

Introduction to PCMH: Foundational Concepts of the Medical Home



PCMH (2017 Version) Eligibility Requirements and Readiness



Eligibility Requirements



Outpatient primary care practices

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

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



Eligibility Requirements



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



Eligibility Requirements

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

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

All eligible clinicians at a site must apply together

Physicians in training (residents) should not be listed





Practice Readiness



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



Practice Readiness

Transformation may take 6-12 months

Your roadmap: PCMH 2017 Standards and Guidelines – everything covered

Implement changes:

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





PCMH 2017 Standards Overview & Scoring



2017 Standards Version Format

Structure – Concepts, Competencies, Criteria

<u>Concepts</u>: Over-arching components of PCMH

Competencies: Ways to think about and/or bucket criteria

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



2017 Standards

Concepts



Team-Based Care and Practice Organization (TC)



Care Management and Support (CM)



Knowing and Managing Your Patients (KM)



Care Coordination and Care Transitions (CC)



Patient-Centered Access and Continuity (AC)



Performance Measurement & Quality Improvement (QI)



PCMH Standards (2017 Version)

Structure - Example

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Competency: A brief description of criteria subgroup, organized within the broader concept.

Concept: A brief title describing the criteria; uses a two-letter abbreviation (XX). Evidence: Proof that a practice meets the criteria. Evidence can be demonstrated by submitting documentation (e.g., policies and procedures, examples, data, reports) and through a virtual review of a practice's systems and electronic capabilities

CONCEPT: TEAM-BASED CARE AND PRACTICE ORGANIZATION (TC)

Intent: 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.

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

Criteria: A brief statement highlighting the PCMH requirements. All criteria are numbered consecutively within their respective concept. Criteria are also labeled with their scoring designation:

- Core= Core criteria
- 1 Credit= Elective criteria
- 2 Credits= Elective criteria worth 2 Credits

Evidence:

- Details about the clinician lead AND
- · Details about the PCMH manager

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Icon indicates evidence that is shareable across practice sites Intent: A brief statement describing the concept goals and intent

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PCMH Recognition

Changes to Levels





PCMH Recognition Scoring

Changes to Points









Recognition Process

3 Pathways



New Customer

Full Transform Process Recognized PCMH 2011 Levels 1-3 & PCMH 2014 Levels 1-2

> Accelerated Renewal Process (Transform w/ Attestation)



Recognized PCMH 2014 Level 3

Bypass Transform Direct to Sustaining Process



New Customers

Transform Steps

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



Completing Enrollment

NCQA will assign a representative to the practice The practice should then address:



Transfer credit

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

Shared credit

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



Multi-Site Process



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



Corporate Credit Transition

Multi-sites recognized under PCMH 2011 or PCMH 2014

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

Criteria	Criteria Title	Shared or Site-Specific?	Eligible for Attestation of Shared Credit?
Competency A: Co	mprehensive Patient/Population Knowled	ige	
KM 01 (Core)	Problem Lists	Site-Specific	
KM 02 (Core) 'F and G are new	Comprehensive Health Assessment	Partially Shared**	
KM 03 (Core)	Depression Screening	Partially Shared**	
KM 04" (1 Credit)	Behavioral Health Screenings	Partially Shared**	
KM 05" (1 Credit)	Oral Health Assessment & Services	Partially Shared**	
KM 06 (1 Credit)	Predominant Conditions & Concerns	2	
KM 07" (2 Credits)	Social Determinants of Health	Celtic	
KM 08" (1 Credit)	Patient Materials	e-Specific	
Competency B: Cu	tural Competency		
KM 09 (Core)	Diversity	Shared	
KM 10 (Core)	Language		
KM 11 (1 Credit) 'A and C are new	Population Needs		
Competency C: Pro	active Population Management		
KM 12 (Core)	Proactive Reminders	Shared	1
KM 13" (2 Credits)	Excellence in Performance		
Competency D: Me	dication Management	Site-Specific	
KM 14 (Core)	Medication Reconciliation		
KM 15 (Core)	Medication Lists		
(M 16 (1 Credit)	New Prescription Education	te-Specific	
KM 17 (1 Credit)	Medication Responses & Barriers	opeenie	
KM 18" (1 Credit)	Controlled Substance Database Review	acific	
KM 19" (2 Credits)	Prescription Claims Data	Slike	
Competency E: Evi	dence-Based Decision Support		
KM 20 (Core)	Clinical Decision Support	Shared	1
Competency F: Co	mmunity Resources		
KM 21" (Core)	Community Resource Needs	Shared	
KM 22 (1 Credit)	Access to Educational Resources	Shared	1
KM 23" (1 Credit)	Oral Health Education	Shared	
KM 24 (1 Credit)	Shared Decision-Making Alds	Shared	1
KM 25" (1 Credit)	School/Intervention Agency Engagement	Shared	
KM 26 (1 Credit)	Community Resource List	Shared	1
KM 27 (1 Credit)	Community Resource Assessment	Shared	1
KM 28" (2 Credits)	Case Conferences	Shared	-

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

Corporate Credit Transition Expectations

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

Criteria Marked Attestation	Criteria Requiring Evidence	PCMH 2014 Level 3 Practices
Organizations may attest that they:	Practices should:Follow the current	Practices that have achieved PCMH 2014
 Have already demonstrated & met the equivalent criteria in their previous PCMH 2011 or 2014 corporate survey 	 PCMH Standards & Guidelines Submit evidence in Q-PASS, as indicated. Prepare to demonstrate virtual 	 Level 3 recognition may: Bypass submission of evidence for criteria Proceed directly to the Annual Reporting phase of recognition.
 Are still performing PCMH activities in 	review-eligible evidence during the	

virtual review.

these criteria.



Shared & Site-Specific Evidence

What is the difference?



Shared evidence

may be submitted once for all sites or site groups.

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

Site-specific data

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



Transform "Check-in" process

Up to 3 "Check-ins" During Review



Determine Criteria to Address

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



Provide Documents for Offsite Review

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



Provide Evidence during Virtual Review

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



Criteria Evidence Options





Q-PASS Documents

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

Virtual Review

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



 Practice decision*







Accelerated Renewal

Eligibility



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

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



Accelerated Renewal

Review & attestation by the numbers

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

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



Transform "Check-in" process

Checking in components

Did you check in enough components for your virtual check-in? Did you check in too many components?

QPASS error message:

A maximum of 70 components are allowed. There are currently 96 components marked as "Ready for check in".

Please remove some components to proceed.

