BEST Practices

1. Know and act on WHAT MATTERS TO PATIENTS.

In the Action and Planning Form intended for clinical staff, risk for hospitalization and emergency use is reported. The risk is based on the sum of five measures contained in the "What Matters Index"(WMI) : lack of confidence with self-management, significant emotional problems or pain, polypharmacy and medications may be causing illness. The WMI identifies risk as well as archetypical, computer generated risk models. (http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0192475). The WMI is also immediately treatable, easy interpretable measure that can be used by practices to compare their sickest or less sick patient reports to other practices. This option for adjustment is included for the summary and registry. However, except for practices only serving poor and very sick patients (e.g. Medicaid settings) or very healthy (e.g. college students) such adjustment is generally not necessary.

The best strategy is to use the Quality Summary to identify domains that are relatively more deficient to set improvement objectives. Once a deficiency is targeted the date selector can be used to document change using a "before-after" analysis. A recent example is described by Lynn Ho, MD, Jean Antonucci, MD. (Using Patient-Entered Data to Supercharge Self-Management. Ann Fam Med 2017;15:382. https://doi.org/10.1370/afm.2068). In support of their experience, the Center for Medicare and Medicaid Service recently endorsed HowsYourHealth.org as a useful tool for improving self-management.

Often underused but better in many ways that trying to have a representative patient advisory council is to use the open-ended option to ask HowsYourHealth.org respondents to make suggestions about ways to fix a problem you might have identified or suggest problems you have not identified.

Finally, your HowsYourHealth.org registry allows you to automatically select patients by many social determinants of health, WMI measures and common diagnoses. Practices use these lists of patients for special email contacts, focus groups, etc.

2. Disregard Proof at Your (and Your Patients) Peril

Simply summarized…well-timed, behaviorally sophisticated feedback between patients and clinicians des make a difference. This can be facilitate by continuity of care - Wasson JH, Sauvigne AE, Mogielnicki RP, et al. Continuity of outpatient medical care in elderly men: A randomized trial. *JAMA* 1984;252(17):2413-2417 - (with very large savings), telephone outreach in the form of "housecalls" - Wasson JH, Gaudette C, Whaley F, Sauvigne A, et al. Telephone care as a substitute for routine clinic follow-up. JAMA 1992;267(13):1788-1793 - with very large effect, and information technologies such as HowsYourHealth - Wasson JH, Stukel TA, Weiss JE,

Hays RD, Jette AM, Nelson EC. A Randomized Trial Of Using Patient Self-Assessment Data To Improve Community Practices. *Effective Clinical Practice* 1999; 2:1-10.

Sadly, we see more fragmentation of care, "outreach" for very few for illusory high cost savings, and many burdensome surveys that provide no useful services for patients or clinicians. The summary for the latter publication is particularly relevant to HYH.

" Ninety-three percent of the patients in intervention practices recalled receiving the tailored patient education materials, and 74% reported reading 3 or more of the 19 sections in the geriatric health manual". [Note this manual, modified from the National Institute of Aging, became a template for HYH chapters that evolved over the subsequent decades]

Furthermore:

"Two years after randomization, patients in intervention practices were more likely than patients in usual care practices to report receiving improved medical care, gaining a better understanding of several important threats to their health, and receiving greater assistance with some functional and clinical problems. The intervention rests on the well-documented observation that a synergistic interaction of standard health assessment, customized patient education, and productive physician–patient communication is necessary to improve care for old and chronically ill persons. The subgroup analysis suggests that increasing provider participation could greatly increase the benefit of the intervention. Unfortunately, we did not give physicians aggressive feedback about patient recall of the intervention. "

3. Interpreting You HowsYourHealth Summary Measures

100 is best. As a measure of equity of care, the Quality Summary lists all patients and those who have financial problems. The difference should be less than 10 absolute points.
In all Tables, "too few" indicates 6 or fewer measures in a cell. Measures are very stable when there are 60 or more; reasonably stable for 20 or more; and crude estimates when < 20.
For the period 2014-2017 the median and cutoff for the top third of over 100 typical clinical settings (in which about half of the patients have a chronic disease or bothersome functional limit) are shown below:

Exactly the Care…: median 40; upper third over 50.
Medical Home: median 70; upper third 80.
Excellent Information for Chronic Disease(s): median 70; upper third 80.
Aware of Functional Limits: median 50; upper third 65.
Patient Confident with Self-Management: median 55; upper third 60.
Preventive and Clinical Benchmarks: median75; upper third 80.
Patient Habits Generally Healthy: median 70; upper third 75.
No ED or Hospital Use in Year: median 90; upper third 92.
Patient Convinced Medications for Chronic Disease(s) Not Causing Illness: median 80; upper third 85.

4. Certifiers and Regulators Turn Toward Patient Report

As certifiers and regulators for the Patient-Centered Medical Home have increasingly become aware of the extreme inefficiency and lack of face validity of process-of-care documentation, they are gradually accepting the summary measure from HowsYourHealth.org to overcome these deficiencies. (HowsYourHealth.org meets NCQA criteria as an "approved" health risk assessment). As an example, for NCQA documentation of medical care access, continuity and coordination the HowsYourHealth.org patient-reported measures may obviate the need for excessive documentation of their processes.

