Maintaining PCMH Recognition

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Agenda

- Exploration of how PCC functionality applies to PCMH standards
- Understanding care management
- Quality improvement reporting for PCMH
- Setting quarterly goals to maintain your recognition

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Takeaways

- An understanding of how PCC reports and functionality can be used to meet specific PCMH requirements
- Steps to implement a successful quality improvement project
- Strategies for closing a care gap

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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

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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.

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Why Become a PCMH?

- 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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Fundamentals of a PCMH

- Identifying chronic patients with high risks
- Understand how social determinants of health play into a patient's overall health outcomes
- Coordinating care for patients with labs, imaging centers, other specialists and hospitals
- Recalling patients to remind them of needed services
- Offering educational resources and community options to patients
- Following evidence-based guidelines when treating and managing patients

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Identifying Patients/Conditions

- Identify your high-risk patients
- Determine if they need care management or a different level of care
- Properly build an individualized care plan
- Document everything!
- Align patient recallers (KM12) to your identified patients/conditions

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, MU report detail, **EHR Patient Recall Reports**)
- Remind patients of needed services (**Broadcast Messaging**)
- Report and outreach materials required

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KM 12.A: Choosing Preventive Care Services

- EHR Patient Recall Reports (Examples):
  - Patients overdue for well visits (pick an age group to focus on)
  - 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

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EHR Patient Recall

- Use EHR Report Library - Patient Recall -> “Preventive Care Recall”

- Restrict on:
  - Visit date (last 3 yrs to include active patients)
  - Exclude by Patient flag (exclude pats w/ any type of inactive flag)
  - Patient age (focus on specific age range)
  - Physical due date (all past dates through next 90 days)
  - Exclude by scheduled appointment (exclude all well visit appointment types over next 365 days)

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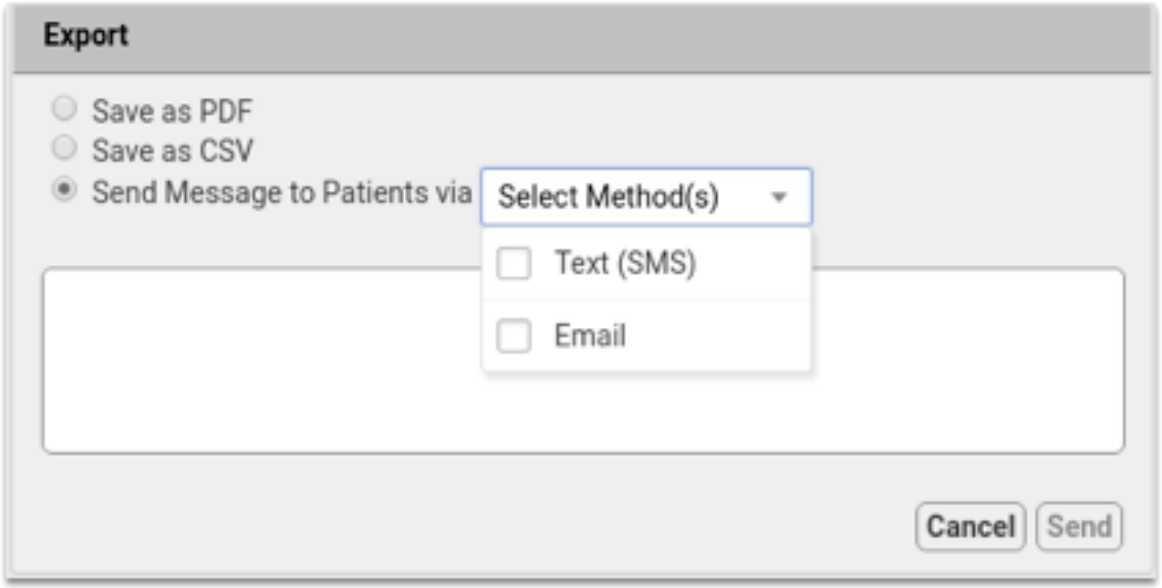
EHR Broadcast Messaging



- A custom message can be sent via text or email to all patients identified within a patient recall report
- There is no additional fee for this service
- Work with PCC support to set this up if you haven't already!

