WACMHC

Washington Association of Community & Migrant Health Centers

Putting PCMH into Practice: A Transformation Series

Team-Based Care and Practice Organization (TC)

May 16, 2018

WEBINAR FACILITATOR

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FEATURED PRESENTER

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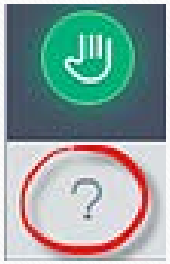
Qualis Health

HOUSEKEEPING

- Your lines are currently muted
- We'll address questions at the end of the presentation
- You can ask a question in the following ways:



RAISE YOUR HAND FUNCTION - your line will be unmuted and you can ask the question verbally

QUESTIONS FUNCTION – type your question in the box and the facilitator will read it aloud

- This webinar is being recorded. A recording will be sent to you in a follow-up email.

Consider the following key changes for team-based care:

1. Describe how your practice carves out protected time for care teams to meet together to discuss team functioning, improvement efforts, other?

2. What is the process to orient/introduce new patients to your medical home practice?

3. How does your practice engage the patient/family/caregiver as a member of the care team?

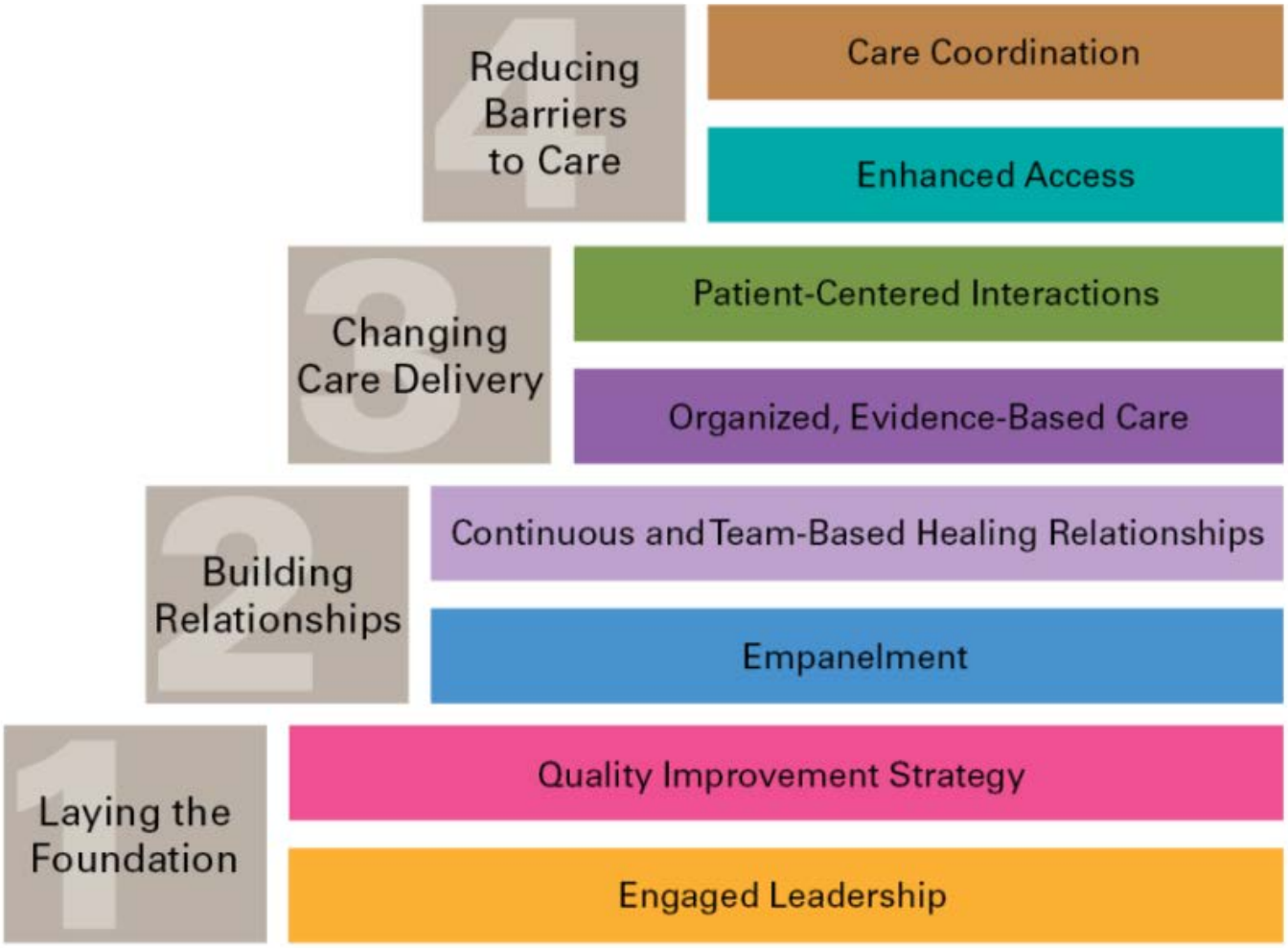
2017 NCQA PCMH Standard 1: Team-Based Care and Practice Organization (TC)

