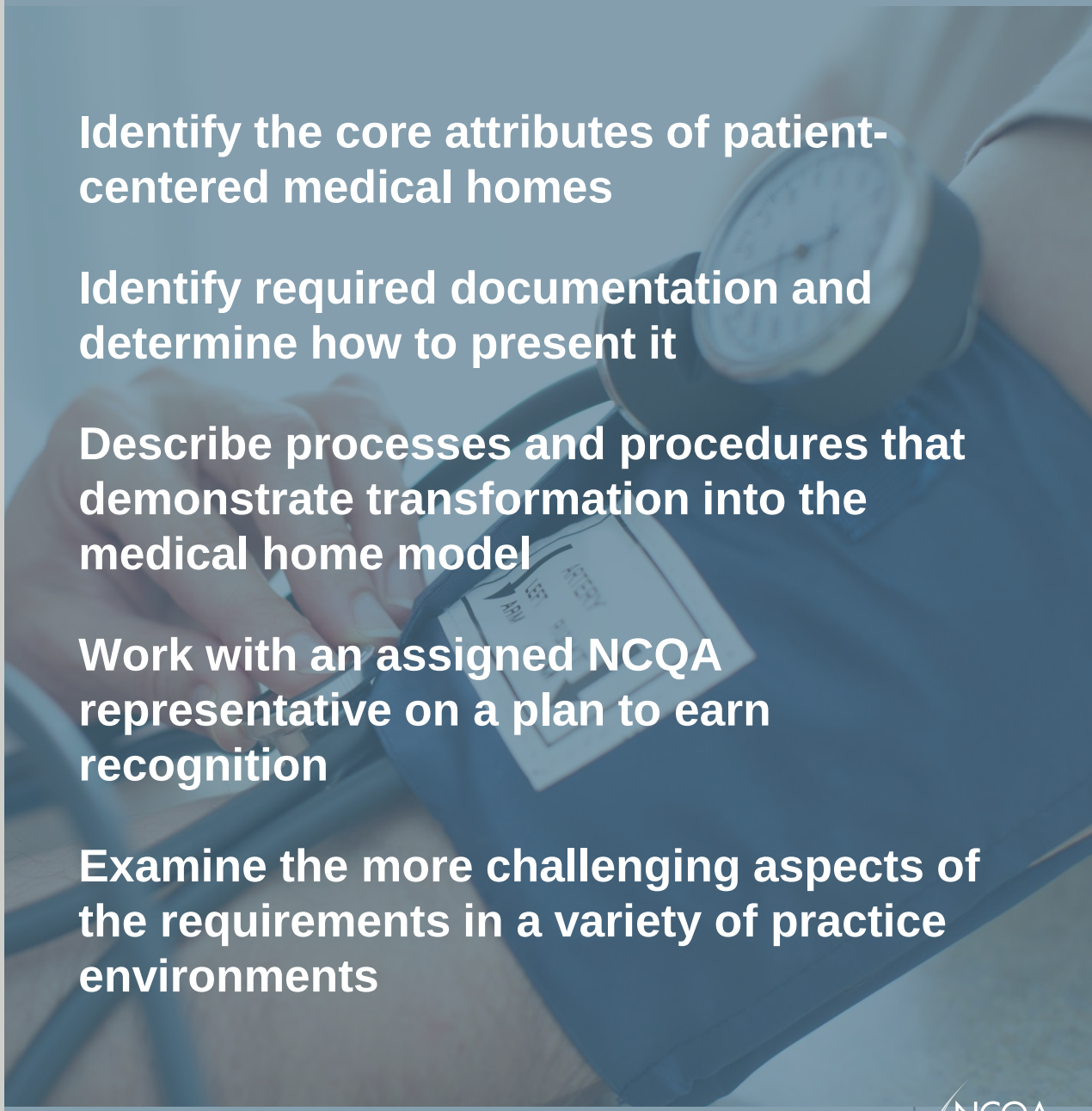
Introduction to PCMH:

Foundational Concepts of the Medical Home

Boston, MA
4/30 - 5/1/18

Learning Objectives



- **Identify the core attributes of patient-centered medical homes**
- **Identify required documentation and determine how to present it**
- **Describe processes and procedures that demonstrate transformation into the medical home model**
- **Work with an assigned NCQA representative on a plan to earn recognition**
- **Examine the more challenging aspects of the requirements in a variety of practice environments**

About the HPC

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.

NCQA

HPC PCMH Certification Program

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

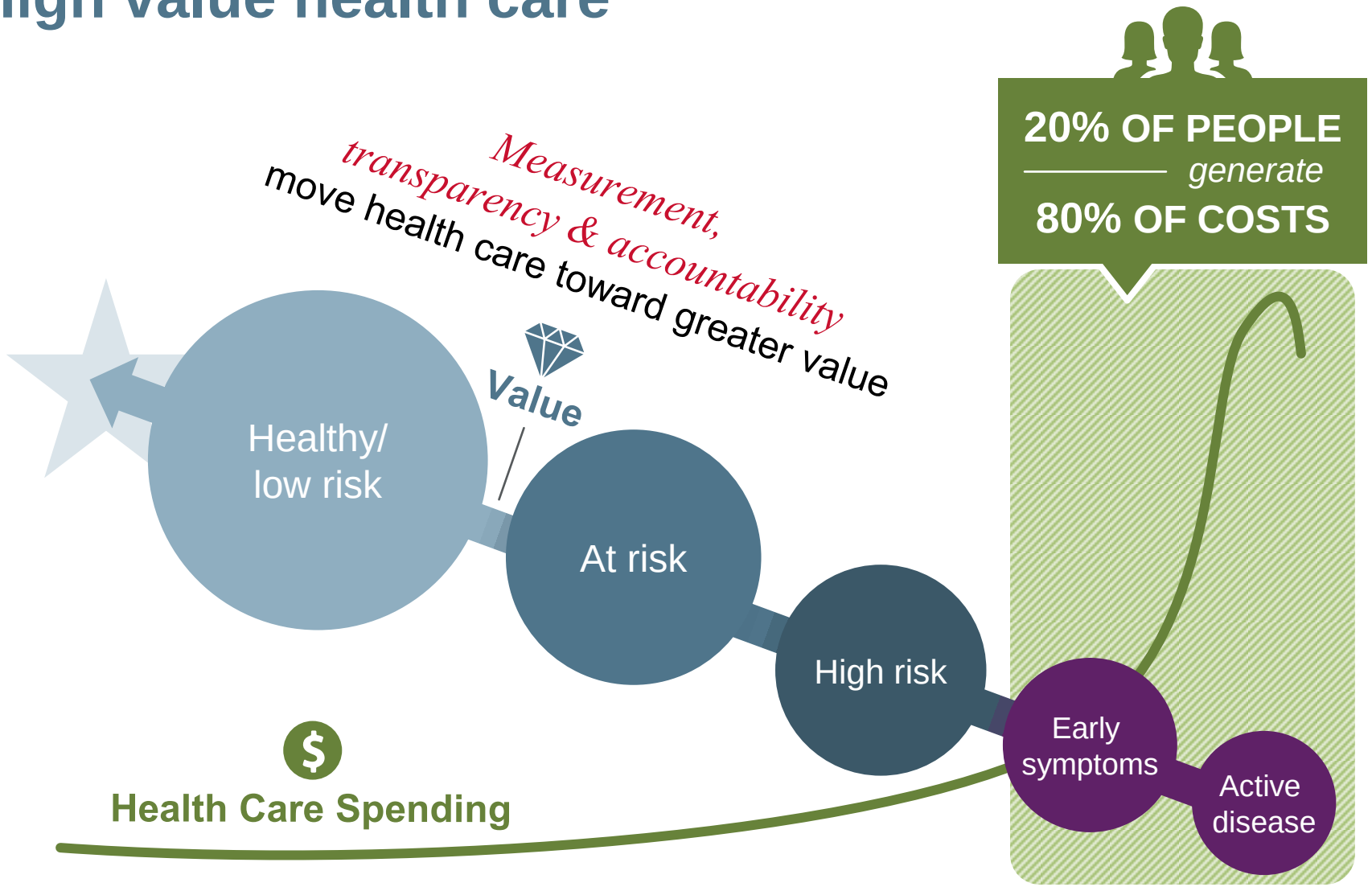
HPC partnered with NCQA to deliver this important program

NCQA

About NCQA

Goal

High value health care



About NCQA

Measuring quality. Improving health care.

Measure

Clinical quality, consumer experience, resource use

Accredit

Health plans, ACOs, etc.

Recognize

Physician practices

What we do, and why

OUR MISSION

To improve the quality of health care

OUR METHOD

Measurement

We can't improve what we don't measure

Transparency

We show how we measure so measurement will be accepted

Accountability

Once we measure, we can expect and track progress

Recognition programs

Identifies providers and practices delivering superior care

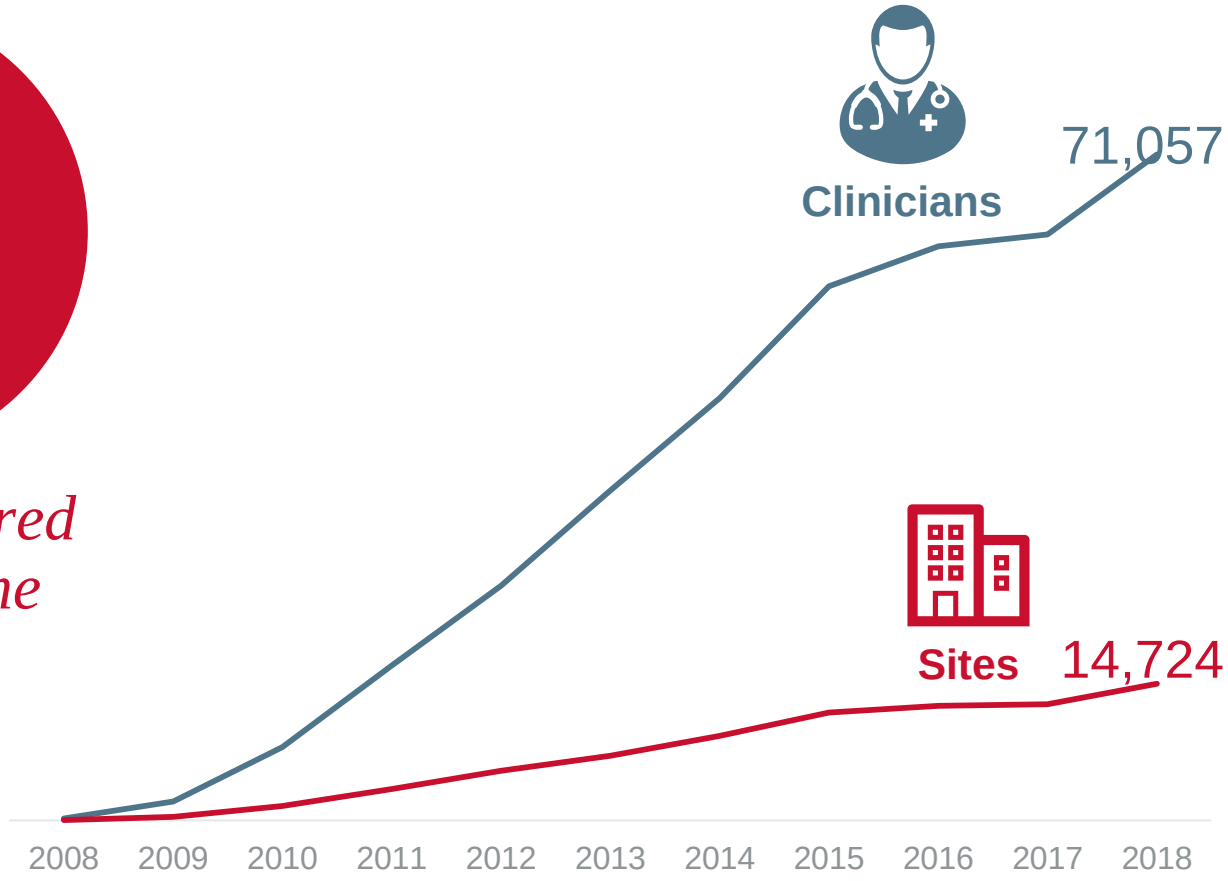
>84,000
clinicians at

>15,150
practice sites

The fastest-growing delivery system reform:

About NCQA

Patient-centered medical home (PCMH)



Patient-Centered Care

Overview

NCQA Recognition Program

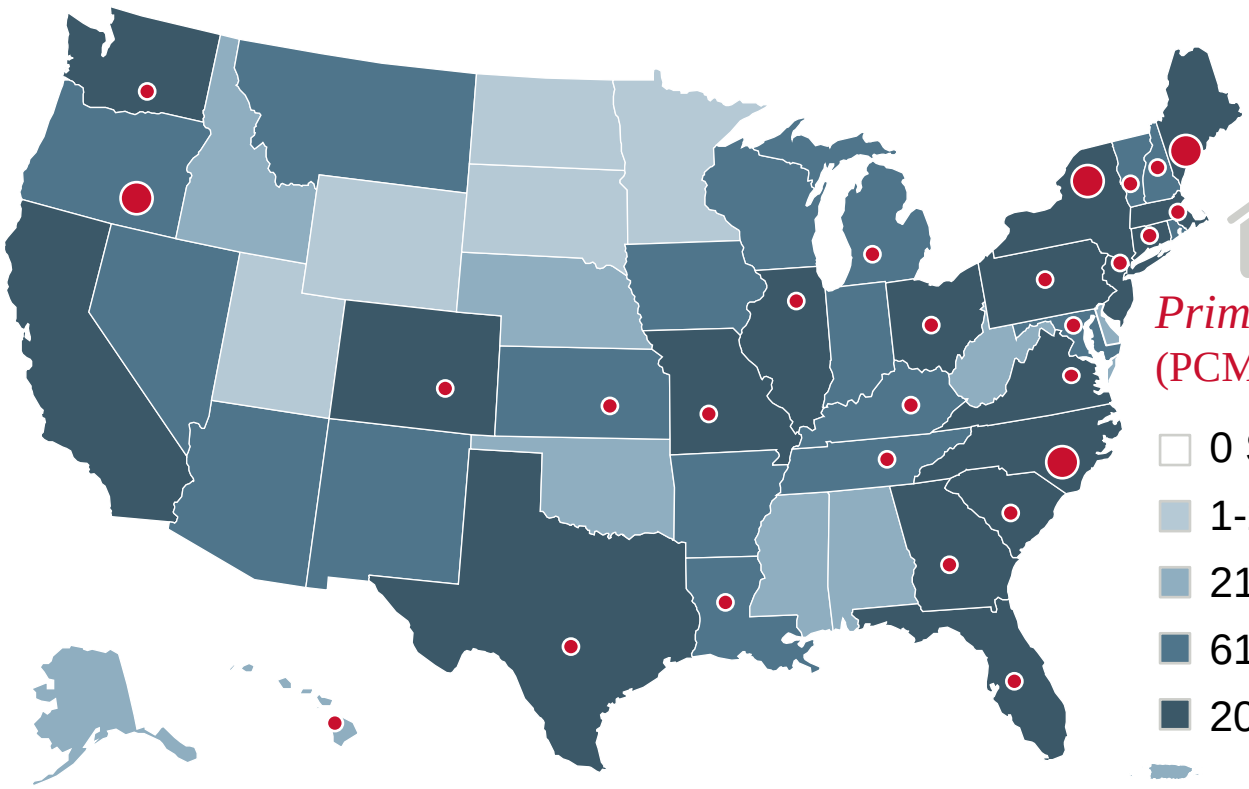
Patient-Centered Medical Home | Patient-Centered Specialty Practice | Patient-Centered Connected Care

NCQA

NCQA medical neighborhood recognitions

Closing the Loop Between Primary & Specialty Care

Over *15,100* Total Sites Recognized
PCMH & PCSP



PCMH

Primary Care (PCMH) SITES

- 0 Sites
- 1-20 Sites
- 21-60 Sites
- 61-200 Sites
- 201+ Sites

Specialty (PCSP) SITES

- 1-9 Sites
- 10+ Sites

Current Landscape

Rewarding Value

Improving Quality

Move towards PCMH and Better Integration

The Triple Aim

A framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to health system performance

The three dimensions are:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

The three key concepts embedded in the PCMH requirements

2001 Institute of Medicine

Crossing the Quality Chasm: A New Health System for the 21st Century

Ten Rules that were foundational to NCQA PCMH

1. Care based on continuous healing relationships
2. Care based on patient needs and values
3. Patient as the source of control
4. Patient access to medical information and clinical knowledge
5. Evidence-based decision making
6. Patient safety
7. Transparency of information
8. Anticipation of needs
9. Continuous decrease in waste
10. Cooperation among clinicians

Theory Behind PCMH Development

Chronic Care Model

- Clinical information Systems
- Decision Support
- Patient self-management
- Delivery system Redesign
- Community linkages
- Health systems

Patient-Centered Care

- Respect patient values
- Accessible
- Family-centered
- Continuous
- Coordinated
- Community linkages
- Compassionate
- Culturally appropriate
- Emotional support
- Information and education
- Physical comfort
- Quality improvement

Cultural Competence

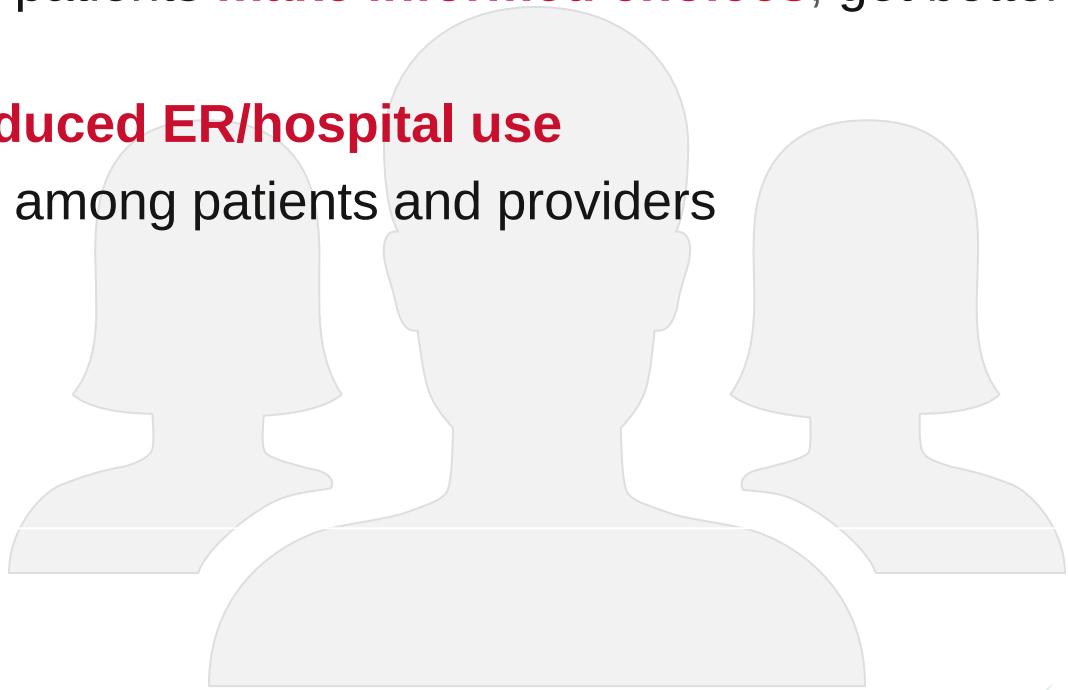
- Culturally competent interactions
- Language services
- Reducing disparities

Medical Home

- Personal physician
- Physician directed team
- Whole person orientation
- Care is coordinated and integrated
- Quality and safety
- Enhanced access

Primary Care: What Patients Want

1. Long-term partnerships, **not hurried visits**
2. **Care that is coordinated** among providers
3. Better access through **expanded hours and online tools**
4. Shared decisions so patients **make informed choices**, get better results
5. Lower costs from **reduced ER/hospital use**
6. **Higher satisfaction** among patients and providers



PCMH Development History

Joint Principles of the Patient-Centered Medical Home

Standards were developed to align with Joint Principles

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced Access
- Payment

PCMH 2017 standards incorporate concepts from a complimentary set of joint principles that recognizes the centrality of behavioral health care as part of the PCMH

What is Patient-Centered Care?

1. **Ongoing relationship with a personal clinician** - first contact, continuous, comprehensive care

2. **Responsibility for all patient's health care** needs or arrange care.

3. **Care for all stages of life;** acute care; chronic care; preventive services; and end of life care.

4. **Team care**, includes clinician who **take responsibility** for care of patients.

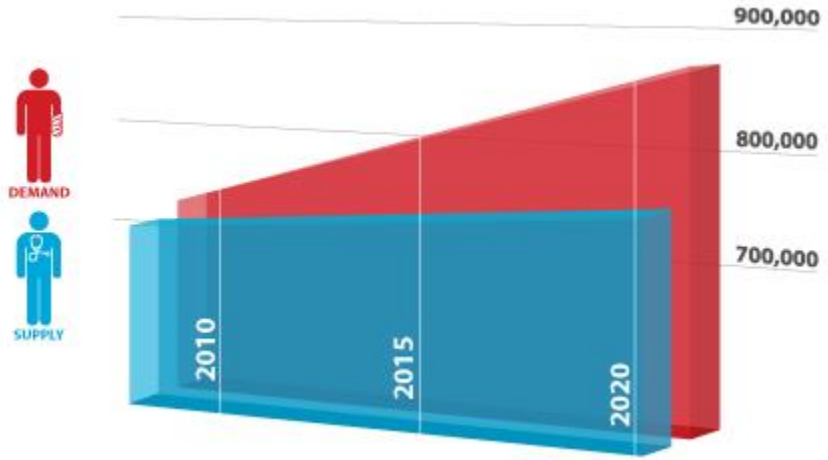
But……Are We Following the IOM Rules?

Americans without access to primary care **60 Million**

Average wait for non-emergency appointment **20.3 Days**

PCPs accepting new patients **49.8%**

Projected Supply and Demand of All Physicians

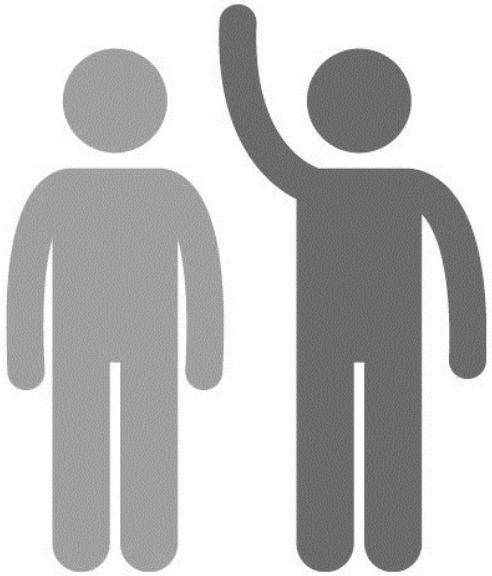


- Anticipated 90K physician shortage by 2020, including a 45K PCP shortage

Key healthcare challenges, such as insufficient resources directed to primary care, drive unsustainable healthcare costs and poor performance

Source: Association of American Medical Colleges, 10/11/10

The Costs: Unsustainable



One in two Americans lives with a chronic condition that is largely preventable.

In one decade,
the cost of health care
has more than doubled.

Sources:
[1] Center for Medicare and Medicaid Services, 2010 data
[2] Centers for Disease Control and Prevention
[3] Milliman Medical Index (MMI) vs. Average Household Income
[4] The Kaiser Family Foundation and Health Research & Educational Trust Employer Health Benefits 2011 Annual Survey

Key Issues Drive High Costs & Poor Performance

Drivers of a Fragmented, Reactive and Costly US Healthcare System

- A payment system that rewards volume rather than value.
- A reactive focus on symptoms rather than proactive health management.
- Fragmentation – poorly coordinated care, and no champion to help patients navigate the system.
- Limited transparency and information sharing – physicians lack the complete picture necessary to manage their patients' health.
- Insufficient resources directed to primary care, contributing to a primary care shortage.
- Treatment decisions that aren't always based on the best available clinical evidence.

PCMH 2017

Eligibility Requirements

Eligibility Requirements

Outpatient primary care practices

Practice defined: a clinician or clinicians practicing together at a single geographic location

- **Includes** nurse-led practices in states as permitted under state licensing laws
- **Does not include**:
  - Urgent care clinics
  - Clinics open on a seasonal basis

Eligibility Requirements

- **Recognition is achieved at the geographic site level --** one Recognition per address, one address per survey
- **MDs, DOs, PAs, and APRNs** with their own or shared panel are listed on the application
- **Clinicians should be listed at <u>each</u> site** where they routinely see a panel of their patients
- **Non-primary care clinicians** should not be included

Eligibility Requirements

At least 75% of each clinician's patients come for:

- First contact for care
- Selected as personal PCP
- Continuous care
- Comprehensive primary care services

All eligible clinicians at a site must apply together

Physicians in training (residents) should not be listed

Eligibility Requirements

- **Practices should have staff skilled to use a computer system** that includes the following:
  - Email & Internet access
  - Microsoft Word
  - Microsoft Excel
  - Adobe Acrobat Reader (available free online)
  - Screen sharing application
- **Access to the electronic systems** used by the practice, e.g. billing system, registry, practice management system, electronic prescription system, EHR, Web portal, etc.

Eligibility Requirements

Transformation may take 6-12 months

Your roadmap: PCMH 2017 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

PCMH 2017

Standards Overview & Scoring

NCQA

Program Highlights

Provides focus and flexibility

- Core/elective approach allows practices to tailor program to their unique population
- Accommodates a spectrum of practices (basic-complex, small-large)

Supports continuous practice transformation

- Includes activities necessary to achieve stated aims and drive improvement
- Focuses on whether the intent was achieved and care was improved

Allows for flexibility with multiple evidence types

- Allows a variety of response options that demonstrate a requirement is met
- Introduces the virtual review process

Emphasizes comprehensive, integrated care

- Understanding behavioral needs and social determinants included in core
- Deeper integration and community connections included in electives

2017 Standards Format

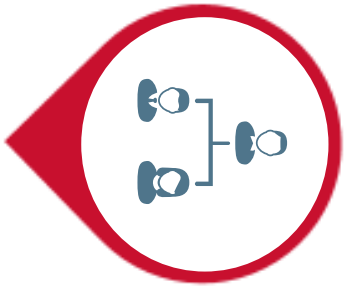
Structure – Concepts, Competencies, Criteria

Concepts: Over-arching components of PCMH

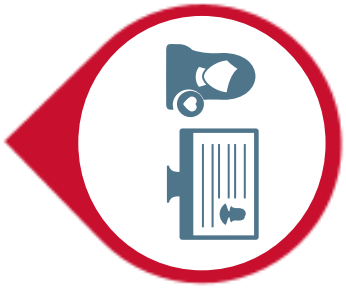
Competencies: Ways to think about and/or bucket criteria

Criteria: The individual things/tasks you do that make you a PCMH

Team-Based Care &
Practice Organization



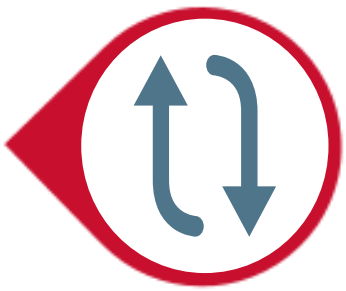
Knowing & Managing
Your Patients



Patient-Centered
Access & Continuity

Care Management
& Support

Care Coordination
& Care Transitions



Performance Measurement
& Quality Improvement

2017 Standards

Concepts

Team-Based Care and Practice Organization

- Practice leadership
- Care team responsibilities
- Orientation of patients/ families/caregivers

Knowing and Managing Your Patients

- Data collection
- Medication reconciliation
- Evidence-based clinical decision support
- Connection with community resources

Patient-Centered Access and Continuity

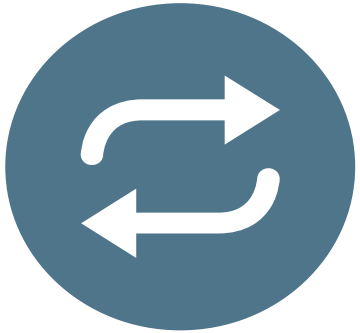
- Access to practice and clinical advice
- Care continuity
- Empanelment

2017 Standards

Concepts

Care Management and Support

- Identifying patients for care management
- Person-centered care plan development



Care Coordination and Care Transitions

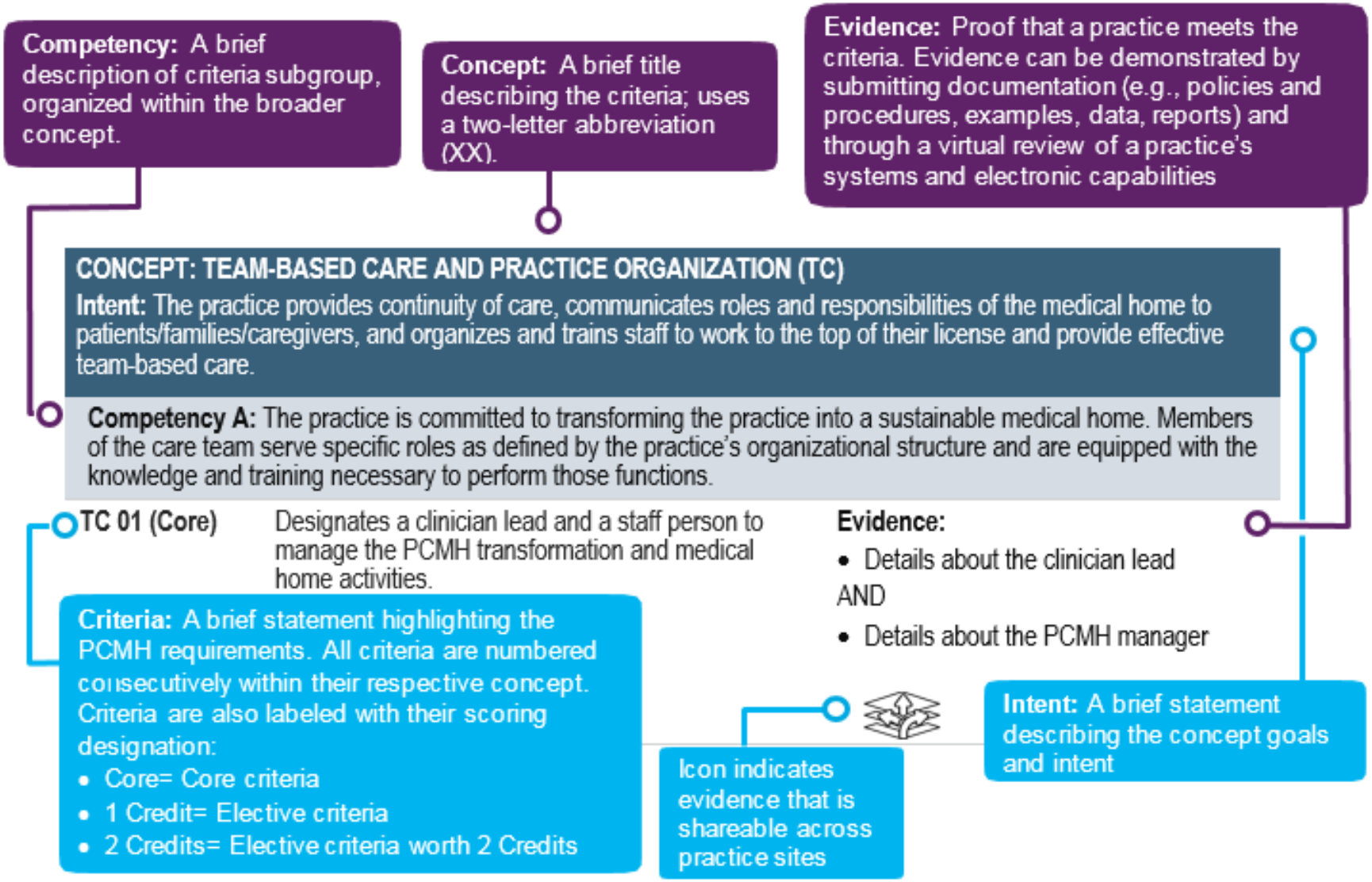
- Management of lab/imaging results
- Tracking and managing patient referrals
- Care transitions

Performance Measurement & Quality Improvement

- Collecting and analyzing performance data
- Setting goals
- Improving practice performance
- Sharing practice performance data

2017 Standards

Structure - Example



2017 Standards

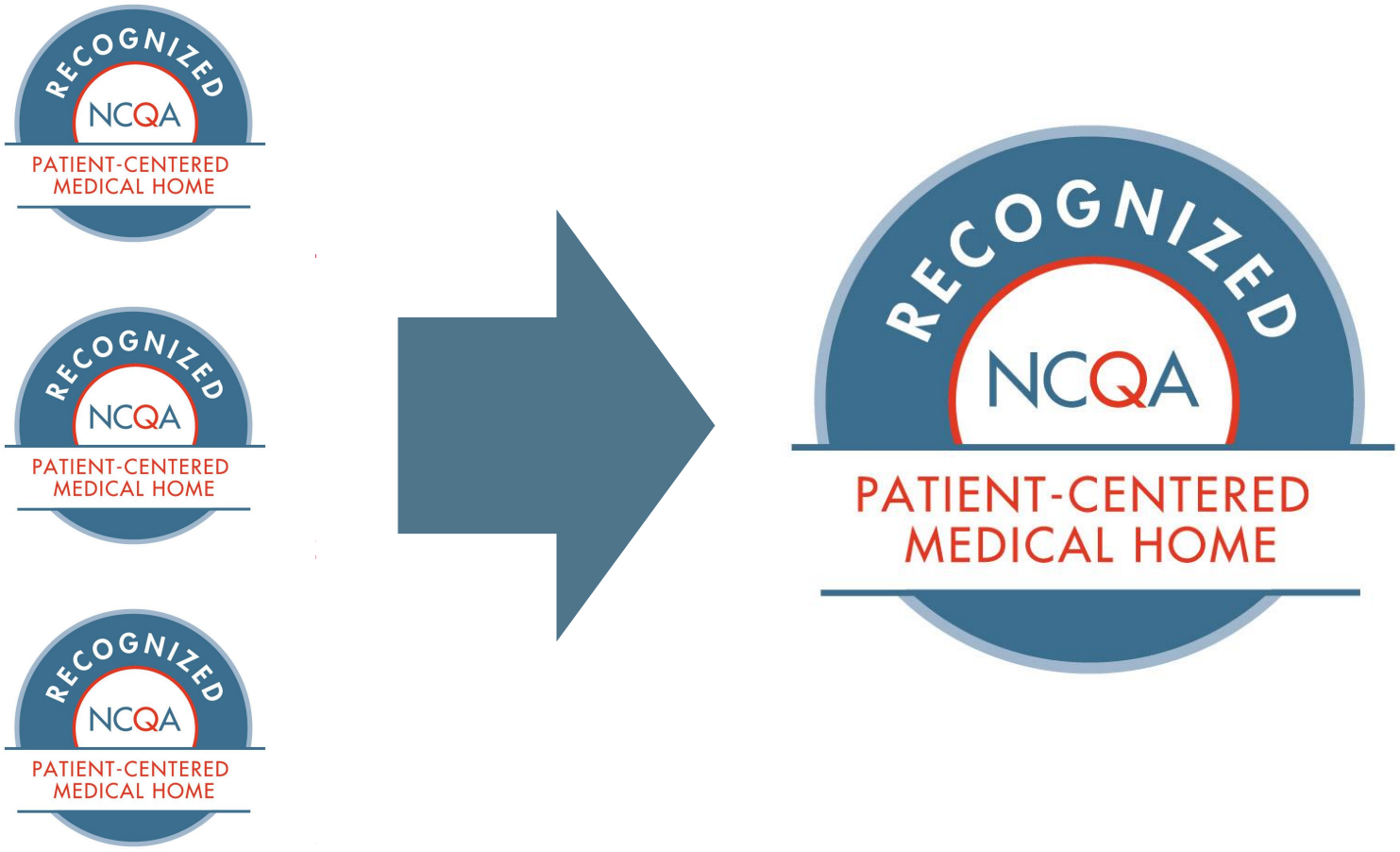
Structure - Example

Concept: Patient-Centered Access and Continuity

Competency	Core Criteria	Elective Criteria
The PCMH model seeks to enhance access by providing appointments and clinical advice based on the patient's needs. In addition to being key to patient-centeredness, evidence explicitly supports that providing enhanced access including same- day, extended hours and telephone advice from clinicians with access to the patient record reduces ED visits and hospitalizations.	Assesses the access needs and preferences of the patient population. Provides same-day appointments for routine and urgent care to meet identified patients' needs. Provides routine and urgent appointments outside regular business hours to meet identified patients' needs. Provides timely clinical advice by telephone. Documents clinical advice in patient records.	Provides scheduled routine or urgent appointments by telephone or other technology supported mechanisms. Has a secure electronic system for patient to request appointments, prescription refills, referrals and test results. Has a secure electronic system for two- way communication to provide timely clinical advice. Evaluates identified health disparities to assess access across the patient population.

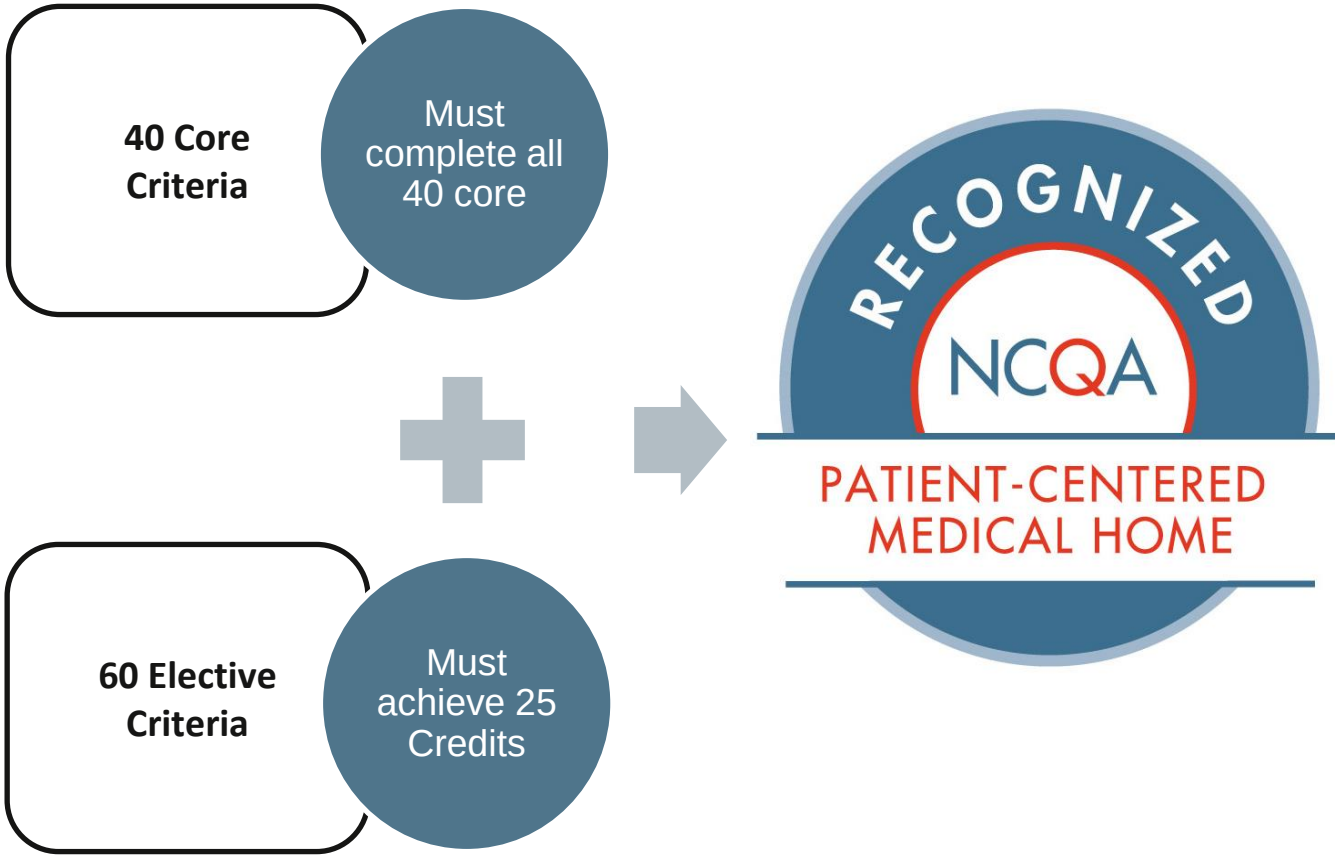
2017 Standards Recognition

Changes to Levels



2017 Standards Scoring

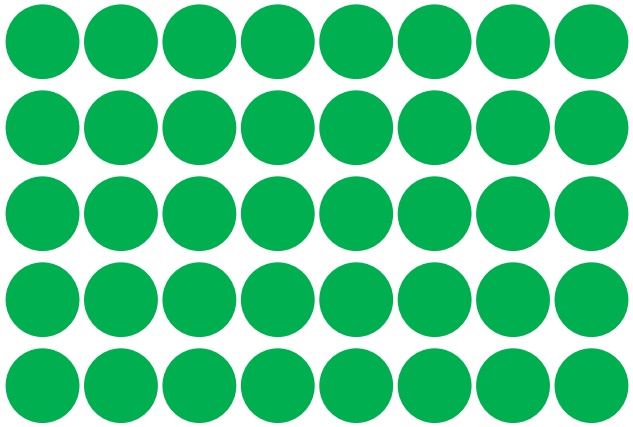
Changes to Points



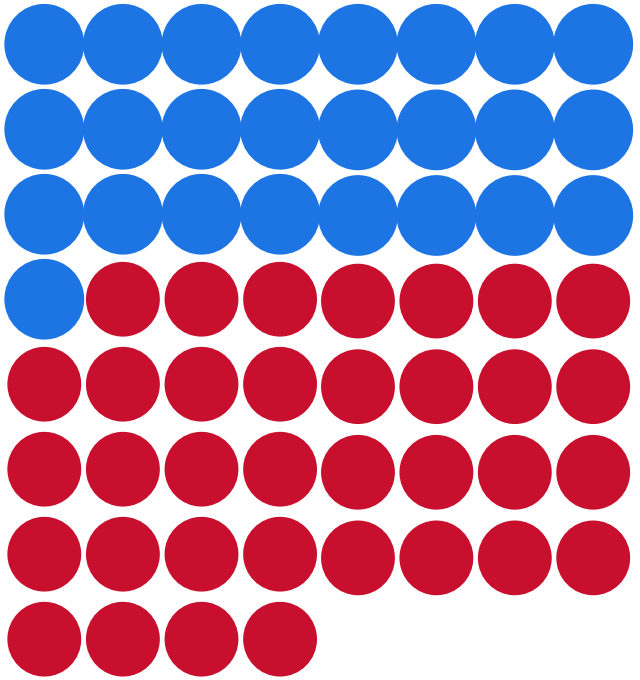
2017 Standards

Scoring

Core Criteria

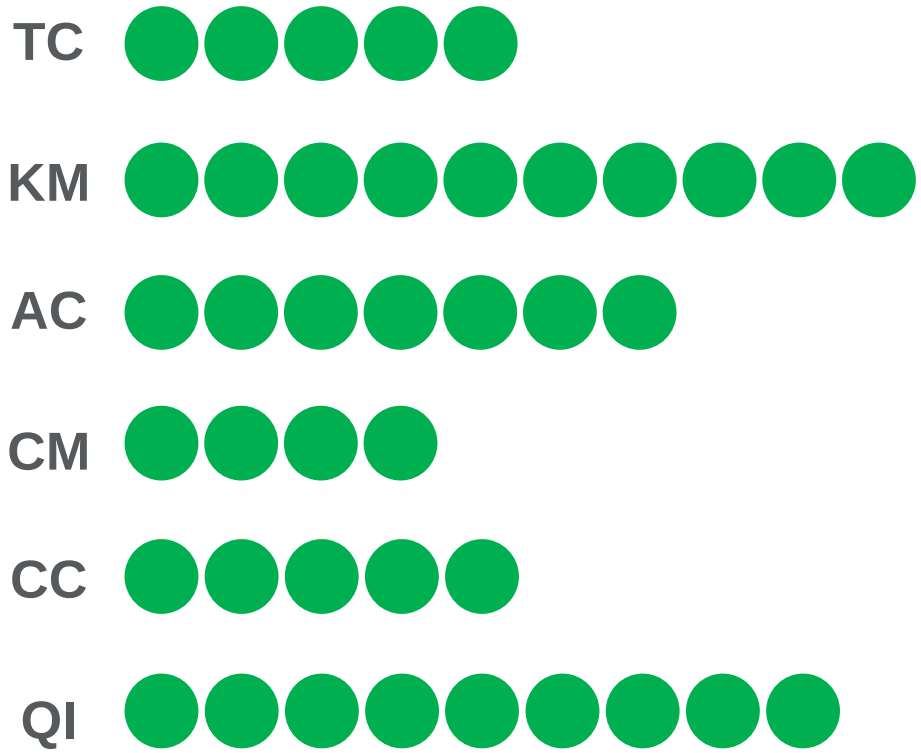


Elective Criteria



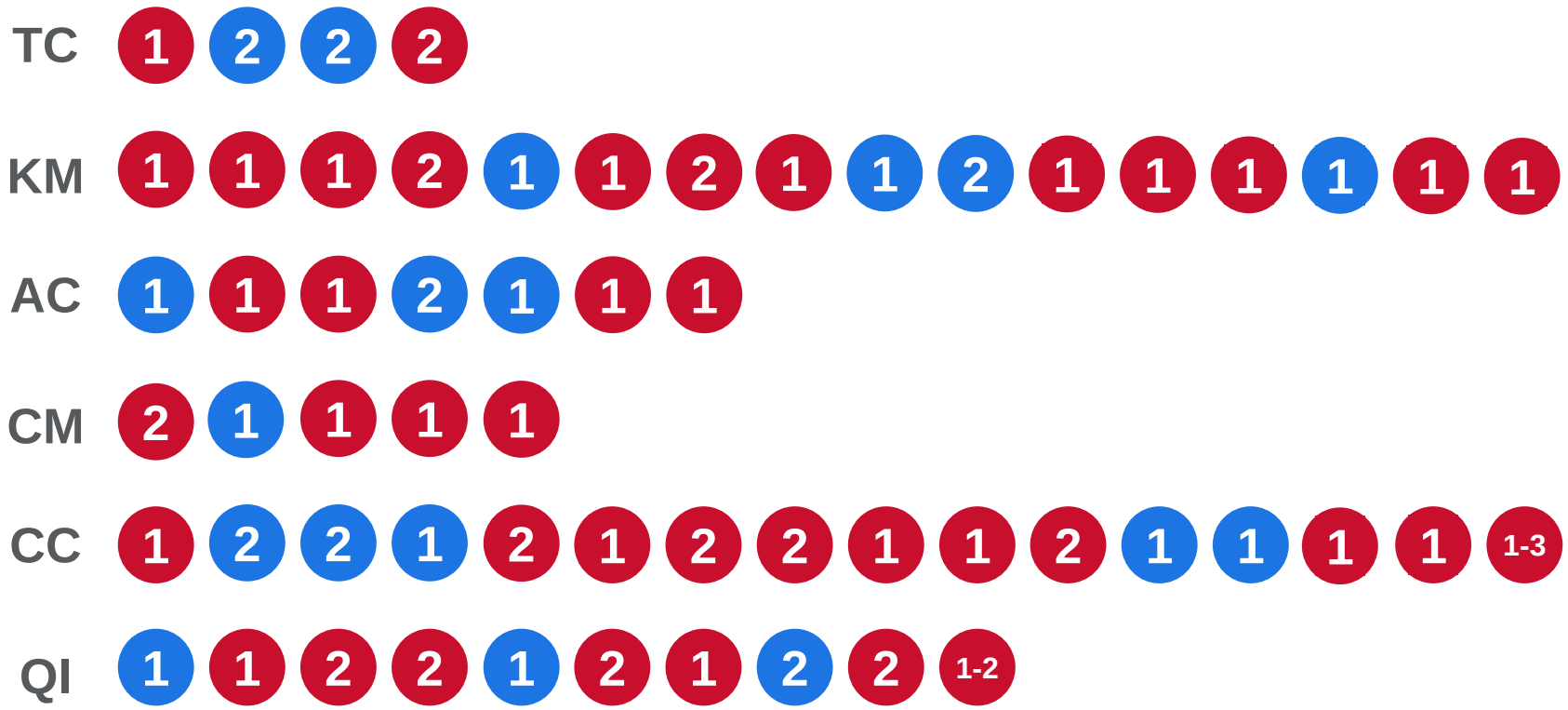
2017 Standards Scoring

Core Criteria



2017 Standards Scoring

Example of Elective Criteria Selection: Must represent 5 of 6 Concepts



- *Each row represents a Concept which is laid out with the number of electives included and the credits identified in the middle of each circle.*
- *The blue circles are an example of the electives chosen by a practice to equal 25 credits.*
- *Red circles are the electives leftover that the practice will not demonstrate performance on.*

2017 Distinction Modules

Practice Opportunities to Show Excellence

Distinction in Patient Experience Reporting

Distinction in Behavioral Health Integration

Distinction in Electronic Measure Reporting

Behavioral Health Integration Distinction Module

Module Competencies

Behavioral Health Workforce

- Incorporates behavioral health expertise
- Utilizes external behavioral health specialists
- Trains care team to address behavioral health and substance use needs of patients

Information Sharing

- Sharing patient information within and outside the practice
- Supports integrated/ coordinated patient treatment plan

Evidence-Based Care

- Demonstrates use of evidence-based protocols
- Utilize evidence-base protocols to address patient needs

Measuring and Monitoring

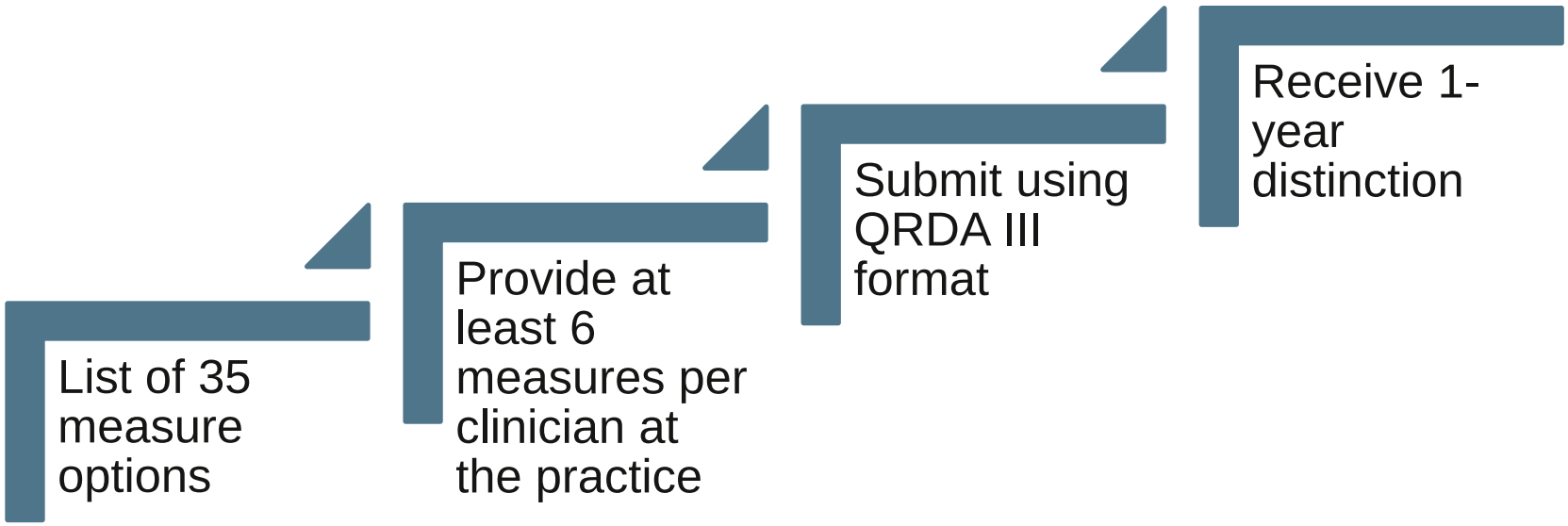
- Utilize quality measurement
- Act to improve on current quality measurement performance

Patient Experience Reporting Distinction Module

Award Distinction to practices as an incentive to participate in the development and field test of a new approach to patient experience measurement

Update current Distinction requirements to CG CAHPS 3.0

eCQM Distinction Module



Prevalidation Program

Overview

NCQA prevalidated Health IT solutions have successfully demonstrated that their technology solution has functionality that **supports or meets one or more criteria in the PCMH standards**

Evaluation can result in approved **fully met criteria** and **partially met criteria** that are transferable to eligible client practices submitting for recognition and acknowledgment of **practice support functionality**

PCMH 2017

Commit, Transform, Succeed

PCMH Redesign

Why Change?

Too much documentation	Practices want more interaction with NCQA	Too challenging for smaller practices
Needs less emphasis on process. More on performance	Two separate, complicated tools	Practices should be demonstrating ongoing improvement

PCMH Redesign

Then vs. Now

Then
Self-guide to recognition

Now
NCQA representative to guide practice

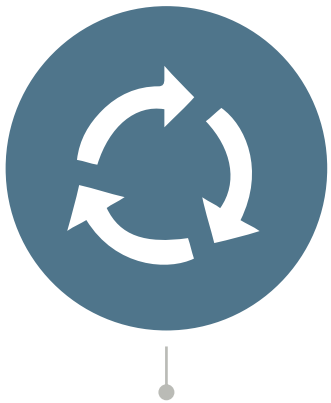
Then
Submit documents all at once

Now
Gradual submissions, steady feedback

Then
Cumbersome survey tool

Now
More intuitive tool, with user tips

Then
Recognition on a 3-year cycle, has 3 levels



Now
Yearly reporting, more frequent help, no levels

PCMH Redesign

3 Parts

Commit

Practice completes an online guided assessment.

Practice works with an NCQA representative to develop an evaluation schedule.

Practice works with NCQA representative to identify support and education for transformation.

New NCQA PCMH online education resources support the transformation process.

Transform

Practice submits initial documentation and checks in with its evaluator

Practice submits additional documentation and checks in with its Evaluator.

Practice submits final documentation to complete submission and begin NCQA evaluation process.

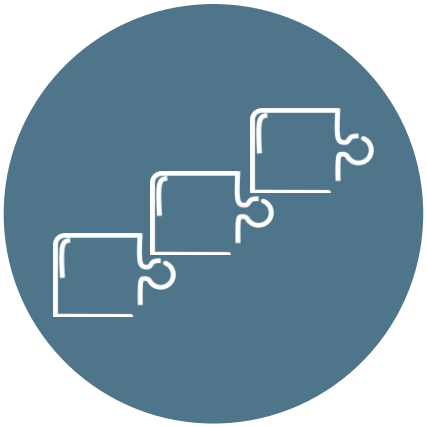
Practice earns NCQA Recognition.

Succeed

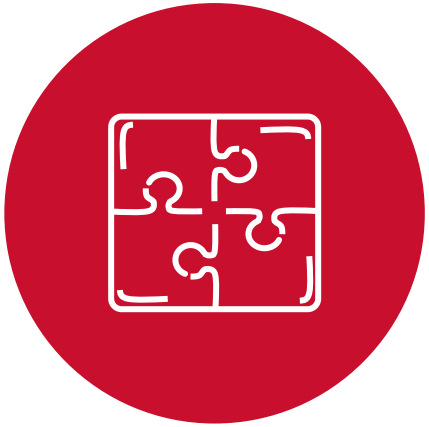
Practice is prepared for new payment environment (value-based payment, MACRA MIPS/APMs).

Practice demonstrates continued readiness and high quality performance through annual reporting with NCQA.

Sustaining Recognition



Engage practices in an annual reporting providing confirmation of continuing commitment and performance



Each practice demonstrates that changes made during the initial recognition effort are part of their culture, and practice is becoming more patient-centered

NCQA will update or review annual requirements each year to assure continued relevance supporting ongoing quality improvement

Recent Program Updates

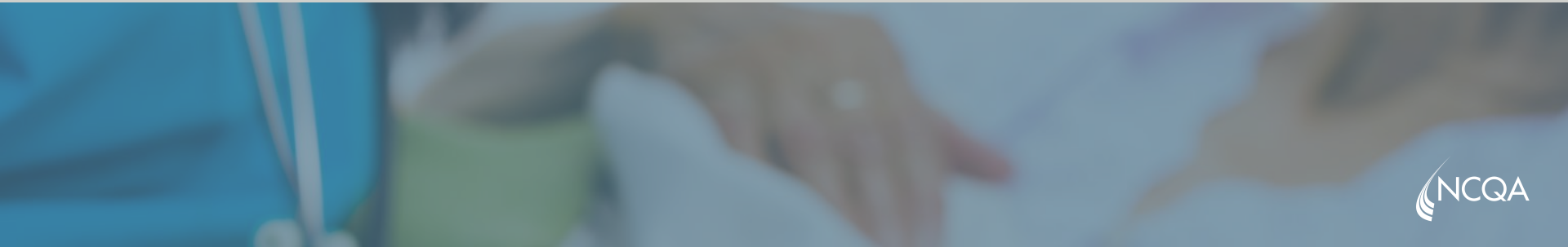
Medical Neighborhood

- ✓ PCMH 2017 & Q-PASS launched on April 3, 2017
- ✓ Bringing PCSP and other recognition programs into new process (2018+)
- ✓ Moving forward with NCQA eMeasure Certification of vendors and evolving Distinction for Electronic Measure Reporting for practices
- ✓ Oncology Medical Home was launched at the end of the first quarter in 2017
- ✓ School-Based Medical Home (SBMH) launched on November 20, 2017

Let's continue to grow the Patient-Centered Medical Neighborhood!

PCMH (2017 Version)

Standards Content



Team-based Care & Practice Organization

The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers, and organizes and trains staff to work to the top of their license and provide effective team-based care

COMPETENCY A

The practice is committed to transforming the practice into a sustainable medical home. Members of the care team serve specific roles as defined by the practice's organizational structure and are equipped with the knowledge and training necessary to perform those functions

Team-Based Care and Practice Organization

TC 01-02: Core Criteria

Designates a clinician lead of medical home, & staff to manage the PCMH transformation and medical home activities

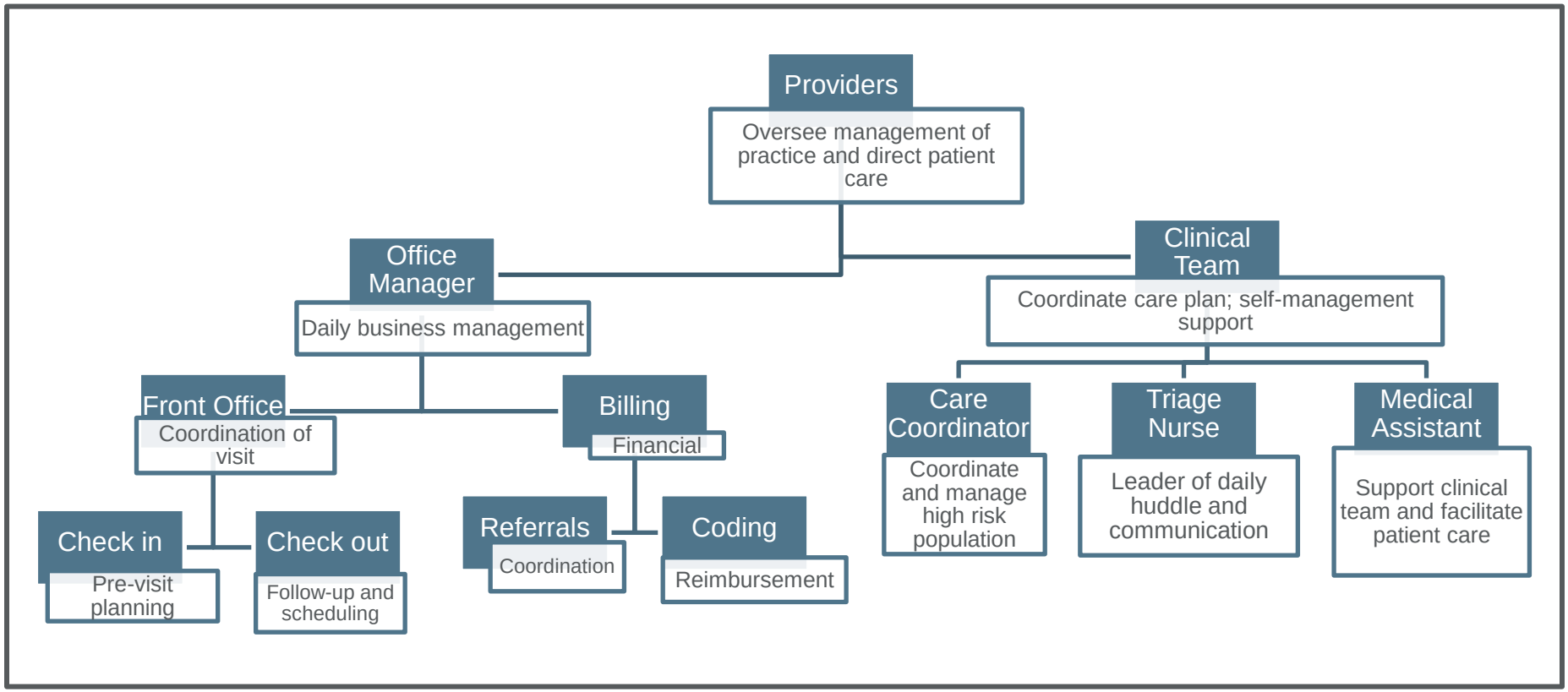
Evidence of Implementation

Defines practice organizational structure & staff responsibilities/skills to support key PCMH functions

Evidence of Implementation

Structure and Staff Responsibilities

TC 02: Example



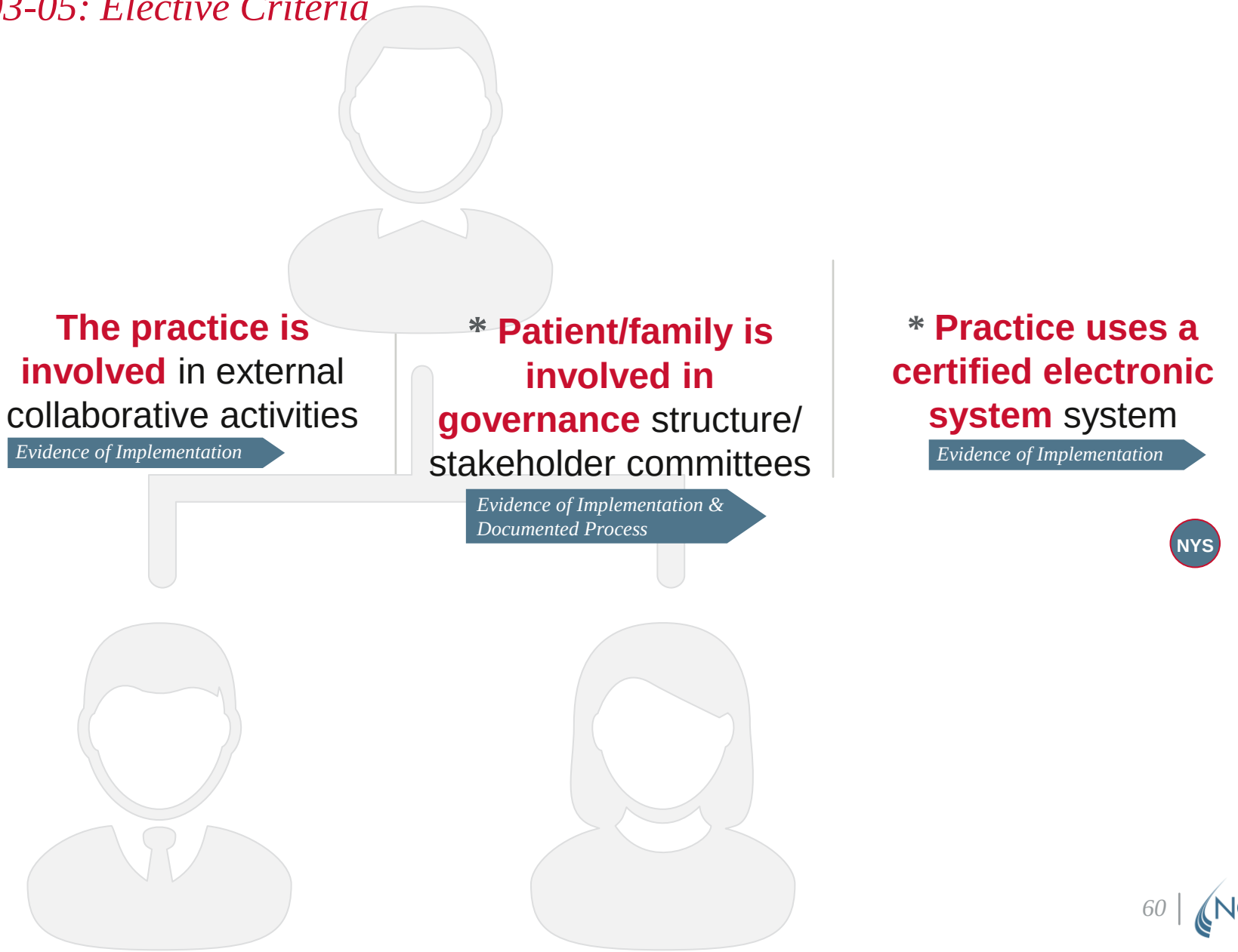
Team-Based Care and Practice Organization

TC 02: Example

Health Information Technologist	• Creates and generates reports and dashboards from the EMR. • Assists in the coordination of UDS, Meaningful Use, and PCMH measures and metrics. • Active member on QI committee to improve processes and meet UDS goals.
Medical Records and Privacy Coordinator	• Ensures patient information is added to chart in a timely fashion • Provides confidential patient information counseling to staff. • Processes event reports in order to improve processes within the organization.
AmeriCorps – PCMH and Community Wellness Coordinator	• Works with after school programs to educate students on healthy lifestyles. • Assists with PCMH efforts by educating staff; presenting survey questions; assisting Care Manager in recall lists. • Coordinating employee wellness activities.
Help Team Member	• Assists patients in the healthcare marketplace. • Utilizes resources in the community. • Assists with outreach services.
Spanish Interpreter	• Assists patients during appointments with understanding provider and paperwork. • Acts as a liaison for staff. • Provides cultural support for patients.
Registration Professional	• Provides patients the necessary paperwork for their appointment and per the organization. • Assists with the Healthy Neighbor Plan (sliding fee scale) application. • Confirms patient demographics, insurance, and completes check-in or patients; communicates with patients about payments.

Team-Based Care and Practice Organization

TC 03-05: Elective Criteria



The practice is involved in external collaborative activities

Evidence of Implementation

*** Patient/family is involved in governance** structure/ stakeholder committees

Evidence of Implementation & Documented Process

*** Practice uses a certified electronic system** system

Evidence of Implementation

NYS

External PCMH Collaborations

TC 03: Example

TC 03

Primary Care Practice participates in the Health Center Controlled Network of NY in collaboration with CHCANYS. Our clinical measure performance data is shared with the other 42 participating health centers in a data warehouse called CPCI or Azara DRVS. Please see below for full descriptions.

STATEWIDE HEALTH IT

Health Center Controlled Network of NY

The Health Center Network of New York (HCNNY) is a federally designated health center controlled network dedicated to ensuring that its members have the ability to effectively leverage information technology to provide high quality, cost effective, patient focused primary health care to the communities they serve. HCNNY was founded in 2007 by six (6) health centers and the Community Health Care Association of New York State (CHCANYS), and today is comprised of eight member health centers and CHCANYS. As of July 1, 2013, HCNNY is operating as an independent 501(c)(3) organization.

HCNNY provides resources for its members for electronic health record implementation and on-going optimization, customized training, workflow development, and reporting to position members to take advantage of payment reform initiatives, recognition opportunities and available incentives. The Network is governed by its board of directors comprised of executives from member centers, and operational efforts are led by clinical, finance and IT committees that meet regularly to identify priorities and share best practices surrounding common challenges. Quality improvement efforts are enhanced by a data warehouse containing demographic and clinical information on the nearly 260,000 patients served network-wide.

COMPETENCY B

Communication among staff is organized to ensure that patient care is coordinated, safe and effective

Team-Based Care and Practice Organization

TC 06-07: Core Criteria

Has regular care team meetings or a structured communication process focused on individual patient care

Evidence of Implementation & Documented Process

Involves care team staff in practice's performance evaluation and quality improvement activities

Evidence of Implementation & Documented Process

Team-Based Care and Practice Organization

SUBJECT: Daily Huddles

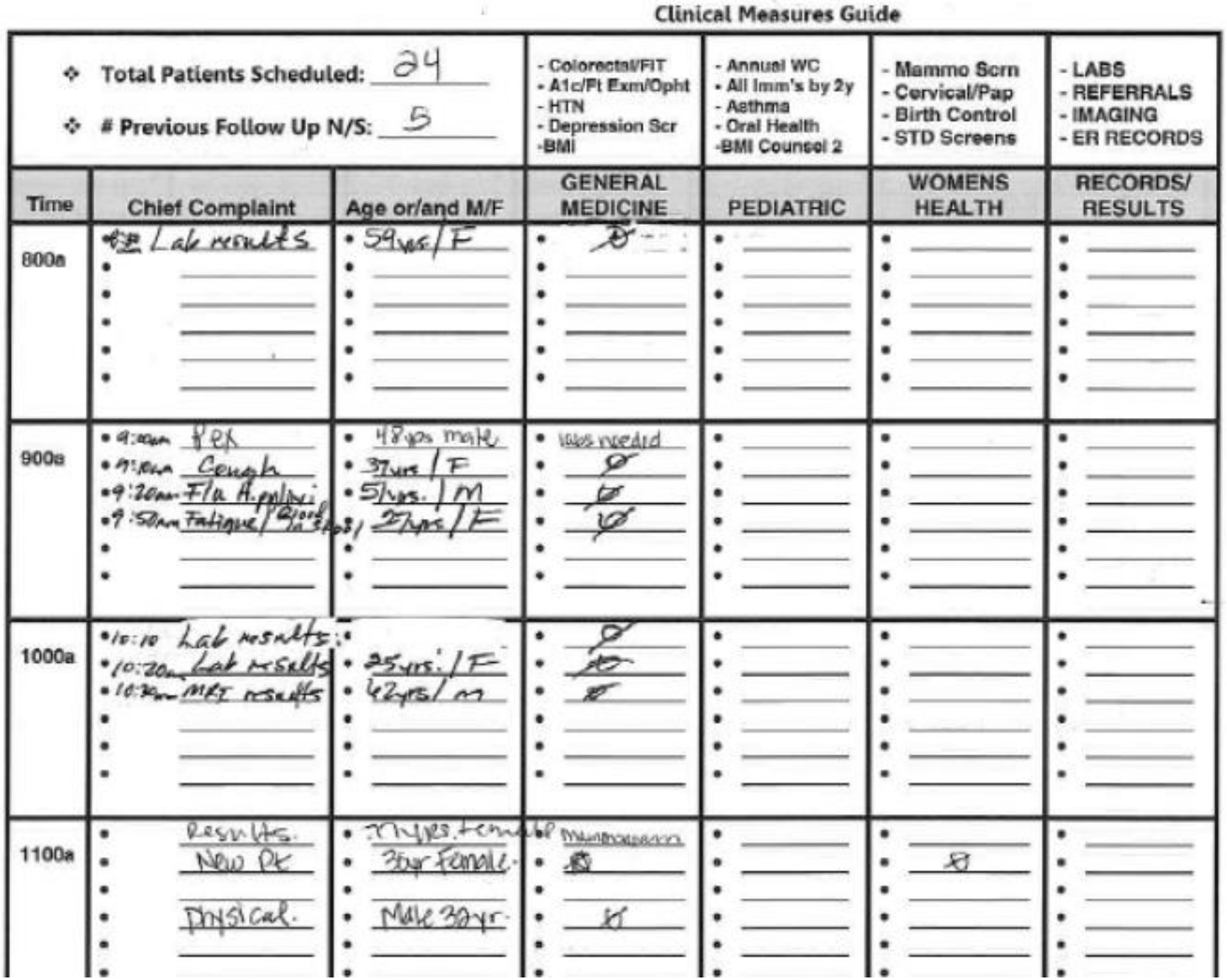
PURPOSE: Each primary care site at conducts a structured team meeting at least daily. The brief "huddle" is scheduled by the site manager or a designated staff member to occur at the same time each day. The purpose of these meetings is to proactively anticipate and plan actions based on patient need and available resources.

RESPONSIBILITY: It is the responsibility of the entire team to attend the meetings and ensure the outcomes/decisions made at the meetings are carried out. It is the responsibility of the site manager to insure that the huddles are conducted daily and appropriate documentation is completed.

PROCEDURE: The care team meets at the same time daily to efficiently and effectively plan the day and to discuss known or potential patient needs. The team:

- Reviews the daily schedule
- Focuses on those patients with known chronic illnesses
- Monitors the need for health maintenance and/ or preventive care services
- Arranges for any special services that may be needed
- Provides any follow up discussion related to care provided on the previous day
- Discusses needs specific to the team's daily workflow including staff flexibility, special patient needs, sick calls, contingency plans, and proactive planning for the next day
- Documents on a Daily Huddle form (filed in a binder at the site for a minimum of 3 months)

Team-Based Care and Practice Organization



Clinical Measures Guide

- Total Patients Scheduled: 24
- # Previous Follow Up N/S: 5

- Colorectal/FIT
- A1c/Ft Exm/Opht
- HTN
- Depression Scr
- BMI

- Annual WC
- All Imm's by 2y
- Asthma
- Oral Health
- BMI Counsel 2

- Mammo Scrn
- Cervical/Pap
- Birth Control
- STD Screens

- LABS
- REFERRALS
- IMAGING
- ER RECORDS

Time	Chief Complaint	Age or/and M/F	GENERAL MEDICINE	PEDIATRIC	WOMENS HEALTH	RECORDS/ RESULTS
800a	Lab results	59yrs/F				
900a	PPD Cough Flu A epidemic Fatigue/Blood in stool	48yrs male 37yrs/F 51yrs./M 25yrs/F	labs needed			
1000a	Lab results Lab results MRI results	25yrs./F 42yrs/M				
1100a	Results. New PT Physical.	37yrs. female 35yr female. Male 32yr.	Mammogram			

Team-Based Care and Practice Organization

Date: 01/01/2017

SBCHC Staff Process Improvement (PI) Committee

The SBCHC Staff Process Improvement Committee will consist of SBCHC staff from a variety of departments. The Staff PI Committee will meet monthly to review event reports, department metrics, satisfaction survey results, and comment cards. The Staff PI Committee will support quality improvement and risk management work through discussion of trends, identification of improvement needs, and development of improvement cycles to address negative trends. The Staff PI Committee is led by the COO. Staff PI Committee members will support the integrity of QI and risk management work that is done within their work departments.

SBCHC Medical Quality Improvement Team

The Medical Quality Improvement Team will consist of at least two staff Registered Nurses, the COO, the electronic health record superuser and the Executive Assistant. This Team will meet every other week to focus on medical quality of care data and discuss and plan for system changes to make improvements to medical data. It is anticipated this Team will transition in 2017 to focus on overall Health Center clinical measures. The Team's work is shared with the medical staff at monthly meetings and with the staff PI committee.

Team-Based Care and Practice Organization

TC 08: Elective Criteria

PCMH PRIME

* **The practice has at least one care manager qualified** to identify and coordinate behavioral health needs

Evidence of Implementation

COMPETENCY C

The practice communicates and engages patients on expectations and their role in the medical home model of care

Team-Based Care and Practice Organization

TC 09: Core Criteria

Has a process for informing patients/ families/caregivers about the role of the medical home and provides materials that contain the information

Evidence of Implementation & Documented Process

Medical Home Information

What type of services does my Medical Home provide for me and my family?

We provide comprehensive, compassionate and continuous care for newborns, children, and teens.

- Same day appointments
- Preventive care and physicals (health risk assessments, sports and school physicals)
- Acute care for illness and injuries
- Well child visits, screening and vaccinations
- 24x7 phone access to your care team
- Online electronic access to your medical records
- Referrals to top specialists and mental health providers
- Management of multi-specialty care plans including mental health

WHAT WE OFFER:

- Adult Medicine
- Pediatric Care
- Chronic Care for Diabetes, Asthma, Hypertension, and Behavioral Health
- Referrals to Specialty Care when needed
- Assistance with Substance Abuse addictions

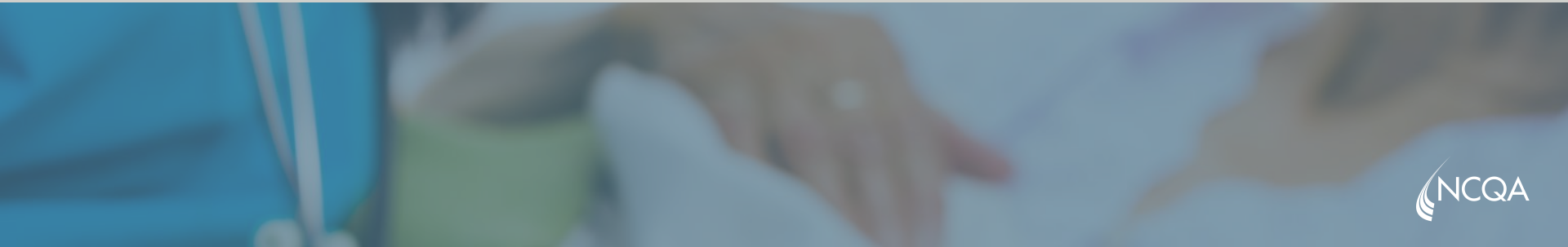
INSURANCE REQUIREMENTS

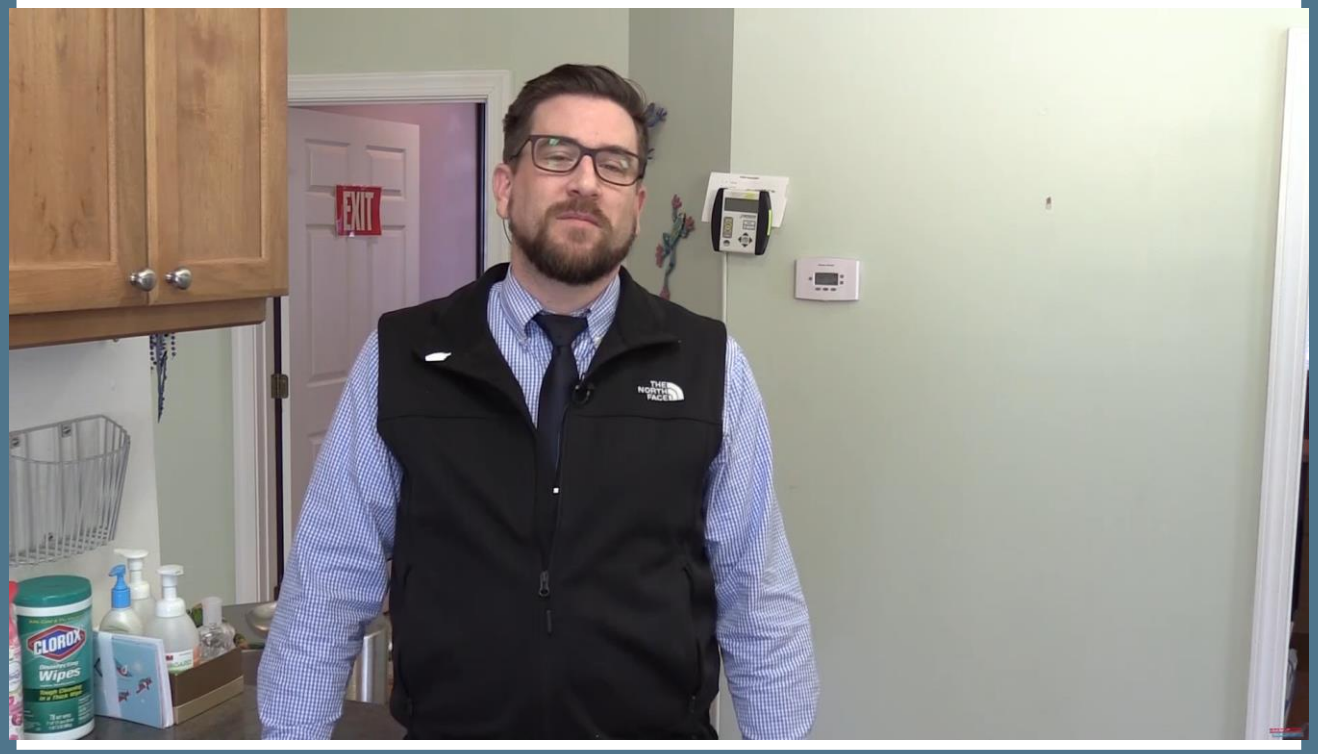
You don't need insurance to be seen at our clinic

- If you do have insurance, please bring your information with you
- If you do not have insurance, we still want to see you. We have staff that will assist you in signing up for insurance

Team-Based Care & Practice Organization

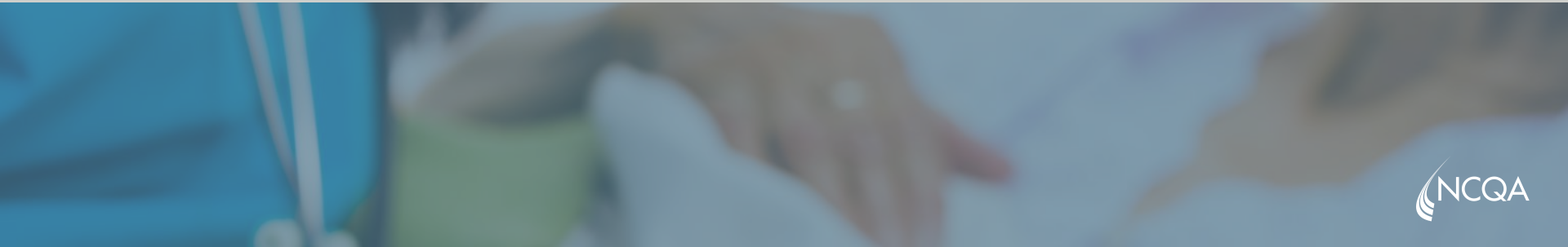
Activity




EXIT
CLOROX
Wipes

PCMH 2017

Owning Your Transformation Process



Owning Your Transformation Process

Documenting your process

Information practices must share to demonstrate performance against specific criteria.

- Evidence should focus on intent and demonstrate performance
- Share how your practice meets the intent of each criteria
- Demonstrate transformation by meeting core & elective criteria in document form or virtual review
- Practice evaluation will be based on the review of evidence prepared or shared during the virtual review
- Evidence listed for each criterion is not prescriptive

Owning Your Transformation Process

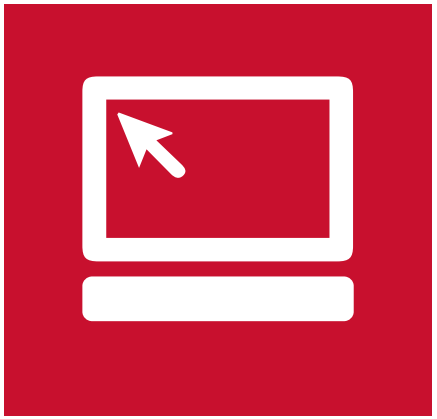
Types of Evidence

Documented Processes - written statements describing the practice's policies and procedures

- Protocols
- Practice guidelines
- Agreements
- Other documents describing actual processes or forms (e.g., Referral forms, checklists and flowsheets)

Owning Your Transformation Process

Types of evidence



Evidence of Implementation – a means of demonstrating systematic uptake and effective demonstration of required practices including:

- Reports
- Materials
- Attestation
- Transfer credit
- Examples
- Data entered into Q-PASS
- Patient records
- Virtual demonstration
- eCQMs
- Survey
- Not applicable

Knowing & Managing Your Patients

The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services

COMPETENCY A

Practice routinely collects comprehensive data on patients to understand background and health risks of patients.

Practice uses information on the population to implement needed interventions, tools and supports for the practice as a whole and for specific individuals

Knowing and Managing Your Patients

KM 01-02: Core Criteria

PCMH PRIME

Documents an up-to-date problem list

Report OR KM 06

Completes a comprehensive health assessment that **includes the examination of all 9 items**

Evidence of Implementation

- Medical history of patient & family
- Mental health/ substance use history of patient & family PRIME
- Family/social/cultural characteristics
- Communication Needs
- Behaviors affecting health PRIME
- Social functioning
- Social determinants of health
- Developmental screening PRIME
- Advanced care planning (NA for pediatrics)

Knowing and Managing Your Patients

Initial Assessment:

The health care provider will initiate an assessment and complete the documentation of that assessment by the end of the **first patient visit**. When appropriate and with the patient's approval, data from family or caregiver will be included. Initial assessment includes review and integration of all available past medical history and records. The assessor will record relevant physical data to include:

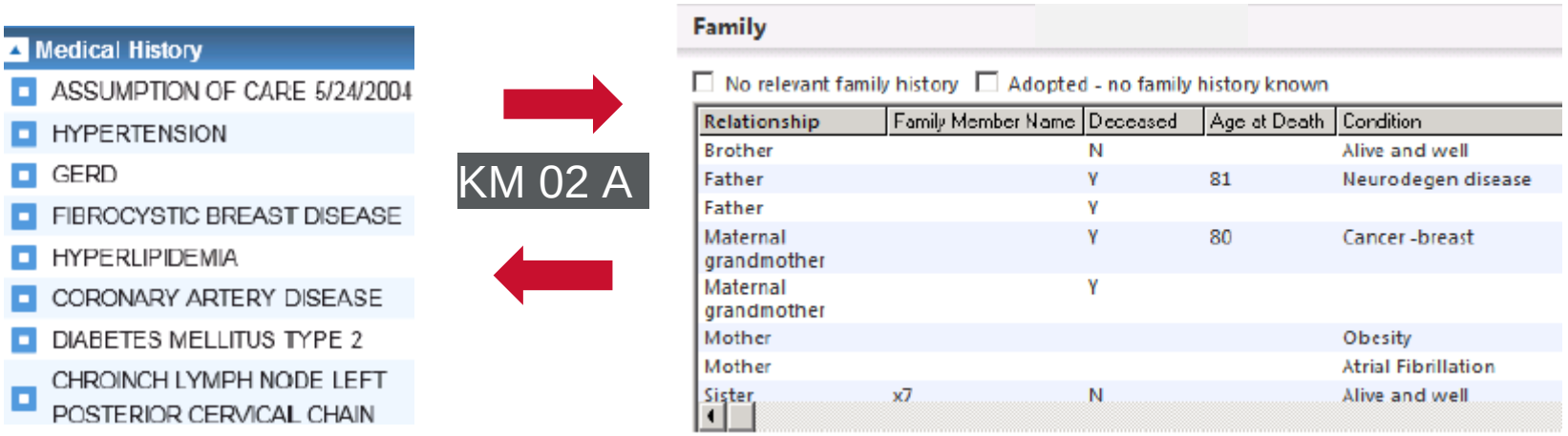
1. Problem List
2. Operations/Hospitalizations/Urgent or Emergent Care (if affirmative, the health assistant will contact the appropriate health center for an emergency department report or hospital discharge summary).
3. Special Procedures, e.g., Colposcopies, colonoscopies, etc.
4. Allergies to medications, Latex, and Foods
5. Family History
6. Social History: Smoking, alcohol, and drug usage, History of domestic violence (in women)
7. Cardiac Rick Factors
8. Health care maintenance screening
9. Immunization status
10. Obstetric history (in women)
11. Focused Review of Systems

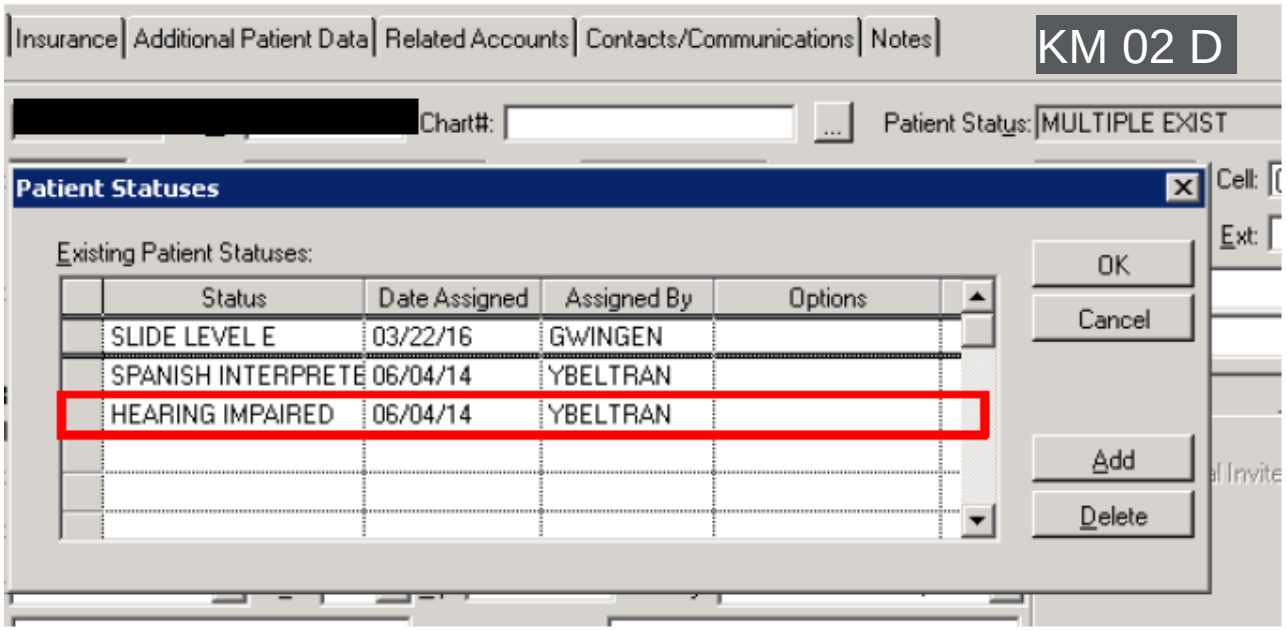
Current medication usage will be recorded on the Medication List if the patient has not been seen with the EMR. If the patient has been seen in the EMR current medication usage will be recorded in the medication module. The Medication list and/or medication module will be used to record changes in prescribed or over the counter medication usage, medication compliance with medications prescribed will be noted in the medication reconciliation section list of the Patient Check-In template.

If the patient responds in the affirmative to either of the depression screening questions, the health assistant will administer a full PHQ. Patients who answer that they have any degree of suicidal ideation will be further evaluated by behavioral health using a structured self-harm assessment.

All of these assessments are repeated by the health assistants at every visit as a part of the routine vital signs.

Knowing and Managing Your Patients





Knowing and Managing Your Patients

KM 03: Core Criteria

KM 04: Elective Criteria

PCMH PRIME

Conducts depression screenings using a standardized tool PRIME

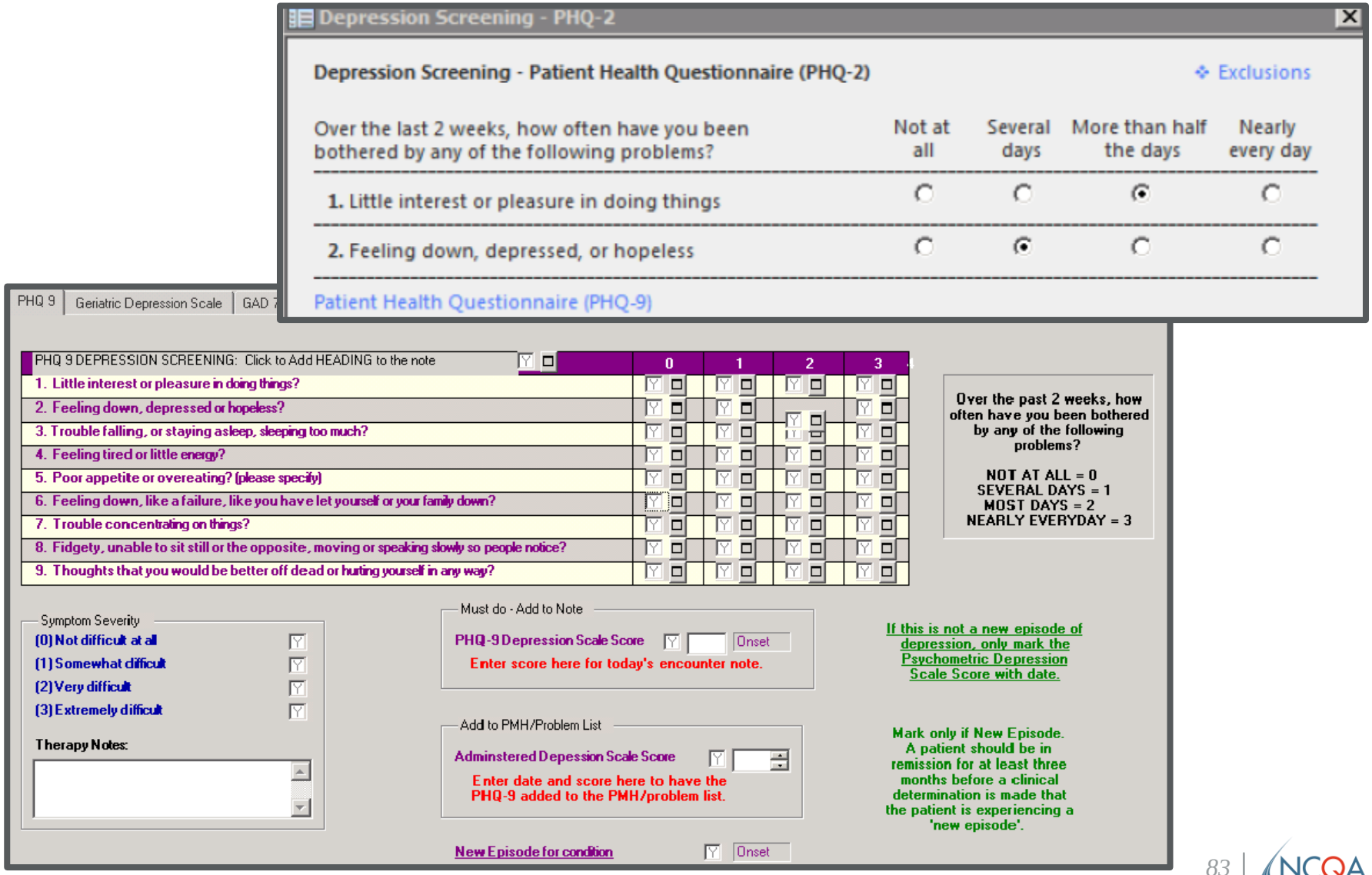
Evidence of Implementation & Report OR Documented Process

and/or assessments (implement two or more)

- Anxiety PRIME
- Alcohol use disorder PRIME
- Substance use disorder PRIME NYS
- Pediatric behavioral health screening
- Post-traumatic stress disorder
- ADHD
- Postpartum depression PRIME

Evidence of Implementation & Documented Process

Knowing and Managing Your Patients



Behavioral Health Screening

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

Resource: http://www.integration.samhsa.gov/images/res/CAGEAID.pdf

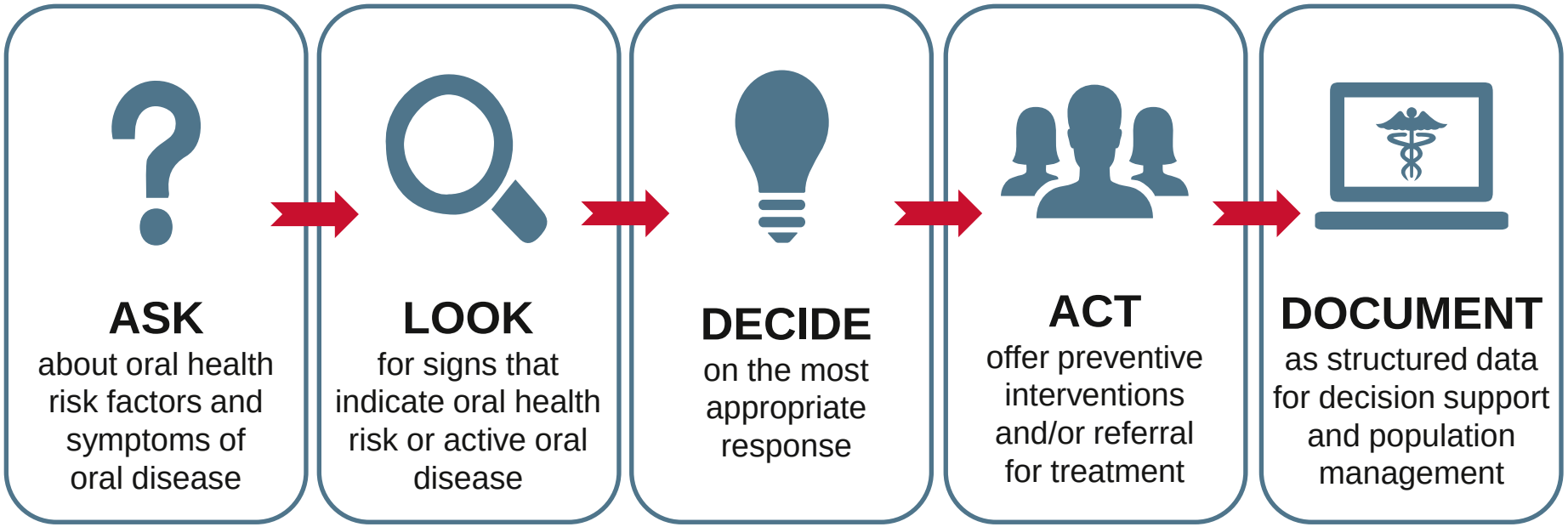
Knowing and Managing Your Patients

KM 05: Elective Criteria

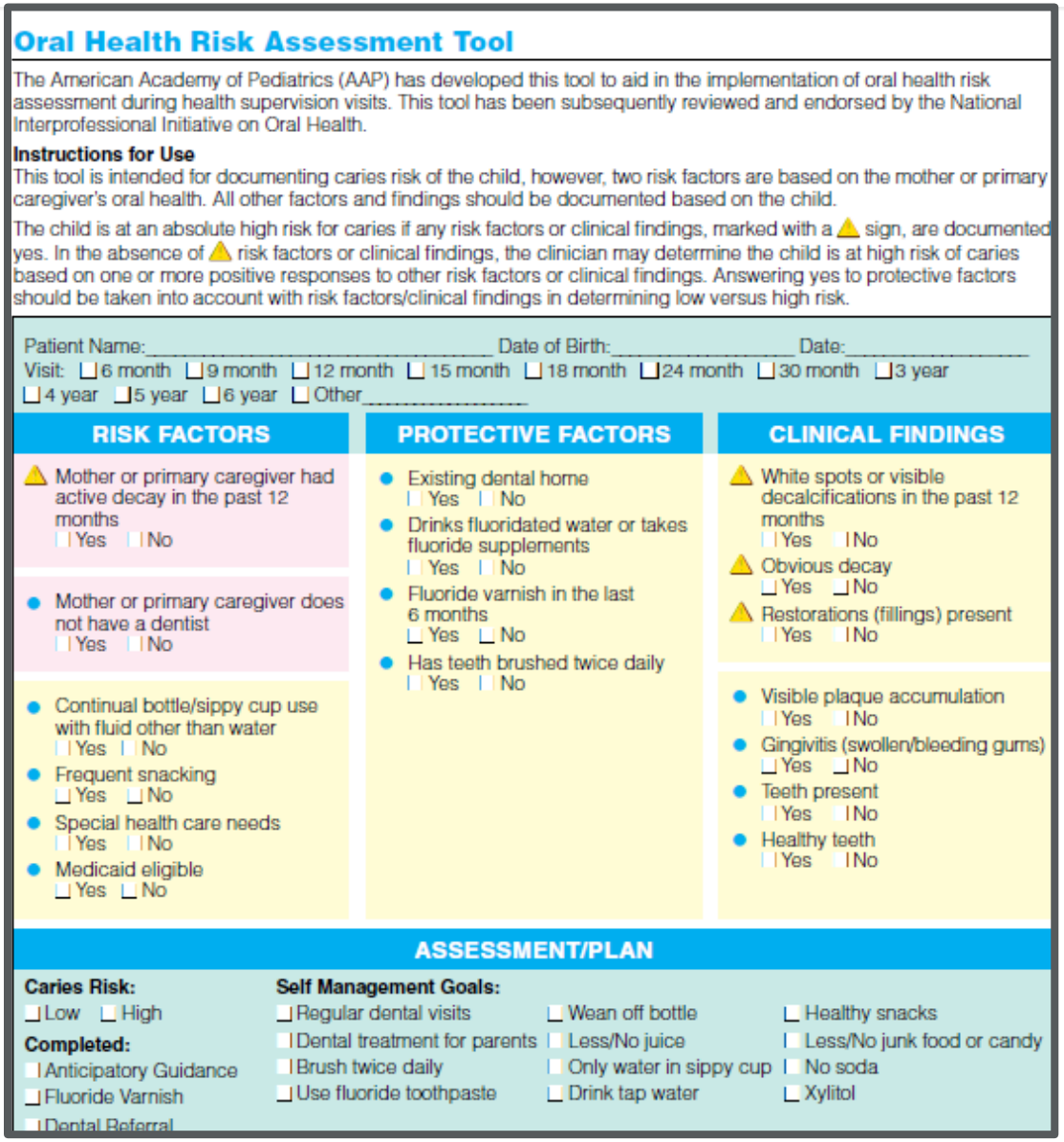
Assesses & provides necessary oral health services or coordinates with oral health partners

Evidence of Implementation & Documented Process

Conducting patient-specific oral health risk assessments.



Oral Health Assessment and Services



Oral Health Risk Assessment Tool

The American Academy of Pediatrics (AAP) has developed this tool to aid in the implementation of oral health risk assessment during health supervision visits. This tool has been subsequently reviewed and endorsed by the National Interprofessional Initiative on Oral Health.

Instructions for Use

This tool is intended for documenting caries risk of the child, however, two risk factors are based on the mother or primary caregiver's oral health. All other factors and findings should be documented based on the child.

The child is at an absolute high risk for caries if any risk factors or clinical findings, marked with a ⚠ sign, are documented yes. In the absence of ⚠ risk factors or clinical findings, the clinician may determine the child is at high risk of caries based on one or more positive responses to other risk factors or clinical findings. Answering yes to protective factors should be taken into account with risk factors/clinical findings in determining low versus high risk.

Patient Name:_____ Date of Birth:_____ Date:_____

Visit: ☐6 month ☐9 month ☐12 month ☐15 month ☐18 month ☐24 month ☐30 month ☐3 year ☐4 year ☐5 year ☐6 year ☐Other_____

RISK FACTORS

- ⚠ Mother or primary caregiver had active decay in the past 12 months — Yes | No
- Mother or primary caregiver does not have a dentist — Yes | No
- Continual bottle/sippy cup use with fluid other than water — Yes | No
- Frequent snacking — Yes | No
- Special health care needs — Yes | No
- Medicaid eligible — Yes | No

PROTECTIVE FACTORS

- Existing dental home — Yes | No
- Drinks fluoridated water or takes fluoride supplements — Yes | No
- Fluoride varnish in the last 6 months — Yes | No
- Has teeth brushed twice daily — Yes | No

CLINICAL FINDINGS

- ⚠ White spots or visible decalcifications in the past 12 months — Yes | No
- ⚠ Obvious decay — Yes | No
- ⚠ Restorations (fillings) present — Yes | No
- Visible plaque accumulation — Yes | No
- Gingivitis (swollen/bleeding gums) — Yes | No
- Teeth present — Yes | No
- Healthy teeth — Yes | No

ASSESSMENT/PLAN

Caries Risk: ☐Low ☐High

Completed: ☐Anticipatory Guidance ☐Fluoride Varnish ☐Dental Referral

Self Management Goals:

☐Regular dental visits ☐Dental treatment for parents ☐Brush twice daily ☐Use fluoride toothpaste ☐Wean off bottle ☐Less/No juice ☐Only water in sippy cup ☐Drink tap water ☐Healthy snacks ☐Less/No junk food or candy ☐No soda ☐Xylitol

Knowing and Managing Your Patients

KM 06-08: Elective Criteria

Identifies the predominant conditions & health concerns of patient population

List

*** Understands social determinants of health** for patients, monitors at population level & implements care interventions

Report & Evidence of Implementation

Evaluates patient population demographics/communication preferences/health literacy & distribution of patient materials

Report & Evidence of Implementation

Social Determinants of Health

KM 07: Example

Barriers

Unable to contact—37 – 12%

Transportation—5 – 2%

Other—52 – 17%

Language—4 – 1%

Demographics

Latino/Hispanic—97 – 32%

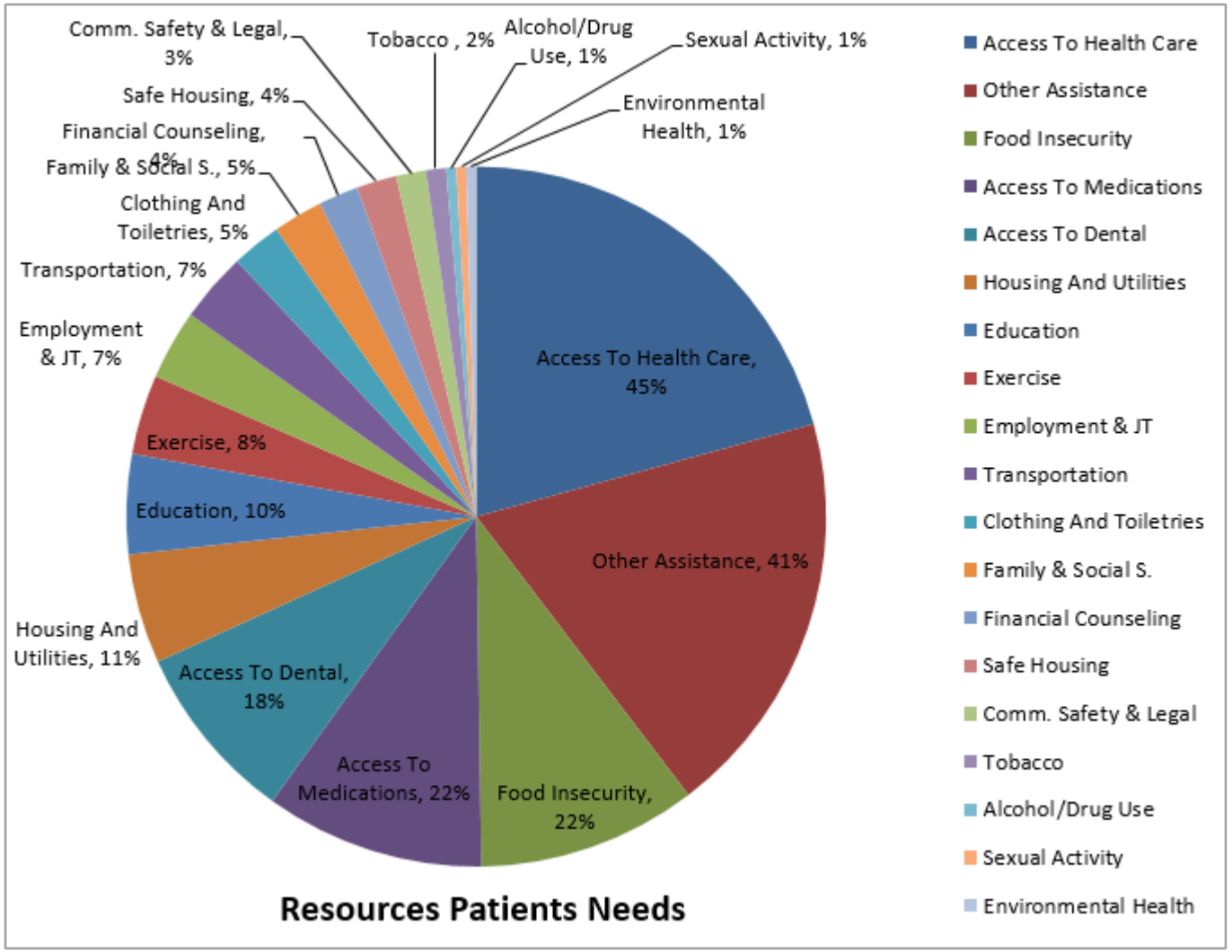
Non-Hispanic or Latino—144 – 48%

Patient Declined—4 – 1%

Gender

Female—193 – 65%

Male—104 – 35%




COMPETENCY B
The practice seeks to meet the needs of a diverse patient population by understanding the population's unique characteristics and language needs. The practice uses this information to ensure linguistic and other patient needs are met

Knowing and Managing Your Patients

KM 09-10: Core Criteria

Assesses the diversity of its population *Report*

Assesses the language needs of its population *Report*

Diversity and Language

Date Range: January 1, 20[redacted] - December 1, 20[redacted]

Race

Asian	African American	Native American	Caucasian	More than one Race	Refused to Report
5	25	289	1603	29	6

Ethnicity

Hispanic	Non-Hispanic	Refused to Report
162	1697	99

Veterans

Veterans
39

Date Range - January 1, 20[redacted] - December 31, 20[redacted]

Patients better served in a language other than English

Patients	English	Spanish
1957	1858	99
100%	94.9%	5.1%

Knowing and Managing Your Patients

Based on the diversity of population and community, the practice recognizes and addresses their needs (demonstrate at least two):

Target population health mgmt on disparities in care

Evidence OR QI 05 & QI 13

NYS

Educates practice staff on health literacy

Evidence of Implementation

Educate staff on cultural competence

Evidence of Implementation

Population Needs - Health Literacy

Example of assessing health literacy at the patient level using a standardized assessment embedded in the electronic system.

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

Example of training materials used to educate staff on topics related to health literacy.

Teach-back:
A Health Literacy Tool to Ensure Patient Understanding

Educational Module for Clinicians

from the

Iowa Health System Health Literacy Collaborative

Teach-back is…

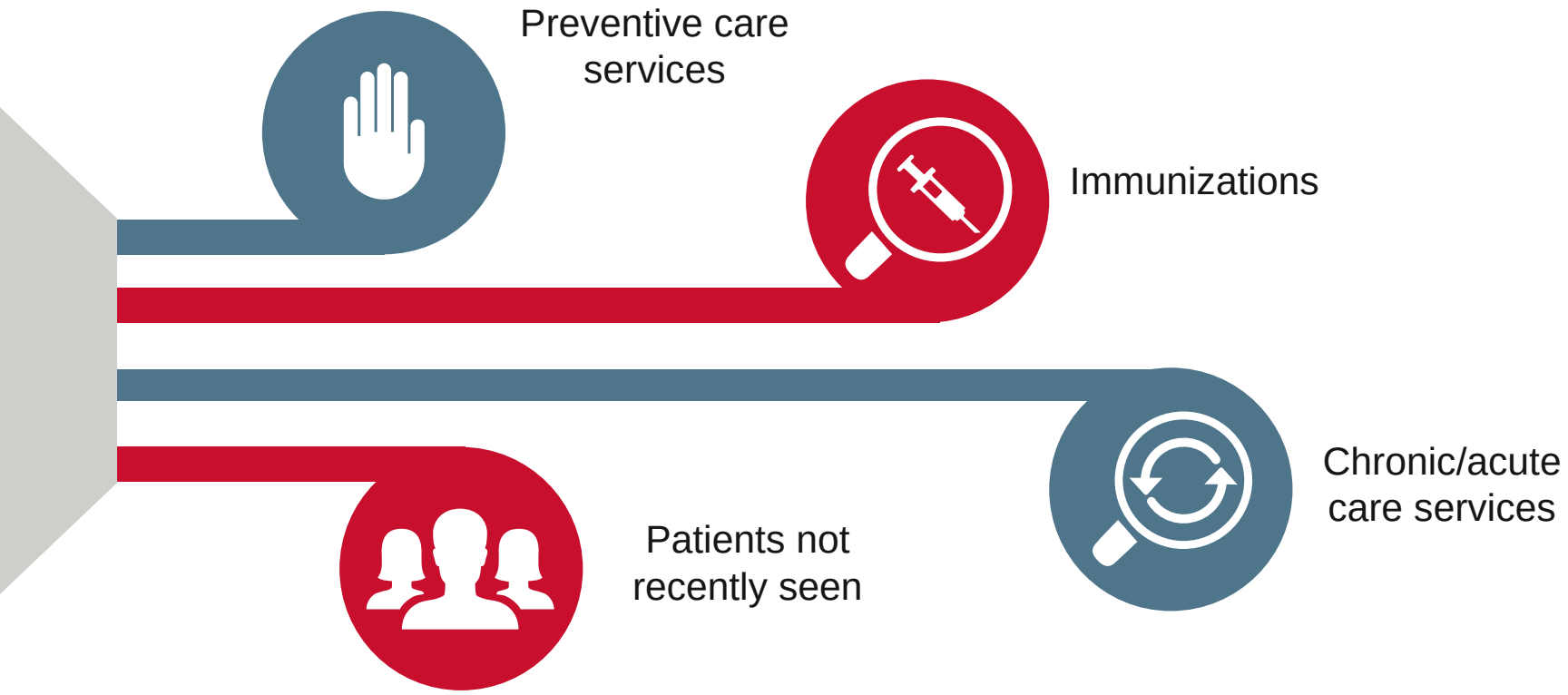
- Asking patients to repeat **in their own words** what they need to know or do, in a non-shaming way.
- **Not** a test of the patient, but of how well ***you*** explained a concept.
- A chance to check for understanding and, if necessary, re-teach the information.

COMPETENCY C

The practice proactively addresses the care needs of the patient population to ensure needs are met

Knowing and Managing Your Patients

Proactively & routinely identifies populations of patients and reminds them about needed care services (must report at least three items):



KM 12 A-B, D - *Report/List & Evidence of Implementation*

KM 12 C - *Report/List & Evidence of Implementation or KM 13*

Population Health Management

Transformed in the PCMH

Current View

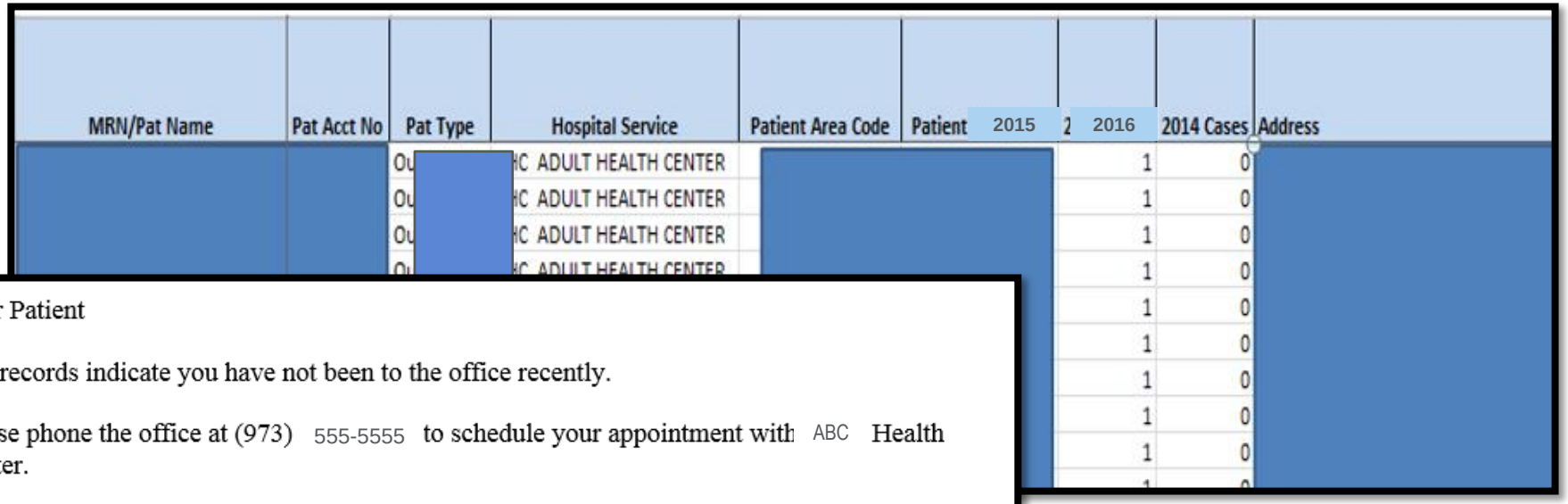
30 Patients Per Day
14 have Chronic Conditions
Unknown Health Risks
Visits Too Short for Coaching

New Population View

2500 Patient Population
900 have Chronic Conditions
1100-1250 have Mod-High Health Risk
Care Teams Leveraged by HIT

Volume-Based/Episodic → **Value-Based/Continuous**

Knowing and Managing Your Patients



MRN/Pat Name	Pat Acct No	Pat Type	Hospital Service	Patient Area Code	Patient	2015	2	2016	2014 Cases	Address
		Ou	C ADULT HEALTH CENTER					1	0	
		Ou	C ADULT HEALTH CENTER					1	0	
		Ou	C ADULT HEALTH CENTER					1	0	
		Ou	C ADULT HEALTH CENTER					1	0	
								1	0	
								1	0	
								1	0	
								1	0	
								1	0	

Dear Patient

Our records indicate you have not been to the office recently.

Please phone the office at (973) 555-5555 to schedule your appointment with ABC Health Center.

For the visit to be as beneficial as possible, we will need your help in preparing for it.

Your participation is vital for good health. Thanks for taking care of yourself and helping to prepare for your visit.

Please bring your current medications list to your checkup. And be prepared to discuss your healthcare goals.

Sincerely,
ABC Health Center

Excellence in Performance

KM 13: Elective Criteria

* **Using evidence-based care guidelines,** the practice demonstrates excellence in benchmarked/ performance-based recognition program

Report

COMPETENCY D

The practice addresses medication safety and adherence by providing information to the patient and establishing processes for medication documentation, reconciliation and assessment of barriers

Knowing and Managing Your Patients

KM 14-15: Core Criteria

Reviews and reconciles medications for more than 80 percent of patients received from care transitions

Report

Maintains an up-to-date list of medications for more than 80 percent of patients

Report

Knowing and Managing Your Patients

KM 16-19: Elective Criteria

Assesses understanding & provides education on new prescriptions

Assesses & addresses response to medications & barriers to adherence

Reviews controlled substance database for relevant medications

***** Systematically obtains prescription claims data

KM 16 & 17 - *Report & Evidence of Implementation*

KM 18 & 19 - *Evidence of Implementation*

COMPETENCY E

The practice incorporates evidence- based clinical decision support across a variety of conditions to ensure effective and efficient care is provided to patients

Knowing and Managing Your Patients

PCMH PRIME

KM 20: Core Criteria

Implements clinical decision support following evidence-based guidelines for care of (Practice must demonstrate at least four items): *Source & Evidence of Implementation*

PRIME *A.* Mental health condition

PRIME *B.* Substance use disorder

C. A chronic medical condition

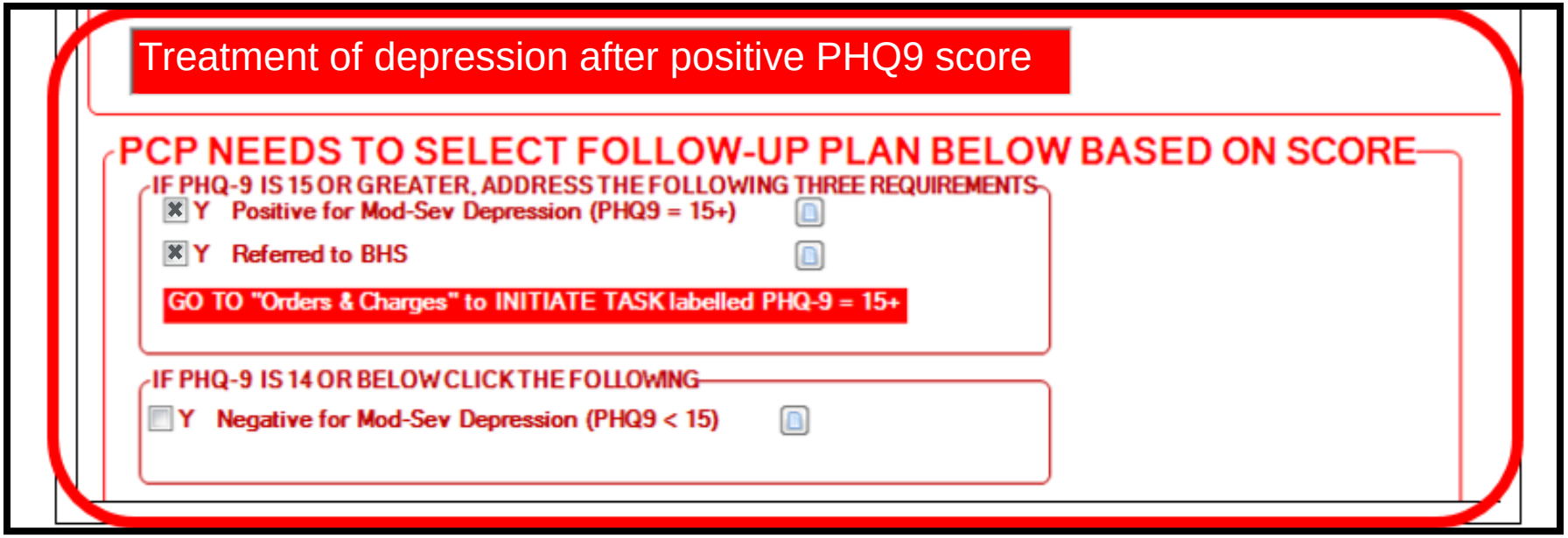
D. An acute condition

E. A condition related to unhealthy behaviors

F. Well child or adult care

G. Overuse/appropriateness issues

Clinical Decision Support – Mental Health

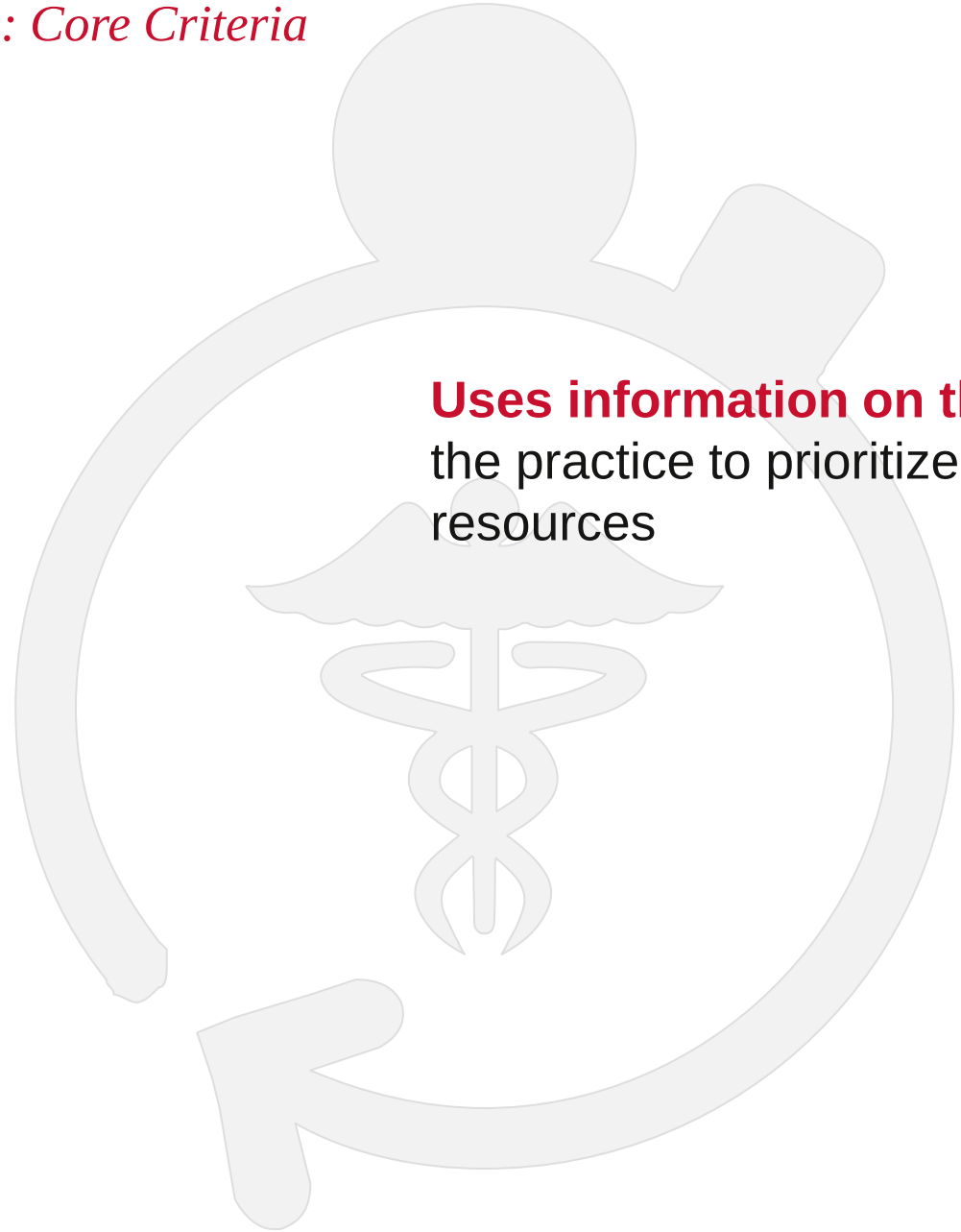


COMPETENCY F

The practice identifies/ considers and establishes connections to community resources to collaborate and direct patients to needed support

Knowing and Managing Your Patients

KM 21: Core Criteria



Uses information on the population served by the practice to prioritize needed community resources

List

Knowing and Managing Your Patients

KM 22-24: Elective Criteria

Provides access to **educational materials**

Evidence of Implementation

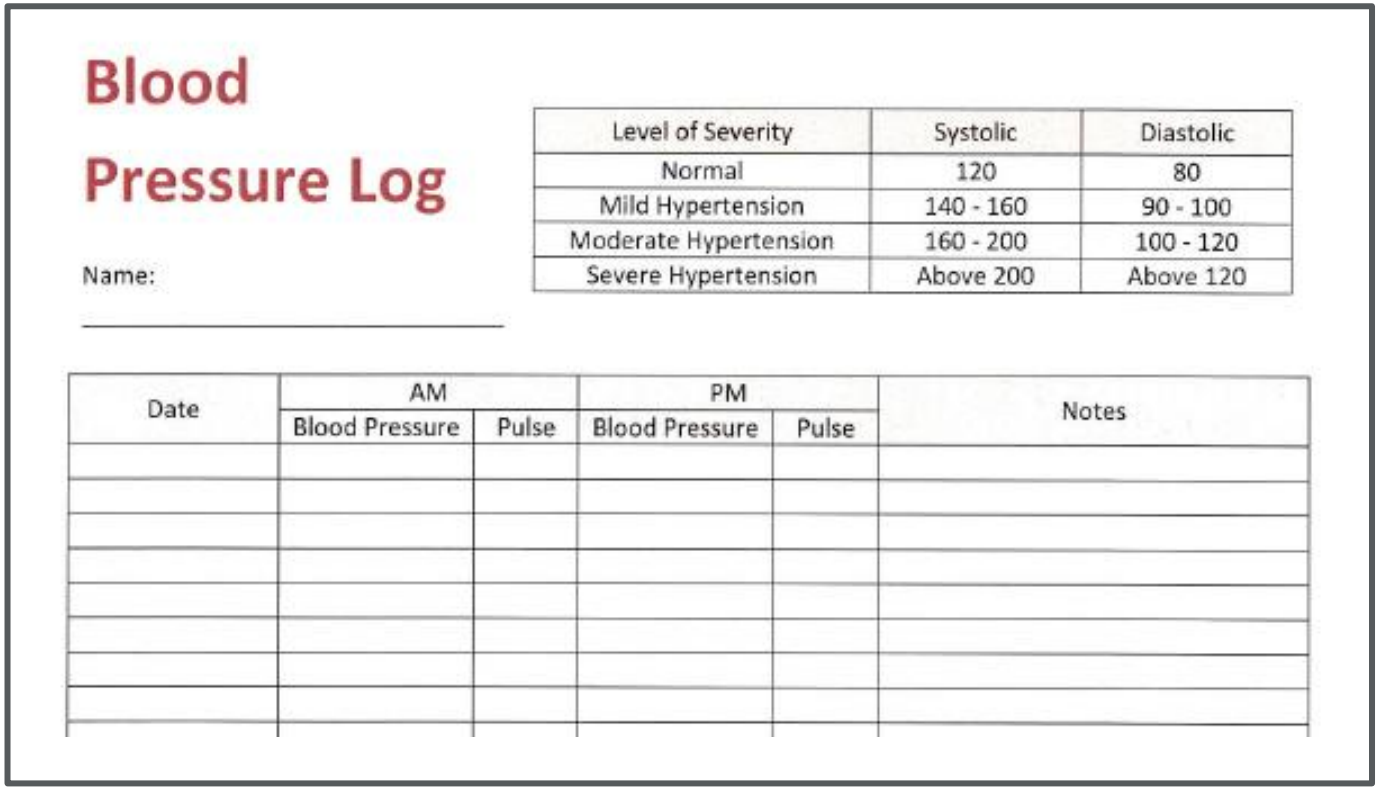
Offers **oral health** education resources

Evidence of Implementation

Adopts **shared decision-making** aids

Evidence of Implementation

Access to Educational Resources



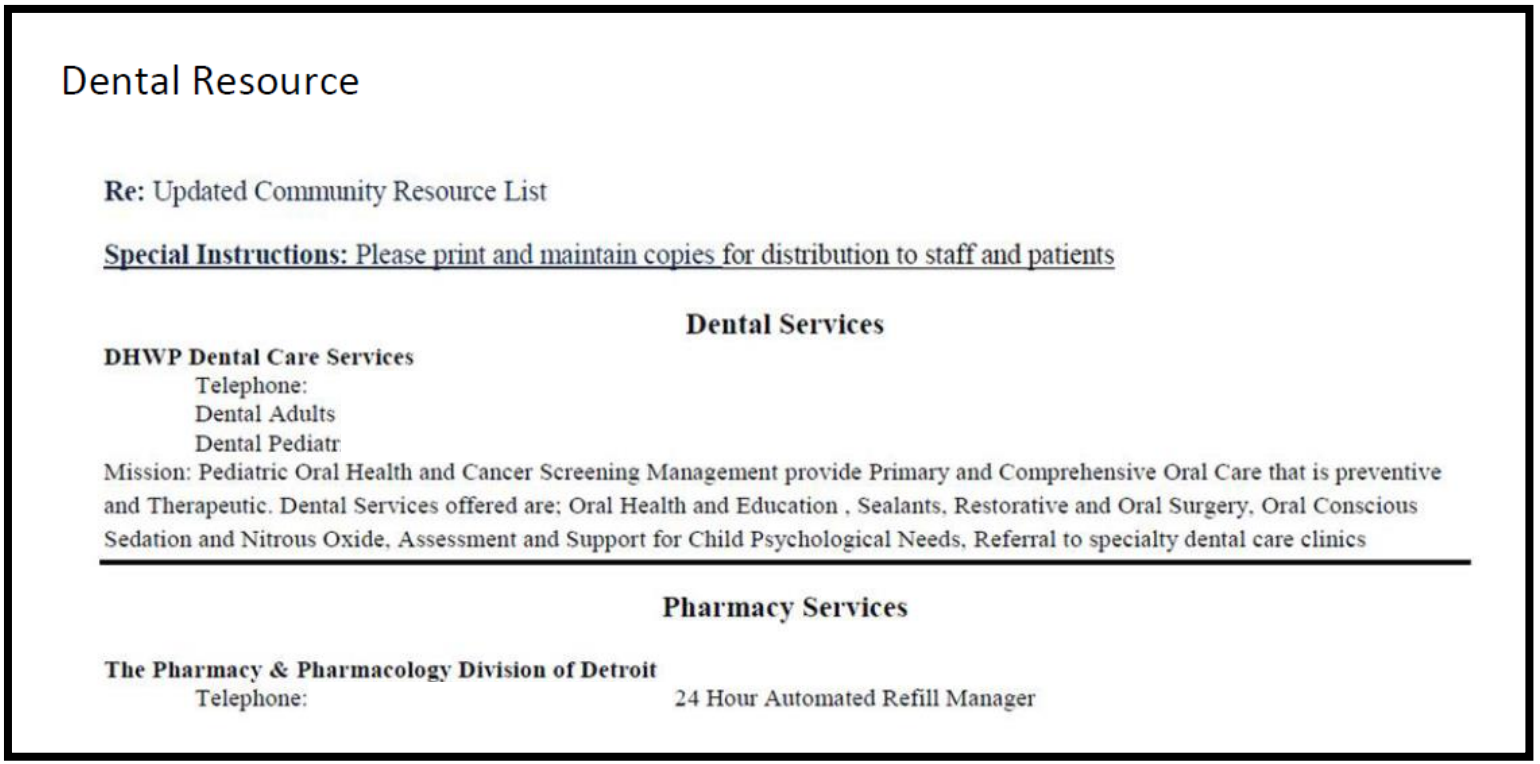
Blood Pressure Log

Name: _____

Level of Severity	Systolic	Diastolic
Normal	120	80
Mild Hypertension	140 - 160	90 - 100
Moderate Hypertension	160 - 200	100 - 120
Severe Hypertension	Above 200	Above 120

Date	AM		PM		Notes
	Blood Pressure	Pulse	Blood Pressure	Pulse	

Knowing and Managing Your Patients



Dental Resource

Re: Updated Community Resource List

Special Instructions: Please print and maintain copies for distribution to staff and patients

Dental Services

DHWP Dental Care Services
Telephone:
Dental Adults
Dental Pediatr
Mission: Pediatric Oral Health and Cancer Screening Management provide Primary and Comprehensive Oral Care that is preventive and Therapeutic. Dental Services offered are; Oral Health and Education , Sealants, Restorative and Oral Surgery, Oral Conscious Sedation and Nitrous Oxide, Assessment and Support for Child Psychological Needs, Referral to specialty dental care clinics

Pharmacy Services

The Pharmacy & Pharmacology Division of Detroit
Telephone: 24 Hour Automated Refill Manager

Shared Decision-Making Aids

What is my risk of breaking a bone?

As you get older, your risk of breaking a bone, often through a fall, increases. This increased risk may be due to weakened bones or ***osteoporosis***.

Your risk is estimated primarily by:
Your age: _____
Your Bone Mineral Density (T score): _____

It is also affected by:
- ☐ If you have had a fracture
- ☐ If a parent had a fracture
- ☐ If you currently smoke
- ☐ If you drink more than 2 drinks of alcohol a day
- ☐ If you have taken prescription steroid medications

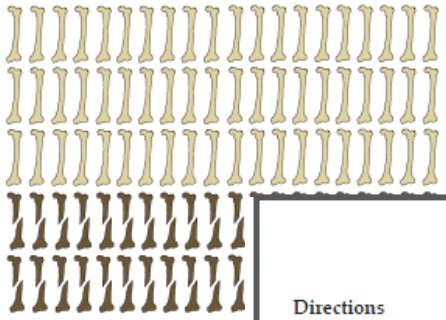
Based on these risk factors, we estimate your risk is
<10% 10-30% >30%

Your fracture risk can be lowered with medications called ***bisphosphonates***, which work to reduce bone loss. This decision aid will walk you through the benefits and downsides of bisphosphonates, so that we can make an informed choice about whether or not they are right for you.

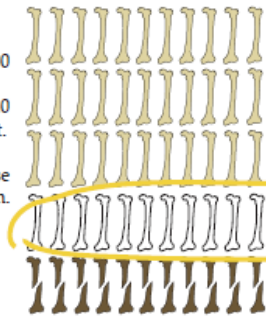
Prepared for: _____

Benefits

Without Medication
Roughly 40 in 100 have a fracture within the next 10 years. 60 will not.



With Medication
Roughly 24 in 100 have a fracture within the next 10 years. 76 will not. 16 have avoided a fracture because of the medication.



Downsides

Directions
This medication must be taken
- Once a week
- On an empty stomach in the morning
- With 8 oz of water
- While upright (sitting or standing for 30 min)
- 30 minutes before eating

Possible Harms

Abdominal Problems
About 1 in 4 people will have heartburn, nausea, or belly pain. However, it may not be from the medication. If the medication is the cause, the problem will go away if you stop taking it.

Osteonecrosis of the Jaw
Fewer than 1 in 10,000 (over the next 10 years) will have bone sores of the jaw that may need surgery.

Out of Pocket Cost
with insurance $30 | without insurance $70-90

What would you like to do?

Knowing and Managing Your Patients

KM 25-27: Elective Criteria

Engages with schools or intervention agencies

Evidence of Implementation & Documented Process

Routinely maintains a current **community resource list**

List

Assesses usefulness of community support resources

Evidence of Implementation

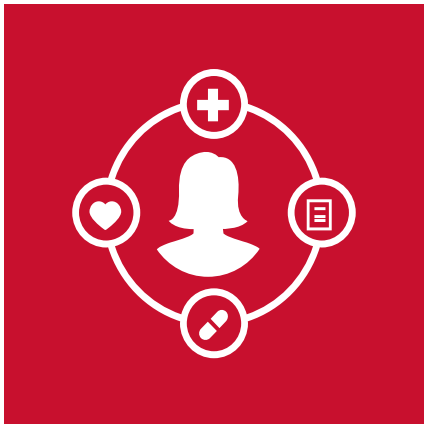
School/Intervention Agency Engagement

The Hispanic Counseling Center

Patient Access	STEP 1 (within 24 hours of visit) ☐ If visit is urgent, PCP office will call The Hispanic Counseling Center office intake line to notify of need for a more expedited appointment and outreach to the patient STEP 2 (within 24-48 hours of visit) ☐ Patient will be scheduled within 2-3 weeks of call to Specialist office unless urgent visit indicated STEP 3 (on-going management) ☐ If patient does not schedule or is a 'no-show', notification from Specialist office will be sent to PCP office within 30 days via fax or telephone encounter ☐ 609 Fulton Pediatrics Pc Care Coordinators run reports & perform outreach to anyone who has not complete appropriate follow-up	STEP 1 (during patient PCP visit) ☐ If visit is urgent, PCP office will call Specialist office to notify of need for expedited appointment STEP 2 (within 24-48 hours of visit) ☐ Referred patient will be scheduled within 2-3 weeks of call to Specialist office unless urgent visit STEP 3 (at visit) ☐ If patient needs to be seen for follow up visit - patient will schedule directly with Specialist office
Transitions of Care	STEP 1 (at visit) ☐ Informs patient of need, purpose, expectations and goals of the specialty visit ☐ Patient/family in agreement with referral, type of referral and selection of Specialist ☐ Unless urgent, PCP office provides patient with Specialist contact information and patient calls to schedule appointment STEP 2 (within 24 hours of visit) ☐ PCP office documents appropriate	STEP 1 (at visit) ☐ Reviews reason for visit with patient/family ☐ If patient needs to be seen in ED or Mental Health Facility, arrangements will be made then Specialist office will notify PCP office within 24 hours STEP 2 (within 7-10 days of initial visit) ☐ The specialist office communicates with the PCP regarding the patient's plan of care, up-dated diagnosis, and medication recommendations. ☐ If there is ongoing visits with the

Knowing and Managing Your Patients

KM 28: Elective Criteria

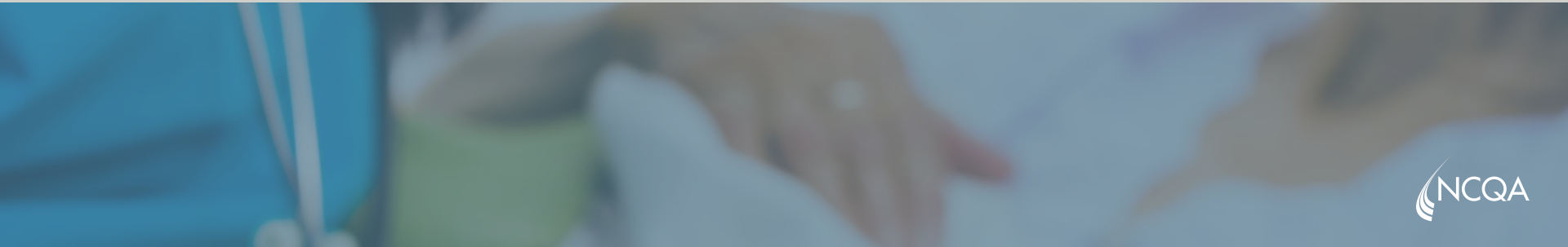


* **Regularly include external parties in "case conferences"** for the purpose of sharing information and discussing care plans for high-risk patients

Evidence of Implementation & Documented Process

Knowing & Managing Your Patients

Activity



Patient-Centered Access & Continuity

The PCMH model expects continuity of care. Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/ care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access

COMPETENCY A

The practice seeks to enhance access by providing appointments and clinical advice based on patients' needs

Patient-Centered Access and Continuity

AC 01: Core Criteria

The practice assesses the **access needs and preferences** of the patient population from collected data to determine if existing methods are sufficient

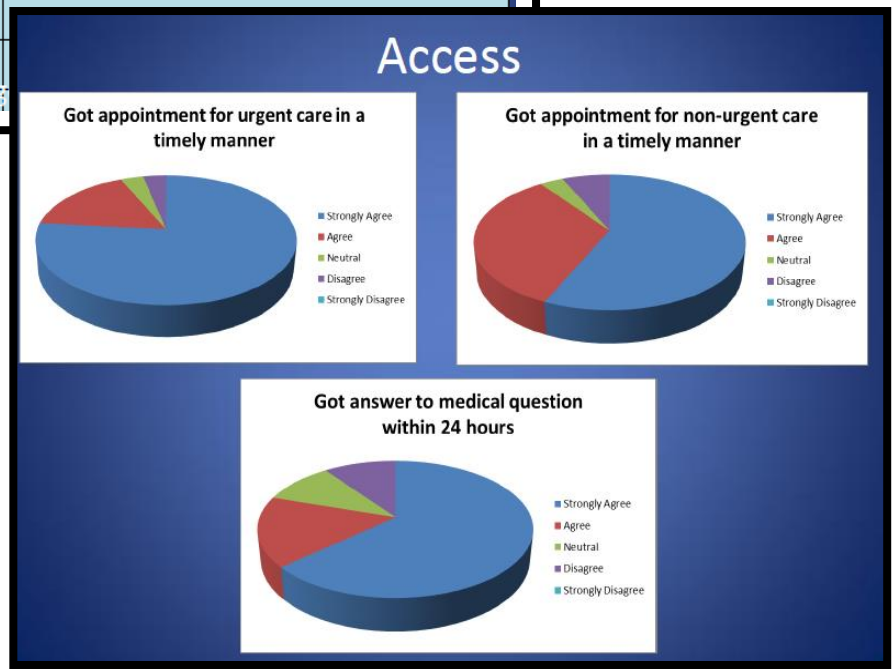
Evidence of Implementation & Documented Process

Patient-Centered Access and Continuity

Question	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Got appointment for urgent care in a timely manner	76.7%	16.7%	3.3%	3.3%	0.0%
Got appointment for non-urgent care in a timely manner	56.7%	33.3%	3.3%	6.7%	0.0%
Got answer to medical question within 24 hours	63.3%	16.7%	10.0%	10.0%	0.0%
Got answer to medical question when office was closed	56.7%	20.0%	10.0%	13.3%	0.0%
Received courteous and respectful answers from office staff	70.0%	30.0%	0.0%	0.0%	0.0%
Felt the provider addressed issues involving family, or alcohol, smoking, mental health, nutrition, exercise					
Felt the provider addressed personal health goals (i.e. weight loss, smoking cessation, etc)					
Felt the provider has given clear explanations regarding prescription					

Access

Self-Manage



Patient-Centered Access and Continuity

AC 02-05: Core Criteria

Provides **same-day appointments** for routine and urgent care

Provides routine and urgent appointments **outside regular business hours**

Provides **timely clinical advice** by telephone during and after business hours

Documents clinical advice and reconciles after-hours advice and care in patient records

AC 02-03, 05 - *Evidence of Implementation & Documented Process*

AC 04 - *Report & Documented Process*

Patient-Centered Access and Continuity

TOTAL ALL PROVIDERS	10-9-2017	10-10-2017	10-11-2017	10-12-2017	10-13-2017
	Day 1	Day 2	Day 3	Day 4	Day 5
Open "Same Day" slots at beginning of day (minimum of 30% per policy)	17 = 31%	13 = 31%	13 = 33%	10 = 53%	13 = 33%
Percent of Same- Day appointments used at end of day	16 of 17=94%	10 of 13 = 77%	10 of 13 = 77%	7 of 10 = 70%	9 of 13 = 69%
All other slots (Routine, PAP, Well Child, New Patient	38 = 69%	29 = 69%	26 = 67%	9 = 47%	26 = 67%
Total all types of appointments	55 = 100%	42 = 100%	39 = 100%	19 = 100%	39 = 100%

Patient-Centered Access and Continuity

Our location

Suburban Family Healthcare

Get in touch

Phone: (Also for After Hours)
Fax:
Email:
(office manager – only for non-medical issues)

Our hours

Monday 8:30a.m. – 12:00p.m., 1:00p.m. – 5:30p.m.
Tuesday 10:00 a.m. – 7:00p.m
Wednesday 8:30a.m. -12:00p.m., 1:00p.m. – 5:00p.m.
Thursday 8:30a.m. – 12:00p.m.
Friday 7:30a.m. – 12:00p.m., 1:00p.m. – 3:00p.m.

Walk in hours 8:30-9:30 am Monday and Fridays (existing patients only) and 1st and 3rd Saturdays of the month from 9-12 by appointment only.

Patient-Centered Access and Continuity

Clinical Advice telephonic response 7 days' log

Patient	Doctor	Date Called	Time Called	Urgent Y/N	Date Responded	Time Responded
		04/11/2016	2:48 PM	Y	04/11/2016	3:04 PM
		04/13/2016	10:55 AM	N	04/13/2016	11:25 AM
		04/14/2016	10:55 AM	N	04/14/2016	11:25 AM
		04/15/2016	2:26 PM	N	04/15/2016	2:37 PM
		04/18/2016	7:26 PM	N	04/18/2016	7:36 PM
		04/21/2016	8:23 PM	N	04/21/2016	8:50 PM

Patient-Centered Access and Continuity

AC 06-08: Elective Criteria

Practice uses phone or other technology supported mechanisms to provide scheduled routine or urgent care appointments

Report & Documented Process

Secure electronic system is available for patient requests for appointments, prescription refills, referrals and test results

Evidence of Implementation

Timely clinical advice is provided using a secure electronic system for two-way communication

NYS

Report & Documented Process

Patient-Centered Access and Continuity

AC 09: Elective Criteria

Practice assesses equity of access that considers health disparities by using information about the population served

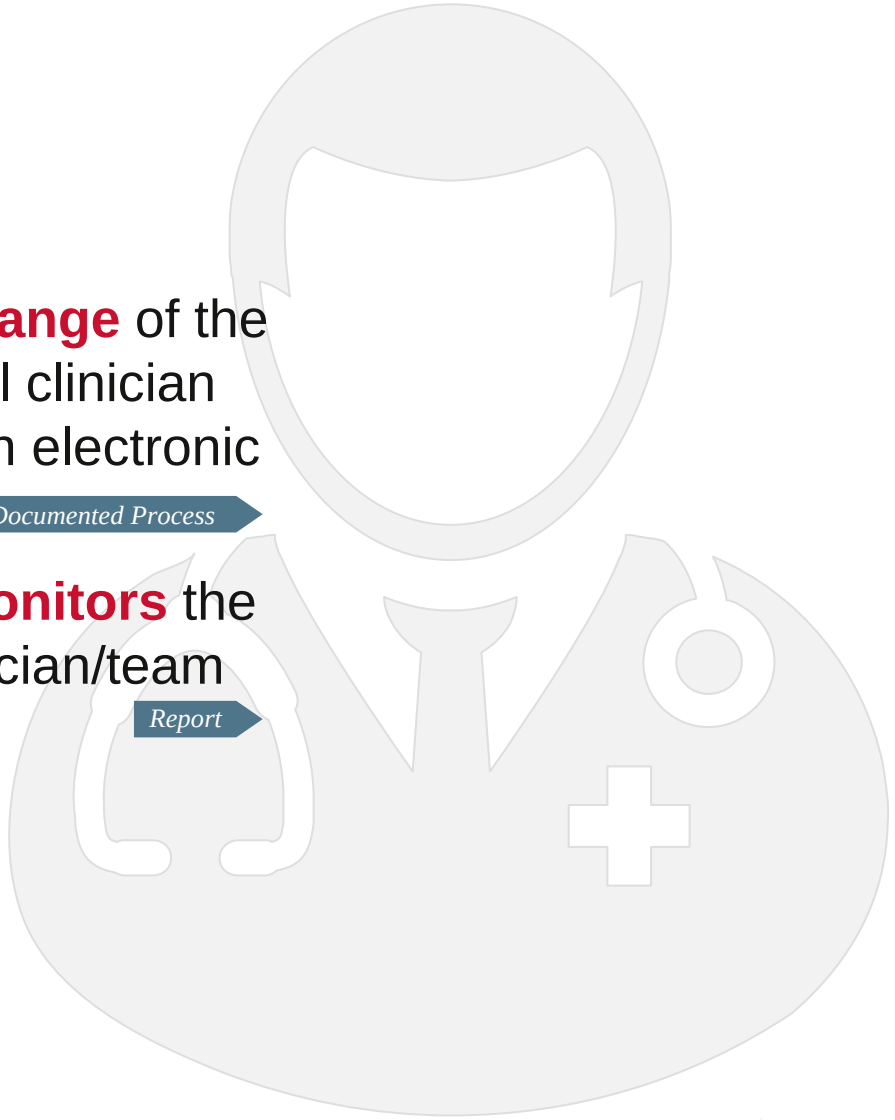
Evidence of Implementation

COMPETENCY B

Practices support continuity through empanelment and systematic access to the patient's medical record

Patient-Centered Access and Continuity

AC 10-11: Core Criteria



Assists in the selection and/or change of the patients/families/caregivers personal clinician choice and documents information in electronic system

Documented Process

Practice establishes goals and monitors the % of patient visits with selected clinician/team

Report

Patient-Centered Access and Continuity

AC 12-14: Elective Criteria

* **Continuity of medical record information** when the office is closed

Documented Process

NYS

Review and actively manage panel sizes

Report & Documented Process

Review and reconcile panels based on external data

Evidence of Implementation & Documented Process

Patient-Centered Access and Continuity

Examine Supply/Demand

To manage clinician supply/patient appointment demand

To determine number of patients it's possible to take care of:

$$\frac{(\text{provider visits/day})(\text{days in clinic/year})}{(\text{patient visits/year})} = \#\ \text{patients}$$

$$\frac{(18)(210)}{(3.6)} = \#\ \text{patients}$$

Fill in values, for example:

- Provider visits/day = 18
- days in clinic/year = 210
- patient visits/year = 3.6

1,050 = # patients

~ Mark Murray, MD

Also compare **appointment demand** with **backlog or wait time for appointments**

Panel Size Review and Management

AC 13: Example

What's Your Number ? ? ? Determining the Right Panel Size

In the process of empanelment, it is important to understand the number of patients that a provider can reasonably support. This number is linked to provider availability and must be understood before the empanelment process begins. This number should be recalculated whenever the provider's availability to see patients changes significantly.

1. Select a provider in your practice/clinic who provides care at least 3 days per week. Provider Name: (insert name)

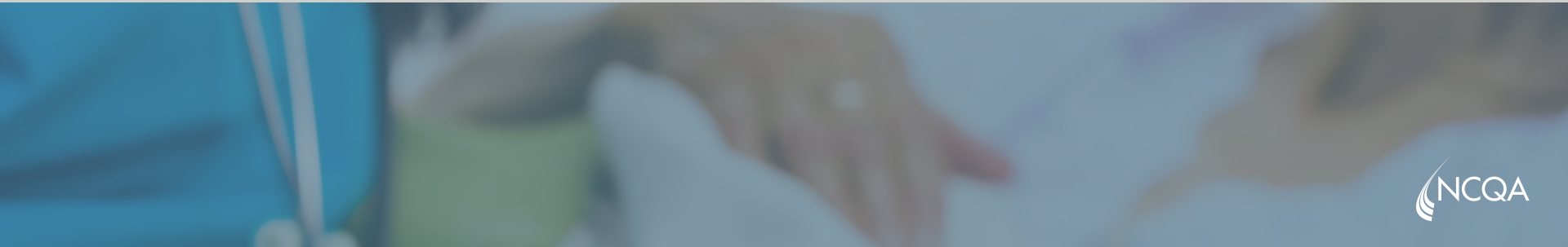
2. For this provider, determine the following:

Encounter volume		
A.	**Total number of encounters for the past two years** **NOTE: Do not count nurse-only visits**	
Unduplicated Patients		
B.	**Number of unduplicated patients seen in the last year**	
C.	**Number of unduplicated patients seen in the year *prior* to last year**	
D.	**Number of unduplicated patients seen in the last two years**	
E.	**Number of *new* unduplicated patients seen last year**	
Average Visits per Patient per Year		
F.	**Calculate: [A / D] = AVPY** (Total number of encounters for the past two years / Number of unduplicated patients seen in the last two years) = Average Visits per Patient per Year	#DIV/0!
Appointment Availability		
G.	**Length of appointment slots (in minutes)** **NOTE: If your practice/clinic has more than one appointment slot length, use the average appointment length. For example, your clinic uses 15 minute and 30 minute appointment slots. The average will be 22 minutes**	
H.	**Number of appointment slots available on the schedule last year**	

Practice site/clinic: (insert name)	**Provider: (insert name)**	
	FORMULA	**RESULT**
DEMAND **Appointment needs of current population**	**B X F** Number of unduplicated patients seen in the last year X Average Visits per Patient per Year	#DIV/0!
SUPPLY **Provider availability**	**H** Number of appointment slots available on the schedule last year	0
RIGHT PANEL SIZE The number of patients the provider can support based on current availability	**H / F** Number of appointment slots available on the schedule last year / Average Visits per Patient per Year	#DIV/0!
%GROWTH	**[B – C] ÷ C** **(**Number of unduplicated patients seen in the last year- Number of unduplicated patients seen in the year prior to last year) ÷ Number of unduplicated patients seen in the year prior to last year	#DIV/0!

Patient-Centered Access & Continuity

Activity



Care Management & Support

The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk

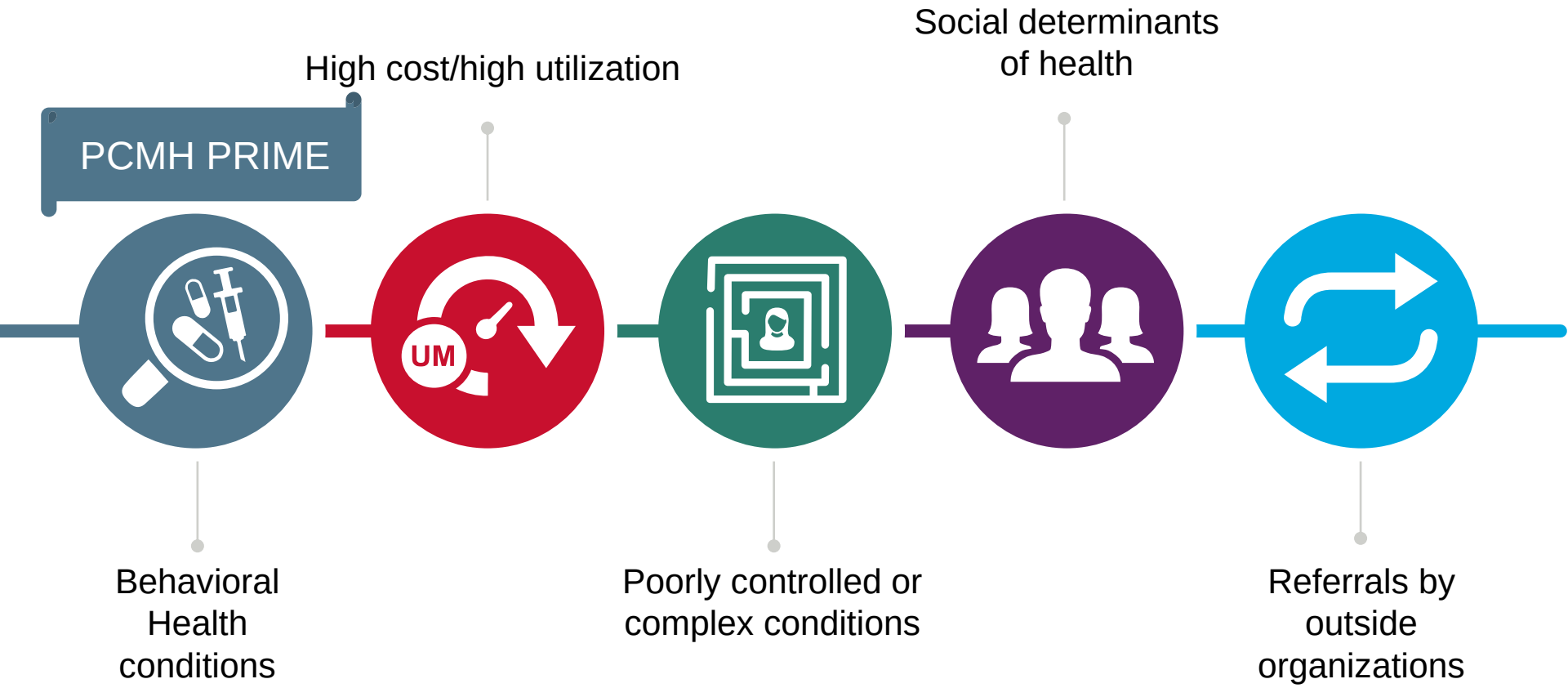
COMPETENCY A

The practice systematically identifies patients who may benefit from care management

Care Management and Support

CM 01-02: Core Criteria

- The practice must include at least three categories in its criteria



CM 01 - *Protocol OR CM 03*

CM 02 - *Report*

Identifying & Monitoring Patients for Care Mgmt

- Behavioral health patients identified – positive PHQ 9
- High utilizers – two or more ER visits in 6 months
- Two or more hospital admissions in past year
- Poorly controlled (multiple co morbidities) – HgbA1C > 9; uncontrolled hypertension
- Social determinants of health – education level < grade 8

Utilizing the criteria outlined above and in our Patient Care Planning and Management protocol, it is determined that 83 patients or 9% of the population serviced at the Ashland center could benefit from care management.

Denominator = 893 patients

Numerator = 83 patients

Percentage of patients identified as benefiting from care management = 9%

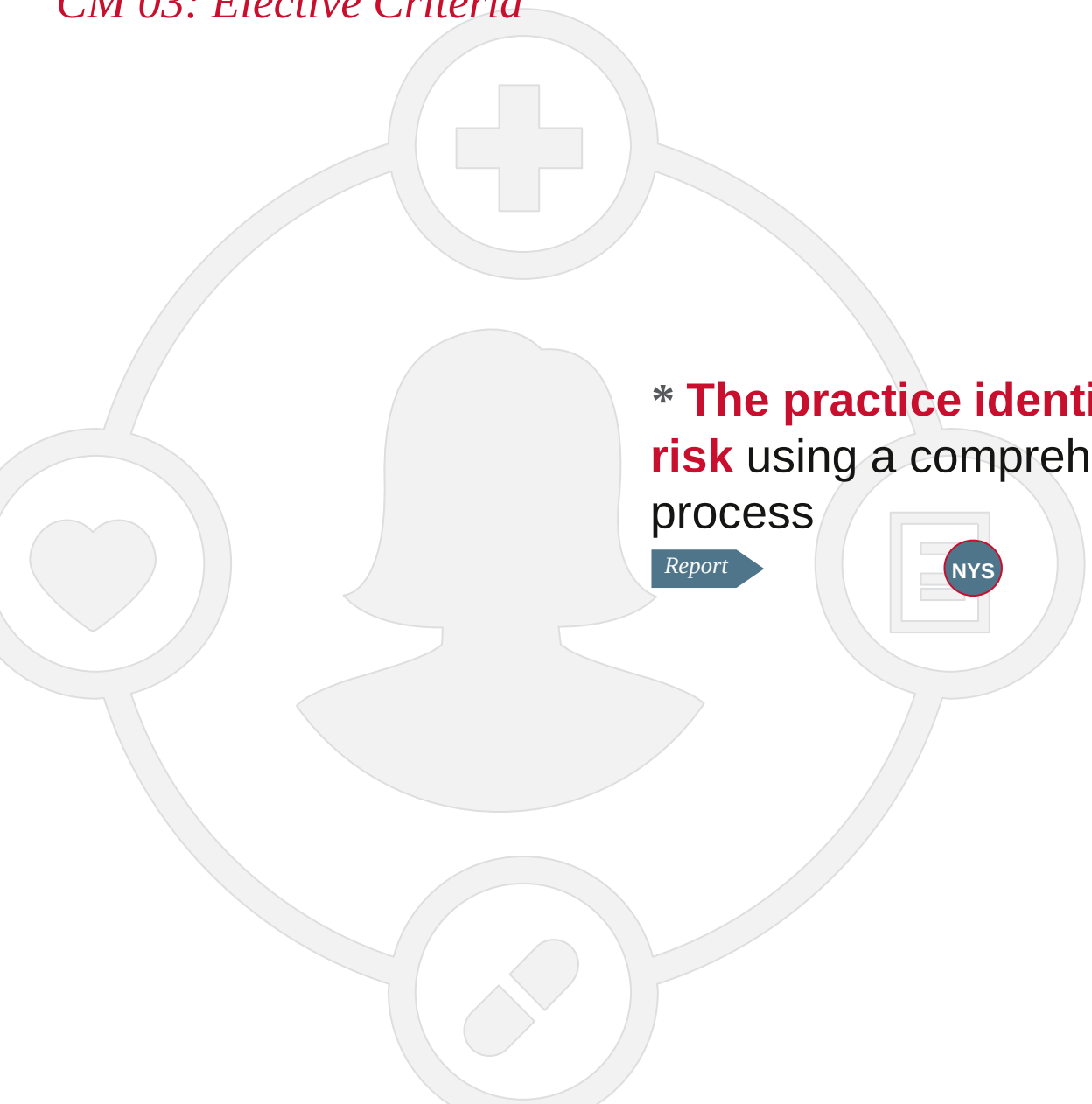
Care Management and Support

Patients Needing Care Management

	Behavioral Health	High Cost/ Utilization	Poor Control/ Complex	Social Determinants of Health	Referrals	Total Patients
Patients in Registry (may be listed more than once)	120	35	200	10	10	375
Unique Patients in Registry	-	-	-	-	-	343
Total Patients in Practice	-	-	-	-	-	3000
Patients Needing Care Management	-	-	-	-	-	11.4% (343 patients)

Care Management and Support

CM 03: Elective Criteria



* **The practice identified patients at high risk** using a comprehensive risk- stratification process

Report NYS

COMPETENCY B

For patients identified for care management, the practice consistently uses patient info. & collaborates with patients/ families/caregivers to develop a care plan that addresses barriers & incorporates patient preferences & lifestyle goals documented in the patient's chart. Demonstration may be through reports, file review or live demonstration of case examples

Care Management and Support

CM 04-05: Core Criteria

A person-centered care plan is established for care management patients

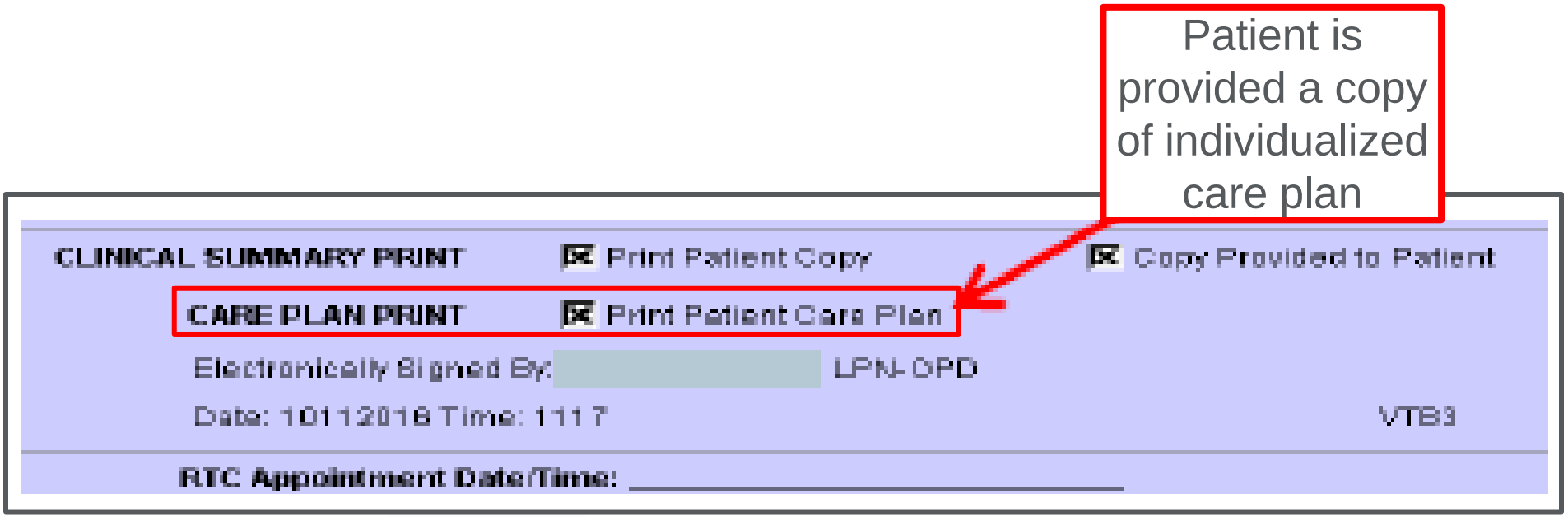
Report OR RRWB & Examples

The practice provides a written care plan to patients/families/caregivers under care management

Report OR RRWB & Examples

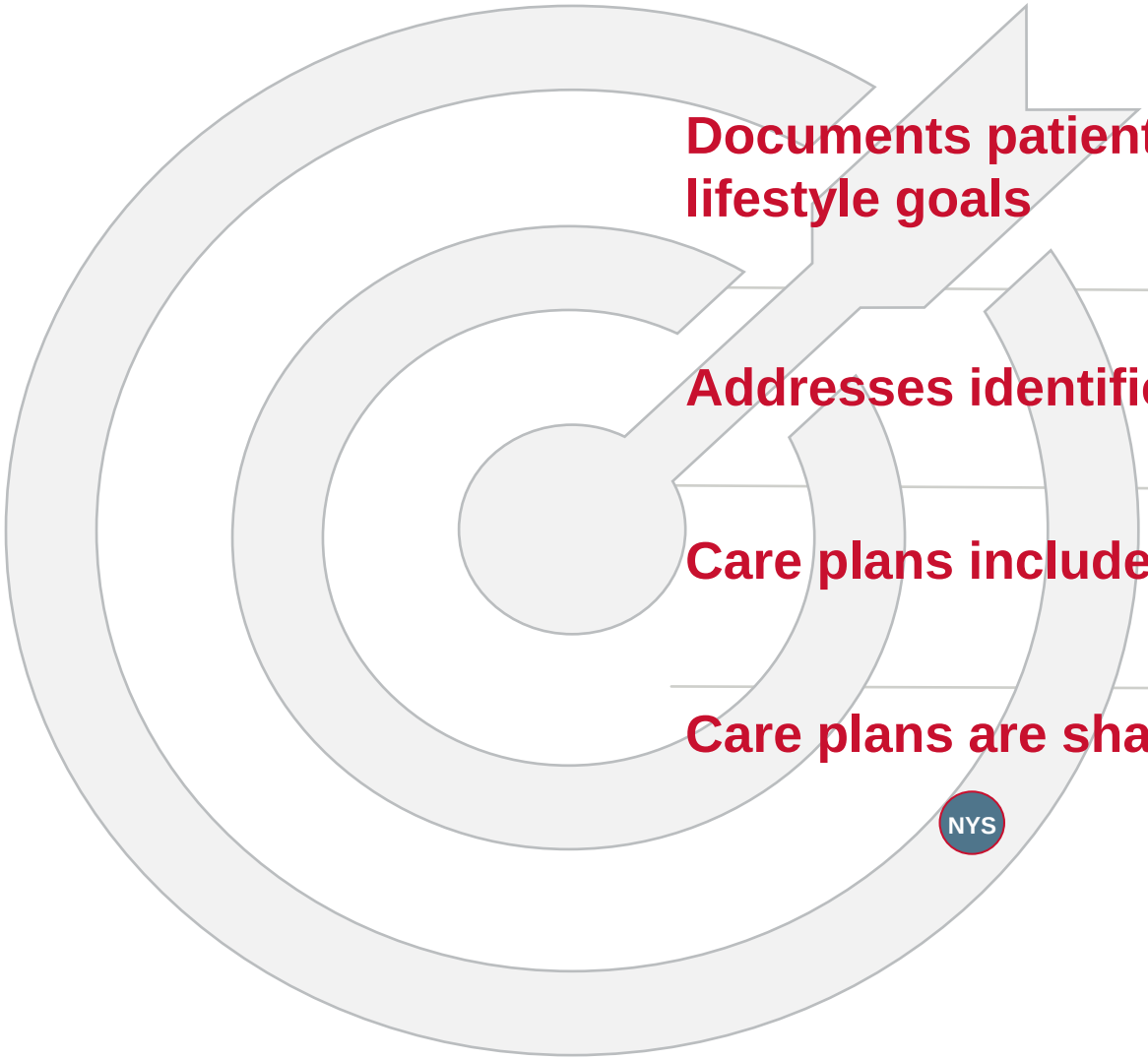
Care Management and Support

CM 05: Example



Care Management & Support

CM 06-09: Elective Criteria



Documents patient preferences & functional/ lifestyle goals

Report OR RRWB & Examples

Addresses identified & potential barriers

Report OR RRWB & Examples

Care plans include a self-management plan

Report OR RRWB & Examples

Care plans are shared across care settings

NYS

Evidence of Implementation & Documented Process

Care Management & Support

CM RRWB: Example

Organization Name:	
Completion Date:	

Patient Number		Care Planning and Self-Care Support				
		CM 04	CM 05	CM 06	CM 07	CM 08
		Establishes a person-centered care plan for patients identified for care management	Provides written care plan to the patient/family/ caregiver for patients identified for care management	Documents patient preference and functional/lifestyle goals in individual care plans	Identifies and discusses potential barriers to meeting goals in individual care plans	Includes a self-management plan in individual care plans
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						

Care Management & Support

CM 08: Example

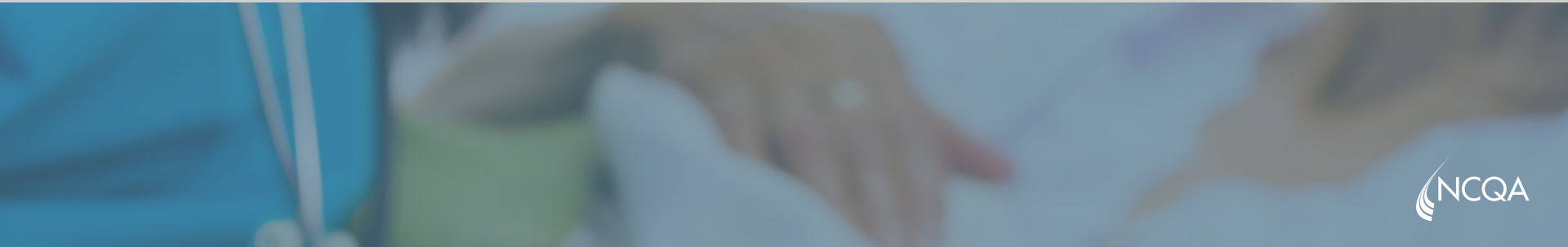
COPD Action Plan

When you are well, be aware of the following:	Action
• How much activity you can do each day • What your breathing is like when you are resting and when you are active • How much phlegm you cough up and what colour it is • Anything that makes your breathing worse • What your appetite is like • How well you are sleeping • Do you have any swelling to your feet/ankles	• Have something to look forward to each day • Plan ahead - pace yourself and allow enough time to do things • Exercise every day • Eat a balanced diet and drink plenty of fluids • Avoid things that make your condition worse • Take your medication as directed by your doctor • Never allow your medications to run out
The following are signs that your symptoms are getting worse:	**Action**
• Feeling more breathless or wheezy than usual • Reduced energy for daily activities • Coughing up more phlegm • Change in colour of phlegm • Poor sleep and/or symptoms waking you in the night • Starting to cough or increased cough • You may also have loss of appetite • New or increased swelling to feet/ankles	• Increase your reliever medication • Contact your _____ on _____ for advice • Consider starting your 'standby' antibiotics and/or Prednisolone • 'Standby' medication details (see next page) • Antibiotics: to use if your sputum becomes coloured or the amount increases due to infection • Prednisolone (Steriod): to reduce inflammation in the lungs when your breathing is bad
The following are signs of a severe attack:	**Action**
• Breathlessness and cough getting worse • You are not able to carry out your normal daily activities • Your medications are not working	• If you have not done so already, start your 'standby' medication • Phone your nurse or doctor if you have started 'standby' medication - and you are not improving - for an urgent appointment or home visit
The following are signs of a severe attack:	**Action**
• Very short of breath when you are at rest, with no relief from medication • Chest pains • High fever (temperature) • Feelings of agitation, fear, drowsiness or confusion	• Dial 999 for an ambulance or ring the GP Out of Hours service

Norfolk Community Health and Care NHS Trust COPD action plan

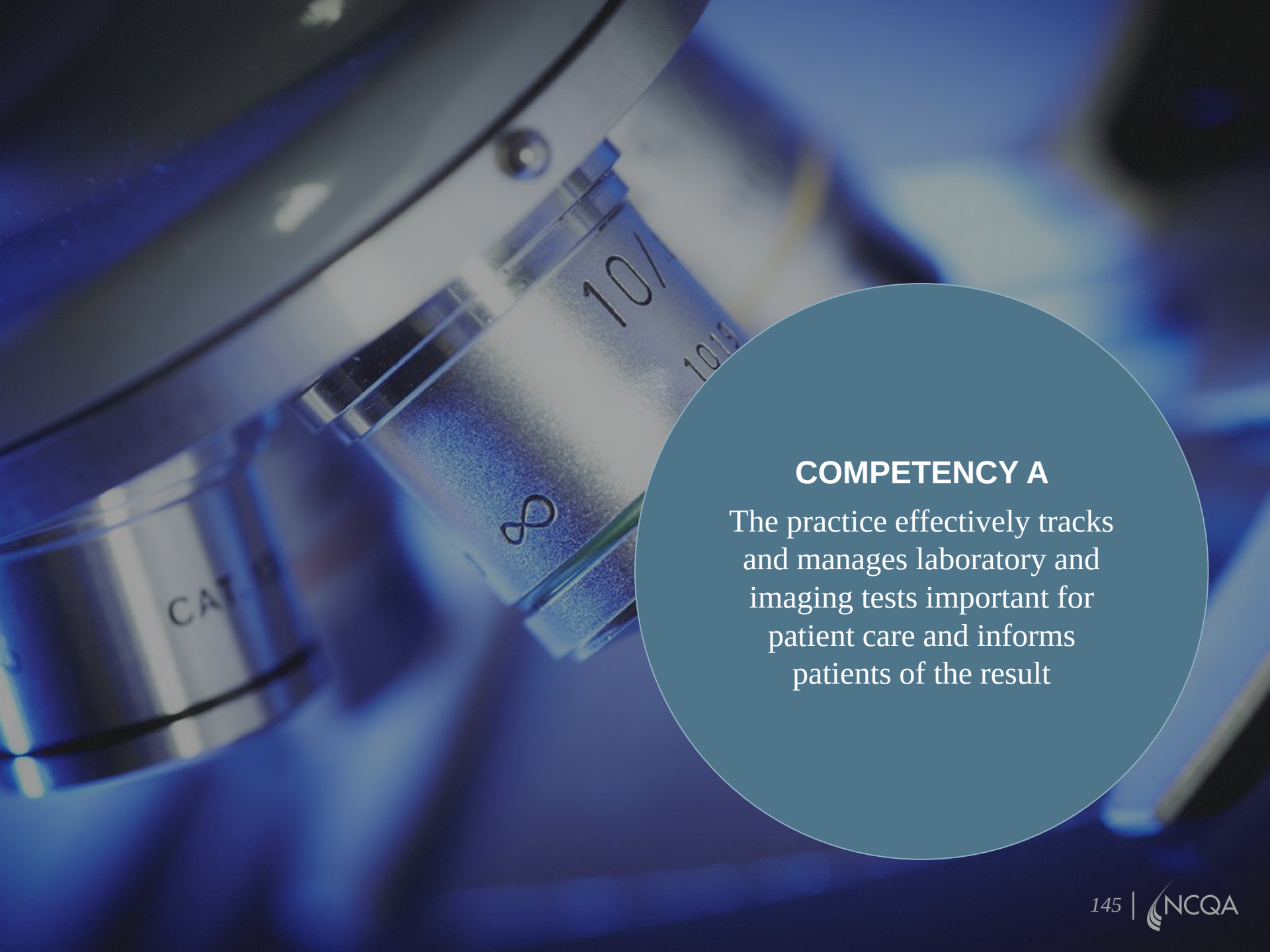
Care Management & Support

Activity



Care Coordination & Care Transitions

The practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood

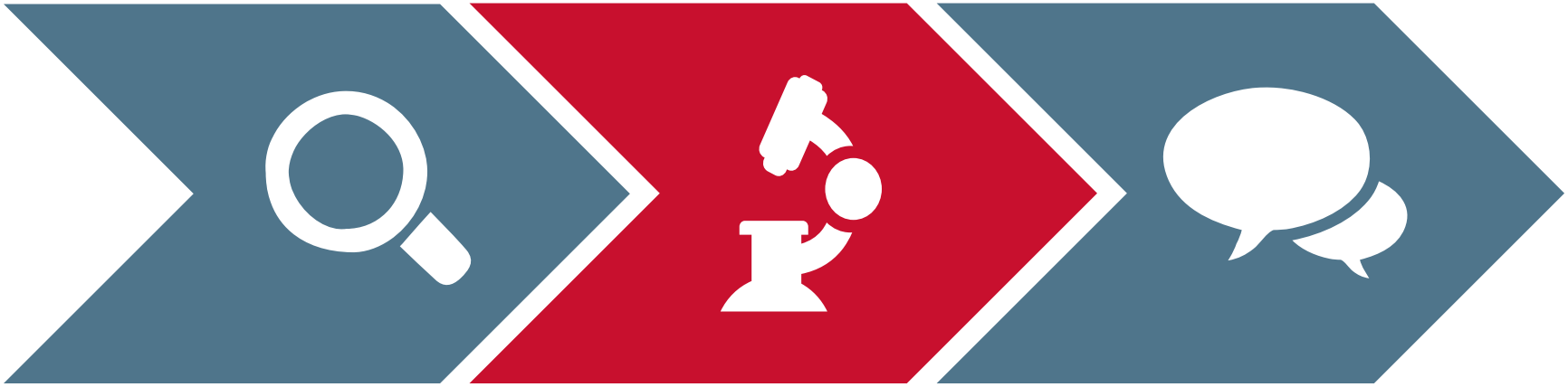


COMPETENCY A

The practice effectively tracks and manages laboratory and imaging tests important for patient care and informs patients of the result

Care Coordination & Care Transitions

Manages lab & imaging tests systematically by:



Tracking, flagging & following-up on overdue tests

Flagging abnormal test results

Notification of test results

Evidence For Test Tracking & Follow-Up

To Minimize Errors:

A decade of research shows that 6 errors are the most widely documented in ambulatory care, leading to hospitalizations, complications, minor physical harm, psychological harm, lost patient pay, physical injury and death. Of these, **two are**

Diagnostic errors such as missed, delayed and wrong diagnoses

Laboratory errors such as missed, delayed and wrong diagnoses

Source: "Research in Ambulatory Patient Safety 2000-2010: A 10-year review," American Medical Association, December 2011 (https://psnet.ahrq.gov/resources/resource/23742/research-in-ambulatory-patient-safety-2000-2010-a-10-year-review)

Care Coordination & Care Transitions

CC 01: Example

EFFECTIVE DATE: November 1, 2014 SUPERSEDES: ISSUE DATE: 8/15/14

Procedure:

1. The provider orders the lab and/or diagnostic in the patient EMR along with diagnosis, diagnosis code and timeframe the test is due.
2. The LPN/MA will generate and print the requisition for labs/diagnostics. The requisition will be given to the patient for those offices that cannot receive the orders via fax.
3. Each LPN/MA will track lab and diagnostic orders using the **OSIS Crystal Report**. Obtain the report from EMR, File, System/Practice Template, Practice, All, OSIS Crystal Report.
4. The LPN/MA will follow up monthly by running the OSIS Crystal Report.
5. At the end of each month, the LPN/MA will confirm the tests have been done by checking the patient records or the Fairfield Medical Center (FMC) portal for results.
6. If the test has NOT been completed, the patient is called by the LPN/MA to find out the reason for the missed lab or diagnostic test. If the patient agrees to reschedule the test, an appointment is rescheduled while patient is on the phone.
7. If LPN/MA is unable to reach the patient on the first call, then a second will be placed no more than seven days later; if no response, a letter will be sent to the patient asking the patient to contact the office. At this time the LPN/MA will inform the provider and request a verbal order to cancel the lab or diagnostic test. The provider may reorder the lab and or diagnostic test again at the patient next appointment.
8. The LPN/MA will document in the patient chart using the **order management** template all attempts to contact the patient by phone and the date the letter has been sent.
9. Providers will receive the test results in their Provider Approval Queue once tests are completed and will require provider signature after reviewing.
10. Provider will order additional tests, medication or follow up in the patients chart and task those orders to either the LPN/MA to carry out and inform patient.
11. LPN/MA will select in Order Management "results received" and the result of the lab value will be entered in the action/comment box.
12. LPN/MA will perform orders written by provider based upon results being normal or abnormal and document in the telephone template in patient chart once patient has been notified.
13. Paper reports received by mail will be reviewed by the triage nurse. Normal results will be scanned into the patients chart within 3 days for the provider to review and sign. Abnormal results or critical results will be given to the provider immediately to address. Once the provider

Care Coordination & Care Transitions

CC 01 A-B: Example

Lab & Diagnostics Tracking Report : February 1-15,			
Order	Action/Comment	Status	rder
SPINE, LUMBAR		result receive	
ELECTROCARDIOGRAM, COMPLETE	due in 3mos. Left msg for pt to call back.	ordered	
X-RAY EXAM OF KNEES Bilateral		completed	
Chlamydia/GC, DNA Probe		completed	
Fasting Glucose, Serum		completed	
HEMOGLOBIN A1C		completed	
HPV, high+low-risk		completed	
PAP, thin prep		completed	
urine for gonorrhea and chlamydia		completed	
CMP		completed	
LIPID PANEL		completed	
ELECTROCARDIOGRAM, COMPLETE		result receive	
CBC		completed	
CBC WITHOUT DIFF		completed	
CMP		completed	
LIPID PANEL		completed	
TSH		completed	
CT LUMBAR SPINE W/O DYE		cancelled	
US liver and gallbladder		scheduled	
ECHO TRANSTHORACIC		result receive	
ELECTROCARDIOGRAM, COMPLETE	letter mailed	ordered	
MRI ABDOMEN W/O & W/DYE liver		completed	

Care Coordination & Care Transitions

CC 01 E: Example

Normal Lab Results of lab work left as message

Telephone Encounter

Telephone Encounter Info

Author	Note Status	Last Update User	Last Update Date/Time
Phillip Andrew, MD	Signed	Phillip Andrew, MD	3/15/ 2:04 PM

Telephone Encounter

Left VM informing him testosterone levels were normal. Also wanted to check in on how the adderall taper is going but didn't get ahold of him; will f/u in 2 weeks at our next appointment

Provider called patient with results of radiology exam

Telephone Encounter

Telephone Encounter Info

Author	Note Status	Last Update User	Last Update Date/Time
MD	Signed	MD	1/27/ 1:59 PM

Telephone Encounter

I spoke to patient on the phone. X-ray is not consistent with severe OA. Symptoms are now more intermittent. Advised him to cancel appointment in Ortho clinic and we will evaluate further at his upcoming appointment.

Care Coordination & Care Transitions

CC 01 F: Example

Lab:HEMOGLOBIN A1c
Result Date:
Session Id: JK673000
Ordering Physician:

Order Date:
Time: 11:46:00

Name	Value	Reference Range
HEMOGLOBIN A1c	13.4 H	<5.7 %

Hemoglobin A1c	Degree of Glucose Control
<5.7	Decreased risk of diabetes
5.7 - 6.4	Increased risk of diabetes
>6.4	Consistent with diagnosis of diabetes

*Notes:
STAT
Fasting: No
All tests are performed at Sunrise Medical Laboratories unless otherwise indicated

Notes: Timestamp Browse...

10:06:07 AM > briefly discussed results with patient, became upset with negative results. has appointment next

Assigned to:

Result:

Status:
Open Reviewed

High Priority
Don't publish to Web Portal

Care Coordination & Care Transitions

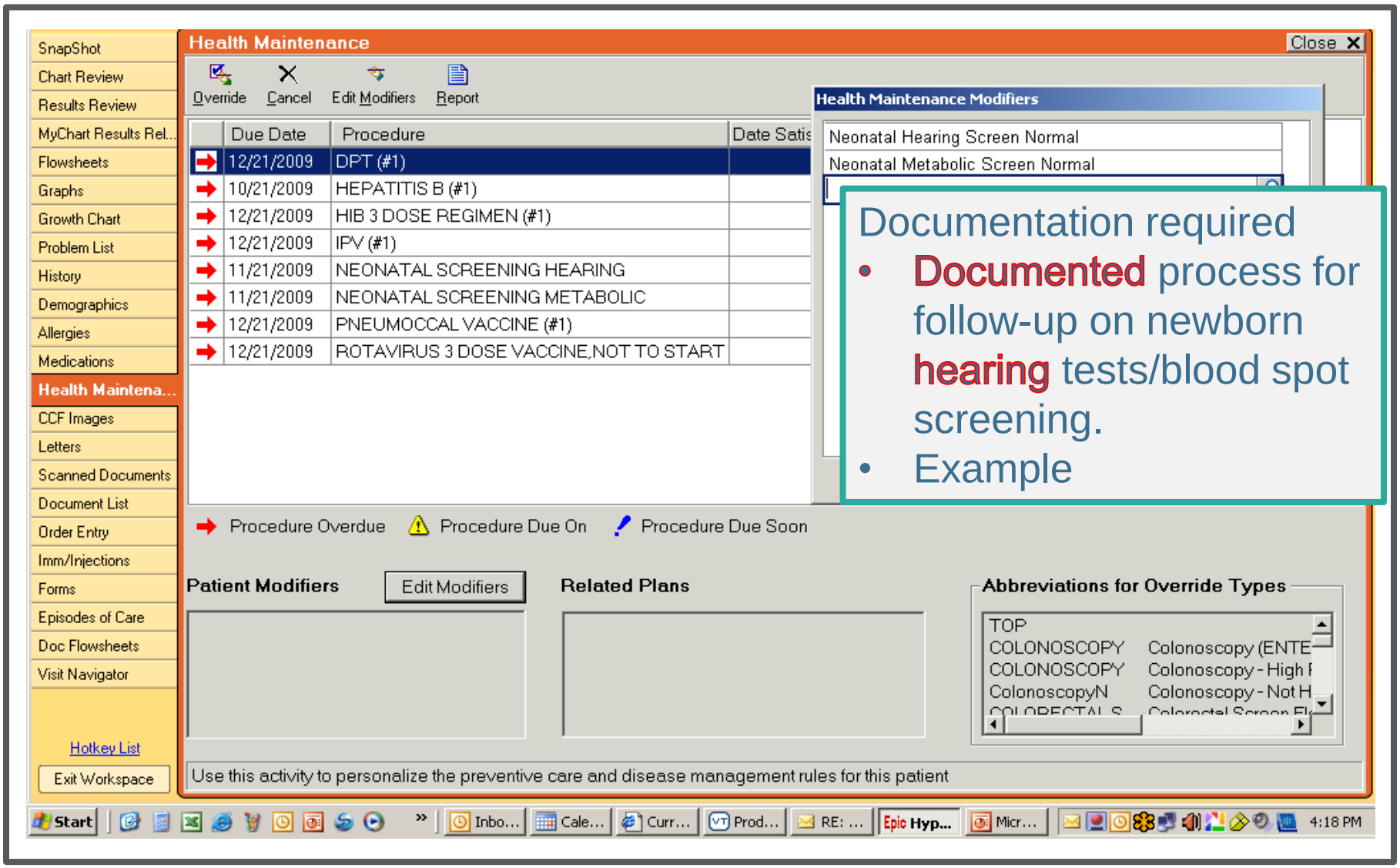
CC 02: Elective Criteria

Follows up on newborn hearing and blood-spot screening with hospitals and/or other inpatient facilities

Evidence of Implementation & Documented Process

Care Coordination & Care Transitions

CC 02: Example



Documentation required

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

Care Coordination & Care Transitions

CC 03: Elective Criteria

* **Clinical protocols are established** based on evidence-based guidelines to determine when imaging and lab tests are necessary

Evidence of Implementation

COMPETENCY B

The practice provides important information in referrals to specialists and tracks referrals until the report is received

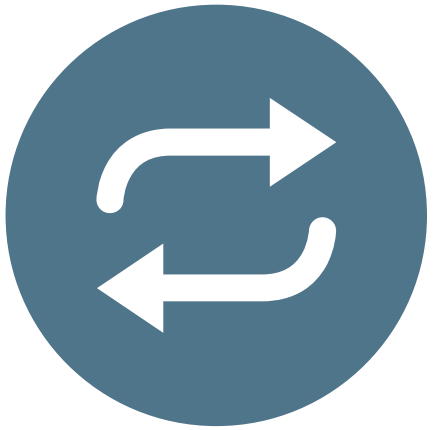
Care Coordination & Care Transitions

CC 04: Core Criteria

The practice systematically manages referrals by providing important information in referrals to specialists and tracks referrals until the report is received.

- Clinical question
- Required timing
- Type of referral

- Demographic & clinical data
  - Test results
  - Care plan



- Track referral until available
- Flag overdue reports
- Follow-up overdue reports

Care Coordination & Care Transitions

CC 05-07: Elective Criteria

* **Clinical protocols are used** to identify necessary specialist referrals

Evidence of Implementation

Commonly used specialists/specialty types are identified

Evidence of Implementation

* **Considers available performance information** on consultants/specialists

Source & Evidence of Implementation

Care Coordination & Care Transitions

CC 07: Example

Age	Clinic	ReferringProvider	Referral Type	Referral Date	Appt Date	Wait Time Days	Status
67.3	Urology (Peds): Montefiore: Hutchinson C		Urology	01/05/2015	04/23/2015	108	Consult
28.0	Headache: Montefiore: Hutchinson Camp		Neurology	01/06/2015	04/01/2015	85	Canceled by clinic
23.0	Cardiology: Montefiore-Einstein Heart Cer		Cardiology	01/09/2015	03/11/2015	61	Patient no-show
69.0	Urology (Peds): Montefiore: Hutchinson C		Urology	01/09/2015	05/05/2015	116	Created
37.0	Plastic Surgery: Montefiore: Hutchinson C		Plastic Surgery	01/13/2015	02/24/2015	42	Patient no-show
36.6	Urology (Peds): Montefiore: Hutchinson C		Urology	01/15/2015	04/02/2015	77	Patient no-show
58.3	Cardiology: Montefiore-Einstein Heart Cer		Cardiology	01/20/2015	02/17/2015	28	Canceled by clinic
23.8	Plastic Surgery: Montefiore: Hutchinson C		Plastic Surgery	01/20/2015	02/02/2015	13	Created
50.6	Allergy: Montefiore - Hutchinson Campus,		Allergy	01/21/2015	03/27/2015	65	Patient no-show
24.8	Endocrine (Peds): Montefiore - Hutchinso		Endocrine	01/22/2015	06/12/2015	141	Consult notes received
58.6	Infectious Disease: Montefiore: Hutchinso		Infectious Diseases	01/22/2015	02/19/2015	28	Consult notes received
74.7	Dermatology: Montefiore: Hutchinson Can		Dermatology	01/24/2015	02/18/2015	25	Canceled by patient
40.6	Dermatology: Montefiore: Hutchinson Can		Dermatology	01/26/2015	05/04/2015	98	Created
36.5	Urology (Peds): Montefiore: Hutchinson C		Urology	01/28/2015	06/09/2015	132	Created
53.3	Urology (Peds): Montefiore: Hutchinson C		Urology	01/28/2015	03/11/2015	42	Created
32.2	Family Planning: Montefiore - AECOM, 16		Family Planning	01/13/2015	03/05/2015	51	Canceled by patient
32.2	Family Planning: Montefiore - AECOM, 16		Family Planning	01/13/2015	04/06/2015	83	Consult notes received
29.0	Family Planning: Montefiore - AECOM, 16		Family Planning	01/14/2015	03/02/2015	47	Patient no-show
28.2	Family Planning: Montefiore - AECOM, 16		Family Planning	01/28/2015	03/12/2015	43	Patient no-show
28.2	Family Planning: Montefiore - AECOM, 16		Family Planning	01/28/2015	05/28/2015	120	Kept Not Seen
35.9	Family Planning: Montefiore - AECOM, 16		Family Planning	01/29/2015	02/09/2015	11	Patient no-show
35.9	Family Planning: Montefiore - AECOM, 16		Family Planning	01/29/2015	02/19/2015	21	Canceled by clinic
38.8	Family Planning: Montefiore - AECOM, 16		Family Planning	01/29/2015	02/02/2015	4	Consult notes received
31.9	URO-GYN: AECOM		URO-GYN	01/08/2015	03/06/2015	57	Canceled by patient
31.9	URO-GYN: AECOM		URO-GYN	01/08/2015	05/07/2015	119	Patient no-show
32.7	URO-GYN: AECOM		URO-GYN	01/08/2015	03/02/2015	53	Patient no-show
33.8	Genetics - AECOM		Genetics	01/13/2015	02/10/2015	28	Canceled by patient
27.2	Ultrasound: AECOM		Ultrasound	01/15/2015	02/09/2015	25	Consult notes received
25.8	Fetal Echo: AECOM		ECHO	01/20/2015	02/23/2015	34	Consult notes received
63.1	Hematology: Albert Einstein College of Me		Hematology	01/20/2015	03/25/2015	64	Created
24.9	Ultrasound: AECOM		Ultrasound	01/22/2015	03/05/2015	42	Consult notes received
37.1	Genetics - AECOM		Genetics	01/23/2015	03/03/2015	39	Consult notes received
33.1	OB/GYN: MFAC - AECOM		OB/GYN	01/29/2015	02/10/2015	12	Canceled by patient
33.1	OB/GYN: MFAC - AECOM		OB/GYN	01/29/2015	02/12/2015	14	Consult notes received
34.9	Neurology: Montefiore North - Medical Vil		Neurology	01/07/2015	05/13/2015	126	Created
63.6	Neurology: Montefiore North - Medical Vil		Neurology	01/08/2015	06/11/2015	154	Created
40.3	Mammogram: MMC - North		Mammogram	01/11/2015	02/10/2015	30	Patient no-show
43.1	Ultrasound: Montefiore - Wakefield Camp		Ultrasound	01/15/2015	02/13/2015	29	Patient no-show

This report is periodically generated from TRMS, a web-based tracking database used by the practice for subspecialty referrals. It shows the total number of referrals to subspecialties for adult patients generated (electronically) in January 2015, appointments scheduled and the location (mostly within), the number of days/waiting period, and the status of those appointments.

Out of a total of 319 referrals, 76 of them were not scheduled within Medical Center, 76% were.

Performance Information for Specialist Referrals

CC 07: Example

Care Coordination & Care Transitions

CC 08-09: Elective Criteria

PCMH PRIME (CC 09)

The practice sets expectations for patient care and sharing information when working with:

- Non-behavioral healthcare specialists — *Documented Process OR Agreement*
- * Behavioral healthcare providers — *Agreement OR Documented Process & Evidence of Implementation*

NYS

Behavioral Health Referral Expectations

CC 09: Example

Behavioral Health Care Compact

between

Referral Process	STEP 1 (at initial office visit) ☐ At the office visit, PCP will discuss reason for referral to Behavioral Health Specialist with patient/family ☐ If visit is urgent, PCP office will call The Center office intake line to notify of need for a more expedited appointment and outreach to the patient ☐ The Center contact information is provided to patient in printed care plan and follow-up plan STEP 2 (within 24-48 hours of visit) ☐ Referrals will be sent via fax or through the electronic health record (EHR) to The Center intake department. The referral will include the patient's face sheet, most recent progress note, and the signed 'authorization to release PHI' form. ☐ Referral/Care Coordinator verifies insurance coverage referral requirements ☐ Pertinent records and information will be included with referral	STEP 1 (within 24 - 48 hours of visit) ☐ The Center intake office receives fax and intake office will contact patient to schedule visit and complete intake assessment ☐ Insurance eligibility/benefits are reviewed when appointment is scheduled ☐ The patient will be placed with a therapist/counselor that is deemed a 'good fit' for the patient based on psychological assessed needs and insurance coverage. STEP 2 (within 7-10 days of initial visit) ☐ The specialist office communicates with the PCP regarding the patient's plan of care, up-dated diagnosis, and medication recommendations. ☐ This report will be sent to the PCP office within 7-10 business days of appointment (f/u recommendations and other pertinent medical information)

Care Coordination & Care Transitions

CC 10: Elective Criteria

PCMH PRIME

* **A behavioral health provider** is integrated into the practice's care delivery system

Evidence of Implementation & Documented Process

Care Coordination & Care Transitions

CC 11-13: Elective Criteria

Monitors the timeliness and quality of referral responses

Documents co-management arrangements in the patient's medical record

***** Engages with patients regarding **cost implications of treatment options**

CC 11 & 13 - *Report & Documented Process*

CC 14 - *Evidence of Implementation*

COMPETENCY C

The practice connects with health care facilities to support patient safety throughout care transitions. The practice receives and shares necessary patient treatment information to coordinate comprehensive patient care

Care Coordination & Care Transitions

CC 14-16: Core Criteria

Identifies patients with unplanned admissions and ED visits

Report & Documented Process

Shares clinical information with inpatient facilities

Evidence of Implementation & Documented Process

Contacts patients/families/ caregivers for follow-up care

Evidence of Implementation & Documented Process

Care Coordination & Care Transitions

CC 14-16, 18-19: Example

Procedure:

CC 14
- 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.

CC 15
- Communication with local hospitals is completed daily.

CC 19
- 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.

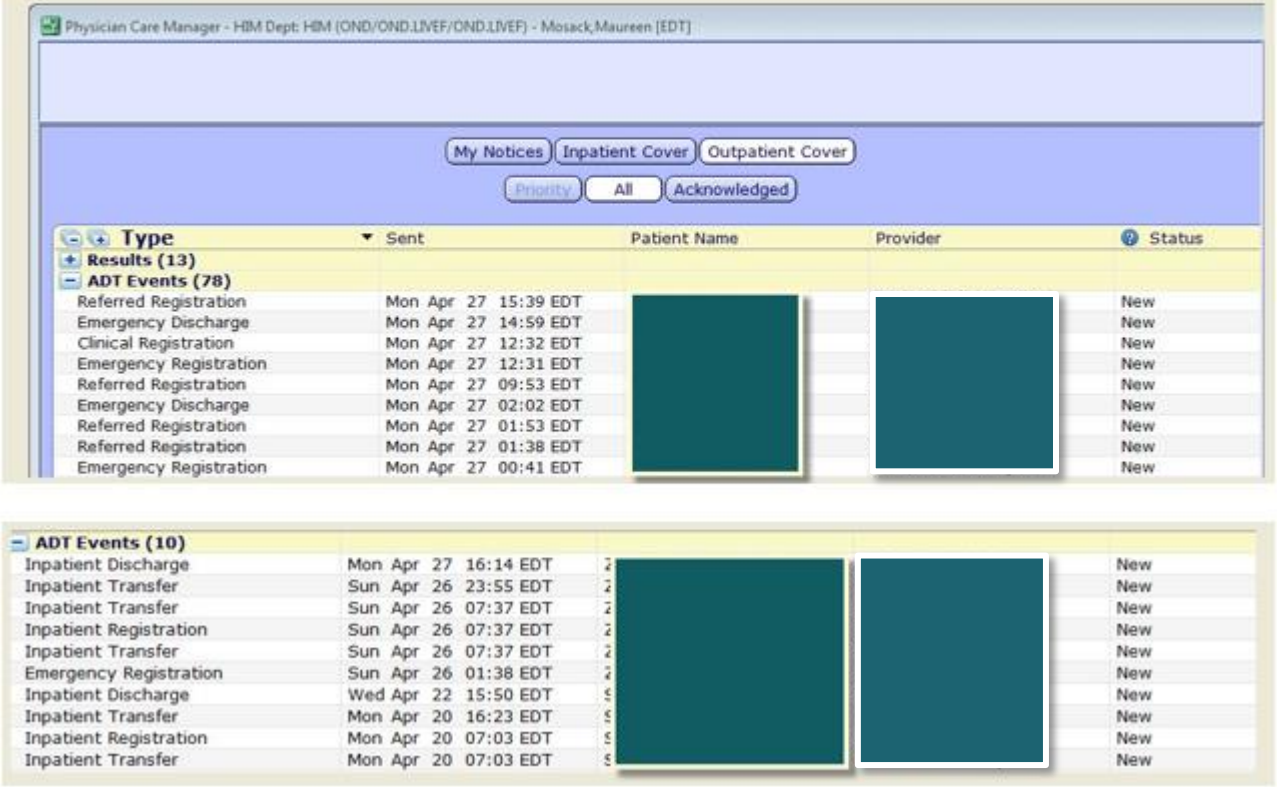
CC 18
- Local hospitals are contacted if additional information is needed.
- After thorough review and obtaining hospital records the Care Coordinator will give the daily census to the Nurse Care Manager for review.
- Nurse Care Manager will be responsible for assuring the medical records were received and scanned into the chart.

CC 16
- 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.

Care Coordination & Care Transitions

CC 14: Example

Referred Registration is an admission
Inpatient Discharge is a hospital discharge
Emergency Discharge is discharge from the ED.



Care Coordination & Care Transitions

CC 16: Example

10:26 AM Telephone

Description: **45 year old female**
Provider:
MRN
Department:

Reason for Call

Follow-up since

Call Documentation

10:32 AM Signed

Following up with patient after visit to ER for abdominal Pain. Pt states that she was discharged and that her CT Scan and labs were fine. Still c/o some slight pain today but that overall it is better. Was told last night that it could be because of her nerves. The ER MD increased zoloft for this and pt states that she has made the changes recommended. Would like to follow up with PCP to make sure that dose will work for her. Schedule F/U in 1 week. Pt voices no further needs at this time.

Encounter Messages

No messages in this encounter

Contacts

	Type	Contact	Phone
10:26 AM	Phone (Outgoing)		

Created by

10:26 AM

Patient Instructions

None

Care Coordination & Care Transition

CC 17-20: Elective Criteria

Coordinate with acute care settings after hours through access to current patient information

Exchange patient information with the hospital during patient's hospitalization

Obtain discharge summaries consistently from the hospital and facilities

NYS

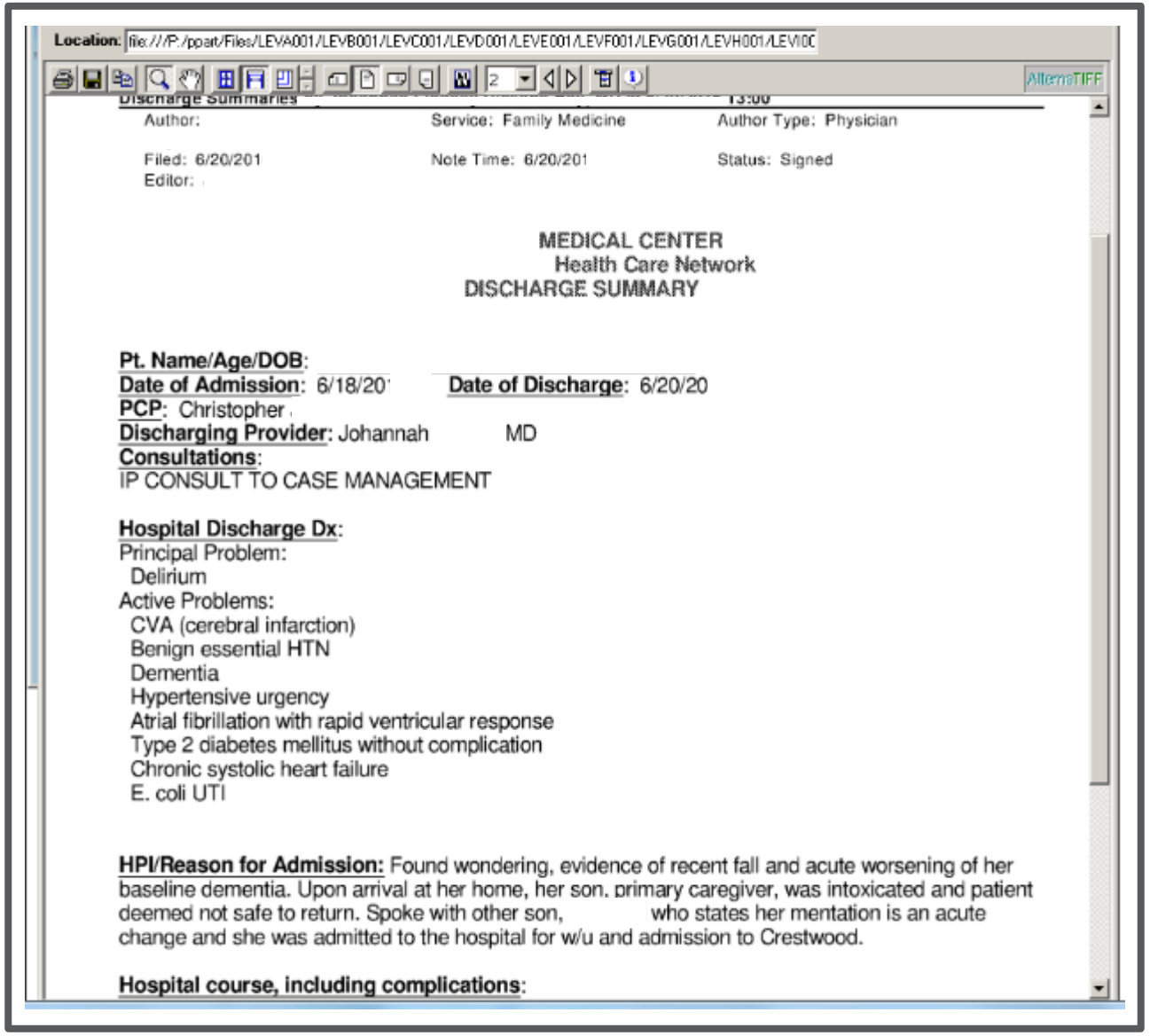
Collaborates on care plan for complex patients transferring in/out of the practice

CC 17-19 - *Evidence of Implementation & Documented Process*

CC 20 - *Evidence of Implementation*

Care Coordination & Care Transition

CC 19: Example



Location: file:///P:/ppart/Files/LEVA001/LEVB001/LEVC001/LEVD001/LEVE001/LEVF001/LEVG001/LEVH001/LEVI0C

AlternaTIFF

Discharge Summaries 13:00

Author: Service: Family Medicine Author Type: Physician

Filed: 6/20/201 Note Time: 6/20/201 Status: Signed
Editor:

MEDICAL CENTER
Health Care Network
DISCHARGE SUMMARY

Pt. Name/Age/DOB:
Date of Admission: 6/18/20 **Date of Discharge**: 6/20/20
PCP: Christopher
Discharging Provider: Johannah MD
Consultations:
IP CONSULT TO CASE MANAGEMENT

Hospital Discharge Dx:
Principal Problem:
Delirium
Active Problems:
CVA (cerebral infarction)
Benign essential HTN
Dementia
Hypertensive urgency
Atrial fibrillation with rapid ventricular response
Type 2 diabetes mellitus without complication
Chronic systolic heart failure
E. coli UTI

HPI/Reason for Admission: Found wondering, evidence of recent fall and acute worsening of her baseline dementia. Upon arrival at her home, her son, primary caregiver, was intoxicated and patient deemed not safe to return. Spoke with other son, who states her mentation is an acute change and she was admitted to the hospital for w/u and admission to Crestwood.

Hospital course, including complications:

Care Coordination & Care Transition

CC 21: Elective Criteria

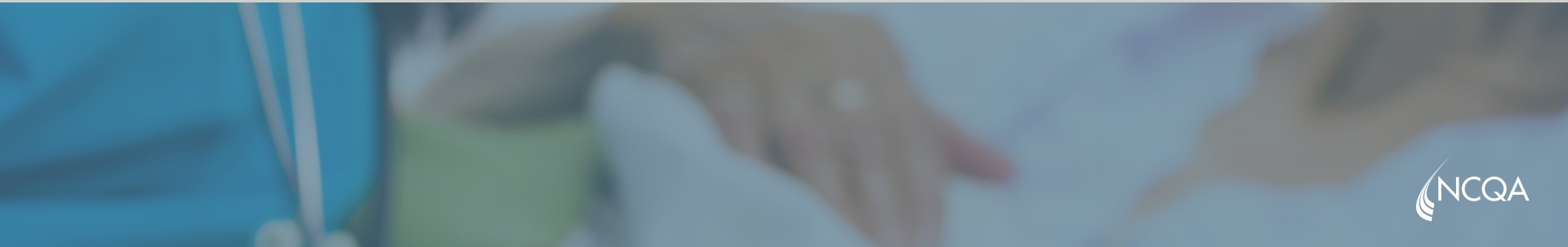
Electronic exchange of information with external entities on 1 or more (max 3 credits):

A. RHIO or HIEs NYS
B. Immunization registries or similar
C. Summary of care to other providers or facilities for care transitions

Evidence of Implementation

Care Coordination & Care Transitions

Activity



Performance Measurement & Quality Improvement

The practice establishes a culture of data-driven performance improvement on clinical quality, efficiency and patient experience, and engages staff and patients/families/caregivers in quality improvement activities

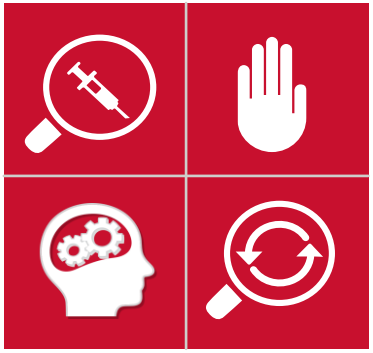
COMPETENCY A

The practice measures to understand current performance and to identify opportunities for improvement

Performance Measurement & Quality Improvement

QI 01: Core Criteria

The practice monitors at least 5 clinical quality measures (must monitor at least one measure of each type):



- **Immunization** measures
- **Other preventive care** measures
- **Chronic or acute** clinical care measures
- **Behavioral health** measures

Reports

Performance Measurement & Quality Improvement

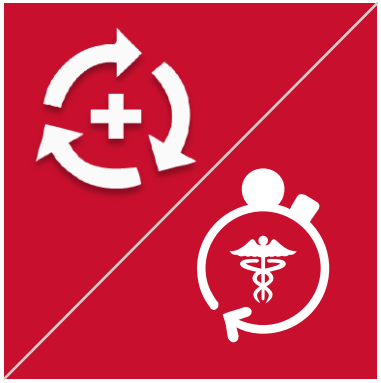
QI 02-03: Core Criteria

The practice **monitors at least two measures of resource stewardship** (must monitor at least 1 measure of each type):

Care coordination measures

Measures affecting **health care costs**

Reports



Assesses performance on availability of **major appointment types**

Report & Documented Process

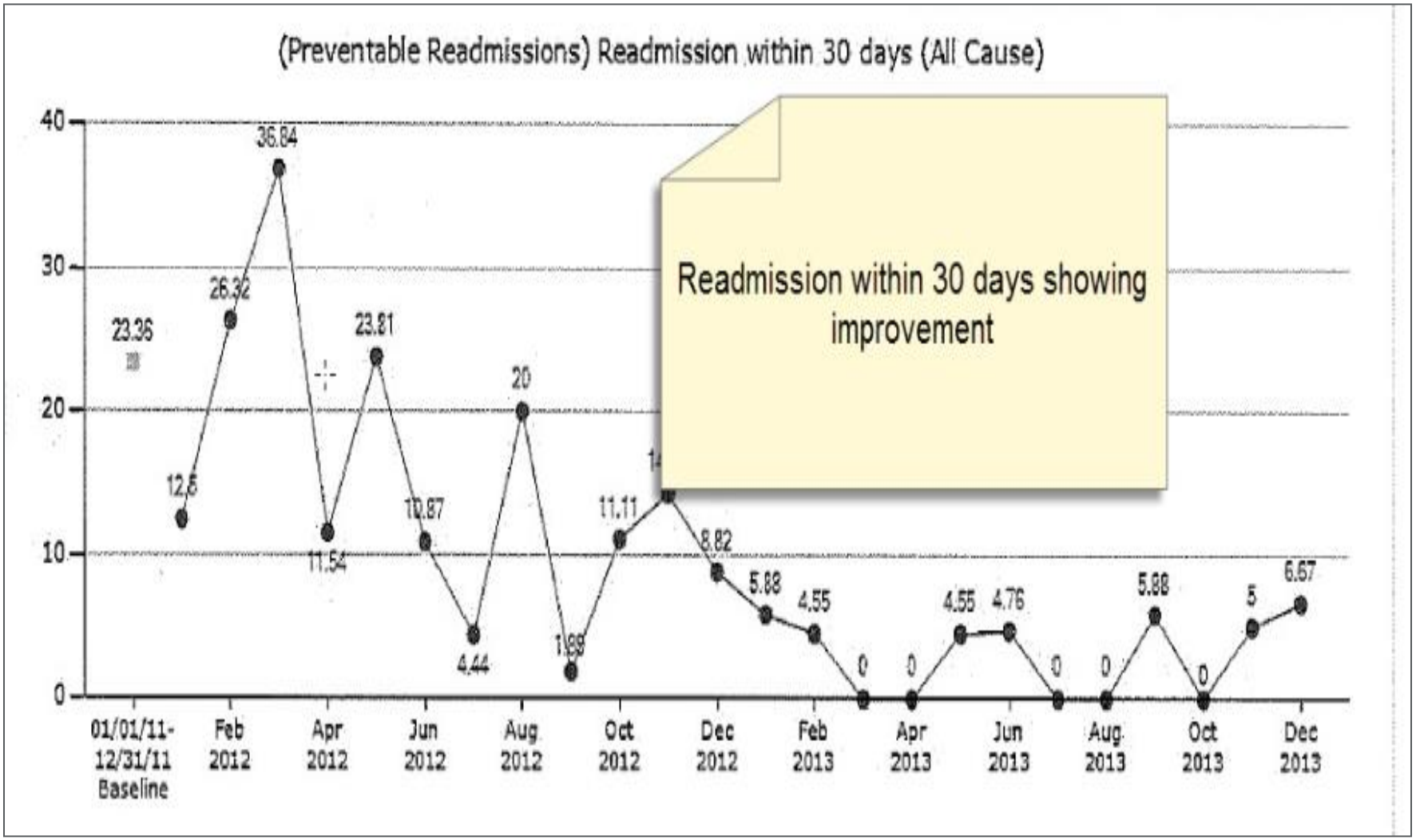
Performance Measurement & Quality Improvement

QI 01 A-D: Example

Health Maintenance Topic 1/1/ – 12/31/	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
Depression screening	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

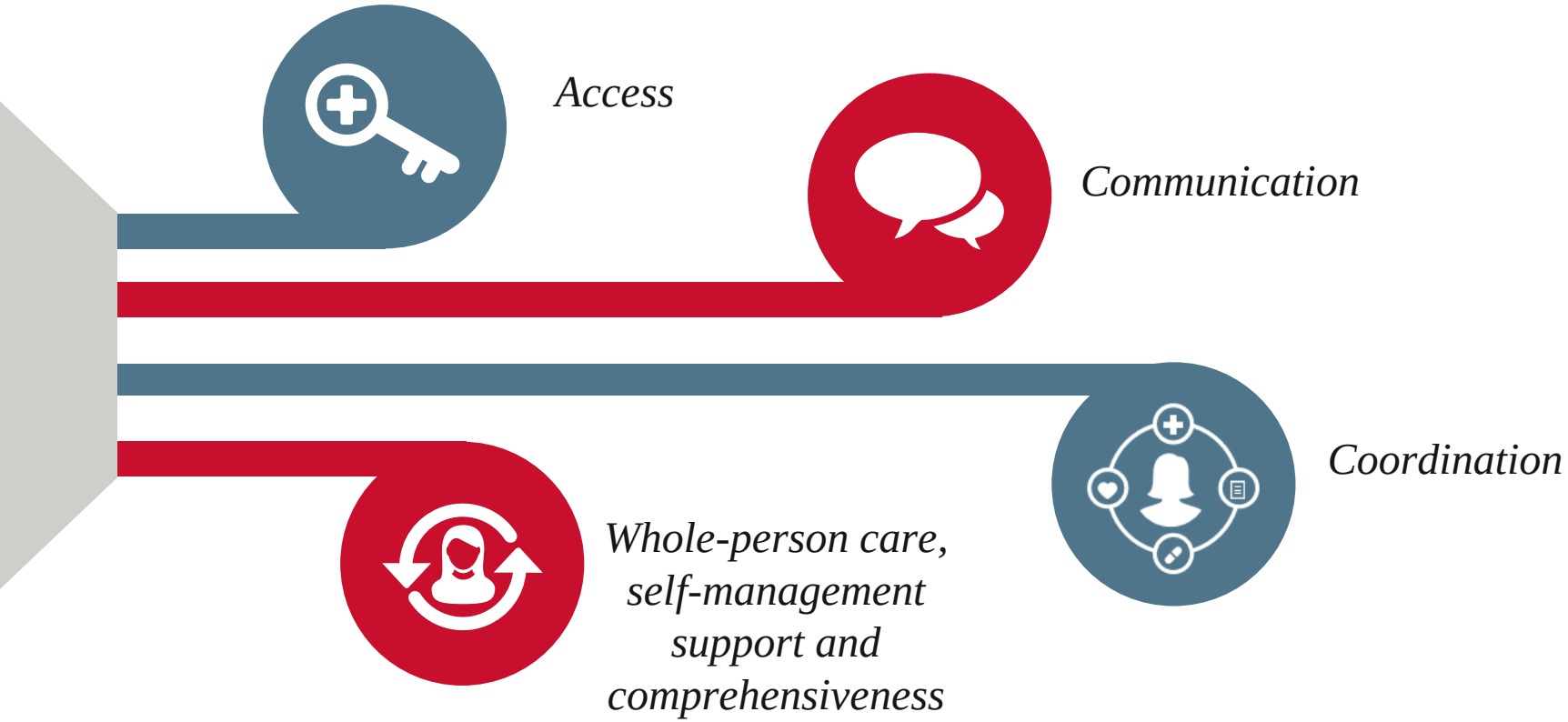
Performance Measurement & Quality Improvement

QI 02 B: Example



Performance Measurement & Quality Improvement

Monitors patient experience through **quantitative data** (across at least three categories) *Report*



Monitors patient experience through **qualitative methods** *Report*

Performance Measurement & Quality Improvement

QI 04 B: Example

NEW PATIENT PHONE SURVEY Provider_____

Did your Provider meet and satisfy your needs?	Speaks English	Age	Insured	Race	Co-morbidity
1.					
2.					
3.					
4.					
5.					
ABC Health would like to be your "Patient Centered Medical Home". Overall, how was your experience?	Speaks English	Age	Insured	Race	Co-morbidity
1.					
2.					
3.					
4.					
5.					
Are you aware we have walk-in hours for acute care if you are unable to get in with your provider today?	Speaks English	Age	Insured	Race	Co-morbidity
1.					
2.					
3.					
4.					
5.					
Are you aware that ABC Health offers Pharmacy & Dental services? Able to get your meds today?	Speaks English	Age	Insured	Race	Co-morbidity
1.					
2.					
3.					
4.					
5.					
Do you have any suggestions or comments on how we can increase quality and your satisfaction?	Speaks English	Age	Insured	Race	Co-morbidity
1.					
2.					
3.					
4.					
5.					

Caller identifies possible vulnerabilities prior to phone survey.

Providers – You will receive a copy of this survey each time it fills. The Patient Satisfaction Coordinator (PSC) calls all new patients a few days after their first visit to provide immediate feedback as well as recognizing vulnerable subgroups. The PSC will provide care coordination as needed when identified. All findings are kept by the Chief Quality Officer for use in QA/QI activities.

Performance Measurement & Quality Improvement

QI 05: Elective Criteria

Assesses health disparities using performance data (must choose one from each section):

- Clinical quality
- Patient experience

Report OR QI Worksheet

Performance Measurement & Quality Improvement

QI Worksheet: Example

NCQA PCMH Quality Measurement and Improvement Worksheet

PURPOSE: This worksheet helps practices organize the measures and quality improvement activities that are outlined in PCMH AC 01-03, AC 06 and QI 08-14. Refer to PCMH AC and QI in the PCMH 2017 Standards and Guidelines 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 but should consult the QI Worksheet Instructions for guidance.*

QUALITY MEASUREMENT & IMPROVEMENT ACTIVITY STEPS

1. **Identify measures for QI.** Select **aspects of performance** to improve:
   - Must Demonstrate (Core Criteria)
     - *PCMH QI 01:* At least five clinical quality measures
     - *PCMH QI 02:* At least two resource stewardship measures
     - *PCMH QI 03:* Assess availability of major appointment types
     - *PCMH QI 04:* Monitors patient experience
   - Optional (Elective Criteria):
     - *PCMH QI 05:* At least two measures for vulnerable populations (one clinical quality, one patient experience)

2. **Identify a baseline performance assessment.** Choose a starting measurement period **(start and end date)** and identify a baseline performance measurement for each measure.
   - *For PCMH QI 08-11 and 13,* use performance measurements from the reports provided in PCMH QI 01-05.

   The baseline measurement period ***must be*** **within 12 months** before evidence submission for check-in, or **within 24 months**, if there is a remeasurement period. The performance measurement ***must be*** a rate (percentage based on numerator and denominator) or number (with number of patients represented by the data).

3. **Establish a performance goal.** Generate at least one performance goal for each identified measure. The specific goal ***must be*** a rate or number greater than the baseline performance assessment. Simply stating that the practice intends to improve does not meet the objective. **(Applies to QI 08-11 and 13)**
   ***For multi-sites:** Organizational goals and actions for each site may be used if remeasurement and performance relate to the practice. Each practice must have its own baseline and performance results.*

4. **Determine actions to work toward performance goals.** List at least one action for each identified measure and the **activity start date**. The action date ***must occur*** after the date of the baseline performance measurement date. You may list more than one activity, but are not required to do so. **(Applies to QI 08-11 and 13)**

5. **Remeasure performance based on actions taken.** Choose a remeasurement period and generate a new performance measurement after action was taken to improve. The remeasurement date ***must occur*** after the date of implementation and ***must be*** within **12 months** before evidence submission for check-in. The performance measurement ***must be*** a rate (percentage based on numerator and denominator) or number (with number of patients represented by the data).

6. **Assess actions taken and describe improvement.** Briefly describe how your practice site showed improvement on measures. Describe the assessment of the actions; correlate actions and the resulting improvement. **(Applies to QI 12 and 14)**

Performance Measurement & Quality Improvement

QI 06-07: Elective Criteria

Uses a standardized, validated survey tool

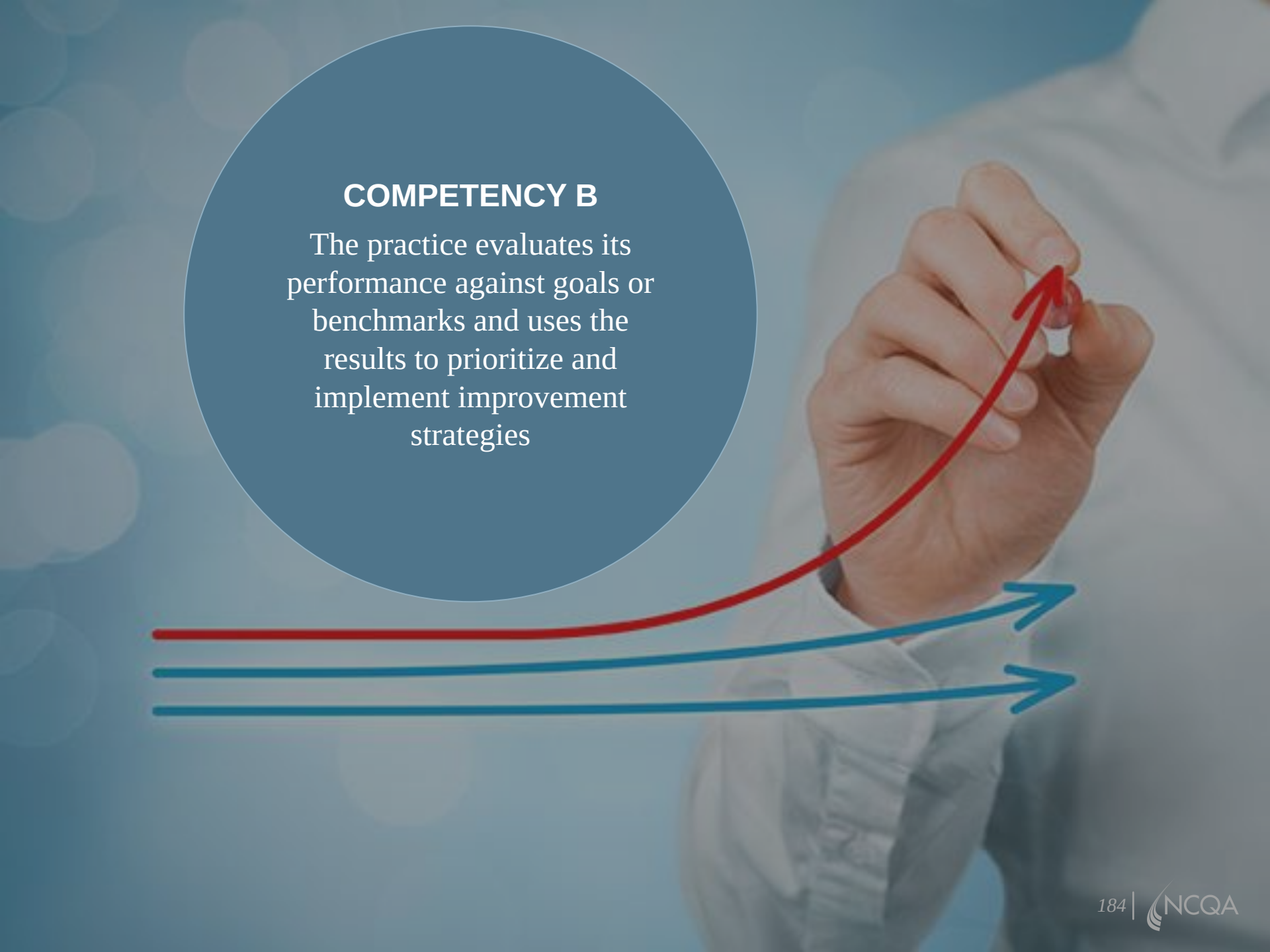
Report

*** Obtains feedback on vulnerable patient groups**

Report

COMPETENCY B

The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies



Performance Measurement & Quality Improvement

QI 08-11: Core Criteria

Sets goals and acts to improve upon at least three measures across at least three of the four categories

Report OR QI Worksheet

Sets goals and acts to improve upon at least one measure of resource stewards

Report OR QI Worksheet

Sets goals and acts to improve availability of major appointments types to meet patient needs

Report OR QI Worksheet

Sets goals and acts to improve on at least one patient experience measure

Report OR QI Worksheet

Performance Measurement & Quality Improvement

QI 12-14: Elective Criteria

*Achieves improved performance on **at least 2 performance measures**

Report OR QI Worksheet

Disparities in care or services

1. Sets goals and acts to improve at least one measure

   Report OR QI Worksheet

2. *Achieves improved performance in at least one measure

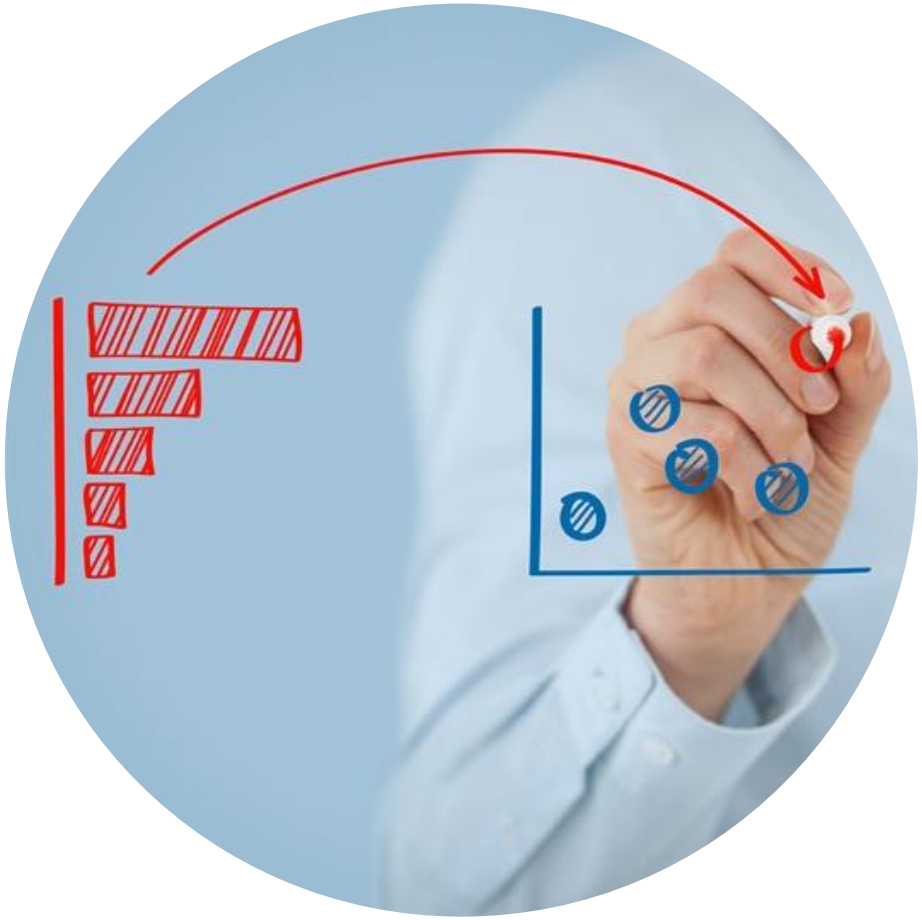
   Report OR QI Worksheet

COMPETENCY C

The practice is accountable for performance. The practice shares performance data with the practice, patients and/or publicly for the measures and patient populations identified in the previous section

Performance Measurement & Quality Improvement

QI 15: Core Criteria



Reports practice-level or individual clinician performance results within the practice for measures reported by the

Evidence of Implementation & Documented Process

Performance Measurement & Quality Improvement

QI 16-19: Elective Criteria

Reports practice/ clinician level performance results publicly or with patients

* Involves patient/ family/caregiver in quality improvement activities

* Reports clinical quality measures to Medicare or Medicaid agency

Practice is engaged in Value-Based Contract Agreement (max 2 credits)

NYS

QI 16 & 17 - *Evidence of Implementation & Documented Process*

QI 18 - *Evidence of Implementation*

QI 19 - *Agreement OR Evidence of Implementation*

Reporting Performance Publicly/Patients

QI 16: Example

Dear

Enclosed in this letter you will find the performance results for your individual clinician, Dr nd practice-level, MD PC, on the important preventive and chronic measures including Depression Screening and Hemoglobin A1C testing. We are working diligently to increase Individual clinician and Practice-level screenings of important preventive and chronic measures.

	Individual Clinician	Practice-level
Depression Screening	38.44 %	39.08 %
Hemoglobin A1c testing	74.02 %	74.15 %

Our practice also would like share with you patient satisfaction information. Based on patients survey that practice conducted in May and November of 2016, patients mostly complained via the survey that they have to wait to being called while they are waiting in waiting room. Please see numbers listed below.

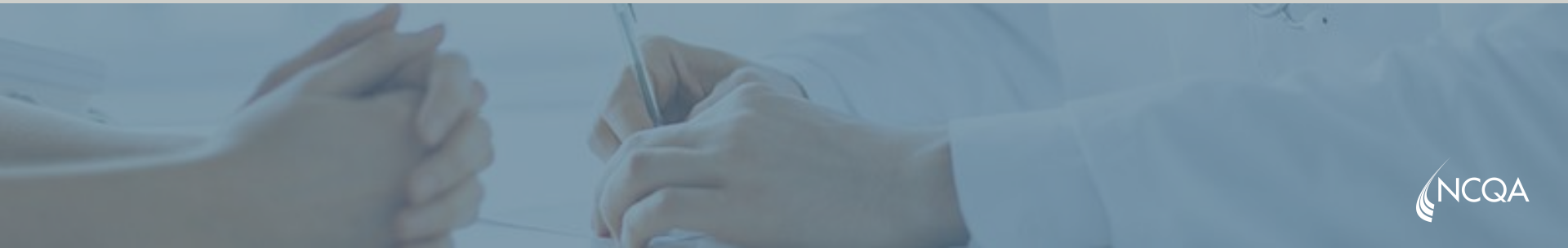
	First time: May 2016	Second time: November 2016
Survey results	21%	18%

Practice supplies this information to make sure you aware of how your individual clinician, and entire practice are doing. We really encourage our patients to take an active and involved roll in their healthcare.

Sincerely

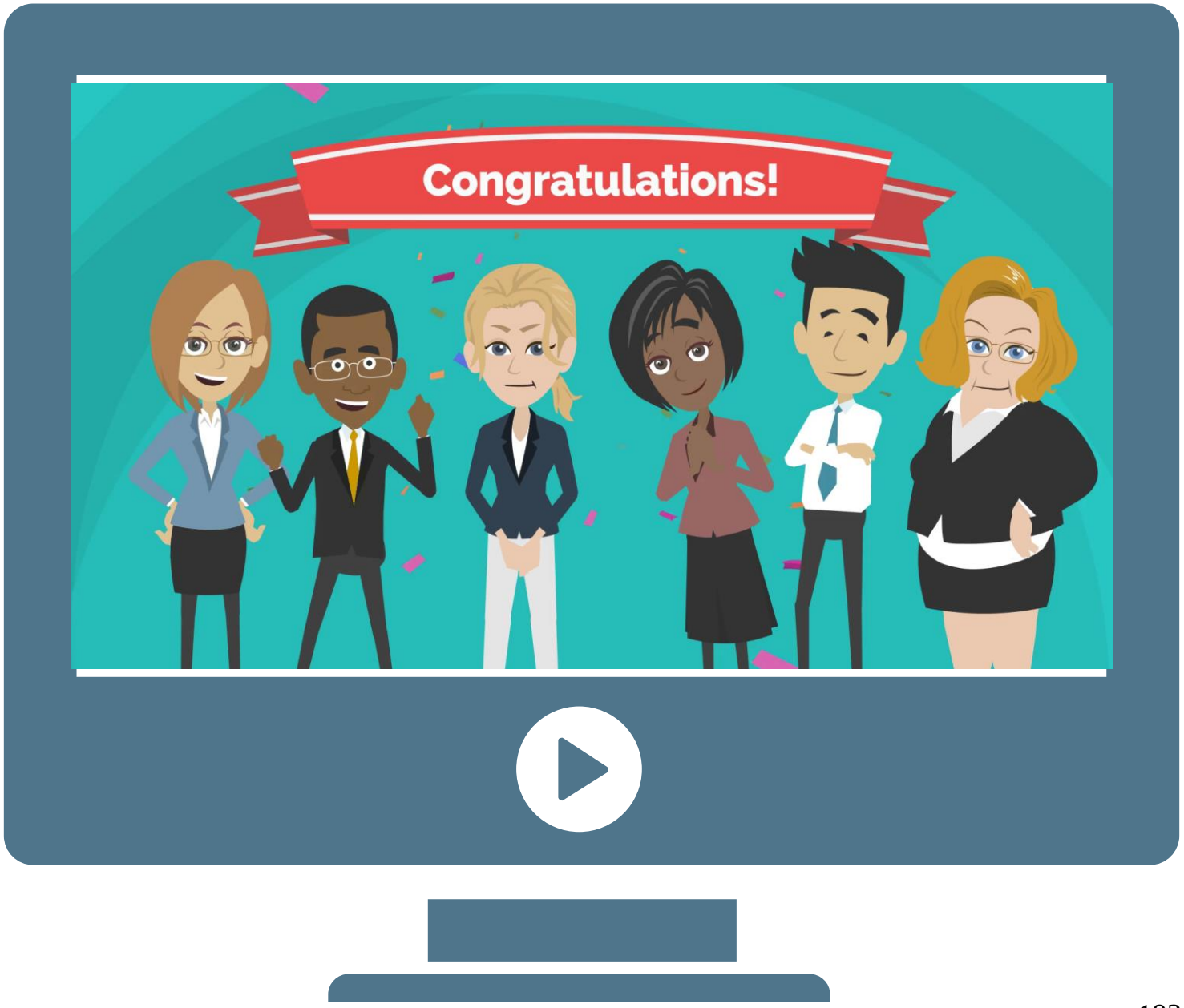
Performance Measurement & Quality Improvement

Activity



Recognition Process

Q-PASS


Congratulations!

Recognition Process

3 Pathways

New Customer

Full Transform Process

Recognized PCMH 2011 Levels 1-3 & PCMH 2014 Levels 1-2

Accelerated Renewal Process (Transform w/ Attestation)

Recognized PCMH 2014 Level 3

Bypass Transform Direct to Sustaining Process

New Customers

Transform Steps

Complete Eligibility/Readiness Survey	Discover Educational Resources	Create Q-PASS Account(s)
Enroll Sites	Meet with NCQA Representative	Provide Evidence during Review

Existing Customers

Transform Steps

~~Complete Eligibility Readiness Survey~~	Discover Educational Resources	Claim Q-PASS Account(s)
Enroll Sites	Meet with NCQA Representative	Provide Evidence during Review

Organization set-up

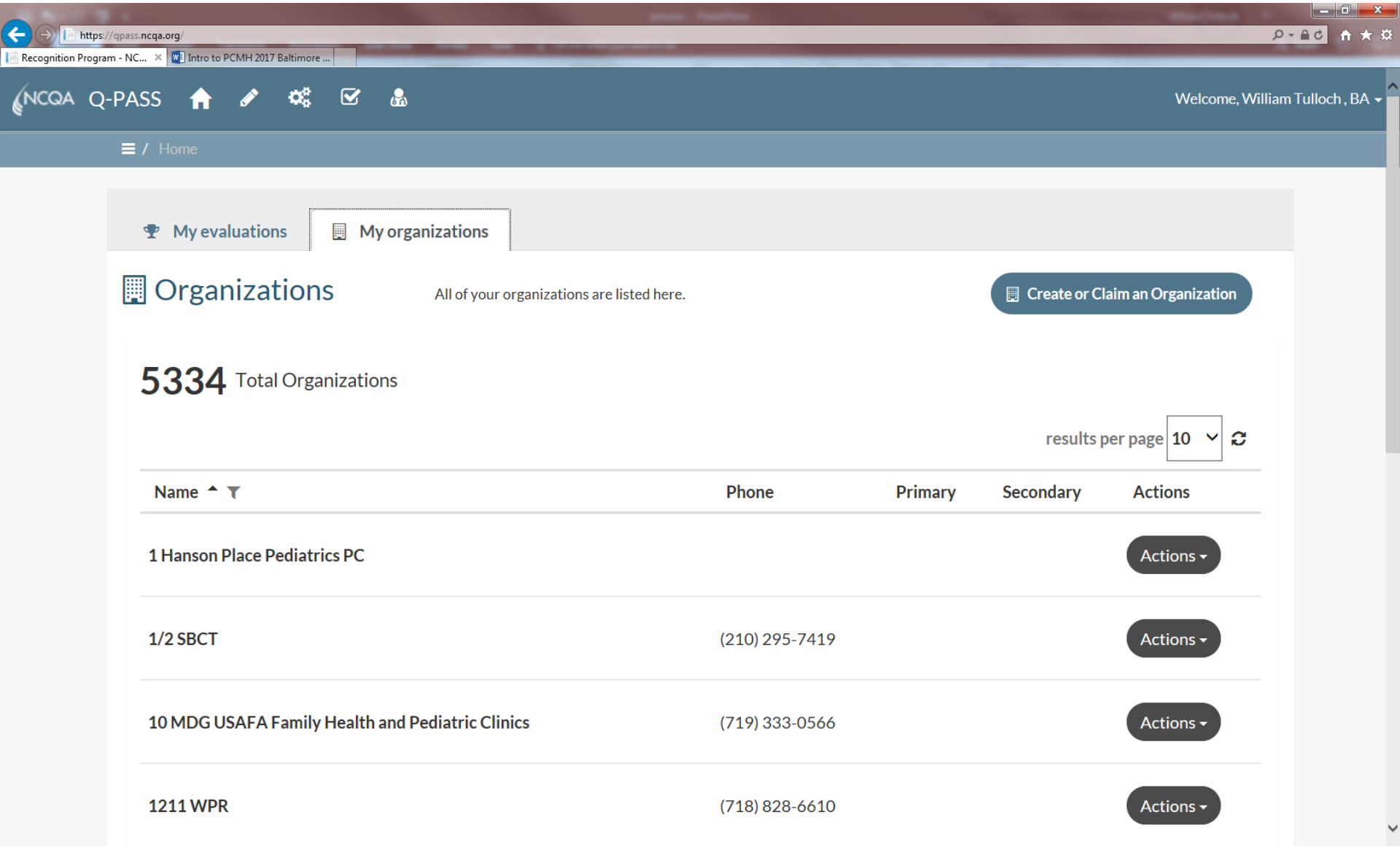
New Organizations

- Create Organization in Q-PASS
- Provide Organization details (address, phone, Tax ID)
- Save Organization

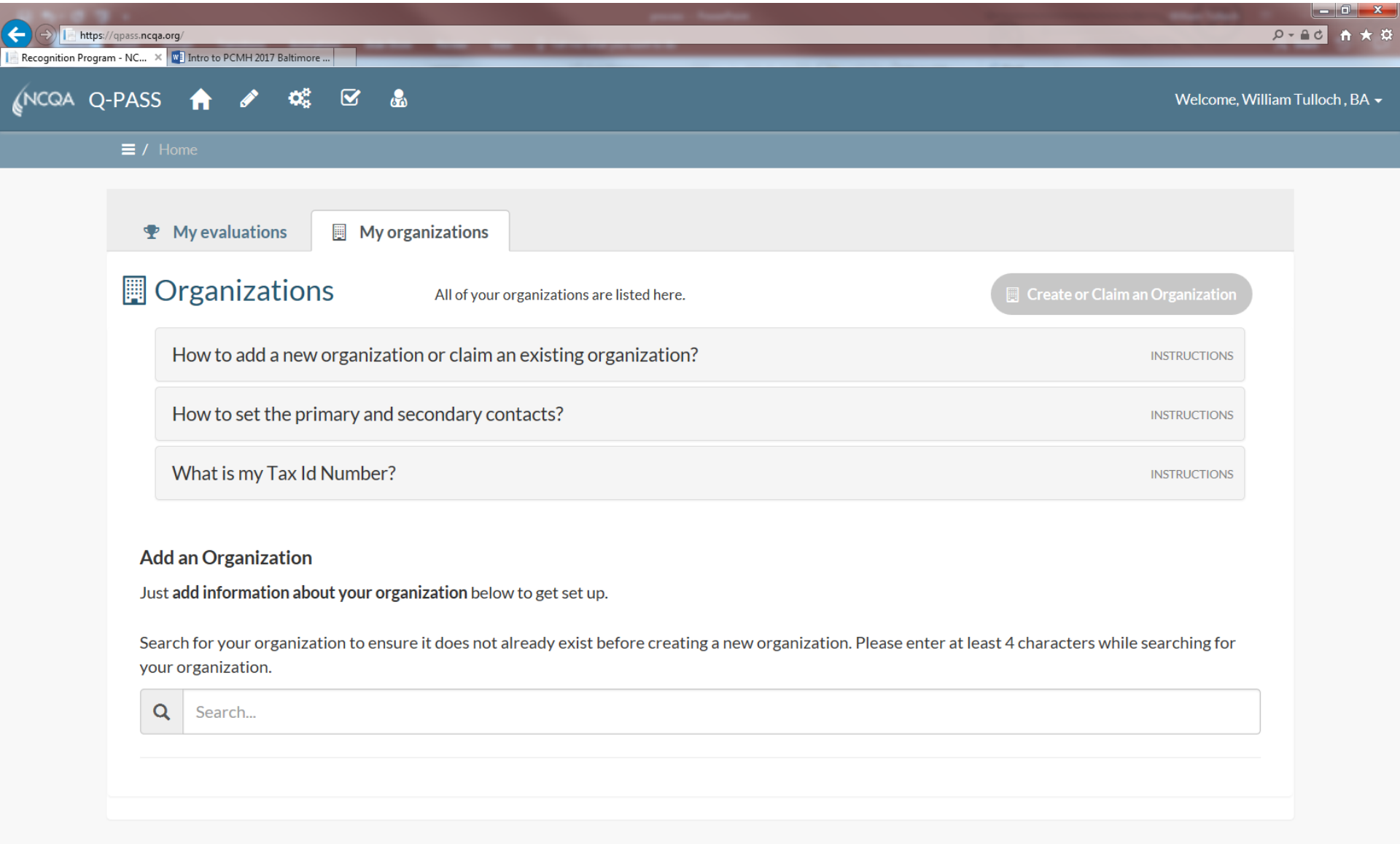
Existing Organizations

- Authorized users – See “My Organizations” tab
- To “claim” an organization otherwise, contact NCQA

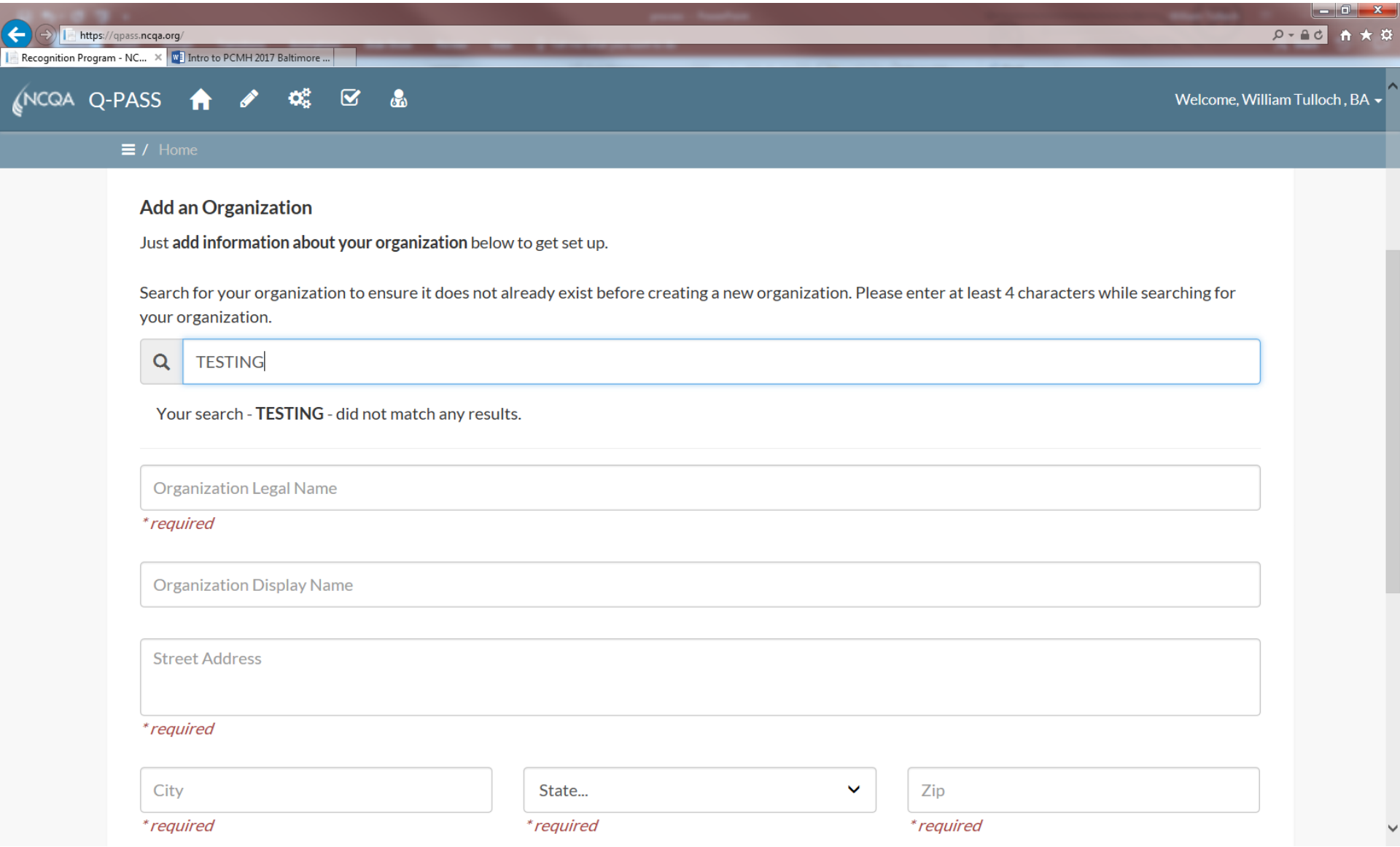
Q-PASS Organization Home Page



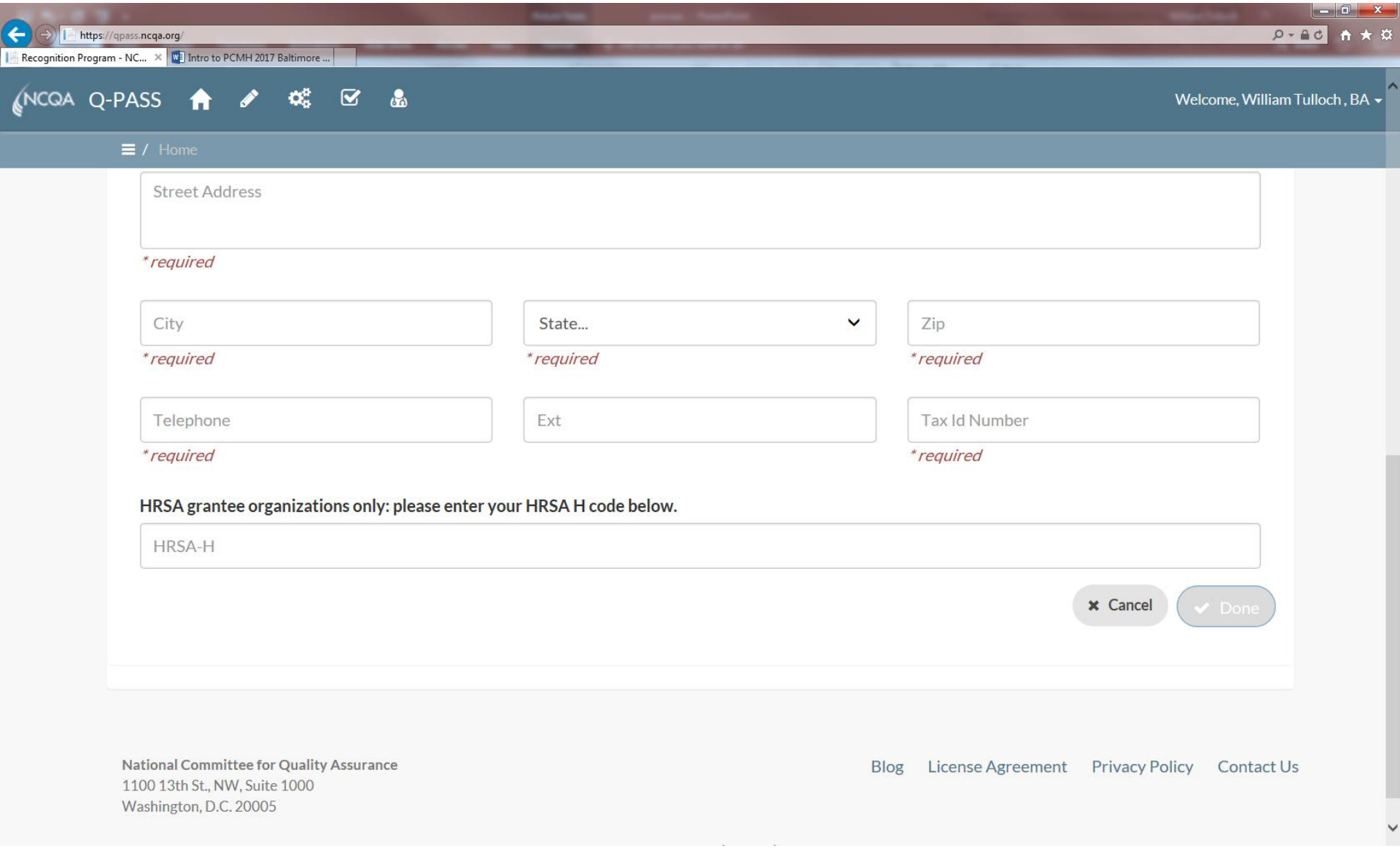
Adding an Organization to Q-PASS



Adding an Organization to Q-PASS II



Adding an Organization to Q-PASS III



Enrollment

Organization needs the following to enroll

- Site information, including NPI
- Clinician information, including NPI & Boards/specialties
- Authorized signatory for agreements
- Payment method

Enrollment

Step-by-Step process in Q-PASS

- Choose sites
- Choose product(s)
- Add/create clinicians
- Sign agreements
- Pay (can’t pay until agreements signed)

PCMH Fee Schedule

PCMH 2017

Single Site Practice

Clinician Tier	Fee Per Clinician
1-12	$500.00
13+	$50.00

Succeed

1-12	$120.00
13+	$12.00

Partners in Quality Sponsored Single Site Practice

Clinician Tier	Fee Per Clinician
1-12	$400.00
13+	$40.00

Succeed

1-12	$120.00
13+	$12.00

Multi-Site Practice

Clinician Tier	Fee Per Clinician
1-12	$250.00
13+	$25.00

Succeed

1-12	$120.00
13+	$12.00

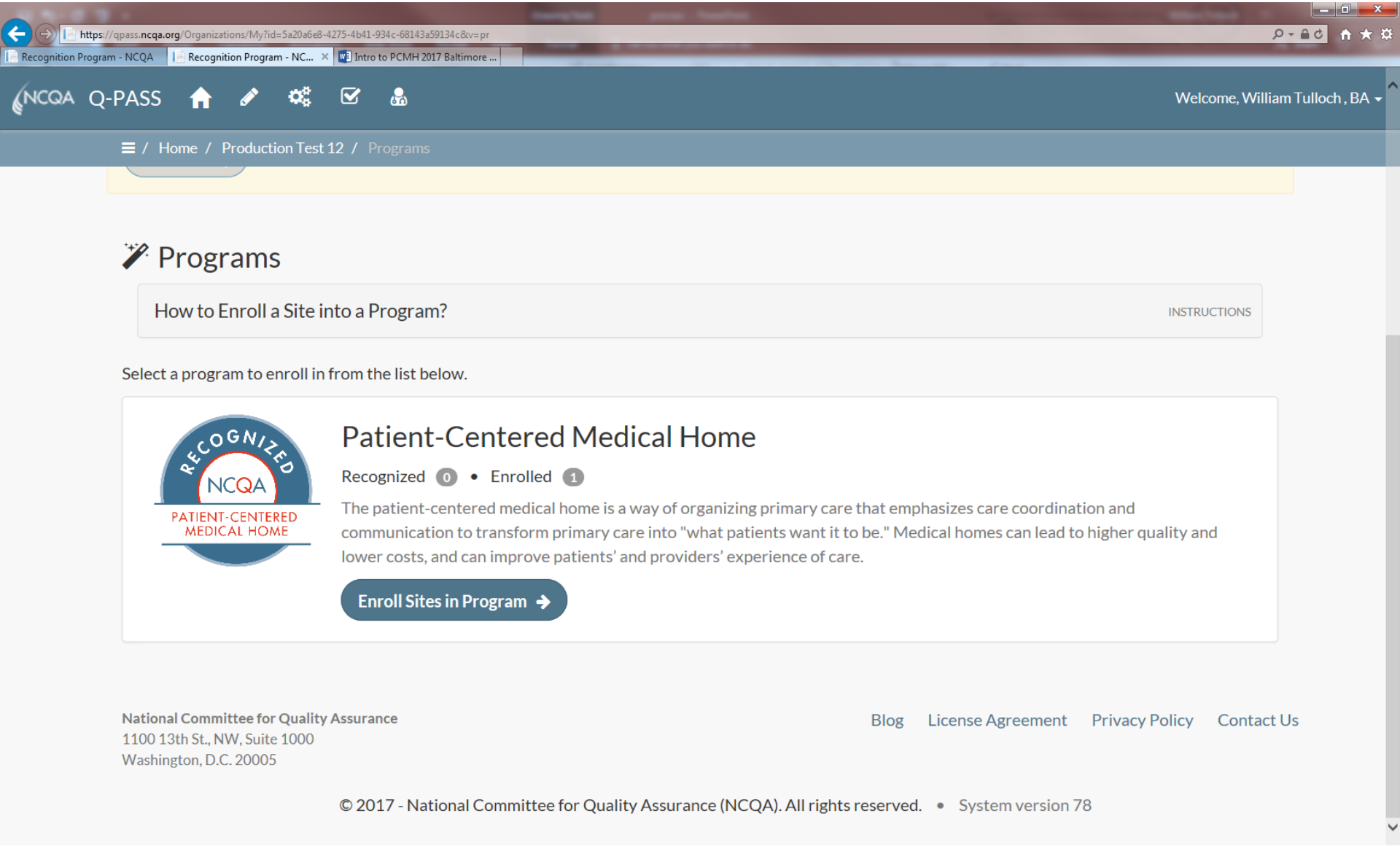
Partners in Quality Sponsored Multi-Site Practice

Clinician Tier	Fee Per Clinician
1-12	$200.00
13+	$12.00

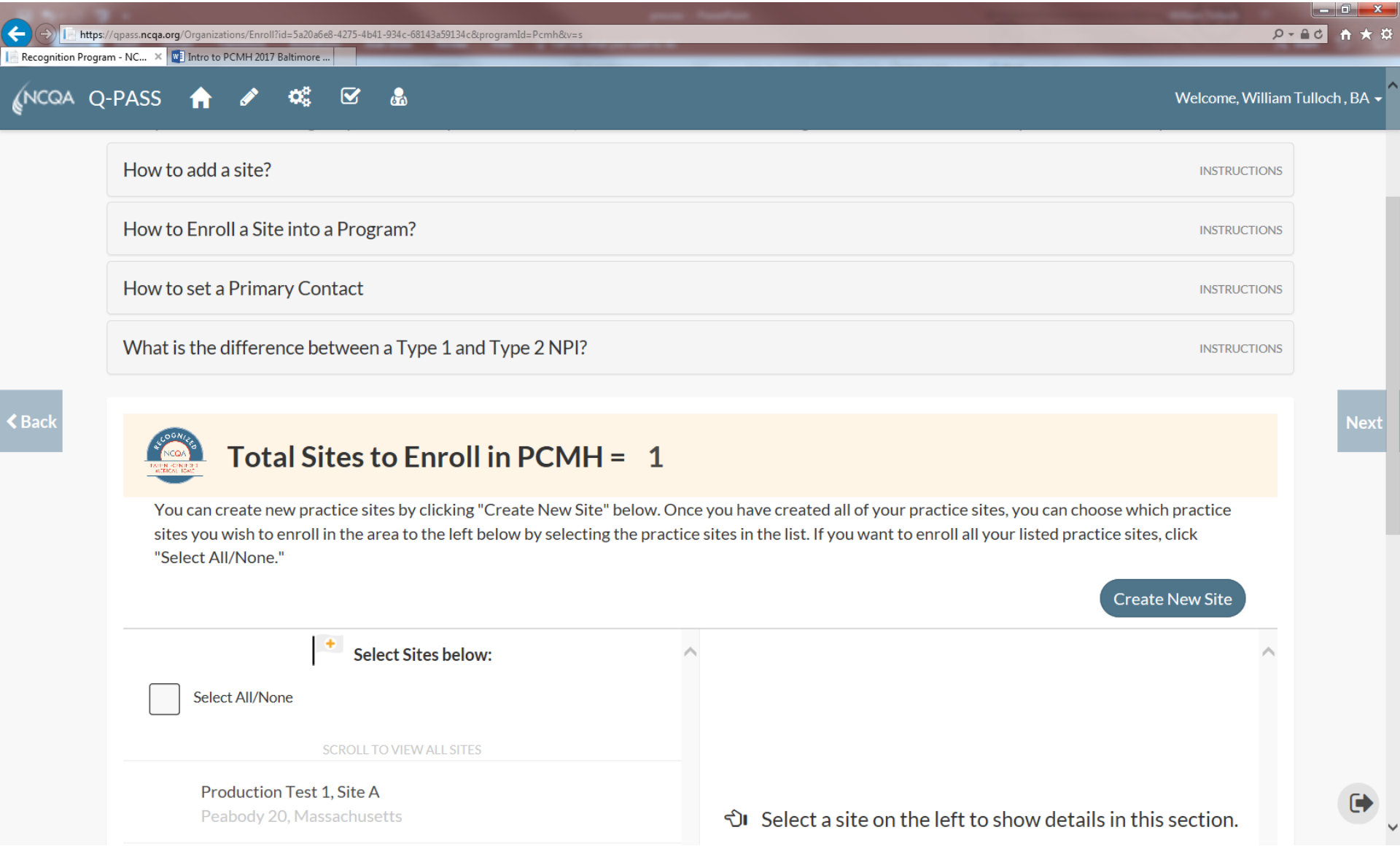
Succeed

1-12	$120.00
13+	$12.00

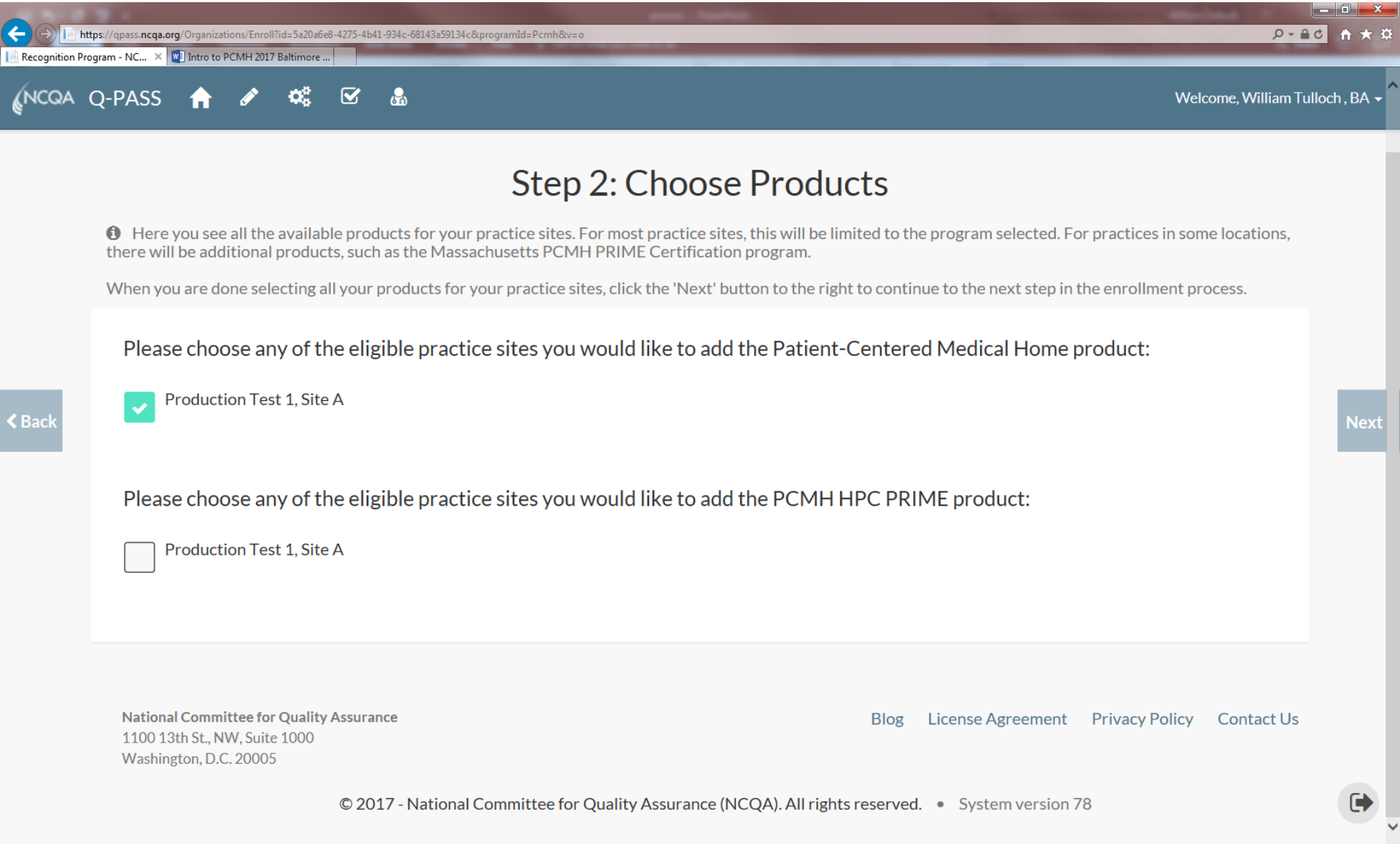
Enrolling in Q-PASS



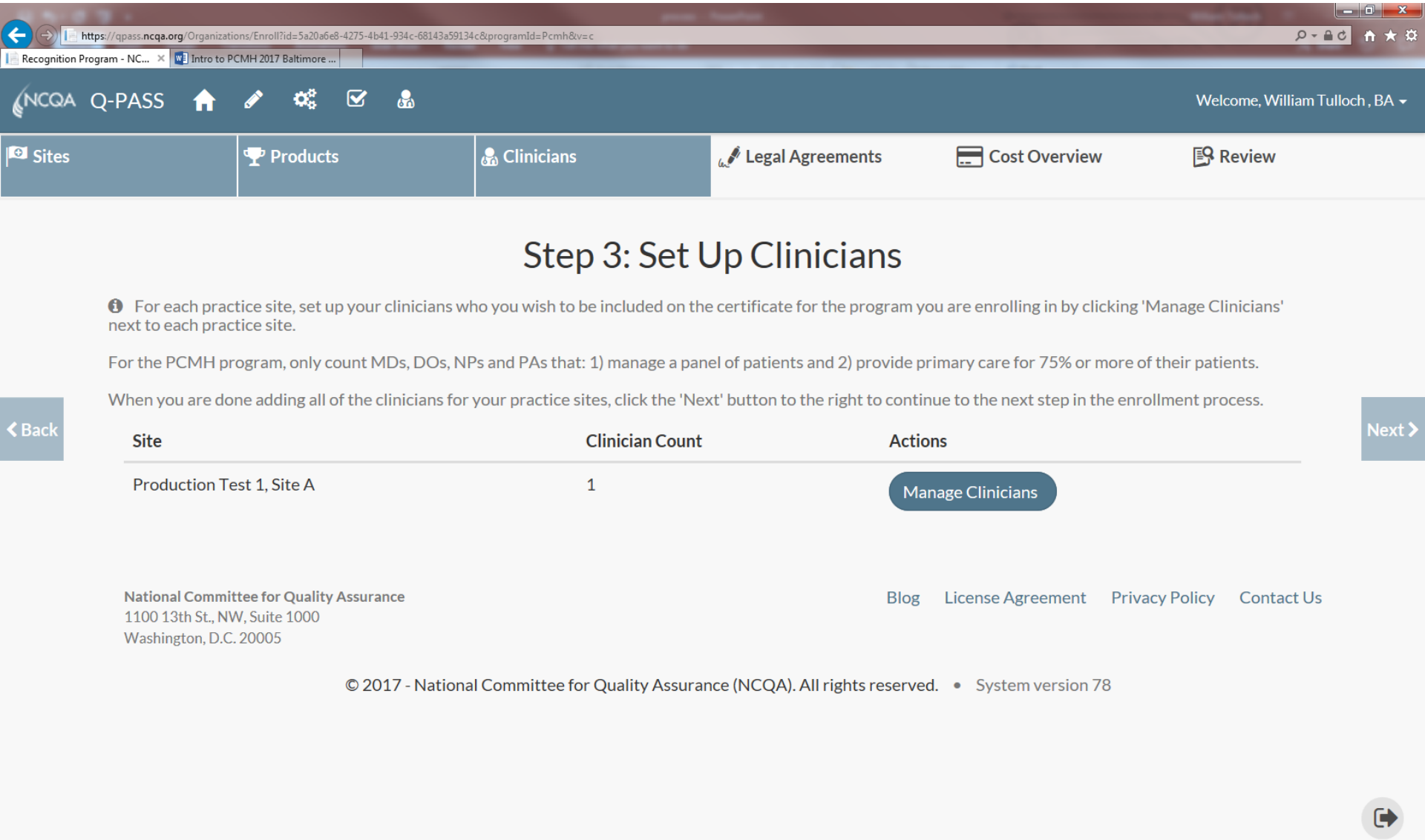
Enrollment – Choose Sites



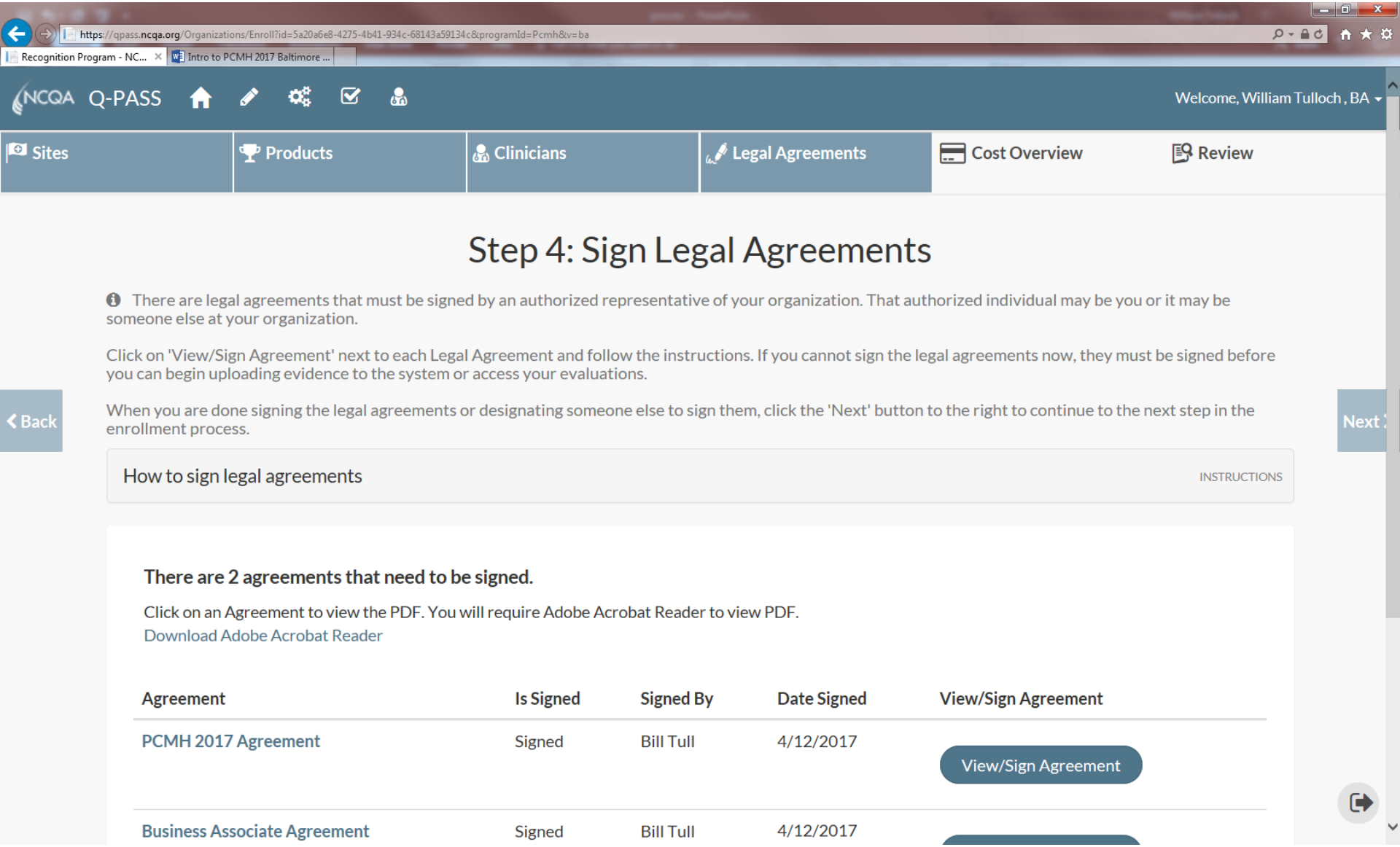
Enrollment – Choose Products



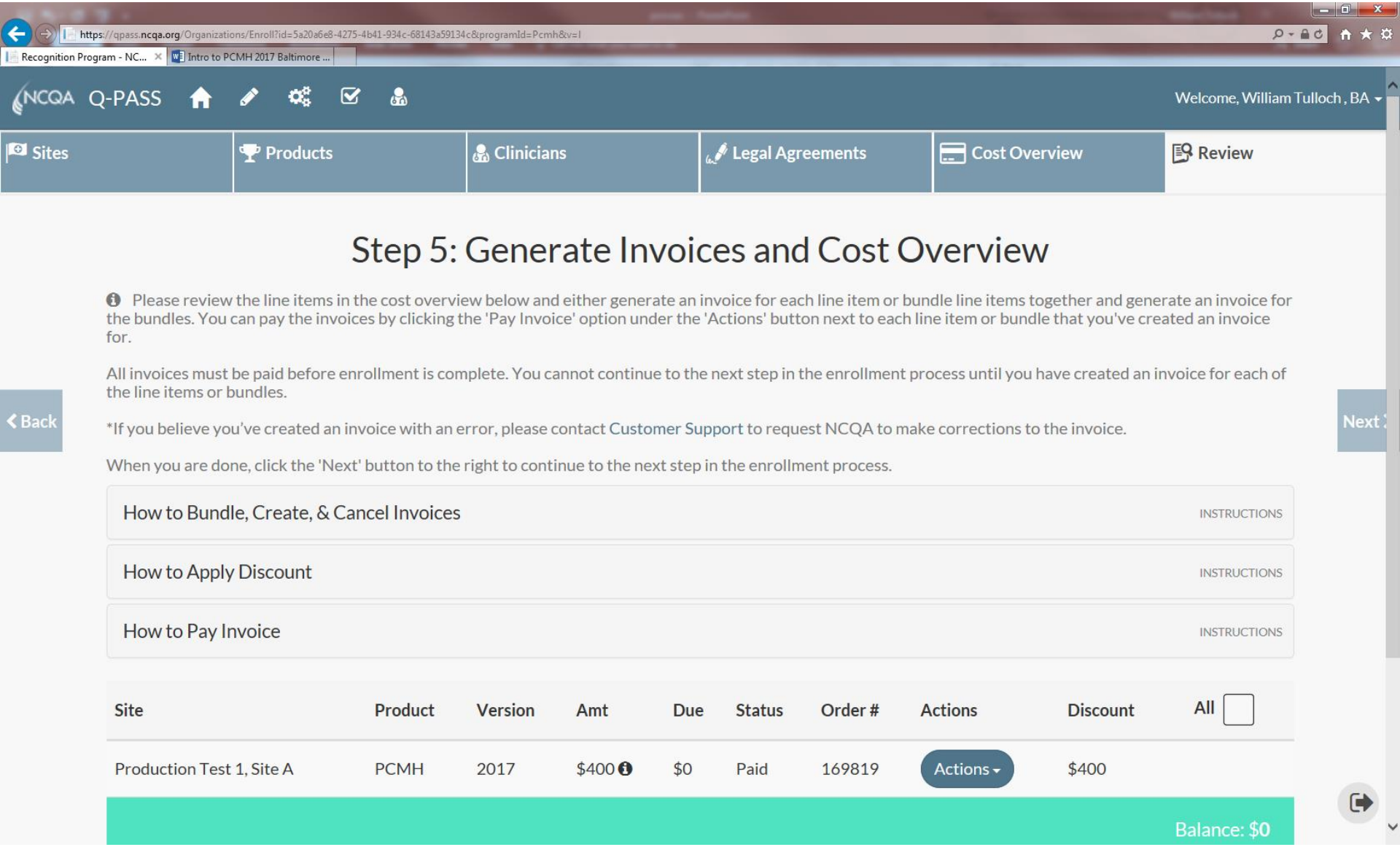
Enrollment – Set Up Clinicians



Enrollment – Sign Agreements



Enrollment Invoicing



After Enrollment

NCQA will assign a representative to the practice

The practice should then address:

Transfer credit

- Pre-validated vendors & transfer-credits
  - Choose vendor with existing auto-credit
  - Vendor supplies implementation letter confirming eligibility
  - Criteria set as “Met” after confirmation by Representative

Shared credit

- Organizations with multiple sites
- Share evidence/credit for criteria done the same
- Create sub-groups if share different electronic system/processes

Multi-Site Process

- **Organizations with 3+ sites**
- **Shared electronic system**, processes and evidence across sites
- **Identify shared criteria** from “sharable list”
- Identify primary site
  - Full review only for this site
  - Shared criteria auto-populate in subsequent sites

Corporate Credit Transition

Multi-sites recognized under PCMH 2011 or PCMH 2014

- **Eligibility:** Organizations adding unrecognized practices during active PCMH 2011 or 2014 recognition (prior to expiration)
- Credit earned from the previous corporate survey tool can contribute toward recognition for their practices at an accelerated pace.

KNOWING AND MANAGING YOUR PATIENTS (KM)			
Criteria	**Criteria Title**	**Shared or Site-Specific?**	**Eligible for Attestation of Shared Credit?**
Competency A: Comprehensive Patient/Population Knowledge			
KM 01 (Core)	Problem Lists	Site-Specific	
KM 02 (Core) **F and G are new*	Comprehensive Health Assessment	Partially Shared**	
KM 03 (Core)	Depression Screening	Partially Shared**	
KM 04* (1 Credit)	Behavioral Health Screenings	Partially Shared**	
KM 05* (1 Credit)	Oral Health Assessment & Services	Partially Shared**	
KM 06 (1 Credit)	Predominant Conditions & Concerns		
KM 07* (2 Credits)	Social Determinants of Health		
KM 08* (1 Credit)	Patient Materials		
Competency B: Cultural Competency			
KM 09 (Core)	Diversity	Shared	
KM 10 (Core)	Language		
KM 11 (1 Credit) **A and C are new*	Population Needs		
Competency C: Proactive Population Management			
KM 12 (Core)	Proactive Reminders	Shared	✓
KM 13* (2 Credits)	Excellence in Performance	Site-Specific	
Competency D: Medication Management			
KM 14 (Core)	Medication Reconciliation		
KM 15 (Core)	Medication Lists		
KM 16 (1 Credit)	New Prescription Education		
KM 17 (1 Credit)	Medication Responses & Barriers		
KM 18* (1 Credit)	Controlled Substance Database Review		
KM 19* (2 Credits)	Prescription Claims Data		
Competency E: Evidence-Based Decision Support			
KM 20 (Core)	Clinical Decision Support	Shared	✓
Competency F: Community Resources			
KM 21* (Core)	Community Resource Needs	Shared	
KM 22 (1 Credit)	Access to Educational Resources	Shared	✓
KM 23* (1 Credit)	Oral Health Education	Shared	
KM 24 (1 Credit)	Shared Decision-Making Aids	Shared	✓
KM 25* (1 Credit)	School/Intervention Agency Engagement	Shared	
KM 26 (1 Credit)	Community Resource List	Shared	✓
KM 27 (1 Credit)	Community Resource Assessment	Shared	✓
KM 28* (2 Credits)	Case Conferences	Shared	

*New criteria in 2017 edition of PCMH Standards & Guidelines.
**Documented processes may be shared, but all other evidence must be site-specific.

Corporate Credit Transition Expectations

Multi-sites with a completed PCMH 2011 or PCMH 2014 corporate survey

Criteria Marked Attestation

Organizations may attest that they:

- Have already demonstrated & met the equivalent criteria in their previous PCMH 2011 or 2014 corporate survey
- Are still performing PCMH activities in these criteria.

Criteria Requiring Evidence

Practices should:

- Follow the current PCMH Standards & Guidelines
- Submit evidence in Q-PASS, as indicated.
- Prepare to demonstrate virtual review-eligible evidence during the virtual review.

PCMH 2014 Level 3 Practices

Practices that have achieved PCMH 2014 Level 3 recognition may:

- Bypass submission of evidence for criteria
- Proceed directly to the Annual Reporting phase of recognition.

Shared & Site-Specific Evidence

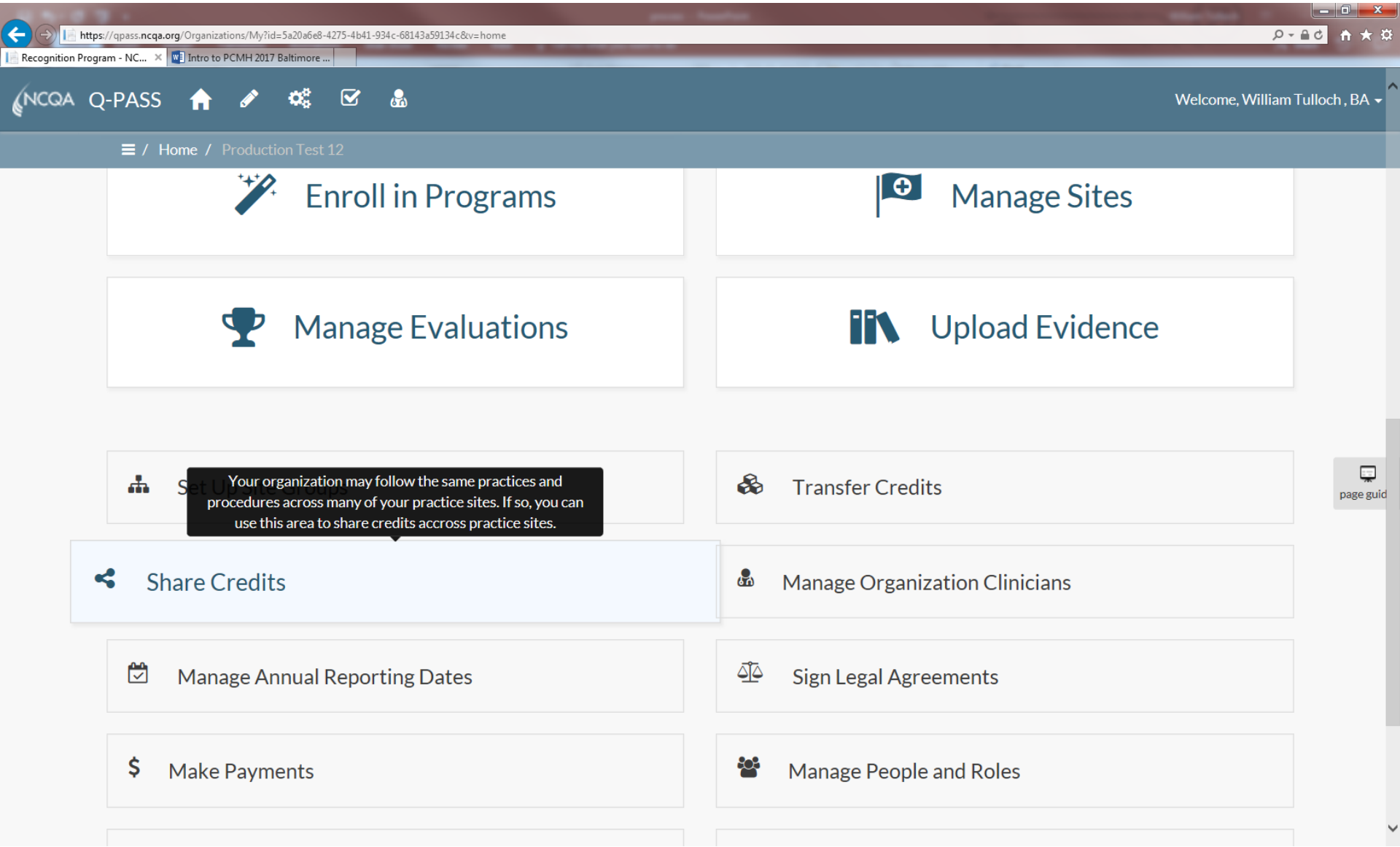
What is the difference?

Shared evidence may be submitted once for all sites or site groups.

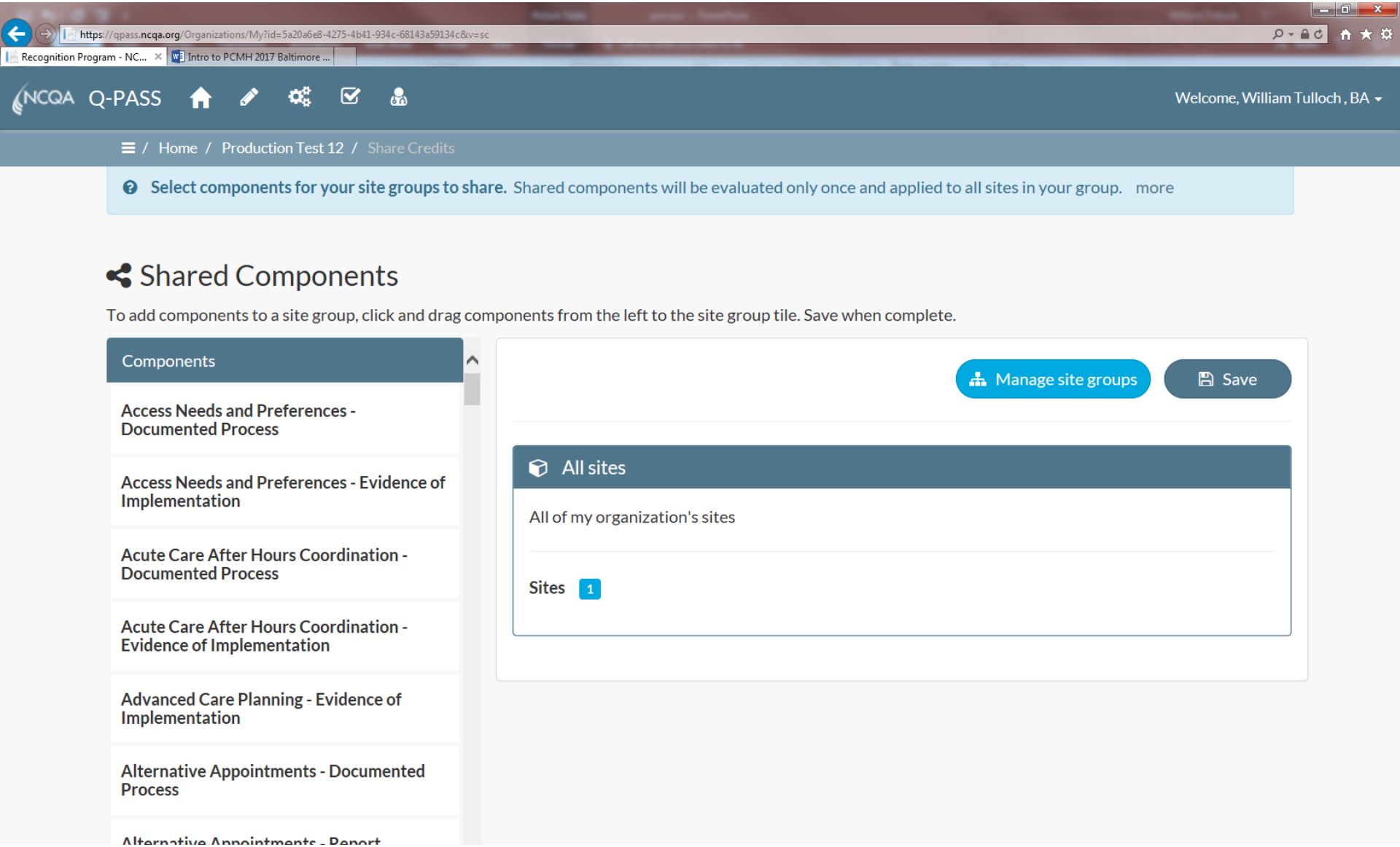
Some criteria is labeled **"Partially Shared"** indicates that the documented process may be shared across all practice sites, but all other evidence must be site-specific.

Site-specific data may be collected and submitted once on behalf of all sites or site groups if the evidence is stratified by site.

Multi-Sites Sharing Evidence/Credit



Choosing What to Share



Transform “Check-in” process

Up to 3 “Check-ins” During Review

Determine Criteria to Address

- Focus on core & documented processes first
- Identify criteria for 25 elective credits

Provide Documents for Offsite Review

- Policies, procedures & protocols
- Website links
- Public information
- Attestation

Provide Evidence during Virtual Review

- Communicate with Evaluator
- Substitute evidence if not sufficient
- Demo systems
- Provide reports

Criteria Evidence Options

Q-PASS Documents

- Documents* (upload for off-site review)
- Weblinks
- Text

Virtual Review

- Reports (create in advance)
- System demo
- Patient examples

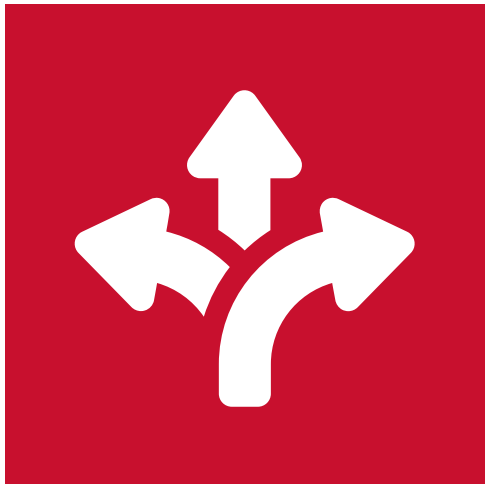
Either Option

- Practice decision*

*All PHI should be removed from documents uploaded in Q-PASS

“*We Have Different Evidence*”

- Flexibility is encouraged
- Suggested evidence not exhaustive
- Meet intent in creative ways
- Not sure? Ask NCQA



After Check-In

- Evaluator marks criteria “met”
- Practice can work on “not met” criteria
- NCQA staff will review questions arising from check-in

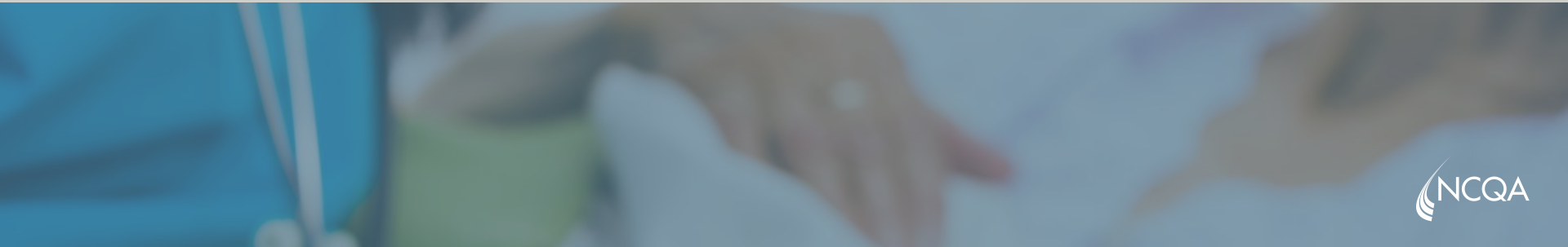
After 3 Check-Ins

Practice meets all core criteria & 25 elective credits, results are forwarded to Review Oversight Committee (ROC)

If required criteria is not met in 3 virtual check-ins, an additional check-in is available for purchase

If the survey process is not completed within 12 months, additional time can be purchased

Accelerated Renewal



Accelerated Renewal

Eligibility

Practices can earn recognition at an accelerated pace that achieved recognition in:

- PCMH 2011
  Levels 1, 2, & 3

- PCMH 2014
  Levels 1 & 2

Accelerated Renewal

What is expected for criteria?

For criteria identified as review practices should:

- Follow standards & guidelines
- Submit evidence in Q-PASS
- Prepare to demonstrate virtual review-eligible evidence

For criteria marked attestation the practice should:

- Attest that your practice is still performing PCMH activities
- You will not need to demonstrate documentation or evidence

Criteria are identified as shared or site specific

Accelerated Renewal

Review & attestation by the numbers

	Core	Electives		
		1 Credit	2 Credits	3 Credits
Review	22 criteria	12 criteria	14 criteria	0 criteria
Attestation	18 criteria	26 criteria	7 criteria	1 criterion
Total Criteria (100 criteria)	**40 criteria**	**38 criteria**	**21 criteria**	**1 criterion**

"Review or Attestation" indicates which criteria require submission of evidence and which criteria simply allow attestation

Succeed

Annual Reporting

Succeed Annual Reporting Process

Practice's recognized PCMH 2014 Level 3 or after Transform process must:

Attest to previous performance	Confirm practice information and make any clinician changes
Provide evidence demonstrating continuing PCMH Activities	Annual fee payment

Annual Reporting Date

- **30 days** before Anniversary Date
- Must complete all Succeed steps prior to anniversary date

- **Date set upon initial Recognition**
  - Or 2014 Level 3 expiration date

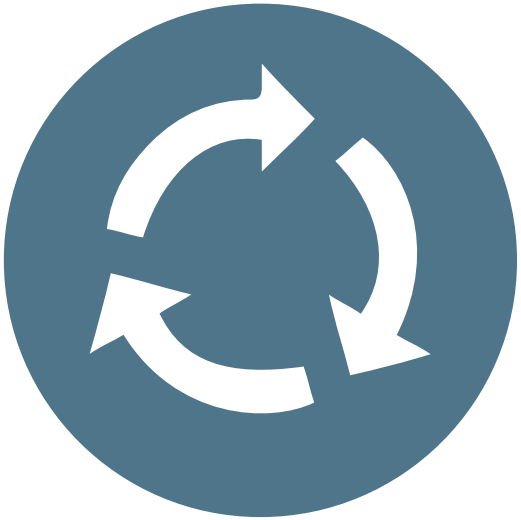
- **Flexibility** to meet practice needs

Annual Reporting Date – Multi-sites

All practices in multi-site group have the same annual reporting date, unless otherwise organization requests differently

The annual reporting date for multi-site group is based on the date of 1st Recognized practice

Evidence & Annual Reporting



- **Evidence can be provided** at any point within the year
- NCQA will only review after:
  - **Reporting date has passed**
  - **Annual fee is paid**

Audit and New Requirements

Audit

- Sample of Succeed practices selected
- Still meeting key Transform criteria?
- Selection after Annual Reporting complete

New Requirements

- Announced 6 months ahead
- Practice must meet at next reporting date

AR-PA: Patient-Centered Access

Has Your Practice Continued to Monitor Appointment Access?

Choose 1 option from the 3 below

Option 1	*Option 2*	*Option 3*
Patient Experience Feedback - Access	Third Next Available Appointment	Other Method of Monitoring Access

AR-TC: Team-Based Care

Has your practice continued to use a team-based approach to provide primary care?

Choose 1 option from the 2 below

Option 1

Attest to pre-visit planning activities

Option 2

Measure team-based care in your employee experience/ satisfaction survey

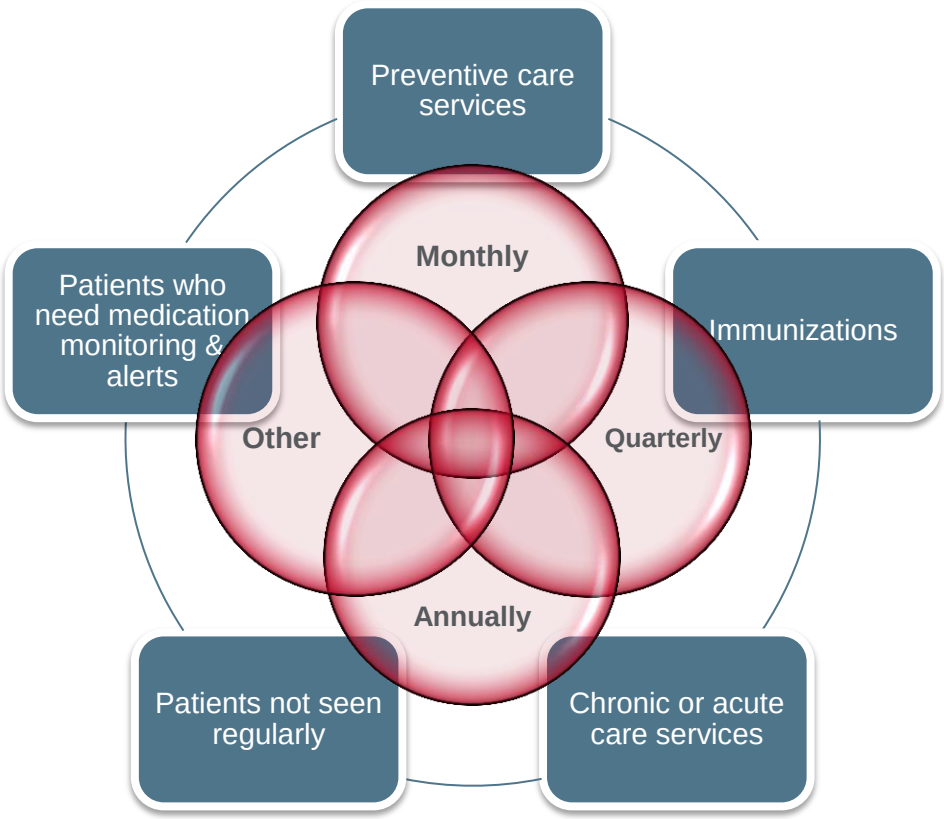
AR-PH: Population Health Management

Has your practice continued to proactively remind patients of upcoming services?

Required:

Does your practice send proactive reminders for a minimum of **5** different services across **2** categories?

For each category, **at what frequency** does your practice **generate lists and reminders** to patients?



AR-CM: Care Management

Has your practice continued to identify patients who may benefit from care management?

Required: Identifying and monitoring patients for care management

AR-CC: Care Coordination & Care Transitions

Has your practice continued to coordinate care with labs, specialists, institutional settings or other care facilities?

AR-CC1 (Required): Attest to referral and test tracking and follow-up, and care transitions
Choose 1 additional item from the 4 options below:

AR-CC2

Patient experience survey – care coordination

AR-CC3

Track lab and imagining tests

AR-CC4

Referral tracking

AR-CC5

Care transitions

AR-QI: Performance Measurement & Quality Improvement

Has your practice continued to collect and use performance measurement data for quality improvement activities?

Required:

Measure Performance

Quality Improvement Activities

- **AR-QI1**

  5 clinical quality measures across 2 categories
- **AR-QI2**

  1 resource stewardship measure
- **AR-QI3**

  1 patient experience measure

Massachusetts HPC PCMH PRIME Certification

The practice is committed to incorporating behavioral health in the primary care setting through additional screenings and special services.

PCMH PRIME Certification

Why PCMH PRIME?

Purpose

Behavioral health (mental illnesses and substance use disorders) conditions can often be appropriately diagnosed in primary care settings

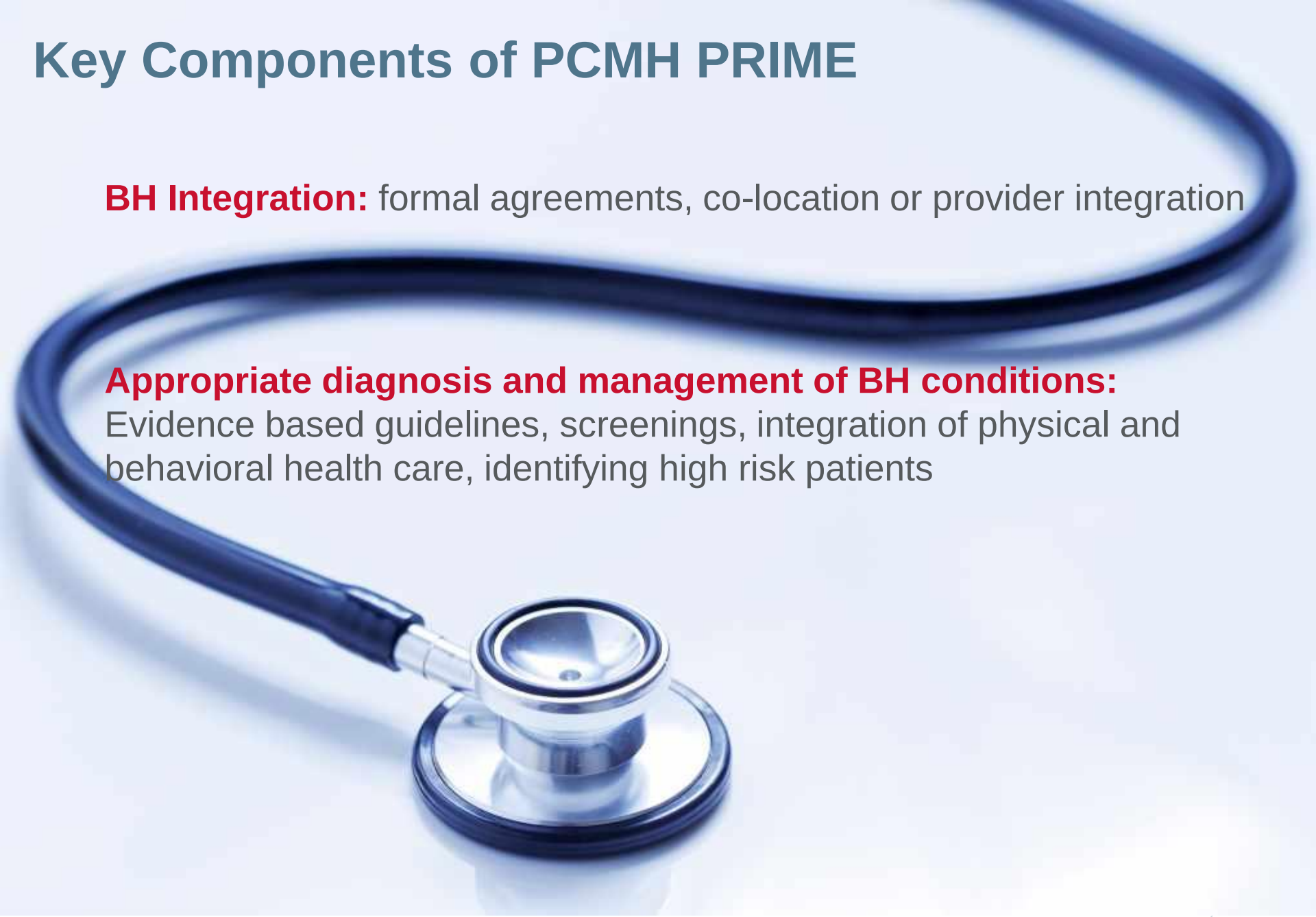
Behavioral health conditions can be exacerbated by under- or delayed diagnosis and treatment

Growing consensus that behavioral health care should be well integrated into primary care

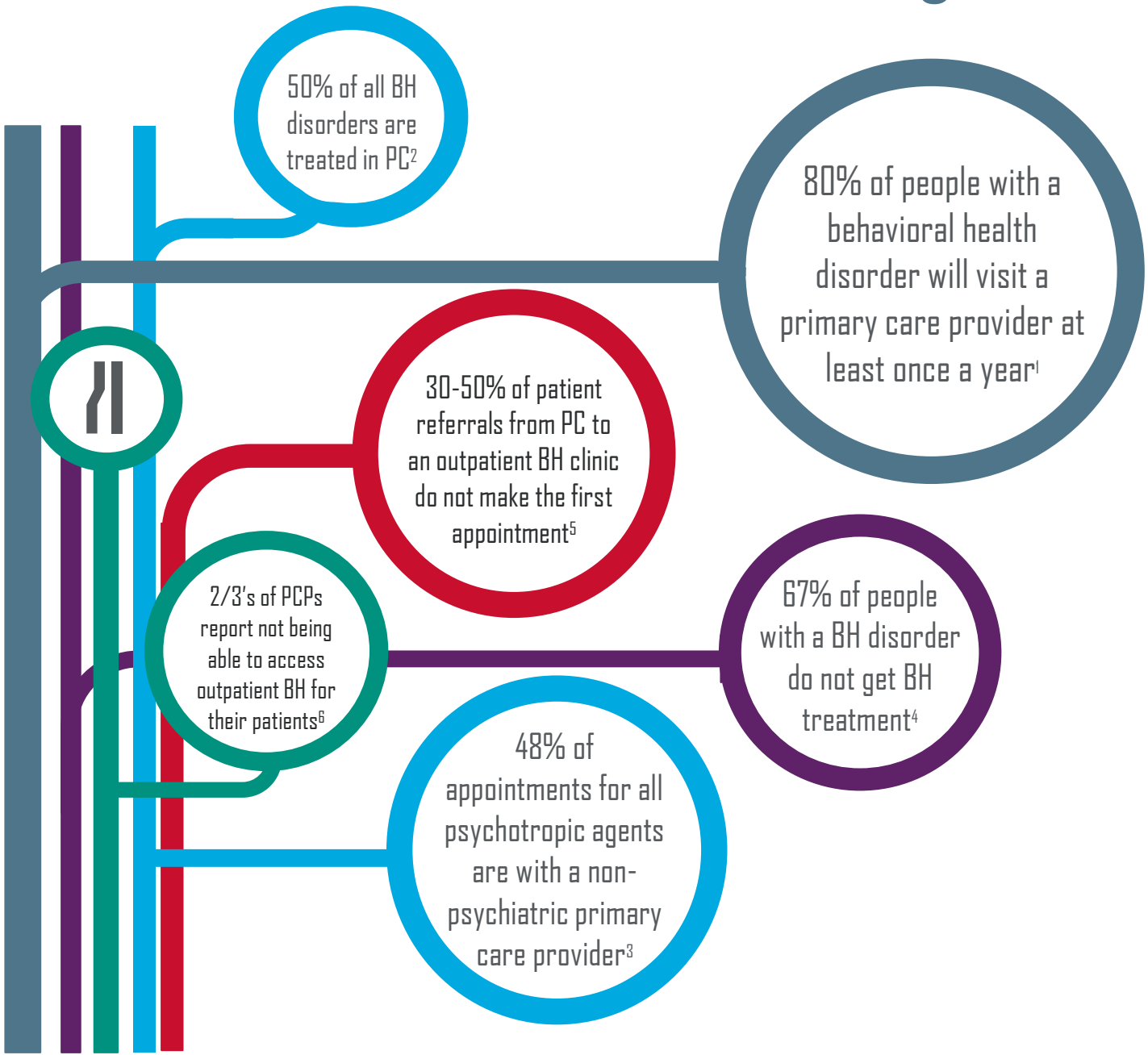
Key Components of PCMH PRIME

BH Integration: formal agreements, co-location or provider integration

Appropriate diagnosis and management of BH conditions: Evidence based guidelines, screenings, integration of physical and behavioral health care, identifying high risk patients



Benefits of Behavioral Health Integration



Behavioral Health and the Medical Home Model

PCMH 2017 strengthened integration of BH

- At least one care manager qualified to identify and coordinate BH needs
- Conducts BH screenings and/or assessments using a standardized tool
- Monitors, set goals and acts to improve clinical quality measures including BH measures.
- Reports clinical quality measures to Medicare or Medicaid agency including one behavioral health measure

Addition of NCQA PCMH Behavioral Health Distinction Module

- Nine criteria in the PCMH PRIME program align with this distinction module

PCMH PRIME further incorporates BH in the primary care setting

- Adds additional focus on BH
- Has stronger requirements for BH
- 10 criteria align with PCMH 2017 standards
- Nine criteria align with the PCMH BH Distinction Module

PCMH PRIME

Eligibility & Scoring

Eligibility

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 or
- PCMH 2017

Note: An NCQA PCMH Recognized practice 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

Scoring

Requirements

Meet eligibility (location and NCQA PCMH Recognition)

Must meet 7 of the 13 possible criteria. (HPC will determine the final score.)

Certification

Certification awarded at the practice site level

PCMH PRIME

Standards Content

Documentation Key

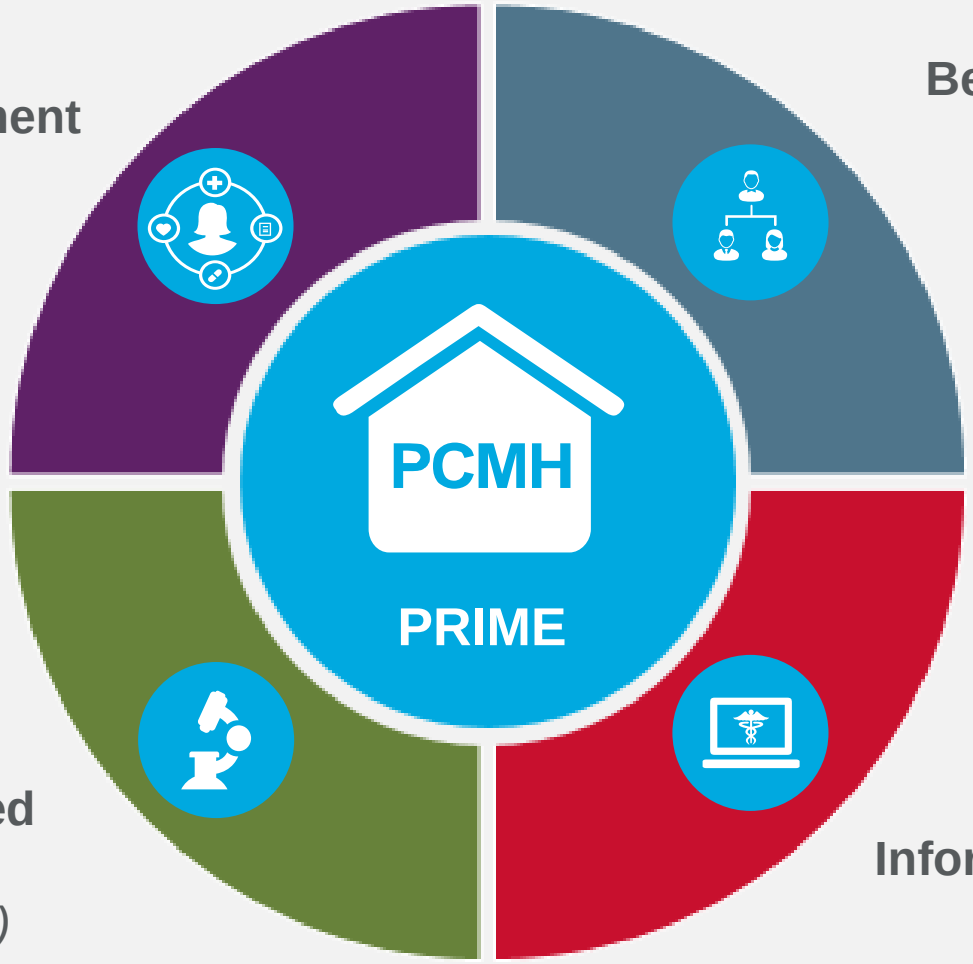
Presentation documentation key:

- (r) - Report
- (e) - Evidence
- (p) - Process
- (l) - List
- (s) - Source
- (a) - Agreement
- (t) - Protocol
- (b) - RRWB
- (w) - Worksheet

PCMH PRIME Competencies

Care Management
(PP 13)

Behavioral Health Workforce
(PP 01 – PP 04)



Evidence Based Care
(PP 06 – PP 12)

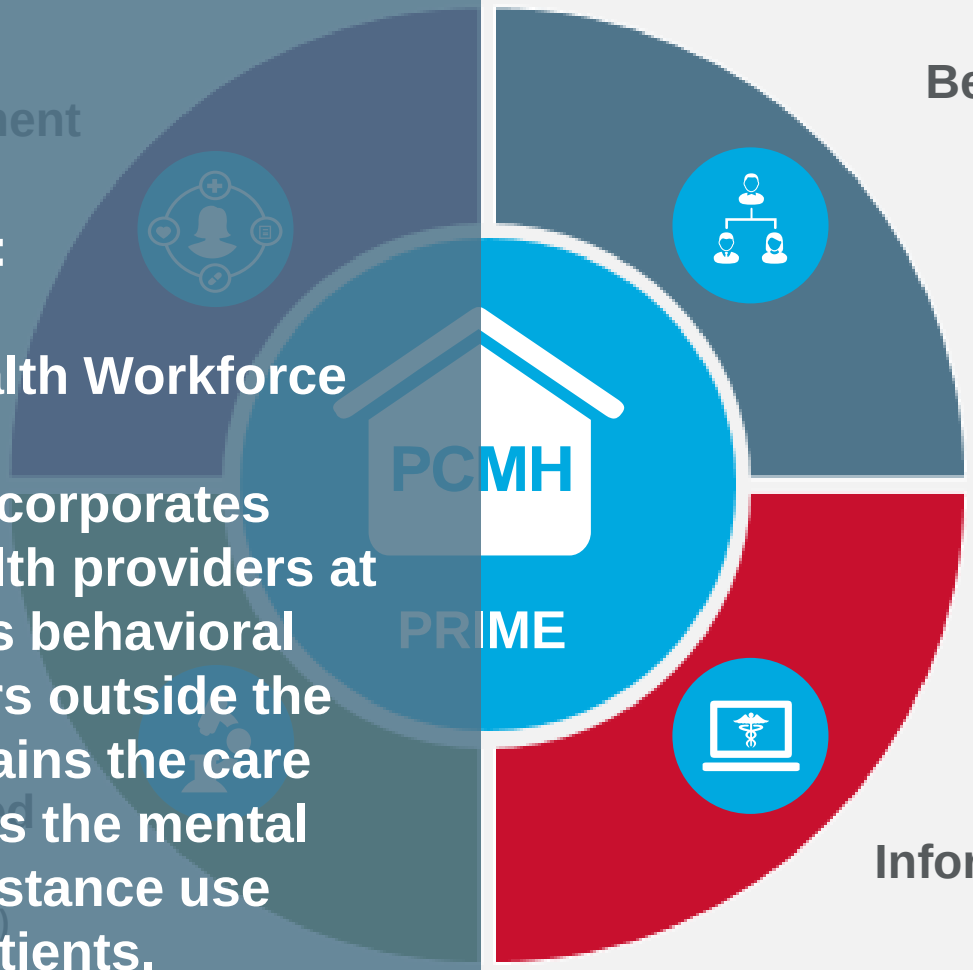
Integrated Information Sharing
(PP 05)

PCMH PRIME Competencies

Competency A:

Behavioral Health Workforce

The practice incorporates behavioral health providers at the site, utilizes behavioral health providers outside the practice and trains the care team to address the mental health and substance use concerns of patients.



Behavioral Health Workforce
(PP 01 – PP 04)

Integrated Information Sharing
(PP 05)

Behavioral Health Workforce

PCMH PRIME Criteria: PP 01 – PP 04

Has at least one care manager **qualified to identify & coordinate BH needs** (e)

Has at least **one clinician** located in the practice who **provides MAT & behavioral therapy** directly or via referral, for substance use disorders (e)

Works with BHP to whom the practice frequently refers, to **set expectations for information sharing & patient care** (e) & (p) OR (a)

Integrates BHPs into the care delivery system of the practice. (e) (p)

Care manager to identify & coordinate BH needs

PP 01: Example

POSITION DESCRIPTION

Position Title	Department	Date
Behavioral Health Specialist in Primary Care	Behavioral Health	04/2014

Function:

Under the general supervision of the Manager of Medical Social Work and Substance Abuse Services, the Behavioral Health Specialist in Primary Care provides and coordinates, support, counseling, advocacy and community resource services to medical department patients.

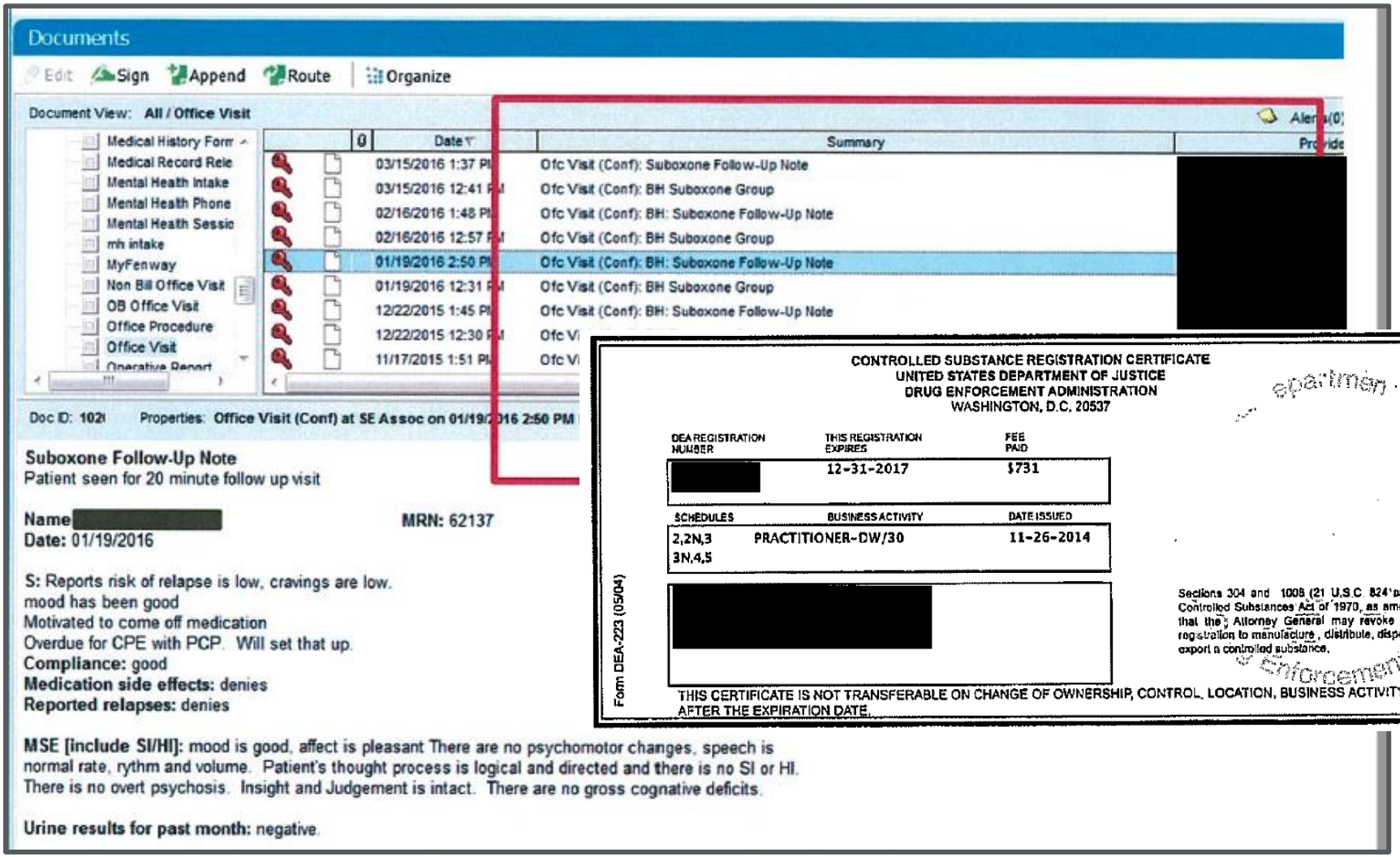
Representative Duties:

1. **Provides direct case management services to medical patients**
   - Upon referral of patients, reviews medical and psychosocial history, assesses problems and refers patients as appropriate in a timely, courteous manner
   - Provides case management services to medical department patients as indicated
   - Provides information to patients about available community resources and assists patients to determine eligibility and obtain services by giving resource list and/or contacting services directly
   - Provides on-going supportive maintenance to patients as appropriate and conducts outreach to persuade clients to utilize further needed services

2. **Provides direct behavioral health services to primary care clients**
   - Provides psychosocial assessments, mental health and substance abuse evaluations for medical patients
   - Provides direct behavioral health treatment to medical patients with an emphasis on short-term, evidence-based psychotherapeutic treatment within the primary care setting
   - Identify high-risk psychosocial factors that impact health status; engage patients by phone and in person to monitor progress, build therapeutic alliance, provide education, encourage treatment adherence, mitigate risk factors, review goals and expectations of treatment in order to stabilize functioning
   - Develops and provides group therapeutic interventions for medical patients
   - Assumes essential role in coordination of care
   - Participates in the development of the Patient Centered Medical Home model
   - Maintains required caseload and productivity expectation
   - Adheres to NASW Code of Ethics

Provides medication assisted treatment

PP 02: Example



Integrates BHP into the care delivery system

PP 04: Example

Effective	Revised	Reviewed
9/2014	2/2015	

Policy:

[redacted] is dedicated to the whole healthcare of all patients seeking primary care services. It is well documented that depression and anxiety are two of the major chronic illnesses impacting patient care. Chronic disease puts patients at higher risk of experiencing depression or anxiety as well as other mental health and substance abuse issues. Patients experiencing mental health or substance abuse issues often have a more difficult time managing their physical health, especially chronic diseases. [redacted] recognizes that physical health and emotional health are not mutually exclusive and the need to address all issues that impact patient care is paramount in helping patient's lead healthier lives. There continues to be stigma around mental health and substance abuse services, preventing many patients from seeking services in an outpatient mental health or substance abuse setting. The integrated model seeks to provide services to many patients who would otherwise not benefit from care.

To address these issues, Behavioral Health clinicians are embedded in primary care as part of the extended care team to provide access to services. In this policy, those clinicians are referred to as Behavioral Health Consultants or BHCs.

Referral process

Integration

Procedure:

1. BHCs spend their clinical time in primary care during sessions when primary care teams see patients. Clinical teams and other relevant employees are notified of the schedule of BHCs. BHCs meet with patients in consultation rooms if available or in exam rooms if not.
2. BHCs use telephone extension mobility to transfer their extension to the phone where they are sitting in primary care. They log off at the end of each session.
3. BHCs periodically walk around primary care to let the care teams know they are available for consultations and where they are sitting during that session. When BHCs walk around they also allow for "water cooler conversations".
4. When possible, BHCs should attend huddles at the beginning of each session to discuss patients the primary care teams are concerned about, in case those patients may be interested in meeting with the BHC.
5. BHCs should attend medical home meetings regularly as part of the extended care team and problem solve issues/topics that emerge regarding integrated care.
6. BHCs should participate in care conferences with primary care teams to discuss patient care for patients who are at higher risk. Patients must provide verbal authorization to primary care teams to be seen by a BHC.
7. Patients can be referred to a BHC for any behavioral health need:
   a. Mental health issues, such as depression, anxiety, grief & loss, trauma, eating disorders or panic.
   b. Substance abuse issues, such as alcohol misuse, illicit drug use or misuse of prescribed medications.
   c. Chronic disease that has not been managed well, such as diabetes or hypertension.
   d. Lifestyle changes, such as better diet, exercise or sleep hygiene.
8. Primary care teams may use screening tools such as the PHQ-9 (Patient Health Questionnaire – 9, a depression screening tool) or Patient Stress Questionnaire (PSQ) to help identify the need for BHC consultations. Having the provider introduce the patient in person to the BHC "a warm hand-off" is the preferred approach to providing consultations for patients. Warm hand-offs occur when patients present to primary care teams with any or all of the concerns presented in #7. The following work flow then takes place:
   a. A member of the primary care team asks the patient if he/she is willing to meet with a BHC.
   b. If yes, a member of the care team contacts the BHC to see if the BHC is available to meet with the patient.
   c. The provider introduces the BHC to the patient to discuss the presenting concerns.
   d. The BHC meets with the patient providing a functional assessment of the presenting concerns, brief interventions if applicable, further screenings if needed and coordination of care as needed.
   e. The BHC arranges to meet again with the patient, if appropriate. If the primary care provider is available, the BHC brings the provider into the room for a follow-up discussion with the provider and patient. If the provider is not available the BHC tasks the provider in NextGen regarding the disposition and services provided.
9. When a patient is interested in meeting with a BHC, but there is not one available, a member of the care team can schedule a future Integrated Behavioral Health (IBH) visit before the patient leaves. Patients can also be sent to the front desk to check out with a PAR who can schedule an IBH appointment.
10. All appointments in the integrated model need to be put into the EPM and checked-in.
11. BHCs need to follow the dedicated work flow in the EMR to document each visit. BHC's and primary care share an integrated electronic health record.
12. Every note must contain a Self-Management Goal (SMG).

[redacted] Process for Referrals

[redacted] does not use the traditional referral order system for Behavioral Health referrals. Patients needing behavioral health services receive them in one of 3 ways:

- Warm hand off while the patient is in the department
- Appointment scheduled directly with a behavioral health therapist by a team member
- Patients requesting services can be scheduled by any clinical staff member as well as PAR and call center staff

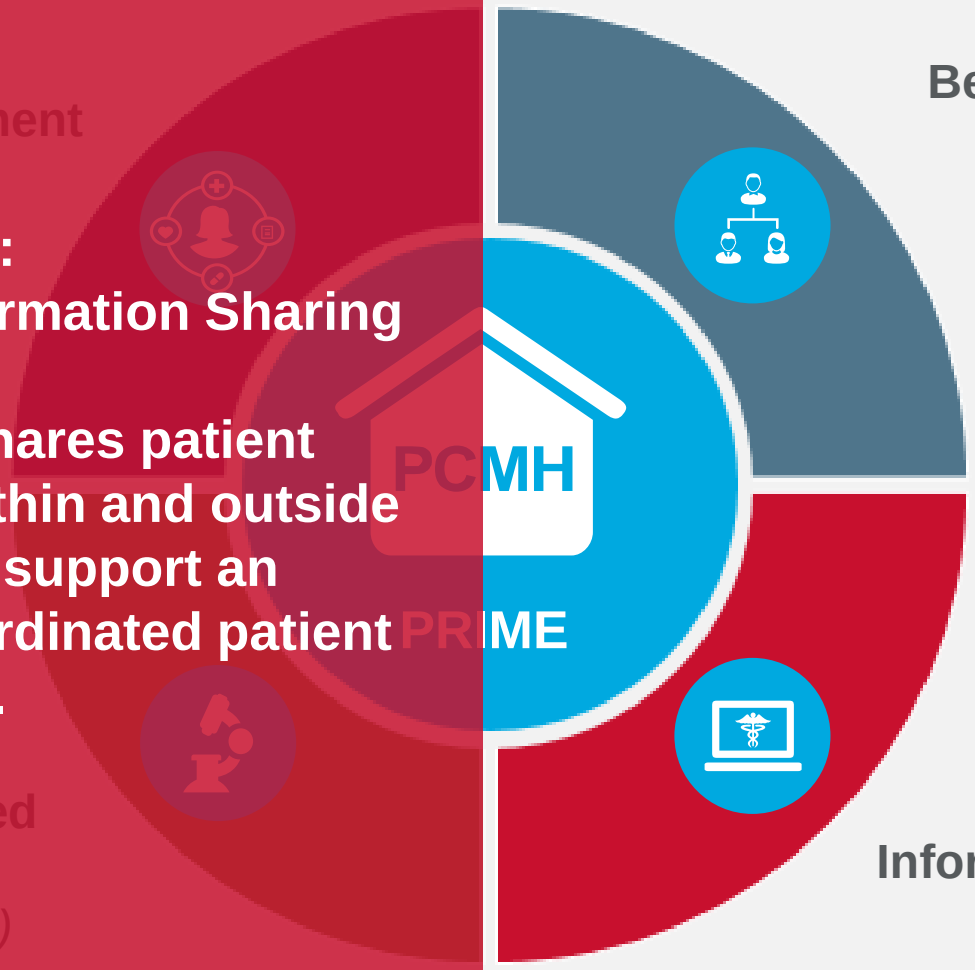
Referral Loop closure:

When a patient cancels or does not show up for a scheduled behavioral health appointment the behavioral health provider enters a note into the EMR on the chart update template and sends a task to the provider notifying them of the patients missed BH appointment. They also send a letter to the patient asking them to re-schedule their appointment.

PCMH PRIME Competencies

Competency B:
Integrated Information Sharing

The practice shares patient information within and outside the practice to support an integrated/coordinated patient treatment plan.



Behavioral Health Workforce
(PP 01 – PP 04)

Integrated Information Sharing
(PP 05)

Evidence Based Care
(PP 06 – PP 12)

Information Sharing

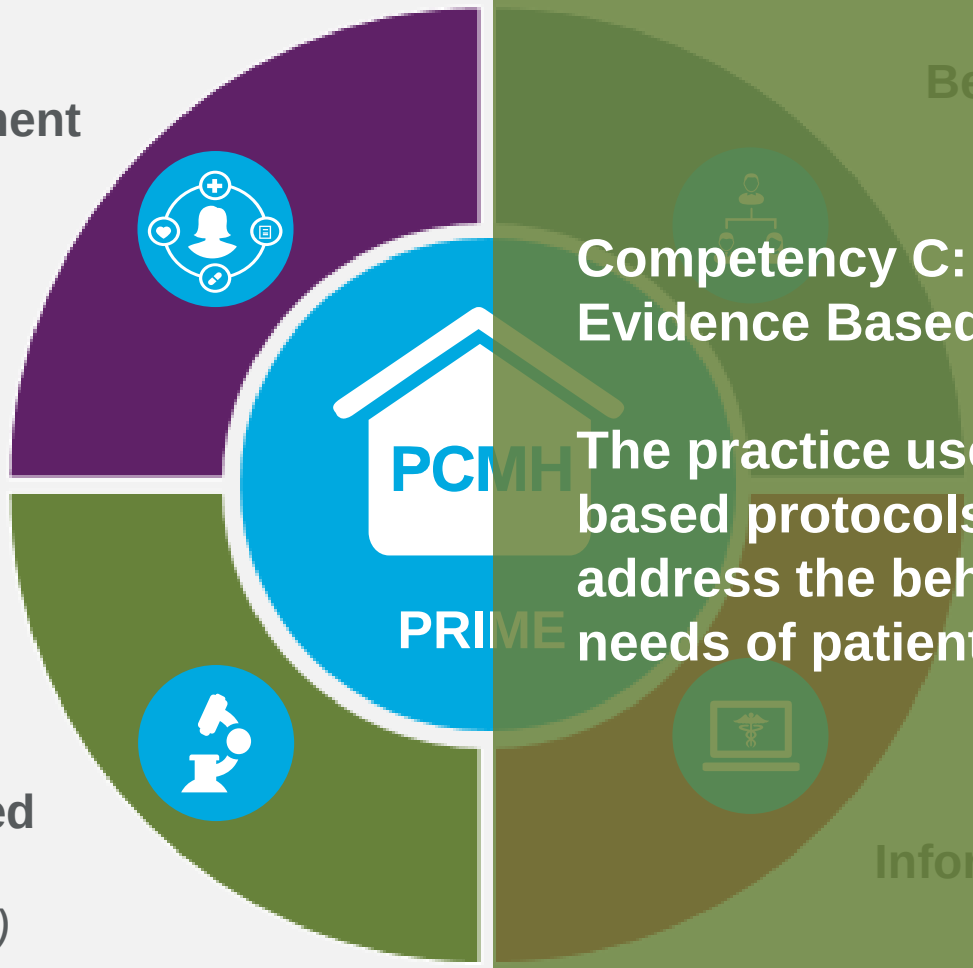
PCMH PRIME Criteria: PP 05

Tracks referrals to behavioral health specialists and has a process to monitor the timeliness and quality of the referral response.

(e) (p)

PCMH PRIME Competencies

Care Management
(PP 13)



Evidence Based Care
(PP 06 – PP 12)

Competency C:
Evidence Based Care

The practice uses evidence-based protocols to identify and address the behavioral health needs of patients.

Integrated Information Sharing
(PP 05)

Evidence Based Care

PCMH PRIME Criteria: PP 06 – PP 11

epr*

Conducts assessments and screenings based on evidence based guidelines.

Behaviors affecting health & BH history

**Practices must submit a system generated report with a numerator and denominator based on all unique patients in a recent 3-month period. If the practice does not have the electronic capability to generate this report, it is acceptable to submit only the documented process and evidence of implementation.*

NCQA

Evidence Based Care

PCMH PRIME Criteria: PP 06 – PP 11

epr*

Conducts assessments and screenings based on evidence based guidelines.

Behaviors affecting health & BH history

Developmental screening

**Practices must submit a system generated report with a numerator and denominator based on all unique patients in a recent 3-month period. If the practice does not have the electronic capability to generate this report, it is acceptable to submit only the documented process and evidence of implementation.*

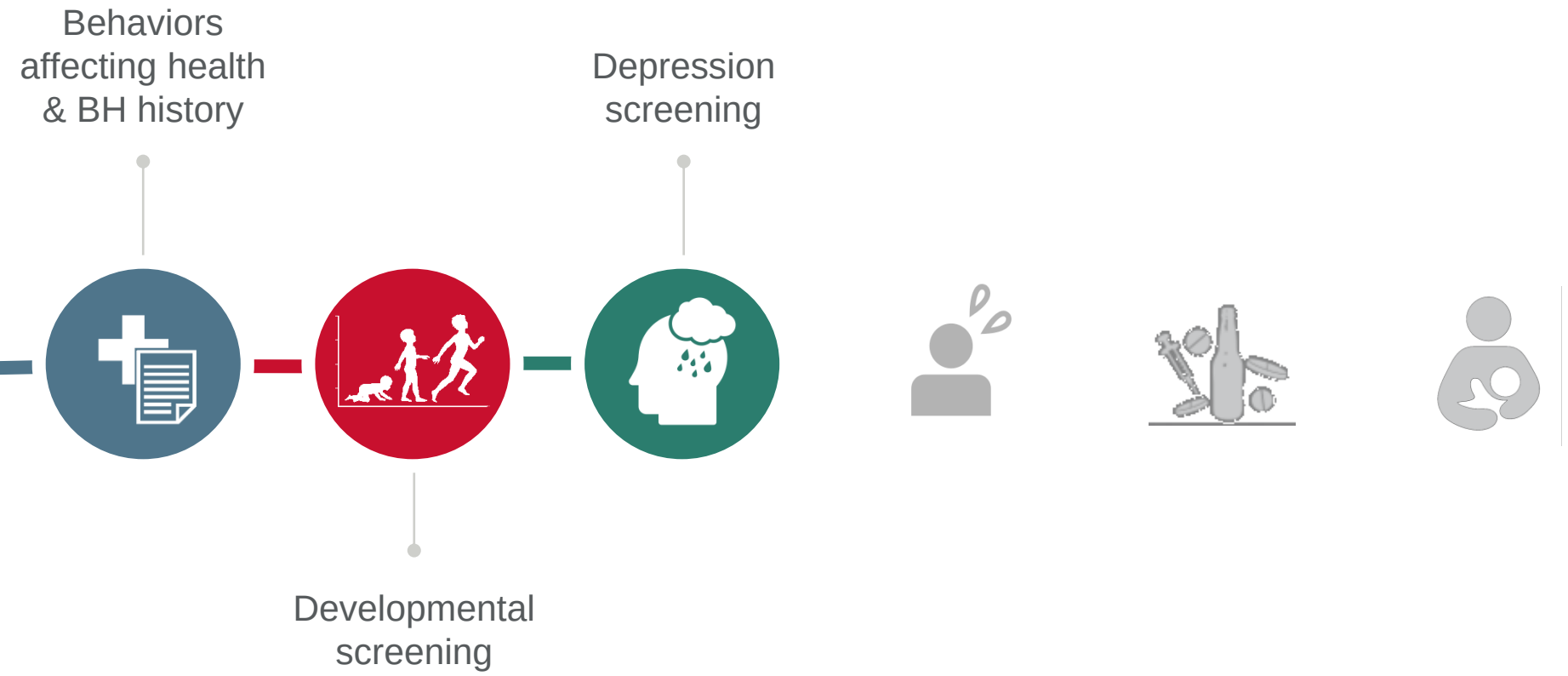
NCQA

Evidence Based Care

PCMH PRIME Criteria: PP 06 – PP 11

epr*

Conducts assessments and screenings based on evidence based guidelines.



**Practices must submit a system generated report with a numerator and denominator based on all unique patients in a recent 3-month period. If the practice does not have the electronic capability to generate this report, it is acceptable to submit only the documented process and evidence of implementation.*

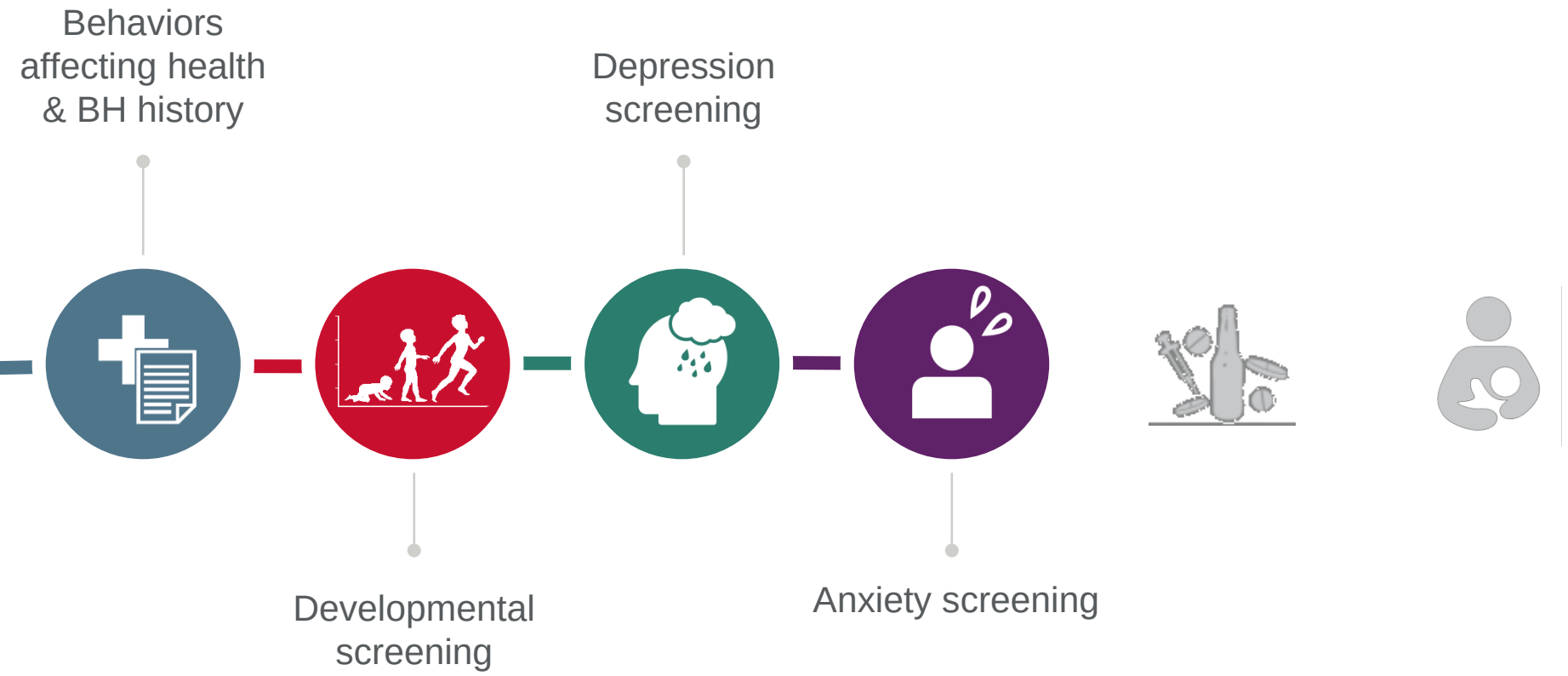
NCQA

Evidence Based Care

PCMH PRIME Criteria: PP 06 – PP 11

epr*

Conducts assessments and screenings based on evidence based guidelines.



**Practices must submit a system generated report with a numerator and denominator based on all unique patients in a recent 3-month period. If the practice does not have the electronic capability to generate this report, it is acceptable to submit only the documented process and evidence of implementation.*

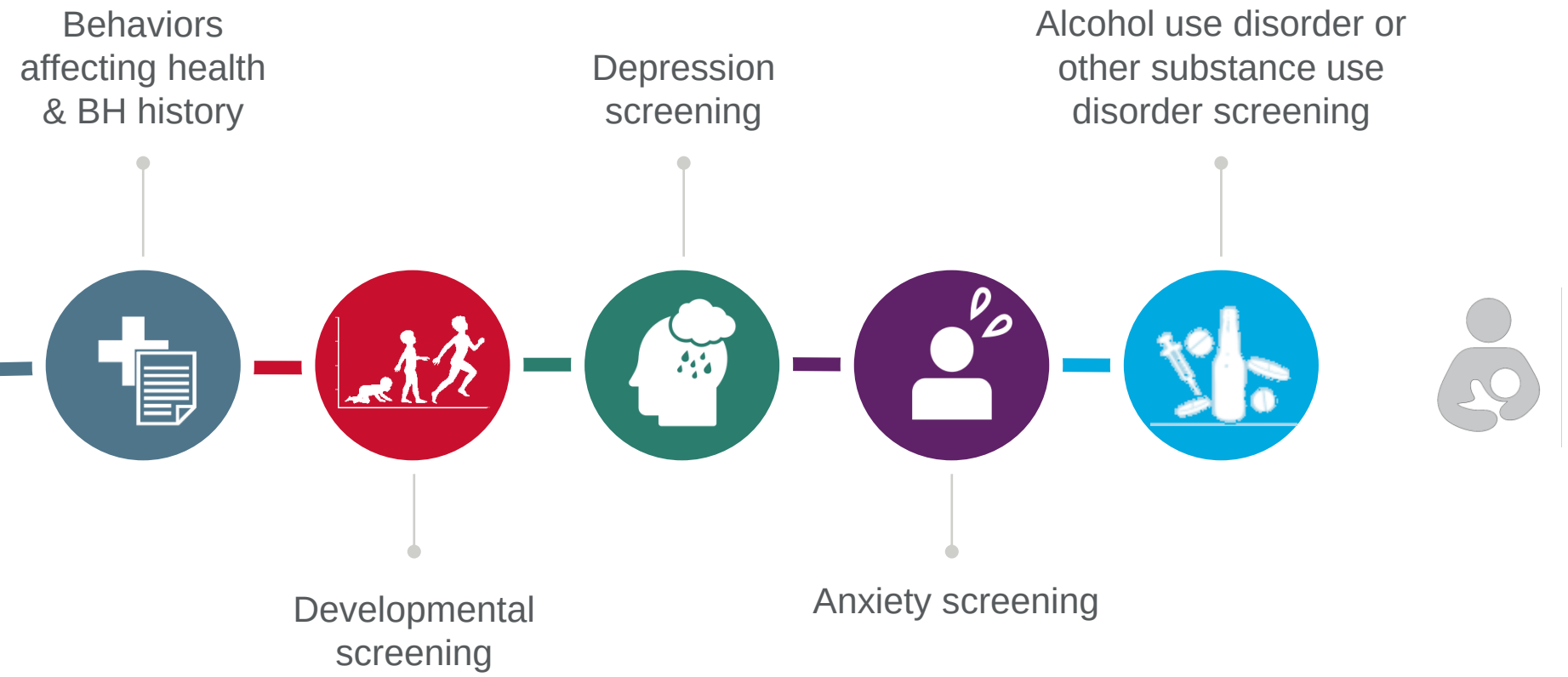
NCQA

Evidence Based Care

PCMH PRIME Criteria: PP 06 – PP 11

epr*

Conducts assessments and screenings based on evidence based guidelines.



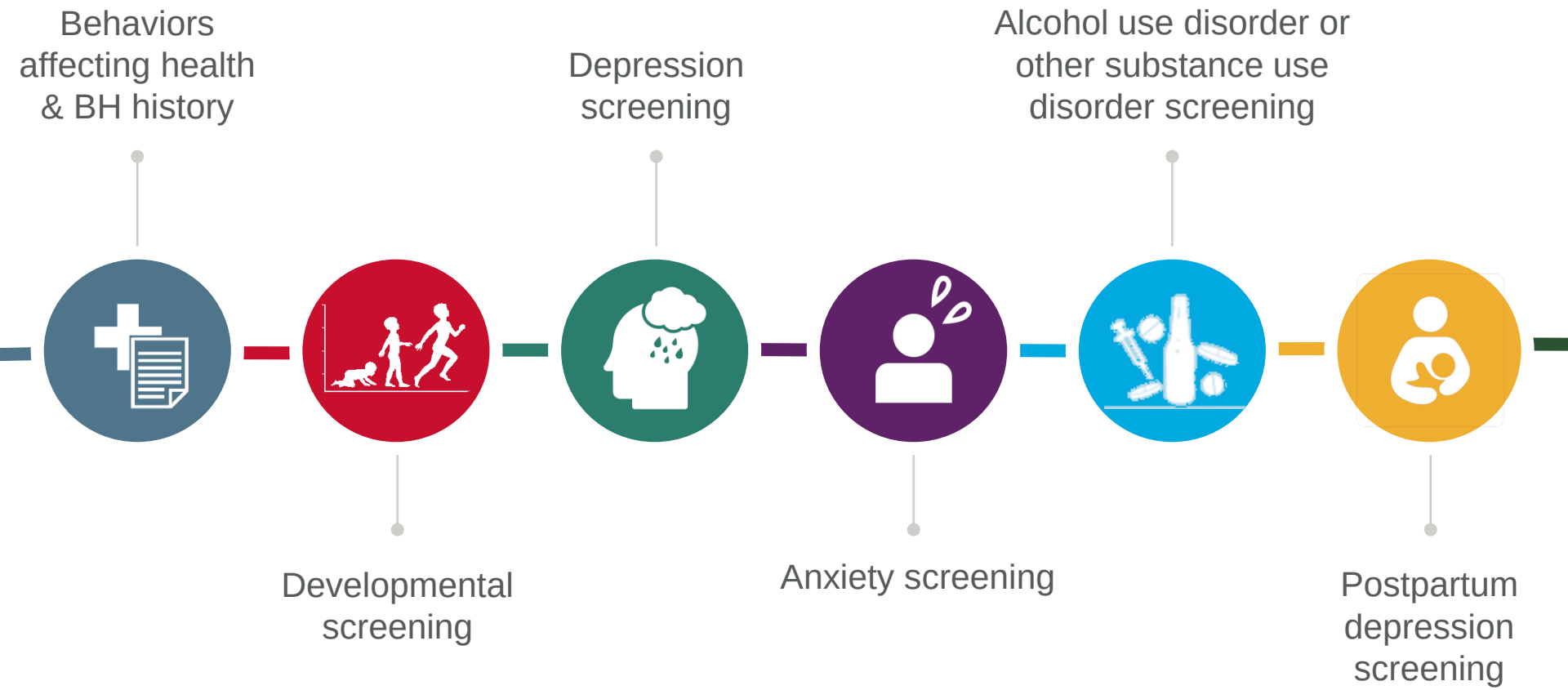
**Practices must submit a system generated report with a numerator and denominator based on all unique patients in a recent 3-month period. If the practice does not have the electronic capability to generate this report, it is acceptable to submit only the documented process and evidence of implementation.*

Evidence Based Care

PCMH PRIME Criteria: PP 06 – PP 11

epr*

Conducts assessments and screenings based on evidence based guidelines.

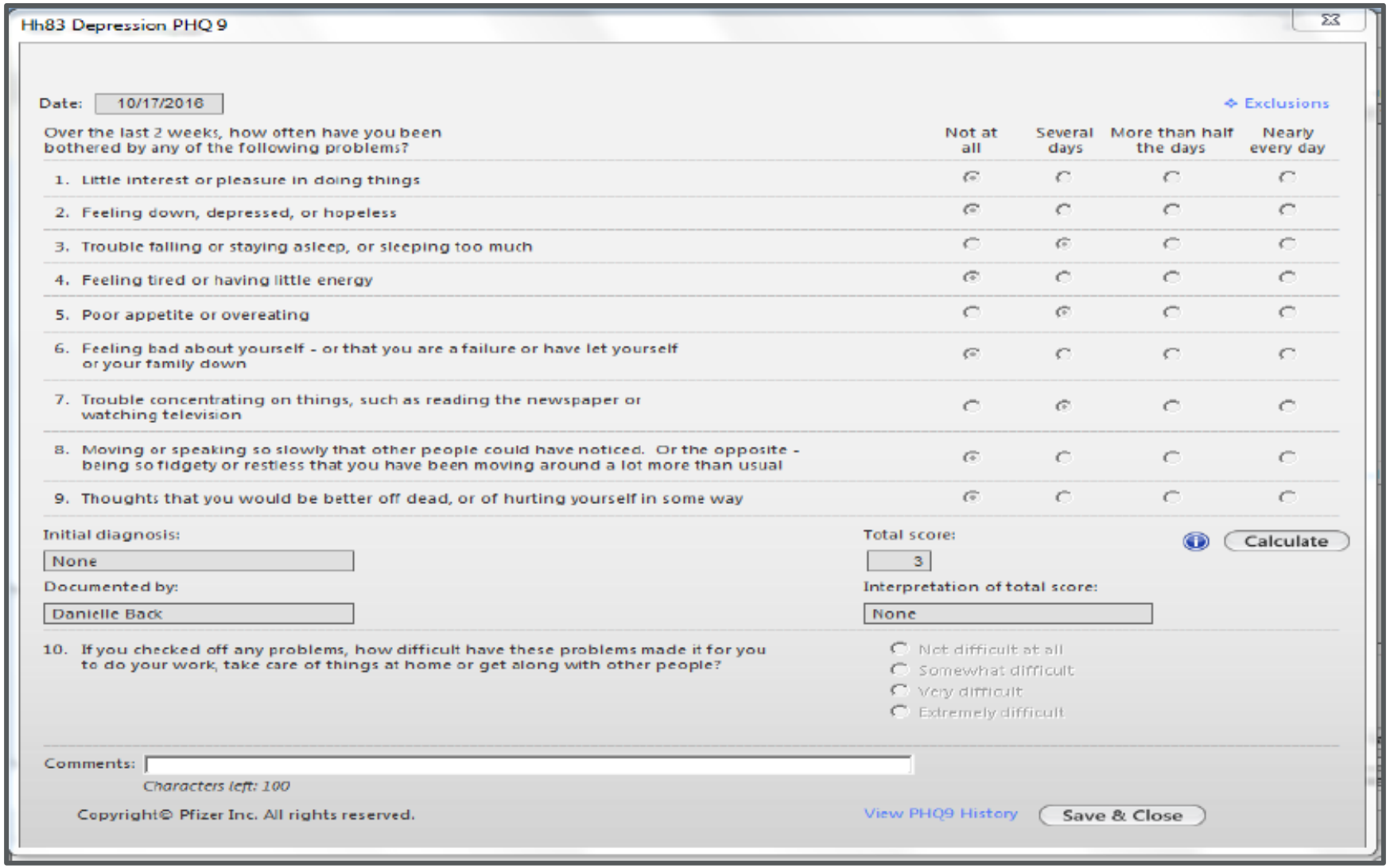


**Practices must submit a system generated report with a numerator and denominator based on all unique patients in a recent 3-month period. If the practice does not have the electronic capability to generate this report, it is acceptable to submit only the documented process and evidence of implementation.*

NCQA

Depression screening tool

PP 08: Example



Hh83 Depression PHQ 9

Date: 10/17/2016

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: None

Total score: 3

Calculate

Documented by: Danielle Back

Interpretation of total score: None

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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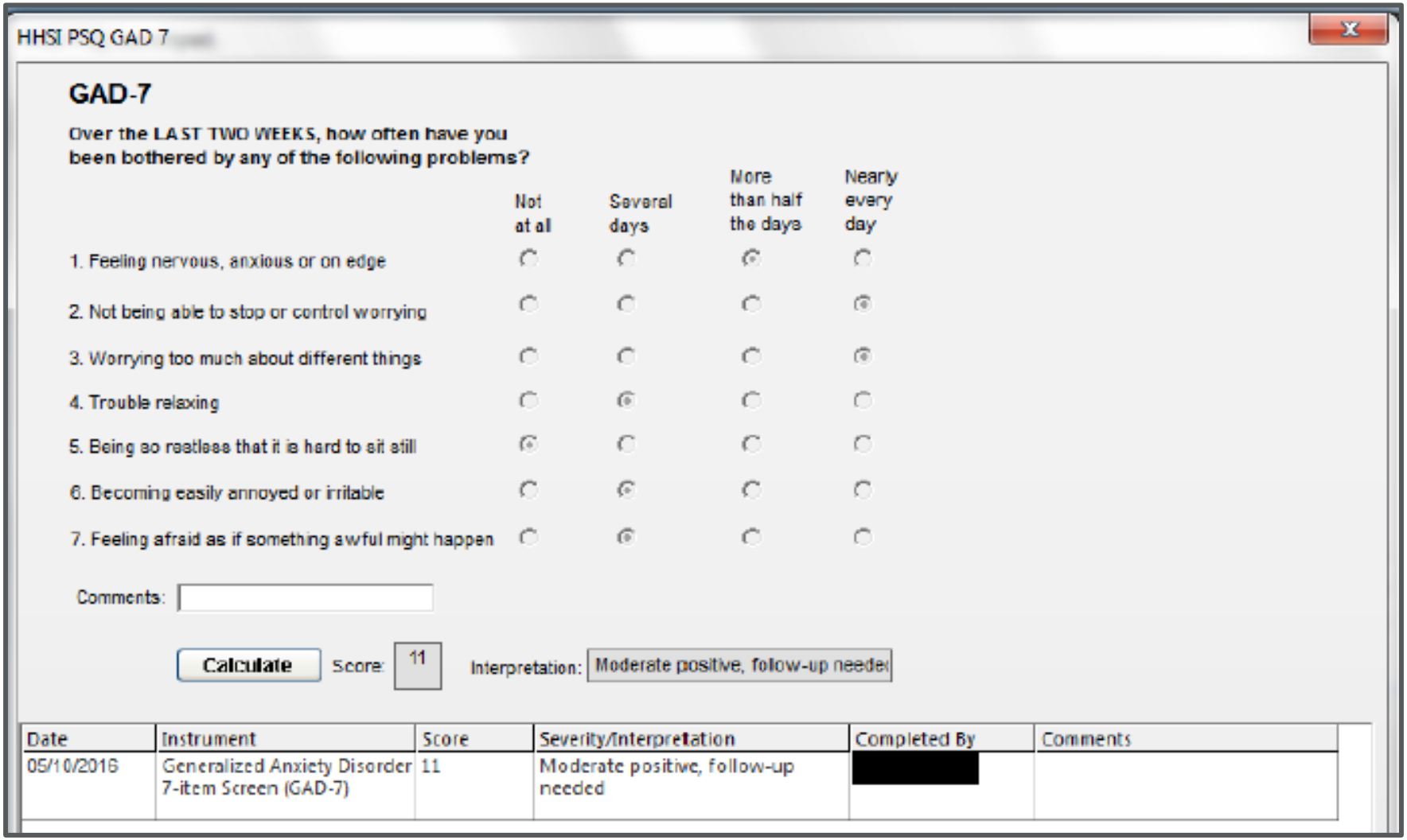
View PHQ9 History

Save & Close

Anxiety screening tool

PP 09: Example



HHSI PSQ GAD 7

GAD-7

Over the LAST TWO 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. Feeling nervous, anxious or on edge	○	○	◉	○
2. Not being able to stop or control worrying	○	○	○	◉
3. Worrying too much about different things	○	○	○	◉
4. Trouble relaxing	○	◉	○	○
5. Being so restless that it is hard to sit still	◉	○	○	○
6. Becoming easily annoyed or irritable	○	◉	○	○
7. Feeling afraid as if something awful might happen	○	◉	○	○

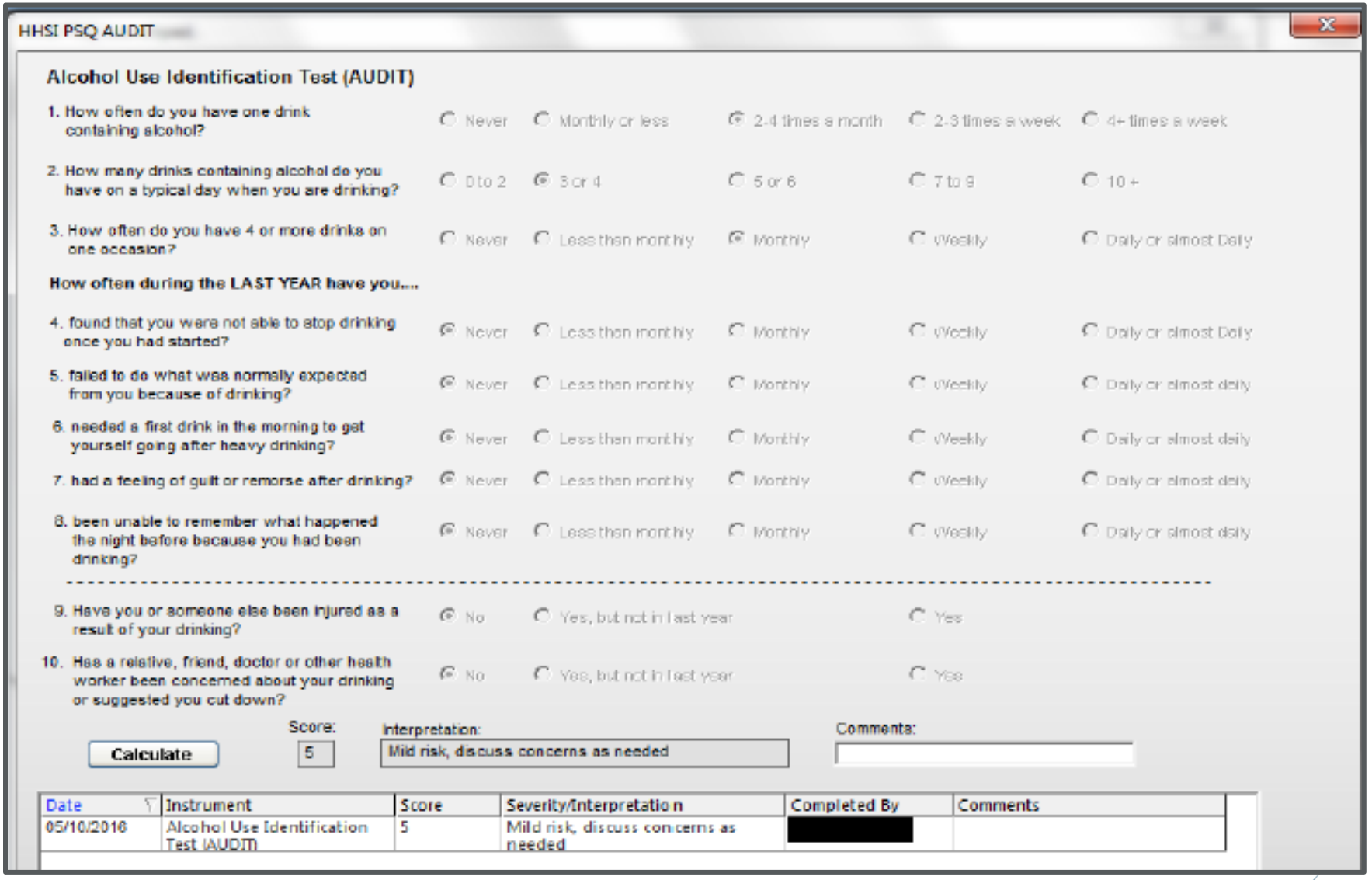
Comments:

Calculate Score: 11 Interpretation: Moderate positive, follow-up neede

Date	Instrument	Score	Severity/Interpretation	Completed By	Comments
05/10/2016	Generalized Anxiety Disorder 7-item Screen (GAD-7)	11	Moderate positive, follow-up needed	[redacted]	

Alcohol screening tool

PP 10: Example



HHSI PSQ AUDIT

Alcohol Use Identification Test (AUDIT)

1. How often do you have one drink containing alcohol?	○ Never	○ Monthly or less	◉ 2-4 times a month	○ 2-3 times a week	○ 4+ times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	○ 0 to 2	◉ 3 or 4	○ 5 or 6	○ 7 to 9	○ 10 +
3. How often do you have 4 or more drinks on one occasion?	○ Never	○ Less than monthly	◉ Monthly	○ Weekly	○ Daily or almost Daily
How often during the LAST YEAR have you....					
4. found that you were not able to stop drinking once you had started?	◉ Never	○ Less than monthly	○ Monthly	○ Weekly	○ Daily or almost Daily
5. failed to do what was normally expected from you because of drinking?	◉ Never	○ Less than monthly	○ Monthly	○ Weekly	○ Daily or almost daily
6. needed a first drink in the morning to get yourself going after heavy drinking?	◉ Never	○ Less than monthly	○ Monthly	○ Weekly	○ Daily or almost daily
7. had a feeling of guilt or remorse after drinking?	◉ Never	○ Less than monthly	○ Monthly	○ Weekly	○ Daily or almost daily
8. been unable to remember what happened the night before because you had been drinking?	◉ Never	○ Less than monthly	○ Monthly	○ Weekly	○ Daily or almost daily
9. Have you or someone else been injured as a result of your drinking?	◉ No	○ Yes, but not in last year		○ Yes	
10. Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	◉ No	○ Yes, but not in last year		○ Yes	

Calculate | Score: 5 | Interpretation: Mild risk, discuss concerns as needed | Comments:

Date	Instrument	Score	Severity/Interpretation	Completed By	Comments
05/10/2016	Alcohol Use Identification Test (AUDIT)	5	Mild risk, discuss concerns as needed	[redacted]	

Evidence Based Care

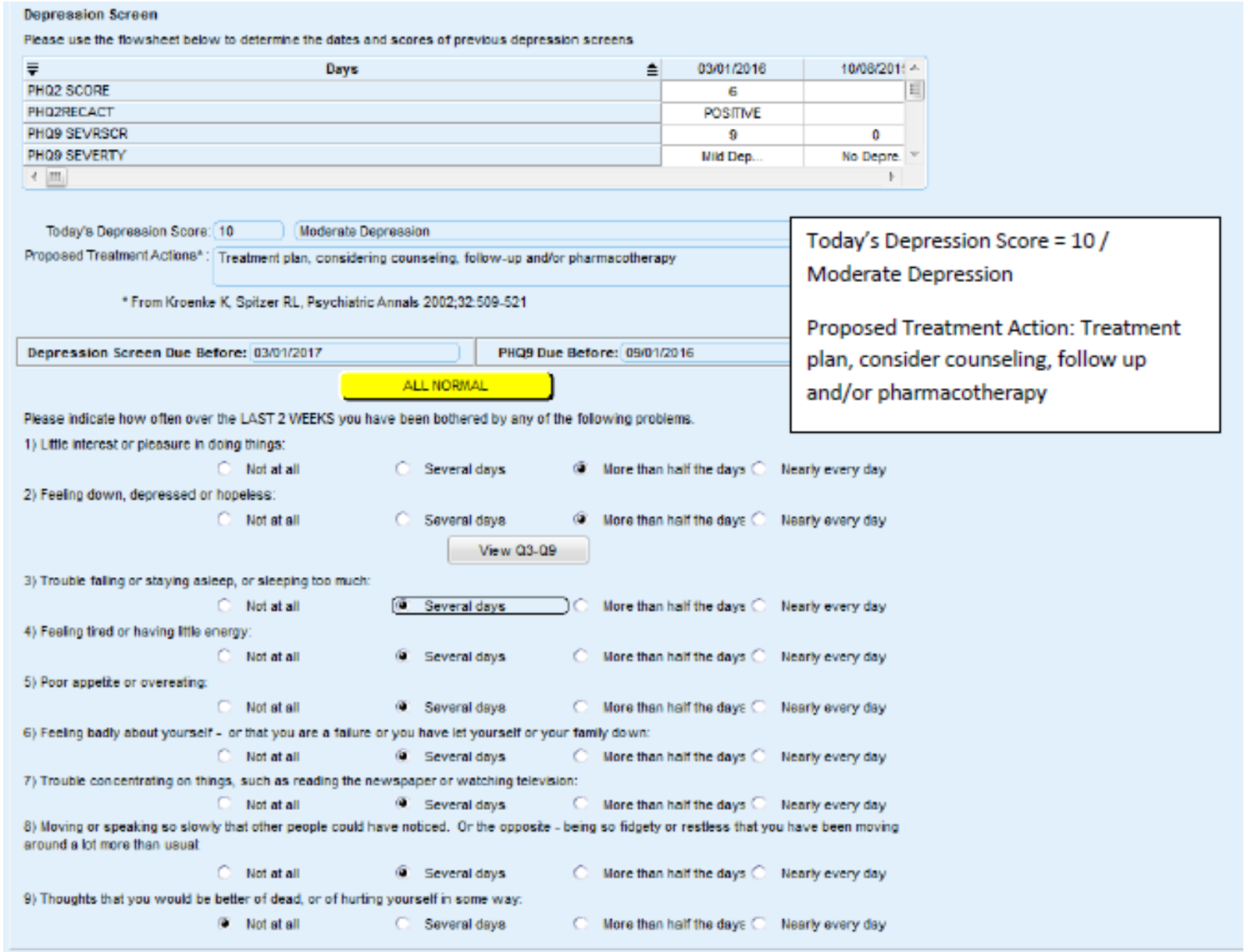
PCMH PRIME Criteria: PP 12

Implements clinical decision support following evidence-based guidelines for care of mental health conditions **AND** substance use disorders.

(s)(e)

Clinical decision support for mental health

PP 12: Example



Depression Screen

Please use the flowsheet below to determine the dates and scores of previous depression screens

Days	03/01/2016	10/08/201
PHQ2 SCORE	6	
PHQ2RECACT	POSITIVE	
PHQ9 SEVRSCR	9	0
PHQ9 SEVERTY	Mild Dep...	No Depre...

Today's Depression Score: 10 Moderate Depression

Proposed Treatment Actions* : Treatment plan, considering counseling, follow-up and/or pharmacotherapy

* From Kroenke K, Spitzer RL, Psychiatric Annals 2002;32:509-521

Depression Screen Due Before: 03/01/2017 PHQ9 Due Before: 09/01/2016

ALL NORMAL

Please indicate how often over the LAST 2 WEEKS you have been bothered by any of the following problems.

1) Little interest or pleasure in doing things:
Not at all | Several days | More than half the days | Nearly every day

2) Feeling down, depressed or hopeless:
Not at all | Several days | More than half the days | Nearly every day

View Q3-Q9

3) Trouble falling or staying asleep, or sleeping too much:
Not at all | Several days | More than half the days | Nearly every day

4) Feeling tired or having little energy:
Not at all | Several days | More than half the days | Nearly every day

5) Poor appetite or overeating:
Not at all | Several days | More than half the days | Nearly every day

6) Feeling badly about yourself - or that you are a failure or you have let yourself or your family down:
Not at all | Several days | More than half the days | Nearly every day

7) Trouble concentrating on things, such as reading the newspaper or watching television:
Not at all | Several days | More than half the days | Nearly every day

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
Not at all | Several days | More than half the days | Nearly every day

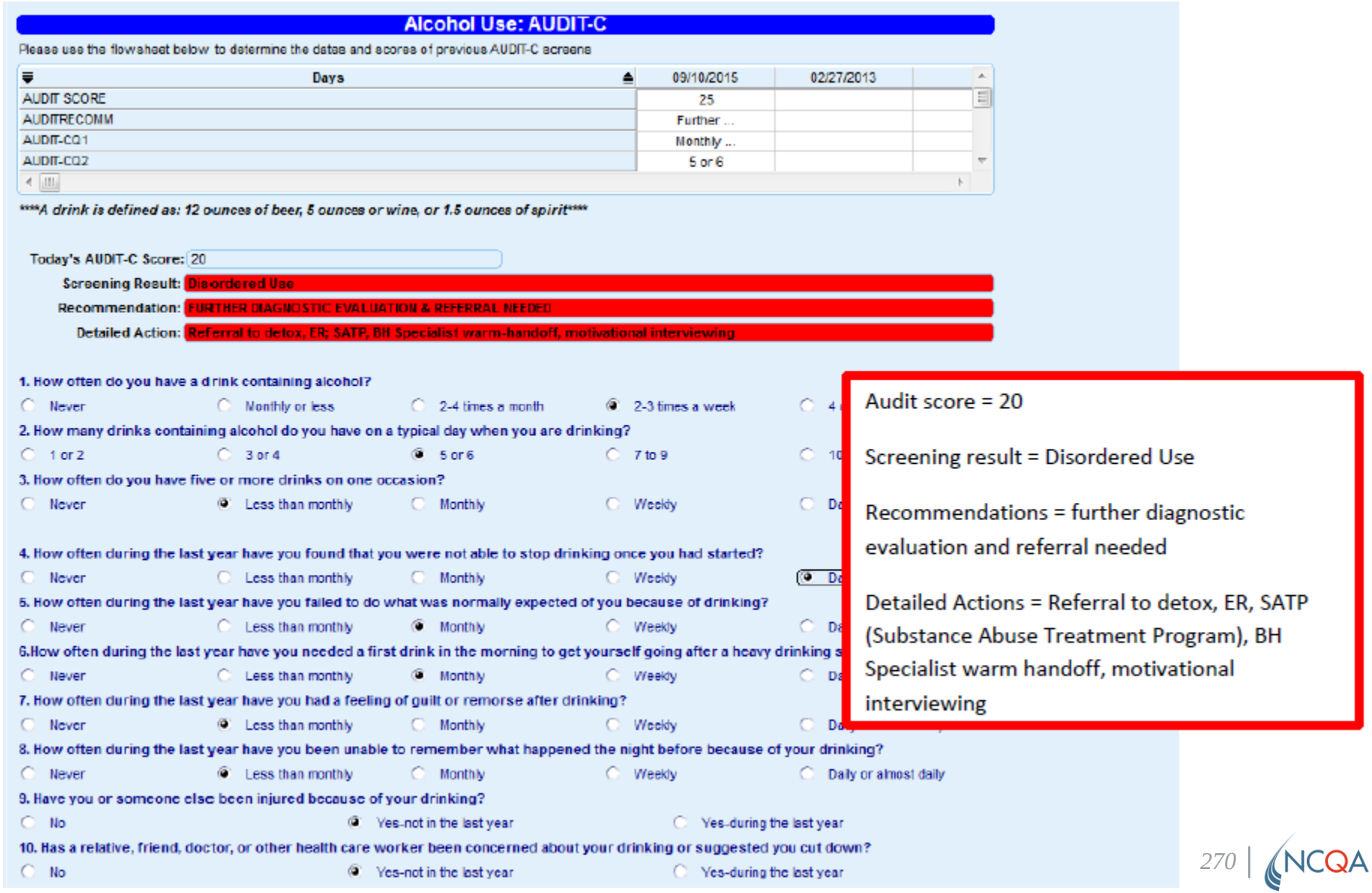
9) Thoughts that you would be better of dead, or of hurting yourself in some way:
Not at all | Several days | More than half the days | Nearly every day

Today's Depression Score = 10 / Moderate Depression

Proposed Treatment Action: Treatment plan, consider counseling, follow up and/or pharmacotherapy

Clinical decision support for SUD

PP 12: Example



Alcohol Use: AUDIT-C

Please use the flowsheet below to determine the dates and scores of previous AUDIT-C screens

Days	09/10/2015	02/27/2013
AUDIT SCORE	25	
AUDITRECOMM	Further ...	
AUDIT-CQ1	Monthly ...	
AUDIT-CQ2	5 or 6	

****A drink is defined as: 12 ounces of beer, 5 ounces or wine, or 1.5 ounces of spirit****

Today's AUDIT-C Score: 20

Screening Result: Disordered Use

Recommendation: FURTHER DIAGNOSTIC EVALUATION & REFERRAL NEEDED

Detailed Action: Referral to detox, ER; SATP, BH Specialist warm-handoff, motivational interviewing

1. How often do you have a drink containing alcohol?
   - Never
   - Monthly or less
   - 2-4 times a month
   - 2-3 times a week
   - 4 ...
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   - 1 or 2
   - 3 or 4
   - 5 or 6
   - 7 to 9
   - 10 ...
3. How often do you have five or more drinks on one occasion?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Da...
4. How often during the last year have you found that you were not able to stop drinking once you had started?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Da...
5. How often during the last year have you failed to do what was normally expected of you because of drinking?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Da...
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking s...
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Da...
7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Da...
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Daily or almost daily
9. Have you or someone else been injured because of your drinking?
   - No
   - Yes-not in the last year
   - Yes-during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?
    - No
    - Yes-not in the last year
    - Yes-during the last year

Audit score = 20

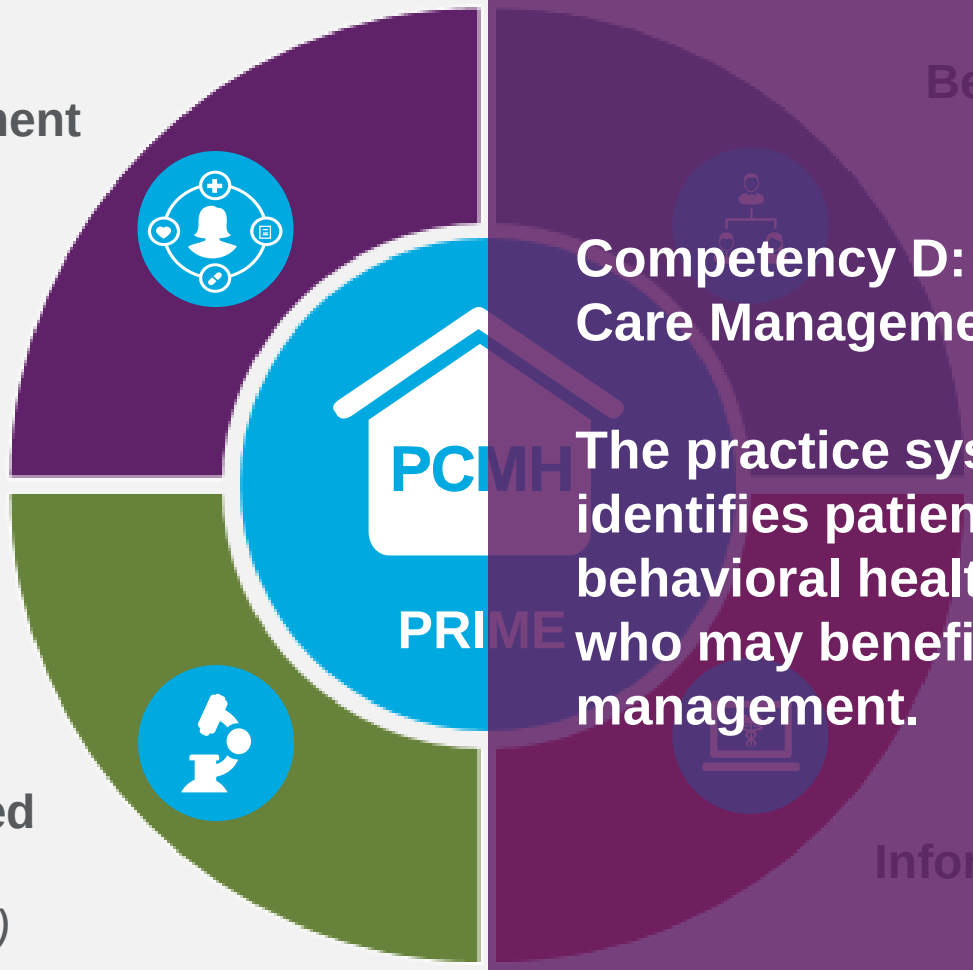
Screening result = Disordered Use

Recommendations = further diagnostic evaluation and referral needed

Detailed Actions = Referral to detox, ER, SATP (Substance Abuse Treatment Program), BH Specialist warm handoff, motivational interviewing

PCMH PRIME Competencies

Care Management
(PP 13)



Evidence Based Care
(PP 06 – PP 12)

Competency D:
Care Management

The practice systematically identifies patients with behavioral health conditions who may benefit from care management.

Integrated Information Sharing
(PP 05)

Care Management

PCMH PRIME Criteria: PP 13

The practice establishes a **systemic process and criteria for identifying patients who may benefit from care management** and includes consideration of **behavioral health conditions**.

Care management process and criteria

PP 13: Example

Version 3: 10/2015

High Risk Stratification

* indicates a new/revised variable since last report

Low Risk			Moderate Risk			High Risk		
Marker	**Result**	**Score**	**Marker**	**Result**	**Score**	**Marker**	**Result**	**Score**
A1c	<7.0	0	A1c	7.0-8.9	1	A1c	>9	2
BP	<140/90	0	BP	140-160/90-100	1	BP	>160/100	2
EGFR	>60	0	EGFR	30-60	1	EGFR	<30	2
HIV, on ART VL	Undetectable	0	HIV, on ART VL	Detectable	1			
Triglicerides	<250	0	Triglicerides	≥250	1	Triglicerides	>500	2
BMI	<30	0	BMI	30-34.9	1	BMI	≥35	2
Fasting Glucose	<110	0	Fasting Glucose	≥ 110	1			
Smoker	no	0	Smoker	yes	1			
PHQ-2	No to both Q's	0	PHQ-2	Yes to either Q	1	PHQ-9 Score	≥ 20	2
ER Use	0-1/year	0	ER Use	2-3 /year	1	ER Use	>3/year	2
Hospitalization	none	0	Hospitalization	1/year	1	Hospitalization	>2/year	2
					1	HIV/Hep C (co-infection)	042 and 70	2
			Age	>80 years	1			
			Conditions	ICD-9 Codes		Conditions	ICD-9 Codes	
			Retinopathy/blind	362, 363, 368, 369	1	MI/CVA/PVD/CAD	410, 412, 434, 43	2
			Foot ulcer/Amputee	707, 785, V49	1	(score only once)	438, 414,	
			CHF	404, 428	1		443.89/90	
			COPD/Asthma	496, 491, 492	1	ESRD (score above)	585.6	
				493 + text specific		gastroparesis	536.3,	2
			BPDO/Schizo/Psychosis	296, 295,	1	Amputee - above/below Knee	v49.76/ v49.77	2
			Suicidality	V62.84,				
			Substance abuse	304.20/21/22	1	Dementia	331, 290, 294	2
			Incl. narotic, cocaine	304.00/01/02/4/41	1	Homelessness	v60	2
			and alcohol abuse	305.00/01/02/7/9	1			
			Polysubstance	304.8/ 305.9	1	ALS	335.2	2
			Seizure Disorders	345/780.30	1			
			*History of pulmonary embolism	v12.55 and 415.11/.13/.19	1	*Neuromuscular Disease	332/340	2
			Personality Disorder	301.7/301.83	1	*Multifocal Leukoencephalopathy	46.3	2
			Developmental Delay	315	1	*Hemiplegia	342.11	2
			*Wheelchair Dependence	v46.3	1	*Blindness	369.XX	2
			Cirrhosis	571	1			
			Warfarin (Med List)		1			
			*Enoxaparin (Med List		1			
			5-9 Meds on med list		1	10 or More meds on list		2

[redacted]

At least annually, a report is run which assigns points to patients based on how many of the criteria the meet in the attached table. All patients scoring over 5 points are reveiwed by the Primary care team. The PCP has the ultimate authority to designate a patient as High Risk -- which we call "Enhanced Care". Once designated as such, the patient's chart is updated to reflect this status and allow reporting and tracking for care management.

Highlighted factors are related to behavioral health and substance abuse conditions which will add risk points to a patient's total score. Hospitalizations and ER use, regardless of the reason (medical or mental health related) would also increase a patietns

Questions

PCMH PRIME

Process

Updated PCMH PRIME Application Process

HPC PCMH PRIME Application

Submit an application to the Massachusetts Health Policy Commission, available at bit.ly/HPCPRIME.

NCQA PCMH Application & Survey

Practices submit NCQA applications and surveys through Q-PASS (https://qpass.ncqa.org).

No additional fee to practice for PCMH PRIME Certification

NCQA

Applying to PCMH PRIME through Q-PASS

Virtual Reviews

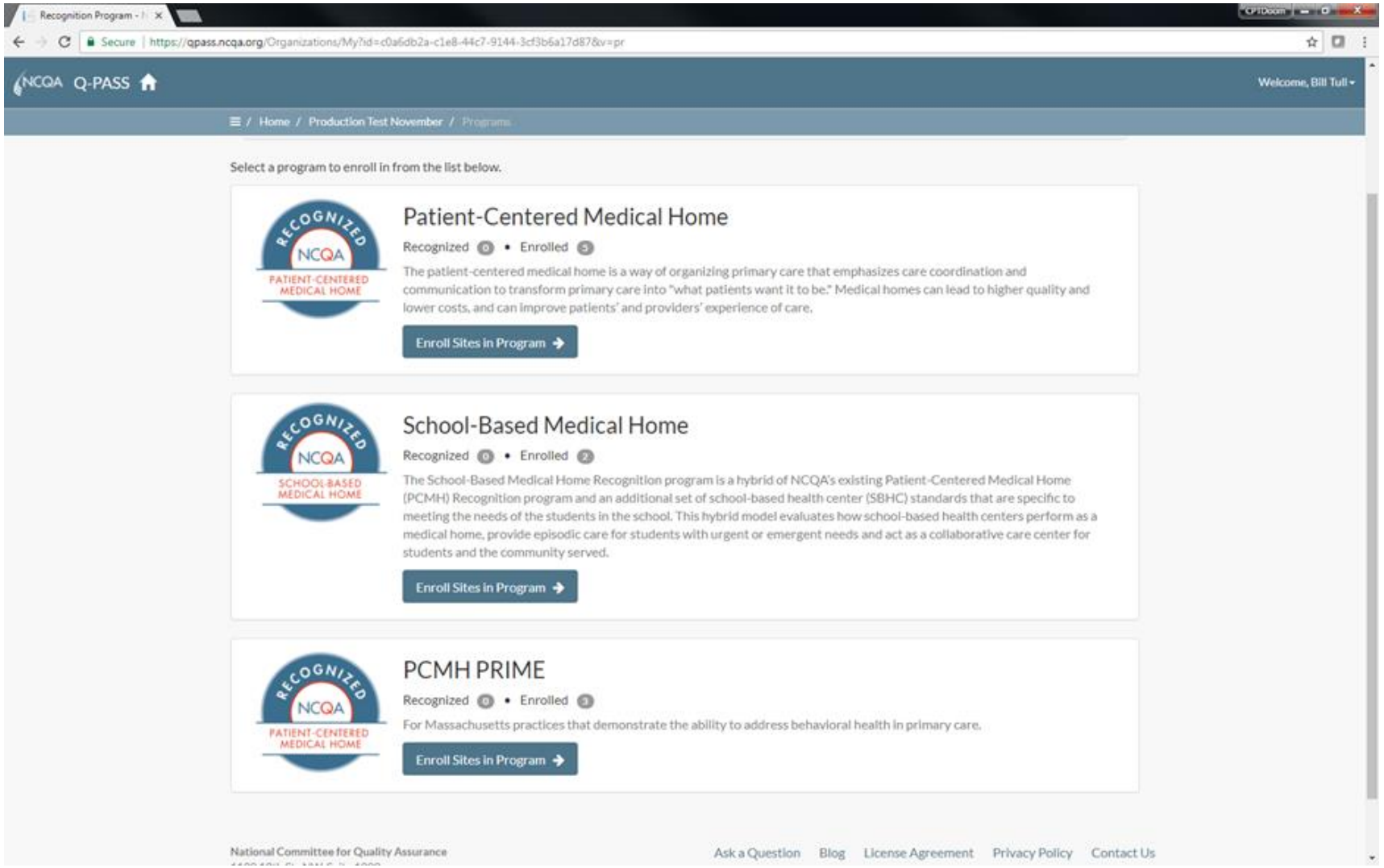
- Practices that seek 2017 PCMH Recognition and PCMH PRIME concurrently will have an integrated review process with NCQA, which may include both uploading documentation and going through NCQA's new "virtual review" process.
- Practices that seek PCMH PRIME separately from the PCMH Recognition process will submit documentation only, with no virtual reviews.

Transfer Credit

- 10 PCMH PRIME criteria align with 2017 PCMH Recognition criteria, and 9 align with criteria in the Behavioral Health Distinction module.
- Practices that successfully meet these criteria in one program (e.g. PCMH 2017) will receive full or partial credit for the aligned criteria in one or both of the other programs (e.g. PCMH PRIME and/or Behavioral Health Distinction).

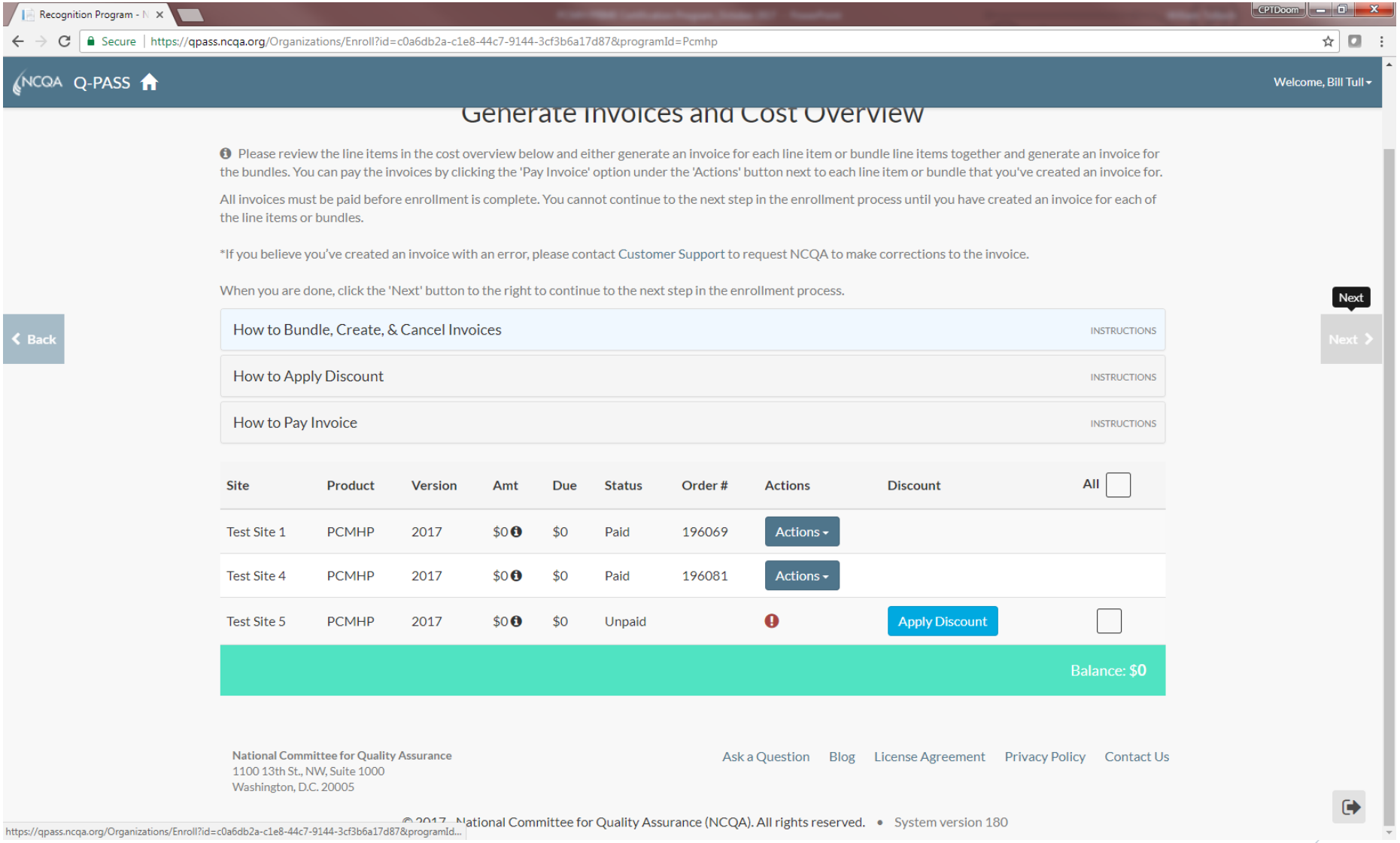
Q-PASS

Practices can choose to enroll in PCMH and PCMH PRIME together or separately



Q-PASS

No Cost to PCMH PRIME Program



Criteria Evidence Options

Q-PASS Documents

- Documents* (upload for off-site review)
- Weblinks
- Text

Virtual Review

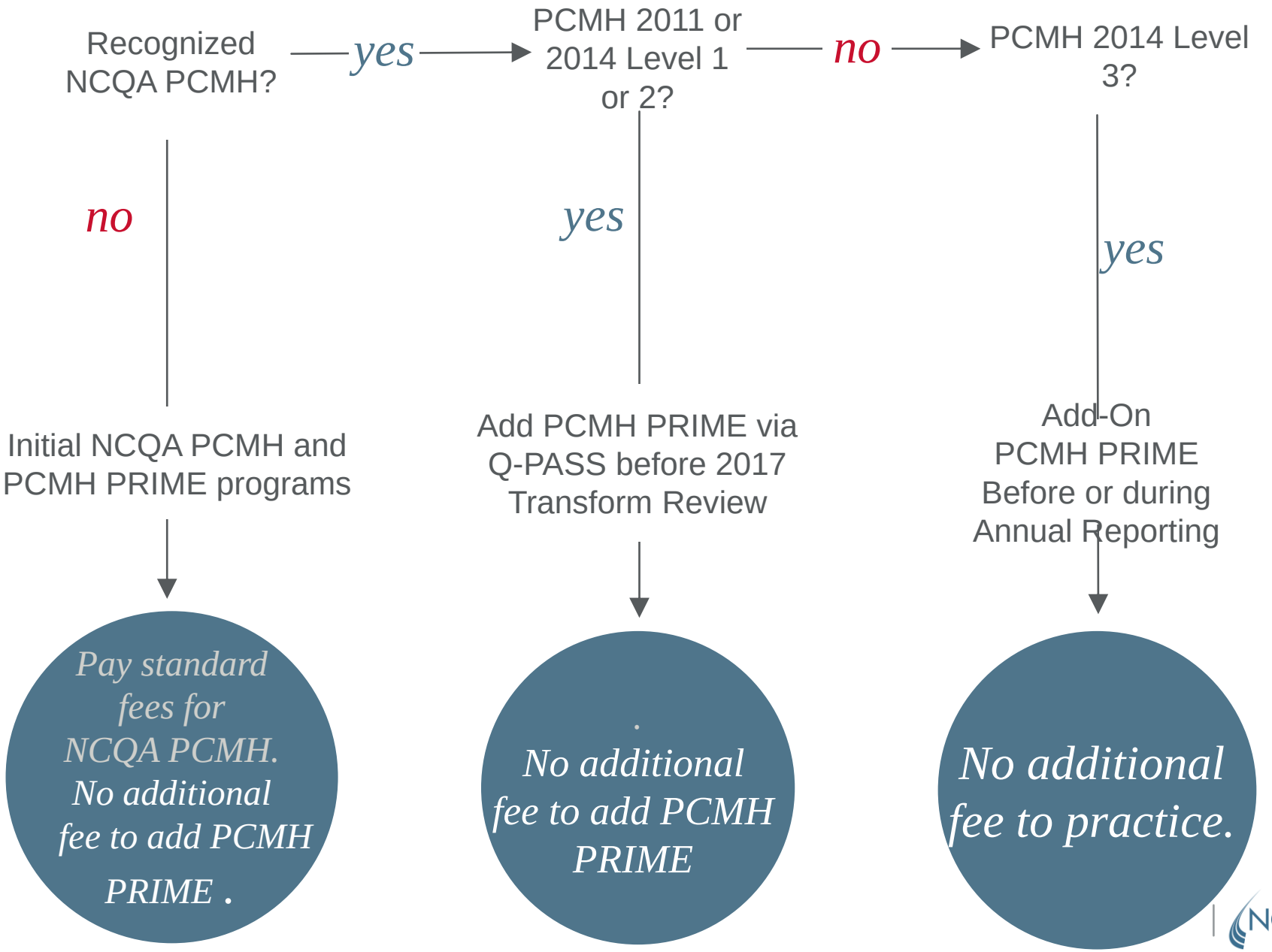
- Reports (create in advance)
- System demo
- Patient examples
- *Used when applying for PCMH and PCMH PRIME together*

Either Option

- Practice decision*

*All PHI should be removed from documents uploaded in Q-PASS

Pathways & Cost



Recognition Review Process

NCQA's Role

- **NCQA evaluates the responses and documentation in Q-PASS as well as evidence shared during virtual check-ins by**
  - Reviewer – initial evaluation
  - Executive reviewer – NCQA PCMH managers
  - Peer review – Recognition Program Review Oversight Committee member (RP-ROC)
- **NCQA checks licensure of all clinicians for restrictions**
- **For NCQA PCMH, status after core and elective criteria met by 3rd check-in**
- **For PCMH PRIME, NCQA reports review results to HPC within 30-45 calendar days**

PCMH PRIME Certification Review Process

HPC's Role

1	2	3	4	5
NCQA sends PCMH PRIME data feed to HPC.	**HPC makes final scoring** determination for PCMH PRIME based on NCQA's review.	**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 – no scores.)	**HPC sends PCMH PRIME certification materials to practices.**

Questions

Thank you