Patient-Centered Medical Home

Getting Started and Ongoing Management
One Year and Another Step Toward Transformation

In last year’s introduction to this guide, we presented the conceptual underpinnings of the patient-centered medical home (PCMH). This year, in the 2012 guide, I’d like to talk about more tangible topics, such as the many foundational structures, organizations, processes, and pilots that have been developed, most with significant input from providers and physician organizations.

Much of what we have built had to be developed from scratch, or at least heavily tailored, for the unique health care experience in Hawaii. To mitigate the risk of these new approaches and to get things right meant starting small, getting physician input, testing and retesting approaches, listening to feedback, and being flexible.

Even though we are all in the embryonic phase of our transformation into a PCMH, we’ve already had to deal with a tremendous amount of change. Our roadmap for 2012 involves new endeavors that could be even more challenging as the local and national health care environments become more complex.

We appreciate your patience, work, and collaboration, and thank you for continuing on the journey with HMSA to a new PCMH model of care. Together we are transforming Hawaii’s health care delivery system at its core, emphasizing value over volume while steadfastly focusing on quality, affordable health care.

Sincerely,

Paul K. Schnur
Vice President, Provider Services

What we’ve accomplished this year with your help:

- Care Planning Registry
- Integrated Service Center Build-out
- Implement Physician Organization Contracts
- Medical Directors’ Collaborative
- Patient Attribution Model
- PCMH Level Verification Process
- Pay-for-Quality Payments
- Physician Organization and Primary Care Provider Baseline and Performance Reports
- Physician Organization and Primary Care Provider Financial Models
- Practice Transformation Seminars
- Quality Improvement Initiatives
- Service Catalog
- Supplemental Data Capability
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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

¹ PCMH definition and Joint Principles of PCMH are available at www.pcpcc.net.
**I. Introduction**

**Building a Sustainable Health Care System for Hawaii**

Our overall objectives in implementing the patient-centered medical home model for care with our PCPs include collaborating with key stakeholders to build a sustainable health care system for Hawaii, encouraging HMSA members to select and use a PCP, and improving provider and patient experiences.

While our goal is to apply these initiatives across all lines of business, the changes currently apply to commercial lines of business, PPO and HMO. Reimbursement for services rendered to HMSA’s QUEST, 65C Plus, Medicare Advantage, Children’s, and FEP plans, and any nonparticipating employer groups are not included at this time.

In addressing the overall need to transform the health care system, our ultimate goal is to support a sustainable health care system. We can work toward this goal by integrating the concept of the Institute for Healthcare Improvement (IHI) Triple Aim, which is the simultaneous pursuit of three aims:

- Improving the experience of care.
- Improving the health of populations.
- Reducing per capita costs of health care.¹

By enhancing the patient care experience, including quality, access, and reliability, the health care system works to achieve major gains in the Institute of Medicine’s six aims for improvement.²

The relationship between these concepts for transforming the health care system in Hawaii is depicted in the diagram below.

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¹ IHI Triple Aim: [www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx](http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx)

II. Basic Expectations and Requirements for Providers

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

1. Providers are one of the following:
   - A general practice, internal medicine, family practice, 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 and/or HMO 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 have a minimum patient panel size of 150 PPO/HMO members.

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

6. 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 do not practice as PCPs (e.g., internal medicine physician who practices primarily as a cardiologist, based on submitted claims as determined by HMSA) as determined by established CMS standards and guidelines.

**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 is no penalty or negative impact to existing HMSA fee payments for those PCPs or group practices that 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 population health management (PHM) fees. The PHM fees will be in effect as long as the PCP meets the requirements for their designated PCMH level. Once HMSA is notified of the contracted PCPs and eligibility is verified according to the parameters set forth in the physician organization's contract with HMSA, these PHM fees will be paid on a monthly basis. HMSA is funding the PCMH population health management fees as follows: Level 1 - $2.00 PMPM, Level 2 - $2.50 PMPM, Level 3 - $3.00 PMPM. Failure to meet PCMH program requirements in a performance year will disqualify a practice from receiving PCMH population health management payments.

Additionally, HMSA funded the pay-for-quality program at $2.00 PMPM in 2011 and will increase that to $4.00 PMPM in 2012. During 2011, PHM fees up to June 2011 were based on eligible PPO members as defined in the Pay-for-Quality Program Guide. In July 2011, HMO members were added. HMSA's PCMH program continues to be based on commercial member counts only but we look forward to the development of programs for all of HMSA's members. Participation in HMSA's pay-for-quality program is not contingent upon a provider's participation in HMSA's PCMH program.

**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 for such patients.

2. Communicate in a timely fashion and cooperate with HMSA's PCMH resource 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 program rules and requirements as set forth 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 about 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.

