DRVS and the Patient Centered Medical Home

2019
Introducing Azara Project Staff

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Goals

1. Understand Azara DRVS NCQA PCMH prevalidation status and credit breakdown.

2. Identify and leverage DRVS functionality to demonstrate for different PCMH requirements and prepare for attestation and potential audits.
2017 NCQA PCMH Standards
A PCMH puts patients at the center of the health care system, and provides primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

—American Academy of Pediatrics
What do the 2017 Requirements Look Like for PCMH?

**Standards**

**Concepts**
Overarching, foundational components of PCMH

**Competencies**
Buckets to organize criteria in each concept

**Criteria**
Individual structures, functions, and activities required for a practice to operate as a medical home
Key Changes from 2014 to 2017 Standards

- New Concept-Competencies-Criteria structure
- Recognition levels, points, and must-pass elements eliminated
- Annual reporting though Q-PASS rather than a 3-year cycle
- Practices with NCQA PCMH 2011 Recognition Levels 1, 2, or 3 and 2014 Levels 1 or 2 will have an expedited recertification process using the crosswalk found in the Recognition Standards. Practices who have attained 2014 PCMH Level 3 recognition will proceed straight to Annual Reporting
- For practices seeking certification for the first time, NCQA offers up to 3 Virtual Review sessions with a designated NCQA Evaluator, allowing practices to present evidence and receive feedback before the final submission
## 2017 Concepts

<table>
<thead>
<tr>
<th>Concept</th>
<th>NCQA Goal</th>
</tr>
</thead>
</table>
| **Team-Based Care and Practice Organization (TC)** | • 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  
• *Examples: regular team huddles, documented staffing models, and empanelment procedures* |
| **Knowing and Managing Your Patients (KM)** | • The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services  
• *Examples: demographics reports, language assessments, connections with local community organizations* |
| **Patient Centered Access and Continuity (AC)** | • The PCMH model expects continuity of care. Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access  
• *Examples: performance reports on appointment availability, offers same day appointments, timely clinical advice by phone* |
## 2017 Concepts Continued

<table>
<thead>
<tr>
<th>Concept</th>
<th>NCQA Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care Management and Support (CM)</strong></td>
<td>• Practice identifies patient needs at the individual and population levels to effectively plan, manage, and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk</td>
</tr>
<tr>
<td></td>
<td>• <em>Examples: documented process to identify patients in need of care management (i.e. risk stratification), provides appropriate care plans to patient and family/caregiver</em></td>
</tr>
<tr>
<td><strong>Care Coordination and Transitions (CC)</strong></td>
<td>• 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</td>
</tr>
<tr>
<td></td>
<td>• <em>Examples: Running reports to identify open referrals and missing lab results, documented processes around transitions of care such as sharing discharge reports</em></td>
</tr>
<tr>
<td><strong>Performance Measurement and Quality Improvement (QI)</strong></td>
<td>• 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</td>
</tr>
<tr>
<td></td>
<td>• <em>Performance monitoring against shared goals and benchmarks for at least 5 clinical quality measures, collects survey data on patient experiences</em></td>
</tr>
</tbody>
</table>
How Does a Center Meet the 2017 PCMH Requirements?

- Complete all 40 Core Criteria
- Achieve 25 Credits
DRVS is Prevalidated for PCMH!

- Full Credit
  - 8 Core
  - 2 Elective

- Partial Credit
  - 5 Core
  - 3 Elective

- Practice Support
  - 10 Core
  - 14 Elective
What Does Prevalidation Mean?

