Rendezvous with MU2

CHCANYS
October 20,2014
3:30pm – 5:30pm

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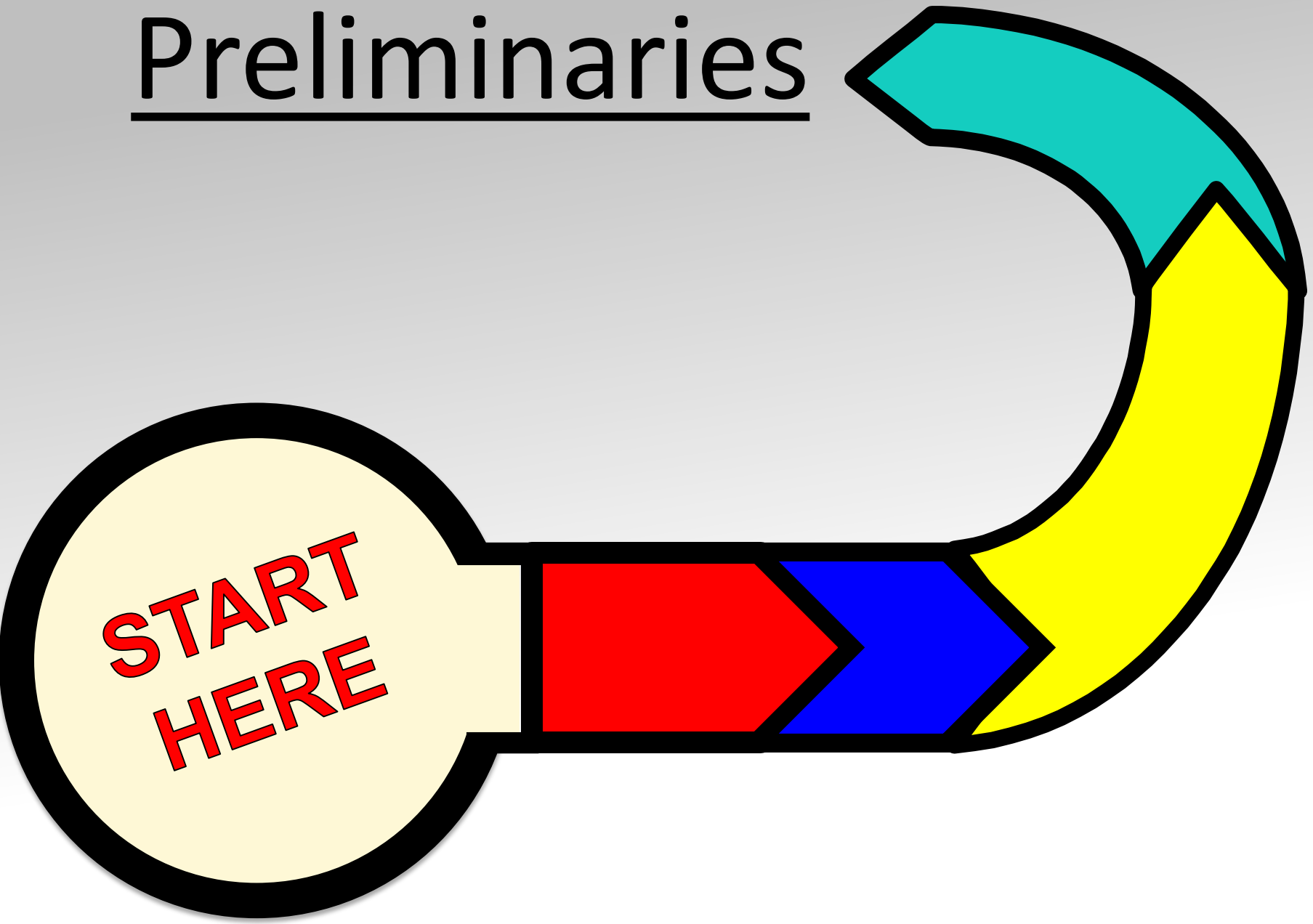
Agenda

I. **MU Compare of Stage 1 to Stage 2 and to PCMH 2014**
   a) Preliminaries
   b) **Comparisons and Strategies (IMPLEGRATION)**
   c) Exhibits Examples and Excuses

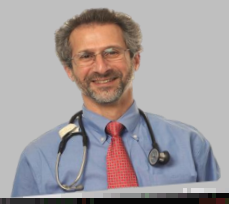
II. **Putting PCMH/MU Values into Practice**
   a) Values
   b) Perspective
   c) Change
   d) 10 Things
   e) Prevention
   f) Spread
   g) NCQA PCMH 2014 Update

III. **Personalizing MU/MH, Roles and Alignments**

Preliminaries



The MU2 News



MU1 Menu now MU2 Core

Secure Messaging

Patient Engagement

Higher Thresholds

3% of Eligible Hospitals

Secure on-line patient access

Patient Portal

1% of eligible providers

Direct Messaging

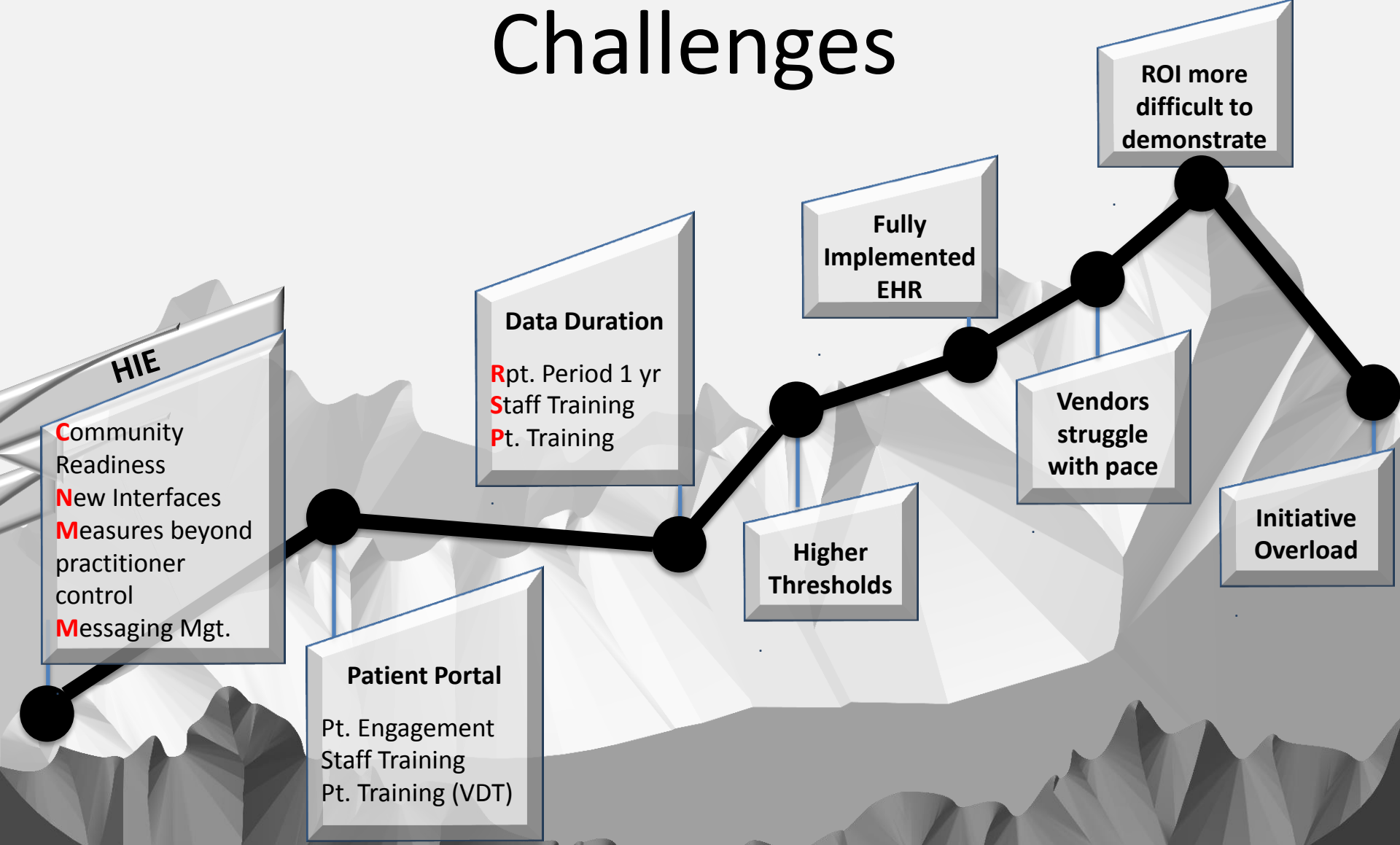
Must be MU2 for two years before MU3

MU 1
Collecting
Data at Rest

MU 2 about
HIE
(Health information Exchange)
Data in Motion

Electronic Referrals

Challenges



Hardest measures = those that require cooperation or coordination with outside parties (the medical neighborhood):

MU C7 C8 - VDT / PCMH 1C Elec. Access

MU C15 – care summary transmissions / PCMH 5B 5C

MU C17 – Messaging / PCMH 1C 6G

Before You Start Stage 2...

Make sure you have upgraded to a system with 2014 certification.
Even if you have successfully attested for Stage 1, all EHR systems have to be re-certified for Stage 2.

Consider Switching to a Cloud-Based EHR

- No need for hardware to install
- No heavy upfront hardware costs
- Scalable subscription packages
- Automatic updates
- **Easy access from anywhere**

62% physicians adopted iPads for work

Stage 2 Starts January 1, 2014

Completing

- **17** Core Objectives
- **3 of 6** Menu Objectives
- **9 of 64** Clinical Quality Measures

=

Receiving

Up to **$12,000** if you begin Stage 2 in **2014**

Are You Prepared for Stage 2?

32% familiarized themselves with Stage 2 Requirements

25% reviewed requirements and are taking action towards Stage 2

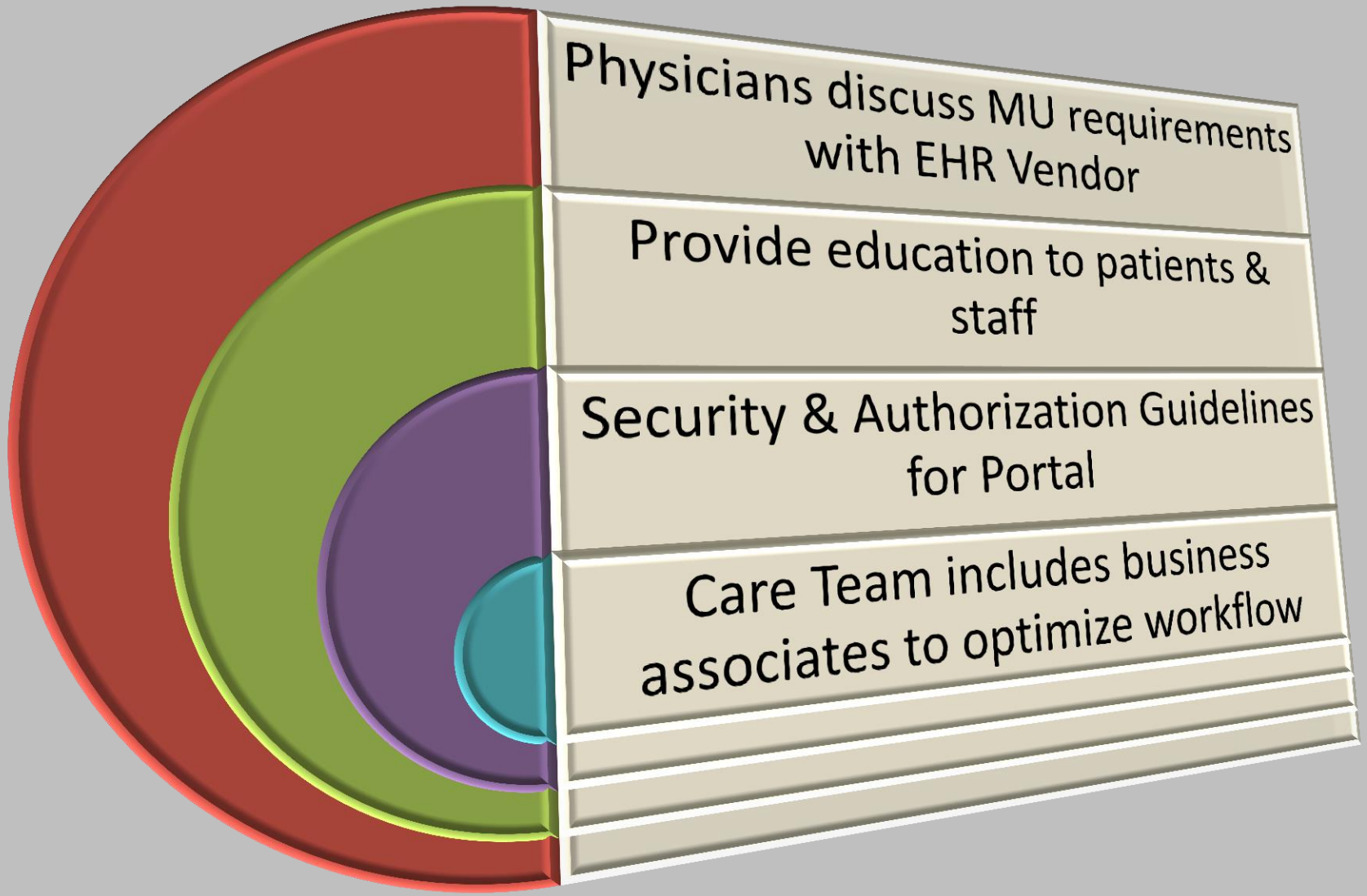
MU PCMH

The six key domains of MU2…

- Public/Population Health
- Patient Engagement
- Efficient Usage of HC Resources
- Patient Safety
- Optimized Clinical Processes
- Coordination

MU PCMH

Include More People



MU Documentation

20 Total Measures
17 Core Measures
3 Menu Measures
+
9 Clinical Measures

Numerators
Denominators

Calculations

10 Numerators

- Rx Order
- Data Entry
- Transmitted eRx
- Labs Ordered
- Reminders
- Rx Reconciliations
- Summaries of Care
- Copy of Record
- Timely Record Access
- Education

6 Denominators

- Unique Patients
- Patients
- Prescriptions
- Lab Test Results
- Visits
- Transitions

Crosswalk Logic

PCMH Element 5C

Consent to exchange info.
Care Coordination
Care Transitions

MU C15 Summary Care Record

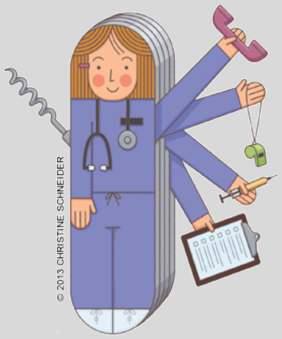
Measures

Provides electronic care summary to another care facility (for more than 50% of transitions of care and referrals)(MU - for all Transitions)

Work Plan

7

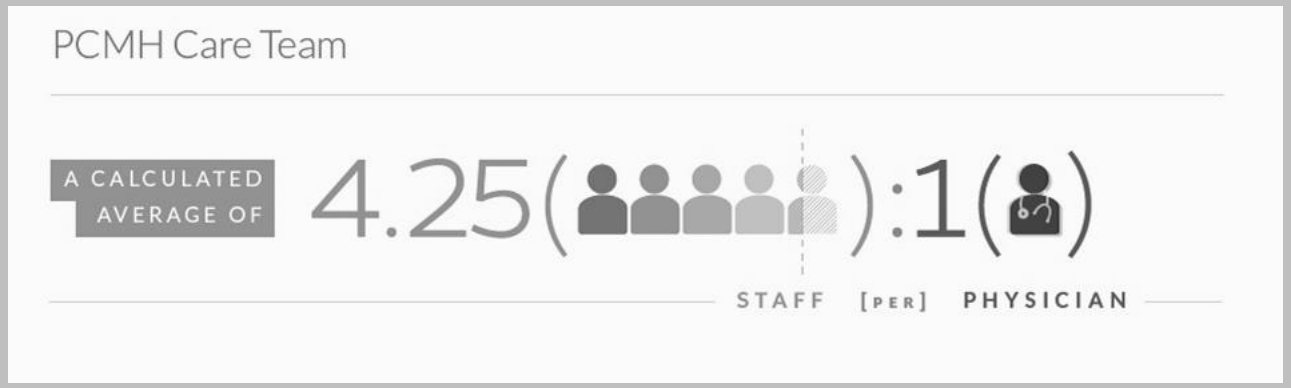
- ☐ Assessing EMR capabilities
- ☐ Process, **Roles** & Workflow Redesign
- ☐ System configuration & upgrades
- ☐ Addressing overlaps between PCMH & MU
- ☐ Producing reports
- ☐ Writing policies & procedures
- ☐ Producing screen shots & documentation



The Care Team Continuum

MD | PA | NP | RN | LPN | MA | Patient Navigator Advocate | Care Mgr. | BH Partners

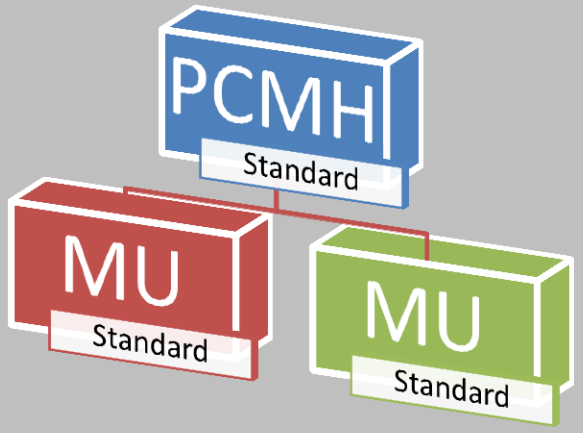
Providers | Nurses | Clinical Support Staff



