Not so Trivial Pursuit - PCMH Edition

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Learning Objectives

• Apply best practices to become a true medical home
• Understand the new 2017 NCQA PCMH standards
• Adapt tools to organize, maintain, and sustain your medical home transformation
Our time together today
PCMH Redesign

**Commit**
Practice completes an online guided assessment.
- Practice works with an NCQA representative to develop an evaluation schedule.
- Practice works with NCQA representative to identify support and education for transformation.
- New NCQA PCMH online education resources support the transformation process.

**Transform**
Practice submits initial documentation and checks in with its evaluator.
- Practice submits additional documentation and checks in with its evaluator.
- Practice submits final documentation to complete submission and begin NCQA evaluation process.
- Practice earns NCQA Recognition.

**Succeed**
Practice is prepared for new payment environment (value-based payment, MACRA, MIPS/APMs).
- Practice demonstrates continued readiness and high quality performance through annual reporting to NCQA.
Commit

- Get buy-in
- Review standards, get trained
- Determine eligible clinicians
- Determine sites and fee schedule
- HRSA Notice of Intent (PAL 2015-02)
- Enroll in QPASS
Welcome to the Quality Performance Assessment Support System (Q-PASS)

- Sign In and Enroll
- Learn About Our Programs
- Eligible?
- Price Calculator
- Contact Us
- Educational Resources
Transform

• Get buy-in
• Identify current state and ideal state
• Implement new workflows, policies and procedures
• Gather documentation for evidence
• Introductory call
• Up to 3 virtual check-ins
• Peer Review Committee
Evidence Library

How to add new evidence?

Click the "Add New Evidence" button to add evidence.
Formats allowed are PDF, JPG, PNG, DOC, DOCX, XLS, XLSX, PPT, and PPTX.

Colorado Coalition For The Homeless - Stout Street Health Center

- Health Literacy Resources
  https://www.healthliteracycolorado.org/

- Health Literacy Conference

- National Institute of Oral Health website
  https://www.nidcr.nih.gov/

- CCH Community Resources
Project Management Tools for Success

- Agile project management methodology
  - Kick off
  - Bi-weekly sprints
- Project Charter
- Communication Tools
The team completed the PCMH Standards review and subsequent work required (policies, workflows, reports, etc.) within 8 Sprints. The 9th Sprint was not needed as such. A small subset of the Project Team involved in the NCQA Check In Calls and related efforts continued to meet and work outside the Sprint format.
Succeed

- Maintain transformation
- Enhance model
- Annual reporting
Maintaining and sustaining
Keeping organized

<table>
<thead>
<tr>
<th>2 COPIES OF EVERYTHING ON DESK BY END OF EACH DAY</th>
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</thead>
<tbody>
<tr>
<td><strong>QUALITY IMPROVEMENT SPECIALISTS MONTHLY CALENDAR</strong></td>
</tr>
<tr>
<td><strong>Monday</strong></td>
</tr>
<tr>
<td>1. Monthly SPA Update (8 hrs.)</td>
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<tr>
<td>2. SPA Enrollment Data (26 hrs.) &amp; send email to NOC &amp; CDS</td>
</tr>
</tbody>
</table>

**WEEK 1**

**Quality Specialist #1**

1. Clinical Indicators monthly and yearly | 1. Clinical Indicators monthly and yearly | 1. Clinical Indicators monthly and yearly | 1. Admin. Team Meeting: 12:00-1:00 (1 hr) Creative Time |
| (2 hrs.) | (2 hrs.) | (2 hrs.) | 2. Post DWP Enrollment Charts to Conference Room. |
| 2. Clinical Indicators by provider (2 hrs.) | 2. CDS measures monthly and yearly (2 hrs.) | 2. Post DWP Enrollment Charts to Conference Room. | 2. Admin. Team Meeting: 12:00-1:00 (1 hr) Creative Time |
| 3. Lab Data (2 hrs.) | 3. Lab Data (2 hrs.) | 3. Lab Data (2 hrs.) | 3. Lab Data (2 hrs.) | 3. Lab Data (2 hrs.) |
| 4. Review Coordinator Call 2:00-3:00 | 4. Review Coordinator Call 2:00-3:00 | 4. Review Coordinator Call 2:00-3:00 | 4. Review Coordinator Call 2:00-3:00 | 4. Review Coordinator Call 2:00-3:00 |

