Sustaining Improvement Workshop Series

Workshop#2: During Visit

WORKSHOP SERIES OVERVIEW

Workshop 1

BEFORE VISIT

- Empanelment
- Pre-visit planning
- Care Team
- Guidelines

Workshop 2

DURING VISIT

- Visit flow
- Care plan
- Patient self-management

Workshop 3

AFTER VISIT

- Monitoring panel
- Closing referral loops
- ED and Hospital follow up

VOLUME BASED CARE

VALUE-BASED CARE

EMPANELED

RISK STRATIFIED

"TOUCHES"

PRE-VISIT PLANNING

DURING VISIT

VISIT FLOW

CARE TEAM

CARE PLANNING

GUIDELINES

DURING VISIT

VISIT FLOW: CHECK IN TO CHECK OUT

INTAKE → VITALS → SCREENINGS → EVALUATION → DIAGNOSIS → PLAN → ORDERS → CARE PLAN → COORDINATE CARE

VISIT FLOW

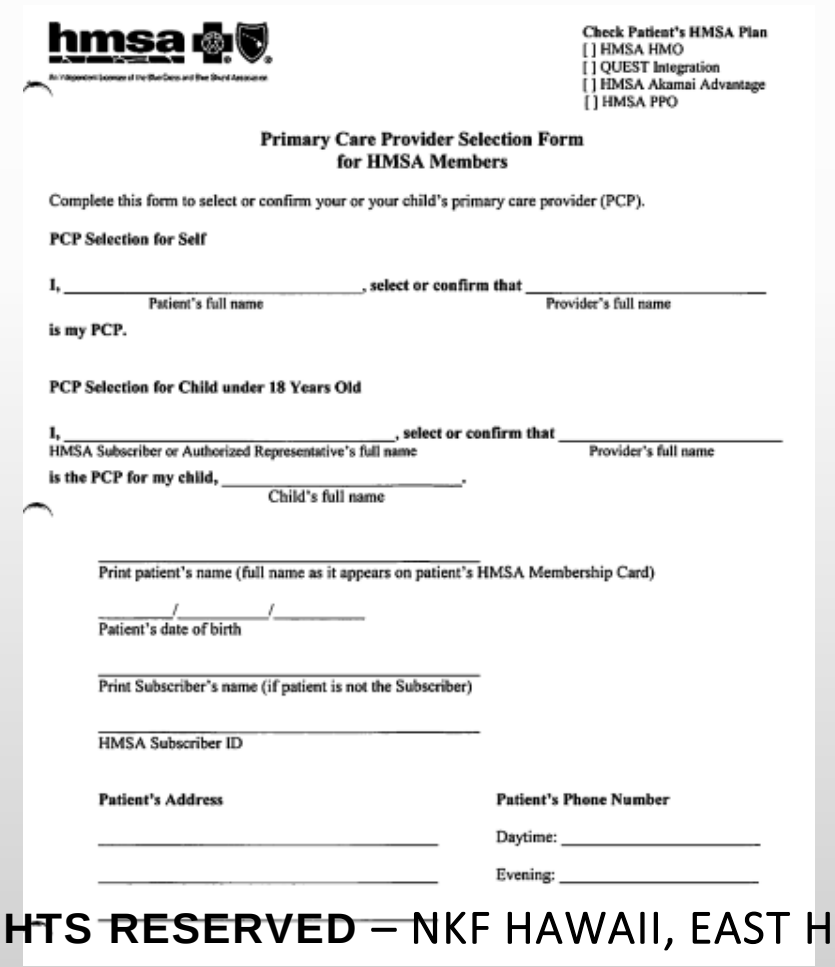
INTAKE → VITALS → SCREENINGS → EVALUATION → DIAGNOSIS → PLAN → ORDERS → CARE PLAN → COORDINATE CARE

FORMS

HMSA PCP SELECTION FORM

At check in

- Have patient sign HMSA member attestation form.
- Fax signed form to HMSA
- If patient has QUEST or HMO, have them call HMSA to change PCP



hmsa

Check Patient's HMSA Plan
[ ] HMSA HMO
[ ] QUEST Integration
[ ] HMSA Akamai Advantage
[ ] HMSA PPO

Primary Care Provider Selection Form for HMSA Members

Complete this form to select or confirm your or your child's primary care provider (PCP).

PCP Selection for Self

I, _____ **, select or confirm that** _____
Patient's full name — Provider's full name
is my PCP.

PCP Selection for Child under 18 Years Old

I, _____ **, select or confirm that** _____
HMSA Subscriber or Authorized Representative's full name — Provider's full name
is the PCP for my child, _____ .
Child's full name

_____
Print patient's name (full name as it appears on patient's HMSA Membership Card)

_____/_____/_____
Patient's date of birth

_____
Print Subscriber's name (if patient is not the Subscriber)

_____
HMSA Subscriber ID

Patient's Address — **Patient's Phone Number**

_____ Daytime: _____

_____ Evening: _____

VISIT FLOW

reminder

INTAKE → VITALS → SCREENINGS → EVALUATION → DIAGNOSIS → PLAN → ORDERS → CARE PLAN → COORDINATE CARE

file:///C:/Users/NKFH%20Office2/Desktop/CPC+/CPC+%20MEDICARE%20BENEFICIARIES%20NOTIFICATION%20INSTRUCTIONS.pdf

FORMS

CPC+ MEDICARE BENEFICIARY NOTIFICATION TEMPLATE

[Practice Name] Participating in Historic Public-Private Partnership to Strengthen Primary Care

Initiative Provides Primary Care Practices with Additional Resources to Improve Coordination of Care

[PRACTICE NAME] is one of more than 3,000 primary care practices nationwide participating in Comprehensive Primary Care Plus (CPC+), a partnership between payer partners from the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, commercial health plans, self-insured businesses, and primary care providers. This partnership is designed to provide improved access to quality health care at lower costs.

"A robust primary care system is essential to achieve better care, smarter spending, and healthier people," said Acting CMS Administrator Patrick Conway. "For this reason, CMS is committed to supporting primary care clinicians to deliver the best, most comprehensive primary care possible for their patients."

Through CPC+, CMS will pay primary care practices a care management fee, initially set at an average of $70 per beneficiary per month in Track 1 and $28 per beneficiary per month in Track 2, to support enhanced, coordinated services on behalf of Medicare beneficiaries. Simultaneously, participating commercial, state, and other federal insurance plans are also offering enhanced payment to primary care practices designed to support them in providing high-quality primary care on behalf of their members.

For patients, this means that physicians may offer longer and more flexible hours, use electronic health records, coordinate care with patients' other health care providers, better engage patients and caregivers in managing their own care, and provide individualized, enhanced care for patients living with multiple chronic diseases and higher needs.

The first year of CPC+ started on January 1, 2017, with CMS selecting a diverse pool of commercial health plans, state Medicaid agencies, and self-insured businesses to work alongside Medicare to support comprehensive primary care. Public and private health plans in 14 regions across the country signed letters of intent with CMS to participate in this model: Arkansas, Colorado, Hawaii, Kansas and Missouri's Greater Kansas City region, Michigan, Montana, New Jersey, New York's Capital District-Hudson Valley region, Ohio and Kentucky's Cincinnati-Dayton region, Oklahoma, Oregon, Pennsylvania's Greater Philadelphia Region, Rhode Island, and Tennessee. The markets were selected in August 2016 based on the percentage of the total population covered by payer partners who expressed interest in joining this partnership.

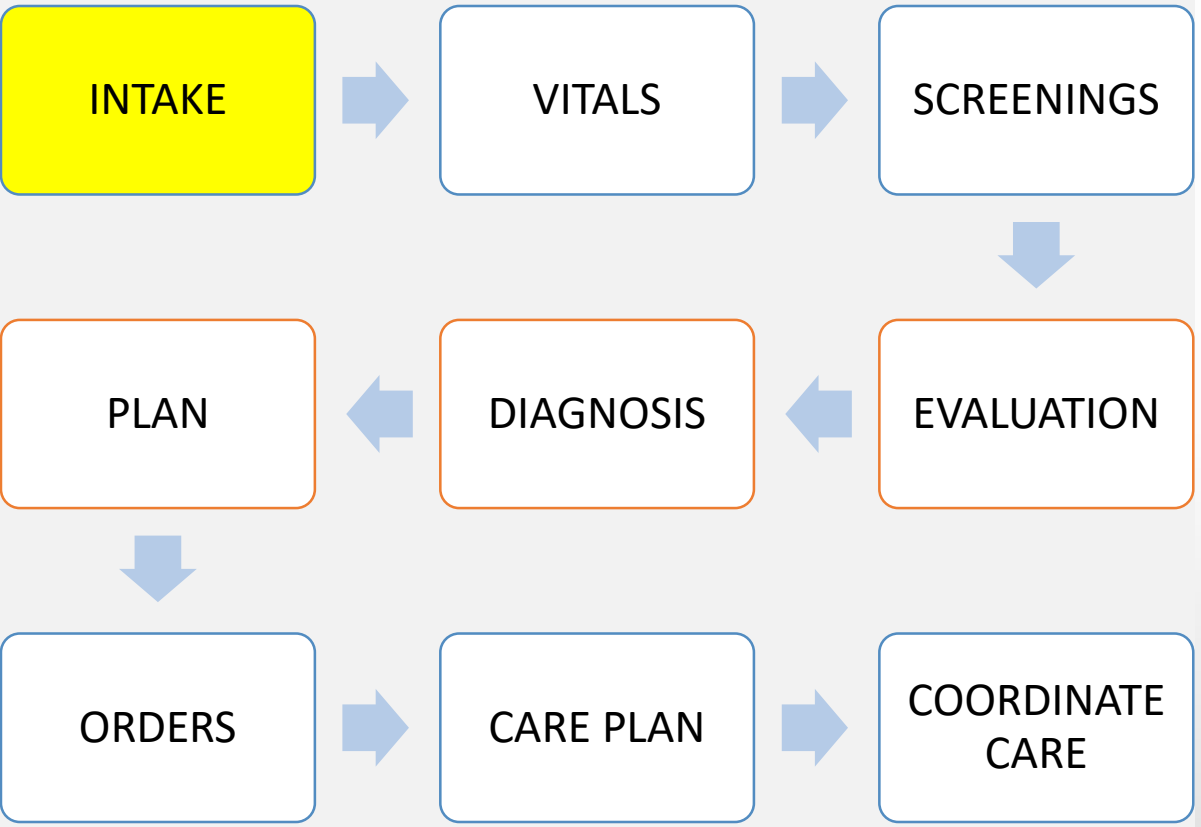
Eligible primary care practices in each market were invited to apply to participate in the winter of 2016. Through a competitive application process, CMS selected primary care practices within the selected markets to participate in CPC+. Practices were chosen based on their use of health information technology, ability to demonstrate recognition of advanced primary care delivery by leading clinical societies, services to patients covered by participating payer partners, participation in practice transformation and improvement activities, and diversity of geography, practice size, and ownership structure.

CPC+ is administered by the Center for Medicare & Medicaid Innovation (CMS Innovation Center). The CMS Innovation Center was created by the Affordable Care Act to test innovative payment and service delivery models that have the potential to reduce program expenditures while preserving or enhancing the quality of care.

For more information about CPC+, visit https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus/

[INSERT BACKGROUND PARAGRAPH ABOUT PRACTICE]

VISIT FLOW



https://www.stepsforward.org/modules/pre-visit-planning

FORMS

INTAKE FORMS

Intake questionnaire

To be completed before or at the patient's current visit	
Patient name:	
Date of birth:	Appointment Date:

What do you hope to accomplish today?

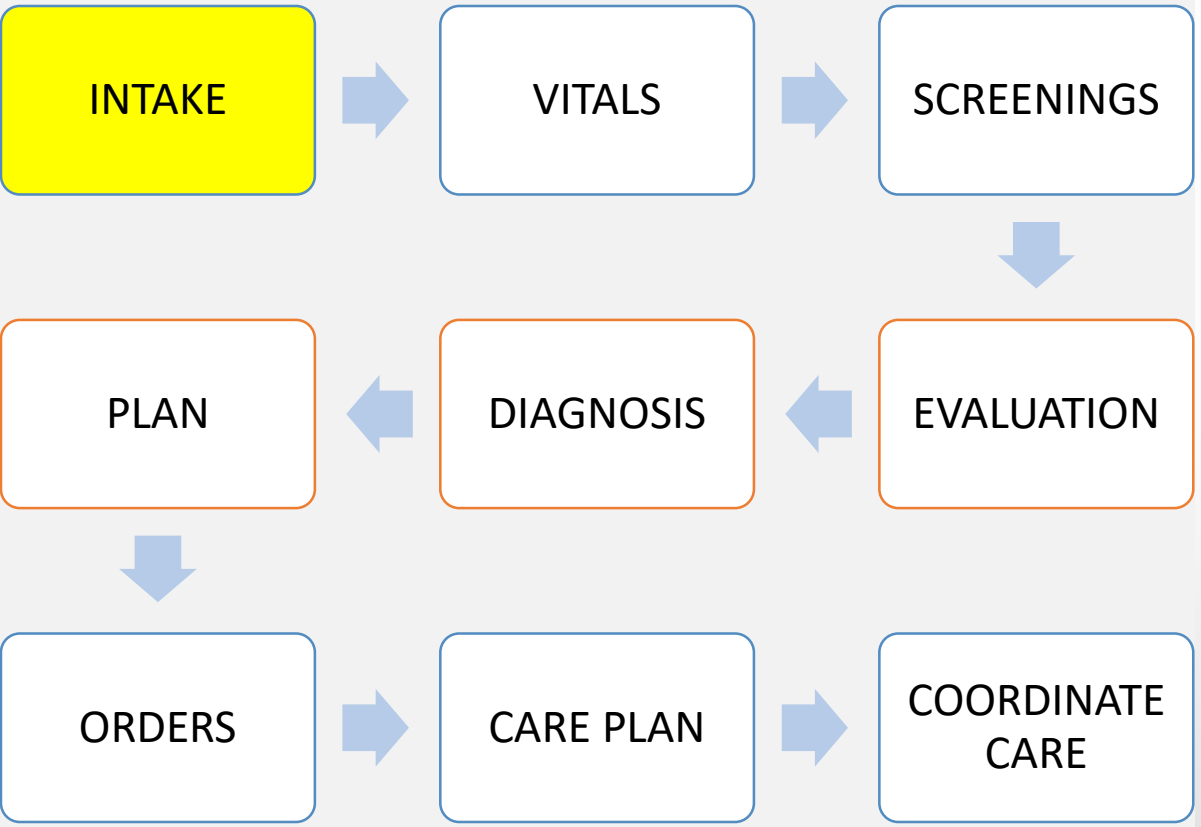
Is there anything you would like to work on to improve your health?

