Accreditation, Certification, and Credentialing: Levers for Training the Healthcare Workforce to Promote Children's Behavioral Health

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Patient-Centered Primary Care COLLABORATIVE

Lessons learned from PCMH certification

- Quick background on Patient-Centered Medical Home
  - What is the PCMH& how has it been operationalized?
  - How can the PCMH be a force for child/family behavioral/mental health and wellness?
- Role of certification/recognition for PCMH
  - Who and how are clinical practices certified as PCMH and why is it important?
  - How have we tried to improve the certification process? An example: Accreditation Work Group & Shared Principles of Primary Care

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BACKGROUND ON PCMH

What, When, Who, Where, & Why PCMH is relevant to child behavioral health

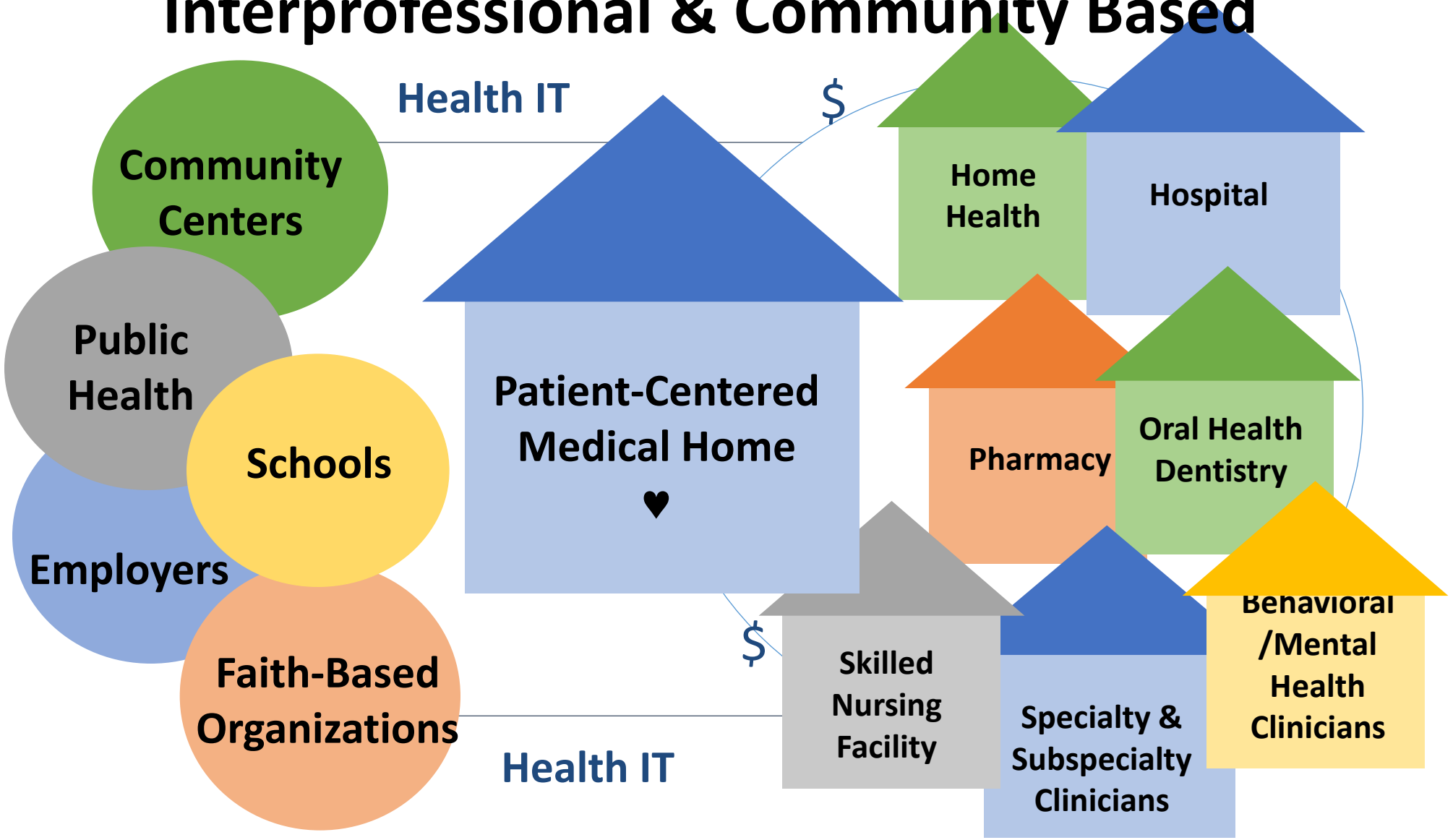
PCMH MODEL/FRAMEWORK

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ). *Patient-centered medical home resource center, defining the PCMH.* Retrieved from http://pcmh.ahrq.gov/page/defining-pcmh

http://bipartisanpolicy.org/library/what-makes-us-healthy-vs-what-we-spend-on-being-healthy/

