Achieving and Maintaining PCMH Recognition

Users Conference 2019

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Agenda

- About NCQA PCMH program
- Starting and organizing your project
- Understanding care management
- Exploration of how PCC functionality applies to 2017 PCMH standards
- Maintaining your recognition with annual reviews

Takeaways

- A basic understanding of NCQA's PCMH Recognition and why it might benefit your practice
- Recognition of how your existing workflow and processes may need to change in order to meet PCMH requirements
- An understanding of how PCC reports and functionality can be used to meet specific PCMH requirements

About NCQA'S PCMH Program

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Why Become a Medical Home?

- Improve patient access and care coordination
- Reduce silos in the workplace
- Boost patient and staff satisfaction
- Efficiently manage chronic patients
- Align with payers/state/Federal initiatives
- Help lower overall healthcare costs

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Evolution of the PCMH Standards

Continue to move practices closer to achieving the Triple Aim

2011	2014	2017
Emphasizes relationship with/expectations of specialists	Further incorporates behavioral health	Addition of Annual reporting requirements
Integrates behaviors affecting health, language, CLAS	Additional emphasis on team-based care	Further integrates social determinants & community connections
Enhances evaluation of patient experience	Focuses on care management of high need populations	Further integrates behavioral health
Underscores importance of system cost-savings	Higher bar, alignment of QI activities with "triple aim"	Shift from focus on structure to focus on outcomes
Enhances use of clinical performance measure results		

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Changes to PCMH

Highlights

Improve focus and flexibility

- Reduced total criteria to 100 from 167 factors in 2014
- Core/elective approach allows practices to tailor program to their population
- Eliminated structure in favor of 'outcome'

Support continuous practice transformation

- Includes activities necessary to achieve stated aims and drive improvement
- Focuses on whether the intent was achieved and care was improved

Update documentation methods

- Accommodates a spectrum of practices (basic-complex, small-large)
- Allows a variety of response options that demonstrate a requirement is met
- Introduces virtual review

Emphasize comprehensive, integrated care

- Understanding behavioral needs and social determinants included in core
- Deeper integration and community connections included in electives

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Getting Started

- Do you fully understand the concept?
  - Research the guidelines, the benefits and the statistics
  - Visit practices who are already medical homes and talk to colleagues about the practicalities of it
  - A medical home is not just a reimbursement model!

  Read the Joint Principles of a Medical Home Visit
  http://medicalhomeinfo.org/downloads/pdfs/JointStatement.pdf

- Will it be financially worthwhile?
  - Maybe! Depends upon region and Payer mix
  - Biggest benefit is streamlined practice operations and continued viability in this new 'era'

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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

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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

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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

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2017 Standards 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

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Scoring

Changes to Points

40 Core Criteria

Must complete all 40 core

60 Elective Criteria

Must achieve 25 Credits

RECOGNIZED
NCQA
PATIENT-CENTERED MEDICAL HOME

No more levels! Pass or Fail only

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2017 Standards Concepts

Concepts

Team-Based Care and Practice Organization

- Practice leadership
- Care team responsibilities
- Orientation of patient/families/ caregivers

Knowing and Managing Your Patients

- Data collection
- Medication reconciliation
- Evidence-based clinical decision support
- Connection with community resources

Patient-Centered Access and Continuity

- Access to practice and clinical advice
- Care continuity
- Empanelment

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2017 Standards Concepts

Concepts

Care Management and Support

- Identifying patients for care management
- Person-centered care plan development

Care Coordination and Care Transitions

- Management of lab/imaging results
- Tracking and managing patient referrals
- Care transitions

Performance Measurement & Quality Improvement

- Collecting and analyzing performance data
- Setting goals
- Improving practice performance
- Sharing practice performance data

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You're Ready to Start…What Now?

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Getting Started – Where Are You Today?

Figure out where you are in the process and what points you may already have:

Scan through the Standards and check off -

- What you are you already doing
- What processes you need to adjust
- What you need to build

AND / OR you can take the PCS free survey and we will help you determine your ‘gaps’ . . .

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PCS Survey

Take the PCS Online Survey

- Complete to the best of your ability – keep it simple
- We will provide feedback to show you where you are today
- It will help to set up your project plan by identifying the areas in which you need to do the least work (quick hits) and the most work
- Yes, it is FREE!

http://ncqasolutions.com/getting-started/

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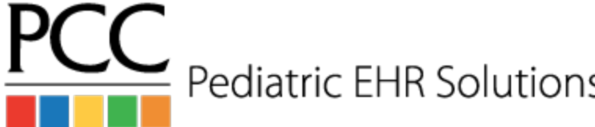
PCC PCMH Resources

http://pcmh.pcc.com

- Documentation and examples of relevant PCC reports and functionality related to 2017 standards
- Also includes other NCQA resources



PCC Prevalidation

- You can attest for automatic credit just for using PCC software
- Will allow you to bypass certain documentation items
- PCC is prevalidated under 2017 standards
- Bonus: Physicians can get MOC credit for being a recognized PCMH.

Build Your Team

- Form a PCMH team comprised of at least:
  - A physician ‘champion’ for each location
  - A nurse / clinical manager
  - An office manager
- Train the members of your PCMH team
- Share information across the entire practice and keep EVERYONE informed ** keep those meeting notes**

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Apply Project Management Principles

Put in place basic project management controls:

- Set an overall project completion goal
- Break down the work that needs to be done
- Start with the most important tasks first (not chronologically!)
- Set a "due-date" for assigned items
- Set standing meetings that work for you (e.g., weekly, bi-weekly, monthly)
- Share regular updates with staff in the form of memos

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Catalogue What You've Got

- Walk through every task, in front and behind the scenes, and follow the patient flow through the office
- Look for these key items:
  - Are there formalized policies and procedures?
  - Technology utilization beside an EMR - what else does your practice have that you can leverage for recognition
    - Website?
    - Patient Portal?
    - Recall system?

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Set Up Templates in the EMR

- Create visit templates for your important conditions (e.g., ADHD, Asthma, Obesity & acute/sick template)
- Try to include care plans in the templates **(we'll discuss this in detail)**
- By utilizing templates you will be collecting more data and be able to meet several criteria options (KM20 & CM section)
- Set up Standing Orders and utilize them
  - Test protocols, defined triggers for prescription orders, medication refills, vaccinations, routine preventive services

Remember when it comes to your system – junk in, junk out!

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Processes Preformed But Not Written?

- First, use what you've got
  - Job descriptions, meeting notes, training handouts etc.
- Start drafting!
  - Don't do an individual policy or procedure for each factor - group them together, and keep it as simple as possible
- Have everyone pitch in
  - Ask staff to draft what they do and those can be edited / refined from there

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Not Meeting Certain Process Requirements?

- Using your initial assessment to identify the gaps
- Implement the easy processes first
- Example – collecting race & ethnicity, assigning PCP, completing medication reconciliation
  - Have your staff begin doing that right away.
  - The longer you have them collecting data, the more likely you will reach your threshold when it comes time to submit your supporting data and documentation

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Compiling the Material for Submission

Capture As You Go

- Create a ‘Master Copy’ binder / **electronic file folder (preferred method)** and have one person manage it
- Keep working versions and final versions separate to avoid version control issues
- Annotate documents to easily draw the evaluators attention to sections you want to them review
- Consistently name your files specific to the criteria (e.g., TC06_Policy & TC06_Evidence)

Use a tool like Basecamp!

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Strategically Tackle the Project

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Build the Foundation (Practice Operations)

- Start with TC items (TC01, TC02, TC06, TC07) to build a strong foundation
- Review your assessment to determine areas that need immediate attention (e.g., CM section, CC01, CC04 & data)
  - Remember to align tasks with team members strengths
- Begin patient satisfaction surveys (QI04)
- Layer in policies

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Identify Patients/Conditions

- Identify patients for care management (CM01-02)
- Review patient visit notes to determine if templates need to be updated or documentation training (this will set you up for KM20 and the CM section)
- If no changes are needed gather your examples for KM20
- Align patient recallers (KM12) to your identified patients/conditions

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Implement Evidence-Based Decision Support

KM 20 (Core): Implements clinical decision support following evidence-based guidelines for care of (Practice must demonstrate at least four criteria):

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

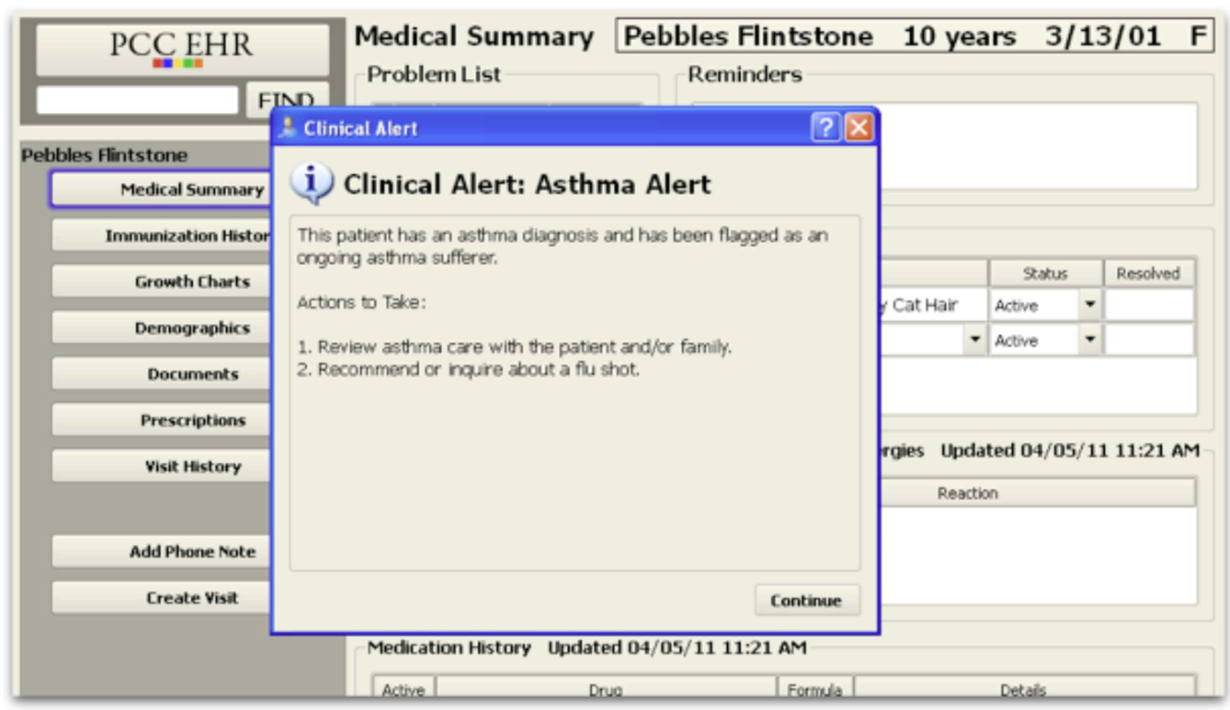
- Demonstrate at least four of the seven criteria
- Identify conditions, source of guidelines, and evidence of implementation

