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MSSNY Health Information Technology Committee
October 13, 2017

Donald Moore, MD, Chair
Deepak Buch, MD
Munish Khaneja, MD
Jef Sneider, MD
Zebulon Taintor, MD
William Zurhellen, MD
Moe Auster, MSSNY staff

The meeting commenced at 7:30 AM. Minutes from the last meeting of the MSSNY HIT Committee on June 2, 2017 were unanimously approved.

HIT Symposium

Dr. Moore discussed his proposal to organize an HIT Symposium sponsored by the Kings County Medical Society with assistance from MSSNY. While it was originally planned for this fall, there were challenges with trying to reserve Brooklyn Borough Hall. Dr. Moore has identified April 21 or 28, 2018 as the likely date for this symposium. He asked for the assistance of each of the Committee members in helping to put together the program.

MACRA Update

Moe Auster gave an update on some of the notable proposed changes to the Medicare Merit Based Incentive Payment System (MIPS) for 2018, effecting Medicare payment in 2020. Some of the key provisions include:

- increasing the exemption threshold to $90,000 in Medicare revenue and 200 Medicare patients
- the ability to continue to use the 2014 certified EHR technology for the purposes of complying with the Advancing Care Information (ACI) component of MIPS, instead of having to use 2015 certified systems
- requiring only a 90 day reporting period for ACI for 2018 and 2019
- keeping the cost efficiency component at 0% of the total MIPS score for 2018 and
- physicians in small practices can report together in "virtual groups".

Summaries of comments submitted by the AMA to the Center for Medicare and Medicaid Services were shared with members of the Committee. It was also noted that MedPAC had recently recommended that the MIPS program be repealed due to concerns that the program is cumbersome and rewards reporting rather than improving care.

AMA Resolutions

The Committee briefly discussed 3 resolutions to be considered at the upcoming AMA House of Delegates including resolutions that would:

- encourage EHR vendors and pharmacy software vendors to have bidirectional communication for an accurate and current medication list in the patient's EMR;
- require EHR vendors to meet all current certification requirements as approved by the ONC's Health IT Certification Program; and b) advocate that EHR vendors, not physicians, be financially penalized for EHR technology not meeting current standards; and
- Establish Health information technology principles

There was no objection to any of the resolutions. However, Dr. Sneider noted that he preferred the MSSNY HIT principles advanced through the HIT Committee, and that the resolutions articulating these principles should be amended to assure that "entities that benefit financially or substantially from required or mandated changes to EHR systems should bear the cost of implementing those changes"

Advanced Primary Care (APC)

The Committee heard a lengthy presentation from DOH Chief Medical Officer Marcus Friedrich, MD, regarding the State's efforts to align New York's Advanced Primary Care (APC) model with Patient Centered Medical Home (PCMH) standards. Dr. Friedrich shared a power point presentation with the Committee. It was in

response to a comment at the June 2 meeting where concerns were expressed by Dr. Sneider that having different standards in New York State could lead to increasing physicians' administrative burdens. Dr. Friedrich during his presentation discussed that his efforts were aimed towards reducing these burdens, particularly on smaller practice physicians, and to address some of the concerns of a confusing landscape by creating greater uniformity.

The presentation had several key points including that DOH is seeking greater standardization in value based payment programs across various payors. He also noted that there were areas where they believe PCMH did not go far enough such as connecting to a local RHIO and with regard to assuring appropriate behavioral health care. There are 16 Practice Transformation Agents in New York to assist physicians in transitioning to APC quality based payments, moving away from volume. There are 324 practices enrolled in the NY's APC program, of which 65% are practices with 4 or less providers. There is an APC scorecard for which practice results will be aggregated at the TIN level. It was also noted that there was an attempt to provide funding to physicians to help with the significant costs of connecting to local RHIOs and the SHIN-NY (up to $13,000). Nearly all health insurers - 23 total – are participating in this program in New York. It was noted that the PCMH transition date is April 1, 2018.

Following the presentation Dr. Zurhellen asked about assuring there are clear articulated differences between the quality measures for the pediatric patient population versus the adult patient population. Dr. Friedrich noted that there are separate quality measures. Dr. Buch noted that increasing consolidation in the health care system placed smaller practice physicians like himself at a great disadvantage. Dr. Friedrich re-iterated his goals to assist small practice physicians in continuing to be able to provide necessary services. Dr. Taintor suggested that this APC issue be a component of the April symposium.

