NCQA Standards Workshop
Patient-Centered Medical Home
PCMH 2011

Part 1: Standards 1 - 3
Agenda: Part 1

- Patient-Centered Medical Home Overview
- Content of PCMH 2011
  - Standards 1 – 3
  - Documentation examples*

* Examples in the presentation only illustrate the element intent. They are NOT definitive nor the only methods of documenting how the elements may be met.
Agenda: Part 2

• Content of PCMH 2011
  – Standards 4 – 6
  – Documentation examples*

* Examples in the presentation only illustrate the element intent. They are NOT definitive nor the only methods of documenting how the elements may be met.
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 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

- 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

- Recognition is at the practice-site level
NCQA’s New Medical Home Standards

• Emphasis on patient-centeredness and patient experience of care
• Reinforces incentives for meaningful use (HIT)
• Focuses attention on aspects of primary care that improve quality and reduce cost
• Based on advances in evidence and changes in practice capability
## 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 Points: 20**

### 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 Points: 16**

### 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 Points: 17**

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

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

**Total Points: 9**

### 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 Points: 18**

### 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 Points: 20**

**Must Pass Elements**

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**NCQA**

Measuring quality. Improving health care.

Patient-Centered Medical Home Standards Workshop 2011
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”

Must Pass Elements

• 1A: Access During Office Hours
• 2D: Use Data for Population Management
• 3C: Manage Care
• 4A: Self-Care Process
• 5B: Referral Tracking and Follow-Up
• 6C: Implement Continuous Quality Improvement
Definitions

Factors – A scored item in an element. For example, an element may require the practice to demonstrate how the practice team provides a range of patient care services. Each type of item, in this case a service, is a factor.

Critical Factors - A factor that is required for practices to receive more than minimal points, or in some cases any points for the element. Critical factors are identified in the scoring section of the element.

Explanation - Specific requirements that a practice must meet and guidance for demonstrating performance against the factor.

Examples/Documentation - Descriptions of the evidence practices need to submit to demonstrate performance for specific factors. Each factor must be documented.
PCMH Scoring
6 standards = 100 points
6 Must Pass elements

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.
PCMH 2011 and Meaningful Use

PCMH closely aligned with MU

1. Electronic prescribing
2. Drug formulary, drug-drug, drug allergy checks
3. Maintaining an up-to-date problem list of current and active diagnoses and medications
4. Recording demographics on preferred language, gender, race, ethnicity, and date of birth
5. Recording and charting changes in vital signs
6. Recording smoking status
7. Reporting ambulatory quality measures
8. Implementing clinical decision support rules…

Associated PCMH 2011 Standard

1. 3E: Use Electronic Prescribing
2. 3E: Use Electronic Prescribing
3. 2B: Clinical Data
4. 2A: Patient Information
5. 2B: Clinical Data
6. 2B: Clinical Data
7. 6F: Report Data Electronically
8. 3A: Implement Evidence-Based Guidelines
PCMH 1: Enhance Access and Continuity

Intent of Standard

- Patients have access to routine/urgent care and clinical advice during/after hours that are culturally and linguistically appropriate
- Electronic access
- Clinician selected by patient
- Team-based care; trained staff

Meaningful Use Criteria

Patients provided electronic:
- Copy of health information
- Access to health information
- Clinical summary of visit
PCMH 1: Enhance Access and Continuity

Elements

- PCMH1A: Access During Office Hours – MUST PASS
- PCMH1B: After-Hours Access
- PCMH1C: Electronic Access
- PCMH1D: Continuity
- PCMH1E: Medical Home Responsibilities
- PCMH1F: Culturally and Linguistically Appropriate Services (CLAS)
- PCMH1G: The Practice Team
Practice has written process/standards and demonstrates that it monitors performance against the standards to:

1. Provide same-day appointments – CRITICAL FACTOR
2. Provide timely advice by telephone
3. Provide timely advice by electronic message
4. Document clinical advice
PCMH1A: Scoring and Documentation

• MUST PASS
• 4 Points
• Scoring
  – 4 factors = 100%
  – 3 factors (including factor 1) = 75%
  – 2 factors (including factor 1) = 50%
  – Factor 1 = 25%
  – 0 factors or missing factor 1 = 0%

• Data Sources:
  – Documented process for scheduling appointments, providing clinical advice and documenting advice
  – Report showing same-day access, response times
  – Screen shots or copies of documented clinical advice
Office Scheduling Policy

Personal Clinicians:
For all routine office visits (check-ups, follow-ups) and physicals, patients are to be scheduled with their personal clinician (which-ever provider they see on a regular basis) to keep continuity of care.

