Patient Centered Medical Home (PCMH) Training
August 11, 2017
Wi-Fi

Network Name: attwifi
Promo Code: rmhp
Overview: What is a Patient-Centered Medical Home?

Anna Messinger, MHA, PCMH CCE
August 11, 2017
Objectives

• Define the Patient-Centered Medical Home model
• Describe the history of the PCMH model
• Demonstrate the need for the framework and discuss evidence of success
• Discuss the “why” behind PCMH 2017 recognition
What IS a Patient –Centered Medical Home

- **Person-Centered**: Supports patients/families in managing decisions/care plans
- **Coordinated**: Organized across medical neighborhood
- **Comprehensive**: Whole-person Care provided by a team
- **Accessible**: Short waiting times, 24/7 access and extended in-person hours
- **Committed to Quality and Safety**: Maximized use of health IT, decision support, and other tools

Source: [www.ahrq.gov](http://www.ahrq.gov)
PCMH: Part of the Whole
Evolution of the PCMH Model

1967: American Academy of Pediatrics introduces the term medical home

1978: The WHO located primary care at the center of the health system

2001: IOM’s Crossing the Quality Chasm was released

2007: Joint Principles of the PCMH were developed

2008: NCQA released its PCMH Recognition program, the first PCMH evaluation program in the country
Foundational Rules for NCQA’s PCMH:

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

- Standards were developed to align with Joint Principles
  - Personal Physician
  - Physician directed medical practice
  - Whole person orientation
  - Care is coordinated and/or integrated
  - Quality and safety
  - Enhanced Access
  - Payment
So... We Keep Talking About the PCMH

40% of visits to the emergency departments in Mesa County in 2015 could have been treated by a routine provider.

**Primary Care**

Disease prevention, chronic disease management, illness, and injury

- **There is 1** primary care physician for every 909 residents (2013)
- Physician assistant for every 2,247 residents
- Nurse practitioner for every 1,610 residents
- Psychologist for every 4,237 residents
- Dentist for every 1,529 residents

**FACTS**

- 40% of residents did not visit a dentist or dental hygienist in the past 12 months
- 34% of residents did not have a check-up or a physical exam in the past 12 months
ask WHY? barriers to care:

- 4% of residents did not visit the doctor due to lack of transportation
- 9% of residents could not afford doctor care
- Among people without insurance, 62% did not seek care because they were uninsured
- 19% of residents were not able to get an appointment within their necessary time frame at a doctor’s office
- 15% of doctors’ offices were not accepting new patients
- 15% of doctors’ offices were not accepting the patient’s type of insurance
- 12% of residents were unable to take off work for a medical appointment
- 16% of residents did not have a usual source of care
Top 10 reasons residents visited the ED in 2014

1. Headache
2. Stomach pain
3. Lower back pain
4. Respiratory infection
5. Urinary tract infection
6. Nausea with vomiting
7. Alcohol abuse
8. Chest pain
9. Problems with teeth/mouth
10. Migraine

17% of residents visited the ED at least once during the past 12 months

8% of residents visited the ED multiple times during the past 12 months

Together, the top 10 account for 17% of total visits to the ED
Health System transformation requires...
### Who Benefits from the PCMH model?

<table>
<thead>
<tr>
<th>Patients</th>
<th>Practices</th>
<th>Community</th>
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<tbody>
<tr>
<td>• Better coordinated, more comprehensive and personalized care</td>
<td>• Joy in practice: increased physician and member satisfaction</td>
<td>• Lower prevalence of disease and disability</td>
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<tr>
<td>• Improved access to medical care and services</td>
<td>• Physicians and staff members who practice at the top of their licenses</td>
<td>• Decreased health costs</td>
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<tr>
<td>• Improved health outcomes, especially for patients with chronic conditions</td>
<td>• Improved safety and quality of care</td>
<td>• Decreased lost productivity</td>
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<td>• Better experience of care</td>
<td>• A more efficient use of practice resources, resulting in cost savings</td>
<td>• Better coordination between clinical and public health efforts</td>
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<td></td>
<td>• Equipped to take advantage of PCMH payment incentives for adopting the functions of a patient-centered medical home</td>
<td>• Improved outcomes for diverse populations</td>
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## Why Become Formally Recognized?

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Benefits</th>
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<tbody>
<tr>
<td><strong>Financial Perspective</strong></td>
<td>• Payers need external validation to justify compensating one provider differently from another (ex. MIPS, PMPMs)</td>
</tr>
<tr>
<td><strong>Patient Perspective</strong></td>
<td>• PCMH recognition indicates that a practice offers enhanced services and higher quality of care</td>
</tr>
<tr>
<td><strong>Medical Neighborhood Perspective</strong></td>
<td>• With an external measurement of performance, medical neighbors may be more likely to engage with a PCMH recognized practice for co-management arrangements, PCP referrals, etc.</td>
</tr>
</tbody>
</table>
The need for change is REAL:

Health care in the United States is transitioning from a volume-based payment system to a value-based payment system. Efforts invested into PCMH transformation not only positions you to respond to the changing health care landscape, but over time, it also benefits your patients, your practice, and your bottom line.
References

- http://www.aafp.org
- https://www.ahrq.gov/
- https://www.pcpcc.org
Practice Testimonials

• Allergy and Asthma Center of Western Colorado (PCSP)
• Western Colorado Pediatric Associates (PCMH 2014 Level 3)
PCSP
David R. Scott, MD - A specialist’s perspective
Change Management

Britta Fuglevand, MSHA
Quality Improvement Advisor and
Staff Training and Development Coordinator
Objectives

- Session participants will:
  - Identify the keys reasons why change management is integral to successful PCMH implementation
  - Develop a plan for creating leadership, team engagement and sustainability when implementing PCMH
What is Change Management?

“The coordination of a structured period of transition from situation A to situation B in order to achieve lasting change within an organization.”

– BNET Business
Why is it Important?

- Successful implementation of PCMH requires changing how things are done, effective communication, and being resilient in the face of failure.
- “Change is okay as long as I don’t have to change.”
- Maintaining the change won’t happen if only a few people understand and do the work.

![Cartoon Illustration: OK, THERE IS A SMALL CHANGE... RED BAG HAS THE SANDWICHES GREEN BAG IS YOUR PARACHUTE.]

4
Dr. John Kotter’s 8 Steps for Leading Change

1. Create urgency
2. Form a powerful coalition
3. Create a vision for change
4. Communicate the vision
5. Empower action
6. Create quick wins
7. Build on the change
8. Make it stick

Creating the climate for change

Implementing & sustaining for change
Step 1: Create Urgency

Help the team see the need for change and the importance of speed
Urgency, Continued

• Build the burning platform –
  – Why MUST the organization change?
  – Why must it be done now?

• How will you communicate this?
  – What evidence do you have?
  – Stories v. Data

• “Honest facts and dramatic evidence — customer and stakeholder testimonies — show that change is necessary. Seeing something new hits people on a deeper emotional level without the usual negative responses and resistance.”
Step 2: Form a Powerful Coalition

• Ensure you have support from top levels with the right skills and credibility to drive change.

“Whomever pulls the sword from the stone will lead this project.”
Coalition, Continued

• Who is leading the change?
  – Are they bought in? Do they have the knowledge and resources needed?

• Who is on the team?
  – Are those people credible within your organization? Do they have the ability to make changes?

• Is anyone missing?
  – Resistant Groups – ignoring people against change doesn’t lead to more engagement. Let them help design the change.
    – Are all areas of expertise present?

• Is the team strong? Do they trust each other?
  – Speaking uncomfortable truths
  – Conflict isn’t bad!
Step 3: Create a Vision for Change

- Leverage the evidence for change to create a shared roadmap
Vision, Continued

1. Prepare a vision that takes you to an end state. What is your goal?
2. Develop a strategy to achieve vision: evaluate and address gaps in current state
3. Create step-by-step plans to carry out your strategy,
4. Evaluate needed resources (people, time, money, IT, etc).

• “Creating a vision that can be conveyed in a matter of minutes is going to move people into action much more effectively than detailed analyses ever will.”
Your Vision

• In a perfect world, without constraints, what does the future look like to your team?
  – Think big!
  – Be passionate and emotional – this is the reason for your work
  – Use clear, concise language

• Use the worksheet to start creating the environment for change. Discuss with your team if you already have one.

• When you’re ready to move on to the next stages, don’t forget to utilize your QIA!
### 8 Steps to Change Management

<table>
<thead>
<tr>
<th>Change Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create Urgency</td>
<td>Help the team see the need for change and the importance of speed.</td>
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<tr>
<td>Create A Coalition</td>
<td>Ensure you have support from top levels with the right skills &amp; credibility to drive change.</td>
</tr>
<tr>
<td>Develop A Vision &amp; Strategy</td>
<td>Leverage the evidence for change to create a shared roadmap &amp; success metrics.</td>
</tr>
<tr>
<td>Communicate the Vision</td>
<td>Confirm acceptance and understanding.</td>
</tr>
<tr>
<td>Empower Action</td>
<td>Remove barriers to make the team successful</td>
</tr>
<tr>
<td>Get Quick Wins</td>
<td>Identify and broadcast early wins to maintain momentum.</td>
</tr>
<tr>
<td>Leverage Wins to Drive Change</td>
<td>Use momentum from quick wins to continue driving change.</td>
</tr>
<tr>
<td>Embed in Culture</td>
<td>Reward and encourage new behaviors to embed into the culture.</td>
</tr>
</tbody>
</table>

Source: Kotter International
Additional Resources and References

• The original: “Leading Change” by John Kotter
• Composite: “On Change Management” HBR’s 10 Must Reads Series
• In Health Care: “Managing Change in Healthcare” by Rashid Al-Abri*
• Brief overview: https://www.leadershipthoughts.com/kotters-8-step-change-model/
• IHI’s Project Planning Form: http://www.ihi.org/resources/Pages/Tools/ProjectPlanningForm.aspx
Questions?

