NEW YORK STATE OF OPPORTUNITY. Department of Health

New York State Department of Health Statewide Steering Committee

June 19, 2017

Agenda

#	Topic	Time	Leader
1	Welcome and Introductions	10:30 - 10:45	Marcus Friedrich Susan Stuard
2	APC Practice Transformation Updates ▪ PTTA Expansion & Rollout ▪ ROMC ▪ Transformation Engagement Dialogue	10:45 - 11:45	Lori Kicinski Susan Stuard Tom Mahoney Danielle Lafhaj
3	HIT Enabled Quality Measurement	11:45 - 12:05	Jim Kirkwood Maria Ayoob
4	Working Lunch	12:05 - 12:20	
5	PCMH 2017 Alignment NYS – NCQA PCMH Program Alignment Strategy ▪ Findings and Analysis ▪ Stakeholder Impact Dialogue ▪ Timeline/Roadmap	12:20 - 1:45	Rodrigo Cerda Sarun Charumilind Marcus Friedrich Susan Stuard
6	Next Steps	1:45 - 2:00	Marcus Friedrich Susan Stuard

APC Practice Transformation Update

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PTTA Expansion & Rollout

NY State of Transformation – SIM/APC Facts

- Launched Round 2 Practice Transformation (PT TA) vendors- 16 in 8 DFS Regions
- Held the first APC PT TA In-Person Summit:

  - attended by 38 Agents from 10 entities,12 Content Experts from 5 agencies, RHIOs, NYAM, and DOH APC staff
- PT TA "Train-the-Trainer" Webinars, Monthly Round Table, 1:1 Monthly PT TA "Pulse" conference calls with APC team
- As of May 24th, 101 practices enrolled, 58 in discussions
- 65% of the practices are small provider size (1-4 provider), the rest medium (5-10) and large (>10)

NY State Transformation – TA Vendors

#	Name of Awardee		Regions
1	Adirondack Health Institute	AHI	Capital District and Adirondacks
2	CDPHP	CDPHP	Capital District, Mid-Hudson Valley and North Country
3	HANYS	HANYS	Capital District and Long Island
4	Chautauqua County Health	CCHN	Western (Buffalo)
5	Solutions 4 Community Health	S4CH	Mid-Hudson Valley and Long Island
6	Institute for Family Health	IFH	NYC
7	IPRO	IPRO	NYC, Central NY (Syracuse) and Long Island
8	PCDC	PCDC	NYC
9	Fund for Public Health in New York	FPHNY	NYC
10	Finger Lakes (Common Ground Health)	CGH	Finger Lakes (Rochester) and Central NY (Syracuse)
11	Niagara Falls Memorial Medical Center	NFMMC	Western New York Region
12	New York eHealth Collaborative	NYeC	Western New York Region, NYC, and Long Island
14	Chinese American IPA, Inc. d/b/a Coalition of Asian-American IPA	CAIPA	New York City Region
15	EmblemHealth Services Company, LLC	Emblem	New York City Region and Long Island
16	Maimonides Medical Center	Maimonides	New York City Region

Round 1 Entities
Round 2 Entities

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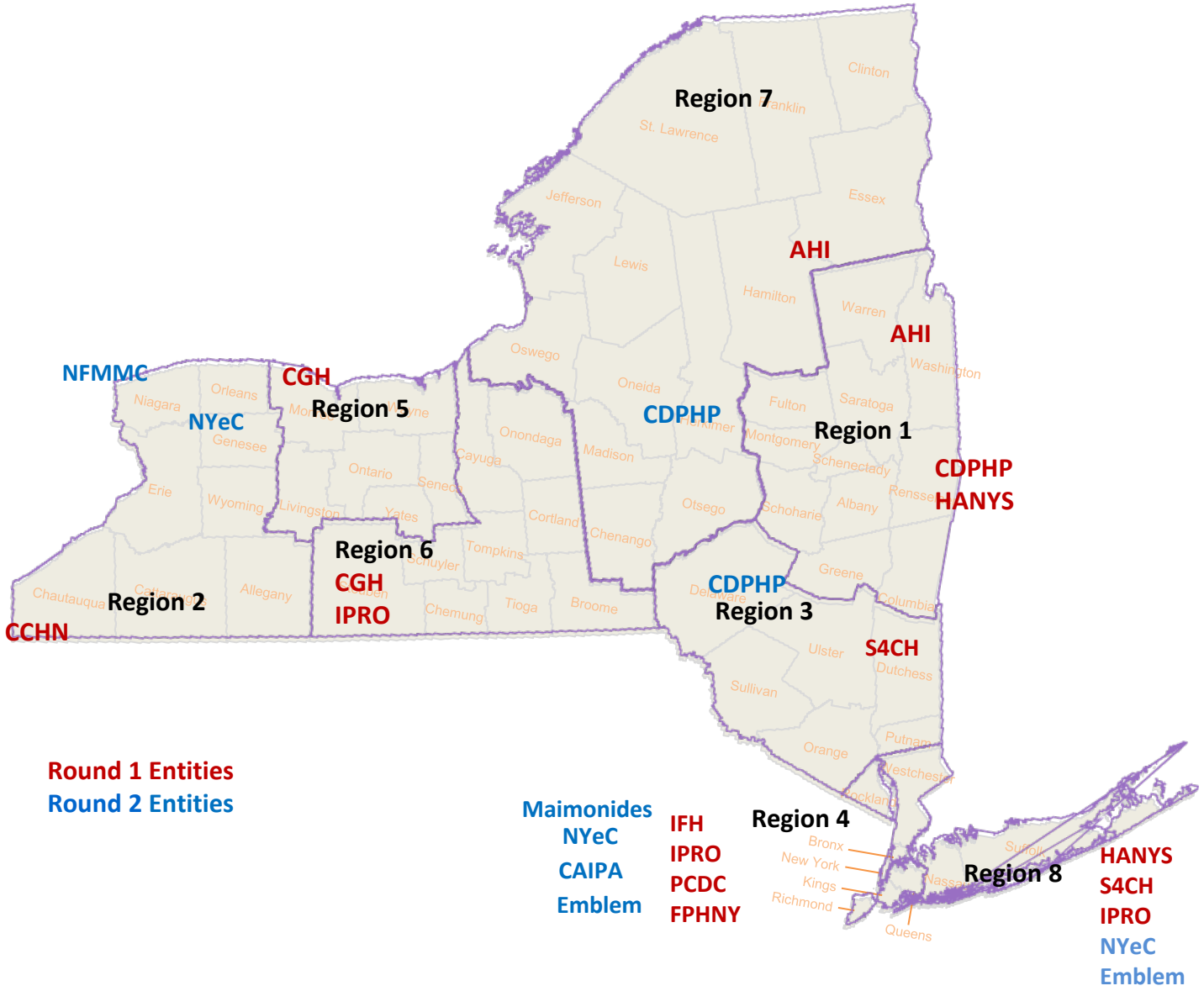
NY State Transformation – TA Vendors and enrolled practices



Capacity Projections-All Regions*

Region	Practices
Region 1	275
Region 2	216
Region 3	125
Region 4	1081
Region 5	70
Region 6	70
Region 7	115
Region 8	379
Total:	**2480**

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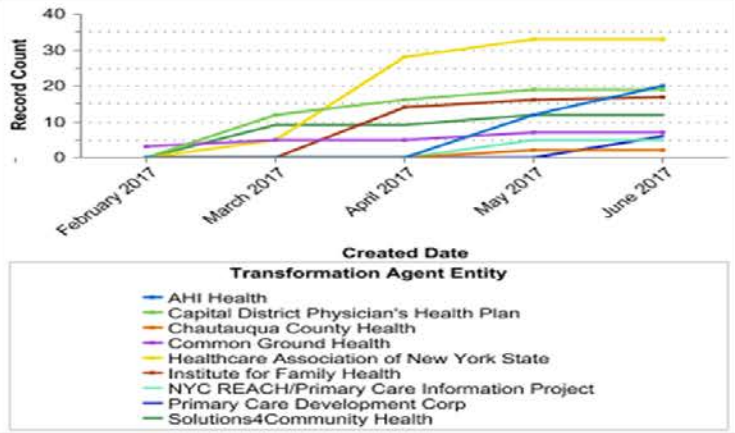
Practice Transformation Tracking System (PTTS)

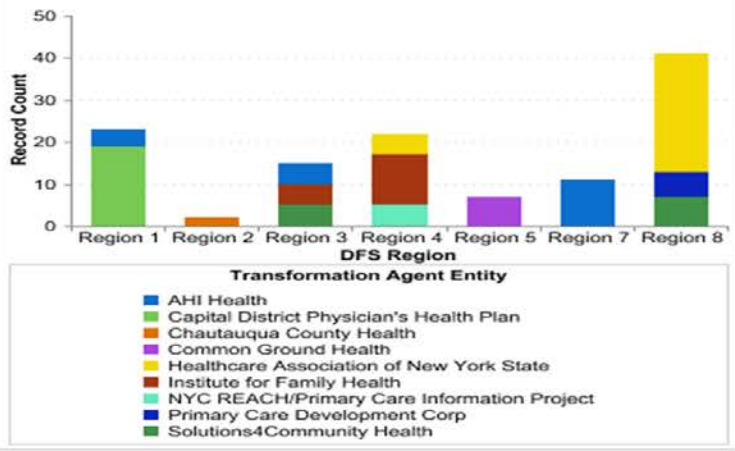
Practice Recruitment

Find a dashboard... | Edit | Clone | Refresh | As of Today at 9:04 AM

Practice Sites Enrolled



Enrolled Practice Sites by Region & TA



Enrollment Goal

Practice Sites Enrolled

Practice Sites Enrolled: **121**

Enrolled Practice Sites by PT TA

Transformation Agent Entity	Record Count
AHI Health	20
Capital District Physician's Health Plan	19
Chautauqua County Health	2
Common Ground Health	7
Healthcare Association of New York State	33
Institute for Family Health	17
NYC REACH/Primary Care Information Project	5
Primary Care Development Corp	6
Solutions4Community Health	12

