Patient-Centered Medical Home (PCMH) 2014 and PCMH PRIME

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Learning Objectives

By the end of the program, participants will be able to:

- Identify the Must-Pass elements of a recognized patient-centered medical home (PCMH)
- Explain the measurement and documentation criteria for the medical home model and PCMH PRIME certification
- Describe processes and procedures that demonstrate the transformation of a practice towards a medical home model
- Discuss scoring for each element
- Identify strategies for improving content and clarity of applications for PCMH Recognition and PCMH PRIME certification
- Examine challenging aspects of the survey and evaluation process in a variety of practice environments

The HPC: At a Glance

MASSACHUSETTS
HEALTH POLICY COMMISSION

Who we are

The Massachusetts Health Policy Commission is an independent state agency governed by an 11-member board with diverse experience in health care.

Mission

The HPC's mission is to advance a more transparent, accountable, and innovative health care system through independent policy leadership. Our goal is better health and better care at a lower cost across the Commonwealth.

Vision

Our vision is a transparent, accountable health care system that ensures quality, affordable, and accessible health care for the Commonwealth's residents.

HPC PCMH Certification Program

MASSACHUSETTS HEALTH POLICY COMMISSION

Statutory Mandate

The HPC is mandated by Ch. 224 to develop and implement standards of certification for PCMHs that complement existing local and national care transformation and payment reform efforts, validate value-based care, and promote investments by payers in efficient, high-quality, and cost-effective primary care.

Creation of PCMH PRIME

PCMH PRIME was developed to fulfill this charge, with significant stakeholder input and feedback

- Reflects an important policy priority: integration of behavioral health care into primary care

HPC partnered with NCQA to deliver this important program

Thank you for your interest and dedication – we look forward to working with you

NCQA Measuring quality. Improving health care.

National Committee for Quality Assurance (NCQA)

Private, independent non-profit health care quality oversight organization founded in 1990

MISSION

To improve the quality of health care.

VISION

To transform health care through quality measurement, transparency, and accountability.

ILLUSTRATIVE PROGRAMS

*** Patient-Centered Medical Home * Patient-Centered Specialty Practice**

*** HEDIS® – Healthcare Effectiveness Data and Information Set**

*** Health Plan Accreditation * Clinician Recognition**

*** Disease Management Accreditation * Wellness & Health Promotion Accreditation**

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NCQA Recognition Programs

Current as of 07/31/16

>70,489 **Clinician Recognitions nationally across all Recognition programs.**

Clinical programs.

- Diabetes Recognition Program (DRP)
- Heart/Stroke Recognition Program (HSRP)
- Back Pain Recognition Program (BPRP) - *Retired*

Medical practice process and structural measures.

- Physician Practice Connections - *Retired*
- Physician Practice Connections-Patient-Centered Medical Home (PPC-PCMH) 2008 - *Retired*
- Patient-Centered Medical Home (PCMH) 2011
- Patient-Centered Medical Home (PCMH) 2014
- Patient Centered Specialty Practice (PCSP)
- Patient Centered Connected Care (PCCC)

RECOGNIZED NCQA DIABETES

8,611 clinicians

RECOGNIZED NCQA HEART/STROKE

3,357 clinicians

RECOGNIZED NCQA PHYSICIAN PRACTICE CONNECTIONS

98 Clinicians
19 Practices

RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME

57,171 Clinicians
11,547 Practices

RECOGNIZED NCQA PATIENT-CENTERED SPECIALTY PRACTICE

1,252 Clinicians
179 Practices

RECOGNIZED NCQA PATIENT-CENTERED CONNECTED CARE™

44 Practices

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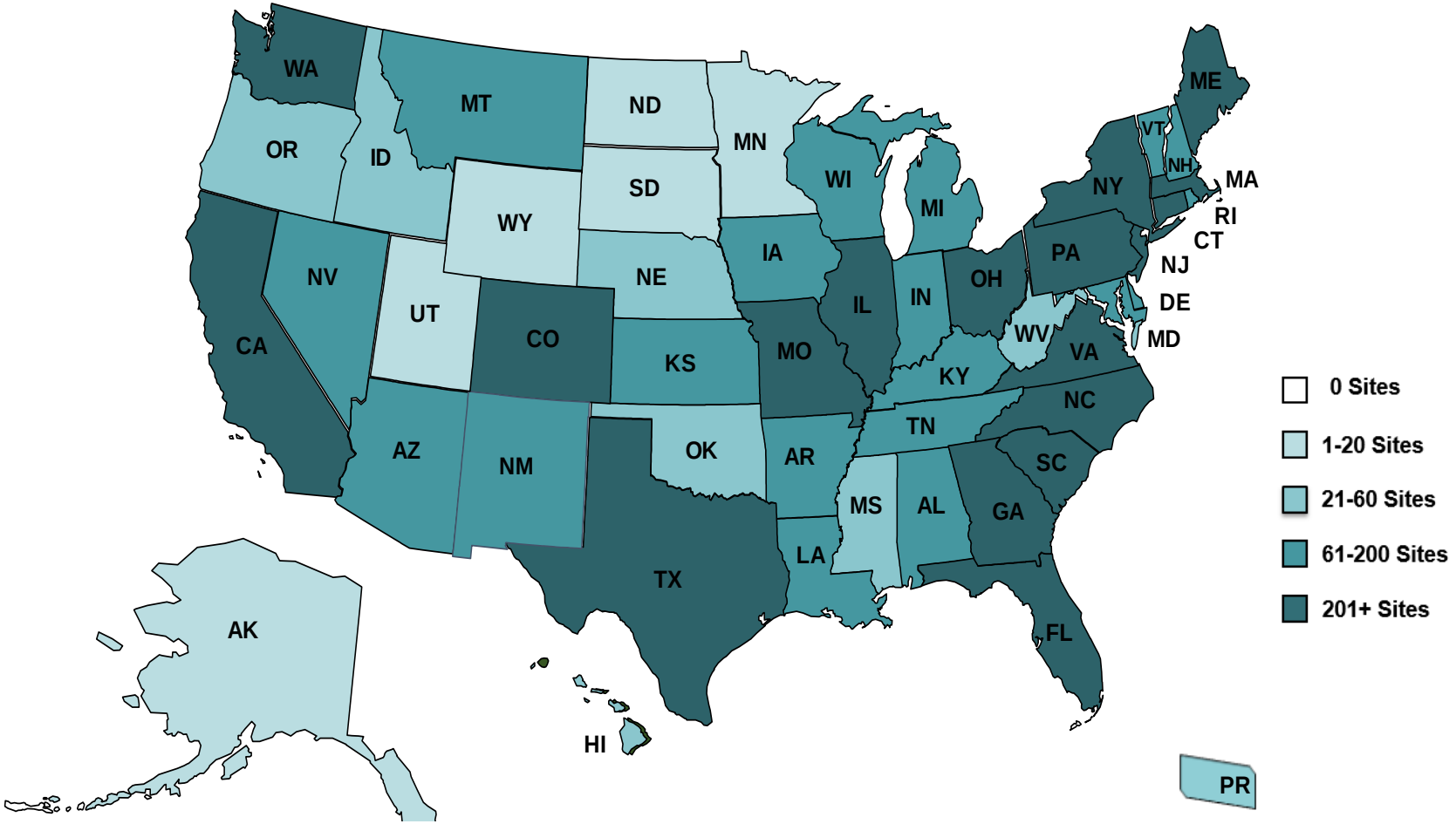
NCQA PCMH SITES
As of 07/31/16



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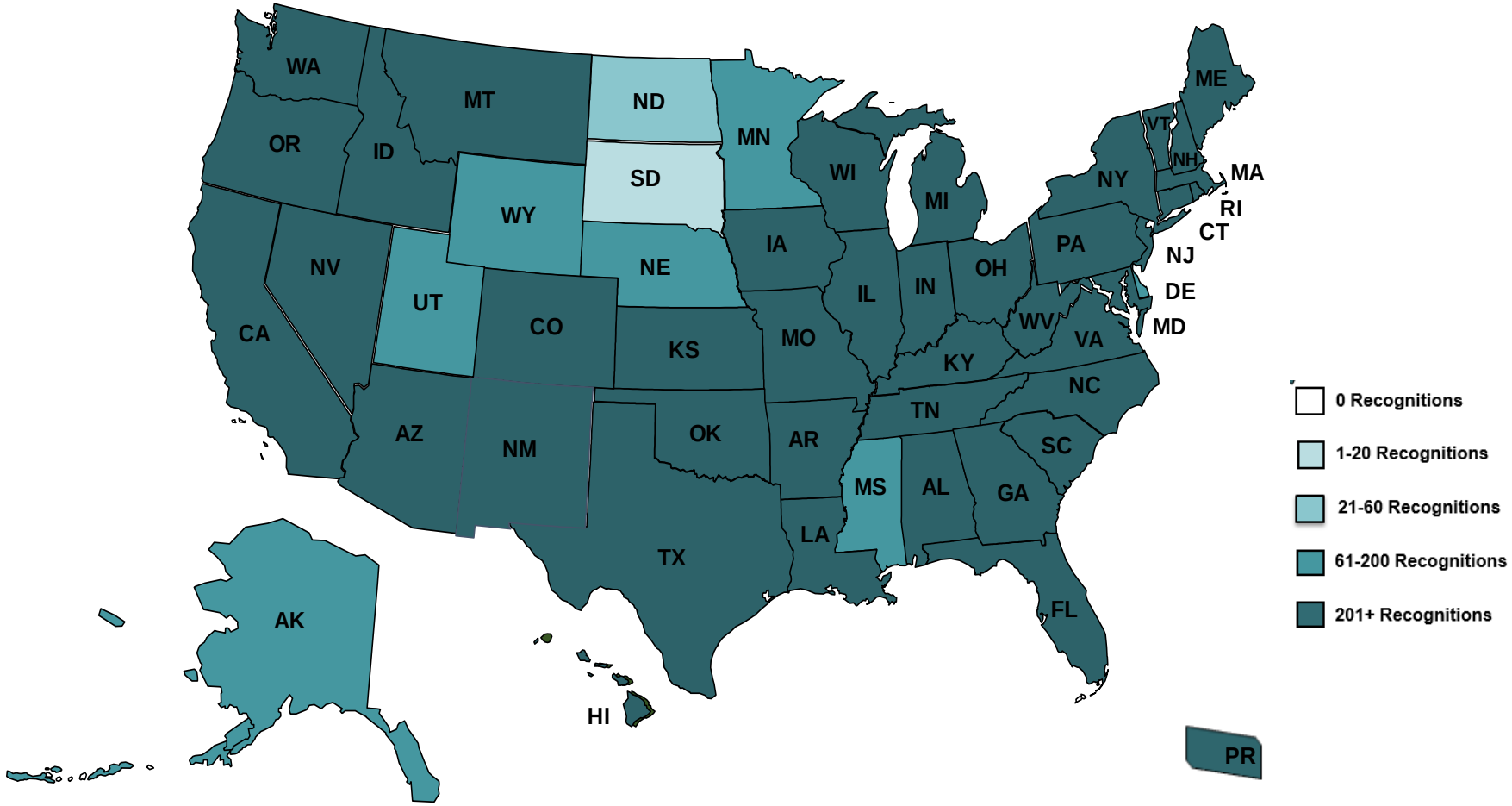
NCQA PCMH CLINICIAN RECOGNITIONS
As of 07/31/16



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Federal Initiatives and PCMH

HRSA Patient-Centered Medical Home Initiative

- Community Health Centers – for rural, underserved, often nurse-led practices
- Recognition costs and technical assistance
- Up to 500 Community Health Centers per year; 5 year contract
- 3,343 sites currently enrolled
- 1,675 CHCs Recognized

*As of 7/27/16

Key Components of PCMH*

- **Personal Clinician:** first contact, continuous, comprehensive
  - care team
- **Whole Person Orientation:** all patient health care needs; all stages of life; acute; chronic; preventive; end of life
- **Coordinated Care:** when and where needed/wanted; culturally and linguistically appropriate; use information technology

**Based on The Joint Principles*

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Does the Patient-Centered Medical Home Work?

How Does Becoming a PCMH Support Practice Success in the Evolving Healthcare Environment?

- Operational efficiency
- Cost reduction/avoidance
- Risk mitigation
- Lower malpractice insurance premiums
- Value-based performance
- Enhanced payer reimbursement & Preferred Provider status
- Employer of choice
- Practice of choice

Benefits of PCMH: The Evidence

Research Shows:

- Lower inpatient admissions (1) (4)
- Improve clinical outcomes (6) (7)
- Reduce ER visits and Hospital Readmissions (2)
- Better engaged & Happier patients (3)
- Lower Costs (especially for individuals with complex chronic conditions (2) (4) (5)
- Increased staff satisfaction (8)

**Refer to Citations on next slide*

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Citations – Evidence Showing Effectiveness of NCQA Recognition

- [1] Department of Vermont Health Access / Vermont Blueprint for Health http://hcr.vermont.gov/sites/hcr/files/pdfs/VTBlueprintforHealthAnnualReport2013.pdf
- [2] Van Hasselt M, McCall N, Keyes V, Wensky S, and Smith K, *Health Services Research*, 2014
- [3] Langston C, Undem T, Dorr D, Hartford Foundation, 2014
- [4] Higgins S, Chawla R, Colombo C, Snyder R, & Nigam S, American Journal of Managed Care 2014
- [5] Perry R, McCall N, Goodwin S. Examining the Impact of Continuity of Care on Medicare Payments in the Medical Home Context. Presented at the Academy Health Annual Research Meeting, Orlando, FL, June 24, 2012, http://www.academyhealth.org/files/2012/sunday/perry.pdf
- [6] Gabbay RA, Bailit MH, Mauger DT, Wagner EH and Siminerio L. "Multipayer patient-centered medical home implementation guided by the chronic care model." Jt Comm J Qual Patient Saf 2011;37(6):265-73. http://ww.bailit-health.com/articles/062211_bhp_mpcmhi.pdf
- [7] DeVries, A, Chia-Hsuan W, Sridhar G; Hummel, J; Breidbart, S, Barron, J. "Impact of Medical Homes on Quality Healthcare Utilization and Costs." AMJC 2012; http://www.ajmc.com/publications/issue/2012/2012-9-vol18-n9/Impact-of-Medical-Homes-on-Quality-Healthcare-Utilization-and-Costs#sthash.vuXFYJRA.dpuf
- [8] Lewis SE, Nocon RS, Tang H, et al. Patient-Centered Medical Home Characteristics and Staff Morale in Safety Net Clinics. Arch Intern Med. 2012;172(1):23-31.

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PCMH 2014

Evolving PCMH and More

- **2003-2004:** Physician Practice Connections (PPC) - developed with Bridges to Excellence)
- **2006:** PPC standards updated
- **2008:** PPC–PCMH
- **2011:** PCMH 2011
- **2011:** ACO Accreditation
- **2013:** Patient-Centered Specialty Practice
- **2014:** PCMH 2014
- **2015:** Patient-Centered Connected Care

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PCMH 2014 Content and Scoring

(6 standards/27 elements)

1: Enhance Access and Continuity	Pts
A. *Patient-Centered Appointment Access	**4.5**
B. 24/7 Access to Clinical Advice	3.5
C. Electronic Access	2
	10

2: Team-Based Care	Pts
A. Continuity	3
B. Medical Home Responsibilities	2.5
C. Culturally and Linguistically Appropriate Services (CLAS)	2.5
D. *The Practice Team	**4**
	12

3: Population Health Management	Pts
A. Patient Information	3
B. Clinical Data	4
C. Comprehensive Health Assessment	4
D. *Use Data for Population Management	**5**
E. Implement Evidence-Based Decision-Support	4
	20

4: Plan and Manage Care	Pts
A. Identify Patients for Care Management	4
B. *Care Planning and Self-Care Support	**4**
C. Medication Management	4
D. Use Electronic Prescribing	3
E. Support Self-Care and Shared Decision-Making	5
	20

5: Track and Coordinate Care	Pts
A. Test Tracking and Follow-Up	6
B. *Referral Tracking and Follow-Up	**6**
C. Coordinate Care Transitions	6
	18

6: Measure and Improve Performance	Pts
A. Measure Clinical Quality Performance	3
B. Measure Resource Use and Care Coordination	3
C. Measure Patient/Family Experience	4
D. *Implement Continuous Quality Improvement	**4**
E. Demonstrate Continuous Quality Improvement	3
F. Report Performance	3
G. Use Certified EHR Technology	0
	20

Scoring Levels

Level 1: 35-59 points
Level 2: 60-84 points
Level 3: 85-100 points

***Must Pass Elements**

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PCMH Scoring

6 standards = 100 points

6 Must Pass elements

NOTE: Must Pass elements require a ≥ 50% performance level to pass

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	85 - 100	6 of 6
Level 2	60 - 84	6 of 6
Level 1	35 - 59	6 of 6
Not Recognized	0 - 34	< 6

Practices with a numeric score of 0 to 34 points and/or achieve less than 6 "Must Pass" Elements are not Recognized.

PCMH PRIME does not impact score. PCMH PRIME responses and assessments will not impact PCMH score or level achieved, only whether or not the practice receives the additional PCMH PRIME Certification.

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PCMH 2014: Key Changes

1. **Additional emphasis on team-based care**
   - **New element = Team-Based Care**
     - Highlights patient as part of team, including QI
2. **Care management focused on high-risk patients**
   - **Use evidence-based decision support**
   - **Identify patients who may benefit from care management and self-care support:**
     - Social determinants of health
     - Behavioral health
     - High cost/utilization
     - Poorly controlled or complex conditions

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PCMH 2014: Key Changes (cont.)

3. **More focused, sustained Quality Improvement (QI) on patient experience, utilization, clinical quality**
   - Annual QI activities; reports must show the practice re-measures at least annually
   - Renewing practices will benefit from streamlined requirements, but must demonstrate re-measurement from at least two prior years
4. **Alignment with Meaningful Use Stage 2 (MU2)**
   - MU is not a requirement for recognition
5. **Further Integration of Behavioral Health.**
   - Show capability to treat unhealthy behaviors, mental health or substance abuse
   - Communicate services related to behavioral health
   - Refer to behavioral health providers

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Behavioral Health and the Medical Home Model

PCMH 2014 strengthened integration of Behavioral Health

- Show capability to treat unhealthy behaviors, mental illness or substance use disorder
- Communicate services related to behavioral health
- Refer to behavioral health providers

PCMH PRIME further incorporates Behavioral Health in the primary care setting

- Adds additional focus on BH
- Has stronger requirements for BH

PCMH PRIME
Eligibility & Criteria

- **Location:** Practices in the Commonwealth of Massachusetts.
- **NCQA PCMH Recognition:**

  Practices must be
  - PCMH 2011 Level 2 or 3 or
  - PCMH 2014 Level 1, 2 or 3

Note: A practice with the required NCQA PCMH Recognition status that makes a commitment to seeking PCMH PRIME certification within 18 months can receive an interim designation – "Pathway to PCMH PRIME" – while they work toward PCMH PRIME

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The practice **coordinates with behavioral health care providers** through formal agreements or has behavioral health care providers co-located at the practice site.

The practice **integrates BHPs** within the practice site. (*Proof of proficiency for criteria #2 automatically satisfies criteria #1.)*

The practice collects and regularly updates a comprehensive health assessment that includes **behaviors affecting health and mental health/ substance use history of patient and family.**

The practice collects and regularly updates a comprehensive health assessment that includes **developmental screening** for children under 3 years of age using a standardized tool.

The practice collects and regularly updates a comprehensive health assessment that includes **depression screening** for adults and adolescents using a standardized tool.

The practice collects and regularly updates a comprehensive health assessment that includes **anxiety screening** for adults and adolescents using a standardized tool.

The practice collects and regularly updates a comprehensive health assessment that includes **Substance Use Disorder (SUD) screening** for adults and adolescents using a standardized tool.

The practice collects and regularly updates a comprehensive health assessment that includes **postpartum depression screening** for patients who have recently given birth using a standardized tool.

- The practice **tracks referrals** until the consultant or specialist's report is available, **flagging and following up** on overdue reports.
- The practice implements clinical decision support following **evidence-based guidelines** for a mental health and substance use disorder.
- The practice establishes a systematic process and criteria for identifying patients who may benefit from **care management**. The process includes consideration of behavioral health conditions.
- The practice has at least one clinician who is providing treatment for addiction with **medication assisted treatment** and **behavioral therapy**, directly or via referral.
- The practice has at least one **care manager** qualified to identify and coordinate behavioral health needs.

PCMH 2014 and Meaningful Use

Meaningful Use & PCMH 2014

- PCMH 2014 originally aligned with MU Stage 2
- CMS released modified Stage 2 rule in October 2015
- Updates to requirements were incorporated in the Standards and Guidelines at the November 16, 2015 release

Meaningful Use (MU) of Health Information Technology (HIT)

- NCQA emphasizes HIT because highly effective primary care is information-intensive
- PCMH 2014 reinforces incentives to use HIT to improve quality
- Meaningful Use language is embedded in PCMH 2014 standards
- Synergy: PCMH 2014 Recognized medical practices are well-positioned to qualify for meaningful use, and vice versa
- Updates: NCQA will review any proposed changes and consider updates to the PCMH program. NCQA will not change requirements to align with MU changes without internal review.

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PCMH-Related Programs

ACO

- Patient-centered medical homes are the central foundation of an ACO.

PCSP

- Improving care coordination with primary care and other specialties, with a focus on strategies that effectively manage the referral process to enhance patient-centered care.

Patient-Centered Connected Care

- Clinical integration and communication, creating a roadmap for how sites delivering intermittent or outpatient treatment—but do not act as the primary care provider for a majority of its patients—can effectively communicate and connect with primary care and fit into the medical home "neighborhood."

CEC

- Allows those certified to highlight their comprehensive knowledge of the requirements, the application process and documentation of the PCMH program.

What are ACOs?

- **Provider-based organizations that are accountable for both quality and costs of care for a defined population**
  - Arrange for the total continuum of care
- **Align incentives and reward providers based on performance (quality and financial)**
  - Incentivized through payment mechanisms such as shared savings or partial/full-risk contracts
- **Goal is to meet the "triple aim"**
  - Improve people's experience of care
  - Improve population health
  - Reduce overall cost of care
- **PCMH is central to ACO**

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Patient-Centered Specialty Practice (PCSP)

Patient-Centered Specialty Practice (PCSP) Recognition

Goal:

- Enhance PCP/specialist collaboration and coordination to benefit the patient

Accommodate range of patient relationships:

1. Consultation
2. Patient evaluation and treatment
3. Co-management
4. Temporary/permanent care management

Practices likely to treat differing percentage of patients in each "category"

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PCSP Content and Scoring

(6 standards/22 elements)

PCSP 1: Track & Coordinate Referrals	Pts
A. *Referral Process & Agreements	**9**
B. Referral Content	5
C. *Referral Response	**8**
	22

PCSP 2: Provide Access & Communication	Pts
A. Access	5
B. Electronic Access	2
C. Specialty Practice Responsibilities	4
D. Culturally & Linguistically Appropriate Services (CLAS)	2
E. *The Practice Team	**5**
	18

PCSP 3: Identify & Coordinate Patient Populations	Pts
A. Patient Information	3
B. Clinical Data	4
C. Coordinate Patient Populations	3
	10

PCSP 4: Plan & Manage Care	Pts
A. Care Planning & Support Self-Care	11
B. *Medication Management	**5**
C. Use Electronic Prescribing	2
	18

PCSP 5: Track & Coordinate Care	Pts
A. Test Tracking & Follow-Up	5
B. Referral Tracking & Follow-Up	6
C. Coordinate Care Transitions	5
	16

PCSP 6: Measure & Improve Performance	Pts
A. Measure Performance	5
B. Measure Patient/Family Experience	5
C. *Implement & Demonstrate Continuous Quality Improvement	**4**
D. Report Performance	2
E. Use Certified EHR Technology	0
	16
	100

Recognition starts with 25 points

***Must Pass Elements**

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Patient-Centered Connected Care

Patient-Centered Connected Care Recognition

Goal:

- Enhance collaboration and coordination to benefit the patient
- Recognize sites who are good neighbors to the medical home.

Eligible sites:

- Provide outpatient or acute/episodic care services.
- Demonstrate a commitment to improving quality, delivering patient-centered care and connecting with primary care clinicians.

Patient-Centered Connected Care Content and Scoring

PCCC 1: Connecting with Primary Care	Pts
A. *Connecting Patients with Primary Care	**9**
B. Sharing Information with Primary Care	7.5
C. *Demonstrating Information Sharing	**4.5**
D. Working with Primary Care	4.5
E. Coordination with Primary Care	4.5
	30

PCCC 2: Identifying Patient Needs	Pts
A. *Informing Patients About Services Offered	**4.5**
B. Triaging Patients	6
C. Connecting Patients with Other Providers	4.5
	15

PCCC 3: Patient Care & Support	Pts
A. *Implement Evidenced-Based Decision Support	**5**
B. Medication Management	5
C. Test Tracking and Follow-Up	5
D. Collaborating with the Patient	5
E. CLAS	5
	25

PCCC 4: System Capabilities	Pts
A. Patient Information	3.5
B. Clinical Data	4
C. Use Electronic Prescribing	2.5
	10

PCCC 5: Measure & Improve Performance	Pts
A. Measure Clinical Quality Performance	4
B. Measure Resource Use and Care Coordination	2
C. Measure Patient/Family Experience	2
D. Set Goals and Analyze Results	2
E. *Take Action to Improve	**3**
F. Reduce Disparities	2
G. Demonstrate Continuous Quality Improvement	3
H. Report Performance	2
	20
	100

Recognition starts with 75 points

***Must Pass Elements**

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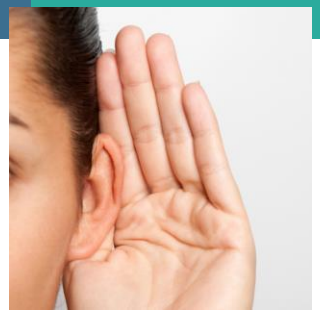
Recognition Programs Redesign

PCMH Critiques



We've been listening. Here's what we've heard.

Too easy

- Can achieve recognition without transforming

Too hard

- Small practices, rural practices, urban practices

Too focused on process

- Needs more performance-based evaluation

Too much

- Burdensome review process

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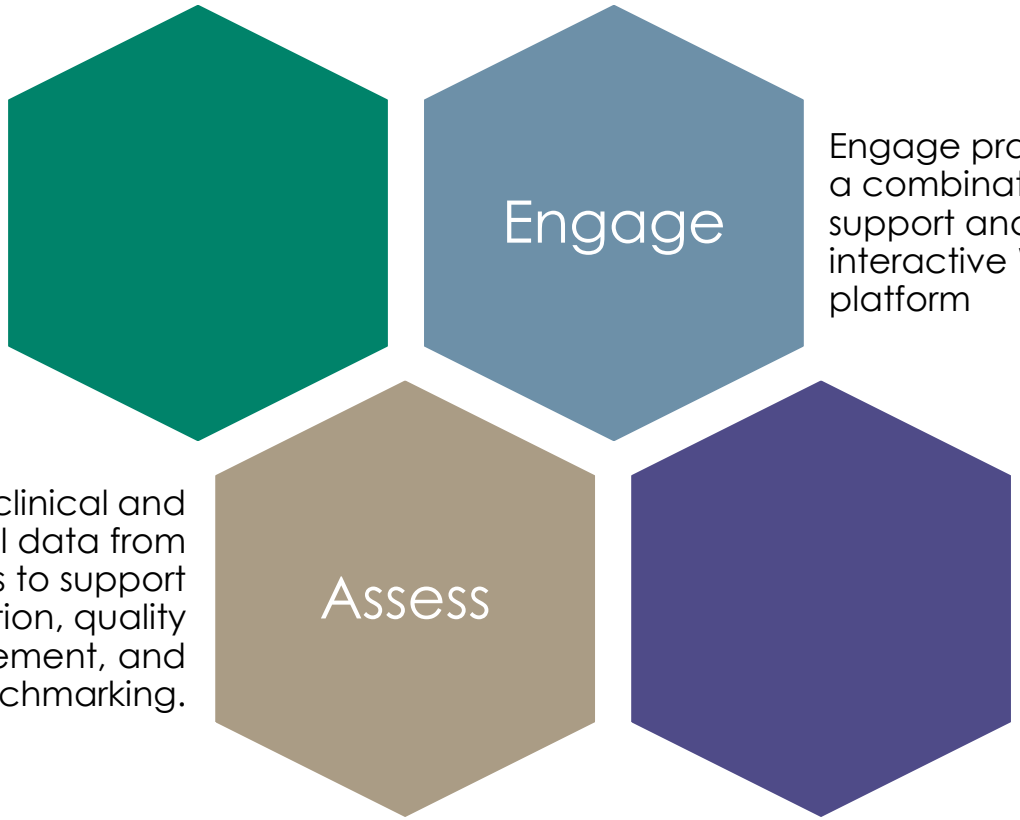
Key Components of Redesign



Engage practices through a combination of live support and a new interactive Web-based platform

Assess clinical and operational data from practices to support recognition, quality measurement, and benchmarking.

Three Core Strategies

- Increase practice engagement while reducing non-value added work
- Strengthen link between recognition & performance
- Be responsive to Federal, State & regional needs/priorities

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Current → Future

Current Process

- Every three years, practice must submit all materials for a full review, with little guidance from NCQA.
- The recognition survey is a desk-top review

Future Process

- NCQA interacts with practice from the start.
- Practice submits information at agreed-upon intervals until Recognized.
- Focused annual review and ongoing data submission to sustain Recognition (no Renewal survey at 3 years).

Redesigned Recognition Program Process

Pre-Assessment

- Guided high-level readiness assessment
- NCQA Navigator & Practice develop Recognition Plan and Evaluation Schedule
- Identify support and resources for transformation

Phased Engagement

- Evidence of transformation evaluated according to Recognition Plan, using a combination of virtual and document reviews.
- Third Phase results in Final Recognition Status

Sustained Recognition

- Annual check-in
  - Demographic updates
  - Verification of continued compliance
  - Credit through engagement

Ongoing Activities & Outreach		
Education	Best practices	User Groups

http://www.ncqa.org/Newsroom/Statements/PCMHIdeas.aspx

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Options for Transitioning to PCMH 2014

Conversion (Level 3)

- Applicable to PCMH 2011 practices expiring in 2016 – 2018, submitted by 9/30/2017
- Documentation required for 6 Elements (1A, 2D, 3E, 4A, 4B*, 6B)
- Practices attest and score remaining Elements based on current operations
- 12 month extension of current recognition prior to starting annual reporting process
- Cost includes survey tool fee and 50% of regular application fee

Stream-lined Renewal (Level 2 & 3)

- Renewals for site surveys accepted until 9/30/2017, corporate surveys by 5/31/2017
- Documentation required for 11 Elements. (1A, 2D, 3C, 3D, 4A, 4B, 4C, 5B, 6B, 6D, 6E)
- Practices attest and score remaining Elements based on current operations
- 3-year recognition with new annual reporting process to start at end of recognition
- Cost includes survey tool fee and 100% application fee

Stay Connected

- **If you have ideas for the PCMH and redesign process, please submit your input via ideas4pcmh@ncqa.org**

- **Stay up to date with program updates, news & more by opting in to NCQA news: http://www.ncqa.org/AboutNCQA/Subscribe.aspx**

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NCQA PCMH Vendor Prevalidation

NCQA PCMH Vendor Prevalidation

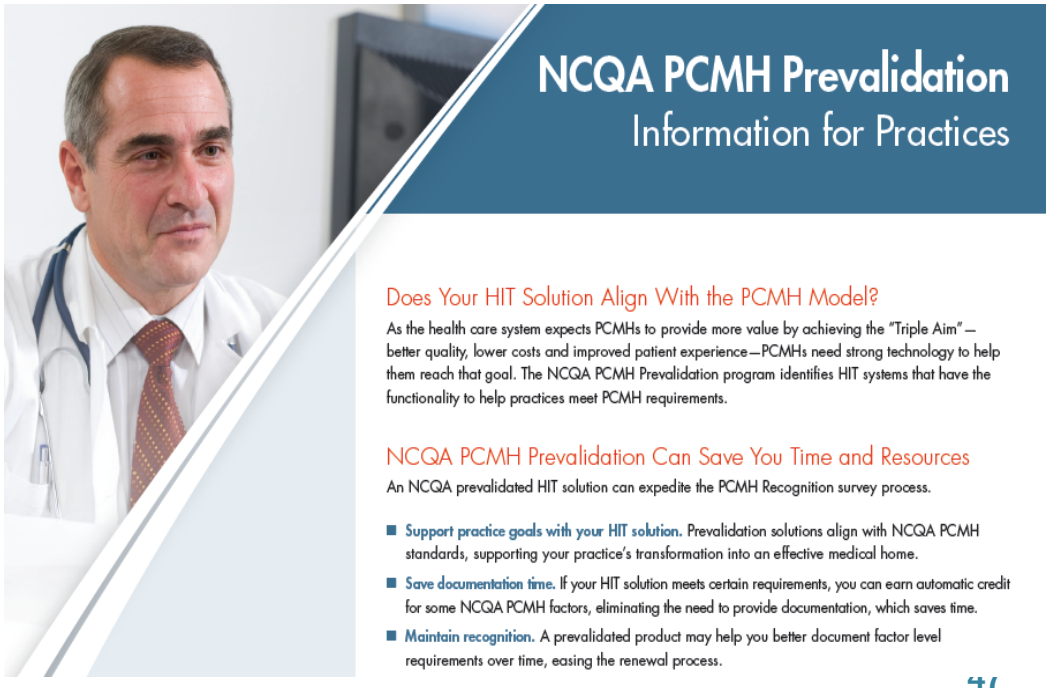
Prevalidated HIT Solutions Save Practices Time and Resources

An NCQA prevalidated HIT solution can expedite the PCMH Recognition survey process.

- **Support practice goals with your HIT solution.** Prevalidated solutions align with NCQA PCMH standards, supporting your practice's transformation into an effective medical home.
- **Save documentation time.** If your HIT Solution meets certain requirements, you can earn automatic credit for some NCQA PCMH factors, eliminating the need to provide documentation.
- **Maintain recognition.** A prevalidated product may help you better document factor level requirements over time, easing the renewal process.

NCQA Prevalidation *evaluates and awards automatic credit points and/or practice support to electronic health record (EHR) systems, advanced registries, population health management tools and other related HIT solutions with functionality that helps practices meet PCMH requirements.*

Visit www.ncqa.org/prevalidation to learn more.



NCQA PCMH Prevalidation
Information for Practices

Does Your HIT Solution Align With the PCMH Model?

As the health care system expects PCMHs to provide more value by achieving the "Triple Aim"—better quality, lower costs and improved patient experience—PCMHs need strong technology to help them reach that goal. The NCQA PCMH Prevalidation program identifies HIT systems that have the functionality to help practices meet PCMH requirements.

NCQA PCMH Prevalidation Can Save You Time and Resources

An NCQA prevalidated HIT solution can expedite the PCMH Recognition survey process.

- **Support practice goals with your HIT solution.** Prevalidation solutions align with NCQA PCMH standards, supporting your practice's transformation into an effective medical home.
- **Save documentation time.** If your HIT solution meets certain requirements, you can earn automatic credit for some NCQA PCMH factors, eliminating the need to provide documentation, which saves time.
- **Maintain recognition.** A prevalidated product may help you better document factor level requirements over time, easing the renewal process.

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PCMH Content Expert Certification

PCMH Content Expert Certification

- **Certification awarded to individuals who demonstrate knowledge of PCMH Recognition**
- **Must achieve passing score on test administered by external test vendor**
- **First complete 2 required NCQA seminars; then take exam**
  1. Introduction to PCMH: Foundational Concepts of the Medical Home
  2. Advanced PCMH 2014: Mastering the Medical Home Transformation
- **Two-year duration; certificate with seal awarded**
- **Certified individuals identified on NCQA web site as PCMH Certified Content Experts**

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PCMH Content Expert Certification

- **Target audience:** consultants, facilitators, coaches, practice management staff and others who assist practices in preparing for PCMH Recognition
- **Exam** offered quarterly: March, June, September, December over a 10-day period
- **For more information about the program: http://www.ncqa.org/EducationEvents.aspx**

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PCMH Eligibility & Survey Components

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Eligible Applicants

- **Outpatient primary care practices**

- **Practice defined: a clinician or clinicians practicing together at a single geographic location**
  - Includes nurse-led practices in states where state licensing designates Advanced Practice Registered Nurses (APRNs) as independent practitioners
  - Does not include urgent care clinics or clinics open on a seasonal basis

PCMH Eligibility Basics

- **Recognitions are conferred at geographic site level -- one Recognition per address, one address per survey**
- **MDs, DOs, PAs, and APRNs practicing at site with their own or shared panel of patients are listed with Recognition**
- **Clinicians should be listed at each site where they routinely see a panel of their patients**
  - Clinicians can be listed at any number of sites
  - Site clinician count determines program fee
  - Non-primary care clinicians should not be included

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PCMH Clinician Eligibility

- **At least 75% of each clinician's patients come for:**
  - First contact for care
  - Continuous care
  - Comprehensive primary care services
- **Clinicians may be selected as personal PCPs**
- **All eligible clinicians at a site must apply together**
- **Physicians in training (residents) should not be listed**
- **Practice may add or remove clinicians during the Recognition period**

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Systems Needed by Practice for PCMH Survey Process

1. **Computer system and staff skill with:**
   - Email
   - Internet access
   - Microsoft Word
   - Microsoft Excel
   - Adobe Acrobat Reader (available free online)
   - Document scanning and screen shots
2. **Access to the electronic systems used by the practice, e.g. billing system, registry, practice management system, electronic prescription system, EHR, Web portal, etc.**

Transformation and Prep Work

- **Transformation may take 3-12 months**
- **Your roadmap: PCMH 2014 Standards and Guidelines – everything covered**
- **Implement changes:**
  - Practice-wide commitment
  - New policies and procedures for staff
  - Staff training and reassignments
  - Medical record systems
  - Reporting capabilities improvement
- **Develop and organize documentation**
- **Procedures and electronic systems must be fully implemented at least 3 months before survey submission**

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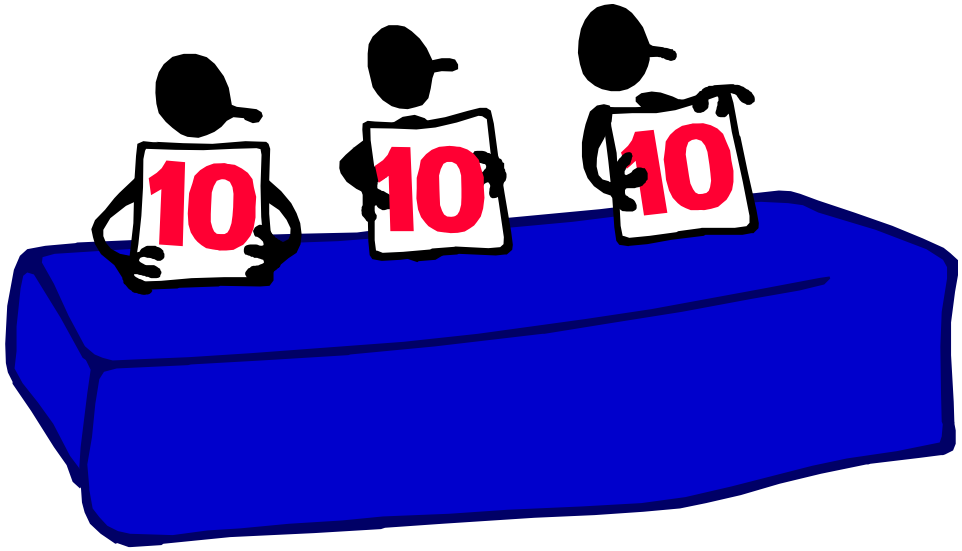
Components of a Standard

- Statement of the Standard
- Elements
- Factors
- Scoring
- Explanation
- Documentation



Reading a Standard

Standard Title and Statement

Element: Component of a standard that is scored and provides details about performance expectations

Scoring: Level of performance organization must demonstrate to receive a specified percentage of element points

Documentation: Evidence practices can use to demonstrate performance against an element's requirements.

Types: documented process, reports, materials, patient records

PCMH 1: Patient-Centered Access — 10.00 points

The practice provides access to team-based care for both routine and urgent needs of patients/families/caregivers at all times.

Element A: Patient-Centered Appointment Access (MUST-PASS) — 4.50 points

The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on:	Yes	No
1. Providing same-day appointments for routine and urgent care. (CRITICAL FACTOR)	☐	☐
2. Providing routine and urgent-care appointments outside regular business hours.	☐	☐
3. Providing alternative types of clinical encounters.	☐	☐
4. Availability of appointments.	☐	☐
5. Monitoring no-show rates.	☐	☐
6. Acting on identified opportunities to improve access.	☐	☐

Scoring

100%	75%	50%	25%	0%
The practice meets 5-6 factors (including factor 1)	The practice meets 3-4 factors (including factor 1)	The practice meets 2 factors (including factor 1)	The practice meets 1 factor (including factor 1)	The practice meets 0 factors

Explanation

MUST-PASS elements are considered the basic building blocks of a patient-centered medical home. Practices must earn a score of 50% or higher. All six must-pass elements are required for recognition.

All practices, including those with walk-in access, must make same-day scheduled appointments available and must monitor their availability. **Walk-in access** is an approach to patient appointment scheduling that allows established patients to be seen by a member of the care team during regular office hours, without prior notice.

Documentation

For all factors that require a documented process for staff, the documented process for staff includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

Factor 1: NCQA reviews a documented process for scheduling same-day appointments that includes a definition of routine and urgent appointments. NCQA reviews a report with at least five days of data, showing the availability and use of same-day appointments for both urgent and routine care.

Factor 2: NCQA reviews materials demonstrating that the practice provides regular

Standard
Score = 10

Element
Score = 4.5

Factor: Item in an element that is scored

Explanation: Guidance for demonstrating performance against an element

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Must Pass Elements

Rationale for Must Pass Elements

- Identifies key concepts of PCMH
- Helps focus Level 1 practices on most important aspects of PCMH
- Guides practices in PCMH evolution and continuous quality improvement
- Standardizes "Recognition"

Must Pass Elements

- 1A: Patient Centered Appointment Access
- 2D: The Practice Team
- 3D: Use of Data for Population Management
- 4B: Care Planning and Self-Care Support
- 5B: Referral Tracking and Follow-Up
- 6D: Implement Continuous Quality Improvement

What is a Critical Factor?

- Required to receive more than minimal or, for some factors, any points
- Identified in the scoring section of the element

PCMH 1A Example: Critical Factor impact on scoring

100%	75%	50%	25%	0%
The practice meets 5-6 factors (including factor 1)	The practice meets 3-4 factors (including factor 1)	The practice meets 2 factors (including factor 1)	The practice meets 1 factor (including factor 1)	The practice meets 0 factors

There are 9 Critical Factors

Three Critical Factors in Must Pass Elements

PCMH 1	PCMH 2	PCMH 3	PCMH 4	PCMH 5
1A, Factor 1 1B, Factor 2	2D, Factor 3	3E, Factor 1	4A, Factor 6 4C, Factor 1	5A, Factor 1 5A, Factor 2 5B, Factor 8

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Documentation Types

1. Documented process Written procedures, protocols, processes for staff, workflow forms (not explanations); must include practice name and date of implementation.
2. Reports Aggregated data showing evidence
3. Records or files Patient files or registry entries documenting action taken; data from medical records for care management.
4. Materials Information for patients or clinicians, e.g. clinical guidelines, self-management and educational resources

NOTE: Screen shots or electronic "copy" may be used as examples (EHR capability), materials (Web site resources), reports (logs) or records (advice documentation)

Documentation Time Periods

Also Called Look-Back Period

- **Report Data, Files, Examples and Materials**
  Should display information that is current within the last 12 months
- **Documented Process**
  Policies, procedures and processes should be in place for at least 3 months prior to survey submission
- **Reporting Period (Meaningful Use)**
  A recent 3 month period
- **Reporting Period (Log or Report)**
  Refer to documentation guidelines for other references to minimum data for logs and reports (one week, one month, etc.)

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ALL DOCUMENTS MUST SHOW DATES

Discuss and Analyze NCQA's PCMH Recognition Requirements

PCMH 1: Patient-Centered Access

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PCMH 1: Patient-Centered Access

Intent of Standard

The practice provides access to team-based care for both routine and urgent needs of patients/families/care-givers at all times

- Patient-centered appointment access
- 24/7 Access to clinical advice
- Electronic access

Meaningful Use Alignment

- Patients receive electronic:
  - On-line access to their health information
  - Secure messages from the practice

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PCMH 1: Patient-Centered Access

10 Points

Elements

- PCMH 1A: Patient-Centered Appointment Access

  MUST PASS
- PCMH 1B: 24/7 Access to Clinical Advice
- PCMH 1C: Electronic Access

PCMH 1A: Patient-Centered Access

The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on:

1. Providing routine and urgent same-day appointments – CRITICAL FACTOR
2. Providing routine and urgent-care appointments outside regular business hours
3. Providing alternative types of clinical encounters
4. Availability of appointments
5. Monitoring no-show rates
6. Acting on identified opportunities to improve access

***NOTE:* Critical Factors in a Must Pass element are essential for Recognition**

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PCMH 1A: Scoring and Documentation

MUST PASS

4.5 Points

Scoring

- 5-6 factors (including Factor 1) = 100%
- 3-4 factors (including Factor 1) = 75%
- 2 factors (including Factor 1) = 50%
- 1 factor (including Factor 1) = 25%
- 0 factors = 0%

Must meet 2 factors (including factor 1) to pass this Must-Pass Element

Documentation

- F1-6: Documented process, definition of appointment types, ***and***
- F1: Report(s) with at least 5 consecutive days of data showing availability/use of same-day appointments for both routine and urgent care

(cont)

PCMH 1A: Documentation (cont.)

- **F2:** Materials with extended hours ***or*** documented process for arranging appointment access with other facilities or clinicians.
- **F3:** Report with frequency of scheduled alternative encounter types in a recent 30 consecutive day period.
- **F4:** Documented process and report showing appointment wait times compared to practice defined standards and policy to monitor appointment availability with at least 5 days of data.
- **F5:** Report showing rate of no shows from a recent 30-calendar day period. (Patients seen/scheduled visits).
- **F6:** Report or QI worksheet showing evaluation of access data and improvement plan to improve access.

PCMH 1A, Factor 1: Example Same-Day Scheduling Policy

- Includes process for scheduling same day appointments
- Defines appointment types

POLICY: ABCD Family Practice Access to Care

(Approval Date: 9/30/14)

SAME DAY ACCESS:

- ABCD Family Practice provides same-day appointments for patients requiring urgent care as well as routine visits when applicable.
- Same-day appointments are available each day on each physician's and provider's schedules. All Physicians at ABCD Family Practice have 3 to 6 same day appointment slots built into their appointment template for work-in or same day appointments.
- Same Day appointment slots numbers are based on the demand for same day access determined through our evaluation process. These slots are purple in color on the appointment schedule.
  - The same day appointment slots are not to be booked in advance. They are for same day use only.
  - When a patient calls with a need to see their physician on the same day the scheduler should look on the patient's primary care doctor's schedule for same day availability. If there is an opening in an established patient slot for that same day then the scheduler should use that established patient slot. If there is not an available established patient slot then the scheduler should look for a work0in or same day appointment slot and offer that time to the patient. If neither one of the options are available the scheduler can look at other physicians in the practice for availability in the same manner.
- If no appointment is available during office hours the next step would be to look for availability for our urgent care or late night clinic. If for some reason there are absolutely no available appointment slots in any of the above mentioned categories then the patient would be offered an appointment on the following day or if their need is urgent then the caller would be given to the triage nurse for alternate instructions or scheduling.

APPOINTMENT TYPE:

- **Urgent Care** (Acute Illnesses) – Patients will be seen same day of request with a physician, PA or NP, if requires is before 2pm. If nothing is available, the patients will be directed to the triage nurse for recommendation.
- **Routine Care** (Chronic Conditions) – Patient is scheduled within 24 hours with physician, PA or NP. No more than 3 day time lapse unless requested by the patient.
- **Wellness Care** (Physical/WWE) – Patient is scheduled within 8 weeks of request with physician, PA or NP. With the exception of those patient has been seen priori to 1 calendar year from that time.

PCMH 1A, Factor 1: 5 Day Report Example

- Practice has 12 clinicians on site
- Policy (previous slide) states clinicians have 3-6 same day appointments each day

Statistical Analysis of Appointments:

Same Day Appt Availability

From 10/27/2014 to 10/31/2014

		Same Day Appt Avail	Appt Fillled	% Filled
ABCD Family Practice				
	10/27/2014			
		67	66	98.5%
	Totals for 10/27/2014 (1)	67	66	98.5%
	10/28/2014			
		65	58	89.2%
	Totals for 10/28/2014 (1)	65	58	89.2%
	10/29/2014			
		60	52	86.6%
	Totals for 10/29/2014 (1)	60	52	86.6%
	10/30/2014			
		48	47	97.9%
	Totals for 10/30/2014 (1)	48	47	97.9%
	10/31/2014			
		60	52	86.6%
	Totals for 10/31/2014 (1)	60	52	86.6%
Totals for ABCD Family Practice (5)		**300**	**275**	**91.6%**

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PCMH 1A, Factor 2: Routine & Urgent Care Outside Regular Hours

From Practice Brochure:

- **Accessible Services:**
- **We have regular extended hours beyond normal 9-5**
- **We have a physician on call for emergency after hours**
- **We strive to achieve excellent communication. . . . . .**

Office Hours
Telephone Advice Hour
Monday - Saturday 7:30 AM - 8:30 AM
Patient Care Hours
Monday - Thursday: 8:30 AM - 7:30 PM
Friday 8:30 AM - 5 PM
Saturday 8:30 AM - 12:00 PM

PCMH 1A, Factor 3: Alternative Clinical Encounter Example

Process for Patient-Centered Appointment Access

Date of Implementation: 01/01/2010 - Date Updated: 09/01/2014

1-A Factor 3

14. The practice provides alternative one-on-one scheduled clinical encounters by telephone, ***'eVisits'*** ***(Date of implementation eVisits: 8/2014)*** and communication messaging via ***'MyChart'*** ***(Date of implementation MyChart: 1/2010)***.
15. Patients are able to schedule their own appointment and schedule an ***'e-visit'*** through ***'MyChart'***.
16. As mentioned before, we provide after hours on-call physician system.

Documented Process & Report covering at least 30 calendar days

Alternative Encounter Types from 11/19/2014 – 12/19/2014

Patient Encounters	Telemedicine	Rate
245	6	2.45%

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PCMH 1A, Factor 3: Shared Medical Appointments/Group Visits

- **Multiple patients are seen as a group for follow-up care or management of chronic conditions**
- **Voluntary**
- **Allows patient interaction with other patients and members of health team**
- **Practice should document in the medical record**
- **NOT an educational session**
- **This factor requires a documented process and a 30 calendar day report**

- **Resource:** http://www.aafp.org/about/policies/all/shared-medical.html

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PCMH 1A, Factor 4: Example Third Next Available Appointment

ABCD Medical Center

Explanation: The practice reserves time for same-day appointments. This report shows the number of days to the *third next available* appointment for each day from 10/14/2014 through 10/18/2014 as measured first thing each morning as the clinic day began.

Provider	Monitoring Date	Days
Jones, MD	10/14/2014	1
Jones, MD	10/15/2014	0
Jones, MD	10/16/2014	0
Jones, MD	10/17/2014	1
Jones, MD	10/18/2014	2
Average # of days		0.8

PCMH 1A, Factors 1,4 & 5: Appointment Audit

SAME DAY APPOINTMENTS				
Provider Name (s)				
Regular Number of Appts	12	13	0	0
BEGINNING OF THE DAY				
Number of Regular Appointments Scheduled	12	10	0	0
Number of Work-In Appointments Scheduled	2	0	0	0
Number of Regular Appointments Available	0	3	0	0
Number of Same Day Appointments Availabl	3	3	3	0
Total Available Appointments	3	6	3	0
Total Available Appointments (Clinic)				12
When is 3rd Next Available Appt?				TODAY
END OF THE DAY				
Number of Cancellations	0	0	0	0
Number of No-Shows	2	0	0	0
Number Same Day Filled	1	0	1	0
Number Regular Filled	0	2	0	0
Total Number of Patients Seen	14	15	31	14
Additional Visits				
Nurse Visits	3	THESE PATIENTS ARE NOT SEEN BY A PROVIDER!		
Company Accounts	4			
Total Number of Patients Seen (Clinic)	81			

SAME DAY APPOINTMENTS

PCMH 1B: 24/7 Access to Clinical Advice

The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times, and regularly assesses its performance on:

1. Continuity of medical record information for care and advice when the office is closed
2. Providing timely clinical advice by telephone - CRITICAL FACTOR
3. Providing timely clinical advice using a secure, interactive electronic system*
4. Documenting clinical advice in patient records

**NA if the practice cannot communicate electronically with patients. NA responses require an explanation*

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PCMH 1B: Scoring and Documentation

3.5 Points

Scoring

- 4 factors = 100%
- 3 factors (including Factor 2) = 75%
- 2 factors (including Factor 2) = 50%
- 1 factor (or does not meet factor 2) = 25%
- 0 factors = 0%

Documentation

- F1-4: Documented process ***and***
- F2&3: Report(s) showing response times during and after hours (7 consecutive day report(s) minimum)
- F4: Three examples of clinical advice documented in record. One example when office open AND one example when office closed.

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PCMH 1B, Factors 1,2, & 4 Example

PROCEDURE: General Internal Medicine Effective Date: 2/17/2012

- Doctors are on call 24 hours per day and are available through the usual office telephone number. Patient phone calls are answered by a live person during office hours and through the answering service after hours. Clinical response time is to be within one hour. After-hour calls are put on hold by the answering service and then immediately put through to the physician on call. If a physician is unable to immediately take an after-hours call, it will be answered within one hour. Factor 2.
- Doctors have access to patient's medical records from their homes/mobile devices. Factor 1.
- Doctors may direct patients to an affiliated urgent care center or to the local emergency room, depending on acuity of symptoms. Doctors will use their own discretion regarding where to refer a patient, based on their clinical judgment. If a patient is referred to an urgent care center or an emergency room, our physician will communicate directly to the attending physician on duty, relaying any pertinent clinical information. Doctors can answer email outside regular office hours. (no timeframe to fully meet factor 3)
- Doctors will document after-hours advice in patient's medical record. This documentation will include the time of patient call and the time call was returned by clinician. Factor 4.

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PCMH 1B, Factors 2 & 4

ABCD PEDIATRICS CLINICAL ADVICE BY TELEPHONE POLICY

- ABCD Pediatrics, P.A. provides clinical advice by telephone for all established patients. During office hours our telephone staff forwards calls from patients regarding a new symptom, illness or concern to clinical staff for triage via telephone. If a clinical staff member is unavailable, a message will be taken or call may be routed to voicemail which is reviewed by a clinical staff member. Non-urgent calls are returned within 24 business hours. Urgent calls are returned within 4 hours. Emergency calls are routed directly to a provider for an immediate response or the caller is directed to seek emergency care at the nearest emergency department.
- Clinical staff members are responsible for documenting clinical advice in the patient's medical record. All clinical advice, delivered by telephone is documented within 24 hours.
- Policy effective date: December 30, 2013
- Policy review date: December 1, 2014

PCMH 1B, Factor 2: Example Response Times to Calls

Shows:

- ✓ **Call date/time**
- ✓ **Response date/time**
- ✓ **If time meets policy**

Response times to meet standards for timely telephone response:

(A telephone call audit was conducted for our practice for two weeks. Below are the results. The encounter number refers to the unique tracking ID our EMR assigns. It has been provided instead of confidential patient information, for tracking purposes. [redacted] Internal Medicine policy for telephone response time is 24 hours.)

Encounter Number	Date we received phone request	Time of request	Date we responded to patient	Time of response	Elapsed Time	Response time meets policies?
	3/20/09	11:26	3/20/09	17:02	6 hours	yes
	3/19/09	11:21	3/19/09	13:10	2 hours	yes
	3/18/09	13:53	3/20/09	17:19	4 hours	yes
	3/17/09	15:02	3/18/09	9:31	18 hours	yes
	3/17/09	14:13	3/18/09	10:00	20 hours	yes
	3/19/09	15:14	3/20/09	9:09	18 hours	yes
	3/16/09	10:30	3/16/09	10:41	.25 hours	yes
	3/20/09	9:28	3/20/09	12:55	3 hours	Yes
	3/17/09	13:53	3/17/09	16:19	3 hours	yes
	3/18/09	14:35	3/19/09	14:34	24 hours	Yes
	3/19/09	11:16	3/19/09	11:32	0.25 hours	Yes

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PCMH 1B, Factor 2: Patient Access Audit

Date	Person Calling	Call Time	Who Responded	Time response entered in OXBOW	Time to Respond
4/23/15	Patient	9:10am	Mary	9:15am	05 min
4/23/15	Patient	11:45am	Barbara	12:00 pm	15 min
4/23/15	Patient	8:20pm	Dr. Smith	8:30pm	10 min
4/24/15	Patient	8:20am	Kathi	8:30am	10 min
4/24/15	Patient	11:25am	Mina	11: 30am	05 min
4/25/15	Patient	6:20am	Dr. Smith	6:30am	10 min
4/27/15	Patient	2:25pm	Johann	2:30pm	05 min
4/27/15	Patient	4:05pm	Mary	4:15pm	10 min

Need:
- **Documented process**
- **Report with minimum 7 days of data**

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PCMH 1B, Factor 3: Example Timely Advice Electronic Message

Clinical Call Response Time: 1/6/2015 – 2/6/2015		
Message Responders	**total # messages**	**avg response in hours:**
Physicians	75	0.91
Residents	16	1.50
Mid-levels	24	0.89
Nurses	73	0.94
Clinical Asst	62	1.03
Total	**250**	**0.98 (standard is 2 hours)**

Also need a documented process

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PCMH 1B, Factor 3: Example Timely Clinical Advice by Secure E-Message

LOG DEMONSTRATING TIMELY CLINICAL ADVICE BY SECURE ELECTRONIC MESSAGES DURING OFFICE HOURS

NOTE:
- Minimum 7 Calendar Day Report Required
- Does NOT show if practice meets its standard.

Non-Urgent	Received Secure Request	Time of Electronic Message	Responded Secure Request	Time of Response	Elapsed Time In Hours/ Minutes
x	06/04/2012	15:36	06/04/2012	16:00	0:24
x	06/04/2012	13:20	06/04/2012	14:00	0:40
x	06/05/2012	10:00	06/05/2012	11:00	1:00
x	06/06/2012	10:30	06/06/2012	12:30	2:00
x	06/07/2012	11:30	06/07/2012	13:00	1:30

PCMH 1B, Factor 4: Documentation of Call Response in Patient Record

Description
Provider
MRN: 01535954 Department: Dc Waunakee Fm

Incoming Call

11/8/2010 9:55 AM [illegible] Dc Waunakee Fm [illegible]

Contacts

11/08/2010 9:55 AM [illegible] 608-516-6186 (W)

Reason for C

Question [illegible]

Ca

Missall Rn, Susan 11/8/10 09:58 AM Signed
She is having right leg excruciating leg ,muscle pain."double over , laying on the floor" she is concerned she has a blood clot. She had surface clots in past and labeled von willebrand's. She had bubbling in veins and then after it felt like ice in veins. Inside calf to other side calf, behind knee and knee cap. She is having functional pain now but the prior pain was worse than labor pain. She drank 2 L of pedia lite. Episodes lasted 15 min and then moved and started again. OV made

Historical Meds Added to List

Hyperlink Historical Meds Added

Meds Removed To Update List

Hyperlink Meds Removed

Patient Instruction

Hyperlink Patient Instruction

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PCMH 1C: Electronic Access

Practice provides through a secure electronic system:

1. More than 50 percent of patients have timely access to their health information+
2. The capability to view, download or transmit their health information to a third party+
3. Clinical summaries are provided to patients/families/caregivers upon request.
4. The capability to send a secure message+
5. Patients have two-way communication with the practice
6. Patients may request appointments, prescription refills, referrals and test results

+ Meaningful Use Modified Stage 2 Alignment (as of October 2015)

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PCMH 1C: Scoring and Documentation

2 Points

Scoring

- 5-6 factors = 100%
- 3-4 factors = 75%
- 2 factors = 50%
- 1 factor = 25%
- 0 factors = 0%

Documentation

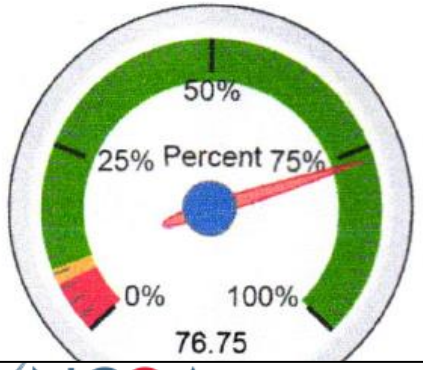
- F1: Reports based on numerator and denominator with at least 3 months of recent data
- F2-4: Reports based on numerator and denominator with at least 3 months of recent data **or** examples showing capability
- F5 & 6: Screen shots showing the capability of the practice's web site or portal including URL.

PCMH 1C, Factor 1 Online Access: MU

Date Range 1/12/16 – 4/11/16

More than 50% of patients have online access to their health information within four business days of when the information available to the practice. (Stage 2 MU)

All Locations	76.75		
Practice/Location	**Denominator**	**Numerator**	**%**
Practice A	750	377	50
Practice B	647	565	87
Practice C	1	0	0
Practice D	886	811	92



Reports need to be at the practice site level and include data for all primary care providers at the site. Data should be aggregated at the site level.

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PCMH 1C, Factor 3 Example

NEXTGEN
HEALTHCARE INFORMATION SYSTEMS

Quality Measures Provider Summary Report

MU2_Clinical_Summary_Core_8

Practice Name: Practice A

Program : MU2_Objectives_2014 Evaluation Date: 3/17/2015			# Patients		Performance	Goal
Measure Start Date : 10/1/2014 AND Measure End Date : 12/31/2014			Final Denominator	Numerator	(%)	(%)
Practice A	Clinical Summary Provided In 1 Business Day	Total	4713	4535	96.22	50

**Final Denominator includes Exclusion Totals*

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PCMH 1C, Factor 5: Example Two-Way Communication

Practice A Portal

Jane Smith
Last login: 05/13/15 (9:37am)

Logout
edit profile

Messages | Appointments | Meds | Allergies | History | Chart | Account Info

Create Message | Move to Saved | Refresh | Delete

Inbox | Saved | Sent | Patient Forms

Inbox for Jane Smith

To view a message, click on the date, time, or subject of the message.

Clicking on the envelope only marks the message as read/unread.

	Date	Time	Subject

Practice A Portal

Jane Smith
Last login: 05/13/15 (9:37am)

Logout
edit profile

Messages | Appointments | Meds | Allergies | History | Chart | Account Info

Create Message | Move to Saved | Delete

Inbox | Saved | Sent | Patient Forms

Send a Message to Practice A

THIS FORM IS TO BE USED FOR **NON-URGENT** ISSUES ONLY.
Please allow 2 business days for a response.

To the staff of: Practice A

Re:

Subject:

Message:

Clinical Questions
Appointments
Billing
Medications
Test Results
Referral
Other

Send

Also demonstrates capability for PCMH 1C, Factor 6

Demonstrates ability practice to send and receive messages through the patient portal

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PCMH 1C, Factor 6: Interactive Web-Site Example

Proxy
- Proxy Access

My Health Record
- Health Summary
- Recent Visits
- Test Results
- Results Summary
- Tests Ordered

Disease Management
- Home Monitoring
- Diabetes Report

Prescriptions
- Renew

Appointments
- Request
- Upcoming/Cancel

Message Center
- Inbox
- Messages Sent
- Archive
- Renew Messaging
- Send Msg to MD/RN

Questions
- Billing
- Non-medical

Can request:
- ✓ Appointments
- ✓ Prescription Refills
- ✓ Test results

DID YOU KNOW.....
High levels of cholesterol in the blood is a major risk factor for coronary artery disease. Coronary artery disease is the leading cause of deaths in the United States. For more information, check out The Cholesterol Low Down on the American Heart Association website.

National Eating Disorder Week starts February 26th.

Running on empty
Despite what you may read or see in magazines, you can be too thin. Dieting to the extreme and overexercising are just two of the symptoms of a very serious illness known as anorexia nervosa. Size it up for yourself and click here to learn more.

What's eating you?
If you think purging after a fattening meal is a quick fix, think again. The cycle of overeating and purging puts your life at risk and can quickly become the eating disorder known as bulimia nervosa. What causes bulimia nervosa?

Keep your e-mail address current/Adjust SPAM Filters
Please take a moment to ensure your e-mail address is up-to-date. We do not want you to miss out on any new communications from our test results, appointment reminders, etc. You can view your e-mail address on

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Activity 1

PCMH 2: Team-Based Care

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PCMH 2: Team-Based Care

Intent of Standard

The practice provides continuity of care using culturally and linguistically appropriate, team-based approaches.

PCMH 2: Team-Based Care

12 Points

Elements

- Element A: Continuity
- Element B: Medical Home Responsibilities
- Element C: CLAS
- Element D: The Practice Team
  Must-Pass

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PCMH 2A: Continuity

The practice provides continuity of care for patients/families by:

1. Assisting patients/families to select a personal clinician and documenting the selection in practice records.
2. Monitoring the percentage of patient visits with selected clinician or team.
3. Having a process to orient patients new to the practice.
4. Collaborating with the patient/family to develop/ implement a written care plan for transitioning from pediatric care to adult care.

PCMH 2A: Scoring

3.0 Points

Scoring

- 3-4 factors = 100%
- No scoring option = 75%
- 2 factors = 50%
- 1 factor = 25%
- 0 factors = 0%

PCMH 2A: Documentation

Documentation

- F1: Documented process for staff and an example of a patient record with choice of personal clinician.
- F2: Report based on 5 days of data.
- F3: Documented process for staff to orient new patients.
- F4: For the following:
  - ✓ Pediatric practices - Example of a written transition care plan
  - ✓ Internal medicine & family medicine practices – "Documented process and materials for receiving adolescent and young adult patients that ensure continued preventive, acute, chronic care."

PCMH 2A, Factor 2: Example of monitoring patient visits

Please Select Care Center

Click to Filter

% of patient visits with preferred provider

Document Responsible Provider	Percentage of Visits with Preferred Provider	Percent
Providers		0.00 %
		12.90 %
		20.51 %
		48.28 %
		57.58 %
		58.23 %
		59.09 %

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PCMH 2A, Factor 2: Example of report showing total of patient encounters

4

Provider	Patients seen by Personal Clinician	Total Patients seen	Percentage
Charles Dawson, DO	26	44	76.70%
Steve Austin, MD	46	79	75.58%
Abby Lander, PA-C	8	39	26.63%
Anthony Martin, MD	57	99	74.73%
Tara Smith, NP	4	31	16.75%
Karen McCauley, DO	28	58	62.66%

PCMH 2A, Factor 4: Pediatric to Adult Transition Diabetes Care Self-Assessment

Self-assessment of worries, concerns, and burdens related to diabetes and preparation for transitioning

Consider the following statements and note how important it would be to discuss the item with your healthcare team as you are moving on from pediatric to adult diabetes care

I WOULD LIKE TO TALK ABOUT THIS	YES	MAYBE	NO
Challenged by Diabetes Burdens			
1. I feel confused about managing my diabetes on my current regimen	YES	MAYBE	NO
2. I am not sure how to keep my blood sugars in range.	YES	MAYBE	NO
3. Diabetes keeps me from doing many things that I want to do in life now.	YES	MAYBE	NO
4. I feel "burned out" from trying to control my blood sugars all the time.	YES	MAYBE	NO
Social/Emotional/Cognitive Issues			
5. I have trouble paying attention in class or at work.	YES	MAYBE	NO
6. I seem to forget things more than most of my friends.	YES	MAYBE	NO
7. I struggle to keep up with my class work or job Responsibilities	YES	MAYBE	NO
8. Organizing my life every day is a challenge for me.	YES	MAYBE	NO
9. I get along well with classmates and/or co-workers.	YES	MAYBE	NO
10. I am not able to do things that others my age can do.	YES	MAYBE	NO
11. I feel sad or 'blue'.	YES	MAYBE	NO
12. I worry about my future.	YES	MAYBE	NO
Transition preparation and readiness to move on			
13. I know how each of my insulins work and what to do if things don't seem to be going right.	YES	MAYBE	NO
14. I can refill a prescription by myself.	YES	MAYBE	NO
15. I can make a doctor's appointment by myself.	YES	MAYBE	NO
16. I know what to do with my diabetes management if I get sick.	YES	MAYBE	NO
17. I know what my insurance covers.	YES	MAYBE	NO
18. I can get myself to my diabetes appointments.	YES	MAYBE	NO
19. I have contacted diabetes organizations in my community.	YES	MAYBE	NO
20. If I need to see a specialist, I know how to find one.	YES	MAYBE	NO

Self-assessment of worries, concerns, burdens related to diabetes and preparation for transitioning

"I would like to talk about:

- ✓ Challenged by diabetes burdens
- ✓ Social/emotional/cognitive issues
- ✓ Transition preparation/readiness to move on"

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PCMH 2A, Factor 4: Example Transition from Pediatric to Adult Care

National Diabetes Education Program

Pediatric to Adult Diabetes Care *Transition Planning Checklist*

- ✓ 1 to 2 years before transition to new adult care providers
- ✓ 6 to 12 months before transition
- ✓ 3 to 6 months before transition
- ✓ Last few visits

NATIONAL DIABETES EDUCATION PROGRAM (NDEP)

Pediatric to Adult Diabetes Care

TRANSITION PLANNING CHECKLIST

This checklist helps the health care provider, young adult, and family discuss and plan the change from pediatric to adult health care. While a variety of events may affect the actual timing when this change occurs, below is a suggested timeline and topics for review. The young adult, family, and health care provider can obtain a copy of this checklist and access many online transition resources at the NDEP website (www.YourDiabetesInfo.org/transitions).

❑ **1 to 2 years before anticipated transition to new adult care providers**
[Date completed_____]

- ❑ Introduce the idea that transition will occur in about 1 year
- ❑ Encourage shared responsibility between the young adult and family for:
  - ___ Making appointments
  - ___ Refilling prescriptions
  - ___ Calling health care providers with questions or problems

http://ndep.nih.gov/transitions/PlanningChecklist.aspx

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PCMH 2B: Medical Home Responsibilities

The practice has a process for informing patients/ families about role of the medical home and gives patients/families materials that contain the following information:

1. The practice is responsible for coordinating patient care across multiple settings.
2. Instructions for obtaining care and clinical advice during office hours and when the office is closed.
3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice.

PCMH 2B: Medical Home Responsibilities (cont.)

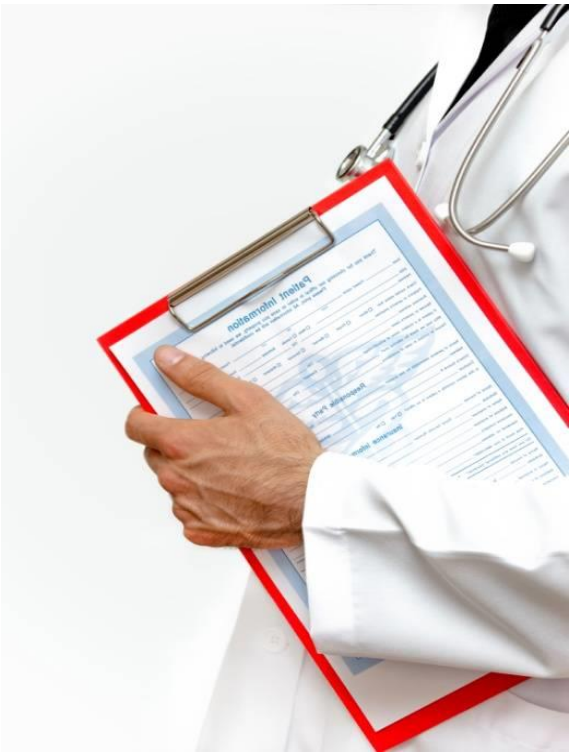
4. The care team provides access to evidence-based care, patient/family education and self-management support.
5. The scope of services available within the practice including how behavioral health needs are addressed.
6. The practice provides equal access to all of their patients regardless of source of payment.
7. The practice gives uninsured patients information about obtaining coverage.
8. Instructions on transferring records to the practice, including a point of contact at the practice.

PCMH 2B: Scoring and Documentation

2.5 Points

Scoring

- 7-8 factors = 100%
- 5-6 factors = 75%
- 3-4 factors = 50%
- 1-2 factor = 25%
- 0 factors = 0%



Documentation

- F1-8: Documented process for providing information to patients and
- F1-8: Patient materials

PCMH 2B, Factors 1, 3-4: Example of Patient Information on Medical Home

What is a Patient-Centered Medical Home?

The Medical Home is an innovative, team-based approach to provid
partnership develops between the patient, his or her primary clinici
Together, following evidence-based guidelines for medical care, the
provide the best health care services possible for you.

What are the changes and additional benefits that I can an

Team Based Care:

- One of us will remain as your Primary Care clinician. However,
  nurses and support staff to work with you to meet all of your h
  information systems tools will assist us (along with other resou
  medical care that is optimal for you.

Improved Health Access and Communication:

- For urgent care issues during working hours, your Primary Care clinician (or another one of our team members) will see you on the very day that you have an urgent health care need. You will need to simply call the main office number during working hours to schedule a same-day appointment with us. Many urgent health care needs, including lacerations, can be handled by your Medical Home team. You will then avoid having a prolonged and expensive visit to the Emergency Room.

***Materials could describe*:**

- **What is a medical home?**
  - Team-based
  - Partnership with patient
  - Evidence-based guidelines
  - Coordinated care
- **Benefits of a medical home**
  - Team-based care
  - Improved access
  - Better communication

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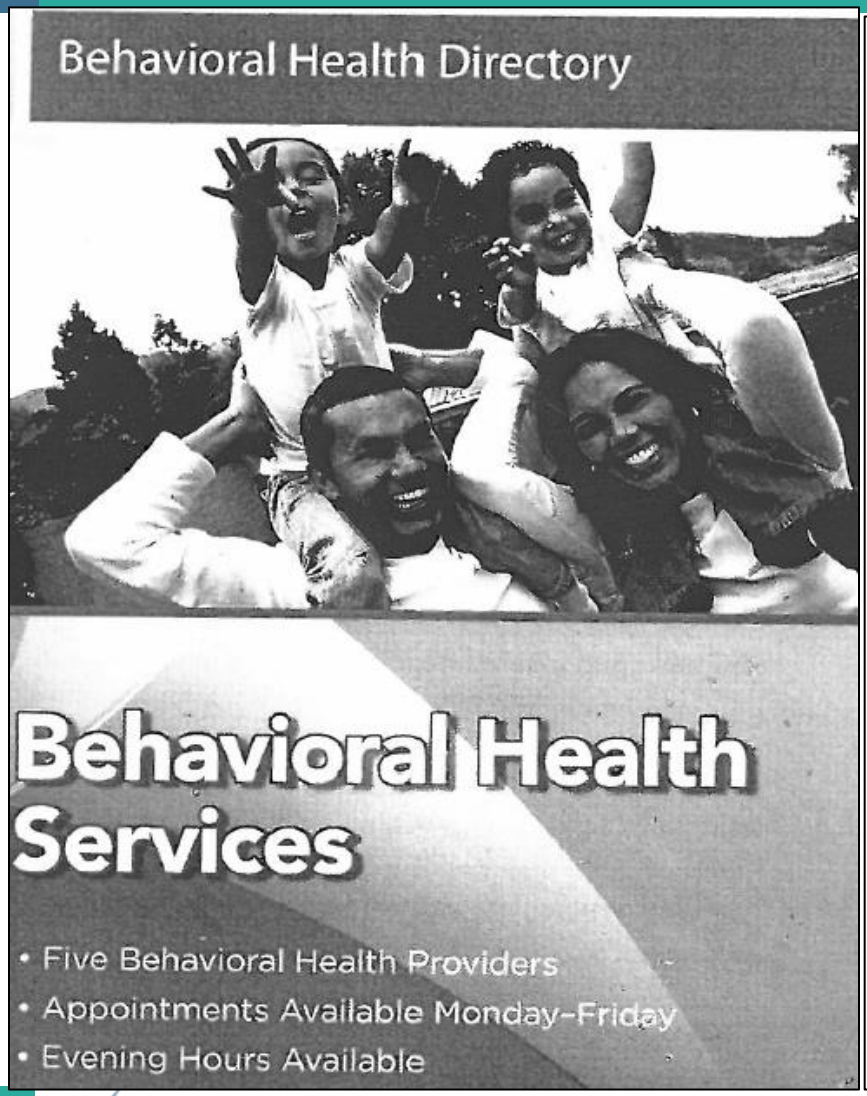
PCMH 2B5: How Behavioral Health Needs Are Addressed



provides services for both adults and children. Our psychology and counseling professionals provide compassionate care for patients' life issues through individual, family and group counseling in a safe and comfortable environment.

Appointments

Office Hours: Monday through Thursday, 8:00 AM to 5:00 PM and Friday, 8:00 AM to 3:30 PM. Early morning and evening hours are available. To make an appointment with any of our providers, please call 812-426-9779.

Emergencies

Non-emergency calls and calls to schedule appointments should wait until 8:00 AM when the daytime staff is in the office. Emergency calls from established patients are answered by the clinician on call between 5:00 PM and 8:00 AM.

PCMH 2C: Culturally and Linguistically Appropriate Services (CLAS)

The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by:

1. Assessing the diversity of its population.
2. Assessing the language needs of its population.
3. Providing interpretation or bilingual services to meet the language needs of its population.
4. Providing printed materials in the languages of its population.

PCMH 2C: Scoring and Documentation

2.5 Points

Scoring

- 4 factors = 100%
- 3 factors = 75%
- 2 factors = 50%
- 1 factor = 25%
- 0 factors = 0%

Documentation

- F1 and 2: Report showing practice's assessment of
  - ✓ F1 - Diversity (include racial, ethnic AND another characteristic of diversity
  - ✓ F2 - Language composition of its patient population
- F3: Documented process for providing bilingual services
- F4: Patient materials

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PCMH 2C, Factor 2: Assessing the Language Needs of the Population

Patient Distribution by Language

	# of Patients	% of Patients
English	2050	87.3%
Spanish	245	10.5%
Russian	12	.5%
Other	15	.6%
Patient refused	25	1.1%
Total	**2347**	**100.0%**

This is based on unique pts seen between 08/07/15 -10/08/15. This sampling indicates that most of our patients speak English. We utilize staff that speak Spanish and also have available language line for any other languages that might be needed.

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PCMH 2D: The Practice Team

The practice uses a team to provide a range of patient care services by:

1. Defining roles for clinical and nonclinical team members.
2. Identifying the team structure and the staff who lead and sustain team based care.
3. Holding scheduled patient care team meetings or a structured communication process focused on individual patient care. (CRITICAL FACTOR)
4. Using standing orders for services.
5. Training and assigning members of the care team to coordinate care for individual patients.

NOTE: Critical Factors in a Must Pass element are essential for Recognition

PCMH 2D: The Practice Team (cont.)

6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change.
7. Training and assigning members of the care team to manage the patient population.
8. Holding scheduled team meetings to address practice functioning.
9. Involving care team staff in the practice's performance evaluation and quality improvement activities.
10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council.

PCMH 2D: Scoring

MUST-PASS

4 Points

Scoring

- 10 factors = 100% (including factor 3)
- 8-9 factors = 75% (including factor 3)
- 5-7 factors = 50% (including factor 3)
- 2-4 factor = 25%
- 0-1 factor = 0%

PCMH 2D: Documentation

Documentation

- F1,2, 5-7: Staff position descriptions or responsibilities
- F3: Description of staff communication processes including frequency of communication and 3 examples showing that practice follows its documented process.
- F4: Written standing orders
- F5-7: Description of training process and schedule or materials
- F8: Description of staff communication processes and sample
- F9: Description of staff role in practice improvement process or minutes demonstrating staff involvement
- F10: Process demonstrating how it involves patients/families in QI teams or advisory council

PCMH 2D, Factor 4: Example Standing Orders

POLICY/STANDING ORDERS FOR ADMINISTERING PNEUMOCOCCAL VACCINE TO ADULTS

PURPOSE: To reduce monthly and mortality from pneumococcal disease by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

POLICY: Under these standing orders, eligible nurses/MOAs may vaccinate patients who meet any of the criteria below:

Identify adults eligible for the pneumococcal vaccination using the checklist in the nurse triage note:

1. Age>65
2. Diabetes
3. Chronic heart disease
4. Chronic lung disease (asthma, emphysema, chronic bronchitis, etc)
5. HIV or AIDS
6. Alcoholism
7. Liver Cirrhosis
8. Sickle cell disease
9. Kidney disease (e.g. dialysis, renal failure, nephrotic syndrome)
10. Cancer
11. Organ transplant
12. Damaged spleen or no spleen
13. Exposure to chemotherapy
14. Chronic Steroid use

Screen all patients for contraindications and precautions to pneumococcal vaccine:

Severe allergic reaction to past pneumococcal vaccine

Pregnant patients

PCMH 2D, Factor 6: Example of Training Materials/Description

Care Team Training: Self-Management Support & Population Management

Factors 5-7, practices need to provide:
- Description of training *AND*
- Schedule or materials showing how staff has been trained

Diabetes/Hypertension Care Team Training Sessions

Joint Staff Meeting

June 3rd 2011 1:30-2:30pm

Participants: All clinic staff and providers at general monthly clinic meeting

Agenda: The utilization of patient registries to manage high-risk diabetics and hypertensive patients.

Summary:

Introduction and education of patient care registries and their value

(con't)

Activity 2

PCMH 3: Population Health Management

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PCMH 3: Population Health Management

Intent of Standard

The practice uses a comprehensive health assessment and evidence-based decision support based on complete patient information and clinical data to manage the health of its entire patient population.

Meaningful Use Alignment

- Practice uses clinical decision support

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PCMH 3: Population Health Management

20 Points

Elements

- Element A: Patient Information
- Element B: Clinical Data
- Element C: Comprehensive Health Assessment
- Element D: Use Data for Population Management

MUST-PASS

- Element E: Implement Evidence-Based Decision Support

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PCMH 3A: Patient Information

The practice uses an electronic system to record patient information, including capturing information for factors 1-13 as structured (searchable) data for more than 80 percent of its patients:

1. Date of birth.
2. Sex.
3. Race.
4. Ethnicity.
5. Preferred language.
6. Telephone numbers.

PCMH 3A: Patient Information (cont.)

7. E-mail address.
8. Occupation (NA for pediatric practices).
9. Dates of previous clinical visits.
10. Legal guardian/health care proxy.
11. Primary caregiver.
12. Presence of advance directives (NA for pediatric practices).
13. Health insurance information.
14. Name and contact information of other health care professionals involved in patient's care.

PCMH 3A: Scoring

3 Points

Scoring

- 10-14 factors = 100%
- 8-9 factors = 75%
- 5-7 factors = 50%
- 3-4 factor = 25%
- 0-2 factors = 0%

NOTE

- *Factors 8 and 12 (NA for pediatric practices).*
- *Written explanation of an NA response is required.*

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PCMH 3A: Documentation

Documentation

- F1-13: Report with numerator and denominator with at least 3 months of recent data.
- F14: Documented process and three examples demonstrating process.

PCMH 3A, Factors 1-5: Example Demographics

This certified system produced very graphic report that shows practice level (all providers) results for a 3 month reporting period

Demographic percentage for 3 month duration 1/1/15 - 4/1/15

Actual - 95%
Stage 1 MU Threshold - 80%

Numerator:	1,291
Denominator:	1,354

Required Demographics Recorded
(Core 7)

Actual - 54%
Stage 1 MU Threshold - 50%

Numerator:	729
Denominator:	1,354

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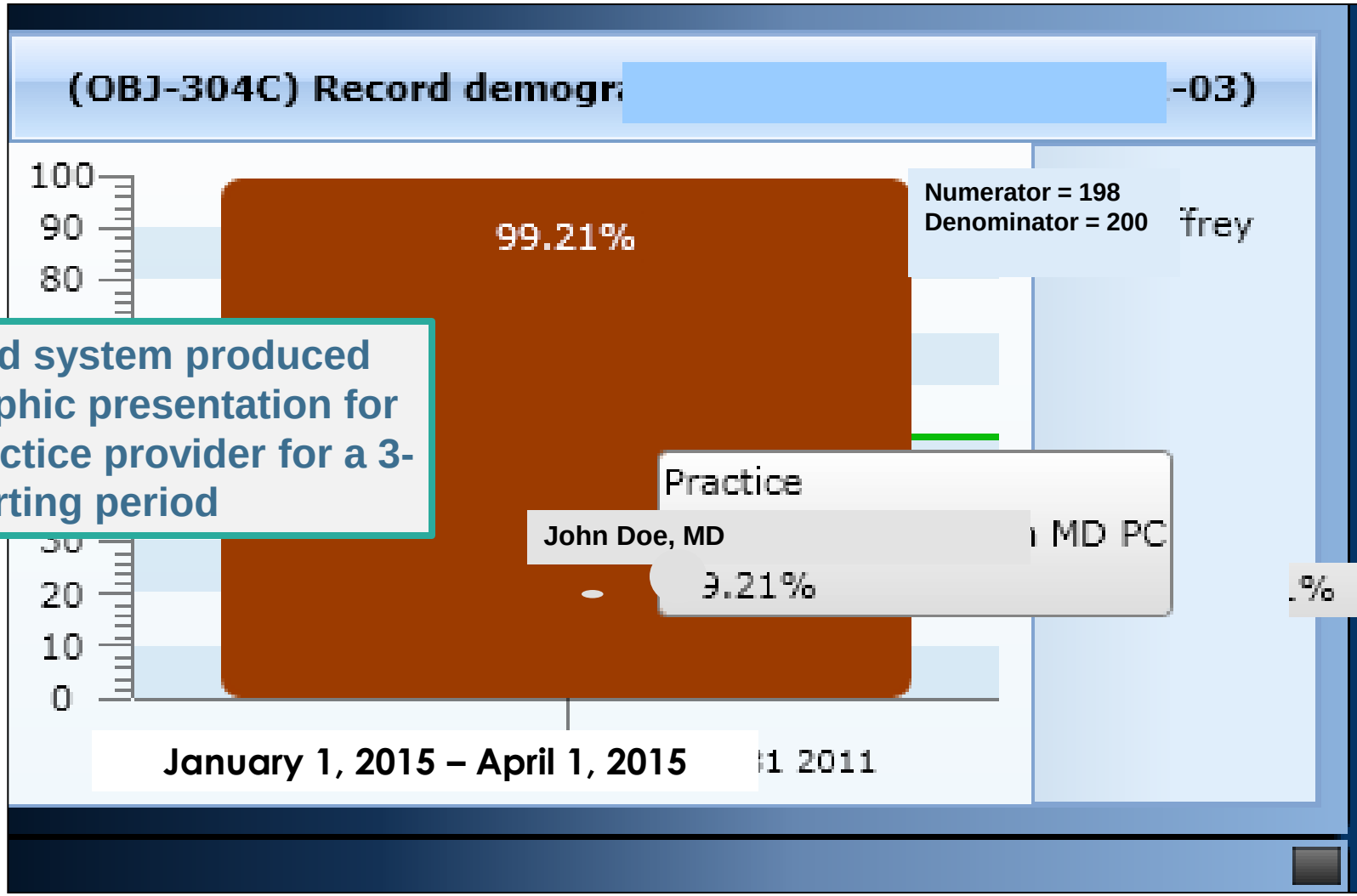
PCMH 3A, Factors 1-5: Solo Provider Practice



This certified system produced another graphic presentation for the solo practice provider for a 3-month reporting period

PCMH 3A: Factors 1-13 Example

Facility Name	Demographics PCP	DoB Compliance Percentage	Gender Compliance Percentage	Race Compliance Percentage	Ethnicity Compliance Percentage	Language Compliance Percentage	Phone Compliance Percentage
[redacted] Health Care Center [redacted]	[redacted]	100.00%	100.00%	99.23%	99.23%	100.00%	100.00%
	[redacted]	100.00%	100.00%	99.70%	99.70%	100.00%	100.00%
	[redacted]	100.00%	100.00%	99.50%	99.50%	100.00%	100.00%
	[redacted]	100.00%	100.00%	99.09%	99.09%	99.80%	100.00%
	[redacted]	100.00%	100.00%	99.02%	99.02%	100.00%	100.00%
	[redacted]	100.00%	100.00%	98.84%	98.84%	100.00%	100.00%
	[redacted]	100.00%	100.00%	99.86%	99.86%	100.00%	100.00%
10/23/13 to 10/23/14	[redacted]	100.00%	100.00%	99.56%	99.56%	100.00%	100.00%
[redacted] Health Care Center [redacted]		100.00%	100.00%	99.35%	99.35%	99.97%	100.00%
Summary		100.00%	100.00%	99.35%	99.35%	99.97%	100.00%

E-Mail Compliance Percentage	Employment and Student Status Compliance Percentage	Appointment Compliance Percentage	Legal Guardian Compliance Percentage	PCG Compliance Percentage	Advance Directive Compliance Percentage	Insurance Compliance Percentage
90.61%	49.37%	100.00%	0.00%	0.00%	13.87%	99.90%
94.13%	51.01%	100.00%	0.00%	0.00%	41.48%	100.00%
92.67%	49.50%	100.00%	0.10%	0.00%	15.21%	99.30%
95.55%	59.01%	100.00%	0.00%	0.00%	56.24%	99.80%
93.34%	58.28%	100.00%	0.00%	0.00%	9.30%	99.90%
93.91%	50.63%	100.00%	0.10%	0.00%	19.70%	99.81%
96.88%	89.42%	100.00%	0.00%	0.00%	44.11%	99.86%
81.24%	28.04%	100.00%	0.11%	0.00%	14.84%	100.00%
92.29%	54.41%	100.00%	0.04%	0.00%	26.84%	99.82%
92.29%	54.41%	100.00%	0.04%	0.00%	26.84%	99.82%
3.A.7	3.A.8	3.A.9	3.A.10	3.A.11	3.A.12	3.A.13

- Shows 9 of 13 items at more than 80%
- Practice received 75% (2.25 points)
- Adult practices are <u>not</u> eligible for NA option for Factor 8 (Occupation) or Factor 12 (Advanced Directives)

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PCMH 3B: Clinical Data

The practice uses an electronic system with the functionality in factors 6 and 7 and records the information in factors 1-5 and 8-11 as structured (searchable) data:

1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients.
2. Allergies, including medication allergies and adverse reactions for more than 80 percent of patients.
3. Blood pressure, with the date of update for more than 80 percent of patients 3 years and older.
4. Height/length for more than 80 percent of patients.
5. Weight for more than 80 percent of patients.
6. System calculates and displays BMI.

PCMH 3B: Clinical Data (cont.)

7. System plots and displays growth charts (length/height, weight and head circumference) and BMI percentile (0-20 years) (NA for adult practices).
8. Status of tobacco use for patients 13 years and older for more than 80 percent of patients.
9. List of prescription medications with date of updates for more than 80 percent of patients.
10. More than 20 percent of patients have family history recorded as structured data.
11. An electronic progress note that can be created, edited and signed by an eligible professional.

PCMH 3B: Scoring and Documentation

4 Points

Scoring

- 9-11 factors = 100%
- 7-8 factors = 75%
- 5-6 factors = 50%
- 3-4 factor = 25%
- 0-2 factors = 0%

NOTE

- Factor 3 (NA for practices with no patients 3 years or older),
- Factor 7 (NA for adult practices)
- Factor 8 (NA for practices who do not see patients 13 years).
- Written explanation is required for NA responses.

Documentation

- F1-5, 8-10: Reports with a numerator and denominator
- F6, 7: Screen shots demonstrating capability
- F11: Report with numerator and denominator (no percentage requirement) **OR** example of capability

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PCMH 3B, Factors 1-5, 8-11: MU Measures

PCMH 3B 1-11 Clinical Data 12/1/14-3/1/15									
	Problems	Allergies	Blood Pressure	Height	Weight	Tobacco Use	Meds	Family History	Progress Note
Numerator	1541	1545	1545	1546	1544	1547	1543	1541	1545
Denominator	1547	1547	1547	1547	1547	1547	1547	1547	1547
Percentage	99%	99%	99%	99%	99%	100%	99%	99%	99%
	3B1	3B2	3B3	3B4	3B5	3B8	3B9	3B10	3B11

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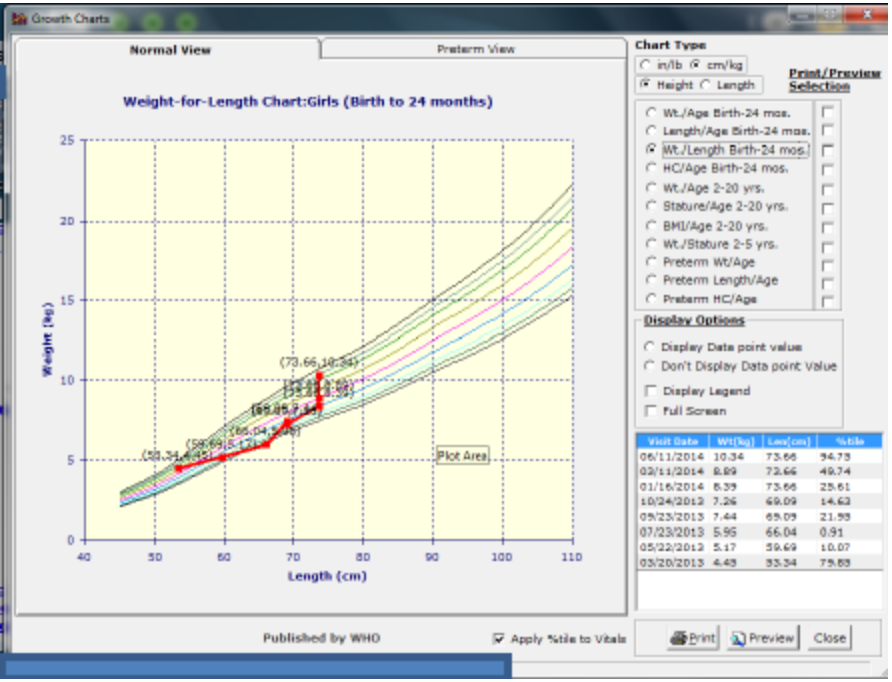
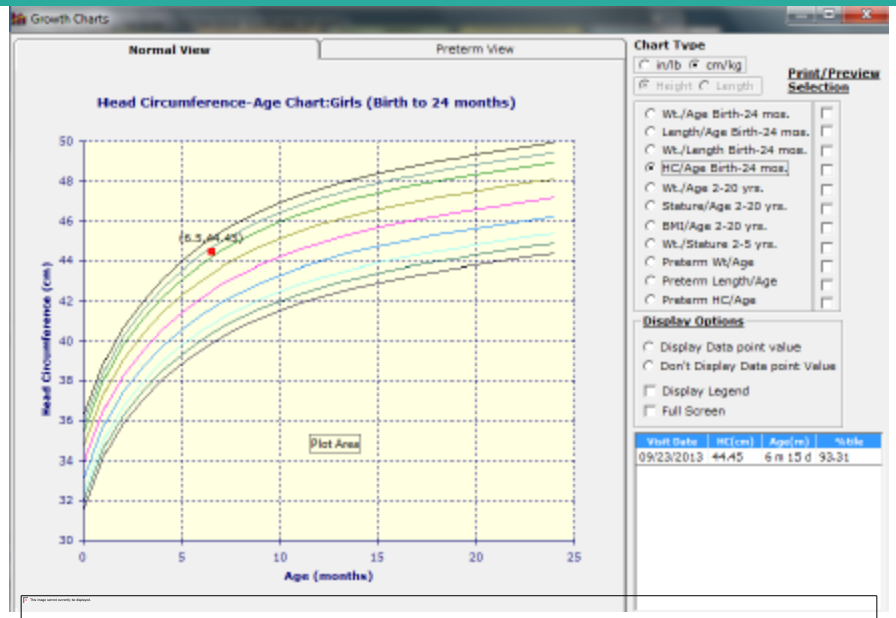
PCMH 3B, Factors 6 & 7: BMI and Growth Chart Example





- Displays growth charts for weight, length/height and head circumference (0-2 years)
- Displays BMI (2-20 years)

PCMH 3C: Comprehensive Health Assessment

To understand the health risks and information needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes:

1. Age- and gender appropriate immunizations and screenings.
2. Family/social/cultural characteristics.
3. Communication needs.
4. Medical history of patient and family.
5. Advance care planning (NA for pediatric practices).
6. Behaviors affecting health.

PCMH 3C: Comprehensive Health Assessment (cont.)

7. Mental health/substance use history of patient and family. ^^
8. Developmental screening using a standardized tool (NA for practices with no pediatric patients). ^^
9. Depression screening for adults and adolescents using a standardized tool. ^^
10. Assessment of health literacy.

^^PCMH PRIME Criteria

PCMH 3C: Scoring

4 Points

Scoring

- 8-10 factors = 100%
- 6-7 factors = 75%
- 4-5 factors = 50%
- 2-3 factor = 25%
- 0-2 factors = 0%

NOTE

- Factor 5 (NA for pediatric practices)
- Factor 8 (NA for practices with no pediatric patients),
- Factor 9 (if practice does not see adolescent or adult patients). (Adolescents age range: 12-18)
- Written explanation is required for NA responses.

PCMH 3C: Documentation

Documentation

- **F1-10:** Report with numerator and denominator based on all unique patients in a recent three month period indicating how many patients were assessed for each factor.

OR

- **F1-10:** Review of patient records selected for the record review required in elements 4B and 4C, documenting presence or absence of information in Record Review Workbook and 1 example for each factor

NOTE: *Report or record review must show more than 50 percent for a factor for the practice to respond "yes" to factor in survey tool.*

- **F8,9:** Completed form (de-identified) demonstrating use of standardized tool.
- **Factor 10**: For practices that do not assess health literacy at the patient level, NCQA reviews materials or screenshots demonstrating that health literacy is addressed at the practice.

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Record Review Workbook

NCQA's Patient-Centered Medical Home (PCMH) 2014
Record Review Worksheet
Please read the Workbook Instructions before completing this worksheet.
IMPORTANT NOTE: Read the instructions to determine if your practice can select the "not used" option available in the drop-down boxes for Patient Number 1.

Organization Name:
Completion Date:

Patient Number	3C – Comprehensive Health Assessment									
	1	2	3	4	5	6	7	8	9	10
	Documentation of age- and gender appropriate immunizations and screenings	Family/social/cultural characteristics	Communication needs	Medical history of patient and family	Advance care planning (NA for pediatric practices)	Behaviors affecting health	Mental health/substance use history of patient and family	Developmental screening using a standardized tool (NA for practices with no pediatric patients)	Depression screening for adults and adolescents using a standardized tool	Assessment of health literacy
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
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20										
21										
22										
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24										
25										
26										
27										
28										
29										
30										
Count of Patients Met (Yes + NA)	0	0	0	0	0	0	0	0	0	0
Count of Patients Not Met (No + Not I	0	0	0	0	0	0	0	0	0	0
Total Count of Patients (Met + Not Me	0	0	0	0	0	0	0	0	0	0
% of Patient that Meet Factor Criteria										
Result for Input Into ISS	< 30 Patients	< 30 Patients	< 30 Patients	< 30 Patients	< 30 Patients	< 30 Patients	< 30 Patients	< 30 Patients	< 30 Patients	< 30 Patients

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PCMH 3C, Factors 4 and 7: Example Family Medical and Mental Health History

Element_2C1_to_2C9_Tulane_CHC_Covenant_House[1].pdf - Adobe Reader

File Edit View Document Tools Window Help

Prefix | Modifier | Result | Status | Episode | Onset | Duration | Value

HPI 1 | HPI-Anx/Dep | HPI-Mood DO | ROS-- G, Anx/Dep | ROS-- Mood DO | Social Hx | Family Hx | PE | APP - BEH | PE Affect-Mood | PE Neurologic | Short Plan - Links | Outline View

Maternal History of:	Paternal History of:	Family History of:
Cancer	Cancer	Cancer
Heart disease	Heart disease	Heart disease
Kidney disease	Kidney disease	Kidney disease
Chronic disabling diseases	Chronic disabling diseases	Chronic disabling diseases
Diabetes Mellitus	Diabetes Mellitus	Diabetes Mellitus
Hypertension (Systemic)	Hypertension (Systemic)	Hypertension (Systemic)
Hepatic Disorders	Hepatic Disorders	Hepatic Disorders
Respiratory Disorders	Respiratory Disorders	Respiratory Disorders
Stroke Syndrome	Stroke Syndrome	Stroke Syndrome
Asthma	Asthma	Asthma

HISTORY

Family history of medical and

Practices must submit examples to demonstrate factor if using the RRWB

PCMH 3C, Factor 9: Completed, De-identified Depression Screening

Patient Health Questionnaire (PHQ-9)

Completed Assessment

Date: 01/12/2015

Exclusions

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				

Initial diagnosis: Consider Major Depressive Disorder

Documented by:

Total score: 17

Calculate

Interpretation of total score: Moderately severe depression

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?
- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

Comments:

Characters left: 100

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Save & Close | Cancel

Patient History

Patient History | Patient Demo... | Categories

New | Lock | Search

F/U 1 month 01/12/2015 09:50 AM AMS

AWV Template
Cognitive Assessment
Chart_Note
cognitive_assessment
intake_note
Master_lm
Patient Plan
Medication
Problem
Procedure

Custom

Review | Age | Comment | Add | Edit | Remov

Review | Provider Role | specialist | specialist | Add

Comments | Review

Add | Edit | Remov

epression Screening | Total Score:

ognitive Assessment | Number Correct:

Health Assessment | Disability Index:

2/2015 | 10:14 AM

PCMH 3C, Factor 10: Example of Health Literacy Assessment Documentation

3C 10

SOCIAL HISTORY

LNA: Speaks Spanish and LNA: Speaks English. LNA: Patient has no special educational needs. LNA: Reads English. LNA: Patient admits to having barriers that may affect ability to learn. LNA: Reads Spanish and LNA: Patient prefers person to person education.

Does not live alone.

Behavioral: Tobacco use.

Alcohol: Not using alcohol.

Drug Use: Not using drugs.

Abuse and Neglect: No abuse neglect was reported.

Education: In grade 7-12 (highest level completed).

Work: No employment history, using safety equipment (I have a smoke detector), and using seatbelts.

Functional: Feeding oneself with no difficulty, no difficulty dressing, no difficulty washing, and able to do one's own shopping.

Health Literacy Score = 1: Patient never needs help reading instructions from doctor or pharmacist.

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PCMH 3D: Use Data for Population Management

At least annually practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidenced-based guidelines including:

1. At least two different preventive care services.
2. At least two different immunizations.
3. At least three different chronic or acute care services.
4. Patients not recently seen by the practice.
5. Medication monitoring or alert.

PCMH 3D: Scoring

MUST-PASS

5 Points

Scoring

- 4-5 factors = 100%
- 3 factors = 75%
- 2 factors = 50%
- 1 factor = 25%
- 0 factors = 0%

PCMH 3D: Documentation

Documentation

- F1-5:

  1) Reports or lists of patients needing services generated within 12 months prior to survey submission (Health plan data okay if 75% of patient population)

AND

  2) Materials showing how patients were notified for each service (e.g., template letter, phone call script, screen shot of e-notice).

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PCMH 3D, Factor 3 – Patients Needing Chronic Care Service

Patents with diabetes who are due for a Hemoglobin A1c test

Chronic Condition - Diabetes

Visits between 05/1/2014-05/1/2015

Provider

Diagnosis

Patient Name	MRN	Birth Date	Age	Gender
Type II or unspecified type diabetes mellitus without mention of complication, not stated as uncontrolled [250.00]				
[redacted]	[redacted]	[redacted]	74	M
[redacted]	[redacted]	[redacted]	67	M
[redacted]	[redacted]	[redacted]	52	M
[redacted]	[redacted]	[redacted]	43	F
[redacted]	[redacted]	[redacted]	69	F
[redacted]	[redacted]	[redacted]	49	F
[redacted]	[redacted]	[redacted]	56	M
[redacted]	[redacted]	[redacted]	58	M
[redacted]	[redacted]	[redacted]	59	F
[redacted]	[redacted]	[redacted]	63	M
[redacted]	[redacted]	[redacted]	67	M
[redacted]	[redacted]	[redacted]	65	M

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PCMH 3D, Factor 3 – Outreach for Chronic Care Service

May 20, 2015

[redacted]

Dear [redacted]

This letter is a reminder that your Hgb A1C test is due. Please call our office to schedule an appointment.

If you've already underwent or scheduled this test, please disregard this notice.

Sincerely,

John Smith, MD

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PCMH 3D, Factor 5: Identify and Contact Patients on Specific Medication

Report run for patients prescribed a high risk medication who were due for a follow-up visit for medication management. Staff sent reminders via mail.

Parameters: Drugs: Clobenzaprine HCL 10 MG POTABS [2017]
Date Range: 03/01/2014-03/01/2015

Patient Name	Phone Number	Patient #	Order Date	Total Days	Days Left	Letter Sent On
Patient A					210	3/08/15
Patient B					3	3/09/15
Patient C					0	3/09/15
Patient D					210	3/09/15
Patient E					30	3/09/15
Patient F					12	3/09/15
Patient G					1	3/09/15
Patient H					4	3/09/15

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PCMH 3D, Factor 5: Specific Medication Outreach

March 8, 2015

Dear Patient A,

Our records indicate that you have been prescribed a particular medication used to treat your symptoms. New information has recently been published suggesting that use of this medication should be closely monitored.

While this information is preliminary, we urge you to work with the medication's prescribing physician to best manage your condition. You and your physician should discuss the potential risks and benefits of continuing to take this medication.

Should the Food and Drug Administration (FDA) publish any specific recommendations regarding your medication or if pertinent new information about this medication becomes available, we will notify you.

If you have any questions or concerns, please don't hesitate to call.

Sincerely,
John Smith, MD

PCMH 3E: Implement Evidence-Based Decision Support

The practice implements clinical decision support+ (e.g., point of care reminders) following evidence-based guidelines for:

1. A mental health or substance use disorder.+ (CRITICAL FACTOR) ^^
2. A chronic medical condition.+
3. An acute condition.+
4. A condition related to unhealthy behaviors.+
5. Well child or adult care.+
6. Overuse/appropriateness issues.+

+Meaningful Use Modified Stage 2 Alignment (as of October 2015)

^^ PCMH PRIME Criteria (note, PRIME requires both)

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PCMH 3E: Scoring and Documentation

4 Points

Scoring

- 5-6 factors (including factor 1) = 100%
- 4 factors (including factor 1) = 75%
- 3 factors = 50%
- 1-2 factors = 25%
- 0 factors = 0%

Documentation

- F 1-6: Provide
  1) Conditions identified by the practice for each factor and
  2) Source of guidelines and
  3) At least one example of guideline implementation at the point of care

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PCMH 3E, Factor 2: Evidence-Based Guidelines

Clinically important condition #1/ Diabetes:
Screening: Based upon recommendations from the American Diabetes Association, all patients greater than 45 years of age are screened for diabetes. Patients are screened by obtaining either random blood glucose or, preferably, a fasting blood glucose. However patients at risk for developing diabetes are screened when they are < 45 years of age. These risk factors for diabetes include:

- BMI > 25
- Family history of DM
- Habitual physical inactivity
- Race- African Americans, Hispanic Americans, Asian Americans, and Pacific Islanders
- Previously identified impaired fasting BG
- BP >140/90
- HDL <35
- Polycystic ovarian disease
- History of vascular disease

Diagnosis: Based upon American Diabetes Association (ADA) recommendations, patients are diagnosed with Diabetes Mellitus if they have, on two separate occasions, a fasting blood glucose >126 mg/dL or a 2 hour postprandial blood glucose > 200mg/dL.

Treatment goals:
Based upon ADA American Association of Clinical Endocrinologist (AACE) recommendations:

1. pre meal BG <120
2. fasting BG >80, <100
3. HgBA1c <6.5%
4. BP <130/80
5. LDL <100
6. Annual eye exam
7. Routine foot exams and neuropathy screenings
8. Routine microalbuminuria screenings

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PCMH 3E, Factor 2: Example EHR Lipid Management

Lipid Management [Insert Text] Add diagnosis of HYPERLIPIDEMIA to Problem List? [Add Diagnosis]

[Most Recent Labs] [Lipid Flowsheet] [View Current Lipid Meds] [Therapeutic Recommendations]

NCEP Adult Treatment Panel III Risk Factors

Age 45 or greater	○ yes	◉ no
Early menopause w/o HRT	○ N/A	○ N/A
Diabetes	◉ yes	○ no
[?] HDL < 40 mg/dl	No Value Available	
[?] HDL > 60 mg/dl (neg. risk)	No Value Available	
FH of cardiovascular disease:		
MI in female age < 65	○ yes	○ no
MI in male age < 55	○ yes	○ no
Smoking status	○ current ○ quit	○ never
Hypertension	○ yes	○ no
ASHD (CAD) or CABG	○ yes	○ no
Stroke or TIA	○ yes	○ no
Peripheral vascular disease	◉ yes	○ no
Abdominal Aortic Aneurysm	◉ yes	○ no

Goals Automatically Calculated based on # Risk Factors

☐ Check here to manually change Lipid Goals

Goals based on CAD, PVD, CVA, TIA, or Aortic aneurysm AND diabetes, smoker, or LDL > 130, HDL < 40, and trig > 200

	Chol:	LDL:	HDL:	Trig:
Goals	200	70	40	150
Last value:	none	none	none	none
Last date:				
Next due:	Now	Now	Now	Now

[?] All lipid goals have NOT been met.

Consider checking an LDL now and annually. Consider checking an HDL now and annually. Consider checking triglycerides now and annually.

LDL cholesterol goal met ? ○ Yes ○ No

Enter Today's BP: [ ] / [ ] mm Hg

PCMH 3E, Factor 2: Example Diabetes Flow Sheet

Diabetes Flowsheet					
	Frequency				Date
History & Physical				09	
Blood Pressure	Every Visit			132/76	
Check Weight (BMI)	Every Visit		40.1	40.6	
Retinal Screening	Annually				
Inspect feet	Every Visit				
Comprehensive Lower Extremity Exam	Annually				
Dental/Oral health assessment	6 Months				
Kidney Assessment	Annually			Y	
Labs & Tests					
A1c	3 Months	7.7		7.3	
Triglycerides	Annually	218		206	
LDL	Annually	86		97	
HDL	Annually	25		35	
Total Cholesterol	Annually	147		173	
Estimated GFR	Annually	<= 60			
Medications & Immunizations					
Aspirin Use	Every Visit			Y	
Assess Need For ACE/ARB	Every Visit		Y	Y	
Assess Need For Statin	Every Visit		Y	Y	
Influenza Vaccination	Annually		Y		
Pneumococcal Vaccination	5 Years				
Lifestyle & Counseling					
Set Self-Management Goals	Every Visit		Y	Y	
Diabetes Patient Education / Nutrition / Exercise	Every Visit		Y	Y	
Tobacco Use/Exposed to 2nd hand smoke	4 Months		N	Y	
Smoking/Second Hand Smoke Counseling	Every Visit		Y	Y	
Depression / Mental Health Screening	Every Visit		Y	Y	
Review blood glucose log	Every Visit		Y	Y	

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PCMH 3E, Factor 3: Asthma Guidelines

Asthma Visit

Name: Last: First: Date of Visit: Phone #:

HISTORY	PHYSICAL EXAM
CC:	HT: _____cm/in WT: _____lb/kg
HPI:	%tile: _____ %tile: _____
	T P R BP
	Peak flow: Pox: %
ROS: trouble breathing chest tightness wheeze	GENERAL
nighttime cough daytime cough	HEENT
fever rhinorrhea URI sx	NECK
other:	HEART
Triggers: pets smoke URI dust pollen molds	ABDOMEN
weather other:	EXT
SH:	NEURO
FH:	SKIN
Meds: Acute: Chronic:	GU
Allergies:	PULM: ASTHMA SCORE: _____
Immunizations UTD: yes no	Pts. Wheeze Air Entry Acc Muscle RR 2-5yr >5yr
PMH: Illnesses:	0 end exp nl none 20-30 15-20
Hospitalizations / ER Visits:	1 exp mi dec mi rtx 31-45 21-35
PICU / Intubations:	2 insp/exp mod dec mod rtx 46-60 36-50
Followed by Allergist: Yes No	3 audible sev dec sev rtx >60 >50
	OTHER

Med	Dose	Time Given/Initials	RR	Wheeze	AirEntry	RTX	Score	Re-exam

Assessment: Asthma Controlled: Y or N Intermittent Mild Persistent Moderate Persistent Severe Persistent

Plan:

Referral: Allergy Asthma Disease Educator

Resident/Student Signature: _____ RETURN TO CLINIC in _____ days wks mos
Printed Name: _____ For _____ (indicate reason)

History reviewed (___), Patient/caretakers interviewed & examined with provider above (___), and I agree with actions:
Signature: _____ Print Name: _____

Asthma Visit Sheet Shows:

- ✓ Physical exam specific to respiratory system
- ✓ Allergies
- ✓ Immunizations
- ✓ Asthma triggers
- ✓ Peak flow
- ✓ Medication tracking
- ✓ Treatment plan
- ✓ Referral

"National Asthma Education and Prevention Program (NAEPP) guidelines are embedded in asthma visit sheet"

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PCMH 3E, Factor 4: Example Pediatric Obesity

Order Sets

Labs — Order | Browse

Description	Date	Status
TSH - Sunrise	-	Other Actions
CBC/DIFF/PLT - Sunrise	06/16/2010	Other Actions
VITAMIN D (1,25-DIHYDROXY) - Sunrise	-	Other Actions
INSULIN - Sunrise	-	Other Actions
FREE T4 - Sunrise	-	Other Actions
LIPID PANEL (AMA) - Sunrise	-	Other Actions
BASIC METABOLIC PANEL (AMA) - Sunrise	-	Other Actions
LIVER PROFILE - Sunrise	-	Other Actions
HEMOGLOBIN A1C - Sunrise	-	Other Actions

Diagnostic Imaging — Order | Browse

Description	Date	Status

Procedures — Order | Browse

Description	Date	Status

Immunizations — Order

Name	Dose	Date	Status

Smart Forms

Name

Appointments — Order

Follow-Up In: 1-3 months

Referrals — Order

Outgoing Referral for: Nutrition

Physician Education

PDF

WEB REFERENCE

Patient Education

PDF — Order

WEB REFERENCE — Order

Pediatric Obesity Order Set in EMR

Q&A

Activity 3

PCMH 4: Care Management and Support

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PCMH 4: Care Management and Support

Intent

The practice systematically identifies individual patients and plans, manages and coordinates care, based on need.

Meaningful Use Alignment

- Practice reviews and reconciles medications with patients
- Practice uses e-prescribing system
- Patient-specific education materials

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PCMH 4: Care Management and Support

20 Points

Elements

- Element A: Identify Patients for Care Management
- Element B: Care Planning and Self-Care Support
  MUST PASS
- Element C: Medication Management
- Element D: Use Electronic Prescribing
- Element E: Support Self-Care and Shared Decision-Making

PCMH 4A: Identify Patients for Care Management

The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following:

1. Behavioral health conditions. ^^
2. High cost/high utilization.
3. Poorly controlled or complex conditions.
4. Social determinants of health.
5. Referrals by outside organizations (e.g. insurers, health system, ACO), practice staff or patient/family/caregiver.
6. The practice monitors the percentage of the total patient population identified through its process and criteria. **(CRITICAL FACTOR)**

^^ PCMH PRIME Criteria

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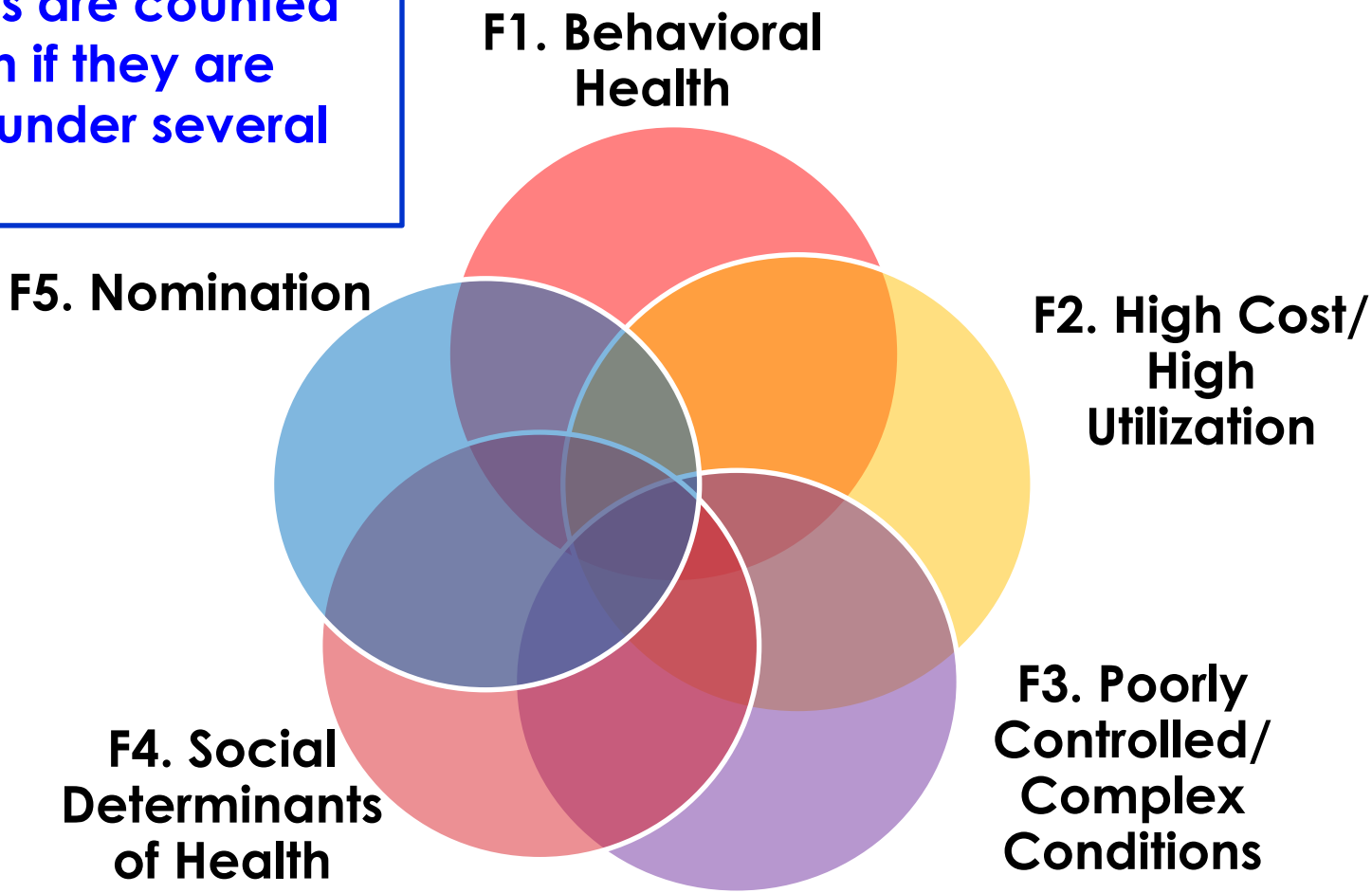
PCMH 4A: Identify Patients for Care Management

F6. Patients are counted once even if they are identified under several factors



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PCMH 4A: Identifying Patients

- **Factor 6 is critical – NO points if no monitoring**
- **Patients may "fit" more than one criterion (Factor), but may only be counted ONCE**
- **Patients may be identified through electronic systems (registries, billing, EHR), staff referrals and/or health plan data.**
- **Review comprehensive health assessment (Element 3C) as a possible method for identifying patients.**
- **Practices *do not* need to include criteria from all factors 1-5 in identifying population for factor 6**

PCMH 4A: Factors 1-6: Scenarios

- **Practice #1 identifies:**
  - all diabetic patients through problem list with:
    - recent hemoglobin over 9 or
    - with a diagnoses of depression
  - all asthmatic patients with ER visits in the last 12months
  - all patients over 90
  - any patients recognized by staff having multiple barriers of meeting their treatment plan
- **What factors are utilized by this practice for factor 6?**

PCMH 4A, Factors 1-6: Scenarios

- **Practice #2 identifies:**
  - all patients with high utilization
  - all patients with 2 or more chronic conditions
- **What factors are utilized by this practice for factor 6?**

- ***Note:*** ***Process used for identifying patients must produce enough patients for reporting and chart review in Elements 4B and 4C.***

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PCMH 4A: Scoring and Documentation

4 Points

Scoring

- 5-6 factors (including factor 6) = 100%
- 4 factors (including factor 6) = 75%
- 3 factors (including factor 6) = 50%
- 2 factors (including factor 6) = 25%
- 0-1 factors (or does not meet factor 6) = 0%

Documentation

- F1-5: Practice criteria for identifying patients for factor 6.
- F6: Report with
  - Denominator = total number of patients in the practice
  - Numerator = number of unique patients in denominator likely to benefit from care management.

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PCMH 4A, Factors 1-3: Example Criteria

S

IDENTIFICATION OF PATIENTS FOR CARE MANAGEMENT

PURPOSE: To identify patients in need of care management beyond that required generally by pediatric patients.

POLICY: Patients who require care planning/case management beyond what is required by the general pediatric population will be identified either via specific diagnosis criteria for certain disease states or more generally as "medically complex patients" through the placement of the code V49.9 (medically complex patient) on their problem list. This decision to place this code on the problem list is at the discretion of the primary care provider, but consideration should be given to the following patients:

- **Patients who are seen in an Emergency Room > 2 times in a 1 year period**
- **Patients who are followed in > 2 specialty clinics**
- **Patients who have > 3 problems identified on their problem list**
- **Patients who are eligible for RSV prophylaxis**

Factor 2

Patients identified via the above criteria who have the medically complex diagnosis code on their problem list should have a care plan completed and stored on their problem list under the medically complex problem. Care planning should include assessing the unmet needs of families including any communication/mobility aids, special equipment, respite care needs, and/or family support needs.

In addition to the patients identified via the criteria above, patients with the following disease states/severity should have the problem added to their problem list and should have a disease specific care plan completed:

- **ADHD on medication** ← **Factor 1**
- Depression (defined as PHQ-9 score >10)
- **Persistent/not well controlled asthma (defined by asthma assessment of severity/control scores)** ← **Factor 3**
- Weight management/obesity

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PCMH 4A, Factor 6: Example Report of Patients Likely to Benefit from Care Management

PCMH 4A Factor 6

Report Date: 04/12/2015

Report Date Range: Includes patients seen in the past 2 years (3/12/13-3/12-15)

ADHD Patients: Patients with ICD-9 Code 314.## on their problem list

Asthma Patients: Patients with 493.## on their problem list identified as 'persistent' OR 493.## on their problem list and currently on a controller medication.
Controller medications identified by the simple generic category (ERX 114) = 4205 (Flovent or equivalent), 60 (Qvar or equivalent), 4107 (Pulmicort or equivalent)

Med Complex Pts: Patients with ICD-9 Code V49.9 on their problem list

	ADHD Patients	Asthma Patients*	Medically Complex Patient	Patients with all 3 conditions
Unique Patients	63	104	13	0
Total Pts in Practice	1562	1562	1562	1562
Percent of Patients	**4.0%**	**6.7%**	**0.8%**	**0.00%**

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PCMH 4B: Care Planning and Self-Care Support

Care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75 percent of the patients identified in 4A.

1. Incorporates patient preferences and functional/ lifestyle goals.
2. Identifies treatment goals.
3. Assesses and addresses potential barriers to meeting goals.
4. Includes a self-management plan.
5. Is provided in writing to patient/family/caregiver.

PCMH 4B: Scoring and Documentation

Must-Pass

4 Points

Scoring

- 5 factors = 100%
- 4 factors = 75%
- 3 factors = 50%
- 1-2 factors = 25%
- 0 factors = 0%

Documentation

- F1-5:
  - ✓ Report from electronic system or
  - ✓ Record Review Workbook and 1 example for each factor
  - ✓ Report may be used to meet some factors and RRWB with examples for other factors

Record Review Workbook: 4B

4B -Care Planning and Self-Care Support				
1	2	3	4	5
Incorporates patient preferences and functional/lifestyle goals	Identifies treatment goals	Assesses and addresses potential barriers to meeting goals	Includes self-management plan	Is provided in writing to patient/family/caregiver

PCMH 4B, Factor 1: Example of Patient Functional/Lifestyle Goal

Patient Info | Chart | Document | Wed, 12/17/14

Route | Edit | Send | Open/Exit | Approve/Exit | Close/Exit | Approve/Next | Close/Next

[redacted]

Care Management Plan - 10/30/14 - CLOSED

Date Created: 10/30/2014

Date Reviewed:

(Date 1)

- [ ] No enhanced care management opportunity per practitioner
- [x] Stable/Well Managed
- [ ] Care plan reviewed, continue current treatment plan, no new interventions at this time
- [ ] Unstable

Problem	Goal	Intervention	Date Resolved
1. Chronic Condition Management- Diabetes	Pt. stated "I would like to try watching my carbohydrates" that are intaken to help manage his diabetes.	Edu: Printed Material- Gave counting carbohydrate handouts to pt. Coaching: Nutrition- Reviewed a low carbohydrate diet including portion size, choosing fresh fruits and vegetables, and choosing non starchy vegetables. Referred pt. to WebMD for more information on a low carbohydrate diet.	
2.			

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PCMH 4B, Factor 5: Care Plan Example

IOM (Institute of Medicine). 2013. Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis. Washington, DC: The National Academies Pr

¶

¶

TABLE 3-4 Example of a Written Plan for Communication

Plan component	Purpose
Name_____	Lets you personalize the plan; make a copy for medical record.
Medical Record No._____	
Date_____	
1. Diagnosis:_____	Gives the disease a name so the patient can look it up.
2. Stage (where it has spread):_____ (list all areas)	Allows discussion of prognosis. Showing metastases to the brain and liver quickly points out the seriousness of the illness.
3. Prognosis:_____ List whether curable or not curable and expected average lifespan	Ask first if patients want to know the full details of their illness! Allows open communication about goals, rest-of-life planning. Some patients will persist in denial, but this allows open dialogue with the family.

¶

PCMH 4B, Factor 5: Care Plan Example (cont.)

IOM (Institute of Medicine). 2013. Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis. Washington, DC: The National Academies Press.

4. Treatment Goals:_____ List cure, long- or short-term control, pain relief, hospice care	Makes explicit what you can and cannot do; for curable disease, this reinforces your goal, and that cure is possible. Use this to bring up do-not-resuscitate and cardiopulmonary resuscitation issues. Allows you to emphasize that hospice care does not mean "no treatment", but a different set of treatment goals.
5. Treatment Options:_____ List all that apply	List treatments, response rates, and common toxicities. Specifically mention vomiting and hair loss, the two most feared symptoms Remember, if you cannot define a real benefit then there is no justification for treatment.
6. Call the doctor if:_____ List your threshold for fever, pain, and other symptoms	Gives explicit reasons to call and gives explicit permission to call.
7. How to reach me:_____ List the phone numbers during office and off-hours	Tell patients to keep this handy. They will call, and for real events. Emails for nonemergency purposes work well for prescription refills, questions about new drugs, encouragement, etc.
8. Signed: _____MD	Personalizes the plan as well as making it a part of the medical record.

SOURCE: Adapted from Smith, T.: *J Clin Oncol* 21(9 Suppl), 2003: 12s-16s. Reprinted with permission.
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PCMH 4C: Medication Management

The practice has a process for managing medications, and systematically implements the process in the following ways:

1. Reviews and reconciles medications for more than 50 percent of patients received from care transitions.+ (CRITICAL FACTOR)
2. Reviews and reconciles medications with patients/families for more than 80 percent of care transitions.
3. Provides information about new prescriptions to more than 80 percent of patients/families/caregivers.
4. Assesses patient/family/caregiver understanding of medications for more than 50 percent of patients/families/caregivers, and dates the assessment.
5. Assesses patient response to medications and barriers to adherence for more than 50 percent of patients/families/caregivers, and dates the assessment.
6. Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients, and dates updates.

+Meaningful Use Modified Stage 2 Alignment (as of October 2015)

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PCMH 4C: Scoring and Documentation

4 Points

Scoring

- 5-6 factors (including factor 1) 100%
- 3-4 factors (including factor 1) 75%
- 2 factors (including factor 1) 50%
- 1 factor (including factor 1) 25%
- 0 factors (or does not meet factor 1) 0%

Documentation

F1-6:

- ✓ Report from electronic system or
- ✓ Record Review Workbook and 1 example for each factor is met
- ✓ Report may be used to meet some factors and RRWB with examples for other factors

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PCMH 4C: Record Review Workbook

4C - Medication Management					
1	2	3	4	5	6
Reviews and reconciles medications for more than 50 percent of patients received from care transitions.	Reviews and reconciles medications with patients/families for more than 80 percent of care transitions.	Provides information about new prescriptions to patients/families	Assesses patient/family understanding of medications for patients with date of assessment	Assesses patient response to medications and barriers to adherence for patients with date of assessment	Documents over the-counter medications, herbal therapies and supplements for patients/families. with the date of updates
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
< 30 Patients	< 30 Patients	< 30 Patients	< 30 Patients	< 30 Patients	< 30 Patients

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PCMH 4C, Factors 3 & 4: Examples of Documentation in Patient Record

PCMH 4C Factor 3

Related Goals

Do not miss more than 3 doses of controller medication per week

Need reliever medication on more than 2 times per week

Relevant Orders

Education Provided: Asthma Goal and Management Chart (Completed)

Education Provided: Krames Flovent(English) (Completed)

Referral to Pulmonary Clinic

PCMH 4C Factor 4

Asthma Triggers

Asthma Triggers: Weather changes;Indoor Allergens;Outdoor Allergens (08/28/14 1035)

Respiratory Allergy Panel completed?: No (08/28/14 1035)

Asthma Medication Assessment

Is your child on a controller medication?: No (08/28/14 1035)

Do you have any questions about your child's asthma medications?: No (08/28/14 1035)

Does your child take any over the counter medications or supplements?: No (08/28/14 1035)

How confident are you that you understand and can manage your's childs asthma?: Very confident (08/28/14 1035)

Asthma Severity - Assessment of Impairment

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PCMH 4D: Use Electronic Prescribing

The practice uses an electronic prescription system with the following capabilities:

1. More than 50 percent of eligible prescriptions written by the practice are compared to drug formularies and electronically sent to pharmacies.+
2. Enters electronic medication orders into the medical record for more than 60 percent of patients with at least one medication in their medication list.+
3. Performs patient-specific checks for drug-drug and drug-allergy interactions.+
4. Alerts prescribers to generic alternatives.

+Meaningful Use Modified Stage 2

Alignment

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PCMH 4D: Scoring and Documentation

3 Points

Scoring

- 4 factors = 100%
- 3 factors = 75%
- 2 factors = 50%
- 1 factor = 25%
- 0 factors = 0%

Factors - 1,2 may be N/A

Documentation

- F1: Report with a numerator and denominator and screenshot
- F2: Report with a numerator and denominator
- F3, 4: Screen shots demonstrating functionality

PCMH 4D: Example Electronic Prescription Writing

	Total Rx
Electronic	2,563 57%
Print then give to patient	1,419 31%
Historical	146 3%
Telephone	145 3%
Print then fax to pharmacy	89 1%
Handwritten	43 0%
Print then mail to patient	35 0%
Reprint	32 0%
Samples given to patient	2 0%
Total	4,474 100%

atients with Rx Counts: 6/3

PPC 5A - #2. Electronic prescription writer linked to patient-specific demographic and clinical information

All prescriptions (75-100% including electronic) are generated within the practice's EMR. All prescription entry is d only from within a designated Patient Chart, which includes patient-specific demographic and clinical information.

Crozer Medical As al Electric's Centricity EMR sys workflows within the EMR without leavin

Cent capability is embedded within a onality (Standard 1B).

For eRx generated received the eRx before the patient tions for Crozer Medical Associate

GE Centricity EMR Scripts clearinghouse.

Prescription Writing Activity

Electronic	57%	2563 Rx
Printed, given to patient	31%	1419 Rx
Print, fax to pharmacy	1%	89 Rx
TOTAL Rx	4474 Rx	
% E-RX	57%	
% Entered in EHR	100%	

Limitations of electronic prescribing are primarily due to restrictions for submitting Schedule 2, 3 or 4 drugs electronically and an inability to submit eRx to pharmacy benefit-managers (ex: CareMark, ExpressScripts).

As such, some Prescriptions may be marked as "Handwritten" for Schedule 2, 3, or 4 drugs depending upon the provider and the patient. Schedule 2, 3 and 4 Narcotic medications must be submitted via paper or phone. Providers will receive warning messages when trying to prescribe Narcotic Medications electronically.

All full-time Faculty and Resident physicians are registered with SureScripts for eRx.

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PCMH 4D, Factor 1: Example Prescribing Decision Support-Formulary Drug

Patient: [redacted]

Allergy » DAYPRO, VICODIN

Age: 56 yr Gender: M DOB: [redacted] Primary Physician: ID#: [redacted]

Primary Ins.: Alt ID#: Elig. Status: eRx Updated: 05/01/2008 Consent: Yes

Appts | Summary | Problems | Med List | Encounter | Active Enc | Rx | Logout

Today: [redacted]

Phone Rx on Aug 21 2008

Warnings

Warnings for olopatadine hcl ophthalmic drops 0
(Pataday, Patanol)

Off Formulary

View alternatives within the same therapeutic class

To prescribe this drug anyway, select a reason for overriding the warning (or select 'other' and type one in), then click the 'Override' button; otherwise, just click the 'Cancel' button.

- No formulary alternative exists.
- Formulary agents not optimal.
- Pt sensitive to formulary agents
- Pt stabilized on chronic therapy.
- Other

AHFS Drug Monograph | Cancel | Override | Defer

PCMH 4D, Factor 2: Example of Report for Electronic Medication Orders

Office Practicum Quality Improvement Calculator (QIC)

Reports | PCMH 2011 Custom | PCMH 2014 Custom | Database Administration

Report group: PCMH 2014 Standard 4 Provider: All or

Date range: 1/1/2015 to: 3/31/2015 Location: All or

Refresh Grid QRDA Save XML

Results Grid | Results Chart | Patient List / Description

NQF	PQRI	Measure Name	Numerator	Denominator	Exclusions	Min %	Perf %
Measure Group :							
907A		CPOE for medication orders, 2014	5,732	5,736	0	60.01%	99.93%

PCMH 4D, Factor 3: Example Drug-Drug Interactions

Drug-Drug Interactions

Drug-Drug Interactions

Drug-Drug Interactions

Drug1	Drug2	Severity	Interaction
aspirin	warfarin	Major	GENERALLY AVOID: Aspirir
fenofibrate	warfarin	Major	GENERALLY AVOID: Fibric i
fenofibrate	simvastatin	Major	GENERALLY AVOID: Severi
insulin glargine	aspirin	Moderate	MONITOR: The hypoglycem
insulin glargine	fenofibrate	Moderate	MONITOR: The hypoglycem

Allergies

Drug	Reaction

Drug-Disease Interactions

Drug Name	Condition	Severity
warfarin	Diabetes Mellitus	Severe Potential Hazard
lisinopril	Renal Dysfunction	Severe Potential Hazard
warfarin	Coagulation Defect	Severe Potential Hazard
aspirin	Renal Dysfunction	Severe Potential Hazard

aspirin - warfarin Interaction

GENERALLY AVOID: Aspirin, even in small doses, may increase the risk of bleeding in patients on oral anticoagulants by inhibiting platelet aggregation, prolonging bleeding time, and inducing gastrointestinal lesions. Analgesic/antipyretic doses of aspirin increase the risk of major bleeding more than low-dose aspirin; however bleeding has also occurred with low-dose aspirin.

MANAGEMENT: This combination, especially with analgesic/antipyretic aspirin doses, should generally be avoided unless the potential benefit outweighs the risk of bleeding. If concomitant therapy is used for additive anticoagulant effects, monitoring for excessive anticoagulation and overt and occult bleeding is recommended. The INR should be checked frequently and the dosage

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PCMH 4D, Factor 3: Example EHR Prescription Allergy

Protocols

Update Medications

Potential medication list for: **Dan Test 4**

Description	Instructions	Start Date	Last Refill
ALTACE 5 MG CAP (RAMIPRIL)	1 po qd	02/04/2004	#30 x 0 : Dawn Sanchez, LVN (11/29/
A METHABRED 125 MG SOLR (METHYLPREDNISO		05/07/2004	#0 x 0 : Dawn Sanchez, LVN (05/07/2(
			Pending

Check Medications and Allergies

Summary | Report

Interactions for **Test 4, Dan**

Show

- all
- severity at least moderate, and certainty at least suspected, and ignore food and ethanol

Description
CODEINE-GUAIFENESIN 10-100 MG/5ML SYRP note prior adverse reaction to CODEINE.

PCMH 4D, Factor 4: Example Prescribing Decision Support – Generic Alternatives

Select Rx - Pharmacy benefit Source : ARGS

Type: MultumRx | Real Time Search | Show Discontinued Drugs | Rx Eligibility

Rx: Starts With | Add to Custom | Add to ... | External Rx History | Dosage Calculator

Find

Serophene
Seroquel
Seroquel XR
Serostim

O	B	F	Name	Strength	Formulation	Take	Route	Frequency	Duration	Dispense	Refills
P	B	4	Seroquel XR	200 mg	tablet, exte	1 tab(s	orally	once a da	30 day(s	30	
P	B	4	Seroquel XR	300 mg	tablet, exte	1 tab(s	orally	once a da	30 day(s	30	
P	B	4	Seroquel XR	400 mg	tablet, exte	1 tab(s	orally	once a da	30 day(s	30	
P	B	4	Seroquel XR	50 mg	tablet, exte	1 tab(s	orally	once a da	30 day(s	30	
P	B	4	Seroquel XR	150 mg	tablet, exte	1 tab(s	orally	once a da	30 day(s	30	

Therapeutic Alternatives

Drug Name	Formulary Status
ziprasidone	Preferred Level - 2
Geodon	Preferred Level - 2
Seroquel	Preferred Level - 2
quetiapine	Preferred Level - 2

Cov Exemptions	Explanation

Payer Specified Alternatives

Alternative Drug	Formulary Desc

Generic alternatives from formulary

<< >> New

Selected Rx | Remove

	Name	Strength	For		ute	Frequen	Duratior	Dispens	Ref
	Cymbalta	30 mg	delayed re	3 cap(s)	orally	qhs	90 day(s	270	0
	promethazine	50 mg	tablet	1 tab(s)	orally	tid prn	90 day(s	270	0
	Seroquel XR	50 mg	tablet, exte	1 tab(s)	orally	qhs	90 day(s	90	0

Copay
Flat Copay Amount ($)
Copay Tier
Max Copay Tier
Days Supply/Copay
Min Copay ($)
Max Copay ($)
Copay Rate (%)
First Copay Term

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PCMH 4E: Support Self-Care and Shared Decision-Making

The practice has, and demonstrates use of, materials to support patients and families/caregivers in self-management and shared decision making.

The practice:

1. Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients.+
2. Provides educational materials and resources to patients.
3. Provides self-management tools to record self-care results.
4. Adopts shared decision-making aids.

+Meaningful Use Modified Stage 2 Alignment (as of October 2015)

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PCMH 4E: Support Self-Care and Shared Decision-Making (cont.)

5. Offers or refers patients to structured health education programs, such as group classes and support.
6. Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates.
7. Assesses usefulness of identified community resources.

PCMH 4E: Scoring and Documentation

5 Points

Scoring

- 5-7 factors = 100%
- 4 factors = 75%
- 3 factors = 50%
- 1-2 factors = 25%
- 0 factors = 0%

Documentation

- F1: Report
- F2-5: Examples of at least three examples of resource, tools, aids.
- F6: Materials demonstrating practice offers at least five resources
- F7: Materials/data collection on usefulness of referrals to community resources.

PCMH 4E, Factor 1: Example MU Report

Meaningful Use (EP) - Eligible Professional Summary

Jane Smith, CPNP
Practice A

Stage 2 Objectives (cont'd)

Reporting Period: 1/2/2015 – 3/31/2015

Menu Measures - Public Health List	Threshold	Score	
M6 / P121: Provide Patient with Educational Resources*	>10%	100% ✔	606 of 612 Patients

PCMH 4E, Factor 3: Example Self-Management Tool

Diabetes Health Record

	Frequency	Common Goals	Individual Goals	My results	My results	My results
Review blood sugar records Pre-meal target: After meal (1 to 2 hours) target:	every visit	 less than 130 less than 180				
Blood pressure	every visit	less than 140/80				
Weight (set realistic goals)	every visit					
Foot exam	every visit					
Hemoglobin A1C	every 3 to 6 months	less than 7.0				
Urine microalbumin/ creatinine ratio	yearly	less than 30				

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PCMH 4E, Factor 4: Example of a Shared Decision-Making Aid for Diabetes

Shared decision-making aids provide detailed information without advising the audience to choose one decision over the other

Other examples and more information can be found at:
http://shareddecisions.mayoclinic.org/

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PCMH 4E, Factor 5: Health Education Offered

Prenatal Care: Steps Toward a Healthy Pregnancy

Prenatal Session #1

PROGRAM: Comprehensive Perinatal Services Program TIME: 1-1 ½ Hours

OBJECTIVES

By the end of the session, the participant will be able to:

1. Identify basic anatomy of human reproductive system
2. Identify common discomforts of pregnancy including aspects of fetal growth and development.
3. Identify danger signs during pregnancy and action to take during complications.
4. Identify lab tests including the importance of ultrasound.
5. Understand the importance of Oral health during pregnancy

PCMH 4E, Factor 6: Community Resource Examples

Community Resources

Teen Pregnancy and Parenting Referral:

- Teen Pregnancy/Parenting Programs: (800) 833-6235
- Garfield Medical Center, 525 N. Garfield Ave. MP, CA (626) 573-2222 (Pico Rivera)
- USC-WCH, 1240 N. Mission Rd, Los Angeles (323) 442-1100
- San Gabriel Perinatology Center. 616 N. Garfield, Monterey Park, CA. 91754.

Medical Choice Referral:

- Health Net Member Service Department: 1-800-675-6110
- AltaMed Assistants: 1-877-GO-2-ALTA
- DPSS 1(800) 660-4066

New Immigrant Resources:

- National Hispanic Prenatal Hotline: 1-800-504-7081
- National Immigration Law Center: (213) 639-3900
- International Rescue Committee Inc (213) 386-6700

Cultural Considerations:

- Local Adult Education Classes, ELA College (323) 233-1283
- ESL Classes, L.A Unified Adult School (323) 262-5163
- Language Line Services: 1 (800) 367-9559

Parenting Stress

- Parental Stress Line Number: (800) 339-6993, or 211
- Elizabeth House: (626) 577-4434

PCMH 4E, Factor 7: Assessing Usefulness of Community Resources Example

Effectiveness/Usefulness of Community Resources - October 2014

Referral Source	# Referred	Positive Response	Negative Response	Comments
New Vision for Independence	2	2	0	"They were amazing", "I would highly recommend them"
Marion County Transit	2	2	0	"Very convenient and helpful"
Meals on Wheels	2	2	0	"Appreciate the daily contact", "The nutrition for me has been great", "The food isn't the greatest but it is a good service"
Alzheimer's Association	8	8	0	"Very helpful, especially the Respite Care Services"
COPD Support Group	2	2	0	"Useful information-helpful", "Feel better just knowing they are there if I need them"
Parkinsons Support Group	1	1	0	"Very helpful, a lot of good information"
MS Support Group	1	1	0	"Good information and good to know this is available when I need it"
Transitions	2	2	0	"Thrilled with the service of driving me shopping and to doctors appts"
Elder Options	3	3	0	"Appreciate having resources to contact when needed"
SHINE	2	2	0	

Q&A

Activity 4

Welcome to Day 2
Introduction to PCMH

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Record Review Workbook Reporting Periods

- **For PCMH 4B and 4C, practice may go back 12 months (with a 2-month grace period) from the care visit to find documentation in patient medical record**
- **Example**
  - If survey tool submitted May 31, 2014
  - Patient #1 had a care visit date on March 2, 2014.
    The practice may go back 12 months (with a 2-month grace period) to locate the data.
- **For PCMH 3C (Comprehensive Health Assessment), it is up to the practice to determine frequency of assessment using evidence-based guidelines**

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Documentation from Patient Records

Elements PCMH 4B and 4C

- Require medical record abstraction of data
- Need % of patients for each factor based on numerator and denominator

Two methods to collect and submit patient data

- Method #1 - report from the electronic system

or

- Method #2 – Record Review Workbook (RRWB)
  - ✓ Excel workbook in the Survey Tool
  - ✓ Tool to identify sample of patients and abstract data needed for Elements 4B and 4C
  - ✓ PLUS 1 example for each factor

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RRWB: Look at Instructions

Record Review Workbook (RRWB) General Instructions

Purpose of the Record Review Workbook

There are three elements in PCMH 2014 that require an accurate estimate of the percentage of patients for wh practice has documented the required information in its medical records. The RRWB calculates the data ente scores each factor based on a sample of patient records. The elements are:

PCMH 3C—Comprehensive Health Assessment:

PCMH 4B—Care Planning and Self-Care Support: Must-Pass Element

PCMH 4C—Medication Management: Factor 1 is a Critical Factor and thus required for the practice to score any points for PCMH 4C.

Refer to each element in the PCMH 2014 Standards and Guidelines for details about scoring PCMH 3C, 4B, and 4C.

There are two methods for collecting data for these elements.

Method 1. Query your electronic medical records or other electronic patient records to obtain the required information.

Method 2. Review a sample of 30 patient records to obtain the information. ***(Note: Patient records may be a registry or electronic records or paper medical records.)***

If you can use Method 1 (above) to respond to these elements, you can enter the responses directly into the Survey Tool and *you do not need to use this Record Review Workbook*. If you cannot use Method 1, you must use Method 2 to respond to these elements and must complete the RRWB. You may respond to some elements with Method 1 and others with Method 2; you may respond to some factors within an element with Method 1 and others with Method 2. If using a combination of Method 1 and 2, for factors where Method 1 is used, select "See Report" (see more below).

General Notes on the Record Review Worksheet

Entries in each worksheet cell must be made by either typing in a valid response or choosing a valid response from the cell's drop-down list. To see the drop-down list for each cell, click the down arrow that appears to the right of a cell when a cell is selected. Depending on the cell, valid responses may include the following.

Yes = Appropriate information present in the patient's medical record

No = Information not present in the patient's medical record

Not Used = Practice does not use or does not document this information in any patient medical record (i.e., 3C #3 - indicate "Not Used" if the practice does not conduct or document in the medical record communication needs.) When selecting the "Not Used" response, always select it in the first patient row in the sample (row 12). "Not Used" scores as a "no".

See Report = Practice is submitting an electronic report for documentation for this factor and is uploading it to the document library in ISS and linking to this report in the ISS survey tool. "See Report" scores as a "no" in the workbook. Only select this option if providing alternate documentation outside the workbook to meet the factor.

Not Applicable = This is one option in the drop-down menu for specific factors in Elements 3C and 4C. Please see details in the Element 3C and 4C instructions below. "Not Applicable" scores as a "yes".

The Record Review Workbook is color coded for your input as follows.

- Gray shading indicates that no input is required – you cannot enter data in these cells
- White (**or no**) shading indicates that input is required.

The RRWB is protected from inappropriate input; inappropriate entries are indicated by error messages.

Instructions | Record Review

Two Tabs:
- **Instructions**
- **Record Review**

RRWB: Overview of Steps for Method 2

1. Locate RRWB file in Survey Tool
2. Download and save file to computer
3. Review RRWB instructions (Tab1) and data needed from patient records
4. Select patient records to review
5. Review patient records for data

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RRWB: Overview of Steps for Method 2 (cont.)

6. Enter data in RRWB (Tab 2)

7. Enter Yes/No responses from RRWB in Survey Tool for Elements 4B and 4C

8. Attach RRWB to Survey Tool and link to Elements 4B and 4C and 3C

Record Review Workbook

C12

NCQA's Patient-Centered Medical Home (PCMH) 2014
Record Review Worksheet
Please read the Workbook Instructions before completing this worksheet.
IMPORTANT NOTE: Read the instructions to determine if your practice can select the "not used" option available in the drop-down boxes

Organization Name:	
Completion Date:	

Patient Number	3C - Comprehen				
	1	2	3	4	5
	Documentation of age- and gender appropriate immunizations and screenings	Family/social/cultural characteristics	Communication needs	Medical history of patient and family	Advance planning pediatric p
1					
2					
3					
4					
5					

Yes
No
Not Used
See Report

Sheet1 | Record Review

***RRWB Responses*:**
- Yes
- No
- Not Used
- See Report
- NA

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PCMH 5: Care Coordination & Care Transitions

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PCMH 5: Care Coordination and Care Transitions

Intent of Standard

- Track and follow-up on all lab and imaging results
- Track and follow-up on all important referrals
- Coordination of care patients receive from specialty care, hospitals, other facilities and community organizations

Meaningful Use Alignment

- Incorporate clinical lab test results into the medical record
- Electronically exchange clinical information with other clinicians and facilities
- Provide electronic summary of care record for referrals and care transitions

PCMH 5: Care Coordination and Care Transitions

The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations.

Elements

- PCMH5A: Test Tracking and Follow-Up
- PCMH5B: Referral Tracking and Follow-Up
  MUST PASS
- PCMH5C: Coordinate Care Transitions

PCMH 5A: Test Tracking and Follow-Up

Practice has a documented process for and demonstrates that it:

1. Tracks lab tests and flags and follows-up on overdue results – CRITICAL FACTOR
2. Tracks imaging tests and flags and follows-up on overdue results – CRITICAL FACTOR
3. Flags abnormal lab results, bringing to attention of clinician
4. Flags abnormal imaging results, bringing to attention of clinician
5. Notifies patients of normal and abnormal lab/imaging results
6. Follows up on newborn screening (NA for adults)
7. > 30% of lab orders are electronically recorded in patient record+
8. > 30% of radiology orders are electronically recorded in patient record+
9. Incorporates clinical lab test results electronically into structured fields in medical record.
10. Makes scans and test that result in an image accessible electronically.

+Meaningful Use Modified Stage 2 Alignment (as of October 2015)

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PCMH 5A, Factors 1-6: Test Tracking/ Follow-Up

Practice has documented process for and demonstrates:

1. Tracks lab test orders, flags/follows-up on overdue results – CRITICAL FACTOR
2. Tracks imaging test orders, flags/ follows-up on overdue results – CRITICAL FACTOR
3. Flags abnormal lab results
4. Flags abnormal imaging results
5. Notifies patients of normal and abnormal lab/imaging results
6. Follows up on newborn screening (NA for adults)

Documentation

F1-5:

- Documented process for staff and
- Report, log or evidence of process use with examples for each requirement in each factor

F6:

- Documented process for follow-up on newborn screenings and
- Example of process use or explanation for NA.

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PCMH 5A, Factors 7-10: Test Tracking/ Follow-up (cont.)

Practice has documented process for and demonstrates:

7. > 30% of lab orders are electronically recorded in pt. record+
8. > 30% of radiology orders are electronically recorded in pt. record+
9. Incorporates clinical lab test results electronically into structured fields in medical record.
10. Makes scans and test that result in an image accessible electronically.

+Meaningful Use Modified Stage 2 Alignment (as of October 2015)

Documentation

F 7-10:

- Practice level data or MU reports from the practice's electronic system with numerator, denominator and percent (at least 3 months of data for each factor)

F 9-10:

- Report OR example showing capability

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PCMH 5A: Scoring and Documentation

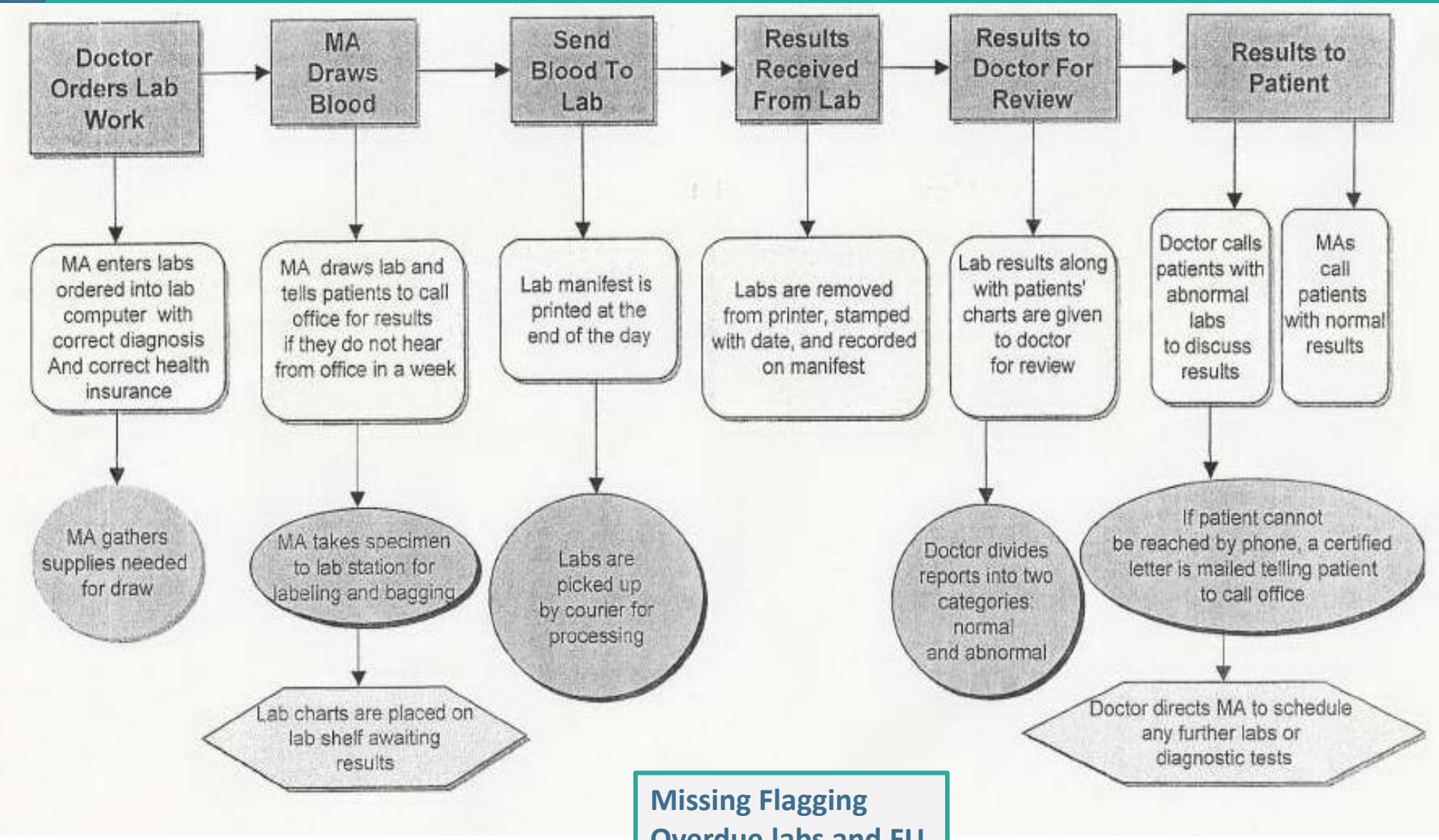
6 Points

Scoring

- 8-10 factors (including Factors 1 and 2) = 100%
- 6-7 factors (including Factors 1 and 2) = 75%
- 4-5 factors (including Factors 1 and 2) = 50%
- 3 factors (including Factors 1 and 2) = 25%
- 0-2 factors (or does not meet factors 1 and 2) = 0%

Both lab and imaging must be included in process and reports in Factors 1 and 2 to receive any score for PCMH 5A

PCMH 5A, Factors 1, 3 & 5 Lab Process

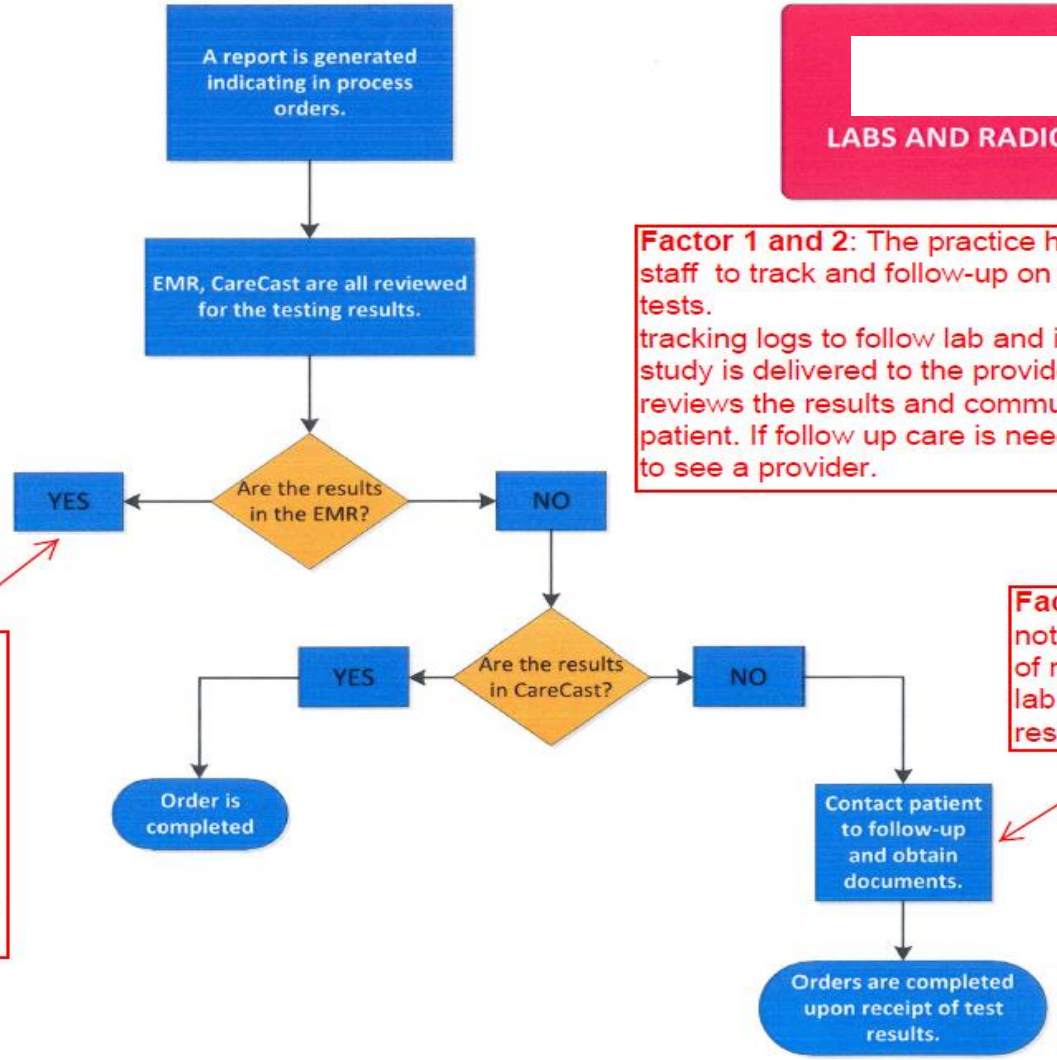


Missing Flagging
Overdue labs and FU

PCMH 5A, Factors 1&2: Documented Process

5A Cont.

LABS AND RADIOLOGY RECONCILIATION



Factor 1 and 2: The practice has a written process for staff to track and follow-up on lab tests and imaging tests. uses tracking logs to follow lab and image results. Once the study is delivered to the provider (in EMR), the provider reviews the results and communicates them to the patient. If follow up care is needed, the patient is booked to see a provider.

Factor 7 and 8: The practice electronically communicates with labs and facilities to order tests and retrieve results.

Center staff members review the Electronic Medical Record (EMR) for any lab and imaging results that were sent to patient charts.

Factor 5: The practice notifies patients/families of normal and abnormal lab and imaging test results.

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PCMH 5A: Example Test Tracking Log

Test Tracking Log

Patient Name	DOB	MR Number	Provider	Order Date	Test Ordered	In House/ Sent Out	Urgency	Date Results Received	Results 1=normal 2=abnormal	Date Results to Provider	Date Results to Patients
					throat						
					CBC/Diff						
					B12/Folate						
					HGB A1C	due 10/30					
					lipid panel						
					Iron/TIBC						
					mammography	left followup message					
					met. panel C	due 11/17					
					CK-Total	due 10/15					
					Hepatic Function						
					Met. panel B						
					urine microalbumin						
					PT INR						
					~~Thyroid profile~~						
					Thyroid profile	due 10/15					
					CXR pa/lat						
					throat						
					lipid panel						
					x-ray, KNB	completed 7/log					
					B12/Folate						
					CBC/DIFF						
					urine c/s						
					~~HGBA1C~~						
					thyroid profile						
					cardio CRP	followed up-will take					
					urine microalbumin						
					throat						
					SED Rate						

DATA COLLECTED

- ✓ Patient name
- ✓ DOB
- ✓ Provider
- ✓ Order date
- ✓ Test ordered
- ✓ Urgency
- ✓ Date results received
- ✓ Results normal/abnormal
- ✓ Date results to provider
- ✓ Date results to patient

This example shows:

Factor 3: Flag abnormal results

Factor 5: Patient notification

Factor 1: Missing Flagging and follow Up on overdue results for

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PCMH 5A, Factors 1&3 : Example Electronic Test Tracking

Date Ordered	Overdue	Abnormal	Priority	St.	Patient Name	Note	# Orders	Provider	Order Descriptions		
01/07/2009					[redacted]		3	Lowther, Kelly H	chest 2 view x-ray; CT chest with and without contrast; Ultrasound, soft tissues of he and neck (eg, thyroid, parathyroid, parotid), real time with image		
12/17/2008	Overdue				[redacted]		2	Lowther, Kelly H	Magnetic resonance imaging, spinal canal and contents, without contrast material, followed by contra; L-Spine 5 view x-ray		
01/14/2009					[redacted]		5	Lowther, Kelly H	Complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) and automated differential WBC co; Thyroid stimulating hormone (TSH); Free thyroxine (FT4); Screening mammogram; DEXA		
12/17/2008	Overdue				[redacted]		2	Lowther, Kelly H	Complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) and automated differential WBC co; Thyroid stimulating hormone (TSH)	12/17	
12/15/2008	Overdue				[redacted]		5	Lowther, Kelly H	DEXA; CBC; Thyroid stimulating hormone (TSH); ABI; Screening mammogram	01/20	
01/19/2009					[redacted]		4	Lowther, Kelly H	Free thyroxine (FT4); Thyroid stimulating hormone (TSH); Complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) and automated differential WBC co; Culture, bacterial; with isolation and presumptive identification of each isolate, urine	01/19	
12/18/2008	Overdue				[redacted]		3	Lowther, Kelly H	CT Head/Brain with & without Contrast; Complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) and automated differential WBC co; Thyroid stimulating hormone (TSH)	12/29	
01/07/2009	Overdue				[redacted]		[redacted]	Kelly H	CBC; Prothrombin time; chest 2 view x-ray	01/09	
12/22/2008	Overdue				[redacted]		3	Lowther, Kelly H	Complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) and automated differential WBC co; Thyroid stimulating hormone (TSH); Prolactin	12/22	
01/14/2009					[redacted]		5	Lowther, Kelly H	Complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) and automated differential WBC co; Thyroid	01/21/2009	01/30/2009

- ✓ All lab and imaging tests are tracked until results are available
- ✓ Overdue results are flagged
- ✓ Abnormal results are flagged

Practice tracks:

- ✓ Date ordered
- ✓ Overdue
- ✓ Abnormal
- ✓ Priority
- ✓ Patient name
- ✓ Provider
- ✓ Order description
- ✓ Last appointment
- ✓ Next appointment

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PCMH 5A, Factors 1&2: Proactive Patient Follow-Up

We hope this letter finds you in good health. Please return to the center at your earliest convenience for the blood work your physician ordered for you on 3/30/15.

Your physician would prefer you to come to the center fasting, not having eaten anything after midnight. For your convenience you may walk in between 8:30 and 4:00.

Please call with any questions or concerns. We look forward to meeting all of your healthcare need.

Sincerely,

Factor 1 and 2: The practice notifies patients/families of overdue labs and imaging tests. Here is an example of a lab letter sent to remind the patient to complete blood work ordered by his physician.

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PCMH 5A, Factors 3: Process/Flagging Abnormal Results

Patient Focused
Policy and Procedure Manual

Title: **Flagging Normal/Abnormal Lab Results**	
Author:	Date: May 23, 2012
Approve	Effective Date:
Updates	Reference Number:

Policy: Lab tests are essential in diagnosing certain cancer types, screening cancer patients for the most appropriate and effective therapy, monitoring effectiveness of and side effects from cancer therapy. Reviewing lab results in a timely manner, taking the necessary action and communicating pertinent details to the patient and family are crucial in the overall quality of care for and satisfaction of the cancer patient.

Procedure:

Normal, Abnormal, and Critical laboratory results are differentiated in the EMR by highlighting with different colors. All results are first verified by laboratory personnel before transmission into the EMR. Established reference ranges are stated in the patient chart beside the test result.

1. Results within the established reference ranges (normal) are not highlighted and remain white.
2. Results outside the established reference ranges (abnormal) are highlighted yellow.
3. Critical results are highlighted red. These results have been confirmed by the laboratory and called directly to the MD/NP/PA or RN per laboratory procedure.
4. Laboratory results are incorporated into the patient chart/EMR.
5. Laboratory results may be viewed within the patient chart where they are flagged if abnormal or critical.
6. Clinicians may view labs in the MD laboratory work list where they can be sorted and viewed by abnormal (warning) or critical (panic) results.

Responsible Parties: Medical Laboratory Technician/Technologist, Physician, Non-Physician Provider, Nursing, Medical Records, HIM, EMR

PCMH 5A, Factor 3: Flagging Abnormal Labs

Lab Results Work List

Filters | Previous Set | Next Set | Review | Add Order | Add QCL | Open Patient | Refresh (0.5m ago)

Date Range: Previous 4 Weeks; Status In:Unreviewed

PatID	Date / Time	# Results	Criticality	Ordering Physician
A120050	1/10/2013 1:59:00 PM	1	Panic	
A122927	1/14/2013 10:47:05 AM	20	Panic	
A124297	1/21/2013 2:00:34 PM	20	Panic	
A110376	1/8/2013 10:28:24 AM	16	Panic	
A090737	1/10/2013 9:50:23 AM	20	Warning	
A130200	1/18/2013 4:43:00 PM	1	Warning	
A062552	1/7/2013 11:06:54 AM	7	Warning	
A089222	1/9/2013 8:55:00 AM	20	Warning	
A092600	1/22/2013 1:44:25 PM	16	Warning	
A002553	1/10/2013 11:25:00 AM	16	Warning	
A111093	1/29/2013 9:53:48 AM	16	Warning	
A124587	1/18/2013 8:45:55 AM	20	Warning	

Warning
Panic
(Custom)
(Blanks)
(Non blanks)
Panic
Warning

PCMH 5A, Factor 5: Abnormal Lab Notification

Summary | History | Problems | Medications | Alerts/Flags | Flowsheet | Orders | Documents

Alerts(0)/Flags(0) Drug interactions Group By Da

Lab Result

Date	Summary	Location	Status
07/08/2013 11:05 AM	Lab Rpt: BASIC METAB PANEL	AC	Signed
07/03/2013 1:02 PM	Ofc Visit: Internal Medicine visit Follow up (	AC	Signed
07/02/2013 5:28 PM	Phone: Prescription for needles	AC	Signed
06/25/2013 9:56 AM	Phone: Other Incoming	AC	Signed
06/25/2013 9:06 AM	Phone: Outgoing Call	AC	Signed
06/25/2013 9:05 AM	Phone: Outgoing Call	AC	Signed
06/24/2013 11:21 AM	Lab Rpt: HEMOGLOBIN A1C	AC	Signed
06/24/2013 11:21 AM	Lab Rpt: LIPID PROFILE	AC	Signed
06/24/2013 11:21 AM	Lab Rpt: LIVER TESTS	AC	Signed
06/24/2013 11:21 AM	Lab Rpt: BASIC METAB PANEL	AC	Signed
06/24/2013 11:21 AM	Lab Rpt: CBC	AC	Signed
06/21/2013 3:19 PM	Ofc Visit: Internal Medicine visit Follow up (	AC	Signed

Factor 1, 5, and 7: The testing facility sent all test results for this patient directly to EMR. The practice then executed multiple attempts to reach the patient to schedule the appropriate follow-up based on the abnormal potassium lab results present in the patient's 06/24/2013 blood work. Patient was scheduled for a follow-up office visit with her PCP on 07/03/2013.

at MAC on 06/25/2013 9:05 AM by Selina Zaman, MD

Phone Note

Outgoing Call

Call back at Home Phone

Call placed by

Summary of Call: pt is called in moltiple numbers several times , no one picked up.

Factor 1 and 5: The PCP attempts to contact the patient following abnormal lab report results.

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PCMH 5A, Factor 5: Normal Lab Notification

I am witting to inform you that your lab work was normal.

Please call us at if you would like to go over the test results or if you have additional questions or concerns.

Thank you for allowing us to participate in your care and we look forward to seeing you at your next visit.

Factor 5: The practice notifies patients/families of normal and abnormal lab and imaging test results. Here is an example of lab letter sent to a patient stating that her lab work was normal.

PCMH 5A, Factor 6 Example: Follow-Up on Newborn Screening

SnapShot
Chart Review
Results Review
MyChart Results Rel...
Flowsheets
Graphs
Growth Chart
Problem List
History
Demographics
Allergies
Medications
Health Maintena...
CCF Images
Letters
Scanned Documents
Document List
Order Entry
Imm/Injections
Forms
Episodes of Care
Doc Flowsheets
Visit Navigator
Hotkey List
Exit Workspace

Health Maintenance Close

Override | Cancel | Edit Modifiers | Report

	Due Date	Procedure	Date Satis
	12/21/2009	DPT (#1)	
	10/21/2009	HEPATITIS B (#1)	
	12/21/2009	HIB 3 DOSE REGIMEN (#1)	
	12/21/2009	IPV (#1)	
	11/21/2009	NEONATAL SCREENING HEARING	
	11/21/2009	NEONATAL SCREENING METABOLIC	
	12/21/2009	PNEUMOCCAL VACCINE (#1)	
	12/21/2009	ROTAVIRUS 3 DOSE VACCINE,NOT TO START	

Health Maintenance Modifiers

Neonatal Hearing Screen Normal
Neonatal Metabolic Screen Normal

Procedure Overdue | Procedure Due On | Procedure Due Soon

Patient Modifiers Edit Modifiers

Related Plans

Abbreviations for Override Types

TOP
COLONOSCOPY Colonoscopy (ENTE
COLONOSCOPY Colonoscopy - High I
ColonoscopyN Colonoscopy - Not H

Use this activity to personalize the preventive care and disease management rules for this patient

Start | Inbo... | Cale... | Curr... | Prod... | RE: ... | Epic Hyp... | Micr... | 4:18 PM

Documentation required

- **Documented** process for follow-up on newborn **hearing** tests/blood spot screening.
- Example

NA for adult only practices.

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PCMH 5A, Factors 7&8: MU Report

Meaningful Use Stage 2 Dashboard Summary

Stage 2 Meaningful Use

CMS EHR Certification ID

If the provider used v20.0 for the entire reporting period: 1314E01OSWZQEAV

If the provider used v20.0 for part of the reporting period and v20.1 for part of the reporting period: 1314E01PNGYWEAP

If the provider used v20.1 for the entire reporting period: 1314E01PM3YBEA1

PCMH 5C7-8: Percentage of lab and radiology orders electronically recorded for a three month period from 1/12/2015-3/12/2015.

	Numerator	Denominator	Achieved	Required
C1: CPOE for Meds, Labs, and Radiology Orders				
Meds	551	592	93.07%	60%
Labs	253	256	98.83%	30%
Radiology	37	38	97.37%	30%
C2: e-Prescribing (eRx)	1057	1662	63.60%	50%
C3: Record Demographics	589	590	99.83%	80%
C4: Record Vital Signs	589	590	99.83%	80%
C5: Record Smoking Status	515	516	99.81%	80%
C6: Clinical Decision Support Rule				
Implement 5 CDS Rules			Met	
Implement Drug/Allergy checking			Met	
C7: Patient Electronic Access / View, Download, Transmit				
Patients seen with portal access	524	590	88.81%	50%
Patients seen who used portal	100	590	16.95%	5%
C8: Clinical Summaries	502	624	80.45%	50%
C9: Protect Electronic Health Information			Met	

PCMH 5A, Factors 9&10: MU Report

Print | Run Reports | New Triage

Meaningful Use Stage 2 Dashboard Summary

Stage 2 Meaningful Use

CMS EHR Certification ID

If the provider used v20.0 for the entire reporting period: 1314E01OSWZQEAV

If the provider used v20.0 for part of the reporting period and v20.1 for part of the reporting period: 1314E01PNGYWEAP

If the provider used v20.1 for the entire reporting period: 1314E01PM3YBEA1

	Numerator	Denominator	Achieved	Required
C9: Protect Electronic Health Information			Met	
C10: Clinical Lab-Test Results	5174	5267	98.23%	55%
C11: Patient Lists			Met	
C12: Preventive Care / Patient Reminders	184	2019	9.11%	10%
C13: Patient-Specific Education Resources	548	572	95.80%	10%
C14: Medication Reconciliation	14	16	87.50%	50%
C15: Summary of Care				
Summary of care provided	200	284	70.42%	50%
Sent electronically	95	284	33.45%	
Exchange of data			Met	
C16: Immunization Registries Data Submission			Met	
C17: Use Secure Electronic Messaging	33	590	5.59%	
M1: Capability to submit electronic syndromic surveillance data			Not Met	
M2: Record electronic notes in patient records	572	572	100.00%	
M3: Imaging results			Met	
M4: Record patient family health history as structured data	585	590	99.15%	20%

PCMH 5C9-10: Percentage of electronically incorporated lab results, and met the 10% threshold for imaging results available electronically.

Need at least 3 months of data in a report with numerator, denominator and percentage results

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PCMH 5B: Referral Tracking & Follow-Up

The Practice:

1. Considers available performance info on consultant/ specialists for referral recommendations
2. Maintains formal and informal agreements with subset of specialists based on established criteria
3. Maintains agreements with behavioral healthcare providers^^
4. Integrates behavioral healthcare providers within the practice site^^
5. Gives the consultant/specialist the clinical question, required timing and type of referral

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PCMH 5B:Referral Tracking & Follow-Up (cont)

6. Gives the consultant/specialist pertinent demographic and clinical data, including test results and current care plan
7. Has capacity for electronic exchange of key clinical information and provides electronic summary of care record to another provider for >10% of referrals+
8. Tracks referrals until consultant/specialist report is available, flagging and following up on overdue reports (Critical Factor) ^^
9. Documents co-management arrangements in patient's medical record
10. Asks patients/families about self-referrals and requests reports from clinicians

+Meaningful Use Modified Stage 2 Alignment (as of October 2015)

^^PCMH PRIME Criteria

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PCMH 5B: Referral Tracking & Follow-Up

Practice tracks referrals:

1. Considers performance info. when making referral recommendations
2. Maintains agreement w/subset of specialist w/established criteria
3. Maintains agreements w/behavioral health providers
4. Integrates behavioral health within the practice site
5. Gives the specialist the clinical question, type and required timing for referral.

Documentation:

- **F1**: Examples of types of info the practice has on specialist performance
- **F2-3**: At least one example for each factor
- **F4**: Materials explaining how BH is integrated with physical health
- **F5**: Documented process ***and*** at least one example or report demonstrating process implementation

(cont.)

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PCMH 5B: Referral Tracking/Follow-Up (cont.)

Practice tracks referrals:

6. Gives the specialist pertinent demographic & clinical data, test results & current care plan
7. Capacity for electronic exchange of key clinical info & provides electronic summary of care record to another provider > 10 % of referrals+
8. Tracks referrals for receipt of report, flags, and follows up on overdue reports (Critical Factor)
9. Documents co-management arrangements in patient medical record
10. Asks patients/families about self-referrals and requests reports from clinicians.

+Meaningful Use Modified Stage 2 Alignment (as of October 2015)

Documentation

F6&8: Documented process ***and*** at least one example or report demonstrating process implementation

F7: Report from electronic system with numerator, denominator and percent (at least 3 months of data)

F9&10: At least three examples

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PCMH 5B: Scoring

MUST-PASS

6 Points

Scoring

- 9-10 factors (including factor 8) = 100%
- 7-8 factors (including factor 8) = 75%
- 4-6 factors (including factor 8) = 50%
- 2-3 factors (including factor 8) = 25%
- 0-1 factors (or does not meet factor 8) = 0%

NOTE: Critical Factors in a Must Pass element are essential for Recognition.

Factor 8 must be met to receive any score for PCMH 5B.

PCMH 5B, Factor 1: Performance of Specialists/Consultants

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A field with an asterisk (*) is required.

* Location

ZIP Code/City, State/Address/Landmark

* What are you searching for?

Doctor Last Name or Specialty or Medical Condition

Search

Additional Search Options

PCMH 5B, Factor 1: Performance of Specialists/Consultants

NCQA RECOGNITION DIRECTORY

CLINICIAN SEARCH HOME

Clinician Search Results

New Search

Search results: (1 - 50) of 300

Clinician / Site	Address	Current Recognitions	Recognition Program(s)
Agostino DO, Nicole Marie	**Hematology Oncology Associates** Morgan Cancer Center, 1240 S. Cedar Crest Blvd. Allentown, PA 18103	PCSP Level2 (03/12/2014 - 03/12/2017)	
Aires MD, Daniel J	**The University of Kansas Physicians - Department of Internal Medicine** 3901 Rainbow Blvd, MS1044 Kansas City, KS 66160	PCSP Level3 (03/10/2014 - 03/10/2017)	
Ajam MD, Ali	**OSU Rheumatology-CarePoint East** 543 Taylor Ave Suite 3084 Columbus, OH 43203	PCSP Level3 (03/17/2014 - 03/17/2017)	
Alexander MD, Chacko	**Woodlands North Houston Heart Center** 17350 St. Lukes Way, Suite 400 The Woodlands, TX 77384	HSRP (04/09/2013 - 04/09/2016) PCSP Level3 (04/06/2014 - 04/06/2017)	

PCMH 5B, Factor 2 Example Agreement

Referring Provider – Cardiology Patient Referral Understanding 2013

Mutually agreed upon expectations outlined for Referring Providers and Cardiologists Medical Group.

When receiving a referral the following are standard expectations of information required by the Cardiology Department (to be made available by the referring provider):

- Diagnosis - why patient is being referred / what question is being asked
- Patient Demographics (insurance, address, dob, etc)
- Pertinent clinical data - Lab results, radiology reports, prior procedures, prior meds etc.

When requesting a referral the following are standard expectations as to what will be provided by the Cardiology Department:

- Timely access for the referred patients [per below unless referring provider or patient specifies otherwise]:
  - Procedure (positive stress test etc.) – appointment (appt.) within 1-2 weeks
  - Cardiology high risk – within 1-2 weeks, as per referring provider (New onset –Fib, SVT, VT or complete heart block etc)
  - Cardiology low risk – referring provider specifies time frame / urgency of appt.
- Consult notes timely
  - Notes to referring provider within a week (available through EMR) will include
    - diagnosis / answer to the referring provider's questions
    - specialist's plan of care, care management, any patient education or secondary referrals
  - Cardiologist to call referring provider sooner if there is a critical issue
- Lab, procedure and other test results cc'd to Referring Provider
  - Available to view through EMR
- Communication regarding who is going to implement plan / manage follow-up
  - It is assumed that the Cardiologist will manage the patient for the associated diagnosis, both to implement a treatment plan and manage future follow-up.
  - It is the Cardiologist's responsibility to specifically notify the referring provider if the referring provider will be responsible for future follow-up.
  - It is the Cardiologist's responsibility to communicate with the patient regarding diagnosis and required follow-up care.

Mutual Expectations as to what Patient / Family / Caregiver can expect for care coordination:

Patients are expected to sign up for a account in order to better facilitate communication.

- Specialist will discuss plan of care with patient at time of visit, and will provide patient with written copy after visit is completed (After Visit Summary- either printed or electronically via
- Specialist will follow up with patient
  - at follow up appt
  - electronically via (labs are auto-released within 96 hours)
  - via telephone if necessary

Other Special Coordination Issues

- Hospice management – Specifically need to address this on a per-patient basis; often is clarified on the Hospice form (patient designates physician when signing up with Hospice)

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PCMH 5B, Factor 2: Co-Management

Procedure: Strategy of Co-Management with Primary Care and Rheumatology. Intent is to specify the components of care that will be managed by Rheumatology and what will be managed by Primary Care or when transition of care is needed.

- Areas managed by Rheumatology
  - Active management of immunologicmodulator agents (including but not limited to steroids and and biologic infusions)
  - Ongoing lab monitoring pertinent to Rheumatology
    - Blood Count
    - Liver monitoring
    - Kidney monitoring
  - Communication of results of tests ordered by Rheumatology
  - Letter to be sent to Primary Care when care is transitioned back to PCP summarizing the issues, results and recommended plan of care

- Areas managed by Primary Care or referring provider
  - Address all age appropriate preventive screening and Immunizations
  - Evaluation and management of chronic care of patients current problem list
    - Plan of care, medications, tests and imaging and monitoring lab results

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PCMH 5B, Factors 3 & 4: Example Integrating Primary Care & Behavioral Health

TABLE 3: COLLABORATIVE CARE CATEGORIZATIONS AT A GLANCE

COORDINATED	CO-LOCATED	INTEGRATED
• Routine screening for behavioral health problems conducted in primary care setting • Referral relationship between primary care and behavioral health settings • Routine exchange of information between both treatment settings to bridge cultural differences	• Medical services and behavioral health services located in the same facility • Referral process for medical cases to be seen by behavioral specialists • Enhanced informal communication between the primary care provider and the behavioral health provider due to proximity	• Medical services and behavioral health services located either in the same facility or in separate locations • One treatment plan with behavioral and medical elements • Typically, a team working together to deliver care, using a prearranged protocol

(continued)

TABLE 3 *(CONTINUED)*

COORDINATED	CO-LOCATED	INTEGRATED
• Primary care provider to deliver behavioral health interventions using brief algorithms • Connections made between the patient and resources in the community	• Consultation between the behavioral health and medical providers to increase the skills of both groups • Increase in the level and quality of behavioral health services offered • Significant reduction of "no-shows" for behavioral health treatment	• Teams composed of a physician and one or more of the following: physician's assistant, nurse practitioner, nurse, case manager, family advocate, behavioral health therapist • Use of a database to track the care of patients who are screened into behavioral health services

Source: Adapted from Blount 2003.

Documentation Required: (Factor 3) One BH Agreement & (Factor 4) Explanation of BH integration into the practice site.

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PCMH 5B, Factor 5 Clinical Reason/Type/ Timing

Report Viewer

Report History | 1 View Pane 1 | 2 View Pane 2 | Split Up/Down | Split Left/Right | Detach Window

1 09/04/2013 AMB REFERRAL TO CARDIOLOGY

Back

Order

AMB REFERRAL TO CARDIOLOGY [112REF] (Or

AMB REFERRAL TO CARDIOLOGY

Status: MyBMGChart: **Not Released** Next appt with me: **6/30/14** Dx: **Paroxysmal**

Order Details | View Encounter | Lab and Collection Details | Routing | Result History

Associated Diagnoses

Paroxysmal atrial fibrillation - Primary

PCSP 2.A. diagnosis

Comments

Pt should have appt within 1-2 months for Consult for second opinion

reason for referral and expected timeframe

Additional Information

Associated Reports

View Encounter

Priority and Order Details

View encounter takes you to the encounter associated with this order - includes all details

Referral Information

Referral ID	Referred By	Referred To
446179		

Referring provider

Specialist

Visits	Status	Start Date	End Date
99	New Request	9/4/13	Not Available

If your referral has a status of pending review or denied, additional information will be sent to support the outcome of this decision.

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PCMH 5B, Factors 5 & 6: Documented Process

Procedure: Criteria for informal agreements with Specialty providers. PCP will coordinate care with Specialty provider through electronic medical record and facsimile. Effective January 1, 2014

Criteria for Informal Agreements between Primary Care/ referring clinician and Specialist (5B5)	
Access • Referral to specialist based on urgency ➢ Routine- within 2 weeks ➢ Urgent within 48 hours ➢ Stat within 24 hours • Work specialist to expedite care in urgent cases • Verify insurance status • Anticipate special needs of patient/family • Agree to engage/consult with specialist regarding a pre-referral consult if requested. **Communication to Specialist Clinician** Notify when appointment is scheduled through electronic medical record and external referral form. • Request that specialist office send report back to PCP after the appointment based on nature of the illness and urgency • Routine- within 2 weeks pending test results (1A3) • Urgent within 24-48 hours • Stat- immediately • Consult letter can be communicated by EMR ,Fax, or mail if electronic option is not available	**Access** • Referral request should identify urgency of referral ➢ Routine ➢ Urgent ➢ Stat **Communication (Referral from) (5B5)** • State the clinical Question and type of referral request • Identify Type of referral request ➢ Consult only (address clinical question and send report back) and referring clinician will follow up with needed tests ➢ Consult and Treat- (address clinical question and follow up with appropriate plan of care and treatment) ➢ Transfer of care (Comprehensive care for all patient needs is transferred to the specialist) • Provide patient demographics; clinical information (allergies, problem list, medications) • Send current primary practice care plan/clinical summary(Treatment, tests, procedures- to avoid duplication • Expectation that communication back to patient on treatment options and test results **if consult only**

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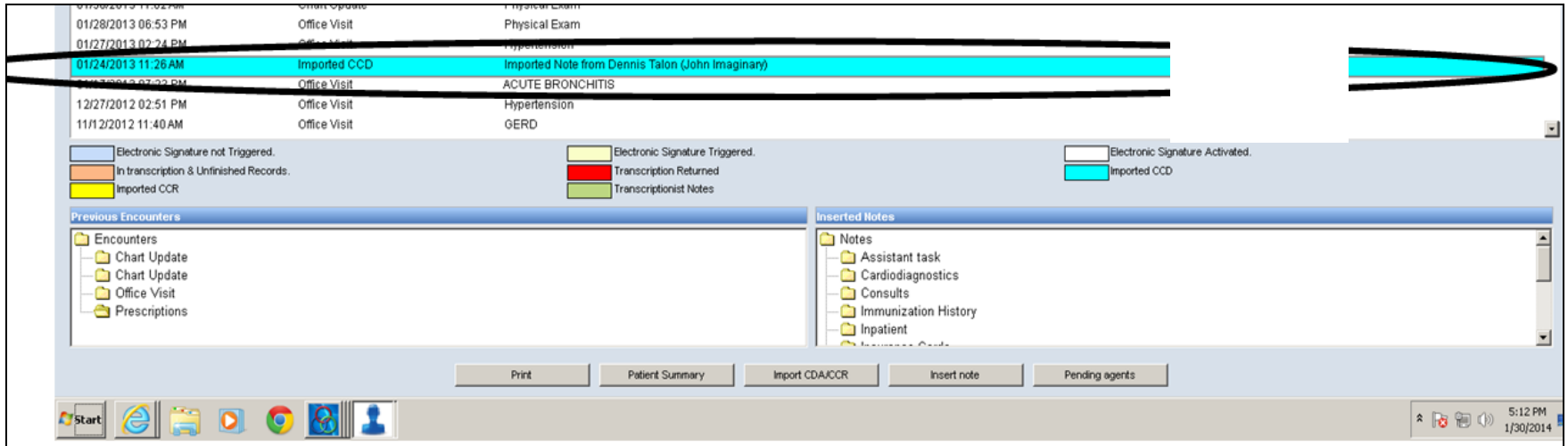
PCMH 5B, Factor 7 & PCMH 5C, Factor 7: Example



This screen shot shows the capability of our EHR to exchange key clinical information electronically. Above shows how the imported information appears in the patient chart.

5B-7 Report showing the Transition of Care give to outside provider for referrals for all providers over the last year.

Outbound Transfer of Care		
2/28/2013-2/28/2014		
Factor 7 (CMU 8)	N-2102	59.7%
	D-3523	

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PCMH 5B, Factor 8: Referral Process/ Flow Chart

Factor 1: workflow for communicating high risk referral information to the specialist. The PCP notes the reason for the high risk (HR) referral, relevant clinical information, and purpose of the referral. Also see below WACC's HR tracking report, which highlights the reason and nature of the referral (HR), relevant clinical information which is communicated between PCPs and specialists in our EMR, and HR follow up details.

Center
High Risk Referral Tracking Workflow

The PCP/Box Buddy places a high risk referral in the EMR

The Specialist is In-house

NO

The information is given to the patient to make the appointment

YES

Patient makes appointment at the window or the "hub"

Referral Coordinator is a staff member whose sole responsibility is to facilitate patient appointments with specialists to whom they were referred by the PCP, track referrals over time to ensure that the patient was seen and received treatment, obtain specialist report, and facilitate scheduling the patient for a follow-up visit with the PCP.

The RC (Referral Coordinator) determines that the patient has not kept the appointment.

Factor 2: The referral tracking system includes the date when the referral was initiated and the timing indicated for receiving the report.

The RC uses the tracking log to record the date of the initial order, the date of the appointment.

The RC contacts the patient to assist in scheduling the appointment or re-scheduling the appointment

A confirmation letter is sent and the interaction is documented in the EMR via an administrative comments

If the patient misses the re-scheduled appointment, the RC alerts the PCP via flag and verbal notification for next steps

Factor 3 process for contacting specialist's office to confirm patient was seen. This process is documented in the EMR and in the referral tracking log.

The RC asks the patient to re-schedule the appoint or re-schedules the appointment for the patient

The RC sends a confirmation follow-up certified letter and documents all attempts in administrative comments of the order

Finally, if the patient misses this appointment the RC will send a flag or speak to the PCP and document the final decision in the administrative comments of the order.

Notes:

- The referral Coordinator (RC) receives the high- risk referral tracking report (RTR) for each day.
- When the RC finds a specialist encounter note within the patients EMR in internal medicine, the RC will mark it as complete and route to PCP. In PEDS the RC will route to PCP for signature first, then complete.
- The RC receives the report via mail or Fax. The report is given to the PCP and the order is completed.

Factor 3: process for reviewing the consult report, once received from the specialist.

Revised 11/2013

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PCMH 5B, Factor 8: Example Referral Tracking Report

REFERRING DR	REF DATE	PATIENT NAME/ DOB	FACILITY/ PHYSICIAN	DIAGNOSIS/ REASON FOR REFERRAL	APPT DATE	INS. INFO./ PRE-AUTHOR., IF NEEDED	STAT	RCVD. REPORT	REPORT OVERDUE	PERSON & DATE NOTIF. PT.
[redacted]	5/16/2015	[redacted]	Diagnostic Imaging	Abd. pain; abdomen. Sono.	5/19/2015	[redacted] HEALTH PLAN – got pre-author.	No	6/15/2015		7
[redacted]	5/16/2015	[redacted]	PT and Rehab	Knee pain – eval. and treat.	TBD	[redacted] HEALTH PLAN – got pre-author.	No		YES	
[redacted]	6/22/2015	[redacted]	[redacted] orthopedist	Suspect torn ACL – eval and treat.	6/24/2015	[redacted] – no pre-author. needed	Yes			

Tracking Table Includes:

- ✓ **Reason for referral**
- ✓ **Purpose of referral**
- ✓ **Date referral initiated**
- ✓ **Timing to receive report**

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PCMH 5B, Factor 9: Co-Management Documentation

Procedures:

We are happy to be part of your medical team. For most people, their primary care practice is the hub of their care. We will communicate with your primary care practice about your medical care in our practice so that your care is coordinated. We will send a report after each visit and if needed call your primary care team to coordinate testing and treatments. We will also work with and coordinate with your other specialists by providing a copy of your visit report to them or calling them if needed.

We specialize in ENDOCRINOLOGY. You have been referred here for SHARED CO-MANAGEMENT. Both your primary care doctor and our practice will work together with you to help follow and/or treat a condition with most of the testing and appointments with your primary care doctor but with an

Print | Fax | Record | Lock | Details | Scan | Templates | Claim | Letters | Ink

PCMH 5B: Factor 10 Documented Process

Patient Self-Referrals and Capturing Other Healthcare Professionals Process

(Revised 1/15/2015)

Purpose: In order to provide the most comprehensive information about our patients and manage their complete healthcare, ABC Health records the name and contact information of the other healthcare clinician providing care, within the patient's medical record.

Process:

1. As part of the new patient enrollment process, patients complete a New Patient Form which asks Name, Specialty (if applicable), city/state of practice and phone number of any current primary or specialty care providers that are currently providing care. This information is placed into the EMR and reviewed/confirmed with patient at the first visit.

The information is documented in the EMR, as follows:

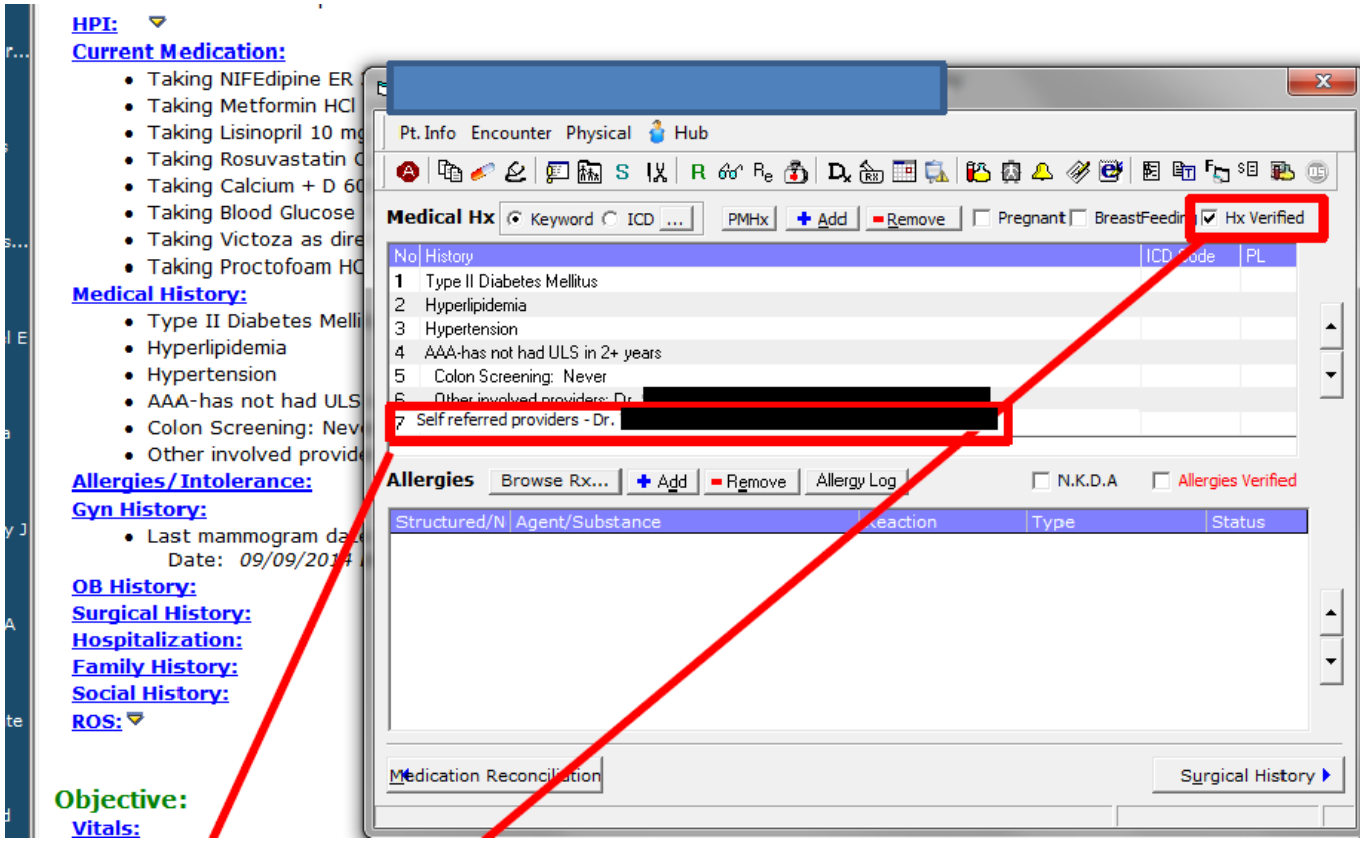
a. In Progress note, under Medical History, select Keyword ellipses.

b. From list on left, then select Other Involved Providers to pull over to Selected Medical History on right

c. Click OK, then document complete information regarding Provider by free texting after Other Involved Providers.

2. As other specialists/providers are involved in the ongoing care of our patient, their information is added.
3. Information of "Other Involved Providers" is reviewed and updated at each subsequent routine patient visit.
4. At each routine visit "Medical History" is brought over into Medical Record, all Medical History if reviewed including information regarding Other Involved Providers as well as patient self-referrals is asked and updated in Medical Record
5. History verified box is checked after confirmation of information with patient
6. If patient reports self-referral, any reports are requested from those specialist clinicians listed

PCMH 5B: Factor 10 Example



5B10: Screenshot of self-referral information asked and verified in EMR with each routine visit.

PCMH 5C: Coordinate Care Transitions

The Practice:

1. Proactively identifies patients with unplanned admissions **and** ED visits
2. Shares clinical information with admitting hospitals/ED
3. Consistently obtains patient discharge summaries
4. Proactively contacts patients/families for follow-up care after discharge from hospital/ED w/in appropriate period
5. Exchanges patient information with hospital during hospitalization
6. Obtains proper consent for release of information and has process for secure exchange of info & coordination of care w/community partners
7. Exchanges key clinical information with facilities and provides electronic summary of care for >10% of patient transitions of care**+** (NA response requires a written explanation)

+Meaningful Use Modified Stage 2 Alignment (as of October 2015)

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PCMH 5C: Scoring and Documentation

6 Points

Scoring

- 7 factors = 100%
- 5-6 factors = 75%
- 3-4 factors = 50%
- 1-2 factor = 25%
- 0 factors = 0%

PCMH 5C, Factors 1-7: Coordinate Care Transitions

Documentation

- F1-6: Documented process to identify patients

  and

  - F1: Log or report.
  - F2: Three examples for each factor.
  - F3: Three examples of discharge summary
  - F4: Three examples of patient follow-up or log documenting systematic follow-up
  - F5: One example of 2 way communication.
- F7: Report with numerator, denominator and percent with at least 3 months of data. If practice does not transfer patients to another facility, it may select N/A and provide a written explanation.

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PCMH 5C, Factors 1-4 Documented Process

Effective Date 6/1/14

Procedure:

5C-1
- Hospital census is obtained daily by fax or from an offsite electronic Health Information System from local hospitals by the Care Coordinator or Nurse Care Manager.

5C-2
- Communication with local hospitals is completed daily.

5C-3
- Discharge records are faxed to the CHCCM from the hospital or pulled from an offsite Health Information System by the Care Coordinator or Nurse Care Manager.

5C-2
- Local hospitals are contacted if additional information is needed.
- After thorough review and obtaining hospital records the Care Coordinator will give the daily census to the Nurse Care Manager for review.
- Nurse Care Manager will be responsible for assuring the medical records were received and scanned into the chart.

5C-4
- Nurse Care Manager or Care Coordinator (if designated) will be responsible for contacting patient's that were admitted and discharged from the hospital within 72 hours to ensure medications and allergies are reconciled in the patient's chart, schedule follow up appointment's if needed and obtain additional information as needed.

PCMH 5C, Factor 1: Identifying Patients in Facilities

MR #: AM03022[redacted]0142437

PT: [redacted]
DOB: [redacted]
UNIT #: AM03022153
REPORT #: 0219-1269

ADM: 02/17/09
LOC: AV2WA (DIS IN)
ACCOUNT #: A&0000142437

HISTORY AND PHYSICAL REPORT
Signed

DATE OF ADMISSION: [redacted]09

CHIEF COMPLAINT: Right upper quadrant abdominal pain.

HISTORY OF PRESENT ILLNESS: The patient is a 62-year-old male who was admitted on February 17, 2009 for some epigastric and right upper quadrant pain that was intermittent. At that time evaluation included blood work showing minimal transaminase elevation and CT scan showing

Practice receives admission reports electronically from hospital

PCMH 5C, Factor 1: Example Documentation

Facility: Patient Type: Edit Preference Status: Active

Census Type: Refresh Data Monitor

Patients (26)

Use Selected | Use All | Add To Patient List | Remove | Remove from Group | Hide | Print Selected | Print A

✓	Pat. Name ▲	Admission Date	Sex	Age	Location	Relationship	Admitting Diagnosis
☐ ⊕	[redacted]		M	65 Y	32-3207-D	Group	HYPOGLYCEMIA
☐ ⊕	[redacted]		F	57 Y	32-3221-W	Group	ACUTE MYLEOD LEUKEMIA SEVERE NEUROPATHY
☐ ⊕	[redacted]		M	80 Y	25-2509-D	Group	ANEMIA FATIGUE RENAL INSUF
☐ ⊕	[redacted]		F	84 Y	32-3201-P	Group	LYMPHOMA
☐ ⊕	[redacted]		F	59 Y	15-1521-W	Group	HEPATIC ENCEPHALOPATHY
☐ ⊕	[redacted]		M	90 Y	32-3204-P	Group	LEUKEMIA PNEUMONIA
☐ ⊕	[redacted]		F	86 Y	34-3411-P	Group	PERFORATED ULCER

PCMH 5C, Factor 1: Example ER Visit Follow-Up Log

Date of ER Visit	Diagnosis	Follow up call	Follow up appointment
	SOB	We admitted pt	Pt has problems with providing care for his wife.
	Cath drop	Yes	no f/u necessary
	Fever dialysis pt	F/u to specialist	no f/u with us
	Injured L. Hand	no f/u necessary	
	Diarrhea,fever, vomiting	Told to go to ER	Pt told to go to Er by us
	Flu	F/u scheduled	
	Leg Bleed	F/u scheduled	
	Dialysis Pt C/p		Pt referred to pt assist for meds
	Blood Test	F/u scheduled	
	Sodium Level Dropped Ams	f/u scheduled	
	Chest Pain	Pt has been called	Not been in since

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PCMH 5C, Factor 2 Example Sharing Information

11/15/2013 Send Records to STAT HIM LC Comp

Note Subject: send records

Pt being hospitalized. Send records to St.

November 15, 2013 3:37:29 PM faxed facesheet, med list, flowsheet
PN 11/11 and 10/30
op/path 11/1
US 10/31
Image other 10/31
labs 10/18-11/13

PCMH 5C, Factors 3 & 4 Example

Notes

Medication List Reconciled 3/10/2014.

Discharged from:

Records management 3/10/2014 Records received.

Hospitalization 3/09/2014 Date of discharge.

A follow-up appointment has been made.

Patient contacted: 3/10/2014.

Assessment of pt symptoms: Spoke to patient regarding recent hospital discharge for numbness in arm. Patient states that she is doing fine, she still have the numbness and tingeling in her arm. She states that she had an MRI, cat scan and an echo with no findings. She states that they do not know why she has this. Scheduled a follow up appointment.

R.N.

Proactively obtaining D/C summary and patient contact for follow-up care

PCMH 5B, Factor 7 & 5C, Factor 7 Example

01/28/2013 06:53 PM	Office Visit	Physical Exam
01/27/2013 02:24 PM	[illegible]	[illegible]
01/24/2013 11:26 AM	Imported CCD	Imported Note from Dennis Talon (John Imaginary)
[illegible]	Office Visit	ACUTE BRONCHITIS
12/27/2012 02:51 PM	Office Visit	Hypertension
11/12/2012 11:40 AM	Office Visit	GERD

Electronic Signature not Triggered.
In transcription & Unfinished Records.
Imported CCR
Electronic Signature Triggered.
Transcription Returned
Transcriptionist Notes
Electronic Signature Activated.
Imported CCD

Previous Encounters
- Encounters
  - Chart Update
  - Chart Update
  - Office Visit
  - Prescriptions

Inserted Notes
- Notes
  - Assistant task
  - Cardiodiagnostics
  - Consults
  - Immunization History
  - Inpatient

Print | Patient Summary | Import CDA/CCR | Insert note | Pending agents

Start | 5:12 PM 1/30/2014

5B-7 Report showing the Transition of Care give to outside provider for referrals for all providers over the last year.

Outbound Transfer of Care		
2/28/2013-2/28/2014		
Factor 7 (CMU 8)	N-2102	59.7%
	D-3523	

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Activity 5

PCMH 6: Performance Measurement and Quality Improvement

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PCMH 6: Performance Measurement and Quality Improvement

Intent of Standard

- Uses performance data to identify opportunities for improvement
- Acts to improve clinical quality, efficiency
- Acts to improve patient experience

Meaningful Use Alignment

Practice uses certified EHR to:

- Protect health information
- Submit electronic data to registries
- Submit electronic syndromic surveillance data
- Identify and report cases

PCMH 6: Performance Measurement and Quality Improvement

Elements

- Element A: Measure Clinical Quality Performance
- Element B: Measure Resource Use and Care Coordination
- Element C: Measure Patient/Family Experience
- Element D: Implement Continuous Quality Improvement **MUST PASS**
- Element E: Demonstrate Continuous Quality Improvement
- Element F: Report Performance
- Element G: Use Certified EHR Technology

PCMH 6A: Measure Clinical Quality Performance

At least annually the practice measures or receives data on:

1. At least two immunization measures
2. At least two other preventive care measures
3. At least three chronic or acute care clinical measures
4. Performance data stratified for vulnerable populations (to assess disparities in care)

Vulnerable Populations Defined

"Those who are made vulnerable by their

- **financial circumstances or place of residence,**
- **health, age, personal characteristics,**
- **functional or developmental status,**
- **ability to communicate effectively, and**
- **presence of chronic illness or disability."**

Source: AHRQ

Vulnerable vs. High-risk

- **Confusion about these items**
- **High-risk patients with clinical conditions and other factors that could lead to poor outcomes for those conditions**
- **Vulnerable characteristics that could lead to different access or quality of care**
  - ✓ Looking for disparities in care/service
  - ✓ Vulnerable patients need not have current clinical conditions

PCMH 6A: Scoring and Documentation

3 points

Scoring

- 4 factors = 100%
- 3 factors = 75%
- 2 factors = 50%
- 1 factor = 25%
- 0 factors = 0%

Documentation

- F1-4: Reports showing performance

Initial Submission: Data report as required for each factor, no more than 12 months old. Annual data for two years NOT needed.

Renewing Practice: Attestation, if level 2 or 3.

PCMH 6A, Factor 2: Example Preventive Care Measures

	>30 BMI Numerator	# BMI Calculated	%
10/1/2012-12/31/2012	2508	5993	41.85%
2/1/2013-4/30/2013	2535	5816	43.59%

	Smoking/Tobacco Cessation Numerator	Smoking/Tobacco Cessation Denominator	%
10/1/2012-12/31/2012	380	1343	28.29%
2/1/2013-4/30/2013	371	1409	26.33%

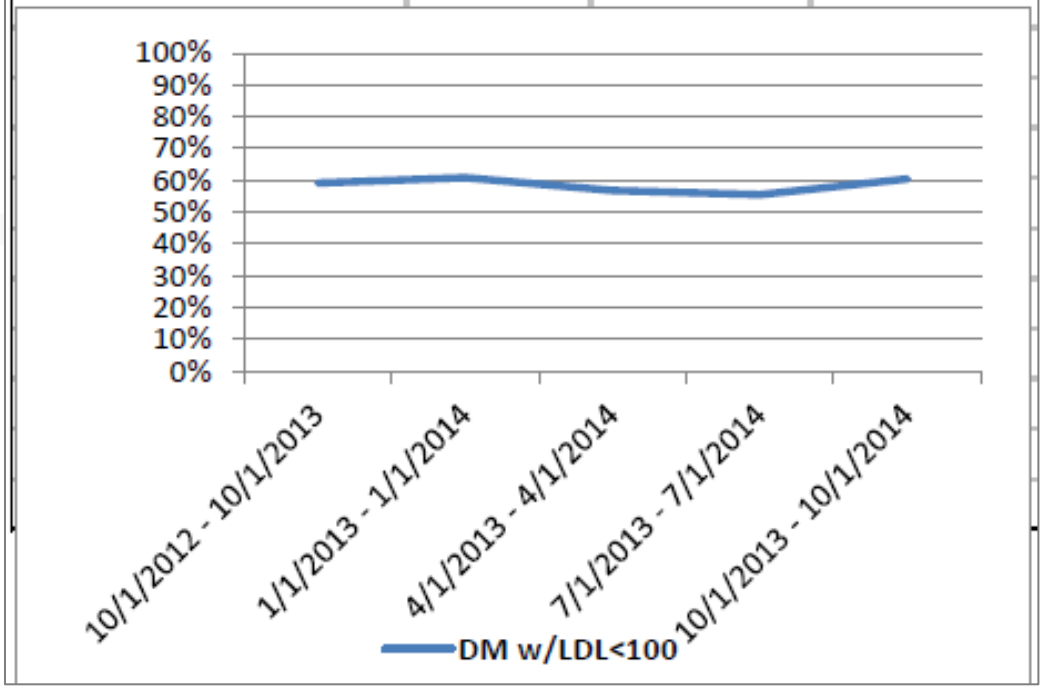
	Colorectal Cancer Screen Numerator	Colorectal Cancer Screen Denominator	%
10/1/2012-12/31/2012	754	3311	22.77%
2/1/2013-4/30/2013	944	3497	26.99%

PCMH 6A, Factors 2&3: Example Preventive & Chronic Measures

Health Maintenance Topic 1/1/13 – 12/31/13	In compliance	Overdue	Total
Breast Cancer Screening	51.05% 1,381	48.95% 1,324	100% 2,705
Colon Cancer Colonoscopy	63.35% 1,965	36.65% 1,137	100% 3,102
Pneumococcal Vaccine	83.11% 743	28.36% 350	100% 1,234
Foot Exam	74.84% 992	25.16% 350	100% 1,232
Hemoglobin A1C	71.64% 884	28.36% 350	100% 1,234
Urine Microalbumin/Creatinine Ratio	67.13% 825	32.87% 404	100% 1,229

PCMH 6A, Factor 3: Example Chronic Care Clinical Measures

DM w/LDL<100			
Date	Numerator (YES)	Denominator (Total Pts)	% compliance
10/1/2012 - 10/1/2013	122	206	59%
1/1/2013 - 1/1/2014	114	187	61%
4/1/2013 - 4/1/2014	103	181	57%
7/1/2013 - 7/1/2014	100	180	56%
10/1/2013 - 10/1/2014	109	180	61%



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PCMH 6B: Measure Resource Use and Care Coordination

At least annually the practice measures or receives quantitative data on:

1. At least two measures related to care coordination
2. At least two utilization measures affecting health care costs

PCMH 6B: Scoring and Documentation

3 points

Scoring

- 2 factors = 100%
- 1 factor = 50%
- 0 factors = 0%

Documentation

- F1-2: Reports showing performance

Initial Submission: Data report as required for each factor, no more than 12 months old. Annual data for two years NOT needed.

Renewing Practices:

Factor 1: Data report as required (no more than 12 months old). Annual data for two years NOT needed.

Factor 2: At least annually for at least two years (current year and a previous year).

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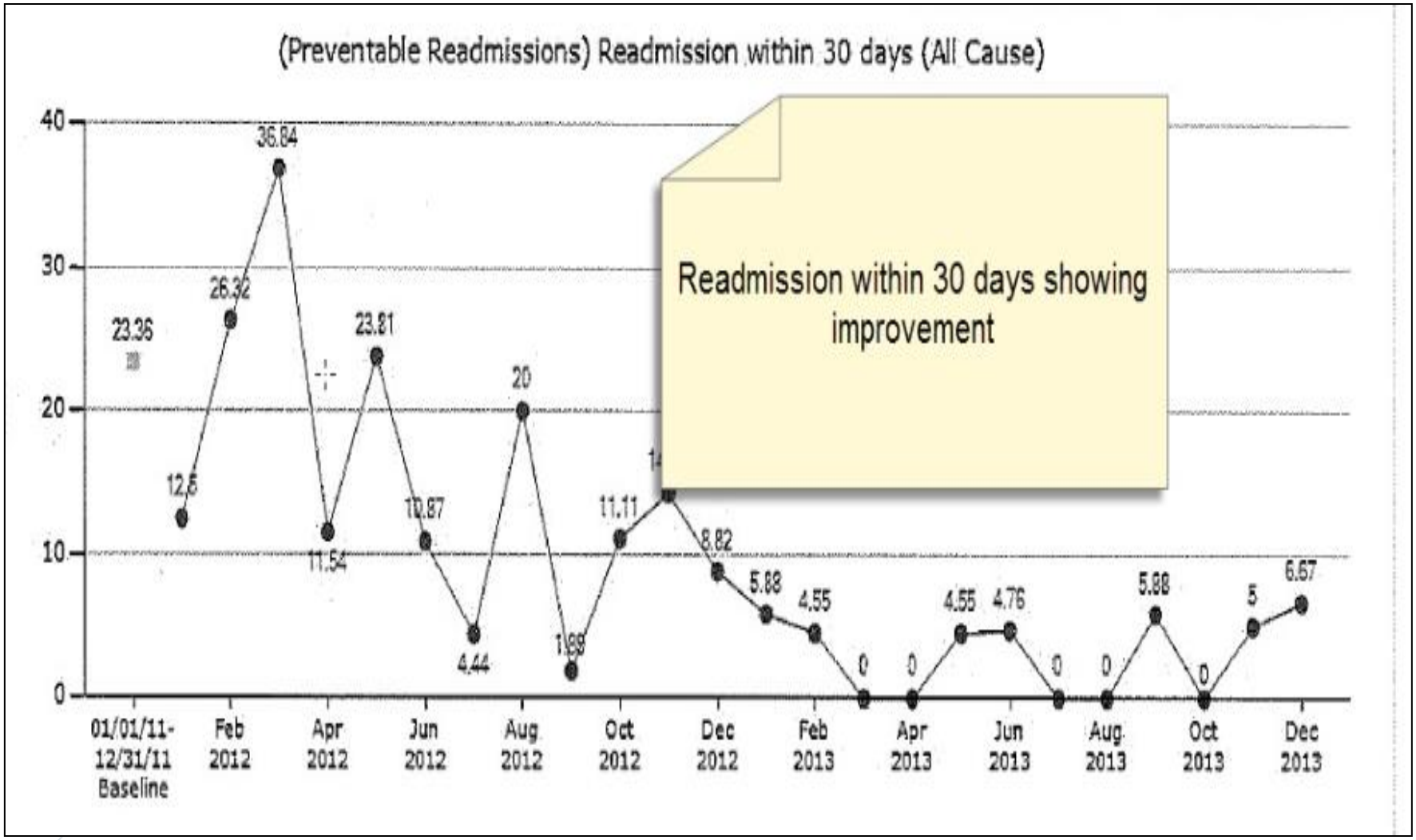
Use of MU Reports to Meet 6B, Factor 1

- **6B1 (care coordination) - may be met with MU Reports**
  - **5B7 and 5C7** (Modified Stage 2 Objective 5)
  - **4C1** (Modified Stage 2 Objective 7)

PCMH 6B: Example Measures Affecting Health Care Costs



PCMH 6C: Measure Patient/Family Experience

At least annually the practice obtains feedback on patient/family experience with practice and their care:

1. Practice conducts survey measuring experience on at least three of the following: access, communication, coordination, whole person care/self-management support
2. Practice uses PCMH CAHPS Clinician & Group Survey Tool
3. Practice obtains feedback from vulnerable patient groups
4. Practice obtains feedback through qualitative means

PCMH 6C: Scoring and Documentation

4 points

Scoring

- 4 factors =100%
- 3 factors = 75%
- 2 factors = 50%
- 1 factor = 25%
- 0 factors = 0%

Documentation

- F1-4: Reports showing results of patient feedback

Initial Submission: Data report as required for each factor, no more than 12 months old. Annual data for two years NOT needed.

Renewing Practices: Attestation for level 2 or 3.

PCMH 6C: What Questions Reflect Whole-person Care/Self-Management Support?

Survey questions <u>may</u> relate to the following:

- Knowledge of patient as a person
- Life style changes
- Support for self-care/self-monitoring
- Shared decisions about health
- Patient ability to monitor their health

Why CAHPS Patient-Centered Medical Home (PCMH) Survey?

- Use of a standardized survey allows "apples to apples" comparison of patient experience across recognized practices
- Non-proprietary survey and can be easily adopted by practices and vendors
- Survey is specifically designed to evaluate patient experience with medical homes
- Survey derived from the most widely used consumer experience survey
- Rigor of the survey design and consumer testing process
- Other entities and initiatives are likely to use CAHPS PCMH

PCMH 6C: Example Patient Experience Survey Results

Survey Results : **1/1/13 -12/31/13**	Strongly disagree				Strongly Agree		Average
	1	2	3	4	5	n/a	
I usually see my primary care provider for my appointments			7	34	77		4.6
I am able to schedule an appointment on the day I want it			10	50	54	4	4.4
If I am sick, I can get an appointment the same day for care			17	43	47	11	4.3
If I leave a message during office hours, I get a return call the same day		3	18	47	36	14	4.1
I know how to get care during evenings or on weekends	4	11	19	40	35	9	3.8
My questions are answered in a way that I can understand				31	87		4.7
I feel comfortable asking questions during my visit		1		30	87		4.7
I have a say in decisions about my care			2	36	79	1	4.7
The practice helps me make appointments for tests or specialists			5	46	63	4	4.5
The practice informs me about the results of blood tests or x-rays		2	3	40	67	6	4.5
My doctor or a nurse reviews my medications at each visit			4	44	64	6	4.5
When I come for a visit, my doctor has my test results in my chart			5	40	67	6	4.6
The practice reminds me when I need follow up appointments or screening tests			8	48	60	2	4.4
Overall I am satisfied with the care I receive at the practice		1		35	81	1	4.7

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PCMH 6C: Patient Experience Data

[redacted]

Adult

Open Month: January, 2012

Close Month: March, 2012

[redacted]

Measure	Denominator	Previous Score	Provider Score	Practice Score	Project Score
			Responses in Period:		12
Rate provider 0 - 10	11	100.00%	81.82%	78.91%	79.88%
How long wait for urgent appt	3	50.00%	33.33%	38.58%	46.55%
Office gave info re: after hours care	11	100.00%	72.73%	59.76%	65.58%
Get reminders between visits	11	100.00%	72.73%	75.29%	69.94%
Someone follow up with results	10	66.67%	80.00%	65.09%	65.48%
Informed and up-to-date on specialist care	7	100.00%	71.43%	62.57%	60.88%
Talk about prescription	11	100.00%	81.82%	88.89%	82.77%
Rate overall health	11	0.00%	0.00%	8.78%	7.60%
Rate overall mental/emotional health	11	33.33%	27.27%	21.15%	20.68%
Access	35	64.29%	60.00%	46.00%	47.38%
Communication	64	100.00%	82.81%	79.68%	81.78%
Shared Decision Making	24	100.00%	83.33%	58.43%	64.81%
Self Management Support	22	50.00%	50.00%	42.89%	46.33%
Comprehensiveness-Adult Behavioral	33	33.33%	51.52%	33.64%	40.37%
Office Staff	22	66.67%	81.82%	67.77%	67.36%

PCMH 6D: Implement Continuous Quality Improvement

Practice uses ongoing quality improvement process:

1. Set goals and analyze at least three clinical quality measures from Element 6A
2. Act to improve performance on at least three clinical quality measures from Element 6A
3. Set goals and analyze at least one measure from Element 6B
4. Act to improve at least one measure from Element 6B

PCMH 6D: Implement Continuous Quality Improvement (cont.)

5. Set goals and analyze at least one patient experience measure from Element 6C
6. Act to improve at least one patient experience measure from Element 6C
7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations

PCMH 6D: Scoring and Documentation

Must Pass

4 Points

Scoring

- 7 factors = 100%
- 6 factors = 75%
- 5 factors = 50%
- 1-4 factors = 25%
- 0 factors = 0%

Documentation

- F1-7: Report or completed PCMH Quality Measurement and Improvement Worksheet

PCMH 6D: Quality Measurement & Improvement Worksheet

ELEMENT D - Implement Continuous Quality Improvement (MUST PASS) View Points | Clear Data

The practice uses an ongoing quality improvement process to:

	Yes	No
1. Set goals and analyze at least three clinical quality measures from Element A.		
2. Act to improve at least three clinical quality measures from Element A.		
3. Set goals and analyze at least one measure from Element B.		
4. Act to improve at least one measure from Element B.		
5. Set goals and analyze at least one patient experience measure from Element C.		
6. Act to improve at least one patient experience measure from Element C.		
7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations.		

Scoring:

100%	75%	50%	25%	0%
The practice meets all 7 factors	The practice meets 6 factors	The practice meets 5 factors	The practice meets 1-4 factors	The practice meets 0 factors

Data Source:

Scope of Review:

Reference Information: Explanation | Examples

ELEMENT SCORE | DOCUMENTS | SUPPORT TEXT / NOTES | SUPPLEMENTAL WORKSHEET

Click here to access worksheet

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PCMH 6D: Quality Measurement and Improvement Template

NCQA PCMH 2014 Quality Measurement and Improvement Worksheet

PURPOSE: The purpose of the worksheet is to help practices organize the measures and quality improvement activities that are required in PCMH 6, Elements D and E. Please consult PCMH 6, Elements A, B, C, D and E for additional information.

NOTE: Practices are not required to submit the worksheet as documentation - it is provided as an option. Practices may submit their own report detailing their quality improvement strategy.

QUALITY MEASUREMENT & IMPROVEMENT ACTIVITY STEPS:

1. Identify measures for quality improvement – From measures selected in elements **6 A, B, and C** as well as a disparity measure, practice will identify a **total of six (6) measures** comprised of the following: from **6A (3) clinical quality measures**; from **6B (1) resource use and/or care coordination measure**; from **6C (1) patient/family experience measure**; **(1) measure focused on vulnerable populations**, does not need to be same as identified in 6A or 6C.

2. Identify a baseline performance assessment – Choose a starting measurement period **(start and end date)** and identify a baseline rate for each measure. You may use rates from the reports provided in PCMH 6 A, B, C. The baseline measurement period **MUST** be **within 24 months** prior to the tool submission if there is a re-measurement period. Otherwise, the measurement period **MUST** be within **12 months** prior to tool submission. The performance rate **MUST** be a percentage or number.

3. Establish a performance goal - Generate at least one performance goal for each identified measure. Specific rate goal **MUST** be a percentage or number greater than your baseline performance assessment. Simply stating that the practice intends to improve does

4. Determine what actions to take to work towards performance goals - List at least one action for each identified measure taken towards meeting the performance goal. Include the **start date** of the activity. The action date **MUST** occur after the date of the baseline performance assessment date. You may list more than one activity but are not required to do so. **(Applies to 6D 2, 4, 6)**

***Note:** If the action period overlapped with some or all of the baseline measurement period, and the practice does not have earlier measurements to report, the practice should provide an analysis of the impact of the action on the baseline measure (e.g., 'this would tend to increase the baseline measure')*

5. Re-measure performance based on actions taken – Choose a re-measurement period and generate a new performance rate after action was taken to improve. The re-measurement date **MUST** occur after the date the action was implemented and **MUST** be within in **12 months** prior to tool submission. If the action was not complete before the re-measurement period, the practice should estimate the completion rate of the action, to evaluate its impact on any re-measurement. It is up to the practice to determine its next follow-up period. **(Applies to 6E 2-4)**

***Note:** To receive credit for 6E Factors 2-4 the re-measurement rate must show improvement on (2) clinical quality measures; (1) resource use/care coordination*

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PCMH 6D and 6E: Quality Measurement and Improvement Template

NCQA PCMH 2014 Quality Measurement and Improvement Worksheet

- ✓ Clinical Activities
- ✓ Disparities in Care
- ✓ Patient/Family Experience

EXAMPLE ON HOW TO COMPLETE A ROW:

Use 3 Measures Identified in 6A		
Measure 1: Colorectal cancer (CRC) screening	1. Measure Selected for Improvement & Reason for Selection	Reason: We want to increase percentage of patients who receive screening for CRC.
	2. & 3. Baseline Performance Measurement & Numeric Goal for Improvement (6D 1)	Baseline Start Date: 5/1/14 Baseline End Date: 5/30/14 Baseline Performance Rate (% or #): 36.3% Numeric Goal Rate (% or #): 58%
	4. What actions were taken to improve and work towards goal? Provide dates actions were initiated. (6D 2) (Only 1 Action Required)	Action : Pop up reminders were added to our EMR for patien Date Action Initiated: 7/1/14 Additional Actions Taken: Provider quality compensation me providers to ensure appropriate health screening
	5. Re-measure Performance (6E 2)	Start Date: 5/1/15 End Date: 5/30/15 Rate (% or #): 69.2%
	6. Assess Actions & Describe Improvement (6E 1)	Since September 2014, there has been an increase of 32.9% in patients receiving CRC screening due to incentivizing providers and use of clinical decision support of EMR to indicate when patients are due for screening.

- ✓ Measure (D)
- ✓ Opportunity Identified (D)
- ✓ Initial Performance/ Measurement Period (D)
- ✓ Performance Goal (D)
- ✓ Action Taken and Date (E)
- ✓ Re-measurement Performance (E)

Identify a Disparity in Care for a Vulnerable Population

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PCMH 6E: Demonstrate Continuous Quality Improvement

Practice demonstrates continuous quality improvement:

1. Measures effectiveness of actions to improve measures selected in Element 6D
2. Achieves improved performance on at least two clinical quality measures
3. Achieves improved performance on one utilization or care coordination measure
4. Achieves improved performance on at least one patient experience measure

PCMH 6E Scoring and Documentation

3 Points

Scoring

- 4 factors = 100%
- 3 factors = 75%
- 2 factors = 50%
- 1 factor = 25%
- 0 factors = 0%

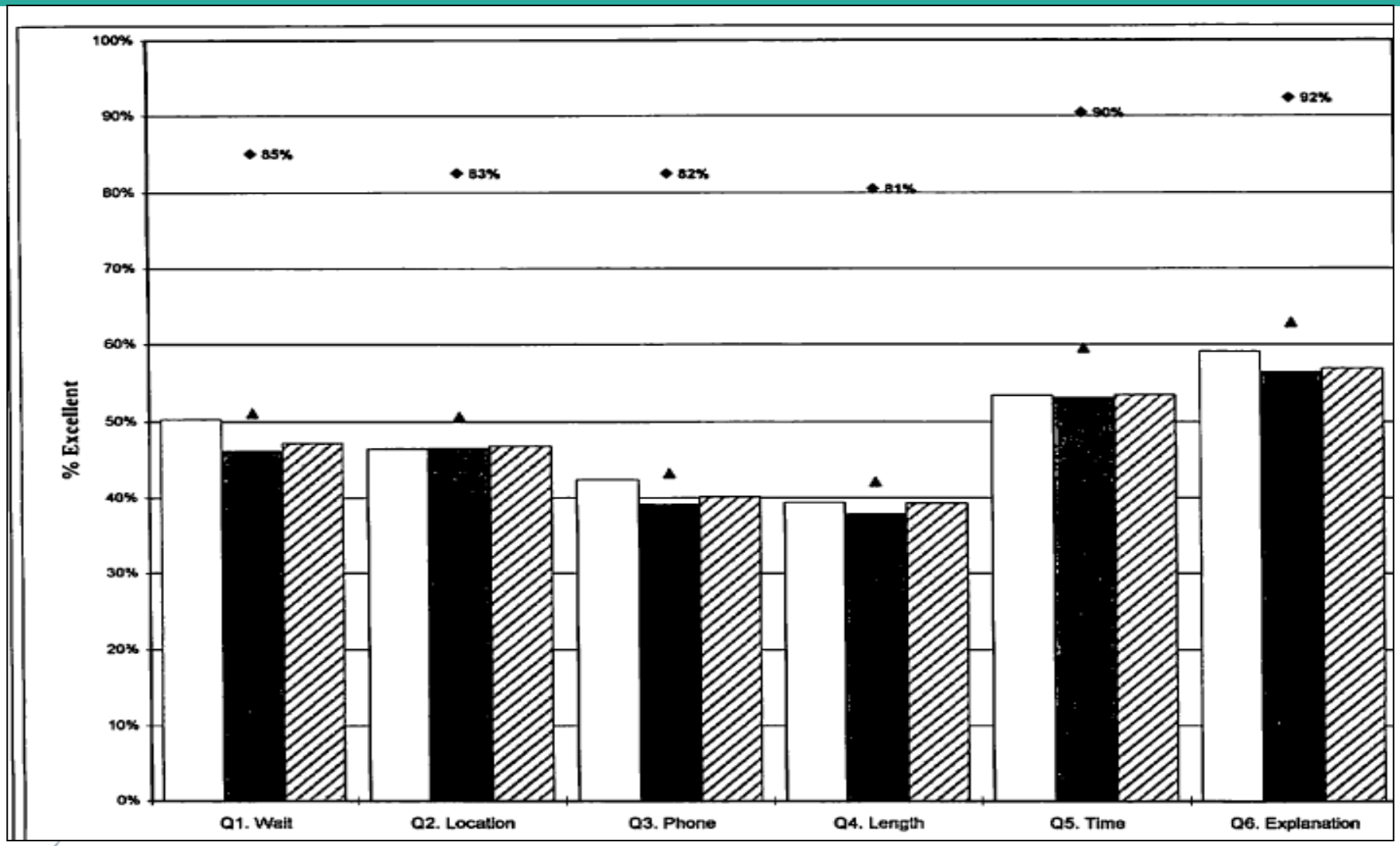
Documentation

- F1-4: Reports or completed Quality Measurement and Improvement Worksheet

PCMH 6E: Example Tracking Data Over Time

	Jan 2014	Dec 2013	Nov 2013	Oct 2013	Sept 2013
Immunizations					
Pneumovax	61.31	61.21	52.25	61.39	60.95
Diabetes					
HgA1C	73.39	73.48	74.12	74.11	71.54
CHF					
Ace Inhibitors	99.18	99.58	99.69	99.13	99.56
CAD					
Antihyperlipidemic	99.07	99.05	99.65	98.67	98.87

PCMH 6E: Example Patient Survey Results Over Time



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PCMH 6F: Report Performance

Practice produces performance data reports and shares data from <u>Elements A, B and C:</u>

1. Individual clinician results with the practice
2. Practice-level results with the practice
3. Individual clinician or practice-level results publicly
4. Individual clinician or practice-level results with patients

PCMH 6F: Scoring and Documentation

3 Points

Scoring

- 3-4 factors = 100%
- 2 factors = 75%
- 1 factor = 50%
- 0 factors = 0%

Documentation

- F1,2: Reports (blinded) showing summary data by clinician and across the practice shared with practice and how results are shared
- F3: Example of reporting to public
- F4: Example of reporting to patients

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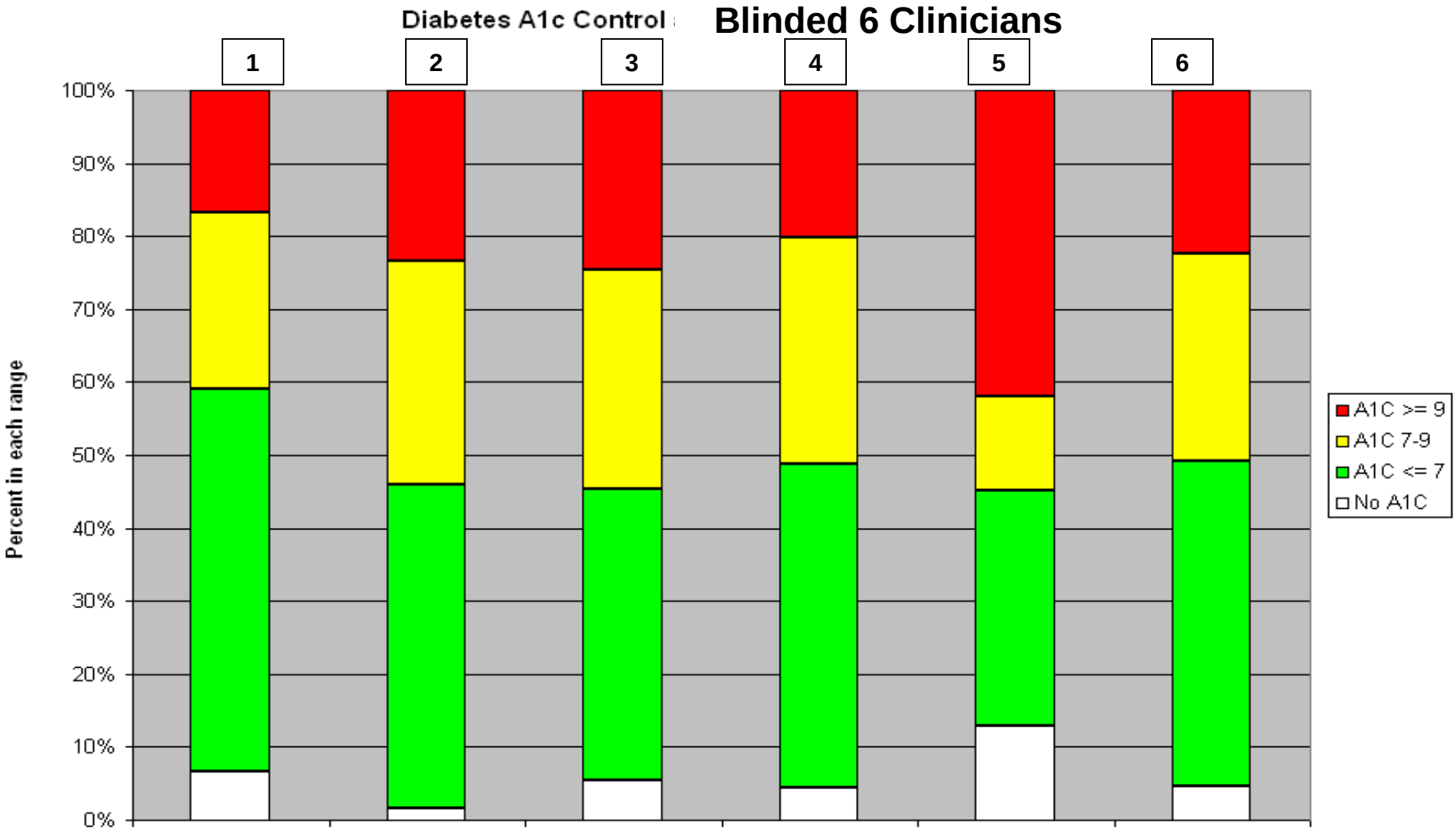
PCMH 6F: Example Reporting by Individual Clinician



PCMH 6F: Example Reporting by Individual Clinician

1/1/13 - 12/31/13
Adult Medicine Practice
Data shared at annual meeting

	Numerator	Denominator	Percentage
Pneumococcal Vaccination Rates	717	902	79%
Dr.	109	114	96%
Dr.	12	15	80%
Dr.	172	208	83%
Dr.	310	334	93%
Dr.	1	5	20%

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PCMH 6F: Example Reporting Across Practice(s)

Shows data for multiple sites

Practice-Level Quality Performance Indicators
Current Quarter Site Comparison
[redacted] 2 2005

QUALITY MEASURE	HVMA AVG	BTR	BUR	CAM	CHE	COP	KEN	MFD	PBY	POS	QCY	SOM
DM - Diabeti am												
% of Patients Screened (at HVMA Sites Only) within the Past Year	54%	54% -	39% -	60% -	54% -	43% -	57% -	66% *	47% -	54%	56%	53% -
DM - HbA1c												
% of Patients Screened within the Past Year	84%	83%	85%	85%	85%	79% -	83%	85%	87% *	86%	83%	78%
DM - HbA1c - Level of Control - <7.0%												
% of Tested Patients with Lab Results <7.0%	45%	41% -	45% -	39% -	50% -	41% -	38% -	50% -	53% - *	45%	47% -	34% -
DM - HbA1c - Level of Control - >9.0%												
% of Tested Patients with Lab Results >9.0%	9%	10%	5% *	11%	6% +	12% +	11%	6%	6% +	11%	8% +	10% +

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PCMH 6G: Use Certified EHR Technology

Practice uses a certified EHR system:

1. Uses EHR system (or module) that has been certified and issued a CMS certification ID++
2. Conducts a security risk analysis of its EHR system (or module), implements security updates and corrects identified security deficiencies+
3. Demonstrates capability to submit electronic syndromic surveillance data to public health agencies electronically+

+ Meaningful Use Modified Stage 2 Alignment

++CMS Meaningful Use Requirement

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PCMH 6G: Use Certified EHR Technology (cont.)

4. Demonstrates capability to identify and report cancer cases to public health central cancer registry electronically+
5. Demonstrates capability to identify/report specific cases to specialized registry (other than a cancer registry) electronically+
6. Reports clinical quality measures to Medicare or Medicaid agency as required for Meaningful Use++

+ Meaningful Use Modified Stage 2 Alignment

++CMS Meaningful Use Requirement

PCMH 6G: Use Certified EHR Technology (cont.)

7. Demonstrates the capability to submit electronic data to immunization registries or immunization information systems electronically+
8. Has access to a health information exchange
9. Has bi-directional exchange with a health information exchange
10. Generates lists of patients, and based on their preferred method of communication, proactively reminds more than 10 percent of patients/families/ caregivers for needed preventive/follow-up care

+ Meaningful Use Modified Stage 2 Alignment

PCMH 6G: Scoring and Documentation

0 Points

Scoring

- 100% Not scored
- 75% Not scored
- 50% Not scored
- 25% Not scored
- 0% Not scored
- NA Factors – 4, 5, 7

Documentation

- Attestation

Activity 6

PRIME 1: Massachusetts HPC PCMH PRIME Certification

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PRIME 1: Patient-Centered Access

Elements

PRIME 1A: NCQA Pre-requisite MUST PASS

PRIME 1B: Behavioral Health Integration and Referrals

PRIME 1C: The Practice Team

PRIME 1D: Comprehensive Health Assessment

PRIME 1E: Implement Evidence-Based Decision Support

PRIME 1F: Identify Patients for Care Management

PRIME 1A: NCQA PCMH Pre-Requisite

The practice:

1. Is currently recognized by NCQA as a 2011 Level 2 or 3 PCMH or a 2014 Level 1, 2, or 3 PCMH.
2. Is applying for NCQA recognition concurrently.

Scoring:

- No scoring option
- **Must Pass Element**

Documentation:

- F1: Entering "yes" indicates attestation of PCMH 2011 Level 2 or 3 recognition or PCMH 2014 Level 1, 2, or 3 recognition. No additional documentation needed.
- F2: Entering "yes" indicates attestation that the practice is concurrently pursuing PCMH 2014 Level 1, 2 or 3 recognition. No additional documentation needed.

NOTE: **Practice must meet at least 1 factor in this Must Pass element to submit their survey for review.**

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PRIME 1B: Behavioral Health Integration and Referrals

The practice:

1. Coordinates with behavioral healthcare providers through formal agreements or has behavioral healthcare providers co-located at the practice site.
2. Integrates behavioral healthcare providers within the practice site.
3. Tracks behavioral health referrals until the consultant or specialist's report is available, flagging and following up on overdue reports.

Documentation:

- F1: At least 1 example of a formal agreement or list of BH providers who work at same physical location
- F2: List of BH providers onsite
- F3: Documented process and at least one example or report demonstrating process implementation

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PRIME 1B: Scoring

Scoring

3 Possible Points

- F1 = 1 point
- F2 = 1 point (Satisfying factor 2 automatically satisfies factor 1 for a total of 2 points)
- F3 = 1 point

PRIME 1B, factors 1 & 2: Primary Care & Behavioral Health Collaboration (Resource)

TABLE 3: COLLABORATIVE CARE CATEGORIZATIONS AT A GLANCE

COORDINATED	CO-LOCATED	INTEGRATED
• Routine screening for behavioral health problems conducted in primary care setting • Referral relationship between primary care and behavioral health settings • Routine exchange of information between both treatment settings to bridge cultural differences	• Medical services and behavioral health services located in the same facility • Referral process for medical cases to be seen by behavioral specialists • Enhanced informal communication between the primary care provider and the behavioral health provider due to proximity	• Medical services and behavioral health services located either in the same facility or in separate locations • One treatment plan with behavioral and medical elements • Typically, a team working together to deliver care, using a prearranged protocol

(continued)

TABLE 3 *(CONTINUED)*

COORDINATED	CO-LOCATED	INTEGRATED
• Primary care provider to deliver behavioral health interventions using brief algorithms • Connections made between the patient and resources in the community	• Consultation between the behavioral health and medical providers to increase the skills of both groups • Increase in the level and quality of behavioral health services offered • Significant reduction of "no-shows" for behavioral health treatment	• Teams composed of a physician and one or more of the following: physician's assistant, nurse practitioner, nurse, case manager, family advocate, behavioral health therapist • Use of a database to track the care of patients who are screened into behavioral health services

Source: Adapted from Blount 2003.

Documentation Required: (Factor 1) One BH Agreement & (Factor 2) List of integrated BH providers and positions.

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PRIME 1C: The Practice Team

The practice uses a team to provide a range of behavioral health patient services. The practice has:

1. At least one care manager qualified to identify and coordinate behavioral health needs.
2. At least one clinician providing medication-assisted treatment, and providing behavioral therapy directly or via referral, for substance use disorder.

Documentation:

- F1: Documented process or description of staff position and documentation of current staff qualifications
- F2: Example demonstrating active MAT and behavioral therapy for at least one de-identified patient

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PCMH 1C: Scoring

Scoring

2 Possible Points

- F1 = 1 point
- F2 = 1 point

PRIME 1D: Comprehensive Health Assessment

To understand the behavioral health-related needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes:

1. Behaviors affecting health and mental health/substance use history of patient and family.
2. Developmental screening for children under 3 years of age using a standardized tool.
3. Depression screening for adults and adolescents using a standardized tool.
4. Anxiety screening for adults and adolescents using a standardized tool.
5. Substance Use Disorder screening for adults and adolescents using a standardized tool.
6. Postpartum depression screening for patients who have recently given birth using a standardized tool.

PRIME 1D: Scoring and Documentation

Scoring

6 possible points

- F1-6 = 1 point each

Documentation

- **F1-6:** Report with numerator and denominator based on all unique patients in a recent three month period indicating how many patients were assessed for each factor OR
- **F1-6:** Documented process describing how data is collected

AND

- **F2-6:** Standardized survey form

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ELEMENT D - Comprehensive Health Assessment

View Points | Clear Data

To understand the behavioral health-related needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes: [For each factor, please enter a percentage in the box.]

1. Behaviors affecting health and mental health/substance use history of patient and family
2. Developmental screening for children under 3 years of age using a standardized tool. NA
3. Depression screening for adults and adolescents using a standardized tool. NA
4. Anxiety screening for adults and adolescents using a standardized tool. NA
5. Substance Use Disorder screening for adults and adolescents using a standardized tool. NA
6. Postpartum depression screening for patients who have recently given birth using a standardized tool. NA

PRIME 1D, Factors 3 and 6: Standardized Survey Form

Standardized Assessment

Patient Health Questionnaire (PHQ-9)

Date: 01/12/2015

Exclusions

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				

Initial diagnosis: Consider Major Depressive Disorder

Total score: 17

Calculate

Documented by:

Interpretation of total score: Moderately severe depression

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?
- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

Comments:

Characters left: 100

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Save & Close | Cancel

Patient History

Patient History | Patient Demo... | Categories

New | Lock | Search

F/U 1 month 01/12/2015 09:50 AM AMS

AWV Template
Cognitive Assessment
Chart_Note
cognitive_assessment
intake_note
Master_lm
Patient Plan
Medication
Problem
Procedure

Custom

Add | Edit | Remov

Depression Screening | Total Score:

Cognitive Assessment | Number Correct:

Health Assessment | Disability Index:

Comments

Provider Role

specialist

specialist

PRIME 1E: Implement Evidence-Based Decision Support

The practice implements clinical decision support (e.g., point-of-care reminders) following evidence-based guidelines for:

1. A mental health condition.
2. A substance use disorder.

Documentation:

- F1-2: Provide
  1. Conditions identified by the practice for each factor **and**
  2. Source of guidelines **and**
  3. Examples of guideline implementation

Scoring

1 possible point

- F1 and 2 = 1 point total

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PRIME 1F: Identify Patients for Care Management

The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following:

1. Behavioral health conditions.

Scoring

1 possible point

- F1 = 1 point total

Documentation

- F1: Documented process describing criteria for identifying patients for care management

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PCMH PRIME PROCESS

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Applications and Scoring

- **HPC PCMH PRIME Application:** Practices must complete and submit an application to the Massachusetts Health Policy Commission, available at bit.ly/HPCPRIME.

- **NCQA Application & Survey:** Practices must submit an application at recognitionportal.ncqa.org and documentation to NCQA for evaluation on the PCMH PRIME behavioral health criteria.

- **Scoring:** Practices must pass Element A and achieve a score of at least 7 points on Elements B through F. HPC will determine the final score.
  - No levels for PCMH PRIME
  - Certification awarded at the practice site level

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PCMH PRIME Certification Review Process

- **HPC makes final scoring determination for PCMH PRIME based on NCQA's review**
- **NCQA sends monthly feeds with PCMH PRIME data**
- **HPC issues final scoring decision to the practice within 15 business days of data feed**
- **HPC reports results:** May post names of PCMH PRIME certified practices on website (not scores)
- **HPC sends PCMH PRIME certification materials to practice**

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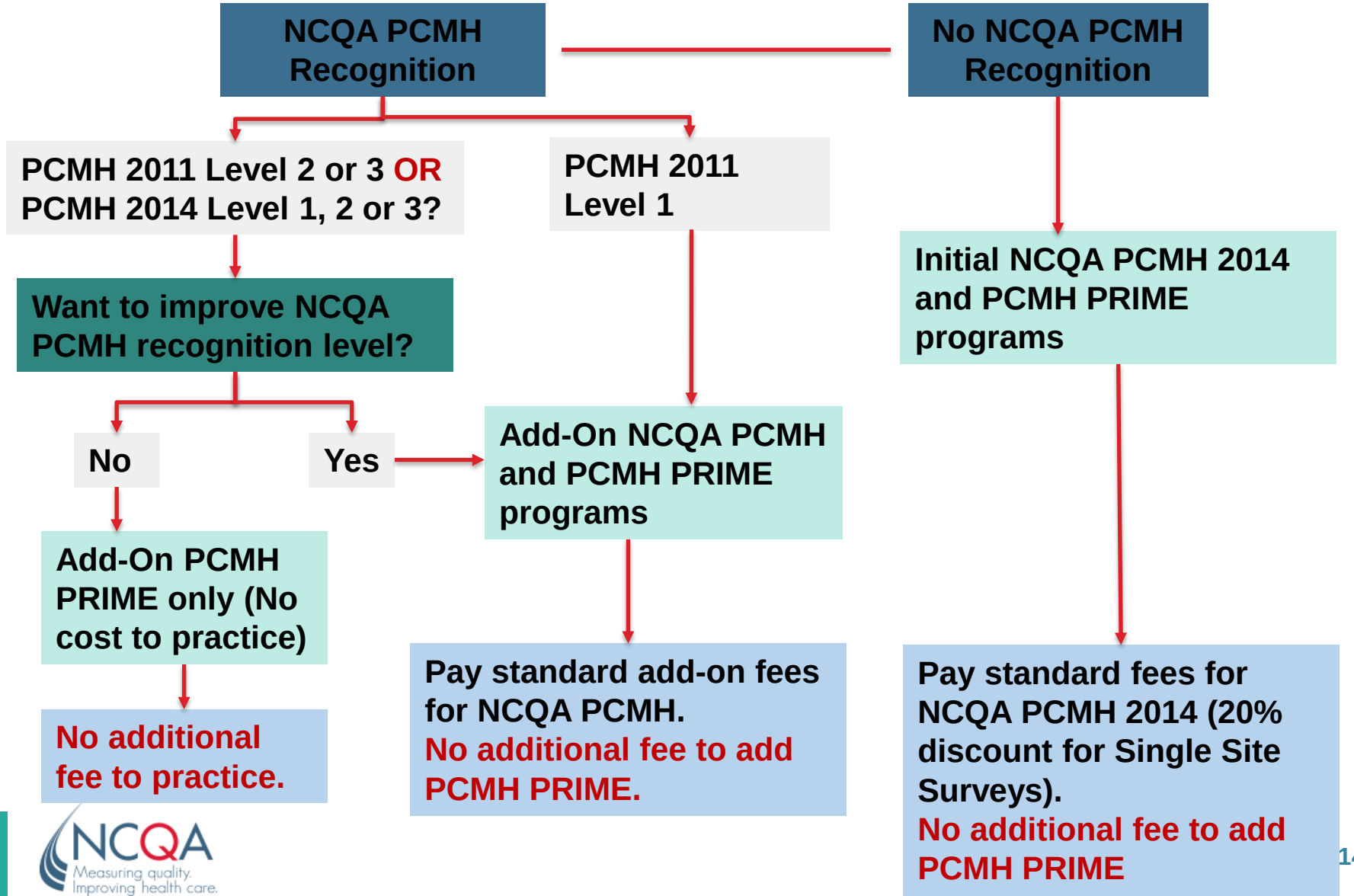

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Add PCMH PRIME to the Application

PCMH 2014 Application

NCQA Survey Tool License Number

Provide the License Number of the NCQA Survey Tool your practice purchased for this survey.
You must **enter and validate** your License number below to complete this application.
(The license number is on the first page of the Survey Tool above the "I agree" statement.)

ISS License Number: 18642

Application Type

Identify Application Type

Initial ▼ Click here for Application Type Description.

Since you are in Massachusetts, you are eligible to take part in the new HPC initiative! You can select to add this new initiative to your PCMH application.

- (●) PCMH
- ( ) PCMH + PCMH PRIME

By selecting the PCMH PRIME initiative, I am indicating my interest in pursuing the Massachusetts Health Policy Commission's (HPC) PCMH PRIME program and give approval for NCQA to share information on my practice and PCMH 2014 application status to the Massachusetts HPC. Practice information may include, but not be limited to, practice location, specialties and providers.

Practice Site Specialties

Identify the primary care specialties represented at the practice site by applying clinicians.

Identify other specialties and sub-specialties represented at the practice site.

Practice Site Description

Select One Entry from the list below that best describes this practice site.

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Process to Obtain an Add-On Survey

Process to obtain an add-on survey

- Request an Add-on survey in the online application account. Practice may choose to add-on:
  - NCQA PCMH **(standard 50% discounted Application Fee)**
  - NCQA PCMH + PCMH PRIME **(standard 50% discounted Application Fee)**
  - PCMH PRIME **(No Fee to the Practice)**
- NCQA merges data from previous Survey Tool into new PCMH Survey Tool and makes available to practice (new license#)
  - For add-ons that include NCQA PCMH, practice may change response in any element with score of <100%; no need to reattach already submitted documents
- Practice submits a new application with the new license #
- Practice uploads new documents and submits survey and payment

New status for NCQA PCMH after 30-60 calendar day review based on:

- Score achieved on total of saved scores and new assessment

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Setting Up Your ISS Survey Tool

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SETUP SURVEY TOOL | DOCUMENT LIBRARY | PRINT | SUBMIT SURVEY TOOL | UTILITIES | HOME | WHAT'S NEW | SEARCH | HELP & INSTRUCTIONS | LOGOUT

POLICIES & PROCEDURES | STANDARDS & GUIDELINES | SURVEY TOOL | ORGANIZATION BACKGROUND | RESULTS | APPENDICES | GLOSSARY | INDEX

PATIENT-CENTERED MEDICAL HOME | MA HPC PCMH PRIME

Survey Tool

To enter the Survey Tool, select a tab above.

This section includes all the Standards that are used for evaluation. The categories in the tabs above organize the Standards. Each category includes information about the Standards necessary to understand the survey process. This information includes:

- the Standards
- elements that specify exactly how the Standards are evaluated and scored
- specific scoring rules for each element
- the data source needed to document the scoring
- the scope of review for each element and
- additional explanation and examples

Setting Up Your ISS Survey Tool (cont.)

Select Evaluation Options

SETUP MENU | EVALUATION OPTIONS | SUBMIT SURVEY TOOL

Instructions

To conduct a readiness evaluation, and undergo survey, you must select from the evaluation options below. For additional information on selecting evaluation options, click on the instructions link above.

To select evaluation options for readiness evaluation, check the box for the product(s) in the "Select for Readiness Evaluation" column. To select evaluation options to submit for survey, check the box for the options in the "Select to Submit for Survey" column.

You may revise these selections at any time during your readiness evaluation.

Save

Evaluation Option	Survey Tool Complete	Select for Readiness Evaluation	Select to Submit for Survey
You may select one or more of the following evaluation options:			
Patient-Centered Medical Home (PCMH)	Not Complete	☑	☑
Mass HPC PCMH PRIME (for practices in MA ONLY)	Not Complete	☐	☐

Save

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Setting Up Your ISS Survey Tool (cont.)

Select Evaluation Options

SETUP MENU | EVALUATION OPTIONS | SUBMIT SURVEY TOOL

Instructions

To conduct a readiness evaluation, and undergo survey, you must select from the evaluation options below. For additional information on selecting evaluation options, click on the instructions link above.

To select evaluation options for readiness evaluation, check the box for the product(s) in the "Select for Readiness Evaluation" column. To select evaluation options to submit for survey, check the box for the options in the "Select to Submit for Survey" column.

You may revise these selections at any time during your readiness evaluation.

Save

Evaluation Option	Survey Tool Complete	Select for Readiness Evaluation	Select to Submit for Survey
You may select one or more of the following evaluation options:			
Patient-Centered Medical Home (PCMH)	Complete	☐	☐
PCMH PRIME (for practices in Massachusetts ONLY)	Not Complete	☑	☑

Save

Q&A

PCMH PRIME Activity

Fact or Fiction?

Question 1:

A practice may apply for 2014 PCMH and PCMH PRIME concurrently.

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Fact or Fiction?

Question 2:

PRIME Element B, in order to receive credit for factor 2, behavioral health providers must be co-located and share the same systems (EHR) with the primary care providers.

Fact or Fiction?

Question 3:

The record review workbook available in 2014 PCMH Element 3C can be used to satisfy PCMH PRIME Element D, factors 1-3.

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Fact or Fiction?

Question 4:

PCMH PRIME Element D factors must be met at >50% to receive credit.

Fact or Fiction?

Question 5:

Practices may submit the same documentation for PCMH 3E factor 1 and PCMH PRIME Element E factor 1.

Fact or Fiction?

Question 6:

A practice that is Recognized PCMH 2014 Level 1 cannot submit a PCMH PRIME Only add-on survey.

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Fact or Fiction?

Question 7:

Practices must use the MA PRIME Option in NCQA's application portal when submitting its application.

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Fact or Fiction?

Question 8:

NCQA has the final determination of PCMH PRIME Certification.

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Fact or Fiction?

Question 9:

A practice must complete the HPC application prior to the NCQA application to be eligible for PCMH PRIME.

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Fact or Fiction?

Question 10:

PCMH PRIME Certification provides a one-year extension of PCMH Recognition.

PCMH Process Start-to-Finish

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Start to Finish: Patient-Centered Medical Home (PCMH) Recognition

BEFORE LEARN IT

1. Is your practice eligible for PCMH recognition? — Yes →
2. Get the FREE PCMH Standards & Guidelines. →
3. **Attend FREE "on board" training.** →
4. Do you want to proceed toward PCMH recognition? — YES!

DURING EARN IT

5. Order FREE online application. →
6. Do you have 3 or more practice sites? — Yes →
7. STOP! Obtain multi-site approval. →
8. **Attend FREE Standards & Guidelines training.** →
9. Transform practice using Standards & Guidelines (3–12 months).

No → 8

10. **Attend FREE software training** (at least 30 days before submitting ISS Survey Tool). →
11. Purchase ISS Survey Tool. →
12. Submit online application. →
13. Prepare and submit ISS Survey Tool to NCQA. →
14. NCQA reviews ISS Survey Tool (30–60 days). →
15. Receive decision (results in ISS).

AFTER KEEP IT

16. Promote your NCQA Recognition status. →
17. Upgrade your NCQA Recognition status. →
18. Maintain your NCQA Recognition status.

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V. 1 PCMH • 03/22/13

Start-to-Finish has 3 Phases

1. **BEFORE: LEARN IT** – Am I eligible?
   Can I make the commitment?
   Why would I want to do this?
2. **DURING: EARN IT** – I am committed what do I need to do submit? What is required?
3. **AFTER: KEEP IT** – I made it!
   How do I keep my recognition?
   What do I do if my practice changes?
   How do I promote my achievement?

Start-to-Finish
1. *Before/Learn It Phase*

1. **Eligibility**
2. **Order the free <u>electronic</u> version of the guidelines and download whenever updates are published**
3. **"Getting on Board" live and recorded**
4. **Are you able and ready to proceed?**

NCQA Free Webinar Training

Programs | HEDIS & Quality Measurement | Report Cards | Public Policy | Publications & Products | Professional Development | Newsroom | Sponsorship & Events | About NCQA

Recognition Programs Research & Resources

Relevant to All Recognition

PCMH/PCSP Multi-site/specialty Eligibility

Recognition Programs Multi-site Process

NCQA PCMH & PCSP Recognition Program Pricing

Announcements

Practices

Clinicians

Programs » Recognition

Recognition

What is Recognition?

NCQA Recognition Programs empower employers, health plans, patients and consumers to make informed heath care decisions based on quality. Participation in a NCQA Recognition Program demonstrates that the practice or clinician values quality health care delivery and the latest clinical protocols to ensure that patients receive the best care at the right time.

Clinician Recognition Di

Sea
Rec

NCQA Recognition Programs

Practice Programs

- Patient-Centered Medical Home Recognition (PCMH)
- Patient-Centered Specialty Practice Recognition (PCSP)
- Government Recognition Initiative (GRIP)
- Retired Physician Practice Connections Recognition Program (PPC)

Clinician Programs

- Diabetes Recognition Program (DRP)
- Heart/Stroke Recognition Program (HSRP)
- Retired Back Pain Recognition Program (BPRP)

RP Announcements
Get the latest information and updates on all Recognition Programs, news and questions.

Industry Resources
Find related research articles and supporting organizations, including consultative and technical support for NCQA Recognition Programs.

Medical Boards Awarding Certification for Recognition

ABFM
ABFM-certified physicians enrolled in NCQA's BPRP, DRP, HSRP and PCMH 2011 Recognition Programs are eligible to receive Part IV Maintenance of Certification credit for achieving NCQA Recognition.

ABIM
ABIM-certified physicians enrolled in NCQA's Diabetes, Back Pain, or Heart/Stroke Recognition Programs can

Questions?

For more information,
"Recognition Program

See if your question h
important FAQs and c
you submit your ques

- PCMH/PCSP/ISS
- GRIP
- DRP
- HSRP

Promote Your NCQA Status

Download NCQA seals and graphics to use in your marketing materials

View Advertising Guidelines

Recognition Program Resources

Free Webinar Training
Free programs help complete the application and submission process.

In-Person Training
NCQA live educational seminars on Recognition programs offered around the country.

Purchase Survey Materials
Materials for Recognition application and submission for Recognition programs

Health Plans Using Recognition
A list of insurers who use NCQA Recognition to improve quality.

Data License

Recognition Notes

The Newsletter of NCQA Recognition Programs

August 2014

April 2014

December 2013

Archives

Click here to see Free Webinar Training

- *Start-to-Finish*
- PCMH Standards
- PCSP Standards
- ISS Survey Tool
- On-line Application

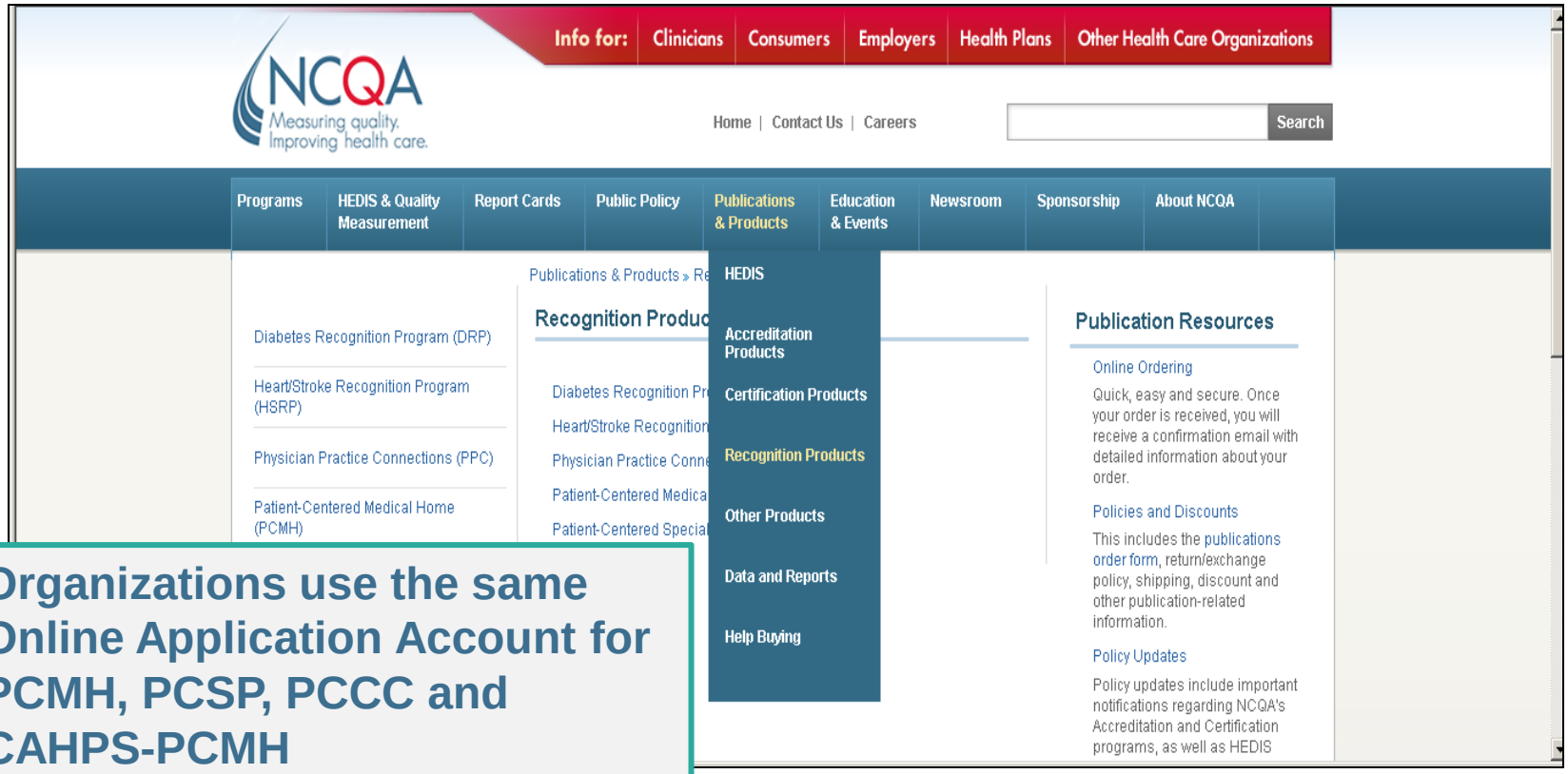
NCQA Software Used During the Recognition Process

Online Application Account

- One account per organization handles many applications, multiple sites. Used for PCMH (2011 & 2014), PCSP, PCCC, CAHPS PCMH
- Enter primary contact, demographic practice, clinician information and certificate name
- Sign BAA (Business Associates Agreement) and Program Agreement, e.g., PCMH 2014 Agreement
- Resource library inside
- One application precedes every ISS survey tool
- Used to initiate Multi-Site approval
- Used to initiate Add-ons
- Safeguard your user names and passwords

Order free Online Application Account

www.ncqa.org/PublicationsProducts/RecognitionProducts.aspx



Organizations use the same Online Application Account for PCMH, PCSP, PCCC and CAHPS-PCMH

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What Are Multi-Site Surveys & Who is Eligible?

- Option for organizations or medical practices with 3 or more sites that share policies and procedures and electronic systems across all of their practice sites.
- NCQA does not give organization-wide Recognition
- A specified number of corporate (shared) elements are completed once for multiple practice sites in an additional survey tool
- All other elements require responses at the site level
- Any possible multi-site should attend the "Getting on Board" training for complete details

2. During/Earn It Phase

Attend FREE Standards Training

"The Rules of the Program"

Recorded Trainings Available on the NCQA Website:

http://www.ncqa.org/Programs/Recognition/RelevanttoAllRecognition/RecognitionTraining/RecordedTrainings.aspx

Live Q&A Sessions are Now Available!

- Attend as often as you want
- Time to ask NCQA staff questions
- Calendar on the NCQA website: http://www.ncqa.org/Programs/Recognition/RelevanttoAllRecognition/RecognitionTraining.aspx

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Transformational Prep Work

- Assess practice site against Standards & Guidelines
- Document gap in performance and need for written documentation
- Write, finalize, and implement new procedures
- Implement electronic systems such as practice management systems, billing systems or registries
- Build electronic systems data to support reporting requirements
- Anticipate at least 3 - 6 months prep time
- Procedures and electronic systems must be fully implemented at least 3 months before survey submission

Software Training

PCMH Software Training

- Online Application
- Interactive Survey System (ISS) Tool

- **Training is Recorded - Attend anytime!**
  - http://www.ncqa.org/Programs/Recognition/RelevanttoAllRecognition/RecognitionTraining/PatientCenteredMedicalHomePatientCentered.aspx
- **Not available as a live monthly training**
- **Demonstrates how to navigate and enter information into the software**
- **Submit any questions or technical difficulties to assigned technical analyst**

Buy ISS Survey Tools

Interactive Survey System Tool

http://www.ncqa.org/tabid/629/Default.aspx#pcmh

- **Survey tool purchase is the first of 2 payments to NCQA for each practice site**
  - ❖ ***Single Site Survey Tool Order Process:***
    - a) **Order and purchase survey tool via NCQA Store (store.ncqa.org) or MyNCQA (my.ncqa.org) at $80**
    - b) **2 e-mails will be sent to acknowledge purchase and to provide username, password and license number for each survey tool purchased**
    - c) **Order with the same practice name used in application**
    - d) **Manager and Analyst assigned after purchase**

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Buy ISS Survey Tools

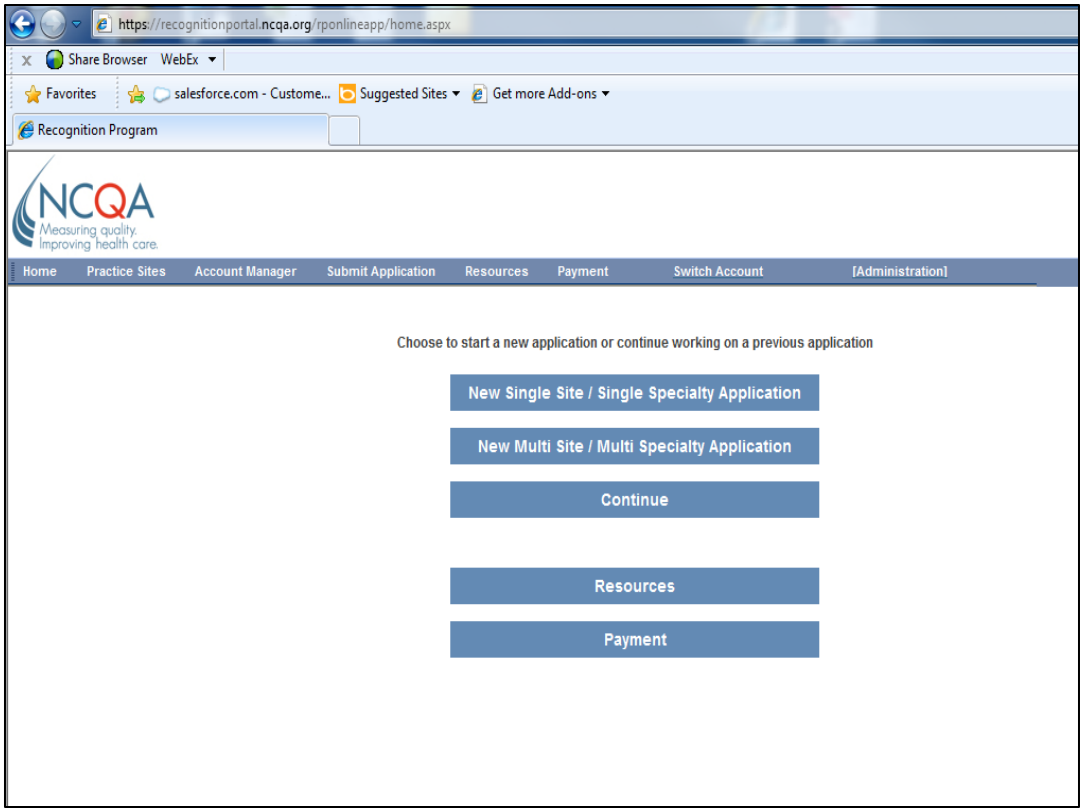
Interactive Survey System Tool

- ***Multi-Site Survey Tool Order Process*:**
  - a) **Access survey tool order form in on-line application tool after multi-site eligibility approval following call with RP manager**
  - b) **E-mail, fax or mail printed order form found in online application tool to NCQA Customer Support**
  - c) **Include credit card information or check at $80 per survey license for each site including corporate**
  - d) **2 e-mails for each site will be sent to acknowledge purchase and to provide username, password and license number for <u>each</u> survey tool purchased**
  - e) **Manager and Analysts will be assigned after purchases**

Complete Your Online Application

- Log in Online Application

- Click new or continue



Completing Online Application

- **Sign applicable Legal Agreements electronically**
- Create separate application for each site under same account
- **Enter clinician data for each site: NPI, Full Name, Tax ID, Specialty for each**

  NOTE: Punctuation and spelling matter
  Do NOT enter ALL CAPS or all lower case letters
- Link clinicians to each application – clinicians currently practicing at each site only
- **Enter ISS license # from your e-mail order for each site – creates a link to each ISS (Survey) tool**
- Pay/Submit application for each site separately by selecting the checkbox and "Submit" button for each, then the "Pay" link to receive the e-mail that includes the **MyEzPay** instructions.
- **NCQA needs 5 business days to verify site prior to accepting ISS tool**
  – NCQA will send a confirmation e-mail

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Submit Program Fees and Surveys

Payment can now be made online via the My EzPay system!

Recorded training for the application and payment process is available on the NCQA website:
http://www.ncqa.org/Programs/Recognition/RelevanttoAllRecognition/RecognitionTraining/RecordedTrainings.aspx

NCQA Website: ISS Login
Access to Survey Tool

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Programs » Recognition » Patient-Centered Medical Home (PCMH)

Before | Learn It (PCMH)

During | Earn It (PCMH)

After | Keep It (PCMH)

New Version of PCMH

Get Answers to Your Question

Patient-Centered Medical Home Recognition

Important Links

ISS Login
Online Application Login
Resources

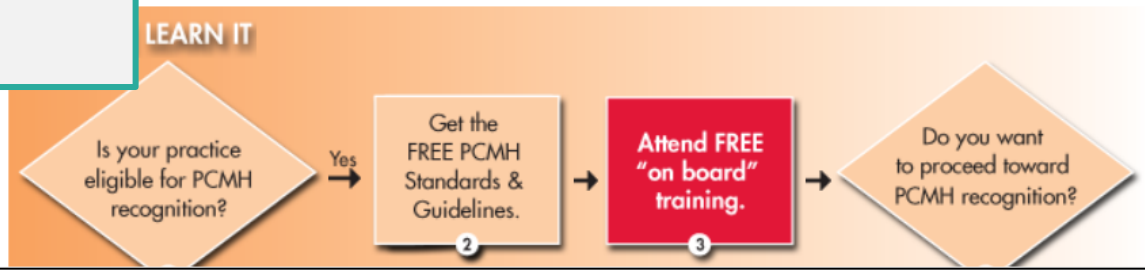
The patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into "what patients want it to be." Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care.

NCQA Patient-Centered Medical Home (PCMH) Recognition is the most widely-used way to transform primary care practices into medical homes.

Click on the numbered shapes in the "Start to Finish" flowchart below to plan your path to PCMH recognition.

Click here to learn about PCMH 2014.

Can access ISS from NCQA Website



Lead Sponsors

abbvie

Using the Survey Tool

Steps for the practice:

1. Organize supporting documentation
2. Respond to ALL factors
3. Build document library
4. Link documents to elements
5. Complete Organizational Background tabs
6. Review results

Build the Document Library

1. Assemble documents in a PC file
2. No Protected Health Information
3. Assign meaningful file names
4. Highlight and label contents to draw reviewer attention
5. Aim for 1- 3 attachments per element
6. Attach one document to several elements
7. Load up to 3 documents at a time into ISS Tool Library and rename
8. Link documents to relevant elements
9. Save
10. Changes to any document requires reloading the document

Manage the Documents

Use a unique naming convention

- Use any organizing principle desired, for example:
  - PCMH 1 A—Name of Document.docx
  - PCMH 1 B—Name of Document.xlsx
- Avoid file names with special characters (e.g. quotation marks, question marks, commas, apostrophes, ampersands)
- Documents can be linked to multiple elements; no duplicates should be in the Document Library
- Use text boxes and highlighting to identify important sections and briefly explain the importance

Respond to All Factors

PREVIOUS STANDARD | Save | NEXT STANDARD

PCMH1: Patient-Centered Access View Points

The practice provides access to team-based care for both routine and urgent needs of patients/families/caregivers at all times.

ELEMENT A - Patient-Centered Appointment Access (MUST PASS) View Points | Clear Data

The practice has a written process and defined star o appointments, and regularly assesses its performance on:

	Yes	No
1. Providing same-day appointments for routine a FACTOR) *	◉	○
2. Providing routine and urgent-care appointment ours.	◉	○
3. Providing alternative types of clinical encounte	◉	○
4. Availability of appointments.	○	◉
5. Monitoring no-show rates.	○	◉
6. Acting on identified opportunities to improve ac	○	◉

* Required for critical factors. Score cannot exceed 0%

Scoring:

100%	75%			0%
The practice meets 5-6 factors	The practice meets 3-4 factors	The practice meets 2 factors (including	The practice meets 1 factor (including	The practice meets 0 factors

Answer EVERY radio button even if the answer is No. If NA make sure to justify in Text/Notes area

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Link Documents and Enter Text for Explanations

PREVIOUS STANDARD | Save | NEXT STANDARD

PCMH1: Patient-Centered Access View Points

The practice provides access to team-based care for both routine and urgent needs of patients/families/caregivers at all times.

ELEMENT A - Patient-Centered Appointment Access (MUST PASS) View Points | Clear Data

The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on:

	Yes	No
1. Providing same-day appointments for routine and urgent care. (CRITICAL FACTOR) *	○	○
2. Providing routine and urgent-care appointments outside regular business hours.	○	○
3. Providing alternative types of clinical encounters.	○	○
4. Availability of appointments.		
5. Monitoring no-show rates.		
6. Acting on identified opportunities to improve access.		

* Required for critical factors. Score cannot exceed 0% if critical factors are not met.

Scoring:

100%	75%	50%	25%	0%
The practice meets 5-6 factors (including factor 1)	The practice meets 3-4 factors (including factor 1)	The practice meets 2 factors (including factor 1)	The practice me 1 factor (includi factor 1)	

Data Source:

Scope of Review:

Reference Information: Explanation | Examples

ELEMENT SCORE | DOCUMENTS | SUPPORT TEXT / NOTES | SUPPLEMENTAL WORKSHEET

Click here to link documents

Click here to enter explanatory text

ISS Survey Tool Organizational Background Tab

Inside the ISS Survey Tool

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PRINT | HOME | WHAT'S NEW | SEARCH | HELP & INSTRUCTIONS | LOGOUT

POLICIES & PROCEDURES | STANDARDS & GUIDELINES | SURVEY TOOL | ORGANIZATION BACKGROUND | RESULTS | APPENDICES | GLOSSARY | INDEX

2014 Patient-Centered Medical Home

Welcome to the Interactive Survey System!

The information in the following sections includes:

- the complete Standards
- information about how your organization will be evaluated against the Standards
- policies and procedures

We designed the system to facilitate understanding of our Standards and the evaluation process. The "Help and Instructions" section above directs users to assistance.

Policies and Procedures - This section provides an overview of the survey option you have selected; it describes the goals and principles that guide our approach to evaluation, and provides a high-level summary of areas addressed by the Standards.

The Policies and Procedures describe:

- eligibility criteria; evaluation options; the interactive survey process
- the structure of the Standards and Guidelines and the Survey Tool
- how we report survey results; and obligations of organizations and individuals undergoing a survey.

Standards and Guidelines - This section allows you to open or download printable versions of publications.

Survey Tool - This section includes the Standards used for evaluation. Standards are organized into categories or

ISS Organizational Background Tab Complete Practice Site Information

PRACTICE INFORMATION | CORPORATE SURVEY TOOL | RECOGNIZED CLINICIANS | RENEWAL ELEMENTS | ADD-ON ELEMENTS | PREVALIDATION

Practice Information

1. Site City
2. Site State
3. Practice Site PCP Specialties
4. Number of PCPs
5. Is **this** survey tool for a single site?

   (If no, please complete the Corporate Survey Tool Section on the following tab)

Save/Update

Load Document to the Library

[close this window]

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Attach more information about the practice. Give it a face to our reviewers.

Complete Recognized Clinicians

PRACTICE INFORMATION | CORPORATE SURVEY TOOL | RECOGNIZED CLINICIANS | RENEWAL ELEMENTS

Recognized Clinicians

Please list all the ELIGIBLE clinicians at the practice that are recognized in other NCQA programs and provide the Clinician Last Nar
Program (DRP, HSRP, BPRP), Recognition Expiration Date. If not all the clinicians are eligible for DRP & HSRP recognition, please
an explanation (i.e. these clinicians do not care for diabetic patients).

Example:

- Smith, DRP, 8/10/15
- Robinson, HSRP/DRP, 6/25/14

```
Tucker, DRP, & HSRP, 10/1/2014 - 10/1/2017
Bates, DRP, 7/30/2014 -7/30/2017
Jones, HSRP, 6/15/2014 - 6/15/2017
Lee, DRP & HSRP 5/8/2014 - 5/8/2017
```

Save/Update

Load Document to the Library

[close this window]

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- List the practice's clinicians with current Recognitions for auto-credit:
  - ✓ Diabetes Recognition Program
  - ✓ Heart/Stroke Recognition Program

Pre-submission Completeness Check

- **ISS Completeness Check Functionality**
  - Shows incomplete elements
  - Multi-Site corporate tools will always show incomplete elements
- **Readiness of ISS Tool**
  - Check complete score and level
  - Check Must Pass elements and critical factors
  - Check that documents are linked to elements
- **Verify Online Application was accepted, if not an error message will appear when trying to submit**

Readiness of ISS Survey Tool Review

POLICIES & PROCEDURES | STANDARDS & GUIDELINES | SURVEY TOOL | ORGANIZATION BACKGROUND | RESULTS | APPENDICES | GLOSSARY | INDEX

Return to Results Index

STATUS | SUMMARIZED & DETAILED RESULTS | MUST PASS RESULTS | CRITICAL FACTOR RESULTS | MEANINGFUL USE RESULTS

2014 Patient-Centered Medical Home

This section provides summary and detailed results and recommendations. Overall scoring results are available and at the category, Standard and element levels.

Based on information compiled during the recent review, We award the status listed below. Status descriptions can be found by clicking the Policies and Procedures tab.

General Information

Name: NCQA Monica McGill

Status: Not Available

Valid Dates: Not Available

Standards Year: 2014 **Score:** 0.00

Overall Score: 0.00 out of 100.00

RESULTS:

- ✓ Summarized & Detailed
- ✓ Must Pass
- ✓ Critical Factors
- ✓ Meaningful Use

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Recognition Review Process

NCQA

- **Checks licensure of all clinicians for restrictions**
- **Evaluates Survey Tool responses, documentation, and explanations by**
  - Reviewer – initial evaluation
  - Executive reviewer – NCQA PCMH managers
  - Peer review – Recognition Program Review Oversight Committee member (RP-ROC)
  - Audit (5%) – may be conducted by email, teleconference, or on-site audit

Recognition Review Process

NCQA

- **Issues final scoring decision and level to the practice within 30 – 60 calendar days by email**
- **Reports results**
  - Recognition posted on NCQA Web site
  - Not passed - not reported
- **Mails PCMH certificate and Recognition packet**

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Recognition Decisions

Recognition awarded at the practice site level

- **Levels 1, 2 and 3**
- **3-year Recognition period**
- **Denial of Recognition**
  - PCMH score below 35 points
  - One or more Must Pass elements <50%
  - Not made public or distributed to P4P
- **Manager sends auto email to practice's primary contact**
- **Levels reported to public; scores are not made public**

How to See Results in ISS

Welcome - Microsoft Internet Explorer provided by NCQA

https://iss.ncqa.org/rdsat/ATWelcome.asp

File Edit View Favorites Tools Help

NCQA Portal | Welcome

NCQA. Once the survey tool has been submitted, you may view the information submitted to NCQA. The survey tool will not contain the results of NCQA's evaluation. To view the preliminary or final results of the NCQA survey, scroll down to Survey & Results.

Please select one to use:

PPC-PCMH

- 2008 PPC-PCMH Survey Tool Web-based (1-4 users)
  (License 10074 , Submitted 9/25/2008)
- 2008 PPC-PCMH Survey Tool Web-based (1-4 users)
  (License 12086)

Survey & Results

This section is where you will find survey results for projects that you have submitted to NCQA.

NCQA has conducted or is conducting the following surveys.

Please select one to view:

PPC-PCMH

- 2008:PPC-PCMH
  (Stage 10, Org 6508, Project 7083, Start 8/26/2008, Submitted 9/25/2008)

program. We've designed our electronic format to facilitate understanding of our standards and make our survey process more efficient.

argaret E. O'Kane, President, NCQA

ines - presents the layered format via the e Survey Tool, which edded in it - you can standards as NCQA will NCQA survey. When s the basis for the NCQA survey. You complete the Survey Tool, attach necessary documentation and submit both to NCQA. Using the Survey Tool allows you to fully understand how you meet the standards and allows NCQA to conduct surveys econom survey occurring off site. o assistance NCQA o

Please let us know how you like ay we can further help wit uality in health care.

To view final results, DON'T open the survey here.

Open the survey here.

Pop-ups were allowed. ocal intranet 100%

start | 2 Microsoft Of... | Welcome - Micr... | Document1 - Mi... | 12:41 PM

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NCQA Evaluation: Example Text/Notes Entry

Support Text/Notes

Evaluation

Reviewer Note

Practice Note

Use this space to provide any additional explanation of the element evaluation.

5/14/2009 NCQA Reviewer Note:
The practice responded "yes" to all factors and the reviewer agrees.
---
1. See "Diagnosis Graph" for data on most commonly used diagnosis codes used in clinical encounters.
2. See "CDC prevalence reports" for data on the prevalence of our three selected conditions within our State and local community.
3. As part of a National PCMH Demonstration Project and in collaboration with NCQA, the Demonstration Project Stakeholders have chosen Diabetes, Hypertension and Hyperlipidemia as Clinically Important Conditions which represent the best likelihood of being amenable to care management and providing value on costs to the health care system based on regional experience. These conditions have associated required metrics which will be reported by the physician practices as part of the National PCMH Demonstration Project.

Edit

Justify all N/As In Text/Notes

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NCQA Recognition Directory

NCQA RECOGNITION DIRECTORY

CLINICIAN SEARCH HOME

Clinician Search Results

New Search

Search results: (1 - 50) of 1055

Clinician	Address	Current Recognitions	Recognition Program(s)
		-PCMH Level1 (07/03/2009 - 07/03/2012)	
		-PCMH Level2 (01/13/2011 - 01/13/2014)	
		-PCMH Level3 (07/23/2010 - 07/23/2013)	
		-PCMH Level3 (10/22/2010 - 10/22/2013) (09/14/2009 - 09/14/2012)	

Website Listing Includes:

- ✓ Clinician name, title (MD, DO, NP, PA)
- ✓ Practice name and address
- ✓ Current Recognition
- ✓ Recognition Program

PCMH Certificates

Patient-Centered Medical Home
NCQA
RECOGNIZED PRACTICE
PHYSICIAN PRACTICE CONNECTIONS
PATIENT-CENTERED MEDICAL HOME

Certificate of Recognition

National Committee for Quality Assurance commends

Name of Practice

Recognized – Level 3

on Achievement of Recognition for Systematic use
of Patient-Centered, Coordinated Care Management Processes

Awarded from: *October 20, 2012* to: *October 20, 2015*

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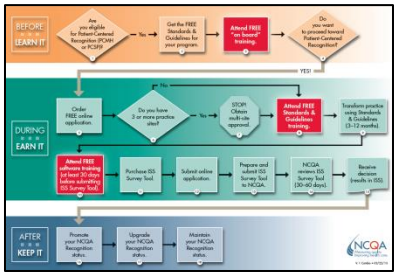
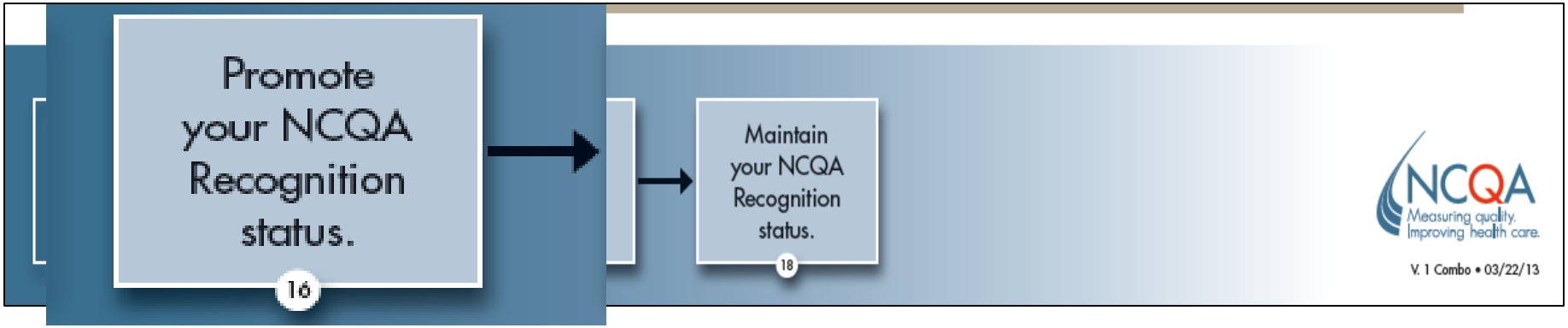
Margaret E. O'Kane
President

- **Routinely sent within 3 weeks of Recognition**
- **Site-level**
- **Fee for replacements or additional certificates**
- **Request at my.ncqa.org select Policy/Program and then Certificates**

What Happens After Recognition? Moving on to *3. Keep It* Phase





Recognized Practices Marketing Materials and Seals

NCQA sends press releases on request

Tools to promote Recognition

NCQA > Clinicians - Microsoft Internet Explorer provided by NCQA

http://www.ncqa.org/Clinicians.aspx

Info for: Clinicians | Consumers | Employers | Health Plans | Other Health Care Organizations

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Programs | HEDIS & Quality Measurement | Report Cards | Public Policy | Publications & Products | Education & Events | Newsroom | Sponsorship | About NCQA

Clinicians

Highlighting Providers' Quality

NCQA Recognition programs distinguish clinicians who follow medical evidence to deliver quality care and improve over time. Insurers, medical specialty boards and others use NCQA Recognition to identify providers for quality-based financial incentives and maintain board certification.

Clinician Recognition Directory
Search for NCQA-Recognized Clinicians

Recognition Programs

Patient-Centered Medical Home (PCMH)
PCMH recognizes clinician practices functioning as medical homes by using systematic, patient-centered and coordinated care management processes.

Diabetes Recognition Program (DRP)
DRP recognizes clinicians who demonstrate that they provide high-quality care to patients with diabetes.

Heart/Stroke Recognition Program (HSRP)
HSRP recognizes clinicians who demonstrate that they provide high-quality care to patients with cardiac conditions or who have had a stroke.

Physician Practice Connections (PPC)
PPC recognizes clinician practices that use up-to-date information and systems to enhance patient care.

Government Recognition Initiative Program (GRIP)
GRIP works with federal agencies to recognize Federally-Qualified Health Centers (FQHC) and Military Treatment Facilities (MTF) as medical homes.

Education & Resources

Free Training Teleconferences
These free monthly audio conferences and online trainings orient clinicians to NCQA Recognition programs. Reservations are not required.

Education Programs
Longer and more formal than our free monthly teleconferences, these programs delve into the details of NCQA Recognition.

Performance Improvement CME
Physicians can earn up to 20 AMA PRA Category 1 CME credits using these HEDIS-based performance improvement activities.

Purchase Recognition Products
One-stop shopping for publications and other materials related to NCQA Recognition.

Additional Resources

Physician Quality Reporting System (PQRS)

CAHPS Patient Experience Reporting

Physician HEDIS

ADVERTISING GUIDELINES AND SEALS

ISS Sign-In
Questions? Please contact NCQA Customer Support.
Sign-In Now

Local intranet | Protected Mode: Off

Reconsiderations

- Available to any practice that does not agree with NCQA's decision
- Initiated by letter to NCQA within 30 calendar days of decision
- Practice provides rationale only – no additional documentation
- Different NCQA reviewers and peer reviewers than original review team
- Fee - $1100
- Decision is final
- Does not prevent from continuing on to do an Add-on

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Add-On Surveys

- **When will a practice utilize an add-on survey?**
  - Not Passing score or Level 1 or 2 Recognition that the practice wants to increase with additional documentation and scoring
  - Practices may submit an add-on survey anytime within the current Recognition period or within 12 months of a Not Passing decision but no later than 9/30/17.
  - Application fee is discounted (50%)
- **Process**
  - Request an Add-on survey in the online application account
  - NCQA merges data from previous Survey Tool into new PCMH Survey Tool and makes available to practice (new license#)
  - Practice may change response in any element with score of <100%; no need to reattach already submitted documents
  - Practice submits a new application with the new license #
  - Practice uploads new documents and submits survey and payment
- **New status after 30-60 calendar day review based on:**
  - Score achieved on total of saved scores and new assessment

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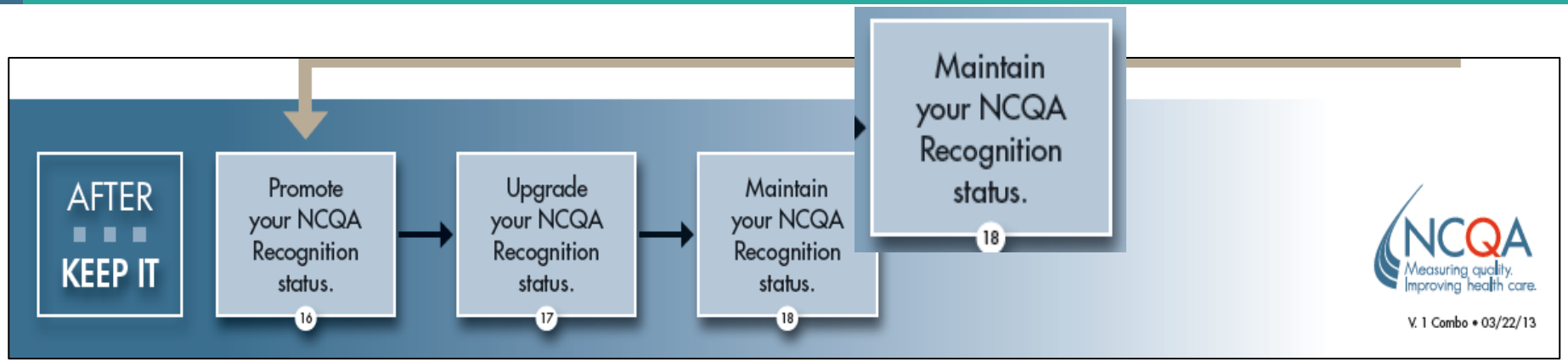
Maintain – Renewal Time



- **NCQA e-mails reminder to practice primary contact 6 months before expiration**
- **Expired practices:**
  - Lose eligibility for streamlined renewal option
  - No longer included in data feed to P4P sponsors
  - No longer displayed on NCQA's directory
  - Practice MUST submit before expiration to avoid a lapse in Recognition

NCQA Policy Re: Practice Changes

PCMH Policies and Procedures require the practice to notify NCQA of changes in: location, mergers or consolidations.

Scenario	NCQA's Usual Response
Ownership change only*	No change in Recognition
Location change only*	No change in Recognition
A material change in clinicians assigned to site*	No change in Recognition
Two or more Recognized practice sites merge or a Recognized practice merges with an unrecognized site*	Merged site takes Recognition level of the final location
Material Change to the structure or operation of the practice*	Case-by-case assessment
Recognized practice splits into two or more locations	Case-by-case assessment.

**** NCQA reserves the right to request a) a written attestation that the change resulted in no material changes in operational procedures or electronic systems, b) additional documentation for selected PCMH elements, c) a new survey submission. Recognitions may be revoked for reasonable cause at NCQA's discretion.***

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Adding/Deleting Clinicians

Practices:

- Add or delete eligible clinicians at any time during the Recognition period
- Delete clinicians who no longer maintain a panel of PCP patients
- Submit clinician changes by the 20th of a month to be effective the following month
- Send *Workbook for Adding/Deleting Clinicians to a Recognition (from* ncqa.org website) to pcmh@ncqa.org

NCQA:

- Sends lists to Pay-for-Performance sponsors each month
- Has no role in administration of payment programs

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NCQA Website Q&A Location

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- Recognition Programs Research & Resources
- Relevant to All Recognition
- PCMH/PCSP Multi-site/specialty Eligibility
- Recognition Programs Multi-site Process
- NCQA PCMH & PCSP Recognition Program Pricing
- Announcements
- Practices
- Clinicians

Programs » Recognition

Recognition

What is Recognition?

NCQA Recognition Programs empower employers, health plans, patients and consumers to make informed heath care decisions based on quality. Participation in a NCQA Recognition Program demonstrates that the practice or clinician values quality health care delivery and the latest clinical protocols to ensure that patients receive the best care at the right time.

Clinician Recognition Directory
Search for NCQA-Recognized Clinicians ›

NCQA Recognition Programs

Practice Programs

- Patient-Centered Medical Home Recognition (PCMH)
- Patient-Centered Specialty Practice Recognition (PCSP)
- Government Recognition Initiative (GRIP)
- Retired Physician Practice Connections Recognition Program (PPC)

Clinician Programs

Questions?

For more information, submit a question to PCS select "Recognition Programs."

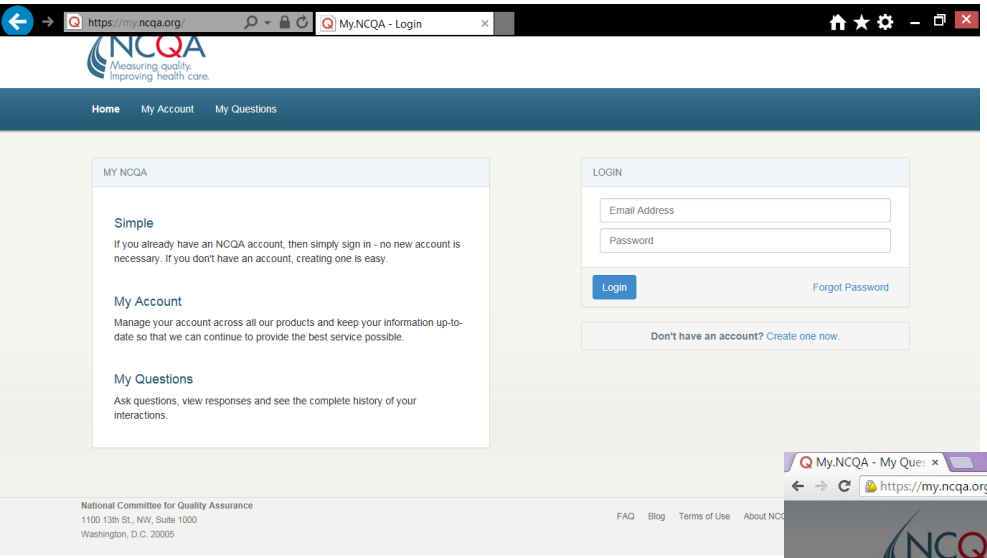
See if your question has already been answered. Access important FAQs and other important information before you submit your question:

- PCMH/PCSP/ISS
- GRIP
- DRP
- HSRP

- ✓ Submit questions here
- ✓ Receive a timely answer from staff
- ✓ Track your questions and answers

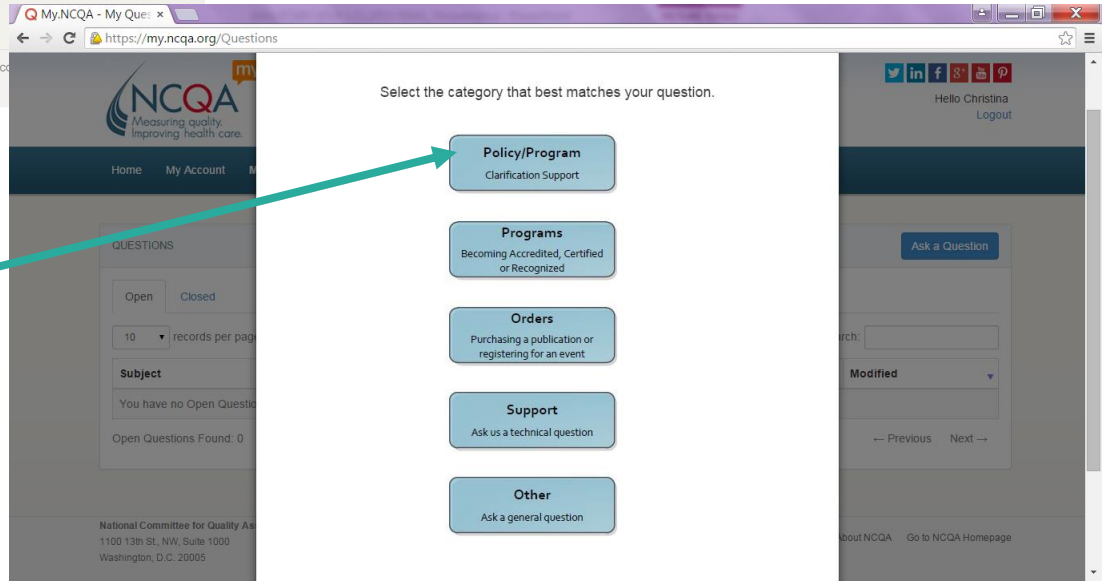
Register and Log-in to MYNCQA

Policy/Program Clarification Support (PCS)



- Go To: my.ncqa.org
- New Users will need to register for an account
- Account is for all items NCQA…purchases, publications, questions

Select Policy/Program



Final Questions?

Thanks so much for attending and best wishes for your upcoming Recognition!

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