

Questionnaire: (10 of 15)

(*) Red asterisk indicates a required field.

Objective: Report ambulatory clinical quality measures to CMS.

Measure: Successfully report to CMS ambulatory clinical quality measures selected by CMS in the manner specified by the CMS.

Complete the following information:

Yes No ← **Enter your yes/ no here**

Core Clinical Quality Measures

Questionnaire: (1 of 3)

(*) Red asterisk indicates a required field.

Instructions: All three Core Clinical Quality Measures must be submitted. For each Core Clinical Quality Measure that has a denominator of zero, an Alternate Core Clinical Quality Measure must also be submitted.

Hypertosis

Title: Hypertension: Blood Pressure Measurement

Description: Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 of the visits, with blood pressure (BP) recorded.

Complete the following information:

*Denominator: ← *Numerator: ← **Enter your numerator and denominator here**

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Core Measure # 11

Clinical Decision Support Rule

Objective	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.
Measure	Implement one clinical decision support rule.
Exclusion	No exclusion.

PCMH 3A Factors 1-3

Element A: Implement Evidence-Based Guidelines 4 points

The practice implements evidence-based guidelines through point-of-care reminders for patients with:	Yes	No
1. The first important condition*	<input type="checkbox"/>	<input type="checkbox"/>
2. The second important condition	<input type="checkbox"/>	<input type="checkbox"/>
3. The third condition, related to unhealthy behaviors or mental health or substance abuse.	<input type="checkbox"/>	<input type="checkbox"/>

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Documentation

The practice provides the following:

- Lists the three important conditions
- Provides the name and source of evidence-based guidelines for each condition
- Demonstrates how the guidelines for each condition are implemented in patient care, using chart tools, screen shots or workflow organizers.
- Examples of guideline implementation, organizers, flow sheets or templates based on condition-specific guidelines enabling the practice to develop treatment plans and document patient status and progress. These tools are used by the practice to manage patient care. Templates of the tools may be provided for documentation.
- Electronic system organizer (e.g., registry, EHR, other system) screenshots showing templates for treatment plans and documenting progress.

Documenting use of evidence based guidelines

PPC 3A This and the following screen shots show our HIV templates now completely filled in following the recommended guidelines and CDSS

Measure Name	Fq	Status	Orders
Smoking status updated	12 M	NON-COMPLIANT	Tobacco Control
HIV screening	6 M	NON-COMPLIANT	HIV
LDL testing (high risk)	12 M	NON-COMPLIANT	LIPID PROFILE
A1C testing	6 M	SNOOZED	GLYCO HGB A1-C
BP control in DM (130/80)	12 M	COMPLIANT	DM - BP Control
Body Mass Index updated	24 M	COMPLIANT	BMI
Cervical cancer screening	6 M	SUPPRESSED (MEDICAL REASON)	CA screen - PAP

CDSS Panel above displaying alerts for screenings due

Core Measure # 12

Electronic Copy of Health Information

Objective	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.
Measure	More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days.
Exclusion	Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.

PCMH 1C Factors 1

Element C: Electronic Access

2 points

The practice provides the following information and services to patients and families through a secure electronic system.

Yes No

- | | | |
|---|--------------------------|--------------------------|
| 1. More than 50 percent of patients who request an electronic copy of their health information (e.g., problem list, diagnoses, diagnostic test results, medication lists, allergies) receive it within three business days* | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. At least 10 percent of patients have electronic access to their current health information (including lab results, problem list, medication lists, and allergies) within four business days of when the information is available to the practice** | <input type="checkbox"/> | <input type="checkbox"/> |

MU menu measure →

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Core Measure # 13

Clinical Summaries

Objective	Provide clinical summaries for patients for each office visit.
Measure	Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.
Exclusion	Any EP who has no office visits during the EHR reporting period.

PCMH 1C Factors 3

Element C: Electronic Access


2 points

The practice provides the following information and services to patients and families through a secure electronic system.

