Enhancements to the NCQA PCMH 2014 Standards

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Objectives

To provide an overview on the major enhancements to the PCMH NCQA 2014 standards

Review recommendation for preparing for PCMH Recognition renewal
Introduction

2004- Physician Practice Connections (PPC)
Developed by Bridges for Excellence

2006- PPC updated

2008 -- PPC-PCMH

2011-- PCMH 2011

2013-- Patient-Centered Specialty Practice

2014 - PCMH 2014
Introduction--

PCMH is a model of care that emphasizes care coordination and communication for primary care practices to deliver care that the patients want.

Patients in medical homes receive the right care, at the right time, in the right amount.

PCMH practices leads to safer, better care, empowers patients, and renews the patient/provider and care team relationship.

PCMH embraces the full meaning of the triple aim which is; better outcomes, cost effective care, and satisfied patients.
The Building Blocks for PCMH Transformation

1. Laying the Foundation
   - Engaged Leadership

2. Building Relationships
   - Empanelment
   - Continuous and Team-Based Healing Relationships

3. Changing Care Delivery
   - Patient-Centered Interactions
   - Organized, Evidence-Based Care

4. Reducing Barriers to Care
   - Enhanced Access
   - Care Coordination
Experience of Care

Health of a Population

Per Capita Cost

IHI Triple Aim
PCMH Recognized Practices

- NCQA reports 8386 practices have received PCMH recognition (November 2014)

- Nationally, 58% of FQHCs have at least 1 site recognized as a PCMH. (October 2014 BPHC)

- In Massachusetts, 81% of health centers are PCMH recognized (MLCHC October 2014)
Recognition Levels and Point Requirements

- **Level 1:**
  35–59 points and all 6 must-pass elements

- **Level 2:**
  60–84 points and all 6 must-pass elements

- **Level 3:**
  85–100 points and all 6 must-pass elements
PCMH Eligibility

Practice defined – Providers practicing together at a single geographic location

Recognition is at the geographic site- one recognition per address, one address per survey

Providers are listed at each site where they routinely see a panel of patients
2014 NCQA PCMH 6 Standards of Care

PCMH 1: Patient-Centered Access

PCMH 2: Team Based Care

PCMH 3: Population Health Management

PCMH 4: Care Management & Support

PCMH 5: Care Coordination & Care Transitions

PCMH 6: Performance Measurement & Quality Improvement
PCMH 2014 – 6 Must Pass Element
Score for each Must-Pass element must be \( \geq 50\% \)

- **PCMH 1A**: Patient Centered Appointments & Access
- **PCMH 2D**: The Practice Team
- **PCMH 3D**: Using Data for Population Management
- **PCMH 4B**: Care Planning & Self Care Support
- **PCMH 5B**: Referral tracking and follow up
- **PCMH 6D**: Implement Continuous Quality Improvement
### 9 Critical Factors

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<td>1A Factor 1</td>
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2014 Standard Updates, Major enhancements

- Team Based Care
- Behavioral & Mental Health integration
- Measuring Health Care Costs
- Population Management
- Care Coordination
- Continuous Improvement
- Meaningful Use Alignment
PCMH Standard 2- Team Based Care

A- Continuity
   Having a process to orient new patients to the practice (2A3)

B- Medical Home Responsibilities
   Inform patients how behavioral health needs are met
   Gives uninsured patients information about obtaining coverage
   Instructions on transferring records and point of contact

C- CLAS
   Clarifies for “Interpretation services”- Family or friend does not meet the intent of this standard

D- The Practice Team
Team Based Care con’t

- 2D Factors 1 thru 10 - the new must pass element
- Factor 2 is new - “Identify practice organizational structure & staff leading & sustaining team based care”
- 2D2 - Focus is on the design and operations of the care teams and training team members
- Factor 8 is new - “Holding regular team meetings addressing practice function”
- 2D8 - Focus is on scheduled team meetings to improve care for all patients, to discuss practice and staff functions
Further Integration of Behavioral and Mental Health

• Point of care reminders includes a mental health or substance use disorder (Standard 3E1)

• ID patients that may benefit from Care management for behavioral health conditions (Standard 4A1)

• Practices to maintain agreements with BH providers (Standard 5B3) & more specific focus on referrals to BH

• Services related to BH are communicated to the patient
Measuring Health Care Cost

- Monitoring “no show” rates (Standard 1A5)
- Identify patients who may benefit from care management; high cost/ high utilization (Standard 4A)
- Measure Resource Use and Care Coordination- at least two measures affecting health care costs (Standard 6B2)
• The comprehensive health assessment which is 3A & 3B- Must provide a report for each factor, no longer just showing “the process”

• New is 3C Factor 10-Assessment of health literacy

• Annually, must show active outreach to patients (point of care reminders) on a scheduled basis for a specific need (3D- must pass)

• Increased requirement for evidence based decision support from 2011
  - Previously 3 conditions, now 5-6 conditions
    2 different preventative care services 3D1
    2 different immunizations 3D2 (new)
    3 different chronic or acute services 3D3
    Patients not recently seen 3D4
    Medication monitoring or alert 3D5

• Renewing practices must show 2 factors have been met during each year of renewal.
Poor patient outcomes
Missed Prevention opportunities
Unsafe practices
Dissatisfied patients
Wasteful spending

The lack of coordinated care can lead to..........

