Purpose of this Seminar

• Examine the characteristics of a Recognized Patient-Centered Medical Home (PCMH)
• Identify the measurement activities and documentation for each of NCQA’s requirements
• Introduce NCQA’s survey and evaluation process
Learning Objectives

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

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

• Discuss:
  – Scoring for each element
  – Strategies to enhance and improve valid content

• Provide an overview of the application process for becoming an NCQA Recognized PCMH

National Committee for Quality Assurance (NCQA)

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

MISSION
To improve the quality of health care.
VISION
To transform health care through quality measurement, transparency, and accountability.

ILLUSTRATIVE PROGRAMS
* Patient-Centered Medical Home * Patient-Centered Specialty Practice
* HEDIS® – Healthcare Effectiveness Data and Information Set
* Health Plan Accreditation * Clinician Recognition
* Disease Management Accreditation * Wellness & Health Promotion Accreditation
NCQA Recognition Programs

- **>56,702** Clinician Recognitions nationally across all Recognition programs.
- Clinical programs.
  - Diabetes Recognition Program (DRP)
  - Heart/Stroke Recognition Program (HSRP)
  - Back Pain Recognition Program (BPRP) - Retired
- Medical practice process and structural measures.
  - Physician Practice Connections - Retired
  - Physician Practice Connections-Patient-Centered Medical Home (PPC-PCMH) 2008 - Retired
  - Patient-Centered Medical Home (PCMH) 2011
  - Patient-Centered Medical Home (PCMH) 2014
  - Patient centered Specialty Practice (PCSP)

NCQA Clinician Recognitions as of 08/31/14

<table>
<thead>
<tr>
<th>State</th>
<th>Recognitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA</td>
<td>4,405 clinicians</td>
</tr>
<tr>
<td>CO</td>
<td>12 Clinicians</td>
</tr>
<tr>
<td>FL</td>
<td>344 Clinicians 68 Practices</td>
</tr>
<tr>
<td>GA</td>
<td>40,841 Clinicians 8,112 Practices</td>
</tr>
<tr>
<td>HI</td>
<td>314 Clinicians 25 Practice</td>
</tr>
</tbody>
</table>

56,702 Total Recognitions
Federal Initiatives with NCQA’s PCMH

Defense Health Agency - Military Treatment Facilities (MTF)
- Initially a PCMH self-assessment; then Recognition
- 50 MTFs per year over 3 years
  - 254 MTFs achieved Recognition to date*
- Includes: Internal Medicine, Family Practice, Pediatrics

*As of 5/6/14

Federal Initiatives Continued

<table>
<thead>
<tr>
<th>HRSA Patient-Centered Medical Health Home Initiative</th>
<th>CMS Advanced Primary Care Practice Demo</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Community Health Centers – for rural, underserved, often nurse-led practices</td>
<td>• Federally Qualified Health Centers (FQHCs)</td>
</tr>
<tr>
<td>• Recognition costs and technical assistance</td>
<td>• 3-year contract for 500 FQHCs</td>
</tr>
<tr>
<td>• Up to 500 Community Health Centers per year; 5 year contract</td>
<td>• Track progress toward being a Medical Home with reassessments every 6 mo.</td>
</tr>
<tr>
<td>• 2,512 sites currently enrolled</td>
<td>• CMS reimburses for managing Medicare beneficiaries</td>
</tr>
<tr>
<td>• 902 CHCs Recognized</td>
<td>• 232 FQHCs in the demonstration have achieved Recognition as of 5/6/14</td>
</tr>
</tbody>
</table>
Key Components of PCMH*

- **Personal Clinician**: first contact, continuous, comprehensive, care team

- **Whole Person Orientation**: all patient health care needs; all stages of life; acute; chronic; preventive; end of life

- **Coordinated Care**: when and where needed/wanted; culturally and linguistically appropriate; use information technology

*Based on The Joint Principles

Does the Patient-Centered Medical Home Work?
Growing Evidence on PCMH

• **PCMH Improves Low-Income Access, Reduces Inequities**
  Berenson, Commonwealth Fund, May 2012

• **PCMH Improves Quality/Patient Satisfaction, Lowers Costs**
  PCPCC, September 2012

• **Colorado PCMH Multi-Payer Pilot Reduced Inpatient Admissions, ER Visits & Demonstrated Plan ROI**
  Harbrecht September 2012

• **The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction And Less Burnout For Providers**
  Soman Health Affairs, May 2010

• **The Patient-Centered Medical Home’s Impact on Cost and Quality: An Annual Update of the Evidence, 2012-2013.**

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PCMHs Save Money

**Better Access and Care Coordination Goes a Long Way**

• **Reduction in hospital and emergency room use**

• **Lower overall per member per month costs**

• **Health plans can have strong return on investment**
  Raskas et al, 2012 / Harbrecht 2012

• **Also see** the Patient-Centered Primary Care Collaborative’s Summary of Patient-Centered Medical Home Cost and Quality Results, 2010-2013
  PCPCC 2014
Evolving PCMH and More

- **2003-2004**: Physician Practice Connections (PPC) - developed with Bridges to Excellence
- **2006**: PPC standards updated
- **2008**: PPC–PCMH
- **2011**: PCMH 2011
- **2011**: ACO Accreditation
- **2013**: Patient-Centered Specialty Practice
- **2014**: PCMH 2014
1. **Additional emphasis on team-based care**
   - New element = Team-Based Care
     - Highlights patient as part of team, including QI

2. **Care management focused on high-risk patients**
   - Use evidence-based decision support
   - Identify patients who may benefit from care management and self-care support:
     - Social determinants of health
     - Behavioral health
     - High cost/utilization
     - Poorly controlled or complex conditions

3. **More focused, sustained Quality Improvement (QI) on patient experience, utilization, clinical quality**
   - Annual QI activities; reports must show the practice re-measures at least annually
   - Renewing practices will benefit from streamlined requirements, but must demonstrate re-measurement from at least two prior years

4. **Alignment with Meaningful Use Stage 2 (MU2)**
   - MU2 is not a requirement for recognition.

5. **Further Integration of Behavioral Health.**
   - Show capability to treat unhealthy behaviors, mental health or substance abuse
   - Communicate services related to behavioral health
   - Refer to behavioral health providers
### PCMH 2014 Content and Scoring

**6 standards/27 elements**

<table>
<thead>
<tr>
<th>1: Enhance Access and Continuity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. *Patient-Centered Appointment Access</td>
<td>4.5</td>
</tr>
<tr>
<td>B. 24/7 Access to Clinical Advice</td>
<td>3.5</td>
</tr>
<tr>
<td>C. Electronic Access</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
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</table>

<table>
<thead>
<tr>
<th>2: Team-Based Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Continuity</td>
<td>3</td>
</tr>
<tr>
<td>B. Medical Home Responsibilities</td>
<td>2.5</td>
</tr>
<tr>
<td>C. Culturally and Linguistically Appropriate</td>
<td>2.5</td>
</tr>
<tr>
<td>Services (CLAS)</td>
<td></td>
</tr>
<tr>
<td>D. *The Practice Team</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
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</table>

<table>
<thead>
<tr>
<th>3: Population Health Management</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Patient Information</td>
<td>3</td>
</tr>
<tr>
<td>B. Clinical Data</td>
<td>4</td>
</tr>
<tr>
<td>C. Comprehensive Health Assessment</td>
<td>4</td>
</tr>
<tr>
<td>D. *Use Data for Population Management</td>
<td>5</td>
</tr>
<tr>
<td>E. Implement Evidence-Based Decision-Support</td>
<td>4</td>
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<td><strong>Total</strong></td>
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</table>

<table>
<thead>
<tr>
<th>4: Plan and Manage Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Identify Patients for Care Management</td>
<td>4</td>
</tr>
<tr>
<td>B. *Care Planning and Self-Care Support</td>
<td>4</td>
</tr>
<tr>
<td>C. Medication Management</td>
<td>3</td>
</tr>
<tr>
<td>D. Use Electronic Prescribing</td>
<td>5</td>
</tr>
<tr>
<td>E. Support Self-Care and Shared Decision-Making</td>
<td></td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
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</table>

<table>
<thead>
<tr>
<th>5: Track and Coordinate Care</th>
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</tr>
</thead>
<tbody>
<tr>
<td>A. Test Tracking and Follow-Up</td>
<td>6</td>
</tr>
<tr>
<td>B. *Referral Tracking and Follow-Up</td>
<td>6</td>
</tr>
<tr>
<td>C. Coordinate Care Transitions</td>
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<tr>
<td><strong>Total</strong></td>
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</table>

<table>
<thead>
<tr>
<th>6: Measure and Improve Performance</th>
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</tr>
</thead>
<tbody>
<tr>
<td>A. Measure Clinical Quality Performance</td>
<td>3</td>
</tr>
<tr>
<td>B. Measure Resource Use and Care Coordination</td>
<td>4</td>
</tr>
<tr>
<td>C. Measure Patient/Family Experience</td>
<td>4</td>
</tr>
<tr>
<td>D. *Implement Continuous Quality Improvement</td>
<td>3</td>
</tr>
<tr>
<td>E. Demonstrate Continuous Quality Improvement</td>
<td>3</td>
</tr>
<tr>
<td>F. Report Performance</td>
<td>3</td>
</tr>
<tr>
<td>G. Use Certified EHR Technology</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>30</strong></td>
</tr>
</tbody>
</table>

#### Scoring Levels

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

**Must Pass Elements**

PCMH 2014 and Meaningful Use
Meaningful Use of Health Information Technology (HIT)

- NCQA emphasizes HIT because highly effective primary care is information-intensive
- PCMH 2014 reinforces incentives to use HIT to improve quality
- Meaningful Use language is embedded in PCMH 2014 standards
- Synergy: PCMH 2014 Recognized medical practices are well-positioned to qualify for meaningful use, and vice versa

PCMH Update Timeline

PCMH 2011
- PCMH 2011 survey tools are no longer available for purchase
- December 31, 2014 last date to submit PCMH 2011 Corporate survey tools
- March 31, 2015 last date to submit PCMH 2011 survey tools

PCMH 2014 Available
- Standards and Guidelines
- Survey tools

March 31, 2014 - March 31, 2015
- May submit PCMH 2011 or PCMH 2014
PCMH-Related Programs

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

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

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

What are ACOs?
- Provider-based organizations that are accountable for both quality and costs of care for a defined population
  - Arrange for the total continuum of care

- Align incentives and reward providers based on performance (quality and financial)
  - Incentivized through payment mechanisms such as shared savings or partial/full-risk contracts

- Goal is to meet the “triple aim”
  - Improve people’s experience of care
  - Improve population health
  - Reduce overall cost of care

- PCMH is central to ACO
Patient-Centered Specialty Practice (PCSP)

Patient-Centered Specialty Practice (PCSP) Recognition

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

Accommodate range of patient relationships:
1. Consultation
2. Patient evaluation and treatment
3. Co-management
4. Temporary/permanent care management

Practices likely to treat differing percentage of patients in each “category”
## PCSP Content and Scoring

(6 standards/22 elements)

<table>
<thead>
<tr>
<th>PCSP 1: Track &amp; Coordinate Referrals</th>
<th>Pts</th>
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<tbody>
<tr>
<td>A. *Referral Process &amp; Agreements</td>
<td>9</td>
</tr>
<tr>
<td>B. Referral Content</td>
<td>5</td>
</tr>
<tr>
<td>C. *Referral Response</td>
<td>8</td>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>PCSP 4: Plan &amp; Manage Care</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Care Planning &amp; Support Self-Care</td>
<td>11</td>
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<tr>
<td>B. *Medication Management</td>
<td>5</td>
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<tr>
<td>C. Use Electronic Prescribing</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>18</td>
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</table>

<table>
<thead>
<tr>
<th>PCSP 5: Track &amp; Coordinate Care</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Test Tracking &amp; Follow-Up</td>
<td>5</td>
</tr>
<tr>
<td>B. Referral Tracking &amp; Follow-Up</td>
<td>6</td>
</tr>
<tr>
<td>C. Coordinate Care Transitions</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>16</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PCSP 6: Measure &amp; Improve Performance</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Measure Performance</td>
<td>5</td>
</tr>
<tr>
<td>B. Measure Patient/Family Experience</td>
<td>5</td>
</tr>
<tr>
<td>C. *Implement &amp; Demonstrate</td>
<td>4</td>
</tr>
<tr>
<td>Continuous Quality Improvement</td>
<td>2</td>
</tr>
<tr>
<td>D. Report Performance</td>
<td>0</td>
</tr>
<tr>
<td>E. Use Certified EHR Technology</td>
<td>16</td>
</tr>
</tbody>
</table>

* *Must Pass Elements*

*Recognition starts with 25 points*
PCMH Content Expert Certification

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

PCMH Content Expert Certification

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

• **Outpatient primary care practices**

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

• Recognitions are conferred at geographic site level -- one Recognition per address, one address per survey

• MDs, DOs, PAs, and APRNs practicing at site with their own or shared panel of patients are listed with Recognition

• Clinicians should be listed at each site where they routinely see a panel of their patients
  – Clinicians can be listed at any number of sites
  – Site clinician count determines program fee
  – Non-primary care clinicians should not be included

PCMH Clinician Eligibility

• At least 75% of each clinician’s patients come for:
  – First contact for care
  – Continuous care
  – Comprehensive primary care services

• Clinicians may be selected as personal PCPs

• All eligible clinicians at a site must apply together

• Physicians in training (residents) should not be listed

• Practice may add or remove clinicians during the Recognition period
Systems Needed by Practice for PCMH Survey Process

1. **Computer system and staff skill with:**
   - Email
   - Internet access
   - Microsoft Word
   - Microsoft Excel
   - Adobe Acrobat Reader (available free online)
   - Document scanning and screen shots

2. **Access to the electronic systems** used by the practice, e.g. billing system, registry, practice management system, electronic prescription system, EHR, Web portal, etc.

