HeartSong Health In Community
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POLICY STATEMENT:
NCQA-COMPLIANT PATIENT-CENTERED MEDICAL HOME

HeartSong's policy is to implement *all* practice guidelines contained in the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) standards that are applicable to its size and demographics. We cannot be officially recognized by the NCQA as a PCMH, due to the fact that the NCQA does not currently accept applications from naturopathic doctors. However, we do intend to seek certification as an Advanced Primary Care Practice (APCP) with Vermont's Blueprint for Health, a state-led initiative to transform the way that health care and overall health services are delivered in Vermont. The success of our application to become an APCP depends upon our NCQA-PCHM score, which is scheduled to take place on September 1, 2013.

Methods:
Our actual methods for compliance and documentation are described in our various policy statements on the *Policies* page under ABOUT US, as well as on related pages throughout the website.

Performance:
Our performance in different areas is reported on the *Quality Improvement* page under SERVICES.

Since HeartSong follows NCQA standards for quality in health care delivery, it is important for you to have information about what these are.

NCQA Standards for Medical Homes

Goal: The NCQA standards for medical homes describe what the Vermont Blueprint hopes all medical practices in Vermont will provide for people receiving health care in the state.

Purpose: The NCQA-PCMH standards are designed to improve the quality of care that you receive and to encourage you to participate more actively in your health care. It is important that you understand your rights in the new health care system and that you know what to expect at HeartSong. It is also helpful for you to understand why we invite you do certain things during the course of your health care, why the practice is organized as it is, and why this website contains certain types of information for your reference.

Basics: The 2011 NCQA standards emphasize the importance of patient-centered care and the patient experience and focus attention on aspects of primary care that improve quality and reduce cost. They are also based on advances in evidence-based protocol for managing different medical conditions and upon changes in practice capabilities due to advances in electronic medical practice management.

Meaningful Use: The standards also reinforce incentives for meaningful use which the federal government has already put into effect to encourage primary care providers to improve the quality of care they provide.

Go to https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp for more information. *Note however, that naturopaths are not eligible for the meaningful use incentives.*

Primary Care Provider: The reason why naturopaths are not eligible for NCQA recognition or meaningful use incentives is that these are both based on current federal definitions of "primary care provider". Naturopathic doctors are currently not included in the definition; medical doctors and osteopathic doctors are.

Recognition & Certification: A medical practice is eligible to be *recognized* as NCQA-PCMH, and *certified* by the Vermont Blueprint as an APCP, if it accomplishes a minimum of 50% of the recommendations contained in the standards. Items designated as "critical factors" are obligatory, regardless of what other factors are accomplished. Please note that all NCQA-PCHM guidelines do not apply to all practices.

HeartSong: Heartsong's policy is to set higher standards for the organization. HeartSong intends to fulfill 90% or more of the recommendations that apply to the practice by June 2013. We will post our final score on our *Quality Improvement* page under ABOUT US in September 2013, after we receive our score from the NCQA.

The NCQA guidelines for operating as a medical home are organized in the following way:

STANDARDS

A. There are SIX *standards* representing different aspects of successful primary care practice.

1. ***Enhanced Access and Continuity***
2. ***Identification and Management of Populations***
3. ***Care Management and Planning***
4. ***Self-Care Support and Community Resources***
5. ***Care Coordination and Tracking***
6. ***Performance Evaluation and Improvement***

ELEMENTS

B. Each standard is comprised of different *elements.*

Each practice is awarded a certain number of points in each element. A minimum of 50% of the total available points for a given element is necessary for certification as a medical home.

1. *Enhanced Access and Continuity* has SEVEN elements:

a. Access during office hours
b. Access after office hours
c. Electronic access
d. Continuity
e. Medical home education
f. Cultural and lingustic services
g. Practice team

2. *Identification and Management of Populations* has FOUR elements:

a. Patient information
b. Clinical data
c. Comprehensive health assessment
d. Data for population management

3. Care Management and Planning has FIVE elements:

a. Evidence-based guideline implementation
b. High risk patient identification
c. Care management
d. Medication management
e. Electronic prescribing

***4. Self-Care Support and Community Resources* has TWO elements:**

a. Self-care support
b. Community resource referrals

***5. Care Coordination and Tracking* has THREE elements:**

a. Test tracking and follow up
b. Referral tracking and follow up
c. Facility coordination during care transitions

***6. Performance Evaluation and Improvement* has SIX elements:**

a. Performance evaluation
b. Patient and family experience assessment
c. Continous quality improvement
d. Demonstration of quality improvement
e. Performance reporting
f. External data reporting

FACTORS

C. In turn, each element consists of different factors.

Implementing a factor contributes to the score that the practice earns for compliance with the guidelines. The total percent of compliance for a practice is based upon the number of factors (services) accomplished divided by the total number of points possible for a given element. For HeartSong's performance related to the various factors, *see* Progess Reports on the *Quality Improvement* page under ABOUT US.

