



TennCare Patient Centered Medical Home Curriculum

June 2019

Training Module Overview

The curriculum includes the training modules listed below, which encompass the key areas for PCMH organization transformation.

Table 1: Modules Overview

No.	Module
Intro	Initial Assessment Results
1.	Transformation Overview and Basics
2.	Change Management
3.	Quality Improvement
4.	Organizational Workflow and Redesign
5.	Measuring Performance with Data
6.	Team Based Care and Practice Organization
7.	Knowing and Managing Your Patient Population
8.	Patient-Centered Access and Continuity
9.	Care Management and Support
10.	Patient Self-Management and Support
11.	Care Coordination and Care Transitions
12.	Care Coordination with Specialists
13.	Care Coordination During Transitions of Care
14.	Behavioral Health Integration
Appendix	<ul style="list-style-type: none"> • NCQA PCMH 2017 Criteria – TennCare PCMH Curriculum Crosswalk • 2018 PCMH Webinars

Module Sessions

Materials in [blue font](#) are available on the SharePoint site.

Module (Intro)

MODULE (INTRO)	INITIAL ASSESSMENT RESULTS
SESSION (INTRO)	<i>Organizations will have a clear understanding of the initial assessment results and the domains in which they may require assistance to be successful with the PCMH program.</i>
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> • Organizational management, • PCMH lead/s, • Site Supervisors, • Any other key personnel overseeing implementation/training for PCMH development. 	
1	Understands PCMH organization’s initial assessment results (cover this learning objective only if it has not already been completed in a previous session)
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> • Complete a review of the initial assessment. <ul style="list-style-type: none"> ○ Review assessment results and discuss agreements on priority areas/objectives. ○ Complete a “<i>stoplight</i>” diagram (establishing strengths shown in green, risks shown in yellow and weaknesses shown in red) in the organization that will impact readiness for change, recognizing which “red light” barriers need to be addressed early to set the stage for change. Establish next steps for addressing these “red light areas.” • Review organization’s pre-established PCMH implementation strategies (e.g., new services, workflows, etc.) and adjust accordingly. • Review PCMH Coaching Overview and discuss the roles of each member of the transformation team and the general improvement model. <ul style="list-style-type: none"> ○ Review the role of the coach on slide 7 and identify where expectations align/misalign. • Establishing organizational roles with coach (main contact, scribes, minutes, follow-up, etc.) specific to organizing and documenting during sessions. • Identify “PCMH” champions, both leaders and key staff members who will drive progress. This should include “front line” champions who will play a role with clinical coaching efforts. • Review any results from MCO quarterly reports that have been delivered. Use those reports to identify key areas for improvement.
ADDITIONAL RESOURCES (documents on SharePoint site):	
	PCMH Initial Assessment (Not on the Curriculum SharePoint Site, Coach to Provide)
	PCMH MCO Reports (Not on the Curriculum SharePoint Site, Coach to Provide)
	TennCare PCMH Curriculum Overview

Module 1

Module 1	TRANSFORMATION OVERVIEW
Session 1A	<i>Practice has a clear understanding of the requirements of the Patient Centered Medical Home model and the TennCare PCMH Program.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1.	Understands the Patient Centered Medical Home model
2.	Understands the core principles of TennCare’s PCMH Program
3.	Understands the foundational elements of the NCQA PCMH Recognition Program
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site) <i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the Quality Improvement (QI) Team with the coach serving as a work facilitator and mentor.</i>	
1	<ul style="list-style-type: none"> Reviews the foundational elements of the patient centered medical home model PCMH Checklist Discusses the question: Why PCMH? PCMH Value Develops an introductory training for organization staff and providers Have a Quality Improvement (QI) Team member(s) present the model and the ‘Why’ to staff and providers
2	<ul style="list-style-type: none"> Ensures the organization has a copy of the TennCare PCMH Provider Operating Manual 2018 Reviews the TennCare PCMH Provider Operating Manual 2018 PCMH Provider Activity Requirements on page 10 of the TennCare PCMH Provider Operating Manual 2018 What Services will a PCMH provide? (p8) How will PCMH organizations be paid? (p9) How will Quality (Table 5 –p33) and Efficiency (Table 6 – p43) be Measured? Additional information on MCO Reports in Session D5 Provider Training (p29-30)
3	<ul style="list-style-type: none"> Shares the NCQA PCMH 2017 Guidelines Reviews organization’s current NCQA PCMH activities if applicable Brainstorms gaps between the organization’s current state and what is needed to meet NCQA PCMH requirements. Documents gaps to ensure areas are addressed during the organization’s PCMH transformation journey
ADDITIONAL RESOURCES (documents on SharePoint site):	
AHRQ The Medical Home What Do We Know	
PCMH TAG Recommendations and Program Information	
PCMH Provider Information Webinar	
PCMH Sustainability Tool	
TN PCMH Appendix	
Module 1 Transformation Overview and Basics	
The Primary Care Landscape (AHRQ)	
PCMH – PCPCC Infographic	

	PCMH Program Description
	Care Coordination Tool Overview
	PCMH Webinar Setting the Foundation slide deck ; webinar recording: https://youtu.be/FX1eewuTxy0

Module 2

Module 2	CHANGE MANAGEMENT
Session 2A	<i>The organization seeks to bring about change using a model that creates a positive climate for change, engages & enables the organization to change, allows for a full implementation, and creates change that is sustainable.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1	Understands the factors of change and how change can be sustained
2	Assesses current flow of information in the organization and addresses systemic gaps in communication.
3	Develops a conceptual framework (shared mental model) for implementing change in the organization that includes: setting a vision, developing goals, using a team approach, enhancing communication and encouraging staff participation in change activities.
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site) <i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor.</i>	
1	<ul style="list-style-type: none"> • Discusses culture change versus process change, resistance to change and what motivates people. The Human Side of QI Change Picture Change Questions to consider • Discusses how change can best be maintained <ul style="list-style-type: none"> ○ Educating staff ○ Dashboards ○ Monitoring outcomes ○ Assigning process owners • Reviews practice's change management process to date <ul style="list-style-type: none"> ○ Training ○ Communicating change ○ Implementing new work and changing current workflow • Discusses what has previously led to success in the organization and what has not. What activities were successful in bringing about sustained change
2	<ul style="list-style-type: none"> • Defines the current communication structure within the organization <ul style="list-style-type: none"> ○ What tools does the organization use? E-mail, quality board, newsletter? ○ Where do most communications begin? Medical Director, organization manager? ○ Is there a method to ensure that all staff receive communications? ○ Is there a place where staff can share their thoughts and ideas?

	<ul style="list-style-type: none"> Brainstorms opportunities for improving organization communication Educate the team on the Plan Do Study Act (PDSA) cycle. It is a structured communication tool to be used with change activities. Considers stopping one communication venue that has not proven to be effective.
3	<ul style="list-style-type: none"> Develops and documents a “Change Vision”. Communicate a commitment to shaping a culture of change to providers and staff Develops a quality improvement team of staff and providers that oversees the transformation process. See Session 3A for additional information on developing a quality improvement team. Sets goals that are best documented and communicated using a Charter. See Session 3A for additional information on developing a Charter. Shares the plan with staff and providers – the vision, the team, the Charter
ADDITIONAL RESOURCES (documents on SharePoint site):	
	TeamSTEPPS Change Management
	Strategies for Accelerating and Sustaining Change in Healthcare Organizations
	Change Reason Worksheet
	3 Stages of Change
	7 Rules for Engaging Physicians in QI
	AMA STEPS Forward innovative strategies-patient care, workflow, change
	Change Picture
	Change Questions to Consider
	Implementing Change
	The Human Side of QI
	Module 2 Change Management
	Kotter’s Change Model
	Kotter’s 8 Steps of Change
	6 Signs of Change Fatigue
	Change Curve & Resistance
	Preventing Resistance
	Resistance to Change Strategies
	IHI Video: Is there a secret to sustaining improvement? (2 minutes) http://www.ihl.org/education/IHIOpenSchool/resources/Pages/Activities/WilliamsSustainingImprovements.aspx

Module 3

MODULE 3	QUALITY IMPROVEMENT: BUILDING THE TEAM
SESSION 3A	<i>The organization has a quality improvement (QI) team whose structure and function is effective in improving quality and bringing about change.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1	Develops a Charter for the QI team that explains the purpose of the team and the member composition of the team
2	Ensures that there is an engaged physician champion on the team
3	Develops roles & responsibilities for the team

4	Employs start up strategies that enhance the ability of the team to be successful
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> Work with the PCMH Director/lead in addition to the broader QI team to develop a QI Team Charter. The Charter should identify: <ol style="list-style-type: none"> Who is leading the team? Who are the team members? Who is the physician champion? What is the purpose of the project? What is the scope of the work the team will do? What measure(s) will show success? What is the timeline for this work? How to complete a Project Charter; Template Project Charter Have the PCMH Director/lead and the Physician Champion to share the project charter with the organization's providers and staff.
2	<ul style="list-style-type: none"> Work with the PCMH Director/lead and other key organization leadership staff to identify a physician champion for the PCMH project. Establish a plan that ensures the PCMH physician champion is knowledgeable about PCMH and about his/her role in the process. This could be done in a one on one training session or with all the members of the QI team learning together. QI Team Roles & Responsibilities
3	<ul style="list-style-type: none"> Educates the QI Team on the responsibilities of each role on the team QI Team Roles & Responsibilities
4	<ul style="list-style-type: none"> Ensure efficient meetings by following the preparation schedule as described in the Anatomy of a Meeting document Develops team rules to guide meetings and enhance conversation Team Ground rules <ul style="list-style-type: none"> Uses an agenda for every meeting Agenda Template Use evidence based techniques for assuring team consensus Consensus Seeking Model of Decision Making
ADDITIONAL RESOURCES (documents on SharePoint site):	
The Team Handbook, authored by Scholtes, Joiner & Streibel	

Module 3	QUALITY IMPROVEMENT: METHODS & TOOLS
Session 3B	<i>The organization uses proven quality improvement methodologies and tools to bring about change and positively impact outcomes.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1	The organization uses an evidence based structured quality improvement methodology, like the IHI Model for Improvement to bring about change.
2	The organization uses evidence based tools, like the Driver Diagram, to guide the quality improvement process.
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	

1	<ul style="list-style-type: none"> • Educate the QI Team on the use of the IHI's model for improvement and the use of Plan-Do-Study-Act cycles in quality improvement. Share the PDSA Tip Sheet • Review the ACP Quality Connect PDSA Planning Worksheet with the QI team, highlighting the need for planning and the need for a measure of improvement Have the QI Team select a PDSA cycle form to document the organization's PDSA cycles. PDSA Cycle Worksheet • Share the Goal Sheet example PDSA PDSA Examples PDSA – Patient Self-Management
2	<p>Use the following tools to support the QI team in making successful changes to transform care:</p> <ul style="list-style-type: none"> • Driver Diagram: The driver diagram shows the relationships among goals, the primary drivers that contribute to achieving those goals, and the subsequent factors that are necessary to achieve the primary drivers. It is used to drive transformation efforts on a larger level with PDSA cycles built into the secondary drivers and associated change concepts. Share Dr. Don Goldmann's 6-minute video: How do you use a driver diagram? https://youtu.be/yfcE_Q-IRFg Example – Key Driver Diagram 10 Things you can do with a Driver Diagram TCPI Change tactics & driver diagrams¹ • Aim Statement: An aim statement clearly articulates both the foundation and the focus of the problem-solving effort. A clearly worded aim statement answers the question "What are we trying to achieve?" See the examples in the Aim Statement document • Communication Plan: The communication plan sets the standards for how and when communication takes place. It ensures that all stakeholders are equally informed of how, when, and why communication will happen. Communication is a very effective way to solve problems, deal with risks, and ensure that tasks are completed on time. Successful communication plans identify stakeholders, the information to be communicated, and how this information will be communicated. Communication Plan Template • Gantt Chart: A Gantt chart, commonly used in project management, is a popular and useful way of showing activities (tasks or events) displayed over time. On the left of the chart is a list of the activities and along the top is a suitable time scale. Each activity is represented by a bar; the position and length of the bar reflects the start date, duration and end date of the activity. This allows you to see at a glance: <ul style="list-style-type: none"> ○ What the various activities are ○ When each activity begins and ends ○ How long each activity is scheduled to last ○ Where activities overlap with other activities, and by how much ○ When an activity has been completed Gantt Chart Template • Gap Analysis: A gap analysis helps identify opportunities for improvement. The gaps between what is happening now (Current State) and what the process should look like (Future State) lead to identification of solutions that can be tested with PDSA cycles.

¹ This document is 32 pages long, but each portion will be relevant depending on the coaching session focus within QI. The coach should review this document and identify the information most relevant for the organization's focus.

	<p>Gap Analysis Worksheet</p> <ul style="list-style-type: none"> • Cause & Effect Diagram (Fishbone / Ishikawa Diagram – named after the creator, Kaoru Ishikawa): The cause & effect diagram is a visual picture that shows factors that may be contributing the problem. The head of the fish is the problem and the scales are possible causes (the central spine is just a visual representation connecting the “head” to the “scales”). This is a helpful qualitative, brainstorming team activity tool. <p>Cause and Effect Diagram ISHIKAWA Template</p> <ul style="list-style-type: none"> • With the QI Team, initiate a PDSA cycle (start the PDSA Cycle Worksheet) around integrating one, or more, of these QI evidence based tools into the team’s daily work.
ADDITIONAL RESOURCES (documents on SharePoint site):	
	IHI Model for Improvement
	Quality Improvement Using Plan Do Study Act
	QI 104 IHI Improvement Project Roadmap
	Patient Satisfaction Survey
	Teach Back PDSA
	FIT Testing PDSA

Module 3	QUALITY IMPROVEMENT: IDENTIFYING OPPORTUNITIES
Session 3C	<i>The organization uses validated measurement tools and techniques to understand current performance and identify opportunities for improvement.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1	The organization uses operational definitions when describing measures of success
2	The organization uses a balanced set of measures for improvement efforts: Structure, Process, Outcome, Satisfaction, and Balancing measures
3	The organization uses graphs and charts to display data and to identify opportunities for improvement
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site) <i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor.</i>	
1	<ul style="list-style-type: none"> • IHI Activity – How do you measure the banana? Operational definitions & the purpose of measurement in improvement http://www.ihl.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/QI-Games-How-Do-You-Measure-the-Banana.aspx • Reviews the 2018 TennCare PCMH Adult, Family Practice, or Pediatric Quality Measures Coding Reference document and discusses the operational definitions for one or two of the measures. Do these definitions provide a clear understanding of what is being measured?

