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.

Competency A: Collecting Patient Information. The practice routinely collects comprehensive patient data and uses the data to understand patients' backgrounds and health risks.

KM 01 (Core) Problem Lists: Documents an up-to-date problem list for each patient with current and active diagnoses.	
GUIDANCE	**EVIDENCE**
Up-to-date means that the most recent diagnoses—ascertained from previous records, transfer of information from other providers, diagnosis by the clinician, or by querying the patient—are added to the problem list. The report shows that the practice updates patients' problem lists at least annually. The patient's active problem list or diagnoses should include acute and chronic conditions, behavioral health diagnoses and oral health issues, as well as past diagnoses that are relevant to the patient's current care. Implementing KM 01 is a foundation for understanding health risks.	• **Report** ***OR*** • **KM 06—predominant conditions and health concerns**

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KM 02 (Core) Comprehensive Health Assessment: Comprehensive health assessment includes (all items required):

A. Medical history of patient and family.
B. Mental health/substance use history of patient and family.
C. Family/social/cultural characteristics.
D. Communication needs.
E. Behaviors affecting health.
F. Social functioning.
G. Social determinants of health.
H. Developmental screening using a standardized tool. (NA for practices with no pediatric population under 30 months of age.)
I. Advance care planning. (NA for pediatric practices.)

GUIDANCE	EVIDENCE
A comprehensive patient assessment includes an examination of the patient's social and behavioral influences in addition to a physical health assessment. The practice uses evidence-based guidelines to determine how frequently the health assessments are completed and updated. Comprehensive, current data on patients provides a foundation for supporting population needs. As part of the comprehensive health assessment, the practice: **A. Medical history of patient and family.** Collects patient and family medical history (e.g., history of chronic disease or event [e.g., diabetes, cancer, surgery, hypertension]) for patient and "first-degree" relatives (who share about 50% of their genes with a specific family member). **B. Mental health/substance use history of patient and family.** Collects patient and family behavioral health history (e.g., schizophrenia, stress, alcohol, prescription drug abuse, illegal drug use, maternal depression). **C. Family/social/cultural characteristics.** Evaluates social and cultural needs, preferences, strengths and limitations. Examples include family/household structure, support systems, and patient/family concerns. Broad consideration should be given to a variety of characteristics (e.g., education level, marital status, unemployment, social support, assigned responsibilities). **D. Communication needs.** Identifies whether a patient has specific communication requirements due to hearing, vision or cognition issues. ***Note:*** *This does not address language; refer to KM 10 for language needs.*	• **Documented process** ***AND*** • **Evidence of implementation**

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KM 02 (Core) Comprehensive Health Assessment (all items required): *continued*	
GUIDANCE	**EVIDENCE**
E. Behaviors affecting health. Assesses risky and unhealthy behaviors that go beyond physical activity, alcohol consumption and smoking status and may include nutrition, oral health, dental care, risky sexual behavior and secondhand smoke exposure. **F. Social functioning.** Assesses a patient's ability to interact with other people in everyday social tasks and to maintain an adequate social life. May include isolation, declining cognition, social anxiety, interpersonal relationships, activities of independent living, social interactions and so on. **G. Social determinants of health.** Collects information on **social determinants of health:** conditions in a patient's environment where people live, learn, work, and play that affect a wide range of health, functioning and quality-of-life outcomes and risks. Examples include availability of resources to meet daily needs; access to educational, economic and job opportunities; public safety, social support; social norms and attitudes; food and housing insecurities; household/environmental **risk factors**; exposure to crime, violence and social disorder; socioeconomic conditions; residential segregation (Healthy People 2020). **H. Developmental screening using a standardized tool.** For newborns through 30 months, uses a standardized tool for periodic developmental screening. If there are no established risk factors or parental concerns, screens are done by 24 months. **I.** Documents patient/family preferences for **advance care planning** (care at the end of life or for patients who are unable to speak for themselves). This may include discussing and documenting a plan of care, with treatment options and preferences. Patients with an advance directive on file meet the requirement.	• **Documented process** ***AND*** • **Evidence of implementation** 

