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Leading Internal Medicine, Impro

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Table 2: Breakdown of Medical Neighborhood Model Quarterly Payments

CCF payment for 3 months of patients.	One-third of PBPA

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Measure Name	Applicable Specialty	Measure Type	Valid per ACP Review
Therapy for Left Ventricular Systolic Dysfunction (QID 005; NQF 0081)			
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) (QID 0083)	Cardiology	Process	Yes

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Patient -Centered Access and Continuity (AC) 56

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QI 03 Goals and Actions to Improve

TC 03 (1 Credit) Collaboration With the Medical Neighborhood : The practice is involved in external medical neighborhood collaborative activities.

Competency B: Team Communication. The practice facilitates communication among staff to ensure that patient care is coordinated, safe and effective.

TC 06 (Core) Individ ual Patient Care Meetings/Communication: Has regular patient care team meetings or a structured communication process focused on individual patient care.	
GUIDANCE	EVIDENCE
The practice has a structured communication	

Competency C: Practice Responsibilities. The practice defines and communicates its role DQG WKH SDWLHQW¶V UROH LQ WKH PHGLFDO QHLJKERUKRRG PRGHO

TC 08 (Core) Specialty Practice Information: Has a process for informing patients/families/caregivers about its role and responsibilities and provides materials that contain the information.	
GUIDANCE	EVIDENCE
The practice has a process for informing and providing patients/families/caregivers with information about its role and responsibilities at the start of care and throughout the care trajectory. Reminding patients periodically ensures that they have ready access to essential information and available resources. The practice is encouraged to provide the information in multiple formats, to accommodate patient preference and language needs. At a minimum, materials include: x Names and phone numbers of practice points of contact. x Instructions for reaching the practice after office hours. x A list of services offered by the practice. x How the practice uses evidence-based care. x A list of resources for patient education and self-management support. The practice explains to patients the importance of maintaining comprehensive information about their health care. It describes how and where (e.g., specialty practice, primary care office, ED) patients should access the care they need.	xDocumented process AND xEvidence of implementation

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Symbol Legend

Initial Referral Management (R M)

The practice sets expectations for referrals and care transitions from primary care and other referring clinicians to deliver high-quality, coordinated care.

Competency A: Care Coordination With Primary Care and Other Referring Clinicians. The practice coordinates with primary care and referring clinicians to ensure timely exchange of information.

RM 01 (Core) Setting Expectations With Referring Clinicians: Works with frequently referring clinicians to set expectations for information shari ng and patient care.	
GUIDANCE	EVIDENCE
The practice promotes effective communication and care coordination by establishing ongoing, collaborative relationships with primary care and other clinicians. Relationships between primary care clinicians and specialists support a coordinated, safe, high-quality care experience for patients. The practice shares information that includes, but is not limited to: x How it interacts and communicates with referring clinicians. x How it shares and exchanges information about patient care. The practice has relationships with primary care and other referring clinicians, regardless of the type of specialty (e.g., procedure-focused, behavioral health, obstetrics-gynecology) or the nature of clinical interactions (consultative, referral and treatment, co-management, temporary or long-term principal care).	xEvidence of implementation OR xRM 02
RM 02 (1 Credit) Agreements With Referring Clinicians: Has agreements with a subset of primary care or other referring clinicians.	
GUIDANCE	EVIDENCE
The practice has jointly agreed upon procedures (referral/care coordination agreements and care compacts) and provides two examples. Agreements or care compacts define the general referral guidelines and exchange of information to expedite timeliness and appropriateness of referrals, J D W K H U L Q I R U P D W L R Q D E R X W W and improve coordination of patient care, as agreed on by the primary care or other referring clinician and the specialty practice. Agreements between specialist and primary care define communication processes for secondary referrals. Agreements may be formal or informal and do not need to be legally binding. The practice determines the number of agreements it needs with referring clinicians but should consider creating agreements with clinicians with whom it commonly works.	x

RM 03 (Core) Communicating Referral Requests: Actively communicates receipt and status of referral requests, including all of the following:

A. Receipt and acceptance of the referral.

B. Date and time of patient appointments.

C. Information the

RM 04 (Core) Verifies Receipt of Information: Verifies that it has received the necessary information from referring clinicians to determine how to proceed with the referral, and:

A. Tracks receipt of the clinical question to be answered, the referral type and the urgency.

B. Assesses if the clinical question is within the scope of the practice.

C.

