

WACMHC

Washington Association of Community & Migrant Health Centers

Putting PCMH into Practice: A Transformation Series

The Redesigned Recognition Process

April 25, 2018

WEBINAR FACILITATOR

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Practice Transformation Coordinator WACMHC



FEATURED PRESENTER

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> Senior Consultant 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.

2017 NCQA PCMH Recognition Process



Advancing Healthcare Improving Health

Objectives

- Highlight the latest updates in the redesigned process from NCQA
- Review the NCQA Accelerated Renewal Process & QPASS set up
- Compare the NCQA Annual Reporting Process and Requirements with the NCQA PCMH 2014 Standards
- Focus on true transformation embedding PCMH into the operations of the practice



Reduced Documentation Burden? Maybe

 From 167 factors in 2014 PCMH to 100 "criteria" in 2017 PCMH





2017 Standards

Concepts



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





Anatomy of a Standard

Concept

Competency and Description of Performance Expectation

Criteria

Description Core or Elective

Additional Information on what NCQA is looking for

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.

GUIDANCE

The practice identifies the clinician lead and the transformation manager (the person leading the PCMH transformation). This may be the same person. The practice provides details including the person's name, credentials and roles/responsibilities.

PCMH transformation is successful when there is support from a clinician lead. Their support sets the tone for how the practice will function as a medical home. The intent is to ensure that the practice has clinician and leadership support to implement the PCMH model and to acknowledge the role of staff in the practice's everyday operations.

EVIDENCE

- Details about the clinician lead AND
- Details about the PCMH manager

Shareable Across

Practice sites

Documentation Requirements

2017 Standards

Structure - Example

Concept: Patient-Centered Access and Continuity

The PCMH model seeks on enhance access to appointments and clinical advice based on the patient's needs. In addition to being key to patientcenteredness, evidence explicitly supports that providing enhanced access including same-day, extended hours and telephone advice from clinicians with access to the patient record reduces ED visits and hospitalizations.

Core Criteria

Assesses the access needs and preferences of the patient population.

Provides same-day appointments for routine and urgent care to meet identified patients' needs.

Provides routine and urgent appointments outside regular business hours to meet identified patients' needs.

Provides timely clinical advice by telephone.

Documents clinical advice in patient records.

Elective Criteria

Provides scheduled routine or urgent appointments by telephone or other technology supported mechanisms.

Has a secure electronic system for patient to request appointments, prescription refills, referrals and test results.

Has a secure electronic system for two- way communication to provide timely clinical advice.

Evaluates identified health disparities to assess access across the patient population.



High Level Crosswalk

PCMH 2017 Concept	PCMH 2014 Standard
Team-Based Care and Practice Organization (TC)	Standard 2
Knowing and Managing Your Patients (KM)	Standards 2, 3 and 4
Patient-Centered Access and Continuity (AC)	Standard 1 and 2
Care Management and Support (CM)	Standard 4
Care Coordination and Care Transitions (CC)	Standard 5
Performance Measurement and Quality Improvement (QI)	Standard 6



Three Paths to 2017

Annual Renewal

Previous 2014 level 3

No check in calls required unless selected for audit

Minimal documentation, few reports, QI data, fill out questionnaires in Q-PASS, provide blanket attestation on 2017 compliance

Accelerated Renewal

Previous 2011 level 1, 2 or 3 or Previous 2014 level 1 or 2

Up to three check-in calls with a reviewer

Core - 22 reviewed, 18 available for attestation
Electives – 26 require review, 34 available for attestation

Full Engagement

Previously not recognized or recognition has expired

Up to 3 check-in calls with a reviewer

Documentation and virtual review for 40 core and 25 elective criteria

PCMH 2017 Scoring

- No levels = No add-on surveys
- Pass or Fail
- Reconsideration is still an option
- Meet all core criteria in the program = 40 credits

- Earn 25 credits in elective criteria across
 5 of 6 concepts
- 40 + 25 credits = Pass
- Option for Distinction in patient experience reporting, eCQM reporting, and behavioral health integration

