The Verden Group | PCS PATIENT CENTERED SOLUTIONS

Your Partner in Practice

# Utilizing The Patient Centered Medical Home for Improving Profit and Quality!

Palm Beach Pediatric Society
February 15th, 2017

# Objectives

- For participants to better understand the shift in care to patient-centric principles for primary and sub-specialty care
- To comprehensively discuss the NCQA patient-centered medical home program and how to begin to transition under 2014 or under the new standards (coming March 2017)
- To facilitate participants comprehension of how to successfully navigate a patient-centric program

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# Agenda

- Why become a recognized PCMH?
- What is the PCMH Program all about anyway?
- Getting started on your project
- A note about re-attestation: 2014 or 2017 Standards?
- What's coming under PCMH 2017

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# Why become a recognized medical home?

# Why Become a Medical Home?

- Improve patient care coordination
- Take advantage of incentive payments
- Help lower overall healthcare costs
- Ensure continued viability in Payer networks
- Compete with / prepare for ACO models
- Realize ROI on technology investments
- Florida MMA Plans paying 100% of Medicare to recognized practices!*

*May also require additional compliance with HEDIS measures, board certification

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# What Medical Home Programs Are There?

There are three primary programs (and these are the three recognized for the MMA Physician Incentive Program):

1. **Accreditation Association for Ambulatory Health Care (AAAHC)**
2. **The Joint Commission (TJC)**
3. **National Committee for Quality Assurance (NCQA)**

Each define their standards differently, but each shares a similar focus on identifying medical practices that exemplify the patient-centered medical home principals and practices.

*May also require additional compliance with HEDIS measures, board certification

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# Why Focus On NCQA PCMH?

NCQA is the most widely recognized across all plans, and the country.

More 11,974 practices, more than 59,000 clinicians recognized in 50 States

Starting from 214 clinicians at 28 practices in 2008, when the NCQA PCMH program debuted, and set to keep on growing . . .

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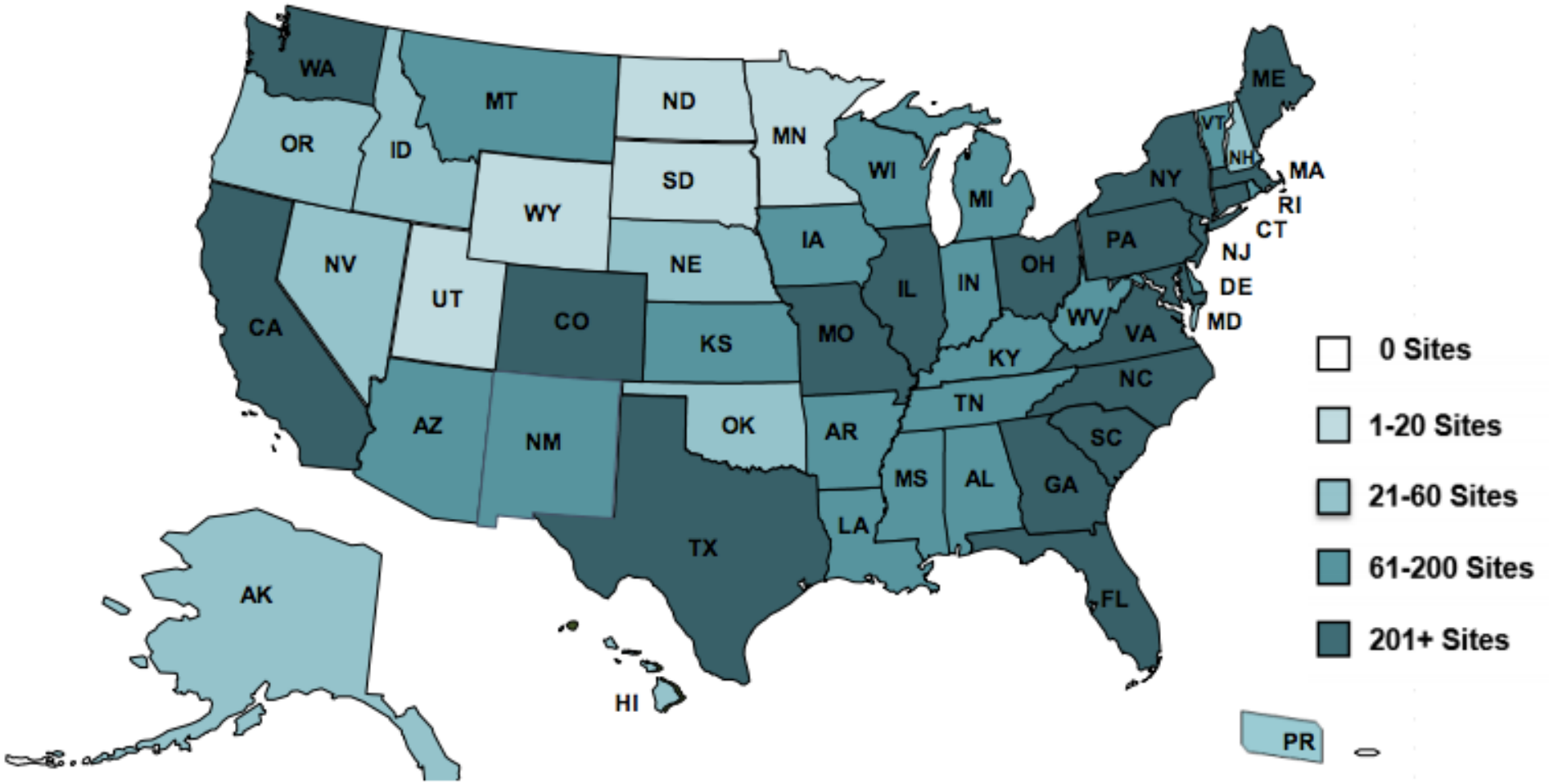
# About NCQA

