Purpose of this Seminar

- Examine the essential characteristics of a Recognized Patient-Centered Medical Home
- Identify the measurement and documentation criteria for each of NCQA’s updated requirements
- Facilitate the NCQA survey and evaluation process
Learning Objectives

• Review and discuss sample submissions for PCMH Recognition including documentation that does and does not meet the requirements

• Discuss:
  – Scoring for each element
  – Strategies to enhance and improve valid content
  – Clarify application process for becoming a Recognized patient-centered medical home

• Identify components that challenge and facilitate the survey, evaluation and submission process in a variety of practice environments
National Committee for Quality Assurance (NCQA)

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

MISSION

To improve the quality of health care.

VISION

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

ILLUSTRATIVE PROGRAMS

* HEDIS® – Healthcare Effectiveness Data and Information Set
  * Health Plan Accreditation  * Clinician Recognition
  * Disease Management Accreditation  * Wellness & Health Promotion Accreditation
  * Quality Compass™
NCQA RECOGNITION PROGRAMS

• > 34,969 Clinician Recognitions nationally across all Recognition programs (as of 4/30/12)

• Clinical programs
  – Diabetes Recognition Program (DRP)
  – Heart/Stroke Recognition Program (HSRP)
  – Back Pain Recognition Program (BPRP)

• Practice process and structural measures
  – Physician Practice Connections (PPC) – includes specialty practices
  – Physician Practice Connections-Patient-Centered Medical Home (PPC-PCMH) 2008
  – NCQA Patient-Centered Medical Home (PCMH) 2011
NUMBER OF PPC-PCMH & PCMH CLINICIAN RECOGNITIONS BY STATE

20,768 PPC-PCMH CLINICIAN RECOGNITIONS

As of 5/31/12

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

Facilitating Patient-Centered Medical Home Recognition for OACHC
June 12, 2012
NUMBER OF PPC-PCMH & PCMH SITES BY STATE

*As of 05/31/12

4,302 PPC-PCMH SITES

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

Facilitating Patient-Centered Medical Home Recognition for OACHC
June 12, 2012
### PPC-PCMH/PCMH Practices*

**NUMBER OF CLINICIANS IN RECOGNIZED PRACTICES**

<table>
<thead>
<tr>
<th></th>
<th>1-2</th>
<th>3-7</th>
<th>8-9</th>
<th>10-19</th>
<th>20-50</th>
<th>50+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>439</td>
<td>366</td>
<td>59</td>
<td>76</td>
<td>14</td>
<td>2</td>
<td>956</td>
</tr>
<tr>
<td>Level 2</td>
<td>108</td>
<td>109</td>
<td>9</td>
<td>15</td>
<td>5</td>
<td>0</td>
<td>246</td>
</tr>
<tr>
<td>Level 3</td>
<td>1111</td>
<td>1365</td>
<td>205</td>
<td>264</td>
<td>70</td>
<td>3</td>
<td>3018</td>
</tr>
<tr>
<td>Total</td>
<td>1658</td>
<td>1840</td>
<td>273</td>
<td>355</td>
<td>89</td>
<td>5</td>
<td>4220</td>
</tr>
</tbody>
</table>

* As of 4/30/12
Federal Initiatives with NCQA’s PCMH

- **Military Health System - Military Treatment Facilities (MTF)**
  - Initially a PCMH self-assessment; then Recognition
  - 50 MTFs per year over 3 years
  - Includes: Internal Medicine, Family Practice, Pediatrics
# Federal Initiatives with NCQA’s PCMH

<table>
<thead>
<tr>
<th>HRSA Patient-Centered Medical Health Home Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Community Health Centers – for rural, underserved, often nurse-led practices</td>
</tr>
<tr>
<td>• Recognition costs and technical assistance</td>
</tr>
<tr>
<td>• Up to 500 Community Health Centers per year; 5 year contract</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CMS Advanced Primary Care Practice Demonstration</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Federally Qualified Health Centers (FQHCs)</td>
</tr>
<tr>
<td>• 500 FQHCs in 3-year</td>
</tr>
<tr>
<td>• Track progress toward being a Medical Home with reassessments every 6 mo.</td>
</tr>
<tr>
<td>• CMS reimburses for managing Medicare beneficiaries</td>
</tr>
</tbody>
</table>
Getting to PCMH 2011

- **2003**: Physician Practice Connections ("private label" program developed with Bridges to Excellence)
- **2006**: PPC standards updated and Recognition program launched
- **2008**: PPC – PCMH Recognition program launched
- **2011**: PCMH 2011 released
# Theoretical Frameworks Informing Development

<table>
<thead>
<tr>
<th>Chronic Care Model</th>
<th>Patient Centered Care</th>
<th>Cultural Competence</th>
<th>Medical Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Clinical information Systems</td>
<td>• Respect Patient Values</td>
<td>• Culturally competent interactions</td>
<td>• Personal physician</td>
</tr>
<tr>
<td>• Decision Support</td>
<td>• Accessible</td>
<td>• Language services</td>
<td>• Physician directed team</td>
</tr>
<tr>
<td>• Patient Self-Management</td>
<td>• Family-Centered</td>
<td>• Reducing disparities</td>
<td>• Whole person orientation</td>
</tr>
<tr>
<td>• Delivery System Redesign</td>
<td>• Continuous</td>
<td></td>
<td>• Care is coordinated and</td>
</tr>
<tr>
<td>• Community Linkages</td>
<td>• Coordinated</td>
<td></td>
<td>integrated</td>
</tr>
<tr>
<td>• Health Systems</td>
<td>• Community Linkages</td>
<td></td>
<td>• Quality and safety</td>
</tr>
<tr>
<td></td>
<td>• Compassionate</td>
<td></td>
<td>• Enhanced access</td>
</tr>
<tr>
<td></td>
<td>• Culturally Appropriate</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Emotional Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Information and Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Physical Comfort</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Quality Improvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PCMH Development History

