

Knowing and Managing Your Patients (KM Competency C and D)

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Community Health Solutions

Knowing and Managing your Patients (KM)



The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.

KM – Competency C

The practice proactively addresses the care needs of the patient population to ensure needs are met.

Criteria	Criteria Description	Required Evidence	Crosswalk to 2014
KM 12 (Core)	<p>Proactive Outreach: Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (must report at least three categories):</p> <ul style="list-style-type: none"> A. Preventive care services. B. Immunizations. C. Chronic or acute care services.* D. Patients not recently seen by the practice. 	<p><i>Report/list AND Outreach materials* (KM 13 can be substituted for B ONLY)</i></p> <p><i>*Outreach materials OR KM 13</i></p>	3D1-4, 6G10
KM 13 * (2 Credits)	<p>Excellence in Performance: Demonstrates excellence in a benchmarked/ performance-based recognition program assessed using evidence-based care guidelines.</p>	<p><i>Report OR HSRP or DRP recognition for at least 75% of eligible clinicians</i></p>	<i>No equivalent</i>

KM 12 (Core)



Proactive Outreach: Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (must report at least three categories):

- A. Preventive care services.**
- B. Immunizations.**
- C. Chronic or acute care services.**
- D. Patients not recently seen by the practice.**

The practice uses lists or reports to manage the care needs of specific patient populations. Using collected data on patients, the practice addresses a variety of health care needs using evidence-based guidelines, including missing recommended follow-up visits. The practice implements this process **at least annually** to proactively identify and remind patients, or their families/caregivers, before they are overdue for services.

KM 12 Examples



- A: Preventive Care examples:
 - Well child, pediatric screenings, well adult, mammograms, colorectal screenings, fasting blood sugar, stress test
- B: Immunizations examples:
 - Flu, Tdap, pneumonia
- C: Chronic or acute care examples
 - Adults: diabetes care, CAD care, lab values outside normal range
 - Children: asthma, ADHD, ADD, obesity, depression
- D: Patients not recently seen by practice examples:
 - overdue for an office visit or service (e.g. care management follow-up visit, overdue periodic physical)

KM 13 (2 Credits)

Excellence in Performance: Demonstrates excellence in a benchmarked/ performance-based recognition program assessed using evidence-based care guidelines.

- At least 75 percent of eligible clinicians have earned NCQA HSRP or DRP Recognition.
- Alternatively, the practice demonstrates that it is participating in a program that uses a common set of measures to benchmark participant results, has a process to validate measure integrity and publicly reports results. The practice shows (through reports) that clinical performance is above national or regional averages. Examples of programs may include MN Community Measures, Bridges to Excellence, IHA or other performance-based recognition programs.

KM Competency C Tips and Tricks

- Our understanding is that KM 12 requires three services over three categories (one service per category). *You can do more - but you don't have to.*
- Outreach correspondence and patient list is needed for EACH identified service
- Patient lists should not exceed (be dated older than) one year.
- Clarify the difference between preventive and chronic measures
- Measures must be unique (no duplicate measures can be used across criteria)

Knowing and Managing Your Patients

KM 12: Example

MRN/Pat Name	Pat Acct No	Pat Type	Hospital Service	Patient Area Code	Patient	2015	2016	2014 Cases	Address
		OU	HC ADULT HEALTH CENTER				1	0	
		OU	HC ADULT HEALTH CENTER				1	0	
		OU	HC ADULT HEALTH CENTER				1	0	
		OU	HC ADULT HEALTH CENTER				1	0	
							1	0	
							1	0	
							1	0	
							1	0	
							1	0	
							1	0	
							1	0	

Dear Patient

Our records indicate you have not been to the office recently.

Please phone the office at (973) 555-5555 to schedule your appointment with ABC Health Center.

For the visit to be as beneficial as possible, we will need your help in preparing for it.

Your participation is vital for good health. Thanks for taking care of yourself and helping to prepare for your visit.

Please bring your current medications list to your checkup. And be prepared to discuss your healthcare goals.

Sincerely,
ABC Health Center

Overdue Menactra Patients

REMINDER RECALL PATIENT LIST

Patients age 0 through 227 months old due between 02/06/2012 and 03/07/2012 for the recommended interval for MEN any dose

58 patients selected.

