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Raising the Bar: Behavioral Health Integration in Patient-Centered Medical Home Standards

July 29, 2015

SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

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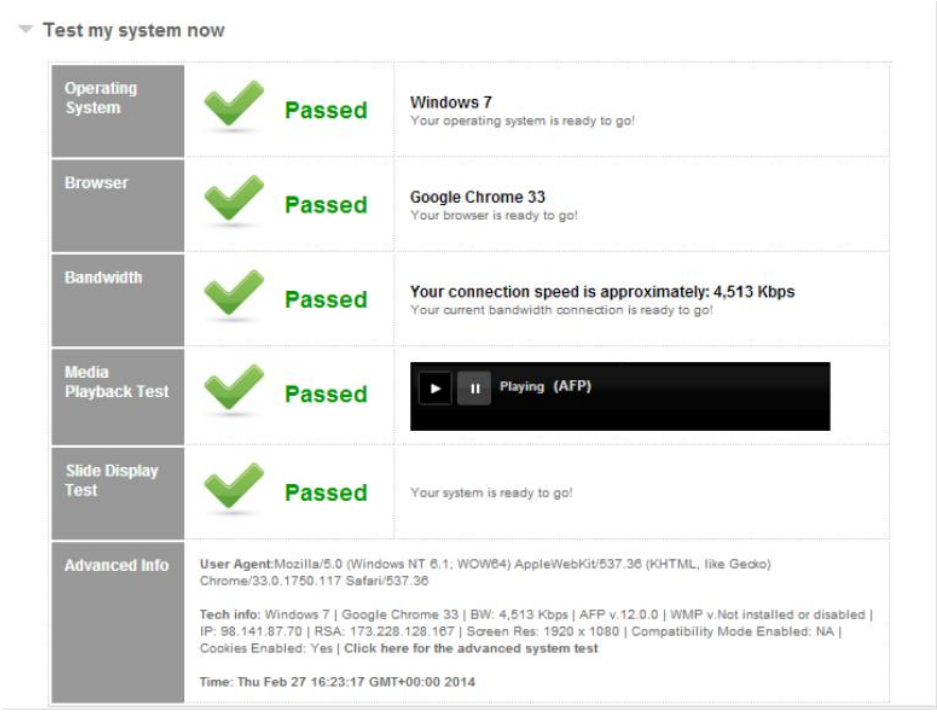

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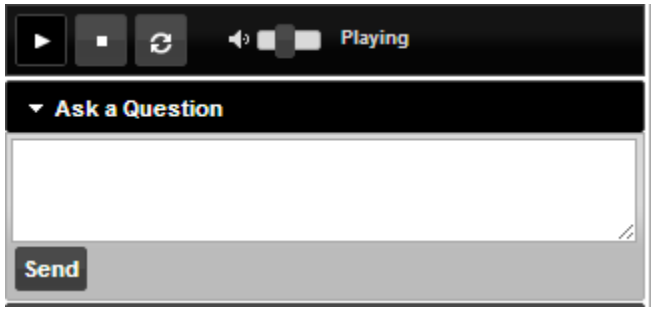

Today's Purpose

This webinar will review the updated NCQA Patient-Centered Medical Home standards as they relate to behavioral health integration and share specific ways providers can incorporate behavioral health integration within these standards. During this webinar, patient-centered medical home leads at state Primary Care Associations and HRSA safety-net primary care providers will also have the opportunity to ask questions and engage with NCQA and subject matter experts.

Today's Presenters

- **Rose Felipe (webinar moderator)**
  Associate, SAMHSA-HRSA Center for Integrated Health Solutions, National Council for Behavioral Health

- **Sue Lin**
  Director, Quality Division, HRSA OQI

- **William Tulloch, MA**
  Director, Government Recognition Initiatives

- **Judith Steinberg, MD, MPH**
  Deputy Chief Medical Officer, Commonwealth Medicine, University of Massachusetts Medical School

Let's Ask the Audience

Question 1: Does your health center currently have PCMH recognition?

* Yes
* No

Question 2: Are you planning to pursue PCMH recognition through NCQA 2014 Standards?

* Yes
* No

Question 3: How familiar are you with the behavioral health components of the NCQA 2014 Standards?

* Very familiar
* Familiar
* Not familiar

PCMH and BHI Staff

Bureau of Primary Health Care (BPHC)
Office of Quality and Improvement (OQI)
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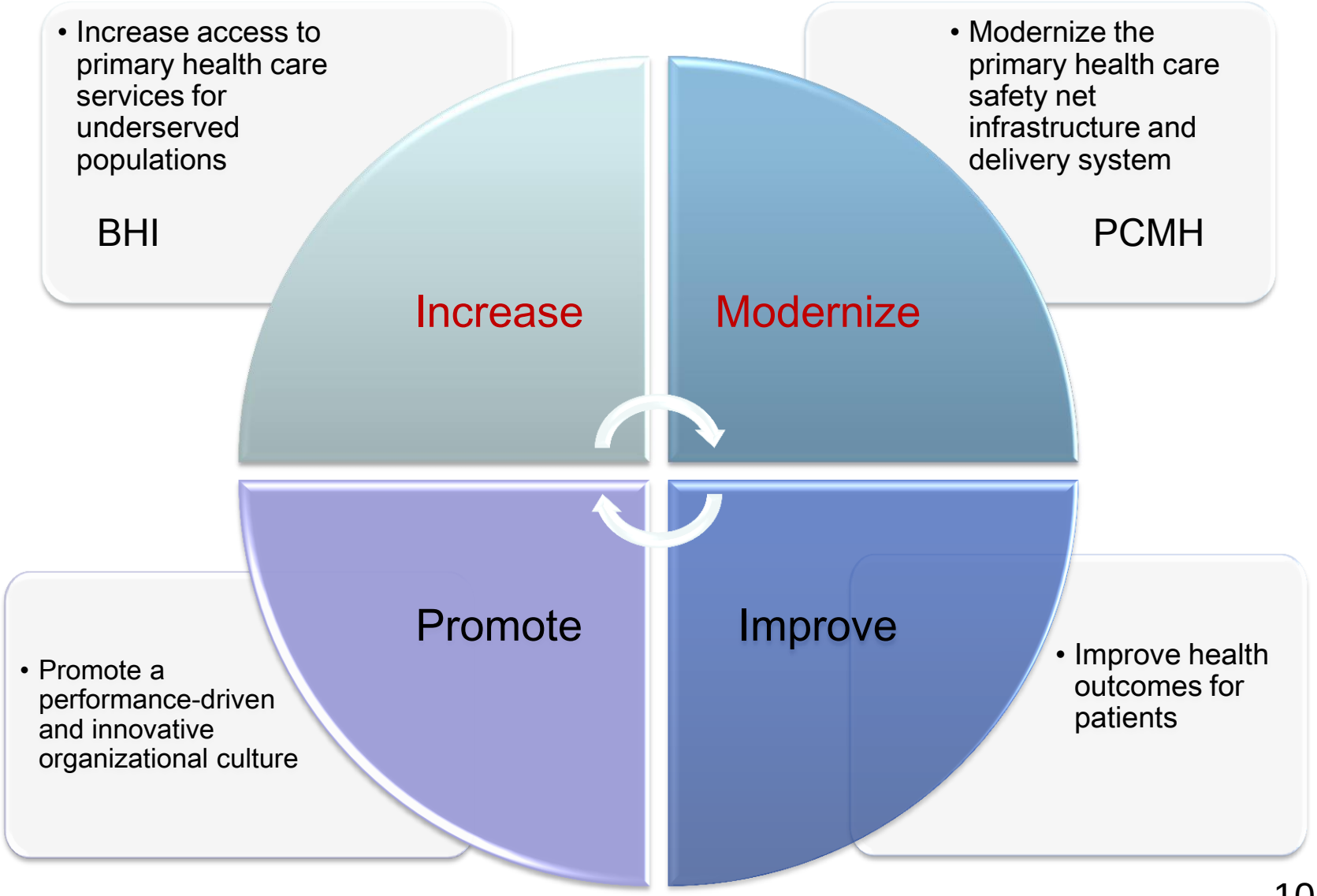
Primary Care: Key Strategies



