Disclaimer

This webinar may be recorded. This webinar presents a sampling of best practices and overviews, generalities, and some laws. This should not be used as legal advice. Itentive recognizes that there is not a “one size fits all” solution for the ideas expressed in this webinar; we invite you to follow up directly with us for more personalized information as it pertains to your specific practice and issues.

Thank you, and enjoy the webinar.
About Us

Our passion is to provide solutions for our healthcare provider partners which help them improve patient care, enhance the patient experience and maintain a financially healthy practice.

Since 2003 we have specialized in NextGen Healthcare services including:

• Consulting
• Hosting
• Customization
• And productivity tools such as ChartGuard® and RefundManager®
Upcoming Webinars:

• Quality Care Program Reporting: So Many Choices, So Little Time
  ▪ Wednesday, April 13, 2016
The Steps to Becoming a Patient Centered Medical Home
Introductions

Kathy Thompson
Managing Consultant

Lindsey Lanning
Healthcare Informatics Coordinator
The Steps to Becoming a Patient Centered Medical Home
Today’s Webinar

• Introduction to a Patient Centered Medical Home
• Transformation into a PCMH
  ▪ National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home Recognition
  ▪ Must-Pass Elements
• Why go through the PCMH transformation process
• NCQA Recognition Process
• PCMH Pre-validation
  ▪ NextGen
• PCMH and the future of healthcare
Patient Centered Medical Home

• The Patient Centered Medical Home is a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand.

• The objective is to have a centralized setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family.

• This model is based on providing and managing all aspects of healthcare, with the goal of enhancing care, creating greater patient engagement, and lowering costs due to reducing hospital stays and emergency room visits.
Foundation of PCMH

- Workforce development
- Payment reform
- Health IT
  - Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in an appropriate manner.
Goals of PCMH Transformation

• Comprehensive Care
• Patient-Centered Care
• Care Coordination
• Ensuring Accessibility of Care
• Focusing on Quality of Care and Patient Safety
Transformation Into a Medical Home
National Recognition and Accreditation Programs

- National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home
  - PCMH 2014 Recognition (previously 2011 standards)
    - Most well-known
- Accreditation Association for Ambulatory Health Care (AAAHC) Medical Home On-site Certification
- The Joint Commission (TJC) Designation for Your Primary Care Home
- URAC Patient-Centered Medical Home

***Be sure to consider the application cost, data and documentation requirements, and staff resources required to complete the application process when choosing which program is best for your practice!
NCQA PCMH 2014 Structure

- 100 Points
- 150+ Factors
- 27 Elements
- 6 Standards:
  1. Patient-Centered Access
  2. Team-Based Care
  3. Population Health Management
  4. Care Management and Support
  5. Care Coordination and Care Transitions
  6. Performance Measurements and Quality Improvement
Levels of Recognition

- Level 1: 35-59
  - Six must-pass elements
  - Required for practices at all recognition levels
  - Practices must achieve a score of 50% or higher on must-pass elements
- Level 2: 60-84
- Level 3: 85-100
Must- Pass Elements
Standard 1: Patient-Centered Access, Element 1A

- Element 1A: Patient-Centered Appointment Access
- Options in NextGen to prove you are meeting these factors:
  - Factor 1 (Critical Factor): Provide a screenshot of available same day appointments or generate a same-day appointment report
  - Factor 2: Run a report showing appointments from 5PM to 10PM
  - Factor 3: Run the alternative clinical appointments report after creating an alternative encounter type and category in Scheduling Admin
  - Factor 4: Run the First Third Available report to show availability of appointments
  - Factor 5: Run an appointment listing report and filter for no-show’s in EPM
Standard 2: Team-Based Care, Element 2D

- Element 2D: The Practice Team

- Options to prove you are meeting these factors:
  - Factor 1, 5, 6, & 7: Provide job descriptions that include staff responsibilities and functions
  - Factor 2: Provide an updated accountability chart to show team structure that specifies team responsibilities
  - Factor 3 (Critical Factor): provide samples of communications such as chart notes, appointment notes, regular email exchanges, tasks, or samples of meeting notes
    - Factor 8: Along with meeting notes supply meeting calendar, memos, or agenda
  - Factor 4: Provide a screenshot of a standing order
  - Factor 9 & 10: Provide a process used to involve everyone in quality improvement
Standard 3: Population Health Management, Element 3D

