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I. Introduction

HMSA’s Patient-Centered Medical Home (PCMH) programs have helped advance provider practices on the journey toward HMSA’s vision of creating a sustainable health care system for Hawaii. The PCMH programs are built on the foundation of the Institute for Healthcare Improvement’s (IHI) Triple Aim:

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

The development of PCMH practice infrastructures enabled providers’ participation in HMSA’s value-based programs, such as the pay-for-quality programs that focus on improving care management and quality outcomes.

Although the principles of the PCMH framework are fundamental to continual practice transformation, there’s clearly a need for stronger alignment of practice design, incentives, and care outcomes. In 2016, HMSA launched a pilot program for our new primary care payment model and incentive structure. Throughout 2017, the remaining participating primary care providers (PCPs) will be moved to the new model. To support this transition, HMSA’s standard PCMH program introduced new requirements that align with the new primary care payment model. (See this guide for details.)

Because HMSA recognizes that Federally Qualified Health Centers (FQHCs) fill a unique role in the communities they serve, PCPs who practice primarily* at FQHCs won’t move to the new payment model in 2017. FQHCs will have a separate PCMH program that retains elements and requirements from previous program years.

Summary of 2017 PCMH Program Changes

PCPs new to PCMH

New FQHC PCPs who join a physician organization (PO) will start at the PCMH level that the other PCPs affiliated with their FQHC have attained. The FQHC must submit proof of its current PCMH recognition from NCQA, The Joint Commission, or URAC.

<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>
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<tr>
<td>The Joint Commission 1 or 2</td>
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<td>URAC 1</td>
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<tr>
<td>NCQA 3</td>
<td>3</td>
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<td>The Joint Commission 3</td>
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<td>URAC 2</td>
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PCMH Level Advancement – Level Reciprocity

Amended level advancement requirements using Level Reciprocity will be implemented. The FQHC and its PCPs must submit the following evidence for HMSA PCMH Level Advancement (e.g., Level 2 to Level 3):

- Copy of current national program level recognition certificate.
- Supporting documentation for completion of the following HMSA PCMH requirements:
  - 1.1 PCMH training programs, conferences, or webinars totaling three hours of instruction.
  - 6.4 Provider quality metrics or access improvement project.
  - 6.5 Physician organization priority project.

* Determined in one of two ways: membership in an FQHC physician organization (PO) or having designated PCMH payments paid to an FQHC.
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 or QUEST Integration agreement and execute a PCMH agreement with a PO that has contracted with HMSA for PCMH.

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

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

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

6. Providers must practice primarily* at an FQHC.

* Determined in one of two ways: membership in an FQHC (PO) or having designated PCMH payments paid to an FQHC.

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 PO 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 POs that 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 PO 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 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 PO’s contract with HMSA, these PHM fees will be paid on a monthly basis. Failure to meet PCMH program requirements will disqualify a practice from receiving PHM payments.

The 2017 budget per member per month (PMPM) is outlined below.

Commercial PCMH program:
- Level 1 = $0.00
- Level 2 = $2.50
- Level 3 = $3.00

QUEST Integration PCMH program:
- Level 1 = $0.00
- Level 2 = $1.00
- Level 3 = $1.50

HMSA may conduct periodic PCMH level verification audits. Providers who fail the audit won’t be allowed to continue in PCMH. The provider’s PO maintains the right to remove a provider from its organization in accordance with the provider’s PO 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. Collaborate with their physician organization, fellow PCPs, and HMSA and our partners to execute strategies, such as programs that engage patients in health-risk mitigation efforts.

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

**Level Reciprocity**

Beginning in January 2014, our PCMH program has granted 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>
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**PCMH Level Advancement – Level Reciprocity**

Amended level advancement requirements using Level Reciprocity will be implemented. The FQHC and its PCPs must submit the following evidence for HMSA PCMH Level Advancement (e.g., Level 2 to Level 3):

- Copy of current national program level recognition certificate.
- Supporting documentation for completion of the following HMSA PCMH requirements:
  - 1.1 PCMH training programs, conferences, or webinars totaling three hours of instruction.
  - 6.4 Provider quality metrics or access improvement project.

Effective January 1, 2017, the following evidence is required for HMSA PCMH recognition:

1. Copy of current 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.
   - 6.4 Provide quality metrics or access improvement project.
   - 6.5 Physician organization priority project.