Same-Day Appointments:
practices as an “Advanced Access” practice. Any patient that needs to be seen on a day the office is open (Monday – Saturday) will be able to be seen that day with the available clinician. Not all clinicians will have opening everyday due to their community schedules, but there will a clinician available to see a patient when they call.

Procedures and Exams:
When scheduling a patient for an annual physical, please make sure that they have the lab work done one week prior to visit. This will ensure that the results are in-house for the doctor to review at time of service.

When a patient is scheduling an office visit, please make sure to note and procedures or exams that need to be done (i.e. hearing test, EKG, skin tag removal...).
### PCMH1A: Example Advanced Access

<table>
<thead>
<tr>
<th>ADVANCED ACCESS</th>
<th>Day of the Week: Wednesday, July 23, 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider Name (s)</strong></td>
<td></td>
</tr>
</tbody>
</table>

#### At the beginning of the day:

<table>
<thead>
<tr>
<th># of Open Slots for:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10 min. appt</td>
<td>N/A</td>
</tr>
<tr>
<td>15 min. appt</td>
<td>1</td>
</tr>
<tr>
<td>20 min. appt</td>
<td>N/A</td>
</tr>
<tr>
<td>30 min. appt</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Other time frame

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>urgent</td>
<td>1</td>
</tr>
<tr>
<td>physical</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Third Next Available Appt. for:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patient Physical</td>
<td>2</td>
</tr>
<tr>
<td>Routine Exam</td>
<td>2</td>
</tr>
</tbody>
</table>

#### At the end of the day:

| # of Work in slots | 1   | 11  | 5   |

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Cancellations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of No Shows</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Appt. slots refilled</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td># of Appt. requests (Int./Ext)</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td># of Appt. Requests Not Filled</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td># of Open Slots</td>
<td>0</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>Clinical Hours Scheduled</td>
<td>2.25</td>
<td>4</td>
<td>1.25</td>
</tr>
<tr>
<td>Clinical Hours Worked</td>
<td>3</td>
<td>2</td>
<td>0.25</td>
</tr>
</tbody>
</table>

**Compares:**

- Available time slots at beginning of day
- Summary of activity at end of day
- Include a description of the process
PCMH1B: After-Hours Access

Practice has written process/standards and monitors performance:

1. Provide access to routine and urgent-care outside business hours
2. Provide continuity of medical record information for care and advice when office is closed
3. Provide timely advice by phone when office is closed – CRITICAL FACTOR
4. Provide timely advice using interactive electronic system when office is closed
5. Document after-hours advice
PCMH1B: Scoring and Documentation

• **4 Points**
  
  **Scoring**
  
  – 5 factors = 100%
  – 4 factors (including factor 3) = 75%
  – 3 factors (including factor 3) = 50%
  – 1-2 factors = 25%
  – 0 factors = 0%

• **Data Sources:**
  
  – Documented process for arranging after hours access, making medical records available after hours, providing timely advice after hours, documenting advice after hours
  – Report showing after hours availability, response times
  – Materials communicating practice hours
  – Screen shots or copies of documented clinical advice
PCMH1C: Electronic Access

Practice provides through a secure electronic system:

1. Electronic copy of health information within 3 days to more than 50% of patients who request it*
2. Electronic access to current health information within 4 days to at least 10% of patients**
3. Clinical summaries provided for more than 50% of office visits within 3 days*
4. Two-way communication
5. Request for appointments or prescription refills
6. Request for referrals or test results

* Core Meaningful Use Requirement
**Menu Meaningful Use Requirement
PCMH1C: Scoring and Documentation

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

- **Data Sources:**
  - Factors 1 – 3: Report showing percentage of patients who received electronic copy of health information, access to requested health information, electronic clinical summaries
  - Factors 4 – 6: Screen shots of its secure web site or portal
PCMH1D: Continuity

Practice provides continuity of care for patients/families by:

1. Expecting patients to select a personal clinician
2. Documenting the choice of clinician
3. Monitoring percent of patient visits with selected clinician
PCMH1D: Scoring and Documentation

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

• Data Sources:
  – Documented process or materials for clinician selection
  – Screen shot showing patients choice of clinician
  – Report showing patient encounters with clinician or clinician team
PCMH1D: Example Visits with Personal Clinician