Transformation and Prep Work

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

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

Reading a Standard

Standard Title And Statement
PCMH 1: Patient-Centered Access 10.00 points

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

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

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

Types: documented process, reports, materials, patient records

Explanation: Guidance for demonstrating performance against an element
Must Pass Elements

Rationale for Must Pass Elements
- Identifies key concepts of PCMH
- Helps focus Level 1 practices on most important aspects of PCMH
- Guides practices in PCMH evolution and continuous quality improvement
- Standardizes “Recognition”

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

What is a Critical Factor?
- Required to receive more than minimal or, for some factors, any points
- Identified in the scoring section of the element

**PCMH 1A Example: Critical Factor impact on scoring**

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets 5-6 factors (including factor 1)</td>
<td>The practice meets 3-4 factors (including factor 1)</td>
<td>The practice meets 2 factors (including factor 1)</td>
<td>The practice meets 1 factor (including factor 1)</td>
<td>The practice meets 0 factors</td>
</tr>
</tbody>
</table>

There are 9 Critical Factors
Three Critical Factors in Must Pass Elements

<table>
<thead>
<tr>
<th>PCMH 1</th>
<th>PCMH 2</th>
<th>PCMH 3</th>
<th>PCMH 4</th>
<th>PCMH 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A, F1</td>
<td>2D, F3</td>
<td>3E, F1</td>
<td>4A, F6</td>
<td>5A, F1</td>
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<tr>
<td>1B, F2</td>
<td></td>
<td></td>
<td>4C, F1</td>
<td>5A, F2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5B, F8</td>
</tr>
</tbody>
</table>
Documentation Types

1. **Documented process** Written procedures, protocols, processes for staff, workflow forms (not explanations); must include practice name and date of implementation.

2. **Reports** Aggregated data showing evidence

3. **Records or files** Patient files or registry entries documenting action taken; data from medical records for care management.

4. **Materials** Information for patients or clinicians, e.g. clinical guidelines, self-management and educational resources

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

Documentation Time Periods

*Also Called Look-Back Period*

- **Report Data, Files, Examples and Materials**
  Should display information that is current within the last 12 months

- **Documented Process**
  Policies, procedures and processes should be in place for at least 3 months prior to survey submission

- **Reporting Period (Meaningful Use)**
  A recent 3 month period

- **Reporting Period (Log or Report)**
  Refer to documentation guidelines for other references to minimum data for logs and reports (one week, one month, etc.)

*ALL DOCUMENTS MUST SHOW DATES*
Questions?

Discuss and Analyze NCQA’s PCMH Recognition Requirements
PCMH 1: Patient-Centered Access

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

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

**Meaningful Use Alignment**
- Patients receive electronic:
  - On-line access to their health information
  - Clinical summaries of office visits
  - Secure messages from the practice
PCMH 1: Patient-Centered Access

10 Points

Elements

• PCMH 1A: Patient-Centered Appointment Access
  MUST PASS
• PCMH 1B: 24/7 Access to Clinical Advice
• PCMH 1C: Electronic Access

PCMH 1A: Patient-Centered Access

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

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

NOTE: Critical Factors in a Must Pass element are essential for Recognition
PCMH 1A: Scoring and Documentation

MUST PASS

4.5 Points

Scoring

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

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

Documentation

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

PCMH 1A: Documentation (cont.)

• F2: Materials communicating extended hours or report showing after-hours availability, process to arrange after-hours access not required if practice has regular extended hours.
• F3: Report with frequency of scheduled alternative encounter types in recent 30-calendar-day period.
• F4: Report showing appointment wait times compared to practice defined standards including policy for how practice monitors appointment availability with at least 5 days of data.
• F5: Report showing rate of no shows from a recent-30-calendar day period. (Patients seen/Scheduled visits).
• F6: Documented process indicating the method a practices uses to select, analyze and update its approach to creating greater access to appointments and a report showing practice has evaluated access data and implemented QI Plan to create greater access.
PCMH 1A, Factor 1: Example Same-Day Scheduling Policy

ABCD Medical Associates
Effective June 6, 2013

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 be 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 procedures or exams that need to be done (i.e. hearing test, EKG, skin tag removal...).

mountain top family medicine uses a advanced access scheduling system. Approximately 30% of the day’s visits are prebooked while the remaining 70% are left open for same day appointments. The office strives to “do today’s work today.” Patients who call before noon for a same day appointment are guaranteed a same day appointment. Patients who call after noon with non-urgent matters may be scheduled the next day if necessary. Urgent matters are scheduled the same day whenever possible. If no appointments are available and the need is not urgent, the patient is asked to schedule an appointment the following day. If the need is urgent, (i.e.: chest pain, abdominal pain, falls, etc.) the scheduler will immediately consult the provider and decide upon an appropriate course of action, or, refer the patient to a local urgent care or emergency room. These instructions will then be documented in the patient’s chart.

Acute illnesses will be seen in the office within 24 hours.

Routine physicals will be scheduled at next available appointment which is usually same day or next day at the latest.

Patients recently discharged from outside facilities (hospitals, nursing home, rehab facilities) will be seen within 1 week of discharge or sooner if necessary based on clinical condition.
**PCMH 1A, Factor 1: Example Third Next Available Appointment**

**ABCD Medical Center**

**Explanation:** The practice reserves time for same-day appointments. This report shows the number of days to the third next available appointment for each day from 10/14/2013 through 10/18/2013 as measured first thing each morning as the clinic day began.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Monitoring Date</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jones, MD</td>
<td>10/14/2013</td>
<td>1</td>
</tr>
<tr>
<td>Jones, MD</td>
<td>10/15/2013</td>
<td>0</td>
</tr>
<tr>
<td>Jones, MD</td>
<td>10/16/2013</td>
<td>0</td>
</tr>
<tr>
<td>Jones, MD</td>
<td>10/17/2013</td>
<td>1</td>
</tr>
<tr>
<td>Jones, MD</td>
<td>10/18/2013</td>
<td>2</td>
</tr>
</tbody>
</table>

*Average # of days: 0.8*

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

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

**Office Hours**

- **Telephone Advice Hour:** Monday - Saturday 7:30 AM - 8:30 AM
- **Patient Care Hours:** Monday - Thursday: 8:30 AM - 7:30 PM
  - Friday: 8:30 AM - 5 PM
  - Saturday: 8:30 AM - 12:00 PM
PCMH 1A, Factor 3: Alternative Clinical Encounters

Shared medical appointments/group visits:
- Multiple patients are seen as a group for follow-up care or management of chronic conditions
- Voluntary
- Allows patient interaction with other patients and members of health team
- Practice should document in the medical record
- This factor requires a documented process and a 30 calendar day report

PCMH 1A, Factors 1, 4 & 5: Appointments Audit
PCMH 1B: 24/7 Access to Clinical Advice

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

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

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

PCMH 1B: Scoring and Documentation

3.5 Points

Scoring

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

Documentation

- F1-4: Documented process and
- F2&3: Report(s) showing response times during and after hours (7 calendar day report(s) minimum)
- F4: Three examples of clinical advice documented in record. One example when office open AND one example when office closed.
PCMH 1B, Factors 1, 2, & 4 Example

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

• Patients will be seen routinely between the hours of 8:00 a.m. and 6:00 p.m., depending on the individual practice. Doctors will make special accommodations when necessary. This means that we may stay later, add additional hours, or meet patients at the office or hospital after hours as needed to provide care.  Factor 2.

• Doctors are on call 24 hours per day and are available through the usual office telephone number. Patient phone calls are answered by a live person during office hours and through the answering service after hours. Clinical response time is to be within one hour. After-hour calls are put on hold by the answering service and then immediately put through to the physician on call. If a physician is unable to immediately take an after-hours call, it will be answered within one hour.

• Doctors have access to patient’s medical records from their homes/mobile devices.  Factor 1.

• Doctors may direct patients to an affiliated urgent care center or to the local emergency room, depending on acuity of symptoms. Doctors will use their own discretion regarding where to refer a patient, based on their clinical judgment. If a patient is referred to an urgent care center or an emergency room, our physician will communicate directly to the attending physician on duty, relaying any pertinent clinical information. Doctors can answer email outside regular office hours. (No timeframe to fully meet factor 3)

• Doctors will document after-hours advice in patient’s medical record. This documentation will include the time of patient call and the time call was returned by clinician.  Factor 4.

ABCD Family Medicine
Clinical Advice Policy

Effective 6/30/2012

Patients have 24/7 telephonic access to a clinician (MD, RN, NP or PA) to provide clinical advice. Calls during office hours are to be responded to within one hour and are to be recorded as a noted patient interaction in the EMR at the time of the call. The on-call provider has computer access by logging onto the EMR remotely while on-call, which enables that care provider access to patient records, to view and search patient records, and also record after hours activity for a patient. After hours calls from patients are to be responded to by the on-call provider within one hour and are to be recorded as a noted patient interaction in the EMR in within 24 hours of communication with the patient.
ABCD PEDIATRICS CLINICAL ADVICE BY TELEPHONE POLICY

• ABCD Pediatrics, P.A. provides clinical advice by telephone for all established patients. During office hours our telephone staff forwards calls from patients regarding a new symptom, illness or concern to clinical staff for triage via telephone. If a clinical staff member is unavailable, a message will be taken or call may be routed to voicemail which is reviewed by a clinical staff member. Non-urgent calls are returned within 24 business hours. Urgent calls are returned within 4 hours. Emergency calls are routed directly to a provider for an immediate response or the caller is directed to seek emergency care at the nearest emergency department.

• Clinical staff members are responsible for documenting clinical advice in the patient’s medical record. All clinical advice, delivered by telephone is documented within 24 hours.

• Policy effective date: December 30, 2013

*Policy review date: December 1, 2014

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

<table>
<thead>
<tr>
<th>Encounter Number</th>
<th>Date we received phone request</th>
<th>Time of request</th>
<th>Date we responded to patient</th>
<th>Time of response</th>
<th>Elapsed Time</th>
<th>Response time meets policies?</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/20/09</td>
<td>11:26</td>
<td>3/20/09</td>
<td>17:02</td>
<td>8 hours</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>3/19/09</td>
<td>11:21</td>
<td>3/19/09</td>
<td>13:10</td>
<td>2 hours</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>3/18/09</td>
<td>13:53</td>
<td>3/19/09</td>
<td>17:19</td>
<td>4 hours</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>3/17/09</td>
<td>15:02</td>
<td>3/18/09</td>
<td>9:31</td>
<td>18 hours</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>3/17/09</td>
<td>14:13</td>
<td>3/18/09</td>
<td>10:00</td>
<td>20 hours</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>3/17/09</td>
<td>15:14</td>
<td>3/18/09</td>
<td>9:09</td>
<td>18 hours</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>3/16/09</td>
<td>10:20</td>
<td>3/16/09</td>
<td>10:41</td>
<td>25 hours</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>3/20/09</td>
<td>9:28</td>
<td>3/20/09</td>
<td>12:55</td>
<td>3 hours</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>3/17/09</td>
<td>13:53</td>
<td>3/17/09</td>
<td>16:19</td>
<td>3 hours</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>3/18/09</td>
<td>14:35</td>
<td>3/19/09</td>
<td>14:34</td>
<td>24 hours</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>3/19/09</td>
<td>11:16</td>
<td>3/19/09</td>
<td>11:32</td>
<td>0.25 hours</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Response times to meet standards for timely telephone response. (A telephone call audit was conducted for our practice for two weeks. Below are the results. The encounter number refers to the unique tracking ID our EMR assigns. It has been provided instead of confidential patient information for tracking purposes.)
### PCMH 1B, Factor 2: Patient Access Audit

