NYS PCMH Annual Reporting – Required Criteria with Guidance

(For PCMH 2014 Level 3 Practices)

About NYS PCMH Recognition

The National Committee for Quality Assurance (NCQA), the creator of the nation's leading patient-centered medical home (PCMH) program, collaborated with the New York State Department of Health (NYSDOH) to develop a customized PCMH Recognition Program that supports the state's initiative to improve primary care through the medical home model and promote the Triple Aim: better health, lower costs and better patient experience. To support the efforts required in transforming New York practices to this new, exclusive model of patient care, NYS DOH provides the following resources:

- **Initial Recognition fees**. NYSDOH covers the first year NYS PCMH Recognition fee OR the first NYS PCMH Annual Reporting fee. If a practice is an NCQA PCMH 2014 Level 3 that is transitioning to Annual Reporting for the first time, NYS DOH will pay for the fee. Practices will then pay for any future Annual Reporting fees.
- **Transformation assistance**. New York State has contracted with organizations that specialize in NYS PCMH transformation and are being made available at no cost to participating practices. These entities provide step-by-step assistance in managing the transformation process and support the efforts of improving the patient experience. For more information, or to find a Transformation Assistance Contractor, visit ncqa.org/ta.
- **Enhanced reimbursement opportunities**. Practices that participate in NYS PCMH transformation may be eligible to receive supplemental payments through state programs such as the Medicaid PCMH Incentive Program. In addition, NYS DOH is engaged regionally with commercial payers to implement voluntary, multi-payer value-based payment (VBP) arrangements to support practices that have not have these opportunities through previous transformation efforts. Many of these models and eligibility to participate will depend on practices achieving NYS PCMH recognition.

Annual Reporting: Overview

The heart of patient-centered care is continuous quality improvement. A PCMH lives and breathes a culture of data-driven improvement in areas of clinical quality, efficiency and patient experience.

As part of maintaining NYS PCMH Recognition, each year practices will undergo an Annual Reporting process to demonstrate ongoing activities are consistent with the PCMH model of care. Practices will attest to continuing to meet PCMH criteria and submit key data and documentation that covers key concept areas as well as special topics. This process is a much lighter lift than initial recognition. It will sustain the practice's recognition and fosters continuous improvement.

When does annual reporting begin?

A practice's **Annual Reporting date is 30 days prior** to their recognition anniversary date. For PCMH 2014 Level 3 practices, this is their recognition end date. If the practice is part of a multi-site organization, all practice sites share the same Annual Reporting date, unless otherwise requested. The Annual Reporting date is based on the date the first practice in a multi-site achieves recognition.

What information will practices need to show NCQA for Annual Reporting?

- Practices will be asked to attest that they continue to meet PCMH requirements and perform a self-assessment, verifying core features of the medical home have been sustained.
- Practices will be asked to demonstrate that they are embracing measurement and quality improvement.
    - In some cases, this means submitting documentation via the Q-PASS System.
    - In some cases, this means providing measurement data.
- Annual Reporting requirements are flexible to meet a practice's unique needs. Practices are probably performing the required tasks already as a PCMH, so they will just need to show NCQA what they are currently doing.

- Practices must submit data and documentation that cover six PCMH concept topics. Practices must meet the minimum number of requirements for each category. The six areas include:
    - Patient-Centered Access
    - Team-Based Care
    - Population Health Management
    - Care Management
    - Care Coordination and Care Transitions
    - Performance Measurement and Quality Improvement.

The New York State PCMH Recognition program is built from the NCQA PCMH model. The NYS PCMH Annual Reporting contains the PCMH Annual Reporting program requirements and NYS required criteria to demonstrate sustained Recognition to NCQA.

Annual Reporting Process: Reporting, Audit and Decision

- Practices will use Q-PASS to submit data and evidence for their annual reporting.
- Practices must verify core features of the medical home have been sustained.
- Practices must meet the minimum number of requirements for each category.
- NCQA reviews submission and notifies practices of their sustained recognition status.
- NCQA will randomly select practices for audit to validate attestation and submission.
- Practices that do not submit on time or fail to meet requirements may have their recognition status suspended or revoked. That may include having their recognition status changed to “Not Recognized.

