Patient-Centered Medical Home (PCMH) 2014
Learning Objectives

• Introduction to PCMH and Eligibility
• Overview of the 6 PCMH Standards
  – Highlight the intent of each element
  – Identify the Must-Pass elements
  – Outline documentation requirements
  – Review examples
### PCMH 2014 Content and Scoring
(6 standards/27 elements)

#### 1: Enhance Access and Continuity

| A. *Patient-Centered Appointment Access | Pts | 4.5 |
| B. 24/7 Access to Clinical Advice | Pts | 3.5 |
| C. Electronic Access | Pts | 2 |
| **Total** | **10** |

#### 2: Team-Based Care

| A. Continuity | Pts | 3 |
| B. Medical Home Responsibilities | Pts | 2.5 |
| C. Culturally and Linguistically Appropriate Services (CLAS) | Pts | 2.5 |
| D. *The Practice Team | Pts | 4 |
| **Total** | **12** |

#### 3: Population Health Management

| A. Patient Information | Pts | 3 |
| B. Clinical Data | Pts | 4 |
| C. Comprehensive Health Assessment | Pts | 4 |
| D. *Use Data for Population Management | Pts | 5 |
| E. Implement Evidence-Based Decision-Support | Pts | 4 |
| **Total** | **20** |

#### 4: Plan and Manage Care

| A. Identify Patients for Care Management | Pts | 4 |
| B. *Care Planning and Self-Care Support | Pts | 4 |
| C. Medication Management | Pts | 3 |
| D. Use Electronic Prescribing | Pts | 5 |
| E. Support Self-Care and Shared Decision-Making | Pts | 20 |

#### 5: Track and Coordinate Care

| A. Test Tracking and Follow-Up | Pts | 6 |
| B. *Referral Tracking and Follow-Up | Pts | 6 |
| C. Coordinate Care Transitions | Pts | 18 |

#### 6: Measure and Improve Performance

| A. Measure Clinical Quality Performance | Pts | 3 |
| B. Measure Resource Use and Care Coordination | Pts | 3 |
| C. Measure Patient/Family Experience | Pts | 4 |
| D. *Implement Continuous Quality Improvement | Pts | 4 |
| E. Demonstrate Continuous Quality Improvement | Pts | 3 |
| F. Report Performance | Pts | 3 |
| G. Use Certified EHR Technology | Pts | 0 |
| **Total** | **20** |

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

**Must Pass Elements**
PCMH Scoring
6 standards = 100 points
6 Must Pass elements

NOTE: Must Pass elements require a ≥ 50% performance level to pass

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

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

**Recognition is for 3 years.** Practices may submit an add-on survey, based on their initial survey, within the 3 year Recognition to achieve a higher level. After 3 years, the practice must submit the survey version available at that time for renewal.
Rationale for Must Pass Elements

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

Must Pass Elements

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

- **Outpatient primary care practices**

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

- Recognitions are conferred at geographic site level -- one Recognition per address, one address per survey
- MDs, DOs, PAs, and APRNs practicing at site with their own or shared panel of patients are listed with Recognition
- Clinicians should be listed at each site where they routinely see a panel of their patients
  - Clinicians can be listed at any number of sites
  - Site clinician count determines program fee
  - Non-primary care clinicians may not be included
At least 75% of each clinician’s patients come for:
- First contact for care
- Continuous care
- Comprehensive primary care services

Clinicians may be selected as personal PCPs

All eligible clinicians at a site must apply together

Physicians in training (residents) should not be listed

Practice may add or remove clinicians during the Recognition period
1. **Documented process** Written procedures, protocols, processes for staff, workflow forms (not explanations); must include practice name and date of implementation.

2. **Reports** Aggregated data showing evidence

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

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

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

Also Called Look-Back Period

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

• **Documented Process**
  Policies, procedures and processes must be in place for at least 3 months prior to review

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

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

ALL DOCUMENTS MUST SHOW DATES
• PCMH 2014 originally aligned with MU Stage 2
• CMS released modified Stage 2 rule in October 2015
• Updates based on modified Stage 2 rule included in November 2015 release
Visit NCQA Web Site at www.ncqa.org to:

- Follow the Start-to-Finish Pathway
- View Frequently Asked Questions
- View Recognition Programs Live Q&A and Training Schedule

For questions about interpretation of standards or elements to submit a question to my.ncqa (Policy/Program Clarification Support & Recognition Programs)

Contact NCQA Customer Support at 888-275-7585 M-F, 8:30 a.m.-5:00 p.m. ET to:

- Acquire standards documents, application account, survey tools
- Questions about your user ID, password, access
PCMH 1: Patient-Centered Access
Intent of Standard
The practice provides access to team-based care for both routine and urgent needs of patients/families/care-givers at all times
• Patient-centered appointment access
• 24/7 Access to clinical advice
• Electronic access

Meaningful Use Alignment
• Patients receive electronic:
  – On-line access to their health information
  – Secure messages from the practice
PCMH 1: Patient-Centered Access

10 Points

Elements

PCMH 1A: Patient-Centered Appointment Access
  MUST PASS

PCMH 1B: 24/7 Access to Clinical Advice

PCMH 1C: Electronic Access
The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on:

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

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

4.5 Points

**Scoring**

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

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

**Documentation**

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

(cont)
**PCMH 1A: Documentation (cont.)**

**F2:** Materials with extended hours OR 5-day (minimum) report showing after-hours availability.

**F3:** Report with frequency of scheduled alternative encounter types in recent 30-calendar-day period.

**F4:** Documented process and report showing appointment wait times compared to practice defined standards and policy to monitor appointment availability with at least 5 days of data.

**F5:** Report showing rate of no shows from a recent 30-calendar day period. (Patients seen/scheduled visits).

**F6:** Documented process practices uses to select, analyze and update creating greater access to appointments and report showing evaluation of access data and improvement plan to improve access.
PCMH 1A, Factor 1: Example Same-Day Scheduling Policy

POLICY: ABCD Family Practice Access to Care
(Approval Date: 9/30/14)

SAME DAY ACCESS:

- ABCD Family Practice provides same-day appointments for patients requiring urgent care as well as routine visits when applicable.
- Same-day appointments are available each day on each physician’s and provider’s schedules. All Physicians at ABCD Family Practice have 3 to 6 same day appointment slots built into their appointment template for same day appointments.
- Same Day appointment slots numbers are based on the demand for same day access determined through our evaluation process. These slots are purple in color on the appointment schedule.
  - The same day appointment slots are not to be booked in advance. They are for same day use only.
  - When a patient calls with a need to see their physician on the same day the scheduler should look on the patient’s primary care doctor’s schedule for same day availability. If there is an opening in an established patient slot for that same day then the scheduler should use that established patient slot. If there is not an available established patient slot then the scheduler should look for a same day appointment slot and offer that time to the patient. If the option is unavailable the scheduler can look at other physicians in the practice for availability in the same manner.
- If no appointment is available during office hours the next step would be to look for availability for our urgent care or late night clinic. If for some reason there are absolutely no available appointment slots in any of the above mentioned categories then the patient would be offered an appointment on the following day or if their need is urgent then the caller would be given to the triage nurse for alternate instructions or scheduling.

APPOINTMENT TYPE:

- **Urgent Care** (Acute Illnesses) – Patients will be seen same day of request with a physician, PA or NP, if requires is before 2pm. If nothing is available, the patients will be directed to the triage nurse for recommendation.
- **Routine Care** (Chronic Conditions) – Patient is scheduled within 24 hours with physician, PA or NP. No more than 3 day time lapse unless requested by the patient.
- **Wellness Care** (Physical/WWE) – Patient is scheduled within 8 weeks of request with physician, PA or NP. With the exception of those patients has been seen priori to 1 calendar year from that time.
From Practice Brochure:

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

![Office Hours](image)
PCMH 1A, Factor 3: Shared Medical Appointments/Group Visits

- Multiple patients are seen as a group for follow-up care or management of chronic conditions
- Voluntary
- Allows patient interaction with other patients and members of health team
- Practice should document in the medical record
- NOT an educational session
- This factor requires a documented process and a 30 calendar day report

Resource: [http://www.aafp.org/about/policies/all/shared-medical.html](http://www.aafp.org/about/policies/all/shared-medical.html)
The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times, and regularly assesses its performance on:

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

*NA if the practice cannot communicate electronically with patients. NA responses require an explanation
PCMH 1B: Scoring and Documentation

3.5 Points

Scoring

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

Documentation

• F1-4: Documented process and
• F2&3: Report(s) showing response times during and after hours (7 calendar day report(s) minimum)
• F4: Three examples of clinical advice documented in record. One example when office open AND one example when office closed.
Patients have **24/7 telephonic access to a clinician (MD, RN, NP or PA) to provide clinical advice.** Calls during office hours are to be **responded to within one hour** and are to be **recorded as a noted patient interaction in the EMR** at the time of the call. The on-call provider has **computer access** by logging onto the EMR remotely while on-call, which enables that care provider access to patient records, to view and search patient records, and also record after hours activity for a patient. After hours calls from patients are to be **responded to by the on-call provider within one hour** and are to be **recorded as a noted patient interaction** in the EMR in within 24 hours of communication with the patient.
### PCMH 1B, Factor 2: Example Response