Dr. Sneider questioned regarding the quality measures articulated by Dr. Freidrich were really the best way to measure a PCP. He noted his belief that the best way to really transform the system would be to pay more for primary care which would give incentive for more physicians to become PCPs. Specifically, he noted, places with more PCPs have better quality and lower cost. As a result, Medicaid should immediately increase reimbursement for PCP care to Medicare levels.

Telehealth Subcommittee

Dr. Moore reminded the Committee that, at Dr. Rothberg's request, a Subcommittee on Telehealth issues was proposed to be created, and that members of the HIT Committee should plan to participoate.

The meeting was adjourned at 8:45 AM

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NY State Practice Transformation Updates: Presentation to MSSNY's - HIT Committee October 13, 2017

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Outline

- Introduction and progress on NY State SIM/APC
- Aligning the models: Introduction of NYS PCMH
- Questions/ Discussion

New York State Health Innovation Plan (SHIP)

Goal	**Delivering the Triple Aim –** *Healthier people, better care and individual experience, smarter spending*				
Pillars	**Improve access to care for all New Yorkers, without disparity** Elimination of financial, geographic, cultural, and operational barriers to access appropriate care in a timely way	**Integrate care to address patient needs seamlessly** Integration of primary care, behavioral health, acute and post-acute care; and supportive care for those that require it	**Make the cost and quality of care transparent to empower decision making** Information to enable individuals and providers to make better decisions at enrollment and at the point of care	**Pay for health care value, not volume** Rewards for providers who achieve high standards for quality and individual experience while controlling costs	**Promote population health** Improved screening and prevention through closer linkages between primary care, public health, and community- based supports
Enablers	**Workforce strategy**	**A**	Matching the capacity and skills of our health care workforce to the evolving needs of our communities		
	Health information technology	**B**	Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation		
	Performance measurement & evaluation	**C**	Standard approach to measuring the Plan's impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation		

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NYS Transformation Efforts

NYS initiatives

DSRIP

SIM/APC

NYS payer initiatives

CMS initiatives

CPC+ Comprehensive Primary Care Plus

TCPi Transforming Clinical Practices Initiative

Federal law

Practices & Providers

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What is advanced primary care (APC)?

Statewide multi-payer approach to align care AND payment reform focused on primary care that:

- Works to achieve triple aim goals
- Engages practices, patients, and payers
- Builds on evidence, experience, existing demonstrations, PCMH
- Supports comprehensive, patient-centric PC with coordinated care for complex patients
- Fosters collaboration between PC, other clinical care, and community-based services
- Effectively utilizes HIT, including EHR, data analytics, and population health tools
- Offers alternative payment models that support the services and infrastructure needed for advanced PC

How is APC different from PCMH 2014?

Model is consistent with the principles of NCQA PCMH 2014, but seeks to move beyond structural criteria to achieve durable, meaningful changes in processes and outcomes

Who can become APC?

Internal Medicine, Family, and Pediatric practices

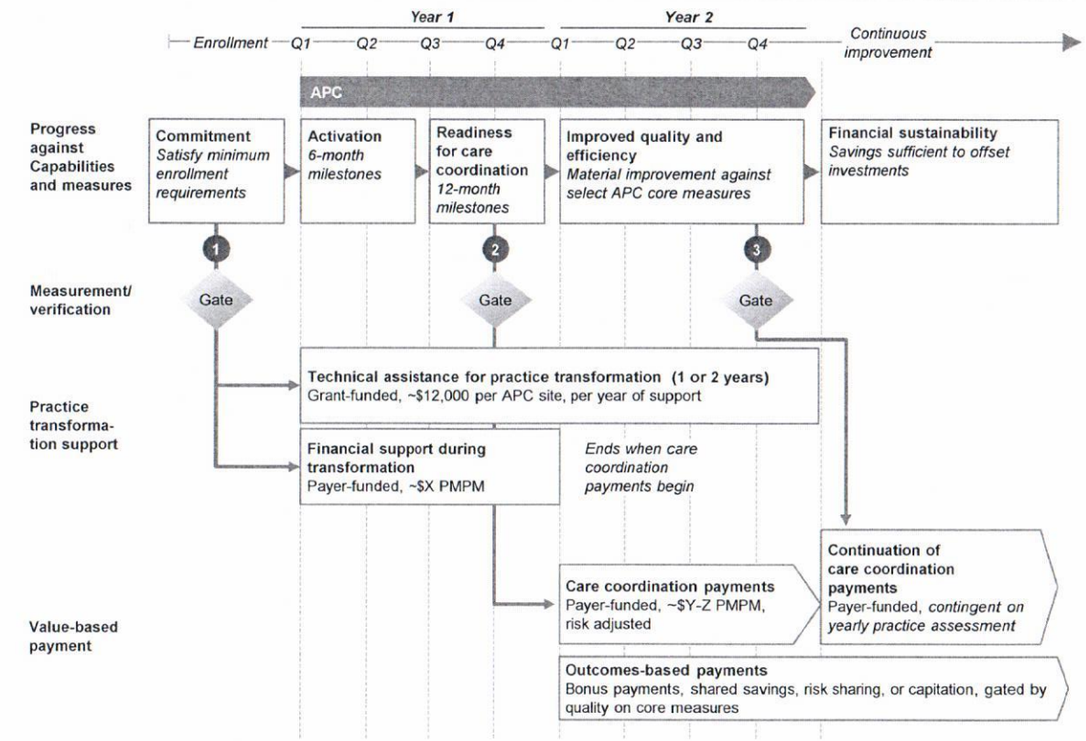
APC Capabilities:

Category	Description
Patient-centered care	▪ Engage patients as active, informed participants in their own care, and organize structures and workflows to meet the needs of the patient population
Population Health	▪ Actively promote the health of both patient panels and communities through screening, prevention, chronic disease management, and promotion of a healthy and safe environment
Care management/ coordination	▪ Manage and coordinate care across multiple providers and settings by actively tracking the sickest patients, collaborating with providers across the care continuum and broader medical neighborhood including behavioral health, and tracking and optimizing transitions of care
Access to care	▪ Promote access as defined by affordability, availability, accessibility, and acceptability of care across all patient populations
HIT	▪ Use health information technology to deliver better care that is evidence-based, coordinated, and efficient
Payment model	▪ Participate in outcomes-based payment models, based on quality and cost performance, for over 60% of the practice's patient panel
Quality and performance	▪ Measure and actively improve quality, experience, and cost outcomes as described by the APC core measures in the primary care panel

Structural milestones

	Commitment Gate 1 *What a practice achieves on its own, before any TA or multi-payer financial support*	Readiness for care coordination Gate 2 *What a practice achieves after 1 year of TA and multi-payer financial support, but no care coordination support yet*	Demonstrated APC Capabilities Gate 3 *What a practice achieves after 2 years of TA, 1 year of multi-payer financial support, and 1 year of multi-payer-funded care coordination*
		Prior milestones, plus ...	**Prior milestones, plus ...**
Participation	i. APC participation agreement ii. Early change plan based APC questionnaire iii. Designated change agent / practice leaders iv. Participation in TA Entity APC orientation v. Commitment to achieve gate 2 milestones in 1 year	i. Participation in TA Entity activities and learning (if electing support)	
Patient-centered care	i. Process for Advanced Directive discussions with all patients	i. Advanced Directive discussions with all patients >65 ii. Plan for patient engagement and integration into workflows within one year	i. Advanced Directives shared across medical neighborhood, where feasible ii. Implementation of patient engagement integrated into workflows including QI plan (grounded in evidence base developed in Gate 2, where applicable)
Population health			i. Participate in local and county health collaborative Prevention Agenda activities ii. Annual identification and reach-out to patients due for preventative or chronic care management iii. Process to refer to structured health education programs
Care Management/ Coord.	i. Commitment to developing care plans in concert with patient preferences and goals ii. Behavioral health: self-assessment for BH integration and concrete plan for achieving Gate 2 BH milestones within 1 year	i. Identify and empanel highest-risk patients for CM/CC ii. Process in place for Care Plan development iii. Plan to deliver CM / CC to highest-risk patients within one year iv. Behavioral health: Evidence-based process for screening, treatment where appropriate[1], and referral	i. Integrate high-risk patient data from other sources (including payers) ii. Care plans developed in concert with patient preferences and goals iii. CM delivered to highest-risk patients iv. Referral tracking system in place v. Care compacts or collaborative agreements for timely consultations with medical specialists and institutions vi. Post-discharge follow-up process vii. Behavioral health: Coordinated care management for behavioral health
Access to care	i. 24/7 access to a provider	i. Same-day appointments ii. Culturally and linguistically appropriate services	i. At least 1 session weekly during non-traditional hours
HIT	i. Plan for achieving Gate 2 milestones within one year	i. Tools for quality measurement encompassing all core measures ii. Certified technology for information exchange available in practice for iii. Attestation to connect to HIE in 1 year	i. 24/7 remote access to Health IT ii. Secure electronic provider-patient messaging iii. Enhanced Quality Improvement including CDS iv. Certified Health IT for quality improvement, information exchange v. Connection to local HIE QE vi. Clinical Decision Support
Payment model	i. Commitment to value-based contracts with APC-participating payers representing 60% of panel within 1 year	i. Minimum FFS with P4P contracts with APC-participating payers representing 60% of panel	i. Minimum FFS + gainsharing contracts with APC-participating payers representing 60% of panel

