

**Health Resources and Services Administration
Bureau of Primary Health Care
Accreditation Update
August 20, 2014 2 to 3:30 p.m. ET**

Coordinator: Welcome and thank you for standing by.

At this time all participant lines are in a listen-only mode.

During today's presentation you will have the opportunity to ask questions, and at those times you may press star then 1 on your phone's keypad to ask a question.

Today's conference is being recorded. If you have any objections to this, please disconnect at this time.

And now I will turn the call over to your host for today, Ms. Suma Nair.

Miss, you may begin.

Suma Nair: Thank you.

Good morning and good afternoon, everyone. Thank you for joining us today for our webinar on the 2014 PCMH and Accreditation update.

During today's call we'll share with you from each of our accrediting bodies -- NCQA, AAAHC, and the Joint Commission. You're going to hear from them similar to a call we had several years ago when we are kicking off this and really helping to bring clarity around the differences in the standards and the types of surveys that are conducted.

Today we have an opportunity because much is involved since we've had that call about three years ago in the delivery system itself and with the standards and concepts with patient-centered medical home. So we're excited to join you today to present some updates on the 2014 standards from our different accrediting bodies.

Each of our accrediting bodies will provide an overview of any changes or revisions to their standards and guideline, and then also go through any important reminders associated with their accrediting system.

Before we transition into their presentations, I'd like to give a brief set of remarks around why this is so important and a couple of reminders for you to consider as we continue down our PCMH journey.

First and foremost I'd like to start with a big round of congratulations to all of our health centers. It is remarkable to note that only a few years ago -- maybe about three years ago now -- we started with less than 1% of our health centers being recognized as patient-centered medical home. Today, more than 54% of health centers across the country have been recognized as patient-centered medical home. That's amazing progress and uptick and far, I think, outshines all of the other primary care providers out there in the landscape.

So, congratulations on your efforts, each of our health centers and all of the health center programs partners who have been supporting you and making this transformation. And kudos to our accreditors who have been working with us to really support this important mission of providing high quality care that's focused on the needs of our patients.

You know, in addition to that were while we've made significant progress we have a goal at the center program for all of our health centers to really move and deliver care in this new model of care delivery. So, part of the call today is for those of you who've made that transformation. Kind of an eye to what you need to consider as you continue to maintain and optimize your patient-centered medical home.

For those of you who have been planning, kind of developing the systems and are ready now to make the commitment to go through transformation, you're going to want to listen with what are some of the requirements and changes that are coming up that you're going to have to consider as you move forward on your process for recognition.

And then in terms of why this is important, hopefully many of you have heard about the investments we are going to be making from the health center program side into our quality strategy in advancing that. Two of the most notable investments, I think and the recent, are around our patient-centered medical home quality award and our quality improvement award. Hopefully, many of you - I think the last base adjustments have now - have trickled through the system so you all are seeing your 2014 base adjustments.

A portion of those base adjustment funds were based upon whether you have received patient-centered medical home recognition at one or any of your site as of July 1. And so, I'm pleased to share that we were able to make \$25,000 available to every health center plus an additional \$5000 per site that was recognized for patient-centered medical home. So you should start seeing those awards in your (unintelligible) now.

The second set of our resources that we - also we anticipate putting up later this year and fiscal year '15 are around quality improvement. And the quality improvement awards we've talked about them so I won't go into the great detail, but really recognize performance improvement on those UDS clinical measures as well as some of our top performers.

And so we've, you know, been in discussions with you all, all along that we've been building the infrastructure support both with adoption of electronic health records and patient-centered medical home transformation to really improve quality outcomes for our patients and increase the value of the services we provide.

So the work that we're doing together and the updates, I think you'll see the enhancement of some of the PCMH standards will position health centers even in a better place to meet some of our quality improvement and goals around meeting and exceeding national and healthy people 2020 standards around clinical outcomes. So we're very, very excited about that. Stay tuned for our quality improvement award as well.

In terms of just kind of moving from that into the next layer, I've a couple of reminders. For those of you who have worked through NCQA to get your patient-centered medical home recognition, we have several health centers -- probably over a thousand tools that have been started.

And I know people are aggressively working on this, but please pay attention to the timeline because the clock is ticking, you have to submit those by March. Otherwise we will not be able to honor those under the old 2011 standards and you're going to have to move forward with the 2014 standards. So if you are in that position, just keep those dates on your calendar.

And then, finally, with our colleagues who are in the CMS Advanced Primary Care Demonstration Project, you remember the deadline is October 31 for having achieved Level 3 PCMH recognition. And so for our colleagues working on that, I think all of the surveys were due, but continue to work on that because I think it's important in terms of this effort we've had collaboratively with CMS to put our best foot forward and having as many of those practice sites meet the standard of having Level 3 recognition as we can. So we encourage you to move forward on that as well.

So without further ado I'll go ahead and turn it over to Elise Young, our lead for our PCMH recognition contract to get us started and, you know, thank you, again, for your efforts today and we look forward in continuing to support you as you continue your efforts through the PCMH process both with the accrediting bodies we have on the phone today and the support we have through contractual mechanism as well as the whole -- for lack of a better word -- safety net of support that we are putting around our health centers to support you with these transformation efforts.

We know it's not an easy journey and so we've had our National Cooperative Agreement partners, our primary care associations, and our health center controlled networks all poised to support you with different elements and aspects of the transformation process as well as kind of optimizing your new transformed practice moving forward.

So without further ado, Elise, I'll turn it over to you.

Elise Young: Thank you, Suma, and great information for our grantees here.

Before I get into - maybe (Rob), could you get to the next slide? I just want to - for those of you who are on Adobe Connect you see that we have our agenda today.

And before I get into introducing our speakers I just want to let you know that we do - if you're on Adobe Connect you should be able to see on your left side of your screen the Q&A pod as we call it. And at any time during the presentation, if you have any questions, feel free to type in your questions there.

We are going to hold questions until the end of our three presenters this afternoon. We will also have the operator assist us with any questions that come over the line.

So please, if you have questions or if you have comments, please feel free to enter it in the chat pod here or the Q&A pod.

So, I'm very happy to have our three organizations with us. We have the Accreditation Association of Ambulatory Health Care or for short AAAHC; we have National Committee for Quality Assurance, NCQA; and the Joint Commission on Accreditation or TJC, or we call it the Joint Commission, to be with us.

So I'm going to do introductions of each of our speakers at this time and then we'll also - transitioning them over as they complete their presentations.

So the first presentation will be by Ray Grundman from AAAHC. He's a Senior Director of External Relations and he's currently the Interim General Manager for Accreditation Operation.

And so, Ray, if you would certainly proceed. Go ahead.

Ray Grundman: Good afternoon and thank you, Elise, for the introduction. And thank you all for participating in this program.

I should note that I am filling in for our Director for Primary Care, Mona Sweeney, who is unable to be with us today. But I do have her contact information at the end of the presentation.

So, currently, those of you who are not familiar with AAAHC, we are celebrating our 35th anniversary this year. We are founded in 1979 and currently we accredit over 5800 ambulatory health care organizations.

We're very pleased to report that almost 400 - we're probably at the 400 mark now this week since we have reports coming in daily, 400 sites have achieved medical home recognition.

In considering AAAHC for your accreditation services, there are some things we'd like to kind of emphasize here. The first is the consultative nature of the survey. The other is that we do an onsite survey at a mutually agreed upon time with the organization, but we do have surveyors that come onsite. And we feel that the report that is a result of that survey process is a good blueprint for organizations in terms of how to improve the services that they provide.

Again, our survey process includes an onsite visit. Our surveyor cadre is made up of tier surveyors. I myself, you know, a surveyor. My background is family nurse practitioner. I'm not an atypical in terms of the type of surveyors that we recruit and train to do the onsite survey. So the value add is that you have

peers who are currently practicing in the field who come from similar backgrounds and can provide feedback not just on your performance on the standard, but also what their experience has been in their own practice setting.

We also have introduced a medical home certification program. So for those organizations who are not quite prepared to go in the entire accreditation program we do have a medical home onsite certification program which does use many of the existing standards from the accreditation program, but in a modified format. And to this (stage) I believe we had about 25 organizations go through the certification program.

Again, the medical home accreditation program involves a comprehensive review of your organization's entire operations including the ability to deliver care as a medical home. Our accreditation standards include a set of eight core chapters that all organizations must accomplish. Those include things such as patient rights, governance, administration, quality of care, quality improvement, health information center, infection control and prevention, and the physical environment.

And then we have what we call adjunct chapters and those that are applicable or are used during the survey. So, for example, Chapter 25 in our handbook is the chapter on medical home. So organizations can choose to go through accreditation with or without the medical home chapter.

We also have many organizations who ask us to do Chapter 25 of the medical home on a consultative basis. They're not quite sure if they're prepared and they don't want potentially less than stellar score to (unintelligible) survey report. So we do provide consultative survey for medical home also.

We have done medical home in a variety of locations -- from solo provider sites to large multispecialty group practices. And, again, we award two certificates under the accreditation program. There's a certificate acknowledging passing the accreditation part of the survey and there's a separate award to recognize the medical home designation.

Again, some of the onsite certification program involves a focused review limited just to medical home delivery of care. And for those of you who are not familiar with those specific standards, you can go to our Web site and pull down the accreditation manual and just look for Chapter 25. They're what we call the five pillars of the medical home. And those five pillars include relationship, comprehensiveness of care, continuity of care, accessibility, and quality of care.

Accreditation, again, is not necessary to accomplish the onsite certification. And we feel that this program is suitable for smaller practices who may be aren't quite prepared to go through this whole accreditation practice. It is less expensive.

Okay. So back home before the survey we have a team of individuals here at our offices at our headquarters in Sokie, Illinois who are prepared to help you through the whole process. And we actually kind of call it hand holding. If you need a lot of hand holding we're prepared to provide that level of support all the way from - starting the application process to scheduling the survey and then in preparation for the onsite survey.

Again, we're looking at developing the program to address the chronic care management standards from CMS. I was with the group of individuals who met with the project directors at the Center for Innovation in Baltimore a

couple of weeks ago and we learned more about the specifications for this program. And our goal is to have our medical home accreditation program recognized by CMS for organizations who'd like to pursue the chronic care management designation.

And I know we - that we'd hold questions for the end so I will just hand it back to Elise at this point.

Elise Young: Well, thank you, Ray. That was very good.

And just up there in that slide is Mona Sweeney who is a who Ray is sitting in for today.

At this time I want to turn it over to Bill Tulloch, who is the Director of Government Recognition Initiative at NCQA.

And I'll turn it right to you, Bill.

Bill Tulloch: Thank you, Elise.

So, as Elise noted we're going to give some updates in terms of the changes to the NCQA products that happened this year and are now in effect. But as Suma Nair noted, we do have - organizations that have 2011 tools will have until March to submit those. But these are 2014 updates, they'll have a little bit more on these deadlines in a later slide.

So we released a new version of our PCMH standards for the 2014 year last March and just some key changes that we've made to the program are part of our evolutionary approach to changing our standards. So we have a new

emphasis on team-based care or a heightened emphasis, I should say, with a new element that is a new must pass which is team-based care which really highlights the teamwork aspect of the medical home, integration of patients into that team and also their focus on QI both in the patient and the staff perspective.

We also have made a change to slightly alter how we are expecting practices to do care management for patients who may benefit from that process rather than sort of everybody with certain conditions being care-managed. We are now requiring practices to have some kind of process using evidence based as well as various criteria including social determinants of health, behavioral health conditions, those patients who may be the most frequent users, the highest cost patients, those with poorly-controlled or complex conditions. Using those kinds of types of parameters and criteria to determine which patients are most in need of care management or who may both benefit from care management rather than just using a simple diagnosis or other condition definition.

We've also highlighted and increased our focus on quality improvement. So two big changes there that in fact practices that are renewing either from the 2008 or the 2011 standards if you're renewing into the 2014 standards you will actually have to show that you're re-measuring the quality improvement at least annually. And for NCQA purposes that means for the previous two years before your renewal.

You know the three year recognition cycle we expect to see annual measures for two years because there may be things you weren't doing correctly when you first went through review so we want to give you that first year of the

recognition to maybe fix those or alter those. So we will be looking for renewing sites to show us two years of measurement.

They'll be streamlined renewal process for Level 2 and Level 3 practices, but they will have to show that quality improvement re-measurement for each site for the previous two years. Each renewing site I should say.

We also have a line with a meaningful use Stage 2. However, a meaningful use is not required for recognition, it's just that in those areas where we have similar requirement we've used the meaningful use definitions and their thresholds of performance.

But it's important to note that unlike meaningful use where you have to show that you're meeting a certain number of core - a certain core of measures and a certain number of menu measures, NCQA treats each of those requirements as a separate factor, typically, and each factors (are treated) independently. So if you only meet three core requirements we have credit for that in the NCQA program even though that wouldn't give you much any meaningful use form.

And we've tried to increase our expectation of the integration of behavioral health so that we're still requiring organizations to show their capability to treat unhealthy behaviors -- things like obesity, things like tobacco use -- but also specifically mental health or substance abuse issues. Whatever services related to behavioral health that are available at the practice are communicated to patients and that those practices with collocated behavioral health providers will also meet a set of requirements including a more specific focus on referrals to behavioral health providers.

This just shows the first three standards now in the 2014 program. Those of you who remember the 2011 are familiar with . We'll note that we took the old Standard 1 and really have divided it into Standards 1 and 2 here. And the old Standard 2 becomes Standard 3 with some additions, but the must passes are still there and highlighted in bold. You know, as the practice changes the new must pass for our new standard on team-based care which is Standard 2.

Standard 4 is looking now at care management, medication management, also, supporting self-care and shared decision making.

Standard 5 still continues to look at care that is referred outside of the office and has to be tracked by the medical home.

And then for Standard 6; it's still our quality improvement standard, although we have added some measures there as well.

Some key dates that you'll have to remember is of course our last date to purchase the 2011 survey tools or to get your notices of intent into us was actually last June 20, 2014. And I know we are processing some of those request that we didn't get on June 30 up through the middle of July. We got a (flood). Actually as an organization NCQA issued something like 2400, I believe it was, survey tools in the period between (unintelligible) and the end of June as folks (unintelligible) 2011 tools. But you still have until March 31 to submit all 2011 survey tools.

However, if you are a multisite organization and you want to do the corporate process where you have certain items reviewed once as your corporate level, we are recommending you get those corporate surveys in by the end of this year, so December 31, 2014, so we have time to do your site reviews before

the end of March because there won't be any additional extensions after March for any 2011 tools whether they'd be corporate or single site.

The 2014 standards are available for purchase, certainly at this point. Even if you don't want to buy a survey tool they're also available as a PDF for free from our publications Web site. And right now practices can submit either 2011 or 2014 tools although we have not had any 2014 submissions yet and we really don't expect any before probably late fall of this year.

