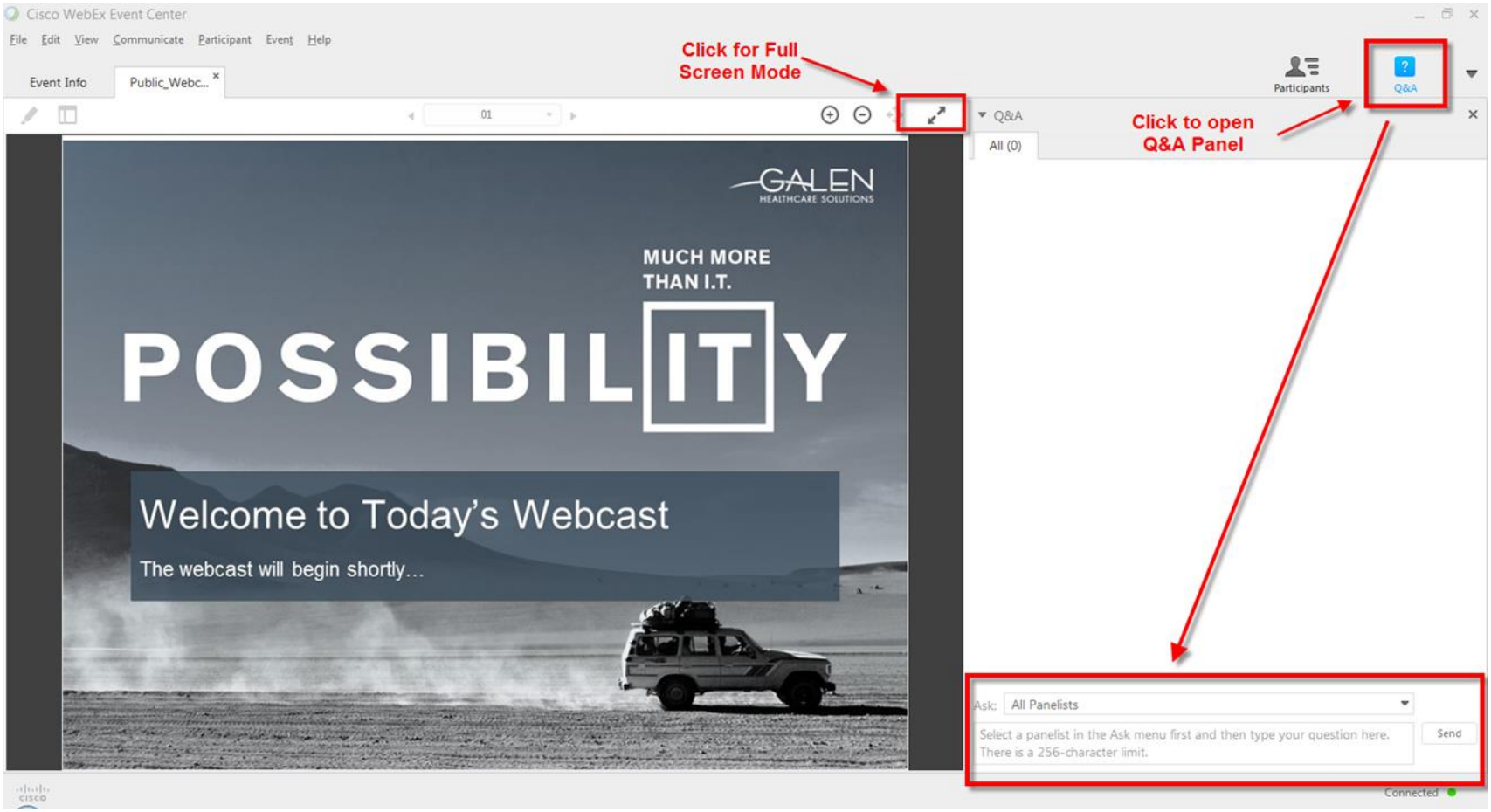
PCMH: PART 3
IDENTIFY AT RISK PATIENT POPULATIONS AND MAKE A DIFFERENCE IN PATIENT HEALTHCARE OUTCOMES

MAY 13, 2016

You have been automatically muted. Please use the Q&A panel to submit questions during the presentation



Presenter

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- Director, Clinical Transformation
- Over 10 years of Healthcare IT & Clinical Informatics experience
- Over 25 years of Nursing & Nurse Practitioner experience

Agenda

- PCMH Overview
- Standard 3- Population Health Management
- Standard 4- Care Management and Support
- Brief review of changes between 2011 and 2014 standards
- MU Alignment of Standards

This just in……MACRA

- MACRA- The Medicare Access and CHIP Reauthorization Act of 2015- WEDNESDAY, 4/27/16 ruling released
  - Changes payment for Medicare beneficiaries FFS program replacing sustainable growth rate (SGR) formula

- 2 Paths
  - MIPS
    - Quality (PQRS) (50%)
    - Advancing Care Information (MU) (25%)
    - Clinical Practice Improvement Activities (15%)
    - Resource Use Measures (VM) (10%)
  - APM'S
    - CPC Plus
    - ACO's (MSSP, Next Generation ACO Model)
    - Comprehensive End Stage Renal Disease Care Model
    - Oncology Care Program

What is PCMH?

- Patient Centered Medical Home
- Primary Care Program
- Emphasizes care coordination/management and team based care
- Triple aim

NCQA Roadmap – Download Standards

PCMH 2014 Content and Scoring (6 Standards/27 Elements)			
1. Patient Centered Access	10 Points	4. Care Management and Support	20 Points
A. *Patient-Centered Appointment Access	4.5	A. Identify Patients for Care Management	4
B. 24/7 Access to Clinical Advice	3.5	B. *Care Planning and Self-Care Support	4
C. Electronic Access	2	C. Medication Management	4
		D. Use Electronic Prescribing	3
		E. Implement Evidence- Based Decision Support	5
2. Team- Based Care	12 Points	5. Care Coordination and Care Transitions	18 Points
A. Continuity	3	A. Test Tracking and Follow Up	6
B. Medical Home Responsibilities	2.5	B. *Referral Tracking and Follow Up	6
C. Culturaly and Linguistically Appropriate Serices (CLAS)	2.5	C. Coordinate Care Transitions	6
D. *Practice Team	4		
3. Population Health Management	20 Points	6. Performance Measurement and Quality Improvement	20 Points
A. Patient Information	3	A. Measure Clinical Quality Performance	3
B. Clinical Data	4	B. Measure Resource Use and Care Coordination	3
C. Comprehensive Health Assessment	4	C. Measure Patient/Family Experience	4
D. *Use Data for Population Management	5	D. Implement Continous Quality Improvement	4
E. Implement Evidence-Based Decision Support	4	E. Demonstrate Continuous Quality Improvement	3
		F. Report Performance	3
		G. Use Certified EHR Technology	N/A

Scoring Levels
Level 1= 35-59 points
Level 2= 60-84 points
Level 3= 85-100 points

*** MUST PASS Elements**

PCMH 3: Population Health Management

20 POINTS

- **Element A**: Patient Information
- **Element B**: Clinical Data
- **Element C:** Comprehensive Health Assessment
- **Element D:** Use Data for Population Management
- **Element E:** Implement Evidence-Based Decision Support

Element 3A: Patient Information

1. Date of birth +
2. Sex +
3. Race +
4. Ethnicity +
5. Preferred language +
6. Telephone numbers
7. E-mail address
8. Occupation (NA for pediatric practices)
9. Dates of previous visits
10. Legal guardian/health care proxy
11. Primary caregiver
12. Presence of advance directive (NA for pediatric practices)
13. Health insurance information
14. Name and contact information of other health care professionals involved in patient's care

+ Stage 2 Core Meaningful Use Requirement

Meaningful Use Alignment
3A-Patient Information

NCQA Requirements	Modified Stage 2 Ruling	NCQA Response
1.Date of birth 2. Sex 3. Race 4. Ethnicity 5.Preferred Language	Removed as MU Measure	NCQA maintaining requirement

Element 3A: Scoring

3.0 points

- 10-14 factors = 100%
- 8-9 factors = 75 %
- 5-7 factors = 50 %
- 3-4 factors = 25 %
- 0-2 factors = 0%

Element 3A Factor 1-14: Documentation

PCMH 3A1-13

- **Report**
  - 3 months (recent data)
  - Numerator
  - Denominator

PCMH 3A14

- **Process/Policy**
  - Date
  - Practice Name
  - Define process for capturing data
- **Example**
  - 3 examples

Element 3A3-5: Sample Report

- Considerations
  - Practice/Site level
  - Modified ruling- are reports still available

