INTEGRATED CARE WORKGROUP

Meeting #2

#	Topic	Time	Leader
1	Welcome and Introductions	10:00 – 10:10	Foster Gesten, MD
2	Ground Rules recap	10:10 – 10:15	Susan Stuard
3	Recap of last meeting	10:15 – 10:25	Susan Stuard
4	Update on initiatives since last meeting (a) PTN/TCPI	10:25 – 10:45	Tom Mahoney, MD
5	The APC Straw-Person – overview	10:45 – 11:45	Susan Stuard Foster Gesten, MD Marietta Angelotti, MD
	Break	11:45 – 12:00	
6	Working lunch: Straw-Person Discussion	12:00 – 1:15	All
7	Closing Discussion and Next Steps	1:15 – 1:45	All
8	Upcoming topics: (a) Measurement (b) Payment (c) Practice Transformation RFP	1:45 – 2:00	Foster Gesten, MD

NEW YORK STATE OF OPPORTUNITY. Department of Health

Welcome and Introductions

Ground Rules Recap

NEW YORK STATE OF OPPORTUNITY. | Department of Health

RULES OF THE ROAD

1. Come to the meeting with a positive attitude.

2. Treat members with respect.

3. Be prompt arriving to the meeting and returning from breaks.

4. Turn cell phones off or to vibrate.

5. If you must take urgent calls, take your conversation outside.

6. Talk one at a time, waiting to be recognized by the Chairpersons.

7. Limit side conversations.

8. Stay on the topic being discussed.

9. Address any concerns about the discussion or the meeting with the Chairpersons.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Recap of Last Meeting

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Integrated Care Workgroup Charge

1. Discuss APC model 'straw person' and refine through discussion

2. Initiate reimbursement model discussions - Value proposition and alignment.

3. Identify legislative requirements, if any, for adoption.

4. Begin discussion of standardized measure set.

5. Develop/recommend practice transformation core curriculum.

6. Define best practices for care coordination and delivery infrastructure.

7. Vet APC model requirements with national accreditation organizations.

8. Develop practice readiness tool and process.

9. Adopt APC model requirements.

10. Convene regional meetings to discuss/refine APC, including reimbursement model.

11. Adopt APC model for implementation, including reimbursement model.

12. Review initial six months of data to inform, revise and evolve delivery and payment systems.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Meeting #1 Recap: Major Themes

1. Three key questions to be answered:
    - What is Advanced Primary Care"?
    - How do you get from where you are to "it"?
    - How do you pay for "it" going forward?

2. Practice Transformation must include:
    - Information sharing (learning collaboratives, library and newsletters)
    - Reporting actionable data to providers, patients and providers
    - Resources (including local support)
    - Funding - during the process of transition.
    - Flexibility to innovate

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Meeting #1 Recap: Major Themes

3. Compelling arguments are needed to motivate providers and payers to "transform".

4. Payment is multi-faceted and complex and not a straightforward dichotomy (FFS vs other).

5. Unanticipated consequences must always be considered.

6. Process is not outcome.

7. Patient engagement requires testing with patients themselves.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Meeting #1 Recap: Major Themes

8. Lessons learned from ongoing initiatives are many and varied and must be utilized moving forward.

9. Limits to what the delivery system can do for population health must be recognized.

11. Transparency and consumer facing information is needed .

12. How the APC model might address disparities must be addressed.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Update on Initiatives:

TRANSFORMING CLINICAL PRACTICE INITIATIVE / PRACTICE TRANSFORMATION NETWORK

NEW YORK STATE OF OPPORTUNITY. | **Department of Health**

Finger Lakes Health Systems Agency

The New York State Practice Transformation Network
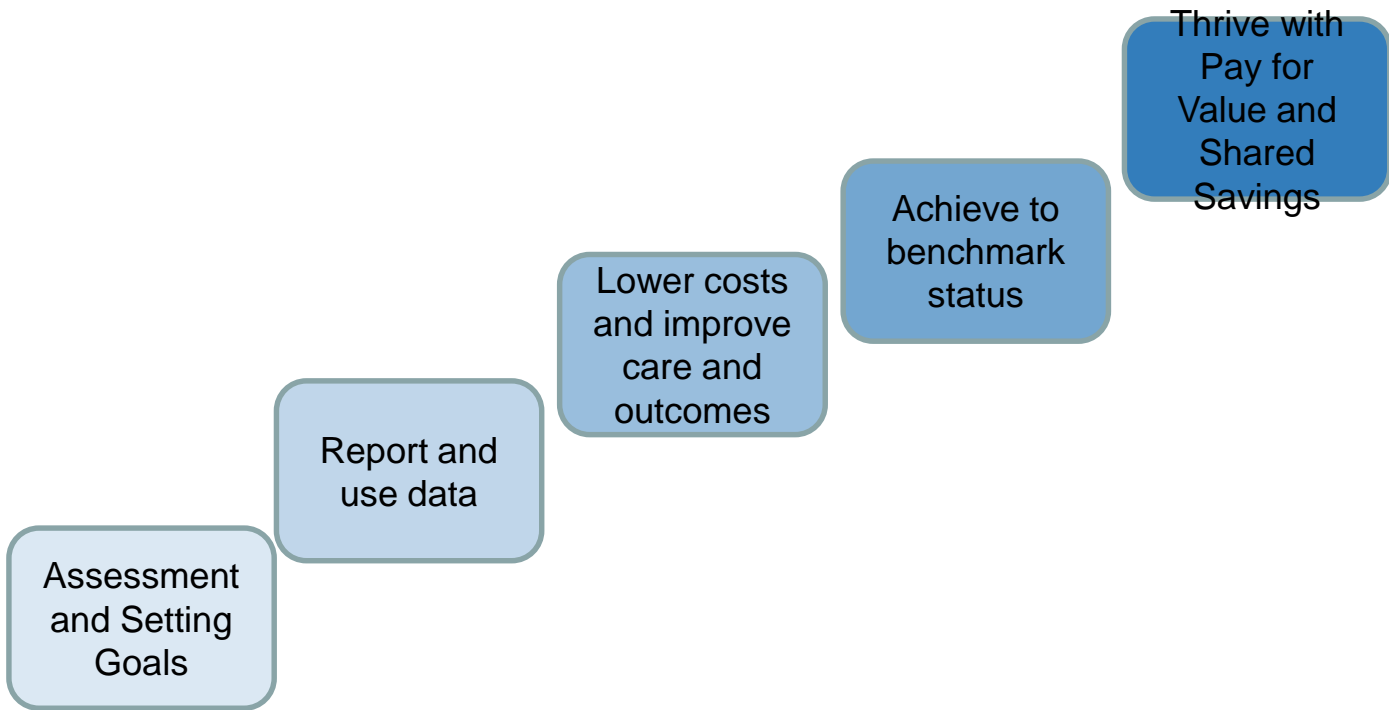
Thomas Mahoney, MD
FLHSA

