PCMH Recognition Nuts & Bolts

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What We Will Cover

- Brief Overview of 2017 NCQA Process
- Steps for New Recognition:
  1. Convene a PCMH Development Team
  2. Schedule Regular PCMH Development Meetings
  3. Complete a Readiness Assessment
  4. Action Plan based on Readiness Assessment
  5. Develop a Goal, Workplan, and Timeline
  6. Begin Implementation
     - Submit Notice of Intent to HRSA (tell them that you plan on applying – this will trigger a notice to NCQA)
     - Register for Q-PASS
     - Explore pre-validation - contact your EHR vendor for a list of “autocredits”
     - Transform
     - Consult resources on chcleadership.com
  7. Track Progress and Re-Assess Status

PCMH Recognition: Association Members

- As of April 2019, 22/26 CHCs (85%) of Virginia community health centers have some level of PCMH recognition for at least one of their sites. Many member CHCs are working on new recognition or renewal.
- Find resources, documentation examples, renewal guides and tools – available to Virginia CHCs to help them in their PCMH development journey for recognition and/or renewal at https://chcleadership.com/pcmh-resources/

2008,
2011,
2014

2017+

PCMH Redesign

Then vs. Now

Intro to PCMH 2017 - Changes

- **One Level.** NCQA is getting rid of Levels 1, 2, and 3. Centers will simply be “NCQA PCMH recognized” based on attainment of a core set of criteria and their selections from a menu of additional criteria.
- **Connection to NCQA representative.** Practices will be assigned an NCQA representative who works with them throughout the recognition process and is a consistent point of contact.
- **Virtual, Instant Review.** Centers will submit documentation and/or have a series of 3 web meetings with the NCQA reviewer to show or demonstrate how they meet certain PCMH requirements. The reviewer will give instant feedback and the practice will have an opportunity to present revised documentation/demonstration during the next web meeting.
- **Annual Renewal/Check-in.** Recognition will now be awarded and renewed on an annual basis, rather than every three years.
- **New Software System – Q-PASS.** NCQA has retired the “Interactive Survey System” used previously. The Q-PASS is a new software for application, submission of documentation, and other interactions with NCQA. *Practices may not submit any documentation that has patient information (e.g. birthdays) via Q-PASS. These should be show during a virtual review, not uploaded to Q-PASS.*

Intro to PCMH 2017 – Process

Commit

Practice completes an online guided assessment.

Practice works with an NCQA representative to develop an evaluation schedule.

Practice works with NCQA representative to identify support and education for transformation.

New NCQA PCMH online education resources support the transformation process.

Transform

Practice submits initial documentation and checks in with its evaluator

Practice submits additional documentation and checks in with its Evaluator.

Practice submits final documentation to complete submission and begin NCQA evaluation process.

Practice earns NCQA Recognition.

Succeed

Practice is prepared for new payment environment (value-based payment, MACRA MIPS/APMs).

Practice demonstrates continued readiness and high quality performance through annual check-ins with NCQA.

Including reporting quality data on select measures

2017 PCMH Guidelines

- **Concepts, Competencies, and Criteria**

  Formerly Standards, Elements, and Factors

  - **Concepts**: over-arching components of PCMH
  - **Competencies**: ways to group or categorize criteria
  - **Criteria**: individual tasks and things you do that comprise/prove PCMH