- **Full Credit**
  - DRVS received Full Credit designation for all required evidence components within a criteria.
  - No additional documentation required; however, centers must be prepared to demonstrate use of the specified functionality in DRVS for a minimum of 3 months in order to receive credit

- **Partial Credit**
  - DRVS received full credit on some, but not all, evidence components within a criteria
  - Some additional documentation

- **Practice Support.**
  - DRVS demonstrates aligned functionality that supports practice in meeting PCMH requirements, however this designation does NOT award any credits.
Benefits of Prevalidation with DRVS

- Automatic credit to reduce documentation burden
- Easier renewal process
  - With Annual Reporting, organizations who have achieved a level 3 recognition from the 2014 standards move straight into attestation, however should be prepared to demonstrate at any time
- Clear alignment with PCMH goals
Azara’s Resources
Available in the Help section of DRVS

- Azara NCQA PCMH Prevalidation Content Details

- Azara NCQA PCMH Prevalidation Summaries (1 Page Summary)

- Azara NCQA PCMH Prevalidation Resources (1 Page Description of Resources)
<table>
<thead>
<tr>
<th>Competency</th>
<th>Competency Num</th>
<th>Criteria Type</th>
<th>Criteria</th>
<th>Evidence Component</th>
<th>NCQA Designation per Preval Letter</th>
<th>Where in DRVS</th>
<th>Full Cred</th>
<th>Partial Cred</th>
<th>Practice Supp</th>
</tr>
</thead>
<tbody>
<tr>
<td>TC</td>
<td>C</td>
<td>TC09</td>
<td>Core</td>
<td>Has a process for informing patients/families/caregivers about the role of the medical home and provides patients/families/caregivers materials that contain the information, such as after-hours access, practice scope of services, evidence-based care, education and self-management support</td>
<td>Medical Home Information—Evidence of Implementation</td>
<td>No Transfer Credit or Practice Support Awarded to Solution</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KM</td>
<td>A</td>
<td>KM01</td>
<td>Core</td>
<td>Documents an up-to-date problem list for each patient with current and active diagnoses.</td>
<td>Option 1: Patient Problem List or Report</td>
<td>Solution Offers Transfer Credit</td>
<td>Care Management Passport</td>
<td>✅</td>
<td></td>
</tr>
<tr>
<td>KM</td>
<td>A</td>
<td>KM01</td>
<td>Core</td>
<td>Documents an up-to-date problem list for each patient with current and active diagnoses.</td>
<td>Option 2: KM 06 (Predominant conditions and health concerns)</td>
<td>Solution Offers Transfer Credit</td>
<td>Care Management Passport</td>
<td>✅</td>
<td></td>
</tr>
<tr>
<td>KM</td>
<td>A</td>
<td>KM02</td>
<td>Core</td>
<td>Comprehensive health assessment includes (all items required): A. Medical History of Patient and Family B. Mental Substance/Substance Use History of Patient and Family C. Family/Social/Cultural Characteristics D. Communication Needs E. Behaviors Affecting Health F. Social Functioning G. Social Determinants of Health</td>
<td>Comprehensive Health Assessment-Documented Process</td>
<td>No Transfer Credit or Practice Support Awarded to Solution</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Required Documents for Submission to NCQA

NCQA Letter of Credit Approval
(available in DRVS Help)

Letter of Product Implementation
(Submit a support ticket through DRVS)
# Prevalidation Overview for Client Practices

## Vendor Solution:
- Azara Healthcare

### Prevalidation Credit Summary

**Key**
- Solution Offers Transfer Credit: Yes
- Solution Supports Practice PCMH Activities (No Transfer Credit): Yes
- No Transfer Credit or Practice Support Awarded to Solution: No

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#### Team-Based Care and Practice Organization (TC)