2	<ul style="list-style-type: none"> • Reviews the definitions of the different measure types <ul style="list-style-type: none"> ○ Shares page 1 of the Measures for Improvement Efforts document ○ Shares page 1 of the Introduction to Quality Measures document • Brainstorms examples for each of the major types of measures
3	<p>Uses the following graphs and charts to support the QI team in identifying opportunities and monitoring change activities over time:</p> <ul style="list-style-type: none"> • Run Chart: Run charts are linear graphs that allow you to track improvements by displaying data in a time sequence. Time is generally displayed on the horizontal (x) axis and the measure that you are tracking is displayed on the vertical (y) axis. Using a run chart allows you to see if improvement is really taking place by displaying a pattern of data that you can observe as you make changes to your process. • Uses the IHI Coin Spinning Activity and IHI Coin Spinning Worksheet to collect real time data and develop a run chart^{2,3} http://www.ihl.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/QI-Games-Learn-How-to-Use-PDSA-Cycles-by-Spinning-Coins.aspx Run Chart Module Run Chart definition and example Run Chart Example IHI Run Chart Template QI 106 Run Chart Template • Control Chart: A Control chart is also used to study how a process changes over time. Unlike the run chart, the control chart also includes three reference lines which are determined by historical data: a central line which represents the average, an upper line which represents the upper control limit (UCL), and a lower line which represents the lower control limit (LCL). By comparing current data to the reference lines, you can assess whether the process variation is in control (consistent) or out of control (unpredictable.) Control Chart Example • Pie Chart & Bar Chart: Rather than tracking data over time, Pie charts and Bar charts are used to visually represent snapshots of data. Pie Chart Example Bar Chart Example • Dashboard Report: A dashboard report, which can be created using Excel, allows you to present at-a-glance information on multiple quality measures. Family Practice Dashboard Example
ADDITIONAL RESOURCES (documents on SharePoint site):	
Introduction to Quality Measures⁴	
IHI Open School Measuring for Improvement	
Getting Started Measuring	
Excel Formulas	
How to Read Your Reports Webinar	

² The coach will need to watch the IHI video prior to the coaching session to learn how to conduct the IHI Coin Spinning activity.

³ This module includes a couple examples of run charts. Coaches may use either depending on an organization's needs and/or preferences.

⁴ This is a document used in the TCPi program, in which some organizations have participated. Coaches may need to explain that the PCMH program is separate from the TCPi program although materials are being shared between the two.

	IHI Whiteboard Video – Family of Measures (7 minutes) http://www.ihl.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard15.aspx
	IHI Whiteboard Video – Pareto Analysis (7 minutes) http://www.ihl.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard20.aspx
	IHI Whiteboard Video - Control Charts (6 minutes) http://www.ihl.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard13.aspx
	IHI Whiteboard Video – Run Chart (7 minutes) http://www.ihl.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard7.aspx

Module 3	QUALITY IMPROVEMENT: SUSTAINING CHANGE
Session 3D	<i>The organization implements tools and techniques to ensure that improvements are sustained.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1	Document the process change
2	Monitor results over time with run charts (Module 3, Session 3C) or control charts
3	Transfer ownership and knowledge of the process to the process owner and/or process team tasked with monitoring the change
4	Share the knowledge gained on the process improvement project with everyone in the organization
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> Document exactly how the QI team wants to pass the new process structure on to the other organization staff, especially those who work in the process. Document using a flowchart (Module 4)⁵, a standard operating procedure document or in a policy. Policy Template Policy Template Instructions Policy Writing Dos and Don'ts Sample Policy – Test Tracking Standard Operating Procedure (SOP) Template Example SOP Referral Process
2	<ul style="list-style-type: none"> Initiate a Process Dashboard.
3	<ul style="list-style-type: none"> Identify a role within the organization that is responsible for monitoring the process and notifying the QI team and leadership team if a negative trend is identified Meet with the process owner to ensure that he/she understands the process and his/her role in process monitoring.
4	<ul style="list-style-type: none"> Have a member(s) of the QI team & an organization leader communicate the new/revised process to all staff at a staff meeting.

⁵ Coaches can use the IHI Introduction to Flow Charting and AMA Flowchart Toolkit from Session 4A.

	<ul style="list-style-type: none"> Identify opportunities to adapt or adopt the process change into other workflows
	ADDITIONAL RESOURCES (documents on SharePoint site):
	Sustaining Improvements in Quality
	IHI Sustaining Improvement White Paper

Module 4

Module 4	ORGANIZATION WORKFLOW & REDESIGN
Session 4A	<i>The organization uses workflow mapping and process observation techniques to understand current performance, identify opportunities for improvement, and plan for process future state.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1	Develops a working knowledge of tools used to map a process; specifically, the flowchart and the swim lane diagram.
2	Understands the concept of “Going to Gemba” (direct observation) and how observing the process plays an important role in workflow redesign.
3	Develops a current state and a future state process map as part of a quality improvement process redesign.
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site) <i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor.</i>	
1	<ul style="list-style-type: none"> FLOWCHARTS <ul style="list-style-type: none"> Watches IHI Introduction to Flow Charting (7 minutes) http://www.ihl.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard11.aspx Review the AMA Flowchart Toolkit Engages in a training activity by producing a flow chart. See Objective 4A3. SWIM LANE DIAGRAMS <ul style="list-style-type: none"> Reviews the Process Mapping – Swim Lane Diagram document Engages in a training activity by producing a swim lane diagram. See Objective 4A3.
2	<ul style="list-style-type: none"> Reviews the document Gemba Walk Training Performs a Gemba Walk with one or two members of the QI team through the clinical areas of the organization where members interact with staff. (e.g. exam rooms, lab, waiting room) <ul style="list-style-type: none"> Walks early in the work day when staff are most engaged Talks to the staff and members During the walk has QI team members make notes of anything they see that needs to be addressed or that they want to remember. Documents the details so as not to forget them. Immediately after the walk sets a plan in place to follow-up on items.
3	<ul style="list-style-type: none"> Reviews the Current State-Future State Mapping document Identifies a process with multiple opportunities from the Gemba Walk in Session 4A2.

<ul style="list-style-type: none"> Develops a current state map followed by a future state map of the same process. (e.g. the check in process from when members enter the clinic until they are called back to the exam room). Remember to focus on one process at a time. It is not helpful to look at everything at one time.
ADDITIONAL RESOURCES (documents on SharePoint site):
Flowchart Template
Swim Lane Template
Process Mapping (32 minutes) https://www.youtube.com/watch?v=LJwKZuQUb7g
AHRQ Mapping and Redesigning Workflow
Lab Current State Sticky Note
Lab Current Future State Computer
Lab Future State Computer

Module 5

Module 5	MEASURING PERFORMANCE WITH DATA: UNDERSTANDING CURRENT PERFORMANCE
Session 5A	<i>The organization measures to understand current performance and to identify opportunities for improvement.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1*	Monitors at least five clinical quality measures across the four categories. (Must monitor at least 1 measure of each type). A. Immunization measures B. Other preventive care measures C. Chronic or acute care clinical measures D. Behavioral health measures
2*	Monitors at least two measures of resource stewardship. (Must monitor at least 1 measure of each type). A. Measures related to care coordination B. Measures affecting health care costs
3*	Assesses performance on availability of major appointment types to meet patient needs and preferences for access.
4*	Monitors patient experience through A. Quantitative data: The organization conducts a survey to evaluate patient/family/caregiver experiences across at least three dimensions such as: i. Access ii. Communication iii. Coordination iv. Whole person care, Self-management support and Comprehensiveness B. Qualitative data: The organization obtains feedback from members/families/caregivers through qualitative means
5	Assesses health disparities using performance data stratified for vulnerable populations. (must choose one from each section) A. Clinical Quality B. Patient Experience

6	The organization uses a standardized, validated patient experience survey tool with benchmarking data available.
7	Obtains feedback on experiences of the organization’s vulnerable patient groups.
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1*	<ul style="list-style-type: none"> • Review how the organization currently monitors clinical quality measures across the four categories. • Training: How to use data to track performance. Share Sample PCMH Performance Dashboard as an example of how to track performance. • Discussion with QI Team: How to use Data to Track Performance Managing Data for PI Infographic • Facilitate the selection of 5 clinical quality measures, ensuring that the measures cover at least one of each of the identified categories. • Have the organization build a performance dashboard for each measure selected. See tabs in Sample PCMH Dashboard • Have the organization assign staff to: <ul style="list-style-type: none"> ○ Create and/or execute each of the reports that populate the dashboard ○ Maintain the performance dashboards by executing each report on a regular schedule ○ Share the dashboard with the QI Team on a regular schedule
2A*	<ul style="list-style-type: none"> • Review how the organization currently coordinates care (e.g. between hospital and referral sources) • Share examples of care coordination resource stewardship. IHI’s Resource Stewardship 2-minute video: https://vimeo.com/93605940 NPA Top 5 List Family Medicine NPA Top 5 List Internal Medicine NPA Top 5 List Pediatrics • Brainstorm with QI team ways to measure resources related to care coordination. • Facilitate the selection of 1 measure related to care coordination resource stewardship • Have the organization build a performance dashboard to monitor this measure over time. • Have the organization assign staff to: <ul style="list-style-type: none"> ○ Create and/or execute the report that populates the dashboard ○ Maintain the performance dashboard by executing the report on a regular schedule ○ Share the dashboard with the QI Team on a regular schedule ○ See care coordination tab in Sample PCMH Dashboard
2B*	<ul style="list-style-type: none"> • Review how the organization currently measures resources related to health care costs. • Provide examples of measures that affect health care costs • Brainstorm ways to measure resources related to health care costs with the QI Team. • Facilitate the selection of one measure that affects health care costs within the organization.

	<ul style="list-style-type: none"> • Have the organization build a performance dashboard as a way to monitor this measure over time. See health care cost tab in Sample PCMH Dashboard • Have the organization assign staff to: <ul style="list-style-type: none"> ○ Create and/or execute the report that populates the dashboard, and ○ Maintenance of the performance dashboard by executing the report on a regular schedule ○ Share the dashboard with the QI Team on a regular schedule
3*	<ul style="list-style-type: none"> • Discuss how the organization assesses performance on the availability of major appointment types to meet patient needs and preferences with QI Team. • Identify major appointment types. • List appointment types to be assessed and tracked in the PCMH Dashboard • Evaluate the success of appointments (see Module 8 for more information): <ul style="list-style-type: none"> ○ Percentage of same day appointments compared to total appointments for the month ○ Percentage of no shows compared to kept appointments ○ Number of days between scheduled and appointment day • Have the organization assign staff to: <ul style="list-style-type: none"> ○ Create and/or execute the report that populates the dashboard, See access tab in Sample PCMH Dashboard ○ Maintain the performance dashboard by executing the report on a regular schedule ○ Share the dashboard with the QI Team on a regular schedule
4A*	<ul style="list-style-type: none"> • Review how the organization quantitatively monitors patient experience • Share the PCMH 12 Month English Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey as a resource for survey question selection. • Identify the survey questions to be distributed to members/families/caregivers across at least three dimensions including: Access, Communication, Coordination, Whole person care, Self-management support, and Comprehensiveness. • Consider Session 5A, Objectives 6 & 7 when developing the survey • Survey organization leadership to identify how and when to conduct a patient survey. • Develop a process for monitoring patient experience using a survey. Define frequency, schedule and workflow. • PDSA the survey with a subset of members and review the results to ensure the survey is producing the desired results. • Review the process and results of the patient survey with the QI team • Share the results with staff and providers • Implement the new process across the organization
4B*	<ul style="list-style-type: none"> • Review how the organization qualitatively monitors patient experience • Brainstorm methods to obtain qualitative feedback, such as: <ul style="list-style-type: none"> ○ Comment box in each waiting area ○ Patient/family/caregiver interviews ○ Patient/family/caregiver focus groups • Develop a process for monitoring patient experience quantitatively. Define frequency, schedule and workflow. • PDSA the process with a subset of members and review the results to ensure the method is producing the desired results.

	<ul style="list-style-type: none"> Review the results of the patient survey with the QI team Share the process and results with staff and providers Implement the new process across the organization
5A	<ul style="list-style-type: none"> Review how the organization currently assesses health disparities using quality performance data stratified for vulnerable populations Provide examples of health disparities and vulnerable populations. Health Disparities and Vulnerable Populations Identify a vulnerable population within the organization Facilitate the selection of 1 quality performance measure to monitor Build a performance dashboard to monitor this measure over time. Have the organization assign staff to: <ul style="list-style-type: none"> Create and/or execute the report that populates the dashboard Maintain the performance dashboard by executing the report on a regular schedule Share the dashboard with the QI Team on a regular schedule
5B	<ul style="list-style-type: none"> Review how the organization currently assesses health disparities in patient experience using performance data stratified for vulnerable populations Review the patient survey to identify a vulnerable population within the organization Facilitate the selection of 1 quality performance measure to monitor Build a performance dashboard to monitor this measure over time. Have the organization assign staff to: <ul style="list-style-type: none"> Create and/or execute the report that populates the dashboard Maintain the performance dashboard by executing the report on a regular schedule Share the dashboard with the QI Team on a regular schedule
6	<ul style="list-style-type: none"> Determine if current survey is a standardized, validated patient experience tool with benchmarking data available. Provide an example of a standardized, validated patient experience survey tools with the organization PCMH 12 Month English Adult CAHPS Survey Have the organization agree on a standardized validated patient experience survey tool that includes benchmarking data to be used by the organization. Follows the process for monitoring as defined in Session 5A, Objective 4A
7	<ul style="list-style-type: none"> Have the organization review patient survey responses to glean feedback specific to an identified vulnerable patient group Share feedback identified in the survey related to patient experience of the identified vulnerable patient group within the organization.
ADDITIONAL RESOURCES (documents on SharePoint site):	
2017 HEDIS Value Set Directory	
Sample PCMH Performance Dashboard	
AHRQ – Monitoring Progress for Sustainable Improvement	
AHRQ – Using HIT to Support QI in Primary Care (pg. 6 – 16)	
CAHPS Child 12mo with PCMH 20x	

Module 5	MEASURING PERFORMANCE WITH DATA: SETTING GOALS
Session 5B	<i>The organization evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1*	Sets goals and acts to improve upon at least five measures across at least three of the four categories. A. Immunization measures B. Other preventive care measures C. Chronic or acute care clinical measures D. Behavioral health measures
2*	Sets goals and acts to improve upon at least one measure of resource stewardship. A. Measures related to care coordination B. Measures affecting health care costs
3*	Sets goals and acts to improve on availability of major appointments types to meet patient needs and preferences.
4*	Sets goals and acts to improve on at least one patient experience measure.
5	Achieves improved performance on at least 2 performance measures.
6	Sets goals and acts to improve disparities in care or service on at least 1 measure.
7	Achieves improved performance on at least 1 measure of disparities in care or service.
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> • Brainstorm with the QI Team in the implementation of PDSA cycles for each measure selected: <ul style="list-style-type: none"> ○ Have the organization assign staff to produce a registry of members due for care related to the measures QI team selected for improvement. ○ Facilitate the selection of the best method for outreach to the members that are due for service contained in each measure selected. ○ Guide the QI Team to track the success of the PDSA each month on the quality improvement dashboard. • Review the goals monthly to track results of each PDSA.
2	<ul style="list-style-type: none"> • Brainstorm with the QI Team to choose which measure to act to improve between a measure for resource stewardship in care coordination OR in affecting health care costs. <u>If resource stewardship in care coordination is determined to be the measure decided to act upon:</u> <ul style="list-style-type: none"> • Facilitate the selection of 1 measure related to care coordination with the QI Team. • Have the organization set a goal for the measure selected. • Assist the QI Team in the implementation of one PDSA cycles for this measure. • Have the QI Team track the success of the PDSA each month on the quality improvement dashboard. <u>If resource stewardship in health care costs is determined to be the measure decided to act upon:</u> <ul style="list-style-type: none"> • Facilitate the selection of 1 measure that affects health care costs in the organization.

