WACMHC

Washington Association of Community & Migrant Health Centers

Putting PCMH into Practice: A Transformation Series

Care Coordination & Care Transitions (CC)

September 12, 2018

WEBINAR FACILITATOR

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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.

Care Coordination & Care Transitions (CC) Pre-Work Questions

1. What metrics are you monitoring to ensure care coordination systems for test and referral tracking are functioning in a manner that delivers results and reports to the provider in a timely manner?

2. What member or members of the care team is responsible for tracking and follow-up of patients recently discharged from the hospital or ED?

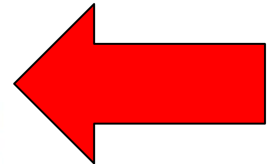
2017 NCQA PCMH Standard 5: Care Coordination and Care Transitions (CC)

Advancing Healthcare
Improving Health

1. Resources for patient readiness assessment?
2. Our renewal date is 2/21/2020. Is there any problem with submitting our application for renewal early, for example October or November of 2019? NCQA said: **Begin enrollment in the QPass system at the beginning of November; this will ensure that the 2020 annual reporting evaluation is loaded in the system. Just be mindful that you will be losing several months of recognition. Also be sure that to have the correct annual reporting document which can be obtained from the NCQA store.**
3. How many months ahead of the chosen completion date would you suggest that we have everything submitted?
4. Did you notice any big changes with the new standards and guidelines that came out in July of 2018?

Change Concepts for Practice

4 Reducing Barriers to Care	Care Coordination
	Enhanced Access
3 Changing Care Delivery	Patient-Centered Interactions
	Organized, Evidence-Based Care
2 Building Relationships	Continuous and Team-Based Healing Relationships
	Empanelment
1 Laying the Foundation	Quality Improvement Strategy
	Engaged Leadership



Objectives

- Identify opportunities to improve your organization's process for closed-loop tracking of lab results, imaging tests, and referrals.
- Consider your organization's current methods of connectivity with health care facilities that support safe care transitions.

Patient Support Aligned with Need

Logistical Support includes appointments, reports, patient follow-up , providing information and support for patients as they navigate the system

High

Intensity of Care Needs

Low

Clinical Care Management

Medication mgmt

Logistical

Clinical Monitoring

Clinical Follow-up Care

Logistical

Clinical Monitoring

Care Coordination

Logistical

High % | Percent of Patients | Low %

©MacColl Institute for Healthcare Innovation, Group Health Research Institute 2011

Care Coordination Metrics Examples. *What are you measuring?*

Community Resources, Self-Management Support, etc.
Patient satisfaction ratings for community resources
Percent community resources for which loop was closed (i.e., patient received or evaluated the resource)
Patient health confidence pre- and post-provision of self-management support
Referrals
Number of open referrals or percentage of referrals open > 60 days
Percent referral results acknowledged by ordering clinician
Test Orders
Percentage lab orders open > 30 days
Percentage of lab results pushed to portal and accessed by patient
Percent lab results with documentation of patient notification
Percent lab results acknowledged by ordering clinician
Post-Discharge Follow-Up
Percent patients called within 72 hours of discharge from hospital
Percent patients scheduled for follow-up within seven days of discharge from hospital (and/or that showed for appt)
Percent patients with discharge summary in chart by day of follow-up visit
Percent high-risk ED discharges called within one business day
Percent patients discharged from the hospital with med reconciliation performed within five business days

Key Design Elements for Care Coordination System

1. *Assume* **accountability**
2. *Provide* **patient support**
3. *Build* **relationships and agreements**
4. *Develop* **connectivity**

Care Coordination System: Better by Design

PATIENT-CENTERED MEDICAL HOME

Accountability

Patient Support

The Space That Separates Us…..
Dangerous Territory for Patients

Community Agencies

Hospitals & ERs

Medical Specialists

- Involved providers receive the information they need when they need it
- Practice knows the status of all referrals/ transitions involving its panel
- Patients report receiving help in coordinating care

High-quality referrals & transitions for providers & patients

Source: The MacColl Center for Health Care Innovation, Group Health Cooperative

SNMHI, Care Coordination Implementation Guide,
http://www.safetynetmedicalhome.org/change-concepts/care-coordination

Care Coordination and Care Transitions (CC)

- The practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood.
- 3 Competencies
- 21 Criteria
- 15 required documented processes

Competency A

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

1 Core criteria
2 Elective criteria

Competency A Criteria

- CC 01 Lab and Imaging Test Management (Core)
- CC 02 Newborn Screenings (1 Credit)
- **CC 03 Appropriate Use for Labs and Imaging (2 Credits) - New**

Competency A Required Documented Processes

CC 01 Core - tracks and manages lab and imaging tests important for care and informs patients of the result

CC 02 Elective – follows up with inpatient facilities about newborn hearing and blood-spot

Competency A - CC 01 (Core) Manages Lab and Imaging Tests – Aligns with PCMH 2014 5A

- A. and B. Tracking lab and imaging tests until results are available, flagging and following up on overdue results.
- C. and D. Flagging abnormal lab and imaging results, bringing them to the attention of the clinician.
- E. and F. Notifying patients/families/caregivers of normal and abnormal lab and imaging test results.
- Evidence = Documented process ***AND*** Evidence of implementation