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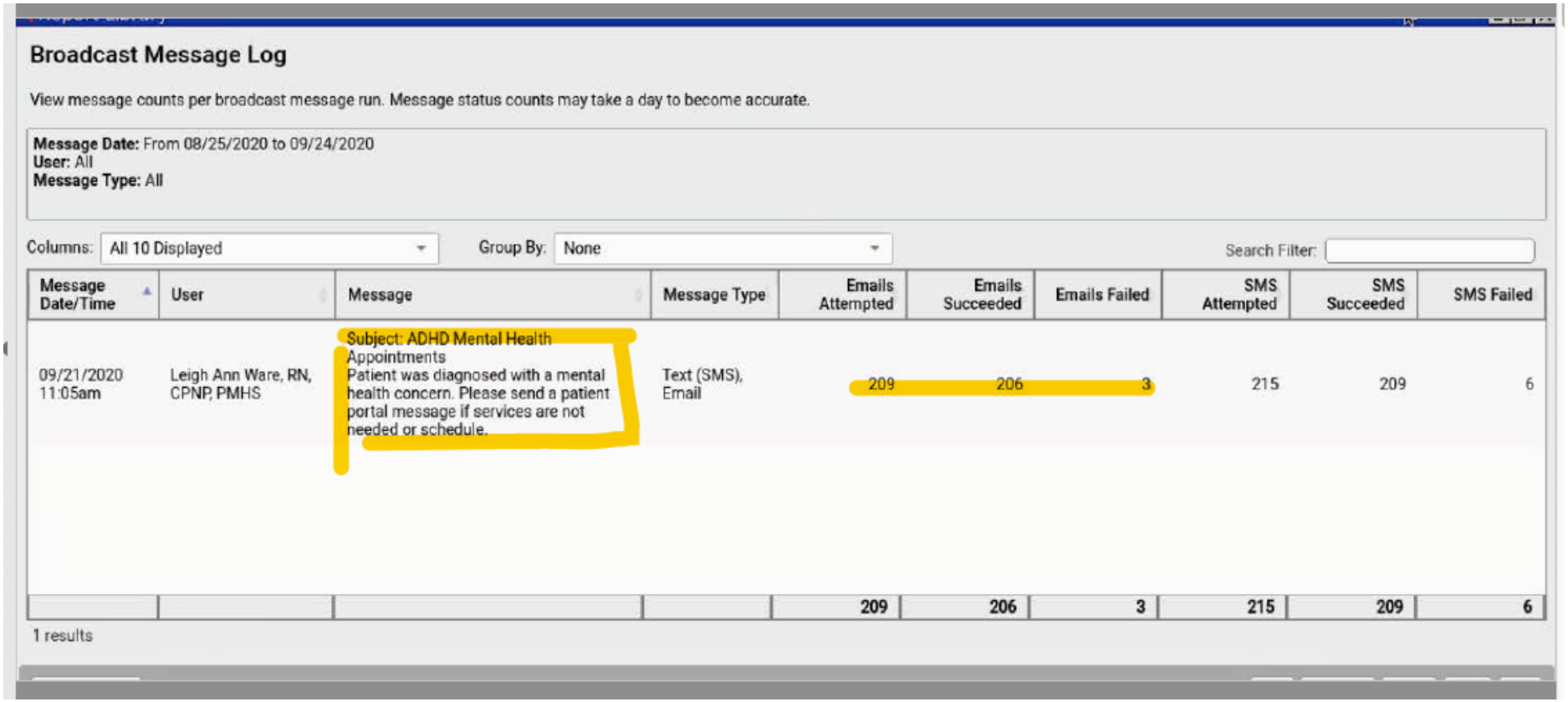
Review Broadcast Message Logs



Broadcast Message Log

View message counts per broadcast message run. Message status counts may take a day to become accurate.

Message Date: From 08/25/2020 to 09/24/2020
User: All
Message Type: All

Columns: All 10 Displayed | Group By: None | Search Filter:

Message Date/Time	User	Message	Message Type	Emails Attempted	Emails Succeeded	Emails Failed	SMS Attempted	SMS Succeeded	SMS Failed
09/21/2020 11:05am	Leigh Ann Ware, RN, CPNP, PMHS	Subject: ADHD Mental Health Appointments Patient was diagnosed with a mental health concern. Please send a patient portal message if services are not needed or schedule.	Text (SMS), Email	209	206	3	215	209	6
				209	206	3	215	209	6

1 results

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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

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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).

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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

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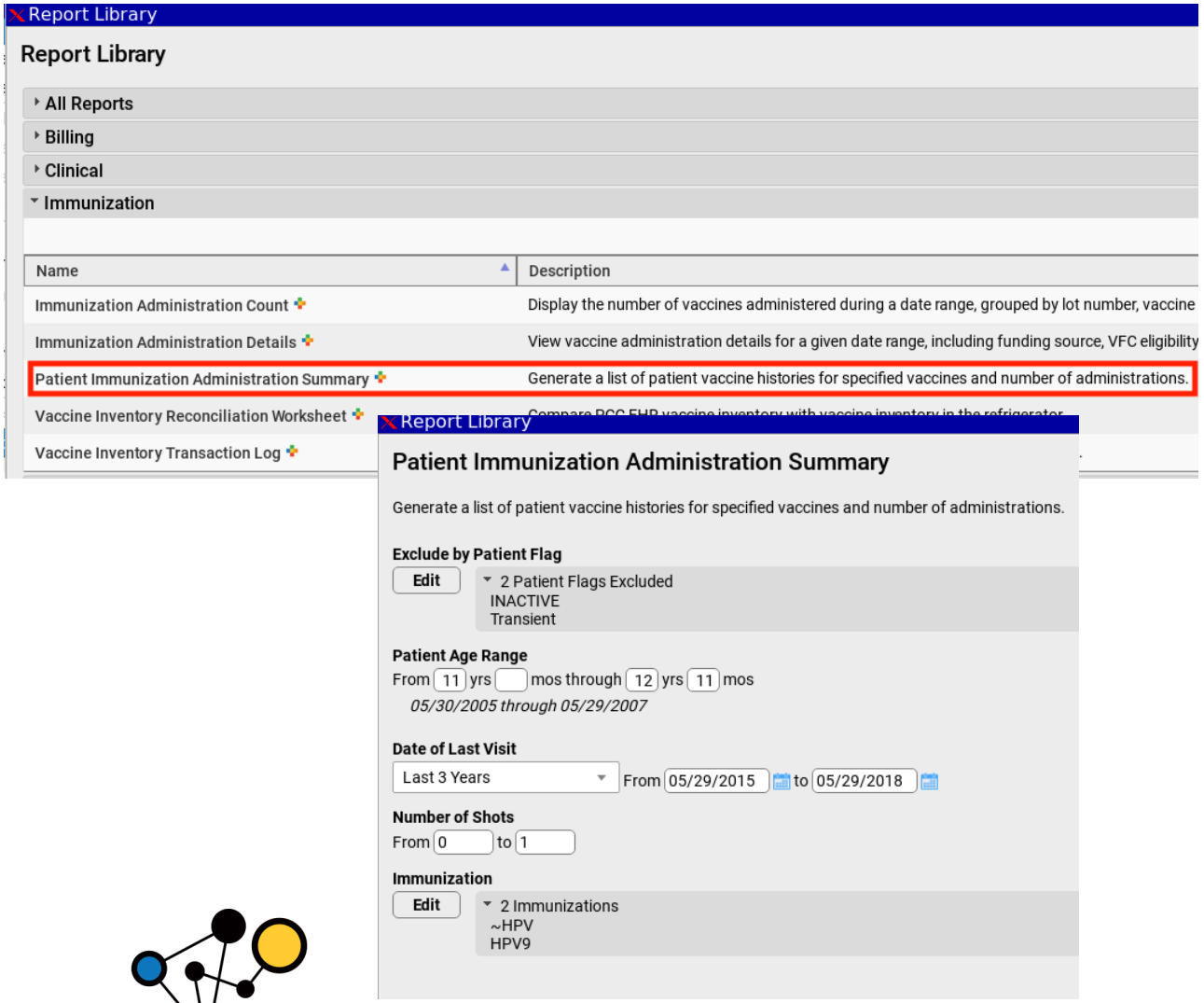
KM 12.B: Choosing Immunization Services



