Not so Trivial Pursuit - PCMH Edition

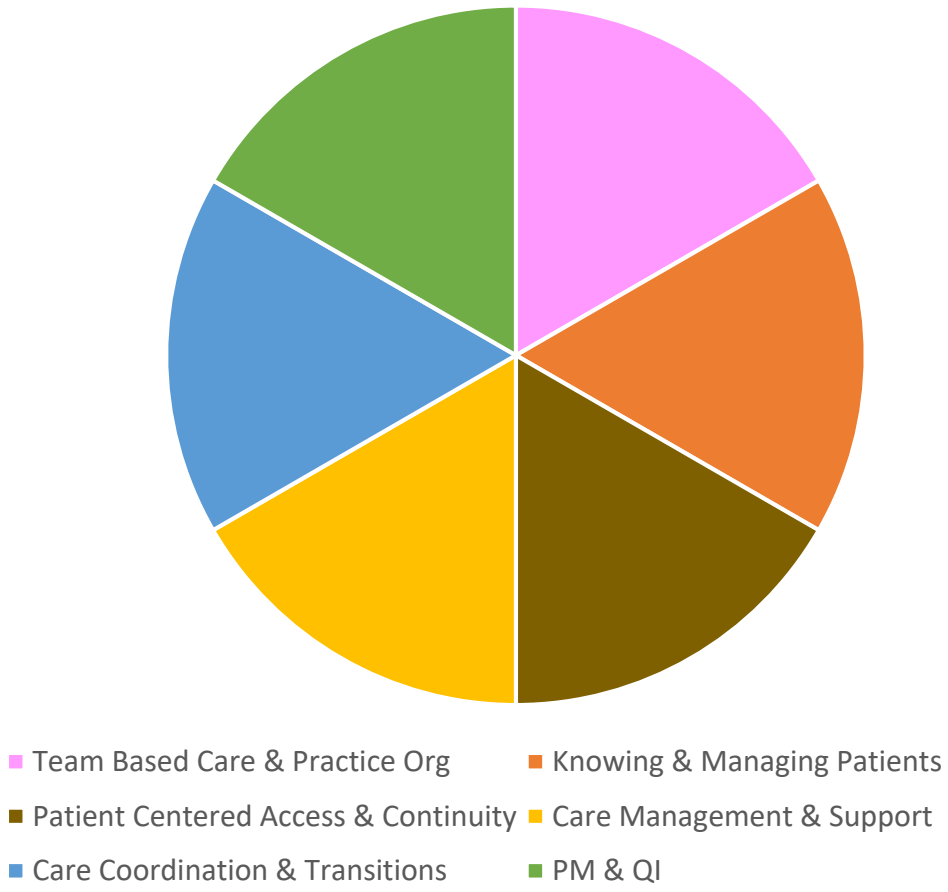
Chris Espersen, MSPH

Mandy May, MPH

Learning Objectives

- Apply best practices to become a true medical home
- Understand the new 2017 NCQA PCMH standards
- Adapt tools to organize, maintain, and sustain your medical home transformation

Our time together today



PCMH Redesign

Commit

Practice completes an online guided assessment.

Practice works with an NCQA representative to develop an evaluation schedule.

Practice works with NCQA representative to identify support and education for transformation.

New NCQA PCMH online education resources support the transformation process.

Transform

Practice submits initial documentation and checks in with its evaluator

Practice submits additional documentation and checks in with its evaluator.

Practice submits final documentation to complete submission and begin NCQA evaluation process.

Practice earns NCQA Recognition.

Succeed

Practice is prepared for new payment environment (value-based payment, MACRA MIPS/APMs).

Practice demonstrates continued readiness and high quality performance through annual reporting to NCQA.

Commit

- Get buy-in
- Review standards, get trained
- Determine eligible clinicians
- Determine sites and fee schedule
- HRSA Notice of Intent (PAL 2015-02)
- Enroll in QPASS

Secure | https://qpass.ncqa.org/Home/Welcome

NCQA Q-PASS

Sign In / Register

Welcome to the Quality Performance Assessment Support System (Q-PASS)

- Sign In and Enroll
- Learn About Our Programs
- Eligible?
- Price Calculator
- Contact Us
- Educational Resources

National Committee for Quality Assurance
1100 13th St., NW, Suite 1000
Washington, D.C. 20005

 • System version 273

Transform

- Get buy-in
- Identify current state and ideal state
- Implement new workflows, policies and procedures
- Gather documentation for evidence
- Introductory call
- Up to 3 virtual check-ins
- Peer Review Committee

Evidence Library

How to add new evidence? INSTRUCTIONS

Click the "Add New Evidence" button to add evidence.
Formats allowed are PDF, JPG, PNG, DOC, DOCX, XLS, XLSX, PPT, and PPTX.

Add New Evidence

Colorado Coalition For The Homeless - Stout Street Health Center

Search for evidence...

use letters (A-Z) and numbers (0-9)

Attached 1

Health Literacy Resources

https://www.healthliteracycolorado.org/

Attached 1

Health Litercy Conference

https://www.uchealth.org/events/events/building-bridges-within-and-between-organizations-third-annual-chlc-conference/

Attached 1

National Institute of Oral Health website

https://www.nidcr.nih.gov/

Attached 1

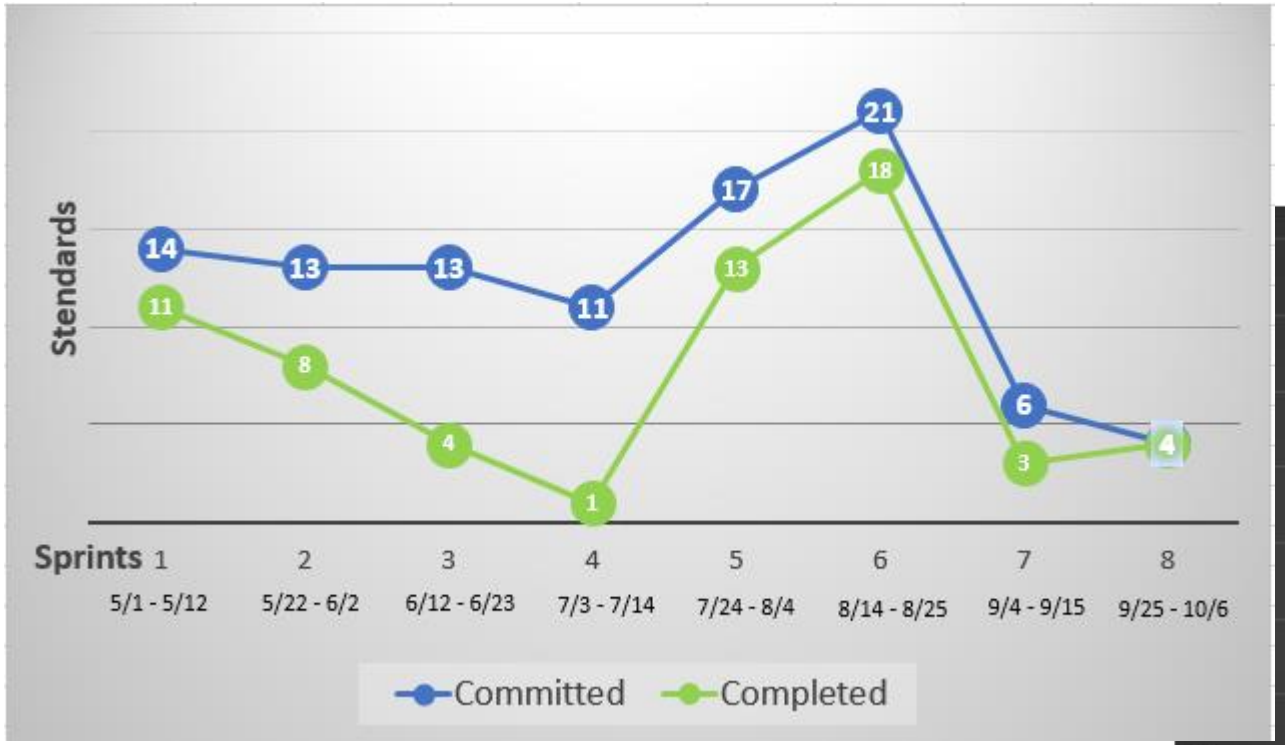
CCH Community Resources

Project Management Tools for Success

- Agile project management methodology
  - Kick off
  - Bi-weekly sprints
- Project Charter
- Communication Tools