**Times to Calls**

<table>
<thead>
<tr>
<th>Encounter Number</th>
<th>Date we received phone request</th>
<th>Time of request</th>
<th>Date we responded to patient</th>
<th>Time of Response</th>
<th>Elapsed time</th>
<th>Response time meets policies?</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/27/15</td>
<td>11:16</td>
<td>9/27/15</td>
<td>11:32</td>
<td>0.25 hours</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>9/27/15</td>
<td>14:35</td>
<td>9/28/15</td>
<td>14:34</td>
<td>24 hours</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>9/27/15</td>
<td>13:53</td>
<td>9/27/15</td>
<td>16:19</td>
<td>3 hours</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>9/28/15</td>
<td>9:28</td>
<td>9/28/15</td>
<td>12:55</td>
<td>3 hours</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>9/28/15</td>
<td>10:30</td>
<td>9/28/15</td>
<td>10:41</td>
<td>0.25 hours</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>9/29/15</td>
<td>15:14</td>
<td>9/30/15</td>
<td>9:09</td>
<td>18 hours</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>9/30/15</td>
<td>14:13</td>
<td>10/1/15</td>
<td>10:00</td>
<td>20 hours</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

**Shows:**

- Call date/time
- Response date/time
- If time meets policy
- Note that a similar format could be used to meet factor 3 if applicable.
Practice provides through a secure electronic system:

1. >50% of patients have online access to their health information w/in 4 business days* of information being available to the practice+

2. >5%** of patients view, and are provided the capability to download, their health information or transmit their health information to a third party+

3. Clinical summaries provided for >50%** of office visits within 1 business day

4. Secure message sent by >5%** of patients+

5. Patients have two-way communication with the practice

6. Patients may request appointments, prescription refills, referrals and test results

+ Meaningful Use Modified Stage 2 Alignment

*4 business day requirement no longer required as of 11/16/2015
**Percent threshold no longer required as of 11/16/2015
PCMH 1C: Scoring and Documentation

2 Points

Scoring

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

Documentation

• F1 & F3: Reports based on numerator and denominator with at least 3 months of recent data
• F2 & F4: Reports based on numerator and denominator with at least 3 months of recent data or screen shots showing the use or capability
• F5 & 6: Screen shots showing the capability of the practice’s web site or portal including URL.
More than 50% of patients have online access to their health information within four business days of when the information available to the practice. (Stage 2 MU)

<table>
<thead>
<tr>
<th>Practice/Location</th>
<th>Denominator</th>
<th>Numerator</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice A</td>
<td>750</td>
<td>377</td>
<td>50</td>
</tr>
<tr>
<td>Practice B</td>
<td>647</td>
<td>565</td>
<td>87</td>
</tr>
<tr>
<td>Practice C</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Practice D</td>
<td>886</td>
<td>811</td>
<td>92</td>
</tr>
</tbody>
</table>

Reports need to be at the practice site level and include data for all primary care providers at the site. Data should be aggregated at the site level.
## Quality Measures Provider Summary Report

**Program:** MU2_Objectives_2014  
**Evaluation Date:** 3/17/2015

<table>
<thead>
<tr>
<th>Measure Start Date</th>
<th>Measure End Date</th>
<th>Practice Name: Practice A</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/2014 AND Measure End Date: 12/31/2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Summary Provided In 1 Business Day</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4713</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Final Denominator</th>
<th>Numerator</th>
<th>(%)</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>96.22</td>
<td>50</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Final Denominator includes Exclusion Totals*
PCMH 1C, Factor 5: Example Two-Way Communication

Demonstrates ability practice to send and receive messages through the patient portal.

Also demonstrates capability for PCMH 1C, Factor 6.
PCMH 1C, Factor 6: Interactive Web-Site Example

Can request:
- Appointments
- Prescription Refills
- Test results

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

National Eating Disorder Week starts February 26th.

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

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

Keep your e-mail address current/Adjust SPAM Filters
Please take a moment to ensure your e-mail address is up-to-date. We do not want you to miss out on any new communications from our test results, appointment reminders, etc. You can view your e-mail address on
PCMH 2: Team-Based Care
Intent of Standard

The practice provides continuity of care using culturally and linguistically appropriate, team-based approaches.
PCMH 2: Team-Based Care

12 Points

Elements

Element A: Continuity
Element B: Medical Home Responsibilities
Element C: CLAS
Element D: The Practice Team

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

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

**Scoring**

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

- **F1**: Documented process for staff and an example of a patient record with choice of personal clinician.
- **F2**: Report based on 5 days of data.
- **F3**: Documented process for staff to orient new patients.
- **F4**: For the following:
  - **Pediatric practices** - Example of a written transition care plan
  - **Internal medicine & family medicine practices** – “Documented process and materials for receiving adolescent and young adult patients that ensure continued preventive, acute, chronic care.”
PCMH 2A, Factor 2: Example of monitoring patient visits

<table>
<thead>
<tr>
<th>Providers</th>
<th>Percentage of Visits with Preferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

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

1. The practice is responsible for coordinating patient care across multiple settings.
2. Instructions for obtaining care and clinical advice during office hours and when the office is closed.
3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice.
4. The care team provides access to evidence-based care, patient/family education and self-management support.

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

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

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

8. Instructions on transferring records to the practice, including a point of contact at the practice.
PCMH 2B: Scoring and Documentation

2.5 Points

Scoring

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

Documentation

- F1-8: Documented process for providing information to patients and
- F1-8: Patient materials
What is a Patient-Centered Medical Home?

The Medical Home is an innovative, team-based approach to provide partnership develops between the patient, his or her primary clinician. Together, following evidence-based guidelines for medical care, provide the best health care services possible for you.

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

Team Based Care:
- One of us will remain as your Primary Care clinician. However, nurses and support staff to work with you to meet all of your information systems tools will assist us (along with other resources) to help you with medical care that is optimal for you.

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

Materials could describe:
- What is a medical home?
  - Team-based care
  - Partnership with patient
  - Evidence-based guidelines
  - Coordinated care
- Benefits of a medical home
  - Team-based care
  - Improved access
  - Better communication
The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by:

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

2.5 Points

**Scoring**

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

**Documentation**

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

<table>
<thead>
<tr>
<th>Language</th>
<th># of Patients</th>
<th>% of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>2191</td>
<td>79.30%</td>
</tr>
<tr>
<td>Spanish</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Russian</td>
<td>2</td>
<td>0.07%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.04%</td>
</tr>
<tr>
<td>All Other</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Blank Field</td>
<td>573</td>
<td>20.74%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2763</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

This is based on unique pts seen between 08/07/15 - 10/08/15. This sampling indicates that most of our patients speak English. We utilize staff that speak Spanish and also have available language line for any other languages that might be needed.
The practice uses a team to provide a range of patient care services by:

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

**NOTE:** Critical Factors in a Must Pass element are required for Recognition
6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change.

7. Training and assigning members of the care team to manage the patient population.

8. Holding scheduled team meetings to address practice functioning.

9. Involving care team staff in the practice’s performance evaluation and quality improvement activities.

10. Involving patients/families/caregivers in quality improvement activities or on the practice’s advisory council.
STH 2D: Scoring

MUST-PASS

4 Points

Scoring

• 10 factors = 100% (including factor 3)
• 8-9 factors = 75% (including factor 3)
• 5-7 factors = 50% (including factor 3)
• 2-4 factor = 25%
• 0-1 factor = 0%
PCMH 2D: Documentation

Documentation

- F1, 5-7: Staff position descriptions or responsibilities
- F2: Overview of staffing structure
- F3: Documented process with description of staff communication processes including frequency of communication and 3 examples showing the process
- F4: Written standing orders
- F5-7: Description of training process and schedule or materials
- F8: Description of staff communication processes and example
- F9: Documented process with description of staff role in practice improvement process
- F10: Documented process demonstrating how it involves patients/families in QI teams or advisory council
Includes notes about needed services for patients coming to the office on 4/23/2015 discussed during a scheduled morning huddle.
Care Team Training: Self-Management Support & Population Management

**Diabetes/Hypertension Care Team Training** Sessions

**Joint Staff Meeting**
June 3rd 2015 1:30-2:30pm

*Participants:* All clinic staff and providers at general monthly clinic meeting

*Agenda:* The utilization of patient registries to manage high-risk diabetics and hypertensive patients.

*Summary:* Introduction and education of patient care registries and their value (con’t)

Factors 5-7, practices need to provide:
- Description of training and
- Schedule or materials showing how staff has been trained
POLICY/STANDING ORDERS FOR ADMINISTERING PNEUMOCOCCAL VACCINE TO ADULTS

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

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

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

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

Screen all patients for contraindications and precautions to pneumococcal vaccine:

Severe allergic reaction to past pneumococcal vaccine

Pregnant patients
PCMH 3: Population Health Management
PCMH 3: Population Health Management

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

**Meaningful Use Alignment**
- Practice uses clinical decision support
PCMH 3: Population Health Management

20 Points

Elements

- Element A: Patient Information
- Element B: Clinical Data
- Element C: Comprehensive Health Assessment
- Element D: Use Data for Population Management
- **MUST-PASS**
  - Element E: Implement Evidence-Based Decision Support
The practice uses an electronic system to record patient information, including capturing information for factors 1-13 as structured (searchable) data for more than 80 percent of its patients:

1. Date of birth.
2. Sex.
3. Race.
4. Ethnicity.
5. Preferred language.
6. Telephone numbers.
7. E-mail address.
8. Occupation (NA for pediatric practices).
10. Legal guardian/health care proxy.
11. Primary caregiver.
13. Health insurance information.
14. Name and contact information of other health care professionals involved in patient’s care.
3 Points

Scoring

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

**NOTE**

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

**Documentation**

- F1-13: Report with numerator and denominator with at least 3 months of recent data.
- F14: Documented process and three examples demonstrating process.
This certified system produced very graphic report that shows practice level (all providers) results for a 3 month reporting period.