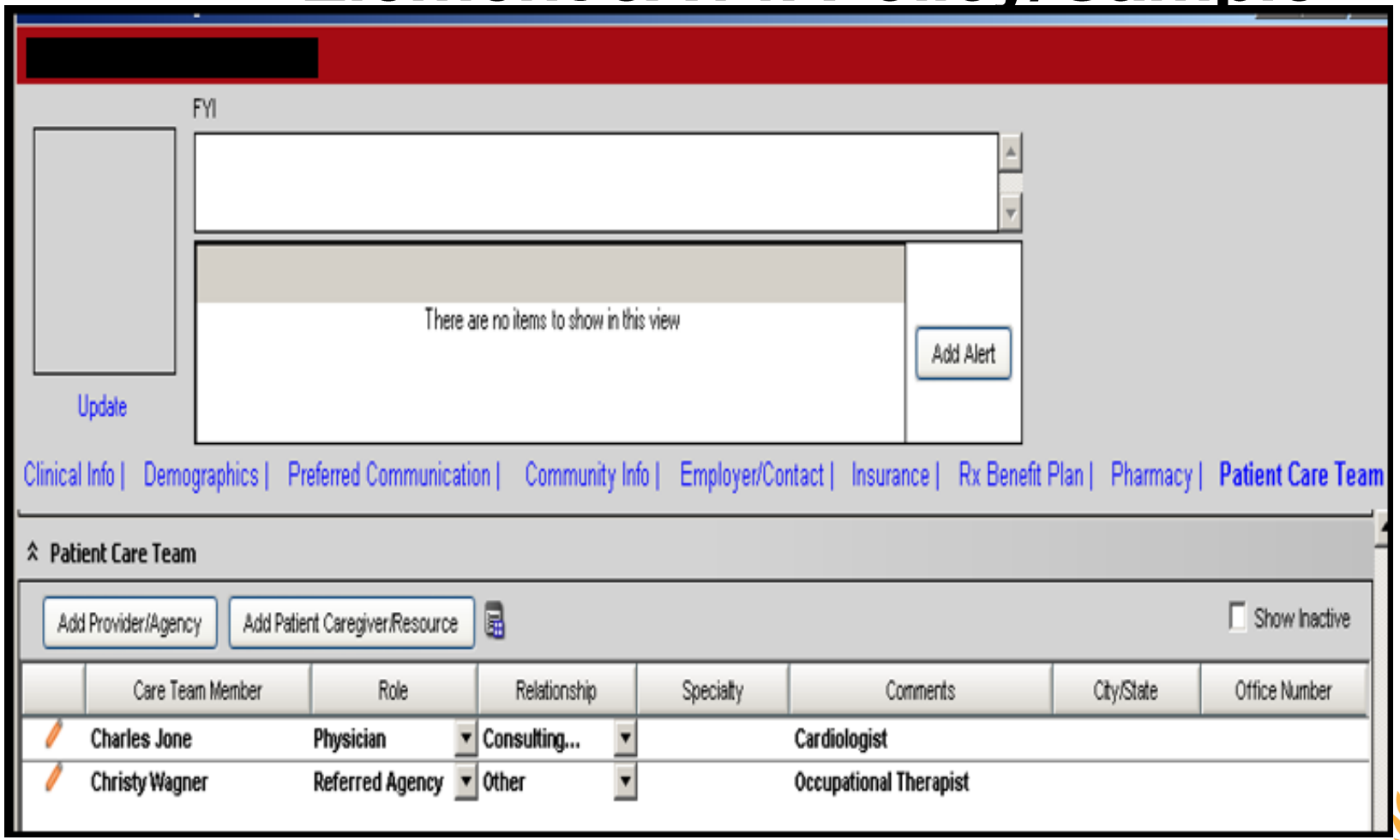
Record Demographics- Race, Language, Ethnicity						
1/1/16-4/30/16						
Practice/Site	Measure	Goal	NumeratorCount	DenominatorCount	ExcludedCount	Score
Practice Site A	7 - Record demographics	50%	1454	1522	0	95.53%
Practice Site B	7 - Record demographics	50%	3255	3400	0	95.74%
Practice Site C	7 - Record demographics	50%	4445	4635	0	95.90%

Element 3A1-7, 9-13: Sample Report

- PCMH 3A, Items 1-7, 9-13 - % of patients with documented items recorded as searchable data within the practice's EMR (denominator shown in first column)
- Report covers 3 months of data January 4, 2014 - March 4, 2014

	Total Patient Count	DOB	Gender	Race	Ethnicity	Lang	Phone #	Email	Dates of Previous Visits	Legal Guardian	Primary Caregiver	Adv Dir	Insur Info
# of PTS	9904	9904	9904	9409	9409	9895	9748	3500	9904	NA	NA	NA	9541
%		100%	100%	95%	95%	100%	98%	35%	100%	NA	NA	NA	96%
Correct Factor Responses		Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No	No	Yes

Element 3A14: Policy/Sample



Policy: Intake Process: PCMH 3A14

Element 3B: Clinical Data

1. An up-to-date problem list with current and active diagnoses for more than 80 % of patients. **+++**
2. Allergies, including medication allergies and adverse reactions * for more than 80 % of patients. **+++**
3. Blood pressure, with the date of update for more than 80 % of patients 3 years and older. **+**
4. Height/length for more than 80 % of patients. **+**
5. Weight for more than 80 % of patients. **+**
6. System calculates and displays BMI. **+**
7. System plots and displays growth charts (length/height, weight and head circumference) and BMI percentile (0-20years) (NA for adult practices). **+**
8. Status of tobacco use for patients 13 years and older for more than 80 % of patients. **+**
9. List of prescription medications with date of updates for more than 80% of patients.
10. More than 20 % of patients have family history recorded as structured data. **++**
11. At least one electronic progress note created, edited and signed by an eligible professional for more than 30 % of patients with at least one office visit. **++**

+ Stage 2 Core MU Requirement
++ Stage 2 Menu MU Requirement
+++ CMS MU Requirement

Meaningful Use Alignment
3B-Clinical Data

NCQA Requirements	Modified Stage 2 Ruling	NCQA Response
Factors 1-10 • Problem List • Allergies/Medications • Blood Pressure • Height/Weight • BMI • Growth Charts • Smoking Status • Family History	Removed as MU Measure	NCQA maintaining requirement
Factor 11 At least one Electronic Progress Note created, edited, and signed by the EP for more than 30% of patients.	Removed as MU Measure	NCQA maintaining requirement however will accept example of capability in lieu of report

Element 3B: Scoring

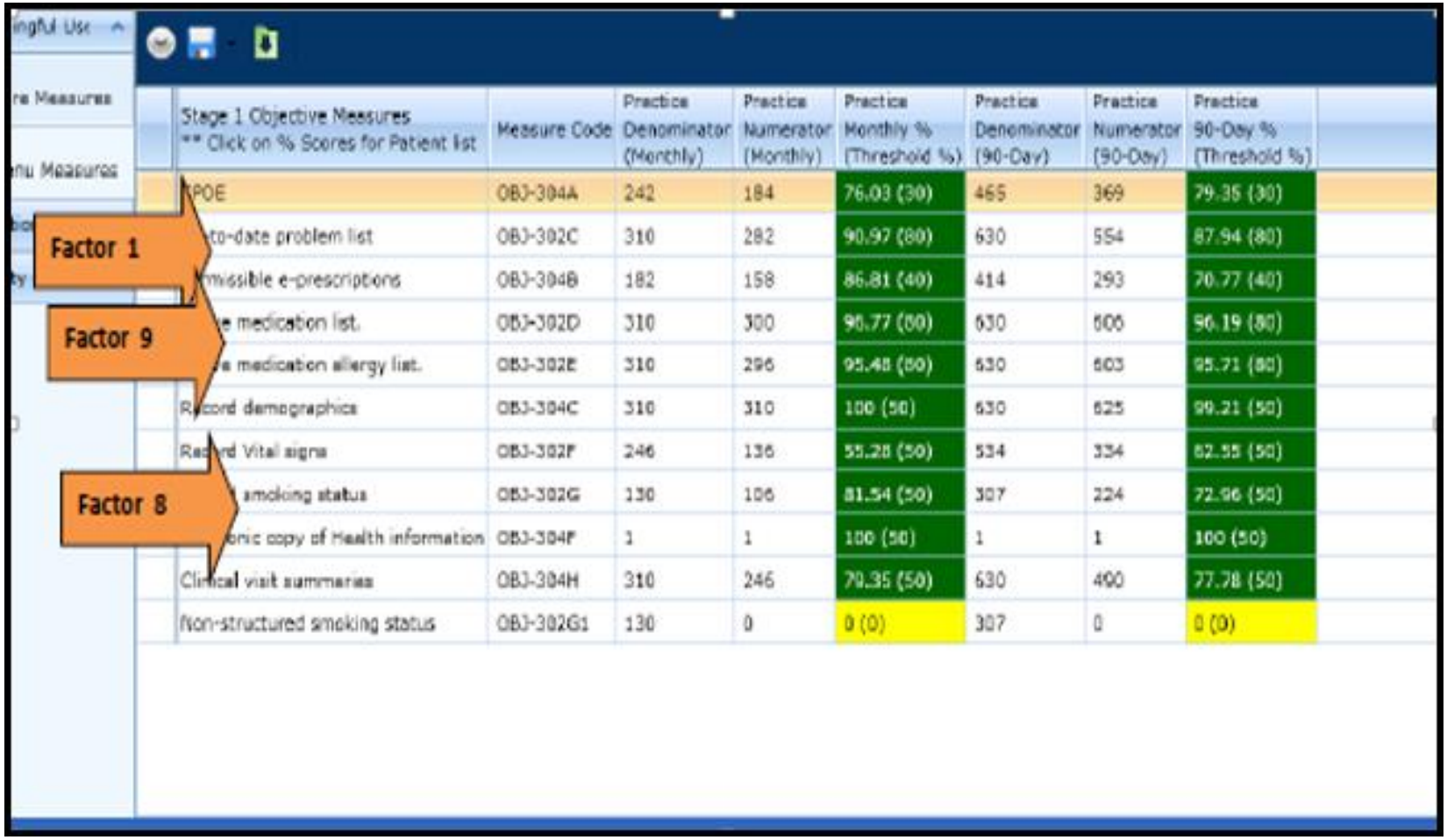
4.0 points

- 10-14 factors = 100%
- 8-9 factors = 75 %
- 5-7 factors = 50 %
- 3-4 factors = 25 %
- 0-2 factors = 0%

