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
Eligibility Requirements

• **Practices should have staff skilled to use and a computer system** that includes the following:
  - Email & Internet access
  - Microsoft Word
  - Microsoft Excel
  - Adobe Acrobat Reader (available free online)
  - Document scanning & screen shots

• **Access to the electronic systems** used by the practice, e.g. billing system, registry, practice management system, electronic prescription system, EHR, Web portal, etc.
Eligibility Requirements

Transformation may take 3-12 months

Your roadmap: PCMH 2017 Standards and Guidelines – everything covered

Implement changes:

• Practice-wide commitment
• New policies and procedures for staff
• Staff training and reassignments
• Medical record systems
• Reporting capabilities improvement
• Develop and organize documentation
Changes to PCMH

**Highlights**

1. **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’

2. **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

3. **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

4. **Emphasize comprehensive, integrated care**
   - Understanding behavioral needs and social determinants included in core
   - Deeper integration and community connections included in electives
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
2017 Standards

Concepts

Team-Based Care and Practice Organization (TC)

Knowing and Managing Your Patients (KM)

Patient-Centered Access and Continuity (AC)

Care Management and Support (CM)

Care Coordination and Care Transitions (CC)

Performance Measurement & Quality Improvement (QI)
2017 Standards

Structure - Example

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

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

**Criteria:** A brief statement highlighting PCMH requirements.

---

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

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

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

**TC1 • (Core)**

Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.
2017 Standards Recognition

Changes to Levels
2017 Standards Scoring

Changes to Points

40 Core Criteria
- Must complete all 40 core

60 Elective Criteria
- Must achieve 25 Credits
2017 Standards

Scoring

Core Criteria

Elective Criteria
### 2017 Standards Scoring

**Example of Elective Criteria Selection: Must represent 5 of 6 Concepts**

<table>
<thead>
<tr>
<th>Concept</th>
<th>Electives</th>
<th>Credits</th>
</tr>
</thead>
<tbody>
<tr>
<td>TC</td>
<td>1 2 2 2</td>
<td></td>
</tr>
<tr>
<td>KM</td>
<td>1 1 1 2 1</td>
<td>1</td>
</tr>
<tr>
<td>AC</td>
<td>1 1 1 2 1</td>
<td>1</td>
</tr>
<tr>
<td>CM</td>
<td>2 1 1 1 1</td>
<td></td>
</tr>
<tr>
<td>CC</td>
<td>1 2 2 1 2</td>
<td>1 2</td>
</tr>
<tr>
<td>QI</td>
<td>1 1 2 2 1</td>
<td>1 2</td>
</tr>
</tbody>
</table>

- Each row represents a Concept which is laid out with the number of electives included and the credits identified in the middle of each circle.
- The blue circles are an example of the electives chosen by a practice to equal 25 credits.
- Red circles are the electives leftover that the practice will **not** demonstrate performance on.
NCQA prevalidated Health IT solutions have successfully demonstrated that their technology solution has functionality that supports or meets one or more criteria in the PCMH standards.

Evaluation can result in approved fully met criteria and partially met criteria that are transferable to eligible client practices submitting for recognition and acknowledgment of practice support functionality.
PCMH 2017
Commit, Transform, Succeed
PCMH Redesign

3 Parts

Commit
Practice completes an online guided assessment.
Practice works with an NCQA representative to develop an evaluation schedule.
Practice works with NCQA representative to identify support and education for transformation.
New NCQA PCMH online education resources support the transformation process.

Transform
Practice submits initial documentation and checks in with its evaluator
Practice submits additional documentation and checks in with its Evaluator.
Practice submits final documentation to complete submission and begin NCQA evaluation process.

Succeed
Practice is prepared for new payment environment (value-based payment, MACRA MIPS/APMs).
Practice demonstrates continued readiness and high quality performance through annual check-ins with NCQA.

Practice earns NCQA Recognition.
PCMH Redesign

Impact

Flexibility
Personalized service
User-friendly approach
Continuous improvement
Aligns with changes

ncqa.org/redesign
PCMH 2017
Standards Content
Presentation documentation key:

- r - Report
- e - Evidence
- p - Process
- l - List
- s - Source
- a - Agreement
- t - Protocol
- b - RRWB
- w - Worksheet
- ✴ - 2 Credit Electives
The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers, and organizes and trains staff to work to the top of their license and provide effective team-based care.
COMPETENCY A

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

TC 01-02: Core Criteria

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

Defines practice organizational structure & staff responsibilities/skills to support key PMCH functions.
Structure and Staff Responsibilities

TC 02: Example

Providers
  - Oversee management of practice and direct patient care

Office Manager
  - Daily business management

Front Office
  - Coordination of visit
    - Check in: Pre-visit planning
    - Check out: Follow-up and scheduling

Billing
  - Financial

Referrals
  - Coordination

Coding
  - Reimbursement

Clinical Team
  - Coordinate care plan; self-management support

Care Coordinator
  - Coordinate and manage high risk population

Triage Nurse
  - Leader of daily huddle and communication

Medical Assistant
  - Support clinical team and facilitate patient care
Team-Based Care and Practice Organization

TC 03-05: Elective Criteria

The practice is involved in external collaborative activities.

