### Primary Care Transformation PIC
**June 24, 2016**
10:00-12:00

<table>
<thead>
<tr>
<th>AGENDA &amp; DESCRIPTION</th>
</tr>
</thead>
</table>
| 1. Welcome            | Karen Joncas, Project Manager - Primary Care Transformation  
Email: Karen.Joncas@cnycares.org |
| 2. Health Homes Presentation | Health Homes-What are they and how do they fit in a PCMH? 
Presented by: Margaret Fontenot, Onondaga Case Management, Eric Stone-St. Joseph’s Care Coordination Network, Jillian Gross-Central New York Health Home Network |
| 3. Update on NCQA PCMH 2014 schedule | Options for submission |
| 4. PCMH Training Opportunities and other CNYCC Supports | On-Site (CNYCC) NCQA Webinar- “Team-Based Care-It Takes a Village to Transform a Medical Home”- 
June 30, 2016 1-3PM  
On-site interactive-PCMH Training- July 20-21, 2016  
Topics include but are not limited to: Creating policies and procedures, care management and care coordination, change management strategies. |
| 5. Hot Topic: Update on NCQA 2017 PCMH | Proposed standards-Public Comments requested |
| 6. Hot Topic: Care Transitions | Alignment with Primary Care Transformation |
| 7. Next PIC Meeting: July 29, 2016 | Meeting will focus on Primary Care Transformation across projects. |
## Practice Transformation PIC – 6/24/16

| --- | --- |

**Organizations Represented:** Upstate University Hospital, Upstate Pediatrics, Rome Medical Group, Crouse Hospital and Medical Practices, St. Joseph’s Hospital and Health Center, Oneida Healthcare, Family Care Medical Group, MV Health System, Community Memorial Hospital, Christian Health, Oswego Hospital, Auburn Community Hospital, Rochester Primary Care Network, Cayuga County Mental Health, North Country Transitional Living, Planned Parenthood

**CNYCC:** Karen Joncas, Shana Rowan, Kate Weidman

**Health Homes:** Eric Stone, Margaret Fontenot, Jillian Gross

<table>
<thead>
<tr>
<th>Discussion</th>
<th>Presentation – Health Homes- Given by Eric Stone, Margaret Fontenot and Jillian Gross</th>
</tr>
</thead>
</table>

*Please see the slide decks presented during today’s PIC for additional information.*

- **Slide: Learning Outcomes**
  - Providers working on behalf of an individual, connecting them to resources and services

- **Slide: Definition of a Health Home**
  - Lead health home
  - Health home care management agency
  - Health home network of providers

- **Slide: What Makes up a Health Home?**
  - Health Home Management-Currently serving adults
  - DSRIP Care Management-Currently serving adults with one Chronic Condition
**Discussion (continued)**

- Children to be added to Health Home and DSRIP Care Management eligibility

**Slide: How does this benefit you in Primary Care?**
- **Recent study yields outcomes improve including: No show rates, Attendance and improved Physical exam compliance.**
- Health Home Care Managers do the billing paperwork for the care coordination services they provide.
- Develop care plans with members that are shared with all care team members.
- Assist members/patients with issues of social determinants of health.
- Care managers are well trained in motivational interviewing skills and availability of helpful community resources.
- Assists members with transportation.
- Availability of care managers in all our geographic regions-no wait time when completing a community referral for placement.
- Frees up limited practice’s care management services for other patients.

**Slide: Local Health Homes**
- St. Joseph’s Care Coordination Network
- Onondaga Case Management Services/HHUNY Central
- Central New York Health Home Network

**Slide: Care Management Agencies associated with each Health Home**
- Note that there is some overlap

**Slide: Types of Referrals**
- Community referrals-Healthcare providers submit community referrals and will receive an email or call explaining the outcome of the referral and updated care plan as part of the member/patient’s care team.
- Self-referrals by person or their family member/support person
- NYS DOH assignments
- MCO assignments (Fidelis, Excellus, United Healthcare)

**Slide: Steps to Process, Referral to Active Care Management**
1. Person is identified as being potentially eligible
2. Community referral completed and submitted to HH
3. HH processes referral and sends to appropriate CNA within 24 hours
   - Patients can specify specific agency/health home
4. CMA immediately begins outreach to referred individual
   - Calling or stopping by home
   - Also reaches out to MCO – very active and progressive
5. Intake documentation
6. Identify member’s care team and notifies each participant
7. Completes comprehensive assessment
8. Completes care plan and shares with all care team members
9. Begins active care management (core services) with member
10. On-going notification to care team of changes to member status or care plan

Slide: Contact Information (information on slide)
- Three presenters contact information given to assist with health home referral or to troubleshoot partner concerns about a member
- The three health homes work very well together and always have the member best interest at heart.

All are welcome to contact the three health home leads that presented today for additional information, organization specific presentation.

Questions/Discussion

Tom Filiak asked if the State will be relaxing the eligibility requirements of 2 chronic conditions and expressed that from a DSRIP perspective, we should be ready to enroll patients with 1 chronic condition into a health home. Eric Stone explained that there seemed to be more patients with two chronic conditions than one, and those patients can be referred to DSRIP Care Management.

Transformation Timeline Options
- NCQA PCMH 2014: Option 2 – NYS DSRIP only- submission dates extended (Recognition will only last for 2 years, submission fees reduced proportionally)

Transformation Support- See more details on each slide
- Slide: PCMH Training Opportunity-NCQA Sponsored Webinar –On-Site at CNYCC-June 30th
- Slide: PCMH Training Opportunity- July 20,21st- Presented by HANYS and Karen Joncas
  - 40 participants max for both programs-registration required

- Slide: CNYCC on-site assessment-Mandatory for partners with no previous NCQA Recognition.
- Slide: CNYCC Website-Member page
- Slide: NCQA Trainings and Q&A sessions
- Slide: CNYCC IT Team- Update on meeting with MEDENT. On-going discussions regarding project reporting requirements and Population Health Management System
- Slide: CNYCC as a Partner in Quality- 20% Reduction in Single Site Submissions
<table>
<thead>
<tr>
<th>Discussion (continued)</th>
</tr>
</thead>
</table>

**Slide: PCMH Template Status**
- Status: Delayed
- Partners are implored to keep working on preparing line item plans reflected in template line items as submission dates are fast approaching despite the template not yet published in final form.
- Staffing Impact tab for PCMH not required by July 14th with the other templates but may be requested at a later date.

**HOT TOPIC #1**
Slide: Review of Draft of PCMH 2017- NCQA requests Public Comments until July 15, 2016 Requirements
- Additional details on slide

Slide:— Proposed NCQA PCMH 2017
- Important to Review and consider offering comment ahead of final Standard rollout in March 2017.
- New Activities align with DSRIP projects
- Understand the future of Primary Care Transformation particularly in a Value Based Payment environment

Slide: Highlight draft – NCQA PCMH 2017
- Karen Joncas will submit any partner comments to NCQA that she receives by July 13, 2016 for a collaborated response.
- Links to the Proposed changes, Public Comment requests shared
- NCQA Webinar’s with further information on Public Comment and new standards shared.

Slides: Series of slides presented on some of the Core and Additional Criteria to be required to validate transformation to a Patient-Centered Medical Home

**HOT TOPIC #2**
Slide: DSRIP Project – Care Transitions 2biv-Goal of project is to improve communications across health care delivery system, reduce hospital readmissions, provide care management services to those at highest risk of readmission
- Slide: Transitions of Care-Definition

Slide: Results of Ineffective Transitions of Care- adverse health effects, readmissions, higher cost of care.

Slides: PCMH Alignment- Research shows that patients with an established relationship with their primary care have fewer hospital readmissions and unnecessary ED visits. Primary
Care should seek to improve communications with their patients on how and when to seek care and provide greater access to avoid unnecessary ED visits.

Primary Care representatives should consider attending monthly coalition meetings to voice their issues with hospitals related to care transitions.

Slides: Multiple slides revealing the overlap of Standards with care transition implications—Details contained on slides

Slide: Care Transitions Coalitions
- Set up across the six county region to assess current state of care transitions and review best practices to improve on region specific goals for improving care transitions to meet DSRIP goals.
- Additional details on slide

Slide: Table of information related to the various regional coalitions provided for consideration of primary care representatives to join their region’s group.

Partner Comment: Joan Dadey shared that the Onondaga County Coalition will likely have their initial meeting with IPRO towards the end of July.

Slide: Upcoming Meetings of Interest
- Include Virtual office hours, trainings and future PIC meetings. Additional details on slide.

**Next Meetings:**
Next PIC meeting scheduled for July 29, 10am – 12pm.

We are revising our Practice Transformation PIC format to be more inclusive across various PCP affected projects; more information forthcoming.
Health Homes

SJCCN/OCMS-HHUNY CENTRAL/CNYHHN INC.
Learning Outcomes

- Understanding Health Homes
- Goals of Health Homes and DSRIP CM
- What constitutes a referral
- Care Management activities
- Health Home benefit to you
- How to refer
Definition of a Health Home

“A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. This is done primarily through a Care Manager who oversees and provides access to all of the services an individual needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital. Health records are shared among providers so that services are not duplicated or neglected. Health Home services are provided through a network of organizations – providers, health plans and community-based organizations. When all the services are considered collectively they become a virtual ‘Health Home.’” – NYS DOH Definition

www.health.ny.gov
What Makes Up a Health Home

- **Lead Health Home**
  - Manage and Support

- **Health Home Care Management Agency**
  - Provide Health Home Core Services to Health Home Member

- **Health Home Network of Providers**
  - Hospitals, Private Practices, Outpatient Clinics, Specialists, Educational Services, Vocational Services, Housing Services, etc.
Currently Health Homes can be found in 14 States
- Alabama, Idaho, Iowa, Maine, Maryland, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Washington, and Wisconsin
  - Variations on Target Population, Provider, Enrollment, Payment, and Geographic Area
- New York Health Home Implementation result of the Medicaid Redesign Team (MRT) established by Governor Cuomo in January 2011.
- 40 Adult Health Homes across New York
  - At least 1 Health Home in each county
- Implemented in Phases (Phase 1, 2, 3) across New York
  - Phase 1: January 2012
  - Phase 2: April 2012
  - Phase 3: July 2012
    - SJCCN, CNYHHN, OCMS all Phase 3 Implementation
- Children’s Health Homes anticipated to begin 10/1/16
Health Home and DSRIP Goals

Health Homes
- Reduce costs
- Increase quality and efficiency
- Reduce preventable hospitalizations and ER visits

DSRIP
- System reform through community level collaborations
  - Reduce avoidable hospital use
  - Increase quality and efficiency
  - Clinical improvement
  - Population health improvement
  - Integrated Delivery Systems
Qualifying Criteria

Health Home Care Management

- Medicaid Recipients 18+
- Single Qualifying Condition (SMI or HIV/AIDS) OR
- 2 Qualifying Chronic Health Conditions AND
- Care Management Need

DSRIP Care Management

- Medicaid Recipients 18+
- 1 Qualifying Chronic Health Condition AND
- Care Management Need
Core Services

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional support
- Patient and family support
- Referral to community and social support services
- Use of health information technology to link services
How does this benefit you?

- Liaison between provider and HH Client (PCP patient)
- Care Manager to provide insight on Social Determinants
- Improved compliance with appointments and treatment recommendations
- Free up limited PCMH Care Management resources
- Clinical improvement performance
- PCP receives completed and updated Health Home Care Plan.
- All billing is managed by Lead Health Home
- Quick turnaround for assignment (HH or CMA)
Local Health Homes

**S.C.C.N.**
- Counties Covered: Onondaga, Cayuga, Oswego, Lewis, Madison, Cortland
- Enrolled Health Home Members: 1,619 (as of 6/22/16, MAPP)

**OCMS/HHUNY Central**
- Counties Covered: Onondaga, Cayuga, Oswego, Madison, Cortland, Tompkins, Tioga, Chemung
- Enrolled Health Home Members: 3,639 (as of 6/22/16, MAPP)

**CNYHHN Inc.**
- Counties Covered: Cayuga, Madison, Oneida, Herkimer, Lewis, St. Lawrence, Jefferson
- Enrolled Health Home Members: 3,931 (as of 6/22/16, MAPP)
Care Management Agencies

SJCCN
- ACR Health
- Liberty Resources
- Hillside Family of Agencies
- Catholic Charities of Oswego
- Oswego Health
- Catholic Charities of Onondaga
- Rescue Mission

OCMS, Inc./HHUNY Central
- ACR Health
- Liberty Resources
- Hillside Family of Agencies
- Catholic Charities of Oswego
- Cayuga County Mental Health
- Catholic Charities of Cortland
- Family Services of Chemung
- OCMS, Inc.
- Southern Tier Care Coordination
- Rehabilitation Support Services
- Elmira Psychiatric Center
- Tompkins County Mental Health Services
- Oswego County Opportunities
- HCR Home Care

CNYHNN, Inc.
- ACR Health
- Liberty Resources
- Cayuga County Mental Health
- HCR
- Kids Oneida
- CNYHNN, Inc.
- Neighborhood center
- Mohawk valley Psychiatric Center
- Upstate CP
- Transitional Living Services of Northern NY
- United Helpers
- St. Lawrence Psychiatric Center
- St. Lawrence Community Services
- Children’s Home of Jefferson County
- Credo Community Center
- Unity House
Types of Referrals

- Community Referrals
  - PCP
  - Hospital
  - Behavioral Health Outpatient
  - Substance Abuse Clinic
- Self-referrals
- NYS DOH Assignments
- MCO Assignments
Process: from referral to active care management

1. Person is identified as being potentially eligible (Doctor, therapist, nurse, specialist, self, etc.)
2. Community referral completed and submitted to HH
3. HH processes referral and sends to appropriate CMA within 24 hours of receipt
   a. CMA within county
      a. Can be identified as preferred by individual, if no preference HH will determine based off of the individual’s service history or areas of need.
4. CMA immediately begins outreach to the referred individual
   a. Potential outreach efforts: phone, home visit (may include shelter or hospital), contact with referral source, reach out to MCO, letters, etc.
5. Once located, HH Care Manager explains HH Care Management to the individual, if the individual is interested the HHCM will complete the intake paperwork with referred individual resulting in HH Member/Enrollment

6. HHCM supports HH Member in identifying Care Team
   HHCM notifies identified Care Team Partners of their addition to HH Member’s Care team.

7. HHCM completes comprehensive assessment with HH Member

8. HHCM completes Care Plan with HH Member and Care Team (if able)

9. HHCM sends copy of completed/approved Care Plan to all Care Team Partners

10. HHCM begins active care management (Core Services) with HH member

11. HHCM notifies Care Team of any changes (ex: discharge of HH Member, changes in Care Team as per HH Member, new/updated goals in Care Plan, etc)
Who to contact with questions/concerns

<table>
<thead>
<tr>
<th>§CCN</th>
<th>OCMS</th>
<th>CNYHHN Inc.</th>
</tr>
</thead>
</table>
| • Eric Stone  
  • (315)726-7169  
  • Eric.Stone@sjhsyr.org | • Margaret Fontenot  
  • (315)472-7363 x191  
  • MFontenot@ocmsinc.org | • Jillian Gross  
  • (315)757-9057  
  • Jillian.Gross@cnyhealthhome.net |

General Questions/Concerns:

- Where is a member assigned?
- How to request a transfer
- Capacity or Wait List
Primary Care Transformation PIC

June 24, 2016
Welcome and Introductions

CNYCC Team

- Karen Joncas, PCMH CCE
  - Primary Care Transformation Project Manager
  - E-mail: Karen.Joncas@cnycares.org
  - Telephone: 315-703-2981
Welcome and Introductions

