Healthcare Innovation Steering Committee

Practice Transformation Task Force Update

Community and Clinical Integration Program Strategy & Advanced Medical Home Standards

February 5, 2015

Practice Transformation Task Force

- Responsible for recommendations to the Healthcare Innovation Steering Committee regarding the design of the Advanced Medical Home model and the Community and Clinical Integration Program under the Connecticut Healthcare Innovation Plan and model test grant
- Phase 1: Advanced Medical Home model
- Phase 2: Community and Clinical Integration Program

Community and Clinical Integration Program (CCIP)

- Nine focus areas common to advanced networks and FQHCs
  - integrating behavioral health and oral health integration,
  - providing medication therapy management services,
  - building dynamic clinical teams, expanding e-consults between primary care providers and specialists,
  - incorporating community health workers as health coaches and patient navigators,
  - closing health equity gaps,
  - improving the care experience for vulnerable populations,
  - establishing community linkages with providers of social services, long term supports and services (LTSS), and preventive health; and
  - identifying “super utilizers” for community care team interventions.

Community and Clinical Integration Program (CCIP)

- Before undertaking the detailed design of these initiatives, we will further examine these focus areas
- We will consider issues such as:
  - the extent to which these items are related and can be clustered under broader domains
  - the extent to which there are essential or important capabilities that have been omitted
  - the extent to which these items include all of the areas that are of the highest priority or would be view as high value to emerging advanced networks (locally and nationally)
  - The extent to which these items align with core capabilities as established by NCQA and URAC in their ACO and clinically integrated network standards
  - The extent to which our focus on these capabilities may depend on the foundational capabilities and level of maturation of the advanced network

National Committee for Quality Assurance (NCQA)

- Reviewed a comparison of national PCMH accreditation and recognition programs and discussed the option of using a single existing national medical home standard or developing a new medical home standard drawn from existing standards
- Recommended use of the 2014 NCQA PCMH standards
  - created and vetted by expert panels,
  - have undergone revisions since 2008, and
  - have approximately 80% of the national market share for PCMH recognition
- Further recommended that practices be required to obtain PCMH recognition as a condition for completing the Glide Path and obtaining the AMH designation

Advanced Medical Home

- If we are using NCQA 2014 standards, is there something special or additional that would be required to receive the AMH designation?
- Task Force referred back to the vision and key points of emphasis in our Innovation Plan
  - Integrated behavioral health
  - Integrated oral health
  - Health equity
  - Prevention
  - Whole person centered/care experience
- Also considered capabilities that are the focus of CMMI's Comprehensive Primary Care Initiative (CPCI)

Advanced Medical Home

- To understand our approach, it's important to understand how the NCQA standards work

National Committee for Quality Assurance

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**

NCQA PCMH - Scoring

- Each standard contains 1 Must-Pass Element
- All 6 standards are required to be recognized as an NCQA PCMH practice
- Each standard is composed of various elements (27 total) which provide details about performance expectations
- Elements all have unique scoring rubrics based on completion of factors
  - Factors are the scored items in an element
  - A *critical factor* is required for practices to receive more than minimal points—or, for some factors, any points. Critical factors are identified in the scoring section of the element.

NCQA PCMH - Scoring

- Impact of altering Must Pass/Critical:
  - "Critical Factor" – although the rules vary by element, provider typically must achieve factor to be eligible for points
  - "Must Pass" - must achieve score of 50% in the scoring rubric for an element

- 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 determine what the vendor and the provider focus on during the transformation process

NCQA Level Requirement (TO BE DISCUSSED)

Level of Qualifying	Points
Level 3	85 - 100
Level 2	60 - 84
Level 1	35 - 59
Not Recognized	0 - 34

NCQA Full Standard Review – Standards

- **Standard 1: Patient-Centered Access**
- **Standard 2: Team-based Care**
- **Standard 3: Population Health Management**
- **Standard 4: Care Management and Support**
- **Standard 5: Care Coordination and Care Transitions**
- **Standard 6: Performance Measurement and Quality Improvement**

NCQA Full Standard Review –Elements

- **Standard 1: Patient-Centered Access**
  - Element A: Patient-centered Appointment Access
  - Element B: 24/7 Access to Clinical Advice
  - Element C: Electronic Access
- **Standard 2: Team-based Care**
  - Element A: Continuity
  - Element B: Medical Home Responsibilities
  - Element C: Cultural and Linguistic Appropriate Services
  - Element D: The Practice Team
- **Standard 3: Population Health Management**
  - Element A: Patient Information
  - Element B: Clinical Data
  - Element C: Comprehensive Health Assessment
  - Element D: Use Data for Population Health Management
  - Element E: Implement Evidence-Based Decision Support

NCQA Full Standard Review – Must Pass Elements

- **Standard 4: Care Management and Support**
  - Element A: Identify Patients for Care Management
  - Element B: Care Planning and Self-Care Support
  - Element C: Medication Management
  - Element D: Use Electronic Prescribing
  - Element E: Support Self-Care and Shared Decision Making
- **Standard 5: Care Coordination and Care Transitions**
  - Element A: Test Tracking and Follow-Up
  - Element B: Referral Tracking and Follow Up
  - Element C: Coordinate Care Transitions
- **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
  - Element D: Implement Continuous Quality Improvement
  - Element E: Demonstrate Continuous Quality Improvement
  - Element F: Report Performance
  - Element G: Use Certified EHR Technology

NCQA Full Standard Review - Factors

- **Standard 1: Patient-Centered Access**
  - Element A: Patient-centered appointment access. (MUST-PASS)
    1. Providing same-day appointments for routine and urgent care. (CRITICAL)
    2. Providing routine and urgent-care appointments outside regular business hours.
    3. Providing alternative types of clinical encounters.
    4. Availability of appointments.
    5. Monitoring no-show rates.
    6. Acting on identified opportunities to improve access.
  - Element B: 24/7 Access to Clinical Advice
    1. Providing continuity of medical record information for care and advice when office is closed.
    2. Providing timely clinical advice by telephone. (CRITICAL)
    3. Providing timely clinical advice using a secure, interactive electronic system.
    4. Documenting clinical advice in patient records.

