PCMH 2014
NCQA Standards and Guidelines

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Training Objectives

- ✓ Overview of process and timeline including new Renewal Option

- ✓ Overview of 2014 Standards
  - Review updates and new concepts with focus on “Must Pass” Elements

http://www.uvm.edu/medicine/vchip/

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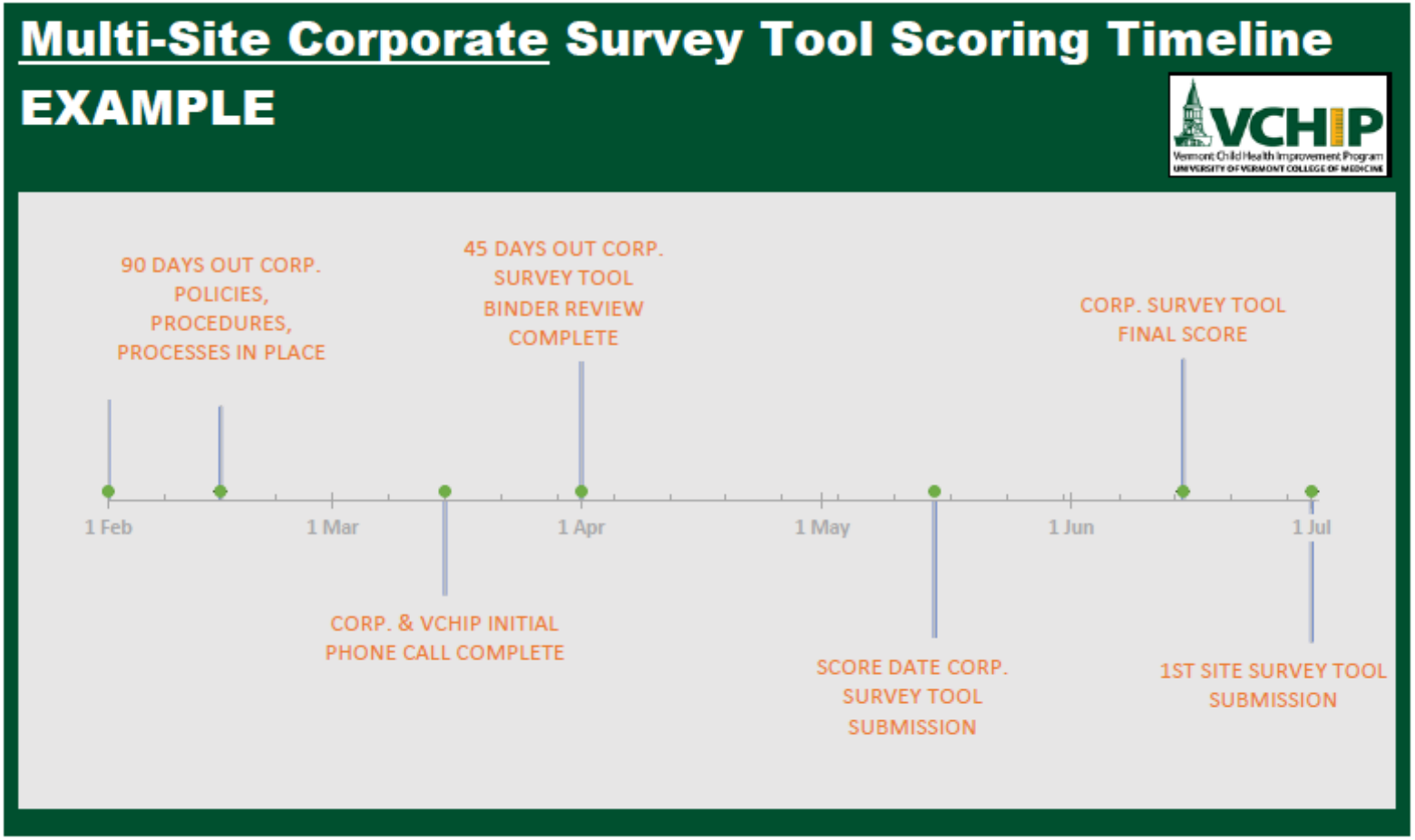
VCHIP Timeline



