NCQA PCMH 2014 RENEWAL PROCESS

Introduction

- This presentation provides an overview of the streamlined NCQA Renewal Process using the 2014 NCQA PCMH Standards.
- Differentiation between Attested Elements and Required Documentation Elements is explained.
- References and Resources are provided at the end of the presentation.
- This process should be reviewed and undertaken with the assistance of your practice's assigned CPTS.
- For further assistance, call the HUSKY Health PCMH Administrator at 203.949.4194 or e-mail pcmhapplication@chnct.org.

Things You Need to Know

- Single-Site process
- Multi-Site process
- Certain Exceptions
- Documentation Requirements for select 11 Elements
- Attestation Process for the remaining 15 Elements
- Timelines
- Resources to support the Renewal process

Single-Site Process

- NCQA offers a streamlined process for renewal through reduced documentation requirements. This is done 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.

- Practices that satisfactorily demonstrate basic medical home transformation can focus on more advanced aspects of redesign for their renewal applications.

- Renewal for Level 1 requires a full survey.

Single-Site Elements for Renewal

The streamlined renewal process requires **documentation** only for the following Elements:

- **PCMH 2014:**

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

* Indicates a MUST-PASS Element

Multi-Site Process

- As many as 17 Elements are eligible for organizations to identify for review in the Corporate Survey Tool.
- All multi-site organizations must be able to respond to at least 12 Elements in their Corporate Survey Tool; the remaining Elements ***must be responded to at the practice-site level.***
- Organizations must indicate, in the "Organization Background" section of the Corporate Survey Tool, which *Corporate Eligible Elements* they selected.
- All other Elements require a response in the site-specific Survey Tools, with site-specific information/data.

Multi-Site Elements for Renewal

The streamlined renewal process requires **documentation** only for the following Elements:

- **PCMH 2014:**

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

* Indicates a MUST-PASS Element

Certain Exceptions

- Renewing multi-site organizations that have practice sites with a combination of NCQA Level 1, Level 2, or Level 3 Recognition, or that want to add practice sites not currently recognized, are eligible to use the reduced documentation in their Corporate Survey Tool.
- However, any Level 1 or non-recognized practice must include responses and documentation for all site-specific Elements in the Survey Tool.
- Only practices with Level 2 or Level 3 PCMH 2011 or PCMH 2014 Recognition are eligible for reduced documentation of the site-specific Elements.
- Refer to the exception example on next slide.

Example

Exception Example:

- An organization has 30 sites: 25 Level 3 practices, and 5 Level 1 or non-recognized practices.
- The organization uses one Corporate Tool for all 30 sites. The organization may use the reduced documentation/attestation process for the corporate Elements.
- The Level 3 practice sites may use the reduced documentation/attestation process for site-specific Elements.
- The Level 1 or non-recognized sites ***must respond to all site-specific Elements and provide full documentation for the Elements*** (reduced documentation/attestation is not an option for site-specific Elements).

Attestation Process

- Organizations/practice sites with NCQA Level 2 or Level 3 Recognition must provide an attestation in their specific Survey Tool for each Element that does not require documentation. Refer to the example below:

“ABC Family Practices achieved 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.”

NCQA PCMH 2014 – Element 1A Patient-Centered Access

Points	PCMH 2014 Standards and Elements	Documentation or Attestation?
10	**PCMH 1: Patient-Centered Access**	
4.5	PCMH 1A: Patient-Centered Appointment Access **MUST PASS**	Documentation
3.5	PCMH 1B: 24/7 Access to Clinical Advice	Attestation
2	PCMH 1C: Electronic Access	Attestation

PCMH 1A: Patient-Centered Access

MUST PASS

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

F1: Providing routine and urgent same-day appointments **CRITICAL FACTOR**

F2: Providing routine and urgent care appointments outside regular business hours

F3: Providing alternative types of clinical encounters

F4: Availability of appointments

F5: Monitoring no-show rates

F6: Acting on identified opportunities to improve access

NOTE: Critical Factors in a Must Pass Element are essential for Recognition

PCMH 1A: Scoring

MUST PASS

4.5 Points = Scoring

5-6 Factors (including Factor 1) = 100%

3-4 Factors (including Factor 1) = 75%

2 Factors (including Factor 1) = 50% **(MUST-PASS THRESHOLD)**

1 Factor (including Factor 1) = 25%

0 Factors = 0%

Must meet 2 Factors (including Factor 1) to pass this Must-Pass Element

PCMH 1A: Documentation

MUST PASS

F1-6: Documented process, definition of appointment types, **and:**

F1: Report(s) with at least 5 days of data showing availability/use of same-day appointments for both routine and urgent care appointments