Care Coordination & Care Transitions

CC 01 A-B: Example

Consider Virtual Review

Lab & Diagnostics Tracking Report : February 1-15,			
Order	Action/Comment	Status	rder
SPINE, LUMBAR		result receive	
ELECTROCARDIOGRAM, COMPLETE	due in 3mos. Left msg for pt to call back.	ordered	
X-RAY EXAM OF KNEES Bilateral		completed	
Chlamydia/GC, DNA Probe		completed	
Fasting Glucose, Serum		completed	
HEMOGLOBIN A1C			
HPV, high+low-risk			
PAP, thin prep			
urine for gonorrhea and chlamydia			
CMP			
LIPID PANEL			
ELECTROCARDIOGRAM, COMPLETE			
CBC			
CBC WITHOUT DIFF			
CMP			
LIPID PANEL			
TSH			
CT LUMBAR SPINE W/O DYE			
US liver and gallbladder			
ECHO TRANSTHORACIC			
ELECTROCARDIOGRAM, COMPLETE			
MRI ABDOMEN W/O & W/DYE liver			

Care Coordination & Care Transitions

CC 01 E: Example

Normal Lab Results of lab work left as message

Telephone Encounter

Telephone Encounter Info

Author	Note Status	Last Update User	Last Update Date/Time
Phillip Andrew, MD	Signed	Phillip Andrew, MD	3/15/ 2:04 PM

Telephone Encounter

Left VM informing him testosterone levels were normal. Also wanted to check in on how the adderall taper is going but didn't get ahold of him; will f/u in 2 weeks at our next appointment

Provider called patient with results of radiology exam

Telephone Encounter

Telephone Encounter Info

Author	Note Status	Last Update User	Last Update Date/Time
MD	Signed	MD	1/27/ 1:59 PM

Telephone Encounter

I spoke to patient on the phone. X-ray is not consistent with severe OA. Symptoms are now more intermittent. Advised him to cancel appointment in Ortho clinic and we will evaluate further at his upcoming appointment.

Care Coordination & Care Transitions

CC 01 F: Example

Consider Virtual Review

Lab:HEMOGLOBIN A1c
Result Date:
Session Id: JK673000
Ordering Physician:

Order Date:
Time: 11:46:00

Name	Value	Reference Range
HEMOGLOBIN A1c	13.4 H	<5.7 %

```
Hemoglobin A1c        Degree of Glucose Control
------------------    -------------------------
<5.7           Decreased risk of diabetes
5.7 - 6.4        Increased risk of diabetes
>6.4           Consistent with diagnosis of diabetes
```

*Notes:
STAT
Fasting: No
All tests are performed at Sunrise Medical Laboratories unless otherwise indicated

Notes: Timestamp Browse...

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

Assigned to:

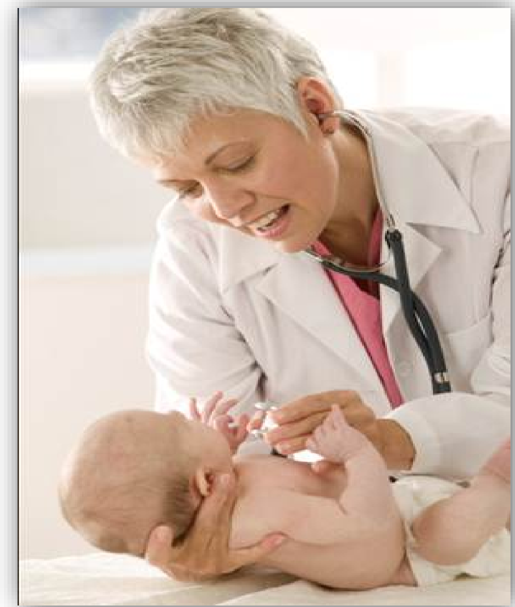
Result:

Status:
Open Reviewed

High Priority
Don't publish to Web Portal

Competency A - CC 02 (1 Credit) Newborn Hearing and Blood-Spot Screening

- Follows up with the hospital or state health department if it does not receive screening results.
- Aligns with PCMH 2014 5A
- Evidence = Documented process ***AND*** evidence of implementation



Care Coordination & Care Transitions

CC 02: Example

Snapshot
Chart Review
Results Review
MyChart Results Rel...
Flowsheets
Graphs
Growth Chart
Problem List
History
Demographics
Allergies
Medications
Health Maintena...
CCF Images
Letters
Scanned Documents
Document List
Order Entry
Imm/Injections
Forms
Episodes of Care
Doc Flowsheets
Visit Navigator

HotkeyList
Exit Workspace

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	PNEUMOCCAL VACCINE (#1)	
→	12/21/2009	ROTAVIRUS 3 DOSE VACCINE.NOT TO START	

Health Maintenance Modifiers
Neonatal Hearing Screen Normal
Neonatal Metabolic Screen Normal

Procedure Overdue   Procedure Due On   Procedure Due Soon

Patient Modifiers   Edit Modifiers   **Related Plans**

Abbreviations for Override Types

TOP	
COLONOSCOPY	Colonoscopy (ENTE
COLONOSCOPY	Colonoscopy - High
ColonoscopyN	Colonoscopy - Not H

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

Start   Inbo...   Cale...   Curr...   Prod...   RE: ...   Hyp...   Micr...   4:18 PM

Documentation required
- **Documented** process for follow-up on newborn **hearing** tests/blood spot screening.
- Example

Consider Virtual Review

Competency A - CC 03 (2 Credits) Appropriate Use for Imaging and Lab Tests are Indicated - ***New***

- Determines when imaging and lab tests are necessary based on established protocols and evidence-based guidelines.
- May implement clinical decision supports to ensure that protocols are used (e.g., embedded in order entry system).
- Evidence = Evidence of implementation

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.