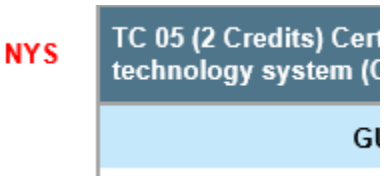
Structure: Concepts, Criteria and Competencies

Concepts. There are six concepts—the overarching themes of PCMH. To sustain recognition, practices must complete criteria in each concept area. If practices are familiar with past iterations of NCQA PCMH Recognition, the concepts are equivalent to standards.

Competencies. Competencies categorize the criteria. Competencies do not offer credit.

Criteria. Specific activities in which a practice engages to demonstrate that it has sustained recognition. The practice must meet the PCMH Annual Reporting requirements and the NYS PCMH Required Criteria. Each Criteria is numbered by two letters representing the concept area, followed by a number (e.g. TC 05, KM 11).

The 12 required criteria are noted by a red “NYS” to the left of the criteria in the Standards and Guidelines section. Example:



Requirements

To sustain PCMH Recognition, practices must meet all Annual Reporting Requirements.

Note: If **PCMH 2014 Level 3** practices transitioning to Annual Reporting for the first time, must also complete the 12 NYS required criteria. Once the practice has met the 12 NYS requirements, they will show as "Met" in Q-PASS for Annual Reporting and the practice will not have to complete them again in subsequent years. For practices that were not previously PCMH 2014 Level 3 practices, they are already completed these criteria as part of their initial recognition and will not have to complete them for Annual Reporting.

See the table below for a list of these 12 additional required criteria and the evidence required for PCMH 2014 Level 3 practices.

Concept Area	Criteria	Description
Team-Based Care and Practice Organization	TC 05	Certified EHR system – Eligible for Attestation
Knowing and Managing Your Patients	KM 04	Behavioral Health Screenings – Documented Process and Evidence of Implementation B. Alcohol use disorder C. Substance use disorder
Knowing and Managing Your Patients	KM 11	Population Needs – Evidence of Implementation A. Target population health management on disparities in care– Assessment, goals and actions **AND** B. Address health literacy of the practice staff - Documentation **or** C. Educate practice staff in cultural competence - Documentation
Patient-Centered Access	AC 08	Two-Way Electronic Communication – Eligible for Attestation
Patient-Centered Access	AC 12	Continuity of Medical Record Information – Eligible for Attestation
Care Management and Support	CM 03	Comprehensive Risk- Stratification Process – Report
Care Management and Support	CM 09	Care plan is integrated and accessible across settings of care – Documented Process and Evidence of Implementation
Care Coordination and Care Transitions	CC 08	Specialist Referral Expectations – Eligible for Attestation
Care Coordination and Care Transitions	CC 09	Behavioral health Referral Expectations – Agreement **OR** Documented Process **and** Evidence of Implementation
Care Coordination and Care Transitions	CC 19	Patient Discharge Summaries – Eligible for Attestation
Care Coordination and Care Transitions	CC 21	External Electronic Exchange of Information – Eligible for Attestation A. Regional health information organization (RHIO) or other health information exchange source that enhances ability to manage complex patients
Performance Measurement and Quality Improvement	QI 19	Value-Based Contract Agreements – Eligible for Attestation A. Practice engages in up-side risk contract

This document has been adapted from the standard NCQA PCMH Recognition Program Standards & Guidelines document. The requirements outlined in this document must be completed in addition to the PCMH Annual Reporting requirements.

NYS

TC 05 (2 Credits) Certified EHR System: The practice uses a certified electronic health record technology system (CEHRT).	
GUIDANCE	**EVIDENCE**
The practice enters the names of the electronic systems it implements. Only systems the practice is actively using should be entered. Use of an EHR can increase productivity, reduce paperwork and enable the practice to provide patient care more efficiently. https://chpl.healthit.gov/#/search	• **CERHT name**

NYS

KM 04 (1 Credit) Behavioral Health Screenings: Conducts behavioral health screenings and/or assessments using a standardized tool. (Implement two or more. Must complete B and C.)