	<ul style="list-style-type: none"> • Have the QI team set a goal for the measure selected. • Assist the QI Team in the implementation of one PDSA cycle for this measure. • Have the QI Team track the success of the PDSA each month on the quality improvement dashboard.
3	<ul style="list-style-type: none"> • Review patient survey results with the QI Team and have them identify one opportunity to improve availability of one major appointment type. • Brainstorm ways to improve availability of one of the identified appointment types. • Guide the QI Team in the implementation of one PDSA for this measure. • Have the organization resurvey the members to determine the success of the PDSA related to enhanced access of major appointment types.
4	<ul style="list-style-type: none"> • Review the results of the patient survey with the QI Team and the organization. • Have the organization identify one opportunity to improve upon for patient experience. • Brainstorm ways to improve patient experience based on patient feedback. • Have the organization set a goal from the survey question responses to be improved upon. • Guide the QI Team in the implementation of one PDSA for this measure. • Have the organization resurvey the members to determine the success of the PDSA related to improving the patient experience. • Have the organization establish a schedule for ongoing patient/family/caregiver feedback within the organization.
5	<ul style="list-style-type: none"> • Have the organization select two performance measures to improve upon based on performance data in the quality improvement dashboard. • Brainstorm ways to improve performance measures with QI Team. • Have the organization set a goal for each of the performance measures • Guide the QI Team in the implementation of one PDSA for each of the selected measures. • Tracks the performance measures over time on the quality dashboard. • Identifies improvement or opportunities that lead to meeting the practice goal.
6	<ul style="list-style-type: none"> • Have the organization select one performance measures to improve upon for disparities in care based on performance data in the quality improvement dashboard. • Sets a goal for the measure. • Brainstorm ways to improve this performance measures with QI Team. • Guide the QI Team in the implementation of one PDSA for the selected measure. • Have the organization track the identified disparity in care or service to track performance improvement. • Have the organization set a goal for improving the disparity in care or service that was identified for this measure.
7	<ul style="list-style-type: none"> • Uses the measure identified in objective 5B6 for this objective. • Continues to track performance on the quality dashboard and perform PDSA cycles until goal achieved.
ADDITIONAL RESOURCES (documents on SharePoint site):	
Sample PCMH Performance Dashboard	
AHRQ – Monitoring Progress for Sustainable Improvement	
Using Health IT Technology to Support QI	
Resource Stewardship Infographic	

	NPA Top 5 List Family Medicine
	NPA Top 5 List Internal Medicine
	NPA Top 5 List Pediatrics
	CAHPS Survey Tool (Version 2.0)

Module 5	MEASURING PERFORMANCE WITH DATA: SHARING DATA
Session 5C	<i>The organization is accountable for performance. The organization shares performance data with the organization, members and/or publicly for the measures and patient populations identified in the previous session.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1*	Reports organization-level or individual clinician performance results within the organization for measures reported by the organization.
2	Reports organization-level or individual clinician performance results publicly or with members for measures reported by the organization.
3	Involves patient/family/caregiver in quality improvement activities.
4	The organization is engaged in Value-Based Contract Agreement. (Maximum 2 credits) A. Practice engages in up-side only risk contract (1 credit) B. Practice engages in two-sided risk contract (2 credits)
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site) <i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor.</i>	
1*	<ul style="list-style-type: none"> Works with the QI team to identify which organization-level or individual performance results will be reported- from Session 5A1. An example of this would be sharing a performance dashboard in the organization's break room. Develops a plan for how the selected performance results will be shared Implements the plan to share results within the organization Defines the process for sharing this data on a regular basis
2	<ul style="list-style-type: none"> Works with the QI team to identify which organization-level or individual performance results will be reported publicly-from Session 5A1. An example of this would be sharing a performance dashboard on the organization's website or in the organization's waiting room Develops a plan for how the selected performance results will be shared publicly Implement the plan to share results publicly. Defines the process for sharing this data on a regular basis
3	<ul style="list-style-type: none"> Identifies if the organization currently involves members/families/caregivers in quality improvement activities Brainstorms ways that members/families/caregivers can be involved in QI activities (e.g. a patient council) Creates a plan for involving members/families/caregivers in QI activities

	<ul style="list-style-type: none"> Assigns a member(s) of the QI team to coordinate the effort to involve members/families/caregivers in QI activities
4	<ul style="list-style-type: none"> Determine if the organization is engaged in a Value-Based Contract Agreement. Identifies if the contract is up-side only risk or two-sided risk (TennCare’s PCMH program is upside only risk)
ADDITIONAL RESOURCES (documents on SharePoint site):	
N/A	

Module 5	USE OF HEALTH INFORMATION TECHNOLOGY, THE CARE COORDINATION TOOL, & MCO PROVIDER REPORTS
Session 5D	<i>The organization uses Health Information Technology, the Care Coordination Tool (CCT), and MCO Cost and Quality Reports to improve care</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1	Understands the importance of Health Information Technology in primary care transformation and the patient centered medical home model C
2	Uses the information available in the Care Coordination Tool to enhance care coordination and care management services within the organization. This includes using the CCT to identify and address gaps in care and for prioritizing member’s care coordination needs
3	Analyzes MCO Cost and Quality Reports and uses the process and outcome measures to monitor the quality improvement process and improve care
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site) The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor.	
1	<ul style="list-style-type: none"> Shares examples of HIT use in primary care transformation HIT and Workflow Opportunities Helping Practices Optimize EHRs for Patient (AHRQ) – page M27-4 Brainstorms current HIT use by the organization. To what degree is the organization using an EHR? Are there other health information technologies available to the organization in addition to the CCT (e.g., telemedicine, HIE)? How can the functionality of the CCT be integrated into other health information technologies available? Identify an EHR “superuser(s)” with the practice that can train staff on new functions and gather feedback from providers on how the EHR is (or is not) supporting the practice.
2	<ul style="list-style-type: none"> Views the Care Coordination Tool training videos in the Training Materials section of the State’s CCT website: https://www.tn.gov/tenncare/health-care-innovation/primary-care-transformation/care-coordination-tool.html <ul style="list-style-type: none"> My Members Training (Video 1 and Video 2) Quality Measures Training Dashboard Training Practice Administrator User Role Training Admission, Discharge, and Transfer (ADT) Training

	<ul style="list-style-type: none"> • Views the Care Coordination Tool demonstration videos in the Demos section of the State's CCT website: https://www.tn.gov/tenncare/health-care-innovation/primary-care-transformation/care-coordination-tool.html <ul style="list-style-type: none"> • Assigning a Care Member in the CCT • Export to Excel from My Members • Risk Stratification in My Members • Finding Claims Based Medication Information • Using Global Search Parameters in My Members • Finding Dual Program Members Information • Uses the following training guide documents and identifies opportunities to incorporate the information into current workflow: • My Members – This tab is useful for viewing members' health record summaries, risk stratifying members, or sorting members by primary health condition or quality indicators. <ul style="list-style-type: none"> • Exercise: In a small group, provides a hands-on walk-through of the successful development of at least one stratification of members report and lists of members sorted by primary care condition. Each team member will demonstrate competency. • Quality Measures – This tab is useful for identifying and managing individual members' gaps in care. <ul style="list-style-type: none"> • Exercise: In a small group, provides a hands-on walk through of how to use the CCT for identification of gaps in care and to review quality measures data. Each team member will demonstrate competency. ○ ADT – This tab allows for review of care transition events for members who have had hospital events. <ul style="list-style-type: none"> ○ Exercise: Demonstration of using the CCT for reviewing care transition events and how to use this information for improving member outcomes by proactively engaging with other providers in facilitating transitions, maintaining communication with members, and communicating transition event information to the treatment team for care follow-up purposes. Each team member will demonstrate competency. ○ Dashboards – This tab allows for review of quality data on a member population level. <ul style="list-style-type: none"> ○ Exercise: Demonstration of using the CCT to review population level gaps in care. Each team member will demonstrate competency. • Identifies at least one opportunity to enhance workflow by using the CCT. (e.g. identifying members for care management) • Implements a PDSA cycle to test the process on the use of the CCT in the identified process.
3	<ul style="list-style-type: none"> • Views the following webinar on how to read the quality report https://stateofennessee.adobeconnect.com/a828793869/p45mxc7psxq/?launcher=false&fcsContent=true&pbMode=normal (38 minutes) • Reviews the organization's quality report. • Uses the coding reference guides as needed to interpret results <ul style="list-style-type: none"> 2018 TennCare PCMH Family Practice Quality Measures Coding Reference 2018 TennCare PCMH Pediatric Quality Measures Coding Reference 2018 TennCare PCMH Adult Quality Measures Coding Reference

	<ul style="list-style-type: none"> Analyzes the outcome and process measures to identify opportunities for improvement Ensures that PCMH goals align with opportunities identified in the quality report
ADDITIONAL RESOURCES (documents on SharePoint site):	
Helping Practices Optimize EHRs for Patient (AHRQ)	
An Introduction to Electronic Health Records and Meaningful Use (AHRQ)	

Module 6

MODULE 6	TEAM-BASED CARE AND PRACTICE ORGANIZATION: DEFINING ROLES
SESSION 6A	<i>The organization is committed to transforming into a sustainable medical home. Members of the care team serve specific roles as defined by the organizational structure and are equipped with the knowledge and training necessary to perform those functions. The organization seeks to enhance services by better understanding members' needs.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1*	Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.
2*	Defines organizational structure and staff responsibilities/skills to support PCMH functions.
3	Is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, TennCare learning collaboratives).
4	Involves members, families, or caregivers in the organization's governance structure or on stakeholder committees.
5	Uses an EHR system that has been certified and issued an ONC Certification ID, conducts a security risk analysis, and implements security updates, as necessary, correcting identified security deficiencies
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> Work with the organization to identify a physician champion and a PCMH lead/director Training: Why care teams? Provider Workload with a 2500 Patient Panel Why a Team Based approach matters Provider Workload Diagram Goals of Team Based Care IHI Jelly Bean Activity Discussion with QI Team: What are the characteristics of an effective care team Team Based Care Diagram Share TeamSTEPPS-Care Teams PowerPoint with the QI team & with all staff

MODULE 6	TEAM-BASED CARE AND PRACTICE ORGANIZATION: DEFINING ROLES
SESSION 6A	<i>The organization is committed to transforming into a sustainable medical home. Members of the care team serve specific roles as defined by the organizational structure and are equipped with the knowledge and training necessary to perform those functions. The organization seeks to enhance services by better understanding members' needs.</i>
2	<ul style="list-style-type: none"> • Develop an organizational chart with the QI Team that define the primary and extended care team roles. • IHI In a Perfect World Activity • Review current role descriptions. • Brainstorm with the organization how to ensure staff are working at the top of their licensure &/or skill. • Provide examples of best-practices for enhanced roles. <ul style="list-style-type: none"> ◦ How to perform a diabetic foot exam document for the MA • Map current workflow. Workflow Mapping Coach Prompt • Brainstorm tactics to implement as part of a team based care workflow. • Change Tactics Team Based Care
3	<ul style="list-style-type: none"> • Practice is involved in at least one state or federal initiative (e.g., CPC+, learning collaboratives through TennCare) OR practice participates in a health information exchange • Practice leadership is involved in implementing collaborative activities
4	<ul style="list-style-type: none"> • Survey organization leadership to identify opportunities to engage members, families, and/or caregivers. • Brainstorm opportunities with the QI Team. Review Change Tactics for involving patients in practice governance • Have the organization agree on at least one opportunity for members, families, and/or caregivers to interact either as a part of the governance structure or on a committee • Implement one PDSA cycle that involves having a patient/family member participate on an organization committee
5	Confirm, with EHR vendor, that current EHR system has an ONC Certification ID
ADDITIONAL RESOURCES (documents on SharePoint site):	
IHI Team Based Care Optimizing Primary Care for Patients and Providers	
Workflow Mapping Checklist	
AHRQ Implementing Care Teams	
FAQs: Why Involve Patients & Families?	
A Toolkit for Creating a Patient and Family Advisory Council (pages 5 – 15)	
Establishing Patient and Family Advisory Councils in the Medical Home (slides 15 – 39)	
Preparing Members of a Patient and Family Advisory Council (slides 15 – 32)	
Establishing a Patient Family Advisory Council (PFAC) slide deck	

Module 6	TEAM-BASED CARE AND PRACTICE ORGANIZATION: STRUCTURED COMMUNICATION
Session 6B	<i>Communication among staff is organized to ensure that patient care is coordinated, safe and effective.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1*	Have regular patient care team meetings or a structured communication process focused on individual patient care.
2*	Involves care team staff in the organization's performance evaluation and quality improvement activities.
3	Have at least one care manager qualified to identify and coordinate behavioral health needs.
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site) <i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor.</i>	
1*	<ul style="list-style-type: none"> • Maps current communication process relative to sharing information on individual patient care. • Determines if a 'structured' communication process is in place (e.g. team meeting, huddles) • Explores current ways care team staff uses the EMR to communicate open gaps of care including the outcome of those gaps after the patient was seen. • If communication does not happen in a structured format, agrees on a format to implement. <p>Team Huddles are an effective means of structured communication and can be added into the clinical workflow with less disruption than meetings or more formal techniques.</p> <p>Huddles:</p> <ul style="list-style-type: none"> ○ TeamSTEPPS-Communication Huddles ○ Communication-Huddle Outline ○ Communication-Huddle ○ Daily Huddle Checklist ○ Huddle Policy Example <p>Team Meeting: Example Structured Communication-Staff Meeting Notes</p> <p>SBAR: SBAR Communication Tool</p> <ul style="list-style-type: none"> • PDSAs the use of the structured communication process • Trains staff on the new communication process
2*	<ul style="list-style-type: none"> • Explores current ways care team staff are involved in the organization's performance evaluation and QI work • Brainstorms ways to enhance involvement of care team staff: <ul style="list-style-type: none"> ○ Posts performance metrics where staff can view results ○ Identifies care team staff member(s) to participate on organization QI team ○ Engages staff through the use of surveys and suggestion boxes ○ Trains staff on the IHI Model for Improvement and encourages staff to participate in PDSA cycles within their work areas
3	<ul style="list-style-type: none"> • Identifies staff member engaged in care management who is qualified to identify and coordinate behavioral health needs.