NCQA Full Standard Review - Factors

- **Standard 1: Patient-Centered Access**
  - Element C: Electronic Access
    1. More than 50 percent of patients have online access to their health information within four business days of when the information is available to the practice.
    2. More than 5 percent of patients view, and are provided the capability to download, their health information or transmit their health information to a third party.
    3. Clinical summaries are provided within 1 business day for more than 50 percent of office visits.
    4. A secure message was sent by more than 5 percent of patients.
    5. Patients have two-way communication with the practice.
    6. Patients can request appointments, prescription refills, referrals and test results.

NCQA Full Standard Review - Factors

- **Standard 2: Team-Based Care**
  - Element A: Continuity
    1. Assisting patients/families to select a personal clinician and documenting the selection in practice records.
    2. Monitoring the percentage of patient visits with selected clinician or team.
    3. Having a process to orient new patients to the practice.
    4. Collaborating with the patient/family to develop/implement a written care plan for transitioning from pediatric care to adult care.
  - Element B: Medical Home Responsibilities
    1. The practice is responsible for coordinating patient care across multiple settings.
    2. Instructions for obtaining care and clinical advice during office hours and when the office is closed.
    3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice.

NCQA Full Standard Review - Factors

- **Standard 2: Team-Based Care**
  - Element B: Medical Home Responsibilities
    4. The care team provides access to evidence-based care, patient/family education and self-management support.
    5. The scope of services available within the practice including how behavioral health needs are addressed.
    6. The practice provides equal access to all of the patients regardless of source of patient.
    7. The practice gives uninsured patients information about obtaining coverage.
    8. Instructions on transferring records to the practice, including a point of contact at the practice.

NCQA Full Standard Review - Factors

- **Standard 2: Team-Based Care**
  - Element C: Culturally and Linguistically Appropriate Services
    1. Assessing the diversity of its population.
    2. Assessing the language needs of its population.
    3. Providing interpretation or bilingual services to meet the language needs of its population.
    4. Providing printed materials in the languages of its population.
  - Element D: The Practice Team (MUST-PASS)
    1. Defining roles for clinical and nonclinical team members.
    2. Identifying the team structure and the staff who lead and sustain team based care.
    3. Holding scheduled patient care team meetings or a structured communication process focused on individual patient care. (CRITICAL)
    4. Using standing orders for services.
    5. Training and assigning members of the care team to coordinate care for individual patients.

NCQA Full Standard Review - Factors

- **Standard 2: Team-Based Care**
  - Element D: The Practice Team (MUST-PASS)
    6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change.
    7. Training and assigning members of the care team to manage the patient population.
    8. Holding scheduled team meetings to address practice functioning.
    9. Involving care team staff in the practice's performance evaluation and quality improvement activities.
    10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council.

NCQA Full Standard Review - Factors

- **Standard 3: Population Health Management**
  - Element A: Patient Information
    1. Date of birth
    2. Sex.
    3. Race.
    4. Ethnicity
    5. Preferred language.
    6. Telephone numbers.
    7. E-mail address.
    8. Occupation (NA for pediatric purposes)
    9. Dates of previous clinical visits.
    10. Legal guardian/health care proxy.
    11. Primary caregiver.
    12. Presence of advance directives (NA for pediatric purposes)
    13. Health insurance information.
    14. Name and contact information of other health care professionals involved in patient's care.

NCQA Full Standard Review - Factors

- **Standard 3: Population Health Management**
  - Element B: Clinical Data
    1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients.
    2. Allergies, including medication allergies and adverse reactions, for more than 80 percent of patients.
    3. Blood pressure, with the date of update, for more than 80 percent of patients 3 years and older.
    4. Height/length for more than 80 percent of patients.
    5. Weight for more than 80 percent of patients.
    6. System calculates and displays BMI.
    7. System plots and displays growth charts (length/height, weight and head circumference) and BMI percentile (0-20 years) (NA for adult practices)
    8. Status of tobacco use for patients 13 years and older for more than 80 percent of patients.
    9. List of prescription medications with date of updates for more than 80 percent of patients.

NCQA Full Standard Review - Factors

- **Standard 3: Population Health Management**
  - Element B: Clinical Data
    10. More than 20 percent of patients have family history recorded as structured data.
    11. At least one electronic progress note created, edited and signed by an eligible professional for more than 30 percent of patients with at least one office visit.
  - Element C: Comprehensive Health Assessment
    1. Age- and gender appropriate immunizations and screenings.
    2. Family/social/cultural characteristics
    3. Communication needs.
    4. Medical history of patient and family.
    5. Advance care planning (NA for pediatric purposes).
    6. Behaviors affecting health.
    7. Mental health/substance use history of patient and family.
    8. Developmental screening using a standardized tool (NA for practices with no pediatric patients).

