Agenda Part 1

• Content of PCMH 2014 Standards and Guidelines
  – Standards 1 - 3
  – Documentation Examples*

Agenda Part 2

• Content of PCMH 2014 Standards and Guidelines
  – Standards 4 - 6
  – Documentation Examples*

*Examples in the presentation only illustrate the element intent. They are NOT definitive nor the only methods of documenting how the requirements may be met.
### PCMH 2014 Content and Scoring
(6 standards/27 elements)

#### 1: Enhance Access and Continuity

<table>
<thead>
<tr>
<th>A. *Patient-Centered Appointment Access</th>
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<tr>
<td></td>
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<td>B. 24/7 Access to Clinical Advice</td>
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<td>C. Electronic Access</td>
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#### 2: Team-Based Care

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<td>B. Medical Home Responsibilities</td>
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<td>C. Culturally and Linguistically Appropriate Services (CLAS)</td>
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#### 3: Population Health Management

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<td>B. Clinical Data</td>
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<td>C. Comprehensive Health Assessment</td>
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<td>D. *Use Data for Population Management</td>
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<tr>
<td>E. Implement Evidence-Based Decision-Support</td>
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#### 4: Plan and Manage Care

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<th>A. Identify Patients for Care Management</th>
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<tr>
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<tr>
<td>B. *Care Planning and Self-Care Support</td>
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<tr>
<td>C. Medication Management</td>
<td>4</td>
</tr>
<tr>
<td>D. Use Electronic Prescribing</td>
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<tr>
<td>E. Support Self-Care and Shared Decision-Making</td>
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#### 5: Track and Coordinate Care

<table>
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<th>A. Test Tracking and Follow-Up</th>
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<tr>
<td>B. *Referral Tracking and Follow-Up</td>
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<tr>
<td>C. Coordinate Care Transitions</td>
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#### 6: Measure and Improve Performance

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<th>A. Measure Clinical Quality Performance</th>
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<tr>
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<tr>
<td>B. Measure Resource Use and Care Coordination</td>
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</tr>
<tr>
<td>C. Measure Patient/Family Experience</td>
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<tr>
<td>D. *Implement Continuous Quality Improvement</td>
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<tr>
<td>E. Demonstrate Continuous Quality Improvement</td>
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</tr>
<tr>
<td>F. Report Performance</td>
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</tr>
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<td>G. Use Certified EHR Technology</td>
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</table>

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

**Must Pass Elements**
PCMH 4: Care Management and Support
### PCMH 4: Care Management and Support

<table>
<thead>
<tr>
<th><strong>Intent</strong></th>
<th><strong>Meaningful Use Alignment</strong></th>
</tr>
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</table>
| The practice systematically identifies individual patients and plans, manages and coordinates care, based on need. | • Practice implements evidence-based guidelines  
• Practice reviews and reconciles medications with patients  
• Practice uses e-prescribing system  
• Patient-specific education materials |
PCMH 4: Care Management and Support

20 Points

Elements

- Element A: Identify Patients for Care Management
- Element B: Care Planning and Self-Care Support
  MUST PASS
- Element C: Medication Management
- Element D: Use Electronic Prescribing
- Element E: Support Self-Care and Shared Decision-Making
PCMH 4A: Identify Patients for Care Management

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

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

- F1. Behavioral Health
- F2. High Cost/High Utilization
- F3. Poorly Controlled/Complex Conditions
- F4. Social Determinants of Health
- F5. Nomination
- F6. Patients Identified for Care Management
**PCMH 4A: Identifying Patients**

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

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

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

4 Points

Scoring

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

Documentation

- F1-5:
  1) Report from electronic system or submission of Record Review Workbook
  and
  2) Example of how each factor is met
### 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): _____ (list all areas)</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>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  

5. Treatment Options:  
List all that apply  

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

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

8. Signed:  
MD  

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

Elements PC MH 4B and 4C

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

Two methods to collect and submit patient data

- Method #1 - report from the electronic system
- Method #2 - Record Review Workbook (RRWB)
  - Excel workbook in the Survey Tool
  - Tool to identify sample of patients and abstract data needed for Elements 4B and 4C
RRWB: Look at Instructions

Two Tabs:
- Instructions
- Record Review

Purpose of the Record Review Workbook

There are three elements in PCMH 2014 that require an accurate estimate of the percentage of the patients for whom you have documented the required information in the medical records of the sample of patients. The elements are:

PCMH 3C—Comprehensive Health Assessment: Number of factors the practice consistently enters information in the medical record for at least 50% of the patients.

PCMH 4B—Care Planning and Self-Care Support: Number of factors for which the practice consistently enters information in the patient’s medical record.

PCMH 4C—Medication Management: Number of factors for which the practice consistently enters information in the patient’s medical record. NOTE: Factor 1 is a Critical Factor and thus required for the practice to score any points.