Element 3B: Documentation

- **PCMH 3B1-5, 8-11 Report**
  - 3 months of recent data
  - Numerator
  - Denominator
- **PCMH 3B6 and 7**
  - Screen shot examples
- ***PCMH 11**
  - Show capability- MU modified ruling

PCMH 3B1, 8, 9: Sample Report



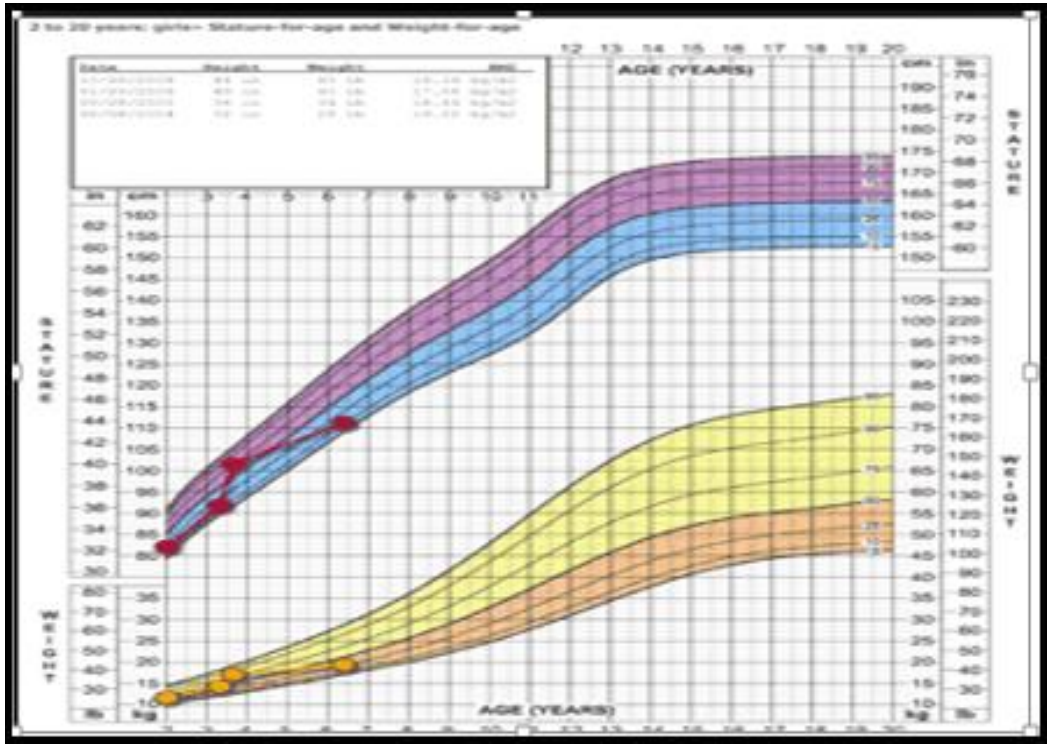
Stage 1 Objective Measures ** Click on % Scores for Patient list	Measure Code	Practice Denominator (Monthly)	Practice Numerator (Monthly)	Practice Monthly % (Threshold %)	Practice Denominator (90-Day)	Practice Numerator (90-Day)	Practice 90-Day % (Threshold %)
CPOE	OBJ-304A	242	184	76.03 (30)	465	369	79.35 (30)
to-date problem list	OBJ-302C	310	282	90.97 (80)	630	554	87.94 (80)
missible e-prescriptions	OBJ-304B	182	158	86.81 (40)	414	293	70.77 (40)
e medication list.	OBJ-302D	310	300	96.77 (80)	630	606	96.19 (80)
e medication allergy list.	OBJ-302E	310	296	95.48 (80)	630	603	95.71 (80)
Record demographics	OBJ-304C	310	310	100 (50)	630	625	99.21 (50)
Record Vital signs	OBJ-302F	246	136	55.28 (50)	534	334	62.55 (50)
smoking status	OBJ-302G	130	106	81.54 (50)	307	224	72.96 (50)
onic copy of Health information	OBJ-304F	1	1	100 (50)	1	1	100 (50)
Clinical visit summaries	OBJ-304H	310	246	79.35 (50)	630	490	77.78 (50)
Non-structured smoking status	OBJ-302G1	130	0	0 (0)	307	0	0 (0)

PCMH 3B6-7: Sample Screen Shots

VitalSigns/Findings

Data Includes: All

Item Name	Select	08 Apr 2016 12:08 PM
Systolic	☐	100 , LUE
Diastolic	☐	64 , LUE
Temperature	☐	98 F , Oral
Heart Rate	☐	68 , L Radial
Respiration	☐	16
Respiration Quality	☐	Normal
Height	☐	5 ft 1 in
2-20 Stature Percentile	☐	39 %
Weight	☐	110 lb
2-20 Weight Percentile	☐	64 %
BMI Calculated	☐	20.78kg/m2
BMI Percentile	☐	77 %
BSA Calculated	☐	1.47m2



Element 3C: Comprehensive Health Assessment

1. Age and gender appropriate immunizations and screenings.
2. Family/social/cultural characteristics.
3. Communication needs.
4. Medical history of patient and family
5. Advance care planning. (NA for pediatric practices)
6. Behaviors affecting health.
7. Mental health/substance use history of patient and family.
8. Developmental screening using a standardized tool (NA for adult practices)
9. Depression screening for adults and adolescents using a standardized tool.
10. Assessment of health literacy.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3

Element 3C: Scoring

4.0 points

- 8-10 factors = 100%
- 6-7 factors = 75%
- 4-5 factors = 50%
- 2-3 factors = 25%
- 0-2 factors = 0%

Element 3C: Documentation

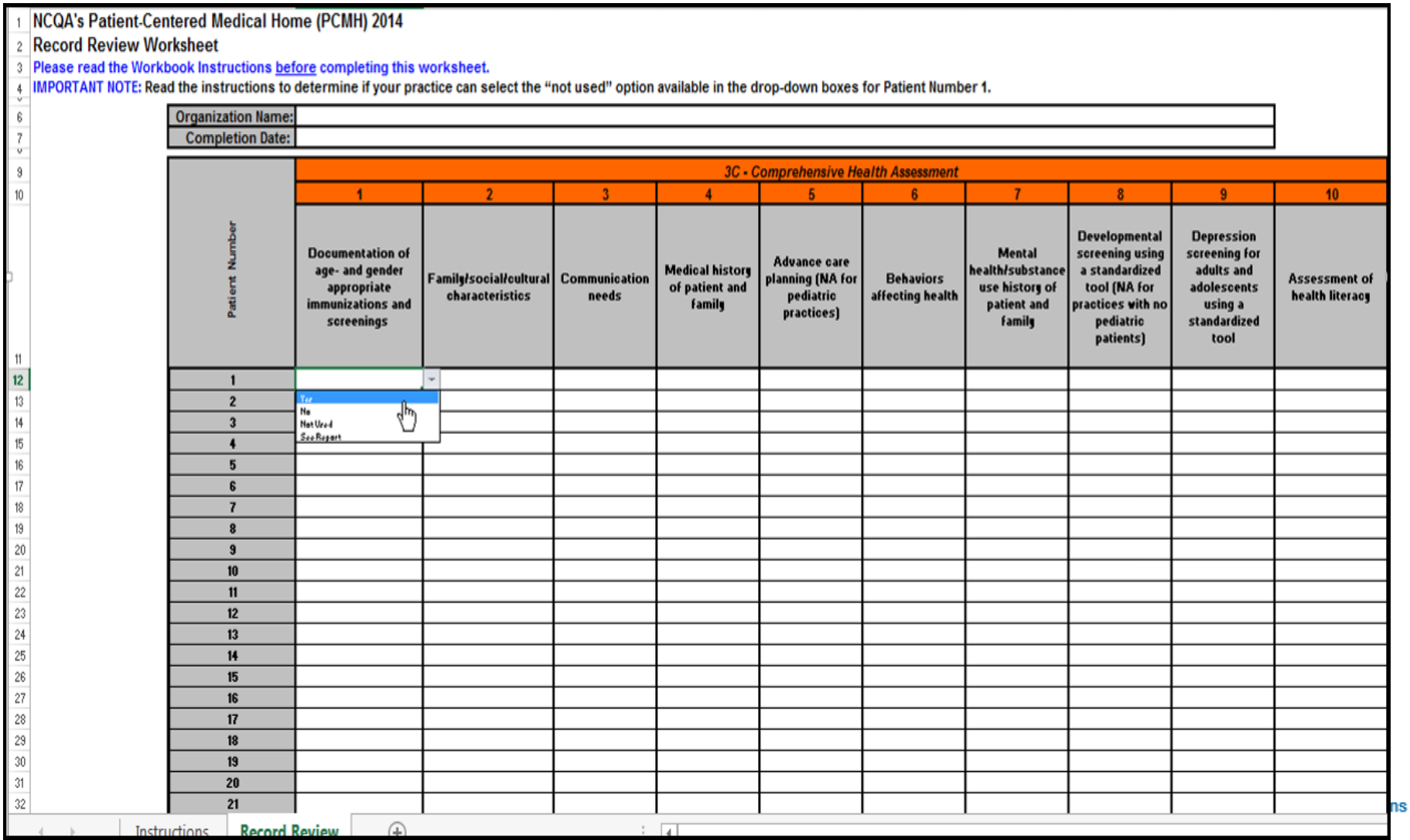
- **PCMH 3C1-10 Report**
  - 3 months of recent data
  - Numerator
  - Denominator

  OR

  - Record Review Workbook

- **PCMH 3C8-9**
  - Completed form (de-identified) demonstrating use of standardized tool

PCMH 3C: Record Review Workbook



NCQA's Patient-Centered Medical Home (PCMH) 2014

Record Review Worksheet

Please read the Workbook Instructions before completing this worksheet.