NCQA Full Standard Review - Factors

- **Standard 3: Population Health Management**
  - Element C: Comprehensive Health Assessment
    9. Depression screening for adults and adolescents using a standardized tool.
    10. Assessment of health literacy.
  - Element D: Use Data for Population Management (MUST-PASS)
    1. At least two different preventive care services.
    2. At least two different immunizations.
    3. At least three different chronic or acute care services.
    4. Patients not recently seen by the practice.
    5. Medication monitoring or alert.

NCQA Full Standard Review - Factors

- **Standard 3: Population Health Management**
  - Element E: Implement Evidence-Based Decision Support (MUST-PASS)
    1. A mental health or substance use disorder. (CRITICAL)
    2. A chronic medical condition.
    3. An acute condition.
    4. A condition related to unhealthy behaviors.
    5. Well child or adult care.
    6. Overuse/appropriateness issues.

NCQA Full Standard Review - Factors

- **Standard 4: Care Management and Support**
  - Element A: Identify Patients for Care Management
    1. Behavioral health conditions.
    2. High cost/high utilization.
    3. Poorly controlled or complex conditions.
    4. Social determinants of health.
    5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver.
    6. The practice monitors the percentage of the total patient population identified through its process and criteria (CRITICAL)
  - Element B: Care Planning and Self-Care Support (MUST-PASS)
    1. Incorporates patient preferences and functional/lifestyle goals.
    2. Identifies treatment goals.
    3. Assesses and addresses potential barriers to meeting goals.
    4. Includes a self-management plan.
    5. Is provided in writing to the patient/family/caregiver.

NCQA Full Standard Review - Factors

- **Standard 4: Care Management and Support**
  - Element C: Medication Management
    1. Reviews and reconciles medications for more than 50 percent of patients received from care transitions. (CRITICAL)
    2. Reviews and reconciles medications with patients/families for more than 80 percent of care transitions.
    3. Provides information about new prescriptions to more than 80 percent of patients/families/caregivers.
    4. Assesses understanding of medications for more than 50 percent of patients/families/caregivers, and dates the assessment.
    5. Assesses response to medications and barriers to adherence fore more than 50 percent of patients, and dates the assessment.
    6. Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients, and dates updates.

NCQA Full Standard Review - Factors

- **Standard 4: Care Management and Support**
  - Element D: Use Electronic Prescribing
    1. More than 50 percent of eligible prescriptions written by the practice are compared to drug formularies and electronically sent to pharmacies.
    2. Enters electronic medication orders in the medical record for more than 60 percent of medications.
    3. Performs patient-specific checks for drug-drug and drug-allergy interactions.
    4. Alerts prescribers to generic alternatives.
  - Element E: Support Self-Care and Shared Decision Making
    1. Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients.
    2. Provides educational materials and resources to patients.
    3. Provides self-management tools to record self-care results.
    4. Adopts shared decision making aids.
    5. Offers or refers patients to structured health education programs, such as group classes and peer support.
    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.
    7. Assesses usefulness of identified community resources.

NCQA Full Standard Review - Factors

- **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)
    2. Tracks imaging tests until results are available, flagging and following up on overdue results. (CRITICAL)
    3. Flags abnormal lab results, bringing them to the attention of the clinician.
    4. Flags abnormal imaging results, bringing them to the attention of the clinician.
    5. Notifies patients/families of normal & abnormal lab and imaging test results.
    6. Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening (NA for adults).
    7. More than 30 percent of laboratory orders are electronically recorded in the patient record.
    8. More than 30 percent of radiology orders are electronically recorded in the patient record.
    9. Electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical record.
    10. More than 10 percent of scans and tests that result in an image are accessible electronically.

NCQA Full Standard Review - Factors

- **Standard 5: Care Coordination and Care Transitions**
  - Element B: Referral Tracking and Follow-Up (MUST-PASS)
    1. Considers available performance information on consultants/specialists when making referral recommendations.
    2. Maintains formal and informal agreements with a subset of specialists based on established criteria.
    3. Maintains agreements with behavioral healthcare providers.
    4. Integrates behavioral healthcare providers within the practice site.
    5. Gives the consultant or specialist the clinical question, the required timing, and the type of referral.
    6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.
    7. Has the capacity for electronic exchange of key clinical information and provides an electronic summary of care record to another provider for more than 50 percent of referrals.
    8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports. (CRITICAL)
    9. Documents co-management arrangements in the patient's medical record.
    10. Asks patients/families about self-referrals and requesting reports from clinicians.

NCQA Full Standard Review - Factors

- **Standard 5: Care Coordination and Care Transitions**
  - Element C: Coordinate Care Transitions
    1. Proactively identifies patients with unplanned hospital admissions and emergency department visits.
    2. Shares clinical information with admitting hospitals and emergency departments.
    3. Consistently obtains patient discharge summaries from the hospital and other facilities.
    4. Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit.
    5. Exchanges patient information with the hospital during a patient's hospitalization.
    6. Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care within community partners.
    7. Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50 percent of patient transitions of care.

NCQA Full Standard Review - Factors

- **Standard 6: Performance Measurement and Quality Improvement**
  - Element A: Measure Clinical Quality Performance
    1. At least two immunization measures.
    2. At least two other preventive care measures.
    3. At least three chronic or acute care measures.
    4. Performance data stratified for vulnerable populations (to assess disparities in care).
  - Element B: Measure Resource use and Care Coordination
    1. At least two measures related to care coordination.
    2. At least two utilization measures affecting health care costs.

