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
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
Evolution of the PCMH Standards

Continue to move practices closer to achieving the Triple Aim

2011
- Emphasizes relationship with/expectations of specialists
- Integrates behaviors affecting health, language, CLAS
- Enhances evaluation of patient experience
- Underscores importance of system cost-savings
- Enhances use of clinical performance measure results

2014
- Further incorporates behavioral health
- Additional emphasis on team-based care
- Focuses on care management of high need populations
- Higher bar, alignment of QI activities with "triple aim"

2017
- Addition of Annual reporting requirements
- Further integrates social determinants & community connections
- Further integrates behavioral health
- Shift from focus on structure to focus on outcomes
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
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

▪ 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’
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
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
Scoring

No more levels! Pass or Fail only
2017 Standards 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
You’re Ready to Start...What Now?
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 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’ . . .
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/
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:
  o A physician ‘champion’ for each location
  o A nurse / clinical manager
  o An office manager

• Train the members of your PCMH team

• Share information across the entire practice and keep EVERYONE informed ** keep those meeting notes**
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
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
    o Website?
    o Patient Portal?
    o Recall system?
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!
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
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
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!
Strategically Tackle the Project
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
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
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
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

- 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
Dashboard Overdue Lists

Well Visit Rates - Patients 12-21 Years

This measure shows the percentage of all active patients between the ages of 12 years and 21 years who have received at least one well visit in the past year.

- 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.

Your Score: 77 out of 100

- Up-to-Date Patients: 1,162
- Qualifying Patients: 1,538
- Percentage: 76%

View overdue patient list - 376 patients overdue
View Detailed Breakdown for Age Group
View PCC Client Distribution

Pediatric EHR Solutions
EHR Patient Recall

- Use EHR Report Library “Preventive Care Recall”

- Restrict on:
  - Patient age
  - Physical due date
  - Procedure
  - Diagnosis
  - Order (screenings, tests, etc)
  - and more
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

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Number Needed By Age 13</th>
<th>Total Patients Age 13</th>
<th>Patients Up-to-Date at Age 13</th>
<th>% Up-to-Date at Age 13</th>
<th>Overdue at Age 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPV</td>
<td>2</td>
<td>158</td>
<td>95</td>
<td>60%</td>
<td>63 patients overdue</td>
</tr>
<tr>
<td>Meningococcal</td>
<td>1</td>
<td>158</td>
<td>148</td>
<td>94%</td>
<td>10 patients overdue</td>
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<tr>
<td>TdaP</td>
<td>1</td>
<td>158</td>
<td>154</td>
<td>97%</td>
<td>4 patients overdue</td>
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<tr>
<td>HEDIS® Combo 2 *</td>
<td>N/A</td>
<td>158</td>
<td>93</td>
<td>59%</td>
<td>65 patients overdue</td>
</tr>
</tbody>
</table>

* "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**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Number Needed By Age 2</th>
<th>Total Patients Age 2</th>
<th>Patients Up-to-Date at Age 2</th>
<th>% Up-to-Date at Age 2</th>
<th>Overdue at Age 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP</td>
<td>4</td>
<td>609</td>
<td>482</td>
<td>79%</td>
<td>127 patients overdue</td>
</tr>
<tr>
<td>IPV</td>
<td>3</td>
<td>609</td>
<td>545</td>
<td>89%</td>
<td>64 patients overdue</td>
</tr>
<tr>
<td>MMR</td>
<td>1</td>
<td>609</td>
<td>535</td>
<td>88%</td>
<td>74 patients overdue</td>
</tr>
<tr>
<td>HIB</td>
<td>3</td>
<td>609</td>
<td>544</td>
<td>89%</td>
<td>65 patients overdue</td>
</tr>
<tr>
<td>Hep B</td>
<td>3</td>
<td>609</td>
<td>474</td>
<td>78%</td>
<td>135 patients overdue</td>
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<tr>
<td>Varicella</td>
<td>1</td>
<td>609</td>
<td>531</td>
<td>87%</td>
<td>78 patients overdue</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>4</td>
<td>609</td>
<td>507</td>
<td>83%</td>
<td>102 patients overdue</td>
</tr>
<tr>
<td>Hep A</td>
<td>1</td>
<td>609</td>
<td>514</td>
<td>84%</td>
<td>95 patients overdue</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>2</td>
<td>609</td>
<td>519</td>
<td>85%</td>
<td>90 patients overdue</td>
</tr>
<tr>
<td>Influenza</td>
<td>2</td>
<td>609</td>
<td>351</td>
<td>58%</td>
<td>258 patients overdue</td>
</tr>
<tr>
<td>Combo 9 *</td>
<td>N/A</td>
<td>609</td>
<td>377</td>
<td>62%</td>
<td>232 patients overdue</td>
</tr>
<tr>
<td>(Includes All Vaccines Above Except Influenza)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combo10 **</td>
<td>N/A</td>
<td>609</td>
<td>267</td>
<td>44%</td>
<td>342 patients overdue</td>
</tr>
<tr>
<td>(Includes All Vaccines Above)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
KM 12.B: Choosing Immunization Services

