WACMHC

Washington Association of Community & Migrant Health Centers

Putting PCMH into Practice: A Transformation Series

Knowing and Managing Your Patients (KM)

June 13, 2018

WEBINAR FACILITATOR

Hannah Stanfield
NCQA PCMH CCE
Practice Transformation Coordinator
WACMHC

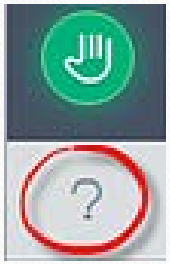
FEATURED PRESENTER

Karen Taubert
RN, BSN, MBA, NCQA PCMH CCE

Senior Consultant
Qualis Health

HOUSEKEEPING

- Your lines are currently muted
- We'll address questions at the end of the presentation
- You can ask a question in the following ways:



RAISE YOUR HAND FUNCTION - your line will be unmuted and you can ask the question verbally

QUESTIONS FUNCTION – type your question in the box and the facilitator will read it aloud

- This webinar is being recorded. A recording will be sent to you in a follow-up email.

Knowing and Managing Your Patients Pre-Work Questions

Using Data for Population Management:

- How does your practice routinely collect comprehensive data on patients to understand the background and health risks of patients?
- Do you use this information on the population to implement needed interventions, tools and supports for the practice as a whole and for specific individuals?

Culturally Competent Care:

- How is data used to meet the needs of a diverse patient population by understanding the population's unique characteristics and language needs?

Using Data for Proactive Outreach:

- Does your practice use data to proactively address the care needs of the patient population to ensure needs are met?

Provision of Evidence-Based Care:

- Is evidence-based care embedded in the practice by use of evidence-based guidelines for key populations?
- How does the electronic health record (or other systems) provide decision-support for provision of evidence-based care?

Connection with Community Resources:

- How does your practice use information (data) on the population served to prioritize needed community resources?

2017 NCQA PCMH Standard 2: Knowing and Managing Your Patients (KM)

Advancing Healthcare
Improving Health

Objectives

1. Identify data sources that provide information on your population, enabling your practice to tailor services specific to meet population health needs
2. Evaluate methods to address cultural competency and diversity within your practice
3. Consider ways to establish connections to community resources based on patients' expressed top needs and concerns

6

Think About How Your Practice is Structured

- Using Data for Population Management
- Culturally Competent Care
- Using Data for Proactive Outreach
- Provision of Evidence-Based Care
- Connection with Community Resources

- Details about meeting these requirements: social functioning and social determinants of health in KM 02
- KM17 – process for assessing and documenting response to meds,
- KM12 – establishing a process for using data for proactive reminders

Change Concepts for Practice

Figure 1: The Chronic Care Model

Developed by The MacColl Center ® ACP-ASIM Journals and Book

CORE CONCEPT

The practice routinely collects comprehensive data on patients to understand background and health risks of patients. The practice uses information on the population to implement needed interventions, tools, and supports for the practice as a whole and for specific individuals.

KM Documented Processes

- KM 02 Core - a process for collecting health assessment data
- KM 03 Elective - a process for depression screening
- KM 04 Elective - a process for behavioral health screenings
- KM 05 Elective - a process for oral health assessment and referral for care
- KM 25 Elective – a process for maintaining partnerships with social service organizations or schools
- KM 28 Elective – a process for holding case conferences

Knowing and Managing Your Patients (KM)

- The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.
- 6 Competencies
- 28 Criteria

Competency A Core Criteria

- KM 01 Problem Lists
- KM 02 Comprehensive Health Assessment
- KM 03 Depression Screening
- All the above align with PCMH 2014 3B and 3C

Competency A Has Five Elective Criteria – All New

- **KM 04 Behavioral Health Screenings (1 Credit)**
- **KM 05 Oral Health Assessment and Services (1 Credit)**
- **KM 06 Predominant Conditions and Concerns (1 Credit)**
- **KM 07 Social Determinants of Health (2 Credits)**
- **KM 08 Patient Materials (1 Credit)**

Competency A - KM 01 (Core)
Up-to-date Problem List

- Up-to-date means that the most recent diagnoses are added to the problem list. ***Aligns with PCMH 2014 3B1.***
- Evidence = Report showing patients with updated problem list at least annually ***or*** **KM06 list of top priority conditions and concerns. Example: may use a report of top ICD 10 codes.**

Competency A - KM 01 (Core) Up-to-date Problem List

Question: Can a practice show a sampling of up-to-date problem lists by provider? Please describe the parameters for this report.

NCQA's Answer: The intent of core criterion KM 01 is for practices to understand how many patients have problem lists documented in the medical record to ensure that this key information is documented in patient records systematically and can enable optimal patient care and resource management. This criterion does require a report that generates a percentage of patients with this information documented in their patient record, but the report does not have to be generated electronically. If a practice is unable to generate a report electronically, it may use its own audit sampling methodology to determine the frequency of documenting an up-to-date problem list in patient medical records.

An up-to-date problem list with current and active diagnoses for more than 80 percent of patients.

All of the factors (1-5, 8-10) will be represented by screenshots of the reporting period 10/1/16 – 12/31/16. Factors 3B 6, 7, and 11 are completed via autocredit.

Factor 3B:1 was reported to be collected for 87.57% of the patients seen during the time reported.

Customer: Arch Health Partners

NEXTGEN HEALTHCARE

Measure Summary Report

Evaluation Date : 3/7/2017		Problem List Core
Measure Start Date: 10/1/2016	Measure End Date: 12/31/2016	More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient, recorded as structured data
Arch Health Partners		87.57 % (29719 / 33938)
Arch Health Partners	Abel AuD, Debra | NPI: 1073519955	100 % (2/2)
	Acheatel MD, Roger | NPI: 1730182619	51.84 % (183/353)
	Arbabi MD, Nasrin | NPI: 1881655462	95.18 % (494/519)
	Badkoobehi MD, Hedieh | NPI: 1689708695	98.1 % (103/105)
	Balikian MD, Philip | NPI: 1407803687	98.61 % (640/649)
	Barba MD, Daniel | NPI: 1407128580	81.1 % (734/905)
	Barmack NP, Kimberly | NPI: 1881018067	75 % (3/4)
	Bayat MD, Hamed | NPI: 1356344196	91.5 % (377/412)
	Blando MD, Ellen | NPI: 1396711644	97.76 % (568/581)
	Boyle FNPC, Victoria | NPI: 1467483685	100 % (123/123)
	Bried MD, James | NPI: 1891809257	57.92 % (406/701)

Competency A Criteria - KM 02 (Core) Comprehensive Health Assessment

- A comprehensive patient assessment includes an examination of the patient's social and behavioral influences in addition to a physical health assessment.
- ***The practice uses evidence-based guidelines*** to determine how frequently the health assessments are completed and updated.

Competency A - KM 02 (Core)
Comprehensive Health Assessment

- All items required – Aligns with PCMH 2014 3B
- F and G are new
- Evidence = Documented process (to upload) ***AND*** evidence of implementation, consider this for Virtual Review!

Competency A - KM 02 (Core) Comprehensive Health Assessment

A. Medical history of patient and family.	B. Mental health/substance use history of patient and family.	C. Family/social/cultural characteristics.
D. Communication needs.	E. Behaviors affecting health.	**F. Social functioning. (NEW)**
G. Social determinants of health. (NEW) https://www.healthypeople.gov/	H. Developmental screening using a standardized tool. (NA for practices with no pediatric population under 30 months of age.)	I. Advance care planning. (NA for pediatric practices.)

Competency A Criteria - KM 02

Question: Can you provide an example of a social functioning assessment?

NCQA's response: For social functioning, the practice must assess and document an individual's ability to interact with others, to maintain relationships with friends or perform work. Several scales for the evaluation of social functioning are available (e.g., SFQ, SASS, GAF), however, NCQA doesn't require practices to utilize a standardized evaluation tool. Practices do not need to limit the evaluation to specific questions and should have a process to document any assessments and observations about social functioning that they may have. Questions to the patient/family/caregiver could include asking about a patient's social life or if they have anxiety in social situations. For pediatric patients, questions could also be directed to the family or caregiver to ask about how the patient interacts with others at school, during extracurricular activities or at home with siblings or family members.

KM02 – Frequency of Assessment

Question: What is the required frequency of the required assessment items for this criteria?

NCQA's Response: For this criteria the requirement states all items are required, however not all items are assessed for every population, at every age or at every visit. The frequency of the assessment is determined by the practices, and/or based on the evidence-based guidelines utilized by the practice. For practices who do not see pediatrics, they may respond NA for KM02-H. For practices who see pediatrics only, they may respond NA for KM02-I.

Knowing and Managing Your Patients

KM 02: Example

Initial Assessment:

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

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

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

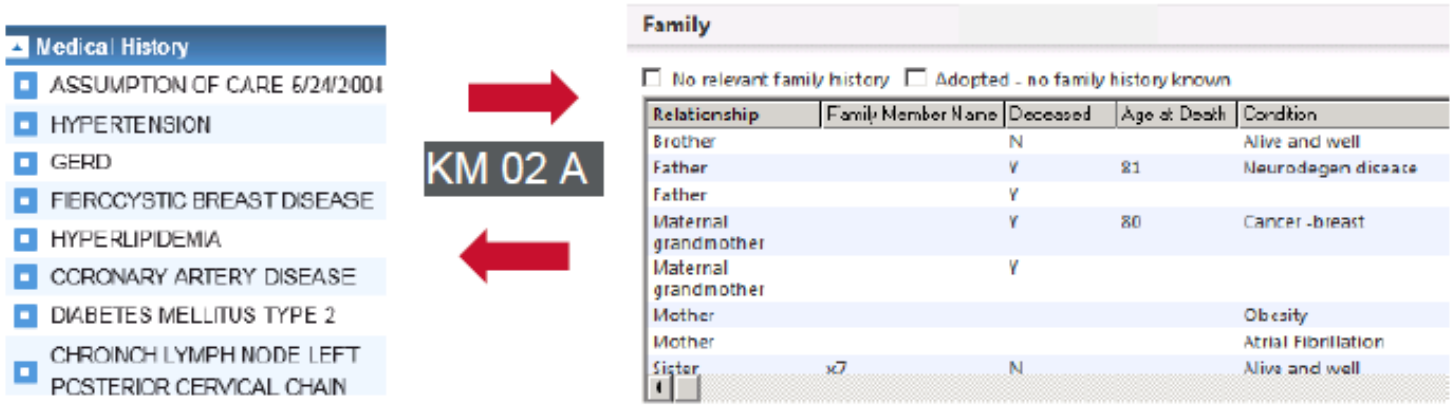
If the patient responds in the affirmative to either of the depression screening questions, the health assistant will administer a full PHQ. Patients who answer that they have any degree of suicidal ideation will be further evaluated by behavioral health using a structured self-harm assessment.