<table>
<thead>
<tr>
<th>Date</th>
<th>Person Calling</th>
<th>Call Time</th>
<th>Who Responded</th>
<th>Time response entered in OXBOW</th>
<th>Time to Respond</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/23/13</td>
<td>Patient</td>
<td>9:10am</td>
<td>Mary</td>
<td>9:15am</td>
<td>05 min</td>
</tr>
<tr>
<td>9/23/13</td>
<td>Patient</td>
<td>11:45am</td>
<td>Barbara</td>
<td>12:00 pm</td>
<td>15 min</td>
</tr>
<tr>
<td>9/23/13</td>
<td>Patient</td>
<td>8:20pm</td>
<td>Dr. Smith</td>
<td>8:30pm</td>
<td>10 min</td>
</tr>
<tr>
<td>9/24/13</td>
<td>Patient</td>
<td>8:20am</td>
<td>Kathi</td>
<td>8:30am</td>
<td>10 min</td>
</tr>
<tr>
<td>9/24/13</td>
<td>Patient</td>
<td>11:25am</td>
<td>Mina</td>
<td>11:30am</td>
<td>05 min</td>
</tr>
<tr>
<td>9/25/13</td>
<td>Patient</td>
<td>6:20am</td>
<td>Dr. Smith</td>
<td>6:30am</td>
<td>10 min</td>
</tr>
<tr>
<td>9/26/13</td>
<td>Patient</td>
<td>2:25pm</td>
<td>Johann</td>
<td>2:30pm</td>
<td>05 min</td>
</tr>
<tr>
<td>9/26/13</td>
<td>Patient</td>
<td>4:05pm</td>
<td>Mary</td>
<td>4:15pm</td>
<td>10 min</td>
</tr>
</tbody>
</table>

Need documented process and report
Minimum 7 days of data

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

**Clinical Call Response Time: 1/6/2014 – 2/6/2014**

<table>
<thead>
<tr>
<th>Message Responders</th>
<th>total # messages</th>
<th>avg response in hours:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>75</td>
<td>0.91</td>
</tr>
<tr>
<td>Residents</td>
<td>16</td>
<td>1.50</td>
</tr>
<tr>
<td>Mid-levels</td>
<td>24</td>
<td>0.89</td>
</tr>
<tr>
<td>Nurses</td>
<td>73</td>
<td>0.94</td>
</tr>
<tr>
<td>Clinical Asst</td>
<td>62</td>
<td>1.03</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>250</strong></td>
<td><strong>0.98</strong> (standard is 2 hours)</td>
</tr>
</tbody>
</table>
### PCMH 1B, Factor 3: Example Timely Clinical Advice by Secure E-Message

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

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

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

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

**Incoming Call**

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Provider</th>
<th>Department</th>
<th>Encounters #</th>
</tr>
</thead>
</table>

**Contacts**

<table>
<thead>
<tr>
<th>Time</th>
<th>Contact</th>
<th>Phone</th>
</tr>
</thead>
</table>

**Reason for Call**

**Call Documentation**

Signed

She is having right leg exacerbating leg, muscle pain “double over, laying on the floor” she is concerned she has a blood clot. She had surface clots in past and labeled von wirebrandt. She had bubbling in veins and then after it felt like ice in veins, inside call to other side call, behind knee and knee cap. She is having functional pain now but the prior pain was worse than labor pain. She drank 2 L of pedia lite. Episode lasted 16 min and then moved and started again. SV made

**Historical Meds Added to List**

**Historical Meds Removed**

**Patient Instruction**
PCMH 1C: Electronic Access

Practice provides through a secure electronic system:

1. > 50% of patients have online access to their health information w/in 4 business days of information being available to the practice *
2. > 5% of patients view, and are provided the capability to download, their health information or transmit their health information to a third party *
3. Clinical summaries provided for > 50% of office visits within 1 business day *
4. Secure message sent by > 5% of patients *
5. Patients have two-way communication with the practice
6. Patients may request appointments, prescription refills, referrals and test results *

* Stage 2 Meaningful Use Requirements

PCMH 1C: Scoring and Documentation

2 Points

Scoring

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

Documentation

- F1-4: Reports based on numerator and denominator with at least 3 months of recent data
- F5 & 6: Screen shots showing the capability of the practice’s web site or portal including URL.
More than 50% of patients have online access to their health information within four business days of when the information available to the practice. (Stage 2 MU)

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

PCMH 1C, Factor 3 Example
(Stage 2 MU now requires clinical summaries w/in 1 business day)
PCMH 1C, Factor 5: Example Two-Way Communication

PCMH 1C, Factor 6: Example Interactive Web Site

DID YOU KNOW ......

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

National Eating Disorder Week starts February 26th.

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

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

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

PCMH 2: Team-Based Care
PCMH 2: Team-Based Care

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

PCMH 2: Team-Based Care

12 Points

**Elements**
- Element A: Continuity
- Element B: Medical Home Responsibilities
- Element C: CLAS
- Element D: The Practice Team
  Must-Pass
PCMH 2A: Continuity

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

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

---

PCMH 2A: Scoring

3.0 Points

Scoring

• 3-4 factors = 100%
• No scoring option = 75%
• 2 factors = 50%
• 1 factor = 25%
• 0 factors = 0%
PCMH 2A: Documentation

**Documentation**

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

---

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

![Table of percentage of patient visits with preferred provider](chart.png)

% of patient visits with preferred provider

<table>
<thead>
<tr>
<th>Document Responsible Provider</th>
<th>Percentage of Visits with Preferred Provider</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocare Family Health 11701</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Olive</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PCMH 2A, Factor 2: Example of report showing total of patient encounters

4/7/14 - 4/11/14

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

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

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

I would like to talk about:
- Challenged by diabetes burdens
- Social/emotional/cognitive issues
- Transition preparation/readiness to move on
PCMH 2A, Factor 4: Example Transition from Pediatric to Adult Care

National Diabetes Education Program
Pediatric to Adult Diabetes Care Transition Planning Checklist
✓ 1 to 2 years before transition to new adult care providers
✓ 6 to 12 months before transition
✓ 3 to 6 months before transition
✓ Last few visits

PCMH 2B: Medical Home Responsibilities

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

1. The practice is responsible for coordinating patient care across multiple settings.

2. Instructions for obtaining care and clinical advice during office hours and when the office is closed.

3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice.
PCMH 2B: Medical Home Responsibilities (cont.)

4. The care team provides access to evidence-based care, patient/family education and self-management support.

5. The scope of services available within the practice including how behavioral health needs are addressed.

6. The practice provides equal access to all of their patients regardless of source of payment.

7. The practice gives uninsured patients information about obtaining coverage.

8. Instructions on transferring records to the practice, including a point of contact at the practice.

PCMH 2B: Scoring and Documentation

2.5 Points

Scoring

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

Documentation

- F1-8: Documented process for providing information to patients and
- F1-8: Patient materials
PCMH 2B, Factors 1, 3-4: Example of Patient Information on Medical Home

What is a Patient-Centered Medical Home?

The Medical Home is an innovative, team-based approach to patient care where a partnership develops between the patient, his or her primary care provider, and other health professionals. Together, following evidence-based guidelines for medical care, the practice will provide the best health care services possible for you.

What are the changes and additional benefits that I can expect?

Team-Based Care:

1. One of us will remain as your Primary Care clinician. How can we help your nurses and support staff to work with you to meet all of your needs? Information systems tools will aid us (along with other ways) to deliver the best care that is optimal for you.

Improved Health Access and Communication:

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

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

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

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

2.5 Points

Scoring

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

Documentation

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

---

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

<table>
<thead>
<tr>
<th>Patient Distribution by Language</th>
<th># of Patients</th>
<th>% of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>2191</td>
<td>79.30%</td>
</tr>
<tr>
<td>Spanish</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Russian</td>
<td>2</td>
<td>0.07%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.04%</td>
</tr>
<tr>
<td>All other</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Blank field</td>
<td>573</td>
<td>20.74%</td>
</tr>
<tr>
<td>Total</td>
<td>2763</td>
<td></td>
</tr>
</tbody>
</table>

This is based on unique pts seen between 08/07/13 - 10/08/13. This sampling indicates that most of our patients speak English. We utilize staff that speak Spanish and also have available language line for any other languages that might be needed.
PCMH 2D: The Practice Team

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

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

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

PCMH 2D: The Practice Team (cont.)

6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change.
7. Training and assigning members of the care team to manage the patient population.
8. Holding scheduled team meetings to address practice functioning.
9. Involving care team staff in the practice’s performance evaluation and quality improvement activities.
10. Involving patients/families/caregivers in quality improvement activities or on the practice’s advisory council.
PCMH 2D: Scoring

MUST-PASS

4 Points

**Scoring**

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

PCMH 2D: Documentation

**Documentation**

- **F1.2, 4-7:** Staff position descriptions or responsibilities
- **F3:** Description of staff communication processes including frequency of communication and 3 examples showing that practice follows its process.
- **F4:** Written standing orders
- **F5-7:** Description of training process, schedule, materials
- **F6:** Description of staff communication process and examples of training materials.
- **F8:** Description of staff communication processes and sample
- **F9:** Description of staff role in practice improvement process or minutes demonstrating staff involvement
- **F10:** Process demonstrating how it involves patients/families in QI teams or advisory council
PCMH 2D, Factor 4: Example Standing Orders

POLICY/STANDING ORDERS FOR ADMINISTERING PNEUMOCOCCAL VACCINE TO ADULTS

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

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

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

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

Screen all patients for contraindications and precautions to pneumococcal vaccine:

Severe allergic reaction to past pneumococcal vaccine

Pregnant patients

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

Care Team Training: Self-Management Support & Population Management

Diabetes/Hypertension Care Team Training Sessions
Joint Staff Meeting
June 3rd 2011 130-230
Participants: All clinic staff and providers at general monthly clinic meeting
Agenda: The utilization of patient registries to manage high-risk diabetics and hypertensive patients.
Summary:
Introduction and education of patient care registries and their value (con’t)
PCMH 3: Population Health Management

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

**Meaningful Use Alignment**
- Practice has searchable electronic system:
  - Race/ethnicity/preferred language
  - Clinical information
- Practice uses clinical decision support and electronic system for patient reminders
PCMH 3: Population Health Management

20 Points

Elements

• Element A: Patient Information
• Element B: Clinical Data
• Element C: Comprehensive Health Assessment
• Element D: Use Data for Population Management
  MUST-PASS
• Element E: Implement Evidence-Based Decision Support

PCMH 3A: Patient Information

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

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

+ Stage 2 Core Meaningful Use Requirement
PCMH 3A: Patient Information (cont.)

7. E-mail address.
8. Occupation (NA for pediatric practices).
10. Legal guardian/health care proxy.
11. Primary caregiver.
13. Health insurance information.
14. Name and contact information of other health care professionals involved in patient’s care.

PCMH 3A: Scoring

3 Points

Scoring

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

NOTE

• Factors 8 and 12 (NA for pediatric practices).
• Written explanation of an NA response is required.
PCMH 3A: Documentation

Documentation

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

Demographic percentage for 3 month duration 1/1/14 - 4/1/14

This certified system produced very graphic Meaningful Use reports that were used to show practice level (all providers) results for a 3 month reporting period.

Report covers all site providers.

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

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

An acceptable summary report with at least 3 months of data with numerators and denominators producing results over 80% for factors shown, explanation should indicate source of data as in a searchable system.
PCMH 3A: Factors 1-7, 9-13 Example

PCMH 3A, Items 1-7, 9-13 - % of patients with documented items recorded as searchable data within the practice’s EMR (denominator shown in first column)
Report covers 3 months of data January 4, 2014 - March 4, 2014

<table>
<thead>
<tr>
<th>Total Patient Count</th>
<th>DOB</th>
<th>Gender</th>
<th>Race</th>
<th>Ethnicity</th>
<th>Lang</th>
<th>Phone #</th>
<th>Email</th>
<th>Dates of Previous Visits</th>
<th>Legal Guardian</th>
<th>Primary Caregiver</th>
<th>Adv Dir</th>
<th>Insur Info</th>
</tr>
</thead>
<tbody>
<tr>
<td># of PTS</td>
<td>9904</td>
<td>9904</td>
<td>9409</td>
<td>9409</td>
<td>9895</td>
<td>9748</td>
<td>3500</td>
<td>9904</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>9541</td>
</tr>
<tr>
<td>%</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>95%</td>
<td>100%</td>
<td>98%</td>
<td>35%</td>
<td>100%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>96%</td>
</tr>
</tbody>
</table>

Correct Factor Responses

- Shows 8 of 12 items at >80%
- Practice received 75% (2.25 points for Element 3A)
- NA is not an option for Factor 10 (Guardian) or Factor 11 (Care Giver)
- Adult practices are not eligible for NA for Factor 12 (Advanced Directives)

PCMH 3B: Clinical Data

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

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

* Stage 2 Core Meaningful Use Requirement
PCMH 3B: Clinical Data (cont.)