So, just some specifics on what we've added in terms of the new team-based care. Standard, of course, the expectation of the patient as part of the care team which is really, you know, that - the whole person focus criteria for the medical home. And, of course, this new must pass element which is really creating this strong care team which has, again, that patient-family involvement in QI, but also that the staff has been trained, has been identified as to what responsibilities they hold, have been trained to do this responsibilities and understand their role in patient management and shared decision making.

And then in later elements we'll be looking at how the practice team does in terms of care management, care planning and self-care support. But the team-based care standard in the new must pass element really focus on the design of the team and the operations of the team and the training of the team versus of actually showing their performance if we look at in other elements.

Some more enhancements we've been more specific in our comprehensive health assessment requirements, we also are expecting a report on that this year. So in 2011 we still expect the practices to do comprehensive health assessments, but in that case we only look to see that there was a process in

that, there was at least one assessment filled out. And now we're actually asking the practices to tell us what percentage of patients have completed an assessment with specific factors in it. And that can be done either through reports from (unintelligible) systems or if you don't have a searchable health assessment you can do it through the workbook patient sample that we pull for other elements. You can also use that for the comprehensive health assessment.

Again, we're looking for more integration for their behavioral care, health care with a primary care setting and also, of course, the use of decision support tools. Things like shared decision making and things like that.

As I mentioned we've also added some measures to the quality improvement area. Specifically we always had measures of utilization that would impact health care cost, but now we've added the attracting of things like over use and appropriateness issues. So measures, looking at perhaps like duplicative lab test or other sets of coordination issues as well that we're looking at.

So coordination would be - could be things like how often does the practice provide the necessary clinical information when the practice is referring patients out to a medical specialist. That might be one measure or that you might be adding in your quality improvement area.

We also get - or looking at things like high cost and high utilization to be considered in the determination as to who may get or may benefit from care management and then also, of course, data on health care cost either from health plans or generated by the practice itself.

We've also tried to strengthen our expectations in terms of referral. So we're looking for agreements, actually, between providers -- so between the medical home and the specialist that they're referring to. Those agreements can be formal agreements or they may be informal agreements.

So formal agreement might be something that's actually an MOU or a letter of understanding between two practices as to how you're going to particularly co-manage patients who are being co-managed. Informal agreements may be more along the lines of a provider or putting into the medical record a series of bullet points. You know, spoke with doctor so and so, we've agreed to handle the patient this way with three or four bullet points. That would be an informal agreement, but to document it somewhere in the record either with a copy of the MOU or listing of the agreements, something like that.

That, of course you engage patients and families in terms of if they've done self-referrals, whether they've referred themselves to a specialist, they've gone to some kind of medical provider without a referral for the medical home or in other cases they may in fact have gotten referrals from providers. For instance school-based clinics that are not affiliated with their medical home may also be referring to kids out to providers so they'll be able to track that as well.

And then also coordinating reports with referred specialist to make sure that you're providing the information that they need and you're getting the information back.

So it's a little bit more of a strong expectation of that back and forth between providers.

And please note we have, of course, our specialty program that's also been launched that specifically looks at the flipside of that relationship for medical specialist as well. That's not actually required as part of the 2014 standards. It's just out there in terms of being able to look at both specialty and medical home and primary care medical home, excuse me.

So, a quick summary, of course, PCMH with the transition to medical home is really a process. It's not an event. The point of becoming medical home is not to pass a test, it was really to provide better care and better service to your patients and to be able to ensure that they're actually getting their needs and that's really important.

We've tried in our 2014 update to really reflect what the evidence is telling us in terms of what works best and what is most effective in the medical home setting. That will still help us work to achieve that AAA but we've also reduced some of the burden practices in certain areas where we didn't feel that with - that burden was really helpful or useful.

And really these are standards that should be (followed) over a long period of time and really we think really show sort of the basic outline and framework, excuse me, that the medical home should follow in terms of their transformation and their continued success.

And so, of course, you can always get more information on our Web site. We've just revamped that as well and we also have linked to a lot more resources from outside organizations -- things like potentially sample policies or templates or things like that that NCQA is very good about creating but certainly we want to learn from those organizations that are out there in helping practices and sort of for free if that is what you're looking for.

So that's my presentation and so I'll turn it back over to Elise.

Elise Young: Well, thank you, Bill. Great presentation.

And at this time I'd like to turn it over to Lon Berkeley who is the Project Director for Community Health Center Accreditation. He's also the Project Co-Lead for the PCMH Initiative at the Joint Commission.

So, Lon, take it away.

Lon Berkeley: Great. Thank you very much, Elise, and welcome to those health centers that are listening. It's always a welcome opportunity just to talk to the community health centers around the country after - as a former director of the Illinois Primary Care Association my heart and the commitment goes to those health centers that have been achieving outstanding services to medically underserved populations. And in that regard I want to compliment HRSA and Suma and her team particularly around the new quality awards as they strive to make sure that the health center model is not only important for access and community participation, but in the quality of services. And the added focus on quality award, I think, as an incentive will help continue to move in that direction.

For those of you who may not be familiar with the Joint Commission -- also known as JCO in some settings -- we have been around since 1951 and it's always important to refer to the organization.