Yes No

- | | | |
|--|--------------------------|--------------------------|
| 3. Clinical summaries are provided to patients for more than 50 percent of office visits within three business days* | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

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Summary of Today's Visit

Arote, Rohi B
01/12/2010 visit with Sam Willis, MD

Treatment

- Start Crestor : 40 MG 1 tablet Orally once a day (for: Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled)

Patient Instructions:
See below (for: Routine general medical examination at health care facility)

Tests ordered/performed today

Labs:

- CBC on 01/12/2010 (for: Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled)
- ALT (SGPT), AST (SGOT) on 01/12/2010 (for: Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled)
- LDL Cholesterol (Direct) on 01/12/2010 (for: Routine general medical examination at health care facility)
- HDL Cholesterol on 01/12/2010 (for: Routine general medical examination at health care facility)
- TSH+Free T4 on 01/12/2010 (for: Routine general medical examination at health care facility)

Recommended Wellness and Prevention Guidelines

Core Measure # 14

Electronic Exchange of Clinical Information	
Objective	Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.
Measure	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.
Exclusion	No exclusion.

PCMH 5B Factor 6

Element B: Referral Tracking and Follow-Up **6 points**
MUST-PASS

The practice coordinates referrals by:	Yes	No
6. Demonstrating the capability for electronic exchange of key clinical information (e.g., problem list, medication list, allergies, diagnostic test results) between clinicians*	<input type="checkbox"/>	<input type="checkbox"/>

Meaningful Use/ PCMH 2011 Overlap

Element C: Coordinate With Facilities and Care Transitions **6 points**

On its own or in conjunction with an external organization, the practice systematically:	Yes	No	NA
7. Demonstrates the capability for electronic exchange of key clinical information with facilities*	<input type="checkbox"/>	<input type="checkbox"/>	

PCMH 5C factor 7 was previously designated as aligning with MU # 14... removed in March 28,11 revision

Example documentation to meet PCMH 5B Factor 6

Factor 6: The practice is asked to show that its certified EHR technology has the capacity to electronically exchange key clinical information with facilities. That is, the practice needs to show its capability to send and receive key clinical information electronically (e.g., problem lists, medication lists, medication allergies, diagnostic test results) with other providers of care, with patient-authorized entities (such as health plans, an entity facilitating health information exchange among providers or a personal health record vendor identified by the patient. The key clinical information is based on the judgment of the clinician. There is no requirement for the practice to be able to exchange data on a regular basis now.

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Meaningful Use/ PCMH 2011 Overlap

Over Five Million Now Victims of Healthcare Breaches

Tuesday, November 23, 2010

Contributed By: Headlines

The Department of Health and Human Services' Office for Civil Rights has released statistics on health information breaches that show a total of 5.35 million Americans' records have been compromised in 192 data loss incidents since September 2009.



One of the most recent breaches at Keystone/AmeriHealth Mercy Health Plans involved over 280,000 records, including personally identifiable information, that were on an unencrypted database that can not be found.

The number of health information breaches is generally on a downward trend according to data collected under the HITECH act mandates, and the majority are due to lost or stolen data storage devices.

According to the HITECH Act's breach reporting rules, all events that affect 500 or more records need to be reported, including notifications being sent to those whose information has been compromised within 60 days.



Stolen Drive
 Date: 2004-05-12
 Records Lost: 95,000
 Organizations: Alameda Alliance for Health, Spitchack
 Source: Outside

Stolen Laptop
 Date: 2004-12-21
 Records Lost: 100,000
 Organizations: Data Blood Bank
 Source: Outside

Web
 Date: 2005-02-11
 Records Lost: 140
 Organizations: Kaiser Permanente
 Source: Inside - Accidental

Stolen Computer
 Date: 2005-04-08
 Records Lost: 187,000
 Organizations: San Jose Medical Group
 Source: Inside - Accidental

Stolen Computer
 Date: 2005-04-28
 Records Lost: 16,000
 Organizations: Christus St. Joseph Hospital, Gateway File Systems
 Source: Outside

100,000 blood donors put at risk
 Date: 2004-12-21
 Records Lost: 100,000
 Organizations: Data Blood Bank
 Source: Outside