*Recognition Programs*




**11,974 Recognized Practices**

**(As of January 1, 2017)**


1 in 6
Doctors practice in an NCQA-Recognized PCMH

# Florida MMA Incentive Program

The following Managed Medicaid companies are recognizing medical home models for qualification to the incentive program:

- Amerigroup
- Better Health*
- Coventry Health Care*
- Florida True Health / Prestige
- Molina Health Care*
- Simply Health Care Plans / Clear Health Alliance*
- Wellcare
- Sunshine State Health
- United Health Care of Florida

*May also require additional compliance with HEDIS measures, board certification

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# What Is The PCMH Program All About Anyway?

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# Key Components of PCMH*

- Personal Clinician
  - First contact, continuous, comprehensive, care team
- Whole Person Orientation
  - All patient health care needs; all stages of life; acute; chronic; preventive; end of life
- Coordinated
  - When and where needed/wanted; culturally and linguistically appropriate; use information technology

* Based on The Joint Principles

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# Focus of 2014 PCMH Standards

- Emphasis on team-based patient care
- Care management focus on high-need populations
- Alignment of quality improvement activities
- Reinforces incentives for meaningful use (HIT)
- Further integration of behavioral health
- Sustained transformation

➢ PCMH 2017 Rolling out on March 31, 2017
➢ Practices can submit under 2014 Standards until Sept 30, 2017

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# PCMH & MU

- NCQA emphasizes HIT because highly effective primary care is information-intensive
- PCMH 2014 reinforces incentives to use HIT to improve quality
- Stage 2 Meaningful Use language is embedded in PCMH 2014 standards
- Synergy: PCMH 2014 Recognized medical practices are well-positioned to qualify for meaningful use, and vice versa

- Note: many practices have not achieved MU2. NCQA have removed text throughout the Standards and Guidelines referring to Meaningful Use Stage 2 and added text to state “demonstrate alignment with Meaningful Use Modified Stage 2.”

# PCMH 2014 Content and Scoring

| 1: Enhance Access and Continuity | Pts |
|---|---|
| A. *Patient-Centered Appointment Access | 4.5 |
| B. 24/7 Access to Clinical Advice | 3.5 |
| C. Electronic Access | 2 |
| | 10 |

| 2: Team-Based Care | Pts |
|---|---|
| A. Continuity | 3 |
| B. Medical Home Responsibilities | 2.5 |
| C. Culturally and Linguistically Appropriate Services (CLAS) | 2.5 |
| D. *The Practice Team | 4 |
| | 12 |

| 3: Population Health Management | Pts |
|---|---|
| A. Patient Information | 3 |
| B. Clinical Data | 4 |
| C. Comprehensive Health Assessment | 4 |
| D. *Use Data for Population Management | 5 |
| E. Implement Evidence-Based Decision-Support | 4 |
| | 20 |