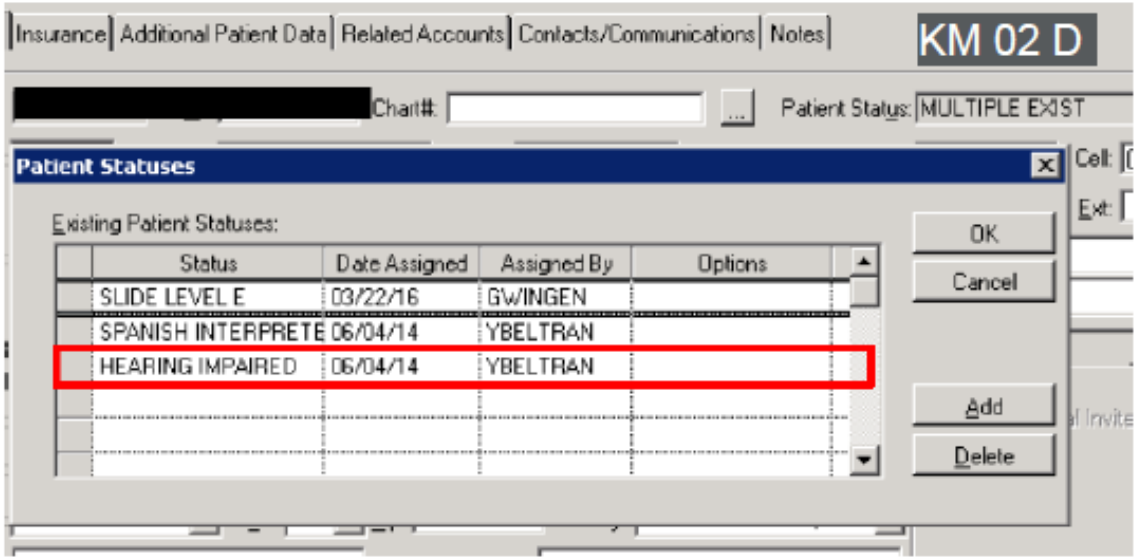
All of these assessments are repeated by the health assistants at every visit as a part of the routine vital signs.

Knowing and Managing Your Patients

KM 02 A&D: Example

Virtual Review





Competency A – KM 03 (Core) Depression Screenings for Adults and Adolescents

- **Screening for adults:** Screening adults for depression with systems in place to ensure accurate diagnosis, effective treatment and follow-up.
- **Screening for adolescents (12–18 years):** Screening adolescents for depression with systems in place to ensure accurate diagnosis, effective treatment and follow-up.
- Aligns with PCMH 2014 3C

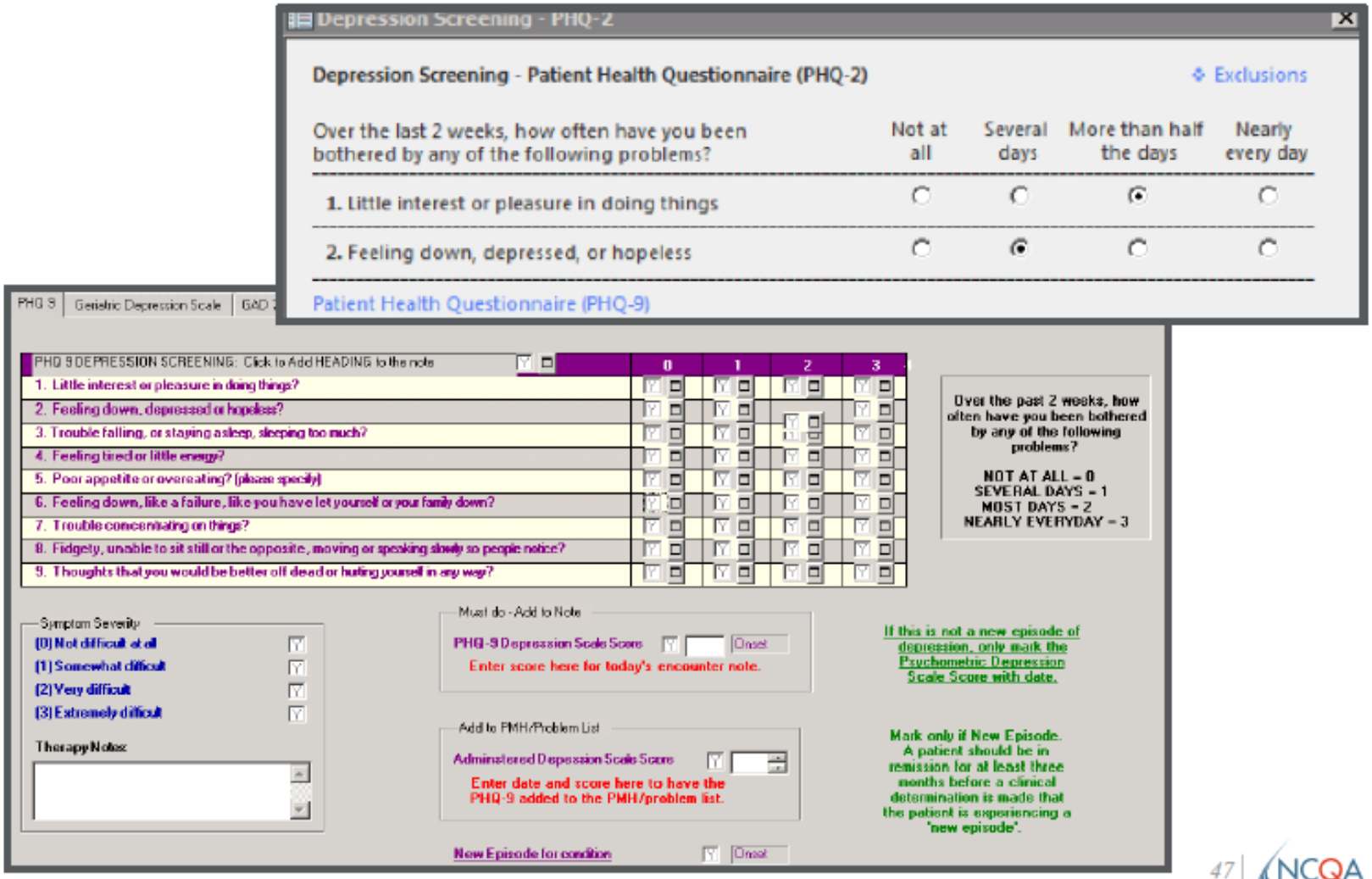
Competency A – KM 03 (Core) Depression Screenings for Adults and Adolescents

- Evidence = Documented process ***OR*** report ***AND*** evidence of implementation. The documented process includes the practice's screening process and approach to follow-up for positive screens.
- Consider for Virtual Review

Knowing and Managing Your Patients

KM 03: Example

Virtual Review



Competency A Elective Criteria – All New for 2017

- **KM 04 Behavioral Health Screenings (1 Credit)**
- **KM 05 Oral Health Assessment and Services (1 Credit)**
- **KM 06 Predominant Conditions and Concerns (1 Credit)**
- **KM 07 Social Determinants of Health (2 Credits)**
- **KM 08 Patient Materials (1 Credit)**

Competency A - KM 04 (1 Credit) Behavioral Health Screenings – ***New – Virtual Review***

Implement two or more:

A. Anxiety.

B. Alcohol use disorder.

C. Substance use disorder.

D. Pediatric behavioral health screening.

E. Post-traumatic stress disorder.

F. Attention deficit/hyperactivity disorder.

G. Postpartum depression.

Evidence = Documented process ***AND*** evidence of implementation

KM 04 Resources - Links to Screening Tools

- https://www.drugabuse.gov/nidamed-medical-evidence-based-screening-tools-adults
- http://www.sbirttraining.com/
- CAGE AID
- DAST-10
- http://www.integration.samhsa.gov/clinical-practice/screening-tools
- AAP Mental Health Tools for Primary Care

Behavioral Health Screening

KM 04: Example

Virtual Review

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

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

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

Resource: http://www.integration.samhsa.gov/images/res/CAGEAID.pdf

Competency A - KM 05
(1 Credit)
Oral Health Assessment & Services -***New***

- Conducts patient-specific oral health risk assessments and keeps a list of oral health partners from which to refer.
- Evidence = Documented process ***and*** evidence of implementation, consider Virtual Review.