- 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
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

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

Your Score: 86 out of 100

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 engaged 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 follow-up visit. You can also view a listing of ADD and ADHD patients who are overdue for a follow-up visit.

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

64 of these patients are overdue for a follow-up visit.

How You Compare

<table>
<thead>
<tr>
<th>% Up-to-Date</th>
<th>Your Practice</th>
<th>PCC Client Average</th>
<th>Top Performers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>84%</td>
<td>73%</td>
<td>86%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Measure#</th>
<th>NQF</th>
<th>Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Performance Rate</th>
<th>Exclusions</th>
<th>Exceptions</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS126v3</td>
<td>0036</td>
<td>Use of Appropriate Medications for Asthma</td>
<td>5</td>
<td>7</td>
<td>71%</td>
<td>0</td>
<td>N/A</td>
<td>Details</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Summary)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stratification 1 - Age 5-11yrs</td>
<td>3</td>
<td>4</td>
<td>75%</td>
<td>0</td>
<td>N/A</td>
<td>Details</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stratification 2 - Age 12-18yrs</td>
<td>2</td>
<td>3</td>
<td>67%</td>
<td>0</td>
<td>N/A</td>
<td>Details</td>
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<tr>
<td></td>
<td></td>
<td>• Stratification 3 - Age 19-50yrs</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stratification 4 - Age 51-64yrs</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
KM 12.D: Patients Not Recently Seen

Use recaller or new EHR Patient Lists restricting by “Date of last visit”
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.
Process of Closing a Care Gap

1. Identify [CM01]
2. Engage [KM12]
3. Prepare [KM20]
4. Document [QI01]
5. Evaluate [QI Worksheet]
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

PCC EHR CQM Reports

• Appropriate Testing for Children with Pharyngitis

• Appropriate Treatment for Children with URI
## Care Coordination Measures

### PCC “Modified Stage 2 MU Report”

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

<table>
<thead>
<tr>
<th>Measure</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPOE Medication</td>
<td>228</td>
<td>228</td>
</tr>
<tr>
<td>CPOE Laboratory</td>
<td>96</td>
<td>96</td>
</tr>
<tr>
<td>CPOE Radiology</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Electronic Prescribing (without Controlled Substances)</td>
<td>135</td>
<td>135</td>
</tr>
<tr>
<td>Electronic Prescribing (with Controlled Substances)</td>
<td>218</td>
<td>218</td>
</tr>
<tr>
<td>Summary of Care (Transmitted Only)</td>
<td>0</td>
<td>33</td>
</tr>
<tr>
<td>Patient-specific Education (Calendar Year)</td>
<td>97</td>
<td>286</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Timely Online Access</td>
<td>277</td>
<td>236</td>
</tr>
<tr>
<td>View, Download, Transmit (VDT)</td>
<td>190</td>
<td>286</td>
</tr>
<tr>
<td>Secure Electronic Messaging (Sent)</td>
<td>41</td>
<td>286</td>
</tr>
</tbody>
</table>
Medication Reconciliation

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

Transition of Care (ARRA)

- Patient transitioned to my care from another clinical setting
- 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)
Care Management
Care Management and Support

- 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
Care Management and Support

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

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

Use “Care Management” flag to identify patients needing care management
Care Management and Support

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

- 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
Clarify Terminology

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Management</td>
<td>Activities performed by healthcare professionals to improve patient outcomes</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Organizing patient care between clinicians and facilities</td>
</tr>
<tr>
<td>Care Plan</td>
<td>Individualized instructions and interventions given to the patient in writing</td>
</tr>
</tbody>
</table>
Reviewing Documentation

