Comprehensive Health Assessment and Population Management

(KM Competency A)

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Community Health Solutions

Community Health Solutions

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.

KM – Competency A

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

Criteria	Criteria Description	Required Evidence	Crosswalk to 2014
KM 01 (Core)	Documents an up-to-date problem list for each patient with current and active diagnoses.	*Report **OR** KM 06—predominant conditions and health concerns*	*3B1*
KM 02 (Core) ***(F) is new** ***(G) is new**	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 D. Communication needs. E. Behaviors affecting health F. Social Functioning * G. Social Determinants of Health * 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)	*Documented process **AND** Evidence of implementation*	*3C2-8*

KM – Competency A
(continued)

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

Criteria	Criteria Description	Required Evidence	Crosswalk to 2014
KM 03 (Core)	Conducts depression screenings for adults and adolescents using a standardized tool.	*Evidence of implementation* ***AND*** *Report or Documented Process*	*3C9*
KM 04 * (1 Credit)	Conducts behavioral health screenings and/or assessments using a standardized tool. (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	*Documented process* ***AND*** *Evidence of implementation*	*No equivalent*

KM – Competency A
(continued)

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

Criteria	Criteria Description	Required Evidence	Crosswalk to 2014
KM 05 * (1 Credit)	Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners.	*Documented process **AND** Evidence of implementation*	*No equivalent*
KM 06 * (1 Credit)	Identifies the predominant conditions and health concerns of the patient population.	*List of top priority conditions and concerns*	*No equivalent*
KM 07 * (2 Credits)	Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data.	*Report **AND** Evidence of implementation*	*No equivalent*
KM 08 * (1 Credit)	Evaluates patient population demographics/communication preferences/ health literacy to tailor development and distribution of patient materials.	*Report AND Evidence of implementation*	*No equivalent*

KM 01 (Core)

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

- **Up-to-date** means that the most recent diagnoses—ascertained from previous records, transfer of information from other providers, diagnosis by the clinician, or by querying the patient—are added to the problem list. Report shows patients with updated problem list at least annually.
- The patient's active problem list or diagnoses should include acute and chronic conditions, behavioral health diagnoses and oral health issues, as well as past diagnoses that are relevant to the patient's current care. Implementing KM 01 is a foundation for understanding health risks.

KM 02 (Core)

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.

D. Communication needs.

E. Behaviors affecting health.

F. Social functioning.

G. Social determinants of health.

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.)

KM 02 (Core) Continued

- 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. Comprehensive, current data on patients provides a foundation for supporting population needs.
- As part of the comprehensive health assessment the practice:

  A. Collects patient and family medical history (e.g., history of chronic disease or event [e.g., diabetes, cancer, surgery, hypertension]) for patient and "first-degree" relatives (i.e., who share about 50% of their genes with a specific family member).

  B. Collects patient and family behavioral health history (e.g., schizophrenia, stress, alcohol, prescription drug abuse, illegal drug use, maternal depression).

  C. Evaluates social and cultural needs, preferences, strengths and limitations. Examples include family/household structure, support systems, and patient/family concerns. Broad consideration should be given to a variety of characteristics (e.g., education level, marital status, unemployment, social support, assigned responsibilities).

  D. Identifies whether a patient has specific communication requirements due to hearing, vision or cognition issues. ***Note:*** *This does not address language; refer to KM10 for language needs.*

KM 02 (Core) Continued

E. Assesses risky and unhealthy behaviors that go beyond physical activity, alcohol consumption and smoking status and may include nutrition, oral health, dental care, risky sexual behavior and secondhand smoke exposure.

F. **NEW** Assesses a patient's ability to interact with other people in everyday social tasks and to maintain an adequate social life. May include isolation, declining cognition, social anxiety, interpersonal relationships, activities of independent living, social interactions and so on.