- Element 3D: Use Data for Population Management
- Screenshots to prove you are meeting these factors:
  - Factor 1: Run a report for two different preventative care services with an applied filter for patients who have never had these services in the correct age range
    - Ex: Colonoscopy, Mammogram
  - Factor 1: User may also use the population health management hub to do this
  - Factor 2: Run a report for at least two different immunizations for patients who have never had them in the correct age range
  - Factor 3: Run a report for 3 different chronic conditions based on patients who have been diagnosed with them and order a test
    - Diabetes ordering hemoglobin A1C
  - Factor 4: Run a report for patients due for an appointment such as a well child check
  - Factor 5: Run a report for patients on a medication that require a follow-up and have not been seen
Standard 4: Care Management and Support, Element 4B

- Element 4B: Care Planning and Self-Care Support
- Screenshots to prove you are meeting these factors:
  - Factor 1: In the patient care plan in the goal field you can select “functional lifestyle goals and patient preferences” as a care plan item and run a report showing percentage of patients with this selected.
  - Factor 2: In the patient care plan in the goal field you can select “treatment goal” as a care plan item and run a report showing percentage of patients with this selected.
  - Factor 3: In the patient chart note there is a “Barriers to Care” section that can be filled out and then a report can be run to show percentage of patients with these included in their chart.
  - Factor 4: Under Education/Recommendations in the patient note the user is able to check “self management discussed” and then run a report showing percentage of patients with this checked.
  - Factor 5: In the patient chart you can select “care plan given to patient/family/caregiver” and then run a report to show percentage of patients with this checked in their chart.
Standard 5: Care Coordination and Care Transitions, Element 5B

- Element 5B: Referral Tracking and Follow-Up
- Options to prove you are meeting these factors:
  - Factor 1: Provide information physicians have access to on the physician compare website
  - Factor 2 & 3: Provide documentation of agreements or an example of a referral that details timelines or patient information to be exchanged
  - Factor 4: Define levels of integration and identify which level the practice is at in a document
  - Factor 5: In the referral order template provide a screenshot and highlight the services requested, the time frame, and reason for referral
  - Factor 6: Provide a screenshot of a referral attachment in the details section of the referral order template
  - Factor 7: Provide a screenshot of the referral process from the referral order template and check the summary of care record sent checkbox
  - Factor 8 (Critical Factor): Provide a screenshot of your order details template for a referral and highlight the ability to check when it was received, completed, or canceled. The user can then run a report based on this criteria as a filter.
  - Factor 9: Provide a co-management agreement signed by the specialist and PCP regarding details on when communication and patient updates are expected
  - Factor 10: In the histories template you are able to click on the interim link and screenshot that a provider asked patient if they saw a specialist and requested report
Standard 6: Performance Measurement and Quality Improvement, Element 6D

• Element 6D: Implement Continuous QI

• Options to prove you are meeting these factors:
  ▪ PDSA Cycle (Plan, Do, Study, Act) is very effective for each of these factors
    • Create a goal or an aim to achieve, pick a measure you have in place to review, or select a change you want to make/improve on.
  ▪ Element A: Performance on Clinical Quality
  ▪ Element B: Performance on Care Coordination and Utilization
  ▪ Element C: Performance on Patient Experience

MUST-PASS
Element 6D: Implement Continuous Quality Improvement
4 points
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 A
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

Documentation:
- Factors 1-7: Report or completed PCMH Quality Measurement and Improvement Worksheet.

Scoring:
100%: 7 factors
75%: 6 factors
50%: 5 factors
25%: 1-4 factors
0%: 0 factors
Why Go Through PCMH Transformation?
Common Reasons Why

• Industry Shift
• Cost reduction
• Population health management
• Ensures high quality care
• Increased reimbursement
• Better overall reputation
Benefits for Patients

• Happier Patients 😊
• Improved access to medical care and services
• Better coordinated, more comprehensive and personalized care
• Improved health outcomes, especially for patients who have chronic conditions
Benefits for Practice

• Increased physician and staff member satisfaction
• Improved safety and quality of care
• A more efficient use of practice resources, resulting in cost savings
• Opportunities to participate in payment incentives for adopting the functions of a PCMH
• Better prepared to succeed once primary care payment reform has become widespread (e.g., value-based payment)
• Better prepared to participate in accountable care organizations
Challenges

• Gaining patient and physician buy-in
• Creating the necessary health IT infrastructure
• Recognition process
• Cost
What is the Cost?