Enrolled Practice Sites by Region

DFS Region	Record Count
Region 1	23
Region 2	2
Region 3	15
Region 4	22
Region 5	7
Region 7	11
Region 8	41

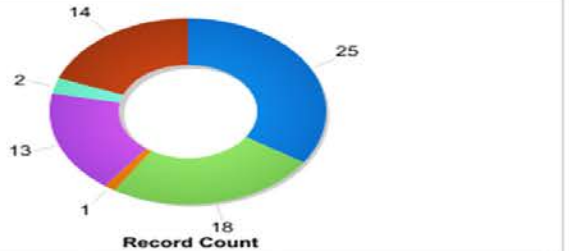
Enrolled Practice Sites by Practice Size

Small = 1-4 primary care physician and mid-level providers; medium =

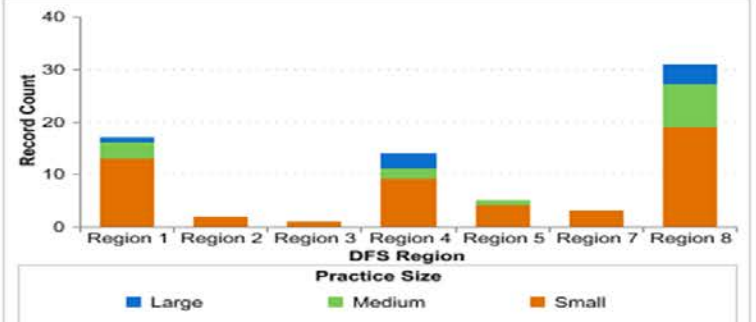
Practice Sites Engaged

Practice Sites Engaged: **73**

Practice Sites Engaged



Enrolled Practice Sites by Region & Size



Small = 1-4 primary care physician a
5-10; large = 11+

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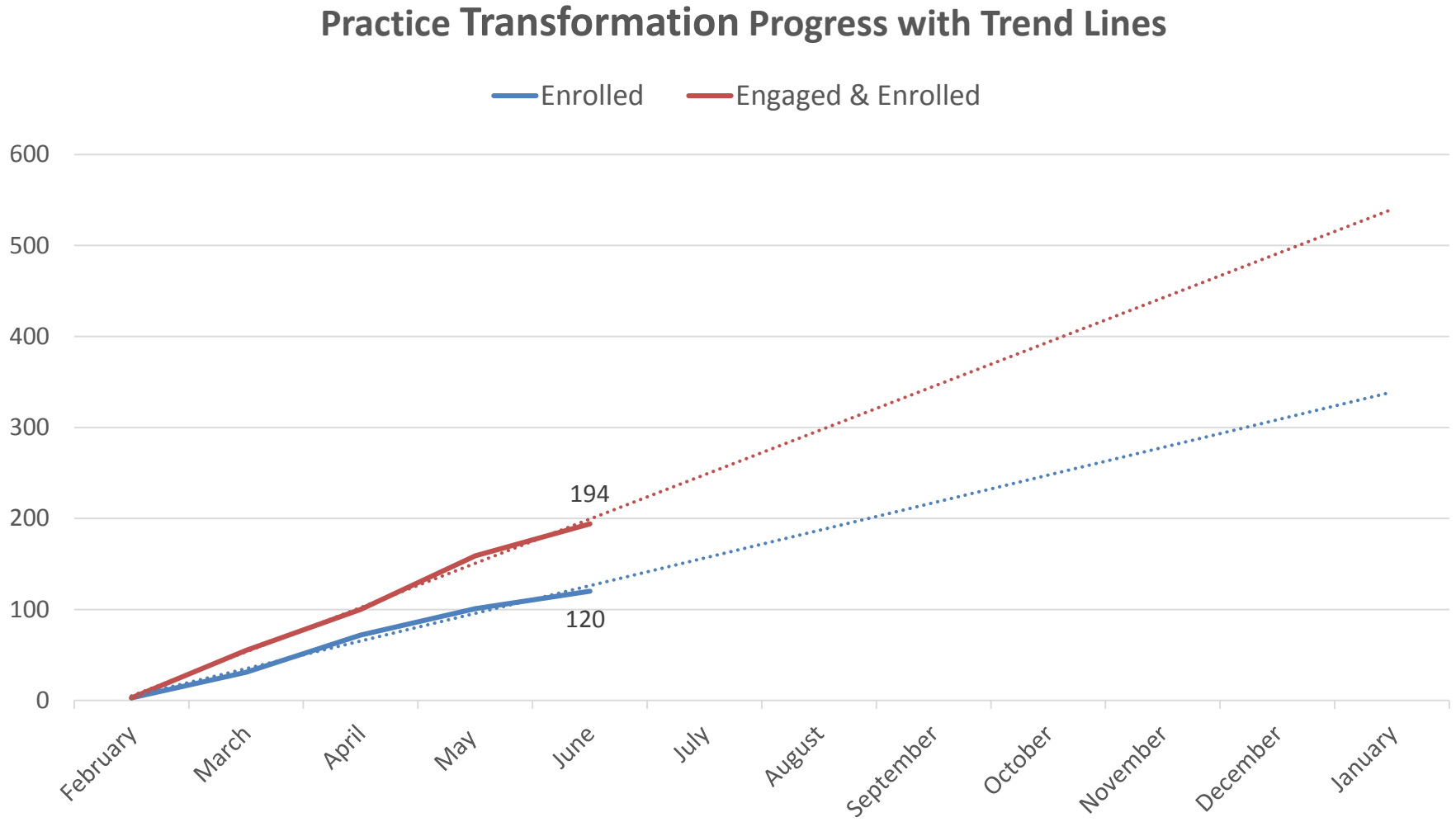

Based on PTTS data on 06/13/17

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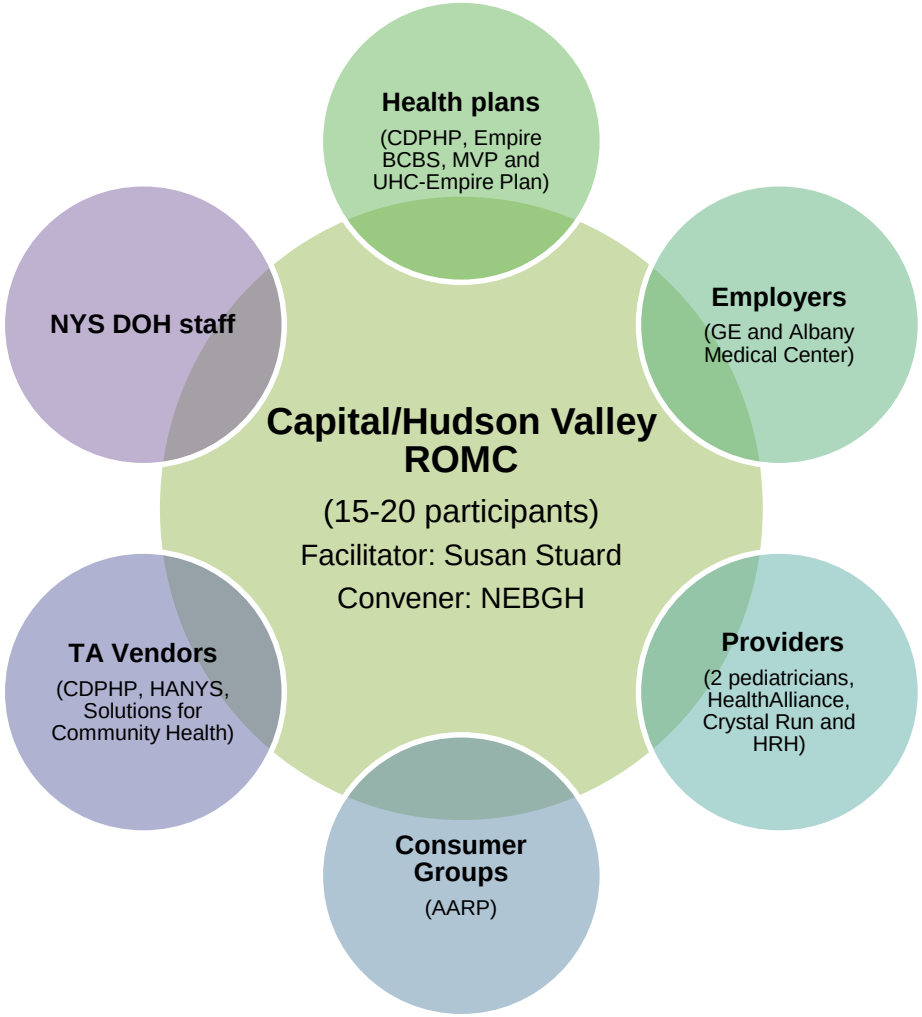
ROMC Update

Capital/Hudson Valley Composition and Current Activity



Capital/Hudson Valley ROMC Update

Quality measure crosswalk and alignment discussion

- At present, of 28 APC core measures:
  - 5 measures common to all four participating payers
  - 3 measures common to three of four participating payers
  - 5 measures common to two of four participating payers

Draft APC payment model grid has been prepared

- Request out to payers to share basic information about advanced primary care payment models