QPASS is set up to accept the following for each check-in:

- Check-in 1 minimum 30, maximum 70
- Check-in 2 minimum 5, maximum 80
- Check-in 3 minimum 1, no maximum





After Check-In



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



After 3 Check-Ins

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

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

25

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







Succeed Annual Reporting Process

Practice's recognized PCMH 2014 Le process must:	evel 3 or after Transform
Attest to previous performance	Confirm practice information and make any clinician changes
Provide evidence demonstrating continuing PCMH Activities	Annual fee payment or Approved Notice of Intent from HRSA



Annual Reporting Date

- 30 days before Anniversary Date
- Must complete all Succeed steps prior to anniversary date
- Date set upon initial Recognition
 - Or 2014 Level 3 expiration date
- Flexibility to meet practice needs

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Annual Reporting Date – Multi-sites

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



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

Audit, New Requirements and Attestation

Audit

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

New Annual Reporting Requirements

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

Practice attests each year to current PCMH Standards



2017 AR-PA: Patient-Centered Access

Has Your Practice Continued to Monitor Appointment Access?

Choose 1 option from the 3 below

Patient Experience

Option 1

Third Next Available Appointment

Option 2

Other Method of Monitoring Access

Option 3



2017 AR-TC: Team-Based Care

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

Choose 1 option from the 2 below

Option 1

Option 2

Attest to pre-visit planning activities

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


2017 AR-PH: Population Health Management

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

Required:

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

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



2017 AR-CM: Care Management

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



Required: Identifying and monitoring patients for care management



2017 AR-CC: Care Coordination & Care Transitions

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

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



2017 AR-QI: Performance Measurement & Quality Improvement

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

Required:

Measure Performance

Quality Improvement Activities

- AR-QI1
 - 5 clinical quality measures across 2 categories
- AR-QI2

1 resource stewardship measure

• AR-QI3

1 patient experience measure



2017 AR-QI: Quality Improvement Worksheet

		Practice Name(s):	< <site 1="" name="">></site>	< <site 2="" name="">></site>	< <site 3="" name="">></site>
		Required Information	Site 1	Site 2	Site 3
	Α	Category (Shared)			
	В	Name (Shared)			
Clinical	С	Denominator description (Shared)			
Quality	D	Numerator description (Shared)			
Measure 1	E	Denominator (Site-specific)			
Ivieasure 1	F	Numerator (Site-specific)			
	G	Reporting Period (Site-specific)			
	н	Was the measure a target for QI? (Site-specific)			
	Α	Category (Shared)			
	В	Name (Shared)			
Clinical	С	Denominator description (Shared)			
Quality	D	Numerator description (Shared)			
Measure 2	E	Denominator (Site-specific)			
Weasure 2	F	Numerator (Site-specific)			
	G	Reporting Period (Site-specific)			
	н	Was the measure a target for QI? (Site-specific)			
	Α	Category (Shared)			
	В	Name (Shared)			
Clinical	С	Denominator description (Shared)			
Quality	D	Numerator description (Shared)			
Measure 3	E	Denominator (Site-specific)			
Weasure 5	F	Numerator (Site-specific)			
	G	Reporting Period (Site-specific)			
	н	Was the measure a target for QI? (Site-specific)			
	Α	Category (Shared)			
	В	Name (Shared)			
Clinical	С	Denominator description (Shared)			
Quality	D	Numerator description (Shared)			
Measure 4	E	Denominator (Site-specific)			
Weasure 4	Г	Numerator (Site coesifie)			

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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 01-02: Core Criteria

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

Evidence of Implementation

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

Evidence of Implementation



Structure and Staff Responsibilities

TC 02: Example



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TC 03-05: Elective Criteria

The practice is involved in external collaborative activities

Evidence of Implementation

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

Evidence of Implementation & Documented Process

* Practice uses a certified electronic system system Evidence of Implementation









External PCMH Collaborations

TC 03: Example

TC 03

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

STATEWIDE HEALTH IT

Health Center Controlled Network of NY



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

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



COMPETENCY B

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

TC 06-07: Core Criteria



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

Evidence of Implementation & Documented Process



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

Evidence of Implementation & Documented Process



TC 06: Example

SUBJECT: Daily Huddles

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

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

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

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

TC 07: Example

Date: 01/01/2017

SBCHC Staff Process Improvement (PI) Committee

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

SBCHC Medical Quality Improvement Team

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



TC 08: Elective Criteria

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

Evidence of Implementation



COMPETENCY C

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

TC 09: Core Criteria



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

Evidence of Implementation & Documented Process



Medical Home Information

TC 09: Example

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

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

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



WHAT WE OFFER:

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

INSURANCE REQUIREMENTS

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

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



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

COMPETENCY A

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Practice routinely collects comprehensive data on patients to understand background and health risks of patients. Practice uses information on the population to implement needed interventions, tools and supports for the practice as a whole and for specific a loo drug to individuals

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KM 01-02: Core Criteria



KM 02: Example

Initial Assessment:

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

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

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

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

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



KM 02 A&D: Example



02 D	KM 02	inications Notes	nts Contacts/Com	Related Accou	ce Additional Patient Date	Irano		
PLE EXIST		Patient Stat <u>u</u> s	Chart#:					
× Cell		-			t Statuses	tient		
	OK				ting Patient Statuses:	<u>E</u> xist		
		Options 🔺	Assigned By	Date Assigned	Status			
	Cancel		GWINGEN	03/22/16	SLIDE LEVEL E			
			YBELTRAN	06/04/14	SPANISH INTERPRETE			
			YBELTRAN	06/04/14	HEARING IMPAIRED			
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ete	Delete							
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KM 03: Core Criteria KM 04: Elective Criteria

Conducts depression screenings using a standardized tool

Evidence of Implementation & Report OR Documented Process



Conducts behavioral health screenings and/or assessments (implement two or more)

- Anxiety
- Alcohol use disorder



- Substance use disorder
- Pediatric behavioral health screening
- Post-traumatic stress disorder
- ADHD
- Postpartum depression

Evidence of Implementation & Documented Process



KM 03: Example

Depression Screening - Patient Health Questionnaire (PHQ-2) Constructions				
Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	C	۹	0
2. Feeling down, depressed, or hopeless	C	•	0	0

PHQ 9 Geriatric Depression Scale GAD 7

Patient Health Questionnaire (PHQ-9)

 PHQ 9 DEPRESSION SCREENING: Click to Add HEADIT 1. Little interest or pleasure in doing things? 2. Feeling down, depressed or hopeless? 3. Trouble falling, or staying asleep, sleeping too much 4. Feeling tired or little energy? 5. Poor appetite or overeating? (please specify) 6. Feeling down, like a failure, like you have let you 	h?				Over the past 2 weeks, how often have you been bothered by any of the following problems? NOT AT ALL = 0 SEVERAL DAYS = 1 MOST DAYS = 2
 Trouble concentrating on things? Fidgety, unable to sit still or the opposite, moving Thoughts that you would be better off dead or hu 	g or speaking slowly so people notice?				NEARLY EVERYDAY = 3
Symptom Severity (0) Not difficult at all (1) Somewhat difficult (2) Very difficult (3) Extremely difficult Y	Must do - Add to Note PHQ-9 Depression Scale Sc Enter score here for tod	ore 🛛 🔽	inset	If this depr Psyc	is not a new episode of ession, only mark the chometric Depression ale Score with date.
Therapy Notes:	Add to PMH/Problem List — Adminstered Depession Sca Enter date and score h PHQ-9 added to the PM New Episode for condition	ere to have the IH/problem list.		A p. remiss mont deterr the pat	only if New Episode. atient should be in sion for at least three ths before a clinical nination is made that tient is experiencing a 'new episode'.