Demographic percentage for 3 month duration 1/1/15 - 4/1/15

**MU Stage 2 Core Measure 3 included:**
- Date of birth
- Sex
- Race
- Ethnicity
- Language
The practice uses an electronic system with the functionality in factors 6 and 7 and records the information in factors 1-5 and 8-11 as structured (searchable) data:

1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients.
2. Allergies, including medication allergies and adverse reactions for more than 80 percent of patients.
3. Blood pressure, with the date of update for more than 80 percent of patients 3 years and older.
4. Height/length for more than 80 percent of patients.
5. Weight for more than 80 percent of patients.
6. System calculates and displays BMI.
7. System plots and displays growth charts (length/height, weight and head circumference) and BMI percentile (0-20 years) (NA for adult practices).

8. Status of tobacco use for patients 13 years and older for more than 80 percent of patients.

9. List of prescription medications with date of updates for more than 80 percent of patients.

10. More than 20 percent of patients have family history recorded as structured data.

11. At least one electronic progress note created, edited and signed by an eligible professional for more than 30 percent* of patients with at least one office visit.

*Percent threshold no longer required as of 11/16/2015
PCMH 3B: Scoring and Documentation

4 Points

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

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

Documentation
- F1-5, 8-10: Reports with a numerator and denominator
- F6, 7: Screen shots demonstrating capability
- F11: Report with numerator and denominator (no percentage requirement) OR example of capability
## PCMH 3B, Factors 1-5, 8-11: MU Measures

### PCMH 3B 1-11 Clinical Data 12/1/14-3/1/15

<table>
<thead>
<tr>
<th></th>
<th>Problems</th>
<th>Allergies</th>
<th>Blood Pressure</th>
<th>Height</th>
<th>Weight</th>
<th>Tobacco Use</th>
<th>Meds</th>
<th>Family History</th>
<th>Progress Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>1541</td>
<td>1545</td>
<td>1545</td>
<td>1546</td>
<td>1544</td>
<td>1547</td>
<td>1543</td>
<td>1541</td>
<td>1545</td>
</tr>
<tr>
<td>Denominator</td>
<td>1547</td>
<td>1547</td>
<td>1547</td>
<td>1547</td>
<td>1547</td>
<td>1547</td>
<td>1547</td>
<td>1547</td>
<td>1547</td>
</tr>
<tr>
<td>Percentage</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>3B1</th>
<th>3B2</th>
<th>3B3</th>
<th>3B4</th>
<th>3B5</th>
<th>3B8</th>
<th>3B9</th>
<th>3B10</th>
<th>3B11</th>
</tr>
</thead>
</table>
PCMH 3C: Comprehensive Health Assessment

To understand the health risks and information needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes:

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

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

NOTE

- Factor 5 (NA for pediatric practices)
- Factor 8 (NA for practices with no pediatric patients)
- Factor 9 (if practice does not see adolescent or adult patients) (Adolescents age range: 12-18)
- Written explanation required for NA responses
Documentation

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

  OR

• **F1-10:** Review of patient records selected for the record review required in elements 4B and 4C, documenting presence or absence of information in Record Review Workbook and 1 example for each factor.

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

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

• **Factor 10:** For practices that do not assess health literacy at the patient level, NCQA reviews materials or screenshots demonstrating that health literacy is addressed at the practice.
PCMH 3C, Factors 4 and 7: Example
Family Medical and Mental Health History

Practices must submit examples to demonstrate each factor if using the RRWB
At least **annually** practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidenced-based guidelines including:

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

MUST-PASS

5 Points

Scoring

• 4-5 factors = 100%
• 3 factors = 75%
• 2 factors = 50%
• 1 factor = 25%
• 0 factors = 0%
PCMH 3D: Documentation

**Documentation**

- **F1-5:**
  1) Reports or lists of patients needing services generated within 12 months prior to survey submission (Health plan data okay if 75% of patient population)

  **AND**

  2) Materials showing how patients were notified for each service (e.g., template letter, phone call script, screen shot of e-notice).
### Chronic Condition - Diabetes

Visits between 05/1/2014-05/1/2015

<table>
<thead>
<tr>
<th>Provider</th>
<th>Diagnosis</th>
<th>MRN</th>
<th>Birth Date</th>
<th>Age</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Type II or unspecified type diabetes mellitus without mention of</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>complication, not stated as uncontrolled [250.00]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patents with diabetes who are due for a Hemoglobin A1c test**
May 20, 2015

Dear [Name]

This letter is a reminder that your Hgb A1C test is due. Please call our office to schedule an appointment.

If you've already underwent or scheduled this test, please disregard this notice.

Sincerely,

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

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

+Meaningful Use Modified Stage 2 Alignment
PCMH 3E: Scoring and Documentation

4 Points

Scoring

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

Documentation

• F 1-6: Provide
  1) Conditions identified by the practice for each factor and
  2) Source of guidelines and
  3) Examples of guideline implementation
**Clinically important condition #1: Diabetes:**

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

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

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

**Treatment goals:**

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

1. Pre meal BG <120
2. Fasting BG >80, <100
3. HgBA1c <6.5%
4. BP <130/80
5. LDL <100
6. Annual eye exam
7. Routine foot exams and neuropathy screenings
8. Routine microalbuminuria screenings
### Diabetes Flowsheet

<table>
<thead>
<tr>
<th><strong>History &amp; Physical</strong></th>
<th>Frequency</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>Every Visit</td>
<td></td>
<td></td>
<td></td>
<td>132/76</td>
</tr>
<tr>
<td>Check Weight (BMI)</td>
<td>Every Visit</td>
<td></td>
<td></td>
<td></td>
<td>40.1</td>
</tr>
<tr>
<td>Retinal Screening</td>
<td>Annually</td>
<td></td>
<td></td>
<td></td>
<td>40.6</td>
</tr>
<tr>
<td>Inspect feet</td>
<td>Every Visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Lower Extremity Exam</td>
<td>Annually</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental/Oral health assessment</td>
<td>6 Months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Assessment</td>
<td>Annually</td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Labs &amp; Tests</strong></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A1c</td>
<td>3 Months</td>
<td>7.7</td>
<td>7.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triglycerides</td>
<td>Annually</td>
<td>218</td>
<td>206</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LDL</td>
<td>Annually</td>
<td>86</td>
<td>97</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HDL</td>
<td>Annually</td>
<td>25</td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Cholesterol</td>
<td>Annually</td>
<td>147</td>
<td>173</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated GFR</td>
<td>Annually</td>
<td>&lt;= 60</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Medications &amp; Immunizations</strong></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin Use</td>
<td>Every Visit</td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Assess Need For ACE/ARB</td>
<td>Every Visit</td>
<td></td>
<td></td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Assess Need For Statin</td>
<td>Every Visit</td>
<td></td>
<td></td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Influenza Vaccination</td>
<td>Annually</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Vaccination</td>
<td>5 Years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Lifestyle &amp; Counseling</strong></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Set Self-Management Goals</td>
<td>Every Visit</td>
<td></td>
<td></td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Diabetes Patient Education / Nutrition / Exercise</td>
<td>Every Visit</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Tobacco Use/Exposed to 2nd hand smoke</td>
<td>4 Months</td>
<td></td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Smoking/Second Hand Smoke Counseling</td>
<td>Every Visit</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Depression / Mental Health Screening</td>
<td>Every Visit</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Review blood glucose log</td>
<td>Every Visit</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>
NCQA Contact Information

Visit NCQA Web Site at www.ncqa.org to:

– Follow the Start-to-Finish Pathway
– View Frequently Asked Questions
– View Recognition Programs Live Q&A and Training Schedule

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– Acquire standards documents, application account, survey tools
– Questions about your user ID, password, access
PCMH 4: Care Management and Support
PCMH 4: Care Management and Support

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

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

20 Points

Elements
Element A: Identify Patients for Care Management
Element B: Care Planning and Self-Care Support
   MUST PASS
Element C: Medication Management
Element D: Use Electronic Prescribing
Element E: Support Self-Care and Shared Decision-Making
The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following:

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

F6. Patients are counted once even if they are identified under several factors

F5. Nomination

F4. Social Determinants of Health

F3. Poorly Controlled/Complex Conditions

F2. High Cost/High Utilization

F1. Behavioral Health
Factor 6 is critical – NO points if no monitoring

- Patients may “fit” more than one criterion (Factor), but may only be counted ONCE
- Patients may be identified through electronic systems (registries, billing, EHR), staff referrals and/or health plan data.
- Review comprehensive health assessment (Element 3C) as a possible method for identifying patients.
- Practices do not need to include criteria from all factors 1-5 in identifying population for factor 6
• **Practice #1 identifies:**
  – all diabetic patients through problem list with:
    • recent hemoglobin over 9 or
    • with a diagnoses of depression
  – all asthmatic patients with ER visits in the last 12 months
  – all patients over 90
  – any patients recognized by staff having multiple barriers of meeting their treatment plan

• **What factors are utilized by this practice for factor 6?**
Practice #2 identifies:
- all patients with high utilization
- all patients with 2 or more chronic conditions

What factors are utilized by this practice for factor 6?