**Scoring Levels**

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

| 4: Plan and Manage Care | Pts |
|---|---|
| A. Identify Patients for Care Management | 4 |
| B. *Care Planning and Self-Care Support | 4 |
| C. Medication Management | 4 |
| D. Use Electronic Prescribing | 3 |
| E. Support Self-Care and Shared Decision-Making | 5 |
| | 20 |

| 5: Track and Coordinate Care | Pts |
|---|---|
| A. Test Tracking and Follow-Up | 6 |
| B. *Referral Tracking and Follow-Up | 6 |
| C. Coordinate Care Transitions | 6 |
| | 18 |

| 6: Measure and Improve Performance | Pts |
|---|---|
| A. Measure Clinical Quality Performance | 3 |
| B. Measure Resource Use and Care Coordination | 3 |
| C. Measure Patient/Family Experience | 4 |
| D. *Implement Continuous Quality Improvement | 4 |
| E. Demonstrate Continuous Quality Improvement | 3 |
| F. Report Performance | 3 |
| G. Use Certified EHR Technology | 0 |
| | 20 |

***Must Pass Elements**

Must Pass Elements require a >50% performance level to pass

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# MUST PASS ELEMENTS

- 1A: Patient Centered Appointment Access
- 2D: The Practice Team
- 3D: Use of Data for Population Management
- 4B: Care Planning and Self-Care Support
- 5B: Referral Tracking and Follow-Up
- 6D: Implement Continuous Quality Improvement

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# DOCUMENTATION TYPES

- Documented process
  - Written procedures, protocols, processes, workflow forms (not explanations); these should show the practice name and date of implementation
- Reports
  - Aggregated data showing evidence
- Records or files
  - Patient files or registry entries documenting action taken; data from medical records for important conditions
- Materials
  - Information for patients or clinicians, e.g. clinical guidelines, self-management and educational resources

NOTE: Screen shots or electronic "copy" may be used as examples (EHR capability), materials (Web site resources), reports (logs) or records (advice documentation)

# DOCUMENTATION TIME PERIODS

- Report Data, Files, Examples and Materials
  - Should display information that is current within the last 12 months
- Documented Process
  - Policies, procedures and processes should be in place for at least 3 months prior to survey submission
- Reporting Period (Meaningful Use)
  - 12 months, or 3 months if 12 months is not available
- Reporting Period (Log or Report)
  - Refer to documentation guidelines for other references to minimum data for logs and reports (one week, one month, etc.)

** ALL DOCUMENTS NEED TO SHOW DATES **

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# DOCUMENTATION CHEAT SHEET

## Factors Requiring Written Policies

You will also find this on the FCAAP Medical Home Transition Program website: http://www.fcaapmedhomeprogram.org/

| Standards & Elements | | Factors | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Element | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| Standard 1 | A | Y | Y* | Y | Y | Y | N | | | | | | | | |
| | B | Y | Y | Y | Y | | | | | | | | | | |
| | C | N | N | N | N | N | N | | | | | | | | |
| Standard 2 | A | Y | N | Y | Y* | | | | | | | | | | |
| | B | Y | Y | Y | Y | Y | Y | Y | Y | | | | | | |
| | C | N | N | Y | N | | | | | | | | | | |
| | D | Y* | Y* | Y | N | Y | Y | Y | Y | Y | Y | | | | |
| Standard 3 | A | N | N | N | N | N | N | N | N | N | N | N | N | N | Y |
| | B | N | N | N | N | N | N | N | N | N | N | N | | | |
| | C* | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | | | |
| | D* | Y | Y | Y | Y | Y | | | | | | | | | |
| | E | N | N | N | N | N | N | | | | | | | | |
| Standard 4 | A | Y | Y | Y | Y | Y | N | | | | | | | | |
| | B** | N | N | N | N | N | N | | | | | | | | |
| | C | Y | Y | Y | Y | Y | | | | | | | | | |
| | D | N | N | N | N | | | | | | | | | | |
| | E | N | N | N | N | N | N | N | | | | | | | |
| Standard 5 | A | Y | Y | Y | Y | Y | Y | N | N | N | N | | | | |
| | B | N | N | N | Y | Y | Y | N | Y | N | N | | | | |
| | C | Y | Y | Y | Y | Y | Y | N | | | | | | | |
| Standard 6 | A | N | N | N | N | | | | | | | | | | |
| | B | N | N | | | | | | | | | | | | |
| | C | N | N | N | N | | | | | | | | | | |
| | D | N | N | N | N | N | N | N | | | | | | | |
| | E | N | N | N | N | | | | | | | | | | |
| | F | N | N | N | N | | | | | | | | | | |