- Patient/family is involved in governance structure/stakeholder committees.

* Practice uses a certified EHR system & security risk analysis.
External PCMH Collaborations

TC 03: Example

TC 03

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

STATEWIDE HEALTH IT

Health Center Controlled Network of NY

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

TC 04: Example

BY-LAWS
Revised November 2015, Approved by the Board of Directors 11/18/2015

Article 1. NAME AND LOCATION

b. User Members. The majority (51%) of Directors shall be individuals who are served by the Corporation and who, as a group, represent the individuals being served by the Corporation in terms of demographic factors such as race, ethnicity, and gender. User members should utilize the Corporation as their principal source of urinary care and

4.2 Duties and Responsibilities.

The Board of Directors shall have specific responsibility for:

4.4 Annual Election of Directors/Board Members.

The Board of Directors shall nominate, at least thirty (30) days prior to the Annual Meeting, a slate of qualified candidates to replace Directors whose terms are set to expire and/or to fill vacant positions. The slate of candidates shall be included with the notice of the Annual Meeting. At the Annual Meeting, any member of the Board of Directors may nominate other candidates for the available Director positions, provided that the nominees agree to serve if elected. At the conclusion of

5.2 Regular Meetings.

The Board of Directors shall have regular meetings at least monthly to accomplish the business of the Corporation. The schedule of regular meetings shall be determined by the President. Notice of such meetings shall be given by any reasonable means, including electronic mail.

d. Quality Assurance Committee. The Quality Assurance Committee shall be responsible for monitoring and making recommendations for the implementation and improvement of the quality assurance/quality improvement program of the Corporation. In addition to Board member
Communication among staff is organized to ensure that patient care is coordinated, safe and effective
Team-Based Care and Practice Organization

TC 06-07: Core Criteria

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

Involves care team staff in practice’s performance evaluation and quality improvement activities.
## Team-Based Care and Practice Organization

### TC 06: Example

<table>
<thead>
<tr>
<th>Time</th>
<th>Chief Complaint</th>
<th>Age or and M/F</th>
<th>GENERAL MEDICINE</th>
<th>PEDIATRIC</th>
<th>WOMENS HEALTH</th>
<th>RECORDS/RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>800a</td>
<td>Lab results</td>
<td>59 yrs/F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>900a</td>
<td>Headache, Cough, Flu, Headache</td>
<td>48 yrs M</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9:30 am, Cold, 9:30 am, Fatigue</td>
<td>52 yrs M</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1000a</td>
<td>Lab results</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10:00 am, Lab results</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10:30 am, MIR results</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1100a</td>
<td>Results, New Pt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SBCHC Staff Process Improvement (PI) Committee
The SBCHC Staff Process Improvement Committee will consist of SBCHC staff from a variety of departments. The Staff PI Committee will meet monthly to review event reports, department metrics, satisfaction survey results, and comment cards. The Staff PI Committee will support quality improvement and risk management work through discussion of trends, identification of improvement needs, and development of improvement cycles to address negative trends. The Staff PI Committee is led by the COO. Staff PI Committee members will support the integrity of QI and risk management work that is done within their work departments.

SBCHC Medical Quality Improvement Team
The Medical Quality Improvement Team will consist of at least two staff Registered Nurses, the COO, the electronic health record superuser and the Executive Assistant. This Team will meet every other week to focus on medical quality of care data and discuss and plan for system changes to make improvements to medical data. It is anticipated this Team will transition in 2017 to focus on overall Health Center clinical measures. The Team’s work is shared with the medical staff at monthly meetings and with the staff PI committee.
* The practice has at least one care manager qualified to identify and coordinate behavioral health needs
COMPETENCY C

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

TC 09: Core Criteria

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

**TC 09: Example**

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

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

**WHAT WE OFFER:**

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

**INSURANCE REQUIREMENTS**

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

- If you do have insurance, please bring your information with you
- If you do not have insurance, we still want to see you. We have staff that will assist you in signing up for insurance
PCMH 2017
Owning Your Transformation Process
Owning Your Transformation Process

Types of Evidence

Documented Processes - written statements describing the practice’s policies and procedures

- Protocols
- Practice guidelines
- Agreements
- Other documents describing actual processes or forms (e.g., Referral forms, checklists and flowsheets)
Owning Your Transformation Process

Types of evidence

Evidence of Implementation – a means of demonstrating systematic uptake and effective demonstration of required practices including:

- Reports -- Patient records
- Materials -- Examples
- Screen shots -- Virtual demonstration
- Attestation -- eCQMs
- Transfer credit -- Survey
- Data entered into Q-PASS -- Not applicable
The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.
COMPETENCY A

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

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

KM 01-02: Core Criteria

Documents an up-to-date problem list

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

- Medical history of patient & family
- Mental health/ substance use history of patient & family
- Family/social/cultural characteristics
- Communication Needs
- Behaviors affecting health
- Social functioning
- Social determinants of health
- Developmental screening
- Advanced care planning (NA for pediatrics)
Knowing and Managing Your Patients

