Practice Transformation Workbook

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Building a Patient Centered Medical Home

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☐ Begin identify the following:

Chronic Condition #1:	Important Condition #2:	Important Condition #3 (Unhealthy Behavior):
Evidence Based Guideline:	Evidence Based Guideline:	Evidence Based Guideline:

Chronic Measure #1: Chronic Measure #2: Chronic Measure #3:	Preventive Measure #1: Preventive Measure #2: Preventive Measure #3:
Chronic Service #1: Chronic Service #2: Chronic Service #3:	Preventive Service #1: Preventive Service #2: Preventive Service #3:

- ☐ Begin to assess practice policies
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Enhancing Access to Care (1A, 1B, 1C)

Operational Plan for Elements 1A, 1B, 1C

Policy Evaluation

1. Evaluate practice processes or policies for the following:

Normal Hours Access

- ☐ (1A1) Same day appointments for routine or urgent care based on patients preference or triage
- ☐ (1A2) Returning phone messages in a timely manner (defined by practice)
- ☐ (1A3) Returning electronic messages in a timely manner (defined by practice)
- ☐ (1A4) Documenting clinical advice in patients EHR for telephone AND electronic messages

After Hours Access

- ☐ (1B1) Providing routine and urgent care appointments outside normal working hours
  - *Agreement with non-ER facility or clinicians is acceptable*
- ☐ (1B2) Providing patient clinical information to on-call staff and external facilities after-hours
  - *Telephone consultations with a clinician who can access the patient's medical record is acceptable as long as it can be accessed after-hours*
  - *It is also acceptable if the practice makes provisions for patients to have printed or electronic portable copy of their health information, if it's update regularly*
- ☐ (1B3) Providing timely clinical advice by phone when office is not open
- ☐ (1B4) Providing timely clinical advice by secure interactive electronic system (patient portal) when office is not open
- ☐ (1B5) Documenting after-hour telephone and electronic messages in EHR

Electronic Access Evaluation

2. Evaluate process and Patient Portal capability (or another electronic system) to achieve the following:

- ☐ (1C1) Return health information for **50% patients** who request an electronic portable copy within **3 business days**
  - Estimate: % of patients who request in a 3 month period: _____
  - Estimate: timeframe for providing copy: _____
- ☐ (1C2) Health information (labs, allergies, problem lists, etc.) returned for **10% of all patients** via patient portal within **4 business days** of when information is available to the practice
  - Estimate: % of total patients who use patient portal in a 3 month period: _____
  - Estimate: timeframe for releasing information once reviewed: _____
- ☐ (1C3) Clinical Summary of patient visits are provided for more than **50% of office visits** within **3 business days**
  - *Note: If the summary is available electronically, the practice must provide patient with a paper copy upon request.*
  - Are clinical summaries automatically sent to patient portal within 3 business days: _____
- ☐ (1C4) Does the patient portal have two-way communication capability between practice and patient? _____
- ☐ (1C5) Does the patient portal have ability for patients to request appointments or prescription refills? _____
- ☐ (1C6) Does the patient portal have ability for patients to request referrals or test results? _____

Practice Implementation

1. Based on the process/policy evaluation, determine which policies need to be refined to meet the factor requirements.
   - ➢ Begin to gather and highlight applicable areas in the policy that meet the PCMH Factor.

Report Abstraction

2. Report Abstraction
   - ➢ Identify person(s) in practice who can pull information from the EHR

   Contact: _____

Tip: The Average 3rd Next Available Appointment may be calculated to meet the report for this requirement.

3. Begin to pull reports and assess against policy:
   A. The following reports from the EHR require **one-week** period for PCMH Report:

Enhancing Access During Normal Hours		
Factor	Description	Reporting Period
☐ 1A1	Providing same day (routine and urgent) appointments	1 Week of Availability of Same-day Appointments
☐ 1A2	Providing timely clinical advice by telephone during office hours	1 Week of Response Times
☐ 1A3	Providing timely clinical advice by secure electronic messages during office hours	1 Week of Response Times

Enhancing Access During After Hours		
Factor	Description	Reporting Period
☐ 1B3	Providing timely clinical advice by telephone when office is not open	1 Week of Response Times
☐ 1B4	Providing timely clinical advice electronically when the office is not open	1 Week of Response Times

   B. The following reports from the EHR require recent **three month period** and have numerators and denominator requirements