- 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

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KM 12.C: Choosing Chronic/Acute Services

- EHR Patient Recall Reports (Examples):
  - Active ADHD patients overdue for checkup
  - Asthma patients overdue for checkup
  - Patients with depression overdue for checkup
  - Patients with obesity overdue for checkup
  - Patients with allergic rhinitis overdue for checkup

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KM 12.C: Choosing Chronic/Acute Services

- Use EHR Report Library - Patient Recall -> “Chronic Condition Recall”

- Restrict on:
  - Visit date (last 3 yrs to include active patients)
  - Exclude by Patient flag (exclude pats w/ any type of inactive flag)
  - Patient age (focus on specific age range)
  - Clinical Diagnosis (include pats w/ specified diagnosis)
  - Exclude by scheduled appointment (exclude all appointment types over next 365 days)
  - Exclude by charges (exclude patients having any charge billed in past X months. If the patient was seen recently, they aren’t overdue)

KM 12.D: Patients Not Recently Seen

- Use EHR Report Library - Patient Recall -> “Preventive Care Recall”
- Restrict on:
  - Visit date (last 3 yrs to include active patients)
  - Exclude by Patient flag (exclude pats w/ any type of inactive flag)
  - Patient age (focus on specific age range)
  - Exclude by scheduled appointment (exclude all well visit appointment types over next 365 days)
  - Exclude by charges (exclude patients having any charge billed in past X months. If the patient was seen recently, they aren’t overdue)

Care Management

Individualized services for your most complex patients

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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

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”
- Suggestions for care coordination measures:
  - Closing the referral loop
  - Medication reconciliation (KM14) - EHR Meaningful Use Report
- Suggestions for health care cost measures:
  - Appropriate treatment of URI - EHR CQM Report

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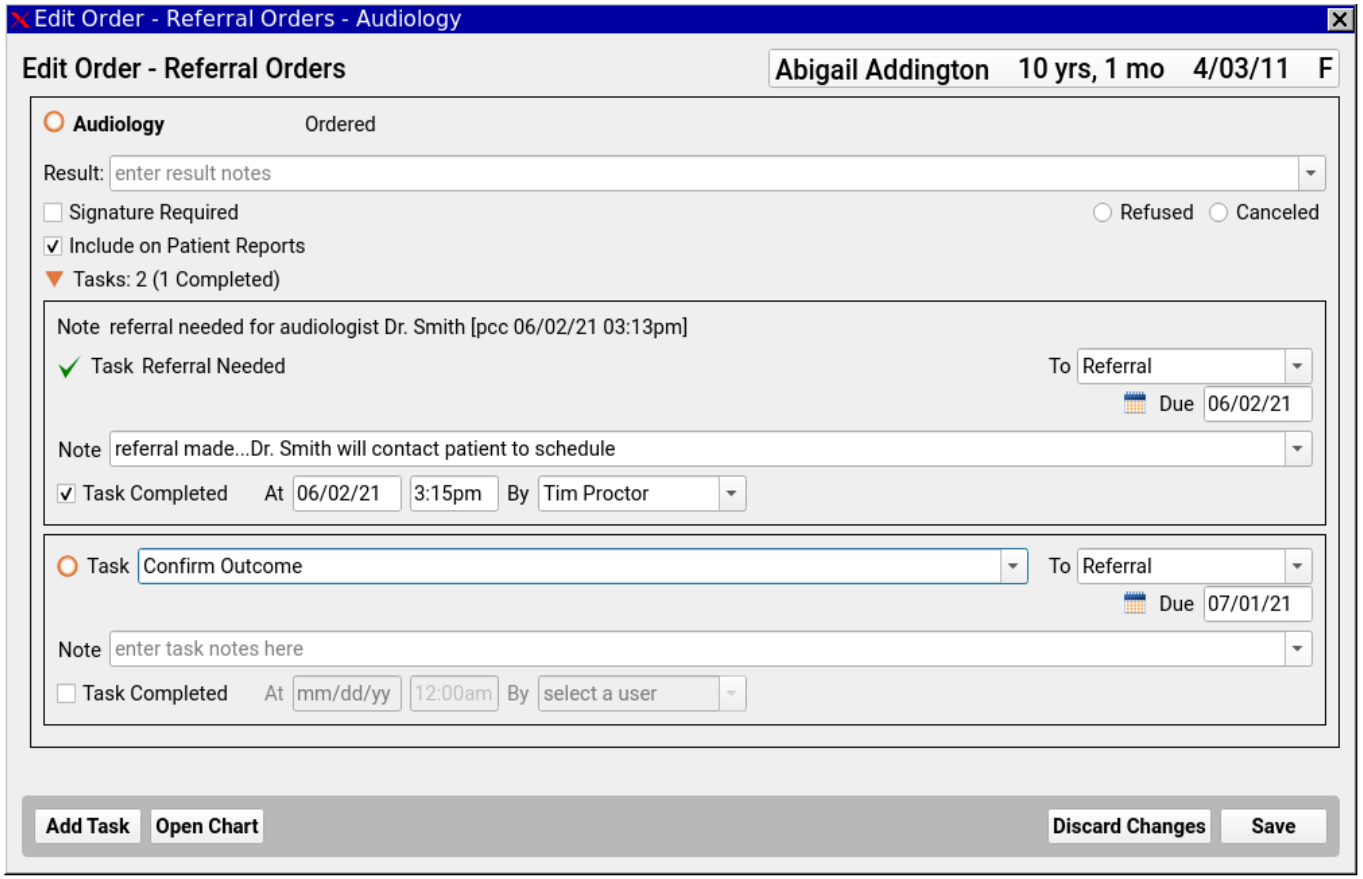
Closing the Referral Loop



