

# NCQA Patient-Centered Medical Home (PCMH) Recognition

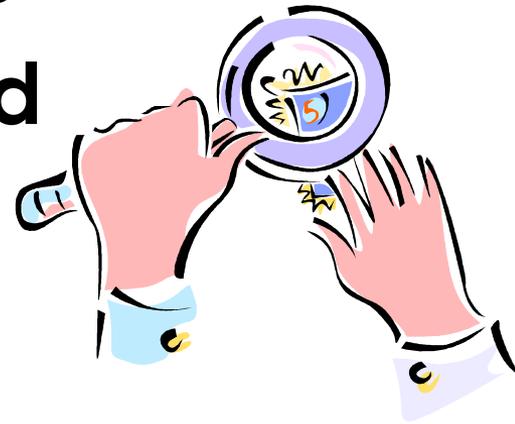


2012



# Purpose of this Seminar

- **Examine the essential characteristics of a Recognized Patient-Centered Medical Home**
- **Identify the measurement and documentation criteria for each of NCQA's updated requirements**
- **Facilitate the NCQA survey and evaluation process**



# Learning Objectives

- **Review and discuss sample submissions for PCMH Recognition including documentation that does and does not meet the requirements**
- **Discuss:**
  - Scoring for each element
  - Strategies to enhance and improve valid content
  - Clarify application process for becoming a Recognized patient-centered medical home
- **Identify components that challenge and facilitate the survey, evaluation and submission process in a variety of practice environments**

# National Committee for Quality Assurance

## NCQA

Private, independent non-profit health care quality oversight organization founded in 1990

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### **MISSION**

*To improve the quality of health care.*

### **VISION**

*To transform health care through quality measurement, transparency, and accountability.*

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### **ILLUSTRATIVE PROGRAMS**

- \* HEDIS – Healthcare Effectiveness Data and Information Set
- \* Health Plan Accreditation
- \* Clinician Recognition
- \* Disease Management
- \* Wellness & Health Promotion Accreditation
- \* Consumer Union’s Health Plans Rankings
- \* Quality Dividend Calculator

# PPC-PCMH/PCMH Practices\*

## NUMBER OF CLINICIANS IN RECOGNIZED PRACTICES

	1-2	3-7	8-9	10-19	20-50	50+	Total
Level 1	395	318	36	53	9	0	811
Level 2	57	63	2	6	2	0	130
Level 3	662	937	157	213	64	3	2036
Total	1114	1318	195	272	75	3	2977

\* As of 10/31/11

# PCMH Development History

- **Systematic approach to delivering preventive and chronic care (Wagner Chronic Care Model)**
- **Built on IOM's recommendation to shift from "blaming" individual clinicians to improving systems**
- **Measures actionable for practices**
- **Validate measures by relating them to clinical performance and patient experience results**
- **PPC-PCMH incorporated Joint Principles:**
  - Whole-person focus
  - Coordinated, integrated, comprehensive care
  - Personal clinician, team-based care

# Theoretical Frameworks Informing Development

## Chronic Care Model

Clinical information Systems  
Decision Support  
Patient Self-Management  
Delivery System Redesign  
Community Linkages  
Health Systems

## Patient Centered Care

Respect Patient Values  
Accessible  
Family-Centered  
Continuous  
Coordinated  
Community Linkages  
Compassionate  
Culturally Appropriate  
Emotional Support  
Information and Education  
Physical Comfort  
Quality Improvement

## Cultural Competence

Culturally competent interactions  
Language services  
Reducing disparities

## Medical Home

Personal physician  
Physician directed team  
Whole person orientation  
Care is coordinated and integrated  
Quality and safety  
Enhanced access

# How NCQA Revised its PCMH Standards

- **Collected, analyzed stakeholder suggestions**
- **Analyzed data from NCQA PCMH practices**
- **Conducted patient experience research**
- **Sought public comment**
- **Interviewed NCQA PCMH practices**
- **Worked closely with thoughtful, committed PCMH Advisory Committee**

# PCMH 2011 Development Goals

- **Increase patient-centeredness**
- **Align requirements with processes that improve quality and eliminate waste**
- **Increase emphasis on patient experience**
- **Enhance use of clinical performance measure results**
- **Integrate: unhealthy behaviors, mental health and substance abuse**
- **Enhance coordination of care**
- **Enhance applicability to pediatric practices**

# 2011 PCMH Content and Scoring

<b>Standard 1: Enhance Access and Continuity</b>	<b>Pts</b>
<b>A. Access During Office Hours**</b>	<b>4</b>
B. After-Hours Access	4
C. Electronic Access	2
D. Continuity	2
E. Medical Home Responsibilities	2
F. Culturally and Linguistically Appropriate Services	2
G. Practice Team	4
	20
<b>Standard 2: Identify and Manage Patient Populations</b>	<b>Pts</b>
A. Patient Information	3
B. Clinical Data	4
C. Comprehensive Health Assessment	4
<b>D. Use Data for Population Management**</b>	<b>5</b>
	16
<b>Standard 3: Plan and Manage Care</b>	<b>Pts</b>
A. Implement Evidence-Based Guidelines	4
B. Identify High-Risk Patients	3
<b>C. Care Management**</b>	<b>4</b>
D. Medication Management	3
E. Use Electronic Prescribing	3
	17

<b>Standard 4: Provide Self-Care Support and Community Resources</b>	<b>Pts</b>
<b>A. Support Self-Care Process**</b>	<b>6</b>
B. Provide Referrals to Community Resources	3
	9
<b>Standard 5: Track and Coordinate Care</b>	<b>Pts</b>
A. Test Tracking and Follow-Up	6
<b>B. Referral Tracking and Follow-Up**</b>	<b>6</b>
C. Coordinate with Facilities/Care Transitions	6
	18
<b>Standard 6: Measure and Improve Performance</b>	<b>Pts</b>
A. Measure Performance	4
B. Measure Patient/Family Experience	4
<b>C. Implement Continuously Quality Improvement**</b>	<b>4</b>
D. Demonstrate Continuous Quality Improvement	3
E. Report Performance	3
F. Report Data Externally	2
G. Use of Certified EHR Technology	0
	20

**\*\*Must Pass Elements**

# PCMH Scoring

6 standards = 100 points  
**6 Must Pass** elements

**NOTE: Must Pass** elements require a  $\geq 50\%$  performance level to pass

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	85 - 100	6 of 6
Level 2	60 - 84	6 of 6
Level 1	35 - 59	6 of 6
Not Recognized	0 - 34	< 6

Practices with a numeric score of 0 to 34 points and/or achieve less than 6 “Must Pass” Elements are not Recognized.

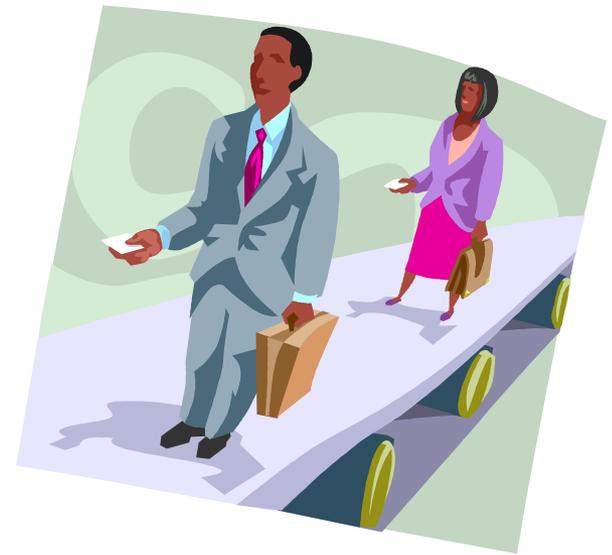
# Stage 1 Meaningful Use

- Congress enacted the **American Recovery & Reinvestment Act (ARRA)** with subsection on Health Information Technology for Economic and Clinical Health Act (HITECH)
- Provides incentives for using health information technology to improve quality for **Meaningful Use [MU]**
  - [https://www.cms.gov/EHRIncentivePrograms/30\\_Meaningful\\_Use#BOOKMARK4](https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use#BOOKMARK4)
  - Medicare incentives – federal
  - Medicaid incentives - state
- **Data Requirements**
  - Core Set - practice must meet all 15 requirements
  - Menu Set - practice must meet 5 of 10 requirements including submitting immunization data or surveillance data
  - Clinical quality measures – 4 core, 3 optional
  - Certified EHR with security analysis

# Meaningful Use of Health Information Technology (HIT)

- NCQA emphasizes HIT because good primary care is information-intensive
- PCMH 2011 reinforces incentives to use HIT to improve quality
- Meaningful use language is embedded, often verbatim, in PCMH 2011 evaluation standards
- Synergy: PCMH 2011 medical practices will be well prepared to qualify for meaningful use, and vice versa

# PCMH Recognition Process Overview



# Eligible Applicants for Recognition as a Patient-Centered Medical Home

- **NCQA Recognizes outpatient primary care practices** that meet the scoring criteria for Level 1, 2, or 3 as assessed against the Patient-Centered Medical Home (PCMH) requirements
- NCQA defines a practice as a clinician or clinicians practicing together at a **single geographic location** , includes nurse-led practices in states where state licensing designates NPs as independent practitioners

# Eligible Applicants for Recognition as a Patient-Centered Medical Home

- PCMH Recognition identifies **primary care clinicians** practicing at the site, including **nurse practitioners and physicians' assistants** that can be designated as a patient's personal clinician (with their own panel of patients)
  - Not applicable to Military Treatment Facility Recognition
- Recognition is at the **practice-site level**

# The NCQA PCMH Recognition Process

## Practice:

- 1. Receive PCMH 2011 Standards and Guidelines**
  - Included in Survey Tool**
- 2. Receive Survey Tool and online application account**
- 3. Participates in NCQA trainings**
- 4. Self-assesses current performance on survey**

# The NCQA PCMH Recognition Process

- 5. Completes online application information: electronic agreements, practice site, clinician details, and application for survey**
- 6. Submits application**
- 7. Receives email confirmation that practice can submit Survey Tool and**
- 8. Submits Survey Tool when ready**

# Practice Needs for PCMH Survey Process

## 1. **Computer system** with:

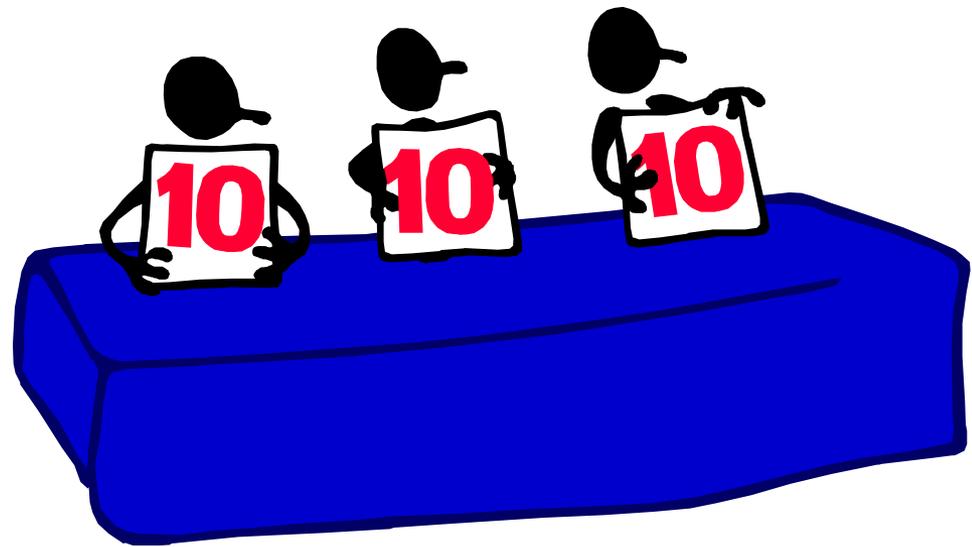
- Email
- Internet access
- Microsoft Word
- Microsoft Excel
- Adobe Acrobat Reader (available for free online)

## 2. **Staff skill** in using above listed computer systems and ...

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

# Components of a Standard

- **Statement of the Standard**
- **Elements**
- **Factors**
- **Scoring**
- **Explanation**
- **Documentation**





# Reading a Standard

**Standard Title And Statement**

→ **PCMH 1: Enhance Access and Continuity**

20 points

← **Standard Score = 20**

The practice provides access to culturally and linguistically appropriate routine care and urgent team-based care that meets the needs of patients/families.

**Element:** Component of a standard that is scored and provides details about performance expectations

→ **Element A: Access During Office Hours**  
**MUST PASS**

4 points

← **Element Score = 4**

The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:

	Yes	No	NA
1. Providing same-day appointments	<input type="checkbox"/>	<input type="checkbox"/>	
2. Providing timely clinical advice by telephone during office hours	<input type="checkbox"/>	<input type="checkbox"/>	
3. Providing timely clinical advice by secure electronic messages during office hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Documenting clinical advice in the medical record.	<input type="checkbox"/>	<input type="checkbox"/>	

← **Factor:** Item in an element that is scored

**Scoring:** Level of performance organization must demonstrate to receive a specified percentage of element points

→ **Scoring**

100%	75%	50%	25%	0%
The practice meets all 4 factors	The practice meets 3 factors, including factor 1	The practice meets 2 factors, including factor 1	The practice meets factor 1	The practice meets no factors or does not meet factor 1

**Explanation**

**MUST PASS** elements are considered the basic building blocks of a patient-centered medical home. Practices must earn a score of 50% or higher.

**Factor 1:** The practice reserves time for same-day appointments (also referred to as "open access," "advanced access" or "same-day scheduling") for routine and urgent care based on patient preference or triage.

**Factors 2 and 3:** Clinicians return calls or respond to secure electronic messages in a timely manner, as defined by the practice to meet the clinical needs of the patient.

**Factor 4:** Clinical advice must be documented in the patient record, whether it is provided by phone or secure electronic message.

← **Explanation:** Guidance for demonstrating performance against an element

**Documentation:** Evidence practices can use to demonstrate performance against an element's requirements.

→

**Documentation**

**Factor 1:** The practice has a documented process for staff to follow for scheduling same-day appointments and has a report that covers at least five consecutive days and shows the use of same-day appointments throughout the practice.

**Factor 2:** The practice has a documented process for staff to follow for providing timely clinical advice by telephone (including the practice's definition of 'timely') and has a report summarizing its actual response times.

**Types:** documented process, reports, materials, patient records

# Must Pass Elements

## Rationale for Must Pass Elements

- Identifies critical concepts of PCMH
- Helps focus Level 1 practices on most important aspects of PCMH
- Guides practices in PCMH evolution and continuous quality improvement
- Standardizes “Recognition”

## Critical Factors

- Required for practices to receive more than minimal or, for some factors, any points.
- Identified in the scoring section of the element

# Definitions

- **Important conditions:** A chronic or recurring condition that a practice manages with evidence-based guidelines including one *unhealthy behavior* (e.g. smoking, obesity), *mental health* (e.g. depression, anxiety, ADHD, ADD) or *substance abuse* (e.g. alcohol, Rx drugs, illegal drugs)
  - **Adults:** diabetes or congestive heart failure, hypertension, COPD, obesity, depression
  - **Pediatrics:** asthma, eczema, allergic rhinitis, otitis media, ADHD, obesity, well-child care (child health ages)

# Definitions

- **High risk patients:** Patients in a practice with high resource use and risk, including high frequency of visits, hospitalizations, ER visits, treatments, multiple co-morbid conditions, non-compliance with treatment, children with special needs
- **May not use:** screenings such as mammograms, immunizations or treatments such as provided in a coumadin clinic

# Documentation

1. **Documented process** Written procedures, protocols, processes, workflow forms (not explanations)
2. **Reports** Aggregated data showing evidence
3. **Records or files** Patient files or registry entries documenting action taken
4. **Materials** Information for patients or clinicians, e.g. clinical guidelines, self-management and educational resources
5. **Screen shots** Electronic “copy” may be used as examples (EHR capability), materials (Web site resources) or records; helps to show specific to the practice and not a vendor demo page

# Discuss and Analyze the PCMH Recognition Requirements



# PCMH 1: Enhance Access and Continuity

## Intent of Standard

- Patients have access to routine/urgent care and clinical advice that are culturally/linguistically appropriate during/after hours
- Electronic access
- Clinician selected by patient
- Team-based care; trained staff

## Meaningful Use Criteria

- Patients provided electronic:
  - Copy of health information
  - Access to health information
  - Clinical summary of visit

# PCMH 1: Enhance Access and Continuity

## Elements

- PCMH1A: Access During Office Hours – MUST PASS
- PCMH1B: After-Hours Access
- PCMH1C: Electronic Access
- PCMH1D: Continuity
- PCMH1E: Medical Home Responsibilities
- PCMH1F: Culturally and Linguistically Appropriate Services (CLAS)
- PCMH1G: The Practice Team

# PCMH 1A: Access During Office Hours

**Practice has written process/defined standards, and demonstrates that it monitors performance against the standards to:**

- 1. Provide same-day appointments – CRITICAL FACTOR**
- 2. Provide timely advice by telephone**
- 3. Provide timely advice by electronic message**
- 4. Document clinical advice in the medical record**

# PCMH 1A: Scoring and Documentation

- **MUST PASS**
- **4 Points**
- **Scoring**
  - 4 factors = 100%
  - 3 factors (including factor 1) = 75%
  - 2 factors (including factor 1) = 50%
  - Factor 1 = 25%
  - 0 factors or missing factor 1 = 0%
- **Documentation:**
  - F1-4: Documented process for scheduling appointments, providing clinical advice and documenting advice
  - F1-3: Reports with 5 days of data showing same-day access, response times compared to practice defined standards
  - F4: Three examples of clinical advice **or** report with percent documented advice in record in recent one month period

# PCMH 1A1: Example Scheduling Policy

## Office Scheduling Policy

### Personal Clinicians:

For all routine office visits (check-ups, follow-ups) and physicals, patients are to be scheduled with their personal clinician (whichever provider they see on a regular basis) to keep continuity of care.

### Same-Day Appointments:

practices as an “Advanced Access” practice. Any patient that needs to be seen on a day the office is open (Monday – Saturday) will be able to be seen that day with the available clinician. Not all clinicians will have opening everyday due to their community schedules, but there will a clinician available to see a patient when they call.

### Procedures and Exams:

When scheduling a patient for an annual physical, please make sure that they have the lab work done one week prior to visit. This will ensure that the results are in-house for the doctor to review at time of service.

When a patient is scheduling an office visit, please make sure to note and procedures or exams that need to be done (i.e. hearing test, EKG, skin tag removal... ).

# PCMH 1A1: Example Scheduling Policy

uses an advanced access scheduling system. Approximately 30% of the day's visits are prebooked while the remaining 70% are left open for same day appointments. The office strives to "do today's work today." Patients who call before noon for a same day appointment are guaranteed a same day appointment. Patients who call after noon with non-urgent matters may be scheduled the next day if necessary. Urgent matters are scheduled the same day whenever possible. If no appointments are available and the need is not urgent, the patient is asked to schedule an appointment the following day. If the need is urgent, (i.e.: chest pain, abdominal pain, falls, etc.) the scheduler will immediately consult the provider and decide upon an appropriate course of action, or, refer the patient to a local urgent care or emergency room. These instructions will then be documented in the patient's chart.

Acute illnesses will be seen in the office within 24 hours.

Routine physicals will be scheduled at next available appointment which is usually same day or next day at the latest.

Patients recently discharged from outside facilities (hospitals, nursing home, rehab facilities) will be seen within 1 week of discharge or sooner if necessary based on clinical condition.