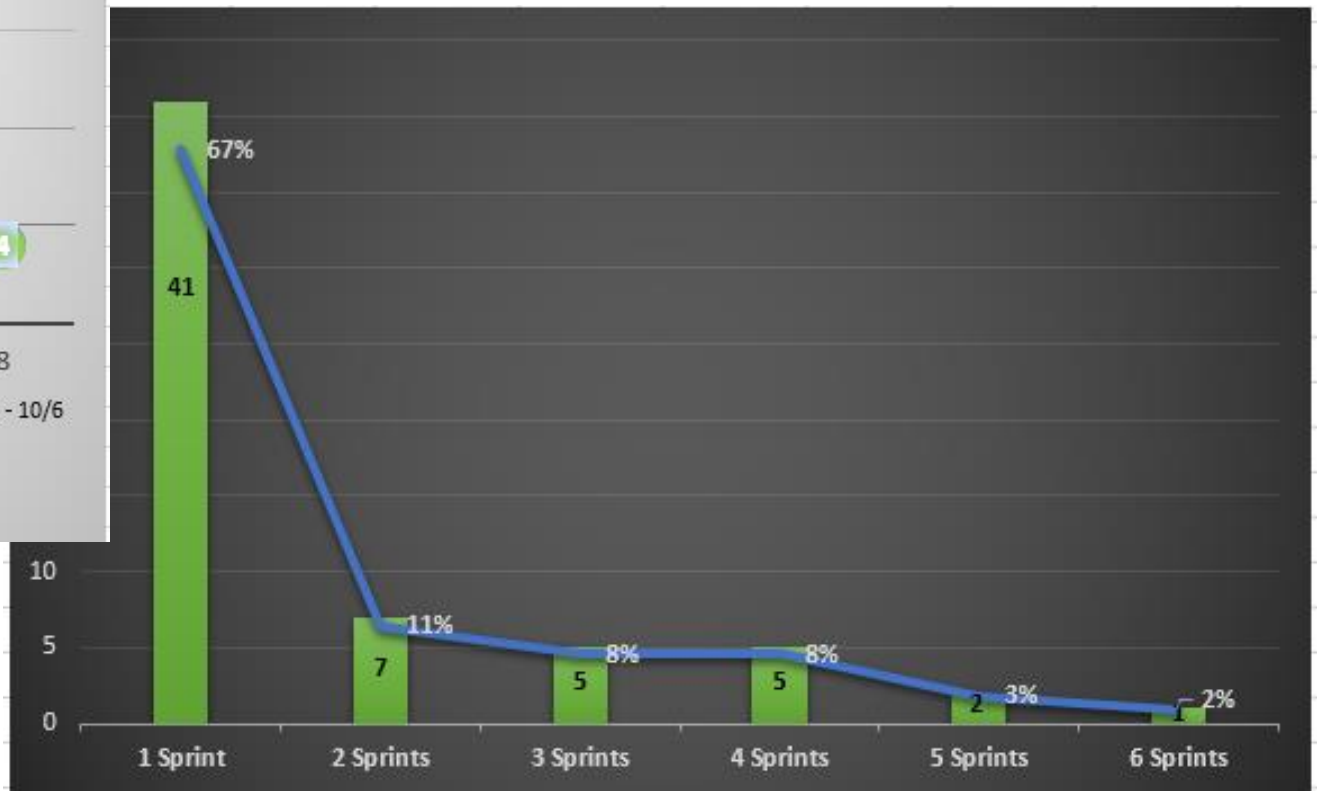
Sprint Effort

The team completed the PCMH Standards review and subsequent work required (policies, workflows, reports, etc.) within 8 Sprints. The 9th Sprint was not needed as such. A small subset of the Project Team involved in the NCQA Check In Calls and related efforts continued to meet and work outside the Sprint format.