THRIVING THROUGH CHANGE

Implement Evidence-Based Decision Support

- PCC has auto-credit for the following conditions (if using specified protocols):
  - ADHD for KM20.A (related to mental health condition) if using built-in protocol following AAP's Clinical Practice Guidelines
  - Well child care for KM20.F if using Bright Futures protocols
- Consider asthma, allergic rhinitis for KM20.C (chronic condition)
- Consider otitis media and strep for KM20.D (acute condition)
- Consider using pediatric obesity for KM20.E (related to unhealthy behaviors)

Implement Evidence-Based Decision Support



- Use Clinical Alerts for point-of-care reminders

Identify Populations and Recall

KM 12 (Core): Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (must report at least three categories):

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

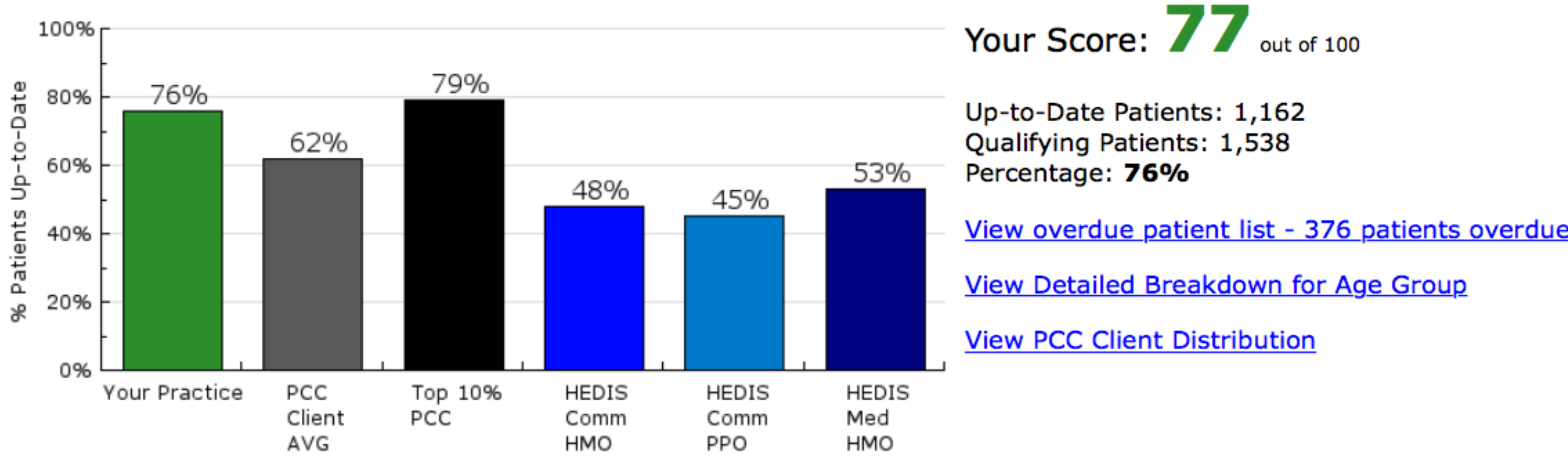
- Identify patients in need of care (Dashboard, recaller, MU report detail, **EHR Patient Recall Reports**)
- Remind patients of needed services (notify, recaller)
- Report and outreach materials required

KM 12.A: Choosing Preventive Care Services

- PCC Dashboard:
  - Patients overdue for well visits (pick an age group to focus on)
- New! EHR Patient Recall Reports
  - Adolescents needing depression screening
  - Infants needing developmental screening
  - 4-5 year olds needing vision or hearing screening
  - Newborns needing hearing screening
  - Children overdue for tobacco and/or alcohol/substance abuse counseling

THRIVING THROUGH CHANGE

Dashboard Overdue Lists



- Report well visit rates, overdue listing and trends for kids under 15 months, 15 - 36mos, 3-6yrs, 7-11yrs, or 12-21yrs.
- Use EHR Patient Recaller reports for up-to-date, refined overdue listing

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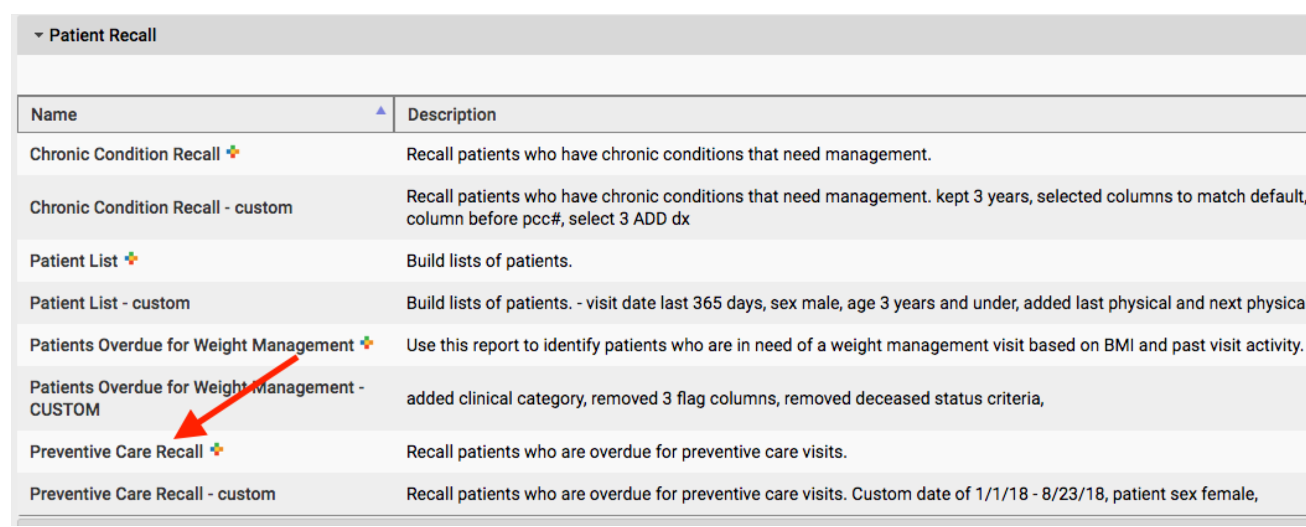
EHR Patient Recall



Patient Recall

Name	Description
Chronic Condition Recall	Recall patients who have chronic conditions that need management.
Chronic Condition Recall - custom	Recall patients who have chronic conditions that need management. kept 3 years, selected columns to match default, column before pcc#, select 3 ADD dx
Patient List	Build lists of patients.
Patient List - custom	Build lists of patients. - visit date last 365 days, sex male, age 3 years and under, added last physical and next physical
Patients Overdue for Weight Management	Use this report to identify patients who are in need of a weight management visit based on BMI and past visit activity.
Patients Overdue for Weight Management - CUSTOM	added clinical category, removed 3 flag columns, removed deceased status criteria,
Preventive Care Recall	Recall patients who are overdue for preventive care visits.
Preventive Care Recall - custom	Recall patients who are overdue for preventive care visits. Custom date of 1/1/18 - 8/23/18, patient sex female,

- Use EHR Report Library "Preventive Care Recall"
- Restrict on:
  - Patient age
  - Physical due date
  - Procedure
  - Diagnosis
  - Order (screenings, tests, etc)
  - and more

THRIVING THROUGH CHANGE

KM 12.B: Choosing Immunization Services

- Dashboard reports:
  - Patients overdue for Adolescent vaccines (HPV, Meningococcal, Tdap)
  - Patients overdue for seasonal flu vaccines
  - 2 year old patients in need of vaccines
- EHR Report Library
  - Patient Immunization Administration Summary

KM 12.B: Choosing Immunization Services

Adolescent vaccines

Vaccine	Number Needed By Age 13	Total Patients Age 13	Patients Up-to-Date at Age 13	% Up-to-Date at Age 13	Overdue at Age 13
HPV	2	158	95	60%	63 patients overdue
Meningococcal	1	158	148	94%	10 patients overdue
TdaP	1	158	154	97%	4 patients overdue
HEDIS® Combo 2 * (Includes All Vaccines Above)	N/A	158	93	59%	65 patients overdue

* "HEDIS® Combo 2" represents the percentage of patients up-to-date on all three of the following vaccine series: one tetanus, diphtheria, and acellular pertussis (TdaP); one meningococcal; and at least two human papillomavirus (HPV).

KM 12.B: Choosing Immunization Services

Childhood vaccines

Vaccine	Number Needed By Age 2	Total Patients Age 2	Patients Up-to-Date at Age 2	% Up-to-Date at Age 2	Overdue at Age 2
DTaP	4	609	482	79%	127 patients overdue
IPV	3	609	545	89%	64 patients overdue
MMR	1	609	535	88%	74 patients overdue
HIB	3	609	544	89%	65 patients overdue
Hep B	3	609	474	78%	135 patients overdue
Varicella	1	609	531	87%	78 patients overdue
Pneumococcal	4	609	507	83%	102 patients overdue
Hep A	1	609	514	84%	95 patients overdue
Rotavirus	2	609	519	85%	90 patients overdue
Influenza	2	609	351	58%	258 patients overdue
Combo 9 * (Includes All Vaccines Above Except Influenza)	N/A	609	377	62%	232 patients overdue
Combo10 ** (Includes All Vaccines Above)	N/A	609	267	44%	342 patients overdue

KM 12.B: Choosing Immunization Services

Report Library

Report Library

- All Reports
- Billing
- Clinical
- Immunization

Name	Description
Immunization Administration Count	Display the number of vaccines administered during a date range, grouped by lot number, vaccine
Immunization Administration Details	View vaccine administration details for a given date range, including funding source, VFC eligibility
Patient Immunization Administration Summary	Generate a list of patient vaccine histories for specified vaccines and number of administrations.
Vaccine Inventory Reconciliation Worksheet	Compare PCC EHR vaccine inventory with vaccine inventory in the refrigerator.
Vaccine Inventory Transaction Log	

Report Library

Patient Immunization Administration Summary

Generate a list of patient vaccine histories for specified vaccines and number of administrations.

Exclude by Patient Flag

Edit — 2 Patient Flags Excluded
INACTIVE
Transient

Patient Age Range

From 11 yrs mos through 12 yrs 11 mos
05/30/2005 through 05/29/2007

Date of Last Visit

Last 3 Years From 05/29/2015 to 05/29/2018

Number of Shots

From 0 to 1

Immunization

Edit — 2 Immunizations
~HPV
HPV9

- Use "Patient immunization Administration Summary" report in EHR Report Library
- Identifies active patients of a certain age having received any number of doses for any vaccine

THRIVING THROUGH CHANGE

KM 12.C: Choosing Chronic/Acute Services

- Dashboard reports:
  - ADHD patients overdue for followup visit
- New! EHR Patient Recall Reports
  - Asthma patients overdue for checkup
  - Patients with depression overdue for checkup
  - Patients with obesity overdue for checkup
  - Patients with allergic rhinitis overdue for checkup
- PCC EHR Clinical Quality Measure (CQM) Reports
  - Followup Care for ADHD Patients
  - Asthma patients in need of medication checkup

KM 12.C: Choosing Chronic/Acute Services

Your Score: **86** out of 100

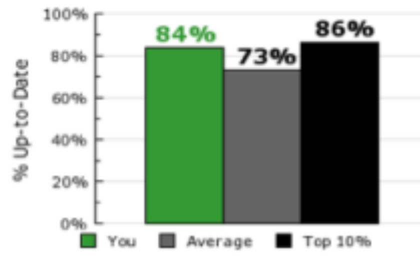
Dashboard reports updated as of 11/30/2013

This clinical benchmark is a measure of your success with chronic disease management of ADD/ADHD patients. Various clinical resources, from the AAP to various state laws, indicate that actively managed ADD and ADHD patients must be seen by your practice at least once every six months, at least. This section includes a count of your active ADD and ADHD population, an indication of how many of your active patients have this diagnosis, and how many of these patients are up-to-date on their routine followup visit. You can also view a listing of ADD and ADHD patients who are overdue for a followup visit.