- Based on a systematic approach to delivering preventive and chronic care (Wagner Chronic Care Model)
- Built on IOM’s recommendation to shift from “blaming” individual clinicians to improving systems
- Identified measures actionable at the practice level
- Validated measures by relating them to clinical performance and patient experience results
- Incorporated the Joint Principles into PPC-PCMH:
  - Whole-person focus
  - Coordinated, integrated, comprehensive care
  - Personal clinician, team-based care
Opportunities for Improvement

Current challenges confronting primary care

- Emergency room visits increased by 36% between 1996 and 2006; 47% of ED visits could have occurred in a physician’s office.1,2

- 20% of patients are re-admitted within 30 days of hospitalization, most of which are avoidable

- 50% of patients that are re-admitted do not see a physician after their first hospitalization

- 75% of health care spending is for patients with chronic diseases

- Over two years, the typical Medicare patient sees 2 different primary care doctors and 5 different specialists

- Millions of additional Americans will enter the primary care system with healthcare reform

Source: Nace, D. iHT2 Conference Proceedings. May 12, 2010
Published and Ongoing Research on PCMH

- Improved patient experience
- Reduced clinician burnout
- Reduced hospitalization rates
- Reduce ER visits
- Increase savings per patient
- Higher quality of care
- Reduced cost of care
Published and Ongoing Research on PCMH

- **Medicaid Pilots**: Improved access to care, reduced PMPM/PMPY costs, decreased ER and inpatient utilization, greater use of evidence-based primary care\(^1\)

- **Access to care** through visits outside of regular hours and same day access shown to reduce emergency department use\(^2\)

---


Medicaid PCMH Pilots: Early Results

- **Oklahoma** (Medicaid-wide): $29 reduced per patient per year costs, increased access, increased use of evidence-based primary care, increased patient satisfaction

- **Colorado** (Medicaid and CHIP): Large increase in access and patient satisfaction, decreased per patient per year costs

- **Vermont** (Blueprint for Health): Decreased inpatient and ER utilization, decreased PMPM costs

Takach, *Health Affairs*, July 2011 (1325-1334)
North Carolina (NC) Medicaid PCMH Pilots

- NC medical homes improved care/lowered costs since 1991
- Affordable Care Act offered pay 90% of costs for two years
- Medicaid patients in a medical home:
  - Received better care
  - Used fewer state dollars
  - Used improved communication with patients
- Primary care practices receive per patient month fee for coordinating patients’ care; in some cases, practices also receive bonuses based on clinical outcomes

Christine Vestal: Medical homes saved North Carolina nearly $1 billion, Stateline, 12/30/11
North Carolina Medicaid PCMH Pilots (cont.)

- **Avoided spending** $984 million by placing 1.1 million Medicaid enrollees in medical homes (2007-2010)
- **Annual cost reductions increased**:
  - $103 million saved in 2007
  - $204 million in 2008
  - $295 million in 2009
  - $382 million in 2010
- **Short term results**: more frequent office visits and treatment of newly diagnosed conditions
- **Long term results**: fewer emergency room visits and hospital admissions; more efficient and improved care resulted in better health and sizeable savings

Christine Vestal: Medical homes saved North Carolina nearly $1 billion, Stateline, 12/30/11
Common Features in PCMH

Common features in demonstrations:

- Dedicated care managers
- Expanded access
- Data-driven analytic tools
- Use of incentives

Source: Fields, et al. 2010
How NCQA Revised its PCMH Standards

• Collected, analyzed stakeholder suggestions
• Analyzed data from NCQA PCMH practices
• Conducted patient experience research
• Sought public comment
• Interviewed NCQA PCMH practices
• Worked closely with thoughtful, committed PCMH Advisory Committee
PCMH 2011 Development Goals

• Increase patient-centeredness
• Align requirements with processes that improve quality and eliminate waste
• Increase emphasis on patient experience
• Enhance use of clinical performance measure results
• Integrate: unhealthy behaviors, mental health and substance abuse
• Enhance coordination of care
• Enhance applicability to pediatric practices
# 2011 PCMH Content and Scoring

## Standard 1: Enhance Access and Continuity

| A. Access During Office Hours** | 4 |
| B. After-Hours Access | 4 |
| C. Electronic Access | 2 |
| D. Continuity | 2 |
| E. Medical Home Responsibilities | 2 |
| F. Culturally and Linguistically Appropriate Services | 2 |
| G. Practice Team | 4 |

**Total: 20 Points**

## Standard 2: Identify and Manage Patient Populations

| A. Patient Information | 3 |
| B. Clinical Data | 4 |
| C. Comprehensive Health Assessment | 4 |
| D. Use Data for Population Management** | 5 |

**Total: 16 Points**

## Standard 3: Plan and Manage Care

| A. Implement Evidence-Based Guidelines | 4 |
| B. Identify High-Risk Patients | 3 |
| C. Care Management** | 4 |
| D. Medication Management | 3 |
| E. Use Electronic Prescribing | 3 |

**Total: 17 Points**

## Standard 4: Provide Self-Care Support and Community Resources

| A. Support Self-Care Process** | 6 |
| B. Provide Referrals to Community Resources | 3 |

**Total: 9 Points**

## Standard 5: Track and Coordinate Care

| A. Test Tracking and Follow-Up | 6 |
| B. Referral Tracking and Follow-Up** | 6 |
| C. Coordinate with Facilities/Care Transitions | 6 |

**Total: 18 Points**

## Standard 6: Measure and Improve Performance

| A. Measure Performance | 4 |
| B. Measure Patient/Family Experience | 4 |
| C. Implement Continuously Quality Improvement** | 4 |
| D. Demonstrate Continuous Quality Improvement | 3 |
| E. Report Performance | 3 |
| F. Report Data Externally | 2 |
| G. Use of Certified EHR Technology | 0 |

**Total: 20 Points**

**Must Pass Elements**
## PCMH Scoring

6 standards = 100 points

**6 Must Pass** elements

**NOTE:** Must Pass elements require a $\geq 50\%$ performance level to pass

<table>
<thead>
<tr>
<th>Level of Qualifying</th>
<th>Points</th>
<th>Must Pass Elements at 50% Performance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 3</td>
<td>85 - 100</td>
<td>6 of 6</td>
</tr>
<tr>
<td>Level 2</td>
<td>60 - 84</td>
<td>6 of 6</td>
</tr>
<tr>
<td>Level 1</td>
<td>35 - 59</td>
<td>6 of 6</td>
</tr>
<tr>
<td>Not Recognized</td>
<td>0 - 34</td>
<td>&lt; 6</td>
</tr>
</tbody>
</table>