Percentage Reports		
Factor	Description	Numerator/Denominator
☐ 1C1	More than **50% of patients** who request an electronic copy of their health information receive it within **3 business days**	# of pts who receive an e-copy of their e-health record in 3 Days / # of pts who request an e-copy of their e-health record
☐ 1C2	At least **10% of patients** have electronic access to their current health information within **4 business days** of when the information is available to the practice	# of pts who can access health info within 4 days availability to practice / # of pts seen by the practice
	Tip: *Requires at least 10% of patient population to have registered for the online patient portal*	
☐ 1C3	Electronic clinical summaries are provided to patients for more than **50% of office visits** within **3 business days**	# of office visits where e-clinical summary was available within 3 business days / # of office visits

Screenshot Examples

4. Begin to pull remaining screenshots:
   - Use actual example from patient chart, but be sure to de-identify all screenshots

Enhancing Access		
Factor	Description	# Screenshot Examples Required
☐ 1A4	Documenting telephone and electronic clinical advice in patient record during regular hours of operation	3 Screenshot Examples of Patent Record (PHI Blocked)
☐ 1B1	Access outside regular hours (either by the practice or through an agreement with another non-ER facility or clinicians)	1 Example of extended hours (website or after-hours agreement with another facility)
☐ 1B5	Documenting after-hours telephone and electronic clinical advice in patient record	3 Screenshot Examples of Patent Record (PHI Blocked)
☐ 1C4	Two-way communication between patient and practice (through patient portal or secure messaging)	1 Screenshot
☐ 1C5	Electronic request for appointment or refill of prescription (through patient portal or secure messaging)	1 Screenshot
☐ 1C6	Electronic Request for referral or test result (through patient portal or secure messaging)	1 Screenshot

Documenting Complete Patient Information

Instructions: Determine the practice's Electronic Medical Record (EHR) capability for documenting patient information, in addition to the practice's ability to standardize information.

Standard 2A – Patient Information

Factor #	Patient Information	Is there a standard place in EHR for this information?	Does the practice document at least 50% of time?	If not documented, what's the likelihood of beginning to document to meet goal:
2A1	Date of Birth	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2A2	Gender	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2A3	Race	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2A4	Ethnicity	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2A5	Preferred Language	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2A6	Telephone Numbers	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2A7	Email Address	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2A8	Dates of previous clinical visits	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2A9	Legal guardian/health care proxy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2A10	Primary caregiver	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2A11	Presence of advance directives	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2A12	Health Insurance Information	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely

Standard 2B – Clinical Information

Factor #	Patient Information	Is there a standard place in EHR for this information?	Does the practice document at least _____% of time?	If not documented, what's the likelihood of beginning to document to meet goal:
2B1	Up-to-Date Problem List with current and active diagnoses	☐ Yes ☐ No	80% of time: ☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2B2	Allergies including medication allergies and active diagnoses	☐ Yes ☐ No	80% of time: ☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2B3	Blood Pressure with the date of update	☐ Yes ☐ No	50% of time: ☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2B4	Height (only 2 years and older)	☐ Yes ☐ No	50% of time: ☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2B5	Weight (only 2 years and older)	☐ Yes ☐ No	50% of time: ☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2B8	Status of Tobacco Use (13 years and older) (N/A for pediatric practices if all patients are younger than 13 years old)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2B9	List of prescription medications with the date of updates	☐ Yes ☐ No	50% of time: ☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2B6	System calculates and displays BMI (N/A for pediatric practices)	☐ Yes ☐ No	*Screenshot of system capability required only, no report*	
2B7	System plots and displays growth charges (length/height, weight and head circumference (for less than 2 years old) and BMI percentile (for 2-20 years old) (N/A for adult practices)	☐ Yes ☐ No	*Screenshot of system capability required only, no report*	

Standard 2C – Comprehensive Health Assessment

For the following factors, the practice's EHR must have capability to collect this information, or the practice must have a manual process (typically paper system) of collecting this information.

- NCQA requires either screenshots of EHR capability for each factor or a documented process describing how this information is collected within the practice.

Factor #	Patient Information	EHR Function?	Does the practice document manually?	If not documented, what's the likelihood of beginning to document?
2C1	Documentation of age – and – gender – appropriate immunizations and screenings	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2C2	Family/social/cultural characteristics	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2C3	Patient communication needs	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2C4	Medical history of patient and family	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2C5	Advance care planning	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2C6	Behaviors affecting health	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2C7	Patient and family mental health/substance abuse, including maternal depression	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2C8	Developmental screening using standardized tool (N/A for adult-only practices)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely
2C9	Depression screening for adults and adolescents using a standardized tool.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Likely ☐ Somewhat Likely ☐ Not Likely

Documenting Complete Patient Information (2A, 2B, 2C)

- Work plan for Standard 2A, 2B & 2C

Preparation Work

1. Pre-assessment – Determine Electronic Medical Record (EHR) capability and practice's capability for documenting information and ability to change workflow, if needed

Standard 2 Assessment.docx

Work Plan for Standard 2A & 2B

Practice Implementation

1. Report Abstraction
   - ☐ Identify person(s) in practice who can pull information from the EHR for Patient Information and Clinical Information:

     Contact: _____

Tip: Many of the factors in 2A & 2B overlap with Meaningful Use Stage 1 Reporting Requirements. Practices can submit MU reports for applicable factors.

