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CHCANYS PCMH Office Hours
July 21, 2022

Karen Taubert RN, BSN, MBA

NCQA CCE

Senior Consultant

Mindfulness Minute

Box breathing relaxation technique: how to calm feelings of stress or anxiety

https://youtu.be/tEmt1Znux58

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NCQA Annual Renewal 2022

- Attestations around specific criteria have changed
- NO QI WORKSHEET
- Increased data reporting requirements
- Standardized Measures are valued
- Submit/Reporting date versus expiration date
- NEW - minimum performance thresholds
- NEW – corporate credit table
- Audit Process
- NYS attestation

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When do I need to add additional information about the measure performance?

General Content Area: PCMH - Patient Centered Medical Home

Specific Area: Annual Reporting Requirements

When do I need to add additional information about the measure performance?

Practices should submit an explanation when their performance falls below 80% for the following AR criteria:

- AR-AC 1: Timely Clinical Advice by Telephone
- AR-AC 2: Patient Visits with Clinician/Team
- AR-CC 3 (Option): Lab and Imaging Test Tracking (2 rates)
- AR-QI 1: Depression Screening and Follow-Up (if selected)

Practices should submit an explanation when their performance falls below 30% for the following AR criteria:

- AR-CC 4: Referral Tracking.

If the practice does not submit an explanation, NCQA will contact the practice.

PCMH 2017

Print or Share

https://ncqa.secure.force.com/faq/

NCQA Updates

- Potential Updates for 2022 – SOGI, Patient Driven Outcomes (PDO)
- Version 7.1 effective 1/01/2022 - Update data submission for Transforming, Behavioral Health Annual with Distinction and Behavioral Health Annual
- PCMH Standards and Guidelines (Version 7.1) and/or the Distinction in Behavioral Health Integration Annual Reporting Requirements (for reporting year 2022).
- Version 8 Standards released this month, effective 1/1/2023

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19 What Electronic Health Record (EHR) is your practice using? (NYS Only)
Enter your EHR.

Athena

20 Does your current EHR have the ability to create a CCD-A file format ? (NYS Only)
Select one.

- (●) Yes
- ( ) No
- ( ) Don't know

21 Does your practice site currently have a Qualified Entity (QE)/Regional Health Information Organization (RHIO)? (NYS Only)
Select all that apply.The SHIN-NY connects regional networks, or Qualified Entities (QEs), that allow participating healthcare professionals, with patient consent, to quickly access electronic health information and securely exchange data statewide. The network enables providers to access information abo/ut their patients from other connected providers in NYS and to make their information available to support the patient's care in other settings.

- [x] HealtheLink
- [ ] Rochester RHIO
- [ ] HealtheConnections
- [ ] HIXNY
- [ ] Bronx
- [ ] Healthix
- [ ] We do not have a QE/RHIO.

22 Does your practice participate in any transformation initiatives? (NYS Only)
Select all that apply.

- [ ] Comprehensive Primary Care (CPC+)
- [x] Accountable Care Organization (ACO MSSP)
- [x] Federally Qualified Health Center (FQHC) or Community Health Center
- [ ] Other
- [ ] We do not participate in any transformation initiatives.

23 Annual Attestation
By submitting this Attestation, you certify and attest to the best of your knowledge and belief that the Practice continues