This is an example of a CDSS alert for diabetes screening in a patient's chart. This alert appears when a patient with diabetes has not had an A1C test within the last 3 months.

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

- 1 Core criteria
- 9 Elective criteria

Competency B Criteria

- CC 04 Referral Management (Core)
- **CC 05 Appropriate Referrals (2 Credits)**
- **CC 06 Commonly Used Specialists Identification (1 Credit)**
- CC 07 Performance Information for Specialist Referrals (2 Credits)
- CC 08 Specialist Referral Expectations (1 Credit)

Competency B Criteria

- CC 09 Behavioral Health Referral Expectations (2 Credits)
- CC 10 Behavioral Health Integration (2 Credits)
- **CC 11 Referral Monitoring (1 Credit)**
- CC 12 Co-Management Arrangements (1 Credit)
- **CC 13 Treatment Options and Costs (2 Credits)**

Competency B Required Documented Processes

CC 04 Core – provides important information in referrals to specialists and tracks referrals until report is received

CC 08 Elective – works with specialists to set expectations for information sharing and patient care

CC 09 Elective - works with behavioral health specialists to set expectations for information sharing and patient care (may use agreement in lieu of documented process)

CC 10 Elective – integrates behavioral health providers into the care delivery system

CC 11 Elective – monitors timeliness of referral responses

CC 13 Elective – engages with patients regarding cost implications of treatment option

Competency B Criteria – CC 04 (Core) Referral Management – Aligns with PCMH 2014 5B

- Provides the clinical question, the required timing and the type of referral.
- Provides pertinent demographic and clinical data, including test results and the current care plan.
- Tracking referrals until the report is available, flagging and following up on overdue reports.
- Evidence = Documented process ***AND*** evidence of implementation

Competency B Elective Criteria CC05 through CC13 = **14 Possible Credits**

Competency B - CC 05 (2 Credits) Appropriate Referrals - ***New***

- Uses clinical protocols or decision support tools to determine if a patient needs to be seen by a specialist or if care can be addressed or managed by the primary care clinician.
- Evidence = Evidence of implementation

Competency B - CC 06 (1 Credit) Commonly Used Specialists - ***New***

- Monitors patient referrals to gain information about the referral specialists and frequently used specialty types.
- Evidence = Evidence of implementation

Competency B - CC 07 (2 Credits) Performance Information on Consultants/Specialists

- Consults available information about the performance of clinicians or practices to which it refers patients, and makes such information available to the practice team.
- Information gathered in **CC 11** regarding timely and appropriate referral response may be useful here.
- Aligns with PCMH 2014 5B
- Evidence = Data source ***AND*** examples

Performance Information for Specialist Referrals

CC 07: Example

Consider Virtual Review

Medicare.gov | Physician Compare

The Official U.S. Government Site for Medicare

Physician Compare Home | About Physician Compare | About the data | Resources | Help

Physician Compare Home

Share

Find physicians and other health care professionals | Find group practices | Search another way

A field with an asterisk (*) is required.

* Location

BROOKLYN, NY, USA

* What are you searching for?