Practices with a numeric score of 0 to 34 points and/or achieve less than 6 “Must Pass” Elements are not Recognized.
Stage 1 Meaningful Use

- Congress enacted the American Recovery & Reinvestment Act (ARRA) with subsection on Health Information Technology for Economic and Clinical Health Act (HITECH)
- Provides incentives for using health information technology to improve quality for Meaningful Use [MU]
  - https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use#BOOKMARK4
  - Medicare incentives – federal
  - Medicaid incentives - state

- Data Requirements
  - Core Set - practice must meet all 15 requirements
  - Menu Set - practice must meet 5 of 10 requirements including submitting immunization data or surveillance data
  - Clinical quality measures – 4 core, 3 optional
  - Certified EHR with security analysis
Meaningful Use of Health Information Technology (HIT)

- NCQA emphasizes HIT because good primary care is information-intensive
- PCMH 2011 reinforces incentives to use HIT to improve quality
- Meaningful use language is embedded, often verbatim, in PCMH 2011 evaluation standards
- Synergy: PCMH 2011 medical practices will be well prepared to qualify for meaningful use, and vice versa
### Meaningful Use & NCQA Requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Meaningful Use</th>
<th>NCQA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certified EHR</td>
<td>Required</td>
<td>Not required</td>
</tr>
<tr>
<td>Unit of measurement</td>
<td>Clinician</td>
<td>Practice</td>
</tr>
<tr>
<td>Reporting period</td>
<td>12 months</td>
<td>12 months if EHR has been in place for &gt; than one year; if not, 3 months</td>
</tr>
<tr>
<td>Calendar year reporting</td>
<td>Required</td>
<td>Not required</td>
</tr>
</tbody>
</table>
ACOs and PCMH 2011: NCQA’s Perspective

• ACOs are provider organizations accountable for quality and costs of care for a defined population
• Patient-centered medical homes are the foundation of ACOs
ACOs and PCMH 2011: NCQA’s Perspective

• Concepts and standards from PCMH 2011 are integrated into ACO Criteria
  – ACO patient-centered capabilities
    • Support patient-centered care in medical home
    • Provide resources to other providers in system to support patient-centered care
  – Primary care capabilities
    • Medical home functions
PCMH 2011: In Summary

- The bar has been raised, requirements remain achievable
- Increased emphasis on patient centeredness, patient experience, whole person care, and improving quality
- Three levels of Recognition; point thresholds increased
- 6 must pass elements apply to each Recognition level
- Aligned with Meaningful Use
PCMH Recognition Process Overview
Eligible Applicants for Recognition as a Patient-Centered Medical Home

• NCQA Recognizes outpatient primary care practices that meet the scoring criteria for Level 1, 2, or 3 as assessed against the Patient-Centered Medical Home (PCMH) requirements.

• NCQA defines a practice as a clinician or clinicians practicing together at a single geographic location, includes nurse-led practices in states where state licensing designates NPs as independent practitioners.
Eligible Applicants for Recognition as a Patient-Centered Medical Home

- **PCMH Recognition** identifies primary care clinicians practicing at the site, including nurse practitioners and physicians’ assistants that can be designated as a patient’s personal clinician (with their own panel of patients)

- Recognition is at the practice-site level
The NCQA PCMH Recognition Process

Practice:

1. Obtains PCMH 2011 Standards and Guidelines
2. Participates in NCQA trainings
3. Obtains Survey Tool and online application account
4. Self-assesses current performance on survey
The NCQA PCMH Recognition Process

5. Completes online application information: electronic agreements, practice site, clinician details, and application for survey

6. Submits application

7. Receives email confirmation that practice can submit Survey Tool and documentation

8. Submits Survey Tool and application fee when ready
Practice Needs for PCMH Survey Process

1. **Computer system** with:
   - Email
   - Internet access
   - Microsoft Word
   - Microsoft Excel
   - Adobe Acrobat Reader (available for free online)

2. **Staff skill** in using above listed computer systems and ...

3. **Access to the electronic systems** used by the practice, e.g. billing system, registry, practice management system, electronic prescription system, EHR, Web portal, etc.
Components of a Standard

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

**Standard Title And Statement**

PCMH 1: Enhance Access and Continuity

The practice provides access to culturally and linguistically appropriate routine care and urgent team-based care that meets the needs of patients/families.

**Element A: Access During Office Hours**

**MUST PASS**

The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:

1. Providing same-day appointments
2. Providing timely clinical advice by telephone during office hours
3. Providing timely clinical advice by secure electronic messages during office hours
4. Documenting clinical advice in the medical record.

**Element Score = 4**

**Factor:** Item in an element that is scored

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

**Explanation:** Guidance for demonstrating performance against an element

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

**Types:** documented process, reports, materials, patient records

**NCQA**

Measuring quality, improving health care.