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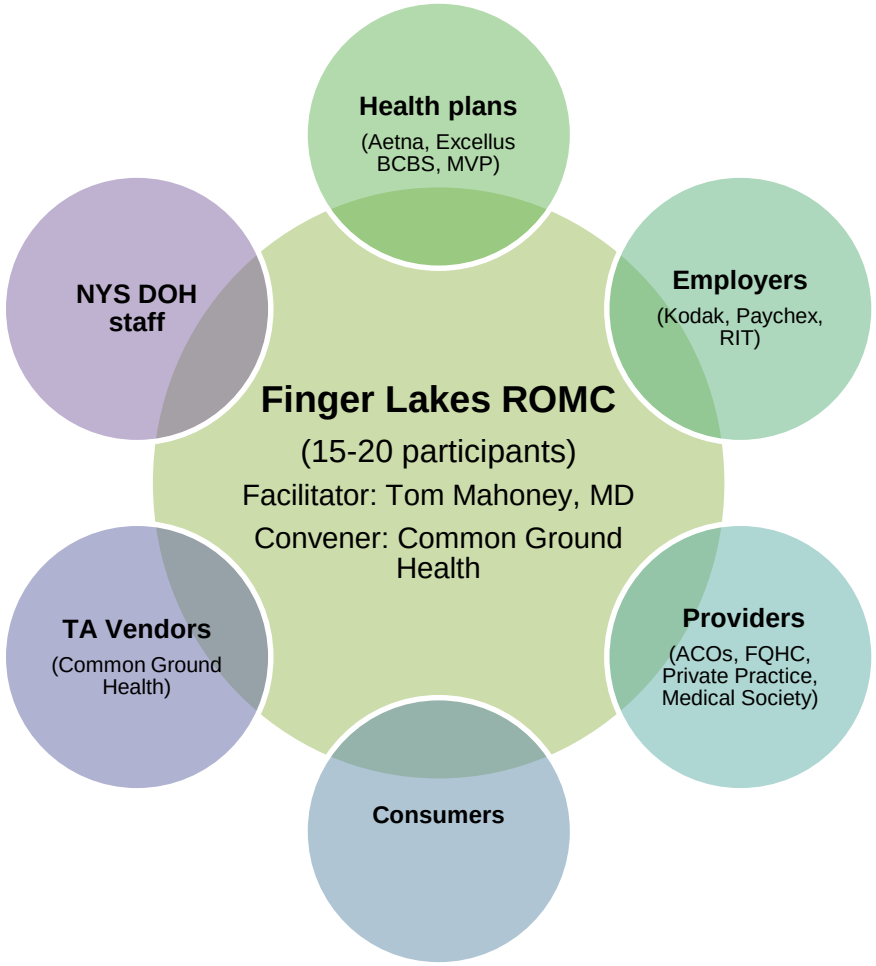
Finger Lakes ROMC Composition and Current Activity



Finger Lakes ROMC Update

- 3 meetings completed (1/23, 3/27 and 5/16)
- Findings from Consumer Focus Groups presented to the committee
- Finalizing meeting schedule through the end of the year

Future Agenda Topics

- Alignment of quality measures across payers and ACO's
- Engage Millenniums in Consumer Focus Groups
- Discuss the potential to leverage CGCAHPS
- One on one meetings with ACO's to discuss payment opportunities
- Analysis of the cost to practices to implement APC model of care

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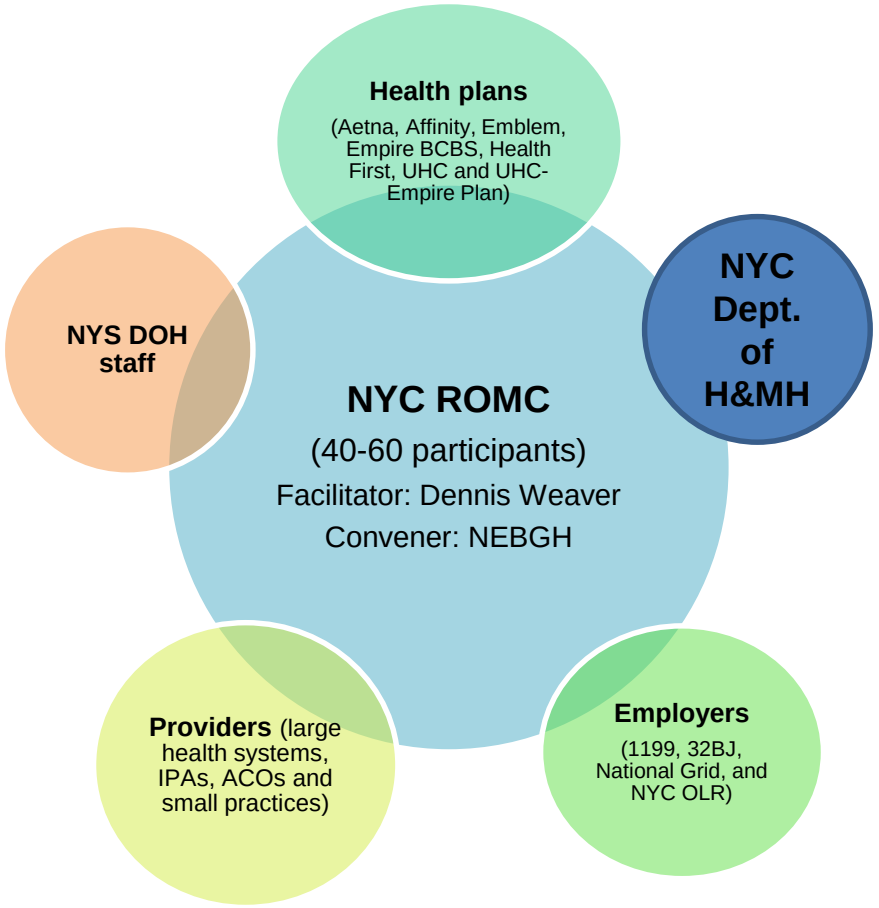
NYC ROMC Composition and Current Activity



NYC ROMC Update

- Three meetings completed - 2/28, 4/26, and 5/16
- Meetings scheduled through December 2017
- Finalized charter approved - 5/16
- Health Plans meeting occurred - 6/16
- Continued 1:1 meetings with health plans, providers and employers underway

Progress

- Strong level of engagement

Challenges

- Multiple “accountable payment” initiatives already underway between health plans and providers (charter validates/excludes those agreements from consideration)
- Engagement of providers targeted for initiative

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Transformation Engagement Dialogue

What is working for Transformation Agents?

What obstacles are there to recruiting practices?

How can the Statewide Steering Committee promote uptake?

HIT Enabled Quality Measurement

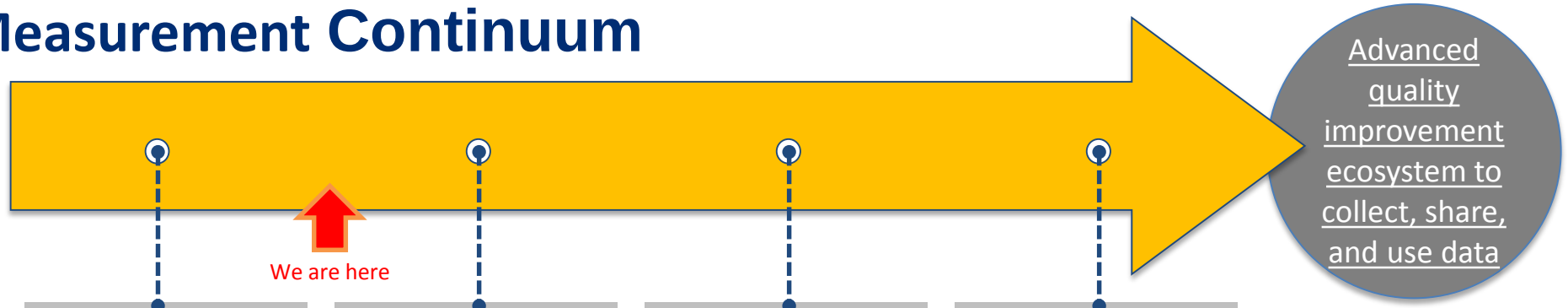
APC Scorecard – Request to Payers

- Request was shared with payers on May 23, 2017
  - Patient Level Detail (PLD) file for a subset of the APC Measures (13 Version 1 measures)
  - First submission leverages HEDIS 2017 data; sent to IPRO in August 2017

- Question from plans about whether they need to send files if not participating in a ROMC

- Benefits to plans to provide PLD file even if not in a ROMC may include
  - A portion of plan networks have low volume of plan members that may have precluded performance evaluation; multi-payer results may provide valuable data about those providers.
  - Federal and NYS transformation efforts are moving forward on the VBP path. Plans may benefit from developing the internal capacity to provide this level of measurement for future VBP.

