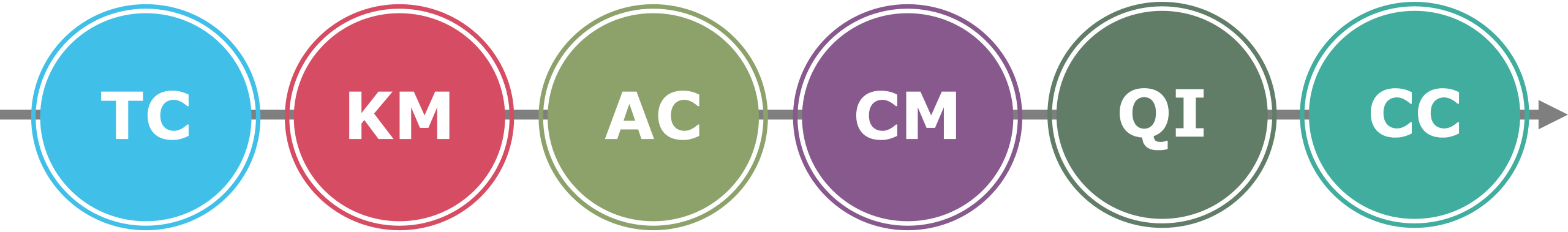
PCMH Standards v5 Overview Training

Virginia Community Healthcare Association Training Event

October 16, 2019



Team-Based Care and Practice Organization

9 Criteria Total – 5 Core, 4 Elective

TC 01: PCMH Transformation Leads
TC 02: Structure and Staff Responsibilities
TC 03: External PCMH Collaborations
TC 04: Patients/Families/Caregivers Involvement in Governance
TC 05: Certified EHR System
TC 06: Individual Patient Care Meetings/ Communication
TC 07: Staff Involvement in Quality Improvement
TC 08: Behavioral Health Care Manager
TC 09: Medical Home Information

TC 01: PCMH Transformation Leads

Designates a clinician lead of the medical home and a staff person to manage the transformation and ongoing patient-centered care.

Tips and Tricks

- Can be the same person
- Clinician lead does not have to be a physician – can be an MD, DO, APRN or PA

TC 02: Structure and Staff Responsibilities

Defines the practice's organizational structure and staff responsibilities/skills to support key practice functions.

Tips and Tricks

- Include job descriptions/roles for all team members who are core to PCMH functions (e.g. anyone who is mentioned as completing a task or responsible for carrying out something in your documented processes)
- Include your definition of how you train, including frequency (annual, 90-day new hire, quarterly)

TC 06: Individual Patient Care Meetings/ Communication

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

Tips and Tricks

- Huddles are a good example of this type of meeting (but not required)
- Other structured communication processes include medical record messaging, email exchanges, or notes on the schedule
- Not relevant for the entire practice, only care teams

FAQ TC 06

Q: Is the clinician required to attend the daily, structured team meetings focused on patient care?

A: All members of the care team must be included in communication, but it is not required that all are there in person as long as there is a process in place for relaying information.

FAQ TC 06

Q: Does it meet the requirement if clinical staff teams meet in their separate teams on different schedules?

A: Yes. The intent of the criterion is for all members of the care team to be involved in communication about patient care, but care teams can meet separately for each clinician's scheduled patients.

TC 07: Staff Involvement in Quality Improvement

Involves care team staff in the practice's performance evaluation and quality improvement activities.

Tips and Tricks

- This is something that is likely already in place at your organization, but it may not be formalized in job descriptions or processes

TC 09: Medical Home Information

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

→ At a minimum include:

- Names & phone numbers
- After hours instructions
- Services offered
- How the practice uses evidence-based care
- List of patient education and self-management resources
- Describe how and where to access the care they need

Tips and Tricks

- Process should include both new and existing patients
- Encouraged to provide the information in multiple formats (e.g. brochure, flyers, and your website)

FAQ TC 09

Q: How can you demonstrate "how the practice uses evidence-based care" in the medical home information?

A: When describing the services provided by the practice, attention should be drawn to defining evidence-based guidelines for preventive and clinical care.