APC VBP Payment Model



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APC measure set– 28 measures. 18 measures in Version 1

Domains	NQF #/Developer	Version 1 /Data Source	Measures	Version 1
Prevention	32/HEDIS	Claims/EHR. Claims-only possible	Cervical Cancer Screening	✓
	2372/HEDIS	Claims/EHR. Claims-only possible	Breast Cancer Screening	✓
	34/HEDIS	Claims/EHR	Colorectal Cancer Screening	
	33/HEDIS	Claims/EHR. Claims-only possible	Chlamydia Screening	✓
	41/AMA	Claims/EHR/Survey	Influenza Immunization -all ages	
	38/HEDIS	Claims/EHR/Survey. Claims-only possible	Childhood Immunization (status)	✓
	2528/ADA	Claims	Fluoride Varnish Application	
Chronic Disease	28/AMA	Claims/EHR	Tobacco Use Screening and Intervention	
	18/HEDIS	Claims/EHR	Controlling High Blood Pressure	
	59/HEDIS	Claims/EHR	Comprehensive Diabetes Care: HbA1C Poor Control	
	57/HEDIS	Claims	Comprehensive Diabetes Care: HbA1C Testing	✓
	55/HEDIS	Claims	Comprehensive Diabetes Care: Eye Exam	✓
	56/HEDIS	Claims	Comprehensive Diabetes Care: Foot Exam	
	62/HEDIS	Claims	Comprehensive Diabetes Care: Medical Attention for Nephropathy	✓
	71/HEDIS	Claims/EHR	Persistent Beta Blocker Treatment after Heart Attack	✓
	1799/HEDIS	Claims/EHR. Claims-only possible.	Medication Management for People With Asthma	✓
	24/HEDIS	Claims/EHR	[Combined obesity measure] Weight Assessment & Counseling for nutrition/physical activity for kids	
	421/CMS	Claims/EHR	[Combined obesity measure] Body Mass Index (BMI) Screening and Follow-Up	
Behavioral Health/ Substance Use	418/CMS	Claims/EHR	Screening for Clinical Depression and Follow-up Plan	
	4/HEDIS	Claims	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	✓
	105/HEDIS	Claims/EHR	Antidepressant Medication Management	✓
Patient-Reported	326/HEDIS	Claims/EHR	Advance Care Plan	
	5/AHRQ	Survey	CAHPS Access to Care, Getting Care Quickly	
Appropriate Use	52/HEDIS	Claims	Use of Imaging Studies for Low Back Pain	✓
	58/HEDIS	Claims	Avoidance of Antibiotic Treatment in adults with acute bronchitis	✓
	--/HEDIS	Claims	Inpatient Hospital Utilization (HEDIS)	✓*
	1768/HEDIS	Claims	All-Cause Readmissions	✓*
	--/HEDIS	Claims	Emergency Department Utilization	✓*
Cost	--	Claims	Total Cost Per Member Per Month	

*Utilization measures to be added in future cycle once modified specifications are developed.