PATIENT-CENTERED PRIMARY CARE:

Interprofessional & Community Based



Milestones in PCMH Development

1967-2006

1967 — American Academy of Pediatrics — DEDICATED TO THE HEALTH OF ALL CHILDREN™

Medical Home term first used in *Standards of Child Health Care*

1978 — **Alma Alta Declaration** — World Health Organization

1979 — **Medical Home and Hawaii Child Health Plan (Calvin Sia, MD)**

1989 — **Surgeon General Koop's Conf. Report: MH for CSHCN** — CSHCN

2002 — **Future of Family Medicine** — FFM future of family medicine

2004 — AAFP & TransforMED — TransforMED℠ TRANSFORMING MEDICAL PRACTICES

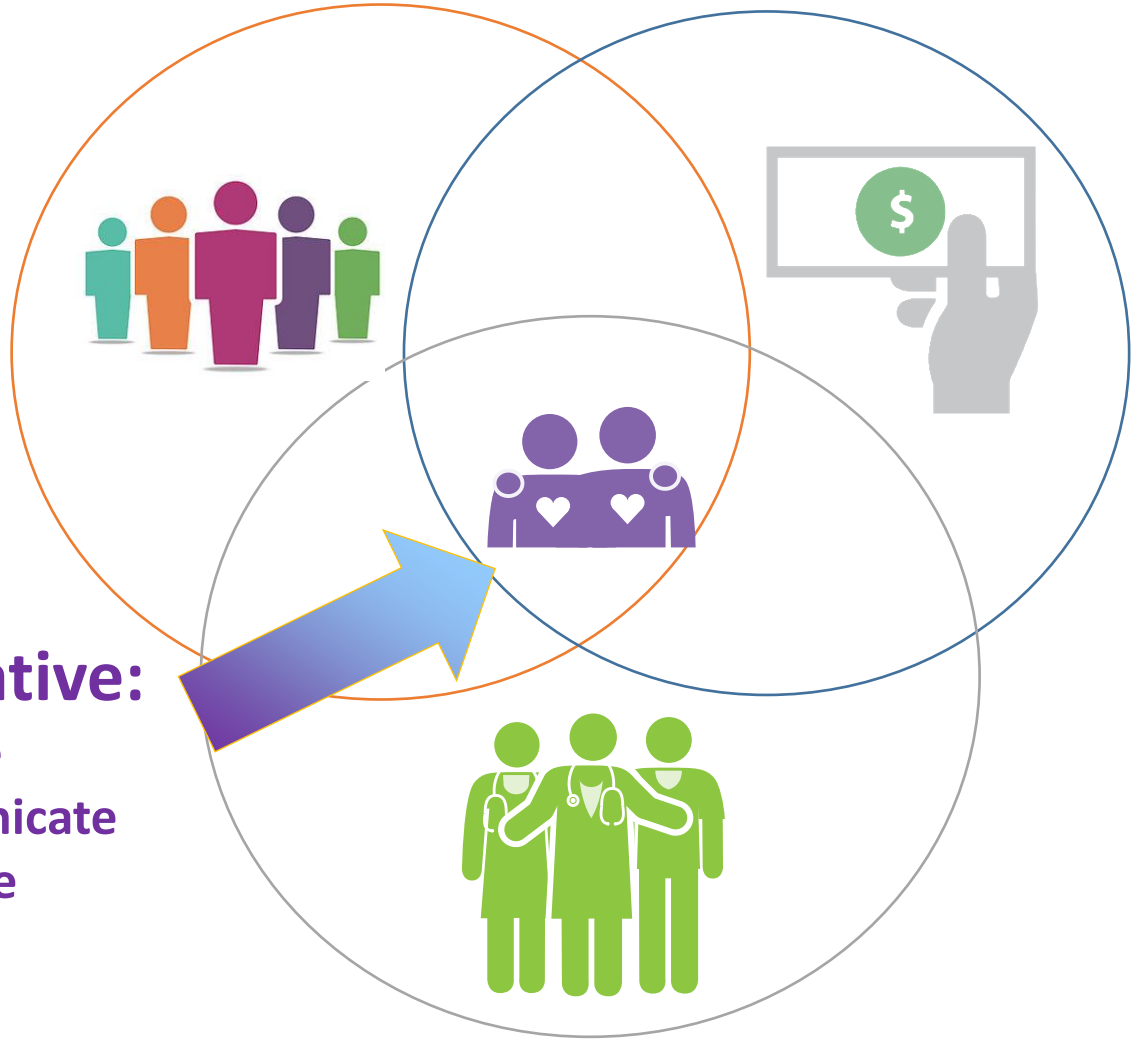
2006 — **ACP & Advanced Medical Home** — ACP American College of Physicians Internal Medicine | Doctors for Adults®