A. Anxiety.
B. Alcohol use disorder.
C. Substance use disorder.
D. Pediatric behavioral health screening.
E. Post-traumatic stress disorder.
F. Attention deficit/hyperactivity disorder.
G. Postpartum depression.

GUIDANCE	EVIDENCE
Many patients go undiagnosed and untreated for mental health and substance use disorders. The medical home can play a major role in early identification of these conditions. Practice staff have been trained on the use of standardized tools to ensure accurate diagnosis, treatment and follow-up. A **standardized tool** collects information using a current, evidence-based approach that was developed, field-tested and endorsed by a national or regional organization. The National Institute on Drug Abuse created a chart of Evidence Based Screening Tools for Adults and Adolescents for opioid screening, as well as alcohol and substance use tools. **A.** The practice conducts assessment for the presence of emotional distress and symptoms of anxiety using any validated tool (e.g., GAD-2, GAD-7). Anxiety disorders (generalized anxiety disorder, panic disorder and social anxiety disorder) are common, often undetected and misdiagnosed, associated with other psychiatric conditions and linked to chronic medical conditions (e.g., heart disease, chronic pain disorders). **B.** The USPSTF recommends screening adults 18 years or older for alcohol misuse. Practices may use the Alcohol Use Disorders Identification Test (AUDIT), a screening for excessive drinking; the Drug Abuse Screening Test (DAST); Cutting down, Annoyance by criticism, Guilty feeling and Eye-openers Questionnaire (CAGE); or another validated screening tool. The American Academy of Pediatrics' (AAP) Bright Futures recommends clinicians screen all adolescents for alcohol use during all appropriate acute care visits using developmentally appropriate screening tools. (e.g., CRAFFT or Alcohol Screening and Brief Intervention for Youth).	• **Documented process** ***AND*** • **Evidence of implementation**

NYS

KM 04 (1 Credit) Behavioral Health Screenings: *continued*	
GUIDANCE	**EVIDENCE**
C. Assessing for substance use can assist the practice to provide needed treatment, referrals and abstinence tools to address the patient's substance use concerns. Substance use is a growing issue that is impacting all types of patients. Screening supports early intervention and facilitating patients' access to the necessary treatments toward sobriety. Available screening tools may include the CAGE AID or DAST-10 instruments, which assess a variety of substance use conditions. Bright Futures recommends clinicians screen all adolescents for substance use during all appropriate acute care visits using developmentally appropriate screening tools. (e.g., CRAFFT or DAST-20). **D.** Pediatric screening for behavioral health is distinct from adult screening and provides opportunities for early interventions that can have lasting effects over a lifetime. This may include tools such as the Behavioral Assessment System for Children (BASC). **E.** The practice uses standardized tools to determine if patients have developed post-traumatic stress disorder (PTSD). This condition develops in patients who have experienced a severe and distressing event. This event causes the patient to subsequently re-live the traumatic experience, causing mental distress. Assessments for PTSD support the practice in recognizing the ailment so it can either provide treatment or referrals to appropriate specialists. **F.** Attention deficit/hyperactivity disorder (ADHD) makes it challenging for a person to pay attention and/or control impulsive behaviors. This condition is most commonly diagnosed during childhood but symptoms can persist through adolescence and adulthood. The Vanderbilt Assessment Scale or the DSM V ADHD checklist for adults or children/adolescents are examples of screening tools used to determine if a patient has ADHD. Screening to identify patients with ADHD can lead to earlier diagnosis and treatment and may and reduce its impact on patients/families/ caregivers.	• **Documented process** ***AND*** • **Evidence of implementation**

