WMC Health | Performing Provider System (PPS)

CROSSWALK of DSRIP Projects to PCMH APC TCPI Requirements
PCMH: 2014 Patient-Centered Medical Home Standards
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WMC Health PPS QUARTERLY PROJECT PERFORMANCE ROADMAP (QPPR) SUPPORTING REPORT FORM (SRF)
DSRIP Year/Quarter: DY3/Q1
Quarter Start and End Dates: April 01, 2017 - June 30, 2017
Website: https://wmchealthnetwork.tfaforms.net/20

Page #/ Question #	Applicable Projects	Task for Partner	PCMH Standard	APC Requirement	TCPI Milestone
Page 2/ Question 1	2aiM4D1* 2aiiiM3D1*	Submit last page of signed participation agreement with HealthLinkNY or other Qualified Entity (QE).	*Standard 5B - Referral Tracking and Follow-up* 5.B.7. Has the capacity for electronic exchange of key clinical information and provides an electronic summary of care record to another provider for more than 50% of referrals 5.C.7. Exchanges key clinical information with facilities and provides an electronic summary of care record to another care facility for more than 50% of patient transitions of care *Standard 6G - Use Certified EHR Technology* 6.G.8. The practice has access to a health information exchange 6.G.9. The practice has bidirectional exchange with a health information exchange	Connected to local RHIOs and uses data for patient care activities	Practice routinely exchanges essential health information with other members of care team outside of the practice (Phase 3)

Note: WMCHealth PPS Projects are listed on Page 7/7

Prepared by: Harman Sidhu, MPH Senior Program Manager at WMCHealth PPS
Updated: June 2017

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Page 3/ Question 2	2aiM4D2* 2aiiiM3D2*	Submit documentation of national certification for EHR vendor.	*Standard 5C - Coordinate Care Transitions* 5.C.1. Proactively identifies patients with unplanned hospital admissions and emergency department visits 5.C.5. Exchanges patient information with the hospital during a patient's hospitalization 5.C.7. Exchanges key clinical information with facilities and provides an electronic summary of care record to another care facility for more than 50% of patient transitions of care	Has system in place to identify and contact patients seen in an ED or discharged from a hospital, measure the effectiveness of these efforts in contacting and following up with patients, and implement QI efforts as needed	Practice has defined improvements in care transition and processes enabled through exchange of essential health information to eliminate waste and decrease costs (Phase 2)

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Page 3/ Question 2	2aiM4D2* 2aiiiM3D2*	Submit documentation of national certification for EHR vendor.	*Standard 5B - Referral Tracking and Follow-up* 5.B.7. Has the capacity for electronic exchange of key clinical information and provides an electronic summary of care record to another provider for more than 50% of referrals 5.C.7. Exchanges key clinical information with facilities and provides an electronic summary of care record to another care facility for more than 50% of patient transitions of care *Standard 6G - Use Certified EHR Technology* 6.G.8. The practice has access to a health information exchange 6.G.9. The practice has bidirectional exchange with a health information exchange	Connected to local RHIOs and uses data for patient care activities	Practice routinely exchanges essential health information with other members of care team outside of the practice (Phase 3)
Page 4/ Question 3	2aiM5D1*	Submit Stage 2 Meaningful Use (MU) certification from CMS or NYS Medicaid or EHR Proof of Certification.	2014 PCMH Standards are aligned with Meaningful Use Stage 2	APC is aligned with Meaningful Use Stage 2	TCPI is aligned with Meaningful Use, though a stage is not specified