Contacts

Questions about the HRSA Patient-Centered Medical Health Home Initiative (PCMHHI)

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SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

William F. Tulloch

Director, Government Recognition Initiatives

NCQA

NCQA's Patient-Centered Medical Home (PCMH) 2014 Behavioral Health Requirements

National Committee for Quality Assurance (NCQA)

Private, independent non-profit health care quality oversight organization founded in 1990

MISSION

To improve the quality of health care.

VISION

To transform health care through quality measurement, transparency, and accountability.

ILLUSTRATIVE PROGRAMS

*** Patient-Centered Medical Home * Patient-Centered Specialty Practice**

*** HEDIS® – Healthcare Effectiveness Data and Information Set**

*** Health Plan Accreditation * Clinician Recognition**

*** Disease Management Accreditation * Wellness & Health Promotion Accreditation**

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NCQA Recognition Programs

Current as of 03/31/15

- **>66,319 Clinician Recognitions nationally across all Recognition programs.**
- **Clinical programs.**
  - Diabetes Recognition Program (DRP)
  - Heart/Stroke Recognition Program (HSRP)
  - Back Pain Recognition Program (BPRP) - *Retired*
- **Medical practice process and structural measures.**
  - Physician Practice Connections - *Retired*
  - Physician Practice Connections-Patient-Centered Medical Home (PPC-PCMH) 2008 - *Retired*
  - Patient-Centered Medical Home (PCMH) 2011
  - Patient-Centered Medical Home (PCMH) 2014
  - Patient Centered Specialty Practice (PCSP)

10,220 clinicians

4,135 clinicians

250 Clinicians
46 Practices

51,117 Clinicians
10,810 Practices

597 Clinicians
66 Practices

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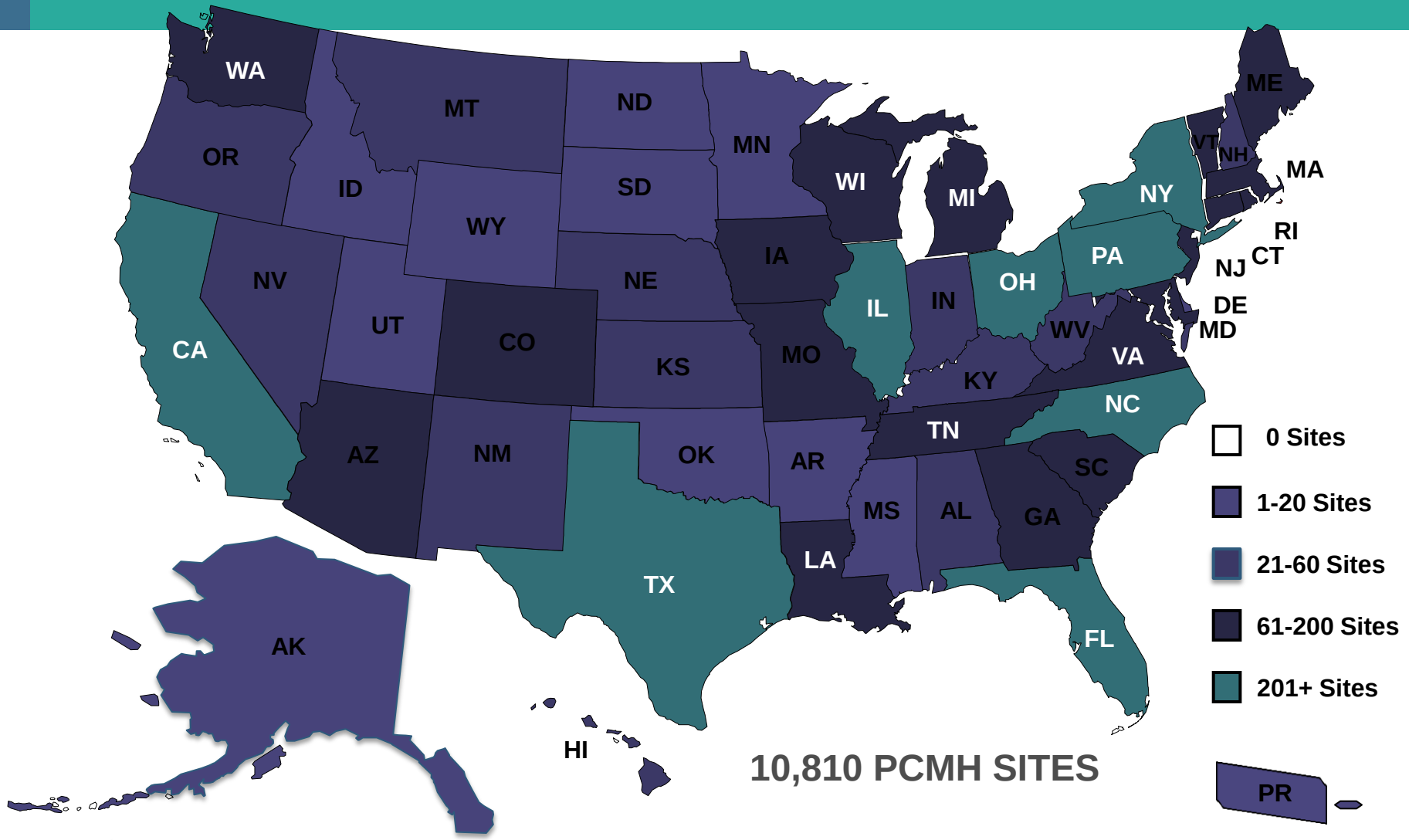
NCQA PCMH SITES