7. System plots and displays growth charts (length/height, weight and head circumference) and BMI percentile (0-20 years) (NA for adult practices).+
8. Status of tobacco use for patients 13 years and older for more than 80 percent of patients.+
9. List of prescription medications with date of updates for more than 80 percent of patients.
10. More than 20 percent of patients have family history recorded as structured data.++
11. At least one electronic progress note created, edited and signed by an eligible professional for more than 30 percent of patients with at least one office visit.++

+ Stage 2 Core Meaningful Use Requirement
++ Stage 2 Menu Meaningful Use Requirement

PCMH 3B: Scoring and Documentation

4 Points

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

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

Documentation
• Factors 1-5, 8-11: Reports with a numerator and denominator
• Factors 6, 7: Screen shots demonstrating capability
To understand the health risks and information needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes:

1. Age- and gender appropriate immunizations and screenings.
2. Family/social/cultural characteristics.
3. Communication needs.
4. Medical history of patient and family.
5. Advance care planning (NA for pediatric practices).
7. Mental health/substance use history of patient and family.
8. Developmental screening using a standardized tool (NA for practices with no pediatric patients).
9. Depression screening for adults and adolescents using a standardized tool.
10. Assessment of health literacy.

PCMH 3C: Scoring

4 Points

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

NOTE
- Factor 5 (NA for pediatric practices)
- Factor 8 (NA for practices with no pediatric patients).
- Factor 9 (if practice does not see adolescent or adult patients).
- Written explanation for NA responses.
PCMH 3C: Documentation

Documentation

- F1-10: Method #1: Report with numerator and denominator based on all unique patients in a recent three month period indicating how many patients were assessed for each factor.

  or

- F1-10: Method #2: Review of patient records selected for the record review required in elements 4B and 4C, documenting presence or absence of information in Record Review Workbook and examples.

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

- F8.9: Completed form (de-identified) demonstrating use of standardized tool.

PCMH 3C, Factor 6: Example Screening and Intervention

Preventive Care

- Tobacco use
- Advised to quit
- Immunizations
- Screenings
- Condition-specific
### PCMH 3C, Factors 4 and 7 Example
**Family Medical and Mental Health History**

<table>
<thead>
<tr>
<th>Family History of Medical and Mental Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>[List of Medical and Mental Disorders]</td>
</tr>
</tbody>
</table>

### PCMH 3D: Use Data for Population Management

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

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

*+ Stage 2 Core Meaningful Use Requirement*
PCMH 3D: Scoring

**MUST-PASS**

5 Points

**Scoring**

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

PCMH 3D: Documentation

**Documentation**

- F1-5:
  1) **Reports or lists** of patients needing services generated within the past 12 months (Health plan data okay if 75% of patient population)
  
  **AND**
  
  2) **Materials** showing how patients were notified for each service (e.g., template letter, phone call script, screenshot of e-notice).

**Initial Submissions:** One measurement for each factor, no more than 12 months old

**Renewing Practices:** Annual data for each of last two years for at least 2 factors.
Patients with abnormal BMI who need follow-up plan.

Dear Patient,

Our medical team is committed to all your health care needs. In reviewing your chart, we have noticed that you have an elevated BMI (Body Mass Index). Having an elevated BMI can potentially lead to health problems such as hypertension or diabetes are just a few. Please schedule an appointment with our providers so it can be discussed in depth what is BMI, how it is calculated and how to decrease this.

Thanking you in advance with helping us make sure all your health care needs are addressed.

Respectfully,

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

Report run for patients prescribed a medication that was recalled May 2012. Staff contacted them by phone about the recall.

Parameters:
- Drugs: Lo/Ovral (28) 0.3-30 mg-mcg Tabs
- Date Range: 05/07/2011-05/07/2012

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Phone Number</th>
<th>Patient #</th>
<th>Issue Date</th>
<th>Total Days</th>
<th>Days Left</th>
<th>Date of Call</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>210</td>
<td>5/08/12</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td>5/09/12</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td>5/09/12</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>210</td>
<td>5/09/12</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>30</td>
<td>5/09/12</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12</td>
<td>5/09/12</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>5/09/12</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
<td>5/09/12</td>
<td></td>
</tr>
</tbody>
</table>

PCMH 3D, Factor 5: Specific Medication Outreach

**Script**

Hi Mrs. Williams, this is Meagan from ABCD General Internal Medicine Associates. I am calling to tell you that recently, the company that manufactures Lo/Ovral has announced a recall. Our system indicated that you have been prescribed this medication and we wanted to inform you of the recall. Our nurse is available to speak with you to answer questions and recommend other medication options. Is now a good time?
PCMH 3E: Implement Evidence-Based Decision Support

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

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

PCMH 3E: Scoring and Documentation

4 Points

Scoring

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

Documentation

• F 1-6: Provide
  1) Conditions identified by the practice for each factor and
  2) Source of guidelines and
  3) Examples of guideline implementation
PCMH 3E, Factor 2: Evidence-Based Guidelines

**Clinically Important condition #1: Diabetes:**

**Screening:** Based upon recommendations from the American Diabetes Association, all patients greater than 45 years of age are screened for diabetes. Patients are screened by obtaining either random blood glucose or, preferably, a fasting blood glucose. However, patients at risk for developing diabetes are screened when they are < 45 years of age. 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 ovary syndrome
- 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 > 200 mg/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

---

PCMH 3E, Factor 2: Example EHR Lipid Management

<table>
<thead>
<tr>
<th>Lipid Management</th>
<th>Insert Text</th>
<th>Add diagnosis of HYPERLIPIDEMIA to Problem List?</th>
<th>Add Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Recent Labs</td>
<td>Lipid flowsheet</td>
<td>View Current Lipids</td>
<td>Therapeutic Recommendations</td>
</tr>
</tbody>
</table>

- **NCEP Adult Treatment Panel III Risk Factors**
  - Age 45 or greater: yes (no)
  - Early menopause w/o HRT: yes (no)
  - Diabetes: yes (no)
- **Lipid values:**
  - HDL < 40 mg/dL
  - HDL > 49 mg/dL (low risk)
  - Triglycerides > 200
- **Hypertension:**
  - Yes (no)
- **Smoking status:**
  - Current (quit never)
- **Peripheral vascular disease:**
  - Yes (no)
- **Abdominal Aortic Aneurysm:**
  - Yes (no)

**Goals Automatically Calculated based on # Risk Factors**

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

- **Check here to manually change lipid goals**

- **Enter Today’s BP:** mm Hg
PCMH 3E, Factor 2: Example Diabetes Flowsheet

<table>
<thead>
<tr>
<th>Flowsheet</th>
<th>Frequent</th>
<th>1st</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History &amp; Physical</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Every Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check Weight (BMI)</td>
<td>Every Visit</td>
<td>0.1</td>
<td>0.06</td>
</tr>
<tr>
<td><strong>Flowsheet</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inspect Feet</td>
<td>Every Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Lower Extremity Exam</td>
<td>Annually</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental/Oral Health Assessment</td>
<td>6 Months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Assessment</td>
<td>Annually</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Labs &amp; Tests</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALT</td>
<td>3 Months</td>
<td>7.7</td>
<td>7.7</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>Annually</td>
<td>218</td>
<td>206</td>
</tr>
<tr>
<td>TGL</td>
<td>Annually</td>
<td>98</td>
<td>97</td>
</tr>
<tr>
<td>HDL</td>
<td>Annually</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Total Cholesterol</td>
<td>Annually</td>
<td>147</td>
<td>173</td>
</tr>
<tr>
<td><strong>Medications &amp; Immunizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma Meds</td>
<td>Every Visit</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Inhaled Corticosteroids</td>
<td>Every Visit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Oral Corticosteroids</td>
<td>Every Visit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Lifestyle &amp; Counseling</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Set Self-Management Goals</td>
<td>Every Visit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Diabetes Patient Education / Nutrition / Exercise</td>
<td>Every Visit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Tobacco Use/Discontinue 2nd hand smoke</td>
<td>4 Months</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Smoking/Second Hand Smoke Counseling</td>
<td>Every Visit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Depression / Mental Health Screening</td>
<td>Every Visit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Review blood glucose log</td>
<td>Every Visit</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

PCMH 3E, Factor 3: Asthma Guidelines

Asthma Visit Sheet Shows:
- Physical exam specific to respiratory system
- Allergies
- Immunizations
- Asthma triggers
- Peak flow
- Medication tracking
- Treatment plan
- Referral

“National Asthma Education and Prevention Program (NAEPP) guidelines are imbedded in asthma visit sheet”
PCMH 3E, Factor 4: Example Pediatric Obesity

Pediatric Obesity Order Set in EMR

Q&A
PCMH 4: Care Management and Support

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

Meaningful Use Alignment
- Practice implements evidence-based guidelines
- Practice reviews and reconciles medications with patients
- Practice uses e-prescribing system
- Patient-specific education materials
PCMH 4: Care Management and Support

20 Points

Elements

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

PCMH 4A: Identify Patients for Care Management

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

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

- Identify **all** patients in practice with conditions referenced in 4A, Factors 1-5.
- Patients may “fit” more than one criterion (Factor).
- **Patients may be identified through electronic systems** (registries, billing, EHR), staff referrals and/or health plan data.
- Review comprehensive health assessment (Element 3C) as a possible method for identifying patients.
- **Factor 6 is critical** – NO points if no monitoring
- Patient identified in Factor 6 may be used **ONLY once** even if a patient meets more than one Factor.
- **Patients identified in Factors 1+2+3+4+5 – (minus) any duplicate patients = numerator**
PCMH 4A, Factors 1-6: Example How to Identify Patients Needing Care Management

Patient Registries/Lists Based on Factors 1-5

<table>
<thead>
<tr>
<th></th>
<th>Factor 1: Behav. Health</th>
<th>Factor 2: High Cost/Utilization</th>
<th>Factor 3: Poor Control/Complex</th>
<th>Factor 4: Social Determinants</th>
<th>Factor 5: Referrals</th>
<th>Factor 6: Total Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients in Registry (patients MAY be listed more than once)</td>
<td>50</td>
<td>75</td>
<td>100</td>
<td>75</td>
<td>50</td>
<td>350</td>
</tr>
<tr>
<td>Unique Patients</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>275</td>
</tr>
<tr>
<td>Total Patients in Practice</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>2500</td>
</tr>
<tr>
<td>Patients Needing Care Management</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>11% (275 Patients)</td>
</tr>
</tbody>
</table>

Practices may not have patient registries or lists for each factor

PCMH 4A: Scoring and Documentation

4 Points

Scoring

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

Documentation

- F1-5: Documented process describing criteria for identifying patients for each factor
- F6: Report with
  - Denominator = total number of patients in the practice
  - Numerator = number of unique patients in denominator likely to benefit from care management.
PCMH 4B: Care Planning and Self-Care Support

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

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

PCMH 4B: Scoring and Documentation

4 Points

Scoring

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

Documentation

• F1-5:
  ✓ Method 1: Report from electronic system
  or
  ✓ Method 2: Record Review Workbook and examples of how each factor is met
  ✓ Practice may use a combination of Method 1 and Method 2
TABLE 3-4 Example of a Written Plan for Communication

<table>
<thead>
<tr>
<th>Plan component</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name _____</td>
<td>Lets you personalize the plan; make a copy for medical record.</td>
</tr>
<tr>
<td>Medical Record No. _____</td>
<td></td>
</tr>
<tr>
<td>Date _____</td>
<td></td>
</tr>
</tbody>
</table>

1. Diagnosis: _____
   Gives the disease a name so the patient can look it up.

2. Stage (where it has spread): _____ (list all areas)
   Allows discussion of prognosis. Showing metastases to the brain and liver quickly points out the seriousness of the illness.

3. Prognosis: _____
   Ask first if patients want to know the full details of their illness! Allows open communication about goals, rest-of-life planning. Some patients will persist in denial, but this allows open dialogue with the family.

4. Treatment Goals: _____
   List cure, long- or short-term control, pain relief, hospice care
   Makes explicit what you can and cannot do; for curable disease, this reinforces your goal, and that cure is possible. Use this to bring up do-not-resuscitate and cardiopulmonary resuscitation issues. Allows you to emphasize that hospice care does not mean "no treatment", but a different set of treatment goals.

5. Treatment Options: _____
   List all that apply
   List treatments, response rates, and common toxicities. Specifically mention vomiting and hair loss, the two most feared symptoms. Remember, if you cannot define a real benefit then there is no justification for treatment.

6. Call the doctor if: _____
   List your threshold for fever, pain, and other symptoms
   Gives explicit reasons to call and gives explicit permission to call.

7. How to reach me: _____
   List the phone numbers during office and off-hours
   Tell patients to keep this handy. They will call, and for real events. Emails for nonemergency purposes work well for prescription refills, questions about new drugs, encouragement, etc.

8. Signed: _____MD
   Personalizes the plan as well as making it a part of the medical record.

SOURCE: Adapted from Smith, T.: *J Clin Oncol* 21(9 Suppl), 2003: 12s-16s. Reprinted with permission. © 2003 American Society of Clinical Oncology. All rights reserved.
Documentation from Patient Records

Elements PCMH 4B and 4C

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

Two methods to collect and submit patient data

- Method #1 - report from the electronic system

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

RRWB: Look at Instructions
RRWB: Overview of Steps for Method 2

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

(cont.)