The following fields from the EHR require reporting for PCMH Documentation:

Patient Information – Element 2A

- ☐ (2A1) Date of Birth
- ☐ (2A2) Gender
- ☐ (2A3) Race
- ☐ (2A4) Ethnicity
- ☐ (2A5) Preferred Language
- ☐ (2A6) Telephone Numbers
- ☐ (2A7) Email Address
- ☐ (2A8) Dates of previous clinical visits
- ☐ (2A9) Legal guardian/health care proxy
- ☐ (2A10) Primary caregiver
- ☐ (2A11) Presence of advance directives
- ☐ (2A12) Health Insurance Information

Clinical Information – Element 2B

- ☐ (2B1) Up-to-Date Problem List with current and active diagnoses (recorded 80% of time)
- ☐ (2B2) Allergies including medication allergies and active diagnoses (recorded 80% of time)
- ☐ (2B3) Blood Pressure with the date of update (50%)
- ☐ (2B4) Height (only 2 years and older) (50%)
- ☐ (2B5) Weight (only 2 years and older) (50%)
- ☐ (2B8) Status of Tobacco Use (13 years and older) (N/A for pediatric practices if all patients are younger than 13 years old) (50%)
- ☐ (2B9) List of prescription medications with the date of updates (recorded 80% of time)

Notes:

1. *Reporting Time Period = Recent 3 Month period*
2. *Each record of information must be recorded in EHR at least 50% of the time for Patient Information – Element 2A. For Element 2B – Clinical Information, check percentage in parenthesis for requirements.*

2. Analyze information to determine practice benchmark
   - Analyze raw information from report to determine where the practice stands on documenting each data element from above

     Person: _____

   - % Report = # Data Elements with Correct Information / Total # Data Elements (including blanks)

     Time criteria = Recent 3 month period

3. Gap-Analysis - Based on percentage report, identify fields the practice can focus on documenting in order to get desired points.

Patient Information – Element 2A

Possible Points: 3
9-12 Factors = 3 Points 7-8 Factors = 2.25 Points 5-6 Factors = 1.5 Points 3-4 Factors = .75 Point

Clinical Information – Element 2B

Possible Points: 4
9 Factors = 4 Points 7-8 Factors = 3 points 5-6 Factors = 2 Points 3-4 Factors = 1 Point

Note: Total possible points includes 2 factors (2B6 & 2B7) that require different screenshots and do not need to be represented in this particular report.

4. Conduct PDSA Cycle Tests improve benchmark percentages for missing data fields
   - ☐ Use the PDSA Poster or form (right) to document tests of improvement for each measure
   - ☐ Use the Improvement Cycle Evaluation Tool (I-CET) form (right) to track and documents all tests of improvement for the missing data fields identified above.

PDSA Worksheet.pdf

ICET.word.template.docx

- Approximately One Month Later -

5. Spot-Audits - Reassess the practices documentation for charting accuracy of factors listed above

- Approximately THREE Months Later -

6. Pull final report for submission
   - Final report to NCQA must be a recent 3-month period.

Work Plan for Standard 2C

1. Based on the pre-assessment, determine if your practice has EHR capability to capture the factors listed below.
   - ☐ If the practice does not have EHR capabilities to capture these factors, these factors should be integrated into the practice's current process.

Comprehensive Health Assessment (2C)

- ☐ Documentation of age – and – gender – appropriate immunizations and screenings (2C1)
- ☐ Family/social/cultural characteristics (2C2)
- ☐ Patient communication needs (2C3)
- ☐ Medical history of patient and family (2C4)
- ☐ Advance care planning (2C5)
- ☐ Behaviors affecting health (2C6)
- ☐ Patient and family mental health/substance abuse, including maternal depression (2C7)
- ☐ Developmental screening using standardized tool (N/A for adult-only practices) (2C8)
- ☐ Depression screening for adults and adolescents using a standardized tool (2C9)

2. Determine person who will pull the documentation required for this element

   ☐ Person: _____

Tip: If the EHR System has capability to capture these elements, a screenshot of these features can be submitted to NCQA.

Use the naming tip sheet tool (right) for examples on naming conventions.

Also, minimize the amount of screenshots by showing multiple factors per screenshot, if possible.

