Practice Transformation Task Force

January 13th, 2015

Meeting Agenda

1. Welcome and Introductions
2. Public Comments
3. Ad Hoc Primary Prevention Recommendations
4. NCQA Level Requirement
5. NCQA Full Standards Review
6. Learning Collaborative
7. Provisional Accountability Milestones
8. Provider Engagement

Appendix: Supplemental Material for Reference

Free Clinic Eligibility

- Discussion on free clinic eligibility in the AMH Pilot Program

Primary Prevention Services

- The US Preventative Services Task Forces' Guide to Clinical Preventive Services (USPSTF) defines primary prevention measures as those provided to individuals to prevent the onset of a targeted condition. Since successful primary prevention helps avoid the suffering, cost and burden associated with disease, it is typically considered the most cost-effective form of health care.

- Our aim should be to ensure a focus on nutrition, exercise and smoke cessation and provide the necessary education to the care team in order to deliver the plan, as well as adequate incentives to maximize cooperation.

Primary Prevention Services

- The starting point is Standard 3: Population Health Management, Element C: Comprehensive Health Assessment
- **Recommend**:
  Factor 6: Comprehensive assessment of risky and unhealthy behaviors must encompass smoking, nutrition, exercise and oral health, and may include familial behaviors, risky sexual behavior, and secondhand smoke. (CRITICAL FACTOR)
- **Factor 10:** The practice assesses the patient/family/caregiver's ability to understand the concepts and care requirements associated with managing their health. (CRITICAL FACTOR)

NCQA Level Requirement

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

CT AMH resources will include practice-level transformation vendor support and participation in a learning community at no cost to participants.

Recommendation: attainment of Level 3 to be aligned with “advanced” medical home.

NCQA Full Standard Review – Must Pass Elements

- **Standard 1: Patient-Centered Access**
  - Element A – Patient-centered appointment access.
- **Standard 2: Team-based Care**
  - Element C - Cultural and Linguistic Appropriate Services
  - Element D – The Practice Team.
- **Standard 3: Population Health Management**
  - Element D – Use Data for Population Health Management.
- **Standard 4: Care Management and Support**
  - Element B – Care Planning and Self-Care Support.
- **Standard 5: Care Coordination and Care Transitions**
  - Element B – Referral Tracking and Follow Up.
- **Standard 6: Performance Measurement and Quality Improvement**
  - Element C - Measure Patient/Family Experience
  - Element D - Implement Continuous Quality Improvement.

NCQA Full Standard Review – Critical Factors

Critical Factors

NCQA includes 9; Task Force Proposed 16 additional items

- Standard 2: A – Continuity: Factor 4
  - Collaborating with the patient/family to develop/implement a written care plan for transitioning from pediatric care to adult care
- Standard 2: C - Cultural and Linguistic Appropriate Service: Factor 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.

NCQA Full Standard Review – Critical Factors

- Standard 3: A – Patient Information: Factor 2: Race
- Standard 3: A – Patient Information: Factor 3: Ethnicity
- Standard 3: A – Patient Information: Factor 4: Preferred Language
- Standard 3: C – Comprehensive Health Assessment: Factor 7
  - Mental health/substance use history of patient and family
- Standard 3: C – Comprehensive Health Assessment: Factor 8
  - Developmental screening using a standardized tool
- Standard 3: C – Comprehensive Health Assessment: Factor 9
  - Depression screening for adults and adolescents using a standardized tool

NCQA Full Standard Review – Critical Factors

- Standard 4: A – Identify Patients for Care Management: Factor 1:
  - Behavioral Health Conditions
- Standard 4: B – Care Planning and Self-Care Support: Factor 1:
  - Incorporates patient preferences and functional/lifestyle goals
- Standard 4: C – Medication Management: Factor 5
  - Assess response to medications and barriers to adherence for more than 50% of patients, and date the assessment.
- Standard 4: D – Use Electronic Prescribing: Factor 3
  - Performs patient-specific checks for drug-drug and drug-allergy interactions

NCQA Full Standard Review – Critical Factors

- Standard 5: B – Referral Tracking and Follow-up: Factor 3:
  - Maintains agreements with behavioral healthcare providers
- Standard 5: C –Coordinate Care Transitions: 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
- Standard 6: A – Measure Clinical Quality Performance: Factor 4:
  - Performance data stratified for vulnerable populations (to assess disparities in care
- Standard 6: C – Measure Patient/Family Experience: Factor 3:
  - The practice obtains feedback on experiences of vulnerable patient groups

NCQA Full Standard Review - Areas of Emphasis

Areas of Emphasis: 17 proposed

List to inform Vendor – Subject to further discussion on Jan 27

- **Standard 2: Element C**
  - The practice should be knowledgeable about culturally appropriate services 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
- **Standard 3: Element C: Factor 2 & 10**
  - Training for: Support of Family/Social/Cultural Characteristics & Assessment of Health Literacy.
- **Standard 3: Element C**
  - 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.