Quality Measurement Continuum



Claims-based Quality Measurement	Self-reported	Live automated data	Integrated data
Claims data quality measurement and/or HEDIS data collected from surveys, chart reviews, and claims data	Data captured, eCQM calculated in EHR and only numerator/ denominator reported	Automated data acquisition from EHRs to central aggregator tool for calculation, comparison, reporting, and population level measures	Claims and clinical data integrated to analyze quality and address population health needs

Provider/Practice/Encounter Level Data

Patient-Centric Reporting
Provider-Centric Reporting
Practice-Centric Reporting
System-centric Reporting
Population-level Reporting

From ONC Conference:
IT-enabled Quality Measurement (Aug 31 –Sep 1, 2016)

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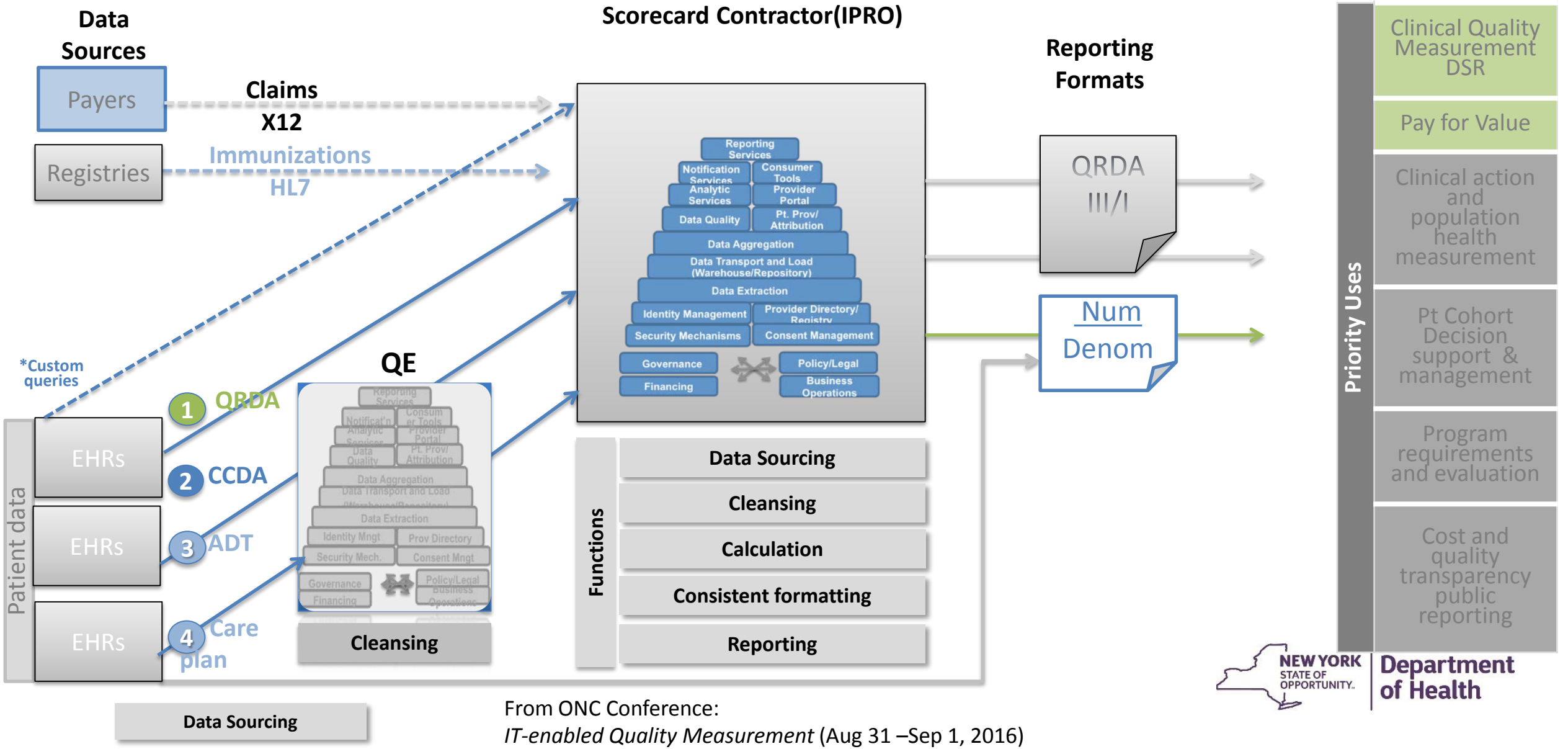
Intermediate Scorecard



From ONC Conference:
IT-enabled Quality Measurement (Aug 31 –Sep 1, 2016)

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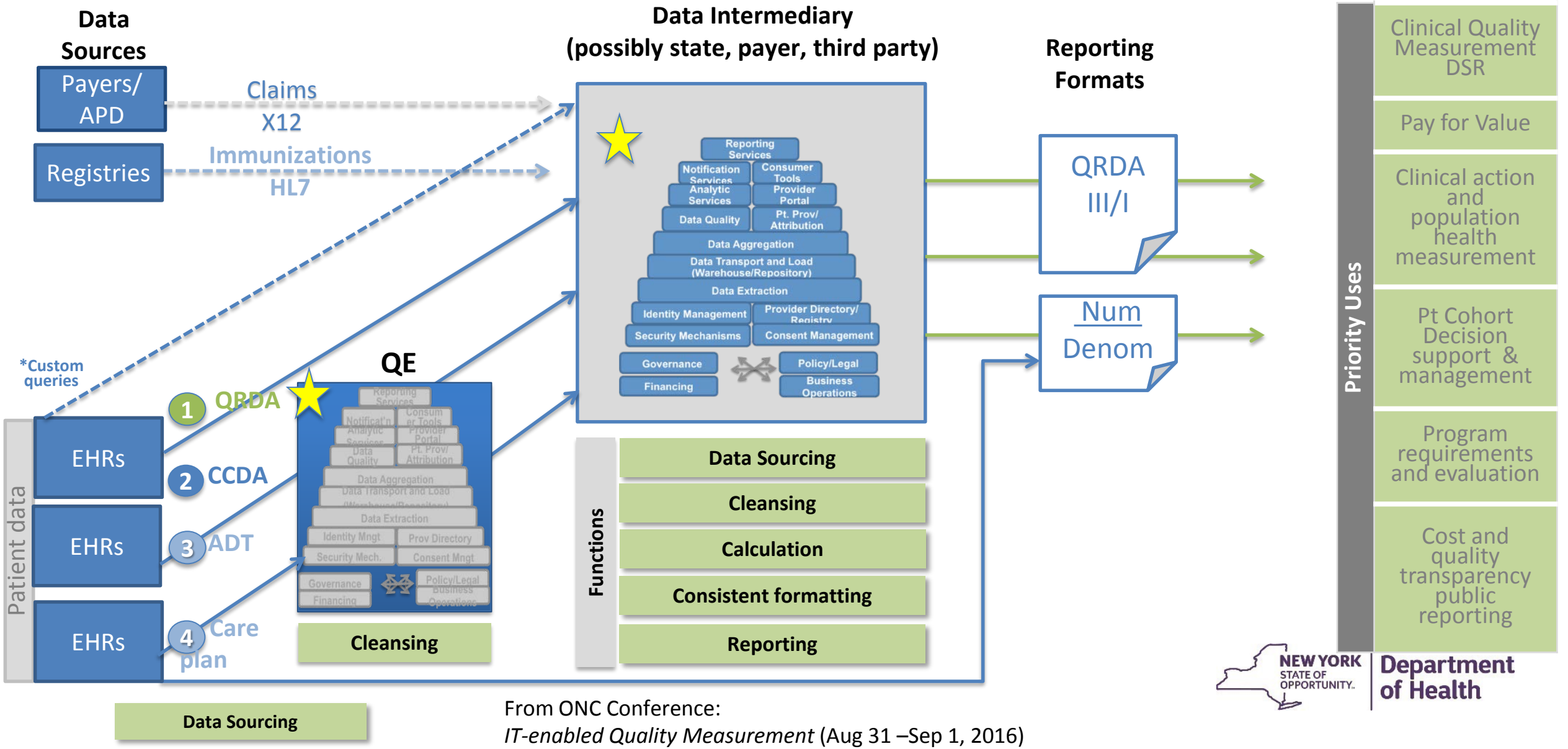
Future Vision for Scorecard



From ONC Conference:
IT-enabled Quality Measurement (Aug 31 –Sep 1, 2016)

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Major Challenges to Implementing HIT-enabled Quality Measurement

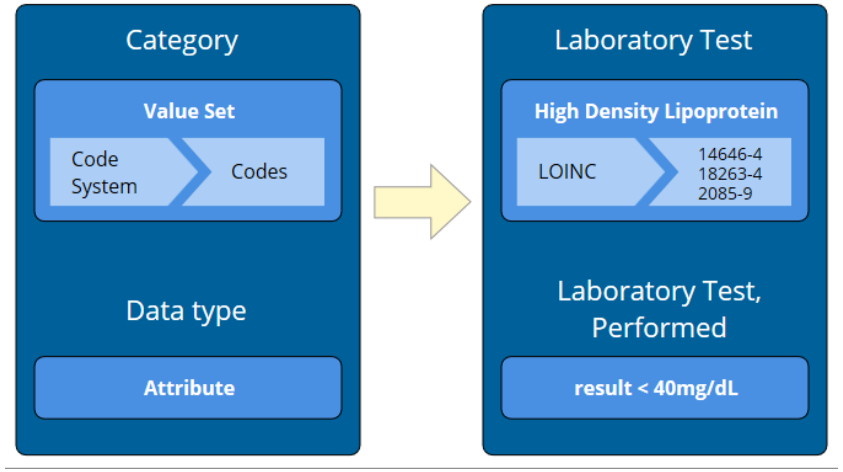
- Increasing quality and completeness of data available through EHRs
  - EHR expectation vs. reality
  - How an EHR is used and implemented
  - Standardization
- Provider-Practice Site Problem
- Ensuring infrastructure is available and avoiding redundancy

Implementing Standards

- SHIN-NY is focused on aligning with standards for Certified Health Information Technology
  - SHIN-NY regulation
  - Incentive programs for providers to connect to the SHIN-NY
  - Supports providers and hospitals that need to meet MACRA and Medicaid Meaningful Use Requirements
  - Aligns with national activities electronic quality measurement initiatives

Aligning with National Activities

- Quality Data Model- Describes the relationship between the patient and clinical concepts to support standardized quality measurement
  - Building blocks of electronic clinical quality measures
  - Relies on multiple, recognized standards implemented in the community