NOTE: Process used for identifying patients must produce enough patients for the chart review.
PCMH 4A: Scoring and Documentation

4 Points

Scoring

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

Documentation

• F1-5: Documented process describing criteria for identifying patients for each factor
• F6: Report with
  – Denominator = total number of patients in the practice
  – Numerator = number of unique patients in denominator likely to benefit from care management.

Note: At least 30 patients must be identified for factor 6
Care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75 percent of the patients identified in 4A.

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

Must-Pass

4 Points

Scoring

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

Documentation

- F1-5:
  - Report from electronic system or
  - Record Review Workbook and 1 example for each factor
  - Report may be used to meet some factors and RRWB with examples for other factors

Note: At least 30 patients must be included in the sample for both methods of reporting
Record Review Workbook: 4B

<table>
<thead>
<tr>
<th>4B - Care Planning and Self-Care Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Incorporates patient preferences and functional/lifestyle goals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>0</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30 Patients</td>
<td>&lt; 30 Patients</td>
<td>&lt; 30 Patients</td>
<td>&lt; 30 Patients</td>
<td>&lt; 30 Patients</td>
</tr>
</tbody>
</table>
### Table 3-4 Example of a Written Plan for Communication

<table>
<thead>
<tr>
<th>Plan component</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name _____</td>
<td>Lets you personalize the plan; make a copy for medical record.</td>
</tr>
<tr>
<td>Medical Record No. _____</td>
<td></td>
</tr>
<tr>
<td>Date _____</td>
<td></td>
</tr>
<tr>
<td>1. Diagnosis: _____</td>
<td>Gives the disease a name so the patient can look it up.</td>
</tr>
<tr>
<td>2. Stage (where it has spread): _____</td>
<td>Allows discussion of prognosis. Showing metastases to the brain and liver quickly points out the seriousness of the illness.</td>
</tr>
<tr>
<td>(list all areas)</td>
<td></td>
</tr>
<tr>
<td>3. Prognosis: _____</td>
<td>Ask first if patients want to know the full details of their illness! Allows open communication about goals, rest-of-life planning. Some patients will persist in denial, but this allows open dialogue with the family.</td>
</tr>
<tr>
<td>List whether curable or not curable and expected average lifespan</td>
<td></td>
</tr>
</tbody>
</table>
4. Treatment Goals: _____
List cure, long- or short-term control, pain relief, hospice care

Makes explicit what you can and cannot do; for curable disease, this reinforces your goal, and that cure is possible. Use this to bring up do-not-resuscitate and cardiopulmonary resuscitation issues. Allows you to emphasize that hospice care does not mean "no treatment", but a different set of treatment goals.

5. Treatment Options: _____
List all that apply

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

6. Call the doctor if: _____
List your threshold for fever, pain, and other symptoms

Gives explicit reasons to call and gives explicit permission to call.

7. How to reach me: _____
List the phone numbers during office and off-hours

Tell patients to keep this handy. They will call, and for real events. Emails for nonemergency purposes work well for prescription refills, questions about new drugs, encouragement, etc.

8. Signed: _____ MD

Personalizes the plan as well as making it a part of the medical record.

SOURCE: Adapted from Smith, T.: J Clin Oncol 21(9 Suppl), 2003: 12s-16s. Reprinted with permission. © 2003 American Society of Clinical Oncology. All rights reserved.
The practice has a process for managing medications, and systematically implements the process in the following ways:

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

+Meaningful Use Modified Stage 2 Alignment
PCMH 4C: Scoring and Documentation

4 Points

Scoring

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

Documentation

F1-6:

- Report from electronic system or
- Record Review Workbook and 1 example for each factor is met
- Report may be used to meet some factors and RRWB with examples for other factors

Note: At least 30 patients must be included in the sample for both methods of reporting
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviews and reconciles medications for more than 50 percent of patients received from care transitions.</td>
<td>Reviews and reconciles medications with patient/families for more than 80 percent of care transitions.</td>
<td>Provides information about new prescriptions to patient/families</td>
<td>Assesses patient/family understanding of medications for patients with date of assessment</td>
<td>Assesses patient response to medications and barriers to adherence for patients with date of assessment</td>
<td>Documents over-the-counter medications, herbal therapies and supplements for patient/families with the date of update</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>0</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30 Patients</td>
<td>&lt; 30 Patients</td>
<td>&lt; 30 Patients</td>
<td>&lt; 30 Patients</td>
<td>&lt; 30 Patients</td>
<td>&lt; 30 Patients</td>
</tr>
</tbody>
</table>
The practice uses an electronic prescription system with the following capabilities:

1. More than 50 percent of eligible prescriptions written by the practice are compared to drug formularies and electronically sent to pharmacies.+

2. Enters electronic medication orders into the medical record for more than 60 percent of patients with at least one medication in their medication list.+


4. Alerts prescribers to generic alternatives.

+Meaningful Use Modified Stage 2 Alignment
PCMH 4D: Scoring and Documentation

3 Points

**Scoring**

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

Factors - 1,2 may be N/A

**Documentation**

- F1: Report with a numerator and denominator and screenshot
- F2: Report with a numerator and denominator
- F3, 4: Screen shots demonstrating functionality
PCMH 4D, Factor 1: Example Electronic Prescription Writing

**Prescription Writing Activity**

<table>
<thead>
<tr>
<th>Activity</th>
<th>%</th>
<th>Rx</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic</td>
<td>57</td>
<td>2563</td>
</tr>
<tr>
<td>Printed, given to patient</td>
<td>31</td>
<td>1419</td>
</tr>
<tr>
<td>Print, fax to pharmacy</td>
<td>1</td>
<td>89</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>4474</strong></td>
</tr>
<tr>
<td>% E-RX</td>
<td></td>
<td><strong>57%</strong></td>
</tr>
<tr>
<td>% Entered in EHR</td>
<td></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Prescription Writing Activity**

- Electronic: 57% 2563 Rx
- Printed, given to patient: 31% 1419 Rx
- Print, fax to pharmacy: 1% 89 Rx

**Total Rx**: 4474 Rx

**% E-RX**: 57%

**% Entered in EHR**: 100%
PCMH 4D, Factor 1: Example Prescribing Decision Support-Formulary Drug

Warnings

Warnings for olopatadine hcl ophthalmic drops 0.1% (Pataday, Patanol)

View alternatives within the same therapeutic class

To prescribe this drug anyway, select a reason for overriding the warning (or select 'other' and type one in), then click the 'Override' button; otherwise, just click the Cancel button.

- No formulary alternative exists.
- Formulary agents not optimal.
- Pt sensitive to formulary agents.
- Pt stabilized on chronic therapy.
- Other

AHFS Drug Monograph Cancel Override Defer
PCMH 4D, Factor 3: Example Drug-Drug Interactions

### Drug-Drug Interactions

<table>
<thead>
<tr>
<th>Drug1</th>
<th>Drug2</th>
<th>Severity</th>
<th>Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>aspirin</td>
<td>warfarin</td>
<td>Major</td>
<td>GENERALLY AVOID: Aspirin</td>
</tr>
<tr>
<td>fibrate</td>
<td>warfarin</td>
<td>Major</td>
<td>GENERALLY AVOID: Fibric</td>
</tr>
<tr>
<td>fibrate</td>
<td>simvastatin</td>
<td>Major</td>
<td>GENERALLY AVOID: Sever</td>
</tr>
<tr>
<td>lirin glargine</td>
<td>aspirin</td>
<td>Moderate</td>
<td>MONITOR: The hypoglyc</td>
</tr>
<tr>
<td>lirin glargine</td>
<td>fenofibrate</td>
<td>Moderate</td>
<td>MONITOR: The hypoglyc</td>
</tr>
</tbody>
</table>

### Allergies

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

### Drug-Disease Interactions

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

**aspirin - warfarin Interaction**

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

**MANAGEMENT:** This combination, especially with analgesic/antipyretic aspirin doses, should generally be avoided unless the potential benefit outweighs the risk of bleeding. If concomitant therapy is used for additive anticoagulant effects, monitoring for excessive anticoagulation and overt and occult bleeding is recommended. The INR should be checked frequently and the dosage adjusted accordingly.
PCMH 4E: Support Self-Care and Shared Decision-Making

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

The practice:

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

+Meaningful Use Modified Stage 2 Alignment
5. Offers or refers patients to structured health education programs, such as group classes and support.

6. Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates.

7. Assesses usefulness of identified community resources.
5 Points

Scoring

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

Documentation

- F1: Report
- F2-5: Examples of at least three examples of resource, tools, aids.
- F6: Materials demonstrating practice offers at least five resources
- F7: Materials/data collection on usefulness of referrals to community resources.
Stage 2 Objectives (cont’d)

Menu Measures - Public Health List
M6 / P121: Provide Patient with Educational Resources*

Threshold | Score
------------|------
>10%        | 100%

606 of 612 Patients

Note: MU reports submitted for recognition must represent all providers at the practice
## Diabetes Health Record

<table>
<thead>
<tr>
<th>Item</th>
<th>Frequency</th>
<th>Common Goals</th>
<th>Individual Goals</th>
<th>My results</th>
<th>My results</th>
<th>My results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review blood sugar records</td>
<td>every visit</td>
<td>less than 130</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-meal target:</td>
<td></td>
<td>less than 180</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After meal (1 to 2 hours) target:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood pressure</td>
<td>every visit</td>
<td>less than 140/80</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight (set realistic goals)</td>
<td>every visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot exam</td>
<td>every visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemoglobin A1C</td>
<td>every 3 to 6 months</td>
<td>less than 7.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine microalbumin/creatinine ratio</td>
<td>yearly</td>
<td>less than 30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Shared decision-making aids provide detailed information without advising the audience to choose one decision over the other.

