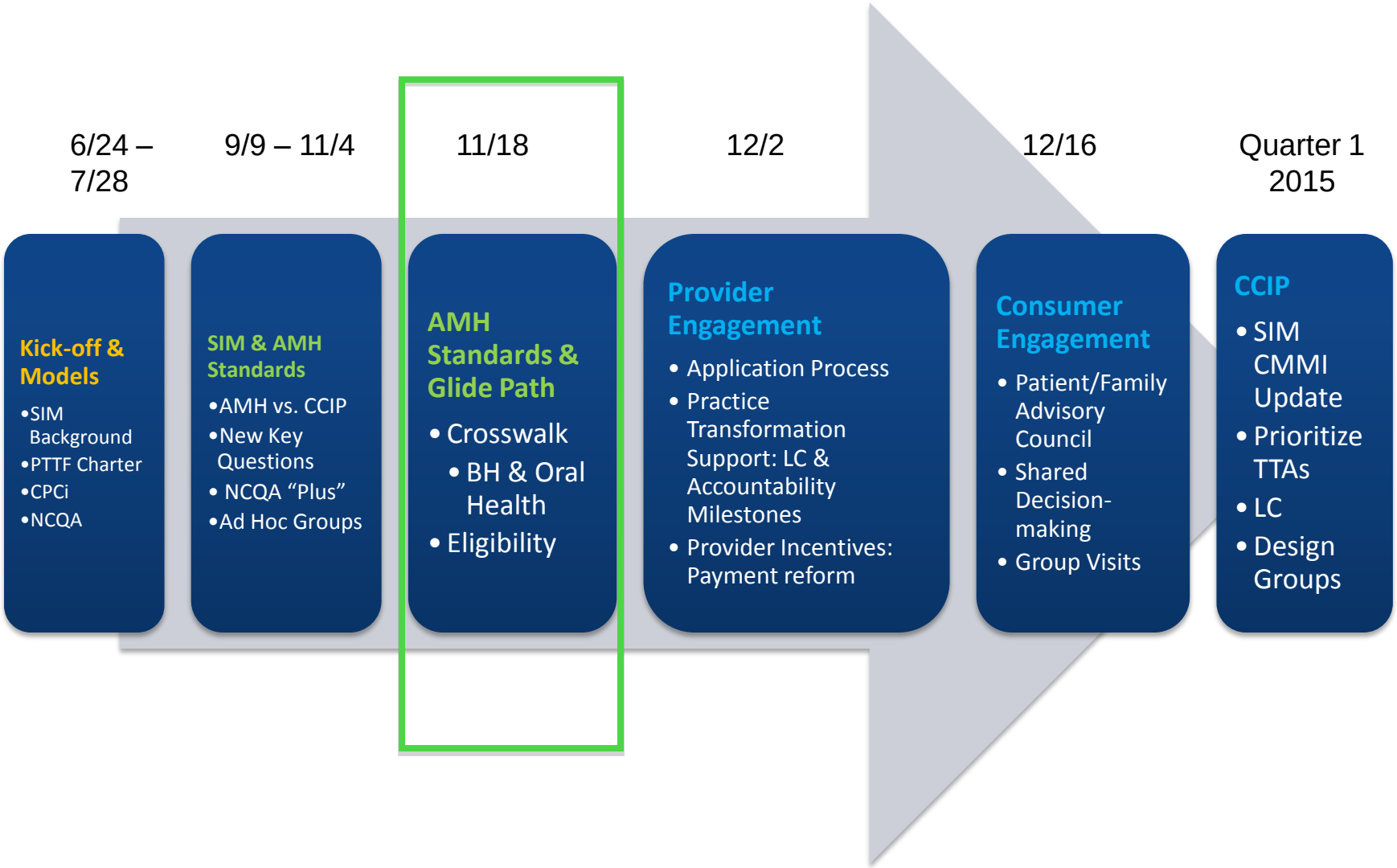
Practice Transformation Taskforce Meeting

November 18th, 2014

Agenda

Introductions/Public Comments
Consensus Decisions to Date
Crosswalk Review – Integrated Oral Health
Crosswalk Review – Standards 5 and 6
Behavioral Health Integration
Eligibility for Enrollment
Next Steps

Practice Transformation Roadmap



Consensus Decisions

- Use of NCQA PCMH 2014 standards as foundation for Advanced Medical Home (AMH) Glide Path Program
- Require NCQA PCMH recognition as a condition for completion of the AMH Glide Path Program
- CCIP will be discussed in depth Quarter 1 2015

Consensus Decisions

- **Plus** selected modifications:
  - Tailor certain must pass elements and critical factors to emphasize key elements of our vision related to
    - Patient centered care
    - Health equity
    - Integrated behavioral health
  - Keep in mind practice burden, avoid the “impossible lift”
  - Use transformation vendors to achieve our vision by emphasizing certain capabilities, going “beyond the standards” in the transformation process

Goals for 11/18

- Complete AMH standards recommendation:
  - Identify additional must-pass elements and critical factors
  - Identify areas of special emphasis for transformation vendors
  - Create new standards/elements/factors (if needed)
  - Integrate Behavioral Health Recommendations
- Practice/Provider Eligibility

Crosswalk

Standard 1 - Patient-Centered Access

No changes recommended

- **Element A: Appointment Access (MUST-PASS)**
  - **1: Providing Same Day Appointments for routine and urgent care (CRITICAL FACTOR)**
- **Element B: 24/7 Clinical Advice Access**
  - **2: Providing timely clinical advice by telephone (CRITICAL FACTOR)**
- **Element C: Electronic Access**
  - **Important but already including in Meaningful Use requirement**

Standard 2: Team-Based Care

- **Element A: Continuity**
- **Element B: Medical Home Responsibilities**
- **Element C: CLAS (Make MUST-PASS)**
  - **1: The practice uses data to assess the diversity and needs of its population so it can meet those needs adequately. Data may be collected by the practice from all patients directly or may be data about the community served by the practice. (MAKE CRITICAL FACTOR)**
  - **Note: Require collection from all patients directly**
  - **Areas of Emphasis - the practice should be knowledgeable about culturally appropriate services and health disparities among patient populations served by the practice.**

Standard 2: Team-Based Care

- **Element D: The Practice Team (MUST PASS)**
  - **3: Holding scheduled patient care team meetings or structured communication process focused on individual patient care. (CRITICAL FACTOR)**

Standard 3: Population Health Management

- **Element A: Patient Information (EHR collection of…)**
  - **2: Race (Make CRITICAL FACTOR)**
  - **3: Ethnicity (Make CRITICAL FACTOR)**
  - **4: Preferred language (Make CRITICAL FACTOR)**
  - **Modify explanation for Factor 14 – require the inclusion of dental provider in the patient information (OH)**
- **Element B: Clinical Data**

Standard 3: Population Health Management

- **Element C: Comprehensive Health Assessment**
  - **2: Family/Social/Cultural characteristics**
  - **10: Assessment of health literacy**
    - **Vendor Area of Emphasis – Training for 2 & 10:** Planetree: Provide meaningful care summaries in a manner that accommodates patient's level of understanding and a language they understand. Patients health & wellness needs are approached holistically & in consideration of person's expressed health goals and activities.
  - **Note:**
    - Planetree: Recommends accommodations be made to integrate individual patients cultural norms, needs, and beliefs into their care and treatment plan upon request
    - HE: Understanding the health needs of the diverse patient populations being served can help inform what family/social/cultural characteristics might be most relevant in the care of an individual patient/family

Standard 3: Population Health Management

- **Element C (pages 52-54)**
  - **Add New Factor 11 – Age appropriate oral health risk and disease screening**
  - **Add Explanation - Factor 11 - The practice implements age appropriate oral health risk and disease assessment, including assessments for caries, periodontal disease and oral cancer.**
  - **Add Documentation – change from Factor 1 – 10 to Factor 1 - 11**