ADDITIONAL RESOURCES (documents on SharePoint site):
Huddles Improve Office Efficiency

Module 6	TEAM-BASED CARE AND PRACTICE ORGANIZATION: STAFF COMMUNICATION
Session 6C	<i>Communication among staff is organized to ensure that patient care is coordinated, safe and effective.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1*	Have a process for informing members/ families/caregivers about the role of the medical home
2*	Provides members/ families/caregivers materials that contain the information. Such as after-hours access, organization scope of services, evidence-based care, education and self-management support
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site) <i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor.</i>	
1*	<ul style="list-style-type: none"> Reviews the current process for informing members/families/caregivers about the role of the medical home Examines the venues currently used for sharing information (e.g., organization website, paper documents, text messaging, waiting room TV, social media, organization portal) Involves members/families/caregivers, via random interview or survey, by asking about their preferences for receiving information Identifies opportunities to enhance, or establish, the process for informing about the role of the medical home Develops a script and other tools to be used with each venue selected Medical Home Patient Info on a Website Medical home vs ED PCMH-PCPCC-Infographic Medical Home Orientation Implements the changes Develop both electronic and paper versions of explanations regarding the role of the medical home so that all patient populations will be informed.
2*	Develops scripts and other tools to be used with each venue selected (Sessions 6C1, 10A5)
ADDITIONAL RESOURCES (documents on SharePoint site):	
How to Write Easy-to-Read Health Materials	
General Health Literacy Guidelines https://health.gov/healthliteracyonline/	
Short Assessment of Health Literacy	
Talking Points About Health Literacy	
Rapid Estimate of Adult Literacy in Medicine – Short Form (REALM-SF) – AHRQ	
Pediatric Medical Home brochure	

Module 7

Module 7	KNOWING AND MANAGING YOUR PATIENT POPULATION: UNDERSTANDING THE BACKGROUND AND HEALTH RISKS OF MEMBERS
Session 7A	<i>Practice routinely collects comprehensive data on members to understand background and health risks of members. Practice uses information on the population to implement needed interventions, tools and supports for the organization as a whole and for specific individuals.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1*	Documents an up-to-date problem list for each patient with current and active diagnoses
2*	Comprehensive health assessment (CHA) 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 organizations with no pediatric population under 30 months of age.) I. Advance care planning. (NA for pediatric organizations)
3*	Conducts depression screenings for adults and adolescents using a standardized tool.
4	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. Vanderbilt Assessment Scale , Vanderbilt Assessment Follow-Up , F. Post-Traumatic Stress Disorder G. ADHD
5	Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners.
6	Identifies the predominant conditions and health concerns of the patient population.
7	Understands social determinants of health for members, monitors at the population level and implements care interventions based on these data.
8	Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials.
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> Gather clinical leadership to identify how they document active problems

	<ul style="list-style-type: none"> • Determine the process for keeping the problem list up to date – are they recording active diagnosis in the problem list at every visit? Are the diagnoses duplicated throughout the problem list? • Talk to Clinical leadership about developing a process for cleaning up the problem list so that there is only one of each active diagnosis – historical diagnoses should be documented in Past Medical History • Use process mapping (Module 4) to outline the necessary steps to ensure problem list remains up to date and free of clutter • Implement process
2	<p><i>NOTE – the purpose of the CHA is to identify what information the organization needs to know about their members to further assess their needs and allocate resources appropriately (see 7A 6-8, 7F1, 8A1 and 9A3)</i></p> <ul style="list-style-type: none"> • For each step ensure the organization is collecting this information for all new members and is updating this information at least <i>annually</i> (Well Care Visits is the likely place) • Ask the organization questions about how their current process works (see below) and define how their current process works. • Identify what information the organization needs to know about their members in order to complete 7A 6-8, 7F1, 8A1 and 9A3. Review the information that is available in the EHR for each section. <ul style="list-style-type: none"> • Consider structured fields that will populate the face sheet and not be attached to an individual encounter – the organization will want to locate this information easily at every visit! • Develop a plan with the organization for what information they will collect, what method and what visit they will collect this information and where they will document in the EMR QUESTIONS TO CONSIDER FOR EACH ITEM IN THE CHA • Evidence based screening tools to share with the organization: <ul style="list-style-type: none"> ○ AUDIT for alcohol ○ DAST for drugs ○ CRAFFT for adolescents ○ MCHAT–R for developmental screening • Develop a process to review screening tool results and review regularly for trends
3	<ul style="list-style-type: none"> • Develop a process for depression screening using a standardized screening tool. • PDSA the process with one provider • Adjust process based upon the results of the PDSA • Implement process across the organization <p>Examples of standardized depression screening tools:</p> <ul style="list-style-type: none"> • PHQ2 (first two questions of the PHQ_9) <ul style="list-style-type: none"> ○ PHQ_9; PHQ_9_Instructions ○ PHQ_9 Teen Screen
4	<ul style="list-style-type: none"> • Develop a process for at least two screening using a standardized screening tool. • PDSA the process with one provider • Adjust process based upon the results of the PDSA • Implement process across the organization <p>Examples of standardized screenings and assessments:</p> <ul style="list-style-type: none"> • AUDIT for alcohol • DAST for substance use disorder (SUD) • CRAFFT for adolescents

	<ul style="list-style-type: none"> • SBIRT Annual Screen for SUD
5	<ul style="list-style-type: none"> • Evaluate evidence-based oral assessment tools: OHAT and THROAT • PDSA with one provider the use of an oral assessment tool until a successful process has been established • Implement the new oral health assessment process • Evaluate capacity to implement fluoride varnishing in the organization. Fluoride varnish Manual; Oral Health Coding for PCPs • Coordinate with local dentists • Use DentaQuest (1-855-418-1622) to ID available dental services.
6	<p><i>NOTE – this coincides with 9A3</i></p> <ul style="list-style-type: none"> • Identify if the EMR can provide a list of all <i>active</i> members with their diagnoses • If so, sort the EMR file in Excel (Pivot Tables are great here!) to identify how many of each condition there are – sort from high to low to identify the most prominent conditions • Identifies practice’s most prevalent and important conditions and concerns, through analysis of diagnosis codes and/or problem lists.
7	<ul style="list-style-type: none"> • Run an EMR report on the items identified in 7A2c & 7A2e-g • Sort the EMR file in Excel (Pivot Tables are great here!) to identify how many of each social determinant there are – sort from high to low to identify the most prominent patient needs • Assesses data from EMR and identifies gaps in care • Assist the QI team in determining necessary care interventions for the most prominent patient needs. • Utilizes community partnerships, self-management resources or other tools to fill these need gaps. • Collect feedback regarding what interventions they already have in place and what interventions they need to add. • Develop a process for implementation.
8	<ul style="list-style-type: none"> • Ensure the organization is collecting relevant demographic data on members and that it is updated at each visit and documented in a structured field. Consider DOB, sex, zip code, occupation, legal guardian/caregiver • Use a swim lane diagram to develop a future process with the QI Team if this process is not currently in place. • Run an EMR report on the identified demographics including data from 7B1&2 • Sort the demographics EMR file in Excel (Pivot Tables are great here!) to look at the different demographics that exist in the organization • Gather QI Team to determine how to tailor and distribute patient materials to these demographics • Identify what materials the organization is distributing • Identify demographics that the organization may not have any relevant materials for and designate a member of the QI team to research appropriate materials and resources. • Develop and implement a plan for delivering patient materials to appropriate demographics. • Gather QI team to evaluate if the organization is currently assessing health literacy for individual members (this may occur along with 7B3b). • If not, assess if they are interested.

<ul style="list-style-type: none"> • If they want to pursue this, use a swim lane diagram to develop a future process with the QI Team – ensure responses are entered in to a structured field so an EMR report can be run. • Run an EMR report on the communication needs identified in 7A2d and data from health literacy above • Sort the communication, health literacy EMR file in Excel (Pivot Tables are great here!) - sort from high to low to identify the most prominent patient needs • Gather the QI team or clinical leadership to determine necessary care interventions for the most prominent patient needs. • Collect feedback regarding what interventions they already have in place and what interventions they need to add. • Develop a process for implementation.
ADDITIONAL RESOURCES (documents on SharePoint site):
Considerations for Oral Health Integration in Primary Care Practices for Children
Child and Adolescent BH Screening Toolkit
Social Emotional Screening flyer

Module 7	KNOWING AND MANAGING YOUR PATIENT POPULATION: MEETING THE NEEDS OF A DIVERSE PATIENT POPULATION
Session 7B	<i>The organization seeks to meet the needs of a diverse patient population by understanding the population's unique characteristics and language needs. The organization uses this information to ensure linguistic and other patient needs are met.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1*	Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population
2*	Assesses the language needs of its population.
3*	Identifies and addresses population-level needs based on the diversity of the organization and the community. Demonstrate at least 2. A. Target population health management on disparities in care B. Address health literacy of the organization C. Educate organization staff in cultural competence
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> • Work with the QI team to determine the third aspect of diversity Consider items that are documented in a structured field within the EMR to ensure that you can run a report for 7A82 This may also align with items from your CHA in 7A3 – think about what information can help you to <i>know</i> your members to direct services and resource appropriately (see 7A 6-8, 7F1, 8A1 and 9A3) • Run a report in the organization EMR that outlines the percentage of the patient population that represents each race, ethnicity and aspect of diversity • Update records for any members that do not have these fields completed

	<ul style="list-style-type: none"> Develop a process for ensuring that these fields are completed on all new members. Consider the use of a flow chart or a scope of work document to share with staff
2	<ul style="list-style-type: none"> Run a report in the organization EMR that outlines the percentage of the patient population that represents each language Update records for any members that do not have these fields completed Develop a process for ensuring that these fields are completed on all new members. Consider the use of a flow chart or a scope of work document to share with staff
3A*	<ul style="list-style-type: none"> Assesses health disparities using performance data stratified for vulnerable populations. <ul style="list-style-type: none"> Facilitates the selection of 1 quality performance measure to monitor Builds a performance dashboard to monitor this measure over time. Shares the dashboard with the QI Team on a regular schedule (See 5A 5 for detail on assessing health disparities) Sets goals and acts to improve disparities in care or service. <ul style="list-style-type: none"> Brainstorms ways to improve this performance measure Sets a goal for the measure Guides the QI Team in the implementation of one PDSA for the measure. (See 5B 6 for detail on setting goals and acting to improve disparities)
3B&C*	<ul style="list-style-type: none"> Has QI team explore the diversity and language reports from 7B1&2 <ul style="list-style-type: none"> Ask what cultures are present that they may need to learn more about? What other languages are spoken aside from English? Which populations may be vulnerable to disparities in care? Develops a training for each of the categories Assigns QI Team members to do the training Plans training sessions for all staff, ensuring there is an opportunity for discussion and Q&A.
ADDITIONAL RESOURCES (documents on SharePoint site):	
How to Write Easy-to-Read Health Materials	
General Health Literacy Guidelines https://health.gov/healthliteracyonline/	
10 Attributes of Health Literate Healthcare Organizations (IOM)	
AHRQ Health Literacy Universal Precautions toolkit	
Alliance for Health Reform Toolkit	
Cultural Competence Resource Guide	

Module 7	KNOWING AND MANAGING YOUR PATIENT POPULATION: POPULATION MANAGEMENT
Session 7C	<i>The organization proactively addresses the care needs of the patient population to ensure needs are met.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1*	Proactively and routinely identifies populations of members and reminds them, or their families/caregivers, about needed services (at least 3 categories): A. Preventive care services

	<p>B. Immunizations C. Chronic or acute care services D. Patients not recently seen by the organization</p>
2	<p>Demonstrates excellence in a benchmarked/performance-based recognition program assessed using evidence-based care guidelines (e.g., DRP/HSRP recognition by NCQA).</p>
<p>*Core requirements for NCQA PCMH 2017</p>	
<p>COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)</p>	
1	<p><i>NOTE: these lists of members who are overdue for services are often called "Registries"</i></p> <ul style="list-style-type: none"> • QI Team identifies the registries that they want to work for each category • Consider aligning with the quality metrics being tracking in 3C/5A Consider this concept: The quality metric is a way to track how well the organization is doing. A registry is a list of members who have <i>not</i> had the service. Contacting members on the registry is a great PDSA to improve the quality metric. Population Health Management Examples list • Align the registry with something the organization wants members to be contacted for. (e.g. If a quality metric is looking at % of Diabetic members with A1C<9 then your registry may want to look at DM members with an A1C >9 who haven't been seen in x months. The organization can then perform actionable outreach to these members who are both overdue for a DM follow up and have an uncontrolled A1C.) • Define numerator and denominator criteria for each registry <ul style="list-style-type: none"> • The denominator is the whole population. For the example above it would be all <i>active</i> Diabetic members • The Numerator is the members who have not had the service. • Be sure that members who are seeing a specialist for care or who have declined the service are documented appropriately. Discuss with the clinical team if it is appropriate to exclude them from the numerator. • Create registry in the EMR Example EHR Patient List needing BH follow-up Example EHR Asthma List needing call back Example EHR HIV List needing call back Example EHR Lead Screening List Example EHR List needing Chronic Care follow-up Example EHR patients not seen list Example EHR Preventative Services • Identify inactivate members who longer attend the organization (e.g. not seen in the last 3 years). • Ensure that inactivated members do not populate registries • Develop a plan for outreach with the QI team • Identify a method for outreach for each registry (e.g. phone calls, robocalls, letters or postcards - either manually or via mail merge in the EMR) Example Hepatitis B Vaccine letter Example Lead screening letter Example Patients needing services letter Example patients needing services outreach via Portal Example Pediatric Immunization letter