Health Homes

- Margaret Fontenot
  - Onondaga Case Management
  - Margaret.Fontenot@ocmsinc.org
  - 315-472-7363 x191

- Eric Stone
  - St. Joseph’s Care Coordination Network
  - Eric.Stone@sjhsyr.org
  - 315-726-7169

- Jillian Gross
  - Central New York Health Homes Network, Inc.
  - Jillian.Gross@cnyhealthhomes.net
  - 315-757-9057
Learning Objectives
Learning Objectives

**Topics**

- Welcome and Introductions
- Health Homes-What are they and what does it mean for Primary Care?
- Understand the Transformation Timeline options
- Know the resources available to you for transformation
- Update on Practice Transformation/PCMH Planning Template
- Hot Topic-PCMH 2017 Update
- Hot Topic- Care Transitions Project overlap
- Q & A
- Important Upcoming Meetings
Transformation Timeline
Transformation Timeline Options

- **NCQA PCMH 2014: Option 1**
  - March 31, 2017 - Purchase Survey tools
  - March 31, 2017 - Submit Corporate Survey Tool
  - September 30, 2017 - Submit all practice site survey tools
  - Recognition - 3 years

- **NCQA PCMH 2014: Option 2**
  - NYS DSRIP only
  - March 31, 2017 - Purchase Survey Tools
  - September 30, 2017 - Submit Corporate Survey tools
  - January 31, 2018 - Submit practice site survey tools
  - Recognition - 2 years (Submission fees reduced proportionally)
Transformation Timeline

- Project charter and plan should include timeline
- All survey tools must be purchased by March 31, 2017
- Final NCQA Submission Due no later than 9/30/2017 for new applications for 3 year renewal recognition.
- Final NCQA Submission Due no later than January 31, 2018 for new applications for 2 year renewal.
- Change must be fully implemented at least three months before survey submission.
Transformation Support
Transformation Support-PCMH Training Opportunity

- NCQA Sponsored Live Webinar: Team-based Care – It Takes a Village to Transform a Medical Practice
- June 30, 2016 12:45-3:30 PM
- On-site at CNYCC- Call-in is not available
- CNYCC is offering this training free to our partners
  - Seating is limited to 40 participants
  - Registration required: E-mail Karen Joncas
Transformation Support-PCMH Training Opportunity

Topics include:
- Ensuring a sustainable transformation
- Creating streamlined policies and procedures
- Care Management
- Care Coordination
- Change management
- Transformation Sustainability
- Practice Care Teams

July 20-21, 2016 CNYCC (1 ½ day training)

CNYCC is offering this 1 ½ day training free to our partners
- Seating is limited to 40 participants
- Registration required: on-line form to be released to website.
Transformation Support-CNYCC On-site Assessment

- Current state (assessment) required for all sites for planning
- On-site assessment with Karen required for all non-recognized practices
- On-site assessment optional for currently recognized practice sites
- Develop your project charter and project team
- Schedule with Karen ASAP (two practices have scheduled to date).
Transformation Support-CNYCC-Stay Informed

- Become a CNYCC member
  - Visit website [https://cnycares.org/signup/](https://cnycares.org/signup/)
  - Create a login name and password
  - To Access visit CNYCC homepage and click on Member login
- Attend PIC meetings, visit website calendar for PIC presentations
Transformation Support-NCQA PCMH Live Q&A Webinar

- Free Customer Service Training Schedule
- Ask specific documentation or policy questions
- Offered Wednesday’s two times a month-May 25th, June 8th and 22nd (Calendar attached)
- Check NCQA website calendar for posted sessions and instructions

http://www.ncqa.org/Portals/0/Programs/Recognition/RPtraining/Training_Calendar.pdf?ver=2016-05-09-105219-097
Transformation Support- Partner in Quality

- For practices that apply as single sites, CNYCC has become a Partner in Quality, allowing our partners a 20% reduction in submission fees. (Multi-site applications are already awarded this discount.)