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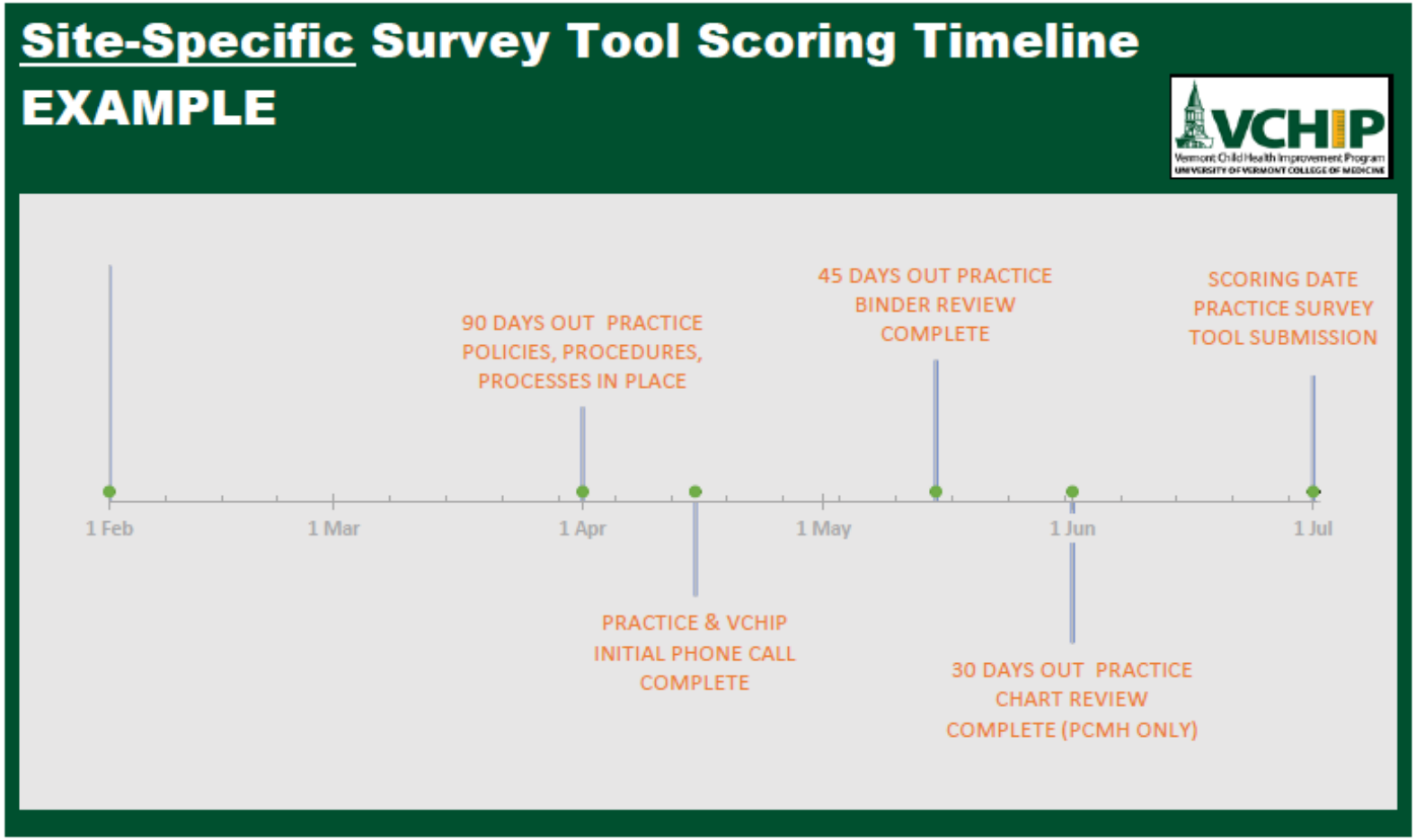
VCHIP Timeline



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VCHIP Timeline

Site-Specific Milestones Table

Score Date		Approx. 90 days before score date	Approx. 60 days before score date	Approx. 30 days before score date
1-Jan		1-Oct	1-Nov	1-Dec
1-Feb		1-Nov	1-Dec	1-Jan
1-Mar		1-Dec	1-Jan	1-Feb
1-Apr		1-Jan	1-Feb	1-Mar
1-May		1-Feb	1-Mar	1-Apr
1-Jun		1-Mar	1-Apr	1-May
1-Jul		1-Apr	1-May	1-Jun
1-Aug		1-May	1-Jun	1-Jul
1-Sep		1-Jun	1-Jul	1-Aug
1-Oct		1-Jul	1-Aug	1-Sep
1-Nov		1-Aug	1-Sep	1-Oct
1-Dec		1-Sep	1-Oct	1-Nov

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Streamlined Renewal Option

Practices with Level 2 or 3 Recognition with the ability to demonstrate panel management and quality improvement for at least two years.

Organizations/practice sites must be able to provide documentation if they are selected for audit.

Attestation		Documentation Required	
1B	4D	1A	5B
1C	4E	2D	6B
2A	5A	3C	6D
2B	5C	3D	6E
2C	6A	4A	
3A	6C	4B	
3B	6F	4C	
3E			
		6G	N/A

http://www.ncqa.org

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Streamlined Renewal Option – Multi-site

Multi-Site Organizations with Practices that have achieved Level 2 or Level 3 Recognition

Must be able to provide documentation if selected for audit.