Knowing and Managing Your Patients

29 Criteria Total – 10 Core, 19 Elective

KM 01: Problem Lists
KM 02: Comprehensive Health Assessment
KM 03: Depression Screening
KM 04: Behavioral Health Screenings
KM 05: Oral Health Assessment and Services
KM 06: Predominant Conditions and Concerns
KM 07: Social Determinants of Health
KM 08: Patient Materials
KM 09: Diversity
KM 10: Language
KM 11: Staff Cultural Competence and Health Literacy Skills
KM 12: Proactive Outreach
KM 13: Excellence in Performance
KM 14: Medication Reconciliation
KM 15: Medication Lists
KM 16: New Prescription Education
KM 17: Medication Responses and Barriers
KM 18: Controlled Substance Database Review
KM 19: Prescription Claims Data
KM 20: Clinical Decision Support
KM 21: Community Resource Needs
KM 22: Access to Educational Resources
KM 23: Oral Health Education
KM 24: Shared Decision-Making Aids
KM 25: School/Intervention Agency Engagement
KM 26: Community Resource List
KM 27: Community Resource Assessment
KM 28: Case Conferences
KM 29: Opioid Treatment Agreement

KM 01: Problem Lists

Documents an up-to-date problem list for each patient with current and active diagnoses.

Tips and Tricks

- Must be updated at least annually, but monitored periodically (you decide how often)
- Provide a report that demonstrates you update patient problem lists based on visits, transfer of information from other providers, or information from the patient.
- No required % threshold yet, but should be run for all patients

KM 02: Comprehensive Health Assessment

Comprehensive health assessment includes (all items required):

A. *Medical history of patient and family.*
B. *Mental health/substance use history of patient and family.*
C. *Family/social/cultural characteristics (e.g. household structure, support systems).*
D. *Communication needs due to hearing, vision, cognition (not language)*
E. *Behaviors affecting health.*
F. *Social functioning (e.g. social interaction, independent living).*
G. *Social determinants of health (e.g. education, employment, food, transportation).*
H. *Developmental screening using a standardized tool. (NA if no pediatric patients.)*
I. *Advance care planning. (NA for pediatric practices.) (advanced directive not required)*

Tips and Tricks

- No percentage requirement or report required
- Must document ‘none’ for items assessed but not present. Blank means you didn’t assess.
- Not required to assess all possible social determinants of health – pick the most relevant

FAQ  KM 02

Q: How frequently should the comprehensive health assessment be completed and updated?

A: NCQA recommends that practices use evidence-based guidelines to determine how frequently the health assessments are completed and updated. Typically practices complete the health assessment at all new patient visits, then update it at least annually.

FAQ KM 02

Q: Are practices required to capture information on the entire patient population for the comprehensive health assessment?

A: Yes. A comprehensive health assessment should be conducted for all patients and described in a documented process, so the practice has relevant and documented information about patients' physical health and social and behavioral influences.

Medical records should clearly indicate that the patient has been asked about the specific item by including a notation that the patient answered “No” or declined to answer. Practices do not lose credit if the patient says “No” or declines to answer as long as it is documented.

KM 03: Depression Screening

Conducts depression screenings for adults and adolescents using a standardized tool.

Tips and Tricks

- Must include screening AND follow-up action on positive results
- Identify standardized tool for adults and adolescents (up to you to choose the tool)
- Should screen all patients, not just those who are symptomatic

KM 09: Diversity

Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.

Tips and Tricks

- Can be collected directly from patients OR from zip code or census tract level community data (not state-level)
- Other aspects of diversity: gender identity, sexual orientation, religion, employment status, housing status, marital status, income, education level

KM 10: Language

Assesses the language needs of its population.