Behavioral Health Screening

KM 04: Example

CAGE-AID Questionnaire		
Patient Name Date of Visit		
When thinking about drug use, include illegal drug use and the use of pr other than prescribed.	escription	drug use
Questions:	YES	NO
 Have you ever felt that you ought to cut down on your drinking or drug use? 		
or drug use?		
or drug use? 2. Have people annoyed you by criticizing your drinking or drug use?		
 Have you ever felt that you ought to cut down on your drinking or drug use? Have people annoyed you by criticizing your drinking or drug use? Have you ever felt bad or guilty about your drinking or drug use? Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? 		

KM 05: Elective Criteria

Assesses & provides necessary oral health services or coordinates

with oral health partners

Evidence of Implementation & Documented Process

Conducting patient-specific oral health risk assessments.





Oral Health Assessment and Services

KM 05: Example

Oral Health Risk Assessment Tool

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

Instructions for Use

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

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

Patient Name:	Date of Birth:	Date:	
Visit: 6 month 9 month 12 month 15 mon	nth 📙 18 month 📙 24	month 30 month 3 year	
4 year _5 year _6 year _Other			

RISK FACTORS	PROTECTIVE FACTORS	CLINICAL FINDINGS	
Mother or primary caregiver had active decay in the past 12 months	 Existing dental home Yes No Drinks fluoridated water or takes fluoride supplements Yes No 	White spots or visible decalcifications in the past 12 months Yes INo Obvious decay	
Mother or primary caregiver does not have a dentist Yes No	 Fluoride varnish in the last 6 months Yes No Has teeth brushed twice daily 	Yes No Restorations (fillings) present Yes No	
 Continual bottle/sippy cup use with fluid other than water Yes No Frequent snacking Yes No Special health care needs Yes No Medicaid eligible Yes No 	Yes No	 Visible plaque accumulation Yes INo Gingivitis (swollen/bleeding gurns) Yes No Teeth present Yes INo Healthy teeth Yes INo 	
	ASSESSMENT/PLAN		
Low High Regula Completed: IDental Anticipatory Guidance	agement Goals: r dental visits Uean off bottle treatment for parents Less/No juice wice daily Only water in sip oride toothpaste Drink tap water	Less/No junk food or candy	



KM 06-08: Elective Criteria



Identifies the predominant conditions & health concerns of patient population

List

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

Report & Evidence of Implementation

Evaluates patient population

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

Report & Evidence of Implementation



Social Determinants of Health

KM 07: Example





COMPETENCY B

LLA

Sain Andr (Col.)

Corpus Christ

Gul

Tuxt

Gation

GUATE

Matamoros

Tampico

chinushus

CU

Guada(a

Cabo San Luca

Montor

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

KM 09-10: Core Criteria



Assesses the diversity of its population Report

Assesses the language needs of its population

Report



Diversity and Language

KM 09-10: Example

ace	Asian	African American	Native American		More than one Race	Refused to Repo	8	
	5	25	289		29	and the second data	6	
Ethnicity	Hispanic	Non- Hispanic	Refused to Report					
	162	1697	99					
/eterans	Veterans 39					en vand		er 31, 20
				tients	Englis		panish	ici dibir Engli
				19	57	1858	99	

KM 11: Elective Criteria

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


Population Needs - Health Literacy

KM 11:B Example

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

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

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

Teach-back:

A Health Literacy Tool to Ensure Patient Understanding

Educational Module for Clinicians

from the

Iowa Health System Health Literacy Collaborative

Teach-back is...

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

COMPETENCY C

Health.

HEALTH CHECK STEP 3

HEALTH CHECK STEP 2

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

KM 12: Core Criteria

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



KM 12: Example

MRN/Pat Name	Pat Acct No Pat Type	e Hospital Service	Patient Area Code	Patient	2015	2 2016	2014 Cases	Address
	Ou	IC ADULT HEALTH CENTER	1			1	0	
	Ou	C ADULT HEALTH CENTER				1	0	
	Ou	IC ADULT HEALTH CENTER				1	0	
	0	C ADULT HEALTH CENTER			_	1	0	
Dear Patient						1	0	
						1	0	
Our records indicate you have	ve not been to the off	fice recently.				1	0	
Please phone the office at (9')73) see sees to so	hadula your appointmer	t with ABC He	alth		1	0	
Center.	75) 555-5555 IU SU	neutre your appointmen		ann		1	0	
Comon.						1	0	
For the visit to be as benefici	ial as possible, we w	ill need your help in pre	paring for it.					
Your participation is vital to prepare for your visit.	for good health. Th	anks for taking care of	f yourself and l	helping				
Please bring your current me healthcare goals.	edications list to you	r checkup. And be prepa	ared to discuss y	our				

Sincerely, ABC Health Center

Excellence in Performance

KM 13: Elective Criteria

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



COMPETENCY D

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

Knowing and Managing Your Patients KM 14-15: Core Criteria



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

Report

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

Report



KM 16-19: Elective Criteria



Assesses understanding & provides education on new prescriptions Assesses & addresses response to medications & barriers to adherence Reviews controlled substance database for relevant medications * Systematically obtains prescription claims data



KM 18 & 19 - Evidence of Implementation

COMPETENCY E

MEDICAL

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

KM 20: Core Criteria

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

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



Clinical Decision Support – Mental Health

KM 20 A: Example

	TO SELECT FOLLO		
	or Mod-Sev Depression (PHQ9 = 15		
X Y Referred t	to BHS		
GO TO "Orders	& Charges" to INITIATE TASK labe	lled PHQ-9 = 15+	
IF PHQ-9 IS 14 O	R BELOW CLICK THE FOLLOWING-		J
11114 313140	The conversion of the control of the		



COMPETENCY F

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

KM 21: Core Criteria

Uses information on the population served by

the practice to prioritize needed community resources



KM 22-24: Elective Criteria

Provides access to educational materials

Evidence of Implementation

Offers **oral health** education resources

Evidence of Implementation

Adopts **shared decision-making** aids

Evidence of Implementation









Access to Educational Resources

KM 22: Example

			Level of Severi	ty	Systolic	Diastolic
Pressure Log			Normal		120 140 - 160 160 - 200	80 90 - 100 100 - 120
			Mild Hypertensi	on		
			Moderate Hyperte			
			Severe Hypertension		Above 200	Above 120
Date	AM Blood Pressure	Pulse	PM Blood Pressure	Pulse	N	otes
Date		Pulse		Pulse	N	otes
Date		Pulse		Pulse	N	otes
Date		Pulse		Pulse	N	otes
Date		Pulse		Pulse	N	otes

KM 23: Example

Dental Resource

Re: Updated Community Resource List

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

Dental Services

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

Pharmacy Services

The Pharmacy & Pharmacology Division of Detroit

Telephone:

24 Hour Automated Refill Manager



Shared Decision-Making Aids

KM 24: Example

What is my risk of breaking a bone?

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

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

It is also affected by: If you have had a fracture

- □ If a parent had a fracture
- □ If you currently smoke
- □ If you drink more than 2 drinks of alcohol a day
- If you have taken prescription steroid medications

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

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

Prepared for: ____



Downsides

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This medication must be taken

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

Possible Harms

Abdominal Problems

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

Osteonecrosis of the Jaw

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

Out of Pocket Cost

with insurance \$30 | without insurance \$70-90

What would you like to do?

KM 25-27: Elective Criteria

Engages with schools or intervention agencies

Evidence of Implementation & Documented Process

Routinely maintains a current **community resource list**

List

Assesses usefulness

of community support resources

Evidence of Implementation









School/Intervention Agency Engagement

KM 25: Example

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

KM 28: Elective Criteria



* **Regularly include external parties in "case conferences**" for the purpose of sharing information and discussing care plans for highrisk patients *Evidence of Implementation & Documented Process*





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

COMPETENCY A

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

AC 01: Core Criteria

The practice assesses the access needs and preferences of the patient population from collected data to determine if existing methods are sufficient Evidence of Implementation & Documented Process

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AC 01 : Example

Question	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree		
Sot appointment for urgent care in a timely manner	76.7%	16.7%	3.3%	3.3%	0.0%		
Sot appointment for non-urgent care in a timely manner	56.7%	33.3%	3.3%	6.7%	0.0%		
Sot answer to medical question within 24 hours Access	63.3%	16.7%	10.0%	10.0%	0.0%		
Sot answer to medical question when office was closed	56.7%	20.0%	10.0%	13.3%	0.0%		
Received courteous and respectful answers from office staff	70.0%	30.0%	0.0%	0.0%	0.0%		
en the provider addressed issues involving family, or alconol, moking, mental health, nutrition, exercise							
elt the provider addressed personal health goals (i.e. weight loss, moking cessation, etc)				A	ccess		
elt the provider has given clear explanations regarding prescription	Got		it for urgent ca y manner	 Strongly Agree Agree Agree Neutral Disagree Strongly Disagree 	Go	t appointment for nor in a timely man	
					to medical qu iin 24 hours	Strongly Agree Agree Negree Negree	



AC 02-05: Core Criteria



Provides same-day appointments for routine and urgent care Provides routine and urgent appointments outside regular business hours Provides timely clinical advice by telephone during and after business hours Documents clinical advice and reconciles after-hours advice and care in patient records



AC 02 : Example

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

AC 03 : Example

Conta	ct Us						
Our loca	tion	Our hours					
Suburban Family Healthcare		Monday 8:30a.m 12:00p.m., 1:00p.m 5:30p.m.					
		Tuesday 10:00 a.m. – 7:00p.m					
		Wednesday 8:30a.m12:00p.m., 1:00p.m 5:00p.m.					
		Thursday 8:30a.m. – 12:00p.m.					
Get in to	uch	Friday 7:30a.m. – 12:00p.m., 1:00p.m. – 3:00p.m.					
Phone: (Also for After Hours)		Walk in hours 8:30-9:30 am Monday and Fridays (existing					
Fax:		patients only) and 1st and 3rd Saturdays of the month from 9-12					
Email:		by appointment only.					
(office manage	er – only for non-medical issues)						



AC 04 : Example

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

AC 06-08: Elective Criteria



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

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

Evidence of Implementation

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

communication
Report & Documented Process



AC 09: Elective Criteria

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

Evidence of Implementation





COMPETENCY B

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

QA

AC 10-11: Core Criteria

Assists in the selection and/or change of the

patients/families/caregivers personal clinician choice and documents information in electronic system

Practice establishes goals and monitors the

% of patient visits with selected clinician/team

Report



AC 12-14: Elective Criteria





Examine Supply/Demand

To manage clinician supply/patient appointment demand To determine number of patients it's possible to take care of:

(provider visits/day)(days in clinic/year) = # patients
 (patient visits/year)

Fill in values, for example:

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

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

~ Mark Murray, MD

Also compare appointment demand with backlog or wait time for appointments



Care Management & Support

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

COMPETENCY A

The practice systematically identifies patients who may benefit from care management
Care Management and Support

CM 01-02: Core Criteria

The practice must include at least three categories in its criteria



Identifying & Monitoring Patients for Care Mgmt

CM 01: Example

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

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

Denominator = 893 patients

Numerator = 83 patients

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



Care Management and Support

CM 02: Example

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

Care Management and Support

CM 03: Elective Criteria

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



COMPETENCY B

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

Care Management and Support

CM 04-05: Core Criteria



A person-centered care plan is established for

care management patients

Report OR RRWB & Examples



The practice provides a written care plan to

patients/families/caregivers under care management

Report OR RRWB & Examples



Care Management and Support

CM 05: Example





Care Management & Support

CM 06-09: Elective Criteria



Care Management & Support

CM RRWB: Example

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

Care Management & Support

CM 08: Example

COPD Action Plan

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

• Chest pains • High fever (temperature)

· Feelings of agitation, fear, drowsiness or confusion



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

COMPETENCY A

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



CC 01: Core Criteria

Manages lab & imaging tests systematically by:



Tracking, flagging & following-up on overdue tests Flagging abnormal test results Notification of test results



CC 01 E: Example

Normal Lab Results of lab work left as message

Telephone Encounter			
Telephone Encounter Info			
Author	Note Status	Last Update User	Last Update Date/Time
Phillip Andrew, MD	Signed	Phillip Andrew, MD	3/15/: 2:04 PM
Telephone Encounter			
Left VM informing him testosterone levels were no	rmal. Also wanted to check in on how the ad	lderall taper is going but didn't get ahold of him; will f/u in 2	weeks at our next appointment