Attestation				Documentation Required			
1B	Corporate	4D	Corporate	1A	Site-specific	5B	Corporate
1C	Corporate	4E	Corporate	2D	Site-specific	6B	Corporate
2A	Site-specific	5A	Corporate	3C	Site-specific	6D	Site-specific
2B	Corporate	5C	Corporate	3D	Corporate	6E	Site-specific
2C	Corporate	6A	Corporate	4A	Site-specific		
3A	Corporate	6C	Corporate	4B	Site-specific		
3B	Corporate	6F	Corporate	4C	Site-specific		
3E	Corporate					6G	N/A

http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH/DuringEarnItPCMH/OtherPCMHResources/PCMH2014MultiSiteRenewalTable.aspx

OR

http://www.ncqa.org search on multi-site streamlined renewal

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Electronic Health Record Pre-Validation

- NCQA offers a Pre-validation Program Review for Certified Electronic Health Record Vendors
- All PCMH-eligible practices that utilize functions associated with their vendor's prevalidated products are eligible for autocredit toward PCMH 2014 recognition
- Please see NCQA website for a list of certified vendors and for a review of the process to receive autocredit

http://www.ncqa.org/Search.aspx?Search=prevalidation

or **http://www.ncqa.org**

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NCQA 2014 PCMH Standards

- Focus on team-based care, integration of behavioral health, measuring costs, quality improvement, and care coordination
- NCQA want practices to understand this “is a process, not an event”
- Changes reflect evidence-based trends
- Focus on the Triple Aim
- Require practices to follow standards over time

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PCMH 1: PATIENT-CENTERED ACCESS

The practice provides access to team-based care for both routine and urgent needs of patients, families, and caregivers at all times.

PCMH 1 Includes the Following Elements:

A: Patient-Centered Appointment Access

B: 24/7 Access to Clinical Advice

C: Electronic Access

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PCMH 1: PATIENT-CENTERED ACCESS

Update and Changes

- PCMH 1A & 1B have been reorganized by type of access (appointment-oriented and clinical advice-oriented) rather than access during office hours and outside of office hours
- Several new concepts addressed
  - **Breaking things out by type of appointment (e.g., urgent vs. routine) and tracking availability of appointments**
  - **Monitoring no-shows**
  - **Actively working to improve access**

PCMH 1A: Patient-Centered Appointment Access

MUST PASS = 2 factors including Factor 1 for 50%

The practice has a written process 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 outside of regular business hours.
3. Providing alternative types of clinical encounters.
4. Availability of appointments
5. Monitoring no-show rates
6. Acting on identified opportunities for improved access

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PCMH 1: PATIENT-CENTERED ACCESS

Patient-Centered Appointment Access (Must Pass)

- **Critical Factor**: providing same-day appointments for routine and urgent care.
  - Documented process for scheduling same day appointments (including definitions for routine and urgent and how requests are triaged)
  - At least 5 days of data, showing availability and use of same-day appointments for routine and urgent care

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PCMH 2: Team-Based Care

The practice provides continuity of care using culturally and linguistically appropriate team-based approaches

PCMH 2 Includes the following elements:

A Continuity

B Medical Home Responsibilities

C Culturally and Linguistically Appropriate Services

D The Practice Team (MUST PASS)

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PCMH 2: Team-Based Care

Update and Changes

2A Continuity

- Builds on concepts from PCMH 2011 1D and 5C
- Practice must now show how they help patient pick PCP
- Practice must show new patient orientation

PCMH 2: Team-Based Care

Update and Changes

2C Culturally and Linguistically Appropriate Services

- Practice asked to asses ***diversity*** instead of race and ethnicity.

PCMH 2: Team-Based Care

Update and Changes

2D Practice Team (Must Pass-with critical factor)

- Show how different members of the care team are involved in improvement activities
- Care team expected to support patients, families *and caregivers* in self-management, self-efficacy and behavior
- Show job descriptions or policies/procedures describing how staff is involved (ie: care coordination, self-management, population management)
- Show a description of training & schedule or materials from staff training

PCMH 2D: The Practice Team

MUST PASS = 5-7 factors including Factor 3 for 50%

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 standard orders for services
5. Training and assigning members of the care team to coordinate care for individual patients.

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PCMH 2D: The Practice Team - Continued