	<ul style="list-style-type: none"> • Create an Annual Registry Schedule Annual Registry Schedule example Annual Registry Schedule example peds Not all registries need to be worked at the same time – identify the most appropriate month or season to work each registry (how busy are you? Is there a National Awareness month?) • Create phone scripts and develop letters • Determine which organization staff person(s) will run the registry list from EMR, will outreach out to members, will stuff envelopes, etc. • Identify and train staff members to use the CCT for managing patient registries • Identify a method of documentation to track outreach (e.g. a note in the EMR or handwritten on a log) • Reference Session 13A
2	<p>Participates in at least one of the two programs that are recognized by NCQA to meet this measure:</p> <ul style="list-style-type: none"> • NCQA Diabetes Recognition Program http://www.ncqa.org/programs/recognition/clinicians/diabetes-recognition-program-drp • NCQA Heart Stroke Recognition Program http://www.ncqa.org/programs/recognition/clinicians/heart-stroke-recognition-program-hsrp
ADDITIONAL RESOURCES (documents on SharePoint site):	
	Paving the Road to Good Health
	https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/immunizations/Practice-Management/Pages/office-strategies.aspx
	Improving Preventive Care Services Toolkit
	TNAAP resources: https://www.tnaap.org/programs/epsdt-coding/epsdt-well-child-visits
	Bright Futures patient/family educational tools and guides: https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/default.aspx
	Managing Populations, Maximizing Technology: https://www.integration.samhsa.gov/news/PCPCC_Population_Health_FINAL_e-version.pdf
	Expert Consensus Survey on Digital Health Tools for Patients With Serious Mental Illness: Optimizing for User Characteristics and User Support: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6019847/#ref1
	Increasing the Capacity of Primary Care Through Enabling Technology: https://rd.springer.com/article/10.1007/s11606-016-3952-3
	Making the Most of Portals: How the Technology Can Improve Patient Communication: http://www.medicaleconomics.com/sites/default/files/legacy/mm/digital/media/me071018_ezine.pdf
	Engaging Behavioral Health Patients Through Digital Tools: https://www.modernhealthcare.com/article/20180804/TRANSFORMATION01/180809977
	KidCentral TN: https://www.kidcentraltn.com/

Module 7	KNOWING AND MANAGING YOUR PATIENT POPULATION: MEDICATION SAFETY AND ADHERENCE
Session 7D	<i>The organization addresses medication safety and adherence by providing information to the patient and establishing processes for medication documentation, reconciliation and assessment of barriers.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1*	Reviews and reconciles medications for more than 80 percent of members received from care transitions.
2*	Maintains an up-to-date list of medications for more than 80 percent of members.
3	Assesses understanding and provides education, as needed, on new prescriptions for more than 50 percent of members/families/caregivers.
4	Assesses and addresses patient response to medications and barriers to adherence for more than 50 percent of members, and dates the assessment.
5	Reviews Controlled Substance Monitoring Database (TN CSMD) when prescribing relevant medications.
6	Systematically obtains prescription claims data in order to assess and address medication adherence.
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site) <i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor.</i>	
1*	<p><i>NOTE: this section is often already part of organization's daily workflow; however, it is important to ensure that they are documenting their work.</i></p> <ul style="list-style-type: none"> • This is a Meaningful Use report. Reviews the MU report. • If the organization is not meeting 80% threshold, identifies the workflow that is needed to ensure that medication reconciliation is being done at all transition of care visits • Considers staff training, for staff working in the process, if medication reconciliation is not being completed. Are staff clicking the appropriate button to ensure the report is capturing that the med rec was completed? • Considers posting visual reminders for staff on how and where to document. • Consider performing an internal chart review daily of at least 10 charts and track this data for at least 3 months to get a true percentage accuracy and compliance.
2*	<ul style="list-style-type: none"> • Reviews current process for maintaining up to date list of medications • Identifies opportunities for improvement in workflow. <ul style="list-style-type: none"> ○ Best practice for reviewing medications is to share the list with the patient at regular intervals (each visit) and document the patient response. ○ Meds not currently being taken become inactivated with a date of inactivation. ○ They then become "archived" or historical medications in the EHR.
3	<ul style="list-style-type: none"> • Works with QI team to identify what the workflow is when a new Rx is prescribed. • Brainstorms ways to ensure patient understanding not currently in the process.

	<ul style="list-style-type: none"> ○ Teach back methods to ensure understanding. See Session 10B2 ○ Researches educational resources available to the organization. ○ EMR may have built in information for medications that can be printed and shared with members ○ Coordinate with local pharmacists ○ Are there other education tools that can be shared? Are there any short 1-2 minute videos that highlight how the medication should be taken? Examples: ○ American Heart Association http://www.heart.org/5HEARTORG/Conditions/Patient-Education-Resources-for-Healthcare-Professionals_UCM_441960_SubHomePage.jsp http://www.heart.org/5HEARTORG/Conditions/Patient-Education-Resources-for-Healthcare-Professionals_UCM_441960_SubHomePage.jsp Indian Health Services https://www.ihs.gov/forproviders/patiented/ American Diabetes Association http://professional.diabetes.org/search/site?f%5B0%5D=im_field_dbp_ct%3A32&retain-filters=1 <ul style="list-style-type: none"> ● Documents the conversation and education given Auto text or customized templates can streamline the workflow for providers ● Incorporates changes in training and documentation into the new Rx workflow ● Educates staff and providers on the changes ● Strategies for how organizations may track and monitor performance for reaching more than 50 percent of members should be added to strategies
4	<p>Patient response to Medications:</p> <ul style="list-style-type: none"> ● Identifies how organization currently addresses this at each office visit Questions to ask: Are they talking with members to find out how well they are responding to the medicine? What tools do they have if patient is not responding well? How are they documenting this? ● Brainstorms opportunities for improvement Consider auto text ● Performs PDSAs to evaluate the effectiveness of identified opportunities ● Documents changes to workflow and share with staff and providers <p>Barriers to Medication Adherence:</p> <ul style="list-style-type: none"> ● Identifies how organization addresses this at each office visit ● Questions to ask: Are they talking with members to find out about barriers to adherence? What tools do they have if patient is not responding well? How are they documenting this? ● Brainstorms opportunities for improvement Considers auto text ● Considers reviewing pharmacy claims to identify if patient has filled their meds as prescribed (see Session 7D6) ● Performs PDSAs to evaluate the effectiveness of identified opportunities ● Documents changes to workflow and share with staff and providers ● Strategies for how organizations may track and monitor performance for reaching more than 50 percent of members should be added to strategies
5	<ul style="list-style-type: none"> ● Reviews the TN Department of Health & TN Prescription Safety Act of 2016 requirements:

	<p>Healthcare practitioners are required to check before prescribing an opioid or benzodiazepine to a patient as a new episode of treatment– and at least annually when said controlled substance remains a part of the treatment.</p> <p>The healthcare practitioners are <u>not</u> required to check if the controlled substance is prescribed or dispensed for a patient who is currently receiving hospice care or the quantity of the controlled substance which is prescribed or dispensed does not exceed an amount which is adequate for a single, seven-day treatment period and does not allow a refill.</p> <p>Source: TN Dept of Health & TN Prescription Safety Act of 2016, Tenn. Pub. Acts, <u>ch. 1002</u></p> <ul style="list-style-type: none"> Evaluates the use of a Delegate(s) in the organization’s workflow. A delegate such as a medical assistant can register at www.tncsmd.com and will need to provide personal verifying information and the supervising practitioner’s driver’s license number to connect him/her with the supervising practitioner. A single delegate may be used across providers if the delegate is linked to each provider. Develops a workflow for reviewing the TN CSMD that considers the following: How will the organization determine which members to check in CMSD – Patients with a new prescription? Every 12 months for patients in treatment? Where will the information be documented? Document the workflow and share with staff and providers
6	<ul style="list-style-type: none"> Identifies resources for obtaining prescription claims data – Is it available through the organizations EMR? Reviews video tutorial on how to view claims based medications in the CCT: https://altruistahealth.webex.com/altruistahealth/ldr.php?RCID=c86a0bef2a9fd8af9d71136fe4bee85d Incorporates claims review into the process defined for Session 7D4.
ADDITIONAL RESOURCES (documents on SharePoint site):	
N/A	

Module 7	KNOWING AND MANAGING YOUR PATIENT POPULATION: EVIDENCE-BASED CLINICAL DECISION SUPPORT
Session 7E	<i>The organization incorporates evidence- based clinical decision support across a variety of conditions to ensure effective and efficient care is provided to members.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1	<p>Implements clinical decision support (CDS) following evidence-based guidelines for care of: (Practice must demonstrate at least 4 criteria.):</p> <ul style="list-style-type: none"> A. Mental health condition B. Substance use disorder C. A chronic medical condition D. An acute condition E. A condition related to unhealthy behaviors F. Well child or adult care (Note: HEDIS/EPSTDT requires 6 visits within the first 15 months of life) G. Overuse/appropriateness issues

*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site) <i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor.</i>	
1	<p><i>NOTE: Clinical Decision Support can be a confusing title. It can be helpful to explain to organizations that this means “evidence-based care reminders at the point of care” This is best done via the EMR.</i></p> <ul style="list-style-type: none"> • Works with the QI team to identify conditions that the organization wants to address for at least 4 of the categories. Consider conditions that the organization is focusing on improving in Session 5A • Identifies the source of the evidence-based guidelines for each condition • Identifies elements that the organization wants to incorporate into the EMR to be reminded of when the patient comes in to the office <p>Examples of clinical decision support could be:</p> <ul style="list-style-type: none"> ○ Reminders that pop up or alert the care team of a patient need such as when a patient with Depression comes into the office the EMR may alert the MA to ensure a PHQ-9 is completed All certified EMRs are required to have built-in Clinical Decision support and organizations are required to turn on at least 5 of these in their EMR to get credit for Meaningful Use Stage 2. The built-in CDS is not always the most helpful information therefore it is critical that providers review the guidelines and determine what is the most important information for the organization ○ Templates or shortlists that act as a checklist – for example an asthma shortlist that the care team opens when an Asthma patient comes in to the office that walks them through the evidence-based details of an Asthma visit. <ul style="list-style-type: none"> ▪ Well-care visits (F) will have templates for each individual visits – consider optimizing if needed ▪ Other conditions will require customization • To discuss overuse of clinical decision supports (CDS), review how different programs/requirements are interwoven. (For example, MU Stage 2 requires practices to turn on at least 5 CDS in their EMR to get credit. Helping the practice match up with 5 CDS they are using with the PCMH requirements meets two program requirements.) • One way to begin is to look at the registries you are running in Session 7C and build those same reminders in to the EMR’s Clinical Decision support so the organization is proactively reaching out to members for overdue services <i>and</i> reminding them of overdue services if they are in the office for a visit • Develops a workflow for the use of CDS • Ensure that triage has access to these reminders – if a patient calls for a sick visit, the triage nurse can identify other services they are overdue for and ensure that enough time is scheduled to complete all services. <p>Views AHRQ YouTube video: https://www.bing.com/videos/search?q=examples+of+evidence+based+care+and+clinical+decision+supports+on+youtube&&view=detail&mid=92E6EA7557A6E638C3C892E6EA7557A6E638C3C8&&FORM=VRDGAR</p>

ADDITIONAL RESOURCES (documents on SharePoint site):
Population Health Management Examples List

Module 7	KNOWING AND MANAGING YOUR PATIENT POPULATION: COMMUNITY RESOURCES
Session 7F	<i>The organization identifies/considers and establishes connections to community resources to collaborate and direct members to needed support.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1*	Uses information on the population served by the organization to prioritize needed community resources.
2	Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.
3	Provides oral health education resources to members.
4	Adopts shared decision-making aids for preference-sensitive conditions.
5	Engages with schools or intervention agencies in the community.
6	Routinely maintains a current community resource list based on the needs identified above in 7F, Objective 1.
7	Assesses the usefulness of community support resources
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site) <i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor.</i>	
1*	<p>NOTE: Identify your patient population needs using information identified in Session 7A1-8 & 7B1-2</p> <ul style="list-style-type: none"> Identifies community resources that are available to support the population served by the organization Prioritizes resources based upon the % of the organization's population that may use the resource (high priority = resources most likely to be used by population served) Works with the QI team to develop a workflow for how the organization will give the appropriate resource to the appropriate patient population. Determines how the organization will track resources that are given to the members <p>Is there a way to document this in a structured field in the EMR?</p>
2	<ul style="list-style-type: none"> Identifies available educational resources Ensures that these resources are up to date. Sets up a process to update this resource list regularly Makes note of resources that take insurance or have other eligibility criteria. Works with the QI team to develop a workflow for how the organization will give the appropriate resource to the appropriate patient population. <p>Here is an example of educational resources and self-management tools for an Obese pediatric patient:</p> <ul style="list-style-type: none"> Obesity Education

	<ul style="list-style-type: none"> ○ Obesity Self-Management Tracking Tool
3	<ul style="list-style-type: none"> • Identifies available oral health resources • Ensures that these resources are up to date • Sets up a process to update this resource list regularly • Makes note of resources that take insurance or have other eligibility criteria. • Works with the QI team to develop a workflow for how the organization will give the appropriate resource to the appropriate patient population.
4	<ul style="list-style-type: none"> • Determines patient populations that may benefit from a shared decision-making tool. • Reviews evidence-based shared decision-making tools from https://decisionaid.ohri.ca/AZinvent.php • Identifies tools that meet the population needs • Develops a workflow for how the organization will use the decision-making tool and support the patient in understanding it and completing it.
5	<ul style="list-style-type: none"> • Identifies if the organization currently: <ul style="list-style-type: none"> ○ Has a relationship with a school nurse, social worker or counselor? ○ Is a member of a school board or advocacy group? ○ Has a partnership with DSS, mediation agencies, non-profit groups that support underserved children such as Head Start or County Partnerships for Children • If not, identifies if the community has a Student Services Director who may be able to support the organization in identifying opportunities for the organization to connect with healthcare-related programs or initiatives in the community • Assigns QI Team member(s) to meet with directors of identified programs to discuss how the organization and the school or agency can support each other • Identifies opportunities to collaborate at each meeting and work towards developing a workflow that can support the partnership • Ensures there is a follow up meeting at least annually to maintain the relationship.
6	<ul style="list-style-type: none"> • Develops a list of current community resources using the identified community resources in 7F1. Be aware that resources change frequently. • Sets up a process to maintain this list regularly <p>Consider the use of established community resource lists. (e.g. Tennessee 2-1-1 http://tn211.mycommunitypt.com/)</p>
7	<ul style="list-style-type: none"> • Gathers feedback from members about the resources (identified in 7F1) that they have been referred to (see 6C resources on health literacy) • Uses the patient satisfaction survey or qualitative feedback from Session 5A4 • Uses this feedback to initiate PDSAs (similar to Session 5B) that assess and direct resources appropriately
<p>ADDITIONAL RESOURCES (documents on SharePoint site):</p>	
<p>Get no-cost rides to your appointments (Amerigroup)</p>	
<p>Need a Ride to Your TennCare Appointments? (BlueCare Tennessee)</p>	