Genesis

CMMI FOA (TCPI) for <u>two new entities</u> to support transformation of practices to a new care model and payment based on improving care and reducing costs:

– *Practice Transformation Networks (PTN)*

– *Support and Alignment Networks (SAN)*

Goals of the PTN

- To support "practice transformation" that will enable primary care and specialty practices to thrive in under "Value-Based Payment"

- <u>Five phases</u>, representing different levels of mastery
  - Core competencies of a PCMH
    - Population Health Management
  - Continuous quality improvement
    - Document, report and improve performance on quality metrics

Thrive with Pay for Value and Shared Savings

Achieve to benchmark status

Lower costs and improve care and outcomes

Report and use data

Assessment and Setting Goals

Stages of Transformation

1   2   3   4   5

The Model

- Statewide Network w Regional "Personality"
  - Hub of administrative, shared support services
  - Regional Extension Centers
    - "On the ground" Practice Transformation providers
    - Each serving a specific cohort of practices
- Leadership:
  - Lead Applicant: NYeC
  - Program Lead: FLHSA
  - Practice Transformation T.A. providers
  - Broad Base of Stakeholders

Participating T.A. Providers

TA Subcontractor	Geography
PCIP – NYC REACH, a New York City EHR and QI promotion project	NYC
CHCANYS, a statewide primary care association	Statewide
Healthcare Association of New York State	Statewide
Primary Care Development Corporation (PCDC	NYC, Central NY
HealtheConnections (RHIO)	Central NY
P2 Collaborative of Western New York, a Western NY QI organization	Western NY
New York State Council for Community Behavioral Healthcare	NYS
FLHSA	Finger Lakes
Fort Drum Regional Health Planning Organization	Tughill Seaway
Adirondack Health Institute, a health care improvement organization	North Country
North Shore-LIJ Health System, an integrated health system	Long Island
Suffolk County Medical Society, a county medical society	Long Island
Mt. Sinai Health System, an integrated health system	NYC, Long Island
MAeHC, a pioneer in delivering strategy, hands-on implementation, and best practices for community EHRs	Northern Adirondacks
Taconic Health Information Network and Community	Hudson Valley

Stakeholders

Name	Stakeholders Description
NYS Department of Health	State agency
United Hospital Fund	Nonprofit health services research and philanthropic organization
Medical Society of the State of New York	Statewide medical society
Greater New York Hospital Association	Association representing hospitals in the New York City metropolitan area
Adirondack Regional Community Health Information Exchange	Regional health information exchange
Coalition of Behavioral Health Agencies	Umbrella advocacy organization of New York's behavioral health community
E-Health Network of Long Island	Regional Health Information Organization (RHIO)
Health Center Network of New York	HRSA-funded health center controlled network
Hudson Headwaters Health Network	Not-for-profit system of community health centers
Montefiore Medical Center	Academic medical center and university hospital
NY State Academy of Family Physicians	Statewide association for family practice physicians
New York Chapter of the American College of Physicians	Statewide association for internists (SAN applicant)
New York State Technology Enterprise	Government technology consultants

NYSPTN Proposal

- Our PTN application requested
  - $50 million to support the costs of practice transformation consulting
  - to over 11,000 primary care (and some specialty) providers, across NYS
- Responding to the FOA required that we design
  - An statewide structure to manage the program, and
  - A mechanism to provide these services, on a regional basis
- PTN will use
  - A consistent approach and curriculum for practice transformation
  - Shared materials and resources
  - Local TA providers

Practice Transformation Curriculum

NYPTN will provide the following technical assistance and consulting services to participating practices:

➢ Standardized assessment of the practice

➢ Transformation plan customized to each practice

➢ Individualized coaching for practices on team based care and continuous quality improvement techniques