There are two methods for collecting data for these elements.

Method 1. Query your electronic medical records or other electronic patient records to obtain the information.

Method 2. Review a sample of 30 patient records to obtain the information. (Note: Patient records may be a registry or electronic records or paper medical records)

Refer to each element in the PCMH 2014 standards for details about scoring PCMH 3C, 4B, and 4C.

If you can use Method 1 (above) to respond to these elements, you can enter the responses directly into the Survey Tool and you do not need to use this Record Review Workbook. If you cannot use Method 1, you must use Method 2 to respond to these elements and must fill out the Patient Conditions and Record Review Worksheets. You may respond to some elements with Method 1 and others with Method 2.

General Notes on the Record Review Worksheet

The Record Review Workbook is color coded for your input as follows.
- Gray shading indicates that no input is required - you cannot enter data in these cells
- White (or no) shading indicates that input is required
RRWB: Overview of Steps for Method 2

1. **Locate** RRWB file in Survey Tool

2. **Download and save** file to computer

3. **Review** RRWB instructions (Tab 1) and data needed from patient records

4. **Select patient records to review**

5. **Review patient records for data**
RRWB: Overview of Steps for Method 2 (cont.)

6. **Enter data** in RRWB (Tab 2)

7. **Enter** Yes/No responses from RRWB in Survey Tool for Elements 4B and 4C

8. **Attach** RRWB to Survey Tool and link to Elements 4B and 4C and 3C
## Record Review Workbook

### NCQA’s Patient-Centered Medical Home (PCMH) 2014 Record Review Worksheet

Please read the Workbook Instructions before completing this worksheet.

**IMPORTANT NOTE:** Read the instructions to determine if your practice can select the “not used” option available in the drop-down boxes for Patient Number 1.

<table>
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<tr>
<th>Organization Name:</th>
<th>Completion Date:</th>
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</table>

<table>
<thead>
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<th>3</th>
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PCMH 4C: Medication Management

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

1. Reviews and reconciles medications for more than 50 percent of patients received from care transitions. (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.

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

4 Points

Scoring

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

Documentation

• F1-6:
  ✓ Report from electronic system or submission of Record Review Workbook and
  ✓ Example of how each factor is met
PCMH 4D: Use Electronic Prescribing

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

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

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


4. Alerts prescribers to generic alternatives.

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

**3 Points**

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

Factors - 1,2 may be N/A

**Documentation**
- **F1, 2:** Report with a numerator and denominator and screenshot
- **F3, 4:** Screen shots demonstrating functionality
## PCMH 4D: Example Electronic Prescription Writing

### Prescription Writing Activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>%</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic</td>
<td>57%</td>
<td>2563 Rx</td>
</tr>
<tr>
<td>Printed, given to patient</td>
<td>31%</td>
<td>1419 Rx</td>
</tr>
<tr>
<td>Print, fax to pharmacy</td>
<td>1%</td>
<td>89 Rx</td>
</tr>
</tbody>
</table>

**TOTAL**

<table>
<thead>
<tr>
<th>Rx</th>
<th>4474 Rx</th>
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<tbody>
<tr>
<td>% E-RX</td>
<td>57%</td>
</tr>
<tr>
<td>% Entered in EHR</td>
<td>100%</td>
</tr>
</tbody>
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Limitations of electronic prescribing are primarily due to restrictions for submitting Schedule 2, 3, or 4 drugs electronically and an inability to submit eRx to pharmacy benefit managers (e.g., CareMark, ExpressScripts).

As such, some Prescriptions may be marked as “Handwritten” for Schedule 2, 3, or 4 drugs depending upon the provider and the patient. Schedule 2, 3 and 4 Narcotic medications must be submitted via paper or phone. Providers will receive warning messages when trying to prescribe Narcotic Medications electronically.

All full-time faculty and resident physicians are registered with SureScripts for eRx.

---

NCQA
Measuring quality, improving health care.
PCMH 4D, Factor 1: Example Prescribing Decision Support - Formulary Drug

Patient: [Redacted]
Age: 56 yr
Gender: M
DOB: [Redacted]
Primary Physician: [Redacted]
ID#: [Redacted]

Today: Aug 21 2008
Phone Rx on Aug 21 2008
Clinician: GLORIA TRUJILLO (PFAM)

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

Off Formulary

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
PCMH 4E: Support Self-Care and Shared Decision-Making

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

The practice:

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

+ Core Meaningful Use Requirement(s)
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.
PC MH 4E: Scoring and Documentation

5 Points

Scoring

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

Documentation

• **F1:** Report
• **F2-5:** Examples of at least three examples of resource, tools, aids.
• **F6:** Materials demonstrating practice offers at least five resources
• **F7:** Materials/data collection on usefulness of referrals to community resources.
# PCMH 4E, Factor 3: Example Self-Management Tool

