HMSA
Patient-Centered
Medical Home

Getting Started and Ongoing Management
Progressing Toward a Sustainable Health Care System

In 2013, we saw further collaboration, growth, and evolution toward patient-centered medical home (PCMH) transformation. Throughout the year, PCPs have notably progressed to higher PCMH levels as shown in the table below.

<table>
<thead>
<tr>
<th>PCMH Level</th>
<th>Number of Providers*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>283</td>
</tr>
<tr>
<td>Level 2</td>
<td>80</td>
</tr>
<tr>
<td>Level 3</td>
<td>189</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>552</strong></td>
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</table>

*Data as of December 2013.

We’re all working together to improve the health of our community and the quality of the health care experience with limited human, technical, and financial resources. Evidence shows that a PCMH model of care is an effective way to achieve those goals.

Your hard work, time, and commitment to PCMH is bringing us closer to the goal of creating a sustainable health care system in Hawaii. Data also indicates that providers participating in PCMH are performing better in HMSA’s primary care pay-for-quality programs than those who aren’t in PCMH.

We understand that there will always be opportunities to refine and improve our PCMH model. Some of these include enhancing interaction with Neighbor Island providers, offering practice transformation and Cozeva support, as well as aligning with national guidelines and standards. With your help, we hope to generate even greater provider engagement and progression in PCMH throughout Hawaii in 2014.

Sincerely,

George Bussey, M.D.
Senior Vice President
Chief Medical Officer
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The Patient-Centered Medical Home: A Path to Quality, Affordable Health Care

PCMH is a health care model that facilitates partnerships between individual patients and their personal providers (as well as the patient’s family, when appropriate). This model puts the patient at the center of care and surrounds the patient with a care coordination team led by a primary care provider (PCP). It’s a way to give the patient better, more personal care. HMSA’s PCMH program adopts the Joint Principles of the PCMH as developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association.¹

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¹ PCMH definition and Joint Principles of PCMH are available at www.pcpcc.net.
Building a Sustainable Health Care System for Hawaii

The PCMH model of care promotes meaningful collaboration with patients, health care providers, and employers. PCMH fosters engaging relationships between HMSA members and their PCPs so that together they can achieve greater health. Additionally, PCMH lays the foundation of an integrated system of health care that reliably delivers high quality and the best value.

The successes of PCMH in our commercial program led us to expand the model to both Medicare and QUEST lines of business. Now all HMSA members can choose to receive care from a PCP in a patient-centered practice.

PCMH lays the foundation for a redesigned health care system that provides better value for Hawaii. To that end, we embrace the vision embodied in the Institute for Healthcare Improvement’s (IHI) Triple Aim:

• Improving the experience of care.
• Improving the health of populations.
• Reducing per capita health care costs.

By enhancing the experience of care, including quality, access, and consistency, a transformed health care system will better succeed in the Institute of Medicine’s (IOM’s) six aims for improvement. The synergy between these concepts leads to the transformation of health care in Hawaii as depicted in the diagram below.

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1 IHI Triple Aim: www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx

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I. Introduction

Improvement Aims for a Sustainable Health Care System

Ultimate Goal: Access to affordable, quality care at the right time in the right place

Sustainability

Optimize performance in three dimensions of care to improve the health care system

IHI’s Triple Aim

Population Health  Patient Experience  Per Capita Cost

Adoption of core beliefs for delivering quality health care

IOM’s Six Aims for Improvement

Safe  Effective  Patient-Centered  Timely  Efficient  Equitable
II. Basic Expectations and Requirements for Providers

The following basic requirements apply to PCPs who are interested in contracting to start a PCMH:

1. Providers are one of the following:
   - A general practice, internal medicine, family medicine, or pediatric physician. (Other specialties may also be eligible, subject to HMSA’s program requirements.)
   - An advanced practice registered nurse (APRN) licensed in a discipline to provide primary care.
   - A physician assistant under the supervision of a PCMH-eligible physician.

2. Providers are covered under an HMSA PPO agreement and execute a PCMH agreement with a physician organization that has contracted with HMSA for PCMH.

3. Providers choose a single physician organization with which they are affiliated for PCMH. HMSA will link the provider’s commercial members to this physician’s organization for PCMH purposes.

4. Providers agree to meet population health management (PHM) requirements outlined in this guide and be held accountable by the physician organization.

5. Providers agree to share quality and other clinical data with the physician organization and with HMSA, including administrative, biometric, and lab values on HMSA members for quality improvement purposes.

Exclusions

1. Providers with the above specialties who are predominantly practicing as hospitalists based on claims submitted to HMSA.

2. Providers with the above specialties who don’t practice as PCPs (e.g., an internal medicine physician who practices primarily as a cardiologist, based on submitted claims as determined by HMSA) as determined by established standards and guidelines from the Centers for Medicare & Medicaid Services.

Guidelines for PCMH Expectations, Payment, Criteria, and Changes

Key Conditions, Expectations, and Payment

Each PCP who chooses to participate in the PCMH program will be required to coordinate through a physician organization and sign a PCMH agreement.

Participation in the PCMH program is entirely voluntary. There’s no penalty or negative impact to existing HMSA fee payments for those PCPs or group practices who elect not to participate. The program expects physician organizations that elect to participate to carry out the intended purposes of the program and abide by the processes and rules of the program as described in this guide. The physician organization is responsible for notifying HMSA upon completing the contracting process with the PCP. The PCP will then be eligible for PCMH PHM fees. The PHM fees will be in effect as long as the PCP meets the requirements for their designated PCMH level within the first year of executing their PCMH contract. Once HMSA is notified that PCPs are contracted and their eligibility is verified according to the parameters in the physician organization’s contract with HMSA, these PHM fees will be paid on a monthly basis. Effective January 1, 2014, HMSA is funding the PHM fees as follows: Level 1 - $2.00 per member per month (PMPM), Level 2 - $3.00 PMPM, Level 3 - $3.50 PMPM. Failure to meet PCMH program requirements in a performance year will disqualify a practice from receiving PHM payments.

Initially HMSA’s PCMH program included HMO and PPO members only. In July 2012, the program was expanded to include QUEST members with PHM fees as follows: Level 1 - $1.00 PMPM, Level 2 - $1.50 PMPM, Level 3 - $2.00 PMPM.

A provider’s PCMH level will be effective for three years from the month that their highest PCMH level was achieved. For example, if a provider submitted Level 3 verification in May 2012 and was approved, the provider would have to resubmit Level 3 verification by May 2015 based on the current year’s requirements to maintain Level 3 status. Providers who fail to resubmit level verification after three years won’t be allowed to continue in PCMH. During the three-year period between resubmission, the provider’s physician organization maintains the right to remove a provider from its organization in accordance with the provider’s physician organization agreement. Providers are expected to continue their participation in PCMH activities, including attending meetings and conducting quality improvement projects every year, following Level 3 achievement.

HMSA’s Expectations for PCMH PCPs

When volunteering to participate in a PCMH, PCPs agree to put forth good-faith efforts to meet program requirements, goals, and expectations. This means that each PCP in a PCMH agrees to:

1. Actively engage with patients identified as in need of care management, including the development, maintenance, and oversight of care plans.

2. Communicate in a timely fashion and cooperate with HMSA’s PCMH Integrated Support Team as well as other involved providers in the execution of care plans and patient health-risk mitigation efforts.

3. Use high-quality, cost-efficient institutions and specialists who participate in HMSA’s PPO and HMO networks.

4. Deliver high-quality and medically appropriate care in a cost-efficient manner.

5. Cooperate with HMSA in its efforts to carry out the program rules and requirements in this guide and related addendums.
6. Not withhold, deny, delay, or underutilize any medically necessary care.

7. Not selectively choose or de-select members.

HMSA has observed a key element in PCMH development – collaboration among providers on improvement activities for their practice. A collaborative environment offers the opportunity for providers to discuss and learn best practices, share strategies to reach PCMH goals, and improve the quality of care provided to their patients.