- 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
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
## Care Plan Intervention

**Status:** Active

### Visit History

(19 yrs, 6 mos; 63)

### 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 adderal xr for ADHD

### Team Members

<table>
<thead>
<tr>
<th>Dr.</th>
<th>Specialty: Pediatrics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Organization:</td>
</tr>
</tbody>
</table>

Created by [Redacted]

[Last Reviewed for this visit by: [Redacted]]

### Prescriptions

**ESCITALOPRAM (LEXAPRO) (Completed)**

- 1 x 5 mg Tablet
- 1 tab PO every day
- Quantity: 30 Tablet(s), 2 refills

<table>
<thead>
<tr>
<th>Date to fill: 07/06/18</th>
<th>Start: 07/06/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 9:48am</td>
<td>8 9:48am</td>
</tr>
<tr>
<td>8 9:48am</td>
<td>8 9:48am</td>
</tr>
</tbody>
</table>

© 2019 The Verden Group
Chronic Care Management (CCM)
Care Plans

SUMMARY FOR VISIT: 06/02/2018
Test, CCM
Account No: 29271

DOB
01/03/1993
Race:
Other Race
Visit Date:
06/02/2018 with Nicanor Alexander, MD

REASON FOR VISIT

VITALS

Height (in)
Weight (lbs)
BMI
Temp (°F)
BP (mm Hg)
Ht cm
Wt kg

ALLERGIES

E10.01: Type 2 diabetes mellitus with hyperosmolality 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
Diagnosis
E11.01
Type 2 diabetes mellitus with hyperosmolality with coma
I10
Accelerated hypertension
F32.0
Mild major depression, single episode
K21.9
Chronic GERD

PREVENTIVE MEDICINE

Counseling:
- Exercise Counseling Provided: Yes
- Patient received educational materials on physical activity: Yes
- Agreed upon exercise goal: 1-2 times/week
- BMI management provided: Yes
- Above Normal BMI Follow-up: Dietary management education, guidance, and counseling

CARE TEAM

- [Patient's name]
- [Healthcare provider's name]
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
- R.I.D.A.

Medication List
- Start Flutinert HFA: 144 MCG/ACT 2 puffs Inhalation twice a day 30 days 3 Refills 2 Step date: 09/03/2018
- Start Flutinert HFA: 110 (90 Base) MCG/ACT 2 puffs as needed Inhalation every 4 hr. 90 days 3 Refills 2
- Not-Taking/Prescription: Note:
  - Eye M with mild intermittent asthma, stable, as needed
  - Furosemide 20 mg, bid, PO
  - Albuterol inhaler: as needed
  - Montelukast 10 mg, PO once daily

Self-management Plan: Avoid exposure to allergens. Take Fuzinert as needed. Keep oral medication close by. Avoid exercise or physical activity for 1 hour after using. Use spacer device to ensure proper inhaling. Use only as directed. Do not exceed one puff every 4 hr. In case of severe reaction, use epinephrine as prescribed by your doctor. Remember to check expiration dates on medications.

Note: Take Zyrtec 1 mg, PO, 1 tab once daily. If needed, take another tab. Do not exceed 2 tabs daily.

Care plan configured on a clinical summary

Self-management plan – see next slide
Policies & Procedures
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
Policies and Procedures
Access and Continuity

POLICY STATEMENT:
<___> provides same-day appointments for routine and urgent care to meet the needs of our patients. <___> 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:
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 <___>.
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.

- 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!!
PCMH Reporting Examples
PCC's PCMH Resources
(http://pcmh.pcc.com)
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

Monitor Fluoride Varnish Rate in Dashboard

PCC Pediatric EHR Solutions
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