Track the "Confirm Outcome" task with future due date separately from the initial referral request from the clinician.

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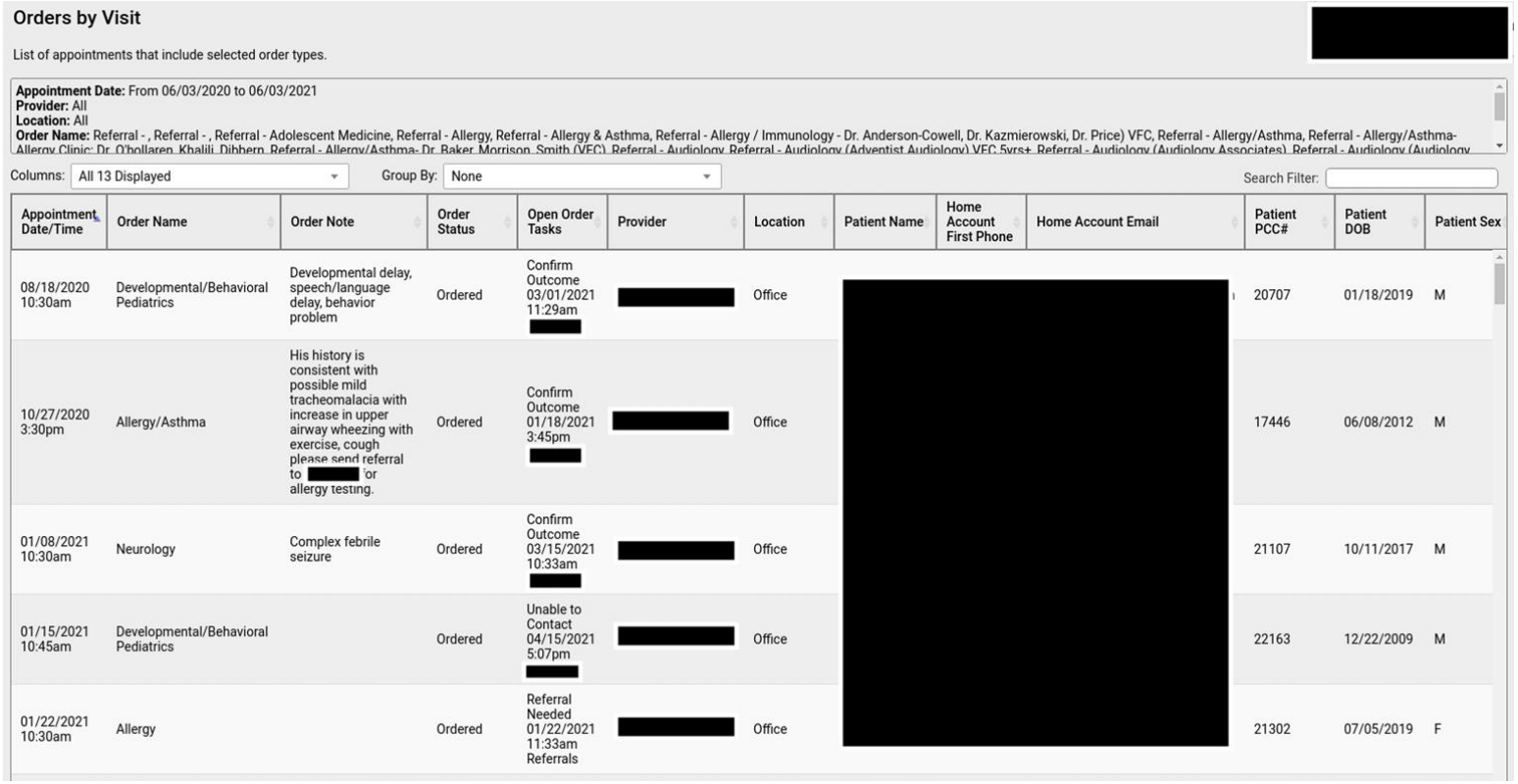
Closing the Referral Loop



Orders by Visit

List of appointments that include selected order types.

