Patient-Centered Medical Home Training

Version 9 guidelines

Humana
Healthy Horizons®
in Florida

Humana Healthy Horizons in Florida is a Medicaid product of Humana Medical Plan, Inc.
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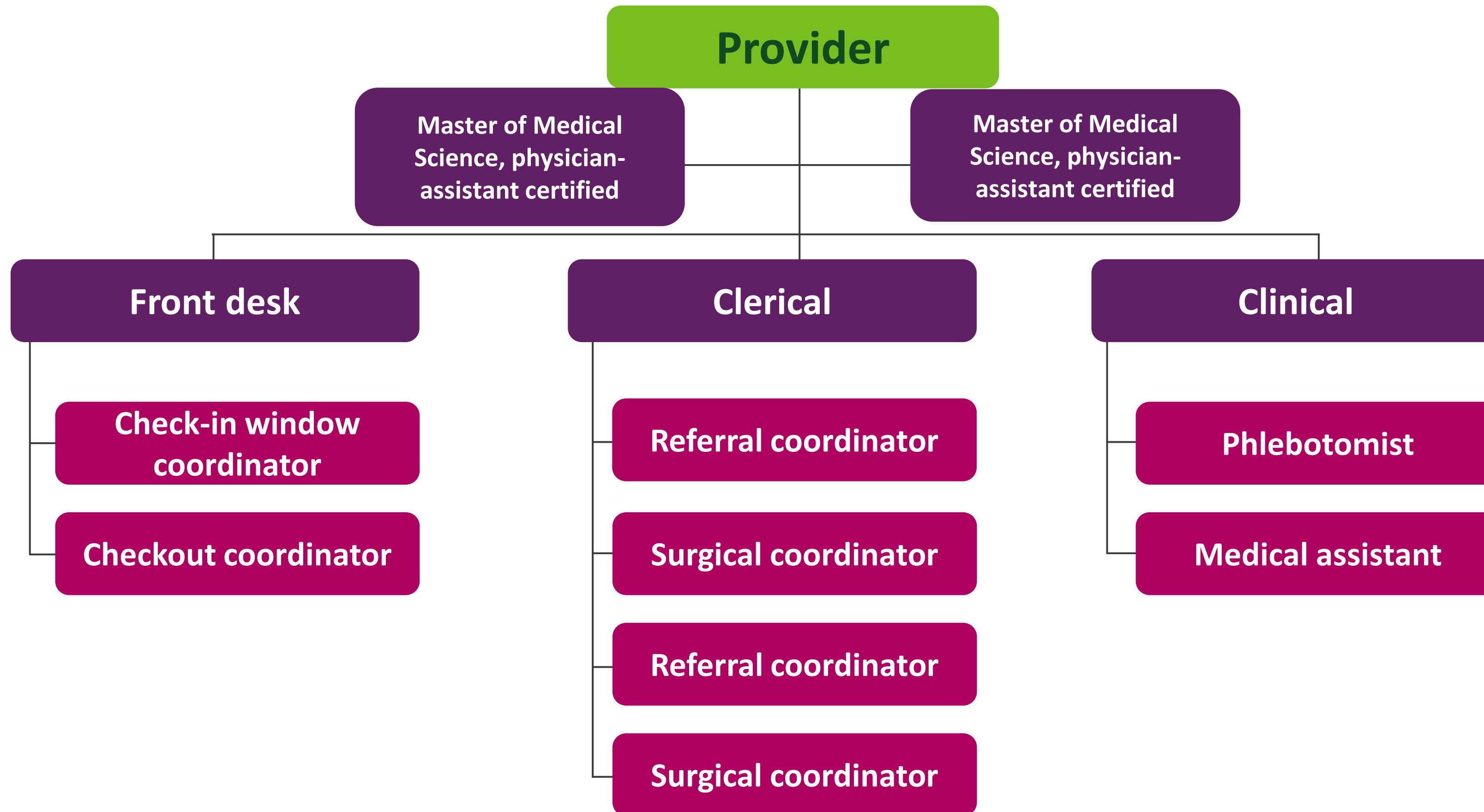
Team-based care and practice organization (TC)

TC 01	Core	Designates a clinician lead of the medical home and a staff person to manage the person-centered medical home (PCMH) transformation and medical home activities
TC 02	Core	Defines practice organizational structure and staff responsibilities/skills to support key PCMH functions
TC 03	1 credit	Involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges)