Competency B: Practice Response to Initial Referrals. The practice facilitates comprehensive care coordination by providing timely, complete and relevant responses to primary care providers and referring clinicians.

RM 06 (Core) Follow -Up After Missed Appointments and Cancellations: Has a process for handling

RM 11 (Core) Contacting the Primary Care Clinician Prior to Treatment: Determines if the primary care clinician needs to be contacted prior to treatment.	
GUIDANCE	

KM 05 (1 Credit) Behavioral Health Screenings: Conducts behavioral health screenings and/or assessments using a standardized tool to ensure accurate diagnosis, treatment and follow -up (implement one or more):

A. Depression.
B. Anxiety.

Competency B: Patient Diversity. The practice uses information about the characteristics of its patient population to provide culturally and linguistically appropriate services.

KM 06 (Core) Diversity: Assesses the diversity (race, ethnicity and one other aspect of diversity) of its population.	
GUIDANCE	EVIDENCE
The practice collects information on how patients identify in at least three areas that include: 1. Race. 2. Ethnicity. 3. One other aspect of diversity, which may include, but is not limited to, gender identity, sexual orientation, religion, occupation, geographic residence. Assessing the diversity of its population can help a practice identify subpopulations with specialized needs or that are subject to systemic barriers, leading to disparities in health outcomes. The practice may collect data directly from patients or may use data about the community (e.g., zip code analysis, community level census data) it serves.	xReport

KM 07

KM 08 (2 Credits) Staff Cultural Competence and Health Literacy Skills:	Educates staff about cultural

Competency C: Medication Management . The practice addresses medication safety and adherence by documenting and reconciliating medications, educating patients about new prescriptions and coordinating with primary care and other referring clinicians.

KM 09 (Core) Document and Reconcile Medications: Documents and reconciles prescription and nonprescription medications for more than 80 percent of patients .	
GUIDANCE	EVIDENCE
The practice maintains an accurate, dated list of all medications a patient is taking and addresses potential conflicts (e.g. incorrect name, dosage, frequency and drug-drug interactions). The list includes prescription and nonprescription medications	

KM 10 (1 Credit) New Prescription Education: Assesses understanding and provides education, as needed, on new prescriptions for more than 50 percent of patients/families/caregivers.	
GUIDANCE	EVIDENCE
The practice uses patient-centered methods, such as open-ended questions (teach-back collaborative method), to assess patient understanding of new medications prescribed by the specialist. Educational materials are designed with regard to patient need (e.g., reading level). Medication is not taken as prescribed 50 percent of the time. (Source: CDC) Barriers to adherence, such as not understanding directions and confusion amongst multiple medication regimens, lead to poorer health outcomes and compromise patient safety.	xReport AND xEvidence of implementation

KM 11 (Core) Managing Medication With the Care Team: Coordinates medication management with primary care, the referring clinician and the patient/family/caregiver.	
GUIDANCE	EVIDENCE
The practice coordinates the exchange of information with the primary care clinician and other referring clinicians about changes in medications. These clinicians share responsibility for managing medication needs and coordinating medication information th U R X J K R X W W K H S D.W L H Q Expectations about information exchange may be established in the expectations set between providers in RM 01 or in an agreement in RM 02. Providers are not prescribing in isolation, so it is critical to patient safety and care coordination to collaboratively manage the medications the patient is taking with the entire care team. The practice involves the patients/families/ caregivers in the coordination and reconciliation of medication. Practices find greater patient engagement if staff reconcile medications with the patient/family/ F D U H J L Y H U D Q s-medication S [list.	[redacted] ion

Competency D: Evidence -Based Care. The practice ensures that it provides effective and efficient care by incorporating evidence-based clinical decision support relevant to patient conditions and the population served.