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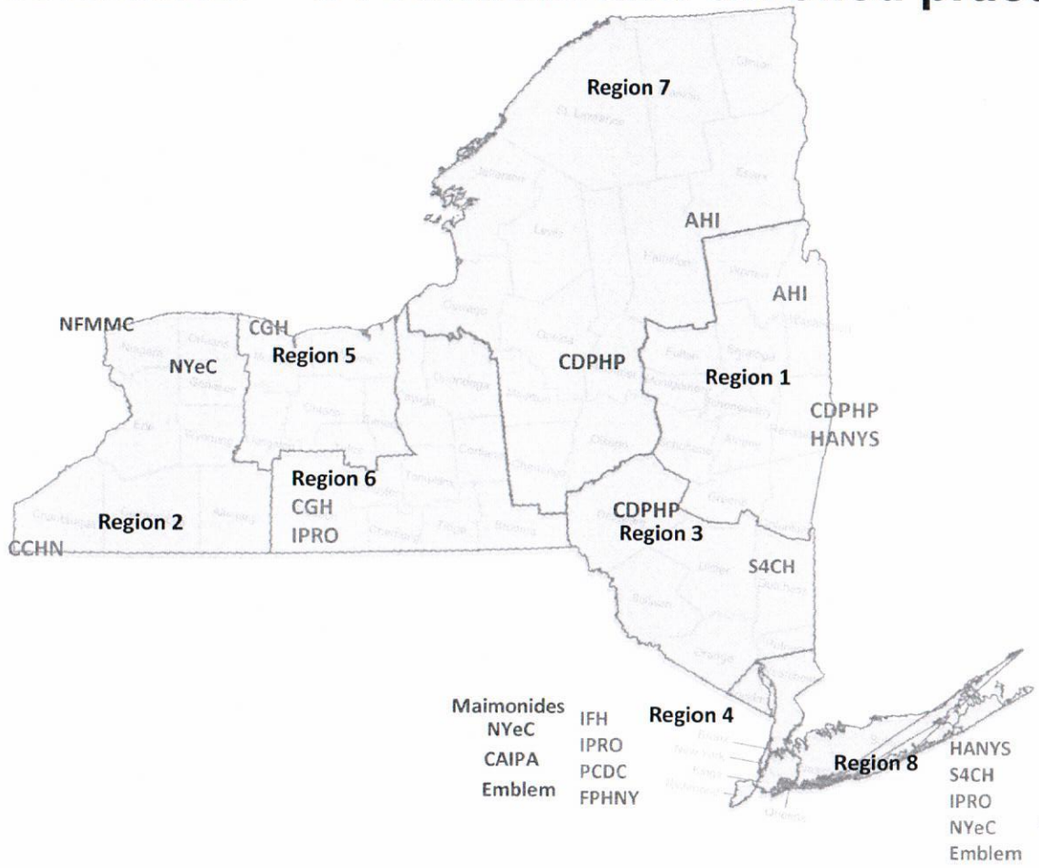
NY State of Transformation – SIM/APC Facts

- 16 Practice Transformation Technical Assistance (PT TA) vendors active throughout NY State
- As of October: 324 practices enrolled; 1,200 in discussions about enrollment
- 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	Acronym	Regions
Adirondack Health Institute	AHI	Capital District and Adirondacks
CDPHP	CDPHP	Capital District, Mid-Hudson Valley and North Country
HANYS	HANYS	Capital District and Long Island
Chautauqua County Health	CCHN	Western (Buffalo)
Solutions 4 Community Health	S4CH	Mid-Hudson Valley and Long Island
Institute for Family Health	IFH	NYC
IPRO	IPRO	NYC, Central NY (Syracuse) and Long Island
PCDC	PCDC	NYC
Fund for Public Health in New York	FPHNY	NYC
Finger Lakes (Common Ground Health)	CGH	Finger Lakes (Rochester) and Central NY (Syracuse)
Niagara Falls Memorial Medical Center	NFMMC	Western New York Region
New York eHealth Collaborative	NYeC	Western New York Region, NYC, and Long Island
Chinese American IPA, Inc. d/b/a Coalition of Asian-American IPA	CAIPA	New York City Region
EmblemHealth Services Company, LLC	Emblem	New York City Region and Long Island
Maimonides Medical Center	Maimonides	New York City Region

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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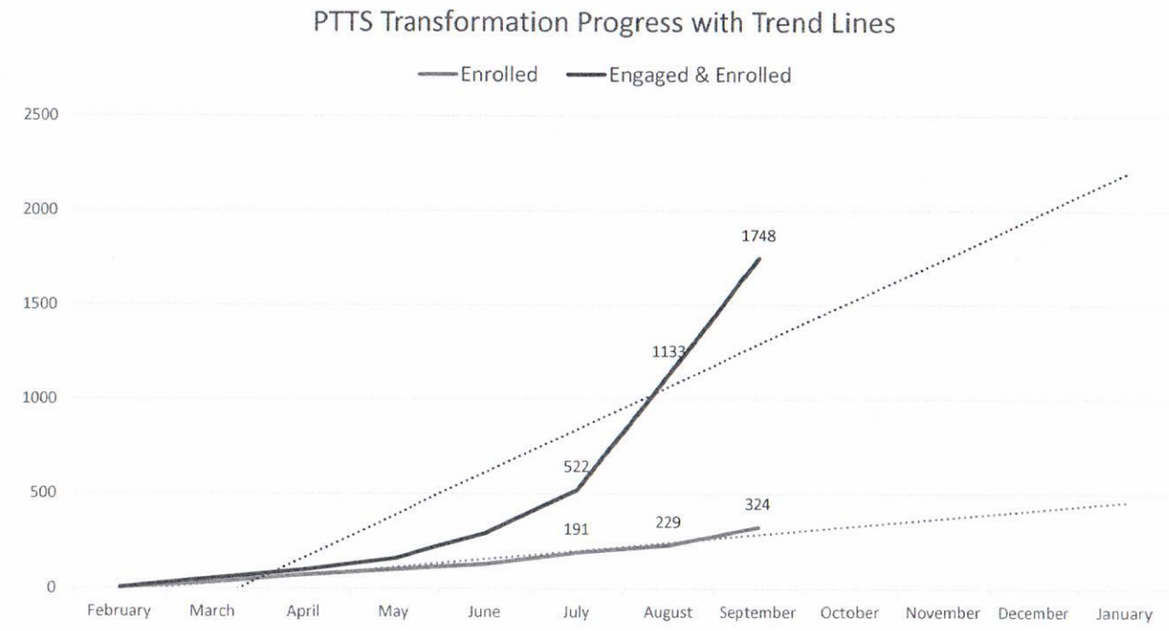
NY State of Transformation – SIM/APC Progression