Oral Health Assessment and Services

KM 05: Example

Virtual Review

Oral Health Risk Assessment Tool

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

Instructions for Use

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

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

Patient Name:_____ Date of Birth:_____ Date:_____

Visit ☐ 6 month ☐ 9 month ☐ 12 month ☐ 15 month ☐ 18 month ☐ 24 month ☐ 30 month ☐ 3 year ☐ 4 year ☐ 5 year ☐ 6 year ☐ Other_____

RISK FACTORS	PROTECTIVE FACTORS	CLINICAL FINDINGS
⚠ Mother or primary caregiver had active decay in the past 12 months ☐ Yes ☐ No	• Existing dental home ☐ Yes ☐ No	⚠ White spots or visible decalcifications in the past 12 months ☐ Yes ☐ No
• Mother or primary caregiver does not have a dentist ☐ Yes ☐ No	• Drinks fluoridated water or takes fluoride supplements ☐ Yes ☐ No	⚠ Obvious decay ☐ Yes ☐ No
• Continual bottle/sippy cup use with fluid other than water ☐ Yes ☐ No	• Fluoride varnish in the last 6 months ☐ Yes ☐ No	⚠ Restorations (fillings) present ☐ Yes ☐ No
• Frequent snacking ☐ Yes ☐ No	• Has teeth brushed twice daily ☐ Yes ☐ No	• Visible plaque accumulation ☐ Yes ☐ No
• Special health care needs ☐ Yes ☐ No		• Gingivitis (swollen/bleeding gums) ☐ Yes ☐ No
• Medicaid eligible ☐ Yes ☐ No		• Teeth present ☐ Yes ☐ No
		• Healthy teeth ☐ Yes ☐ No

ASSESSMENT/PLAN

Caries Risk:
☐ Low ☐ High

Completed:
☐ Anticipatory Guidance
☐ Fluoride Varnish
☐ Dental Referral

Self Management Goals:

☐ Regular dental visits	☐ Wean off bottle	☐ Healthy snacks
☐ Dental treatment for parents	☐ Less/No juice	☐ Less/No junk food or candy
☐ Brush twice daily	☐ Only water in sippy cup	☐ No soda
☐ Use fluoride toothpaste	☐ Drink tap water	☐ Xylitol

Competency A - KM 05
(1 Credit)
Oral Health Assessment & Services

Question: We only provide dental services for our pediatric patients, but we see adults also. Can we meet this criteria by demonstrating compliance with pediatrics only?

NCQA's Answer: No. Assessment of oral health needs and provision of services must be across the practice and across all populations in order to meet this criteria. Services may be provided by the practice directly, or referred outside of the practice, or be a mix of both.

Competency A - KM 06 (1 Credit) Identifies Predominant Conditions and Concerns - ***New***

- The practice identifies its patients' most prevalent and important conditions and concerns, through analysis of diagnosis codes or problem lists.
- Evidence = List of top priority conditions and concerns

Competency A - KM 06 (1 Credit) Predominant Conditions and Concerns

Question: Would a report of the top 10 predominant diagnosis codes meet the intent of this criteria?

NCQA's response: Yes, a list or report of the top conditions based on diagnosis codes could meet KM 06. The intent of this criterion is for practices to leverage data collected and maintained in the practice's systems to generate a report or list that can help the practice understand its patient population and then use that information to determine the best resources and supports for its patients. If a practice meets KM 06, it will also meet KM 01.

Competency A - KM 07 (2 Credits) Understands Social Determinants of Health - ***NEW***

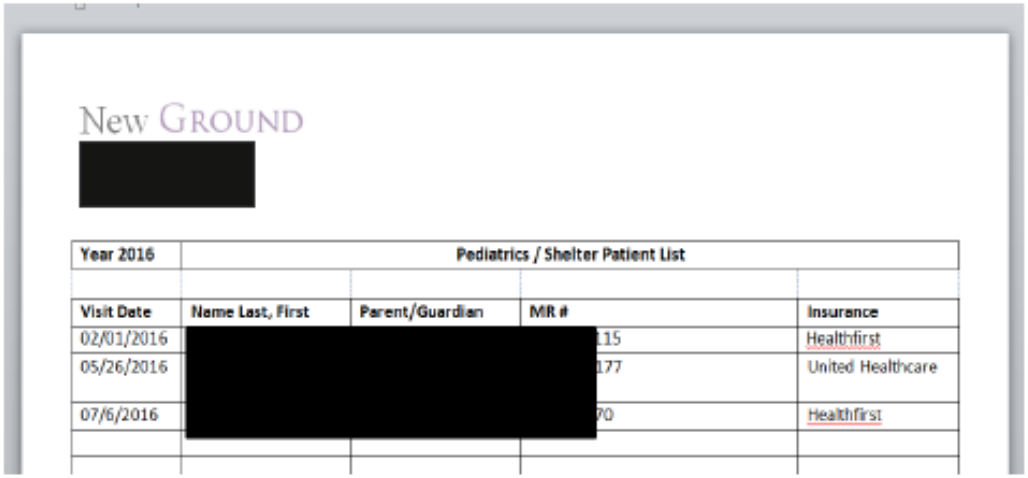
- Collects information on social determinants of health, demonstrates the ability to assess data and address identified gaps using community partnerships, self-management resources, or other tools to serve the on-going needs of its population.
- Evidence = Report ***and*** evidence of implementation
- Aligns with PCMH 2014 4A

Social Determinants of Health

KM 07: Example

PCMH KM 07 Social Determinants of Health

We receive referrals from New Ground Shelter. A registry of shelter patients is maintained annually. Patient/Family members that seek health insurance are directed to visit the clinic when our Children's Health Insurance Program counselors are on site.



New GROUND

[redacted]

Year 2016	Pediatrics / Shelter Patient List			
Visit Date	Name Last, First	Parent/Guardian	MR #	Insurance
02/01/2016	[redacted]		115	Healthfirst
05/26/2016			177	United Healthcare
07/6/2016			70	Healthfirst

The PRAPARE toolkit has been pilot tested on a small scale by our Help Team From June to January, we assessed just over 260 people with the PRAPARE tool. The data was compiled and analyzed by

This is a small sampling of our overall patient numbers but the results are telling:

- 18 people are currently Homeless
- 20 are worried about losing housing
- 20 who have less than High School degree
- 28 are unemployed
- 11 need childcare
- 8 need clothing
- 15 need food
- 89 need access to medicine or any health
- 21 concerned with their ability to maintain a phone
- 11 who are concerned with utilities
- 28 people say lack of transportation affects their daily life
- 15 who experience social isolation - interacting with others only 1-2 times/week
- 6 people who experience more severe social isolation - seeing others less than 1 time/week
- 24 who quantify their stress levels as "Quite a Bit" and "very much"
- 11 who are concerned about their physical and emotional safety at home
- 5 people live in fear of a partner or ex-partner

Competency A - KM 08 (1 Credit) Evaluates Patient Materials - ***New***

- Demonstrates an understanding of the patients' communication needs by utilizing materials and media that are easy for their patient population to understand and use.
- Considers patient demographics such as age, language needs, ethnicity, and education when creating materials for its population.

Competency A - KM 08 (1 Credit) Evaluates Patient Materials - ***New***

- Considers how its patients like to receive information (i.e., paper brochure, phone app, text message, e-mail), in addition to the readability of materials (e.g., general literacy and health literacy).
- Evidence = Report ***and*** evidence of implementation

Virtual Review

Competency A - KM 08 (1 Credit) Evaluates Patient Materials - ***New***

Question: What are the report parameters for this criteria: communication needs (speech, vision, hearing, language), plus demographic parameters as well as assessment of health literacy? Ethnicity and language are also assessed in KM09 and KM 10 - how does KM 08 differ?

NCQA's response: KM 08 requires the practice to use patient data to ensure that educational and resource materials provided to patients meet the needs of patients regarding communication needs, health literacy levels, language and other characteristics that could impact a patient's understanding of materials. KM 09 and KM 10 are specific to collecting data and generating reports to analyze the diversity and language of the patient population. This information would be used to identify areas to tailor patient materials in KM 08 but would not be sufficient to demonstrate how the practice uses the information.

Competency A - KM 08 (1 Credit) Evaluates Patient Materials - ***New***

NCQA's response (cont.): In addition to data from KM 09 and KM 10, practices could also look at data collected in other criteria, including KM 02 that addresses communication needs (D). Practices could also consider the patients family/social/cultural characteristics (C), social functioning (F) or social determinants of health (G) from KM 02 in determining how best to provide information to patients. In determining the best way to tailor information, the practice can take this information and determine the best way to convey important educational and other resources by considering all of these characteristics of patients together. Please note that for KM 08, the practice must demonstrate the information it collects and uses to identify ways to tailor patient materials as well as evidence of how it tailors materials to meet the needs of its patient population.

Competency B

- Meets the needs of a diverse patient population by understanding the population's unique characteristics and language needs. The practice uses this information to ensure linguistic and other patient needs are met.

Competency B Criteria

- KM 09 (Core) Assess the Diversity of the Population – Aligns with PCMH 2014 2C
- KM 10 (Core) Assess the Language Needs of the Population – Aligns with PCMH 2014 2C
- **KM 11 (1 Credit) Identifies Population-level Needs based on Diversity of the Practice and Community**

Competency B - KM 09 (Core)
Diversity – Aligns with PCMH 2014 2C

- Collects information on how patients identify in at least three areas that include:
    1. Race
    2. Ethnicity
    3. One other aspect of diversity, which may include, but is not limited to, gender identity, sexual orientation, religion, occupation, geographic residence.
- Evidence = Report

Competency B - KM 10 (Core) Language Needs

- Documents in its records whether the patient declined to provide language information, that the primary language is English or that the patient does not need language services.
- A blank field does not mean the patient's preferred language is English.
- Evidence = Report

Diversity and Language

KM 09-10: Example

Date Range: January 1, 20[redacted] - December 1, 20[redacted]

Race	Asian	African American	Native American	Caucasian	More than one Race	Refused to Report
	5	25	289	1603	29	6

Ethnicity	Hispanic	Non-Hispanic	Refused to Report
	162	1697	99

Veterans	Veterans
	39

Date Range - January 1, 20[redacted] - December 31, 20[redacted]

Patients better served in a language other than English

Patients	English	Spanish
1957	1858	99
100%	94.9%	5.1%

Competency B - KM 11 (1 Credit) Addresses Population-Level Needs Based on Diversity - ***New***

- Recognizes the varied needs of its population and the community it serves, and uses that information to take proactive, health literate, culturally competent approaches to address those needs.