Please respond to questions if you have one of the following conditions:

High Cholesterol	Problems with medication(s)? ☐No ☐Yes ☐N/A
Diabetes	Problems with medication(s)? ☐No ☐Yes ☐N/A Most recent home glucose readings:
High Blood Pressure	Problems with medication(s)? ☐No ☐Yes ☐N/A Most recent home blood pressure readings:
Depression	Problems with medication(s)? ☐No ☐Yes ☐N/A Any suicidal thoughts? ☐No ☐Yes ☐N/A

Have you been to the emergency room, hospital or any other provider since your last visit?
If yes, please explain:

VISIT FLOW



https://www.stepsforward.org/modules/pre-visit-planning

FORMS

INTAKE FORMS

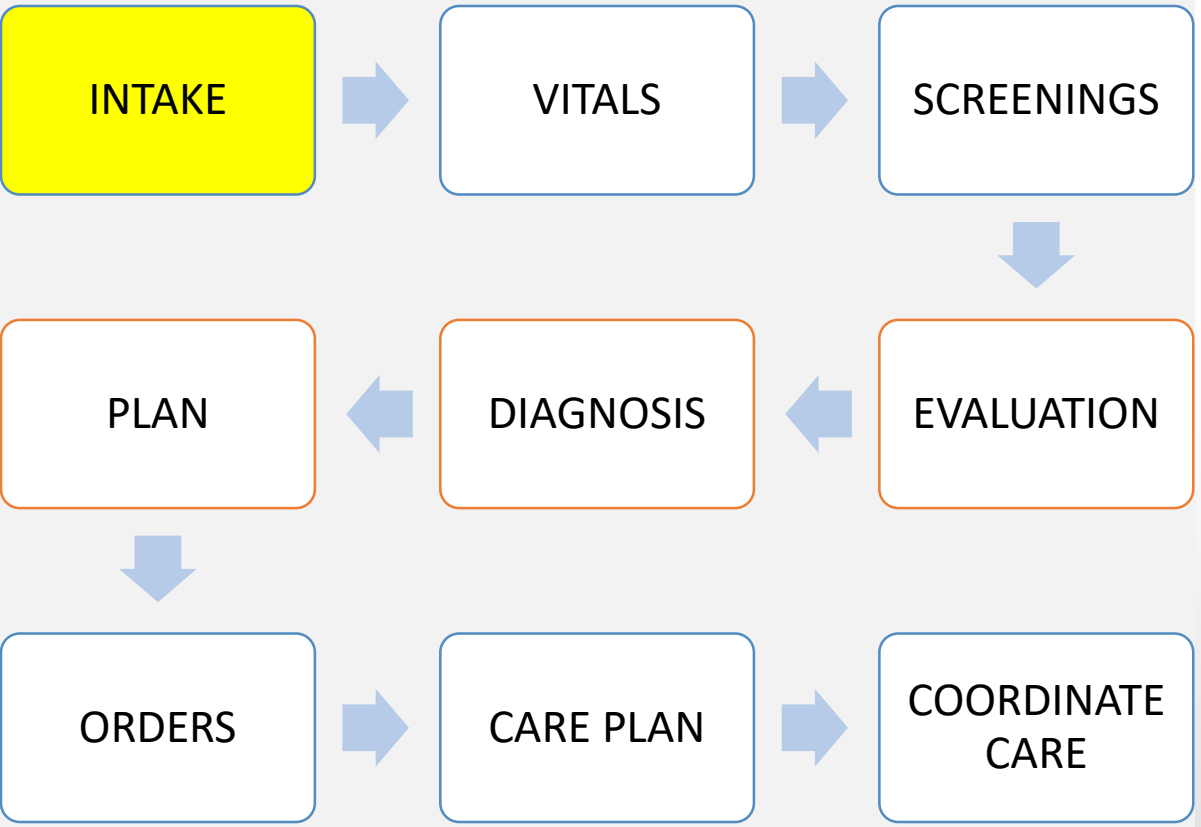
Are you experiencing any of the following?

☐ Abdominal pain	☐ Diarrhea	☐ Headache	☐ Runny nose
☐ Anxiety	☐ Double vision	☐ Heart palpitations	☐ Shortness of breath
☐ Blood in stools	☐ Ear pain	☐ Heat/cold intolerance	☐ Sore throat
☐ Bloody urine	☐ Enlarged lymph nodes	☐ Impotence	☐ Sudden vision loss
☐ Breast mass	☐ Excessive thirst	☐ Irregular menses	☐ Suicidal thoughts
☐ Bruising	☐ Extreme fatigue	☐ Joint pain	☐ Vomiting
☐ Changing mole	☐ Falling	☐ Muscle weakness	☐ Unusual bleeding
☐ Chest pain	☐ Fever	☐ Nausea	☐ Weakness
☐ Constipation	☐ Frequent urination	☐ Numbness	☐ Weight loss
☐ Cough	☐ Hay fever	☐ Painful urination	☐ Wheezing
☐ Depression			

Do you have any other concerns? If yes, please describe below.

Source: AMA. *Practice transformation series: pre-visit planning*. 2015.

VISIT FLOW



https://www.stepsforward.org/modules/pre-visit-planning

FORMS

INTAKE FORMS

Lifestyle

Alcohol

How often do you have a drink containing alcohol?
☐ Never ☐ Monthly or less ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4 or more times per week

How many standard drinks containing alcohol do you have on a typical day?
☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often do you have six or more drinks on one occasion?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Caffeine

Do you consume any caffeine? ☐ No ☐ Yes: How often? How much?

Exercise

Do you exercise? ☐ No ☐ Yes: How often? How long?

Smoking

Do you smoke? ☐ No ☐ Yes: How often? How much?

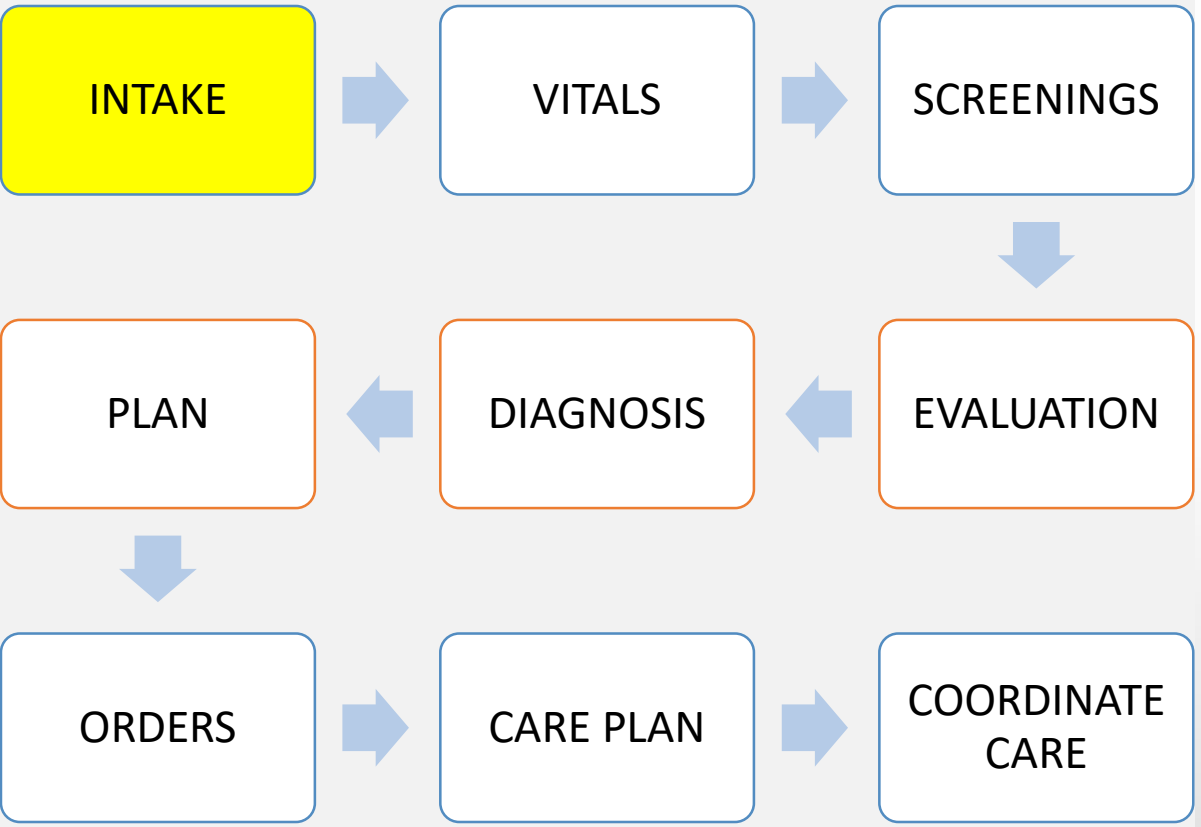
Birth control

Do you use any form of birth control? ☐ No ☐ Yes: What method?

Medication adherence

Do you have trouble taking any of your medications? ☐ No ☐ Yes: Describe.

VISIT FLOW



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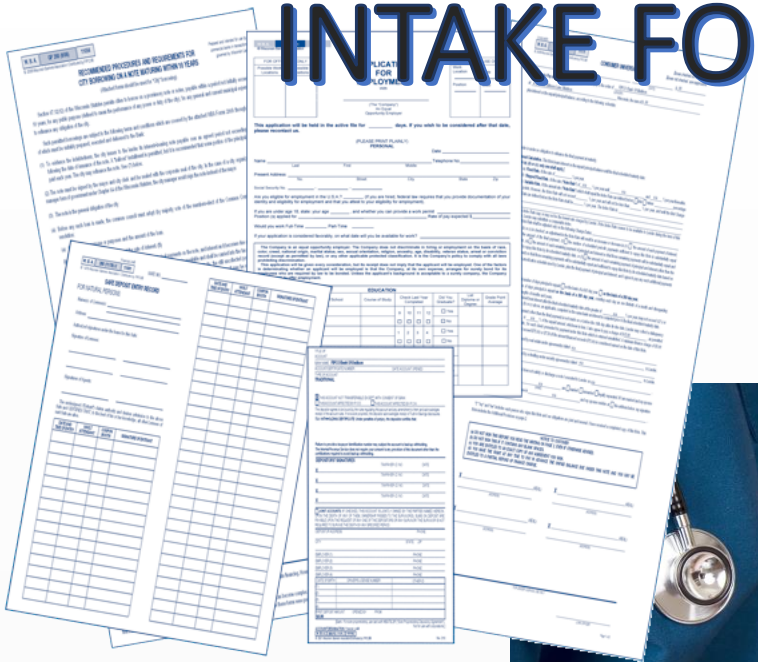
INTAKE FORMS



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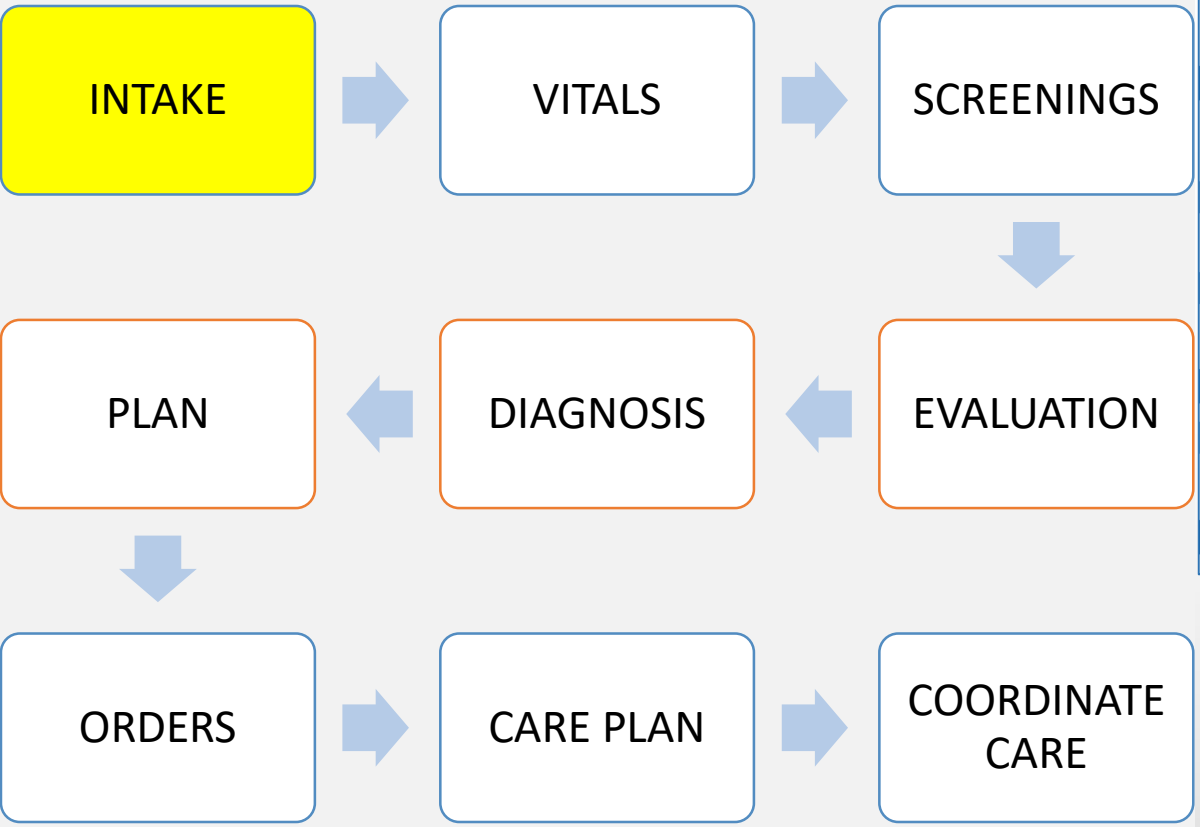