Tips and Tricks

- Can be collected directly from patients OR from zip code/ census tract level community data (e.g. census)
- If collected from patients, all responses must be recorded in the medical record (no blank fields)

KM 12: Proactive Outreach

Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (must report an item/service in at least 3 categories):

A. *Preventive care services.*
B. *Immunizations.*
C. *Chronic or acute care services.*
D. *Patients not recently seen by the practice*

Tips and Tricks

- Must be done at least annually – no older than 12 months
- Must be personalized to the patients, not a general letter (e.g. flu season)
- Must provide outreach evidence (e.g. phone script, letters) per service
- Representative of patient population – adults and children if applicable

FAQ KM 12

Q: Can we "count" flu vaccination for adults for KM12A and flu vaccination for children for KM12B?

A: No. The practice must report separate services across each of the categories. So in this example, flu vaccination could only be used for KM12B and the practice would choose another service for KM12A.

NOTE: Regarding immunizations, NCQA considers Tdap and DTaP the same immunization for different age groups and does not accept them as two different services. The practice can only use this service for one of the categories in KM12.

KM 14: Medication Reconciliation

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

Tips and Tricks

- Aligns with Meaningful Use
- Review occurs at transitions of care, but at least annually
- Documentation in medical record must be completed on all patients, in order to get an accurate report and hit 80%

KM 15: Medication Lists

Maintains an up-to-date list of medications for more than 80 percent of patients.

Tips and Tricks

- Should be captured in searchable fields in EHR.
- Documentation in medical record should include date of last update
- Should include over the counter medications and supplements

FAQ KM 14/15

Q: Can you use the same report for documentation of KM 14 and KM 15?

A: Yes. Medication reconciliation (KM 14) includes the process to check for drug and condition interactions in addition to confirming the list of medications with the patient (KM 15). The practice may be asked to provide a documented process to confirm the same report can be used.

KM 20: Clinical Decision Support

Implements clinical decision support following evidence-based guidelines for care of (Practice must demonstrate at least 4 criteria):

A. A mental health condition.
B. A substance use disorder.
C. A chronic medical condition.
D. An acute condition (e.g. acute back pain, influenza, sinusitis, otitis media, UTI).
E. A condition related to unhealthy behaviors (e.g. obesity, smoking).
F. Well-child or adult care (e.g. age appropriate screenings, immunizations).
G. Overuse/appropriateness issues (e.g. antibiotic use, avoiding unnecessary tests).

Tips and Tricks

- Provide a patient example demonstrating use at point of care (not blank)
- Intent is that the clinician is alerted at the point of care – built into EHR or part of the workflow

FAQ  KM 20

Q: Would an EHR prompt to conduct a PHQ depression screening meet the intent of KM 20-A?

A: No. An EMR prompt to conduct a PHQ depression screening would not meet the intent of KM 20A. Clinical decision support is designed to aid clinicians in making evidence-based decisions about care of patients with an already diagnosed condition, not to screen for new ones. Depression screening is addressed in KM 03.

KM 21: Community Resource Needs

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

Tips and Tricks

- Generate a list of key patient needs and concerns
- Consider social determinants of health, predominant conditions, ED use, etc.
- Community resources include food banks, support groups, social services organizations

Patient Centered Access and Continuity

14 Criteria Total – 7 Core, 7 Elective

AC 01: Access Needs and Preferences
AC 02: Same-Day appointments
AC 03: Appointments Outside Business Hours
AC 04: Timely Clinical Advice by Telephone
AC 05: Clinical Advice Documentation
AC 06: Alternative Appointments
AC 07: Electronic Patient Requests
AC 08: Two-Way Electronic Communication
AC 09: Equity of Access
AC 10: Personal Clinician Selection
AC 11: Patient Visits with Clinician/Team
AC 12: Continuity of Medical Record Information
AC 13: Panel Size Review and Management
AC 14: External Panel Review and Reconciliation

AC 01: Access Needs and Preferences

Assesses the access needs and preferences of the patient population.

Tips and Tricks

- Typically practices use a survey
- Can be qualitative feedback as long as there are specific instructions on giving feedback on access.
- May consider appointments as well as other access-related items (e.g. after hours, communication via patient portal)

AC 02: Same-Day Appointments

Provides same-day appointments for routine and urgent care to meet identified patient needs.