Company fined US \$200,000 for publicly posting information
 Date: 2005-02-11
 Records Lost: 140
 Organizations: Kaiser Permanente
 Source: Inside - Accidental

Stolen computer leads to 185,000 patient notifications
 Date: 2005-04-08
 Records Lost: 187,000
 Organizations: San Jose Medical Group
 Source: Inside - Accidental

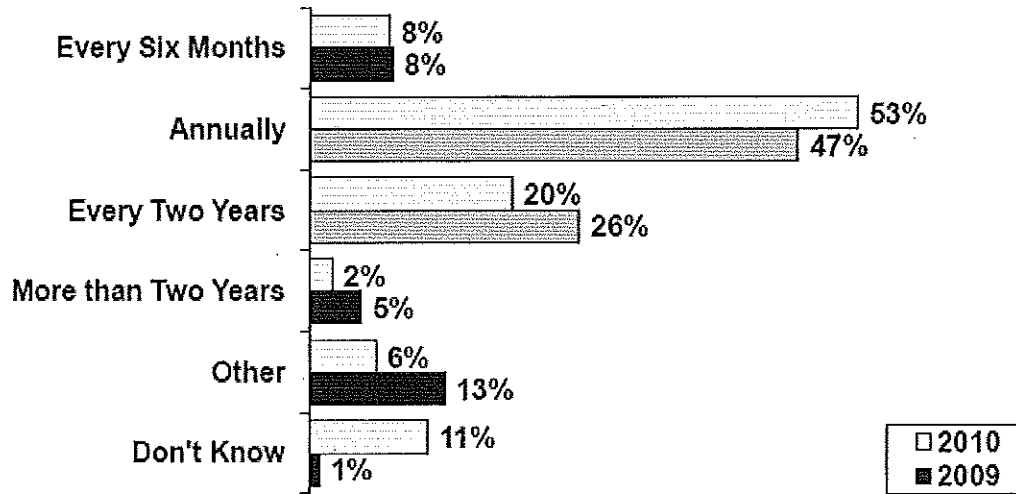
Letters sent to 16,000 patients regarding breach
 Date: 2005-04-28
 Records Lost: 16,000
 Organizations: Christus St. Joseph Hospital, Gateway File Systems
 Source: Outside

Top Risks Patients Face When Their Data Is Breached

Public Embarrassment	61%
Financial Identity Theft	56%
Medical Identity Theft	45%

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Frequency of Conducting a Formal Risk Analysis



