

# Practice Transformation Taskforce Meeting

December 16, 2014



# Agenda

Introductions/Public Comments



Consensus Decisions to Date



Crosswalk Review – Standards 5-6 (With BH & OH & Consumer Engagement)



Eligibility for Enrollment



Next Steps

# 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

- We have reviewed standards 1-4 with the integration of Oral Health and Behavioral Health
  - Established new critical factors and must pass elements
- We have added areas of emphasis to supplement NCQA and create our “NCQA Plus”

# Goals for 12/2

- Complete AMH standards recommendation (5 and 6):
  - Identify additional must-pass elements and critical factors
  - Identify areas of emphasis for transformation vendors
  - Create new standards/elements/factors (if needed)
  - Integrate Behavioral Health & Oral Health Recommendations
- Practice/Provider Eligibility

# Crosswalk



# **Resume Standards Review**

# Standard 5: Care Coordination and Care Transitions

## 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 (Voted to make CRITICAL FACTOR)**
  - **BH recommendation and HE/Plantetree Recommendation**

# 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: Modify Explanation to 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)**

# 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?**

# Consumer Engagement in the Standards

- **Patient Family Advisory Councils**

- 2: Team Based Care: D - The Practice Team (must pass element)

- 10: Involving patients/families/caregivers in quality improvement activities or on practice's advisory council

- 6: Performance Measurement and QI: C – Measure Patient/Family Experience

- 4: The practice obtains feedback from patients/families through qualitative means.

- **Propose Area of Emphasis**

# Consumer Engagement in the Standards

- **Shared-Decision Making**
  - Standard 4: Voted to make Shared Decision Making an area of emphasis and to develop a shared decision making plan for 2 health conditions
- **Group Visits**
  - Standard 1: Patient-Centered Access: A – Patient-Centered Appointment Access
    - 3: Providing alternative types of clinical encounters
    - In lieu of traditional visit: Group visits where the patient is one of several patients scheduled for care and education at the same time.
  - **No proposed changes**



# 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?
- Surveyed Medicaid and 3 Commercial Payers and compared with CPCI and NCQA to inform a local and national perspective to propose our eligibility criteria

# 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, FQHCs, hospital outpatient clinics, School Based Health Centers (provided if they close for part of the year the group sees their patients at another site with access to the medical records)
- 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), APRNs, Physician Assistants (provided they manage their own panel)
- Medical specialists (e.g., Ob-Gyns, Cardiologists, Endocrinologists)
- Medical residents and preceptors (the resident will not be listed and the preceptor must be physically at the practice site)