The PCMH program assesses the performance of PCMH collaborations through reporting from physician organizations. PCMH collaborations may also be subject to onsite reviews, audit visits, or other means of assessment.

Beginning on January 1, 2014, our PCMH program will grant reciprocity to participating PCPs who are members of a contracted physician organization and have achieved PCMH recognition through NCQA, The Joint Commission, or URAC. Reciprocity is conditioned on PCPs maintaining active, annual participation with their physician organization in HMSA PCMH program elements 1 and 6 (Collaborative PCMH Meetings and Training and Quality Improvement, respectively). Reciprocal level recognition is as follows:

<table>
<thead>
<tr>
<th>NATIONAL PROGRAM LEVEL</th>
<th>HMSA PCMH LEVEL</th>
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<tbody>
<tr>
<td>NCQA 1 or 2</td>
<td>2</td>
</tr>
<tr>
<td>NCQA 3</td>
<td>3</td>
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<tr>
<td>URAC 1</td>
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<td>URAC 2</td>
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<td>The Joint Commission 1, 2</td>
<td>2</td>
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<tr>
<td>The Joint Commission 3</td>
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Evidence required for reciprocal HMSA PCMH recognition:

1. Copy of NCQA, URAC, or The Joint Commission Certificate or document showing the recognition level.

2. Evidence of completion of HMSA standards:

   1.1 One PCMH training program, conference, or webinar with three hours of instructional time.

      Based on PCMH level requirements, attend a combination of:

      (1.2) Large physician organization meetings.

      (1.3) Small breakout group meetings.

   6.4 Provide quality metrics or access improvement project.

   6.5 Physician organization priority project.

   6.8 Administer survey.

   6.9 Action plan based on most recent survey results as described in this guide.

**Termination and Changes in PCP Membership**

PCPs may change their physician organization affiliation once during an open enrollment period and commit to their new physician organization for at least 12 months. This must be done through the physician organization. The physician organization is required to notify HMSA monthly of any changes (e.g., additions, deletions/terminations, and requests for adjustments to the PCP’s PCMH Level [1, 2, or 3]) and must notify HMSA of any changes during the open enrollment period described in the physician organization’s PCMH contract. Changes made during the open enrollment period that ends December 15 will take effect on January 1.

Physician organizations may dissolve, change their PCP membership, or allow PCPs to leave and join other PCMHs during the enrollment period as long as they continue to meet the minimum size requirements of the program and notify HMSA of these occurrences.
The program requirements aim to align with national PCMH standards, reflect feedback received from the PCMH provider community, and highlight the fundamental components of PCMH implementation. The tiered point structure recognizes the various stages of transformation in the development of PCMH practices while promoting flexibility and statewide applicability. The minimum required elements reflect the core, foundational components of PCMH required for a provider who is beginning the transformation. Additional details and instructions for the requirements are on pages 8–11.

### General Details

| Level 1: | 45–69 points and all minimum required elements |
| Level 2: | 70–94 points and all minimum required elements |
| Level 3: | 95–110 points and all minimum required elements PLUS EHR Meaningful Use |
| Total Possible Points = 110 |

### Minimum Required Elements

1. One PCMH Training Program, Conference, or Webinar (1.1)
2. Collaborative PCMH Meeting (8 for Level 1) (1.2 & 1.3)
3. Access During Office Hours (2.2)
4. Document and Track Transitions of Care (3.1)
5. Implement PCMH Provider-Patient Agreement (3.2)
6. Counsel to Adopt Healthy Behaviors (3.5)
7. Registry Use (4.1 or 4.2)
8. Track Additional Quality Measures (5.1)
9. Complete Assessment and Share Findings with Physician Organization Leadership (6.1)
10. Provider Quality Metric or Patient Access Improvement Project (6.4)
11. Physician Organization Priority Project (6.5)
12. Action Plan Based on Survey Results (6.9)

Minimum Required Elements = 32
### 1.2 & 1.3 Physician Organization and Small Group Meetings

- Each meeting counts as one point.
- Any combination of physician organization and small group meetings is acceptable.
- Level 1 = 8 meetings
- Level 2 = 9 meetings
- Level 3 = 10 meetings
- Only one DVD meeting will count toward this requirement.

### Budget per member per month (PMPM)

<table>
<thead>
<tr>
<th>Level</th>
<th>Budget per member per month (PMPM)</th>
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<tbody>
<tr>
<td>Level 1</td>
<td>$2 PMPM</td>
</tr>
<tr>
<td>Level 2</td>
<td>$3 PMPM</td>
</tr>
<tr>
<td>Level 3</td>
<td>$3.50 PMPM</td>
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Detailed PCMH Level Requirements

Each requirement will count once toward your level verification request, except for the physician organization and small group meetings, which are worth one point each and capped at 10 points maximum. The minimum required elements must be met for all levels. The Meet Objectives of Meaningful Use (7.3) requirement must be met to reach Level 3. Minimum required elements must be completed for each level verification submission or re-verification, not annually.

★ Minimum Required Elements

1. One PCMH Training Program, Conference, or Webinar (1.1)
2. Collaborative PCMH Meetings (8 for Level 1) (1.2 & 1.3)
3. Access During Office Hours (2.2)
4. Document and Track Transitions of Care (3.1)
5. Implement PCMH Provider-Patient Agreement (3.2)
6. Counsel to Adopt Healthy Behaviors (3.5)
7. Registry Use (4.1 or 4.2)
8. Track Additional Quality Measures (5.1)
9. Complete Assessment and Share Findings with Physician Organization Leadership (6.1)
10. Provider Quality Metric or Patient Access Improvement Project (6.4)
11. Physician Organization Priority Project (6.5)
12. Action Plan Based on Survey Results (6.9)

Detailed Requirements

1. Collaborative PCMH Meetings and Training
   1.1. ★ One PCMH Training Program, Conference, or Webinar (2 points)
        *Please provide documentation/certificate confirming that the provider has attended a minimum of one PCMH training program, conference, or webinar (with a minimum of three hours of instructional time). Participation in a TransforMed learning collaborative (WHIP, Five Mountain, and EHIPA) and Rainbow book program also qualifies.

   Attend Meetings (Level 1=8, Level 2=9, and Level 3=10)
   (10 points maximum)

   1.2. ★ Large Physician Organization Group Meetings (1 point each)
        Attend physician organization-scheduled PCMH meetings in person or via webinar. The purpose of this requirement is to generate collaboration and help providers with their PCMH development.
        *Please provide a list of meetings attended including date, topic, name of person who led the meeting, and whether the provider attended in person, via webinar, or via DVD. Only one DVD meeting is acceptable for level verification purposes.

   1.3. ★ Small Breakout Group Meetings (1 point each)
        Attend small group meetings organized by a physician mentor, the physician organization medical director, or the physician organization quality improvement staff.

2. Access to Care
   2.1. Beyond Office Hours Care (2 points)
        Patients have access to care (routine and urgent-care appointments) beyond regular office hours and are able to get timely clinical advice by telephone, secure email, or other means when the office isn’t open. This includes early morning, lunch, evening, and weekend appointments. Answering/paging services that direct the patient to their PCP, including physician’s exchange, are also acceptable ways to meet this requirement.
        *Please provide a list of beyond office hour visit requests including how they were accommodated over one week. Note: Directing patients to the ER doesn’t satisfy this requirement unless indicated as necessary.

   2.2. ★ Access During Office Hours (3 points)
        Patients can access the provider and care team for same-day appointments by office visit, telephone consultation, and secure email or electronic messaging. Clinical advice should be documented in the medical record.
        *Please provide a list of same-day care requests including how they were accommodated over one week.

2.3. Culturally and Linguistically Appropriate Services (4 points)

2.3.1. Assess racial, ethnic, and language needs of the patient population. Provide interpretation services and printed materials (e.g., educational brochures, care plans) that meet the language needs of the population.
        *Please provide the name of a translator/interpreter service and an example of printed material in foreign language. English isn’t an option.

3. Care Coordination
   3.1. ★ Document and Track Transitions of Care (2 points)
        Physician/staff facilitates, documents, and tracks transition to and from other care resources including specialists, imaging and lab centers, the Healthways...
Well-Being Improvement Center, etc.