• To do this costs money—in labor associated with staff, the cost of technology such as an electronic health record (EHR) and patient portal, and the opportunity cost.

• Many practices find they need additional support not just for the work of compiling application materials for PCMH recognition but also to implement new workflows that result from practice transformation.

• Practices should also consider the expense of potentially spending more time with patients. If you’re really practicing patient-centered medical care, you’re running a continuous improvement, lifestyle-type visit, and that takes time.
Return on Investment

• Even in 2015, direct payer incentives for becoming a PCMH range from none to as much as a 30% increase in reimbursement across the board, and the landscape is constantly shifting.

• One example is Geisinger Health System’s patient-centered medical home:
  - Their PCMH initiatives produced a 7.9 percent total cost savings over the life of the 90-month study period, which translates to an average savings of $53 per patient per month in each care site.
  - Savings on acute inpatient care also dropped by 19 percent, accounting for approximately two-thirds of the total financial gains.
  - Approximately 84 percent of provider panels earned outcomes-based incentives averaging more than $40,000 due to their efforts to reduce hospital admissions by 19 percent, cut hospital bed days by 15 percent, and slash all-cause readmissions by 20 percent.
Statistical Evidence

• The Patient-Centered Primary Care Collaborative (PCPCC) annual report indicates the patient-centered medical homes are improving cost, utilization, access, and satisfaction.

• Of the 28 reports serving as evidence in the annual review, PCPCC found that:
  - 17 found improvements in cost
  - 24 found improvements in utilization
  - 11 found improvements in quality
  - 10 found improvements in access
  - 8 found improvements in satisfaction

• ED visits, preventable hospitalizations, and the use of urgent care instead of primary care services all fell in many of the projects included in the report, while patient satisfaction scores rose significantly.

• Another PCPCC report found that 21 out of the 23 studies that included data on spending saw cost reductions, while 23 out of the 25 reports that measured utilization saw improvements on one or more measures.
PCMH Recognition and Accreditation Process
5 Essentials to Become a PCMH

• A plan
• Strong leadership and commitment
• An underlying technical infrastructure
• Effective patient engagement tools
• Community stakeholder buy-in
What EHR Needs

• Registry functions
• Communication systems
  ▪ Between the practice and the patient
  ▪ Between providers in the practice
• The ability to track and document what you have communicated and collaborated on
• The ability to give patients information and data about themselves
• The ability to open your practice for extended access by patients
  ▪ Portal
  ▪ Scheduling
PCMH Eligibility

• The Patient Centered Medical Home (PCMH) program is for practices that provide first contact, continuous, comprehensive, whole person care for patients across the practice.

• A PCMH is not an institution, nursing home, or home health agency. A PCMH is a medical office or clinic that offers coordinated, comprehensive primary care that is personal and focused on making sure the patient’s health care needs are met.

• If a specialty practice can demonstrate that it provides whole person care and meets the other elements of the joint principles for most of its patients (at least 75 percent), it can be eligible for PCMH recognition by NCQA even if it is not a traditional primary care practice.
The Process (NCQA Recognition)

• Obtain the electronic survey tool.
  - The survey tool is $80 and can be ordered through www.ncqa.org or by calling NCQA Customer Support

• Self-assess your practice’s current performance.
  - The self-assessment will take approximately six to nine months. The survey process will vary among practices depending on the work required during the practice transformation process.

• Submit your information to NCQA.
  - Once you complete your assessment, submit your application, agreement, fee and results to NCQA.