Standard 2, Element D

Patient Name	DOB Age	Series	Dose	Due Date	Guardian Name (Relationship)	Home Phone Work Phone	Address
		DTAP	6	03/07/2012			
		) MEN	1	08/16/2011			
		TDAP	1	08/16/2010			
		DTAP	6	10/18/2011			
		) HEP A	2	02/17/2012			
		MEN	1	10/18/2011			
		VZV	2	09/14/2011			
		TDAP	1	10/18/2010			
		DTAP	6	02/13/2012			
		) MEN	1	02/13/2012			
		TDAP	1	02/13/2011			
		DTAP	6	02/28/2012			
		) MEN	1	02/28/2012			
		VZV	2	01/05/2010			
		TDAP	1	02/28/2011			
		DTAP	6	02/28/2012			
		) MEN	1	02/28/2012			
		TDAP	1	02/28/2011			
		HPV	3	02/28/2012			
		) MEN	2	08/05/2011			
		VZV	2	09/13/2011			
		TDAP	1	07/12/2007			
		DTAP	6	02/23/2012			
		) MEN	1	02/23/2012			
		TDAP	1	02/23/2011			
		MEN	2	02/08/2012			
		) VZV	2	11/22/2010			
		DTAP	4	02/18/2008			
		) MEASLES	1	03/27/2002			
		MUMPS	1	03/27/2002			
		RUBELLA	1	03/27/2002			
		MEN	1	02/18/2012			
		POLIO	3	02/18/2005			
		TDAP	1	02/18/2011			
		DTAP	6	02/23/2012			
		) MEN	1	02/23/2012			
		VZV	2	08/13/2005			
		TDAP	1	02/23/2011			
		DTAP	6	03/02/2011			
		) MEASLES	2	03/02/2005			
		MEN	1	03/02/2012			
		POLIO	4	03/02/2005			
		TDAP	1	03/02/2011			
		DTAP	5	03/03/2011			
		) MUMPS	1	11/09/2010			
		RUBELLA	2	11/09/2010			
		MEN	1	03/03/2012			
		POLIO	4	03/03/2005			
		TDAP	1	03/03/2011			