NCQA Full Standard Review - Factors

- **Standard 6: Performance Measurement and Quality Improvement**
  - Element C: Measure Patient/Family Experience
    1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories:
       - Access.
       - Communication.
       - Coordination.
       - Whole person care/self-management support.
    2. The practice uses the PCMH version of the CAHPS Clinician & Group Survey Tool.
    3. The practice obtains feedback on experiences of vulnerable patient groups.
    4. The practice obtains feedback from patients/families through qualitative means.

NCQA Full Standard Review - Factors

- **Standard 6: Performance Measurement and Quality Improvement**
  - Element D: Measure Patient/Family Experience (MUST-PASS)
    1. Set goals and analyze at least three clinical quality measures from Element A.
    2. Act to improve at least three clinical quality measures from Element A.
    3. Set goals and analyze at least one measure from Element B.
    4. Act to improve at least one measure from Element B.
    5. Set goals and analyze at least one patient experience measure from Element C.
    6. Act to improve at least one patient experience measure from Element C.
    7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations.
  - Element E: Demonstrate Continuous Quality Improvement
    1. Measuring the effectiveness of the actions it takes to improve the measures selected in Element D.
    2. Achieving improved performance on at least two clinical quality measures.
    3. Achieving improved performance on one utilization or care coordination measure.
    4. Achieving improved performance on at least one patient experience measure.

NCQA Full Standard Review - Factors

- **Standard 6: Performance Measurement and Quality Improvement**
  - Element F: Report Performance
    1. Individual clinician performance results with the practice.
    2. Practice-level performance results with the practice.
    3. Individual clinician or practice-level performance results publicly.
    4. Individual clinician or practice-level performance results with patients.
  - Element G: Use Certified EHR Technology
    1. The practice uses an EHR system (or modules) that has been certified and issued a CMS certification ID.
    2. The practice conducts a security risk analysis of its EHR system (or modules), implements security updates as necessary and corrects identified security deficiencies.
    3. The practice demonstrates the capability to submit electronic syndromic surveillance data to public health agencies electronically.
    4. The practice demonstrates the capability to identify and report cancer cases to a public health central cancer registry electronically.
    5. The practice demonstrates the capability to identify and report specific cases to a specialized registry (other than a cancer registry) electronically.

NCQA Full Standard Review - Factors

- **Standard 6: Performance Measurement and Quality Improvement**
  - Element G: Use Certified EHR Technology
    6. The practice reports clinical quality measures to Medicare or Medicaid agency, as required for meaningful use.
    7. The practice demonstrates the capability to submit data to immunization registries or immunization information systems electronically.
    8. The practice has access to a health information exchange.
    9. The practice has bi-directional exchange with a health information exchange.
    10. The practice generates lists of patients, and based on their preferred method of communication, proactively reminds more than 10 percent of patients/families/caregivers about needed preventive/follow-up care.

Advanced Medical Home

- Task Force proposed selected modifications to the NCQA standards
- Designate *optional* elements as "must pass" and *optional* factors as "critical" if they align with our vision and goals
- Considered proposing *new* elements or factors
- Modifications would, in effect, establish special requirements that a practice must meet in order to be designated a *Connecticut Advanced Medical Home*

Advanced Medical Home

- Mindful of the fact that the new 2014 standards are substantially harder to achieve than 2011
- Wished to avoid an *excessive* real or perceived additional burden – avoid the “impossible lift”
- In light of above, Task Force recommended using our transformation vendor(s) to achieve our vision by emphasizing certain capabilities, going “beyond the standards” in the transformation process
- Accordingly, they recommended establishing “areas of emphasis” for the transformation process *instead of* adding new elements or factors

Advanced Medical Home

- Key points of emphasis in our Innovation Plan
  - Integrated behavioral health
  - Integrated oral health
  - Health equity
  - Prevention
  - Whole person centered/care experience

Health Equity

- Engaged Connecticut Health Foundation (CHF) to advise re: health equity
  - CHF arranged a consultation with Ignatius Bau and Dora Hughes, national health equity and health policy experts
  - Applied analysis of NCQA standards that align with health equity

Whole Person Centered Care

- Engaged Planetree to discuss person-centered care
  - Presentation to Task Force on 9/30/14
  - Emphasized moving beyond the standards to achieve the spirit of patient centeredness
  - Applied analysis of NCQA standards that align with patient-centered care

Advanced Medical Home

- Key points of emphasis in our Innovation Plan
  - Integrated behavioral health
  - Integrated oral health
  - Health equity
  - Prevention
  - Whole person centered/care experience

Design Groups

- Three design groups were formed to submit detailed recommendations in their respective areas
- Task Force members led these design group deliberations
  - Behavioral health – Heather Gates
  - Oral health – Mary Boudreau
  - Primary preventative services – Dr. Randy Trowbridge

Advanced Medical Home

- Each group or consultation resulted in specific recommendations to designate additional “must pass” elements and “critical factors” or areas of emphasis
- Each proposed “must pass” element or “critical factor” was discussed in depth
- Task Force members consider whether the element or factor in question is essential to achieving the vision or goal
- Considered the impact of each proposed change on quality of care and clinical or administrative burden