Your office has **393** active ADD/ADHD patients. (**4%** of total active patients)

64 of these patients are overdue for a followup visit.

How You Compare



Your Practice	PCC Client Average	Top Performers
84%	73%	86%

(% of ADD/ADHD patients up-to-date on their followup visit)

- Dashboard example measuring % of ADHD patients seen in past six months

KM 12.C: Choosing Chronic/Acute Services

PCC EHR CQM Report: ADHD Followup Care for Children Prescribed ADHD Medication

- Use "Details" links to see list of overdue patients who need followup care after starting ADHD medication

Measure#	NQF	Measure	Numerator	Denominator	Performance Rate	Exclusions	Exceptions	Details
CMS136v4	0108	ADHD: Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication	N/A	N/A	N/A	N/A	N/A	N/A
		Initiation Phase	6	50	67%	41	N/A	Details
		Continuation and Maintenance Phase	0	7	N/A	7	N/A	Details

KM 12.C: Choosing Chronic/Acute Services

PCC EHR CQM Report: Use of appropriate medications for Asthma

- Use "Details" links to see list of patients with persistent asthma who are in need of medication checkup

Measure#	NQF	Measure	Numerator	Denominator	Performance Rate	Exclusions	Exceptions	Details
CMS126v3	0036	Use of Appropriate Medications for Asthma (Summary)	5	7	71%	0	N/A	Details
		• Stratification 1 - Age 5-11yrs	3	4	75%	0	N/A	Details
		• Stratification 2 - Age 12-18yrs	2	3	67%	0	N/A	Details
		• Stratification 3 - Age 19-50yrs	0	0	N/A	0	N/A	N/A
		• Stratification 4 - Age 51-64yrs	0	0	N/A	0	N/A	N/A

THRIVING THROUGH CHANGE

KM 12.D: Patients Not Recently Seen

Use recaller or new EHR Patient Lists restricting by "Date of last visit"

```
Include by Age
Include by Appointment (All Providers)
Include by Appointment and Provider
Include by Birthday (Next)
Include by Date Added to Partner
Include by Date of Last Physical
Include by Date of Last Visit
Include by Date of Physical Due
Include by Diagnosis
Include by Ethnicity
```

```
Recaller - Select mm/dd/yy Dates          Question 1 of 1

    Include by Date of Last Visit

    between 05/06/11  and 05/06/12
```

Aligning Clinical Quality Data

- Align clinical quality measures with patients identified in care management and recallers:
  - Care management patient (CM01): asthma
  - Clinical decision support (KM20): asthma template/visit note example
  - Recaller (KM12): identified asthmatics in need of a flu shot
  - Quality measure (QI01): asthma (influenza) vaccine
  - By aligning the patients/conditions with multiple sections you're easily able to identify, close care gaps, and improve metrics.

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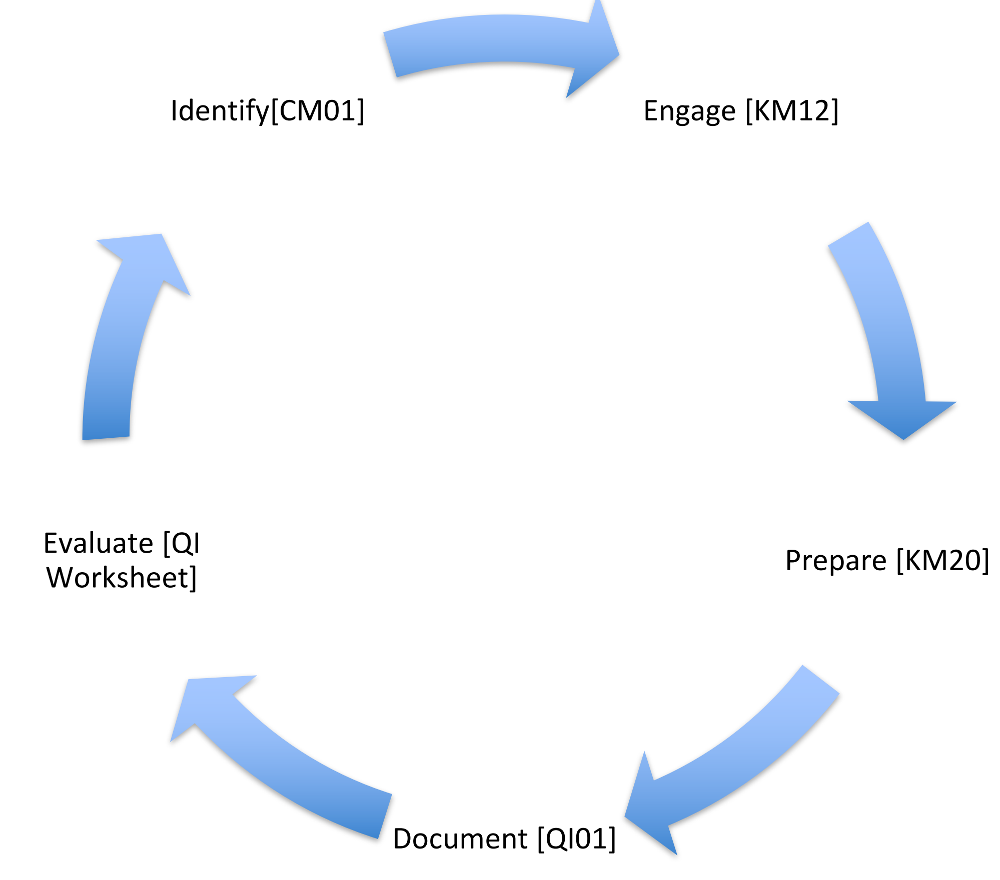
Process of Closing a Care Gap



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Monitor Resource Measures

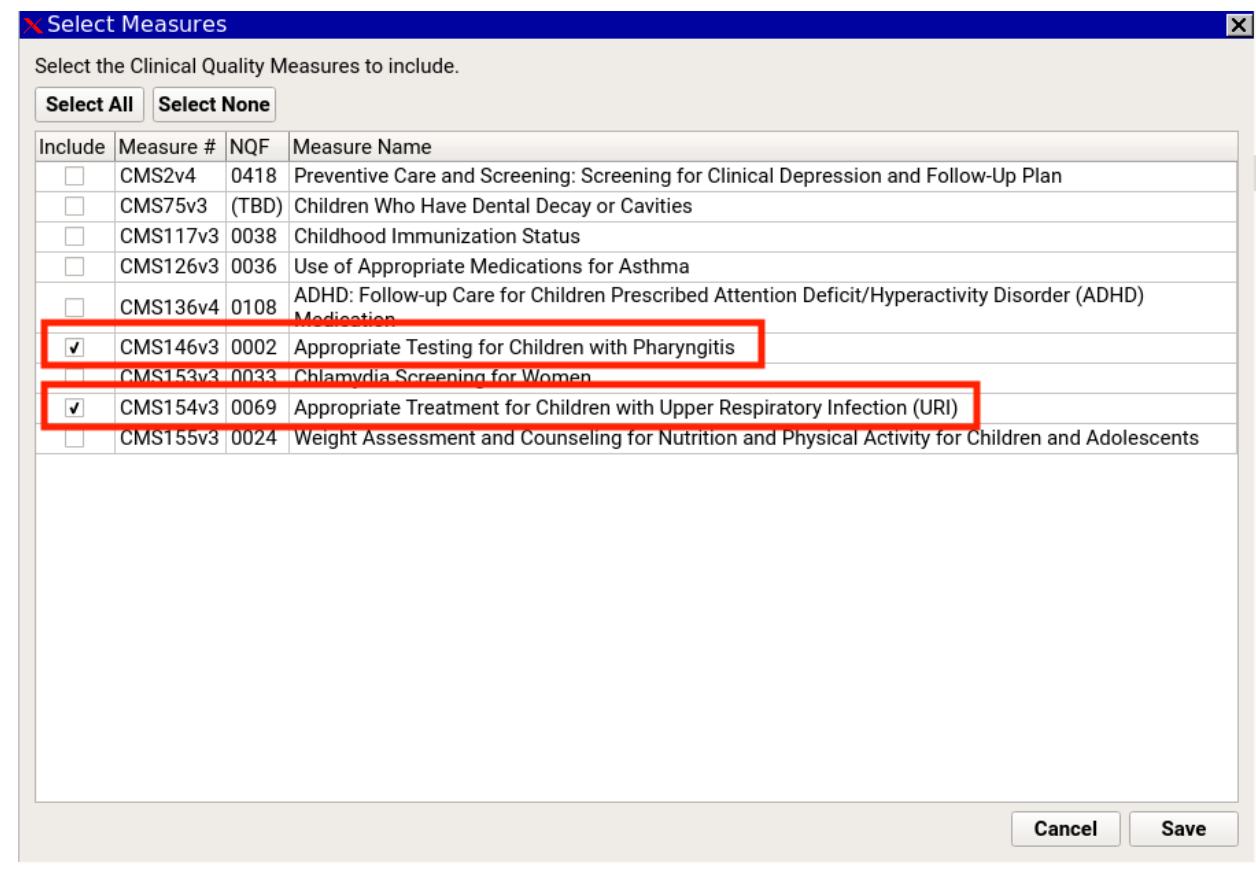
QI 02 (Core): Monitors at least two measures of resource stewardship (must monitor at least 1 measure of each type):

A. Measures related to care coordination.

B. Measures affecting health care costs.

- Pick resource measures at the beginning of the project
- Align health care cost resource measure to CM01 – B “high-cost/high-utilization”
- Health care cost measures:
  - Appropriate treatment of URI
  - Appropriate testing for Pharyngitis
- Care coordination measures:
  - Medication reconciliation (KM14)
  - Newborn screens (CC02)
  - Referrals completed by flag date

Health Care Cost Measures


Select Measures

Select the Clinical Quality Measures to include.

