Person-Centered Medical Home (PCMH)
Glide Path Instructions and Application

Revision E – March 12, 2018

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PERSON-CENTERED MEDICAL HOME (PCMH) GLIDE PATH APPLICATION INSTRUCTIONS

I. Glide Path Application Requirements

Prerequisites include completing a **Readiness Evaluation Questionnaire** and a **PCMH Application** prior to submitting your **Glide Path Application**. These three forms and detailed instructions are available at http://www.huskyhealthct.org/providers/pcmh.html. If you have any questions, please contact the PCMH Administrator at 203.949.4194 or **pcmhglideapplication@chnct.org**.

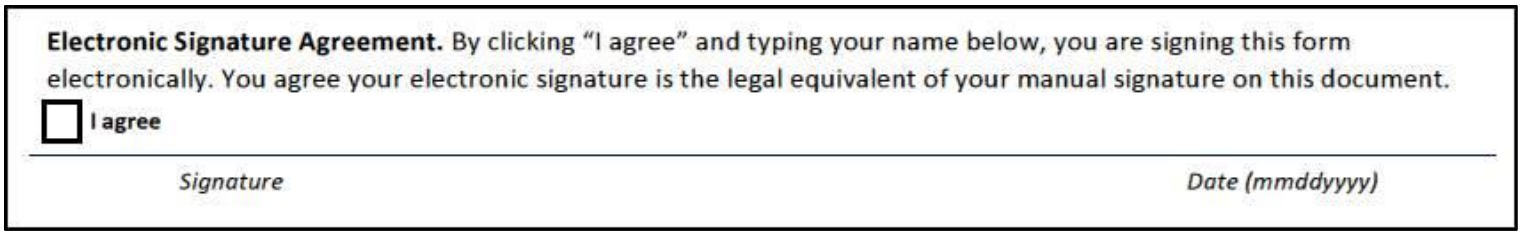
If the practice has more than one site, please ***complete a Glide Path Application for each site***.

To complete a Glide Path Application:

1. It is important to download and save the form before entering data. Save the application using the convention:

   PracticeName_PCMHGlidePath_mm-dd-yyyy.pdf.

   The form was created using Adobe® Acrobat® 10 Pro Version 10.1.16. It has been tested using Adobe® Acrobat® Reader 11 and Microsoft Internet Explorer® 11.0.
   The form should be submitted using an Adobe® Acrobat® application using Internet Explorer®.
2. Complete the application by entering data directly in the fields provided on the application. As you enter data, be sure to periodically save the form.
3. The last section of the application is the electronic signature agreement. By clicking "I agree" and signing below, you are signing the agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on the agreement.



4. Upon completion, save the form. Contact your assigned Community Practice Transformation Specialist (CPTS) to review the draft of your application prior to submission. Please note if you do not have an assigned CPTS, please contact the PCMH Program Administrator at 203.949.4194 or **pcmhglideapplication@chnct.org**.
5. Once approved, click the **SUBMIT** button on the last page to transmit the data to the Medical Administrative Service Organization (ASO). You will automatically receive a **Message Received** reply with a tracking number. Save this for future reference. You can expect to be contacted by the ASO within three business days.

Glide Path Application requirements and detailed data field descriptions are provided below.

II. Additions or Changes to the Glide Path Application

Open your original, saved Glide Path Application and make the appropriate additions or changes. An individual authorized to act as a signatory for the practice must re-sign the application. In doing so, the signatory certifies that all updated information provided in the application is accurate.

Once your application is updated and signed, follow the submission instructions on page 14.

Please direct any questions to your Community Practice Transformation Specialist. Please note: if you do not have an assigned CPTS please contact the PCMH Program Administrator at 203.949.4194 or pcmhglideapplication@chnct.org.