Provider called patient with results of radiology exam

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

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



CC 01 F: Example





CC 02: Elective Criteria

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

Evidence of Implementation & Documented Process





CC 02: Example

SnapShot	Health Maintenance	Close X
Chart Review	🕰 🗙 🗢 🗎	
Results Review	<u>Override</u> <u>Cancel</u> Edit <u>M</u> odifiers <u>R</u> eport	Health Maintenance Modifiers
MyChart Results Rel	Due Date Procedure	Date Satis Neonatal Hearing Screen Normal
Flowsheets	→ 12/21/2009 DPT (#1)	Neonatal Metabolic Screen Normal
Graphs	→ 10/21/2009 HEPATITIS B (#1)	
Growth Chart	→ 12/21/2009 HIB 3 DOSE REGIMEN (#1)	Documentation required
Problem List	→ 12/21/2009 IPV (#1)	
History	➡ 11/21/2009 NEONATAL SCREENING HEARING	• Documented process for
Demographics	→ 11/21/2009 NEONATAL SCREENING METABOLIC	
Allergies	→ 12/21/2009 PNEUMOCCAL VACCINE (#1)	follow-up on newborn
Medications	➡ 12/21/2009 ROTAVIRUS 3 DOSE VACCINE, NOT TO START	hearing tests/blood spot
Health Maintena		licaling lesis/blood spot
CCF Images		screening.
Letters		U
Scanned Documents		• Example
Document List		·
Order Entry	🔶 Procedure Overdue 🛛 🔥 Procedure Due On 🏒 Procedure	Due Soon
Imm/Injections		
Forms	Patient Modifiers Edit Modifiers Related Plans	Abbreviations for Override Types
Episodes of Care		
Doc Flowsheets		COLONOSCOPY Colonoscopy (ENTE
Visit Navigator		COLONOSCOPY Colonoscopy - High F
		ColonoscopyN Colonoscopy - Not H
Hotkey List		
Exit Workspace	Use this activity to personalize the preventive care and disease man	agement rules for this patient
🎒 Start 🛛 🚱 📓	💌 🥭 🦉 💽 🗿 📀 🔹 👋 🙆 Inbo 🥅 Cale 🖉 Curr 🗹) Prod 🖂 RE: 🛛 Epic Hyp 💽 Micr 🖂 🖳 🖸 🕄 🗐 📜 🔗 🥘 🜉 4:18 PM

125 | **(NCQA**

CC 03: Elective Criteria



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

Evidence of Implementation



COMPETENCY B

Watch list

Laptop Pro

40

010

Search

Irdio Test Monitor Pro 4,5

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



CC 04: Core Criteria

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



- Clinical question
- Required timing
- Type of referral



- Demographic & clinical data
 - Test results
 - Care plan

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

CC 05-07: Elective Criteria



* Clinical protocols are used to identify necessary specialist referrals

Evidence of Implementation

Commonly used specialists/specialty types are identified

* Considers available performance information on consultants/specialists

Source & Evidence of Implementation



CC 07: Example

					Wait				
					Time				
Age Clinic	ReferringProvider	Referral Type	Referral Date	Appt Date	Days	Status			
67.3 Urology (Peds): Montefiore: Hutchinson C		Urology	01/05/2015	04/23/2015		Consult			
28.0 Headache: Montefiore: Hutchinson Camp		Neurology	01/06/2015	04/01/2015		Canceled by clinic			
23.0 Cardiology: Montefiore-Einstein Heart Cer		Cardiology	01/09/2015	00(11/2015		Patient no-show			
69.0 Urology (Peds): Montefiore: Hutchinson C	<u>/</u>	Urology	01/09/2015	05/05/2015		Created			
37.0 Plastic Surgery: Montefiore: Hutchinson C	1 /	Plastic Surgery	01/13/2015	02/24/2015		Patient no-show			
36.6 Urology (Peds): Montefiore: Hutchinson C		Urology	01/15/2015	04/02/2015	77	Patient no-show			
58.3 Cardiology: Montefiore-Einstein Heart Cer		Cardiology	01/20/2015	02/17/2015		Canceled by clinic	- This	report is perio	dically
23.8 Plastic Surgery: Montefiore: Hutchinson C		Plastic Surgery	01/20/2015	02/02/2015	13	Created			-
50.6 Allergy: Montefiore - Hutchinson Campus,	1)	Allergy	01/21/2015	03/27/2015		Patient no-show		rated from TR	
24.8 Endocrine (Peds): Montefiore - Hutchinso	1	Endocrine	01/22/2015	06/12/2015	141		web	based trackin	g
58.6 Infectious Disease: Montefiore: Hutchinso	1	Infectious Diseases	01/22/2015	02/19/2015	28	Consult notes received		base used by t	
74.7 Dermatology: Montefiore: Hutchinson Car	1	Dermatology	01/24/2015	02/18/2015	25			tice for subspe	
40.6 Dermatology: Montefiore: Hutchinson Can	1)	Dermatology	01/26/2015	05/04/2015	98	Created			-
36.5 Urology (Peds): Montefiore: Hutchinson C	/	Urology	01/28/2015	06/09/2015	132	Created	refe	rals. It shows	the
53.3 Urology (Peds): Montefiore: Hutchinson C	l)	Urology	01/28/2015	03/11/2015	42	Created	tota	number of re	ferrals
32.2 Family Planning: Montefiore - AECOM, 16	E /	Family Planning	01/13/2015	03/05/2015	51	Canceled by patient	to su	bspecialties fo	or adult
32.2 Family Planning: Montefiore - AECOM, 16	1 /	Family Planning	01/13/2015	04/06/2015	83	Consult notes received		-	
29.0 Family Planning: Montefiors - AECOM, 16	ī I	Family Planning	01/14/2015	03/02/2015	47	Patient no-show		ents generate	
28.2 Family Planning: Montefiore - AECOM, 19		Family Planning	01/28/2015	03/12/2015	43	Patient no-show	elec	tronically) in J	anuary
28.2 Family Planning: Montefiore - AECOM, 16		Eamily Planning	01/28/2015	05/28/2015	120	Kept Not Seen	2015	, appointmen	ts
35.9 Family Planning: Montefiore - AECOM, 16	/	Family Planning	01/29/2015	02/09/2015	11	Patient no-show	sche	duled and the	
35.9 Family Planning: Montefiore - AECOM, 16	/	Family Planning	01/29/2015	02/19/2015	21	Canceled by clinic			
38.8 Family Planning: Montefiore - AECOM, 16	/	Family Planning	01/29/2015	02/02/2015		Consult notes received		ion (mostly w	
31.9 URO-GYN: AECOM	1 /	URO-GYN	01/08/2015	03/06/2015	57	Canceled by patient), the n	umber
31.9 URO-GYN: AECOM	1 /	URO-GYN	01/08/2015	05/07/2015	119	Patient no-show	of da	ys/waiting pe	riod,
32.7 URO-GYN: AECOM	7	URO-GYN	01/08/2015	03/02/2015	53	Patient no-show	and	the status of t	hose
33.8 Genetics - AECOM	1 /	Genetics	01/13/2015	02/10/2015	28	Canceled by patient			
27.2 Ultrasound: AECOM	1 /	Ultrasound	01/15/2015	02/09/2015		Consult notes receive		intments.	
25.8 Fetal Echo: AECOM	T.	ECHO	01/20/2015	02/23/2015		Consult notes received	Out	of a total of 31	.9
63.1 Hematology: Albert Einstein College of Me	7	Hematology	01/20/2015	03/25/2015	64	Created	refer	rals, 76 of the	em were
24.9 Ultrasound: AECOM	1	Ultrasound	01/22/2015	03/05/2015		Consult notes received		cheduled with	
37.1 Genetics - AECOM		Genetics	01/23/2015	03/03/2015		Consult notes received			
33.1 OB/GYN: MFAC - AECOM	4	OB/GYN	01/29/2015	02/10/2015		Canceled by patient		Medic	ai
33.1 OB/GYN: MFAC - AECOM	4	OB/GYN	01/29/2015	02/12/2015	-	Consult notes received	- Cent	er, 76% were.	
34.9 Neurology: Montefiore North - Medical Vil	7	Neurology	01/07/2015	05/13/2015	126				
63.6 Neurology: Montefiore North - Medical Vil		Neurology	01/08/2015	06/11/2015		Created			
40.3 Mammogram: MMC - North	7	Mammogram	01/11/2015	02/10/2015		Patient no-show			
43.1 Ultrasound: Montefiore - Wakefield Camp		Ultrasound	01/15/2015	02/13/2015		Patient no-show	—		
40.1 Oldasound, Montenore - Wakelield Camp	<u>'</u>	oluasounu	01/10/2010	02/13/2013	28	r auent no-snow			



