

NCQA				TTA	CPG (SIM Appx B)	PTTF Recommendation	TTA Areas	CPCI Areas
Standard 1	Patient-Centered Access				Access and Continuity	NCQA Standard 1 is sufficient.	Integrating Behavioral and Oral health	Access and Continuity
	Element A	Appointment Access					MTM	Patient and Caregiver Engagement
		1	Providing Same Day Appointments for routine and urgent care		NCQA 1A/1B - focus on 24/7 clinical access and alternate clinical encounters.		Dynamic Teams	Care Management for High Risk Patients
	Element B	24/7 Clinical Advice Access					E-consults	Quality Improvement
		2	Providing timely clinical advice by telephone.				CHWs	Care Coordination Across the Medical Neighborhood
	Element C	Electronic Access					Close HE gaps	Shared Decision Making
Standard 2	Team-Based Care			Dynamic Teams		Need to strengthen CLAS in vendor transformation services. Other elements are sufficient.	Care Exp for vulnerable pops	Learning Collab
	Element A	Continuity					Community Linkages for social services and LTSS	HIT
	Element B	Medical Home Responsibilities			Shared Decision Making		Super utilizer interventions	
	Element C	CLAS				Vendor Area of Focus		
	Element D	Practice Team						
		3	Holding scheduled patient care team meetings or structured communication process focused on individual patient care.				Must Pass Element	
Standard 3	Population Health Management			Community Linkages for social services and LTSS; Close HE gaps		NCQA Standard 3 is sufficient.	Critical Factor	
	Element A	Patient Info						
	Element B	Clinical Data						
	Element C	Comprehensive Health Assessment						
	Element D	Use Data for Pop Management						
	Element E	Evidence-Based Decision Support						
		1	A mental health or substance use disorder					
Standard 4	Care Management and Support			Integrating Behavioral and Oral health; MTM; Super-Utilizers	Care Management for High Risk Populations	Will need heavy support from Vendor and TTA to complete promises to CMMI. Requires potential build out and ad hoc discussion for requirements; CPCI gap= self-management for 3 chronic conditions		
	Element A	Identify Patients for Care Management			NCQA 4A,4B,4C all focus on care management, care planning, and med management. Want 95% empanelment. Risk-stratification for 75% of empanelled patients. Provide 80% of high risk patients with care management. Integrate BH, OH, MM.			
		6	The practice monitors the percentage of the total patient population identified through its process and criteria			Need 95% empanelled and 75% risk-stratified.		
	Element B	Care Planning and Self-Care Support						
	Element C	Medication Management		Medication Management				
		1	Reviews and reconciles medications for more than 50% of patients received from care transitions					
	Element D	Use Electronic Prescribing						
	Element E	Support Self-Care and Shared Decision Making			Shared Decision Making: NCQA 4E - support self-care and shared-decision making. Implement shared decision making tools for 2 health conditions and metrics to track use.	More stringent than NCQA - TTA/Vendor should be implemented 2 health condition shared decision making tools.		
Standard 5	Care Coordination and Care Transitions				Care Coordination Across the Medical Neighborhood	Standard 5 is sufficient as is. Vendor should track and monitor usage rates and goals set for CMMI.		
	Element A	Test Tracking and Follow-Up						
		1	Tracks lab tests until results are available, Flagging and following up on overdue results.					
		2	Tracks imaging tests until results are available, Flagging and following up on overdue results.					
	Element B	Referral Tracking and Follow-Up			NCQA 5B/5C care coordination and care transitions. SIM will also track % of patients with ED visits who received follow-up; contact 75% of patients who were hospitalized within 72 hours; collab agreements with at least 2 groups of high-volume specialties to improve care transitions. To track indicators of change: asthma ED visits, Ambulatory Care Sensitive Conditions hospitalizations, readmissions for avoidable complications, medication reconciliation.			
		8	Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports					
	Element C	Coordinate Care Transitions						
Standard 6	Performance Measurement and Quality Improvement				Quality Improvement: NCQA: All of Standard 6; additionally want panel reports on three measures at least quarterly; EHR Clinical quality reports.	Enact adequate monitoring for patient and provider satisfaction and engagement. Create functioning and accountable PFAC. QI measures are sufficient in standard 6; Quality Council will discuss other measures.		

	Element A	Measure Clinical Quality Performance					
	Element B	Measure Resource Use and Care Coordination					
	Element C	Measure Patient/Family Experience		Care Exp for vulnerable pops	Patient and Caregiver Engagement: NCQA 6C - measures patient/family experience. Also investigating PFAC, practice-based monthly surveys, care experience surveys.		
	Element D	Implement Continuous Quality Improvement					
	Element E	Demonstrate Continuous Quality Improvement					