KM 15 (Core) Proactive Reminder: Identifies and proactively reminds patients of one condition - related service.	
GUIDANCE	

KM 17 (Core) Clinical Decision Support: Adopts at least one diagnostic or therapeutic clinical decision support at the point of care relevant to the population served.

KM 19 (1 Credit) Pathways for Symptom Management: Adopts clinical pathways for symptom management that are relevant to the population served.	
GUIDANCE	EVIDENCE
The practice has a process for identifying and implementing pathways for symptom management that address common symptoms or medication side effects experienced by its patient population. Using pathways to triage symptoms ensures that they are addressed and managed appropriately to prevent unnecessary ED and hospital utilization. When patients call the practice, the telephone triage team uses standardized symptom management protocols to provide a response based on described symptoms. During business hours, staff are available to answer and triage patient calls appropriately. After business hours, an on-call clinician is available to address patient concerns in a timely manner.	xIdentifies conditions, source of guidelines AND xEvidence of implementation

KM 20 (2 Credits) Excellence in Performance: Demonstrates excellence in a benchmarked/ performance -based Recognition program assessed using evidence -based care guidelines.	
GUIDANCE	EVIDENCE
At least 75 percent of eligible clinicians have earned NCQA HSRP or DRP Recognition. Alternatively, the practice demonstrates that it participates in a program that uses a standardized set of measures to benchmark participant results, has a process to validate measure integrity and publicly reports results. The practice shows (through reports) that clinical performance is above national or regional averages. Examples of programs may include MN Community Measures, $ 6 & 2 ¶ V 4® 2.3, certification, IHA or other performance-based Recognition program.	xReport OR xHSRP or DRP Recognition for at least 75% of eligible clinicians

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Knowing and Managing Your Patients (KM)

AC 03 (1 Credit) Patient Portal : Has a secure electronic system where patients can (must show at least three) :

A. Request appointments.

B.

AC

Patient-Centered Access and Continuity (AC)

Plan and Manage Car 10.8 BT /F3 9.96

Plan and Manage Care
(PM)

PM 04 (Core) Transition to Primary Care: Identifies patients transitioning back to primary care and communicates with the patient/family/caregiver about the care transition.	
GUIDANCE	EVIDENCE
The practice has a process for identifying patients who are ready to transition to a primary care clinician for principal care management. This includes all patient/provider relationships, especially those no longer requiring co-managed care. Specialists may determine if the patient is ready to transition back to primary care at the conclusion of treatment, after meeting care goals or upon reaching other milestones.	xDocumented process AND xEvidence of implementation

PM 05 (1 Credit) Discusses Barrier s to Treatment With the Primary Care Clinician: Uses the primary care clinician as a resource to gather information about barriers to treatment or adherence.	
GUIDANCE	EVIDENCE
The practice uses the patient ¶ V S U L P D U \ F D clinician to give the spe F L D O L V W L Q V L J K W L Q W environment and available services. Primary care clinicians often have a deeper understanding of I D F W R U V D I I H F W L Q J S D W L H Q W V work in the same neighborhoods as their patients. The primary care clinician may have solutions for alleviating barriers to care and can be a resource for insights into the best course of treatment3 200.9 re W	

PM 06 (Core) Communication Plan for Co -Managed Patients: Establishes a plan to communicate with the primary care clinician about routine updates or changes in the status of co -managed patients.	
GUIDANCE	EVIDENCE
The practice has a strategy for coordinating co-management with the primary care clinician. This specifies the care responsibilities of the primary care provider and the specialist. The specialist has a plan for providing the primary care clinician interim updates about the patient's care, which could include: x Changes in the patient ¶ status. x Plans for transition to hospice or other care transitions. x Missed appointments, for established patients. x Changes to a course of treatment. x Progress notes on continued care. x Other updates as established by the specialist and primary care clinician in the referral/care agreement or care compact. Establishing a co-management plan ensures that both providers understand their responsibilities.	xDocumented process AND xEvidence of implementation
PM 07 (1 Credit) Shared Decision -Making Process : Informs patients about treatment options and makes evidence available to them, to ensure collaborative and patient -centric treatment decisions.	
GUIDANCE	

Competency B: Care Management and Support . For patients with complex needs, the practice develops and shares care plans that address barriers and incorporate patient preferences and personal health goals.