Tips and Tricks

- Define routine AND urgent appointments and provide for both
- Demonstrate available and used same-day appointments
- Not required to be provided by every provider or for every appointment type (e.g. not required for new patient appointments)
- May be provided by other clinical team members (e.g. NP, PA)
- May use utilization of same-day appointment access as an indication of patient need.

FAQ AC 02

Q: How are "routine" visits defined, and can the practice give first priority for same-day scheduling for urgent appointments?

A: As long as same-day appointments are provided for both routine and urgent needs, it is up to the practice to determine how to prioritize scheduling. NCQA leaves the definitions of urgent and routine appointments (and all appointment types) up to the practice. Here is one example:

- Urgent Care (Acute Illness) - Patients will be seen same day of request with physician, PA or NP if call is before 2. If nothing available, patient will be directed to triage nurse for recommendation.
- Routine Care (Chronic Conditions) Patient scheduled within 24 hours with physician, NP or PA. No more than 3-day time lapse unless requested by the patient.
- Wellness Care (Physical/WWE) Patient is scheduled within 8 weeks of request with physician, PA or NP. With exception of those patients seen prior to one calendar year from that time.

FAQ AC 02

Q: Does a walk-in clinic count for AC 02? If not, how many same-day appointments are required?

A: No. A clinic may provide walk-in hours in addition to same day appointments; however, providing walk-in hours or “working patients into the schedule” alone do not meet the intent for AC 02.

NCQA does not specify a required number of same-day appointments. The practice should determine the schedule of same-day appointments based on usage and patient feedback.

AC 03: Appointments Outside Business Hours

Provides routine and urgent appointments outside regular business hours to meet identified patient needs.

Tips and Tricks

- Define routine AND urgent appointments and provide for both
- Define regular business hours, then determine how/when to provide “after hours” appointments. It does not have to be every day.
- Can be provided as extended hours by the practice, another practice site, or through partnerships (must have access to patient records, cannot be an unaffiliated ED or urgent care center)

AC 04: Timely Clinical Advice by Telephone

Provides timely clinical advice by telephone.

Tips and Tricks

- Must be interactive (a person, not recording), and provided 24 hours
- Define timeframe for returning calls and monitor response times
- Clinical staff who are qualified to provide advice is determined by state licensing laws

AC 05: Clinical Advice Documentation

Documents clinical advice in patient records and confirms clinical advice and care provided after hours does not conflict with the patient's medical record.

Tips and Tricks

- Must demonstrate clinical advice provided during and after hours
- Reconcile advice with medical record by next business day, address any identified conflicts

AC 10: Personal Clinician Selection

Helps patients/families/caregivers select or change a personal clinician.

Tips and Tricks

- Single-clinician sites automatically meet AC 10
- May document a defined pair or team of clinicians (e.g. physician and resident, physician and NP)
- NP can be considered a primary care provider or as part of a physician team, as determined by the practice for AC 10 (as long as the practice has one physician listed on the NCQA PCMH application)

AC 11: Patient Visits with Clinician/ Team

Sets goals and monitors the percentage of patient visits with the selected clinician or team.

Tips and Tricks

- Linked to clinician/team definitions in AC 10.
- Determine the goal for percentage of visits with designated clinician, then monitor the performance. No NCQA threshold.
- Consider AC 02 (same-day) policy and “timely” appointment availability when setting the goal for AC 11

Care Management and Support

9 Criteria Total – 4 Core, 5 Elective

CM 01: Identifying Patients for Care Management
CM 02: Monitoring Patients for Care Management
CM 03: Comprehensive Risk-Stratification Process
CM 04: Person-Centered Care Plans
CM 05: Written Care Plans
CM 06: Patient Preferences and Goals
CM 07: Patient Barriers to Goals
CM 08: Self-Management Plans
CM 09: Care Plan Integration

CM 01: Identifying Patients for Care Management

Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least 3 in its criteria):