Items Completed per Sprint

Number of Sprints to Complete Items



Succeed

- Maintain transformation
- Enhance model
- Annual reporting

Maintaining and sustaining

Keeping organized

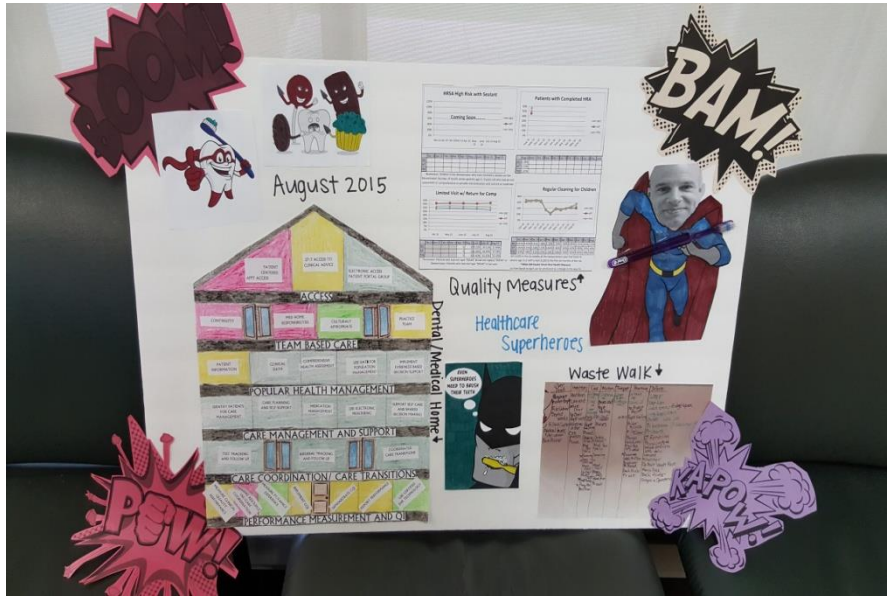
2 COPIES OF EVERYTHING ON DESK BY END OF EACH DAY

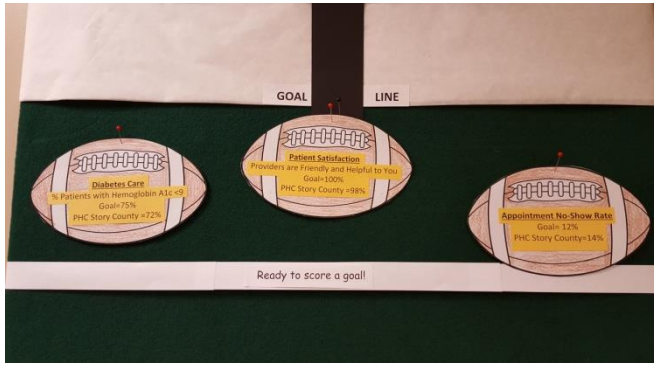
QUALITY IMPROVEMENT SPECIALISTS MONTHLY CALENDAR

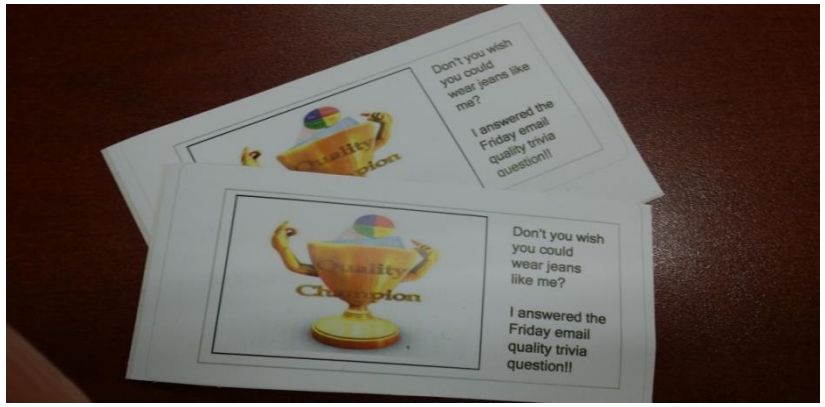
		Monday	Tuesday	Wednesday	Thursday	Friday
WEEK 1	Quality Specialist #1	1. Monthly SPA Update (8 hrs.) 2. SPA Enrollment Data (20 min.) & send email to NCMs & CDs 3. Run UDS Income report –email CDS with unknown %	1. Empanelment (4 hrs.) 2. No Show data for clinics – 3 No shows in last 90 days. (Save lists of patients on S Drive for Clinic Managers)	1. Check in on Wellness Plan. 2. Post IWP Enrollment Charts to Conference Room.	**Admin. Team Meeting: 12:00 – 1:00 (1 hr.)** **Creative Time** 1. Meaningful Use Data (2 hrs.)	1. Data Requests/NCM questions (30 min) 2. Update Instructions (1hr) 3. Admin Time (1hr) **Clinic M QI Meeting: 12:00-1:00 (3.5 hrs. Prep, Meeting, Travel, Write-Up, Follow-Up)**
	Quality Specialist #2	1. Clinical Indicators monthly and yearly (6 hrs) 2. Clinical Indicators by provider (2 hrs)	1. SPA measures monthly and yearly (2hrs) 2. Post PDF's to intranet (5 min) 3. ACO, LockIn measures, monthly and yearly (6hrs)	1. Diabetic Disparity Charts (1 hr) 2. Print and send DWP letters (10 minutes) – do on the 1st of every month 3. Payer Scoreboard	**Admin. Team Meeting: 12:00 – 1:00 (1 hr.)** **Creative Time** Get Last weeks winner from Chris, send new quality trivia question	1. Standard Five Review (30 min) 2. Data Requests/NCM questions (30 min) 3. Weekly DV Update (1 hr) 4. Monthly DV Data (1 hr) 5. Supportive Services (1 hr) 6. BH Dashboard (1 hr) Post to Intranet 7. Pts Not Recently Seen (30 min) 8. Update Instructions (1hr)
WEEK 2	Quality Specialist #1	1. Deceased Pts. (30 mins.) 2. Monthly Letter Preparation (Data, Printing, Lists to CDs). (7 hrs.) 3. SPA Enrollment Data (20 min.) & send email to NCMs & CDS 4. Referral Coordinator Call 2:00-3:00	1. HIV Data (4 hrs.) **Clinic O QI Meeting: 12:00 – 1:00 (3.5 hrs Prep, Meeting, Travel, Write-up, Follow-up)**	1. 3NA Data (2 hrs.)	1. Mail Monthly Letters	1. Admin Time (1hr) 2. Data Requests/NCM questions (30min) 3. Update Instructions (1 hr)
	Quality Specialist #2	1. Dental Clinic Indicators (1 hr) 2. 2A, 2B, Obesity, Responsible Provider, High Risk, Clinic Visit Summary (2 hrs) Post to Intranet 3. Risk Adjustment Data/DV Risk Adjustment (2 hrs) 4. RC Call 2:00-3:00	1. Referral Tracking (8 hrs)	**Clinic B QI Meeting: 12:00-1:00 (3.5 hrs. Prep, Meeting, Travel, Write-up, F/up on Action Items)** 1. Risk Adjustment Codes vs. Problems (1 hrs) 2. Appointment Statistics (2 hrs) 3. Provider Project Data and HPV list for clinic (2 hrs)	**Clinic B Dental QI Meeting: 1:00-2:00 (3.5 hrs, Prep Meeting, Travel, Write-up, F/up on Action Items)** **Creative Time** Get Last weeks winner from Chris, send new quality trivia question 1. Homeless Tracking Type 2. Homeless Quality Measures	1. Standard Five Review (30 min) 2. Data Requests/NCM questions (30 min) 3. Weekly DV Update (1 hr) 4. Update Instructions (1 hr)

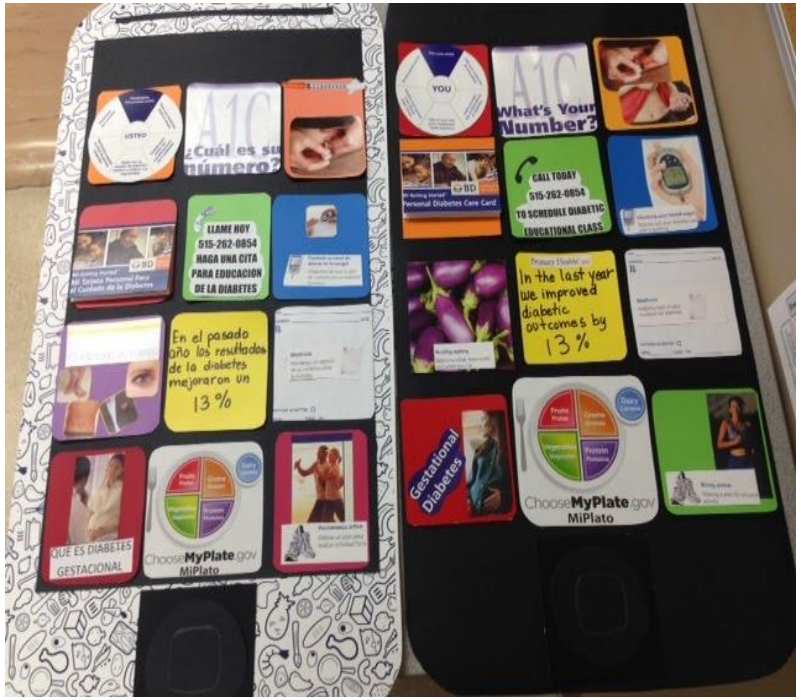
2 hour task

Data Engagement





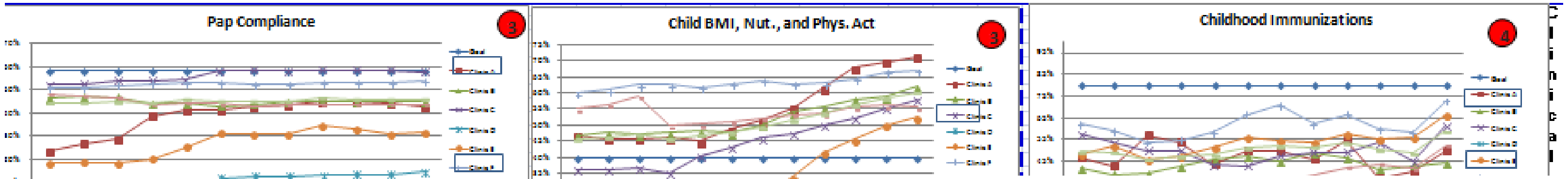


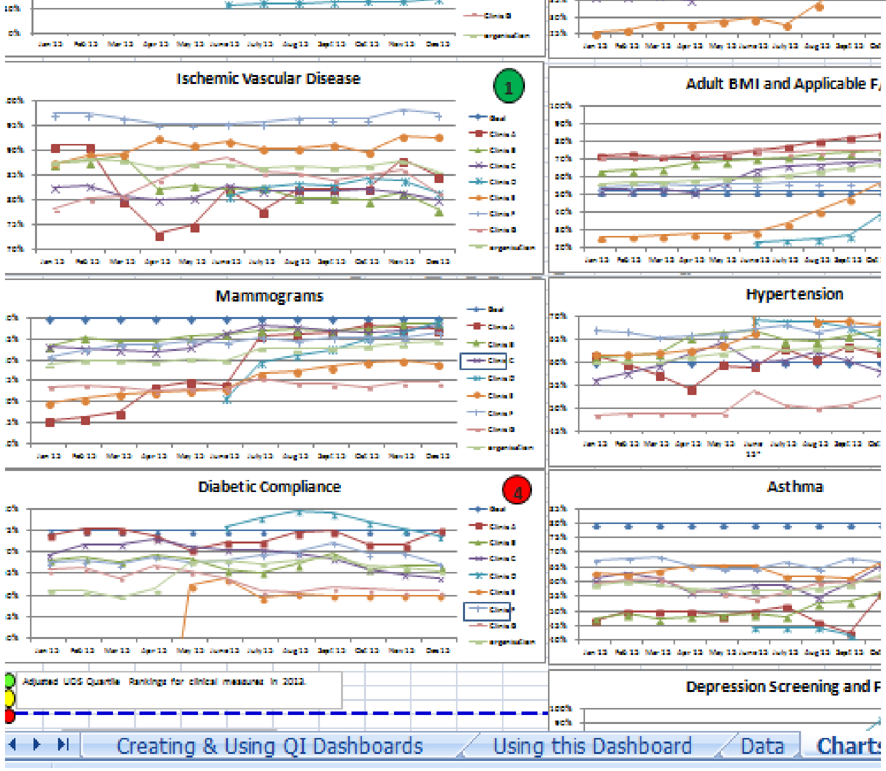


Patient and Staff Engagement

Goal # 5
Improve Patient Experience

Dashboards





NURSE CARE MANAGER SUCCESS CARD- MM YYYY

Medical Home Documentation

Site	3C - Comprehensive Health Assessment: 3C1 Clinical Protocols Reviewed (Checkbox on PVP form)	3C2 - DV/Gender/Homeless Assessed	3C3 Possible Barriers (Initial Intake form)	3C4 Medical Hx Reviewed (Checkbox on Patient History form)	3C6 - Food/Financial Ed/Dental Ed Assessed (Adult HM & Ed form)	3C7 - Pre-AUDIT Done (SBIRT form)	3C9 - PHQ Completed	3C10
Clinic A	99%	100%	58%	96%	12%	94%	96%	N/A
Clinic B	93%	100%	74%	69%	1%	86%	87%	N/A
Clinic C	90%	100%	20%	73%	2%	80%	88%	N/A
Clinic D	94%	100%	45%	79%	16%	73%	84%	N/A
Clinic E	98%	100%	71%	71%	4%	83%	85%	N/A
Clinic F	93%	100%	4%	69%	6%	76%	89%	N/A
GOAL	NEED TO SET GOALS FOR 3C							