Select All | Select None

Include	Measure #	NQF	Measure Name
☐	CMS2v4	0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
☐	CMS75v3	(TBD)	Children Who Have Dental Decay or Cavities
☐	CMS117v3	0038	Childhood Immunization Status
☐	CMS126v3	0036	Use of Appropriate Medications for Asthma
☐	CMS136v4	0108	ADHD: Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication
✓	CMS146v3	0002	Appropriate Testing for Children with Pharyngitis
☐	CMS153v3	0033	Chlamydia Screening for Women
✓	CMS154v3	0069	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
☐	CMS155v3	0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

Cancel | Save

PCC EHR CQM Reports

- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with URI

Care Coordination Measures

Measure	Numerator	Denominator
CPOE Medication	228	228
CPOE Laboratory	96	96
CPOE Radiology	2	2
Electronic Prescribing (without Controlled Substances)	135	135
Electronic Prescribing (with Controlled Substances)	218	218
Summary of Care (Transmitted Only)	0	33
Patient-specific Education (Calendar Year)	97	286
Medication Reconciliation	12	12
Timely Online Access	277	286
View, Download, Transmit (VDT)	190	286
Secure Electronic Messaging (Sent)	41	286

PCC "Modified Stage 2 MU Report"

- % of Transitions of Care where medication reconciliation is performed
- Also used for KM14 - addressing medication safety and adherence

Medication Reconciliation

Use special component in EHR to indicate medications are reconciled for patients transitioning to you

Transition of Care (ARRA)

- [x] Patient transitioned to my care from another clinical setting
- [x] Medication Reconciliation performed

Organizing Data for the QI Worksheet

- Run historical data – last 4 quarters
- Choose 3 clinical quality measures & 1 resource measure to use for the QI worksheet – start your "story"
- Analyze patient satisfaction surveys, choose 1 measure to use for the QI worksheet
- Pick an access measure for improvement
  - Improving no-shows
  - Reducing wait times for scheduled appointments

Have a team meeting to discuss performance improvement – document meeting minutes (TC07/QI15)

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Care Management

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Care Management and Support

CM 01 (Core): Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria):

A. Behavioral health conditions.
B. High cost/high utilization.
C. Poorly controlled or complex conditions.
D. Social determinants of health.
E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/family/caregiver.

- Include at least three of the five criteria
- Provide protocol for identifying patients for care management

Care Management and Support

- Use recaller or EHR Patient Lists in Report Library for identifying patients needing Care Management based on diagnosis or problem list
- Add “Care Management” flag to these patients
- Create clinical alerts reminding clinicians when working with these patients

THRIVING THROUGH CHANGE

Care Management and Support

CM 02 (Core): Monitors the percentage of the total patient population identified through its process and criteria.

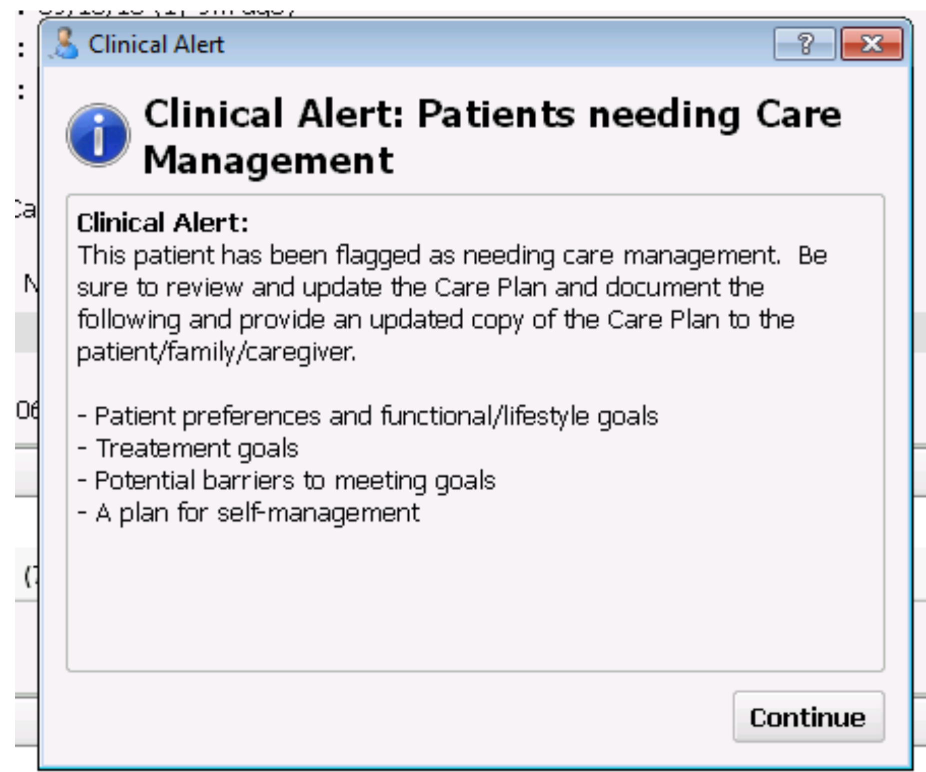
```
Recaller - Report Details
Criteria:
  Build a list of patients based on the following criteria:
  Include by Date of Last Visit
and Exclude by Flag - Account Flag
and Exclude by Flag - Patient Flag
and Include by Flag - Patient Flag

Selections:

  Include by Date of Last Visit
   in the past 3 yrs
   calculated from today

  Exclude by Flag - Match any ONE Account Flag
   Archived                          Collection
   Inactive                          Physician Coverage

  Exclude by Flag - Match any ONE Patient Flag
   2001-Transferred                  Inactive
   Referred by Another Physician     Unborn

  Include by Flag - Match any ONE Patient Flag
   Care Management
```

Use "Care Management" flag to identify patients needing care management

- Use recaller or new EHR Patient Lists to monitor population of kids needing care management

Care Management and Support

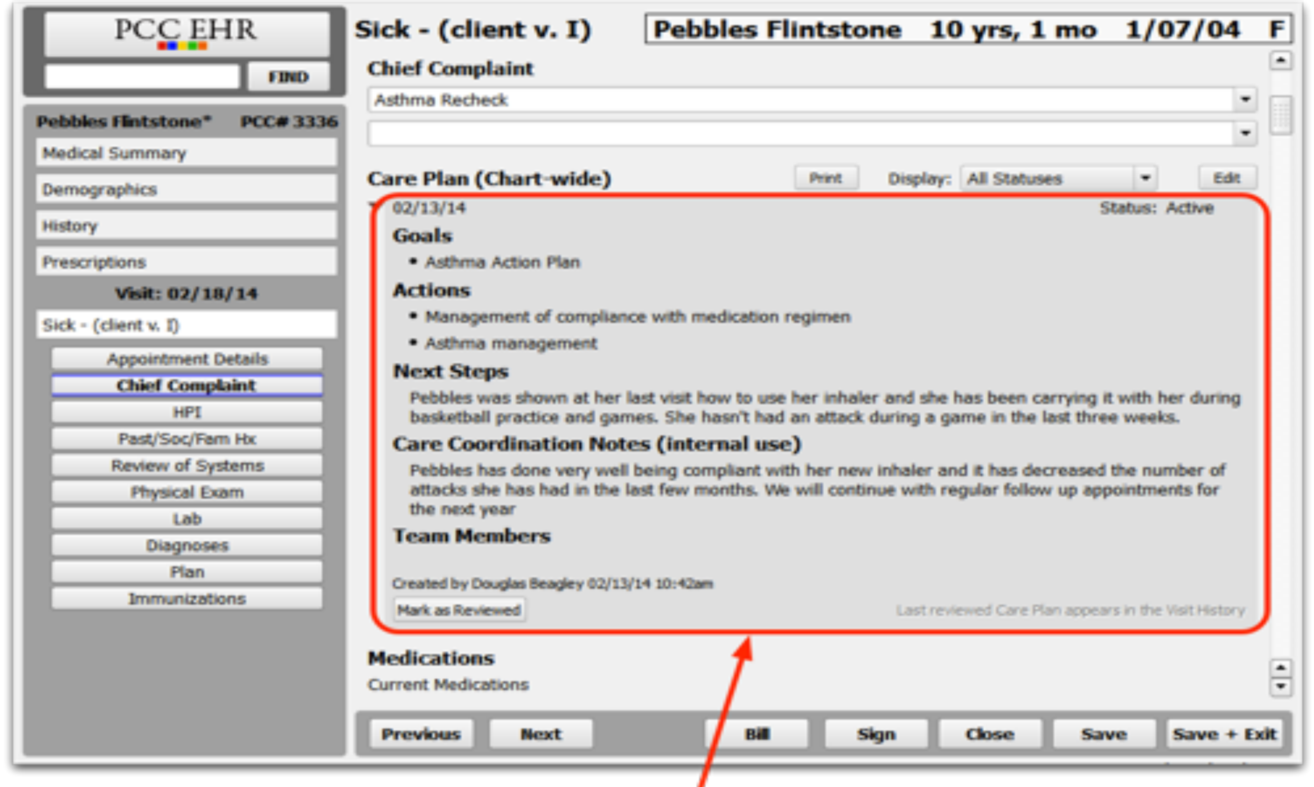
- Use clinical alert in EHR to remind about updating Care Plan



Pediatric EHR Solutions

Care Management and Support

CM 04 (Core): Establishes a person-centered care plan for patients identified for care management.



If you add the Care Plan component to chart notes, you can review, update, print, and mark interventions as reviewed during a visit

- Use PCC's Care Plan component embedded within visit templates
- Use EHR Report "Care Plans by Date" to identify all patients with a Care Plan

THRIVING THROUGH CHANGE

Clarify Terminology

Care Management	Activities performed by healthcare professionals to improve patient outcomes
Care Coordination	Organizing patient care between clinicians and facilities
Care Plan	Individualized instructions and interventions given to the patient in writing

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Reviewing Documentation

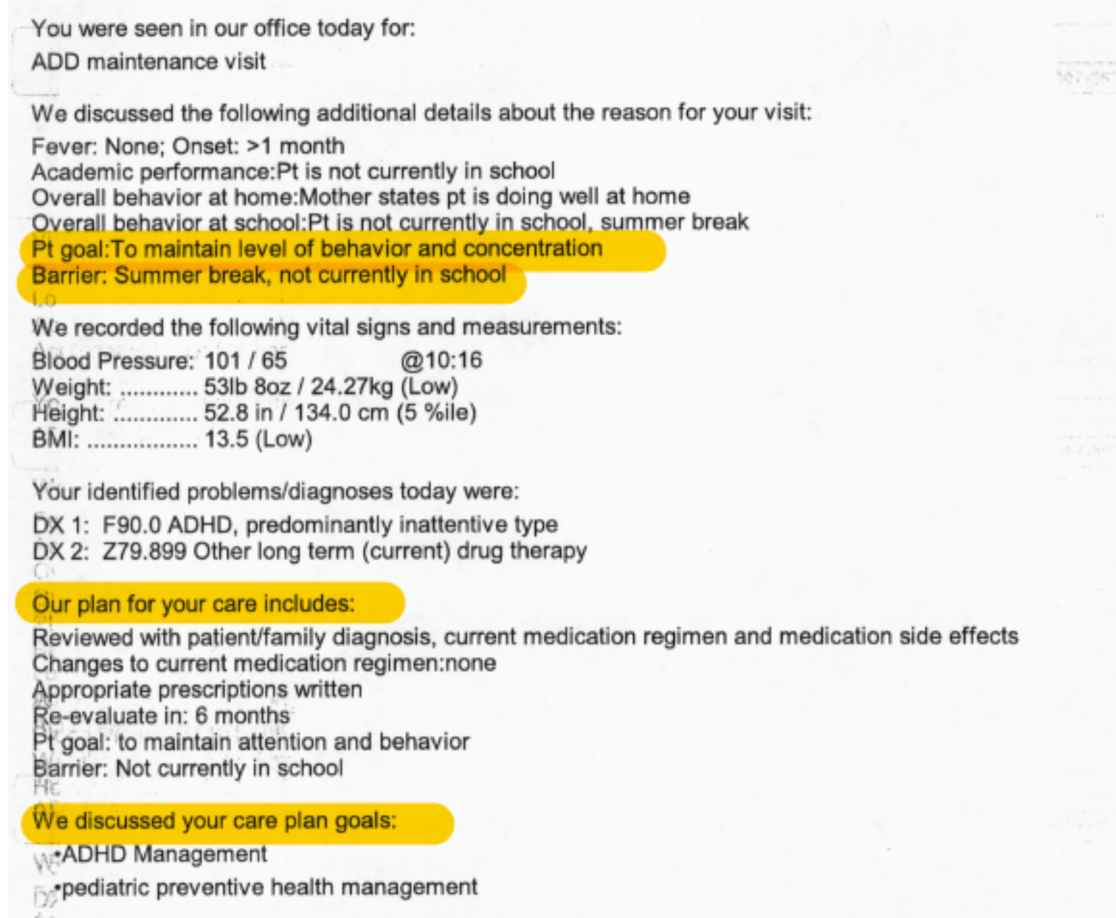
Chief Complaint
F/U visit for ADD/ADHD:

History of Present Illness
Fever: None; Onset: >1 month; Duration: Chronic; Severity: Moderate; Quality: Improving
Academic performance: Mom states child is doing better in school
Overall behavior at home: Child's behavior has improved per mom
Overall behavior at school:

Assessment
DX 1: F90.2 Attention-deficit hyperactivity disorder, combined type
DX 2: Z79.899 Other long term (current) drug therapy
DX 3: R63.4 Abnormal weight loss

Plan
Reviewed with patient/family diagnosis, current medication regimen and medication side effects
Changes to current medication regimen:
Appropriate prescriptions written
Re-evaluate in: 3 weeks
recommend peanut butter,carnation instant breakfast-recheck wt in 3 weeks

Care Plan: Goals
- •ADHD Management
- •pediatric preventive health management
- •Copy of ADHD


You were seen in our office today for:
ADD maintenance visit

We discussed the following additional details about the reason for your visit:
Fever: None; Onset: >1 month
Academic performance:Pt is not currently in school
Overall behavior at home:Mother states pt is doing well at home
Overall behavior at school:Pt is not currently in school, summer break
Pt goal:To maintain level of behavior and concentration
Barrier: Summer break, not currently in school

We recorded the following vital signs and measurements:
Blood Pressure: 101 / 65 @10:16
Weight: .... 53lb 8oz / 24.27kg (Low)
Height: .... 52.8 in / 134.0 cm (5 %ile)
BMI: .... 13.5 (Low)

Your identified problems/diagnoses today were:
DX 1: F90.0 ADHD, predominantly inattentive type
DX 2: Z79.899 Other long term (current) drug therapy

Our plan for your care includes:
Reviewed with patient/family diagnosis, current medication regimen and medication side effects
Changes to current medication regimen:none
Appropriate prescriptions written
Re-evaluate in: 6 months
Pt goal: to maintain attention and behavior
Barrier: Not currently in school

We discussed your care plan goals:
•ADHD Management
•pediatric preventive health management

- Note is not completed
- No real care plan created
- Clinical summary not given to patient

- Added goals and barriers to template
- Data is in structured data fields
- Care plan has details
- Clinical summary & care plan given to patient

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Building a Usable Care Plan

Determine where the care plan will live (e.g., chart or visit note)

Add ***patient*** goals (e.g., play with kids or lose 5 pounds)

Include ***barriers*** (e.g., cost of medications, compliance issues or lack of transportation)

Provide educational resources or tools encourage ***self-management***

Configure the care plan to print with the clinical summary or be pushed to the portal

Structure data fields to increase adoption and efficiency

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Structured Data Fields

Care Plan Intervention
Status: Active

Visit History (19 yrs, 6 mos;

Goals

- manage symptoms of ADHD, reduce anxiety, reduce panic attacks, develop healthy coping skills

Actions

- Medication action/side effects care
- Stress management surveillance
- Rest/sleep surveillance
- Nutritional monitoring
- Substance use surveillance

Next Steps

follow up in 2 weeks

Care Coordination Notes

med check
trial of lexapro
taking adderall xr for ADHD

Team Members

Dr. — Specialty: Pediatrics — Organization:

Created by
[Last Reviewed for this visit by

Prescriptions

ESCITALOPRAM (LEXAPRO) (Completed) — Date to fill: 07/06/18, Start: 07/06/18
1 x 5 mg Tablet
1 tab PO every day
Quantity: 30 Tablet(s), 2 refills
8 9:48am
8 9:48am
8 9:48am

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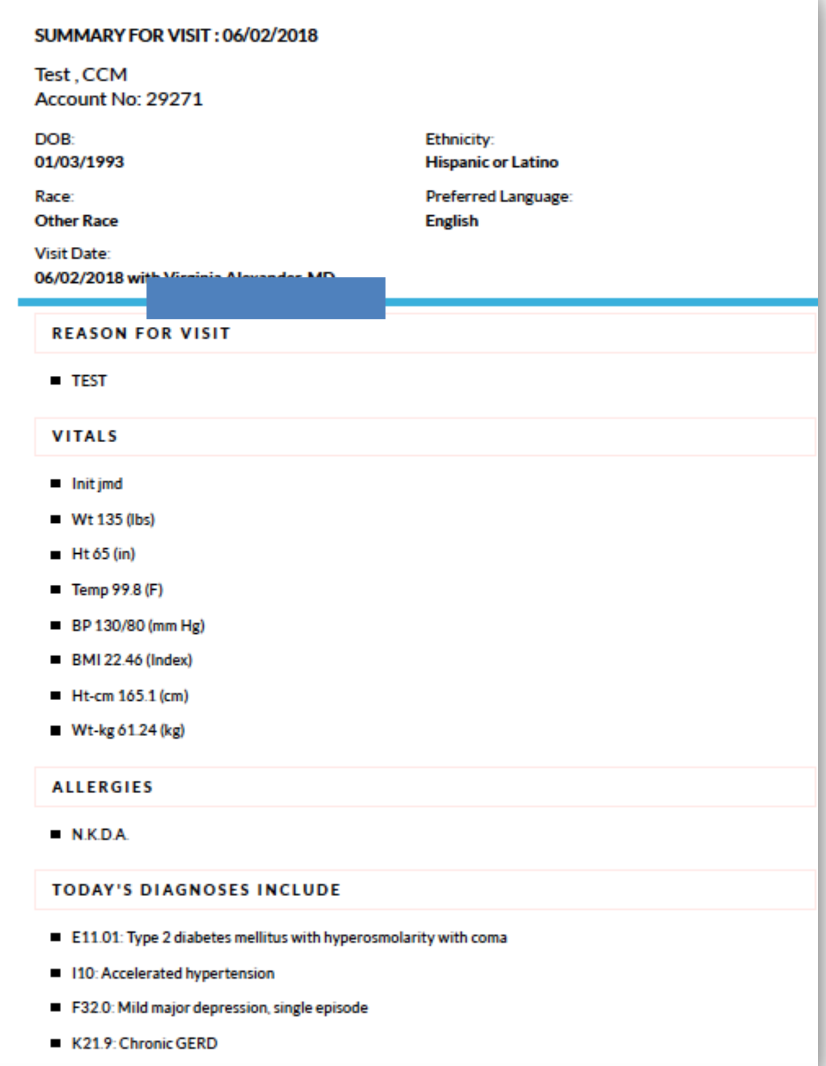
Chronic Care Management (CCM)
Care Plans



SUMMARY FOR VISIT : 06/02/2018

Test , CCM
Account No: 29271

DOB:	Ethnicity:
01/03/1993	**Hispanic or Latino**
Race:	Preferred Language:
Other Race	**English**

Visit Date:
06/02/2018 wi[illegible]

REASON FOR VISIT

- TEST

VITALS

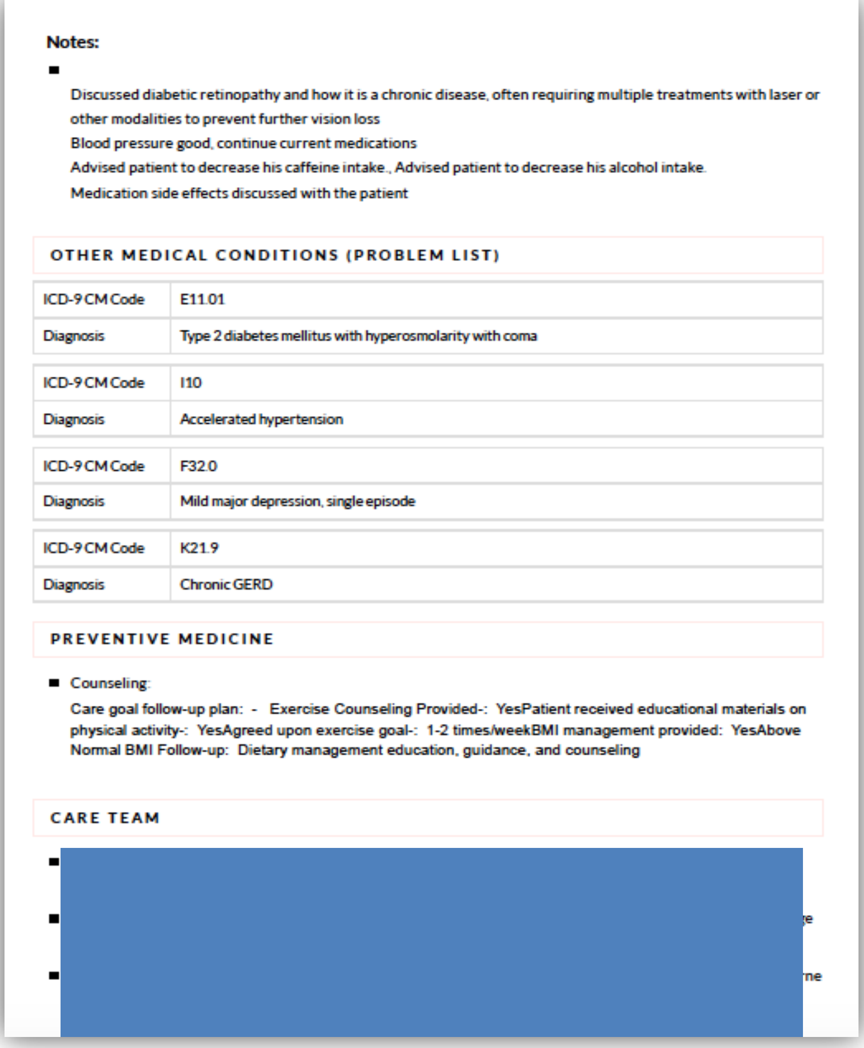
- Init jmd
- Wt 135 (lbs)
- Ht 65 (in)
- Temp 99.8 (F)
- BP 130/80 (mm Hg)
- BMI 22.46 (Index)
- Ht-cm 165.1 (cm)
- Wt-kg 61.24 (kg)

ALLERGIES

- N.K.D.A.