Standard 3: Population Health Management

No changes

- **Element D: Use Data for Pop Management (MUST-PASS)**
  - **Modify explanation - Factor 1 – add to (e.g. list – referral to local dental home and fluoride application as applicable)**
- **Element E: Evidence-Based Decision Support**
  - **1: A mental health or substance use disorder (CRITICAL FACTOR)**

Standard 4: Care Management and Support

- **Element A: Identify Patients for Care Management**
  - 4: Social determinants of health (leave normal factor)
  - **6: The practice monitors the percentage of the total patient population identified through its process and criteria (CRITICAL FACTOR)**
  - **Add New Factor 7: Oral health conditions**
    - Add to Explanation: Factor 7: The practice has specific criteria for identifying and referring patients with oral disease conditions.
  - Criteria are developed from a profile of patient assessments and may include the following or a combination of the following:
    - A diagnosis of an oral health issue (e.g. oral health risk and disease assessment to include caries, periodontal disease and cancer detection)
    - A positive diagnosis by a dentist of an oral disease condition or risk of the disease.
  - Add to Documentation – Factor 1 – 5, 7

Standard 4: Care Management and Support

- **Element B: Care Planning and Self-Care Support (MUST-PASS)**
  - **1: Incorporates patient preferences and functional/lifestyle goals (Make CRITICAL FACTOR)**
  - **Instead of adding a few Factor 6: "Have a process in place for when an adverse clinical event or unanticipated outcome occurs to provide support to patient/family and staff affected" the Task Force recommended that we add empathic communication as an area of emphasis**
  - **QC member asked whether this is captured in CAHPS? (See RWJF Issue Brief)**

Standard 4: Care Management and Support

- **Element C: Medication Management**
  - **1: Reviews and reconciles medications for more than 50% of patients received from care transitions (CRITICAL FACTOR)**

  Note: care transitions include medical and behavioral health settings

- **Element D: Use Electronic Prescribing**

Standard 4: Care Management and Support

- **Element E: Support Self-Care and Shared Decision Making**
  - **2: Provides educational materials and resources to patients (Make CRITICAL FACTOR)**
  - **4: Adopts shared decision making tools**
  - **Note 1: Task Force recommends area of emphasis on shared decision making processes, but not necessarily use of tools**
  - **6: Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates (Make CRITICAL FACTOR)**
  - **Note 2: Task Force recommends identifying two target health conditions for Element E (as a whole) – vendor task**

Resume Standards Review

Standard 4: Care Management and Support

Proposed Vendor Areas of Emphasis:

- Require 95% empanelment
  - "Empanelled" means that all attributed patients have a designated provider/care team within the practice and that systems are in place to produce reports based on provider/care team
- Risk-stratification for 75% of empanelled patients
  - Group patients based on risk low, medium, high
- Provide 80% of high risk patients with care management

Standard 5: Care Coordination and Care Transitions

- **Element A: Test Tracking and Follow-Up**
  - **1: Tracks lab tests until results are available, Flagging and following up on overdue results. (CRITICAL FACTOR)**
  - **2: Tracks imaging tests until results are available, Flagging and following up on overdue results. (CRITICAL FACTOR)**
  - **5: Notifies patients/family of normal and abnormal lab and imaging test results (Make CRITICAL FACTOR)**

Standard 5: Care Coordination and Care Transitions

- **Element B: Referral Tracking and Follow-Up (Must Pass)**
  - **8: Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports (CRITICAL FACTOR)**
- **Element C: Coordinate Care Transitions**
  - **6: Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners (Make CRITICAL FACTOR)**

Standard 5: Care Coordination and Care Transitions

Proposed areas of emphasis :

- SIM will also track % of patients with ED visits who received follow-up; Practice responsible to contact 75% of patients who were hospitalized within 72 hours; collaborative agreements with at least 2 groups of high-volume specialties to improve care transitions.
- Metrics required for: asthma ED visits, Ambulatory Care Sensitive Condition hospitalizations, readmissions for avoidable complications, and medication reconciliation.