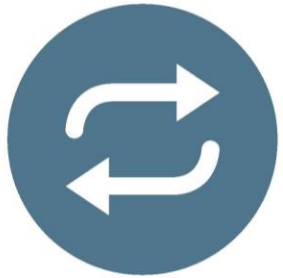
2017 PCMH Guidelines

Team-Based Care and Practice Organization

Knowing and Managing Your Patients

Patient-Centered Access and Continuity

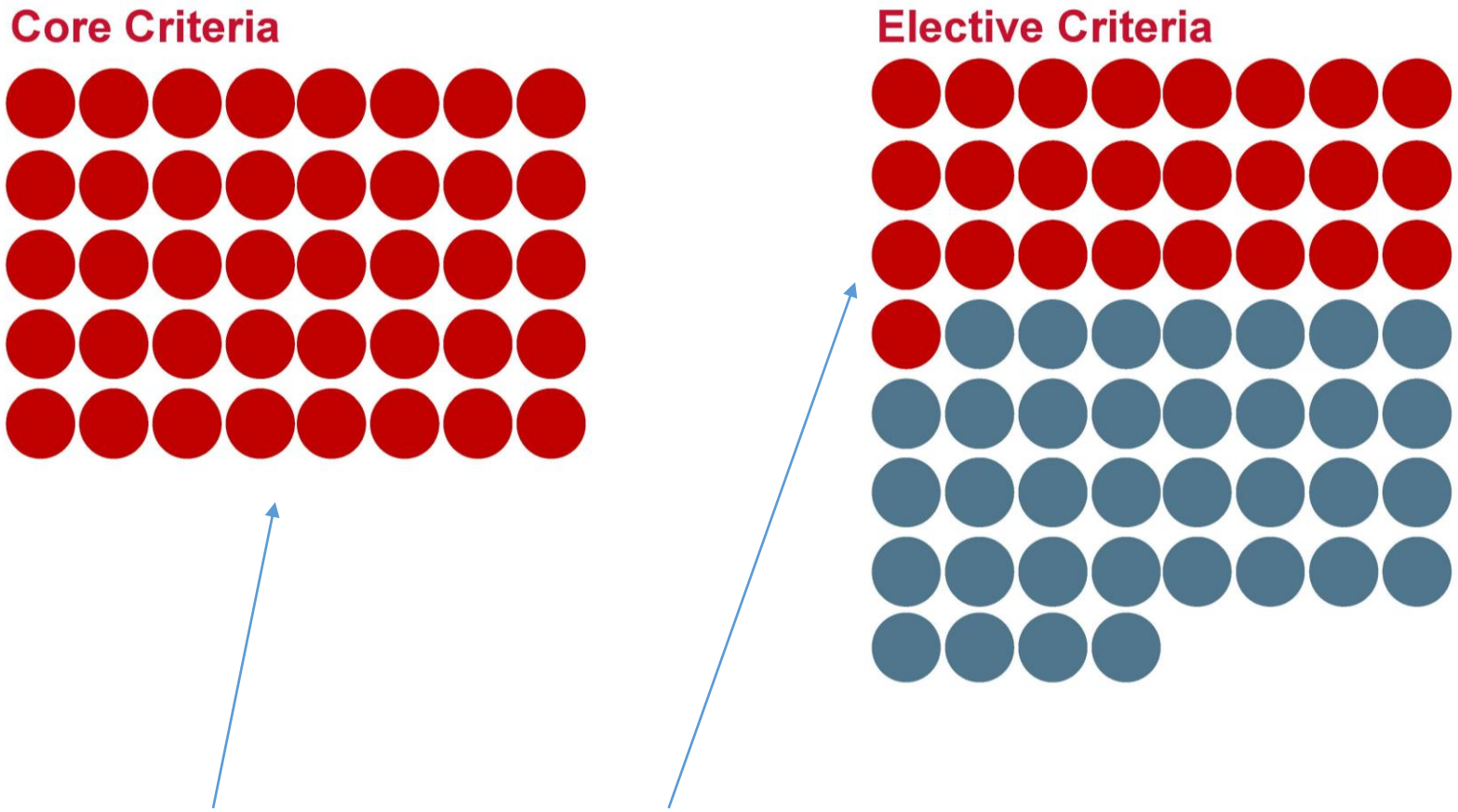
Care Management and Support



Care Coordination and Care Transitions

Performance Measurement & Quality Improvement

2017 PCMH Guidelines



40 Core Criteria **+** **25 Credits from the 60 Elective Criteria**

Scoring in Detail

- 100 Criteria in total, 40 of which are Core
- Total of 83 credits across the 60 elective criteria.
  - There are 38 criteria worth 1 credit.
  - There are 21 criteria worth 2 credits
  - One criterion is worth a maximum of 3 credits.

- Need to get all 40 Core criteria, plus **25 elective credits from 5 of the 6 concepts**.

Concepts

Team-Based Care and Practice Organization (TC)

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 provide effective team-based care.

Knowing and Managing Your Patients (KM)

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

Patient-Centered Access and Continuity (AC)

The practice **provides 24/7 access to clinical advice and appropriate care** facilitated by their designated clinician/care team, **considers the needs and preferences of the patient population** when modeling standards for access.

Concepts

Care Management and Support (CM)

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 (CC)

The practice systematically **tracks tests, referrals and care transitions** to achieve high quality care coordination, lower costs, improve patient safety and ensure effective **communication with specialists and other providers** in the medical neighborhood.