Plan and Manage Care
(PM)

Competency C: Coordinating Patient -Centered Support During Treatment . The practice

PM 17 (2 Credits) Connects to Financial Resources: Engages with patients regarding cost implications of treatment options, provides information about current coverage and make connections to financial resources as needed. s	
GUIDANCE	EVIDENCE

CC 03 (Core) Referral Management continued	
GUIDANCE	EVIDENCE
C. A tracking report includes the date when a referral was initiated and the timing indicated for receiving the report. If the secondary specialist does not send a report, the practice contacts the V H F R Q G D U \ V S H F L D O L V W ¶ V R effort to retrieve the report in a log or an electronic system.	xDocumented process AND xEvidence of implementation
CC 04 (1 Credit) Notification of Secondary Referral Results: Ensures that the primary care clinician and the original referring clinician are notified of secondary referral results.	

Competency B : Diagnostic Test Tracking and Follow -Up. The practice tracks and manages diagnostic tests and shares the results with patients.

CC 05 (Core) Diagnostic Test Management: The practice systematically manages diagnostic tests, including lab and imaging, by:

A. Tracking diagnostic tests until results are available, flagging and following up on overdue results.

B. Flagging abnormal diagnostic results, bringing them to the attention of the clinician.

C. Notifying patients/families/caregivers about normal and abnormal diagnostic test results.

QI 01 (Core) Measure continued	
GUIDANCE	EVIDENCE
E. The practice (directly or through a survey vendor) conducts a patient survey to assess the patient/family/caregiver experience with the practice. The patient survey may be conducted as a written questionnaire (paper or electronic) or by telephone, and includes questions related to at least three of the following categories: x Access (may include routine, urgent and after-hours care). x Communication with the practice, clinicians DQG VWDII PD\ LQFOXGH ³II OLVWHQHG WR´ DQG ³DEOH TXHVWLRQV´ x Coordination of care (may include being informed and up to date on referrals to specialists, changes in medications and diagnostic results). x Person-centered care/self-management support (may include provision of comprehensive care and self-management support; emphasizing the spectrum of care needs, such as mental health, urgent care, advice, assistance and support for changing health habits and making health care decisions). F. Qualitative methods (e.g., focus groups, individual interviews, patient walkthrough, suggestion box) are another opportunity, distinct from surveys, to obtain feedback from patients. The practice may use a feedback methodology conducive to its patient population, such as ³YLUWXDO´ H J WHOHSKRQH participation. The requirement is not met by: x Comments that were collected on surveys to satisfy QI01, component E, and/or x Feedback collected by a Patient and Family Advisory Committees (PFAC) that represent more than one practice and/or do not depict the entire patient population. Measure resources x MIPS Quality Measures https://qpp.cms.gov/mips/quality-measures x $+54¶V 1DWLRQDO 4XDOLW\ 0H https://www.qualitymeasures.ahrq.gov/ x NatLRQDO 4XDOLW\ )RUXP¶V 4X System http://www.qualityforum.org/QPS/QPSTool.aspx	

Competency C: Assess and Set Goals to Reduce Disparities. The practice seeks to reduce disparities in care for its vulnerable patients by measuring, monitoring and acting to improve on stated goals.

QI 05 (Maximum 2 Credits) Health Disparities Assessment: Assesses health disparities using performance data stratified for vulnerable pop ulations: A. Clinical quality (1 Credit). B. Patient experience (1 Credit).	
GUIDANCE	EVIDENCE
The practice stratifies quantitative performance data	

QI 11 (2 Credits) Patient/Family/Caregiver Involvement in Quality Improvement: Involves the patient/family/caregiver in quality improvement activities.	
GUIDANCE	EVIDENCE