*Please provide one example of a complete referral feedback loop, such as initiation of referral, tracking log, receipt of specialist, imaging, or lab reports, and any resulting PCP-patient follow-up.

3.2. ★ Implement PCMH Provider-Patient Agreement (2 points)
Implement use of provider-patient medical home agreement that defines the expectations of the provider and patient/family, including roles and responsibilities in PCMH. The expectation for this requirement is that every patient signs a PCMH provider-patient agreement.

*Please provide one signed agreement, a script for the discussion, and any printed material the patient receives.

3.3. Train Office Staff (3 points)
Practice has organized and trained office staff to support coordination of care activities and/or the use of external resources. Staff training can include motivational interviewing or other behavior change modality training, referral tracking, Cozeva training, etc.

*Please provide training materials, including presentations, handbooks, DVDs, and/or implemented office workflow defining roles and responsibilities.

3.4. Individualized Care Plans (3 points)
Patients' care coordination needs are assessed and an individualized care plan is created in collaboration with the patient/family, communicated during the visit, and sent home with the patient/family. The care plan must include patient/family education, treatment goals, the care coordination strategy, and may be template-based. It should be reviewed and updated at each subsequent visit. Documentation of care must be noted in the medical record.

*Please provide one acute care and one chronic care example over a six-month period of management that includes status updates from follow-up visits.

3.5. ★ Counsel to Adopt Healthy Behaviors (3 points)
Practice provides evidence-based coaching, motivational interviewing, and/or patient education to establish healthy behaviors. The goal is to engage patients and families in their care management, help them understand their health problems and care plan, and improve their quality of life and health outcomes.

*Please identify the person who is providing the counseling services and describe the policy that explains which patients should receive counseling and education.

3.6. Care Plans Reflect Specialized Referral Tracking and Follow-Up (4 points)
Individualized care plans reflect follow-up on referrals to other resources for additional care management support, including referrals to community resources, mental health, substance abuse, or health education programs, and Healthways resources. Demonstrate documentation and tracking process of patient/family self-management plans and goals, making periodic updates when necessary.

*Please provide a documented process for specialized referral tracking and follow-up as well as one example of a patient who received a referral for specialized care management, tracking, and PCP follow-up.

3.7. Provide Referrals to Health Education Programs (4 points)
The practice offers referrals to health education programs and/or resources that include information about a medical condition and the patient/family's role in managing the condition. Examples include diabetes education classes, smoking cessation, weight management and nutrition workshops, and mental health/substance abuse peer support groups.

*Please provide the curriculum of the class, duration, frequency, class instructor, number of patients who attended, and a success story of improved disease management/health outcome.

4. Registry Use

4.1. ★ Cozeva Registry (2 points)
The provider/practice uses Cozeva to review preventive care and chronic disease registries at least twice a month.

*HMSA will verify this requirement through the monthly Cozeva usage report.

4.2. ★ Electronic Health Record (EHR) Registry (2 points)
Provider/practice monitors condition-specific disease registry from EHR at least monthly.

*Please provide example of one disease registry you monitor.

4.3. Analysis of Registry and Patient Outreach (3 points)
Practice analyzes registry and determines which patients need: preventive care screenings, chronic care services, medication monitoring, or a check-up. Practice then performs appropriate outreach to patients via secure email, telephone, or mail (Cozeva, Healthways, and EHR) to ensure that the necessary care is provided.

*Please provide documentation of the results of the registry analysis and one example of the outreach performed.

4.4. Standing Orders Based on Registry Analysis (4 points)
Implement staff delegation with standing orders. For example, if a diabetic patient's most recent HbA1c result is more than six months old, the practice should schedule and provide an HbA1c test.

*Please provide an example of standing orders for a health condition identified from the registry analysis and a document that describes roles and responsibilities of staff that accompany the standing orders.
5. Improve Clinical Outcomes

5.1. ★ Track Additional Quality Measures (2 points)
Demonstrate ability to track specified additional quality measures:
- Adults: Track blood pressure (BP) of patients with hypertension; track BP, LDL, and HbA1c of patients with diabetes; and track body mass index (BMI) in the electronic health record (EHR) or other tracking tool.
- Pediatrics: Complete the Child with Special Health Care Needs (CSHCN) Screener and track BMI as described in the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents section on page 12.
*Please provide screen shot or a copy of the track log for each of the specified measures.

5.2. Track Additional Quality Measures (25 percent) (3 points)
Track specified additional quality measures for 25 percent of patients.
- Adults: Track BP of patients with hypertension; track BP, LDL, and HbA1c of patients with diabetes; and track BMI in the EHR or other tracking tool for 25 percent of patients.
- Pediatrics: Complete the CSHCN Screener for 25 percent of patients. Track BMI for 25 percent of patients in the EHR or other tracking tool.
*Please provide the exact percentage of panel tracked and a screen shot/copy of the tracking log.

5.3. Track Additional Quality Measures (50 percent) (4 points)
Track specified additional quality measures for 50 percent of patients.
- Adults: Track BP of patients with hypertension; track BP, LDL, and HbA1c of patients with diabetes; and track BMI in the EHR or other tracking tool.
- Pediatrics: Complete the CSHCN Screener for 50 percent of patients. Track BMI for 50 percent of patients in the EHR or other tracking tool.
*Please provide the exact percentage of panel being tracked and a screen shot/copy of the tracking log.

5.4. Show Trends Toward Improvement or Maintenance of 90th Percentile Performance (4 points)
Demonstrate that tracking BP, HbA1c, BMI, and LDL led to appropriate surveillance and treatment for patients with hypertension and diabetes, through improvement in correlating values of the tracked metrics over time. Maintenance of 90th percentile performance is also acceptable to meet this requirement. For the CSHCN screener, providers must show one documented referral, treatment plan, and follow-up for a patient with a positive screener.
*Please provide a report that shows three months of consistent improvement from the baseline value in tracked metrics or three months of 90th percentile maintenance.

6. Quality Improvement Projects

6.1. ★ Complete Assessment and Share Findings with Physician Organization (2 points)
The PCMH readiness assessment must be completed within the first 90 days after the effective date of the executed PCMH agreement. Providers must share summary findings with physician organization leadership as well as identify and document improvement opportunities.
*Please provide certificate of completion, the date that findings were shared with physician organization administration, and the improvement opportunities identified.
The assessment can be completed using one of the following PCMH readiness assessment tools (or others as agreed with HMSA):
- NCQA PCMH Survey Tool.
- TransforMED MHIQ survey.
- CMHI Medical Home Index and Medical Home Family Index.
- Family Voices Family-Centered Care Provider Self-Assessment Tool.

6.2. Create Transformation Plan (3 points)
Work with physician organization to create written transformation plan for providers and show process after plan has been implemented. The plan should include a roadmap of objectives based on identified areas of improvement. Physician organization and provider will maintain a copy of the plan and have monthly checkpoints to ensure progress is made.
*Please provide a copy of the transformation plan with at least one checkpoint documented by physician organization administration.

6.3. Implement and Execute Plan (4 points)
Work with physician organization and Integrated Support Team to implement the transformation plan. Physician organization and provider track activities and progress monthly. For example, a practice can implement an office workflow using Cozeva for panel management.
*Please provide the plan and three progress updates (one per month).

Quality Metric (Must be completed within 12 months of PCMH agreement execution)

6.4. ★ Provider Quality Metric or Access Improvement Project (Annual Requirement) (2 points)
Quality improvement project related to improvement on a quality metric or patient access to services.
*Please provide analysis that led to the identified project, baseline metrics, intervention, and post-intervention metrics.

6.5. ★ Physician Organization Priority Project (Annual Requirement) (2 points)
Quality improvement project conducted in conjunction with physician organization’s defined quality improvement priorities.

*Please provide analysis that led to the identified project, baseline metrics, intervention, and post-intervention metrics.

