The DSS PCMH Program & NCQA 2017 Standards

June 6, 2019

A Department of Social Services
PCMH Presentation hosted by
Community Health Network of Connecticut, Inc.

Connecticut Department of Social Services
Making a Difference

Connecticut Person-Centered Medical Home

Learning Objectives

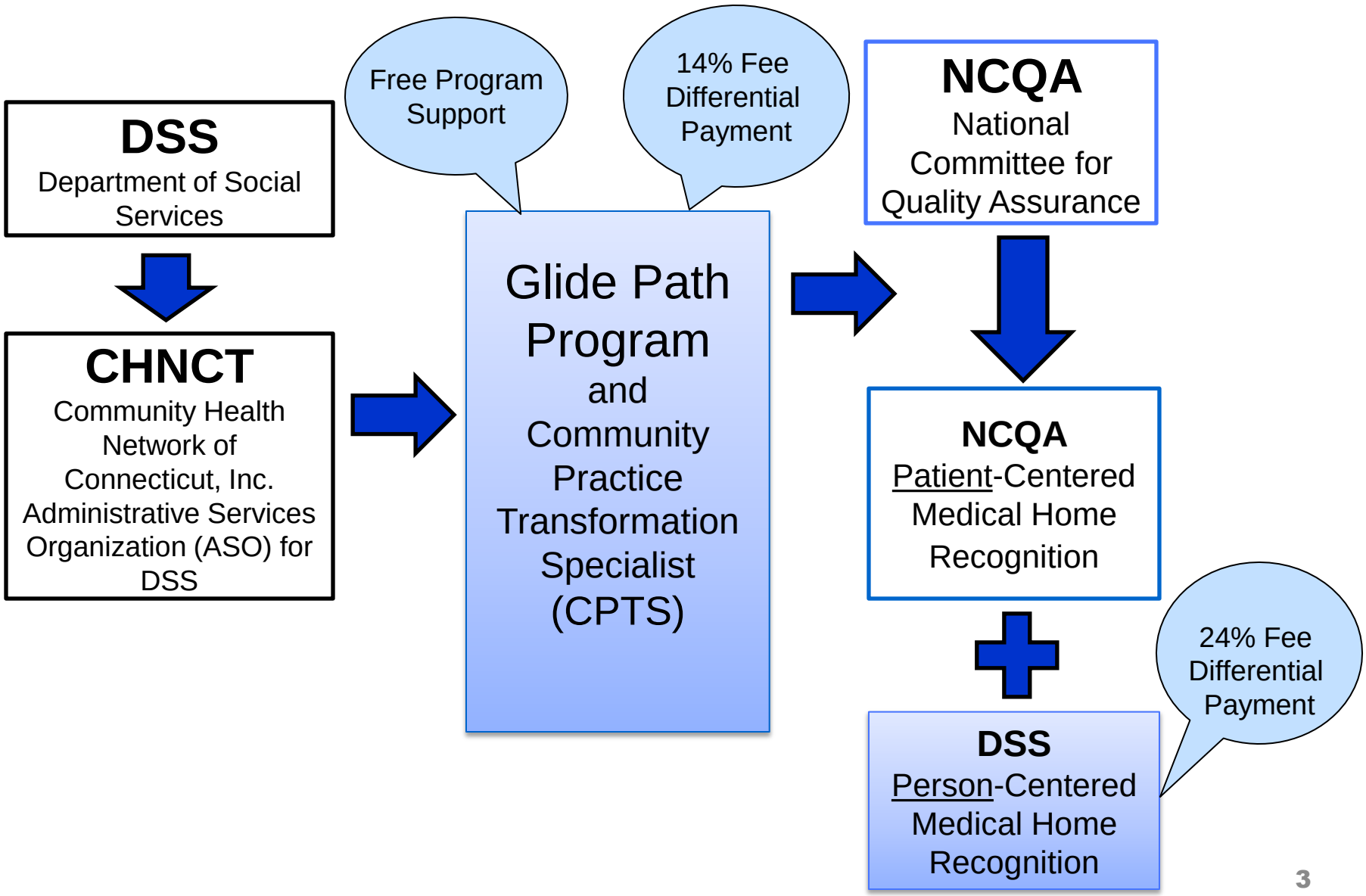
- Detail the Department of Social Services (DSS) Person-Centered Medical Home (PCMH) Program Process
- Define important aspects of National Committee for Quality Assurance (NCQA) PCMH 2017 Program
- Review the NCQA 2017 Standards and outline changes from the NCQA 2014 Standards
- Identify importance of continuous quality improvement

Connecticut Person-Centered Medical Home

PCMH Concept

- Team-based healthcare delivery model led by a physician with trained staff that provides coordinated care
- Comprehensive and continuous primary care with the Quadruple Aim of maximizing health outcomes, enhancing the patient care experience, lowering costs, and improving care team satisfaction
- Responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs

DSS PCMH Program



DSS PCMH Financial Incentives

- Participation Enhanced Rates
  - An enhanced reimbursement rate on 78 selected Current Procedural Terminology (CPT) codes
- Performance Payments
  - Annual payments possible based on practice performance of DSS selected health measure results
- Improvement Payments
  - Annual payments are based on the practice's improvement of health measures

Community Practice Transformation Specialist (CPTS) Support

- The CPTS team assists with:
  - NCQA processes and annual reporting
  - Analysis of practice's Annual Profile Report
  - CareAnalyzer® data analytic software
  - HUSKY Health Provider Portal Reports training

NCQA's Redesign

Previous Process	Current Process
■ Every 3 years, practices needed to submit all materials for a full review, with little guidance from NCQA	■ NCQA interacts with practice from the start ■ Practice submits information at agreed-upon intervals until recognized ■ Focused annual review and ongoing data submission to sustain recognition (no Renewal Survey at 3 years)

NCQA 2014 vs. 2017 Recognition

Nomenclature changes from the 2014 to 2017 Standards and Guidelines
Standard > Concept
Element > Competency
Factor > Criterion

2017 Standards and Guidelines Eliminated
Recognition levels
Critical factors
Scoring up to 100 points
Must-pass elements

2017 Core & Elective Criteria

- **Core**: Mandatory for all practices seeking recognition (40 criteria)
- **Elective**: A selection of additional criteria a practice chooses from includes:
  - Five of the six concepts
  - 25 credits required

Quality Performance Assessment Support System (Q-PASS) Features

- New web-based platform
- Claim your organization in Q-PASS
- Upload evidence and attest to standards
- Payment portal
- View all practice sites via one login
- Pose questions to NCQA

NCQA Annual PCMH Requirements

- Attestation to 2017 Standards and Guidelines
  - 40 core criteria
  - Identify and meet 25 elective credits
- PCMH Annual Reporting Requirements
  - Updates to the requirements are made each calendar year
  - Subset of the 40 core criteria
  - Special topic questions (not scored)
  - Submit one month prior to NCQA recognition anniversary date (date NCQA recognition expires)
- Submit payment

CHNCT Quality Assurance Annual Review (QAAR)

- Collaboratively review QAAR Gap Analysis Checklist
  - Timing - six months prior to practice's NCQA anniversary date
  - On-site visit
- Identify gaps
- Create action plans for practice transformation maintenance

Team-Based Care & Practice Organization (TC) Concept

Competencies

- Practice leadership
- Care team responsibilities
- Staff communication
- Orientation of patients, families, and caregivers

Criteria

- 5 Core
  - 1 **(new to 2017)**
- 4 Elective
  - 3 **(new to 2017)**

TC Core Criteria

- Correlates to NCQA 2014 Elements **2B & 2D**
  - Staff structure & roles
  - Huddles
  - Staff involvement in quality improvement (QI) activities
  - Medical home responsibilities
- Clinician Lead and PCMH Manager **(new to 2017)**

TC Elective Criteria

TC 03 **(new to 2017)**	External PCMH Collaboration • Participation in the DSS PCMH Program counts toward external PCMH collaboration • CPTS will provide a DSS PCMH Program Participation letter
TC 04 **(new to 2017)**	Patient Advisory Council or Practice Governance
TC 05	Use certified electronic health record (EHR)
TC 08 **(new to 2017)**	Behavioral Healthcare Manager to coordinate behavioral health referrals

TC: Tips and Lessons Learned

- Earn 3 easy-to-meet elective credits
  - TC 01 Your CPTS has a template available to you
  - TC 03 CPTS to provide a letter
  - TC 05 Simply provide the name of your EHR
- Announcement of project leaders
  - Opportunity to create enthusiasm
- When starting your attestation project assign TC as the first concept
- Completion of TC “sets the stage”

Knowing and Managing Your Patients (KM) Concept

Competencies

- Collection of patient data including diversity
- Proactive outreach to reduce gaps in care
- Medication management
- Evidence-based care
- Connection with community resources

Criteria

- 10 Core
  - 1 **(new to 2017)**
- 18 Elective
  - 12 **(new to 2017)**

KM Core Criteria

- Correlates to NCQA 2014 Elements **3A, 3B, 3E** and **4C**
  - Up-to-date patient problem & medication lists
  - Diversity of population & language assessments
  - Outreach for gaps in care
  - Medication reconciliation
  - Evidence-based clinical decision support
- KM 03 - depression screenings - **now mandatory for 2017**
- KM 02 - comprehensive health assessments - **more extensive (F & G)**
- KM 21 - listing of key patient needs and concerns **(new to 2017)**