As of 5/31/15



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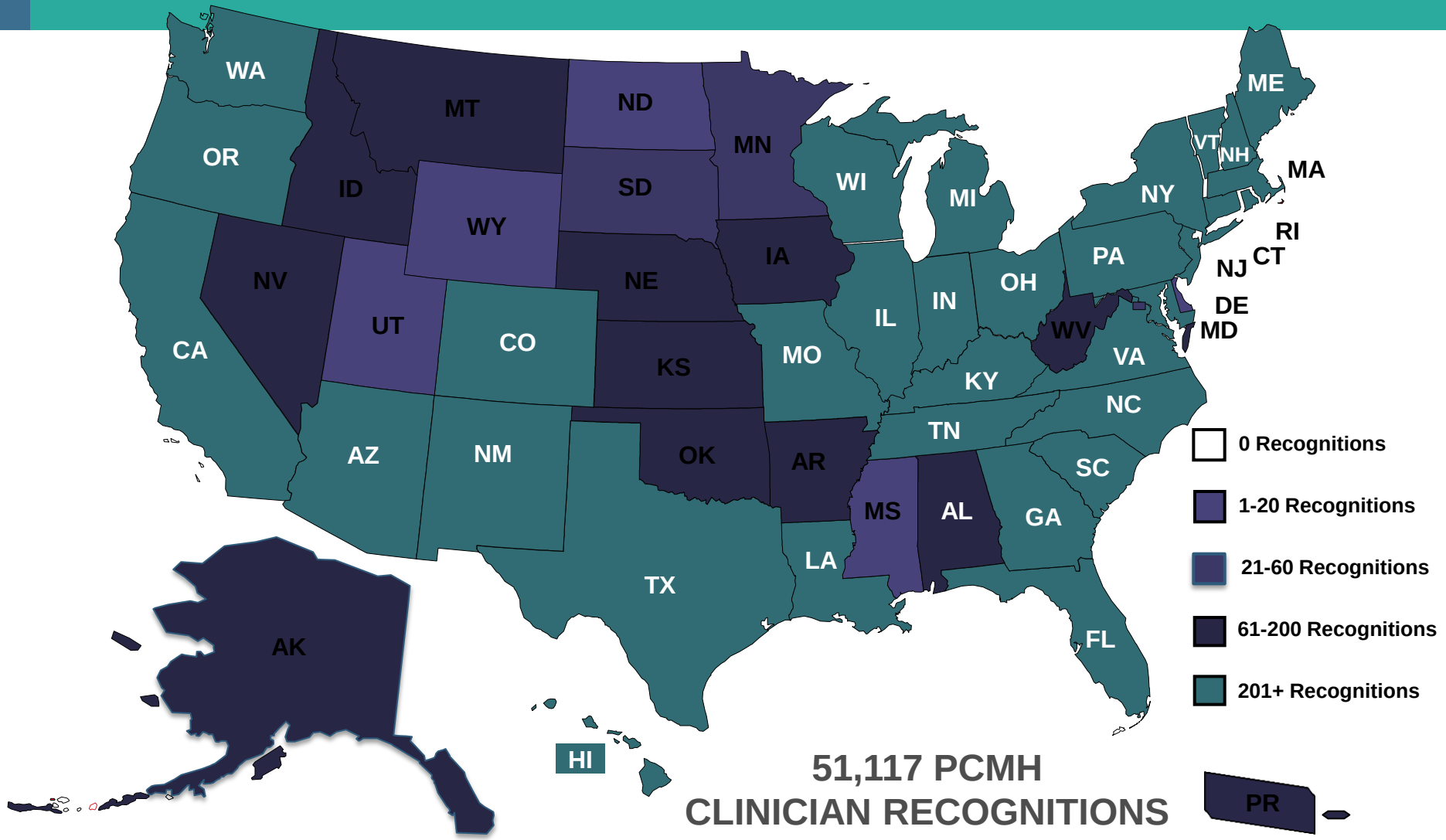
NCQA PCMH Clinician Recognitions

As of 5/31/15



51,117 PCMH CLINICIAN RECOGNITIONS

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PCMH 2014: Key Changes

1. **Additional emphasis on team-based care**
   - **New element = Team-Based Care**
     - Highlights patient as part of team, including QI
2. **Care management focused on high-risk patients**
   - **Use evidence-based decision support**
   - **Identify patients who may benefit from care management and self-care support:**
     - Social determinants of health
     - Behavioral health
     - High cost/utilization
     - Poorly controlled or complex conditions

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PCMH 2014: Key Changes (cont.)

3. **More focused, sustained Quality Improvement (QI) on patient experience, utilization, clinical quality**
   - Annual QI activities; reports must show the practice re-measures at least annually
   - Renewing practices will benefit from streamlined requirements, but must demonstrate re-measurement from at least two prior years
4. **Alignment with Meaningful Use Stage 2 (MU2)**
   - MU2 is not a requirement for recognition.
5. **Further Integration of Behavioral Health.**
   - Show capability to treat unhealthy behaviors, mental health or substance abuse
   - Communicate services related to behavioral health
   - Refer to behavioral health providers

PCMH 2014 Content and Scoring

(6 standards/27 elements)

1: Enhance Access and Continuity	Pts
A. *Patient-Centered Appointment Access	**4.5**
B. 24/7 Access to Clinical Advice	3.5
C. Electronic Access	2
	10

2: Team-Based Care	Pts
A. Continuity	3
B. Medical Home Responsibilities	2.5
C. Culturally and Linguistically Appropriate Services (CLAS)	2.5
D. *The Practice Team	**4**
	12

3: Population Health Management	Pts
A. Patient Information	3
B. Clinical Data	4
C. Comprehensive Health Assessment	4
D. *Use Data for Population Management	**5**
E. Implement Evidence-Based Decision-Support	4
	20

Scoring Levels

Level 1: 35-59 points
Level 2: 60-84 points
Level 3: 85-100 points

4: Plan and Manage Care	Pts
A. Identify Patients for Care Management	4
B. *Care Planning and Self-Care Support	**4**
C. Medication Management	4
D. Use Electronic Prescribing	3
E. Support Self-Care and Shared Decision-Making	5
	20

5: Track and Coordinate Care	Pts
A. Test Tracking and Follow-Up	6
B. *Referral Tracking and Follow-Up	**6**
C. Coordinate Care Transitions	6
	18