# Getting Started On Your PCMH Project

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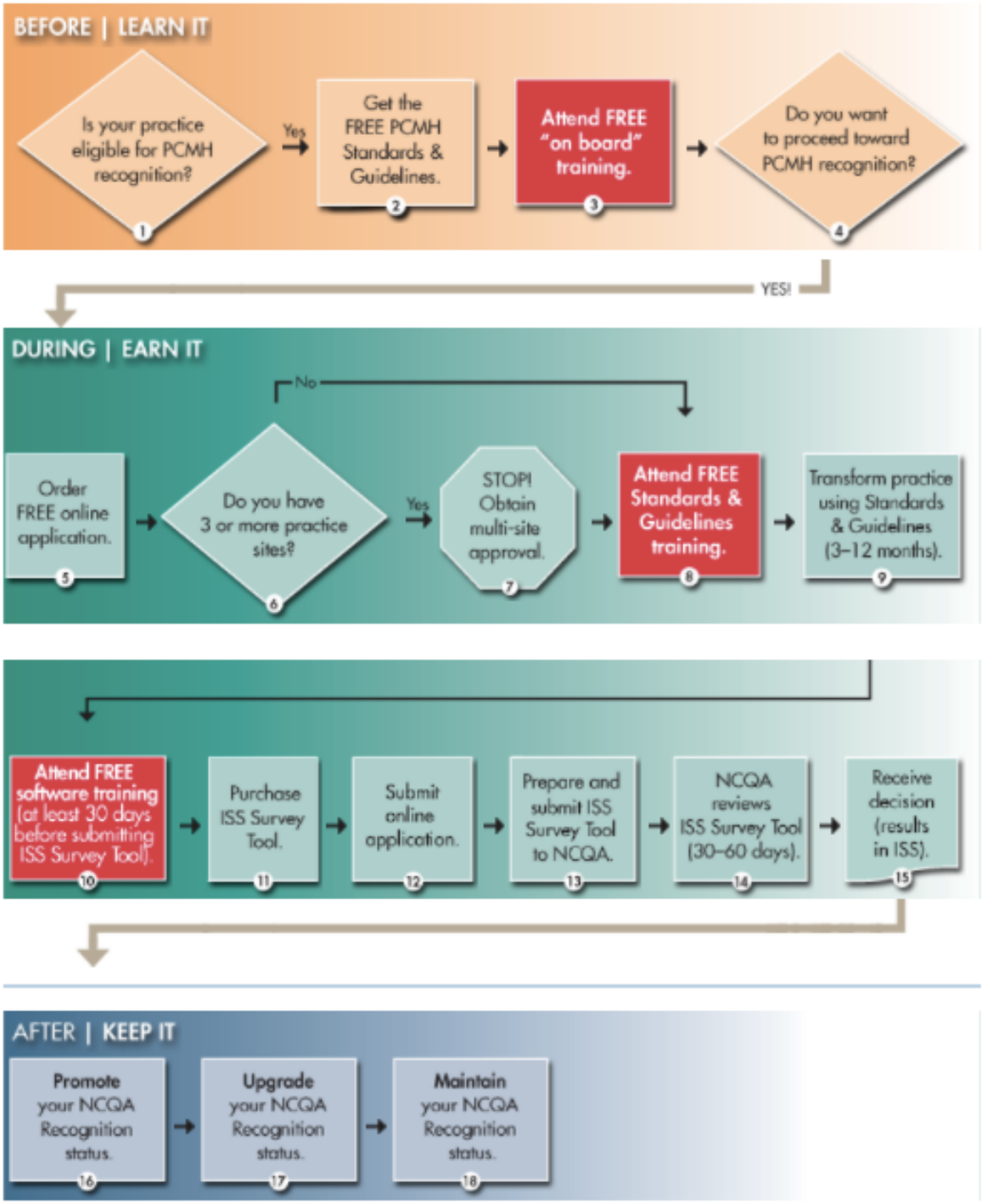
# Make Yourself Familiar With the Program