➢ Training on leadership development and care management, provided through a combination of remote and on-site training and support

➢ Support preparing for Value Based Payment Modifiers that require PQRS reporting, Meaningful Use Attestation

➢ Support on new billing options related to PCMH activities: Wellness visits, TOC, and CCM codes

➢ Peer-level support

➢ Assistance from the Support and Alignment Network

Recruiting Practices

- Challenge of no funding incentive available for the practices
- Our value proposition is:
  - This is direction payment is heading and this offers the opportunity to be prepared
  - VBP modifiers in place 1/15 can result in 4% reduction in payments if not in compliance
  - New payment options can improve bottom line even with the added costs of the transformed model of care
  - This will help the practice meet the requirements of DSRIP

Exclusions

PTN funding <u>cannot</u> be used to support practice transformation in any practices participating in other CMMI initiatives :

- The MAP-CP program
    - Adirondacks Medical Home demonstration
- The CPCi program
    - Hudson Valley initiative;
- The CMMI Innovation Challenge
    - FLHSA
- The Medicare ACO program
    - Pioneer ACO and Medicare Shared Savings Program

These exclusions may apply to SIM

Practices Participating

Recruitment	Applicant Response
Primary Care clinicians	
Number committed at time of application	*2,800*
Total number targeted during the TCPI Model	**7,275**
Specialty Care clinicians	
Number committed at time of application	*1,952*
Total number targeted during the TCPI Model	**3,918**
Total number of clinicians that the PTN will enroll	**11,193**
Small, rural, and/or serving the medically underserved Does the number of clinicians from small practices, practices located in rural areas, and/or practices serving the medically underserved include at least 20% of total clinicians?	Yes
What percentages of the total clinicians practice in FQHCs?	7%
Overall value = total requested funding ($49,999,131) divided by the total number of clinicians to be supported	$4,467 per clinician

What Does This Have To Do With SIM?

- PTN required that we design and "test-drive" an approach to delivering practice transformation to practices, across NYS
  - Which is what we're proposing to do under SIM

- As part of this effort, we had to:
  - Define the care model we're trying to achieve
    - Elements of PCMH and CPC / measuring and rewarding QI and performance
  - Design a common curriculum for training
    - A mix of on-site and "lighter-touch" training
  - Figure out how and by whom to deliver that service
    - Hub and spokes, w regional "extension center" services by TA providers
  - Figure out how to do it cost-effectively, within a proscribed budget
    - The proposed model is "affordable" within the available funds, but
    - May require adjustment to make it work for smaller practices

- Collaboration prevailed
  - Primary care providers and TA providers working together to do something important, at scale

The Integrated Care Workgroup

ADVANCED PRIMARY CARE STRAW-PERSON OVERVIEW AND DISCUSSION

NEW YORK STATE OF OPPORTUNITY. | Department of Health
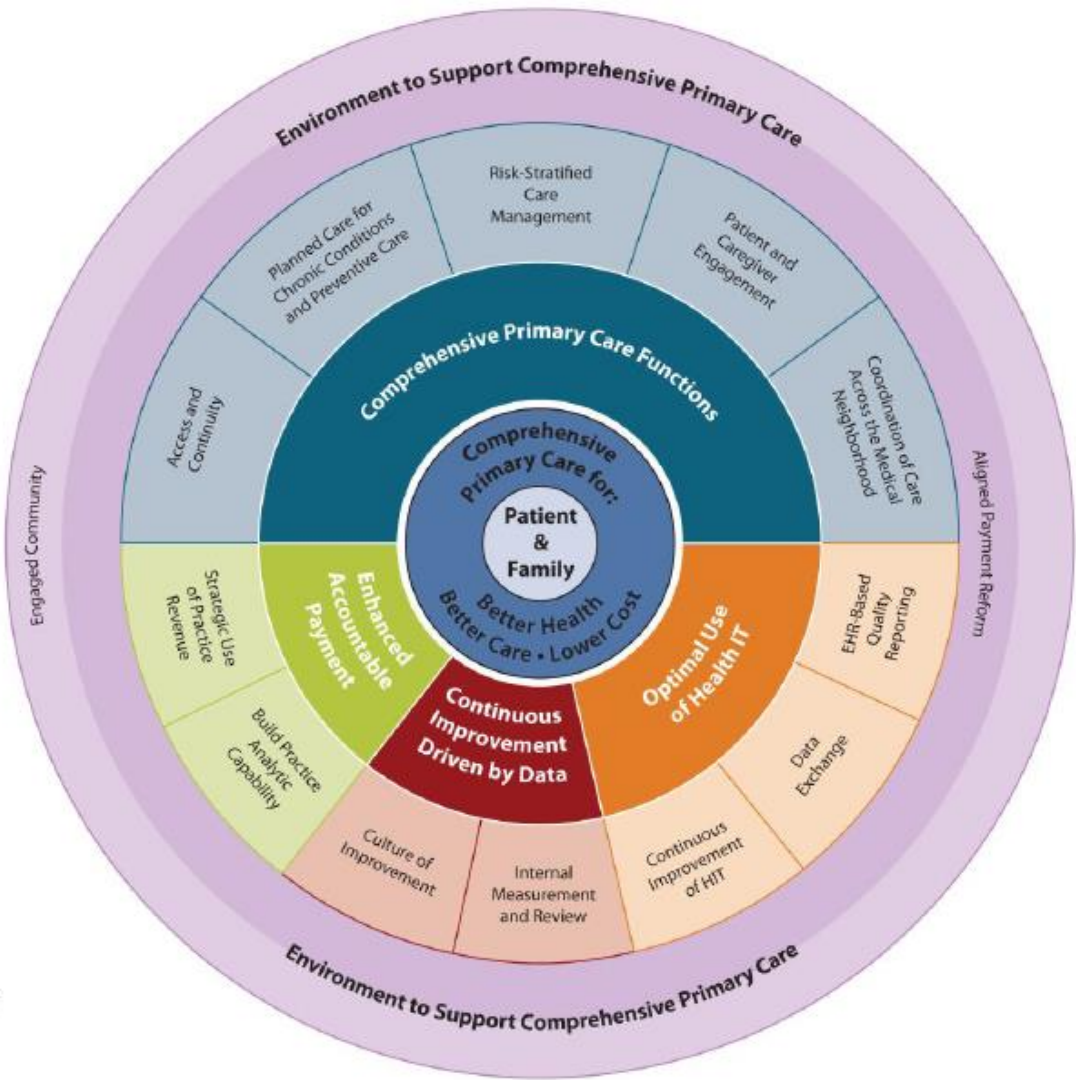
Context: CPCI Milestones