Appointment Date: From 06/03/2020 to 06/03/2021
Provider: All
Location: All
Order Name: Referral - , Referral - , Referral - Adolescent Medicine, Referral - Allergy, Referral - Allergy & Asthma, Referral - Allergy / Immunology - Dr. Anderson-Cowell, Dr. Kazmierowski, Dr. Price) VFC, Referral - Allergy/Asthma, Referral - Allergy/Asthma-Allergy Clinic: Dr. O'hollaren, Khalili, Dibbern, Referral - Allergy/Asthma- Dr. Baker, Morrison, Smith (VFC), Referral - Audiology, Referral - Audiology (Adventist Audiology) VFC 5yrs+, Referral - Audiology (Audiology Associates), Referral - Audiology (Audiology

Columns: All 13 Displayed | Group By: None | Search Filter:

Appointment Date/Time	Order Name	Order Note	Order Status	Open Order Tasks	Provider	Location	Patient Name	Home Account First Phone	Home Account Email	Patient PCC#	Patient DOB	Patient Sex
08/18/2020 10:30am	Developmental/Behavioral Pediatrics	Developmental delay, speech/language delay, behavior problem	Ordered	Confirm Outcome 03/01/2021 11:29am [redacted]	[redacted]	Office	[redacted]	[redacted]	[redacted]	20707	01/18/2019	M
10/27/2020 3:30pm	Allergy/Asthma	His history is consistent with possible mild tracheomalacia with increase in upper airway wheezing with exercise, cough please send referral to [redacted] for allergy testing.	Ordered	Confirm Outcome 01/18/2021 3:45pm [redacted]	[redacted]	Office				17446	06/08/2012	M
01/08/2021 10:30am	Neurology	Complex febrile seizure	Ordered	Confirm Outcome 03/15/2021 10:33am [redacted]	[redacted]	Office				21107	10/11/2017	M
01/15/2021 10:45am	Developmental/Behavioral Pediatrics		Ordered	Unable to Contact 04/15/2021 5:07pm [redacted]	[redacted]	Office				22163	12/22/2009	M
01/22/2021 10:30am	Allergy		Ordered	Referral Needed 01/22/2021 11:33am Referrals	[redacted]	Office				21302	07/05/2019	F

Use the "Orders by Visit" report to identify referral orders that are not yet completed and need follow-up

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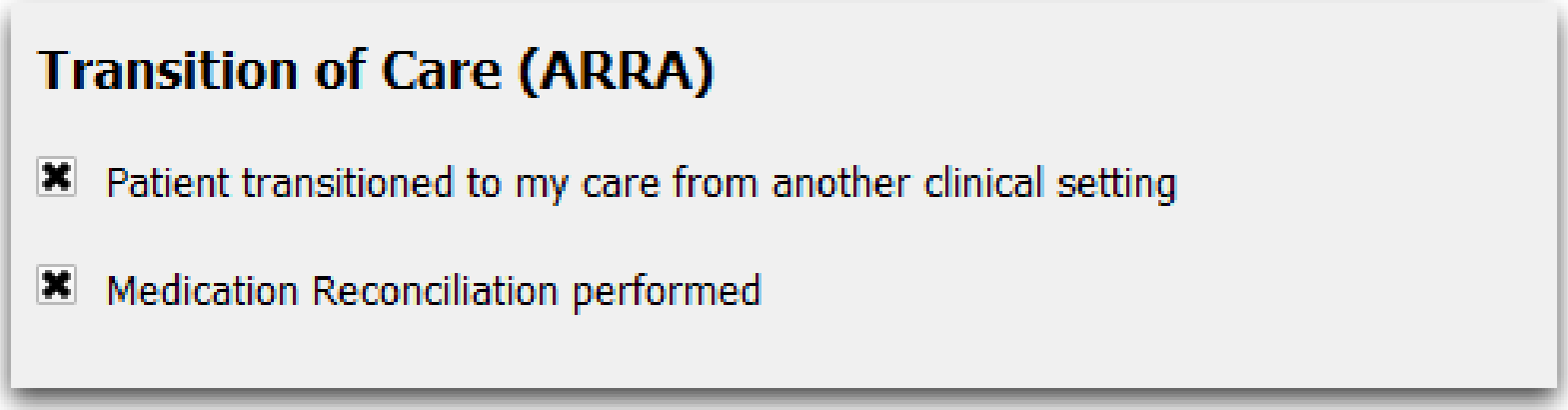
Medication Reconciliation

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



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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

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Care Management and Support

- Use EHR Patient Lists in Report Library for identifying patients needing Care Management based on diagnosis or problem list

- Create “Care Management” patient flag and add to these patients
  - Patient flags are maintained in Partner Config -> Table Editor -> Patient Flags