TC 02 example: Structure and staff responsibilities



TC 02 example: Care team responsibilities

Care coordination		Population management		Self-management
Transitions coordinator Receptionist/medical assistant (MA)	**Diagnostics coordinator** Medical assistant	**Outreach/recall** Receptionist/medical assistant (MA)	**Care management** Provider, doctor of osteopathy (D.O.), nurse practitioner (NP)	**Patient education** Medical assistant, provider, doctor of osteopathy (D.O.), nurse practitioner (NP)
• Obtain previous medical record(s). • Get Heath Insurance Portability and Accountability Act of 1996 (HIPAA) release signed and fax it to previous providers. • Check patients in/out. • Obtain referrals/authorizations. • Communicate with insurance companies regarding eligibility, benefits and authorizations. • Schedule urgent specialist appointments.	• Perform in-house labs as instructed. • Take vital signs and inform provider if they are abnormal. • Perform electrocardiograms and pulmonary function tests (spirometry).	• Recall patients to schedule well-child visits and complete immunizations. • Perform other patient recalls as instructed by provider. • Contact patients for normal and abnormal lab results.	• Review medical record(s) from previous provider. • Review accuracy of information entered in electronic medical records by MAs and receptionists. • Take history. • Perform exams. • Order diagnostic tests.	• Evaluate health literacy of patients and families regularly. • Provide verbal and written information on healthy lifestyles and normal child development and milestones. • Provide information on medications and other therapeutic modalities.

Team-based care and practice organization (cont'd)

TC 04	2 credits	Patients, families or caregivers are involved in the practice's governance structure or on stakeholder committees.
TC 05	2 credits	The practice uses ~~a~~ certified electronic health record technology (CEHRT).

Team-based care and practice organization (cont'd)

TC 06	Core	Has regular patient care team meetings or a structured communication process focused on individual patient care
TC 07	Core	Involves care team staff in the practice's performance evaluation and quality improvement activities
TC 08	2 credits	Has at least 1 care manager qualified to identify and coordinate behavioral health needs

TC 06 example: Policy

Subject: Daily huddles

Purpose: Each day, the practice conducts a structured meeting (huddle) with the entire care team to anticipate and plan actions based on patient needs and available resources.

Responsibility: The entire team must attend meetings and ensure that outcomes or decisions made during the meetings are carried out. It is the responsibility of the site manager to ensure that huddles are conducted daily and appropriate documentation is completed.

Procedure: The care team meets at the same time daily to efficiently and effectively plan the day and discuss known or potential patient needs. The team:

- Reviews the daily schedule
- Focuses on those patients with known chronic illnesses
- Monitors the need for health maintenance and/or preventive care services
- Arranges for any needed special services
- Provides any follow-up discussion related to care provided the previous day
- Discusses specific needs for the team's daily workflow, including staff flexibility, special patient needs, sick calls, contingency plans and proactive next-day planning
- Ensures meeting minutes are documented on a huddle form and kept in a binder for a minimum of 3 months

Team-based care and practice organization (cont'd)

TC 09	Core	Has a process for informing patients, families or caregivers about the role of the medical home and provides patients/families/caregivers materials that contain the information

Knowing and managing your patients (KM)

KM 01	Core	Documents an up-to-date patient problem list with current and active diagnoses
KM 02	Core	A comprehensive health assessment includes: • Medical history of patient and family • Mental health or substance use history of patient and family • Family, social and cultural characteristics • Communication needs • Behaviors affecting health • Social functioning • Social determinants of health • Developmental screening using a standardized tool • Advance care planning (excluding pediatric practices)

Knowing and managing your patients (cont'd)

KM 03	Core	Conducts depression screenings for adults and adolescents using a standardized tool
KM 04	1 credit	Conducts 2 or more behavioral health screenings and/or assessments using a standardized tool: • Anxiety • Alcohol use disorder • Substance use disorder • Pediatric behavioral health screening • Post-traumatic stress disorder • Attention deficit/hyperactivity disorder • Postpartum depression

KM 04 example: Alcohol use test

Alcohol Use Disorders Identification Test (interview version)