Module 8

Module 8	PATIENT-CENTERED ACCESS AND CONTINUITY: ACCESS
Session 8A	<i>The organization seeks to enhance access by providing appointments and clinical advice based on members' needs.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1*	Assesses the access needs and preferences of the patient population.
2*	Provides same-day appointments for routine and urgent care to meet identified members' needs.
3*	Provides routine and urgent appointments outside regular business hours (generally considered 8-5 M-F) to meet identified members' needs.
4*	Provides timely clinical advice by telephone.
5*	Documents clinical advice in patient records and confirms clinical advice and care provided after-hours does not conflict with patient medical record.
6	Provides scheduled routine or urgent appointments by telephone or other technology supported mechanisms.
7	Has a secure electronic system for members to request appointments, prescription refills, referrals and test results.
8	Has a secure electronic system for two-way communication to provide timely clinical advice.
9	Uses information on the population served by the organization to assess equity of access that considers health disparities.
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site) <i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor.</i>	
1*	<ul style="list-style-type: none"> Uses patient satisfaction survey and patient qualitative feedback in Sessions 5A4 to determine access needs and patient preferences Patient Access Survey
2*	<p><i>NOTE: Same Day appointments do not include walk-in clinics, "fitting members in" or appointments available outside of regular office hours. The organization must have appointment slots identified as "same day appointments" on the schedule</i></p> <ul style="list-style-type: none"> Uses information on panel size from Session 8B2 as well as patient needs and preferences from Session 8A1 to define availability for same-day appointment access <i>NOTE: there is no threshold for how many appointments, how many providers, or how many days of the week these are required. (Work with the practice to develop a standardized tool that a scheduler can use to determine the need for same day appointments.)</i> Considers Open Access Scheduling Develops a scheduling policy Patient Access Same Day Appointment Policy Trains staff on the new policy and process Implements scheduling process changes Notifies members about same day appointment availability. See Session 6C Reassesses patient preferences and needs regularly to ensure needs are met

3*	<ul style="list-style-type: none"> • Uses information from Session 8A1 to determine patient needs and preferences for after-hours care • Develops a schedule for after hour care teams • Develops a scheduling policy (can be a part of the policy in 8A2) • Trains staff on the new policy and process • Implements scheduling process changes <ul style="list-style-type: none"> • Map out current workflow of office scheduling. • Identify changes to workflow and map out “ideal state” workflow. • Measure and monitor number of same day, sick, sick urgent, appointments scheduled and unable to be scheduled for xx months. • Re-draw workflow map to incorporate needed changes. • Notifies members about after-hours appointment availability. See Session 6C • Reassesses patient preferences and needs regularly to ensure needs are met.
4*	<ul style="list-style-type: none"> • Develops a policy that states the organization’s defined response time to providing clinical advice by phone during office hours and after office hours Patient Access Same Day Appointment Policy • Be sure members are aware of the expected response time. See Session 6C • Tracks (at least annually) the organization’s response rate to assess if the organization is meeting the policy requirements Clinical Advice Response Time Log • Evaluates data and reassess workflow or defined response time as needed.
5*	<ul style="list-style-type: none"> • Performs random chart audits to identify if clinical advice (e.g. after hours or telephonic) is being documented in the medical record. • Organizations using third party vendor for after-hours call services should request a daily print out of what calls were received during evening and/or weekend hours to assist in random chart audits. • For after-hours care, this will require providers have remote EMR access or to develop a process for ensuring documentation is entered into the patient record the following day. <ul style="list-style-type: none"> • If the practice uses a system of documentation outside of the medical record (EHR) for after-hours clinical advice, or provides after-hours advice without access to the patient’s record, the practice also develops a process for reconciling this information with the medical record “on the next business day”. • Interviews providers to find out if there are common barriers to documentation that can be addressed by the QI Team • Looks to the PCMH physician champion to re-educate providers on the requirements for documenting all clinical advice in the medical record.
6	<p><i>NOTE: this must be for scheduled encounters. Having an email exchange or clinical advice by phone does not meet the requirement.</i></p> <ul style="list-style-type: none"> • Considers alternative types of clinical encounters such as group visits, telehealth or secure instant messenger • Uses information on patient needs and preferences from Session 8A1 to determine best fit and need for alternative encounters • Develops models, including best practices, billable codes and workflows. • Develops policy, train staff and implement (develops a training schedule to train staff) • Reassesses patient need regularly to ensure needs are met.

7	<ul style="list-style-type: none"> Identifies the organization’s process for scheduling appointments – will they use the patient portal to assist with this? If so, develops an organization workflow policy, ensure capability, train staff and implement accordingly – outline any differences for routine and urgent care in the policy Patient Access Same-Day-Appointment Policy (refer to secure electronic messaging) <ul style="list-style-type: none"> Identify a scheduling champion to lead front office staff Develop a training schedule to train staff Develop a patient log to collect data on success/challenges for the first month of use of the patient portal Notifies members about how they can schedule appointments with the organization. See Session 6C
8	<ul style="list-style-type: none"> Identifies the organization’s process for providing clinical advice– will they use the patient portal to assist with this? If so, develops an organization workflow along with a policy that states the organization’s defined response time to providing clinical advice by phone during office hours and after office hours Patient Access Same-Day-Appointment Policy (refer to secure electronic messaging) Be sure members are aware of the expected response time. See Session 6C Tracks (at least annually) the organization’s response rate to assess if the organization is meeting the policy requirements Clinical Advice Response Time Log Notifies members about how they can use the portal to seek clinical advice with the organization. See Session 6C Evaluates data and reassess workflow or defined response time as needed
9	<ul style="list-style-type: none"> Identifies organization patient population needs using information identified in Session 7A1-8 & 7B1-2, as well as 54Ai, 8A1, 8B2 Identifies health disparities that make access challenging Risk Stratification Information: Use the CCT to identify critical and high-risk members Brainstorms ways to make access more equitable within the organization and develop processes to implement and PDSA these actions. (See 7F for transportation resources from MCOs)
ADDITIONAL RESOURCES (documents on SharePoint site):	
FPM: The Outcomes of Open Access Scheduling	
AHRQ Open Access Scheduling	
Effects of Improving Patient Access	
CCT Demo Video: Risk Stratification in My Members https://altruistahealth.webex.com/altruistahealth/ldr.php?RCID=5a1c570bf482c99c15ae31b59906e8d3	
Chronic Illness and Disability Payment System (CDPS) Webinar Slides	
Chronic Illness and Disability Payment System (CDPS) Webinar Recording: https://www.youtube.com/watch?v=2E7EYXWYtRU&feature=youtu.be	

Module 8	PATIENT-CENTERED ACCESS AND CONTINUITY: EMPANELMENT
Session 8B	<i>Practices support continuity through empanelment and systematic access to the patient's medical record.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1*	Helps members/families/caregivers select or change a personal clinician
2*	Sets goals and monitors the percentage of patient visits with selected clinician or team
3	Provides continuity of medical record information for care and advice when the office is closed.
4	Reviews and actively manages panel sizes.
5	Reviews and reconciles panel based on health plan or other outside patient assignments
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site) <i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor.</i>	
1*	<ul style="list-style-type: none"> • Maps the current process for helping members change a personal clinician, if there is one in place. • Develops a new process or update the current process to ensure: <ul style="list-style-type: none"> ○ Every patient has a personal clinician assigned when they become a new patient ○ Patients feel supported to make an educated choice ○ Patients can change their personal clinician at any time ○ Patients are educated on the process of changing their personal clinician • Trains staff who work in the process on the changes to assigning/changing a patient's clinician • Educates members on the new process Why a PCP is Important Patient Access Same Day Appointment Policy (see scheduling with the personal physician)
2*	<ul style="list-style-type: none"> • Sets a goal for what % of patient visits are expected to be with the personal clinician • Develops a process to regularly monitor these visits to ensure continuity of care • Implements PDSAs as necessary to reach goal or address a negative trend Percent of Patient Visits with Selected Provider
3	<ul style="list-style-type: none"> • Develops a process to ensure that patient clinical information is available to on-call staff, external facilities and clinicians outside the practice, as appropriate, when the office is closed. Access to records may include direct access to a paper or electronic record or arranging a phone consultation with a clinician who has access to the medical record. Patient Access Same-Day Appointment Policy (see telephone response timeliness standard)
4	<ul style="list-style-type: none"> • Develops new or review current process for regularly monitoring panel size • Ensures that process includes a regular review of panel • Ensures that process includes a means for adjustments based on patient need and preference from Session 8A1

	<ul style="list-style-type: none"> Documents process in a policy or standard operating procedure format Panel Size Slides Calculating Panel Size Measure and Understand Supply and Demand
5	<ul style="list-style-type: none"> Evaluates current use of practice patient lists (panels) received from outside entities (e.g. health plans, ACOS, Medicaid MCOs) Develops process for reviewing the reports Develops a process to inform the outside entities of patients known, or not know, to be under the care of each clinician Process to include a plan for regular reconciliation of panels with health plans and other entities. Use the CCT to monitor panel size and reconcile panels
ADDITIONAL RESOURCES (documents on SharePoint site):	
True Demand Formula	
Balancing Supply and Demand on a Daily, Weekly and Long-Term Basis	
Reduce Scheduling Complexity	
Practice Supply Worksheet	
Continuity of Care Improves Patient Outcomes: http://www.mdedge.com/online/article/60297/does-continuity-care-improve-patient-outcomes	

Module 9

Module 9	CARE MANAGEMENT AND SUPPORT
Session 9A	<i>The organization systematically identifies members that would benefit most from care management.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1*	Considers the following in establishing a systematic process and criteria for identifying members who may benefit from care management (organization must include at least three in its criteria): A. Behavioral health conditions B. High cost/high utilization C. Poorly controlled or complex conditions D. Social determinants of health E. Referrals by outside organizations (e.g., insurers, health system, ACO), organization staff or patient/family/caregiver
2*	Monitors the percentage of the total patient population identified through its process and criteria.
3	Applies a comprehensive risk- stratification process to entire patient panel in order to identify and direct resources appropriately.
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site) <i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor.</i>	

1*	<ul style="list-style-type: none"> • Read Appendix 3 of the 2017 NCQA Standards and Guidelines with a particular focus on page 5: Identifying Patients for Care Management • Makes available the Population Health Management Infographic details • Reviews the AAFP-Risk Stratification document • Document current process for identifying members for care management. • Identification of pre-defined criteria • If no pre-defined criteria exist, determine standards based on the organization's patient population. Note: minimum of 3 criteria from the above list must be used. • Ensure that pre-defined criteria include at least 3 of the criteria listed above • Use the CCT to identify members who are also enrolled in TennCare's Health Link program for members with the highest behavioral health needs. For more information about Health Link see: https://www.tn.gov/content/dam/tn/tenncare/documents2/TennesseeHealthLinkOverview.pdf • Establish a "future state" process that includes the pre-defined criteria for identifying members who may benefit from care management • Initiate a PDSA of the process with planned review dates • Implements the new/revised process for identifying members for care management
2*	<ul style="list-style-type: none"> • Develop a plan to monitor the total patient population and the subgroup that may benefit from care management. Session 9A1. Note: Patients who fit multiple criteria from 9A1 are only to be counted once in the numerator • Patients who fit multiple criteria from 9A1 are only to be counted once in the numerator • Utilizes an Excel spreadsheet or other data sharing/graphing tool to report the results of the Percent of Population • Establishes a frequency to review the total patient population
3	<ul style="list-style-type: none"> • Explore risk stratification models for the entire population • Ensure the QI team members examine the following resources on total population risk stratification: Three Steps to Prioritize Population Health Interventions Nine things practices should know about risk stratification and panel management • Evaluates the organization's ability to implement one of the introduced models or to develop a model of its own. • Maps a "future state" process that includes risk stratification for the organization's whole population • Establish a "future state" process that includes risk stratification for the organization's entire population and the means to identify and direct resources appropriately, based on the needs of high risk, or likely to be high risk, patients. • PDSAs the future state process and adjusts the process based upon the results of the PDSA • Implements the new/revised process for identifying members for care management • Initiate a PDSA for the risk stratification process with planned review dates
ADDITIONAL RESOURCES (documents on SharePoint site):	
Choosing High Risk Populations	
Population Health Management Infographic	
Risk Stratification & Team Based Care	
CCT Demo Video:	

Finding Dual Program Members Information: https://altruistahealth.webex.com/altruistahealth/ldr.php?RCID=a5afb1bd8b97e50d3f5a69cf43c9289b
PCMH Risk Stratification Webinar part 1 slide deck; webinar recording: https://youtu.be/3YYWmPlef2A

Module 10

Module 10	PATIENT SELF MANAGEMENT SUPPORT
Session 10A	<i>For members identified for care management, the organization consistently uses patient information and collaborates with members/families/caregivers to develop <u>care plans</u> that address barriers and incorporates patient preferences and lifestyle goals documented in the patient's chart. Demonstration of such may be through reports, file review or live demonstration of case examples.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1*	Establishes a person-centered care plan for members identified for care management.
2*	Provides written care plan to the patient/family/caregiver for members identified for care management.
3	Documents patient preference and functional/lifestyle goals in individual care plans.
4	Identifies and discusses potential barriers to meeting goals in individual care plans.
5	Includes a self-management plan in individual care plans.
6	Care plan is integrated and accessible across settings of care.
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1*	<ul style="list-style-type: none"> Walk the QI Team through their current process for development and documentation of a person-centered care plan Delegate assigned homework to an organization QI Team member(s) to: <ul style="list-style-type: none"> Research examples of Brief Action Planning on <i>YouTube</i> or other resource. Share 3 examples with organization team members that best represent the organization's population. Introduce and share the Goal Setting form instructions document with the QI Team Identify if the sample Goal Setting Form works for the organization or needs modification. Delegate revisions to the Goal Setting Form to the QI Team based on their feedback. Discuss how the approved Goal Setting Form can be integrated into the patient encounter and into the EHR. Determine how to translate the Goal Setting For into a patient centered care plan With the QI Team, develop a process for the identification, selection, and documentation of a patient centered goal Perform PDSAs that test the process for establishing a care plan for the identified population needing care management Develop strategies to verify that care planning is consistently occurring with the identified patient population
2*	<ul style="list-style-type: none"> Ask the question: Is a written care plan provided to the patient/family/caregiver?