## Diabetes Health Record

<table>
<thead>
<tr>
<th>Test</th>
<th>Frequency</th>
<th>Common Goals</th>
<th>Individual Goals</th>
<th>My results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review blood sugar records</td>
<td>every visit</td>
<td>less than 130</td>
<td>less than 180</td>
<td></td>
</tr>
<tr>
<td>Pre-meal target:</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>
</tr>
<tr>
<td>Blood pressure</td>
<td>every visit</td>
<td>less than 140/80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight (set realistic goals)</td>
<td>every visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot exam</td>
<td>every visit</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>
</tr>
<tr>
<td>Urine microalbumin/creatinine ratio</td>
<td>yearly</td>
<td>less than 30</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Prenatal Care: Steps Toward a Healthy Pregnancy
Prenatal Session #1
PROGRAM: Comprehensive Perinatal Services Program TIME: 1-1 1/2 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, LA 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 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
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

- PC MH5A: Test Tracking and Follow-Up
- PC MH5B: Referral Tracking and Follow-Up
- PC MH5C: Coordinate Care Transitions

MUST PASS
PCMH 5A: Test Tracking and Follow-Up

Practice has a documented process for and demonstrates that it:

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

*Meaningful Use Requirement
**PCMH 5A, Factors 1-6: Test Tracking/ Follow-Up**

**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 F1-6:**

1) Documented process for staff

   and

2) Report, log or evidence of process use

   and

3) Examples for each requirement in each factor
PCMH 5A, Factors 7-10: Test Tracking/ Follow-up (cont.)

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

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

*Meaningful Use Requirement

**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
PCMH 5A: Scoring and Documentation

6 Points

Scoring

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

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

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

5A Cont.

A report is generated indicating in process orders.

EMR, CareCast are all reviewed for the testing results.

Are the results in the EMR?

YES NO

Are the results in CareCast?

YES NO

Order is completed

Contact patient to follow-up and obtain documents.

Orders are completed upon receipt of test results.

Factor 1 and 2: The practice has a written process for staff tracking tests. Wakefield Ambulatory Care Center (WACC) 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.

The practice electronically communicates with labs and facilities to order tests and retrieve results. Ambulatory Care Center staff members review the Electronic Medical Record (EMR) for any lab and imaging results that were sent to patient charts.
### PCMH 5A: Example Electronic Test Tracking

<table>
<thead>
<tr>
<th>Date Ordered</th>
<th>Overdue</th>
<th>Abnormal</th>
<th>Priority</th>
<th>St.</th>
<th>Patient Name</th>
<th>Note</th>
<th># Orders</th>
<th>Provider</th>
<th>Order Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/07/2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>check 2 views: CT chest, wall, and neck (parathyroid, with image).</td>
</tr>
<tr>
<td>12/17/2008</td>
<td>Overdue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Overdue results are flagged</td>
</tr>
<tr>
<td>12/15/2008</td>
<td>Overdue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Abnormal results are flagged</td>
</tr>
<tr>
<td>01/19/2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Overdue results are flagged</td>
</tr>
<tr>
<td>01/16/2008</td>
<td>Overdue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Abnormal results are flagged</td>
</tr>
<tr>
<td>01/07/2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Overdue results are flagged</td>
</tr>
<tr>
<td>12/22/2008</td>
<td>Overdue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Overdue results are flagged</td>
</tr>
<tr>
<td>01/14/2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Abnormal results are flagged</td>
</tr>
</tbody>
</table>

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

**Practice tracks:**
- Date ordered
- Overdue
- Abnormal
- Priority
- Patient name
- Provider
- Order description
- Last appointment
- Next appointment
PCMH 5A, Factors 3&4: Documented Process/Flagging Abnormal Results

Patient Focused Oncology Quality Program
Policy and Procedure Manual

Title: Flagging Normal/Abnormal Lab Results
Author:                    Date: May 23, 2012
Approved:                 Effective Date:               Reference Number:  
Updates/_______:           1/10/13

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, FMR
### 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>A110376</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>
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: No one answered, no one picked up.

