Division of TennCare

STATE OF TENNESSEE

PCMH Documentation 1:
Documented Processes and Evidence of Implementation
for NCQA PCMH Recognition

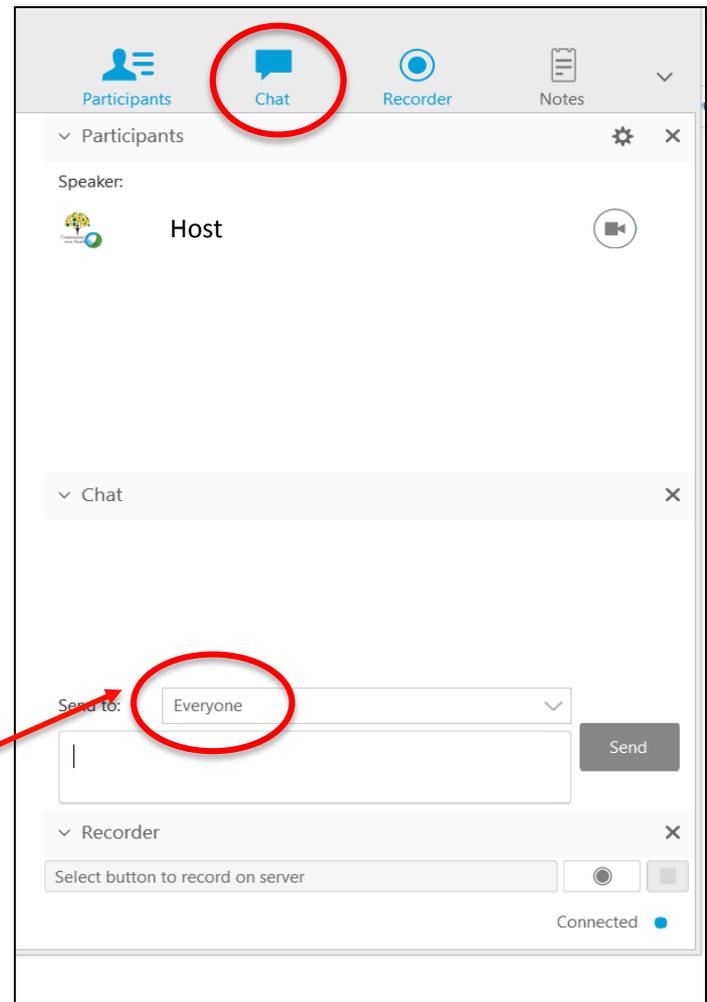*Presenter: Rick Walker, TN Coach Lead, PCMH CCE*

January 30, 2019

Introduction to the Webinar

Chat Box During the Presentation

Send:

- Best Practices

- Challenges

- Novel Ideas

- Questions

Select "Everyone" and enter your question or comment

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Quick Review: PCMH 2017 Terminology

Today's Concepts:

AC: Patient Access and Continuity

CC: Care Coordination and Care Transitions

CM: Care Management and Support

KM: Knowing and Managing Your Patients

TC: Team-Based Care and Practice Organization

QI: Performance Measurement and Quality Improvement

Today's Agenda

- ## 11:00-11:45am (CT)
  - ▫ Documented processes and evidence of implementation
    - – Definitions
    - – Examples
  - ▫ Annual Reporting

- ## 11:45am-12:00pm (CT)
  - ▫ Facilitated Discussion
    - – Questions, Best Practices, Challenges and Novel Ideas
  - ▫ Wrap-up

Documented Processes and Evidence of Implementation For NCQA PCMH Recognition

NCQA PCMH Documented Processes and Evidence Requirements

- As part of PCMH recognition, NCQA requires practices to show evidence that they meet PCMH criteria

- The *NCQA PCMH Standards and Guidelines* lists the evidence that practices must provide for each PCMH criteria

- NCQA will evaluate practices based on evidence prepared or shared during the virtual review

Documented Process and Evidence Examples

In this webinar we provide documentation examples from practices and NCQA to illustrate different ways you can demonstrate how your practice meets NCQA PCMH criteria.

Why Documentation?

- For NCQA
  - Trust, but verify
  - Ensure practices are doing what they say they're doing
  - Track record
  - Shows transformation

Why Documentation?, cont.

- For your practice
  - Documented policies, procedures, protocols
    - Accountability
    - Continuity
    - Standard Operating Procedures (SOPs)
  - Training
    - New staff
    - Annual
    - Refresher/corrective

NCQA Definition of Documented Process

- Written statements describing the practice's policies and procedures
  - Protocols
  - Practice Guidelines
  - Agreements
  - Other documents describing actual processes or forms

- Must include:
  - Date of implementation
  - Instructions for following the practices' policies and procedures

NCQA Definition of Evidence of Implementation

- A means of demonstrating systemic uptake and effective demonstration of required practices, such as:
  - Reports
  - Patient Records
  - Materials
  - Examples
  - Screenshots
  - Surveys
  - Transfer Credits
  - Attestation
  - Other

Source: NCQA PCMH Standards and Guidelines, 2017 Edition, Version 3

NCQA Provides Guidance Regarding Information Practices Must Submit to Demonstrate Performance Against Criteria

- Focus on the intent and demonstrate performance
- Show how your practice meets the intent of each criteria
- Meet core and elective criteria in document form or virtual review
- NCQA will evaluate practices based on evidence prepared or shared during the virtual review
- The evidence listed for each criterion is not prescriptive
- There may be acceptable alternatives

Source: NCQA

Example of Evidence Requirements in NCQA PCMH Standards and Guidelines

AC 06 (1 Credit) Alternative Appointments: Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms.

GUIDANCE	EVIDENCE
The practice uses a mode of real-time communication (e.g., a combination of telephone, video chat, secure instant messaging) in place of a traditional in-person office visit with a clinician or care manager. The practice provides a report of the number and types of visits in a specified time period. These types of visits do not meet the requirement: • Unscheduled alternative clinical encounters, including clinical advice by telephone and secure electronic communication (e.g., electronic message, website) during office hours. • An appointment with an alternative type of clinician (e.g., diabetic counselor).	• **Documented process** *AND* • **Report** Documented process is sharable across the practice, however, the reports must be site specific *Documented process only*

AC 07 (1 Credit) Electronic Patient Requests: Has a secure electronic system for patients to request appointments, prescription refills, referrals and test results.