	<ul style="list-style-type: none"> • Discuss the value of a written care plan that can be sent home with the patient. • Share the 7 activities involved in Self-Management Support Infographic • Develop a process for the provision of a written care plan, including a patient centered goal, with the QI Team • Develop a strategy to verify that members are receiving a written care plan consistently
3	<ul style="list-style-type: none"> • Have the QI team perform an audit of the care planning process to see if patient preferences and functional/lifestyle goals are documented in the care plan. • If it is found that patient preferences are not being documented in the care plan brainstorm ways with the team to resolve this issue, for example: <ul style="list-style-type: none"> ○ Staff trainings on the importance of patient preferences & lifestyle goals • Adding a new section to the care plan that speaks specifically to patient preferences and lifestyle goals. • Perform a root cause analysis (RCA) to focus the team in on the best option for change. Use The 5 Whys technique • Perform a PDSA that implements the best option for change and evaluate the results
4	<ul style="list-style-type: none"> • Have the QI team perform an audit of the care planning process to see if potential barriers are assessed and documented in the care plan. • If it is found that barriers are not assessed and document following the brainstorming, RCA, and PDSA process in #3.
5	<ul style="list-style-type: none"> • Discuss the essential elements of a self-management plan with the QI Team <ul style="list-style-type: none"> ○ Share The 7 activities involved in Self-Management Support Infographic • Have the team identify current tools and resources being used to support patient self-management. • Assign staff member(s) to identify evidence-based self-management support tools to support the patient populations. Self-Management Support Resources • Have organizational leaders vet and approve the self-management tools. • Work with the organization to integrate the tools into the workflow.
6	<ul style="list-style-type: none"> • Discuss use of the EHR portal for patient access to their personal health records. • Identify if organization provides the individualized care plan through the patient portal. • Brainstorm ways to provide the care plan to members and how to further integrate care plans across settings of care with the QI Team. • Perform PDSAs that test alternate ways of providing care plans across settings of care to determine feasibility.
ADDITIONAL RESOURCES (documents on SharePoint site):	
Dancing, not wrestling. Motivational interviewing helps case managers cultivate relationships and elicit change.	
Care Plan Example 1 and 2	

Module 10	PATIENT ENGAGEMENT
Session 10B	<i>The organization engages members in their own health care planning and decision making to improve health outcomes.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	

1	Uses evidence based strategies to engage members in their health care. (e.g. Motivational Interviewing)
2	Uses evidence based communication interventions (tools) to promote stronger engagement. (e.g., Teach-Back)
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> • Discuss which evidence based strategies the organization currently uses to engage members in their health care • If the organization is not using an evidence based strategy to engage members <ul style="list-style-type: none"> ○ Share the Building a Therapeutic Alliance Infographic with the QI Team ○ Share the Motivational Interviewing using OARS Infographic with the QI team ○ Share the SMART Goal Setting Infographic with the QI Team • Have the QI Team develop training materials for patient engagement • Have the organization vet and approve training for their clinical teams • Have the QI Team train the clinical staff on the use of strategies to engage members using the organizational approved training • Have the organization staff record their training using sign in sheets • Have the QI team integrate the training on evidence based communication interventions into new employee orientation
2	<ul style="list-style-type: none"> • Discuss the communication tools which are currently being used in the organization for patient engagement • If the organization is not currently using communication tools: <ul style="list-style-type: none"> ○ Share the Why Teach Back infographic with the QI Team ○ Share the What is Teach Back infographic with the QI Team ○ Share the Ruler of Change infographic with the QI Team • Have the organization vet and approve which communication intervention tool will be used to promote stronger patient engagement with the organization team • Have the QI Team train the clinical staff on the communication intervention tool identified by the organization • Have the organization staff record their training using sign in sheets • Have the QI team integrate the training on evidence based communication interventions into new employee orientation
ADDITIONAL RESOURCES (documents on SharePoint site):	
Dancing, not wrestling. Motivational interviewing helps case managers cultivate relationships and elicit change.	
Patient Engagement Whitepaper	
Motivational Interviewing Presentation	
Individual and Family Engagement in the Medicaid Population: Emerging Best Practices and Recommendations	
PCMH Participant Engagement webinar slide deck ; webinar recording: https://www.youtube.com/watch?v=yq6BdvvYXKc&feature=youtu.be	

Module 11

Module 11	CARE COORDINATION AND TEST TRACKING
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Session 11A	<i>The organization effectively tracks and manages laboratory and imaging tests important for patient care and informs members of the result.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1*	The organization systematically manages lab tests by: <ul style="list-style-type: none"> A. Tracking lab tests until results are available, flagging and following up on overdue results B. Flagging abnormal lab results, bringing them to the attention of the clinician C. Notifying members/families/caregivers of normal lab test results D. Notifying members/families/caregivers of abnormal lab test results
2*	The organization systematically manages imaging tests by: <ul style="list-style-type: none"> A. Tracking imaging tests until results are available, flagging and following up on overdue results B. Flagging abnormal imaging results, bringing them to the attention of the clinician C. Notifying members/families/caregivers of normal imaging test results D. Notifying members/families/caregivers of abnormal imaging test results
3	Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening (NA for organizations that do not care for newborns).
4	Uses clinical protocols to determine when lab and imaging tests are necessary.
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site) <i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor.</i>	
1*	<ul style="list-style-type: none"> • Maps the current workflow of how the organization: 1) tracks lab tests ordered by providers, 2) follows up on overdue labs, 3) flags abnormal labs, 4) brings them to the attention of the clinician, and 5) notifies the patient/family/caregiver of both normal and abnormal lab results either by phone or through the portal. • Identifies whether the organization EHR can track labs, flag abnormal results, and bring them to the attention of the clinician. Lab Tracking Screenshots Lab Follow-Up Screenshots If the EHR is not able to track and flag overdue labs, identify what manual workflow the organization will use to track, flag, and follow up on overdue labs or abnormal lab results. • Develops the process that the organization will use to: <ul style="list-style-type: none"> ◦ Track labs until the results are available using a log or other tracking tool. Lab Tracking Log Example ◦ Flag abnormal lab results and bring them to the attention of the clinician. ◦ Notify the patient/family/caregiver of both normal and abnormal results • Assigns QI team member(s) to verify that the process for tracking, flagging and following up with labs is followed, including the notification (either by phone or through the portal) of both normal and abnormal lab results to the patient/family/caregiver • Adopts a policy or standard operating procedure outlining the new workflow Sample-Policy Test Tracking Policy Example

2*	<ul style="list-style-type: none"> • Maps the current workflow of how the organization: 1) tracks imaging tests ordered by providers, 2) follows up on overdue image results, 3) flags abnormal imaging results, 4) brings them to the attention of the clinician and 5) notifies the patient/family/caregiver of both normal and abnormal image results • Identifies whether the organization EHR can track imaging tests, flag abnormal results, and bring them to the attention of the clinician. If the EHR is not able to track and flag overdue imaging tests, identify what manual workflow the organization will use to track, flag, and follow up on overdue imaging tests or abnormal results. • Develops the process that the organization will use to: <ul style="list-style-type: none"> ◦ Track imaging tests until the results are available using a log or other tracking tool. Imaging Tracking Log Example Test Tracking Log Spreadsheet ◦ Flag abnormal imaging test results and bring them to the attention of the clinician. ◦ Notify the patient/family/caregiver of both normal and abnormal results • Assigns QI team member(s) to verify that the process for tracking, flagging and following up with imaging tests is followed, including the notification of both normal and abnormal results to the patient/family/caregiver • Adopts a policy or standard operating procedure outlining the new workflow Test Tracking Policy Example
3	<ul style="list-style-type: none"> • Determines if the EHR is able to record and track newborn hearing screening and blood-spot screening • Maps the current workflow of how the organization follows up with the inpatient facilities to obtain newborn hearing and blood-spot screening results. • If the EHR is not able to newborn hearing and blood-spot screening results, identify what manual workflow the organization will use to record and track newborn hearing and blood-spot screening results. • Develops the process that the organization will use to: <ul style="list-style-type: none"> • Track newborn hearing and blood-spot screening results until the results are available using a log or other tracking tool. • Test Tracking Log Example • Flag abnormal lab results and bring them to the attention of the clinician. • Follow up with patient/family/caregiver of both normal and abnormal results • Has the QI team developed the process that the organization will use to: <ul style="list-style-type: none"> ◦ Follow up with the inpatient facility about how the newborn hearing results are obtained and how the provider is notified using a log or other tracking tool. ◦ Follow up with the inpatient facility about how the newborn blood-spot screening results are obtained and how the provider is notified using a log or other tracking tool. ◦ Document the results of the newborn blood-spot screening and hearing screen in the EHR. ◦ Test Tracking Log Example • Assigns QI team member(s) to verify that results of newborn hearing screenings and blood-spot screenings are being documented consistently in the EHR. • Adopts a policy or standard operating procedure outlining the new workflow • Test Tracking Policy Example

4	<ul style="list-style-type: none"> • Determines if the organization currently uses clinical protocols to determine when lab and imaging tests are necessary • Discusses the benefits of using Standing Orders (SO) or Standing Operating Procedures (SOP) that can be implemented for these protocols. • Develops a plan with the QI team for using clinical protocols for lab and image studies. • Has the QI team identify the clinical champion(s) responsible for clinical protocols for lab and imaging test ordering. • Implements the new protocols across the organization
ADDITIONAL RESOURCES (documents on SharePoint site):	
N/A	

Module 12

Module 12	CARE COORDINATION WITH SPECIALISTS
Session 12A	<i>The organization provides important information in referrals to specialists and tracks referrals until the report is received.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1*	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
2*	Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports
3	Uses clinical protocols to determine when a referral to a specialist is necessary.
4	Identifies the specialists/specialty types most commonly used by the organization
5	Considers available performance information on consultants/specialists when making referral recommendations.
6	Works with non-behavioral healthcare specialists to whom the organization frequently refers to set expectations for information sharing and patient care.
7	Works with behavioral healthcare providers to whom the organization frequently refers to set expectations for information sharing and patient care.
8	Integrates behavioral healthcare providers into the care delivery system of the organization site.
9	Monitors the timeliness and quality of the referral response.
10	Documents co-management arrangements in the patient's medical record.
11	Engages with members regarding cost implications of treatment options
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site) <i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor.</i>	

1*	<ul style="list-style-type: none"> • Identifies if the organization currently gives a consultant the: <ul style="list-style-type: none"> ○ Clinical question ○ Required timing ○ Type of referral ○ Pertinent demographic data ○ Current clinical data, including test results & the care plan • If not currently happening, brainstorms ways to ensure all requirements are sent to the consultant or specialist • Creates a process for ensuring the ensuring the requirements are sent • PDSAs the process with one provider • Adjusts the process as needed based upon the results of the PDSA • Assigns QI team member(s) to implement the process for ensuring all requirements are sent
2*	<ul style="list-style-type: none"> • Maps the current workflow of how the organization tracks referrals • Identifies if the organization has an EHR that can track overdue reports and bring them to the attention of the staff responsible for tracking referrals <ul style="list-style-type: none"> ○ If the EHR is not able to track and flag overdue referral reports, brainstorm what the manual workflow should be for tracking, flagging, and following up on overdue referrals • Develops the process that the organization will use to: <ul style="list-style-type: none"> ○ Track referrals until the results are available using a log or other tracking tool ○ Flag overdue reports and request the results from the consultant's office until the report is received • PDSAs the process with one provider • Adjusts process based upon the results of the PDSA • Communicates the new/revised protocol to all staff involved in the process • Implements the new process across the organization • Verifies that the process is being followed, including the notification of both normal and abnormal lab results to the patient/family/caregiver
3	<ul style="list-style-type: none"> • Determines if the organization currently uses clinical protocols to determine when a referral to a specialist is necessary • Identifies a clinical champion(s) responsible for the creation of clinical protocols for referral to a specialist • Develops a process for using clinical protocols for referrals to specialists • PDSAs the process with one provider • Adjusts process based upon the results of the PDSA • Communicates the new/revised protocol to staff involved in the process • Implement the new process across the organization
4	<ul style="list-style-type: none"> • Reviews historical referral patterns for the organization. Look at type of specialist and frequency of referral to that type of specialist. • Creates a spreadsheet of specialists/specialty types and the frequency of each used by the organization in a given time frame • Share the most common specialists/specialty types with providers
5	<ul style="list-style-type: none"> • Investigates available resources: <ul style="list-style-type: none"> ○ Physician Compare CMS website is the most widely available but has no quality metrics reporting yet • Considers available performance on consultants-specialists when referring

	<ul style="list-style-type: none"> ○ Healthcare Incentives Improvement website lists quality sources by state Considers available performance on consultants-specialists when referring ○ <i>Health Grades</i> to identify the consultants/specialist's performance information: https://www.healthgrades.com/specialty-directory • Develops a process for reviewing the performance of consultants/specialists prior to referral • Implements the review process
6	<ul style="list-style-type: none"> • Works with non-behavioral healthcare specialists with whom the organization frequently refers to set expectations for information sharing and patient care. • Examples of an expectation: <ul style="list-style-type: none"> ○ We expect a follow-up report within 2 weeks of the patient's visit or if there is a worsening of symptoms referral source will call and inform the referring provider. ○ We expect to be notified if the patient does not show up for the referral visit ○ We expect to be notified if the referral visit results in hospitalization CC11- Referral Tracking Log
7	<ul style="list-style-type: none"> • Works with behavioral healthcare providers with whom the organization frequently refers to set expectations for information sharing and patient care. Review list of Health Link organizations in the region to determine if there is an opportunity for partnership or referrals. A list of participating Health Link organizations is available on TennCare's website at: https://www.tn.gov/content/dam/tn/tenncare/documents2/HealthLinkOrganizationList.pdf • Examples of an expectation: <ul style="list-style-type: none"> ○ We expect a follow-up report within 2 weeks of the patient's visit or if there is a worsening of symptoms referral source will call and inform the referring provider. ○ We expect to be notified if the patient does not show up for the referral visit ○ We expect to be notified if the referral visit results in hospitalization Policy-Outbound Consult and Mental Health Referrals
8	<ul style="list-style-type: none"> • Shares with the QI team the AMA article: Embedded Behavioral Health • Assesses current needs • Assesses available resources • Designs a team-based care model appropriate to support the organization given the current needs and available resources • Implements the team-based behavioral health model
9	<ul style="list-style-type: none"> • Develops a method to monitor the timeliness and quality of referral responses • Creates a tracking tool that monitors timeliness and quality for each consultant/specialist containing, at a minimum: <ul style="list-style-type: none"> ○ The name of the consultant/specialist or their organization ○ The time from referral request to referral response received ○ The thoroughness of the referral response. • Brainstorms a structured model for the evaluation of the quality of referral responses that includes key response requirements (medications, tests, additional follow-up) • Implements the use of the tracking tool
10	<ul style="list-style-type: none"> • Determines if the organization currently obtains co-management agreements from specialists

	<ul style="list-style-type: none"> • Shares a sample of a co-management agreement with the QI team to be shared with the organization: Behavioral Health Co-Management Agreement Specialist co-management agreement • Defines the elements of a co-management agreement • Develops a process for obtaining co-management agreements • Identifies where the co-management arrangements will be documented in the EHR • Educates staff that will be documenting the co-management arrangements in the medical record following the identified process • Implements the process for obtaining co-management agreements
11	<ul style="list-style-type: none"> • Identify if the organization has current patient education materials focusing on appropriateness of treatment and cost of care. • Evaluate current treatment options and identify opportunities for cost savings. • Develop patient education materials that support evidence-based care at the lowest cost • Engage members in conversations with organization staff that focus on care needs and care costs. Utilize case management and care coordination staff to initiate these conversations when working with patients around specialty referral and access to care.
ADDITIONAL RESOURCES (documents on SharePoint site):	
	Agency for Healthcare Research and Quality: Care Coordination: https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html
	Coordinating Care in the Medical Neighborhood
	AHRQ Lexicon for BH and Primary Care Integration
	Evolving Health for BH
	Integrating Behavioral Health and Primary Care for Children and Youth – Concepts and Strategies (SAMHSA)
	Make Referrals Easy – AHRQ
	Sample Referral Form – AAFP
	Closing the Referral Loop Toolkit
	Performance Information for Specialist Referrals Example
	Care Coordination and Care Transitions Example
	Care Compact - Behavioral Health Referral Expectations Example

Module 13

Module 13	CARE COORDINATION THROUGHOUT CARE TRANSITIONS
Session 13A	<i>The organization connects with other health care facilities to support patient safety throughout care transitions. The organization receives and shares necessary patient treatment information to coordinate comprehensive patient care.</i>
COACHING OBJECTIVES: Fundamental Practice Building Blocks	
1*	Systematically identifies members with unplanned hospital admissions and emergency department visits.