6. Enter data in RRWB (Tab 2)
7. Enter Yes/No responses from RRWB in Survey Tool for Elements 4B and 4C
8. Attach RRWB to Survey Tool and link to Elements 4B and 4C and 3C
PCMH 4C: Medication Management

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

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

\textsuperscript{+} Core Meaningful Use Requirement(s)
PCMH 4C: Scoring and Documentation

4 Points

Scoring

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

Documentation

• F1-6:
  ✓ Method 1: Report from electronic system
  or
  ✓ Method 2: Record Review Workbook and examples of how each factor is met
  ✓ Practice may use a combination of Method 1 and Method 2

PCMH 4D: Use Electronic Prescribing

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

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

+ Core Meaningful Use Requirement(s)
PCMH 4D: Scoring and Documentation

3 Points

Scoring

• 4 factors = 100%
• 3 factors = 75%
• 2 factors = 50%
• 1 factor = 25%
• 0 factors = 0%
Factors - 1,2 may be N/A

Documentation

• F1, 2: Report with a numerator and denominator and screenshot
• F3, 4: Screen shots demonstrating functionality

PCMH 4D: Example Electronic Prescription Writing

<table>
<thead>
<tr>
<th>Prescription Writing Activity</th>
<th>Electronic</th>
<th>Printed, given to patient</th>
<th>Print, fax to pharmacy</th>
<th>Total Rx</th>
</tr>
</thead>
<tbody>
<tr>
<td>57%</td>
<td>57%</td>
<td>31%</td>
<td>1%</td>
<td>1419 Rx</td>
</tr>
<tr>
<td>57%</td>
<td>1419 Rx</td>
<td>4474 Rx</td>
<td>89 Rx</td>
<td>8474 Rx</td>
</tr>
</tbody>
</table>

% E-RX 57% 100%
PCMH 4D, Factor 1: Example Prescribing Decision Support - Formulary Drug

PCMH 4D, Factor 3: Example Drug-Drug Interactions
PCMH 4D, Factor 3: Example
EHR Prescription Allergy

PCMH 4D, Factor 4: Example Prescribing Decision Support – Generic Alternatives
PCMH 4E: Support Self-Care and Shared Decision-Making

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

The practice:

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

+ Core Meaningful Use Requirement(s)

---

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

5. Offers or refers patients to structured health education programs, such as group classes and support.
6. Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates.
7. Assesses usefulness of identified community resources.
PCMH 4E: Scoring and Documentation

5 Points

Scoring

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

Documentation

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

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

<table>
<thead>
<tr>
<th>Diabetes Health Record</th>
<th>Frequency</th>
<th>Common Goals</th>
<th>Individual Goals</th>
<th>My results</th>
<th>My results</th>
<th>My results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review blood sugar records</td>
<td>every visit</td>
<td>less than 130</td>
<td>less than 180</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood pressure</td>
<td>every visit</td>
<td>less than 140/80</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight (set realistic goals)</td>
<td>every visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot exam</td>
<td>every visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemoglobin A1C</td>
<td>every 3 to 6 months</td>
<td>less than 7.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine microalbumin/creatinine ratio</td>
<td>yearly</td>
<td>less than 30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PCMH 4E, Factor 5: Health Education Offered

Prenatal Care: Steps Toward a Healthy Pregnancy
Prenatal Session #1

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

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

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

PCMH 4E, Factor 6: Community Resource Examples

<table>
<thead>
<tr>
<th>Community Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Teen Pregnancy and Parenting Referral:</strong></td>
</tr>
<tr>
<td>• Teen Pregnancy/Parenting Programs: (800) 833-6235</td>
</tr>
<tr>
<td>• Garfield Medical Center, 525 N. Garfield Ave. MP, CA (626) 573-2222 (Pico Rivera)</td>
</tr>
<tr>
<td>• USC-WCH, 1240 N. Mission Rd, Los Angeles (323) 442-1100</td>
</tr>
<tr>
<td>• San Gabriel Perinatology Center, 616 N. Garfield, Monterey Park, CA. 91754.</td>
</tr>
<tr>
<td><strong>Medical Choice Referral:</strong></td>
</tr>
<tr>
<td>• Health Net Member Service Department: 1-800-675-6110</td>
</tr>
<tr>
<td>• AltaMed Assistants: 1-877-GO-2-ALTA</td>
</tr>
<tr>
<td>• DPSS 1(800) 660-4066</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New Immigrant Resources:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• National Hispanic Prenatal Hotline: 1-800-504-7081</td>
</tr>
<tr>
<td>• National Immigration Law Center: (213) 639-3900</td>
</tr>
<tr>
<td>• International Rescue Committee Inc (213) 386-6700</td>
</tr>
<tr>
<td><strong>Cultural Considerations:</strong></td>
</tr>
<tr>
<td>• Local Adult Education Classes, ELA College (323) 233-1283</td>
</tr>
<tr>
<td>• ESL Classes, L.A Unified Adult School (323) 262-5163</td>
</tr>
<tr>
<td>• Language Line Services: 1 (800) 367-9559</td>
</tr>
<tr>
<td><strong>Parenting Stress</strong></td>
</tr>
<tr>
<td>• Parental Stress Line Number: (800) 339-6993, or 211</td>
</tr>
<tr>
<td>• Elizabeth House: (626) 577-4434</td>
</tr>
</tbody>
</table>
PCMH 5: Care Coordination & Care Transitions
PCMH 5: Care Coordination and Care Transitions

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

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

---

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

**Elements**
- PCMH5A: Test Tracking and Follow-Up
- PCMH5B: Referral Tracking and Follow-Up
  **MUST PASS**
- PCMH5C: Coordinate Care Transitions
**PCMH 5A: Test Tracking and Follow-Up**

**Practice has a documented process for and demonstrates that it:**

1. Tracks lab tests and flags and follows-up on overdue results – **CRITICAL FACTOR**
2. Tracks imaging tests and flags and follows-up on overdue results – **CRITICAL FACTOR**
3. Flags abnormal lab results, bringing to attention of clinician
4. Flags abnormal imaging results, bringing to attention of clinician
5. Notifies patients of normal and abnormal lab/imaging results
6. Follows up on newborn screening **(NA for adults)**
7. > 30% of lab orders are electronically recorded in patient record
8. > 30% of radiology orders are electronically recorded in patient record
9. > 55% of clinical lab tests results are electronically incorporated into structured fields in medical record
10. >10% of scans & test that results in an image are accessible electronically *

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

Practice has documented process for and demonstrates:

7. > 30% of lab orders are electronically recorded in pt. record
8. > 30% of radiology orders are electronically recorded in pt. record
9. > 55% of clinical lab tests results are electronically incorporated into structured fields in pt. record
10. > 10% of scans & test that results in an image are accessible electronically

*Meaningful Use Requirement

<table>
<thead>
<tr>
<th>Documentation F 7-10:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice level data or MU reports from the practice’s electronic system with numerator, denominator and percent</td>
</tr>
<tr>
<td>At least 3 months of data for each factor</td>
</tr>
</tbody>
</table>

PCMH 5A: Scoring and Documentation

6 Points

Scoring

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

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

Both lab and imaging must be included in process and reports in Factors 1 and 2 to receive any score for PCMH 5A
PCMH 5A, Factors 1, 3 & 5 Lab Process

**Missing Flagging Overdue labs and FU**

PCMH 5A, Factors 1&2: Documented Process

5A Cont.

Factor 1 and 2: The practice has a written process for staff to track and follow-up on lab tests and imaging tests. The practice electronically communicates with labs and facilities to order tests and retrieve results. Care center staff members review the Electronic Medical Record (EMR) for any lab and imaging results that were sent to patient charts.
### PCMH 5A: Example Test Tracking Log

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

**This example shows:**
- **Factor 3:** Flag abnormal results
- **Factor 5:** Patient notification
- **Factor 1:** Missing Flagging and follow Up on overdue results for

### PCMH 5A: Example Electronic Test Tracking

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

**Practice tracks:**
- Date ordered
- Overdue
- Abnormal
- Priority
- Patient name
- Provider
- Order description
- Last appointment
- Next appointment
PCMH 5A, Factors 1&2: Proactive Patient Follow-Up

We hope this letter finds you in good health. Please return to the center at your earliest convenience for the blood work your physician ordered for you on 10/30/13.

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

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

Sincerely,

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

---

PCMH 5A, Factors 3&4: Process/Flagging Abnormal Results

<table>
<thead>
<tr>
<th>Patient Focused Oncology Quality Program Policy and Procedure Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title: Fl. 3 &amp; 4: normal Lab Results</td>
</tr>
<tr>
<td>Author:</td>
</tr>
<tr>
<td>Approved:</td>
</tr>
<tr>
<td>Updates/Incorporations: 5/21/19</td>
</tr>
<tr>
<td>Date: May 23, 2019</td>
</tr>
<tr>
<td>Reference Number: 5A S A 5</td>
</tr>
</tbody>
</table>

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

**Procedure:**

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

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

**Responsible Parties:** Medical Laboratory Technician/Technologist, Physician, Non-Physician Provider, Nursing, Medical Records, HIM, EMR
PCMH 5A, Factor 3: Flagging Abnormal Labs

PCMH 5A, Factor 5: Abnormal Lab Notification

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

Factor 1 and 5: The PCP attempts to contact the patient following abnormal lab report results.
PCMH 5A, Factor 5: Normal Lab Notification

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

Please call us at 341 if you would like to go over the test results or if you have additional questions or concerns.

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

Sincerely,

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

---

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

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

NA for adult only practices.
PCMH 5A, Factor 9: MU Report

<table>
<thead>
<tr>
<th>Facility</th>
<th>Discrete Labs Ordered</th>
<th>Discrete Results Received</th>
<th>Results Received (&gt;40%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>86,157</td>
<td>83,917</td>
<td>97.40%</td>
</tr>
</tbody>
</table>

**Report Summary**

This report demonstrates that lab results are electronically integrated into the EMR and recorded in the patient’s record, rather than requiring a manual look-up of results in a separate system and manual data entry of the results into the EMR. The practice must achieve at least 40% in order to meet this measure. Results below 40% are displayed in red.

Specific labs used in this analysis are identified by the CEMR team and cover tests where the result is expressed in a positive/negative or numeric format. Actual lab values returned are determined to meet the measure if they are numeric or contain the text “Neg”, “Pos”, “React” or “Detect”.

Users must make a selection in the Location prompt in order to run the report.

**Report Period**
The time period covered in the report

**Facility**
Facility name

**Discrete Labs Ordered**
The number of labs ordered by the practice where the results are expected to be in a specific discrete format (positive/negative or number, or as a number).

**Discrete Results Received**
The number of labs ordered where the result values received were in fact in the discrete format expected

**Discrete Results Received (>40%)**
Discrete Labs Ordered divided by Discrete Results Received

---

**Discrete Labs Report**
Period: 02/24/2013 - 02/23/2014

Report reflects data over a 12 month period.

---

PCMH 5A, Factor 10: Imaging Results Electronically Accessible

Imaging results are automatically sent to office from imaging center via electronic fax and merged into the EHR

*Need min 3 month MU report or data report w/ numerator/denominator and percentage results
PCMH 5B: Referral Tracking & Follow-Up

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

6. Gives the consultant/specialist pertinent demographic and clinical data, including test results and current care plan
7. Has capacity for electronic exchange of key clinical information* and provides electronic summary of care record to another provider for >50% of referrals
8. Tracks referrals until consultant/specialist report is available, flagging and following up on overdue reports (Critical Factor)
9. Documents co-management arrangements in patient’s medical record
10. Asks patients/families about self-referrals and requests reports from clinicians

*Meaningful Use Requirement
PCMH 5B: Referral Tracking & Follow-Up

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

Documentation:
- F1: Examples of types of info the practice has on specialist performance
- F2-3: At least one example for each factor
- F4: Materials explaining how BH is integrated with physical health
- F5-6: Documented process and at least one example or report demonstrating process implementation

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

Practice tracks referrals:
6. Gives the specialist pertinent demographic & clinical data, test results & current care plan
7. Capacity for electronic exchange of key clinical info & provides electronic summary of care record to another provider > 50 % of referrals*
8. Tracks referrals for receipt of report, flags, and follows up on overdue reports (Critical Factor)
9. Documents co-management arrangements in patient medical record
10. Asks patients/families about self-referrals and requests reports from clinicians.