Standard 6: Performance Measurement and Quality Improvement

- **Element A: Measure Clinical Quality Performance**
  - **2: Explanation - add:**
    - Oral health risk and disease assessment , use of fluoride varnish and counseling
  - **4: Performance data stratified for vulnerable populations (to assess disparities in care) (Make CRITICAL FACTOR)**
- **Element B: Measure Resource Use and Care Coordination**

Standard 6: Performance Measurement and Quality Improvement

- **Element C: Measure Patient/Family Experience (Make MUST-PASS)**
  - **3: The practice obtains feedback on experiences of vulnerable patient groups (Make CRITICAL FACTOR)**
  - **4: The practice obtains feedback from patients/families through qualitative means (Make CRITICAL FACTOR)**

Connects to 2D: The Practice Team

- HE: Patients/families/caregivers from culturally and linguistically diverse backgrounds should be recruited for involvement in quality improvement activities or the practice's advisory council
- Planetree: Patient experience need to be regularly assessed, patients/families need to be actively involved in the design, ongoing assessment, and communication of performance improvement.

Standard 6: Performance Measurement and Quality Improvement

- **Element D: Implement Continuous Quality Improvement (MUST-PASS)**
  - **5: Set goals and analyze at least one patient experience measure (Make CRITICAL FACTOR)**
  - **7: Set goals and address at least one identified disparity in care/service for identified vulnerable population (Make CRITICAL FACTOR)**
- **Element E: Demonstrate Continuous Quality Improvement**
- **Element F: Report Performance**
- **Element G: Use of Certified EHR Technology**
  - **Eligibility requirement for participation in AMH Glide Path program**

Standard 6: Performance Measurement and Quality Improvement

Discussion Topics:

- New Element or area of emphasis: primary care team satisfaction and engagement?
- New Element or area of emphasis: Create functioning and accountable Patient/Family Advisory Council

Proposed BH Elements and Factors

Standard 1 - Patient-Centered Access

Element A: Appointment Access (MUST-PASS)

- **1: Providing Same Day Appointments for routine and urgent care (CRITICAL FACTOR)**
- **5: Monitoring no-show rates (Make CRITICAL FACTOR)**
  - Has to be some kind of tracking system. Practices need to monitor and engage in rapid performance improvement process; need to know the profile of people not appearing for appointments and the reasons for not showing--could be barriers such as housing, transportation, etc., at play. Can point to underlying causes related to social determinants (i.e., housing, transportation, cost considerations such as co-payments), plus a person's health condition(s)

Standard 1 - Patient-Centered Access

Element B: 24/7 Clinical Advice Access

- **2: Providing timely clinical advice by telephone (CRITICAL FACTOR)**

Element C: Electronic Access

Standard 2: Team-Based Care

Element A: Continuity

- **4: Collaborating with the patient/family to develop/implement a written care plan for transitioning from pediatric care to adult care (Make CRITICAL FACTOR)**
  - This is an area where many young adults drop out of treatment and do not surface again until there is a significant issue.

Element B: Medical Home Responsibilities

Element C: CLAS

- **1: Assessing the diversity of its population (Make CRITICAL FACTOR)**
  - This is a **critical** component for the **medical population**, which would include BH patients. Should at least require assessment.

NOTE: ITEMS IN GREEN WERE PREVIOUSLY RECOMMENDED AS CRITICAL FACTORS.

Standard 2: Team-Based Care

Element D: The Practice Team (MUST PASS)

- **3: Holding scheduled patient care team meetings or structured communication process focused on individual patient care. (CRITICAL FACTOR)**

Standard 3: Population Health Management

Element A: Patient Information (EHR collection of…)

Element B: Clinical Data

Element C: Comprehensive Health Assessment

- **6: Behaviors affecting health (Make CRITICAL FACTOR)**
- **7: Mental health/substance use history of patient and family (Make CRITICAL FACTOR)**
- **8: Developmental screening using a standardized tool (NA for practices with no pediatric patients (Make CRITICAL FACTOR)**
- **9: Depression screening for adults and adolescents using a standardized tool (Make CRITICAL FACTOR)**