So just in case you're not aware of the - the mission of the Joint Commission is to not only evaluate health care organizations, but as indicated in the - in

our mission statement, but also inspire them to excel at the same time. And at the heart of that is our effort to come onsite to health centers beyond the organizations - other organizations besides health centers, hospitals, nursing homes, care agencies, behavioral health and long term care that we have been focusing on the ambulatory environments in 1965 - 1975 and in that regard in the contract that we had with the Health Resources and Services Administration since 1997 have almost 300 community health centers now that are accredited.

Beyond the accreditation, the Joint Commission began in 2011 to introduce our primary care medical home certification option which will be the major focus of this - as to my presentation. But just in terms of the progress we've made in that regard there's now 128 community health centers providing care over - well over a thousand sites. But as we look at those numbers, the more important thing is the number of patients, that that covers a little over three-and-a-half million patients and including a 2500 primary care clinicians.

So, the opportunity to use the Joint Commission as one of your choices is something now that has been well-established and adopted by a number of your colleagues.

The history though of the Joint Commission's involvement really goes back to 1997, as I mentioned, when the Bureau of Primary Health Care -- which is now very focused on the PCMH Initiative -- began their accreditation initiative at that time and has continued it since then whereby the Bureau of Primary Health Care has been providing financial incentives to become m accredited, and now PCMH certified by paying the cost of the Joint Commission of that cost.

The benefits they saw at that point was to because of this validation of the quality and care by outside vendor it also has increased competitiveness and probably more importantly in this - certainly it's been emphasized by my predecessors, the goal here, of course, is really to support quality improvement and risk management throughout your structure and processes. And you're doing that by engaging staff, board, and patients.

So as part of that voluntary participation the Joint Commission and the certification so that we became a two-for-one opportunity. So that goal to accomplish at the same time with the Bureau of Primary Health Care picking up the accreditation processing cost.

As a quick overview of some distinguishing features particularly the opportunity to go third is a little bit of an advantage and I wanted to emphasize that the Joint Commission's approach for PCMH certification is that it does apply to accredited organizations, accredited ambulatory care organizations or when seeking accreditation. So that can be done both at the same time. And parenthetically, this might be the time just to mention that the Joint Commission does also have two other primary care medical home certification options for accredited hospitals and accredited behavioral health care organizations.

So I won't be touching on those because they're slightly different in their approach and their criteria. Today we'll be focusing on just our primary care medical and certification option for ambulatory or accredited ambulatory care organizations.

The other key aspect is we do come onsite to evaluate some clients and at that point is evaluating compliance both with the accreditation standards as well as

the additional primary care medical home certification requirements. And that as a result it means that there are really no special application requirements other than checking off the box on the overall application for accreditation.

We do provide organization wide certification for up to three years. And so it is not a site-by-site application, it is a - similar to accrediting organizations as a whole. We are also certifying them as a whole as well.

I mentioned that the Bureau of Primary Health Care does pay the cost of this five-year contract. And the recognition of that is displayed on the Joint Commission's Web site some Quality Check where you can go to identify any accredited organization and now a PCMH certification shows it up there as well.

Another way of sort of describing this is a little busy slide, but it helps to capture a couple of things. One is the fact that the accreditation certification process is built on top of and is an addition to accreditation.

And this block on the bottom happens to focus on the - as I mentioned both the Joint Commission Ambulatory Care Hospital and Behavioral Health and it reflects the fact there's a whole host of standards or chapters not unlike which you heard Ray referred to relative to AAAHC that we do uncover as our base. Areas related to infection control, environment of care, emergency management, (unintelligible) testing. These are all standards specific to becoming accredited by the Joint Commission.

We then did add standards relating to patient-centeredness, superb access to care, care coordination, comprehensiveness and systems across the quality and

safety that really are built on the basis of the characteristics from the Agency for Healthcare Research and Quality.

This is a really just opportunity to demonstrate how easy it is to indicate - this is a screenshot from electronic application by simply checking off yes. That is the sole trigger for when either your next tri-annual surveys do every three years for the surveyor to include PCMH or as an initial applicant that you'll include primary care medical home certification as part of that onsite survey. Or there's a third option, if you are seeking accreditation - excuse me, if you are already accredited by us but you're not in the window of our re-survey cycle you can request an extension survey. So a couple of ways to capitalize on that.

I'm going to just spend a brief time just quickly going over the categories of patient centeredness. We have available the details of these standards on the Joint Commission Web site with the link indicated at the end. But because of the hope that there are many on the call who are maybe already patient (made) certified by Joint Commission, I did want to mainly just highlight those changes that are - were effective as of July 1 that will now be applicable to any survey that - whether it's an initial survey for the first time or a resurvey when we come onsite that you all will be subject to for continued certification to also be in compliance with the with the additional PCMH revisions.

At the heart of those revisions as you also heard from NCQA that we are aligning the changes with (unintelligible) requirements so that includes things like electronic prescribing, the computer or entry system, patients having online access to their health information. And this is where I'll skip over the details of the clinical record.

I do want to emphasize that the Joint Commission as of July does require a certified electronic health record. Again, that's a bit of a contention with - I do have to say -- (thanks to the QA) -- there is a change from the Joint Commission that you will have to have a certified EHR. And that it performs certain functions of course regarding appointment reminders and submitting reports and providing patient-specific education resources.