patrice

Search

Additional search options

Spotlight

Additional information

Care Coordination & Care Transitions

CC 07: Example

Age	Clinic	ReferringProvider	Referral Type	Referral Date	Appt Date	Wait Time Days	Status
67.3	Urology (Peds): Montefiore: Hutchinson C		Urology	01/05/2015	04/23/2015	108	Consult
28.0	Headache: Montefiore: Hutchinson Camp		Neurology	01/06/2015	04/01/2015	85	Canceled by clinic
23.0	Cardiology: Montefiore-Einstein Heart Cer		Cardiology	01/09/2015	[illegible]	61	Patient no-show
69.0	Urology (Peds): Montefiore: Hutchinson C		Urology	01/09/2015	[illegible]	116	Created
37.0	Plastic Surgery: Montefiore: Hutchinson C		Plastic Surgery	01/13/2015	02/24/2015	42	Patient no-show
36.6	Urology (Peds): Montefiore: Hutchinson C		Urology	01/16/2015	04/02/2015	77	Patient no-show
59.3	Cardiology: Montefiore-Einstein Heart Cer		Cardiology	01/20/2015	02/17/2015	28	Canceled by clinic
23.8	Plastic Surgery: Montefiore: Hutchinson C		Plastic Surgery	01/20/2015	02/02/2015	13	Created
50.6	Allergy: Montefiore - Hutchinson Campus,		Allergy	01/21/2015	03/27/2015	[illegible]	Patient no-show
24.8	Endocrine (Peds): Montefiore - Hutchinso		Endocrine	01/22/2015	06/12/2015	141	Consult notes received
59.6	Infectious Disease: Montefiore: Hutchinso		Infectious Diseases	01/22/2015	02/19/2015	28	Consult notes received
74.7	Dermatology: Montefiore: Hutchinson Can		Dermatology	01/24/2015	02/18/2015	25	Canceled by patient
40.6	Dermatology: Montefiore: Hutchinson Can		Dermatology	01/26/2015	05/04/2015	98	Created
36.5	Urology (Peds): Montefiore: Hutchinson C		Urology	01/28/2015	06/09/2015	132	Created
53.3	Urology (Peds): Montefiore: Hutchinson C		Urology	01/28/2015	03/11/2015	42	Created
32.2	Family Planning: Montefiore - AECOM, 16		Family Planning	01/13/2015	03/05/2015	51	Canceled by patient
32.2	Family Planning: Montefiore - AECOM, 16		Family Planning	01/13/2015	04/06/2015	83	Consult notes received
28.0	Family Planning: Montefiore - AECOM, 16		Family Planning	01/14/2015	03/02/2015	47	Patient no-show
28.2	Family Planning: Montefiore - AECOM, 16		Family Planning	01/28/2015	03/12/2015	43	Patient no-show
28.2	Family Planning: Montefiore - AECOM, 16		Family Planning	01/28/2015	05/28/2015	120	Kept Not Seen
35.9	Family Planning: Montefiore - AECOM, 16		Family Planning	01/29/2015	02/09/2015	11	Patient no-show
35.9	Family Planning: Montefiore - AECOM, 16		Family Planning	01/29/2015	[illegible]	21	Canceled by clinic
38.8	Family Planning: Montefiore - AECOM, 16		Family Planning	01/29/2015	02/02/2015	[illegible]	Consult notes received
31.9	URO-GYN: AECOM		URO-GYN	01/08/2015	03/06/2015	57	Canceled by patient
31.9	URO-GYN: AECOM		URO-GYN	01/08/2015	05/07/2015	119	Patient no-show
32.7	URO-GYN: AECOM		URO-GYN	01/08/2015	03/02/2015	53	Patient no-show
33.8	Genetics - AECOM		Genetics	01/13/2015	02/10/2015	28	Canceled by patient
27.2	Ultrasound: AECOM		Ultrasound	01/15/2015	02/09/2015	25	Consult notes received
25.8	Fetal Echo: AECOM		ECHO	01/20/2015	02/23/2015	34	Consult notes received
63.1	Hematology: Albert Einstein College of Me		Hematology	01/20/2015	03/25/2015	64	Created
24.9	Ultrasound: AECOM		Ultrasound	01/22/2015	03/05/2015	42	Consult notes received
37.1	Genetics - AECOM		Genetics	01/23/2015	03/03/2015	39	Consult notes received
33.1	OB/GYN: MFAC - AECOM		OB/GYN	01/29/2015	02/10/2015	12	Canceled by patient
33.1	OB/GYN: MFAC - AECOM		OB/GYN	01/29/2015	02/12/2015	14	Consult notes received
34.9	Neurology: Montefiore North - Medical Vil		Neurology	01/07/2015	05/13/2015	126	Created
63.6	Neurology: Montefiore North - Medical Vil		Neurology	01/08/2015	06/11/2015	154	Created
40.3	Mammogram: MMC - North		Mammogram	01/11/2015	02/10/2015	30	Patient no-show
43.1	Ultrasound: Montefiore - Wakefield Camp		Ultrasound	01/15/2015	02/13/2015	29	Patient no-show

This report is periodically generated from TRMS, a web-based tracking database used by the practice for subspecialty referrals. It shows the total number of referrals to subspecialties for adult patients generated (electronically) in January 2015, appointments scheduled and the location (mostly within), the number of days/waiting period, and the status of those appointments.

Out of a total of 319 referrals, 76 of them were not scheduled within Medical Center, 76% were.

Competency B – CC 08 (1 Credit) Specialist Referral Expectations

- Has established relationships with healthcare specialists through formal or informal agreements that establish expectations for exchange of information (e.g., frequency, timeliness, content).
- Aligns with PCMH 2014 5B
- Evidence = Documented process ***OR*** Agreement

Competency B - CC 09 (2 Credits) Behavioral Health Referral Expectations – Aligns with PCMH 2014 5B

- Has established relationships with behavioral healthcare providers through formal or informal agreements that establish expectations for exchange of information (e.g., frequency, timeliness, content).

❖ A practice needs an agreement if it shares the same facility or campus as behavioral health professionals, but has separate systems.

