Introduction to PCMH: Foundational Concepts of the Medical Home
PCMH (2017 Version)

Eligibility
Requirements and Readiness
Eligibility Requirements

Outpatient primary care practices

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

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

- Recognition is achieved at the geographic site level -- one Recognition per address, one address per survey

- MDs, DOs, PAs, and APRNs with their own or shared panel are listed on the application

- Clinicians should be listed at each site where they routinely see a panel of their patients

- Non-primary care clinicians should not be included
Eligibility Requirements

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

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

All eligible clinicians at a site must apply together

Physicians in training (residents) should not be listed
• **Practices should have staff skilled to use a computer system** that includes the following:
  - Email & Internet access
  - Microsoft Word
  - Microsoft Excel
  - Adobe Acrobat Reader (available free online)
  - Screen sharing application

• **Access to the electronic systems** used by the practice, e.g. billing system, registry, practice management system, electronic prescription system, EHR, Web portal, etc.
Transformation may take 6-12 months

Your roadmap: PCMH 2017 Standards and Guidelines – everything covered

**Implement changes:**

- Practice-wide commitment
- New policies and procedures for staff
- Staff training and reassignments
- Medical record systems
- Reporting capabilities improvement
- Develop and organize documentation
PCMH 2017
Standards Overview & Scoring
2017 Standards Version Format

Structure – Concepts, Competencies, Criteria

**Concepts:** Over-arching components of PCMH

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

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

Concepts

Team-Based Care and Practice Organization (TC)

Knowing and Managing Your Patients (KM)

Patient-Centered Access and Continuity (AC)

Care Management and Support (CM)

Care Coordination and Care Transitions (CC)

Performance Measurement & Quality Improvement (QI)
PCMH Standards (2017 Version)

Structure - Example

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

**CONCEPT: A brief title describing the criteria; uses a two-letter abbreviation (XX).**

**Evidence: Proof that a practice meets the criteria. Evidence can be demonstrated by submitting documentation (e.g., policies and procedures, examples, data, reports) and through a virtual review of a practice’s systems and electronic capabilities.**

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

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

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

**TC 01 (Core)**

Designates a clinician lead and a staff person to manage the PCMH transformation and medical home activities.

**Criteria:** A brief statement highlighting the PCMH requirements. All criteria are numbered consecutively within their respective concept. Criteria are also labeled with their scoring designation:
- Core = Core criteria
- 1 Credit = Elective criteria
- 2 Credits = Elective criteria worth 2 Credits

**Evidence:**
- Details about the clinician lead
- Details about the PCMH manager

**Intent:** A brief statement describing the concept goals and intent.
PCMH Recognition

Changes to Levels
PCMH Recognition Scoring

Changes to Points

- **40 Core Criteria**: Must complete all 40 core
- **60 Elective Criteria**: Must achieve 25 Credits
PCMH 2017
Commit, Transform, Succeed
Recognition Process

3 Pathways

New Customer
Full Transform Process

Recognized PCMH 2011 Levels 1-3 & PCMH 2014 Levels 1-2
Accelerated Renewal Process (Transform w/ Attestation)

Recognized PCMH 2014 Level 3
Bypass Transform Direct to Sustaining Process
New Customers

Transform Steps

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

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

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

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

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

Multi-sites recognized under PCMH 2011 or PCMH 2014

- **Eligibility:** Organizations adding unrecognized practices during active PCMH 2011 or 2014 recognition (prior to expiration)

- Credit earned from the previous corporate survey tool can contribute toward recognition for their practices at an accelerated pace.
**Corporate Credit Transition Expectations**

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

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

What is the difference?

**Shared evidence**
May be submitted once for all sites or site groups.

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

**Site-specific data**
May be collected and submitted once on behalf of all sites or site groups if the evidence is stratified by site.
Transform “Check-in” process

Up to 3 “Check-ins” During Review

**Determine Criteria to Address**
- Focus on core & documented processes first
- Identify criteria for 25 elective credits

**Provide Documents for Offsite Review**
- Policies, procedures & protocols
- Website links
- Public information
- Attestation

**Provide Evidence during Virtual Review**
- Communicate with Evaluator
- Substitute evidence if not sufficient
- Demo systems
- Provide reports
Criteria Evidence Options

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

**Virtual Review**
- Reports (create in advance)
- System demo
- Patient examples

**Either Option**
- Practice decision*

*All PHI should be removed from documents uploaded in Q-PASS
Accelerated Renewal
Accelerated Renewal

*Eligibility*

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

- PCMH 2011
  Levels 1, 2, & 3

- PCMH 2014
  Levels 1 & 2
**Accelerated Renewal**

*Review & attestation by the numbers*

<table>
<thead>
<tr>
<th></th>
<th>Core</th>
<th>1 Credit</th>
<th>2 Credits</th>
<th>3 Credits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Review</strong></td>
<td>22 criteria</td>
<td>12 criteria</td>
<td>14 criteria</td>
<td>0 criteria</td>
</tr>
<tr>
<td><strong>Attestation</strong></td>
<td>18 criteria</td>
<td>26 criteria</td>
<td>7 criteria</td>
<td>1 criterion</td>
</tr>
<tr>
<td><strong>Total Criteria</strong></td>
<td><strong>40 criteria</strong></td>
<td><strong>38 criteria</strong></td>
<td><strong>21 criteria</strong></td>
<td><strong>1 criterion</strong></td>
</tr>
</tbody>
</table>

“Review or Attestation” indicates which criteria require submission of evidence and which criteria simply allow attestation.
Transform “Check-in” process

Checking in components

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

QPASS error message:

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

Please remove some components to proceed.

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

• Check-in 1 – minimum 30, maximum 70
• Check-in 2 – minimum 5, maximum 80
• Check-in 3 – minimum 1, no maximum
After Check-In

- Evaluator marks criteria “met”
- Practice can work on “not met” criteria
- NCQA staff will review questions arising from check-in
After 3 Check-Ins

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

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

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

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

<table>
<thead>
<tr>
<th>Attest to previous performance</th>
<th>Confirm practice information and make any clinician changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide evidence demonstrating continuing PCMH Activities</td>
<td>Annual fee payment or Approved Notice of Intent from HRSA</td>
</tr>
</tbody>
</table>
Annual Reporting Date

• **30 days** before Anniversary Date
• Must complete all Succeed steps prior to anniversary date

• **Date set upon initial Recognition**
  – Or 2014 Level 3 expiration date

• **Flexibility** to meet practice needs
Annual Reporting Date – Multi-sites

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

The annual reporting date for multi-site group is based on the date of 1st Recognized practice.
Audit, New Requirements and Attestation

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

New Annual Reporting Requirements
• Announced 6 months ahead
• Practice must meet at next reporting date

Practice attests each year to current PCMH Standards
2017 AR-PA: Patient-Centered Access

Has Your Practice Continued to Monitor Appointment Access?

Choose 1 option from the 3 below

**Option 1**
Patient Experience Feedback - Access

**Option 2**
Third Next Available Appointment

**Option 3**
Other Method of Monitoring Access
Has your practice continued to use a team-based approach to provide primary care?

Choose 1 option from the 2 below

Option 1
Attest to pre-visit planning activities

Option 2
Measure team-based care in your employee experience/satisfaction survey
2017 AR-PH: Population Health Management

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

Required:

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

For each category, **at what frequency** does your practice **generate lists and reminders** to patients?
Has your practice continued to identify patients who may benefit from care management?