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HIT Enabled Quality Measurement Current State Assessment

- Key Project Activities
  - Stakeholder interviews and literature review re:
    - Quality measurement needs for various State initiatives
    - Initiatives outside of NYS working to enhance quality measurement with electronic clinical data
    - Current efforts of QEs to support quality measurement and population health
  - Assessed alignment of measures across APC, DSRIP and SIM

HIT Enabled Quality Measurement Current State Assessment

- Key Findings
  - Data aggregation and analytics capabilities are the foundation for quality measurement
  - Data quality and completeness are barriers to HIT-enabled quality measurement
  - Analytics and measurement use cases can be a driver of QE/QE-participant data quality efforts
  - QEs have projects underway to support quality measurement and population health management, driven by participant needs

HIT Enabled Quality Measurement Current State Assessment

- QE Activities
  - Providing high-quality data to organizations (e.g. plans, ACOs) for use in generating quality measures and meeting other analytical needs
  - Generating proxy measures to support organizations in monitoring performance and targeting quality measurement efforts
  - Providing actionable data for patient outreach and intervention

HIT Enabled Quality Measurement Current State Assessment

- Data Quality Considerations
  - Quality measurement/population health management requires high-quality, structured (i.e. machine-readable), complete data
  - Each measure/use case has its own unique challenges in terms of data quality
  - Examples of data quality issues
    - Use of local codes vs. national standards
    - Reliance on text vs. structured fields
    - Variation across EHR vendors in completeness of data sent to QE

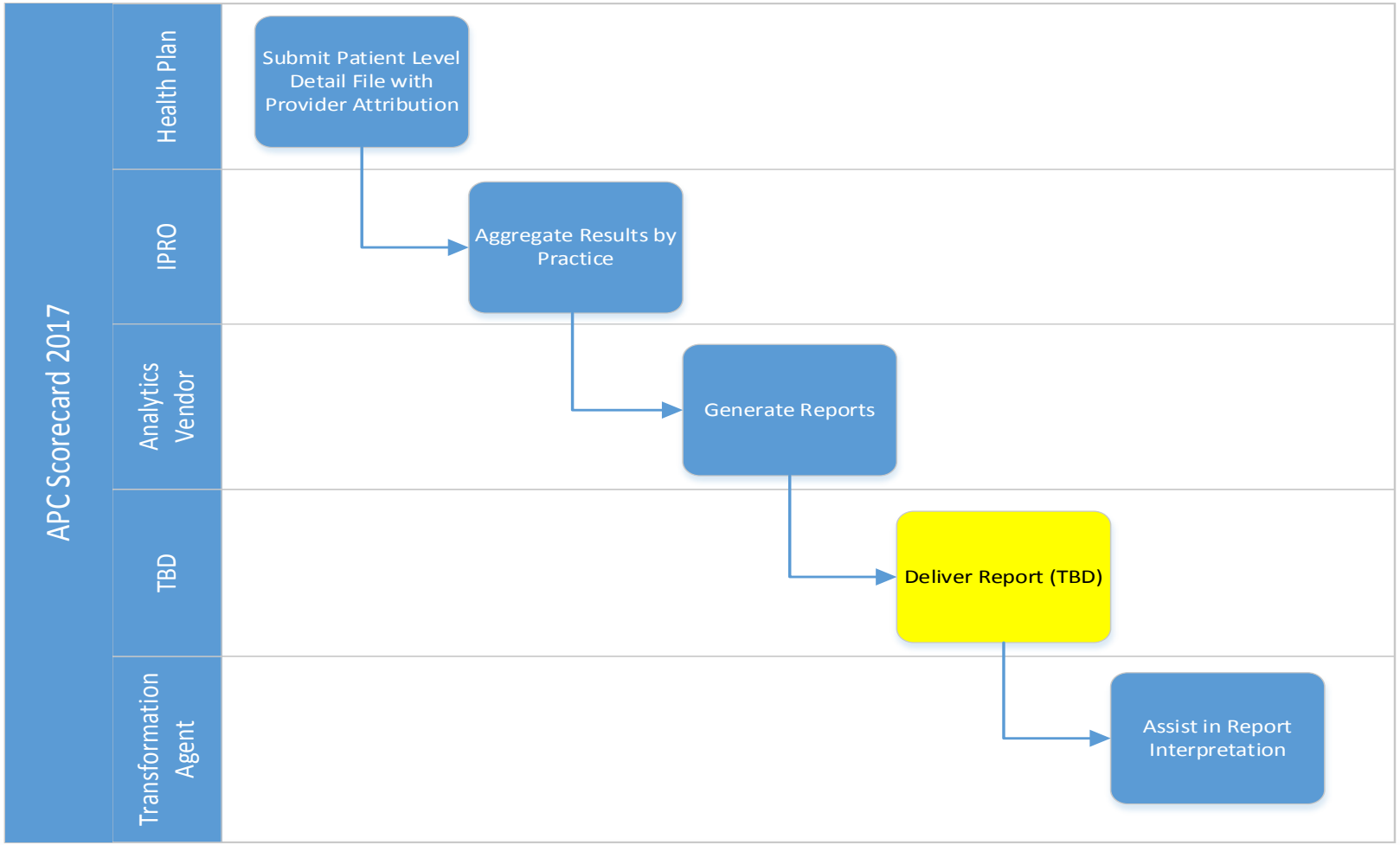
HIT Enabled Quality Measurement Current State Assessment

- Examples of QE Data Quality Activities
  - "Interrogating" data based on specific use case requirements
  - Exploring ways to work with unstructured data
  - Mapping local codes to national code sets
  - Working directly with facilities to encourage use of LOINC or other standards

HIT Enabled Quality Measurement Current State Assessment

- Next Steps
  - Understand needs of plans and provider organizations
  - Determine how QEs fit into APC needs
    - Design an approach to testing QE-enabled quality measurement in the context of APC
    - Identify objectives, guiding principles, use cases, measures and participants
    - Explore possible data flows and approaches to patient attribution, provider attribution, data sharing policies

HIT Enabled Quality Measurement Current State Assessment



HIT Enabled Quality Measurement Current State Assessment

Cross-Cutting Measures					
Measure Title	**Hybrid Measure**	**APC 1.0**	**APC Full**	**DSRIP**	**VBP (IPC)**
Anti-Depressant Medication Management	N	Y	Y	Y	Y
Cervical Cancer Screening	Y	Y	Y	Y	Y
Childhood Immunization Status	Y	Y	Y	Y	Y
Chlamydia Screening for Women	N	Y	Y	Y	Y
Comprehensive Diabetes Care: Eye Exam	Y	Y	Y	Y	Y
Comprehensive Diabetes Care: HbA1C Testing	Y	Y	Y	Y	Y
Comprehensive Diabetes Care: HbA1c Poor Control	Y	N	Y	Y	Y
Controlling High Blood Pressure	Y	N	Y	Y	Y
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	N	Y	Y	Y	Y
Medication Mgmt for People with Asthma	N	Y	Y	Y	Y
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	N	N	Y	Y	Y

PCMH Alignment

Contents

There are clear benefits for aligning NYS APC and NCQA PCMH 2017 programs

Why align with PCMH (NCQA PCMH 2017)?

- **A clear capability-based roadmap for NYS is important for accelerating the transition toward delivering value** and succeeding in new payment models for all practices in the State
- **As NCQA PCMH 2017 sufficiently captures the intention and substance of NYS APC criteria, there is an opportunity to simplify a complicated landscape** and reduce confusion among healthcare stakeholders in the state
- **>95% alignment with PCMH**, with only select modifications, will enable **rapid provider uptake** of time-limited transformation funding
- **Operational considerations are solvable**, but should also be executed with a **"keep it simple" approach** – i.e., implications on TA, Independent Validation Agent, NCQA arrangements and scopes of work

Why to create a distinct "NYS PCMH"?

Recap: We considered three options and are now proposing a adapted PCMH program for New York State

Proposed option

Proposal options	What you have to believe
A Continue with independent NYS APC	▪ There is **momentum among payers and providers on APC**, an remaining consistent with agreed-upon plan is important to maintaining it ▪ APC allows **independence and self-determination** for what is most important to the state ▪ Current TA resources with an independent verification body will be the **most efficient** way of moving forward while reducing fees to practices
B Adapt custom NCQA PCMH program to meet NYS needs	▪ Alignment with new **NCQA guidelines will better allow for multi-payer support** (e.g., Medicaid, Medicare, and private payers), **provided that certain APC changes are made** ▪ NCQA verification can be financed through practice fees, and is a familiar framework for many practices in NY
C Use 2017 NCQA PCMH as-is for APC program	▪ The new **NCQA guidelines now fulfill the reasons for which APC was designed**, including gaining payor support, and adaptation would introduce unnecessary complexity ▪ NCQA is sufficient to merit financial support from Medicare, and nationwide alignment will make Medicare participation with APC more likely ▪ NCQA verification can be financed through practice fees, and is a familiar framework for many practices in NY

Adjustments to the NCQA PCMH 2017 program can help properly reflect the context and priorities of New York State

Why align with PCMH (NCQA PCMH 2017)?

Why create a distinct "NYS PCMH"?

- **A NYS PCMH program has to consider several state-specific components that NCQA PCMH 2017 does not**, including investments in Health IT, State-funded Technical Assistance (TA), Medicaid incentive payments, and the potential for multi-payer support
- **Accelerating the transition toward value-based payment is a priority for NY**, and has been a core part of the APC initiative
- **In this NYS context, several currently 'Elective' NCQA criteria are sufficiently aligned NYS priorities to make 'Core'**
  - Behavioral health care management
  - Rigorous capabilities in Care Coordination
  - Health IT capabilities
  - Value-based payment (VBP) arrangements
  - Population Health

In considering options for alignment with NCQA 2017, we received input from a broad range of stakeholders and experts. Thank you!