A. *Behavioral health conditions (e.g. substance use other than tobacco, mental health diagnosis)*
B. *High cost/high utilization (e.g. multiple ER visits, hospital readmissions)*
C. *Poorly controlled or complex conditions (e.g. high A1C or BP results, multiple comorbidities)*
D. *Social determinants of health (e.g. public safety, social support, socioeconomic, employment)*
E. *Referrals by outside organizations (e.g. insurers, health system, ACO), practice staff, family*

Tips and Tricks

- Select conditions based on patient population needs and capacity
- Chosen criteria must yield at least 30 patients, but we recommend more
- Patients with one or more conditions, not patients who meet all criteria
- Not a set study group to follow, but a dynamic group receiving services based on criteria

CM 02: Monitoring Patients for Care Management

Monitors the percentage of the total patient population identified through its process and criteria.

Tips and Tricks

- Use criteria definition from CM 01
- Calculate percentage that the CM 01 definition yields – patients who fit one or more criteria, not all criteria
- Account for attrition in definitions of CM 01 (always must be ≥ 30 patients if randomly sampled)

FAQ  CM 01/02

Q: What number or percentage of the practice's patient population should we target for care management?

A: NCQA does not specify a target or a requirement but emphasizes that the intent is to use a defined criteria to identify true vulnerability. 'Unofficial' guidance suggests an estimated 10-15% of a clinic's patient population is reasonable starting point.

For documentation, you need at least 30 patients TOTAL per site who meet one or more criteria. If you do not have at least 30 patients per site, then you would need to expand your definition of CM 01.

But this is not a set group of patients – if, for example, a patient joins the practice or has a health event that makes them fit the defined criteria for care management then they should receive those services.

CM 04: Person-Centered Care Plans

Establishes a person-centered care plan for patients identified for care management.

Tips and Tricks

- Can tweak the clinical summary/summary of care
- Include problem list, outcome/prognosis, treatment goals, medication management, and a review schedule
- Must be updated not re-created at relevant visits (visits pertinent to the condition identified for care management – anything that could affect progress towards goals). Document when created & updated.
- Unofficial minimum threshold is 75% of patients identified for CM.

FAQ CM 04

Q: Does care management need to be provided in person at a visit with a provider?

A: No. Care planning is not limited to visits with a physician and it is not limited to just in-person office visits. Care planning can be discussed and documented at patient visits with the health educator, chronic care manager, nurse, or other health professional. If your practice supplements office visits with telephonic visits and updates the care plan based on what is discussed during those calls, that would be appropriate.

CM 05: Written Care Plans

Provides a written care plan to the patient/family/caregiver for patients identified for care management.

Tips and Tricks

- Tailor to patients' health literacy and language preferences (may be different than the internal one for practice team)
- Printed and given to patient or made available electronically
- Must document when provided (in medical record)
- Unofficial minimum threshold is 75% of pts. eligible for CM
- If patient declines a written care plan, the practice may count it as a 'Yes' in numerator (but must document in record)

FAQ CM 05

Q: Can the care plan be made available via the patient portal?

A: No. Although the care plan can be made available via the patient portal, it is essential that all patients have access to the document. If patients are not registered for the portal, they will not have access. In those cases, practices should use an alternative method to provide the written care plan to patients to ensure that all patients have access after an appointment.

Make sure to document in the medical record when the care plan is provided to the patient.

Performance Measurement and Quality Improvement

19 Criteria Total – 9 Core, 10 Elective

QI 01: Clinical Quality Measures
QI 02: Resource Stewardship Measures
QI 03: Appointment Availability Assessment
QI 04: Patient Experience Feedback
QI 05: Health Disparities Assessment
QI 06: Validated Patient Experience Survey Use
QI 07: Vulnerable Patient Feedback
QI 08: Goals and Actions to Improve Clinical Quality Measures
QI 09: Goals and Actions to Improve Resource Stewardship Measures
QI 10: Goals and Actions to Improve Appointment Availability
QI 11: Goals and Actions to Improve Patient Experience
QI 12: Improved Performance
QI 13: Goals and Actions to Improve Disparities in Care/Service
QI 14: Improved Performance for Disparities in Care/Service
QI 15: Reporting Performance Within the Practice
QI 16: Reporting Performance Publicly or With Patients
QI 17: Patient/Family/Caregiver Involvement in Quality Improvement
QI 18: Reporting Performance Measures to Medicare/Medicaid
QI 19: Value-Based Contract Agreements