2*	Shares clinical information with admitting hospitals and emergency departments.
3*	Contacts members/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit.
4	Systematic ability to coordinate with acute care settings after hours through access to current patient information.
5	Exchanges patient information with the hospital during a patient's hospitalization.
6	Implements process to consistently obtain patient discharge summaries from the hospital and other facilities.
7	Collaborates with the patient/family/caregiver to develop/implement a written care plan for complex members transferring in to/out of the organization (e.g., transitioning from pediatric care to adult care).
8	Demonstrates electronic exchange of information with external entities, agencies and registries: A. Regional health information organization (RHIO) or other Health information exchange source that enhances ability to manage complex members B. Immunization registries or immunization information systems C. Summary of care record to other providers or care facilities for care transitions
*Core requirements for NCQA PCMH 2017	
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site) <i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor.</i>	
1*	<ul style="list-style-type: none"> • Maps current process for identifying members with unplanned hospitalizations and emergency department visits • Based upon the process mapping identifies gaps in workflow. • Brainstorms opportunities for improvement <ul style="list-style-type: none"> ○ Design/revise the organization's information infrastructure to track and manage transitions. The information infrastructure can include use of <ul style="list-style-type: none"> ▪ The EHR ▪ Spreadsheets ▪ Staff assigned to make phone calls and document interactions. ▪ The Care Coordination Tool's Admission, Discharge, and Transfer (ADT) feeds ▪ Staff assigned to track the ADT feeds on a regular basis (e.g. daily) ○ Coordinate with hospitals to make sure organization is informed when members are seen ○ Give members organization ID cards to show to hospital staff when they are seen • Documents the process as outlined in PCMH Care Transitions
2*	<ul style="list-style-type: none"> • Maps current process for sharing information with the admitting facility. • Based upon the process mapping identifies gaps in workflow. • Brainstorms opportunities for improvement <ul style="list-style-type: none"> ○ Investigate the potential of shared EHRs with the hospital ○ Develop relationships (agreements) with key specialist groups and hospitals – include verbal or written agreements that include guidelines and expectations for the transition processes

	<ul style="list-style-type: none"> ○ Designate an organization care coordinator to outreach to acute care facilities and be responsible for the exchange of patient information ● Documents the process as outlined in PCMH Care Transitions
3*	<ul style="list-style-type: none"> ● Reviews current process for outreach to members after hospitalization or emergency department visit. ● Defines the time period in which members should be contacted. Time period can be set based upon diagnosis and/or whether visit was an inpatient, observation or ED stay. Important to note if all members with a hospital stay are contacted and a follow up visit scheduled or if it is a subset. The same with ED visits. ● Documents the process of patient follow-up and appointment scheduling after an inpatient, observation or ED visit including the details of: who will contact, within what time frame, which members will be contacted and what the time frame is for a follow-up visit. Review PCMH Care Transitions for more information.
4	<ul style="list-style-type: none"> ● Evaluates organization's current ability to coordinate care with acute care facilities after hours ● If this is not happening, or gaps are identified, brainstorms opportunities for improvement: <ul style="list-style-type: none"> ○ Enhanced use of triage nurse to provide information to acute care facilities after hours ○ Plan for how on call provider(s) will interact with acute care facilities when information is needed ○ Evaluates the EHR for opportunities to enhance two-way electronic communication with the hospital (e.g. shared EHR access) ● Develops a new or revised process as needed ● Completes a PDSA process for making the needed changes ● Documents the process as outlined in PCMH Care Transitions
5	<ul style="list-style-type: none"> ● Creates a flowchart to determine the process for exchanging information with the hospital during a patient hospitalization ● Identifies current gaps, if any, and brainstorms improvement opportunities based on gaps <ul style="list-style-type: none"> ○ Develop relationships (agreements) with key hospitals – include verbal or written agreements that include guidelines and expectations for communication before, during and post-hospitalization ○ Utilize organization care coordinator to monitor hospitalizations and have conversations with key hospital staff about patient progress (e.g. inpatient care managers and discharge planners) ● Develops new/revised process ● PDSAs new/revised process ● Documents process for providing hospitals and ERs with clinical information AND for obtaining discharge summaries PCMH Care Transitions Coordinated Transitions of Care Policy
6	<ul style="list-style-type: none"> ● Reviews current process for obtaining discharge summaries ● Identifies current gaps, if any, and brainstorms improvement opportunities based on gaps ● Evaluates ability to obtain summaries via an electronic process – EHR, Fax ● Develops/revises process for obtaining patient discharge summaries. ● PDSAs new/revised process

	<ul style="list-style-type: none"> Documents process for providing hospitals and ERs with clinical information AND for obtaining discharge summaries (flowchart, policy, standard operating procedure (SOP) PCMH Care Transitions Review Coordinated Transitions of Care Policy
7	<ul style="list-style-type: none"> For complex members transferring in to/out of the organization, follows the process developed in Module 10 Session 10A of developing a person-centered care plan and providing the plan of care to the patient/family/caregiver. Review PCMH Care Transitions
8	<ul style="list-style-type: none"> Demonstrates EHR information exchange with RHIO, TennIIS, or other providers or care facilities for care transitions as outlined in PCMH Care Transitions If no EHR information exchange in place, evaluates the ability of the current organization EHR to engage in information exchange with any of the above. Partners with RHIO, TennIIS or other provider/facility to implement an electronic exchange of information.
ADDITIONAL RESOURCES (documents on SharePoint site):	
Improving Transitions of Care	
TCM Workflow Example (Note: This resource includes Medicare specific information)	
TOC Services Example (Note: This resource includes Medicare specific information)	
Coordinate Transitions of Care Policy Example	
Care Coordination and Care Transitions Examples	

Module 14

MODULE 14	BEHAVIORAL HEALTH INTEGRATION
SESSION 14A	<i>The organization has a robust understanding of the components of behavioral health integration including the resources required to promote integration and whole person care.</i>
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Understand how physical and behavioral health interface.
2	Identify resources to promote physical and behavioral health integration.
3	Understand organizational impacts to daily processes with integration. (Also included in Module 7)
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> Review organization's population demographics and the most common behavioral health conditions Ask about behavioral health condition needs (e.g., what conditions are most common in the organization, what staffing needs have been identified, what are the gaps in knowledge about integration)
2	<ul style="list-style-type: none"> Discuss current staff and/or plans to hire additional staff to assist with integration experience (e.g., physicians, mid-level practitioners, nurses, etc.) Conduct focus group with nursing staff to maximize participation with care coordination – understand behavioral health training. Practice identifying Health Link members (these are TennCare members with the

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	<p>highest behavioral health needs), behavioral health diagnoses, and prescription information in the Care Coordination Tool.</p> <ul style="list-style-type: none"> • Discuss and document the provider’s behavioral health collaborative relationships that are currently in place and how they are working • Provide list of participating Health Links: https://www.tn.gov/assets/entities/hcfa/attachments/HealthLinkOrganizationList.pdf
3	<ul style="list-style-type: none"> • Review the organization’s assessment tool(s) to determine how well they address the following domains: <i>Does the Comprehensive Health Assessment (CHA) include all the following?</i> <ol style="list-style-type: none"> A. Medical history of member and family B. Mental health/substance use history of member and family C. Family/social/cultural characteristics D. Communication needs E. Behaviors affecting health F. Medication management and health literacy G. Social Functioning H. Social Determinants of Health I. Developmental screening using a standardized tool (for organizations with pediatric populations under 30 months of age) J. Member’s Perspective of Care K. Patient-Centered Approach to Self-Management • Shadow staff during assessment administration – are they asking the “right” questions to drill down to the appropriate health information? • Review a sampling of care plans and team documentation – identify where documentation can be strengthened, and establish training topics related to communicating via formal documentation.
ADDITIONAL RESOURCES (documents on SharePoint site):	
	<p>CCT Demo Videos:</p> <p>Finding Claims Based Medication Information: https://altruistahealth.webex.com/altruistahealth/ldr.php?RCID=c86a0bef2a9fd8af9d71136fe4bee85d</p> <p>Finding Dual Program Members Information: https://altruistahealth.webex.com/altruistahealth/ldr.php?RCID=a5afb1bd8b97e50d3f5a69cf43c9289b</p>
	PCMH Provider Operating Manual 2018
	A Quick Start Guide to BH Integration for Safety-Net PCPs (SAMHSA)
	Advancing BH Integration within NCQA Recognized PCMHs (SAMHSA) (pages 3 - 7)
	Standard Framework for Levels of Integrated Healthcare (SAMHSA)
	A Standard Framework for Levels of Integrated Healthcare report (SAMHSA)

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	A Family Guide - Integrating Mental Health and Pediatric Primary Care (NAMI) (pages 9 - 12, page 15)
	Website with models of BH Integration: https://www.integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care#integrated%20models%20of%20BH%20in%20PC
	Integrated Behavioral Health in Primary Care - Brief APA
	<p>AHRQ Playbook for Integrating Behavioral Health Care in Ambulatory Care: https://integrationacademy.ahrq.gov/products/playbook/about-playbook</p> <ol style="list-style-type: none"> 1. Integrating BH and Ambulatory Care Self-Assessment Checklist https://integrationacademy.ahrq.gov/products/playbook/integrating-behavioral-health-and-ambulatory-care-self-assessment-checklist 2. Planning for Integration (15 sections): <ol style="list-style-type: none"> a. Define your Vision https://integrationacademy.ahrq.gov/products/playbook/define-your-vision b. Develop Your Game Plan https://integrationacademy.ahrq.gov/products/playbook/develop-your-game-plan c. Implementing the Plan for Integrating Behavioral Health in Your Ambulatory Care Setting https://integrationacademy.ahrq.gov/products/playbook/implementing-plan-integrating-behavioral-health-your-ambulatory-care-setting d. Establish Operational Systems to Support Integration https://integrationacademy.ahrq.gov/products/playbook/establish-operational-systems-support-integration e. Secure Financial Support for Behavioral Health Services https://integrationacademy.ahrq.gov/products/playbook/secure-financial-support-behavioral-health-services f. Collect and Use Data for Quality Improvement https://integrationacademy.ahrq.gov/products/playbook/collect-and-use-data-quality-improvement g. Educate Patients and Families About Integrated Ambulatory Care https://integrationacademy.ahrq.gov/products/playbook/educate-patients-and-families-about-integrated-ambulatory-care h. Obtain Behavioral Health Expertise and Build a Culture of Integration https://integrationacademy.ahrq.gov/products/playbook/obtain-behavioral-health-expertise-and-build-culture-integration i. Establish Protocols to Identify Patients Who Could Benefit From Integrated Care https://integrationacademy.ahrq.gov/products/playbook/establish-protocols-identify-patients-who-could-benefit-integrated-care

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	<p>j. Tailor the Care Team to Meet the Needs of Identified Patients https://integrationacademy.ahrq.gov/products/playbook/tailor-care-team-meet-needs-identified-patients</p> <p>k. Develop a Shared Care Plan https://integrationacademy.ahrq.gov/products/playbook/develop-shared-care-plan</p> <p>l. Build Patient Understanding of Setbacks and How to Deal With Them https://integrationacademy.ahrq.gov/products/playbook/build-patient-understanding-setbacks-and-how-deal-them</p> <p>m. Track Patients and Monitor Their Outcomes https://integrationacademy.ahrq.gov/products/playbook/track-patients-and-monitor-their-outcomes</p> <p>n. Observations from Exemplary Sites https://integrationacademy.ahrq.gov/products/playbook/observations-exemplary-sites</p> <p>o. What Not to Do https://integrationacademy.ahrq.gov/products/playbook/what-not-do</p>

APPENDIX
NCQA PCMH 2017 Criteria – TennCare PCMH Curriculum Crosswalk
2017 PCMH Concepts with PHiT Activities
PHiT January Support Call
2018 PCMH Webinars:
Population Management Stratification Part 2 Webinar recording
PCMH Webinar Population Health Management and Brief Action Planning Webinar Webinar recording
PCMH Webinar: Performance Management Webinar recording
PCMH Webinar: How to Succeed with EPSDT Visits Webinar slides
A Review of NCQA Accreditation and HEDIS Webinar recording
PCMH Webinar: Connecting the Dots for Population Health Management Webinar recording
2019 PCMH Webinars:
PCMH Webinar: Performance Management Webinar recording
PCMH: Evidenced Based Care Webinar recording
2019 PCMH Program Enhancements Webinar recording
PCMH Webinar: Behavioral Health in PCMH and Distinction in Behavioral Health Integration Webinar recording
PCMH Provider Information Webinar Webinar recording
PCMH Webinar: Documented Processes and Evidence, Part 1 Webinar recording

PCMH Webinar: Documented Processes and Evidence, Part 2

[Webinar recording](#)

PCMH Webinar: NCQA Annual Reporting

[Webinar recording](#)