6: Measure and Improve Performance	Pts
A. Measure Clinical Quality Performance	3
B. Measure Resource Use and Care Coordination	3
C. Measure Patient/Family Experience	4
D. *Implement Continuous Quality Improvement	**4**
E. Demonstrate Continuous Quality Improvement	3
F. Report Performance	3
G. Use Certified EHR Technology	0
	20

***Must Pass Elements**

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Behavioral Health and PCMH

- NCQA increasing focus on BH issues throughout its programs
- Explicit requirements look specifically at the practice's ability to handle common BH issues
  - Also examine integration of BH services within the practice
- BH providers who are part of the practice team can provide key examples of other important PCMH principles

Examples of BH/PCMH Interaction

- Care management for patients with BH issues or comorbid medical and BH conditions can be conducted by BH providers
- Educational sessions/trainings can cover BH issues or processes
- Outreach to patients for needed services can include patients requiring BH treatment

Understanding NCQA Documentation Requirements

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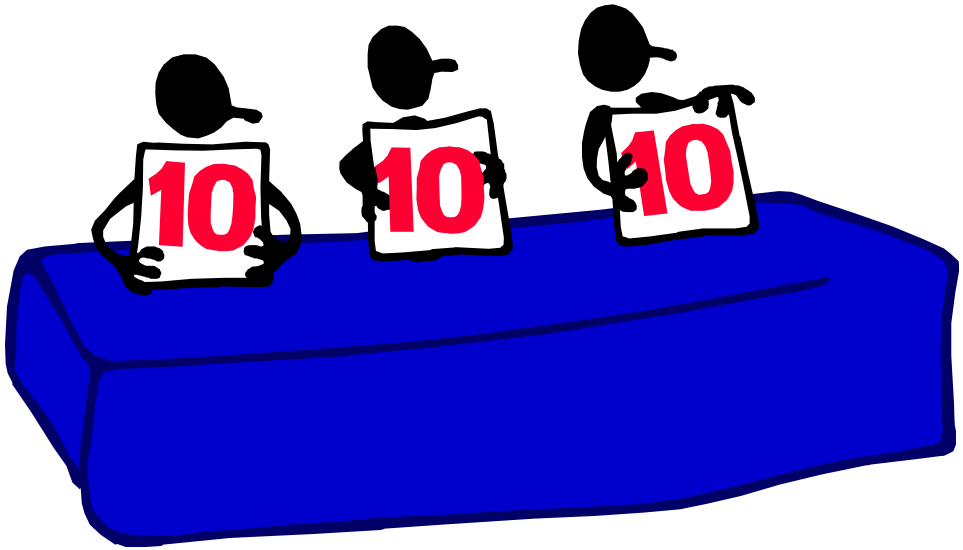
Components of a Standard

- **Statement of the Standard**
- **Elements**
- **Factors**
- **Scoring**
- **Explanation**
- **Documentation**



Reading a Standard

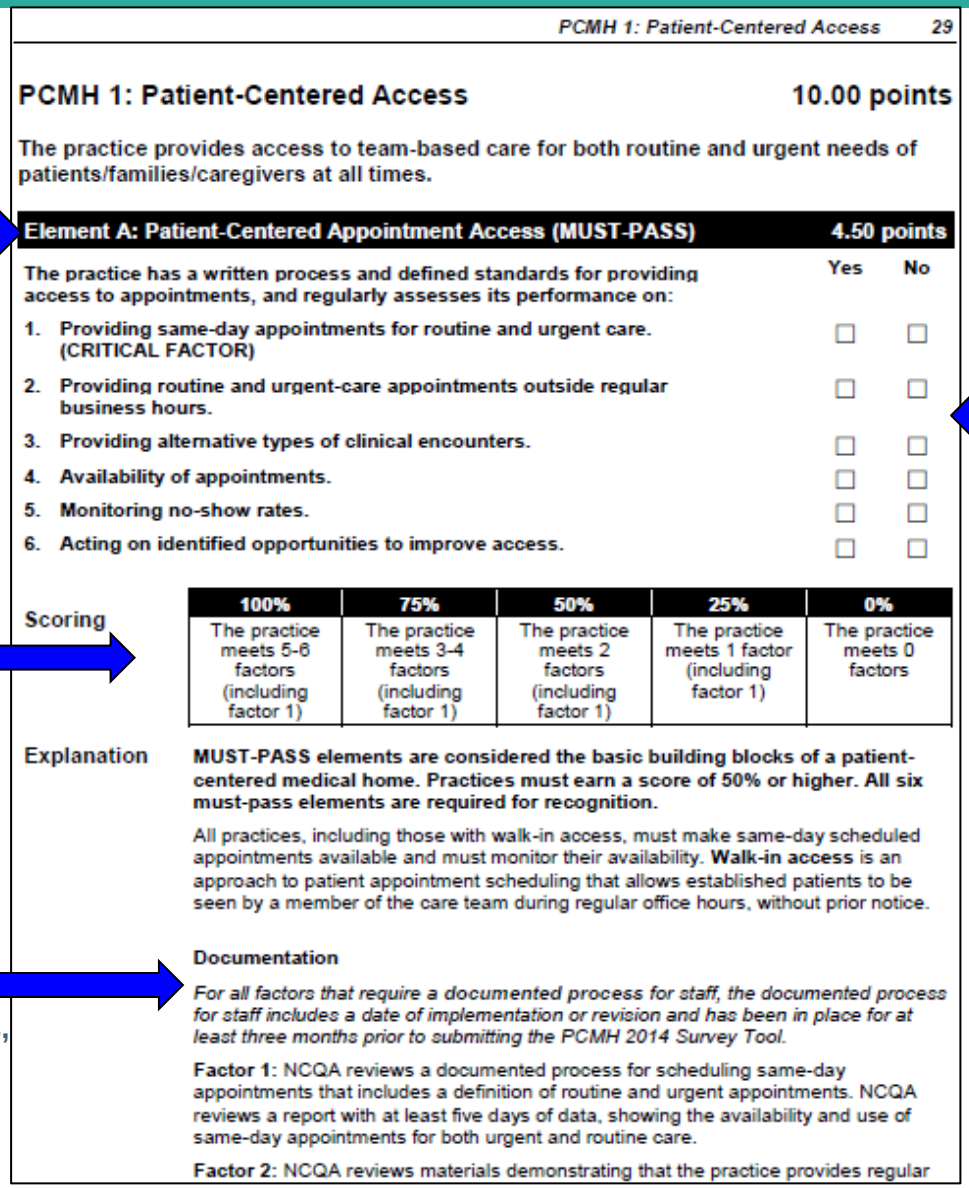
Standard Title and Statement

Element: Component of a standard that is scored and provides details about performance expectations

Scoring: Level of performance organization must demonstrate to receive a specified percentage of element points

Documentation: Evidence practices can use to demonstrate performance against an element's requirements.