**Required:** Identifying and monitoring patients for care management
2017 AR-CC: Care Coordination & Care Transitions

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

AR-CC1 (Required): Attest to referral and test tracking and follow-up, and care transitions

Choose 1 additional item from the 4 options below:

- **AR-CC2**: Patient experience survey – care coordination
- **AR-CC3**: Track lab and imagining tests
- **AR-CC4**: Referral tracking
- **AR-CC5**: Care transitions
2017 AR-QI: Performance Measurement & Quality Improvement

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

Required:

Measure Performance

Quality Improvement Activities

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

- **AR-QI2**
  1 resource stewardship measure

- **AR-QI3**
  1 patient experience measure
## 2017 AR-QI: Quality Improvement Worksheet

<table>
<thead>
<tr>
<th>Practice Name(s):</th>
<th>&lt;&lt;SITE 1 NAME&gt;&gt;</th>
<th>&lt;&lt;SITE 2 NAME&gt;&gt;</th>
<th>&lt;&lt;SITE 3 NAME&gt;&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Required Information</strong></td>
<td><strong>Site 1</strong></td>
<td><strong>Site 2</strong></td>
<td><strong>Site 3</strong></td>
</tr>
<tr>
<td>A</td>
<td>Category (Shared)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Name (Shared)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Denominator description (Shared)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Numerator description (Shared)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Denominator (Site-specific)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Numerator (Site-specific)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Reporting Period (Site-specific)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>Was the measure a target for QI? (Site-specific)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Clinical Quality Measure 1

| A | Category (Shared) | | |
| B | Name (Shared) | | |
| C | Denominator description (Shared) | | |
| D | Numerator description (Shared) | | |
| E | Denominator (Site-specific) | | |
| F | Numerator (Site-specific) | | |
| G | Reporting Period (Site-specific) | | |
| H | Was the measure a target for QI? (Site-specific) | | |

### Clinical Quality Measure 2

| A | Category (Shared) | | |
| B | Name (Shared) | | |
| C | Denominator description (Shared) | | |
| D | Numerator description (Shared) | | |
| E | Denominator (Site-specific) | | |
| F | Numerator (Site-specific) | | |
| G | Reporting Period (Site-specific) | | |
| H | Was the measure a target for QI? (Site-specific) | | |

### Clinical Quality Measure 3

| A | Category (Shared) | | |
| B | Name (Shared) | | |
| C | Denominator description (Shared) | | |
| D | Numerator description (Shared) | | |
| E | Denominator (Site-specific) | | |
| F | Numerator (Site-specific) | | |
| G | Reporting Period (Site-specific) | | |
| H | Was the measure a target for QI? (Site-specific) | | |

### Clinical Quality Measure 4

| A | Category (Shared) | | |
| B | Name (Shared) | | |
| C | Denominator description (Shared) | | |
| D | Numerator description (Shared) | | |
| E | Denominator (Site-specific) | | |
| F | Numerator (Site-specific) | | |
PCMH (2017 Version)

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

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

TC 01-02: Core Criteria

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

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

Evidence of Implementation
Structure and Staff Responsibilities

TC 02: Example

Providers
Oversee management of practice and direct patient care

Clinical Team
Coordinate care plan; self-management support

Office Manager
Daily business management

Front Office
Coordination of visit

Check in
Pre-visit planning

Check out
Follow-up and scheduling

Billing
Financial

Referrals
Coordination

Coding
Reimbursement

Medical Assistant
Support clinical team and facilitate patient care

Care Coordinator
Coordinate and manage high risk population

Triage Nurse
Leader of daily huddle and communication
Team-Based Care and Practice Organization

**TC 03-05: Elective Criteria**

- The practice is involved in external collaborative activities
  - *Evidence of Implementation*
- **Patient/family is involved in governance structure/stakeholder committees**
  - *Evidence of Implementation & Documented Process*
- *Practice uses a certified electronic system system*
  - *Evidence of Implementation*
External PCMH Collaborations

TC 03: Example

TC 03

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

STATEWIDE HEALTH IT

Health Center Controlled Network of NY

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

HCNNY provides resources for its members for electronic health record implementation and on-going optimization, customized training, workflow development, and reporting to position members to take advantage of payment reform initiatives, recognition opportunities and available incentives. The Network is governed by its board of directors comprised of executives from member centers, and operational efforts are led by clinical, finance and IT committees that meet regularly to identify priorities and share best practices surrounding common challenges. Quality improvement efforts are enhanced by a data warehouse containing demographic and clinical information on the nearly 280,000 patients served network-wide.
COMPETENCY B

Communication among staff is organized to ensure that patient care is coordinated, safe and effective
Team-Based Care and Practice Organization

TC 06-07: Core Criteria

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

Evidence of Implementation & Documented Process

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

Evidence of Implementation & Documented Process
Team-Based Care and Practice Organization

TC 06: Example

SUBJECT: Daily Huddles

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

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

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

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

TC 07: Example

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

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

TC 08: Elective Criteria

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

Evidence of Implementation
COMPETENCY C

The practice communicates and engages patients on expectations and their role in the medical home model of care.
Team-Based Care and Practice Organization

**TC 09: Core Criteria**

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

_Evidence of Implementation & Documented Process_
Medical Home Information

TC 09: Example

What type of services does my Medical Home provide for me and my family?
We provide comprehensive, compassionate and continuous care for newborns, children, and teens.

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

WHAT WE OFFER:

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

INSURANCE REQUIREMENTS

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

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

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

Practice routinely collects comprehensive data on patients to understand background and health risks of patients.

Practice uses information on the population to implement needed interventions, tools and supports for the practice as a whole and for specific individuals.
Knowing and Managing Your Patients

**KM 01-02: Core Criteria**

Documents an up-to-date problem list

Completes a comprehensive health assessment that includes the examination of all 9 items

Medical history of patient & family

Mental health/ substance use history of patient & family

Family/social/cultural characteristics

Communication Needs

Behaviors affecting health

Social functioning

Social determinants of health

Developmental screening

Advanced care planning (NA for pediatrics)
Knowing and Managing Your Patients

KM 02: Example

Initial Assessment:

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

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

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

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

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

KM 02 A&D: Example

KM 02 A

Medical History
- ASSUMPTION OF CARE 5/24/2004
- HYPERTENSION
- GERD
- FIBROCYSTIC BREAST DISEASE
- HYPERLIPIDEMIA
- CORONARY ARTERY DISEASE
- DIABETES MELLITUS TYPE 2
- CHRONIC LYMPH NODE LEFT
- POSTERIOR CERVICAL CHAIN

KM 02 D

Insurance | Additional Patient Data | Related Accounts | Contacts/Communications | Notes

Patient Statuses
- **HEARING IMPAIRED** 06/04/14 YBELTRAN

Family
- No relevant family history
- Adopted - no family history known

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Family Member Name</th>
<th>Deceased</th>
<th>Age at Death</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brother</td>
<td>N</td>
<td></td>
<td></td>
<td>Alive and well</td>
</tr>
<tr>
<td>Father</td>
<td>Y</td>
<td>81</td>
<td>Neurodegen disease</td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal grandmother</td>
<td>Y</td>
<td>80</td>
<td>Cancer - breast</td>
<td></td>
</tr>
<tr>
<td>Maternal grandmother</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>x7</td>
<td>N</td>
<td></td>
<td>Alive and well</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td>Obesity</td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td>Atrial Fibrillation</td>
<td></td>
</tr>
</tbody>
</table>
Knowing and Managing Your Patients

KM 03: Core Criteria
KM 04: Elective Criteria

Conducts depression screenings using a standardized tool

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

- Anxiety
- Alcohol use disorder
- Substance use disorder
- Pediatric behavioral health screening
- Post-traumatic stress disorder
- ADHD
- Postpartum depression
Knowing and Managing Your Patients

**KM 03: Example**

![Image of Depression Screening PHQ-2 and PHQ-9 scales](image_url)

**Depression Screening - Patient Health Questionnaire (PHQ-2)**

Over the last 2 weeks, how often have you been bothered by any of the following problems?

- **1. Little interest or pleasure in doing things**
- **2. Feeling down, depressed, or hopeless**

**Not at all** | **Several days** | **More than half the days** | **Nearly every day**
---|---|---|---
- |  |  |  
- |  |  |  

**Patient Health Questionnaire (PHQ-9)**

**PHQ 9 DEPRESSION SCREENING: Click to Add HEADING to the note**

1. Little interest or pleasure in doing things? [Y] [Y] [Y] [Y]
2. Feeling down, depressed or hopeless? [Y] [Y] [Y] [Y]
3. Trouble falling, or staying asleep, sleeping too much? [Y] [Y] [Y] [Y]
4. Feeling tired or little energy? [Y] [Y] [Y] [Y]
5. Poor appetite or overeating? Please specify. [Y] [Y] [Y] [Y]
6. Feeling down, like a failure, like you've let yourself or your family down? [Y] [Y] [Y] [Y]
7. Trouble concentrating on things? [Y] [Y] [Y] [Y]
8. Fidgety, unable to sit still or the opposite, moving or speaking slowly so people notice? [Y] [Y] [Y] [Y]
9. Thoughts that you would be better off dead or hurting yourself in any way? [Y] [Y] [Y] [Y]

**Symptom Severity**

1. Not difficult at all
2. Somewhat difficult
3. Very difficult
4. Extremely difficult

**Therapy Notes:**

- [ ]

**Must do:** Add to Note

**PHQ-9 Depression Scale Score**

- [ ]

**Enter score here for today's encounter note.**

**Administered Depression Scale Score**

- [ ]

**Enter date and score here to have the PHQ-9 added to the PMH/problem list.**

**New Episode for condition**

- [ ]

**If this is not a new episode of depression, only mark the Psychometric Depression Scale Score with date.**

**Mark only if New Episode.**

A patient should be in remission for at least three months before a clinical determination is made that the patient is experiencing a "new episode."
# Behavioral Health Screening

**KM 04: Example**

## CAGE-AID Questionnaire

Patient Name ______________________________ Date of Visit ________________

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

### Questions:

<table>
<thead>
<tr>
<th>Questions</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever felt that you ought to cut down on your drinking or drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have people annoyed you by criticizing your drinking or drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Have you ever felt bad or guilty about your drinking or drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Knowing and Managing Your Patients

KM 05: Elective Criteria

Assesses & provides necessary oral health services or coordinates with oral health partners

Conducting patient-specific oral health risk assessments.