"The caterpillar doesn't know that he'll come out as a butterfly. All he knows is that he's alone, it's dark, and it's a little scary." -- Mort Meyerson, Chairman, Perot Systems

Contact: britta.fuglevand@rmhp.org
Objectives

- Introduce timeline for new PCMH 2017 standards
- Discuss the path to conversion/renewal
- Briefly review the organization of the new Standards and Guidelines
- Present the basics of Quality Performance Assessment Support System (Q-Pass)
**PCMH 2017 Redesign**

- **PCMH Critiques**
  - Too easy—can achieve recognition without transforming
  - Too hard—small practices, rural practices, urban practices
  - Too focused on process—needs more performance evaluation
  - Too much—burdensome review process

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

**There will be no more levels with the redesign; a recognized practice is equivalent to a PCMH 2014 Level 3 practice**

**Revisions to S&Gs will occur annually instead of three times per year**
PCMH Redesign

*Then vs. Now*

**Then**
- Self-guide to recognition
- Submit documents all at once
- Cumbersome e survey tool
- Recognition on a 3-year cycle, has 3 levels

**Now**
- NCQA representative to guide practice
- Gradual submissions, steady feedback
- More intuitive tool, with user tips
- Yearly reporting, more frequent help, no levels
Impact of the Redesign

- Flexibility
- Personalized service
- User-friendly approach
- Continuous improvement
- Aligns with changes
Eligibility Requirements

Outpatient primary care practices

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

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

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

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

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

All eligible clinicians at a site must apply together

Physicians in training (residents) should not be listed
Eligibility Requirements

**Transformation may take 3-12 months**

Your roadmap: PCMH 2017 Standards and Guidelines – everything covered

**Implement changes:**

- Practice-wide commitment
- New policies and procedures for staff
- Staff training and reassignments
- Medical record systems
- Reporting capabilities improvement
- Develop and organize documentation
Prevalidation Program

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

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

Commit | Transform | Succeed
Steps to Recognition

- Learn it: download the NCQA standards and guidelines and begin learning the concept areas and required criteria

- Application of concepts: begin to implement changes to align with NCQA PCMH standards

- Enroll thru Q-Pass: create an account, enroll in the recognition process, complete an initial questionnaire, and pay the enrollment fee

* NCQA anticipates this step will take practices 2-6 months
# PCMH 2017 Pricing

Pricing: Single Site

Single site pricing is for organizations with fewer than three practice sites, or for organizations with three or more practice sites that do not meet multi-site criteria. Practices seeking recognition for the first time pay the recognition fee at enrollment. Thereafter, they pay the recognition fee at their annual check-in. Fees apply to each clinician associated with the practice's recognition.

<table>
<thead>
<tr>
<th>Number of Clinicians</th>
<th>Initial Recognition Fee</th>
<th>Annual Reporting Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-12</td>
<td>$500 $400 <em>Save 20% through September 30, 2017</em></td>
<td>$120</td>
</tr>
<tr>
<td>13+</td>
<td>$50 $40 <em>Save 20% through September 30, 2017</em></td>
<td>$12</td>
</tr>
</tbody>
</table>
PCMH 2017 Pricing

Example: The example below will provide you some context as to how pricing is applied. For this example, an organization has 1 practice site with 16 clinicians.

<table>
<thead>
<tr>
<th></th>
<th>Site A</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Initial Recognition Fee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Site A</td>
<td>Cost for clinicians 1-12 ($500 each)</td>
<td>Cost for clinicians 13+ ($50 each)</td>
<td>Total</td>
</tr>
<tr>
<td>16 clinicians</td>
<td>$6,000</td>
<td>$200</td>
<td></td>
<td>$6,200</td>
</tr>
</tbody>
</table>

The organization pays $6,200 for its Initial Recognition Fee, *but receives a 20% discount if it enrolls before September 30, 2017, bringing its total to $4,960.*

<table>
<thead>
<tr>
<th></th>
<th>Site A</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Annual Reporting Fee</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Site A</td>
<td>Cost for clinicians 1-12 ($120 each)</td>
<td>Cost for clinicians 13+ ($12 each)</td>
<td>Total</td>
</tr>
<tr>
<td>16 clinicians</td>
<td>$1,440</td>
<td>$48</td>
<td></td>
<td>$1,448</td>
</tr>
</tbody>
</table>

The organization pays $1,448 each year during its annual reporting period.
PCMH 2017 Pricing

### Initial Recognition Fee

<table>
<thead>
<tr>
<th>Site</th>
<th>Cost for clinicians 1-12 ($250 each)</th>
<th>Cost for clinicians 13+ ($25 each)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site A (14 clinicians)</td>
<td>$3,000</td>
<td>$50</td>
<td>$3,050</td>
</tr>
<tr>
<td>Site B (6 clinicians)</td>
<td>$1,500</td>
<td>-</td>
<td>$1,500</td>
</tr>
<tr>
<td>Site C (16 clinicians)</td>
<td>$3,000</td>
<td>$100</td>
<td>$3,100</td>
</tr>
</tbody>
</table>

The organization pays $7,650 for its Initial Recognition Fee, but receives a **20% discount if it enrolls before September 30, 2017, bringing its total to $6,120.**

### Annual Reporting Fee

<table>
<thead>
<tr>
<th>Site</th>
<th>Cost for clinicians 1-12 ($120 each)</th>
<th>Cost for clinicians 13+ ($12 each)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site A (14 clinicians)</td>
<td>$1,440</td>
<td>$24</td>
<td>$1,464</td>
</tr>
<tr>
<td>Site B (6 clinicians)</td>
<td>$720</td>
<td>-</td>
<td>$720</td>
</tr>
<tr>
<td>Site C (16 clinicians)</td>
<td>$1,440</td>
<td>$48</td>
<td>$1,488</td>
</tr>
</tbody>
</table>

The organization pays $3,672 each year during its annual reporting period.
Steps to Recognition

• Virtual Introduction with NCQA rep: single point of contact assigned to your practice; will discuss timeline for three virtual check-ins

• Begin working with Q-Pass: gather evidence, prepare documentation and track your practice’s progress toward recognition

• Complete virtual reviews via screen sharing technology

*NCQA anticipates this step will take practices 10-12 months
Steps to Recognition

- Earn PCMH recognition: your practice and clinicians will be listed in the NCQA directory and on the NCQA website.

- Annual Reporting: practices will check in with NCQA annually to demonstrate that their ongoing activities are consistent with the PCMH model of care; this process includes attesting to certain policies and procedures, as well as submitting some data to the NCQA.
What to Expect After Recognition

• Complete your annual reporting 30 days before your practice’s recognition anniversary date

• In preparation:
  – Know what is required
  – Embrace PCMH and Quality Improvement
  – Submit in stages
Example of Annual Reporting Requirements

<table>
<thead>
<tr>
<th>Option #</th>
<th>Requirements</th>
<th>Data/Documentation Required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>CD = Corporate Data Accepted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SS = Site-Specific Data Required</td>
</tr>
<tr>
<td>1</td>
<td>Monitor appointment access on patient experience survey</td>
<td></td>
</tr>
<tr>
<td></td>
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<tr>
<td>2</td>
<td>Provide third next available appointment</td>
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</tbody>
</table>

**Note:**

- **Data/Documentation Required**
  - CD = Corporate Data Accepted
  - SS = Site-Specific Data Required

**Patient-Centered Access**

Has your practice continued to monitor appointment access?

*Choose 1 option from the 3 below to submit for your annual check-in.*

1. Copy of the patient experience survey tool. Practices that use a CAHPS survey do not need to provide the survey. (Documentation, CD)
2. Number of patients surveyed in the past 12 months. (Data, SS)
3. Number of completed surveys in the past 12 months. (Data, SS)
4. A report with results from the access questions. (Documentation; CD, if report is stratified by site.)

Option 1: Monitor appointment access on patient experience survey

- If your patient experience survey includes questions related to access, provide the following:
  1. 1. Copy of the patient experience survey tool. Practices that use a CAHPS survey do not need to provide the survey. (Documentation, CD)
  2. Number of patients surveyed in the past 12 months. (Data, SS)
  3. Number of completed surveys in the past 12 months. (Data, SS)
  4. A report with results from the access questions. (Documentation; CD, if report is stratified by site.)

Option 2: Provide third next available appointment

- Provide the third next available appointment for urgent appointments. (Data, SS)
- Provide the third next available appointment for routine appointments (new patient physical, routine exam, return visit exam). For routine requests, exclude any appointments blocked for same-day or urgent visits (since they are "blocked off" the schedule). (Data, SS)

Practices may use the Institute for Healthcare Improvement’s (IHI) method to calculate the third next available appointment.

- Sample all clinicians on the team once a week, on the same day, at the same time of day, for at least one month between annual check-ins.
- Count the number of days between a request for an appointment (e.g., enter dummy patient) with a physician and the third next available appointment for a new patient physical, routine exam, or return visit exam.
- Report the average number of days for all physicians sampled.

**Note:** Count calendar days (e.g., include weekends and days off.)
Path to Conversion to PCMH 2017

Accelerated Renewal

Eligibility

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

- PCMH 2011
  Levels 1, 2, & 3

- PCMH 2014
  Levels 1 & 2
Path to Conversion to PCMH 2017

Accelerated Renewal

*What is expected for criteria?*

---

**For criteria identified as review practices should:**
- Follow standards & guidelines
- Submit evidence in Q-PASS
- Prepare to demonstrate virtual review-eligible evidence

**For criteria marked attestation the practice should:**
- Attest that your practice is still performing PCMH activities
- You will not need to demonstrate documentation or evidence

**Criteria are identified as shared or site specific**
# Example of Accelerated Renewal Requirements

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Criteria Title</th>
<th>Shared or Site-Specific?</th>
<th>Review or Attestation?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Competency A: Practice Organization, Team Roles and Training</strong></td>
<td>TC 01* (Core) PCMH Transformation Leads</td>
<td>Shared</td>
<td>Review</td>
</tr>
<tr>
<td></td>
<td>TC 02 (Core) Structure &amp; Staff Responsibilities</td>
<td>Shared</td>
<td>Attestation</td>
</tr>
<tr>
<td></td>
<td>TC 03* (1 Credit) External PCMH Collaborations</td>
<td>Shared</td>
<td>Attestation</td>
</tr>
<tr>
<td></td>
<td>TC 04* (2 Credits) Patient/Family/Caregiver Involvement in Governance</td>
<td>Shared</td>
<td>Review</td>
</tr>
<tr>
<td></td>
<td>TC 05 (2 Credits) Certified EHR System</td>
<td>Shared</td>
<td>Attestation</td>
</tr>
<tr>
<td><strong>Competency B: Care Team Communication and Functioning</strong></td>
<td>TC 06 (Core) Individual Patient Care Meetings/Communication</td>
<td>Partially Shared**</td>
<td>Review</td>
</tr>
<tr>
<td></td>
<td>TC 07 (Core) Staff Involvement in Quality Improvement</td>
<td>Shared</td>
<td>Attestation</td>
</tr>
<tr>
<td></td>
<td>TC 08* (2 Credits) Behavioral Health Care Manager</td>
<td>Shared</td>
<td>Review</td>
</tr>
</tbody>
</table>
Path to Conversion to PCMH 2017

Succeed Annual Reporting Process

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

- Attest to previous performance
- Provide evidence demonstrating continuing PCMH Activities

- Confirm practice information and make any clinician changes
- Annual fee payment
## Example of Annual Reporting Requirements

### Patient-Centered Access

Has your practice continued to monitor appointment access?  
*Choose 1 option from the 3 below to submit for your annual check-in.*

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<td></td>
<td>1. Copy of the patient experience survey tool. Practices that use a CAHPS survey do not need to provide the survey. (Documentation, CD)</td>
<td>Data/Documentation Required</td>
</tr>
<tr>
<td></td>
<td>2. Number of patients surveyed in the past 12 months. (Data, SS)</td>
<td>Data/Documentation Required</td>
</tr>
<tr>
<td></td>
<td>3. Number of completed surveys in the past 12 months. (Data, SS)</td>
<td>Data/Documentation Required</td>
</tr>
<tr>
<td></td>
<td>4. A report with results from the access questions. (Documentation; CD, if report is stratified by site.)</td>
<td>Data/Documentation Required</td>
</tr>
<tr>
<td>2</td>
<td>Provide third next available appointment</td>
<td>Data/Documentation Required</td>
</tr>
<tr>
<td></td>
<td>1. Provide the third next available appointment for urgent appointments. (Data, SS)</td>
<td>Data/Documentation Required</td>
</tr>
<tr>
<td></td>
<td>2. Provide the third next available appointment for routine appointments (new patient physical, routine exam, return visit exam). For routine requests, exclude any appointments blocked for same-day or urgent visits (since they are “blocked off” the schedule). (Data, SS)</td>
<td>Data/Documentation Required</td>
</tr>
</tbody>
</table>

Practices may use the Institute for Healthcare Improvement’s (IHI) method to calculate the third next available appointment.

