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Tips for PCMH Application Submission

Remain calm. The certification process is not as complicated as it looks. You will probably find you are already doing many of the required processes, and these are strengths you can build on.

Read the entire survey before you start. Focus on the "MUST PASS" elements of the survey first. The focus on the "critical-critical" factors (ie, the critical factors within a "MUST PASS" element) and then focus on the remaining "critical" factors.

Involve your whole team from the beginning. Not everyone needs to be directly involved with completing the assessment, but everyone needs to support it. Explain to all staff how these standards help improve patient care and the financial health of the practice.

Phrase your questions with "How" instead of "If." When clarifying problems for your practice to solve, engage your teams by focusing on how you will achieve goals, instead of whether or not you will attempt the goal.

Stay organized. Print out the survey, divide up the work and note who needs to help with each section. You can keep track of responses on the master copy. To help keep track of all the documentation, name each file to correspond with the question it supports in the survey.

Be prepared to change your workflow and job descriptions. You may not need to hire new staff to accomplish certification, but staff may have to do things a little differently. Be open to change.

Use screen shots to document your processes. When elements require reports, often a screen shot of your software will suffice. Just be sure to remove all patient names. And remember you are able to link one document to multiple elements.

Get to the intent of standards. NCQA is not looking for cookie-cutter responses to the survey. Instead, it wants to know what your process is, and how you know it is working. Processes can be different as long as you're getting to the right outcome.

Don't overthink it. NCQA has a lot of applications to read, so keep your responses simple and direct. NCQA can always follow up if they need more information.

Ask for help. NCQA responds quickly to questions. Reps can explain in detail what they are looking for in each element. You can find contact information on the NCQA website.

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MUST PASS Elements & Critical Factors

MUST PASS Elements. Six "must pass" elements are considered essential to the patient-centered medical home, and are required for practices at all recognition levels. Practices must achieve a score of 50% or higher on must-pass elements:

- PCMH 1A – Patient Centered Appointment Access
- PCMH 2D – The Practice Team
- PCMH 3D – Use Data for Population Management
- PCMH 4B – Care Planning and Self Care Support
- PCMH 5B – Referral Tracking and Follow Up
- PCMH 6D – Implement Continuous Quality Improvement

CRITICAL Critical Factors. A critical factor is one identified as central to the concept being assessed within a particular element and is required for practices to receive more than minimal or, for some elements, any points. (CRITICAL critical factors are those critical factors within a MUST PASS element):

- PCMH 1A-1 – Providing same day appointments for routine and urgent care
- PCMH 2D-3 – Holding scheduled patient care team meetings or a structured communication process focused on individual patient care
- PCMH 5B-8 – The practice tracks referrals until the consultant or specialists report is available, flagging and following up on overdue reports

Other Critical Factors.

- PCMH 1B-2 – Providing timely clinical advice by telephone
- PCMH 3E-1 – Implement clinical decision support following evidence based guidelines for a mental health or substance use disorder
- PCMH 4A-6 – The practice monitors the percentage of patients who may benefit from care management as a subset of the total patient population
- PCMH 4C-1 – The practice has a process to review and reconcile medications for more than 50 percent of patients
- PCMH 5A-1 and PCMH 5-A-2 – The practice has a documented process for and demonstrate that it tracks lab and imaging tests until results are available, flagging and following up on overdue results

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PCMH 3D: Population Health 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:

- At least two different preventive care services
- At least two different immunizations
- At least three different chronic or acute care services
- Patients not recently seen by the practice
- Medication monitoring or alert

This element ensures the practice uses registries and proactive reminders to address a variety of health care needs.

The practice may use mail, telephone or email, directly or through external providers (vendors) to remind patients when services are due.