Competency B - CC 09 (2 Credits) Behavioral Health Referral Expectations – Aligns with PCMH 2014 5B

- Evidence = Agreement ***OR*** Documented process ***AND*** evidence of implementation
- **A notification demonstrating legal inability to receive a report or confirmation that a behavioral health visit occurred is sufficient.**

Behavioral Health Referral Expectations

CC 09: Example

Behavioral Health Care Compact
between

Referral Process	STEP 1 (at initial office visit)	STEP 1 (within 24 - 48 hours of visit)
	☐ At the office visit, PCP will discuss reason for referral to Behavioral Health Specialist with patient/family ☐ If visit is urgent, PCP office will call The Center office intake line to notify of need for a more expedited appointment and outreach to the patient ☐ The Center contact information is provided to patient in printed care plan and follow-up plan	☐ The Center intake office receives fax and intake office will contact patient to schedule visit and complete intake assessment ☐ Insurance eligibility/benefits are reviewed when appointment is scheduled ☐ The patient will be placed with a therapist/counselor that is deemed a 'good fit' for the patient based on psychological assessed needs and insurance coverage.
	STEP 2 (within 24-48 hours of visit) ☐ Referrals will be sent via fax or through the electronic health record (EHR) to The Center intake department. The referral will include the patient's face sheet, most recent progress note, and the signed 'authorization to release PHI' form. ☐ Referral/Care Coordinator verifies insurance coverage referral requirements ☐ Pertinent records and information will be included with referral	STEP 2 (within 7-10 days of initial visit) ☐ The specialist office communicates with the PCP regarding the patient's plan of care, up-dated diagnosis, and medication recommendations. ☐ This report will be sent to the PCP office within 7-10 business days of appointment (f/u recommendations and other pertinent medical information)

Competency B - CC 10 (2 Credits) Behavioral Health Providers Integration Aligns with PCMH 2014 5B

- Behavioral health integration includes care settings that have merged to provide behavioral health services and care coordination at a single practice setting.
- Providers work together to integrate patients' primary care and behavioral health needs.
- Evidence = Documented process ***AND*** evidence of implementation

CC10 – Additional Detail from NCQA

- Question: The criteria guidance states - behavioral health integration includes care settings that have merged to provide behavioral health services and care coordination at a single practice setting. "This is more involved than co-location of practices, because all providers work together to integrate patients' primary care and behavioral health needs, have shared accountability and collaborative treatment and workflow strategies." Does this indicate a practice must have co-location of BH services to meet the criteria?
- Answer: No, co-location of BH services is not required to meet elective criterion CC 10; however, the practice must be able to demonstrate that it (at least partially) shares systems with a BH provider and that both providers work together to manage patient physical and behavioral healthcare needs to facilitate warm hand-offs and improved access to BH care. Please let us know if you have any further questions, and we are more than happy to assist!

Competency B - CC 11 (1 Credit) Monitors Timeliness and Quality of the Referral Response *- New*

- Assesses the response received from the consulting/specialty provider, evaluates whether the response was timely and provided appropriate information about the diagnosis and treatment plan.

Competency B - CC 11 (1 Credit) Monitors Timeliness and Quality of the Referral Response - *New*

- The practice bases its definition of “timely” on patient need
- On-going assessment and referral monitoring may be helpful in CC 07
- Evidence = Documented process ***AND*** report. Aligns with PCMH 2014 5B

VIDEO

DAILY DOUBLE

CC 11 (1 Credit) may be used to meet CC 07 (2 Credits)

Competency B - CC 12 (1 Credit) Co-management Arrangements

- When a particular specialist regularly treats a patient, the primary care clinician and the specialist enter into an agreement that enables safe and efficient co-management of the patient's care.
- Aligns with PCMH 2014 5B
- Evidence = ***3*** examples of implementation

Competency B - CC 13 (2 Credits) Treatment Options and Cost - ***New***

- Makes patients aware of treatment costs as indicated.
- Evidence = Documented process ***AND*** evidence of implementation

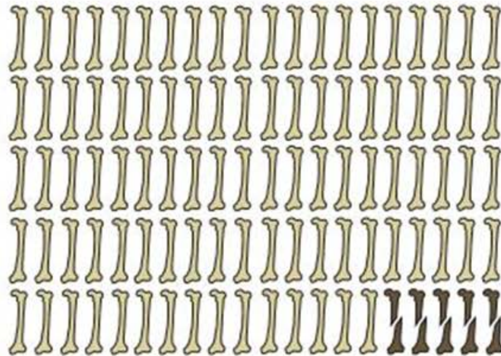
Examples of CC 13 Implementation

- Add a financial question to the clinical intake screening
- Directs patients to copay and prescription assistance programs
- Use shared decision-making tools
- Ask about prescription drug coverage
- Tell patients which services are critical and should not be skipped
- Recommend less expensive treatment options, if appropriate

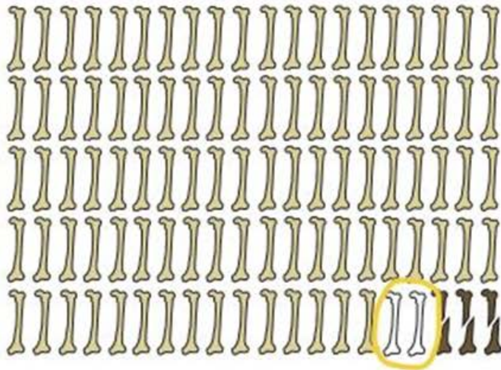
Shared Decision Making Tool with Reference to Cost

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?

Competency C

Connects with health care facilities to support patient safety throughout care transitions. The practice receives and shares necessary patient treatment information to coordinate comprehensive patient care.