*As of: October, 2017

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Aligning the Models: NYS PCMH

NCQA PCMH / APC program alignment - overview

APC criteria was designed with intention that this would be best solution for NYS needs

- Verifiable progress over time
- Transition to performance
- Building capacity for VBP payments
- Transforming with technical support

...But complexity in the setting of multiple primary care transformation programs has been an ongoing challenge

TCPi Transforming Clinical Practice Initiative

CPC Behavioral HEALTHCARE

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NY State DOH made decision to align transformation programs under NYS PCMH program

Department of Health

Why align with PCMH (NCQA PCMH 2017)?

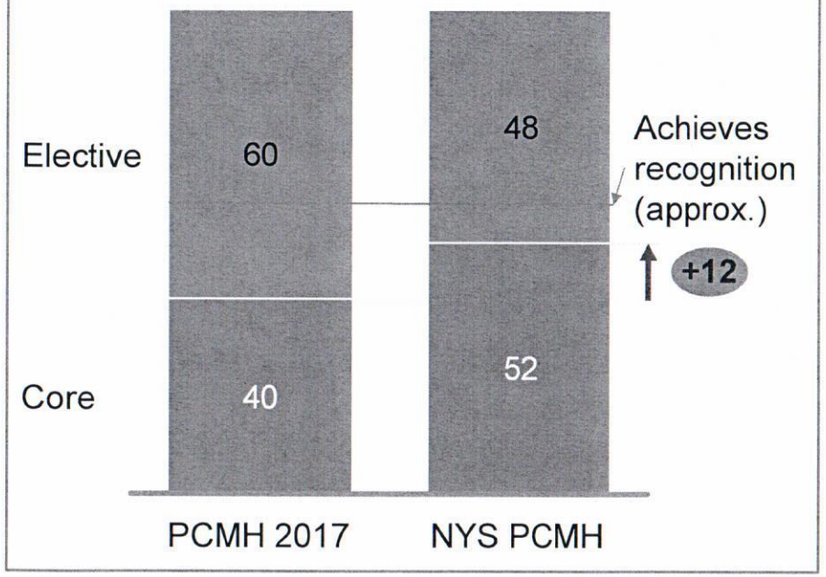
- Accelerating the transition toward delivering value and succeeding in new payment models for all practices in NY State
- Opportunity to simplify a complicated landscape and reduce confusion

Why create a distinct "NYS PCMH"?

- A NYS PCMH program considers several state-specific components including investments in Health IT, Behavior Health integration, rigorous Care Coordination, Population Health, and the potential for multi-payer support
- Accelerating the transition toward value-based payment is a priority for NY

NYS PCMH builds on APC/PCMH 2017 by converting 12 Electives into Core without asking the practices to do more

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]
- **Continuation of TA vendor activities**

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

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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

Other Updates

SHIN-NY Connections Program

- The SHIN-NY Connections Program (SCP) for Enrolled APC Practices will provide a maximum potential funding amount of $13,000 per Practice. While the actual cost of connecting a practice's Certified EHR to the SHIN-NY varies by EHR vendor, size of practice, etc. an estimate of $10,000 - $15,0000 is the market average.