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KM 03 (Core) Depression Screening: Conducts depression screenings for adults and adolescents using a standardized tool.	
GUIDANCE	**EVIDENCE**
The documented process includes the practice's screening process and approach to follow-up for positive screens. The practice reports the screening rate and identifies the standardized screening tool. **Screening for adults,** Screening adults for depression with systems in place to ensure accurate diagnosis, effective treatment and follow-up. **Screening for adolescents (12–18 years),** Screening adolescents for depression with systems in place to ensure accurate diagnosis, effective treatment and follow-up. A **standardized tool** collects information using a current, evidence-based approach that was developed, field-tested and endorsed by a national or regional organization. In caring for the whole person, the medical home recognizes the impact depression can have on a patient's physical and emotional health. The practice uses a standardized screening tool (e.g., PHQ-9) and acts on the results.	• **Documented process *or*** • **Report** ***AND*** • **Evidence of implementation**

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KM 04 (1 Credit) Behavioral Health Screenings: Conducts behavioral health screenings and/or assessments using a standardized tool. (Implement two or more.)

A. Anxiety.
B. Alcohol use disorder.
C. Substance use disorder.
D. Pediatric behavioral health screening.
E. Post-traumatic stress disorder.
F. Attention deficit/hyperactivity disorder.
G. Postpartum depression.

GUIDANCE	EVIDENCE
Many patients go undiagnosed and untreated for mental health and substance use disorders. The medical home can play a major role in early identification of these conditions. Practice staff have been trained on the use of standardized tools to ensure accurate diagnosis, treatment and follow-up. The documented process must include what happens if the patient has a positive screening. A **standardized tool** collects information using a current, evidence-based approach that was developed, field-tested and endorsed by a national or regional organization. The National Institute on Drug Abuse created a chart of Evidence Based Screening Tools for Adults and Adolescents for opioid screening, as well as alcohol and substance use tools. **A.** The practice conducts assessment for the presence of emotional distress and symptoms of anxiety using any validated tool (e.g., GAD-2, GAD-7). Anxiety disorders (generalized anxiety disorder, panic disorder and social anxiety disorder) are common, often undetected and misdiagnosed, associated with other psychiatric conditions and linked to chronic medical conditions (e.g., heart disease, chronic pain disorders). **B.** The USPSTF recommends screening adults 18 years or older for alcohol misuse. Practices may use the Alcohol Use Disorders Identification Test (AUDIT), a screening for excessive drinking; the Drug Abuse Screening Test (DAST); Cutting down, Annoyance by criticism, Guilty feeling and Eye-openers Questionnaire (CAGE), CAGE AID for substance abuse; or another validated screening tool. The American Academy of Pediatrics' (AAP) Bright Futures recommends clinicians screen all adolescents for alcohol use during all appropriate acute care visits using developmentally appropriate screening tools. (e.g., CRAFFT or Alcohol Screening and Brief Intervention for Youth).	• **Documented process** ***AND*** • **Evidence of implementation** • .