III. Summary of Glide Path Application Submission Requirements

SUMMARY OF SUBMISSION REQUIRMENTS		
GLIDE PATH PRACTICE MUST PROVIDE:	**INCLUDING:**	**THE INFORMATION MUST BE PROVIDED:**
A. Readiness Evaluation Questionnaire	A series of questions to determine a practice's readiness to proceed with the program. The Readiness Evaluation Questionnaire is available at http://www.huskyhealthct.org/providers/PCMH/PCMH-Documents/PCMH_Readiness_Evaluation_Questionnaire.pdf.	Prior to submitting a PCMH Application.
B. PCMH Application	Practice and provider data are required and the PCMH Application is available at http://www.huskyhealthct.org/providers/PCMH/PCMH-Documents/PCMH_Instructions_and_Application.pdf.	Prior to submitting a Glide Path Application.
C. Grant access to the practice's NCQA Q-PASS account	Contributor user access rights to the practice's NCQA Q-PASS account.	During Glide Path Phase 1 or Phase 2.
D. Glide Path Application	Practice Information specific to NCQA requirements, Glide Path Program requirements, Glide Path Summary Timeline and Signatures. The Glide Path Application can be found at http://www.huskyhealthct.org/providers/PCMH/PCMH-Documents/PCMH_Glide_Path_Instructions_and_Application.pdf.	Within 30 days after submitting a complete PCMH application. NOTE: The effective date for enhanced reimbursement rates is the first day of the month ***after*** the practice submits a complete Glide Path application to the Department of Social Services ("the Department" or DSS) that meets all requirements.
If awarded Glide Path Practice status, your practice will receive a letter from the DSS PCMH program.		
E. Documentation for each Glide Path Phase	Documentation that demonstrates compliance with the Glide Path phase requirements as described below.	At least 30 days prior to the scheduled end date for each Glide Path phase.
F. Update the CHNCT PCMH Gap Analysis Checklist	Revise the CHNCT PCMH Gap Analysis Checklist.	At least 30 days prior to the scheduled end date for each Glide Path phase.

IV. Detailed Description of Glide Path Application Requirements

This section describes how to complete the Glide Path Application.

A. PRACTICE INFORMATION	
Field Number and Name	Description
Practice Name	Enter the legal name of the practice.
Individual Responsible for Glide Path Requirements	Enter the name of the individual that will be working directly with the ASO staff to ensure that all Glide Path requirements are met.
Connecticut Medical Assistance Program (CMAP) numbers under which the practice bills primary care services for all Primary Care Providers (PCPs) listed in the Practices' PCMH Application	Enter all applicable billing CMAP provider ID numbers used by the practice to bill DSS for care provided to HUSKY Health Plan recipients. CMAP provider numbers are sometimes referred to as "AVRS IDs" on CMAP remittance advice. Typically, a practice will have different CMAP numbers (which may map to one or multiple NPI's) maintained for different specialties such as Internal Medicine, Family Practice, Pediatrics, and Nurse Practitioners. All relevant CMAP billing provider numbers should be included.
Address Line 1	Enter the number and street name of the practice's primary site address. **This cannot be a P.O. Box**.
Address Line 2	Enter the second line of the practice's primary site street address, if necessary.
Practice City	Enter the city name of the practice's primary site address.
Practice State	Enter the state name or abbreviation of the practice's primary site address.
Practice Zip Code	Enter the 5-digit zip code of the Practice's primary site address.
Practice Telephone Number	Enter the telephone number of the practice's primary site.
Practice Fax Number	Enter the practice's fax number at their primary site address.

B. NCQA Q-PASS ACCOUNT AND REQUIRED CRITERIA	
Field Name	Description
NCQA Q-PASS ACCOUNT	Enter the NCQA Q-PASS account number. Glide Path Practices must provide the Department's Medical ASO with access to their NCQA Q-PASS account by registering the Medical ASO as a Contributor. If a Q-PASS account has not been established, enter the projected Phase, which would be either Phase 1 or Phase 2.
NCQA CORE CRITERIA	Listed are the required core criteria that the practice must complete. Practice must select "yes" for the criteria that are currently met or "no" for any criteria that is not yet met.
NCQA ELECTIVE CRITERIA	Check the box to attest that the practice will complete the required NCQA elective criteria with the selection of at least 25 credits across five of the six concepts, as mandated by NCQA.
PCMH DISTINCTION MODULES	Check the boxes if your practice has achieved any of PCMH Distinctions in addition to 2017 PCMH Recognition (check all that apply).