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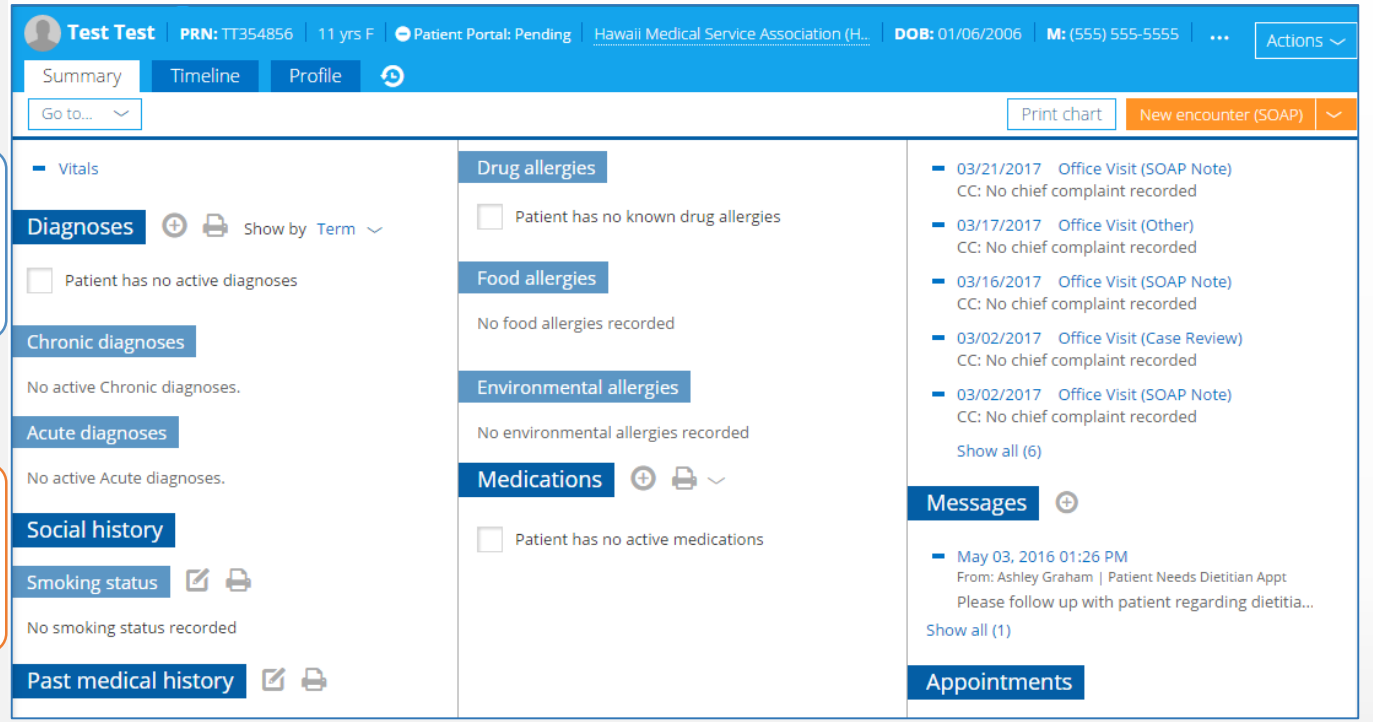
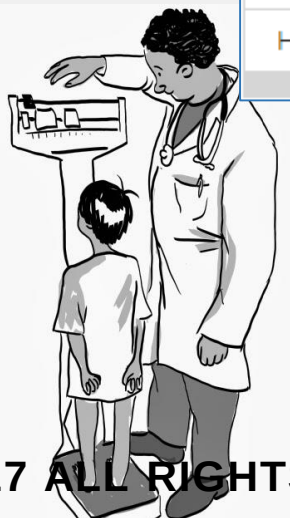
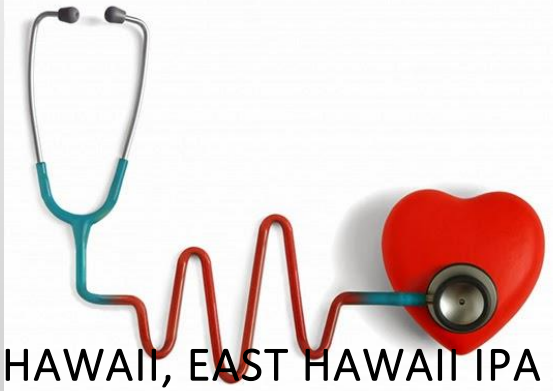


CHIEF COMPLAINT
HISTORY OF PRESENT ILLNESS
MEDICATIONS
REVIEW OF SYSTEMS

VISIT FLOW

Vitals	
Height	
Weight	
BMI	
BMI Percentile	
BP	
Temperature	
Pulse	
Respiratory rate	
O2 Saturation	
Pain	
Head Circumference	





VISIT FLOW

reminder

INTAKE → VITALS → SCREENINGS

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PLAN ← DIAGNOSIS ← EVALUATION

↓

ORDERS → CARE PLAN → COORDINATE CARE

ECQM

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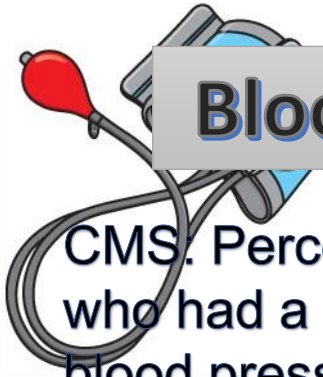


Blood Pressure screening

CMS: Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period

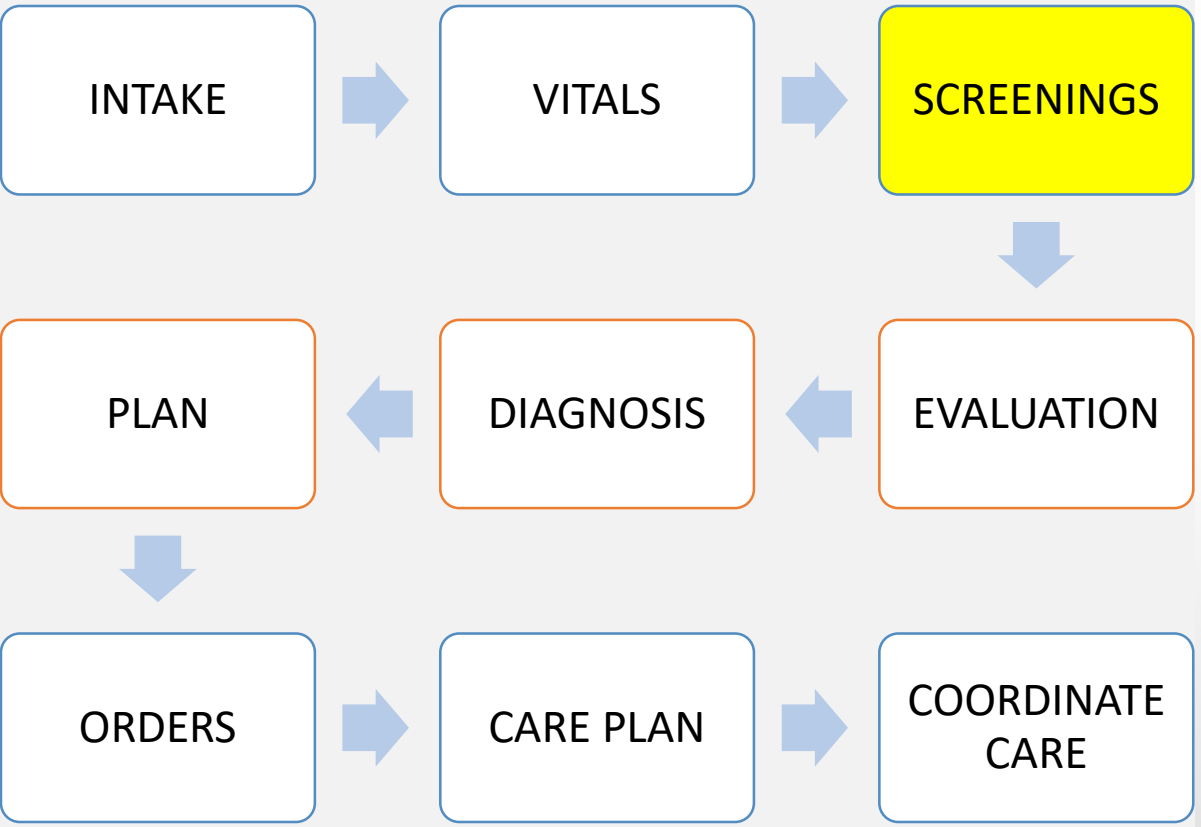
HMSA Payment Transformation

Age 65 – 80: <150/90mmHg

PCPs must report the actual blood pressure reading to satisfy measure reporting requirements. To describe systolic and diastolic blood pressures, each must be reported separately. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure.

Medical records must support the diagnosis for the denominator and identify the representative blood pressure reading for the numerator.

VISIT FLOW



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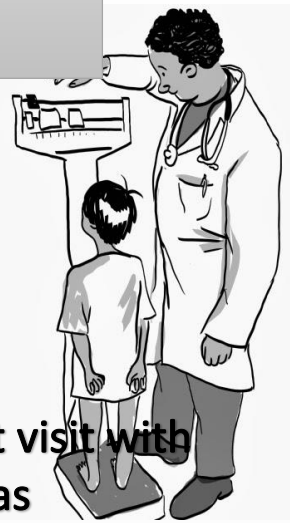
BMI screening



HMSA Payment Transformation

patients 18-74 years of age who had an outpatient visit with any provider and whose body mass index (BMI) was documented during the measurement year .

The U .S . Preventive Services Task Force recommends screening all adults for obesity .

Clinicians should offer or refer patients with a body mass index (BMI) of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions

VISIT FLOW

reminder

INTAKE → VITALS → SCREENINGS

SCREENINGS → EVALUATION → DIAGNOSIS → PLAN

PLAN → ORDERS → CARE PLAN → COORDINATE CARE

ECQM

https://www.cdc.gov/steadi/pdf/tug_test-a.pdf

Fall Risk screening

Patient: Date: Time: AM/PM

The Timed Up and Go (TUG) Test

Purpose: To assess mobility

Equipment: A stopwatch

Directions: Patients wear their regular footwear and can use a walking aid if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters or 10 feet away on the floor.

Instructions to the patient:
When I say "Go," I want you to:

1. Stand up from the chair
2. Walk to the line on the floor at your normal pace
3. Turn
4. Walk back to the chair at your normal pace
5. Sit down again

On the word "Go" begin timing.

Stop timing after patient has sat back down and record.

Time: _____ **seconds**

An older adult who takes ≥12 seconds to complete the TUG is at high risk for falling.

Observe the patient's postural stability, gait, stride length, and sway.

Circle all that apply: Slow tentative pace ■ Loss of balance ■ Short strides ■ Little or no arm swing ■ Steadying self on walls ■ Shuffling ■ En bloc turning ■ Not using assistive device properly

Notes:

For relevant articles, go to: www.cdc.gov/injury/STEADI

CDC Centers for Disease Control and Prevention National Center for Injury Prevention and Control

STEADI Stopping Elderly Accidents, Deaths & Injuries

VISIT FLOW

reminder

INTAKE → VITALS → SCREENINGS

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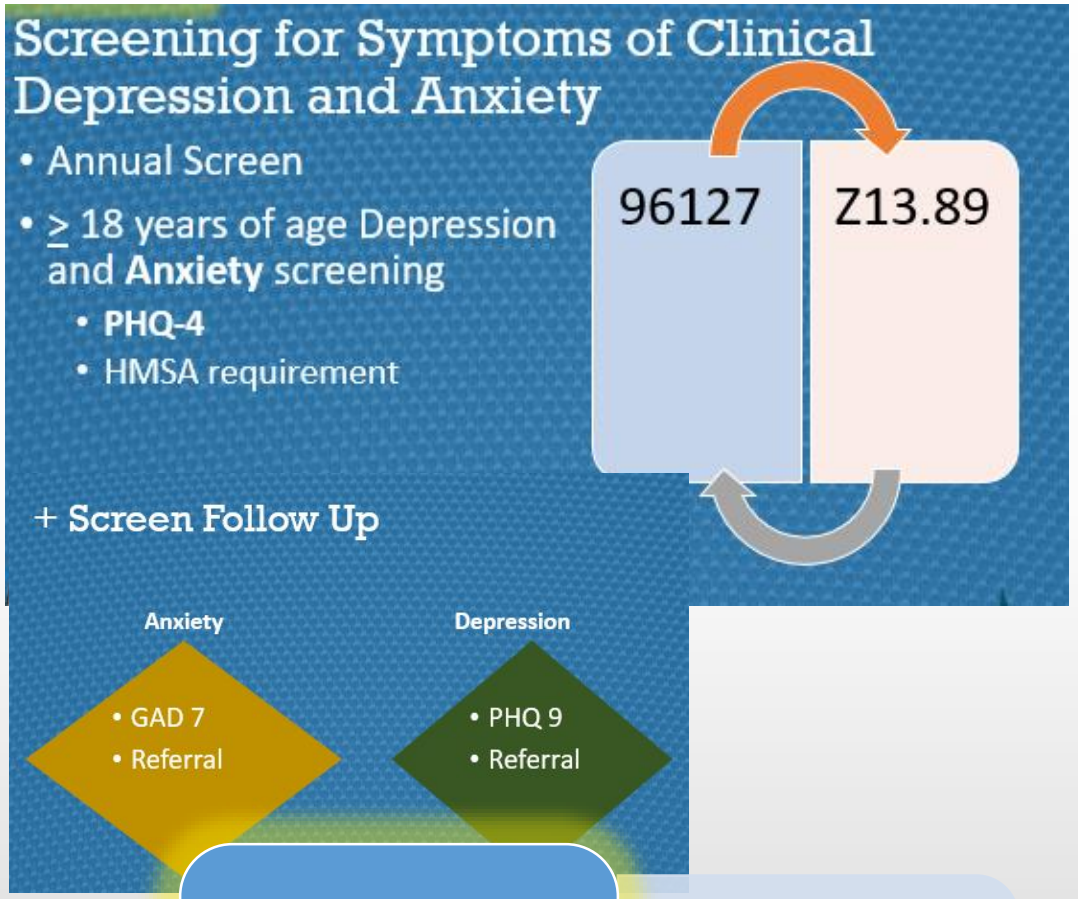
EVALUATION → DIAGNOSIS → PLAN