Other examples and more information can be found at: [http://shareddecisions.mayoclinic.org/](http://shareddecisions.mayoclinic.org/)
Prenatal Care: Steps Toward a Healthy Pregnancy
Prenatal Session #1
PROGRAM: Comprehensive Perinatal Services Program TIME: 1 - 1 ½ Hours

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

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

Teen Pregnancy and Parenting Referral:
• Teen Pregnancy/Parenting Programs: (800) 833-6235
• Garfield Medical Center, 525 N. Garfield Ave. MP, CA (626) 573-2222 (Pico Rivera)
• USC-WCH, 1240 N. Mission Rd, Los Angeles (323) 442-1100
• San Gabriel Perinatology Center. 616 N. Garfield, Monterey Park, CA. 91754.

Medical Choice Referral:
• Health Net Member Service Department: 1-800-675-6110
• AltaMed Assistants: 1-877-GO-2-ALTA
• DPSS 1 (800) 660-4066

New Immigrant Resources:
• National Hispanic Prenatal Hotline: 1-800-504-7081
• National Immigration Law Center: (213) 639-3900
• International Rescue Committee Inc (213) 386-6700

Cultural Considerations:
• Local Adult Education Classes, ELA College (323) 233-1283
• ESL Classes, L.A Unified Adult School (323) 262-5163
• Language Line Services: 1 (800) 367-9559

Parenting Stress
• Parental Stress Line Number: (800) 339-6993, or 211
• Elizabeth House: (626) 577-4434
PCMH 5: Care Coordination & Care Transitions
PCMH 5: Care Coordination and Care Transitions

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

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

NCQA
Measuring quality
Improving health care
PCMH 5: Care Coordination and Care Transitions

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

Elements

PCMH5A: Test Tracking and Follow-Up

PCMH5B: Referral Tracking and Follow-Up

MUST PASS

PCMH5C: Coordinate Care Transitions
Practice has a documented process for and demonstrates that it:

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

+Meaningful Use Modified Stage 2 Alignment

*Percent threshold no longer required as of 11/16/2015
Practice has documented process for **and** demonstrates:

1. Tracks lab test orders, flags/follows-up on overdue results – **CRITICAL FACTOR**
2. Tracks imaging test orders, flags/follows-up on overdue results – **CRITICAL FACTOR**
3. Flags abnormal lab results
4. Flags abnormal imaging results
5. Notifies patients of normal and abnormal lab/imaging results
6. Follows up on newborn screening (**NA for adults**)

Documentation

**F1-5:**
- Documented process for staff **and**
- Report, log or evidence of process use with examples for each requirement in each factor

**F6:**
- Documented process for follow-up on newborn screenings **and**
- Example of process use or explanation for NA.
PCMH 5A, Factors 7-10: Test Tracking/Follow-up (cont.)

Practice has documented process for **and** demonstrates:

7. > 30% of lab orders are electronically recorded in pt. record+

8. > 30% of radiology orders are electronically recorded in pt. record+

9. > 55%* of clinical lab tests results are electronically incorporated into structured fields in pt. record

10. > 10%* of scans & test that results in an image are accessible electronically

---

**Documentation**

**F 7-10:**
- Practice level data or MU reports from the practice’s electronic system with numerator, denominator and percent (at least 3 months of data for each factor)

**F 9-10:**
- OR example showing capability

---

+Meaningful Use Modified Stage 2 Alignment

*Percent threshold no longer required as of 11/16/2015
PCMH 5A: Scoring and Documentation

6 Points

Scoring

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

Both lab and imaging must be included in processes and reports in Factors 1 and 2 to receive any score for PCMH 5A.
PCMH 5A, Factors 1&2: Documented Process

Factor 1 and 2: The practice has a written process for staff to track and follow-up on lab tests and imaging tests. The facility uses tracking logs to follow lab and image results. Once the study is delivered to the provider (in EMR), the provider reviews the results and communicates them to the patient. If follow-up care is needed, the patient is booked to see a provider.

Factor 7 and 8: The practice electronically communicates with labs and facilities to order tests and retrieve results. Staff members review the Electronic Medical Record (EMR) for any lab and imaging results that were sent to patient charts.
PCMH 5A, Factors 1&3: Example Electronic Test Tracking

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

Practice tracks:
- Date ordered
- Overdue
- Abnormal
- Priority
- Patient name
- Provider
- Order description
- Last appointment
- Next appointment

<table>
<thead>
<tr>
<th>Date Ordered</th>
<th>Overdue</th>
<th>Abnormal</th>
<th>Priority</th>
<th>Patient Name</th>
<th>Provider</th>
<th>Order Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/07/2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>chest 2 view xray</td>
</tr>
<tr>
<td>12/17/2008</td>
<td>Overdue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/14/2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/17/2008</td>
<td>Overdue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/15/2008</td>
<td>Overdue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/19/2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/18/2008</td>
<td>Overdue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/07/2009</td>
<td>Overdue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/22/2008</td>
<td>Overdue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
We hope this letter finds you in good health. Please return to the center at your earliest convenience for the blood work your physician ordered for you on 3/30/15.

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

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

Sincerely,

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

<table>
<thead>
<tr>
<th>Title:</th>
<th>Flagging Normal/Abnormal Lab Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author:</td>
<td>Date: May 23, 2012</td>
</tr>
<tr>
<td></td>
<td>Effective Date:</td>
</tr>
<tr>
<td></td>
<td>Reference Number:</td>
</tr>
</tbody>
</table>

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

**Procedure:**

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

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

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

## Lab Results Work List

<table>
<thead>
<tr>
<th>PatID</th>
<th>Date / Time</th>
<th># Results</th>
<th>Criticality</th>
<th>Ordering Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>A120050</td>
<td>1/10/2013 1:59:00 PM</td>
<td>1</td>
<td>Panic</td>
<td></td>
</tr>
<tr>
<td>A122927</td>
<td>1/14/2013 10:47:05 AM</td>
<td>20</td>
<td>Panic</td>
<td></td>
</tr>
<tr>
<td>A124297</td>
<td>1/21/2013 2:00:34 PM</td>
<td>20</td>
<td>Panic</td>
<td></td>
</tr>
<tr>
<td>A110396</td>
<td>1/8/2013 10:28:24 AM</td>
<td>16</td>
<td>Panic</td>
<td></td>
</tr>
<tr>
<td>A090737</td>
<td>1/10/2013 9:50:23 AM</td>
<td>20</td>
<td>Warning</td>
<td></td>
</tr>
<tr>
<td>A130200</td>
<td>1/18/2013 4:43:00 PM</td>
<td>1</td>
<td>Warning</td>
<td></td>
</tr>
<tr>
<td>A062552</td>
<td>1/7/2013 11:06:54 AM</td>
<td>7</td>
<td>Warning</td>
<td></td>
</tr>
<tr>
<td>A089222</td>
<td>1/9/2013 8:55:00 AM</td>
<td>20</td>
<td>Warning</td>
<td></td>
</tr>
<tr>
<td>A092600</td>
<td>1/22/2013 1:44:25 PM</td>
<td>16</td>
<td>Warning</td>
<td></td>
</tr>
<tr>
<td>A002553</td>
<td>1/10/2013 11:25:00 AM</td>
<td>16</td>
<td>Warning</td>
<td></td>
</tr>
<tr>
<td>A111093</td>
<td>1/29/2013 9:53:48 AM</td>
<td>16</td>
<td>Warning</td>
<td></td>
</tr>
<tr>
<td>A124587</td>
<td>1/18/2013 8:45:55 AM</td>
<td>20</td>
<td>Warning</td>
<td></td>
</tr>
</tbody>
</table>

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

Phone Note
Outgoing Call
Call back at Home Phone

Call placed by
Summary of Call: pt is called in multiple numbers several times, no one picked up.

Factor 1 and 5: The PCP attempts to contact the patient following abnormal lab report results.
The Practice:

1. Considers available performance info on consultant/specialists for referral recommendations
2. Maintains formal and informal agreements with subset of specialists based on established criteria
3. Maintains agreements with behavioral healthcare providers
4. Integrates behavioral healthcare providers within the practice site
5. Gives the consultant/specialist the clinical question, required timing and type of referral
6. Gives the consultant/specialist pertinent demographic and clinical data, including test results and current care plan

7. Has capacity for electronic exchange of key clinical information and provides electronic summary of care record to another provider for >50%* of referrals+

8. Tracks referrals until consultant/specialist report is available, flagging and following up on overdue reports (Critical Factor)

9. Documents co-management arrangements in patient’s medical record

10. Asks patients/families about self-referrals and requests reports from clinicians

+Meaningful Use Modified Stage 2 Alignment

*>10% threshold will be accepted as of 11/16/2015
PCMH 5B: Referral Tracking & Follow-Up

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

Documentation:
- F1: Examples of types of info the practice has on specialist performance
- F2-3: At least one example for each factor
- F4: Materials explaining how BH is integrated with physical health
- F5-6: Documented process and at least one example or report demonstrating process implementation (cont.)
PCMH 5B: Referral Tracking/Follow-Up (cont.)