3rd Annual HIMSS Security Survey, sponsored by Intel



Meaningful Use/ PCMH 2011 Overlap

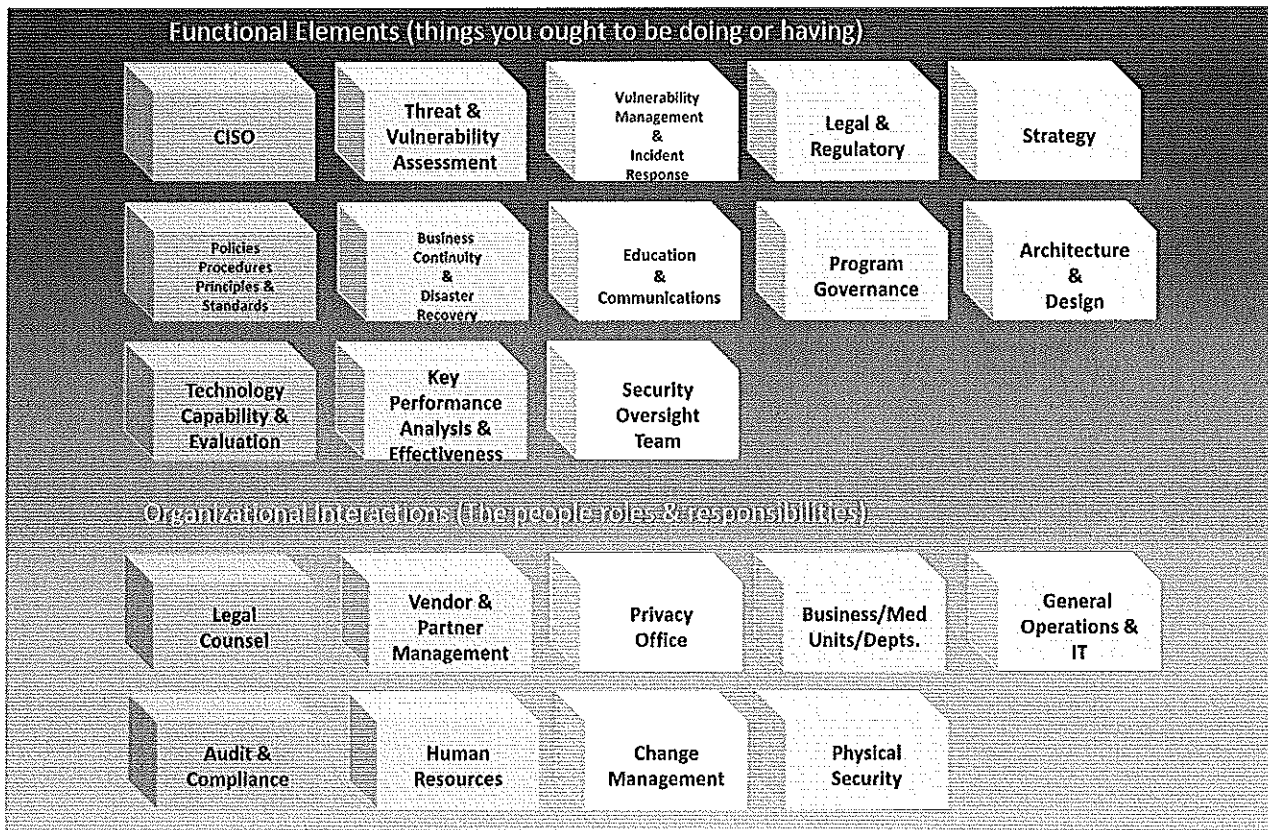
Core Measure # 15

Protect Electronic Health Information

Objective	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.
Measure	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
Exclusion	No exclusion.

Ensure adequate privacy and security protections for personal health information

Meaningful Use/ PCMH 2011 Overlap



Aligning PCMH 2008-2011

Workflow Redesign with Care Management in Mind

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PCMH 3C Care Management

PCMH 3: Plan and Manage Care

17 points

The practice systematically identifies individual patients and plans, manages and coordinates their care, based on their condition and needs and on evidence-based guidelines.

Element C: Care Management **MUST-PASS**

4 points

The care team performs the following for at least 75 percent of the patients identified in Elements A and B.

	Yes	No
1. Conducts pre-visit preparations	<input type="checkbox"/>	<input type="checkbox"/>
2. Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit	<input type="checkbox"/>	<input type="checkbox"/>
3. Gives the patient/family a written plan of care	<input type="checkbox"/>	<input type="checkbox"/>
4. Assesses and addresses barriers when the patient has not met treatment goals	<input type="checkbox"/>	<input type="checkbox"/>
5. Gives the patient/family a clinical summary at each relevant visit	<input type="checkbox"/>	<input type="checkbox"/>
6. Identifies patients/families who might benefit from additional care management support	<input type="checkbox"/>	<input type="checkbox"/>
7. Follows up with patients/families who have not kept important appointments	<input type="checkbox"/>	<input type="checkbox"/>

Scoring

100%	75%	50%	25%	0%
The practice meets 6-7 factors	The practice meets 5 factors	The practice meets 3-4 factors	The practice meets 1-2 factors	The practice meets no factors

Explanation *MUST-PASS* elements are considered the basic building blocks of a patient-centered medical home. Practices must earn a score of 50% or higher. All six must-pass elements are required for recognition.

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What is Your Care Management Process

- How many of you have a “Care Manager”
 - Care Management Activities
 - Developed a program and measure success
 - Have Written Protocols

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What is NCQA looking for?

There are two method for collecting data for these elements.