Sample questions

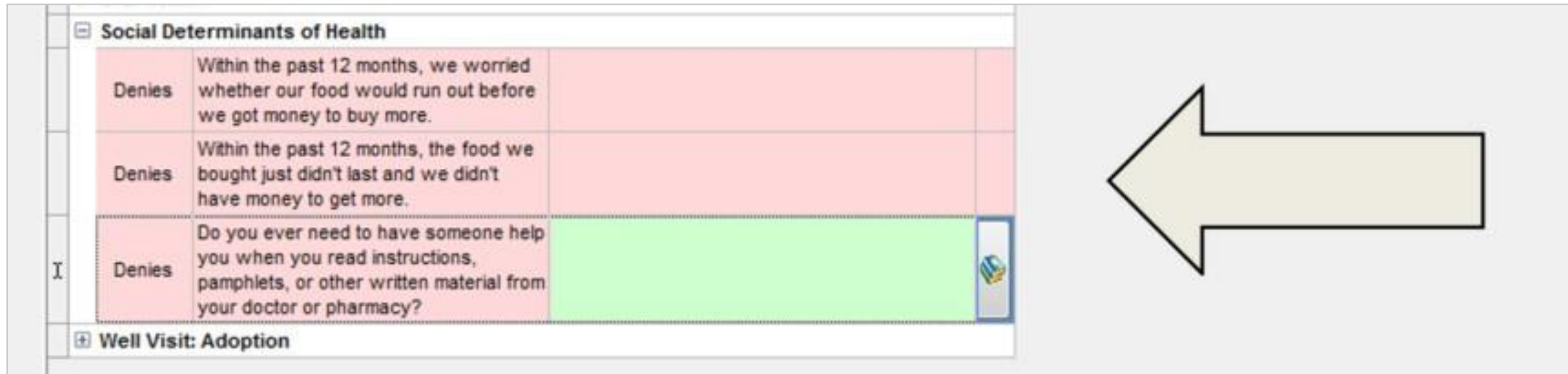
1. How often do you have a drink containing alcohol?
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
3. How often do you have 6 or more drinks on 1 occasion?
4. How often during the last year have you found that you were not able to stop drinking once you started?
5. How often during the last year have you failed to do what was normally expected from you because of drinking?

Reference
Thomas F. Babor et al., *Audit, the Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care*, 2nd ed. (Geneva, Switzerland: World Health Organization, Dept. of Mental Health and Substance Dependence, 2001).

Knowing and managing your patients (cont'd)

KM 05	1 credit	Assesses oral health needs and provides necessary care visit services based on evidence-based guidelines or coordination with oral health partners
KM 06	1 credit	Identifies predominant conditions and health concerns of the patient population
KM 07	2 credits	Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data
KM 08	1 credit	Evaluates patient population demographics, communication preferences and health literacy to tailor development and distribution of patient materials

KM 07 example: Social determinants



Measure Group : KM07

		Assess social determinants of health	190	5,141	0	.00%	3.70%

Knowing and managing your patients (cont'd)

KM 09	Core	Assesses the diversity of its population: • Race • Ethnicity • Gender identity • Sexual orientation • One other aspect of diversity
KM 10	Core	Assesses the language needs of its population
KM 11	1 credit	Identifies and addresses population-level needs based on the diversity of the practice and the community (demonstrate at least 2): • Targets population health management on disparities in care • Educates practice staff on health literacy • Educates practice staff on cultural competence

KM 09 example: Diversity assessment

Dates: Jan. 1, 2019 to Oct. 31, 2019

Race			
Black	White	Hispanic	Refused to report
1.2%	98.1%	0.5%	0.2%

Ethnicity			
Hispanic	Non-Hispanic	Refused to report	
1.1%	98.1%	0.8%	

Low economic status by ZIP code
27.78%

Knowing and managing your patients (cont’d)

KM 12	Core	Proactively and routinely identifies populations of patients and reminds them or their families/caregivers about needed services (must report from at least 3 categories) • Preventive care services • Immunizations • Chronic or acute care services • Patients not recently seen by the practice
KM 13	2 credits	Demonstrates excellence in a benchmarked/performance-based recognition program assessed using evidence-based care guidelines

KM 12 example: Proactive communication

Dear parent or guardian of _________,

Our records indicate your child has not received the recommended tests or screenings marked below. They are available at no cost to you with your current Medicaid plan.

Please call our office at [XXX-XXX-XXXX] to schedule an appointment or if you have questions. Our office hours are Monday through Friday, 8:30 a.m. to 5 p.m., and Saturday, 9 a.m. to 2 p.m.