↓

ORDERS → CARE PLAN → COORDINATE CARE

Depression & Anxiety screening



CMS: DEPRESSION

- Use PHQ9
- Remission

ECQM

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VISIT FLOW

reminder

INTAKE → VITALS → SCREENINGS

SCREENINGS → EVALUATION → DIAGNOSIS → PLAN

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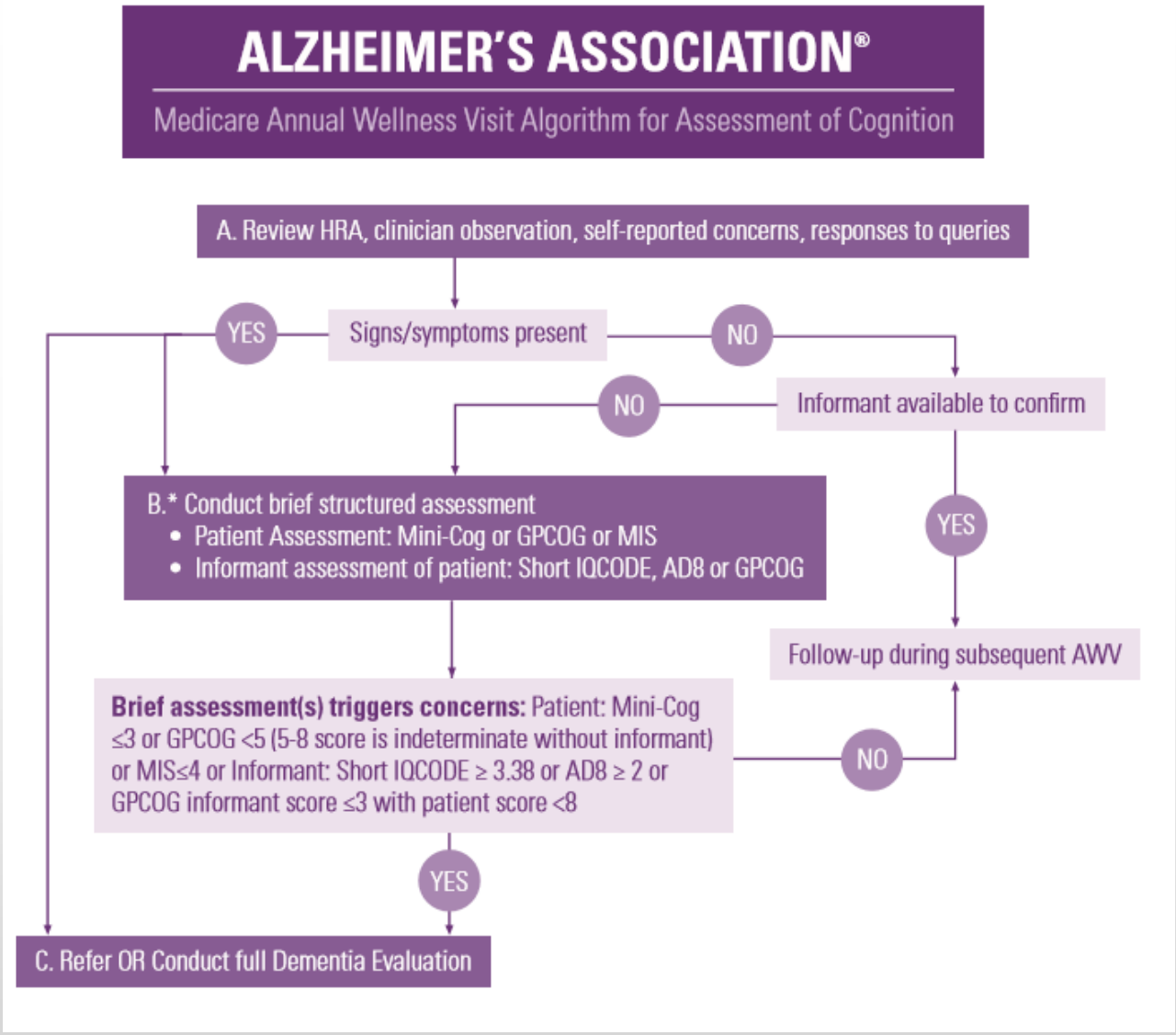
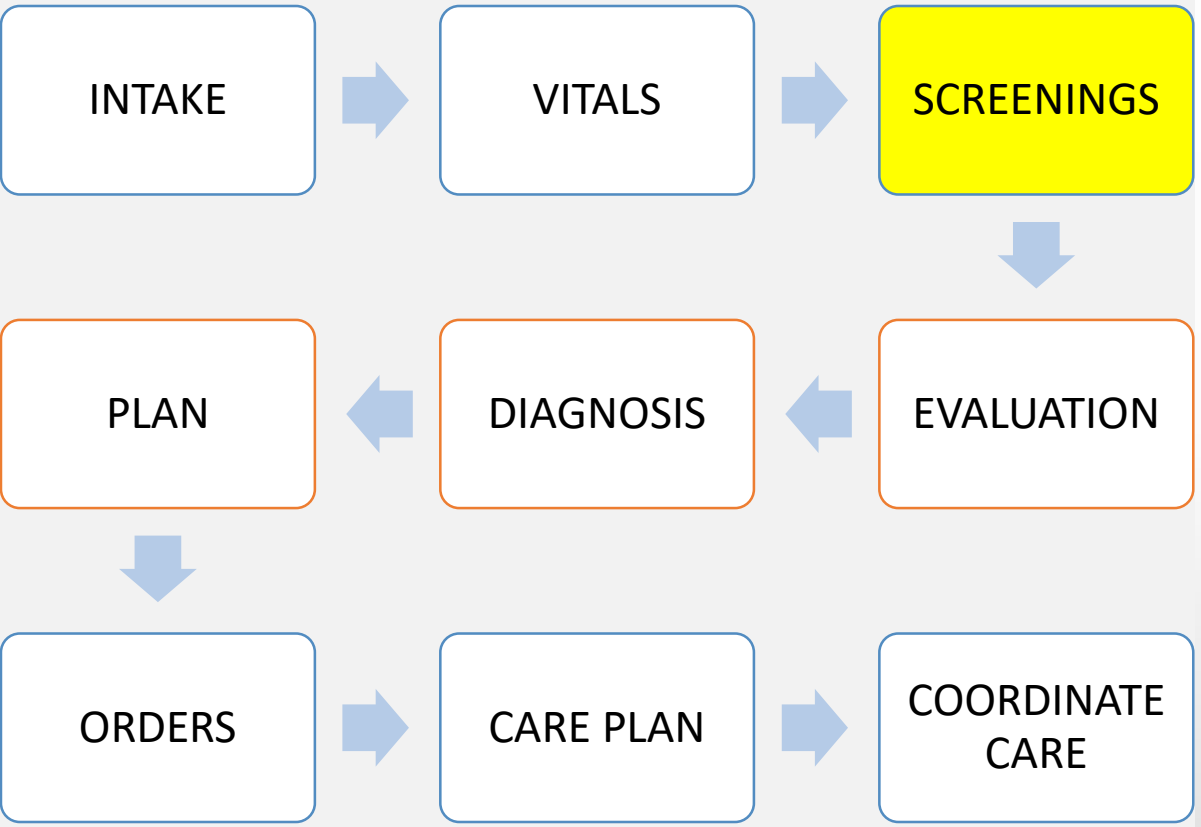
ECQM

Dementia screening



VISIT FLOW



ECQM

Dementia screening

Mini-Cog™

Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

Word List Version: _____ Person's Answers: _____ _____ _____

Scoring

Word Recall: _____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw: _____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (±30). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score. A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

http://mini-cog.com/

VISIT FLOW

reminder

INTAKE → VITALS → SCREENINGS

SCREENINGS → EVALUATION → DIAGNOSIS → PLAN

PLAN → ORDERS → CARE PLAN → COORDINATE CARE

ECQM

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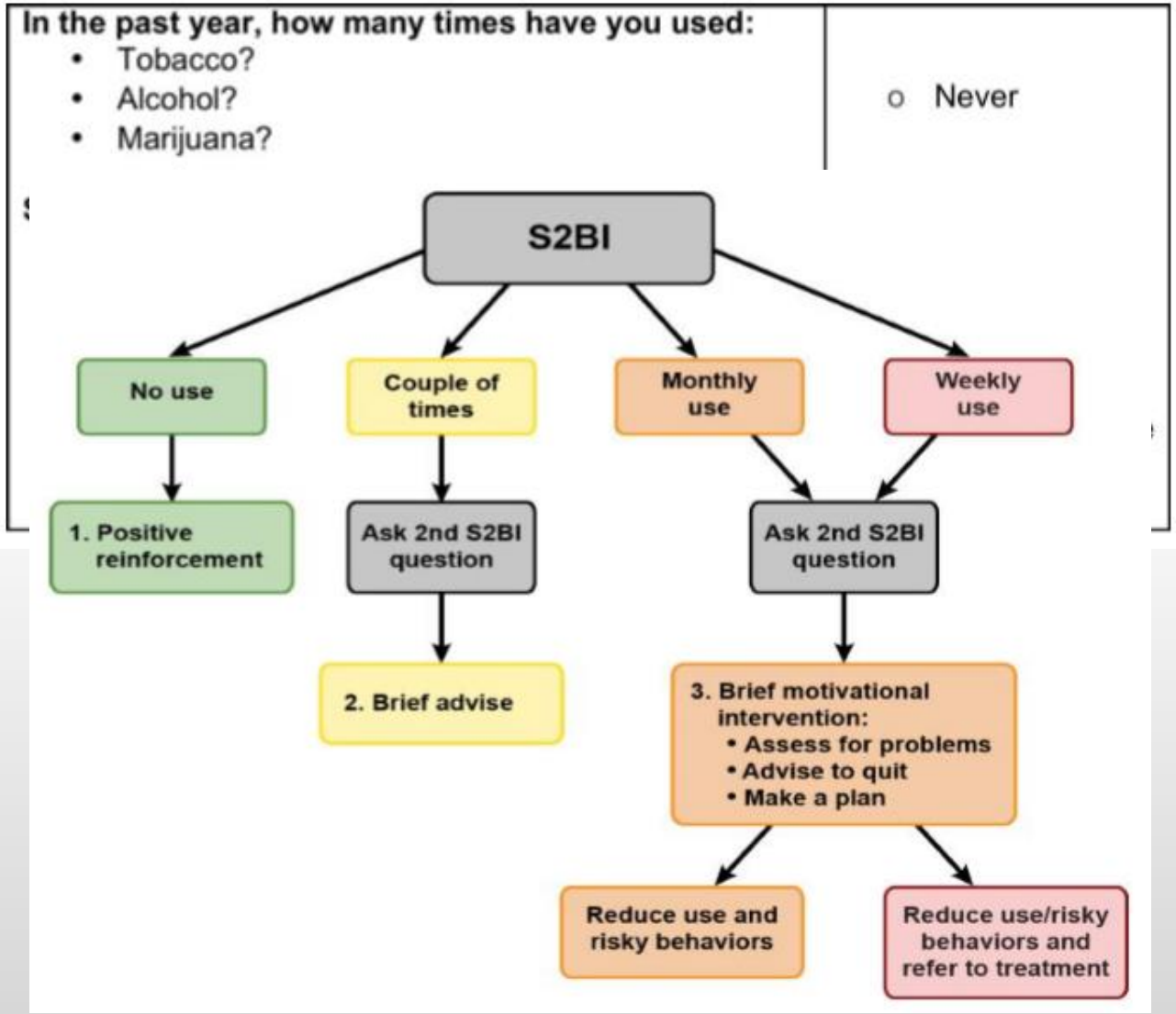
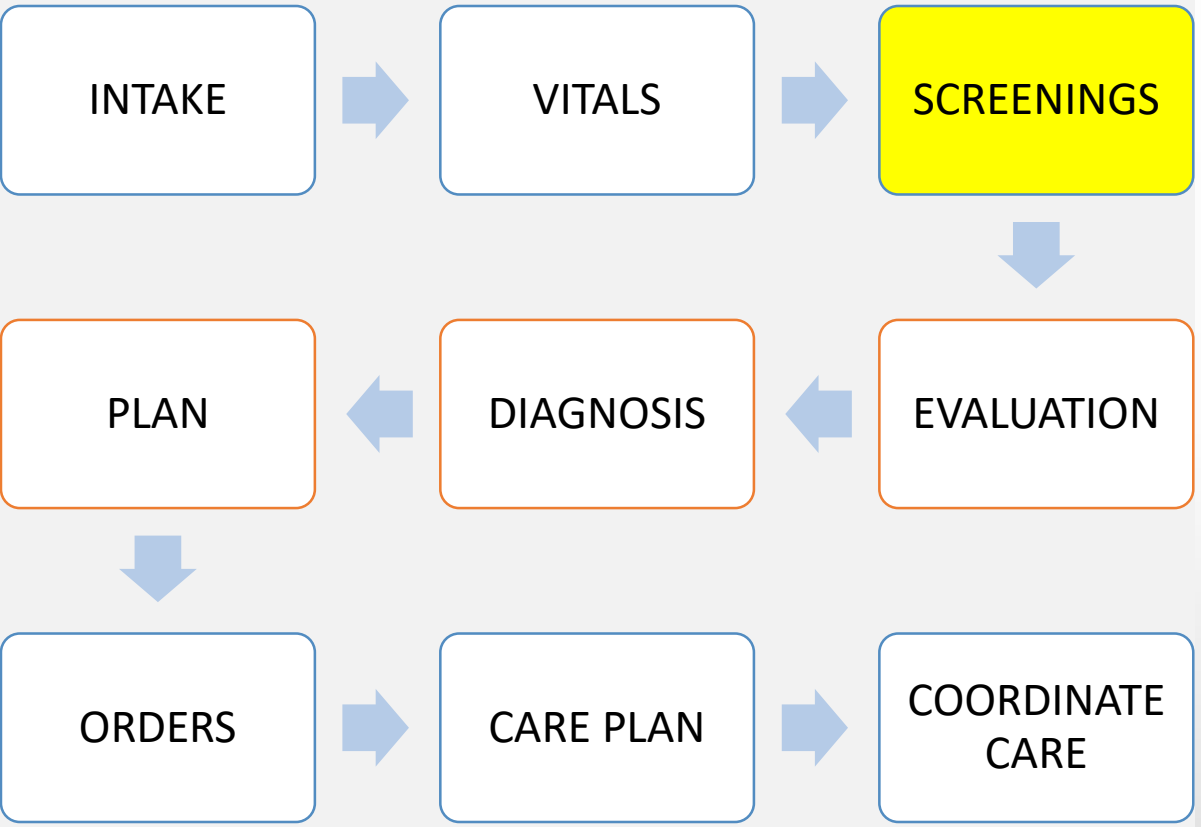
Tobacco & alcohol screening



VISIT FLOW



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Tobacco & alcohol screening

SBIRT is an approach to the delivery of early intervention and treatment to people with substance use disorders and those at risk of developing these disorders.