Evidence = Documentation

Documentation Key



Presentation documentation key:

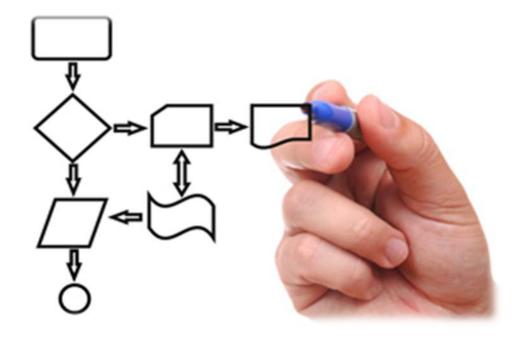
- r Report
- (e) Evidence
- p Process
- List
- (s) Source
- (a) Agreement
- t Protocol
- (b) RRWB
- W Worksheet



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New Recognition Process

Risky = Commit, Transform, Succeed?



Better = Transform, Commit, Succeed!



Succeed or Sustain = Annual Process

- Annual data submission and attestation
- Done through Q-PASS and will not require a virtual check-in unless selected for audit
- Multisite practices submit annual data at same time





Transform First! Then....

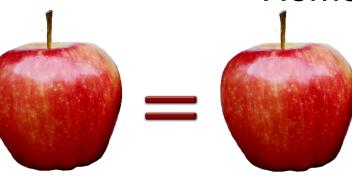
- Register in Q-PASS
- Pay your fees
- Submit evidence via Q-PASS
- Schedule 3 virtual check-in calls over a 12 month period



What Hasn't Changed

- Eligibility Criteria
- 2014 Must Pass
 Elements are
 embedded in Core
 Concepts
- Record Review Workbook
- QMIW

- Types of documentation (Data Sources)
- Multisite Requirement
- Pre-Validation Credits
- Foundation of Medical Home Model





Where to Begin?

- Convene your team!
- Review existing documents that might be used to meet the standards – policies, procedures, workflows, reports
- Compile a list of new documents and processes that need to be created
- Format the documents to communicate clearly to the NCQA Reviewers
- Consider what will be submitted for review and what will be virtual

Organization set-up



New Organizations

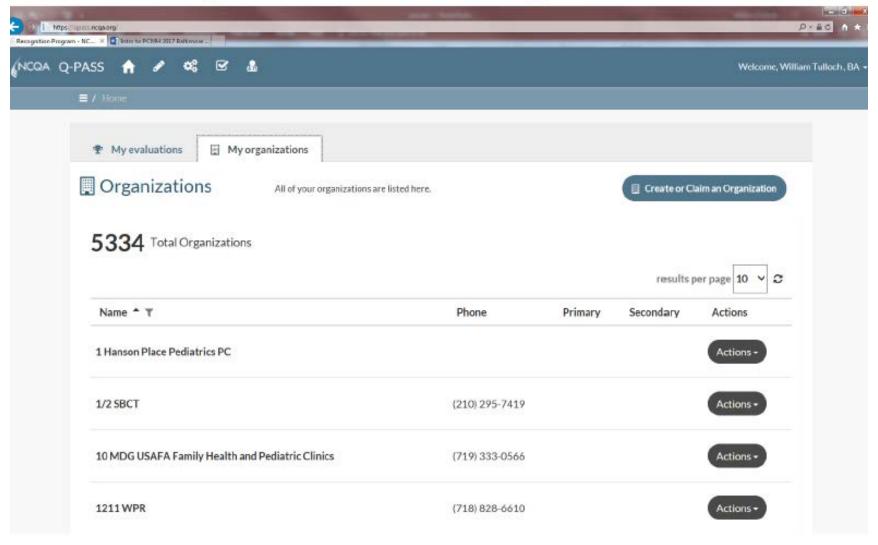
- Create Organization in Q-PASS
- Provide Organization details (address, phone, Tax ID)
- Save Organization