- Through the $13,000 in available funding per practice, the SCP will help offset the cost of connecting to the SHIN-NY for Primary Care practices

- Issued payments to APC practices:
  - Gate 2: $2,000
  - Gate 3: $11,000

SHIN-NY Connections Program

- NYeC will work with the state to achieve the following:
  - Track APC practices enrolled in SCP
  - Verify eligibility and cross-reference eligibility for Data Exchange Incentive Program (DEIP), if eligible for DEIP, direct practice to enroll in DEIP
  - Verify that Practice site has not enrolled in DEIP and received payment already
  - Track attainment of Gate 2 (QE Participation Agreements) and Gate 3 (contribution of clinical data to the SHIN-NY)

The scorecard is a cornerstone of the APC program

What the Scorecard is:

- A statewide report aggregating all primary care data relevant to APC Core Measures
- The first tool to enable practices to view their performance across a consistent set of measures for their entire patient panel (rather than on a per payer basis)
- The basis for practices to pass APC gates and access outcome-based payments

What the Scorecard isn't:

- A replacement for scorecards and measures required for ACOs, MA Stars, etc.
- A collection of brand new measures

Need for interim solution

The **eventual APC Scorecard** leverages both administrative claims data from the APD and clinical data from EHRs.

The **timelines for APC launch and APD roll out do not align**. The APC program launches in 2016, while the APD launch is not anticipated until 2018.

We need **an interim non-APD solution** that:

- Uses easily accessible data
- Minimizes burden on providers and payers
- Is high quality and consistent across all types of patients and payers
- Leverages already existing processes
- Employs processes that can be used in future versions of the scorecard

All Payer Database anticipates commercial data intake to begin in 2018

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APC Scorecard Report Overview

- Practice results are aggregated at a TIN (tax id) level.
- Table with measure results grouped by domain (Prevention, Chronic Disease, Behavioral Health/Substance Abuse, Appropriate) with benchmarks by product line (Commercial, Medicaid, Medicare).
  - Patient count information: total count, stratified by product line and by payer.
- Bar graph with practice measure results compared to the statewide benchmark.

Measures Included in the Scorecard

- Childhood Immunization Combo 3
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening
- Medication Management for People with Asthma
- Persistent Beta Blocker Treatment After Heart Attack
- Comprehensive Diabetes Care: HbA1c Testing, Eye Exam, Nephropathy
- Antidepressant Medication Management
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Use of Imaging Studies for Low Back Pain
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Payers that contributed data

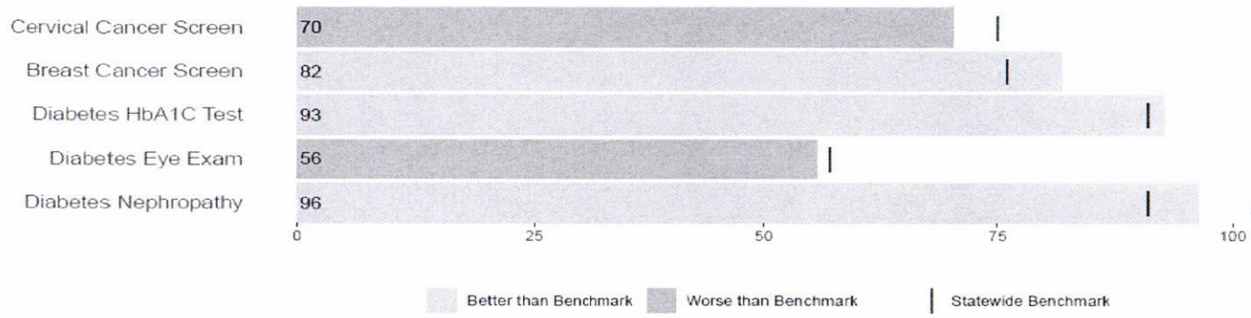
23 payers in total:

- Affinity
- Amida Care
- CDPHP
- Empire
- Empire BCBS
- Excellus
- Fidelis
- GHI
- HIP (EmblemHealth
- HealthNow NY
- HealthFirst
- Independent Health
- MetroPlus
- MVP
- Oscar
- Oxford
- Total Care
- United HealthCare
- United Community
- Univera
- VNS
- WellCare
- YourCare

APC Scorecard Report Overview: Example

Domain	Measure	*Numerator*	*Denominator*	*Result*	*Commercial*	*Medicaid*	*Medicare*
	Cervical Cancer Screening	45	64	70	78	65	57
	Breast Cancer Screening	59	72	82	74	73	79
	Chlamydia Screening						
Prevention	Patients of age 16 - 20 years	SS	SS	SS	64	75	NA
	Patients of age 21 - 24 years	SS	SS	SS	70	76	50
	Total	SS	SS	SS	67	76	40
	Childhood Immunization Status - Combo 3	SS	SS	SS	76	76	NA