- (●) Yes
- ( ) No

NCQA Q-PASS

Welcome, Karen Taubert

/ Adams County Health Center Inc / Programs

Back to dashboard

Program

PCMH: Patient-Centered Medical Home

Patient-Centered Medical Home 2022 Select

PCMH-BH: Distinction in Behavioral Health Integration

Distinction in Behavioral Health Integration 2021 Select

PCMH Audit: Patient-Centered Medical Home Audit

Patient-Centered Medical Home 2022 Audit Select

Appendix 5 – Standard Measures and Reporting Periods

Measure	CMS eCQM #	Measure Steward	PCMH QI Category (Best fit, many measures may fit multiple categories)
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	CMS 136	NCQA	Behavioral
Screening for Depression and Follow-Up Plan	CMS 2	CMS	Behavioral
Closing the Referral Loop	CMS 50	CMS	Care Coordination
Documentation of Current Medications in the Medical Record	CMS 68	CMS	Care Coordination
Controlling High Blood Pressure	CMS 165	NCQA	Chronic or Acute
Diabetes HbA1C Poor Control (>9%)	CMS 122	NCQA	Chronic or Acute
Diabetes Eye Exam	CMS 131	NCQA	Chronic or Acute
Appropriate Testing for Pharyngitis	CMS 146	NCQA	Health Care Costs
Appropriate Treatment for Upper Respiratory Infection (URI)	CMS 154	NCQA	Health Care Costs
Influenza Immunization	CMS 147	NCQA	Immunizations
Pneumococcal Vaccination Status for Older Adults	CMS 127	NCQA	Immunizations
Childhood Immunization Status: Combination 10 (CIS)	CMS 117	NCQA	Immunizations
Cervical Cancer Screening	CMS 124	NCQA	Preventive
Colorectal Cancer Screening	CMS 130	NCQA	Preventive
Breast Cancer Screening	CMS 125	NCQA	Preventive
Body Mass Index Screening and Follow-Up Plan	CMS 69	CMS	Preventive
Tobacco Use: Screening and Cessation Intervention	CMS 138	NCQA	Preventive

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RRWB and Examples – From a Person-Centered View

How can I overcome any barriers? - Como puedo superar cualquier barrera?	Join a community class, group/Unirse a una clase, grupo comunitario;Get a text,e-mail reminder from [redacted] to turn off the tv,video games/Obtener un texto, llamada o E-mail de [redacted] recordando apagar la TV, video juegos. PCMH 4B; 3 - Potential Barriers
Provider Goal - Meta del Provedor	No more that 2 hours of screen time (tv, video games, cell phone) per day./ No mas de 2 horas por dia de tiempo en la pantalla or monitor (TV, video juegos, telefono celular) PCMH 4B; 2 - Treatment Goals
What might stop me from reaching my goals? - Que puede detenerme de alcanzar mis metas?	Limited, no family support/Limitado, No soporte familiar

What might stop me from reaching my goals? - Que puede detenerme de cumplir mis metas?	Time Management challenges/Retos de control del tiempo
By next visit - Para la siguiente visita	1-2 pounds/1-2 Libras
What type of exercise are you willing to do? - Que tipo de ejercicios estas dispuesto(a) a hacer?	Walking/Caminar;Running/Correr PCMH 4B; 1 - Patient Preferences and Goals
How can I overcome any barriers? - Como puedo superar cualquier barrera?	Text or e-mail reminder from THCC to exercise/Recordatorio de ejercicios de parte de THCC por medio de texto, llamada o e-mail.

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CARE PLAN: Diabetes

CM 04: There is no problem list on file for this patient.