GUIDANCE	EVIDENCE
Patients can use a secure electronic system (e.g., website, patient portal, email) to request appointments, prescription refills, referrals and test results. The practice must demonstrate at least two functionalities or provide patients with guidelines for at least two types of these requests that can be made electronically. Electronic patient requests are another means to patients' access to services that meet their needs and preferences.	• **Evidence of implementation** Evidence is shareable across all practice sites

Source: NCQA PCMH Standards and Guidelines, 2017 Edition, Version 3

Example of Evidence Requirements in NCQA PCMH Standards and Guidelines, cont.

QI 06 (1 Credit) Validated Patient Experience Survey Use: The practice uses a standardized, validated patient experience survey tool with benchmarking data available.	
GUIDANCE	**EVIDENCE**
The practice uses the standardized survey tool to collect patient experience data and inform its quality improvement activities. The intent is for the practice to administer a survey that can be benchmarked externally and compared across practices. The practice may use standardized tools such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) PCMH survey, CAHPS-CG or another standardized survey administered through measurement initiatives providing benchmark analysis external to the practice organization. It may not be a proprietary instrument. The practice must administer the entire approved standardized survey (not sections of the survey) to receive credit.	• Report
QI 07 (2 Credits) Vulnerable Patient Feedback: Obtains feedback from vulnerable patient groups on the experiences of disparities in care or services.	
GUIDANCE	**EVIDENCE**
The practice identifies a vulnerable population where data (clinical, resource stewardship, quantitative patience experience, access) show evidence of disparities of care or services. The practice obtains qualitative patient feedback from population representatives to acquire better understanding of disparities and to support quality improvement initiatives to close gaps in care.	• Report

Evidence is **_NOT_** shareable, each practice site must submit it's own evidence

Source: NCQA PCMH Standards and Guidelines, 2017 Edition, Version 3

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Patient Access and Continuity (AC) Examples

AC 01 – Access Needs and Preferences (core)
Example of a Completed Survey

Name: ~~████~~ # 933   Satisfaction Survey   Date: 8/22

How satisfied are you with the following?	Extremely Dissatisfie	Very Dissatifie	Satisfied	Very Satisfied	Extremely Satisfied
1. Ease of making appointment for checkups (physicals, well visits, routine followup appointments)?	1	2	3	(4)	5
2. Ease of making appointment for sickness?	1	2	(3)	4	5
3. Ease in contacting your doctor when our office is closed (nights, weekends, and holidays)?	1	2	3	(4)	5
4. Ease in speaking directly with your doctor by telephone when you call during office hours?	1	2	3	(4)	5
5. The time it takes someone from our office to respond when you call the office with an urgent problem?	1	2	3	(4)	5
6. Waiting time in our office?	1	2	(3)	4	5
7. Ease in obtaining follow up information and care (test results, medicines, care instructions)?	1	2	3	(4)	5
8. Overall medical care at our office?	1	2	3	(4)	5
9. Our office appearance?	1	2	3	(4)	5
10. Our office's convenience (location, parking, hours, and office layout)?	1	2	3	(4)	5
11. Our teaching you how to improve your child's health?	1	2	3	(4)	5
12. The way your doctor involves other doctors and caregivers in your Childs care when needed?	1	2	3	(4)	5

AC 01 – Access Needs and Preferences (core)
Example of a Report

Question	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Got appointment for urgent care in a timely manner	76.7%	16.7%	3.3%	3.3%	0.0%
Got appointment for non-urgent care in a timely manner	56.7%	33.3%	3.3%	6.7%	0.0%
Got answer to medical question within 24 hours	63.3%	16.7%	10.0%	10.0%	0.0%
Got answer to medical question when office was closed	56.7%	20.0%	10.0%	13.3%	0.0%
Received courteous and respectful answers from office staff	70.0%	30.0%	0.0%	0.0%	0.0%
Felt the provider addressed issues involving family, or alcohol, smoking, mental health, nutrition, exercise					
Felt the provider addressed personal health goals (i.e. weight loss, smoking cessation, etc)					
Felt the provider has given clear explanations regarding prescription					

Access

Got appointment for urgent care in a timely manner

Got appointment for non-urgent care in a timely manner

Got answer to medical question within 24 hours

AC 02 – Same Day Appointments (core)
Example of a Report

1A1 - Appts Scheduled Same Day Vs. Total Appts
01/01/2017 to 12/31/2017

When generating this report, select "Financial Patients" for any Context of Query box that displays.

This report compares the number of same day appointments with the number of total appointments. You will be prompted for a beginning and ending date to determine the date range of your appointments. Prompts for Scheduling Resource and Scheduled Location are also provided.

Resource Name	Same Day Appts	Total Appts	% Same Day
	1,532	2,530	60.55 %
	363	2,815	12.90 %
	806	2,718	29.65 %
	2,263	2,981	75.91 %
	2,722	3,613	75.34 %
	2,676	3,612	74.09 %
	377	2,448	15.40 %
	2,738	3,664	74.73 %
	529	2,333	22.67 %
Total:	**14,006**	**26,714**	**52.43 %**

AC 03 – Appointments Outside Business Hours (core)
Example of a Documented Process

AC 03: Provides routine and urgent appointments outside regular business hours to meet identified patient needs.

- {Insert practice name here} recently extended our office hours until 5 pm, Monday through Friday. Previously, since 1994, the office closed at 4:30 pm. We recognize that patients have health care needs outside of regular business hours and our physicians and CPNP routinely meet families at the office after hours during the week and on the weekend.

- Please see the homepage of our website as evidence: {Insert practice website URL}

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AC 03 – Appointments Outside Business Hours (core), cont.
Example of a Report

Code indicates services provided after hours

AC 04 – Timely Clinical Advice by Telephone (core)
Example of Call Log

PT ID	Date and Time of Call (0/00/00_H:MM_AM/PM)	Urgent (Y/N)	Reason For Call	Action Taken	Triage Nurse (Y/N)	Date and Time of Resolution (0/00/00_H:MM_AM/PM)	Total Response Time
Test001	5/12/11 3:30 PM	No	Advice	Take 2 aspirin and call back in AM	N	5/12/11 3:35 PM	0:05:00

AC 11 – Patient Visits with Clinician/Team (core)
Example of a Report

Office Practicum Quality Improvement Calculator (QIC)

Reports | **PCMH Custom** | Database Administration | CMS QDE

Standards: 2017 ▼   Provider: ☑ All or ▼

Date range: 5/11/2017 ▼ to: 5/11/2018 ▼   Location: ☑ All or ▼

Visits with PCP

ID	Provider Name	Well PCP	Well Total	% Well PCP	Sick PCP	Sick Total	% Sick PCP
	MD	474	563	84.19%	1,532	2,037	75.21%
	MD	553	650	85.08%	1,179	1,832	64.36%
	CPNP	264	663	39.82%	574	1,928	29.77%
326	OP ADMIN			.00%			.00%
331	OP Administrator II			.00%			.00%