Advanced Medical Home

- After the discussion of each proposed “must-pass” element or “critical factor,” the Task Force voted to approve or reject the change
- Also identified “areas of emphasis” to address topics that were
  - a) not included in the NCQA standards,
  - b) only superficially addressed in the NCQA standards, or
  - c) central to the SIM vision and needing extra emphasis
- Areas of emphasis do not impact the NCQA standards scoring
- Guidelines for the practice transformation vendor, which should adapt its approach to emphasize these areas

Advanced Medical Home

- Added 3 MUST PASS elements and
- Added 12 CRITICAL FACTORS as follows…

NCQA Full Standard Review –Elements

- **Standard 1: Patient-Centered Access**
  - Element A: Patient-centered Appointment Access
  - Element B: 24/7 Access to Clinical Advice
  - Element C: Electronic Access
- **Standard 2: Team-based Care**
  - Element A: Continuity
  - Element B: Medical Home Responsibilities
  - Element C: Cultural and Linguistic Appropriate Services
  - Element D: The Practice Team
- **Standard 3: Population Health Management**
  - Element A: Patient Information
  - Element B: Clinical Data
  - Element C: Comprehensive Health Assessment
  - Element D: Use Data for Population Health Management
  - Element E: Implement Evidence-Based Decision Support

NCQA Full Standard Review – Must Pass Elements

- **Standard 4: Care Management and Support**
  - Element A: Identify Patients for Care Management
  - Element B: Care Planning and Self-Care Support
  - Element C: Medication Management
  - Element D: Use Electronic Prescribing
  - Element E: Support Self-Care and Shared Decision Making
- **Standard 5: Care Coordination and Care Transitions**
  - Element A: Test Tracking and Follow-Up
  - Element B: Referral Tracking and Follow Up
  - Element C: Coordinate Care Transitions
- **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
  - Element D: Implement Continuous Quality Improvement
  - Element E: Demonstrate Continuous Quality Improvement
  - Element F: Report Performance
  - Element G: Use Certified EHR Technology

NCQA Full Review – Task Force Recommendations

- **Standard 1: Patient-Centered Access**
  - Element A: Patient-centered appointment access. (MUST-PASS)
    1. Providing same-day appointments for routine and urgent care. (CRITICAL)
    2. Providing routine and urgent-care appointments outside regular business hours.
    3. Providing alternative types of clinical encounters.
    4. Availability of appointments.
    5. Monitoring no-show rates.
    6. Acting on identified opportunities to improve access.
  - Element B: 24/7 Access to Clinical Advice
    1. Providing continuity of medical record information for care and advice when office is closed.
    2. Providing timely clinical advice by telephone. (CRITICAL)
    3. Providing timely clinical advice using a secure, interactive electronic system.
    4. Documenting clinical advice in patient records.

NCQA Full Review – Task Force Recommendations

- **Standard 1: Patient-Centered Access**
  - Element C: Electronic Access
    1. More than 50 percent of patients have online access to their health information within four business days of when the information is available to the practice.
    2. More than 5 percent of patients view, and are provided the capability to download, their health information or transmit their health information to a third party.
    3. Clinical summaries are provided within 1 business day for more than 50 percent of office visits.
    4. A secure message was sent by more than 5 percent of patients.
    5. Patients have two-way communication with the practice.
    6. Patients can request appointments, prescription refills, referrals and test results.

NCQA Full Review – Task Force Recommendations

- **Standard 2: Team-Based Care**
  - Element A: Continuity
    1. Assisting patients/families to select a personal clinician and documenting the selection in practice records.
    2. Monitoring the percentage of patient visits with selected clinician or team.
    3. Having a process to orient new patients to the practice.
    4. Collaborating with the patient/family to develop/implement a written care plan for transitioning from pediatric care to adult care. (NEW CRITICAL)
  - Element B: Medical Home Responsibilities
    1. The practice is responsible for coordinating patient care across multiple settings.
    2. Instructions for obtaining care and clinical advice during office hours and when the office is closed.
    3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice.

NCQA Full Review – Task Force Recommendations

- **Standard 2: Team-Based Care**
  - Element B: Medical Home Responsibilities
    4. The care team provides access to evidence-based care, patient/family education and self-management support.
    5. The scope of services available within the practice including how behavioral health needs are addressed.
    6. The practice provides equal access to all of the patients regardless of source of patient.
    7. The practice gives uninsured patients information about obtaining coverage.
    8. Instructions on transferring records to the practice, including a point of contact at the practice.

NCQA Full Review – Task Force Recommendations

- **Standard 2: Team-Based Care**
  - Element C: Culturally and Linguistically Appropriate Services (NEW MUST-PASS)
    1. Assessing the diversity of its population.
    2. Assessing the language needs of its population.
    3. Providing interpretation or bilingual services to meet the language needs of its population.
    4. Providing printed materials in the languages of its population.
  - Element D: The Practice Team (MUST-PASS)
    1. Defining roles for clinical and nonclinical team members.
    2. Identifying the team structure and the staff who lead and sustain team based care.
    3. Holding scheduled patient care team meetings or a structured communication process focused on individual patient care. (CRITICAL)
    4. Using standing orders for services.
    5. Training and assigning members of the care team to coordinate care for individual patients.