Screening	Brief Intervention	Brief Treatment	Referral to Treatment
• **Incorporate into provider visit** • Use only validated instruments	• **If moderate risk post screening, have verbal conversation w/pt.** • Raise awareness about risk of behavior and its consequences • Use motivational interviewing to help promote behavioral change	• **If moderate to high risk detected** • Use motivational interviewing to provide education and problem-solving • Develop coping mechanisms and build a supportive social environment	• **For severe screening results and substance dependence** • Provide an outside referral for treatment

VISIT FLOW

reminder

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Education on cancer screenings

BREAST

Mammogram

- CMS: Percentage of women 50-74 years of age
- HMSA: Women 52–74 years of age as of the end of the measurement year

CERVICAL

Pap Smear

- CMS: Percentage of women 21-64 years of age
- HMSA: percentage of women 24–64 years of ag

COLORECTAL

FOBT, Colonoscopy, Flex Sigmoidoscopy

- CMS: Percentage of adults 50-75 years of age
- HMSA: Percentage of adults 51–75 years of age

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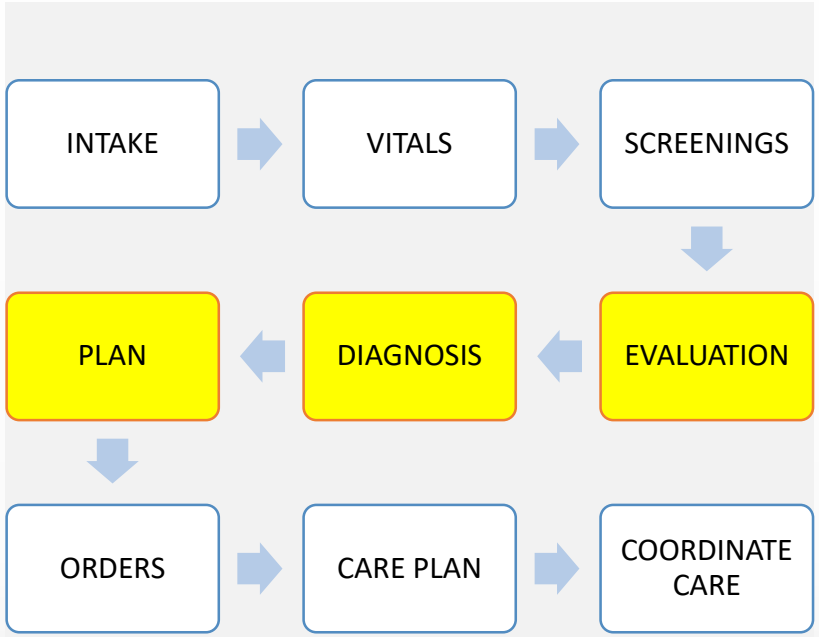
VISIT FLOW



ECQM

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Blood Pressure screening

BMI screening

Depression screening

Dementia screening

Tobacco & alcohol screening

FOLLOW UP & PLAN

Use of High Risk medications

Advance Care Planning

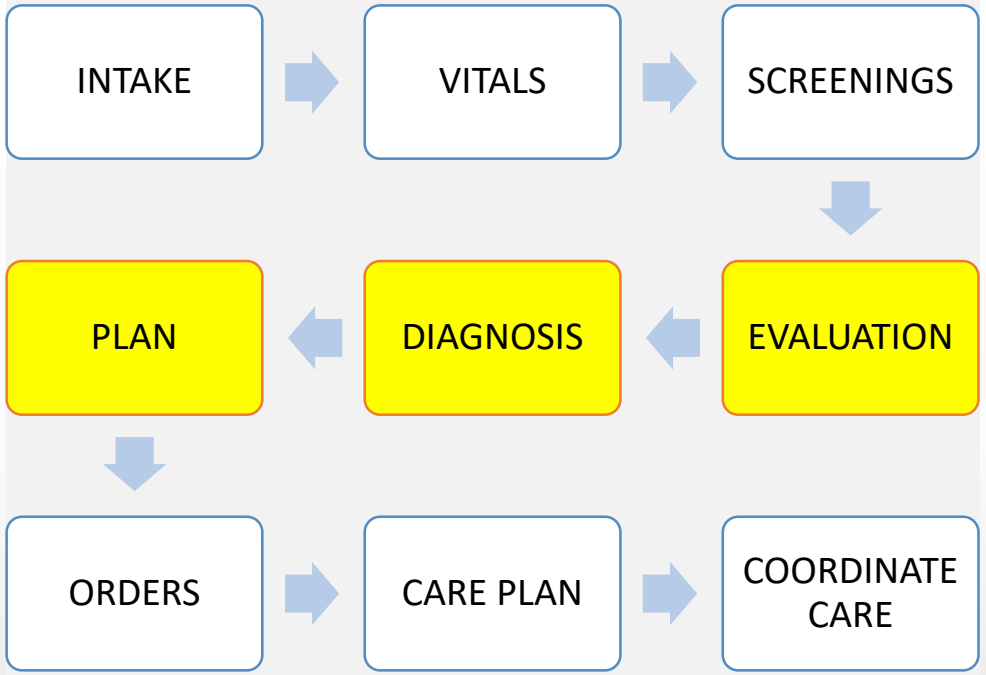
ASSESS & ADDRESS

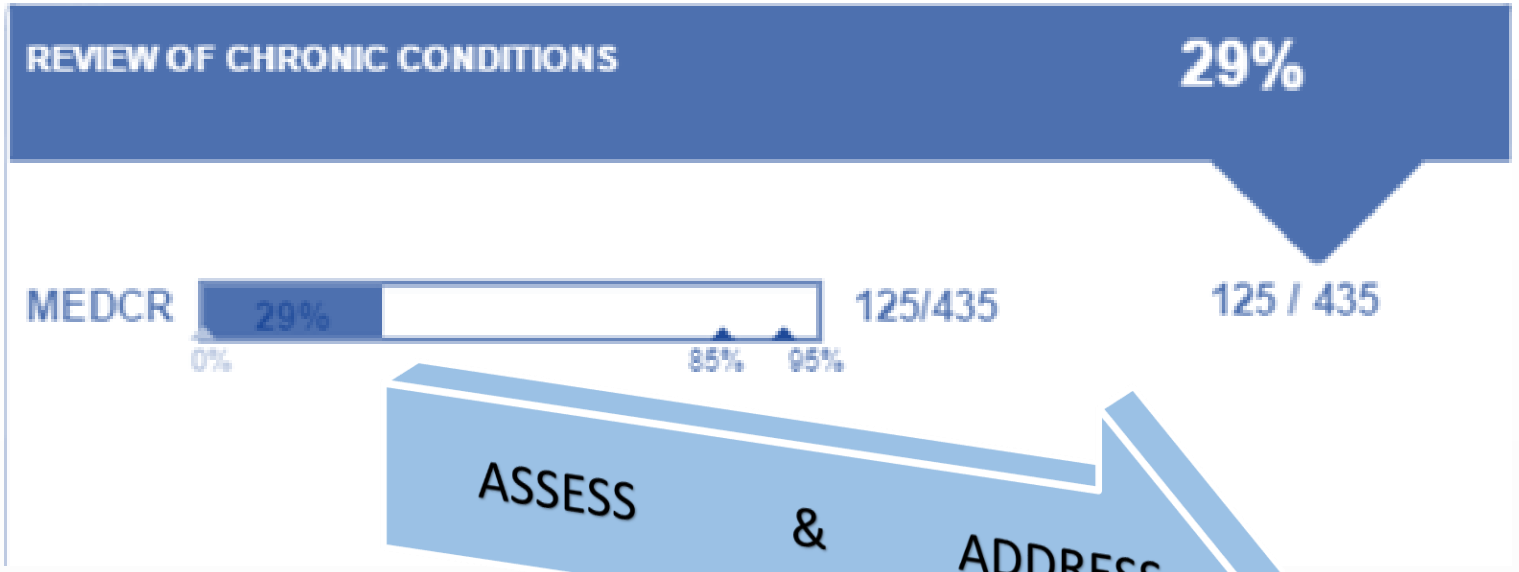
ORDER

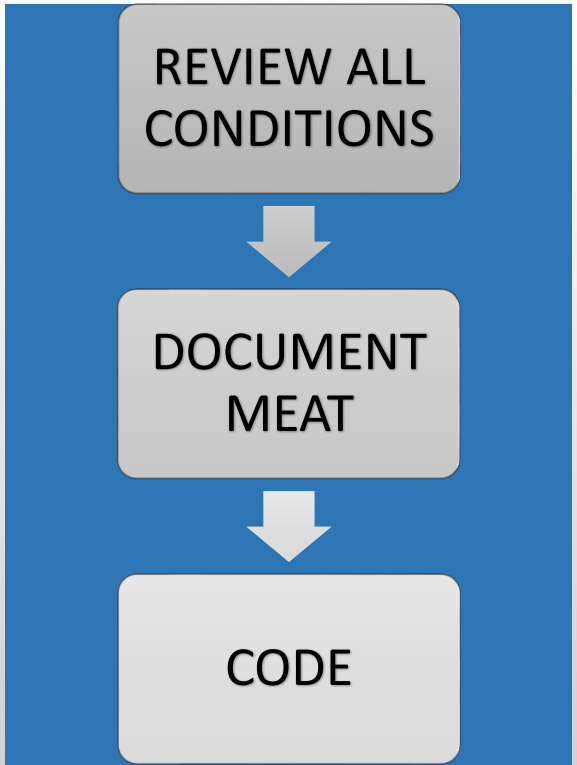
DOCUMENT

CODE

VISIT FLOW







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VISIT FLOW

reminder

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EVALUATION → DIAGNOSIS → PLAN

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ECQM

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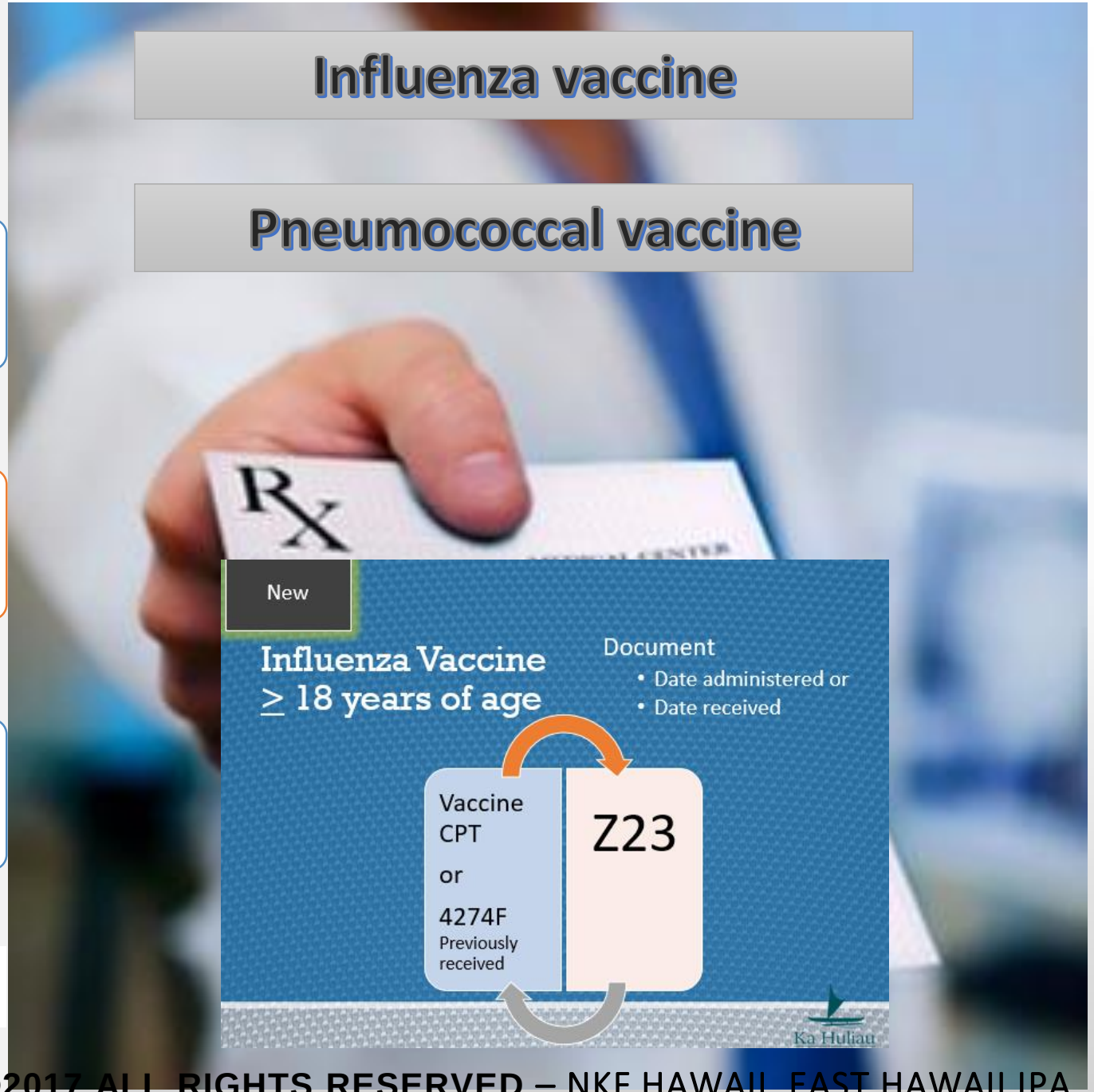

VISIT FLOW

reminder

INTAKE → VITALS → SCREENINGS

↓

EVALUATION → DIAGNOSIS → PLAN

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ECQM

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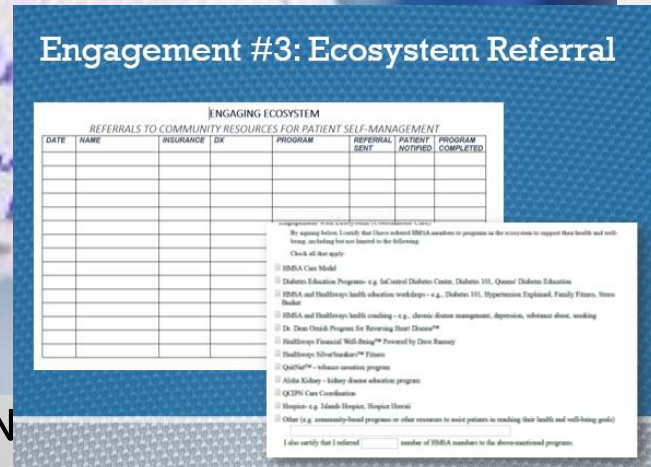
- Care gaps including cancer screens
- Diagnostic tests

Referral orders:

- Consults with Specialists
- "ECOSYSTEM"



VISIT FLOW

reminder

INTAKE → VITALS → SCREENINGS → EVALUATION → DIAGNOSIS → PLAN → ORDERS → CARE PLAN → COORDINATE CARE

Care Delivery Requirements: Care Management

Requirements for **Track 1**

- **Risk stratify** all empanelled patients
- **Targeted, proactive, relationship-based care management** to all patients identified as at increased risk and who are likely to benefit from intensive care management
- **Short-term care management with medication reconciliation** to high and increasing percentage of empanelled patients who have a **hospital admission/discharge/transfer** and who are likely to benefit from care management
- **Patients with ED visits** receive a follow up interaction within **one week of discharge**
- Contact **at least 75%** of patients who are **hospitalized in target hospital(s)** within **2 business days**

Requirements for **Track 2**

- Use a **two-step risk stratification** process for all empanelled patients
- Use a **plan of care** centered on patient's actions and support needs in management of chronic conditions for patients receiving longitudinal care management

TRACK	CMF: CARE MANAGEMENT FEE (PBPM)	PBIP: PERFORMANCE-BASED INCENTIVE PYMNT (PBPM)	FEE SCHEDULE PYMNT
1	AVG $15	$2.50 based on utilization, quality & patient experience	FFS
2	AVG $28	$4.00 based on utilization, quality & patient experience	Reduced FFS w/prospective CPCP

Longitudinal

- Systematically risk stratify empanelled population
- Proactively monitor
- Co-manage care with specialists
- Self-management support
- Long-term, personalized care management using care plan

Episodic

- Event triggers
- Follows-up with patients post discharge
- Accurate information shared across care settings (hospital to home, hospital to skilled nursing facility)
- Medication reconciliation
- Short-term care management support

DURING VISIT

CARE PLAN

CMS defines a care plan as, “The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components:

- problem (the focus of the care plan),
- goal (the target outcome) and
- any instructions that the provider has given to the patient.