Three Implegration Strategies

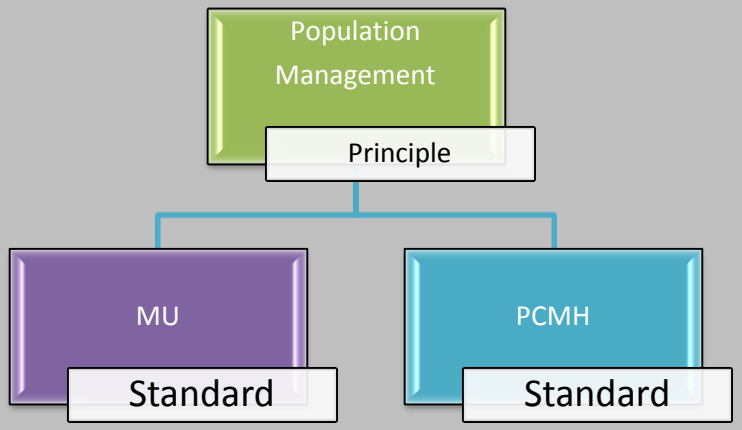
I

Standard to Standard



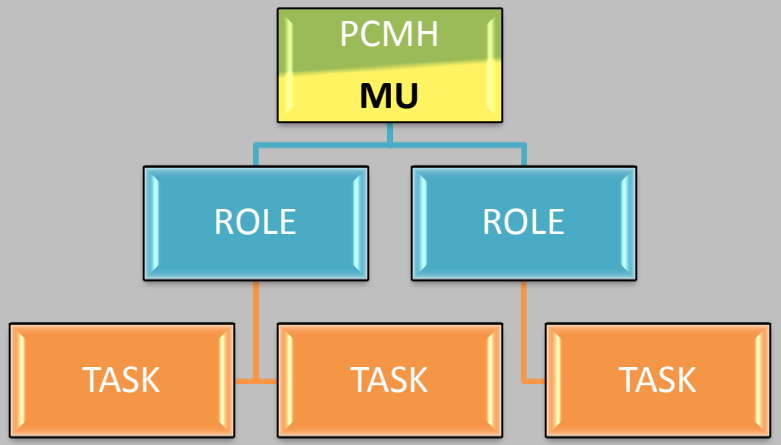
II

Principle to Standard



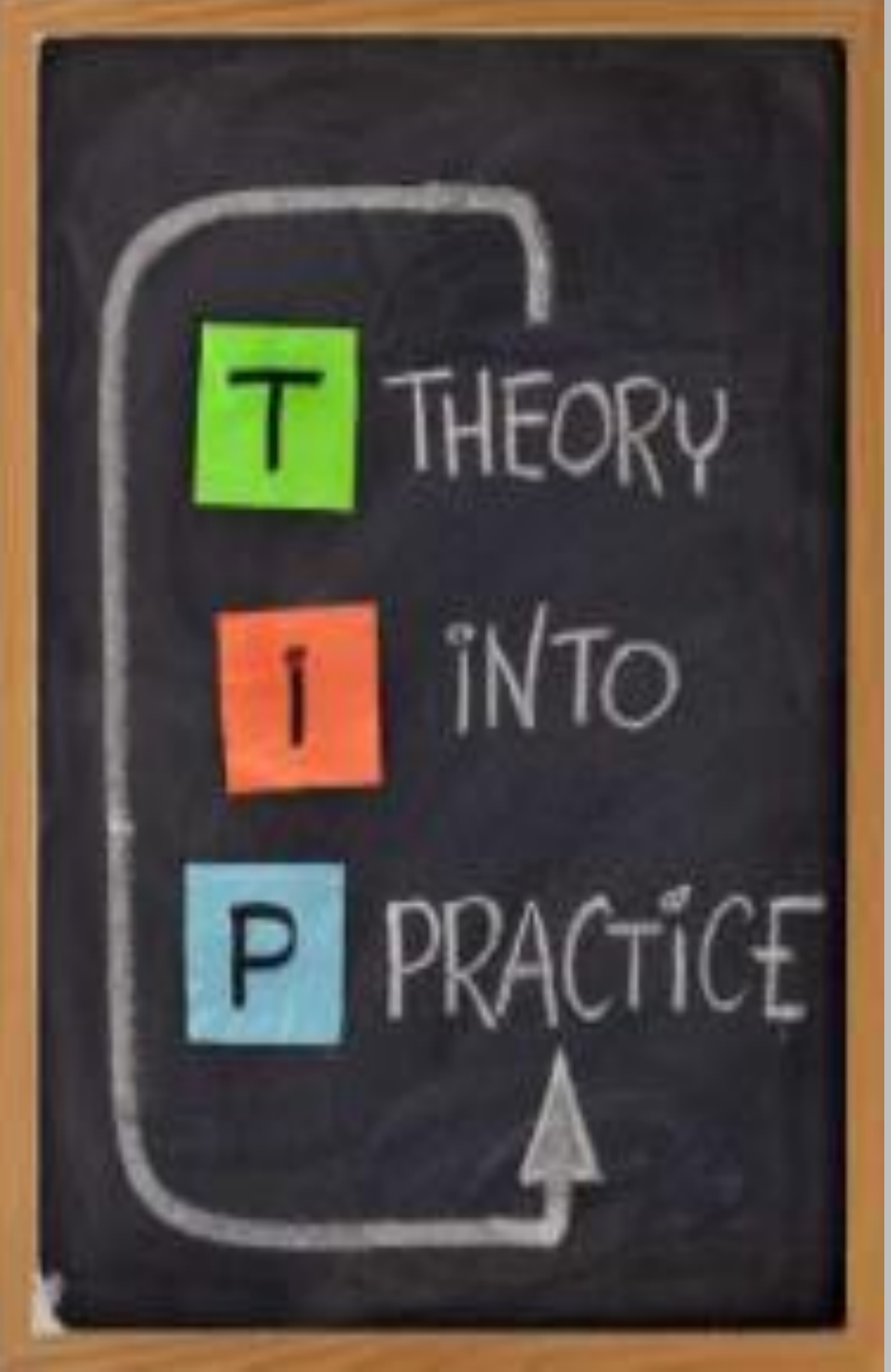
III

Standard/Principle to Role To Task

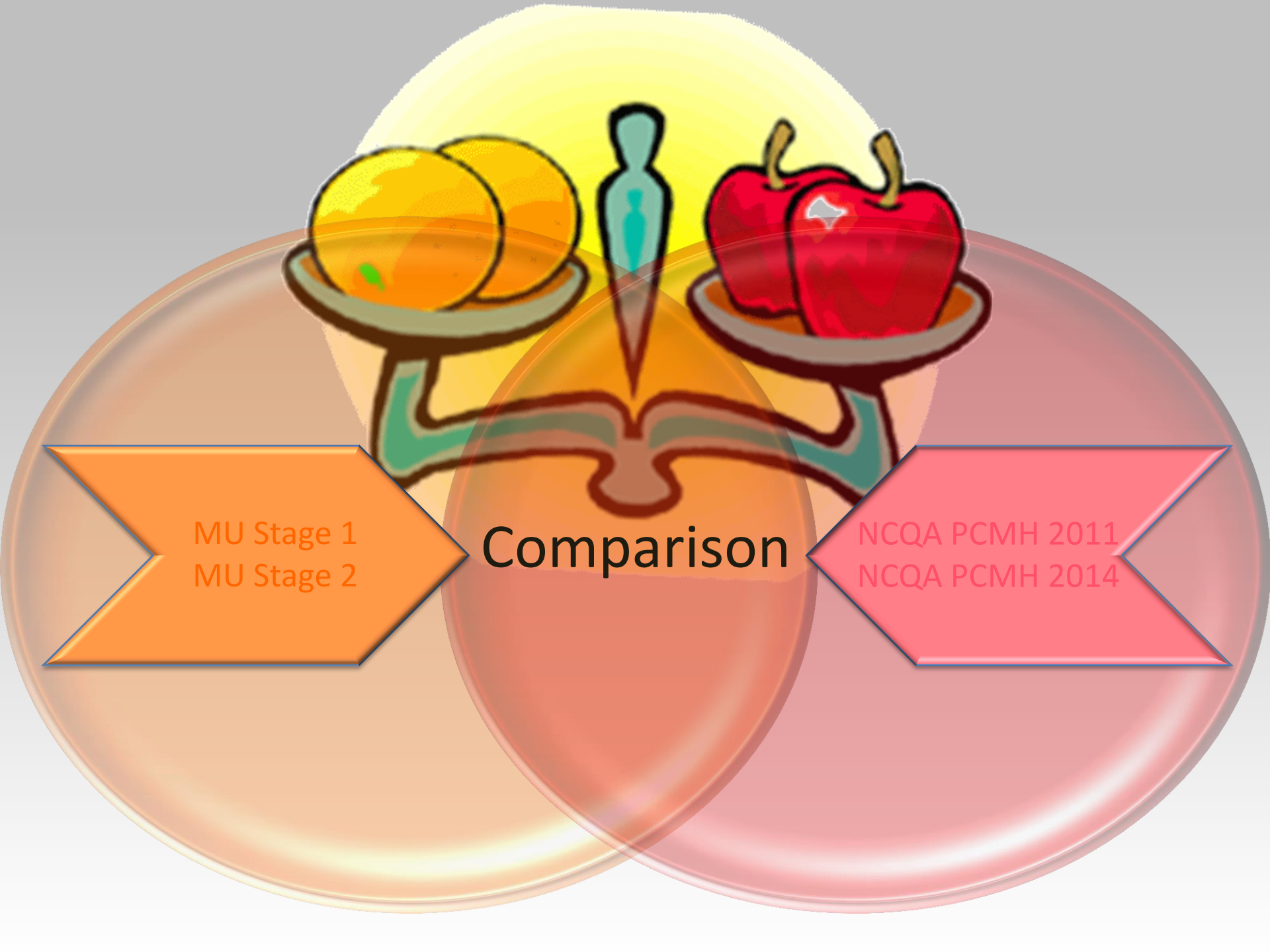


Quiz Question

Choosing which, to do first,
MU or PCMH,
gets you
farther along the
transformation trail?



Component	MU	PCMH	%
Element	18	27	67%
Factors	25	127	20%
		Average	43%


MU Stage 1
MU Stage 2
Comparison
NCQA PCMH 2011
NCQA PCMH 2014

MU Stage 1 and Stage 2 PCMH 2011 and PCMH 2014

The following slides compare the progress of MU and PCMH and then compares the two standards

The overlaps and alignments are opportunities to sustainably optimize your efforts

CORE 1

USE COMPUTERIZED PROVIDER ORDER ENTRY (CPOE) FOR MEDICATION, LABORATORY AND RADIOLOGY ORDERS DIRECTLY ENTERED BY ANY LICENSED HEALTHCARE PROFESSIONAL WHO CAN ENTER ORDERS INTO THE MEDICAL RECORD PER STATE, LOCAL AND PROFESSIONAL GUIDELINES.

CPOE

STAGE 1

>30% of unique pts. with >= 1 med. In med list seen by EP have >= 1 med ordered via CPOE.

STAGE 2

>60% of meds, 30% of labs and 30% radiology orders created by EP are ordered via CPOE.

Overlap

E-prescribing

4D PCMH

Uses an electronic prescription system with the following capabilities.

- **50 percent** of eligible prescriptions written by the practice are **compared to drug formularies** and **electronically sent to pharmacies.**
- **Enters electronic medication orders** in the medical record for > 60 percent of medications.
- Performs patient-specific checks for **drug-drug and drug-allergy interactions.**

CORE 2

GENERATE AND TRANSMIT PERMISSIBLE PRESCRIPTIONS ELECTRONICALLY (eRX)

eRX

STAGE 1

>40% of permissible Rxs written by EP transmitted using CEHRT

STAGE 2

>50% of permissible Rxs written by EP are compared to >= 1 drug formulary and tranmitted via CEHRT

Overlap

E-prescribing

4D PCMH

Uses an electronic prescription system with the following capabilities.

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- Performs patient-specific checks for **drug-drug and drug-allergy** interactions.

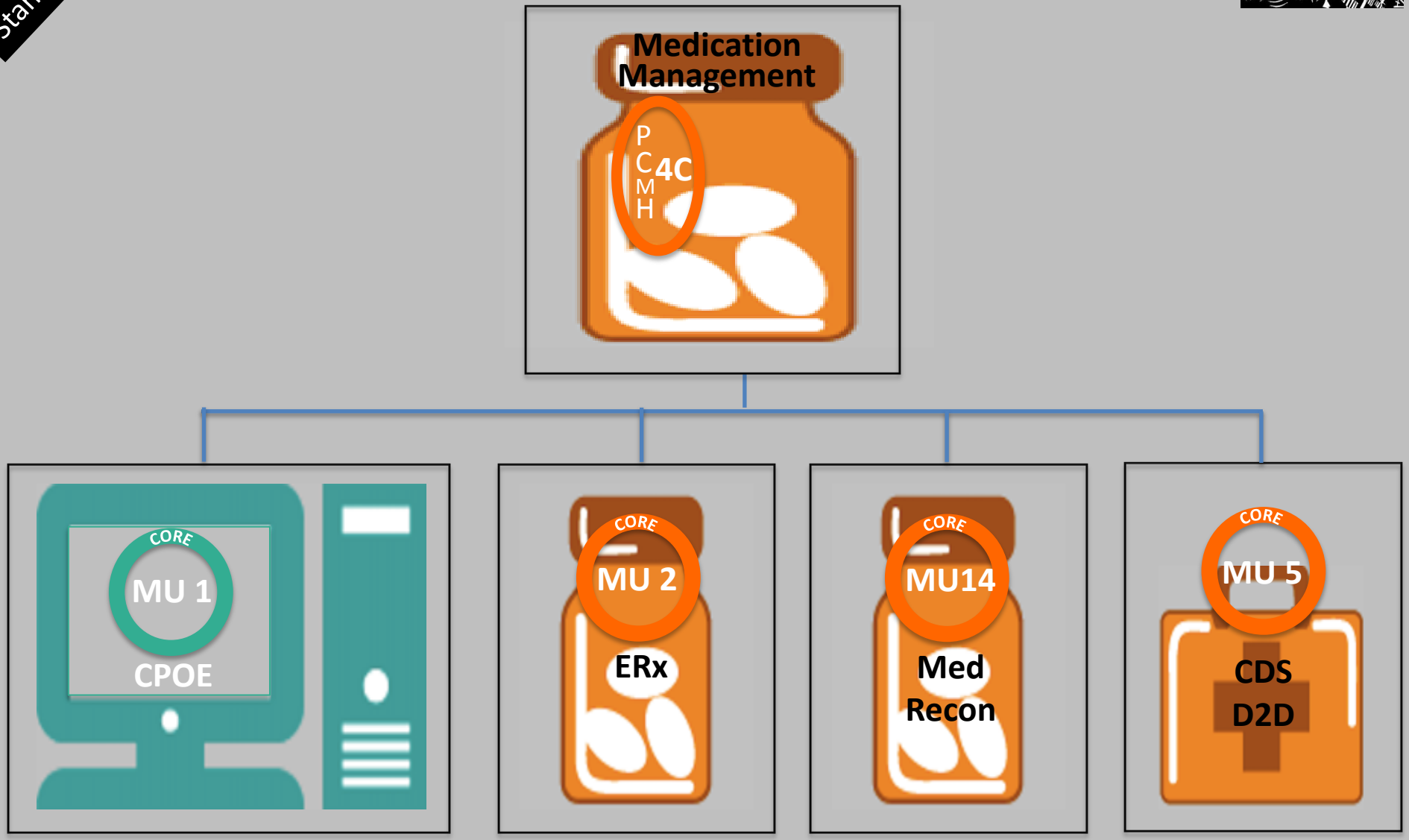
Quiz Question

You have just seen the first two standards and their overlaps. What strategic work integration opportunities do they suggest?