NCQA Full Review – Task Force Recommendations

- **Standard 2: Team-Based Care**
  - Element D: The Practice Team (MUST-PASS)
    6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change.
    7. Training and assigning members of the care team to manage the patient population.
    8. Holding scheduled team meetings to address practice functioning.
    9. Involving care team staff in the practice's performance evaluation and quality improvement activities.
    10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council.

NCQA Full Review – Task Force Recommendations

- **Standard 3: Population Health Management**
  - Element A: Patient Information
    1. Date of birth
    2. Sex.
    3. Race.
    4. Ethnicity
    5. Preferred language.
    6. Telephone numbers.
    7. E-mail address.
    8. Occupation (NA for pediatric purposes)
    9. Dates of previous clinical visits.
    10. Legal guardian/health care proxy.
    11. Primary caregiver.
    12. Presence of advance directives (NA for pediatric purposes)
    13. Health insurance information.
    14. Name and contact information of other health care professionals involved in patient's care.

NCQA Full Review – Task Force Recommendations

- **Standard 3: Population Health Management**
  - Element B: Clinical Data
    1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients.
    2. Allergies, including medication allergies and adverse reactions, for more than 80 percent of patients.
    3. Blood pressure, with the date of update, for more than 80 percent of patients 3 years and older.
    4. Height/length for more than 80 percent of patients.
    5. Weight for more than 80 percent of patients.
    6. System calculates and displays BMI.
    7. System plots and displays growth charts (length/height, weight and head circumference) and BMI percentile (0-20 years) (NA for adult practices)
    8. Status of tobacco use for patients 13 years and older for more than 80 percent of patients.
    9. List of prescription medications with date of updates for more than 80 percent of patients.

NCQA Full Review – Task Force Recommendations

- **Standard 3: Population Health Management**
  - Element B: Clinical Data
    10. More than 20 percent of patients have family history recorded as structured data.
    11. At least one electronic progress note created, edited and signed by an eligible professional for more than 30 percent of patients with at least one office visit.
  - Element C: Comprehensive Health Assessment (NEW MUST-PASS)
    1. Age- and gender appropriate immunizations and screenings.
    2. Family/social/cultural characteristics
    3. Communication needs.
    4. Medical history of patient and family.
    5. Advance care planning (NA for pediatric purposes).
    6. Behaviors affecting health. (NEW CRITICAL)
    7. Mental health/substance use history of patient and family. (NEW CRITICAL)
    8. Developmental screening using a standardized tool (NA for practices with no pediatric patients). (NEW CRITICAL)

NCQA Full Review – Task Force Recommendations

- **Standard 3: Population Health Management**
  - Element C: Comprehensive Health Assessment (NEW MUST-PASS)
    9. Depression screening for adults and adolescents using a standardized tool. (NEW CRITICAL)
    10. Assessment of health literacy. (NEW CRITICAL)
  - Element D: Use Data for Population Management (MUST-PASS)
    1. At least two different preventive care services.
    2. At least two different immunizations.
    3. At least three different chronic or acute care services.
    4. Patients not recently seen by the practice.
    5. Medication monitoring or alert.

NCQA Full Review – Task Force Recommendations

- **Standard 3: Population Health Management**
  - Element E: Implement Evidence-Based Decision Support (MUST-PASS)
    1. A mental health or substance use disorder. (CRITICAL)
    2. A chronic medical condition.
    3. An acute condition.
    4. A condition related to unhealthy behaviors.
    5. Well child or adult care.
    6. Overuse/appropriateness issues.

NCQA Full Review – Task Force Recommendations

- **Standard 4: Care Management and Support**
  - Element A: Identify Patients for Care Management
    1. Behavioral health conditions. (CRITICAL)
    2. High cost/high utilization.
    3. Poorly controlled or complex conditions.
    4. Social determinants of health.
    5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver.
    6. The practice monitors the percentage of the total patient population identified through its process and criteria (CRITICAL)
  - Element B: Care Planning and Self-Care Support (MUST-PASS)
    1. Incorporates patient preferences and functional/lifestyle goals. (CRITICAL)
    2. Identifies treatment goals.
    3. Assesses and addresses potential barriers to meeting goals.
    4. Includes a self-management plan.
    5. Is provided in writing to the patient/family/caregiver.

NCQA Full Review – Task Force Recommendations

- **Standard 4: Care Management and Support**
  - Element C: Medication Management
    1. Reviews and reconciles medications for more than 50 percent of patients received from care transitions. (CRITICAL)
    2. Reviews and reconciles medications with patients/families for more than 80 percent of care transitions.
    3. Provides information about new prescriptions to more than 80 percent of patients/families/caregivers.
    4. Assesses understanding of medications for more than 50 percent of patients/families/caregivers, and dates the assessment.
    5. Assesses response to medications and barriers to adherence fore more than 50 percent of patients, and dates the assessment. (NEW CRITICAL)
    6. Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients, and dates updates.

NCQA Full Review – Task Force Recommendations

- **Standard 4: Care Management and Support**
  - Element D: Use Electronic Prescribing
    1. More than 50 percent of eligible prescriptions written by the practice are compared to drug formularies and electronically sent to pharmacies.
    2. Enters electronic medication orders in the medical record for more than 60 percent of medications.
    3. Performs patient-specific checks for drug-drug and drug-allergy interactions.
    4. Alerts prescribers to generic alternatives.
  - Element E: Support Self-Care and Shared Decision Making
    1. Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients.
    2. Provides educational materials and resources to patients.
    3. Provides self-management tools to record self-care results.
    4. Adopts shared decision making aids.
    5. Offers or refers patients to structured health education programs, such as group classes and peer support.
    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.
    7. Assesses usefulness of identified community resources.