6.6. Plan Do Study Act (PDSA) Documentation (3 points)

PDSA is a fast-paced quality improvement activity developed as a way to integrate change in a manageable way. The aim is to adopt small-scale, incremental change in a cyclical process to generate consistent progress.

Plan = Plan to test the change
Do = Carry out the test
Study = Observe and learn from the consequences
Act = Determine what modifications should be made to the test

*Please provide documentation that each component of the PDSA cycle has been addressed.

6.7. PDSA Implications and Next Steps (4 points)

The purpose of PDSA is to document a plan for change and to carry out (test) the plan. Generally, each change will go through multiple PDSA cycles for continuous improvement. With improved knowledge after additional PDSA cycles, the objective of the PDSA can be refined to reach the goal.

*Please provide an analysis of lessons learned from the initial PDSA cycle(s) as well as next steps/future implications specific to the project. Evidence that more than one PDSA cycle was conducted is preferable.

Evaluate and Improve Patient Experience

6.8. Administer Survey (2 points)

Providers have the option to conduct their own patient satisfaction survey if it includes four key elements: access to care, communication, care coordination, and whole-person care/self-management support. This requirement is also applicable for providers with panels of less than 150 patients or who joined PCMH after May 2012.

Options for a survey tool include:

- Create your own.
- Clinician and Group CAHPS PCMH adult or child survey.
- Family Voices Family-Centered Care Self-Assessment Tools: Family Tool.

*Please provide a copy of the survey tool and evidence that there were at least 40 respondents from patients who were seen in the last year.

6.9. ★ Action Plan Based on Survey Results (2 points)

Create and implement an action plan or quality improvement project based on analysis of survey results.

*Please provide baseline metrics and an action plan. A PDSA template may be used to document the action plan.

6.10. Evaluate and Re-Survey (3 points)

Evaluate the impact of the action plan by conducting a follow-up patient satisfaction survey to assess if any improvement has been made. Refer to the Administer Survey requirement for guidelines on how to conduct the follow-up survey.

*Please provide a copy of the follow-up survey tool and response rates.

6.11. Follow-Up Survey Demonstrates Improvement (4 points)

The follow-up survey shows at least a 10 percent improvement in patient satisfaction from the previous survey results.

*Please provide a comparison of survey results and highlight the areas that showed improvement.

7. Electronic Health Records

7.1. Implement EHR (2 points)

Implementation of a certified EHR as specified by the Centers for Medicare & Medicaid Services (CMS). A list of certified EHRs is available at: http://onchpl.force.com/ehrcert. Implementation means the EHR was acquired and installed and utilization commenced. Utilization refers to staff training on EHR use and data entry of patient demographic information.

*Please provide a CMS EHR Certification ID and the type of EHR you have implemented.

7.2. Active Use of EHR (3 points)

This requirement serves as a step between implementation and meaningful use of an EHR. The following CMS meaningful use core requirements must be met to fulfill this requirement:

- E-Prescribing (eRx) - Generate and transmit more than 40 percent permissible prescriptions electronically using certified EHR technology.
- Record and chart changes in vital signs for more than 50 percent of all unique patients age two years and older seen by the provider. Record and chart height, weight, and blood pressure; calculate and display BMI; and plot and display growth charts for children two to 20 years, including BMI.

*Please provide a copy of your Hawai’i Pacific Regional Extension Center (HPREC) active use validation certificate.

7.3. ★ Meet Objectives of Meaningful Use (4 points)

Achieve the objectives of meaningful use according to current CMS guidelines.

*Please provide a copy of your Office of the National Coordinator for Health Information Technology (ONC)/CMS attestation or HPREC validation certificate.
IV. Additional Reporting Requirements

One of PCMH’s core principles is to improve quality of care for the patient. HMSA’s Commercial Primary Care Pay-for-Quality Program builds upon experience gained through the Practitioner Quality and Service Recognition and Quality & Performance programs to create a pay-for-quality program aligned with the challenges and opportunities of PCPs. A complete description of HMSA’s Commercial Primary Care Pay-for-Quality Program is available on hmsa.com.

PCMH builds on the pay-for-quality program to improve health outcomes for the patient. Additional quality metrics, designed to better use non-claims data, have been established to move us along the quality continuum. PCPs participating in PCMH are required to report the following additional metrics.

Generalists (i.e., general practice and family medicine physicians, APRNs, and physician assistants) and physicians double-boarded in internal medicine and pediatrics will be responsible for all adult and pediatric requirements. Internal medicine physicians will be responsible for only adult requirements; pediatricians will be responsible for only pediatric requirements.

Please refer to the Population Health Management requirements for level verification submission guidelines.

Pediatric Requirements:
- Completion of the Child with Special Needs Screener.

Pediatric Measure Definitions

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (BMI measurement)

The percentage of members age 3–17 years who had an outpatient visit with a PCP and who had evidence of BMI percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

Completion of the Child with Special Needs Screener

The Child and Adolescent Health Measurement Initiative’s CSHCN Screener® uses consequence-based criteria that aren’t condition-specific to identify children with special health care needs for quality assessment and population-based health applications. Children are screened for one or more current functional limitations or service use needs that are the direct result of an ongoing physical, emotional, behavioral, developmental, or other health condition.

Using an approach that is not diagnosis-specific, the CSHCN Screener identifies children across the range of childhood chronic conditions and special needs, which provides a more comprehensive assessment of patient panels within the medical home.

If the screen is positive, add diagnosis code V13.89 to the claim for the visit to report the status.

<table>
<thead>
<tr>
<th>RESULT OF SCREENING</th>
<th>CLAIMS FILING INSTRUCTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report screenings with positive findings.</td>
<td>Use ICD-9 CM diagnosis code V13.89. Append HA modifier (child/adolescent program) to E&amp;M CPT code for that specific visit on the screening date.</td>
</tr>
<tr>
<td>Report screenings with negative findings.</td>
<td>Append modifier HA to E&amp;M CPT code for that specific visit on the screening date.</td>
</tr>
</tbody>
</table>

Adult Requirements:
- CDC: Blood Pressure Control (<140/90).
- CDC: HbA1c (Poor) Control (>9%).
- CDC: LDL-C Controlled <100 mg/dL.
- Controlling High Blood Pressure.
- Body Mass Index (BMI).

Adult Measure Definitions

CDC: Blood Pressure Control (<140/90)
Percentage of adult patients with diabetes age 18 to 75 years whose most recent BP reading during the measurement year is <140/90. Members aren’t compliant if their BP is ≥140/90 mm Hg or if there was no BP reading during the measurement year.

CDC: HbA1c (Poor) Control (>9%)
Percentage of adult patients with diabetes age 18 to 75 years whose most recent HbA1c test during the measurement year is >9.0% or whose HbA1c wasn’t measured. (Note: A lower score indicates better performance.)

CDC: LDL-C Controlled <100 mg/dL
Percentage of adult patients with diabetes age 18 to 75 years whose most recent LDL-C level during the measurement year is <100 mg/dL, as documented through automated laboratory data or medical record review.

Controlling High Blood Pressure
The percentage of members age 18 to 85 years who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90) during the measurement year. The member isn’t compliant if the BP is ≥140/90 mm Hg or if there was no BP reading during the measurement year.

Body Mass Index (BMI)
The percentage of members age 18 to 74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

Quality and Performance Reports

To help providers more effectively execute quality improvement action plans and positively impact their pay-for-quality performance, HMSA will provide data and analytic reports on quality performance at least quarterly through Cozeva. Details about the primary care pay-for-quality programs are available in the respective pay-for-quality program guides.
V. Requirements for Physician Organizations

The physician organization plays an instrumental role in supporting PCPs for PCMH. The physician organization leads PCP collaboratives, supports quality improvement, coordinates resources, and facilitates education and training regardless of the plan a member is enrolled in once providers contract to become a PCMH. The physician organization’s leadership and support is critical to achieving the goals of the PCMH program.

Below are the requirements for any physician organization that contracts to participate in the PCMH program.