KM 12A
Example
Patient List

KM 12C Example Patient List

Body Mass Index(BMI) Screening and Follow-up

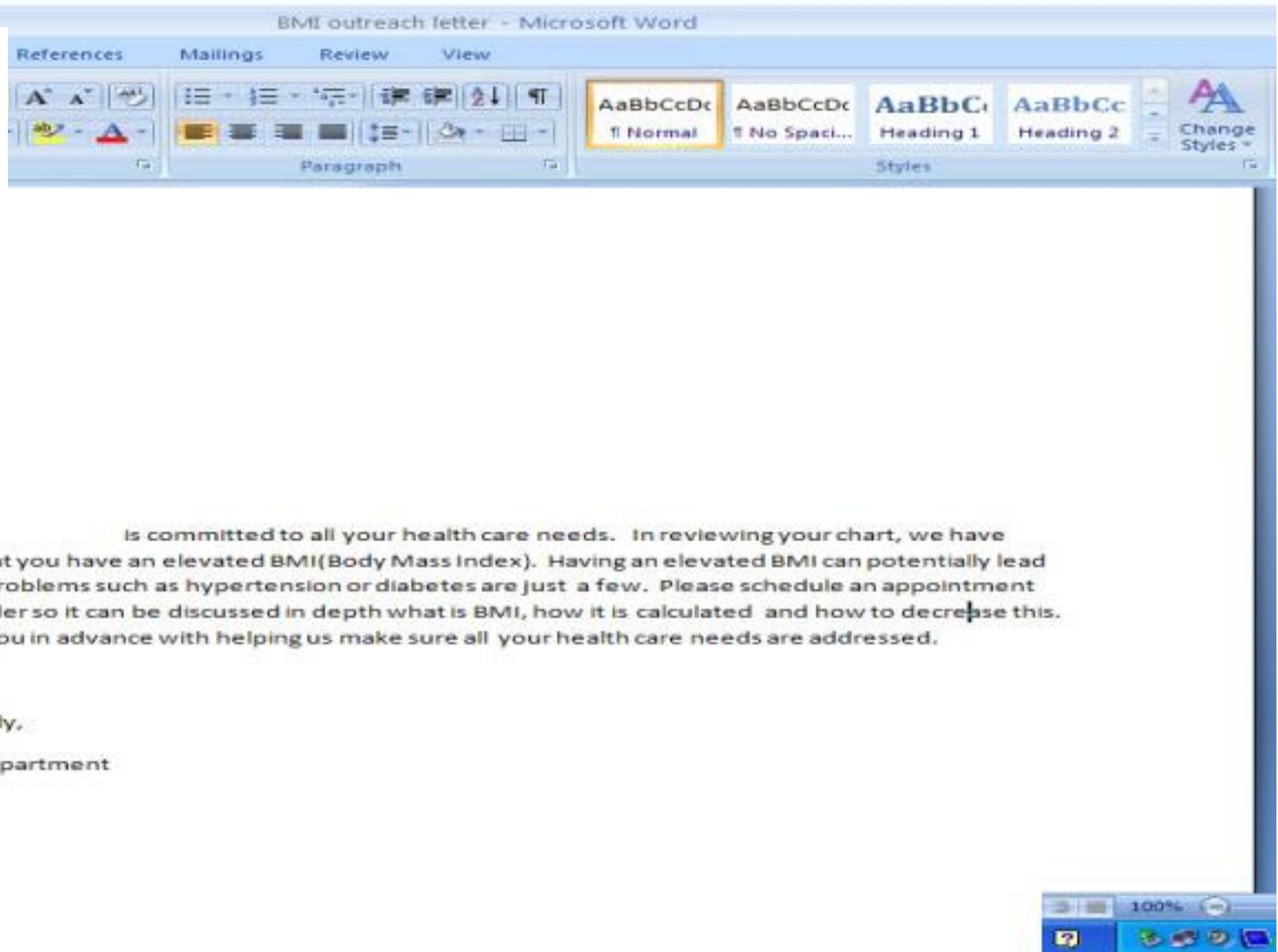
Date Range: 1/3/2011 to 1/3/2012
Instructor Class: ALL
Age Range: 15 to 110
Report Type: ALL
Printed: 02/05/2012 02:37 PM
Date: 11/07/10

of Patients without documentation or BMI or if abnormal, no follow up plan noted: 1,085
Total # of Eligible Patients: 1,596

Age	Gender	Visit Date
85y	M	11/11/2011
59y	M	12/20/2011
76y	M	01/03/2012
55y	F	10/11/2011
64y	F	12/07/2011
23y	F	05/10/2011
47y	M	12/12/2011
46y	F	12/29/2011
46y	F	12/16/2011
27y	M	11/04/2011
78y	F	08/23/2011
58y	F	07/08/2011
84y	M	11/16/2011
59y	F	11/04/2011
59y	M	06/17/2011
60y	F	12/15/2011
36y	F	11/22/2011
29y	M	03/16/2011
61y	F	08/10/2011
55y	F	12/07/2011
46y	F	12/19/2011
74y	F	10/10/2011
41y	F	09/06/2011
58y	M	05/26/2011
74y	M	12/16/2011
47y	M	07/26/2011
82y	F	11/08/2011
74y	F	08/17/2011
47y	F	07/19/2011
35y	F	12/21/2011
61y	F	11/22/2011
43y	F	10/19/2011
42y	F	06/01/2011
38y	F	02/17/2011
46y	M	08/10/2011
79y	F	11/09/2011
26y	F	10/27/2011
		4/2011

Patients having abnormal BMI who need a follow-up plan.

KM 12C Example Outreach Letter



KM Competency C FAQs



How many reports are practices required to submit to meet the criteria of KM 12?

For KM 12 A-D, practices should submit the following for each service:

- 1. Reports or lists of patients needing each service (A-D), generated within the past 12 months, and*
- 2. Materials showing how patients are notified of the needed service.*

So if you are submitting three services total, you would submit three separate reports. Note: Practices may run one report for all criteria if the report indicates the date when it was run and the service(s) for which the patient is due.