Types: documented process, reports, materials, patient records



PCMH 1: Patient-Centered Access 29

PCMH 1: Patient-Centered Access **10.00 points**

The practice provides access to team-based care for both routine and urgent needs of patients/families/caregivers at all times.

Element A: Patient-Centered Appointment Access (MUST-PASS) **4.50 points**

The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on:	Yes	No
1. Providing same-day appointments for routine and urgent care. (CRITICAL FACTOR)	☐	☐
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.	☐	☐

Scoring

100%	75%	50%	25%	0%
The practice meets 5-6 factors (including factor 1)	The practice meets 3-4 factors (including factor 1)	The practice meets 2 factors (including factor 1)	The practice meets 1 factor (including factor 1)	The practice meets 0 factors

Explanation

MUST-PASS elements are considered the basic building blocks of a patient-centered medical home. Practices must earn a score of 50% or higher. All six must-pass elements are required for recognition.

All practices, including those with walk-in access, must make same-day scheduled appointments available and must monitor their availability. **Walk-in access** is an approach to patient appointment scheduling that allows established patients to be seen by a member of the care team during regular office hours, without prior notice.

Documentation

For all factors that require a documented process for staff, the documented process for staff includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

Factor 1: NCQA reviews a documented process for scheduling same-day appointments that includes a definition of routine and urgent appointments. NCQA reviews a report with at least five days of data, showing the availability and use of same-day appointments for both urgent and routine care.

Factor 2: NCQA reviews materials demonstrating that the practice provides regular

Standard
Score = 10

Element
Score = 4.5

Factor: Item in an element that is scored

Explanation: Guidance for demonstrating performance against an element

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Must Pass Elements

Rationale for Must Pass Elements

- Identifies key concepts of PCMH
- Helps focus Level 1 practices on most important aspects of PCMH
- Guides practices in PCMH evolution and continuous quality improvement
- Standardizes "Recognition"

Must Pass Elements

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

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What is a Critical Factor?

- **Required to receive more than minimal or, for some factors, any points**
- **Identified in the scoring section of the element**

PCMH 1A Example: Critical Factor impact on scoring

100%	75%	50%	25%	0%
The practice meets 5-6 factors (including factor 1)	The practice meets 3-4 factors (including factor 1)	The practice meets 2 factors (including factor 1)	The practice meets 1 factor (including factor 1)	The practice meets 0 factors

There are 9 Critical Factors

Three Critical Factors in Must Pass Elements

PCMH 1	PCMH 2	PCMH 3	PCMH 4	PCMH 5
1A, Factor 1 1B, Factor 2	2D, Factor 3	3E, Factor 1	4A, Factor 6 4C, Factor 1	5A, Factor 1 5A, Factor 2 5B, Factor 8

NCQA Documentation Requirements

- **NCQA reviews all documents electronically**
- **Typically require, NCQA requires evidence that the practice:**
  - Has a mechanism for conducting a specific service and
  - Can demonstrate it is providing that service
- **Required documentation, by factor, is included in the Explanation section of each element**

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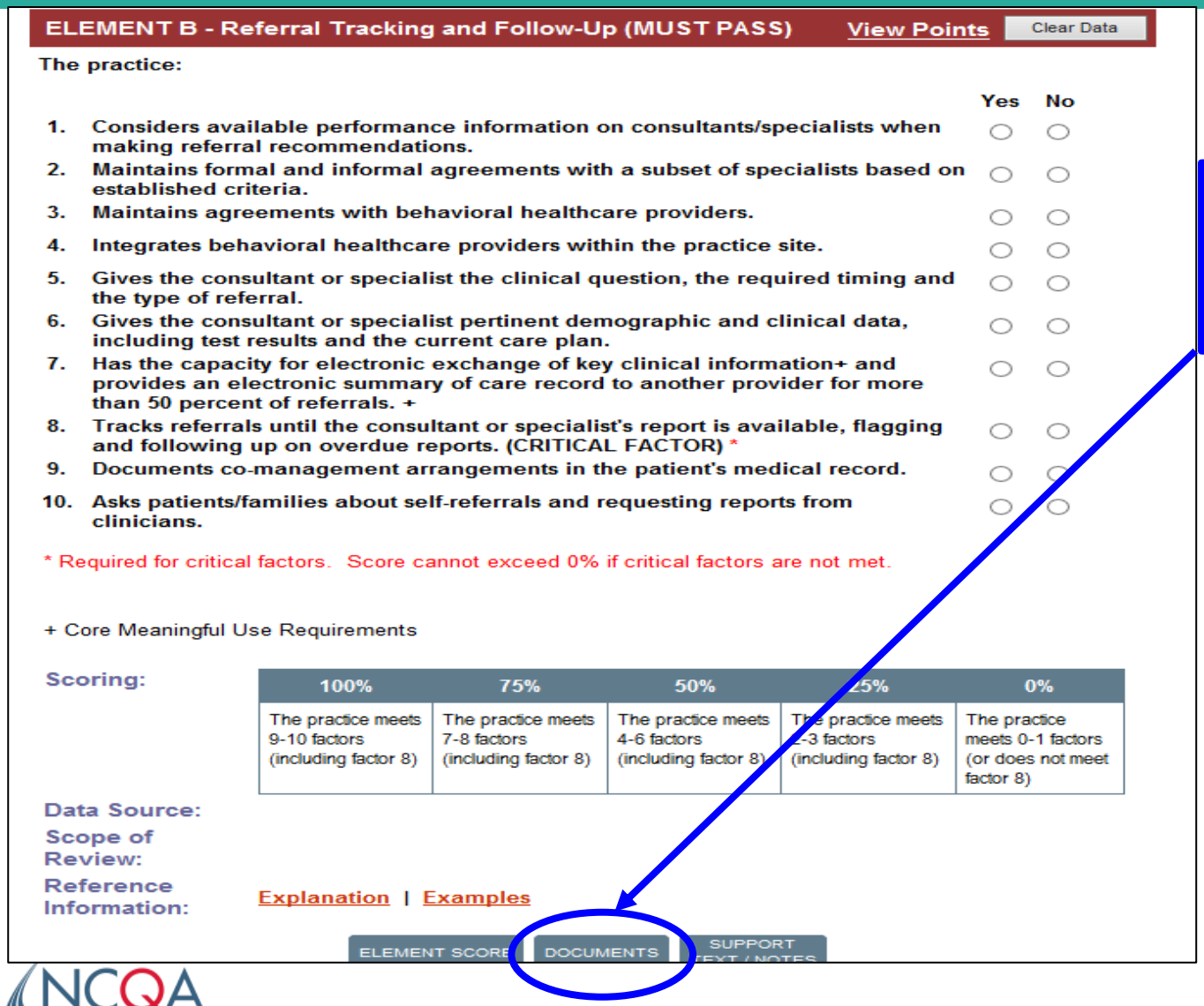
Documentation