**Minimum Structure (meets all criteria)**
1. Has an executed PCMH agreement with HMSA.
2. Has a quality improvement committee or structure.
3. Has a designated physician leader who serves as a medical director or in a comparable role, provides leadership, and interacts with providers on a regular basis.
4. Is a legal entity.
5. Includes at least five PCPs.
6. Can provide budget and financial statements for the organization as needed.

**Operations (implements all criteria)**
1. Meets with HMSA’s PCMH Integrated Support Team (IST) to help accomplish PCMH goals and transformation activities.
2. Medical director(s) participate in HMSA’s PCMH collaborative.
3. Collaborates with industry experts to learn effective PCMH leadership techniques.
4. Shares its PCMH contract template with HMSA to ensure consensus on PCP roles and responsibilities before the physician organization enrolls the first provider into the PCMH and notifies HMSA of any material changes.
5. Contracts with providers, facilitates provider enrollment in PCMH, and reports to HMSA monthly.
6. Provides oversight and ensures that PCMH providers meet their obligations under the PCMH agreement.
7. Supports and tracks providers’ progress on PCMH Level 1, 2, and/or 3 requirements and reviews, validates, and submits level verification change requests for PCPs.
8. Informs member providers of its PCMH support services.
9. Determines inclusion/exclusion of physician extenders and physician specialists as defined PCPs for PCMH. HMSA enrolled only PCPs in certain specialties in PCMH in 2011. In 2012, HMSA continued to develop its program to include the addition of other specialties and physician extenders.

The leadership responsibilities of physician organizations as needed for PCMH are described in detail in Section VI.

The primary source of information about all HMSA services for physician organizations is HMSA’s PCMH IST. The team will provide resources to support each physician organization in the development and execution of its respective PCMH, including data and analytics, education and training, and many other services. The details of this support will be discussed during the contracting phase with each physician organization and further during the post-contracting planning meeting.

**HMSA will conduct an annual audit of physician organizations to ensure that their providers are meeting the PCMH level requirements. Providers who are at Level 1 and have been in the commercial PCMH program for at least 12 months as of June 30, 2014, will be included in the audit. The audit will be based on the current year’s requirements.**

Physician organizations should notify PCPs who meet these criteria of the review and work with them to prepare a level verification form with documentation to substantiate their fulfillment of the Level 1 status requirements by June 30, 2014. Please keep these documents on file within your physician organization and submit them to HMSA between July 1 and 31, 2014. HMSA will complete a review and report the names of providers who don’t meet PCMH Level 1 requirements by September 1, 2014.

Please work with PCPs who can’t substantiate their Level 1 standing to create an action plan for completing the 2013 Level 1 requirements by November 30, 2014. Providers who don’t demonstrate fulfillment of Level 1 requirements by November 30 won’t be eligible to receive their total PCMH fees until the physician organization and HMSA have verified their satisfactory fulfillment of the Level 1 requirements. The physician organization won’t be eligible to receive PCMH fees for providers who don’t meet program requirements.
VI. Physician Organization Leadership Responsibilities

The matrix below describes the physician organization leadership responsibilities required for PCMH with examples of proof that responsibilities have been met. The requirements are critical in producing meaningful results for PCMH and are based on experience with existing PCMH collaborations. In addition, physician organizations should refer to their PCMH contract for additional obligations of the physician organization.

<table>
<thead>
<tr>
<th>PHYSICIAN ORGANIZATION LEADERSHIP RESPONSIBILITIES</th>
<th>EXAMPLES OF PROOF THAT RESPONSIBILITIES HAVE BEEN MET</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leading Provider Collaborative (LC)</strong></td>
<td></td>
</tr>
<tr>
<td>LC 1 – Provide leadership and coordinate regular meetings.</td>
<td>• Meetings with PCMH PCPs at least 12 times per year.</td>
</tr>
<tr>
<td>LC 2 – Engage providers to develop PCMH.</td>
<td>• Meeting minutes reflect attendance and topic related to PCMH and/or quality improvement (QI).</td>
</tr>
<tr>
<td>LC 3 – Use an assessment to determine provider readiness for PCMH.</td>
<td>• Maintain PCMH PCPs’ progress on Levels 1, 2, or 3.</td>
</tr>
<tr>
<td></td>
<td>• Apply physician organization resources toward practice transformation and quality improvement projects.</td>
</tr>
<tr>
<td><strong>Quality Improvement (QI)</strong></td>
<td></td>
</tr>
<tr>
<td>QI 1 – Establish a minimum of three QI priorities.</td>
<td>• Physician organization QI work plan.</td>
</tr>
<tr>
<td>QI 2 – Monitor performance, distribute quality reports, and facilitate discussion on QI activities.</td>
<td>• Copy of QI discussion and planning documents facilitated by the physician organization.</td>
</tr>
<tr>
<td>QI 3 – Reduce variation in quality metrics among PCPs.</td>
<td>• Improvement in quality metrics/reduction in variation (results should be achieved within six to nine months).</td>
</tr>
<tr>
<td>QI 4 – Implement a minimum of two utilization reduction activities.</td>
<td>• Utilization reduction activities, which may include ER visit reduction, inpatient re-admission reduction, or pharmacy cost compliance.</td>
</tr>
<tr>
<td><strong>Coordinated Resources (CR) &amp; Advanced Technology</strong></td>
<td></td>
</tr>
<tr>
<td>CR 1 – Direct effective use of shared resources.</td>
<td>• Quarterly report summarizing the following:</td>
</tr>
<tr>
<td>CR 2 – Support implementation of care coordination.</td>
<td>- Number of PCPs with EHRs.</td>
</tr>
<tr>
<td>CR 3 – Support use of EHR and other technologies (EHR, e-visits, etc.).</td>
<td>- Number of meetings/sessions promoting active use of EHR.</td>
</tr>
<tr>
<td></td>
<td>- Number of sessions to educate PCPs on the use of care coordinators.</td>
</tr>
<tr>
<td></td>
<td>- Redesign of functions within the PCP’s office that includes care coordination by current staff.</td>
</tr>
<tr>
<td></td>
<td>- Implementation of high-risk care coordination/patient education/group visits.</td>
</tr>
</tbody>
</table>

After a physician organization enrolls in a PCMH, HMSA’s PCMH Integrated Support Team (IST) will help it develop a plan to meet PCMH requirements, including establishing regular meetings and a structure for status reporting. The physician organization may hold planning sessions and PCMH orientation sessions at its discretion to discuss PCMH roles and responsibilities and develop a work plan to assist the PCP in developing a PCMH.
As stated in the introduction, the ultimate goal for the PCMH program is to build a sustainable health care system that enables access to affordable, quality care at the right time in the right place.

While quality may be difficult to define and measure, there is growing consensus among health professionals, consumers, employers, health plans, and a number of third-party entities around a core set of quality measures that encompass both process and outcome metrics.

The multi-stakeholder organization National Quality Forum (NQF) is the gold standard for evaluation and endorsement of these measures. In recent years, the NQF has expanded its measures to include additional quality measures that cover the entire continuum of care across all settings.

NCQA has continued to refine the HEDIS (Healthcare Effectiveness Data and Information Set) measurement system, which has been widely applied to health plans for the past 20 years and is seen throughout the medical profession as a highly credible set of measures. HEDIS is updated annually to reflect best medical practices consistent with scientific advancement. The technical specifications are transparent and can be applied to health plans, providers, and physician organizations. NCQA has also developed an objective process for PCMH certification of provider practices.

The Agency for Healthcare Research and Quality has also contributed measures related to potentially avoidable poor outcomes (also called “preventable quality indicators”), which measure rates of inpatient hospitalizations that could have been avoided with access to optimal outpatient management, particularly of chronic conditions.

In addition, there are a number of standardized instruments to measure patient satisfaction, which can be used in their entirety or as a subset.

The PCMH program will use all of these nationally recognized quality measurement standards as well as a number of other measures that are directly applicable to the goals of the program.

HMSA plans to use the FOCUS framework to measure the overall success of implementing PCMH. Metrics from the following categories will be used to evaluate individual PCMH physician organizations as well as the PCMH initiative overall.