Renewing practice: the practice should by identifying patients and conducting outreach for needed services at least annually

Examples:

- Preventive – well child visits, mammograms, pap smears, colonoscopy, fasting blood sugar. Preventive services consider the practice's entire population and are not limited to a population with chronic conditions. Immunizations do NOT meet the requirement of this factor.
- Immunizations – at least two different immunizations appropriate to patient age or gender. Practices may not use the same immunization for two different age groups.
- Chronic/Acute Care – diabetes care, coronary artery disease care, lab values outside norm range, post hospitalization follow up appointments, follow up related to asthma, ADD, obesity or depression, repeated sinusitis or flu symptoms, repeated pharyngitis or otitis media ear infections (*** the practice may focus on three chronic care services related to one condition – example: for diabetes, the A1c, micro albumin and diabetic retinopathy exam)
- Patient Not Seen – patients overdue for an office visit (care management follow up visit or overdue periodic physical exam)
- Medication – manage patients prescribed medication with potentially harmful side effects; identify patients prescribed a brand name drug instead of a generic; notify patients about a

medication recall; remind patients about necessary monitoring because of specific medications (warfarin, liver function test, growth hormone); inform patients about drug-drug or dosage concerns

Documentation

- Identified services for each factor,
- Reports used by the practice in the previous 12 months to remind patients of needed services specified in the factors,
- Materials showing how patients were notified of each service with specific de-identified patient examples

PCMH 3E: Evidence Based Decision Support

The practice implements clinical decision support (eg, point of care reminders) following evidence based guidelines for:

- A mental health or substance use disorder
- A chronic medical condition
- An acute condition
- A condition related to unhealthy behaviors
- Well child or adult care
- Overuse/appropriateness issues

(This aligns with Meaningful Use Modified Stage 2)

The practice maintains continuous relationships with patients through care management processes based on evidence based guidelines. A key to successful implementation of guidelines is to embed them in the practice's day-to-day operations.

Clinical decision support (CDS) is a systematic way to prompt clinicians to consider evidence based guidelines at the point of care.

CMS notes that CDS is "not simply an alert, notification or explicit care suggestion, CDS encompasses a variety of tools including, but not limited to:

- Computerized alerts and reminders for providers and patients
- Clinical guidelines
- Condition specific order sets
- Focused patient data reports and summaries
- Documentation templates
- Diagnostic support
- Contextually relevant reference information"

When selecting conditions, the practice considers diagnoses and risk factors prevalent in patients seen by the practice.

Sources of evidence-based guidelines:

- www.choosingwisely.org
- www.uptodate.com
- http://www.guideline.gov

Documentation

- The conditions that the practice identified for each factor
- The source of guidelines used by the practice, for each condition
- Examples of guideline implementation, such as tools to manage patient care, organizers, flow sheets, or electronic system templates based on condition specific guidelines, enabling the practice to develop treatment plans and document patient status and progress
  (NOTE: examples need to be de-identified patient specific examples; blank tools/templates are not acceptable)

PCMH 4A: 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:

- Behavioral health conditions
- High cost/high utilization
- Poorly controlled or complex conditions
- Social determinants of health
- Referrals by outside organizations (eg, insurers, practice staff or patient/family/caregiver)
- The practice monitors the percentage of the total patient population identified through its process and criteria

The intent of this element is that practices use defined criteria to identify true vulnerability – a single criterion, such as cost, may not be an appropriate indicator of need for care management.

Although patients can be identified for care management by diagnosis or condition, the emphasis of care must be on the whole person over time and on managing all of the patient's care needs.

The practice considers how its comprehensive health assessment (PCMH 3C) supports establishing criteria and a systematic process for identifying patients for care management.

The practice receives credit for each factor (1-5) included in its criteria for identification of patients for care management. A patient may fall into more than one category and may be included in some or all of these counts; for calculating the percentage (factor 6) a patient must be counted one time.

Examples:

- Behavioral health – diagnosis of behavioral issue, psychiatric hospitalizations, substance use treatment, positive screening result from a standard behavioral health screening tool
- High cost – ER visits, readmissions, unusually high numbers of imaging or lab tests ordered, high cost medications, number of specialty referrals, reports from health plans indicating high cost/high utilization (health plan reports must comprise 75% of patient base)
- Poorly controlled or complex conditions – poorly controlled patients with chronic conditions (abnormally high A1c or blood pressure results) or patients who consistently fail to meet treatment goals or having multiple comorbid conditions
- Social determinants of heath – conditions in the environment that affect a wide range of health, functioning and quality of life outcomes and risks. Examples include: availability to meet daily

needs, access to education, job opportunities, public safety, exposure to crime (Healthy People 2020)

- Referrals – the process based on these criteria allows referrals by external entities and nominations by those closes to patients (family/caregivers)

The practice must be able to report on the total number of patients identified by the criteria, as a percentage of the total patient panel.