QI 01: Clinical Quality Measures

Monitors at least five (5) clinical quality measures across the four (4) categories (must monitor at least 1 measure from each category):

A. *Immunization measures.*
B. *Other preventive care measures (not including immunizations)*
C. *Chronic or acute care clinical measures.*
D. *Behavioral health measures.*

Tips and Tricks

- Include measurement period, numerator, denominator, rate, and measure source
- Measures must be unique – counted only once per category

FAQ QI 01

Q: What is an example set of measures for QI 01? And can we use our UDS measures?

A: Data must be specific to the site. Only single-site FQHCs can use UDS data for QI 01. One example measure set for QI 01 could include the following:

- Pneumococcal Vaccine (QI 01-A)
- Colorectal Cancer Screening (QI 01-B)
- Blood Pressure Control (QI 01-C)
- Hemoglobin A1c Control (QI 01-C)
- Depression Screening and Follow-Up (QI 01-D)

FAQ QI 01-B

Q: May practices use well-child visits for two different preventive care measures?

A: Yes. Practices may only count well-child visits for different age groups as distinct preventive care measures if the measures are aimed at assessing completion of age-specific screenings and tests (e.g. autism screen at 2-year check-up, adolescent depression screen), according to evidence-based guidelines. Assessing patient access to well visits for two different pediatric age groups would not be considered two different measures.

QI 02: Resource Stewardship Measures

Monitors <u>at least</u> two (2) measures of resource stewardship (must monitor at least one of each type):

A. *Measures related to care coordination.*
B. *Measures affecting health care costs.*

Tips and Tricks

- Consider alignment with other programs and measures (e.g. Meaningful Use)

FAQ  QI 02-A

Q: Example care coordination measures (QI 02-A)?

A: The intent of QI 02A is to evaluate the communication/coordination that occurs between providers or providers and patients, so it's generally looking at closing the loop on care coordination tasks/processes. Some examples may include but are not limited to:

- Reduced % of patients seeing multiple providers (3 or more)
- Medication reconciliation after care transition (MU)
- Outreach to patients not recently seen that result in an appointment
- Follow up with patients or providers to ensure ordered lab or imaging tests were completed – related to CC 01
- Follow-up phone calls to check on the patient after an ER visit (or hospitalization) – related to CC 16

FAQ QI 02-B

Q: Example measures affecting health costs (QI 02-B)?

A: The intent of QI 02B is for practices to use measures to help them understand how efficiently they're providing care and judiciously using resources – to examine how the practice can impact utilization and costs in healthcare. Some examples may include but are not limited to:

- Total cost per patient or medical cost per medical visit
- # of medications prescribed or use of high cost medications
- Use of imaging for low back pain
- Redundant imaging or lab tests
- Emergency department utilization
- Hospital readmission rates
- Use of generic versus brand name medication

Note: Preventive care measures are not considered utilization measures. No show rates would not satisfy this criterion as they are at the practice-level only.

QI 03: Appointment Availability Assessment

Assesses performance on availability of major appointment types to meet patient needs and preferences for access

Tips and Tricks

- Linked to AC 01 (access needs and preferences) and AC 02 (same-day)
- Define appointment types and standards for each
- Third next available appointment is one way of measuring availability (see IHI resource online)

QI 04: Patient Experience Feedback

Monitors patient experience through <u>both</u>:

A. *Quantitative data. Conducts a survey (using any instrument, not just CAHPS) to evaluate patient/family/caregiver experiences across ≥ 3 categories:*
   - *Access (e.g. routine, urgent, after-hours)*
   - *Communication (e.g. feeling respected and listened to, able to get answers to questions)*
   - *Coordination (e.g. informed and up to date on referrals, changes in medications, lab or imaging results)*
   - *Whole-person care, self-management support, and comprehensiveness*

B. *Qualitative data. Obtains feedback from patients/families/caregivers through qualitative means. (e.g. focus group, individual interviews, suggestion box)*

Tips and Tricks

- No minimum sample size required but should represent entire pop.
- Scheduling an appointment, waiting room amenities, and ease of getting to the practice would NOT satisfy “Access” for QI 04-A
- QI 04-B Qualitative data must be collected outside of the survey

FAQ QI 04-B

Q: Would responses in the comment boxes of our patient experience survey or a Patient and Family Advisory Committee satisfy QI 04-B?