Overview of Milestones for CMS's Comprehensive Primary Care Initiative (CPC)

I.   Budget

II.   Care Management for High Risk Patients

III.   Access and Continuity

IV.   Patient Experience

V.   Quality Improvement

VI.   Care Coordination Across the Medical Neighborhood

VII.   Shared Decision Making

VIII.   Participate in Learning Collaborative

IX.   Health Information Technology

NEW YORK STATE OF OPPORTUNITY. | Department of Health

CPC Milestones are driven by this logic model.

For full explanation see:
http://innovation.cms.gov/Files/x/cpcidiagram.pdf

er 2014

Milestone Progression Years 1-4

- CMS' Comprehensive Primary Care (CPC) initiative is a four year project
- Milestone areas have remained the same in years 1-3 (2013-2015)
- Difficulty of milestones has increase with each year as practices move through transformation
- Practices report on milestones quarterly or annually (depending on milestone) and this documentation is reviewed by local faculty and CMMI staff

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Milestone 1: Budget

- "Complete an annual budget or forecast with projected new CPC Initiative practice revenue flow and plan for anticipated practice expenses associated with practice change."

Milestone	2013	2014	2015
I. Budget	Complete an annual budget or forecast with projected new CPC Initiative practice revenue flow and plan for anticipated practice expenses associated with practice change (practices can submit their own budgets with defined domains, or build off of a template provided by the Innovation Center). This is due to the Innovation Center within 3 months of enrollment.	a. Record actual CPC expenditures and CPC revenue from program year 1. b. Complete an annotated annual budget forecast with projected new CPC Initiative practice revenue flow and plan for anticipated practice expenses associated with practice change in program year 2. This information will be due Q1 of program year 2.	a. Record actual CPC expenditures from PY 2014. b. Complete an annotated annual budget with projected CPC initiative practice revenue flow and actual revenue/expenses from PY 2014. This information will be due Q1 of PY 2015.

- *Commentary*: critical strategic planning exercise. Was incredibly challenging for many practices in year 1

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Milestone 2: Care Management for High Risk Patients

Year 1: Provide information about care management of high risk patients:

a) Indicate the methodology used to assign a risk status to every empanelled patient.

b) Establish and track a baseline metric for percent assignment of risk status and proportion of population in each risk category.

c) Provide practice-based care management capabilities and indicate the following:

- Who provides care management services
- Process for determining who receives care management services
- Examples of care management plans on request.
- Be able to generate lists of patients by risk category

NEW YORK
STATE OF
OPPORTUNITY. | **Department of Health**

Milestone 2: Care Management for High Risk Patients

Year 2:

- Maintain at least 95% empanelment to provider and care teams.
- Continue to risk stratify all patients, achieving risk stratification of at least 75% of empanelled patients.
- Provide care management to at least 80% of highest risk patients
- Implement one or more of the following three specific care management strategies for patients in higher risk cohorts :
  1. Integration of behavioral health;
  2. Self-management support for at least 3 high risk conditions;
  3. Medication management and review.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Milestone 2: Care Management for High Risk Patients

Year 3:

- Maintain at least 95% empanelment to provider and care teams.
- Continue to risk stratify all patients, maintaining risk stratification of at least 75% of empanelled patients.
- Refine the methodology being used to assign a risk status to every empanelled patient.
- Provide care management resources to the population identified as most likely to benefit from those services. Focus on patients identified by the practice's risk stratification methodology to be high risk or with rapidly rising risk and likely to benefit from active, ongoing, intensive care

NEW YORK
STATE OF
OPPORTUNITY. | Department of Health

Milestone 3: Access and Continuity

Year 1:

   a) **Provide and attest to 24 hour, 7 days a week patient access to nurse or practitioner who has real-time access to practice's medical record** for patient advice and to inform care by other professionals.

Year 2:

   a) Attest that patients continue to have 24 hour/7 day a week access to a care team practitioner who has real-time access to the electronic medical record.
   b) **Enhance access by implementing at least one asynchronous form of communication** (e.g., patient portal, email, text messaging) and make a commitment for a timely response.