Hint: either implementation or workflow

Strategy 1
Standard to Standard

Implegration Strategy Considerations



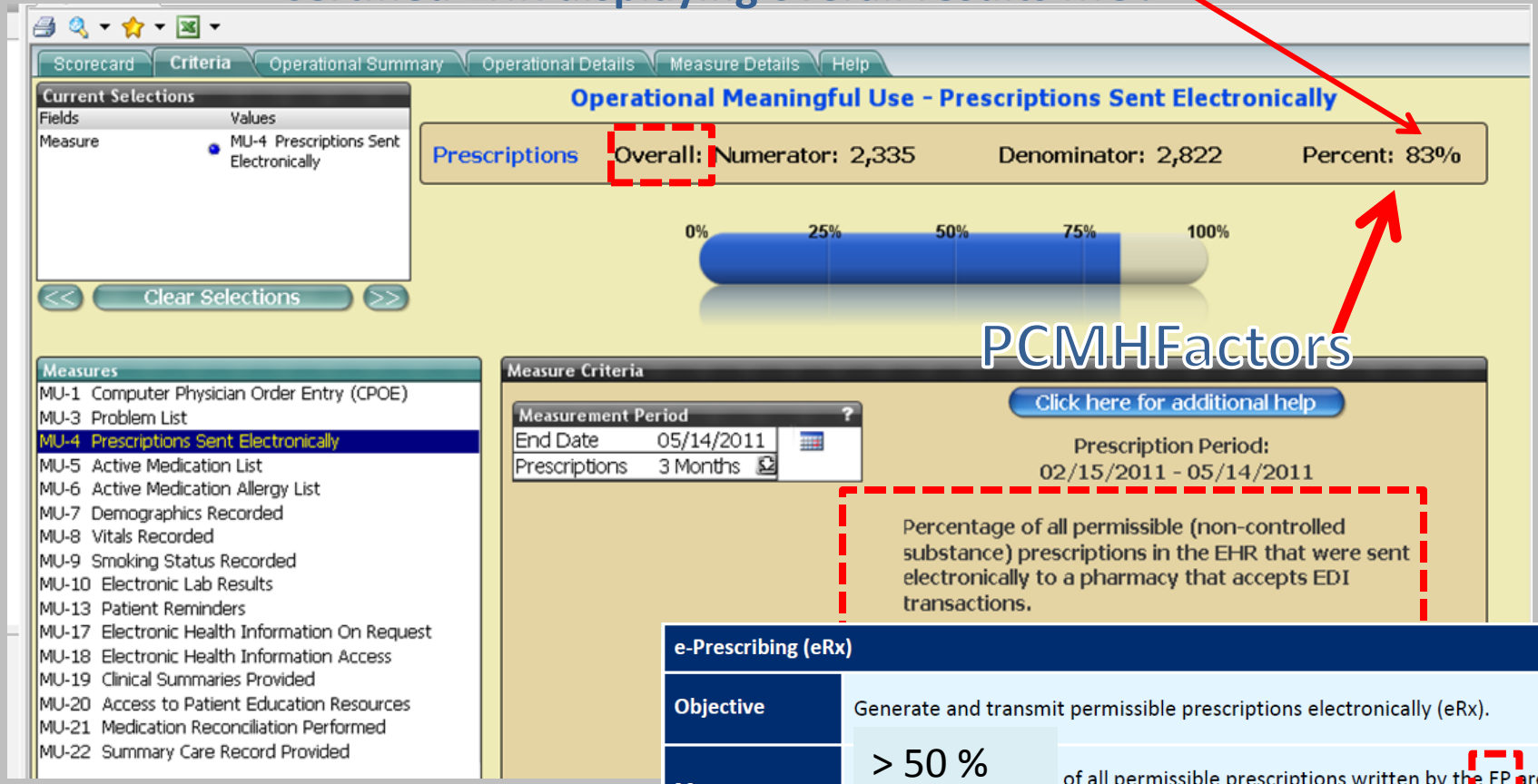
Quiz Question

OK that was fun!

Let’s try one more

Meaningful Use/ PCMH 2014 Overlap

Certified EHR displaying overall results MU?



e-Prescribing (eRx)	
Objective	Generate and transmit permissible prescriptions electronically (eRx).
Measure	> 50 % of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
Exclusion	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

Use Electronic Prescribing		
The practice uses an electronic prescription system with the following capabilities.	**Yes**	**No**
1. Generates and transmits at least 50% **of eligible prescriptions to pharmacies***	☐	☐
2. Generates at least 75 percent of eligible prescriptions*	☐	☐
3. Integrates with patient medical records	☐	☐

CORE 6

USE CLINICAL DECISION SUPPORT TO IMPROVE PERFORMANCE ON HIGH-PRIORITY HEALTH CONDITIONS.

Clinical Decision Support

STAGE 1

Implement one CDS rule

STAGE 2

Implement 5 CDS interventions for 4 or more related to clinical quality measures during entire rpt. period/ Enable drug to drug for entire rpt. period

Overlap

CDS

3E PCMH

Clinical Decision Support

The practice implements **clinical decision support** + (e.g. point-of-care reminders) following evidence-based guidelines

CORE 7

PROVIDE PATIENTS THE ABILITY TO VIEW ONLINE, DOWNLOAD AND TRANSMIT THEIR HEALTH INFORMATION WITHIN FOUR BUSINESS DAYS OF THE INFORMATION BEING AVAILABLE TO THE EP.

View Online, Download &Transmit

STAGE 1

>50% of all pts. who request copy of their record/provided in 3 days (menu)

STAGE 2

>50% of all pts. seen during rpt period have their record available 4 biz days after available to EP

>5% VDT HI to 3rd party

Overlap

Electronic Access

1C PCMH

Electronic Access

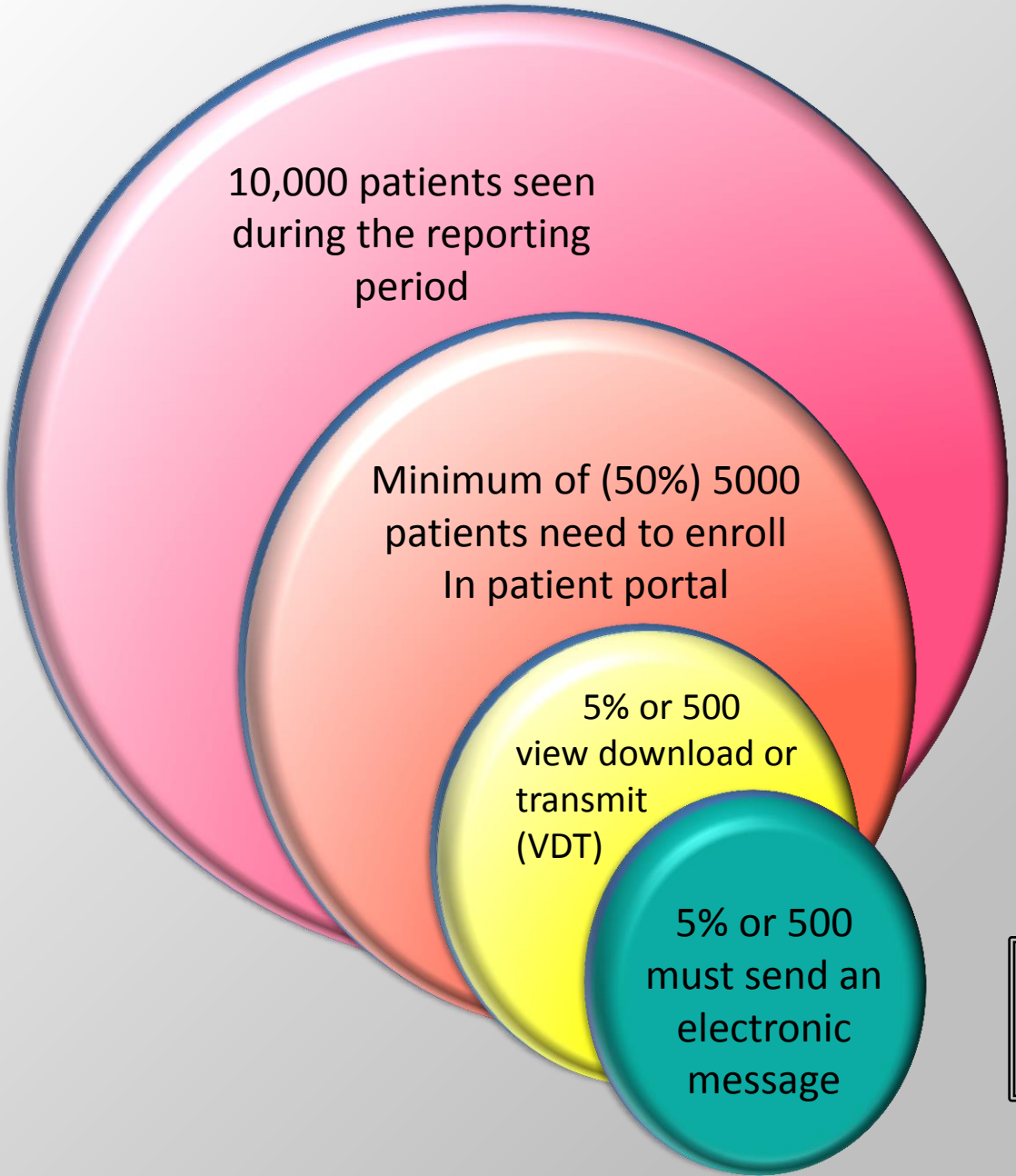
*More **than 50 percent of patients have online access** to their health information within four business days of when the information is available to the practice.
*More than **5 percent of patient**s view, and are provided the capability to download, their health information or transmit their health information to a third party.
***Clinical summaries** are provided within 1 business day(s) for more than **50 percent of office visits**.
*A **secure message** was sent to more than **5 percent of patients***

Quiz Question

If you believe that the patient portal is a priority what strategic considerations merit attention?

What is the technical piece?
The non-technical piece?

Patient Portal Implegration Strategic Considerations



If you target only the minimum, you will have to get 100% of the VDT group to also send an electronic message

CORE 8

PROVIDE CLINICAL SUMMARIES FOR PATIENTS FOR EACH OFFICE VISIT.

Clinical Summaries

STAGE 1

Clinical summaries provided to pts. for >50% of all office visits within 3 business days

STAGE 2

One business day

Overlap

Electronic Access

1C PCMH

Electronic Access

*More than 50 percent of patients have online access to their health information within four business days of when the information is available to the practice+.
*More than 5 percent of patients view, and are provided the capability to download, their health information or transmit their health information to a third party+.
*Clinical summaries are provided within 1 business day(s) for more than 50 percent of office visits+.
*A secure message was sent to more than 5 percent of patients+

Strategy III
STD to Role to Task

Implegration Strategic Considerations

Clinical Summaries

Practice uses the patient portal to post, summaries, appt. reminders , preventive or chronic care services needed

Pt. On-line Access

PCMH 1C

CORE MU 7

CORE MU 8

Provider

- completes and closes visit note after each encounter… triggers posting to pt portal and visit summaries
- Lab orders and other test results are completed timely and posted to pt portal

CORE MU 7

Pt. On-line Access

Front Desk

- **gathers patient's email information to coordinate pt. portal set up and use instructions**
- **runs monthly reports to gauge patient portal access**

CORE MU 17

prints or informs patients of PHR availability w/in 1 day, visit summaries for patient

CORE MU 17

Secure Elec. Access

Clinical Support Staff

- Practice uses the pt. portal to post, summaries, appt. reminders , preventive or chronic care services needed
- Threshold reports run & reviewed

CORE 11

GENERATE LISTS OF PATIENTS BY SPECIFIC CONDITIONS TO USE FOR QUALITY IMPROVEMENT, REDUCTION OF DISPARITIES, RESEARCH, OR OUTREACH.

Generate Lists of Patients

STAGE 1

Generate **at least one** report listing patients of the EP with a specific condition

Moved from Menu to Core

STAGE 2

No change from Stage 1

3D PCMH

Data for Population Management

At **least annually** identify populations of patients and remind them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines

Implegration Strategy Considerations

Population Management

Population Management

PCMH 3D

Generate Patient Lists

CORE MU11

Electronic Access

PCMH 1C

Secure Electronic Messaging

MU17

Cert EHR Condit. Specific Lists

PCMH 6G

Cancer Cases To a Registry

MENU MU 4

Data to Immu.n Registry

CORE MU16

Care Coord Transitions

PCMH 5C

Referral Tracking F/U

PCMH 5B

Summary Care Record

MU15

Pt. Education

MU13

Self Care Shared Decisions

PCMH 4E

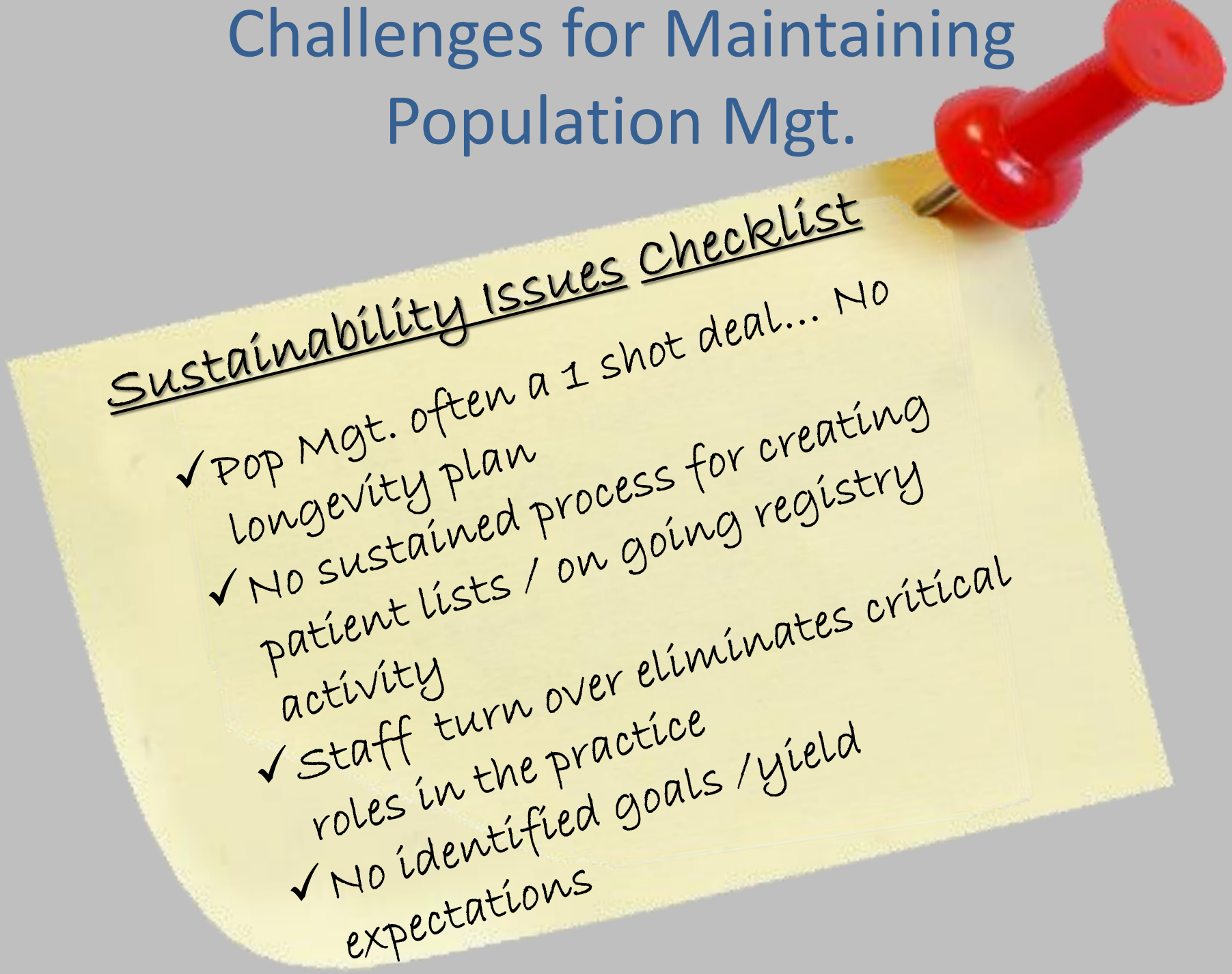
POC Reminders

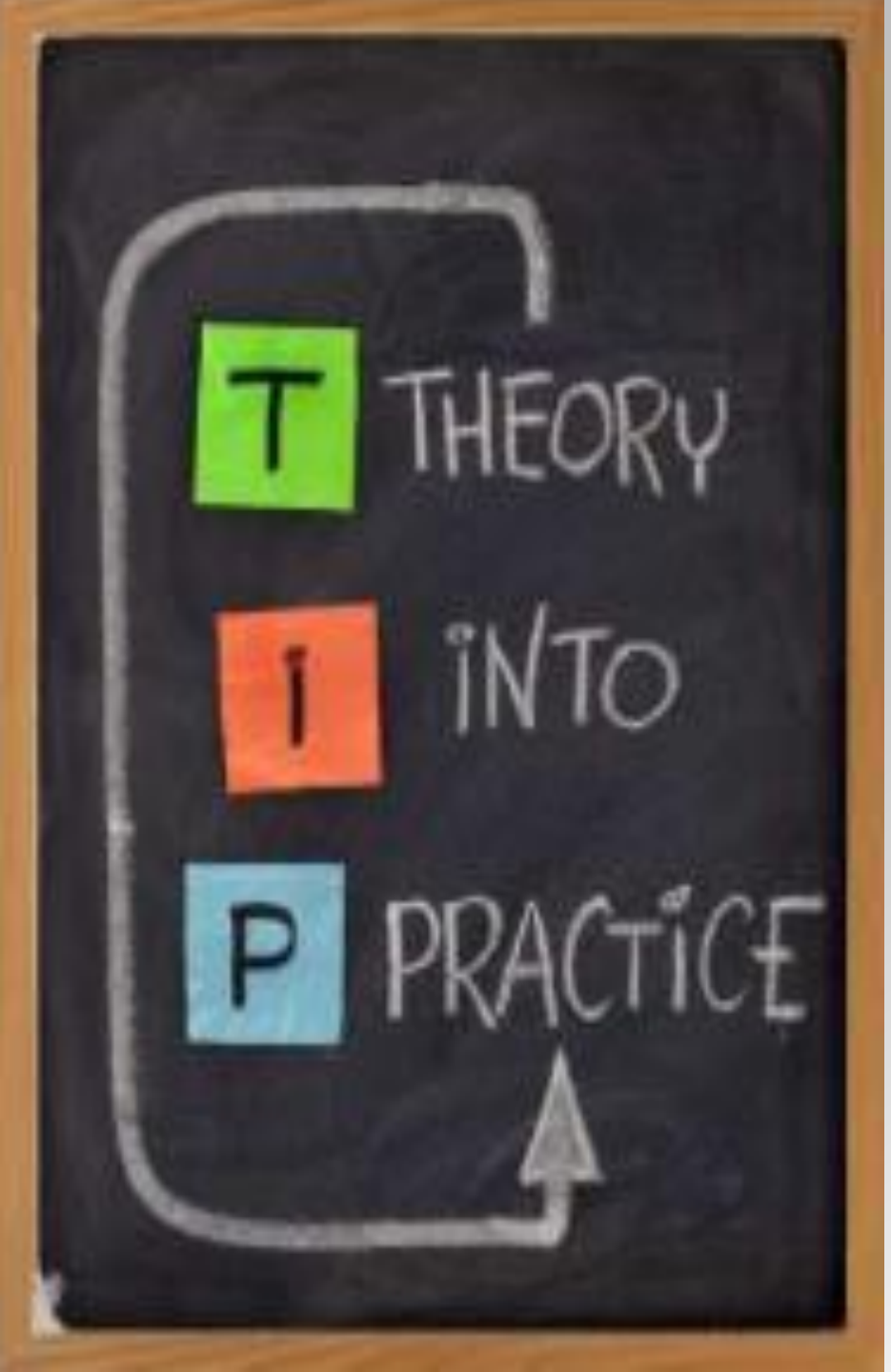
PCMH 3E

CDS

MU6

Challenges for Maintaining Population Mgt.