- Create clinical alerts reminding clinicians when working with these patients

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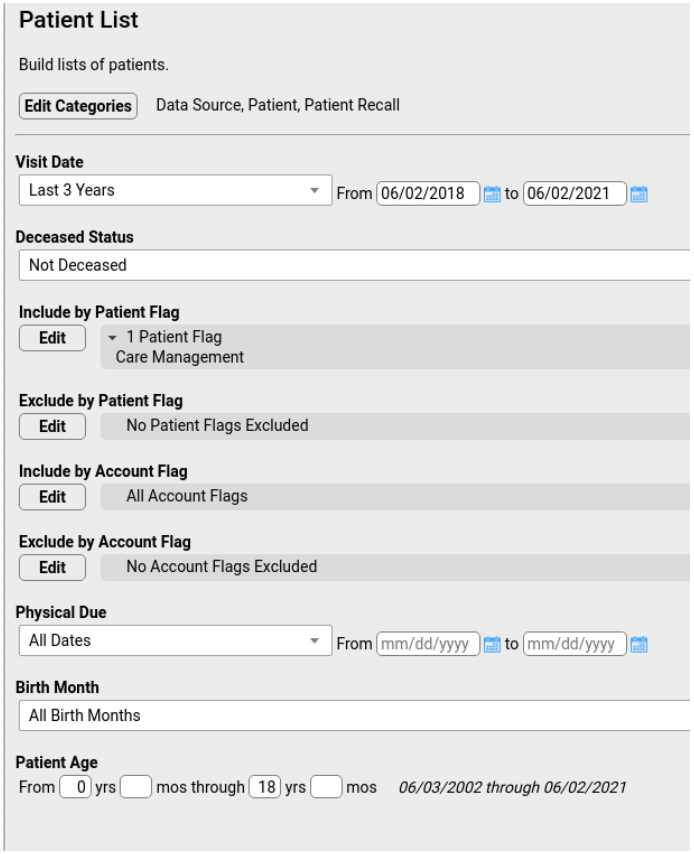
Care Management and Support

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



- Use EHR Patient Lists to identify kids needing care management
  - Restrict to include patients with “Care Management” flag
  - Be sure to restrict on patient age range

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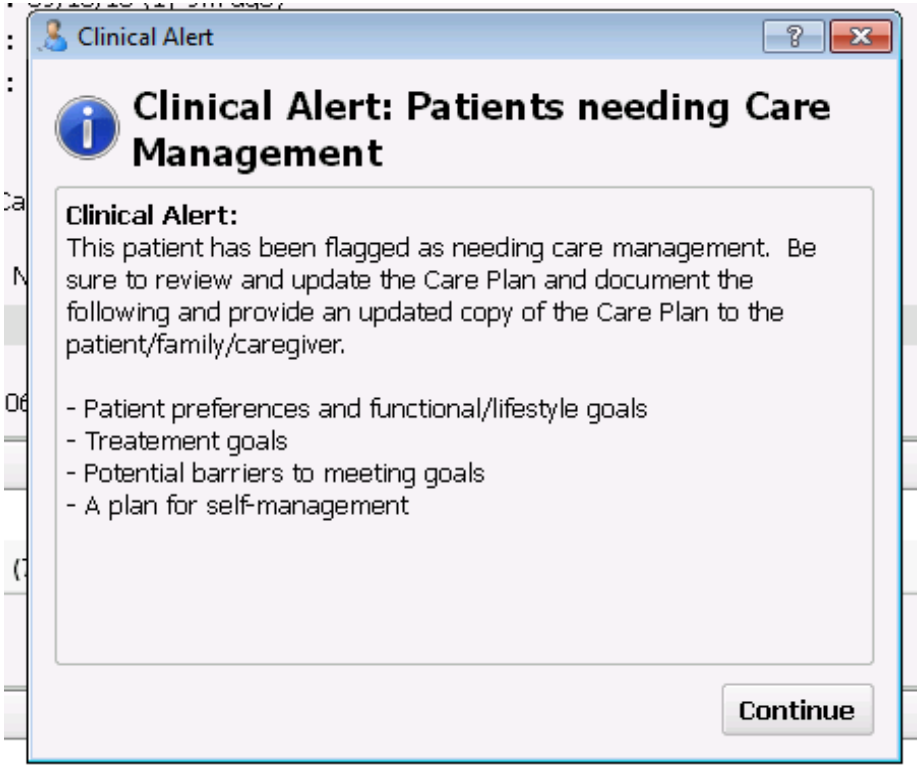
Care Management and Support