KM 04 (1 Credit) Behavioral Health Screenings: *continued*	
GUIDANCE	**EVIDENCE**
C. Assessing for substance use can assist the practice to provide needed treatment, referrals and abstinence tools to address the patient's substance use concerns. Substance use is a growing issue that is impacting all types of patients. Screening supports early intervention and facilitating patients' access to the necessary treatments toward sobriety. Available screening tools may include the CAGE AID or DAST-10 instruments, which assess a variety of substance use conditions. Bright Futures recommends clinicians screen all adolescents for substance use during all appropriate acute care visits using developmentally appropriate screening tools. (e.g., CRAFFT or DAST-20). **D.** Pediatric screening for behavioral health is distinct from adult screening and provides opportunities for early interventions that can have lasting effects over a lifetime. This may include tools such as the Behavioral Assessment System for Children (BASC). **E.** The practice uses standardized tools to determine if patients have developed post-traumatic stress disorder (PTSD). This condition develops in patients who have experienced a severe and distressing event. This event causes the patient to subsequently re-live the traumatic experience, causing mental distress. Assessments for PTSD support the practice in recognizing the ailment, so it can either provide treatment or referrals to appropriate specialists. **F.** Attention deficit/hyperactivity disorder (ADHD) makes it challenging for a person to pay attention and/or control impulsive behaviors. This condition is most commonly diagnosed during childhood but symptoms can persist through adolescence and adulthood. The Vanderbilt Assessment Scale or the DSM V ADHD checklist for adults or children/adolescents are examples of screening tools used to determine if a patient has ADHD. Screening to identify patients with ADHD can lead to earlier diagnosis and treatment and may and reduce its impact on patients/families/ caregivers.	• **Documented process** ***AND*** • **Evidence of implementation**

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KM 04 (1 Credit) Behavioral Health Screenings: *continued*	
GUIDANCE	**EVIDENCE**
G. The USPSTF recommends screening of adults, including pregnant and postpartum women, for depression. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. The USPSTF guidelines suggest screening during and after pregnancy. The AAP's Bright Futures acknowledges that primary care practices that see both infants and their families have a unique opportunity to integrate postpartum depression screening into the well-child care schedule. Validated screening tools may include PHQ-2, PHQ-9 or Edinburgh Postnatal Depression Scale (EPDS) or other validated screening tools and may be conducted 4–6 weeks postpartum or during the 1-, 2-, 4- or 6-month well-child visits. For a list of screening tools, visit SAMHSA.gov, or for a list of pediatric screening tools, visit the American Academy of Pediatrics website. (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/Primary-Care-Tools.aspx)	• **Documented process** ***AND*** • **Evidence of implementation** 
KM 05 (1 Credit) Oral Health Assessment and Services: Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners.	
GUIDANCE	**EVIDENCE**
The practice conducts patient-specific oral health risk assessments and keeps a list of oral health partners such as dentists, endodontists, oral surgeons and/or periodontists from which to refer. Poor oral health can have a significant impact on quality of life and overall health. Primary care practices are uniquely positioned to improve oral health, oral health awareness through education, preventive interventions (e.g., fluoride application for pediatric patients) and timely referrals.	• **Documented process** ***AND*** • **Evidence of implementation** 

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KM Competency A: Collecting Patient Information.

KM 06 (1 Credit) Predominant Conditions and Concerns: Identifies the predominant conditions and health concerns of the patient population.	
GUIDANCE	**EVIDENCE**
The practice analyzes diagnosis codes or problem lists to identify its patients' most prevalent and important conditions and concerns. Although the general conditions treated in primary care are similar across practices, each medical home has a unique population that influences how the practice organizes work and resources. Knowing its population's top concerns allows the practice to adopt guidelines, focus decision support and outreach efforts, identify specialties to establish clear referral relationships and determine what special services to offer (e.g., group sessions, education, counseling).	• **List of top priority conditions and concerns** 
KM 07 (2 Credits) Social Determinants of Health: Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data.	
GUIDANCE	**EVIDENCE**
After the practice collects information on social determinants of health, it demonstrates the ability to assess data and address identified gaps using community partnerships, self-management resources or other tools to serve the ongoing needs of its population. Routine collection of data on social determinants of health (as required in KM 02) is an important step, but the real benefit to the population comes when the practice uses the information to continuously enhance care systems and community connections to systematically address needs.	• **Report** ***AND*** • **Evidence of implementation**