Site	4B- Care Planning & Self-Care Report: 4B1 Care Plan developed with pt/fam. (Checkbox on Care Mgmt Plan form)	4B2 Tx Plan (Pt Instruct/Care Plan based on Assessment and Plan form)	4B3 Barriers to Self Mgmt Goals (Barriers checkbox)	4B4 Self Mgmt Goals Created	4B5 CM Plan Printed
Clinic A	8%	96%	6%	8%	88%
Clinic B	53%	68%	42%	66%	71%
Clinic C	13%	70%	14%	17%	67%
Clinic D	50%	48%	24%	28%	50%
Clinic E	46%	83%	46%	47%	85%
Clinic F	23%	75%	17%	25%	63%
GOAL	75%	75%	75%	75%	80%

Site	4C - Medication Management: 4C1 - Meds Reviewed	4C2 - Meds Reviewed	4C3 - New Rx Info Given (Checkbox on Care Mgmt Plan form)	4C4 - Med Understanding Assess. (Checkbox on Care Mgmt Plan form)	4C5 - Barriers to Meds Assess. (Checkbox on Care Mgmt Plan form)	4C6 - Meds Reviewed
Clinic A	99%	99%	10%	8%	8%	99%
Clinic B	89%	89%	15%	63%	63%	89%
Clinic C	94%	94%	51%	15%	15%	94%
Clinic D	89%	89%	17%	17%	17%	89%
Clinic E	97%	97%	45%	46%	46%	97%
Clinic F	95%	95%	10%	23%	23%	95%
GOAL	80%		80%	50%	50%	50%

Patient Enrollment and Graduation

Site	SPA	Non-Spa	Low-Risk	Total	Grad
Clinic A	85	75	0	160	0
Clinic B	277	29	12	318	2
Clinic C	341	7	0	348	0
Clinic D	189	49	0	238	0
Clinic E	386	17	0	403	0
Clinic F	332	22	1	355	0
GOAL	250				

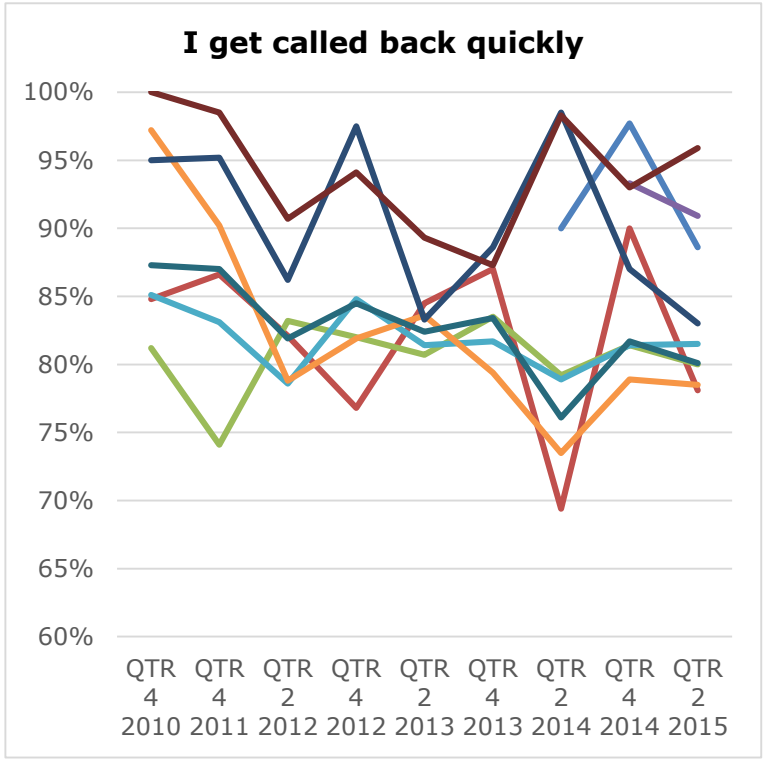
Productivity

Site	# PVP	F2F	Phone	Total	Hosp F/U
Clinic A	26	195	48	269	N/A
Clinic B	637	1542	377	2556	N/A
Clinic C	252	471	374	1097	N/A
Clinic D	57	163	57	277	N/A
Clinic E	408	789	18	1215	N/A
Clinic F	496	1550	236	2282	N/A

Clinical Indicators

Site	A1C	HTN	Asthma	CAD	IVD	Immun	Pap	Child BMI	Adult BMI	CRC	Tobacco	PHQ
Clinic A	46%	65%	86%	100%	83%	N/A	53%	67%	89%	25%	100%	82%
Clinic B	64%	66%	80%	80%	88%	N/A	63%	75%	86%	27%	100%	45%
Clinic C	72%	55%	56%	60%	90%	50%	59%	50%	80%	40%	100%	82%
IM	67%	61%	25%	100%	89%	N/A	7%	N/A	56%	5%	100%	91%
Clinic D	50%	69%	67%	100%	81%	100%	24%	61%	65%	1%	100%	79%
Clinic E	73%	67%	80%	100%	93%	N/A	59%	68%	80%	27%	100%	76%
Clinic F	65%	49%	69%	91%	96%	100%	68%	91%	74%	23%	100%	82%
GOAL	84%	68%*	81%	95%*	95%*	80%	58%	57%	66%*	35%	90%	50%*