<table>
<thead>
<tr>
<th>No of Pts</th>
<th>Attending</th>
<th>Pts Assigned to Physician</th>
<th>% Assigned to a Personal Physician</th>
<th>% of appts with personal physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td></td>
<td>43</td>
<td>100%</td>
<td>72%</td>
</tr>
<tr>
<td>49</td>
<td></td>
<td>49</td>
<td>100%</td>
<td>81%</td>
</tr>
<tr>
<td>56</td>
<td></td>
<td>56</td>
<td>100%</td>
<td>77%</td>
</tr>
<tr>
<td>66</td>
<td></td>
<td>66</td>
<td>100%</td>
<td>84%</td>
</tr>
<tr>
<td><strong>Total for practice</strong></td>
<td><strong>214</strong></td>
<td><strong>214</strong></td>
<td>100%</td>
<td>79%</td>
</tr>
</tbody>
</table>

Data reflects review of random charts reviewed from visits between July 1, 2008 and June 30, 2009.

All patients were assigned to a personal physician team (resident and attending).

The last column reflects the percent of times the patient saw a physician form their personal physician team.
PCMH1E: Medical Home Responsibilities

Practice has process and provides materials about role of medical home covering:

1. Practice responsible for coordinating patient care
2. How to obtain care/advice during/after office hours
3. Patients provide complete medical history and information on care obtained outside practice
4. Care team gives patient access to evidence-based care and self-management support
PCMH1E: Scoring and Documentation

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

• Data Sources:
  – Documented process for providing patient information
  – Patient materials
PCMH1F: CLAS

Practice engages in activities to understand and meet the cultural and linguistic needs of its patients:

1. Assesses racial/ethnic diversity of patients
2. Assesses language needs of patients
3. Provides interpretation services
4. Provides printed materials in patient language
PCMH1F: Scoring and Documentation

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

• Data Sources:
  – Report showing assessment of racial/ethnic/language of patients
  – Documentation showing use of interpretation service
  – Materials in other languages or website in other languages
PCMH 1C and 1F: Example Web Access and Translation Services

Web Access Policy

13. PPC [ ] The practice maintains an interactive website www.xxxxx.com. The website has information about the practice and an electronic communication portal. This portal allows patients to request an appointment, prescription refill, referral, address billing issues, create and manage their health record, and communicate securely with their care provider(s) via e-mail through XXX, which is linked to the above website. There is a fee associated with contacting the provider directly through XXX.

14. PPC [ ] Spanish-speaking and sign-language patients will be scheduled with Dr. XXXXXX and XXXXX, RMA. Other foreign-language patients will have translation services available through Language Line Services.

APPROVED BY:

Translation Services Policy
PCMH1G: The Practice Team

Practice utilizes a team care approach to provide patient care services by:

1. Defining roles for clinical/nonclinical team members
2. Holding regular team meetings - CRITICAL FACTOR
3. Using standing orders
4. Training and assigning care team to coordinate care
5. Training on self-management, self-efficacy and behavior change
6. Training on patient population management
7. Training on communication skills
8. Care team involvement in performance evaluation and QI
PCMH1G: Scoring and Documentation

• 4 Points
• Scoring:
  – 7-8 factors (including factor 2) = 100%
  – 5-6 factors (including factor 2) = 75%
  – 4 factors (including factor 2) = 50%
  – 2-3 factors = 25%
  – 0-1 factors = 0%

• Data Sources:
  – Staff position descriptions
  – Description of staff communication processes
  – Written standing orders
  – Description of training process, schedule, materials
  – Description of how staff is involved in practice improvements
1. **Preparation for patient appointments**

Front desk staff will remind patients of their scheduled appointments per scheduling policy 1B. In addition, front desk staff will respond to the follow-up plan reminders sent electronically from the providers regarding recommendations for when to call patients for follow-up appointments and will contact patients at the appropriate time. After meeting with the provider for a chart review meeting 2-3 days before a patient’s scheduled appointment, the medical assistant will contact appropriate entities for medical data collection (labs, imaging studies, consultation reports, etc.) as needed to help prepare for the office visit.