> *Continuity: median 85; upper third 90.*
> *In Charge (Coordination if 2 or more clinicians): median 90; upper third 95.*
> *Very Easy Access: median 50; upper third 60.*

A few additional measures included above are also often requested by certifiers and regulators. (In fact, the comprehensive list of your patients' responses below will meet almost any reasonable request.

An additional example illustrates this point. Recently, some clinical sites that are being asked to measure and report social determinants of health according to a scheme proposed by the Institute of Medicine (IOM). To attain IOM suggested standards a practice using HowsYourHealth.org will be able to report measures for stress or emotional problems, health habits and behaviors, exposure to community violence and domestic abuse, physical activity limits, social connections and isolation, and financial status.

5. NCQA PCMH and HowsYourHealth.org. (HYH)

If you are applying for NCQH certification or recertification, you can use HYH to provide data.

Lynn Ho, MD of Rhode Island illustrates how this can be accomplished.

"If you are going through the NCQA process, I just qualified using HYH data for about 45 - 50 of the total 65 items required (of possible 100 items offered by NCQA)"

Just note below:

NCQA Criteria For PCMH	Content		HYH Component(s) Offered
Accepted by NCQA: about 50/100 possible criteria		Require all 40 core and 25 elective, 65 total to pass.	
Core (red) Elective (black)			
Knowing and Managing			
1. KM 01	Predominant practice conditions		BP, DM, CAD, respiratory, obesity
2. KM 02A	Medical History of Patient	They wanted to see this in EHR	BP, DM, CAD, respiratory, obesity

		Medical History of Family		CAD, DM, cancer, cholesterol, other
3.	KM 02B	Mental Health/Substance Use of Patient		emotional bothers, alcohol use, tobacco
4.	KM 02C	Family Characteristics Social Characteristics		Domestic violence screen Social Support
5.	KM 02D	Communication Needs	EHR	-
6.	KM 02E	Behaviors Affecting Health		Exercise, Nutrition, Seat belts
7.	KM 02F	Social Functioning		Social functioning
8.	KM 02G	Social Determinant of Health	Did they take this? Not sure	Financial Insufficiency
9.	KM 02H	Developmental Screen Peds	EHR	-
10.	KM 02I	Advance Care Planning		DPA designee, written instrument
11.	KM 03	Depression/Anxiety Screen		Provider aware, explanation and improved with treatment
12.	KM 04	Anxiety Screening Alcohol Screening	Did not try this but it should work	Provider aware, explanation and improved with treatment Alcohol >10/w, told to reduce
13.	KM 05	Oral health screening		-
14.	KM 06	Predominant practice conditions		Summary report (htn, dm, CAD, respiratory, obesity)
15.	KM 07	Social determinant of health		Financial insufficiency
16.	KM 08	Evaluate Pop-Health Literacy Comm		-
17.	KM09-10	Ass Pop Racial/Ethn Divers & Lang		-
18.	KM11A	Ass Pop Health Disparities		HYH disparity measure (choice)
19.	KM11B,C	Health Literacy or Cult Competency		-
20.	KM12	Proactive Reminders		-
21.	KM13	Excellence Benchmarked Program		HYH HTN, DM?
22.	KM14	Medication Reconciliation		-
23.	KM15	Updated Med List		-
24.	KM16	Assess Pt Knowledge of New Meds		-
25.	KM17	Assess Barriers to Med Adherence		
26.	KM18	Check PDMP prior to prescribing		
27.	KM19	Use Claims Data Addr Med Adherence		
28.	KM20A	Use Evidence Based CDS – mental health	respond to 4 (options A-G)	HYH – emotional screening and f/u data
29.	KM20B	Use Evidence Based CDS – alcohol use		HYH – alcohol use and f/u MI
30.	KM20C	Use Evidence Based CDS – chronic cond		Hypertension AND Diabetes
31.	KM20D	Use Evidence Based CDS- acute condition		-
32.	KM20E	Use Evidence Based CDS - lifestyle		Smoking, Obesity/nutrition
33.	KM20F	Use Evidence Based CDS - preventive		Pneumovax
34.	KM20G	Use Evidence Based CDS – overuse		-
35.	KM21	Use Pop Info to Prioritize Comm Resources		Sections on: ‘ bothered by’ , ‘concerned about’, ‘ aids used’ , ‘habits’, ‘ diagnoses’
36.	KM22	Access to Education		Action Plan chronic conditions; https://howsyourhealth.com/pblmslv/
37.	KM23	Provides Oral Health Resources		-
38.	KM24	Adopts Shared Decision Making		-
39.	KM25	Partners with Schools or other Agencies		-
40.	KM26	Updated List of Community Resources		Community resources- HYH action plan
41.	KM27	Assesses Utility of Resources (above)		-
42.	KM28	Regular Case Conf (outside practice)		-
Care Management				
43.	CM1-2	Care Management/Plans		Activate registry Report: total # surveys/total active pts seen in measurement year Virtual review: registry, action plans and integration of use into patient plan
44.	CM 03	Risk Stratification		If using registry this should satisfy