KM Competency C FAQs



Are practices required to provide a separate letter, phone script or other method for each service needed? **KM 12**

No. Practices may use the same documentation if:

- *The same method is used for each service.*
- *Practices provide an example of the outreach used.*

KM Competency C FAQs



What are some examples of adult preventive services or screenings? **KM 12**

- *Adult practices may identify lists of patients needing screenings (e.g., mammograms, colorectal screenings), check-up visits, annual lab testing or well-woman visits. Preventive measures must encompass a practice's entire appropriate population (not only patients with chronic conditions). The intent of preventive measures is that practices use their systems to identify specific groups of patients in need of services and to improve the quality of care for all patients in the practice.*

KM Competency C FAQs (cont'd)



Our clinic treats adults and children. How do we handle the criteria of KM 12?

- *If your practice serves both adult and pediatric populations, for criteria in KM 12 that require more than one service, you should demonstrate that you use data for population management for both patient populations but you do not have to identify patients from both population for every sub-criteria in KM 12.*
- *For example, for KM 12 B, you may use one of the immunizations for your pediatric population, but the second immunization should focus on your adult population. For A, C or D, you may use either your pediatric or adult patient population or both depending on the criteria you use for patient not recently seen (D). Please note that the practice may not use two age groups of patients for the same service. For example (still using KM 12 B), if you use flu shots as your pediatric immunization, then you must select another service as the second, different immunization for the adult population.*

KM – Competency D

The practice addresses medication safety and adherence by providing information to the patient and establishing processes for medication documentation, reconciliation and assessment of barriers.

Criteria	Criteria Description	Required Evidence	Crosswalk to 2014
KM 14 (Core)	Medication Reconciliation: Reviews and reconciles medications for more than 80 percent of patients received from care transitions.	<i>Report</i>	<i>4C1-2</i>
KM 15 (Core)	Medication Lists: Maintains an up-to-date list of medications for more than 80 percent of patients.	<i>Report</i>	<i>3B9; 4C6</i>
KM 16 (1 Credit)	New Prescription Education: Assesses understanding and provides education, as needed, on new prescriptions for more than 50 percent of patients/families/caregiver.	<i>Report AND Evidence of implementation</i>	<i>4C3-4</i>
KM 17 (1 Credit)	Medication Responses and Barriers: Assesses and addresses patient response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment.	<i>Report AND Evidence of implementation</i>	<i>4C5</i>

KM – Competency D

(continued)

The practice addresses medication safety and adherence by providing information to the patient and establishing processes for medication documentation, reconciliation and assessment of barriers.

Criteria	Criteria Description	Required Evidence	Crosswalk to 2014
KM 18 * (1 Credit)	Controlled Substance Database Review: Reviews controlled substance database when prescribing relevant medications.	<i>Evidence of implementation</i>	<i>No equivalent</i>
KM 19 * (2 Credits)	Prescription Claims Data: Systematically obtains prescription claims data in order to assess and address medication adherence.	<i>Evidence of implementation</i>	<i>No equivalent</i>

KM 14 (Core)

Medication Reconciliation: Reviews and reconciles medications for more than 80 percent of patients received from care transitions

- The practice reviews all prescribed medications a patient is taking and documents this in the medical record. Conflicts or potential discrepancies in medications are identified and addressed by clinical staff. Medication review and reconciliation occurs at transitions of care, or at least annually.
- Maintaining an accurate list of a patient's medications reduces the possibility of duplicate medications, medication errors and adverse drug events. Medication reconciliation is an important safety net for patients received from care transitions, because they are more likely to be elderly, use multiple pharmacies, multiple providers and have co-morbid conditions.
- **Medication reconciliation** is the process of obtaining and maintaining an accurate list of all medications a patient is taking and addresses any potential conflicts including name, dosage, frequency and drug-drug interactions.

KM 15 (Core)

Medication Lists: Maintains an up-to-date list of medications for more than 80 percent of patients.