IMPORTANT NOTE: Read the instructions to determine if your practice can select the "not used" option available in the drop-down boxes for Patient Number 1.

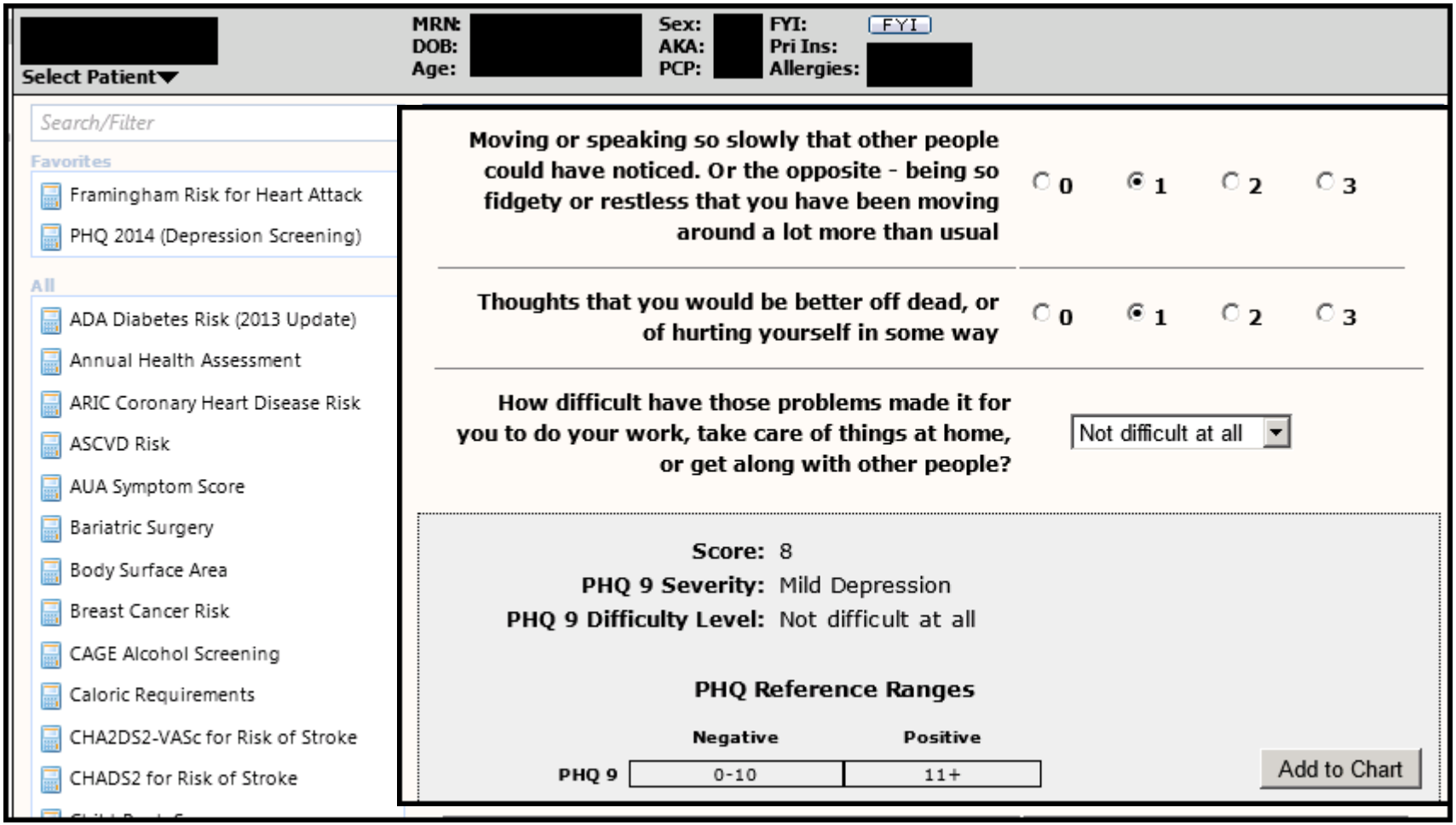
Organization Name:	
Completion Date:	

	3C - Comprehensive Health Assessment									
	1	2	3	4	5	6	7	8	9	10
Patient Number	Documentation of age- and gender appropriate immunizations and screenings	Family/social/cultural characteristics	Communication needs	Medical history of patient and family	Advance care planning (NA for pediatric practices)	Behaviors affecting health	Mental health/substance use history of patient and family	Developmental screening using a standardized tool (NA for practices with no pediatric patients)	Depression screening for adults and adolescents using a standardized tool	Assessment of health literacy
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										

Yes
No
Not Used
See Report

Instructions | Record Review

PCMH 3C9: Sample De-Identified Data



Element 3D: Use Data for Population Management

MUST PASS

1. At least two different preventive care services. +
2. At least two different immunizations +
3. At least three different chronic or acute care services. +
4. Patient not recently seen by the practice
5. Medication monitoring or alert.

+ Stage 2 Core Meaningful Use Requirement

Meaningful Use Alignment
3D-Use of Data for Population Management

NCQA Requirements	Modified Stage 2 Ruling	NCQA Response
Factor 1: At least two different preventive care services	Removed as MU Measure	NCQA maintaining requirement
Factor 2: At least two different immunizations	Removed as MU Measure	NCQA maintaining requirement
Factor 3: At least three different chronic or acute care services	Removed as MU Measure	NCQA maintaining requirement

Element 3D: Scoring

5.0 points

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

Must meet at 2 factors to pass this Must-Pass Element

Element 3D1-5: Documentation

- **Reports or lists** of patients needing services
  - Past 12 months
  - Health plan data okay if 75% of patient population