Standard 3: Population Health Management

Element D: Use Data for Pop Management (MUST-PASS)

Element E: Evidence-Based Decision Support

- **1: A mental health or substance use disorder (CRITICAL FACTOR)**
  - Add to explanation: A decision-tree exists for assessment, brief treatment and referral to specialty care for patients with BH disorders.
- **4: A condition related to unhealthy behaviors (Make CRITICAL FACTOR)**
- **6: Overuse/appropriateness issues (Make CRITICAL FACTOR)**

Standard 4: Care Management and Support

Element A: Identify Patients for Care Management

- **1: Behavioral health conditions (Make CRITICAL FACTOR)**
- 6: The practice monitors the percentage of the total patient population identified through its process and criteria (CRITICAL FACTOR)
  - Add to explanation: The practice should include BH diagnoses in monitoring patients with medical conditions requiring care management.

Standard 4: Care Management and Support

Element B: Care Planning and Self-Care Support (MUST-PASS)

- **1: Incorporates patient preferences and functional/lifestyle goals (Make Critical Factor)**
  - *Highly desirable.* Important to keeping patient with BH issues engaged. Should include BH goals when identified. Include functional and lifestyle goals. Aligns with recovery-oriented systems of care (DMHAS)

Standard 4: Care Management and Support

Element C: Medication Management

- **1: Reviews and reconciles medications for more than 50% of patients received from care transitions (CRITICAL FACTOR)**
- **5: Assesses response to medications and barriers to adherence for more than 50% of patients, and dates the assessment (Make CRITICAL FACTOR)**

Element D: Use Electronic Prescribing

- **3: Performs patient-specific checks for drug-drug and drug-allergy interactions (Make CRITICAL FACTOR)**

Element E: Support Self-Care and Shared Decision Making

Standard 5: Care Coordination and Care Transitions

Element A: Test Tracking and Follow-Up

- **1: Tracks lab tests until results are available, Flagging and following up on overdue results. (CRITICAL FACTOR)**
- **2: Tracks imaging tests until results are available, Flagging and following up on overdue results. (CRITICAL FACTOR)**
- **5: Notifies patients/families of normal and abnormal lab and imaging test results (Make CRITICAL FACTOR)**

Standard 5: Care Coordination and Care Transitions

Element B: Referral Tracking and Follow-Up (Must Pass)

- **8: Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports (CRITICAL FACTOR)**

Element C: Coordinate Care Transitions

- **1: Proactively identifies patients with unplanned hospital admissions and emergency department visits (Make CRITICAL FACTOR)**
- **2: Shares clinical information with admitting hospitals and emergency departments (Make CRITICAL FACTOR)**
- **6: Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners (Make CRITICAL FACTOR)**

Standard 6: Performance Measurement and Quality Improvement

Element A: Measure Clinical Quality Performance

Element B: Measure Resource Use and Care Coordination

Element C: Measure Patient/Family Experience

Standard 6: Performance Measurement and Quality Improvement

Element D: Implement Continuous Quality Improvement (MUST-PASS)

Element E: Demonstrate Continuous Quality Improvement

Element F: Report Performance

Element G: Use of Certified EHR Technology

Practices/Practitioners Eligible for Enrollment in the Glide Path

Provider/Practice Eligibility

- What type of practice should be permitted to participate?
- What type of practitioner should be eligible for designation as an AMH practitioner?

Default positions

1. Align with NCQA criteria to reduce confusion and administrative burden for PMO, unless there is a reason to depart from NCQA rules to achieve our vision

2. Designation does not have implications for attribution, any payer is still free to attribute a patient to a practitioner without regard to their status as a PCMH practice or practitioner within a practice.