Advancing Healthcare
Improving Health

Webinar 2 Objectives

- Describe the relationship between the Change Concepts for Practice Transformation “Team-Based Healing Relationships” and the NCQA PCMH recognition requirements for “Team-Based Care (TC)”
- Identify current processes within your practice that align with the NCQA requirements

Change Concepts for Practice Transformation



Key Changes

- Establish and provide organizational support for care delivery teams accountable for the patient population/panel.
- Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care.
- Ensure that patients are able to see their provider or care team whenever possible.
- Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.

Team-Based Care and Practice Organization (TC)

Standard 1 (TC) Questions

- Details about requirements for TC 01, can this be one person for multiple sites?
- Details about what will work for documented process and evidence in general.
- Communication (TC 06)
- Defining team roles and responsibility development (TC 02)
- TC 03 & TC 04 - need more training/guidance

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.
- 3 Competencies
- 9 Criteria

TEAM-BASED CARE AND PRACTICE ORGANIZATION (TC)			
Criteria	**Criteria Title**	**Shared or Site-Specific?**	**Review or Attestation?**
Competency A: Practice Organization, Team Roles and Training			
TC 01* (Core)	PCMH Transformation Leads	Shared	Review
TC 02 (Core)	Structure & Staff Responsibilities	Shared	Attestation
TC 03* (1 Credit)	External PCMH Collaborations	Shared	Attestation
TC 04* (2 Credits)	Patient/Family/Caregiver Involvement in Governance	Shared	Review
TC 05 (2 Credits)	Certified EHR System	Shared	Attestation
Competency B: Care Team Communication and Functioning			
TC 06 (Core)	Individual Patient Care Meetings/Communication	Partially Shared**	Review
TC 07 (Core)	Staff Involvement in Quality Improvement	Shared	Attestation
TC 08* (2 Credits)	Behavioral Health Care Manager	Shared	Review
Competency C: Patient/Family/Caregiver Orientation			
TC 09 (Core)	Medical Home Information	Shared	Attestation

*New criteria in 2017 edition of PCMH Standards & Guidelines.
**Documented processes may be shared, but all other evidence must be site-specific.

TC Criteria Requiring Documented Processes

- TC 04 Elective-patient involvement in governance - New
- TC 06 Core-staff structured communication – Aligns with PCMH 2014 2D3 (huddles)
- TC 07 Core-staff involvement in QI – Aligns with PCMH 2014 2D9
- TC 09 Core-informs patients about the role of the medical home – Aligns with PCMH 2B

Competency A

- The practice is committed to transforming 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 to perform those functions.

Competency A Criteria

- **TC 01 (Core) PCMH Transformation Leads**
- TC 02 (Core) Structure and Staff Responsibilities – Aligns with PCMH 2014 2D 1 and 2
- **TC 03 (Elective 1 Credit) External PCMH Collaborations**
- **TC 04 (Elective 2 Credits) Patient/Family/Care giver Involvement in Governance**
- TC 05 (Elective 2 Credits) Certified EHR System – Aligns with PCMH 2014 6G 1 - 2

Competency A - TC 01 (Core) PCMH Transformation Leads - ***New***

- Identifies the clinician lead and the transformation manager (the person leading the PCMH transformation). This may be the same person.
- Evidence = details about the clinician lead and the PCMH manager; the practice provides details including the person's name, credentials, roles & responsibilities.

TC 01 Clarification

- Question: Who can be the clinical lead?

- Answer: For core criterion TC 01, the clinician lead of the medical home must be a clinician as defined in the PCMH Policies and Procedures, which includes clinicians with an unrestricted license as an MD, DO, APRN or PA; however, NCQA is not prescriptive regarding the staff member who can be designated as the PCMH manager.