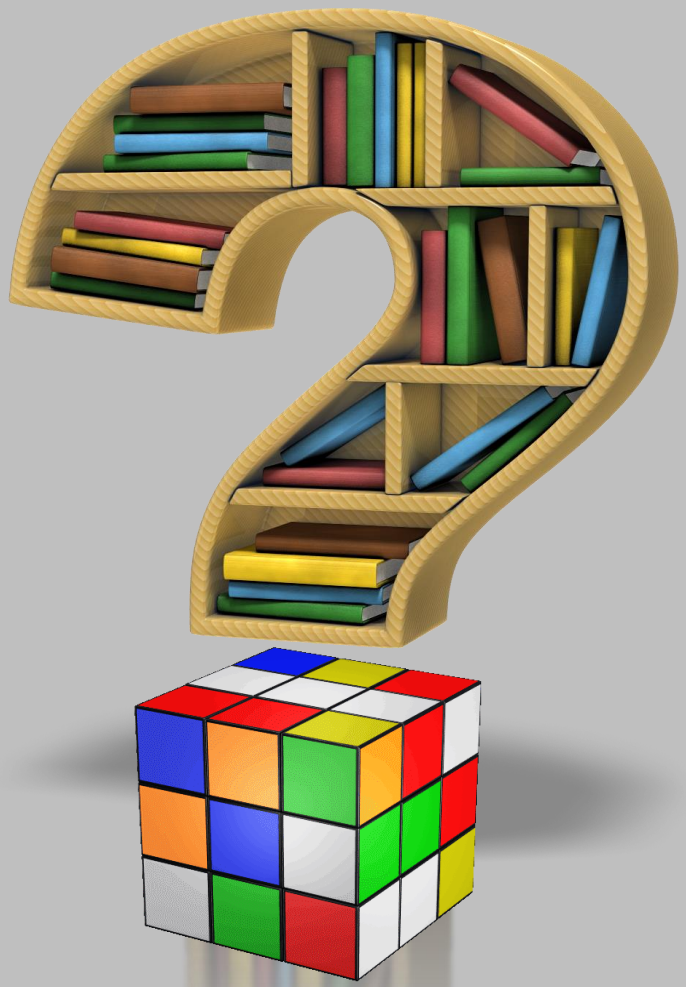




Develop Pop Management activities based on clinical data outcomes

Pop Mgt. should be **the** activity behind PI.
It's the exercise to assess if efforts yield results…

..and your UDS/TJC/HRSA 19/ Clinical QI activities



Quiz Question

Whose job is Population Health?

Why?

MD	PA	NP	RN	LPN	MA	Patient Navigator Advocate	Care Mgr.	BH Partners

Providers Nurses Clinical Support Staff

CORE 13

USE CLINICALLY RELEVANT INFORMATION FROM CERTIFIED EHR TECHNOLOGY TO IDENTIFY PATIENT-SPECIFIC EDUCATION RESOURCES AND PROVIDE THOSE RESOURCES TO THE PATIENT.

Patient-Specific Education Resources

STAGE 1

Pt Specific Educ Resources
Menu in stage 1
Core in Stage 2

STAGE 2

Pt. Ed. Resources id. CEHRT provided to pts. **>10% unique pts**. with Visits during rpt.per.

Healthwise

Overlap

Self Care
Shared
Decisions

4E PCMH

Patient Self Care Shared Decision Making

Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients+

Quiz Question

A practice is on its way to meet medication reconciliation criteria because its patient portal enables post-op access to a clinical summary of care including a medication reconciliation list.

Does this meet meaningful use criteria?

NO!

WHY NOT?

MU criteria specifically addresses transitions of care thus providers have to be trained to use a specific code to identify a post-op visit as a transition of care event.

This is an EMR awareness, a workflow issue, and a data flow issue.

CORE 15

THE EP WHO TRANSITIONS THEIR PATIENT TO ANOTHER SETTING OF CARE OR PROVIDER OF CARE OR REFERS THEIR PATIENT TO ANOTHER PROVIDER OF CARE SHOULD PROVIDE A SUMMARY CARE RECORD FOR EACH TRANSITION OF CARE OR REFERRAL.

Summary of Care Record

STAGE 1

Summary of Care for **50% of T.O.C outbound and referrals**

STAGE 2

1. The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitio

2. The EP w … of care … or provide … ectronically … transmitte … eceives the … summary … on that is a … NwHIN Exc … blished … governanc … ons and … referrals

3. The EP w … of care … or provide … electronic … exchanges … hnology … that was designed by a different EHR developer than the sender's, or b) conduct one or more successful tests with the CMS-designated test EHR during the EHR reporting period

Summary of care sent electr. Via CEHRT, HIE
For 10% of T.O.C
Conduct 1 Test to different EHR

Overlap

Referral Trk. & F/U
Care Transitions

5C PCMH

Care Transitions

Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners.

Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50 percent of patient transitions of care.

5B PCMH

Referral Tracking & Follow Up

Has the capacity for electronic exchange of key clinical information+ and provides an electronic summary of care record to another provider for more than 50 percent of referrals.+

Documents co-management arrangements in the patient's medical record.

Asks patients/families about self-referrals and requesting reports from clinicians.

CLINICAL QUALITY MEASURES

CLINICAL QUALITY MEASURE(CQM) REPORTING HAS BEEN REMOVED AS A CORE OBJECTIVE FOR BOTH EPS AND ELIGIBLE HOSPITALS AND CAHS, ALL PROVIDERS ARE REQUIRED TO REPORT ON CQMS IN ORDER TO DEMONSTRATE MEANINGFUL USE

EPS MUST REPORT ON 9 OF THE 64 APPROVED CQMS

MENU MEASURES

TO ACHIEVE THE MENU OBJECTIVES OF MU-STAGE 2, EPS MUST SELECT 3 OF 6 MENU OBJECTIVES BELOW

1 Submit Syndromic Data

Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period

2 Family Health History

More than 20% of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.

3 Electronic Notes

Enter at least one electronic progress note created, edited and signed by an EP for more than 30% of unique patientsElectronic Notes

4 Report Cancer Cases

Successful ongoing submission of cancer case information from certified EHR technology (CEHRT) to a public health central cancer registry for the entire EHR reporting period.

5 Imaging Results

More than 10% of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.

6 Report Specific Cases

Successful ongoing submission of specific case information from certified EHR technology (CEHRT) to a specialized registry for the entire EHR reporting period.

Source: http://www.healthit.gov

Let’s talk about it

PRIMARY CARE
DEVELOPMENT
CORPORATION

PCMH and MU
Putting Values into Practice

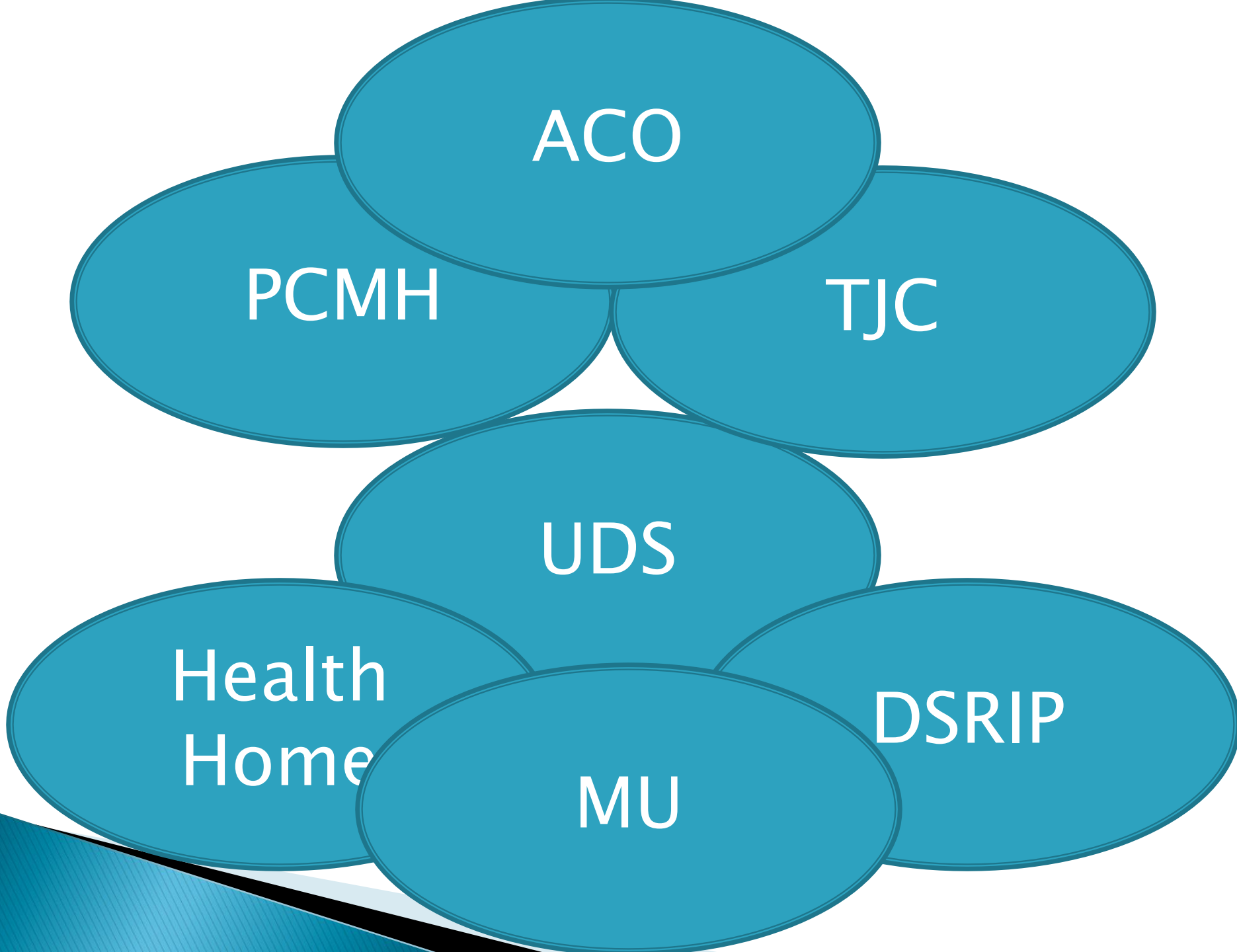
Daniel Miller, MD
Chief of Clinical Quality & Training
Hudson River HealthCare

October 20, 2014

HRHCare
HUDSON RIVER
COMMUNITY HEALTH

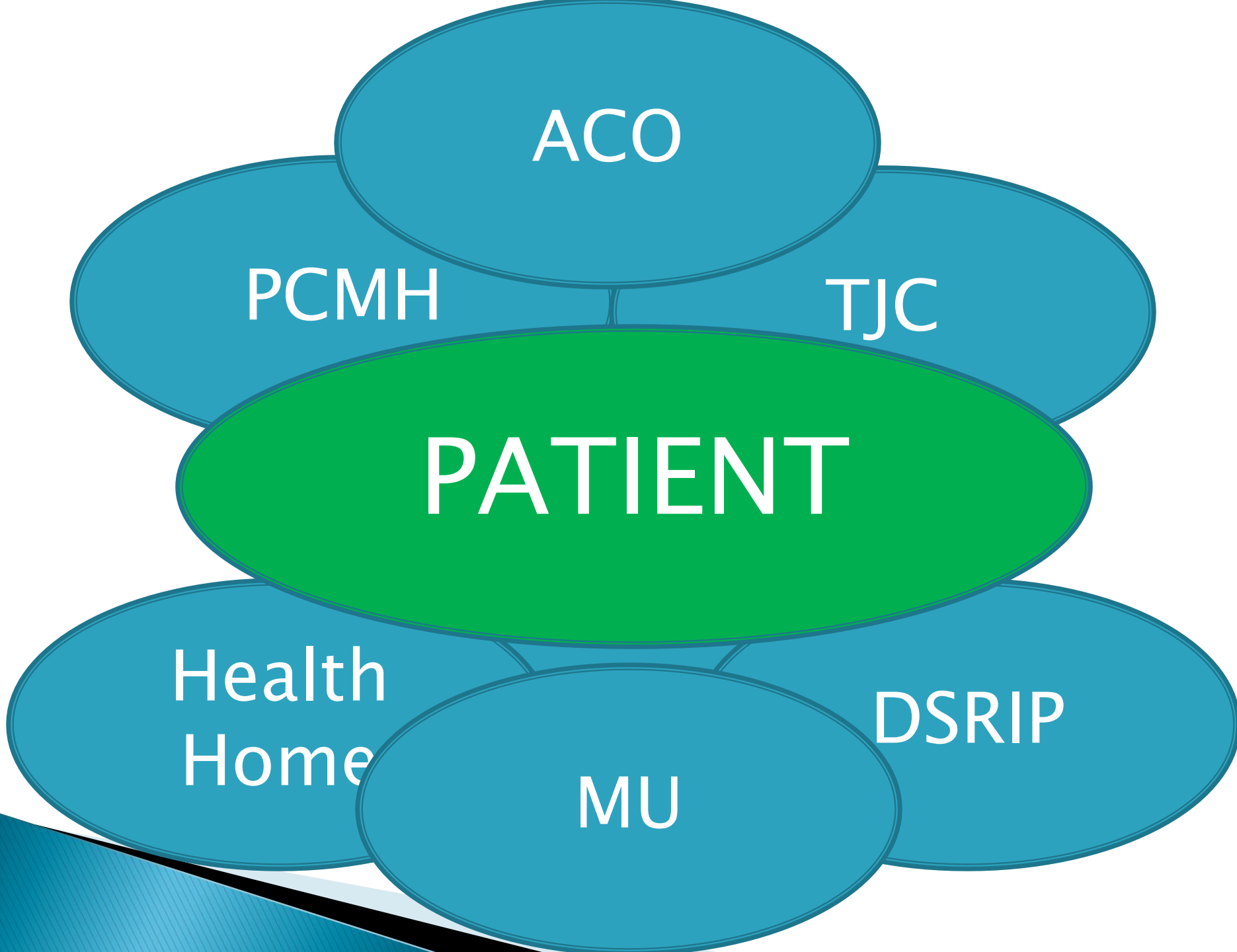
Values

What Do You Care About


ACO
PCMH
TJC
UDS
Health Home
DSRIP
MU

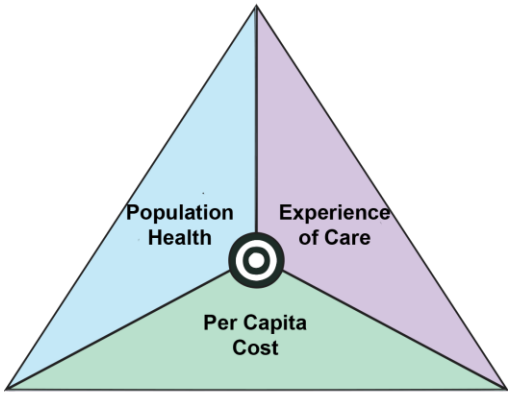
“The most important thing is to keep the most important thing the most important thing”