AND

- **Materials** showing how patients were notified for each service

PCMH3D3: Report Sample

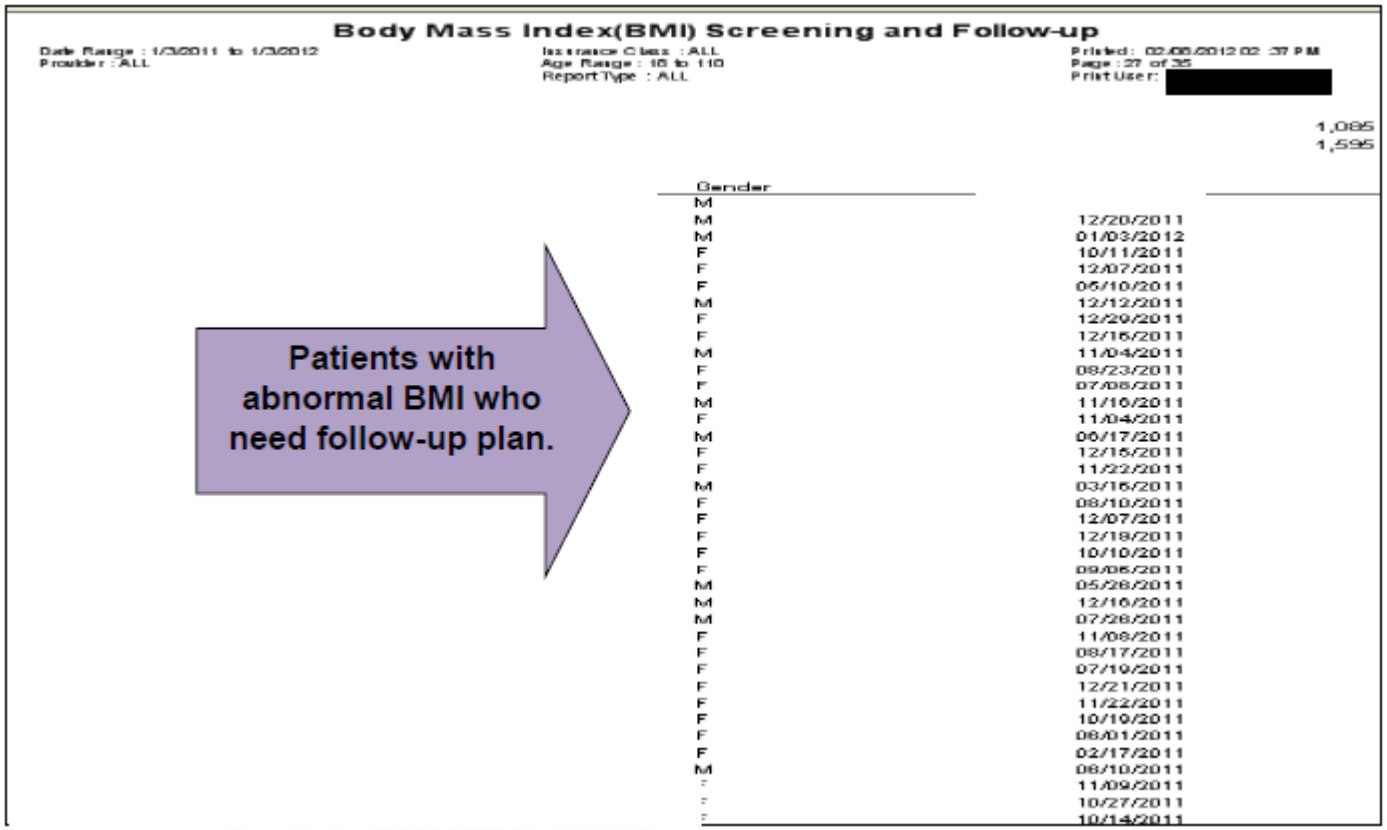
GALEN HEALTHCARE SOLUTIONS

Diabetic Patients- Type 2 Overdue for HgbA1C and Appointment

Report Date 4/30/14-4/30/15

encounterGroup	encounterLocation	billingProvider	billingProviderNpi	patientMrn	patient	patientDOB	lastEncounter	HbA1cTestName	lastHbA1cDate	lastHbA1c
Group A	Group A Primary Care ()	[redacted]					6/23/2015	HEMOGLOBIN A1C	6/26/2015	5.70%
Group A	Group A Primary Care ()						6/2/2015	N/A	N/A	N/A
Group A	Group A Primary Care ()						6/22/2015	HEMOGLOBIN A1C	6/22/2015	6.30%
Group A	Group A Primary Care ()						5/27/2015	HEMOGLOBIN A1C	5/27/2015	10.90%
Group A	Group A Primary Care ()						7/21/2015	Hemoglobin A1C	4/30/2015	6.70%
Group A	Group A Primary Care ()						7/10/2015	HEMOGLOBIN A1C	7/6/2015	6.70%
Group A	Group A Primary Care ()						6/29/2015	HEMOGLOBIN A1C	12/30/2014	8.20%
Group A	Group A Primary Care ()						6/22/2015	HEMOGLOBIN A1C	11/19/2014	5.50%
Group A	Group A Primary Care ()						5/11/2015	HEMOGLOBIN A1C	2/16/2015	7.90%
Group A	Group A Primary Care ()						7/16/2015	HEMOGLOBIN A1C	7/16/2015	9.70%
Group A	Group A Primary Care ()						5/27/2015	HEMOGLOBIN A1C	5/27/2015	7.50%
Group A	Group A Primary Care ()						7/27/2015	HEMOGLOBIN A1C	7/13/2015	6.10%
Group A	Group A Primary Care ()						7/13/2015	HEMOGLOBIN A1C	7/13/2015	6.10%
Group A	Group A Primary Care ()						5/20/2015	HEMOGLOBIN A1C	4/1/2015	7.30%
Group B	Group B South Primary Care (						7/15/2015	HEMOGLOBIN A1C	12/20/2012	6.40%
Group B	Group B South Primary Care (						7/1/2015	HEMOGLOBIN A1C	6/26/2015	6.00%
Group B	Group B South Primary Care (						6/23/2015	Hemoglobin A1C Fing	6/24/2015	6.90%
Group B	Group B South Primary Care (						6/30/2015	HEMOGLOBIN A1C	6/25/2015	6.00%
Group B	Group B South Primary Care (						7/16/2015	Hemoglobin A1C	2/19/2015	6.80%
Group B	Group B South Primary Care (						7/13/2015	HEMOGLOBIN A1C	3/19/2015	7.60%
Group B	Group B South Primary Care (						6/26/2015	HEMOGLOBIN A1C	5/27/2015	7.90%
Group B	Group B South Primary Care (						5/29/2015	HEMOGLOBIN A1C	3/27/2015	8.10%
Group B	Group B South Primary Care (						7/13/2015	HEMOGLOBIN A1C	7/13/2015	10.50%

PCMH3D3: Report Sample



Body Mass Index(BMI) Screening and Follow-up

Date Range : 1/3/2011 to 1/3/2012
Provider : ALL

Insurance Class : ALL
Age Range : 18 to 110
Report Type : ALL

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Page : 27 of 35
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1,085
1,595

Patients with abnormal BMI who need follow-up plan.

Gender	
M	
M	12/20/2011
M	01/03/2012
F	10/11/2011
F	12/07/2011
F	06/10/2011
M	12/12/2011
F	12/29/2011
F	12/16/2011
M	11/04/2011
F	08/23/2011
F	07/08/2011
M	11/16/2011
F	11/04/2011
M	06/17/2011
F	12/16/2011
F	11/22/2011
M	03/15/2011
F	08/10/2011
F	12/07/2011
F	12/18/2011
F	10/10/2011
F	09/06/2011
M	05/28/2011
M	12/16/2011
M	07/28/2011
F	11/08/2011
F	08/17/2011
F	07/19/2011
F	12/21/2011
F	11/22/2011
F	10/19/2011
F	08/01/2011
F	02/17/2011
M	08/10/2011
:	11/09/2011
:	10/27/2011
:	10/14/2011

PCMH3D3: Letter Reach Out Sample

Dear Patient,

[redacted] is committed to all your health care needs. In reviewing your chart, we have noticed that you have an elevated BMI(Body Mass Index). Having an elevated BMI can potentially lead to health problems such as hypertension or diabetes are just a few. Please schedule an appointment with provider so it can be discussed in depth what is BMI, how it is calculated and how to decrease this. Thanking you in advance with helping us make sure all your health care needs are addressed.

Respectfully,

Nursing Department

Element 3E: Implement Evidence-Based Decision Support

CRITICAL FACTOR

1. A mental health or substance use disorder. +
2. A chronic medical condition. +
3. An acute condition. +
4. A condition related to unhealthy behaviors. +
5. Well child or adult care. +
6. Overuse/appropriateness issues. +

BEST IN KLAS 2015/2016

+ Stage 2 Core Meaningful Use Requirement

Element 3E: Scoring

4.0 points

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

Element 3E1-6: Documentation

Provide:

- Conditions identified by the practice for factor

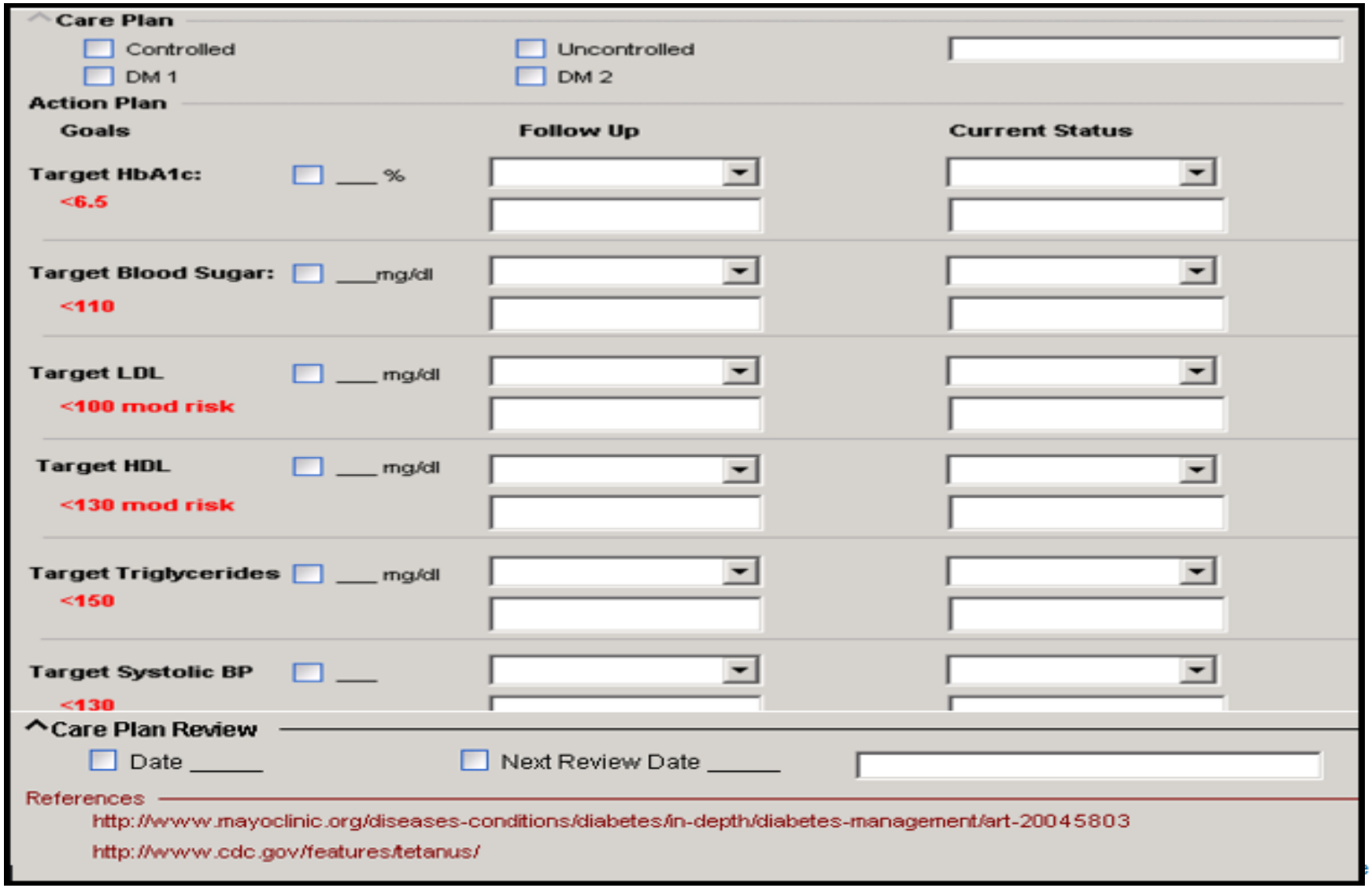
AND

- Source of guidelines

AND

- Examples of guideline implementation

PCMH 3E2 Documentation



PCMH 4: Care Management and Support

20 POINTS

- **Element A**: Identify Patients for Care Management
- **Element B**: Care Planning and Self-Care Support
- **Element C:** Medication Management
- **Element D:** Use Electronic Prescribing
- **Element E:** Support Self-Care and Shared Decision Making