PCMH Naming Conventions.docx

EHR Capability	Manual System (Paper) Process
➢ *Screenshot(s) should be a completed (de-identified) patient assessment for each factor.*	➢ *If the practice uses a manual system, map out the process showing how the information is consistently collected.*

3. Start to pull and organize screenshots or revise workflow processes to capture listed information above.

Population Management (2D)

- Work plan for Standard 2D – Population Management

Preparation Work

2. Pre-assessment – Determine Electronic Medical Record (EHR) capability for generating lists of patients for the criteria below.

3. Training and Assigning Team Members for Population Management (1G6)

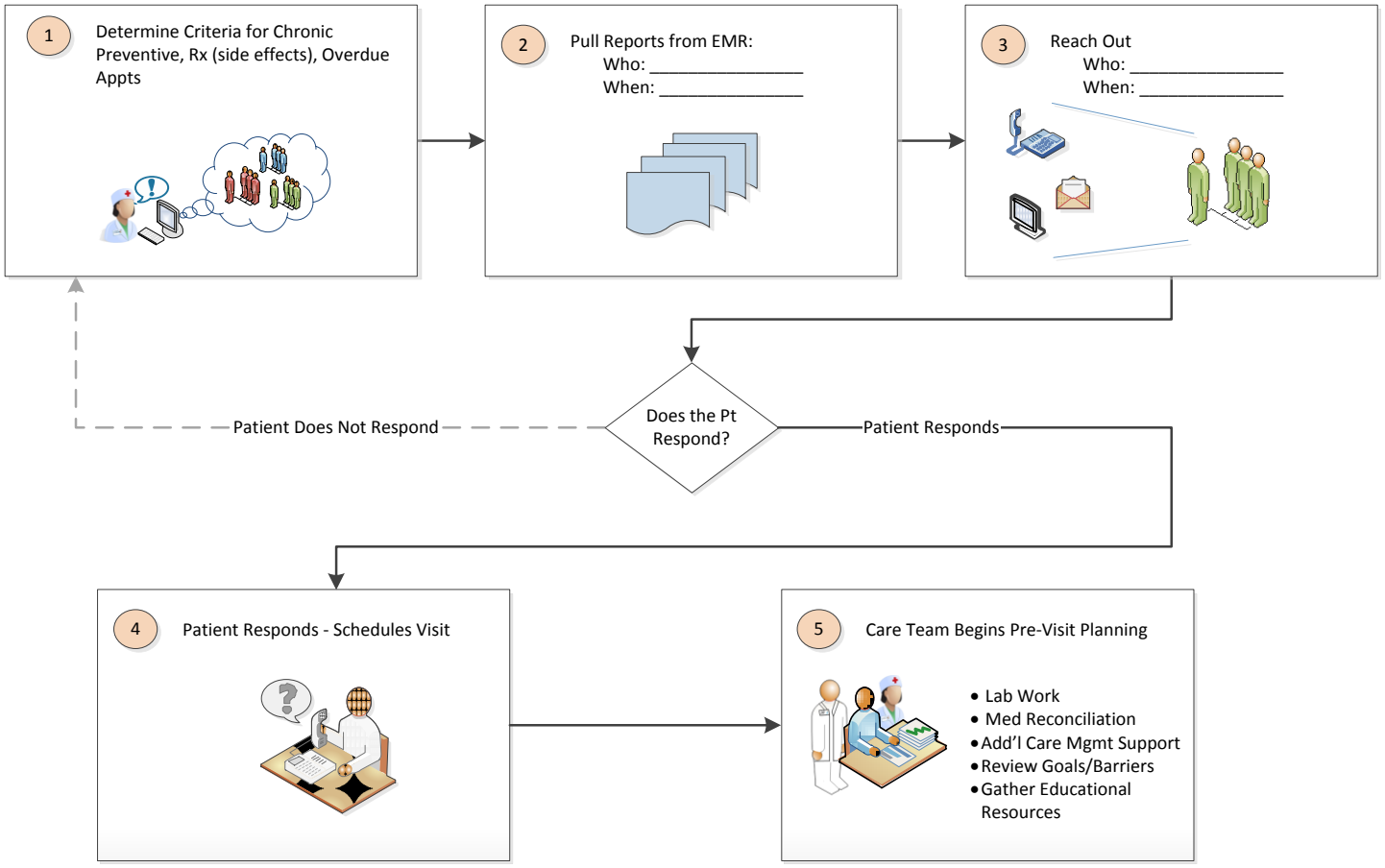
4. As a team, determine the preventive, chronic, and specific medication criteria the practice wants use to pull lists of patients:
   - ☐ (2D1) Three Preventive Care Services:
     1. _____
     2. _____
     3. _____
   - ☐ (2D2) Three Chronic Care Measures:
     1. _____
     2. _____
     3. _____
   - ☐ (2D3) Patients not recently seen by practice
   - ☐ (2D4) Specific Medications with potential side effects:
     1. _____
     2. _____

Tip: Use the same preventive and chronic conditions identified for the evidence-based guideline requirement in 3A and measurement requirement for factors 6A1, 6A2.