A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).”

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

DURING VISIT

CARE PLAN

Medical Home Care Plan

Prepared for: _____ **PCP:** _____ **Prepared by:** _____

Need:

Problem	*Activity*	*Who will do*	*By when*	*Expected outcome*	*Follow-up*

Add'l Info:

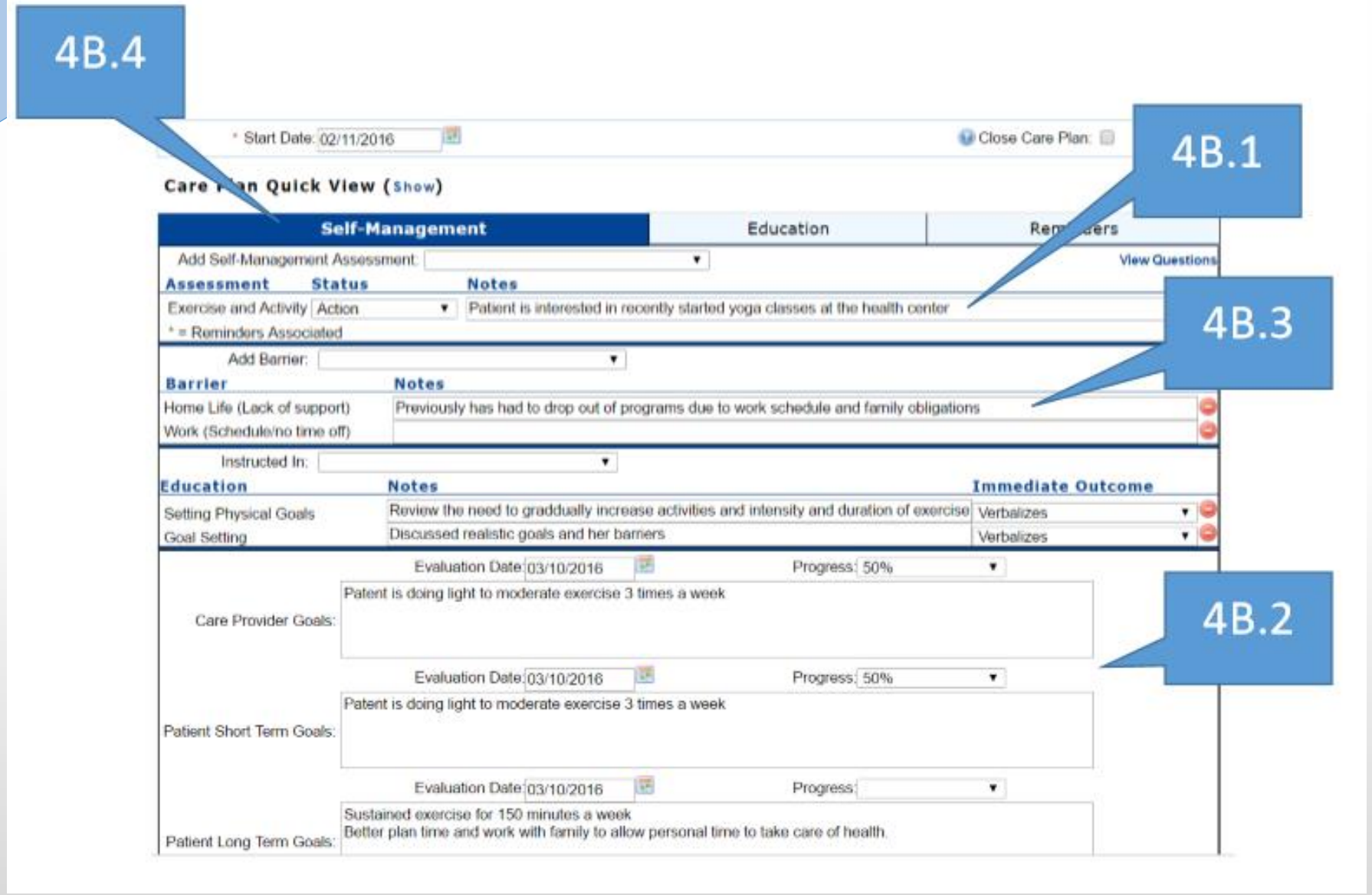
Best way to contact family: _____

Point of contact for PCMH _____

Best way to contact PCMH: _____

DURING VISIT

CARE PLAN



DURING VISIT

CARE PLAN

- Problem list
- Expected outcomes
- Symptom & medication management
- Planned interventions
- Measurable treatment goals
- Risk Factors/barriers
- Community/social resources
- Patient Self-management
- Shared decision making
- Schedule for periodic review & revision

DURING VISIT

PATIENT SELF-MANAGEMENT

Self-management support refers to help given to people with chronic conditions that enables them to manage their health on a day-to-day basis

DURING VISIT

PATIENT SELF-MANAGEMENT

DURING VISIT

PATIENT SELF-MANAGEMENT

Dr Dean Ornish PROGRAM for reversing heart disease

Engagement #3: Ecosystem Referral


ENGAGING ECOSYSTEM

REFERRALS TO COMMUNITY RESOURCES FOR PATIENT SELF-MANAGEMENT

DATE	NAME	INSURANCE	DX	PROGRAM	REFERRAL SENT	PATIENT NOTIFIED	PROGRAM COMPLETED

Check all that apply:

- HMSA Care Model
- Diabetes Education Programs- e.g. InControl Diabetes Center, Diabetes 101, Queens' Diabetes Education
- HMSA and Healthways health education workshops - e.g., Diabetes 101, Hypertension Explained, Family Fitness, Stress Busket
- HMSA and Healthways health coaching - e.g., chronic disease management, depression, substance abuse, smoking
- Dr. Dean Ornish Program for Reversing Heart Disease™
- Healthways Financial Well-Being™ Powered by Dave Ramsey
- Healthways SilverSneakers™ Fitness
- QuitNet™ - tobacco cessation program
- Aloha Kidney - kidney disease education program
- QCEPN Care Coordination
- Hospice- e.g. Islands Hospice, Hospice Hawaii
- Other (e.g. community-based programs or other resources to assist patients in reaching their health and well-being goals)

I also certify that I referred _____ member of HMSA members to the above-mentioned programs.

Better Choices, Better Health

KE OLA PONO

A six-week workshop for people living with any ongoing health problem or chronic disease

Aloha Kidney

2017 class series offered: Jan, May, Sept

With	Ramona Wong MD Nephrologist	What	6 weekly classes, 2 ½ hours each
Where	HMSA Center @ Hilo 303A East Maka'ala St. Hilo HI 96720	When	1 – 3:30 pm Thursday afternoons
Who	Anyone interested in, at risk for, or with CKD, GFR less than 60, or excess protein in urine	Bring	Pen, a family or friend who loves you (one who buys/cooks the food)
		Cost	No cost

What we talk about

1/19/17 – You and your kidneys: What kidneys do, what happens when they fail

1/26/27 – Aloha kidney: How to slow loss of kidney function, protect what's left

2/2/17 - Kidney, heart, brain connection: Why at risk and what to do about it

2/9/17 - Options if kidneys fail: Dialysis, transplant, natural life options

2/16/17 – Food, labs, meds . . . help?! Understand what matters with CKD

TBA – Choices: Others share their journey with dialysis, transplant, natural life

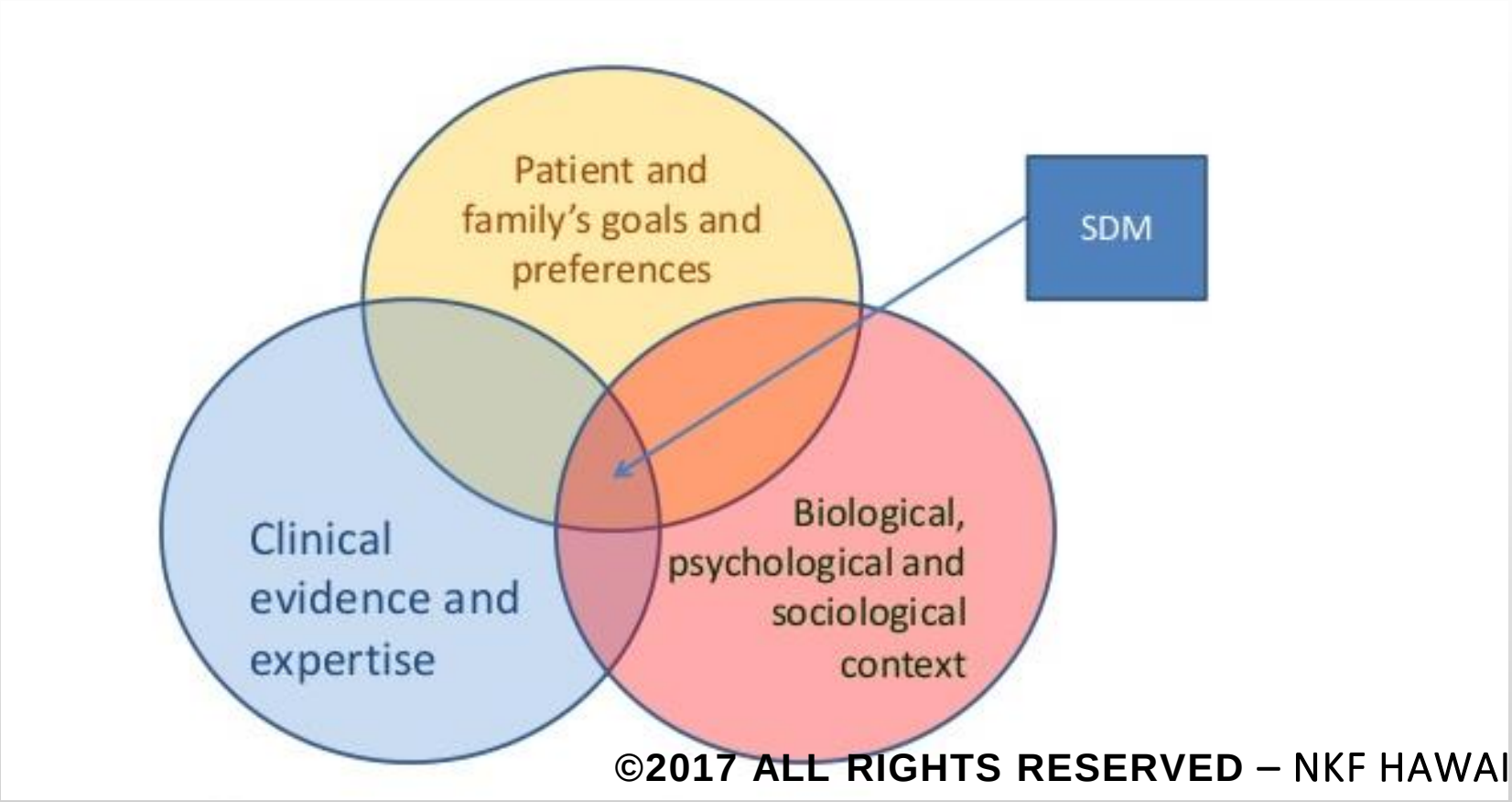
Come see if these classes can help you and your family.

Call to register: (808) 585-8404

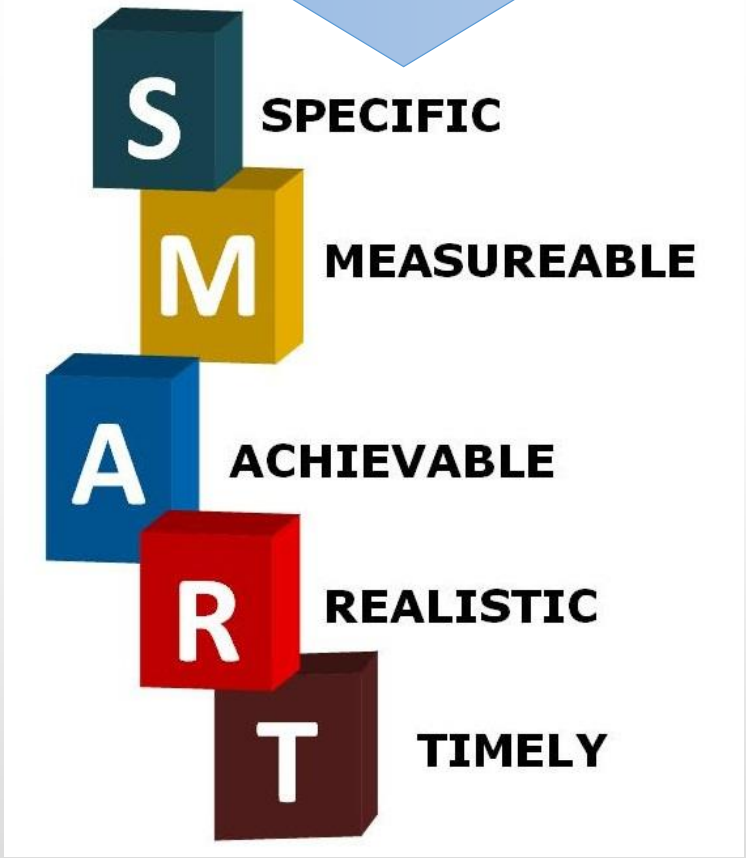
DURING VISIT

SHARED DECISION MAKING

Shared decision making is an approach to care that seeks to fully inform patients about the risks and benefits of available treatments for preference sensitive conditions and engage them as participants in decisions about the treatments



DURING VISIT



SHARED DECISION MAKING

SMART Goals:

Specific: The goal should be specific to the patient's situation and focused on one desired outcome.

Measurable: The goal must be a measurable, evidence-based outcome.

Achievable: The goal must be reasonably achievable based on patient's condition

Relevant: The goal must be individualized to the patient, based on stated needs, desires, and assessment findings

Time Specific: Goals need to include a target date that is achievable.

Goal Concepts:

1. Problem statement with an action plan that is measurable, obtainable, and important to the patient.
2. What is highest priority for the patient?
3. Identify what the patient wants to happen/do, when to have it completed, and how you will as the PCP know that it is done.
4. Barrier(s): Any factor that can limit the patient from achieving the goals set forth in the care plan (i.e., lack of transportation, financial issues, social issues, lack of knowledge.
5. Intervention(s): The steps that need to be taken to assist the patient to reach the goal(s):
   - Intervention must be prioritized and customized for each patient to resolve the issue/problem that will have the highest impact on patient's health status
   - Continuous reprioritization of the care/interventions for the patient must occur based on the most recent interactions and new information from clinician.
6. Evaluation: Ongoing review and revision of the care plan until goals or met. This may include development of new goals

HOW DO WE DO THIS?