Performance Measurement and Quality Improvement (QI)

The practice establishes a **culture of data-driven performance improvement** on clinical quality, efficiency and patient experience, and **engages staff and patients/families/ caregivers in quality improvement activities.**

Steps to Work Towards New PCMH Recognition

Steps

1. Convene a PCMH Development Team
2. Schedule Regular PCMH Development Meetings
3. Complete a Readiness Assessment
4. Action Plan based on Readiness Assessment
5. Develop a Goal, Workplan, and Timeline
6. Begin Implementation
   a) Submit Notice of Intent to HRSA (tell them that you plan on applying – this will trigger a notice to NCQA)
   b) Register for Q-PASS
   c) Explore pre-validation - contact your EHR vendor for a list of “autocredits”
   d) Transform
   e) Consult resources on chcleadership.com
7. Track Progress and Re-Assess Status

1. Convene PCMH Development TEAM

Convene a PCMH Team that includes a designated Coordinator or Manager as well as staff who:

- Interact with patients in some fashion
- Influence policy, process, or practice
- Are knowledgeable about data and how it can be extracted
- Are committed to PCMH development
- Are committed to learning and sharing knowledge
- Are committed to rolling up their sleeves and getting it done

2. Schedule regular PCMH development meetings with the **TEAM**

Ten steps for effective team meetings

- Identify the team
- Meet regularly and "on-the-clock"
- Agree on ground rules
- Set a consistent meeting agenda
- Rotate meeting roles
- Solve problems as a group
- Record action steps, owners and due dates
- Practice good meeting skills
- Have some fun!
- Celebrate your successes

Resource: ***AMA STEPSforward Conducting Effective Team Meetings***

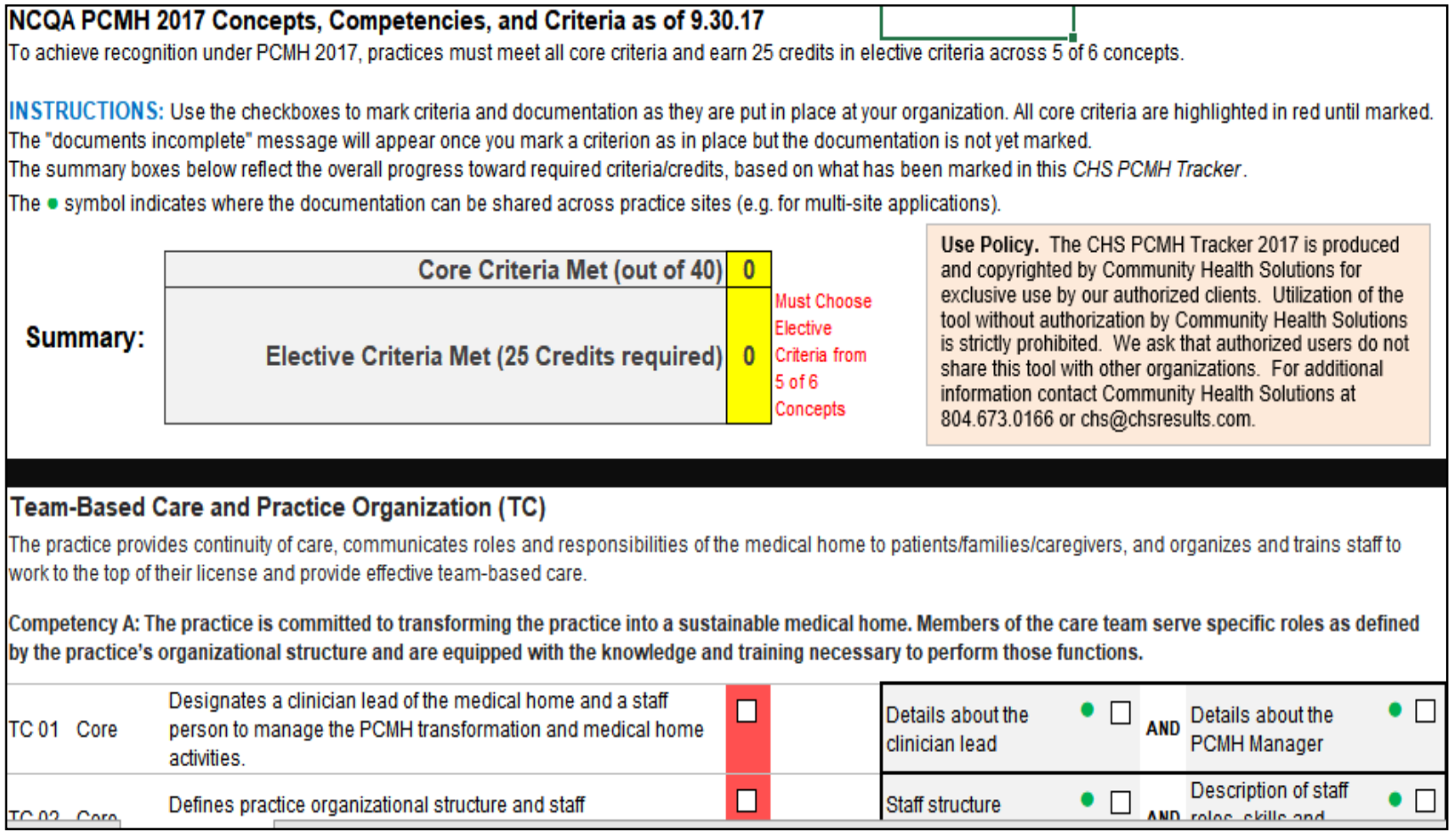
3. Complete a Readiness Assessment

This can be completed by the team at one of your first meetings

- Use the CHS PCMH Tracker 2017 to do a self-assessment of the core criteria.