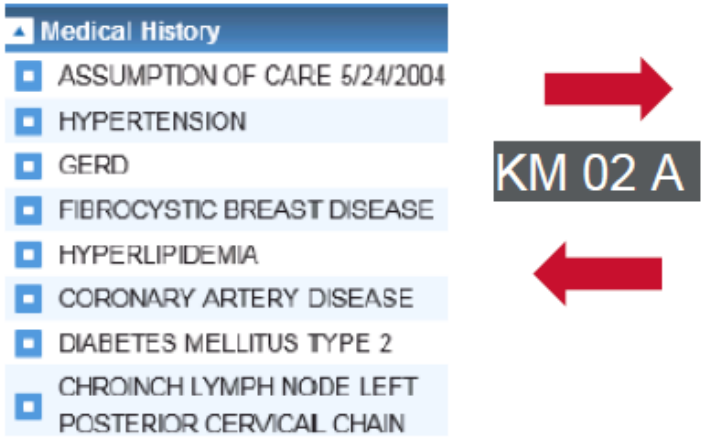
G. **NEW** Collects information on **social determinants of health:** conditions in a patient's environment that affect a wide range of health, functioning and quality-of-life outcomes and risks. Examples include availability of resources to meet daily needs; access to educational, economic and job opportunities; public safety, social support; social norms and attitudes; food and housing insecurities; household/environmental **risk factors**; exposure to crime, violence and social disorder; socioeconomic conditions; residential segregation (Healthy People 2020).

H. For newborns through 3 years of age, uses a standardized tool for periodic developmental screening. If there are no established risk factors or parental concerns, screens are done by 24 months.

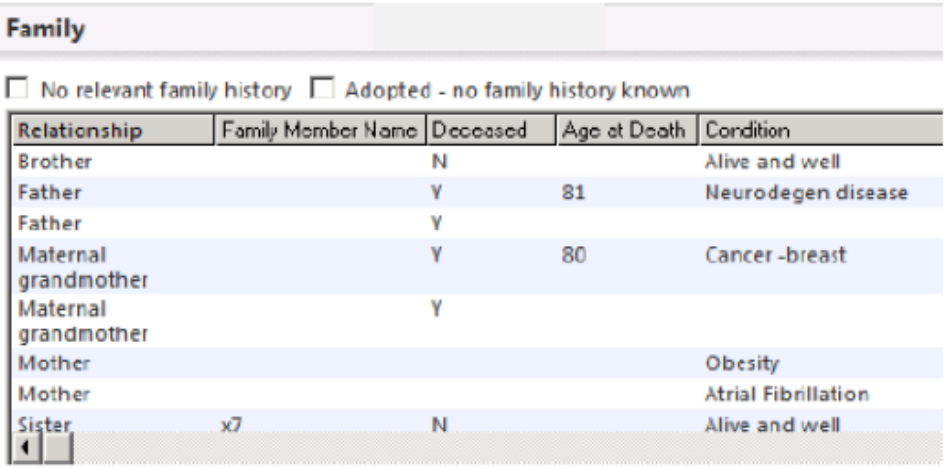
I. Documents patient/family preferences for **advance care planning** (i.e., care at the end of life or for patients who are unable to speak for themselves). This may include discussing and documenting a plan of care, with treatment options and preferences. Patients with an advance directive on file meet the requirement.