C. GLIDE PATH TIMELINE

Each phase is six months from Start Date to Completion Date.

Glide Path Phase:	Start Date	Completion Date
Glide Path Phase 1	Enter the date when the practice will begin Glide Path Phase 1 (mm/dd/yyyy).	Enter the date when the practice expects to complete Glide Path Phase 1 (mm/dd/yyyy).
Glide Path Phase 2	Enter the date when the practice will begin Glide Path Phase 2 (mm/dd/yyyy).	Enter the date when the practice expects to complete Glide Path Phase 2 (mm/dd/yyyy).
Glide Path Phase 3	Enter the date when the practice will begin Glide Path Phase 3 (mm/dd/yyyy).	Enter the date when the practice expects to complete Glide Path Phase 3 (mm/dd/yyyy).

D. GLIDE PATH DELIVERABLES

The Glide Path Program requires applicants to complete all Glide Path tasks and provide the required documentation for each Glide Path phase. Please refer to pages 11-14 in the Glide Path Application for the complete listing of the required documentation.

Glide Path Practices must submit all documentation to the Medical ASO at least 30 days prior to the end of each Glide Path phase, unless an extension has been granted.

Practices must complete the entire Glide Path in no more than 24 months, including any requested extensions. In the event that a practice does not complete the Glide Path within a 24 month period, DSS will be notified and the practice's ability to continue the Glide Path program and obtain the enhanced reimbursements will be determined.

E. REQUIREMENTS FOR GLIDE PATH COMPLETION

1. Copy of the Notification of Recognition Decision email from NCQA denoting the practice has been granted recognition.
2. Copy of the NCQA PCMH Certificate of Recognition.

Person-Centered Medical Home (PCMH)

Glide Path Application

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Save this form periodically while completing or editing your application. Any data not saved will be lost.

A. PRACTICE INFORMATION

FIELD NUMBER AND REQUIRED INFORMATION		PRACTICE RESPONSE	
*A.1	**Practice Name		
*A.2	Individual Contact responsible for Glide Path requirements		
A.3	Connecticut Medical Assistance Program (CMAP) numbers under which the practice bills primary care services for all Primary Care Providers (PCPs) listed in Section E of the PCMH Application	1.	
		2.	
		3.	
		4.	
		5.	
*A.4	Practice Address Line 1		
A.5	Practice Address Line 2		
*A.6	Practice City		
*A.7	Practice State		
*A.8	Practice Zip Code		
*A.9	Practice Telephone Number		
A.10	Practice Fax Number		

*** Please complete all required fields marked by an asterisk ***

**** If the practice has multiple sites, complete an application for each site with different addresses. You may incorporate the name of the practice with its location. For example, "ABC Practice – South Street."**

B. NCQA Q-PASS ACCOUNT

	Description	
NCQA Q-PASS ACCOUNT	Enter the NCQA Q-PASS account number. Glide Path practices must provide the Department's Medical ASO with Contributor user access rights to their Q-PASS account. If a Q-PASS account has not been established enter the projected Phase, which would be either Phase 1 or Phase 2.	

The following sections are included in the Glide Path Work Plan

C. NCQA REQUIRED CORE CRITERIA

Below is a listing of **required core criteria** that a practice must complete in addition to the **CHNCT PCMH Gap Analysis Checklist** with your assigned Community Practice Transformation Specialist (CPTS). Please note if you do not have an assigned CPTS, please contact the PCMH Program Administrator at 203.949.4194 or pcmhglideapplication@chnct.org.