3 Core criteria
5 Elective criteria

Competency C Core Criteria = 3

- CC 14 Identifying Unplanned Hospital and ED Visits
- CC 15 Sharing Clinical Information
- CC 16 Post-Hospital/ED Visit Follow-up

Competency C Elective Criteria = 5

- **CC 17 Acute Care After Hours Coordination (1 Credit)**
- CC 18 Information Exchange During Hospitalization (1 Credit)
- CC 19 Patient Discharge Summaries (1 Credit)
- CC 20 Care Plan Collaboration for Practice Transitions (1 Credit)
- CC 21 External Electronic Exchange of Information (Max 3 Credits)

Competency C Criteria Requiring Documented Processes

CC 14 Core – Systematically identifies patients with unplanned hospital admissions and ED visits

CC 15 Core - Shares clinical information with admitting hospitals and emergency departments

CC 16 Core - Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit

CC 17 Elective - Systematic ability to coordinate with acute care settings after office hours through access to current patient information.

CC 18 Elective - Exchanges patient information with the hospital during a patient's hospitalization

CC 19 Elective - Implements a process to consistently obtain patient discharge summaries from the hospital and other facilities

Competency C Criteria - CC 14 (Core) Identifies Unplanned Hospital and ED Visits

- Works with local hospitals, EDs and health plans to identify patients with recent unplanned visits
- Aligns with PCMH 2014 5C
- Evidence = Documented process and evidence of implementation

Care Coordination & Care Transitions

CC 14: Example

Consider Virtual Review

Referred Registration is an admission
Inpatient Discharge is a hospital discharge
Emergency Discharge is discharge from the ED.

Physician Care Manager - HIM Dept: HIM (OND/OND.1IVEF/OND.1IVEF) - Mosack, Maureen [EDT]

My Notices | Inpatient Cover | Outpatient Cover

Priority | All | Acknowledged

Type	Sent	Patient Name	Provider	Status
Results (13)				
ADT Events (78)				
Referred Registration	Mon Apr 27 15:39 EDT			New
Emergency Discharge	Mon Apr 27 14:59 EDT			New
Clinical Registration	Mon Apr 27 12:32 EDT			New
Emergency Registration	Mon Apr 27 12:31 EDT			New
Referred Registration	Mon Apr 27 09:53 EDT			New
Emergency Discharge	Mon Apr 27 02:02 EDT			New
Referred Registration	Mon Apr 27 01:53 EDT			New
Referred Registration	Mon Apr 27 01:38 EDT			New
Emergency Registration	Mon Apr 27 00:41 EDT			New

ADT Events (10)				
Inpatient Discharge	Mon Apr 27 16:14 EDT			New
Inpatient Transfer	Sun Apr 26 23:55 EDT			New
Inpatient Transfer	Sun Apr 26 07:37 EDT			New
Inpatient Registration	Sun Apr 26 07:37 EDT			New
Inpatient Transfer	Sun Apr 26 07:37 EDT			New
Emergency Registration	Sun Apr 26 01:38 EDT			New
Inpatient Discharge	Wed Apr 22 15:50 EDT			New
Inpatient Transfer	Mon Apr 20 16:23 EDT			New
Inpatient Registration	Mon Apr 20 07:03 EDT			New
Inpatient Transfer	Mon Apr 20 07:03 EDT			New

CC14 – Additional Detail from NCQA

- Question: The criteria guidance states - "The practice should develop a process for monitoring unplanned admissions and emergency department visits and states how often monitoring takes place. The practice works with local hospitals, EDs and health plans to identify patients with recent unplanned visits. The practice provides a report with the proportion of local admissions and ED visits (reported separately) to facilities where practices have an established notification exchange mechanism." Can the "notification exchange mechanism" be a manual process such as faxing the ADT record to the practice daily for review, or does this imply an electronic exchange of data or shared system?
- Answer: Yes, the practice may use a manual process to identify and monitor any unplanned admissions to hospitals or emergency departments to meet core criterion CC 14. NCQA is not prescriptive regarding whether the process is manual vs. electronic, but the practice must provide both a documented process and evidence of implementation such as monitoring these admissions at facilities with which it works with regularly and has a relationship.

Care Coordination & Care Transitions

CC 14-16, 18-19: Example

CC 14

CC 15

CC 19

CC 18

CC 16

Procedure:

- Hospital census is obtained daily by fax or from an offsite electronic Health Information System from local hospitals by the Care Coordinator or Nurse Care Manager.
- Communication with local hospitals is completed daily.
- Discharge records are faxed to the CHCCM from the hospital or pulled from an offsite Health Information System by the Care Coordinator or Nurse Care Manager.
- Local hospitals are contacted if additional information is needed.
- After thorough review and obtaining hospital records the Care Coordinator will give the daily census to the Nurse Care Manager for review.
- Nurse Care Manager will be responsible for assuring the medical records were received and scanned into the chart.
- Nurse Care Manager or Care Coordinator (if designated) will be responsible for contacting patient's that were admitted and discharged from the hospital within 72 hours to ensure medications and allergies are reconciled in the patient's chart, schedule follow up appointment's if needed and obtain additional information as needed.

Competency C - CC 15 (Core) Sharing Clinical Information

- Demonstrates timely sharing of information with admitting hospitals and emergency departments. Shared information supports continuity in patient care across settings.
- Aligns with PCMH 2014 5C
- Evidence = Documented process ***AND*** evidence of implementation. The practice provides three examples to meet the criteria.