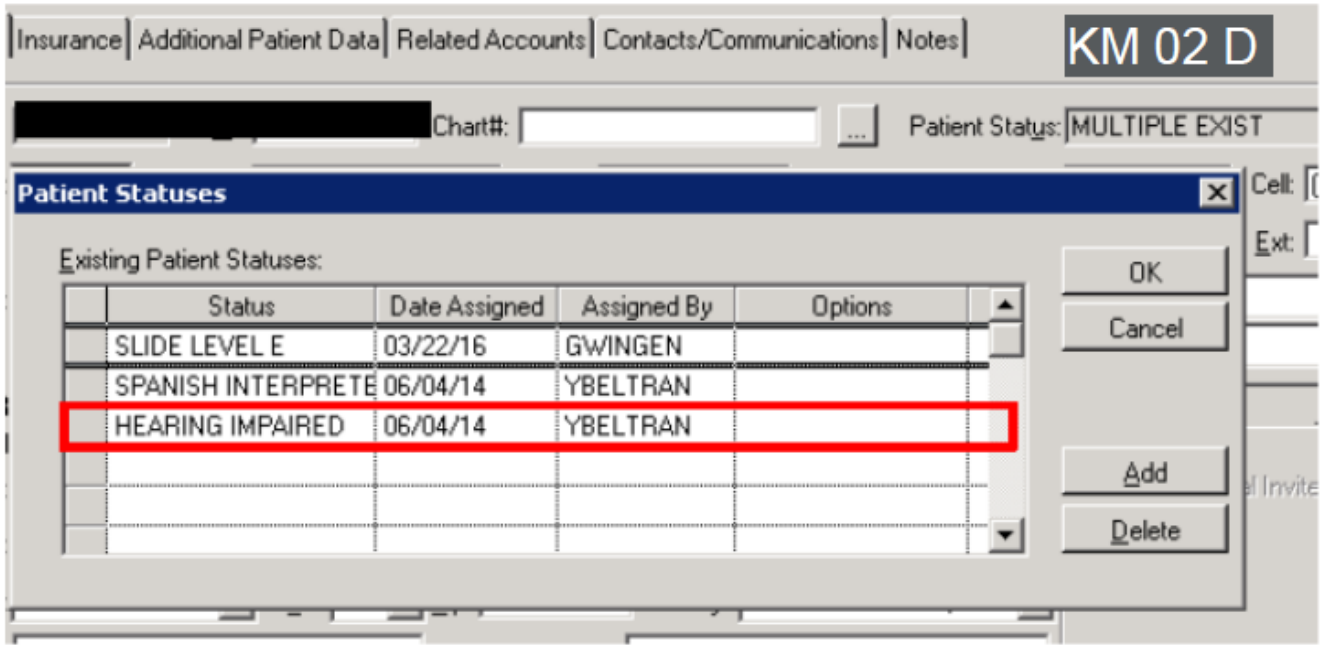
Knowing and Managing Your Patients

KM 02 A&D: Example



KM 02 A





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.