Concepts	Required Core Criteria	Met
Team-Based Care and Practice Organization(TC)	**Competency A** **TC 01: PCMH Transformation Leads**	☐ Yes ☐ No
	TC 02: Structure and Staff Responsibilities	☐ Yes ☐ No
	Competency B **TC 06: Individual Patient Care Meetings/Communication**	☐ Yes ☐ No
	TC 07: Staff Involvement in Quality Improvement	☐ Yes ☐ No
	Competency C **TC 09: Medical Home Information**	☐ Yes ☐ No
Knowing and Managing Your Patients (KM)	**Competency A** **KM 01: Problem Lists**	☐ Yes ☐ No
	KM 02: Comprehensive Health Assessment	☐ Yes ☐ No
	KM 03: Depression Screening	☐ Yes ☐ No
	Competency B **KM 09: Diversity**	☐ Yes ☐ No
	KM 10: Language	☐ Yes ☐ No
	Competency C **KM 12: Proactive Reminders**	☐ Yes ☐ No
	Competency D **KM 14: Medication Reconciliation**	☐ Yes ☐ No
	KM 15: Medication Lists	☐ Yes ☐ No
	Competency E **KM 20: Clinical Decision Support**	☐ Yes ☐ No
	Competency F **KM 21: Community Resource Needs**	☐ Yes ☐ No

Patient-Centered Access and Continuity (AC)	**Competency A** **AC 01: Access Needs and Preferences**	☐ Yes ☐ No
	AC 02: Same-Day Appointments	☐ Yes ☐ No
	AC 03: Appointments Outside Business Hours	☐ Yes ☐ No
	AC 04: Timely Clinical Advice by Telephone	☐ Yes ☐ No
	AC 05: Clinical Advice Documentation	☐ Yes ☐ No
	Competency B **AC 10: Personal Clinician Selection**	☐ Yes ☐ No
	AC 11: Patient Visits with Clinician/Team	☐ Yes ☐ No
Care Management and Support (CM)	**Competency A** **CM 01: Identifying Patients for Care Management**	☐ Yes ☐ No
	CM 02: Monitoring Patients for Care Management	☐ Yes ☐ No
	Competency B **CM 04: Person-Centered Care Plans**	☐ Yes ☐ No
	CM 05: Written Care Plans	☐ Yes ☐ No
Care Coordination and Care Transitions (CC)	**Competency A** **CC 01: Lab and Imaging Test Management**	☐ Yes ☐ No
	Competency B **CC 04: Referral Management**	☐ Yes ☐ No
	Competency C **CC 14: Identifying Unplanned Hospital and ED Visits**	☐ Yes ☐ No
	CC 15: Sharing Clinical Information	☐ Yes ☐ No
	CC 16: Post-Hospital/ED Visit Follow-Up	☐ Yes ☐ No
Performance Measurement and Quality Improvement (QI)	**Competency A** **QI 01: Clinical Quality Measures**	☐ Yes ☐ No
	QI 02: Resource Stewardship Measures	☐ Yes ☐ No
	QI 03: Appointment Availability Assessment	☐ Yes ☐ No
	QI 04: Patient Experience Feedback	☐ Yes ☐ No

	Competency B **QI 08: Goals and Actions to Improve Clinical Quality Measures**	☐ Yes ☐ No
	QI 09: Goals and Actions to Improve Resource Stewardship Measures	☐ Yes ☐ No
	QI 10: Goals and Actions to Improve Appointment Availability	☐ Yes ☐ No
	QI 11: Goals and Actions to Improve Patient Experience	☐ Yes ☐ No
	Competency C **QI 15: Reporting Performance within the Practice**	☐ Yes ☐ No

D. NCQA REQUIRED ELECTIVE CRITERIA

Elective Criteria	**By checking the box to the right, you agree to complete the required elective criteria with the selection of at least 25 credits across five of the six concepts as mandated by NCQA.**	☐
PCMH Distinction Modules **(check all that apply)**	**Behavioral Health Integration – (BHI)** **Electronic Quality Measures Reporting – (eCQM)** **Patient Experience Reporting – (PEX)** **Not Applicable**	☐ ☐ ☐ ☐

E. GLIDE PATH TIMELINE

Each phase must be a total of six months	Start Date MM/DD/YYYY	Completion Date MM/DD/YYYY
Glide Path Phase 1	(mm/dd/yyyy)	(mm/dd/yyyy)
Glide Path Phase 2	(mm/dd/yyyy)	(mm/dd/yyyy)
Glide Path Phase 3	(mm/dd/yyyy)	(mm/dd/yyyy)

F. GLIDE PATH DELIVERABLES

Refer to Page 5 of the Glide Path Instructions for further direction regarding completing all Glide Path tasks and providing the required documentation for each Glide Path phase.