**Terminations 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.
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 7–10.

### III. Population Health Management Levels and Requirements

<table>
<thead>
<tr>
<th>Level</th>
<th>Points</th>
<th>Collaborative PCMH Meetings and Training</th>
<th>Access to Care</th>
<th>Care Coordination</th>
<th>Registry Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>2</td>
<td>1.1 One Training Program, Conference, or Webinar</td>
<td>2.1 Beyond Office Hours Care</td>
<td>3.1 Document and Track Transitions of Care</td>
<td>4.1 Cozeva Registry</td>
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<td></td>
<td></td>
<td>1.2 Large Group Meetings</td>
<td>2.2 Access During Office Hours</td>
<td>3.2 Implement PCMH Provider-Patient Agreement</td>
<td>4.2 Electronic Health Record (EHR) Registry</td>
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<td></td>
<td>1.3 Small Group Meetings</td>
<td>3.3 Train Office Staff</td>
<td>3.4 Individualized Care Plans</td>
<td>4.3 Analysis of Registry and Patient Outreach</td>
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<tr>
<td>3</td>
<td>3</td>
<td>1.4 Design and Conduct a Meeting</td>
<td>3.5 Counsel to Adopt Healthy Behaviors</td>
<td>3.6 Care Plans Reflect Specialized Referral Tracking and Follow-Up</td>
<td>4.4 Standing Orders Based on Registry Analysis</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>2.3 Culturally and Linguistically Appropriate Services</td>
<td>3.7 Provide Referrals to Health Education Programs</td>
<td>3.8 Review Specialized Referral Tracking and Follow-Up</td>
<td>4.5 Use of EHR Registry for Patient Outcomes and Quality Improvement Projects</td>
</tr>
</tbody>
</table>

**General Details**

- **Level 1:** 22-43 points, including all minimum required elements
- **Level 2:** 44-70 points, including all minimum required elements
- **Level 3:** 71-110 points, including all minimum required elements PLUS EHR Meaningful Use
- **Total Possible Points = 110**

**2017 Budget per member per month (PMPM)-Commercial:**

- Level 1 = $0.00 PMPM
- Level 2 = $2.50 PMPM
- Level 3 = $3.00 PMPM

**2017 Budget PMPM-QUEST Integration:**

- Level 1 = $0.00 PMPM
- Level 2 = $1.00 PMPM
- Level 3 = $1.50 PMPM
### 5. Improve Clinical Outcomes

<table>
<thead>
<tr>
<th>Practice Readiness Assessment</th>
<th>Quality Metrics</th>
<th>Patient Satisfaction Survey</th>
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</thead>
<tbody>
<tr>
<td><strong>5.1</strong> Track Additional Quality Measures</td>
<td><strong>6.1</strong> Practice Readiness Assessment</td>
<td><strong>6.4</strong> Provider Quality Metric or Access Improvement Project</td>
</tr>
<tr>
<td><strong>5.2</strong> Track Additional Quality Measures (25%)</td>
<td><strong>6.2</strong> Create Transformation Plan</td>
<td><strong>6.5</strong> Physician Organization Priority Project</td>
</tr>
<tr>
<td><strong>5.3</strong> Track Additional Quality Measures (50%)</td>
<td><strong>6.3</strong> Implement and Execute Plan</td>
<td><strong>6.6</strong> Plan Do Study Act (PDSA) Documentation</td>
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<tr>
<td><strong>5.4</strong> Trends Toward Improvement or 90th Percentile Maintenance</td>
<td><strong>6.7</strong> PDSA Implications and Next Steps</td>
<td><strong>6.8</strong> Administer Survey</td>
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<tr>
<td></td>
<td><strong>6.9</strong> Action Plan Based on Survey Results</td>
<td></td>
</tr>
<tr>
<td><strong>6.1</strong> Complete Practice Readiness Assessment</td>
<td><strong>7.1</strong> Implement EHR</td>
<td><strong>7.2</strong> Active Use of EHR</td>
</tr>
<tr>
<td><strong>6.2</strong> Create Transformation Plan</td>
<td><strong>7.3</strong> Meet Objectives of Meaningful Use</td>
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### 1.2 & 1.3 Large and Small Group Meetings
Each meeting counts as one point.

Any combination of physician organization and small group meetings is acceptable.