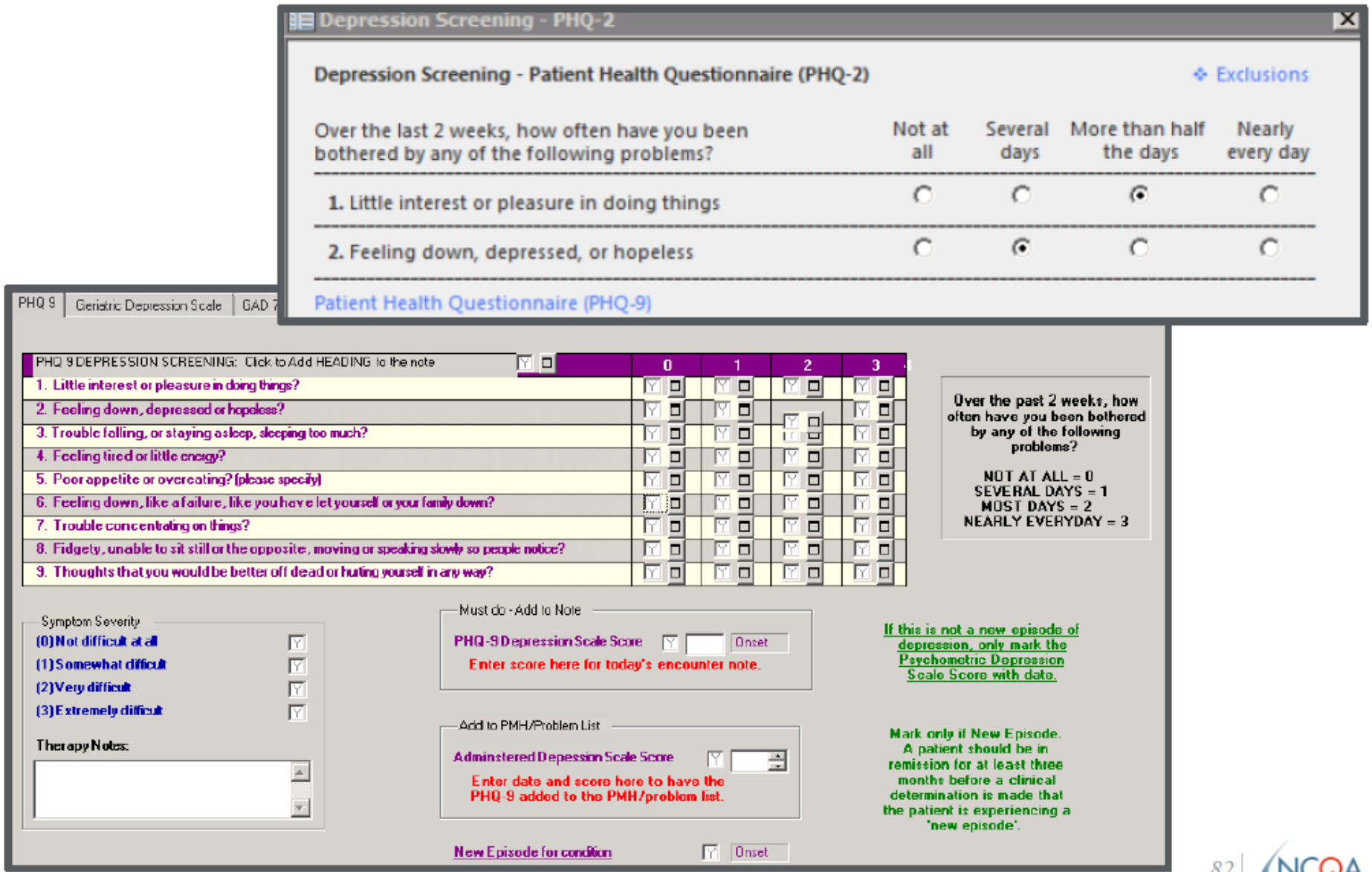
KM 03 (Core)

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

- The documented process includes the practice's screening process and approach to follow-up for positive screens. The practice reports screening rate and identifies the standardized screening tool.
- **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.
- A **standardized tool** collects information using a current, evidence-based approach that was developed, field-tested and endorsed by a national or regional organization.
- In caring for the whole person, the medical home recognizes the impact depression can have on a patient's physical and emotional health. The practice uses a standardized screening tool (e.g., PHQ-9) and acts on the results. This criterion is not met if the practice does not screen for depression or if screening is not performed with a standardized tool.

Knowing and Managing Your Patients

KM 03: Example



KM 04 (1 Credit)

Conducts behavioral health screenings and/or assessments using a standardized tool. (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.

- Many patients go undiagnosed and untreated for mental health and substance use disorders. The medical home can play a major role in early identification of these conditions. Practice staff have been trained on the use of standardized tools to ensure accurate diagnosis, treatment and follow-up.

KM 04 (1 Credit) Continued

- A **standardized tool** collects information using a current, evidence-based approach that was developed, field-tested and endorsed by a national or regional organization.
- The National Institute on Drug Abuse created a chart of Evidence Based Screening Tools for Adults and Adolescents for opioid screening, as well as alcohol and substance use tools.

  A. The practice conducts screening for the presence of emotional distress and symptoms of anxiety using any validated tool (e.g., GAD-2, GAD-7). Anxiety disorders are common, often undetected and misdiagnosed, associated with other psychiatric conditions and linked with medical conditions (e.g., heart disease, chronic pain disorders).