- **ASK** about oral health risk factors and symptoms of oral disease
- **LOOK** for signs that indicate oral health risk or active oral disease
- **DECIDE** on the most appropriate response
- **ACT** offer preventive interventions and/or referral for treatment
- **DOCUMENT** as structured data for decision support and population management

Evidence of Implementation & Documented Process
Oral Health Assessment and Services

KM 05: Example

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

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

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

Patient Name: ____________________________ Date of Birth: __________ Date: __________
Visit: [ ] 6 month [ ] 9 month [ ] 12 month [ ] 15 month [ ] 18 month [ ] 24 month [ ] 30 month [ ] 3 year
[ ] 4 year [ ] 5 year [ ] 6 year [ ] Other

RISK FACTORS
△ Mother or primary caregiver had active decay in the past 12 months
[ ] Yes [ ] No

△ Mother or primary caregiver does not have a dentist
[ ] Yes [ ] No

PROTECTIVE FACTORS
• Existing dental home
[ ] Yes [ ] No

• Drinks fluoridated water or takes fluoride supplements
[ ] Yes [ ] No

• Fluoride varnish in the last 6 months
[ ] Yes [ ] No

• Has teeth brushed twice daily
[ ] Yes [ ] No

• Continual bottle/sippy cup use with fluid other than water
[ ] Yes [ ] No

• Frequent snacking
[ ] Yes [ ] No

• Special health care needs
[ ] Yes [ ] No

• Medicaid eligible
[ ] Yes [ ] No

CLINICAL FINDINGS
△ White spots or visible decalcifications in the past 12 months
[ ] Yes [ ] No

△ Obvious decay
[ ] Yes [ ] No

△ Restorations (fillings) present
[ ] Yes [ ] No

• Visible plaque accumulation
[ ] Yes [ ] No

• Gingivitis (swollen/bleeding gums)
[ ] Yes [ ] No

• Teeth present
[ ] Yes [ ] No

• Healthy teeth
[ ] Yes [ ] No

ASSESSMENT/PLAN
Caries Risk:
[ ] Low [ ] High

Completed:
[ ] Anticipatory Guidance
[ ] Fluoride Varnish
[ ] Dental Referral

Self Management Goals:
[ ] Regular dental visits
[ ] Dental treatment for parents
[ ] Brush twice daily
[ ] Use fluoride toothpaste
[ ] Water bottle
[ ] Less/No juice
[ ] Only water in sippy cup
[ ] Drink tap water
[ ] Healthy snacks
[ ] Less/No junk food or candy
[ ] No soda
[ ] Xylitol
Knowing and Managing Your Patients

KM 06-08: Elective Criteria

Identifies the predominant conditions & health concerns of patient population

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

Evaluates patient population demographics/communication preferences/health literacy & distribution of patient materials
Social Determinants of Health

KM 07: Example

**Barriers**

Unable to contact—37 – 12%
Transportation—5 – 2%
Other—52 – 17%
Language—4 – 1%

**Demographics**

Latino/Hispanic—97 – 32%
Non-Hispanic or Latino—144 – 48%
Patient Declined—4 – 1%

**Gender**

Female—193 – 65%
Male—104 – 35%

---

`Resources Patients Needs`

- Access To Health Care, 45%
- Other Assistance, 41%
- Food Insecurity, 22%
- Access To Medications, 22%
- Access To Dental, 18%
- Housing And Utilities, 11%
- Education, 10%
- Exercise, 8%
- Financial Counseling, 4%
- Safe Housing, 4%
- Comm. Safety & Legal, 3%
- Tobacco, 2%
- Alcohol/Drug Use, 1%
- Sexual Activity, 1%
- Environmental Health, 1%
COMPETENCY B

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

**KM 09-10: Core Criteria**

- Assesses the diversity of its population
- Assesses the language needs of its population
### Diversity and Language

**KM 09-10: Example**

#### Race

<table>
<thead>
<tr>
<th>Race</th>
<th>Asian</th>
<th>African American</th>
<th>Native American</th>
<th>Caucasian</th>
<th>More than one Race</th>
<th>Refused to Report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>25</td>
<td>289</td>
<td>1603</td>
<td>29</td>
<td>6</td>
</tr>
</tbody>
</table>

#### Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Hispanic</th>
<th>Non-Hispanic</th>
<th>Refused to Report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>162</td>
<td>1697</td>
<td>99</td>
</tr>
</tbody>
</table>

#### Veterans

<table>
<thead>
<tr>
<th>Veterans</th>
<th>39</th>
</tr>
</thead>
</table>

#### Language Preference

Patients better served in a language other than English

<table>
<thead>
<tr>
<th>Patients</th>
<th>English</th>
<th>Spanish</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1957</td>
<td>99</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>94.9%</td>
</tr>
</tbody>
</table>
Knowing and Managing Your Patients

KM 11: Elective Criteria

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

- Target population health mgmt on disparities in care
  - Evidence OR QI 05 & QI 13

- Educates practice staff on health literacy
  - Evidence of Implementation

- Educate staff on cultural competence
  - Evidence of Implementation

NYS
Population Needs - Health Literacy

**KM 11:B Example**

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

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

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

---

**Teach-back:**
A Health Literacy Tool to Ensure Patient Understanding

---

Educational Module for Clinicians
from the
Iowa Health System Health Literacy Collaborative

---

**Teach-back is...**

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

The practice proactively addresses the care needs of the patient population to ensure needs are met.
Knowing and Managing Your Patients

**KM 12: Core Criteria**

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

- Preventive care services
- Immunizations
- Patients not recently seen
- Chronic/acute care services

KM 12 A-B, D - Report/List & Evidence of Implementation
KM 12 C - Report/List & Evidence of Implementation or KM 13
Dear Patient

Our records indicate you have not been to the office recently.

Please phone the office at (973) 555-5555 to schedule your appointment with ABC Health Center.

For the visit to be as beneficial as possible, we will need your help in preparing for it.

Your participation is vital for good health. Thanks for taking care of yourself and helping to prepare for your visit.

Please bring your current medications list to your checkup. And be prepared to discuss your healthcare goals.

Sincerely,  
ABC Health Center
Excellence in Performance

KM 13: Elective Criteria

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

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

**KM 14-15: Core Criteria**

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

Maintains an up-to-date list of medications for more than 80 percent of patients
Knowing and Managing Your Patients

*KM 16-19: Elective Criteria*

Assesses understanding & provides education on new prescriptions

Assesses & addresses response to medications & barriers to adherence

Reviews controlled substance database for relevant medications

* Systematically obtains prescription claims data

KM 16 & 17 - Report & Evidence of Implementation
KM 18 & 19 - Evidence of Implementation
COMPETENCY E

The practice incorporates evidence-based clinical decision support across a variety of conditions to ensure effective and efficient care is provided to patients.
## Knowing and Managing Your Patients

**KM 20: Core Criteria**

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong></td>
<td>Mental health condition</td>
</tr>
<tr>
<td><strong>B.</strong></td>
<td>Substance use disorder</td>
</tr>
<tr>
<td><strong>C.</strong></td>
<td>A chronic medical condition</td>
</tr>
<tr>
<td><strong>D.</strong></td>
<td>An acute condition</td>
</tr>
<tr>
<td><strong>E.</strong></td>
<td>A condition related to unhealthy behaviors</td>
</tr>
<tr>
<td><strong>F.</strong></td>
<td>Well child or adult care</td>
</tr>
<tr>
<td><strong>G.</strong></td>
<td>Overuse/appropriateness issues</td>
</tr>
</tbody>
</table>
Clinical Decision Support – Mental Health