2. **Standing orders for:**
   a. **Medication Refills**

Medical assistants will review each patient’s chart to validate appropriate follow-up by the patient in regards to the medication refill request. If they have not been seen in follow-up as recommended by the provider, then the patient will be contacted to schedule the appropriate follow-up appointment. An emergency refill of a 30 day supply of their medication(s) may be refilled if needed until they have a chance to be seen. Examples of the chart reviews include:

1. All patients > 50 years old should have an annual complete physical examination prior to ANY medication refill.
2. All patients with diabetes should have office visits and appropriate blood tests at least every 6 months (or as indicated per the provider) for well-controlled diabetics (A1C <7), and every 3 months for diabetics who are not well-controlled (A1C >7) prior to ANY medication refill.
3. All women on contraceptives should have an annual PAP smear and gynecological examination.
PCMH1G: Example Standing Orders

### Medication Refill Protocol

** Exceptions (Route to Doctor) 
- Antibiotics
- Pregnant
- Allergies/Adverse Reactions to Medications Being Prescribed
- Any class of medication other than below

<table>
<thead>
<tr>
<th>Class of meds</th>
<th>Cholesterol Reducing</th>
<th>Hypertension</th>
<th>HCTZ/Diuretic for HTN</th>
<th>Cardiac (Digoxin and others)</th>
<th>Metered Dose Inhalers</th>
<th>Allergy (allegra, zyrtec, nasal steroids)</th>
<th>Diabetes</th>
<th>GI (Nexium, Protonix, etc.)</th>
<th>Anti Depressant (Paxil, Prozac, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of lab</td>
<td>Lipid fast CMP</td>
<td>BMP or CMP</td>
<td>BMP Q6mo</td>
<td>Digoxin level, potassium</td>
<td></td>
<td>HbA1c Q3mo, Lipid Q6 mo</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visit Frequency</td>
<td>6 mo.</td>
<td>6 mo. If pt comes in regularly, otherwise 1 month and revisit</td>
<td>6 mo. If pt comes in regularly, otherwise 1 month and revisit</td>
<td>6 mo.</td>
<td>Check chart note for revisit; no less than every 6 mo.</td>
<td>3 months unless HbA1C&lt;7, then Q6 mo.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: If patient needs OV or labs, refill up to one month (one time only). If more requested, check with physician.
Intent of Standard

- Electronic systems have searchable fields for demographic and clinical data
- Patients receive documented comprehensive health assessments
- Electronic systems used to identify patients who need services

Meaningful Use Criteria

Practice has searchable electronic system:
- Race/ethnicity/preferred language
- Clinical information

Practice uses electronic system for patient reminders
PCMH 2: Identify and Manage Patient Populations

Elements

• PCMH2A: Patient Information
• PCMH2B: Clinical Data
• PCMH2C: Comprehensive Health Assessment
• PCMH2D: Use Data for Population Management - MUST PASS
PCMH2A: Patient Information

Practice uses a searchable electronic system and records data more than 50% of the time for the following:

1. Date of birth*
2. Gender*
3. Race*
4. Ethnicity*
5. Preferred language*
6. Telephone numbers
7. E-mail address
8. Dates of previous clinical visits
9. Legal guardian/health care proxy
10. Primary caregiver
11. Advance directives (NA for pediatrics)
12. Health insurance

* Core Meaningful Use Requirement
PCMH2A: Scoring and Documentation

• 3 Points

• Scoring
  – 9-12 factors = 100%
  – 7-8 factors = 75%
  – 5-6 factors = 50%
  – 3-4 factors = 25%
  – 0-2 factors = 0%

• Data Sources:
  – Report showing percentage of all patients for each populated data field (not just those with the important conditions)
  – For each field the denominator is the number of patients seen in the reporting period; the numerator is the number of patients for whom the specified data is entered
### PCMH2A: Searchable Patient Data

#### Patient Tracking and Registry Functions - Jan 1, 2009 to Mar 31, 2009

<table>
<thead>
<tr>
<th>#</th>
<th>Element</th>
<th>Total Patients</th>
<th>%</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Name</td>
<td>6,351</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Date of Birth</td>
<td>6,351</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Gender</td>
<td>6,351</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Marital Status</td>
<td>5,799</td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Language preference</td>
<td>-</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Voluntarily self-identified race / ethnicity</td>
<td>-</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Address</td>
<td>6,349</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Telephone (primary contact number)</td>
<td>6,351</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>E-mail address (or &quot;none&quot; for patients)</td>
<td>2,206</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Internal ID</td>
<td>6,351</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>External ID</td>
<td>6,351</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Emergency contact information</td>
<td>-</td>
<td>0%</td>
<td></td>
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<tr>
<td>13</td>
<td>Current and past diagnosis</td>
<td>6,351</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Dates of previous clinical visits</td>
<td>6,351</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Billing codes for services</td>
<td>6,351</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Legal guardian</td>
<td>6,351</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Health insurance coverage</td>
<td>6,351</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Patient / family preferred method of</td>
<td>6,351</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>communication</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total**: 6,351

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**Shows 14 items documented in medical records and % of patients**
PCMH2A: Example Advance Directives

Presence of advanced directives:
(Below is a patient’s chart. Advanced directives are documented in the Social History template.)