Competency C - CC 16 (Core) Post Hospital/ED Visit Follow-Up

- Contacts patients to evaluate their status after discharge from an ED or hospital, and to make a follow-up appointment, if appropriate.
- The practice's policies define the appropriate contact period in addition to a log documenting systematic follow-up was completed.
- Aligns with PCMH 2014 5C
- Evidence = Documented process ***AND*** evidence of implementation

Care Coordination & Care Transitions

CC 16: Example

Consider Virtual Review

10:26 AM Telephone

MRN

Description: **45 year old female**
Provider:
Department:

Reason for Call

Follow-up since

Call Documentation

10:32 AM Signed

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

Encounter Messages

No messages in this encounter

Contacts

	Type	Contact	Phone
10:26 AM	Phone (Outgoing)		

Created by

10:26 AM

Patient Instructions

None

Competency C Elective Criteria
CC 17 – CC 21
7 Credits Total

CC 17 Acute Care After Hours Coordination
(1 Credit)

CC 18 Information Exchange During Hospitalization
(1 Credit)

CC 19 Patient Discharge Summaries
(1 Credit)

CC 20 Care Plan Collaboration for Practice Transitions
(1 Credit)

CC 21 External Electronic Exchange of Information
(Maximum 3 Credits)

Competency C - CC 17 (1 Credit) Acute Care After Hours Coordination - ***New***

- Communicates with acute care facilities when a patient is seen after the office is closed.
- Sharing patient information allows the facility to coordinate patient care based on current health needs and engage with practice staff.
- Evidence = Documented process ***AND*** at least one example of coordination with a facility

CC 17 – Additional Detail

- Question: We have providers on call after-hours who are responsible for coordinating the exchange of current information with acute care settings. Our process is a manual one, however, it is across our practice sites. Is this acceptable?

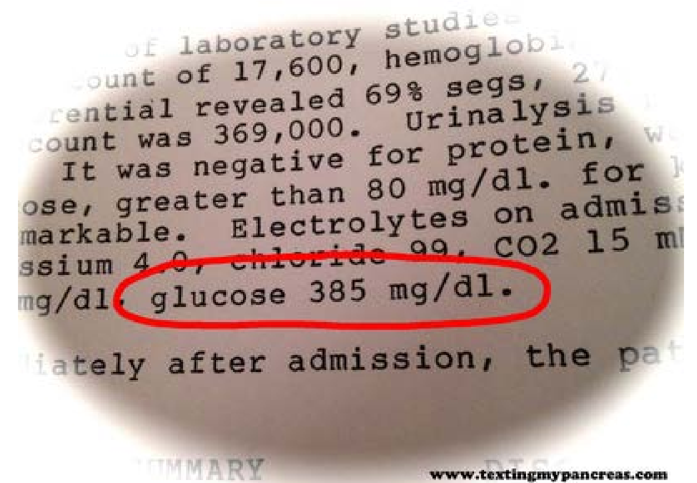
- Answer: Yes, a practice can meet CC 17 using a manual process. As long as the practice has an arrangement with one or more acute care settings that specifies how they can contact someone to access relevant patient information needed for care coordination, then it would meet the intent of the criterion. If you have any additional questions, please don't hesitate to contact us.

Competency C - CC 18 (1 Credit) Information Exchange During Hospitalization

- The practice demonstrates that it can send and receive patient information during the patient's hospitalization.
- *Note: CC 15 assesses the practice's ability to share information, but the focus of CC 18 is two-way exchange of information.*
- Aligns with PCMH 2014 5C
- Evidence = Documented process ***AND*** evidence of implementation

Competency C - CC 19 (1 Credit) Patient Discharge Summaries

- Proactively attempts to obtain discharge summaries. The process may include a local database or active outreach to ensure that the practice is notified when a patient is discharged from a hospital or other care facility.
- Aligns with PCMH 2014 5C
- Evidence = Documented process ***AND*** evidence of implementation



Care Coordination & Care Transition

CC 19: Example

Consider Virtual Review

Location: file:///F:/ppat/Files/LEVA001/LEVB001/LEVC001/LEVD001/LEVE001/LEVF001/LEVG001/LEVH001/LEVI0(

Author: Service: Family Medicine Author Type: Physician

Filed: 6/20/201 Note Time: 6/20/201 Status: Signed

Editor:

MEDICAL CENTER
Health Care Network
DISCHARGE SUMMARY

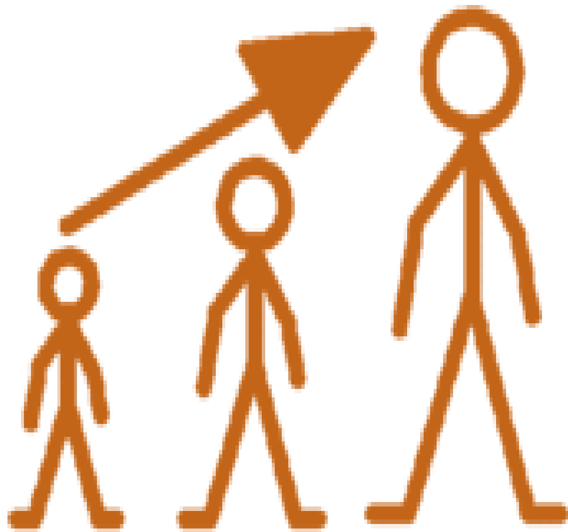
Pt. Name/Age/DOB:
Date of Admission: 6/18/20' **Date of Discharge**: 6/20/20
PCP: Christopher .
Discharging Provider: Johannah MD
Consultations:
IP CONSULT TO CASE MANAGEMENT