# PCMH 1A1: Example Advanced Access

1	<b>ADVANCED ACCESS</b>	Day of the Week: Wednesday, July 23, 2008		
2	<b>Provider Name (s)</b> →			
3	<b>At the beginning of the day:</b>			
4	<b># of Open Slots for:</b>			
5	<b>10 min. appt</b>	N/A	N/A	N/A
6	<b>15 min. appt</b>		1	11
7	<b>20 min. appt.</b>	N/A	N/A	N/A
8	<b>30 min. appt</b>		0	5
9	<b>other time frame</b>			
10				
11	<b>urgent</b>		1	11
12	<b>physical</b>		0	5
13	<b>Third Next Available Appt. for:</b>			
14	<b>New Patient Physical</b>			
15	<b>Routine Exam</b>			
16	<b># of Work in slots</b>		1	11
17				
18	<b>At the end of the day:</b>			
19	<b># of Cancellations</b>		0	0
20	<b># of No Shows</b>		0	0
21	<b># of Appt. slots refilled</b>		0	0
22	<b># of Appt. requests (Int./Ext)</b>		2	1
23	<b># of Appt. Requests Not Filled</b>		0	0
24	<b># of Open Slots</b>		0	12
25	<b>Clinical Hours Scheduled</b>	2.25	4	1.25
26	<b>Clinical Hours Worked</b>	3	2	0.25

## Compares:

- ✓ Available time slots at beginning of day
- ✓ Summary of activity at end of day
- ✓ Third Next Available Appointment for
  - New Patient Physical
  - Routine Exam

# PCMH 1A2: Example Response

## Times to Calls

### Shows:

- ✓ Call date/time
- ✓ Response date/time
- ✓ If time meets policy

Response times to meet standards for timely telephone response:

*(A telephone call audit was conducted for our practice for two weeks. Below are the results. The encounter number refers to the unique tracking ID our EMR assigns. It has been provided instead of confidential patient information, for tracking purposes. policy for telephone response time is 24 hours.)*

Encounter Number	Date we received phone request	Time of request	Date we responded to patient	Time of response	Elapsed Time	Response time meets policies?
	3/20/09	11:26	3/20/09	17:02	6 hours	yes
	3/19/09	11:21	3/19/09	13:10	2 hours	yes
	3/18/09	13:53	3/20/09	17:19	4 hours	yes
	3/17/09	15:02	3/18/09	9:31	18 hours	yes
	3/17/09	14:13	3/18/09	10:00	20 hours	yes
	3/19/09	15:14	3/20/09	9:09	18 hours	yes
	3/16/09	10:30	3/16/09	10:41	.25 hours	yes
	3/20/09	9:28	3/20/09	12:55	3 hours	Yes
	3/17/09	13:53	3/17/09	16:19	3 hours	yes
	3/18/09	14:35	3/19/09	14:34	24 hours	Yes
	3/19/09	11:16	3/19/09	11:32	0.25 hours	Yes

# PCMH 1A2: Example Providing Timely Messaging Advice

Clinical Call Response time for 5/7/2009 – 5/11/2009 (data attached)

Message Responders	total # messages	avg response time in hours:
Physicians	75	0.91
Residents	16	1.50
Midlevels	24	0.89
Nurses	73	0.94
Clinical Asst	62	1.03
Total	250	0.98 (standard is 2 hours)

# PCMH 1A2: Example of Documentation

## of Call Response in Patient Record

**Report Viewer** [?] [Resize] [Close]

Report History | 1 | View Pane 1 | 2 | View Pane 2 | Split Up/Down | Split Left/Right | Detach Window

1 | Telephone FM

Back | [Icons]

**Telephone** | Description: 55 year old female  
Provider: [Redacted]  
Department: [Redacted]

**Incoming Call**

Date & Time	Provider	Department	Encounter #
[Redacted]	[Redacted] MD	[Redacted]	54588434

**Contacts**

Date & Time	Type	Contact	Phone
[Redacted] 2010 9:55 AM	Phone (Incoming)	[Redacted] (Self)	[Redacted] (W)

**Reason for Call**  
Question since 11/8/2010

**Call Documentation**  
[Redacted] 09:58 AM Signed  
She is having right leg excruciating leg ,muscle pain."double over , laying on the floor" she is concerned she has a blood clot. She had surface clots in past and labeled von willebrand's. She had bubbling in veins and then after it felt like ice in veins. Inside calf to other side calf, behind knee and knee cap. She is having functional pain now but the prior pain was worse than labor pain. She drank 2 L of pedia lite. Episodes lasted 15 min and then moved and started again. OV made

**Historical Meds Added to List**  
[Hyperlink Historical Meds Added](#)

**Meds Removed To Update List**  
[Hyperlink Meds Removed](#)

**Patient Instruction**  
[Hyperlink Patient Instruction](#)

Calendar - ... | Hotmail - h... | Hyperspac... | original files | PPC 1B - Pl... | PPC 1B#2... | 5 | [Icons] | 9:39 AM

# PCMH 1B: After-Hours Access

Practice has a written process/defined standards and monitors performance against the standards to:

1. Provide access to routine and urgent-care outside business hours
2. Provide continuity of medical record information for care and advice when office is closed
3. Provide timely advice by phone when office is closed – CRITICAL FACTOR
4. Provide timely advice using interactive electronic system when office is closed
5. Document after-hours advice

# PCMH 1B: Scoring and Documentation

- **4 Points**

- **Scoring**

- 5 factors = 100%
- 4 factors(including factor 3) = 75%
- 3 factors(including factor 3) = 50%
- 1-2 factors = 25%
- 0 factors = 0%

- **Documentation**

- F1-5: Documented process for arranging after hours access, making medical records available after hours, providing timely advice after hours, documenting advice after hours
- F1: Report showing after hours availability **or** materials with after-hours care
- F3,4: Report showing after hours availability, response times
- F5: Three examples of clinical advice **or** report with percent documented advice in record in recent one month period

# PCMH 1C: Electronic Access

Practice provides through a secure electronic system:

1. Electronic copy of health information within 3 days to more than 50% of patients who request it\*
2. Electronic access to current health information within 4 days to at least 10% of patients\*\*
3. Clinical summaries provided for more than 50% of office visits within 3 days\*
4. Two-way communication
5. Request for appointments or prescription refills
6. Request for referrals or test results

\* Core Meaningful Use Requirement

\*\* Menu Meaningful Use Requirement

# PCMH 1C: Scoring and Documentation

- **2 Points**
- **Scoring:**
  - 5-6 factors = 100%
  - 3-4 factors = 75%
  - 2 factors = 50%
  - 1 factor = 25%
  - 0 factors = 0%
- **Documentation**
  - F1-3: Report showing percentage of patients who received electronic copy of health information, access to requested health information, electronic clinical summaries
  - F4-6: Screen shots of its secure web site or portal, web page where patients can make requests and communication capability with patients

# PCMH 1C4-5: Example Interactive Web Site



Proxy
Proxy Access
<b>My Health Record</b>
Health Summary
Recent Visits
Test Results
Results Summary
Tests Ordered
<b>Disease Management</b>
Home Monitoring
Diabetes Report
<b>Prescriptions</b>
Renew
<b>Appointments</b>
Request
Upcoming/Cancel
<b>Message Center</b>
Inbox
Messages Sent
Archive
Renew Messaging
Send Msg to MD/RN
<b>Questions</b>
Billing
Non-medical

- ✓ Health Record
- ✓ Disease Management
- ✓ Prescription Renewal
- ✓ Appointments
- ✓ Message Center

## Announcements

### DID YOU KNOW.....

High levels of [cholesterol](#) in the [blood](#) is a major [risk factor](#) for [coronary artery disease](#). [Coronary artery disease](#) is the leading cause of deaths in the United States. For more information, check out The [Cholesterol](#) Low Down on the [American Heart Association website](#).

**National Eating Disorder Week starts February 26th.**

### Running on empty

Despite what you may read or see in magazines, you can be too thin. Dieting to the extreme and overexercising are just two of the symptoms of a very serious illness known as anorexia nervosa. Size it up for yourself and click [here](#) to learn more.

### What's eating you?

If you think purging after a fattening meal is a quick fix, think again. The cycle of overeating and purging puts your life at [risk](#) and can quickly become the eating disorder known as bulimia nervosa. What causes [bulimia nervosa](#)?

### Keep your e-mail address current/Adjust SPAM Filters

Please take a moment to ensure your e-mail address is up-to-date. We do not want you to miss out on any new communications from \_\_\_\_\_ such as your test results, appointment reminders, etc. You can view your e-mail

# PCMH 1C5: Example Interactive Website

## Requesting Appointment



Home

Appointments

Appointments

Request Appointment

Schedule Appointment

Clinical

Billing

Profile

Preferences

Help

HealthView > Appointments > [Request Appointment](#)

### Welcome back to [REDACTED]

### Request Appointment

This is for **non-urgent** appointments only. For medical emergencies, dial 911.

With this form, you are submitting a request for an appointment - you are not scheduling the appointment. We will make our best effort to schedule your appointment or contact you within two business days. You will receive an email confirming your appointment when it is scheduled.

Some specialties require a physician referral to ensure that you are directed to the most appropriate provider for your needs. Please have your physician call [REDACTED] to make a referral for the following: Allergy and Immunology, Gastroenterology, Hematology, Hematology-Oncology, Nephrology, Neuro-oncology, Neurosurgery, Rheumatology, and the Sleep Disorders Clinic.

You may also contact the [REDACTED], Monday through Friday from 7:30 AM to 6:00 PM, for assistance with scheduling appointments.

#### Appointment Basics

Your first name \*

Your last name \*

Email address \*



# PCMH 1C6: Example Electronically Contacting Patient to Review Test Results

Appointments
Appointments
Request Appointment
Schedule Appointment
Clinical
Medical Records
Medical Allergies
Billing
Profile
Preferences
Help

Welcome back to HealthView ( [REDACTED] )

## Medical Records

for [REDACTED]

From:

To:

REFRESH

Date	Description
08/28/2008	<a href="#">URINALYSIS COMPLETE</a>
06/19/2008	<a href="#">FEMUR RIGHT 2 VIEWS</a>
03/17/2008	<a href="#">GLUCOSE FASTING</a>
03/14/2008	<a href="#">LIPID PANEL (CALCULATED LDL)</a>
03/14/2008	<a href="#">THYROID PROFILE</a>

You may view the results of most of your outpatient laboratory and radiology tests online. There will be a delay of up to seven days for displaying new results to you, allowing your provider time to review your results and communicate any significant findings with you personally.

If you have questions about your clinical results, bring them to your next clinic visit. If your question is urgent, contact your provider. This service is not a substitute for communicating with your health care provider. Health care decisions should only be made in consultation with your health care provider and never based on this information alone.

This is not your complete record. The following is a partial list of data that is not currently displayed:

- Tests conducted during inpatient and emergency room visits
- Tests related to pregnancy, sexually transmitted diseases, or substance abuse for anyone under eighteen years of age
- Pathology reports

To view your records, click on a document title on the list to the left. Twenty-five items are listed at a time. Use the paging arrows at the bottom left to move between pages. The default

# PCMH 1D: Continuity

**Practice provides continuity of care for patients/families by:**

- 1. Expecting patients to select a personal clinician and care team**
- 2. Documenting the patient's/family's choice of clinician**
- 3. Monitoring percent of patient visits with selected clinician or team**



# PCMH 1D: Scoring and Documentation

- **2 Points**
- **Scoring:**
  - 3 factors = 100%
  - 2 factors = 50%
  - 1 factor = 25%
  - 0 factors = 0%
- **Documentation**
  - F1: Documented process or materials for clinician selection
  - F2: Screen shot showing patients choice of clinician
  - F3: Report showing patient encounters with clinician (1 wk. of data)



# PCMH 1D3: Example Visits with Personal Clinician

Visits with assigned personal clinician for each patient:

No of Pts	Attending	Pts Assigned to Physician	% Assigned to a Personal Physician	% of appts with personal physician
43		43	100%	72%
49		49	100%	81%
56		56	100%	77%
66		66	100%	84%
<b>Total for practice</b>				
<b>214</b>		<b>214</b>	<b>100%</b>	<b>79%</b>

Data reflects review of random charts reviewed from visits between July 1, 2008 and June 30, 2009

All patients were assigned to a personal physician team (resident and attending)

The last column reflects the percent of times the patient saw a physician from their personal physician team

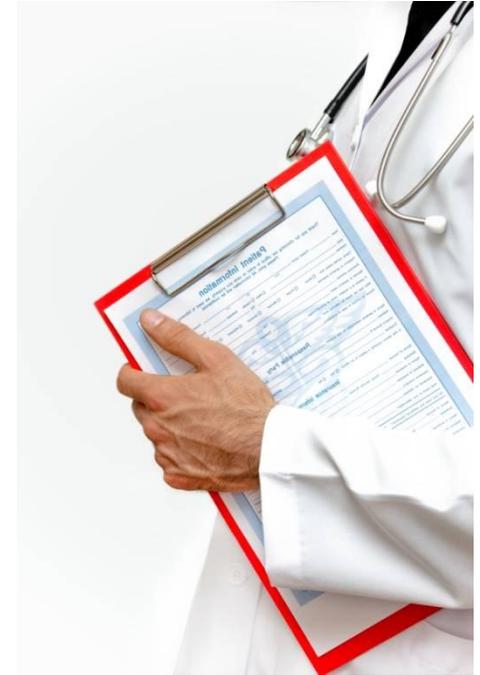
# PCMH 1E: Medical Home Responsibilities

Practice has process and provides materials about role of medical home to patients/families which include the following:

1. Practice responsible for coordinating patient care across multiple settings
2. How to obtain care/advice during/after office hours
3. Patients provide complete medical history and information on care obtained outside practice
4. Care team gives patient access to evidence-based care and self-management support

# PCMH 1E: Scoring and Documentation

- **2 Points**
- **Scoring:**
  - 4 factors = 100%
  - 3 factors = 75%
  - 2 factors = 50%
  - 1 factor = 25%
  - 0 factors = 0%
- **Documentation**
  - F1-4: Documented process for providing patient information
  - F1-4: Patient materials





# PCMH 1E: Example of Medical Home Materials on Responsibilities

**What is a medical home?**

.....> It's an approach to providing comprehensive primary care that facilitates partnership between individual patients and their personal providers, and when appropriate, the patient's family.

**How do you begin?**  
If you or a family member are interested in participating in a medical home, talk about it with your physician at your next office visit.



**A new approach to improve your healthcare**

.....> When you partner with your health professionals, you have a medical home.



# PCMH 1E: Sample Patient Letter Language from PCPCC

## Improved Communication and Access to Information:

- You can communicate with a Medical Home Team member anytime during normal working hours by calling <Number>.
- You will no longer need to use the Internal Medicine message center to leave messages.
- We will be implementing a Web-based computer system that will allow you to learn about a particular medical condition, electronically communicate with your Healthcare Team, and receive electronic reminders about your personal conditions. We will be providing you with more information on how to enroll in such a system in the near future!

## How will I contact my Medical Home Team?

- You can contact your Medical Home Team directly to arrange an appointment or to discuss your healthcare needs by calling <Number> Monday – Friday (except holidays) between the hours of 0730 and 1530. Outside of normal clinic hours, for urgent matters you can call < Number> and an on-call provider will call you back. Please continue to call 911 for all emergencies. It will be necessary for you (or a surrogate) to let the Medical Home Team know if you are seen by any other provider. This will allow us to continue to coordinate your healthcare needs.

# PCMH 1F: Culturally and Linguistically Appropriate Services (CLAS)

**Practice engages in activities to understand and meet the cultural and linguistic needs of its patients:**

- 1. Assesses racial and ethnic diversity of its population**
- 2. Assesses language needs of its population**
- 3. Provides interpretation or bilingual services to meet the language needs of its population**
- 4. Provides printed materials in the languages of its population**

# PCMH 1F: Scoring and Documentation

- **2 Points**
- **Scoring:**
  - 4 factors = 100%
  - 3 factors = 75%
  - 2 factors = 50%
  - 1 factor = 25%
  - 0 factors = 0%
- **Documentation**
  - F1-2: Report showing assessment of racial/ethnic/language of patients
  - F3: Documentation showing use of interpretation service
  - F4: Materials in other languages or Website in other languages



# PCMH 1F2: Example Language Report

**Language Report:** 1/1/09 through 6/30/09

On May 1, 2009 our office revised its policies and procedures to mandate capturing language preference under the demographics additional screen in Vision. Thus, our compliance for the first half of 2009 does not seem ideal however, our compliance for quarter 2 moving forward will be considerably better. This is one area that we have targeted for improvement.

## Summary of Data:

Language preference was captured on 4,711 patients out of 11,808 patients = 40%.

Preferred language English: 4564/4711 = 97%

Preferred language Spanish: 98/4711 = 2%

Other preferred languages: 49/4711 = 1%

Portuguese = 18 patients

Turkish = 6 patients

Russian = 4 patients

Polish = 4 patients

Chinese = 2 patients

German = 2 patients

Japanese = 2 patients

Arabic = 2 patients

Hindi = 2 patients

French = 1 patient

Italian = 1 patient

Ukrainian = 1 patient

Czech = 1 patient

Hungarian = 1 patient

# PCMH 1F2: Assessing the Language Needs of the Population

## Patient Distribution by Language

	# of Patients	% of Patients
<b>English</b>	2191	79.30%
<b>Spanish</b>	0	0.00%
<b>Russian</b>	2	0.07%
<b>Other</b>	1	0.04%
<b>All other</b>	0	0.00%
<b>Blank field</b>	<u>573</u>	20.74%
<b>Total</b>	2763	

This is based on unique pts seen between 08/07/09 10/08/09. This sampling indicates that most of our patients speak English. We utilize staff that speak Spanish and also have available language line for any other languages that might be needed



# PCMH 1F3: Example of Providing Bilingual Services

The screenshot displays a web-based medical application window titled "Hyperspace - DBO OPERATIONS". The interface includes a navigation bar with options like Home, Schedule, In Basket, Chart, Encounter, Telephone Call, Appts, Secure, and Media Manager. A patient information section shows "Allergies: Not on File" and "HM: Health Maintenance".

The main content area is a "Report Viewer" window displaying a report titled "8/9/10 to 8/9/10<-INTERPRETER SERVICES DOCUMENTATION Flowsheet<-08/09/2010 Office Visit FM". The report content is as follows:

Row Name	INTERPRETER SERVICES DOCUMENTATION
<b>INTERPRETER SERVICES DETAILS</b>	
Type of Interpreter Used	
Interpreter Name or Telephonic ID Number	
<b>IF OTHER OR NONE IS CHOSEN PLEASE PROVIDE EXPLANATION BELOW</b>	
Reason or Description if Other or None	<b>LPH Speaks Spanish</b>

The Windows taskbar at the bottom shows the Start button, several open applications (Inbox, Hotmail, Hyperspace, 18 re..., RE: ..., PPC ...), and the system clock at 1:12 PM.

# PCMH 1F: Example of Policy Statement

**It is advised that qualified medical interpreters be utilized who are not family members or friends of the patient. The Office for Civil Rights Policy Guidance states that any hospital or clinic that receives federal funds “may expose itself to liability under the Title VI if it requires, suggests, or encourages a limited-English-proficiency (LEP) person to use friends, minor children or family members as interpreters”. This is because family members, friends or children may:**

- provide inadequate service, or their services may result in breach of confidentiality,**
- have no training in medical terminology,**
- not interpret or translate accurately,**
- produce family stress especially when using younger family members,**
- no longer be fluent in their native language,**
- be reluctant to be involved in invasive procedures and during injections,**
- not have the skills necessary to offer cultural recommendations and explanations to XXX staff and physicians.**

# PCMH 1G: The Practice Team

**Practice provides patient care services by:**

- 1. Defining roles for clinical/nonclinical team members**
- 2. Holding regular team meetings - CRITICAL FACTOR**
- 3. Using standing orders**
- 4. Training and assigning care team to coordinate care**
- 5. Training on self-management, self-efficacy and behavior change**
- 6. Training on patient population management**
- 7. Training on communication skills**
- 8. Care team involvement in performance evaluation and QI**

# PCMH 1G: Scoring and Documentation

- **4 Points**

- **Scoring:**

- 7-8 factors (including factor 2) = 100%
- 5-6 factors (including factor 2) = 75%
- 4 factors (including factor 2) = 50%
- 2-3 factor = 25%
- 0-1 factors = 0%

- **Documentation**

- F1, 4-7: Staff position descriptions
- F2: Description of staff communication processes and sample
- F3: Written standing orders
- F4-7: Description of training process, schedule, materials
- F8: Description of how staff is involved in practice improvements



# PCMH 1G1: Example of Care Team Members Responsibilities

## 1. Preparation for patient appointments

Front desk staff will remind patients of their scheduled appointments per scheduling policy 1B. In addition, front desk staff will respond to the follow-up plan reminders sent electronically from the providers regarding recommendations for when to call patients for follow-up appointments and will contact patients at the appropriate time. After meeting with the provider for a chart review meeting 2-3 days before a patient's scheduled appointment, the medical assistant will contact appropriate entities for medical data collection (labs, imaging studies, consultation reports, etc.) as needed to help prepare for the office visit.

## 2. Standing orders for:

### a. Medication Refills

Medical assistants will review each patient's chart to validate appropriate follow-up by the patient in regards to the medication refill request. If they have not been seen in follow-up as recommended by the provider, then the patient will be contacted to schedule the appropriate follow-up appointment. An emergency refill of a 30 day supply of their medication(s) may be refilled if needed until they have a chance to be seen. Examples of the chart reviews include:

1. All patients > 50 years old should have an annual complete physical examination prior to ANY medication refill.
2. All patients with diabetes should have office visits and appropriate blood tests at least every 6 months (or as indicated per the provider) for well-controlled diabetics (A1C <7), and every 3 months for diabetics who are not well-controlled (A1C >7) prior to ANY medication refill.
3. All women on contraceptives should have an annual PAP smear and gynecological examination.

# PCMH 1G2: Regular Team Meetings

## A SUGGESTED HUDDLE AGENDA

- Check for patients on the schedule who may require more time and assistance due to age, disability, personality or language barriers. Who can help?
- Check for back-to-back lengthy appointments, such as physicals. How can they be worked around to prevent backlog?
- Check for openings that can be filled or chronic no-shows that can be anticipated. Any special instructions for the scheduler?
- Check provider and staff schedules. Does anyone need to leave early or break for a phone call or meeting?
- Ask whether lab results, test results and notes from other physicians are ready in the patient's chart. What will be the most efficient path of patient flow?

**Team huddles are one example of regular team meetings**

Stewart EE, Johnson BC. Huddles: Improve Office Efficiency in Mere Minutes. Family Practice Management Web site at [www.aafp.org/fpm](http://www.aafp.org/fpm). Copyright© 2007 American Academy of Family Physicians.



# PCMH 1G3: Example Standing Orders

## Medication Refill Protocol

### Exceptions (Route to Doctor)

- Antibiotics
- Pregnant
- Allergies/ Adverse Reactions to Medications Being Prescribed
- Any class of medication other than below

Class of meds	Cholesterol Reducing	Hypertension	HCTZ/ Diuretic For HTN	Cardiac (Digoxin and others)	Metered Dose Inhalers	Allergy (allegra, zyrtec, nasal steroids)	Diabetes	GI (Nexium, Protonix, etc.)	Anti Depressant (Paxil, Prozac, etc)
Type of lab	Lipid fast CMP	BMP or CMP	BMP Q6mo	Digoxin level, potassium			HbA1c Q3mo, Lipid Q6 mo		
Visit Frequency	6 mo.	6 mo. If pt comes in regularly, otherwise 1 month and revisit	6 mo. If pt comes in regularly, otherwise 1 month and revisit	6 mo.	Check chart note for revisit; no less than every 6 mo.		3 months unless HbA21C<7, then Q 6 mo.		See chart note; minimum Q 6 mo.