NCQA Full Review – Task Force Recommendations

- **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)
    2. Tracks imaging tests until results are available, flagging and following up on overdue results. (CRITICAL)
    3. Flags abnormal lab results, bringing them to the attention of the clinician.
    4. Flags abnormal imaging results, bringing them to the attention of the clinician.
    5. Notifies patients/families of normal & abnormal lab and imaging test results.
    6. Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening (NA for adults).
    7. More than 30 percent of laboratory orders are electronically recorded in the patient record.
    8. More than 30 percent of radiology orders are electronically recorded in the patient record.
    9. Electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical record.
    10. More than 10 percent of scans and tests that result in an image are accessible electronically.

NCQA Full Review – Task Force Recommendations

- **Standard 5: Care Coordination and Care Transitions**
  - Element B: Referral Tracking and Follow-Up (MUST-PASS)
    1. Considers available performance information on consultants/specialists when making referral recommendations.
    2. Maintains formal and informal agreements with a subset of specialists based on established criteria.
    3. Maintains agreements with behavioral healthcare providers.
    4. Integrates behavioral healthcare providers within the practice site.
    5. Gives the consultant or specialist the clinical question, the required timing, and the type of referral.
    6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.
    7. Has the capacity for electronic exchange of key clinical information and provides an electronic summary of care record to another provider for more than 50 percent of referrals.
    8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports. (CRITICAL)
    9. Documents co-management arrangements in the patient's medical record.
    10. Asks patients/families about self-referrals and requesting reports from clinicians.

NCQA Full Review – Task Force Recommendations

- **Standard 5: Care Coordination and Care Transitions**
  - Element C: Coordinate Care Transitions
    1. Proactively identifies patients with unplanned hospital admissions and emergency department visits.
    2. Shares clinical information with admitting hospitals and emergency departments.
    3. Consistently obtains patient discharge summaries from the hospital and other facilities.
    4. Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit.
    5. Exchanges patient information with the hospital during a patient's hospitalization.
    6. Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care within community partners. (NEW CRITICAL)
    7. Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50 percent of patient transitions of care.

NCQA Full Review – Task Force Recommendations

- **Standard 6: Performance Measurement and Quality Improvement**
  - Element A: Measure Clinical Quality Performance
    1. At least two immunization measures.
    2. At least two other preventive care measures.
    3. At least three chronic or acute care measures.
    4. Performance data stratified for vulnerable populations (to assess disparities in care). (NEW CRITICAL)
  - Element B: Measure Resource use and Care Coordination
    1. At least two measures related to care coordination.
    2. At least two utilization measures affecting health care costs.

NCQA Full Review – Task Force Recommendations

- **Standard 6: Performance Measurement and Quality Improvement**
  - Element C: Measure Patient/Family Experience (NEW MUST-PASS)
    1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories:
       - Access.
       - Communication.
       - Coordination.
       - Whole person care/self-management support.
    2. The practice uses the PCMH version of the CAHPS Clinician & Group Survey Tool.
    3. The practice obtains feedback on experiences of vulnerable patient groups. (NEW CRITICAL)
    4. The practice obtains feedback from patients/families through qualitative means.

NCQA Full Review – Task Force Recommendations

- **Standard 6: Performance Measurement and Quality Improvement**
  - Element D: Measure Patient/Family Experience (MUST-PASS)
    1. Set goals and analyze at least three clinical quality measures from Element A.
    2. Act to improve at least three clinical quality measures from Element A.
    3. Set goals and analyze at least one measure from Element B.
    4. Act to improve at least one measure from Element B.
    5. Set goals and analyze at least one patient experience measure from Element C.
    6. Act to improve at least one patient experience measure from Element C.
    7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations.
  - Element E: Demonstrate Continuous Quality Improvement
    1. Measuring the effectiveness of the actions it takes to improve the measures selected in Element D.
    2. Achieving improved performance on at least two clinical quality measures.
    3. Achieving improved performance on one utilization or care coordination measure.
    4. Achieving improved performance on at least one patient experience measure.

NCQA Full Review – Task Force Recommendations

- **Standard 6: Performance Measurement and Quality Improvement**
  - Element F: Report Performance
    1. Individual clinician performance results with the practice.
    2. Practice-level performance results with the practice.
    3. Individual clinician or practice-level performance results publicly.
    4. Individual clinician or practice-level performance results with patients.
  - Element G: Use Certified EHR Technology
    1. The practice uses an EHR system (or modules) that has been certified and issued a CMS certification ID.
    2. The practice conducts a security risk analysis of its EHR system (or modules), implements security updates as necessary and corrects identified security deficiencies.
    3. The practice demonstrates the capability to submit electronic syndromic surveillance data to public health agencies electronically.
    4. The practice demonstrates the capability to identify and report cancer cases to a public health central cancer registry electronically.
    5. The practice demonstrates the capability to identify and report specific cases to a specialized registry (other than a cancer registry) electronically.

NCQA Full Review – Task Force Recommendations

- **Standard 6: Performance Measurement and Quality Improvement**
  - Element G: Use Certified EHR Technology
    6. The practice reports clinical quality measures to Medicare or Medicaid agency, as required for meaningful use.
    7. The practice demonstrates the capability to submit data to immunization registries or immunization information systems electronically.
    8. The practice has access to a health information exchange.
    9. The practice has bi-directional exchange with a health information exchange.
    10. The practice generates lists of patients, and based on their preferred method of communication, proactively reminds more than 10 percent of patients/families/caregivers about needed preventive/follow-up care.