- Which core criteria are practiced at each site?

Resource: CHS PCMH Tracker 2017



NCQA PCMH 2017 Concepts, Competencies, and Criteria as of 9.30.17

To achieve recognition under PCMH 2017, practices must meet all core criteria and earn 25 credits in elective criteria across 5 of 6 concepts.

INSTRUCTIONS: Use the checkboxes to mark criteria and documentation as they are put in place at your organization. All core criteria are highlighted in red until marked.
The "documents incomplete" message will appear once you mark a criterion as in place but the documentation is not yet marked.
The summary boxes below reflect the overall progress toward required criteria/credits, based on what has been marked in this *CHS PCMH Tracker*.
The ● symbol indicates where the documentation can be shared across practice sites (e.g. for multi-site applications).

Summary:

Core Criteria Met (out of 40)	0
Elective Criteria Met (25 Credits required)	0

Must Choose Elective Criteria from 5 of 6 Concepts

Use Policy. The CHS PCMH Tracker 2017 is produced and copyrighted by Community Health Solutions for exclusive use by our authorized clients. Utilization of the tool without authorization by Community Health Solutions is strictly prohibited. We ask that authorized users do not share this tool with other organizations. For additional information contact Community Health Solutions at 804.673.0166 or chs@chsresults.com.

Team-Based Care and Practice Organization (TC)

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 provide effective team-based care.

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 practice's organizational structure and are equipped with the knowledge and training necessary to perform those functions.

TC 01 Core	Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.	☐	Details about the clinician lead ● ☐	AND	Details about the PCMH Manager ● ☐
TC 02 Core	Defines practice organizational structure and staff	☐	Staff structure ● ☐	AND	Description of staff roles, skills and ● ☐

4. Action Planning based on Readiness Assessment

Identify a Pathway for PCMH Development

- Which criteria are already “in place” but need to have a policy/evidence of implementation? *Note: through this exploration and development you may find that you make a few tweaks to your processes – that’s typical!*
- Do you have sufficient criteria and credits already identified?
- Are there additional criteria you may need to implement in order to achieve recognition?
- The list of criteria you have or plan to implement is your pathway/roadmap