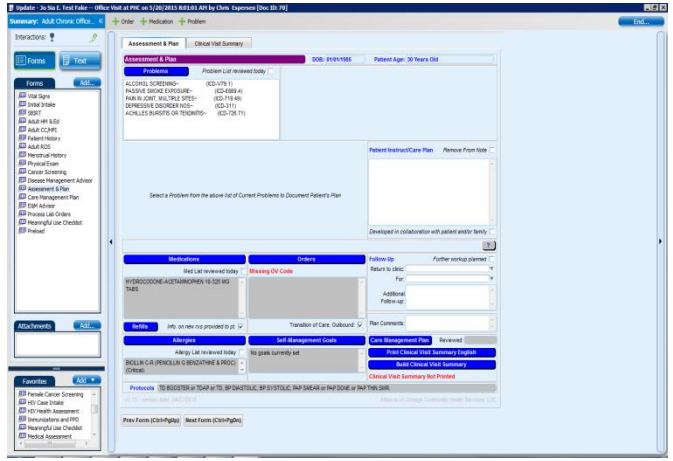
Insatiable thirst for data



Patient Satisfaction Data

Staff questionnaire on phone note process

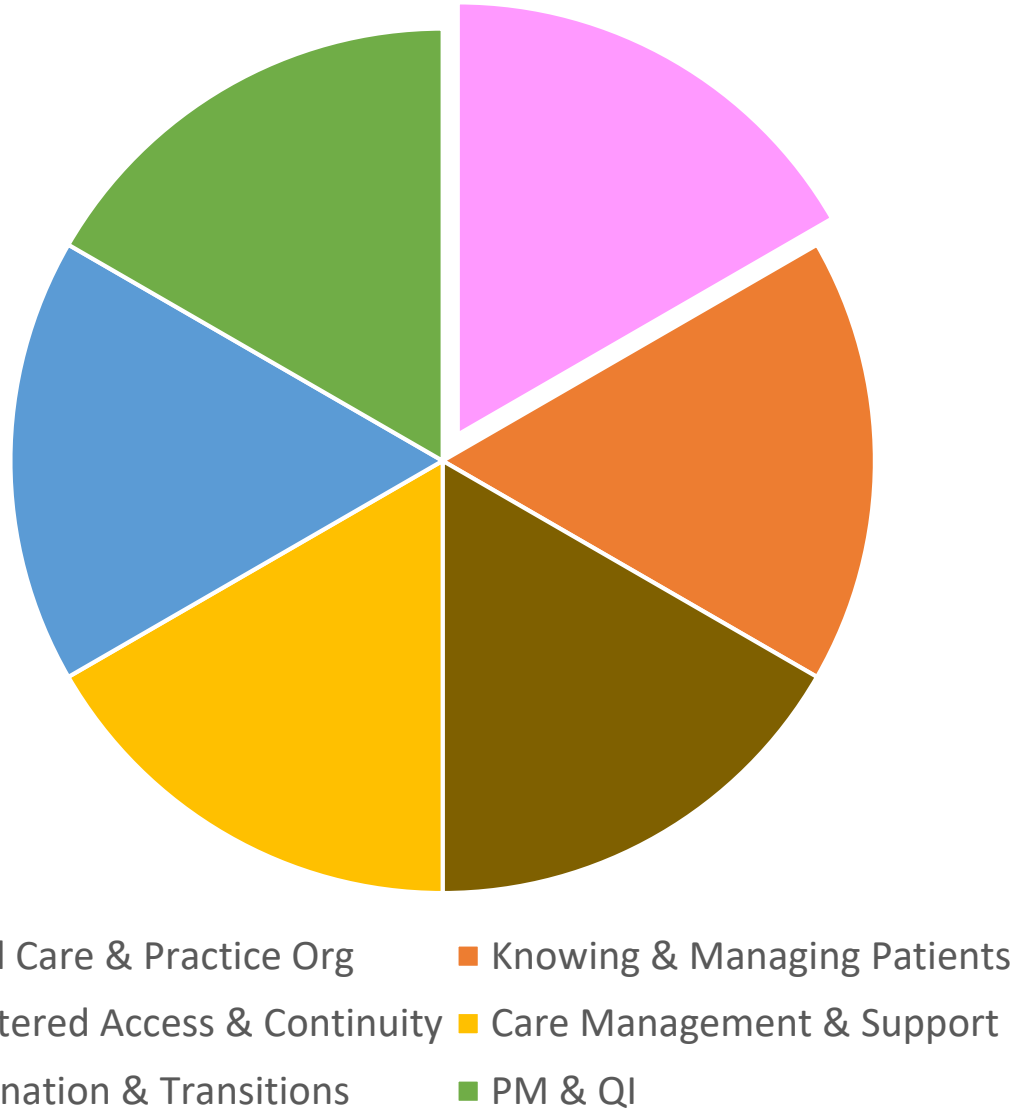
1. How is a client call documented?	2. How do we know what time a patient/client called?	3. How do we know how long it took to return a call?	4.Anything interesting about the proce
A: Call comes in to clinic, client chart opened, select phone note, document caller, phone number and appropriate	A: Ideally, when the call comes in, the client chart is accessed, a phone note is generated, and sent/held to	A: We would know how long it took for a call to be returned by the date/time stamp on the message/document held to the team or	A: -Messages are at times written, vs generated, and then typed at a later tir forgotten et changes the time frame fr
1. Through a phone note sent to corresponding party, for example, if a message is to providers we hold to them 2. In phone note with what was discussed, signed and dated. 3. A phone note is opened and call documented in there. 4. through a phone note 5. On a phone note 6. In a phone note 7. Phone note is opened and everything is documented in the note.	specified in the note 2. When documenting note hit button to sign it with time. 3. It is selected in the phone note 4. By selecting drop down box 5. When we put phone note in option for drop down on time 6. Click on time called when filling out phone note 7. We don't if we take a message from the voicemail only know if we take the call at that	1. Documentation on phone note 2. Time it was originally taken and the time we try to return it with sign with date button.3. We sign off when we make the call and it gives time and date 4. unsure 5. Not a clue?? 6. Date/time marked 7. Only know how long it takes to return call from the phone note.	1. It does take 24 to 48 hours for resp however sometimes provider is out a sent to them anyway which delays res sent to wrong provider. 2. Nothing nothing 5. Nothing
Through phone note-date, time, what call is about.	The time patient calls is written down and transferred onto phone note or a phone note is immediately created with time and date put in __time placed__.	Time patient called is documented and time patient call is returned is documented. All calls have documented time on them.	Calls come in so quick on occasion h writing them down then going back to We (triage) take care of lot of calls tha through.
Through a phone note	You don't know a time if patient has to leave a message. If you answer the phone right away and start the phone note then, it is documented then. Otherwise you have no idea what time a patient calls.	Only if a phone note has been created the time of the initial call. Answering the phone note immediately because another patient needs roomed.	I find it hard to take Spanish speaking because they usually hang up before has time to get to the phone to help, b language barrier they don't understan
open phone notes. Refill Rx are sometimes also open. Some are still opening	In phone notes when the note was		The process is well set, but needs to CMA/Nurses need to use the "new" ca call returned. Make sure the phone s working. Open phone notes for voice



Phone note chart audit

Team Based Care & Practice Organization

The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers, and organizes and trains staff to work to the top of their license and provide effective team-based care.



Team Based Care & Practice Organization

Competency A: The practice is committed to transforming the practice into a sustainable medical home. Members of the care team serve specific roles as defined by the practice's organizational structure and are equipped with the knowledge and training necessary to perform those functions.	**TC 01 (Core): Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.**
	TC 03 (1 Credit): The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges).
	TC 04 (2 Credits): Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees.
Competency B: Communication among staff is organized to ensure that patient care is coordinated, safe and effective.	**TC 08 (2 Credits) Has at least one care manager qualified to identify and coordinate behavioral health needs.**

https://www.ncqa.org/Portals/0/Programs/Recognition/Intro_to_PCMH_2017.pdf?ver=2017-11-01-220650-193

TC – Community Focused Criteria

- TC 03 (1 Credit): The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges).
- TC 04 (2 Credits): Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees.

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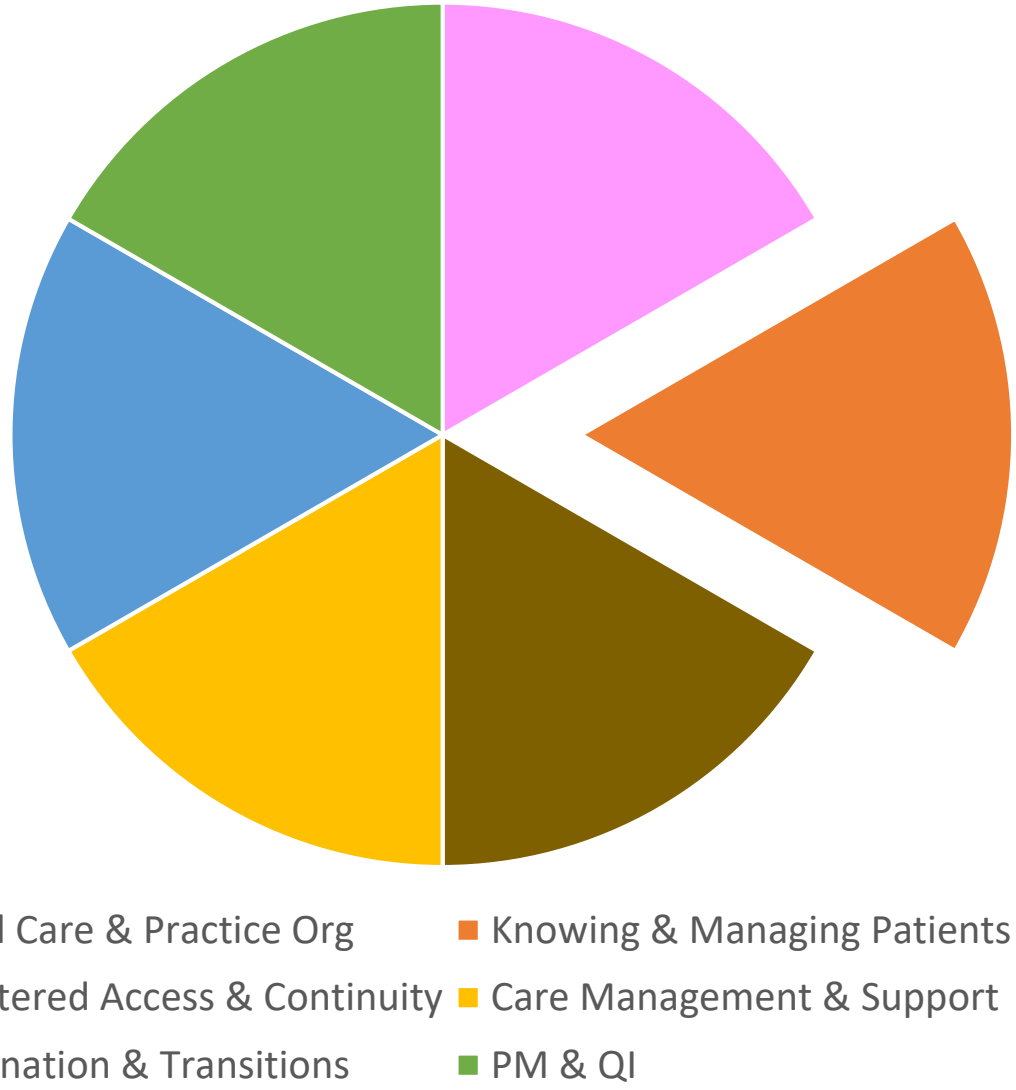
Knowing and Managing Your Patients