**Termination and Changes in PCP Membership**

HMSA recognized that 2011 was the foundational year for PCMH. PCPs were allowed to change their physician organization affiliation once during 2011 as new physician organizations contracted for PCMH.

Beginning in January 2012 and each year thereafter, PCPs may change their physician organization affiliation once during an open enrollment period and commit to the 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 Dec. 15 will take effect on Jan. 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 expectations for PCMH PCPs are listed in the matrix below, with examples of how PCPs can demonstrate achievement of those expectations. HMSA will coordinate with the PCP’s physician organization as needed to review and validate that criteria are being met. Providers should maintain and make available documentation supporting the achievement of the accountability criteria. HMSA will coordinate with physician organizations to ensure expectations are being met without causing undue or unnecessary burden to providers when they are asked to show evidence of achievement.

Provider practices that are able to implement the criteria as part of their standard workflow should be better positioned to improve quality of care and will earn a larger PMPM payment with each level they attain.

To submit a request for level verification, please refer to the instructions for completing the PCMH level verification form in Appendix D.

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<tr>
<th>ACTIVITIES</th>
<th>REASON/INTENTION</th>
<th>EXPECTATIONS</th>
<th>ACCOUNTABILITY CRITERIA</th>
<th>EXAMPLES OF WAYS TO MEET THE REQUIREMENTS</th>
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<tr>
<td>Learn how to transform your practice into a PCMH.</td>
<td>Practice transformation requires continuous application of the concepts and operational changes of PCMH facilitated by collaboration within the physician organization. Meetings are intended to improve providers’ understanding of PCMH principles and enhance collaboration and teamwork over time.</td>
<td>1. Attend educational meetings with other providers regarding PCMH (coordinated/ held by physician organization leadership).</td>
<td>In the 12 months after execution of PCMH agreement: - Attend a minimum of 9 of the physician organization-scheduled PCMH meetings per PCP agreement year. - Attend a minimum of 1 training program, conference, or webinar with the National Committee for Quality Assurance (NCQA), TransforMED, IHI, or other locally/nationally sponsored PCMH educational event (with a minimum of 3 CME units or 3 hours of instructional time) per PCP agreement year.</td>
<td>• Physician organization’s meeting attendance records that indicate the provider has attended a minimum of 9 of the physician organization-scheduled PCMH meetings. • Attendance documentation and CME certificate confirming that the provider has attended a minimum of 1 PCMH training program, conference, or webinar (with a minimum of 3 CME units or 3 hours of instructional time).</td>
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<tr>
<td>To improve/expand the patient experience and quality of care provided, it is important to evaluate and assess a practice’s current performance and capabilities. Results of the assessment will help provide baseline information to better position our providers in the transformation to a PCMH.</td>
<td>2. Assess practice for PCMH readiness.</td>
<td>Complete assessment within the first 90 days after the effective date of the executed PCMH agreement.</td>
<td>Assessment report using one of the following PCMH readiness assessment tools (or others as agreed upon with HMSA): • NCQA PCMH Survey Tool (<a href="http://www.ncqa.org/tabid/629/default.aspx">www.ncqa.org/tabid/629/default.aspx</a>). • TransforMED MHIQ survey (<a href="http://www.transformed.com/MHIQ/welcome.cfm">www.transformed.com/MHIQ/welcome.cfm</a>). • CMHI Medical Home Index and Medical Home Family Index (medicalhomeimprovement.org/knowledge/practices.html).</td>
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1 Use of the assessment tool may require registration and/or payment of fees. Refer to the individual organizations for details.
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<tr>
<td>Work to improve care coordination in your practice.</td>
<td>Enhanced access is a key component for a PCMH (e.g. open scheduling, expanded hours). It is important to offer patients additional options to access a provider or care team for routine or urgent care during and after office hours, either via office visit, telephone, or secure electronic messaging. This promotes continuity in care and patient-centeredness.</td>
<td>1. Enhance care between visits by improving access via phone or secure email.</td>
<td>Ensure patient access to a clinician after hours if/when needed. Note: An answering machine directing patients to the emergency room (ER) does not qualify for this activity.</td>
<td>Evidence that patients have access to care beyond regular office hours and are able to obtain timely clinical advice by telephone, email, or other means when the office is not open, including: • Information provided to patients on how to access care (e.g., after-hours care policies, office postings, other materials indicating coverage via Physicians Exchange or coverage arranged with other PCPs).</td>
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<td>Improving care coordination in your practice is intended to:</td>
<td>• Prevent miscommunication between PCPs and specialists. • Reduce medical errors that may result from transitions in care. • Reduce poor outcomes for transitions in care that are not optimized. • Increase efficiencies and reduce redundancies in care.</td>
<td>2. Improve coordination between specialists and sites of care.</td>
<td>Assess patients’ care coordination needs and create a care plan during their visit. Provider/staff facilitates and documents transition to other care resources as needed. Include care coordination capabilities within provider’s practice (e.g., re-tool medical assistant functions, use external care coordinator) within 12 months of execution of PCMH agreement.</td>
<td>Evidence that individualized care plans are developed, communicated to patients, and reviewed/updated at each visit, including: • Care plan templates or other documentation that show patient care needs have been identified, treatment goals established, and appropriate review and follow-up completed at each visit. Evidence that individualized care plans indicate referrals to other resources (external or internal) for additional care management support as applicable, including: • Referrals to disease management services, case management services, mental health/substance abuse services, community resources, or health education programs. Evidence that practice has a process to track and follow up on referrals, including: • Documented process or procedure and documentation for at least 1 month of referrals (e.g., referral forms, specialist report, electronic or paper reports/logs and medical record notes [P section of SOAP notes]). Evidence that the practice has organized and trained office staff to support coordination of care activities and/or the use of external resources, including: • Self-reported statement of practice process and staff roles/responsibilities in care coordination. Evidence that reflects care coordinated for patients for hospital stays, emergency room (ER) visits, specialist care, and other services as defined by the provider, including: • Indication of care coordination in care plan. • Electronic or paper logs/reports of the most recent month’s data for coordinated care arranged by provider or of which the provider has knowledge.</td>