Biggest enhancements to 2014- Care coordination
Element A: Identify Patients for Care Management

The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following:

1. Behavioral health conditions.
2. High cost/high utilization.
3. Poorly controlled or complex conditions.
5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver.
6. The practice monitors the percentage of the total patient population identified through its process and criteria. (CRITICAL FACTOR)

4A Factors 1 to 6 are all new factors
Care Coordination con’t

• New record review or electronic reports are from identified patients for care management in 4A. No longer the three important condition from 2011.

• Documentation from medical records for;
  - 3C Comprehensive health assessment
  - 4B Care planning and self-support- Expanded to include caregivers, evaluate collaboration to develop & update individualized care plans
  - 4C Medication management

• Two (2) methods for medical record abstraction of data;
  Method #1- Report from electronic system, requires numerator/denominator for each factor
  Method #2- Record Review Workbook- Now 30 records AND each factors must have “documentation” example.
Continues to be the “Continuous Improvement Standard” ...only sequencing of factors different

Practices make efforts to improve in patient experience, cost and clinical quality i.e. Triple Aim

Practices conduct activities at least annually and are subject to audit (annually is new)
6A1- Measure Clinical Quality Performance

Measure at least annually (new)
Renewing practices demonstrate annual measurement for two (2) years
- Must identify at least eight (8) different clinical measures

- Two (2) immunization measures (new)
- Two (2) preventative care measures (2011 it was 3)
- Three (3) chronic or acute care measures (same as 2011)
- One (1) immunization, preventative or chronic/acute care measure for a vulnerable population (new)
PCMH 6- Monitoring & Improving Performance con’t

6B - Measure Resource use and Care Coordination
   - Measure annually
   - Renewing practices must demonstrate annual measurement for two (2) years (new)
   - Must identify at least four (4) measures
     - Two (2) measures related to care coordination (new)
     - Two (2) utilization measures affecting health care costs

6C - Measure Patient & Family Experience
   -(new) Annual Patient Surveys

6D - Implement Continuous Quality Improvement
   -(new) Must improve one patient experience measure
Meaningful Use Alignment

- Where there are similar requirement, MU stage 2 definitions and thresholds are embedded in the 2014 standards
- NCQA treats each of the MU requirements as a separate factor
Questions on the standards?
Renewals

NCQA emails reminders to practice primary contact 6 months before expiration

Keep NCQA updated on primary contact changes so you don’t miss out on this notification

Practices should apply for renewal at least two months before their recognition expiration date

Level 1 Practices- Full Survey tool for 2014 Standards
Streamlined Renewals

• NCQA offers a streamlined process for renewal through reduced documentation requirements for single & multi-site practices with current NCQA Level 2 or Level 3 Recognition

• Even though some elements do not require a practice to submit documentation, practices must be able to produce documentation if selected for audit

• Required to “attest” to standard eligibility and meeting the requirements for identified factors, must sign a waiver.
Single Site Streamline Renewal Requirements
15 Attestation Elements
11 Documentation Elements

The 11 documentation elements include:

*1A  - Patient centered appointment access
*2D  - The Practice Team
  3C  - Comprehensive Health Assessment
*3D  - Data for population Management
  4A  - Patients identified for Care Management
*4B  - Care planning & Self-Care Support
  4C  - Medication Management
*5B  - Referral Tracking & follow-up
  6B  - Measure Resource Use & Care Coordination
*6D  - Implement CQI
  6E  - Demonstrate QI

*The six (6) Must Pass Elements
Multi-site Streamline Renewal Requirements

17 elements available for Corporate Survey must be able to respond to at least 12 elements, 9 site specific elements

Same attestation statement as single site

15 Attestation elements & 11 Documentation Elements

Multi-sites with combination of Level 1, 2, 3 Recognitions Can use the reduced documentation, however, Level 1 or non-recognized practices, must include responses and documentation for all site specific elements in the survey tool
Recommendations for 2014 PCMH

Get your 2014 NCQA PCMH Standards-free of charge

Purchase the $80 ISS survey tool and use it as your guide /scoring for the 2014 Standards

Decide if pursuing single or multi-site survey start preparing documents 9 to 12 months before you plan to renew

Multi-site survey process is followed for multi-site renewals
Recommendations for 2014 PCMH con’t

Plan adequate time - team approach is recommended

Focus on Must Pass Elements first and secondly the critical factors

Prepare NCQA reviewer friendly documents and pay attention to the document requirements

Always submit NOI, application & ISS tool together-one for each initial, add-on, or renewal.

NOI to HRSA first, application next - 5 days before sending ISS tool.
Auto Credit

NCQA provides auto credit to EMR vendors for scored factors where EMR technology meets the factor requirements.

EMR vendors must go through a NCQA Prevalidation for auto credit.

The need for practices to provide required documentation within the PCMH survey is eliminated.
Pre-validated Vendor List

A full list is on the NCQA web-site

EMR vendors familiar to our health centers are:
- GE Centricity
- e-Clinical Works
- Athena
- Greenway Intergy
NCQA RESOURCES

“Start to Finish” flowchart to plan your path to PCMH recognition- Learn It, Earn It, Keep It
http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx

PCS system - Policy Clarification Support
http://ncqa.force.com/pcs/login

Webinars/Seminars
Thank you
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