KM Elective Criteria

- Correlates to NCQA 2014
  - Element **4C**
    - KM 16 - new prescription education
    - KM 17 - medication responses and barriers
  - Element **4E**
    - KM 22 - provide educational resources
    - KM 24 - shared decision-making aids
    - KM 26 - community resource list
    - KM 27 - assess community resources

KM Elective Criteria **(new to 2017)**

KM 04	Behavioral health screenings
KM 05	Oral health services - reimbursable fluoride applications
KM 06	Main patient conditions & concerns - Top 20 Diagnosis Code Report
KM 07	Care interventions based on social determinants of health
KM 08	Health literacy data used to tailor patient materials
KM 11	Staff education health literacy & cultural competence, identifies and takes actions to reduce disparities (**new to 2017**: A & C)
KM 13	Benchmarked/performance-based recognition program
KM 18	Controlled substance database usage
KM 19	Prescription claims data used to address adherence
KM 23	Oral health education & resources
KM 25	School/intervention agency engagement
KM 28	Multidisciplinary case conferences

KM: Tips and Lessons Learned

- KM 07,13,19, 28 each assigned two elective credits
- KM 26 = KM 06 + KM 21
- KM 28 - TeleECHO® Clinic
  - 2 NCQA elective credits earned for a case presentation for a high-risk patient
  - 1 continuing medical education (CME) credit earned for participating as an expert, presenter, or participant
  - For more information: https://www.huskyhealthct.org/ECHO/echo_clinics.html

Patient-Centered Access and Continuity (AC) Concept

Competencies

- 24/7 access to practice and clinical advice
- Continuity of care
- Empanelment

Criteria

- 7 Core
  - 1 **(new to 2017)**
- 7 Elective
  - 3 **(new to 2017)**

Concept AC Core Criteria

- Correlates to NCQA 2014 Standard **1** & Element **2A**
  - AC 02 - reserved same-day appointments
  - AC 03 - extended hours
  - AC 04 - timely clinical advice by phone
  - AC 05 - documentation/reconciliation after hours clinical advice
  - AC 10 - empanelment
  - AC 11 - percentage visits with PCP
- AC 01 - evaluate patient access and preferences **(new to 2017)**

Concept AC Elective Criteria

- AC 06 - technology supported visits **(new to 2017)**
- AC 07 - patient portal functionalities
- AC 08 - two-way portal communication
- AC 09 - address equity of access **(new to 2017)**
- AC 12 - continuity of medical records when office is closed (two elective credits)
- AC 13 - actively manages provider panel size **(new to 2017)**
- AC 14 - reconciles health plan panels **(new to 2017)**
  - HUSKY Health Secure Provider Portal

AC: Tips and Lessons Learned

- It's concept "AC" not "PC"
  - Patient-centered **A**ccess and **C**ontinuity
- AC 01 data is not used for QI 10
  - Use QI 03 data for QI 10
- AC 02 - walk-in data not permitted
- AC 10 & 11 - solo providers receive auto credit
- AC 13 - cannot be selected by solo providers
- AC 14 - Medicaid population (75%+) use HUSKY Health Patient Panel Report

Care Management and Support (CM) Concept

Competencies

- Identifying patients for care management
- Care plan development

Criteria

- 4 Core
- 5 Elective
  - 2 **(new to 2017)**

Correlates to NCQA 2014 Elements **4A, B, and E**

CM Core Criteria

CM 01	Identify vulnerable populations
CM 02	Unique vulnerable patient report
CM 04	Care plans
CM 05	Care plan offered to patient

CM Elective Criteria

- CM 03 - risk stratification for all patients **(new to 2017)**
- CM 06 - patient preferences and goals
- CM 07 - patient barriers to goals
- CM 08 - self-management tools & resources
- CM 09 - care plan accessible to external care settings **(new to 2017)**

CM: Tips and Lessons Learned

- Choose populations that will benefit from care plans
- Ongoing provider involvement is important
- Write care plan text so that patients can understand the wording
- Outcomes can improve when patients take responsibility for their self-care

Care Coordination & Care Transitions (CC) Concept

Competencies

- Management of lab and imaging results
- Tracking and managing important patient referrals
- Care transitions

Criteria

- 5 Core
- 16 Elective
  - 6 **(new to 2017)**

CC Core Criteria

CC 01	Lab and imaging test management
CC 04	Referral management
CC 14	Identifying unplanned hospital & ED visits
CC 15	Sharing clinical data with hospital & EDs
CC 16	Post hospital/ED visit follow-up