Method 1. Query your electronic medical records or other electronic patient records to obtain the information for the important conditions identified in PCMH 3: Elements A and the high-risk or complex patients identified in PCMH 3: Element B to calculate the percentage directly.

If you can use Method 1 (above) to respond to these elements, you can enter the responses directly into the Survey Tool and *you do not need to use this Record Review Workbook.*

Method 2. Review a sample of 48 patient records to obtain the information.
(Note: Patient records may be a registry or electronic records or paper medical records.)

Refer to each element in the PCMH 2011 standards for details about scoring PCMH 3C, 3D, and 4A.

If you cannot use Method 1, you must use Method 2 to respond to these elements and must fill out the Patient Conditions and Record Review Worksheets. You may respond to some elements with Method 1 and others with Method 2.

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48 Patient Record Review

A	B	C	D	E	F	G	
NCQA's Patient-Centered Medical Home (PCMH) 2011 Record Review Worksheet Please read the Workbook Instructions and fill out the <i>Patient Conditions</i> Worksheet <u>before</u> completing this worksheet. IMPORTANT NOTE: Read the instructions to determine if your practice can select the "not used" option available in the drop-down boxes for							
Organization Name:							
Worksheet Completion Date:							
Patient Number	Clinically Important Condition	3C - Care Management					Identify patient who is from at risk
		1	2	3	4	5	
		Conducts pre-visit preparations	Collaborates with patient/family to develop individual care plan, including treatment goals reviewed and updated at each relevant visit	Gives the patient/family a written plan of care	Assesses and addresses barriers when the patient has not met treatment goals	Gives the patient/family a clinical summary at each relevant visit	
39	Diabetes						
40							
41	Diabetes						
42	Hypertension						
43	Smoker						
44							
45							
46							
47							
48							

Care Management Best Practices

- Identify a population that would benefit from Care management activities (DM, CAD, COPD, Non-compliant patients)
- Define CM activities for patients and articulate them to all staff.
 - Define measures of performance when possible.
 - Internal and external benchmarks
 - Make your patients aware of your CM program
 - Give them summaries of their status

Workflow Redesign with Access in Mind

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Where Are You Today?

PCMH 1: Enhance Access and Continuity 31

PCMH 1: Enhance Access and Continuity 20 points

The practice provides access to culturally and linguistically appropriate routine care and urgent team-based care that meets the needs of patients/families.

Element A: Access During Office Hours 4 points **MUST-PASS**

The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:

	Yes	No	NA
1. Providing same-day appointments	<input type="checkbox"/>	<input type="checkbox"/>	

Explanation **Factor 1:** The practice reserves time for same-day appointments (also referred to as "open access," "advanced access" or "same-day scheduling") for routine and urgent care based on patient preference or triage. Adding *ad hoc* or unscheduled appointments to a full day of scheduled appointments does not meet the requirement. An example of a measure of access is "third available appointment," with an open-access goal of zero days (same-day availability). Third available appointment measures the length of time from when a patient contacts the practice to request an appointment, to the third next available appointment on his/her clinician's schedule. The practice may measure availability for a variety of appointment types including urgent care, new patient physicals, routine exams and return-visit exams. **Factor 1** has been identified as a critical factor and must be met for practices to receive any score on the element.

32 PCMH 1: Enhance Access and Continuity

Examples **Documentation**
Factor 1: The practice has a documented process for staff to follow for scheduling same-day appointments *and* has a report that covers at least five consecutive days and shows the use of same-day appointments throughout the practice. The practice may provide a report showing the average third available appointment.

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Where Are You Today?

A *system designed* to provide timely access
requires daily *capacity and demand*
to be *in balance*.

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Where Are You Today?

What is Demand?

- Reflects **need for service** by a panel of patients for
 - Clinical care, referrals, advice, condition monitoring
 - Prescriptions, forms and results
 - Self-management support, education
- Two types of demand:
 - **External:** from patients directly, or referral sources on behalf of patients
 - **Internal:** generated by provider-directed return visits to the clinic or health center.