Facilitating Patient-Centered Medical Home Recognition for OACHC

June 12, 2012
Must Pass Elements

Rationale for Must Pass Elements

• Identifies critical concepts of PCMH
• Helps focus Level 1 practices on most important aspects of PCMH
• Guides practices in PCMH evolution and continuous quality improvement
• Standardizes “Recognition”

Critical Factors

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

• **Important conditions**
  Chronic or recurring condition that a practice manages with evidence-based guidelines including one unhealthy behavior (e.g. smoking, obesity), mental health (e.g. depression, anxiety, ADHD, ADD) or substance abuse (e.g. alcohol, Rx drugs, illegal drugs)
  - **Adults**: diabetes or congestive heart failure, hypertension, COPD, obesity, depression
  - **Pediatrics**: asthma, eczema, allergic rhinitis, otitis media, ADHD, obesity, well-child care (one age cohort)

• **Used in 3 PCMH elements (3C, 3D, 4A)**
Definitions

• **May not use for important conditions:** screenings such as mammograms, immunizations, treatments such as anti-thrombotic therapy, or physical exams

• **High risk patients:** Patients in a practice with high resource use and risk, including high frequency of visits, hospitalizations, ER visits, treatments, multiple co-morbid conditions, non-compliance with treatment, children with special needs
Documentation

1. **Documented process**  Written procedures, protocols, processes, workflow forms (not explanations)
2. **Reports**  Aggregated data showing evidence
3. **Records or files**  Patient files or registry entries documenting action taken; data from medical record for review of patients with important conditions
4. **Materials**  Information for patients or clinicians, e.g. clinical guidelines, self-management and educational resources
5. **Screen shots**  Electronic “copy” may be used as examples (EHR capability), materials (Web site resources) or records; helps to show specific to the practice and not a vendor demo page
Discuss and Analyze the PCMH Recognition Requirements
PCMH 6: Measure and Improve Performance

Intent of Standard

• Measure preventive, chronic and acute care; utilization affecting costs; patient experience and report performance
• Use and monitor effectiveness of quality improvement process

Meaningful Use Criteria Report:

• Ambulatory quality measures to CMS
• Immunization data to registries
• Syndromic surveillance data to public health agencies
PCMH 6: Measure and Improve Performance

Elements

- PCMH6A: Measure Performance
- PCMH6B: Measure Patient/Family Experience
- PCMH6C: Implement Continuous Quality Improvement — **MUST PASS**
- PCMH6D: Demonstrate Continuous Quality Improvement
- PCMH6E: Report Performance
- PCMH6F: Report Data Externally
- PCMH6G: Use Certified EHR Technology
PCMH 6A: Measure Performance

Practice measures or receives the following data:

1. Three (3) preventive care measures
2. Three (3) chronic or acute care measures
3. Two (2) utilization measures affecting health care costs
4. Vulnerable population data
Vulnerable Populations Defined

“Those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability.”

Source: AHRQ
PCMH 6A: Scoring and Documentation

• 4 Points
• Scoring
  – 4 factors = 100%
  – 2-3 factors = 75%
  – 1 factor = 25%
  – 0 factors = 0%
• Documentation
  – F1-4: Reports showing performance
PCMH 6A: Example Chronic Care Clinical Measures

7. Control of lipids in diabetic patients

a. Percentage of patients with LDL $<100$ (desired range of control)

<table>
<thead>
<tr>
<th>QTR</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 04</td>
<td>41%</td>
<td>60%</td>
</tr>
<tr>
<td>Q2 04</td>
<td>42%</td>
<td>60%</td>
</tr>
<tr>
<td>Q3 04</td>
<td>44%</td>
<td>60%</td>
</tr>
<tr>
<td>Q4 04</td>
<td>45%</td>
<td>60%</td>
</tr>
<tr>
<td>Q1 05</td>
<td>45%</td>
<td>60%</td>
</tr>
<tr>
<td>Q2 05</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Q3 05</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Q4 05</td>
<td>60%</td>
<td>60%</td>
</tr>
</tbody>
</table>

b. Percentage of patients with LDL $<130$ (minimum desired range of control)

<table>
<thead>
<tr>
<th>QTR</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2 03</td>
<td>61%</td>
<td>80%</td>
</tr>
<tr>
<td>Q3 03</td>
<td>63%</td>
<td>80%</td>
</tr>
<tr>
<td>Q4 03</td>
<td>65%</td>
<td>80%</td>
</tr>
<tr>
<td>Q1 04</td>
<td>65%</td>
<td>80%</td>
</tr>
<tr>
<td>Q2 04</td>
<td>64%</td>
<td>80%</td>
</tr>
<tr>
<td>Q3 04</td>
<td>65%</td>
<td>80%</td>
</tr>
<tr>
<td>Q4 04</td>
<td>65%</td>
<td>80%</td>
</tr>
<tr>
<td>Q1 05</td>
<td>65%</td>
<td>80%</td>
</tr>
</tbody>
</table>
NCQA Clinical Program Recognition
Where Can it Be Used to Meet Elements?

- **NCQA Clinical Recognition Programs**
  - Diabetes Recognition Program (DRP)
  - Heart/Stroke Recognition Program (HSRP)

- **Credit for Clinical Program Recognition may be used for meeting some requirements in 7 elements if 75% of clinicians are Recognized:**
  - PCMH 3A, 3C (each factor or patient in chart review with condition matching the Recognition program)
  - PCMH 6A Factor 2, 6C Factor 1, 6D Factor 1 (if renewed), 6E Factors 1 and 3 for Element A portion, 6F Factor 2
NCQA Clinical Program Recognition
Where Can it Be Documented to Meet Elements?

Recognized Clinicians

Please list the clinicians at the practice that are recognized in other NCQA programs and provide the Clinician Last Name, Program (DRP, HSRP, BPRP), Recognition Expiration Date.

Example:

- Smith, DRP, 8/10/12
- Robinson, HSRP/DRP, 2/25/11

[Attach Document]
PCMH 6A: Example Measures Affecting Health Care Costs

PCMH 6 ELEMENT A: Factor 3
Care Managers receive referrals from PCP'S, Hospitalists, Social Workers or family members requesting evaluation for patients to be treated at an alternative level of care (home, SNF) or in the office. The team has had a 22% success rate in saving hospital admissions since Nov 2007.