I will note the one item that is in red. That is beyond the requirements for the meaningful use Stage 2 that we anticipated will be a requirement probably not until Stage 3 or 4. That's along with collecting information about a patient's family history and personal physical history, which will also take information recording about their work history as well given the importance of the workplace setting in impacting both in assessing and treatment of their patients conditions.

The other items that we've added to that are not related to the meaningful use. Stage 2 have to do with the expectation for information that you provide to patients. We have noted in this case very specifically that rather than any - rather than the determination about what should be provided to the patient to help them select their primary care clinician, that specifically that information will include the credentials and educational background of that primary care clinician. We just made that explicit. Most organizations were doing that any way.

In addition, relative to the Joint Commissions requirement that there is a interdisciplinary team that supports that primary care clinician, now we have also just made it clear - clarify that a physician needs to be a member of that interdisciplinary team.

And then another area that we have broadened from the comprehensiveness that we had before that includes behavioral health and oral health and urgent care, we specifically added the requirement that you, you know, provide or facilitate access to optical health, or vision health and rehabilitative services such as physical therapy. So let's just say - and then effort to try and continue to make sure that the model is holistic and that we're dealing with all parts of the body and whole aspects of care that are critical to that person's health.

That's sort of just as a recap of the major changes as of July 1. And, you know, skipping over the expectations that are already in place we'll be happy to comment on those further during our Q&A session or of course reference where they are available on the Web site.

I did want to go and make sure I also answer the question we often get the issue of what the heck really happens when a surveyor shows up onsite. And I just want to touch on that.

First of all -- making sure it was clear -- that the Joint Commission Ambulatory Care surveyors that are available to us for all ambulatory care, there is actually only a subset of those that are eligible to - under our Joint Commission contract with the Bureau of Primary Health Care that will actually be coming onsite to a community health center. And those are surveyors that have - either do work in a health center currently, have been on the board of a health center, have worked in some capacity with health centers or in some cases we have also surveyors who have been involved under certain populations. So, it is the goal to - along with our annual training of the surveyors and refreshing of the latest Bureau of Primary Health Care expectations, these are folks who understand very much the unique role that health centers have in the health care industry that their goal is to not only

access - assess compliance with standards, (but up at) educational, collaborate, courteous and inspiring as our mission requires.

And the bulk of these surveys are two or three days. We have a couple of very small community health centers where there's only one surveyor for two days. We have several very large health centers where there are three surveyors for multiple days. Their goal is to at a minimum visit and survey compliance with at least half of all the - all of our sites. We strive to get to all of them. Our minimum mix of patients are half of the size we'll be visiting.

If you really want to get the details what happens on a survey we do have something called the Survey Activity Guide also available on our Web site and that can guide you through what actually occurs at each stage of the agenda ranging from when we walk in the door to do our patient tracers, to what happens when we do environmental care of, a sit down session or we have a leadership. Or we talk to the governing board or we deal with the folks in infection control. So that Survey Activity Guide really describes what goes on in our effort to may be transparent and we'd like to consider this an open book test. We're going to give you all the standards and we're going to give you the activities that the survey is going to cover. And with that as a background I hope that helps take some of the mystery out of the process.

The goal is to be customer and patient focused. Minimal interruptions do come onsite, but the processes are very intimate where we will talk to the staff that's delivering the care. We are literally being in the exam room with permission of the patient until any close come off to hear and understand exactly what the interaction is between the providers and the patients.

We do have opportunity, of course, to also talk to the leadership and as I mentioned the board of directors as well. And in that regard you are provided with an agenda covering the two or three days -- some cases longer -- and it does incorporate the meeting with your governing board, your clinical leadership, and if you do receive any special population funding from the Bureau of Primary Health care, you know, the homeless migrant or the housing residents that we do have some special extra components to the agenda that is included.

In case you are not aware, as part of the deal with the Bureau of Primary Health Care where they are covering the cost, the report does go to the central office and is available to your project officer. And then lastly the Joint Commission had been including as a requirement the review of the 19 program requirements or (unintelligible) if you are not familiar with HRSA's onsite operational site visit that is now an operational assessment and we hope to pilot test that in the 2015 to potentially bring those two processes back together again in the late 2015.

After though the survey is over organizations do get a written report listing the requirements for improvement. And that report will now not only include accreditation and how compliant there is and we call those evidence of standard compliance, but it does include now the primary care medical home certification requirements improvement at the same time.

Their last step is because we - uses that as our vehicle for helping you get better, helping you address those areas that you may not - or you may not have been aware of issues that needs to be addressed, you submit what you're going to do to fix the problem, how you're going to do, when you're going to do it

provided that is acceptable and we will then issue a certificate both for the PCMH as well as the accreditation award.

In some rare situations we're - you know, there's a large number of (unintelligible) for improvement. Instead of accepting a written report we do go back on site to confirm that the standards were in compliance.