Competency A -TC 02 (Core) Structure and Staff Responsibilities

- Provide an overview of practice staff; an outline of duties the staff are expected to execute as part of the medical home; and how the practice will support and train staff to complete these duties.
- Evidence = Staff structure overview and description of staff roles, skills and responsibilities. Care team staff training program. ***Aligns with PCMH 2D1, 2, 5, 6, 7***

Sample POSITION DESCRIPTION

SECTION 1 - POSITION INFORMATION

Department Name: Health

Division Name: Clinical Services

Current Job Class Title: **Clinic Medical Assistant**

Class Code # Position #

Working title: Panel Manager
(if different than class title)

Is this (please check the appropriate box) your
☐ regular assignment ☐ out of class work assignment
☐ Full time ☐ Part-time, hours/week ____

Origin Date: 12/11/2015

Phone Number: ext.

Supervisor Name/Title:

Phone Number: ext.

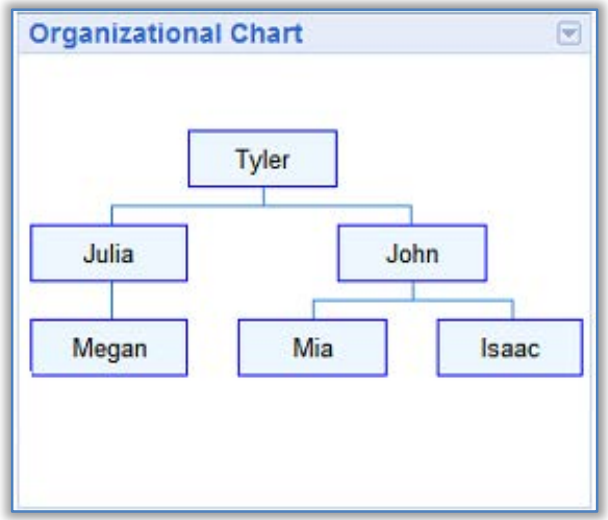
SECTION 2 - PROGRAM INFORMATION: Integrated Clinical Services provides quality health services for people who experience barriers to accessing care. The vision of Integrated Clinical Services is to provide services that are integrated and connected to support optional health, reducing wait times and optimizing access

PURPOSE OF POSITION: The Panel Manager tracks the health of the population of patients assigned to a provider panel. This includes proactively tracking prevention activities, screening and chronic disease monitoring and providing patient education. Manages team communication including team phone messages and in-basket as well as patient communication and follow-up. Performs general provider support duties as needed to support clinic flow.

SECTION 3 - DESCRIPTION OF JOB DUTIES -- Most jobs generally consist of four to six major functions that relate directly to the purpose of the position. List these major functions, along with key tasks performed. Functions will be sets of tasks that generally take 10% or more of the job. List the major functions with the corresponding percentage of time, in **descending** order of time required.

% of Time	ESSENTIAL JOB FUNCTIONS
35%	FUNCTION 1: **TRACKING** Utilizes electronic reports and review of provider schedules to proactively assess needs for prevention screening and communicates via EHR. Monitors chronic disease reports and initiates follows up with clients or ensures appropriate referrals as needed. Forecasts immunizations. Collaborates with Team Clerical assistant to ensure appropriate tracking and follow-up of referrals

Competency A -TC 02 (Core) Organizational Structure – Examples



Training Schedules

PCMH 2D; 5, 6, & 7- Clinic
Training schedule for staff
Clinic Operation Manual Origin
February 1, 2012 and Updated
June 1, 2015

Employees of Turner House Children's Clinic will be trained on the first week of each month according to the following schedule:

Certified Medical Assistant Training Schedule:

	January	Review of Medical Records Policies and HIPAA
PCMH 2D; 6	February	Vulnerable Population - Uninsured; Communication and Sensitivity skills
PCMH 2D; 7	March	Review of Chronic Disease Management, Registry Patients/Evidence Based Guidelines
	April	Review of Laboratory and Radiology Policies
	May	HIPAA
	June	MA Competencies/Training for Reviews
	July	OSHA
	August	Review of Immunization Policies
	September	Review of Physical Assessment Policies
	October	Review of Best Practices Communication with Patients
PCMH2D; 5	November	Care team Coordination for Patient Care
	December	MA Competencies/Training for Reviews

Competency A -TC 03 (1 Credit) External PCMH Collaborations - ***New***

- Demonstrates involvement in at least one state or federal initiative or participates in a health information exchange.
- Evidence = Description of involvement in external collaborative activity (e.g., CPC+, care management learning collaborative led by the state, two-way data exchange with a local health information exchange; population-based care or learning collaborative).