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



Knowing and Managing Your Patients

KM 02 (Core): Comprehensive health assessment includes (all items required): **F. Social functioning.** **G. Social determinants of health.**	**KM 04 (1 Credit): 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.**
KM 05 (1 Credit): Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners.	**KM 06 (1 Credit): Identifies the predominant conditions and health concerns of the patient population.**
KM 07 (2 Credits): Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data.	**KM 08 (1 Credit): Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials.**
KM 11 (1 Credit): Identifies and addresses population-level needs based on the diversity of the practice and the community (at least two): A. Target population health management on disparities in care. C. Educate practice staff in cultural competence.	**KM 13 (2 Credits): Demonstrates excellence in a benchmarked/ performance-based recognition program assessed using evidence-based care guidelines.**
KM 18 (1 Credit): Reviews controlled substance database when prescribing relevant medications.	**KM 19 (2 Credits): Systematically obtains prescription claims data in order to assess and address medication adherence.**
KM 21 (Core): Uses information on the population served by the practice to prioritize needed community resources.	**KM 23 (1 Credit): Provides oral health education resources to patients.**
KM 25 (1 Credit): Engages with schools or intervention agencies in the community.	**KM 28 (2 Credits): Has regular "case conferences" involving parties outside the practice team (e.g., community supports, specialists)**

https://www.ncqa.org/Portals/0/Programs/Recognition/Intro_to_PCMH_2017.pdf?ver=2017-11-01-220650-193

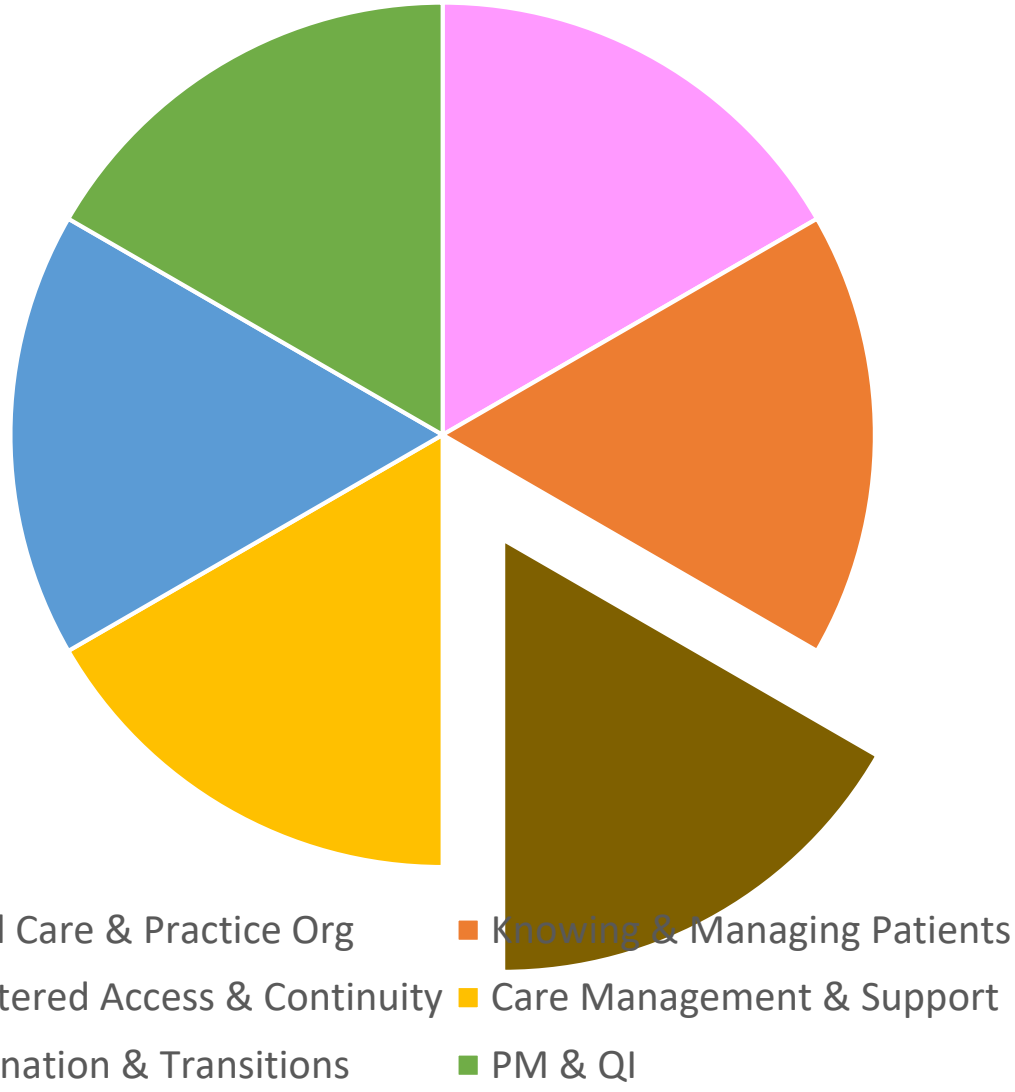
KM – Community focused criteria

- KM 07 (2 Credits): Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data.
- **KM 10 (Core): Assesses the language needs of its population.**
- KM 19 (2 Credits): Systematically obtains prescription claims data in order to assess and address medication adherence.
- KM 21 (Core): Uses information on the population served by the practice to prioritize needed community resources.
- **KM 22 (1 Credit): Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.**
- KM 25 (1 Credit): Engages with schools or intervention agencies in the community.
- **KM 26 (1 Credit): Routinely maintains a current community resource list based on the needs identified in KM 21.**
- **KM 27 (1 Credit): Assesses the usefulness of identified community support resources.**
- KM 28 (2 Credits): Has regular “case conferences” involving parties outside the practice team (e.g., community supports, specialists).

https://www.ncqa.org/Portals/0/Programs/Recognition/Intro_to_PCMH_2017.pdf?ver=2017-11-01-220650-193

Patient Centered Access and Continuity

The practice provides 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team, considers the needs and preferences of the patient population when modeling standards for access.



Patient Centered Access and Continuity

Competency	Core Criteria
Competency A: The practice seeks to enhance access by providing appointments and clinical advice based on patients needs	**AC 01 (core) Assess the access needs and preferences of the patient population**
	AC 09 (1 Credit): Uses information about the population served by the practice to assess equity of access that considers health disparities.
Competency B: Practices support continuity through empanelment and systematic access to the patient's medical record	**AC 13 (1 credit) Reviews and actively manages panel sizes.**
	AC 14 (1 credit) Reviews and reconciles panels based on health plan or other outside patient assignments.

https://www.ncqa.org/Portals/0/Programs/Recognition/Intro_to_PCMH_2017.pdf?ver=2017-11-01-220650-193

