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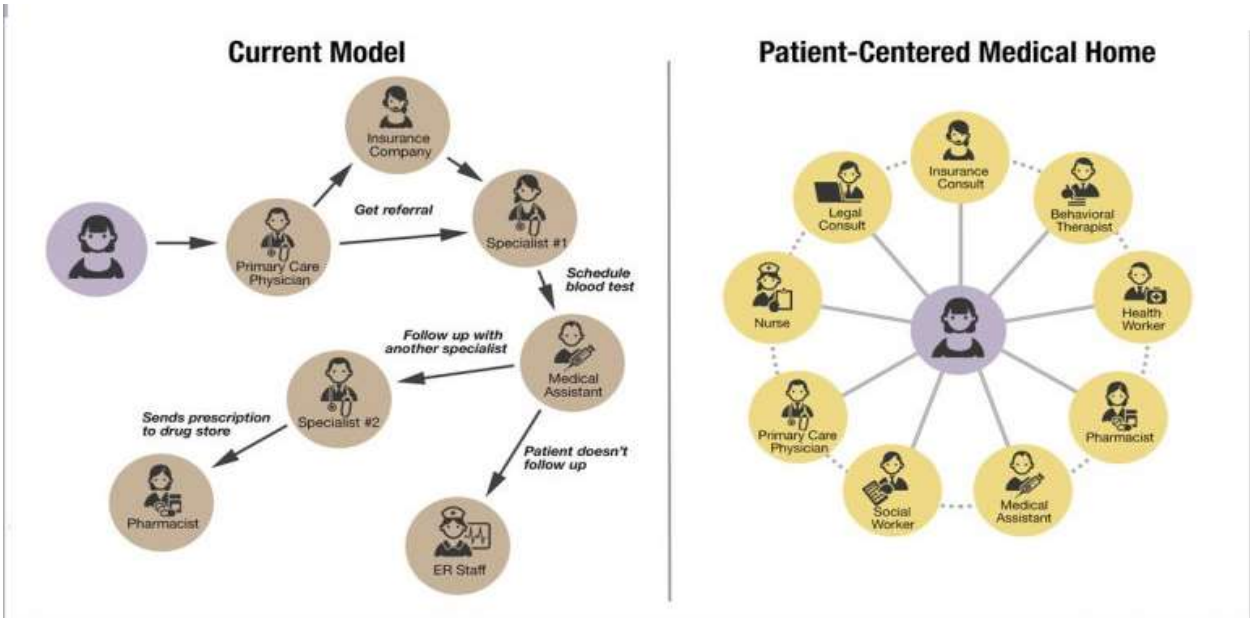
Better Outcomes, Reduced Costs, Meaningfully

White Paper | PCMH

Driving value-driven care through Patient Centered Medical Home (PCMH)



Entire Health care in the United States is moving away from a volume-based payment system to value-based system. Even the recent changes in 2017 with Medicare Access and CHIP Reauthorization Act (MACRA) puts major emphasis on value based care delivery. 15% of the total value score under one of the category in Merit Based Incentive Payment System (MIPS) guaranteed if a practice is certified Patient Centered Medical Home- PCMH. Requirements for the PCMH program are almost in line with Alternative Payment Model and Advanced APMs, a value based programs, which are given great importance under MACRA.

The patient-centered medical home (PCMH) is a model of care in which patients are engaged in a direct relationship with a chosen provider who coordinates a cooperative team of healthcare professionals, in another word PCMH 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. 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.

Instead of the primary care physician trying to do everything in a 20-30 minutes appointment, let the whole team of healthcare providers be responsible for the patient's care that starts from nurses to doctors to community workers to mental health specialists to pharmacists. The whole team works together to anticipate the patient's needs, communicate their findings with each other and they make sure no aspect of the patient's health slips through the cracks.
If we look at the patient's perspective, it's a one-stop shopping experience for them. In a single visit to doctor's practice, a patient could receive treatment from his or her primary care doctor, do a preventative screening with a nurse and visit with a mental health specialist. This collaborative approach actually costs less and a patients enjoy a better coordinated, more comprehensive and personalized care. Treating all aspects of a patient's health is a key part of patient-centered medical homes.