Year 3:

   a) Attest that patients continue to have 24 hour/7 day a week access to a care team practitioner who has real-time access to the electronic medical record.
   b) Continue to implement at least one asynchronous form of communication (e.g., patient portal, email, text messaging) and make a commitment to responding to patients within a specific time.
   c) **Measure visit continuity by empanelled patients to providers in the practice**.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Milestone 4: Patient Experience

- Year 1: Assess and improve patient experience of care by selecting at least one of the following:
  - a. Provide at least 2 quarters CG-CAHPS
  - b. Patient and Family Advisory Council (PFAC).

- Year 2: Continue year 1 efforts by conducting surveys and/or meetings with a Patient and Family Advisory Council (PFAC).
  - Option A: Conduct practice-based survey monthly.
  - Option B: PFAC that meets quarterly.
  - Option C: Office based surveys administered quarterly and PFAC convened semi-annually.

- Year 3 (add to above):
  - Specify the changes as a result of practice survey/PFAC activities.
  - Continue to communicate to patients about the specific changes the practice is implementing as a result of the survey or PFAC.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Milestone 5: Quality Improvement

Year 1:
- At least quarterly, generate and review practice- or provider-based reports with a minimum of one quality measure and one utilization measure.

Year 2:
- Report the EHR clinical quality measures required by CPC for your region.
- Provide panel (provider or care team) reports on at least three measures at least quarterly to support improvement in care.

Year 3:
- Continue to perform continuous quality improvement using EHR CQM data on at least 3 such measures, at both the practice and panel level, at least quarterly.
- Review quarterly at least one payer data feedback report to identify:
  - A high cost area and a practice strategy to reduce cost in this area while maintaining or improving quality.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Milestone 6: Care Coordination Across the Medical Neighborhood

Year 1: Demonstrate active engagement and care coordination across the medical neighborhood by creating and reporting a measurement – with numerator and denominator data – to assess impact and guide improvement in one of the following:

- Notification of ED visit in timely fashion.

- Practice medication reconciliation process completed within 72 hours of hospital discharge.

- Notification of admission and clinical information exchange at the time of admission.

- Notification of discharge, clinical information exchange, and care transition management at hospital discharge.

- Information exchange between primary care and specialty care related to referrals to specialty care.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Milestone 6: Care Coordination Across the Medical Neighborhood

Year 2: Select two of the three options below, building on your Year 1 activities:

- Track % of patients with ED visits who received a follow up phone call within one week.
- Contact at least 75% of patients who were hospitalized in target hospital(s), within 72 hours.
- Enact care compacts/collaborative agreements with at least 2 groups of high-volume specialists in different specialties to improve transitions of care.

NEW YORK
STATE OF
OPPORTUNITY.

Department
of Health

Milestone 6: Care Coordination Across the Medical Neighborhood

Year 3: Continue to implement two of the three options below, building on your PY 2013 and PY 2014 activities:

- Track % of patients with ED visits who received a follow up phone call within one week.
- Contact at least 75% of patients who were hospitalized in target hospital(s), within 72 hours or 2 business days.
- Maintain or enact care compacts/collaborative agreements with at least 2 groups of high-volume specialists in different specialties to improve transitions of care.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Milestone 7: Shared Decision Making

Identify a priority condition, decision, or test that would benefit from shared decision making and the use of a decision aid. Make a decision aid available to appropriate patients and generate a metric for the proportion of patients who received the decision aid for this priority area. Information about shared decision making is available at https://www.cahps.ahrq.gov/Quality-Improvement/Improvement-Guide/Browse-Interventions/Communication/Shared-Decision-Making.aspx	a. Implement shared decision making tools or aids in two health conditions, decisions or tests as component of shared decision-making.
	
	b. Generate a metric for the proportion of patients who received the decision aid, OR
	
	c. Provide quarterly counts on run charts of patients receiving the decision aids and show growth in use of the aids.
		a. Use at least three decision aids to support shared decision making in preference-sensitive care.
		
		b. Track use of the aids using one of the following methods:
		
		  1. A metric tracking the proportion of patients eligible for the decision aid who receive the decision aid; OR
		
		  2. Quarterly counts of patients receiving individual aids.

Milestone 8: Participate in Learning Collaborative

Participate in the market-based learning collaborative and share knowledge, tools, and expertise with other practices in the market as indicated by:

a. Attendance at three face-to-face meetings annually and in web-based meetings at least monthly.

b. Sharing of materials or resources on the collaboration site.

c. Reporting on the Innovation Center's on-line Collaboration Site of at least 6 key measures that are of importance to the practice and which will be used to guide active testing of changes in the practice. These may include measures required for patient experience, risk status assignment, care coordination, etc., as described above.

a. Participate in all three all-day CPC learning sessions in your region.

b. Participate in one learning webinar per month.

c. Contribute a minimum of one document or experiential story to the CPC Collaboration Website.

d. Fully engage and cooperate with the Regional Learning Faculty, including by providing regular status information as requested, for the purposes of monitoring progress towards Milestones and/or for the purposes of providing support to meet the Milestones. As a contractor for CMS, the faculty are bound by confidentiality agreements.

a. Participate in all CPC learning sessions in your region.

b. Participate in at least one of the following Advanced Primary Care Action Groups:

- Integration of behavioral health;
- Medication management;
- Self-management support.

c. Fully engage and cooperate with the Regional Learning Faculty, including by providing regular status information as requested, for the purposes of monitoring progress towards Milestones and/or for the purposes of providing support to meet the Milestones. As a contractor for CMS, the faculty is bound by confidentiality agreements.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Milestone 9: Health Information Technology

Year 1:
- Attest to the requirements for **Stage 1** of Meaningful Use for the EHR Incentive Programs (for practitioners participating in the Medicaid EHR Incentive Program, adopting, implementing, or upgrading certified EHR technology is not sufficient, the practitioner must attest to Stage 1).