Existing Organizations

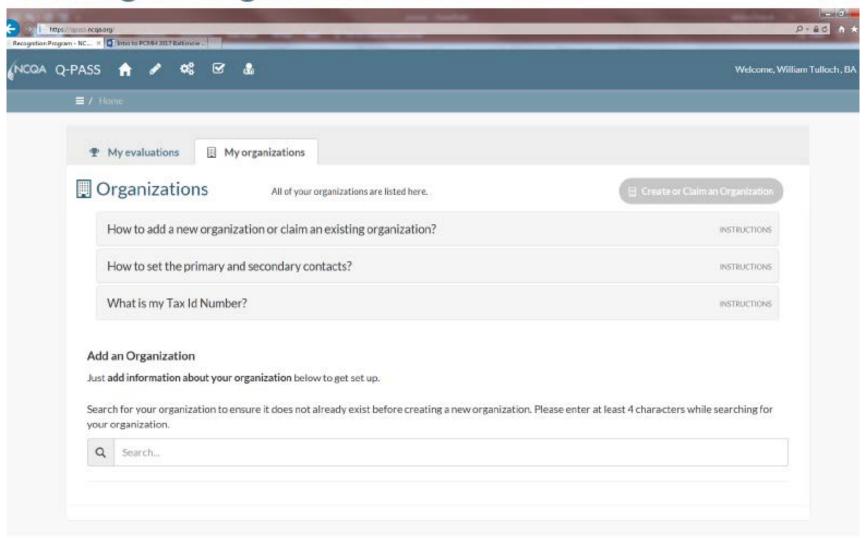
- Authorized users See "My Organizations" tab
- To "claim" an organization otherwise, contact NCQA



Q-PASS Organization Home Page



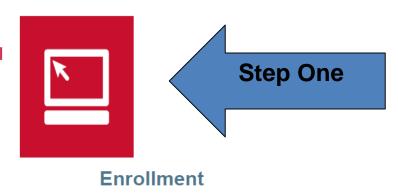
Adding an Organization to Q-PASS

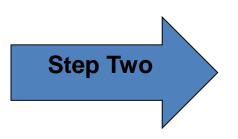


Enrollment

Organization needs the following to enroll

- Site information, including NPI
- Clinician information, including NPI & Boards/specialties
- Authorized signatory for agreements
- Payment method/Discount code