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KM 08 (1 Credit) Patient Materials: Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials.	
GUIDANCE	**EVIDENCE**
The practice demonstrates an understanding of the patients' communication needs by utilizing materials and media that are easy for their patient population to understand and use. The practice considers patient demographics such as age, language needs, ethnicity and education when creating materials for its population. The practice may consider how its patients like to receive information (i.e., paper brochure, phone app, text message, email), in addition to the readability of materials (e.g., general literacy and health literacy). Health-literate organizations understand that lack of health literacy leads to poorer health outcomes and compromises patient safety and establish processes that address health literacy to improve patient health behaviors and safety in the practice setting. Reducing barriers to the patient's ability to access, understand and absorb health information supports their ability to comply with their care.	• **Report** ***AND*** • **Evidence of implementation** 

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Competency B: Patient Diversity. The practice uses information about the characteristics of its patient population to provide culturally and linguistically appropriate services.

KM 09 (Core) Diversity: Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.	
GUIDANCE	**EVIDENCE**
The practice collects information on how patients identify in at least three areas that include: 1. Race. 2. Ethnicity. 3. One other aspect of diversity, which may include, but is not limited to, gender identity, sexual orientation, religion, occupation, geographic residence. Assessing the diversity of its population can help a practice identify subpopulations with specialized needs or that are subject to systemic barriers, leading to disparities in health outcomes. The practice may collect data directly from patients or may use data about the community (e.g., zip code analysis, community level census data) it serves.	• **Report**
KM 10 (Core) Language: Assesses the language needs of its population.	
GUIDANCE	**EVIDENCE**
The practice identifies the prevalent language needs of its population. It may collect data directly from all patients or from community-level statistics for the community it serves. If the practice collects data directly, all responses (e.g., patient declined to provide language information, primary language is English, patient does not need language services) must be recorded; a blank field does not mean the patient's preferred language is English. Documenting patients' preferred spoken and written language helps the practice identify the language resources required to serve the population effectively (e.g., materials in prevalent languages, translation services, bilingual staff).	• **Report**

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KM 11 (1 Credit) Population Needs: Identifies and addresses population-level needs based on the diversity of the practice and the community (demonstrate at least two):

A. Targets population health management on disparities in care.

B. Educates practice staff on health literacy.

C. Educates practice staff in cultural competence.

GUIDANCE	EVIDENCE
The practice recognizes the varied needs of its population and the community it serves, and uses that information to take proactive, health literate, culturally competent approaches to address those needs. The practice: **A.** Identifies disparities in care and implements actions to reduce the disparity. Practices that reduce disparities provide patient-centered care to their vulnerable populations equal to their general population. **B.** Builds a health-literate organization (e.g., apply universal precautions, provide health literacy training for staff, system redesign to serve patients at different health literacy levels, utilize the AHRQ or Alliance for Health Reform Health Literacy toolkit). Health-literate organizations understand that lack of health literacy leads to poorer health outcomes and compromises patient safety, and act to establish processes that address health literacy to improve patient outcomes. **C.** Builds a culturally competent organization that educates staff on how to interact effectively with people of different cultures. It supports practice staff to become respectful and responsive to the health beliefs and cultural and linguistic needs of patients. **Health literacy resources** Institute of Medicine: Ten Attributes of Health Literate Health Care Organizations http://www.ahealthyunderstanding.org/Portals/0/Documents1/IOM_Ten_Attributes_HL_Paper.pdf Agency for Healthcare Research & Quality: Health Literacy Universal Precautions Toolkit: http://www.ahrq.gov/professionals/ quality-patient-safety/quality-resources/tools/literacy-toolkit/healthliteracytoolkit.pdf Alliance for Health Reform Toolkit: http://www.allhealth.org/publications/Private_health_insurance/Health-Literacy-Toolkit_163.pdf	• **A*: Evidence of implementation*** ***OR*** • **A*: QI 05 and*** • **A*: QI 13*** • **B: Evidence of implementation** • **C: Evidence of implementation**

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Competency C: Addressing Patient Needs. The practice proactively addresses the care needs of the patient population to ensure needs are met.