CARE MANAGEMENT ACTIVITIES

2011 JANUARY - MAY

<table>
<thead>
<tr>
<th>TOTAL CM REFERRALS / SAVED ADMISSIONS</th>
<th>2011</th>
<th>2011</th>
<th>2011</th>
<th>2011</th>
<th>2011</th>
<th>TOTAL TO DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>JAN</td>
<td>220</td>
<td>202</td>
<td>299</td>
<td>221</td>
<td>219</td>
<td>1161</td>
</tr>
<tr>
<td>FEB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MARCH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APRIL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL CM REFERRALS</td>
<td>220</td>
<td>202</td>
<td>299</td>
<td>221</td>
<td>219</td>
<td>1161</td>
</tr>
<tr>
<td>SAVED ADMISSIONS</td>
<td>57</td>
<td>53</td>
<td>55</td>
<td>49</td>
<td>57</td>
<td>271</td>
</tr>
<tr>
<td>FAILED ATTEMPTS</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>20</td>
</tr>
</tbody>
</table>
### PCMH 6A: Example Factor 4

**Data for Vulnerable Populations**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th># of pts by race</th>
<th>total # of pts</th>
<th>% of pts</th>
<th># of pts with A1C done by race</th>
<th>total # of pts with A1C</th>
<th>% of pts with A1C</th>
<th># of pts with LDL done by race</th>
<th>total # of pts with LDL</th>
<th>% of pts with LDL</th>
<th># of pts with EYE EXAM done by race</th>
<th>total # of pts with EYE EXAM</th>
<th>% of pts with EYE EXAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>76</td>
<td>4271</td>
<td>1.78%</td>
<td>70</td>
<td>4271</td>
<td>1.64%</td>
<td>66</td>
<td>4271</td>
<td>1.55%</td>
<td>36</td>
<td>4271</td>
<td>0.84%</td>
</tr>
<tr>
<td>Black</td>
<td>1620</td>
<td>4271</td>
<td>37.93%</td>
<td>1528</td>
<td>4271</td>
<td>35.78%</td>
<td>1328</td>
<td>4271</td>
<td>31.09%</td>
<td>737</td>
<td>4271</td>
<td>17.26%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>2160</td>
<td>4271</td>
<td>50.57%</td>
<td>2017</td>
<td>4271</td>
<td>47.23%</td>
<td>1835</td>
<td>4271</td>
<td>42.96%</td>
<td>994</td>
<td>4271</td>
<td>23.27%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>58</td>
<td>4271</td>
<td>1.36%</td>
<td>51</td>
<td>4271</td>
<td>1.19%</td>
<td>46</td>
<td>4271</td>
<td>1.08%</td>
<td>17</td>
<td>4271</td>
<td>0.40%</td>
</tr>
<tr>
<td>Other</td>
<td>77</td>
<td>4271</td>
<td>1.80%</td>
<td>68</td>
<td>4271</td>
<td>1.59%</td>
<td>62</td>
<td>4271</td>
<td>1.45%</td>
<td>22</td>
<td>4271</td>
<td>0.52%</td>
</tr>
<tr>
<td>Unidentified</td>
<td>278</td>
<td>4271</td>
<td>6.51%</td>
<td>247</td>
<td>4271</td>
<td>5.78%</td>
<td>216</td>
<td>4271</td>
<td>5.06%</td>
<td>101</td>
<td>4271</td>
<td>2.36%</td>
</tr>
</tbody>
</table>
PCMH 6B: Measure Patient/Family Experience

Practice obtains feedback on patient experience with the practice and their care:

1. Practice conducts survey measuring experience on at least three (3) of the following: access, communication, coordination, whole-person care/self-management support
2. Practice uses CAHPS PCMH survey tool
3. Practice obtains feedback from vulnerable populations
4. Practice obtains feedback through qualitative means
Why Require CAHPS Patient-Centered Medical Home (PCMH)?

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

**Purpose:** Acknowledge practices that put in the extra effort to collect and report patient experience information in a standardized way

- Provides PCMH Recognized practices with Distinction
- Requires the CAHPS Patient-Centered Medical Home (PCMH) survey which assesses:
  - Access, Communication, Coordination, Whole person care/self-care management support
- Requires a standardized sampling approach
- Requires use of approved data collection methodologies
- Program details released in October 2011
- Submissions accepted in April and September 2012.
PCMH6B: Scoring and Documentation

• 4 Points
• Scoring
  – 4 factors = 100%
  – 3 factors = 75%
  – 2 factors = 50%
  – 1 factor = 25%
  – 0 factors = 0%

• Documentation
  – F1-4: Reports showing results of patient feedback
PCMH 6B: Example of Communications Questions for Patient Experience

10. In the last 12 months, how often did this doctor explain things in a way that was easy to understand?
   - Never
   - Sometimes
   - Usually
   - Always

11. In the last 12 months, how often did this doctor listen carefully to you?
   - Never
   - Sometimes
   - Usually
   - Always

12. In the last 12 months, did you talk with this doctor about any health problems or concerns?
   - Yes
   - No If No, go to Question 14

13. In the last 12 months, how often did this doctor give you easy to understand instructions about taking care of these health problems or concerns?
   - Never
   - Sometimes
   - Usually
   - Always
PCMH6B: Whole-person Care/Self-Management Support

Survey questions may relate to the following:

- Knowledge of patient as a person
- Life style changes
- Support for self-care/self-monitoring
- Shared decisions about health
- Patient ability to monitor their health
Patient Satisfaction Survey
This survey will be kept anonymous. Please answer honestly so we can improve our care and service to you. How would you rate the practice’s overall performance? Thank You.

1. Ability to obtain an appointment soon enough to meet your medical needs.
   - Excellent
   - Good
   - Fair
   - Poor

2. Courteous and professional treatment by Staff, Nurse Practitioners & Physicians.
   - Excellent
   - Good
   - Fair
   - Poor

3. In office wait time to see your Physician/Nurse Practitioner.
   - Excellent
   - Good
   - Fair
   - Poor

4. Did you understand your diagnosis and treatment instructions provided by your care team.
   - Excellent
   - Good
   - Fair
   - Poor

5. Overall satisfaction with care provided.
   - Excellent
   - Good
   - Fair
   - Poor

6. Availability of Chronic Disease Information, such as Diabetes, Asthma, etc.
   - Excellent
   - Good
   - Fair
   - Poor