- Level 1 = 2 meetings
- Level 2 = 4 meetings
- Level 3 = 6 meetings

### Minimum Required Elements = 22

1.1 One PCMH Training Program, Conference, or Webinar.
1.2 Large Group Meetings.
1.3 Small Group Meetings.
2.2 Access During Office Hours.
3.1 Document and Track Transitions of Care.
3.2 Implement PCMH Provider-Patient Agreement.
4.1 Cozeva Registry or 4.2 EHR Registry.
6.1 Complete Practice Readiness Assessment.
6.2 Create Transformation Plan.
6.4 Provider Quality Metric or Patient Access Improvement Project.
6.5 Physician Organization Priority Project.
Detailed PCMH Level Requirements

Each requirement will count once toward your level verification and advancement 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 advancement submission or re-verification, not annually.

★ Minimum Required Elements

1. One PCMH Training Program, Conference, or Webinar.
2. Large Group Meetings.
3. Small Group Meetings.
5. Implement PCMH Provider-Patient Agreement.
6. Cozeva Registry or EHR Registry.
7. Complete Practical Readiness Assessment.
9. Provider Quality Metric or Patient Access Improvement Project.
11. Meet Meaningful Use (Needed for PCMH Level 3).

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), Rainbow book program, and trainings or conferences with PCMH content that are hosted by FQHCs also qualifies.

1.2. ★ 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.

1.3. ★ Small Group Meetings (1 point each)

Participate in small group meetings organized by a physician mentor, a physician organization medical director, or a physician organization quality improvement staff. The purpose of this requirement is to generate collaboration and help providers with their PCMH development toward achieving IHI’s Triple Aim.

*Please provide a list of meetings attended including date, topic, and name of person who led the meeting and whether the provider attended in person or via webinar.

1.4. Design and Conduct a Meeting or Learning Collaborative (4 points)

Design, coordinate, and conduct a meeting for PCMH providers. It can be open to one or more physician organizations. Content should be focused on PCMH development or HMSA’s new primary care payment model and incentive structure, and must be approved by physician organization leadership. Meetings should be a minimum of one hour long and have a minimum of four attendees including the leader.

*Please provide the meeting objective, date, agenda, list of attendees, and accomplishments of the meeting.

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 Physicians 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)

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. Material printed in English does not satisfy this requirement.
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.
*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)
Patient's 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 and health education programs. 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 checkup. Practice then performs appropriate outreach to patients via secure email, telephone, or mail 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 as described in Section IV.
Adults: Track blood pressure (BP) of patients with hypertension; track BP 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 Children with Special Health Care Needs (CSHCN) Screener and track Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents.
*Please provide screen shot or a copy of the tracking 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 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 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents 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, as described in Section IV, for 50 percent of patients.
Adults: Track BP of patients with hypertension; track BP 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 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents 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, and BMI 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 Practice Readiness Assessment (2 points)
Each PCP must complete the readiness assessment for their own practice office. The assessment is intended to help PCPs reflect on the practice transformation undertaken thus far, while also highlighting some enhanced practice characteristics that will be necessary to succeed within HMSA’s new payment models.
Templates of the assessment and plan are available on hmsa.com/portal/provider/prc_pcmh.htm.

6.2. ★ Create Transformation Plan (3 points)
PCPs can collaborate with their physician organization to complete the transformation plan. Each PCP is responsible for submitting a transformation plan that reflects their practice. The plan will introduce PCPs to the enhanced practice characteristics that will be needed to succeed in HMSA’s new payment models.
Templates of the assessment and plan are available on hmsa.com/portal/provider/prc_pcmh.htm.

6.3. Implement and Execute Plan (4 points)
Work with your office staff and physician organization to implement the transformation plans and then track the activities and progress monthly. An example of a transformation plan could be to 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.
*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 Administrator 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://oncchpl.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.
One of PCMH's core principles is to improve quality of care for the patient. HMSA's Primary Care Pay-for-Quality Programs build upon experience gained through the Practitioner Quality and Service Recognition and Quality & Performance programs to create programs aligned with the challenges and opportunities of PCPs. A complete description of HMSA's Primary Care Pay-for-Quality Programs is available on hmsa.com.

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 Section III of this guide for details on requirements for reporting these additional quality measures. For further details on these measures, please refer to the specifications from HMSA's Primary Care Pay-for-Quality programs.