Documentation
F7: Report from electronic system with numerator, denominator and percent
At least 3 months of data
F6, 8, & 10: Documented process and at least one example or report demonstrating process implementation
F9: At least three examples

*Meaningful Use Requirement
PCMH 5B: Scoring

**MUST PASS**

**6 Points**

**Scoring**

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

Must meet minimum of 4 factors (including factor 8) to pass this Must-Pass Element
PCMH 5B, Factor 1: Performance of Specialists/Consultants

PCMH 5B, Factor 2 Example Agreement

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

1. Referring provider - Cardiology Patient Care Plan outlines 2022

2. Communication: When is going to happen

3. Hospital

4. Other Special Coordination Issues

5. Hospice - specifically need to address this on a per-patient basis, often clarified on the Hospice form (patient designates physician when signing up with Hospice)
PCMH 5B, Factor 2: Co-Management

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

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

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

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

<table>
<thead>
<tr>
<th>TABLE 3: COLLABORATIVE CARE CATEGORIZATIONS AT A GLANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COORDINATED</strong></td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td>Routine screening for behavioral health problems conducted in primary care setting</td>
</tr>
<tr>
<td>Referral relationship between primary care and behavioral health settings</td>
</tr>
<tr>
<td>Routine exchange of information between both treatment settings to bridge cultural differences</td>
</tr>
</tbody>
</table>

**CONTINUED:**

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

Documentation Required: (Factor 3) One BH Agreement & (Factor 4) Explanation of BH Integration into the practice site.
PCMH 5B, Factor 5 Clinical Reason/Type/Timing

PCMH 5B, Factors 5 & 6: Documented Process

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

Criteria for Informal Agreements between Primary Care referring clinician and Specialist (855)

Access
- Referral to specialist based on urgency
  - Routine - within 2 weeks
  - Urgent - within 48 hours
  - Stat within 24 hours
- Work specialist to expedite care in urgent cases
- Verify insurance status
- Anticipate special needs of patient/family
- Agree to engage/consult with specialist regarding a pre-referral consult if requested.

Communication to Specialist Clinician
Notify when appointment is scheduled through electronic medical record and external referral form.
- Request that specialist office send report back to PCP after the appointment based on nature of the illness and urgency
  - Routine - within 2 weeks pending test results (1A3)
  - Urgent - within 24-48 hours
  - Stat immediately
- Consult letter can be communicated by EMR, Fax, or mail if electronic option is not available

Access
- Referral request should identify urgency of referral
  - Routine
  - Urgent
  - Stat

Communication (Referral from) (855)
- State the clinical question and type of referral request
- Identify type of referral request
  - Consult only (address clinical question and send report back) and referring clinician will follow up with needed tests
  - Consult and Treat (address clinical question and follow up with appropriate plan of care and treatment)
  - Transfer of care (Comprehensive care for all patient needs is transferred to the specialist)
- Provide patient demographics, clinical information (allergies, problem list, medications)
- Send current primary care plan/clinical summary, treatment, tests, procedures - to avoid duplication
- Expectation that communication back to patient on treatment options and test results if consult only
PCMH 5B, Factor 7 & PCMH 5C, Factor 7: Example

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

Outbound Transfer of Care
Factor 7 (CMU 8)
Cr-2102
0.3523
59.7%

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

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

5B-7 Report showing the Transition of Care give to outside provider for referrals for all providers over the last year.
PCMH 5B, Factor 8: Example Referral Tracking Report

<table>
<thead>
<tr>
<th>REFERRING DR</th>
<th>HIS DATE</th>
<th>PATIENT NAME/DOB</th>
<th>FACILITY/PHYSICIAN</th>
<th>DIAGNOSIS/REASON FOR REFERRAL</th>
<th>APPT DATE</th>
<th>INS, INFO./PRE-AUTHOR., IF NEEDED</th>
<th>STAT</th>
<th>RCVD. REPORT</th>
<th>REPORT OVERDUE</th>
<th>PERSON &amp; DATE NOTIF. PT.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6/16/2100</td>
<td>1/01/1990</td>
<td>Diagnostic Imaging</td>
<td>Abd. pain, abdomen, Seps.</td>
<td>6/19/2100</td>
<td>HEALTH PLAN - get pre-author.</td>
<td>No</td>
<td>7/15/2100</td>
<td></td>
<td>7/17/2000 - JOE</td>
</tr>
<tr>
<td></td>
<td>6/16/2100</td>
<td>3/06/1970</td>
<td>Pediatric Orthopedic</td>
<td>Knees pain - eval. and treat.</td>
<td>TED</td>
<td>HEALTH PLAN - get pre-author.</td>
<td>No</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7/22/2100</td>
<td>10/16/1990</td>
<td>Orthopedic</td>
<td>Suspect torn ACL - eval. and treat.</td>
<td>7/24/2100</td>
<td>- follow-up author. needed</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tracking Table Includes:
- Reason for referral
- Purpose of referral
- Date referral initiated
- Timing to receive report

PCMH 5B, Factor 9: Co-Management Documentation

**Procedures:**

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

We specialize in ENDOCRINOLOGY. You have been referred here for SHARED CO-MANAGEMENT. Both your primary care doctor and our practice will work together with you to help follow and/or treat a condition with most of the testing and appointments with your primary care doctor but with an
PCMH 5B, Factor 10: Documented Process

- WHEN PATIENTS ARE BROUGHT BACK TO THE ROOM, PLEASE ASK IF THEY HAVE SEEN ANY SPECIALISTS SINCE LAST VISIT WITH PHYSICIAN
  - IF YES – PLEASE CHECK CHART FOR CONSULT LETTER
  - IF CONSULT LETTER NOT PRESENT, PLEASE CALL SPECIALIST OFFICE FOR LETTER

PCMH5B 10 Example

<table>
<thead>
<tr>
<th>Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>- <strong>Medication</strong> List Recalled.</td>
</tr>
<tr>
<td>- Return to the clinic if condition worsens or new symptoms arise and amplifies negative J01.02.3 &amp; 805.3.2.</td>
</tr>
<tr>
<td>- <strong>Seeing</strong> a Specialist - Self Referral - patient following with Dr. Hopkins. Reviewed labs from her office. Will request records.</td>
</tr>
<tr>
<td>Allergies: Reviewed.</td>
</tr>
</tbody>
</table>
PCMH 5C: Coordinate Care Transitions

The Practice:
1. Proactively identifies patients with unplanned admissions and ED visits
2. Shares clinical information with admitting hospitals/ED
3. Consistently obtains patient discharge summaries
4. Proactively contacts patients/families for follow-up care after discharge from hospital/ED w/in appropriate period
5. Exchanges patient information with hospital during hospitalization
6. Obtains proper consent for release of information (ROI) and has process for secure exchange of info & coordination of care w/community partners
7. Exchanges key clinical information with facilities and provides electronic summary of care for > 50% of patient transitions of care (NA response requires a written explanation)

PCMH 5C: Scoring and Documentation

6 Points
Scoring
- 7 factors = 100%
- 5-6 factors = 75%
- 3-4 factors = 50%
- 1-2 factor = 25%
- 0 factors = 0%
PCMH 5C, Factors 1-7: Coordinate Care Transitions

Documentation
• F1: Documented process to identify patients and log or report.
• F2-4: Documented process and examples of providing clinical information, obtaining discharge summaries, follow up, and exchange of information and 3 examples for each factor.
• F5: Documented process for 2 way communication with hospitals and one example of 2 way communication.
• F6: Documented process for obtaining consent for release of information.
• F7: Report with numerator, denominator and percent with at least 3 months of data.

PCMH 5C, Factors 1-4 Documented Process

<table>
<thead>
<tr>
<th>Procedure:</th>
<th>Effective Date 6/1/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC4</td>
<td>Hospital census is obtained daily by fax or from an offsite electronic Health Information System from local hospitals by the Care Coordinator or Nurse Care Manager.</td>
</tr>
<tr>
<td></td>
<td>Communication with local hospitals is completed daily.</td>
</tr>
<tr>
<td>SC2</td>
<td>Discharge records are faxed to the CHCCM from the hospital or pulled from an offsite Health Information System by the Care Coordinator or Nurse Care Manager.</td>
</tr>
<tr>
<td>SC3</td>
<td>Local hospitals are contacted if additional information is needed.</td>
</tr>
<tr>
<td>SC2</td>
<td>After thorough review and obtaining hospital records the Care Coordinator will give the daily census to the Nurse Care Manager for review.</td>
</tr>
<tr>
<td></td>
<td>Nurse Care Manager will be responsible for assuring the medical records were received and scanned into the chart.</td>
</tr>
<tr>
<td>SC4</td>
<td>Nurse Care Manager or Care Coordinator (if designated) will be responsible for contacting patient’s that were admitted and discharged from the hospital within 72 hours to ensure medications and allergies are reconciled in the patient’s chart, schedule follow up appointment’s if needed and obtain additional information as needed.</td>
</tr>
</tbody>
</table>
PCMH 5C, Factor 1: Identifying Patients in Facilities

Practice receives admission reports electronically from hospital.

PCMH 5C, Factor 1: Example Documentation

[Table showing patient information including name, admission date, sex, age, and admitting diagnosis]
PCMH 5C, Factor 1: Example ER Visit
Follow-Up Log

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

PCMH 5C, Factor 2: Example Sharing Information

11/15/2013
Note Subject: send records
Pt being hospitalized. Send records to St

November 15, 2013 3:37:29 PM
faxed facsheet, med list, flowsheet
PN 11/11 and 1030
op/path 11/1
US 10/31
image other 10/31
labo10/11-11/13
PCMH 5C, Factors 3 & 4 Example

Notes
Discharged from:
Records management 3/10/2014 Records received.
Hospitalization 3/09/2014 Date of discharge.
A follow-up appointment has been made.
Patient contacted: 3/10/2014,
Assessment of pt symptoms: Spoke to patient regarding recent hospital discharge for numbness in arm. Patient states that she is doing fine, she still have the numbness and tingling in her arm. She states that she had an MRI, cat scan and an echo with no findings. She states that they do not know why she has this. Scheduled a follow up appointment.
R.N.

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

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

Outbound Transfer of Care
Factor 7 (CMU 8) N-2103 D-3523 59.7%
Questions?

PCMH 6: Performance Measurement and Quality Improvement
### PCMH 6: Performance Measurement and Quality Improvement

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

#### Meaningful Use Alignment
Practice uses certified EHR to:
- Protect health information
- Generate preventive and follow-up care reminders
- Submit electronic data to registries
- Submit electronic syndromic surveillance data
- Identify and report cases

### Elements
- **Element A: Measure Clinical Quality Performance**
- **Element B: Measure Resource Use and Care Coordination**
- **Element C: Measure Patient/Family Experience**
- **Element D: Implement Continuous Quality Improvement**  **MUST PASS**
- **Element E: Demonstrate Continuous Quality Improvement**
- **Element F: Report Performance**
- **Element G: Use Certified EHR Technology**
PCMH 6A: Measure Clinical Quality Performance

At least annually the practice measures or receives data on:

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

Vulnerable Populations Defined

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

Source: AHRQ
Vulnerable vs. High-risk

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

PMCH 6A: Scoring and Documentation

3 points

**Scoring**

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

**Documentation**

- F1-4: Reports showing performance

  **Initial Submission:** One measurement for each factor (no more than 12 months old)

  **Renewing Practice:** Attestation
PCMH 6A, Factor 2: Example Preventive Care Measures

<table>
<thead>
<tr>
<th>&gt;30 BMI Numerator</th>
<th># BMI Calculated</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/2012-12/31/2012</td>
<td>2508</td>
<td>5993</td>
</tr>
<tr>
<td>2/1/2013-4/30/2013</td>
<td>2535</td>
<td>5816</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Smoking/Tobacco Cessation Numerator</th>
<th>Smoking/Tobacco Cessation Denominator</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/2012-12/31/2012</td>
<td>380</td>
<td>1343</td>
</tr>
<tr>
<td>2/1/2013-4/30/2013</td>
<td>371</td>
<td>1409</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Colorectal Cancer Screen Numerator</th>
<th>Colorectal Cancer Screen Denominator</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/2012-12/31/2012</td>
<td>754</td>
<td>3311</td>
</tr>
<tr>
<td>2/1/2013-4/30/2013</td>
<td>944</td>
<td>3497</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Health Maintenance Topic</th>
<th>In compliance</th>
<th>Overdue</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>51.05% 1,381</td>
<td>48.95% 1,324</td>
<td>100% 2,705</td>
</tr>
<tr>
<td>Colon Cancer Colonoscopy</td>
<td>63.35% 1,965</td>
<td>36.65% 1,137</td>
<td>100% 3,102</td>
</tr>
<tr>
<td>Pneumococcal Vaccine</td>
<td>83.11% 745</td>
<td>16.89% 350</td>
<td>100% 1,234</td>
</tr>
<tr>
<td>Foot Exam</td>
<td>74.84% 992</td>
<td>25.16% 350</td>
<td>100% 1,332</td>
</tr>
<tr>
<td>Hemoglobin A1C</td>
<td>71.34% 884</td>
<td>28.66% 350</td>
<td>100% 1,234</td>
</tr>
<tr>
<td>Urine Microalbumin/Creatinine Ratio</td>
<td>67.13% 825</td>
<td>32.87% 404</td>
<td>100% 1,229</td>
</tr>
</tbody>
</table>
PCMH 6A, Factor 3: 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>HVI</th>
<th>FR</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 04</td>
<td>41%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Q2 04</td>
<td>42%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Q3 04</td>
<td>44%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Q4 04</td>
<td>45%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Q1 05</td>
<td>46%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Q2 05</td>
<td>60%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Q3 05</td>
<td>60%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Q4 05</td>
<td>60%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Q1 06</td>
<td>60%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Q2 06</td>
<td>60%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Q3 06</td>
<td>60%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Q4 06</td>
<td>60%</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>HVI</th>
<th>FR</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 05</td>
<td>61%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Q2 05</td>
<td>63%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Q3 05</td>
<td>65%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Q4 05</td>
<td>66%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Q1 06</td>
<td>66%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Q2 06</td>
<td>66%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Q3 06</td>
<td>66%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Q4 06</td>
<td>66%</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