Factor 1 and 5: The PCP attempts to contact the patient following abnormal lab report results.
## PCMH 5A, Factor 9: MU Report

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

### Report Element

#### Description

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

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

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

### Report Period

The time period covered in the report

### Facility

Facility name

### Discrete Labs Ordered

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

### Discrete Results Received

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

### Discrete Results Received (>=40%)

Discrete Labs Ordered divided by Discrete Results Received

---

**Discrete Labs Report**

Period: 02/24/2013 - 02/23/2014

Report reflects data over a 12 month period.
PCMH 5B: Referral Tracking & Follow-Up

The Practice:

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

*Meaningful Use Requirement
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
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:** Documented process and Report or log based on one week of referrals

(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 Requirement

Documentation

F7: Report from electronic system with numerator, denominator and percent
At least 3 months of data
F6, 8, & 10: Documented process and
Report or log based on one week of referrals
F9: At least three examples
PC MH 5B: Scoring

MUST PASS

6 Points

Scoring

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

Must meet minimum of 4 factors (including factor 8) to pass this Must-Pass Element
Referring Provider – Cardiology Patient Referral Understanding 2013

Mutually agreed upon expectations outlined for Referring Providers and 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 timeframe / 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

- 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 patient portal account in order to better facilitate communication.
- Specialist will discuss plan of care with patient at time of visit, and will provide patient copy after visit is completed (After Visit Summary – either printed or electronically via patient portal).
- Specialist will follow up with patient:
  - at follow up appt
  - electronically via (tabs are auto-released within 96 hours)
  - via telephone if necessary

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)
### PCMH 5B, Factor 2: Co-Management

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

- **Areas managed by Rheumatology**
  - Active management of 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
### 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>
<tr>
<td>- Referral to specialist based on urgency</td>
</tr>
<tr>
<td>- Routine- within 2 weeks</td>
</tr>
<tr>
<td>- Urgent within 48 hours</td>
</tr>
<tr>
<td>- Stat within 24 hours</td>
</tr>
<tr>
<td>- Work specialist to expedite care in urgent cases</td>
</tr>
<tr>
<td>- Verify insurance status</td>
</tr>
<tr>
<td>- Anticipate special needs of patient/family</td>
</tr>
<tr>
<td>- Agree to engage/consult with specialist regarding a pre-referral consult if requested</td>
</tr>
<tr>
<td><strong>Communication (Referral from) (5B5)</strong></td>
</tr>
<tr>
<td>- State the clinical question and type of referral request</td>
</tr>
<tr>
<td>- Identify Type of referral request</td>
</tr>
<tr>
<td>- Consult only (address clinical question and send report back) and referring clinician will follow up with needed tests</td>
</tr>
<tr>
<td>- Consult and Treat- (address clinical question and follow up with appropriate plan of care and treatment)</td>
</tr>
<tr>
<td>- Transfer of care (Comprehensive care for all patient needs is transferred to the specialist)</td>
</tr>
<tr>
<td>- Provide patient demographics; clinical information (allergies, problem list, medications)</td>
</tr>
<tr>
<td>- Send current primary practice care plan/clinical summary (Treatment, tests, procedures- to avoid duplication</td>
</tr>
<tr>
<td>- Expectation that communication back to patient on treatment options and test results if consult only</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Communication (Referral from) (5B5)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- State the clinical question and type of referral request</td>
</tr>
<tr>
<td>- Identify Type of referral request</td>
</tr>
<tr>
<td>- Consult only (address clinical question and send report back) and referring clinician will follow up with needed tests</td>
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</tr>
<tr>
<td>- Expectation that communication back to patient on treatment options and test results if consult only</td>
</tr>
</tbody>
</table>
### PC MH 5B, Factor 8: Example Referral Tracking 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-AUTHOR., IF NEEDED</th>
<th>STAT</th>
<th>RCVD. REPORT</th>
<th>REPORT OVERDUE</th>
<th>PERSON &amp; DATE NOTIF. PT.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6/15/2000</td>
<td>1/21/1900</td>
<td>Diagnostic Imaging</td>
<td>Abd. pain, abdomen, Sono.</td>
<td>6/19/2000</td>
<td>HEALTH PLAN - got pre-author.</td>
<td>No</td>
<td>7/15/2000</td>
<td></td>
<td>7/17/00 - JCC</td>
</tr>
<tr>
<td></td>
<td>7/22/2000</td>
<td>10/10/1900</td>
<td>Orthopedist</td>
<td>Suspect torn ACL – eval. and treat</td>
<td>7/24/2000</td>
<td>No pre-author. needed</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Tracking Table Includes:**
- Reason for referral
- Purpose of referral
- Date referral initiated
- Timing to receive report
PCMH 5C: Coordinate Care Transitions

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

**6 Points Scoring**

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

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, may use N/A with note in text box.
PCMH 5C, Factors 1-4 Documented Process

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 CHCCM from the hospital or pulled from an 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 Documentation

<table>
<thead>
<tr>
<th>Facility:</th>
<th>Patient Type: Edit Preference</th>
<th>Status: Active</th>
</tr>
</thead>
</table>

