PCMH 2014

- Care Coordination
- Team-based care
- Access
- Referrals
- QI
- MU Stage 2
- Behavioral health
Access and Care Teams

Access

- Credit for telehealth and group visits
- Process to evaluate access
- 5% patients view record electronically
- Secure message to >5% patients

Team-based care

- New Must Pass stand alone standard
- Patient-centered “huddles”
Care Management & Referral Management

Care management

• No longer applies to all patients for 3 diseases
• Limited to high risk patients
• Requires a process to define patients eligible for care management

Referral Management

• Requires PCP to consider quality of specialists in referral decisions
• Referral agreements
• BH agreements and integration
Care Management Eligibility Criteria Must Include:

- Behavioral health conditions
- High cost/high utilization
- Poorly controlled or complex conditions
- Social determinants of health
- Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver
Some Important New Factors

- Document other providers (with contact info) involved in patient’s care
- Alignment with MU Stage 2
- Assessment of health literacy
- Assessment of usefulness of community resources
- Consent for info release/agreements for e-exchange
- Care coordination measures in QI
- Renewing practices must show 2 years of ongoing QI measurements
Must Pass Elements

- 1A
  - Access-during office hours
- 2D
  - Team-based care
- 3D
  - Population management
- 4B
  - Care plan/Self-care
- 5B
  - Referral tracking
- 6D
  - CQI

Hyper-Critical Factors

- 1A1  Same day appointments
- 2D3  “Huddles”
- 5B8  Track to close
Focus on the “Medical Neighborhood”

1. Behavioral health referrals and/or integration
2. Specialty referrals
3. ER transitions of care/avoidance
4. Inpatient visit transitions of care/avoidance
Choose a topic → Design an Intervention → Answer 3 Questions