NCQA Patient Centered Medical Home Renewal Requirements

TPCA Clinical Webinar
November 10, 2015
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Objectives

At the end of this webinar the participant will:

• Understand the PCMH renewal process using the 2014 NCQA PCMH standards

• Identify which standards/elements require documentation and which require attestation
PCMH Renewal Process

Much of the information for this webinar was obtained from the NCQA website, specifically:

http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH/AfterKeepItPCMH/PCMH2011RenewalRequirements.aspx

PCMH Renewal Process

• If the site is recognized at Level 1, a full survey is required for renewal.

• To acknowledge that practices with Level 2 or Level 3 Recognition have taken steps toward practice redesign and have systems in place that support their recognition level, NCQA offers a streamlined process for renewal through reduced documentation requirements
PCMH Renewal Process

Only the following elements require documentation for renewals for the streamlined process when renewing under PCMH 2014:

- 1A*
- 2D*
- 3C, 3D*
- 4A, 4B*, 4C
- 5B*
- 6B, 6D*, 6E

* Indicates a MUST-PASS Element

PCMH Renewal Process

- MUST-PASS elements are considered the basic building blocks of a patient-centered medical home. Practices must earn a score of 50% or higher.
- Critical Factors – critical factors must be met in order to achieve varying point values as defined in the specific PCMH elements.
Standard 1A (MUST-PASS)

Patient-Centered Appointment Access

The practice has written processes and defined standards for providing access to appointments, and regularly assesses its performance on:

1. Providing same-day appointments for routine and urgent care (Critical Factor)
2. Providing routine and urgent-care appointments outside regular business hours
3. Providing alternative types of clinical encounters
4. Availability of appointments
5. Monitoring no-show rates
6. Acting on identified opportunities to improve access

Standard 1A (MUST-PASS)

- 4.5 points

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www.tnpca.org
Standard 2D (MUST-PASS)
The Practice Team

The practice uses a team to provide a range of patient care services by:

1. Defining roles for clinical and nonclinical team members
2. Identifying the team structure and the staff who lead and sustain team-based care
3. Holding scheduled patient care team meetings or a structured communication process focused on individual patient care (Critical Factor)
4. Using standing orders for services
5. Training and assigning members of the care team to coordinate care for individual patients

6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change
7. Training and assigning members of the care team to manage the patient population
8. Holding scheduled team meetings to address practice functioning
9. Involving care team staff in the practice’s performance evaluation and quality improvement activities
10. Involving patients/families/caregivers in quality improvement activities or on the practice’s advisory council
Standard 2D (MUST-PASS)
The Practice Team

- 4.0 points

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Standard 3C
Comprehensive Health Assessment

To understand the health risks and information needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes:

1. Age and gender appropriate immunizations and screenings
2. Family/social/cultural characteristics
3. Communication needs
4. Medical history of patient and family
Standard 3C

Comprehensive Health Assessment

5. Advance care planning (NA for peds practices)
6. Behaviors affecting health
7. Mental health/substance use history of patient and family
8. Developmental screening using a standardized tool (NA for practices with no pediatric patients)
9. Depression screening for adults and adolescents using a standardized tool
10. Assessment of health literacy

Standard 3C

Comprehensive Health Assessment

• 4.0 points

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www.tnpca.org
Standard 3D (MUST-PASS)
Use Data for Population Management

At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including:
1. At least 2 different preventive care services
2. At least 2 different immunizations
3. At least 3 different chronic or acute care services
4. Patients not recently seen by the practice
5. Medication monitoring or alert

Standard 3D (MUST-PASS)
Use Data for Population Management

• 5.0 points

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Standard 4A
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
4. Social determinants of health
5. Referrals by outside organizations (insurers, health systems, practice staff or pt/family/caregiver)
6. The practice monitors the percentage of the total patient population identified through its process and criteria (Critical Factor)

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<td>Practice meets 0 -1 factors or does not meet factor 6</td>
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• 4.0 points
Standard 4B (MUST-PASS) Care Planning and Self-Care Support

The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75% of the patients identified in Element A:

1. Incorporates patient preferences and functional/lifestyle goals
2. Identifies treatment goals
3. Assesses and addresses potential barriers to meeting goals
4. Includes a self-management plan
5. Is provided in writing to the patient/family/caregiver

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Standard 4B (MUST-PASS) Care Planning and Self-Care Support

• 4.0 points
Standard 4C
Medication Management

The practice has a process for managing medications, and systematically implements the process in the following ways:
1. Reviews and reconciles meds for more than 50% of patients received from care transitions *(Critical Factor)*
2. Reviews and reconciles meds with patients/families for more than 80% of care transitions
3. Provides information about new prescriptions to more than 80% of patients/families/caregivers
4. Assesses understanding of meds for more than 50% of patients/families/caregivers, and dates the assessment
5. Assesses response to meds and barriers to adherence for more than 50% of patients, and dates the assessment
6. Documents over-the-counter meds, herbal therapies and supplements for more than 50% of patients, and dates updates