TC 03

- Question: If a practice has an MOU with specialty providers to send and receive e-consults, or an arrangement with a local hospital to share patient information through an HIE or other secure interface - does this meet the intent of TC03?
- NCQA's response: For this criterion, the practice must demonstrate that it participates in an initiative that focuses on practice transformation and PCMH activities. The initiative must be external to practice, involve multiple practices, be ongoing (not a short term activity), cover multiple aspects of patient-centered care, and involve some level of collaboration between practices to share information. CPC+ is one example of this type of initiative because it focuses on implementation of multiple aspects of the PCMH model to improve patient care. TCPI participation meets the intent of TC 03, as long as PCMH recognition is a key component of this collaborative activity. We understand the TCPI initiatives vary from state to state as far as required activities. Please make sure to explain how practice leadership is involved.

Competency A -TC 04 (2 Credits) Patient/Family/Caregiver Involved in Governance - ***New***

- Patients/families/caregivers have a role in the practice's governance structure or Board of Directors.
- Organizing a patient and family advisory council (i.e., stakeholder committee).
- Evidence = Documented process and evidence of implementation

TC 04

- Question: Patient-Family-Caregiver Involvement in Governance. Would an FQHC Board which is 51% consumer meet this criteria?

- NCQA's response: TC 04 aims to have a practice engage with patients/families/caregivers to involve them in improving patient services and the care they receive at the practice, so an FQHC with 51% of the board composed of patients/families and/or consumers at that practice would meet this criteria, just be sure to explain their role. Please let us know if you have additional questions.

Competency A -TC 05 (2 Credits) Certified EHR System – Aligns with 6G

- The practice enters the name and certification number of the electronic system(s) implemented in the practice.

- Evidence = Certified EHR name. Only systems that actively used should be entered. https://www.healthit.gov/providers-professionals/security-risk-assessment

TC 05 Uses a Certified EHR

- Question: Is there any requirement that a practice use the most current version of certified EHR, an older software version will "count" as long it is certified by the ONC? What about practices who are transitioning to a new EHR that has not been fully implemented i.e. all of the modules have not "gone live"-can they claim credit for this criteria, or must they wait for the system to be fully implemented?

- NCQA's response: There is no requirement that you use the most recent version of a software available as long as it is current in meeting ONC security risk analyses and updates, as specified in TC 05. To your second question - a practice must be using an EHR that has been fully implemented.

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Competency B

- Communication among staff is organized to ensure patient care is coordinated, safe, and effective.

Competency B Criteria

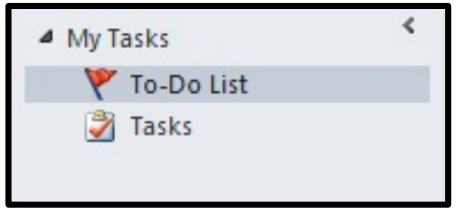
- TC 06 (Core) Individual Patient Care Meetings/Communication – Aligns with PCMH 2014 2D3
- TC 07 (Core) Staff Involvement in Quality Improvement – Aligns with PCMH 2014 2D9
- **TC 08 (2 Credits) Behavioral Health Care Manager - NEW**

Competency B -TC 06 (Core) Individual Patient Care Meetings

- The practice maintains a structured communication process, sharing information about patients, care needs, concerns for the day and other information that encourages efficient patient care and practice flow.