CM 04: Needs addressed today: Diabetes Compliance

CM 04: Expected Outcome/Prognosis: good

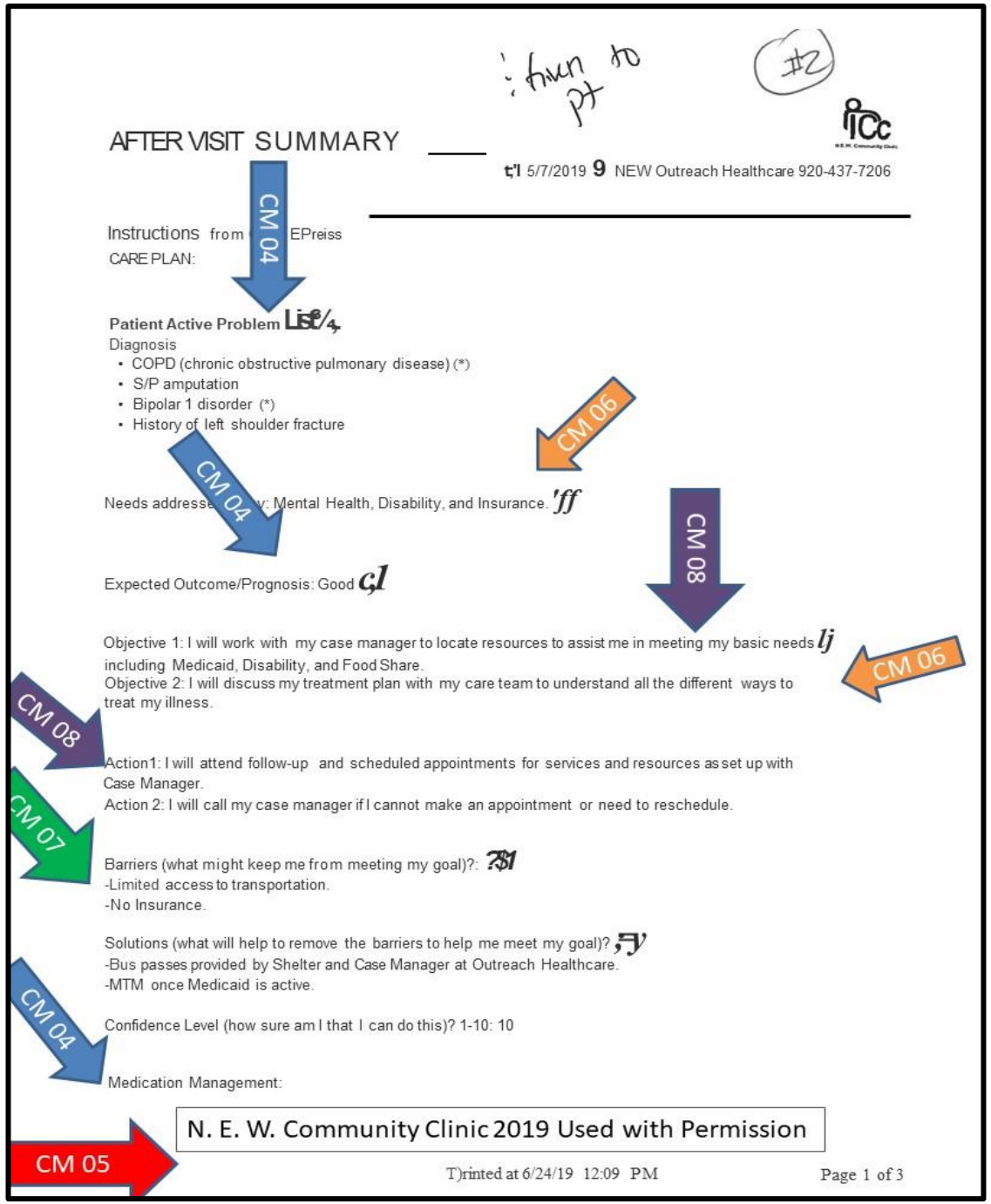
CM 06: Objective: I will work hard to keep my A1C less than 9.

CM 08: Action: I will follow my medication plan. If I have questions about my medications, I will report these to my care team.

CM 07: Barriers (what might keep me from meeting my goal)?: following a healthy diet

Solutions (what will help to remove the barriers to help me meet my goal)? Speak with my case manager and provider, referral to diabetic educator

Confidence Level (how sure am I that I can do this)? 1-10: 8



AFTER VISIT SUMMARY

5/7/2019 9 NEW Outreach Healthcare 920-437-7206

CM 04

Instructions from EPreiss

CARE PLAN:

Patient Active Problem List

Diagnosis

- COPD (chronic obstructive pulmonary disease) (*)
- S/P amputation
- Bipolar 1 disorder (*)
- History of left shoulder fracture

CM 06

CM 04

Needs addressed by: Mental Health, Disability, and Insurance.

CM 08

Expected Outcome/Prognosis: Good

Objective 1: I will work with my case manager to locate resources to assist me in meeting my basic needs including Medicaid, Disability, and Food Share.

Objective 2: I will discuss my treatment plan with my care team to understand all the different ways to treat my illness.

CM 06

CM 08

Action1: I will attend follow-up and scheduled appointments for services and resources as set up with Case Manager.

Action 2: I will call my case manager if I cannot make an appointment or need to reschedule.

CM 07

Barriers (what might keep me from meeting my goal)?:

-Limited access to transportation.

-No Insurance.

Solutions (what will help to remove the barriers to help me meet my goal)?

-Bus passes provided by Shelter and Case Manager at Outreach Healthcare.

-MTM once Medicaid is active.

CM 04

Confidence Level (how sure am I that I can do this)? 1-10: 10

Medication Management:

N. E. W. Community Clinic 2019 Used with Permission

CM 05

Printed at 6/24/19 12:09 PM

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*Are you able to obtain all prescribed medications? Yes

*Are you taking all medications as prescribed? Yes

*Do you know who to contact if you have questions about your medications? Yes

CM 04

Follow-Up visit with Case Management in: As needed.

Follo w- Up visit with Provider in: 1 week.
Appointment with [redacted] 7/6/19 at 8:30am at New Community Shelter .

Care Plan Reviewed / Updated: 5/7/19

Your medications have changed today

See your updated medication list for details.