• Receive recognition from NCQA.
  - Once your information is received, your practice will receive the final recognition decision and corresponding level within 60 days.
# The Cost (NCQA Recognition)

<table>
<thead>
<tr>
<th>Number of Clinicians in the practice</th>
<th>Initial Fee for Practice to Obtain a Survey Tool License</th>
<th>Application Fees for NCQA Review and Recognition</th>
<th>Total License and Application Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$80</td>
<td>$550</td>
<td>$630</td>
</tr>
<tr>
<td>2</td>
<td>$80</td>
<td>$1,110</td>
<td>$1,180</td>
</tr>
<tr>
<td>3</td>
<td>$80</td>
<td>$1,650</td>
<td>$1,730</td>
</tr>
<tr>
<td>4</td>
<td>$80</td>
<td>$2,200</td>
<td>$2,280</td>
</tr>
<tr>
<td>5</td>
<td>$80</td>
<td>$2,750</td>
<td>$2,830</td>
</tr>
<tr>
<td>6</td>
<td>$80</td>
<td>$3,300</td>
<td>$3,380</td>
</tr>
<tr>
<td>7</td>
<td>$80</td>
<td>$3,850</td>
<td>$3,930</td>
</tr>
<tr>
<td>8</td>
<td>$80</td>
<td>$4,400</td>
<td>$4,480</td>
</tr>
<tr>
<td>9</td>
<td>$80</td>
<td>$4,950</td>
<td>$5,030</td>
</tr>
<tr>
<td>10</td>
<td>$80</td>
<td>$5,500</td>
<td>$5,580</td>
</tr>
<tr>
<td>11</td>
<td>$80</td>
<td>$6,050</td>
<td>$6,130</td>
</tr>
<tr>
<td>12</td>
<td>$80</td>
<td>$6,600</td>
<td>$6,680</td>
</tr>
<tr>
<td>&gt;50</td>
<td>$80</td>
<td>$6,600 + $10 / (# of Clinicians)</td>
<td>$6,600 + $10 / (# of Clinicians)</td>
</tr>
</tbody>
</table>
PCMH Pre-validation and NextGen
PCMH Pre-validation Program

- NCQA’s Patient-Centered Medical Home (PCMH) Pre-validation program evaluates electronic health record (EHR) systems, advanced registries, population health management tools and other related technology solutions to identify alignment with PCMH standards requirements.

- For IT Vendors:
  - Vendors with PCMH pre-validated products have successfully demonstrated their technology solution has functionality that completely meet one or more factor level requirements within the PCMH standards. The evaluation can result in approved automatic credit (auto-credit) scores that are transferable to eligible client practices submitting for PCMH Recognition.

- For Practices:
  - Practices that use PCMH Pre-validated products will benefit from reduced documentation support, saving time and alleviating some of the administrative burden associated with meeting PCMH survey requirements.
Benefits of Participation in Pre-validation

• Ability to transfer auto-credit scores to eligible client practices, alleviating the administrative burden of providing documentation support for those factors approved for auto-credit

• Ability to communicate direct alignment of product functionality to NCQA PCMH factor requirements

• Establishes an ongoing, collaborative relationship with NCQA and gives vendors frontline details about planned policy changes and enhancements to PCMH Recognition Program requirements

• Offers a competitive edge with marketing support
NextGen Gains PCMH Pre-validation

- On January 12, 2016, NextGen gained NCQA PCMH 2014 pre-validation.

- Clients may benefit from reduced documentation and have scoring associated with awarded auto-credit applied to their total PCMH 2014 survey score.

- NextGen Ambulatory EHR has been awarded a total of 17.87 points in PCMH 2014 auto-credit.
How to Use Auto-credit

- **Step 1:** Obtain the NCQA-issued Pre-validation Summary Approval Table, NCQA Letter of Product Auto-credit Approval as well as a Letter of Product Implementation from the vendor, indicating which pre-validated tool(s)/modules approved for auto-credit have been implemented at the practice.

- **Step 2:** Complete an application and enter into required agreements for the NCQA Recognition program.
How to Use Auto-credit

• **Step 3:** Upload all of the documents obtained in step 1 into the “Organizational Background” section of the ISS Survey Tool
  - You can access all of these required documents from this link: [https://www.community.nextgen.com/kA3330000008V7c?srPos=0&srKp=ka3&lang=en_US](https://www.community.nextgen.com/kA3330000008V7c?srPos=0&srKp=ka3&lang=en_US)

• **Step 4:** In the Organization Background section under Pre-validation Tab of your ISS Survey tool, complete the site attestation under question 2B by checking the box. By doing so, you attest to the implementation and use of an NCQA Pre-validated health IT solution for associated auto-credit points as specified in your attached NCQA Pre-validation Summary Approval Table

• **Step 5:** Submit the Survey Tool
Guide to reaching the peak of PCMH

Your guide to reaching the peak of Patient Centered Medical Home (PCMH)

1. Goal 1: Enhance Patient-Centered Access and Continuity
   Practice demonstrates it has a number of communication processes in place to achieve the first standard.