- CNYCC has enhanced access to NCQA for questions related to all programs.
Transformation Support-CNYCC IT Team

- PCMH Assessment and DSRIP Tracker Tool

- Vendor Coordination-Initial meeting -MEDENT June 1, 2016- Began discussions on Population Health Platform needs and collaboration on reporting for actively engaged patients for CVDM

- Other Vendor cohort collaborations-TBD

- HIT Planning template in development-Release date TBD

- Webinar/tools on vendor selection and EMR project planning (Slides and recording on May 12th Vendor selection webinar)
PCMH Planning Template Status
PCMH Planning Template

Status

❖ Due Date: TBD Roll-out delayed to allow partners to complete other templates.

❖ Partners should complete project charter and project team as soon as possible. Partners new to PCMH should call for an appointment for completion of baseline assessment once team is established.

❖ Partners can continue to implement plan components for reporting on finalized template.

❖ Staffing impact for PCMH will not be due by July 14th with the other project staffing impacts. More details to follow.
Transformation Hot Topic: PCMHH 2017 Proposed Updates
Why do I care about Proposed PCMH 2017 Requirements?

- Practices with current PCMH 2014 Recognitions may wish to wait for the March release of PCMH 2017 to renew their recognitions.

- An opportunity to comment on proposed program components which will affect your on-going transformation journey.

- Understand transformation standard upgrades as you continue transformation in a value based payment environment.

- Proposed standards have significant alignment with current DSRIP projects.
Public Comments-Proposed NCQA PCMH 2017

- Draft Standard available for public comment through July 15, 2016
- Proposed PCMH 2017 Recommendations Overview and Table are available here: http://www.ncqa.org/homepage/ncqa-public-comments/pcmh-2017-public-comment
- Webinar schedule to review process:
  - Monday June 27 3PM-4PM
  - Tuesday June 28 1PM-2PM
- Each partner can respond during public comment OR submit concerns to Karen Joncas for a collaborative response by July 13, 2016.
- Public comments include specific questions to be answered on-line
- Following public comment and approval from the NCQA Clinical Programs Committee and NCQA Board of Directors, final program standards to be released in March 2017.
Standards are organized into two groups
- Core Activities - Essential to primary practice function
- Additional Criteria - Includes Advanced criteria

Practices must meet all core activities and a yet to be defined number of additional criteria

Practices may be subject to an annual review to validate transformation to a patient-centered medical home

Practices are supported through the process through a combination of live support and an interactive, Web-based platform.
Highlights New Core Activities- NCQA PCMH 2017

- Categories and Concepts roughly follow PCMH 2014 Six Standards and include:
  - Team Based Care and Practice Organization
  - Knowing and Managing your patients
  - Patient Centered Access and Continuity
  - Care Management and Support
  - Care Coordination and Care Transitions
  - Performance Measurement and Quality Improvement

- 51 Core Activities required for Recognition
- 76 Additional Criteria to choose an undisclosed number of requirements
- NCQA will no longer use levels in determining recognition
- NCQA is increasing flexibility in methods used for documentation of validation of meeting the core or additional criteria.
Has a designated clinician leader that supports the PCMH model.

Training and assigning members of the care team for care management.

Maintains an up-to-date drug list

Identifies and prioritizes most relevant community resources based on assessment of social determinates and common conditions.

Assesses the access needs and preferences of the patient population (consider using for additional qualitative survey for PCMH 2014)
Highlights New Additional Criteria-NCQA PCMH 2017-Continued

- Approximately 30 new criteria, many of them advanced
- Attesting to ownership support of PCMH model
- Patients involved in practice governance or stakeholder activities
- Has at least one care manager qualified for behavioral health needs
- Has at least one clinician providing MAT and therapy directly or by referral for substance abuse disorder
- Documents social determinants of health, monitors at population level and implements care based on this data
- Anxiety screening using a standardized tool
- Substance Use Disorder screening using a standardized tool
Highlights New Additional Criteria- NCQA PCMH 2017

- Uses identified health disparities to tailor population health management
- Addresses health literacy at the population level (i.e. teach back method, medication brown bag etc.)
- Assesses oral health needs and provides necessary services
- Systematically obtains medication claims data to assess medication adherence.
- Evaluates the number of patients assigned to a provider patient panel.
- Evaluates social determinants of health to assess access for individual patients.
- Demonstrates a systematic process for monitoring and balancing the active patient panel
Follows up on community referrals to determine impact on individual patients.