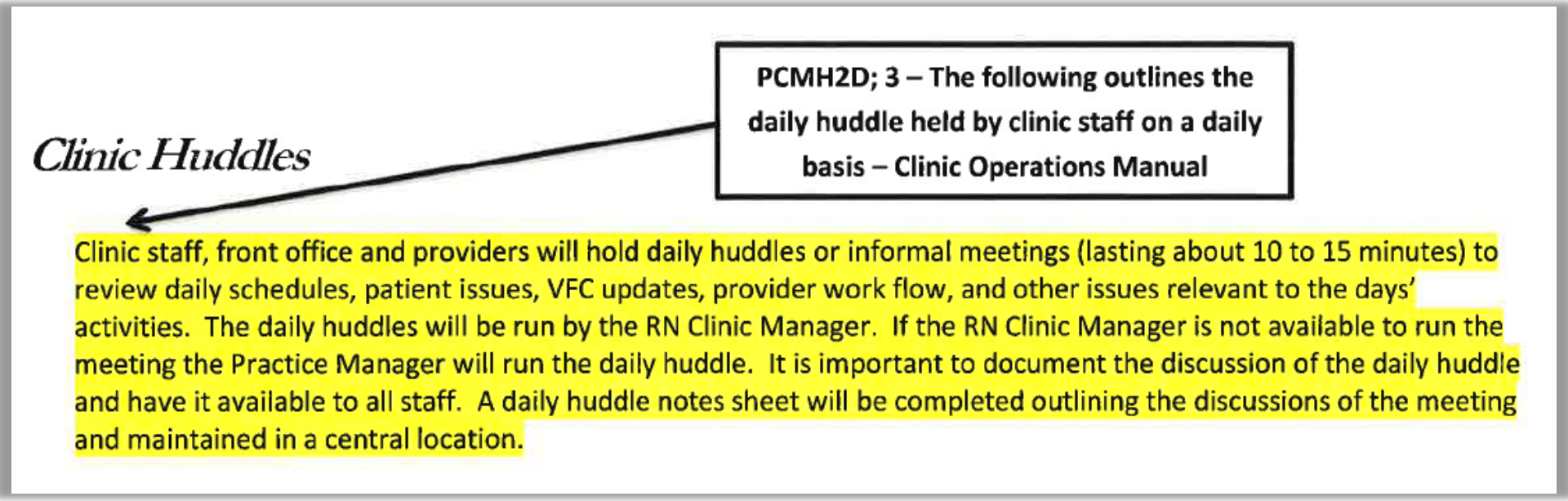
Competency B -TC 06 (Core) Individual Patient Care Meetings

- The process may include tasks or messages in the medical record, regular e-mail exchanges, or notes on the schedule about a patient and the roles of the clinician or team leader and others in the communication process.



- Evidence = Documented process and evidence of implementation. ***Aligns with PCMH 2014 2D3***

Competency B Criteria -TC 06 (Core) Structured Communication Process Evidence



Source: Turner House Children's Clinic, 2015, used with permission.

Weekly Clinical Huddle Meetings June 1st thru 5th, 2015

Date	Today's Schedule	Clincal Topics	VFC Updates	Human Resource Reminders	Provider Work Flow Topics	Clinical Statistics Review	Upcoming Events	Misc	No Huddle Held Today	Huddle Leader Initials
6/1	✓	✓			✓		✓	✓		

Notes: Discussed dental integration into the clinic

06/30/2015	[redacted]	2015/06/30 ED/UCC Provider Not	Quinones, Maria

Cartagena,Evelyn 06/30/2015 04:38:04 PM CDT > do you want us to schedule a PE? Pankey,William A 06/30/2015 05:05:49 PM CDT > yes with carefully documented telephone encounter that we have not heard from them since warning letter about missed appts for [redacted] and [redacted] on 12/14/14. Will terminate with next missed appt and inform insurance co. If they have been seeing another PCP, please identify and change. Quinones,Maria 07/29/2015 03:36:05 PM CDT > Spoke to dad, dad states him and wife are getting devorice, but also no longer live in clinic. he states they have been taking children to a different clinic but does not know where because he has no contact with mom, asked for valid # and he states that he only talks to her through Facebook. Dad states they have been recently taken to Missouri Health Dept for immunizations. Dad stated he would tell mom to contact clinic so she could provide us with information needed. Pankey,William A 07/29/2015 04:51:19 PM CDT > Inactivate pt and sibs if mom does not call by

Documents 1 to 1 of 1

PCMH 2D; 3 - This is Example 3 of an Emergency Room (ED) note in the Review Documents section of the patient chart. The Care Coordinator is contacting the Provider through the patient chart as an outstanding issue to determine if a PE is needed after the ED visit.

Turner House Children's Clinic

Source: Turner House Children's Clinic, 2015, used with permission.

Turner House Children's Clinic

[redacted]