AC02 | AC04 | AC11 | CC06 | KM06 | KM08 | KM09/10

Care Coordination and Care Transitions (CC) Examples

CC 04 – Referral Management (core)
Example of Screenshot from Referral Tracking System

Clinic:								
Month:								
DATE	REFERRING PROVIDER	DIAGNOSIS	REFERRING TO	CODE	D=Diagnostic C=Consultation	Is Service Available	APPT DATE	DATE REC'VD RESULTS
10/4/2006		chest pain	sehco	CHC	D=Diagnostic	N	10/11/2006	
10/4/2006		size/dates	ob u/s	ne rad	D=Diagnostic	N	10/4/2006	
10/4/2006		r density	breast u/s	ne rad	D=Diagnostic	N	10/5/2006	11/3/2006
10/5/2006		back pain	Jim Miller	pt/ot	D=Diagnostic	N	10/12/2006	
10/5/2006		sleep walking	psg	PSD	D=Diagnostic	N		
10/5/2006		insomnia	psg	PSD	D=Diagnostic	N	10/29/2006	
10/5/2006		neck pain	mri c-spine	CDI	D=Diagnostic	N	10/12/2006	
10/5/2006		sleep apnea	cpap	ne sleep	D=Diagnostic	N	10/11/2006	
10/5/2006		hearing loss	eval	ne audio	D=Diagnostic	N	10/12/2006	10/18/2006
10/5/2006		htn	ven dop	ne rad	D=Diagnostic	N	10/10/2006	
10/6/2006		fatigue	psg	PSD	D=Diagnostic	N	10/30/2006	
10/6/2006		h/a	ct-head	CDI	D=Diagnostic	N	10/13/2006	
10/6/2006		speech delay	speech eval	ne audio	D=Diagnostic	N	11/9/2006	
10/6/2006		colon scr	colon scr		D=Diagnostic	N		
10/9/2006		sleep apnea	psg	PSD	D=Diagnostic	N	10/30/2006	
10/9/2006		colon scr	colon scr		D=Diagnostic	N		
10/9/2006		colon scr	colon scr	NE GI	D=Diagnostic	N		
10/9/2006		insomnia	psg	PSD	D=Diagnostic	N		
10/9/2006				RHEUM	C=Consultation	N		
10/9/2006		colon scr	colon scr	NE DIG	D=Diagnostic	N		
10/9/2006		hearing	screening	ne audio	D=Diagnostic	N	10/18/2006	
10/9/2006		colon scr	colon scr	C GI	D=Diagnostic	N		
10/9/2006		sleep probs	psg	PSD	D=Diagnostic	N	10/31/2006	
10/9/2006		chr cough	ct-chest	CDI	D=Diagnostic	N	10/10/2006	10/9/2006

CC 16 – Post Hospital/ED Visit Follow-Up (core)
Example of Follow-up Note

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

10:26 AM Telephone

MRN

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

Source: NCQA

Care Management and Support (CM)

CM 01 – Identify Patients for Care Management (core)
Example of a Protocol

{Insert Practice name} here considers the following patient categories among the group that would benefit from care management.

1. Asthma: (High Cost-High Utilization) As part of our PHIIT participation we generate a report of the asthma patients that are seen by each provider in the practice each quarter. Chart review is done on about 10 charts per provider and the goal is to ensure that all asthma patients have an asthma action plan, counseling and education is provided at the visit and follow up appointments are scheduled. (Last PHIIT asthma report)

2. Obesity (Poorly Controlled-Complex Condition) BMI is calculated based on the height and weight entered at each visit. If a patient is diagnosed as being obese, education is provided, counseling on both nutrition and physical activity done, labs are drawn and follow up appointments are scheduled to monitor. For children from 3 years to 17 years, this includes BMI > 85th percentile, and for patients 18years and older, this includes BMI of 30 or greater.

3. Behavioral health needs are assessed during WCE and in new patients. if there is a behavioral health condition such as ADHD or Depression diagnosed, counseling is provided, medication management done, and school and parents are involved in the care plan.

Date of Implementation: 01/2017

CM 02 – Monitoring Patients for Care Management (core)
Example of a Monitoring Tool

	Behavioral Health	High Cost/ Utilization/ Asthma	Poor Control/ Complex/ BMI	Social Determinants Of Health	Referrals	Total Patients
Patients in Registry	69	30	150	25	25	350
Unique Patients in Registry						300
Total Patients in Practice						4044
Patients Needing Care Management						7.5% (300 Patients)

CM 03 – Comprehensive Risk-Stratification (2 credits)
Example of a Screenshot

Knowing and Managing Your Patients (KM) Examples

KM 01 – Problem Lists (core)
KM 06 – Predominant Conditions and Concerns (1 credit)

KM06-Predominant Conditions and Concerns

The predominant conditions for patients seen in our office for the current calendar year of 2018 are as follows. Due to multiple asthma and otitis media diagnoses variations, they are actually the highest number of patients seen in the office.

J06.9	**Acute upper respiratory infection, unspecified**	**128**	
J30.9	Allergic rhinitis, unspecified	127	
F90.9	Attention-deficit hyperactivity disorder, unspecified type	125	
D50.9	Iron deficiency anemia, unspecified	109	
L30.9	Dermatitis, unspecified	106	
J02.9	Acute pharyngitis, unspecified	99	
J45.30	Mild persistent asthma, uncomplicated	93	309 total
J45.909	Unspecified asthma, uncomplicated	88	
B34.9	Viral infection, unspecified	84	
J02.0	Streptococcal pharyngitis	53	
J45.20	Mild intermittent asthma, uncomplicated	53	
H66.90	Otitis media, unspecified, unspecified ear	44	146 total
J10.1	Influenza due to other identified influenza virus with other respiratory manifestations	44	
A08.4	Viral intestinal infection, unspecified	33	

KM 02 – 05 – Documented process required for each

- KM 02 – Comprehensive Health Assessment (CHA) (core)
  KM 03 – Depression Screening(core)

- KM 04 - Behavioral Health Screenings (1 Credit)

- KM 05 - Oral Health Assessment and Services (1 Credit)

Consider combining the documented processes into one document

KM 02-KM 05 – Combined Documented Process (core)

PCMH - KM 02-05: Comprehensive Health Assessment

{Insert Practice name here} understands that to provide comprehensive medical care, a comprehensive health assessment must be documented. Our EHR, has rigorous tools to evaluate all aspects of a patient and family medical history.