PCMH 6A, Factor 4: Example Data for Vulnerable Populations

<table>
<thead>
<tr>
<th></th>
<th># of pts by race</th>
<th># of pts with A1C done by race</th>
<th>% of pts with A1C done by race</th>
<th># of pts with LDL done by race</th>
<th>% of pts with LDL done by race</th>
<th># 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>20</td>
<td>4271</td>
<td>1.84%</td>
<td>36</td>
</tr>
<tr>
<td>Black</td>
<td>1520</td>
<td>4271</td>
<td>57.9%</td>
<td>1928</td>
<td>4271</td>
<td>35.78%</td>
<td>737</td>
</tr>
<tr>
<td>Caucasian</td>
<td>2160</td>
<td>4271</td>
<td>50.57%</td>
<td>2077</td>
<td>4271</td>
<td>47.23%</td>
<td>994</td>
</tr>
<tr>
<td>Hispanic</td>
<td>58</td>
<td>4271</td>
<td>1.36%</td>
<td>51</td>
<td>4271</td>
<td>1.18%</td>
<td>17</td>
</tr>
<tr>
<td>Other</td>
<td>77</td>
<td>4271</td>
<td>1.80%</td>
<td>68</td>
<td>4271</td>
<td>1.58%</td>
<td>22</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>101</td>
</tr>
</tbody>
</table>
PCMH 6B: Measure Resource Use and Care Coordination

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

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

PCMH 6B: Scoring and Documentation

3 points

Scoring

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

Documentation

- F1-2: Reports showing performance

Initial Submission: One measurement for each factor (no more than 12 months old)

Renewing Practice:
- Factor 1: One measurement (no more than 12 months old)
- Factor 2: Once in each of last 2 yrs.
PCMH 6B: Example Measures Affecting Health Care Costs

(Preventable Readmissions) Readmission within 30 days (All Cause)

Readmission within 30 days showing improvement

PCMH 6C: Measure Patient/Family Experience

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

1. Practice conducts survey measuring experience on at least three of the following: access, communication, coordination, whole person care/self-management support
2. Practice uses PCMH CAHPS Clinician & Group Survey Tool
3. Practice obtains feedback from vulnerable patient groups
4. Practice obtains feedback through qualitative means
PCMH 6C: What Questions Reflect 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

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

- Use of a standardized survey allows “apples to apples” comparison of patient experience across recognized practices
- Non-proprietary survey and can be easily adopted by practices and vendors
- Survey is specifically designed to evaluate patient experience with medical homes
- Survey derived from the most widely used consumer experience survey
- Rigor of the survey design and consumer testing process
- Other entities and initiatives are likely to require use of CAHPS PCMH
PCMH 6C: Scoring and Documentation

4 points

Scoring

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

Documentation

- F1-4: Reports showing results of patient feedback

Initial Submission: One measurement for each factor (no more than 12 months old)

Renewing Practices: Attestation

PCMH 6C: Example Patient Experience

Survey Results

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

<table>
<thead>
<tr>
<th>Measure</th>
<th>Denominator</th>
<th>Previous Score</th>
<th>Provider Score</th>
<th>Practice Score</th>
<th>Project Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate provider 0 – 10</td>
<td>11</td>
<td>100.00%</td>
<td>81.82%</td>
<td>78.91%</td>
<td>79.98%</td>
</tr>
<tr>
<td>How long wait for urgent appt</td>
<td>3</td>
<td>50.00%</td>
<td>33.33%</td>
<td>38.58%</td>
<td>46.56%</td>
</tr>
<tr>
<td>Office gave info re: after hours care</td>
<td>11</td>
<td>100.00%</td>
<td>72.73%</td>
<td>59.76%</td>
<td>65.52%</td>
</tr>
<tr>
<td>Get reminders between visits</td>
<td>11</td>
<td>100.00%</td>
<td>72.73%</td>
<td>75.29%</td>
<td>69.94%</td>
</tr>
<tr>
<td>Someone follow up with results</td>
<td>10</td>
<td>66.67%</td>
<td>60.00%</td>
<td>65.09%</td>
<td>65.46%</td>
</tr>
<tr>
<td>Informed and up-to-date on specialist care</td>
<td>7</td>
<td>100.00%</td>
<td>71.43%</td>
<td>62.57%</td>
<td>60.86%</td>
</tr>
<tr>
<td>Talk about prescription</td>
<td>11</td>
<td>100.00%</td>
<td>81.82%</td>
<td>88.89%</td>
<td>82.77%</td>
</tr>
<tr>
<td>Rate overall health</td>
<td>11</td>
<td>0.00%</td>
<td>0.00%</td>
<td>8.78%</td>
<td>7.00%</td>
</tr>
<tr>
<td>Rate overall mental/physical health</td>
<td>11</td>
<td>33.33%</td>
<td>27.27%</td>
<td>21.15%</td>
<td>20.68%</td>
</tr>
<tr>
<td>Access</td>
<td>35</td>
<td>64.29%</td>
<td>60.00%</td>
<td>46.00%</td>
<td>47.38%</td>
</tr>
<tr>
<td>Communication</td>
<td>64</td>
<td>100.00%</td>
<td>82.81%</td>
<td>79.68%</td>
<td>81.78%</td>
</tr>
<tr>
<td>Shared Decision Making</td>
<td>24</td>
<td>100.00%</td>
<td>83.33%</td>
<td>58.43%</td>
<td>64.81%</td>
</tr>
<tr>
<td>Self Management Support</td>
<td>22</td>
<td>50.00%</td>
<td>50.00%</td>
<td>42.89%</td>
<td>46.33%</td>
</tr>
<tr>
<td>Comprehensiveness-Adult Behavioral</td>
<td>33</td>
<td>33.33%</td>
<td>51.52%</td>
<td>33.64%</td>
<td>40.37%</td>
</tr>
<tr>
<td>Office Staff</td>
<td>22</td>
<td>66.67%</td>
<td>81.82%</td>
<td>67.77%</td>
<td>67.36%</td>
</tr>
</tbody>
</table>

**PCMH 6D: Implement Continuous Quality Improvement**

Practice uses ongoing quality improvement process:

1. Set goals and analyze at least three clinical quality measures from Element 6A
2. Act to improve performance on at least three clinical quality measures from Element 6A
3. Set goals and analyze at least one measure from Element 6B
4. Act to improve at least one measure from Element 6B
PCMH 6D: Implement Continuous Quality Improvement (cont.)

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

PCMH 6D: Scoring and Documentation

Must Pass
4 Points

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

Documentation
- F1-7: Report or completed PCMH Quality Measurement and Improvement Worksheet
PCMH 6D: Quality Measurement & Improvement Worksheet

**ELEMENT D - Implement Continuous Quality Improvement (MUST PASS)**

The practice uses an ongoing quality improvement process to:

1. Set goals and analyze at least three clinical quality measures from Element A.
2. Act to improve at least three clinical quality measures from Element A.
3. Set goals and analyze at least one measure from Element B.
4. Act to improve at least one measure from Element B.
5. Set goals and analyze at least one patient experience measure from Element C.
6. Act to improve at least one patient experience measure from Element C.
7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations.

**Scoring:**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>10 factors</td>
<td>5 factors</td>
<td>2.5 factors</td>
<td>1.25 factors</td>
<td>0 factors</td>
</tr>
</tbody>
</table>

**Data Source:**

**Scope of Review:**

**Reference Information:**

[Click here to access worksheet]

---

PCMH 6D: Quality Measurement and Improvement Template

**NCQA’s Patient-Centered Medical Home (PCMH) 2014 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 enable organizations in understanding and in achieving NCQA – the measures and quality improvement activities that are required in PCMH: Element A, Factor 5 and PCMH: Elements 2, 3, and 4. Please note that practices are not required to use the worksheet, as documentation for PCMH: Element A, Factor 5 and PCMH: Elements 2, 3, and 4 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: Element A, Factor 5 and PCMH: Elements 2, 3, and 4 for additional information.

<table>
<thead>
<tr>
<th>Column</th>
<th>A. Measure</th>
<th>B. Opportunity Identified</th>
<th>C. Initial Performance</th>
<th>D. Performance Goal</th>
<th>E. Action Plan for Development of Improvement</th>
<th>F. Performance at Time of Implementation</th>
<th>G. Demonstrated Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>Identify at least one (1) measure from PCMH: Element A, Factor 5 (either clinical or patient experience measures)</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>
<td>List the initial performance rate as a percentage in the form of a percentage or number</td>
<td>List at least one performance goal for each identified opportunity. Provide the goal as a specific percentage or number</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>
<td>List the measurement period and the performance rate after the action was taken to improve the initial (baseline) rate. The date must occur after the activity implementation date</td>
<td>Describe the baseline and remeasurement period; describe the interventions implemented; and describe the link between the interventions and the resulting rate improvement</td>
</tr>
</tbody>
</table>
PCMH 6D and 6E: Quality Measurement and Improvement Template

PCMH 6E: Demonstrate Continuous Quality Improvement

Practice demonstrates continuous quality improvement:

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

3 Points

Scoring

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

Documentation

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

PCMH 6E: Example Tracking Data Over Time

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations</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>Diabetes</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>CHF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ace Inhibitors</td>
<td>99.18</td>
<td>99.58</td>
<td>99.69</td>
<td>99.13</td>
<td>99.56</td>
</tr>
<tr>
<td>CAD</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>99.65</td>
<td>98.67</td>
<td>98.87</td>
</tr>
</tbody>
</table>
PCMH 6E: Example Patient Survey Results Over Time

PCMH 6F: Report Performance

Practice produces performance data reports and shares data from Elements A, B and C:

1. Individual clinician results with the practice
2. Practice-level results with the practice
3. Individual clinician or practice-level results publicly
4. Individual clinician or practice-level results with patients
PCMH 6F: Scoring and Documentation

3 Points

Scoring

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

Documentation

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

PCMH 6F: Example Reporting by Individual Clinician
### PCMH 6F: Example Reporting by Individual Clinician

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

<table>
<thead>
<tr>
<th></th>
<th>Numerator</th>
<th>Denominator</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pneumococcal Vaccination Rates</strong></td>
<td>717</td>
<td>902</td>
<td>79%</td>
</tr>
<tr>
<td>Dr.</td>
<td>109</td>
<td>114</td>
<td>96%</td>
</tr>
<tr>
<td>Dr.</td>
<td>12</td>
<td>15</td>
<td>80%</td>
</tr>
<tr>
<td>Dr.</td>
<td>172</td>
<td>208</td>
<td>83%</td>
</tr>
<tr>
<td>Dr.</td>
<td>310</td>
<td>334</td>
<td>93%</td>
</tr>
<tr>
<td>Dr.</td>
<td>1</td>
<td>5</td>
<td>20%</td>
</tr>
</tbody>
</table>

### PCMH 6F: Example Practice Level Diabetes Data

**Show data for**  
Count of DM patients 18-75 yo  
Pct of DM patients with latest LDL <100  
Pct DM pts w/ smoking cessation counselling  
Pct of DM patients with latest A1C <=7  
Pct of DM patients with >=1 LDL tests  
Pct of DM patients with foot exam  
Pct of DM patients aged 40-75 on aspirin

<table>
<thead>
<tr>
<th></th>
<th>Goal</th>
<th></th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count of DM patients 18-75 yo</td>
<td>70</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Pct of DM patients with latest LDL &lt;100</td>
<td>90</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Pct DM pts w/ smoking cessation counselling</td>
<td>90</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Pct of DM patients with latest A1C &lt;=7</td>
<td>90</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Pct of DM patients with &gt;=1 LDL tests</td>
<td>90</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Pct of DM patients with foot exam</td>
<td>90</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Pct of DM patients aged 40-75 on aspirin</td>
<td>85</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Pct of DM patients with latest LDL &lt;100</td>
<td>76</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Pct of DM patients with eye exam</td>
<td>90</td>
<td>90</td>
<td></td>
</tr>
</tbody>
</table>

![Graphs showing diabetes data](image-url)
PCMH 6F: Example Reporting Across Practice(s)

Shows data for multiple sites

<table>
<thead>
<tr>
<th>QUALITY MEASURE</th>
<th>VGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM - Diabetic Eye Exam</td>
<td></td>
</tr>
<tr>
<td>% of Patients Screened (Out Only) within the Past Year</td>
<td>54%</td>
</tr>
<tr>
<td></td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>45%</td>
</tr>
<tr>
<td></td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>64%</td>
</tr>
<tr>
<td></td>
<td>67%</td>
</tr>
<tr>
<td></td>
<td>56%</td>
</tr>
<tr>
<td></td>
<td>52%</td>
</tr>
</tbody>
</table>

| DM - HbA1c |   |
| % of Patients Screened within the Past Year | 84% |
| 83% |
| 85% |
| 85% |
| 79% |
| 83% |
| 85% |
| 87% |
| 86% |
| 83% |

| DM - HbA1c: Level of Control - <7.0% |   |
| % of Tested Patients with Lab Results <7.0% | 43% |
| 41% |
| 43% |
| 39% |
| 50% |
| 41% |
| 38% |
| 50% |
| 53% |
| 45% |
| 47% |

| DM - HbA1c: Level of Control - >9.0% |   |
| % of Tested Patients with Lab Results >9.0% | 9% |
| 10% |
| 5% |
| 11% |
| 6% |
| 12% |
| 11% |
| 6% |
| 6% |
| 11% |
| 8% |
| 10% |

PCMH 6G: Use Certified EHR Technology

Practice uses a certified EHR system:

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

+ Stage 2 Core Meaningful Use Requirement
++ Stage 2 Menu Meaningful Use Requirement
+++ Meaningful Use Requirement
PCMH 6G: Use Certified EHR Technology
(cont.)