Competency B - KM 11 (1 Credit) Addresses Population-Level Needs Based on Diversity - ***New***

- The practice considers at least two:
  A. Disparities in care - ***NEW***
  B. Educates practice staff on health literacy
  C. Educates staff on cultural competency - ***NEW***
- Evidence for A, B, and C =

  A. Evidence of implementation or QI 5 and QI 13 (assess disparities and act to improve)

  B. Evidence of Implementation

  C. Evidence of implementation

Population Needs - Health Literacy

KM 11:B Example

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

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

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

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

Educational Module for Clinicians

from the

Iowa Health System Health Literacy Collaborative

Teach-back is…

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

Competency B - KM 11 (1 Credit) Resources

- IOM Ten Attributes of Health Literate Organizations
- AHRQ Health Literacy Toolkit.pdf
- Alliance for Health Reform Toolkit

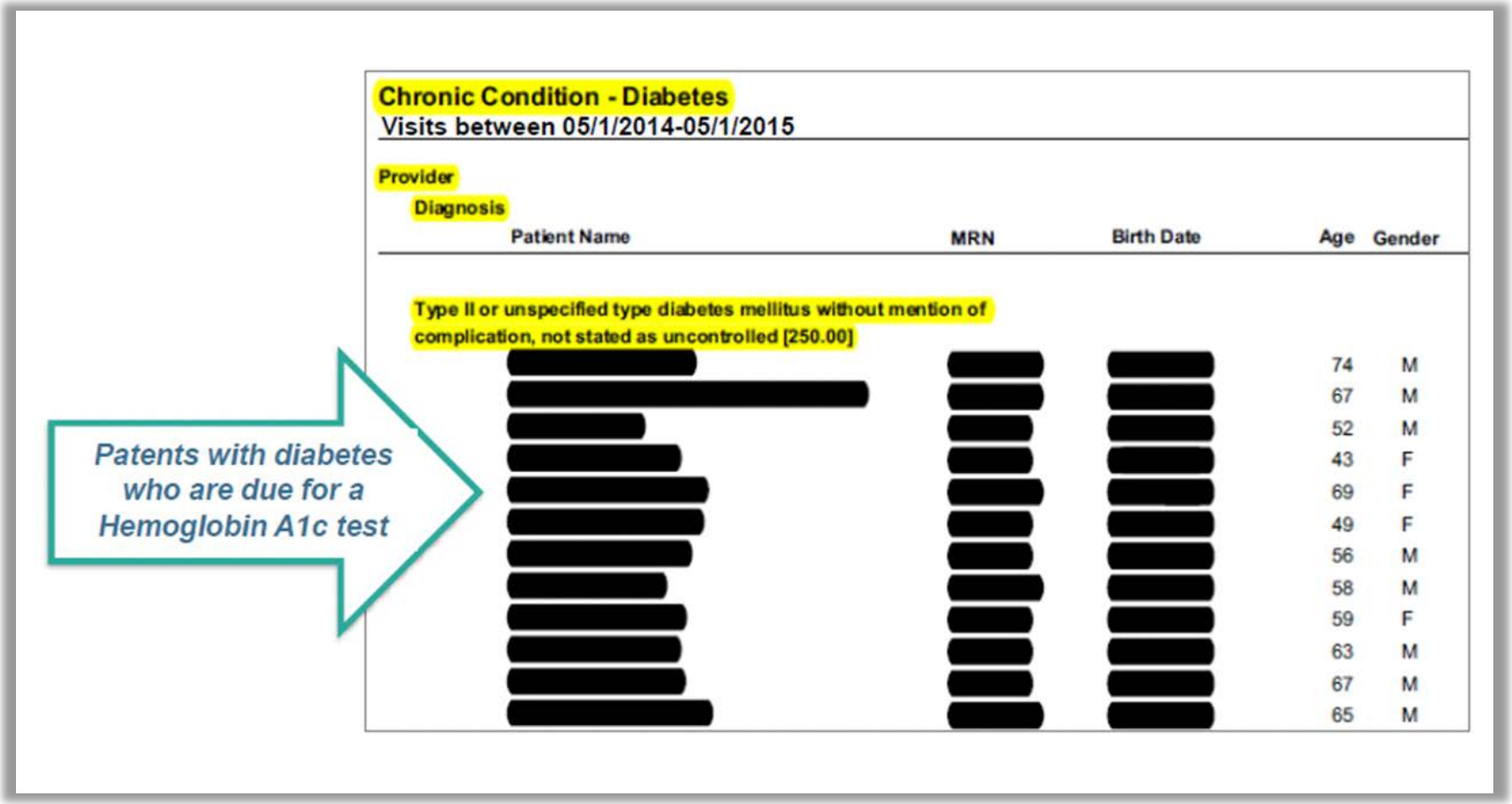
Competency C

- The practice proactively addresses the care needs of the patient population to ensure needs are met.
- 2 Criteria:
  - KM 12 (Core) Proactive Reminders – Aligns with PCMH 2014 3D
  - **KM 13 (2 Credits) Excellence in Performance**

Competency C - KM 12 (Core) Proactive Reminders

- Must report at least 3:
  - A. Preventive care services.
  - B. Immunizations.
  - C. Chronic or acute care services.
  - D. Patients not recently seen by the practice.
- Evidence =
  - Report/list and outreach materials
  - May use KM 13 to meet C. (chronic or acute care services)

KM 12 Examples



Patient Centered Medical Home (PCMH 2014) Standards Training material is reproduced with permission from the National Committee for Quality Assurance (NCQA) website. Source: http://www.ncqa.org/Programs/Recognition/RelevanttoAllRecognition/RecognitionTraining/PCMH2014Standards.aspx. Last accessed: October 2015.

KM 12 Examples

Turner House Children's Clinic

Turner House Children's Clinic
21 North 12th St. Suite 300
Kansas City, KS 66102
9/4/2015

[redacted]

Dear Turner House Children's Clinic Parent,

This letter will serve as a notification that your child [redacted] needs to set up a well c
appointment. It is important you contact the Clinic and let us know if you are attending a di
We tried to contact you several times but were unable to do it. If we don't hear from you in
couple of weeks, we will be placing the medical records of your child as inactive. It is import
provide us with a correct telephone number and attend the appointments scheduled.

Sample reminder postcard mailed to patients:

The best protection is early detection.

Inspiring Bette

Please call us today to schedule your annual women's wellness appointment.

Name:

Address:

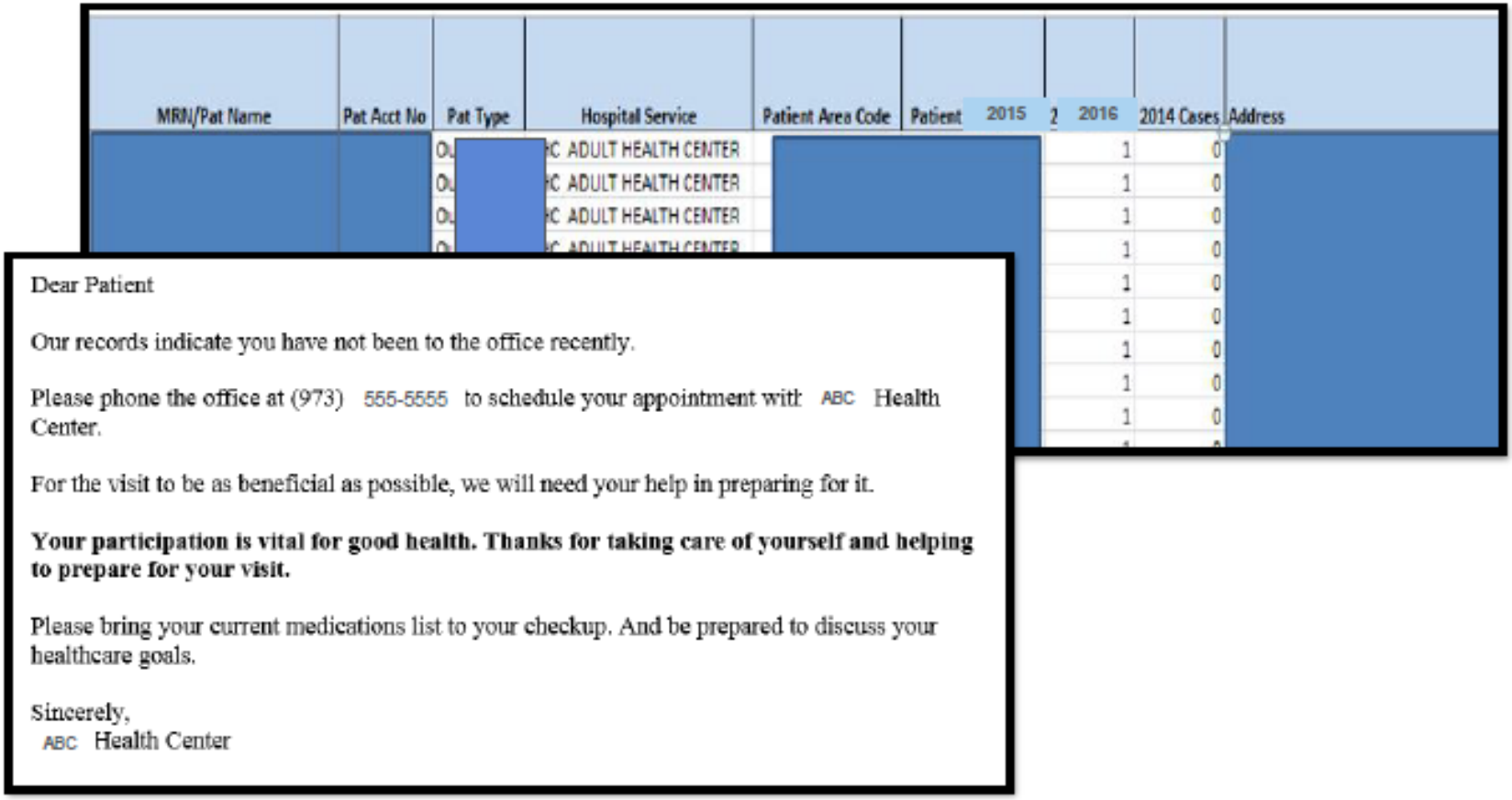
[redacted]

1840 E. Gypsy Ln.
Bowling Green, Oh 43402
419-354-9049

Source: Turner House Children's Clinic, 2015, used with permission.