**KM 02: Example**

**Initial Assessment:**

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

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

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

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

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

KM 02 A&D: Example

KM 02 A

KM 02 D
Knowing and Managing Your Patients

KM 03: Core Criteria

KM 04: Elective Criteria

Conducts depression screenings using a standardized tool

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

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

KM 03: Example
Behavioral Health Screening

**KM 04: Example**

---

**CAGE-AID Questionnaire**

Patient Name ____________________________ Date of Visit _____________

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

**Questions:**

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

---

Knowing and Managing Your Patients

**KM 05-08: Elective Criteria**

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

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

Identifies the predominant conditions & health concerns of patient population

Evaluates patient population demographics/communication preferences/health literacy & distribution of patient materials
### Oral Health Risk Assessment Tool

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

#### Instructions for Use

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

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

#### Risk Factors

| ▲ Mother or primary caregiver had active decay in the past 12 months | ☐ Yes ☐ No |
| ▼ Mother or primary caregiver does not have a dentist | ☐ Yes ☐ No |
| ▼ Continual bottle/sippy cup use with fluid other than water | ☐ Yes ☐ No |
| ▼ Frequent snacking | ☐ Yes ☐ No |
| ▼ Special health care needs | ☐ Yes ☐ No |
| ▼ Medicaid eligible | ☐ Yes ☐ No |

#### Protective Factors

- Existing dental home
- Drinks fluoridated water or takes fluoride supplements
- Fluoride varnish in the last 6 months
- Has teeth brushed twice daily

#### Clinical Findings

- ▲ White spots or visible decalcifications in the past 12 months
- ▲ Obvious decay
- ▲ Restorations (fillings) present
- ▲ Visible plaque accumulation
- ▲ Gingivitis (swollen/bleeding gums)
- ▲ Teeth present
- ▲ Healthy teeth

#### Assessment/Plan

- **Caries Risk:** ☐ Low ☐ High
- **Completed:**
  - Anticipatory Guidance
  - Fluoride Varnish
  - Dental Referral
- **Self Management Goals:**
  - Regular dental visits
  - Dental treatment for parents
  - Brush twice daily
  - Use fluoride toothpaste
  - Wipe off bottle
  - Less/No juice
  - Only water in sippy cup
  - Drink tap water
  - Healthy snacks
  - Less/No junk food or candy
  - No soda
  - Xyitol
We receive referrals from New Ground Shelter. A registry of shelter patients is maintained annually. Patient/Family members that seek health insurance are directed to visit the clinic when our Children’s Health Insurance Program counselors are on site.
COMPETENCY B

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

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

**KM 09-10: Example**

#### Race

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

#### Ethnicity

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

#### Veterans

| Veterans | 39 |

#### Date Range: January 1, 20- December 31, 20

Patients better served in a language other than English

<table>
<thead>
<tr>
<th>Patients</th>
<th>English</th>
<th>Spanish</th>
</tr>
</thead>
<tbody>
<tr>
<td>1957</td>
<td>1858</td>
<td>99</td>
</tr>
<tr>
<td>100%</td>
<td>94.9%</td>
<td>5.1%</td>
</tr>
</tbody>
</table>
Knowing and Managing Your Patients

KM 11: Elective Criteria

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

- Target population health mgmt on disparities in care
- Address health literacy of practice staff
- Educate staff on cultural competence

(e OR QI 05 & QI 13)
Population Needs - Health Literacy

KM 11:B Example

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

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

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

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

Educational Module for Clinicians

from the

Iowa Health System Health Literacy Collaborative

Teach-back is...

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

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

**KM 12: Core Criteria**

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

1. **Preventive care services**
2. **Immunizations**
3. **Patients not recently seen**
4. **Chronic/acute care services**
Dear Patient,

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

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

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

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

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

Sincerely,

ABC Health Center
Excellence in Performance

*KM 13: Elective Criteria*

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

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

**KM 14-15: Core Criteria**

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

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

**KM 16-19: Elective Criteria**

- **Assesses understanding & provides education on new prescriptions**
- **Assesses & addresses response to medications & barriers to adherence**
- **Reviews controlled substance database for relevant medications**
- **Systematically obtains prescription claims data**
COMPETENCY E

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

KM 20: Core Criteria

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

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
Clinical Decision Support – Mental Health

KM 20 A: Example

SCREENSHOT of TEMPLATE where tool information entered into EHR.

PHQ9 Total Score (MA SHOULD FREE TEXT RESULT)

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

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

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

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

IF PHQ-9 IS 14 OR BELOW CLICK THE FOLLOWING

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

The practice identifies/considers and establishes connections to community resources to collaborate and direct patients to needed support.
Knowing and Managing Your Patients

KM 21: Core Criteria

Uses information on the population served by the practice to prioritize needed community resources

①
Knowing and Managing Your Patients

**KM 22-27: Elective Criteria**

<table>
<thead>
<tr>
<th>Provides access to educational materials</th>
<th>Offers oral health education resources</th>
<th>Adopts shared decision-making aids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engages with schools or intervention agencies</td>
<td>Routinely maintains a current community resource list</td>
<td>Assesses usefulness of community support resources</td>
</tr>
</tbody>
</table>