NYS

KM 04 (1 Credit) Behavioral Health Screenings: *continued*	
GUIDANCE	**EVIDENCE**
G. The USPSTF recommends screening of adults, including pregnant and postpartum women, for depression. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. The USPSTF guidelines suggest screening during and after pregnancy. The AAP's Bright Futures acknowledges that primary care practices that see both infants and their families have a unique opportunity to integrate postpartum depression screening into the well-child care schedule. Validated screening tools may include PHQ-2, PHQ-9 or Edinburgh Postnatal Depression Scale (EPDS) or other validated screening tools, and may be conducted 4–6 weeks postpartum or during the 1-, 2-, 4- or 6-month well-child visits. For a list of screening tools, visit SAMHSA.gov, or for a list of pediatric screening tools, visit the American Academy of Pediatrics website. (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/Primary-Care-Tools.aspx)	• **Documented process** ***AND*** • **Evidence of implementation** 

NYS

KM 11 (1 Credit) Population Needs: Identifies and addresses population-level needs based on the diversity of the practice and the community (Demonstrate at least two. Must complete A):

A. Targets population health management on disparities in care.

B. Educates practice staff on health literacy.

C. Educates practice staff in cultural competence.

GUIDANCE	EVIDENCE
The practice recognizes the varied needs of its population and the community it serves, and uses that information to take proactive, health literate, culturally competent approaches to address those needs. The practice: **A.** Identifies disparities in care and implements actions to reduce the disparity. Practices that reduce disparities provide patient-centered care to their vulnerable populations equal to their general population. **B.** Builds a health-literate organization (e.g., apply universal precautions, provide health literacy training for staff, system redesign to serve patients at different health literacy levels, utilize the AHRQ or Alliance for Health Reform Health Literacy toolkit). Health-literate organizations understand that lack of health literacy leads to poorer health outcomes and compromises patient safety, and act to establish processes that address health literacy to improve patient outcomes. **C.** Builds a culturally competent organization that educates staff on how to interact effectively with people of different cultures. It supports practice staff to become respectful and responsive to the health beliefs and cultural and linguistic needs of patients. **Health literacy resources** • Institute of Medicine: Ten Attributes of Health Literate Health Care Organizations http://www.ahealthyunderstanding.org/Portals/0/Documents1/IOM_Ten_Attributes_HL_Paper.pdf • Agency for Healthcare Research & Quality: Health Literacy Universal Precautions Toolkit: http://www.ahrq.gov/professionals/ quality-patient-safety/quality-resources/tools/literacy-toolkit/healthliteracytoolkit.pdf • Alliance for Health Reform Toolkit: http://www.allhealth.org/publications/Private_health_insurance/Health-Literacy-Toolkit_163.pdf	• **A*: Evidence of implementation*** ***OR*** • **A*: QI 05 and*** • **A*: QI 13*** • **B: Evidence of implementation** • **C: Evidence of implementation**

NYS

AC 08 (1 Credit) Two-Way Electronic Communication: Has a secure electronic system for two-way communication to provide timely clinical advice.	
GUIDANCE	**EVIDENCE**
The practice has a secure, interactive electronic system (e.g., website, patient portal, secure email system) that allows two-way communication between the practice and patients/families/ caregivers, as applicable for the patient. The practice can send messages to and receive messages from patients. NCQA reviews a report summarizing the practice's expected response times and how it monitors its performance against standards for timely response. The practice must present data on at least 7 days of such activity. The report may be system generated. The practice defines the time frame for a response and monitors the timeliness of responses against the time frame.	• **Documented process** ***AND*** • **Report**

NYS

AC 12 (2 Credits) Continuity of Medical Record Information: Provides continuity of medical record information for care and advice when the office is closed.	
GUIDANCE	**EVIDENCE**
The practice makes patient clinical information available to on-call staff, external facilities and clinicians outside the practice, as appropriate, when the office is closed. Access to medical records may include direct access to a paper or electronic record or arranging a telephone consultation with a clinician who has access to the medical record.	• **Documented process**

NYS

CM 03 (2 Credits) Comprehensive Risk-Stratification Process: Applies a comprehensive risk-stratification process for the entire patient panel in order to identify and direct resources appropriately.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it can identify patients who are at high risk, or likely to be at high risk, and prioritize their care management to prevent poor outcomes. The practice identifies and directs resources appropriately based on need. **Risk-stratification resources** • American Academy of Family Physicians' Risk Stratified Care Management Rubric. • CMS-Hierarchical Condition Categories (CMS-HCC) Risk Adjustment Model.	• **Report**