Knowing and Managing Your Patients

KM 12: Example



MRN/Pat Name	Pat Acct No	Pat Type	Hospital Service	Patient Area Code	Patient	2015	2	2016	2014 Cases	Address
		O	C ADULT HEALTH CENTER					1	0	
		O	C ADULT HEALTH CENTER					1	0	
		O	C ADULT HEALTH CENTER					1	0	
		O	C ADULT HEALTH CENTER					1	0	
								1	0	
								1	0	
								1	0	
								1	0	
								1	0	

Dear Patient

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

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

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

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

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

Sincerely,
ABC Health Center

Competency C - KM 13 (2 Credits) Demonstrates Excellence in Benchmarked/Performance - ***New***

- At least 75% of eligible clinicians have earned NCQA HSRP or DRP recognition

- OR-

- The practice demonstrates participation in a benchmarked program ***and*** demonstrates (through reports) that clinical performance is above national or regional averages.

Competency C - KM 13 (2 Credits) Demonstrates Excellence in Benchmarked/Performance - ***New***

- Evidence = Report or ***at least*** 75% of eligible clinicians have earned NCQA HSRP or DRP recognition

Competency C - KM 13 (2 Credits) Demonstrates Excellence in Benchmarked/Performance - ***New***

Question: What are some examples of recognition programs besides the HSRP and DRP offered by NCQA?

Answer: The intent of KM 13 is for practices to demonstrate recognition in a practice-level program where their specific performance is compared to external practices and compared to benchmarks to demonstrate performance. One example aside from NCQA's HSRP and DRP is the Million Hearts Champions program, which is a performance-based recognition program that publicly reports practice data compared to benchmarks and provides recognition to practices. Other examples include some state-specific programs that provide recognition based on performance. Please note that this requirement is elective, so if a practice is not recognized by a program like this, it could opt to pursue other elective criteria that are more pertinent to its current capabilities and patient population.

Competency D

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

Competency D Criteria

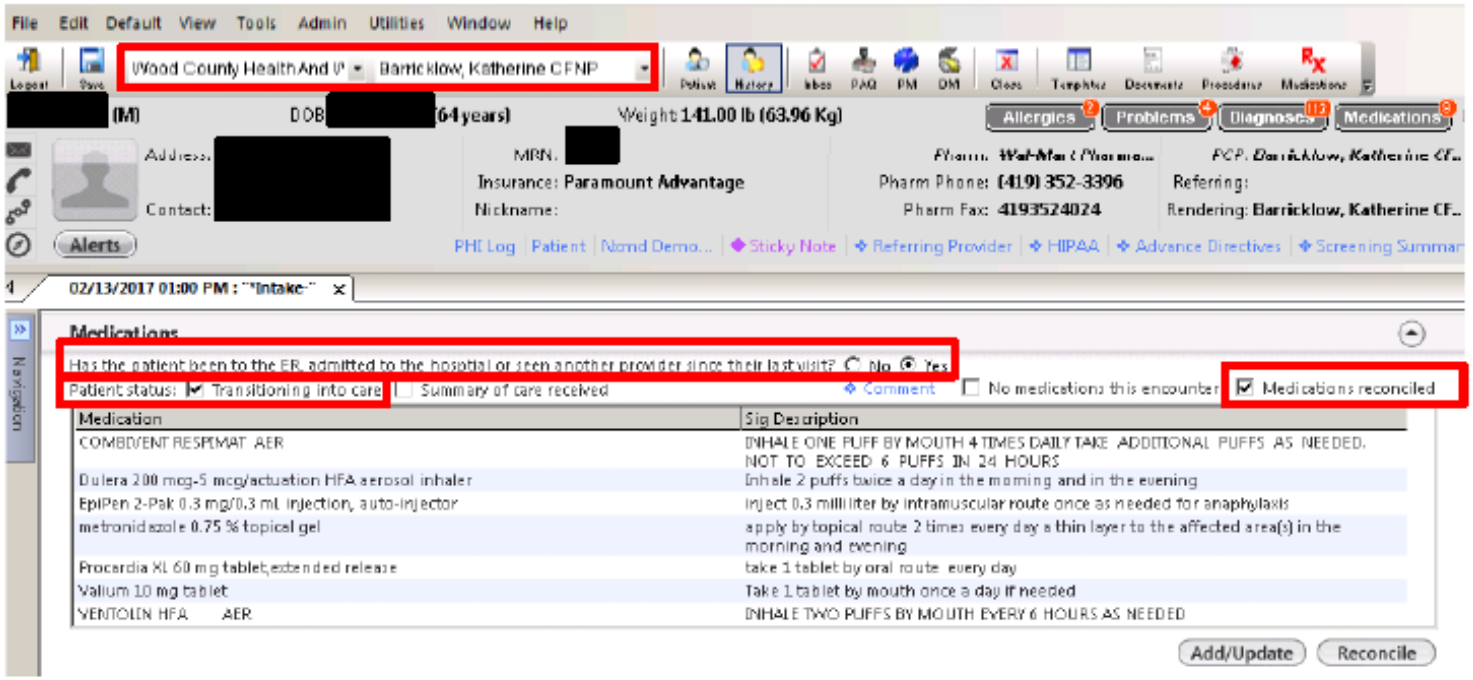
- KM 14 (Core) Medication Reconciliation
- KM 15 (Core) Medication Lists
- KM 16 (1 Credit) New Prescription Education
- KM 17 (1 Credit) Medication Responses and Barriers
- **KM 18 (1 Credit) Controlled Substance Database Review**
- **KM 19 (2 Credits) Prescription Claims Data**

Competency D - KM 14 and 15 (Core) Reconciles Meds and Maintains Med List

- Medication review and reconciliation occurs at transitions of care, or at least annually
- Maintains an up-to-date med list
- Evidence = Report > 80% (May use MU report)
- Aligns with PCMH 2014 4C

Program : MU2 Objectives 2016 Reporting Period: 1/1/2017-3/31/2017 Job : 42 (4/12/2017)			Patients In		Performance
Practice	Provider	Measure	DEN	NUM	%
		Medication Reconciliation 7	120	113	94.17
		Medication Reconciliation 7	62	59	95.16
		Aggregated Results	182	172	94.5

Here is where it can be documented in our electronic health record:



MU Report Updated Med List

Wood County Community Health and Wellness Center's electronic prescribing system is integrated with patient records, allowing us to view patient diagnoses and patent medications, enter new medications or make changes, and identify documented allergies. We enter 100% of prescribed medication orders in the integrated electronic prescribing system.

Program : MU2 Objectives 2016 Reporting Period: 1/1/2017-3/31/2017 Job : 22 (3/28/2017)			Patients In		Performance
Practice	**Provider**	**Measure**	**DEN**	**NUM**	**%**
Wood County Health And Wellness Center	Barricklow, Katherine	CPOE Medications 3	1206	1206	100
	Dood, Steven	CPOE Medications 3	329	329	100
	TOTALS		1535	1535	100

Competency D - KM 16 -17 (1 Credit Each) Assess Understanding of New Meds, Response, and Barriers

- Uses patient-centered methods, such as open-ended questions (i.e., teach-back collaborative method), to assess med understanding.
- Asks patients if they are having difficulty taking a medication, are experiencing side effects and are taking the medication as prescribed.
- Evidence = Report > 50% ***and*** evidence of implementation. ***Chart review may be used in lieu of a report.***
- Aligns with PCMH 2014 4C

Competency D - KM 16 -17 (1 Credit Each) Asses Understanding of New Meds, Response, and Barriers

Question: Can a practice complete a chart review in lieu of a report for these criteria, KM 16 and KM 17?

NCQA's Response: If a practice cannot run a report of structured data for KM 16 and KM 17, it would be acceptable to do an audit of patient medical records that is representative of the patient population to generate reports to demonstrate meeting the percentage thresholds required by the factors. It would be up to the practice to determine the appropriate time frame for sampling that would ensure a representative sample of patients to demonstrate that this is done systematically for all patients prescribed new medication. Please note that in addition to the report, practices must also demonstrate evidence that the information is documented in the medical record during the virtual check-in.

