Becoming a Person-Centered Medical Home (PCMH)
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:
Apply

Applications and instructions are available at [www.ct.gov/husky](http://www.ct.gov/husky). Click “For Providers,” then “Person-Centered Medical Home.” You can also email pcmhaplication@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:

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
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: