Becoming a Person-Centered Medical Home (PCMH)

Connecticut Department of Social Services
Making a Difference

Connecticut Person-Centered Medical Home

What is a Person-Centered Medical Home (PCMH)?

- Team-based healthcare delivery model led by a physician with trained staff that provides coordinated care
- Comprehensive and continuous primary care with the triple aim of maximizing health outcomes, enhancing the patient care experience, and lowering costs
- Care coordination is the cornerstone of the PCMH model
- Health Information Technology (HIT) assists in completing PCMH requirements

“Person-Centered” Care

An approach that:

- Provides the individual with needed information, education, and support required to make fully informed decisions about his or her healthcare options and actively participate in his or her self-care and care planning
- Supports the individual, and any representative(s) whom he or she has chosen, in working together with his or her non-medical, medical, and behavioral health providers and care manager(s) to obtain necessary supports and services
- Reflects care coordination under the direction of and in partnership with the individual and his/her representative(s), that is consistent with his or her personal preferences, choices and strengths, and that is implemented in the most integrated setting
- Is responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs

Connecticut's Model of Care for HUSKY Health Program Members

- Provides healthcare that is person-centered where the patient is the focus of the team
- Puts providers, not insurers, in charge of medical decisions
- Improves healthcare outcomes, patient experience, and reduces costs
- Primary care team coordinates care with specialists, hospitals, and pharmacists to reduce duplication and errors and assures continuity of care
- Ensures patients follow through with treatment plans
- Addresses personal barriers to achieving good health, including cultural considerations and social determinants of health
- Preventive medicine keeps people healthy and out of emergency rooms

Criteria to Become a Department of Social Services (DSS) PCMH Participant

- A primary care provider (practitioner) participating in the Connecticut Medical Assistance Program (CMAP), providing care to a panel of HUSKY Health members
- A practice site that is recognized as a National Committee for Quality Assurance (NCQA) PCMH practice. The site can complete a Glide Path application with DSS, if not yet recognized, to pursue NCQA PCMH recognition
- Devotes 60% of clinical time to primary care
- Must share all medical records among all practice sites within the practice group
- Meet federal requirements for Early & Periodic Screening, Diagnostic & Treatment (EPSDT), and state requirements to address smoking cessation, racial & ethnic disparities, and adherence to consumer protections per DSS policy

DSS PCMH Program Benefits

- CHNCT's PCMH Support Team will guide and support practices through the NCQA process at no cost to the practice
- DSS will pay enhanced rates for either achieving or working to achieve PCMH recognition*
- DSS will pay financial incentives to qualifying practices for PCMH program performance and improvement on select quality measures

**Enhanced rates and financial incentives do not apply to FQHC practices; only to community-based primary care practices.*

Three Types of Financial Incentives

- Participation Enhanced Rates
  - A 14-24% increased rate on 78 selected Current Procedural Terminology (CPT) codes depending on Glide Path status or NCQA PCMH recognition status*
- Performance Payments
  - Annual payments based on practice performance of DSS selected health measure results during the measurement year compared to all eligible PCMH practices*
- Improvement Payments
  - Annual payments based on the practice's improvement of health measure results compared to their results from the previous year*

**Based on attributed HUSKY Health members*

The Role of Community Health Network of Connecticut, Inc. (CHNCT)

- CHNCT is the medical Administrative Services Organization (ASO) contracted with DSS
- CHNCT's PCMH support team includes:
  - **Regional Network Managers (RNMs):** educate practices about the program assist with the application process
  - **Community Practice Transformation Specialists (CPTS):** provides assistance throughout the NCQA process which usually takes 18 to 24 months to complete

Learn More About this Initiative

- Contact an RNM at CHNCT by calling 203.949.4194
- Visit the NCQA website and review the information on PCMH recognition:
  - https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/

Apply

- Applications and instructions are available at www.ct.gov/husky. Click "***For Providers***," then "***Person-Centered Medical Home***." You can also email pcmhapplication@chnct.org
- Practices should work directly with their RNM on their Readiness Evaluation Questionnaire and their PCMH Application