DURING VISIT

CARE TEAM

TEAM MEMBERS: Identified & defined

Providers

Leadership

Clinical staff

Clerical staff

Tasks, roles & responsibilities are defined by skillset, protocols established

DURING VISIT

Re-thinking & delegating

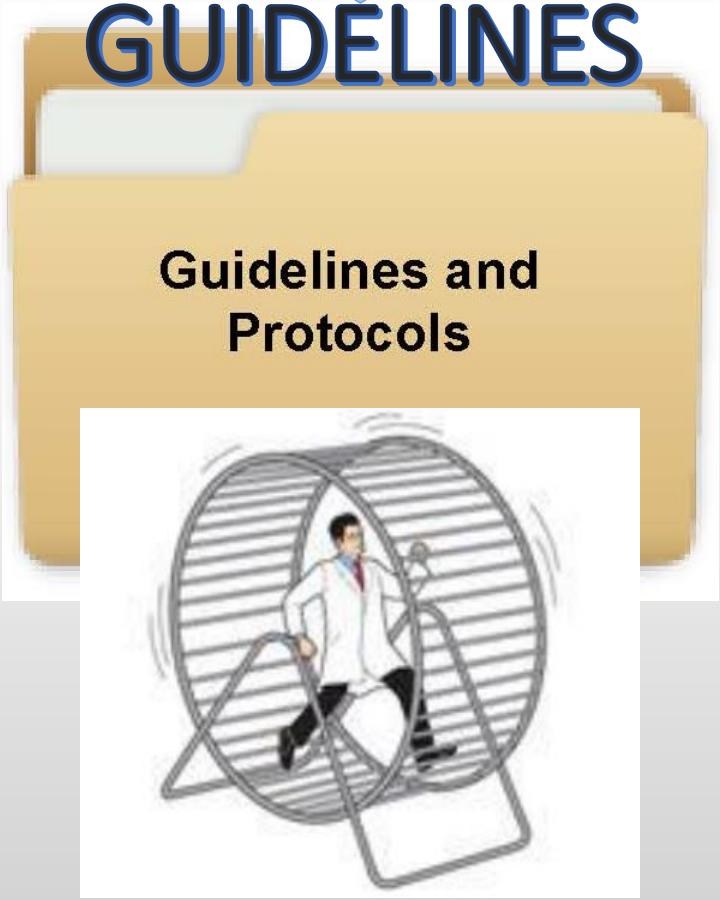
CARE TEAM

In a traditional practice model, failure to delegate often limits efficiency.

Each individual performs at the highest level of his or her qualifications.

BEFORE VISIT

GUIDELINES



Written guidelines for:

Frequent tasks, evidence based guidelines, standing orders

Documentation **Intake**

Screenings **Triage protocols**

Care Management **Patient Education**

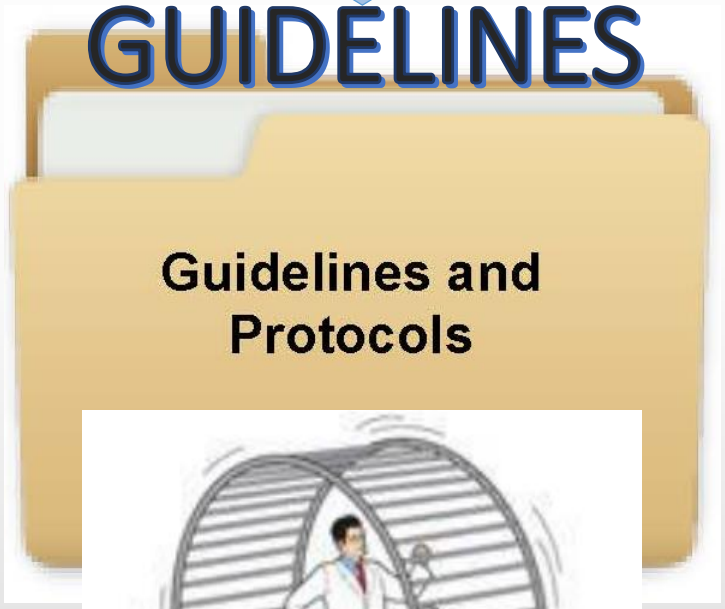
Chronic disease management

Patient self-management

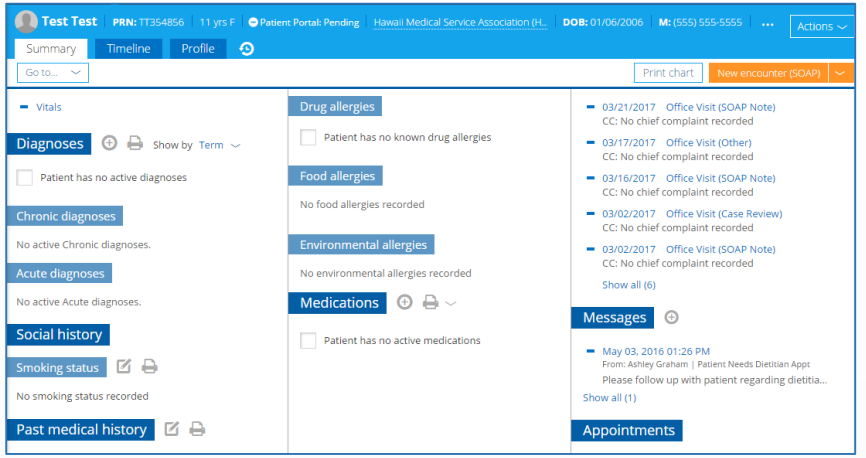
Frequent tasks, standing orders

BEFORE VISIT

GUIDELINES



Documentation



Screenings

Patient: Date: Time: AM/PM

The Timed Up and Go (TUG) Test

Purpose: To assess mobility

Equipment: A stopwatch

Directions: Patients wear their regular footwear and can use a walking aid if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters or 10 feet away on the floor.

Instructions to the patient:
When I say "Go," I want you to:

1. Stand up from the chair
2. Walk to the line on the floor at your normal pace
3. Turn
4. Walk back to the chair at your normal pace
5. Sit down again

On the word "Go" begin timing.

Stop timing after patient has sat back down and record.

Time: _____ seconds

An older adult who takes ≥12 seconds to complete the TUG is at high risk for falling.

Observe the patient's postural stability, gait, stride length, and sway.

Circle all that apply: Slow tentative pace ■ Loss of balance ■ Short strides ■ Little or no arm swing ■ Steadying self on walls ■ Shuffling ■ En bloc turning ■ Not using assistive device properly

Notes:

For relevant articles, go to: www.cdc.gov/injury/STEADI

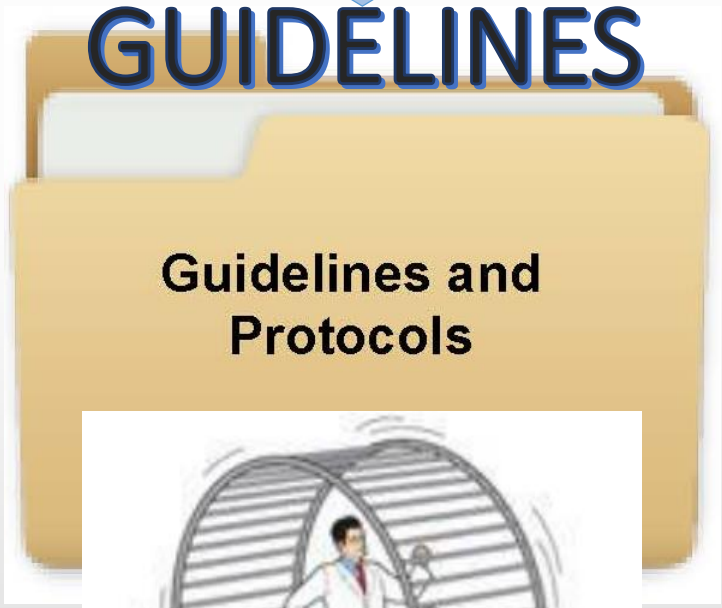
CDC Centers for Disease Control and Prevention

BEFORE VISIT

Evidence based guidelines, standing orders

Care Management, Patient Education

Patient self-management



HMSA PMSO Support *(For contracted PMSO Providers only)*

- **People:**
  - Local Hawaii based Community Resources
  - Access to a dedicated team to support your patients including care coordinators and nurses needed to meet CPC+ requirements for care management
  - PMSO resources such as practice advancement team to assist practices

QI ACTIVITY: DEFINING TEAM ROLES

DEFINING ROLES & RESPONSIBILITIES

TASK	WHO'S ROLE IS IT NOW?	WHO MIGHT BE ABLE TO DO IT?	TRAINING OR TEMPLATES NEEDED?	NEXT STEPS FOR ROLE TRANSITION?
INTAKE				
FORMS: HMSA, CPC+				
FORMS: INTAKE				
DOCUMENTATION: HPI				
DOCUMENTATION: ROS				
DOCUMENTATION: MED REC				
VITALS				
SCREENINGS				
FALL RISK				
DEPRESSION/ANXIETY				
COGNITION				
TOBACCO & ALCOHOL				
LONGITUDINAL CARE MANAGEMENT				
DOCUMENT CARE PLAN				
SMART GOALS				
SELF-MANAGEMENT				
PATIENT EDUCATION				

TO DO:

FORMS

FOR IMMEDIATE RELEASE
MONTH DAY, 2017

[Practice Name] Participating in Historic Public-Private Partnership to Strengthen Primary Care

Initiative Provides Primary Care Practices with Additional Resources to Improve Coordination of Care

[PRACTICE NAME] is one of more than 3,000 primary care providers nationwide participating in Comprehensive Primary Care Plus (CPC+), a partnership between payer partners from the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, commercial health plans, self-insured businesses, and primary care providers. This partnership is designed to provide improved access to quality health care at lower costs.

"A robust primary care system is essential to achieve better care, smarter spending, and healthier people," said Acting CMS Administrator Patrick Conway. "For this reason, CMS is committed to supporting primary care clinicians to deliver the kind of comprehensive primary care possible for their patients."

Through CPC+, CMS will pay primary care practices a care management fee, initially set at an average of $15 per beneficiary per month in Track 1 and $28 per beneficiary per month in Track 2, to support enhanced, coordinated services on behalf of Medicare beneficiaries. Simultaneously, participating commercial, state, and other federal insurance plans are also offering enhanced payment to primary care practices designed to support them in providing high-quality primary care on behalf of their members.

For patients, this means that physicians may offer longer and more flexible hours, use electronic health records, coordinate care with patients' other health care providers, better engage patients and caregivers in managing their own care, and provide individualized, enhanced care for patients living with multiple chronic diseases and higher needs.

The first year of CPC+ started on January 1, 2017, with CMS including a diverse pool of commercial health plans, state Medicaid agencies, and self-insured businesses to work alongside Medicare to support comprehensive primary care. Public and private health plans in 18 regions across the country signed letters of intent with CMS to participate in this model: Arkansas, Colorado, Hawaii, Kansas and Missouri's Greater Kansas City region, Michigan, Montana, New Jersey, New York's Capital District-Hudson Valley region, Ohio and Kentucky's Cincinnati-Dayton region, Oklahoma, Oregon, Pennsylvania's Greater Philadelphia Region, Rhode Island, and Tennessee. The markets were extended in August 2016 based on the percentage of the total population covered by payer partners who expressed interest in joining this partnership.

Eligible primary care practices in each market were invited to apply to participate in the winter of 2016. Through a competitive application process, CMS selected primary care practices within the selected markets to participate in CPC+. Practices were chosen based on their use of health information technology, ability to demonstrate recognition of advanced primary care delivery by leading clinical societies, services to patients covered by participating payer partners, participation in practice transformation and improvement activities, and diversity of geography, practice size, and ownership structure.

CPC+ is administered by the Center for Medicare & Medicaid Innovation (CMS Innovation Center). The CMS Innovation Center was created by the Affordable Care Act to test innovative payment and service delivery models that have the potential to reduce program expenditures while preserving or enhancing the quality of care.

For more information about CPC+, visit: https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus/

[INSERT BACKGROUND PARAGRAPH ABOUT PRACTICE]

###

hmsa

Check Patient's HMSA Plan
[ ] HMSA HMO
[ ] QUEST Integration
[ ] HMSA Akamai Advantage
[ ] HMSA PPO

Primary Care Provider Selection Form for HMSA Members

Complete this form to select or confirm your or your child's primary care provider (PCP).

PCP Selection for Self

I, _____, select or confirm that _____
Patient's full name — Provider's full name

is my PCP.