[Images and icons related to the criteria]
Access to Educational Resources

KM 22: Example

Blood Pressure Log

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

Name: ________________________________

<table>
<thead>
<tr>
<th>Date</th>
<th>AM</th>
<th>PM</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Blood Pressure</td>
<td>Pulse</td>
<td>Blood Pressure</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>


Dental Resource

Re: Updated Community Resource List

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

Dental Services

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

Pharmacy Services

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

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

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

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

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

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

What would you like to do?
# School/Intervention Agency Engagement

## KM 25: Example

### The Hispanic Counseling Center

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

### Transitions of Care

<table>
<thead>
<tr>
<th>Transitions of Care</th>
<th>STEP 1 (at visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Informs patient of need, purpose, expectations and goals of the specialty visit.</td>
</tr>
<tr>
<td></td>
<td>□ Patient/family in agreement with referral, type of referral and selection of Specialist.</td>
</tr>
<tr>
<td></td>
<td>□ Unless urgent, PCP office provides patient with Specialist contact information and patient calls to schedule appointment.</td>
</tr>
<tr>
<td></td>
<td>□ Reviews reason for visit with patient/family.</td>
</tr>
<tr>
<td></td>
<td>□ If patient needs to be seen in ED or Mental Health Facility, arrangements will be made then Specialist office will notify PCP office within 24 hours.</td>
</tr>
<tr>
<td></td>
<td>□ The specialist office communicates with the PCP regarding the patient’s plan of care, up-dated diagnosis, and medication recommendations.</td>
</tr>
<tr>
<td></td>
<td>□ If there is ongoing visits with the</td>
</tr>
</tbody>
</table>
* Regularly include external parties in “case conferences” for the purpose of sharing information and discussing care plans for high-risk patients.
The PCMH model expects continuity of care. Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/ care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access.
COMPETENCY A

The practice seeks to enhance access by providing appointments and clinical advice based on patients’ needs.
Patient-Centered Access and Continuity

AC 01-05: Core Criteria

Assesses patient access needs
- Provides same day appt. availability
- Extended hours are available for appts.
- Timely clinical advice by phone
- Documents clinical advice in EHR
Patient-Centered Access and Continuity

AC 01: Example

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

Feel the provider addressed issues involving family, alcohol, smoking, mental health, nutrition, exercise

Feel the provider addressed personal health goals (i.e. weight loss, smoking cessation, etc)

Feel the provider has given clear explanations regarding prescription...

Access

Access

Got appointment for urgent care in a timely manner

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

Got appointment for non-urgent care in a timely manner

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

Got answer to medical question within 24 hours

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree
Jones Medical Center

Explanation: The practice reserves time for same-day appointments. This report shows the number of days to the third next available appointment for each day from 10/14/20XX through 10/18/20XX as measured first thing each morning as the clinic day began.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Monitoring Date</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jones, MD</td>
<td>10/14/20XX</td>
<td>1</td>
</tr>
<tr>
<td>Jones, MD</td>
<td>10/15/20XX</td>
<td>0</td>
</tr>
<tr>
<td>Jones, MD</td>
<td>10/16/20XX</td>
<td>0</td>
</tr>
<tr>
<td>Jones, MD</td>
<td>10/17/20XX</td>
<td>1</td>
</tr>
<tr>
<td>Jones, MD</td>
<td>10/18/20XX</td>
<td>2</td>
</tr>
</tbody>
</table>

Average # of days 0.8
Patient-Centered Access and Continuity

AC 03: Example

Contact Us

Our location
Suburban Family Healthcare

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

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

Walk in hours 8:30-9:30 am Monday and Fridays (existing patients only) and 1st and 3rd Saturdays of the month from 9-12 by appointment only.
### Clinical Advice telephonic response 7 days’ log

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

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

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

AC 09: Elective Criteria

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

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

Practice establishes goals and monitors the % of patient visits with selected clinician/team.
* Continuity of medical record information when the office is closed

Review and actively manage panel sizes

Review and reconcile panels based on external data
Patient-Centered Access and Continuity

Examine Supply/Demand

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

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

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

1,050 = \# \text{ patients}

Fill in values, for example:
• Provider visits/day = 18
• days in clinic/year = 210
• patient visits/year = 3.6

Also compare appointment demand with backlog or wait time for appointments

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

The practice systematically identifies patients who may benefit from care management
The practice must include at least three categories in its criteria.

- Behavioral Health conditions
- Poorly controlled or complex conditions
- Social determinants of health
- Referrals by outside organizations
- High cost/high utilization

Care Management and Support

**CM 01-02: Core Criteria**
Identifying & Monitoring Patients for Care Mgmt

**CM 01: Example**

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

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

Denominator = 893 patients

Numerator = 83 patients

Percentage of patients identified as benefiting from care management = 5%
## Patients Needing Care Management