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.**	
GUIDANCE	**EVIDENCE**
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.	• **A, B, D: Report/list *and*** • **A, B, D: Outreach materials** • **C: Report/list *and*** • **C: Outreach materials** ***OR*** • **C: KM 13** 
KM 13 (2 Credits) Excellence in Performance: Demonstrates excellence in a benchmarked/ performance-based recognition program assessed using evidence-based care guidelines.	
GUIDANCE	**EVIDENCE**
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, IHA or other performance-based recognition programs.	• **Report** ***OR*** • **HSRP or DRP recognition for at least 75% of eligible clinicians**

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KM Competency D: Medication Management.

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

KM 14 (Core) Medication Reconciliation: Reviews and reconciles medications for more than 80 percent of patients received from care transitions.	
GUIDANCE	**EVIDENCE**
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.	• **Report**
KM 15 (Core) Medication Lists: Maintains an up-to-date list of medications for more than 80 percent of patients.	
GUIDANCE	**EVIDENCE**
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.	• **Report**

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KM Competency D: Medication Management.

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.	
GUIDANCE	**EVIDENCE**
The practice uses patient-centered methods, such as open-ended questions (teach-back collaborative method), to assess patient understanding of new medications prescribed by the primary care provider. Educational materials are designed with regard to patient need (e.g., reading level). Medication is not taken as prescribed 50 percent of the time. (Source: CDC) Barriers to adherence, such as not understanding directions and confusion amongst multiple medication regimens, lead to poorer health outcomes and compromise patient safety.	• **Report** ***AND*** • **Evidence of implementation**
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.	
GUIDANCE	**EVIDENCE**
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 benefits of their medications if they do not take them as prescribed.	• **Report** ***AND*** • **Evidence of implementation**
KM 18 (1 Credit) Controlled Substance Database Review: Reviews a controlled substance database when prescribing relevant medications.	
GUIDANCE	**EVIDENCE**
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	• **Evidence of implementation**

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KM 19 (2 Credits) Prescription Claims Data: Systematically obtains prescription claims data in order to assess and address medication adherence.	
GUIDANCE	**EVIDENCE**
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.	• **Evidence of implementation** 

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KM Competency E: Evidence-Based Care.

Competency E: Evidence-Based Care. The practice ensures that it provides effective and efficient care by incorporating evidence-based clinical decision support relevant to patient conditions and the population served.

KM 20 (Core) Clinical Decision Support: Implements clinical decision support following evidence-based guidelines for care of (Practice must demonstrate at least four criteria):

A. A mental health condition.
B. A substance use disorder.
C. A chronic medical condition.
D. An acute condition.
E. A condition related to unhealthy behaviors.
F. Well-child or adult care.
G. Overuse/appropriateness issues.

GUIDANCE	EVIDENCE
The practice utilizes systems in its day-to-day operations that integrate evidence-based guidelines (frequently referred to as clinical decision support [CDS]). **CDS** is a systematic method of prompting clinicians to consider evidence-based guidelines at the point of care. CDS encompasses a variety of tools, including, but not limited to: • Computerized alerts and reminders for providers and patients. • Condition-specific order sets. • Focused patient data reports and summaries. • Documentation templates. • Diagnostic support. • Contextually relevant reference information. Although CDS may relate to clinical quality measures, measures alone do not achieve the broader goals of CDS. **A. Mental health.** The practice uses evidence-based guidelines to support clinical decisions related to at least one mental health issue (e.g., depression, anxiety, bipolar disorder, ADHD, ADD, dementia, Alzheimer's) in the care of patients. **B. Substance use disorder treatment.** The practice uses evidence-based guidelines to support clinical decisions related to at least one substance misuse issue (e.g., illegal drug use, prescription drug addiction, alcoholism) in the care of patients.	• **Identifies conditions, source of guidelines** ***AND*** • **Evidence of implementation**