State / Public

- NEW YORK STATE Department of Health
- NYC Health
- NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

Payer

- Department of Health | Office of Health Insurance Programs
- Empire BlueCross BlueShield An Anthem Company
- CDPHP
- MVP HEALTH CARE

ROMC

- Albany / Hudson
- Finger Lakes
- New York City

TA vendor

- FLHSA
- HANYS Healthcare Association of New York State
- THE INSTITUTE FOR FAMILY HEALTH

Provider

- GNYHA
- CHCANYS DEFINING NEW DIRECTIONS Community Health Care Association of New York State
- HANYS Healthcare Association of New York State
- CAIPA Coalition of Asian-American IPA, Inc.
- HUDSON HEADWATERS Health Network
- Crystal Run Healthcare
- PRIMARY CARE DEVELOPMENT CORPORATION
- United Hospital Fund

External Context

- COMMONWEALTH OF MASSACHUSETTS
- NCQA Measuring quality. Improving health care.
- Ohio Department of Health
- TN Department of Health

“NYS PCMH” will align largely with the NCQA program, with several targeted revisions

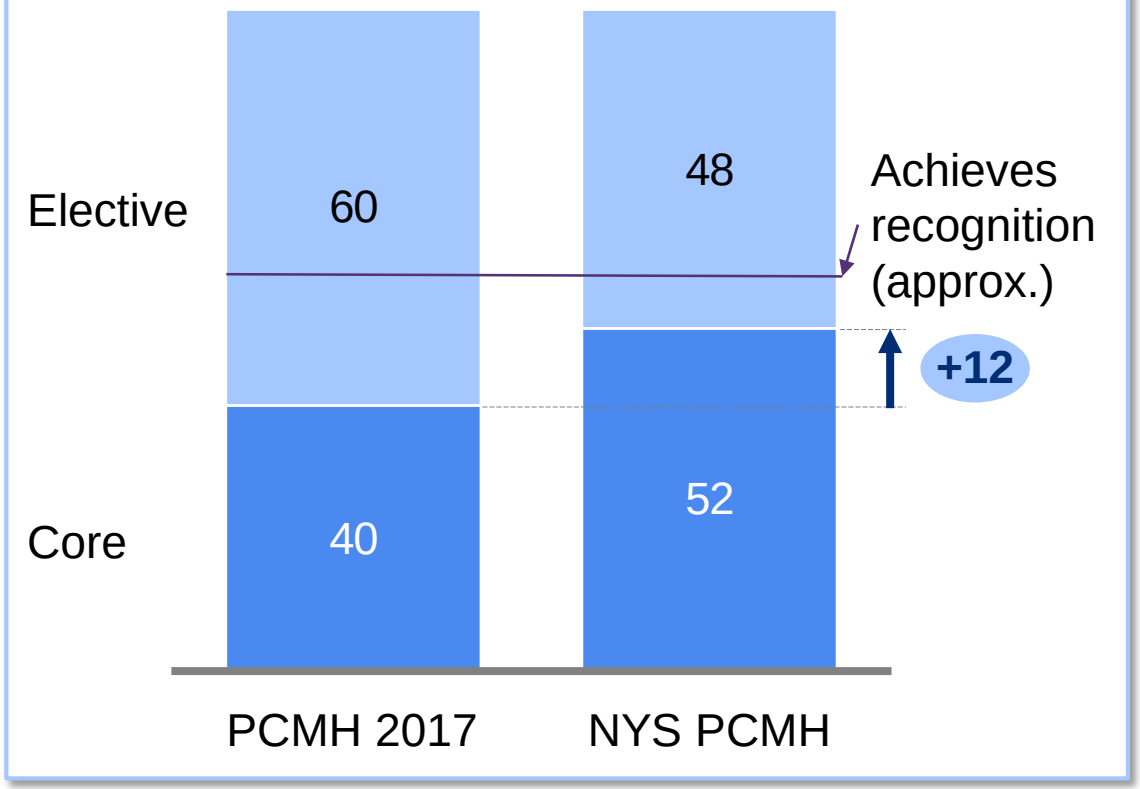
Key differences

	From: NCQA PCMH 2017	To: NYS PCMH
Phases of transformation	1. Commit 2. Transform 3. Succeed	▪ Same- in the spirit of simplification, the current NCQA PCMH phases and assessment model would fully replace APC Gates
Requirements	1. Commit, self-assess, plan 2. Develop and document PCMH capabilities 3. Re-certify on an annual basis	1. Same, **plus commitment to adopt VBP** 2. **Additionally require 12 NCQA-elective Behavioral Health, Care management, Population Health, and Health IT capabilities as “Core”[1]** 3. Same
Recognition	▪ Recognition by NCQA as a PCMH 2017 practice	▪ Recognition by NYS and NCQA as an **NYS PCMH 2017** practice
State-funded Technical Assistance (TA)	▪ None	▪ **State-funded TA** to achieve NYS PCMH recognition (with minimal to no need for changes in curriculum), contingent on continued participation for up to 2 years
Medicaid support	▪ PMPM payment (tiered) upon achieving PCMH 2014 Levels II or III recognition	▪ PMPM payment upon reaching NYS PCMH recognition

1 The 12 additional criteria for NYS PCMH represent 18 elective credits in NCQA PCMH- so NYS PCMH practices would need to complete only an additional 7 credits of electives to achieve recognition

NYS PCMH 2017 builds on PCMH 2017 by converting 12 Electives into Core, with focus on Health IT, BH integration, and care management

NYS PCMH criteria compared to PCMH 2017



Changes compared to NCQA PCMH

- **12 Additional Core criteria** represent fundamental building blocks in the areas of:
  - Behavioral Health integration
  - More rigorous Care Coordination
  - Health IT capabilities
  - VBP arrangements
  - Population Health
- Providers would then complete **4-7 elective criteria to earn 7 additional credits**[1]

1 From an NCQA point of view, the practice will have then completed NCQA's 40 Core criteria and earned 25 Elective credits (18-19 credits – depending on if VBP is upside only or full risk – earned from completing the 12 Elective criteria that were converted to Core for NYS PCMH, plus 6 additional credits).

Source: NCQA PCMH 2017

Detail: Proposed 12 new “core” criteria

	Code	Criteria
Behavioral health	CC9	Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care
	KM4	Conducts BH screenings and/or assessments using a standardized tool. (implement two or more) A. Anxiety B. Alcohol Use Disorder C. Substance Use Disorder D. Pediatric Behavioral Health Screening E. PTSD F. ADHD G. Postpartum Depression
Care manage-ment and coordina-tion	CM3	Applies a comprehensive risk - stratification process to entire patient panel in order to identify and direct resources appropriately
	CC8	Works with non-behavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care
	CM9	Care plan is integrated and accessible across settings of care
	CC19	Implements process to consistently obtain patient discharge summaries from the hospital and other facilities
	KM11	Identifies and addresses population-level needs based on the diversity of the practice and the community (Demonstrate at least 2) A. Target pop. health mgmt. on disparities in care B. Address health literacy of the practice C. Educate staff in cultural competence
Health IT	AC8	Has a secure electronic system for two-way communication to provide timely clinical advice
	AC12	Provides continuity of medical record information for care and advice when the office is closed
	CC21	Demonstrates electronic exchange of information with external entities, agencies and registries (may select 1 or more): RHIO, Immunization Registry, Summary of care record to other providers or care facilities for care transitions
	TC5	The practice uses an EHR system (or modules) that has been certified and issued an ONC Certification ID, conducts a security risk analysis, and implements security updates as necessary correcting identified security deficiencies
VBP	QI19	The practice is engaged in Value-Based Contract Agreement. (Maximum 2 credits) A. Practice engages in up-side risk contract[1]

1 A value-based program where the clinician/practice receives an incentive for meeting performance expectations but do not share losses if costs exceed targets.

Source: 2017 NCQA PCMH

Detail: NCQA criteria for VBP can be satisfied by P4P arrangements that may be more feasible for small practices to participate in

Code	Criteria	Standards and guidelines	Operational effect
VBP: QI 19	Is engaged in Value-Based Agreement. A. Practice engages in upside risk contract (1 Credit). B. Practice engages in two-sided risk contract (2 Credits).	▪ Upside Risk Contract: A value-based program where the clinician/practice receives an incentive for meeting performance expectations but do not share losses if costs exceed targets. ▪ Two-Sided Risk Contract: A value-based program where the clinician/practice incur penalties for not meeting performance expectations but receive incentives when the care requirements of the agreement are met. Expectations relate to quality and cost.	▪ **Performance expectations** could take the form of **P4P/P4V agreements**, e.g. hospital admissions, ER visits, appropriate use of medications (to be confirmed with NCQA and potentially adjusted as necessary)

Source: NCQA PCMH 2017 Standards and Guidelines

Detail: NCQA standards address the APC specification for monitoring and treatment of depression

Code	NCQA Criteria	NCQA Standards and guidelines	Operational effect
KM3	▪ Conducts depression screenings for adults and adolescents using a standardized tool	▪ Screening adults for depression with systems in place to ensure accurate diagnosis, effective treatment and follow-up ▪ The practice uses a standardized screening tool (e.g., PHQ-9) and acts on the results.	▪ The practice will implement systematic **detection of depression** ▪ Results of screening will trigger treatment with follow-up to ensure that **depression treatment is effective**
CC9	▪ Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care	▪ Relationships between primary care practitioners and specialists support consistency of information shared across practices. The practice has established relationships with behavioral healthcare providers through formal or informal agreements that establish expectations for exchange of information (e.g., frequency, timeliness, content).	▪ The practice will **work with a behavioral health provider** to establish how to coordinate sharing of clinical information