- Sample all clinicians on the team once a week, on the same day, at the same time of day, for at least one month between annual check-ins.
- Count the number of days between a request for an appointment (e.g., enter dummy patient) with a physician and the third next available appointment for a new patient physical, routine exam, or return visit exam.
- Report the average number of days for all physicians sampled.

**Note:** Count calendar days (e.g., include weekends) and days off.
Recognition Process

3 Pathways

New Customer
- Full Transform Process

Recognized PCMH 2011/2014
- Level 1 or 2
  - Accelerated Renewal Process (Transform w/ Attestation)

Recognized PCMH 2014 Level
- 3
  - Bypass Transform Direct to Sustaining Process
New PCMH Standards Structure

- **Concept**
  - Over-arching components of PCMH

- **Competencies**
  - Ways to think about and/or bucket criteria

- **Criteria**
  - The individual things/tasks you do that make you a PCMH
PCMH 2017 Standards

Concepts

- Team-Based Care and Practice Organization (TC)
- Knowing and Managing Your Patients (KM)
- Patient-Centered Access and Continuity (AC)
- Care Management and Support (CM)
- Care Coordination and Care Transitions (CC)
- Performance Measurement & Quality Improvement (QI)
Team-Based Care and Practice Organization (TC)

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

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

TC 01 (Core): Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.

<table>
<thead>
<tr>
<th>GUIDANCE</th>
<th>EVIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice identifies the clinician lead and the transformation manager (the person leading the PCMH transformation). This may be the same person. The practice provides details including the person’s name, credentials and roles/responsibilities. PCMH transformation is successful when there is support from a clinician lead. Their support sets the tone for how the practice will function as a medical home. The intent is to ensure that the practice has clinician and leadership support to implement the PCMH model and to acknowledge the role of staff in the practice’s everyday operations.</td>
<td>• Details about the clinician lead AND • Details about the PCMH manager</td>
</tr>
</tbody>
</table>

TC 02 (Core): Defines practice organizational structure and staff responsibilities/skills to support key PCMH functions.

<table>
<thead>
<tr>
<th>GUIDANCE</th>
<th>EVIDENCE</th>
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<tbody>
<tr>
<td>The practice provides an overview of practice staff; an outline of duties the staff are expected to execute as part of the medical home; and how the practice will support and train staff to complete these duties. Structured tasks and stated staff responsibilities enable a practice to ensure that staff are providing efficient medical care and have training for the skills necessary to support medical home functions.</td>
<td>• Staff structure overview AND • Description of staff roles, skills and responsibilities</td>
</tr>
</tbody>
</table>
TC 03 (1 Credit): The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges).

<table>
<thead>
<tr>
<th>GUIDANCE</th>
<th>EVIDENCE</th>
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<tbody>
<tr>
<td>The practice demonstrates involvement in at least one state or federal initiative (e.g., CPC+, care management learning collaborative led by the state, two-way data exchange with a local health information exchange; population-based care or learning collaborative) or participates in a health information exchange. The practice recognizes the value of participation in external collaboration and has the support of leadership to implement collaborative activities.</td>
<td>Description of involvement in external collaborative activity</td>
</tr>
</tbody>
</table>

TC 04 (2 Credits): Patients/families/caregivers are involved in the practice’s governance structure or on stakeholder committees.

<table>
<thead>
<tr>
<th>GUIDANCE</th>
<th>EVIDENCE</th>
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</table>
| The practice demonstrates involvement by:  
- Giving patients/families/caregivers a role in the practice’s governance structure or Board of Directors.  
- Organizing a patient and family advisory council (i.e., stakeholder committee).  
At a minimum, the process specifies how patients/families/caregivers are selected for participation, their role and frequency of meetings.  
Patients are more than consumers in their care, they are partners. Involving patients/families/caregivers in the practice’s governance can provide additional input to improve patient services and help engage patients in the care they receive from the practice. | Documented process  
AND  
Evidence of implementation |
PCMH 2017 Scoring

**Practices must select elective criteria in 5 out of the 6 concepts**
Types of Evidence

GOOD NEWS! NCQA not very prescriptive in this redesign!

• **Documented process:** policies and procedures, process maps, flowsheets, checklists, etc.; must be dated and have been in place for at least 3 months

• **Reports:** aggregated data with a numerator, denominator and rate; the practice will decide the appropriate time window of the report for the criteria

• **Virtual demonstration:** think “evidence of implementation”; practices will walk the NCQA rep. through their evidence via virtual sharing technology within the Q-Pass platform during the virtual check-in

• **Record Review Workbook:** Excel spreadsheet to document chart review results

• **Quality Improvement Worksheet:** template to document PDSAs
2017 Distinction Models

Practice Opportunities to Show Excellence

- Distinction in Patient Experience Reporting
- Distinction in Behavioral Health Integration
- Distinction in Electronic Measure Reporting
Behavioral Health Integration Distinction Module

**Behavioral Health Workforce**
- Incorporates behavioral health expertise
- Utilizes external behavioral health specialists
- Trains the care team to address behavioral health and substance use needs of patients

**Evidence-Based Care**
- Sharing patient information within and outside the practice
- Supports integrated/coordinated patient treatment plan

**Information Sharing**
- Demonstrate use of evidence-based protocols
- Utilize evidence-based protocols to address patient needs

**Measuring and Monitoring**
- Utilize quality measurement
- Act to improve on current quality measurement performance
Survey Platform

Q-PASS System
Q-PASS

- Stands for “Quality Performance Assessment Support System”
- Includes a series of dashboards to manage organizations, sites and programs to pursue recognition; combines the application and ISS tool from previous versions
- The steps to get started are outlined in the “Getting Started Toolkit”
- Within Q-Pass, there are short videos instructing practices on the reporting process
- After enrolling, can add evidence to criteria and will use for annual reporting to sustain recognition
- Main users can add any users they like, and specify access levels within Q-Pass (so QIAs/CCEs can have access to the tool, if permitted by practice)
- Steps to enroll in Q-P
- Practices will pay the initial enrollment fee upon enrollment
To Access Q-Pass: qpass.ncqa.org
Q-PASS

Each practice will have a Dashboard to manage their work
Q-PASS

Click on tiles below to expand and interact.

TC: Team-Based Care and Practice Organization

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

TC 01: PCMH Transformation Leads (Core)
TC 02: Structure & Staff Responsibilities (Core)
TC 03: External PCMH Collaborations (1 Credit)
TC 04: Patient/Family/Caregiver Involvement in Governance (2 Credits)
TC 05: Certified EHR System (2 Credits)
TC 06: Individual Patient Care Meetings/Communication (Core)
TC 07: Staff Involvement in Quality Improvement (Core)
TC 08: Behavioral Health Care Manager (2 Credits)
TC 09: Medical Home Information (Core)
Q-Pass

MHIM: Medical Home Information and Materials

MHIM-P: Medical Home Information and Materials Process

DESCRIPTION
The practice has a documented process to inform patients, families and caregivers about the role of the medical home and provide materials including that information.

SUGGESTED EVIDENCE
The documented process includes providing patients, families and caregivers with information about the role and responsibilities of the medical home. The practice is encouraged to provide the information in multiple formats, to accommodate patient preference and language needs.

The information that the practice provides may include, but is not limited to:
• Practice office hours and where to seek after-hours care.
• How to communicate with the personal clinician and team, including how to request and receive clinical advice during and after business hours.
• Whom to contact with questions about specific concerns.
• Care-team roles.

ACTIONS
• We need help
• This is not applicable to us
• Ready for check in
Q-Pass

Practices can select and link documents and present examples virtually
Q-Pass

SUGGESTED EVIDENCE

MHIM: Medical Home Information & Materials (for reporting year)

The practice demonstrates that it informs patients, families and caregivers about the role of the medical home and provides materials containing that information.

- **Link evidence**
- **Add new evidence**

**Document**
- **Text**
- **Hyperlink**

ℹ️ You may add more than one type at once. Evidence will appear once uploaded.

Drag and drop or 🖹️ click to browse
QUESTIONS?
PCMH 2017 Standards and Guidelines

Presented by:
Andy Keith, MBA
  Quality Improvement Advisor, RMHP
Heather Steele, MHA
  Quality Improvement Advisor, RMHP
The PCMH’s recognition program aligns six concepts that are fundamental to advanced primary care:

- Team-Based Care and Practice Organization (TC)
- Knowing and Managing Your Patients (KM)
- Patient-Centered Access and Continuity (AC)
- Care Management and Support (CM)
- Care Coordination and Care Transitions (CC)
- Performance Measurement and Quality Improvement (QI)
PCMH 2017 Scoring

40 Core Criteria
Must complete all 40 core

60 Elective Criteria
Must achieve 25 Credits

RECOGNIZED
NCQA
PATIENT-CENTERED MEDICAL HOME
Concept
Team-Based Care and Practice Organization (TC)

The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients and families and organizes and trains staff to work to the top of their license and provide effective team-based care.
Team-Based Care and Practice Organization (TC)
Competency A: Transforming the practice into a sustainable medical home

TC01 (Core):
Designate Clinician and Staff Champions

Having clinician leaders sets practices up for successful transformation

Identify clinician and staff leader to drive implementation of the PCMH model

Providing details about the clinician and PCMH staff manager
Team-Based Care and Practice Organization (TC)
Competency A: Transforming the practice into a sustainable medical home

TC02 (Core)
Define practice organizational structure and job responsibility

Staff understanding and alignment of job functions allows for efficient medical care that supports the medical home model.

Practice provides an organizational structure inclusive of job responsibilities and states how the practice will support and train employees to complete expected duties.