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence Component</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>TC 01 (Core)</td>
<td>Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.</td>
<td>Clinical Lead—Details, PCMH Manager—Details</td>
</tr>
<tr>
<td>TC 02 (Core)</td>
<td>Defines practice organizational structure and staff responsibility/skills to support key PCMH functions.</td>
<td>Staff Roles, Skills and Responsibilities—Details, Staff Structure—Overview</td>
</tr>
<tr>
<td>TC 03 - 2 Credit Elective</td>
<td>The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges)</td>
<td>Involvement in External Collaborative Activities—Details</td>
</tr>
<tr>
<td>TC 04 - 2 Credit Elective</td>
<td>Patients/families/caregivers are involved in the practice’s</td>
<td>Patient/Family/Caregiver Involvement—Documented Process</td>
</tr>
<tr>
<td>TC 05 - 2 Credit Elective</td>
<td>The practice uses a certified electronic health record technology system (CEHRT).</td>
<td>Certified Electronic Health Records System (EHR)—Details</td>
</tr>
<tr>
<td>TC 06 (Core)</td>
<td>Has regular patient care team meetings or a structured communication process focused on individual patient care.</td>
<td>Care Team Meetings—Documented Process, Care Team Meetings—Evidence of Implementation</td>
</tr>
<tr>
<td>TC 07 (Core)</td>
<td>Involves care team staff in the practice’s performance evaluation and quality improvement activities.</td>
<td>Staff Involvement in QI—Documented Process, Staff Involvement in QI—Evidence of Implementation</td>
</tr>
<tr>
<td>TC 08 - 2 Credit Elective</td>
<td>Has at least one care manager qualified to identify and coordinate behavioral health needs.</td>
<td>Behavioral Health Care Manager</td>
</tr>
<tr>
<td>TC 09 (Core)</td>
<td>Has a process for informing patients/families/caregivers about the role of the medical</td>
<td>Medical Home Information—Documented Process</td>
</tr>
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</table>
NCQA PCMH 2017 Prevalidation

Letter of Product Implementation

To whom it may concern,

This letter serves as documentation that [insert CHC organizational name as used in OPass] has implemented Azara Healthcare DRVS.

<table>
<thead>
<tr>
<th>Functionality/Module</th>
<th>Date of Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRVS Implementation</td>
<td></td>
</tr>
<tr>
<td>Referral Module</td>
<td></td>
</tr>
<tr>
<td>Social Determinants of Health</td>
<td></td>
</tr>
<tr>
<td>Payer Integration</td>
<td></td>
</tr>
<tr>
<td>Controlled Substance</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: It is the responsibility of the CHC to assure all tools/modules with are in place a minimum of 3 months prior to submission of the Survey Tool to NCQA for review.

Sincerely,

Jeff Brandes, President and CEO
Azara Healthcare

Date:
DRVS and the Patient Centered Medical Home
DRVS Alignment with PCMH

PCMH Concepts

- Team Based Care and Practice Coordination (TC)
- Care Coordination and Transitions (CC)
- Knowing and Managing Your Patients (KM)
- Patient Centered Access and Continuity (AC)
- Filters + Risk Stratification
- Filters, Registries, Dashboards
- Registries, Dashboards, Filters
- Performance Measurement and Quality Improvement (QI)
- Quality Measures
- Patient Visit Planning

Referrals*, Labs, Measures
Using DRVS to Satisfy PCMH Requirements

- Demonstrate adherence to PCMH Requirements by using the following features in DRVS:
  - Custom Registries to identify specific populations
  - Measure targets to monitor performance
  - Custom Scorecards and Dashboards to group measures and offer insight about populations
  - Patient Visit Planning and Care Management Passport tools to identify risk factors and chronic conditions and configure alerts (decision support) to help close care gaps
  - Filters to identify patients across all reports, measures, and dashboards
Using DRVS Functionality for PCMH Demonstration
**Step 1: Use Content Details Resource to Identify *Where in DRVS* and Actions**