Source: NCQA PCMH 2017 Standards and Guidelines

Discussions

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Contents

All practices in the state can participate in the NYS PCMH program

Type of practice	# of practice sites in NYS	What changes with NYS PCMH (compared to APC)	TA support	Payer support	Aligned measure set
APC contracted "greenfield"	120[1]	▪ Similar content in concept, but with new NCQA-based chassis with NYS additions ▪ Minimized additional documentation burden for proven capabilities	▪ Minimal change. Provide 2 years of TA support; minimal curriculum changes	▪ Medicaid support upon NYS PCMH recognition ▪ Commercial payer support TBD	▪ NYS PCMH Core measures
NCQA recognized (2011 and 2014)	1,503	▪ 12 NYS-specific criteria (the Electives changed to Core) to achieve for NYS PCMH recognition	▪ No change. SIM-funded TA support to reach NYS PCMH may be available for 2011 and 2014 levels 1 and 2 practices that request it		
TCPI	168	▪ Reduced potential for confusion given aligned NYS PCMH	▪ Continued support though TCPI		
Others (not part of above)	~4,500	▪ Reduced potential for confusion given aligned NYS PCMH	▪ Eligible through joining NYS PCMH program		

Source: DOH, May 2017. MCCA, NCQA, SK&A, NPI database 2014 (total # of providers)

1 As of end of June 12th 2017

Discussion: NYS PCMH Design

Implications for stakeholders

- Other implications should be considered for:
  - Medicaid
  - Commercial payers
  - TA providers
  - Primary care practices
  - Patients

Potential implementation timeline, targeting Q4 2017 go-live

State decision point on approach

	Development	Systems and contracting	Engagement and communication	NYS PCMH go-live
Activities	▪ Subcommittee-led alignment on revised program criteria, customized for NYS needs ▪ State-led operational planning: implications on program structure, technical assistance model, Medicaid incentive, etc.	▪ Adjustment of vendor contracts as necessary (e.g., TA vendors, NCQA) ▪ Integration and testing of customized elements into systems, workflows, etc.	▪ Focused provider engagement campaign to drive narrative ▪ E.g., updated website, marketing materials, stakeholder webinars ▪ ROMC discussions ▪ Steerco-led stakeholder communication cascade	▪ Go-live[1]: – Practices can sign-up for NYS PCMH – Access to NYS PCMH assessment
Estimated timing	▪ Q2 2017	▪ Q2-3 2017	▪ Q2-3 2017	▪ Q4 2017

Ongoing recruitment, transformation, and technical assistance to practices

How can we best manage risks to the implementation timeline?
What additional efforts can complement alignment?

1 TBD on when and how individual payers (including Medicaid) will incorporate NYS PCMH into their current value-based programs

Discussions

NEW YORK STATE | Department of Health

Contents

Patient-centered access and continuity

Core | Switch from Elective to Core | Elective

Reason for switching: B BH C CM E EHR V VBP

Status	Code	Criteria
		Competency AC-A: The practice seeks to enhance access by providing appointments and clinical advice based on patients' needs
Core	AC1	Assesses the access needs and preferences of the patient population
Core	AC2	Provides same-day appointments for routine and urgent care to meet identified patients' needs
Core	AC3	Provides routine and urgent appointments outside regular business hours (generally considered 8-5 M-F) to meet identified patients' needs
Core	AC4	Provides timely clinical advice by telephone
Core	AC5	Documents clinical advice in patient records and confirms clinical advice and care provided after-hours does not conflict with patient medical record
Elective	AC6	Provides scheduled routine or urgent appointments by telephone or other technology supported mechanisms
Elective	AC7	Has a secure electronic system for patients to request appointments, prescription refills, referrals and test results
E	AC8	Has a secure electronic system for two-way communication to provide timely clinical advice
Elective	AC9	Uses information on the population served by the practice to assess equity of access that considers health disparities
		Competency AC-B: Practices support continuity through empanelment and systematic access to the patient's medical record
Core	AC10	Helps patients/families/caregivers select or change a personal clinician
Core	AC11	Sets goals and monitors the percentage of patient visits with selected clinician or team
E	AC12	Provides continuity of medical record information for care and advice when the office is closed
Elective	AC13	Reviews and actively manages panel sizes
Elective	AC14	Reviews and reconciles panel based on health plan or other outside patient assignments

Source: 2017 NCQA PCMH

Care coordination and care transitions (1/2)

Core | Switch from Elective to Core | Elective

Reason for switching: B BH C CM E EHR V VBP

Status	Code	Criteria
		Competency CC-A: The practice effectively tracks and manages laboratory and imaging tests important for patient care and informs patients of the result
●	CC1	The practice systematically manages lab and imaging tests by: A. Tracking lab tests until results are available, flagging and following up on overdue results B. Tracking imaging tests until results are available, flagging and following up on overdue results C. Flagging abnormal lab results, bringing them to the attention of the clinician D. Flagging abnormal imaging results, bringing them to the attention of the clinician E. Notifying patients/families/caregivers of normal lab and imaging test results F. Notifying patients/families/caregivers of abnormal lab and imaging test results
●	CC2	Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening (NA for practices that do not care for newborns)
●	CC3	Uses clinical protocols to determine when imaging and lab tests are necessary
		Competency CC-B: The practice provides important information in referrals to specialists and tracks referrals until the report is received
●	CC4	The practice systematically manages referrals by: A. Giving the consultant or specialist the clinical question, the required timing and the type of referral B. Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan C. Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports
●	CC5	Uses clinical protocols to determine when a referral to a specialist is necessary
●	CC6	Identifies the specialists/specialty types most commonly used by the practice
●	CC7	Considers available performance information on consultants/specialists when making referral recommendations
C	CC8	Works with non-behavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care
B	CC9	Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care
●	CC10	Integrates behavioral healthcare providers into the care delivery system of the practice site

Source: 2017 NCQA PCMH

Care coordination and care transitions (2/2)

Core | Switch from Elective to Core | Elective

Reason for switching: B BH C CM E EHR V VBP

Status	Code	Criteria
	CC11	Monitors the timeliness and quality of the referral response
	CC12	Documents co-management arrangements in the patient's medical record
	CC13	Engages with patients regarding cost implications of treatment options
		Competency CC-C: The practice connects with other health care facilities to support patient safety throughout care transitions. The practice receives and shares necessary patient treatment information to coordinate comprehensive patient care
	CC14	Systematically identifies patients with unplanned hospital admissions and emergency department visits
	CC15	Shares clinical information with admitting hospitals and emergency departments
	CC16	Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit
	CC17	Systematic ability to coordinate with acute care settings after hours through access to current patient information
	CC18	Exchanges patient information with the hospital during a patient's hospitalization
C	CC19	Implements process to consistently obtain patient discharge summaries from the hospital and other facilities
	CC20	Collaborates with the patient/family/caregiver to develop/implement a written care plan for complex patients transferring in to/out of the practice (e.g., transitioning from pediatric care to adult care)
E	CC21	Demonstrates electronic exchange of information with external entities, agencies and registries (may select 1 or more): RHIO, Immunization Registry, Summary of care record to other providers or care facilities for care transitions

Source: 2017 NCQA PCMH

Care management and support

Core | Switch from Elective to Core | Elective

Reason for switching: B BH C CM E EHR V VBP

Status	Code	Criteria
		Competency CM-A: The practice systematically identifies patients that would benefit most from care management.
●	CM1	Considers the following in establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria): A. Behavioral health conditions B. High cost/high utilization C. Poorly controlled or complex conditions D. Social determinants of health E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver"
●	CM2	Monitors the percentage of the total patient population identified through its process and criteria
C	CM3	Applies a comprehensive risk - stratification process to entire patient panel in order to identify and direct resources appropriately
		Competency CM-B: The practice provides important information in referrals to specialists and tracks referrals until the report is received
●	CM4	Establishes a person-centered care plan for patients identified for care management
●	CM5	Provides written care plan to the patient/family/caregiver for patients identified for care management
●	CM6	Documents patient preference and functional/lifestyle goals in individual care plans
●	CM7	Identifies and discusses potential barriers to meeting goals in individual care plans
●	CM8	Includes a self-management plan in individual care plans
C	CM9	Care plan is integrated and accessible across settings of care

Source: 2017 NCQA PCMH

Knowing and managing your patients (1/3)

Core | Switch from Elective to Core | Elective

Reason for switching: B BH C CM E EHR V VBP

Status	Code	Criteria
		Competency KM-A: Practice routinely collects comprehensive data on patients to understand background and health risks of patients. Practice uses information on the population to implement needed interventions, tools and supports for the practice as a whole and for specific individuals
Core	KM1	Documents an up-to-date problem list for each patient with current and active diagnoses
Core	KM2	Comprehensive health assessment including A. Medical history of patient and family B. Mental health/substance use history of patient and family C. Family/social/cultural characteristics D. Communication needs E. Behaviors affecting health F. Social Functioning * G. Social Determinants of Health *H. Developmental screening using a standardized tool. (NA for practices with no pediatric population under 30 months of age.) I. Advance care planning. (NA for pediatric practices)
Core	KM3	Conducts depression screenings for adults and adolescents using a standardized tool
B	KM4	Conducts behavioral health screenings and/or assessments using a standardized tool. (implement two or more) A. Anxiety B. Alcohol Use Disorder C. Substance Use Disorder D. Pediatric Behavioral Health Screening E. Post-Traumatic Stress Disorder F. ADHD G. Postpartum Depression
Elective	KM5	Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners
Elective	KM6	Identifies the predominant conditions and health concerns of the patient population
Elective	KM7	Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data
Elective	KM8	Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials
		Competency KM-B: The practice seeks to meet the needs of a diverse patient population by understanding the population's unique characteristics and language needs. The practice uses this information to ensure linguistic and other patient needs are met.
Core	KM9	Assesses the diversity (race, ethnicity and one other aspect of diversity) of its population