#### Census Type: Patients (26)

<table>
<thead>
<tr>
<th>Use Selected</th>
<th>Use All</th>
<th>Add To Patient List</th>
<th>Remove</th>
<th>Remove from Group</th>
<th>Hide</th>
<th>Print Selected</th>
<th>Print</th>
<th>Pat. Name ▲</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Admission Date</th>
<th>Sex</th>
<th>Age</th>
<th>Location</th>
<th>Relationship</th>
<th>Admitting Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>65</td>
<td>32-3207-</td>
<td>Group</td>
<td>HYPOGLYCEMIA</td>
</tr>
<tr>
<td></td>
<td>Y</td>
<td>D</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>57</td>
<td>32-3221-</td>
<td>Group</td>
<td>ACUTE MYELOID LEUKEMIA SEVERE NEUROPATHY</td>
</tr>
<tr>
<td></td>
<td>Y</td>
<td>W</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>80</td>
<td>25-2509-</td>
<td>Group</td>
<td>ANEMIA FATIGUE RENAL INSUF</td>
</tr>
<tr>
<td></td>
<td>Y</td>
<td>D</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>84</td>
<td>32-3201-P</td>
<td>Group</td>
<td>LYMPHOMA</td>
</tr>
<tr>
<td></td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>59</td>
<td>15-1521-</td>
<td>Group</td>
<td>HEPATIC ENCEPHALOPATHY</td>
</tr>
<tr>
<td></td>
<td>Y</td>
<td>W</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>90</td>
<td>32-3204-P</td>
<td>Group</td>
<td>LEUKEMIA PNEUMONIA</td>
</tr>
<tr>
<td></td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>86</td>
<td>34-3411-P</td>
<td>Group</td>
<td>PERFORATED ULCER</td>
</tr>
<tr>
<td></td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**NCQA**

Measuring quality, improving health care.
### 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></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>Chest Pain</td>
<td>Pt has been called</td>
<td>Not been in since</td>
</tr>
</tbody>
</table>
PCMH 6: Performance Measurement and Quality Improvement
PCMH 6: Performance Measurement and Quality Improvement

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

**Meaningful Use Alignment**

*Practice uses certified EHR to:*
- Protect health information
- Generate preventive and follow-up care reminders
- Submit electronic data to registries
- Submit electronic syndromic surveillance data
- Identify and report cases
PCMH 6: Performance Measurement and Quality Improvement

**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)
Vulnerable Populations Defined

“Those who are made vulnerable by their

1. financial circumstances or place of residence,
2. health, age, personal characteristics,
3. functional or developmental status,
4. ability to communicate effectively, and
5. presence of chronic illness or disability.”

Source: AHRQ
Vulnerable vs. High-risk

• Confusion about these items
• High-risk patients with clinical conditions and other factors that could lead to poor outcomes for those conditions
• Vulnerable characteristics that could lead to different access or quality of care

✓ Looking for disparities in care/service
✓ Vulnerable patients need not have current clinical conditions
PMCH 6A: Scoring and Documentation

3 points

Scoring

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

Documentation

- **F1-4**: Reports showing performance
- **Initial submissions**
  - One measurement (no more than 12 months old); continue annually
- **Renewals**
  - Attestation if Level 2 or 3; then continue annually
## PCMH 6A, Factor 2: Example Preventive Care Measures

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

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

<table>
<thead>
<tr>
<th>Colorectal Cancer Screen Numerator</th>
<th>Colorectal Cancer Screen Denominator</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/2012-12/31/2012</td>
<td>754</td>
<td>3311</td>
</tr>
<tr>
<td>2/1/2013-4/30/2013</td>
<td>944</td>
<td>3497</td>
</tr>
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</table>
### PCMH 6A, Factors 2&3: Example Chronic & Preventive Measures

<table>
<thead>
<tr>
<th>Health Maintenance Topic</th>
<th>In compliance</th>
<th>Overdue</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>51.05%</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>Colon Cancer Colonoscopy</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>Pneumococcal Vaccine</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>Foot Exam</td>
<td>74.84%</td>
<td>25.16%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>992</td>
<td>350</td>
<td>1,232</td>
</tr>
<tr>
<td>Hemoglobin A1C</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>Urine Microalbumin/Creatinine Ratio</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>
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</table>
PCMH 6A, Factor 3: Example Chronic Care Clinical Measures

7. Control of lipids in diabetic patients

a. Percentage of patients with LDL <100 (desired range of control)

<table>
<thead>
<tr>
<th>HVR</th>
<th>Actual</th>
<th>Target</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Q1 04</td>
<td>41%</td>
</tr>
<tr>
<td></td>
<td>Q2 04</td>
<td>42%</td>
</tr>
<tr>
<td></td>
<td>Q3 04</td>
<td>44%</td>
</tr>
<tr>
<td></td>
<td>Q4 04</td>
<td>45%</td>
</tr>
<tr>
<td></td>
<td>Q1 05</td>
<td>45%</td>
</tr>
<tr>
<td></td>
<td>Q2 05</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>Q3 05</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>Q4 05</td>
<td>60%</td>
</tr>
</tbody>
</table>