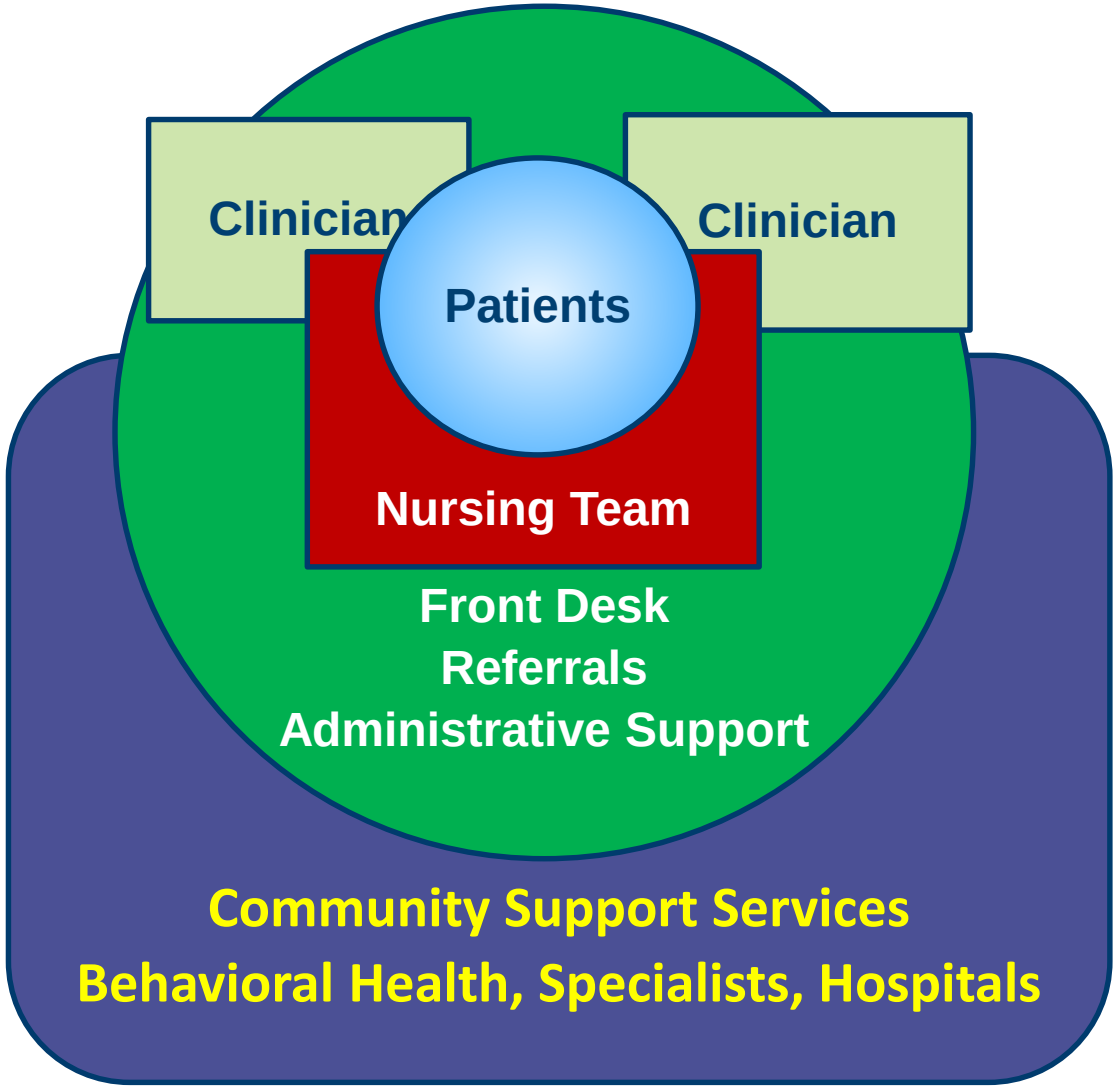
6. Training and assigning members of the care team to support patients, families, caregivers in self-management, self-efficacy, and behavior change.
7. Training and assigning members of the care team to manage the patient population.
8. Holding scheduled team meetings to address practice functioning
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.

PCMH 2: Team-Based Care

2D Practice Team Continued (Must Pass-with critical factor)

- Critical factor: scheduled patient care team meetings or structured communication process focused on individual patient care
  - documented process and at least 3 examples (meeting summaries, checklists, appointment notes or chart notes)
- Describe team meetings and give example
- Documented process for practice QI and for involving patients/ families/caregivers
- Show a description of training & schedule or materials from staff training