- Survey includes questions on:
  - Access
  - Communication

- Sample survey not accepted
  - Needs data
**PCMH6B: Patient Experience Data**

<table>
<thead>
<tr>
<th>PCP</th>
<th>Q1* Access to Care</th>
<th>Q5* Waiting Time</th>
<th>Q7* Communication</th>
<th>Q8* Lab &amp; Test Results</th>
<th>Q9* Referrals</th>
<th>Q10* PCP Satisfaction</th>
<th>Q11* Office Staff Satisfaction</th>
<th>Q12* Recommend to family and friends</th>
<th>N/A</th>
<th>TOTAL SURVEYS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>52</td>
<td>0</td>
<td>50</td>
<td>2</td>
<td>50</td>
<td>2</td>
<td>32</td>
<td>20</td>
<td>29</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>30</td>
<td>0</td>
<td>27</td>
<td>1</td>
<td>29</td>
<td>1</td>
<td>18</td>
<td>12</td>
<td>17</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>48</td>
<td>0</td>
<td>46</td>
<td>1</td>
<td>48</td>
<td>0</td>
<td>28</td>
<td>19</td>
<td>20</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>69</td>
<td>0</td>
<td>67</td>
<td>2</td>
<td>66</td>
<td>1</td>
<td>34</td>
<td>30</td>
<td>30</td>
<td>39</td>
</tr>
</tbody>
</table>

Survey questions include:
- Access
- Communication
- Coordination

* indicates survey answers of “Strongly Agree” or “Agree” to indicated question
* indicates survey answers of “N/A” to indicated question
PCMH6B: Example Patient Experience Survey Results

Survey Questions:
1. Ability to obtain an appointment soon enough to meet your medical needs
2. Courteous and professional treatment by Staff, Nurse Practitioners & Physicians
3. Time waiting in the office to see your Physician/Nurse Practitioner
4. Did you understand your diagnosis and treatment instructions provided by your care team?
5. Overall satisfaction with care provided
6. Availability of Chronic Disease Information, such as High Blood Pressure, Diabetes, Asthma, etc.

Survey questions include:
- Access
- Communication
- NEEDS A THIRD CATEGORY
PCMH6C: Implement Continuous Quality Improvement

Practice uses ongoing quality improvement process:

1. Set goals and act to improve performance on three (3) measures from Element 6A
2. Set goals and act to improve performance on one (1) measure from Element 6B
3. Set goals and address at least one (1) identified disparity in care for vulnerable populations
4. Involve patients in QI teams or on the practice’s advisory council
PCMH 6C: Scoring and Documentation

• **Must Pass**

• **4 Points:**
  – 3-4 factors = 100%
  – 2 factors = 50%
  – 1 factor = 25%
  – 0 factors = 0%

• **Documentation**
  – F1-3: Report or completed PCMH Quality Measurement and Improvement Template
  – F4: Process demonstrating how it involves patients/families in QI teams or advisory council
## PCMH 6C: Quality Measurement and Improvement Template

**NCQA's Patient-Centered Medical Home (PCMH) 2011 Quality Measurement and Improvement Worksheet**

### How to Complete the Worksheet

These instructions are a guide for completing NCQA's PCMH Quality Measurement and Improvement Worksheet. The purpose of the worksheet is to assist organizations in understanding and outlining for NCQA the measures and quality improvement activities that are required in PCMH 6 Elements C and D. Please note that practices are not required to submit the worksheet as documentation for PCMH 6 Elements C and D—it is provided as an option. Practices may submit their own report detailing their quality improvement strategy. Directions for attaching the worksheet are provided on the next page. See PCMH 6 Elements A, B, C, and D for additional information.

<table>
<thead>
<tr>
<th>Column</th>
<th>Section</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Measure</td>
<td>Identify at least five (5) measures from PCMH 6 Elements A and B selected for your quality improvement strategy: at least three (3) clinical and/or utilization measures; at least one (1) patient/family experience measure; and at least one (1) measure focused on vulnerable populations.</td>
</tr>
<tr>
<td>B</td>
<td>Opportunity Identified</td>
<td>List the opportunity for improvement that you have identified for each measure and on which you have decided to take action. You may list more than one identified opportunity for improvement per measure, but are not required to do so.</td>
</tr>
<tr>
<td>C</td>
<td>Initial Performance</td>
<td>List the initial (or baseline) performance rate and measurement period for each identified opportunity. You may use rates from the reports provided in PCMH 6A and B. Provide the performance rate as a specific percentage or number.</td>
</tr>
<tr>
<td>D</td>
<td>Performance Goal (PCMH 6, Element C)</td>
<td>List at least one performance goal for each identified opportunity. Provide the goal as a specific percentage or number.</td>
</tr>
<tr>
<td>E</td>
<td>Action Taken and Date of Implementation (PCMH 6, Element C)</td>
<td>List at least one action that you have taken in response to the identified opportunity. Include the start date of the activity. You may list more than one activity but are not required to do so.</td>
</tr>
<tr>
<td>F</td>
<td>Performance at Re-measurement (PCMH 6, Element D)</td>
<td>List the measurement period and the performance rate after action was taken to improve the initial (or baseline) rate. The date must occur after the activity implementation date.</td>
</tr>
<tr>
<td>G</td>
<td>Demonstrated Improvement (PCMH 6, Element D)</td>
<td>Describe the baseline and remeasurement period, describe the interventions implemented, and describe the link between interventions the practice implemented and the resulting rate improvement.</td>
</tr>
</tbody>
</table>
Facilitating Patient-Centered Medical Home Recognition for OACHC

June 12, 2012

PCMH C and D: Quality Measurement and Improvement Worksheet

NCQA provided a breast cancer screening measure as a guide. Your practice information (to be entered below the example) does not have to exactly match the example. You may delete the example prior to submitting your worksheet.