G. GLIDE PATH PHASE 1

To complete Phase 1 of the Glide Path and maintain DSS Glide Path Status, the practice must demonstrate fulfillment of all of the tasks within a six-month timeframe, unless the practice is granted an extension.

The Following Tasks Must Be Completed
DO NOT submit Glide Path documentation for specific tasks with this application

TASK	NCQA X-REF	REQUIRED PRACTICE CRITERIA:	THE PRACTICE IS REQUIRED TO SUBMIT THE FOLLOWING EVIDENCE:
1A	AC 02	Provides reserved same day appointments for routine and urgent care	▪ Provide a documented process and a five day report showing same day access
	AC 03	Provides routine and urgent care appointments outside regular hours	▪ Provide a documented process and evidence showing routine and urgent appointments outside regular business hours
	AC 04	Provides timely clinical advice by telephone	▪ Provide a documented process and a seven day report for providing timely clinical advice to patients, by telephone, during and after office hours
1B	TC 01	Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities	▪ Details about the clinical lead and the PCMH manager which includes the person's name, credentials, and roles/responsibilities
	QI 01	Monitors at least five clinical quality measures across the four categories: A. Immunization measures B. Other preventative care measures C. Chronic or acute care clinical measures D. Behavioral health measures	▪ A report for each of five selected clinical quality measures across four categories ▪ A report for each measure
	QI 02	Monitors at least two measures of resource stewardship: A. Measures related to care coordination B. Measures affecting health care costs	▪ Provide a report which includes a description of the practice's ongoing quality improvement strategy or the populated NCQA Quality Improvement Worksheet for each measure
	QI 08 QI 09	Set goals and acts to improve upon at least one clinical quality measure and one measure of resource stewardship	▪ Provide a report which includes a description of the practice's ongoing quality improvement strategy or the populated NCQA Quality Improvement Worksheet for each measure

1C	KM12	Identify population of patients and notify them of needed care for at least three of the following: A. Preventative care services B. Immunizations C. Chronic or acute care services D. Patients not recently seen	▪ A, B, D: Provide a report/list that identifies patient population and outreach materials used to remind patients ▪ C: Provide a report/list that identifies patient population and outreach materials used to remind patients OR ▪ C: KM 13 – NCQA HSRP or DRP Recognition for at least 75% of eligible clinicians
1D	CM 02	Monitors the percentage of the total patient population of patients who may benefit from care management for at least three of the categories or conditions: 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	▪ Provide a report
	CM 04 CM 05	Operationalize one care plan for one population identified for care management	▪ Provide an example of a de-identified written care plan that includes evidence-based treatment goals which incorporate patient preferences and functional/lifestyle/goals ▪ Provide evidence that a written care plan was given to patient/family/caregiver

H. GLIDE PATH PHASE 2

To complete Phase 2 of the Glide Path and maintain DSS Glide Path Status, the practice must demonstrate fulfillment of all of the tasks within a six-month timeframe, unless the practice is granted an extension.

The Following Tasks Must Be Completed.
Do NOT submit Glide Path documentation for specific tasks with this application.