Advanced Medical Home – Areas of Emphasis

- Recommended 17 “Areas of Emphasis”
- Task Force will consider establishing a high priority subset for CT AMH designation
- Areas that follow in black text were rated by 50% of Task Force members as “high importance”

Advanced Medical Home - Areas of Emphasis

- **Standard 2: Element C**
  - The practice should be knowledgeable about culturally appropriate services in the practice's catchment area and health disparities among patient populations served by the practice
- **Standard 2: Element D and Standard 6: Element C**
  - Implementation of Patient-Family Advisory Panels at the practice for quarterly feedback and continuous quality improvement. Patient-Family Advisory Panels will help to inform the practice team on how to provide better patient-centered care and improve patient satisfaction.
- **Standard 3: Element C: Factor 2 & 10**
  - Provide practices with training and support for evaluation and assessment of family/social/cultural characteristics and health literacy. Train practices to use this information to identify patients for care management and provide more individualized care incorporating a patients cultural norms, needs, and beliefs.

Advanced Medical Home - Areas of Emphasis

- **Standard 3: Element C**
  - Instruct practices in the provision of age appropriate oral health risk and disease screening. The practice should be advised how to implement age appropriate oral health risk and disease assessment, Including assessments for caries, periodontal disease and oral cancer.
  - Instruct practices how to better understand the health risks and information needs of patients/families and train practices to perform an accurate, patient-centered, culturally and linguistically appropriate comprehensive health assessment.

Advanced Medical Home - Areas of Emphasis

- **Standard 4: Element A-E**
  - Focus on empathetic care and communication between practitioners and patient/families. Provide training for techniques and best practices to support patients and improve care experience.
- **Standard 4: Element A**
  - Identify patients for care management that include 95% empanelment, with 75% risk stratification, and 80% of care management for high risk patients
  - Criteria for identifying patients for care management are developed from a profile of patient assessments and may include 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.

Advanced Medical Home - Areas of Emphasis

- **Standard 4: Element E**
  - Focus on shared decision making communications between patient and practitioner (taking into account patient preferences) giving the patient the support they need to make the best individualized care decisions.
  - Improve educational materials and resources available to patients.
  - Identify two target health conditions for self-care and shared decision-making for the practice's population
- **Standard 5: Element B**
  - Focus on the development of collaborative agreements with at least 2 groups of high-volume specialties to improve care transitions
  - Focus on enabling the practice to track the percentage of patients with ED visits who receive follow-up

Advanced Medical Home - Areas of Emphasis

- **Standard 5: Element C**
  - Proactively identifies patients with unplanned hospital admissions and emergency department visits
  - Shares clinical information with admitting hospitals and emergency departments
  - Practice responsible to contact 75% of patients who were hospitalized within 72 hours
- **Standard 6: Element D**
  - Set goals and address at least one identified disparity in care/service for identified vulnerable population
- **CT AMH Specific (not in NCQA 2014)**
  - Track primary care team satisfaction pre- and post- AMH program

Eligibility

- Task Force proposed eligibility requirements at the December 16, 2014 meeting
- Default position: adopt NCQA eligibility requirements to minimize confusion and PMO administrative burden
- Designation as CT AMH program participant not intended to dictate attribution rules used by payers
- Proposed eligible practitioners for the CT AMH program were:
  - 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 preceptor must be physically at the practice site)

Eligibility

- Proposed eligible practice sites for the CT AMH program were:
  - 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 practices that can demonstrate the provision of whole person care and meet the other elements of the NCQA 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.

Eligibility

- Proposed eligible practice sites for the CT AMH program were:
  - Practices with a functioning ONC-certified EHR system
  - Practices with a commitment to apply for NCQA PCMH 2014
  - Practices with a commitment to participate in the AMH learning collaborative

Provider Engagement

- Outreach & Recruitment
  - Target: 1st Practices with no PCMH recognition or lapsed 2008 recognition, 2nd those beginning to 2014 recognition, and 3rd those with 2011 or equivalent
  - Communicate opportunity broadly to participating advanced networks, professional organizations, state organizations, and public announcements
- Benefits
  - Discounted fees for NCQA PCMH 2014 Recognition process
  - No cost transformation vendor support at practice level to complete NCQA PCMH 2014 (on-site and remote assistance),
  - No cost membership in the AMH Learning Collaborative,
  - Prepare practices for success in emerging value-based payment programs

Advanced Medical Home Pilot

- Proposed approach is untested, 2014 standards are relatively new
- Task Force recommended test of transformation methods allowing for flexibility in the application of these methods so that participating practices can help us to identify the optimal approach, as well as those methods or features that may not work or may have a negative impact on patient and practice experience.

AMH Pilot – Rationale (abridged)

- Test program administration such as methods of practice recruitment, criteria for participation, and progress monitoring and make adjustments before finalizing our statewide strategy,
- Determine whether our method provides enough assistance and tools to make participation in the NCQA recognition process less challenging and resource intensive,
- Assess and optimize impact on practice experience…if satisfaction with practice does not improve, expansion will be challenging, and
- Recruit practices to champion the value of AMH Glide Path transformation support, which will support practice recruitment later in the year.

Questions