PCPCC founded — Patient-Centered Primary Care COLLABORATIVE

PATIENT-CENTERED PRIMARY CARE COLLABORATIVE

Unifying for a better health system - by better investing in *team-based* person-centered primary care

PUBLIC:
Patients,
Families,
Caregivers,
Communities



PAYERS:
Employers,
Government,
Health plans,
Consumers

Collaborative:

- **Convene**
- **Communicate**
- **Advocate**

HEALTH CARE PROVIDERS: People who care for patients/families/communities

Milestones in PCMH Development

2006-Present

National Business Group on Health

National Business Group on Health Award

THE COMMONWEALTH FUND

Commonwealth Fund PCMH Programs

GOLD STANDARD
QUALITY CONTROL VERIFIED

Recognition or accreditation of medical homes begins

Various multi-payer initiatives tested (CPC, MAPCP, IAH)

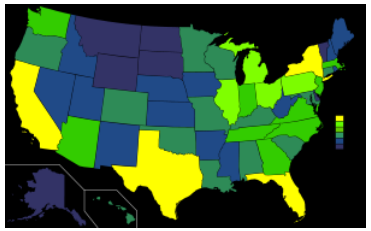
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

2007 | **2008** | **2010** | **2015**

Joint Principles of PCMH

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

State & Local PCMH Pilots



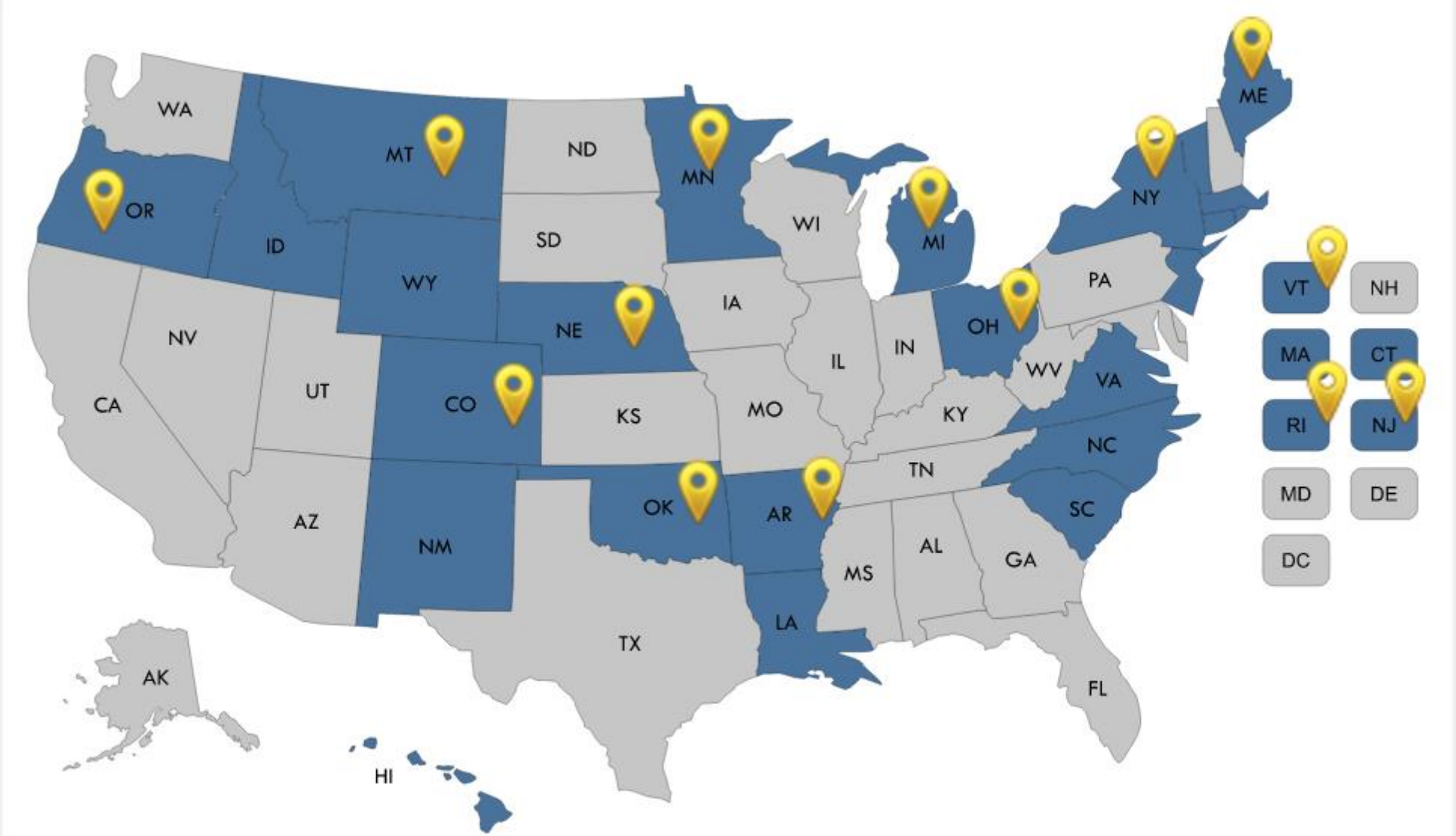
Affordable Care Act passed

Medicare Access & CHIP Reauthorization Act (MACRA) Passes

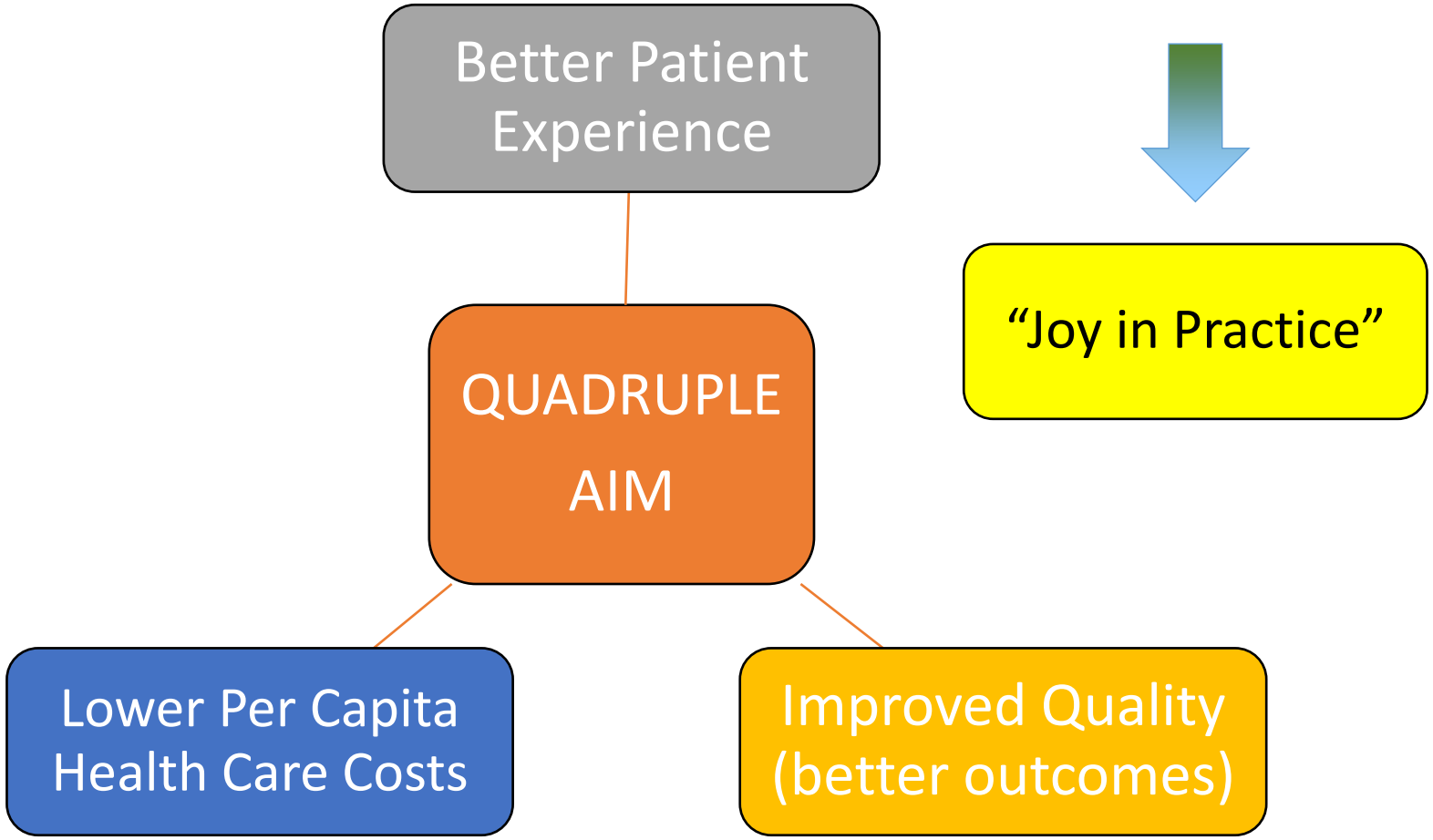
the YMCA
FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