### Pediatric Requirements:
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents.
- Completion of the Children with Special Health Care Needs Screener.

### Pediatric Measure Definitions

**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents**

The percentage of members age 3–17 years who had an outpatient visit with an eligible PCP-type provider 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 Children with Special Health Care 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 Z87.898 to the claim for the visit to report the status.

### Adult Requirements:
- CDC: Blood Pressure Control (<140/90).
- CDC: HbA1c Control (≤9%).
- 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 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%. If a patient's HbA1c was not taken during the measurement year, the patient is considered noncompliant for this measure.

**Controlling High Blood Pressure**

The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year based on the following criteria:

- Patients 18–59 years of age whose BP was <140/90 mm Hg.
- Patients 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.
- Patients 60-85 years of age with a diagnosis of diabetes, whose BP was <140/90 mm Hg.

The member isn't compliant if there was no BP reading during the measurement year.

**Body Mass Index (BMI)**

The percentage of members 18 to 74 years of age who had an outpatient visit with an eligible PCP-type provider and whose body mass index (BMI) was documented during 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 at least quarterly through Cozeva. Details about the primary care pay-for-quality programs can be found in the program guide available on hmsa.com.

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 and a recognized Federally Qualified Health Center (FQHC).
5. Includes at least five PCPs.
6. Can provide budget and financial statements for the organization as needed.

Operations (implements all criteria)

1. Supports HMSA programs and initiatives.
2. Physician organization leaders participate in HMSA-hosted meetings, including the PCMH Collaboratives and information sessions on the new primary care payment model and incentive structure.
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 advancement 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.

The leadership responsibilities of physician organizations as needed for PCMH are described in detail in Section VI.
VI. FQHC 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>Leading Provider Collaborative (LC)</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 and prepare for HMSA's new payment model and incentive structure for primary care.</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 and HMSA's new payment models.</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>Quality Improvement (QI)</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>Coordinated Resources (CR) &amp; Advanced Technology</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 Provider Services staff 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.
Appendix A: PCMH Framework

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 Patient-Centered Medical Home as developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association.

The Joint Principles of the Patient-Centered Medical Home

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

HMSA’s mission is to provide the people of Hawaii access to a sustainable, quality health care system that improves the overall health and well-being of our state.

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.

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.¹

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.² The synergy between these concepts leads to the transformation of health care in Hawaii as depicted in the diagram below.

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

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**Improvement Aims for a Sustainable Health Care System**

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

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

**Adoption of core beliefs for delivering quality health care**
Appendix B: Patient Attribution

The goal of the attribution process is to reflect members’ preference for a provider as their PCP by member selection or based on their office-visit pattern. Member attribution must be verified monthly with their HMSA membership status. A PCP’s panel will be based on HMSA’s attribution methodology, which consists of two elements:

**Member selection:** HMSA members are attributed to their selected PCP.
- Members who selected a PCP are never attributed to a PCP based on anything other than their PCP selection; claims don’t change the attribution of these members. A PCP is selected during enrollment or when a member contacts HMSA to change their PCP. HMO and QUEST Integration members must contact HMSA to select or change their PCP.

**Claims history:** HMSA PPO members and HMSA Akamai Advantage® members who haven’t selected a PCP are attributed to a provider they’ve seen most frequently based on the following methodology:
- In the immediately preceding 16 months, claims for the PCP seen most often.
- If there’s a tie between the number of claims for two or more PCPs, the member is attributed to the PCP they visited most recently (as determined by submitted claim).

A PCP’s attribution list is updated monthly and sent to Cozeva® monthly.

Use of Cozeva to Manage Attribution

PCPs can manage their attributed panel using Cozeva. Using the Panel tab when logged in to Cozeva, PCPs can see their list of attributed patients, including the new and transferred. PCPs may submit requests through Cozeva to add, transfer, or remove patients from their panel.

**PCP attestation/request:** To attest/request that a patient be attributed, a PCP must use the process in Cozeva. The provider should log in to Cozeva, click the Panel tab, and select Add Patient. This will take the PCP to an electronic request form that must be completed with the patient’s full name, date of birth, HMSA subscriber ID, and gender. The PCP must also attest with an electronic signature that there’s a medical need to access this patient’s personal health information.