CC 08-09: Elective Criteria



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

- > Non-behavioral healthcare
- NYS

specialists Documented Process OR Agreement

* Behavioral healthcare providers

Agreement OR Documented Process & Evidence of Implementation



Behavioral Health Referral Expectations

CC 09: Example

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

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CC 10: Elective Criteria

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

Evidence of Implementation & Documented Process





CC 11-13: Elective Criteria



Monitors the timeliness and quality of referral responses Documents comanagement arrangements in the patient's medical record

* Engages with patients regarding cost implications of treatment options



COMPETENCY C

04

3.45

03

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

CC 14-16: Core Criteria

Identifies patients with unplanned admissions and ED visits

Report & Documented Process

Shares clinical information with inpatient facilities

Evidence of Implementation & Documented Process

Contacts patients/families/ caregivers for follow-up care

Evidence of Implementation & Documented Process





CC 14-16, 18-19: Example



CC 16: Example

40.20 AM Tala		Description: 45 y	ear old female
10:26 AM Tele MRN	pnone	Provider: Department:	
Reason for Call		SAULUSE: AL PRIEN 1 LINDORSCHERE	
Follow-up since			
Call Documentation			
and that her CT Scan better. Was told last r this and pt states that	and labs were fine. hight that it could be	Still c/o some slight pain to	e ER MD increased zoloft for
to make sure that dos time. Encounter Messages No messages in this encounter	e will work for her. S	Schedule F/U in 1 week. Pt	voices no further needs at this
time. Encounter Messages	e will work for her. S	Schedule F/U in 1 week. Pt	voices no further needs at this
time. Encounter Messages No messages in this end	e will work for her. S	Schedule F/U in 1 week. Pt	Phone
time. Encounter Messages No messages in this end Contacts	e will work for her. S counter Type	Schedule F/U in 1 week. Pt	voices no further needs at this
time. Encounter Messages No messages in this end Contacts 10:26 AM	e will work for her. S counter Type	Schedule F/U in 1 week. Pt	voices no further needs at this
time. Encounter Messages No messages in this end Contacts 10:26 AM	e will work for her. S counter Type Phone (Outgoing)	Schedule F/U in 1 week. Pt	voices no further needs at this

CC 17-20: Elective Criteria

Coordinate with acute care settings after hours through access to current patient information Exchange patient information with the hospital during patient's hospitalization

Obtain discharge summaries consistently from the hospital and facilities



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

CC 17-19 -

CC 20 -

Evidence of Implementation & Documented Process

Evidence of Implementation

139 | **NCQA**

CC 19: Example



140 | **(NCQA**

CC 21: Elective Criteria



Electronic exchange of information with

external entities on 1 or more (max 3 credits):

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

Evidence of Implementation





Performance Measurement & Quality Improvement

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

COMPETENCY A

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

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INCQA

Performance Measurement & Quality Improvement

QI 01: Core Criteria

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



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

Reports


QI 02-03: Core Criteria

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

Care coordination measures

Measures affecting health care costs





Assesses performance on availability of major appointment types

Report & Documented Process

Reports



QI 01 A-D: Example

Health Maintenance Topic 1/1/ – 12/31/	In compliance	Overdue	Total
Breast Cancer Screening	51.05%	48.95%	100%
	1,381	1,324	2,705
Colon Cancer Colonoscopy	63.35%	36.65%	100%
	1,965	1,137	3,102
Pneumococcal Vaccine	83.11%	28.36%	100%
	743	350	1,234
Depression screening	74.84%	25.16%	100%
	992	350	1,232
Hemoglobin A1C	71.64%	28.36%	100%
	884	350	1,234
Urine Microalbumin/Creatinine Ratio	67.13%	32.87%	100%
	825	404	1,229

Performance Measurement & Quality Improvement *QI 02 B: Example*



QI 04 A-B: Core Criteria

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



Monitors patient experience through qualitative methods



Report

QI 04 B: Example

NEW PATIENT PHONE SURVEY Provider							
Did your Provider meet and satisfy your needs?	Speaks English	Age	Insured	Race	Co-morbidity		
1.	[-	*	-	-*	
2.	Caller identifies possible			-			
3.	vulnerabilities prior to						
4.	phone survey.						
5.							
ABC Health would like to be your "Patient Centered Medical	Home". Overall, how was yo	our experience?	Speaks English	Age	Insured	Race	Co-morbidity
1.							
2.							
3.							
4.							
5.							
Are you aware we have walk-in hours for acute care if you a	re unable to get in with your	provider today?	Speaks English	Age	Insured	Race	Co-morbidity
1.							
2.							
3.							
4.							
5.							
Are you aware that ABC Health offers Pharmacy & Dental se	ervices? Able to get your me	ds today?	Speaks English	Age	Insured	Race	Co-morbidity
1.							
2.							
3.							
4.							
5.							
Do you have any suggestions or comments on how we can	Speaks English	Age	Insured	Race	Co-morbidity		
1.							
2.							
3.							
4.							
5.							

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

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QI 05: Elective Criteria



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

- Clinical quality
- Patient experience

Report OR QI Worksheet



QI Worksheet: Example

NCQA PCMH Quality Measurement and Improvement Worksheet

PURPOSE: This worksheet helps practices organize the measures and quality improvement activities that are outlined in PCMH AC 01-03, AC 06 and QI 08-14. Refer to PCMH AC and QI in the PCMH 2017 Standards and Guidelines for additional information.

NOTE: Practices are not required to submit the worksheet as documentation; it is provided as an option. Practices may submit their own report detailing their quality improvement strategy but should consult the QI Worksheet Instructions for guidance.

QUALITY MEASUREMENT & IMPROVEMENT ACTIVITY STEPS

- Identify measures for QI. Select aspects of performance to improve:
 - Must Demonstrate (Core Criteria)
 - PCMH QI 01: At least five clinical quality measures
 - PCMH QI 02: At least two resource stewardship measures
 - PCMH QI 03: Assess availability of major appointment types
 - PCMH QI 04: Monitors patient experience
 - · Optional (Elective Criteria):
 - PCMH QI 05: At least two measures for vulnerable populations (one clinical quality, one patient experience)
- Identify a baseline performance assessment. Choose a starting measurement period (start and end date) and identify a baseline performance measurement for each measure.
 - For PCMH QI 08-11 and 13, use performance measurements from the reports provided in PCMH QI 01-05.