5. Based on the lists generated above, as a team determine the following:
   - ☐ Who will pull list: _____
   - ☐ Frequency of pulling list (daily, weekly, monthly, quarterly): _____

   - ☐ Who will reach out to patients:_____
   - ☐ When reach out will occur (daily, weekly, monthly, quarterly):_____
   - ☐ Number of patients to reach out to:_____
   - ☐ Determine Method for reaching out:
     - ☐ Patient Portal/Electronic Messaging
     - ☐ Phone (requires phone script)
     - ☐ Letter/Template
     - ☐ Other: _____

Process Implementation



Documentation Requirements

- ☐ Process used to train team members on Population Management (1G6)
- ☐ Example of materials used during training (powerpoint, agenda with topics, etc) (1G6)
- ☐ Report (List) of patients for the criteria identified above. (2D)
- ☐ Example(s) of method used to reach out to patients (2D):
  - ☐ Patient Portal/Electronic Messaging
  - ☐ Phone (requires phone script)
  - ☐ Letter/Template
  - ☐ Other: _____

Tool Box

- ☐ RACI – Defining Team Roles
- ☐ Population Management Slides
- ☐ Risk Stratification Tool?

Plan and Manage Care (3A, 3B, 3C, 3D, 4A)

Preparation Work

1. Pick (3) Evidence-Based Guidelines based on the practice's patient population with:
   - ☐ (3A1) First Important Condition: _____
   - ☐ (3A2) Second Important Condition: _____
   - ☐ (3A3) Third Important Condition: _____
     - ➢ *Related to unhealthy behaviors, mental health, or substance abuse*
     - ➢ *Conditions should be based on:*
       1. *Common diagnoses and risk factors prevalent in patient population*
       2. *Importance of Care Management and Self-Management Support in reducing complications*
       3. *Availability of Evidence Based Guidelines*
   - ☐ *Determine Evidence Based Guidelines*
   - ☐ *Identify required EHR or Paper-based Workflow Organizers*

2. Establish systematic process for identifying high risk-complex patients
   - ☐ Document Systematic Process for identify high-risk complex patients
     - ➢ High-Risk Patients Defined as:
       1. High-level resource use (many visits, 5+ Meds, treatment or other cost measures)
       2. Frequent visits for urgent or emergent care (two or more visits in last six months)
       3. Frequent Hospitalizations (two or more in the last year)
       4. Multiple co-morbidities, including Mental Health
       5. Non-compliance with prescribed treatment or medications

3. Determine the percentage of high-risk patients
   - ☐ Percentage Report showing number of high-risk patients
   - ☐ Percentage of high-risk patients: _____
     - ➢ % High-Risk Patients = $\frac{\text{\# High-Risk Patients}}{\text{Total \# Patients seen by Practice}}$

4. Assess practice's ability for capturing required info for pre-visit planning, care, self, & medication management
   - ☐ Data Standardization/DotPhrase Integration
   - ☐ Workflow Process Integration

5. PDSA & Rapid Cycle Test Training

Practice Implementation

1. Practice will need to conduct the following for all patients identified with the important conditions:

Care Management

- ☐ (3C1) Pre-Visit Planning
- ☐ (3C2) Treatment Plan & Goal
- ☐ (3C3) Give Patient Written Plan of Care
- ☐ (3C4) Address Barriers to Treatment Plan
- ☐ (3C5) Give After-Visit Summary
- ☐ (3C6) Referral or Assess Need for Self-Mgmt Support
- ☐ (3C7) Follow-up Call/Letter for No Show

Medication Management

- ☐ (3D1 & 3D2) Reconcile Medications
- ☐ (3D3) Give Information on New Meds
- ☐ (3D4) Assess Patient Understanding Current Meds
- ☐ (3D5) Address Barriers to Current Med Adherence
- ☐ (3D6) Document Over-the-Counter Therapies

Self-Management

- ☐ (4A1) Provide Educational Materials for Self-Mgmt
- ☐ (4A2) Use EHR to Identify Patient-Specific Educational Materials
- ☐ (4A3) Develop and Document Self-Mgmt Goal
- ☐ (4A4) Documenting Patient Self-Mgmt Confidence
- ☐ (4A5) Providing Patient with Self-Mgt Tools
- ☐ (4A6) Counseling on Adopting Behaviors

Mock Chart-Review Audit or Report Pull

1. Conduct 48 patient record review of those patients with three important conditions & high-risk complex (12 each)
   - ☐ Use NCQA Workbook to perform Audit
     - ➢ Alternately, if the practice has the capability, a percentage report may be abstracted from Electronic Medical Record