Provider: Thorne, Julie

Telephone Encounter

Answered by Cartagena, Evelyn

Date: 07/29/2015
Time: 01:46 PM

Caller Nadine @ CMH

Reason Neurology Referral

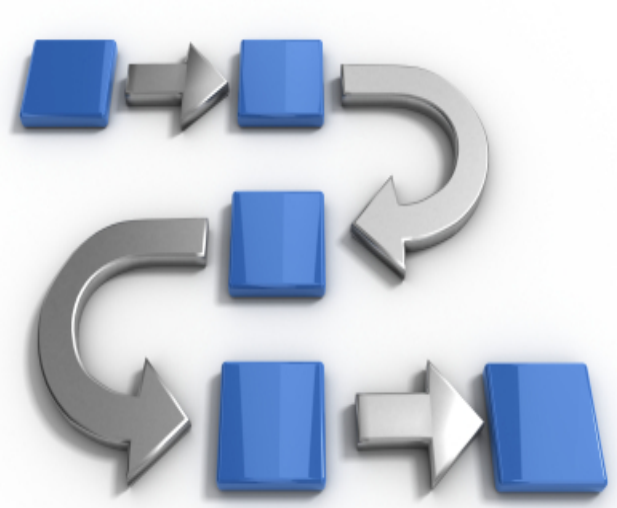
Message Julie for the neurology referral they are scheduling out until October. Does [redacted] need something sooner? Let me know.

Action Taken Thorne,Julie 07/30/2015 08:56:29 AM CDT > I think that will be fine. He's only had the one incident. Just let mom know if he has additional problems, come to the clinic and we will try to get him in earlier. Thanks, Julie

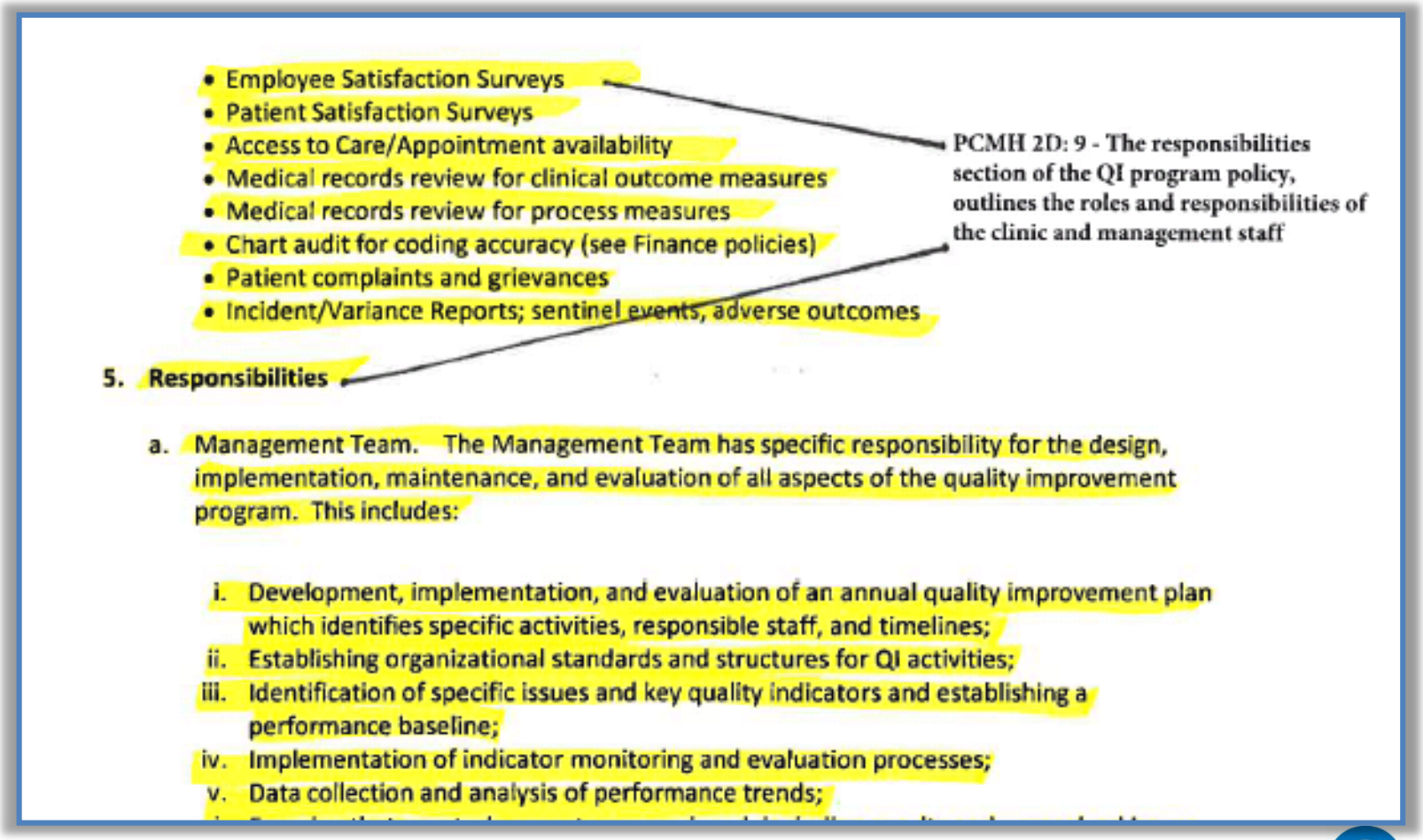
Source: Turner House Children's Clinic, 2015, used with permission.