TODAY'S DIAGNOSES INCLUDE

- E11.01: Type 2 diabetes mellitus with hyperosmolarity with coma
- I10: Accelerated hypertension
- F32.0: Mild major depression, single episode
- K21.9: Chronic GERD



Notes:

- Discussed diabetic retinopathy and how it is a chronic disease, often requiring multiple treatments with laser or other modalities to prevent further vision loss
  Blood pressure good, continue current medications
  Advised patient to decrease his caffeine intake., Advised patient to decrease his alcohol intake.
  Medication side effects discussed with the patient

OTHER MEDICAL CONDITIONS (PROBLEM LIST)

ICD-9 CM Code	E11.01
Diagnosis	Type 2 diabetes mellitus with hyperosmolarity with coma
ICD-9 CM Code	I10
Diagnosis	Accelerated hypertension
ICD-9 CM Code	F32.0
Diagnosis	Mild major depression, single episode
ICD-9 CM Code	K21.9
Diagnosis	Chronic GERD

PREVENTIVE MEDICINE

- Counseling:
  Care goal follow-up plan: - Exercise Counseling Provided-: YesPatient received educational materials on physical activity-: YesAgreed upon exercise goal-: 1-2 times/weekBMI management provided: YesAbove Normal BMI Follow-up: Dietary management education, guidance, and counseling

CARE TEAM

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Care plan configured on a clinical summary

Summary Of Today's Visit Page 1 of 2

CM04/05: This is an example of a care plan for an asthma patient. It is pushed to the portal after the visit. Asthma action plans are handed to the patient in writing.

Summary of Today's Visit

DOB:
Account No
Gender:Male
Race:White
Ethnicity:Hispanic or Latino
Preferred Language:English

Allergies

- N.K.D.A.

Medication List

- Start Flovent HFA : 44 MCG/ACT 2 puffs Inhalation Twice a day,30 days ,1 ,Refills: 0 , stop date: 06/02/2018
- Start ProAir HFA : 108 (90 Base) MCG/ACT 4 puffs as needed Inhalation every 4 hrs,30 days ,1 ,Refills: 2

Other medications you are on

- Taking ZyrTEC :
- Not-Taking/PRN Albuterol Sulfate : (2.5 MG/3ML) 0.083% 3 ml Inhalation every 4 hrs prn,1 Box ,Refills: 2
- Not-Taking/PRN Flonase :

Notes:
8yo M with mild intermittent asthma, stable, no resp distress.
CM07 Barriers: likely trigger seasonal allergies,
Plan: given refill of albuterol and use PRN. mom requesting flovent - discussed that would not recommend flovent initation as has not needed alb inhaler in many years, current resp exam stable, and is super well app - do not feel that we need to start inh CS, however mom wishes to have as a back up/in back pocket in case breathing gets worse. rx provided.
CM06 Goal: maintain stable respiratory state and utilize medications only if needed as stated is asthma action plan. Try to not use Flovent if feeling well.
CM08 Self-Management Plan: reviewed current asthma management and follow as written, return if increased difficulty breathing, needing albuterol inhaler more frequently than q4H, labored breathing, changes in mental status, fever with cough, any other respiratory issues.
Mom aleady has up to date asthma action plan in possession.
history consistent with seasonal allergies. recommend starting allergy med (Claritin or zyrtec), initiate Flonase, antihistamine eye drops and practice allergen avoidance: avoid playing outside near shrubbery, flowerbeds; wear hats when outside; wash hands once returning indoors, change out of clothes, wash pillowcases and bedding weekly. Return should symptoms persist or worsen, develops diff breathing, changes in vision/worsening eye redness, decreased urination, fever with symptoms, changes in mental status, any other questions or concerns.

Self-management plan – see next slide

Other Medical Conditions (Problem List)

- 493.90 Asthma w/o flare
- V20.2 WCE
- 464.4 Croup
- Z00.129 Encounter for routine child health examination without abnormal findings

Summary of Today's Visit for

Summary generated by eClinicalWorks (www.eclinicalworks.com)

This document contains confidential information about your health. To maintain your privacy, do not throw this document in the trash. If you do not wish to keep this document for your records, please shred or otherwise securely dispose of your copy. If you are not the intended recipient, please destroy this document and report it to the physician's office named above.

5/9/2018

Summary Of Today's Visit Page 2 of 2

- J02.0 Streptococcal pharyngitis
- J45.991 Cough variant asthma
- J30.9 Allergic rhinitis, unspecified
- H65.02 Acute serous otitis media, left ear
- J45.20 Mild intermittent asthma, uncomplicated
- J30.2 Other seasonal allergic rhinitis

Summary generated by eClinicalWorks (www.eclinicalworks.com)

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Policies & Procedures

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Tips & Tricks

- Combine policies together
    - TC07 & QI15
    - Access policy (AC01-12)

- Create them with the intent of creating a PCMH manual
- Avoid extra words and procedures that don't make sense
- Label them in a manner that works for you
- Keep a Word document version for easy edits
- Have the individuals that do the job write the policy & procedure
- If possible, utilize a template

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<Practice Name>
Policies and
Procedures
Access and Continuity

POLICY STATEMENT:

<__> provides same-day appointments for routine and urgent care to meet the needs of our patients. Our practice seeks to enhance access by providing appointments based on our patients' needs. <__> reserves time on our daily appointment schedule to accommodate requests for a same-day appointment for routine and urgent care needs. <__> offers appointments and telephone access with a clinician outside of business hours. <__> allows patients to call the office with clinical questions. <__> offers patients access to a patient portal.

POLICY:

<__> gathers data by means of the patient satisfaction survey and third next available appointment report regarding the access needs of our patients and provides same- day appointments for routine and urgent care appointments according to this data. Our office reserves time on our daily schedule to meet requests for same-day appointments. We adjust access based on seasonal needs of our patient population (e.g., additional sick visits during flu seasons and additional well visits before school in August). <__> offers patients access to a patient portal where they can check their current diagnosis, medications and communicate with a provider.

OFFICE HOURS:

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PROCEDURE:

- ☐ <__>Pediatrics has determined that a certain number of same-day appointments should be available each day.
- ☐ <___>Pediatrics adjusts the availability of same-day appointments based on seasonal variations, flu and respiratory illness local outbreaks as well as local school and holiday vacations schedules.
- ☐ Our office uses the above variations, as well as other collected patient preferences, to reserve time on our daily appointment schedule to accommodate patient requests for same-day appointments.
- ☐ Same-day appointments are placed using "BLOCKS" in our providers' schedules ahead of time.
- ☐ "BLOCKS" are then released, or opened, for same-day appointments on the mornings that the designated provider is working in the office.
- ☐ "BLOCKS" can be reviewed and adjusted (daily or weekly) according to patient load and provider availability.
- ☐ Patient satisfaction surveys are done X times a year in <__> and <__>.
- ☐ Third next available appointment report is performed X times a year in <__> and <__>.

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- ☐ A patient can call <___> during office hours to get clinical advice from a staff member. If the patient's question is not answered immediately by a staff member, the call will be returned within<___>. All telephone calls and clinical advice are documented in the patient chart and sent to the provider, if necessary.
- ☐ During after-hours, the patient can call <___> and reach the on-call provider. If the phone call is not answered immediately the patient can expect a return call within <___>. All after-hours calls and clinical advice are documented in the patient chart by noon the next business day.
- ☐ <__> clinicians have access to the EMR <__> 24-hours a day with remote access.
- ☐ <___> patients can send clinical questions through the patient portal. Messages are checked several times a day and returned within <__> hours/days. We ask patients to call the office with urgent needs as the portal is not monitored on a real-time basis. Patient portal messages are automatically recorded in the patient record. We ask that minor children do not communicate on the portal.

APPOINTMENT EXPECTATIONS:

- New patients are to be given an appointment within <X> days.
- Newborns ---
- Lactation consults
- Follow-up visits including ADHD, asthma and obesity
- Nurse visits
- Sick visits
- Urgent visits

APPLICABILITY:
This policy is applicable for all schedulers, front desk staff and medical care providers employed by <___>. This policy will be reviewed yearly.

Revised 4/17/18

- Add a date of implementation & review dates (if applicable)
- Policies always look best with the practice logo
- Avoid fancy formatting – it won't translate well when printing and will be difficult for down-the-road edits
- Make the policies work for you!!

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PCMH Reporting Examples

PCC's PCMH Resources

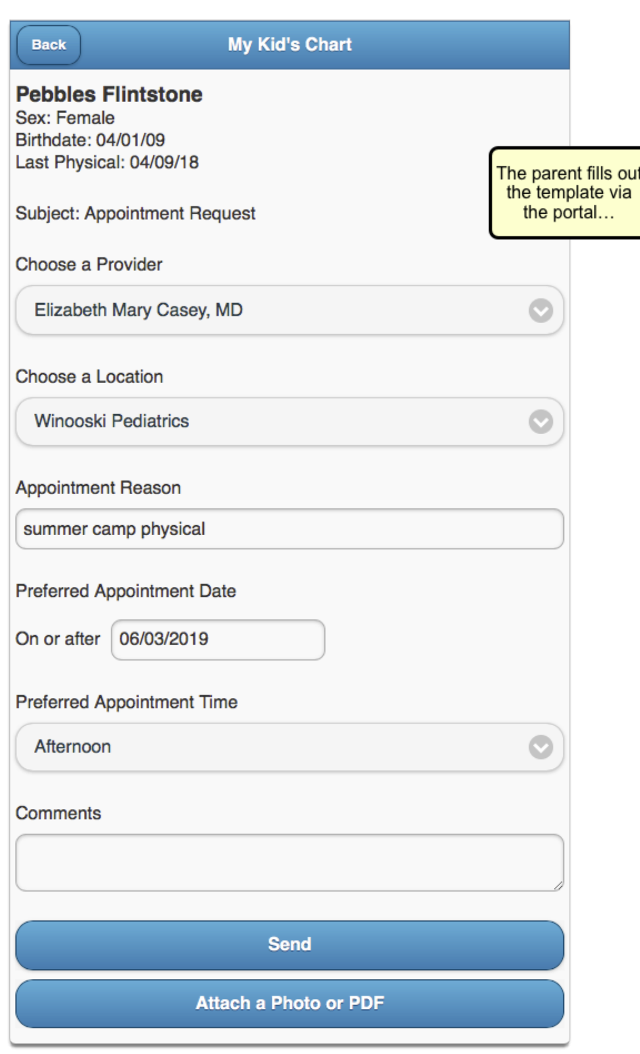
(http://pcmh.pcc.com)

Use Portal For Patient Requests

AC 07 (1 Credit): Has a secure electronic system for patient to request appointments, prescription refills, referrals and test results.	
GUIDANCE	**EVIDENCE**
Patients can use a secure electronic system (e.g., website, patient portal) to request appointments, prescription refills, referrals and test results. The practice must demonstrate at least two functionalities.	• **Evidence of implementation**