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

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

Hospital course, including complications:

Competency C - CC 20 (1 Credit) Transitional Care Plans



- The practice involves the patient/family/caregiver in the development or implementation of a written care plan for young adults and adolescent patients with complex needs transitioning to adult care.
- Aligns with PCMH 2014 2A

The Plan May Include…

- A summary of medical information
- A list of providers, medical equipment and medications for patients with special health care needs
- Patient response to the transition
- Obstacles to transitioning to an adult care clinician
- Special care needs
- Information provided to the patient about the transition of care
- Arrangements for release and transfer of medical records

Competency C - CC 20 Transitional Care Plans – Family Medicine

- For family medicine practices that do not transition patients from pediatric to adult care, they should still educate patients and families about ways in which their care experience may change as the patient moves into adulthood.
- Evidence = Evidence of implementation

03/23/2017

Test Patient
123 Anywhere Street
Horsham, PA 19044-

Dear Test and family,

The Wood County Community Health & Wellness Center is committed to helping our patients make a smooth transition from pediatric to adult care. This process involves working with youth, beginning at ages 12 to 14, and their families to prepare for the change from a "pediatric" model of care where parents make most decisions to an "adult" model of care where youth take full responsibility for decision-making.

As children transition to adulthood, we respect that many of our young adult patients choose to continue to involve their families in health care decisions. Only with the young adult's consent will we be able to discuss any personal health information with family members. If the youth has a condition that prevents him/her from making health care decisions, we encourage parents/caregivers to consider options for supported decision-making.

We will work with youth and families regarding the age for transitioning to adult care, but recommend that this transition occur before age 19. During this transition, we may spend time during the visit with the teen without the parent present in order to assist them in setting health priorities and supporting them in becoming more independent with their own health care. Important preventative screenings, vaccinations, and other educational materials are some of the things to expect during this transition.

Our goal is to appropriately educate our families and young adult patients on what "adult care" means. Any questions regarding this transition can be directed to any member of our care team.

Sincerely,

Electronically signed by:
Barricklow, Katherine 03/23/2017 12:31 PM

Competency C - CC 20 Transitional Care Plans – Internal Medicine

- Internal medicine practices receiving patients from pediatricians are expected to request/review the transition plan provided by pediatric practices or develop a plan if one is not provided to support a smooth and safe transition.
- Evidence = Evidence of implementation

Competency C - CC 21 (Up to 3 Credits) Electronic Information Exchange - *New*

- Utilizes an electronic system to exchange patient health record data and other clinical information with external organizations
- The practice demonstrates the capability for two-way data exchange

Competency C - CC 21 (Up to 3 Credits) Electronic Information Exchange - *New*

A. Regional health information organization or other health information exchange source that enhances the practice's ability to manage complex patients. (1 Credit)

B. Immunization registries or immunization information systems. (1 Credit)

C. Summary of care record to another provider or care facility for care transitions. (1 Credit)

Evidence = Evidence of implementation

Competency C - CC 21 (Up to 3 Credits) Electronic Information Exchange - ***New***

Practices can demonstrate this by:

- A. Exchanging patient medical record information to facilitate care management of patients with complex conditions or care needs. **Aligns with PCMH 2014 6G**
- B. Submitting electronic data to immunization registries to share immunization services provided to patients. **Aligns with PCMH 2014 6G**
- C. Making the summary of care record accessible to another provider or care facility for care transitions. **Aligns with PCMH 2014 6G**

Questions?

COMPLEX CARE

- All of the below, and…
- Provide enhanced services & tracking

CHRONIC CONDITIONS

- All of the below, and…
- Monitor, according to guidelines
- Identify and address chronic care gaps

WELL

- Provide screenings, immunizations, and follow-up
- Administer at-risk assessments
- Track referrals and test orders
- Connect with between-visit support
- Support during transitions, including…
- Follow-up after ED visits and hospital admissions

Join us for the Final PCMH Webinar in the series!

Performance Measurement & Quality Improvement (QI)

Wednesday, October 10, 12-1 PM

REGISTER HERE

Learning Objectives:

- Name the model for quality improvement used by your organization.
- Identify the metrics (measures) used to evaluate improvement efforts and outcomes at your organization.
- Specify how patients, families, providers, and care team members are involved in quality improvement activities.

Upcoming WACMHC Training Events

Social Determinants of Health: A Washington Roundtable for FQHCs

Wednesday, September 26| Seattle, WA

REGISTER HERE

Managers, directors, and key positions in Social Determinants of Health work are encouraged to join us for a day dedicated to discussions about statewide efforts in collecting and using Social Determinants of Health. Hear from partners in the healthcare safety net, and connect with peers to discuss challenges, successes, and experiences in implementing a screening program.

SAVE THE DATE

Quality Improvement Roundtable

Change Management

November 5

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