Lastly, beyond the three year compliance period I mentioned - I want to make sure to mention that we don't just go away after every two years. There is a (focused) standards assessment where in the two intervening years before we come out that we have expectation that you'll self-report your compliance with our standards in an electronic means.

I did want to emphasize that the whole process for both PCMH does have a lot of resources on our Web site as indicated. That self-assessment tool that is mentioned is probably the most valuable opportunity to see the additional set of requirements specific to PCMH organized by those five characteristics. And that will also enable you to determine how ready you are for being in compliance for areas that you need to address.

This is a - other areas that we've mentioned are - a lot of you know Rex Zordan, our corporate account exec specific to the community health centers. He's the one who is there to help guide you in most of the processes, but we also have standards interpretation group should you need some specific questions, you don't know - unsure whether you're in compliance with the standard, you actually can call us and ask us to see, "We're planning on doing such and such, is this sufficient to be in compliance with the standard?"

Other aspects are highlighted here, but I want to make sure - just note in our last slide that you're not alone in this process, lots of resources. There is a - if you are interested for the first time in being accredited, there is a separate notice of interest that you have to submit. So it's separate for the one at the moment, separate for the one for the health home. You do need to go into the HRSA's Web site and submit a notice of interest for accreditation and there's a separate check-off box for PCMH at that time.

We also intend - shortly have on the Web site a - a lot of organizations have asked us to do - just a crosswalk comparison between ourselves and NCQA as well.

If you have any questions about any of the process, you got my number at the bottom, but I did want to also emphasize (Christine Persyanski). She is also available to help guide you through that (NOI) process.

I hope that we'll have questions to get more details, but other than that I'll turn it back over to Elise.

Elise Young: Lon, thank you very much for your comprehensive background on the Joint Commission process. And to all our speakers, thank you very much.

At this time we'd like to open it up for questions.

So, operator, would you please instruct the callers?

Coordinator: Absolutely.

If you would like to ask a question at this time, please press star then 1. Please unmute your phone and record your name when prompted.

If at any time your question has been answered you may remove your request by pressing Star 2.

Once again, please press Star 1 if you'd like to ask a question.

Once again, please press Star 1.

Elise Young: We do not have any questions in the Q&A pod.

Coordinator: We have one over the phone. One moment please.

Elise Young: Thank you.

Coordinator: The name was not announced, but yes the question was about the PowerPoint.

Your line is open.

Woman: In the (unintelligible) portion is the PowerPoint going to be available?

Elise Young: Yes. It should be available on the HRSA...

Man: (Unintelligible) right there at the Q&A pod...

Elise Young: Okay.

Man: Underneath the Q&A pod.

Elise Young: Okay. So underneath the Q&A pod that you can download...

Man: I'll have it back up in about five minutes. And you can download it directly to your computer.

Woman: Thank you.

Coordinator: And we have a couple more responses from the phone.

Our next is from (Darla). Your line is open.

Elise Young: Hello, (Darla).

(Darla): I'm sorry. I was disconnected and just called back in so I don't have a question.

Elise Young: All righty. Thank you.

Coordinator: One moment for our next question, please.

Our question is from Lisa. Please go ahead with your question.

(Lisa): Hi. Currently we're surveyed under the Joint Commission and we are surveyed for our 50 sites and that includes two surveyors for three days. If we decide to opt for the Joint Commission PCMH certification, will that add additional surveyors and additional days?

Elise Young: (Lisa), I'd like to turn it over to Lon.

Lon Berkeley: Okay, great. Thank you and congratulations on your accreditation under the Joint Commission, Lisa.

The current number of days that we are used for determining our complement of surveyors is based on the total number of sites, your volume and the distance between the sites. We've been able to incorporate the PCMH certification as a component of the accreditation visits so per se alone for your next tri-annual survey will not increase the number of days, but we - every three years we do examine whether or not you reach our thresholds for expanding beyond your two surveyor for three days and it does depend on also what the services are delivered at those sites as well.

So you would work with Rex Zordan. He would be the one to answer that question, but it would not per se be specific to the PCMH component.

(Lisa): Okay. Thank you.

Coordinator: Once again if you have a question, please press star then one at this time. One moment for our next question.

Our next question is from (Dana). Your line is open.

(Dana): Hi. The PowerPoint presentation came up back briefly and then it went away. Is that where you're expecting us to download it from?

Man: I'll bring it over...

((Crosstalk))

(Dana): It's gone again.

Can you leave it up for a while or do you need to get it down?

Man: Nope. I'm just fine with that. Thank you.

(Dana): Thank you.

Coordinator: Once again, for question or comment, please press star then one. Please standby.

We have no further responses at this time.

Elise Young: Great. Thank you, operator.

I want to - this is Elise Young, again, and I want to thank our presenters and thank all of you who've dialed in on the call. And (Rob), if you could go to the final - very final slide?

Coordinator: Excuse me, we did have two more responses coming, if you would like to take them.

Elise Young: Okay. Certainly.

Coordinator: Our next is from (Barbara). Your line is open.

(Barbara): Yes, hi. I had a question for JCAHO. Do the behavioral health requirements address the coordination and integration of primary care?

Lon Berkeley: I assume I can answer that one, Elise, right?