PCMH Support Team

Role of the Regional Network Manager

- CHNCT employs three RNMs with assigned territories covering the state
- Their principal functions related to PCMH are:
  - Recruitment by telephone contact is used to screen for interest and readiness
  - Active assistance in the completion of a Readiness Evaluation Questionnaire and a PCMH Application
  - Support in alignment of DSS/DXC technology data with practice billing information to ensure payment of enhanced rates
  - Review of PCMH Application for accuracy and completeness
  - Face-to-face appointments to educate practice about DSS PCMH program details and NCQA
  - A second meeting includes a CPTS if applying for the Glide Path process

Role of the Community Practice Transformation Specialist

- CHNCT employs 9 CPTS's throughout the state who are specifically trained in the NCQA PCMH recognition standards and process
- CPTS principal functions include:
  - Collaborating with Glide Path practices to enable NCQA recognition
  - Assisting PCMH and Glide Path practices in their use of available resources to manage HUSKY Health members
  - Support practices in maintaining and benefiting from their DSS PCMH participation

Role of the Community Practice Transformation Specialist (cont.)

- CPTS/practice collaboration begins following contact by the RNM with a focus on:
  - Evaluating the practice for understanding of the NCQA recognition process
  - Completing the Glide Path application
  - Monitoring progress on completion of Glide Path tasks, including gap analysis
  - Providing resources and support to address gaps and deficits
  - Directing practices in education/training on NCQA requirements
  - Providing access to patient utilization data through CHNCT's secure provider portal

Role of the Community Practice Transformation Specialist (cont.)

- The CPTS will accommodate the practice's schedule to provide support in person, by email, by phone, and through online meetings
- Throughout the entire Glide Path process, the CPTS is available to the practice to offer advice and counsel on any matter related to the NCQA and DSS PCMH process
- Support from your assigned CPTS is always at no cost to the practice

Additional Role of the CPTS

Assists Practices to Integrate Care Coordination into their Model of Care

- Provides educational materials on concepts of care coordination
- Instructs practices to designate a professional to assume the role of care coordinator
- Educates practices on utilization of a team concept that supports a division of care coordination duties among clinical and non-clinical staff
- Facilitates meetings with CHNCT's Intensive Care Management staff to assist with care coordination needs if requested by practices

PCMH Readiness Evaluation Questionnaire

- The Readiness Evaluation Questionnaire helps CHNCT's PCMH support team:
  - Understand and evaluate practices that have chosen the path to PCMH and those that are just getting started
  - Obtain a better understanding of the practice's needs
  - Acquaint the practice with the requirements of NCQA, PCMH, DSS programs, and HIT
- The form can be downloaded from the HUSKY Health website and submitted online:
  - http://www.huskyhealthct.org/providers/PCMH/pcmh-documents.html#

PCMH Readiness Evaluation Questionnaire (cont.)

- The questionnaire gathers practice information in order to begin or continue to assess where the practice is in the process of becoming a Person-Centered Medical Home and includes:
  - Practice demographic information
  - Additional practice information
  - Person-Centered Medical Home (PCMH) knowledge
  - Health Information Technology (HIT) inventory
  - Familiarity with NCQA process
- Once complete, click "***Submit***"
- A copy is sent to CHNCT and a confirmation email will be sent to the person completing the form
- An RNM will reach out if contact has not yet been made with the practice

Questionnaire Results

- The Readiness Evaluation Questionnaire results are used to make efficient use of time and resources for both the practice and CHNCT Regional Teams
- The RNM will advise a practice on whether they are ready to move forward in the application process or if the practice needs to take more time with NCQA, PCMH, or HIT
- The RNM will schedule an onsite meeting with the practice and/or recommend a CPTS meet with the practice to provide support and assistance with the NCQA process

For More Information

- Contact the Regional Network Management team at 203.949.4194
- An assigned RNM will assist you in completing your Readiness Evaluation Questionnaire and PCMH Application
- An assigned CPTS will assist you in completing your Glide Path Application
- Contact: pcmhglideapplication@chnct.org
- Visit the NCQA website and review the information on PCMH recognition:
  - https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/