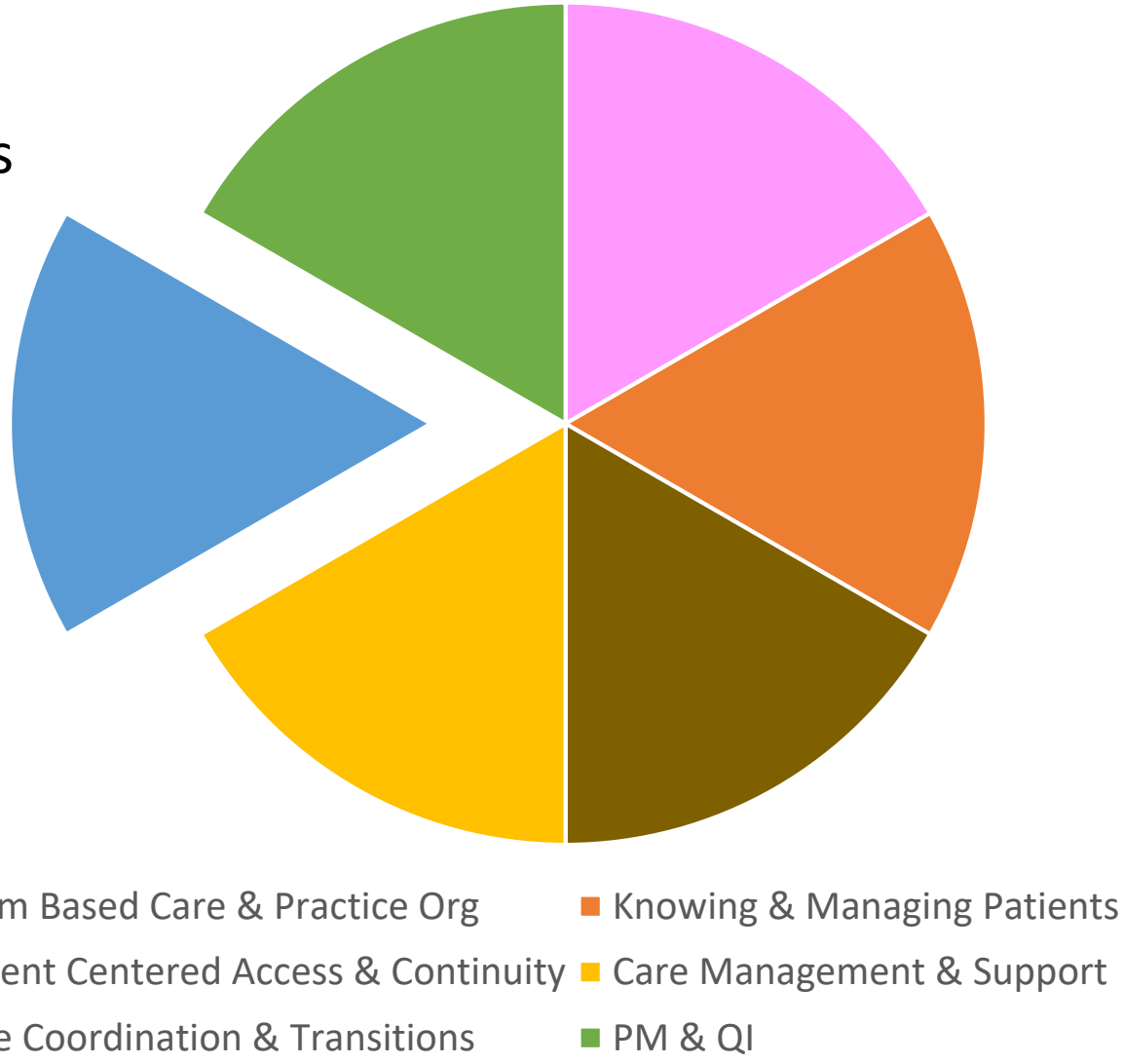
AC – Community Focused Criteria

- AC 03 (core) Appointments Outside Business Hours: Provides routine and urgent appointments outside regular business hours to meet identified patient needs. *May arrange for patients to schedule appointments with other facilities or clinicians.
- **AC 14 (1 credit) External Panel Review and Reconciliation: Reviews and reconciles panels based on health plan or other outside patient assignments**

https://www.ncqa.org/Portals/0/Programs/Recognition/Intro_to_PCMH_2017.pdf?ver=2017-11-01-220650-193

Care Coordination and Transitions

The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations



Care Coordination and Care Transitions

Competency	Core Criteria
Competency A: The practice effectively tracks and manages laboratory and imaging tests important for patient care and informs patients of the result.	**CC 03 (2 Credits): Uses clinical protocols to determine when imaging and lab tests are necessary.**
	CC 05 (2 Credits): Uses clinical protocols to determine when a referral to a specialist is necessary.
	CC 06 (1 Credit): Identifies the specialists/specialty types frequently used by the practice.
Competency B: The practice provides important information in referrals to specialists and tracks referrals until the report is received.	**CC 11 (1 Credit): Monitors the timeliness and quality of the referral response.**
	CC 13 (2 Credits): Engages with patients regarding cost implications of treatment options.
Competency C: The practice connects with health care facilities to support patient safety throughout care transitions. The practice received and shares necessary patient treatment information to coordinate comprehensive patient care.	**CC 17 (1 Credit): Systematic ability to coordinate with acute care settings after office hours through access to current patient information.**

https://www.ncqa.org/Portals/0/Programs/Recognition/Intro_to_PCMH_2017.pdf?ver=2017-11-01-220650-193

CC – Community Focused Criteria

- CC 04 (Core) Practice systematically manages referrals.
- **CC05 (2 credits) Uses clinical protocols to determine when a referral to a specialist is necessary.**

- **CC 06 (1 credit) Identifies the specialist/specialty types frequently used by the practice**.
- CC 07 (2 credits) Considers available performance information on consultants/specialists when making referrals.
- CC 08 (1 credit) Works with nonbehavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care.
- CC 09 (2 credits) Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care.
- **CC 11 (1 credit) Monitors the timeliness and quality of the referral response.**
- CC 15 (Core) Shares clinical information with admitting hospitals and emergency departments
- **CC 17 (1 Credit) Systematic ability to coordinate with acute care settings after office hours through access to current patient information.**

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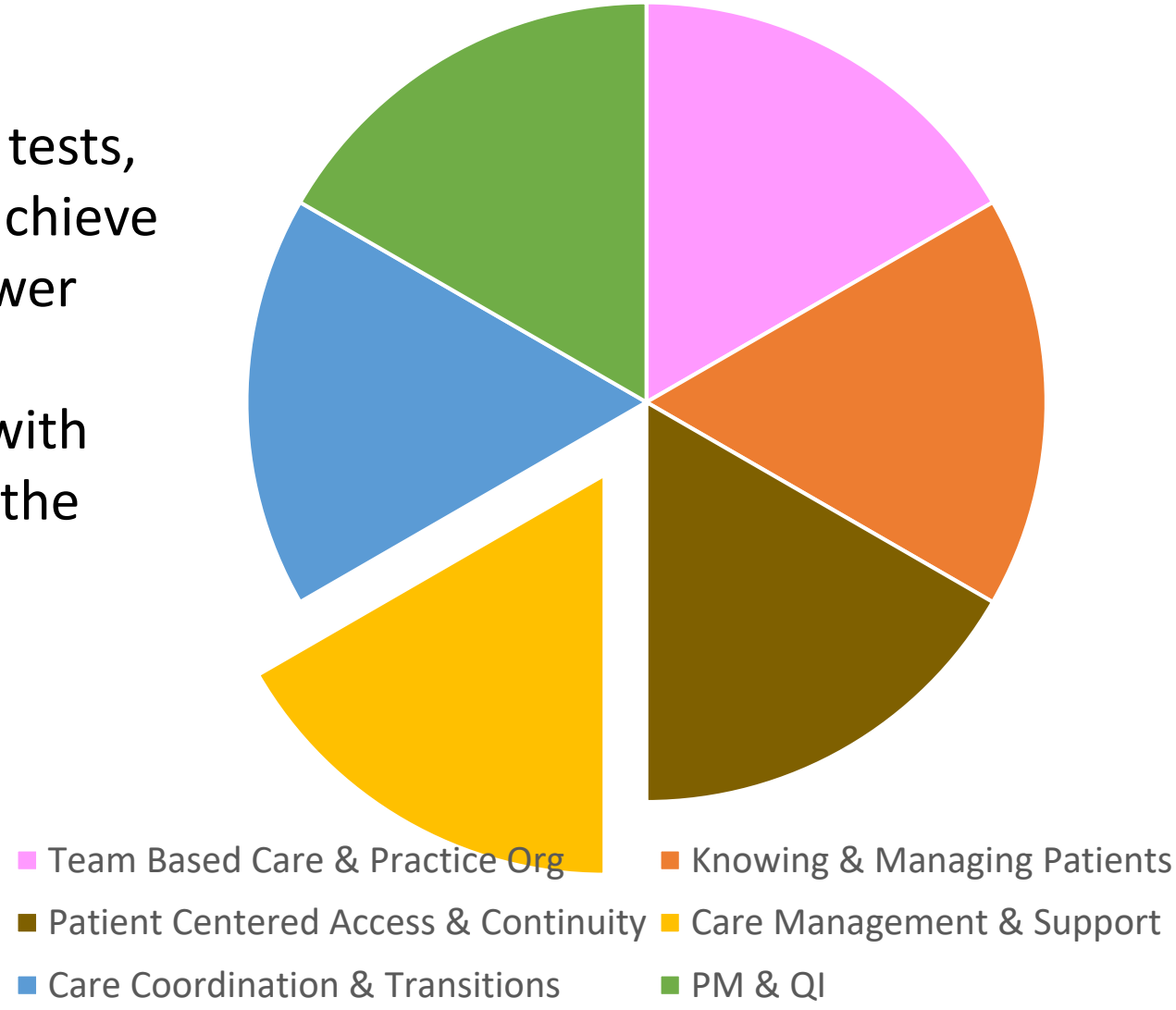
Care Management and Support

The practice systematically tracks tests, referrals, and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood.