<table>
<thead>
<tr>
<th></th>
<th>Behavioral Health</th>
<th>High Cost/Utilization</th>
<th>Poor Control/Complex</th>
<th>Social Determinants of Health</th>
<th>Referrals</th>
<th>Total Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients in Registry</td>
<td>120</td>
<td>35</td>
<td>200</td>
<td>10</td>
<td>10</td>
<td>375</td>
</tr>
<tr>
<td>(may be listed more than once)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unique Patients in Registry</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>343</td>
</tr>
<tr>
<td>Total Patients in Practice</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3000</td>
</tr>
<tr>
<td>Patients Needing Care Management</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>11.4% (343 patients)</td>
</tr>
</tbody>
</table>
* The practice identified patients at high risk using a comprehensive risk-stratification process.
COMPETENCY B

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

CM 04-05: Core Criteria

A person-centered care plan is established for care management patients

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

CM 05: Example

Patient is provided a copy of individualized care plan.
Care Management & Support

CM 06-09: Elective Criteria

Documents patient preferences & functional/lifestyle goals

Addresses identified & potential barriers

Care plans include a self-management plan

Care plans are shared across care settings
## Care Management & Support

**CM RRWB: Example**

<table>
<thead>
<tr>
<th>Patient Number</th>
<th>CM 04</th>
<th>CM 05</th>
<th>CM 06</th>
<th>CM 07</th>
<th>CM 08</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>3</td>
<td></td>
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<tr>
<td>4</td>
<td></td>
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<tr>
<td>5</td>
<td></td>
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<tr>
<td>6</td>
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<td>7</td>
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<td>8</td>
<td></td>
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<tr>
<td>9</td>
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<tr>
<td>10</td>
<td></td>
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<tr>
<td>11</td>
<td></td>
<td></td>
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<tr>
<td>12</td>
<td></td>
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<tr>
<td>13</td>
<td></td>
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<tr>
<td>14</td>
<td></td>
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<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood.
COMPETENCY A

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

CC 01: Core Criteria

Manages lab & imaging tests systematically by:

- Tracking, flagging & following-up on overdue tests
- Flagging abnormal test results
- Notification of test results
### Lab & Diagnostics Tracking Report: February 1-15,

<table>
<thead>
<tr>
<th>Order</th>
<th>Action/Comment</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPINE, LUMBAR</td>
<td></td>
<td>result</td>
</tr>
<tr>
<td>ELECTROCARDIOGRAM, COMPLETE</td>
<td>due in 3mos. Left msg for pt to call back.</td>
<td>receive</td>
</tr>
<tr>
<td>X-RAY EXAM OF KNEES Bilateral</td>
<td></td>
<td>ordered</td>
</tr>
<tr>
<td>Chlamydia/GC, DNA Probe</td>
<td></td>
<td>completed</td>
</tr>
<tr>
<td>Fasting Glucose, Serum</td>
<td></td>
<td>completed</td>
</tr>
<tr>
<td>HEMOGLOBIN A1C</td>
<td></td>
<td>completed</td>
</tr>
<tr>
<td>HPV, high+low-risk</td>
<td></td>
<td>completed</td>
</tr>
<tr>
<td>PAP, thin prep</td>
<td></td>
<td>completed</td>
</tr>
<tr>
<td>urine for gonorrhea and chlamydia</td>
<td></td>
<td>completed</td>
</tr>
<tr>
<td>CMP</td>
<td></td>
<td>completed</td>
</tr>
<tr>
<td>LIPID PANEL</td>
<td></td>
<td>completed</td>
</tr>
<tr>
<td>ELECTROCARDIOGRAM, COMPLETE</td>
<td></td>
<td>result</td>
</tr>
<tr>
<td>CBC</td>
<td></td>
<td>receive</td>
</tr>
<tr>
<td>CBC WITHOUT DIFF</td>
<td></td>
<td>completed</td>
</tr>
<tr>
<td>CMP</td>
<td></td>
<td>completed</td>
</tr>
<tr>
<td>LIPID PANEL</td>
<td></td>
<td>completed</td>
</tr>
<tr>
<td>TSH</td>
<td></td>
<td>completed</td>
</tr>
<tr>
<td>CT LUMBAR SPINE W/O DYE</td>
<td></td>
<td>cancelled</td>
</tr>
<tr>
<td>US liver and gallbladder</td>
<td></td>
<td>scheduled</td>
</tr>
<tr>
<td>ECHO TRANSTHORACIC</td>
<td></td>
<td>result</td>
</tr>
<tr>
<td>ELECTROCARDIOGRAM, COMPLETE</td>
<td></td>
<td>receive</td>
</tr>
<tr>
<td>MRI ABDOMEN W/O &amp; W/DYE Liver</td>
<td>letter mailed</td>
<td>ordered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>completed</td>
</tr>
</tbody>
</table>
Normal Lab Results of lab work left as message

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

CC 01 F: Example

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

*Notes:
STAT
Fasting: No

All tests are performed at Sunrise Medical Laboratories unless otherwise indicated.
Care Coordination & Care Transitions

CC 02: Elective Criteria

Follows up on newborn hearing and blood-spot screening with hospitals and/or other impatient facilities.
Documentation required

- **Documented** process for follow-up on newborn hearing tests/blood spot screening.
- Example
Care Coordination & Care Transitions

CC 03: Elective Criteria

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

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

CC 04: Core Criteria

A. • Clinical question
   • Required timing
   • Type of referral

B. • Demographic & clinical data
   ➢ Test results
   ➢ Care plan

C. • Track referral until available
   • Flag overdue reports
   • Follow-up overdue reports
Care Coordination & Care Transitions

*Clinical protocols are used* to identify necessary specialist referrals

Commonly used specialists/specialty types are identified

*Considers available performance information* on consultants/specialists
Performance Information for Specialist Referrals

CC 07: Example

[Image: Medicare.gov - Physician Compare]

A field with an asterisk (*) is required.