CC Elective Criteria

CC 02	Newborn testing follow-up
CC 07	Use performance data when selecting specialists
CC 08	Agreements with specialists for expectations for exchange of information
CC 09	Agreements with behavioral health specialists for expectations for exchange of information
CC 10	Integrate behavioral health providers
CC 12	Co-management arrangement documentation
CC 18	Bidirectional information exchange with hospital
CC 19	Obtain discharge summaries
CC 20	Care plan collaboration for practice transitions
CC 21	External electronic exchange of information

CC Elective Criteria **(new to 2017)**

CC 03	Protocols for imaging and lab test necessity
CC 05	Protocols for referral necessity
CC 06	Monitor specialists used by practice
CC 11	Evaluates timeliness/quality of referral responses
CC 13	Cost implications of treatment options
CC 17	Use of acute care settings after hours

CC: Tips and Lessons Learned

- 16 elective criteria (24 credits)
- Opportunities are always present for improvement of care coordination
- Utilize Connecticut Choosing Wisely Collaborative
  - http://www.choosingwiselyct.org/
- NCQA emphasis - behavioral health coordination

Quality Improvement

- The mission of NCQA:
  - “Improve the quality of health care”
- The mission of DSS:
  - “We, along with our partners, provide person-centered programs and services to enhance the well-being of individuals, families and communities”
- The mission of CHNCT:
  - “To improve the health of the underserved and vulnerable populations by providing access to high quality and comprehensive healthcare, as a not-for-profit community health-sponsored health plan”
- These missions emulate the NCQA Performance Measurement and Quality Improvement, Concept QI

Reasons to Focus on Quality Improvement

- Improve patient outcomes
- Increase patient, staff, and provider satisfaction
- Revenue opportunities
  - Reimbursement model shift from fee for service
  - Value-based contract agreements
  - PCMH Performance-Based Payment Program

Performance Measurement and Quality Improvement (QI) Concept

Competencies

- Collecting performance data
- Analyzing performance data
- Setting goals
- Improving practice performance
- Sharing practice performance data

Criteria

- 9 Core
- 10 Elective
  - 2 **(new to 2017)**

QI Core Criteria

QI 01	Clinical measurement baseline reports
QI 02	Usage/care coordination baseline reports
QI 03	Third next available appointment report
QI 04	Patient satisfaction survey & qualitative data
QI 08	Act to improve upon three QI 01 measures
QI 09	Act to improve upon one QI 02 measure
QI 10	Act to improve upon one QI 03 measure
QI 11	Act to improve upon one QI 04 measure
QI 15	Report QI improvement results to staff

QI Elective Criteria

QI 05	Assess clinical & experience disparities
QI 06	Benchmarked patient experience survey
QI 07	Vulnerable patient feedback
QI 12	Achieves improved performance
QI 13	Act to improve upon QI 05 data
QI 14	Achieves improvement for QI 13 **(new to 2017)**
QI 16	Performance reporting - publicly or with patients
QI 17	Patient Advisory Council involved with QI
QI 18	Report to Medicaid or Medicare
QI 19	Engage in value-based contract agreements **(new to 2017)**

QI: Tips and Lessons Learned

- NCQA AR QI Worksheet “preferred” by reviewers
  - AR = Annual Reporting
- Correlations - baseline reports and act & succeed
  - QI 01, QI 08, & QI 12
  - QI 02, QI 09, & QI 12
  - QI 03 & QI 10
  - QI 04, QI 11, & QI 12
  - QI 05, QI 13, & QI 14 (total: 4 elective credits)
- QI 18 - report to Medicaid or Medicare
  - Medicaid population (75%+) use Annual Profile Report

Next Steps

- Read the NCQA 2017 Standards
  - https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/
- Read the NCQA Annual Reporting Requirements
- Use NCQA's PCMH 2014-PCMH 2017 Crosswalk
- Download and save the NCQA PCMH AR QI Worksheet
- Claim your organization in NCQA's Q-PASS
  - https://qpass.ncqa.org/spa/#!/sign-in/

Resources

- Slides 12 - 39 are derived from the following document:
  - https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/
- Provider Portal Reports (Concepts AC, CC, KM, & QI)
  - https://www.huskyhealthct.org/providers.html#
- CareAnalzyer® Data Analytics Software (Concept CM)
  - https://www.huskyhealthct.org/providers/reports-data.html#
- CultureVision™ (Concept KM)
  - https://www.huskyhealthct.org/providers/culturevision.html#
- Transitional Care Services (Concept CC)
  - https://www.huskyhealthct.org/providers/transitional-care.html#
- Connecticut Dental Health Partnership (Concept KM)
  - https://www.ctdhp.com/clients_login.asp

PCMH Contact Information

- By email: pathwaytopcmh@chnct.org
- By phone: 203.949.4194
- Online: www.huskyhealthct.org/providers/pcmh.html
- All PCMH webinars located on the HUSKY Health website page “Webinars” under the “Person-Centered Medical Home” menu item

Questions?