-From the book “Foundation Design,” by Donald P. Coduto


ACO
PCMH
TJC
PATIENT
Health Home
DSRIP
MU

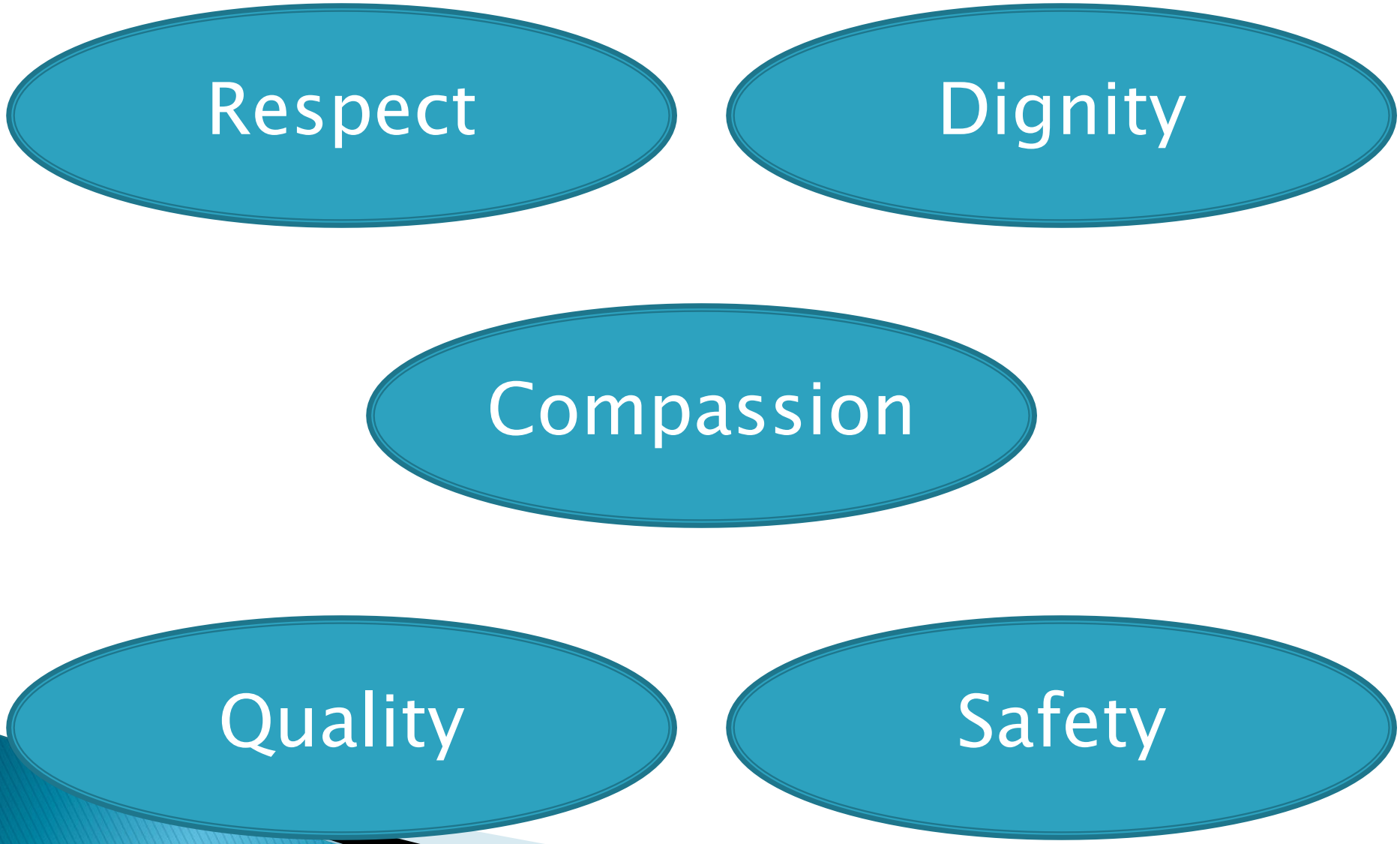
PCMH

Triple Aim



IHI Triple Aim

Medical Home



Perspective

Our History

Peekskill
Ambulatory
Health Care Center, Inc.

Peekskill Area Health Center

HUDSON RIVER HEALTHCARE

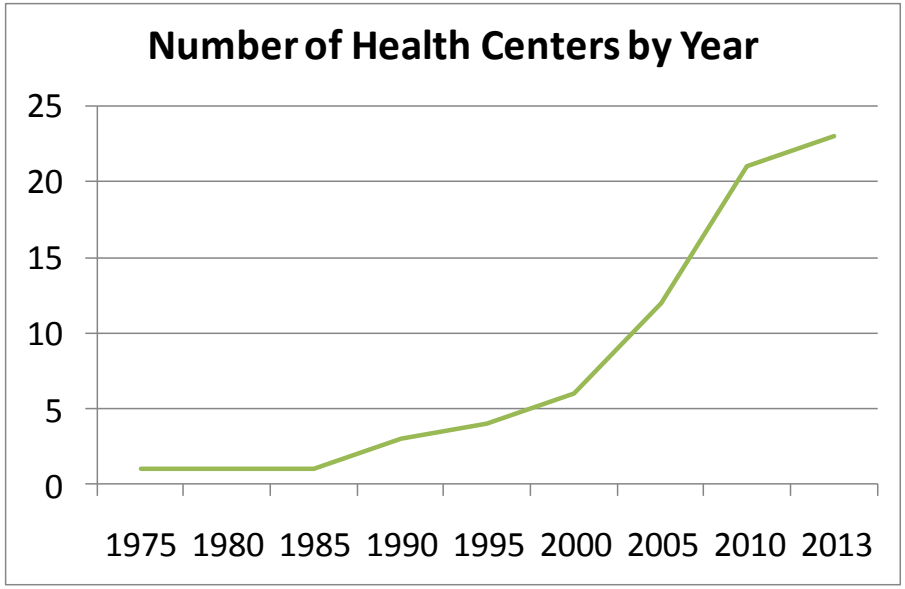
communityhealth
Hudson River HealthCare

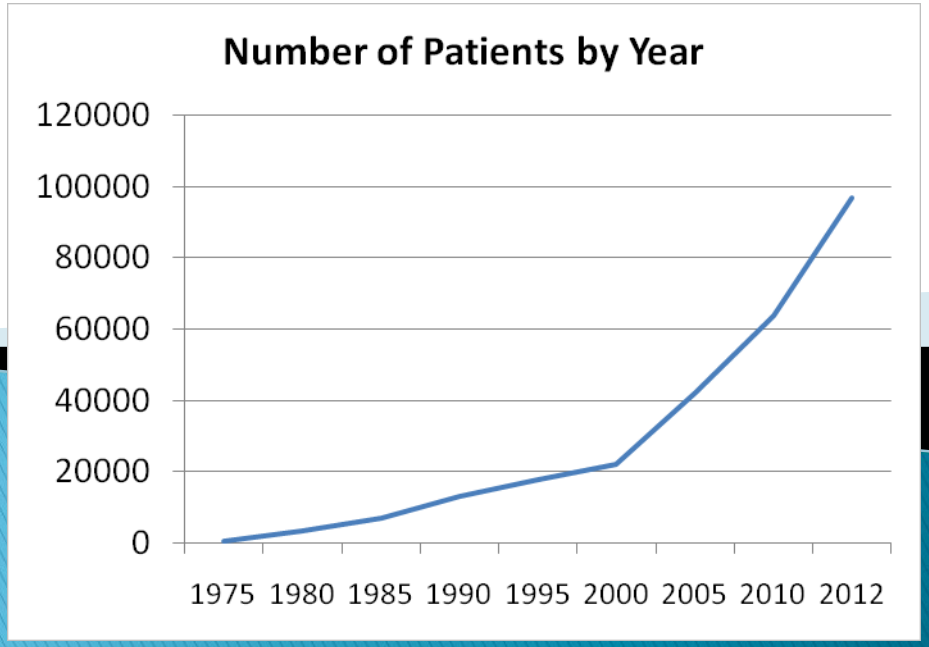
HRHCare
COMMUNITY HEALTH

Growth

1975: Peekskill
1987: Peekskill Dental Sealant Program
1990: Beacon
1990: William J. Thayer Alamo Farmworker Health Center
1993: New Paltz Farmworker Health Center
1998: Poughkeepsie Partnership
1999: Wallkill Valley Health Center at Walden
2001: Amenia
2001: Dove Plains
2001: Pine Plains
2002: Poughkeepsie Atrium
2003: William E. Shands Community Health Center at Bohlmann Towers
2003: Migrant Voucher Program
2004: Monticello
2006: Greenport
2007: Haverstraw
2008: Park Care Yonkers
2008: South Broadway Yonkers
2010: Hempstead*
2010: Elmont*
2010: Roosevelt*
2010: Westbury*
2011: Spring Valley
2012: Elsie Owens at Coram
2013: HRH*Care* Center at Vassar

***Sub-recipient Health Center**





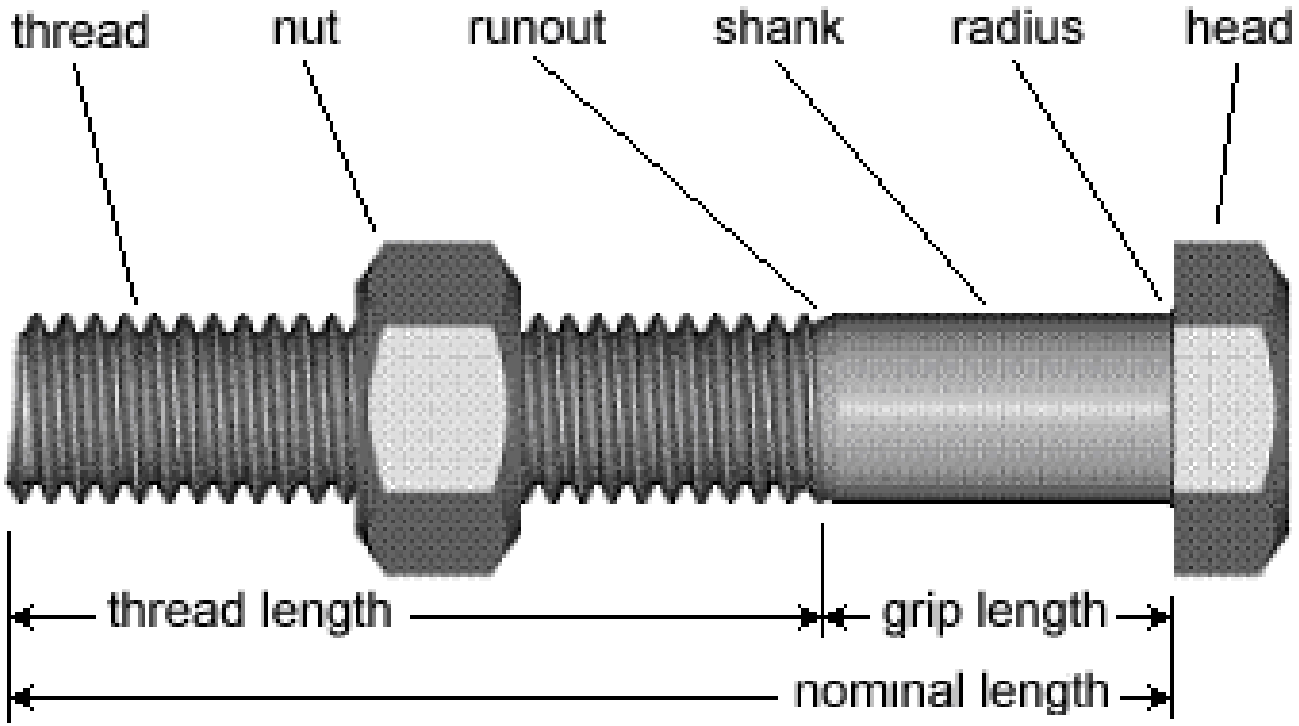
Change

Change requires TRANSFORMATION

Transformation is Systemic

- Multilevel Interventions & Support
- EMR
- Alerts
- Templates
- Order Sets
- Workflow and Team Redesign
- Incentives (Emotional, Intellectual, Monetary)
- Ongoing Feedback & Data

The Nuts and Bolts



IHI Model for Improvement

- Figure out What Needs To Be Done
- Form a Team
- Create a Change Package
- Implement and Spread Change

Gap Analysis

4E	Support Self-Care and Shared Decision Making		5		Corporate	Attestation	**The practice has, and demonstrates use of, materials to support patients and families/ caregivers in self-management and shared decision making. The practice:**		100%: 5-7 factors 75%: 4 factors 50%: 3 factors 25% 1-2 factors 0%: 0 factors	3.75
				4E1			Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients+	Report showing percentage of patients provided educational resources.	1) Identify HealthWise products that meet standard for anticoagulation education, re-educate staff to use these rather than AHRQ document 2) Audit, give regular feedback to care teams, and encourage increased use of HealthWise material	
				4E2			Provides educational materials and resources to patients	At least three examples resources, tools or aids.	Identify resources and have on file with documentation	
				4E3			Provides self-management tools to record self-care results	At least three examples resources, tools or aids.	1) Develop branded HRHCare blood sugar, BP and/or other logs, and/or smart phone app 2) Develop documentation in eCW that patient has/used self-mgmt tool.	
				4E4			Adopts shared decision making aids	At least three examples resources, tools or aids.	1) Define shared decision making aids 2) Create tools 3) Create documentation of tools	
				4E5			Offers or refers patients to structured health education programs such as group classes and peer support	At least three examples resources, tools or aids.	Identify resources and have on file with documentation	
				4E6			Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates	Materials demonstrating that the practice offers at least five resources.	Identify materials to be assessed (see 4E7). (Varies by site)	
				4E7			Assesses usefulness of identified community resources.	Survey or materials showing how the practice collects information on the usefulness of referrals to community resources.	Develop assessment of usefulness of identified community resources Implement the assessment Collect and analyze assessment	

~~20 Things~~

10 Things

The Ten Things:

	Standard Satisfied
1) Medication reconciliation	3D1, 3D2
2) Instruct patients about new medications	3D3
3) Provide a visit summary to every patient at the end of each visit	3C5
4) Provide the Diabetes/CVH Encounter form for each patient with a diagnosis of diabetes or hypertension, or who is currently a smoker	3C2
5) Pre-visit planning, using an updated care team model	3C1
6) Contact patients who need specific chronic or preventive care services, or who have not had an appointment	2D1, 2D2, 2D3
7) Provide and document appropriate services at “transitions of care”	5C1, 5C2, 5C3, 5C4
8) Counsel patients for tobacco cessation and document in preventive medicine	UDS Quality Measure
9) Refer patients who are obese and/or have diabetes or hypertension to a nutritionist	UDS Quality Measure
10) Use the Formula for Good Health to help patients set goals toward healthy behaviors	4A3

Test, Christa
407506

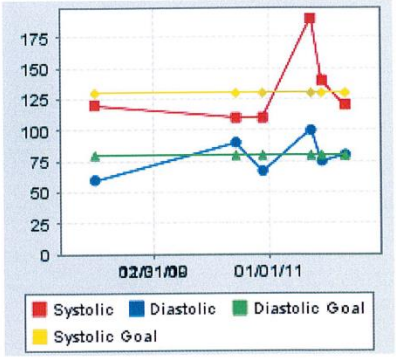
Patient Summary as of: 02/08/2012

Your Weight History

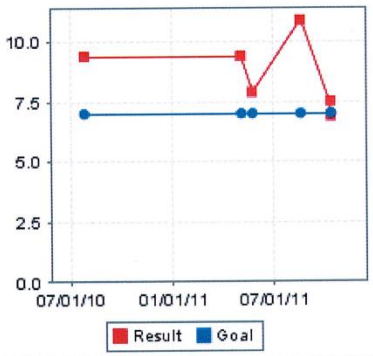
Your weight and blood pressure history:

Date	Weight	Blood Pressure
08/29/2011	145.0	120/80
06/21/2011		140/75
05/19/2011	133.0	190/100
12/14/2010	200.0	110/67
09/21/2010	125.0	110/90
07/01/2009		120/60
Your Goal Weight:		123
Your Goal BP :		130/80

Your Blood Pressure History



Your HbA1c History



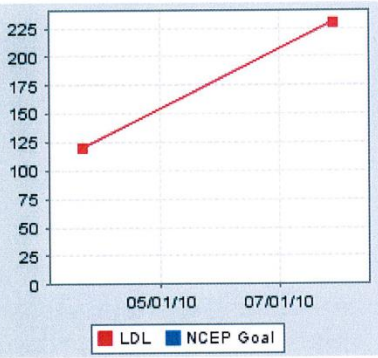
Your HbA1c history:

Date	Result
10/11/2011	6.9
10/10/2011	7.5
08/18/2011	10.9
05/24/2011	7.9
05/04/2011	9.4
07/27/2010	9.4

Recommendations:

Test/Treatment Type:
GlycoHgb(HbA1c)
Standard for your care:
Check every 6 months:Goal < 7
Additional Information:
Measures average blood glucose over the last 3 months

Your LDL History



Your LDL history:

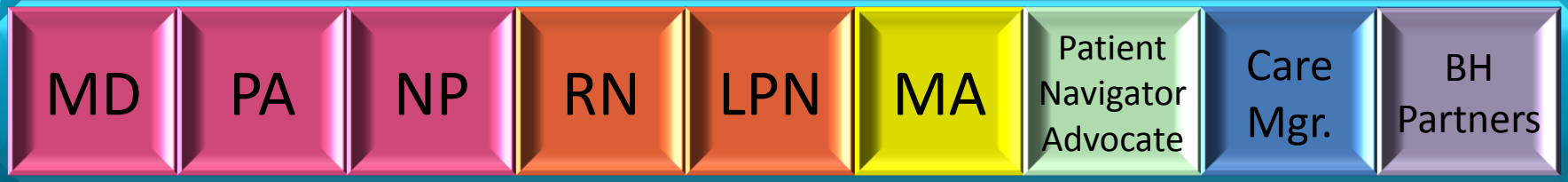
Date	Result
07/29/2010	230.0
03/22/2010	120.0

	Current	Goal
Cholesterol	250.0	200
Triglyceride		
HDL	1020.0	>40

LDL checks for "bad" cholestrol that can increase risk of heart attacks

Generated By eClinicalWorks

Care Team Model



Updated Care Team Model

Phase	Responsibility	Task	Suggested
Before visit	Schedule appointment	Calls to patients with HTN, DM, and smokers (as well as "high risk" patients) who have not been seen, and to those needing 2-year immunizations, mammogram, or pneumovax	Patient reps, PCPs
		When scheduling, ask for reason for visit and enter in "Chief Complaint"	
	Confirmation calls	Is this your appointment?	Patient rep
		Is the time correct?	Patient rep
		Do you plan to keep this appointment?	Patient rep
		Have you been to the ER since we last saw you?	Patient rep
		Have you seen another provider since we last saw you?	Patient rep
		(If "yes" to one of previous two questions) have you had any tests done that were ordered by a provider outside HRHCare?	Patient rep
		Please bring your medications with you	Patient rep
	Chart Prep (day before or day of, if walk-in)	Chief complaint	Nurse
		Pre-op clearance	Nurse
		CPE	Nurse
		Diabetes	Nurse
		Other chief complaint-oriented activities	Nurse
	CDSS	Prepare for all outstanding alerts	Nurse
		Pediatric and Adolescent Immunizations	Nurse
	Review Last visit	Labs	PCP
		X-rays / DI	PCP
		Referrals	PCP
		Other Tests	PCP
		a. Were they done?	PCP
		b. Is the report back? (if not, request it)	PCP
Day of Visit	Huddle	5-10 minutes-Pt Rep, MA, Provider before session to discuss day's strategy	Provider, nurse, PCP, patient rep all together

The Ten Things:
#10: The Formula for Good Health

The Formula for Good Health

		I do this now ✓	I'm interested in trying ✓
	0 Cigarettes	.....	.....
	5 Servings of fruits and vegetables per day	.....	.....
	10 Minutes of silence, relaxation or meditation per day	.....	.....
	30 Body Mass Index < 30 kg/m²	.....	.....
	150 Minutes of exercise per week (e.g., brisk walking or equivalent)	.....	.....