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THE TRANSITION TO SCHEDULING THAT IS PATIENT-CENTERED

- CREATE PREDICTABILITY
IN SCHEDULE
- CREATE RELIABLE SAME-
DAY CAPACITY
- CLEAR THE PATIENT'S
PATH TO APPOINTMENTS
- BROADCAST! SAME-DAY
APPOINTMENTS
- USE CAPACITY
- DECLUTTER THE
SCHEDULE!
 - CREATE WHITE SPACE
- BALANCE SAME-DAY
CAPACITY WITH SAME-
DAY DEMAND

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THE TRANSITION TO SCHEDULING THAT IS PATIENT-CENTERED

- CREATE PREDICTABILITY
IN SCHEDULE
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- BROADCAST! SAME-DAY
APPOINTMENTS
- USE CAPACITY
- DECLUTTER THE
SCHEDULE!
 - CREATE WHITE SPACE
- BALANCE SAME-DAY
CAPACITY WITH SAME-
DAY DEMAND

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THE TRANSITION TO SCHEDULING THAT IS PATIENT-CENTERED



STEP	THE CLINIC	THE PATIENT
CREATE PREDICTABILITY IN SCHEDULE	Drop the no-show rate using confirmation calls, combing, investigating no-shows and other strategies. When the no-shows in the single-digits, your schedule is "predictable." You know who is coming and which slots are available.	Patients begin to learn about your new scheduling system. They know it is very important to call to cancel or reschedule so another patient can see a provider.
CREATE RELIABLE SAME-DAY CAPACITY	Implement same day access. The Open/Same-Day slots create same-day capacity so that you can immediately offer same-day appointments to patients rather than turning them away. Unused capacity may rise temporarily.	Patients can get an appointment today if they want it. Walk-ins wait less time because they are served in same-day slots.
CLEAR THE PATIENT'S PATH TO APPOINTMENTS	Make sure that the path for the patient to "find" your same-day and other slots is clear whether they call during regular hours or after hours. Give patients who want appointments today an appointment today!	Patient is offered a same-day appointment when they call. They don't wait a long time to speak to someone. They see their own provider. If they need to cancel or reschedule, they can get through ...

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THE TRANSITION TO SCHEDULING THAT IS PATIENT-CENTERED

- Create predictability in the schedule
- Create reliable same day access

GUIDE TO: MAKING CONFIRMATION CALLS

A well-executed confirmation call process provides intelligence for the daily plan of what to expect and assists in efficiency of the patient visit. This process supports and builds relationships between patients and their Patient Care Team (PCT). For highest impact, confirmation calls must be done on a consistent basis and will require preparation.

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THE TRANSITION TO SCHEDULING THAT IS PATIENT-CENTERED

Day of Week	Provider						Weekly Avg & Totals
	M	T	W	Th	F	S	
At Start of Each Day:							
# of Total Slots							0
# Pts Scheduled (including overbooks)							0
# of Open Slots							0
% Same Day Availability	#####	#####	#####	#####	#####	#####	#DIV/0!
Summary of Day							
# of Scheduled Pts Seen							0
# of No Shows	0	0	0	0	0	0	0
No Show Rate	#####	#####	#####	#####	#####	#####	#DIV/0!
# of Walk Ins							0
# Same Day Appts							0

No Show Rate Tool

THE TRANSITION TO SCHEDULING THAT IS PATIENT-CENTERED

- | | |
|--|--|
| <ul style="list-style-type: none"> <input checked="" type="checkbox"/> CREATE PREDICTABILITY
IN SCHEDULE <input checked="" type="checkbox"/> CREATE RELIABLE SAME-
DAY CAPACITY <input checked="" type="checkbox"/> CLEAR THE PATIENT'S
PATH TO APPOINTMENTS <input type="checkbox"/> BROADCAST! SAME-DAY
APPOINTMENTS | <ul style="list-style-type: none"> <input type="checkbox"/> USE CAPACITY <input type="checkbox"/> DECLUTTER THE
SCHEDULE! <input type="checkbox"/> CREATE WHITE SPACE <input type="checkbox"/> BALANCE SAME-DAY
CAPACITY WITH SAME-
DAY DEMAND |
|--|--|

THE TRANSITION TO SCHEDULING THAT IS PATIENT-CENTERED

• Clear the patient's path to appointments

Secret Shopper Call Instructions

What is a Secret Shopper?