NYS

CM 09 (1 Credit) Care Plan Integration: Care plan is integrated and accessible across settings of care.	
GUIDANCE	**EVIDENCE**
Sharing the care plan supports its implementation across all settings that address the patient's care needs. The practice makes the care plan accessible across external care settings. It may be integrated into a shared electronic medical record, information exchange or other cross-organization sharing tool or arrangement.	• **Documented process** ***AND*** • **Evidence of implementation**

NYS

CC 08 (1 Credit) Specialist Referral Expectations: Works with nonbehavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care.	
GUIDANCE	**EVIDENCE**
Relationships between primary care practitioners and specialists support a coordinated, safe, high-quality care experience for patients. The practice has established relationships with nonbehavioral healthcare specialists through formal or informal agreements that establish expectations for exchange of information (e.g., frequency, timeliness, content).	• **Documented process** ***OR*** • **Agreement** 

NYS

CC 09 (2 Credits) Behavioral Health Referral Expectations: Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care.	
GUIDANCE	**EVIDENCE**
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). A notification demonstrating legal inability to receive a report that includes confirmation a behavioral health visit occurred meets the content requirement. A practice needs an agreement if it shares the same facility or campus as behavioral healthcare professionals but has separate systems (basic onsite collaboration). The practice may present existing internal processes if there is partial integration of behavioral healthcare services.	• **Agreement** ***OR*** • **Documented process *and*** • ***E*vidence of implementation** 

NYS

CC 19 (1 Credit) Patient Discharge Summaries: Implements a process to consistently obtain patient	
GUIDANCE	**EVIDENCE**
The practice has a process for obtaining patient discharge summaries for patients following discharge from a hospital or other care facility. The practice shows that it obtains discharge summaries directly or demonstrates participation in a local admission, discharge, transfer (ADT) system. Actively gathering information about patient admissions, discharges or transfers from the hospital and other care facilities improves care coordination, safe handoffs and reduces readmissions.	• **Documented process** ***AND*** • **Evidence of implementation** 

NYS

CC 21 (*Maximum* 3 Credits) External Electronic Exchange of Information: Demonstrates electronic exchange of information with external entities, agencies and registries (May select one or more. Must Complete A.):

A. Regional health information organization or other health information exchange source that enhances the practice's ability to manage complex patients. (1 Credit)

B. Immunization registries or immunization information systems. (1 Credit)

C. Summary of care record to another provider or care facility for care transitions. (1 Credit)

GUIDANCE	EVIDENCE
The practice utilizes an electronic system to exchange patient health record data and other clinical information with external organizations. Exchange of data across organizations supports enhanced coordination of patient care. Practices can demonstrate this electronic exchange by: A. Exchanging patient medical record information to facilitate care management of patients with complex conditions or care needs. B. Submitting electronic data to immunization registries, to share immunization services provided to patients. C. Making the summary of care record accessible to another provider or care facility for care transitions. Practices may provide the required evidence for each criterion, for up to three credits. Each option is part of CC 21, but is listed separately in Q-PASS for scoring purposes.	• **Evidence of implementation**

NYS

QI 19 (*Maximum* 2 Credits) Value-Based Contract Agreements: Is engaged in Value-Based Agreement. (Must Complete A)

A. Practice engages in upside risk contract (1 Credit).

B. Practice engages in two-sided risk contract (2 Credits).

GUIDANCE	EVIDENCE
The practice demonstrates it participates in a value-based program by providing information about its participation or a copy of agreement. Involvement in value-based contracts represents a shift from fee-for-service billing to compensating practices and providers for administering quality care for patients. Participation in these programs signals that a practice is willing to be accountable for the value of care provided, rather than emphasizing the volume of services provided. **Upside Risk Contract:** A value-based program where the clinician/practice receives an incentive for meeting performance expectations but does not share losses if costs exceed targets. **Two-Sided Risk Contract:** A value-based program where the clinician/practice incurs penalties for not meeting performance expectations, but receives incentives when care requirements of the agreement are met. Expectations relate to quality and cost.	• **Agreement** ***OR*** • **Evidence of implementation**