- The practice routinely collects information from patients about medications they take and keeps up-to-date lists of patients' medications.
- Medication data should be captured in searchable fields.
- The list should include the date when it was last updated, prescription and nonprescription medications, over-the-counter medications and herbal and vitamin/mineral/dietary (nutritional) supplements.
- Evidence is a Report.

KM 16 (1 Credit)



New Prescription Education: Assesses understanding and provides education, as needed, on new prescriptions for more than 50 percent of patients/families/caregivers.

The practice uses patient-centered methods, such as open-ended questions (i.e., teach-back collaborative method), to assess patient understanding. Educational materials are designed with regard to patient need (e.g., reading level). Lack of understanding, due to low health literacy or communication barriers, leads to poorer health outcomes and compromises patient safety.

KM 17 (1 Credit)

Medication Responses and Barriers: Assesses and addresses patient response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment.

- The practice asks patients if they are having difficulty taking a medication, are experiencing side effects and are taking the medication as prescribed. If a patient is not taking a medication as prescribed, the practice determines why.
- Patients cannot get the full benefit of their medications if they do not take them as prescribed.

KM 18 (1 Credit)

Controlled Substance Database Review: Reviews a controlled substance database when prescribing relevant medications.

- The practice consults a state controlled-substance database—also known as a Prescription Drug Monitoring Program (PDMP) or Prescription Monitoring Program (PMP)—before dispensing Schedule II, III, IV and V controlled substances. The practice follows established guidelines or state requirements to determine frequency of review.
- This can prevent overdoses and misuse, and can support referrals for pain management and substance use disorders.
- For a list of PDMPs by state: <http://www.pdmpassist.org/content/state-pdmp-websites>

KM 19 (2 Credit)

Prescription Claims Data: Systematically obtains prescription claims data in order to assess and address medication adherence.

The practice systematically obtains prescription claims data or other medication transaction history. This may include systems such as SureScripts e-prescribing network, regional health information exchanges, insurers or prescription benefit management companies. The practice uses prescription claims data to determine whether a patient is adhering to the medication treatment plan.

KM Competency D FAQs



How frequently must medication reconciliation occur? KM 14 (Core)

- *Medication reconciliation must occur at least annually and at all transitions of care.*

Do excerpts from medical records indicating that new medications and side effects were reviewed with the patient/family/caregiver meet the requirement, or must practices submit a specific medication handout? KM 16 (1 credit)

- *Practices determine the best method for sharing new medication information with patients; however, for documentation purposes, practices must note in the medical record how they provided the information to the patient. To earn credit, practices must meet the threshold of more than 50 percent, and provide an example demonstrating how this information is recorded in the medical record.*

KM Competency D FAQs



Does supplying information on all new prescriptions duplicate information provided by a pharmacy? KM 16 (1 credit)

- *No. Although it may be duplicate information, practices cannot assume that the pharmacy provided the information to the patient. Practices must ensure that patients/families/caregivers understand why medication was prescribed and its benefits and potential harms to the patient. Additionally, patients might not review prescription information provided by a pharmacy, and information might not be tailored to the needs of the patient/family/ caregiver. Communication and partnership with patients are critical functions of the patient-centered medical home.*

KM Competency D FAQs



May practices assess response to medications relevant to treating a specific disease of interest? KM 17 (1 credit)

- *No. Practices must ask about all medications prescribed to the patient and assess their efficacy, especially for patients identified in CM 01 as needing care management. They may have multiple comorbidities and medications, so it is crucial to evaluate their response and barriers to adherence for all medications prescribed to them.*

Questions?



Announcements



- ***NCQA PCMH Standards and Guidelines (2017 Edition, Version 2) was published on 09/30/2017.***
- *The reason for this is that the changes made were mainly cosmetic. NCQA was focused on fixing typos and rephrasing some guidance language for clarity.*
- *There were only three changes that are worth noting. Those include changes to TC 05, TC 08 and KM 11B.*
 - ***For TC 05***, *the requirements outlined in the guidance for practices to have "completed the required security risk analysis. and implemented security updates to correct identified risks" have been removed. This criterion now only requires evidence that the practice has a certified EHR.*
 - ***For TC 08***, *the guidance language for this requirement was revised to remove the part in the first sentence indicating that the care manager has "training and licensure to provide psychotherapeutic treatment directly".*
 - ***For KM 11B***, *the criterion language was changed for clarity. It now reads: "Educates practice staff on health literacy" instead of "Address health literacy of the practice staff".*

We plan to post these changes and/or notify customers about these changes but haven't identified the best avenue for doing so as we also didn't feel these small changes required a table. If you have any additional questions, please don't hesitate to contact us.