The baseline measurement period *must be* within 12 months before evidence submission for check-in, or within 24 months, if there is a remeasurement period. The performance measurement *must be* a rate (percentage based on numerator and denominator) or number (with number of patients represented by the data). 3. Establish a performance goal. Generate at least one performance goal for each identified measure. The specific goal *must be* a rate or number greater than the baseline performance assessment. Simply stating that the practice intends to improve does not meet the objective. (Applies to QI 08-11 and 13) For multi-sites: Organizational goals and actions for each site may be used if remeasurement and performance relate to the practice. Each

used if remeasurement and performance relate to the practice. Each practice must have its own baseline and performance results.

- 4. Determine actions to work toward performance goals. List at least one action for each identified measure and the activity start date. The action date *must occur* after the date of the baseline performance measurement date. You may list more than one activity, but are not required to do so. (Applies to QI 08-11 and 13)
- 5. Remeasure performance based on actions taken. Choose a remeasurement period and generate a new performance measurement after action was taken to improve. The remeasurement date *must occur* after the date of implementation and *must be* within 12 months before evidence submission for check-in. The performance measurement *must be* a rate (percentage based on numerator and denominator) or number (with number of patients represented by the data).
- Assess actions taken and describe improvement. Briefly describe how your practice site showed improvement on measures. Describe the assessment of the actions; correlate actions and the resulting improvement. (Applies to QI 12 and 14)

EXAMPLE: HOW TO COMPLETE A ROW

	Exa	mple: Clinical Measure
<i>Measure 1:</i> Colorectal cancer (CRC) screening	1. Measure selected for improvement; reason for selection	<i>Reason:</i> The USPSTF has recommended screening for colorectal cancer as a preventive test for adults. We want to increase percentage of patients who receive screening for CRC.
	2./3. Baseline performance measurement; numeric goal for improvement <i>(Ql 01)</i>	Baseline Start Date: 5/1/16Baseline End Date: 5/30/16Baseline Performance Measurement (% or #): 175/547 = 32.0%Numeric Goal (% or #): 58%
	4. Actions taken to improve and work toward goal; dates of initiation (Ql 08) (Only 1 action required)	Action: Pop-up reminders were added to our EMR for patients due/overdue screening Date Action Initiated: 7/1/16 Additional Actions: Provider quality compensation metric put in place to incentivize providers to ensure appropriate health screening.
	5. Remeasure performance (QI 12)	<i>Start Date: 5/1/17 End Date: 5/30/17 Performance <u>Remeasurement</u> (% or #): 380/550 = 69.1%</i>
	6. Assess actions; describe improvement. <i>(Ql 12)</i>	Since July 2016, there has been an increase of 37.1 percentage points in patients receiving CRC screening due to incentivizing providers and use of clinical decision support of EMR to indicate when patients are due for screening.



QI 06-07: Elective Criteria



Uses a standardized, validated survey tool Report

* Obtains feedback on vulnerable patient groups

Report



COMPETENCY B

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

QI 08-11: Core Criteria



Sets goals and acts to improve upon at least one

measure of resource stewardship

Report OR QI Worksheet

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

Report OR QI Worksheet

Sets goals and acts to improve on at least one

patient experience measure

Report OR QI Worksheet



QI 12-14: Elective Criteria



*Achieves improved performance on at least 2 performance measures



Disparities in care or services

Report OR QI Worksheet

- 1. Sets goals and acts to improve at least one measure Report OR QI Worksheet
- 2. *Achieves improved performance in at least one measure Report OR QI Worksheet





263.00

84.00

34.00

\$8.50

8.15

42.75

53.00

36.50

115.00

156.50

8.75

21.90 9.05

195.00

60.00

11.50 772.00

> 26.75 25.75 326.00

> > 152.00

8.20

43.00

36.75

115.50

157.00

8.85

16.30

196

185.00

HEALTH

COMPETENCY C

EBITDA

EBIT

493

86

61

43

563

44

44

18

24.5%

84

61

(4.3%)

(45.0%) 13.8%

24.9%

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

Performance Measurement & Quality Improvement *QI 15: Core Criteria*



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

Evidence of Implementation & Documented Process



QI 16-19: Elective Criteria

* Involves patient/ Practice is Reports practice/ * Reports clinical engaged in Valueclinician level family/caregiver in quality measures **Based Contract** performance quality to Medicare or results publicly or improvement Agreement (max 2 Medicaid agency with patients activities credits) NYS

QI 16 & 17 -

QI 18 -

QI 19 -

Reporting Performance Publicly/Patients

QI 16: Example

Dear							
Enclosed in this letter you will find the performance results for your individual clinician, Dr nd practice-level, MD PC, on the important preventive and chronic measures including Depression Screening and Hemoglobin A1C testing. We are working diligently to increase Individual clinician and Practice-level screenings of important preventive and chronic measures.							
	Individual Clinician	Practice-level					
Depression Screening	38.44 %	39.08 %					
Hemoglobin A1c testing	74.02 %	74.15 %					
Our practice also would like share with you patient satisfaction information. Based on patients survey that practice conducted in May and November of 2016, patients mostly complained via the survey that they have to wait to being called while they are waiting in waiting room. Please see numbers listed below.							
	First time: May 2016	Second time: November 2016					
Survey results	21%	18%					

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

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Sincerely





Organization set-up



New Organizations

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

Existing Organizations

- Authorized users See "My Organizations" tab
- To "claim" an organization otherwise, contact NCQA

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Q-PASS Organization Home Page

← → I https://qpass.ncqa.org/ Recognition Program - NC × 🕎 Intro to PCMH 2017 Baltimore			_		<mark>× =</mark> ם = \$ ★ ∰ \$ → ם - Q
(NCQA Q-PASS 🏫 🖋 📽 🤮				Welcome, Wil	lliam Tulloch , BA 🗸
≡ / Home					
My evaluations My organizations					
Organizations All of your organizations are listed here.			🗒 Create or Cla	aim an Organization	
5334 Total Organizations					
			results p	er page 10 🖌 🛱	
Name A T	Phone	Primary	Secondary	Actions	
1 Hanson Place Pediatrics PC				Actions -	
1/2 SBCT	(210) 295-7419			Actions -	
10 MDG USAFA Family Health and Pediatric Clinics	(719) 333-0566			Actions -	
1211 WPR	(718) 828-6610			Actions -	
				163	

Adding an Organization to Q-PASS

1	//qpass.ncqa.org/ um - NC × ☑ Intro to PCMH 2017 Baltimore - PASS ♠ & ₩ ☑ &	Nelsons William Tullach, DA –
(NCQA Q		Welcome, William Tulloch , BA 🚽
	≡ / Home	
	My evaluations My organizations	
	I Organizations All of your organizations are listed here.	r Claim an Organization
	How to add a new organization or claim an existing organization?	INSTRUCTIONS
	How to set the primary and secondary contacts?	INSTRUCTIONS
	What is my Tax Id Number?	INSTRUCTIONS
	Add an Organization Just add information about your organization below to get set up. Search for your organization to ensure it does not already exist before creating a new organization. Please enter at least 4 character	rs while searching for
	your organization.	