**WEEK 2**

**Quality Specialist #2**

1. Deceased Patients (30 min.) | 1. Deceased Patients (30 min.) | 1. Deceased Patients (30 min.) | 1. Admin. Team Meeting: 12:00-1:00 (1 hr) Creative Time |
| 3. SPA Enrollment Data (26 hrs.) & send email to NOC & CDS | 3. SPA Enrollment Data (26 hrs.) & send email to NOC & CDS | 3. SPA Enrollment Data (26 hrs.) & send email to NOC & CDS | 3. SPA Enrollment Data (26 hrs.) & send email to NOC & CDS |
| 4. Referral Coordinator Call 2:00-3:00 | 4. Referral Coordinator Call 2:00-3:00 | 4. Referral Coordinator Call 2:00-3:00 | 4. Referral Coordinator Call 2:00-3:00 |

**Quality Specialist #1**

1. Dental Clinic Indicators (1 hr) | 1. Dental Clinic Indicators (1 hr) | 1. Dental Clinic Indicators (1 hr) | 1. Admin. Team Meeting: 12:00-1:00 (1 hr) Creative Time |
| 2. 2A, 2B, Clarchy, Responsible Provider, high risk, Clinic Visit Summary (2 hrs.) | 2. 2A, 2B, Clarchy, Responsible Provider, high risk, Clinic Visit Summary (2 hrs.) | 2. 2A, 2B, Clarchy, Responsible Provider, high risk, Clinic Visit Summary (2 hrs.) | 2. Admin. Team Meeting: 12:00-1:00 (1 hr) Creative Time |

**Quality Specialist #2**

1. Clinic B QI Meeting: 1:00-1:30 (30 min) Creative Time | 1. Clinic B QI Meeting: 1:00-1:30 (30 min) Creative Time | 1. Clinic B QI Meeting: 1:00-1:30 (30 min) Creative Time | 1. Clinic B QI Meeting: 1:00-1:30 (30 min) Creative Time |
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| 1. Referral Tracking (8 hrs) | 1. Referral Tracking (8 hrs) | 1. Referral Tracking (8 hrs) | 1. Referral Tracking (8 hrs) |

*2 hour task*
Data Engagement
Patient and Staff Engagement

Goal #5
Improve Patient Experience
Dashboards
Insatiable thirst for data

I get called back quickly

Staff questionnaire on phone note process

Patient Satisfaction Data

Phone note chart audit
The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers, and organizes and trains staff to work to the top of their license and provide effective team-based care.
## Team Based Care & Practice Organization

### Competency A: 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.

<table>
<thead>
<tr>
<th>TC 01 (Core): Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.</th>
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<tbody>
<tr>
<td>TC 03 (1 Credit): The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges).</td>
</tr>
<tr>
<td>TC 04 (2 Credits): Patients/families/caregivers are involved in the practice’s governance structure or on stakeholder committees.</td>
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</table>

### Competency B: Communication among staff is organized to ensure that patient care is coordinated, safe and effective.

| TC 08 (2 Credits) Has at least one care manager qualified to identify and coordinate behavioral health needs. |

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TC – Community Focused Criteria

• TC 03 (1 Credit): The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges).