ELEMENT B - Referral Tracking and Follow-Up (MUST PASS) View Points | Clear Data

The practice:

		Yes	No
1.	Considers available performance information on consultants/specialists when making referral recommendations.	○	○
2.	Maintains formal and informal agreements with a subset of specialists based on established criteria.	○	○
3.	Maintains agreements with behavioral healthcare providers.	○	○
4.	Integrates behavioral healthcare providers within the practice site.	○	○
5.	Gives the consultant or specialist the clinical question, the required timing and the type of referral.	○	○
6.	Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.	○	○
7.	Has the capacity for electronic exchange of key clinical information+ and provides an electronic summary of care record to another provider for more than 50 percent of referrals. +	○	○
8.	Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports. (CRITICAL FACTOR) *	○	○
9.	Documents co-management arrangements in the patient's medical record.	○	○
10.	Asks patients/families about self-referrals and requesting reports from clinicians.	○	○

* Required for critical factors. Score cannot exceed 0% if critical factors are not met.

+ Core Meaningful Use Requirements

Scoring:

100%	75%	50%	25%	0%
The practice meets 9-10 factors (including factor 8)	The practice meets 7-8 factors (including factor 8)	The practice meets 4-6 factors (including factor 8)	The practice meets 2-3 factors (including factor 8)	The practice meets 0-1 factors (or does not meet factor 8)

Data Source:

Scope of Review:

Reference Information: Explanation | Examples

ELEMENT SCORE | DOCUMENTS | SUPPORT TEXT / NOTES

Documentation requirements in Explanation

Documentation Requirements in Explanation

Documentation

Factor 1: NCQA reviews examples of the type of information the practice team has available on specialist performance.

Factor 2, 3: For each factor, the practice provides at least one example.

Same as PCMH 2014 Standards and Guidelines

Factor 4: The practice provides materials that explain how behavioral health is integrated with physical health.

Factor 5, 6, 8, 10: For each factor, the practice provides a documented process for staff, ***and*** at least one example or report demonstrating that the process has been implemented.

Factor 7: The practice provides a report from the electronic system.

The practice calculates a percentage that requires a numerator and a denominator, based on a recent period of at least three months. The practice may use the following methodology to calculate the percentage:

- *Denominator* = Number of transitions of care and referrals.
- *Numerator* = Number of transitions of care and referrals in the denominator where a summary care record was provided electronically.

Factor 9: The practice provides at least one example.

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Documentation Types

Types of Documents	Examples/Explanation
Documented process	Written procedures, protocols, processes, workflow forms (not explanations); the practice name and date of implementation should be included.
Report	Reports Aggregated data showing evidence; the reporting period should be included.
Records or Files	Patient files or registry entries documenting action taken; data from medical records
Materials	Information for patients or clinicians E.g. clinical guidelines, self-management and educational resources
NOTE: Screen shots, i.e., electronic "copy", may be used as: 1) examples (system capabilities of an electronic health record-- EHR), 2) materials (Web site resources), 3) reports (logs, patient lists) or 4) records (e.g., documentation of clinical advice in the medical record)	

Documentation Time Periods

Types of Documentation	Time Period
Report Data, files, examples and materials	Current within the last 12 months.
Documented Process	Policies, procedures and processes must be in place for at least 3 months prior to submitting the survey tool
Meaningful Use reporting period	3 months
Reporting period (log or report)	Refer to documentation guidelines for each element in the Standards and Guidelines for other references to minimum data for logs and reports (e.g., one week, one month)
NOTE: All documents must include date of implementation, data collection or reporting period	

Questions ?

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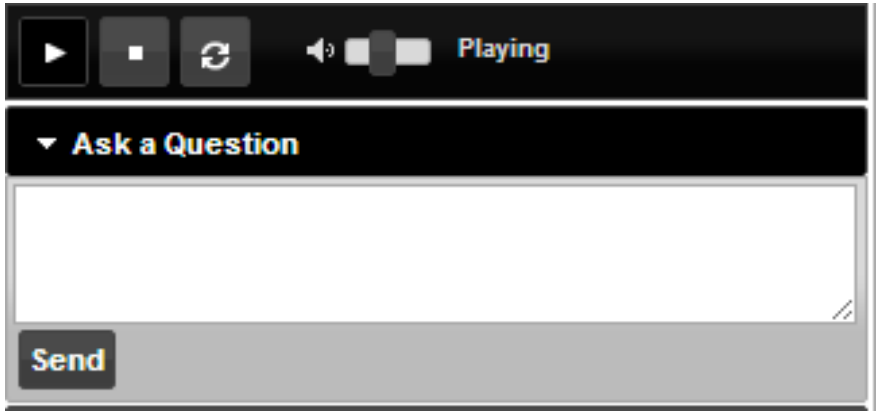

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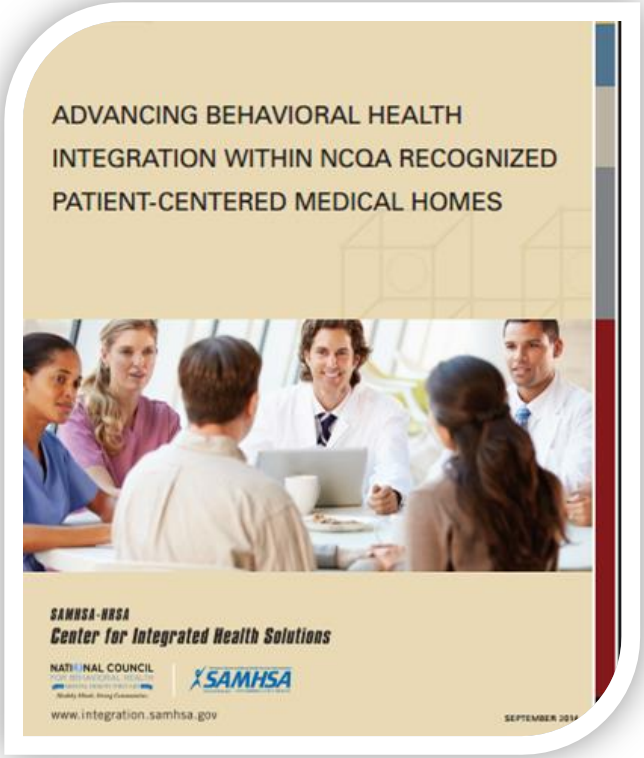
Judith Steinberg, MD, MPH, Deputy Chief Medical Officer, Commonwealth Medicine, University of Massachusetts Medical School