FOCUS stands for:
• Financial.
• Operations.
• Clinical.
• Utilization.
• Satisfaction.

HMSA will work with physician organizations to develop incremental measurements to monitor progress on improving quality and containing overall health care costs.

VII. Evaluation of PCMH Collaboration

Source: CareFirst’s PCMH Program Description and Guidelines.
HMSA’s PCMH Integrated Support Team (IST) is available to help coach and support physician organizations to develop a sustainable PCMH. Once a PCMH contract has been signed and executed, the team can begin working with the physician organization on their PCMH obligations through a series of collaborative sessions. While the team’s support may vary depending on the goals and priorities of each physician organization, it will ensure that all meet the same goals and objectives of HMSA’s PCMH program. The IST will also work with physician organizations to ensure that their providers are meeting the PCMH level requirements over time.

The team will provide the following services to physician organizations:

- Manage the relationship between HMSA and physician organizations that are participating in HMSA’s PCMH and pay-for-quality programs.
- Facilitate understanding of and leadership in the PCMH.
- Provide tactical support for both HMSA’s PCMH and pay-for-quality programs.

The team will evolve over time to provide appropriate support to physician organizations. To learn more, please contact your Provider Relations and Advocacy representative.
Appendix A: Patient Attribution Process

The patient attribution process aims to reflect our members' preference for a provider as a PCP based on the member's choice of PCP and office visit pattern. HMSA Akamai Advantage and HMSA's HMO and QUEST members are included in the PCMH patient panel of the PCP they selected upon enrolling. All other HMSA members are attributed to a PCP based on the provider they've seen most frequently or most recently, which is determined by a review of HMSA claims for a specified period.

The attribution process includes members of HMSA's HMO, PPO, and Akamai Advantage plans, The HMSA Plan for QUEST Members, and The HMSA Children's Plan.

An initial attribution, using the process described as follows, was completed when HMSA launched its PCMH and commercial primary care pay-for-quality programs. Thereafter, the same attribution process has been completed at the close of every calendar month after HMSA has posted all the claims processed and eligible members for that month.

1. Keep the PCP selection for the members who have selected a PCP.
2. For all other members, attribute the member to a PCP using a 16-month claims window. (A 37-month claims window was used for the initial attribution.) For eligible PCP specialties, the claims represent face-to-face encounters between the provider and patient.
3. Select the PCP who was most frequently seen or, in cases of a tie, most recently seen.
4. Confirm that the member has valid eligibility for that month.

If there is no change to the attribution for a patient, the previous month's attribution results will apply for the current month. Attribution results will be available as an updated patient panel on Cozeva. You're encouraged to view your patient panel and follow the update process described on Cozeva.

You may add patients to your patient panel through Cozeva. Patients will need to sign an attestation to complete the process. Their attestations will supersede all prior attributions.
Appendix B: Provider Toolkit for PCMH

This toolkit provides sample materials to help you inform your patients about and engage them in your PCMH. Feel free to customize each document to fit the needs of your practice. (You aren’t required to use these materials. Make sure they reflect your practice before using them.)

On the following pages you’ll find:

- **Patient-Provider Partnership Agreement.**
  A “best practice” used in many PCMHs, this agreement should be discussed with and signed by your patients to indicate an understanding of and agreement to participate in a PCMH.

- **Medical Home Care Plan.**

- **Plan Do Study Act (PDSA) Template.**

These documents are available for download at hmsa.com/providers/pcmh/toolkit.aspx.

The following documents aren’t printed in this guide, but are available for download:

- **Pre-Visit Contact Form.** Questions your staff can ask a patient to help you prepare for a visit.

- **Introductory Letter to Patient with Rights and Responsibilities.** Announce your PCMH approach to your patients and describe how they’ll participate in a PCMH.

- **Patient Checklists.** Help your patients prepare for their first and future appointments with you under the PCMH.

Also available is the **Information for Families Brochure** to help a patient’s family maximize the benefits of the PCMH. The brochure is available for download at hmsa.com/providers/assets/info-for-families-brochure.pdf. For a hard copy, contact your HMSA Provider Relations and Advocacy representative.
SAMPLE PATIENT-PROVIDER PARTNERSHIP AGREEMENT

Dear Patient,

Welcome and thank you for choosing my practice. I am committed to providing you with the best medical care based on your health needs. My hope is that we can form a partnership to keep your whole self as healthy as possible, no matter what your current state of health.

Your commitment to my patient-centered medical home practice will provide you with an expanded type of care. I will work with both you and other health care providers as a team to take care of you. You will also have better access to me through phone and Web visits and secure email through HMSA’s Online Care.

As your primary care provider, I will:

- Learn about you, your family, life situation, and health goals and preferences. I will remember these and your health history every time you seek care and suggest treatments that make sense for you.
- Take care of any short-term illness, long-term chronic disease, and your all-around well-being.
- Keep you up-to-date on all your vaccines and preventive screening tests.
- Connect you with other members of your care team (specialists, health coaches, etc.) and coordinate your care with them as your health needs change.
- Be available to you after hours for your urgent needs.
- Notify you of test results in a timely manner.
- Communicate clearly with you so you understand your condition(s) and all your options.
- Listen to your questions and feelings. I will respond promptly to you in a way you understand.
- Help you make the best decisions for your care.
- Give you information about classes, support groups, or other services that can help you learn more about your condition and stay healthy.

We trust you, as our patient, to:

- Know that you are a full partner with us in your care.
- Come to each visit with any updates on medications, dietary supplements, or remedies you’re using, and questions you may have.
- Let us know when you see other health care providers so we can help coordinate the best care for you.
- Keep scheduled appointments or call to reschedule or cancel as early as possible.
- Understand your health condition, ask questions about your care, and tell us when you don’t understand something.
- Learn about your condition(s) and what you can do to stay as healthy as possible.
- Follow the plan that we have agreed is best for your health.
- Take medications as prescribed.
- Call if you do not receive your test results within two weeks.
- Contact us after hours only if your issue cannot wait until the next work day.
- If possible, contact us before going to the emergency room so someone who knows your medical history can care for you.
**PCMH Provider Toolkit**

- Agree that all health care providers in your care team will receive all information related to your health care.
- Learn about your health insurance coverage and contact HMSA if you have questions about your benefits.
- Pay your share of any fees.
- Give us feedback to help us improve our care for you.

I look forward to working with you as your primary care provider in your patient-centered medical home.

Provider Signature  
Printed Provider Name  
Date

Patient Signature  
Printed Patient Name  
Date

Parent/Guardian Signature  
Printed Parent/Guardian Name  
Date

*Cell Phone Number _____________________  
*Email Address _________________________

*By providing your cell phone number and/or email address, you consent to your PCMH care team contacting you regarding your medical care via cell phone or email.
# Medical Home Care Plan

**Prepared for:** ___________________  **PCP:** ___________________  **Prepared by:** ___________________

**Need:**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Activity</th>
<th>Who will do</th>
<th>By when</th>
<th>Expected outcome</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**Add'l Info:**

Best way to contact family: ___________________

Best way to contact PCMH: ___________________

Point of contact for PCMH: ___________________

Date plan prepared: ___________________

Date of last plan update: ___________________
### PDSA Worksheet for Testing Change

**Aim:** (overall goal you wish to achieve)

*Every goal will require multiple smaller tests of change.*

<table>
<thead>
<tr>
<th>Describe your first (or next) test of change.</th>
<th>Person responsible</th>
<th>When to be done</th>
<th>Where to be done</th>
</tr>
</thead>
</table>

**Plan**

<table>
<thead>
<tr>
<th>List the tasks needed to set up this test of change.</th>
<th>Person responsible</th>
<th>When to be done</th>
<th>Where to be done</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Predict what will happen when the test is carried out.</th>
<th>Measures to determine if prediction succeeds:</th>
</tr>
</thead>
</table>

**Do**

Describe what actually happened when you ran the test.

**Study**

Describe the measured results and how they compared to the predictions.

**Act**

Describe what modifications to the plan will be made for the next cycle based on what you learned.