Year 2:
- All eligible professionals in the practice successfully attest to Meaningful Use in accordance with the requirements of the Meaningful Use program.
- **Upgrade EHR technology to the 2014 edition ONC Certification**.
- Identify the care settings/providers for which the practice has the ability to exchange health information electronically.

Year 3:
- Attest that each Eligible Professional within the practice is engaged with, and working towards, attestation for **Stage II** of Meaningful Use in the timelines set by the Meaningful Use program.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Context: Meaningful Use

MU Current Status Eligible Professionals

- MU Stage One:
    - Nationally, approx 278,000 since 2011.
    - 41,000 for 2014 attested among 500,000 active registrants.
    - Approx 250,000 providers will have 1% penalty to Medicare physician fee schedule payments beginning Jan 5, 2015 for failing to meet MU by Oct 1, 2014.
    - 55,000 qualified for hardship exemption.

- MU Stage TWO includes Stage One Core and all Menu and other requirements.

- MU Stage TWO-Less than 4% (approx. 11,000 across U.S.) of eligible physicians have attested to Stage Two.

- New rule requires attestation to only 3 months rather than one year.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

MU Stage One

Required Core Objectives:
- CPOE
- Drug and drug allergy interaction
- Problem list
- Transmit Rx electronically
- Medication list
- Medication allergy list
- Demographics
- Vital signs
- BMI
- Growth charts for children
- Smoking status
- One clinical decision support rule
- Patient ability to view online, download, and transmit information
- Clinical summaries for patients
- Protect electronic health information

Must also choose five of:
- **drug formulary checks**
- **lab test results as structured data**.
- **lists of patients by specific conditions** to use for quality improvement, reduction of disparities, research, or outreach.
- **Send patient reminders** per patient preference for preventive/follow up care.
- **patient specific education** resources and provide
- **medication reconciliation**
- **summary care record for each transition** of care or referral.
- **electronic data to immunization registries** or immunization information systems and actual submission according to applicable law and practice.
- **electronic syndromic surveillance** data to public health agencies and actual submission according to applicable law and practice.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

2014 Core Set – Required CQM for All Stages

- Controlling High Blood Pressure
- Use of high risk medications in the elderly
- Tobacco screening and cessation intervention
- Use of Imaging studies for low back pain
- Screening for clinical depression and follow up plan
- Current med list
- BMI screening and follow up
- Receipt of specialist report
- Functional status assessment for complex chronic conditions

NEW YORK
STATE OF
OPPORTUNITY. | Department of Health

Context: NCQA 2014 Standards

PCMH 2014 Content and Scoring
(6 standards/27 elements)

1: Enhance Access and Continuity	Pts
A. ***Patient-Centered Appointment Access**	**4.5**
B. 24/7 Access to Clinical Advice	3.5
C. Electronic Access	2
	10

2: Team-Based Care	Pts
A. Continuity	3
B. Medical Home Responsibilities	2.5
C. Culturally and Linguistically Appropriate Services (CLAS)	2.5
D. ***The Practice Team**	**4**
	12

3: Population Health Management	Pts
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
	20

4: Plan and Manage Care	Pts
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
	20

5: Track and Coordinate Care	Pts
A. Test Tracking and Follow-Up	6
B. ***Referral Tracking and Follow-Up**	**6**
C. Coordinate Care Transitions	6
	18

6: Measure and Improve Performance	Pts
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
	20

Scoring Levels
Level 1: 35-59 points.
Level 2: 60-84 points.
Level 3: 85-100 points.

*Must Pass Elements

NCQA
Measuring quality.
Improving health care.

Must Pass Elements

Rationale for Must Pass Elements

- Identifies critical concepts of PCMH
- Helps focus Level 1 practices on most important aspects of PCMH
- Guides practices in PCMH evolution and continuous quality improvement
- Standardizes "Recognition"

Must Pass Elements

- 1A: Patient Centered Appointment Access
- 2D: The Practice Team
- 3D: Use of Data for Population Management
- 4B: Care Planning and Self-Care Support
- 5B: Referral Tracking and Follow-Up
- 6D: Implement Continuous Quality Improvement

PCMH 1A: Patient-Centered Access

The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on:

1. Providing routine and urgent same-day appointments – CRITICAL FACTOR
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

NOTE: Critical Factors in a Must Pass element are essential for Recognition

NCQA
Measuring quality.
Improving health care.

PCMH 2D: The Practice Team

The practice uses a team to provide a range of patient care services by:

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 FACTOR)
4. Using standing orders for services.
5. Training and assigning members of the care team to coordinate care for individual patients.

NOTE: Critical Factors in a Must Pass element are essential for Recognition

PCMH 2D: The Practice Team (cont.)

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.

PCMH 3D: Use Data for Population Management

At least annually practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidenced-based guidelines including:

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.

