PCMH3: Population Health Management

A practice's ability to identify patients within their practice that may need care for proactive outreach is a key element of a successful PCMH. Instead of waiting for these patients to schedule an appointment, a PCMH practice actively outreaches to those who need services. A proactive approach to care allows practices to:

- Make sure their patients get the right care at the right time in the right setting
- Provide care coordination and support family participation in care including providing connections to community resources

Element D: Use Data for Population Management—Must Pass

Proactive Patient Care: The practice uses patient information, clinical data and evidence-based guidelines to generate lists of patients *and* to proactively remind patients and clinicians of services needed for the following (at least 2 to obtain the minimum 50% score needed for must-pass elements):

Factor 1: At least two different preventive care services
Examples: mammograms, colonoscopies, immunizations, well-child visits, fasting blood sugar, stress tests, etc.

Factor 2: At least two different immunizations (*New for 2014*)

Factor 3: At least three different chronic care services
Examples: diabetes care (A1C, micro-albumin, foot & eye exams, etc.), coronary artery disease care, lab values outside normal range, asthma care, ADHD, obesity, depression, etc.

Factor 4: Patients not recently seen by the practice
Examples: care management follow-up visits, overdue periodic physical exams, etc.

Factor 5: Medication monitoring or alerts *(Revised 2014)*
Examples: harmful side effects, generic options, recall notice, etc.

Getting Started

Identify **patients that are overdue for important preventive and chronic care services and immunizations.**

Using an electronic system to mine and pull the necessary data the practice identifies (examples):

- Patients needing immunizations
- Patients needing mammogram reminders
- Diabetic patients overdue for A1C lab tests

Identify practice patients who have not been seen recently and may be overdue for periodic physical exams?

Instead of waiting for patients to come to their office, a PCMH practice routinely pulls lists of their patients who haven't been seen recently and reaches out to them to schedule needed visits.

- Generate a list of patients that haven't been seen in over a year and are overdue for their annual

physicals.

- Target diabetic patients that have not been seen within the past six months for routine chronic care.

Create a list of patients that are taking specific medications for follow-up

The ability to pull a list of patients taking a certain medication allows practices to notify their patients of recalls or harmful side effects.

Cost-effective care is also a consideration of a PCMH practice. Practices may also use these types of lists to notify patients on name-brand drugs when there is a suitable generic version available.

Check EMR or e-scribing system to see if you can pull this type of list.

Documentation Requirements:

Proactive patient care (NCQA element 3D) is a **must-pass** element so practice must satisfy at least 2 factors to receive a passing score.

Factors 1-5: Lists or summary reports of patients who need services within past 12 mo. (Health plan data okay if 75% of patient population) and
Factors 1-5: Documented process demonstrating staff responsibilities and desired timing of reminders and materials showing how patients were notified for each service.

The practice must perform these functions at least annually and make documentation of each reminder available to NCQA upon request.

Recommended Links/Resources:

https://www.communitycarenc.org/emerging-initiatives/pcmh-central1/2011-pcmh-resources/

- Webinars on all standards
- Tools/practice examples for all measures/NCQA standards
- Practical tools/resources for practice transformation
- Specific tools to consider: (https://www.communitycarenc.org/media/files/web-based-pcmh-2011-workbook-1-xls.xls)
    - PPC2F-5 -
    - 2011 Quick Reference Guide (HEDIS QARR Measures)
    - PPC2F-4
    - PPC2F – 2.7
    - For 2A – Example Data Elements (Elizabeth Family Medicine)
    - PCMH2D Example Identifying Patients on Specific Medication
    - Example: Provider Quick Reference Guide: Cholesterol Management Screening

- Safety Net Medical Home Initiative

http://www.safetynetmedicalhome.org/change-concepts/organized-evidence-based-care

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