F2: Materials communicating extended hours or a report showing after-hours availability (process to arrange after-hours access is not required if the practice has regular extended hours)

F3: Report with frequency of scheduled alternative encounter types in recent 30-calendar-day period

F4: Report showing appointment wait times compared to practice-defined standards, including policy for how the practice monitors appointment availability (include at least 5 days of data)

F5: Report showing rate of no-shows from a recent 30-calendar-day period (patients seen/scheduled visits)

F6: Documented process indicating the method the practice uses to select, analyze, and update its approach to creating greater access to appointments, and a report showing the practice has evaluated access data and implemented QI Plan to create greater access to appointments

NCQA PCMH 2014 – Element 2D
The Practice Team

Points	PCMH 2014 Standards and Elements	Documentation or Attestation?
12	**PCMH 2: Team-Based Care**	
3	PCMH 2A: Continuity	Attestation
2.5	PCMH 2B: Medical Home Responsibilities	Attestation
2.5	PCMH 2C: Culturally and Linguistically Appropriate Services (CLAS)	Attestation
4	PCMH 2D: The Practice Team **MUST PASS**	Documentation

PCMH 2D: The Practice Team

MUST PASS

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

F1: Defining roles for clinical and nonclinical team members

F2: Identifying the team structure and the staff who lead and sustain team-based care

F3: Holding scheduled patient care team meetings or a structured communication process focused on individual patient care
CRITICAL FACTOR

F4: Using standing orders for services

F5: Training and assigning members of the care team to coordinate care for individual patients

NOTE: Critical Factors in a “Must Pass” Element are essential for Recognition

PCMH 2D: The Practice Team (cont.)

MUST PASS

F6: Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change

F7: Training and assigning members of the care team to manage the patient population

F8: Holding scheduled team meetings to address practice functioning

F9: Involving care team staff in the practice's performance evaluation and quality improvement activities

F10: Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council

PCMH 2D: Scoring

MUST PASS

4 Points = Scoring

10 Factors = 100%

8-9 Factors = 75%

5-7 Factors = 50% **(MUST-PASS THRESHOLD)**

2-4 Factors = 25%

0-1 Factors = 0%

Must meet Factor 3 – Critical Factor – to pass this Must-Pass Element

PCMH 2D: Documentation

MUST PASS

F1, 2, 5-7: Staff position descriptions or responsibilities

F3: Description of staff communication processes and sample of how pre-visit planning is conducted

F4: Written standing orders

F5-7: Description of training process, schedule, materials

F6: Description of staff communication process and examples of training materials

F8: Description of staff communication processes and sample

F9: Description of staff role in practice improvement process or minutes demonstrating staff involvement

F10: Process demonstrating how it involves patients/families in QI teams or advisory council

NCQA PCMH 2014 – Element 3C Comprehensive Health Assessment

Points	PCMH 2014 Standards and Elements	Documentation or Attestation?
20	**PCMH 3: Population Health Management**	
3	PCMH 3A: Patient Information	Attestation
4	PCMH 3B: Clinical Data	Attestation
4	PCMH 3C: Comprehensive Health Assessment	Documentation
5	PCMH 3D: Use Data for Population Management **MUST-PASS**	Documentation
4	PCMH 3E: Implement Evidence-Based Decision-Support	Attestation

PCMH 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:

F1: Age- and gender-appropriate immunizations and screenings

F2: Family/social/cultural characteristics

F3: Communication needs

F4: Medical history of patient and family

F5: Advance care planning (**N/A for pediatric practices**)

F6: Behaviors affecting health

F7: Mental health/substance use history of patient and family

F8: Developmental screening using a standardized tool (**N/A for practices with no pediatric patients**)

F9: Depression screening for adults and adolescents using a standardized tool

F10: Assessment of health literacy

PCMH 3C: Scoring

4 Points = Scoring

8-10 Factors = 100%

6-7 Factors = 75%

4-5 Factors = 50%

2-3 Factors = 25%

0-1 Factors = 0%

NOTE:

Factor 5 (N/A for pediatric practices)

Factor 8 (N/A for practices with no pediatric patients)

Factor 9 (if practice does not see adolescent or adult patients)

*Need a written explanation for N/A responses

PCMH 3C: Documentation

F1-10: Report with numerator and denominator based on all unique patients in a recent three month period indicating how many patients were assessed for each factor

OR

F1-10: Review of patient records selected for the record review required in Elements 4B and 4C, documenting presence **or** absence of information in Record Review Workbook

NOTE: Report or record review must show more than 50 percent for a factor for the practice to respond "yes" to the factor in survey tool.

F8, 9: Completed form (de-identified) demonstrating use of standardized tool

NCQA PCMH 2014 – Element 3D
Use Data for Population Management

Points	PCMH 2014 Standards and Elements	Documentation or Attestation?
20	**PCMH 3: Population Health Management**	
3	PCMH 3A: Population Information	Attestation
4	PCMH 3B: Clinical Data	Attestation
4	PCMH 3C: Comprehensive Health Assessment	Documentation
5	PCMH 3D: Use Data for Population Management **MUST-PASS**	Documentation
4	PCMH 3E: Implement Evidence-Based Decision Support	Attestation

PCMH 3D: Use Data for Population Management

MUST PASS

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:

F1: At least two different preventive care services **+**

F2: At least two different immunizations **+**

F3: At least three different chronic or acute care services **+**

F4: Patients not recently seen by the practice

F5: Medication monitoring or alerts

+ Stage 2 Core Meaningful Use Requirement

PCMH 3D: Scoring

MUST PASS

5 Points = Scoring

4-5 Factors = 100%

3 Factors = 75%

2 Factors = 50% **(MUST-PASS THRESHOLD)**

1 Factor = 25%

0 Factors = 0%

PCMH 3D: Documentation

MUST PASS

F1-5:

Reports or lists of patients needing services generated within the past 12 months (health plan data okay if 75% of patient population)

AND

Materials showing how patients were notified for each service (e.g., template letter, phone call script, screen shot of e-notice)

The practice must perform these functions at least **annually**

NCQA PCMH 2014 – Element 4A
Identify Patients for Care Management

Points	PCMH 2014 Standards and Elements	Documentation or Attestation?
20	**PCMH 4: Care Management and Support**	
4	PCMH 4A: Identify Patients for Care Management	Documentation
4	PCMH 4B: Care Planning and Self-Care Support **MUST-PASS**	Documentation
4	PCMH 4C: Medication Management	Documentation
3	PCMH 4D: Use Electronic Prescribing	Attestation
5	4E: Support Self-Care and Shared Decision-Making	Attestation

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:

F1: Behavioral health conditions

F2: High cost/high utilization

F3: Poorly controlled or complex conditions

F4: Social determinants of health

F5: Referrals by outside organizations (e.g. insurers, health system, ACO), practice staff, or patient/family/caregiver

F6: The practice monitors the percentage of the total patient population identified through its process and criteria **CRITICAL FACTOR**

NOTE: Critical Factors in a "Must Pass" Element are essential for Recognition

PCMH 4A: Scoring

4 Points = **Scoring**

5-6 Factors (including Factor 6) = 100%

4 Factors (including Factor 6) = 75%

3 Factors (including Factor 6) = 50%

2 Factors (including Factor 6) = 25%

0-1 Factors (or does not meet Factor 6) = 0%

PCMH 4A: Documentation

F1-5: Documented process describing criteria for identifying patients for each factor

F6: Report with:

- Denominator = total number of patients in the practice
- Numerator = number of unique patients identified in denominator as likely to benefit from care management

Note:

- 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 – NO points if no monitoring

PCMH 2014 – Element 4B
Care Planning and Self-Care Support

Points	PCMH 2014 Standards and Elements	Documentation or Attestation?
20	**PCMH 4: Care Management and Support**	
4	PCMH 4A: Identify Patients for Care Management	Documentation
4	PCMH 4B: Care Planning and Self-Care Support **MUST-PASS**	Documentation
4	PCMH 4C: Medication Management	Documentation
3	PCMH 4D: Use Electronic Prescribing	Attestation
5	4E: Support Self-Care and Shared Decision-Making	Attestation