Proposed CT AMH Eligibility Criteria

1. **Practices:**
   - Internal medicine, family medicine, pediatrics, geriatrics, and FQHCs
   - Medical specialty practice that can demonstrate that it provides whole person care and meets the other elements of the joint principles for most of its patients (at least 75 percent), it can be eligible for PCMH recognition by NCQA even if it is not a traditional primary care practice

2. **Practitioners:**
   - Physicians (MDs and DOs) and APRNs
   - Medical specialists (e.g., Ob-Gyns, Cardiologists, Endocrinologists)

Proposed CT AMH Eligibility Criteria

4. **EHRs are required.**

5. **Not currently recognized as existing medical home including NCQA 2011 or 2014**

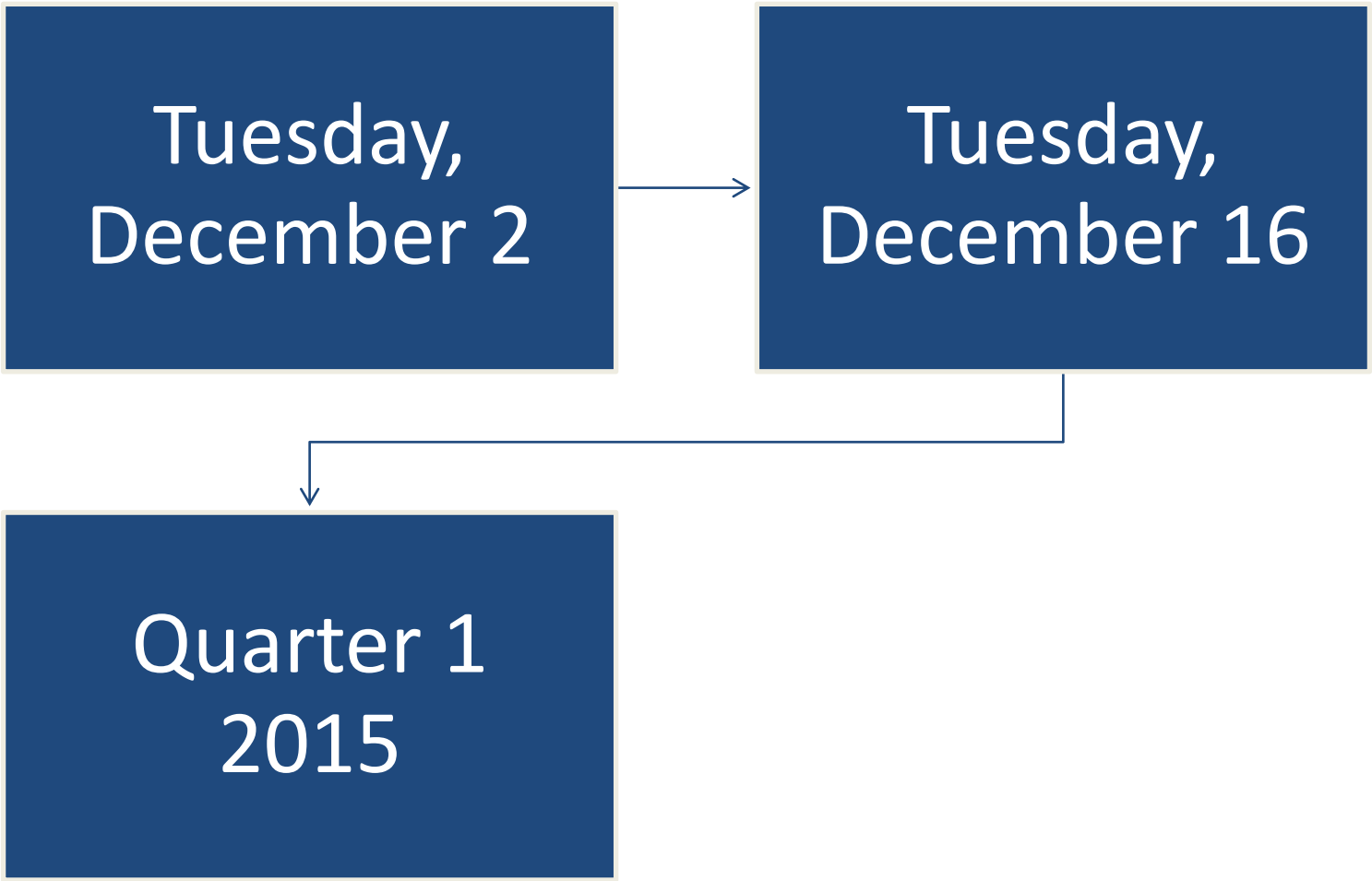
6. **Commitment to apply for NCQA 2014 medical home recognition**