Organizational structure overview AND description of staff roles, skills and responsibilities.
Team-Based Care and Practice Organization (TC)
Competency A: Transforming the practice into a sustainable medical home

TC03 (1 Credit):
Involvement in external PCMH-oriented collaborative activities

Participation in PCMH-oriented collaborative activities shows a commitment to the medical home model beyond NCQA recognition

Practice demonstration of involvement of at least one state or federal initiative (e.g., CPC+, state practice transformation programs) OR participation in a Health Information Exchange (HIE)

Description of involvement in external collaborative activity
Team-Based Care and Practice Organization (TC)
Competency A: Transforming the practice into a sustainable medical home

TC04 (2 Credits):
Patients/caregivers are involved in practice’s governance structure

Involving patients in their practice’s governance structure can provide additional input to improve patient services and engage them in the care they receive from the practice.

Practice demonstrates involvement by:
- Patient/caregiver role in governance structure or Board of Directors
- Organizing a patient and family advisory council (PFAC)

Documented Process: At a minimum the process includes specifics on how patients are selected for participation, their role and frequency of meetings
Evidence of Implementation: Meeting notes
Team-Based Care and Practice Organization (TC)
Competency A: Transforming the practice into a sustainable medical home

TC05 (2 Credits): Practice uses ONC certified EHR system and keeps it secure

- Use of an EHR can increase productivity, and enable the practice to provide more efficient patient care.
- Practice needs to actively use a certified EHR system, complete a security risk analysis and implement security updates to correct identified risks.
- Certified Electronic Health Records System (EHR) name
Team-Based Care and Practice Organization (TC)

Competency B: Communication across the care team is optimized to ensure coordinated, safe and effective patient care

TC06 (Core): Practice has patient care team meetings or a structured communication process on individualized care

Why?
Consistent care team meetings (e.g. huddles) provides a structured process for staff to effectively communicate about individual patient needs

How?
The structured communication process regarding sharing of information about patients may include huddles, tasks or messages in EHR, notes on schedule accessible to all care team members.

What?
1. Documented Process (written P&P, workflow, guideline that includes date of implementation that must be in place for at least 3 months prior to submission)
2. Evidence of Implementation
Team-Based Care and Practice Organization (TC)

Competency B: Communication across the care team is optimized to ensure coordinated, safe and effective patient care

Engaging the team in reviewing practice’s performance and goals is a foundational element in identifying meaningful quality improvement activities that will drive sustainable change.

Include staff roles and responsibilities in practice performance evaluation documents and align performance and future goals with meaningful QI activities that will result in goal attainment.

1. Documented Process (written P&P, workflow, guideline that includes date of implementation that must be in place for at least 3 months prior to submission)
2. Evidence of Implementation
Team-Based Care and Practice Organization (TC)

Competency B: Communication across the care team is optimized to ensure coordinated, safe and effective patient care

**TC08 (2 Credits):**
Practice has a care manager qualified to identify and coordinate behavioral health needs.

Supporting behavioral health needs in the primary care setting through a trained and licensed behavioral health provider demonstrates that the practice understands the importance of behavioral health in patient care.

The behavioral health provider has the licensing and training to provide psychotherapeutic treatment directly, can support the patient’s behavioral health needs and has the ability to coordinate other BH services outside of the clinic.

Identified behavioral healthcare provider.
Team-Based Care and Practice Organization (TC)

Competency C: The practice communicates and engages patients on expectations and the patient role in the medical home

**TC09 (Core):**
Practice has a process for informing patients about the role of the medical home and makes material available to patients.

1. **What?** Documeted Process (written P&P, workflow, guideline that includes date of implementation that must be in place for at least 3 months prior to submission)

2. **Evidence of Implementation**

**Why?**
Educating patients to the concept of comprehensive coordinated care and helping patient’s understand how to access the care they need as well as the practice’s expectations of the patient improves care.

**How?**
The process of communicating the medical home concept to patients should be documented and include at minimum, after-hours access information, scope of services, evidence-based care, education availability and practice points of contact.
Concept
Knowing and Managing your Patients (KM)

The practice captures and analyzes information about its patients and the community as a whole and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.
Knowing and Managing your Patients (KM)

Competency A: Practice routinely collects comprehensive data on patients to understand background and health risk of patients and uses information to implement needed interventions, tools and supports for practice and specific individuals.

**KM01 (Core):**
Practice documents an up-to-date problem list for each patient with diagnoses.

**Why?**
To implement needed interventions, tools and supports for the practice as a whole and for specific individuals.

**How?**
Up-to-date means most recent diagnoses. Transfer from other providers, diagnosis from clinician or by querying the patient are added to the problem list at least annually.

**What?**
Report
OR
KM 06 – predominant conditions and health concerns.
Knowing and Managing your Patients (KM)

**Competency A:** Practice routinely collects comprehensive data on patients to understand background and health risk of patients and uses information to implement needed interventions, tools and supports for practice and specific individuals

**KM02 (Core):** Comprehensive health assessment

- A. Medical history of patient and family
- B. Mental health/substance use history of patient and family
- C. Family/social/cultural characteristics
- D. Communication needs
- E. Behaviors affecting health
- F. Social functioning
- G. Social determinates of health
- H. Developmental screening using a standardized tool
- I. Advance care planning

Comprehensive, current data on patients provides a foundation for supporting population needs

A comprehensive patient assessment includes an examination of the patient’s social and behavioral influences in addition to a physical health assessment

Documented process

AND

Evidence of implementation
Knowing and Managing your Patients (KM)

Competency A: Practice routinely collects comprehensive data on patients to understand background and health risk of patients and uses information to implement needed interventions, tools and supports for practice and specific individuals.

KM03 (Core): Practice conducts depression screening using standardized tool (e.g., PHQ-9)

In caring for the whole person, the medical home recognizes the impact depression can have on a patient’s physical and emotional health.

The documented process includes the practice’s screening process and approach to follow-up for positive screens. The practice reports screening rate and identifies the standardized screening tool.

Evidence of implementation AND Report or Documented process
Knowing and Managing your Patients (KM)

Competency A: Practice routinely collects comprehensive data on patients to understand background and health risk of patients and uses information to implement needed interventions, tools and supports for practice and specific individuals.

KM04 (1 Credit):
Practice conducts behavioral health screenings and/or assessments using standardized tool

A. Anxiety
B. Alcohol use disorder
C. Substance use disorder
D. Pediatric behavioral health screening
E. Post-traumatic stress disorder
F. Attention deficit/hyperactivity disorder
G. Postpartum depression

Many patients go undiagnosed and untreated for mental health and substance use disorders and the medical home can play a major role in early identification of these conditions.

A standardized tool collects information using a current, evidence-based approach that was developed, field-tested and endorsed by a national or regional organization.

Evidence of implementation using 2 or more screening tools AND Documented process
Knowing and Managing your Patients (KM)

Competency A: Practice routinely collects comprehensive data on patients to understand background and health risk of patients and uses information to implement needed interventions, tools and supports for practice and specific individuals.

**KM05 (1 Credit):** Practice assesses oral health needs

**Why?**
Poor oral health can have significant impact on quality of life and overall health. Primary care practices are uniquely positioned to improve oral health, oral health awareness through education, preventive interventions and timely referrals.

**How?**
The practice conducts patient-specific oral health risk assessments and keep a list of oral health partners.

**What?**
Documented process AND Evidence of implementation.
Competency A: Practice routinely collects comprehensive data on patients to understand background and health risk of patients and uses information to implement needed interventions, tools and supports for practice and specific individuals.

**KM06 (1 Credit):**
Practice identifies predominant conditions and health concerns of population.

Knowing its population’s top concerns allows the practice to adopt guidelines, focus decision support and outreach efforts, identify specialists and determine what special services to offer.

The practice identifies its patients’ most prevalent and important conditions and concerns, through analysis of diagnosis codes or problem lists.

List of top priority conditions and concerns.
Knowing and Managing your Patients (KM)

Competency A: Practice routinely collects comprehensive data on patients to understand background and health risk of patients and uses information to implement needed interventions, tools and supports for practice and specific individuals

The real benefit to the population comes when the practice uses the information to continuously enhance care systems and community connections to systematically address needs

The practice demonstrates the ability to assess data and address identified gaps using community partnerships, self-management resources or other tools

Report AND Evidence of implementation

KM07 (2 Credit): Practice understands social determinants of health
Competency A: Practice routinely collects comprehensive data on patients to understand background and health risk of patients and uses information to implement needed interventions, tools and supports for practice and specific individuals.

To reduce barriers to the patient’s ability to access, understand and absorb health information supports their ability to comply with their care.

The practice considers patient demographics such as age, language needs, ethnicity and education when creating materials for its population.

Report AND Evidence of implementation.
Knowing and Managing your Patients (KM)

Competency B: The practice seeks to meet the needs of a diverse patient population by understanding the population’s unique characteristics and language needs

**KM09 (Core):**
Practice assesses the diversity of its population

**Why?**
Assessing the diversity of its population can help a practice identify segments of the population with special needs or subject to systematic barriers leading to disparities in health outcomes

**How?**
The practice collects information on how patients identify in at least three areas that include: race, ethnicity and one other aspect of diversity (gender identity, sexual orientation, religion, occupation, geographic residence)

**What?**
Report
Knowing and Managing your Patients (KM)

Competency B: The practice seeks to meet the needs of a diverse patient population by understanding the population’s unique characteristics and language needs

Documenting patients’ preferred spoken and written language helps the practice identify the language resources required to serve the population.

The practice documents in its records whether the patient declined to provide language information, that the primary language is English or that the patient does not need language services. A blank field does not mean the patient’s preferred language is English.

Report
Knowing and Managing your Patients (KM)

Competency B: The practice seeks to meet the needs of a diverse patient population by understanding the population’s unique characteristics and language needs

**KM11 (1 Credit):** Practice identifies diversity-based population-level needs

- **WHY?** To provide patient-centered care to their vulnerable populations equal to their general populations

- **HOW?** Identify disparities in care, build a health-literate and a culturally competent organization that educates staff how to interact effectively with people of different cultures

- **WHAT?**
  - A: Evidence of implementation
  - OR
  - A: QI 05 and A: QI 13
  - B: Evidence of implementation
  - C: Evidence of implementation

Demonstrate at least two

A. Target population health management on disparities in care
B. Address health literacy of the practice staff
C. Educate practice staff in cultural competence
Knowing and Managing your Patients (KM)

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

KM12 (Core): Practice proactively and routinely identifies populations and reminds them about needed services

The practice can proactively address a variety of health care needs using evidence-based guidelines, including missed recommended follow-up visits

The practice uses lists or reports to manage the care needs of specific patient populations. The practice implements this process at least annually to proactively identify and remind patients before they are overdue for services

Report at least 3
A. Preventive care services
B. Immunizations
C. Chronic or acute care services
D. Patients not recently seen by the practice

A, B, D: Report/list and outreach materials
A, B, D: Outreach materials
C: Report/list and C: Outreach materials
OR C: KM13
Knowing and Managing your Patients (KM)

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

KM13 (2 Credits):
Practice demonstrates excellence in performance-based recognition program

To show third party verification of clinical performance

At least 75 percent of eligible clinicians have earned NCQA HSRP or DRP Recognition. Alternatively, demonstrates clinical performance above national or regional averages

Report
OR
HSRP or DRP recognition for at least 75% of eligible clinicians
Knowing and Managing your Patients (KM)

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

**KM14 (Core):** Practice reviews and reconciles medications from care transitions.

- **Why?** Reduces the possibility of duplicate medications, medication errors and adverse drug events.
- **How?** The practice reviews all prescribed medications a patient is taking and documents this in the medical record. Medical review and reconciliation occurs at transitions of care, or at least annually.
- **What?** Report.
Knowing and Managing your Patients (KM)

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

**Process to promote safety and adherence to prescription medications**

- The practice routinely collects information from patients about medications they take and keeps up-to-date lists of patients’ medications of at least 80% of patients.