Benefits of the PCMH accreditation:

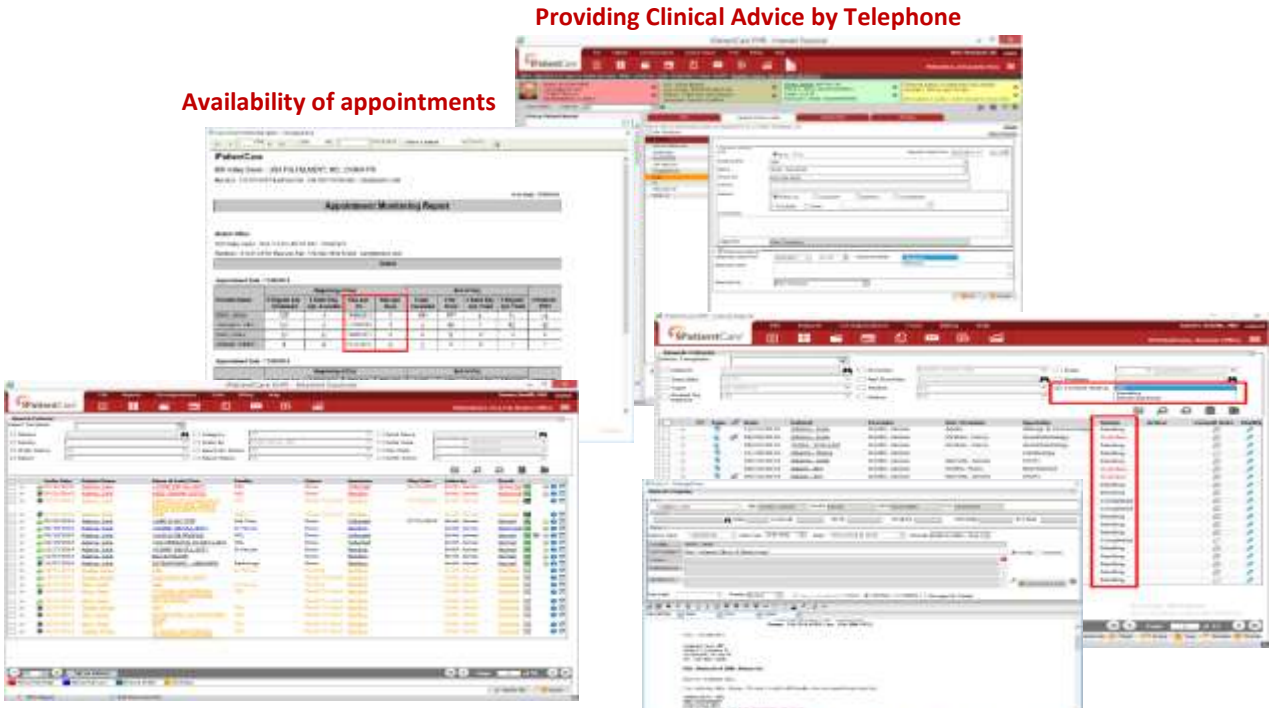
There are several national programs that award this distinction, including the Accreditation Association for Ambulatory Health Care (AAAHC), The Joint Commission, the National Committee for Quality Assurance (NCQA), and the Utilization Review Accreditation Commission (URAC). Some states and private insurers also offer accreditation. Building a patient-centered medical home (PCMH) requires hard work from you and your practice team. PCMH accreditation is required to obtain an increase in reimbursement from a health plan and there are no shortcuts to get accredited, it requires time, money, dedication, and sustained effort, and you will not see results overnight. In a global capitation arrangement, a provider is reimbursed per-member per-month (PMPM) for the entire network population. PCMH accreditation signifies that a provider has become an advanced primary care practice.

PCMHs are currently not under Advanced APMs, there is a possibility that they would get considered under the Expanded Medical Homes model. Once this happens all PCMHs would get 5% Medicare FFS bonus and would be exempted from MIPS adjustments. There are many Private payers such as Aetna, Anthem, BCBS, Cigna are having a programs that provide financial incentives to providers for being NCQA PCMH certified and demonstrate that they are performing the activities of a Medical Home. Also there are government programs running which require

primary care practices to adopt the functions of a PCMH and these programs may not require the primary care practices to be PCMH accredited but will need them to perform similar functions that a PCMH accredited practice would perform. Patient-centered medical home (PCMH) incentive programs are local, state, and public/private payer initiatives that offer payment incentives to participating practices that adopt the functions of a PCMH. To determine whether such initiatives exist in your area, visit the Primary Care Innovations and PCMH Map (www.pcpcc.org) or contact your local AAFP chapter.

EHR align with PCMH

World has been radically transformed by digital technology – smart phones, tablets, and web-enabled devices have transformed our daily lives and the way we communicate. EHR adoption is not required to establish a Patient Centered Medical Home (PCMH) but it plays a central role in the medical home, the new roles and relationships of providers and staff may be even more important in driving quality improvement, greater and more seamless flow of information within a digital health care infrastructure, created by electronic health records (EHRs), encompasses and leverages digital progress and can transform the way care is delivered and



compensated. An investment in EHRs is a foundational investment in PCMH. It can add value to the medical home model as a means to maintain and share a **comprehensive** record of health between providers. Particular functionalities of EHR such as secure messaging, access to test

results, and capabilities for scheduling patient appointment provides accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective care.