• TC 04 (2 Credits): Patients/families/caregivers are involved in the practice’s governance structure or on stakeholder committees.
Knowing and Managing Your Patients

The practice uses information about the patients and community it serves to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.
**Knowing and Managing Your Patients**

| KM 02 (Core): Comprehensive health assessment includes (all items required): F. Social functioning. G. Social determinants of health. | KM 04 (1 Credit): Conducts behavioral health screenings and/or assessments using a standardized tool. (Implement two or more.) A. Anxiety. B. Alcohol use disorder. C. Substance use disorder. D. Pediatric behavioral health screening. E. Post-traumatic stress disorder. F. Attention deficit/hyperactivity disorder. G. Postpartum depression. |
| KM 05 (1 Credit): Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners. | KM 06 (1 Credit): Identifies the predominant conditions and health concerns of the patient population. |
| KM 07 (2 Credits): Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data. | KM 08 (1 Credit): Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials. |
| KM 11 (1 Credit): Identifies and addresses population-level needs based on the diversity of the practice and the community (at least two): A. Target population health management on disparities in care. C. Educate practice staff in cultural competence. | KM 13 (2 Credits): Demonstrates excellence in a benchmarked/performance-based recognition program assessed using evidence-based care guidelines. |
| KM 18 (1 Credit): Reviews controlled substance database when prescribing relevant medications. | KM 19 (2 Credits): Systematically obtains prescription claims data in order to assess and address medication adherence. |
| KM 21 (Core): Uses information on the population served by the practice to prioritize needed community resources. | KM 23 (1 Credit): Provides oral health education resources to patients. |
| KM 25 (1 Credit): Engages with schools or intervention agencies in the community. | KM 28 (2 Credits): Has regular “case conferences” involving parties outside the practice team (e.g., community supports, specialists). |

KM – Community focused criteria

• KM 07 (2 Credits): Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data.
• KM 10 (Core): Assesses the language needs of its population.
• KM 19 (2 Credits): Systematically obtains prescription claims data in order to assess and address medication adherence.
• KM 21 (Core): Uses information on the population served by the practice to prioritize needed community resources.
• KM 22 (1 Credit): Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.
• KM 25 (1 Credit): Engages with schools or intervention agencies in the community.
• KM 26 (1 Credit): Routinely maintains a current community resource list based on the needs identified in KM 21.
• KM 27 (1 Credit): Assesses the usefulness of identified community support resources.
• KM 28 (2 Credits): Has regular “case conferences” involving parties outside the practice team (e.g., community supports, specialists).
Patient Centered Access and Continuity

The practice provides 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team, considers the needs and preferences of the patient population when modeling standards for access.
### Patient Centered Access and Continuity

<table>
<thead>
<tr>
<th>Competency</th>
<th>Core Criteria</th>
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<tr>
<td><strong>Competency A:</strong> The practice seeks to enhance access by providing appointments and clinical advice based on patients needs</td>
<td>AC 01 (core) Assess the access needs and preferences of the patient population</td>
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<td></td>
<td>AC 09 (1 Credit): Uses information about the population served by the practice to assess equity of access that considers health disparities.</td>
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<tr>
<td><strong>Competency B:</strong> Practices support continuity through empanelment and systematic access to the patient’s medical record</td>
<td>AC 13 (1 credit) Reviews and actively manages panel sizes.</td>
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<td>AC 14 (1 credit) Reviews and reconciles panels based on health plan or other outside patient assignments.</td>
</tr>
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AC – Community Focused Criteria

• AC 03 (core) Appointments Outside Business Hours: Provides routine and urgent appointments outside regular business hours to meet identified patient needs. *May arrange for patients to schedule appointments with other facilities or clinicians.

• AC 14 (1 credit) External Panel Review and Reconciliation: Reviews and reconciles panels based on health plan or other outside patient assignments