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<td>Add popula-</td>
<td>Expand PCP’s focus</td>
<td>1. Plan care pro-</td>
<td>Conduct review of registries for preventive</td>
<td>• Documentation of regular log-in to HBIOnline™ and access to care planning registry OR document-</td>
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<td>tion health</td>
<td>from the individual</td>
<td>actively by using</td>
<td>care and chronic disease at least quarterly</td>
<td>ation of condition-specific disease registry from electronic health record (EHR).</td>
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<td>management</td>
<td>to a population</td>
<td>registries for preventive</td>
<td>and perform outreach to patients as needed.</td>
<td>• Policy and procedure on how provider/staff incorporates registry data into workflow of patient office visit.</td>
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<tr>
<td>to your prac-</td>
<td>health management</td>
<td>care and chronic</td>
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<td>• Documentation of outreach to patient by telephone, email, or mail for preventive care and chronic diseases (e.g., outreach reminders).</td>
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<td>tice.</td>
<td>level. Registries ensure</td>
<td>diseases.</td>
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<td>• Documentation of closure of gaps in care over time.</td>
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<td>attention to patients</td>
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<td>who are seen rarely or</td>
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<td>non-compliant with follow-</td>
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<td>up visits.</td>
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<td>2. Share data for clinical outcomes and show trends toward improvement.</td>
<td>Maintain non-claims data related to identified quality measures for PCMH. (Adult: diabetes measures [BP, LDL, A1C &gt;9%] and hypertension measure [BP]. Pediatrics: BMI and submission of CSHCN screening [or other tool]).</td>
<td>• Use of information from reports to manage specific populations of patients, including:</td>
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<td>- Tracking blood pressure (BP) of patients with hypertension.</td>
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<td>- Tracking A1C of patients with diabetes.</td>
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<td>- Tracking LDL of patients with diabetes and CAD.</td>
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<td>- Tracking BMI of children and adults.</td>
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<td>• For internal medicine, general, and family practice physicians: Reports to the physician organization and HMSA for the period beginning 6 months prior to the review on at least 75 percent of their patients who meet the criteria for inclusion on 4 PCMH adult measures (see Section VIII of this guide).</td>
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<td>• For pediatricians: Reports to the physician organization and HMSA for the period beginning 6 months prior to the review on at least 75 percent of their patients who meet the criteria for inclusion on 4 PCMH pediatric measures (see Section VIII of this guide).</td>
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<td>• Evidence that provider has participated in at least 2 QI initiatives per year, including the review of their patient population, which may include unique registries, baseline metrics, and post-intervention evaluation measurements.</td>
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<td>• Documentation of provider’s understanding of the Plan-Do-Study-Act (PDSA) process and their role in the QI project.</td>
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<td>• Documentation that each component of the PDSA cycle or its equivalent has been addressed. Analysis to include the lesson learned from the QI activity.</td>
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<td>Make your</td>
<td>Self-improvement through continuous quality improvement (QI) is necessary to</td>
<td>1. Implement quality improvement (QI) projects to improve patient-centeredness, effectiveness, and efficiency.</td>
<td>Complete a minimum of 2 QI projects that focus on different quality measures within 12 months of execution of PCMH agreement (e.g., improvement on quality metric or patient access to services). At least 1 QI plan and related activities are in conjunction with physician organization-defined QI priorities.</td>
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| Level 2 ($2.50 PMPM) | Level 1 activities are annual expectations and are required as part of level 2. | 1. Actively use EHR for e-prescribing, maintaining electronic charts, and electronic receipt of lab results. | Demonstrate active use of EHR as determined by CMS, the Office of the National Coordinator for Health Information Technology (ONC), or other agreed-upon source. | • Regional Extension Center (REC) certification/attestation.  
• Copies of output from work with the REC (e.g., secure two-way communication system and website access for appointment scheduling, medication refills, referrals, and test results).  
Note: REC will provide documentation (certification/attestation) to the PCP’s physician organization that the requirement has been met. |
| To promote support and alignment in meeting CMS meaningful use requirements and coordinate technology with improvements in the care and safety of patients. | To help individual providers identify the strengths and weaknesses patients see in their practice. | 2. Gain patient-centered care insights through an annual PCMH provider-specific survey on patient experience. | Send/provide survey to a percentage of the patients who received care within the year or to all patients during one quarter of the year, sufficient to accumulate responses from at least 50 patients. | Evidence that the provider or practice conducted a patient experience survey via telephone, paper, or electronic means, with a random sample of patients who received care during the year, and responses from at least 50 patients per provider, including:  
• HMSA-accepted surveys that include²:  
  - CAHPS Clinician and Group Survey  
  - Family Voices Family-Centered Care Self-Assessment Tool (org2.democracyinaction.org/o/6739/images/fcca_FamilyTool.pdf).  
• A report summarizing the results of patient feedback. |
| Level 3 ($3.00 PMPM) | Levels 1 and 2 are required activities as part of Level 3. | 1. Achieve objectives of meaningful use. | Demonstrate achievement of meaningful use objectives of EHR as defined by CMS. | • REC or ONC certification/attestation.  
• Copies of output from work with the REC (e.g., secure two-way communication system and website access for appointment scheduling, medication refills, referrals, and test results).  
Note: REC will provide documentation (certification/attestation) to the PCP’s physician organization that the requirement has been met. The REC will produce a Meaningful Use Gap Analysis report indicating the percent of meaningful use core priorities and overall assessment. |