Element 4A: Identify Patient for Care Management

CRITICAL FACTOR

1. Behavioral health conditions
2. High cost/high utilization
3. Poorly controlled or complex conditions
4. Social determinants of health
5. Referrals by outside organizations
6. Practice monitors the percentage of the total population identified through its process and criteria

Element 4A: Scoring

4.0 points

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

Element 4A: Documentation

PCMH 4A1-5

- Policy/Process
- Date
- Practice Name
- Criteria for identifying patients for Factors 1-5

PCMH 4A6

- Report
  - Numerator=Unique patient identified to benefit from care management based on Factors 1-5
  - Denominator=Total Patient Population

Element 4A1-3: Sample Documentation

Policy: Family Practice Medical Group- Care Management Program
Effective Date: 2/1/14, Revised 1/15/15, 1/30/16

Care Management Program:

Policy: Family Practice Medical Group will provide care management services to those patients that require additional monitoring and services beyond standard adult and pediatric populations. The following criteria are considered "medically complex patients"

- Greater than 2 Emergency Visits within 1 year
- Patients with 3 or more active problems listed in their chart **Factor 2**
- Patients who see 2 or more specialists

Patients identified via the above criteria will be referred to the care management team and have a Care Management referral order placed as well as a care plan implemented by their primary care provider.

In addition, the following patient criteria will be referred to the care management team and have a care plan implemented.

- Patients currently taking ADHD medication **Factor 1**
- CAGE screening result >2
- Patients with uncontrolled diabetes HgBA1C >9 and a diagnosis of hyperlipidemia **Factor 3**

Element 4A6: Sample Report

Care Management Report: Run Date 1/8/16	
7/1/15-12/31/15	
Greater than 2 ED Visits/1 year	
Unique Patients >2 ED visits	855
Total Patient Population	7038
Total Percent	**12.15%**
CAGE screening result >2	
Unique Patients >2 on CAGE screening	89
Total Patient Population	7038
Total Percent	1.26%
HgbA1C>9 and Dx (272.x/E78.x)	
Unique Patients with HgBA1C>9 and Dx	2,407
Total Patient Population	7038
Total Patient Population	34.20%

Element 4B: Care Planning and Self-Care Support

MUST PASS

1. Incorporates patient preferences and functional/lifestyle goals
2. Identifies treatment goals
3. Assesses and addresses potential barriers to meeting goals
4. Includes a self management plan
5. Is provided in writing to the patient/family/caregiver

Element 4B: Scoring

4.0 points

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

Must meet at 3 factors to pass this Must-Pass Element

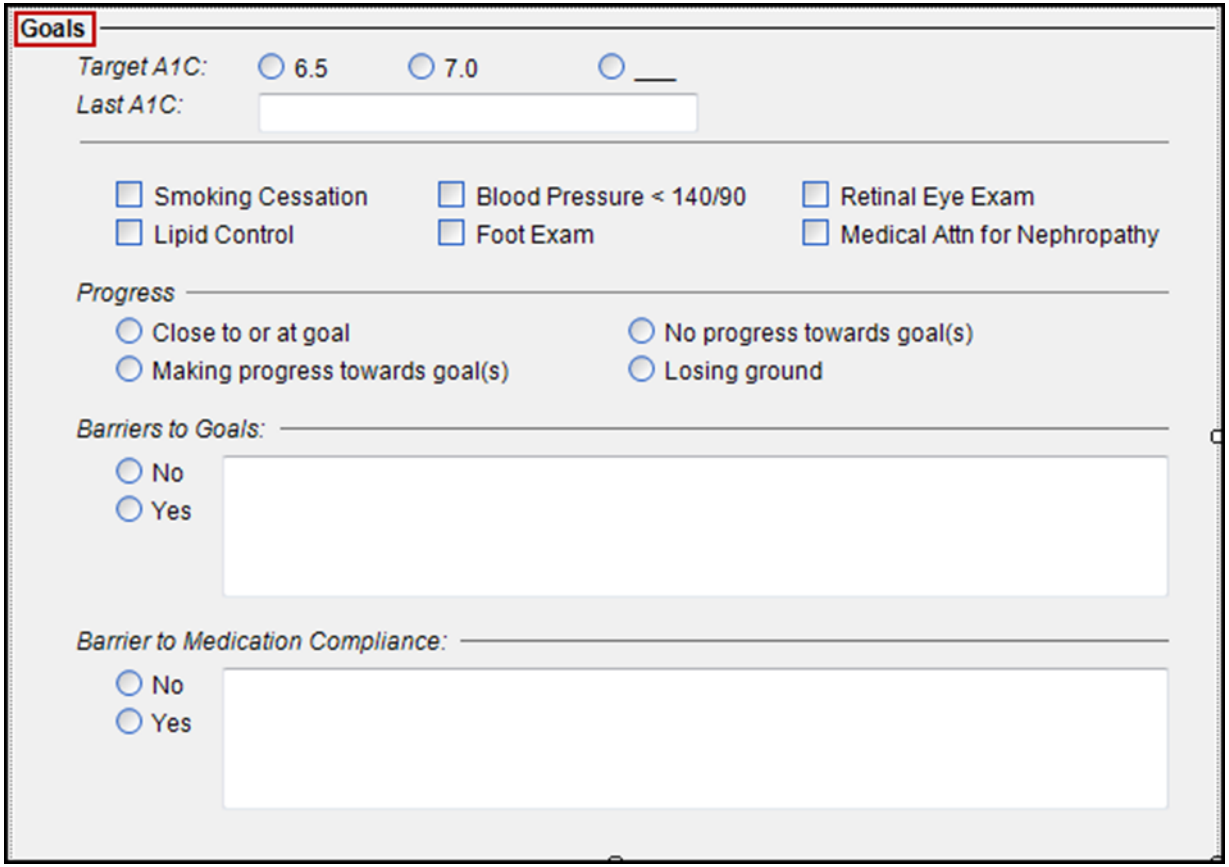
Element 4B: Documentation

- **PCMH 4B1-5 Report**
  - Numerator
  - Denominator

OR

- Record Review Workbook

Element 4B: Care Plan Sample



Element 4B: Record Review Workbook

4B -Care Planning and Self-Care Support				
1	2	3	4	5
Incorporates patient preferences and functional/lifestyle goals	Identifies treatment goals	Assesses and addresses potential barriers to meeting goals	Includes self-management plan	Is provided in writing to patient/family/ caregiver

Element 4C: Medication Management

CRITICAL FACTOR

1. Reviews and reconciles medications for more than 50% of patients received from care transitions+
2. Reviews and reconciles medications with patients/families for more then 80% of care transitions.
3. Provides information about new prescriptions to more than 80% of patients/families.
4. Assesses understanding of medications for more than 50% of patients/families/caregivers, and dates the assessment.
5. Assesses response to medications and barriers to adherence for more than 50% of patients and dates the assessment.
6. Documents over-the-counter medications, herbal therapies, and supplements for more than 50% of patients and dates updates

+ Stage 2 Core Meaningful Use Requirement

Element 4C: Scoring

4.0 points

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

Element 4C: Documentation

- **PCMH 4C1-6 Report**
  - Numerator
  - Denominator

OR

- Record Review Workbook

Element 4C: Record Review Workbook

4C - Medication Management					
1	2	3	4	5	6
Reviews and reconciles medications for more than 50 percent of patients received from care transitions.	Reviews and reconciles medications with patients/families for more than 80 percent of care transitions.	Provides information about new prescriptions to patients/families	Assesses patient/family understanding of medications for patients with date of assessment	Assesses patient response to medications and barriers to adherence for patients with date of assessment	Documents over-the-counter medications, herbal therapies and supplements for patients/families, with the date of updates

Element 4D: Use Electronic Prescribing

1. More than 50% of eligible prescriptions written by the practice are compared to drug formularies and electronically sent to pharmacies.+
2. Enters electronic medication orders in the medical record for more than 60% of medications.+
3. Performs patient-specific checks for drug-drug and drug-allergy interactions.+
4. Alerts prescribers to generic alternatives

+ Stage 2 Core Meaningful Use Requirement

Element 4D: Scoring

3.0 points

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

Element 4D: Documentation

- **PCMH 4D1-2 Report**
  - Numerator
  - Denominator
  - 3 months

AND

- **PCMH 4D1, 3, 4- Screen Shots**
  - Formulary Decision- Support mechanism
  - Drug-Drug, Drug- Allergy
  - System alert for generic, cost-effective