Prevention and screenings

___ Yearly well-care visit

___ Blood lead screening at 12 months and 24 months

Sincerely,

Dr. John Brown

Knowing and managing your patients (cont'd)

KM 14	Core	Reviews and reconciles medications for more than 80% of patients received from care transitions
KM 15	Core	Maintains an up-to-date medication list for more than 80% of patients
KM 16	1 credit	Assesses understanding and provides education, as needed, on new prescriptions for more than 50% of patients/families or caregivers
KM 17	1 credit	Assesses and addresses patient response to medications and barriers to adherence for more than 50% of patients and dates the assessment

Knowing and managing your patients (cont'd)

KM 18	1 credit	Reviews a controlled substance database when prescribing relevant medications
KM 19	2 credits	Systematically obtains prescription claims data to assess and address medication adherence

Knowing and managing your patients (cont'd)

KM 20	Core	Implements clinical decision support following evidence-based guidelines demonstrating at least 4 of the following criteria: • Mental health condition • Substance use disorder • A chronic condition • An acute condition • A condition related to unhealthy behaviors • Well-child or adult care • Overuse/appropriateness issues

KM 20 example

SCREENSHOT of TEMPLATE where tool information entered into EHR.

m: 2016 ADULT Encounter Note

Auto Neg | Uncheck All

A Immunizations & Refusals | MA Check In | MA Screening | MA & PCP: Screenings | PCP: HPI & Soc/Fam/PMH/PSH | PCP: ROS | PCP: PE | PCP: Asthr

- Y COLECTOMY
- Y Mastectomy BILATERAL
- Y Mastectomy RIGHT Breast
- Y Mastectomy LEFT Breast

FREE TEXT DATE OF SURGERY, LOCATION, & RESULTS OF PATHOLOGY

IMPORTANT SCREENINGS

- Y Hx of Fecal Occult Blood
- Y Hx of Complete Colonoscopy
- Y Hx of Cervical Pap Smear
- Y Hx of Mammogram Screening

Enter Date Completed in Box, then FREE TEXT LOCATION, RESULTS, AND DATE NEXT SCREENING IS DUE

PHQ9 Total Score (MA SHOULD FREE TEXT RESULT)

PCP NEEDS TO SELECT FOLLOW-UP PLAN BELOW BASED ON SCORE

IF PHQ-9 IS 15 OR GREATER, ADDRESS THE FOLLOWING THREE REQUIREMENTS

- Y Positive for Mod-Sev Depression (PHQ9 = 15+)
- Y Referred to BHS

GO TO "Orders & Charges" to INITIATE TASK labelled PHQ-9 = 15+

IF PHQ-9 IS 14 OR BELOW CLICK THE FOLLOWING

- Y Negative for Mod-Sev Depression (PHQ9 < 15)

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Knowing and managing your patients (cont'd)

KM 21	1 credit	Uses information on the population served by the practice to prioritize needed community resources
KM 22	1 credit	Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs
KM 23	1 credit	Provides oral health education resources to patients

Knowing and managing your patients (cont'd)

KM 24	1 credit	Adopts shared decision-making aids for preference-sensitive conditions
KM 25	1 credit	Engages with schools or intervention agencies in the community

Knowing and managing your patients (cont’d)

KM 26	1 credit	Routinely maintains a current community resource list based on the needs identified in KM 21
KM 27	1 credit	Assesses the usefulness of identified community support resources
KM 28	2 credits	Conducts regular “case conferences” involving outside parties (e.g., community supports, specialists)
KM 29	1 credit	Incorporates an opioid treatment agreement into the medical record for patients prescribed Schedule II opioid prescriptions

Patient-centered access and continuity (AC)

AC 01	Core	Assesses the access needs and preferences of the patient population
AC 02	Core	Provides same-day appointments for routine and urgent care to meet identified patient needs
AC 03	Core	Provides routine and urgent appointments outside regular business hours to meet identified patient needs
AC 04	Core	Provides timely clinical advice by telephone

AC 04 example: Clinical advice telephone response log

Patient name	Doctor	Date called	Time called	Urgent Y/N	Date responded	Time responded
Jane Doe	Dr. John Smith	04/11/2017	2:48 p.m.	Y	04/11/2017	3:04 p.m.
Jim Joe	Dr. Mark Smith	04/13/2017	10:55 a.m.	N	04/13/2017	11:25 a.m.
Lisa Doe	Dr. John Smith	04/14/2017	10:00 a.m.	N	04/14/2017	11:30 a.m.
Elizabeth Doe	Dr. Mark Smith	04/15/2017	7:30 p.m.	N	04/15/2017	8:00 p.m.
Sam Doe	Dr. John Smith	04/17/2017	7:26 a.m.	N	04/17/2017	8:00 a.m.