² Use of the assessment tool may require registration and/or payment of fees. Refer to the individual organizations for details.
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| Defines expectations of provider and patient regarding roles and responsibilities in the PCMH. | 2. Implement use of provider-patient medical home agreements. | Demonstrate the process and tracking of agreements with patients regarding PCMH obligations. | Evidence that the practice has a process for providing patients with information and materials about PCMH obligations and tracks the number of completed agreements, including:  
  - A patient compact (a written agreement between the practice and patient specifying their roles in PCMH).  
  - Patient brochure.  
  - Written statement for the patient. |
IV. 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. Physician organization has an executed PCMH agreement with HMSA.
2. Physician organization has a QI committee or structure.
3. Physician organization 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. Physician organization is a legal entity.
5. Physician organization includes at least five PCPs.
6. Physician organization is able to provide budget and financial statements for the organization as needed.

Operations (implements all criteria)

1. Physician organization meets with HMSA’s PCMH resource team to support the accomplishment of PCMH goals and transformation activities.
2. Physician organization’s medical director(s) participate in HMSA’s PCMH collaborative.
3. Physician organization collaborates with industry experts to learn effective PCMH leadership techniques.
4. Physician organization shares its PCMH contract template with HMSA to assure 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. Physician organization contracts with providers, facilitates provider enrollment in PCMH, and reports to HMSA monthly.
6. Physician organization provides oversight and ensures that PCMH providers meet their obligations under the PCMH agreement.
7. Physician organization supports and tracks providers’ progress on PCMH level 1, 2, and/or 3 requirements and is responsible for reviewing, validating, and submitting level verification change requests for PCPs.
8. Physician organization provides reports to HMSA on PCMH activities: PCPs’ achievement of levels 1, 2, and/or 3 for financial payout, transformation activities, etc.
9. Physician organization informs member providers of its PCMH support services.
10. Physician organization 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. Beginning in 2012, HMSA will continue 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 V.

The primary source of information about all HMSA services for physician organizations is HMSA’s PCMH resource team. 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.
V. Physician Organization Leadership Responsibilities