**Report**

**KM15 (Core):** Practice maintains and up-to-date list of medications.
Knowing and Managing your Patients (KM)

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

Lack of understanding, due to low health literacy or communication barriers, leads to poorer health outcomes and compromises patient safety

The practice uses patient-centered methods, such as open-ended questions (i.e., teach-back collaborative method), to assess patient understanding

Report AND Evidence of implementation

KM16 (1 Credit):
Practice assesses understanding and provides education on new prescriptions
Knowing and Managing your Patients (KM)

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

**KM17 (1 Credit):**
Practice assesses and addresses response to medications and barriers to adherence for more than 50% of patients.

**Why?**
Patients cannot get the full benefit of their medications if they do not take them as prescribed.

**How?**
The practice asks patients if they are having difficulty taking a medication, are experiencing side effects and are taking the medications prescribed.

**What?**
Report AND Evidence of implementation.
Knowing and Managing your Patients (KM)

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

**What?**
Evidence of implementation

**Why?**
This can prevent overdoses and misuse, and can support referrals for pain management and substance use disorders.

**How?**
The practice consults a state controlled-substance database known as Prescription Drug Monitoring Program (PDMP) or Prescription Monitoring Program (PMP) before dispensing Schedule II, III, IV and V controlled substances.

**KM18 (1 Credit):**
Practice reviews controlled substances database when prescribing relevant medications.
Knowing and Managing your Patients (KM)

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

**KM19 (2 Credits):** Practice systematically obtains prescription claims data

In order to assess and address medication adherence

The practice systematically obtains prescription claims data or other medication transaction history. This may include systems such as SureScripts e-prescribing network, regional health information exchanges, insurers or prescription benefit management companies.

Evidence of implementation
Knowing and Managing your Patients (KM)

Competency E: The practice incorporates evidence-based clinical decision support across a variety of conditions to ensure effective and efficient care

To ensure effective and efficient care is provided to patients

The practice utilizes systems in its day-to-day operations that integrate evidence-based guidelines referred to as clinical decision support (CDS).

Identifies conditions, source of guidelines
AND
Evidence of implementation

Demonstrate at least four
A. Mental health condition
B. Substance use disorder
C. A chronic medical condition
D. An acute condition
E. A condition related to unhealthy behaviors
F. Well child or adult care
G. Overuse/appropriateness issues

KM20 (Core):
Practice implements clinical decision support
Knowing and Managing your Patients (KM)

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

**KM21 (Core):**
Practice uses population information to prioritize community resources.

**Why?**
Using collected population information to prioritize community resource allows for patient population needs to be addressed unique to the practice.

**How?**
The practice identifies needed resources by assessing social determinants, predominant conditions, ED usage and other health concerns to prioritize community resources that support patient population.

**What?**
List of key patient needs and concerns.
Knowing and Managing your Patients (KM)

Competency F: The practice incorporates evidence-based clinical decision support across a variety of conditions to ensure effective and efficient care.

- Giving patients access to educational materials, peer support sessions, group classes and other resources can engage them in their care and teach them better ways to manage it and help them stay healthy.

- **Expected outcomes:**
  - Practice provides educational resources
  - **Educations programs and resources** may include information about a medical condition or about the patient’s role in managing the condition. **Self-management tools** enable patients to collect health information at home that can be discussed with the clinician.

- Evidence of implementation
Knowing and Managing your Patients (KM)

Competency F: The practice incorporates evidence-based clinical decision support across a variety of conditions to ensure effective and efficient care

**KM23 (1 Credit):**
- Practice provides oral health education resources

**Why?**
- Oral disease is largely preventable with knowledge and attention to hygiene. Poor oral health can complicate the care for chronic conditions such as diabetes and heart disease

**How?**
- The practice provides an example of how it provides patients with educational and other resources that pertain to oral health and hygiene

**What?**
- Evidence of implementation
Knowing and Managing your Patients (KM)

Competency F: The practice incorporates evidence-based clinical decision support across a variety of conditions to ensure effective and efficient care

KM24 (1 Credit):
Practice adopts shared decision-making aids for preference-sensitive conditions

Why?
Allows care team to collaborate with patients and help them make informed decisions that align with their preferences and values. Engaging patients in understanding their health condition and in shared decision making helps build a trusting relationship

How?
The care team demonstrates use of at least three shared decision-making aids that provide detailed information without advising patients to choose one option over another

What?
Evidence of implementation
Knowing and Managing your Patients (KM)

Competency F: The practice incorporates evidence-based clinical decision support across a variety of conditions to ensure effective and efficient care.

**KM25 (1 Credit):** Practice engages with schools or intervention agencies.

- **Why?**
  - To develop supportive partnerships with social services organizations or schools in the community.

- **How?**
  - The practice demonstrates this through formal or informal agreements or identifies practice activities in which community entities are engaged to support better health.

- **What?**
  - Documented process AND Evidence of implementation.
Knowing and Managing your Patients (KM)

Competency F: The practice incorporates evidence-based clinical decision support across a variety of conditions to ensure effective and efficient care

**KM26 (1 Credit):** Practice routinely maintains a current community resource list

**WHY?**
Maintaining a current resource list can help a practice guide patients to community resources that support their health and well-being

**HOW?**
The practice maintains a community resource list by selecting five topics or community service areas of importance to the patient population

**WHAT?**
List of resources
Knowing and Managing your Patients (KM)

Competency F: The practice incorporates evidence-based clinical decision support across a variety of conditions to ensure effective and efficient care

KM27 (1 Credit):
Practice assesses the usefulness of identified community support resources

Meeting the patient’s social needs supports their self-management and reduces barriers to care

Community referrals differ from clinical referrals, but may be tracked using the same system

Evidence of implementation
Knowing and Managing your Patients (KM)
Competency F: The practice incorporates evidence-based clinical decision support across a variety of conditions to ensure effective and efficient care

**KM28 (2 Credit):**
Practice has regular “case conferences” involving parties outside the practice team

**Promotes a collaborative approach to care planning for high-risk, complex patients**
Case conferences are planned, multidisciplinary meetings with community organizations or specialists to plan treatment for complex patients

**Documented process**
AND
**Evidence of implementation**
Concept
Patient-Centered Access and Continuity (AC)

Patients/families/caregivers have 24/7 access to clinically relevant appropriate care facilitated by their clinician/care team and this is supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access and continuity.
Patient-Centered Access and Continuity (AC)

Competency A: The practice enhances access by providing appointments and clinical advice based on patients' needs

AC01 (Core): Practice assesses the needs and preferences of its patient population in respect to access

One of the fundamental elements of the patient centered medical home is continuity of care. This can only be accomplished if patients have access to care outside of normal business hours.

To assess the access needs of the patient population, the practice will collect data (surveys, interviews, comment boxes) regarding access preferences. The practice can then use this data to develop alternative methods for access may include evening/weekend hours, or alternative types of appointments.

1. Documented Process (written P&P, workflow, guideline that includes date of implementation that must be in place for at least 3 months prior to submission)

2. Evidence of Implementation
Patient-Centered Access and Continuity (AC) Competency A: The practice enhances access by providing appointments and clinical advice based on patients' needs

AC02 (Core): Practice provides same-day appointments for routine and urgent patient care

**Why?**
Providing same-day patient appointments improves the likelihood that the practice can provide continuity of care to its patients

**How?**
The practice reserves time to accommodate patient request for same-day routine or urgent care appointments. Appointment types can be determined by the needs of the patient population

**What?**
1. Documented Process (written P&P, workflow, guideline that includes date of implementation that must be in place for at least 3 months prior to submission)
2. Evidence of Implementation (5 day schedule to demonstrate same day availability or a report that demonstrates which same-day appointments were used)
Patient-Centered Access and Continuity (AC)
Competency A: The practice enhances access by providing appointments and clinical advice based on patients' needs

AC03 (Core):
Practice provides routine and urgent appointments outside of business hours to meet identified patient needs

The practice recognizes that patient’s care needs are not confined to normal operating hours. This service encourages the patient centered model of access and improves continuity of care

The practice may offer appointments outside of normal business hours. If the practice is part of a larger system or if an urgent care has access to the practices patient record they may arrange for patients to schedule there

1. Documented Process (written P&P, workflow, guideline that includes date of implementation that must be in place for at least 3 months prior to submission)
2. Evidence of Implementation
Patient-Centered Access and Continuity (AC)
Competency A: The practice enhances access by providing appointments and clinical advice based on patients' needs

AC04 (Core):
Practice provides timely clinical advice by telephone

Why?
Providing advice outside of appointments helps reduce unnecessary utilization of emergency department services

How?
Clinical advice must be available any time day/night. If practice chooses a messaging format, clinician must return calls in a timely manner and must be provided by a qualified clinical staff member

What?
1. Documented Process that summarizes the practice’s expected response times and process of monitoring performance of timely responses
2. Report that shows data from at least 7 days of calls
Patient-Centered Access and Continuity (AC)

Competency A: The practice enhances access by providing appointments and clinical advice based on patients' needs

AC05 (Core):
Clinical advice is documented in patient record and confirms after-hours care does not conflict with patient record

Reconciliation of clinical advice given in an after-hours encounter (phone call or visit) ensures that care needs are not in conflict for the patient

The practice documents all clinical advice in the patient record regardless of the way it was delivered. If practice uses a system of documentation outside of the patient record for after hours care, the care is reconciled and entered into the patient record the next day.