**Note: If patient needs OV or labs, refill up to one month (one time only). If more requested, check with physician**

# PCMH 2: Identify and Manage Populations

## Intent of Standard

- Electronic systems have searchable fields for demographic and clinical data
- Patients receive documented comprehensive health assessments
- Electronic systems used to identify patients who need services

## Meaningful Use Criteria

- Practice has searchable electronic system:
  - Race/ethnicity/preferred language
  - Clinical information
- Practice uses electronic system for patient reminders

# PCMH 2: Identify and Manage Populations

## Elements

- PCMH 2A: Patient Information
- PCMH 2B: Clinical Data
- PCMH 2C: Comprehensive Health Assessment
- PCMH 2D: Use Data for Population Management - MUST PASS

# PCMH 2A: Patient Information

Practice uses a searchable electronic system and records data more than 50% of the time for the following:

1. Date of birth\*
2. Gender\*
3. Race\*
4. Ethnicity\*
5. Preferred language\*
6. Telephone numbers
7. E-mail address
8. Dates of previous clinical visits
9. Legal guardian/health care proxy
10. Primary caregiver
11. Advance directives (NA pediatric only practices)
12. Health insurance

\* Core Meaningful Use Requirement

# PCMH 2A: Scoring and Documentation

- **3 Points**

- **Scoring**

- 9-12 factors = 100%
- 7-8 factors = 75%
- 5-6 factors = 50%
- 3-4 factors = 25%
- 0-2 factors = 0%



- **Documentation**

- F1-12: Report from electronic system showing the percentage of all patients for each populated data field. The report contains each required data item to determine how many factors are consistently entered (numerator and denominator showing > 50%) for a sample of patients.
- 12 mo. (or 3 mo. of data)

# PCMH 2A: Example of Practice Management or Billing System Query on Basic Patient Information

	Name Box	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
		name	DOB	Gender	marital S.	lang. pref.	race/eth	address	phone	email	int. ID	ext. ID	ER cont.	dx	visit dates	billing codes
1																
2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
3	2	1	1	1	1	0	0	1	1	1	1	1	1	1	1	1
4	3	1	1	1	0	0	0	1	1	1	1	1	1	1	1	1
5	4	1	1	1	0	0	0	1	1	1	1	1	1	1	1	1
6	5	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1
7	6	1	1	1	1	0	0	1	1	1	1	1	1	1	1	1
8	7	1	1	1	1	0	0	1	1	1	1	1	1	1	1	1
9	8	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1
10	9	1	1	1	0	1	1	1								
11	10	1	1	1	0	0	1	1								
12																
13	# entries	10	10	10	5	3	5	10								
14	%	100.00	100.00	100.00	50.00	30.00	50.00	100.00	100.00							
15																

## Patient Information Needed:

1. DOB 100%
2. Gender 100%
3. Race
4. Ethnicity
5. Preferred language
6. Telephone numbers 100%
7. E-mail address 100%
8. Dates of previous clinical visits 100%
9. Legal guardian/health care proxy
10. Primary care giver
11. Presence of advance directives
12. Health ins. Information

- Shows 5 of 12 items at 100%
- Recent 3 month query is required

# PCMH 2A: Tracking and Registry Functions

## Patient Tracking and Registry Functions - Jan 1, 2009 to Mar 31, 2009

#	Element	Total Patients	%	Comment
1	Name	6,351	100%	
2	Date of Birth	6,351	100%	
3	Gender	6,351	100%	
4	Marital Status	5,799	91%	
5	Language preference	-	0%	
6	Voluntarily self-identified race / ethnicity	-	0%	
7	Address	6,349	100%	
8	Telephone (primary contact number)	6,351	100%	
9	E-mail address (or "none" for patients)	2,206	35%	
10	Internal ID	6,351	100%	
11	External ID	6,351	100%	
12	Emergency contact information	-	0%	
13	Current and past diagnosis	6,351	100%	
14	Dates of previous clinical visits	6,351	100%	
15	Billing codes for services	6,351	100%	
16	Legal guardian	6,351	100%	
17	Health insurance coverage	6,351	100%	
18	Patient / family preferred method of communication	6,351	100%	
<b>Total</b>		<b>6,351</b>		

**6/12 items in medical record >50%**

# PCMH 2A: Example Electronic Inquiry Report on Basic Patient Information

A	B	C	D	E
	Total number of patients seen at least once in last 3 months			24,860
	<b>Data Elements</b>	<b># of times used</b>	<b>%</b>	
1	Name	24,860	100.00%	
2	Birthdate	24,859	100.00%	
3	Gender	24,859	100.00%	
4	Marital Status	19,565	78.70%	
5	Language	22,916	92.18%	
6	Race/Ethnicity	822	3.31%	
7	Address	24,860	100.00%	
8	Telephone	24,841	99.92%	
9	Email	3,678	14.79%	
10	Internal ID	24,860	100.00%	
11	External ID	24,860	100.00%	
12	Emergency contact	9,605	38.64%	
13	Current and past diagnoses	24,860	100.00%	
14	Dates of previous clinical visits	24,860	100.00%	
15	billing codes for services	24,860	100.00%	

**5/12 needed items entered at >50%**

- 1. DOB**
- 2. Gender**
- 3. Language**
- 4. Phone**
- 5. Previous visits**

# PCMH 2B: Clinical Data

Practice uses a searchable electronic system to record the following data:

1. Up-to-date problem list of active diagnoses for >80% of patients
2. Allergies, including medications and reactions for >80% of patients
3. Blood pressure with the date of update for >50% of patients >2 (or 3) years
4. Height for >50% of patients >2 years
5. Weight for >50% of patients >2 years
6. System calculates/displays BMI (NA for pediatrics)
7. System plots/displays growth charts (length/height, weight, head circumference (less than 2 years); BMI percentile (2-20 years))
8. Tobacco use status for patients 13 and older for >50% of patients
9. List of prescription medications with date of update for >80% of patients

All factors are Core Meaningful Use Requirements

# PCMH 2B: Scoring and Documentation

- **4 Points**

- **Scoring**

- 9 factors = 100%
- 7-8 factors = 75%
- 5-6 factors = 50%
- 3-4 factors = 25%
- 0-2 factors = 0%

- **Documentation**

- F1-5,8,9: Report showing percentage of patients for each data field
- F6-7: Screen shots demonstrating BMI/BMI percentile capability of electronic system



# PCMH 2C: Comprehensive Health Assessment

**Practice conducts and documents a health assessment:**

- 1. Age and gender appropriate immunizations/screenings**
- 2. Family/social/cultural characteristics**
- 3. Communication needs**
- 4. Medical history of patient and family**
- 5. Advance care planning (N/A for pediatric practices)**
- 6. Behaviors affecting health**
- 7. Patient and family mental health/substance abuse, including maternal depression**
- 8. Developmental screening using standardized tool (N/A for adult only practices)**
- 9. Depression screening for teens/adults using standardized tool**

# PCMH 2C: Scoring and Documentation

- **4 Points**

- **Scoring**

- 8-9 factors = 100%
- 6-7 factors = 75%
- 4-5 factors = 50%
- 2-3 factors = 25%
- 0-1 factors = 0%

- **Documentation**

- F1-9: Process to show how information collected or completed patient assessment (de-identified)





# PCMH 2C6: Example Screening and Intervention

**Preventive Care**

Tobacco Use  never  quit  current

Advised to quit  yes  no

Pneumovax	<input type="text"/>	Date (blank=today)	<input type="text"/>	Record	Last: <input type="text" value="contraindicated (02/16/2007 1)"/>
Flu shot	<input type="text"/>	Date (blank=today)	<input type="text"/>	Record	Last: <input type="text" value="Not in Season"/>
Colon CA Screen	<input type="text"/>	Date (blank=today):	<input type="text"/>	Record	Last: <input type="text" value="done (06/21/2007 12:00:00 A)"/>
Mammogram	<input type="text"/>	Date (blank=today)	<input type="text"/>	Record	Last: <input type="text" value="done elsewhere (07/17/2007)"/>
Pap	<input type="text"/>	Date (blank=today)	<input type="text"/>	Record	Last: <input type="text" value="No pap in record"/>

**Diabetes** Not Applicable

**CHF** Not Applicable

**CAD** Not Applicable

**Asthma** Asthma Type:  Persistent  Intermittent

**Depression** Not Applicable

- ✓ Preventive Care
- ✓ Tobacco use
- ✓ Advised to quit
- ✓ Immunizations
- ✓ Screenings
- ✓ Condition-specific

# PCMH 2D: Use Data for Population Management

Practice uses patient data and evidence-based guidelines to generate lists and remind patients about needed services:

1. At least three different preventive care services\*\*
2. At least three different chronic care services\*\*
3. Patients not recently seen by the practice
4. Specific medications

**\*\* Menu Meaningful Use Requirement**

# PCMH 2D: Scoring and Documentation

- **MUST PASS**

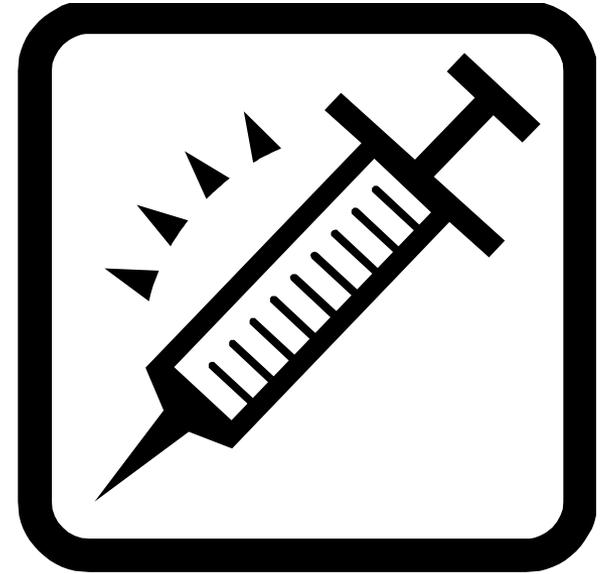
- **5 Points**

- **Scoring**

- 4 factors = 100%
- 3 factors = 75%
- 2 factors = 50%
- 1 factors = 25%
- 0 factors = 0%

- **Documentation**

- F1-4: Lists or summary reports of patients who need services within past 12 mo. (Health plan data okay if 75% of patient population)
  - Must include at least three different immunizations/ screenings and three different acute/chronic care services
- F1-4: Materials demonstrating patient notification (letter, phone call script, screen shot of e-notice)



# PCMH 2D4: Example Identifying Patients on Specific Medication



**Search & Reporting**

Practice

**Search By:** Medication

4466

Toprol XL

Search

**Search Single Criteria**

**Search Multiple Criteria**

Age  
 Phone  
 Address  
 Insurance  
 Medication  
 Diagnosis  
 Free Text  
 Schedule  
 Laboratory  
 Chart ID

**Searched by: Medication**

ID	Age	Last Name, First Name	Phone	Email	Medication
					Toprol XL
					Toprol XL 25mg
					TOPROL XL EXTENDED RELEASE TABLETS 200 MG
					TOPROL XL TABLETS 100 MG
					TOPROL XL TABLETS 100 MG
					TOPROL XL TABLETS 100 MG
					TOPROL XL TABLETS 100 MG
					TOPROL XL TABLETS 100 MG
					TOPROL XL TABLETS 100 MG
					TOPROL XL TABLETS 100 MG
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					TOPROL XL TABLETS 100 MG
					TOPROL XL TABLETS 100 MG
					TOPROL XL TABLETS 100 MG
					TOPROL XL TABLETS 200 MG
					TOPROL XL TABLETS 200 MG
					TOPROL XL TABLETS 200 MG
					TOPROL XL TABLETS 200 MG
					TOPROL XL TABLETS 25 MG
					TOPROL XL TABLETS 25 MG

Total Patients: 37

Sort list by

Print List | Email All (bcc) | Export to Excel

Report showing all patients on a particular medication (Toprol XL)

# PCMH 2D4: Example of Practice Action Based on Practice-Wide Search

Dear Patient,

Unfortunately as we are approaching allergy season, a question has been raised as to whether your medication - \_\_\_\_\_ may increase your risk of suicide. This concern has been released early in its analysis due to the severity of its side effect.

If you (or your child) are feeling more depressed, and certainly at all suicidal, we would like you to stop the medication immediately and call for a prompt appointment. If you are feeling fine, we are comfortable with you continuing this medication while a more complete analysis is made.

If you are uncomfortable taking the medication or would like to discuss this in more detail, please call to make an appointment to review alternative approaches.

We do not mean to scare you with this letter but want to be sure you are aware of this concern.

Sincerely,

# PCMH 3: Plan and Manage Care

## Intent of Standard

- Practice implements evidence-based guidelines
- High-risk patients identified
- Care team performs care management through pre-visit planning, developing plan and treatment goals

## Meaningful Use Criteria

- Practice implements evidence-based guidelines
- Practice reviews and reconciles medications with patients
- Practice uses e-prescribing system

# PCMH 3: Plan and Manage Care

## Elements

- PCMH3A: Implement Evidence-Based Guidelines
- PCMH3B: Identify High-Risk Patients
- PCMH3C: Care Management - MUST PASS
- PCMH3D: Medication Management
- PCMH3E: Use Electronic Prescribing



# PCMH 3A: Implement Evidence-Based Guidelines

Practice implements guidelines **through point of care reminders** for patients with:

1. The first important condition\*
2. The second important condition
3. The third condition, related to **unhealthy behaviors or mental health or substance use/abuse** – **CRITICAL FACTOR**

\* Core Meaningful Use Requirement

# PCMH 3A: Scoring and Documentation

- **4 Points**

- **Scoring**

- 3 factors = 100%
- 2 factors (including factor 3)= 50%
- 1 factor = 25%
- 0 factors = 0%

- **Documentation**

- F1-3: Identification of 3 conditions
- F1-3: Name and source of guidelines
- F1-3: Demonstrate how guidelines are used (e.g. charting tools, screen shots, workflow organizers, condition-specific templates for treatment plans/patient progress)

# PCMH 3A: Evidence-Based Guidelines Source



## **Clinically important condition #1/ Diabetes:**

**Screening:** Based upon recommendations from the American Diabetes Association, all patients greater than 45 years of age are screened for diabetes. Patients are screened by obtaining either random blood glucose or, preferably, a fasting blood glucose. However patients at risk for developing diabetes are screened when they are < 45 years of age.

These risk factors for diabetes include:

- BMI  $\geq$  25
- Family history of DM
- Habitual physical inactivity
- Race- African Americans, Hispanic Americans, Asian Americans, and Pacific Islanders
- Previously identified impaired fasting BG
- BP  $\geq$ 140/90
- HDL  $<$ 35
- Polycystic ovarian disease
- History of vascular disease

**Diagnosis:** Based upon American Diabetes Association (ADA) recommendations, patients are diagnosed with Diabetes Mellitus if they have, on two separate occasions, a fasting blood glucose  $\geq$ 126 mg/dL or a 2 hour postprandial blood glucose  $\geq$  200mg/dL.

## **Treatment goals:**

Based upon ADA American Association of Clinical Endocrinologist (AAACE) recommendations:

1. pre meal BG  $<$ 120
2. fasting BG  $\geq$ 80,  $<$ 100
3. HgBA1c  $<$ 6.5%
4. BP  $<$ 130/80
5. LDL  $<$ 100
6. Annual eye exam
7. Routine foot exams and neuropathy screenings
8. Routine microalbuminuria screenings

# PCMH 3A: Example EHR Prompting Lipid Management Evidence-Based Guidelines

**Lipid Management**  Add diagnosis of HYPERLIPIDEMIA to Problem List?

**NCEP Adult Treatment Panel III Risk Factors**

Age 45 or greater  yes  no

Early menopause w/o HRT  II/A  II/A

**Diabetes**

HDL < 40 mg/dl No Value Available

HDL > 60 mg/dl (neg. risk) No Value Available

FH of cardiovascular disease:

MI in female age < 65  yes  no

MI in male age < 55  yes  no

Smoking status  current  quit  never

Hypertension  yes  no

ASHD (CAD) or CABG  yes  no

Stroke or TIA  yes  no

**Peripheral vascular disease**  yes  no

**Abdominal Aortic Aneurysm**  yes  no

**Goals Automatically Calculated based on # Risk Factors**

Check here to manually change Lipid Goals

Goals based on CAD, PVD, CVA, TIA, or Aortic aneurysm AND diabetes, smoker, or LDL > 130, HDL < 40, and trig > 200

	Chol:	LDL:	HDL:	Trig:
<b>Goals</b>	200	70	40	150
Last value:	none	none	none	none
Last date:				
Next due:	How	How	How	How

All lipid goals have NOT been met.

Consider checking an LDL now and annually. Consider checking an HDL now and annually. Consider checking triglycerides now and annually.

LDL cholesterol goal met?  Yes  No

Enter Today's BP:  /  mm Hg



# PCMH 3A: Example Diabetes Flowsheet

Diabetes Flowsheet

	Frequency	Date	Date	Date	Date
<b>History &amp; Physical</b>					
Blood Pressure	Every Visit				
Check Weight (BMI)	Every Visit		40.1	40.6	
Retinal Screening	Annually				
Inspect feet	Every Visit				
Comprehensive Lower Extremity Exam	Annually				
Dental/Oral health assessment	6 Months				
Kidney Assessment	Annually			Y	
<b>Labs &amp; Tests</b>					
A1c	3 Months	7.7		7.3	
Triglycerides	Annually	218		206	
LDL	Annually	86		97	
HDL	Annually	25		35	
Total Cholesterol	Annually	147		173	
Estimated GFR	Annually	<= 60			
<b>Medications &amp; Immunizations</b>					
Aspirin Use	Every Visit			Y	
Assess Need For ACE/ARB	Every Visit		Y	Y	
Assess Need For Statin	Every Visit		Y	Y	
Influenza Vaccination	Annually		Y		
Pneumococcal Vaccination	5 Years				
<b>Lifestyle &amp; Counseling</b>					
Set Self-Management Goals	Every Visit		Y	Y	
Diabetes Patient Education / Nutrition / Exercise	Every Visit		Y	Y	
Tobacco Use/Exposed to 2nd hand smoke	4 Months		N	Y	
Smoking/Second Hand Smoke Counseling	Every Visit		Y	Y	
Depression / Mental Health Screening	Every Visit		Y	Y	
Review blood glucose log	Every Visit		Y	Y	



# PCMH 3A: Example Evidence-Based Diabetic Workflow Organizer (shows documentation at visits)

## CLINICAL PRACTICE RECOMMENDATIONS FOR DIABETES MELLITUS

This guideline indicates minimum standards of continuing care for stabilizing patients with diabetes; it is not intended to preclude more extensive evaluation and management. A comprehensive medical history should be taken at the initial visit to confirm the diagnosis, review previous treatment, evaluate glycemic control and complications status, and provide a basis for continuing care. Any abnormal findings on physical examination should be re-evaluated at subsequent visits.

Indicate that a task was performed by initialing box. Shaded boxes are optional tasks.

VISIT	Initial	3	6	9	Annual	3	6	0 mo	Annual
DATE									
<b>PHYSICAL:</b>									
Complete history and physical, including height	✓				✓				
Weight	171	171	180	171	179	172	171		
Blood pressure	130/90	128/78	118/76	120/75	117/78	124/80	118/70		
Ophthalmoscopic exam	✓				✓				
Foot exam	✓	✓			✓	✓	✓		
Interim history and physical	✓	✓	✓	✓	✓	✓	✓		
<b>LABORATORY:</b>									
HbA <sub>1c</sub>	5.7	6.0	6.2	6.0	6.7	6.1	6.2		
Fasting plasma glucose	129	142	145	118	150	126	128		
Lipid profile	✓	✓	✓	✓	✓	✓	✓		
Urinalysis ✓1	✓	✓	✓	✓	✓	✓	✓		
Urinary microalbumin	✓				✓				
Serum creatinine	✓	✓	✓	✓	✓	✓	✓		
ESG	✓				✓				

# PCMH 3A: Asthma Guidelines and Use

## Asthma Visit

Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Date of Visit: \_\_\_\_\_  
 Phone #: \_\_\_\_\_

### HISTORY

CC: \_\_\_\_\_  
 HPI: \_\_\_\_\_

HT: \_\_\_\_\_ cm/in WT: \_\_\_\_\_ lb/kg  
 %tile: \_\_\_\_\_ %tile: \_\_\_\_\_

T P R BP

Peak flow: \_\_\_\_\_ Pox: \_\_\_\_\_ %

### GENERAL

HEENT \_\_\_\_\_

NECK \_\_\_\_\_

HEART \_\_\_\_\_

ABDOMEN \_\_\_\_\_

EXT \_\_\_\_\_

NEURO \_\_\_\_\_

SKIN \_\_\_\_\_

GU \_\_\_\_\_

PULM: ASTHMA SCORE: \_\_\_\_\_  
 Pts: Wheeze Air Entry Acc Muscles RR2-6yr >6yr  
 0 and exp ql none 20-30 15-20  
 1 exp ml dx ml dx 31-45 21-35  
 2 ins/exp mod dx mod dx 46-60 36-50  
 3 audible sev dx sev dx >60 >50

OTHER \_\_\_\_\_

Allergies: \_\_\_\_\_  
 Immunizations UTD: yes no

PMH: Illnesses: \_\_\_\_\_  
 Hospitalizations / ER Visits: \_\_\_\_\_  
 PICU / Intubations: \_\_\_\_\_  
 Followed by Allergist: Yes No

Med	Dose	Time Given/Initials	RR	Wheeze	Air Entry	RTX	Score	Re-exam
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

Assessment: Asthma Intermittent Mild Persistent Moderate Persistent Severe Persistent  
 Controlled: Y or N

Plan: \_\_\_\_\_

Referral: Allergy Asthma Disease Educator

Resident/Student Signature: \_\_\_\_\_ RETURN TO CLINIC in \_\_\_\_\_  
 Printed Name: \_\_\_\_\_ For \_\_\_\_\_ (indicate reason)

History reviewed (\_\_\_\_), Patient/caretakers interviewed & examined with provider above (\_\_\_\_), and I agree with actions:  
 Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

- Asthma Visit Sheet Shows:**
- ✓ Physical exam specific to respiratory system
  - ✓ Allergies
  - ✓ Immunizations
  - ✓ Asthma triggers
  - ✓ Peak flow
  - ✓ Medication tracking
  - ✓ Treatment plan
  - ✓ Referral

**“NAEPP Asthma Guidelines are imbedded in Asthma Visit Sheet”**



# PCMH 3A: Asthma Flow Sheet

## Patient Information:

Provider: \_\_\_\_\_

Date: \_\_\_\_\_

Symptom Assessment:    Yes        No

Asthma Classification: Intermittent Persistent  
If Persistent, on Controller Medication: Yes        No

Asthma Control: Very Well Controlled    Not well controlled    Very Poorly Controlled

Exacerbations Since Last Visit: ER/Urgent Hospital        None

Days Missed School/Work Since Last Visit: \_\_\_\_\_

Review Asthma Triggers: Yes        No

Review Medication:    Yes        No

Date of Flu Vaccine: \_\_\_\_\_

Review Action Plan:    Yes        No

Patient Education:    Yes        No

Tobacco Use/2<sup>nd</sup> Hand Smoke Exposure:    Yes    No  
If yes, Counseled 2<sup>nd</sup> Hand Smoke or Cessation: Yes    No

- Includes:**

  - ✓ Asthma classification
  - ✓ Level of asthma control
  - ✓ Exacerbations
  - ✓ Days missed from school
  - ✓ Asthma triggers
  - ✓ Medication
  - ✓ Review action plan
  - ✓ Patient education
  - ✓ Tobacco use/2<sup>nd</sup> hand smoke exposure



# PCMH 3A: Example of Implemented Guidelines for Pediatric Obesity

Preventive Notes

Free-form      **Structured**

Guidelines for 5210 Clear All

Name	Value	Notes
<input type="checkbox"/> (3) Meals consumed per day		X
<input type="checkbox"/> STATUS:		X
<input type="checkbox"/> ABILITY TO SELF MANAGE:		X
<input type="checkbox"/> (5) Fruits and Vegetable cons		X
<input type="checkbox"/> (2) Hours spent for screen tir		X
<input type="checkbox"/> (1) Hours spent doing physio		X
<input type="checkbox"/> (0) Sugary drinks consumed		X
<input type="checkbox"/> Discussed Nutrition Diary with		X
<input type="checkbox"/> READINESS TO CHANGE:		X
<input type="checkbox"/> GOAL PROGRESS:		X

**Guidelines Treatment Template when Obesity is selected, It is designated 5210. Each selection brings up tools.**

Custom      Close

# PCMH 3A: Example of Point of Care Reminders for Unhealthy Behavior

**Order Sets**

**Labs**   **Diagnostic Imaging**

<input type="checkbox"/>	Description	Date	Status	<input type="checkbox"/>	Description	Date	Status
<input type="checkbox"/>	TSH - Sunrise	-	Other Actions	<input type="checkbox"/>			
<input type="checkbox"/>	CBC/DIFF/PLT - Sunrise	06/16/2010	Other Actions	<input type="checkbox"/>			
<input type="checkbox"/>	VITAMIN D (1,25-DIHYDROXY) - Sunrise	-	Other Actions	<input type="checkbox"/>			
<input type="checkbox"/>	INSULIN - Sunrise	-	Other Actions	<input type="checkbox"/>			
<input type="checkbox"/>	FREE T4 - Sunrise	-	Other Actions	<input type="checkbox"/>			
<input type="checkbox"/>	LIPID PANEL (AMA) - Sunrise	-	Other Actions	<input type="checkbox"/>			
<input type="checkbox"/>	BASIC METABOLIC PANEL (AMA) - Sunrise	-	Other Actions	<input type="checkbox"/>			
<input type="checkbox"/>	LIVER PROFILE - Sunrise	-	Other Actions	<input type="checkbox"/>			
<input type="checkbox"/>	HEMOGLOBIN A1C - Sunrise	-	Other Actions	<input type="checkbox"/>			

**Procedures**

<input type="checkbox"/>	Description	Date	Status
<input type="checkbox"/>			

**Immunizations**  **Smart Forms**

<input type="checkbox"/>	Name	Dose	Date	Status	<input type="checkbox"/>	Name
<input type="checkbox"/>					<input type="checkbox"/>	

**Appointments**  **Referrals**

Follow-Up In: 1-3 months  Outgoing Referral for: Nutrition

**Physician Education** **Patient Education**

PDF  PDF

WEB REFERENCE  WEB REFERENCE

## Pediatric Obesity Order Set in EMR

# PCMH 3B: Identify High-Risk Patients

**The practice does the following to identify high-risk patients:**

- 1. Establishes criteria and a process to identify high-risk or complex patients**
- 2. Determines the percentage of high-risk patients in the population**

# Identifying High-Risk Patients

- Practice has specific criteria and a process to identify complex or high-risk patients for whole-person care planning and management
- Based on:
  - High resource use (e.g., visits, medication, treatment or other measures of cost)
  - Frequent visits for urgent or emergent care (e.g., two or more visits in the last six months)
  - Frequent hospitalizations (i.e., two or more in last year)
  - Multiple co-morbidities, including mental health

# Identifying High-Risk Patients

- Noncompliance with prescribed treatment/medications
- Terminal illness
- Impediments to care, e.g. psychosocial status, lack of social or financial support
- Advanced age, with frailty
- Multiple risk factors

# PCMH 3B: Scoring and Documentation

- **3 Points**
- **Scoring**
  - 2 factors = 100%
  - 1 factor = 25%
  - 0 factors = 0%
- **Documentation**
  - F1: Criteria and process to identify patients
  - F2: Report showing number and percentage of high-risk patients

$$\frac{\text{Number of high risk patients}}{\text{Number of patients}} = \% \text{ of high risk patients}$$

# Documentation from Patient Records

- **Elements PCMH 3C, 3D, 4A**
  - Require **medical record abstraction** of data
  - Need % of patients for each factor based on numerator and denominator
- **Two methods to collect and submit patient data**
  - **Method #1** - report from the electronic system
  - **Method #2 – Record Review Workbook (RRWB)**
    - Excel workbook in the Survey Tool
    - Tool to identify sample of patients and abstract data needed for Elements 3C, 3D, 4A



# NCQA's Patient-Centered Medical Home (PCMH) 2011 Record Review Workbook (RRWB) General Instructions

## Purpose of the Record Review Workbook

There are three elements in PCMH 2011 that require an accurate estimate of the percentage of the patients for whom you have documented the required information in the medical records of the sample of patients. The elements are:

**PCMH 3C—Care Management:** Number of factors the practice consistently enters information in the patients' medical records.  
**NOTE:** 3C is a **MUST PASS** element so the practice must consistently enter information in the medical records of 50% of the patients to reach 50% of the points needed for Recognition.