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Page 4/ Question 3	2aiM5D1*	Submit Stage 2 Meaningful Use (MU) certification from CMS or NYS Medicaid or EHR Proof of Certification.	*Standard 4A - Identify Patients for Care Management* The practice establishes a systematic process and criteria for identifying patients who may benefit from care management, including consideration of the following: 4.A.1. Behavioral health conditions 4.A.2. High cost/high utilization 4.A.3. Poorly controlled or complex conditions 4.A.4. Social determinants of health 4.A.5. Referrals by outside organizations	Monitor clinical risk and provide/offer care management services to all patients at highest risk	The practice implements at least three specific care management strategies for patients in higher risk cohorts; samples may include, but are not limited to: o Integration of behavioral health o Self-management support for at least three high risk conditions o Medication management and review (Phase 2) Practice has identified high risk patients and has ensured they are receiving appropriate care and case management services (Phase 3) Practice has a process in place for identifying 90% of high-risk patients on a monthly basis and has ensured that 75% are receiving appropriate care and case management services as part of their continuous practice improvement plan (Phase 4)
Page 5/ Question 4	2aiiiM4D2* 3aiM1D1*	Submit list of persons (physicians/practitioners) achieving NCQA 2014 Level 3 PCMH standards and/or APCM.	2014 PCMH Standards are aligned with Meaningful Use Stage 2	APC is aligned with Meaningful Use Stage 2	TCPI is aligned with Meaningful Use, though a stage is not specified

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WMC Health Performing Provider System (PPS)
Westchester Medical Center Health Network

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Page 5/ Question 4	2aiiiM4D2* 3aiM1D1*	Submit list of persons (physicians/practitioners) achieving NCQA 2014 Level 3 PCMH standards and/or APCM.	*Standard 5B - Referral Tracking and Follow-Up* 5.B.4. The practice integrates behavioral health care providers within the practice site	APC does not require co-location of services	TCPI does not require co-location of services
Page 11/ Question 10	3aiM3D3*	The stated goal is to demonstrate that 90% of eligible patients are screened for depression or substance use. Required documentation is a roster of identified patients and the number of screenings completed. Participating primary care sites should attend 3ai Project Advisory Quality Committee meetings or consult with Aby Diop to design a study to meet this requirement.	*Standard 3C - Comprehensive Health Assessment* 3.C.9. The practice collects and regularly updates a comprehensive health assessment that includes depression screening for adults and adolescents using a standardized tool *Standard 4A - Care Management and Support* 4.A.1. The practice establishes a systematic process and criteria for identifying patients who may benefit from care management, including behavioral health conditions	Provide core elements of collaborative care model for depression screening and management, including assessment and integration, data collection, and tracking metrics over time Provide behavioral health assessment, depression, and substance abuse screening and referrals	The practice implements at least three specific care management strategies for patients in higher risk cohorts, samples may include, but are not limited to integration of behavioral health (Phase 2) Practice has increased the number of patients who have received the appropriate health screenings and completion of referrals (Phase 3)

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Page 12/ Question 11	3aiM3D4*	Submit: Warm handoff policy AND 1 redacted screenshot of EHR demonstrating a warm hand-off.	*Standard 3C - Comprehensive Health Assessment* 3.C.9. The practice collects and regularly updates a comprehensive health assessment that includes depression screening for adults and adolescents using a standardized tool *Standard 4A - Care Management and Support* 4.A.1. The practice establishes a systematic process and criteria for identifying patients who may benefit from care management, including behavioral health conditions	Provide core elements of collaborative care model for depression screening and management, including assessment and integration, data collection, and tracking metrics over time Provide behavioral health assessment, depression, and substance abuse screening and referrals	The practice implements at least three specific care management strategies for patients in higher risk cohorts, samples may include, but are not limited to integration of behavioral health (Phase 2) Practice has increased the number of patients who have received the appropriate health screenings and completion of referrals (Phase 3)

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WMCHealth PPS DSRIP Projects	
2ai:	Create Integrated Delivery System
2aiii:	Extending Care Management (Health Home At-Risk)
2aiv:	Medical Village
2biv:	Post-Hospital Care Transitions
2di:	Patient Activation (PAM); Integrate the uninsured
3ai:	Integration of Primary Care and Behavioral Health Services
3aii:	Behavioral Health Community-Crisis Stabilization Services
3ci:	Diabetes Management
3diii:	Asthma Management
4bi:	Tobacco Cessation
4bii:	Cancer Screening