**Practice tracks referrals:**

6. Gives the specialist pertinent demographic & clinical data, test results & current care plan

7. Capacity for electronic exchange of key clinical info & provides electronic summary of care record to another provider >50%* of referrals+

8. Tracks referrals for receipt of report, flags, and follows up on overdue reports (Critical Factor)

9. Documents co-management arrangements in patient medical record

10. Asks patients/families about self-referrals and requests reports from clinicians.

+Meaningful Use Modified Stage 2 Alignment

F7: Report from electronic system with numerator, denominator and percent (at least 3 months of data)

F6, 8, & 10: Documented process and at least one example or report demonstrating process implementation

F9: At least three examples

*=>10% threshold will be accepted as of 11/16/2015
PCMH 5B: Scoring

**MUST-PASS**

6 Points

Scoring

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

**NOTE:** Critical Factors in a Must Pass element are essential for Recognition. Factor 8 must be met to receive any score for PCMH 5B.
## Clinician Search Results

**Search results: (1 - 50) of 300**

<table>
<thead>
<tr>
<th>Clinician / Site</th>
<th>Address</th>
<th>Current Recognitions</th>
<th>Recognition Program(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agostino DO, Nicole Marie</td>
<td>Hematology Oncology Associates, Morgan Cancer Center, 1240 S. Cedar Crest Blvd. Allentown, PA 18103</td>
<td>PCSP Level 2 (03/12/2014 - 03/12/2017)</td>
<td>[NCQA Logo]</td>
</tr>
<tr>
<td>Aires MD, Daniel J</td>
<td>The University of Kansas Physicians - Department of Internal Medicine, 3901 Rainbow Blvd, MS1044, Kansas City, KS 66160</td>
<td>PCSP Level 3 (03/10/2014 - 03/10/2017)</td>
<td>[NCQA Logo]</td>
</tr>
<tr>
<td>Aliani MD, Ali</td>
<td>OSU Rheumatology-CarePoint East, 543 Taylor Ave Suite 3084, Columbus, OH 43203</td>
<td>PCSP Level 3 (03/17/2014 - 03/17/2017)</td>
<td>[NCQA Logo]</td>
</tr>
<tr>
<td>Alexander MD, Chacko</td>
<td>Woodlands North Houston Heart Center, 17256 St Luke's Way, Suite 420, The Woodlands, TX 77384</td>
<td>HSFP (04/05/2013 - 04/05/2016) PCSP Level 3 (04/06/2014 - 04/06/2017)</td>
<td>[NCQA Logo]</td>
</tr>
</tbody>
</table>
Referring Provider – Cardiology Patient Referral Understanding 2013

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

When receiving a referral the following are standard expectations of information required by the Cardiology Department (to be made available by the referring provider):

- Diagnosis - why patient is being referred / what question is being asked
- Patient Demographics (insurance, address, dob, etc)
- Pertinent clinical data - Lab results, radiology reports, prior procedures, prior meds etc.

When requesting a referral the following are standard expectations as to what will be provided by the Cardiology Department:

- Timely access for the referred patients [per below unless referring provider or patient specifies otherwise]:
  - Procedure (positive stress test etc.) – appointment (appt.) within 1-2 weeks
  - Cardiology high risk – within 1-2 weeks, as per referring provider (New onset –Fib, SVT, VT or complete heart block etc)
  - Cardiology low risk – referring provider specifies time frame / urgency of appt.

- Consult notes timely:
  - Notes to referring provider within a week (available through EMR) will include:
    - diagnosis / answer to the referring provider’s questions
    - specialist’s plan of care, care management, any patient education or secondary referrals
  - Cardiologist to call referring provider sooner if there is a critical issue

- Lab, procedure and other test results cc’d to Referring Provider:
  - Available to view through EMR

- Communication regarding who is going to implement plan / manage follow-up:
  - It is assumed that the Cardiologist will manage the patient for the associated diagnosis, both to implement a treatment plan and manage future follow-up.
  - It is the Cardiologist’s responsibility to specifically notify the referring provider if the referring provider will be responsible for future follow-up.
  - It is the Cardiologist’s responsibility to communicate with the patient regarding diagnosis and required follow-up care.

Mutual Expectations as to what Patient / Family / Caregiver can expect for care coordination:

*Patients are expected to sign up for a... account in order to better facilitate communication.*

- Specialist will discuss plan of care with patient at time of visit, and will provide patient with written copy after visit is completed (After Visit Summary - either printed or electronically via ...)

- Specialist will follow up with patient:
  - at follow up appt
  - electronically via
  - via telephone if necessary (labs are auto-released within 96 hours)

Other Special Coordination Issues:

- Hospice management – Specifically need to address this on a per-patient basis; often is clarified on the Hospice form (patient designates physician when signing up with Hospice)
Procedure: Strategy of Co-Management with Primary Care and Rheumatology. Intent is to specify the components of care that will be managed by Rheumatology and what will be managed by Primary Care or when transition of care is needed.

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

- Areas managed by Primary Care or referring provider
  - Address all age appropriate preventive screening and Immunizations
  - Evaluation and management of chronic care of patients current problem list
    - Plan of care, medications, tests and imaging and monitoring lab results
### Documentation Required: (Factor 3) One BH Agreement & (Factor 4) Explanation of BH integration into the practice site.
**PCMH 5B, Factors 5 & 6: Documented Process**

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

<table>
<thead>
<tr>
<th>Criteria for Informal Agreements between Primary Care/referring clinician and Specialist (5B5)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access</strong></td>
</tr>
</tbody>
</table>
| - Referral to specialist based on urgency  
  - Routine - within 2 weeks  
  - Urgent within 48 hours  
  - Stat within 24 hours  
- Work specialist to expedite care in urgent cases  
- Verify insurance status  
- Anticipate special needs of patient/family  
- Agree to engage/consult with specialist regarding a pre-referral consult if requested. |
| **Access** |
| - Referral request should identify urgency of referral  
  - Routine  
  - Urgent  
  - Stat  |
| **Communication (Referral from) (5B5)** |
| - State the clinical Question and type of referral request  
- Identify Type of referral request  
  - Consult only (address clinical question and send report back) and referring clinician will follow up with needed tests  
  - Consult and Treat (address clinical question and follow up with appropriate plan of care and treatment)  
  - Transfer of care (Comprehensive care for all patient needs is transferred to the specialist)  
- Provide patient demographics; clinical information (allergies, problem list, medications)  
- Send current primary practice care plan/clinical summary (Treatment, tests, procedures- to avoid duplication  
- Expectation that communication back to patient on treatment options and test results if consult only |
### PCMH 5B, Factor 8: Example Referral Tracking Report

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

<table>
<thead>
<tr>
<th>Referring Dr</th>
<th>Ref Date</th>
<th>Patient Name/DOB</th>
<th>Facility/Physician</th>
<th>Diagnosis/Reason for Referral</th>
<th>Appt Date</th>
<th>Ins. Info/PRE-AUTH., IF Needed</th>
<th>Stat</th>
<th>RCVD. Report</th>
<th>Report Overdue</th>
<th>Person &amp; Date Notif. Pt.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5/16/2015</td>
<td></td>
<td>Diagnostic Imaging</td>
<td>Abd. pain; abdom. Soc.</td>
<td>5/19/2015</td>
<td>HEALTH PLAN-got pre-author.</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5/16/2015</td>
<td></td>
<td>PT and Rehab</td>
<td>Knee pain - eval. and treat.</td>
<td>TBD</td>
<td>HEALTH PLAN-got pre-author.</td>
<td>No</td>
<td></td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6/22/2015</td>
<td></td>
<td>Orthopedist</td>
<td>Suspect torn ACL - eval.</td>
<td>6/24/2015</td>
<td>- no pre-author. needed</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**The Practice:**

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

*Meaningful Use Modified Stage 2 Alignment

*->10% threshold will be accepted as of 11/16/2015
PCMH 5C: Scoring and Documentation

6 Points
Scoring

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

• **F1-6**: Documented process to identify patients and
  • **F1**: Log or report.
  • **F2**: Three examples for each factor.
  • **F3**: Three examples of discharge summary
  • **F4**: Three examples of patient follow-up or log documenting systematic follow-up
  • **F5**: One example of 2 way communication.
• **F7**: Report with numerator, denominator and percent with at least 3 months of data. If practice does not transfer patients to another facility, it may select N/A and provide a written explanation.
PCMH 5C, Factors 1-4 Documented Process

**Effective Date 6/1/14**

**Procedure:**

- **5C-1**
  - Hospital census is obtained daily by fax or from an offsite electronic Health Information System from local hospitals by the Care Coordinator or Nurse Care Manager.
  - Communication with local hospitals is completed daily.
  - Discharge records are faxed to the offsite Health Information System by the Care Coordinator or Nurse Care Manager.
  - Local hospitals are contacted if additional information is needed.

- **5C-2**
  - After thorough review and obtaining hospital records the Care Coordinator will give the daily census to the Nurse Care Manager for review.
  - Nurse Care Manager will be responsible for assuring the medical records were received and scanned into the chart.