![Image of a medical record with advanced directives highlighted.]

Advance Directives In Place:
- None
- DNR
- Living Will
- HC Proxy
PCMH2B: Clinical Data

Practice uses a searchable electronic system to record the following data:

1. Up-to-date problem list of active diagnoses for 80% of patients
2. Allergies, including medications and reactions for 80% of patients
3. Blood pressure with the date of update for 50% of patients
4. Height for 50% of patients
5. Weight for 50% of patients
6. BMI for 50% of patients
7. Length/height, weight head circumference (less than 2 years); BMI percentile (2-20); for pediatric patients for 50% of patients
8. Tobacco use status for patients 13 and older for 50% of patients
9. List of prescription medications with date of update for 80% of patients

All factors are Core Meaningful Use Requirements
PCMH2B: Scoring and Documentation

• 4 Points

• Scoring
  – 9 factors = 100%
  – 7-8 factors = 75%
  – 5-6 factors = 50%
  – 3-4 factors = 25%
  – 0-2 factors = 0%

• Data Sources:
  – Report showing percentage of all patients seen in last three months, for each data field
  – A chart review of a patient sample is not acceptable.
PCMH2C: Comprehensive Health Assessment

Practice conducts and documents a health assessment:

1. Age and gender appropriate immunizations/screenings
2. Family/social/cultural characteristics
3. Communication needs
4. Medical history of patient and family
5. Advance care planning (NA for pediatrics)
6. Behaviors affecting health
7. Patient and family mental health/substance abuse
8. Developmental screening using standardized tool (NA for adult only practices)
9. Depression screening for teens/adults using standardized tool
PCMH2C: Scoring and Documentation

• 4 Points

• Scoring
  – 8-9 factors = 100%
  – 6-7 factors = 75%
  – 4-5 factors = 50%
  – 2-3 factors = 25%
  – 0-1 factors = 0%

• Data Sources:
  – Report or a completed patient assessment (de-identified)
Practices uses patient data and evidence-based guidelines to generate lists and remind patients about needed services:

1. At least three different preventive care services**
2. At least three different chronic care services**
3. Patients not recently seen by the practice
4. Specific medications

** Menu Meaningful Use Requirement
PCMH2D: Scoring and Documentation

- **MUST PASS**
- **5 Points**
- **Scoring**
  - 4 factors = 100%
  - 3 factors = 75%
  - 2 factors = 50%
  - 1 factor = 25%
  - 0 factors = 0%

- **Data Sources:**
  - Lists or summary reports of patients who need services
    - Reports must contain at least three different immunizations/screenings and three different acute/chronic care services
    - A registry is not specifically required but will facilitate the process
  - Materials demonstrating patient notification
### PCMH2D: Example Population Management

#### Query for Babies Needing Immunization

<table>
<thead>
<tr>
<th>REPORT CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>FROM AGE: 0 month</td>
</tr>
<tr>
<td>TO AGE: 5 months</td>
</tr>
<tr>
<td>AS OF: CLINIC: PROVIDER: SERIES: ALL</td>
</tr>
</tbody>
</table>

#### Patients Needing Follow-Up Visit for Hypertension

**February Review Physician Action Form**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Diagnosis</th>
<th>Acct. #</th>
<th>Last Name</th>
<th>First Name</th>
<th>Last appt.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hypertension</td>
<td></td>
<td>BLINDED</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Internal Data**

- [Data Entry Fields]

---

**NCQA**

Measuring quality. Improving health care.
PCMH2D: Example Identifying Patients on Specific Medication

Report showing all patients on a particular medication (Toprol XL)
PCMH 3: Plan and Manage Care

Intent of Standard
• Practice implements evidence-based guidelines
• High-risk patients identified
• Care team performs care management through pre-visit planning, developing plan and treatment goals

Meaningful Use Criteria
• Practice implements evidence-based guidelines
• Practice reviews and reconciles medications with patients
• Practice uses e-prescribing system
PCMH 3: Plan and Manage Care