4. Demonstrates capability to identify and report cancer cases to public health central cancer registry electronically++

5. Demonstrates capability to identify/report specific cases to specialized registry (other than a cancer registry) electronically++

6. Reports clinical quality measures to Medicare or Medicaid agency as required for Meaningful Use+++

++ Stage 2 Menu Meaningful Use Requirement
+++ Meaningful Use Requirement

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

7. Demonstrates the capability to submit electronic data to immunization registries or immunization information systems electronically+

8. Has access to a health information exchange

9. Has bi-directional exchange with a health information exchange

10. Generates lists of patients, and based on their preferred method of communication, proactively reminds more than 10 percent of patients/families/caregivers for needed preventive/follow-up care+

  + Stage 2 Core Meaningful Use Requirement
PCMH 6G: Scoring and Documentation

0 Points

Scoring

- 100% Not scored
- 75% Not scored
- 50% Not scored
- 25% Not scored
- 0% Not scored
- NA Factors – 4, 5, 7 (Standards and Guidelines pages 90-91)

Documentation

- Attestation
- F8, 9 – Attestation and name of HIE
NCQA Free Webinar Training

- PCMH Standards
- PCSP Standards
- ISS Survey Tool
- On-line Application

Click here to see Free Webinar Training

http://www.ncqa.org/Programs/Recognition.aspx
Start-to-Finish (S2F) has 3 Phases

1. **BEFORE: LEARN IT** – Am I eligible? Can I make the commitment? Why would I want to do this?
2. **DURING: EARN IT** – I am committed what do I need to do submit? What is required?
3. **AFTER: KEEP IT** – I made it! How do I keep my recognition? What do I do if my practice changes? How do I promote my achievement?
1. **Before/Learn It Phase**

1. Eligibility
2. Order the free electronic version of the guidelines and download whenever updates are published
3. “Getting on Board” live and recorded
4. Are you able and ready to proceed?

2. **During/Earn It Phase**

*The Nuts & Bolts of the Recognition Process*
NCQA Software Used During the Recognition Process

Online Application Account
- One account per organization handles many applications, multiple sites. Used for PCMH (2011 & 2014), PCSP, CAHPS PCMH
- Enter primary contact, demographic practice and clinician information
- Sign BAA and program agreement
- Resource library inside
- One application precedes every ISS survey tool
- Used to initiate Multi-Site approval
- Used to initiate Add-Ons
- Safeguard your user names and passwords

Start-to-Finish
Multi-Site Process...Approval is Required
What Are Multi-Site Surveys & Who is Eligible?

• Option for organizations or medical practices with 3 or more sites that share policies and procedures and electronic systems across all of their practice sites.
• NCQA does not give organization-wide Recognition
• A specified number of corporate (shared) elements are completed once for multiple practice sites in an additional survey tool
• All other elements require responses at the site level
• Any possible multi-site should attend the “Getting on Board” training for complete details

2. During/Earn It Phase

Start-to-Finish Step 8
Attend FREE Standards Training
“The Rules of the Program”

Free training each month


• PCMH Standards (2 part program)
• Attend as often as you want
• Recorded version of PCMH 2014 (Coming Soon)
• Time to ask NCQA staff questions
Transform Practice

Transformational Prep Work
Start-to-Finish Step 9

- Assess practice site against Standards & Guidelines
- Document gap in performance and need for written documentation
- Write, finalize, and implement new procedures
- Implement electronic systems such as practice management systems, billing systems or registries
- Build electronic systems data to support reporting requirements
- Anticipate at least 3 - 6 months prep time
- Procedures and electronic systems must be fully implemented at least 3 months before survey submission
Now Prepare Your Submission
Start-to-Finish Steps 10-13

Software Training: Start-to-Finish Step 10

**PCMH Software Training**
- **Online Application**
- **Interactive Survey System (ISS) Tool**

- Training is Recorded - Attend anytime!
  - [http://www.ncqa.org/Programs/Recognition/RelevanttoAllRecognition/RecognitionTraining/PatientCenteredMedicalHomePatientCentered.aspx](http://www.ncqa.org/Programs/Recognition/RelevanttoAllRecognition/RecognitionTraining/PatientCenteredMedicalHomePatientCentered.aspx)

- Not available as a live monthly training
- Demonstrates how to navigate and enter information into the software
- Submit any questions or technical difficulties to assigned technical analyst
Complete Your Online Application

Completing Online Application

- **Sign Agreements electronically**
- **Create separate application for each site**
- **Enter clinician data for each site**
  
  **NOTE:** Punctuation and spelling matter
  
  Do **NOT** enter **ALL CAPS**
  
  - Link clinicians to each application – clinicians currently practicing at each site
  - **Enter ISS license # from your e-mail order for each site** – creates a link to the ISS (Survey) tool
  - Submit each site application to NCQA
  - **NCQA needs 5 business days to verify site prior to accepting ISS tool**
  - NCQA will send you an e-mail
Prepare and Submit ISS Tool

Using the Survey Tool

Steps for the practice:

1. Organize supporting documentation
2. Respond to ALL factors
3. Build document library
4. Link documents to elements
5. Complete Organizational Background tabs
6. Review results
Build the Document Library

1. Assemble documents in a PC file
2. No Protected Health Information
3. Assign meaningful file names
4. Highlight and label contents to draw reviewer attention
5. Aim for 1-3 attachments per element
6. Attach one document to several elements
7. Load up to 3 documents at a time into ISS Tool Library and rename
8. Link documents to relevant elements
9. Save
10. Changes to any document requires reloading the document

Manage the Documents

Use a unique naming convention

• Use any organizing principle desired, for example:
  – PCMH 1 A—Name of Document.docx
  – PCMH 1 B—Name of Document.xlsx

• Avoid file names with special characters (e.g. quotation marks, question marks, commas, apostrophes, ampersands)

• Documents can be linked to multiple elements; no duplicates should be in the Document Library

• Use text boxes and highlighting to identify important sections and briefly explain the importance
ISS Survey Tool Organizational Background Tab

Inside the ISS Survey Tool

2014 Patient-Centered Medical Home

Welcome to the Interactive Survey System!

The information in the following sections includes:

- the complete Standards
- information about how your organization will be evaluated against the Standards
- policies and procedures.

We designed the system to facilitate understanding of our Standards and the evaluation process. The "Help and Instructions" section above directs users to assistance.

Policies and Procedures. This section provides an overview of the survey option you have selected; it describes the goals and principles that guide our approach to evaluation, and provides a high-level summary of areas addressed by the Standards.

The Policies and Procedures describe:

- eligibility criteria; evaluation options; the interactive survey process
- the structure of the Standards and Guidelines and the Survey Tool
- how we report survey results; and obligations of organizations and individuals undergoing a survey.

Standards and Guidelines. This section allows you to open or download printable versions of publications.

ISS Organizational Background Tab

Complete Practice Site Information

Attach more information about the practice. Give it a face to our reviewers.
Complete Recognized Clinicians

- List the practice’s clinicians with current Recognitions for auto-credit:
  - Diabetes Recognition Program
  - Heart/Stroke Recognition Program

Submit Program Fees and Surveys

Each practice site has separate application fee based on the number of clinicians that see patients at that site – this is the 2nd payment to NCQA

- Find current fees owed, check cover sheet and credit card forms in Online Application payment tab
- Applicable fees are those current on the day of submission
- NCQA will contact you if payment is not received or correct when survey is submitted
- Survey review is not initiated until full payment is confirmed
- No time limit on survey submission
Recognition Review Process

NCQA

- Checks licensure of all clinicians for restrictions
- Evaluates Survey Tool responses, documentation, and explanations by
  - Reviewer – initial evaluation
  - Executive reviewer – NCQA PCMH managers
  - Peer review – Recognition Program Review Oversight Committee member (RP-ROC)
  - Audit (5%) – may be conducted by email, teleconference, or on-site audit
Recognition Review Process

NCQA

• Issues final scoring decision and level to the practice within 30–60 calendar days by email

• Reports results
  – Recognition posted on NCQA Web site
  – Not passed - not reported

• Mails PCMH certificate and Recognition packet

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NCQA Evaluation: Example Text/Notes Entry

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Use this space to provide any additional explanation of the element evaluated.

6/14/2009 NCQA Reviewer Note:
The practice responded "yes" to all factors and the reviewer agrees.

1. See "Diagnosis Graph" for data on most commonly used diagnosis codes used in clinical encounters.
2. See "CDC prevalence reports" for data on the prevalence of our three selected conditions within our State and local community.
3. As part of a National PCMH Demonstration Project and in collaboration with NCQA, the Demonstration Project Stakeholders have chosen Diabetes, Hypertension and Hyperlipidemia as Clinically Important Conditions which represent the best likelihood of being amenable to care management and providing value on costs to the health care system based on regional experience. These conditions have associated required metrics which will be reported by the physician practices as part of the National PCMH Demonstration Project.

Justify all N/As In Text/Notes
Recognition Decisions

Recognition awarded at the practice site level

- Levels 1, 2 and 3
- 3-year Recognition period
- Denial of Recognition
  - PCMH score below 35 points
  - One or more Must Pass elements <50%
  - Not made public or distributed to P4P
- Manager sends auto email to practice’s primary contact
- Levels reported to public; scores are not made public

NCQA Recognition Directory

Website Listing Includes:
- Clinician name, title (MD, DO, NP, PA)
- Practice name and address
- Current Recognition
- Recognition Program
What Happens After Recognition?
Moving on to 3. Keep It Phase

Recognized Practices
Marketing Materials and Seals

NCQA sends press releases on request
Tools to promote Recognition

Promote your NCQA Recognition status.
Maintain your NCQA Recognition status.
Resources Available -- Website

FREE Customer Resources

• **NCQA Website contains a wealth of resources**
  – Check frequently for new and updated materials

• **Website is configured with “Start-to-Finish” and pertinent information is associated with each node**

• **FAQs to help answer your questions** –
  [http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH/DuringEarnItPCMH/OtherPCMHResources.aspx](http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH/DuringEarnItPCMH/OtherPCMHResources.aspx)

NCQA Support
Submitting Questions to NCQA

- Submit questions to Policy Clarification Support (PCS) System: [http://ncqa.force.com/pcs/login](http://ncqa.force.com/pcs/login)
- **Do not** submit questions to [pcmh@ncqa.org](mailto:pcmh@ncqa.org)
  - Only submit payment or practice changes to the mailbox
- Check for existing FAQs
  [http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH/DuringEarnItPCMH/OtherPCMHResources.aspx](http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH/DuringEarnItPCMH/OtherPCMHResources.aspx)
- Do you already have an assigned manager? Continue to submit questions to them

How to Submit a Question

2. Register if you are a new user
3. Click “Ask a New Question”
4. Select “Recognition Programs” in the first drop down selection
5. Select program and category in the other drop downs that best fits your question
6. Type in question and submit
After Submitting a Question

• You will receive a confirmation email with your case #
• Any correspondence is sent directly to your email registered
• Might be asked for further clarification
• Track your question and the response

NCQA Contact Information

Contact NCQA Customer Support at 1-888-275-7585
M-F, 8:30 a.m. - 5:00 p.m. ET to:
✓ Acquire standards documents, application account, survey tools
✓ Questions about your user ID, password, access

Visit NCQA Web Site at www.ncqa.org to:
✓ Follow the Start-to-Finish Pathway
✓ View Frequently Asked Questions
✓ View Recognition Programs Training Schedule

• For questions about interpretation of standards or elements to submit a question to PCS
  (Policy/Program Clarification Support)
Final Questions?

Thanks so much for attending and best wishes for your upcoming Recognition!