Tools to Help you Develop a Pathway to PCMH Recognition *(see next 2 slides)*

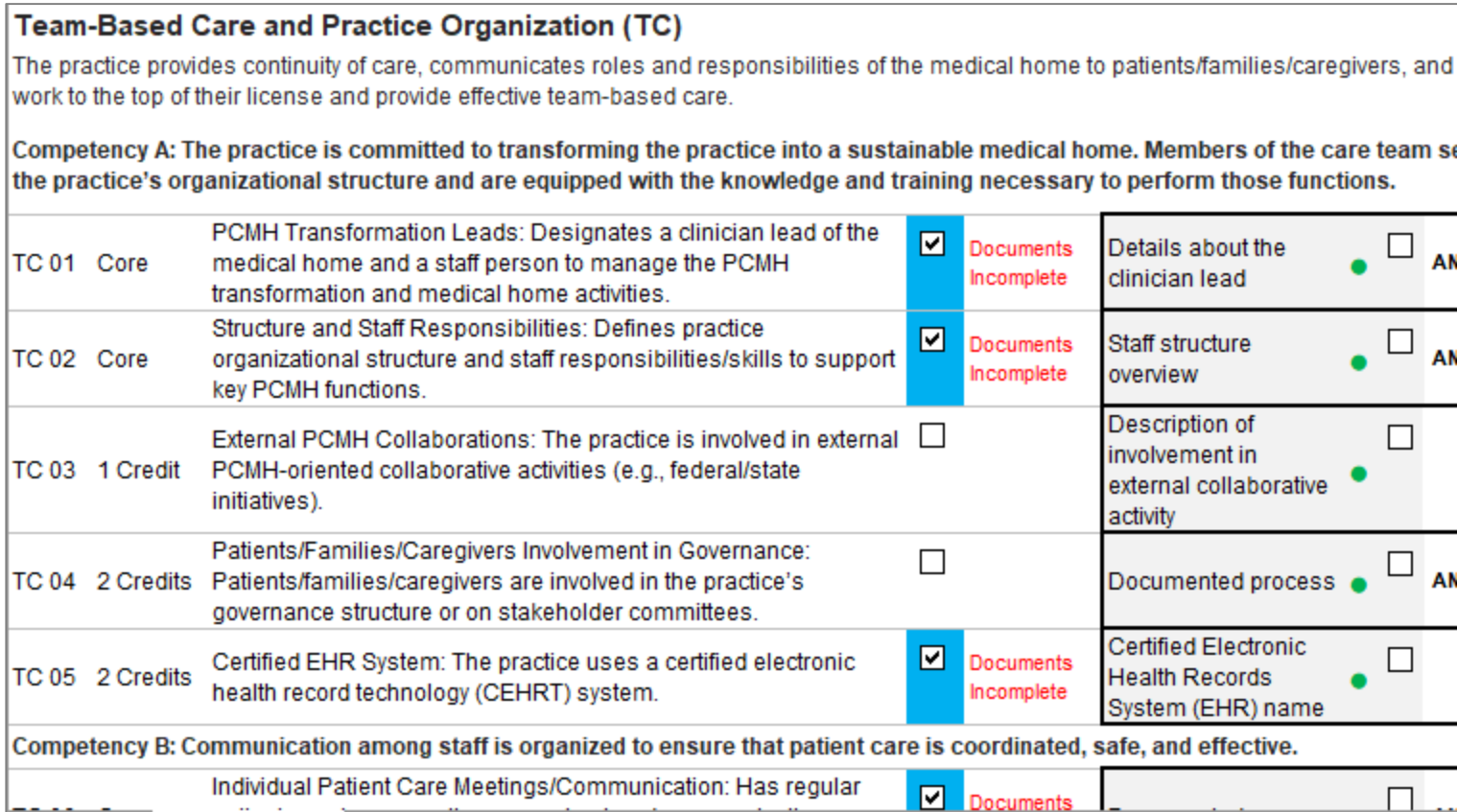
- We developed a version of the CHS PCMH Tracker where we highlighted a set of elective criteria that could get you to PCMH recognition
  - This is a jump start – not a prescription
  - This is meant for organizations new to PCMH recognition
  - Downloadable from Jump Start Pathway to PCMH Recognition
- We also created an accompanying tool – a Core Criteria Implementation Priorities Pathway.
  - One approach for choosing implementation priorities/order of operations

***Tool**: The CHS PCMH Tracker_Pathway*

- We evaluated all 100 criteria and considered which criteria **may be the most feasible for safety net organizations**.

We realize that decisions about these criteria are best left to each organization. Please consider this Pathway as just one approach, from which your organization may further tailor the criteria you wish to put in place for PCMH recognition.

https://chcleadership.com/jump-start-pathway-to-pcmh-recognition/



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Competency A: The practice is committed to transforming the practice into a sustainable medical home. Members of the care team se the practice's organizational structure and are equipped with the knowledge and training necessary to perform those functions.

TC 01	Core	PCMH Transformation Leads: Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.	☑	Documents Incomplete	Details about the clinician lead	☐	AN
TC 02	Core	Structure and Staff Responsibilities: Defines practice organizational structure and staff responsibilities/skills to support key PCMH functions.	☑	Documents Incomplete	Staff structure overview	☐	AN
TC 03	1 Credit	External PCMH Collaborations: The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives).	☐		Description of involvement in external collaborative activity	☐	
TC 04	2 Credits	Patients/Families/Caregivers Involvement in Governance: Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees.	☐		Documented process	☐	AN
TC 05	2 Credits	Certified EHR System: The practice uses a certified electronic health record technology (CEHRT) system.	☑	Documents Incomplete	Certified Electronic Health Records System (EHR) name	☐	

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

		Individual Patient Care Meetings/Communication: Has regular	☑	Documents		☐	

***Tool**: Core Criteria Implementation Priorities*

- We put together a list of core criteria, in order of priority for implementation (what to work on first, second…)
- This is one approach, we encourage you to adjust based on your organizational capacity and capabilities determined in the self-assessment
- **How to use it:**
  1. New recognition: Systematically study each criterion, engage team members, develop capacity, and prepare evidence of implementation
  2. Existing recognition: Preparing for annual check-in or accelerated renewal by reviewing core criteria to ensure processes are still in place

A Pathway for Implementation of Core Criteria
NCQA PCMH 2017 Guidelines

There are 40 core/required criteria in the NCQA PCMH 2017 Standards and Guidelines. Based on our knowledge of implementation considerations for these criteria, we recommend a pathway and priority list below. This is not meant to be prescriptive but is one approach for practices to use as they work through implementation and transformation.