KM 20 A: Example

Treatment of depression after positive PHQ9 score

PCP NEEDS TO SELECT FOLLOW-UP PLAN BELOW BASED ON SCORE

IF PHQ-9 IS 15 OR GREATER, ADDRESS THE FOLLOWING THREE REQUIREMENTS

- Y Positive for Mod-Sev Depression (PHQ9 = 15+)
- Y Referred to BHS

GO TO “Orders & Charges” to INITIATE TASK labelled PHQ-9 = 15+

IF PHQ-9 IS 14 OR BELOW CLICK THE FOLLOWING

- Y Negative for Mod-Sev Depression (PHQ9 < 15)
COMPETENCY F

The practice identifies/considers and establishes connections to community resources to collaborate and direct patients to needed support.
Uses information on the population served by the practice to prioritize needed community resources.
Knowing and Managing Your Patients

KM 22-24: Elective Criteria

- Provides access to **educational materials**
- Offers **oral health education resources**
- Adopts **shared decision-making aids**

*Evidence of Implementation*
Access to Educational Resources

KM 22: Example

Blood Pressure Log

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Systolic</th>
<th>Diastolic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>120</td>
<td>80</td>
</tr>
<tr>
<td>Mild Hypertension</td>
<td>140 - 160</td>
<td>90 - 100</td>
</tr>
<tr>
<td>Moderate Hypertension</td>
<td>160 - 200</td>
<td>100 - 120</td>
</tr>
<tr>
<td>Severe Hypertension</td>
<td>Above 200</td>
<td>Above 120</td>
</tr>
</tbody>
</table>

Name: ____________________________

<table>
<thead>
<tr>
<th>Date</th>
<th>AM</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Blood Pressure</td>
<td>Pulse</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Knowing and Managing Your Patients

KM 23: Example

Dental Resource

Re: Updated Community Resource List

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

Dental Services

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

Pharmacy Services

The Pharmacy & Pharmacology Division of Detroit
Telephone: 24 Hour Automated Refill Manager
What is my risk of breaking a bone?

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

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

It is also affected by:
- If you have had a fracture
- If a parent had a fracture
- If you currently smoke
- If you drink more than 2 drinks of alcohol a day
- If you have taken prescription steroid medications

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

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

Prepared for: ____________________________
Knowing and Managing Your Patients

KM 25-27: Elective Criteria

Engages with schools or intervention agencies

Routinely maintains a current community resource list

Assesses usefulness of community support resources

Evidence of Implementation & Documented Process

List

Evidence of Implementation
# School/Intervention Agency Engagement

## KM 25: Example

### The Hispanic Counseling Center

<table>
<thead>
<tr>
<th>Patient Access</th>
<th>STEP 1 (within 24 hours of visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ If visit is urgent, PCP office will call The Hispanic Counseling Center office intake line to notify of need for a more expedited appointment and outreach to the patient</td>
</tr>
<tr>
<td></td>
<td>STEP 2 (within 24-48 hours of visit)</td>
</tr>
<tr>
<td></td>
<td>□ Patient will be scheduled within 2-3 weeks of call to Specialist office unless urgent visit indicated</td>
</tr>
<tr>
<td></td>
<td>STEP 3 (ongoing management)</td>
</tr>
<tr>
<td></td>
<td>□ If patient does not schedule or is a 'no-show', notification from Specialist office will be sent to PCP office within 30 days via fax or telephone encounter</td>
</tr>
<tr>
<td></td>
<td>□ 609 Fulton Pediatrics Pc Care Coordinators run reports &amp; perform outreach to anyone who has not completed appropriate follow-up</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transitions of Care</th>
<th>STEP 1 (at visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Informs patient of need, purpose, expectations and goals of the specialty visit</td>
</tr>
<tr>
<td></td>
<td>□ Patient/family in agreement with referral, type of referral and selection of Specialist</td>
</tr>
<tr>
<td></td>
<td>□ Unless urgent, PCP office provides patient with Specialist contact information and patient calls to schedule appointment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 2 (within 24 hours of visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ PCP office documents appropriate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 1 (during patient PCP visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ If visit is urgent, PCP office will call Specialist office to notify of need for expedited appointment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 2 (within 24-48 hours of visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Referred patient will be scheduled within 2-3 weeks of call to Specialist office unless urgent visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 3 (at visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ If patient needs to be seen for follow up visit – patient will schedule directly with Specialist office</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 1 (at visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Reviews reason for visit with patient/family</td>
</tr>
<tr>
<td>□ If patient needs to be seen in ED or Mental Health Facility, arrangements will be made then Specialist office will notify PCP office within 24 hours</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 2 (within 7-10 days of initial visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ The specialist office communicates with the PCP regarding the patient’s plan of care, up-dated diagnosis, and medication recommendations.</td>
</tr>
<tr>
<td>□ If there is ongoing visits with the</td>
</tr>
</tbody>
</table>
Regularly include external parties in “case conferences” for the purpose of sharing information and discussing care plans for high-risk patients.

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

The practice seeks to enhance access by providing appointments and clinical advice based on patients’ needs.
The practice assesses the **access needs and preferences** of the patient population from collected data to determine if existing methods are sufficient.

**Evidence of Implementation & Documented Process**
**Patient-Centered Access and Continuity**

**AC 01 : Example**

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Got appointment for urgent care in a timely manner</td>
<td>76.7%</td>
<td>16.7%</td>
<td>3.3%</td>
<td>3.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Got appointment for non-urgent care in a timely manner</td>
<td>56.7%</td>
<td>33.3%</td>
<td>3.3%</td>
<td>6.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Got answer to medical question within 24 hours</td>
<td>63.3%</td>
<td>16.7%</td>
<td>10.0%</td>
<td>10.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Got answer to medical question when office was closed</td>
<td>56.7%</td>
<td>20.0%</td>
<td>10.0%</td>
<td>13.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Received courteous and respectful answers from office staff</td>
<td>70.0%</td>
<td>30.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

**Access**

- Felt the provider addressed issues involving family, or alcohol, smoking, mental health, nutrition, exercise
- Felt the provider addressed personal health goals (i.e. weight loss, smoking cessation, etc)
- Felt the provider has given clear explanations regarding diagnosis

**Self-Mangement**

- Access to information on patient’s condition
- Access to information on medications
- Access to information on recommended treatments
- Access to information on health insurance
- Access to information on health risks and prevention
- Access to information on treatment options

**Access**

- Got appointment for urgent care in a timely manner
- Got appointment for non-urgent care in a timely manner
- Got answer to medical question within 24 hours
Patient-Centered Access and Continuity

AC 02-05: Core Criteria

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

**AC 02 : Example**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>17 = 31%</td>
<td>13 = 31%</td>
<td>13 = 33%</td>
<td>10 = 53%</td>
<td>13 = 33%</td>
</tr>
<tr>
<td>Open &quot;Same Day&quot; slots at beginning of day (minimum of 30% per policy)</td>
<td>16 of 17 = 94%</td>
<td>10 of 13 = 77%</td>
<td>10 of 13 = 77%</td>
<td>7 of 10 = 70%</td>
<td>9 of 13 = 69%</td>
</tr>
<tr>
<td>Percent of Same-Day appointments used at end of day</td>
<td>38 = 69%</td>
<td>29 = 69%</td>
<td>26 = 67%</td>
<td>9 = 47%</td>
<td>26 = 67%</td>
</tr>
<tr>
<td>All other slots (Routine, PAP, Well Child, New Patient)</td>
<td>55 = 100%</td>
<td>42 = 100%</td>
<td>39 = 100%</td>
<td>19 = 100%</td>
<td>39 = 100%</td>
</tr>
</tbody>
</table>
Patient-Centered Access and Continuity

AC 03 : Example

Contact Us

Our location
Suburban Family Healthcare

Get in touch
Phone: (Also for After Hours)
Fax:
Email: (office manager – only for non-medical issues)

Our hours
Monday 8:30a.m. – 12:00p.m., 1:00p.m. – 5:30p.m.
Tuesday 10:00 a.m. – 7:00p.m
Wednesday 8:30a.m. -12:00p.m., 1:00p.m. – 5:00p.m.
Thursday 8:30a.m. – 12:00p.m.
Friday 7:30a.m. – 12:00p.m., 1:00p.m. – 3:00p.m.