WHAT'S NEXT?

MEDICAID & MEDICAL HOME ACTIVITY

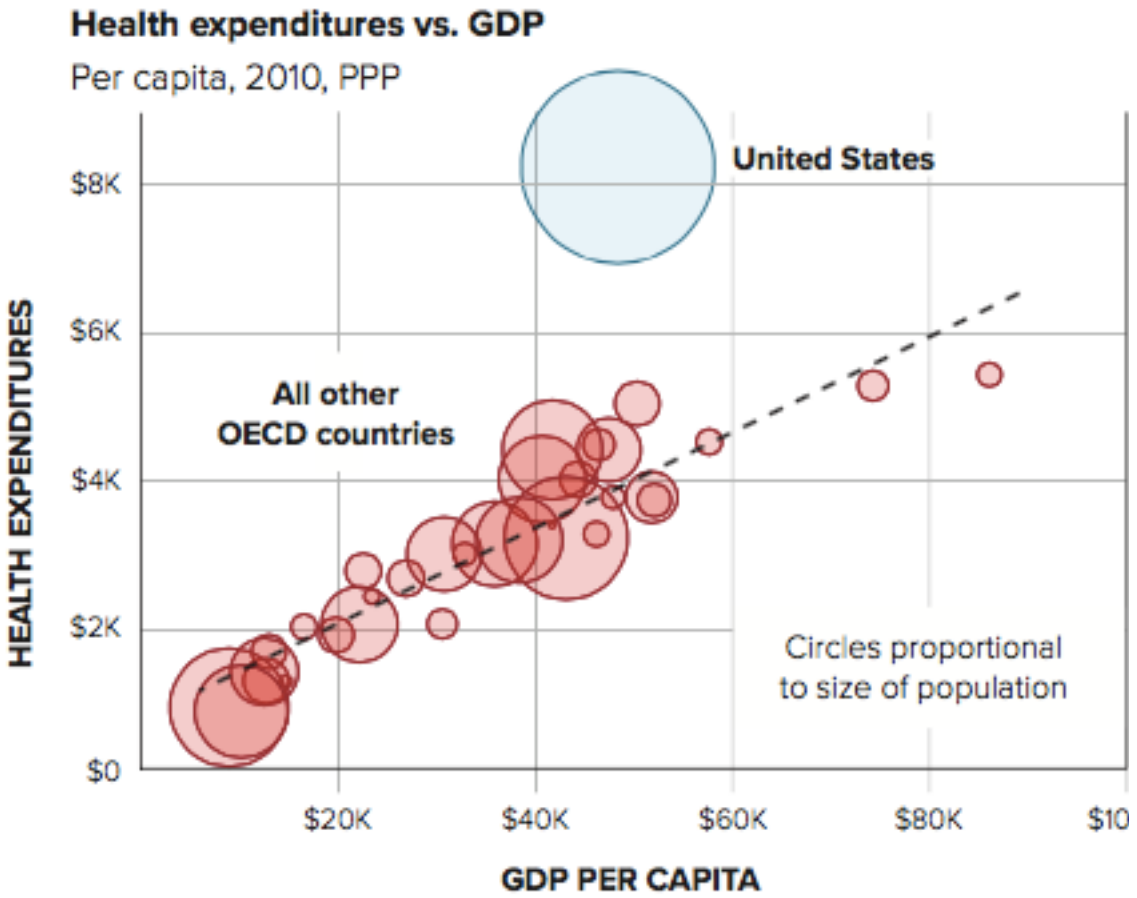


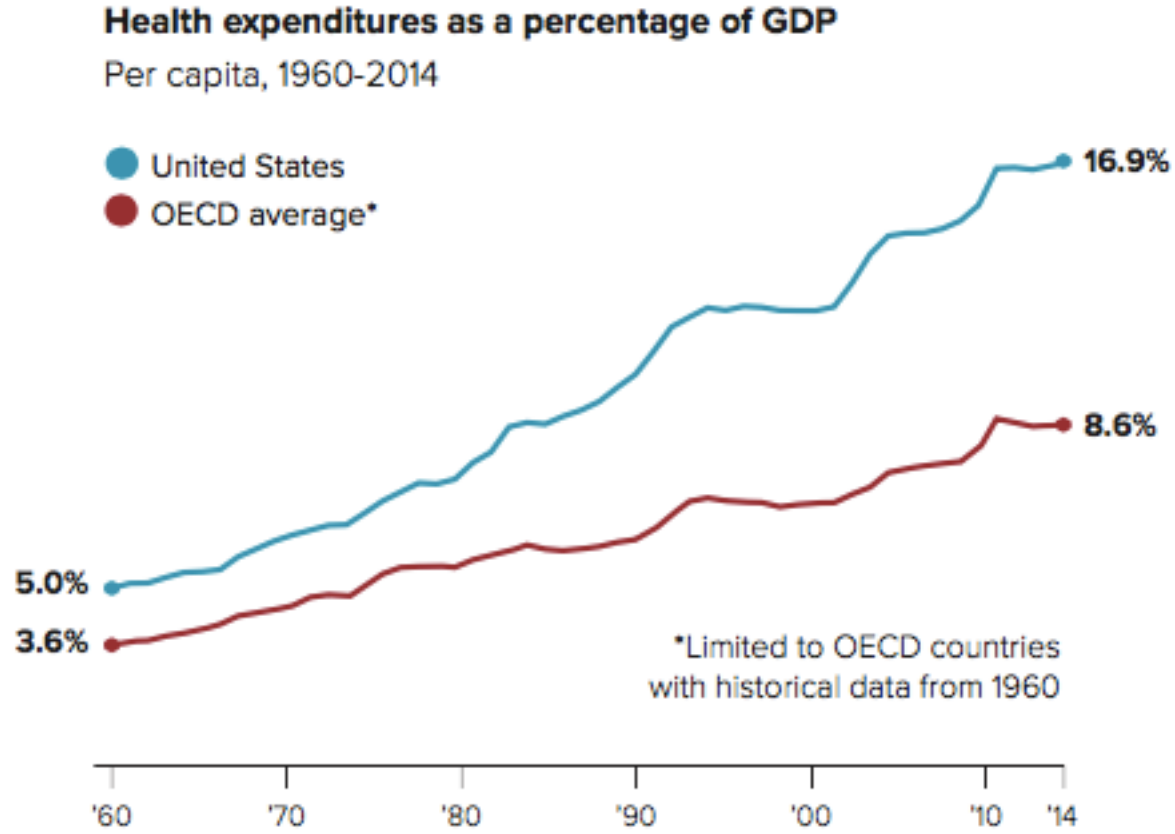
"~~TRIPLE~~ AIM" to "QUADRUPLE AIM"



Source : Berwick, Donald M., Thomas W. Nolan, and John Whittington. "The triple aim: care, health, and cost." *Health Affairs* 27.3 (2008): 759-769.

US HEALTH EXPENDITURES





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CERTIFICATION/RECOGNITION

Opportunities, challenges, and lessons learned

But what is a PCMH?

Is it a "Good Housekeeping" Seal of Approval for the Public?

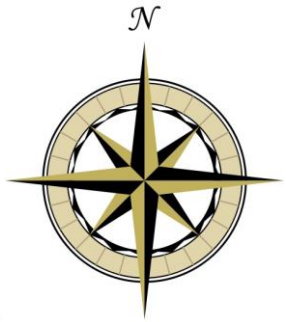
Is it a quality improvement process for practices?

Is it a recognition or certification process for payers and purchasers?

Is it a payment model for government and/or commercial plans?