PCMH 4B: Care Planning and Self-Care Support

MUST PASS

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 4A:

F1: Incorporates patient preferences and functional/lifestyle goals

F2: Identifies treatment goals

F3: Assesses and addresses potential barriers to meeting goals

F4: Includes a self-management plan

F5: Is provided in writing to patient/family/caregiver

PCMH 4B: Scoring and Documentation

MUST PASS

4 Points = **Scoring**

5 Factors = 100%

4 Factors = 75%

3 Factors = 50% **(MUST-PASS THRESHOLD)**

1-2 Factors = 25%

0 Factors = 0%

Documentation

F1-5: Report from electronic system **OR** submission of Record Review Workbook

AND

Examples of how each factor is met

NCQA PCMH 2014 – Element 4C Medication Management

Points	PCMH 2014 Standards and Elements	Documentation or Attestation?
20	**PCMH 4: Care Management and Support**	
4	PCMH 4A: Identify Patients for Care Management	Documentation
4	PCMH 4B: Care Planning and Self-Care Support **MUST-PASS**	Documentation
4	PCMH 4C: Medication Management	Documentation
3	PCMH 4D: Use Electronic Prescribing	Attestation
5	PCMH 4E: Support Self-Care and Shared Decision-Making	Attestation

PCMH 4C: Medication Management

The practice has a process for managing medications, and systematically implements the process in the following ways:

F1: Reviews and reconciles medications for more than 50% of patients received from care transitions **+ CRITICAL FACTOR**

F2: Reviews and reconciles medications with patients/families for more than 80% of care transitions

F3: Provides information about new prescriptions to more than 80% of patients/families/caregivers

F4: Assesses patient/family/caregiver understanding of medications for more than 50% of patients/families/caregivers, and dates the assessment

F5: Assesses patient response to medications and barriers to adherence for more than 50% of patients/families/caregivers, and dates the assessment

F6: Documents over-the-counter medications, herbal therapies and supplements for more than 50% of patients, and dates updates

+ Core Meaningful Use Requirement

NOTE: Critical Factors in a "Must Pass" Element are essential for Recognition

PCMH 4C: Scoring and Documentation

4 Points = **Scoring**

5-6 Factors (including Factor 1) = 100%
3-4 Factors (including Factor 1) = 75%
2 Factors (including Factor 1) = 50%
1 Factor (including Factor 1) = 25%
0 Factors (or does not meet Factor 1) = 0%

Documentation

F1-6: Report from electronic system **OR** submission of Record Review Workbook

AND

Example of how each factor is met

PCMH 2014 – Element 5B
Referral Tracking and Follow-Up

Points	PCMH 2014 Standards and Elements	Documentation or Attestation?
18	**PCMH 5: Care Coordination and Care Transitions**	
6	5A: Test Tracking and Follow-Up	Attestation
6	5B: Referral Tracking and Follow-Up **MUST-PASS**	Documentation
6	5C: Coordinate Care Transitions	Attestation

PCMH 5B: Referral Tracking and Follow-Up

MUST PASS

The Practice:

F1: Considers available performance info on consultant/ specialists for referral recommendations

F2: Maintains formal and informal agreements with subset of specialists based on established criteria

F3: Maintains agreements with behavioral healthcare providers

F4: Integrates behavioral healthcare providers within the practice site

F5: Gives the consultant/specialist the clinical question, required timing and type of referral

F6: Gives the consultant/specialist pertinent demographic and clinical data, including test results and current care plan

PCMH 5B: Referral Tracking and Follow-Up (cont.)

MUST PASS

F7: Has capacity for electronic exchange of key clinical information**+** and provides electronic summary of care record to another provider for >50% of referrals

F8: Tracks referrals until consultant/specialist report is available, flagging and following up on overdue reports **CRITICAL FACTOR**

F9: Documents co-management arrangements in patient's medical record

F10: Asks patients/families about self-referrals and requests reports from clinicians

+ Core Meaningful Use Requirement

NOTE: Critical Factors in a "Must Pass" Element are essential for Recognition

PCMH 5B: Scoring

MUST PASS

6 Points = Scoring

9-10 Factors (including Factor 8) = 100%

7-8 Factors (including Factor 8) = 75%

4-6 Factors (including Factor 8) = 50% **(MUST-PASS THRESHOLD)**

2-3 Factors (including Factor 8) = 25%

0-1 Factors (or does not meet Factor 8) = 0%

Must meet minimum of 4 Factors (including Factor 8) to pass this Must-Pass Element