HRHCare HUDSON RIVER COMMUNITY HEALTH

Produced by Hudson River HealthCare with permission from Colin Kopes-Kerr, MD, MPH, JD

What can a **Healthy Lifestyle** do for **You?**

14 recent studies from the medical literature show that just these **5 simple habits** can reduce your chance of developing...

- **Type 2 Diabetes** by **93%**
- **Hypertension** by **78%**
- **Heart Attacks** by **83%**
- **Strokes** by **79%**
- **Heart Failure** by **47%**
- All **Cancers** by **36-64%**
- & reduce your overall chance of **dying early** by **40-65%**

This is the #1 way to stay healthy and to prevent serious diseases!

HRHCare HUDSON RIVER COMMUNITY HEALTH

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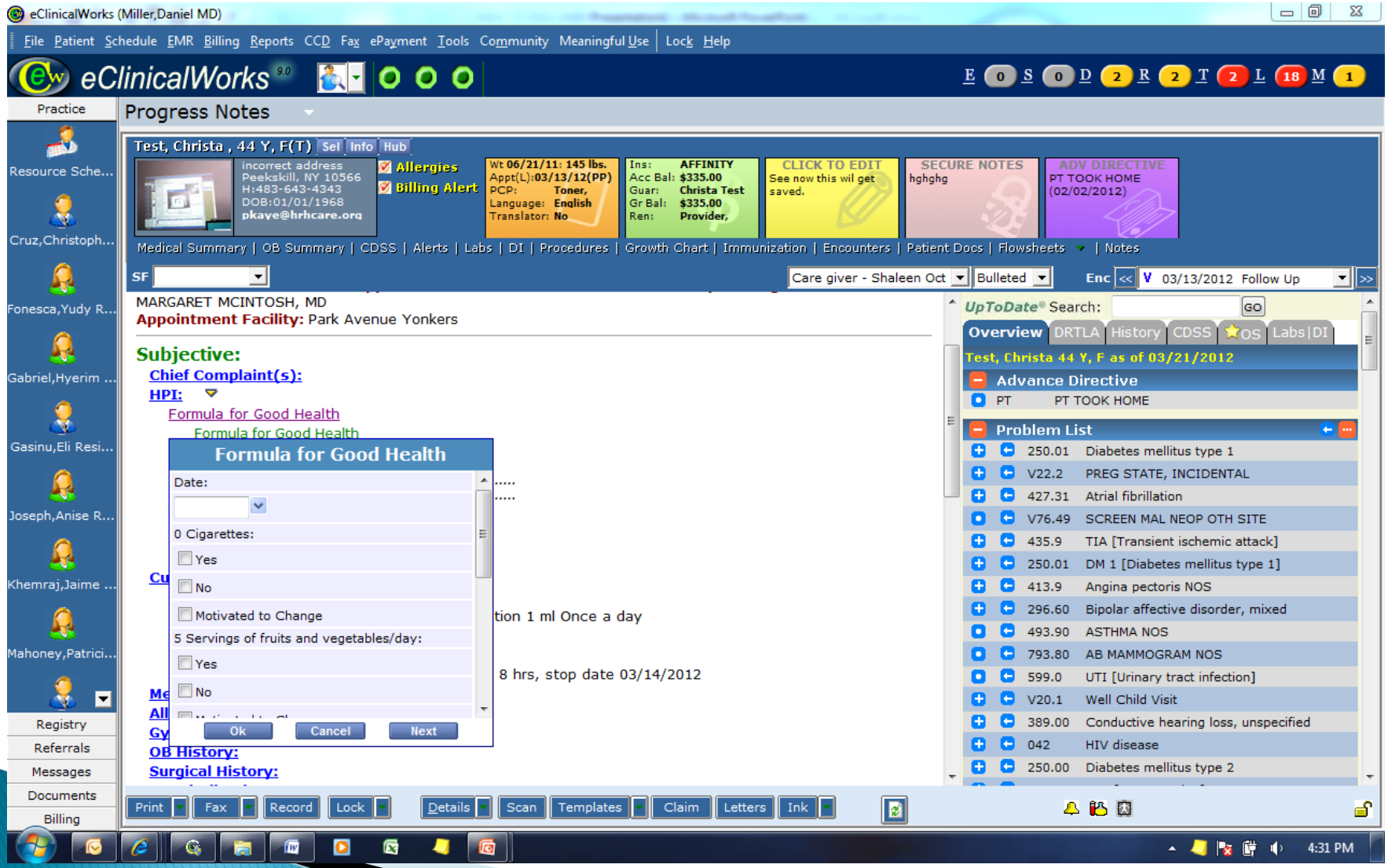
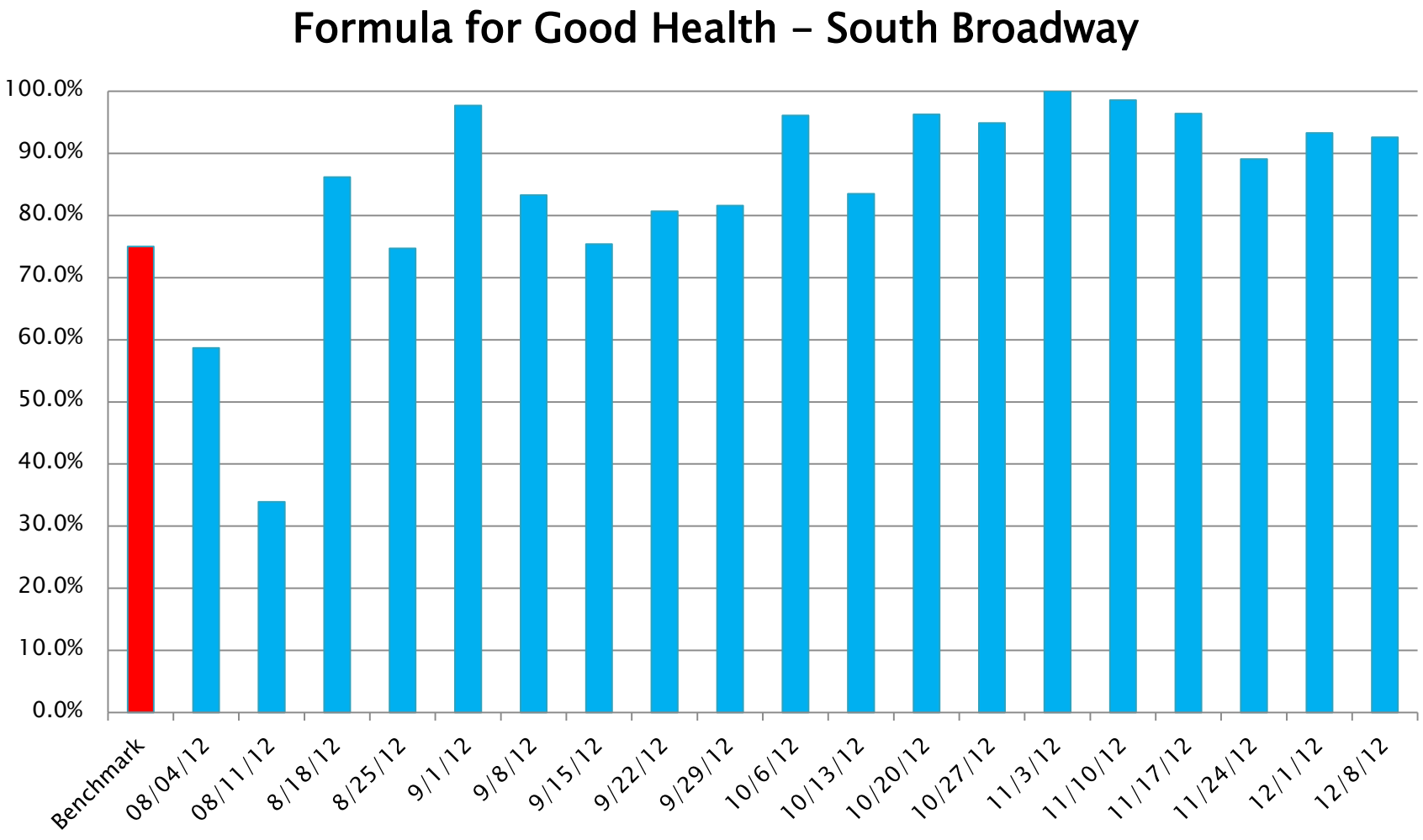
Formula for Good Health Documentation



Spread and Inspire Change

Site-specific trend for one measure

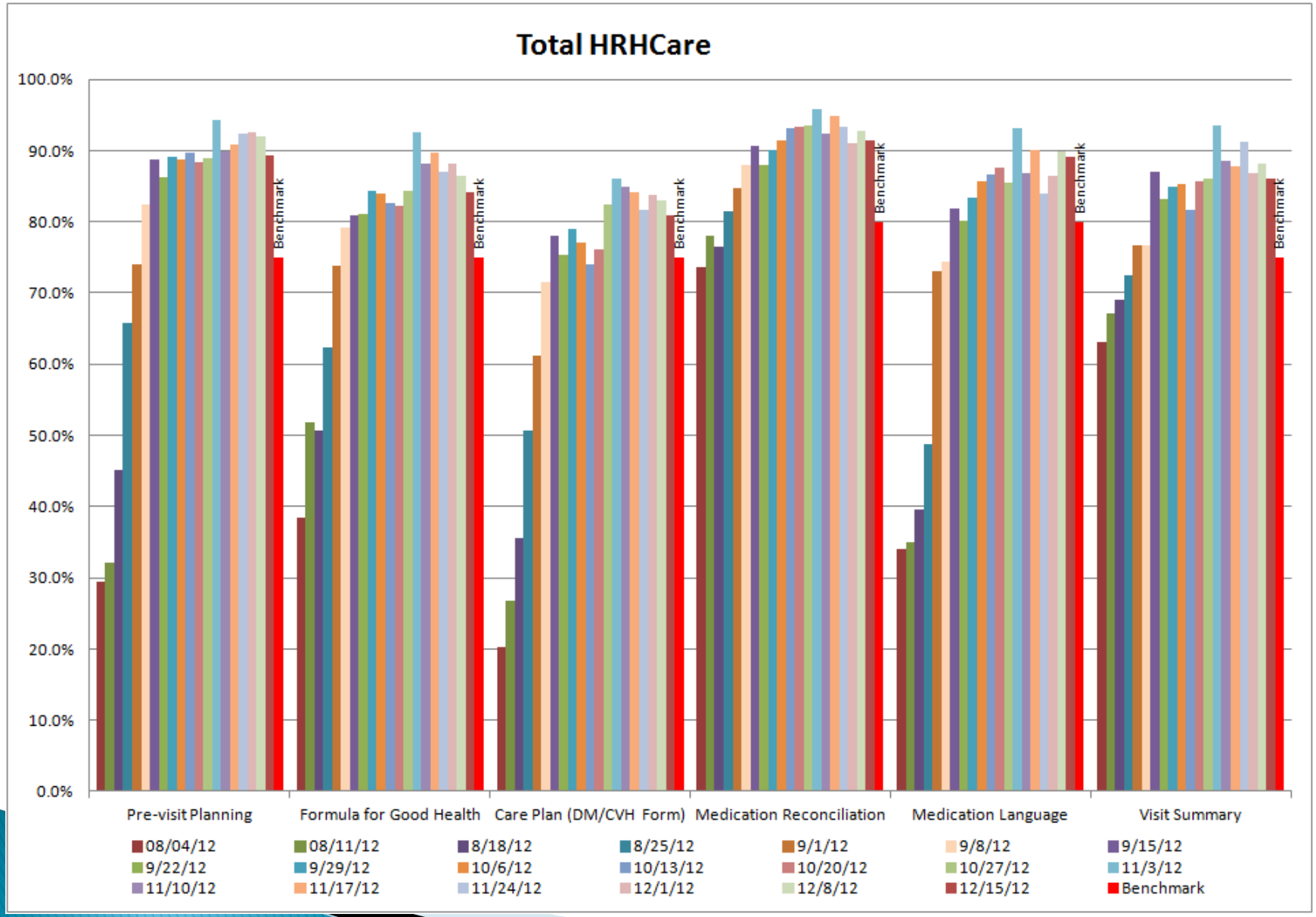


Key measures by site and provider

Week ending 12/8/12	Visit Provider	# of patients	Med Language	Reconcile Meds	Pre-Visit Plan	Care Plan DM/CVH	Visit Summary	FFGH
Location (Visit Facility)	*Benchmark*		*80.0%*	*80.0%*	*75.0%*	*75.0%*	*75.0%*	*50.0%*
Alamo	Provider A	1	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Provider B	20	85.0%	90.0%	100.0%	85.0%	80.0%	90.0%
	Provider C	3	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%
Alamo - Total		**24**	**79.2%**	**91.7%**	**100.0%**	**87.5%**	**83.3%**	**91.7%**
Amenia	Provider A	6	83.3%	100.0%	100.0%	100.0%	100.0%	100.0%
	Provider B	36	88.9%	97.2%	91.7%	80.6%	94.4%	100.0%
	Provider C	12	100.0%	100.0%	100.0%	100.0%	91.7%	100.0%
	Provider D	35	91.4%	100.0%	94.3%	74.3%	100.0%	94.3%
	Provider E	12	100.0%	100.0%	100.0%	100.0%	91.7%	91.7%
	Provider F	25	100.0%	96.0%	96.0%	84.0%	96.0%	92.0%
Amenia - Total		**126**	**93.7%**	**98.4%**	**95.2%**	**84.1%**	**96.0%**	**96.0%**
Beacon	Provider A	59	94.9%	100.0%	100.0%	93.2%	100.0%	91.5%
	Provider B	31	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Provider C	10	60.0%	60.0%	100.0%	70.0%	90.0%	100.0%
	Provider D	13	100.0%	100.0%	92.3%	92.3%	92.3%	92.3%
	Provider E	52	100.0%	100.0%	100.0%	90.4%	98.1%	96.0%
Beacon - Total		**165**	**95.8%**	**97.6%**	**99.4%**	**92.1%**	**98.2%**	**95.1%**
Dover Plains	Provider A	34	85.3%	88.2%	100.0%	85.3%	100.0%	90.9%
	Provider B	17	100.0%	94.1%	100.0%	100.0%	94.1%	100.0%
Dover Plains - Total		**51**	**90.2%**	**90.2%**	**100.0%**	**90.2%**	**98.0%**	**94.0%**
Greenport	Provider A	16	87.5%	100.0%	100.0%	93.8%	93.8%	93.8%
	Provider B	31	74.2%	64.5%	77.4%	64.5%	71.0%	60.0%
Greenport - Total		**47**	**78.7%**	**76.6%**	**85.1%**	**74.5%**	**78.7%**	**71.7%**
Haverstraw	Provider A	35	100.0%	94.3%	100.0%	100.0%	77.1%	97.1%
	Provider B	9	66.7%	77.8%	88.9%	66.7%	77.8%	77.8%
Haverstraw - Total		**44**	**93.2%**	**90.9%**	**97.7%**	**93.2%**	**77.3%**	**93.2%**
Monticello	Provider A	10	90.0%	90.0%	90.0%	90.0%	70.0%	90.0%
	Provider B	10	100.0%	60.0%	100.0%	100.0%	80.0%	100.0%
	Provider C	22	86.4%	95.5%	95.5%	90.9%	95.5%	90.5%
	Provider D	12	75.0%	83.3%	91.7%	75.0%	83.3%	66.7%
	Provider E	15	86.7%	100.0%	100.0%	73.3%	100.0%	93.3%
	Provider F	13	100.0%	100.0%	100.0%	100.0%	84.6%	84.6%
Monticello - Total		**82**	**89.0%**	**90.2%**	**96.3%**	**87.8%**	**87.8%**	**87.7%**
Overall HRHCare		**1,278**	**89.8%**	**92.8%**	**91.9%**	**83.0%**	**88.1%**	**86.5%**

"Must Pass" elements are highlighted in blue.