Source: 2017 NCQA PCMH

Knowing and managing your patients (2/3)

Core | Switch from Elective to Core | Elective

Reason for switching: B BH C CM E EHR V VBP

Status	Code	Criteria
Core	KM10	Assesses the language needs of its population
C	KM11	Identifies and addresses population-level needs based on the diversity of the practice and the community (Demonstrate at least 2) A. Target population health management on disparities in care* B. Address health literacy of the practice C. Educate practice staff in cultural competence*
		Competency KM-C: The practice proactively addresses the care needs of the patient population to ensure needs are met
Core	KM12	Proactively and routinely identifies populations of patients and reminds them, or their families/ caregivers about needed services (practice must report at least 3 categories): A. Preventive care services B. Immunizations C. Chronic or acute care services D. Patients not recently seen by the practice
Elective	KM13	Demonstrates excellence in a benchmarked/performance-based recognition program assessed using evidence-based care guidelines. [Specifics yet to be defined but at minimum includes DRP/HSRP recognition by NCQA.]
		Competency KM-D: The practice addresses medication safety and adherence by providing information to the patient and establishing processes for medication documentation, reconciliation and assessment of barriers
Core	KM14	Reviews and reconciles medications for more than 80 percent of patients received from care transitions
Core	KM15	Maintains an up-to-date list of medications for more than 80 percent of patients
Elective	KM16	Assesses understanding and provides education, as needed, on new prescriptions for more than 50 percent of patients/families/caregivers
Elective	KM17	Assesses and addresses patient response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment

Source: 2017 NCQA PCMH

Knowing and managing your patients (3/3)

Core | Switch from Elective to Core | Elective

Reason for switching: B BH C CM E EHR V VBP

Status	Code	Criteria
	KM18	Reviews controlled substance database when prescribing relevant medications
	KM19	Systematically obtains prescription claims data in order to assess and address medication adherence
		Competency KM-E: The practice incorporates evidence- based clinical decision support across a variety of conditions to ensure effective and efficient care is provided to patients
	KM20	Implements clinical decision support following evidence-based guidelines for care of: (Practice must demonstrate at least 4 criteria.) A. Mental health condition B. Substance use disorder C. A chronic medical condition D. An acute condition E. A condition related to unhealthy behaviors F. Well child or adult care G. Overuse/appropriateness issues
		Competency KM-F: The practice identifies/considers and establishes connections to community resources to collaborate and direct patients to needed support
	KM21	Uses information on the population served by the practice to prioritize needed community resources
	KM22	Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs
	KM23	Provides oral health education resources to patients
	KM24	Adopts shared decision-making aids for preference-sensitive conditions
	KM25	Engages with schools or intervention agencies in the community
	KM26	Routinely maintains a current community resource list based on the needs identified in Core KM21
	KM27	Assesses the usefulness of identified community support resources
	KM28	Has regular “case conferences” involving parties outside the practice team (e.g., community supports, specialists)

Source: 2017 NCQA PCMH

Perf. measurement & Qual. improvement (1/2)

Core | Switch from Elective to Core | Elective

Reason for switching: B BH C CM E EHR V VBP

Status	Code	Criteria
		Competency QI-A: The practice measures to understand current performance and to identify opportunities for improvement
●	QI1	Monitors at least five clinical quality measures across the four categories (Must monitor at least 1 measure of each type). A. Immunization measures B. Other preventive care measures C. Chronic or acute care clinical measures D. Behavioral health measures*
●	QI2	Monitors at least two measures of resource stewardship. (Must monitor at least 1 measure of each type). A. Measures related to care coordination B. Measures affecting health care costs
●	QI3	Assesses performance on availability of major appointment types to meet patient needs and preferences for access
●	QI4	Monitors patient experience through A. Quantitative data: The practice conducts a survey (using any instrument) to evaluate patient/family/caregiver experiences across at least three dimensions such as: Access, Communication, Coordination, Whole person care, Self-management support and Comprehensiveness B. Qualitative data: The practice obtains feedback from patients/families/caregivers through qualitative means
●	QI5	Assesses health disparities using performance data stratified for vulnerable populations. (Must choose one from each section) A. Clinical Quality B. Patient Experience
●	QI6	The practice uses a standardized, validated patient experience survey tool with benchmarking data available
●	QI7	The practice obtains feedback on experiences of vulnerable patient groups
		Comp. QI-B: The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies
●	QI8	Sets goals and acts to improve upon at least three measures across at least three of the four categories. A. Immunization measures B. Other preventive care measures C. Chronic or acute care clinical measures D. Behavioral health measures*

Source: 2017 NCQA PCMH

Perf. measurement & Qual. improvement (2/2)

Core | Switch from Elective to Core | Elective

Reason for switching: B BH C CM E EHR V VBP

Status	Code	Criteria
Core	QI9	Sets goals and acts to improve upon at least one measure of resource stewardship. A. Measures related to care coordination B. Measures affecting health care costs
Core	QI10	Sets goals and acts to improve on availability of major appointments types to meet patient needs and preferences
Core	QI11	Sets goals and acts to improve on at least one patient experience measure
Elective	QI12	Achieves improved performance on at least 2 performance measures
Elective	QI13	Sets goals and acts to improve disparities in care or service on at least 1 measure
Elective	QI14	Achieves improved performance on at least 1 measure of disparities in care or service
		Competency QI-C: The practice establishes a culture of data-driven performance improvement on clinical quality, efficiency and patient experience and engages the staff and patients/families/caregivers in the quality improvement activities
Core	QI15	Reports practice-level or individual clinician performance results within the practice for measures reported by the practice
Elective	QI16	Reports practice-level or individual clinician performance results publicly or with patients for measures reported by the practice
Elective	QI17	Involves patient/family/caregiver in quality improvement activities
Elective	QI18	Reports clinical quality measures to Medicare or Medicaid agency
V	QI19	The practice is engaged in Value-Based Contract Agreement. (Maximum 2 credits) A. Practice engages in up-side risk contract (1 credit) B. Practice engages in two-sided risk contract (2 credits)[1]

1 Subject to availability

Source: 2017 NCQA PCMH

June 19, 2017

Team based care and practice organization

Core | Switch from Elective to Core | Elective

Reason for switching: B BH C CM E EHR V VBP

Status	Code	Criteria
		Competency TC-A: The practice is committed to transforming the practice into a sustainable medical home. Members of the care team serve specific roles as defined by the practice's organizational structure and are equipped with the knowledge and training necessary to perform those functions
●	TC1	Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities
●	TC2	Defines practice organizational structure and staff responsibilities/skills to support key PCMH functions
●	TC3	The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges)
●	TC4	Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees
E	TC5	The practice uses an EHR system (or modules) that has been certified and issued an ONC Certification ID, conducts a security risk analysis, and implements security updates as necessary correcting identified security deficiencies
		Competency TC-B: Communication among staff is organized to ensure that patient care is coordinated, safe and effective
●	TC6	Has regular patient care team meetings or a structured communication process focused on individual patient care
●	TC7	Involves care team staff in the practice's performance evaluation and quality improvement activities
●	TC8	Has at least one care manager qualified to identify and coordinate behavioral health needs
		Competency TC-C: The practice communicates and engages patients on expectations and their role in the medical home model of care
●	TC9	Has a process for informing patients/ families/caregivers about the role of the medical home and provides patients/ families/caregivers materials that contain the information. Such as after-hours access, practice scope of services, evidence-based care, education and self-management support

Source: 2017 NCQA PCMH

Backup: NYS PCMH criteria relevant to Behavioral health

Core | Switch from Elective to Core | Elective | Reason for switching: B BH C CM E EHR V VBP

NYS PCMH Status	Code	Criteria
Elective	CC10	Integrates behavioral healthcare providers into the care delivery system of the practice site
B	CC9	Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care
Core	CM1	Considers the following in establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria): A. Behavioral health conditions B. High cost/high utilization C. Poorly controlled or complex conditions D. Social determinants of health E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver
Core	KM2	Comprehensive health assessment including A. Medical history of patient and family B. Mental health/substance use history of patient and family C. Family/social/cultural characteristics D. Communication needs E. Behaviors affecting health F. Social Functioning *G. Social Determinants of Health *H. Developmental screening using a standardized tool.(NA for practices with no pediatric population under 30 months of age.) I. Advance care planning. (NA for pediatric practices)
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Elective	KM18	Reviews controlled substance database when prescribing relevant medications
Core	KM20	Implements clinical decision support following evidence-based guidelines for care of: (Practice must demonstrate at least 4 criteria.) A. Mental health condition B. Substance use disorder C. A chronic medical condition D. An acute condition E. A condition related to unhealthy behaviors F. Well child or adult care G. Overuse/appropriateness issues
Core	QI1	Monitors at least five clinical quality measures across the four categories (Must monitor at least 1 measure of each type). A. Immunization measures B. Other preventive care measures C. Chronic or acute care clinical measures D. Behavioral health measures*
Core	QI8	Sets goals and acts to improve upon at least three measures across at least three of the four categories. A. Immunization measures B. Other preventive care measures C. Chronic or acute care clinical measures D. Behavioral health measures*
Elective	TC8	Has at least one care manager qualified to identify and coordinate behavioral health needs

Source: 2017 NCQA PCMH

Next Steps