Pick up these medications at STREU'S LTC PHARMACY - GREEN BAY, WI - 528 N. MON ROE STREET

lisinopril • loratadine • predniSONE

Address: 528 N. MONROE STREET, GREEN BAY WI 54301
Phone: 920-593-2499

Ask your doctor where to pick up these medications

- guaiFENesin (12-hour) 600 mg tablet
- predniSONE 20 mg tablet

CM 06

Today's Visit

You sa[redacted] Tuesday May 7, 2019. The following issue was addressed: Housing or economic circumstance .

What's Next

You currently have no upcoming appointments scheduled.

MyBellinHealth

Our records indicate that you have an active **MyBellinHealth** account.

You can view your health information by going to **www.m ybellin.org**and logging in with your **MyBellinHealth** username and password. If you don't have a **MyBellinHealth** username and password but a parent or guardian has access to your record, the parent or guardian should login with their own **MyBellinHealth** username and password and access your record to view your health info rmati on.

If you have any questions on the **MyBellinHealth** website, please call us toll-free 24/7 at 888-899-9114.

Shared Care Plan – Patient Level

Healthy Lifestyle: Healthy lifestyle choices will help you feel better.
Eat well, increase your physical activity, get enough sleep, practice relaxing. The basics of good health are hard to do when you have little energy. Slowly increasing your activity level through activities you enjoy can help other areas of physical wellbeing, including rest.

Scale 1-10 the degree your general health has been affected by this illness:

less 1 2 3 4 5 6 7 8 9 10 more

Every day during the next week I will be active by _____ for _____minutes.

___ I will avoid foods with high fat, high sugar and high caffeine content.

___ I will drink _____ glasses of water each day.

___ I will try to sleep for _____ hours each night.

Other healthy behavior:
_____
_____

Adapted from brochure designed and formatted by Lori Scanlan-Hansen, BSN, MB, Lake City Medical Center. May be edited as needed for individual patients or facility use.

Spirituality: Spend time doing things that feed your spirit and feel healing to you.
Think about the things that you feel strongly or passionately about (or have in the past). What gives your life meaning? Do you feel connected with others? Participate in religious activities if this is important to you. Find quiet time for self-reflection and restoring your sense of hopefulness for the future. Nature walks, meditation, music, inspirational reading, or time with a valued friend can be healing to the spirit.

Scale 1-10 the degree which this illness has affected your spirit:

less 1 2 3 4 5 6 7 8 9 10 more

During the next week, I will spend at least _____ minutes each day for healing my spirit through self-reflection or other activities such as:
_____
_____
_____
_____
_____
_____
_____

Recreation/Hobbies: Make time for pleasurable events.
Even though you may not feel as motivated, or get the same amount of pleasure as you used to, commit to scheduling some fun activities every day. Enjoy a hobby, listen to music, go out into nature for a walk, or attend a sporting event.

Scale 1-10 the degree which this illness has affected your hobbies/leisure life:

less 1 2 3 4 5 6 7 8 9 10 more

Every day I will spend at least _____ minutes doing recreational activity.

I will list at least five hobbies or recreational activities I enjoy:
_____
_____
_____
_____
_____
_____
_____

Updated 9/2015

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Care Plan – Medical Treatment Plan – Patient Self Management Plan

Subjective – history of present illness, review of systems

Objective – physical exam, tests

Assessment – for each diagnosis, better, worse or the same – stable, improving, deteriorating

Plan – or is it the CARE PLAN?

Education

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Care Plan vs. Shared Care Plan

Care Plan	Shared Care Plan
Completed by clinician	Shared care plan is co-developed
Directions and instructions	Person-centered elements: goals (and steps to get to those goals) and barriers
Clinician-centric	Emphasizes the person's central role in managing their own health

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Shared Care Plan
Operational Definition

1. Treatment goals – chronic condition follow-up, preventive health goals, diagnostic follow-up (CM 04)
2. Patient's self-management goals (CM 06, CM 08)
3. Assessment of patient's barriers to health and well-being & potential solutions and resources to overcome barriers (CM 07)
4. Care coordination information: primary care team, specialists and community resources beyond primary care team (CM 09)
5. Shared care plan follow-up frequency (CM 04)

Additional elements may include: patient's confidence in ability to manage health (rated on a scale 1 – 10), self-rated health status (excellent, very good, good, fair, poor), original date of plan and date of latest update, advance directive, health care proxy.

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Thank You!

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Certified Content Expert

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