  B. The USPSTF recommends screening for adults aged 18 years or older for alcohol misuse and providing patients engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse. Practices may use the Alcohol Use Disorders Identification Test (AUDIT), a screening for excessive drinking, the Drug Abuse Screening Test (DAST), CAGE or another validated screening tool. The American Academy of Pediatrics' (AAP) Bright Futures recommends clinicians screen all adolescents for alcohol and drug use during all appropriate acute care visits using developmentally appropriate screening tools. (e.g., CRAFFT or Alcohol Screening and Brief Intervention for Youth).

KM 04 (1 Credit) Continued

C. Screening for substance use can assist the practice to provide needed treatment, referrals and abstinence tools to address the patient's substance use concerns. Substance use is a growing issue that is impacting all types of patients. Screening supports early intervention and facilitating patients' access to the necessary treatments toward sobriety. Available screening tools may include the Screening, Brief Intervention and Referral to Treatment (SBIRT) tool, CAGE AID or DAST-10 instruments which assess a variety of substance use conditions.

D. Pediatric screening for behavioral health is distinct from adult screening and provides opportunities for early interventions that can have lasting affects over a lifetime. This may include tools such as the Behavioral Assessment System for Children (BASC).

E. The practice uses standardized tools to determine if patients have developed PTSD. This condition develops in patients who have experienced a severe and distressing event. This event causes the patient to subsequently re-live the traumatic experience causing mental distress. Assessments for PTSD support the practice in recognizing the ailment so it can either provide treatment or referrals to appropriate specialists.

F. The Vanderbilt Assessment Scale or the DSM V ADHD checklist for adults or children/adolescents are examples of screening tools used to determine if a patient has Attention Deficit/ Hyperactivity Disorder (ADHD). ADHD makes it challenging for a person to pay attention and/or control impulsive behaviors. This condition is most commonly diagnosed during childhood but symptoms can persist through adolescence and adulthood. Screening and helping a patient understand their ADHD diagnosis and treatment plan can help the patient/family/caregiver manage symptoms and reduce the impact of the condition.

KM 04 (1 Credit) Continued

G. The USPSTF recommends screening of adults, including pregnant and postpartum women, for depression. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. The USPSTF guidelines suggest screening during and after pregnancy. The AAP's Bright Futures acknowledges that primary care practices that see both infants and their families have a unique opportunity to integrate postpartum depression screening into the well-child care schedule. Validated screening tools may include PHQ-2, PHQ-9 or Edinburgh Postnatal Depression Scale (EPDS) or other validated screening tools, and may be conducted 4–6 weeks postpartum or during the 1-, 2-, 4- or 6-month well-child visits.

- For a list of screening tools, visit SAMHSA.gov, or for a list of pediatric screening tools, visit the American Academy of Pediatrics website. (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/Primary-Care-Tools.aspx)

Behavioral Health Screening

KM 04: Example

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

KM 05 (1 Credit)

Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners.

- The practice conducts patient-specific oral health risk assessments and keeps a list of oral health partners such as dentists, endodontists, oral surgeons and/or periodontists from which to refer.
- Poor oral health can have a significant impact on quality of life and overall health. Primary care practices are uniquely positioned to improve oral health, oral health awareness through education, preventive interventions (e.g. fluoride application for pediatric patients) and timely referrals.