Core Criteria	Criteria Brief Description	Implementation Priority
TC 01	PCMH Transformation Leads	1
TC 02	Structure and Staff Responsibilities	1
AC 02	Same-Day Appointments	2
AC 03	Appointments Outside Business Hours	2
CM 01	Identifying Patients for Care Management	3
CM 02	Monitoring Patients for Care Management	3
CM 04	Person-Centered Care Plans	4
CM 05	Written Care Plans	4
TC 06	Individual Patient Care Meetings/Communication	5
KM 03	Depression Screening	6
KM 12	Proactive Outreach	6
CC 01	Lab and Imaging Test Management	7
CC 04	Referral Management	7
CC 14	Identifying Unplanned Hospital and ED Visits	8
CC 16	Post-Hospital/ED visit Follow-Up	8
CC 15	Sharing Clinical Information	9
TC 07	Staff Involvement in Quality Improvement	10
QI 01	Clinical Quality Measures	11
QI 08	Goals and Actions to Improve Clinical Quality Measures	11
QI 02	Resource Stewardship Measures	12
QI 09	Goals and Actions to Improve Resource Stewardship Measures	12
AC 01	Access Needs and Preferences	13
QI 03	Appointment Availability Assessment	13
QI 10	Goals and Actions to Improve Appointment Availability	13
QI 04	Patient Experience Feedback	14
QI 11	Goals and Actions to Improve Patient Experience	14
QI 15	Reporting Performance within the Practice	15
AC 04	Timely Clinical Advice by Telephone	16
AC 05	Clinical Advice Documentation	16
KM 20	Clinical Decision Support	17
KM 01	Problem Lists	18
KM 02	Comprehensive Health Assessment	18
AC 10	Personal Clinician Selection	19
AC 11	Patient Visits with Clinician/Team	19
KM 14	Medication Reconciliation	20
KM 15	Medication Lists	20
TC 09	Medical Home Information	21
KM 09	Diversity	22
KM 10	Language	22
KM 21	Community Resource Needs	23

Resource: Core Criteria Implementation Priorities Pathway

5. Develop a Goal, Workplan, and Timeline

- Determine what your organization's goal will be for achieving recognition *(we typically estimate 12-18 months for new recognition)*
- Your workplan and timeline should be tied to your overall goals for PCMH recognition
- Including targets and responsibilities for **TEAM** members to develop additional patient-centered processes, as necessary
- See DRAFT workplan on the next slide

Example work plan (Month 1)

Action Steps	PCMH Criteria	Owner (List Names)	Begin Date	Target Due date	Completion
Convene PCMH Team	TC01	CHC leadership	M1	M1	M1
Identify clinical and administrative leads	TC01	CHC leadership	M1	M1	M1
Determine goals for PCMH development	n/a	CHC leadership and PCMH Team	M1	M1	M1
Complete Readiness Assessment	n/a	PCMH Team	M1	M1	M1
Identify Pathway to PCMH Implementation	n/a	PCMH Team	M1	M1	M2
Submit NOI	n/a	Admin Lead	M1	M1	M3
Request Pre-validation Documentation from EHR vendor	All	IT Lead	M1	M1	M2