Appendix C: PCMH Care Coordination

Care Coordination
The joint principles of PCMH are:

- A personal provider.
- Provider-directed medical practice.
- Whole-person orientation.
- Quality and safety.
- Enhanced access to care.
- Payment structure.
- Care coordination.

Coordination of care across the health system is a critical component for the effective delivery of HMSA's PCMH program.

Care coordination is the integration of all care delivery elements in the health care system and the patient's community. The goal is to coordinate providers, technology, and operational workflows into a cohesive unit and have them work together to ensure a patient's needs are understood, shared, and met.

Care Coordination: Cornerstone to PCMH Success
HMSA's PCMH program is designed to incorporate care coordination into the daily workflow of provider practices and provide enhanced access to the Well-Being Improvement Center. The service center is a central access point to care coordination support services for primary care practices. More information on the service center follows.

Care coordination is a core component of a PCMH and is essential to each participating physician organization and each participating provider. While care coordination support services will differ from practice to practice, providers will focus on meeting the patient's needs (before, during, and after a visit) and implementing plans to enhance care between visits. The provider's practice may also benefit from using other health care professionals to expand the care team as needed.

The following services are available to help PCPs coordinate care for their patients:

1. Care Planning Registries.
2. Support Services Catalog.
3. Central access point to the Well-Being Improvement Center.
Providers can most effectively use these care coordination support services by following the steps below:

### PCMH Care Coordination Support Services - Getting Started

1. **Know Your Panel**
   - Review and understand the Patient Panel Report.
   - Request changes to your patient panel as needed.

2. **View Your Registry**
   - Access your Care Planning Registry through Cozeva.
   - Review and understand the Care Planning Registry.
   - Identify measures with opportunities for improvement.

3. **Work Your Gaps**
   - Find gaps in care on the Care Planning Registry.
   - Work with your support teams to generate reminders to your patients of the services needed based on the gaps in care.
   - Contact the Well-Being Improvement Center to request care coordination support services.

4. **Leverage the Center**
   - Determine what additional support services are required for your patients.
   - Review the Support Services Catalog to see if the applicable services are available via the Well-Being Improvement Center.
   - Contact the Well-Being Improvement Center to request care coordination support services.

### The Care Planning Registry

All PCPs participating in pay-for-quality programs will have access to monthly Care Planning Registry reports via Cozeva. The registry reports on all adult and pediatric measures as defined by the 2014 pay-for-quality programs.

Providers can submit supplemental data to report on filled gaps in care that weren’t captured in their registries.
The Support Services Catalog

The Support Services Catalog is a list of the support services available to providers to help address their patients' gaps in care. These services can be assessed and requested via the Well-Being Improvement Center. The diagram below (PCMH Phase I Support Services Summary) provides a high-level view of the available services. HMSA's PCMH program will be enhanced as the support services available via the service center expand.

<table>
<thead>
<tr>
<th>Support Services (How HMSA can help)</th>
<th>PATIENT OUTREACH</th>
<th>CONDITION MANAGEMENT</th>
<th>PROVIDER RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Metrics</td>
<td>Telephone-based screening reminders/education</td>
<td>Assessment, Education, Coaching &amp; case management, Inter-appointment support &amp; monitoring, Medication adherence, Care coordination</td>
<td></td>
</tr>
<tr>
<td>Quality Metrics</td>
<td>Mail-based screening reminders/education</td>
<td>Provider quick reference guides, Provider office materials (brochures, posters, prescription pads)</td>
<td></td>
</tr>
</tbody>
</table>

For Adults – Preventive Health Screenings, Diabetes, Heart Disease, Asthma

- Breast cancer screening ✔ ✔ ✔
- Colorectal cancer screening ✔ ✔
- Chlamydia screening (18-24 years) ✔ ✔
- Asthma – appropriate medication ✔ ✔
- Diabetes care – LDL-C screening ✔ ✔
- Diabetes care – HbA1c testing ✔ ✔
- Diabetes care – nephropathy screening or treatment ✔ ✔
- Diabetes care – eye examination ✔ ✔
- Cholesterol management – LDL-C screening ✔ ✔

For Children – Access to Care, Immunizations, Appropriate Respiratory Care, Asthma

- Childhood immunizations ✔ ✔
- Well-child visit – first 15 months ✔ ✔
- Well-child visit – 3rd, 4th, 5th, 6th year ✔ ✔
- Children with pharyngitis – appropriate testing ✔ ✔
- Children with upper respiratory infections – appropriate use of antibiotics ✔ ✔
- Asthma – appropriate medication ✔ ✔

To request services:
- Call 1 (855) 765-PCMH (7264)
- Fax your request to 440-7010 on Oahu or 1 (800) 470-8418 on the Neighbor Islands

Hours of operation
Monday to Friday
8:00 a.m. – 7:00 p.m.
The Well-Being Improvement Center

HMSA’s PCMH program offers providers the Well-Being Improvement Center, a single, consolidated access point to care coordination. The service center links patients with gaps in care to needed care services. Providers may access the service center using a dedicated phone line or fax to request various services within the categories of wellness, lifestyle management, collaborative care, education, community resources, hospital discharge follow-up, and improvement of quality of care. Functions of the service center will evolve as additional services become available.

Summary

The Care Planning Registry, Support Services Catalog, and Well-Being Improvement Center are essential tools for effective delivery of quality care. Over time, these tools will mature with the PCMH program to bring more value to coordinating care across providers, technology, and operational workflows.
Appendix D: PCMH Level Verification Request Process

The following steps explain the process for PCMH level verification requests.

Step 1
Review the population health management levels and requirements to determine whether a provider is eligible to move up in PCMH levels.

- The information on population health management levels and requirements is located in Section III of this guide.
- The physician organization must confirm a provider has completed all requirements prior to submitting a level verification request.

Step 2

Step 3
Complete the form and compile the supporting documentation listed in the population health management levels and requirements matrix.

- Note: If a provider requests to move from Level 1 to Level 2, they must satisfy both Level 1 and 2 requirements to be considered for Level 2.
- The provider should work with their physician organization leadership to complete the form and compile the necessary documentation.
- For questions regarding the requirements, physician organization leadership should contact their HMSA Provider Relations and Advocacy representative.

Step 4
Submit the required materials to HMSA.

- The physician organization, and not the provider, must submit the completed HMSA PCMH Level Verification Form and supporting documentation to HMSA. The physician organization is responsible for ensuring that the information is complete.
- The materials may be submitted at any time. However, submitting in the first week of each month increases the likelihood that PCMH level changes can take effect by the first day of the following month.
- The materials may be submitted by:
  - Email to PSInquiries@hmsa.com. Submitting by email will expedite the administrative process.
  - Fax to 948-6887 on Oahu, attention PCMH Coordinator.
  - Mail to:
    HMSA
    Attn: POA-Room 503
    P.O. Box 860
    Honolulu, HI 96808
  - If additional information or clarification is needed, HMSA’s PCMH coordinator will contact the provider by phone or email and send a copy to the physician organization.

Step 5
The PCMH Level Verification Review Committee meets during the second and fourth weeks of every month. The committee will make a determination regarding the provider’s request by the 15th of the month. If the request is approved, payments at the new level will take effect on the first day of the following month.

To verify that we’ve received your submitted materials and for information on the status of your request, contact HMSA’s PCMH coordinator at 952-7591 on Oahu or at PSInquiries@hmsa.com.

Step 6
Once the committee has made its determination, the decision will be communicated in writing to the physician organization and provider no later than 30 business days following the receipt of the request. HMSA will mail a letter to the physician organization and provider explaining the decision. For example, if the committee didn’t approve the request, the letter will specify what requirements need to be fulfilled to qualify for a PCMH level change. Providers are encouraged to submit a new request when they have fulfilled these requirements.

Note: HMSA may request, through the physician organization, that a provider’s PCMH level be verified. In these cases, the same steps should be followed.