Oral Health Assessment and Services

KM 05: Example

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

- ⚠ Mother or primary caregiver had active decay in the past 12 months — Yes | No
- Mother or primary caregiver does not have a dentist — Yes | No
- Continual bottle/sippy cup use with fluid other than water — Yes | No
- Frequent snacking — ☐Yes ☐No
- Special health care needs — Yes | No
- Medicaid eligible — ☐Yes ☐No

PROTECTIVE FACTORS

- Existing dental home — Yes | No
- Drinks fluoridated water or takes fluoride supplements — Yes | No
- Fluoride varnish in the last 6 months — ☐Yes ☐No
- Has teeth brushed twice daily — Yes | No

CLINICAL FINDINGS

- ⚠ White spots or visible decalcifications in the past 12 months — Yes | No
- ⚠ Obvious decay — ☐Yes ☐No
- ⚠ Restorations (fillings) present — Yes | No
- Visible plaque accumulation — Yes | No
- Gingivitis (swollen/bleeding gums) — ☐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

KM 06 (1 Credit)

Identifies the predominant conditions and health concerns of the patient population.

- The practice identifies its patients' most prevalent and important conditions and concerns, through analysis of diagnosis codes or problem lists.
- Although the general conditions treated in primary care are similar across practices, each medical home has a unique population that influences how the practice organizes their work and resources. Knowing its population's top concerns allows the practice to adopt guidelines, focus decision support and outreach efforts, identify specialties to establish clearer referral relationships and determine what special services to offer (e.g., group sessions, education, counseling) that align with those needs.

KM 07 (2 Credits)

Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data.

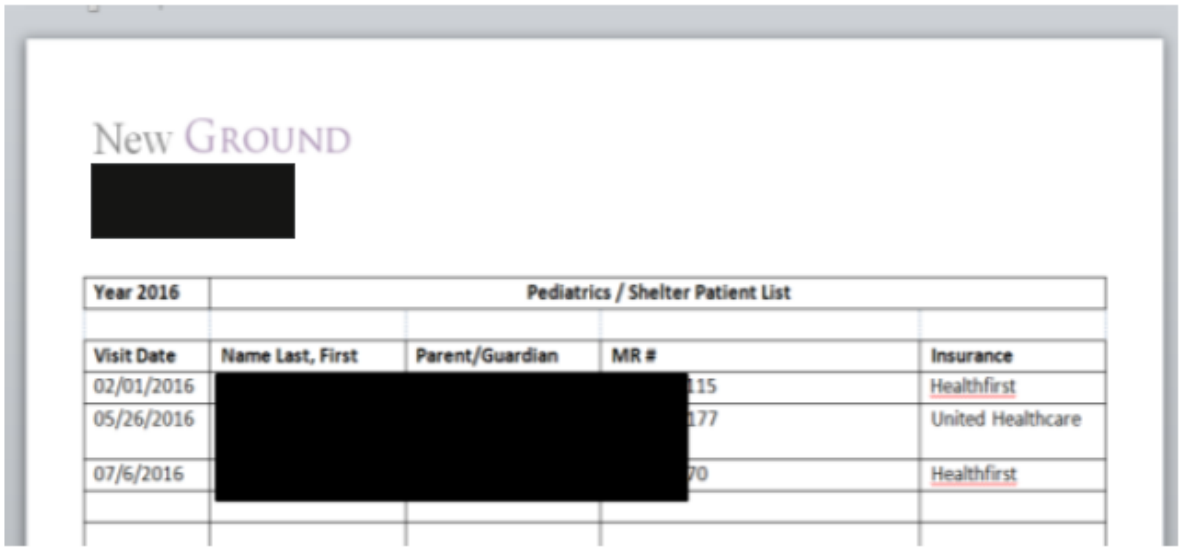
- After the practice collects information on social determinants of health, it demonstrates the ability to assess data and address identified gaps using community partnerships, self-management resources or other tools to serve the on-going needs of its population.
- Routine collection of data on social determinants of health (as required in KM 02) is an important step, but the real benefit to the population comes when the practice uses the information to continuously enhance care systems and community connections to systematically address needs.