Walk in hours 8:30-9:30 am Monday and Fridays (existing patients only) and 1st and 3rd Saturdays of the month from 9-12 by appointment only.
## Patient-Centered Access and Continuity

*AC 04: Example*

### Clinical Advice telephonic response 7 days' log

<table>
<thead>
<tr>
<th>Patient</th>
<th>Doctor</th>
<th>Date Called</th>
<th>Time Called</th>
<th>Urgent Y/N</th>
<th>Date Responded</th>
<th>Time Responded</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>04/11/2016</td>
<td>2:48 PM</td>
<td>Y</td>
<td>04/11/2016</td>
<td>3:04 PM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>04/13/2016</td>
<td>10:55 AM</td>
<td>N</td>
<td>04/13/2016</td>
<td>11:25 AM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>04/14/2016</td>
<td>10:55 AM</td>
<td>N</td>
<td>04/14/2016</td>
<td>11:25 AM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>04/15/2016</td>
<td>2:26 PM</td>
<td>N</td>
<td>04/15/2016</td>
<td>2:37 PM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>04/18/2016</td>
<td>7:26 PM</td>
<td>N</td>
<td>04/18/2016</td>
<td>7:36 PM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>04/21/2016</td>
<td>8:23 PM</td>
<td>N</td>
<td>04/21/2016</td>
<td>8:50 PM</td>
</tr>
</tbody>
</table>
Practice uses phone or other technology supported mechanisms to provide scheduled routine or urgent care appointments.

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

Timely clinical advice is provided using a secure electronic system for two-way communication.
Patient-Centered Access and Continuity

AC 09: Elective Criteria

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

Evidence of Implementation
COMPETENCY B

Practices support continuity through empanelment and systematic access to the patient’s medical record
Assists in the selection and/or change of the patients/families/caregivers personal clinician choice and documents information in electronic system

Practice establishes goals and monitors the % of patient visits with selected clinician/team
Patient-Centered Access and Continuity

AC 12-14: Elective Criteria

* Continuity of medical record information when the office is closed

Review and actively manage panel sizes

Review and reconcile panels based on external data

Documented Process

Report & Documented Process

Evidence of Implementation & Documented Process

NYS
Patient-Centered Access and Continuity

Examine Supply/Demand

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

\[
\text{(provider visits/day)} \times \text{(days in clinic/year)} = \# \text{ patients}
\]
\[
\text{(patient visits/year)}
\]

\[
(18)(210) = \# \text{ patients}
\]
\[
(3.6)
\]

\[
1,050 = \# \text{ patients}
\]

Fill in values, for example:

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

Also compare appointment demand with backlog or wait time for appointments

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

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

**CM 01-02: Core Criteria**

- The practice must include at least three categories in its criteria

- Social determinants of health
- Referrals by outside organizations
- Poorly controlled or complex conditions
- High cost/high utilization
- Behavioral Health conditions
Identifying & Monitoring Patients for Care Mgmt

CM 01: Example

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

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

Denominator = 893 patients

Numerator = 83 patients

Percentage of patients identified as benefiting from care management = 9%
### Patients Needing Care Management

<table>
<thead>
<tr>
<th>Patients in Registry (may be listed more than once)</th>
<th>Behavioral Health</th>
<th>High Cost/Utilization</th>
<th>Poor Control/Complex</th>
<th>Social Determinants of Health</th>
<th>Referrals</th>
<th>Total Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients in Registry</td>
<td>120</td>
<td>35</td>
<td>200</td>
<td>10</td>
<td>10</td>
<td>375</td>
</tr>
<tr>
<td>Unique Patients in Registry</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>343</td>
</tr>
<tr>
<td>Total Patients in Practice</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3000</td>
</tr>
<tr>
<td>Patients Needing Care Management</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td><strong>11.4%</strong> (343 patients)</td>
</tr>
</tbody>
</table>

CM 02: Example
Care Management and Support

*CM 03: Elective Criteria*

*The practice identified patients at high risk using a comprehensive risk-stratification process.*
COMPETENCY B

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

The practice provides a written care plan to patients/families/caregivers under care management
Care Management and Support

CM 05: Example

Patient is provided a copy of individualized care plan
Documents patient preferences & functional/lifestyle goals

Addresses identified & potential barriers

Care plans include a self-management plan

Care plans are shared across care settings

CM 06-09: Elective Criteria

Evidence of Implementation & Documented Process
# Care Management & Support

**CM RRWB: Example**

<table>
<thead>
<tr>
<th>Patient Number</th>
<th>CM 04</th>
<th>CM 05</th>
<th>CM 06</th>
<th>CM 07</th>
<th>CM 08</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Care Management & Support

### CM 08: Example

### COPD Action Plan

#### When you are well, be aware of the following:

<table>
<thead>
<tr>
<th>When you are well, be aware of the following:</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>How much activity you can do each day</td>
<td>Have something to look forward to each day</td>
</tr>
<tr>
<td>What your breathing is like when you are resting and when you are active</td>
<td>Plan ahead - pace yourself and allow enough time to do things</td>
</tr>
<tr>
<td>How much phlegm you cough up and what colour it is</td>
<td>Exercise every day</td>
</tr>
<tr>
<td>Anything that makes your breathing worse</td>
<td>Eat a balanced diet and drink plenty of fluids</td>
</tr>
<tr>
<td>What your appetite is like</td>
<td>Avoid things that make your condition worse</td>
</tr>
<tr>
<td>How well you are sleeping</td>
<td>Take your medication as directed by your doctor</td>
</tr>
<tr>
<td>Do you have any swelling to your feet/ankles</td>
<td>Never allow your medications to run out</td>
</tr>
</tbody>
</table>

#### The following are signs that your symptoms are getting worse:

<table>
<thead>
<tr>
<th>The following are signs that your symptoms are getting worse:</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling more breathless or wheezy than usual</td>
<td>Increase your reliever medication</td>
</tr>
<tr>
<td>Reduced energy for daily activities</td>
<td>Contact your ________________________________ on __________________________ for advice</td>
</tr>
<tr>
<td>Coughing up more phlegm</td>
<td>Consider starting your 'standby' antibiotics and/or Prednisolone</td>
</tr>
<tr>
<td>Change in colour of phlegm</td>
<td>'Standby' medication details (see next page)</td>
</tr>
<tr>
<td>Poor sleep and/or symptoms waking you in the night</td>
<td>Antibiotics: to use if your sputum becomes coloured or the amount increases due to infection</td>
</tr>
<tr>
<td>Starting to cough or increased cough</td>
<td>Prednisolone (Steriod): to reduce inflammation in the lungs when your breathing is bad</td>
</tr>
<tr>
<td>You may also have loss of appetite</td>
<td></td>
</tr>
<tr>
<td>New or increased swelling to feet/ankles</td>
<td></td>
</tr>
</tbody>
</table>

#### The following are signs of a severe attack:

<table>
<thead>
<tr>
<th>The following are signs of a severe attack:</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathlessness and cough getting worse</td>
<td>If you have not done so already, start your 'standby' medication</td>
</tr>
<tr>
<td>You are not able to carry out your normal daily activities</td>
<td>Phone your nurse or doctor if you have started 'standby' medication - and you are not improving - for an urgent appointment or home visit</td>
</tr>
<tr>
<td>Your medications are not working</td>
<td></td>
</tr>
</tbody>
</table>

#### The following are signs of a severe attack:

<table>
<thead>
<tr>
<th>The following are signs of a severe attack:</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very short of breath when you are at rest, with no relief from medication</td>
<td>Dial 999 for an ambulance or ring the GP Out of Hours service</td>
</tr>
<tr>
<td>Chest pains</td>
<td></td>
</tr>
<tr>
<td>High fever (temperature)</td>
<td></td>
</tr>
<tr>
<td>Feelings of agitation, fear, drowsiness or confusion</td>
<td></td>
</tr>
</tbody>
</table>
The practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood.
COMPETENCY A

The practice effectively tracks and manages laboratory and imaging tests important for patient care and informs patients of the result.
Care Coordination & Care Transitions

CC 01: Core Criteria

Manages lab & imaging tests systematically by:

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

Evidence of Implementation & Documented Process
Care Coordination & Care Transitions

**CC 01 E: Example**

Normal Lab Results of lab work left as message

---

**Telephone Encounter**

<table>
<thead>
<tr>
<th>Author</th>
<th>Note Status</th>
<th>Last Update User</th>
<th>Last Update Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phillip Androw, MD</td>
<td>Signed</td>
<td>Phillip Androw, MD</td>
<td>3/15  2:04 PM</td>
</tr>
</tbody>
</table>

**Telephone Encounter**

Left VM informing him testosterone levels were normal. Also wanted to check in on how the adderall taper is going but didn't get ahold of him, will f/u in 2 weeks at our next appointment.