+ Stage 2 Core Meaningful Use Requirement

PCMH 4B: Care Planning and Self-Care Support

Care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75 percent of the patients identified in 4A.

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 patient/family/caregiver.

PCMH 5B: Referral Tracking & Follow-Up

The Practice:

1. Considers available performance info on consultant/ specialists for referral recommendations
2. Maintains formal and informal agreements with 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/specialist the clinical question, required timing and type of referral

PCMH 5B:Referral Tracking & Follow-Up (cont)

6. Gives the consultant/specialist pertinent demographic and clinical data, including test results and current care plan

7. Has capacity for electronic exchange of key clinical information and provides electronic summary of care record to another provider for >50% of referrals*

8. Tracks referrals until consultant/specialist report is available, flagging and following up on overdue reports (Critical Factor)

9. Documents co-management arrangements in patient's medical record

10. Asks patients/families about self-referrals and requests reports from clinicians

*Meaningful Use Requirement

NCQA
Measuring quality.
Improving health care.

PCMH 6D: Implement Continuous Quality Improvement

Practice uses ongoing quality improvement process:

1. Set goals and analyze at least three clinical quality measures from Element 6A

2. Act to improve performance on at least three clinical quality measures from Element 6A

3. Set goals and analyze at least one measure from Element 6B

4. Act to improve at least one measure from Element 6B

PCMH 6D: Implement Continuous Quality Improvement (cont.)

5. Set goals and analyze at least one patient experience measure from Element 6C

6. Act to improve at least one patient experience measure from Element 6C

7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations

Advanced Primary Care Straw-Person: Version 1.0

APC Straw-Person – v 1.0 (1 of 5)

PRE APC	APC	PREMIUM APC
1. PAYMENT MODEL	**1. PAYMENT MODEL**	**1. PAYMENT MODEL**
a. Interested/able to explore alternative payment model(s) that move away from FFS.	a. Agrees to negotiate alternative payment model(s) with interested payers.	a. Agrees to negotiate alternative payment model(s) beyond FFS with interested payers with goal *to impact at least 50% of covered lives in the practice*
2. CARE MANAGEMENT FOR HIGH RISK PATIENTS	**2. CARE MANAGEMENT FOR HIGH RISK PATIENTS**	**2. CARE MANAGEMENT FOR HIGH RISK PATIENTS**
a. Able to identify and monitor number of high risk patients who would benefit from care management and prepare care plans as appropriate	a. Able to *risk stratify all patients, identify and provide appropriate care management for at least 75% of those at highest risk* b. *Most care management should be on-site* with some referrals as appropriate c. Able to conduct medication reconciliation for patients transitioning from institutional care sites.	a. Able to risk stratify all patients, identify highest risk, and *provide care management services on site to all at highest risk* b. *Includes behavioral health assessment and referral as part of risk stratification and referrals for care management.* c. *Commits to core elements of collaborative care model for depression screening including data collection and tracking.* d. *Refers and integrates practice care management with Medicaid health home and health plan care managers as appropriate.* e. Provides timely medication reconciliation for patients transitioning from institutional care.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

APC Straw-Person – v 1.0 (2 of 5)

PRE APC	APC	PREMIUM APC
3. ACCESS AND CONTINUITY OF CARE	**3. ACCESS AND CONTINUITY OF CARE**	**3. ACCESS AND CONTINUITY OF CARE**
a. Provision of 24/7 patient access to nurse or other clinician	a. 24/7 patient access to nurse or other clinician including reliable access to EHR after hours. b. Provide and assess performance on provision of routine and same day appointments. c. Provides at least one method of *asynchronous communication* between patient and provider with commitment to explicit response time goal.	a. 24/7 patient access to nurse or other clinician including reliable access to EHR after hours. ***b. Provides "open access" for routine and urgent same day appointments and assess performance on this access*** c. Provides at least one method of *asynchronous communication* between patient and provider with commitment to explicit response time goal. ***d. Able to measure and report on patient and provider continuity.***
4. PATIENT EXPERIENCE	**4. PATIENT EXPERIENCE**	**4. PATIENT EXPERIENCE**
a. Conduct of annual patient survey and/or; b. Include patient or family member as part of practice advisory council	a. Conduct at least semi-annual patient survey and show evidence of *incorporation of survey results as part of QI plan.*	a. Conduct at least *quarterly* patient survey and show evidence of incorporation of survey results as part of QI plan. ***b. Be able/willing to report survey results to patients, payers or both***

NEW YORK STATE OF OPPORTUNITY. | Department of Health

APC Straw-Person – v 1.0 (3 of 5)