PCMH 2: Team-Based Care



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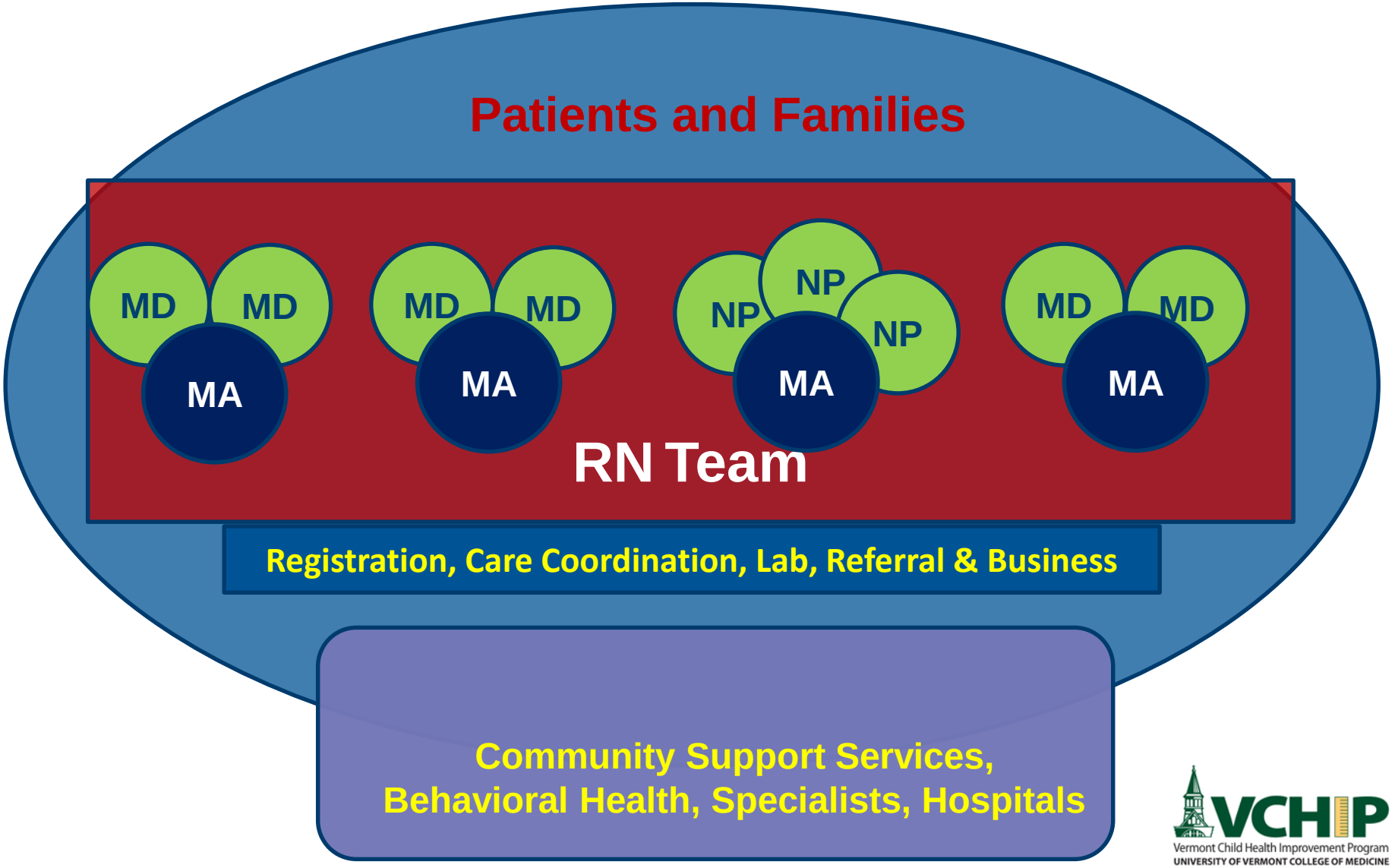
PCMH 2: Team-Based Care



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PCMH 3: Population Health Management

The practice uses a comprehensive health assessment and evidence-based decision support based on complete patient information and clinical data to manage the health of its entire patient population.

PCMH 3 Includes the following elements:

A Patient Information

B Clinical Data

C Comprehensive Health Assessment

D Use data for Population Management (MUST PASS)

E Implement Evidenced-Based Decision Support

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PCMH 3: Population Health Management

Update and Changes

3A Patient Information

Patient Information: crosswalks with MU Stage 2 Core 3 (change from >50 to >80% and from gender to sex)

Same as 2A with a few additions

- Occupation
- Name/contact info for other health care providers (does not have to be searchable field—can provide a written process, screen shots showing source, and 3 examples)

PCMH 3: Population Health Management

Update and Changes

3B Clinical Data

- Clinical Data: MU Stage 2
  - MU Core #4 – 3B3
  - MU Core #5 – 3B8
  - MU Menu #4 – 3B10
  - MU Menu #2 -3B11
- Small changes to several factors

PCMH 3: Population Health Management

Updates and Changes

3C Comprehensive Health Assessment

- Adds “regularly updates” to element
- Adds health literacy
- Show that the practice does the assessment regularly/for all patients (>50%).
  - documentation is some sort of report, chart review, or other method defined by the practice.

PCMH 3D: Use Data for Population Management

MUST PASS = 2 factors for 50%

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 **two** different **preventive care services**
2. At least **two** different **immunizations**
3. At least **three** different **chronic or acute care services**

Stage 2 MU Core 11 Factors 1,2,3

4. Patients not recently seen by the practice
5. Medication monitoring or alert.

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PCMH 3: Population Health Management

Updates and Changes

3E Implement Evidence-Based Decision Support (expansion of 3A), focus on point-of-care reminders

- Critical Factor Mental health/substance use disorder--required to get 75-100%
- Chronic medical condition
- Acute condition
- Condition related to unhealthy behaviors
- Well child or adult care
- Overuse/appropriateness issues (choosing wisely)
- *Potential connection to Stage II, MU Core 6*

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PCMH 4: Care Management and Support

The practice systematically identifies individual patients and plans, manages and coordinates care, based on need.