<table>
<thead>
<tr>
<th>Competency</th>
<th>Criteria Number</th>
<th>Criteria Type</th>
<th>Criteria</th>
<th>Evidence Component</th>
<th>NCOA Designation per Prevail Letter</th>
<th>Where in DRVS</th>
<th>Full Credit</th>
<th>Partial Credit</th>
<th>Practice Support</th>
<th>Demonstrate In DRVS (Y/N)</th>
<th>Notes/Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>KM</td>
<td>B</td>
<td>KM10</td>
<td>Core</td>
<td>Assess the language needs of its population.</td>
<td>Assess Language Needs — Report</td>
<td>Solution Offers Transfer Credit</td>
<td>Dashboard, UDS Filters across all reports, measures and dashboards</td>
<td>✓</td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>KM</td>
<td>A</td>
<td>KM08</td>
<td>Core</td>
<td>Conducts depression screenings for adults and adolescents using a standardized tool</td>
<td>Depression Screening — Documented Process or Report</td>
<td>Solution Offers Transfer Credit</td>
<td>Measures, Registrils Alerts</td>
<td>✓</td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>KM</td>
<td>C</td>
<td>KM12</td>
<td>Core</td>
<td>Preventive care services.</td>
<td>A. Preventive Care Outreach — Report</td>
<td>Solution Offers Transfer Credit</td>
<td>Measures, Registrils, Dashboards</td>
<td>✓</td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>KM</td>
<td>C</td>
<td>KM12</td>
<td>Core</td>
<td>Immunizations.</td>
<td>B. Immunizations Outreach — Report</td>
<td>Solution Offers Transfer Credit</td>
<td>Measures, Registrils, Dashboards</td>
<td>✓</td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>KM</td>
<td>C</td>
<td>KM12</td>
<td>Core</td>
<td>Chronic or acute care services</td>
<td>C. Chronic or Acute Care Outreach — Report</td>
<td>Solution Offers Transfer Credit</td>
<td>Measures, Registrils, Dashboards</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>Y</td>
</tr>
<tr>
<td>KM</td>
<td>C</td>
<td>KM12</td>
<td>Core</td>
<td>Patients not recently seen by the practice.</td>
<td>D. Not Recently Seen Outreach — Report</td>
<td>Solution Offers Transfer Credit</td>
<td>Measures, Registrils, Dashboards</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>Y</td>
</tr>
</tbody>
</table>
## Step 2: Select and Document Criteria for Demonstration in DRVS

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Functionality in DRVS</th>
</tr>
</thead>
</table>
| **AC**   | • AC 11
          | • AC 12
          | • Provider Continuity Measure
          | • Care Management Passport |
| **CC**   | • CC 01
          | • Alerts on the PVP – can show print out of enabled alerts, as well as show lab alerts on printed copies of the PVP. Also use report in EHR |
| **CM**   | • CM 01
          | • CM 02
          | • No action needed – full credit (core)*
          | • No action needed – full credit (core)* |
| **KM**   | • KM 01
          | • KM 02
          | • KM 03
          | • KM 04
          | • KM 06
          | • KM 09
          | • KM 10
          | • KM 12
          | • No action needed – full credit (core)*
          | • No action needed – full credit (core)*
          | • No action needed – full credit (core)*
          | • Build new dashboard for all of KM12 |
| **QI**   | • QI 01
          | • No action needed – full credit (core)* |
| **TC**   | • TC 06
          | • Printed copies of the PVP + huddle documentation + Usage Logs filters on PVP + eCW report |

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* Core credit indicates that the action is mandatory for full participation in the program.
Step 3: Build Custom Content
PCMH Standards Update Summary

- Updated Fee Schedule information to include other fees that may be incurred.
- Clarified expectations for practices that don't complete the Recognition process within 12 months or 3 check-ins.
- Added guidance on purchasing and using an additional check-in.
- Clarified the Audit and NCQA Investigation process: Clinicians on the Review Oversight Committee make the final revocation decision.
- Updated Reporting Results to state that information collected during evaluations may be used for NCQA education and research.
- Retired and added new measures to the Quality Measures Crosswalk (Appendix 5).
  - Coming soon: see DRVS Help section for Measure Crosswalk
- PCMH Distinction in Patient Experience Reporting will be retired after the April 2019 submission period (refer to Appendix 6).
- Replaced "Report" with "Evidence of Implementation" in Required Evidence (CM 03) – Content Details spreadsheet updated.
Questions?
For more information on PCMH and DRVS...

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Support
support@azarahealthcare.com
OR enter a portal case OR click on the Support icon from DRVS