- **5C-4**
  - Nurse Care Manager or Care Coordinator (if designated) will be responsible for contacting patient’s that were admitted and discharged from the hospital within 72 hours to ensure medications and allergies are reconciled in the patient’s chart, schedule follow up appointment’s if needed and obtain additional information as needed.
## PCMH 5C, Factor 1: Example ER Visit

### Follow-Up Log

<table>
<thead>
<tr>
<th>Date of ER Visit</th>
<th>Diagnosis</th>
<th>Follow up call</th>
<th>Follow up appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SOB</td>
<td>We admitted pt</td>
<td>Pt has problems with providing care for his wife.</td>
</tr>
<tr>
<td></td>
<td>Cath drop</td>
<td>Yes</td>
<td>no f/u necessary</td>
</tr>
<tr>
<td></td>
<td>Fever dialysis pt</td>
<td>F/u to specialist</td>
<td>no f/u with us</td>
</tr>
<tr>
<td></td>
<td>Injured L. Hand</td>
<td>no f/u necessary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diarrhea, fever, vomiting</td>
<td>Told to go to ER</td>
<td>Pt told to go to Er by us</td>
</tr>
<tr>
<td></td>
<td>Flu</td>
<td>F/u scheduled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Leg Bleed</td>
<td>F/u scheduled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dialysis Pt C/p</td>
<td></td>
<td>Pt referred to pt assist for meds</td>
</tr>
<tr>
<td></td>
<td>Blood Test</td>
<td>F/u scheduled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sodium Level</td>
<td>f/u scheduled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dropped Ams</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chest Pain</td>
<td>Pt has been called</td>
<td>Not been in since</td>
</tr>
</tbody>
</table>
Practice receives admission reports electronically from hospital.
PCMH 5C, Factors 3 & 4 Example

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

Proactively obtaining discharge summary and patient contact for follow-up care
PCMH 6: Performance Measurement and Quality Improvement
PCMH 6: Performance Measurement and Quality Improvement

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

**Meaningful Use Alignment**
Practice uses certified EHR to:
- Protect health information
- Submit electronic data to registries
- Submit electronic syndromic surveillance data
- Identify and report cases
PCMH 6: Performance Measurement and Quality Improvement

20 points

Elements

Element A: Measure Clinical Quality Performance
Element B: Measure Resource Use and Care Coordination
Element C: Measure Patient/Family Experience
Element D: Implement Continuous Quality Improvement

MUST PASS

Element E: Demonstrate Continuous Quality Improvement
Element F: Report Performance
Element G: Use Certified EHR Technology
At least annually the practice measures or receives data on:

1. At least two immunization measures
2. At least two other preventive care measures
3. At least three chronic or acute care clinical measures
4. Performance data stratified for vulnerable populations (to assess disparities in care)
“Those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability.”

Source: AHRQ
Vulnerable vs. High-risk

- Confusion about these items
- High-risk patients with clinical conditions and other factors that could lead to poor outcomes for those conditions
- Vulnerable characteristics that could lead to different access or quality of care
  - Looking for disparities in care/service
  - Vulnerable patients need not have current clinical conditions
PCMH 6A: Scoring and Documentation

3 points

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

**Documentation**
- F1-4: Reports showing performance

**Initial Submission**: Data report as required for each factor, no more than 12 months old. Annual data for two years **NOT** needed.

**Renewing Practice**: Attestation, if level 2 or 3.
### PCMH 6A, Factors 1-3: Example Preventive & Chronic Measures

<table>
<thead>
<tr>
<th>Health Maintenance Topic</th>
<th>In compliance</th>
<th>Overdue</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breast Cancer Screening</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/1/14 – 12/31/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>51.05%</td>
<td>48.95%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>1,381</td>
<td>1,324</td>
<td>2,705</td>
</tr>
<tr>
<td><strong>Colon Cancer Colonoscopy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>63.35%</td>
<td>36.65%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>1,965</td>
<td>1,137</td>
<td>3,102</td>
</tr>
<tr>
<td><strong>Pneumococcal Vaccine</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>83.11%</td>
<td>28.36%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>743</td>
<td>350</td>
<td>1,234</td>
</tr>
<tr>
<td><strong>Foot Exam</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>74.84%</td>
<td>25.16%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>992</td>
<td>350</td>
<td>1,342</td>
</tr>
<tr>
<td><strong>Hemoglobin A1C</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>71.64%</td>
<td>28.36%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>884</td>
<td>350</td>
<td>1,234</td>
</tr>
<tr>
<td><strong>Urine Microalbumin/Creatinine Ratio</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>67.13%</td>
<td>32.87%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>825</td>
<td>404</td>
<td>1,229</td>
</tr>
</tbody>
</table>
## PCMH 6A, Factor 4: Example Data for Vulnerable Populations

<table>
<thead>
<tr>
<th>Race</th>
<th># patients by race</th>
<th>% patients by race</th>
<th># patients w/A1C done by race</th>
<th>% patients w/A1C done by race</th>
<th># patients w/LDL done</th>
<th>% patients w/LDL done</th>
<th># patients w/eye exam done</th>
<th>% patients w/eye exam done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>76</td>
<td>2%</td>
<td>70</td>
<td>92%</td>
<td>66</td>
<td>87%</td>
<td>36</td>
<td>47%</td>
</tr>
<tr>
<td>Black</td>
<td>1620</td>
<td>38%</td>
<td>1528</td>
<td>94%</td>
<td>1328</td>
<td>82%</td>
<td>737</td>
<td>45%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>2160</td>
<td>51%</td>
<td>2017</td>
<td>93%</td>
<td>1835</td>
<td>85%</td>
<td>994</td>
<td>46%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>58</td>
<td>1%</td>
<td>51</td>
<td>88%</td>
<td>46</td>
<td>79%</td>
<td>17</td>
<td>29%</td>
</tr>
<tr>
<td>Other</td>
<td>77</td>
<td>2%</td>
<td>68</td>
<td>88%</td>
<td>62</td>
<td>81%</td>
<td>22</td>
<td>29%</td>
</tr>
<tr>
<td>Unidentified</td>
<td>278</td>
<td>7%</td>
<td>247</td>
<td>89%</td>
<td>216</td>
<td>78%</td>
<td>101</td>
<td>36%</td>
</tr>
<tr>
<td>TOTAL PATIENTS</td>
<td>4269</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
At least annually the practice measures or receives quantitative data on:

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

Scoring

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

Documentation

• F1-2: Reports showing performance

Initial Submission: Data report as required for each factor, no more than 12 months old. Annual data for two years NOT needed.

Renewing Practices:

Factor 1: Data report as required (no more than 12 months old). Annual data for two years NOT needed.

Factor 2: At least annually for at least two years (current year and a previous year).
Use of MU Reports to Meet 6B, Factor 1

6B1 (care coordination) - may be met with MU Reports

- 5B7 and 5C7 (Modified Stage 2 Objective 5)
- 4C1 (Modified Stage 2 Objective 7)
PCMH 6B, Factor 2 : Example Measures Affecting Health Care Costs

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

Readmission within 30 days showing improvement

01/01/11-12/31/11 Baseline
PCMH 6C: Measure Patient/Family Experience

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

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

- Knowledge of patient as a person
- Life style changes
- Support for self-care/self-monitoring
- Shared decisions about health
- Patient ability to monitor their health
4 points

**Scoring**

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

**Documentation**

- **F1-4:** Reports showing results of patient feedback

**Initial Submission:** Data report as required for each factor, no more than 12 months old. Annual data for two years NOT needed.

**Renewing Practices:** Attestation for level 2 or 3.
## PCMH 6C: Example Patient Experience Survey Results

### Survey Results:

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

<table>
<thead>
<tr>
<th>Measure</th>
<th>Denominator</th>
<th>Previous Score</th>
<th>Provider Score</th>
<th>Practice Score</th>
<th>Project Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate provider 0 - 10</td>
<td>11</td>
<td>100.00%</td>
<td>81.82%</td>
<td>78.91%</td>
<td>79.88%</td>
</tr>
<tr>
<td>How long wait for urgent appt</td>
<td>3</td>
<td>50.00%</td>
<td>33.33%</td>
<td>38.59%</td>
<td>46.55%</td>
</tr>
<tr>
<td>Office gave info re: after hours care</td>
<td>11</td>
<td>100.00%</td>
<td>72.73%</td>
<td>59.76%</td>
<td>65.58%</td>
</tr>
<tr>
<td>Get reminders between visits</td>
<td>11</td>
<td>100.00%</td>
<td>72.73%</td>
<td>75.29%</td>
<td>69.94%</td>
</tr>
<tr>
<td>Someone follow up with results</td>
<td>10</td>
<td>66.67%</td>
<td>80.00%</td>
<td>65.09%</td>
<td>65.48%</td>
</tr>
<tr>
<td>Informed and up-to-date on specialist care</td>
<td>7</td>
<td>100.00%</td>
<td>71.43%</td>
<td>62.57%</td>
<td>60.88%</td>
</tr>
<tr>
<td>Talk about prescription</td>
<td>11</td>
<td>100.00%</td>
<td>81.82%</td>
<td>88.89%</td>
<td>82.77%</td>
</tr>
<tr>
<td>Rate overall health</td>
<td>11</td>
<td>0.00%</td>
<td>0.00%</td>
<td>8.78%</td>
<td>7.60%</td>
</tr>
<tr>
<td>Rate overall mental/emotional health</td>
<td>11</td>
<td>33.33%</td>
<td>27.27%</td>
<td>21.15%</td>
<td>20.68%</td>
</tr>
<tr>
<td>Access</td>
<td>35</td>
<td>64.29%</td>
<td>60.00%</td>
<td>46.00%</td>
<td>47.38%</td>
</tr>
<tr>
<td>Communication</td>
<td>64</td>
<td>100.00%</td>
<td>82.81%</td>
<td>79.68%</td>
<td>81.78%</td>
</tr>
<tr>
<td>Shared Decision Making</td>
<td>24</td>
<td>100.00%</td>
<td>83.33%</td>
<td>58.43%</td>
<td>64.81%</td>
</tr>
<tr>
<td>Self Management Support</td>
<td>22</td>
<td>50.00%</td>
<td>50.00%</td>
<td>42.89%</td>
<td>46.33%</td>
</tr>
<tr>
<td>Comprehensiveness-Adult Behavioral</td>
<td>33</td>
<td>33.33%</td>
<td>51.52%</td>
<td>33.64%</td>
<td>40.37%</td>
</tr>
<tr>
<td>Office Staff</td>
<td>22</td>
<td>66.67%</td>
<td>81.82%</td>
<td>67.77%</td>
<td>67.36%</td>
</tr>
</tbody>
</table>