Elements

• PCMH3A: Implement Evidence-Based Guidelines
• PCMH3B: Identify High-Risk Patients
• PCMH3C: Care Management - MUST PASS
• PCMH3D: Medication Management
• PCMH3E: Use Electronic Prescribing
PCMH3A: Implement Evidence-Based Guidelines

Practice implements guidelines through point of care reminders for patients with:

1. The first important condition*
2. The second important condition
3. The third condition, related to unhealthy behaviors or mental health or substance abuse

* Core Meaningful Use Requirement
PCMH3A: Scoring and Documentation

• 4 Points

• Scoring
  – 3 factors = 100%
  – 2 factors (including factor 3) = 50%
  – 1 factor = 25%
  – 0 factors = 0%

• Data Sources:
  – Identification of 3 conditions, these are not screening or a single preventive service process
  – Name and source of guidelines
  – Demonstration of how guidelines are implemented
**Clinically important condition #1: Diabetes:**

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

These risk factors for diabetes include:

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

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

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

1. pre meal BG < 120
2. fasting BG > 80, < 100
3. HgBA1c < 6.5%
4. BP < 130/80
5. LDL < 100
6. Annual eye exam
7. Routine foot exams and neuropathy screenings
8. Routine microalbuminuria screenings
PCMH3A: Example EHR Prompting Lipid Management Evidence-Based Guidelines

Lipid Management

NCEP Adult Treatment Panel III Risk Factors

- Age 45 or greater
  - yes
  - no

- Early menopause w/o HRT
  - II/A
  - II/A

- Diabetes
  - yes
  - no

- HDL < 40 mg/dl
  - No Value Available

- HDL > 60 mg/dl (neg. risk)
  - No Value Available

FH of cardiovascular disease:

- MI in female age < 65
  - yes
  - no

- MI in male age < 55
  - yes
  - no

Smoking status:

- current
  - quit
  - never

Hypertension

- yes
  - no

ASHD (CAD) or CABG

- yes
  - no

Stroke or TIA

- yes
  - no

Peripheral vascular disease

- yes
  - no

Abdominal Aortic Aneurysm

- yes
  - no

Goals Automatically Calculated based on # Risk Factors

- Check here to manually change Lipid Goals

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

- Chol: 200
- LDL: 70
- HDL: 40
- Trig: 150

Last value:
- none
- none
- none
- none

Last date:

Next due:
- How
- How
- How
- How

All lipid goals have NOT been met.

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

LDL cholesterol goal met?
- Yes
- No

Enter Today’s BP: [ ] / [ ] mm Hg
### Diabetes Flowsheet

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History &amp; Physical</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Every Visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check Weight (BMI)</td>
<td>Every Visit</td>
<td></td>
<td>40.1</td>
<td>40.6</td>
<td></td>
</tr>
<tr>
<td>Retinal Screening</td>
<td>Annually</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inspect feet</td>
<td>Every Visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Lower Extremity Exam</td>
<td>Annually</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental/Oral health assessment</td>
<td>6 Months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Assessment</td>
<td>Annually</td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
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<tr>
<td><strong>Labs &amp; Tests</strong></td>
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<tr>
<td>A1c</td>
<td>3 Months</td>
<td>7.7</td>
<td>7.3</td>
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<tr>
<td>Triglycerides</td>
<td>Annually</td>
<td>218</td>
<td>206</td>
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<tr>
<td>LDL</td>
<td>Annually</td>
<td>86</td>
<td>97</td>
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</tr>
<tr>
<td>HDL</td>
<td>Annually</td>
<td>25</td>
<td>35</td>
<td></td>
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<tr>
<td>Total Cholesterol</td>
<td>Annually</td>
<td>147</td>
<td>173</td>
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<tr>
<td>Estimated GFR</td>
<td>Annually</td>
<td>&lt;= 60</td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Medications &amp; Immunizations</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Aspirin Use</td>
<td>Every Visit</td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assess Need For ACE/ARB</td>
<td>Every Visit</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Assess Need For Statin</td>
<td>Every Visit</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Influenza Vaccination</td>
<td>Annually</td>
<td></td>
<td>Y</td>
<td></td>
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<tr>
<td>Pneumococcal Vaccination</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>5 Years</td>
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<tr>
<td><strong>Lifestyle &amp; Counseling</strong></td>
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</tr>
<tr>
<td>Set Self-Management Goals</td>
<td>Every Visit</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Diabetes Patient Education / Nutrition / Exercise</td>
<td>Every Visit</td>
<td></td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Tobacco Use/Exposed to 2nd hand smoke</td>
<td>4 Months</td>
<td></td>
<td>N</td>
<td>Y</td>
<td></td>
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<tr>
<td>Smoking/Second Hand Smoke Counseling</td>
<td>Every Visit</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Depression / Mental Health Screening</td>
<td>Every Visit</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td></td>
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<tr>
<td>Review blood glucose log</td>
<td>Every Visit</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>
PCMH3B: Identify High-Risk Patients