Patient identified in this element is used to draw the sample for the medical record review required in PCMH 3C, PCMH 4B and PCMH 4C.

Documentation

- Documented process that describes the criteria for identifying patients for each factor
- Report showing the number and percentage of its total population identified as likely to benefit from care management

  Numerator = number of unique patients identified as likely to benefit from care management by the criteria in factors 1-5

  Denominator = total number of patients in the practice

Record Review

At least 30 patients is selected per practice for the medical record review required for PCMH 3C, PCMH 4B and PCMH 4C.

The selection is from those patients identified likely to benefit from care management, based on most recent visit to the office – and the selection goes back in time until 30 unique patients are identified.

There is a 12 month lookback in the medical record (ie, all elements of the record review do not have to be done at every visit but at least during the annual physical).

Elements of the record review:

For PCMH 3C – Comprehensive Health Assessment

- Age- and gender appropriate immunizations and screenings
- Family/social/cultural characteristics
- Communication needs
- Medical history of patient and family
- Advance care planning (NA for pediatric practices)
- Behaviors affective health
- Mental health/substance use history of patient and family
- Development screening using a standardized tool (NA for practice with no pediatric patients)
- Depression screening for adults and adolescents using a standardized tool
- Assessment of health literacy

For PCMH 4B – Care Planning and Self Care Support (MUST PASS)

- The patient has a care plan that:
    - Incorporates patient preference and functional/lifestyle goals
    - Identifies treatment goals
    - Assesses and addresses potential barriers to meeting goals
    - Includes a self-management plan
    - Is provided in writing to the patient/family/caregiver

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) and 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)."

The care plan must be updated at relevant visits. A relevant visit addresses an aspect of care that will affect program toward meeting existing goals or that require modification of an existing goal. The care plan must be reviewed/updated no less than once a year.

For PCMH 4C – Medication Reconciliation

- Reviewed and reconciles medications
- Provides information about new prescriptions
- Assesses understanding of medication
- Assesses response to medications and barriers to adherence
- Documents over-the-counter medications, herbal therapies and supplements

PCMH 6A: Quality Improvement

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

- At least two immunization measures
- At least two other preventive care measures
- At least three chronic or acute care clinical measures
- Performance data is stratified for vulnerable populations (to assess disparities in care)

The practice reviews its performance on a range of measures to help it understand its care delivery system's strengths and opportunities for improvement.

If data is obtained from an external source (such as a health plan) the health plan membership must represent at least 75% of the total patient panel.

When possible, the practice uses measures from existing sources and other reporting activities it is involved in (eg, PQRS, Meaningful Use, UDS, and HEDIS).

Data collected by the practice for one or more measures are stratified by race and ethnicity or by other indicators of vulnerable groups that reflect the practice's population demographics, such as age, gender, language needs, education, income, type of insurance, disability or health status.

Vulnerable populations are "those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability." (AHRQ)

Documentation

If this element is selected for the Multi-Site Corporate Survey Tool, you must provide a report with data specified for each individual site in the corporate tool.

The practice documents the following for each measure selected:

- Period of measurement
- Number of patients represented by the data
- Rate (percent) based on a numerator and denominator

NCQA reviews reports or recognition results showing performance measures.

Renewing practice: the practice needs to provide reports showing that is has measured annually for two years (current year and previous year). If a renewing practice is currently recognized as a Level 2 or 3, this element is available for attestation. However, if a practice is unable to show evidence that it has reported data annually for at least two years, it must submit as an initial applicant and may not use the streamlined renewal process.

PCMH 6D – Implement Continuous Quality Improvement (MUST PASS) requires the practice to set goals and analyze at least three clinical quality measures from Element A – and – requires the practice to act to improve at least three clinical quality measures from Element A.

(Also included in this element is acting to improve at least one resource use/care coordination measure from Element B and at least one patient experience measure from Element C).

PCMH 6D – Demonstrate Continuous Quality Improvement requires the practice to achieve improved performance on at least two clinical quality measures from Element A.

(Also included in this element is achievement of improved performance on at least one utilization or care coordination measure from Element B and at least one patient experience measure from Element C)

PCMH 6E – Report Performance requires the practice produce reports demonstrating performance data using measures from Elements A, B and C and shares individual clinician performance and practice level performance within the practice, publicly and with patients.