Behavioral Health Integration within 2014 NCQA PCMH standards

Two approaches:

- Part A: standards specific to behavioral health integration
- Part B: expanded interpretation of all standards with a behavioral health integration lens

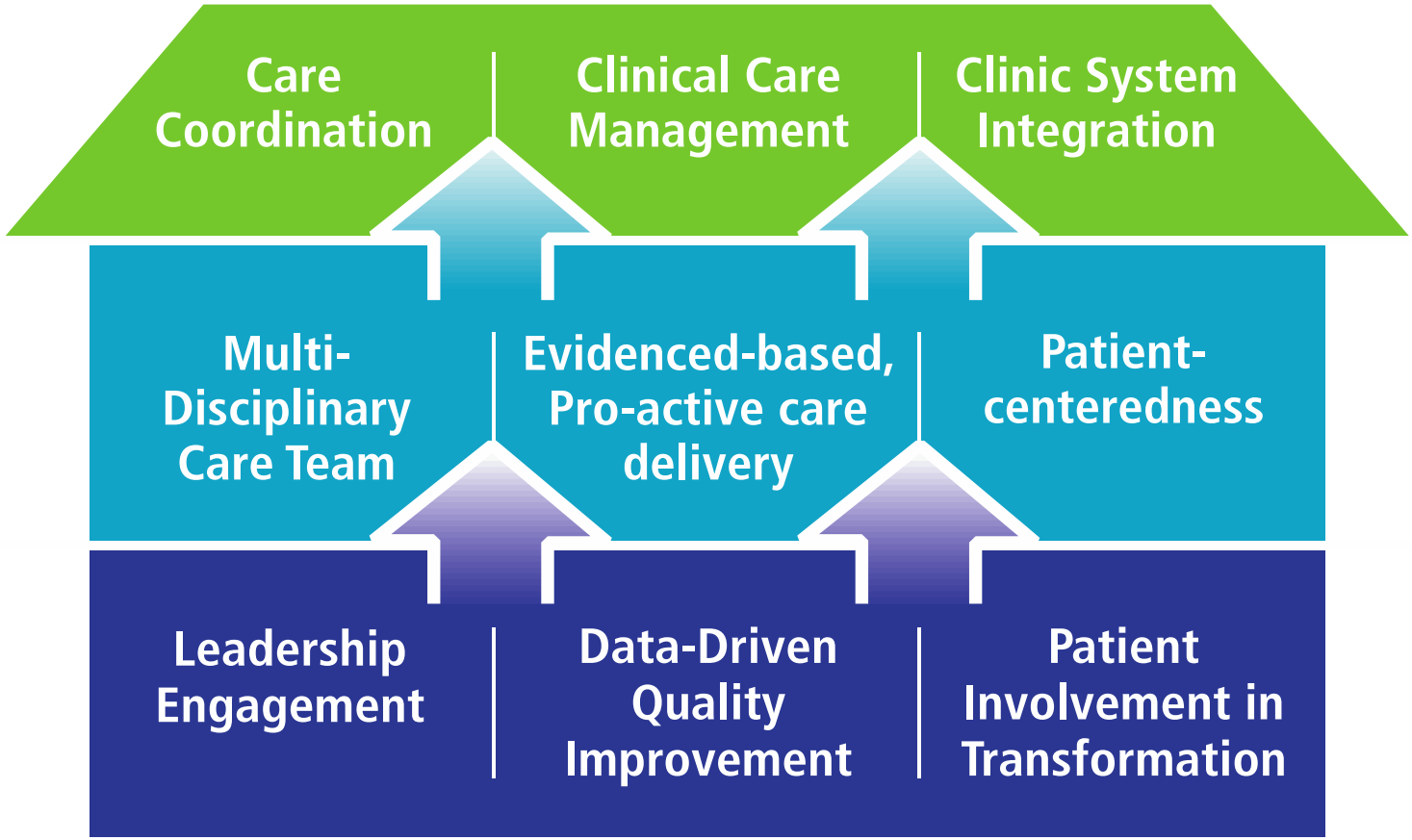


Patient Centered Medical Home Joint Principles: Then and Now

Original (2007)	2014
Personal physician	Home of the team
Whole person orientation	Requires BH service as part of care
Care coordinated	Shared problem & medication lists
Quality and safety	Requires BH on team
Enhanced access	Includes BH for patient, family & provider
Appropriate payment	Funding pooled & flexible

- *www.acponline.org/running_practice/delivery_and_payment_models/pcmh/demonstrations/jointprinc_05_17.pdf*
- *Ann Fam Med* 2014; 183-185; Joint Principles from AAFP, ABFM, STFM
- Slide adapted from Sandy Blount

Implement Care Integration in each PCMH Component



NCQA PCMH 2014 & Behavioral Health

1: Enhance Access and Continuity	Pts
A. Patient-Centered Appointment Access*	4.5
B. 24/7 Access to Clinical Advice	3.5
C. Electronic Access	2
	10

2: Team-Based Care	Pts
A. Continuity	3
B. Medical Home Responsibilities‡	**2.5**
C. Culturally and Linguistically Appropriate Services (CLAS)	2.5
D. The Practice Team*‡	4
	12

3: Population Health Management	Pts
A. Patient Information	3
B. Clinical Data‡	**4**
C. Comprehensive Health Assessment‡	**4**
D. Use Data for Population Management*	5
E. Implement Evidence-Based Decision-Support‡	**4**
	20

4: Plan and Manage Care	Pts
A. Identify Patients for Care Management‡	**4**
B. Care Planning and Self-Care Support*	4
C. Medication Management	4
D. Use Electronic Prescribing	3
E. Support Self-Care and Shared Decision-Making	5
	20

5: Track and Coordinate Care	Pts
A. Test Tracking and Follow-Up	6
B. Referral Tracking and Follow-Up*‡	**6**
C. Coordinate Care Transitions	6
	18

6: Measure and Improve Performance	Pts
A. Measure Clinical Quality Performance	3
B. Measure Resource Use and Care Coordination	3
C. Measure Patient/Family Experience	4
D. Implement Continuous Quality Improvement*	4
E. Demonstrate Continuous Quality Improvement	3
F. Report Performance	3
G. Use Certified EHR Technology	0
	20

* Must-pass elements

‡ Elements specific to behavioral health integration

Standard 2: Team-Based Care

Element	Description
Element 2B: Medical Home Responsibilities	Document and communicate to patients the practice's process for addressing patients'/families' behavioral health (BH) needs
Element 2D: The Practice Team	Train and assign members of the care team to support patients/ families/caregivers in self-management, self-efficacy and behavior change