Graph showing control of lipids in diabetic patients for Q1 04 and Q2 04.

b. Percentage of patients with LDL <130 (minimum desired range of control)

<table>
<thead>
<tr>
<th>HVR</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q2 03</td>
<td>61%</td>
</tr>
<tr>
<td></td>
<td>Q3 03</td>
<td>63%</td>
</tr>
<tr>
<td></td>
<td>Q4 03</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>Q1 04</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>Q2 04</td>
<td>64%</td>
</tr>
<tr>
<td></td>
<td>Q3 04</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>Q4 04</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>Q1 05</td>
<td>65%</td>
</tr>
</tbody>
</table>

Graph showing control of lipids in diabetic patients for Q2 03, Q3 03, and Q4 03.
### PCMH 6A, Factor 4: Example Data for Vulnerable Populations

<table>
<thead>
<tr>
<th>Race</th>
<th># of pts by race</th>
<th>total # of pts</th>
<th>% of pts by race</th>
<th># of pts with A1C done by race</th>
<th>total # of pts with A1C done by race</th>
<th>% of pts with A1C</th>
<th># of pts with LDL done by race</th>
<th>total # of pts with LDL done by race</th>
<th>% of pts with LDL</th>
<th>% of pts with EYE EXAM done by race</th>
<th>total # of pts with EYE EXAM done by race</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>76</td>
<td>4271</td>
<td>1.78%</td>
<td>70</td>
<td>4271</td>
<td>1.64%</td>
<td>66</td>
<td>4271</td>
<td>1.55%</td>
<td>36</td>
<td>4271</td>
</tr>
<tr>
<td>Black</td>
<td>1620</td>
<td>4271</td>
<td>37.93%</td>
<td>1528</td>
<td>4271</td>
<td>35.78%</td>
<td>1328</td>
<td>4271</td>
<td>31.09%</td>
<td>737</td>
<td>4271</td>
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<tr>
<td>Causasian</td>
<td>2160</td>
<td>4271</td>
<td>50.57%</td>
<td>2017</td>
<td>4271</td>
<td>47.23%</td>
<td>1835</td>
<td>4271</td>
<td>42.96%</td>
<td>994</td>
<td>4271</td>
</tr>
<tr>
<td>Hispanic</td>
<td>58</td>
<td>4271</td>
<td>1.36%</td>
<td>51</td>
<td>4271</td>
<td>1.19%</td>
<td>46</td>
<td>4271</td>
<td>1.08%</td>
<td>17</td>
<td>4271</td>
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<tr>
<td>Other</td>
<td>77</td>
<td>4271</td>
<td>1.80%</td>
<td>68</td>
<td>4271</td>
<td>1.59%</td>
<td>62</td>
<td>4271</td>
<td>1.45%</td>
<td>22</td>
<td>4271</td>
</tr>
<tr>
<td>Unidentified</td>
<td>278</td>
<td>4271</td>
<td>6.51%</td>
<td>247</td>
<td>4271</td>
<td>5.78%</td>
<td>216</td>
<td>4271</td>
<td>5.06%</td>
<td>101</td>
<td>4271</td>
</tr>
</tbody>
</table>
PCMH 6B: Measure Resource Use and Care Coordination

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

1. At least two measures related to care coordination

2. At least two utilization measures affecting health care costs
PCMH 6B: Scoring and Documentation

3 points

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

Documentation
• **F1-2:** Reports showing performance
• **Initial submissions:**
  • One measurement (no more than 12 months old); continue annually
• **Renewals:**
  • Factor 1: one measurement (no more than 12 months old)
  • Factor 2: once in each of last 2 yrs.; continue annually
PC MH 6B: Example Measures Affecting Health Care Costs

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

Readmission within 30 days showing improvement
PCMH 6C: Measure Patient/Family Experience

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

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

Survey questions may relate to the following:

- Knowledge of patient as a person
- Life style changes
- Support for self-care/self-monitoring
- Shared decisions about health
- Patient ability to monitor their health
Why Require CAHPS Patient-Centered Medical Home (PCMH) Survey?