2. Goal 2: Identify and Manage Patient Population
   Practice assesses and documents patient risk factors and identifies patients for proactive reminders through continual collection of demographic and clinical data.

3. Goal 3: Plan and Manage Care
   Practice analyzes entire patient population to identify high-risk or complex patients, addresses barriers, and manages care.

4. Goal 4: Provide Self-Care Support and Community Resources to:
   - Assess patient and family self-management abilities
   - Work with patients and families to develop self-care plans
   - Provide tools and resources

5. Goal 5: Track and Coordinate Care
   Practice tracks, follows up, and coordinates lab and diagnostic tests, referrals, and care at other facilities as well as managing care transition in and out of the practice.

6. Goal 6: Measure and Improve Performance
   Practice uses performance and patient experience data to continually improve the quality of healthcare, identifying vulnerable patient populations and demonstrating improved performance over time.

30% of PCMHs recognized by the NCQA are using NextGen® solutions. That translates into more than 2,300 NextGen Healthcare providers who have achieved Levels 1, 2, and 3 Patient Centered Medical Home recognition.

Get on the road to PCMH!
Contact us at: pcmh@nextgen.com
PCMH in the Future
PCMH and Meaningful Use

The Patient-Centered Medical Home (PCMH) 2014 recognition program was developed to align with Meaningful Use Stage 2. Alignment has been updated to reflect the Meaningful Use Modified Stage 2 Final Rule released in October 2015. Below is a list of the PCMH elements and factors that directly align with MU objectives:

- **Element 1C: Electronic Access**
  - View, download, access
  - Have online and timely access
  - Secure message was sent

- **Element 3E: Clinical Decision Support**

- **Element 4C: Medication Management**
  - Review and reconcile medications

- **Element 4D: Use Electronic Prescribing**
  - Compare to drug formulary and electronically sent to pharmacies
  - Electronic orders
  - Drug-drug and drug-allergy interactions

- **Element 4E: Patient-specific education**

- **Element 5A: Test Tracking and Follow-Up**
  - Lab and Radiology Orders

- **Element 5B: Referral Tracking and Follow-Up**
  - Electronic summary of care
  - Electronic exchange of clinical information

- **Element 6G: Use Certified EHR Technology**
  - Security Risk Analysis
  - Ability to submit registry data
PCMH and MACRA

• Healthcare in the United States is moving away from a volume-based payment system and toward a value-based system. PCMH transformation will allow your practice to have a better position to respond to this change.
  ▪ Focus is on PCMHs, ACOs and bundled payments

• The Merit-Based Incentive Payment System (MIPS) created by MACRA promotes the PCMH as a promising innovative care model that can accelerate the transition towards a comprehensive value-based care ecosystem.

• Starting in 2019, practices that certify as a PCMH will be able to reap the benefits of Medicare’s new alternative payment model program by receiving a 5% pay bonus while avoiding the down-side risk usually associated with value-based payment models such as accountable care organizations.
Uncertain Where Your Practice Stands?

Let Itentive help:

• By assessing your current readiness
• Providing recommendations
• Implementation of new processes and procedures
Next Steps

• Visit us Itentive.com
• Sign-up for our informative webinars and blog
• Consider our 3-day, fixed price on-site consultations:
  ▪ Clinical Workflow
  ▪ Revenue Cycle and Front Office
  ▪ Technology and Performance
• Test Drive our Products
Resources

- **NCQA PCMH Recognition Website**
- **NextGen PCMH Resource Page**
  - White Papers
  - Request Pre-validation Letter
  - Download
    - NextGen PCMH 2014 Letter of Product Auto-credit Approval
    - NextGen PCMH 2014 Summary Approval Table
Questions

• Lindsey Lanning
  ▪ Healthcare Informatics Coordinator
  ▪ llanning@Itentive.com
  ▪ 224-220-5621

• Kathy Thompson
  ▪ Managing Consultant
  ▪ kthompson@Itentive.com
  ▪ 224-220-5531

• Cindi Kincade
  ▪ Vice President, Client Solutions
  ▪ ckincade@Itentive.com
  ▪ 224-220-5575
Thank you