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



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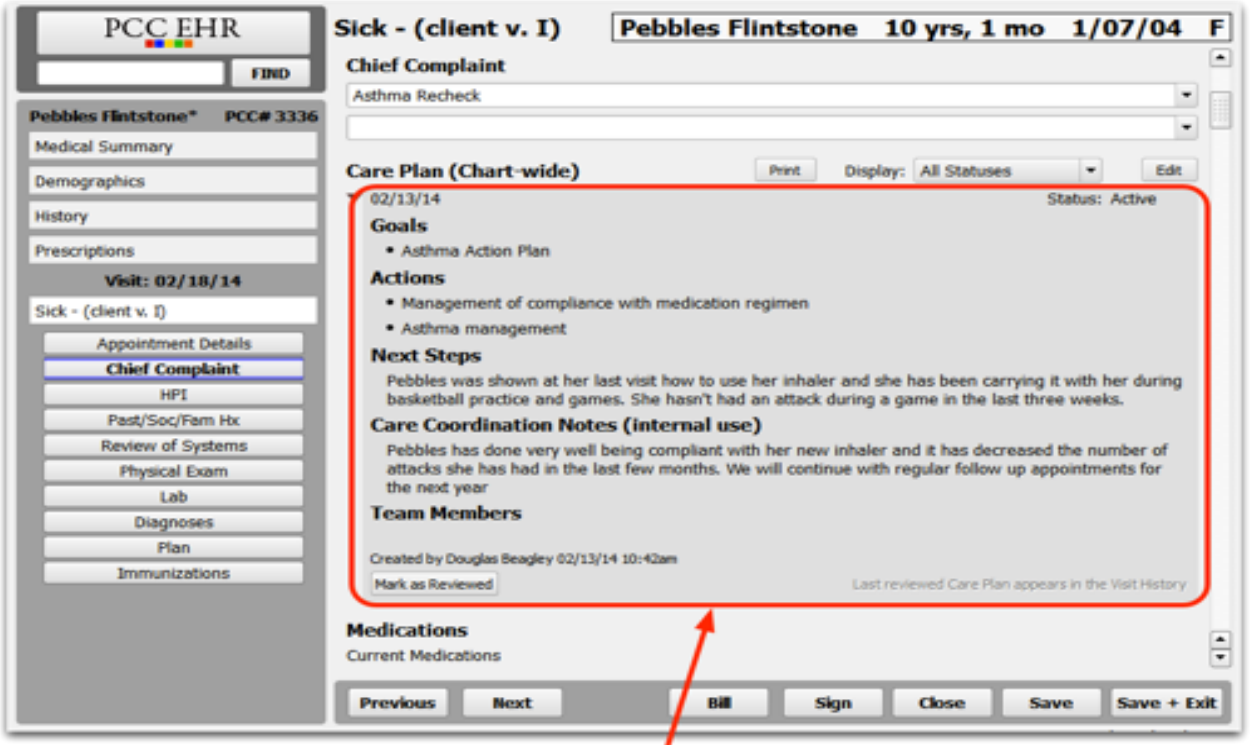
Care Management and Support

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
- Be sure to click "mark as reviewed" when appropriate
- Use EHR Report "Care Plans by Date" to identify all patients with a Care Plan

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Building a 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***
- Mark the Care Plan as reviewed so it will be included with the visit summary.
- PCC care plans are automatically pushed to portal

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03/17/21 Status: Active

Goals

- Suicide Attempt

Actions

- Potential suicide care

Next Steps

Barriers:
Pt was hospitalized at Methodist Children's for 3 days following overdose on Tylenol, Concerta & Abilify resulting in liver damage. Was Discharged to Clarity Behavior Unit.

Plan:
Reviewed Discharge record and recommendations from Clarity:
1. Medication safe for all OTC and RX medications.
2. Remove any access to weapons.
3. Limit access to risky social situations.
4. Encourage people, places that provide support, take walks & spend time with parents, karate & taekwondo.
5. Continue counseling wit[redacted]er at Courage Ranch. Continue once a week with new plan.
6. Suicide Hotline: 1-800-273- TALK (8255).
7. Clarity Guidance Center: 1-210-616-0300.

Continue current medications with monthly follow-ups.

Care Coordination Notes (internal use)

Team Members

Documents

Title: ER REPORT FROM METHODIST CHILDREN'S ER
Category: ER/Urgent Report
Attached to: 03/17/21 - Care Plan Goal "Suicide Attempt"
Signature Requested: [redacted]
Signed: [redacted]
Last Modified: [redacted]

Date: 12/02/20
Pages: 8

View Document

Attach relevant documents to the care plan

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Care Plan

Print

▼ 09/26/20

Goals

- Special Educational Needs and school - requested testing in school for placement
- Management of aggressive behavior in school.

Actions

- Anger management surveillance
- Arrange care attender
- Arrange home help
- Close supervision
- Crisis intervention with follow-up
- Mental health caregiver support
- Mental health crisis resolution

Next Steps

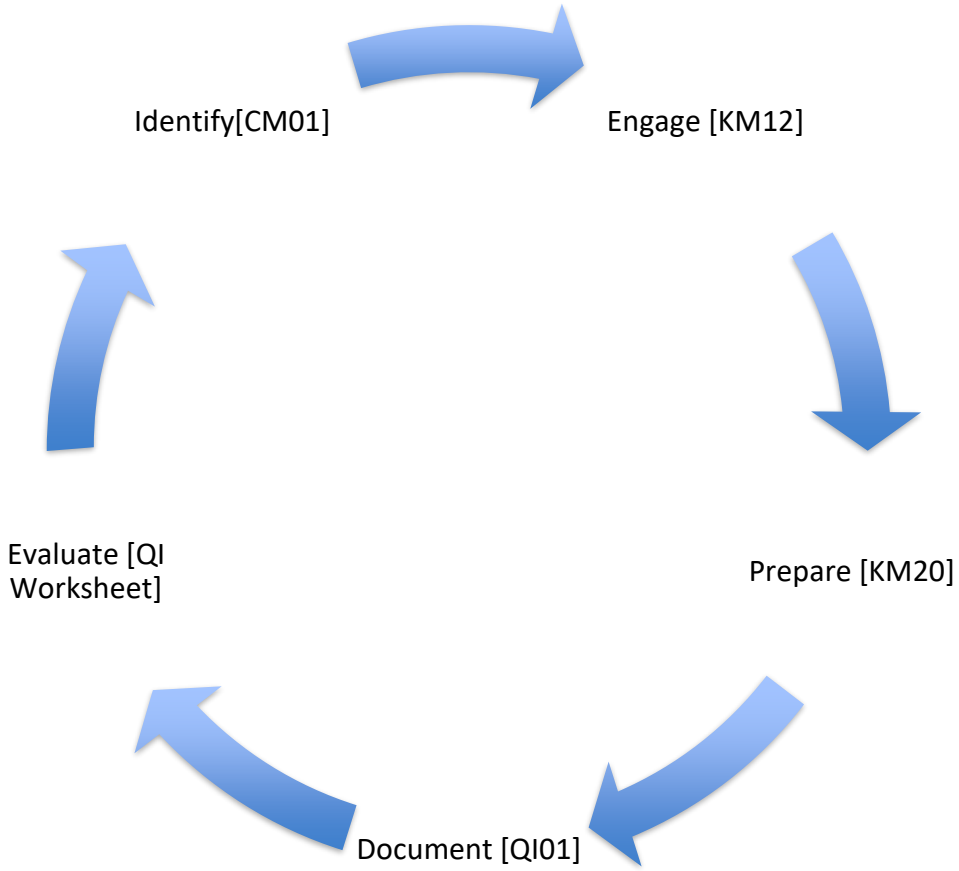
Barriers:
Child has developmental needs - is aversive to being touched.
GMOC is legally blind - unable to assist child with school work.
Child's reaction escalates when provoked.
Child imitates actions and solutions (sharpening pencil with scissors) without realizing the dangers of actions.
Child doesn't want to "follow the rules" in school.