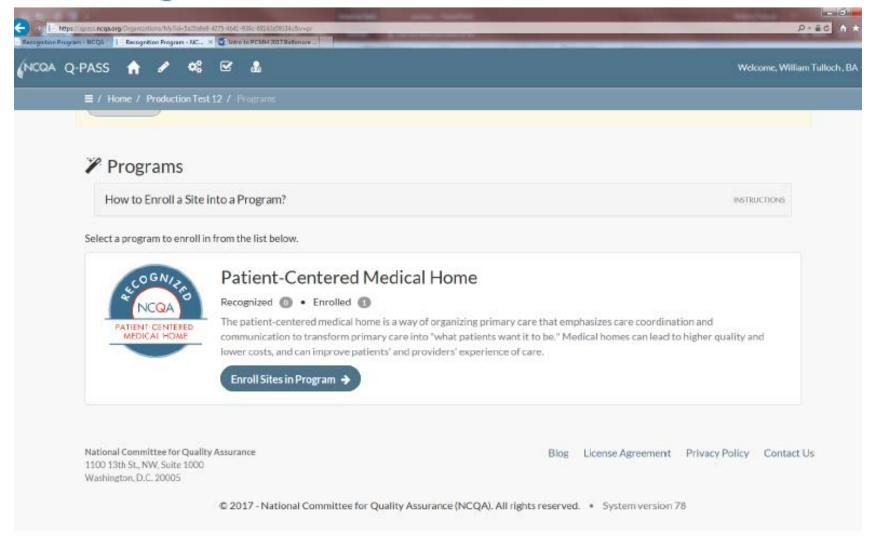




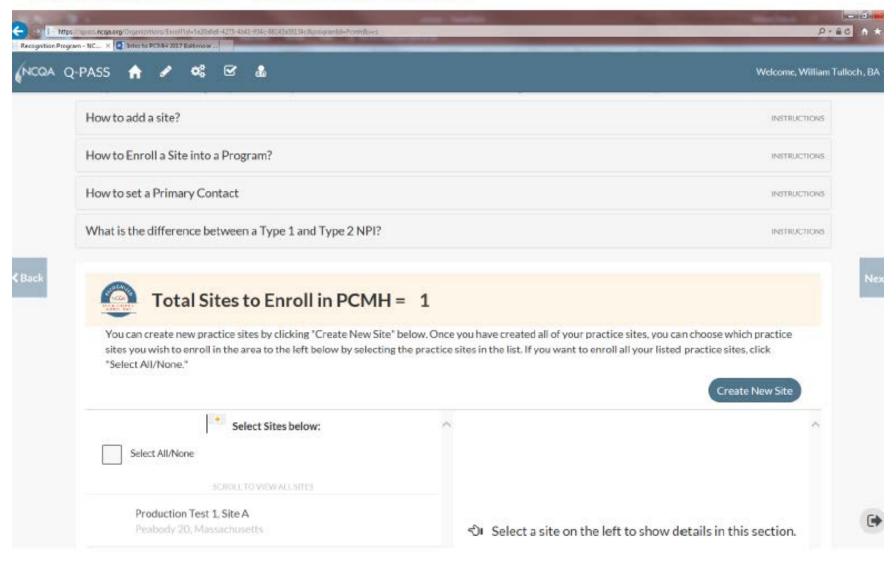
Step-by-Step process in Q-PASS

- · Choose sites
- Choose product(s)
- · Add/create clinicians
- · Sign agreements