Organizational trend on key measures



PCMH 2014 Update

Timeline

- December 31, 2014: *suggested* last date to submit 2011 corporate survey tools
- March 31, 2015: last date to submit 2011 survey tools

PCMH 2014 Update

(6 standards/27 elements)

1) Enhance Access and Continuity (10)
   - A) *Patient-Centered Appointment Access
   - B) 24/7 Access to Clinical Advice
   - C) Electronic Access
2) Team-Based Care (12)
   - A) Continuity
   - B) Medical Home Responsibilities
   - C) Culturally and Linguistically Appropriate Services
   - D) *The Practice Team
3) Identify and Manage Patient Populations (20)
   - A) Patient Information
   - B) Clinical Data
   - C) Comprehensive Health Assessment
   - D) *Use Data for Population Management
   - E) Implement Evidence-Based Decision Support
4) Plan and Manage Care (20)
   - A) Identify Patients for Care Management
   - B) *Care Planning and Self-Care Support
   - C) Medication Management
   - D) Use Electronic Prescribing
   - E) Support Self-Care and Shared Decision Making
5) Track and Coordinate Care (18)
   - A) Test Tracking and Follow-Up
   - B) *Referral Tracking and Follow-Up
   - C) Coordinate Care Transitions
6) Performance Measurement and Quality Improvement (20)
   - A) Measure Clinical Quality Performance
   - B) Measure Resource Use and Care Coordination
   - C) Measure Patient/Family Experience
   - D) *Implement Continuous Quality Improvement
   - E) Demonstrate Continuous Quality Improvement
   - F) Report Performance
   - G) Use Certified EHR Technology

*Indicates Must Pass Element

Scoring Levels

Level 1: 35-59 points.
Level 2: 60-84 points.
Level 3: 85-100 points.

PCMH 2011 vs. PCMH 2014

PCMH 2011	PCMH 2014
1. Enhance Access & Continuity	1. Enhance Access and Continuity
	2. Team-Based Care
2. Identify & Manage Populations	3. Identify & Manage Patient Populations
3. Plan & Manage Care	4. Plan and Manage Care
4. Provide Self-Care Support & Community Resources	
5. Track & Coordinate Care	5. Track & Coordinate Care
6. Measure & Improve Performance	6. Performance Measurement and Quality Improvement

Key Changes to PCMH 2014

1. Additional emphasis on team-based care.
   - Team-focused elements have been moved to their own standard (new PCMH 2: Team-Based Care).
   - To highlight the importance of the patient as part of the team, incorporating patients in improvement activities has moved (from PCMH 6 to PCMH 2).
2. Focus care management on high-need populations.
   - Evidence-based decision support on a range of topics (previously 'three important conditions') moved to standard PCMH 3: Identify and Manage Populations.
   - Expect practices to identify patients who may benefit from care management and self-care support.
   - Criteria should consider social determinants of health, behavioral health, high cost/utilization, poorly controlled or complex conditions and patients 'referred'.

Key Changes to PCMH Recognition (cont.)

3. Higher bar and alignment of Quality Improvement (QI) activities with the triple aim.
   - Practices must make efforts in all three domains (patient experience, cost and clinical quality).
   - Practices must conduct activities at least annually and are subject to audit; renewing practices will continue to benefit from streamlined requirements around existing capabilities to focus on improving outcomes.
4. Alignment with Meaningful Use Stage 2 (MU2)
   - Until March 2015, practices may elect to seek PCMH 2011 recognition (MU1) or use the updated program (MU2).
   - MU2 is not a requirement for recognition.

Key Changes to PCMH Recognition (cont.)

5. Further Integration of Behavioral Health.
   - The updated criteria delineate capability related to treating unhealthy behaviors and conditions related to mental health or substance abuse
   - It asks practices to communicate the scope of services available including how behavioral health concerns are addressed.
   - New referral requirements include specific factors on establishing relationships with behavioral health providers.

PCMH: Not Enough Time

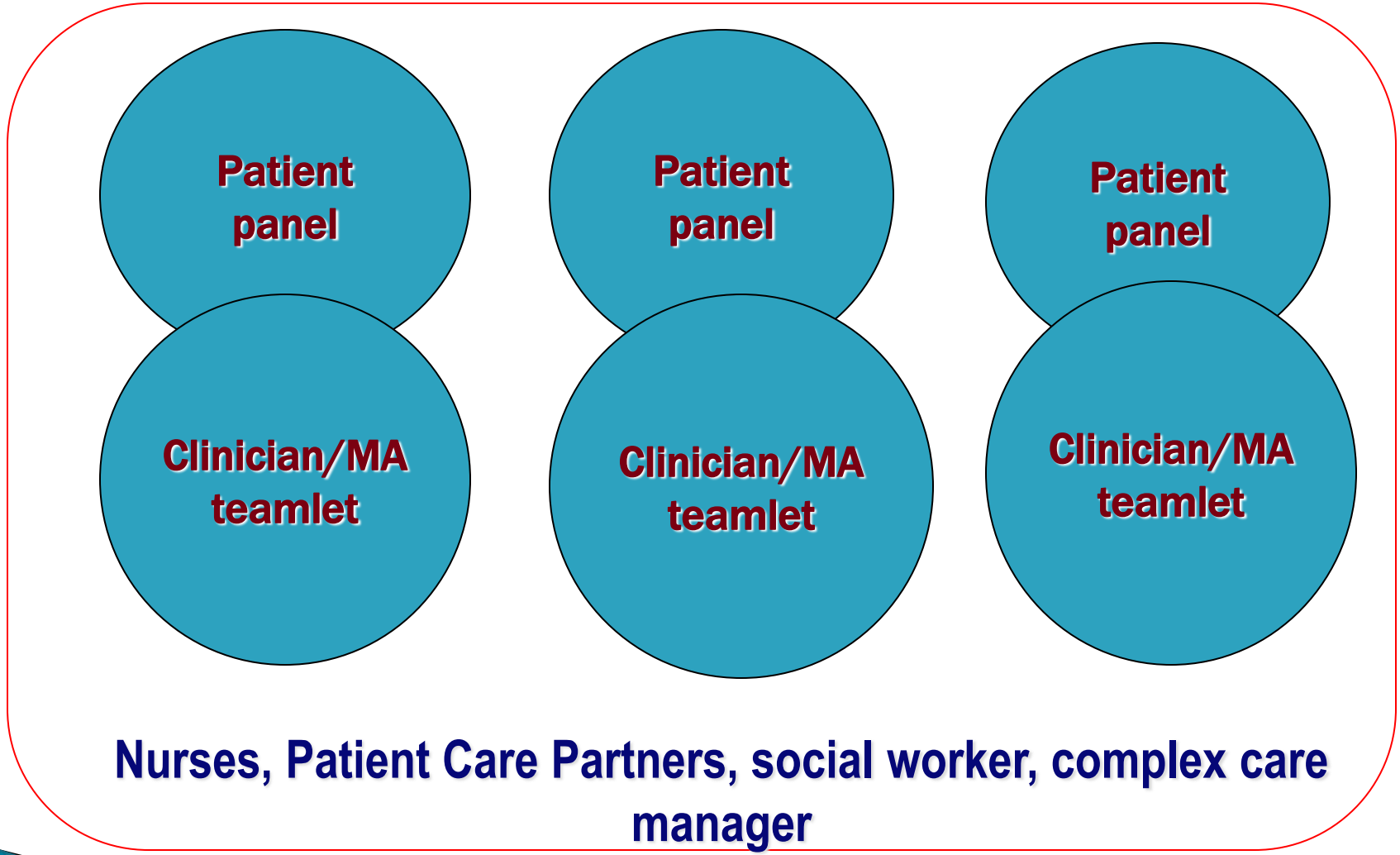
Table 2. Time Required to Meet Current Clinical Guideline Recommendations

Type of Visit	Hours/Day	Hours/Week	% of Clinical Time
Acute	3.7[a]	18.4	17.0
Chronic	10.6[b]	53.0	48.9
Preventive	7.4[c]	37.0	34.1
Total	21.7	108.4	100.0

Yarnall, et al 2009


TRUTH
C. Barsotti

Team-based care: stable teamlets



1 team, 3 teamlets

South Broadway Yonkers (53) - Site Quality Report for January, 2014

Category	Measure	Org. Avg.	Bench Mark	Report Month Site (%)	Report Month Site (n)	Previous Month Site (%)	3-Months Ago Site (%)	1-Year Ago Site (%)
Effective / Equitable	Childhood Immunizations	80.4%	86.0% (1)	87.8%	41	83.9%	85.1%	59.4%
	Childhood Lead Screening	75.6%	94.0% (5)	90.7%	43	92.3%	88.9%	91.8%
	Childhood Weight Counseling	59.7%	77.0% (1)	72.7%	326	81.1%	77.7%	34.6%
	Adult Weight Management	52.4%	77.0% (1)	83.2%	660	83.7%	38.7%	42.2%
	Tobacco Cessation Counseling	75.2%	81.0% (1)	80.2%	131	86.5%	80.3%	78.3%
	Asthma Therapy	61.0%	91.0% (1)	75.0%	8	75.0%	40.0%	60.0%
	Diabetic LDL Control (<100)	59.5%	50.0% (3)	57.1%	98	52.4%	45.6%	57.6%
	Diabetic HbA1C Control (>9)	25.0%	15.0% (3)	28.3%	106	36.8%	25.2%	27.8%
	Hypertensive BP Control (<140/90)	60.6%	68.0% (1)	67.4%	172	68.3%	64.2%	60.5%
	CAD Patients w/ Lipid-Lowering Meds	75.1%	72.0% (5)	87.5%	8	100.0%	85.7%	87.5%
	IVD Patients w/ Antithrombotic Meds	69.8%	72.0% (5)	88.9%	9	66.7%	77.8%	85.7%
	Breast Cancer Screening	42.4%	65.0% (1)	38.9%	144	32.3%	79.4%	79.1%
	Cervical Cancer Screening	49.1%	79.0% (1)	68.5%	518	61.8%	59.1%	57.5%
	Colorectal Cancer Screening	8.0%	74.0% (5)	5.9%	203	5.9%	11.6%	8.6%
	HIV Screening	38.6%	100.0% (5)	47.9%	693	51.5%	40.3%	49.2%
	HIV Viral Load Control (<200)	87.1%	90.0% (5)					
	Positive PHQ2 FollowUp (PHQ9)	77.9%	76.0% (4)	93.0%	142	90.1%	86.5%	71.6%
Safety	Lab/DI/Procedure (Outstanding)	86.4%		48.8%	2,271	61.4%	77.0%	
	Lab/DI/Procedure (ToBeReviewed)	1.4%		0.6%	8,946	0.4%	0.8%	
	Referrals	30.3%		29.9%	5,021	31.6%	35.9%	
	Telephone Encounters	3.8%		5.1%	1,247	2.4%	0.8%	
	Electronic Prescription Rate	71.5%	40.0% (6)	86.7%	3,679	84.4%	80.4%	81.3%
Access	New Patient Rate	12.0%	5.0% (7)	9.0%	1,459	6.7%	10.0%	9.6%
	Retention Rate	65.5%	90.0% (7)	72.7%	5,719	73.2%	73.1%	72.0%
	Prenatal Entry into Care	77.7%	93.0% (1)	74.7%	79	71.6%	85.1%	78.9%
	Preventive Dental Rate	39.9%	90.0% (7)	46.3%	389	45.7%	48.2%	33.3%
	Medical-to-Dental Crossover Rate	14.1%		7.4%	1,227	5.3%	4.4%	0.0%
Vital	Unlocked Encounters	1,909		4.2%	1,696	1.8%	5.1%	0.0%
	Encounters - Report Month	81.8%	100.0% (7)	71.3%	1,613	86.7%	141.7%	N/A
	Encounters - Report YTD	81.8%	100.0% (7)	71.3%	1,613			
	Average Productivity		18 (7)	12.75		18.93	19.23	19.35
	Average Productivity - Dental		12 (7)			8.45	7.23	
	Broken Appt Rate	35.7%	25.0% (7)	37.3%	2,995	37.5%	35.5%	29.7%
	No-Show Rate	14.0%	10.0% (7)	18.3%	2,995	20.5%	17.8%	15.9%
	Utilization Rate			103.3%		105.2%	106.4%	N/A
Patient-Centered	PCG Accuracy	76.8%	85.0% (7)	78.5%	1,440	72.1%	69.4%	81.7%
	Phone - Avg Wait Time	1m, 38s	30 Sec. (7)	2 mins., 20 secs.		2 mins., 15 secs.	3 mins., 20 secs.	N/A
	Phone - Call Answer Rate	82.7%	85.0% (7)	72.1%	4,164	69.0%	65.0%	N/A
	CAHPS - Positive Feedback	85.8%	90.0% (7)	83.2%	12	82.2%	86.2%	87.6%
Timely	CAHPS - Access To Care	81.2%	90.0% (7)	71.4%		76.5%	74.2%	72.3%
	Time to 3rd Appointment - Days	4.0		0.8		1.3	3.7	2.2

Benchmark Sources: 1 (2012 NCQA 90th %tile), 3 (2012 DRP), 4 (2012 Organizational Avg), 5 (Other), 6 (Meaningful Use), 7 (Organizational Goal)

HRHCare Clinician Practice Information

Provider: **Miller MD, Daniel (458927)**
Provider's Discipline: **(01) Family Physician**
Provider's Location (Primary): **South Broadway Yonkers (53)**

Report Year: **2013**
Report Specific Time-Period: **Quarter 4**
# of Providers at Location (Same Discipline): **3**
# of Providers in Organization (Same Discipline): **46**

Description	Provider Data		Comparative Data Internal (Same Discipline)	
	Patient Count	% of Patients	Location	Organization
Hypertension	53	14.0%	14.5%	22.5%
Diabetes	31	8.2%	8.2%	10.8%
IVD, CAD, CVD, and PVD	13	3.4%	3.1%	4.7%
HIV and AIDS	0	0.0%	0.1%	0.4%
Asthma	33	8.7%	6.2%	7.5%
Obesity (Child >= 95%, Adult >= 30)	133	35.2%	35.5%	36.0%
Developmental Delay	51	13.5%	7.9%	4.7%
Depression	66	17.5%	10.0%	8.1%
Bipolar and Schizophrenia	18	4.8%	3.1%	4.7%
Chronic Opioid Use	6	2.0%	1.4%	3.3%
Chronic Medications (>5)	38	12.7%	16.6%	19.0%
Payer Mix - Uninsured	56	14.8%	22.6%	37.0%
Payer Mix - Medicaid (NYS Straight)	13	3.4%	5.3%	5.1%
Payer Mix - Medicaid Mngd Care (FHP/MCD)	176	46.6%	45.5%	26.9%
Payer Mix - Commercial	83	22.0%	17.3%	17.4%
Payer Mix - Medicare (Straight and HMO)	24	6.3%	5.2%	10.6%
Payer Mix - ACA Exchange	0	0.0%	0.0%	0.0%
Special Populations - Homeless	3	0.8%	1.0%	7.7%
Special Populations - Migrant/Seasonal	3	0.8%	1.2%	6.9%
Special Populations - Public Housing	7	1.9%	2.6%	3.7%
Poverty Level - 100% and below	223	59.0%	60.8%	45.1%
Poverty Level - 101% - 150%	17	4.5%	5.5%	10.5%
Poverty Level - 151% - 200%	8	2.1%	1.8%	4.0%
Poverty Level - 201% and above	7	1.9%	1.1%	5.7%
Age Group - Age 1 and under	2	0.5%	0.9%	1.9%
Age Group - Age 2 - 5	10	2.6%	2.1%	3.4%
Age Group - Age 6 - 11	21	5.6%	4.8%	4.3%
Age Group - Age 12 - 21	62	16.4%	18.6%	11.1%
Age Group - Age 22 - 64	267	70.6%	69.0%	70.3%
Age Group - Age 65 - 69	8	2.1%	2.2%	3.4%
Age Group - Age 70 - 74	3	0.8%	0.9%	2.2%
Age Group - Age 75 - 79	1	0.3%	0.7%	1.5%
Age Group - Age 80 - 84	2	0.5%	0.4%	0.9%
Age Group - Age 85 and over	2	0.5%	0.3%	0.8%
Actual Panel Size	378	N/A		
Weighted Panel Size	357	94.4%		
Provider FTE(s)				
Weighted Panel Size per 1 FTE				

NOTE: This comprehensive data is based on 2-years worth of medical visits up to and including the last day of the reporting period; where the provider listed above was the patient's PCG as of the date the data was imported into the system.