<http://chcleadership.com/pcmh-resources/>

The screenshot shows a web browser window displaying the PCMH Resources page. The browser's address bar shows the URL chcleadership.com/pcmh-resources/. The page header includes the logo for The Virginia CHC Leadership Institute and a navigation menu with items like 'What's New', '2017-18 Program', '2016-17 Program', 'CHS Mind Tools', 'Best Practices', 'Project Value', and 'PCMH Resources'. The main content area features a blue header with 'PCMH Resources' and a breadcrumb trail 'Home / PCMH Resources'. Below this, there is a paragraph explaining Patient Centered Medical Home (PCMH) and its focus on standardizing care. A table of contents follows, listing sections such as 'About PCMH', 'Webinar / Office Hours Content', 'Tools for PCMH Development', and 'PCMH 2017 Resources'. Three specific resources are highlighted: '2017 NCQA PCMH Guidelines', 'CHS PCMH Tracker 2017', and 'CHS PCMH Knowledge Base 2017', each with a brief description of its purpose.

PCMH Resources - The V

chcleadership.com/pcmh-resources/

The Virginia CHC Leadership Institute Customize 0 New Edit Page Avada Copy to a new draft

Questions? Contact Community Health Solutions - ctfeller@chsresults.com | 804.673.0166 Members Edit Profile Request Support Logout

THE VIRGINIA CHC LEADERSHIP INSTITUTE

What's New 2017-18 Program 2016-17 Program CHS Mind Tools Best Practices Project Value **PCMH Resources**

Project Value Workshop Q

PCMH Resources Home / PCMH Resources

Patient Centered Medical Home is a way of standardizing care so that patient satisfaction, quality, and cost savings are the focus. These three principles are reflective of the triple aim which is used to guide health care quality initiatives like PCMH. Currently 80.8% of community health centers in our membership have some level of PCMH recognition for at least one of their sites. Most have chosen to get their recognition through the National Committee for Quality Assurance.

This page is the table of contents for resources and information relevant to PCMH recognition and renewal.