PCMH 4 Includes the Following Elements:

A Identify Patients for Care Management

B Care Planning and Self-Care Support **MUST PASS**

C Medication Management

D Use Electronic Prescribing

E Support Self-Care and Shared Decision Making

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PCMH 4A: Identify Patients for Care Management

Updates and Changes

4A Identify Patients for Care Management

- Rather than identifying patients who are high risk or complex, this element focuses on developing a list of patients that may benefit from care management
- Must have a report (% may benefit from care management) to get any credit (critical factor)
- Will be used in chart review

PCMH 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 utilization**
3. **Poorly controlled or complex conditions**
4. **Social determinants of health**
5. **Referrals by outside organizations, 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)**

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PCMH 4A: Identifying Patients

- **Identify all patients in practice with conditions referenced in 4A, Factors 1-5.**
- Patients may "fit" more than one criterion (Factor).
- **Patients may be identified through electronic systems (registries, billing, EHR), staff referrals and/or health plan data.**
- Review comprehensive health assessment (Element 3C) as a possible method for identifying patients
- **Factor 6 is CRITICAL FACTOR – NO points if no monitoring**
- Patients identified in Factor 6 may be used **ONLY once** even if a patient meets more than one Factor
- **Patients identified in Factors 1+2+3+4+5 (minus any duplicate patients) = numerator. Denominator = total patient population**

Reminder: numerator must equal at least 30 patients as the chart review will be based on patients identified for Factors 1-5

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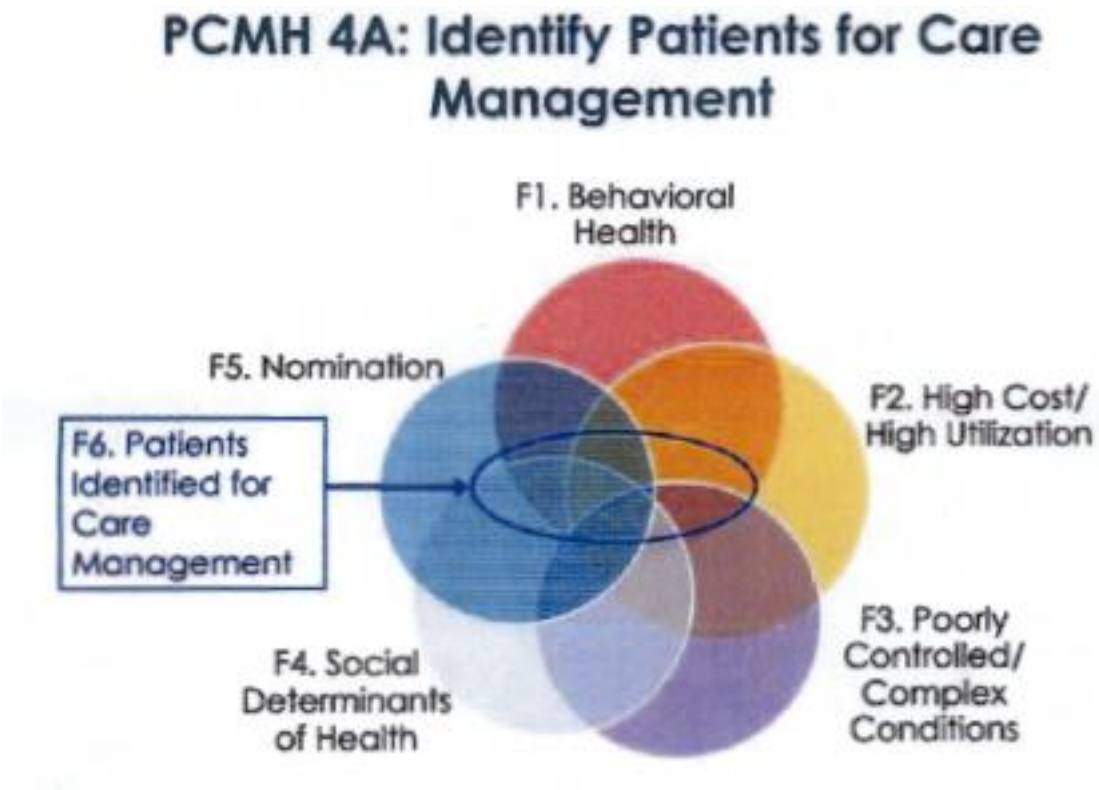
PCMH 4A: Identify Patients for Care Management



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PCMH 4A: Documentation

Factors 1-5

- ✓ Documented process describing criteria for identifying patients for each factor
  - ➢ *Suggest providing a report with number of patients identified for each factor*

Factor 6: Report with

- ✓ Numerator = number of **unique** patients likely to benefit from care management
- ✓ Denominator = total number of patients in the practice
  - ➢ *Suggest showing number of patients categorized by factor in this report if not shown in factors 1-5*

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Patient Selection Using Visit Date

- Choose patients meeting criteria from PCMH 4A
- Based on visit dates, go back one month from the date you are selecting your patient sample (to be included in chart review). Choose weekday nearest that date.
- Go back one day at a time (up to 12 months) until you have identified 30 (+4) patients who meet the criteria from PCMH4A and who had a care visit related to any one or more of the selected criteria in 4A.

PCMH 4: Care Management and Support

Update and Changes

4B Care Planning and Self-Care Support must pass

- 75% of patient charts reviewed have to get a "yes" to get credit for the factor
- Submit an example from a patient's medical record of each "yes" factor to NCQA

PCMH 4B: Care Planning and Self-Care Support

MUST PASS = 3 factors for 50%

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 percent** of the patients identified in Element 4A.