The matrix below describes the types of physician organization leadership responsibilities needed for PCMH, with examples of proof that responsibilities have been met. The requirements are critical in working toward 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>
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<tr>
<th>PHYSICIAN ORGANIZATION LEADERSHIP RESPONSIBILITIES</th>
<th>EXAMPLES OF PROOF THAT RESPONSIBILITIES HAVE BEEN MET</th>
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<tbody>
<tr>
<td>Leading Provider Collaborative (LC)</td>
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<tr>
<td>LC 1 – Provide leadership and coordinate regular meetings.</td>
<td>• Meetings with PCMH PCPs at least 12 times per year.</td>
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<td>• Meeting minutes reflect attendance and topic related to PCMH and/or QI.</td>
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<td>LC 2 – Engage providers to develop PCMH.</td>
<td>• Report summarizing the following:</td>
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<td>- Number of PCPs with PCMH agreements.</td>
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<td>LC 3 – Use an assessment to determine provider readiness for PCMH.</td>
<td>- Number of PCPs participating in QI action planning.</td>
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<td>- Number of PCMH-readiness assessments completed by PCPs.</td>
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<tr>
<td></td>
<td>• Reports reflecting PCMH PCPs’ progress on Levels 1, 2, or 3.</td>
</tr>
<tr>
<td></td>
<td>• Apply physician organization resources toward practice transformation and QI projects.</td>
</tr>
<tr>
<td>Quality Improvement (QI)</td>
<td></td>
</tr>
<tr>
<td>QI 1 – Establish a minimum of 3 QI priorities.</td>
<td>• Report summarizing number of PCPs with QI action plans and a description of the focus of action plans.</td>
</tr>
<tr>
<td></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 6–9 months).</td>
</tr>
<tr>
<td>QI 4 – Implement a minimum of 2 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>Coordinated Resources (CR) &amp; Advanced Technology</td>
<td></td>
</tr>
<tr>
<td>CR 1 – Direct effective use of shared resources.</td>
<td>• Report summarizing the following:</td>
</tr>
<tr>
<td></td>
<td>- Number of PCPs with EHR.</td>
</tr>
<tr>
<td>CR 2 – Support implementation of care coordination.</td>
<td>- Number of meetings/sessions promoting active use of EHR.</td>
</tr>
<tr>
<td></td>
<td>- Number of sessions to educate PCPs on use of care coordinators.</td>
</tr>
<tr>
<td>CR 3 – Support use of EHR and other technologies (EHR, E-visits, etc.).</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>
<tr>
<td></td>
<td>• Assistance with implementation of patient/family-centered care surveys.</td>
</tr>
<tr>
<td>Education and Training (ET)</td>
<td></td>
</tr>
<tr>
<td>ET 1 – Coordinate orientation for new PCMH providers.</td>
<td>• Report of new PCMH orientation sessions conducted, including attendance record.</td>
</tr>
<tr>
<td></td>
<td>• Orientation materials for PCMH PCPs available for review.</td>
</tr>
</tbody>
</table>

After a physician organization enrolls in a PCMH, HMSA’s PCMH resource team 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.

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

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

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3 Source: CareFirst’s PCMH Program Description and Guidelines.
One of PCMH’s core principles is to improve quality of care for the patient. HMSA’s 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. It is a single program with a single set of metrics servicing HMSA’s HMO and PPO populations. A complete description of HMSA’s 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 new, additional metrics.

Generalists (i.e., general practice and family practice 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.

HMSA is developing a process to support the submission of these reports and will notify providers when it is established.

VII. Additional Reporting Requirements

**Pediatric Requirements:**

<table>
<thead>
<tr>
<th>PCMH PEDIATRIC MEASURES</th>
<th>REPORTING GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (BMI measurement).</td>
<td>• Non-claims data (e.g., BP readings, lab values, BMI).</td>
</tr>
<tr>
<td></td>
<td>• Submission (via Excel spreadsheet, HBIOnline, data feed from EHR, etc.) of non-claims data that are useable for HEDIS and can be mapped to codes such as CPT and Logical Observation Identifiers Names and Codes (LOINC).</td>
</tr>
<tr>
<td>Completion of the Child with Special Needs screener.</td>
<td></td>
</tr>
<tr>
<td>Completion of the Family-centered Self-Care Assessment Tool – Family.</td>
<td></td>
</tr>
<tr>
<td>Completion of the Family-centered Self-Care Assessment Tool – Provider.</td>
<td></td>
</tr>
</tbody>
</table>

**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 or ob-gyn 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**

To be defined with assistance from the Hawaii Chapter of the American Academy of Pediatrics (HAAP).

**Completion of the Family-centered Self-Care Assessment Tool – Family**

To be defined with assistance from HAAP.

**Completion of the Family-centered Self-Care Assessment Tool – Provider**

To be defined with assistance from HAAP.

**Adult Requirements:**

<table>
<thead>
<tr>
<th>PCMH ADULT MEASURES</th>
<th>REPORTING GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDC: Blood Pressure Control (&lt;140/90).</td>
<td>• Non-claims data (e.g., BP readings, lab values, BMI).</td>
</tr>
<tr>
<td>CDC: HbA1C (Poor) Control (&gt;9%).</td>
<td>• Submission (via Excel spreadsheet, HBIOnline, data feed from EHR, etc.) of non-claims data that are useable for HEDIS and can be mapped to codes such as CPT and Logical Observation Identifiers Names and Codes (LOINC).</td>
</tr>
<tr>
<td>CDC: LDL-C Controlled &lt;100 mg/dL.</td>
<td></td>
</tr>
<tr>
<td>Controlling High Blood Pressure.</td>
<td></td>
</tr>
</tbody>
</table>

**Adult Measure Definitions**

**CDC: Blood Pressure Control (<140/90)**

Percentage of adult patients with diabetes age 18–75 years whose most recent BP reading during the measurement year is <140/90. The member is not 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 18–75 years whose most recent HbA1C test during the measurement year is >9.0% or whose HbA1C was not measured. (Note: A lower score indicates better performance.)