Competency D - KM 18 (1 Credit) Controlled Substance Database - ***New***

- Consults a state controlled-substance database - also known as a Prescription Drug Monitoring Program (PDMP) or Prescription Monitoring Program (PMP) - before dispensing Schedule II, III, IV, and V controlled substances.
- Evidence = Evidence of implementation, consider Virtual Review
- http://www.pdmpassist.org/content/state-pdmp-websites

Competency D - KM 19 (2 Credits)
Prescription Claims Data - ***New***

- Systematically obtains prescription claims data or other medication transaction history. This may include systems such as SureScripts e-prescribing network, regional health information exchanges, insurers, or prescription benefit management companies.
- Evidence = Evidence of implementation, consider Virtual Review

Virtual Review

Competency E

Competency E - KM 20 (Core) Evidence-Based Clinical Decision Support

- Must demonstrate at least 4 criteria
- Evidence = Identifies condition, source of guidelines, **AND** evidence of implementation, consider Virtual Review Virtual Review
- The American Board of Internal Medicine Foundation's Choosing Wisely campaign provides information about implementing evidence-based guidelines as clinical decision support:
- http://www.choosingwisely.org/

Competency E - KM 20 (Core) Aligns with PCMH 2014 3E

A. Mental health condition

B. Substance use disorder

C. A chronic medical condition

D. An acute condition

E. A condition related to unhealthy behaviors

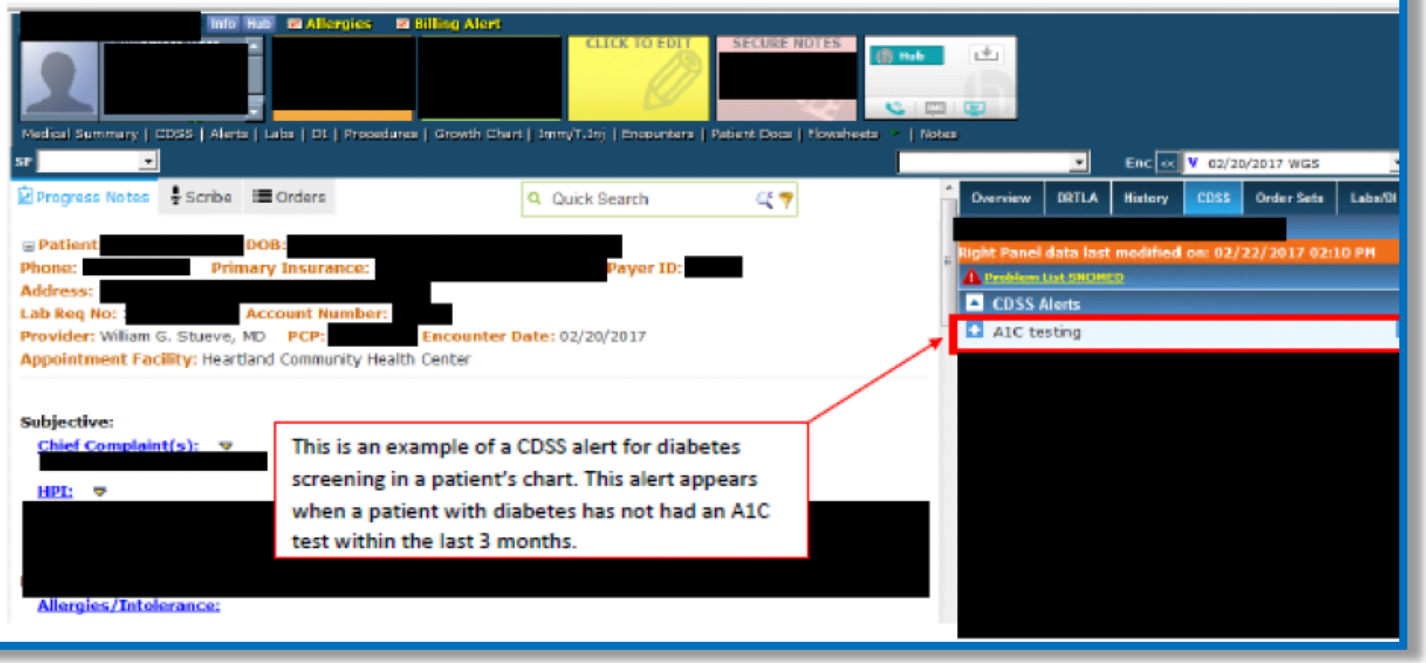
F. Well child or adult care

G. Overuse or appropriateness issues

Heartland has identified diabetes as an important chronic medical condition and provides evidenced-based care using the guideline referenced below.

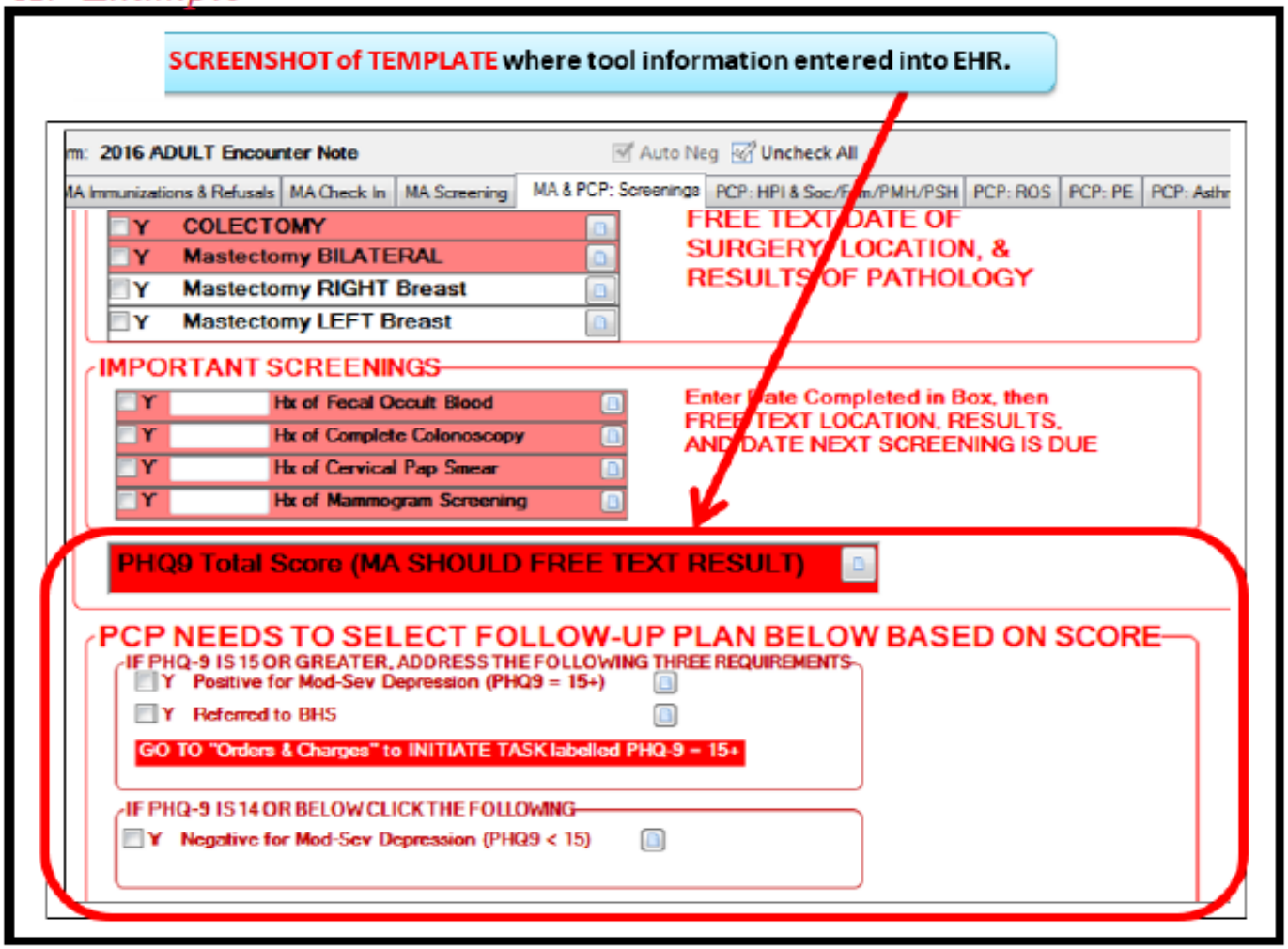
Source of guideline: American Diabetes Association
http://professional.diabetes.org/sites/professional.diabetes.org/files/media/dc_40_s1_final.pdf

Following are several examples of clinical decision support at the point of care around diabetes care in our EHR eCW.



Clinical Decision Support – Mental Health

KM 20 A: Example



Competency F

Identifies, considers and establishes connections to community resources to collaborate and direct patients to needed support.

Competency F Criteria

- **KM 21 Community Resource Needs (Core)**
- KM 22 Access to Educational Resources (1 Credit). Aligns with PCMH 2014 4E
- **KM 23 Oral Health Education (1 Credit)**
- KM 24 Shared Decision-Making Aids (1 Credit). Aligns with PCMH 2014 4E

Competency F Criteria

- **KM 25 School/Intervention Agency Engagement (1 Credit)**
- KM 26 Community Resource List (1 Credit). Aligns with PCMH 2014 4E
- KM 27 Community Resource Assessment (1 Credit). Aligns with PCMH 2014 4E
- **KM 28 Case Conferences (2 Credits)**

Competency F - KM 21 (Core) Community Resource Needs - ***New***

- Identifies needed resources by assessing collected population information.
- Assesses social determinants, predominant conditions, emergency department usage, and other health concerns to prioritize community resources.
- Evidence = List of key patient needs and concerns, aligns with KM 06, KM 07, KM 26

The PRAPARE toolkit was first utilized on a small-scale by our Help Team, who assist patients and non-patients with insurance enrollment and other needs related to their health.