Competency B -TC 07 (Core) Involves Care Team in QI Activities

- The documented process for quality improvement activities includes a description of staff roles and staff involvement in the performance evaluation and improvement process.
- Evidence = Documented process and evidence of implementation. ***Aligns with PCMH 2014 2D9***



TC 07 Example



- Employee Satisfaction Surveys
- Patient Satisfaction Surveys
- Access to Care/Appointment availability
- Medical records review for clinical outcome measures
- Medical records review for process measures
- Chart audit for coding accuracy (see Finance policies)
- Patient complaints and grievances
- Incident/Variance Reports; sentinel events, adverse outcomes

PCMH 2D: 9 - The responsibilities section of the QI program policy, outlines the roles and responsibilities of the clinic and management staff

5. Responsibilities

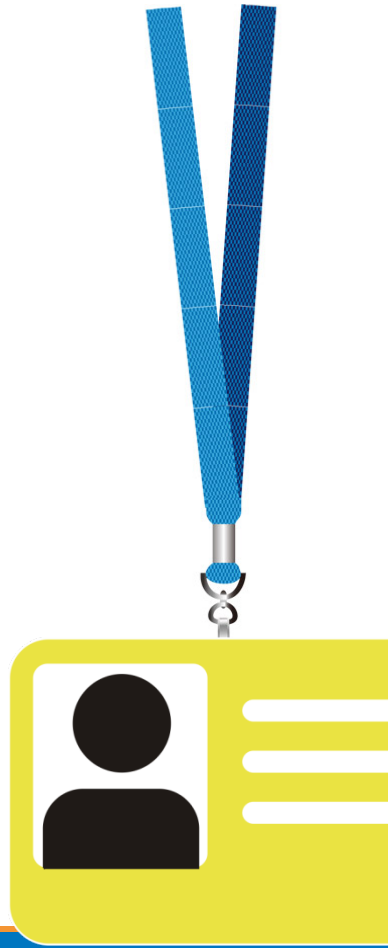
a. Management Team. The Management Team has specific responsibility for the design, implementation, maintenance, and evaluation of all aspects of the quality improvement program. This includes:

i. Development, implementation, and evaluation of an annual quality improvement plan which identifies specific activities, responsible staff, and timelines;
ii. Establishing organizational standards and structures for QI activities;
iii. Identification of specific issues and key quality indicators and establishing a performance baseline;
iv. Implementation of indicator monitoring and evaluation processes;
v. Data collection and analysis of performance trends;

Source: Turner House Children's Clinic, 2015, used with permission.

Competency B -TC 08 – ***New*** (2 Credits) Behavioral Health Care Manager *UPDATED!*

- The practice demonstrates that it is working to provide meaningful behavioral healthcare services to its patients by employing a care manager who is qualified to address patients' behavioral health needs.
- Evidence = identifying the behavioral healthcare manager and providing their qualifications.



Competency C

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

Competency C TC 09 (Core) – Medical Home Information

- The documented process includes providing patients/families/caregiver with information about the role and responsibilities of the medical home.
- ***Aligns with PCMH 2014 2B 1-5***

TC 09 – At a Minimum Includes Information On:

- After-hours access
- Scope of services
- Evidence-based care
- Availability of education
- Self-management support
- Points of contact

- Evidence = Documented process and evidence of implementation

Competency C TC 09 – Medical Home Information

Patient Orientation: (effective 1/1/2017) Clinical Operation Manual
All patients establishing care are provided with a new patient "Welcome Packet". The welcome packet introduces our patient's to our team based medical center model.
Packet information:

- Welcome Letter
- Care Team Card
- Is Your Family's Care Affordable Brochure
- Refer A Friend Card
- Missed Appointment Agreement
- Coverage To Care Roadmap

All new patients schedule with in the Electronic Health Record System become linked with a scheduled appointment with the Social Worker. The Social Worker is responsible for orienting patients to the Wood County Community Health and Wellness Center and providing the Welcome Packet.
Orientation includes:

- Overview of services
- Patients Responsibilities
- Health Center Responsibilities
- Care Team Card
- Sliding fee program
- Patient Portal

Welcome Packet Material:

Competency C TC 09 – Medical Home Information

Convenient. Affordable. Comprehensive.