**CDC: LDL-C Controlled <100 mg/dL**

Percentage of adult patients with diabetes age 18–75 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 18–85 years who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90) during the measurement year. The member is not compliant if the BP is ≥140/90 mm Hg or if there was no BP reading during the measurement year.

**Quality and Performance Reports**

To help providers more effectively execute QI action plans and positively impact their pay-for-quality performance, HMSA will provide data and analytic reports on quality performance at least quarterly through HBIOnline. Details about the primary care pay-for-quality program are available in the Pay-for-Quality Program Guide.
HMSA's PCMH resource team 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 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 the 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 office visit pattern. 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, based on a review of HMSA claims for a specified period.

HMSA’s commercial members are currently the only eligible population in the PCMH program and primary care pay-for-quality program. However, the attribution process includes members of The HMSA Plan for QUEST members, 65C Plus and Medicare Advantage plans, and The HMSA Children’s Plan.

An initial attribution, using the process described below, was completed when HMSA launched its PCMH and pay-for-quality programs. Thereafter, the same attribution process has been completed after 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 used 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 list on HBIOline. Providers are encouraged to view their patient lists and follow the update process described on HBIOline.

Providers may add patients to their patient lists through HBIOline. Patients will need to sign an attestation to complete the process. Their attestations will supersede claims-based 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 are not required to use these materials. Make sure they reflect your practice before using them.)

Included are the following:

- **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 patient and describe how they will participate in a PCMH.

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

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

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

Also available is the Information for Families Brochure to help your 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 PRE-VISIT CONTACT FORM

Note to Staff: Please check with scheduling to allow enough time for the visit.

Date __________

Patient’s name ____________________________________________ Chart # or DOB __________

Phone ____________________ Other type of contact __________________________

Help us prepare for your visit. Please let us know:

1. Have you been to an emergency room (ER) or urgent care clinic since your last visit? Yes No
   If yes, where, when, and why?
   What happened? What did they tell you to do?
   Staff: Is there a record of the visit available? Yes No

2. Have you been in the hospital since your last visit? Yes No
   If yes, where, when, and why?
   What happened? What did they tell you to do?
   Staff: Is there a record of the hospital stay available? Yes No

3. Have you seen or consulted any other health care providers since your last visit? Yes No
   If yes, where, when, and why?
   What happened? What did they tell you to do?
   Staff: Is the specialist note in the chart? Yes No

4. Have you had any blood work or X-rays done since your last visit? Yes No
   If yes, where, when, and why?
   Staff: Is the specialist note/letter in the chart? Yes No

5. Are there any forms or letters you will need us to fill out? Yes No
   If yes, please describe the purpose of the forms.

6. What are your top areas of concern or topics that you want to talk about at this visit?
   1.
   2.
   3.
SAMPLE INTRODUCTORY LETTER TO PATIENT

Re: Patient-Centered Medical Home Model of Care

Dear Patient:

Welcome to the patient-centered medical home (PCMH) model of care, a new way of managing your health care! PCMH is not a building, a house, or a hospital. It is a model of care designed to improve the coordination of your health care with an emphasis on your all-around well-being.

Optional: HMSA has identified me as your potential primary care provider (PCP) based on your enrollment selection or your pattern of doctor visits. I would be happy to be your PCP and work with you on your health care needs.

I invite you to continue working with me in this new model of care.

I will work with other health care providers to take care of you. As your care team, we will involve you in decisions about your health and health care, and thus be able to develop a stronger relationship with you. You will also have easier access to me through: <insert as applicable: phone visits, Web visits, secure email through HMSA’s Online Care>. These are all elements in my PCMH approach to your care.

Optional: If you are over 40 years of age or have a chronic condition for which you are being treated and have not seen me within the last year, please contact my office and schedule an appointment so we may reconnect.

Attached is a list of our roles in working together to keep you healthy. If you have any questions, please call my office at <insert telephone number>. I look forward to working with you on the path to a healthier you!

Sincerely,

Enc.
OUR ROLES IN WORKING TOGETHER

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.
- 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.
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.
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- 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.
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- If possible, contact us before going to the emergency room so someone who knows your medical history can care for you.
- 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.