Open Month: January, 2012  
Close Month: March, 2012  
Responses in Period: 12
PCMH 6D: Implement Continuous Quality Improvement

Practice uses ongoing quality improvement process:

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

Must Pass

4 Points

Scoring

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

Documentation

• F1-7: Report or completed PCMH Quality Measurement and Improvement Worksheet
NCQA PCMH 2014 Quality Measurement and Improvement Worksheet

PURPOSE: The purpose of the worksheet is to help practices organize the measures and quality improvement activities that are required in PCMH 6, Elements D and E. Please consult PCMH 6, Elements A, B, C, D and E 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.

QUALITY MEASUREMENT & IMPROVEMENT ACTIVITY STEPS:

1. Identify measures for quality improvement – From measures selected in elements 6A, B, and C as well as a disparity measure, practice will identify a total of six (6) measures comprised of the following: from 6A (3) clinical quality measures; from 6B (1) resource use and/or care coordination measure; from 6C (1) patient/family experience measure; (1) measure focused on vulnerable populations, does not need to be same as identified in 6A.

2. Identify a baseline performance assessment – Choose a starting measurement period (start and end date) and identify a baseline rate for each measure. You may use rates from the reports provided in PCMH 6A, B, C. The baseline measurement period MUST be within 24 months prior to the tool submission if there is a re-measurement period. Otherwise, the measurement period MUST be within 12 months prior to tool submission. The performance rate MUST be a percentage or number.

3. Establish a performance goal - Generate at least one performance goal for each identified measure. Specific rate goal MUST be a percentage or number. Simply stating that the practice intends to...

4. Determine what actions to take to work towards performance goals - List at least one action for each identified measure taken towards meeting the performance goal. Include the start date of the activity. The action date MUST occur after the date of the baseline performance assessment date. You may list more than one activity but are not required to do so. (Applies to 6D 2, 4, 6)

   Note: If the action period overlapped with some or all of the baseline measurement period, and the practice does not have earlier measurements to report, the practice should provide an analysis of the impact of the action on the baseline measure (e.g., ‘this would tend to increase the baseline measure’)

5. Re-measure performance based on actions taken – Choose a re-measurement period and generate a new performance rate after action was taken to improve. The re-measurement date MUST occur after the date the action was implemented and MUST be within in 12 months prior to tool submission. If the action was not complete before the re-measurement period, the practice should estimate the completion rate of the action, to evaluate its impact on any re-measurement. It is up to the practice to determine its next follow-up period. (Applies to 6E 2-4)

   Note: To receive credit for 6E Factor 3, the re-measurement rate must show...
**NCQA PCMH 2014 Quality Measurement and Improvement Worksheet**

**EXAMPLE ON HOW TO COMPLETE A ROW:**

<table>
<thead>
<tr>
<th>Measure 1: Colorectal cancer (CRC) screening</th>
<th>1. Measure Selected for Improvement &amp; Reason for Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason: We want to increase percentage of patients who receive screening for CRC.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. &amp; 3. Baseline Performance Measurement &amp; Numeric Goal for Improvement (6D 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Start Date: 5/1/14   Baseline End Date: 5/30/14   Baseline Performance Rate (% or #): 36.3%</td>
</tr>
<tr>
<td>Numeric Goal Rate (% or #): 58%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. What actions were taken to improve and work towards goal? Provide dates actions were initiated. (6D 2) (Only 1 Action Required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action: Pop up reminders were added to our EMR for patients. Date Action Initiated: 7/1/14</td>
</tr>
<tr>
<td>Additional Actions Taken: Provider quality compensation mechanism to providers to ensure appropriate health screening</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Re-measure Performance (6E 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start Date: 5/1/15   End Date: 5/30/15   Rate (% or #): 69.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Assess Actions &amp; Describe Improvement (6E 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Since September 2014, there has been an increase of 32.9% 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.</td>
</tr>
</tbody>
</table>

- ✔ Clinical Activities
- ✔ Disparities in Care
- ✔ Patient/Family Experience
- ✔ Measure (D)
- ✔ Opportunity Identified (D)
- ✔ Initial Performance/Measurement Period (D)
- ✔ Performance Goal (D)
- ✔ Action Taken and Date (E)
- ✔ Re-measurement Performance (E)
Practice demonstrates continuous quality improvement:

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

**Scoring**

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

**Documentation**

- F1-4: Reports or completed Quality Measurement and Improvement Worksheet
## PCMH 6E: Example Tracking Data Over Time

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immunizations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumovax</td>
<td>61.31</td>
<td>61.21</td>
<td>52.25</td>
<td>61.39</td>
<td>60.95</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HgA1C</td>
<td>73.39</td>
<td>73.48</td>
<td>74.12</td>
<td>74.11</td>
<td>71.54</td>
</tr>
<tr>
<td><strong>CHF</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ace Inhibitors</td>
<td>99.18</td>
<td>99.58</td>
<td>99.69</td>
<td>99.13</td>
<td>99.56</td>
</tr>
<tr>
<td><strong>CAD</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antihyperlipidemic</td>
<td>99.07</td>
<td>99.05</td>
<td>99.65</td>
<td>98.67</td>
<td>98.87</td>
</tr>
</tbody>
</table>
PCMH 6E: Example Patient Survey Results Over Time
Practice produces performance data reports and shares data from **Elements A, B and C:**

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

3 Points

Scoring

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

Documentation

- F1,2: Reports (blinded) showing summary data by clinician and across the practice shared with practice and how results are shared
- F3: Example of reporting to public
- F4: Example of reporting to patients
PCMH 6F: Example Reporting by Individual Clinician

Blinded 6 Clinicians

Diabetes A1c Control

Percent in each range

A1C >= 9
A1C 7-9
A1C <= 7
No A1C
### PCMH 6F: Example Practice Level Diabetes Data

#### Show data for

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

#### Graphs

- **Count of DM patients 18-75 yo**
  - Graph showing the trend from Jan-08 to Nov-08.

- **Pct of DM patients with latest LDL <100**
  - Graph showing the trend from Jan-08 to Nov-08.

- **Pct of DM patients with latest BP <=130/80**
  - Graph showing the trend from Jan-08 to Nov-08.

- **Pct of DM patients with eye exam**
  - Graph showing the trend from Jan-08 to Nov-08.
PCMH 6F: Example Reporting Across Practice(s)

Shows data for multiple sites

<table>
<thead>
<tr>
<th>QUALITY MEASURE</th>
<th>DM - Diabetic Eye Exam</th>
<th>DM - HbA1c</th>
<th>DM - HbA1c - Level of Control - &lt;7.0%</th>
<th>DM - HbA1c - Level of Control - &gt;9.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Patients Screened (at Sites Only) within the Past Year</td>
<td>54%</td>
<td>84%</td>
<td>45%</td>
<td>9%</td>
</tr>
<tr>
<td>% of Patients Screened within the Past Year</td>
<td>-</td>
<td>83%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>% of Tested Patients with Lab Results &lt;7.0%</td>
<td>57%</td>
<td>85%</td>
<td>41%</td>
<td>6%</td>
</tr>
<tr>
<td>% of Tested Patients with Lab Results &gt;9.0%</td>
<td>54%</td>
<td>87%</td>
<td>39%</td>
<td>12%</td>
</tr>
</tbody>
</table>

* Denotes significant difference

NCQA Measuring quality Improving health care
PCMH 6G: Use Certified EHR Technology

Practice uses a certified EHR system:

1. Uses EHR system (or module) that has been certified and issued a CMS certification ID

2. Conducts a security risk analysis of its EHR system (or module), implements security updates and corrects identified security deficiencies

3. Demonstrates capability to submit electronic syndromic surveillance data to public health agencies electronically

+ Meaningful Use Modified Stage 2 Alignment
++CMS Meaningful Use Requirement
4. Demonstrates capability to identify and report cancer cases to public health central cancer registry electronically+

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

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

+ Meaningful Use Modified Stage 2 Alignment
++CMS Meaningful Use Requirement
7. Demonstrates the capability to submit electronic data to immunization registries or immunization information systems electronically.

8. Has access to a health information exchange.

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

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

+ Meaningful Use Modified Stage 2 Alignment
PCMH 6G: Scoring and Documentation

0 Points

Scoring
- 100% Not scored
- 75% Not scored
- 50% Not scored
- 25% Not scored
- 0% Not scored
- NA Factors – 4, 5, 7

Documentation
- Attestation
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- Questions about your user ID, password, access