### Three tabs

- ✓ **Instructions**
- ✓ **Patient Conditions**
- ✓ **Record Review**

patients.  
of

**PCMH 3D—Medication Management:** Number of factors for which the practice consistently enters information in the patients' medical record.  
**NOTE: Factor 1 is a Critical Factor** and thus required for the practice to score any points.

**PCMH 4A—Support Self-Care Process:** Number of factors for which the practice consistently enters information in the patients' medical record.  
**NOTE:** 4A is a **MUST PASS** element so the practice must consistently enter information for 3 factors in the medical record to reach 50% of the points needed for Recognition. **In addition, Factor 3 is a Critical Factor** and thus required for the practice to score any points.

There are two method for collecting data for these elements.

**Method 1. Query your electronic medical records** or other electronic patient records to obtain the information for the important conditions identified in PCMH 3: Elements A and the high-risk or complex patients identified in PCMH 3: Element B to calculate the percentage directly.

**Method 2. Review a sample of 48 patient records** to obtain the information. *(Note: Patient records may a registry or electronic records or paper medical records.)*



# PCMH 3C: Care Management

Care team performs the following for at least 75% of patients from Elements A and B:

1. Conducts pre-visit preparations
2. Collaborates with patient to develop care plan, including treatment goals
3. Gives patient written care plan
4. Assesses and addresses barriers to treatment goals
5. Gives patient clinical summary at relevant visits
6. Identifies patients who need more care management support
7. Follows up with patients who have not kept important appointments

# PCMH 3C: Scoring and Documentation

- **MUST PASS**

- **4 Points**

- **Scoring** - 75% of patients for each factor

- 6-7 factors = 100%
- 5 factors = 75%
- 3-4 factors = 50%
- 1-2 factors = 25%
- 0 factors = 0%

- **Documentation**

- F1-7: Report from electronic system or submission of Record Review Workbook





# PCMH 3C: Care Management

Patient Number	Clinically Important Condition	3C - Care Management				
		1	2	3	4	5
		Conducts pre-visit preparations	Collaborates with patient/family to develop individual care plan, including treatment goals reviewed and updated at each relevant visit	Gives the patient/family a written plan of care	Assesses and addresses barriers when the patient has not met treatment goals	Gives the patient/family a clinical summary at each relevant visit
1	diabetes	Yes	Not Used	Yes	NA	Yes
2	hypertension	Yes			Yes	
3	depression	No			No	
4	High Risk / Complex	Yes			NA	
5	diabetes	No			Not Used	
6	diabetes	No				
7	hypertension	Yes				
8	diabetes	No				
9	High Risk / Complex	Yes				
10	depression	No				
11	depression					
12	depression					
13	depression					
14	depression					
15	depression	Yes				
16	diabetes	Yes				
17	depression	Yes				
18	depression	Yes				
19	diabetes	Yes				
20	depression	Yes				

Entering **NOT USED** in row 1 "grays" out the column

- Response Options**
- ✓ Yes
  - ✓ No
  - ✓ Not Used
  - ✓ Not applicable

# PCMH 3D: Medication Management

Practice manages medications in the following ways:

1. Reviews and reconciles medications for more than 50% of care transitions\*\* - CRITICAL FACTOR
2. Reviews and reconciles medications for more than 80% of care transitions
3. Provides information about new prescriptions to more than 80% of patients
4. Assess patient understanding of medications for more than 50% of patients
5. Assesses patient response to medication and barriers to adherence for more than 50% of patients
6. Documents OTCs, herbal/supplements, for more than 50% of patients, with date of update

\*\* Menu Meaningful Use Requirement

# PCMH 3D: Scoring and Documentation

- **3 Points**

- **Scoring**

- 5-6 factors (including factor 1) = 100%
- 3-4 factors (including factor 1) = 75%
- 2 factors (including factor 1) = 50%
- Factor 1 = 25%
- 0 factors or does not meet Factor 1 = 0%

- **Documentation**

- F1-6: Report from electronic system or submission of Record Review Workbook

# PCMH 3D: Example Medication Management

3D - Medication Management					
1	2	3	4	5	6
Reviews and reconciles medications with patients/families	Reviews and reconciles medications with patients/families	Provides information about new prescriptions	Assesses patient/family understanding of medications	Assesses patient response to medications and barriers to adherence	Documents over-the-counter medications, herbal therapies and supplements, with the date of updates
NA					
Yes					

**Response Options**

- ✓ Yes
- ✓ No
- ✓ Not Applicable
- ✓ Not Used

**“Not Applicable” response.....if the patient is not on any medications**

# PCMH 3E: Use Electronic Prescribing

Practice uses e-prescribing system with the following capabilities:

1. Generates and transmits at least 40% of prescriptions to pharmacies \*
2. Generates at least 75% of eligible prescriptions – CRITICAL FACTOR
3. Enters electronic medication orders into medical record for more than 30% of patients with at least one medication in their medication list\*
4. Performs patient-specific checks for drug-drug and drug-allergy interactions\*
5. Alerts prescribers to generic alternatives
6. Alerts prescribers to formulary status\*\*

\* Core Meaningful Use Requirement

\*\* Menu Meaningful Use Requirement

# PCMH 3E: Scoring and Documentation

- **3 Points:**

- 5-6 factors (including factor 2) = 100%
- 4 factors= (including factor 2) = 75%
- 2-3 factors= (including factor 2) = 50%
- 1 factor = 25%
- 0 factors = 0%



- **Documentation**

- F1-3: Reports showing percent of electronic prescriptions generated, transmitted and entered into medical record
- F2 alternative: Prescribing process, report, explanation
- F4-6: Reports or screen shots demonstrating the system's capabilities



# PCMH 3E2: Example Electronic Prescription Writing

Electronic prescription writer linked to patient-specific demographic and clinical information:

	Total Rx
Electronic	2,563 57%
Print then give to patient	1,419 31%
Historical	146 3%
Telephone	145 3%
Print then fax to pharmacy	89 1%
Handwritten	43 0%
Print then mail to patient	35 0%
Reprint	32 0%
Samples given to patient	2 0%
Total	4,474 100%

All prescription entry is generated through demographic information.

Cooper Medical Centricity EMR  
EMR without link

Centricity allow embedded with IIS.

For eRx generated before the patient's Medical Association.

GE Centricity clearinghouse.

## Prescription Writing Activity

Electronic	57%	2563 Rx
Printed, given to patient	31%	1419 Rx
Print, fax to pharmacy	1%	89 Rx

### TOTAL

Rx	4474 Rx
% E-RX	89%

**Limitations of electronic prescribing** are primarily due to restrictions for submitting Schedule 2, 3 or 4 drugs electronically and an inability to submit eRx to pharmacy benefit-managers (ex: CareMark, ExpressScripts).

As such, some Prescriptions may be marked as "Handwritten" for Schedule 2, 3, or 4 drugs depending upon the provider and the patient. Schedule 2, 3 and 4 Narcotic medications must be submitted via paper or phone. Providers will receive warning messages when trying to prescribe Narcotic Medications electronically.

All full-time Faculty and Resident physicians are registered with SureScripts for eRx.

Patients with Rx Counts: 673



# PCMH 3E4: Example Drug-Drug Interactions

Drug-Drug Interactions

Drug-Drug Interactions

Drug1	Drug2	Severity	Interaction
aspirin	warfarin	Major	GENERALLY AVOID: Aspirin
fenofibrate	warfarin	Major	GENERALLY AVOID: Fibric i
fenofibrate	simvastatin	Major	GENERALLY AVOID: Severi
insulin glargine	aspirin	Moderate	MONITOR: The hypoglycem
insulin glargine	fenofibrate	Moderate	MONITOR: The hypoglycem

Allergies

Drug	Reaction

Drug-Disease Interactions

Drug Name	Condition	Severity
warfarin	Diabetes Mellitus	Severe Potential Hazard
lisinopril	Renal Dysfunction	Severe Potential Hazard
warfarin	Coagulation Defect	Severe Potential Hazard
aspirin	Renal Dysfunction	Severe Potential Hazard

**aspirin - warfarin Interaction**

GENERALLY AVOID: Aspirin, even in small doses, may increase the risk of bleeding in patients on oral anticoagulants by inhibiting platelet aggregation, prolonging bleeding time, and inducing gastrointestinal lesions. Analgesic/antipyretic doses of aspirin increase the risk of major bleeding more than low-dose aspirin; however bleeding has also occurred with low-dose aspirin.

MANAGEMENT: This combination, especially with analgesic/antipyretic aspirin doses, should generally be avoided unless the potential benefit outweighs the risk of bleeding. If concomitant therapy is used for additive anticoagulant effects, monitoring for excessive anticoagulation and overt and occult bleeding is recommended. The INR should be checked frequently and the dosage

NOTES ADV DIRECTIV

Notes

6/2009 RSH DIABETIC

OS Labs DI

ective

lipidemia

es mellitus type 2 or

ified type with renal

estations, unc

lation disorder NOS

tension, Benign

le bowel syndrome

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erm use of insulin

nt)

tis and nephropathy, not

ed as acute/chronic, in

disease

cations Stop Date



# PCMH 3E5: Example Prescribing Decision Support – Generic Alternatives

Medication Name  
lotensin

Class + Subclass   
 OTC 

Search results for 'lotensin' Formulary (Healthplan)

**CL** Class > **SC** Sub-Class > **G** Generic > **BR** Brand

**UL** ANTIHYPERTENSIVES

- SC** ACE Inhibitors
  - G** Benazepril HCl ✓✓ Preferred
  - BR** Lotensin **NF** Non Formulary
- SC** Antihypertensive Combinations
  - G** Benazepril-Hydrochlorothiazide
  - BR** Lotensin HCT

**Generic Alternatives**  
✓✓ Benazepril HCl, Captopril, Enalapril Maleate, Fosinopril Sodium, Lisinopril, Quinapril HCl



# PCMH 3E6: Example Prescribing Decision Support-Formulary Drug

Patient: [Redacted] Allergy: DAYPRO, VICODIN  
 Age: 5 DOB: [Redacted] Primary Physician: [Redacted] ID#: [Redacted]  
 Primary: [Redacted] Alt ID#: [Redacted] Elig. Status: eRx Updated: 05/01/2008 Consent: Yes  
 Apts: [Redacted] mmary Problems Med List Encounter Active Enc Rx Logout  
 Today: [Redacted] Warnings [Redacted] 56 yr M  
 Phone [Redacted] Clinician [Redacted]

**Warnings**  
 Warnings for olopatadine hcl ophthalmic drops 0.1% (Pataday, Patanol)

Off Formulary

View alternatives within the same therapeutic class

To prescribe this drug anyway, select a reason for overriding the warning (or select 'other' and type one in), then click the 'Override' button; otherwise, just click the 'Cancel' button.

- No formulary alternative exists.
- Formulary agents not optimal.
- Pt sensitive to formulary agents
- Pt stabilized on chronic therapy.
- Other

AHFS Drug Monograph Cancel Override Defer

# PCMH 3E: Example Percent of Use for Electronic Prescriptions

## Evaluation:

Our Physicians and nurses put all prescriptions in our EMR which is linked to patient - specific demographic and clinical data

Note the screen shot that denotes the number of scripts for our physicians in the last three months, **2046** and the report which notes the number of patients seen during that same time period, **2482**

We propose that this represents a percentage between 75% and 100%, understanding that one prescription does not mean one patient

**2046 prescriptions = numerator**  
**Another report showed summary of 2482 patients = denominator**  
**Determined percentage**

# PCMH 4: Provide Self-Care Support and Community Resources

## Intent of Standard

- Assess self-management abilities
- Document self-care plan; provide tools and resources
- Counsel on healthy behaviors
- Assess/provide/arrange for mental health/substance abuse treatment
- Provide community resources

## Meaningful Use Criteria

- Patient-specific education materials

# PCMH 4: Provide Self-Care Support and Community Resources

## Elements

- PCMH4A: Support Self-Care Process – MUST PASS
- PCMH4B: Provide Referrals to Community Resources



# PCMH 4A: Support Self-Care Process

Practice conducts activities to support patients in self-management:

1. Provides education resources or refers at least 50% of patients to educational resources
2. Uses EHR to identify education resources and provide them to 10% of patients\*\*
3. Collaborates with at least 50% of patients to develop and document self-management plans and goals - CRITICAL FACTOR
4. Documents self-management abilities for at least 50% of patients
5. Provides self-management result recording tools to at least 50% of patients
6. Counsels at least 50% of patients on adopting healthy lifestyles

**\*\* Menu Meaningful Use Requirement**

# PCMH 4A: Scoring and Documentation

- **MUST PASS**
- **6 Points**
- **Scoring**
  - 5-6 factors (including factor 3) = 100%
  - 4 factors (including factor 3) = 75%
  - 3 factors (including factor 3) = 50%
  - 1-2 factors = 25%
  - 0 factors = 0%
- **Documentation**
  - F1-6: Report from electronic system or submission of Record Review Workbook



# PCMH 4B: Provide Referrals to Community Resources

**Practice supports patients who need access to community resources:**

- 1. Maintains current resource list covering five (5) community service areas (e.g. smoking cessation, weight loss, parenting, dental, transportation, fall prevention, meal support)**
- 2. Tracks referrals provided to patients**
- 3. Arranges for or provides treatment for mental health/substance abuse disorders**
- 4. Offers opportunities for health education and peer support**

# PCMH 4B: Scoring and Documentation

- **3 Points**

- **Scoring**

- 4 factors = 100%
- 3 factors = 75%
- 2 factors = 50%
- 1 factor = 25%
- 0 factors = 0%

- **Documentation**

- F1: List of community services or agencies
- F2: Referral log or report covering at least one month
- F3-4: Processes to provide/arrange for mental health/substance abuse treatment and health education support

# PCMH 5: Track and Coordinate Care

## Intent of Standard

- Track and follow-up on lab and imaging results
- Track and follow-up on referrals
- Coordinates care received at hospitals and other facilities

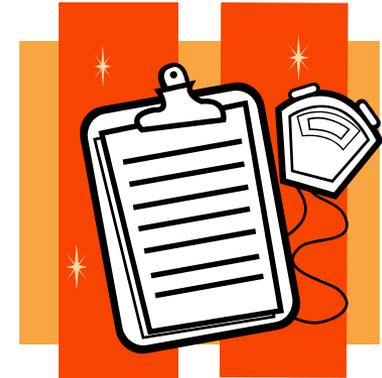
## Meaningful Use Criteria

- Incorporate clinical lab test results into the medical record
- Electronically exchange clinical information with other clinicians and facilities
- Provide electronic summary of care record for referrals and care transitions

# PCMH 5: Track and Coordinate Care

## Elements

- PCMH5A: Test Tracking and Follow-Up
- PCMH5B: Referral Tracking and Follow-Up – MUST PASS
- PCMH5C: Coordinate with Facilities and Care Transitions



# PCMH 5A: Test Tracking and Follow-Up

Practice has documented process for and demonstrates:

1. Tracks lab tests and flags and follows-up on overdue results – CRITICAL FACTOR
2. Tracks imaging tests and flags and follows-up on overdue results – CRITICAL FACTOR
3. Flags abnormal lab results
4. Flags abnormal imaging results
5. Notifies patients of normal and abnormal lab/imaging results
6. Follows up on newborn screening (NA for adults)
7. Electronically order and retrieve lab tests and results
8. Electronically order and retrieve imaging tests and results
9. Electronically incorporates at least 40% of lab results in records\*\*
10. Electronically incorporate imaging test results into records

**\*\*Menu Meaningful Use Requirement**

# PCMH 5A, F1-6: Test Tracking/Follow-Up

Practice has documented process for and demonstrates:

1. Tracks lab tests....flags/follows-up on overdue results – CRITICAL FACTOR
2. Tracks imaging tests...flags/follows-up on overdue results – CRITICAL FACTOR
3. Flags abnormal lab results
4. Flags abnormal imaging results
5. Notifies patients of normal and abnormal lab/imaging results
6. Follows up on newborn screening (NA for adults)

## Documentation

- F1-6: Process /procedure for staff
- F1-6: Example of how factors are met

# PCMH 5A, F7-10: Test Tracking/Follow-up

Practice has documented process for and demonstrates:

7. Electronically order and retrieve lab tests and results
8. Electronically order and retrieve imaging tests and results
9. Electronically incorporates at least 40% of lab results in records in structured fields\*\*
10. Electronically incorporate imaging test results into records

**\*\*Menu Meaningful Use Requirement**

Documentation

- F7, 8,10: Process and electronic system examples
- F9: Report with numerator, denominator and percent

# PCMH 5A: Scoring and Documentation

- **6 Points**
- **Scoring**
  - 8-10 factors (including factors 1 and 2) = 100%
  - 6-7 factors (including factors 1 and 2) = 75%
  - 4-5 factors (including factors 1 and 2) = 50%
  - Fewer than 3 factors = 0%

# PCMH 5A: Example Test Tracking Log

Test Tracking Log

Patient Name	DOB	MR Number	Provider	Order Date	Test Ordered	In House/ Sent Out	Urgency	Date Results Received	Results 1=normal 2=abnormal	Date Results to Provider	Date Results to Patients
					throat						
					CBC/DIF						
					B12/Folate						
					HGB A1C	due 10/30					
					lipid panel						
					iron/TIBC						
					mammography	left follow up message					
					met. panel	due 11/17					
					CK-total	due 10/15					
					Hepatic Function						
					Met. Panel B						
					urine microalbumi						
					PT/INR						
					thyroid profile						
					Thyroid profile	due 10/15					
					CXR pa/lat						
					throat						
					lipid panel						
					X-ray, KUB	completed 7/1/09					
					B12/Folate						
					CBC/DIFF						
					urine C/S						
					<del>met. panel</del>						
					thyroid profile						
					cardio CRP	followed up - will take					
					urine microalbumi						
					throat						
					SED RATE						

## DATA COLLECTED

- ✓ Patient name
- ✓ DOB
- ✓ Provider
- ✓ Order date
- ✓ Test ordered
- ✓ Urgency
- ✓ Date results received
- ✓ Results normal/abnormal
- ✓ Date results to provider
- ✓ Date results to patient

# PCMH 5A: Example Electronic Test Tracking

Date Ordered	Overdue	Abnormal	Priority	St.	Patient Name	Note	# Orders	Provider	Order-Descriptions	Last Appt.	Next Appt.
01/07/2009							3		chest 2 view xray; with and without contrast; Ultrasound, soft tissue and neck (eg, thyroid, parathyroid, parotid) with image		
12/17/2008	Overdue						2		Magnetic resonance spinal canal and coccyx without contrast media followed by contrast view xray		
01/14/2009							5		Complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) and automated differential WBC co; Thyroid stimulating hormone (TSH); Free thyroxine (FT4); mammogram; DEXA		
12/17/2008	Overdue						2		Complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) and automated differential WBC co; Thyroid stimulating hormone (TSH)		
12/15/2008	Overdue						5		DEXA; CBC; Thyroid stimulating hormone (TSH); ABL; Screening mammogram	01/20/20	
01/19/2009							4		Free thyroxine (FT4); Thyroid stimulating hormone (TSH); Complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) and automated differential WBC co; Culture, bacterial; with isolation and presumptive identification of each isolate, urine	01/19/20	
12/18/2008	Overdue						3		CT Head/Brain with & without Contrast; Complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) and automated differential WBC co; Thyroid stimulating hormone (TSH)	12/26/20	
01/07/2009	Overdue						3		CBC; Prothrombin time; chest 2 view xray	01/07/20	
12/22/2008	Overdue						3		Complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) and automated differential WBC co; Thyroid stimulating hormone (TSH); Prolactin	12/22/20	
01/14/2009							5		Complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) and automated differential WBC co; Thyroid	01/21/20	

- ✓ All lab and imaging tests are tracked until results are available
- ✓ Overdue results are flagged
- ✓ Abnormal results are flagged

- Practice tracks:**
- ✓ Date ordered
  - ✓ Overdue
  - ✓ Abnormal
  - ✓ Priority
  - ✓ Patient name
  - ✓ Provider
  - ✓ Order description
  - ✓ Last appointment
  - ✓ Next appointment

# PCMH 5A: Example Notifies Patient of Abnormal Results

The screenshot displays a medical home software interface. On the left is a navigation tree with categories like Encounters, Messages, Scanned Documents, and X-Ray Results. The X-Ray Results section is expanded, showing a list of reports including 'X-Ray Results - AMH MRI Pelvis' and 'X-Ray Results - Final CT Abd. wj'. The main window shows a document viewer with a 'Pages' pane on the left and a 'Details' pane on the right. The document content includes a legal disclaimer, a clinical finding: 'Sections through the pelvis demonstrates no evidence for mass, fluid, collection, or inflammatory process. Prostate is enlarged.', an 'Impression' section, and a date stamp 'Thursday, July 10, 2008 14:27:34'. A handwritten note in blue ink reads 'Notified pt Needs MRI Ab/pelvis'. A red arrow points from a text box at the bottom left to this note.