Accreditation or Recognition as PCMH

- External validation
- “Short term” view of model
- Focused more on process measures
- Role in practice transformation & increased reimbursement
- Role in assessing value by payers



Attributes of Ideal PCMH

- “North star” – aspirational guide
- “Long term” view of model
- Focused more on outcomes
- What’s most important to patients, families, caregivers & consumers?

PCPCC Board Request to Accreditation Workgroup (AWG)

Due to growing concern about PCMH certification/recognition potential lack of alignment with meaningful primary care practice transformation*, PCPCC Board of Directors requested a diverse workgroup help us to:

- Obj. 1: Identify and analyze opportunities in the current PCMH certification/recognition marketplace, especially as it relates to meaningful and on-going primary care practice transformation,
  - i.e. *identify the aspirations of the medical home model of care;*
- Obj. 2: Identify and analyze challenges, to include administrative burden, in the current PCMH certification/recognition marketplace,
  - i.e. *identify where there are needed improvements in the current approach and/or standards;*
- Obj. 3: Provide the PCPCC Board of Directors with recommendations
  - that can be used to *help inform PCPCC advocacy efforts concerning public and private sector policies* that promote the PCMH model of care *(aspirational goal).*

In order to obtain the perspective and expertise of accrediting organizations, we asked representatives to serve as technical advisors.

*PCPCC Annual Review of the Evidence (2015); Stout & Weeng (2014); Sugarman et al (2014), Friedberg et al (2015)

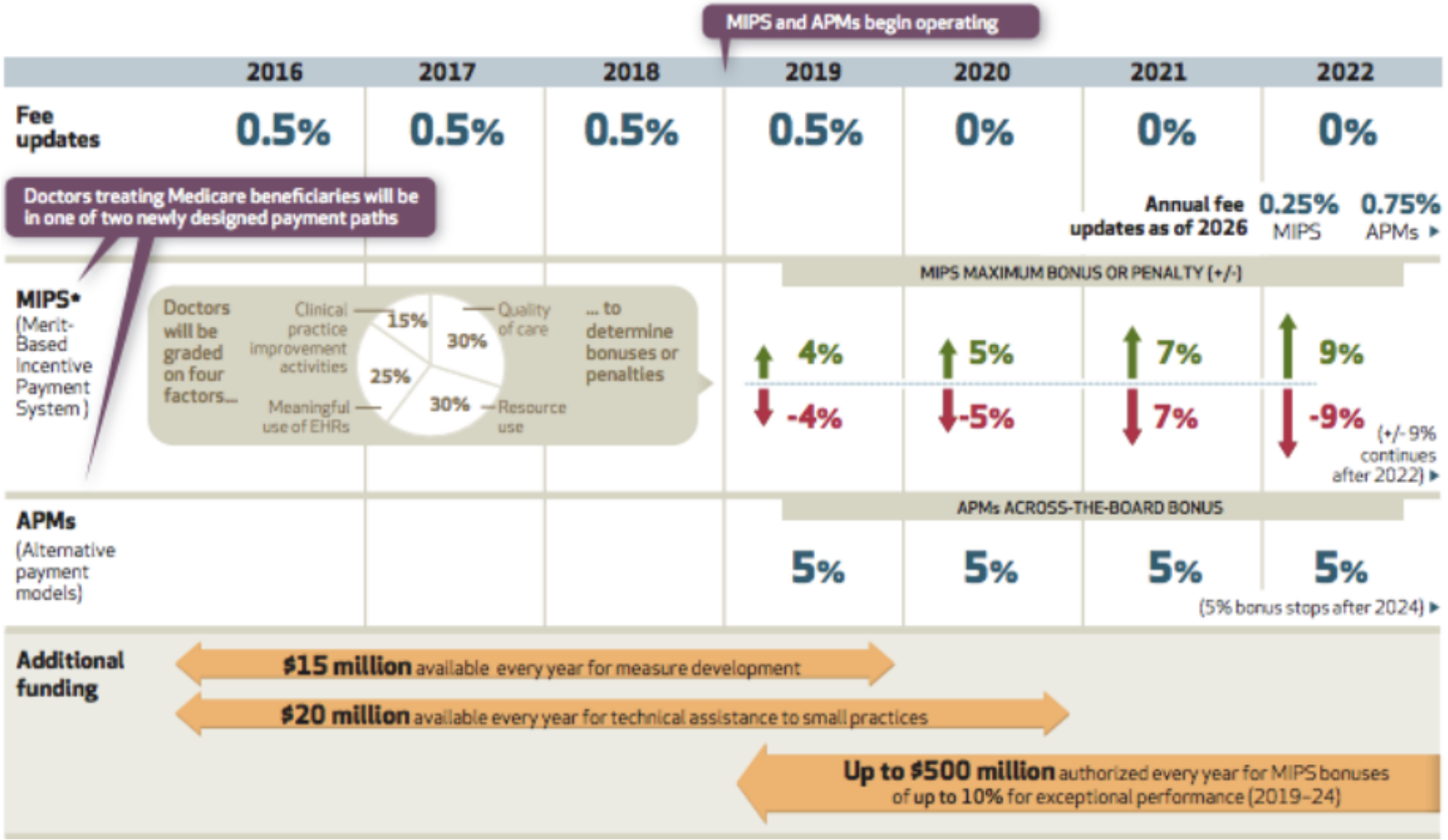
Guiding Principles to Improve PCMH Certification