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

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	03/11/2015	61	Patient no-show
69.0	Urology (Peds): Montefiore: Hutchinson C		Urology	01/09/2015	05/05/2015	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	01/15/2015	04/02/2015	77	Patient no-show
58.3	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	65	Patient no-show
24.8	Endocrine (Peds): Montefiore - Hutchinso		Endocrine	01/22/2015	06/12/2015	141	Consult notes received
58.6	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
29.0	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	02/19/2015	21	Canceled by clinic
38.8	Family Planning: Montefiore - AECOM, 16		Family Planning	01/29/2015	02/02/2015	4	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 M		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.

KM 08 (1 Credit)

Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials.

- The practice demonstrates an understanding of the patients' communication needs by utilizing materials and media that are easy for their patient population to understand and use. The practice considers patient demographics such as age, language needs, ethnicity and education when creating materials for its population. The practice may consider 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).
- Health-literate organizations understand that lack of health literacy leads to poorer health outcomes and compromises patient safety, and establish processes that address health literacy to improve patient health behaviors and safety in the practice setting. Reducing barriers to the patient's ability to access, understand and absorb health information supports their ability to comply with their care.

Tips and Tricks

- KM 01
  - No required % threshold (yet).
  - Report must be run for all patients in the practice.
- KM 02
  - No report is required - so make sure the evidence shows the 9 categories (i.e. pick a good one).
  - You must document ‘none’ for items assessed that are not present - can’t leave it blank for “no.” Blank means you didn’t assess.

KM- Competency A: FAQs

What is the required frequency for a patient health assessment? (KM 02)

- *NCQA does not prescribe a frequency; practices determine the time frame for conducting patient health assessments according to a protocol that suits their patient population. The element assesses the components and comprehensiveness of the assessment.*

May a "smart form" be used for the comprehensive health assessment? (KM 02)

- *Forms or processes demonstrating that a practice conducts, collects and documents a comprehensive health assessment for each criteria must clearly show how these criteria are collected consistently. Practices should follow a standard protocol to explain how the forms are used and to ensure they are updated regularly. Submitting a blank form does not meet the Requirement.*

KM- Competency A: FAQs

How is advance care planning different from advance directives? (KM 02 - I)

- ***Advance care planning*** *is an ongoing process that can occur when a patient is well or sick; the advance care plan can be updated as circumstances or health status changes. The practice assesses the patient's preferences and the plan of care when the time comes that the patient cannot speak for him or herself. Advance care planning can include advance directives, but the two are not synonymous. An advance directive in the patient's file meets the requirement for advance care planning.*
- *An* ***advance directive*** *is a standing legal document that goes into effect if a patient is incapacitated and cannot make medical decisions. The directive includes the patient's assent to or refusal of health care and may name a representative to make decisions on the patient's behalf.*

KM- Competency A: FAQs

We only document advanced care plans for people who have them. Do we have to have an advanced care plan for all patients? (KM 02 - I)

- *The practice documents patient/family preferences for advance care planning (i.e., care at the end of life or for patients who are unable to speak for themselves). This may include discussing and documenting a plan of care, with treatment options and preferences. This criteria is met if the practice sees only pediatric patients and documents "NA" in the field. The practice provides a written explanation for an NA response in the Support Text/Notes box in the Survey Tool. Documentation that the patient declined to provide information counts toward the numerator. Patients with an advance directive on file meet the criteria requirement.*

Is a signed copy of a patient's advance directive required to be included in the medical record? (KM 02 - I)

- No, the signed directive does not need to be included directly in the patient's medical record; however, the information must be directly accessible at the practice site (i.e., the practice should not have to call another site or person to obtain the information). The patient medical record should include information that the patient has an advance directive on file (or has declined to provide one), and the practice should be able to access the information in the directive immediately if needed.

KM- Competency A: FAQs

What documentation demonstrates use of a developmental screening tool? **(KM 03)**

Practices must submit: Evidence of Implementation AND Report or Documented process

- Evidence may include:
  - An example of the criteria documented in the patient record, **and** a de-identified, completed developmental screening form.

OR

  - A report, **and** a de-identified, completed developmental screening form.