Adding an Organization to Q-PASS II

	ps://qpass.ncqa.org/ gram - NC × 🕎 Intro to PCMH 2017 Baltimore			× ם =] צ★ ה כ≙-Q
4	Q-PASS 🏫 🖋 📽 🌡			Welcome, William Tulloch , BA 🗸
	≡ / Home			
	Add an Organization			
	Just add information about your organi	zation below to get set up.		
	Search for your organization to ensure your organization.	it does not already exist before creating a	new organization. Please enter at least 4 ch	naracters while searching for
	Q TESTING			
	Your search - TESTING - did not mate	ch any results.		
	Organization Legal Name			
	*required			
	Organization Display Name			
	Street Address			
	*required			
	City	State	✓ Zip	
	*required	* required	*required	

Adding an Organization to Q-PASS III

Q-PASS 🏫 🖋 📽 🌡			Welcome, William Tulk
≡ / Home			
Street Address			
*required			
City	State	~	Zip
* required	* required		*required
Telephone	Ext		Tax Id Number
* required			*required
HRSA grantee organizations only: plea	ase enter your HRSA H code below.		
			🗙 Cancel < Done



Enrollment

Organization needs the following to enroll

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

K	



Enrollment



Step-by-Step process in Q-PASS

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



Enrolling in Q-PASS



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Enrollment – Choose Sites



Total Sites to Enroll in PCMH = 1

You can create new practice sites by clicking "Create New Site" below. Once you have created all of your practice sites, you can choose which practice sites you wish to enroll in the area to the left below by selecting the practice sites in the list. If you want to enroll all your listed practice sites, click "Select All/None."



Next

Enrollment – Choose Products





Enrollment – Set Up Clinicians



Step 3: Set Up Clinicians

O For each practice site, set up your clinicians who you wish to be included on the certificate for the program you are enrolling in by clicking 'Manage Clinicians' next to each practice site.

For the PCMH program, only count MDs, DOs, NPs and PAs that: 1) manage a panel of patients and 2) provide primary care for 75% or more of their patients.

When you are done adding all of the clinicians for your practice sites, click the 'Next' button to the right to continue to the next step in the enrollment process.

Site	Clinician Count	Actions			Next >	
Production Test 1, Site A	1	Ma	nage Clinicians			
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Enrollment – Sign Agreements



Step 4: Sign Legal Agreements

() There are legal agreements that must be signed by an authorized representative of your organization. That authorized individual may be you or it may be someone else at your organization.

Click on 'View/Sign Agreement' next to each Legal Agreement and follow the instructions. If you cannot sign the legal agreements now, they must be signed before you can begin uploading evidence to the system or access your evaluations.

When you are done signing the legal agreements or designating someone else to sign them, click the 'Next' button to the right to continue to the next step in the enrollment process.

How to sign legal agreements

🕻 Bacl

There are 2 agreements that need to be signed.

Click on an Agreement to view the PDF. You will require Adobe Acrobat Reader to view PDF. Download Adobe Acrobat Reader

Agreement	Is Signed	Signed By	Date Signed	View/Sign Agreement
PCMH 2017 Agreement	Signed	Bill Tull	4/12/2017	View/Sign Agreement
Business Associate Agreement	Signed	Bill Tull	4/12/2017	

INSTRUCTIONS

Enrollment Invoicing

🕻 Bac

				The second se	
Recognition Program - NC × I Intro to PCM	ns/Enroll?id=5a20a6e8-4275-4b41-934c-68143a59134c	&programId=Pcmh&v=I			
(NCQA Q-PASS 🏫 🔥	🖋 🕰 🗹 🤷				Welcome, William Tulloch , BA 🗸 🔒
~					
🔊 Sites	ሞ Products	🔒 Clinicians	🖋 Legal Agreements	Cost Overview	Review

Step 5: Generate Invoices and Cost Overview

Please review the line items in the cost overview below and either generate an invoice for each line item or bundle line items together and generate an invoice for the bundles. You can pay the invoices by clicking the 'Pay Invoice' option under the 'Actions' button next to each line item or bundle that you've created an invoice for.

All invoices must be paid before enrollment is complete. You cannot continue to the next step in the enrollment process until you have created an invoice for each of the line items or bundles.

*If you believe you've created an invoice with an error, please contact Customer Support to request NCQA to make corrections to the invoice.

When you are done, click the 'Next' button to the right to continue to the next step in the enrollment process.

How to Bundle, Create, & Cancel Invoices											
How to Apply Discount									INSTRUCTIONS		
How to Pay Invoice									INSTRUCTIONS		
Site	Product	Version	Amt	Due	Status	Order #	Actions	Discount			
Production Test 1, Site A	РСМН	2017	\$400 🚯	\$0	Paid	169819	Actions -	\$400			
									Balance: \$0		

Multi-Sites Sharing Evidence/Credit





Choosing What to Share



Shared Components

To add components to a site group, click and drag components from the left to the site group tile. Save when complete.

Components	^	A Manage site groups						
Access Needs and Preferences - Documented Process								
Access Needs and Preferences - Evidence of Implementation		All sites						
		All of my organization's sites						
Acute Care After Hours Coordination - Documented Process		Sites 1						
Acute Care After Hours Coordination - Evidence of Implementation								
Advanced Care Planning - Evidence of Implementation								
Alternative Appointments - Documented Process								
Alternative Annointments - Deport								



PCMH Redesign

Each practice will have a Dashboard to manage their work





NCQA's Redesigned System - Q-PASS

 Click on tiles below to ex 	Check In Components for Review		
TC : Team-Based Care and Prac	tice Organization		- collapse
PCMH / All PCMH Criteria / TC			
	atinuity of care, communicates roles and res air license and provide effective team-based		ts/families/caregivers, organizes and
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)	



NCQA's Redesigned System - Q-PASS

Practices can select and link documents and present examples virtually

PCMH / All PCMH Criteria / TC / TC 09

Has a process for informing patients/families/caregivers about the role of the medical home and provides patients/ families/caregivers materials that contain the information. Such as after-hours access, practice scope of services, evidence-based care, education and self-management support

A MHIM : Medical Home Information and Materials

DESCRIPTION

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

SUGGESTED EVIDENCE

ACTIONS







NCQA's Redesigned System - Q-PASS

Practices can select and link documents and present examples virtually

SUGGESTED EVIDENCE





Questions