WELCOME.

Welcome to your medical home! Thank you for choosing the Wood County Community Health and Wellness Center. Our team approach focuses on you.

BENEFITS

- We are available 24/7.
- We know you and remember your health history.
- We take the time to make sure you understand your condition(s) and how to take care of yourself.
- We help you coordinate your health care with specialists.
- We help you transfer records from other providers.
- We support you to set goals for your care and help you reach them.
- We return calls within 24 business hours.
- We offer same day appointments.

PATIENT RESPONSIBILITIES

- You are the center of your care. What you say and do matters.
- You must pay for services when you come in for your appointment.
- You are responsible for updating any personal information.
- Please give at least a 24-hour notice for cancellations.
- If you are late for your appointment you may be asked to reschedule.

WHAT TO BRING TO YOUR VISIT

- Insurance and benefit cards.
- Proof of income, such as a check stub (to apply for our sliding fee benefit).
- All medicines and vitamins that you are taking.
- Questions you have about the reason for your visit.
- Cash, check, credit or debit cards to pay for co-pays or nominal fees. (There is a small fee for credit or debit card use.)
- Please arrive early to have time to complete any paperwork.

We look forward to providing you and your family with the highest quality care.

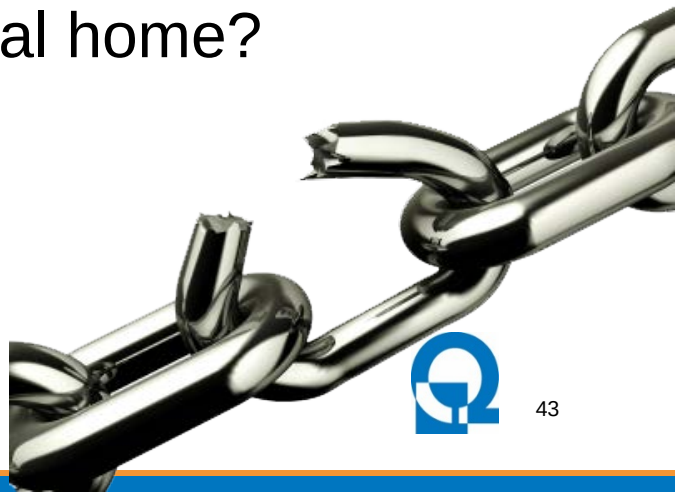
YOUR CARE TEAM.

NCQA Nuggets

- Evidence reviewed during virtual check-ins does not have to be uploaded to Q-PASS
- The Annual Reporting (AR) requirements have been updated for 2018 through 9/30/18.
- Version 2 of the 2017 standards published 10/4/2017
- QPASS has been update twice since its inception with more follow

TC Weak Links – from 2011 to 2017 Core Criteria

- How are you structured to provide regular training to the care team on PCMH topics
- Describe your structured care team communication processes (huddle, email, direct messaging through EHR, other?)
- How are care team members involved in QI?
- How are patients/caregivers informed of the role of the medical home?



Questions?

Where Can I Learn More?

- Recognition Program - NCQA Q-Pass
- NCQA seminars-and-webinars/live-seminars-webinars
- Change Concepts - Team-Based Care
- What to Expect During a Virtual Review
- NCQA PCMH 2017 Getting Started Page

Join us for the Series!

Knowing and Managing Your Patients (KM)

Wednesday, June 13, 12-1:15 PM

REGISTER HERE

Learning Objectives:

-Identify data sources that provide information on your population, enabling your practice to tailor services specific to meet population health needs

-Evaluate methods to address cultural competency and diversity within your practice

-Consider ways to establish connections to community resources based on patients' expressed top needs and concerns

Upcoming WACMHC Trainings

Enhancing Workplace Dynamics through Managerial Skills Training
Teambuilding Through Inspiring | June 13 & 25
Foundations of Emotional Intelligence | June 14 & 26

APM: A Path to Innovative Care - An Oregon FQHC's Experience
May 31 | 12:00 – 1:00pm
REGISTER

Supporting Patients at Risk for Diabetes
June 6 | 12:00 – 1:00pm
REGISTER

Please complete the evaluation after the end of the session. Your feedback is appreciated!

Questions? Contact the WACMHC Practice Transformation Team at
QualityImprove@wacmhc.org