Miller MD, Daniel (458927) - Quality Report for 2013 (Q4)

Category	Measure	Org Avg	Site Avg	Bench Mark	2013 (Q4) (%)	2013 (Q4) (n)	2013 (Q3) (%)	2013 (Q2) (%)
Effective / Equitable	Childhood Immunizations	78.4%	86.3%	86.0% (1)	100.0%	1	100.0%	0.0%
	Childhood Lead Screening	71.9%	91.3%	94.0% (5)				
	Childhood Weight Counseling	63.9%	79.7%	77.0% (1)	52.2%	23	50.0%	38.9%
	Adult Weight Management	51.6%	80.2%	77.0% (1)	55.4%	121	48.1%	51.3%
	Tobacco Cessation Counseling	70.3%	81.3%	81.0% (1)	83.3%	18	73.9%	72.7%
	Asthma Therapy	36.9%	44.0%	91.0% (1)	0.0%	2	66.7%	100.0%
	Diabetic LDL Control (<100)	58.9%	51.2%	50.0% (3)	80.0%	10	90.9%	80.0%
	Diabetic HbA1C Control (>9)	20.5%	29.0%	15.0% (3)	63.6%	11	30.8%	40.0%
	Hypertensive BP Control (<140/90)	64.5%	69.6%	68.0% (1)	70.0%	20	66.7%	69.2%
	CAD Patients w/ Lipid-Lowering Meds	72.9%	93.3%	72.0% (5)	100.0%	2	100.0%	100.0%
	IVD Patients w/ Antithrombotic Meds	50.2%	52.6%	72.0% (5)	33.3%	3	100.0%	0.0%
	Breast Cancer Screening	40.5%	36.2%	65.0% (1)	47.4%	19	90.0%	88.9%
	Cervical Cancer Screening	37.9%	59.0%	79.0% (1)	44.2%	43	53.7%	51.0%
	Colorectal Cancer Screening	6.2%	7.0%	74.0% (5)	55.9%	34	62.2%	48.7%
	HIV Screening	30.6%	43.8%	100.0% (5)	57.9%	121	54.3%	61.0%
	HIV Viral Load Control (<200)	84.1%		90.0% (5)				
	Positive PHQ2 FollowUp (PHQ9)	77.9%	86.4%	76.0% (4)	100.0%	21	100.0%	95.5%
Safety	Lab/DI/Procedure (Outstanding)	19,368	1,157		93	115	78	0
	Lab/DI/Procedure (ToBeReviewed)	1,030	36		0	389	0	0
	Referrals (Provider Logic)	13,308	1,578		0	0	2	0
	Telephone Encounters	1,297	84		0	75	2	0
	Electronic Prescription Rate	69.6%	84.1%	40.0% (6)	86.2%	247	88.6%	80.5%
Access	New Patient Rate	16.5%	11.9%	5.0% (7)	9.7%	155	18.1%	18.5%
	Retention Rate	65.8%	73.2%	90.0% (7)	72.2%	273	71.0%	70.1%
	Prenatal Entry into Care	71.0%	73.8%	93.0% (1)	100.0%	2	100.0%	80.0%
	Medical-to-Dental Crossover Rate	13.6%	5.2%		6.8%	146	4.1%	0.7%
Vital	Unlocked Encounters	970	24		0	179	0	0
	Broken Appt Rate	34.4%	36.6%	25.0% (7)	44.1%	320	31.3%	34.6%
	No-Show Rate	15.8%	19.4%	10.0% (7)	14.7%	320	17.1%	16.7%
Patient-Centered	PCG Accuracy	75.3%	70.2%	85.0% (7)	77.2%	197	77.5%	91.7%

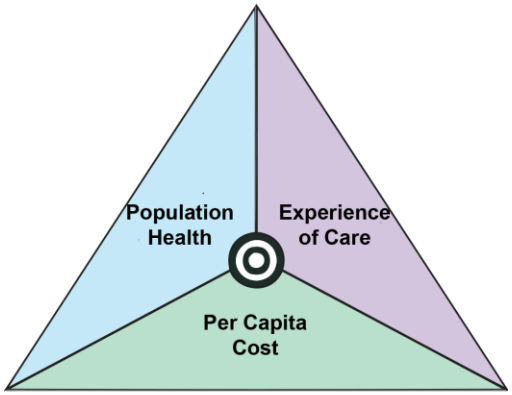
Most Recent Benchmark Sources: 1 (2013 NCQA 90th %tile), 3 (2012 DRP), 4 (2012 Organizational Avg), 5 (Other), 6 (Meaningful Use), 7 (Organizational Goal)

Preventive Care Patient-Specific Standing Orders

Condition	Gender	Age	Order
Breast Cancer	F	50 - 74	Order "Mammogram – screening" for all women who have not had one performed within the last 2 years.
Colon Cancer	F,M	50 - 75	Refer to a gastroenterologist for "colonoscopy" if one has not been performed within the previous 10 years and the patient has not a negative FIT test within the prior 1 year Or Order FIT test every year.
Cervical Cancer	F	21-65	Make an appointment for a Pap smear for all women who have not had one completed within the last 3 years. If done elsewhere, obtain patient consent and request copy of result.
Pneumococcal Vaccine (PPSV)	F,M	65 and over	Administer once (See Pneumococcal Vaccine Standing Order).
HCV EIA	F,M	Born between 1945-1965	Order HCV EIA blood test once.
Chlamydia	F	16-24	Obtain urine specimen and order "Chlamydia/GC RRNA, Aptima, Urine" once yearly
Urine Pregnancy	F	Any	Perform test for all females who request it or when clinically indicated
HIV Point of Care Test	F, M	Any	Perform test for all who request it or when clinically indicated
Urinalysis Point of Care Test	F,M	Any	Perform test when clinically indicated
Venous Lead Level	F,M	12-24 months	Order Venous Lead Level if not already performed in this age range.

PCMH

Triple Aim



IHI Triple Aim

Let’s talk about it

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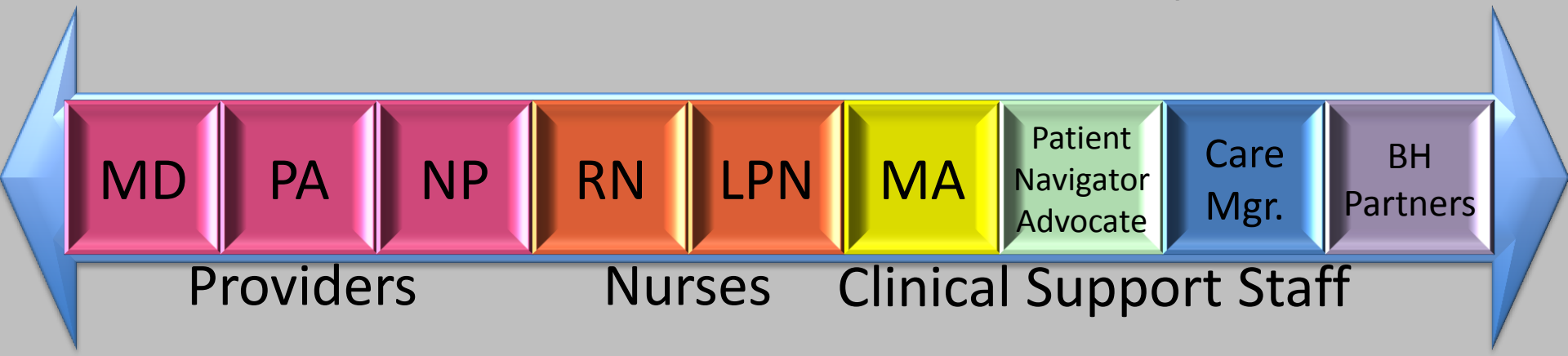
Standards Roles Tasks Crosswalk Tool

Standard/Element	Factor Verbiage	Task(s)	Patient Centered Clinical Roles									
			MD	PA	NP	RN	LPN	MA	Pt. Navigator Advocate	Care Mgr.	BH Partners	Soci
PCMH - 1 Access (1MU/3MH)	(3MU/16MH)											
PCMH (1C) - Electronic Access	*More than 50 percent of patients have online access to their health information within four business days of when the information is available to the practice+.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	*More than 5 percent of patients view, and are provided the capability to download, their health information or transmit their health information to a third party+.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	*Clinical summaries are provided within 1 business day(s) for more than 50 percent of office visits+.											
	*A secure message was sent to more than 5 percent of patients+.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
MU (C7) - Pt. Online Access MU (C8) - Clinical Summaries MU (C17) - Secure Messaging	7.More than **50 percent** of patients have **online access** to their health information within **four business days** of when the information is available to the practice+. More than **5 percent** of patients view, and are provided the capability to download, their health information or transmit their health information to a third party+. 8.Provide **clinical summaries** for patients for each office visit. Clinical summaries provided to patients or patient-authorized representatives **within 1 business day** for more than **50 percent** of office visits. 17. Use secure electronic messaging to communicate with patients on relevant health information.	☐ Use secure messaging with pts	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
			☑MU-C17	☑MU-C17	☐	☐	☐	☐	☑MU-C17	☐	☐	☐
PCMH - 2 - Team Based Care (0MU/4MH)	(0MU/26MH)											
PCMH - 3 Pop. Health Mgt. (4MU/5MH)	(7MU/46MH)											
PCMH (3A) - Pt. Information	The practice uses an **electronic system to records patient information**, including capturing information for factors 1–13 as structured (searchable) data for more than 80 percent of its patients	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
MU (C3) - Demographics	3. Record the following demographics: • Preferred language	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

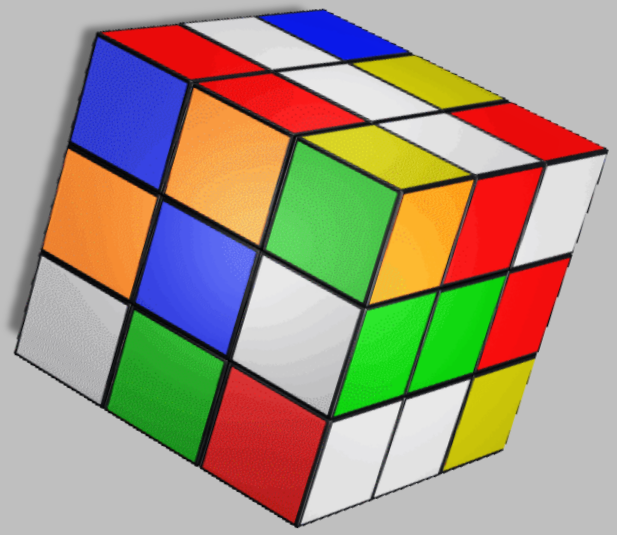
Sheet1 Sheet2 +

Normal View Ready Sum=0

Standard Role Task Activity



1. Select the Role You Wish to Play
2. Move to that table
3. Define tasks for each of 18 overlapped standards
4. Write them on post it notes
5. Post the tasks on the appropriate wall chart
6. Discuss

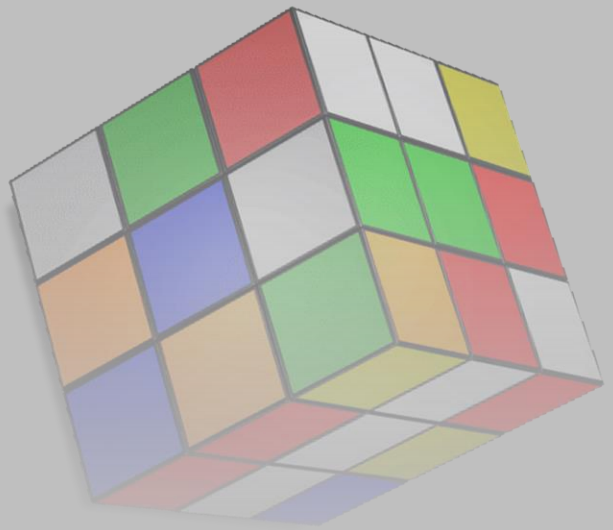


Interactive Exercise Personalizing

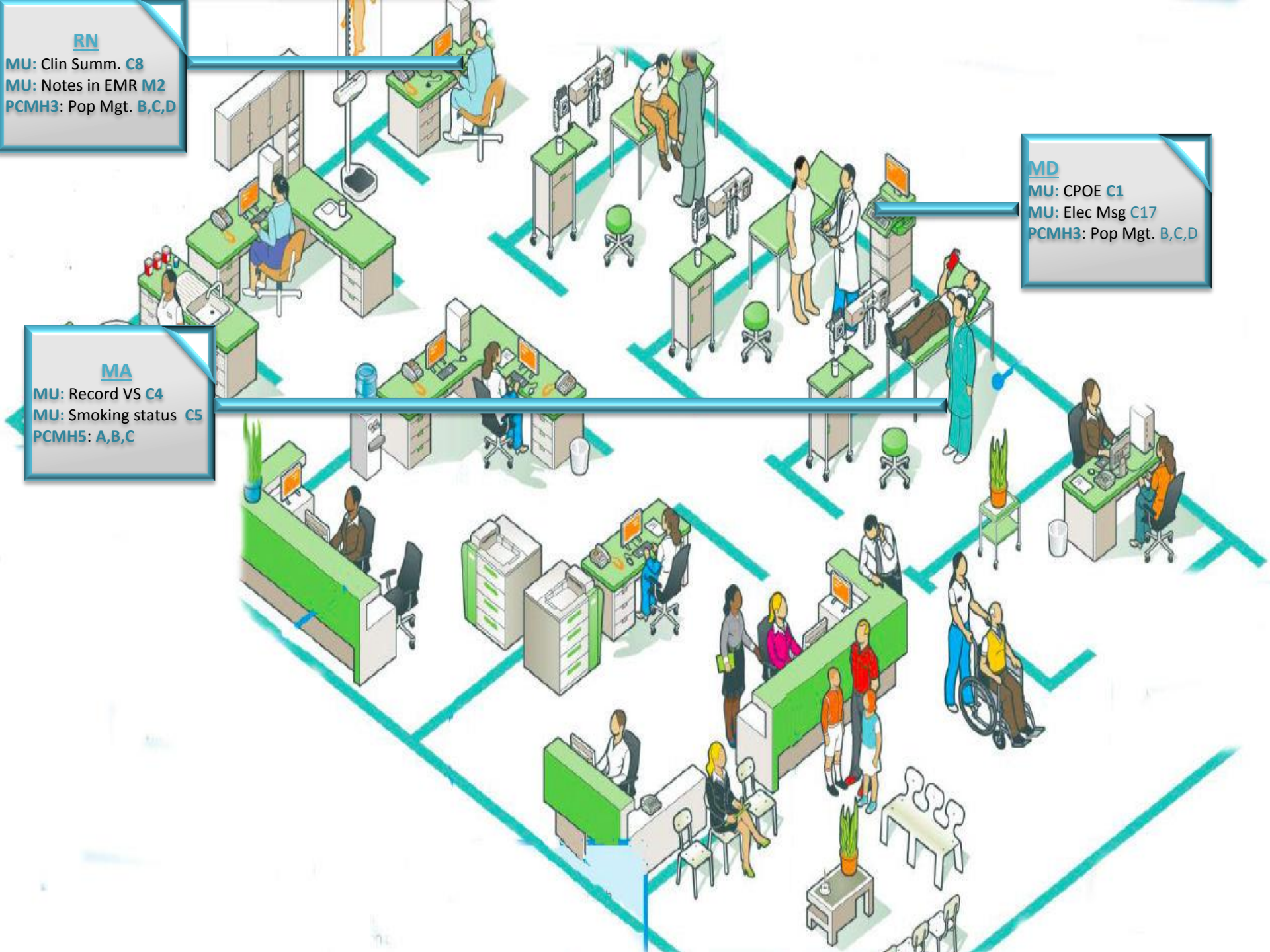
Standards

Roles

Tasks



The Results


RN
MU: Clin Summ. C8
MU: Notes in EMR M2
PCMH3: Pop Mgt. B,C,D
MD
MU: CPOE C1
MU: Elec Msg C17
PCMH3: Pop Mgt. B,C,D
MA
MU: Record VS C4
MU: Smoking status C5
PCMH5: A,B,C

Let’s talk about it

PRIMARY CARE
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Peter Cucchiara is the Managing Director of the Performance Improvement Practice for Primary Care Development Corporation (PCDC). He has built a performance improvement consultancy and led the development of a portfolio of assessment, implementation and evaluation life-cycle services around Patient Centered Medical Home, HIT/Meaningful Use and practice operations improvement.

PCDC has delivered these services throughout New York and around the country to hundreds of FQHCs and other primary care organizations. Currently the PCDC Performance Improvement Practice is delivering a unique set of integrated meaningful use and medical home adoption and evaluation services to primary care practices and consortiums nationally. Under Mr. Cucchiara's direction the Performance Improvement Practice has advanced its product and service lines to not only include assessment and implementation tools and methods but also to include the delivery of process and performance improvement evaluation and analysis services.

Peter Cucchiara is a senior HIT Executive with over 30 years of experience in adding value in small to mid-size private and public organizations by leveraging Health Information Technology as a catalyst for business growth. He leads efforts in strategic plan realization, business development, and in product and services development for many types of Healthcare and Healthcare Professional Services organizations. Further areas of experience include organizational embrace of technology, operations, Electronic Medical Records, primary care performance improvement and medical informatics.

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Daniel Miller, MD is a practicing Family Physician and the Chief of Clinical Quality and Training for Hudson River HealthCare (HRHCare), a not-for-profit, New York State licensed, federally qualified health center (FQHC) with 22 primary care sites in 10 New York county regions serving over 100,000 patients annually. In 2000, HRHCare was one of the first Community Health Centers in the nation to adopt an electronic medical record. In 2009, it received its first recognition from NCQA as a Level 3 PCMH and was recognized again at the same level in 2013. In addition, HRHCare has been accredited since 1998 for both its primary and behavioral healthcare services by The Joint Commission (TJC) and is a Ryan White funded program, providing comprehensive HIV clinical care and social work case management to approximately 400 patients and their families.

HRHCare was awarded the prestigious 2011 HIMSS Davies Community Health Organization Award of Excellence for outstanding achievement in the implementation and value derived from its EHR. It is a New York State designated Health Home and has recently formed and ACO with 2 sister FQHC's.

In his role at HRHCare, Dr. Miller coordinates all clinical quality improvement and training initiatives as well as all PCMH and TJC endeavors and the workflow redesign they inspire. In 2013 he was invited by NCQA to be member of their PCMH Advisory Committee that helped create the 2014 PCMH standards.

Dr. Miller has been board-certified by the American Board of Family Medicine since 1987. He is a graduate of Brown University and the University of Cincinnati College of Medicine and completed his family medicine residency training in Montefiore Medical Center's Residency Program in Social Medicine. He is an Assistant Professor of Family Medicine at New York Medical College.

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