45. CM 4-5	Care Plans		If responding to care plans this should satisfy
46. CM 6-8	Patient preferences, goals, barriers SMS		Same as above
47. CM9	Share care plan across facilities	Not yet available in RI did not submit	? possible HYH interation with RI HIE
Access and Continuity			
Access		Process + access score as evidence	
48. AC 01	Survey access needs, same day/urgent during and after hours, phone advice		Practice access score > x% gives credit
49. AC 02	Provide same day appointments		Practice access score > x% gives credit
50. AC 03	Provide appnts outside usual business hrs		Practice access score > x% gives credit
51. AC 04	Provide timely clinical advice by phone		Practice access score > x% gives credit
52. AC 05	Document concordant clinical advice in chart		Practice access score > x% gives credit
53. AC 06	Provide appnt by phone or other tech		Practice access score > x% gives credit
54. AC 07	Sec pt request rxn,appnt,refill,result	No process doc required	Practice access score > x% gives credit
55. AC 08	Secure 2 way communication		Practice access score > x% gives credit
56. AC 09	Access disparities		Access disparity between “haves” and “have-nots”
Continuity			
57. AC10	Pick or change PCP	Process only (solos exempt)	Practice continuity score >x% gives credit
58. AC11	Monitor % visits with PCP/team	Evidence only	Practice continuity score >x% gives credit
59. AC12	Continuity medical record when office closed	Process only	-
60. AC13	Reviews and manages panel size	Process and report	Practice continuity score >x% gives credit
61. AC14	Rev and rec panel based on outside entity		-
Performance and Quality Improvement			
62. QI 01A	Immunizations	5 total (at least one each A-D)	69+ pneumonia vaccine rate
63. QI 01B	Preventive Care Measure		colon cancer screen rate OR mammogram rate
64. QI 01C	Chronic Care Measure		Blood pressure >150 OR Blood sugar > 140
65. QI 01D	Behavioral Health Measure		Aware of bothersome emotional
66. QI 02A	Care Coordination	2 total (one from each)	Practice coordination score
67. QI 02B	Health Care Costs		Hospital/ER for chronic disease
68. QI 03	Access		Practice access score
69. QI 04A	Patient Experience	Measure 3 of 4 options	
a.	Access		Practice access score
b.	Coordination		Practice coordination score
c.	Self-Management Support		Practice confidence score
d.	Whole Person Care		Practice global care score
70. QI 04B	Qualitative Survey	Elec survey comm not allowed	-
71. QI 05A	Clinical Quality – Disparities		Disparities BP not controlled
72. QI 05B	Patient Experience - Disparities		Disparities global care score
73. QI 06	Uses standardized survey		Refer to HYH entire report
74. QI 07	Obtains feedback from vulnerable population		Refer to HYH entire report disparities
75. QI 08	Sets goals and acts to improve on:	Pick 3 of 4 options	
a.	Immunizations		Pneumovax (or other)
b.	Other Preventive Care		Colon cancer screen or mamm (or other)
c.	Chronic or Acute Care Measures		BP or DM (or other)
d.	Behavioral Health Measures		Emotional (or? Alcohol or Tobacco)
76. QI 09	Sets goals and acts to improve on:	Pick 1 of 2 options	
a.	Hospital/ER use		Current ER/Hosp use for chronic disease
b.	Care coordination		Coordination
77. QI 10	Access Describe Actions/Set Goals		(Access score)

78. QI 11	Confidence Describe Act/Set Goals		(Confidence score)
79. QI 12	Improved Performance (2) QI 8, 9 or 11		(6 -12 month improvement, provider choice metrics)
80. QI 13	Disparities Describe Act/Set Goals		(provider choice)
81. QI 14	Improved Performance (1) Disparities (QI 13)		(provider choice)
Care Coordination and Care Transitions			
82. CC 01	Managing Lab and Imaging Results		-
83. CC 02	Obtaining newborn screens		-
84. CC 03	Protocols to determine testing need		-
85. CC 04	Managing Referrals to Specialists	Describe process	Practice coordination score >x% credit
86. CC 05	Use Clin Prot to determine refer need		-
87. CC 06	IDs specialists used by practice		?Practice coordination score >x% credit
88. CC 07	Use perf input on specialists to refer		-
89. CC 08	Works w/ non BH to set expectations		-
90. CC 09	Works w/ BH to set expectations		-
91. CC 10	Integrates behavioral health into site		-
92. CC 11	Assess specialist response	Process	? Practice coordination score >x% credit
93. CC 12	Co-management arrangements		-
94. CC 13	Engages with pts around cost	Process – document examples EHR	% of patients with financial hardship
95. CC 14-16	Care Transitions ER/Hosp		-
96. CC 17-20	Care Coordination Between Sites		-
97. CC 21	Electronic Info Exch/Entity		-
Team Based Care			
98. TC 1-2	Lead Transformation/Structure/Staff		-
99. TC 3-8	Ext PCMH activities, patient input governance, EHR, team meetings clinical/QI, CM for behavioral		-
100. TC 09	Medical home proselytizing		-