2. Review mock-audit findings & determine need for follow-up plan
   - ☐ Determine next steps based on mock-audit:

Final Audit or Report Pull

1. Conduct Final Audit for Application Submission

Tracking and Coordinating Care (Standard 5 & 3E)

Operational Plan for Standard 5 & 3E (E-Prescribing)

Preparation Work

- ☐ Care Coordination Training (1G4)
- ☐ Assessment of Tracking, Coordinating Care, and E-Prescribing (below)

Process & EHR Assessment

1. Evaluate practice processes for:

Test/Image Tracking & Follow-Up

- ☐ Tracking and flagging test results
- ☐ Tracking and flagging image results
- ☐ Notifying patients of both normal & abnormal results

Care Coordination with Specialists

- ☐ Giving specialists the clinical reason for referral
- ☐ Tracking status of referrals, including timing for obtaining specialist report back
- ☐ Following up to obtain specialist's reports
- ☐ Establishing agreements with specialists in medical record if co-management is needed
- ☐ Asking patients or families about self-referrals and requesting reports from them or the referred clinician

Care Coordination with Facilities

- ☐ Identifying patients in hospital/emergency room(ER)
- ☐ Sharing information with admitting hospital/ER
- ☐ Consistently obtain patient discharge summary from hospital and other facilities
- ☐ Follow-up with patient or family for care within an appropriate period of time from a hospital/ER

Pediatric Practices

- ☐ Follow-up with inpatient facility on newborn hearing and blood spot screening
- ☐ Collaborate with family/patient to develop written care plan for transitions from pediatric to adult care

2. Evaluate EHR System functionality for ability to:

- ☐ Electronically communicate with labs to order tests and retrieve results
- ☐ Electronically communicate with facilities to order and retrieve imaging results
- ☐ Electronically incorporate at least 40% of all clinical lab test results into structured fields within the EHR
- ☐ Electronically incorporate image test results into EHR
- ☐ Capability to exchange key clinical information between other clinicians
- ☐ Capability to exchange key clinical information between other facilities
- ☐ Provide an electronic summary of care record for referrals
- ☐ Provide an electronic summary of care record for transitions of care
- ☐ Generate and transmit eligible prescriptions to pharmacies (required to do at least 40% of time, but ideally 75%)
- ☐ Enter med orders into patient records for those who have 1 medication on their medication list (30% requirement)
- ☐ Perform patient-specific checks for drug to drug and drug to allergy interactions
- ☐ System alerts prescriber to generic alternatives
- ☐ System alerts prescribers to medications with a formulary status

Standard 5 - Critical Path Scoring Assessment

Tip: *Not all factors in Standard 5 have to be completed to gain full points.*

1. Determine which factors the practice can obtain easily without pulling percentage reports or utilizing Meaningful Use Reports

Tip: *5A1 and 5A2 can be done using a manual paper system.*

☐ Assess the capabilities of the electronic medical record and determine the critical path for obtaining the maximum amount of points. Use the checklist below.

- ***Note**: Checklist below does not represent all factors. If additional scoring factors are needed see next section for 5A9, 5B7, 5C8, Meaningful Use Reports)*

Test Tracking and Follow-Up			
Factor	Description	Example	Documented Process
☐ 5A1	Tracks lab tests until results are available, flagging and following up on overdue results **(Critical Factor)**	☐ Screenshot (Log with 1 week info)	☐ Process Description
☐ 5A2	Tracks imaging rests until results are available, flagging and following up on overdue results **(Critical Factor)**	☐ Screenshot (Log with 1 week info)	☐ Process Description
☐ 5A3	Flags abnormal lab results, bringing them to the attention of the clinician	☐ Screenshot (Log with 1 week info)	☐ Process Description
☐ 5A4	Flags abnormal image results, bringing them to the attention of the clinician	☐ Screenshot (Log with 1 week info)	☐ Process Description
☐ 5A5	Notifies patients/families of normal and abnormal lab and imaging test results	☐ Screenshot (Log with 1 week info)	☐ Process Description
☐ 5A6	Follows up with inpatient facilitates on newborn hearing and blood-spot screening (N/A for Adult-only Practices)	☐ Screenshot (Log with 1 week info)	☐ Process Description
☐ 5A7	Electronically communicates with labs to order tests and retrieve results	☐ Screenshot	☐ Process Description
☐ 5A8	Electronically communicates with facilities to order and retrieve imaging results	☐ Screenshot	☐ Process Description
☐ 5A10	Electronically incorporates imaging test results into medical records	☐ Screenshot	☐ Process Description
8 -9 Factors Completed = 6 Points (maximum number of points)			