Shows that patient/ family was notified by provider of abnormal test results and given follow-up instructions

# PCMH5A: Example Ordering Lab Tests

**Transmit Labs**

Select All

NAME	LAB CO.
<input checked="" type="checkbox"/> Comp. Metabolic Panel (14)	LabCorpBi
<input checked="" type="checkbox"/> Lipid Panel	LabCorpBi
<input checked="" type="checkbox"/> CBC With Differential/Platelet	LabCorpBi
<input checked="" type="checkbox"/> Sedimentation Rate-Wesergren	LabCorpBi
<input checked="" type="checkbox"/> ARTHRITIS PROFILE	Quest:Bi, LabC
<input checked="" type="checkbox"/> THIN PREP	

Collection Date: [ ] Time: 10:32 AM Actual Fasting: Not Recorded

Assigned To: [ ]

Select Lab: [ ]

Transmit [ ] Cancel

**Test ordered**  
**Collection date**  
**Assigned to**  
**Select lab**  
**Transmit**

**Order Options**

Lab Company: [ ]

Lookup: [ ] By: [ ]

ORDER NAME	LAB CO.
(LIPID PROFILE), NOT SPECIFIC	Quest
	LabCo
	001362
17-alpha-hydroxyprogesterone	
17-alpha-hydroxyprogesterone	LabCo
24 HR BP CHECK	
5-HIAA, 24 HR URINE	Quest
5-HIAA,Quant,24 Hr Urine	LabCo
726778 74Alc-Unb	LabCo
794388 7 Drug-Bund	LabCo
799452 5 Drug-Bund	LabCo
ABO Grouping and Rho(D) Typir	LabCo
Acetylchol Recept Bind Ab W/Rfx	LabCo
acid phosph	LabCo
Acid Phosphatase, Total	LabCo
ACTH, Plasma	LabCo
Actin (Smooth Muscle) Antibody	LabCo
Additional	

**Assessments**

Current Order : Comp. Metabolic Panel (14)

Select All

- V72.31 Exam, Gynecolor
- 244.9 Hypothyroidism N
- 696.1 Psoriasis
- 783.1 Weight gain
- 719.40 Arthralgia

# PCMH 5A: Example EHR Order Screens

## Laboratory Test Order Screen

Custom List | Categories | Search | Order Details

Use custom list: Labs PPD [Organize...]

<input checked="" type="checkbox"/> Venipuncture	<input type="checkbox"/> ANA	<input type="checkbox"/> Hep A antibody
<input checked="" type="checkbox"/> Urinalysis	<input type="checkbox"/> RF	<input type="checkbox"/> Hep B antibody
<input checked="" type="checkbox"/> CBC	<input type="checkbox"/> FSH	<input type="checkbox"/> Hep B surface antigen
<input checked="" type="checkbox"/> Basic panel	<input type="checkbox"/> Culture, Stool	<input type="checkbox"/> Hep C antibody
<input checked="" type="checkbox"/> Hepatic function panel	<input type="checkbox"/> Culture, Throat	<input type="checkbox"/> Hepatitis panel, acute
<input checked="" type="checkbox"/> Lipid panel	<input type="checkbox"/> Culture, urine	<input type="checkbox"/> H. pylori med
<input checked="" type="checkbox"/> TSH	<input type="checkbox"/> GC probe	<input type="checkbox"/> H. pylori test
<input checked="" type="checkbox"/> PSA	<input type="checkbox"/> Chi probe	
<input checked="" type="checkbox"/> HgA1c	<input type="checkbox"/> HCG Qualitative	
<input type="checkbox"/> ESR	<input type="checkbox"/> Antibody, HIV-1	

## Radiology Test Order Screen

Pt Record | Scheduling | Order Entry Request [save] [cancel]

Transport: A [Visit No: [Order Code: ROUTIN...]

Help | Chg Pwd | Prefs | Logout

Signs & Symptoms: MRI BRAIN DX HEADACHES | History: NO PRIOR FILMS

Comments: CPDPD PLEASE CALL PT AT 785-5881WITH

Dx Code: [Exam: MRIHD | Exam Modifiers: [Date: [Time: 1:15 PM EDT Patient Location: C...]

# PCMH5A: Example Retrieving Imaging Results

The screenshot shows a software interface with a table at the top and a detailed view below. The table has columns for Type, Create Date, Created By, Priority, and Memo. The first row is highlighted in yellow and contains a document icon, the date 09/22/2008, and the text 'Pt currently hospita biopsy 3/08 which'. Below the table is a toolbar with various navigation icons. The main area displays a report with the following text:

ADM: [REDACTED] 1245  
LOC: PKLS PK129-1 (ADM IN)

REPORT #: 09211-1205

EXAM: CT CHEST WO CONT      DATE OF EXAM: [REDACTED] 1332

Signed

CT CHEST WITHOUT IV CONTRAST  
[REDACTED]

INDICATION: Follow-up lung nodule.

TECHNIQUE: Unenhanced.

Imaging results are automatically sent to office from imaging center via electronic fax and merged into the EHR

Dated when received **AND** reviewed



# PCMH 5A6 Example: Follow Up on Newborn Screening

**Health Maintenance** [Close X]

Override Cancel Edit Modifiers Report

Due Date	Procedure	Date Satis
12/21/2009	DPT (#1)	
10/21/2009	HEPATITIS B (#1)	
12/21/2009	HIB 3 DOSE REGIMEN (#1)	
12/21/2009	IPV (#1)	
11/21/2009	NEONATAL SCREENING HEARING	
11/21/2009	NEONATAL SCREENING METABOLIC	
12/21/2009	PNEUMOCOCCAL VACCINE (#1)	
12/21/2009	ROTAVIRUS 3 DOSE VACCINE,NOT TO START	

→ Procedure Overdue    ⚠ Procedure Due On    🔑 Procedure Due Soon

**Health Maintenance Modifiers**

- Neonatal Hearing Screen Normal
- Neonatal Metabolic Screen Normal

Accept Cancel

**Patient Modifiers** [Edit Modifiers]    **Related Plans**

**Abbreviations for Override Types**

- TOP
- COLONOSCOPY Colonoscopy (ENTE
- COLONOSCOPY Colonoscopy - High F
- ColonoscopyN Colonoscopy - Not H
- COLORECTALS Colorectal Screen Fl

Use this activity to personalize the preventive care and disease management rules for this patient

Start [Icons] Inbo... Cale... Curr... Prod... RE: ... Epic Hyp... Micr... 4:18 PM

# PCMH 5B: Referral Tracking & Follow-Up

## Practice coordinates referrals:

1. Provides specialist with reason **and** pertinent information for the referral
2. Tracks status of referrals and timing indicated
3. Follows up to obtain specialist reports
4. Has agreements with specialists documented in the record if co-management needed
5. Asks patients about self-referrals and requests specialist reports
6. Demonstrates capability for electronic exchange of key clinical information between clinicians (prob. lists, meds.)\*
7. Provides electronic summary of care for more than 50% of referrals\*\*

\* Core Meaningful Use Requirement

\*\* Menu Meaningful Use Requirement

# PCMH 5B, F1-5: Referral Tracking & Follow-Up

## Practice coordinates referrals:

1. Provides specialist with reason and pertinent information for the referral
2. Tracks status of referral and timing indicated
3. Follows up to obtain specialist reports
4. Has agreements with specialists documented in the record if co-management needed
5. Asks patients about self-referrals and requests specialist reports

## Documentation

- F1-3: Reports or logs demonstrating tracking system data collection
- F4-5: Documented processes and three examples

# PCMH 5B, F6-7: Referral Tracking/Follow-Up

## Practice coordinates referrals:

6. Demonstrates capability for electronic exchange of key clinical information between clinicians (problem lists, allergies, test results, meds.)\*
7. Provides electronic summary of care for more than 50% of referrals\*\*

\* Core Meaningful Use Requirement

\*\* Menu Meaningful Use Requirement

## Documentation

- F6: Screen shot showing capability
- F7: Report with numerator, denominator and percent

# PCMH 5B: Scoring and Documentation

- **MUST PASS**
- **6 Points**
- **Scoring**
  - 5-7 factors = 100%
  - 4 factors = 75%
  - 3 factors = 50%
  - 1-2 factors = 25%
  - 0 factors = 0%

# PCMH 5B: Example Referral Tracking Log

Clinic:								
Month:								
DATE	REFERRING PROVIDER	DIAGNOSIS	REFERRING TO	CODE	D=Diagnostic C=Consultation	Is Service Available	APPT DATE	DATE REC'VD RESULTS
10/4/2006		chest pain	sehco	CHC	D=Diagnostic	N		
10/4/2006		size/dates	ob u/s	ne rad	D=Diagnostic	N		
10/4/2006		r density	breast u/s	ne rad	D=Diagnostic	N		11/3/2006
10/5/2006		back pain		pt/ot	D=Diagnostic	N		
10/5/2006		sleep walking	psg	PSD	D=Diagnostic	N		
10/5/2006		insomnia	psg	PSD	D=Diagnostic	N		
10/5/2006		neck pain	mri c-spine	CDI	D=Diagnostic	N		
10/5/2006		sleep apnea	cpap	ne sleep	D=Diagnostic	N		
10/5/2006		hearing loss	eval	ne audio	D=Diagnostic	N		10/18/2006
10/5/2006		htn	ven dop	ne rad	D=Diagnostic	N		
10/6/2006		fatigue	psg	PSD	D=Diagnostic	N		
10/6/2006		h/a	ct-head	CDI	D=Diagnostic	N		
10/6/2006		speech delay	speech eval	ne audio	D=Diagnostic	N		
10/6/2006		colon scr	colon scr		D=Diagnostic	N		
10/9/2006		sleep apnea	psg	PSD	D=Diagnostic	N		
10/9/2006		colon scr	colon scr		D=Diagnostic	N		
10/9/2006		colon scr	colon scr	NE GI	D=Diagnostic	N		
10/9/2006		insomnia	psg	PSD	D=Diagnostic	N		
10/9/2006				RHEUM	C=Consultation	N		
10/9/2006		colon scr	colon scr	NE DIG	D=Diagnostic	N		
10/9/2006		hearing	screening	ne audio	D=Diagnostic	N		
10/9/2006		colon scr	colon scr	C GI	D=Diagnostic	N		
10/9/2006		sleep probs	psg	PSD	D=Diagnostic	N		
10/9/2006		chr cough	ct-chest	CDI	D=Diagnostic	N		10/9/2006

# PCMH 5B: Example Referral Tracking

REFERRING DR	REF DATE	PATIENT NAME/ DOB	FACILITY/ PHYSICIAN	DIAGNOSIS/ REASON FOR REFERRAL	APPT DATE	INS. INFO./ PRE-AUTHOR., IF NEEDED	STAT	RCVD. REPORT	REPORT OVERDUE	PERSON & DATE NOTIF. PT.
CHANIN	6/16/2100	BEAR, MAMA 1/21/1900	Diagnostic Imaging	Abd. pain; abdomen. Sono.	6/19/2100	BEAR LAIR HEALTH PLAN – got pre-author.	No	7/15/2100		7/17/00 - JCC
CHANIN	6/16/2100	BEAR, PAPA 9/6/1900	PT and Rehab	Knee pain – eval. and treat.	TBD	BEAR LAIR HEALTH PLAN – got pre-author.	No		YES	
CHANIN	7/22/2100	SMITH, GOLDBLOCKS 10/10/1900	George Jones, orthopedist	Suspect torn ACL – eval and treat.	7/24/2100	CCD Health Plan – no pre-author. needed	Yes			

## Tracking Table Includes

- ✓ Reason for referral
- ✓ Relevant clinical information:  
history, clinical findings,  
current treatment
- ✓ Purpose of referral
- ✓ Date referral initiated
- ✓ Timing to receive report
- ✓ Follow-up to get report
- ✓ Agreement for co-mgmt.

# PCMH 5C: Coordinate with Facilities and Care Transitions

Practice systematically demonstrates:

1. Process to identify patients with hospital admissions **and** ED visits
2. Process to share clinical information with hospital/ED
3. Process to obtain patient discharge summaries
4. Process to contact patients for follow-up care after discharge
5. Process to exchange patient information with hospital
6. Collaboration with patient/family to develop written care plan for transitions from pediatric to adult care (**NA for adults**)
7. Electronic exchange of key clinical information with facilities\*
8. Provides electronic summary of care for more than 50% of transitions of care\*\*

\* **Core Meaningful Use Requirement**

\*\***Menu Meaningful Use Requirement**

# PCMH 5C, F1-5: Coordinate with Facilities and Manage Care Transitions

## Practice demonstrates:

1. Process to identify patients with hospital admissions and ED visits
2. Process to share clinical information with hospital/ED
3. Process to obtain patient discharge summaries
4. Process to contact patients for follow-up care after discharge
5. Process to exchange patient information with hospital

## Documentation

- F1: Documented process to identify patients and log or report
- F2,4,5: Documented process and examples of providing clin. Info., obtaining discharge summaries and two-way communication
- F3: Documented process for post-discharge follow-up and examples or log with 1 wk. of follow-up data

# PCMH 5C, F6-8: Coordinate with Facilities and Manage Care Transitions

## Practice systematically demonstrates:

6. Collaboration with patient/family to develop written care plan for transitions from pediatric to adult care (NA for adults)
7. Demonstrates capability for electronic exchange of key clinical information with facilities
8. Provides electronic summary of care for more than 50% of transitions of care\*\*

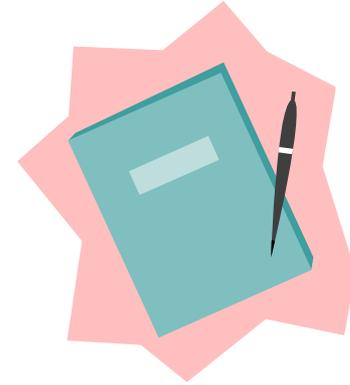
**\*\*Menu Meaningful Use Requirement**

## Documentation

- F6: Example of a written transition care plan
- F7: Screen shot showing test of capability
- F8: Report with numerator, denominator and percent of care transitions where summary of care record was provided

# PCMH 5C: Scoring and Documentation

- **6 Points**
- **Scoring:**
  - 5-8 factors = 100%
  - 4 factors = 75%
  - 2-3 factors = 50%
  - 1 factor = 25%
  - 0 factors = 0%



# PCMH 5C: Example Identifying Patients in Facilities

Practice receives admission reports electronically from hospital

HISTORY AND PHYSICAL REPORT  
PATIENT NAME: [REDACTED]

Ordering: N/A

PT: ADM: [REDACTED]  
DOB: LOC: [REDACTED]  
UNIT ACCOUNT #: [REDACTED]  
REPC

HISTORY AND PHYSICAL REPORT  
Signed

DATE OF ADMISSION: 0 [REDACTED]

CHIEF COMPLAINT: Right upper quadrant abdominal pain.

HISTORY OF PRESENT ILLNESS: The patient is [REDACTED] who was admitted on February 17, 2009 for some epigastric and right upper quadrant pain that was intermittent. At that time evaluation included blood work showing minimal transaminase elevation and CT scan showing [REDACTED]

# PCMH5C: Example ER Visit Follow-Up Log

Date of ER Visit	Diagnosis	Follow up call	Follow up appointment
	SOB	We admitted pt	Pt has problems with providing care for his wife.
	Cath drop	Yes	no f/u necessary
	Fever dialysis pt	F/u to specialist	no f/u with us
	Injured L. Hand	no f/u necessary	
	Diarrhea, fever, vomiting	Told to go to ER	Pt told to go to Er by us
	Flu	F/u scheduled	
	Leg Bleed	F/u scheduled	
	Dialysis Pt C/p		Pt referred to pt assist for meds
	Blood Test	F/u scheduled	
	Sodium Level	f/u scheduled	
	Dropped Ams		
	Chest Pain	Pt has been called	Not been in since



# PCMH 5C: Example Follow-Up Care after Hospital Admission

**ADULT PROGRESS NOTE**

Reason for visit: F/U Hospitalized w/  
Good Sam 8/4 - 8/19  
EE - with status epilepticus

ER or Hosp: [Redacted]

**HISTORY** GLUCOSE 408 PEAK ELD [Redacted] WT 804 PR 104 RR 20 T 98.5 LMP N/A

CHIEF COMPLAINT: 35 retake 361  
59 uof - by DM, H.W. CAR - recanted  
Rnd Fm / 1100 Amule Fm

ROS:  See PHF  MPL Reviewed and Updated

Check if negative, list positive responses

- Constitutional:
- Eyes: and
- ENMT:
- Cardiovascular:
- Respiratory:
- Gastrointestinal:
- Genitourinary:
- Musculoskeletal:
- Skin/Breast:
- Neuro:
- Psyche:
- Endo:
- Heme/Lymph:
- Allergy/Immune:

IF  MPL

**PHYSICAL EXAM** Check if normal, slash if not examined, record notable findings

- GEN NAD, A&Ox3
- EYES PERRL, anicteric
- EARS nl pinna, canal, TM, hearing
- PHARYNX no lesions, erythema
- NOSE/SINUS no discharge, sinus tenderness

A/A NAD  
VSS

Breast L.....

Pap Test

Stool/Rectal Exam

Foot Exam

Mammography

Flex Sig/Colonoscopy

Ophthalmology

Ordered

- Flu
- Pneumo
- Tetanus
- PPD

# PCMH 5C6: Example Transition from Pediatric to Adult Care

## National Diabetes Education Program

### *Pediatric to Adult Diabetes Care Transition Planning Checklist*

- ✓ 1 to 2 years before transition to new adult care providers
- ✓ 6 to 12 months before transition
- ✓ 3 to 6 months before transition
- ✓ Last few visits

## NATIONAL DIABETES EDUCATION PROGRAM (NDEP)

# Pediatric to Adult Diabetes Care TRANSITION PLANNING CHECKLIST

This checklist helps the health care provider, young adult, and family discuss and plan the change from pediatric to adult health care. While a variety of events may affect the actual timing when this change occurs, below is a suggested timeline and topics for review. The young adult, family, and health care provider can obtain a copy of this checklist and access many online transition resources at the NDEP website ([www.YourDiabetesInfo.org/transitions](http://www.YourDiabetesInfo.org/transitions)).

- 1 to 2 years before anticipated transition to new adult care providers  
[Date completed \_\_\_\_\_]
  - Introduce the idea that transition will occur in about 1 year
  - Encourage shared responsibility between the young adult and family for:
    - Making appointments
    - Refilling prescriptions
    - Calling health care providers with questions or problems

# PCMH 6: Measure and Improve Performance

## Intent of Standard

- Measure preventive, chronic and acute care; utilization affecting costs; patient experience and report performance
- Use and monitor effectiveness of quality improvement process

## Meaningful Use Criteria

### Report:

- Ambulatory quality measures to CMS
- Immunization data to registries
- Syndromic surveillance data to public health agencies

# PCMH 6: Measure and Improve Performance

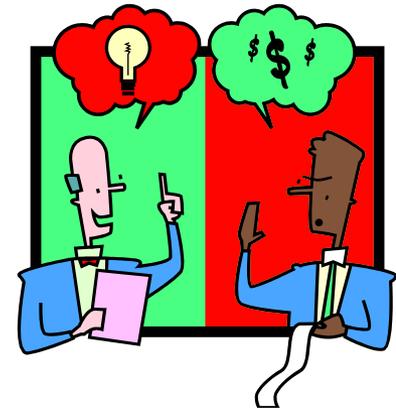
## Elements

- PCMH6A: Measure Performance
- PCMH6B: Measure Patient/Family Experience
- PCMH6C: Implement Continuous Quality Improvement – MUST PASS
- PCMH6D: Demonstrate Continuous Quality Improvement
- PCMH6E: Report Performance
- PCMH6F: Report Data Externally

# PCMH 6A: Measure Performance

Practice measures or receives the following data:

1. Three (3) preventive care measures
2. Three (3) chronic or acute care measures
3. Two (2) utilization measures affecting health care costs
4. Vulnerable population data



# Vulnerable Populations Defined

**“Those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability.”**

**Source: AHRQ**

# PCMH 6A: Scoring and Documentation

- **4 Points**
- **Scoring**
  - 4 factors = 100%
  - 2-3 factors = 75%
  - 1 factor = 25%
  - 0 factors = 0%
- **Documentation**
  - F1-4: Reports showing performance



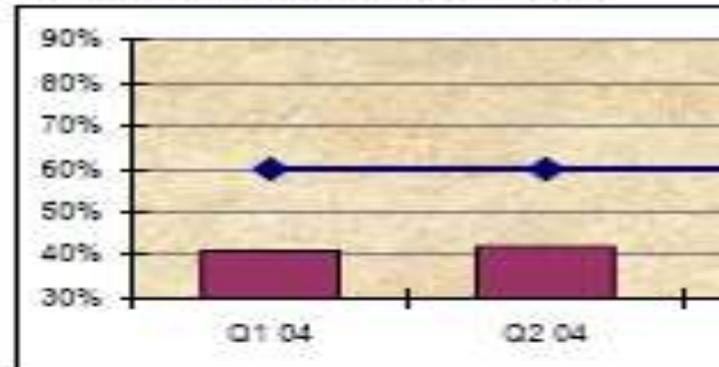


# PCMH 6A: Example Chronic Care Clinical Measures

## 7. Control of lipids in diabetic patients

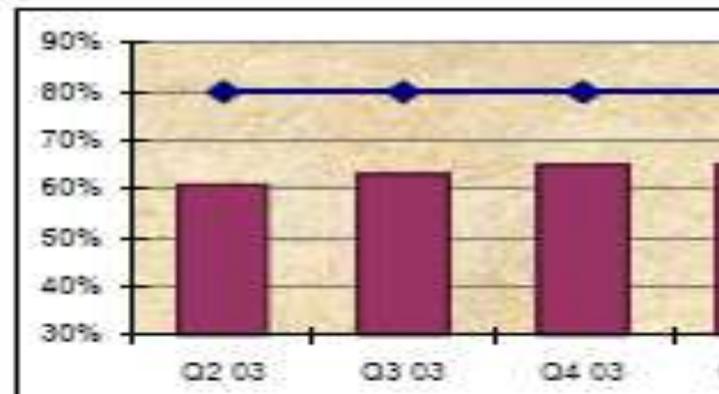
### a. Percentage of patients with LDL <100 (desired range of control)

QTR	Actual	Target
Q1 04	41%	60%
Q2 04	42%	60%
Q3 04	44%	60%
Q4 04	45%	60%
Q1 05	45%	60%
Q2 05		60%
Q3 05		60%
Q4 05		60%



### b. Percentage of patients with LDL <130 (minimum desired range of control)

QTR	Actual	Target
Q2 03	61%	80%
Q3 03	63%	80%
Q4 03	65%	80%
Q1 04	65%	80%
Q2 04	64%	80%
Q3 04	65%	80%
Q4 04	66%	80%
Q1 05	65%	80%



# PCMH 6A: Example

## Measures Affecting Health Care Costs

PCMH 6 ELEMENT A: Factor 3

Care Managers receive referrals from PCP'S, Hospitalists, Social Workers or family members requesting evaluation for patients to be treated at an alternative level of care (home, SNF) or in the office. The team has had a 22% success rate in saving hospital admissions since Nov 2007.