The following are areas in which we question a small population of our patients; however they are all optional (which results in fluctuations in denominator data):

Housing Status

- Currently Homeless –6% (18/32)
- Worried About Losing Housing –8% (20/252)

Education Level

- Less than High School –23% (20/87)
- High School or GED –45% (39/87)

Employment Status

- Unemployed –11% (28/256)

Lack of Access to Necessities

- Childcare –6% (11/196)
- Clothing –4% (8/196)
- Food –8% (15/196)
- Medicine or any Health Care –45% (89/196)
- Phone –11% (21/196)
- Utilities –6% (11/196)

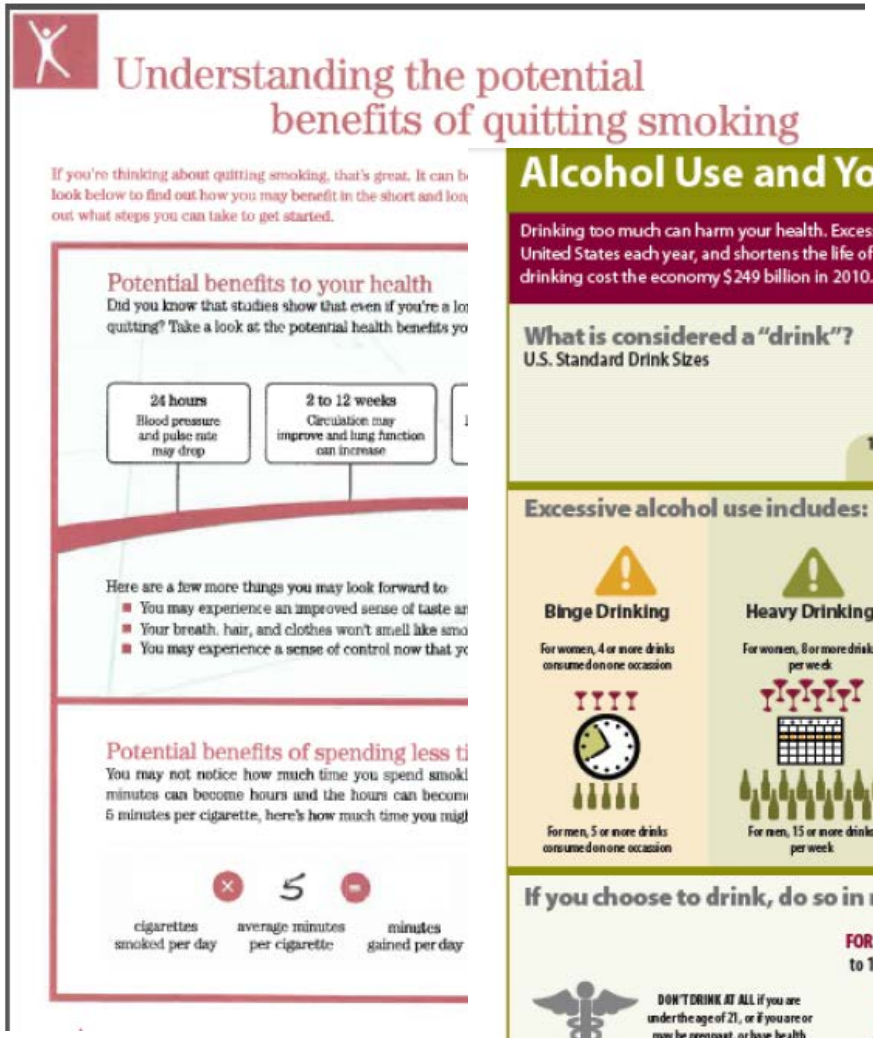
Competency F - KM 22 (1 Credit) Access to Educational Resources – Aligns with PCMH 2014 4E

- Provide access to educational materials, peer support sessions, group classes, and other resources.
- Evidence = Evidence of implementation, 3 examples

Offers or refers patients to structured health education programs, such as group classes and peer support.

Arch Health Partners, as a medical foundation of Palomar Health, offers free and low costs classes to our patients.

Virtual Review


Understanding the potential benefits of quitting smoking
If you're thinking about quitting smoking, that's great. It can b
look below to find out how you may benefit in the short and lon
out what steps you can take to get started.
Potential benefits to your health
Did you know that studies show that even if you're a lo
quitting? Take a look at the potential health benefits yo
24 hours
Blood pressure and pulse rate may drop
2 to 12 weeks
Circulation may improve and lung function can increase
Here are a few more things you may look forward to:
You may experience an improved sense of taste a
Your breath, hair, and clothes won't smell like smo
You may experience a sense of control now that y
Potential benefits of spending less t
You may not notice how much time you spend smok
minutes can become hours and the hours can becom
6 minutes per cigarette, here's how much time you mig
5
cigarettes smoked per day
average minutes per cigarette
minutes gained per day


Alcohol Use and Your Health
Drinking too much can harm your health. Excessive alcohol use leads to about 88,000 deaths in the United States each year, and shortens the life of those who die by almost 30 years. Further, excessive drinking cost the economy $249 billion in 2010. Most excessive drinkers are not alcohol dependent.
What is considered a "drink"?
U.S. Standard Drink Sizes
12 ounces 5% beer
8 ounces 7% malt liquor
5 ounces 12% wine
1.5 ounces 40% (80 proof) distilled spirits
(examples: gin, rum, vodka, whiskey)
Excessive alcohol use includes:
Binge Drinking
For women, 4 or more drinks consume on one occasion
For men, 5 or more drinks consume on one occasion
Heavy Drinking
For women, 8 or more drinks per week
For men, 15 or more drinks per week
Any alcohol used by pregnant women
Any alcohol used by those under the age of 21 years
If you choose to drink, do so in moderation:
DON'T DRINK AT ALL if you are under the age of 21, or if you are or may be pregnant, or have health problems that could be made worse by drinking.
FOR WOMEN, up to 1 drink a day
FOR MEN, up to 2 drinks a day
NO ONE should begin drinking or drink more frequently based on potential health benefits.
National Center for Chronic Disease Prevention and Health Promotion
Division of Population Health
CDC


Cornerstones4Care
your guide to better office visits
diabetes care

Competency F - KM 23 (1 Credit) Provides Oral Health Education and Resources - ***New***

- The practice provides an example of how it provides patients with educational and other resources that pertain to oral health and hygiene.
- Evidence = Evidence of implementation, one example

Virtual Review

Competency F - KM 24 (1 Credit) Adopts Shared Decision-Making Aids – Aligns with PCMH 2014 4E

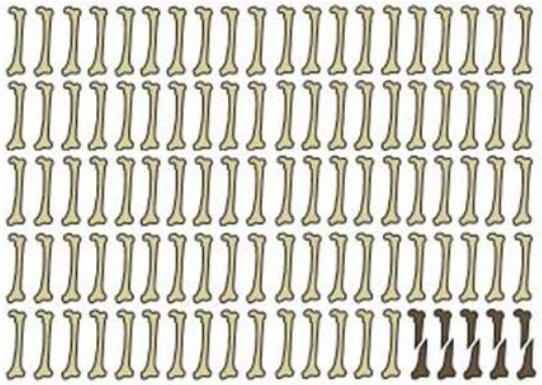
- The care team has, and demonstrates use of, at least three shared decision-making aids that provide detailed information without advising patients to choose one option over another.
- Evidence = Evidence of implementation, 3 examples

Virtual Review

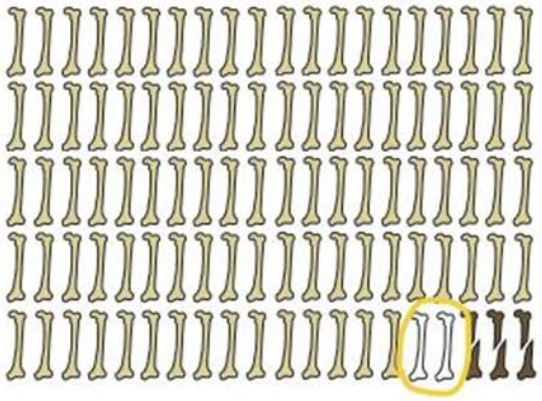
Shared Decision-Making Tools Examples

Benefits

Without Medication
Roughly 5 in 100 have a fracture within the next 10 years. 95 will not.



With Medication
Roughly 3 in 100 have a fracture within the next 10 years. 97 will not. 2 have avoided a fracture because of the medication.



Downsides

Directions
This medication must be taken

- Once a week
- On an empty stomach in the morning
- With 8 oz of water
- While upright (sitting or standing for 30 min)
- 30 minutes before eating

Possible Harms

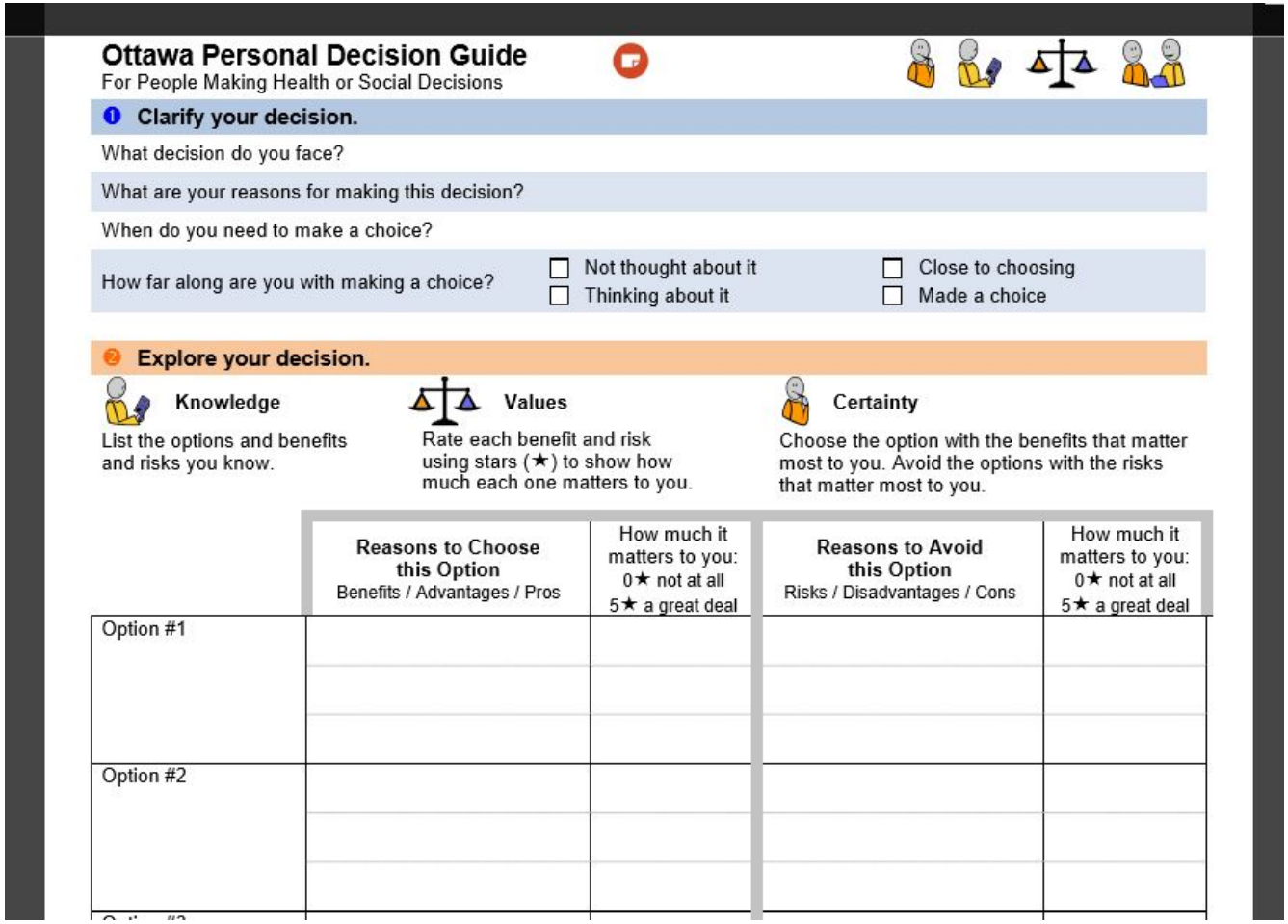
Abdominal Problems
About 1 in 4 people will have heartburn, nausea, or belly pain. However, it may not be from the medication. If the medication is the cause, the problem will go away if you stop taking it.