Element 4D: Sample Report

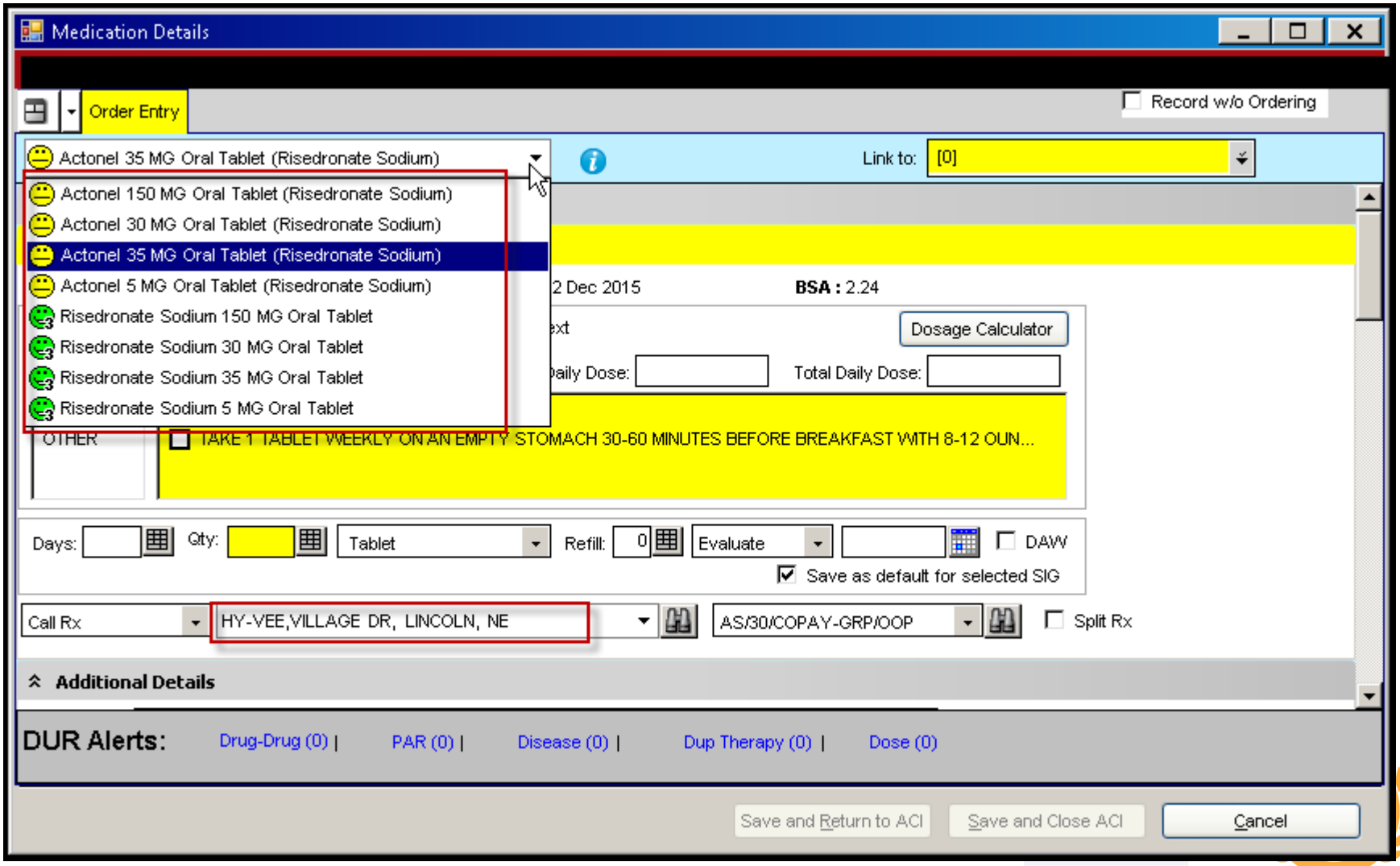
- **PCMH 4D1-2 Report**
  - Numerator
  - Denominator

Reporting Period 1/1/16-3/31/16

obj4			
Electronic Prescribing			
Num	Den	Excl	Score
1,613	1,784	100	90.41%
397	421	100	94.30%
2,434	2,713	100	89.72%
3,756	4,008	100	93.71%

obj3.1			
CPOE Medication			
Num	Den	Excl	Score
2,339	2,381	100	98.24%
479	492	100	97.36%
3,771	3,904	100	96.59%
4,884	4,946	100	98.75%

Element 4D: Sample Screen Shot



Element 4E: Support Self-Care and Shared Decision Making

1. Use an EHR to identify patient-specific education resources and provide them to more than 10% of patients.+
2. Provides educational materials and resources to patients.
3. Provides self-management tools to record self-care results.
4. Adopts shared decision making aids.
5. Offers or refers patients to structured health education programs such as groups classes and peer support.
6. Maintains a current resource list on 5 topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates.
7. Assesses usefulness of identified community resources.

+ Stage 2 Core Meaningful Use Requirement

Element 4E: Scoring

5.0 points

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

Element 4E: Documentation

- **PCMH 4E1 Report**
  - Numerator
  - Denominator

- **PCMH 4E2-5- Screen Shots**
  - 3 examples for each factor

- **PCMH 4E6-7- Materials**
  - Demonstrating practice offers 5 resources
  - Survey or materials how practice collects feedback

Element 4E: Samples

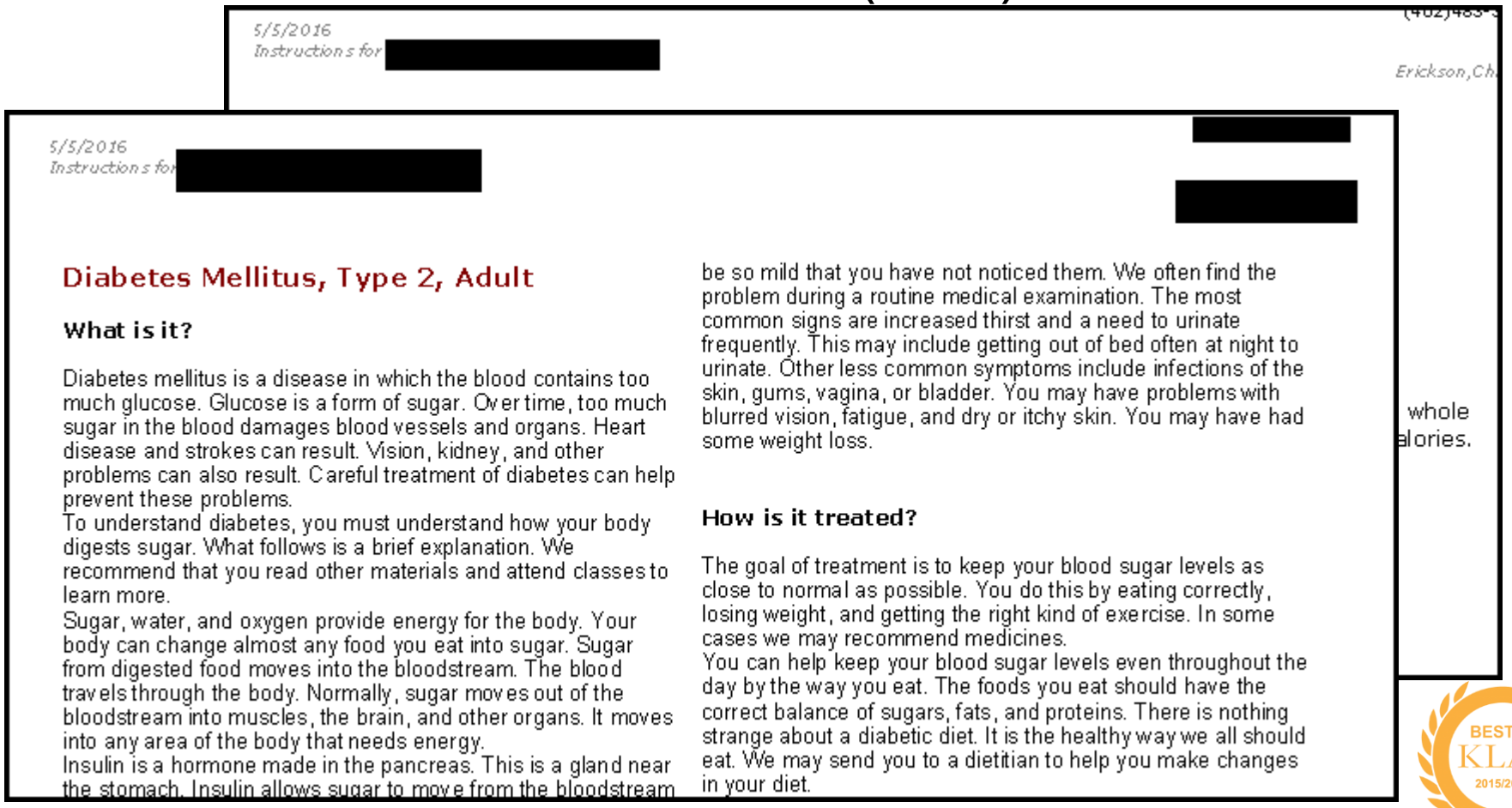
4E1- MU report

Reporting Period: 1/1/16-3/31/16

obj6			
Patient Specific Education			
Num	Den	Excl	Score
191	712	0	26.83%
94	421	0	22.33%
95	784	0	12.12%
233	1,017	0	22.91%

Element 4E: Samples

4E2- Educational resources (EHR)



5/5/2016
Instructions for [redacted]

Erickson,Ch

5/5/2016
Instructions for [redacted]

Diabetes Mellitus, Type 2, Adult

What is it?

Diabetes mellitus is a disease in which the blood contains too much glucose. Glucose is a form of sugar. Over time, too much sugar in the blood damages blood vessels and organs. Heart disease and strokes can result. Vision, kidney, and other problems can also result. Careful treatment of diabetes can help prevent these problems.

To understand diabetes, you must understand how your body digests sugar. What follows is a brief explanation. We recommend that you read other materials and attend classes to learn more.

Sugar, water, and oxygen provide energy for the body. Your body can change almost any food you eat into sugar. Sugar from digested food moves into the bloodstream. The blood travels through the body. Normally, sugar moves out of the bloodstream into muscles, the brain, and other organs. It moves into any area of the body that needs energy.