Patient-centered access and continuity (cont'd)

AC 05	Core	Documents clinical advice in patient records and confirms clinical advice and care provided after hours does not conflict with the patient medical records
AC 06	1 credit	Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms
AC 07	1 credit	Has a secure electronic system for patients to request appointments, prescription refills, referrals and test results

Patient-centered access and continuity (cont'd)

AC 08	1 credit	Has a secure electronic system for two-way communication to provide timely clinical advice
AC 09	1 credit	Uses information about the population served by the practice to assess equity of access that considers health disparities

Patient-centered access and continuity (cont'd)

AC 10	Core	Helps patients, families and/or caregivers select or change a personal clinician
AC 11	Core	Sets goals and monitors the percentage of patient visits with the selected clinician or team
AC 12	2 credits	Provides continuity of medical record information for care and advice when the office is closed
AC 13	1 credit	Reviews and actively manages panel size
AC 14	1 credit	Reviews and reconciles panels based on health plan or other outside patient assignments

Care management and support (CM)

CM 01	Core	Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (must include at least 3): • Behavioral health conditions • High cost/high utilization • Poorly controlled or complex conditions • Social determinants of health • Referrals by outside organizations (e.g., insurers, health system, accountable care organizations, practice staff, patients, families and or/caregivers)

Care management and support (CM)

CM 02	Core	Monitors the percentage of the total patient population identified through its process and criteria
CM 03	2 credits	Applies a comprehensive risk-stratification process for the entire patient panel to appropriately identify and direct resources

Care management and support (cont'd)

CM 04	Core	Establishes a person-centered care plan for patients identified for care management
CM 05	Core	Provides a written care plan to patient, family and/or caregiver for at least 75% of patients identified for care management
CM 06	1 credit	Documents patient preferences and functional/lifestyle goals in at least 75% of individual care plans

Care management and support (cont’d)

CM 07	1 credit	Identifies and discusses potential barriers to meeting goals in at least 75% of individual care plans
CM 08	1 credit	Includes a self-management plan in at least 75% of individual care plans
CM 09	1 credit	Provides integration and accessibility of the care plan across all settings of care
CM 10	1 credit	Collects and documents care plan goals using the person-centered outcomes approach in at least 75% of individual care plans
CM 11	1 credit	Monitors and follows up on care plan goals within 180 days for at least 75% of individual care plans

Care coordination and care transitions (CC)

CC 01	Core	The practice systematically manages lab and imaging tests by: • Tracking lab tests until results are available, flagging and following up on overdue results • Tracking imaging tests until results are available, flagging and following up on overdue results • Flagging abnormal lab results, bringing them to the clinician's attention • Flagging abnormal imaging results, bringing them to the clinician's attention • Notifying patients, families and/or caregivers of normal lab and imaging test results • Notifying patients, families and/or caregivers of abnormal lab and imaging test results

CC 01 example: Test result notification

Dear Jane Brown,

We are writing to inform you that your lab work was normal. Please call us at [XXX-XXX-XXXX] if you would like to go over the test results or have additional questions or concerns.

Thank you for allowing us to participate in your care. We look forward to seeing you at your next visit.

Sincerely,

Your care team

Care coordination and care transitions (CC)

CC 02	1 credit	Follows up with the inpatient facility about newborn hearing and blood spot screening
CC 03	2 credits	Uses clinical protocols to determine when imaging and lab tests are necessary

Care coordination and care transitions (cont'd)

CC 04	Core	The practice systematically manages referrals by: • Giving the consultant or specialist the clinical question, required timing and type of referral • Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan • Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports

Care coordination and care transitions (cont'd)

CC 05	2 credits	Uses clinical protocols to determine when a referral to a specialist is necessary
CC 06	1 credit	Identifies the specialist and other specialty types frequently used by the practice
CC 07	2 credits	Considers available performance information on consultants or specialists when making referrals
CC 08	1 credit	Works with nonbehavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care

Care coordination and care transitions (cont'd)

CC 09	2 credits	Works with behavioral healthcare providers who receive frequent practice referrals to set information sharing and patient care expectations
CC 10	2 credits	Integrates behavioral healthcare providers into the care delivery system of the practice site
CC 11	1 credit	Monitors the timeliness and quality of the referral response

Care coordination and care transitions (cont'd)