- **Align all certification programs with the attributes/outcomes of the ideal PCMH (in PCMH definitions, such as AHRQ & Joint Principles of PCMH)**
  - **Clarify language around PCMH certification (accreditation, recognition, qualification, etc.)**
  - **Update attributes (outcomes) of PCMH to include AWG additions**
  - **PCMHs are foundational to ACOs and other organized, integrated health systems and primary care teams should be included in shared savings/financial incentives models**
- **Identify "change concepts"** most essential to achieving the attributes/outcomes
  - **Identify (through continued research) those change concepts that result in attributes, in the most parsimonious/simple manner (as demonstrated by the evidence)**
  - **Include AWG recommendations in "change concepts" (process)**
- **Promote change concepts** that result in PCMH attributes/outcomes
  - **Re-focus certification programs toward PCMH attributes and essential change concepts**
  - **Reference to public sector payment reforms (increased reimbursement through MACRA, etc)**
  - **Reference to private sector payment reforms (increased reimbursement, benefit redesign, tiered networks, etc)**
- **Support a pathway for Technical Assistance** (TA) for certification
  - **TA is outside scope of AWG project (because TA is not required to be part of certification) but its role is critical – must have an "on ramp" for practices wanting to transform**
  - **Acknowledge role of multi-payer initiatives (eg. CPC, MAPCP, SIM), Transforming Clinical Practices Initiative**

RECOMMENDATIONS FOR PCMH ACCREDITING ORGANIZATIONS:

- Reduce level of specificity: focus more on the spirit/intent of the PCMH model; be less prescriptive and incentivize innovation
- Push for parsimony – focus on the essential change concepts for high performing practices; recognize that practices begin at different starting points (i.e. fewer requirements for more advanced practices)
- Use aligned measures from an evidence base that assesses: patient experience and quality outcomes; professional and staff satisfaction; cost efficiency/value for patients, payers, & providers
- Simplify documentation reporting requirements, make them reciprocal across various programs, aligned across accreditors (by all payers), and a logical by-product of high quality care (not an add-on)
- Move toward performance demonstrating adoption of PCMH policies/procedures (away from documentation of policies and procedures)
- Apply certification standards to all patients – not a subset of high-risk high-cost patients
- Recognize established national/regional certification entities who have developed successful PCMH models that are supported by payers and providers in the region
- Develop and use better quality measures related to attributes
- Develop better methodologies to measure change concepts or outcomes

MACRA IN ONE EASY SLIDE



SOURCE Author's analysis. NOTES EHR is electronic health record. CMS is Centers for Medicare and Medicaid Services. HHS is Department of Health and Human Services. GAO is Government Accountability Office. MedPAC is Medicare Payment Advisory Commission.

Improvements in MACRA Final Rule

- Revise the implementation timeline
  - ✓ CMS moved to the “pick your pace” framework
- Expand recognition of patient-centered medical homes
  - ✓ CMS added state-based, regional or state programs, private payers, or entities that administer patient-centered medical home accreditation to at least 500 practices
- Streamline quality measurement
  - ✓ CMS reduced/simplified quality measure reporting
- Acknowledge the challenges of solo and small practices and provide greater support for them
  - ✓ CMS changed the low volume threshold & increased technical support aimed at small/solo providers
- Strengthen beneficiary engagement
  - ✓ Various CPIA activities aimed at beneficiaries
- Provide multiple pathways for medical homes to qualify as advanced alternative payment models
  - ✓ Medical homes subject to unique nominal risk requirements; CPC+

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HOME PROGRAM SPEAKERS SPONSORSHIP CONTACT REGISTER

NOVEMBER 11th, 2016