Osteonecrosis of the Jaw
Fewer than 1 in 10,000 (over the next 10 years) will have bone sores of the jaw that may need surgery.

Out of Pocket Cost
with insurance $30 | without insurance $70-90

What would you like to do?

Shared Decision-Making Tools Examples



Ottawa Personal Decision Guide
For People Making Health or Social Decisions

1 Clarify your decision.

What decision do you face?

What are your reasons for making this decision?

When do you need to make a choice?

How far along are you with making a choice?
☐ Not thought about it ☐ Thinking about it ☐ Close to choosing ☐ Made a choice

2 Explore your decision.

Knowledge
List the options and benefits and risks you know.

Values
Rate each benefit and risk using stars (★) to show how much each one matters to you.

Certainty
Choose the option with the benefits that matter most to you. Avoid the options with the risks that matter most to you.

	Reasons to Choose this Option Benefits / Advantages / Pros	How much it matters to you: 0★ not at all 5★ a great deal	**Reasons to Avoid this Option** Risks / Disadvantages / Cons	How much it matters to you: 0★ not at all 5★ a great deal
Option #1				
Option #2				

Shared Decision-Making Tools

- "Helping Patients Make Better Treatment Choices with Decision Aids" by the Commonwealth Fund: http://www.commonwealthfund.org/publications/newsletters/quality-matters/2012/october-november/in-focus

- International Patient Decision Aid Standards Collaboration

Competency F - KM 25 (1 Credit) Schools or Intervention Agencies Engagement - ***New***

- Develops supportive partnerships with social services organizations or schools in the community.
- The practice demonstrates this through formal or informal agreements or identifies practice activities in which community entities are engaged to support better health.
- Evidence = Documented process ***AND*** evidence of implementation

School/Intervention Agency Engagement

KM 25: Example

The Hispanic Counseling Center

Patient Access	STEP 1 (within 24 hours of visit) ☐ If visit is urgent, PCP office will call The Hispanic Counseling Center office intake line to notify of need for a more expedited appointment and outreach to the patient STEP 2 (within 24-48 hours of visit) ☐ Patient will be scheduled within 2-3 weeks of call to Specialist office unless urgent visit indicated STEP 3 (on-going management) ☐ If patient does not schedule or is a 'no-show', notification from Specialist office will be sent to PCP office within 30 days via fax or telephone encounter ☐ 609 Fulton Pediatrics Pc Care Coordinators run reports & perform outreach to anyone who has not complete appropriate follow-up	STEP 1 (during patient PCP visit) ☐ If visit is urgent, PCP office will call Specialist office to notify of need for expedited appointment STEP 2 (within 24-48 hours of visit) ☐ Referred patient will be scheduled within 2-3 weeks of call to Specialist office unless urgent visit STEP 3 (at visit) ☐ If patient needs to be seen for follow up visit - patient will schedule directly with Specialist office
Transitions of Care	STEP 1 (at visit) ☐ Informs patient of need, purpose, expectations and goals of the specialty visit ☐ Patient/family in agreement with referral, type of referral and selection of Specialist ☐ Unless urgent, PCP office provides patient with Specialist contact information and patient calls to schedule appointment STEP 2 (within 24 hours of visit) ☐ PCP office documents appropriate	STEP 1 (at visit) ☐ Reviews reason for visit with patient/family ☐ If patient needs to be seen in ED or Mental Health Facility, arrangements will be made then Specialist office will notify PCP office within 24 hours STEP 2 (within 7-10 days of initial visit) ☐ The specialist office communicates with the PCP regarding the patient's plan of care, up-dated diagnosis, and medication recommendations. ☐ If there is ongoing visits with the

Competency F - KM 26 (1 Credit) Community Resource List – Aligns with PCMH 2014 4E

- Based on the needs identified in KM 21, the practice maintains a community resource list by selecting five topics or community service areas of importance to the patient population.
- Evidence = List of resources, with date of recent update. The list includes services offered outside the practice and its affiliates.

Competency F - KM 27 (1 Credit) Community Resource Assessment – Aligns with PCMH 2014 4E

- Assesses the usefulness of resources by requesting and reviewing feedback from patients/families/caregivers about community referrals. Community referrals differ from clinical referrals, but may be tracked using the same system.
- Evidence = Evidence of implementation

Competency F - KM 28 (1 Credit) Case Conferences - ***New***

- Uses “case conferences” to share information and discuss care plans for high-risk patients with clinicians and others outside its usual care team.
- Case conferences are planned, multidisciplinary meetings with community organizations, or specialists to plan treatment for complex patients.
- Evidence = Documented process (to upload) ***AND*** evidence of implementation, consider Virtual Review Virtual Review

KM 28 – Case Conference Detail

Question: We use technology to facilitate the exchange of information between specialty providers outside the practice specifically around e-referrals where information is exchanged with the specialist at the time of referral. The specialist will review the information and provide guidance to the PCP regarding current treatment options the PCP may try, or whether the specialty referral is indicated. There is an electronic dialogue and exchange of information as the PCP and specialist comment back and forth. Does this meet the intent of a case conference?

NCQA's Response: The description you provided is of a professional discussion between a referring primary care clinician and a specialist. A case conference would engage these parties and others engaged in the care of a patient with complex needs, one that would benefit from a collaborative and/or multi-disciplinary approach. This would be an expansion of the consultation described.

KM 28 – Case Conference Detail

Question: Can you provide an example as to what might meet this criteria? Does "interdisciplinary" mean across disciplines within the practice and also must include external providers of care? What is the expected frequency of these case conferences?

NCQA's Response: Yes, it may include those across disciplines within the practice and external parties. The intent of KM 28 is for practices to have regular case conferences with all of the parties involved in the care for high risk patients seen by the practice, which could include families/caregivers but should also include any specialists or staff (such as nursing home staff) that help to manage the patient. Meetings between the primary care staff and patient's family in and of itself would not meet the intent of the requirement. (cont)

KM 28 – Case Conference Detail

NCQA's Response: To meet KM 28, the practice must demonstrate its documented process for holding case conferences regularly to discuss high risk patients' care as well as evidence of these case conferences. There is no minimum number of examples and NCQA is not prescriptive about how the case conferences are held, but it must demonstrate that this occurs regularly for high risk patients and that there is a time for all of the specialists and staff participating in the patient's care to meet and discuss.

There is no minimum frequency, but they should be held regularly as appropriate to provide the needed care and support for the high-risk patient(s). Please also note that KM 28 is an elective criterion and may not be applicable to all practices, so if practices do not engage in these types of meetings regularly, it may select other elective criteria that may be more applicable to the patient population they serve. Please let us know if you have any further questions.

Recap – KM Core Concepts

1. Problem Lists - SS
2. Comprehensive Health Assessment - PS
3. Depression Screening - PS
4. Diversity - SS
5. Language – SS
6. Proactive Reminders - Shared
7. Med Reconciliation – SS
8. Med Lists - SS
9. Clinical Decision Support - Shared
10. **Community Resource Needs - Shared**

SS = site specific PS = partially shared S = shared

To Learn More About PCMH Best Practices Go To

http://www.safetynetmedicalhome.org/resources-tools/all-resources

Questions?

Join us for the Series!

Patient-Centered Access and Continuity (AC)

Wednesday, July 11, 12-1 PM

REGISTER HERE

Learning Objectives:

- Identify processes within your practice that ensure reliable access to care 24/7
- Explain your practice's systematic approach to empanelment and continuity of care measures
- Describe methods your practice employs to determine patient needs and preferences when establishing standards for access to care

Upcoming WACMHC Trainings

Lean Boot Camp Office Hours
July 16 | 12:00 – 1:00 pm
REGISTER HERE

NAHQ CPHQ Review Course
August 16-17 | Seattle, WA
Registration Coming Soon

Please complete the evaluation after the end of the session. Your feedback is appreciated!

Questions? Contact the WACMHC Practice Transformation Team at QualityImprove@wacmhc.org