***1. Enhanced Access and Continuity* has SEVEN elements:**

a. Access during office hours:

Practice has written standards and demonstrates that it monitors performance against these standards to provide:

1 Same-day appointments **CRITICAL FACTOR**
2 Timely advice by telephone
3 Timely advice by electronic messaging
4 Appropriate documentation of clinical advice

b. Access after office hours:

Practice has written standards and demonstrates that it monitors performance to against these standards to provide:

1 Access to routine & urgent-care outside of business hours
2 Continuity of medical record info for care and advice when office is closed
3 Timely advice by phone when office closed **CRITICAL FACTOR**
4 Timely advice by interactive electronic system when office closed.
5 Document after-hours advice

c. Electronic access:

Practice provides through a secure electronic system:

1 Electronic copy of health information within 4 days to more than 50% of patients who request it
2 Electronic access to current health info w/in 4 days to at least 10% of patients
3 Clinical summaries for more than 50% of office visits within 3 days.
4 Two-way communication
5 Requests for appointments or script refills
6 Requests for referrals or test results

d. Continuity

Practice provides continuity by:

1 Allowing patient to select personal clinician
2 Documenting the choice of clinician
3 Monitoring percent of visits w/clinician

e. Medical home education

Practice has process and provides materials about role of medical home:

1 Responsible for coordinating care
2 Policies for after hour care
3 Patients provide complete history and information regarding care obtained outside practices
4 Patient access to evidence-based care and self-management support

f. Cultural and linguistic services

Practice meets the cultural and linguistic needs of its patients

1 Assesses racial/ethnic diversity of patient.
2 Provides interpretation services
3 Provides interpretation services
4 Provides printed materials in patient language

g. Practice team

Practice provide patient services by:

1 Defining roles for clinical/nonclinical team members
2 Holding regular team meetings.
3 Training on self-management, self-efficacy, and behavior change.
4 Training on patient population management
5 Training on communication skills.
6 Care team involvement in performance evaluation and quality improvement.

2. Identification and Management of Populations has FOUR elements:

a. Patient information

Practice has a searchable electronic system and records data *more than 50%* of the time for the following. *Due to HeartSong's commitment to equal access and parity of care, our goal for this element is 100% for all factors.*

1 Date of birth
2 Gender
3 Race
4 Ethnicity
5 Preferred language
6 Telephone numbers
7 Email
8 Dates of previous clinical visits
9 Legal guardian/health care proxy
10 Primary caregiver
11 Advance directives (NA for peds)
12 Health Insurance

b. Clinical data

Practice uses searchable electronic system to record the following data. *Again, HeartSong's goal is 100% for all factors.*

1 Up-to-date problem list of active dx for 80%
2 Allergies, including medication and reactions for 80%
3 BP and date of update for 50%
4 Height for 50%
5 Weight for 50%
6 BMI for 50%
7 Length/height/head for 50% < 2 yo; BMI 50% 2-20 yoa
8 Tobacco use >13 yoa for 50%
9 Prescription meds w/ date of update for 80%

c. Comprehensive health assessment

Practice conducts and documents a health assessment:

1 Age and gender appropriate immunizations/screenings
2 Family, social, cultural characteristics
3 Communication needs
4 Medical history patient and family
5 Advance care planning
6 Behaviors affecting health: nutrition, substance abuse
7 Patient/Family mental health/substance abuse
8 Developmental screening w/standardized tool
9 Depression screening using standardized tool

d. Data for population management

Practice uses patient data and evidence-based guidelines to generate lists and remind patients about needed services

1 For three different preventive medicine services
2 For three different chronic care services
3 Patients not recently seen by the practice
4 Specific medications

3. Care Management and Planning has FIVE elements:

a. Evidence-based guideline implementation

Practice implements guidelines through point of care reminders for patients with:

1 The first important condition: *HTN management (HeartSong)*
2 The second important condition: *Diabetes management (HeartSong)*
3 The third condition, related to unhealthy behaviors, mental health, or substance abuse: *Body composition management (HeartSong)*

b. High risk patient identification

The practice does the following:

1 Establishes a criteria and a process to ID high risk or complex patients
2 Determines the % of high risk patients in the population

c. Care management

Care team performs the following for at least 75% of patients from Elements a and b:

1 Conducts pre-visit preparations
2 Collaborates with patient to develop care plan, including treatment goals
3 Gives patient written care plan
4 Assesses and addresses barriers to treatment goals
5 Gives patient clinical summary at relevant visits
6 Identify patients who need care management support
7 Follows up with patients who have not kept important appointment

d. Medication management

Practice manages medications in the following way:

1 Reviews & reconciles medications for more than 50% care transitions.
CRITICAL FACTOR
2 Reviews & reconciles medications for more than 80% care transitions
3 Provides information about new prescriptions to more than 80%
4 Assesses patient understanding of medications for more than 50% of patients
5 Assesses patient response to medication and barriers to adherence for more than 50% of patients
6 Documents OTCs, herbal/supplements for more than 50% of patients with date of update

e. Electronic prescribing

Practice uses e-prescribing with the following capabilities:

1 Generates and transmits at least 40% of prescriptions to pharmacies
2 Generates at least 75% of eligible prescriptions
3 Integrates with patient medical records
4 Performs patient-specific checks for drug-drug and drug-allergy interactions
5 Alerts prescribers to generate alternatives
6 Alerts prescribers to formulary status

4. Self-Care Support and Community Resources has TWO elements:

a. Self-care support

Practice conducts activities to support patients in self-management:

1 Provides education resources or refers at least 50% to educational resources
2 Uses EMR to identify education resources and provide them to 10%
3 Collaborates with at least 50% of patients to develop and document self-management plans and goals **CRITICAL FACTOR**
4 Documents self-management abilities for at least 50% of patients
5 Provides self-management recording tool to at least 50% of patients
6 Counsels at least 50% of patients on living healthy lifestyles

b. Community resource referrals

Practice supports patients who need access to community resources:

1 Maintain current resource list covering five (5) community service area (e.g. smoking cessation, weight loss, parenting, dental, transportation, fall prevention, meal support).
2 Tracks referrals provided to patients
3 Arranges for or provides treatment for mental health/substance abuse disorders.
4 Offers opportunities for health education and peer support

5. Care Coordination and Tracking has THREE elements:

a. Test tracking and follow up

Practice has documented processes for and demonstrates:

1 Tracks lab tests & flags & follows up on overdue results **CRITICAL FACTOR**
2 Tracks imagine tests and flags and follows-up on overdue results **CRITICALFACTOR**
3 Flags abnormal lab results
4 Flags abnormal imaging results
5 Notifies patients of normal and abnormal results
6 Follows up on newborn screening
7 Electronically order and retrieve lab tests & results
8 Electronically order and retrieve imaging tests & results
9 Electronically incorporate at least 40% of lab results in records
10 Electronically incorporate imaging results in records

b. Referral tracking and follow up:

Practice coordinates referrals:

1 Provides specialist with key information & reason for the referral
2 Tracks referral status
3 Follows up to obtain specialist reports
4 Has agreements with specialists documented in the records
5 Asks patients about self-referrals and requests specialist reports
6 Demonstrates electronic exchange of key clinical information
7 Provides electronic summary of care for at least 50% of referrals

c. Facility coordination during care transitions

Practice systematically demonstrates

1 Process to ID patients with hospital admissions or ED visits
2 Process to share clinical info with hospital/ED
3 Process to obtain patient discharge summaries
4 Process to contact patients for FU care after discharge
5 Process to exchange patient info w/hospital
6 Collaborates w/patients to create written care plan for transitions from pediatric to adult care
7 Electronic exchange of key clinical information w/facilities
8 Provides electronic summary of care for more than 50% of transitions of care

6. Performance Evaluation and Improvement has SIX elements:

a. Performance evaluation

Practice measures or receives the following data:

1 Three (3) preventive care measures.
For HeartSong: PAP, HPV, Chlamydia, PSA, mammogram, colonoscopy
2 Three (3) chronic or acute care measures.
For HeartSong: BMI, BP, HbA1c
3 Two (2) utilization measures affecting health care costs.
For HeartSong, the number of hospitalizations and ER visits
4 Vulnerable population data.
For HeartSong, Medicaid

b. Patient and family experience assessment

Practice obtains patient feedback on patient experience with the practice and their care:

1 Practice conducts survey measuring experience on at least 3 of the following: access, communication, coordination, whole person care.
2 Practice uses PCMH CAHPS-CG survey tool
3 Practice obtains feedback from vulnerable populations
4 Practice obtains feedback through qualitative means

c. Continous quality improvement

Practice uses ongoing quality improvement process:

1 Set goals and act to improve performance on three measures from element 6a.

2 Set goals and act to improve performance on one measure from element 6b

3 Set goals and address at last one identified disparity in care for vulnerable populations

4 Involve patients in quality improvement teams or on the practice's advisory council.

d. Demonstration of quality improvement

Practice demonstrates ongoing monitoring of the effectiveness of the improvement process:

1 Tracks results over time

2 Assesses effects of its actions

3 Achieves improved performance on one measure

4 Achieves improved performance on a second measure

e. Performance reporting

Practice shares data from Element a and b

1 Individual clinician results within the practice

2 Practice results within the practice

3 Individual clinician or practice results to patients or public.

f. External data reporting

Practice electronically reports

1 Ambulatory clinical quality measures to CMS

2 Data to immunization registries or systems.

3 Syndromic surveillance data to public health