<table>
<thead>
<tr>
<th>Provider Signature</th>
<th>Printed Provider Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Signature</th>
<th>Printed Patient Name</th>
<th>Date</th>
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</table>

<table>
<thead>
<tr>
<th>Parent/Guardian Signature</th>
<th>Printed Parent/Guardian Name</th>
<th>Date</th>
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<tr>
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<td></td>
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</tbody>
</table>

*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.
SAMPLE PATIENT CHECKLIST – BEFORE APPOINTMENT

A patient-centered medical home is an approach to providing total health care for you. With a medical home, you will have a care team to support you, helping you to make the best decisions for your health. So please help us know you better by using this handy checklist to get ready for your appointment.

☐ Make a list of any questions you have about your health. Put the questions that are most important to you at the top of the list.

☐ Make a list of other health care providers you have visited. Jot down their contact information and the reason why you visited them.

☐ Bring all of your medications, in their original containers, to your appointment. Be sure to include prescription, over-the-counter, natural, and herbal medications and dietary supplements.

☐ Take your HMSA membership card and other insurance information with you.
SAMPLE PATIENT CHECKLIST – DURING APPOINTMENT

The patient-centered medical home is a way for you to be involved in and better understand your own health care. To help you do that, use this handy checklist during your appointment.

- Write down the names of the members of your care team.
- Let your provider know about any changes in your health and/or condition.
  - Are there any updates on your use of medications or dietary supplements?
  - Have you visited other health care providers?
- Use your list of questions. Ask your top questions first. That way, even if you can’t get all the answers you need at one time, you can at least keep track of them.
- Talk with your provider about what health issue(s) you should work on first.
- Make sure you understand what you should do before you leave the office.
- Ask how you can reach your care team after hours if it becomes necessary.
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 Integrated Service 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 Integrated Service Center.
Providers can most effectively use these care coordination support services by following the steps below:

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### PCMH Care Coordination Support Services - Getting Started

<table>
<thead>
<tr>
<th>Know Your Panel</th>
<th>View Your Registry</th>
<th>Work Your Gaps</th>
<th>Leverage the Center</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td><strong>2</strong></td>
<td><strong>3</strong></td>
<td><strong>4</strong></td>
</tr>
</tbody>
</table>
| • Access your Patient Panel Report through HBIOnline.  
  • Review and understand the Patient Panel Report.  
  • Request edits to your patient panel as needed. | • Access Care Planning Registry through HBIOnline.  
  • Review and understand the Care Planning Registry.  
  • Identify measures with opportunities for improvement. | • Find gaps in care from the Care Planning Registry.  
  • PCMH outreach campaign will automatically send out general mail and telephone reminders that services are needed based on the gaps in care.  
  • Identify which patients need additional support beyond the general reminders. | • 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 Integrated Service Center.  
  • Contact the service center to request care coordination support services. |

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**The Care Planning Registry**

All PCPs participating in the P4Q program will have access to monthly Care Planning Registry reports via HBIOnline. The registry reports on 14 of the 15 gaps in care for adults and five of the seven gaps in care for pediatrics, as defined by the 2012 pay-for-quality program. One adult measure (avoidance of antibiotic treatment with acute bronchitis) and two pediatric measures (appropriate testing for children with pharyngitis and appropriate treatment for children with upper respiratory infection) are excluded because the rate can only be determined after a member did not receive appropriate care. Since September 2011, providers have been submitting supplemental data to report on filled gaps in care that were not 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 Integrated Service 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.
The Integrated Service Center

HMSA’s PCMH program offers providers the Integrated Service 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. Functionalities of the service center will evolve as additional services become available.

Summary

The Care Planning Registry, Support Services Catalog, and Integrated Service 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 most recent version of this matrix was mailed to physician organization leadership on Nov. 21, 2011.
- The physician organization must confirm a provider has completed all requirements prior to submitting a level verification request.

Step 2

Download the HMSA PCMH Level Verification Form from www.hmsa.com/providers/assets/HMSA_PCMHLevelVerification.pdf.

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 reach out to their HMSA Provider Relations and Advocacy manager.

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 (808) 948-6887 on Oahu, attention PCMH Coordinator.
  - Mail to:
    Attn: POA, Room 503
    HMSA
    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 be take effect on the first day of the following month.

To verify that we have 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 did not 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 located on HMSA’s website at www.hmsa.com/providers/assets/HMSA_PCMHLevelVerification.pdf.
**HMSA PCMH LEVEL VERIFICATION FORM**

**INSTRUCTIONS:** Please complete this form when your physicians have fulfilled all PCMH requirements to move levels (e.g., Level 2 or 3). Please type or print legibly. Refer to the HMSA PCMH Population Health Management Levels and Requirements document for guidelines and detailed expectations. Supporting documentation should be maintained by the physician organization and made available upon request to validate achievement of level requirements.