A. Medical history of patient and family
- At the first visit and all yearly well child check-ups (EPSDT) the medical history of the patient and family history of first-degree relatives is updated.

B. Mental health/substance use history of patient and family KM 03 & KM 04
- Screening for postpartum and later maternal depression is performed at well visits; 1, 2, 4, and 6 months. The Edinburg is a standard screening tool included in our template at these visits.
- Screening for adolescent substance use/abuse is performed at all preteen and teen well visits starting at age 11. The CRAFFT is a standardized screen tool in our templates at these visits.
- Screening for depression in adolescents is performed at all preteen and teen well visits starting at age 11. The PHQ2 is a standard screen in our templates at these visits.

KM 02-KM 05 – Combined Documented Process (core), cont.

C. Family/social/cultural characteristics

- At the first visit and all well child check-ups, the household members are updated on their section of the physical assessment. At all well child check-ups, food insecurity is documented. This question is standard in all well visit templates.

D. Communication needs

- At all well visits, hearing, vision is assessed subjectively by history or objectively with the Binocular screening or Snellen chart, depending on the age of the child. Audiograms are done to assess hearing. These screenings follow the Bright Futures recommendations.
- At all well visits, a child's development is assessed using standard screening questions incorporated into our EHR templates.

E. Behaviors affecting health

- The Tobacco Risk assessment section in the patient chart documents second hand smoke exposure, smoking, and oral health.
- The Nutrition section of all EPSDT visits documents dietary behavioral of patient.

KM 02-KM 05 – Combined Documented Process (core), cont.

F. Social functioning

●The Social Development/Activities of all EPSDT visits for school age children and teens assesses a patient's functional status in school and their community.

●The Vanderbilt Assessment scales for both parent and teacher are used to diagnose ADHD. The parent is given the assessment tool for both parent and teacher to complete. Parent returns with the completed form. Forms are scored by the provider and the determination is made for medical treatment and/or professional counseling.

G. Social determinants of health

●At all EPSDT visits, screening for poverty is performed with a food insecurity questionnaire. This is included under the section screening for anemia in the HPI.

●Oral health risk assessment questions are formally built in templates beginning at the 12-month check-up. Parents are advised on oral care with the eruption of the first teeth at the 6- and 9-month visits. Parents are provided a list of community dentists if needed.

H. Developmental screening using a standardized tool

Developmental surveillances are completed at each EPSDT visit. Screening questions are built in as part of our well child template.

●The PEDS response is done on at the 2 months and the 9-month-old visits.

●At the 18-month and 24-month EPSDT visit, the MCHAT-R is used to screen for autism.

●Starting at age 11, the teen completes the CRAFFT and PHQ-2 at all EPSDT visits.

KM 02-05 – Combined Evidence of Implementation (core)

KM 02 A

Family History

Discussed Family History

Father   **- No current problems or disability**

Mother   **- No current problems or disability**

Social History

KM 02 B-G

Discussed Social History
General Pediatric *(deleted)*
Diet: Regular
Caffeine intake: None
Exercise level: Moderate
Sporting activities: Football/Basketball
Parents' marital status: Divorced
Home situation: Mother
Siblings: 3
Childcare?: None
Animal exposure?: Y
Passive smoke exposure?: N
Smoke/CO detectors in home?: Y
Seat belt/car seat used routinely?: Y
Sunscreen used routinely: Y

KM 02-05 – Combined Evidence of Implementation (core), cont.

KM 02 B-G →

KM 02 B-G →

Smoking Status: Never smoker
Fluoride status of home water: Unknown
Pool exposure: Y
Bike helmets: Y
Bully/Bullying?: N
Changes in family/social situation: N
Assigned sex at birth?: Male
Blind or serious difficulty seeing: N
Breast feeding?: N
Can child swim?: Y
Chewing tobacco: none
Concentration: I can concentrate fully whent I want to with no difficulty
Concerns about meeting basic needs (food, housing, heat, etc)?: N
Deaf or serious difficulty hearing: N
Diabetes: N
Difficulty concentrating, remembering or making decisions: N
Difficulty reading?: N
Do you have moisture problems in your home?: N
Family history of heart disease?: N
General stress level: Low
Grades: Excellent
Hand Dominance: Right
Headaches: I have no headaches at all
High number of sexual partners: N
Hobbies/Activities: Football, Basketball,soccer
How many days in the past year have you had a heavy drinking consumption (4+ female, 5+ male)?: 0
Mother with HIV?: N
Participation in social media?: Y
Patient at moderate to high risk for dental caries: N
Patient counseled on unhealthy alcohol use?: Y
Performs monthly self-breast exam: N
Repeated any grades?: N
Sexually active?: N
Smoke alarm in home: Y
Tobacco cessation counseling provided?: N
Tobacco-years of use: 0
Able to swim?: Y

KM 02-05 – Combined Evidence of Implementation (core), cont.

☐ HEARING SCREENING - 06/28/18

Screening

Name	Score
PHQ-2/PHQ-9	0 (out of 27 for the PHQ-9)
PSC-17 Youth	2 (out of 34)
CRAFFT	0

KM 02 H

HPI

Patient presents for well child exam. No concerns at this time.

ROS

Patient reports 3 meals/day, well balanced diet, normal portions, fast food <1 time per week, <8oz. sugar containing beverag
diet includes fruits, and diet includes vegetables. He reports regular dental visits, brushes teeth 2 times/day, and flosses teet
bedtime routine, sleeps through the night, and no trouble getting up. He reports normal bowel movement frequency and norn
testicular self exams. He reports safe practices around pool & water, understanding of sun protection, understands insect rep
biking/scootering, maintains adequate hydration, and understands conflict resolution/violence prevention. He reports denies
denies tobacco use, and denies sexual activity. He reports no behavior problems, normal transition, normal attention span, g
academic performance good. He reports socializes well with peers and responds well to discipline (privilege restrictions). He
no family crises/stressors.