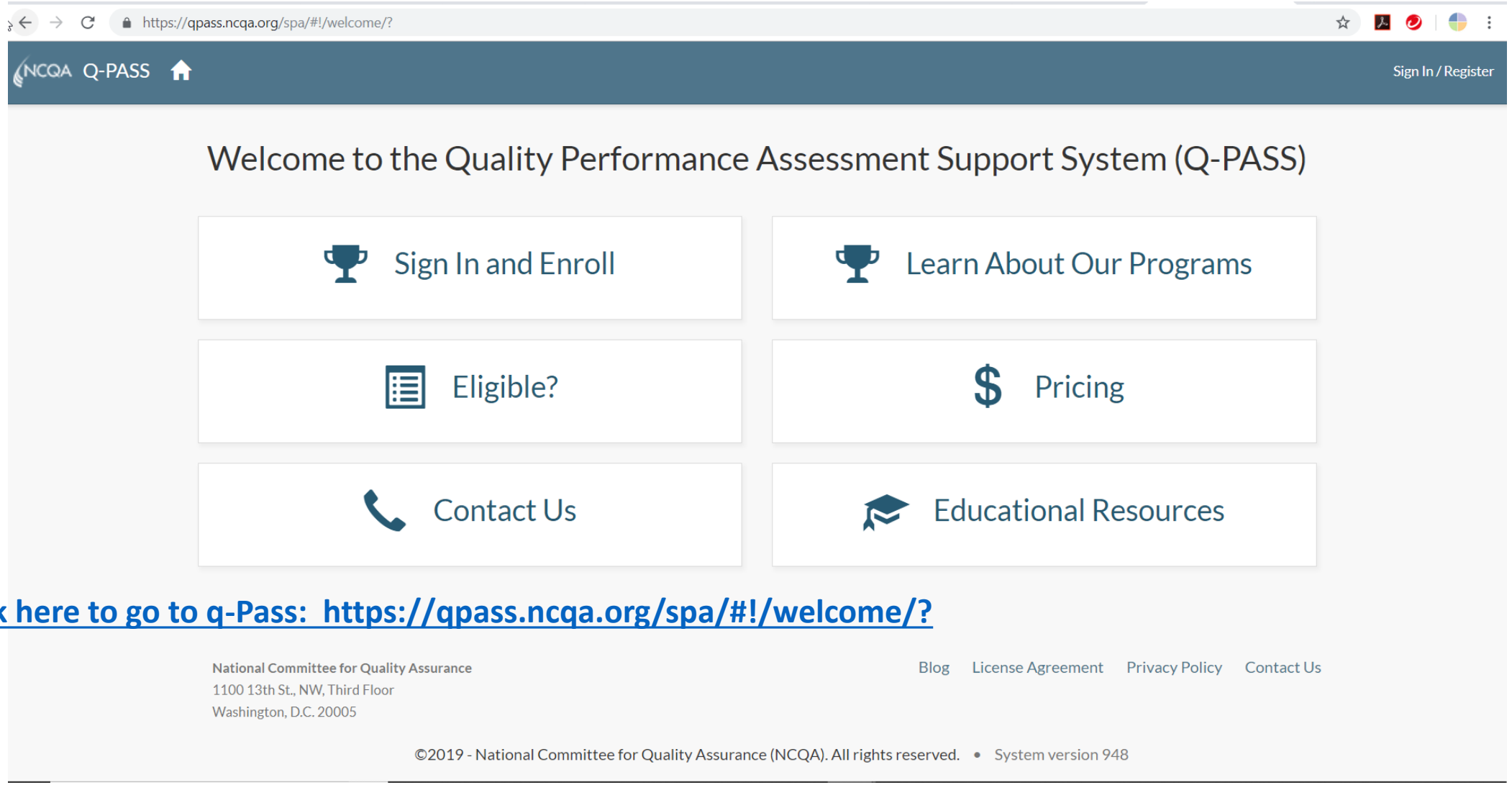
6. Begin Implementation

- Submit the NOI
- Register for Q-PASS
- Contact your EHR vendor about pre-validation
- Consult resources on chcleadership.com

How to Submit Notice of Intent (NOI) to HRSA

- https://chcleadership.com/submit-notice-intent-noi-hrsa/
- Necessary in order to have HRSA pay for recognition
- Must be done ahead of time – will not “reimburse” if you retroactively
- Functionality now in EHBs

NCQA Q-Pass



Click here to go to q-Pass: https://qpass.ncqa.org/spa/#!/welcome/?

Prevalidation and Autocredit

Prevalidation Program

Overview

NCQA prevalidated Health IT solutions have successfully demonstrated that their technology solution has functionality that **supports or meets one or more criteria in the PCMH standards**

Evaluation can result in approved **fully met criteria** and **partially met criteria** that are transferable to eligible client practices submitting for recognition and acknowledgment of **practice support functionality**