PRE APC	APC	PREMIUM APC
5. QUALITY IMPROVEMENT	**5. QUALITY IMPROVEMENT**	**5. QUALITY IMPROVEMENT**
a. Able to evaluate practice performance using at least three NQF quality measures and evidence improvement on at least one (measure).	a. Be able to measure and report at least six NQF measures; set goals for each and implement QI activities for three (measures) *b. At least half of measures should be from EHR.* *c. Have systems in place to at least annually identify (independently or with payer) patient populations due for preventive or chronic care management services and communicate reminders.*	a. Be able to measure and report at least six NQF measures; set goals for each and implement QI activities for three (measures) b. At least half of measures should be from EHR and make use of CQM data ***c. Be able/willing to report results of at least one measure to patients, payers or both.*** d. Have systems in place to identify, ***more than once annually,*** those populations due for preventive or chronic care management services and communicate reminders.
6. CARE COORDINATION	**6. CARE COORDINATION**	**6. CARE COORDINATION**
a. System in place or in development to track referrals and follow up and follow up on overdue reports as necessary	a. Has system in place to track referrals, completed reports and process to address uncompleted referrals or reports. *b. Has care compacts, collaborative agreements with at least 2 groups of high volume specialists to improve transitions in care* *c. Has systems in place to identify and contact patients seen in an ED or discharges from a high volume hospital.*	a. Has system in place to track referrals and both completed and uncompleted referrals and reports. b. Has care compacts/collaborative agreements in place with at least 2 groups of high volume specialists to improve transitions in care c. Has system in place to identify and contact patients seen in an ED or discharged from a high volume hospital

APC Straw-Person – v 1.0 (4 of 5)

PRE APC	APC	PREMIUM APC
7. SHARED DECISION MAKING	**7. SHARED DECISION MAKING**	**7. SHARED DECISION MAKING**
a. Clinical or care team able/willing to develop care plans in concert with patient preferences and goals.	a. Clinical and/or care team develops care plans that incorporate patient preferences and goals and *communicates these plans in writing to the patient or caregiver.* b. *Plan includes documentation of advanced directives or patient declination to discuss*	a. Clinical and/or care team develops care plans that incorporate patient preferences and goals and communicates these plans in writing to the patient or caregiver. b. *Plan includes documentation of advanced directives or patient declination to discuss*
8. LOCAL/DISTANCE LEARNING COLLABORATIVES	**8. LOCAL/DISTANCE LEARNING COLLABORATIVES**	**8. LOCAL/DISTANCE LEARNING COLLABORATIVES**
a. Willingness to participate in on-site or distance learning.	a. Willingness to actively *participate in at least 75%* of on-site or distance learning through meetings and webinars *including at least one face-to-face meeting.*	a. Willingness to actively participate in local or distance learning collaboratives (meetings or webinars) *including at least one face-to-face meeting*

NEW YORK STATE OF OPPORTUNITY. | Department of Health

APC Straw-Person – v 1.0 (5 of 5)

PRE APC	APC	PREMIUM APC
9. HEALTH INFORMATION TECHNOLOGY	**9. HEALTH INFORMATION TECHNOLOGY**	**9. HEALTH INFORMATION TECHNOLOGY**
a. Has or is in the process of obtaining EHR	*a. Meets all MU State 1 requirements and is working towards or has achieved stage 2* *b. Currently connected to and contributes to RHIO or has plans to connect with 6 months.* *c. Agrees to participate in NYS SHIN-NY.*	a. Meets all MU stage 1 and 2 requirements b. Working towards MU Stage 3 c. Connected and contributing to RHIOs and can demonstrate significant use of data for patient care activities d. Agrees to participate in NYS SHIN-NY
10. PARTICIPATION AGREEMENT	**10. PARTICIPATION AGREEMENT**	**10. PARTICIPATION AGREEMENT**
a. Agrees to standardized self-assessment tool and on-site audit to evaluate readiness for/interest in change b. Is interested and able to explore alternative payment models that move away from FFS c. Commits to meeting APC standards within 1-2 years d. Sponsorship for education and training support is available e. Up-to-date board certification	a. Agrees to use standardized self-assessment tool and on site audit to evaluate current capacities and readiness for change *b. Agrees to negotiate alternative payment models with interested payers.* c. Has proof that sponsorship is available d. Up to date board certification	a. Agrees to use standardized self-assessment tool and on site audit to evaluate current capacities and readiness for change b. Agrees to negotiate alternative payment models beyond FFS with interested payers with goal ***to impact at least 50% of covered lives in the practice***

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Discussion

NEXT STEPS

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Upcoming Topics

OVERVIEW OF NEXT TOPICS

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Measures

- Measures for:
  - Success
  - Payment
  - Evaluation
  - Quality improvement
  - Public reporting

- The Crowded Measurement Field
  - PQRS
  - ACO
  - QARR/HEDIS
  - DSRIP/PPS
  - Private Payers
  - Meaningful Use CQMs

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Payment

- Goals
  - Two types of payment are required:
    - Investments in transformation support
    - Infrastructure (on-going) support to meet standards
  - Must align with movement from volume to value
    - Improved outcomes and reduced costs
  - Requires 'critical mass' of payers and alignment
  - May be different payment methods
    - Many payers have developed their own models, not "one true cross"
    - Payment may vary, depending on practice's status
      - Freestanding practice, paid directly, or
      - Part of larger system, that has AC-oid (e.g., shared savings) payment in place

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Practice Transformation RFP

- Clear articulation of the 'what' (standards or desired practice capacities)
- Approach to prioritizing the 'who' is eligible (which practices?)
  - Avoiding duplication (of payment or efforts)
  - Prioritizing need coupled with likelihood of 'success'
    - Defining how to assess 'likelihood'
  - Defining 'sponsorship' functions
  - Role of payer alignment and support
- Approach to defining "by whom" and "how"
  - Who does the "practice transformation"?
  - What's the curriculum (common, statewide?)
  - What and how should they get paid?

NEW YORK STATE OF OPPORTUNITY. | Department of Health