- Use secure portal messaging to allow patients to make these requests
- Need to demonstrate only two functionalities

Use Portal For Patient Requests



- Families can now request **appointments, referrals, refills**, and more with new customizable portal message templates

Adolescent Depression Screening

KM 03 (Core) - Conducts depression screenings for adults and adolescents using a standardized tool

- Use PCC Dashboard measure - “Depression Screening - Adolescents”
- No % threshold is required
- Must identify standardized screening tool
- Evidence and report or documented process required

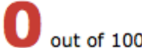
Assess Oral Health Needs

KM 05 (1 Credit) - Assesses oral health needs and provides necessary services based on evidence-based guidelines or coordinates with oral health partners

- Incorporate oral health assessment into protocols
- Do fluoride varnish
- Document referrals to oral health partners
- Evidence and documented process required

Assess Oral Health Needs

Measure: Fluoride Varnish Rate



Dashboard reports updated as of 7/2/2017

Your Score: 0 out of 100

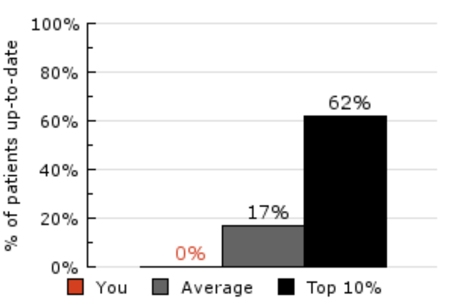
The AAP's Bright Futures Guidelines recommend the application of fluoride varnish to all children every 3-6 months once teeth are present through age 5. For active patients 1-5 years old with a well visit in the past year, this measure tracks how many of those patients also had a recommended fluoride varnish application billed with CPT code 99188, D1206, or 99429 within the last year. See how you measure up to other PCC clients and also see a breakdown of your performance by age and insurance group.

You have **779** active patients between 1 year and 5 years of age who have had a well visit in the past year.

0 of these patients received a fluoride varnish application within the past year.

How You Compare

View Age and Insurance Breakdown



Your Practice	PCC Client Average	Top Performers
0%	17%	62%

(% of active patients 1-5 years old having recent fluoride varnish)

Monitor Fluoride Varnish Rate in Dashboard

Identify Predominant Conditions

KM 06 (1 Credit) - Identifies the predominant conditions and health concerns of the patient population

- Generate PCC report showing predominant diagnoses for each provider
- KM 06 credit also counts for KM 01 (up-to-date problem list)

Identify Predominant Conditions

PCMH

Name	Description
Care Plans by Date	Find care plans by creation date and status.
Document Modification Report	Find documents by user, date, time, and/or category. This report can be used t
Orders by Visit	List of appointments that include selected order types.
Patient Count and Percentage by Ethnicity	Stratification of your patient population by ethnicity
Patient Count and Percentage by Primary Preferred Language	Stratification of your
Patient Count and Percentage by Race	Stratification of your
Patient Count and Percentage by Sex	Stratification of your
Patient Diagnoses by Date	List diagnoses and d
Patient Visits By Protocol	Find patient visits ba
Patients Overdue for Weight Management	Use this report to ide
Portal Message Response Time	Time between the re
Predominant Conditions of Your Patient Population	Identify the predomir
Prescription Count by Provider	Number of prescripti
Prescription Formulary by Provider	View ratios of On-For
Radiology Orders	List of open radiolog
Referral Orders	List of open referral

Report Library

Predominant Conditions of Your Patient Population

Identify the predominant conditions of your patient population.

Clinical Diagnosis:
Diagnosis Date: From 04/03/2019 to 07/02/2019
Diagnosis Name: All
Diagnoses/Problems: Combined

Columns: All 3 Displayed   Group By: None   Search:

Diagnosis	Number of Patients	Number of Diagnoses
Well child	1544	4083
Childhood obesity	464	1250
Well child visit	852	1237
Child examination	707	1147
Fever	679	1125
Cough	553	978
Upper respiratory infection	615	879
Active immunization	660	877
History and physical examination, school	722	870
Speech delay	215	551
Dental caries	277	544

Assess Diversity of Population

KM 09 (Core) - Assess the diversity (race, ethnicity, and one other aspect)

KM 10 (Core) - Assess the language needs

- Use EHR Report Library Reports
    - Patient Count and Percentage by Ethnicity
    - Patient Count and Percentage by Race
    - Patient Count and Percentage by Sex
    - Patient Count and Percentage by Primary Preferred Language

Identify Patients With Unplanned Hospital/ED Visits

CC 14 (Core): Systematically identifies patients with unplanned hospital admissions and emergency department visits

- Scan faxed hospital summaries into EHR and use "Document Modification Report" to identify these patients

Identify Patients With Unplanned Hospital/ED Visits

Report Library

Document Modification Report

Find documents by user, date, time, and/or category. This report can be used to find documents attached to the wrong patient or all documents in a particular category.

Modified by User

Edit | All Modified by Users

Date Range for Last Modified Date

From 04/12/2017 to 07/12/2017

Time Range for Document Time

From 8:00am to 5:00pm

Category

Hospital

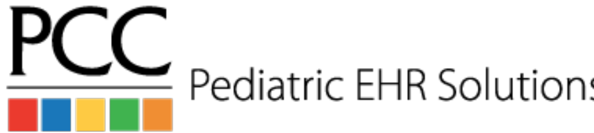
- Scan these documents into a special "Hospital" category
- Use "Document Modification Report" in EHR Report Library, filtered to show only patients with documents in this "Hospital" Category

THRIVING THROUGH CHANGE

Contact Patients For Followup After Hospital or ED

CC 16 (Core): Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or ED visit

- Once hospital summary is received, add task for follow-up care
- View tasks on messages queue



Contact Patients For Followup After Hospital or ED

Import Documents | **Pebbles Flintstone 10 years 3/16/07 F**

File Selection

File Source: All File Sources

Sort By: Date / Filename

Date

1 Page

04/07/17 11:21am
0001S120090709_132502007...
1 Page

04/07/17 11:21am
0001S120090709_132502007...
1 Page

04/07/17 11:21am
0001S120090709_132502006...
1 Page

04/07/17 11:21am
0001S120090709_132502006...
1 Page

Split File | Remove | Load New Files

Preview

Page 1 of 1

0001S12009070... 04/07/17 11:21am

Print | Rotate Document | Full Screen

Tags

Tasks: 1 (0 Completed)

Task:
Appointment Needed

To:
Nurse

Note:
call to schedule followup

Task Completed

By: select a user

At: mm/dd/yy 12:00am

Add Task

Communication Preferences

Patient's Confidential Communication Preference
Wilma Flintstone Cell Phone:
802-555-0161

Cancel | Save

Pediatric EHR Solutions

THRIVING THROUGH CHANGE

Monitor Clinical Quality Measures

QI 01 (Core): Monitors at least five clinical quality measures across the four categories (must monitor at least one measure of each type):

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

- Refer to PCMH page in the Dashboard
- Need report including # of patients, rate, and measure source

THRIVING THROUGH CHANGE

Monitor Clinical Quality Measures

Patient Centered Medical Home (PCMH) Measures

This dashboard page contains all of the PCC Practice Vitals Dashboard measures that relate to NCQA's 2017 PCMH standards and can be used to monitor your performance toward meeting specific criteria. You can also print this page to share the data with staff and providers and for submission to NCQA as part of your application for PCMH recognition. Visit PCC's PCMH WIKI page for screenshots, documentation, and other information about how PCC tools can help you meet various PCMH elements.

QI 01 (Core) – Clinical Quality Measurement

To understand current performance and to identify opportunities for improvement, the practice monitors clinical quality measurement. When it selects measures of performance, the practice indicates the following for each measure: period of measurement, number of patients represented by the date, and rate (percent) based on a numerator and denominator.

Choose at least five clinical quality measures across the four categories (A-D) listed below. You must monitor at least one measure of each category, and you cannot use the same measure for different categories.

Reporting period includes active patients as of 6/1/2019

A. Immunization Measures

Measure	Qualifying Patients	Up-to-Date Patients	% Up-to-Date	% Change (3 mo.)
Immunization Rates - Adolescents	158	93	59%	Insufficient Data
Immunization Rates - HPV (Patients 13-17 Years)	872	724	83%	0.4% ↑
Immunization Rates - HPV (Patients 13 Years)	158	105	66%	0.6% ↑
Immunization Rates - Influenza *	2,902	2,042	70%	3.7% ↑
Immunization Rates - Influenza (Asthma) *	391	307	79%	5.6% ↑
Immunization Rates - Meningococcal	872	850	97%	0.2% ↑
Immunization Rates - Patients 2 Years Old	158	147	93%	3.9% ↑
Immunization Rates - Tdap	872	862	99%	0.7% ↑

* Influenza rates are seasonal. This measure represents patients vaccinated since July 1. The percent change is compared to the same month last year.

B. Other Preventive Care Measures

Measure	Qualifying Patients	Up-to-Date Patients	% Up-to-Date	% Change (3 mo.)
Depression Screening Rates - Adolescents	1,084	959	88%	Insufficient Data
Developmental Screening Rates - Infants	149	142	95%	-0.9% ↓
Fluoride Varnish Rate	801	82	10%	3.0% ↑
Weight Assessment and Counseling - Nutritional Counseling	2,254	2	0%	-0.1% ↓
Weight Assessment and Counseling - Physical Activity Counseling	2,254	3	0%	-0.2% ↓
Weight Assessment and Counseling - Weight Assessment	2,254	2,228	99%	-0.2% ↓
Well Visit Rates - Under 15 Months	134	131	98%	0.0% ↑
Well Visit Rates - 15-36 Months	277	256	92%	2.0% ↑
Well Visit Rates - 3-6 Years	686	638	93%	1.0% ↑
Well Visit Rates - 7-11 Years	772	675	87%	1.0% ↑
Well Visit Rates - 12-21 Years	1,538	1,162	76%	-1.0% ↓

- PCMH page updated and replaced monthly
- Log your measure results monthly, including # patients

Pediatric EHR Solutions

THRIVING THROUGH CHANGE

Performance Data Stratified for Vulnerable Populations

QI 05 (1 Credit): Assesses health disparities using performance data stratified for vulnerable populations (must choose one from each section):

A. Clinical quality.

B. Patient experience.

- Use vulnerable population reporting on PCMH Dashboard

Performance Data Stratified for Vulnerable Populations

QI 05 (1 Credit) Health Disparities Assessment

The practice assesses health disparities using performance data stratified for vulnerable populations. You must choose one clinical quality experience measure. Use the menus below to stratify one clinical quality measure for a selected vulnerable population.