Referral Tracking and Follow-Up			
Factor	Description	Example	Documented Process
☐ 5B1	Giving the consultant or specialist the clinical reason for the referral and pertinent clinical information	☐ Log (Log with 1 week info)	*No Process Description Needed*
☐ 5B2	Tracking the status of referrals, including required timing for receiving a specialist's report	☐ Log (Log with 1 month info)	*No Process Needed* ***Use this log for 4B2 requirement***
☐ 5B3	Following up to obtain a specialists report	☐ Log (Log with 1 week info)	*No Process Description Needed*
☐ 5B4	Establishing and documenting agreements with specialists in the medical record if co-management is needed	☐ 3 Examples	☐ Process Description
☐ 5B5	Asking patients/families about self-referrals and requesting reports from clinicians	☐ 3 Examples	☐ Process Description
☐ 5B6	Demonstrating the capability for electronic exchange of key clinical information (ex: problem list, medication list, allergies diagnostic test results, etc.) between clinicians	☐ 1 Example (Screenshot)	*No Process Description Needed*
5-6 Factors Completed = 6 Points (maximum number of points)			

Continued on Next Page

Test Tracking and Follow-Up			
Factor	Description	Example	Documented Process
☐ 5C1	Demonstrates its process for identifying patients with a hospital admission and patients with an emergency department visit	☐ Log or Screenshot	☐ Process Description
☐ 5C2	Demonstrates its process for sharing clinical information with admitting hospitals and emergency departments	☐ 3 Screenshot Examples	☐ Process Description
☐ 5C3	Demonstrates its process for consistently obtaining patient discharge summaries from the hospital and other facilities	☐ 3 Screenshot Examples	☐ Process Description
☐ 5C4	Demonstrates its process for contacting patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit	☐ Example (1 Screenshot) or Log with 1 week info)	☐ Process Description
☐ 5C5	Demonstrating its process for exchanging patient information with the hospital during a patient's hospitalization	☐ 1 Screenshot	☐ Process Description
☐ 5C6	Collaborates with the patient/family to develop a written care plan for patients transitioning from pediatric care to adult care (N/A for adult-only or family medicine practices)	☐ Example (Copy of Plan)	*No Process Description Needed*
☐ 5C7	Demonstrates the capability for electronic exchange of key clinical information with facilities	☐ 1 Screenshot	*No Process Description Needed*
5-7 Factors Completed = 6 Points (maximum number of points)			

2. Based on checked items above, begin to gather documentation for each factor.
   - Be sure to explicitly describe and call out clearly how each screenshot/example matches the PCMH Factor Description.

- Next Section Continued on Next Page-

Standard 5 - Percentage/Meaningful Use Reports

This section applies to the percentage report requirement for factors 5A9, 5B7, 5C8, which are also Meaningful Use Reports

The following factors require a percentage report of a minimum of three months of information. Documentation for these items can be Meaningful Use reports. However, the practice did not attest for Meaningful Use, and want to aim for these points, the practice will have to ensure the three months of data meet the required threshold.

7. Report Abstraction

   ☐ Identify person(s) in practice who can pull information from the EHR for Patient Information and Clinical Information:

   Contact: _____

8. Analyze information to determine practice benchmark
   ☐ Analyze raw information from report to determine where the practice stands on documenting each data element from above

The following reports from the EHR are required for PCMH Documentation:

Percentage Reports for 5A9, 5B7, 5C8

☐ **(5A9)** Electronically incorporate at least 40% of all clinical lab tests results in structured fiends within the electronic medical record

➢ % Report = $\frac{\text{\# of lab tests with a positive or negative affirmation (or as number) in structured field}}{\text{\# of lab tests with a positive or negative affirmation (or as number)}}$

Time criteria = Recent 3 month period

☐ **(5B7)** Provide electronic summary of care record for more than 50% of patients

➢ % Report =

Time criteria = Recent 3 month period

☐ **(5C8)** Provide electronic of care record to other care facilities for more than 50% of transitions of care

➢ % Report =

Time criteria = Recent 3 month period

Element 3D – E-Prescribing System

Screenshots:

☐ Assess the capabilities of the electronic prescribing system

➢ ***Note**: Checklist below does not represent all factors. See next section for required percentage reports.*

Element 3D - Use of E-Prescribing System		
Factor	Description	Documentation
☐ 3E4	Perform patient-specific checks for drug-drug and drug-allergy	☐ 1 Screenshot
☐ 3E5	System alerts prescribers to generic alternatives	☐ 1 Screenshot
☐ 3E6	System alerts prescribers to formulary status	☐ 1 Screenshot

Percentage Reports:

The following factors require a percentage report of a minimum of three months of information. Documentation for these items can be Meaningful Use reports. However, the practice did not attest for Meaningful Use, and want to aim for these points, the practice will have to ensure the three months of data meet the required threshold.