1. Documented Process (written P&P, workflow, guideline that includes date of implementation that must be in place for at least 3 months prior to submission)
2. Evidence of Implementation
Patient-Centered Access and Continuity (AC)

Competency A: The practice enhances access by providing appointments and clinical advice based on patients' needs

AC06 (1 Credit):
Practice provides scheduled routine or urgent appointments by phone or other technology supported mechanisms

Offering scheduled alternative visit types encourages continuity of care for patients who cannot get into the office during normal business hours

The practice uses a mode of real-time communication (e.g. telephone, video chat, secure instant messaging) in place of a traditional office visit

1. Documented Process (written P&P, workflow, guideline that includes date of implementation that must be in place for at least 3 months prior to submission)
2. Report of the number and types of visits during a specified time period
Patient-Centered Access and Continuity (AC)
Competency A: The practice enhances access by providing appointments and clinical advice based on patients' needs

**AC07 (1 Credit):**
Practice has a secure electronic system for patient to request appointments, prescriptions, referrals and test results

**Why?**
Use of a secure electronic system for patients to request medications and services they need creates alternative methods of communicating their needs

**How?**
Patients can use a secure electronic system (e.g. website, patient portal, secure voicemail) to request appointments, prescription refills, referrals and test results. The practice must demonstrate at least 2 functionalities

**What?**
Evidence of Implementation
Patient-Centered Access and Continuity (AC)
Competency A: The practice enhances access by providing appointments and clinical advice based on patients' needs

**AC08**
(1 Credit):
Practice has a secure electronic system for two-way communication to provide timely clinical advice

**Why?**
Use of a secure electronic systems for two-way communication increases continuity of care and offers patients alternative visit methods to the traditional office visit

**How?**
Patients and clinicians can use a secure electronic system (e.g. website, patient portal, secure email) to discuss patient needs outside of the traditional office visit setting

**What?**
1. Documented Process that summarizes the practice’s expected response times and process of monitoring performance of timely responses
2. Report that shows data from at least 7 days of secure communication methods
Patient-Centered Access and Continuity (AC)

Competency A: The practice enhances access by providing appointments and clinical advice based on patients' needs

**AC09** (1 Credit):

Practice uses information about its patient population to assess equity of access that considers health disparities

Knowing whether groups of patients within your population experience differences in access to health care can help practices focus efforts to address these health inequities

Practice identifies health disparities and evaluated how they may impact access to care differently than the average patient in the practice

Evidence of Implementation through a report of how an identified group of patients has a lower rate of access than the general population

**Healthy People 2020 defines health disparity as “a particular type of health difference that is closely linked with social, economic and or environmental disadvantage”**
Patient-Centered Access and Continuity (AC)

Competency B: The practice supports continuity through empanelment and access of the patient record

AC10 (Core):
Practice has a process for helping patients select or change their personal clinician

**Why?**
Giving patients/families/caregivers choice to choose and change their personal clinician within the practice emphasizes the importance of building a strong continuous patient-provider relationship.

**How?**
The practice documents the choice of clinician and gives information to patients about the importance of continuity of care. The practice may document a defined practice team. Single provider sites automatically meet this criterion.

1. **What?**
   Documented Process (written P&P, workflow, guideline that includes date of implementation that must be in place for at least 3 months prior to submission)
Patient-Centered Access and Continuity (AC)
Competency B: The practice supports continuity through empanelment and access of the patient record

AC11
(Core):
PRACTICE SETS GOALS AND MONITORS THE PERCENTAGE OF PATIENT VISITS WITH EMPANELED CLINICIAN OR CARE TEAM

Empanelment is defined as assigning individual patients to specific primary care providers and care teams with sensitivity to patient and family preferences.

Why?
Empanelment is the basis for population health management and the key to continuity of care. Simply put, patients build better relationships with clinicians or teams they see regularly for their care.

How?
The practice establishes its own goal for the proportion of visits a patient should have with their empaneled physician or care team. The goal should acknowledge that timely appointments may sometimes be compromised due to this fact but that continuity of care is the driver of this decision.

What?
Report

**Empanelment is defined as assigning individual patients to specific primary care providers and care teams with sensitivity to patient and family preferences.**
Patient-Centered Access and Continuity (AC)

Competency B: The practice supports continuity through empanelment and access of the patient record

**AC12 (2 Credits):**
Practice provides continuity of medical record information for care and advice outside of normal business hours

- **Why?** Making the patient’s medical record available to on-call staff, external facilities, and clinicians outside of the practice increases communication of patient current diagnosis, medications, and plans in place by the PCP.

- **How?** Patient medical record availability may include direct access to electronic record, arranging a telephone consultation, or use of a health information exchange.

- **What?** Documented Process (written P&P, workflow, guideline that includes date of implementation that must be in place for at least 3 months prior to submission)
Patient-Centered Access and Continuity (AC)

Competency B: The practice supports continuity through empanelment and access of the patient record

AC13 (1 Credit):
Practice reviews and actively manages panel size

Reviewing and balancing patient panels facilitates improved patient satisfaction, patient access to care and provider workload because of the laws of supply and demand

The practice has a process and actively reviews the number of patients assigned to each clinician and balances the size of each providers’ panel

1. Documented Process (written P&P, workflow, guideline that includes date of implementation that must be in place for at least 3 months prior to submission)
2. Report
Patient-Centered Access and Continuity (AC)

Competency B: The practice supports continuity through empanelment and access of the patient record

AC14 (1 Credit): Practice reviews and reconciles panels based on health plan or other outside patient assignments

Reconciling panels with health plans and other entities improves accountability, continuity and access

The practice has a process and actively reviews reports that are obtained from outside the practice (e.g. health plans, ACOs, Medicaid agencies) and has a process to give attribution feedback to those entities

1. Documented Process (written P&P, workflow, guideline that includes date of implementation that must be in place for at least 3 months prior to submission)
2. Evidence of implementation
Concept
Care Management and Support (CM)

The practice captures and analyzes information about its patients and the community as a whole and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.
Care Management and Support (CM)

Competency A: The practice systematically identifies patients who may benefit from care management

CM01 (Core):
Practice establishes a systematic process and criteria for identifying patients for care management

To effectively plan, manage and coordinate patient care with emphasis on supporting patients at highest risk

The practice defines a protocol to identify patients who may benefit from care management

Protocol for identifying patients for care management

OR

CM 03

A. Behavioral health conditions
B. High cost/high utilization
C. Poorly controlled or complex conditions
D. Social determinants of health
E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/family/caregiver
Care Management and Support (CM)
Competency A: The practice systematically identifies patients who may benefit from care management

CM02 (Core):
Practice monitors percentage of total population identified for care management

To determine a subset of patients for care management

Subset based on the patient population and the practice’s capacity to provide services. Patients who fit multiple criteria count once in the numerator

Report
Care Management and Support (CM)

Competency A: The practice systematically identifies patients who may benefit from care management

CM03
(2 Credits):
Practice applies a comprehensive risk-stratification process for entire patient panel

To demonstrate practice can identify patients who are at high risk and prioritize their care management to prevent poor outcomes

Practices identifies and directs resources appropriately based on need

Report
Care Management and Support (CM)

**Competency B:** For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/caregivers to develop a care plan that addresses barriers and incorporates patient preferences and goals in patient’s chart.

To ensure that a care plan is meaningful, realistic and actionable.

The practice has a process to consistently develop patient care plans for the patients identified for care management.

**CM04 (Core):**
Practice establishes a person-centered care plan for patients in care management.

Report
OR
Record Review Workbook and Patient examples
Care Management and Support (CM)

Competency B: For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/caregivers to develop a care plan that addresses barriers and incorporates patient preferences and goals in patient’s chart.

It’s beneficial to tailor the written care plan to accommodate the patient’s health literacy and language preferences.

The practice provides the patient’s written care plan to the patient/family/caregiver. This version may use different words or formats from the version used by the practice team.

CM05 (Core): Practice provides a written care plan for patients in care management.

Report OR Record Review Workbook and Patient examples
Competency B: For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/caregivers to develop a care plan that addresses barriers and incorporates patient preferences and goals in patient’s chart.

Including patient preferences and goals encourages a collaborative partnership between patient/family/caregiver and provider, and ensures that patients are active participants in their care.

The practice works with patient/families/caregivers to incorporate patient preferences and functional lifestyle goals in the care plan. Functional/lifestyle goals can be individually meaningful activities that a person wants to be able to perform but may be at risk due to health condition or treatment plan.

CM06 (1 Credit): Practice documents patient preference and functional/lifestyle goals in care plan.

Report
OR
Record Review Workbook and Patient examples
Care Management and Support (CM)

Competency B: For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/caregivers to develop a care plan that addresses barriers and incorporates patient preferences and goals in patient’s chart.

Addressing barriers supports successful completion of the goals stated in the care plan.

Barriers may include physical, emotional or social barriers. Practice works with patients, other providers and community resources to address potential barriers to achieving treatment and functional/lifestyle goals.

CM07 (1 Credit):
Practice identifies and discusses potential barriers to meeting goals.

Report
OR
Record Review Workbook and
Patient examples
Care Management and Support (CM)

Competency B: For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/caregivers to develop a care plan that addresses barriers and incorporates patient preferences and goals in patient’s chart.

CM08 (1 Credit):
Practice includes a self-management plan in individual care plans.

- Providing tools and resources to self-manage complex conditions can empower patients to become more involved in their care and to use tools to address barriers.
- The practice works with patient/families/caregivers to develop self-management instructions to manage day-to-day challenges of a complex condition.

Report OR
Record Review Workbook and Patient examples
Competency B: For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/caregivers to develop a care plan that addresses barriers and incorporates patient preferences and goals in patient’s chart.

**CM09 (1 Credit):**
Care plan is integrated and accessible across settings of care.

- **Why?**
  - Sharing the care plan supports its implementation across all settings that address the patient’s care needs.

- **How?**
  - The practice makes the care plan accessible across external care settings.

- **What?**
  - Documented process
    - AND
    - Evidence of implementation.
Concept
Care Coordination and Care Transitions (CC)

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

Competency A: The practice effectively tracks and manages lab and imaging tests important for patient care and informs patients of the result

Systematic monitoring helps ensure that needed tests are performed, results are acted on and optimal care is given to patients.

A,B: Practice tracks lab and imaging test from time they are ordered until results are available and flags test results that are overdue. Practice has a systematic process and time frame to follow up and documents follow up efforts.

C,D: Abnormal results of lab or imaging results are flagged to ensure timely follow up.

E,F: The practice has a process to notify patients of normal and abnormal test results that occurs in a timely manner.

1. Documented Process (written P&P, workflow, guideline that includes date of implementation that must be in place for at least 3 months prior to submission)

2. Evidence of implementation
Care Coordination and Care Transitions (CC)

Competency A: The practice effectively tracks and manages lab and imaging tests important for patient care and informs patients of the result.

CC02 (1 Credit):
Practice follows up with inpatient facility about newborn hearing and blood-spot screening.

Early detection and treatment of congenital disorders can enhance health outcomes for newborns who have abnormal screening results.

The practice has a documented process of follow up with hospital or state health department if it is not receiving screening results for both blood spot screening and hearing screening.