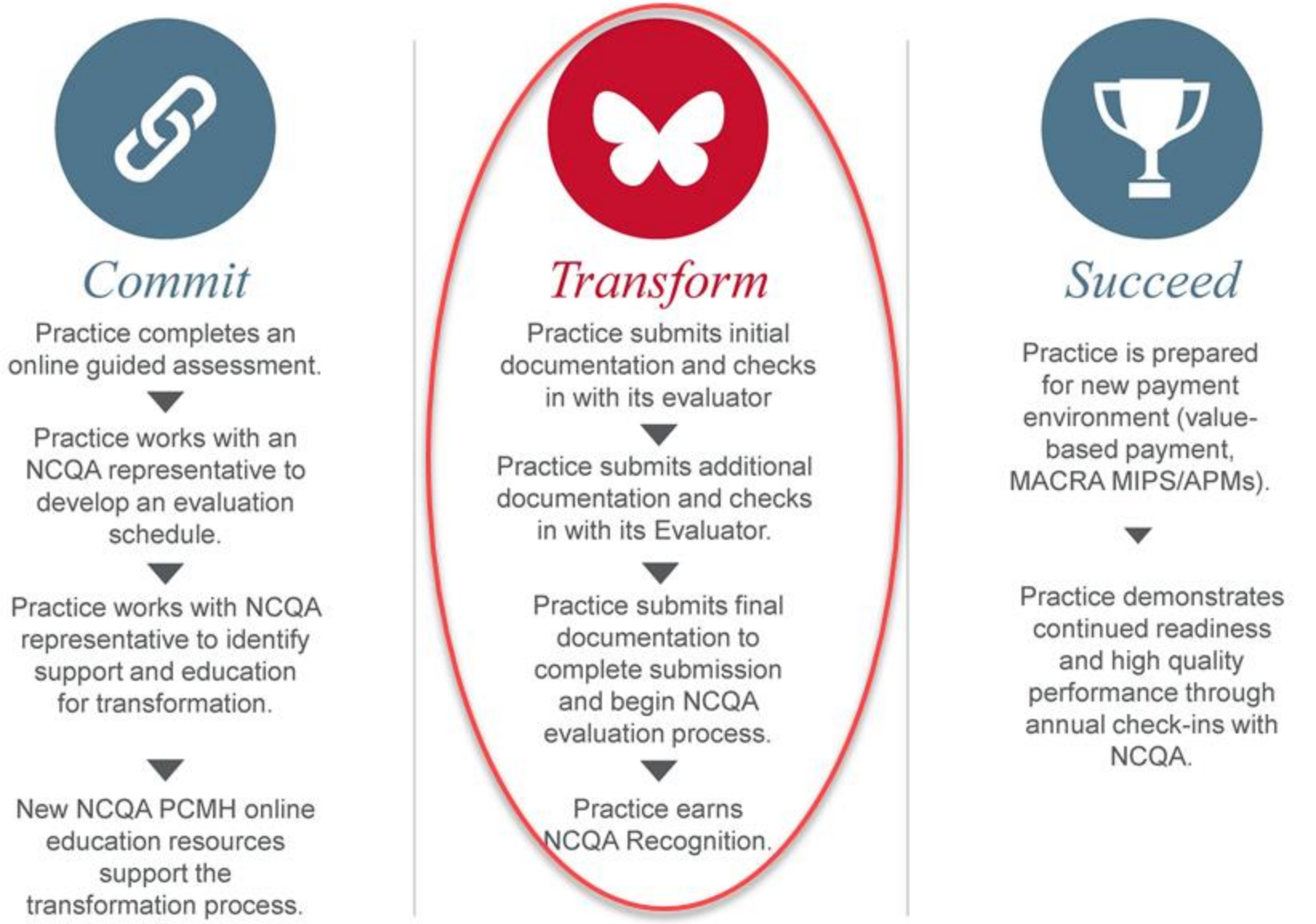
[Click here to view the NCQA Prevalidated Vendor Directory]

44 | NCQA

Transform

- As you implement certain criteria and “transform” there will be some that take more time because of “tweaks” and process changes
- Here are some of the core criteria that will take the most time for those going for new recognition:
  - KM 12: proactively identify and reach out to pts
  - AC 2: same-day appointments
  - AC 3: after hours appointments
  - CM 4 & CM 5: care plan, provided in writing
  - CC 15: share clinical information with hospitals

Transform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Practice completes an online guided assessment.
Practice works with an NCQA representative to develop an evaluation schedule.
Practice works with NCQA representative to identify support and education for transformation.
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Practice submits initial documentation and checks in with its evaluator
Practice submits additional documentation and checks in with its Evaluator.
Practice submits final documentation to complete submission and begin NCQA evaluation process.
Practice earns NCQA Recognition.
Succeed
Practice is prepared for new payment environment (value-based payment, MACRA MIPS/APMs).
Practice demonstrates continued readiness and high quality performance through annual check-ins with NCQA.

Resources available through CHCLeadership.com

- Work through each criteria one or a few at a time
- If you have questions on a specific criterion, consult chcleadership.com then reach out to your support team with additional questions
- Find resources, documentation examples, renewal guides and tools – available to Virginia CHCs to help them in their PCMH development journey for recognition and/or renewal at https://chcleadership.com/pcmh-resources/

7. Track Progress and Reassess Status

- **The CHS PCMH Tracker 2017**
  - The practice used this tool to complete an initial self assessment
  - The results were used to identify gaps and guide their pathway to recognition
  - Use the CHS PCMH Tracker to mark off criteria and documentation as they are put into place.
  - See a summary at the top of your progress toward requirements.

Resource: CHS PCMH Tracker 2017

Questions

Request Support

Your PCMH Support Team:

Caitlin Feller, Terry Laine, Sherrina Gibson

Online:

http://chcleadership.com/support/

Phone:

804-673-0166

Community Health Solutions