Uses evidence based guidelines to determine if referral to specialist is necessary.

Monitors referrals by specialty type.

Monitors the completeness and quality of referral response.

Monitors depression over time and provides or refers for intervention if patient does not improve.
Transformation Hot Topic: Care Transitions
DSRIP Project-Care Transitions 2biv

- Goal: Reduce 30 day hospital readmissions for chronic care

- Transfer from Hospital to other settings, specifically linkage to Primary Care
  - Developing standards of care for PCP notification that may include: use of RHIO alerts, Discharge summaries and Continuity of Care Documents

- Identification of patients at high risk for readmission

- Use of Multi-Disciplinary Hospital-based Teams to assist with the transition
  - Health Coaching, Transitions Teams, Follow up with Patient

- Engagement and Linkage with Community Based Resources to meet additional patient needs (behavioral health, food insecurity, housing, financial)
What is a Transition of Care?

“‘Transitions of care’ refer to the movement of patients between health care practitioners, settings, and home as their condition and care needs change.”

https://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf
Results of Ineffective Transitions of Care

Ineffective transitions of care processes between medical providers, in particular from the hospital to another setting, leads to:

- Adverse events for the patients,
- Higher hospital readmission rates and
- Higher costs associated with the patient care and readmission
Patient-Centered Medical Home Alignment

Research shows that patients with an established relationship with their primary care have fewer hospital readmissions and unnecessary ED visits.

- Communicate to your patients on how to seek care during and after office hours.
- Communicate to your patients what is an appropriate use of the Emergency Department.
- Develop strong care team relations with your patients so they will call you first before going to the ED.
- Proactively follow-up on patients following hospital or ED admissions.
- Consider joining a care transition coalition in your region-Contact CNYCC Project Manager, Tammy VanEpps.
Patient-Centered Medical Home Alignment

- **Standard 1, Element A: Patient Centered Appointment Access**
  - Factor 1: Practice provides same day access for routine and urgent care-
  - Factor 2: Practice provides routine and urgent-care appointments outside regular business hours.

- **Standard 1, Element B: 24/7 Access to Clinical Advice**
  - Factor 1: Provides continuity of medical record information for care and advice when the office is closed.
  - Factor 2: Practice provides timely clinical advice by telephone during and after office hours.
Patient-Centered Medical Home Alignment

❖ Standard 2, Element A: Continuity of Care

➢ Factor 1: Patients choose a primary care provider (and are assigned a care team-2D)

➢ Factor 2: Practice monitors the percentage of visits with the primary care provider or team
  ✓ High percentage of visits with the primary care provider/team builds relationships

➢ Factor 3: Practice has a process in place to orient new patients to the practice
  ✓ Use this time to communicate instructions on how to obtain care

❖ Standard 2, Element B: Medical Home Responsibilities

➢ Factor 2: The practice provides instructions on how to obtain care and clinical advice during and after office hours
Patient-Centered Medical Home Alignment

- **Standard 5, Element C: Coordinate Care Transitions**
  - **Factor 1:** Proactively identifies patients with unplanned hospital admissions and ED visits
  - **Factor 2, 5:** Shares clinical information with admitting hospitals and Emergency Depts.
  - **Factor 3:** Consistently obtains patient discharge summaries from the hospital and other facilities
  - **Factor 4:** Proactively contacts patients for follow-up care following a hospital admission and/or ED visit
  - **Factor 7:** Provides electronic summary of care (to other care facilities) for more than 50% of patient transitions of care
Patient-Centered Medical Home Alignment

 Standard 6, Element B: Measure Resource Use and Care Coordination

➢ Practice must report their performance in Care coordination and Utilization measures that affects health care costs.