### CARE MANAGEMENT ACTIVITIES

2011 JANUARY - MAY

#### TOTAL CM REFERRALS / SAVED ADMISSIONS

	2011	2011	2011	2011	2011	TOTAL TO DATE	
	JAN	FEB	MARCH	APRIL	MAY	2011	
TOTAL CM REFERRALS	220	202	299	221	219	1161	TOTAL CM REFERRALS
SAVED ADMISSIONS	57	53	55	49	57	271	SAVED ADMISSIONS
FAILED ATTEMPTS	5	7	2	3	3	20	FAILED ATTEMPTS

# PCMH 6A: Example Factor 4

## Data for Vulnerable Populations

				# of pts with A1C			# of pts with LDL			# of pts with EYE EXAM		% of pts with EYE EXAM
	# of pts by race	total # of pts	% of pts by race	done by race	total # of pts	% of pts done by race	done by race	total # of pts	% of pts done by race	done by race	total # of pts	% of pts done by race
Asian	76	4271	1.78%	70	4271	1.64%	66	4271	1.55%	36	4271	0.84%
Black	1620	4271	37.93%	1528	4271	35.78%	1328	4271	31.09%	737	4271	17.26%
Causasion	2160	4271	50.57%	2017	4271	47.23%	1835	4271	42.96%	994	4271	23.27%
Hispanic	58	4271	1.36%	51	4271	1.19%	46	4271	1.08%	17	4271	0.40%
Other	77	4271	1.80%	68	4271	1.59%	62	4271	1.45%	22	4271	0.52%
Unidentified	278	4271	6.51%	247	4271	5.78%	216	4271	5.06%	101	4271	2.36%

# PCMH 6B: Measure Patient/Family Experience

**Practice obtains feedback on patient experience with the practice and their care:**

- 1. Practice conducts survey measuring experience on at least three (3) of the following: access, communication, coordination, whole-person care/self-management support**
- 2. Practice uses CAHPS PCMH survey tool**
- 3. Practice obtains feedback from vulnerable populations**
- 4. Practice obtains feedback through qualitative means**

# Why Require CAHPS Patient-Centered Medical Home (PCMH)?

- Use of a standardized survey allows “apples to apples” comparison of patient experience across recognized practices
- Non-proprietary survey and can be easily adopted by practices and vendors
- Survey is specifically designed to evaluate patient experience with medical homes
- Survey derived from the most wide used consumer experience survey
- Rigor of the survey design and consumer testing process
- Other entities and initiatives are likely to require use of CAHPS PCMH

# Distinction in Patient Experience Reporting

**Purpose:** Acknowledge practices that put in the extra effort to collect and report patient experience information in a standardized way

- Provides PCMH Recognized practices with **Distinction**
- Requires the **CAHPS Patient-Centered Medical Home (PCMH)** survey which assesses:
  - Access
  - Communication
  - Coordination
  - Whole person care/self-care management support
- Requires a **standardized sampling** approach
- Requires use of **approved data collection** methodologies
- Program details to be released in **October 2011**

# PCMH6B: Scoring and Documentation

- **4 Points**
- **Scoring**
  - 4 factors = 100%
  - 3 factors = 75%
  - 2 factors = 50%
  - 1 factor = 25%
  - 0 factors = 0%
- **Documentation**
  - F1-4: Reports showing results of patient feedback



# PCMH 6B: Example of Communications Questions for Patient Experience

- 10. In the last 12 months, how often did this doctor explain things in a way that was easy to understand?
  - Never
  - Sometimes
  - Usually
  - Always
- 11. In the last 12 months, how often did this doctor listen carefully to you?
  - Never
  - Sometimes
  - Usually
  - Always
- 12. In the last 12 months, did you talk with this doctor about any health problems or concerns?
  - Yes
  - No  If No, go to Question 14
- 13. In the last 12 months, how often did this doctor give you easy to understand instructions about taking care of these health problems or concerns?
  - Never
  - Sometimes
  - Usually
  - Always

# PCMH6B: Whole-person Care/Self-Management Support

Survey questions may relate to the following:

- Knowledge of patient as a person
- Life style changes
- Support for self-care/self-monitoring
- Shared decisions about health
- Patient ability to monitor own health

# PCMH6B: Patient Experience Survey

## Patient Satisfaction Survey

This survey will be kept anonymous. Please answer honestly so we can improve our care and service to you. How would you rate the practice's overall performance? Thank You.

**1. Ability to obtain an appointment soon enough to meet your medical needs.**

Excellent  
Good  
Fair  
Poor

**2. Courteous and professional treatment by Staff, Nurse Practitioners & Physicians.**

Excellent  
Good  
Fair  
Poor

**3. In office wait time to see your Physician/Nurse Practitioner.**

Excellent  
Good  
Fair  
Poor

**4. Did you understand your diagnosis and treatment instructions provided by your care team.**

Excellent  
Good  
Fair  
Poor

**5. Overall satisfaction with care provided.**

Excellent  
Good  
Fair  
Poor

**6. Availability of Chronic Disease Information, such as Diabetes, Asthma, etc.**

Excellent  
Good  
Fair  
Poor

- ✓ Survey includes questions on:
  - ✓ Access
  - ✓ Communication
- ✓ Sample survey not accepted
- ✓ Needs data

10-08/cmz

# PCMH6B: Patient Experience Data

PCP	Q1* Access to Care	N/A^	Q5* Waiting Time	N/A^	Q7* Communication	N/A^	Q8* Lab & Test Results	N/A^	Q9* Referrals	N/A^	Q10* PCP Satisfaction	N/A^	Q11* Office Staff Satisfaction	N/A^	Q12* Recommend to family and friends	N/A^	TOTAL SURVEYS
	52	0	50	2	50	2	32	20	29	22	50	1	50	1	50	1	52
	30	0	27	1	29	1	18	12	17	13	29	1	30	0	30	0	30
	48	0	46	1	48	0	28	19	20	27	48	0	48	0	47	1	48
	5	0	5	0	4	1	1	4	1	4	5	0	5	0	5	0	5
	8	0	8	0	8	0	4	4	4	4	8	0	8	0	8	0	8
	69	0	67	2	66	1	34	30	30	39	69	0	69	0	69	0	69

## Survey questions include:

- ✓ Access
- ✓ Communication
- ✓ Coordination

• \*indicates survey answers of “Strongly Agree” or “Agree” to indicated question

• ^indicates survey answers of “N/A” to indicated question

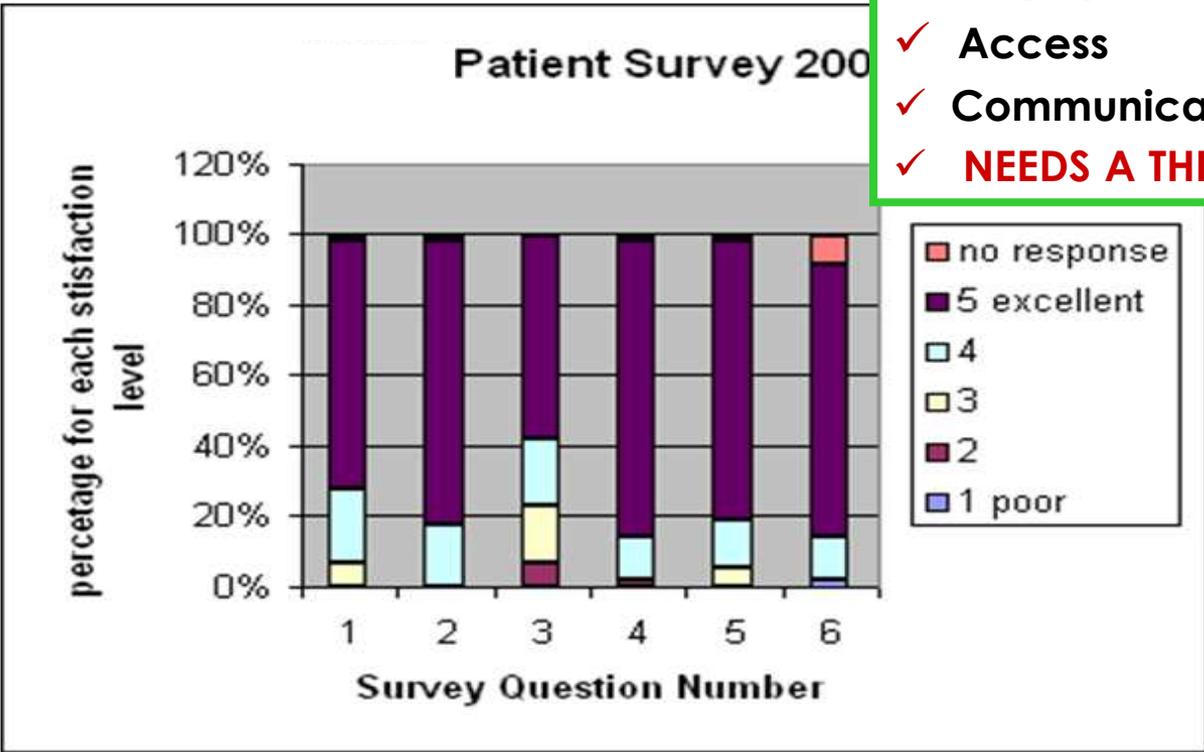
# PCMH6B: Example Patient Experience Survey Results

**Survey Questions:**

1. Ability to obtain an appointment soon enough to meet your medical needs
2. Courteous and professional treatment by Staff, Nurse Practitioners & Physicians
3. Time waiting in the office to see your Physician/Nurse Practitioner
4. Did you understand your diagnosis and treatment instructions provided by your care team?
5. Overall satisfaction with care provided
6. Availability of Chronic Disease Information, such as High Blood Pressure, Diabetes, Asthma, etc.

**Survey questions include:**

- ✓ Access
- ✓ Communication
- ✓ **NEEDS A THIRD CATEGORY**



# PCMH6C: Implement Continuous Quality Improvement

**Practice uses ongoing quality improvement process:**

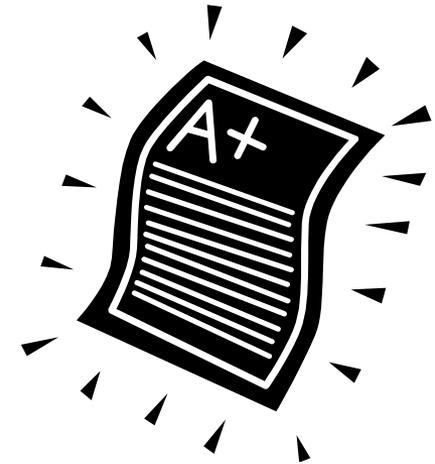
- 1. Set goals and act to improve performance on three (3) measures from Element 6A**
- 2. Set goals and act to improve performance on one (1) measure from Element 6B**
- 3. Set goals and address at least one (1) identified disparity in care for vulnerable populations**
- 4. Involve patients in QI teams or on the practice's advisory council**

# PCMH 6C: Scoring and Documentation

- **Must Pass**

- **4 Points:**

- 3-4 factors = 100%
- 2 factors = 50%
- 1 factor = 25%
- 0 factors = 0%



- **Documentation**

- F1-3: Report or completed PCMH Quality Measurement and Improvement Template
- F4: Process demonstrating how it involves patients/families in QI teams or advisory council

# PCMH 6C: Quality Measurement and Improvement Template

## NCQA's Patient-Centered Medical Home (PCMH) 2011 Quality Measurement and Improvement Worksheet

Practice \_\_\_\_\_

Date Completed \_\_\_\_\_

### How to Complete the Worksheet

These instructions are a guide for completing NCQA's PCMH Quality Measurement and Improvement Worksheet. The purpose of the worksheet is to assist organizations in understanding – and in outlining for NCQA – the measures and quality improvement activities that are required in PCMH 6, Elements C and D. Please note that practices are not *required* to submit the worksheet as documentation for PCMH 6 Elements C and D—it is provided as an option. Practices may submit their own report detailing their quality improvement strategy. Directions for attaching the worksheet are provided on the next page. See PCMH 6, Elements A, B, C and D for additional information.

Column	Section	Instructions
A	Measure	Identify at least <b>five (5) measures</b> from PCMH 6, Elements A and B selected for your quality improvement strategy: at least <b>three (3) clinical and/or utilization measures</b> ; at least <b>one (1) patient/family experience measure</b> ; and at least <b>one (1) measure focused on vulnerable populations</b> .
B	Opportunity Identified	List the opportunity for improvement that you have identified for each measure and on which you have decided to take action. You may list more than one identified opportunity for improvement per measure, but are not required to do so.
C	Initial Performance	List the initial (or baseline) performance rate and measurement period for each identified opportunity. You may use rates from the reports provided in PCMH 6A and B. Provide the performance rate as a specific percentage or number.
D	Performance Goal (PCMH 6, Element C)	List at least one performance goal for each identified opportunity. Provide the goal as a specific percentage or number.
E	Action Taken and Date of Implementation (PCMH 6, Element C)	List at least one action that you have taken in response to the identified opportunity. Include the start date of the activity. You may list more than one activity but are not required to do so.
F	Performance at Re-measurement (PCMH 6, Element D)	List the measurement period and the performance rate after action was taken to improve the initial (or baseline) rate. The date must occur after the activity implementation date.
G	Demonstrated Improvement (PCMH 6, Element D)	Describe the baseline and re-measurement period; describe the interventions implemented; and describe the link between interventions the practice implemented and the resulting rate improvement.



# PCMH C and D: Quality Measurement and Improvement Worksheet

## Quality Measurement and Improvement Worksheet with an Example

NCQA provided a breast cancer screening measure as a guide. Your practice information (to be entered below the example) does not have to exactly match the example. You may delete the example prior to submitting your worksheet.

A. Measure	B. Opportunity Identified	C. Initial Performance/ Measurement Period	D. Performance Goal	E. Action Taken/Date of Implementation	F. Performance at Re-measurement	G. Demonstrated Improvement
		PCMH 6 Elements A/B	PCMH 6 Element C	PCMH 6 Element C	PCMH 6 Element D	PCMH 6 Element D
1. Breast Cancer Screening	Uninsured patients receive fewer mammograms than insured patients	01/09-01/10: 25% of uninsured women receive mammograms	50% of uninsured women receive mammograms	2/10: Identified community resources for free or low-cost mammograms and shared with uninsured patients	01/10-01/11: 40% of uninsured women receive mammograms	During a one year measurement period from Jan 2009 to Jan 2010, there was a 30 percentage point difference in screening rates between insured and uninsured women. After compiling a list of community resources and
EXAMPLE						
<b>Performance Measures (Identified in 6A)</b>						
1.						
2.						
3.						
<b>Disparity in care for vulnerable populations (Identified in 6B)</b>						
1.						
<b>Patient/Family Experience Measures (Identified in 6B)</b>						
1.						

- ✓ Clinical Activities
- ✓ Disparities in Care
- ✓ Patient/Family Experience

- ✓ Measure (C)
- ✓ Opportunity Identified (C)
- ✓ Initial Performance/ Measurement Period (C)
- ✓ Performance Goal (C)
- ✓ Action Taken and Date (D)
- ✓ Re-measurement Performance (D)



# PCMH6C: Example NCQA's QI Worksheet

## Documenting Setting Goals And Taking Action

A	B	C	D	E	F
Areas for Analysis	Data Source or Measure	Opportunity Identified	Current Performance	Performance Goal	Action Taken and Date of Implementation
<i>To complete table –</i>	<i>List at least one data source or measure for each opportunity</i>	<i>List at least one opportunity</i>	<i>List current rate of performance</i>	<i>List at least one goal for each opportunity</i>	<i>List at least one activity for each opportunity and the start date of the activity</i>
Care Management					
	Follow up rate of Diabetics	We have found a direct correlation between the number of follow up visits and the control of the diabetic patient. The more frequent the visits the better the control.	Current recall rate for Diabetics is 49.3%	75% recall rate to start, with the further goal of increasing on a regular basis	Using our Protocol, we are monitoring the recall rate at this practice and supplying the practice with the Physician Action Forms that identify the patients that are due/overdue for their follow up appointments. We also have asked the reception staff to make follow up appointments at the point of service.



# PCMH 6C: Example Quality Measurement and Improvement Breast Cancer Screening

## Quality Measurement and Improvement Worksheet with an Example

NCQA provided a breast cancer screening measure as a guide. Your practice information (to be entered below the example) does not have to exactly match the example. You may delete the example prior to submitting your worksheet.

A. Measure	B. Opportunity Identified	C. Initial Performance/ Measurement Period  <i>PCMH 6 Elements A/B</i>	D. Performance Goal  <i>PCMH 6 Element C</i>	E. Action Taken/Date of Implementation  <i>PCMH 6 Element C</i>	F. Performance at Remeasurement  <i>PCMH 6 Element D</i>	G. Demonstrated Improvement  <i>PCMH 6 Element D</i>
Breast Cancer Screening	Uninsured patients receive fewer mammograms than insured patients	01/09-01/10: 25% of uninsured women receive mammograms	50% of uninsured women receive mammograms	2/10: Identified community resources for free or low-cost mammograms and shared with uninsured patients	01/10-01/11: 40% of uninsured women receive mammograms	During a one year measurement period from Jan 2009 to Jan 2010, there was a 30 percentage point difference in screening rates between insured and uninsured women. After compiling a list of community resources and sharing the information with our uninsured population, we saw a 15 percentage point increase in the number of uninsured women receiving mammograms during the re-measurement period of Jan 2010 to Jan 2011.

# PCMH 6C Example of Goals for Vulnerable Populations

- **EQUITABLE**
  - ...whoever you are.
  - *No inequality*
  - **Aim Statement:**
  - *Eliminate differences in clinical care & health status between racial, ethnic and socioeconomic groups*
  - **Measure:**
  - 1) “0” disparity by race for all effectiveness measures
- 
- **ACCESSIBLE**
  - We promote access to comprehensive health services to all in our service area, regardless of ability to pay.
  - No barriers to health care services for all who seek it
  - **Aim Statement:**
  - **Serve 50% of our target populations**
  - **Measure:**
  - 1) Health center penetration rate for underserved/special populations in specified service areas

# PCMH 6D: Demonstrate Continuous Quality Improvement

**Practice demonstrates ongoing monitoring of the effectiveness of its improvement process:**

- 1. Tracks results over time**
- 2. Assesses effect of its actions**
- 3. Achieves improved performance on one measure**
- 4. Achieves improved performance on a second measure**

# PCMH 6D: Scoring and Documentation

- **3 Points:**

- 4 factors = 100%
- 3 factors = 75%
- 2 factors = 50%
- 1 factor = 25%
- 0 factors = 0%



- **Documentation**

- F1-4: Reports showing measures over time, recognition results or completed Quality Measurement and Improvement Worksheet



# PCMH 6D: Example Quality Measurement and Improvement Breast Cancer Screening

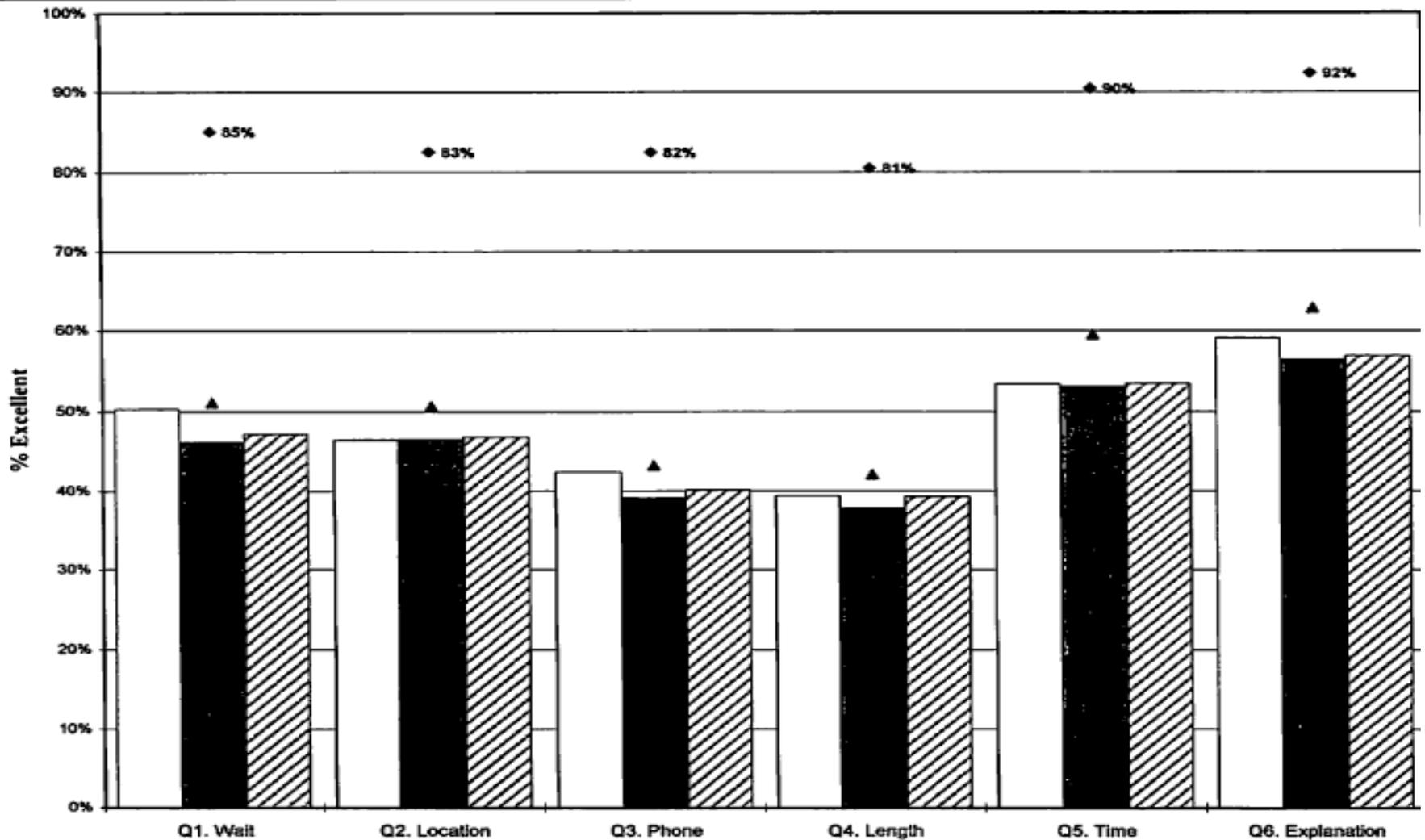
## Quality Measurement and Improvement Worksheet with an Example

NCQA provided a breast cancer screening measure as a guide. Your practice information (to be entered below the example) does not have to exactly match the example. You may delete the example prior to submitting your worksheet.