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

4 points

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

Documentation
• **F1-4:** Reports showing results of patient feedback
• **Initial submissions**
  • One measurement (no more than 12 months old); continue annually
• **Renewals**
  • Attestation for Level 2 or 3; continue annually
### Survey Results:

**1/1/13 - 12/31/13**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Strongly Agree</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>I usually see my primary care provider for my appointments</td>
<td>7</td>
<td>34</td>
<td>77</td>
</tr>
<tr>
<td>I am able to schedule an appointment on the day I want it</td>
<td>10</td>
<td>50</td>
<td>54</td>
</tr>
<tr>
<td>If I am sick, I can get an appointment the same day for care</td>
<td>17</td>
<td>43</td>
<td>47</td>
</tr>
<tr>
<td>If I leave a message during office hours, I get a return call the same day</td>
<td>3</td>
<td>18</td>
<td>47</td>
</tr>
<tr>
<td>I know how to get care during evenings or on weekends</td>
<td>4</td>
<td>11</td>
<td>19</td>
</tr>
<tr>
<td>My questions are answered in a way that I can understand</td>
<td></td>
<td>31</td>
<td>87</td>
</tr>
<tr>
<td>I feel comfortable asking questions during my visit</td>
<td>1</td>
<td>30</td>
<td>87</td>
</tr>
<tr>
<td>I have a say in decisions about my care</td>
<td>2</td>
<td>36</td>
<td>79</td>
</tr>
<tr>
<td>The practice helps me make appointments for tests or specialists</td>
<td>5</td>
<td>46</td>
<td>63</td>
</tr>
<tr>
<td>The practice informs me about the results of blood tests or x-rays</td>
<td>2</td>
<td>3</td>
<td>40</td>
</tr>
<tr>
<td>My doctor or a nurse reviews my medications at each visit</td>
<td>4</td>
<td>44</td>
<td>64</td>
</tr>
<tr>
<td>When I come for a visit, my doctor has my test results in my chart</td>
<td>5</td>
<td>40</td>
<td>67</td>
</tr>
<tr>
<td>The practice reminds me when I need follow up appointments or screening tests</td>
<td>8</td>
<td>48</td>
<td>60</td>
</tr>
<tr>
<td>Overall I am satisfied with the care I receive at the practice</td>
<td>1</td>
<td>35</td>
<td>81</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>38.58%</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>

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
PCMH 6D: Quality Measurement & Improvement Worksheet

ELEMENT D - Implement Continuous Quality Improvement (MUST PASS)

The practice uses an ongoing quality improvement process to:

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

Scoring:

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets all 7 factors</td>
<td>The practice meets 6 factors</td>
<td>The practice meets 5 factors</td>
<td>The practice meets 1-4 factors</td>
<td>The practice meets 0 factors</td>
</tr>
</tbody>
</table>

Data Source:
Scope of Review:
Reference Information:

Explanation | Examples

Click here to access worksheet
**PCMH 6D: Quality Measurement and Improvement Template**

**NCQA’s Patient-Centered Medical Home (PCMH) 2014 Quality Measurement and Improvement Worksheet**

Practice  ____________________________  Date Completed  ____________

**How to Complete the Worksheet**

These instructions are a guide for completing NCQA’s PCMH Quality Measurement and Improvement Worksheet. The purpose of the worksheet is to assist organizations in understanding — and in outlining for NCQA — the measures and quality improvement activities that are required in PCMH 1 Element A, Factor 6 and PCMH 6, Elements D and E. Please note that practices are not required to submit the worksheet as documentation for PCMH 1 Element A, Factor 6 and/or PCMH 6, Elements D and E—it is provided as an option. Practices may submit their own report detailing their quality improvement strategy. Directions for attaching the worksheet are provided on the next page. See PCMH 1, Element A, PCMH 6, Elements A, B, C, D and E for additional information.

<table>
<thead>
<tr>
<th>Column</th>
<th>Section</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Measure</td>
<td>Identify at least one (1) measure of access from PCMH Element A, Factor 6, six (6) measures from PCMH 6, Elements A, B and C selected for your quality improvement strategy: at least three (3) clinical quality measures; at least one (1) measure focused on vulnerable populations; at least one (1) resource use and/or care coordination measure; and at least one (1) patient/family experience measure.</td>
</tr>
<tr>
<td>B</td>
<td>Opportunity Identified</td>
<td>List the opportunity for improvement that you have identified for each measure and on which you have decided to take action. You may list more than one identified opportunity for improvement per measure, but are not required to do so.</td>
</tr>
<tr>
<td>C</td>
<td>Initial Performance</td>
<td>List the initial (or baseline) performance rate and measurement period for each identified opportunity. You may use rates from the reports provided in PCMH 6A and B. Provide the performance rate as a specific percentage or number.</td>
</tr>
<tr>
<td>D</td>
<td>Performance Goal</td>
<td>List at least one performance goal for each identified opportunity. Provide the goal as a specific percentage or number.</td>
</tr>
<tr>
<td>E</td>
<td>Action Taken and Date of Implementation</td>
<td>List at least one action that you have taken in response to the identified opportunity. Include the start date of the activity. You may list more than one activity but are not required to do so.</td>
</tr>
<tr>
<td>F</td>
<td>Performance at Re-measurement</td>
<td>List the measurement period and the performance rate after action was taken to improve the initial (or baseline) rate. The date must occur after the activity implementation date.</td>
</tr>
<tr>
<td>G</td>
<td>Demonstrated Improvement</td>
<td>Describe the baseline and remeasurement period; describe the interventions implemented; and describe the link between interventions the practice implemented and the resulting rate improvement.</td>
</tr>
<tr>
<td>Measure</td>
<td>Opportunity Identified</td>
<td>Initial Performance/Measurement Period</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
</tbody>
</table>
| 1. Breast Cancer Screening     | Uninsured patients receive fewer mammograms than insured patients | 01/13-01/14: 25% of uninsured women receive mammograms | 50% of uninsured women receive mammograms | 20%; identified community resources for free or low-cost mammograms and shared with uninsured patients | 01/14-01/15: 40% of uninsured women receive mammograms | During a one year measurement period from Jan 2013 to Jan 2014, there was a 30 percentage point difference in screening rates between...