Care Management and Support

Competency A: The practice systematically identifies patients who may benefit from care management.	**CM 03 (2 Credits): Applies a comprehensive risk-stratification process for the entire patient panel in order to identify and direct resources appropriately.**
Competency B: For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/ caregivers to develop a care plan that addresses barriers and incorporates patient preferences and lifestyle goals documented in the patient's chart.	**CM 09 (1 Credit): Care plan is integrated and accessible across settings of care.**

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CM – Community Focused Criteria

- **CM 01 (Core): Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria):**
  - **A. Behavioral health conditions.**
  - **B. High cost/high utilization.**
  - **C. Poorly controlled or complex conditions.**
  - **D. Social determinants of health.**
  - **E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/ family/caregiver.**
- **CM 07 (1 Credit): Identifies and discusses potential barriers to meeting goals in individual care plans.**
- CM 09 (1 Credit): Care plan is integrated and accessible across settings of care.

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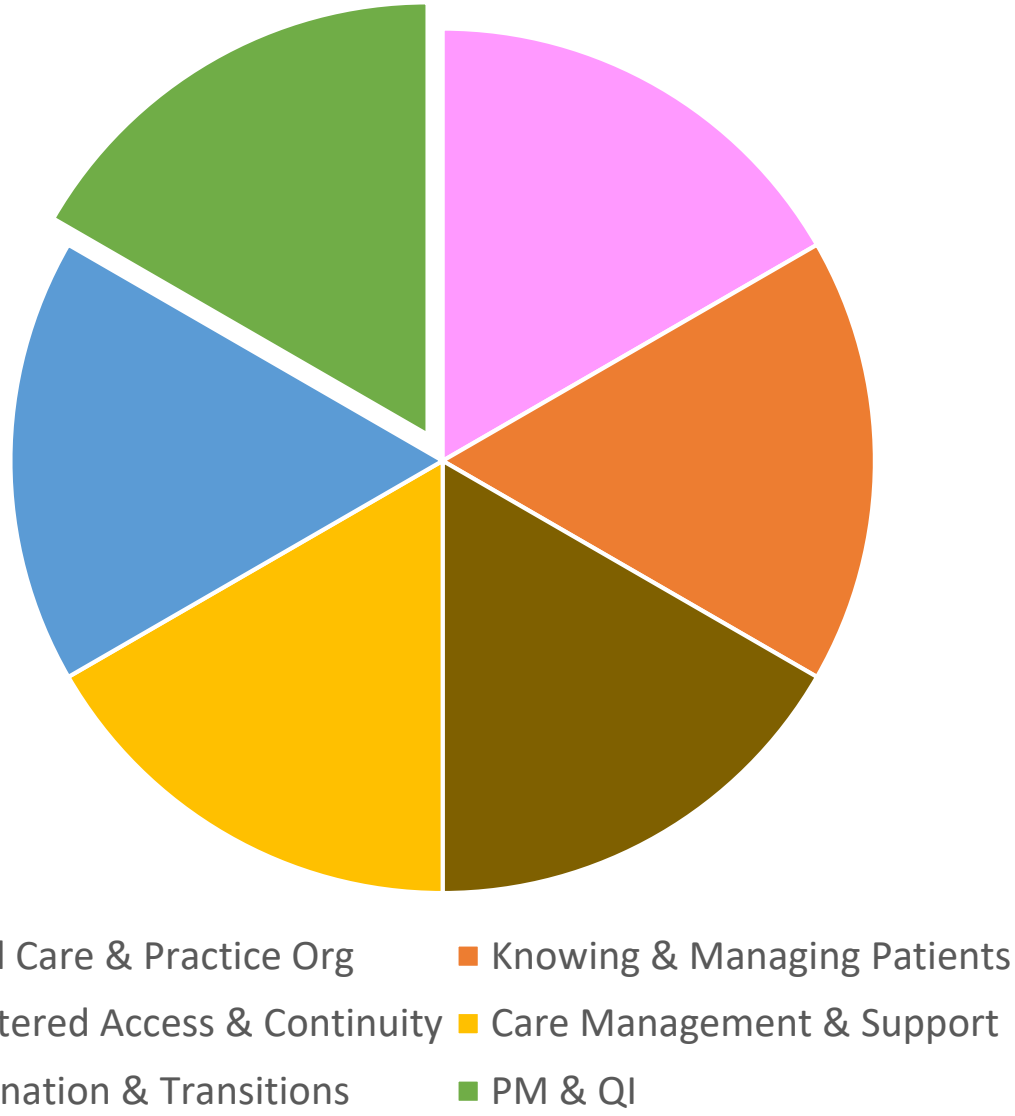
Performance Measurement and Quality Improvement

The practice establishes a culture of data-driven performance improvement on clinical quality, efficiency, and patient experience, and engages staff and patients/families/caregivers in quality improvement activities.



Performance Measurement and Quality Improvement

Competency	Core Criteria
Competency A: The practice measures to understand current performance and to identify opportunities for improvement	**QI 01 (Core) Monitors at least 5 clinical quality measures across the 4 categories (includes behavioral health measure)**
Competency B: The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies	**QI 08 (Core) Sets goals and acts to improve performance upon at least 3 measures across 3 of 4 categories (includes behavioral health measure)**
	QI 14 (2 credits) Achieves improved performance on at least 1 measure of disparities in care or service.
Competency C: The practice is accountable for performance. The practice shares performance data with the practice, patients and/or publicly for the measures and patient populations identified in the previous section	**QI 19 (max 2 credits) Is engaged in value based agreement (upside risk contract or two-sided risk contract)**

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QI – Community Focused Criteria

- QI 16 (1 credit) Reports practice-level or individual clinician performance results publicly or with patients for measures reported by the practice.
- QI 18 (2 credits) Reports clinical quality measures to Medicare or Medicaid agency.
- **QI 19 (Max 2 credits Is engaged in Value-Based Agreement (upside risk contract = 1 credit, two-sided risk contract = 2 credits).**

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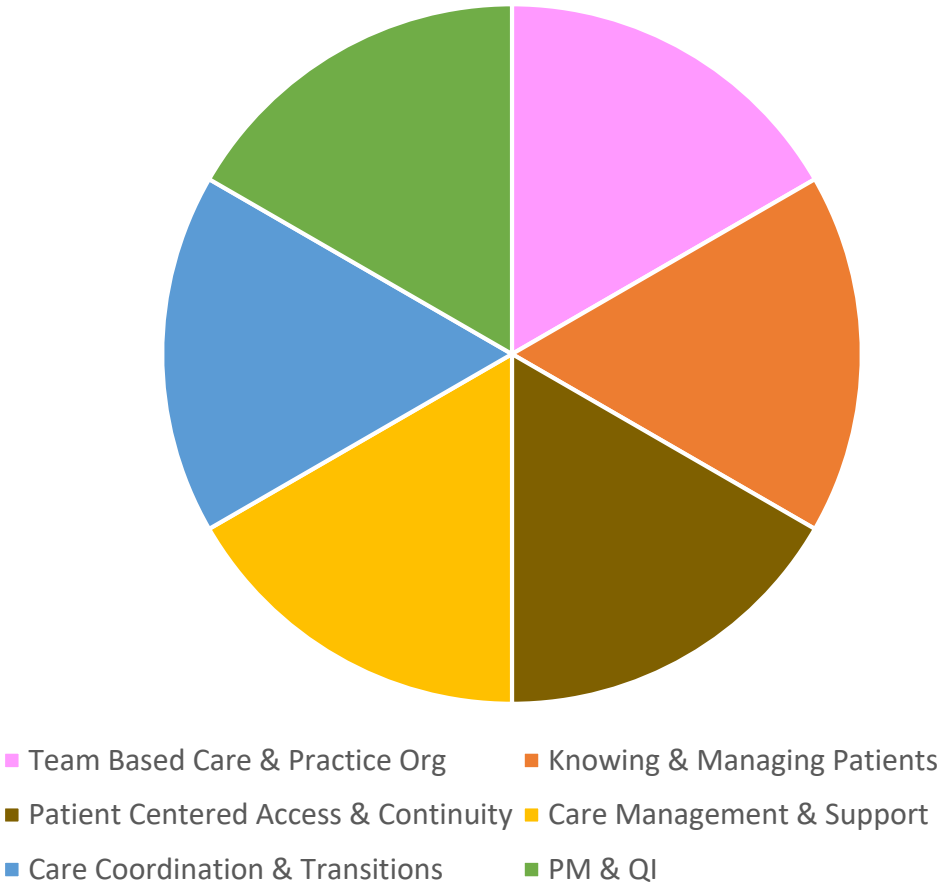
Good Luck in Your Pursuits!

Chris Espersen
espersenc@gmail.com
(919) 619-6055



Mandy May
mmay@coloradocoalition.org
(303) 312-9660