Table displays measure results and benchmarks by product



Graphic displays practice results compared to the statewide benchmark, with color indicating performance (better vs. worse than benchmark)

Better Results →

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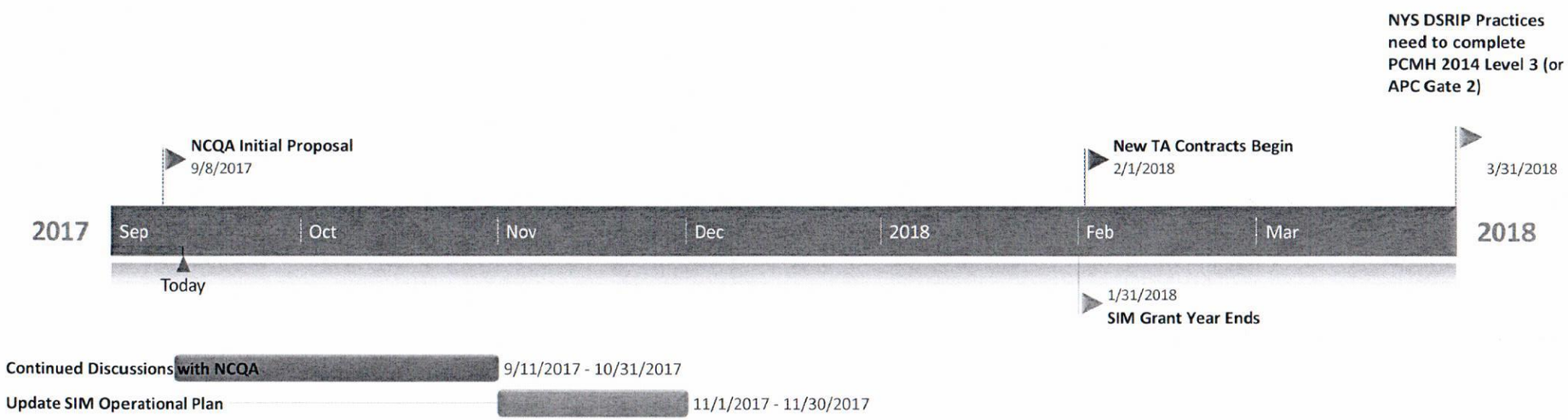
Other updates

- NYS PCMH Transition date: 04/01/2018
- Discussions with NCQA
- CMS Discussions - NYS proposal to use SIM grant funds to cover NCQA Initial recognition fee for practices

October 3, 2017

Aligning Transformation Model Timeline



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Questions/ Discussion

Appendix

NYS PCMH Core Criteria

Core Switch from Elective to Core

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
	AC1	Assesses the access needs and preferences of the patient population
	AC2	Provides same-day appointments for routine and urgent care to meet identified patients' needs
	AC3	Provides routine and urgent appointments outside regular business hours (generally considered 8-5 M-F) to meet identified patients' needs
	AC4	Provides timely clinical advice by telephone
	AC5	Documents clinical advice in patient records and confirms clinical advice and care provided after-hours does not conflict with patient medical record
E	AC8	Has a secure electronic system for two-way communication to provide timely clinical advice
		Competency AC-B: Practices support continuity through empanelment and systematic access to the patient's medical record
	AC10	Helps patients/families/caregivers select or change a personal clinician
	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
		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
		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
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
		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
C	CC19	Implements process to consistently obtain patient discharge summaries from the hospital and other facilities
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

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NYS PCMH Core Criteria

Core Switch from Elective to Core

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

		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
C	CM9	Care plan is integrated and accessible across settings of care
		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
	KM1	Documents an up-to-date problem list for each patient with current and active diagnoses
	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)
	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
		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.
	KM9	Assesses the diversity (race, ethnicity and one other aspect of diversity) of its population
	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
	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
		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
	KM14	Reviews and reconciles medications for more than 80 percent of patients received from care transitions
	KM15	Maintains an up-to-date list of medications for more than 80 percent of patients
		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

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		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
		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
		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*
	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
	QI10	Sets goals and acts to improve on availability of major appointments types to meet patient needs and preferences
	QI11	Sets goals and acts to improve on at least one patient experience measure
		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
	QI15	Reports practice-level or individual clinician performance results within the practice for measures reported by the practice
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]
		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
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
		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

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