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KM 20 (Core) Clinical Decision Support: *continued*	
GUIDANCE	**EVIDENCE**
C. A chronic medical condition. The practice has evidence-based guidelines it uses for clinical decision support related to at least one chronic medical condition (e.g., arthritis, asthma, cardiovascular disease, COPD, diabetes) in the care of patients. **D. An acute condition.** The practice uses evidence-based guidelines to support clinical decisions related to at least one acute medical condition (e.g., acute back pain, allergic rhinitis, bronchiolitis, influenza, otitis media, pharyngitis, sinusitis, urinary tract infection) in the care of patients. **E. A condition related to unhealthy behaviors.** The practice uses evidence-based guidelines to support clinical decisions related to at least one unhealthy behavior (e.g., obesity, smoking) in the care of patients. **F. Well child or adult care.** The practice uses evidence-based guidelines to support clinical decisions related to well-child or adult care (e.g., age appropriate screenings, immunizations) in the care of patients. **G. Overuse/appropriateness issues.** The practice uses evidence-based guidelines to support clinical decisions related to overuse or appropriateness of care issues (e.g., use of antibiotics, avoiding unnecessary testing, referrals to multiple specialists) in the care of patients. The American Board of Internal Medicine Foundation's Choosing Wisely campaign provides information about implementing evidence-based guidelines as clinical decision support (http://www.choosingwisely.org).	• **Identifies conditions, source of guidelines** ***AND*** • **Evidence of implementation**

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Competency F: Connecting With Community Resources. The practice identifies/ considers and establishes connections to community resources to collaborate and direct patients to needed support.

KM 21 (Core) Community Resource Needs: Uses information on the population served by the practice to prioritize needed community resources.	
GUIDANCE	**EVIDENCE**
The practice identifies needed resources by assessing collected population information. It may assess social determinants, predominant conditions, ED use and other health concerns to prioritize community resources (e.g., food banks, support groups) that support the patient population.	• **List of key patient needs and concerns** 
KM 22 (1 Credit) Access to Educational Resources: Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.	
GUIDANCE	**EVIDENCE**
Giving patients access to educational materials, peer support sessions, group classes and other resources can engage them in their care and teach them better ways to manage it, and help them stay healthy. The practice provides three examples of how it implements these tools for its patients. • **Educational programs and resources** may include information about a medical condition or about the patient's role in managing the condition. Resources include brochures, handout materials, videos, website links and pamphlets, as well as community resources (e.g., programs, support groups). • **Self-management tools** enable patients to collect health information at home that can be discussed with the clinician. Patients can track their progress and adjust the treatment or their behavior, if necessary. Such as a practice gives its hypertensive patients a method of documenting daily blood pressure readings. The practice provides or shares available **health education classes,** which may include alternative approaches such as **peer-led discussion groups** or **shared medical appointments** (i.e., multiple patients meet in a group setting for follow-up or routine care). These types of appointments may offer access to a multidisciplinary care team and facilitate patients to interact with and learn from each other.	• **Evidence of implementation** 

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KM 23 (1 Credit) Oral Health Education: Provides oral health education resources to patients.	
GUIDANCE	**EVIDENCE**
The practice provides an example of how it provides educational and other resources to patients pertaining to oral health and hygiene. Oral disease is largely preventable with knowledge and attention to hygiene. Poor oral health can complicate the care for chronic conditions such as diabetes and heart disease.	• **Evidence of implementation** 
KM 24 (1 Credit) Shared Decision-Making Aids: Adopts shared decision-making aids for preference-sensitive conditions.	
GUIDANCE	**EVIDENCE**
The care team has, and demonstrates use of, at least three shared decision-making aids that provide detailed information without advising patients to choose one option over another. The care team collaborates with patients to help them make informed decisions that align with their preferences and values. Helping patients understand their health condition and engaging them in shared decision making helps build a trusting relationship. **Shared decision-making resources** • International Patient Decision Aid Standards Collaboration (IPDASC) http://ipdas.ohri.ca/index.html • AHRQ's SHARE Approach https://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html	• **Evidence of implementation** 
KM 25 (1 Credit) School/Intervention Agency Engagement: Engages with schools or intervention agencies in the community.	
GUIDANCE	**EVIDENCE**
The practice develops supportive partnerships with social services organizations or schools in the community. The practice demonstrates this through formal or informal agreements or identifies practice activities in which community entities are engaged to support better health.	• **Documented Process** ***AND*** • **Evidence of implementation** 