Standard 3: Population Health Management

Element	Description
Element 3B: Clinical Data	Capture status of tobacco use for patients age >13 in structured fields of the electronic record
Element 3C: Comprehensive Health Assessment	Perform comprehensive health assessments with: • Attention to behaviors that affect health • History and family history of BH conditions • An understanding of social and cultural factors that impact health Screen for depression with a standardized tool (if there is access to relevant services when results are positive)
Element 3E: Implement Evidence-Based Decision Support	Clinical decision support for a mental health or substance use (SU) disorder and a condition related to unhealthy behaviors

3E, Factor 1 must be met for practices to receive a 75% or 100% score

Standard 4: Care Management Support

Element	Description
Element 4A: Identify Patients For Care Management	Identify through a systematic process, patients who benefit from clinical care management. Use criteria that consider: (1) behavioral health conditions (2) certain social determinants of health (3) high use/ high costs of healthcare services Populations serviced by care management have a high prevalence of behavioral health conditions/issues

4A Factor 6 must be met for practices to receive a score above 0% on this element.

Standard 5: Care Coordination & Transitions

Element	Description
Element 5B: Referral Tracking and Follow-up	Maintain agreements with behavioral health providers to enhance access, communication and coordination across disciplines Describe the approach to integrate behavioral health providers within the practice site

5B is a must pass element and a stage 2 core meaningful use requirement: Practices that do not score above 50% will not receive recognition.

A Broader Interpretation:

PCMH Standards with a Behavioral Health Lens

Standard 1: Patient-Centered Access

1A: Patient Centered Appointment Access	• Team-based care for routine and urgent needs at all times for both primary care (PC) & BH
1B: 24/7 Access to Clinical Advice	• Practice addresses BH concerns after hours • PCP has access to BH record
1C: Electronic Access (for patients)	• Access to BH record • Secure messaging for clinical advice, test results, med refills and appointment reminders

Standard 2: Team-Based Care

2B: Medical Home Responsibilities: Inform patients about…

- Care teams include BH providers
- Integrated care plans
- Access to BH appointments
- Self management support for behavioral change

2C: Culturally and Linguistically Appropriate Services

- Assess diversity of patient population
- Track care for underserved individuals:
  - Severe and persistent mental illness
  - Substance use disorders

2D: The Practice Team

- BH provider - an integral member of care team
- Team *trained* to manage care of vulnerable populations:
  - Engage patients in care and behavioral change
  - Person-centered, integrated care plans

Standard 3: Population Health Management

3B: Clinical Data

- Problem list - BH/SU conditions.
- Med list - BH meds (include meds prescribed outside of primary care)
- Family history - BH and SU

3D: Use Data for Population Management

- Registry of patients with a BH condition
- Evidence-based guidelines
- Outreach and engagement for:
  - Prevention, disease management, med monitoring
  - PC & BH coordinate to monitor meds

Standard 4: Care Management & Support

4B: Care Planning and Self-Care Support

- Care plan - physical and behavioral goals
- Care team - BH providers, as needed
- Care plan developed with patient/family/caregivers
- PC & BH coordinate to develop & implement care plan

4C: Medication Management

- One med list for physical and behavioral conditions
- Accurate med list requires:
  - Skilled med review with patient
  - Input from specialists and pharmacist

Standard 4: Care Management & Support

4D: Use Electronic Prescribing

- Helps avoid drug interactions
- Promotes use of less costly generic equivalents

4E: Support Self-Care and Shared Decision Making

- For physical and behavioral conditions
- Chronic disease management & wellness requires behavioral change support
- Train providers:
  - Techniques to engage patients in behavioral change
  - Use of community resources
- Generalist BH provider supports behavioral change
  - Systematic approach to identify individuals

Standard 5: Care Coordination & Transitions

5A: Test Tracking & Follow-up

- HIE permits sharing lab test and procedural results across PC & BH

5C: Coordinate Care Transitions

- Transitions in care related to BH/SU inpatient, ED and outpatient visits

Standard 6: Performance Measurement & Quality Improvement

6A: Measure Clinical Quality Performance	• Screening for BH & SU • Chronic disease management and prevention – patients with BH conditions • Management of BH conditions
6B: Measure Resource Use & Care Coordination	• BHI processes across PC and BH • Hospital/ED visits • Avoidable BH inpatient and readmissions • Redundant lab tests

6C: Measure Patient/Family Experience	• Whole-person care & self-management support:
	  • Screening for BH & SU
	  • Support behavioral change & health decisions
	• Coordination across BH & PC
	• Respect for privacy

Standard 6: Performance Measurement & Quality Improvement

6D: Implement Continuous Quality Improvement	• QI plan - Goal setting and interventions to improve BH care and BHI
6E: Demonstrate Continuous Quality Improvement	• Implement interventions and document improvement in performance
6F: Report Performance	• Share data reports on BH & BHI measures – to individual clinician, practice, publicly

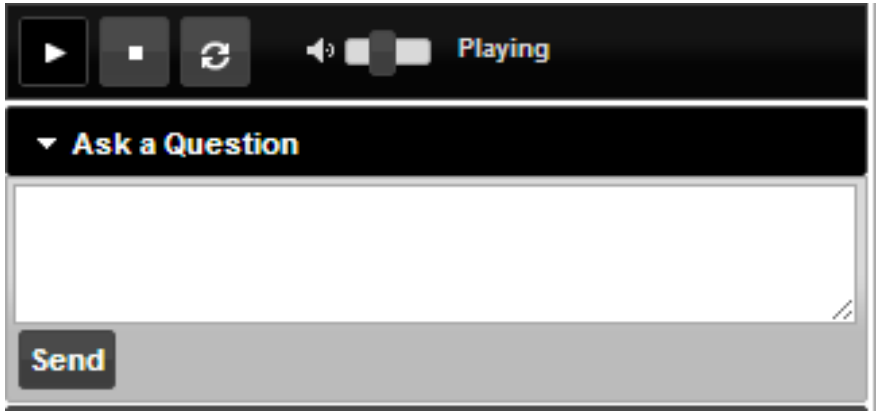
Summary

- Primary care providers must integrate behavioral health care to fully achieve the PCMH principles
- Four of the six standards in the 2014 NCQA PCMH recognition program include BHI requirements; several are must pass and/or critical factors
- As safety-net providers transform to PCMHs and seek NCQA recognition, they will be helped by understanding models of BHI, the NCQA recognition expectations for BHI and resources available to support their efforts

Questions ?

- You may submit questions at any time during the presentation by typing a question into the “Ask a Question” box in the lower left portion of your player.

- If you require further assistance, you can contact the Technical Support Center. Toll Free: 888-204-5477 or Toll: 402-875-9835



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Additional Questions?

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