- ✓ Measure (D)
- ✓ Opportunity Identified (D)
- ✓ Initial Performance/Measurement Period (D)
- ✓ Performance Goal (D)
- ✓ Action Taken and Date (E)
- ✓ Re-measurement Performance (E)

✓ Clinical Activities
✓ Disparities in Care
✓ Patient/Family Experience
PCMH 6E: Demonstrate Continuous Quality Improvement

Practice demonstrates continuous quality improvement:

1. Measures effectiveness of actions to improve measures selected in Element 6D

2. Achieves improved performance on at least two clinical quality measures

3. Achieves improved performance on one utilization or care coordination measure

4. Achieves improved performance on at least one patient experience measure
PCMH 6E Scoring and Documentation

3 Points

Scoring

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

Documentation

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive</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>Antihyperlipidemetic</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

% Excellent

Q1. Wait
Q2. Location
Q3. Phone
Q4. Length
Q5. Time
Q6. Explanation
PCMH 6F: Report Performance

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

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

3 Points

Scoring

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

Documentation

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

Blinded 6 Clinicians

Diabetes A1c Control

Percent in each range

A1C >= 9
A1C 7-9
A1C <= 7
No A1C

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Measuring quality. Improving health care.
PCMH 6F: Example Practice Level Diabetes Data

Show data for

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

Goal

May-08

Pct of DM patients with latest BP <130/80
Pct of DM patients with eye exam
Pct DM pts w/ medical attention for nephropathy
Pct of DM patients with latest BP <=140/90
Pct of DM patients with latest LDL <=130
Pct of DM patients with current flu vaccination
Pct of DM patients with SM Goal

Goal

95
80
90
90
90
75
90
### PCMH 6F: Example Reporting Across Practice(s)

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Practice-Level Quality Performance Indicators</th>
<th>Current Quarter Site Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DM - Diabetic Eye Exam</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Patients Screened (Sites Only) within the Past Year</td>
<td>54%</td>
<td>54% 39% 60% 54% 43% 57% 66% 47% 54% 56% 53%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DM - HbA1c</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Patients Screened within the Past Year</td>
<td>84%</td>
<td>83% 85% 85% 85% 79% 83% 85% 87% 86% 83% 78%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DM - HbA1c - Level of Control - &lt;7.0%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Tested Patients with Lab Results &lt;7.0%</td>
<td>45%</td>
<td>41% 45% 39% 50% 41% 38% 50% 53% 45% 47% 34%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DM - HbA1c - Level of Control - &gt;9.0%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Tested Patients with Lab Results &gt;9.0%</td>
<td>9%</td>
<td>10% 5% 11% 6% 12% 11% 6% 6% 11% 8% 10%</td>
</tr>
</tbody>
</table>

* Shows data for multiple sites
PCMH 6G: Use Certified EHR Technology

Practice uses a certified EHR system:

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

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

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

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

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PCMH 6G: Use Certified EHR Technology (cont)

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

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

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

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

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

8. Has access to a health information exchange.

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

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

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

0 Points

Scoring

• 100% = Not scored
• 75%  = Not scored
• 50%  = Not scored
• 25%  = Not scored
• 0%   = Not scored
• N/A Factors 4, 5, 7 (PCMH 2014, 6G, Standards and Guidelines)

Documentation

• **F1-7:** Attestation
• **F8, 9:** Attestation and name of HIE
NCQA Resources Available

Free training each month [http://www.ncqa.org/rptraining.aspx](http://www.ncqa.org/rptraining.aspx)

- **Getting On Board**
  - Includes How to Submit as a Multi-site

- **Standards (2-part program)**

- **Software Training**
  - Using the ISS System
  - The Online Application
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 Training Schedule

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

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
Questions?