A: No. The intent of QI 04B is to get input from a broader audience and from different avenues beyond the patient experience survey to allow patients to voice opinions on a variety of practice features. If input is restricted to just the PFAC, the same few voices are heard and you may be missing input from the majority of patients at your practice. When it mentions using a focus group in QI 04-B, it would need to be a group that is different from your PFAC so that you are getting a more robust picture of patient experience.

If your practice has convened a PFAC that discusses quality improvement and governance, your practice could meet two electives, TC 04 (2 credits) and QI 17 (2 credits).

FAQ QI 01-04 and 08-11

QI 01 - 04 **Analyze**			*QI 08 - 11* **Set goals and Act to Improve**	
QI 01	5 clinical measures from 4 categories	→	QI 08	3 measures (out of the 5) from 3 categories
QI 02	2 resource stewardship measures from 2 categories	→	QI 09	1 measure (out of the 2)
QI 03	Availability of major appointment types	→	QI 10	Same
QI 04	Monitor patient experience	→	QI 11	1 measure

QI 08: Goals and Actions to Improve Clinical Quality Measures

Sets goals and acts to improve upon at least three (3) measures across at least three of the four categories from QI 01:

A. *Immunization measures.*
B. *Other preventive care measures (not including immunizations)*
C. *Chronic or acute care clinical measures.*
D. *Behavioral health measures (e.g. depression or postpartum depression screening).*

Tips and Tricks

- Linked to QI 01- here you are choosing 3 of the 5 measures you identified, then setting goals and acting to improve just these 3
- You define the goal - must be higher than baseline. Set a goal with large margin for improvement
- Consider existing QI initiatives. A Plan-Do-Study-Act cycle is one type of “action” to improve.

QI 09: Goals and Actions to Improve Resource Stewardship Measures

Sets goals and acts to improve performance on at least one (1) measure of resource stewardship from QI 02:

A. Measures related to care coordination.

B. Measures affecting health care costs.

Tips and Tricks

- Linked to QI 02- here you are choosing 1 of the 2 identified, then setting a goal and acting to improve just one measure
- You define the goal - must be higher than baseline. Set a goal with large margin for improvement
- Consider existing QI initiatives. A Plan-Do-Study-Act cycle is one type of “action” to improve.

QI 10: Goals and Actions to Improve Appointment Availability

Sets goals and acts to improve on availability of major appointment types to meet patient needs and preferences for access

Tips and Tricks

- Linked to QI 03
- You define the goal - must be higher than baseline. Set a goal with large margin for improvement
- If appointment-availability access goals have all been met and no room for improvement, may choose another access area (e.g. time spent in waiting room, no show rates, extended hours, alternative visit types) as the focus
- Consider existing QI initiatives. A Plan-Do-Study-Act cycle is one type of “action” to improve.

QI 11: Goals and Actions to Improve Patient Experience

Sets goals and acts to improve performance on at least one (1) patient experience measure.

Tips and Tricks

- Linked to QI 04 – choose one of the patient experience measures from QI 04-A
- You define the goal - must be higher than baseline. Set a goal with large margin for improvement.
- Improve results of a specific question on the survey, not the overall number of patients who complete it
- Consider existing QI initiatives. A Plan-Do-Study-Act cycle is one type of “action” to improve.

FAQ QI 11

Q: Would responses in the comment boxes of our patient experience survey or a Patient and Family Advisory Committee satisfy QI 04-B?