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KM Competency F: Connecting With Community Resources.

KM 26 (1 Credit) Community Resource List: Routinely maintains a current community resource list based on the needs identified in KM 21.	
GUIDANCE	**EVIDENCE**
The practice maintains a community resource list by selecting five topics or community service areas of importance to the patient population. The list includes services offered outside the practice and its affiliates, and an update/maintenance date to demonstrate that the list is regularly updated. Maintaining a current resource list that prioritizes the central needs and concerns of the population can help a practice guide patients to community resources that support their health and well-being from that additional support.	• **List of resources**
KM 27 (1 Credit) Community Resource Assessment: Assesses the usefulness of identified community support resources.	
GUIDANCE	**EVIDENCE**
The practice assesses the usefulness of resources by requesting and reviewing feedback from patients/ families/caregivers about community referrals. Community referrals differ from clinical referrals, but may be tracked using the same system. When a practice's patients have unmet social needs, the practice can refer patients to useful community support resources. Meeting the patient's social needs supports self-management and reduces barriers to care.	• **Evidence of implementation**
KM 28 (2 Credits) Case Conferences: Has regular "case conferences" involving parties outside the practice team (e.g., community supports, specialists).	
GUIDANCE	**EVIDENCE**
The practice uses "case conferences" to share information and discuss care plans for high-risk patients with clinicians and others outside its usual care team. **Case conferences** are planned, multidisciplinary meetings with community organizations or specialists to plan treatment for complex patients.	• **Documented process** ***AND*** • **Evidence of implementation**

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Competency G: Additional Patient Collaboration. The practice collaborates with patients to support their specific needs.

KM 29 (1 Credit) Opioid Treatment Agreement: Incorporates opioid treatment agreement for patients prescribed Schedule II opioid prescriptions into the patient medical record.	
GUIDANCE	**EVIDENCE**
For patients on long-term chronic opioid therapy, a treatment agreement is established between the clinician and patient to support safe prescribing of opioids. Patients prescribed a Schedule II opioid require a treatment agreement signed by both parties that, at a minimum: • Outlines joint expectations and responsibilities of both clinician and patient. • Includes the patient's pain management plan, to prevent development of an opioid dependency. • Is included in the patient's medical record. Patients with a signed opioid treatment agreement have shown improved guideline adherence and reduced addiction risk. This criterion aligns with Quality Payment Program final policies for CY 2019 (published in November 2018) to address efforts to improve treatment of opioid use disorders. **Opioid Agreement Resources:** • Federation of State Medical Board Chronic Use of Opioid Analgesics Guidelines https://www.fsmb.org/globalassets/advocacy/policies/opioid_guidelines_as_adopted_april-2017_final.pdf. • Washington State Department of Labor & Industries: http://www.lni.wa.gov/ClaimsIns/Files/OMD/agreement.pdf • Hegmann KT, et al., eds. "Opioids Guideline." Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers. Reed Group, 2017 http://www.acoem.org/uploadedFiles/Public_Affairs/Policies_And_Position_Statements/Guidelines/Library_and_Reference_Material/OPIOID%20TREATMENT%20-%20Reed%20Group%20Guidelines.pdf • Rhode Island Department of Health: http://health.ri.gov/publications/bytopic.php?parm=Addiction%20and%20Overdose#Healthcare%20Providers	• **Evidence of implementation**

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