A. Measure	B. Opportunity Identified	C. Initial Performance/ Measurement Period <i>PCMH 6 Elements A/B</i>	D. Performance Goal <i>PCMH 6 Element C</i>	E. Action Taken/Date of Implementation <i>PCMH 6 Element C</i>	F. Performance at Remeasurement <i>PCMH 6 Element D</i>	G. Demonstrated Improvement <i>PCMH 6 Element D</i>
Breast Cancer Screening	Uninsured patients receive fewer mammograms than insured patients	01/09-01/10: 25% of uninsured women receive mammograms	50% of uninsured women receive mammograms	2/10: Identified community resources for free or low-cost mammograms and shared with uninsured patients	01/10-01/11: 40% of uninsured women receive mammograms	During a one year measurement period from Jan 2009 to Jan 2010, there was a 30 percentage point difference in screening rates between insured and uninsured women. After compiling a list of community resources and sharing the information with our uninsured population, we saw a 15 percentage point increase in the number of uninsured women receiving mammograms during the re-measurement period of Jan 2010 to Jan 2011.

EXAMPLE

# PCMH6D: Example Patient Survey Results Over Time



# PPC6D: Example Tracking Data Over Time

	Mar-09	Feb-09	Jan-09	Dec-08	Nov-08
Preventive					
Pneumovax	61.31	61.21	62.25	61.39	60.95
Diabetes					
HgA1c	73.39	73.48	74.12	74.11	71.54
CHF					
Aoe Inhibitors	99.19	99.59	99.59	99.13	99.56
CAD					
Antihyperlipidemic	99.07	99.05	98.86	98.67	98.87

# PCMH 6E: Report Performance

Practice shares data from Element A and B:

1. Individual clinician results within the practice
2. Practice results within the practice
3. Individual clinician or practice results to patients or public



# PCMH 6E: Scoring and Documentation

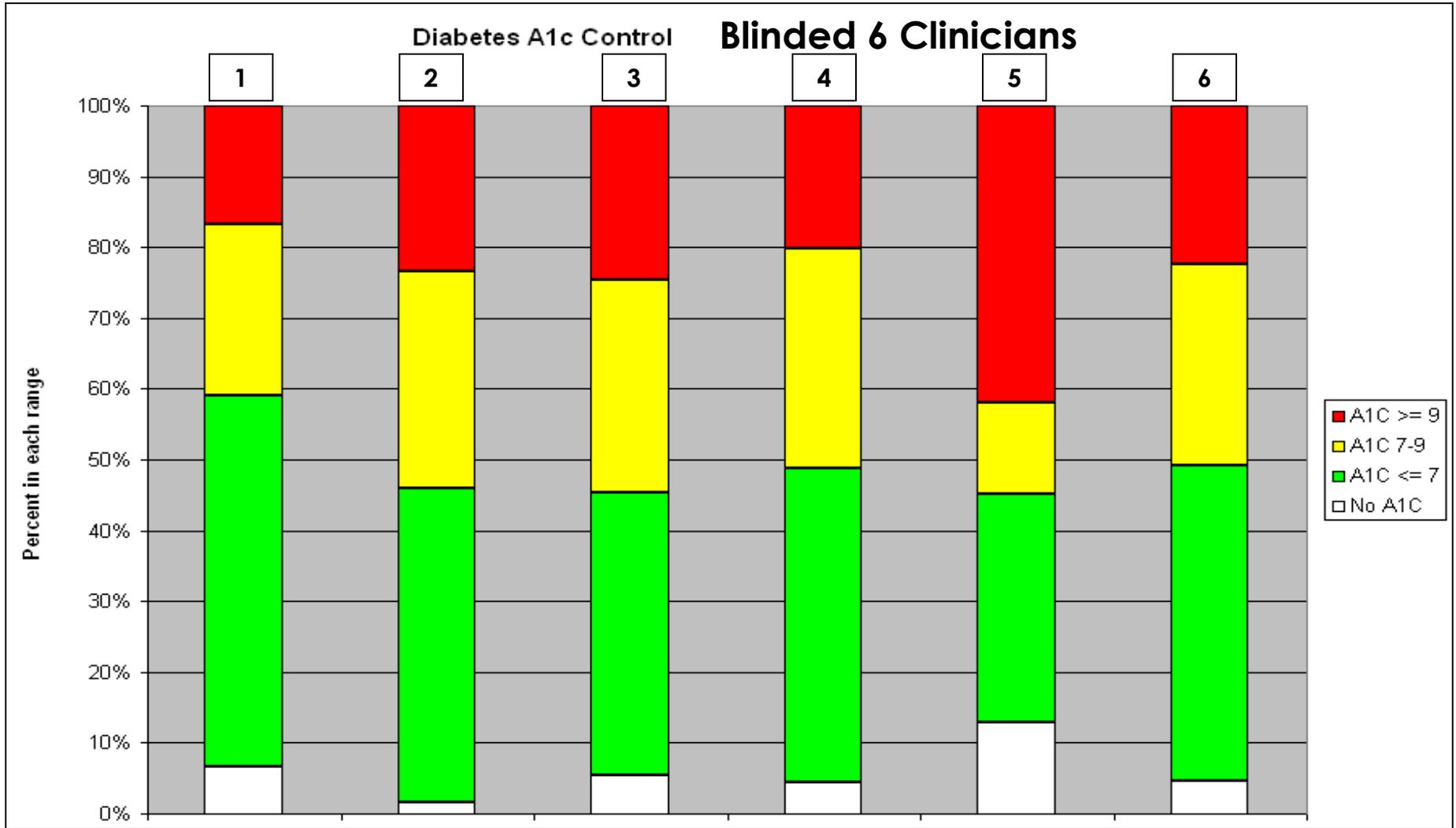
- **3 Points:**

- 3 factors = 100%
- 2 factors = 75%
- 1 factors = 50%
- 0 factors = 0%

- **Documentation**

- F1 and 2: Reports (blinded) showing summary data by clinician and across the practice shared with the practice **and** how the results are shared
- F3: Example of reporting to patients or the public

# PCMH 6E: Example Reporting by Clinician





# PCMH 6E: Example Reporting Across Practice(s)

Practice-Level Quality Performance Indicators Current Quarter Site Comparison												
QUALITY MEASURE	AVG											
<b>DM - Diabetic Eye Exam</b>												
% of Patients Screened ( Sites Only) within the Past Year	54%	54%	39%	60%	54%	43%	57%	66%	47%	54%	56%	53%
		-	-	-	-	-	-	*	-			-
<b>DM - HbA1c</b>												
% of Patients Screened within the Past Year	84%	83%	85%	85%	85%	79%	83%	85%	87%	86%	83%	78%
						-			*			
<b>DM - HbA1c - Level of Control - &lt;7.0%</b>												
% of Tested Patients with Lab Results <7.0%	45%	41%	45%	39%	50%	41%	38%	50%	53%	45%	47%	34%
		-	-	-	-	-	-	-	-	-	-	-
									*			
<b>DM - HbA1c - Level of Control - &gt;9.0%</b>												
% of Tested Patients with Lab Results >9.0%	9%	10%	5%	11%	6%	12%	11%	6%	6%	11%	8%	10%
					+	+			+		+	+
			*									

Shows data for multiple sites



# PCMH6E: Example Practice Level Diabetes Data

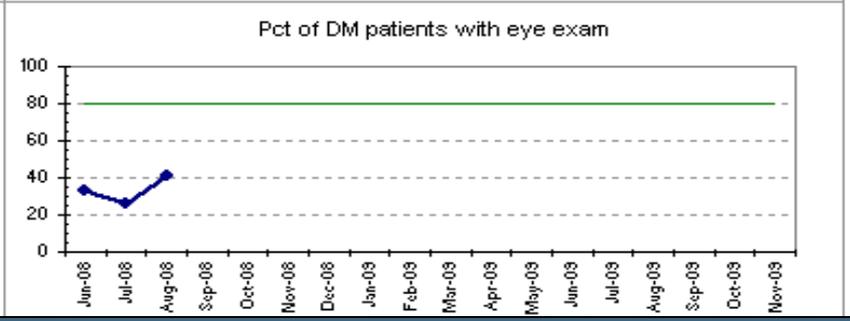
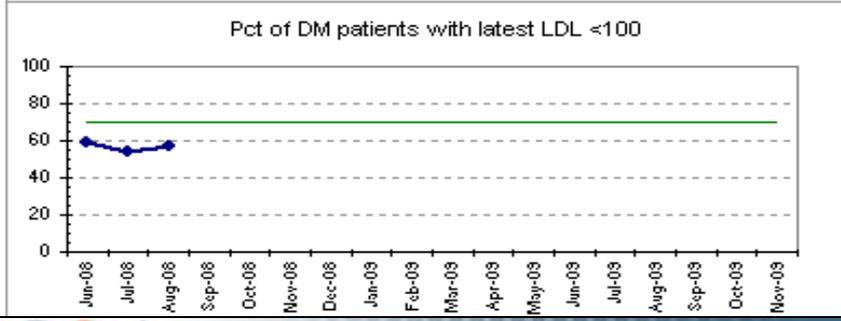
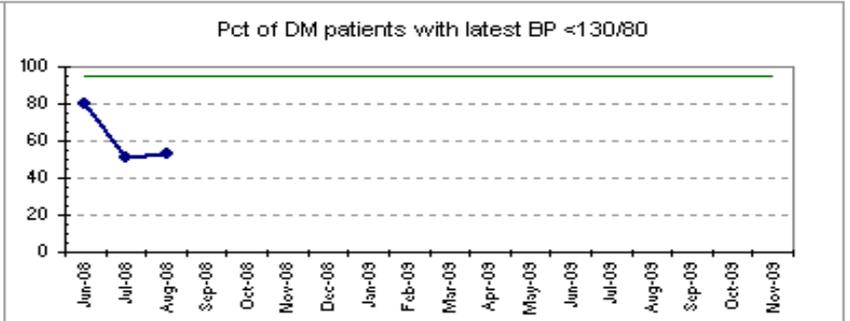
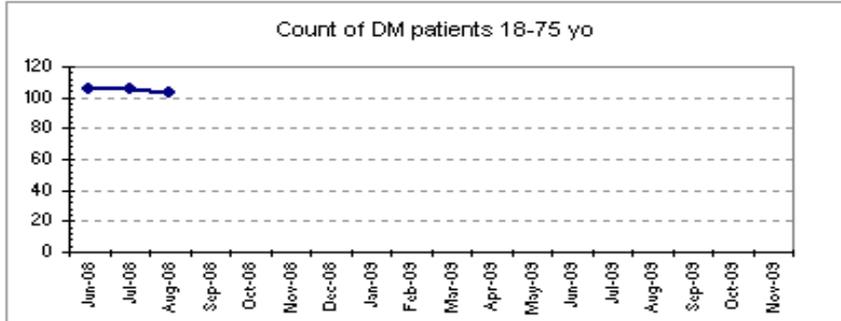
Show data for

- Count of DM patients 18-75 yo
- Pct of DM patients with latest LDL <100
- Pct DM pts w/ smoking cessation counseling
- Pct of DM patients with latest A1C <=7
- Pct of DM patients with >=1 LDL tests
- Pct of DM patients with foot exam
- Pct of DM patients aged 40-75 on aspirin

Goal	May-08
70	
90	
75	
90	
90	
85	

- Pct of DM patients with latest BP <130/80
- Pct of DM patients with eye exam
- Pct DM pts w/ medical attention for nephropathy
- Pct of DM patients with latest BP <=140/90
- Pct of DM patients with latest LDL <=130
- Pct of DM patients with current flu vaccination
- Pct of DM patients with SM Goal

Goal	May-08
95	
80	
90	
90	
90	
75	
90	





# PCMH6E: Example by Clinician

Current Report Month

=Current Report Month     =Optional Measure

Report Period	Count of DM patients 18-75 yo	Count of DM patients 40-75yo	Count of DM patients 55-75yo	Count of DM patients who smoke	Count of DM patients with latest A1C >9	Count of DM patients with latest BP <130/80	Count of DM patients with latest LDL <100	Count of DM patients with eye exam	Count of DM pts w/ smoking cessation counseling	Count DM pts w/ medical attention for nephropathy	Count of DM patients with latest A1C <7	Count of DM patients with latest BP <140/90	Count of DM patients with >=1 LDL tests	Count of DM patients with latest LDL <130	Count of DM patients with foot exam	Count of DM patients with current flu vaccination	Count of DM patients aged 40-75 on aspirin
	44	44		5	13	16	20	4	5	4	25	28	27	26	6	3	17
	46	46		44	18	17	21	5	5	7	22	27	28	27	8	4	18
	46	46		7	18	17	20	5	6	7	21	26	27	26	8	5	18
	47	47		7	19	16	20	5	6	8	20	26	27	25	10	5	20
	46	46		7	20	15	18	6	6	9	16	25	25	22	10	5	20
	47	47		7	24	11	16	8	6	10	14	22	23	20	11	6	18
	47			7	24	10	16	8	7	13	13	21	24	21	12	6	18
	48			7	26	10	17	8		15	13	22	24	21	12	6	17
	52	49		5	29	9	16	9	5	17	13	19	21	19	12	7	18
	53	50		2	28	10	17	10	0	19	14	16	22	20	15	11	17
	53	50		5	29	8	15	10	3	19	13	12	19	17	13	11	16
	45	43		5	20	8	15	9	3	19	13	11	19	17	13	10	16
	46	44		5	21	7	13	12	5	20	15	12	19	17	13	9	17
	41	39		5	15	7	13	12	5	20	17	12	19	17	13	9	17
	41	39		6	8	7	20	13	6	23	20	13	28	24	14	10	17

# PCMH 6F: Report Data Externally

## Practice electronically reports:

1. Ambulatory clinical quality measures to CMS or states\*
2. Ambulatory clinical quality measures to other external entities
3. Data to immunization registries or systems\*\*
4. Syndromic surveillance data to public health agencies\*\*

**\*Core Meaningful Use Requirement**

**\*\*Menu Meaningful Use Requirement**

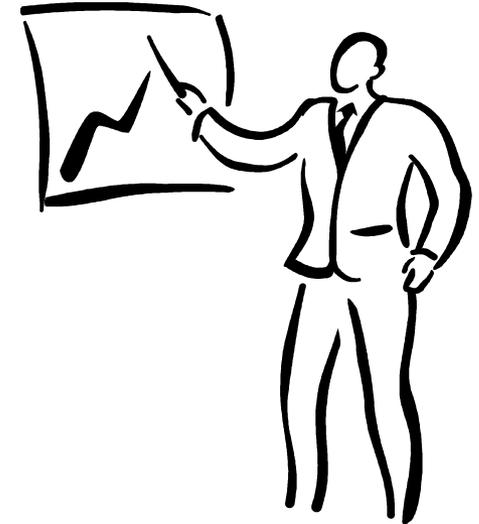
# PCMH 6F: Scoring and Documentation

- **2 Points:**

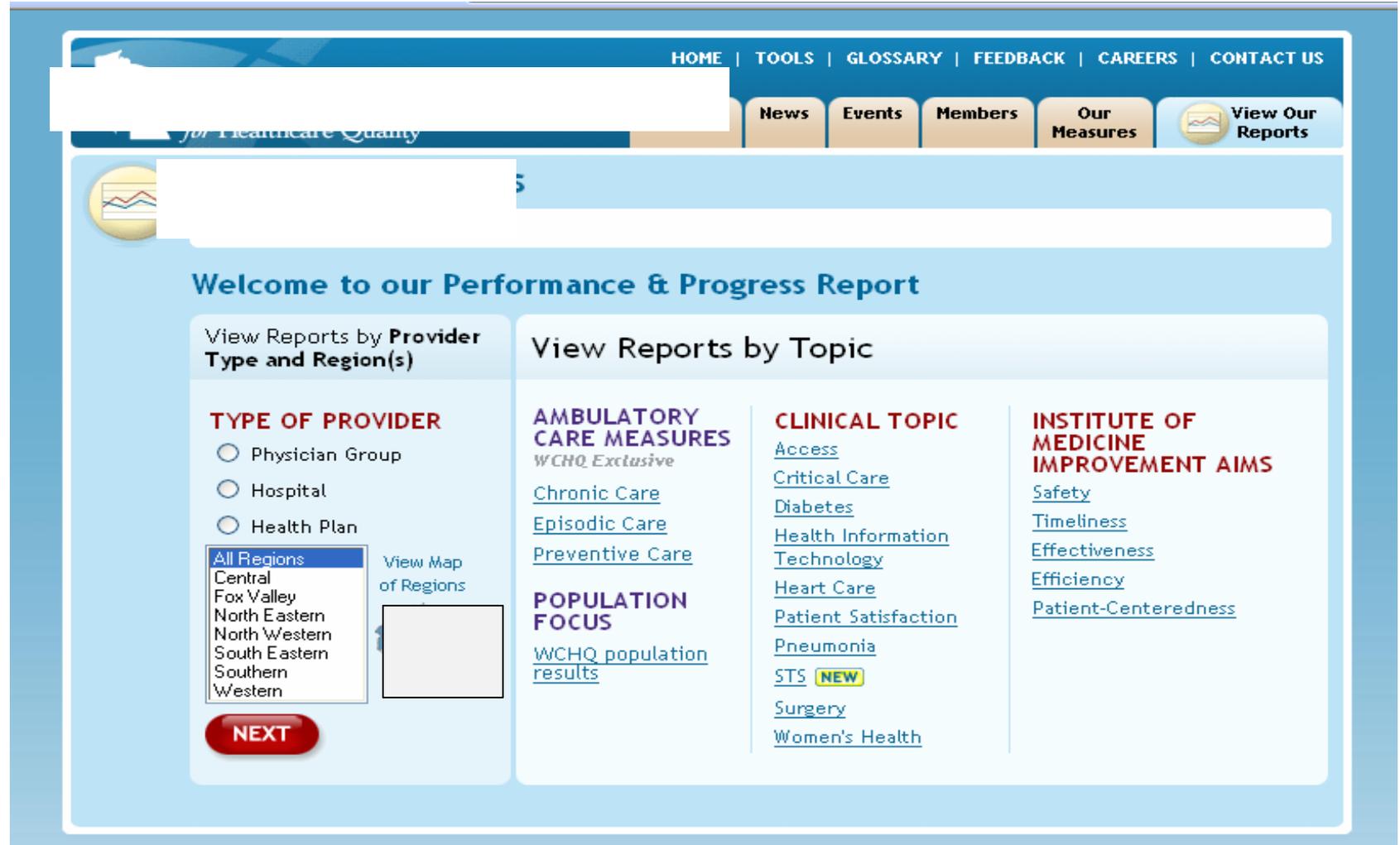
- 3-4 factors = 100%
- 2 factors = 75%
- 1 factor = 50%
- 0 factors = 0%

- **Documentation**

- F1 and 2: Reports demonstrating data submission
- F3 and 4: Reports demonstrating data submission **or** screen shot showing capability was tested



# PCMH 6F: Example of External Reporting



The screenshot shows a website interface for a performance report. At the top, there is a navigation bar with links: HOME | TOOLS | GLOSSARY | FEEDBACK | CAREERS | CONTACT US. Below this is a secondary navigation bar with buttons for News, Events, Members, Our Measures, and View Our Reports. The main content area is titled "Welcome to our Performance & Progress Report". It is divided into two main sections: "View Reports by Provider Type and Region(s)" and "View Reports by Topic".

**View Reports by Provider Type and Region(s)**

**TYPE OF PROVIDER**

- Physician Group
- Hospital
- Health Plan

**View Map of Regions**

- All Regions
- Central
- Fox Valley
- North Eastern
- North Western
- South Eastern
- Southern
- Western

**NEXT**

**View Reports by Topic**

**AMBULATORY CARE MEASURES**  
*WCHQ Exclusive*

- [Chronic Care](#)
- [Episodic Care](#)
- [Preventive Care](#)

**POPULATION FOCUS**

- [WCHQ population results](#)

**CLINICAL TOPIC**

- [Access](#)
- [Critical Care](#)
- [Diabetes](#)
- [Health Information Technology](#)
- [Heart Care](#)
- [Patient Satisfaction](#)
- [Pneumonia](#)
- [STS](#) **NEW**
- [Surgery](#)
- [Women's Health](#)

**INSTITUTE OF MEDICINE IMPROVEMENT AIMS**

- [Safety](#)
- [Timeliness](#)
- [Effectiveness](#)
- [Efficiency](#)
- [Patient-Centeredness](#)



# PCMH 6F: Example of Syndromic Surveillance Data Reporting

## Uniform Data System (UDS) Report

TABLE 6A: SELECTED DIAGNOSES AND SERVICES RENDERED - UNIVERSAL

Grantee Name	Funding Stream	UDS Tracking No./Version No.	Reporting Year	UDS No.	Submitted Date
[REDACTED]					

Diagnostic Category	Applicable ICD - 9 - CM Code	Number of Visits by Primary Diagnosis (a)	Number of Patients with Primary Diagnosis (b)
Selected Infectious and Parasitic Diseases			
1. Symptomatic HIV	042.xx, 079.53	92	24
2. Asymptomatic HIV	V08	324	55
3. Tuberculosis	010.xx - 018.xx	31	29
4. Syphilis and other venereal Diseases	090.xx-099.xx	488	395

# PCMH 6G: Use of Certified EHR Technology

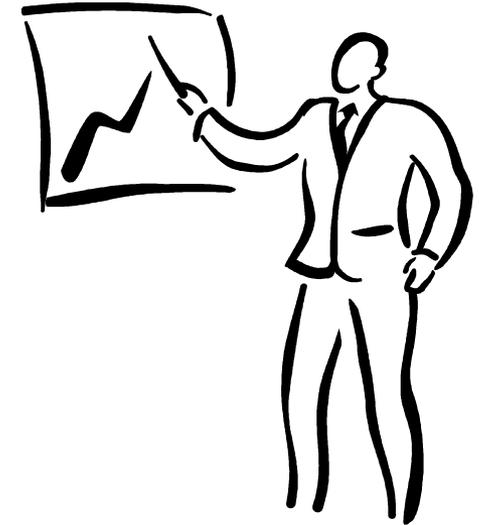
To meet federal Core and Menu Meaningful Use requirements the practice:

1. Uses an EHR that has been certified and issued a Certified HIT Products List (CHPL) Number under ONC HIT certification program\*
2. Attests to conducting a security risk analysis of its EHR and implementing security updates or resolving deficiencies\*

\*Core Meaningful Use Requirement

# PCMH 6G: Scoring and Documentation

- **0 Points**
- **Documentation**
  - F1: CHPL Number(s) entered in survey tool text box
  - F2: Entering “yes” in the survey tool is attestation to the appropriate security analysis and updates



# Review and Discuss

- **Survey Process and Policies**
- **Add-on Surveys**
- **Multi-site Surveys**
- **Upgrades and Renewals**
- **The Interactive Survey System**



# The NCQA PCMH Recognition Process

## Practice:

- **Obtains PCMH 2011 Standards**
- **Participates in NCQA trainings**
- **Obtains survey tool and online application account**
- **Self-assesses current performance on survey**
- **Completes online application information: electronic agreements, practice site, clinician details, and application for survey**
- **Submits application**
- **Receives email confirmation that practice can submit survey tool and documentation**
- **Submits survey tool and application fee when ready**

# Online Application System

## Practice can:

- **Electronically sign the PCMH program agreement and Business Associate Agreement (BAA)**
- **Enter practice site and clinician information**
- **See if you should submit as a group of linked surveys or proceed as individual practice sites**
- **Submit your application data and receive confirmation that you can submit your survey(s)**
- **Find instructions and other resources “inside”**

# Login to Begin the Application Process



Welcome to NCQA's PCMH Online Application Tool.