The practice does the following to identify high-risk patients:

1. Establishes criteria and a process to identify high-risk or complex patients
2. Determines the percentage of high-risk patients in the population
PCMH3B: Scoring and Documentation

• 3 Points

• Scoring
  – 2 factors= 100%
  – 1 factor= 25%
  – 0 factors = 0%

• Data Sources:
  – Process to identify patients
  – Report showing number and percentage of high-risk patients
PCMH3C: Care Management

Care team performs the following for at least 75% of patients from Elements A and B:

1. Conducts pre-visit preparations
2. Collaborates with patient to develop care plan, including treatment goals
3. Gives patient written care plan
4. Assesses and addresses barriers to treatment goals
5. Gives patient clinical summary at relevant visits
6. Identifies patients who need more care management support
7. Follows up with patients who have not kept important appointments
PCMH3C: Scoring and Documentation

- **MUST PASS**
- **4 Points**
- **Scoring**
  - 6-7 factors = 100%
  - 5 factors = 75%
  - 3-4 factors = 50%
  - 1-2 factors = 25%
  - 0 factors = 0%
- **Data Sources:**
  - Report from electronic system or submission of Record Review Workbook
# PCMH 3C: Care Management

## Clinically Important Condition

<table>
<thead>
<tr>
<th>Patient Number</th>
<th>Conducts pre-visit preparations</th>
<th>Collaborates with patient/family to develop individual care plan, including treatment goals reviewed and updated at each relevant visit</th>
<th>Gives the patient/family a written plan of care</th>
<th>Assesses and addresses barriers when the patient has not met treatment goals</th>
<th>Gives the patient/family a clinical summary at each relevant visit</th>
<th>Identifies patients/families who might benefit from additional care management support</th>
<th>Follows up with patients/families who have not kept important appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
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<td></td>
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<td>3</td>
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<td>9</td>
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<td>18</td>
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<td>20</td>
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<td>21</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

## Response Options

- **Yes**
- **No**
- **Not Used**
PCMH3D: Medication Management

Practice manages medications in the following ways:

1. Reviews and reconciles medications for more than **50%** of care transitions** - CRITICAL FACTOR**
2. Reviews and reconciles medications for more than **80%** of care transitions
3. Provides information about new prescriptions to more than **80%** of patients
4. Assess patient understanding of medications for more than **50%** of patients
5. Assesses patient response to medication and barriers to adherence for more than **50%** of patients
6. Documents OTCs, herbal/supplements, for more than **50%** of patients, with date of update

** Menu Meaningful Use Requirement
PCMH3D: Scoring and Documentation

• 3 Points

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

• Data Sources:
  – Report from electronic system or submission of Record Review Workbook
### PCMH3D: Example Medication Management

#### 3D - Medication Management

<table>
<thead>
<tr>
<th></th>
<th>Reviews and reconciles medications with patients/families</th>
<th>Reviews and reconciles medications with patients/families</th>
<th>Provides information about new prescriptions</th>
<th>Assesses patient/family understanding of medications</th>
<th>Assesses patient response to medications and barriers to adherence</th>
<th>Documents over-the-counter medications, herbal therapies and supplements, with the date of updates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2</td>
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<td>3</td>
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<td>4</td>
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<td>6</td>
<td></td>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Response Options**

- Yes
- No
- Not Applicable
- Not Used

**Not Applicable Response may be used**

- ONLY in pediatrics practices AND
- if the patient is not on any medications
PCMH3E: Use Electronic Prescribing

Practice uses e-prescribing system with the following capabilities:

1. Generates and transmits at least 40% of prescriptions to pharmacies *
2. Generates at least 75% of eligible prescriptions* 
3. Integrates with patient medical records 
4. Performs patient-specific checks for drug-drug and drug-allergy interactions* 
5. Alerts prescribers to generic alternatives 
6. Alerts prescribers to formulary status**

* Core Meaningful Use Requirement 
** Menu Meaningful Use Requirement
PCMH3E: Scoring and Documentation