• 4.0 points

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Standard 5B (MUST-PASS)  
Referral Tracking and Follow-Up

The practice:
1. Considers available performance information on consultants/specialists when making referral recommendations
2. Maintains formal and informal agreements with a subset of specialists based on established criteria
3. Maintains agreements with behavioral healthcare providers
4. Integrates behavioral healthcare providers within the practice site
5. Gives the consultant or specialist the clinical question, the required timing and the type of referral

6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan
7. Has the capacity for electronic exchange of key clinical information and provides an electronic summary of care record to another provider for more than 50% of referrals
8. Tracks referrals until the consultant or specialist’s report is available, flagging and following up on overdue reports (Critical Factor)
9. Documents co-management arrangements in the patient’s medical record
10. Asks patients/families about self-referrals and requesting reports from clinicians
Standard 5B (MUST-PASS)
Referral Tracking and Follow-Up

- 6.0 points

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Standard 6B
Measure Resource Use and Care Coordination

At least annually, the practice measures or receives quantitative data on:

1. At least 2 measures related to care coordination
2. At least 2 utilization measures affecting healthcare costs
Standard 6B
Measure Resource Use and Care Coordination

• 3.0 points

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Standard 6D (MUST-PASS)
Implement Continuous Quality Improvement

The practice uses an ongoing quality improvement process to:
1. Set goals and analyze at least 3 clinical quality measures from Element A
2. Act to improve at least 3 clinical quality measures from Element A
3. Set goals and analyze at least 1 measure from Element B
4. Act to improve at least 1 measure from Element B
5. Set goals and analyze at least 1 patient experience measure from Element C
6. Act to improve at least 1 patient experience measure from Element C
7. Set goals and address at least 1 identified disparity in care/service for identified vulnerable populations
Standard 6D (MUST-PASS)
Implement Continuous Quality Improvement

- 4.0 points

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Standard 6E
Demonstrate Continuous Quality Improvement

The practice demonstrates continuous quality improvement by:
1. Measuring the effectiveness of the actions it takes to improve the measures selected in Element D
2. Achieving improved performance on at least 2 clinical quality measures
3. Achieving improved performance on 1 utilization or care coordination measure
4. Achieving improved performance on at least 1 patient experience measure
Standard 6E
Demonstrate Continuous Quality Improvement

• 3.0 points

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PCMH Renewal Requirements

• For all remaining elements for factors answered “Yes,” you must attest to the language below, and you must implement those factors. To attest, indicate the elements on the "Renewal Elements" tab of the Organization Background section of your ISS survey tool.

• "Our practice achieved Level 2 or Level 3 Recognition as a patient-centered medical home and attests that the responses to the factors of this element reflect the current operation of the organization/practice sites. Documentation to support these responses can be provided upon request."
# PCMH Renewal Requirements

<table>
<thead>
<tr>
<th>Points</th>
<th>2014 Standards and Elements</th>
<th>Documentation or Attestation?</th>
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<tr>
<td>10</td>
<td>PCMH 1: Patient Centered Access</td>
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<td>PCMH 1A: Patient-Centered Appointment Access <strong>MUST-PASS</strong></td>
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<td>PCMH 1B: 24/7 Access to Clinical Advice</td>
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<td>PCMH 1C: Electronic Access</td>
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<td>PMCH 2B: Medical Home Responsibilities</td>
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<td>PCMH 2C: Culturally and Linguistically Appropriate Services</td>
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<td>PCMH 2D: The Practice Team (<strong>MUST-PASS</strong>)</td>
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<td>PCMH 3E: Implement Evidence-Based Decision Support</td>
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## PCMH Renewal Requirements

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<tr>
<th>Points</th>
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<td>PCMH 4A: Identify Patients for Care Management</td>
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<td>PCMH 4B: Care Planning and Self-Care Support (MUST-PASS)</td>
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<td>PCMH 4E: Support Self-Care and Shared Decision Making</td>
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<td>PCMH 5: Care Coordination and Care Transitions</td>
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<td>PCMH 6D: Implement Continuous Quality Improvement (MUST-PASS)</td>
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<td>PCMH 6F: Report Performance</td>
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<td>Not Scored</td>
<td>PCMH 6G: Use Certified EHR Technology</td>
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PCMH Renewal Requirements

- Attestation – 15 elements
- Documentation – 11 elements
- NA – 1 element
- 6 Must-Pass Elements
- All Must-Pass Elements require documentation

Thank you for your time and attention during this clinical webinar. Please forward any questions to terri.crutcher@tnpca.org