---

**Telephone Encounter**

<table>
<thead>
<tr>
<th>Author</th>
<th>Note Status</th>
<th>Last Update User</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
<td>Signed</td>
<td>MD</td>
</tr>
</tbody>
</table>

**Telephone Encounter**

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

Provider called patient with results of radiology exam
# Care Coordination & Care Transitions

**CC 01 F: Example**

<table>
<thead>
<tr>
<th>Lab: HEMOGLOBIN A1c</th>
<th>Value</th>
<th>Reference Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Result Date:</td>
<td>13.4 H</td>
<td>&lt;5.7 %</td>
</tr>
<tr>
<td>Session Id: JK673009</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordering Physician:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

10:06:07 AM > briefly discussed results with patient, became upset with negative results, has appointment next.

<table>
<thead>
<tr>
<th>Assigned to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Result:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open</td>
</tr>
<tr>
<td>Reviewed</td>
</tr>
</tbody>
</table>

*Notes:*

- STAT
- Fasting: No
- All tests are performed at Sunrise Medical Laboratories unless otherwise indicated.
Care Coordination & Care Transitions

CC 02: Elective Criteria

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

Evidence of Implementation & Documented Process
Care Coordination & Care Transitions

CC 02: Example

Documentation required

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

- Example
Clinical protocols are established based on evidence-based guidelines to determine when imaging and lab tests are necessary.
COMPETENCY B

The practice provides important information in referrals to specialists and tracks referrals until the report is received.
Care Coordination & Care Transitions

CC 04: Core Criteria

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

- Clinical question
- Required timing
- Type of referral
- Demographic & clinical data
  - Test results
  - Care plan
- Track referral until available
- Flag overdue reports
- Follow-up overdue reports
* Clinical protocols are used to identify necessary specialist referrals

Commonly used specialists/specialty types are identified

* Considers available performance information on consultants/specialists
Care Coordination & Care Transitions

CC 07: Example

<table>
<thead>
<tr>
<th>Age</th>
<th>Clinic</th>
<th>ReferringProvider</th>
<th>Referral Type</th>
<th>Referral Date</th>
<th>Appt Date</th>
<th>Wait Time Days</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>67.3</td>
<td>Urology (Peds): Montefiore; Hutchinson</td>
<td>Urology</td>
<td>01/05/2015</td>
<td>04/23/2015</td>
<td>108</td>
<td>Consult</td>
<td></td>
</tr>
<tr>
<td>28.0</td>
<td>Headache: Montefiore; Hutchinson Camp</td>
<td>Neurology</td>
<td>01/06/2015</td>
<td>04/01/2015</td>
<td>85</td>
<td>Canceled by clinic</td>
<td></td>
</tr>
<tr>
<td>23.0</td>
<td>Cardiology: Montefiore-Einstein Heart Center</td>
<td>Cardiology</td>
<td>01/09/2015</td>
<td>01/11/2015</td>
<td>61</td>
<td>Patient no-show</td>
<td></td>
</tr>
<tr>
<td>69.0</td>
<td>Urology (Peds): Montefiore; Hutchinson</td>
<td>Urology</td>
<td>01/09/2015</td>
<td>05/03/2015</td>
<td>116</td>
<td>Created</td>
<td></td>
</tr>
<tr>
<td>37.0</td>
<td>Plastic Surgery: Montefiore; Hutchinson</td>
<td>Plastic Surgery</td>
<td>01/13/2015</td>
<td>10/24/2015</td>
<td>42</td>
<td>Patient no-show</td>
<td></td>
</tr>
<tr>
<td>36.6</td>
<td>Urology (Peds): Montefiore; Hutchinson</td>
<td>Urology</td>
<td>01/15/2015</td>
<td>04/02/2015</td>
<td>77</td>
<td>Patient no-show</td>
<td></td>
</tr>
<tr>
<td>58.3</td>
<td>Cardiology: Montefiore-Einstein Heart Center</td>
<td>Cardiology</td>
<td>01/20/2015</td>
<td>02/17/2015</td>
<td>28</td>
<td>Canceled by clinic</td>
<td></td>
</tr>
<tr>
<td>23.8</td>
<td>Plastic Surgery: Montefiore; Hutchinson</td>
<td>Plastic Surgery</td>
<td>01/20/2015</td>
<td>02/17/2015</td>
<td>28</td>
<td>Canceled by clinic</td>
<td></td>
</tr>
<tr>
<td>50.6</td>
<td>Allergy: Montefiore - Hutchinson Campus</td>
<td>Allergy</td>
<td>01/21/2015</td>
<td>03/27/2015</td>
<td>58</td>
<td>Patient no-show</td>
<td></td>
</tr>
<tr>
<td>40.6</td>
<td>Dermatology: Montefiore; Hutchinson</td>
<td>Dermatology</td>
<td>01/24/2015</td>
<td>02/18/2015</td>
<td>25</td>
<td>Canceled by patient</td>
<td></td>
</tr>
<tr>
<td>36.5</td>
<td>Urology (Peds): Montefiore; Hutchinson</td>
<td>Urology</td>
<td>01/28/2015</td>
<td>04/05/2015</td>
<td>98</td>
<td>Created</td>
<td></td>
</tr>
<tr>
<td>53.2</td>
<td>Family Planning: Montefiore - AECOM, 1650</td>
<td>Family Planning</td>
<td>01/13/2015</td>
<td>03/05/2015</td>
<td>51</td>
<td>Canceled by patient</td>
<td></td>
</tr>
<tr>
<td>31.9</td>
<td>URO-GYN: AECOM</td>
<td>URO-GYN</td>
<td>01/08/2015</td>
<td>03/08/2015</td>
<td>57</td>
<td>Canceled by patient</td>
<td></td>
</tr>
<tr>
<td>31.9</td>
<td>URO-GYN: AECOM</td>
<td>URO-GYN</td>
<td>01/08/2015</td>
<td>03/08/2015</td>
<td>57</td>
<td>Canceled by patient</td>
<td></td>
</tr>
<tr>
<td>32.7</td>
<td>URO-GYN: AECOM</td>
<td>URO-GYN</td>
<td>01/08/2015</td>
<td>03/08/2015</td>
<td>57</td>
<td>Canceled by patient</td>
<td></td>
</tr>
<tr>
<td>33.8</td>
<td>Genetics - AECOM</td>
<td>Genetics</td>
<td>01/13/2015</td>
<td>02/02/2015</td>
<td>28</td>
<td>Canceled by patient</td>
<td></td>
</tr>
<tr>
<td>27.2</td>
<td>Ultrasound: AECOM</td>
<td>Ultrasound</td>
<td>01/15/2015</td>
<td>02/23/2015</td>
<td>34</td>
<td>Consult notes received</td>
<td></td>
</tr>
<tr>
<td>25.8</td>
<td>Fetal Echo: AECOM</td>
<td>Ultrasound</td>
<td>01/20/2015</td>
<td>03/03/2015</td>
<td>39</td>
<td>Consult notes received</td>
<td></td>
</tr>
<tr>
<td>63.1</td>
<td>Hematology: Albert Einstein College of Medicine</td>
<td>Hematology</td>
<td>01/20/2015</td>
<td>03/05/2015</td>
<td>42</td>
<td>Consult notes received</td>
<td></td>
</tr>
<tr>
<td>24.9</td>
<td>Ultrasound: AECOM</td>
<td>Ultrasound</td>
<td>01/22/2015</td>
<td>03/09/2015</td>
<td>25</td>
<td>Consult notes received</td>
<td></td>
</tr>
<tr>
<td>37.1</td>
<td>Genetics - AECOM</td>
<td>Ultrasound</td>
<td>01/22/2015</td>
<td>03/09/2015</td>
<td>25</td>
<td>Consult notes received</td>
<td></td>
</tr>
<tr>
<td>33.1</td>
<td>OBJ/GYN: MFAC - AECOM</td>
<td>OBJ/GYN</td>
<td>01/26/2015</td>
<td>02/10/2015</td>
<td>23</td>
<td>Consult notes received</td>
<td></td>
</tr>
<tr>
<td>33.1</td>
<td>OBJ/GYN: MFAC - AECOM</td>
<td>OBJ/GYN</td>
<td>01/26/2015</td>
<td>02/10/2015</td>
<td>23</td>
<td>Consult notes received</td>
<td></td>
</tr>
<tr>
<td>34.9</td>
<td>Neurology: Montefiore North - Medical Village</td>
<td>Neurology</td>
<td>01/07/2015</td>
<td>05/13/2015</td>
<td>126</td>
<td>Created</td>
<td></td>
</tr>
<tr>
<td>63.6</td>
<td>Neurology: Montefiore North - Medical Village</td>
<td>Neurology</td>
<td>01/08/2015</td>
<td>06/11/2015</td>
<td>154</td>
<td>Created</td>
<td></td>
</tr>
<tr>
<td>40.3</td>
<td>Mammogram: MMC - North</td>
<td>Mammogram</td>
<td>01/11/2015</td>
<td>02/10/2015</td>
<td>30</td>
<td>Patient no-show</td>
<td></td>
</tr>
<tr>
<td>43.1</td>
<td>Ultrasound: Montefiore - Wakefield Campus</td>
<td>Ultrasound</td>
<td>01/15/2015</td>
<td>02/13/2015</td>
<td>29</td>
<td>Patient no-show</td>
<td></td>
</tr>
</tbody>
</table>