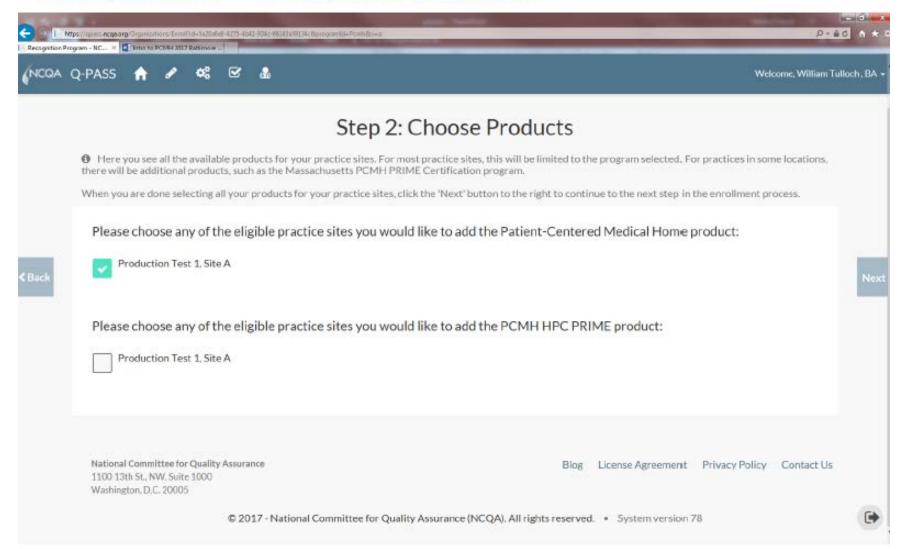
Enrolling in Q-PASS



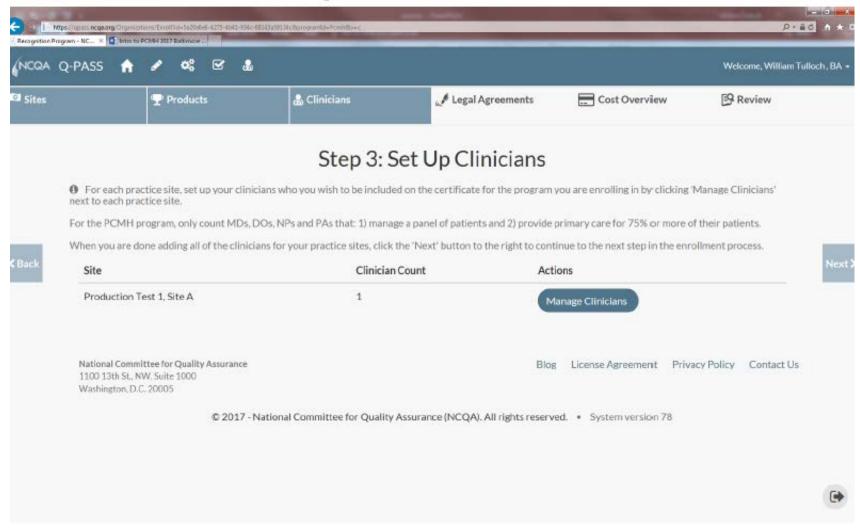
Enrollment - Choose Sites



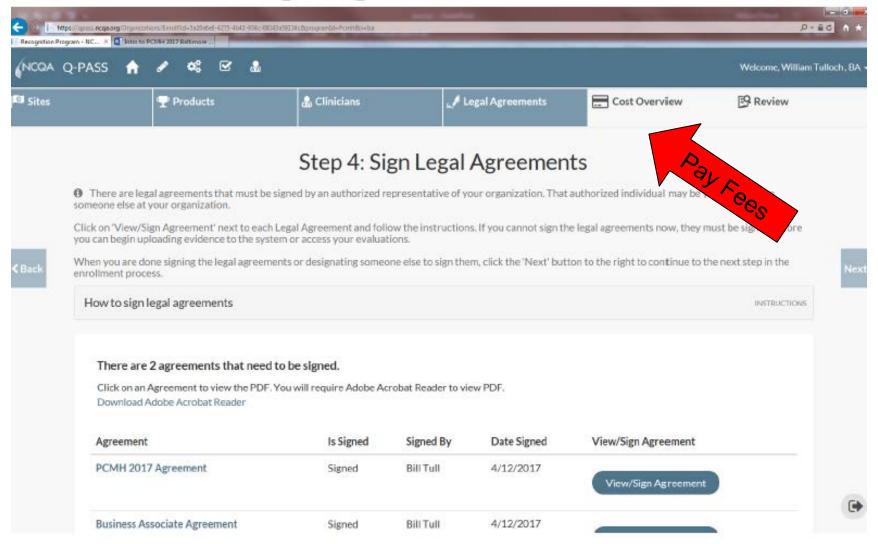
Enrollment – Choose Products



Enrollment – Set Up Clinicians



Enrollment – Sign Agreements



After Enrollment

Subtitle

NCQA will assign a representative to the practice The practice should then address:

Transfer credit

- Pre-validated vendors & transfer-credits
 - Choose vendor with existing auto-credit
 - Vendor supplies implementation letter confirming eligibility
 - Criteria set as "Met" after confirmation by Representative

Shared credit

- Organizations with multiple sites
- Share evidence/credit for criteria done the same
- Create sub-groups if share different EHR/processes

Transfer Credits?
Shared Credits?
Site Groups?
Multi-site?

Multi-Site Process



- Organizations with 3+ sites
- Shared EHR, processes and evidence across sites
- · Identify shared criteria from "sharable list"
- · Identify primary site
 - Full review only for this site
 - Shared criteria auto-populate in subsequent sites



Transform "Check-in" process

Up to 3 "Check-ins" During Review

For practices new to NCQA or doing an accelerated renewal



Determine Criteria to Address

- Focus on core & documented processes first
- Identify criteria for 25 elective credits



Provide Documents for Offsite Review

- Policies, procedures
 & protocols
- Website links
- Public information
- Attestation



Provide Evidence during Virtual Review

- Communicate with Evaluator
- Substitute evidence if not sufficient
- · Demo systems
- Provide reports



After Check-In



- Evaluator marks criteria "met"
- Practice can work on "not met" criteria
- NCQA staff will review questions arising from check-in

After 3 Check-Ins



Practice meets all core criteria & 25 elective credits, results are forwarded to Review Oversight Committee (ROC)



If required criteria is not met in 3 virtual check-ins, an additional check-in is available for purchase



If the survey process is not completed within 12 months, additional time can be purchased

Accelerated Renewal

What is expected for criteria?