7. **Commitment to participate in the Learning Collaborative**

OTHER DETERMINANTS for DISCUSSION

- **Other Practices: School-based clinics? Free clinics? Hospital outpatient clinics?**
  - **SBHCs** - propose alignment with Medicaid rules: **eligible** if parent entity is hospital, FQHC or physician group in AMH program
  - **Free clinic - not eligible** because use of SIM federal funds and free-clinics are inconsistent with the terms of the SIM cooperative agreement with CMMI. Potential for outside funding.
  - **Hospital Outpatient Clinics** - propose to make **eligible;** this is an area where our advanced networks may not be as advanced.
- **Other Providers: Medical residents? Community preceptors?**
  - To be determined

Meeting Schedule



Appendix

NCQA Recognition

PCMH 2014 SCORING

Scoring Summary

Recognition Levels	Required Points	Must-Pass Elements
Level 1	35–59 points	▪ 6 of 6 elements are required for each level ▪ Score for each Must-Pass element must be ≥ 50%
Level 2	60–84 points	
Level 3	85–100 points	

100 Points, 27 Elements, 6 Must-Pass Elements

Intro to Crosswalk

- Our AMH Standards are based on NCQA standards, elements, and factors
- NCQA standards contain "must pass" elements and "critical factors" that every practice has to meet.
- Crosswalk lists all of the 2014 standards and the NCQA "must pass" elements and "critical factors"

Intro to Crosswalk

- Our job is to consider whether other elements should be "must pass" or other factors should be "critical" because they align with parts of our vision.
  - Are they essential to advancing health equity?
  - Are they essential to patient-centered care?
  - Are they essential to integrated Behavioral Health?
- To help up do this the crosswalk presents additional "must pass" elements or "critical factors" that we recommend for based on their alignment

Patient-Centered Medical Home 2014

(6 standards/27 elements)

1) **Patient-Centered Access (10)**
   - A) ***Patient-Centered Appointment Access (4.5)**
   - B) 24/7 Access to Clinical Advice (3.5)
   - C) Electronic Access (2)
2) **Team-Based Care (12)**
   - A) Continuity (3)
   - B) Medical Home Responsibilities (2.5)
   - C) Culturally and Linguistically Appropriate Services (2.5)
   - D) ***The Practice Team (4)**
3) **Population Health Management (20)**
   - 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)
4) **Care Management and Support (20)**
   - 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)
5) **Care Coordination and Care Transitions (18)**
   - A) Test Tracking and Follow-Up (6)
   - B) ***Referral Tracking and Follow-Up (6)**
   - C) Coordinate Care Transitions (6)
6) **Performance Measurement and Quality Improvement (20)**
   - 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)

***Indicates Must Pass Element**

Intro to Crosswalk (continued)

Impact of altering Must Pass/Critical:

•Critical Factor: must achieve factor to be eligible for points

"Must Pass" designation: must achieve score of 50% in the factors

EXAMPLE - Standard 2: Team-based Care (12 Point Total)

A: Continuity (3 points)

B: Medical Home Responsibility (2.5 points)

C: CLAS (2.5 Points)

D: The Practice Team **(Must-Pass)** (4 points)

- 10 factors total; to reach the 50% required pass threshold they must meet 5-7 factors including the "Critical Factor"

Adding critical factors will help to target the areas of focus.

Intro to Crosswalk (continued)

- In making these recommendations we considered the recommendations of:
  - Planetree for patient centered care
  - Ignatius Bau, health equity and health policy consultant
- We made additional recommendations based on best practices
- Finally, we promised CMMI we would consider alignment with CMMI's Comprehensive Primary Care Initiative (CPCI) standards. We suggest additional CPCI aligned "must pass" elements or "critical factors" for consideration.