1. Documented Process (written P&P, workflow, guideline that includes date of implementation that must be in place for at least 3 months prior to submission)
2. Evidence of implementation
Care Coordination and Care Transitions (CC)

Competency A: The practice effectively tracks and manages lab and imaging tests important for patient care and informs patients of the result

**CC03 (2 Credits):**
Practice uses clinical protocols to determine appropriateness of imaging and labs

**Why?**
Inappropriate use of laboratory and imaging tests lead to increased costs, potential increases in risk and does not improve patient outcomes

**How?**
Practice has established evidence-based protocols to determine when imaging and lab tests are necessary. This may be part of a clinical decision support tool in the EHR

**What?**
1. Evidence of implementation
Care Management and Support (CM)

Competency B: The practice provides important information in referrals to specialists and tracks referrals until follow up report is received

**CC04 (Core):** Practice manages referrals by:

1. Documented Process (written P&P, workflow, guideline that includes date of implementation that must be in place for at least 3 months prior to submission)
2. Evidence of implementation

**WHY?**

Referral tracking and follow up is part of good patient care. Poor communication can lead to uncoordinated and fragmented care leading to duplication, increased costs and provider frustration

**HOW?**

A. Referring clinician provides a reason for the referral stated as the clinical question, and indicates type of referral requested
B. Referrals include clinical information relevant to visit (current medications, diagnosis, clinical findings of current treatment, expectations of follow-up communication etc)
C. Practice uses tracking report that includes date when referral is initiated, timing indicated for receiving report from specialist and f/u if report is not received

**WHAT?**

A. Providing specialist the clinical question, required timing and type of referral requesting
B. Provides the specialist pertinent demographic and clinical data, including test results and current care plan if applicable
C. Practice will track referrals until the consultant or specialists’ report is available, flagging and f/u on reports that are overdue
Care Coordination and Care Transitions (CC)

Competency B: The practice provides important information in referrals to specialists and tracks referrals until follow up report is received

**CC05 (2 Credits):**
Practice uses clinical protocols to determine when they should refer patients to a specialist

Unnecessary referrals can lead to overuse of tests, decreases patient’s overall satisfaction and may reduce availability for other patients who need specialist care

The practice uses clinical protocols or decision support tools to determine the circumstances in which the primary care physician needs to refer a patient to specialty care

Evidence of implementation
Care Coordination and Care Transitions (CC)

Competency B: The practice provides important information in referrals to specialists and tracks referrals until follow up report is received

CC06 (1 Credits):
Practice identifies the types of specialties they most utilize for patient care

Why?
Tracking high volume specialty referrals can help the practice identify opportunities where they may be able to expand their primary care services or create coordinated agreements with specialists they use most.

How?
The practice monitors patient referrals through EHR and payer data to identify high volume specialists

What?
Evidence of implementation
Care Coordination and Care Transitions (CC)

Competency B: The practice provides important information in referrals to specialists and tracks referrals until follow up report is received.

**CC07 (2 Credits):** The practice considers specialist’s performance information when making referrals.

- **Why?** Practices need to make informed decisions about referrals as this process is an extension of high quality care.
- **How?** The practice provides information or examples of available performance data for specialists they commonly use as referral sources for patients.
- **What?**
  1. Data source
  2. Examples
Care Coordination and Care Transitions (CC)

Competency B: The practice provides important information in referrals to specialists and tracks referrals until follow up report is received

CC08 (1 Credit): The practice works with non-behavioral healthcare specialists to set expectations for information sharing and patient care

 Relationships between primary care and specialists supports coordinated, safe and high quality care experiences for patients

The practice develops formal or informal agreements with specialists that establish expectations for exchange of information and defines sharing of patient care

1. Documented process
   OR
2. Agreement
Care Coordination and Care Transitions (CC)

Competency B: The practice provides important information in referrals to specialists and tracks referrals until follow up report is received

CC09 (2 Credits):
The practice works with behavioral healthcare providers to set expectations for information sharing and patient care

Relationships between primary care and behavioral health supports consistency of information across practices whether housed within the practice or co-located offsite

The practice develops formal or informal agreements that established expectations for information exchange with behavioral healthcare providers. If BH is located in practice internal processes must be set up to ensure information sharing

Documented process and Evidence of Implementation OR Agreement
Care Coordination and Care Transitions (CC)

Competency B: The practice provides important information in referrals to specialists and tracks referrals until follow up report is received

In this setting behavioral health providers work together to integrate patients’ primary care and behavioral health needs in the primary care setting

Practice has shared accountability, collaborative treatment and workflow strategies that successfully integrates behavioral health into the primary care setting

CC10 (2 Credits): The practice integrates behavioral healthcare providers into the care delivery system of the practice

1. Documented process
2. Evidence of Implementation
Care Coordination and Care Transitions (CC)

Competency B: The practice provides important information in referrals to specialists and tracks referrals until follow up report is received

CC11
(1 Credit):
The practice monitors the timeliness and quality of the referral response from specialists

Monitoring the timeliness and quality of referrals insures the delivery of high value care to patients

The practice assesses responses received from specialists and evaluates its timeliness based on definition derived from the practices perception of the patient’s need

1. Documented process
2. Report
Care Coordination and Care Transitions (CC)

Competency B: The practice provides important information in referrals to specialists and tracks referrals until follow up report is received

**CC12 (1 Credit):**
The practice documents co-management arrangements in the patient’s medical record

**Why?**
Effective communication around the co-management of a patient enables the primary care provider and the specialist to provide safe, coordinated care for patients

**How?**
The practice has a written agreement regarding the communication of the shared treatment plan, patient health status, and will record this information in the patient medical record in an agreed upon time frame.

**What?**
The practice must provide three examples of co-management arrangements as evidence of implementation
Care Coordination and Care Transitions (CC)

Competency B: The practice provides important information in referrals to specialists and tracks referrals until follow up report is received

Cost can be a barrier to drug and treatment adherence for patients. Having an effective communication strategy to assist patients in removing this barrier improves patient care and treatment adherence.

The practice may add a financial question regarding cost barriers as it relates to treatment, directs patients to resources and discusses the reasons why adherence is necessary to improving the patient’s health.

1. Documented Process
2. Evidence of Implementation

CC13 (2 Credits): The practice engages with patient regarding cost implications of treatment options.
Care Coordination and Care Transitions (CC)

Competency C: The practice connects with healthcare facilities to support patient safety throughout care transitions. This includes receiving and sharing necessary treatment information.

**CC14 (Core):** The practice systematically identifies patients’ ED and hospital utilization.

1. **Documented Process**
2. **Report**

Developing a process for monitoring emergency department and hospital admissions allows the practice to provide continued care upon discharge and creates an opportunity to help patients understand when ED visits are appropriate.

The practice works with local hospitals and health plans to identify patients with recent ED/hospital visits. The practice develops a plan to track these visits that shows an established notification exchange mechanism.
Care Coordination and Care Transitions (CC)

Competency C: The practice connects with healthcare facilities to support patient safety throughout care transitions. This includes receiving and sharing necessary treatment information.

**CC15 (Core):** The practice shares clinical information with admitting hospitals and ED’s.

**Shared information between primary care and hospitals/emergency departments supports continuity in patient care across settings.**

The practice demonstrates timely sharing of information with admitting hospitals and EDs. The practice provides three examples of the exchange of patient information.

1. Documented Process
2. Evidence of Implementation
Care Coordination and Care Transitions (CC)

Competency C: The practice connects with healthcare facilities to support patient safety throughout care transitions. This includes receiving and sharing necessary treatment information.

**CC16 (Core):** The practice contacts patients/caregivers for follow-up care, if needed within a set period of time following an ED visit or hospital discharge.

**WHY?**
Effective follow-up from primary care to patients who have recently utilized the ED or have been discharged from the hospital improves continuity of patient care and may reduce unnecessary hospital readmission.

**HOW?**
The practice contacts patients to evaluate status in a timely manner as defined by the practice after discharge from ED or hospital and documents that systematic follow-up was completed.

**WHAT?**

1. Documented Process
2. Evidence of Follow-up

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Care Coordination and Care Transitions (CC)

Competency C: The practice connects with healthcare facilities to support patient safety throughout care transitions. This includes receiving and sharing necessary treatment information.

**CC17** (1 Credit):
The practice has the ability to coordinate with acute care settings after office hours through access to current patient information.

**Why?**
Sharing patient information allows the facility to coordinate patient care based on current health needs and engage with practice staff.

**How?**
The practice has a process of coordinating with acute care facilities when a patient is seen after the office is closed.

**What?**
1. Documented Process
2. Evidence of documentation of at least 1 example of coordination with a facility
Care Coordination and Care Transitions (CC)

Competency C: The practice connects with healthcare facilities to support patient safety throughout care transitions. This includes receiving and sharing necessary treatment information.

Sharing patient information allows the hospital to coordinate patient care based on current health needs while the patient is receiving care.

The practice has a process of two-way communication between the hospital and the provider during a patient’s hospitalization.

Note: CC15 assess practices ability to share information, CC18 has a focus on two-way exchange of information.

1. Documented Process
2. Evidence of implementation with 3 examples of data exchange
Competency C: The practice connects with healthcare facilities to support patient safety throughout care transitions. This includes receiving and sharing necessary treatment information.

**CC19 (1 Credit):**

The practice implements a process to consistently obtain patient discharge summaries from the hospital.

- **Why?** Obtaining patient information upon hospital discharge provides the necessary information to the primary care physician to conduct effective follow up care.
- **How?** The practice has a process in place to actively attempt to receive discharge summaries from hospitals. This may be a local database, active outreach or participation in a local ADT system.
- **What?**
  1. Documented Process
  2. Evidence of implementation with 3 examples of practice obtaining discharge summaries.
Care Coordination and Care Transitions (CC)
Competency C: The practice connects with healthcare facilities to support patient safety throughout care transitions. This includes receiving and sharing necessary treatment information.

**CC20**
(1 Credit):
The practice collaborates with patients/caregivers to develop written care plans for complex patients transitioning into/out of the practice.

Effectively communicating the process for transitioning complex patients into/out of care from adolescent to adult care) helps patients better understand the expectations of the practice and their responsibilities as patients.

The practice has a care plan for patients that includes summary of medical information, list of other providers involved with the patients care, obstacles to transitioning, arrangements for release of medical records and a patient’s transition plan.

Evidence of implementation

Note: Family medicine practices that do not transition care should document the process of how they educate patients regarding how their care may change as they move into adulthood.
The practice establishes a culture of data-driven performance improvement on clinical quality, efficiency and patient experience, and engages staff and patients/families/caregivers in quality improvement activities.
Performance Measurement and Quality Improvement (QI) Competency A: The practice measures to understand current performance and to identify opportunities for improvement

**QI 01 (Core):**
Practice monitors at least five clinical quality measures across these four categories

A. Immunization measures
B. Other preventive care measures
C. Chronic or acute care clinical care
D. Behavioral health measures

- **Why?** Measuring and reporting clinical quality measures helps practices deliver safe, effective, patient-centered and timely care
- **How?** The practice shows that it monitors at least five clinical quality measures
- **What?** Report
Performance Measurement and Quality Improvement (QI) Competency A: The practice measures to understand current performance and to identify opportunities for improvement

When pursuing high-quality, cost-effective outcomes, the practice has a responsibility to consider how it uses resources.