PCP Selection for Child under 18 Years Old

I, _____, select or confirm that _____
HMSA Subscriber or Authorized Representative's full name — Provider's full name

is the PCP for my child, _____.
Child's full name

_____
Print patient's name (full name as it appears on patient's HMSA Membership Card)

_____/_____/_____
Patient's date of birth

_____
Print Subscriber's name (if patient is not the Subscriber)

_____
HMSA Subscriber ID

Patient's Address

_____
_____
_____

Patient's Phone Number

Daytime: _____

Evening: _____

reminder

TO DO: IMPLEMENT NEW ROLES & RESPONSIBILITIES

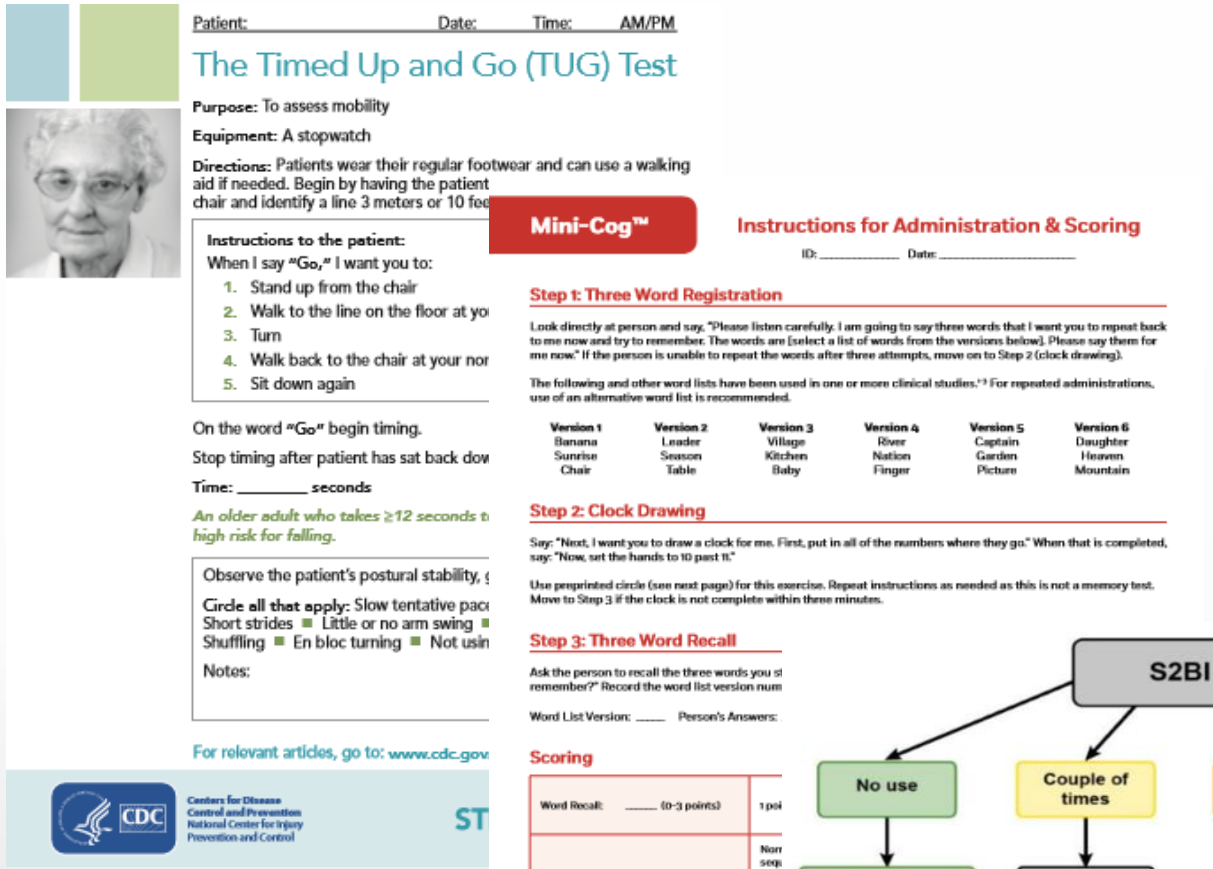
DEFINING ROLES & RESPONSIBILITIES

TASK	WHO'S ROLE IS IT NOW?	WHO MIGHT BE ABLE TO DO IT?	TRAINING OR TEMPLATES NEEDED?	NEXT STEPS FOR ROLE TRANSITION?
INTAKE				
FORMS: HMSA, CPC+				
FORMS: INTAKE				
DOCUMENTATION: HPI				
DOCUMENTATION: ROS				
DOCUMENTATION: MED REC				
VITALS				
SCREENINGS				
FALL RISK				
DEPRESSION/ANXIETY				
COGNITION				
TOBACCO & ALCOHOL				
LONGITUDINAL CARE MANAGEMENT				
DOCUMENT CARE PLAN				
SMART GOALS				
SELF-MANAGEMENT				
PATIENT EDUCATION				

reminder

TO DO:

IMPLEMENT SCREENINGS



Patient: Date: Time: AM/PM

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Equipment: A stopwatch

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Instructions to the patient:
When I say "Go," I want you to:
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2. Walk to the line on the floor at yo
3. Turn
4. Walk back to the chair at your nor
5. Sit down again

On the word "Go" begin timing.

Stop timing after patient has sat back dow

Time: _____ seconds

An older adult who takes ≥12 seconds t high risk for falling.

Observe the patient's postural stability,

Circle all that apply: Slow tentative pac Short strides ■ Little or no arm swing ■ Shuffling ■ En bloc turning ■ Not usin

Notes:

For relevant articles, go to: www.cdc.gov

CDC Centers for Disease Control and Prevention National Center for Injury Prevention and Control

ST

Mini-Cog™

Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

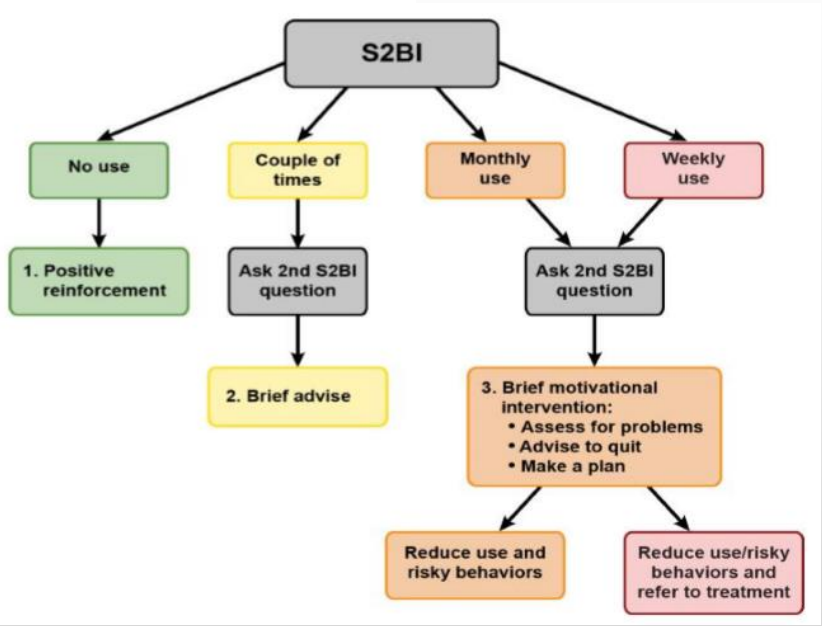
Ask the person to recall the three words you s remember?" Record the word list version num

Word List Version: _____ Person's Answers:

Scoring

Word Recall:	_____ (0-3 points)	1 poi
Clock Draw:	_____ (0 or 2 points)	Nor seq posi and Inab
Total Score:	_____ (0-5 points)	Tota A cu but high it m

Mini-Cog™ © S. Borson. All rights reserved. Repr May not be modified or used for commercial, us



TO DO:
SCREENINGS FOR eCQMS

MEASURE NAME	SCREENER	CPC+	MIPS	HMSA	eMEASURE ID	DATA SUBMISSION METHOD
GROUP 1: OUTCOME MEASURES						
Depression Remission at Twelve Months	PHQ9	X	X	PT	CMS159v5	Claims,Web Intfce,EHR,Regty
Controlling High Blood Pressure		X	X	PT	CMS165v5	Claims,Web Intfce,EHR,Regty
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)		X	X	PT	CMS122v5	Claims,Web Intfce,EHR,Regty
GROUP 2: COMPLEX CARE MEASURES						
Use of High-Risk Medications in the Elderly		X	X	AA	CMS156v5	EHR,Registry
Dementia: Cognitive Assessment	MINI-COG	X	X	AA	CMS149v5	EHR
Falls: Screening for Future Fall Risk	TIMED GET UP & GO	X	X		CMS139v5	CMS Web Interface,EHR
Initiation & Engagement of Drug Dependence Treatment	SBIRT	X	X		CMS137v5	EHR
GROUP 3: OTHER MEASURES						
Closing the Referral Loop: Receipt of Specialist Report		X	X		CMS50v5	EHR
Cervical Cancer Screening	CERVICAL CYTO	X	X	PT	CMS124v5	EHR
Colorectal Cancer Screening	FOBT, SCOPE	X	X	PT	CMS130v5	Claims,Web Intfce,EHR,Regty
Diabetes: Eye Exam	DRE	X	X	PT	CMS131v5	Claims,Web Intfce,EHR,Regty
Tobacco Use: Screening and Cessation Intervention	SBIRT	X	X	PT	CMS138v5	Claims,Web Intfce,EHR,Regty
Use of Imaging Studies for Low Back Pain		X	X		CMS166v6	EHR
Breast Cancer Screening	MAMMOGRAM	X	X	PT	CMS125v5	Claims,Web Intfce,EHR,Regty

https://qpp.cms.gov/measures/quality

TO DO:
CARE PLAN

Medical Home Care Plan

Prepared for: _____ **PCP:** _____ **Prepared by:** _____

Need:

Problem	*Activity*	*Who will do*	*By when*	*Expected outcome*	*Follow-up*

Add'l Info:

Best way to contact family: _____

Point of contact for PCMH _____

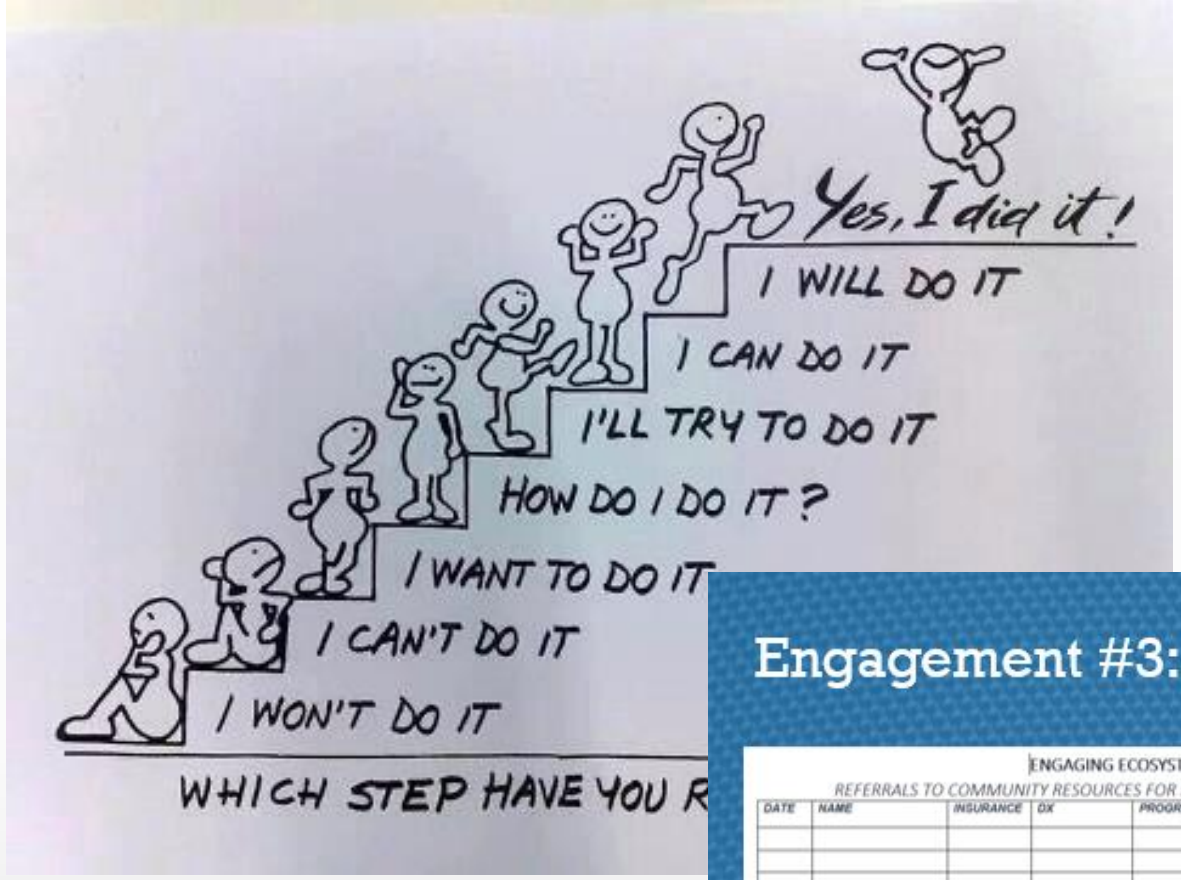
Best way to contact PCMH: _____

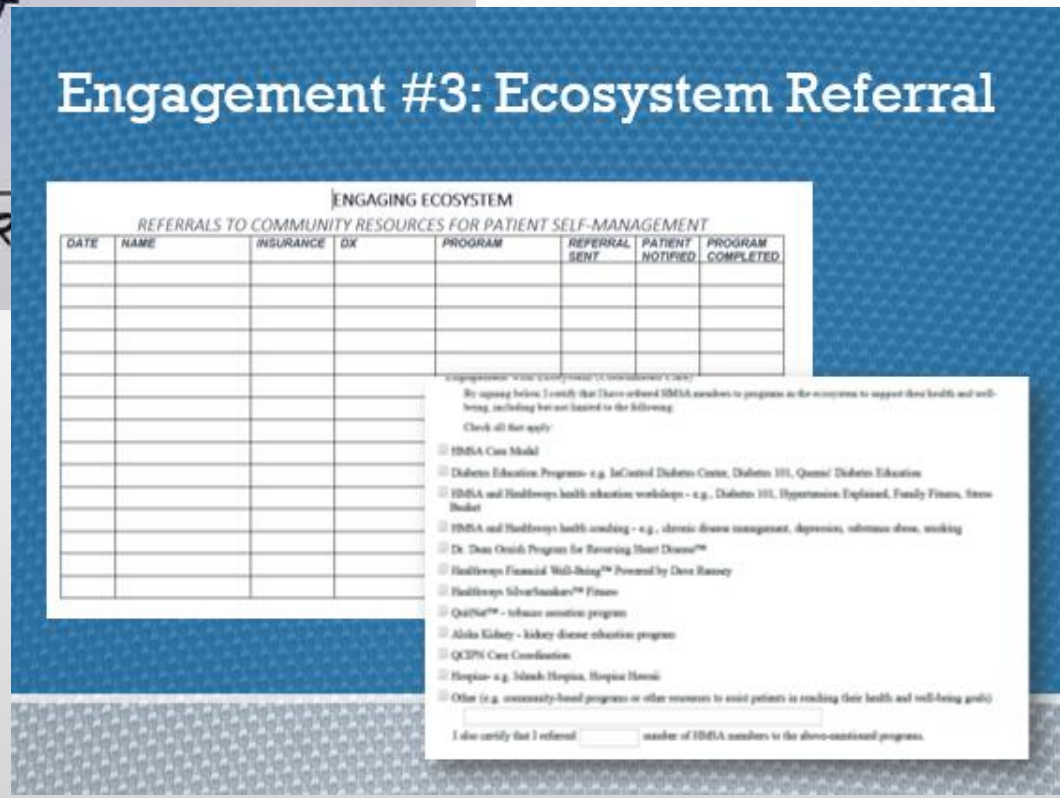
reminder

TO DO:

PATIENT SELF-MANAGEMENT

REFER TO "ECOSYSTEM"





WEBSITES:

CPC+ HELPDESK

CPCPlus@cms.hhs.gov

CPC+ WEBINARS

https://engage.vevent.com/index.jsp?eid=7381&ecid=64

CPC+ eCQM

https://innovation.cms.gov/Files/x/cpcplus-qualrptpy2017.pdf

MIPS – QPP WEBSITE

https://qpp.cms.gov

HMSA Payment Transformation Toolkit

https://hmsa.com/portal/provider/zav_pel.aa.PAY.100.htm

HMSA P4Q

https://hmsa.com/portal/provider/1180-7076_P4Q_Guide_Commercial_QUEST_AA_Primary_Care_010117.pdf

HMSA PMSO SUPPORT:

QUESTIONS

Please complete evaluation form

MAHALO!