This report is periodically generated from TRMS, a web-based tracking database used by the practice for subspecialty referrals. It shows the total number of referrals to subspecialties for adult patients generated (electronically) in January 2015, appointments scheduled and the location (mostly within ), the number of days/waiting period, and the status of those appointments. Out of a total of 319 referrals, 76 of them were not scheduled within Medical Center, 76% were.
The practice sets expectations for patient care and sharing information when working with:

- Non-behavioral healthcare specialists
- *Behavioral healthcare providers

**Care Coordination & Care Transitions**

*CC 08-09: Elective Criteria*
### Behavioral Health Care Compact

#### between

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

Evidence of Implementation & Documented Process
Monitors the timeliness and quality of referral responses

Documents co-management arrangements in the patient’s medical record

* Engages with patients regarding cost implications of treatment options
COMPETENCY C

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

**CC 14-16: Core Criteria**

**Identifies patients** with unplanned admissions and ED visits
- Report & Documented Process

**Shares clinical information** with inpatient facilities
- Evidence of Implementation & Documented Process

**Contacts patients/families/caregivers** for follow-up care
- Evidence of Implementation & Documented Process
Care Coordination & Care Transitions

CC 14-16, 18-19: Example

**Procedure:**

- 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.
- 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.

- 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.
## Care Coordination & Care Transitions

**CC 16: Example**

<table>
<thead>
<tr>
<th>MRN</th>
<th>10:26 AM Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Description:** 45 year old female

**Provider:**

**Department:**

<table>
<thead>
<tr>
<th>Reason for Call</th>
<th>10:26 AM Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up since</td>
<td></td>
</tr>
</tbody>
</table>

**Call Documentation**

10:32 AM Signed

Following up with patient after visit to ER for abdominal pain. Pt states that she was discharged and that her CT scan and labs were fine. Still c/o some slight pain today but that overall it is better. Was told last night that it could be because of her nerves. The ER MD increased zoloft for this and pt states that she has made the changes recommended. Would like to follow up with PCP to make sure that dose will work for her. Schedule F/U in 1 week. Pt voices no further needs at this time.

**Encounter Messages**

No messages in this encounter

**Contacts**

<table>
<thead>
<tr>
<th>10:26 AM</th>
<th>Phone (Outgoing)</th>
</tr>
</thead>
</table>

**Created by**

10:26 AM

**Patient Instructions**

None
Care Coordination & Care Transition

CC 17-20: Elective Criteria

**Coordinate** with acute care settings after hours through access to current patient information

**Exchange** patient information with the hospital during patient’s hospitalization

**Obtain** discharge summaries consistently from the hospital and facilities

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

CC 17-19 - Evidence of Implementation & Documented Process
CC 20 - Evidence of Implementation
Care Coordination & Care Transition

CC 19: Example

MEDICAL CENTER
Health Care Network
DISCHARGE SUMMARY

Pt. Name/Age/DOB: [Redacted]
Date of Admission: 6/18/20
PCP: [Redacted]
Discharging Provider: [Redacted] MD
Consultations: IP CONSULT TO CASE MANAGEMENT

Hospital Discharge Dx:
Principal Problem: Delirium
Active Problems: CVA (cerebral infarction) Benign essential HTN Dementia Hypertensive urgency Atrial fibrillation with rapid ventricular response Type 2 diabetes mellitus without complication Chronic systolic heart failure E. coli UTI

HPI/Reason for Admission: Found wondering, evidence of recent fall and acute worsening of her baseline dementia. Upon arrival at her home, her son, primary caregiver, was intoxicated and patient deemed not safe to return. Spoke with other son, who states her mentation is an acute change and she was admitted to the hospital for w/u and admission to Crestwood.

Hospital course, including complications:
Care Coordination & Care Transition

CC 21: Elective Criteria

Electronic exchange of information with external entities on 1 or more (max 3 credits):

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

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

The practice measures to understand current performance and to identify opportunities for improvement
The practice monitors at least 5 clinical quality measures (must monitor at least one measure of each type):

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

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

- **Care coordination measures**
- Measures affecting health care costs

Assesses performance on availability of major appointment types

Reports
### Performance Measurement & Quality Improvement

**QI 01 A-D: Example**

<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>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>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>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>Depression screening</strong></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><strong>Hemoglobin A1C</strong></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>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>
Performance Measurement & Quality Improvement

QI 02 B: Example

![Graph](image)
Monitors patient experience through **quantitative data** (across at least three categories)

Monitors patient experience through **qualitative methods**

**Access**

**Communication**

**Coordination**

Whole-person care, self-management support and comprehensiveness
### NEW PATIENT PHONE SURVEY

**Provider______________**

<table>
<thead>
<tr>
<th>Did your Provider meet and satisfy your needs?</th>
<th>Speaks English</th>
<th>Age</th>
<th>Insured</th>
<th>Race</th>
<th>Co-morbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ABC Health would like to be your “Patient Centered Medical Home”. Overall, how was your experience?**  
<table>
<thead>
<tr>
<th>Speaks English</th>
<th>Age</th>
<th>Insured</th>
<th>Race</th>
<th>Co-morbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Are you aware we have walk-in hours for acute care if you are unable to get in with your provider today?**  
<table>
<thead>
<tr>
<th>Speaks English</th>
<th>Age</th>
<th>Insured</th>
<th>Race</th>
<th>Co-morbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Are you aware that ABC Health offers Pharmacy & Dental services? Able to get your meds today?**  
<table>
<thead>
<tr>
<th>Speaks English</th>
<th>Age</th>
<th>Insured</th>
<th>Race</th>
<th>Co-morbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Do you have any suggestions or comments on how we can increase quality and your satisfaction?**  
<table>
<thead>
<tr>
<th>Speaks English</th>
<th>Age</th>
<th>Insured</th>
<th>Race</th>
<th>Co-morbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**QI 05: Elective Criteria**

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

- Clinical quality
- Patient experience

Report OR QI Worksheet
Performance Measurement & Quality Improvement

QI Worksheet: Example

NCQA PCMH Quality Measurement and Improvement Worksheet

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

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

**QUALITY MEASUREMENT & IMPROVEMENT ACTIVITY STEPS**

1. Identify measures for QI. Select aspects of performance to improve:
   - **Must Demonstrate (Core Criteria):**
     - PCMH QI 01: At least five clinical quality measures
     - PCMH QI 02: At least two resource stewardship measures
     - PCMH QI 03: Assess availability of major appointment types
     - PCMH QI 04: Monitors patient experience
   - **Optional (Elective Criteria):**
     - PCMH QI 05: At least two measures for vulnerable populations (one clinical quality, one patient experience)

2. Identify a baseline performance assessment. Choose a starting measurement period (start and end date) and identify a baseline performance measurement for each measure.
   - For PCMH QI 08-11 and 13, use performance measurements from the reports provided in PCMH QI 01-05.
   - The baseline measurement period must be within 12 months before evidence submission for check-in, or within 24 months, if there is a remeasurement period. The performance measurement must be a rate (percentage based on numerator and denominator) or number (with number of patients represented by the data).

3. Establish a performance goal. Generate at least one performance goal for each identified measure. The specific goal must be a rate or number greater than the baseline performance assessment. Simply stating that the practice intends to improve does not meet the objective. (Applies to QI 08-11 and 13)

   For multi-sites: Organizational goals and actions for each site may be used if remeasurement and performance relate to the practice. Each practice must have its own baseline and performance results.

4. Determine actions to work toward performance goals. List at least one action for each identified measure and the activity start date. The action date must occur after the date of the baseline performance measurement date. You may list more than one activity, but are not required to do so. (Applies to QI 08-11 and 13)

5. Remeasure performance based on actions taken. Choose a remeasurement period and generate a new performance measurement after action was taken to improve. The remeasurement date must occur after the date of implementation and must be within 12 months before evidence submission for check-in. The performance measurement must be a rate (percentage based on numerator and denominator) or number (with number of patients represented by the data).

