6 PCMH Concepts within the standards

1. Team-Based Care and Practice Organization (TC).
2. Knowing and Managing Your Patients (KM).
5. Care Coordination and Care Transitions (CC).
ANATOMY OF A STANDARD

The “4 C’s”

- A brief title describing the criteria; uses a “two-letter” abbreviation (XX).
- A brief statement of the intent of the concept.
- A brief description of criteria subgroup, organized within the broader concept. Practices are not scored at this level.
- A brief statement highlighting PCMH requirements. This is the scoring component.

MORE ABOUT CRITERIA

- There are 100 criteria.
- 40 are Core and considered mandatory.
- 60 are elective- the elective criteria can be pieced together to = 25 credits and must have at least one credit across 5 of the 6 concepts.
Practices that achieved recognition in PCMH 2011 at Level 1, 2 or 3, or PCMH 2014 at Level 1 or 2, can earn recognition at an accelerated pace.

To achieve recognition, practices must:

1. Meet all 40 core criteria and
2. Earn 25 credits in elective criteria across 5 of 6 concepts.

** As a 2011 level 3 recognized practice you will be able to attest to “18” Core and “33” elective criteria.

2017 PCMH
3 PARTS

- **Commit**: The practice completes a self-assessment before committing to transformation and the recognition process and works with the assigned NCQA representative to conduct an online assessment and develop an evaluation plan and schedule.

- **Transform**: Practices gradually transform, building on successes. During this time, progress is demonstrated by submitting documentation and data to NCQA through a new system designed to reduce paperwork and administrative hassles.

- **Succeed**: Each year, the practice checks in with NCQA to show that its ongoing activities are consistent with the PCMH model of care. The annual check-in includes attesting to certain policies and procedures and submission of key data. This process will sustain the practice’s recognition, foster continuous improvement and strengthen the transformation.
CHECK-INS - TRANSFORM

- A check-in will be conducted virtually online with an NCQA evaluator.
- The evaluator will assess the practice’s progress towards recognition and provide immediate personalized feedback.
- The timing is flexible and up to the practice to determine.
- The practice will attach evidence prior to each virtual check in session and through screen sharing documentation will review and complete requirements.

FINAL PHASE - SUCCEED

- Each year you will check in with NCQA and demonstrate that your practice is functioning as patient-centered medical home.
- NCQA will assign your annual reporting date and provide more details about the process when you reach this stage.
Once a practice is eligible and ready, the next step is to enroll in a Recognition Program through the Quality Performance Assessment Support System (Q-PASS). Enrollment in to Q-PASS should be 6 months before the end of the current recognition.

Vendors are in process of pre-validating for the 2017 standards. Many vendors have already completed this process. Check the NCQA website often for updates.

http://www.ncqa.org/programs/recognition/prevalidation-program/vendor-list
The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients, families, and caregivers, and organizes and trains staff to work at the top of their license and provide effective team-based care.

- Three competencies
  - 5 Core Criteria (TC 01, 02, 06, 07, 09)
  - 4 Elective Criteria (TC 03, 04, 05, and 08)
Competency A: TC 01, 02, 03, 04, and 05

- 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 is a Core Criteria and is **New** for 2017

The practice designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.

**Evidence (Shared):**

- Details about the above staff which can be the same person. Information provided includes name(s), credentials, and roles/responsibilities.
- Suggested documentation are job descriptions and resume of identified staff.
CONCEPT 1: TEAM BASED CARE AND PRACTICE ORGANIZATION (TC)

TC-02 is a Core Criteria (Aligns with 2014 2D Factors 1 and 2)
The practice defines its organizational structure and staff responsibilities/skills to support key PCMH functions.
Evidence (Shared):
- Overview of practice staff including an outline of duties and how the practice supports and trains staff to complete these duties.
- Suggested documentation is a documented process and PCMH organization chart.

TC-03 is a Elective Criteria and is New for 2017
1 Credit
The practice is involved in external PCMH-oriented collaborative activities or participates in a health information exchange
Evidence (Shared):
- Suggested documentation is a description of involvement.
TC-04 is a Elective Criteria and is New for 2017

2 Credits

Patients/families/caregivers are involved in the practice’s governance structure or on stakeholder committees.

Evidence (Shared):

- At a minimum, there is a documented process that specifies how patients/families/caregivers are selected for participation, their role and frequency of meetings.
- Minutes of meetings showing participation.
- Board Committees, patient advisory councils, participation in QI/QA activities.

TC-05 is a Elective Criteria (Aligns with 2014 6G Factors 1 and 2)

2 Credits

The practice uses a certified electronic health record technology system (CEHRT).

Evidence (Shared):

- Provide the name of the electronic system(s) implemented.
Competency B: TC 06, 07, and 08
- Communication among staff is organized to ensure that patient care is coordinated, safe, and effective.

TC-06 is a Core Criteria (Aligns with 2014 2D Factor 3)
The practice has regular patient care team meetings or a structured communication process focused on individual patient care.

Evidence (Shared-Documented Process Only):
- Documented process that describes the practice’s patient care team communication process including roles of the clinician or team leader and others involved.
- Evidence of process implementation (care team meetings, huddles, electronic tasking or messaging, regular email exchanges, notes of the patient schedule).
CONCEPT 1: TEAM BASED CARE AND PRACTICE ORGANIZATION (TC)

TC-07 is a Core Criteria *(Aligns with 2014 2D Factor 9)*

The practice involves care team staff in the practice’s performance evaluation and QI activities.

Evidence *(Shared)*:
- Documented process for QI includes a description of staff roles and staff involvement in the performance evaluation and improvement process.
- Evidence of process implementation (QI Committee meeting minutes, work groups, PDSA activities, staff meetings, etc.).

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TC-08 is an Elective Criteria and is *New* to 2017

- 2 Credits

The practice has at least one care manager qualified to identify and coordinate behavioral health needs.

Evidence *(Shared)*:
- Identified behavioral healthcare manager.
- Suggested documentation: Job description for staff responsible to support BH needs in the office and coordinates referrals when needed.
CONCEPT 1: TEAM BASED CARE AND PRACTICE ORGANIZATION (TC)

Competency C: TC 09
- The practice communicates and engages patients on expectations and their role in the medical home model of care.

TC-09 is a Core Criteria *(Aligns with 2014 2B Factors 1-5)*

The practice has a process for informing patients, families, caregivers about the role of the medical home and provides them materials that contain the information.

Evidence *(Shared)*:
- Documented process describing how patients, families, and caregivers are informed.
- Evidence includes materials at a minimum addressing after-hours access, practice scope of services, evidence-based care, availability of education and self-management support, and practice points of contact. It also includes info about the importance of patients providing comprehensive information.
NEXT STEPS

- Review the standards. Free download from NCQA [www.ncqa.org](http://www.ncqa.org)
- Identify any gaps [http://pcmhquestionnaire.ncqa.org/question/1/](http://pcmhquestionnaire.ncqa.org/question/1/)
- Enroll in Q-Pass [https://qpass.ncqa.org/Home/Welcome](https://qpass.ncqa.org/Home/Welcome)
- Create your work plan
- Begin at minimum bi-weekly PCMH update meetings

NEXT WEBINAR

Concept 2: Knowing and Managing Your Patients (KM)

Wednesday, April 11, 2018 from 1PM - 2PM Central