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



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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

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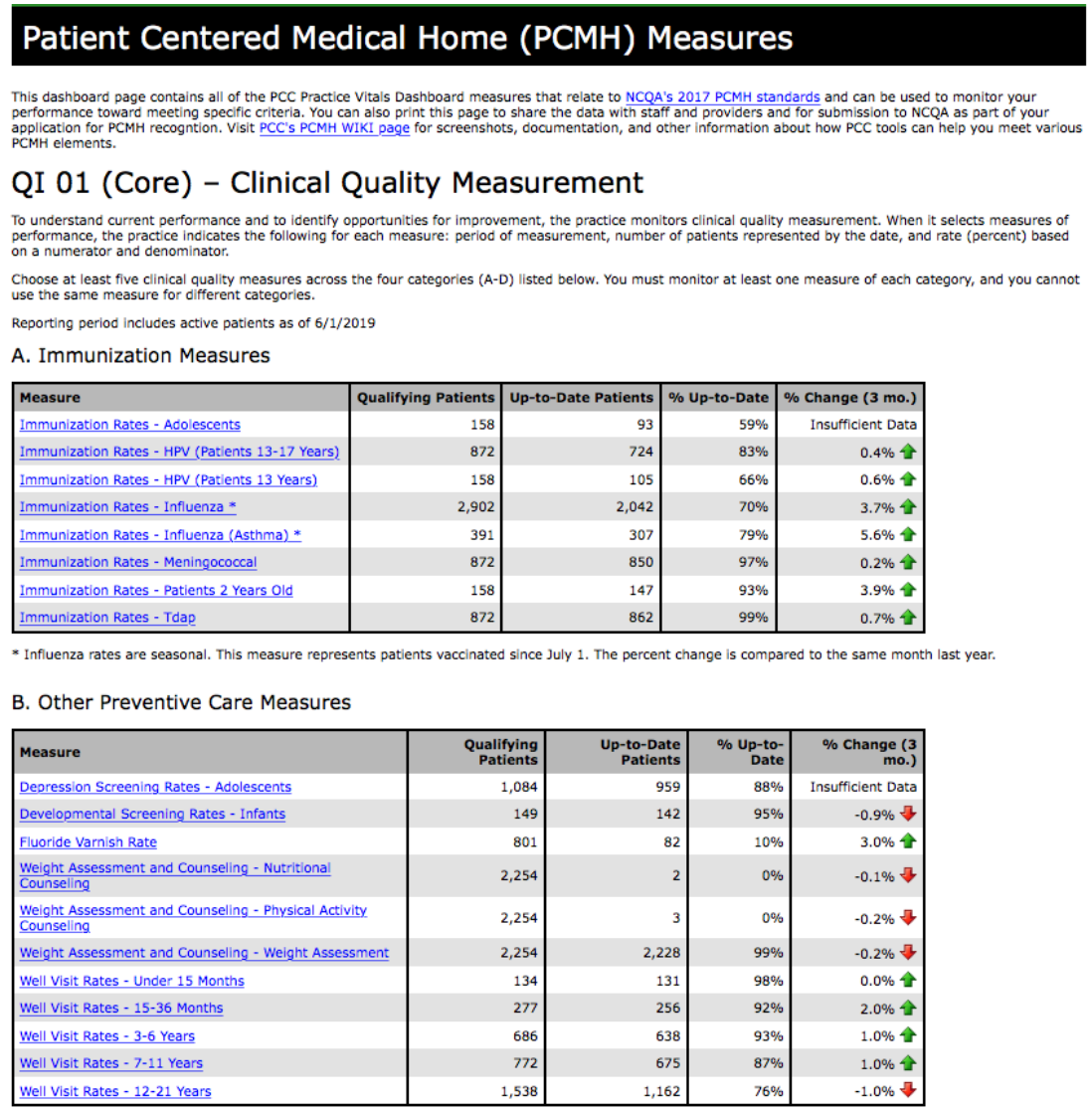
Monitor Clinical Quality Measures



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 recogntion. 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

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Location-specific Reporting

- Practices with multiple locations need to measure and report results separately for each location
- PCC's Dashboard now allows for location-specific clinical measure reporting
- Patients are attributed to the location of their last well visit (or last sick visit if no well visit on record)

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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)

Thank you!

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