PCMH 5B: Documentation

MUST PASS

F1: Examples of types of information the practice has on specialist performance

F2-3: At least one example for each factor

F4: Materials explaining how BH is integrated with physical health

F5-6: Documented process and at least one example or report demonstrating process implementation

F7: Report from electronic system with numerator, denominator, percent, and screenshot **At least 3 months of data**

F6, 8, & 10: Documented process and at least one example, or report demonstrating process implementation

F9: At least three examples

PCMH 2014 – Element 6B
Measure Resource Use and Care Coordination

Points	PCMH 2014 Standards and Elements	Documentation or Attestation?
20	**PCMH 6: Performance Measurement and Quality Improvement**	
3	6A: Measure Clinical Quality Performance	Attestation
3	6B: Measure Resource Use and Care Coordination	Documentation
4	6C: Measure Patient/Family Experience	Attestation
4	6D: Implement Continuous Quality Improvement **MUST-PASS**	Documentation
3	6E: Demonstrate Continuous Quality Improvement	Documentation
3	6F: Report Performance	Attestation
0	6G: Use Certified EHR Technology	N/A

PCMH 6B: Measure Resource Use and Care Coordination

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

F1: At least two measures related to care coordination

F2: At least two utilization measures affecting healthcare costs

PCMH 6B: Scoring and Documentation

3 points = **Scoring**

2 Factors = 100%

1 Factor = 50%

0 Factors = 0%

Documentation

F1-2: Reports showing performance

PCMH 6D: Implement Continuous Quality Improvement

MUST PASS

Practice uses ongoing quality improvement process:

F1: Set goals and analyze at least three clinical quality measures from Element 6A

F2: Act to improve performance on at least three clinical quality measures from Element 6A

F3: Set goals and analyze at least one measure from Element 6B

F4: Act to improve at least one measure from Element 6B

F5: Set goals and analyze at least one patient experience measure from Element 6C

F6: Act to improve at least one patient experience measure from Element 6C

F7: Set goals and address at least one identified disparity in care/service for identified vulnerable populations

PCMH 6D: Scoring and Documentation

MUST PASS

4 Points = Scoring

7 Factors = 100%

6 Factors = 75%

5 Factors = 50% **(MUST-PASS THRESHOLD)**

1-4 Factors = 25%

0 Factors = 0%

Documentation

F1-7: Reports **OR** completed PCMH Quality Measurement and Improvement Worksheet (QIW)

PCMH 6E: Demonstrate Continuous Quality Improvement

Practice demonstrates continuous quality improvement:

F1: Measures effectiveness of actions to improve measures selected in Element 6D

F2: Achieves improved performance on at least two clinical quality measures

F3: Achieves improved performance on one utilization or care coordination measure

F4: Achieves improved performance on at least one patient experience measure

PCMH 6E: Scoring and Documentation

3 Points = **Scoring**

4 Factors = 100%

3 Factors = 75%

2 Factors = 50%

1 Factor = 25%

0 Factors = 0%

Documentation

F1-4: Reports **OR** completed Quality Measurement and Improvement Worksheet

Summary of Renewal Elements
Single-Site

- Attestation: 15 Elements = 54.5 points – Maximum
- Documentation: 11 Elements = 45.5 points – Maximum
- Standard 6G = 0 points – no points

Summary of Renewal Elements
Multi-Site

- Corporate Eligible Elements: 17 = 65.5 points – Maximum
- Site Eligible Elements: 9 = 34.5 points – Maximum
- Standard 6G = 0 points – no points

PCMH 2014: Enhancements

- Team-Based Care
- Behavioral and Mental Health Integration
- Measuring Health Care Costs
- “Meaningful Use” – Stage 2 - Alignment
- Continuous Improvement
- Care Coordination

References

- NCQA Website: www.ncqa.org
  - For PCMH-specific resources, click here
  - For free trainings each month, click here

Additional PCMH Resources

- AHRQ Website: http://www.ahrq.gov
- HUSKY Health Pathway to PCMH webpage: http://www.huskyhealthct.org/pathways_pcmh/pathways_home.html

Thank you!