PRIVIA QUALITY NETWORK Connecticut

Privia Quality Network – Connecticut
116 Washington Avenue, 3rd Floor
North Haven, Connecticut 06473

REQUIRED PROCESSES AND PATIENT CENTEREDNESS CRITERIA POLICY

PURPOSE: To outline the ACO's policies for ensuring compliance with the Medicare Shared Savings Program's required processes and patient-centeredness criteria contained in 42 CFR §425.112.

SCOPE: CMG ACO, LLC ("ACO")

DEFINITIONS:
"ACO participant", "ACO provider/supplier", and "Medicare Shared Savings Program" shall have the meanings set forth in 42 CFR §425.20.

POLICY:
General. The ACO will-

(1) Promote evidence-based medicine and beneficiary engagement, internally report on quality and cost metrics, and coordinate care;

(2) Adopt a focus on patient centeredness that is promoted by the governing body and integrated into practice leadership and management working with the organization's health care teams; and

(3) Have defined processes to fulfill these requirements.

(4) Have a qualified healthcare professional responsible for the ACO's quality assurance and improvement program, which must include the defined processes included in 42 CFR §425.112(b)(1)-(4).

(5) Require ACO participants and ACO providers/suppliers to comply with and implement each process (and supplement thereof), including the remedial processes and penalties (including the potential for exclusion) applicable to ACO participants and ACO providers/suppliers for failure to comply with and implement the required process; and

(6) Employ its internal assessments of cost and quality of care to improve continuously the ACO's care practices.

Required processes. The ACO will define, establish, implement, evaluate, and periodically update processes to accomplish the following:

(1) Promote evidence-based medicine. These processes must cover diagnoses with significant potential for the ACO to achieve quality improvements considering the circumstances of individual beneficiaries.

a. The ACO has adopted Clinical Practice Guidelines (CPGs) that provide a framework for clinical decisions and evidenced-based, best practices. They are informed by a systematic review of evidence by collaborating professionals which describe a specific plan, arrangement, and sequence of procedures to be followed in clinical settings. CPGs follow an established methodology to translate best evidence into clinical practice for improved patient outcomes.

b. The ACO distributes these CPGs to applicable participating practices at least annually.

c. Participating practices (as applicable) sign an attestation that they have received and followed the CPGs.

(2) Promote patient engagement. These processes must address the following areas:

a. Compliance with patient experience of care survey requirements in 42 CFR §425.500 or §425.510, as applicable.

b. Compliance with beneficiary representative requirements in 42 CFR §425.106.

c. A process for evaluating the health needs of the ACO's population, including consideration of diversity in its patient populations, and a plan to address the needs of its population.

i. In its plan to address the needs of its population, the ACO must describe how it intends to partner with community stakeholders to improve the health of its population.

d. Communication of clinical knowledge/evidence-based medicine to beneficiaries in a way that is understandable to them. see Attachment A.

e. Beneficiary engagement and shared decision-making that considers the beneficiaries' unique needs, preferences, values, and priorities; see Attachment A.

f. Written standards in place for beneficiary access and communication, and a process in place for beneficiaries to access their medical record.

(3) Develop an infrastructure for its ACO participants and ACO providers/suppliers to internally report on quality and cost metrics that enables the ACO to monitor, provide feedback, and evaluate its ACO participants and ACO provider(s)/supplier(s) performance and to use these results to improve care over time.

a. The ACO uses data analytics tools to assess physician performance on quality and cost metrics and uses the results to monitor, provide feedback, and evaluate its participants.

b. The ACO distributes quality scorecards to applicable participating providers quarterly.

(4) Coordinate care across and among primary care physicians, specialists, and acute and post-acute providers and suppliers. The ACO must-

a. Define its methods and processes established to coordinate care throughout an episode of care and during its transitions, such as discharge from a hospital or transfer of care from a primary care physician to a specialist (both inside and outside the ACO); and

b. Have a written plan to:

i. Implement an individualized care program that promotes improved outcomes for, at a minimum, the ACO's high-risk and multiple chronic condition patients.

ii. Identify additional target populations that would benefit from individualized care plans. Individualized care plans must consider the community resources available to the individual.

iii. Encourage and promote use of enabling technologies for improving care coordination for beneficiaries. Enabling technologies may include one or more of the following:

1. Electronic health records and other health IT tools.
2. Telehealth services, including remote patient monitoring.
3. Electronic exchange of health information.
4. Other electronic tools to engage beneficiaries in their care.

iv. Partner with long-term and post-acute care providers, both inside and outside the ACO, to improve care coordination for its assigned beneficiaries.

c. The written plan is attached as Attachment A.

APPROVAL BODY: ACO governing body.

EFFECTIVE DATE:

APPROVAL SIGNATURE: Joseph Quaranta (Dec 12, 2024 17:57 EST)

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Attachment A
(Written Plan)

The clinical support team ensures that the patient, the patients' support systems, and health care professionals are connected and working to achieve the best outcomes for the patient. To assist in these efforts, care coordination standards were developed in the following areas:

- Assessment
- Teaching and coaching
- Care coordination

Identify and address any potential barriers to medical compliance, such as financial, transportation, support system, and time commitment
Provide an assessment of the patient's needs and health status, including:
Assess the patient's psychological needs and address any underlying issues including depression, anxiety, and substance use disorders
Depression screening (PHQ-2)
Evaluate social determinants of health
Teaching and coaching – ensuring that the patient understands:
Diagnosis and treatment plan(s)
Medications and how to take them
Assess for medication reconciliation issues
Identify and mitigate medication adherence issues
Review risks and opportunities related to medication adherence
What to do when symptoms appear, including when to call a physician
Confirm patient has follow up appointments with clinical team, including primary care clinician
Urgent vs emergency care; contacting primary care office first
After hours resources
Access to telehealth medicine
Care coordination
Referrals to community-based services for other patient care needs
Facilitate communication among the patients' health care professionals as needed to ensure clinicians are aware of the diagnosis, medications, and patient concerns
High risk meetings are held for patients whose needs and challenges require care coordination between providers and community.