KM 09 – Diversity (core)

Office Practicum Quality Improvement Calculator (QIC)

| Reports | PCMH Custom | Database Administration | CMS QDE |

Standards: 2017

Date range: 6/19/2017 to: 6/19/2018

Provider: ☑ All or

Location: ☑ All or

Refresh

AC02 ○ Primary Language ○ Ethnicity ● Race

Race	Occurs	%
[unknown]	2,015	32.78%
Asian	54	.88%
Asian + White	3	.05%
Black + White	11	.18%
Black or African American	70	1.14%
Declined to specify	897	14.59%
Native American (Indian or Alas	15	.24%
Native American + White	2	.03%
Pacific Islander (or Hawaiian N	4	.07%
White	3,076	50.04%

AC04
AC11
CC06
KM06
KM08
KM09/10

TN

Source: Practice evidence from Office Practicum

KM 09 – Diversity cont., (core)

Office Practicum Quality Improvement Calculator (QIC)

| Reports | PCMH Custom | Database Administration | CMS QDE |

Standards: 2017

Provider: ☑ All or

Date range: 6/19/2017 to: 6/19/2018

Location: ☑ All or

AC02 ◯ Primary Language ◉ Ethnicity ◯ Race

AC04	Ethnicity	Occurs	%
AC11	[unknown]	1,984	32.28%
	Declined to specify	1,513	24.61%
CC06	Hispanic or Latino	74	1.20%
KM06	Not Hispanic or Latino	2,567	41.76%
KM08	Unknown	9	.15%

KM09/10

Source: Practice evidence from Office Practicum

TN

KM 09 – Diversity cont., (core)

U.S. Census Bureau

AMERICAN
FactFinder

S2201   FOOD STAMPS/Supplemental Nutrition Assistance Program (SNAP)

2013-2017 American Community Survey 5-Year Estimates

Supporting documentation on code lists, subject definitions, data accuracy, and statistical testing can be found on the American Community Survey website in the Technical Documentation section.

Sample size and data quality measures (including coverage rates, allocation rates, and response rates) can be found on the American Community Survey website in the Methodology section.

Although the American Community Survey (ACS) produces population, demographic and housing unit estimates, it is the Census Bureau's Population Estimates Program that produces and disseminates the official estimates of the population for the nation, states, counties, cities, and towns and estimates of housing units for states and counties.

Subject	Cookeville city, Tennessee					
	Total		Percent		Households receiving food stamps/SNAP	
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
Households	13,591	+/-471	(X)	(X)	1,508	+/-251
With one or more people in the household 60 years and over	4,523	+/-300	33.3%	+/-1.9	491	+/-158
No people in the household 60 years and over	9,068	+/-409	66.7%	+/-1.9	1,017	+/-212
HOUSEHOLD TYPE						
Married-couple family	4,429	+/-332	32.6%	+/-2.5	314	+/-135
Other family:	2,422	+/-292	17.8%	+/-2.2	592	+/-147
Male householder, no wife present	582	+/-155	4.3%	+/-1.1	47	+/-36
Female householder, no husband present	1,840	+/-259	13.5%	+/-1.9	545	+/-145
Nonfamily households	6,740	+/-524	49.6%	+/-2.9	602	+/-176
With children under 18 years	3,182	+/-289	23.4%	+/-2.4	601	+/-181
Married-couple family	1,582	+/-239	11.6%	+/-1.9	209	+/-108
Other family:	1,566	+/-273	11.5%	+/-2.0	383	+/-125
Male householder, no wife present	330	+/-118	2.4%	+/-0.9	35	+/-32
Female householder, no husband present	1,236	+/-246	9.1%	+/-1.8	348	+/-124
Nonfamily households	34	+/-34	0.3%	+/-0.2	9	+/-15
No children under 18 years	10,409	+/-604	76.6%	+/-2.4	907	+/-204
Married-couple family	2,847	+/-294	20.9%	+/-2.0	105	+/-71

1 of 4   01/25/2019

TN

Source: https://www.census.gov/

KM 12 – Proactive Outreach (core)

KM 12 – Proactive Outreach, cont. (core)

KM 20 – Clinical Decision Support (core)
Mental Health Example

Source: NCQA

KM 20 – Clinical Decision Support (core), cont.
CDS Example

KM 20-G: Overuse/Appropriateness issues: Avoiding Abx adults w/acute bronchitis

Source: CDC; https://www.cdc.gov/antibiotic-use/

Team-Based Care and Practice Organization (TC) Examples

TC 02 – Structure and Staff Responsibilities
Example of Organizational Structure

Source: NCQA
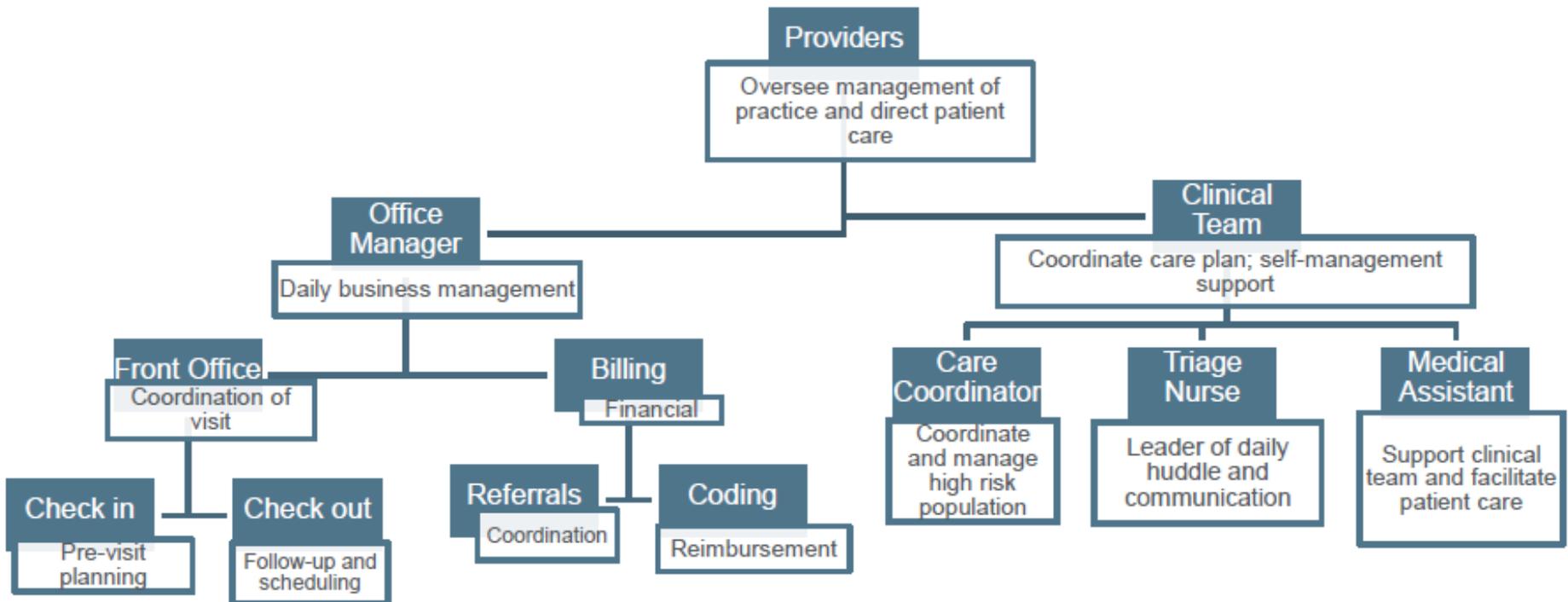
TC 02 – Structure and Staff Responsibilities, cont.
Example of Responsibilities