6. Assess actions taken and describe improvement. Briefly describe how your practice site showed improvement on measures. Describe the assessment of the actions; correlate actions and the resulting improvement. (Applies to QI 12 and 14)
**EXAMPLE: HOW TO COMPLETE A ROW**

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

* Obtains feedback on vulnerable patient groups
COMPETENCY B
The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies.
Sets goals and acts to improve upon at least three measures across at least three of the four categories

Sets goals and acts to improve upon at least one measure of resource stewardship

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

Sets goals and acts to improve on at least one patient experience measure
Performance Measurement & Quality Improvement

QI 12-14: Elective Criteria

*Achieves improved performance on at least 2 performance measures

Disparities in care or services

1. Sets goals and acts to improve at least one measure

2. *Achieves improved performance in at least one measure
COMPETENCY C
The practice is accountable for performance. The practice shares performance data with the practice, patients and/or publicly for the measures and patient populations identified in the previous section.
Performance Measurement & Quality Improvement

QI 15: Core Criteria

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

Evidence of Implementation & Documented Process
Performance Measurement & Quality Improvement

**QI 16-19: Elective Criteria**

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

---

QI 16 & 17 - Evidence of Implementation & Documented Process
QI 18 - Evidence of Implementation
QI 19 - Agreement OR Evidence of Implementation
Reporting Performance Publicly/Patients

QI 16: Example

Dear

Enclosed in this letter you will find the performance results for your individual clinician, Dr. [name] and practice-level, [practice name], on the important preventive and chronic measures including Depression Screening and Hemoglobin A1C testing. We are working diligently to increase Individual clinician and Practice-level screenings of important preventive and chronic measures.

<table>
<thead>
<tr>
<th></th>
<th>Individual Clinician</th>
<th>Practice-level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression Screening</td>
<td>38.44 %</td>
<td>39.08 %</td>
</tr>
<tr>
<td>Hemoglobin A1c testing</td>
<td>74.02 %</td>
<td>74.15 %</td>
</tr>
</tbody>
</table>

Our practice also would like share with you patient satisfaction information. Based on patients survey that practice conducted in May and November of 2016, patients mostly complained via the survey that they have to wait to being called while they are waiting in waiting room. Please see numbers listed below.

<table>
<thead>
<tr>
<th></th>
<th>First time: May 2016</th>
<th>Second time: November 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey results</td>
<td>21%</td>
<td>18%</td>
</tr>
</tbody>
</table>

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

Sincerely
Survey Platform

Q-PASS System
Organization set-up

New Organizations

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

Existing Organizations

• Authorized users – See “My Organizations” tab
• To “claim” an organization otherwise, contact NCQA
Q-PASS Organization Home Page

Organizations

All of your organizations are listed here.

5334 Total Organizations

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
<th>Primary</th>
<th>Secondary</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Hanson Place Pediatrics PC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/2 SBCT</td>
<td>(210) 295-7419</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 MDG USAFA Family Health and Pediatric Clinics</td>
<td>(719) 333-0566</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1211 WPR</td>
<td>(718) 828-6610</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Adding an Organization to Q-PASS

Organizations
All of your organizations are listed here.

- How to add a new organization or claim an existing organization?
- How to set the primary and secondary contacts?
- What is my Tax Id Number?

Add an Organization
Just add information about your organization below to get set up.

Search for your organization to ensure it does not already exist before creating a new organization. Please enter at least 4 characters while searching for your organization.

Search...
Adding an Organization to Q-PASS II

Add an Organization
Just add information about your organization below to get set up.

Search for your organization to ensure it does not already exist before creating a new organization. Please enter at least 4 characters while searching for your organization.

search: TESTING

Your search - TESTING - did not match any results.

Organization Legal Name
* required

Organization Display Name

Street Address
* required

City
* required

State...

Zip
* required
Adding an Organization to Q-PASS III

HRSA grantee organizations only: please enter your HRSA H code below.

HRSA-H
Organization needs the following to enroll

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

Step-by-Step process in Q-PASS

• Choose sites
• Choose product(s)
• Add/create clinicians
• Sign agreements
• Pay (can’t pay until agreements signed)
Enrolling in Q-PASS

How to Enroll a Site into a Program?

Select a program to enroll in from the list below.

Patient-Centered Medical Home

The patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into "what patients want it to be." Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care.

Enroll Sites in Program

National Committee for Quality Assurance
1100 13th St., NW, Suite 1000
Washington, D.C. 20005

© 2017 - National Committee for Quality Assurance (NCQA). All rights reserved.
Enrollment – Choose Sites

How to add a site?

How to Enroll a Site into a Program?

How to set a Primary Contact

What is the difference between a Type 1 and Type 2 NPI?

Total Sites to Enroll in PCMH = 1

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

Select Sites below:

- Select All/None

SCROLL TO VIEW ALL SITES

Production Test 1, Site A
Peabody 20, Massachusetts

Select a site on the left to show details in this section.
Step 2: Choose Products

Here you see all the available products for your practice sites. For most practice sites, this will be limited to the program selected. For practices in some locations, there will be additional products, such as the Massachusetts PCMH PRIME Certification program.

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

Please choose any of the eligible practice sites you would like to add the Patient-Centered Medical Home product:

- Production Test 1, Site A

Please choose any of the eligible practice sites you would like to add the PCMH HPC PRIME product:

- Production Test 1, Site A
Enrollment – Set Up Clinicians

Step 3: Set Up Clinicians

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

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

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

<table>
<thead>
<tr>
<th>Site</th>
<th>Clinician Count</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Production Test 1, Site A</td>
<td>1</td>
<td>Manage Clinicians</td>
</tr>
</tbody>
</table>

National Committee for Quality Assurance
1100 13th St., NW, Suite 1000
Washington, D.C. 20005

© 2017 - National Committee for Quality Assurance (NCQA). All rights reserved. • System version 78
Enrollment – Sign Agreements

Step 4: Sign Legal Agreements

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

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

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

How to sign legal agreements

There are 2 agreements that need to be signed.

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

Download Adobe Acrobat Reader

<table>
<thead>
<tr>
<th>Agreement</th>
<th>Is Signed</th>
<th>Signed By</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCMH 2017 Agreement</td>
<td>Signed</td>
<td>Bill Tull</td>
<td>4/12/2017</td>
</tr>
<tr>
<td>Business Associate Agreement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Signed</td>
<td>Bill Tull</td>
<td>4/12/2017</td>
</tr>
</tbody>
</table>
Step 5: Generate Invoices and Cost Overview

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

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

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

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

### How to Bundle, Create, & Cancel Invoices

### How to Apply Discount

### How to Pay Invoice

<table>
<thead>
<tr>
<th>Site</th>
<th>Product</th>
<th>Version</th>
<th>Amt</th>
<th>Due</th>
<th>Status</th>
<th>Order #</th>
<th>Actions</th>
<th>Discount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Production Test 1, Site A</td>
<td>PCMH</td>
<td>2017</td>
<td>$400</td>
<td>$0</td>
<td>Paid</td>
<td>169819</td>
<td>Actions</td>
<td>$400</td>
</tr>
</tbody>
</table>

Balance: $0
Multi-Sites Sharing Evidence/Credit

- Enroll in Programs
- Manage Evaluations
- Manage Sites
- Upload Evidence
- Share Credits
- Manage Annual Reporting Dates
- Make Payments
- Transfer Credits
- Manage Organization Clinicians
- Sign Legal Agreements
- Manage People and Roles
Choosing What to Share

**Shared Components**

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

**Components**

- Access Needs and Preferences - Documented Process
- Access Needs and Preferences - Evidence of Implementation
- Acute Care After Hours Coordination - Documented Process
- Acute Care After Hours Coordination - Evidence of Implementation
- Advanced Care Planning - Evidence of Implementation
- Alternative Appointments - Documented Process
- Alternative Appointments - Report

**All sites**

All of my organization's sites

Sites 1
PCMH Redesign

Each practice will have a Dashboard to manage their work.
NCQA’s Redesigned System - Q-PASS

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

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

Practices can select and link documents and present examples virtually

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

MHIM: Medical Home Information and Materials

DESCRIPTION

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

SUGGESTED EVIDENCE

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

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

Let's do a virtual review

We have different evidence

We need help

This is not applicable to us

Ready for check in

Link evidence

Add new evidence
NCQA’s Redesigned System - Q-PASS

Practices can select and link documents and present examples virtually

SUGGESTED EVIDENCE

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

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

- Link evidence
- Add new evidence

Document  Text  Hyperlink

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

Drag and drop or click to browse

Type  Name
Questions