Care Coordination and Transitions

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

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<th>Core Criteria</th>
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<tr>
<td><strong>Competency A</strong>: The practice effectively tracks and manages laboratory and imaging tests important for patient care and informs patients of the result.</td>
<td>CC 03 (2 Credits): Uses clinical protocols to determine when imaging and lab tests are necessary.</td>
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<tr>
<td></td>
<td>CC 05 (2 Credits): Uses clinical protocols to determine when a referral to a specialist is necessary.</td>
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<td>CC 06 (1 Credit): Identifies the specialists/specialty types frequently used by the practice.</td>
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<tr>
<td><strong>Competency B</strong>: The practice provides important information in referrals to specialists and tracks referrals until the report is received.</td>
<td>CC 11 (1 Credit): Monitors the timeliness and quality of the referral response.</td>
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<td></td>
<td>CC 13 (2 Credits): Engages with patients regarding cost implications of treatment options.</td>
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<tr>
<td><strong>Competency C</strong>: The practice connects with health care facilities to support patient safety throughout care transitions. The practice received and shares necessary patient treatment information to coordinate comprehensive patient care.</td>
<td>CC 17 (1 Credit): Systematic ability to coordinate with acute care settings after office hours through access to current patient information.</td>
</tr>
</tbody>
</table>

CC – Community Focused Criteria

• CC 04 (Core) Practice systematically manages referrals.
• CC05 (2 credits) Uses clinical protocols to determine when a referral to a specialist is necessary.
• CC 06 (1 credit) Identifies the specialist/specialty types frequently used by the practice.
• CC 07 (2 credits) Considers available performance information on consultants/specialists when making referrals.
• CC 08 (1 credit) Works with nonbehavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care.
• CC 09 (2 credits) Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care.
• CC 11 (1 credit) Monitors the timeliness and quality of the referral response.
• CC 15 (Core) Shares clinical information with admitting hospitals and emergency departments
• CC 17 (1 Credit) Systematic ability to coordinate with acute care settings after office hours through access to current patient information.
The practice systematically tracks tests, referrals, and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood.
## Care Management and Support

<table>
<thead>
<tr>
<th><strong>Competency A:</strong> The practice systematically identifies patients who may benefit from care management.</th>
<th><strong>CM 03 (2 Credits):</strong> Applies a comprehensive risk-stratification process for the entire patient panel in order to identify and direct resources appropriately.</th>
</tr>
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<tr>
<td><strong>Competency B:</strong> For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/caregivers to develop a care plan that addresses barriers and incorporates patient preferences and lifestyle goals documented in the patient’s chart.</td>
<td><strong>CM 09 (1 Credit):</strong> Care plan is integrated and accessible across settings of care.</td>
</tr>
</tbody>
</table>

CM – Community Focused Criteria

• CM 01 (Core): Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria):
  • A. Behavioral health conditions.
  • B. High cost/high utilization.
  • C. Poorly controlled or complex conditions.
  • D. Social determinants of health.
  • E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/family/caregiver.

• CM 07 (1 Credit): Identifies and discusses potential barriers to meeting goals in individual care plans.

• CM 09 (1 Credit): Care plan is integrated and accessible across settings of care.
The practice establishes a culture of data-driven performance improvement on clinical quality, efficiency, and patient experience, and engages staff and patients/families/caregivers in quality improvement activities.
## Performance Measurement and Quality Improvement

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<tr>
<td><strong>Competency A</strong>: The practice measures to understand current performance and to identify opportunities for improvement</td>
<td>QI 01 (Core) Monitors at least 5 clinical quality measures across the 4 categories (includes behavioral health measure)</td>
</tr>
</tbody>
</table>
| **Competency B**: The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies | QI 08 (Core) Sets goals and acts to improve performance upon at least 3 measures across 3 of 4 categories (includes behavioral health measure)  
QI 14 (2 credits) Achieves improved performance on at least 1 measure of disparities in care or service. |
| **Competency C**: The practice is accountable for performance. The practice shares performance data with the practice, patients and/or publicly for the measures and patient populations identified in the previous section | QI 19 (max 2 credits) Is engaged in value based agreement (upside risk contract or two-sided risk contract) |

QI – Community Focused Criteria

• QI 16 (1 credit) Reports practice-level or individual clinician performance results publicly or with patients for measures reported by the practice.

• QI 18 (2 credits) Reports clinical quality measures to Medicare or Medicaid agency.

• QI 19 (Max 2 credits Is engaged in Value-Based Agreement (upside risk contract = 1 credit, two-sided risk contract = 2 credits).
Good Luck in Your Pursuits!

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