Health Information Technologist	• Creates and generates reports and dashboards from the EMR. • Assists in the coordination of UDS, Meaningful Use, and PCMH measures and metrics. • Active member on QI committee to improve processes and meet UDS goals.
Medical Records and Privacy Coordinator	• Ensures patient information is added to chart in a timely fashion. • Provides confidential patient information counseling to staff. • Processes event reports in order to improve processes within the organization.
AmeriCorps – PCMH and Community Wellness Coordinator	• Works with after school programs to educate students on healthy lifestyles. • Assists with PCMH efforts by educating staff; presenting survey questions; assisting Care Manager in recall lists. • Coordinating employee wellness activities.
Help Team Member	• Assists patients in the healthcare marketplace. • Utilizes resources in the community. • Assists with outreach services.
Spanish Interpreter	• Assists patients during appointments with understanding provider and paperwork. • Acts as a liaison for staff. • Provides cultural support for patients.
Registration Professional	• Provides patients the necessary paperwork for their appointment and per the organization. • Assists with the Healthy Neighbor Plan (sliding fee scale) application. • Confirms patient demographics, insurance, and completes check-in or patients; communicates with patients about payments.

Source: NCQA

TC 07 - Staff Involvement in Quality Improvement (core)
Example of Quality Improvement Meeting Log

TC 08 - Behavioral Health Care Manager (2 credits)
Example of BH care manager qualifications

PCMH - TC 08: Has a care manager qualified to identify and coordinate behavioral health needs.

(Insert Practice Name here) recognizes that children and teens are best served in the pediatric medical home for behavioral health needs. Therefore, the physicians and the CPNP have sought further training to enhance our capacity to meet these mental and behavioral health needs. TNAAP, the Tennessee Chapter of the American Academy of Pediatrics, provides training to enhance behavioral and mental health care in primary care with the program, BeHiP (Behavioral Healthcare in Pediatrics.) ▇▇▇▇▇▇ received the training and has trained ▇▇▇▇▇▇ ▇▇▇▇▇▇ and other pediatric practices in Tennessee using the BeHiP model.
https://www.tnaap.org/programs/behip/behip-overview

Through BeHiP, the medical team at ▇▇▇▇▇▇▇▇▇▇ is trained to address these behavioral health needs:

- Inattention and Impulsivity
- Anxiety
- Disruptive Behavior and Aggression
- Depression
- Social-Emotional Problems in Children Birth to age 5
- Substance Abuse

Additionally, both pediatricians and the CPNP are trained in STAT (Screening Tool for Autism in Toddlers and Young Children) and are skilled at diagnosing and treating children with ASD, autistic spectrum disorders. The STAT is an empirically based, interactive tool developed to screen for autism in children between 24 and 36 months of age. The training is provided by TRIAD (Treatment and Research Institute for Autism Spectrum Disorders) at the Vanderbilt Kennedy Center. http://stat.vueinnovations.com/about

Performance Measurement and Quality Improvement (QI) Examples

QI 01 – Clinical Quality Measures (core)
Example of a Report

PCMH Performance Measurement and Quality Improvement (QI)
Competency A
Criterion: QI01

Clinic Name:

Immunization Measure

% Eligible Patients Receiving Pneumococcal Vaccine
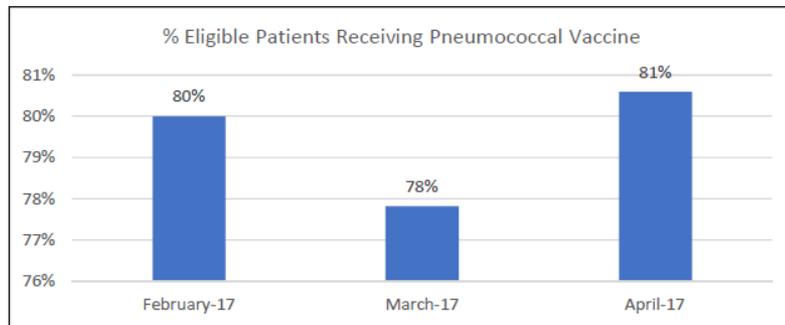
	2017		
Month	Num	Den	%
Feb-17	152	190	80%
Mar-17	172	221	78%
Apr-17	162	201	81%

Numerator (Num) = From these, the patients who had a pneumococcal vaccine on that visit or anytime before that visit

Denominator (Den) = Patients age 65 years and older who had a visit within the reporting period

Preventive Care Measure

% Eligible Patients Receiving Breast Cancer Screening Mammography
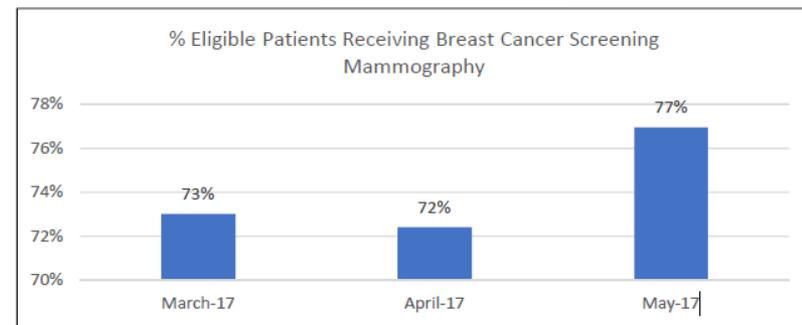
	2017		
Month	Num	Den	%
Mar-17	184	252	73%
Apr-17	139	192	72%
May-17	167	217	77%

Numerator (Num) = From these, the patients who had a mammogram on a particular visit or within 27 months prior to the visit

Denominator (Den) = Female patients age 50-74 who had an office visit within the reporting period, excluding those with a mastectomy