- ✦ About PCMH
- ✦ Webinar / Office Hours Content
- ✦ Tools for PCMH Development

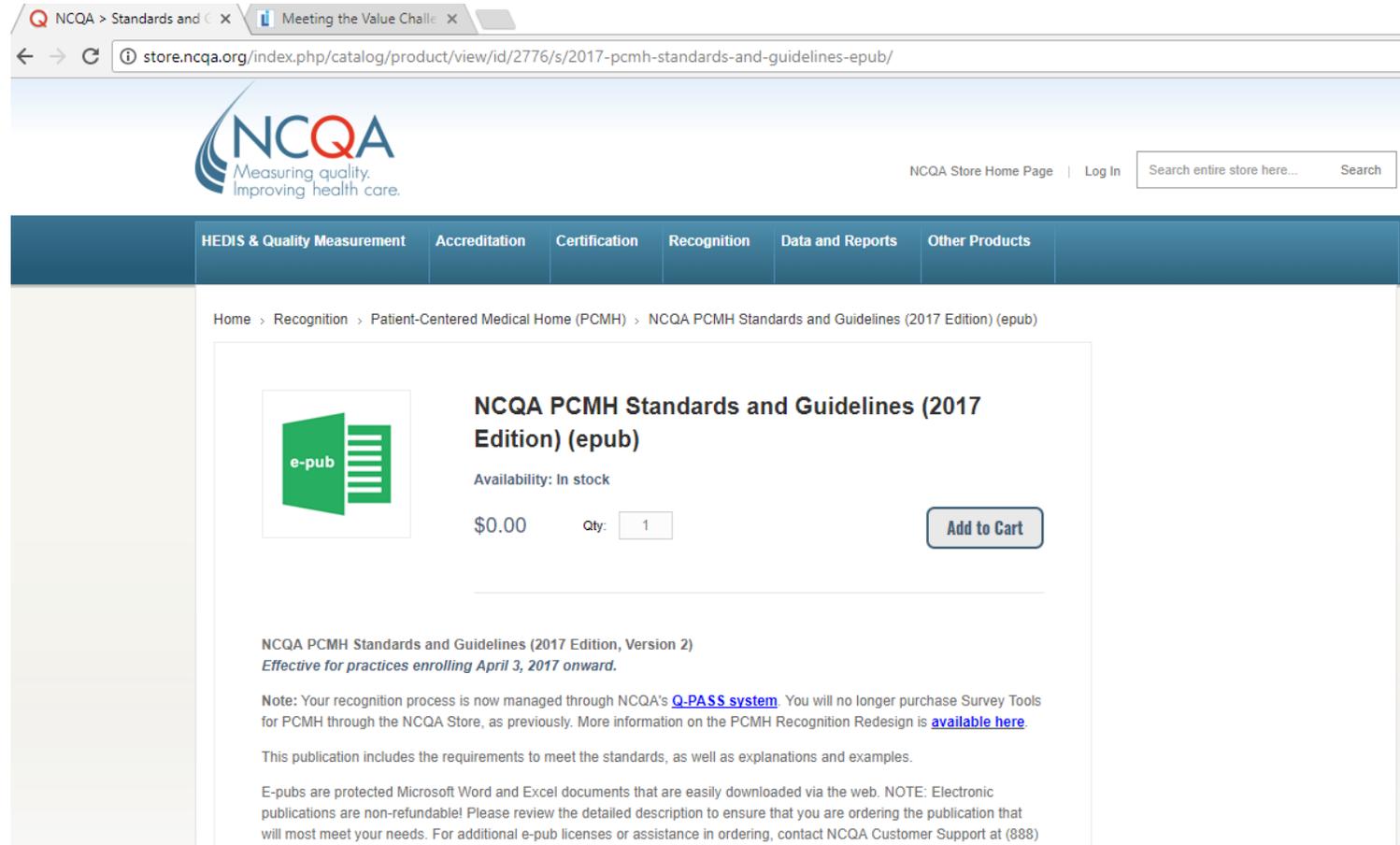
2017 NCQA PCMH Guidelines
The redesigned PCMH 2017 requirements focus on assessing a practice's transformation into a medical home and specify goals for [...]

CHS PCMH Tracker 2017
The CHS PCMH Tracker 2017 is an organizational management tool to be used by PCMH leaders to keep track of [...]

CHS PCMH Knowledge Base 2017
The CHS PCMH Knowledge Base is a database of hundreds of documentation examples, frequently asked questions, tools and resources [...]

- ✦ PCMH 2017 Resources

<http://store.ncqa.org/index.php/catalog/product/view/id/2776/s/2017-pcmh-standards-and-guidelines-epub/>



NCQA > Standards and Guidelines > Meeting the Value Challenge

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Home > Recognition > Patient-Centered Medical Home (PCMH) > NCQA PCMH Standards and Guidelines (2017 Edition) (epub)

 **NCQA PCMH Standards and Guidelines (2017 Edition) (epub)**

Availability: In stock

\$0.00 Qty: [Add to Cart](#)

NCQA PCMH Standards and Guidelines (2017 Edition, Version 2)
Effective for practices enrolling April 3, 2017 onward.

Note: Your recognition process is now managed through NCQA's [Q-PASS system](#). You will no longer purchase Survey Tools for PCMH through the NCQA Store, as previously. More information on the PCMH Recognition Redesign is [available here](#).

This publication includes the requirements to meet the standards, as well as explanations and examples.

E-pubs are protected Microsoft Word and Excel documents that are easily downloaded via the web. NOTE: Electronic publications are non-refundable! Please review the detailed description to ensure that you are ordering the publication that will most meet your needs. For additional e-pub licenses or assistance in ordering, contact NCQA Customer Support at (888) 888-8888.