Eligibility Criteria and Applicants

Eligible Applicants are the Outpatient primary care practices that meet the scoring criteria for Level 1, 2, or 3 as assessed against Patient-Centered Medical Home (PCMH) requirements. A Practice defined as a clinician or clinicians practicing together at a single geographic location. It also include nurse-led practices in states. A nurse-led clinic is any outpatient clinic that is run or managed by registered nurses. It doesn't include urgent care clinics or clinics open on a seasonal basis.

As the PCMH program has grown, different physician specialists and other clinicians have become interested in participating. Originally limited to physician-led practices, in 2010, NCQA decided to open the program up to nurse-led practices in states that allow these clinicians to provide the full range of primary care and practice independently. Advanced Practice Registered Nurses (APRNs) are also eligible to be listed as part of a recognized practice if they manage their own panel of patients. The following list provides a broad outline about eligible applicants:

1. Primary care practices
2. Pediatric practices
3. Multi-specialty groups inclusive of primary care or pediatric practitioners
4. Outpatient clinics
5. General practitioners
6. Internists
7. Academically-affiliated ambulatory clinics
8. Advanced Practice Registered Nurses (APRNs) managing their own panel of patients

PCMH 2014 Measures and Elements

NCQA Patient-Centered Medical Home (PCMH) Recognition is the most widely adopted model for transforming primary care practices into medical homes and there are six PCMH NCQA standards as mentioned here:

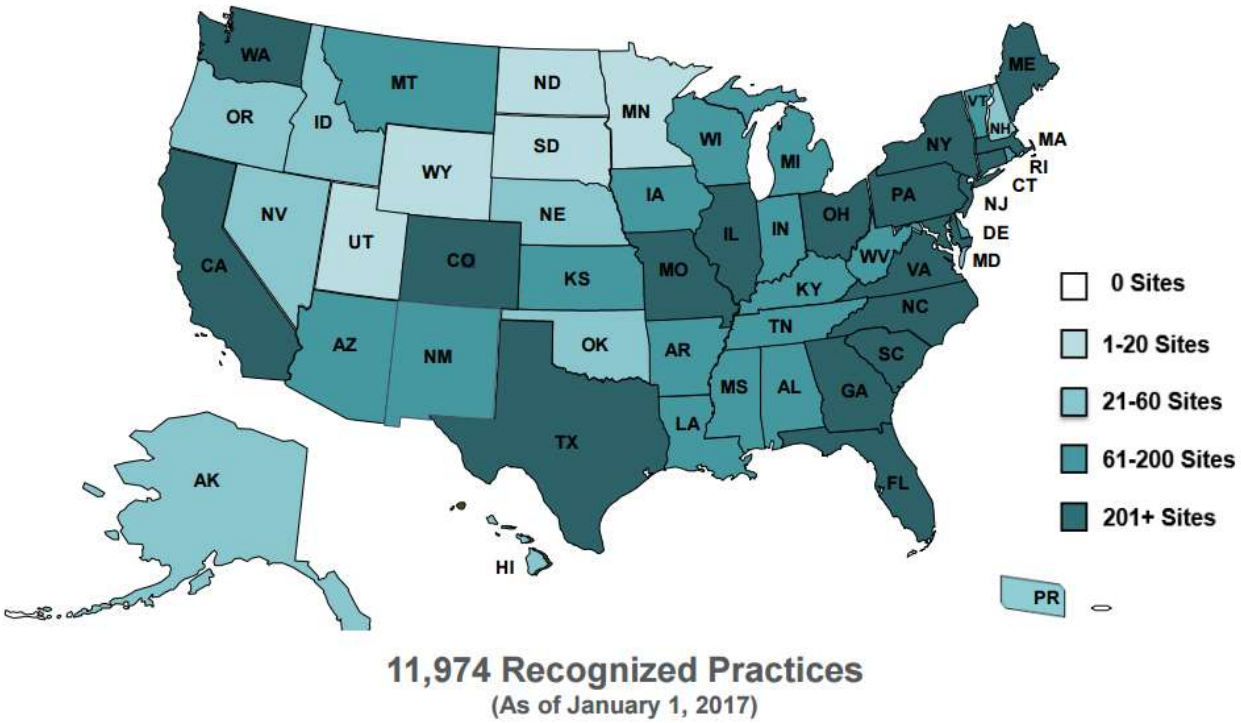
1. PCMH 1. Patient-Centered Access: That Accommodate patients' needs during and after hours, provide medical home information, offer team-based care
2. PCMH 2. Team-Based Care: It Engage all practice team members by providing medical home information, meet cultural and linguistic needs of patients and offer team-based care
3. PCMH 3. Population Health Management: It Collect and use data for population management
4. PCMH 4. Care Management and Support: This is to Use evidence-based guidelines for preventive, acute and chronic care management
5. PCMH 5. Care Coordination and Care Transitions: It Track and coordinate tests, referrals and care transitions
6. PCMH 6. Performance Measurement and Quality Improvement: It Use performance and experience data for continuous improvement