Elise Young: Yes, please.

Lon Berkeley: This is Lon.

Elise Young: Yes.

Lon Berkeley: Lon Berkeley from the Joint Commission.

When you refer to the behavioral health requirements, (Barbara), are you referring to our separate distinct accreditation for behavioral health or are you...

(Barbara): Yes I am.

Lon Berkeley: ...referring to...

(Barbara): Yes.

Lon Berkeley: Okay. Yes. So, as part of the Joint Commission's existing accreditation standards, actually, and not actually specific to PCMH...

(Barbara): Okay.

Lon Berkeley: ..., we do expect that it would be a coordination between behavioral health services and physical health and actually with even within physical health that the key questions is also between dental health and physical health.

And so, surveyors as part of our tracer process will be looking at - in fact we have what we call, even a continuity of care system tracer that examines relationships between how well you have integration occurring between the different components of your services.

(Barbara): And...

((Crosstalk))

(Barbara): And for the BHH requirements?

Lon Berkeley: Okay, good.

So, the BHH is our behavioral health home certification -- which we just launched earlier this year. That is in response to those states, actually, that are providing additional funding for behavioral health home certification.

At this point you do have to have that behavioral health accreditation as well and we're hoping to have a conversation with you if you think that it might be helpful to go for the behavioral health home certification instead of the primary care medical home certification. We haven't come across any situations where you - it was more appropriate to PCMH as opposed to BHH but we'd have to talk to you more about that to determine what meets your needs the best.

(Barbara): All right. Thank you very much.

Lon Berkeley: And hopefully, you know, you'll - if you are already credited you've got Rex Zordan's number or his contact information. Start with him and we'll - I'll be involved as necessary.

(Barbara): Great. Thank you.

Lon Berkeley: You're very welcome.

Coordinator: And we have one more question from (Billy Joe). Your line is open.

(Billy Joe): Yes, we are currently accredited from Joint Commission for ambulatory care but are in the process of getting PCMH certified through NCQA. How does that affect our future surveys with Joint Commission?

Lon Berkeley: I think I - okay, can I answer the question that is (unintelligible) question (Billy Joe).

Again, Lon Berkeley from the Joint Commission.

The Joint Commission developed our primary care medical home certification option really in response to enabling accredited organizations to combine both into a single site visit if that's their choice. If they would prefer to use, you know, either the NCQA or even the AAAHC standalone PCMH, it's entirely up to you as an organization in terms of what's - you feel what's best for you for various reasons and therefore it has really no bearing on the Joint Commission Accreditation process.

You know, the surveyors may comment if you want them to or you would like them to comment on your aspects dealing with your care coordination or

patient-centeredness or any of the NCQA specific requirements, but they are not familiar or they are not trained for saying NCQA expectations only in a very general sense so the bottom line is that it will have - should have no bearing at all on your Joint Commission accreditation (places).

(Billy Joe): So when we update our application on a yearly basis or whatever, do we check, you know, them for PCMH?

Lon Berkeley: Correct. That is correct.

(Billy Joe): Okay.

Lon Berkeley: Good question. (Billy Joe).

If you are seeking PCMH, or an NCQA, or AAAHC and decide not to use the Joint Commission's PCMH certification, you just select no on that (unintelligible) screenshot.

And then it's even up to you, even when the surveyors come on site you can mention it or you cannot mention it. That'd be left up to you.

(Billy Joe): Okay. Thank you.

Elise Young: Thank you, Lon.

Lon Berkeley: Thank you. I should probably just say parenthetically for us, you do have the opportunity to change your mind either way -- if you were Joint Commission PCMH and decide to drop it, go at NCQA, or if you're NCQA and decide to join - and do PCMH and Joint Commission. I'm not aware of any restrictions

to your flexibility in that regard, at least at this point, from HRSAs (unintelligible).

Elise Young: Operator, are there any other questions?

Coordinator: We have no further questions at this time.

Suma Nair: Great. This is fantastic. Thank you very much, again, and I just want to make a couple final comments.

It was referred in the presentation and Lon you just mentioned it about HRSAs support. I want to let callers know that HRSA will continue to support our health centers and health center sites in receiving accreditation and PCMH. And when I mean support we will cover your fees associated with the review process in the event of NCQA. We also cover the cost of the tools that you need to purchase.

So, HRSA will do that. Our only request, the requirement is that you complete a notice of intent. It is a form that identifies specifically what you are seeking. That notice of intent format form is available on the PCMH HI webpage in a PDF form and you can fill that out.

And I also want to call your attention that if you have any additional question regarding any of our presentations today or any general inquiries regarding accreditation of PCMH, please feel free to contact us either by email and I have the slide up there. It's the last slide in the deck with the email as well as our general (unintelligible) phone number...

((Crosstalk))

Elise Young: ...contact us there.

So hearing that there are no more questions, any final comments.

Man: If there's anyone who hasn't sought out the post please do so, This helps us stretch our next webinar to be more effective for you.

And...

Woman: And I want to thank everyone very much.

And this concludes our call.

Coordinator: Thank you for your participation on the conference call today. At this time all parties may disconnect.

END