CC 12	1 credit	Documents co-management arrangements in the patient's medical record
CC 13	2 credits	Engages with patients regarding cost implications of treatment options, provides information about current coverage and makes connections to financial resources as needed

Care coordination and care transitions (cont'd)

CC 14	Core	Systematically identifies patients with unplanned hospital admissions and emergency department visits
CC 15	Core	Shares clinical information with admitting hospitals and emergency departments
CC 16	Core	Contacts patients, families and/or caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit
CC 17	1 credit	Systematically coordinates with acute care settings after office hours through access to current patient information

Care coordination and care transitions (cont'd)

CC 18	1 credit	Exchanges patient information with the hospital during a patient's hospitalization
CC 19	1 credit	Implements a process to consistently obtain patient discharge summaries from the hospital and other facilities
CC 20	1 credit	Collaborates with the patient, family or caregiver to develop or implement a written care plan for complex patients transitioning in or out of the practice (e.g., from pediatric care to adult care)

Care coordination and care transitions (cont'd)

CC 21	3 credits (maximum)	Demonstrates electronic exchange of information with 1 or more external entities, agencies and registries: • Regional health information organization or other health information exchange source that enhances the practice's ability to manage complex patients (1 credit) • Immunization registries or immunization information systems (1 credit) • Summary of care record to another provider or care facility for care transitions (1 credit)

Performance measurement and quality improvement (QI)

QI 01	Core	Monitors at least 5 clinical quality measures across the 4 categories (must monitor at least 1 measure of each type): • Immunization measures • Other preventive care measures • Chronic or acute care clinical measures • Behavioral health measures

Performance measurement and quality improvement (QI)

QI 02	Core	Monitors at least 2 measures of resource stewardship (must monitor at least 1 measure of each type): • Measures related to care coordination • Measures affecting healthcare costs
QI 03	Core	Assesses performance on availability of major appointment types to meet patient needs and preferences for access

Performance measurement and quality improvement (cont’d)

QI 04	Core	Monitors patient experience through: **Quantitative data—**Conducts a survey (using any instrument) to evaluate patient, family and/or caregiver experiences across 3 dimensions, such as: • Access • Communication • Coordination • Whole-person care, self-management support and comprehensiveness **Qualitative data—**Obtains feedback from patients, families and/or caregivers through qualitative means

Performance measurement and quality improvement (cont'd)

QI 05	1 credit	Assesses health disparities using performance data stratified for vulnerable populations (must choose 1 from each section): • Clinical quality • Patient experience
QI 06	1 credit	Uses a standardized, validated patient experience survey tool with available benchmarking data
QI 07	2 credits	Obtains feedback from vulnerable patient groups on their experiences of disparities in care or services

Performance measurement and quality improvement (cont’d)

QI 08	Core	Sets goals and acts to improve upon at least 3 measures across at least 3 of the 4 categories: • Immunization measures • Other preventive care measures • Chronic or acute care clinical measures • Behavioral health measures
QI 09	Core	Sets goals and acts to improve performance on at least 1 measure of resource stewardship: • Measures related to care coordination • Measures affecting healthcare costs

Performance measurement and quality improvement (cont’d)

QI 10	Core	Sets goals and acts to improve availability of major appointment types to meet patient needs and preferences
QI 11	Core	Sets goals and acts to improve performance of at least 1 patient experience measure
QI 12	2 credits	Achieves improved performance of at least 2 performance measures

Performance measurement and quality improvement (cont'd)

QI 13	1 credit	Sets goals and acts to improve performance on at least 1 measure of disparities in care or services
QI 14	2 credits	Achieves improved performance on at least 1 measure of disparities in care or services

Performance measurement and quality improvement (cont'd)

QI 15	Core	Shares clinician-level or practice-level performance results with clinicians and staff for measures it reports
QI 16	1 credit	Shares clinician-level or practice-level performance results publicly or with patients for measures it reports
QI 17	2 credits	Involves patient, family and/or caregiver in quality improvement activities

Performance measurement and quality improvement (cont'd)

QI 18	2 credits	Electronically reports clinical quality measures to an external entity such as Medicare, Medicaid or a health plan
QI 19	2 credits (maximum)	Engages in value-based agreement: • Practice engages in upside risk contract (1 credit) • Practice engages in two-sided risk contract (2 credits)

NCQA website: NCQA

Application: Quality Performance Assessment Support System

Policy clarification support: NCQA sign-in page

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