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 (encompasses factors 1-4)

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PCMH 4B: Care Plan

A care plan considers and/or specifies:

- Patient/preference and functional/lifestyle goal
- Assessment of potential barriers to meeting goals
- Strategies for addressing potential barriers to meeting goals
- Care team members, including primary care provider of record and team members beyond the referring or transitioning provider and the receiving provider
- Current problems (may include historical problems, at the practice's discretion)
- Current Medications
- Medication Allergies
- A self-care plan

PCMH 4B: Care Plan

CMS defines a care plan as:

"The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components:

- ✓ Problem (the focus of the care plan)
- ✓ Goal (the target outcome)
- ✓ Any instructions that the provider has given to the patient

A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome)"

PCMH 4B: VCHIP Review

Minimum components of a care plan for chart review

- ✓ Patient preferences and functional/lifestyle goals
- ✓ Treatment Goals
- ✓ Assessment of potential barriers to meet goals
- ✓ Strategies for addressing potential barriers to meeting goals
- ✓ A self-care plan

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PCMH 4B: Care Plan Examples

Case Note #1: Assessment & Plan

DM TYPE II, NO COMPLICATION, UNCONTROLLED (250.02)

4B Factor 2

Today's Impression: Greatly improved and so will continue to work on more weight loss. Patient is shooting for 160 pounds which is much better than her 215 pounds when she started.

Patient with good control of Diabetes. Suggested eliminating carbs, increasing protein and green vegetables. DM foot exam done today.

Weight loss a must so as to prevent the need for increasing medications. Patient aware

Current Plans: Reading comprehension assessment (REALM-SF (96105) Routine

Word List: Menopause, Antibiotics, Exercise, Jaundice, Rectal, Anemia, Behavior.
EXAM SCORE: 7 points

4B Factor 3: Assesses Health Literacy as potential barrier

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PCMH 4B: Example

Case Note #1: Assessment & Plan (con't.)

Met with patient today after her visit with the doctor. Patient is doing well with an A1C of 5.8. The patient has gained some weight. She is an accountant. The patient plans to use portion control and will start to bring a bagged lunch instead of eating out daily.

4B Factor 1,4

Care Plan and Goals: Manage your diabetes

4B Factor 2

Status: Started

Patient Engagement: Making the Change

4B Factor 3

4B Factor 4

Plan(s)	Barrier(s)	Progress
Maintain a healthy weight	Low activity in job	Started
• Preferred Self-Management: Portion Control/Bring bagged lunch to work	Enjoys eating out.	Started

Please bring care plan to next visit for review

Assess and address

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PCMH 5: Care Management and Care Transitions

The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations.

PCMH 5 Includes the following 5 factors:

A Test Tracking and Follow-Up

B Referral Tracking and Follow-Up (MUST PASS)

C Coordinate Care Transitions

PCMH 5: Care Management and Care Transitions

Update and Changes

5A Test Tracking and Follow-up

- Test Tracking and Follow-Up (2 critical factors to get any points)
- Same critical factors as before (tracking labs & images, flagging & follow-up on overdue results)
- Similar to 5A in 2011 Standards
- Differences in MU: Stage 2 Core 1 & 10, Menu 3

PCMH 5: Care Management and Care Transitions

Update and Changes

5B Referral Tracking and Follow-up

- Referral Tracking and Follow-Up (must pass)
- Tracking referrals is a critical factors (factor 8)
- MU Stage 2 Core 15 may apply
- Examples and in some cases, processes too

PCMH 5B: Referral Tracking and Follow-up

MUST PASS = 4-6 factors including Factor 8 for 50%

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.

PCMH 5B: Referral Tracking and Follow-up continued

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 percent 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.

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5C Care Coordination and Care Transitions

Update and Changes

5C Coordinate Care Transitions

- Process required for each element, supplemented by examples/logs
- Very similar to 2011 5C

PCMH 6: Performance Measurement and Quality

The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.

PCMH 6 Includes the following elements:

A Measure Clinical Quality Performance

B Measure Resource Use and Care Coordination

C Measure Patient/Family Experience

D Implement Continuous Quality Improvement (MUST PASS)

E Demonstrate Continuous Quality Improvement

F Report Performance

G Use Certified EHR Technology

PCMH 6: Performance Measurement and Quality

Update and Changes

6A Measure Clinical Quality Performance

- Similar to 2011 version
- Immunizations and preventive care measures get their own factors
- Expectation is that these are measured at least annually

PCMH 6: Performance Measurement and Quality

Update and Changes

6A Measure Clinical Quality Performance

$$\frac{\text{\# of patients meeting measure criteria}}{\text{\# of eligible patients}} = \text{Rate}$$

Expectation is that these are measured at least annually

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PCMH 6: Performance Measurement and Quality

Update and Changes

6B Measure Resource Use and Care Coordination

- Care coordination measures

  http://qualityforum.org/

- Utilization measures

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PCMH 6: Performance Measurement and Quality

Update and Changes

6C Measure Patient/Family Experience

- Aligns with 2011 6B
- Expectation is that renewing practices have measured at least annually