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Plans by Date</td>
<td>Find care plans by creation date and status.</td>
</tr>
<tr>
<td>Document Modification Report</td>
<td>Find documents by user, date, time, and/or category. This report can be used</td>
</tr>
<tr>
<td>Orders by Visit</td>
<td>List of appointments that include selected order types.</td>
</tr>
<tr>
<td>Patient Count and Percentage by Ethnicity</td>
<td>Stratification of your patient population by ethnicity.</td>
</tr>
<tr>
<td>Patient Count and Percentage by Sex</td>
<td>Stratification of your patient population by sex.</td>
</tr>
<tr>
<td>Patient Diagnoses by Date</td>
<td>List diagnoses and dates.</td>
</tr>
<tr>
<td>Patient Visits By Protocol</td>
<td>Find patient visits by protocol.</td>
</tr>
<tr>
<td>Patients Overdue for Weight Management</td>
<td>Use this report to identify patients overdue for weight management.</td>
</tr>
<tr>
<td>Portal Message Response Time</td>
<td>Time between the receipt of the portal message and the response.</td>
</tr>
<tr>
<td>Predominant Conditions of Your Patient Population</td>
<td>Identify the predominant conditions of your patient population.</td>
</tr>
<tr>
<td>Prescription Count by Provider</td>
<td>Number of prescriptions written by provider.</td>
</tr>
<tr>
<td>Prescription Formulary by Provider</td>
<td>View ratios of On-Formulary to Off-Formulary for medications.</td>
</tr>
<tr>
<td>Radiology Orders</td>
<td>List of open radiology orders.</td>
</tr>
<tr>
<td>Preferred Centers</td>
<td>List of preferred centers.</td>
</tr>
</tbody>
</table>

## Predominant Conditions of Your Patient Population

Identify the predominant conditions of your patient population.

### Clinical Diagnosis
- **Diagnosis Date:** From 04/01/2019 to 07/01/2019
- **Diagnosis Name:** All
- **Diagnoses/Problems:** Combined

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number of Patients</th>
<th>Number of Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well child</td>
<td>1544</td>
<td>4823</td>
</tr>
<tr>
<td>Childhood obesity</td>
<td>464</td>
<td>1250</td>
</tr>
<tr>
<td>Well child visit</td>
<td>652</td>
<td>1237</td>
</tr>
<tr>
<td>Child examination</td>
<td>707</td>
<td>1147</td>
</tr>
<tr>
<td>Fever</td>
<td>679</td>
<td>1125</td>
</tr>
<tr>
<td>Cough</td>
<td>533</td>
<td>979</td>
</tr>
<tr>
<td>Upper respiratory infection</td>
<td>651</td>
<td>879</td>
</tr>
<tr>
<td>Active immunization</td>
<td>160</td>
<td>877</td>
</tr>
<tr>
<td>History and physical examination, school</td>
<td>722</td>
<td>870</td>
</tr>
<tr>
<td>Speech delay</td>
<td>215</td>
<td>533</td>
</tr>
<tr>
<td>Dental cavity</td>
<td>277</td>
<td>244</td>
</tr>
</tbody>
</table>
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

- 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
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

Tasks:
- Appointment Needed
- To: Nurse
- Note: call to schedule followup
- Task Completed
- By: select a user
- At: mm/dd/yyyy 12:00am
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
Monitor Clinical Quality Measures

- PCMH page updated and replaced monthly
- Log your measure results monthly, including # patients
Performance Data Stratified for Vulnerable Populations

- Use vulnerable population reporting on PCMH Dashboard

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.
Performance Data Stratified for Vulnerable Populations

- Define your vulnerable population and use Dashboard report

- Vulnerable population options:
  - Primary Insurance
  - Race
  - Ethnicity
  - Preferred Language

### Performance Data Stratified for Vulnerable Populations

<table>
<thead>
<tr>
<th>Primary Insurance</th>
<th>Qualifying Patients</th>
<th>Up-to-Date Patients</th>
<th>% Up-to-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Insurance</td>
<td>36</td>
<td>21</td>
<td>55%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>312</td>
<td>227</td>
<td>73%</td>
</tr>
<tr>
<td>BCBS</td>
<td>636</td>
<td>506</td>
<td>80%</td>
</tr>
<tr>
<td>Cigna</td>
<td>172</td>
<td>130</td>
<td>76%</td>
</tr>
<tr>
<td>MVP</td>
<td>125</td>
<td>90</td>
<td>72%</td>
</tr>
<tr>
<td>First Health</td>
<td>15</td>
<td>13</td>
<td>87%</td>
</tr>
<tr>
<td>Tricare</td>
<td>6</td>
<td>2</td>
<td>33%</td>
</tr>
<tr>
<td>CBA BLUE</td>
<td>19</td>
<td>16</td>
<td>84%</td>
</tr>
<tr>
<td>United HC</td>
<td>44</td>
<td>31</td>
<td>70%</td>
</tr>
<tr>
<td>AETNA</td>
<td>25</td>
<td>22</td>
<td>88%</td>
</tr>
<tr>
<td>BCBS OTHER</td>
<td>146</td>
<td>104</td>
<td>71%</td>
</tr>
</tbody>
</table>
Practice Shares Performance Data