QI 02 – Resource Stewardship Measures (core)
Example of Report

Office Practicum Quality Improvement Calculator (QIC)

Reports | PCMH Custom | Database Administration | CMS QDE

Report group: PCMH 2017 QI Concepts ▼   Provider: ☑ All or ▼   🖨 Grid
Date range: 5/8/2017 ▼ to: 5/8/2018 ▼   Location: ☑ All or ▼   🔄 Refresh   📧 Send

Results Grid | Results Chart | Patient List / Description

NQF	PQRI	Measure Name	Numerator	Denominator	Exclusions	Min %	Perf %
		Measure Group : Care Coordination					
6B1		Newborn care coordination	10	43	0	.00%	23.26%
		Urgent care use	2	3,688	0	.00%	.05%
		Urgent care excess use	0	3,688	0	.00%	.00%
		Emergency department excess use	2	3,688	0	.00%	.05%
		Generic medications prescribed	1,403	1,848	0	.00%	75.92%

Health care cost measure

Care coordination measure

QI 03 – Appointment Availability Assessment (core)
Example of a Report

Provider	New Well Check	Established Well Check	New Sick Visit	Established Sick Visit	Follow Up VIsits
Dr. Strange	5/10/18 5/15/18 5/21/18	5/10/18 5/11/18 5/17/18	5/10/18 5/11/18 5/14/18	5/10/18 5/11/18 5/14/18	5/10/18 5/15/18 5/17/18
Dr. Pepper	5/9/18 5/15/18 6/16/18	5/9/18 5/11/18 5/15/18	5/9/18 5/11/18 5/14/18	5/9/18 5/11/18 5/14/18	5/9/18 5/11/18 5/14/18
PA System	5/9/18 5/10/18 5/11/18	5/9/18 5/10/18 5/11/18	5/9/18 5/10/18 5/11/18	5/9/18 5/10/18 5/11/18	5/9/18 5/10/18 5/11/18

QI 04 – Patient Experience Feedback (core)
Example of Patient Satisfaction Survey Results

BAD DOCUMENTATION ENDS HERE

THIS FAR, NO FARTHER!!!
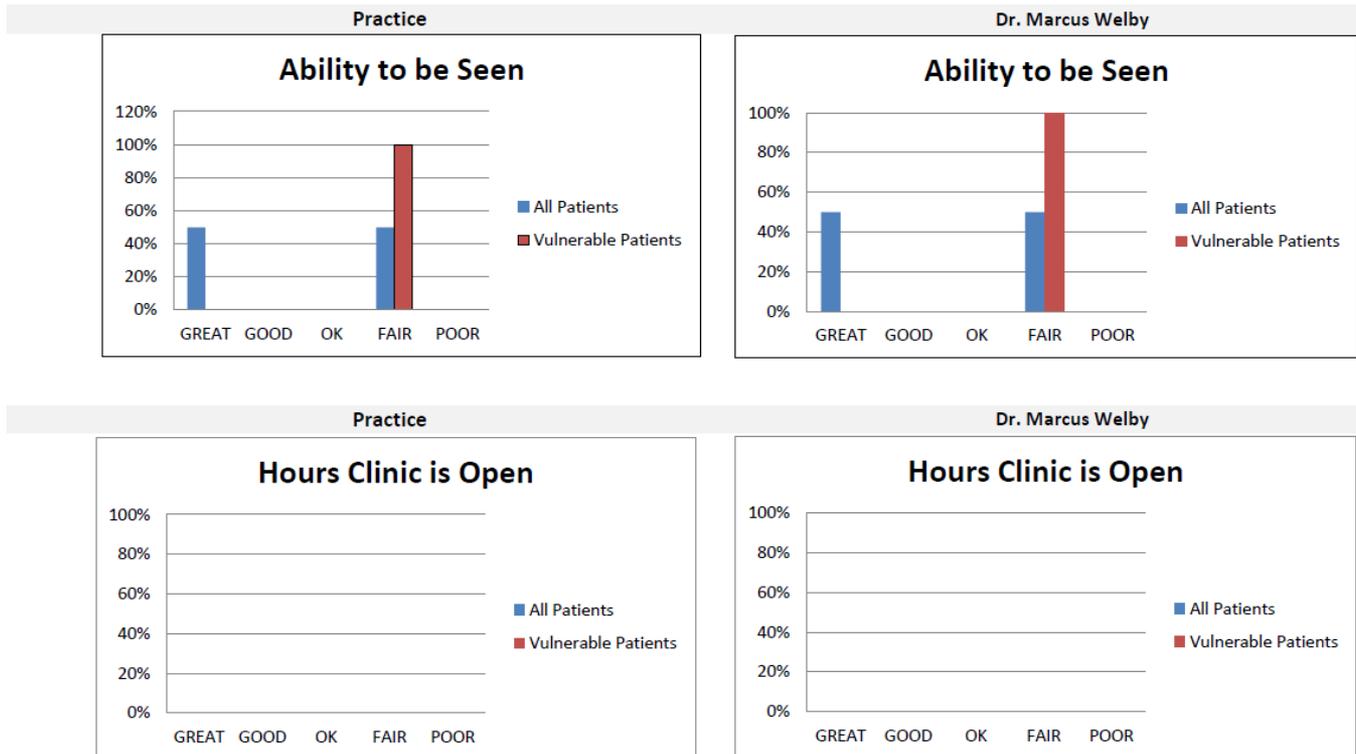
Annual Reporting

Annual Reporting

- Annual Reporting date is 30 days prior to your recognition anniversary date

- Multi-site organizations
  - Share the same Annual Reporting date

Source: Annual Reporting Requirements for PCMH Recognition
REPORTING PERIOD: JANUARY 1 – DECEMBER 31, 2019, Updated July 24, 2018

Annual Reporting, cont.

- Practices will:
  - Attest that they have continued to adopt the medical home principles
  - Maintained their medical home recognition
  - Demonstrate continued measurement and quality improvement

Source: Annual Reporting Requirements for PCMH Recognition
REPORTING PERIOD: JANUARY 1 – DECEMBER 31, 2019, Updated July 24, 2018

Annual Reporting, cont.