**Physician/Practice Name:**

**PCMH Contract Effective Date:**

**Physician Organization Name/Contact:**

**HMSA PRA Contact:**

**Current Level Designation:**

- [ ] Level 1
- [ ] Level 2
- [ ] Level 3

**Request Change for Level Designation to:**

- [ ] Level 1
- [ ] Level 2
- [ ] Level 3

**Provider Number:**

List below all requirements achieved and date completed. Please describe how the requirement was met in detail.

<table>
<thead>
<tr>
<th>LEVEL 1 REQUIREMENTS</th>
<th>EXPECTATIONS</th>
<th>ACCOUNTABILITY CRITERIA ACHIEVED</th>
<th>DATE COMPLETED</th>
<th>DESCRIPTION OF HOW REQUIREMENT WAS MET</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Educational Meetings</td>
<td>☐ a. Attend a minimum of 9 physician organization-scheduled PCMH meetings per PCP agreement year</td>
<td></td>
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<tr>
<td></td>
<td>☐ b. Attend a minimum of 1 training program, conference, or webinar with NCQA, TransferMED, IHI, or other locally/nationally sponsored PCMH educational event (with a minimum of 2 CME units or 3 hours of instructional time) per PCP agreement year</td>
<td></td>
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<tr>
<td>2. PCMH Readiness Assessment</td>
<td>☐ a. Complete assessment within the first 90 days after the effective date of the executed PCMH agreement</td>
<td></td>
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</tr>
<tr>
<td>3. Enhanced Care and Access</td>
<td>☐ a. Patients have access to a clinician after hours if/when needed. Note: An answering machine directing patients to the ER does not qualify for this activity</td>
<td></td>
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<tr>
<td></td>
<td>☐ b. Provide/staff facilitates and documents transition to other care resources as needed</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>☐ c. Include care coordination capabilities within provider’s practice (e-tool medical assistant functions, use external care coordinator, etc.) within 12 months of execution of PCMH agreement</td>
<td></td>
<td></td>
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<tr>
<td>4. Care Coordination</td>
<td>☐ a. Patients' care coordination needs are assessed and a care plan created during visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ b. Provide/staff facilitates and documents transition to other care resources as needed</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>5. Population Health Management</td>
<td>☐ a. Conduct review of preventive care and chronic disease registries at least quarterly and perform outreach to patients as needed</td>
<td></td>
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<tr>
<td></td>
<td>☐ b. Maintain non-claims data related to identified quality measures for PCMH (Adult: diabetes measures [BP, LDL, A1C&gt;9%] and hypertension measure [BP]; Pediatrics: BMI &amp; submission of CSHCN screening [or other tool])</td>
<td></td>
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<tr>
<td>6. Quality Improvement (QI) Projects</td>
<td>☐ a. A minimum of 2 QI projects focusing on different quality measures are to be completed within 12 months of execution of PCMH agreement (e.g., improvement on quality metric or patient access to services)</td>
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<td></td>
<td>☐ b. At least 1 QI plan and related activities are in conjunction with physician organization-defined QI priorities</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>LEVEL 2 REQUIREMENTS</th>
<th>EXPECTATIONS</th>
<th>ACCOUNTABILITY CRITERIA ACHIEVED</th>
<th>DATE COMPLETED</th>
<th>DESCRIPTION OF HOW REQUIREMENT WAS MET</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Active use of Electronic Health Record (EHR)</td>
<td>☐ a. Demonstrate active use of EHR as determined by CMS, the Office of the National Coordinator for Health Information Technology (ONC), or other agreed-upon source</td>
<td></td>
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<tr>
<td>2. PCMH Physician-Specific Patient Experience Survey</td>
<td>☐ a. Send/provide survey to 40% of the patients who received care within the year or to all patients during one quarter of the year, sufficient to accumulate responses from at least 50 patients</td>
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</table>

<table>
<thead>
<tr>
<th>LEVEL 3 REQUIREMENTS</th>
<th>EXPECTATIONS</th>
<th>ACCOUNTABILITY CRITERIA ACHIEVED</th>
<th>DATE COMPLETED</th>
<th>DESCRIPTION OF HOW REQUIREMENT WAS MET</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Meaningful Use</td>
<td>☐ a. Demonstrate achievement of meaningful use objectives of EHR as defined by CMS</td>
<td></td>
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</tr>
<tr>
<td>2. Provider-Patient Medical Home Agreements</td>
<td>☐ a. Demonstrate the process and tracking of agreements with patients regarding the obligations of the medical home</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**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 upon request by HMSA.

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

**Physician Organization Medical Director (Print Name):**

**Signature**

**Effective Date of New Level Designation:**

**Date Requested by PCMH Coordinator:**

**PO Coordinator Initials:**

[Signature]

**Date received by PCMH Coordinator:**

**Date to PCMH LVR Committee:**

**HMSA USE ONLY**

[Submit by email] [Reset]