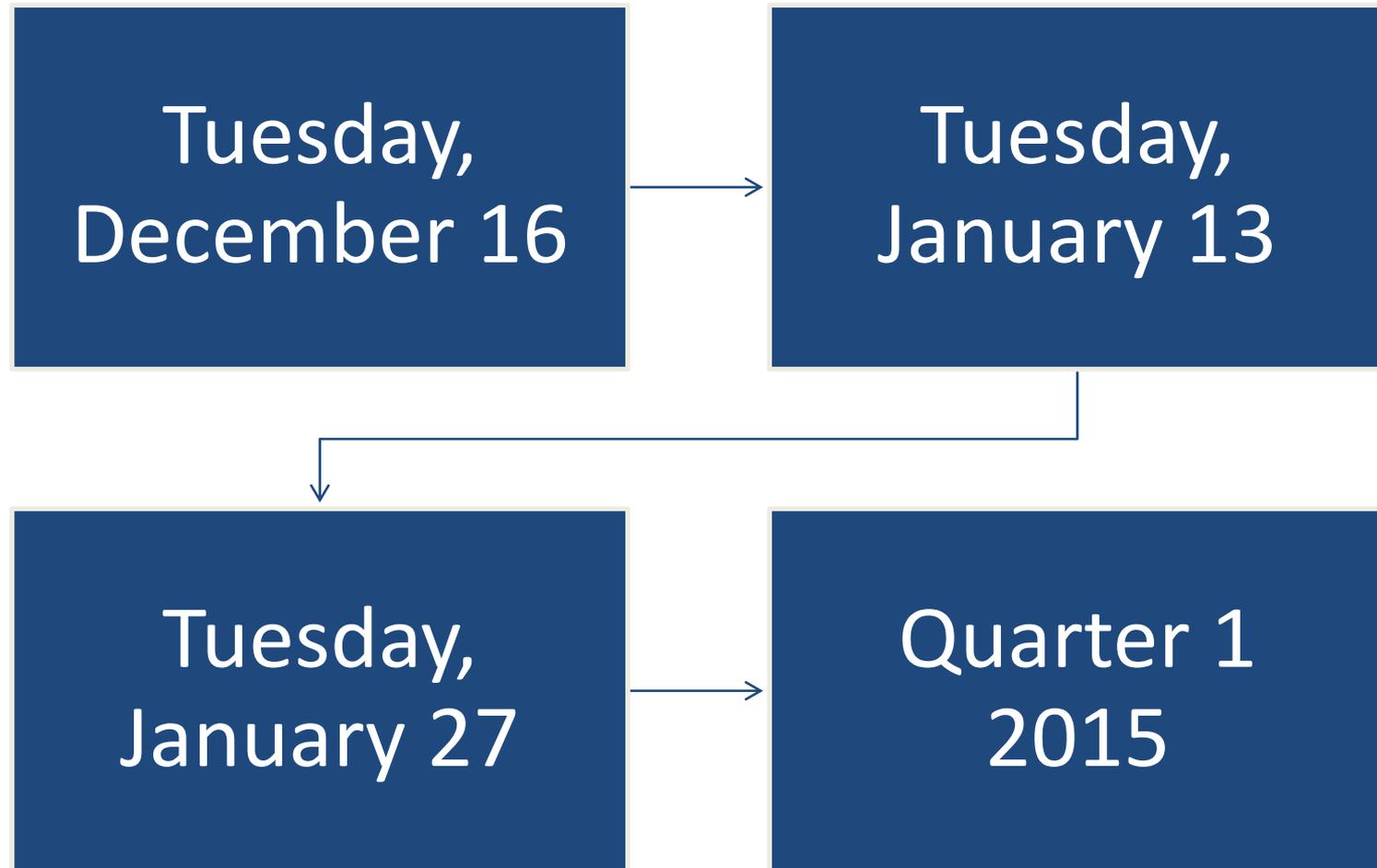
# Proposed CT AMH Eligibility Criteria

- 3. EHRs are required.**
- 4. Not currently recognized as existing medical home including NCQA 2011 or 2014**
- 5. Commitment to apply for NCQA 2014 medical home recognition**
- 6. Commitment to participate in the Learning Collaborative**

# Other Determinants for Discussion

- **Other Practices: Free clinics?**
  - **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.

# Meeting Schedule



# Appendix

# NCQA Recognition

## PCMH 2014 SCORING

### Scoring Summary

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Recognition Levels	Required Points	Must-Pass Elements
Level 1	35–59 points	<ul style="list-style-type: none"><li>▪ 6 of 6 elements are required for each level</li><li>▪ Score for each Must-Pass element must be <math>\geq 50\%</math></li></ul>
Level 2	60–84 points	
Level 3	85–100 points	

**100 Points, 27 Elements, 6 Must-Pass Elements**

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# 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.

# 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 (Voted to keep optional)**
  - 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)
- **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**  
**(Voted to 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.
  - Concern with documentation. Is just documenting effective?

- **Element B: Medical Home Responsibilities**

# Standard 2: Team-Based Care

- **Element C: CLAS (Voted to 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. (Voted to 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.**

## 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 (**Voted to Make CRITICAL FACTOR**)
  - 3: Ethnicity (**Voted to Make CRITICAL FACTOR**)
  - 4: Preferred language (**Voted to Make CRITICAL FACTOR**)
  - **Modify explanation for Factor 14 – require the inclusion of dental provider in the patient information (OH)**
    - **Concern is there a clear EHR field for Dentist?**
- **Element B: Clinical Data**

# Standard 3: Population Health Management

## Element C: Comprehensive Health Assessment

- 6: Behaviors affecting health **(Voted to keep optional)**
- 7: Mental health/substance use history of patient and family **(Voted to Make CRITICAL FACTOR)**
- 8: Developmental screening using a standardized tool (NA for practices with no pediatric patients) **(Voted to Make CRITICAL FACTOR)**
- 9: Depression screening for adults and adolescents using a standardized tool **(Voted to Make CRITICAL FACTOR)**
- **Vendor Area of Emphasis – Training for 2 & 10:**
  - Support of Family/Social/Cultural Characteristics & Assessment of Health Literacy. With these factors also support empathetic care and techniques.

# Standard 3: Population Health Management

- **Element C (pages 52-54)**
  - Area of emphasis – Age appropriate oral health risk and disease screening, the practice implements age appropriate oral health risk and disease assessment, including assessments for caries, periodontal disease and oral cancer.
  - **Voted to make area of emphasis rather than new factor**
  - **Questions & Concerns: How will payment work for OH? Training and services?**

# Standard 3: Population Health Management

## 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)**
  - **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 (Voted to keep optional)**
- **6: Overuse/appropriateness issues (Voted to keep optional)**

# Standard 4: Care Management and Support

- **Element A: Identify Patients for Care Management**
  - **1: Behavioral health conditions (Voted to Make CRITICAL FACTOR)**
  - **4: Social determinants of health (Voted to keep optional)**
  - **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 A: Identify Patients for Care Management**
  - ~~Add New Factor 7: Oral health conditions~~ (Voted to make an area of emphasis)
  - 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.

# Standard 4: Care Management and Support

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

- **1: Incorporates patient preferences and functional/lifestyle goals (Voted to make Critical Factor)**
  - *BH 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)*
- **Instead of adding a new 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)**
- **5: Assesses response to medications and barriers to adherence for more than 50% of patients, and dates the assessment (Voted to Make CRITICAL FACTOR)**

## Element D: Use Electronic Prescribing

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

# Standard 4: Care Management and Support

- **Element E: Support Self-Care and Shared Decision Making**
  - **2: Provides educational materials and resources to patients (Voted to keep NCQA As Is)**
    - **Area of Emphasis**
  - **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 (Voted to keep NCQA as is)**
  - **Note 2: Task Force recommends identifying two target health conditions for Element E (as a whole) – vendor task (Voted to keep at area of emphasis)**

# 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

Note: Is above possible without advance/enhanced payment from most payers including Medicare?

# 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 (Voted to keep NCQA as is)**

# Standard 5: Care Coordination and Care Transitions

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

- **3: Maintains agreements with Behavioral Healthcare providers (Voted to Make CRITICAL FACTOR)**
- **8: Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports (CRITICAL FACTOR)**
- **9: Documents co-management arrangements in the patient's medical record. (Voted to keep NCQA as is)**
- **10: Asks patients/families about self-referrals and requesting reports from clinicians. (Voted to keep NCQA as is)**