Reporting period includes active patients as of 6/1/2019

Performance data stratified for vulnerable populations

Measure: Well Visit Rates - 12-21 Years

Breakdown By: Primary Insurance

Well Visit Rates - 12-21 Years			
Primary Insurance	**Qualifying Patients**	**Up-to-Date Patients**	**% Up-to-Date**
Other Insurance	38	21	55%
Medicaid	312	227	73%
BCBS	636	506	80%
Cigna	172	130	76%
MVP	125	90	72%
First Health	15	13	87%
Tricare	6	2	33%
CBA BLUE	19	16	84%
United HC	44	31	70%
AETNA	25	22	88%
BCBS OTHER	146	104	71%

- Define your vulnerable population and use Dashboard report
- Vulnerable population options:
  - Primary Insurance
  - Race
  - Ethnicity
  - Preferred Language

THRIVING THROUGH CHANGE

Practice Shares Performance Data

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

- Use Dashboard PCMH page to see breakdown by provider (PCP) for certain measures
- Documented process and evidence of implementation is required

Practice Shares Performance Data

QI 15 (Core) Reporting Performance within the Practice

The practice provides individual clinician or practice-level reports to clinicians and practice staff. Performance results reflect care provided to all patients in the practice (relevant to the measure), not only to patients covered by a specific payer. Select a measure from the menu below to see clinician-level reporting, broken down by primary care provider:

Reporting period includes active patients as of 6/1/2019

Performance data stratified for individual clinicians

Measure: Depression Screening Rates - Adolescents

Depression Screening Rates - Adolescents			
Primary Care Provider	**Qualifying Patients**	**Up-to-Date Patients**	**% Up-to-Date**
Provider 0	4	4	100%
Provider 13	58	48	83%
Provider 16	10	10	100%
Provider 18	3	3	100%
Provider 2	723	662	92%
Provider 3	43	39	91%
Provider 5	243	193	79%

- Includes provider breakdown for the following measures: ADD/ADHD Patient Followup, Developmental Screening Rates, Well Visit Rates, and Influenza vaccination for asthma patients

PCC Pediatric EHR Solutions

THRIVING THROUGH CHANGE

Behavioral Health Distinction

- Add on module/recognition if you offer behavioral health services
- In-house clinicians (psychiatrist, psychologist, social worker, mental health counselor)
- Tele-health services can qualify if you're coordinating
- Follow evidence-based guidelines for appropriate treatment
- Stand out to payers
- Easily incorporate with a full PCMH project
- $500 flat fee for distinction (as of 1/4/19)

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NCQA Submission Tools And Details

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Pricing (as of January 2019)

Single site

Number of Clinicians	Initial Recognition Fee	Annual Reporting Fee
1-2	$750	$150
3-12	$450	$150
13+	$50	$15

Multi-site

Number of Clinicians	Initial Recognition Fee	Annual Reporting Fee
1-12	$250	$150
13+	$25	$15

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ANNUAL REPORTING REQUIREMENTS TIMELINE AND CHECKLIST

DATE GUIDANCE	TASK
July prior to the reporting year	NCQA releases the next year's requirements. Go to the NCQA eStore and download the Annual Reporting Requirements.

6-9 months before Annual Reporting Date	• Review Annual Reporting Requirements.
	• For concepts with options, select the option for which your practice would like to submit.
	• Start gathering evidence for Annual Reporting requirements.
	• Perform tasks in Q-PASS:
	  • Confirm clinicians and practice information.
	  • Upload documents and enter data to meet requirements.
	  • Pay the Annual Reporting fee.

Annual Reporting Date (1 month before Anniversary Date)	Submit Annual Reporting requirements.

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ANNUAL REPORTING

HOW TO SUBMIT YOUR ANNUAL REPORTING REQUIREMENTS

The entire recognition process is now managed through the Q-PASS system. You will use this system to upload documentation; track progress; manage practice sites, clinicians and recognition; and pay recognition fees.

- Log into Q-PASS using login information from the practice's My NCQA account. Claim your organization and update/confirm your organization information.
- Enroll in Annual Reporting through Q-PASS and make payment. Once you enroll, practices are assigned an NCQA representative who can be emailed with questions about the process.
- Submit documentation and data via Q-PASS.
- NCQA reviews your submission and notifies your practice that you have earned recognition.

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Annual Reporting Requirements for PCMH Recognition

Requirements Overview—Reporting Period January 1 – December 31, 2019

Team-Based Care and Practice Organization (AR-TC)

Report the following:

AR-TC 01 Patient Care Team Meetings

Knowing and Managing Your Patients (AR-KM)

Report the following:

AR-KM 01 Proactive Reminders

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Patient-Centered Access and Continuity (AR-AC)

*Choose to report **one** of the following options:*

AR-AC 01 Patient Experience Feedback—Access

OR

AR-AC 02 Third Next Available Appointment

OR

AR-AC 03 Monitoring Access—Other Method

Care Management and Support (AR-CM)

Report the following:

AR-CM 01 Identifying and Monitoring Patients for Care Management

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Care Coordination and Care Transitions (AR-CC)

Report the following:

AR-CC 01 Care Coordination Process

AND

Choose to report ***one*** *of the following options:*

AR-CC 02 Patient Experience Feedback—Care Coordination **OR** **AR-CC 03 Lab and Imaging Test Tracking** **OR** **AR-CC 04 Referral Tracking** **OR** **AR-CC 05 Care Transitions**

Performance Measurement and Quality Improvement (AR-QI)

Report the following:

AR-QI 01 Clinical Quality Measures **AND** **AR-QI 02 Resource Stewardship Measures** **AND** **AR-QI 03 Patient Experience Feedback**

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Special Topic: Behavioral Health (AR-BH)

*Report **ALL** of the following (Required, but not scored):*

AR-BH 01 Behavioral Health eCQMs	**AND**	**AR-BH 02 Behavioral Health Staffing**	**AND**	**AR-BH 03 Behavioral Health Referral Monitoring**
AR-BH 04 Depression Screening	**AND**	**AR-BH 05 Anxiety Screening**	**AND**	**AR-BH 06 Behavioral Health Clinical Decision Support**

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Q-PASS

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Welcome, Hubert Smith

≡ / Home / HKDRS 1 / HK MEDICAL ACCESS GROUP INC

Practice Site Dashboard

HK MEDICAL ACCESS GROUP INC

Edit

10001 W ROOSEVELT RDSUITE 224, WESTCHESTER, Illinois, 60154-2664

708-356-4300

Specialties: Orthopedic surgery,Emergency medicine,Family medicine,Internal medicine

Choose an area by clicking on the tiles below. Hover over a tile to learn more about what you can do in that area.

Edit Practice Site Details

Manage Evaluations

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Upload Evidence

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Q-PASS

Click on tiles below to expand and interact.

Check In Components for Review

TC : Team-Based Care and Practice Organization

– collapse

PCMH / All PCMH Criteria / TC

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)

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Q-PASS

⚠ MHIM : Medical Home Information and Materials

⚠ MHIM-P : Medical Home Information and Materials Process

DESCRIPTION

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

SUGGESTED EVIDENCE

MHIM-P : Medical Home Information & Materials Process

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

The information that the practice provides may include, but is not limited to:

- Practice office hours and where to seek after-hours care.
- How to communicate with the personal clinician and team, including how to request and receive clinical advice during and after business hours.
- Whom to contact with questions about specific concerns.
- Care-team roles.

ACTIONS

- We need help
- This is not applicable to us
- Ready for check in

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Q-PASS

PCMH / All PCMH Criteria / TC / TC 09

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

MHIM : Medical Home Information and Materials

DESCRIPTION

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

SUGGESTED EVIDENCE

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 conttaining that information.

Link evidence | Add new evidence

Type	Name

We have different evidence

Let's do a virtual review

ACTIONS

- We need help
- This is not applicable to us
- Ready for check in

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Q-PASS

SUGGESTED EVIDENCE

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

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

Cancel | Done

Type Name

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Check In Process

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

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Criteria Options

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

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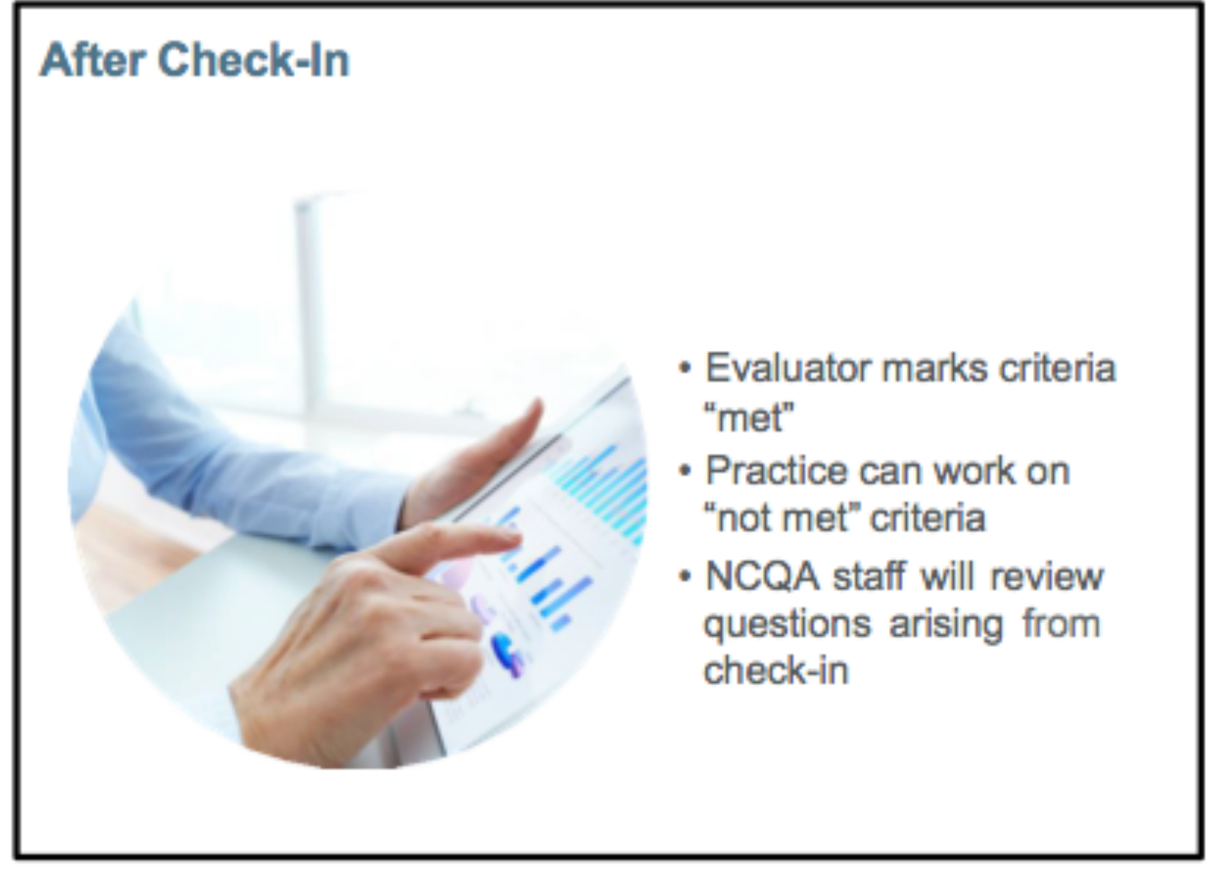
Check In Process



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Check In Process

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

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Websites

- Ncqa.org (NCQA main page)
- Store.ncqa.org (Download center)
- My.ncqa.org (Ask NCQA a question)
- Qpass.ncqa.org (QPASS site)
- https://ncqasolutions.com (PCS website)

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Thank you!

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