A Secret Shopper is someone who poses as a regular customer at a business that focuses on providing service like department stores, banks, restaurants and even doctors' offices and health centers. Companies use what the Secret Shoppers learn while posing as a customer to improve their services and to determine what is needed to increase customer satisfaction.

In this case, the Secret Shopper is you! Remember it is a secret, so don't tell anyone

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THE TRANSITION TO SCHEDULING THAT IS PATIENT-CENTERED

- | | |
|---|--|
| <input checked="" type="checkbox"/> CREATE PREDICTABILITY
IN SCHEDULE | <input checked="" type="checkbox"/> USE CAPACITY |
| <input checked="" type="checkbox"/> CREATE RELIABLE SAME-
DAY CAPACITY | <input checked="" type="checkbox"/> DECLUTTER THE
SCHEDULE! |
| <input checked="" type="checkbox"/> CLEAR THE PATIENT'S
PATH TO APPOINTMENTS | <input checked="" type="checkbox"/> CREATE WHITE SPACE |
| <input checked="" type="checkbox"/> BROADCAST! SAME-DAY
APPOINTMENTS | <input type="checkbox"/> BALANCE SAME-DAY
CAPACITY WITH SAME-
DAY DEMAND |

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What is TNAA (Third Next Available Appointment)?

- It is a measure of access on a provider's schedule. It measures the wait for an appointment in your system due to patient, provider and system generated demand.
- the next or even the second next available appointment may have become available due to a cancellation or other event that is not predictable.

Why TNAA is Important

- High TNAA indicates a clogged and backlogged system which typically results in:
 - Poor access and continuity
 - Delay in care for patients who must wait
 - High no-show rates
 - High walk-in/drop-in rates

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How do I measure TNAA?

- Same day and time each week
- *Look at schedule and ask:*
“As of right now, what is the third next available appointment for this provider?”

Simple rule: Count all calendar days including weekends and holidays as it makes it easier to compare waits across providers and patients wait all of these days

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Understanding TNAA: Declutter the Schedule/Use Capacity

How to Record TNAA

- Record the number of days from today to the third next available appointment
- Do this for new visits and return visits for each provider
- If there are three appointments available today, the TNAA is 0. If the third next available is tomorrow, the TNAA is 1; the day after that the TNAA is 2, and so on.
- Record the date and number of days of wait on the TNAA Calculation Tool for each provider
- Share the results with the provider and the team.

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Understanding TNAA: Declutter the Schedule/Use Capacity

Third Next Available (TNAA)											
Health Center:											
New Visits											
Week	Date Collected	Provider 1:		Provider 2:		Provider 3:		Provider 4:		Pr	F
		FTE:		FTE:		FTE:		FTE:			
		Date	# days	Date	# days	Date	# days	Date	# days		
1											
2											
3											
4											
5											
6											

Third Next Available Appointment (TNAA) Tool

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Action Planning & Getting Organized

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Action Planning/Getting Organized

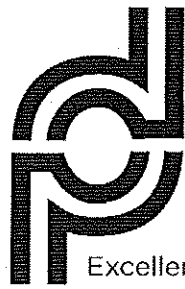
Part 1: Access & Communication (20 mins)

- As a team, brainstorm how you will begin to implement same day access at your organization.
- What can you do tomorrow?
- Select a team member to report out your on 1 of your next steps

Part 2: MU/PCMH: Goal Setting (20 mins)

- Refer to your MU/PCMH Goal Setting Tool
- As a team, review the MU section first
 - In developing your goals, consider your MU assessment findings as well as what you've learned today.
- Next, begin your Barrier Analysis
- Select a team member to report out on your MU goal/timeline and 1 barrier that you have identified

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PRIMARY CARE
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