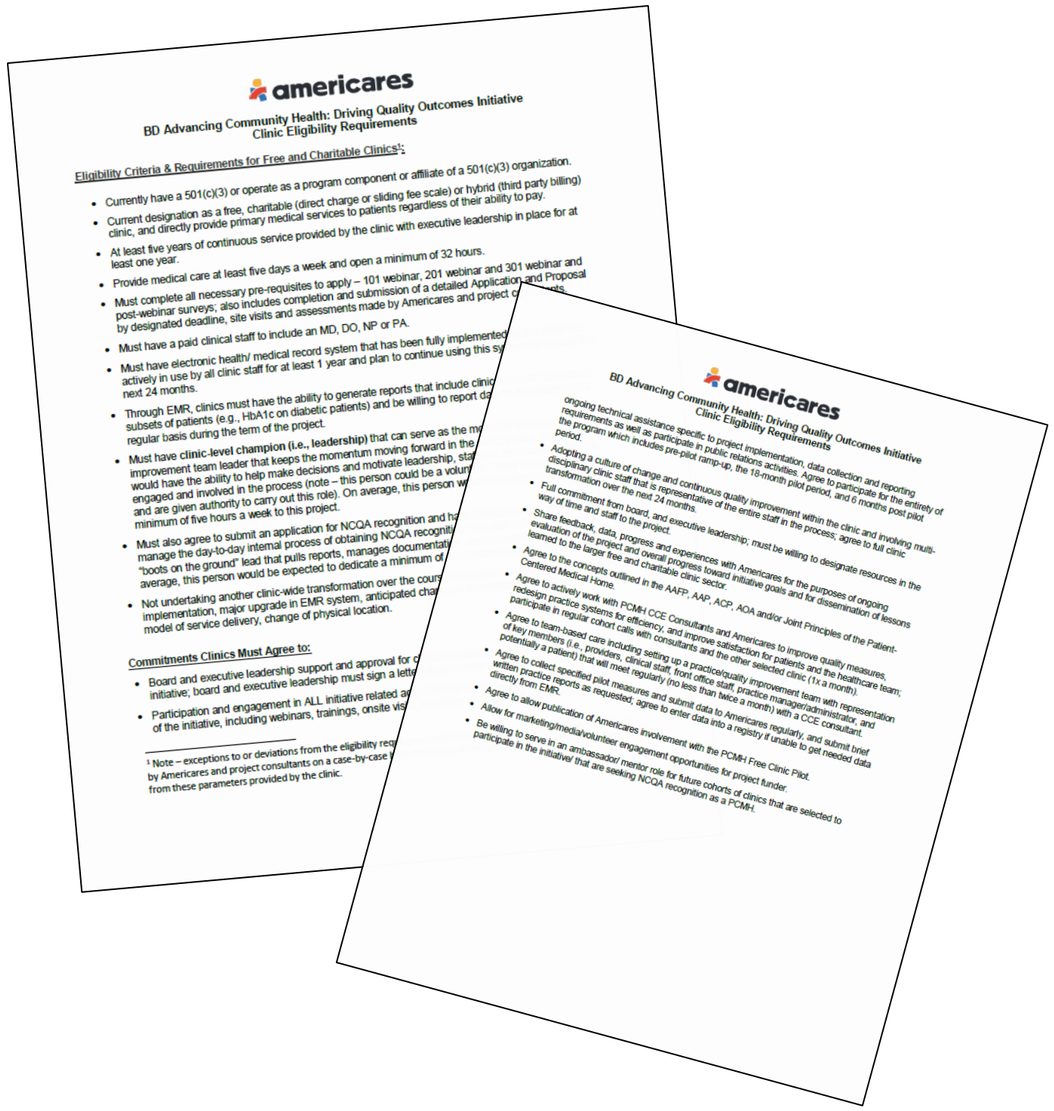
Before we get started, please select your current recognition status for the practice sites you want to bring through recognition:

- ○ We are currently recognized by NCQA
- ○ We are not currently recognized by NCQA
- ○ We were recognized in the past but let the recognition lapse. We are interested in seeking recognition again

Continue →

Americares Clinic Eligibility Requirements

- ✓ Must complete all the preparatory webinars and surveys
- ✓ Staffing expectations
- ✓ Clinic expectations
- ✓ Exceptions may be considered on case-by-case basis
- ✓ Encourage continued participation – future opportunities
- ✓ Sustainability planning
- ✓ Download requirements in Documents Pod



Support

- ✓ $100,000 over 2 years
- ✓ Direct coaching and technical assistance from NCQA CCEs
- ✓ Clinic ambassador
- ✓ Opportunities to collaborate with the other participating clinic

Timeline

Jun '17

PCMH 301 Webinar

Jul '17

RFP/ Application Released

Aug '17

Site Visits / Assessments (4)

Sep '17

Final Clinic Selections Announced

Oct '17

Meet Clinic Ambassador

Oct '17

Foundational work begins

Survey Link:

https://www.surveymonkey.com/r/pcmh201survey

Thank you! Questions?

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Survey Link:
https://www.surveymonkey.com/r/pcmh201survey