- Follow standards & guidelines
- Submit evidence in Q-PASS
- Prepare to demonstrate virtual review-eligible evidence



For criteria marked attestation the practice should:

- Attest that your practice is still performing PCMH activities
- You will not need to demonstrate documentation or evidence

Criteria are identified as shared or site specific

Accelerated Renewal Table

		Electives		
	Core	1 Credit	2 Credits	3 Credits
Review	22 criteria	12 criteria	14 criteria	0 criteria
Attestation	18 criteria	26 criteria	7 criteria	1 criterion
Total Criteria (100 criteria)	40 criteria	39 criteria	20 criteria	1 criterion

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	Shadad	Attestation			

Succeed Annual Reporting Process

Practice's recognized PCMH 2014 Level 3 or after Transform process must:

Attest to previous performance

Confirm practice information and make any clinician changes

Provide evidence demonstrating continuing PCMH Activities

Annual fee payment/discount code from HRSA

Annual Reporting Date

- 30 days before Anniversary Date
- Must complete all Succeed steps prior to anniversary date
- Date set upon initial Recognition
 - Or 2014 Level 3 expiration date
- Flexibility to meet practice needs



Annual Reporting Date – Multi-sites

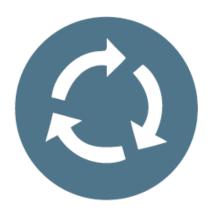


All practices in multi-site group have the same annual reporting date, unless otherwise organization requests differently



The annual reporting date for multi-site group is based on the date of 1st Recognized practice

Evidence & Annual Reporting



- Evidence can be provided at any point within the year
- NCQA will only review after:
 - Reporting date has passed
 - NOI Approved



Annual Requirements

- AR PA (Patient Access) appointment monitoring or patient experience
- AR TC (Team-based Care) pre-visit planning processes or care team experience
- AR PH (Population Health) proactive reminders, how many and how often?
- AR CM (Care Management) criteria, number of patients on care management, per cent of total population



Annual Requirements

- AR CC (Care Coordination) care coordination processes for lab, imaging, referrals and care transitions. Provide data for one of the previous categories or patient experience survey results for CC measures.
- AR QI (Quality Improvement) provide quality improvement measures for clinical quality, resource stewardship and patient experience measures.



Audit and New Requirements

Audit

- Sample of Succeed practices selected
- Still meeting key Transform criteria?
- Selection after Annual Reporting complete

New Requirements

- Announced one year ahead
- Practice must meet at next reporting date

Get Answers to Your Questions

- What are the new requirements
- How to ask questions of NCQA when needed
- Key updates and items requiring documented history
- Understand if past standards will be expected to be carried over, especially care management plan for important populations from prior application



Where Can I Learn More?

- Recognition Program NCQA Q-Pass
- NCQA seminars-and-webinars/live-seminarswebinars
- What to Expect During a Virtual Review
- GRIP Program Resource Page
- NCQA PCMH 2017 Getting Started Page
- MyNCQA.org
- WACMHC PCMH Assistance



Join us for the Series!

Team Based Care and Practice Organization (TC)

Wednesday, May 16, 12-1 PM

REGISTER HERE

Learning 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

Upcoming WACMHC Trainings

Lean Boot Camp

Seattle, WA
May 8, 8:30 AM – 4 PM
REGISTER

Residency Development Seminar

Portland, OR
May 18
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