Lastly, PCPs must check the box, “Add patient to P4Q program, or Payment Transformation program,” to request that the patient be added to their attributed panel. (PCPs who don’t check the box will have access to the patient’s Cozeva profile and care history, but won’t have the patient attributed to them or have them added to the quality measures. The only PCPs who shouldn’t check this box are those who are covering for the patient’s PCP or are providing specialty care. PCPs will have access to newly added patients’ Cozeva profiles within 24 hours. The patient will be considered attributed to the PCP as of the month they were added. A patient may only be added by one PCP each month in Cozeva.

Cozeva is a registered trademark of Applied Research Works, Inc.
Applied Research Works® is an independent company that provides COZEVA®, an online tool for HMSA providers to engage members on behalf of HMSA.
Appendix C: 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.**
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 may be.

Your commitment to my patient-centered medical home practice will provide you with an expanded type of care. I will work with 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.
**PCMH Provider Toolkit**

This is an example of a patient care plan. Other examples include care plans used by the QUEST Integration care coordinators or the Care Model Patient Support Plan.

---

## 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: ___________________

Best way to contact 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>
<tbody>
<tr>
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<td></td>
<td></td>
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</tbody>
</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>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</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>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</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 D: PCMH Level Advancement Request Process

The following steps explain the process for PCMH level advancement 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 advancement request.

**Step 2**
Download the HMSA PCMH Level Advancement Form from hmsa.com/providers/pcmh/default.aspx.

**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 can contact their HMSA strategic relationship manager (SRM) or HMSA Provider Services by email at PSInquiries@hmsa.com or by phone at 948-6820 on Oahu or 1 (877) 304-4672 toll-free on the Neighbor Islands.

**Step 4**
Submit the required materials to HMSA.

- The physician organization, and not the provider, must submit the completed HMSA PCMH Level Advancement 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:
  - Secure 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: Office of Payment Transformation - PCMH Coordinator
    P.O. Box 860
    Honolulu, HI 96808
- If additional information or clarification is needed, HMSA’s PCMH coordinator will contact the HMSA Strategic Relationship Manager (SRM) who supports your physician organization.

**Step 5**
The PCMH Level Advancement Review Committee meets every month. If the request is submitted within the first week of the month and approved by the 15th of the month, 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 the HMSA Strategic Relationship Manager (SRM) who supports your physician organization.

**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 60 business days following the receipt of the request. HMSA send written correspondence (e.g., mailed letter or email) to the physician organization and provider explaining the decision. For example, if the committee didn’t approve the request, the correspondence 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.
HMSA PCMH LEVEL ADVANCEMENT FORM

INSTRUCTIONS: Please complete this form when a PCP has fulfilled all PCMH requirements to advance levels (e.g., Level 2 or 3). Please print legibly or type. Refer to section III in the HMSA PCMH program guide for details and expectations on Levels and Requirements. Supporting documentation should be submitted to HMSA per the instructions below and maintained by the physician organization (PO). The PO should provide additional documentation on request to validate achievement of level requirements.

Provider/Practice Name: ___________________________  Physician Organization Name/Contact: ___________________________
Provider Number: ___________________________  HMSA Provider Services Contact: ___________________________

Current Level Designation:  ❑ Level 1  ❑ Level 2  ❑ Level 3

Request Change for Level Designation to:

❑ Level 2 (44-70 points)  ❑ Level 3 (71-110 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>1.1. One PCMH training Program, Conference, or Webinar (2 points)</td>
<td></td>
</tr>
<tr>
<td>❑ Documentation/certificate confirming provider attendance.</td>
<td></td>
</tr>
<tr>
<td>Collaborative Meeting (10 points maximum):</td>
<td></td>
</tr>
<tr>
<td>4 points for level 2, and 6 points for level 3.</td>
<td></td>
</tr>
<tr>
<td>1.2. Large group meetings (1 point each)</td>
<td></td>
</tr>
<tr>
<td>❑ List of meetings attended, data, topic, leader, and if the provider attended in person or via webinar.</td>
<td></td>
</tr>
<tr>
<td>1.3. Small group meetings (1 point each)</td>
<td></td>
</tr>
<tr>
<td>❑ List of meetings attended, data, topic, leader, and if the provider attended in person or via webinar.</td>
<td></td>
</tr>
<tr>
<td>2.2. Access During Office Hours (3 points)</td>
<td></td>
</tr>
<tr>
<td>❑ List of same-day care requests including how they were accommodated over one week.</td>
<td></td>
</tr>
<tr>
<td>3.1. Document and Track Transitions of Care (2 points)</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>3.2. Implement PCMH Provider-Patient Agreement (2 points)</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>Registry (Either one of the two options below will meet the requirement):</td>
<td></td>
</tr>
<tr>
<td>4.1. Cozeva (2 points)</td>
<td></td>
</tr>
<tr>
<td>❑ HMSA will verify this requirement through the monthly Cozeva usage report.</td>
<td></td>
</tr>
<tr>
<td>4.2. Electronic Health Record (EHR) Registry (2 points)</td>
<td></td>
</tr>
<tr>
<td>❑ Example of one disease registry you monitor.</td>
<td></td>
</tr>
<tr>
<td>6.1. Complete Practice Readiness Assessment (2 points)</td>
<td></td>
</tr>
<tr>
<td>❑ Copy of completed assessment.</td>
<td></td>
</tr>
<tr>
<td>6.2. Create Transformation Plan (3 points)</td>
<td></td>
</tr>
<tr>
<td>❑ Copy of completed plan.</td>
<td></td>
</tr>
<tr>
<td>6.4. Provider Quality Metric or Access Improvement Project (2 points)</td>
<td></td>
</tr>
<tr>
<td>❑ Analysis that led to the identified project, baseline metrics, intervention, and post-intervention metrics.</td>
<td></td>
</tr>
<tr>
<td>6.5. PO Priority Project (2 points)</td>
<td></td>
</tr>
<tr>
<td>❑ Analysis that led to the identified project, baseline metrics, intervention, and post-intervention metrics.</td>
<td></td>
</tr>
<tr>
<td>7.3. Meet Objectives of Meaningful Use (4 points) (Required for Level 3)</td>
<td></td>
</tr>
<tr>
<td>❑ CMS/ONC attestation or HPREC validation certificate.</td>
<td></td>
</tr>
</tbody>
</table>

ADDITIONAL PCMH ELEMENTS AND DOCUMENTATION

<table>
<thead>
<tr>
<th>POINTS</th>
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</thead>
<tbody>
<tr>
<td>1.4. Design and Conduct a Meeting or Learning Collaborative (4 points)</td>
</tr>
<tr>
<td>❑ Date, agenda, list of attendees, and learnings from the meeting.</td>
</tr>
<tr>
<td>2.1. After-Hours Care (2 points)</td>
</tr>
<tr>
<td>❑ List of after-hours visit requests including how they were accommodated over one week.</td>
</tr>
<tr>
<td>2.3. Culturally and Linguistically Appropriate Services (4 points)</td>
</tr>
<tr>
<td>❑ Name of translator/interpreter service and an example of printed material in a foreign language.</td>
</tr>
<tr>
<td>3.3. Train Office Staff (3 points)</td>
</tr>
<tr>
<td>❑ Training materials including presentations, handbooks, DVDs, and office workflow defining roles and responsibilities.</td>
</tr>
<tr>
<td>3.4. Individualized Care Plans (3 points)</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>
</tr>
</tbody>
</table>
**HMSA PCMH LEVEL ADVANCEMENT FORM**

3.5. Counsel to Adopt Healthy Behaviors (3 points)
- Identify counseling services provider and describe the policy that explains which patients should receive counseling and education.

3.6. Care Plan Tracking and Follow-up (4 points)
- 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.

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.

5.1. Track Additional Quality Measures (2 points)
- Screen shot or copy of tracking log for each of the specified measures.

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.

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

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 that each component of the PDSA cycle has been addressed.

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.

6.9. Action Plan (2 points)
- Baseline metrics and action plan. A Plan Do Study Act (PDSA) template may be used to document the action plan.

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.

**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 PROVIDER SERVICES**

Email: PSinquiries@hmsa.com Fax: 948-6887 on Oahu
Mailing Address: HMSA, Attn: PS-POA, P.O. Box 860, Honolulu, HI 96808

**HMSA USE ONLY**

Date received by Provider Services: ___________________ Date to PCMH LVR Committee: ___________________
Coordinator initials: ___________________ Date of decision: ___________________
PO code: ___________________ Effective date of new level designation: _______________