<table>
<thead>
<tr>
<th>Measure (C)</th>
<th>Opportunity Identified (C)</th>
<th>Initial Performance/Measurement Period (C)</th>
<th>Performance Goal (C)</th>
<th>Action Taken and Date (D)</th>
<th>Re-measurement Performance (D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Breast Cancer Screening</td>
<td>Uninsured patients receive fewer mammograms than insured patients</td>
<td>01/09-01/10. 25% of uninsured women receive mammograms</td>
<td>50% of uninsured women receive mammograms</td>
<td>2/10: Identified community resources for free or low-cost mammograms and shared with uninsured patients</td>
<td>01/10-01/11. 40% of uninsured women receive mammograms</td>
</tr>
</tbody>
</table>

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

**EXAMPLE:**

<table>
<thead>
<tr>
<th>Performance Measures (Identified in 6A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disparity in care for vulnerable populations (Identified in 6A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient/Family Experience Measures (Identified in 6B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
</tbody>
</table>
**PCMH 6C: Example Quality Measurement and Improvement**

Breast Cancer Screening

<table>
<thead>
<tr>
<th>Measure</th>
<th>B. Opportunity Identified</th>
<th>C. Initial Performance/Measurement Period</th>
<th>D. Performance Goal</th>
<th>E. Action Taken/Date of Implementation</th>
<th>F. Performance at Remeasurement</th>
<th>G. Demonstrated Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>Uninsured patients receive fewer mammograms than insured patients</td>
<td>01/09-01/10: 25% of uninsured women receive mammograms</td>
<td>50% of uninsured women receive mammograms</td>
<td>01/10-01/11: 40% of uninsured women receive mammograms</td>
<td>During a one year measurement period from Jan 2009 to Jan 2010, there was a 30 percentage point difference in screening rates between insured and uninsured women. After compiling a list of community resources and sharing the information with our uninsured population, we saw a 15 percentage point increase in the number of uninsured women receiving mammograms during the re-measurement period of Jan 2010 to Jan 2011.</td>
<td></td>
</tr>
</tbody>
</table>
PCMH 6C Example of Goals for Vulnerable Populations

1. EQUITABLE
   - …whoever you are.
   - No inequality
   - **Aim Statement:**
   - Eliminate differences in clinical care & health status between racial, ethnic and socioeconomic groups

**Measure**
- “0” disparity by race for all effectiveness measures

2. ACCESSIBLE
   - We promote access to comprehensive health services to all in our service area, regardless of ability to pay.
   - No barriers to health care services for all who seek it
   - **Aim Statement:**
   - Serve 50% of our target populations

**Measure**
- Health center penetration rate for underserved/special populations in specified service areas
PCMH 6D: Demonstrate Continuous Quality Improvement

Practice demonstrates ongoing monitoring of the effectiveness of its improvement process:

1. Tracks results over time
2. Assesses effect of its actions
3. Achieves improved performance on one measure
4. Achieves improved performance on a second measure
PCMH 6D: Scoring and Documentation

• 3 Points:
  – 4 factors = 100%
  – 3 factors = 75%
  – 2 factors = 50%
  – 1 factor = 25%
  – 0 factors = 0%

• Documentation
  – F1-4: Reports showing measures over time, recognition results or completed Quality Measurement and Improvement Worksheet
NCQA provided a breast cancer screening measure as a guide. Your practice information (to be entered below the example) does not have to exactly match the example. You may delete the example prior to submitting your worksheet.

<table>
<thead>
<tr>
<th>Measure</th>
<th>B. Opportunity Identified</th>
<th>C. Initial Performance/Measurement Period</th>
<th>D. Performance Goal</th>
<th>E. Action Taken/Date of Implementation</th>
<th>F. Performance at Remeasurement</th>
<th>G. Demonstrated Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>Uninsured patients receive fewer mammograms than insured patients</td>
<td>01/09-01/10: 25% of uninsured women receive mammograms</td>
<td>50% of uninsured women receive mammograms</td>
<td>2/10: Identified community resources for free or low-cost mammograms and shared with uninsured patients</td>
<td>01/01-01/11: 40% of uninsured women receive mammograms</td>
<td>During a one year measurement period from Jan 2009 to Jan 2010, there was a 30 percentage point difference in screening rates between insured and uninsured women. After compiling a list of community resources and sharing the information with our uninsured population, we saw a 15 percentage point increase in the number of uninsured women receiving mammograms during the re-measurement period of Jan 2010 to Jan 2011</td>
</tr>
</tbody>
</table>
PCMH6D: Example Patient Survey Results Over Time
### PPC6D: Example Tracking Data Over Time

<table>
<thead>
<tr>
<th></th>
<th>Mar-09</th>
<th>Feb-09</th>
<th>Jan-09</th>
<th>Dec-08</th>
<th>Nov-08</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumovax</td>
<td>61.31</td>
<td>61.21</td>
<td>52.25</td>
<td>61.39</td>
<td>60.95</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HgA1c</td>
<td>73.39</td>
<td>73.48</td>
<td>74.12</td>
<td>74.11</td>
<td>71.54</td>
</tr>
<tr>
<td><strong>CHF</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CAD</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antihyperlipidemic</td>
<td>99.07</td>
<td>99.05</td>
<td>96.86</td>
<td>98.67</td>
<td>98.87</td>
</tr>
</tbody>
</table>
PCMH 6E: Report Performance

Practice shares data from Element A and B:

1. Individual clinician results within the practice
2. Practice results within the practice
3. Individual clinician or practice results to patients or public
PCMH 6E: Scoring and Documentation

• 3 Points:
  – 3 factors = 100%
  – 2 factors = 75%
  – 1 factors = 50%
  – 0 factors = 0%

• Documentation
  – F1 and 2: Reports (blinded) showing summary data by clinician and across the practice shared with the practice and how the results are shared
  – F3: Example of reporting to patients or the public
PCMH 6E: Example Reporting by Clinician

Blinded 6 Clinicians

<table>
<thead>
<tr>
<th>Clinician</th>
<th>Diabetes A1c Control</th>
<th>Percent in each range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legend:
- A1C >= 9
- A1C 7.9
- A1C <= 7
- No A1C
### Practice-Level Quality Performance Indicators