The HMSA PCMH Level Verification Form is on HMSA’s website at www.hmsa.com/providers/assets/HMSA_PCMHLevel Verification2013.pdf.
HMSA PCMH LEVEL VERIFICATION FORM

INSTRUCTIONS: Please complete this form when your providers have fulfilled all PCMH requirements to advance levels (e.g., Level 2 or 3). Please print legibly or type. Refer to the HMSA PCMH Levels and Requirements document for detailed guidelines and expectations. Supporting documentation should be submitted to HMSA per the instructions below and maintained by the physician organization (PO). The PO should make any additional documentation available on request to validate achievement of level requirements.

Provider/Practice Name: ____________________  Physician Organization Name/Contact: ____________________
Provider Number: ____________________  HMSA PRA Contact: ____________________

Current Level Designation: [ ] Level 1  [ ] Level 2  [ ] Level 3
Request Change for Level Designation to: [ ] Level 1 (45-69 points)  [ ] Level 2 (70-94 points)  [ ] Level 3 (95-110 points)

Place a check in the box under all criteria achieved. Please submit supporting evidence with this form.

<table>
<thead>
<tr>
<th>MINIMUM REQUIRED PCMH ELEMENTS AND DOCUMENTATION</th>
<th>POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.1. One PCMH training Program, Conference, or Webinar (2 points)</strong></td>
<td></td>
</tr>
<tr>
<td>❑ Documentation/certificate confirming provider attendance.</td>
<td></td>
</tr>
<tr>
<td><strong>1.2. Large PO group meetings (1 point each)</strong></td>
<td></td>
</tr>
<tr>
<td>❑ List of meetings attended, data, topic, leader, and if the provider attended in person, via webinar, or via DVD (1 DVD meeting max).</td>
<td></td>
</tr>
<tr>
<td><strong>1.3. Small break-out group meetings (1 point each)</strong></td>
<td></td>
</tr>
<tr>
<td>❑ List of meetings attended, data, topic, leader, and if the provider attended in person, via webinar, or via DVD (1 DVD meeting max).</td>
<td></td>
</tr>
<tr>
<td><strong>2.2. Access During Office Hours (3 points)</strong></td>
<td></td>
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<tr>
<td>❑ List of same-day care requests including how they were accommodated over one week.</td>
<td></td>
</tr>
<tr>
<td><strong>3.1. Document and Track Transitions of Care (2 points)</strong></td>
<td></td>
</tr>
<tr>
<td>❑ One example of a complete transition including referral, tracking log, receipt of specialist, imaging/lab reports, and PCP-patient follow-up.</td>
<td></td>
</tr>
<tr>
<td><strong>3.2. Implement PCMH Provider-Patient Agreement (2 points)</strong></td>
<td></td>
</tr>
<tr>
<td>❑ One signed agreement, script for the discussion, and any printed material the patient receives.</td>
<td></td>
</tr>
<tr>
<td><strong>3.3. Culturally and Linguistically Appropriate Services (4 points)</strong></td>
<td></td>
</tr>
<tr>
<td>❑ Name of translator/interpreter service and an example of printed material in a foreign language.</td>
<td></td>
</tr>
<tr>
<td><strong>3.4. Individualized Care Plans (3 points)</strong></td>
<td></td>
</tr>
<tr>
<td>❑ One example of an acute care plan and one chronic care plan over a six-month period of management with status updates from follow-up visits.</td>
<td></td>
</tr>
<tr>
<td><strong>3.5. Care Plan Tracking and Follow-up (4 points)</strong></td>
<td></td>
</tr>
<tr>
<td>❑ Documented process for specialized referral tracking and follow-up and one example of a patient who received a referral for specialized care management, tracking, and PCP follow-up.</td>
<td></td>
</tr>
</tbody>
</table>

ADDITIONAL PCMH ELEMENTS AND DOCUMENTATION

<table>
<thead>
<tr>
<th>ADDITIONAL PCMH ELEMENTS AND DOCUMENTATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.4. Design and Conduct a Meeting or Learning Collaborative (4 points)</strong></td>
<td></td>
</tr>
<tr>
<td>❑ Date, agenda, list of attendees, and learnings from the meeting.</td>
<td></td>
</tr>
<tr>
<td><strong>2.3. Culturally and Linguistically Appropriate Services (4 points)</strong></td>
<td></td>
</tr>
<tr>
<td>❑ Name of translator/interpreter service and an example of printed material in a foreign language.</td>
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</tr>
<tr>
<td><strong>3.3. Train Office Staff (3 points)</strong></td>
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<tr>
<td>❑ Training materials including presentations, handbooks, DVDs, and office workflow defining roles and responsibilities.</td>
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<tr>
<td><strong>3.6. Care Plan Tracking and Follow-up (4 points)</strong></td>
<td></td>
</tr>
<tr>
<td>❑ Documented process for specialized referral tracking and follow-up and one example of a patient who received a referral for specialized care management, tracking, and PCP follow-up.</td>
<td></td>
</tr>
</tbody>
</table>
3.7. Provide Referrals to Health Education Programs (4 points)
   ❏ Curriculum of the class, duration, frequency, instructor, number of patients attending, and improved disease management/health outcome.

4.3. Analysis of Registry and Patient Outreach (3 points)
   ❏ Documentation of the results of the registry analysis and one example of outreach performed.

4.4. Standing Orders Based on Registry Analysis (4 points)
   ❏ Example of standing orders for a health condition identified from the registry analysis and a description of the roles and responsibilities of staff that accompany the standing orders.

5.2. Track Additional Quality Measures - 25% (3 points)
   ❏ Exact percentage of panel tracked and screen shot/copy of the tracking log.

5.3. Track Additional Quality Measures – 50% (4 points)
   ❏ Exact percentage of panel tracked and screen shot/copy of the tracking log.

5.4. Show Trends Toward Improvement (4 points)
   ❏ Report that shows three months of consistent improvement from the baseline value in tracked metrics.

6.2. Create Transformation Plan (3 points)
   ❏ Transformation plan with at least one check point documented by PO administration.

6.3. Implement and Execute Plan (4 points)
   ❏ Plan and implement three progress updates (1 per month).

6.6. Plan Do Study Act (PDSA) (3 points)
   ❏ Documentation of the results of the registry analysis and one example of outreach performed.

6.7. PDSA Implications and Next Steps (4 points)
   ❏ Analysis of learning from initial PDSA cycle(s) and next steps/future implications specific to the project. More than one cycle preferred.

6.8. Administer survey (2 points)
   ❏ Copy of survey tool and at least 40 responses from patients seen in the last year.

6.10. Evaluate and Re-Survey (3 points)
   ❏ Copy of the follow-up survey tool and response rates.

6.11. Follow-up Survey Demonstrates Improvement (4 points)
   ❏ Comparison of initial and follow-up survey results highlighting the areas that showed improvement.

7.1. Implementation (2 points)
   ❏ CMS EHR Certification ID and indicate the type of EHR implemented.

7.2. Active use (3 points)
   ❏ Hawai‘i Pacific Regional Extension Center (HPREC) active use validation certificate.

7.3. Meet Objectives of Meaningful Use (4 points) (Required for level 3)
   ❏ CMS/ONC attestation or HPREC validation certificate.

TOTAL

AFFIRMATION:
By signing below, I [we] certify that all the information reported on this form is complete and accurate and will provide supporting documentation if deemed necessary to validate level achievement request by HMSA.

NOTE: Intentionally providing false or misleading information on this form may affect the payment of any current and future PCMH funds.

PO Medical Director (Print Name) __________________________________________

PO Medical Director Signature __________________________________________ Date ____________

RETURN COMPLETED FORM AND DOCUMENTATION TO HMSA PCMH COORDINATOR
Email: PSinquiries@hmsa.com Fax: 948-6887 on Oahu
Mailing Address: HMSA, Attn: POA-Room 503, P.O. Box 860, Honolulu, HI 96808

HMSA USE ONLY
Date received by PCMH Coordinator: __________________________ Date to PCMH LVR Committee: __________________________
PCMH Coordinator initials: __________________________ Date of decision: __________________________
PO code: __________________________ Effective date of new level designation: __________________________

1178-0018 2014 PCMH Level Verification Form F