NCQA Full Standard Review - 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
  - Oral health 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.

NCQA Full Standard Review - Areas of Emphasis

- **Standard 4: Element E**
  - Focus on shared decision making communications between patient and practitioner (taking into account patient preferences)
  - 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**
  - Collaborative agreements with at least 2 groups of high-volume specialties to improve care transitions
  - Track the percentage of patients with ED visits who receive follow-up

NCQA Full Standard Review - Areas of Emphasis

- **Standard 5: Element C**
  - 1: Proactively identifies patients with unplanned hospital admissions and emergency department visits
  - 2: 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 provider satisfaction pre- and post- AMH program

Review of Survey Results for Proposed Critical Factors

Medium scoring critical factors:
N=11 Range 1.91 - 2.5

1. Standard 6: C – Measure Patient/Family Experience: Factor 3: The practice obtains feedback on experiences of vulnerable patient groups (**1.91)**
2. Standard 5: B – Referral Tracking and Follow-up: Factor 3 Maintains agreements with behavioral healthcare providers (**2.0**)
3. Standard 3: A – Patient Information: Factor 2: Race 6 (**2.09**)
4. Standard 3: A – Patient Information: Factor 3: Ethnicity 8 (**2.18**)
5. Standard 4: C – Medication Management: Factor 5 Assess response to medications and barriers to adherence for more than 50% of patients, and date the assessment. (**2.18**)
6. Standard 4: B – Care Planning and Self-Care Support: Factor 1: Incorporates patient preferences and functional/lifestyle goals (**2.18**)
7. Standard 4: D – Use Electronic Prescribing: Factor 3 Performs patient-specific checks for drug-drug and drug-allergy interactions (**2.36**)
8. Standard 5: C –Coordinate Care Transitions: 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 (**2.36**)
9. Standard 2: A – Continuity: Factor 4 Collaborating with the patient/family to develop/implement a written care plan for transitioning from pediatric care to adult care (**2.36**)

Review of Survey Results for Proposed Critical Factors

High scoring critical factors:
N=11 Range 2.5 - 3

1. Standard 2: C - Cultural and Linguistic Appropriate Service: Factor 1: Assessing the diversity of its population (**2.55**)
2. Standard 3: A – Patient Information: Factor 4: Preferred Language (**2.55**)
3. Standard 6: A – Measure Clinical Quality Performance: Factor 4: Performance data stratified for vulnerable populations (to assess disparities in care (**2.55**)
4. Standard 4: A – Identify Patients for Care Management: Factor 1: Behavioral Health Conditions (**2.55**)
5. Standard 3: C – Comprehensive Health Assessment: Factor 9 Depression screening for adults and adolescents using a standardized tool (**2.64**)
6. Standard 3:C – Comprehensive Health Assessment: Factor 7 Mental health/substance use history of patient and family (**2.64**)
7. Standard 3: C – Comprehensive Health Assessment: Factor 8 Developmental screening using a standardized tool (NA for practices with no pediatric patients) (**2.73**)

AMH Learning Collaborative

Goal: Build the internal capacity of participating practices to achieve AMH recognition (includes CT AMH must pass elements/critical factors) and address Areas of Emphasis (AE) topics

- Foster continuous individual and group learning opportunities to address practice gaps
- Share peer-to-peer expertise among participating practices ("bright spots")
  - Host site visits, serve as presenters on selected topics
- Exchange tools (e.g., policies, workflows, forms, templates) and experiences among practices
- Motivate practices to accomplish work between LC sessions

Provisional Accountability Milestones

DSS Glide Path Milestones

- 3 Phases each with 6 month time frame
- Each phase is progressive and builds upon the last
- Documentation for the phases prepares the practice for the documentation submission required by NCQA
- Phase 1 focuses on workflow, system set-up and updates, and implementing clinical decision support
  - Ex. Orient clinical and non-clinical staff to PCMH requirements and strategies to accomplish them
- Phase 2 focuses on implementation and application, clinical practice, strengthening of care management and support
  - Ex. Demonstrate practice provides care planning and self-care support
- Phase 3 focuses on quality improvement, goal setting, and final submission
  - Ex. Set goals and act to improve upon one patient experience measure

Provisional Accountability Milestones - CPCi

Reporting on the Web Application - Behavioral Health Integration [Quarters 2- 4]

How have you organized the behavioral health services in your practice? For each of the services identified tell us if it is available through your practices and if so, who provides the service and how they fit into the system of care.