A: No. The intent of QI 04B is to get input from a broader audience and from different avenues beyond the patient experience survey to allow patients to voice opinions on a variety of practice features. If input is restricted to just the PFAC, the same few voices are heard and you may be missing input from the majority of patients at your practice. When it mentions using a focus group in QI 04-B, it would need to be a group that is different from your PFAC so that you are getting a more robust picture of patient experience.

If your practice has convened a PFAC that discusses quality improvement and governance, your practice could meet two electives, TC 04 (2 credits) and QI 17 (2 credits).

QI 15: Reporting Performance within the Practice

Shares clinician-level or practice-level performance results with clinicians and staff for measures it reports.

Tips and Tricks

- Must demonstrate sharing of performance of at least one measure from QI 01 (clinical), QI 02 (resource stewardship), and QI 04 (patient experience)
- For one-clinician sites, the report would be the same

Care Coordination and Care Transitions

21 Criteria Total – 5 Core, 16 Elective

CC 01: Lab and Imaging Test Management
CC 02: Newborn Screenings
CC 03: Appropriate Use for Labs and Imaging
CC 04: Referral Management
CC 05: Appropriate Referrals
CC 06: Commonly Used Specialists Identification
CC 07: Performance Information for Specialist Referrals
CC 08: Specialist Referral Expectations
CC 09: Behavioral Health Referral Expectations
CC 10: Behavioral Health Integration
CC 11: Referral Monitoring
CC 12: Co-Management Arrangements
CC 13: Treatment Options and Costs
CC 14: Identifying Unplanned Hospital and ED Visits
CC 15: Sharing Clinical Information
CC 16: Post-Hospital/ED Visit Follow-Up
CC 17: Acute Care After Hours Coordination
CC 18: Information Exchange During Hospitalization
CC 19: Patient Discharge Summaries
CC 20: Care Plan Collaboration for Practice Transitions
CC 21: External Electronic Exchange of Information

CC 01: Lab and Imaging Test Management

The practice systematically manages lab and imaging tests by:

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

Tips and Tricks

- Determine tracking mechanism (report, log, electronic tracking system)
- Flag can be an automated icon in the electronic system or manual with timely surveillance process
- Not required to receive all reports in timely manner (not in practice's control), but to set clear expectations and follow-up on overdue reports
- No "official" minimum data requirements in terms of tests tracked

CC 04: Referral Management

The practice systematically manages referrals by:

A. *Giving the consultant or specialist the clinical question, the required timing and the type of referral.*
B. *Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.*
C. *Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports. (include date initiated and timing for receiving report)*

Tips and Tricks

- Determine tracking mechanism (report, log, electronic system)
- Not required to track all referrals; focus on important referrals (e.g. high-risk patients)
- Not required that all patients keep the referral visit (not in practice's control), but to track and follow-up on overdue reports

CC 14: Identifying Unplanned Hospital and ED Visits

Systematically identifies unplanned hospital admissions and emergency department visits

Tips and Tricks

- Does not have to be with every facility – just the one(s) most used by your patients
- Relying on discharge notification does not meet intent
- Can use health plan data if provided weekly and if collectively represent 75% of patient population

CC 15: Sharing Clinical Information

Shares clinical information with admitting hospitals and emergency departments (when made aware of an admission or on request)

Tips and Tricks

- You define “timely” in terms of information sharing
- Does not have to be with every facility – just the one(s) most often used by your patients
- Not required to be electronic

FAQ CC 04/15

Q: If the practice shares an EHR with specialists and hospital facilities, how would they document evidence of shared information?

A: The practice should have a documented process on referrals (how the PCP sends referrals and how the specialist accesses the records) and a documented process that describes how the hospital and ER are able to access the patient data via the shared EHR. The practice would also provide screenshots (or demonstrate in a virtual review) how the specialist/ER viewed the patient record.

Please note that the practice should also have a process in place for sharing patient information in the case that a patient is admitted to an ER or a hospital outside of the system.

CC 16: Post-Hospital/ED Visit Follow-Up

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

Tips and Tricks

- You define the appropriate contact period
- May include offering care to prevent worsening of condition, clarifying discharge instructions, encouraging follow-up care