**http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh**

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# Determine Where You Are Today

Figure out how your processes and procedures compare to the program:

- Scan through the guidelines and check off -
  - What you are you doing already
  - What processes you may need to adjust
  - What processes you may need to build

❑ Use the Standards as your checklist

Access the FCAAP Medical Home Transition Program website to work through a self-scoring Program Readiness Survey (gap analysis):

http://www.fcaapmedhomeprogram.org/

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# Determine If You Have Points Already

Check to see what 'points' you may have already:

- Certain **EMR vendors have 'pre-validation'** meaning that you automatically receive points for using a particular EMR system

- If you are participating in the **Meaningful Use Program**, you can use certain components of your MU data to receive points for this program

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# Example of How Pre-Validation Points Work

| Points Approved | Standard and Element | Factors Scored | Factors Reported Not Scored | Factors Not Reported |
|---|---|---|---|---|
| | **1 Enhance Access and Continuity** | | | |
| | A Access During Office Hours **(Must Pass)** | | 3-4 | 1-2 |
| 1 | B After-Hours Access (Practice Solution) | 2 | | 1, 3-5 |
| 1.5 | C Electronic Access (Patient Portal) | 4-6 | | 1-3 |
| .5 | D Continuity (Practice Solution) | 2 | | 1, 3 |
| | E Medical Home Responsibilities | | | 1-4 |
| .5 | F Culturally and Linguistically Appropriate Services (CLAS) (Practice Solution) | 4 | 1-2 | 3 |
| | G The Practice Team | | | 1-8 |
| | **2 Identify and Manage Patient Populations** | | | |

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# MU-PCMH Crosswalk Calculator
## (from FCAAP MHTP Website)

| MEANINGFUL USE OBJECTIVE | MU SCORE % | REQUIRED SCORE | PCMH ELEMENT |
|---|---|---|---|
| Stage 2: 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 | 0 | 50% | 1.C.01 |
| ↳ | | 5% | 1.C.02 |
| Stage 2: Provide clinical summaries to patients for each visit | 0 | 5% | 1.C.03 |
| Stage 2: Use secure electronic messaging to communicate with patients on relevant health information | 0 | 5% | 1.C.04 |
| | | Requirements met for 0 of 4 factors: 0.00 points | |
| Stage 1: Maintain up-to-date problem list with current and active diagnoses | 0 | 80% | 3.B.01 |
| Stage 1: Maintain active medication allergy list | 0 | 80% | 3.B.02 |
| Stage 1: Record and chart changes in vital signs (blood pressure for kids 3 and older) | 0 | 80% | 3.B.03 |
| Stage 1: Record and chart changes in vital signs (height/length) | 0 | 80% | 3.B.04 |
| Stage 1: Record and chart changes in vital signs (weight) | 0 | 80% | 3.B.05 |
| Stage 2: Record smoking status for patients 13 years and older | 0 | 80% | 3.B.08 |
| Stage 1: Maintain active medication list | 0 | 80% | 3.B.09 |
| Stage 2: Record patient family health history as structured data | 0 | 20% | 3.B.10 |
| Stage 2: Record electronic notes in patient records | 0 | 30% | 3.B.11 |

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# The Team and The Plan

- Who should you have on your team?
  - Clinical staff
  - Administrative staff
  - Physician Champion
- How frequently should you meet?
- How will you stay on track with the project?
- Who should receive training, and what type?

➢ Keep the ENTIRE team up-to-date with progress

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# Apply Project Management Principles

Put in place basic project management controls:

- Break down the work that needs to be done
- Start with the most important tasks first
- Set a timeline to accomplish each item
- Create an organized process for compiling your data and documentation
- Have standing meetings on a weekly basis
- Share regular updates with staff in the form of memos

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# Processes Performed But Not Written?

- First, use what you've got
  - Job descriptions, meeting notes, training handouts etc.
- Start drafting!
  - Don't do an individual policy or procedure for each factor - group them together, and keep it as simple as possible
- Have everyone pitch in
  - Ask staff to draft what they do and those can be edited / refined from there
  - ➢ Utilize the Policy and Procedure Templates on the FCAAP Medical Home Transition Program website!