• **3 Points:**
  – 5-6 factors (including factor 2) = 100%
  – 4 factors (including factor 2) = 75%
  – 2-3 factors (including factor 2) = 50%
  – 1 factor = 25%
  – 0 factors = 0%

• **Data Sources:**
  – Reports showing percent of electronic prescriptions written and transmitted and demonstrating the system’s capabilities
### PCMH 3E: Example Electronic Prescription Writing

#### 6 Month Summary

![Graph showing 6 month summary](image)

#### Data Table

<table>
<thead>
<tr>
<th>Year</th>
<th>MonthName</th>
<th>Rx Sent Electronically to Retail - New</th>
<th>Rx Sent Electronically to Retail - Refill</th>
<th>Rx Sent Electronically to Mail Order</th>
<th>Controlled Rx Printed</th>
<th>Non-Controlled Rx Printed</th>
<th>Controlled Rx Faxed</th>
<th>Non-Controlled Rx Faxed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>April</td>
<td>1921</td>
<td>0</td>
<td>18</td>
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<td>June</td>
<td>1917</td>
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<td>2010 Total</td>
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<td>475</td>
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<tr>
<td>2011 January</td>
<td></td>
<td>779</td>
<td>261</td>
<td>12</td>
<td>0</td>
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<tr>
<td>2011 Total</td>
<td></td>
<td>779</td>
<td>261</td>
<td>12</td>
<td>0</td>
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<tr>
<td>Grand Total</td>
<td></td>
<td>18602</td>
<td>4336</td>
<td>487</td>
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</table>
### Prescription Writing Activity

<table>
<thead>
<tr>
<th>Prescription Method</th>
<th>Percentage</th>
<th>Number of RX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic</td>
<td>57%</td>
<td>2563 Rx</td>
</tr>
<tr>
<td>Printed, given to patient</td>
<td>31%</td>
<td>1419 Rx</td>
</tr>
<tr>
<td>Print, fax to pharmacy</td>
<td>1%</td>
<td>89 Rx</td>
</tr>
<tr>
<td><strong>TOTAL Rx</strong></td>
<td></td>
<td><strong>4474</strong> Rx</td>
</tr>
</tbody>
</table>

**Patients with Rx Counts:** 673
PCMH3E: Example Drug-Drug Interactions

Drug-Drug Interactions

Drug Interactions

<table>
<thead>
<tr>
<th>Drug1</th>
<th>Drug2</th>
<th>Severity</th>
<th>Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>aspirin</td>
<td>warfarin</td>
<td>Major</td>
<td>GENERAL AVOID: Aspirin</td>
</tr>
<tr>
<td>fenoibrate</td>
<td>warfarin</td>
<td>Major</td>
<td>GENERAL AVOID: Fibrici</td>
</tr>
<tr>
<td>fenoibrate</td>
<td>simvastatin</td>
<td>Major</td>
<td>GENERAL AVOID: Seveni</td>
</tr>
<tr>
<td>insulin glargine</td>
<td>aspirin</td>
<td>Moderate</td>
<td>MONITOR: The hypoglycin</td>
</tr>
<tr>
<td>insulin glargine</td>
<td>fenoibrate</td>
<td>Moderate</td>
<td>MONITOR: The hypoglycin</td>
</tr>
</tbody>
</table>

Drug Interactions

Allergies

<table>
<thead>
<tr>
<th>Drug</th>
<th>Reaction</th>
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</table>

Drug-Disease Interactions

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Condition</th>
<th>Severity</th>
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</thead>
<tbody>
<tr>
<td>warfarin</td>
<td>Diabetes Mellitus</td>
<td>Severe Potential Hazard</td>
</tr>
<tr>
<td>lisonopril</td>
<td>Renal Dysfunction</td>
<td>Severe Potential Hazard</td>
</tr>
<tr>
<td>warfarin</td>
<td>Coagulation Defect</td>
<td>Severe Potential Hazard</td>
</tr>
<tr>
<td>aspirin</td>
<td>Renal Dysfunction</td>
<td>Severe Potential Hazard</td>
</tr>
</tbody>
</table>

aspirin - warfarin Interaction

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

MANAGEMENT: This combination, especially with analgesic/antipyretic aspirin doses, should generally be avoided unless the potential benefit outweighs the risk of bleeding. If concomitant therapy is used for additive anticoagulant effects, monitoring for excessive anticoagulation and overt and occult bleeding is recommended. The INR should be checked frequently and the dosage adjusted accordingly.
PCMH3E: Example Prescribing Decision Support – Generic Alternatives
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