1. Report Abstraction

   ☐ Identify person(s) in practice who can pull information from the EHR for Patient Information and Clinical Information:

   Contact: _____

2. Analyze information to determine practice benchmark

   ☐ Analyze raw information from report to determine where the practice stands on documenting each data element from above

   The following reports from the EHR are required for PCMH Documentation:

Percentage Reports for 3E1, 3E2, 3E3

☐ **(3E1)** Generate and transmit at least 40% of eligible prescriptions to pharmacies

➢ % Report = $\frac{\text{\#of eligible prescriptions generated \textbf{and} transmitted with the practice's e-prescribing system}}{\text{\# of eligible prescriptions written by the practice}}$

Time criteria = Recent 3 month period

☐ **(3E2)** Generates at least 75% of eligible prescriptions **(Critical Factor)**

➢ % Report = $\frac{\text{\# of eligible prescriptions generated by the practice using the practice's e-prescribing system}}{\text{\# of eligible prescriptions written by the practice}}$

Time criteria = Recent 3 month period

☐ **(3E3)** Enters electronic medication orders into medical record for more than 30% of patients with at least 1 medication on their mediation list

➢ % Report = $\frac{\text{\# of patients in denominator with at least 1 med entered directly into EMR using integrated e-prescribing system}}{\text{\# of patients in the practice's system with at least one medication on their med list}}$

Time criteria = Recent 3 month period

Measure and Improve Performance (Standard 6)

Operational Plan for Standard 6

Preparation Work

1. As a practice, determine measures to track performance:
    - ☐ (6A1) Three Preventive Care Measures:
        1. _____
        2. _____
        3. _____
    - ☐ (6A2) Three Chronic Care Measures:
        1. _____
        2. _____
        3. _____
    - ☐ (6A3) Two Utilization Measures affecting Cost:
        1. _____
        2. _____
    - ☐ (6A4) Stratify data from one or more measures above by race, ethnicity, or by indicators of vulnerable groups that reflect the patient population
        - ☐ Vulnerable Population Characteristic: _____
    - ☐ (6C4) Involve patients or family on quality improvement teams or practice advisory council
        - ☐ Patient/Family Name: _____

2. Determine plan for data collection and analysis
    - ☐ Data Collection
    - ☐ Data Analysis

Performance Measures Implementation

1. Baseline Run Chart Report
   - ☐ Reporting Start Date: _____

2. (6C1) Set goals & act to improve performance on at least three measures from above
   - ☐ Measure 1: _____
   - ☐ Measure 2: _____
   - ☐ Measure 3: _____


PDSA Worksheet.pdf

   - ☐ Conduct PDSA Cycle Tests to act to improve performance
     - ➢ Use the PDSA Poster or form (right) to document tests of improvement for each measure

3. (6C3) Set goals & address 1 disparity in care or service for vulnerable population
   - ☐ Goal: _____

4. (6D1) Track performance on measures over time (monthly dashboards or run-chart reports) at practice level and individual provider level
   - ☐ Time Criteria: _____

5. (6E1 & 6E2) Practice posts performance results by practice and individual clinicians for all staff members
   - ☐ Post Time Criteria (Monthly/Quarterly):_____

6. (6E3) Practice posts performance results by practice for patient or public
   - ☐ Post Time Criteria (Monthly/Quarterly):_____


ICET.word.template.docx

7. (6D2) Assess the effect of the actions took from PDSA Tests
   - ☐ Use the Improvement Cycle Evaluation Tool (I-CET) form (right) to track and documents all tests of improvement for the three measures identified above.

8. (6D3 & 6D4) Achieve Performance on Two Measures
   - ☐ Improved Performance Measure 1: _____
   - ☐ Improved Performance Measure 2: _____

Reporting Data Externally (6F)

Check the following that apply to the practice. Transmission reports (screenshot confirming information was transmitted) will be required for documentation.

- ☐ (6F1) Ambulatory Clinical Quality Measures to CMS or State (electronic reporting required in 2012, based on quality measures for Meaningful Use)

- ☐ (6F2) Ambulatory Clinical Quality Measures to other external entities (such as HRSA's UDS measures)
  - ☐ Other: _____
    - ➢ Note: data must be transmitted electronically and not manually abstracted

- ☐ (6F3) Data to immunization registries
  - ☐ N/A if communities public health organizations do not have the means to receive the data electronically

- ☐ (6F4) Data to syndromic surveillance data to public health agencies
  - ☐ N/A if communities public health organizations do not have the means to receive the data electronically

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Patient Satisfaction Implementation (6B)