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# No Process At All?

- Start by adding the easy ones first
  - Example – collecting race & ethnicity, PCP
    - Have your staff begin doing that right away.
    - The longer you have them collecting data, the more likely you will reach your percentage targets when it comes time to submit your supporting data and documentation

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# Set Up Protocols

- Create visit templates for your important conditions
  - The longer you are collecting data, the more likely you will reach your percentage targets when it comes time to meet the guidelines.
- Set up Standing Orders and utilize them
  - Example: defined triggers for prescription orders, medication refills, vaccinations, routine preventive services etc.

# Focus On The Important Work First

Tackle the major pieces first -

- Figure out what 'conditions' you want to focus on first and set up visit templates for those
  - While you work through the rest of the project, those most important pieces of data will already be in the process of being gathered
- Figure out the best ways to identify and stratify your 'high-need' patients (vulnerable and high risk populations)
- Determine what data you can get at readily for items like recalling, tracking preventive care and immunizations and improving quality

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# Focus on Must Pass & High Scores

| 1: Enhance Access and Continuity | Pts |
|---|---|
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|---|---|
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**Scoring Levels**

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| E. Demonstrate Continuous Quality Improvement | 3 |
| F. Report Performance | 3 |
| G. Use Certified EHR Technology | 0 |
| | 20 |

*Must Pass Elements

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# Utilize Your Resources!

FCAAP Tools & Support

- http://www.fcaapmedhomeprogram.org/

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# What You Will Find On the Site

Florida Chapter
American Academy of Pediatrics

Medical Home Transition Program

*Brought to you by The Verden Group*

Menu | Contact

## The FCAAP Medical Home Transition Program

Since the settlement of the Medicaid access lawsuit in April 2016, FCAAP leadership has been working with the Agency for Health Care Administration ("AHCA") to improve access to quality care for Florida children on Medicaid and to pave the way for increased Medicaid rates for Florida's pediatricians.

As part of the settlement agreement, Medicaid plans now provide incentive programs that offer pediatricians the opportunity to earn Medicare-equivalent fees. Each Medicaid plan has adopted an incentive program that went into effect on October 1, 2016.

While the specific incentive program varies among the plans, many of the plans have adopted programs that initially provide this opportunity to practices that have been recognized under 'medical home' programs.


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## Transitioning To A Medical Home Model

This program, developed in collaboration with The Verden Group, is designed to provide Florida's pediatric practices with the resources, tools, and support needed to understand, select, and complete a medical home program and achieve medical home recognition.

**This program is designed to help you:**

- Determine the opportunity for increased revenues for you.
- Identify any activities that you have currently undertaken that may help you achieve 'medical home' recognition faster and more efficiently.
- Identify how much work may be involved for you to undertake such a transition.
- Determine costs associated with participating in a recognition program.
- Help you compare the different 'medical home' programs available.
- Provide you with educational materials, easy-to-understand guides, and 'cheat' sheets and templates for the NCQA Patient Centered Medical Home program.

1. **How would medical home recognition increase your revenue?**

   Compare Medicaid and Medicare fees

2. **How much work will you need to do to achieve recognition?**

   Complete the Program Readiness Survey

3. **How much will it cost to participate in a recognition program?**

   Calculate Program Pricing

4. **Which recognition program is best for you?**

   Compare Program Features

5. **Guides, Templates, and Resources for PCMH Standards 2014**

   NCQA Resources

**Browser Requirements**

Google Chrome, Firefox, Safari, or Internet Explorer 10-11. Earlier versions of Internet Explorer are not supported.

Cookies are required, and some tools require a tablet-sized screen or larger.

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# Re-Attest Under 2014 or 2017?

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# Certified Under 2011 Standards

## Option 1: Convert or Renew Under 2014

- **Conversion** allows a practice with a current PCMH 2011 recognition to "convert" to a PCMH 2014 recognition and add 1 year to their current recognition end date (e.g., a practice with June 1, 2016 end date would extend recognition until June 1, 2017).
- **Streamlined renewal** process (for practices currently recognized as PCMH level 2 or 3) is for practices with an expiring recognition who are renewing for another three-year recognition period.