TASK	NCQA X-REF	REQUIRED PRACTICE CRITERIA:	THE PRACTICE IS REQUIRED TO SUBMIT THE FOLLOWING EVIDENCE:
2A	QI 04	Conducts a survey to evaluate patient/family/caregiver experiences across at least three dimensions: • Access • Communication • Coordination • Whole-person care, self-management support, and comprehensiveness	▪ Provide a report which includes a description of the practice's survey results
	QI 08	Set goals and acts to improve upon at least 3 clinical quality measures	▪ Provide a report which includes a description of the practice's ongoing quality improvement strategy or a populated NCQA Quality Improvement Worksheet for each measure

	QI 10 QI 11	Set goals and acts to improve on availability of major appointment types to meet patient needs and preferences Set goals and acts to improve performance on at least one patient experience measure	▪ Provide a report which includes a description of the practice's ongoing quality improvement strategy or a populated NCQA Quality Improvement Worksheet ▪ Provide a report which includes a description of the practice's ongoing quality improvement strategy or a populated NCQA Quality Improvement Worksheet
2B	CM 04 CM 05	Operationalize remaining person-centered care plans for patients identified for care management Provides written care plan to patient/family/caregiver identified for care management	▪ Provide a de-identified example of each type of written care plan that includes evidence-based treatment goals which incorporates patient preferences and functional/lifestyle goals ▪ Provide evidence that each type of written care plan was given to patient/family/caregiver
2C	CC 01 CC 04 CC 14 CC 16	The practice tracks and manages laboratory and imaging tests and informs patients of the results The practice provides important information in referrals to specialists and tracks referrals until the report is received The practice identifies patients with unplanned hospital admissions and emergency department visits The practice contacts patients/families/caregivers for follow-up care within an appropriate period following a hospital admission or emergency department visit	▪ Provide a tracking log or report and a process demonstrating tracking, flagging, and follow-up of care coordination for the following: ○ Lab and diagnostic imaging tests ○ Referrals to specialists ▪ Provide a report and a process for monitoring unplanned admissions and emergency department visits ▪ Provide a process that defines the appropriate contact period and a log documenting systematic follow-up was completed
2D	None	NCQA Practice Work Plan	▪ Provide a copy of the NCQA Practice Work Plan provided to the practice by NCQA

I. GLIDE PATH PHASE 3

To complete Phase 3 of the Glide Path and maintain DSS Glide Path Status, the practice must demonstrate fulfillment of all of the tasks within a six-month timeframe, unless the practice is granted an extension

The Following Tasks Must Be Completed.
DO NOT submit Glide Path documentation for specific tasks with this application.

TASK	NCQA X-REF	REQUIRED PRACTICE CRITERIA:	THE PRACTICE IS REQUIRED TO SUBMIT THE FOLLOWING EVIDENCE:
3A	None	Mock virtual review with Community Practice Transformation Specialist	▪ Mock Virtual Review

3B	QI 12 QI 14 QI 15	Achieves improved performance on two performance measures Achieves improved performance on one measure of disparities in care or service Reports performance results within the practice	▪ Provide reports which include a description of the practice's ongoing quality improvement strategy or a completed NCQA Quality Improvement Worksheet
3C	CM 04 CM 05	For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/caregivers to develop a care plan and provides the written care plan to the patient/family/caregiver	▪ Provide a report or a completed NCQA Record Review Workbook and patient examples

J. REQUIREMENTS FOR GLIDE PATH COMPLETION

1. Copy of the Notification of Recognition Decision email from NCQA denoting the practice has been granted recognition
2. Copy of the NCQA PCMH Certificate of Recognition

K. SIGNATURE

The information provided in this PCMH GLIDE PATH APPLICATION is true and correct to the best of my knowledge as an individual authorized by the practice.

An individual authorized to act as a signatory for the practice must also provide an electronic signature on the application. In doing so, the signatory certifies that all information provided in the application is accurate.

Provider Entity Name (doing business as)

Name of Authorized Representative

Electronic Signature Agreement. By clicking "I agree" and typing your name below, you are signing this application electronically. You agree your electronic signature is the legal equivalent of your manual signature on this document.

☐ *** I agree**

**Signature* **Date (mm/dd/yyyy)*

Click the **SUBMIT** button on this page to send this application to the Medical ASO. You will automatically receive a **Message Received** reply with a tracking number. Save this for future reference. You can expect to be contacted by the Medical ASO within three business days.

SUBMIT

If you have any questions about this Glide Path application,
contact the Medical ASO at **203.949.4194** or pcmhglideapplication@chnct.org.