User Name:

Password:

[Forgot your password?](#)

Login

#### Announcements

- The PCMH 2011 Survey Tool is now available. [Click here](#) to order your PCMH 2011 Survey Tool today.
- PCMH 2011 materials have been released! [Click here](#) to see What's New, access the new information and materials, and to retrieve the PCMH 2011 Standards & Guidelines.
- If you already have an Online Application account for PPC-PCMH 2008 you need to purchase the PCMH 2011 Online Application if you would like to submit a PCMH 2011 application and survey tool. Your one account will not work for PCMH 2011 if you have just purchased a PPC-PCMH 2008 account.



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# Your Application Account

Choose to start a new application or continue working on a previous application

[New Single Site Application](#)

[New Multi-Site Application](#)

[Continue Working](#)

[NCQA Administration](#)

- [Access NCQA Recognition Program Website](#)
- [Access Resources and Training Information](#)

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**A single on-line application account is designed for multiple users within the same organization. From that account an organization can sign one program agreement and BAA for one or many sites, and list and submit applications for each site.**

# Overview of Recognition Review Process

## NCQA

- Checks licensure of all clinicians
- Evaluates Survey Tool responses, documentation, and explanations by
  - ✓ Reviewer – initial evaluation
  - ✓ Executive reviewer – NCQA PCMH managers
  - ✓ Peer review – Recognition Program Review Oversight Committee member (RP-ROC)
  - ✓ Audit (5%) – by email, teleconference, or on-site audit
- Issues final decision and level to the practice within 30 – 60 days
- Reports results
  - ✓ Recognition posted on NCQA Web site
  - ✓ Not passed - not reported
- Mails PCMH certificate and Recognition packet



# NCQA Recognition Directory

 <b>RECOGNITION DIRECTORY</b> <small>CLINICIAN SEARCH HOME</small>			
<b>Clinician Search Results</b> <a href="#">New Search</a> Search results: (1 - 50) of 1055			
Clinician	Address	Current Recognitions	Recognition Program(s)
		PPC-PCMH Level1 (07/03/2009 - 07/03/2012)	
		PPC-PCMH Level2 (01/13/2011 - 01/13/2014)	
		PPC-PCMH Level3 (07/23/2010 - 07/23/2013)	
		PPC-PCMH Level3 (10/22/2010 - 10/22/2013) DRP (09/14/2009 - 09/14/2012)	 

## Website Listing Includes:

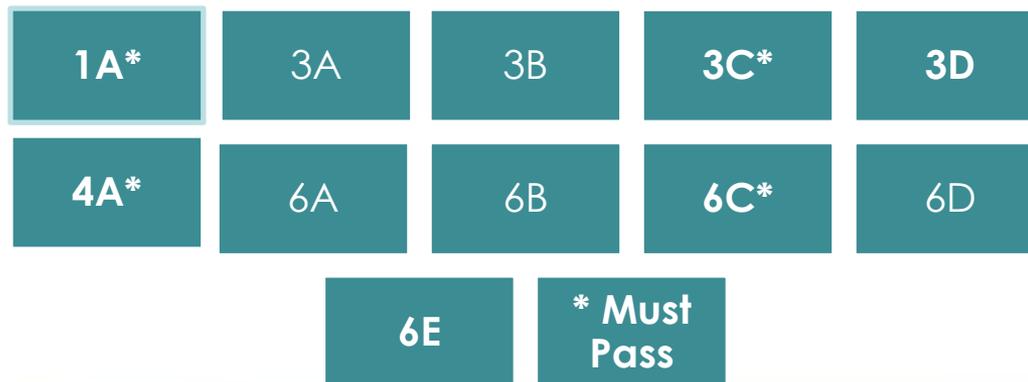
- ✓ Clinician name, title (MD, DO, NP, PA)
- ✓ Practice name and address
- ✓ Current Recognition
- ✓ Recognition Program

# Add-On Surveys

- **When will a practice utilize an add-on survey?**
  - Practices with Level 1 or 2 Recognition who want to increase their Level with additional documentation and scoring
  - Practice may submit an add-on survey anytime within the current Recognition period, application fee is discounted
- **Process**
  - Complete application information from your online application account
  - NCQA merges data from previous Survey Tool into new PCMH Survey Tool and makes available to practice
  - Practice may change response in any element with score of <100%; no need to reattach already submitted documents
  - Once completed, practice uploads new documents and submits survey and payment
- **New status based on**
  - Score achieved on saved scores and new assessment

# What Are Multi-Site Surveys?

- The multi-site application process is an option for organizations or medical practices that have 3 or more sites that share policies and procedures and electronic systems across all of their physician sites
- NCQA does not give organization-wide Recognition
- Multi-site surveys enable practices to **complete specified** PCMH assessments once for multiple practice sites
- Elements where responses and documentation are always required for each site:



# Multi-site Eligibility and Policies

- Requires electronic systems implemented at 3 or more practice sites for at least 3 months
- Application fees are determined by site along with a multi-site review fee and based on listed clinicians for each site
- Clinicians can be listed at multiple sites
- Not all sites need to be included
- All sites must be submitted within 12 months
- Practices may not combine sites for one Recognition survey

# Multi-Site Application Process

- Request assessment as an eligible multi-site through the online application system, complete eligibility questions and list practice sites
- Receive instructions, self-assessment element table, FAQs and fee calculator and scheduling for conference call
- Assigned manager reviews the Elements that may be submitted once in the group survey tool and the Elements that will require site specific responses in each of the practice site survey tools on the call
- Order form created following approval to purchase the required number of survey tools for the sites identified

# Multi-Site Survey Process

- Complete and submit multi-site applications and multi-site practice site information (in online system)
- Record survey tool license numbers in your online applications
- Complete and submit multi-site survey (corporate) tool when ready
- Complete and submit individual practice site survey tools within 12 months
- NCQA will merge the score of the multi-site survey with each site survey tool to determine the Recognition Level for each site



# Corporate Element Detail

TOOL | UTILITIES

POLICIES & PROCEDURES | STANDARDS & GUIDELINES | SURVEY TOOL | ORGANIZATION BACKGROUND | RESULTS | APPENDICES | GLOSSARY | INDEX

PRACTICE INFORMATION | **CORPORATE SURVEY TOOL** | RECOGNIZED CLINICIANS

## Corporate Survey Tool

**This section is only applicable to organizations submitting 3 or more site tools and a single corporate tool. Please do not complete this section if this survey tool pertains only to a single site.**

This list includes the 16 elements that are eligible for the Corporate Survey Tool. All other elements require responses in the site-specific survey tools. You must respond to at least 11 elements in the Corporate Survey Tool. Please designate which elements you will be responding to at the Corporate level.

NOTE: Do not respond to the designated elements in the site survey as this will cause loss of data.

- PCMH 1B: After-Hours Access
- PCMH 1C: Electronic Access
- PCMH 1D: Continuity
- PCMH 1E: Medical Home Responsibilities
- PCMH 1F: Culturally and Linguistically Appropriate Services (CLAS)
- PCMH 1G: The Practice Team
- PCMH 2A: Patient Information
- PCMH 2B: Clinical Data
- PCMH 2C: Comprehensive Health Assessment
- PCMH 2D: Use Data for Population Management
- PCMH 3E: Use Electronic Prescribing
- PCMH 4B: Provide Referrals to Community Resources
- PCMH 5A: Test Tracking and Follow-up
- PCMH 5B: Referral Tracking and Follow-up
- PCMH 5C: Coordinate with Facilities and Care Transitions
- PCMH 6F: Report Data Externally

# Upgrades and Renewals

*Streamlined process for upgrades or renewals  
with fewer documentation requirements*

## Upgrade: PPC-PCMH to PCMH 2011

- PCC-PCMH Level 2 or 3
- No extension of Recognition
- Practice must purchase and complete the entire survey
- Submit documentation for 12 designated elements\*
- Multi-sites – only site-level
- Add-on survey pricing

## Renewal : PPC-PCMH to PCMH 2011

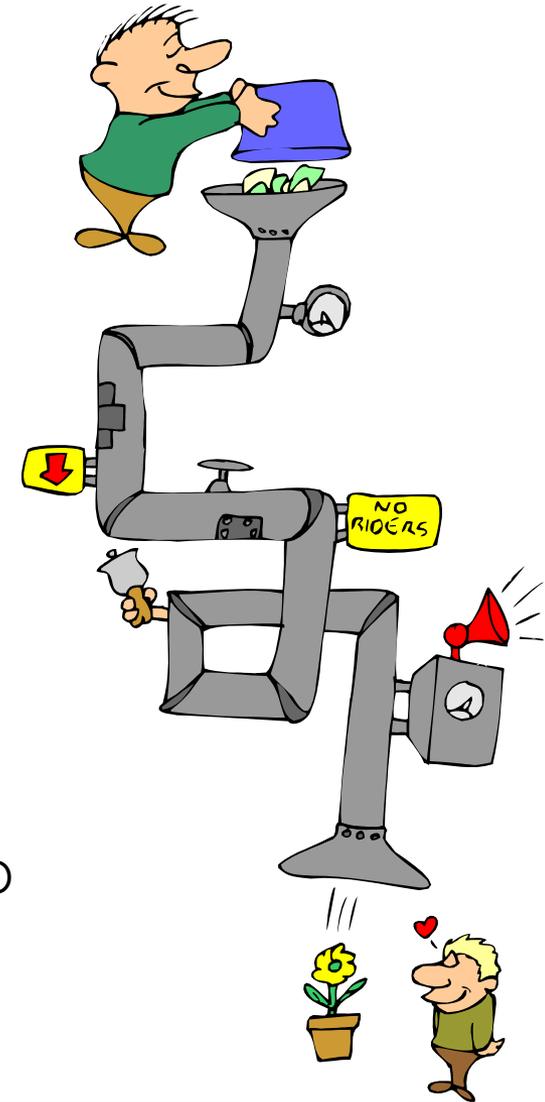
- PPC-PCMH Level 2 or 3
- Practice must purchase and complete the entire survey
- Submit documentation for 12 designated elements\*
- Multi-site process is followed
- Full survey pricing

\*12 Designated elements:

1C, 1G, 2C, 2D, 3A, 3B, 3C, 3D, 4A, 5C, 6A, 6C

# Renewal Requirements

- **Goal for PCMH 2011** to streamline documentation requirements for renewal submissions
- **Renewal Guidelines**
  - For practices Recognized at Level 2 or 3
  - Practice must always respond to all standards/elements
  - Practice only required to provide documentation for subset of elements (12)
    - PCMH 1C and PCMH 1G
    - PCMH 2C and PCMH 2D
    - PCMH 3A, PCMH 3B, PCMH 3C, and PCMH 3D
    - PCMH 4A
    - PCMH 5C
    - PCMH 6A (Factors 3 and 4) and PCMH 6C



# Review the Interactive Survey System Tool



# Using the Survey Tool

## Steps for the practice:

1. Organize supporting documentation
2. Purchase license to use Survey Tool
3. Get user ID and password from NCQA
4. View WebEx training
5. Enter responses
6. Attach documents
7. Review Results
8. Upload documents
9. Submit Survey Tool



# Organize Supporting Documents

1. Create a folder on the hard-drive for documents the practice MAY want to attach
2. Develop a checklist of documentation already used in the practice and documents that need to be prepared
3. Refer to printed standards and use to identify what the practice has and what needs to be created
4. Save a copy of the *Record Review Workbook* and *Quality Measurement and Improvement Worksheet*
5. NCQA advises a maximum of three (3) documents or fewer per element (*averaged – some require more, others just one*)
5. Consider putting multiple examples in one document for a single element, e.g. screenshots

# Manage the Documents

## Use a unique naming convention

- Use any organizing principle desired, for example:
  - PPC 1 A—Name of Document.doc
  - PPC 1 B—Name of Document.xls
- Avoid odd characters and punctuation in document name (e.g. quotation marks, question marks, commas, apostrophes, ampersands)
- Use the Element in the name, e.g. 1A Access and Communication Policy
  - Consider using document for all factors in an element, e.g. 1B Access and Communication Results
  - Use text boxes to identify important sections and briefly explain the importance
- If N/A is marked, explain the reason in Support Text/  
Notes Section

# Manage the Documents (cont.)

- Don't use the same name for **two different documents**
- Don't put the same document in two different places in the document library; instead, enter it once and link to multiple elements
- **Two ways to enter documents**
  - Add documents to the library directly and then link them to elements
  - Add documents from the survey tool as you enter responses and supporting text for an element



# Emails from NCQA

NCQA sends emails that give practice access to the **PPC-PCMH Survey Tool**

1. Acknowledge purchase of PCMH Survey Tool and Temporary User ID and Password
2. Provides Permanent User ID and Password

NCQA sends emails that give practice access to the **PCMH Application System**

1. Acknowledge (no charge) purchase of PCMH Application Materials
2. Provides User ID and Password

# NCQA Website: ISS Login Access to Survey Tool



Click here (same as link in NCQA email)

[Home](#) | [Contact Us](#) | [Site Map](#)

[Email Alerts](#) | [Print Page](#)

Programs

HEDIS & Quality  
Measurement

Report Cards

Public Policy

Publications & Products

Education & Events

Newsroom

Sponsors

About NCQA

Recognized PCMH  
Practices

**Patient-Centered Medical Home 2011**  
An Established Model of Care Coordination

Updated standards now available. [Click here](#) for more information.

ACCREDITATION    CERTIFICATION    RECOGNITION    **ISS LOGIN**



### 2012 Products Update Public Comment

Now Open for Public Comment: 2012 Accreditation and Certification Products Update.

From March 4 until 5 pm on April 1, 2011.

[Learn More](#) ->



### 2012 HEDIS Public Comment

Now Open for Public Comment: 2012 HEDIS Measures.

From February 22 until 5 pm on March 22, 2011.

[Learn More](#) ->

### NCQA Headlines

[>Visit Newsroom](#)

3.8.11

NCQA Consortium Awarded \$7.7 Million To Create Pediatric Quality Measures

3.7.11

Fourteen Software Vendors Receive NCQA'S Software Certification





# Link Documents and Enter Text of Explanation

- 9. e-mail address (or "none" for patients)
- 10. internal ID
- 11. external ID
- 12. emergency contact information
- 13. current and past diagnoses
- 14. dates of previous clinical visits
- 15. billing codes for services
- 16. legal guardian
- 17. health insurance coverage
- 18. patient/family preferred method of communication.

## Scoring:

100%	75%	50%	25%	0%
12-18 items were entered for 75-100% of patients	8-11 items were entered for 75-100% of patients	6-7 items were entered for 75-100% of patients	4-5 items were entered for 75-100% of patients	0-3 items were entered for 75-100% of patients

## Data Source:

Reports

## Scope of Review:

ONCE--NCQA scores this element once for the organization.

## Reference Information:

[Explanation](#) | [Examples](#)

Click here to link documents

Click here to enter explanatory text

- ELEMENT SCORE
- DOCUMENTS
- TEXT / NOTES AVAILABLE

# Enter RRWB Responses in Survey Tool

## ELEMENT C - Care Management

[View Points](#)

[Clear Data](#)

The care team performs the following for at least 75 percent of the patients identified in Elements A and B.

1. Conducts pre-visit preparations
2. Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit
3. Gives the patient/family a written plan of care
4. Assesses and addresses barriers when the patient has not met treatment goals
5. Gives the patient/family a clinical summary at each relevant visit
6. Identifies patients/families who might benefit from additional care management support
7. Follows up with patients/families who have not kept important appointments

Yes	No	Comments Needed
<input type="radio"/>	<input type="radio"/>	

**Enter responses  
From RRWB**

✓ **Yes or No**  
**AND**

✓ **Percent**

### Scoring:

100%	75%	50%	25%	0%
The practice meets 6-7 factors	The practice meets 5 factors	The practice meets 3-4 factors	The practice meets 1-2 factors	The practice meets no factors

### Data Source:

Scope of Review:

Reference Information:

[Explanation](#) | [Examples](#)

ELEMENT SCORE

DOCUMENTS

SUPPORT  
TEXT / NOTES

SUPPLEMENTAL  
WORKSHEET



# Example Text/Notes Entry

Support Text/Notes

Evaluation

Use this space to provide any additional explanation of the element evaluation.

5/14/2009 NCQA Reviewer Note:

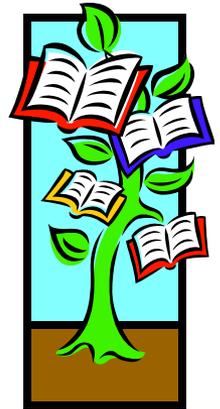
The practice responded "yes" to all factors and the reviewer agrees.

- 
1. See "Diagnosis Graph" for data on most commonly used diagnosis codes used in clinical encounters.
  2. See "CDC prevalence reports" for data on the prevalence of our three selected conditions within our State and local community.
  3. As part of a National PCMH Demonstration Project and in collaboration with NCQA, the Demonstration Project Stakeholders have chosen Diabetes, Hypertension and Hyperlipidemia as Clinically Important Conditions which represent the best likelihood of being amenable to care management and providing value on costs to the health care system based on regional experience. These conditions have associated required metrics which will be reported by the physician practices as part of the National PCMH Demonstration Project.

Edit

# Document Library

- **What is the Document Library?**
  - Location of documents practice will attach to Survey Tool and submit to NCQA
  - Useful tool in organizing documents to submit
- **Using the Document Library Overview**
  - Select documents that substantiate responses in Survey Tool elements (combine in one document, if possible)
  - Label the document to identify it with the element
  - Link to other elements, if possible
  - Add documents to Document Library
  - Documents will automatically upload (copy only) to NCQA



# Notification About Number of Documents in Document Library

Your document library has links to 121 document(s).

Your library currently has more than 100 documents\*. Any completed documents should be uploaded in small batches at your earliest convenience. The same is true of any completed documents you may add subsequently. Uploading large or large numbers of documents may take several hours -- early submission of completed documents will help you avoid missing your submission deadline. The ISS does allow users to delete and replace documents even after they have been uploaded should this prove necessary. Uploaded documents remain *inaccessible* to surveyors until you have submitted your Survey Tool.

- 1. Reminder to begin uploading documents in small batches**
- 2. Uploading large or large numbers of documents may take several hours**
- 3. Even after uploading, can still delete or replace documents**

**4. Reviewers cannot see documents until Survey Tool submitted**

# Example: List in Document Library

## Sorted by *Standard*

Sort by: [Document](#) | [Standard](#) | [Date Attached](#)

[ [Add Document to the Library](#) ]

Click to edit or unlink documents

Link New Document

PPC1A

Has the following documents linked to it:

PPC1 A,Access and Communication Document	<a href="#">Edit</a>	<a href="#">Unlink</a>
File Path: <a href="#">PPC 1 A 1, 2, 3, 4, 5, 6, 7, 8, 9.doc</a> Reference Pages: page 30   Relevance: Primary   DateAttached: 6/27/2008   StageAttached: 1		
PPC1, A,2	<a href="#">Edit</a>	<a href="#">Unlink</a>
File Path: <a href="#">PPC1,A,2b.jpg</a> Reference Pages: page 01   Relevance: Primary   DateAttached: 6/27/2008   StageAttached: 1		
PPC1,A, 2	<a href="#">Edit</a>	<a href="#">Unlink</a>
File Path: <a href="#">PPC1,A,2c.jpg</a> Reference Pages: page 01   Relevance: Secondary   DateAttached: 6/27/2008   StageAttached: 1		

# Results Review

POLICIES & PROCEDURES | STANDARDS & GUIDELINES | SURVEY TOOL | ORGANIZATION BACKGROUND | RESULTS | APPENDICES | GLOSSARY | INDEX

[Return to Results Index](#)

STATUS | SUMMARIZED & DETAILED RESULTS | MUST PASS RESULTS | CRITICAL FACTOR RESULTS | MEANINGFUL USE RESULTS

## 2011 Patient-Centered Medical Home

This section provides summary and detailed results and recommendations. Overall scoring results are available and at the category, Standard and element levels.

Based on information compiled during the recent review, We award the status listed below. Status descriptions can be found by clicking the Policies and Procedures tab.

### General Information

**Name:**  
**Status:** Not Available  
**Valid Dates:** Not Available  
**Standards Year:** 2011    **Score:** 1.00  
**Overall Score:** 1.00 out of 100.00  
**Unit Of Assessment:**

**RESULTS:**

- ✓ Summarized & Detailed
- ✓ Must Pass
- ✓ Critical Factors
- ✓ Meaningful Use

# Questions?



# NCQA Contact Information

## Contact NCQA Customer Support to:

- Acquire standards documents, application account, and survey tools
- Questions about your user ID, password, access
- 1-888-275-7585

## Visit NCQA Web Site to:

- View Frequently Asked Questions
- View Recognition Programs Training Schedule

## Submit to questions to [PCMH-GRIP@ncqa.org](mailto:PCMH-GRIP@ncqa.org)

Please use this e-mail box to:

- Ask about interpretation of standards or elements
- Request registration for ISS Survey Tool demonstration (WebEx)