* Location
  BROOKLYN, NY, USA

* What are you searching for?  
  patrice

Search

Additional search options

Spotlight

Additional information
Care Coordination & Care Transitions

CC 08-09: Elective Criteria

The practice sets expectations for patient care and sharing information when working with:

- Non-behavioral healthcare specialists
- * Behavioral healthcare providers
# Behavioral Health Referral Expectations

**CC 09: Example**

## Behavioral Health Care Compact

between

<table>
<thead>
<tr>
<th>Referral Process</th>
<th>STEP 1 (at initial office visit)</th>
<th>STEP 1 (within 24 - 48 hours of visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>At the office visit, PCP will discuss reason for referral to Behavioral Health Specialist with patient/family.</td>
<td>The Center intake office receives fax and intake office will contact patient to schedule visit and complete intake assessment.</td>
</tr>
<tr>
<td></td>
<td>If visit is urgent, PCP office will call The Center office intake line to notify of need for a more expedited appointment and outreach to the patient</td>
<td>Insurance eligibility/benefits are reviewed when appointment is scheduled.</td>
</tr>
<tr>
<td></td>
<td>The Center contact information is provided to patient in printed care plan and follow-up plan</td>
<td>The patient will be placed with a therapist/counselor that is deemed a ‘good fit’ for the patient based on psychological assessed needs and insurance coverage.</td>
</tr>
</tbody>
</table>

**STEP 2 (within 24-48 hours of visit)**

- Referrals will be sent via fax or through the electronic health record (EHR) to The Center intake department. The referral will include the patient’s face sheet, most recent progress note, and the signed ‘authorization to release PHI’ form.
- Referral/Care Coordinator verifies insurance coverage referral requirements.
- Pertinent records and information will be included with referral.

**STEP 2 (within 7-10 days of initial visit)**

- The specialist office communicates with the PCP regarding the patient’s plan of care, updated diagnosis, and medication recommendations.
- This report will be sent to the PCP office within 7-10 business days of appointment (l/u recommendations and other pertinent medical information).
A behavioral health provider is integrated into the practice's care delivery system.
Care Coordination & Care Transitions

CC 11-13: Elective Criteria

- Monitors referrals
- Document Co-mgmt. agreements
- * Cost implications of treatment options
COMPETENCY C

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

**CC 14-16: Core Criteria**

- **Identifies patients** with unplanned admissions and ED visits
- **Shares clinical information** with impatient facilities
- **Contacts patients/families/caregivers** for follow-up care
Care Coordination & Care Transitions

**CC 14-16, 18-19: Example**

**Procedure:**

- Hospital census is obtained daily by fax or from an offsite electronic Health Information System from local hospitals by the Care Coordinator or Nurse Care Manager.
- Communication with local hospitals is completed daily.
- Discharge records are faxed to the CHCCM from the hospital or pulled from an offsite Health Information System by the Care Coordinator or Nurse Care Manager.
- Local hospitals are contacted if additional information is needed.
- After thorough review and obtaining hospital records the Care Coordinator will give the daily census to the Nurse Care Manager for review.
- Nurse Care Manager will be responsible for assuring the medical records were received and scanned into the chart.

**CC 16**

- Nurse Care Manager or Care Coordinator (if designated) will be responsible for contacting patient’s that were admitted and discharged from the hospital within 72 hours to ensure medications and allergies are reconciled in the patient’s chart, schedule follow up appointment’s if needed and obtain additional information as needed.
Referred Registration is an admission
Inpatient Discharge is a hospital discharge
Emergency Discharge is discharge from the ED.
Care Coordination & Care Transitions

**CC 16: Example**

---

**10:26 AM Telephone**

**Reason for Call**
Follow-up since

**Call Documentation**

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

**Encounter Messages**
No messages in this encounter

**Contacts**

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

**Created by**
10:26 AM

**Patient Instructions**
None
# Care Coordination & Care Transition

**CC 17-21: Elective Criteria**

<table>
<thead>
<tr>
<th>Coordinate</th>
<th>Exchange</th>
<th>Obtain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinate with acute care settings after hours</td>
<td>Exchange patient info. during hospitalization</td>
<td>Obtain discharge summaries from impatient facilities</td>
</tr>
</tbody>
</table>

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

**Electronic exchange of information** with external entities on 1 or more (max 3 credits):
- A. RHIO or HIEs
- B. Immunization registries or similar
- C. Summary of care to other providers or facilities for care transitions
Care Coordination & Care Transition

CC 19: Example

MEDICAL CENTER
Health Care Network
DISCHARGE SUMMARY

Pt. Name/Age/DOB:
Date of Admission: 6/18/20  Date of Discharge: 6/20/20
PCP: Christopher
Discharging Provider: Johannah MD
Consultations:
IP CONSULT TO CASE MANAGEMENT