- Evidence:
  - ▫ Data and documentation
  - ▫ Cover the 6 PCMH concepts
  - ▫ Meet the minimum number of requirements
  - ▫ Embrace PCMH and quality improvement

Source: Annual Reporting Requirements for PCMH Recognition
REPORTING PERIOD: JANUARY 1 – DECEMBER 31, 2019, Updated July 24, 2018

Annual Reporting Requirements: Timeline and Checklist

DATE GUIDANCE	TASK
July prior to the reporting year	NCQA releases the next year's requirements. Go to the NCQA eStore and download the Annual Reporting Requirements.
6-9 months before Annual Reporting Date	•Review Annual Reporting Requirements. For concepts with options, select the option for which your practice would like to submit. Start gathering evidence for Annual Reporting requirements. Perform tasks in Q-PASS: Confirm clinicians and practice information. •Upload documents and enter data to meet requirements. •Pay the Annual Reporting fee.
Annual Reporting Date (1 month before Anniversary Date)	Submit Annual Reporting requirements.

Source: https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/current-customers/annual-reporting/

Annual Reporting Requirements: Reporting Period 1/1/19-12/31/19

Team-Based Care and Practice Organization (AR-TC)

Report the following:

> AR-TC 01 Patient Care Team Meetings

Knowing and Managing Your Patients (AR-KM)

Report the following:

> AR-KM 01 Proactive Care Reminders

Patient-Centered Access and Continuity (AR-AC)

*Choose to report **one** of the following:*

> AR-AC 01 Patient Experience Feedback—Access

OR

> AR-AC 02 Third Next Available Appointment

OR

> AR-AC 03 Monitoring Access—Other Method

Care Management and Support (AR-CM)

Report the following:

> AR-CM 01 Identifying and Monitoring Patients for Care Management

Source: Annual Reporting Requirements for PCMH Recognition
REPORTING PERIOD: JANUARY 1 – DECEMBER 31, 2019, Updated July 24, 2018

Annual Reporting Requirements: Reporting Period 1/1/19-12/31/19, cont.

Care Coordination and Care Transitions (AR-CC)

Report the following:

AR-CC 01 Care Coordination Process

AND

*Choose to report **one** of the following:*

AR-CC 02 Patient Experience Feedback—Care Coordination	**OR**	AR-CC 03 Lab and Imaging Test Tracking	**OR**	AR-CC 04 Referral Tracking	**OR**	AR-CC 05 Care Transitions

Performance Measurement and Quality Improvement (AR-QI)

*Report **all** of the following:*

AR-QI 01 Clinical Quality Measures	**AND**	AR-QI 02 Resource Stewardship Measures	**AND**	AR-QI 03 Patient Experience Feedback

Source: Annual Reporting Requirements for PCMH Recognition
REPORTING PERIOD: JANUARY 1 – DECEMBER 31, 2019, Updated July 24, 2018

Annual Reporting Quality Improvement Worksheet

This example represents 3 of the required measures (1 of 5 required by AR-QI 01, 1 of 2 required by AR-QI 02 and 1 required by AR-QI 03) reported by an organization with 3 practice sites. In Clinical Quality Measure 1, the practice sites report different measures and list the specific measure detail associated with each site in the site columns. In Resource Stewardship Measure 1 and Patient Experience Measure 1, all 3 practice sites report the same care coordination or patient experience measure, so the organization may input measure information for A-D once in Column D.

		Required Information	Site 1	Site 2	Site 3
EXAMPLE Clinical Quality Measure 1	A	Category (Shared)	Immunization	Immunization	Immunization
	B	Name (Shared)	Influenza vaccination	DTaP vaccination	Pneumococcal vaccination
	C	Denominator description (Shared)	Adults 18-64 years of age	Children under 2 years of age	Adults 65 years of age and older
	D	Numerator description (Shared)	Patients in the denominator who received an influenza vaccination within the 12 months prior to the reporting date	Patients in the denominator who received at least 4 DTaP vaccinations on or before the child's second birthday	Patients in the denominator who received a pneumococcal vaccination
	E	Denominator (Site-specific)	1700	1950	3000
	F	Numerator (Site-specific)	1600	1600	2000
	G	Reporting Period (Site-specific)	9/1/2018	8/15/2018	5/1/2018
	H	Was the measure a target for QI? (Site-specific)	Yes	Yes	Yes

Source: Annual Reporting Requirements for PCMH Recognition
REPORTING PERIOD: JANUARY 1 – DECEMBER 31, 2019, Updated July 24, 2018

Annual Reporting Quality Improvement Worksheet, cont.

EXAMPLE Resource Stewardship Measure 1	A	Category (Shared)	Care coordination		
	B	Name (Shared)	Receipt of referral report from specialist		
	C	Denominator description (Shared)	Number of patient referrals in the reporting period		
	D	Numerator description (Shared)	Number of referral reports received after a referral		
	E	Denominator (Site-specific)	2500	3500	4000
	F	Numerator (Site-specific)	1750	2225	2500
	G	Reporting Period (Site-specific)	8/1/2018-8/31/2018	6/1/2018-6/30/2018	6/1/2018-6/30/2018
	H	Was the measure a target for QI? (Site-specific)	Yes	Yes	No
EXAMPLE Patient Experience Measure 1	A	Category (Shared)	Patient Experience		
	B	Name (Shared)	Telephone Response Rate		
	C	Denominator description (Shared)	Patients who responded to the satisfaction survey during to the reporting period		
	D	Numerator description (Shared)	Patients who ranked telephone response rate as "ok", "fair", or "poor".		
	E	Denominator (Site-specific)	2200	2000	3500
	F	Numerator (Site-specific)	1550	1015	2000
	G	Reporting Period (Site-specific)	9/1/2018-10/31/2018	8/1/2018-9/30/2018	9/1/2018-10/31/2018
	H	Was the measure a target for QI? (Site-specific)	Yes	No	Yes

Source: Annual Reporting Requirements for PCMH Recognition
REPORTING PERIOD: JANUARY 1 – DECEMBER 31, 2019, Updated July 24, 2018

Questions?

Collaborative Discussion

- Best Practices

- Challenges

- Novel Ideas

- Questions

Housekeeping

- Select "Everyone" and enter your question or comment
- The host will read comments from the chat box

PCMH Curriculum Module References

- AC 01, 02, 03, 04, 11 – Module 8A, 8B

- CC 04, 16 – Module 12A, 13A

- CM 01, 02, 03 – Module 9A

- KM 02, 03, 04, 05, 09, 12, 20 - Module 7A, 7B, 7C, 7E

- QI 01, 02, 03, 04 – Module 5A

- TC 02, 07, 08 – Module 6A, 6B

Next Session

PCMH Documentation 2:

Record Review Workbook
Quality Improvement Worksheet

TBD, March 2019

11am-12pm CT / 12-1pm ET

Contact Information

rwalker@ccwnc.org