PCMH 6: Performance Measurement and Quality

Update and Changes

PCMH 6D Implement Continuous Quality Improvement MUST PASS

- Similar to 6C of 2011 Standards but breaks up goal setting and taking actions

PCMH 6D: Implement Continuous QI

MUST PASS = 5 factors for 50%

The practice uses an ongoing quality improvement process to:

1. **Set goals** and **analyze** at least **three** clinical quality measures from Element A.
2. **Act to improve** at least **three** clinical quality measures from Element A.
3. **Set goals** and **analyze** at least **one** measure from Element B
4. **Act to improve** at least **one** measure from Element B
5. **Set goals** and **analyze** at least **one** patient experience measure from Element C.
6. **Act to improve** at least **one** patient experience measure from Element C
7. **Set goals** and **address** at least **one** identified disparity in care/service for identified vulnerable populations.

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PCMH 6: Performance Measurement and Quality

A. Measure	B. Opportunity Identified	C. Initial Performance/ Measurement Period	D. Performance Goal	E. Action Taken/Date of Implementation	F. Performance at Remeasurement	G. Demonstrated Improvement
→	→	*PCMH 6 Elements A/B/C*	*PCMH 6 Element D*	*PCMH 6 Element D*	*PCMH 6 Element E*	*PCMH 6 Element E*
Performance Measures (Identified in 6A)						
1. Pneumococcal vaccination clinical measure 1	Increase the percentage of patients who receive pneumococcal vaccination as recommended	8/1/14 405 = total patients age 65 & older 139 = without pneumococcal vaccines 266 = patients with pneumococcal vaccines 266/405 = 65.6% baseline	Increase compliance rate to 90%	August 2014, outreach letters were sent to Clinic patients overdue for pneumococcal vaccination	9/12/14 Re-measurement 405 total patients age 65 & older 115 without pneumococcal vaccines 209 with pneumococcal vaccination 290/405 = 71.6%	After approximately 6 weeks, as the result of an outreach letter campaign, the percentage of patients who were compliant with pneumococcal vaccination increased from 65.6% baseline to 71.6% at re-measurement
2. Meningococcal Vaccination clinical measure 2	Increase the percentage of patients who receive Meningococcal vaccinations as recommended	8/1/14 95 = total patients Age 11 to 18 44 = patients without Meningococcal vaccinations 51 = patients with Meningococcal vaccinations 51/95 = 53.6%	Increase compliance rate to 90%	August 2014 outreach letters were sent to children/parents/guardians describing the importance of compliance with meningococcal vaccination encouraging patients to receive the vaccination	9/12/14 re-measurement 95 = total patients age 11 to 18 37 patients without meningococcal vaccination 58 patients with meningococcal vaccination 58/95 = 61%	After approximately 6 weeks, as the result of an outreach letter campaign, the percentage of patients also were compliant with meningococcal vaccinations increased from baseline of 53.6% to re-measurement 61.0%
3. Colorectal screening clinical measure 3	Increase the percentage of patients age 51-75 years old who have had colorectal screenings as recommended	8/1/14 733 = total number of patients age 51-75 years old 364 = patients without colorectal screening 369 = patients with colorectal screening 369/733 = 50.3%	Increase compliance rate to 60%	August 2014,outreach letters were sent to Clinic patients Overdue for colorectal Screening to encourage Them to have the screening	9/12/14 Re-measurement 733 = total patients Age 51-75 years 350 = patients Without colorectal Screening 383 = patients with	After approximately 6 weeks, as the result of an outreach letter campaign, the percentage of patients who were compliant with colorectal screening increased from a baseline of 50.3% to 52.2% at re-measurement

examples shown represent 6A factor 3

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PCMH 6: Performance Measurement and Quality

Update and Changes

6E Demonstrate Continuous Quality Improvement

- Measuring effectiveness
- Achieving improvements

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PCMH 6: Performance Measurement and Quality

Update and Changes

6F Report Performance

- Report practice level and provider level performance within the practice
- Report practice or provider level performance publically
- Report practice or provider level performance to patients (which includes letting them know that reports are available publically)
- Need to include at least one clinical measure, one resource measure, and one patient experience measure

PCMH 6G: Use Certified EHR Technology

6G Use Certified EHR Technology

NCQA is interested in collecting data on practice's use of certified EHR technology

Conclusion

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http://www.uvm.edu/medicine/vchip/

http://www.ncqa.org

VCHIP
Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT COLLEGE OF MEDICINE

Vermont Blueprint for Health
ANNOUNCEMENT

You are invited to join the next joint meeting of the Blueprint Executive Committee and the Blueprint Planning and Evaluation Committee. The agenda will focus on proposed modifications to the Blueprint payment model and the development of a plan to best use the new $2,446,075 State appropriation. Your input on the impact of Community Health Teams and payment models is invited. Contact your Blueprint Project Manager for more information about this meeting.

Date: Thursday, June 18, 2015
Time: 8:00 – 10:00 am
Location is 10 East Allen St (VSAC Building), Winooski, VT (Community Room)
Dial in number for those who are unable to attend in person: Dial in 877-273-4202; Participant #3989432.

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