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

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

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

The practice measures to understand current performance and to identify opportunities for improvement
Performance Measurement & Quality Improvement

QI 01-03: Core Criteria

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

**Care coordination** measures

Measures affecting **health care costs**

Assesses performance on availability of **major appointment types**

Monitors at least 5 clinical quality measures (must monitor at least one measure of each type)
## Performance Measurement & Quality Improvement

**QI 01 A-C: Example**

<table>
<thead>
<tr>
<th>Health Maintenance Topic</th>
<th>In compliance</th>
<th>Overdue</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breast Cancer Screening</strong></td>
<td>51.05%</td>
<td>48.95%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>1,381</td>
<td>1,324</td>
<td>2,705</td>
</tr>
<tr>
<td><strong>Colon Cancer Colonoscopy</strong></td>
<td>63.35%</td>
<td>36.65%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>1,965</td>
<td>1,137</td>
<td>3,102</td>
</tr>
<tr>
<td><strong>Pneumococcal Vaccine</strong></td>
<td>83.11%</td>
<td>28.36%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>743</td>
<td>350</td>
<td>1,234</td>
</tr>
<tr>
<td><strong>Foot Exam</strong></td>
<td>74.84%</td>
<td>25.16%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>992</td>
<td>350</td>
<td>1,232</td>
</tr>
<tr>
<td><strong>Hemoglobin A1C</strong></td>
<td>71.64%</td>
<td>28.36%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>884</td>
<td>350</td>
<td>1,234</td>
</tr>
<tr>
<td><strong>Urine Microalbumin/Creatinine Ratio</strong></td>
<td>67.13%</td>
<td>32.87%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>825</td>
<td>404</td>
<td>1,229</td>
</tr>
</tbody>
</table>
Performance Measurement & Quality Improvement

QI 02 B: Example

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

Readmission within 30 days showing improvement
Performance Measurement & Quality Improvement

**QI 04 A-B: Core Criteria**

**Monitors patient experience** through quantitative and qualitative data (across at least three categories)

- **Access**
- **Communication**
- **Coordination**

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

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

**Caller identifies possible vulnerabilities prior to phone survey.**

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

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

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

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

Providers – You will receive a copy of this survey each time it fills. The Patient Satisfaction Coordinator (PSC) calls all new patients a few days after their first visit to provide immediate feedback as well as recognizing vulnerable subgroups. The PSC will provide care coordination as needed when identified. All findings are kept by the Chief Quality Officer for use in QA/QI activities.
Assesses health disparities using performance data (must choose one from each section):

- Clinical quality
- Patient experience
NCQA PCMH Quality Measurement and Improvement Worksheet

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

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

**QUALITY MEASUREMENT & IMPROVEMENT ACTIVITY STEPS**

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

2. **Identify a baseline performance assessment.** Choose a starting measurement period (start and end date) and identify a baseline performance measurement for each measure.
   - For PCMH QI 08-11 and 13, use performance measurements from the reports provided in PCMH QI 01-05.

   The baseline measurement period must be within 12 months before evidence submission for check-in, or within 24 months, if there is a remeasurement period. The performance measurement must be a rate (percentage based on numerator and denominator) or number (with number of patients represented by the data).

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

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

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

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

6. **Assess actions taken and describe improvement.** Briefly describe how your practice site showed improvement on measures. Describe the assessment of the actions; correlate actions and the resulting improvement. **(Applies to QI 12 and 14)**
Performance Measurement & Quality Improvement

QI 06-07: Elective Criteria

Uses a standardized, validated survey tool

* Obtains feedback on vulnerable patient groups
COMPETENCY B

The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies.
Performance Measurement & Quality Improvement

QI 08-11: Core Criteria

Sets goals and acts to improve upon at least three measures across at least three of the four categories

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

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

Sets goals and acts to improve on at least one patient experience measure
Achieves improved performance on at least 2 performance measures

Sets goals and acts to improve disparities in care or service on at least 1 measure

Achieves improved performance on at least 1 measure of disparities in care or service
COMPETENCY C

The practice is accountable for performance. The practice shares performance data with the practice, patients and/or publicly for the measures and patient populations identified in the previous section.
Performance Measurement & Quality Improvement

QI 15: Core Criteria

Reports practice-level or individual clinician performance results within the practice for measures reported by the practice.
Performance Measurement & Quality Improvement

QI 16-19: Elective Criteria

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

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

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

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

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

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

Sincerely
Recognition Process

Q-PASS
Recognition Process

3 Pathways

- **New Customer**
  - Full Transform Process

- **Recognized PCMH 2011/2014 Level 1 or 2**
  - Accelerated Renewal Process (Transform w/ Attestation)

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

Transform Steps

Complete Eligibility/Readiness Survey

Discover Educational Resources

Create Q-PASS Account(s)

Enroll Sites

Meet with NCQA Representative

Provide Evidence during Review
Existing Customers

Transform Steps

- Complete Eligibility Readiness Survey
- Enroll Sites
- Discover Educational Resources
- Meet with NCQA Representative
- Claim Q-PASS Account(s)
- Provide Evidence during Review
Organization set-up

New Organizations

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

Existing Organizations

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

My evaluations

My organizations

Organizations

All of your organizations are listed here.