Every measure contains Elements, and every Element contains Factors. To give you one example see as follows**:**

Measure 1: Patient Centered Access
Element A: Patient-Centered Appointment Access
Factors:

1. Providing same-day appointments for routine and urgent care.
2. Providing routine and urgent-care appointments outside regular business hours.
3. Providing alternative types of clinical encounters.
4. Availability of appointments.
5. Monitoring no show rates.
6. Acting on identified opportunities to improve access.

NCQA Recognized PCMH sites



11,974 Recognized Practices
(As of January 1, 2017)

NCQA Pre-validation Program for Practices and HIT vendors

Organizations with a technology solution that fully meets one or more NCQA PCMH factor level requirements submit documentation to NCQA about the program's functionality. After reviewing that documentation, NCQA determines if a solution earns pre-validation status and whether/how many auto credit points can be awarded. This program is for EHR vendors, advanced registries, Population Health Management systems and other related technology solutions as well as for the practices. If a practice uses a pre-validated HIT solution that is awarded auto credit points, the practice can earn automatic credit for the factor requirements for which their HIT solution earned points without having to submit documentation to NCQA for those factors. This credit means practices using your solution have a lower administrative burden of providing supporting documentation, thus save time.

2017 NCQA PCMH Recognition Redesign Overview

NCQA is redesigning its PCMH Recognition program and the redesigned program - to be launched April 3, 2017, includes ongoing, sustained recognition status with annual check-in and

reporting instead of the current program's three-year recognition cycle. The new 2017 PCMH Standards focus on identifying best practices and core activities, signaling that a primary care practice functions as a medical home. The updates separate the requirements into six categories which align with pre-existing PCMH requirements. Those categories include team-based care and practice organization, knowing and managing patients, patient-centered access and continuity, care management and support, care coordination and care transitions, and performance measurement and quality improvement. In each of this categories, NCQA separated requirements into two groups: core recommendations and additional criteria. The core recommendations include characteristics required for PCMH recognition, such as establishing a designated clinician leader who spearheads the patient-centered medical home charge, and identifying and prioritizing community resources based on social influencers of certain conditions. The additional criteria include critical PCMH characteristics, but don't require complete adoption. Instead, patient-centered medical homes may select the recommendations which best suit their patient populations, thus creating a more individualized care approach

Conclusion

PCMH represents the essentials for better primary care, the improved delivery of chronic care, and active partnership with informed patients synergized by appropriate use of information and communication technology. PCMH report performance measures will establish benchmarks to identify and address gaps and will support more advanced payment models as well as a model that offers significant promise as a method of both improving the patient experience and reducing cost.

References:

- http://healthitanalytics.com/news/ncqa-releases-patient-centered-medical-home-standards-updates
- http://www.ncqa.org/portals/0/public%20policy/2014%20comment%20letters/the_future_of_pcmh.pdf
- http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/pcmh-redesign
- http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/pcmh-redesign/practice-details-graph
- http://www.aha.org/research/cor/content/patient-centered-medical-home.pdf

iPatientCare supports the reports required by NCQA. We not just provide a software but as a complete service to position your practice to succeed in an evolving landscape. Contact us today for more information to see how we can help you to achieve your PCMH recognition.

About iPatientCare:

iPatientCare, Inc. is a privately held medical informatics company based at Woodbridge, New Jersey. The company's unified product suite includes Electronic Health/Medical Record and integrated Practice Management/Billing System, Patient Portal/PHR, Health Information Exchange (HIE), and Mobile Point-of-Care Solutions for both Ambulatory and Acute/Sub-acute market segments. iPatientCare has been recognized as a preferred MU partner by numerous Regional Extension Centers (REC), hospitals/health systems, and professional academies.

iPatientCare is also an approved MIPS 2017 Qualified Registry

iPatientCare EHR 2014 (2.0) has received 2014 Edition Ambulatory Complete EHR certification by ICSA Labs, an Office of the National Coordinator-Authorized Certification Body (ONC-ACB), in accordance with the applicable eligible professional certification criteria adopted by the Secretary of Health and Human Services (HHS).

Full certification details can be found at ONC Certified Health IT Product List.

The ONC 2014 Edition criteria support both Stage 1 and 2 Meaningful Use measures required to qualify eligible providers and hospitals for funding under the American Recovery and Reinvestment Act (ARRA).

Visit http://www.iPatientCare.com for more information.

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