- 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

<table>
<thead>
<tr>
<th>Measure: Depression Screening Rates - Adolescents</th>
<th>Provider 0</th>
<th>Provider 13</th>
<th>Provider 16</th>
<th>Provider 18</th>
<th>Provider 2</th>
<th>Provider 3</th>
<th>Provider 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualifying Patients</td>
<td>4</td>
<td>58</td>
<td>10</td>
<td>3</td>
<td>723</td>
<td>43</td>
<td>243</td>
</tr>
<tr>
<td>Up-to-Date Patients</td>
<td>4</td>
<td>48</td>
<td>10</td>
<td>3</td>
<td>662</td>
<td>39</td>
<td>193</td>
</tr>
<tr>
<td>% Up-to-Date</td>
<td>100%</td>
<td>83%</td>
<td>100%</td>
<td>100%</td>
<td>92%</td>
<td>91%</td>
<td>79%</td>
</tr>
</tbody>
</table>

- Includes provider breakdown for the following measures: ADD/ADHD Patient Followup, Developmental Screening Rates, Well Visit Rates, and Influenza vaccination for asthma patients
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)
NCQA Submission Tools And Details
# Pricing (as of January 2019)

## Single site

<table>
<thead>
<tr>
<th>Number of Clinicians</th>
<th>Initial Recognition Fee</th>
<th>Annual Reporting Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>$750</td>
<td>$150</td>
</tr>
<tr>
<td>3-12</td>
<td>$450</td>
<td>$150</td>
</tr>
<tr>
<td>13+</td>
<td>$50</td>
<td>$15</td>
</tr>
</tbody>
</table>

## Multi-site

<table>
<thead>
<tr>
<th>Number of Clinicians</th>
<th>Initial Recognition Fee</th>
<th>Annual Reporting Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-12</td>
<td>$250</td>
<td>$150</td>
</tr>
<tr>
<td>13+</td>
<td>$25</td>
<td>$15</td>
</tr>
</tbody>
</table>
# Annual Reporting Requirements Timeline and Checklist

<table>
<thead>
<tr>
<th>Date Guidance</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>July prior to the reporting year</td>
<td>NCQA releases the next year’s requirements. Go to the NCQA eStore and download the Annual Reporting Requirements.</td>
</tr>
</tbody>
</table>
| 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. |
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.
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
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
Care Coordination and Care Transitions (AR-CC)

Report the following:

AR-CC 01 Care Coordination Process

Choose to report one of the following options:

- AR-CC 02 Patient Experience Feedback—Care Coordination
- AR-CC 03 Lab and Imaging Test Tracking

AND

- AR-CC 04 Referral Tracking

OR

- AR-CC 05 Care Transitions

Performance Measurement and Quality Improvement (AR-QI)

Report the following:

AND

- AR-QI 01 Clinical Quality Measures

AND

- AR-QI 02 Resource Stewardship Measures

AND

- AR-QI 03 Patient Experience Feedback
Special Topic: Behavioral Health (AR-BH)

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

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

Practice Site Dashboard

HK MEDICAL ACCESS GROUP INC
10001 W ROOSEVELT RD SUITE 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
- Upload Evidence
Q-PASS

Click on tiles below to expand and interact.

TC: Team-Based Care and Practice Organization

**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
Q-PASS

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**

<table>
<thead>
<tr>
<th>Type</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Link evidence</td>
<td>Add new evidence</td>
</tr>
</tbody>
</table>

We have different evidence

Let's do a virtual review

**ACTIONS**

- 🕓 We need help
- ☛ This is not applicable to us
- ☑ Ready for check in
The practice demonstrates that it informs patients, families and caregivers about the role of the medical home and provides materials containing that information.
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
Criteria Options

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

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

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

**Either Option**
- Practice decision*
Check In Process

After Check-In

- Evaluator marks criteria “met”
- Practice can work on “not met” criteria
- NCQA staff will review questions arising from check-in
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
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)
Thank you!

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