5334 Total Organizations

Name | Phone | Primary | Secondary | Actions
--- | --- | --- | --- | ---
1 Hanson Place Pediatrics PC | | | | 
1/2 SBCT | (210) 295-7419 | | | 
10 MDG USAFA Family Health and Pediatric Clinics | (719) 333-0566 | | | 
1211 WPR | (718) 828-6610 | | | 

Create or Claim an Organization

results per page: 10
Adding an Organization to Q-PASS

Organizations

All of your organizations are listed here.

How to add a new organization or claim an existing organization?

How to set the primary and secondary contacts?

What is my Tax Id Number?

Add an Organization

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

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

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

Add an Organization

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

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

Search

TESTING

Your search - TESTING - did not match any results.

Organization Legal Name

* required

Organization Display Name

Street Address

* required

City

* required

State...

* required

Zip

* required
Enrollment

Organization needs the following to enroll

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

Step-by-Step process in Q-PASS

• Choose sites
• Choose product(s)
• Add/create clinicians
• Sign agreements
Enrolling in Q-PASS

Programs

How to Enroll a Site into a Program?

Select a program to enroll in from the list below.

Patient-Centered Medical Home

Recognized 0 • Enrolled 1

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

Enroll Sites in Program

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

Blog License Agreement Privacy Policy Contact Us

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Enrollment – Choose Sites

How to add a site?
How to Enroll a Site into a Program?
How to set a Primary Contact
What is the difference between a Type 1 and Type 2 NPI?

Total Sites to Enroll in PCMH = 1

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

Select Sites below:

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

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

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

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

- Production Test 1, Site A

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

- Production Test 1, Site A
Step 3: Set Up Clinicians

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

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

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

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

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

Step 4: Sign Legal Agreements

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

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

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

How to sign legal agreements

There are 2 agreements that need to be signed.

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

Download Adobe Acrobat Reader

<table>
<thead>
<tr>
<th>Agreement</th>
<th>Is Signed</th>
<th>Signed By</th>
<th>Date Signed</th>
<th>View/Sign Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCMH 2017 Agreement</td>
<td>Signed</td>
<td>Bill Tull</td>
<td>4/12/2017</td>
<td></td>
</tr>
<tr>
<td>Business Associate Agreement</td>
<td>Signed</td>
<td>Bill Tull</td>
<td>4/12/2017</td>
<td></td>
</tr>
</tbody>
</table>
After Enrollment

Subtitle

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

Transfer credit

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

Shared credit

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

- Organizations with 3+ sites
- Shared EHR, processes and evidence across sites
- **Identify shared criteria** from “sharable list”
- Identify primary site
  - Full review only for this site
  - Shared criteria auto-populate in subsequent sites
Multi-Sites Sharing Evidence/Credit

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

Your organization may follow the same practices and procedures across many of your practice sites. If so, you can use this area to share credits across practice sites.
Transform “Check-in” process

Up to 3 “Check-ins” During Review

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

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

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

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

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

Either Option
- Practice decision*

*All PHI should be removed from documents uploaded in Q-PASS
“We Have Different Evidence”

• Flexibility is encouraged
• Suggested evidence not exhaustive
• Meet intent in creative ways
• Not sure? Ask NCQA
After Check-In

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

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

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

If the survey process is not completed within 12 months, additional time can be purchased
Accelerated Renewal
Accelerated Renewal

Eligibility

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

- PCMH 2011
  Levels 1, 2, & 3

- PCMH 2014
  Levels 1 & 2
Accelerated Renewal

What is expected for criteria?

For criteria identified as review practices should:
• Follow standards & guidelines
• Submit evidence in Q-PASS
• Prepare to demonstrate virtual review-eligible evidence

For criteria marked attestation the practice should:
• Attest that your practice is still performing PCMH activities
• You will not need to demonstrate documentation or evidence

Criteria are identified as shared or site specific
Accelerated Renewal

*Review & attestation by the numbers*

<table>
<thead>
<tr>
<th></th>
<th>Core</th>
<th>Electives</th>
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</table>

“Review or Attestation” indicates which criteria require submission of evidence and which criteria simply allow attestation.
### Succeed Annual Reporting Process

<table>
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<tr>
<th>Practice’s recognized PCMH 2014 Level 3 or after Transform process must:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Attest to previous performance</td>
<td>Confirm practice information and make any clinician changes</td>
</tr>
<tr>
<td>Provide evidence demonstrating continuing PCMH Activities</td>
<td>Annual fee payment/discount code from HRSA</td>
</tr>
</tbody>
</table>
Annual Reporting Date

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

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

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

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

The annual reporting date for multi-site group is based on the date of 1st Recognized practice.
Evidence & Annual Reporting

• **Evidence can be provided** at any point within the year

• NCQA will only review after:
  - Reporting date has passed
  - NOI Approved
Audit and New Requirements

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

**New Requirements**
- Announced one year ahead
- Practice must meet at next reporting date
Questions