Insulin is a hormone made in the pancreas. This is a gland near the stomach. Insulin allows sugar to move from the bloodstream

be so mild that you have not noticed them. We often find the problem during a routine medical examination. The most common signs are increased thirst and a need to urinate frequently. This may include getting out of bed often at night to urinate. Other less common symptoms include infections of the skin, gums, vagina, or bladder. You may have problems with blurred vision, fatigue, and dry or itchy skin. You may have had some weight loss.

How is it treated?

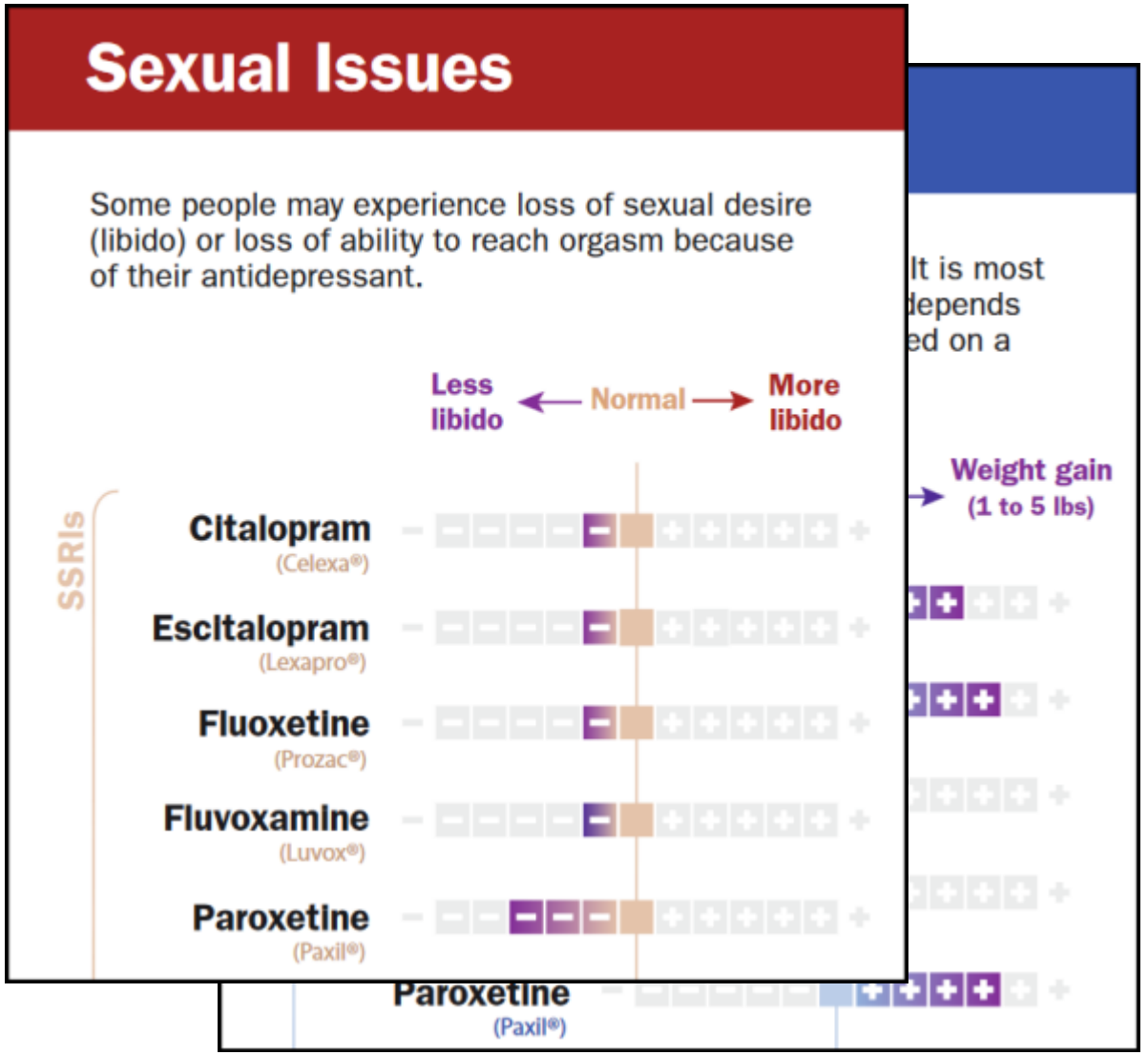
The goal of treatment is to keep your blood sugar levels as close to normal as possible. You do this by eating correctly, losing weight, and getting the right kind of exercise. In some cases we may recommend medicines.

You can help keep your blood sugar levels even throughout the day by the way you eat. The foods you eat should have the correct balance of sugars, fats, and proteins. There is nothing strange about a diabetic diet. It is the healthy way we all should eat. We may send you to a dietitian to help you make changes in your diet.

whole
alories.

Element 4E: Samples

4E4- Shared decision support http://shareddecisions.mayoclinic.org/



Cross Walk 2011-2014

http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/pcmh-2011-pcmh-2014-crosswalk

Standard 3

- 3A10-Legal guardian/health care proxy
- 3A14-Name and contact information of other health care professionals involved in patient's care
- 3B-increase thresholds on existing
- 3B10-More than 20 percent of patients have family history recorded as structured data++
- 3B11-At least one electronic progress note created, edited and signed by an eligible professional
- for more than 30 percent of patients with at least one office visit++
- 3C10- Assessment of health literacy
- 3D2-At least two different immunizations
- 3E1- A mental health or substance use disorder
- 3E2- A chronic medical condition
- 3E3.-An acute condition
- 3E5-Well child or adult care
- 3E6-Overuse/appropriateness issues

Cross Walk 2011-2014

http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/pcmh-2011-pcmh-2014-crosswalk

Standard 4

- 4A1- Behavioral health conditions
- 4A2- High cost/high utilization
- 4A3- Poorly controlled or complex conditions
- 4A4- Social determinants of health
- 4A5- Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver
- 4A6. The practice monitors the percentage of the total patient population identified through its process and criteria
- 4B1- Incorporates patient preferences and functional/lifestyle goals
- 4B4- Includes a self-management plan
- 4D- Increase thresholds
- 4E4- Adopts shared decision making aids
- 4E5- Offers or refers patients to structured health education programs such as group classes and peer support
- 4E6- Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates
- 4E7- Assesses usefulness

Next Steps- Tips/Tricks

- **Gap Analysis/Audit**

- **Identify areas requiring work**
  - Process/Policy
  - Organizational change
  - Reports, Samples

- **Focus on areas that are quick wins first**

GALEN HEALTHCARE SOLUTIONS

Gap Analysis Sample

PCMH 1: Patient-Centered Access

Element	Factor	Factor Present?	Policy/ Process	Report Timeframe	Report Met	Report Available? (Y/N) Source?	Additional Notes
ELEMENT A: Patient- Centered Appointment Access [MUST PASS]	The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:						
	1. Providing same-day appointments for routine and urgent care.	0.75	X	5 days	Yes		Consecutive days when practice is open
	2. Providing routine and urgent-care appointments outside regular business hours.	0.75	X	5 days	Yes		
	3. Providing alternative types of clinical encounters.	0	X	30 days	No		Consecutive days
	4. Availbility of appointments.	0.75	X	5 days	Yes		
	5. Monitoring no-show rates.	0.75	X	30 days	Yes		
	6. Acting on identified opportunities to improve access.	0.75	X	1 opp.to improve, 1 action taken	Yes		a completed PCMH Quality Measurement and Improvement Worksheet
	Total Possible Points for PCMH 1A:	4.5				*Action Plan 1A:*	
	Total # of Points Received for PCMH 1A:	3.75					
	% Points Received for PCMH 1A:	75%					
	MUST PASS Element - Passed at 50% Level? 2 or more factors plus including factor 1	Yes					
JT B: linical Advice	The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:						
	1.Continuity of medical record information for care and advice when the office is closed	0.875	X	N/A	Yes		
	2. Timely clinical advice by telephone	0.875	X	7 days	Yes		Consecutive days

Gap Analysis Sample

Factor								
	Date (>3 mo <12 mo)	Practice Name	Defines Routine	Time requirements	Defines Urgent	Time requirements	Triage urgency	Comments
PCMH 1A1: Providing same-day appointments for routine and urgent care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	Date (>3 mo <12 mo)	Practice Name	Outside of 8-5pm (M-F)	Contracted with outside providers*				
PCMH 1A2: Providing routine and urgent-care appointments outside regular business hours.	Yes	Yes	Yes	Yes				
	Date (>3 mo <12 mo)	Practice Name	Define Alternative Encounters					
PCMH 1A3: Providing alternative types of clinical encounters.	Yes	Yes	Yes					
	Date (>3 mo <12 mo)	Practice Name	Define Appt. Availability	Define monitoring of appt availability				
PCMH 1A4: Availability of Appointments	Yes	Yes	Yes	Yes				
	Date (>3 mo <12 mo)	0.312	Define No Show Rate Monitoring					
PCMH 1A5: Monitoring of Scheduled Visits	Yes	Yes	Yes					

References

http://store.ncqa.org/index.php/recognition/patient-centered-medical-home-pcmh.html

http://www.ncqa.org/Portals/0/Programs/Recognition/PCMH/8.%20PCMH%20Recognition%202014_Appendix%206_Summary%20of%20Updates%20to%20PCMH%202014%2003.28.2016%20FINAL.pdf?ver=2016-04-01-142019-047

http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/pcmh-2011-pcmh-2014-crosswalk

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