Services:

- ○ Screening
- ○ Evaluation/diagnosis
- ○ Evidence-Based Treatment
- ○ Referral coordination
- ○ Tracking and measurement
- ○ Family and Caregiver Support
- ○ Peer support
- ○ Other (describe)

After selecting each service, identify who provides for this service. Select all that apply.

- ○ Physician
- ○ PA
- ○ APRN/NP
- ○ MA
- ○ Care manager
- ○ Health educator
- ○ Pharmacist
- ○ Behavioral Health Specialist (specify what discipline)
- ○ Other

For each provider selected, you will select a description of where they are in the system of care:

- ○ Practice care team
- ○ Available outside of the practice through contract or as a system resource (for practices that are within systems)
- ○ Available through coordinated referral in the medical neighborhood

Provisional Accountability Milestones - CPCi

How are you identifying patients in need of integrated behavioral health services? Select all that apply.

- ○ Use of your risk stratification methodology
- ○ Positive screen (indicate screening tool used from the pick list in question 4 below)
- ○ The presence of a specific diagnosis (indicate diagnoses)
- ○ Inability to reach goals in management of chronic conditions (indicated target chronic conditions)
- ○ Other (indicate)
- ○ In planning

What evidence-based instruments or tools are used to systematically assess patients and monitor or adjust care? If in use, select a tool or instrument in this pick list:

Broad measure:	○ Brief Psychiatric Rating Scale (BPRS)
Depression/ mood disorders:	○ Patient Health Questionnaire for Depression PHQ 2 PHQ-9 ○ Mood Disorder Questionnaire (MDQ) ○ Composite International Diagnostic Interview (CIDI) for depression
Anxiety:	○ Generalized Anxiety Disorder subscale (GAD-7)
ADHD:	○ Adult ADHD Self-Report Scale (ASRSv1.1)
Pain:	○ Brief Pain Inventory (BPI)
OCD:	○ Yale-Brown Obsessive Compulsive Scale (Y-BOCS)
PTSD:	○ PTSD Checklist (PCL-C) ○ Primary Care PTSD Screener (PC-PTSD)
Alcohol use disorder:	○ The Alcohol Use Disorders Identification Test (AUDIT-C) ○ Drug Abuse Screen Test (DAST)
Cognitive function:	○ Montreal Cognitive Assessment (MoCA) ○ Mini Mental Status Examination (MMSE) ○ Mini-COG
Other (specify):	

Provisional Accountability Milestones - CPCi

In Quarter 1, your practice will select the assessment method(s) that will be used *(please note: this selection cannot be changed in subsequent quarters)*:

- ○ Option A: Conduct monthly practice-based survey
- ○ Option B: Patient and Family Advisory Council (PFAC) that meets quarterly
- ○ Option C: Office-based surveys administered quarterly and PFAC convened semi-annually

Option B: PFAC that meets quarterly

Area of Focus [Quarterly, X]

Identify the area(s) of focus for Patient and Family Advisory Council involvement in your practice transformation activities from the following selections. Select all that apply.

- ○ Access
- ○ Communication
- ○ Coordination of Care
- ○ Self-management Support
- ○ Shared Decision Making

PFAC Composition [Quarterly, N]

Identify the composition of your Patient and Family Advisory Council below:

Role	Number of Individuals
Physician (MD/DO)	
Physician Assistant (PA)	
APRN or Nurse Practitioner (NP)	
Registered Nurse (RN)	
Medical Assistant (MA)	
Behavioral Health Professional	
Health Educator	
Pharmacist	
Patient	
Family/Caregiver	
Hospital Representative	
Administrative	
Other (practices will be able to added up to 5 additional roles)	

Communicating the Role of the PFAC [Quarterly, X]

Indicate how your practice is communicating the role of the PFAC to the patients in your practice and how your practice is demonstrating its commitment to integrating the patient voice into your practice environment. Select all that apply.

- ○ Posted in office
- ○ Brochure or other communication provided to patient in office
- ○ Website
- ○ Brochure or other communication mailed to patients
- ○ Other *(text box provided)*

Provider Engagement

- Outreach & Recruitment
  - Target: 1st Practices with no PCMH recognition, 2nd practice with lapsed 2008 NCQA, and 3rd 2011 PCMH or equivalent
  - Network through 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 of the AMH Learning Collaborative,
  - Preparation for health plan incentives or value-based payment programs
  - Others?

Next Steps