✓ Medication Reconciliation at Health care transitions

✓ Hospital Readmissions within 30 days

✓ Emergency Department use

Standard 6D and 6E: Set goals, analyze and improve on at least one performance measure from Standard 6B.
Care Transitions Coalitions

- Meeting of diverse stakeholders that come together in their respective regions/community (Facilitated by CNYCC and IPRO)

- Identification of regions’ patient outcomes as they relate to Care Transitions

- Identification of overlap of resources and referral sources

- Examine Current systems of Care Transitions and Best Practices within each region/community

- Goal is to improve communications and systems as they relate to the transitions of care specific to each region. Goals are identified by each region.

- Monthly meetings planned
<table>
<thead>
<tr>
<th>REGION/HOSPITAL(S)</th>
<th>MEETING DATE</th>
<th>TIME</th>
<th>LOCATION</th>
<th>COALITION LEAD</th>
<th>IPRO LEAD</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAYUGA COUNTY</td>
<td></td>
<td></td>
<td></td>
<td>Danielle Audick (315)567-0450</td>
<td>Fred</td>
<td>Several emails trying to connect</td>
</tr>
<tr>
<td>Auburn Community Hospital</td>
<td>7/6/16</td>
<td>11:30 - 1:30</td>
<td>Lewis County Hospital John Herman Conference Room</td>
<td>Gale Gunert (315)376-5463</td>
<td>Chris</td>
<td>Initial meeting 6/3/16</td>
</tr>
<tr>
<td>LEWIS COUNTY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lewis County Hospital</td>
<td>6/29/16</td>
<td>10:00-11:30</td>
<td>Large Classroom at Oneida Hospital, 321 Genesee Street, Oneida, NY.</td>
<td>Sherry Buglione (315)361-2031</td>
<td>Sara</td>
<td>Launch followed the 4/7/16 RPAC Meeting but only hospitals attended</td>
</tr>
<tr>
<td>MADISON COUNTY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Memorial Hospital Oneida Hospital</td>
<td>9/29/16</td>
<td>8:30-10:30</td>
<td>Rome Memorial Hospital Class Room</td>
<td>Patty King (315)338-7190</td>
<td>Sara</td>
<td>Initial in-house meeting for Rome Hospital Managers completed for 6/14/16</td>
</tr>
<tr>
<td>Oswego County</td>
<td></td>
<td></td>
<td></td>
<td>Katie Pagliaroli (315)349-5961</td>
<td>Chris</td>
<td></td>
</tr>
<tr>
<td>Oswego Hospital</td>
<td>5/17/16</td>
<td>2:30-3:30</td>
<td>Oswego Hospital Room JPC1; JPC2</td>
<td>Joan Dadey (315)470-7290</td>
<td>Sara</td>
<td>Initial calls with individual hospitals completed as of 6/22/16. Planning meeting early July</td>
</tr>
<tr>
<td>SYRACUSE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crouse Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Joseph’s Health Center Upstate University Hospital</td>
<td>Late July (Per Joan Dadey- PIC 6.24)</td>
<td>TBD</td>
<td>TBD</td>
<td>Joan Dadey (315)470-7290</td>
<td>Sara</td>
<td></td>
</tr>
<tr>
<td>Utica 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faxton/St. Luke’s Hospital St. Elizabeth’s Hospital</td>
<td>Early July</td>
<td>TBD</td>
<td>TBD</td>
<td>Lisa Volo (315)624-5654</td>
<td>Sara</td>
<td>Initial meeting 06/13/16</td>
</tr>
</tbody>
</table>
Q&A
Upcoming Meetings of Interest
Upcoming Meetings of Interest


❖ June 30, 2016 Training Webinar: Team-Based Care-It Takes a Village to Transform a Medical Home- Register by e-mail to Karen Joncas karen.Joncas@cnycare.org

❖ July 20-21, 2016 PCMH Training-Multiple topics-Register on-line TBD

❖ HIT PIC-July 22, 2016  
  https://attendee.gotowebinar.com/register/3427491475975626497

❖ July 29, 2016: 10AM-12 Noon- Practice Transformation PIC Redesign