#### Current Quarter Site Comparison

<table>
<thead>
<tr>
<th>QUALITY MEASURE</th>
<th>%VG</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM - Diabetic Eye Exam</td>
<td></td>
</tr>
<tr>
<td>% of Patients Screened (Sites Only) within the Past Year</td>
<td>54%</td>
</tr>
<tr>
<td></td>
<td>54%</td>
</tr>
<tr>
<td>DM - HbA1c</td>
<td></td>
</tr>
<tr>
<td>% of Patients Screened within the Past Year</td>
<td>84%</td>
</tr>
<tr>
<td></td>
<td>83%</td>
</tr>
<tr>
<td>DM - HbA1c - Level of Control - &lt;7.0%</td>
<td></td>
</tr>
<tr>
<td>% of Tested Patients with Lab Results &lt;7.0%</td>
<td>45%</td>
</tr>
<tr>
<td></td>
<td>41%</td>
</tr>
<tr>
<td>DM - HbA1c - Level of Control - &gt;9.0%</td>
<td></td>
</tr>
<tr>
<td>% of Tested Patients with Lab Results &gt;9.0%</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
</tr>
</tbody>
</table>

* Shows data for multiple sites
**PCMH6E: Example Practice Level Diabetes Data**

Show data for

<table>
<thead>
<tr>
<th>Metric</th>
<th>Goal</th>
<th>May-08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count of DM patients 18-75 yo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pct of DM patients with latest LDL &lt;100</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Pct DM pts w/ smoking cessation counseling</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Pct of DM patients with latest A1C &lt;=7</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Pct of DM patients with &gt;=1 LDL tests</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Pct of DM patients with foot exam</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Pct of DM patients aged 40-75 on aspirin</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td>Pct of DM patients with latest BP &lt;=130/80</td>
<td></td>
<td>95</td>
</tr>
<tr>
<td>Pct of DM patients with eye exam</td>
<td></td>
<td>80</td>
</tr>
<tr>
<td>Pct DM pts w/ medical attention for nephropathy</td>
<td></td>
<td>90</td>
</tr>
<tr>
<td>Pct of DM patients with latest BP &lt;=140/90</td>
<td></td>
<td>90</td>
</tr>
<tr>
<td>Pct of DM patients with latest LDL &lt;=130</td>
<td></td>
<td>90</td>
</tr>
<tr>
<td>Pct of DM patients with current flu vaccination</td>
<td></td>
<td>75</td>
</tr>
<tr>
<td>Pct of DM patients with SM Goal</td>
<td></td>
<td>90</td>
</tr>
</tbody>
</table>
### PCMH6E: Example by Clinician

<table>
<thead>
<tr>
<th>Current Report Month</th>
<th>PCMH6E: Example by Clinician</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report Period</strong></td>
<td><strong>Count of DM patients 18-75 yo</strong></td>
</tr>
<tr>
<td>Report Period</td>
<td>44</td>
</tr>
<tr>
<td>Report Period</td>
<td>46</td>
</tr>
<tr>
<td>Report Period</td>
<td>46</td>
</tr>
<tr>
<td>Report Period</td>
<td>47</td>
</tr>
<tr>
<td>Report Period</td>
<td>47</td>
</tr>
<tr>
<td>Report Period</td>
<td>48</td>
</tr>
<tr>
<td>Report Period</td>
<td>52</td>
</tr>
<tr>
<td>Report Period</td>
<td>53</td>
</tr>
<tr>
<td>Report Period</td>
<td>53</td>
</tr>
<tr>
<td>Report Period</td>
<td>53</td>
</tr>
<tr>
<td>Report Period</td>
<td>46</td>
</tr>
<tr>
<td>Report Period</td>
<td>41</td>
</tr>
<tr>
<td>Report Period</td>
<td>41</td>
</tr>
</tbody>
</table>
PCMH 6F: Report Data Externally

Practice electronically reports:

1. Ambulatory clinical quality measures to CMS or states*
2. Ambulatory clinical quality measures to other external entities
3. Data to immunization registries or systems**
4. Syndromic surveillance data to public health agencies**

*Core Meaningful Use Requirement
**Menu Meaningful Use Requirement
PCMH 6F: Scoring and Documentation

• **2 Points:**
  – 3-4 factors = 100%
  – 2 factors = 75%
  – 1 factor = 50%
  – 0 factors = 0%

• **Documentation**
  – **F1 and 2:** Reports demonstrating data submission
  – **F3 and 4:** Reports demonstrating data submission or screen shot showing capability was tested
Facilitating Patient-Centered Medical Home Recognition for OACHC

PCMH 6F: Example of External Reporting
Facilitating Patient-Centered Medical Home Recognition for OACHC  
June 12, 2012  

PCMH 6F: Example of Syndromic Surveillance Data Reporting

<table>
<thead>
<tr>
<th>Grantee Name</th>
<th>Funding Stream</th>
<th>UDS Tracking No./Version No.</th>
<th>Reporting Year</th>
<th>UDS No.</th>
<th>Submitted Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Uniform Data System (UDS) Report**

**TABLE 6A: SELECTED DIAGNOSES AND SERVICES RENDERED - UNIVERSAL**

<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>Applicable ICD - 9 - CM Code</th>
<th>Number of Visits by Primary Diagnosis (a)</th>
<th>Number of Patients with Primary Diagnosis (b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selected Infectious and Parasitic Diseases</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Symptomatic HIV</td>
<td>042.xx, 079.53</td>
<td>92</td>
<td>24</td>
</tr>
<tr>
<td>2. Asymptomatic HIV</td>
<td>V08</td>
<td>324</td>
<td>55</td>
</tr>
<tr>
<td>3. Tuberculosis</td>
<td>010.xx - 018.xx</td>
<td>31</td>
<td>29</td>
</tr>
<tr>
<td>4. Syphilis and other venereal Diseases</td>
<td>090.xx-099.xx</td>
<td>488</td>
<td>395</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PCMH 6G: Use of Certified EHR Technology

To meet federal Core and Menu Meaningful Use requirements the practice:

1. Uses an EHR that has been certified and issued a Certified HIT Products List (CHPL) Number under ONC HIT certification program*

2. Attests to conducting a security risk analysis of its EHR and implementing security updates or resolving deficiencies*

*Core Meaningful Use Requirement
PCMH 6G: Scoring and Documentation

• 0 Points

• Documentation
  – F1: CHPL Number(s) entered in survey tool text box
  – F2: Entering “yes” in the survey tool is attestation to the appropriate security analysis and updates
Questions?