# Certified Under 2011 Standards

## Option 2: Re-Attest Under 2017 from 2011

- The details about how this will work are still being worked out by NCQA, but they expect to be able to give credit for work that has not changed between the 2011 and 2017 standards.
- This will be in place by the time NCQA rolls out the 2017 PCMH Standards on March 31.

# What's Coming Under NCQA PCMH 2017

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# Redesign of the Program

## PCMH Redesign

*Why Change?*

| | | |
|---|---|---|
| Too much documentation | Practices want more interaction with NCQA | Too challenging for smaller practices |
| Needs less emphasis on process. More on performance | Two separate, complicated tools | Practices should be demonstrating ongoing improvement |

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# Redesign of the Program

*Now vs. Futur*e


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# Redesign of the Program

*3 Parts*

## *Commit*

Practice completes an online guided assessment.

Practice works with an NCQA representative to develop an evaluation schedule.

Practice works with NCQA representative to identify support and education for transformation.

New NCQA PCMH online education resources support the transformation process.

## *Transform*

Practice submits initial documentation and checks in with its evaluator

Practice submits additional documentation and checks in with its Evaluator.

Practice submits final documentation to complete submission and begin NCQA evaluation process.

Practice earns NCQA Recognition.

## *Succeed*

Practice is prepared for new payment environment (value-based payment, MACRA MIPS/APMs).

Practice demonstrates continued readiness and high quality performance through annual check-ins with NCQA.

# 2017 Structure Change

*Structure*

**Concepts, Competencies and Criteria**

Replaces the model of Standards, Elements and Factors

- Concepts: Over-arching components of PCMH
- Competencies: Ways to think about/bucket criteria
- Criteria: The individual things/tasks you do to make up a PCMH

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# Shift from Elements to Concepts

*Concepts*

*Team-Based Care and Practice Organization*

*Knowing and Managing Your Patients*

*Patient-Centered Access and Continuity*

*Care Management and Support*

*Care Coordination and Care Transitions*


*Performance Measurement & Quality Improvement*

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# 2017 Concepts

*Concepts*

*Team-Based Care and Practice Organization*

- Practice leadership
- Care team responsibilities
- Orientation of patient/families/caregivers

*Knowing and Managing Your Patients*

- Data collection
- Medication reconciliation
- Evidence-based clinical decision support
- Connection with community resources

*Patient-Centered Access and Continuity*

- Access to practice and clinical advice
- Care continuity
- Empanelment

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# 2017 Concepts

*Concepts*

*Care Management and Support*

- Identifying patients for care management
- Person-centered care plan development

*Care Coordination and Care Transitions*

- Management of lab/imaging results
- Tracking and managing patient referrals
- Care transitions


*Performance Measurement & Quality Improvement*

- Collecting and analyzing performance data
- Setting goals
- Improving practice performance
- Sharing practice performance data

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# 2017 Standards

*Structure - Example*

**Concept: Patient-Centered Access and Continuity**

| Competency | Core Criteria | Elective Criteria |
|---|---|---|
| The PCMH model seeks to enhance access by providing appointments and clinical advice based on the patient's needs. In addition to being key to patient-centeredness, evidence explicitly supports that providing enhanced access including same- day, extended hours and telephone advice from clinicians with access to the patient record reduces ED visits and hospitalizations. | Assesses the access needs and preferences of the patient population.<br><br>Provides same-day appointments for routine and urgent care to meet identified patients' needs.<br><br>Provides routine and urgent appointments outside regular business hours to meet identified patients' needs.<br><br>Provides timely clinical advice by telephone.<br><br>Documents clinical advice in patient records. | Provides scheduled routine or urgent appointments by telephone or other technology supported mechanisms.<br><br>Has a secure electronic system for patient to request appointments, prescription refills, referrals and test results.<br><br>Has a secure electronic system for two- way communication to provide timely clinical advice.<br><br>Evaluates identified health disparities to assess access across the patient population. |

# Q & A

## Contact Information

The Verden Group, Inc
*Your Partner in Practice*
www.TheVerdenGroup.com

Susanne Madden, MBA, NCQA CEC
madden@theverdengroup.com

Amanda Ciadella, NCQA CCE
amanda@theverdengroup.com


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