The practice reports at least two measures related to resource stewardship, including a measure related to health care cost and a measure related to care coordination.

A. Measures related to care coordination
B. Measures affecting health care costs

Report
Performance Measurement and Quality Improvement (QI) Competency A: The practice measures to understand current performance and to identify opportunities for improvement

QI 03 (Core): Practice assesses performance on availability of major appointment types to meet patient needs and preference for access

- **Why?**
  - Patients who cannot get a timely appointment with their primary care provider may seek out-of-network care, facing potentially higher costs and treatment from a provider who does not know their medical history.

- **How?**
  - The practice consistently reviews the availability of major appointment types and adjusts appointment availability, if necessary. A common approach is to use the 3rd next available appt. for each appointment type.

- **What?**
  - Documented process AND Report
Performance Measurement and Quality Improvement (QI)

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

QI 04 (Core): Practice monitors patient experience through:

A. Quantitative data. Conducts a survey (using any instrument) to evaluate patient/family/caregiver experiences across at least three dimensions:
   - Access
   - Communication
   - Coordination
   - Whole-person care, self-management support and comprehensiveness

B. Qualitative data. Obtains feedback through qualitative means

To assess the patient/family/caregiver experience with the practice

The practice gathers feedback from patients and provides summarized results to inform quality improvement activities

Report
Performance Measurement and Quality Improvement (QI)

Competency A: The practice measures to understand current performance and to identify opportunities for improvement.

**QI 05 (1 Credit):**
Practice assesses health disparities using performance data stratified for vulnerable populations.

**Why?**
The intent of this criteria is for practices to work towards eliminating disparities in health and delivery of health care for their vulnerable patient populations.

**How?**
The practice stratifies performance data by race and ethnicity or by other indicators of vulnerable groups that reflect the practice’s population demographics.

**What?**

- Report
- OR
- Quality Improvement Worksheet

Must choose one from each section:
A. Clinical quality
B. Patient experience
Performance Measurement and Quality Improvement (QI)

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

QI 06 (1 Credit):
Practice uses a standardized, validated patient experience survey tool with benchmarking available

The intent is for the practice to administer a survey that can be benchmarked externally and compared across practices

The practice uses a standardized survey tool to collect patient experience data and inform its quality improvement activities

Report: The practice may use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) PCMH Survey
Competency A: The practice measures to understand current performance and to identify opportunities for improvement

**QI 07 (2 Credits):** Practice obtains feedback on experience of vulnerable patient groups

The intent of this criteria is for practices to work towards eliminating disparities in health and delivery of health care for their vulnerable patient populations.

The practice should identify a vulnerable group where there is evidence of disparities of care or service then obtain patient feedback from that group to support quality improvement initiatives.

Report
Performance Measurement and Quality Improvement (QI) Competency B: The practice evaluates its performance against or benchmarks and uses the results to prioritize and implement improvement strategies

QI 08 (Core): Practice sets goals and acts to improve upon at least three measures across at least three of the four categories

Review and evaluation offer an opportunity to identify and prioritize areas for improvement

The practice has an ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks

A. Immunization measures
B. Other preventive care measures
C. Chronic or acute care clinical measures
D. Behavioral health measures

Report
OR
Quality Improvement Worksheet
Performance Measurement and Quality Improvement (QI) Competency B: The practice evaluates its performance against or benchmarks and uses the results to prioritize and implement improvement strategies

QI 09 (Core): Practice sets goals and acts to improve performance on at least one measure of resource stewardship

A. Measures related to care coordination
B. Measures affecting health care costs

The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care

The practice may participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA) on these measures that represents a commitment to ongoing quality improvement

Report
OR
Quality Improvement Worksheet
Performance Measurement and Quality Improvement (QI) Competency B: The practice evaluates its performance against or benchmarks and uses the results to prioritize and implement improvement strategies.

**QI10 (Core):**
Practice sets goals and acts to improve on availability of major appointment types.

- Knowing that a variety of factors can affect appointment availability, the practice can adjust to meet patient preferences and needs.

- After assessing performance on the availability of common appointment types, the practice sets goals and acts to improve on availability.

- Report OR Quality Improvement Worksheet.
Performance Measurement and Quality Improvement (QI) Competency B: The practice evaluates its performance against or benchmarks and uses the results to prioritize and implement improvement strategies.

QI11 (Core): Practice sets goals and acts to improve performance on at least one patient experience measure.

To improve patient experience:
- The practice acts to reach a desired level of achievement based on its self-identified standard of care.

Report OR Quality Improvement Worksheet.
Performance Measurement and Quality Improvement (QI) Competency B: The practice evaluates its performance against or benchmarks and uses the results to prioritize and implement improvement strategies

**QI 12 (2 Credits):**
Practice achieves improved performance on at least two performance measures

To improve patient outcomes

The practice demonstrates that it has improved performance on at least two measures determined by the goals set in QI 08, QI 09 or QI 11

Report
OR
Quality Improvement Worksheet
Performance Measurement and Quality Improvement (QI) Competency B: The practice evaluates its performance against or benchmarks and uses the results to prioritize and implement improvement strategies

QI 13 (1 Credit):
Practice sets goals and acts to improve disparities in care or services on at least one measure

To improve disparities in care or services among vulnerable populations

The practice identifies health disparities in care or services among vulnerable populations. The practice sets goals and acts to improve performance

Report
OR
Quality Improvement Worksheet
Performance Measurement and Quality Improvement (QI) Competency B: The practice evaluates its performance against or benchmarks and uses the results to prioritize and implement improvement strategies

QI 14 (2 Credit):
Practice achieves improved performance on at least one measure of disparities in care or service

To improve disparities in care or services among vulnerable populations

The practice demonstrates that it has improved performance on at least one measure related to disparities in care or service

Report
OR
Quality Improvement Worksheet
Performance Measurement and Quality Improvement (QI) Competency C: The practice is accountable for performance and shares performance data with practice, patients and/or publicly.

**QI 15 (Core):** Reports practice-level or individual clinician performance results within the practice for measures reported by the practice.

**Why?** To improve clinical performance.

**How?** The practice provides individual and practice level reports to clinician or practice level reports to clinicians and staff.

**What?** Documented process AND Evidence of implementation.
Performance Measurement and Quality Improvement (QI) Competency C: The practice is accountable for performance and shares performance data with practice, patients and/or publicly

QI 16 (1 Credit):
Reports practice-level or individual clinician performance results publicly or with patients for measures reported by the practice

To improve clinical performance

The practice provides individual and practice level reports with patients and the public

Documented process AND Evidence of implementation
Performance Measurement and Quality Improvement (QI) Competency C: The practice is accountable for performance and shares performance data with practice, patients and/or publicly

**QI 17 (2 Credits):** Practice involves patient/family/Caregiver in quality improvement activities

- The ongoing inclusion of patients/families/caregivers in quality improvement activities provides the voice of the patient to patient-centered care
- The practice has a process for involving patients and their families in its quality improvement efforts or on the practice’s patient advisory council (PFAC)
- Documented process
- AND
- Evidence of implementation
Performance Measurement and Quality Improvement (QI) Competency C: The practice is accountable for performance and shares performance data with practice, patients and/or publicly.

QI 18 (2 Credits): Practice reports clinical quality measures to Medicare or Medicaid agency.

The practice demonstrates that it reports a minimum number of clinical quality measures to Medicare or to a state Medicaid agency.

Evidence of submission.
Performance Measurement and Quality Improvement (QI) Competency C: The practice is accountable for performance and shares performance data with practice, patients and/or publicly

Involvement in value-based contracts represents a shift from fee-for-service billing to compensating practices and providers for administering quality care for patients

The practice demonstrates it participates in a value-based program by providing information about their participation or a copy of the agreement

A. Practice engages in upside risk contract (1 Credit)
B. Practice engages in two-sided risk contract (2 Credits)

Agreement
Or
Evidence of implementation
From the Practice Transformation Team at Rocky Mountain Health Plans
PCMH 2017 from Start to Finish

Anna Messinger, MHC, PCMH CCE
August 11, 2017
Objectives

• Review steps for conversion and renewal for previously recognized practices
• Review steps for recognition for new practices
Previously Recognized Practices: Step 1

**PCMH 2011/PCMH 2014 Level 1 & 2**

- Download and review PCMH 2017 Standards and Guidelines (NCQA store)
- Download the Accelerated Renewal Table (NCQA website)

**PCMH 2014 Level 3**

- Download and review the PCMH 2017 Standards and Guidelines (NCQA store)
- Download the Annual Reporting Requirements (NCQA website)
Previously Recognized Practices: Step 2

**PCMH 2011/PCMH 2014 Level 1 & 2**

Complete gap analysis based on Renewal Table to identify areas of focus (core criteria)

Select your elective criteria

**PCMH 2014 Level 3**

Complete a gap analysis based on annual reporting requirements

Select the options that you will be reporting or attesting to
Previously Recognized Practices: Step 3

**PCMH 2011/PCMH 2014 Level 1 & 2**

Enroll in Q-Pass

You will be assigned an NCQA representative that will be your single point of contact for scheduling evaluations

**PCMH 2014 Level 3**

Enroll in Q-Pass

You will be assigned a NCQA representative, who will explain the next steps
Previously Recognized Practices: Step 4

- Earn recognition under the PCMH 2017 standards
- Begin promoting your practice as a recognized PCMH
- Spread and sustain your changes to maintain the level of quality of a recognized PCMH
QUESTIONS?
New Practices: Steps to Recognition

Download PCMH 2017 documents

1. PCMH 2017 Standards and Guidelines
   [http://store.ncqa.org/](http://store.ncqa.org/)

2. Toolkit: Getting Started with NCQA Patient-Centered Medical Home Recognition
New Practices: Steps to Recognition

• Evaluate your current status on PCMH concepts
  – Complete a Gap Analysis to identify starting points
  – Begin working on implementing and documenting core criteria
  – Select the elective criteria you will report on and begin implementation and documentation
New Practices: Steps to Recognition

• (Optional) Begin entering practice information in the Q-Pass platform
• Reassess your status on the core and elective criteria (complete gap analysis)
• Enroll in Q-Pass and pay the recognition fee
• Schedule the introductory meeting with your NCQA representative
• Develop a timeline for submission
New Practices: Steps to Recognition

- Begin loading documentation into Q-Pass
- Schedule your first virtual check-in with the NCQA representative
- Continue to work on documentation, based on feedback during the check-in
- Continue loading documentation for the next check-in
New Practices: Steps to Recognition

• Purchase additional check-ins, if necessary
• Earn your recognition!!
• Begin promoting your practice as a recognized PCMH
• Spread and sustain your changes to maintain the level of quality of a recognized PCMH
QUESTIONS?