CQMC Core Quality Measures Collaborative

Meeting Summary

ACO/PCMH/Primary Care Workgroup Web Meeting 1

The National Quality Forum (NQF) convened a web meeting for the Accountable Care Organizations (ACO)/Patient Centered Medical Home (PCMH)/Primary Care Workgroup on Monday, July 25, 2022.

Welcome, Roll Call, and Review of Web Meeting Objectives

NQF staff welcomed participants to the meeting, as well as introducing the two new co-chairs of the ACO/PCMH/Primary Care Workgroup (provider co-chair Dr. Karen Johnson and payer co-chair Dr. Martha Walsh). The co-chairs provided welcoming remarks to the Workgroup. NQF staff reviewed the antitrust statement, as well as acknowledging that CQMC is a member-funded effort with additional support from the Centers for Medicare & Medicaid Services (CMS) and America's Health Insurance Plans (AHIP).

NQF staff facilitated roll call and reviewed the meeting objectives:

- Review the CQMC's work from last year, including updates to the 2021 ACO/PCMH/Primary Care Core Set
- Discuss potential changes to the ACO/PCMH/Primary Care Core Set as part of the yearly maintenance process

Last Year's Work

NQF staff provided an overview of the CQMC's work during 2020-2021, including recent accomplishments and future opportunities for work. Last year, the CQMC maintained the ten clinical core sets as well as updating and releasing supporting documents including the Approaches to Future Core Set Prioritization, Measure Selection Criteria, Implementation Guide, and Analysis of Measurement Gap Areas and Measure Alignment report. The CQMC is also convening a new Health Equity Workgroup to discuss disparities-sensitive measures and health equity-related measures for future consideration across the CQMC.

NQF shared an overview of the ACO/PCMH/Primary Care Workgroup's updates to the core set in 2021. During the last ad hoc maintenance cycle, the Workgroup removed one measure (#0057 *Comprehensive Diabetes Care: Hemoglobin A1c [HbA1c] Testing*) due to high performance, redundancy with other measures, and plans to retire the measure from the Healthcare Effectiveness Data and Information Set (HEDIS). The Workgroup also replaced #0062 *Comprehensive Diabetes Care: Medical Attention for Nephropathy* with a new *Kidney Health Evaluation for Patients with Diabetes* measure. #0062 is being retired due to concerns with precision and misalignment with clinical practice guidelines and is being replaced by the *Kidney Health Evaluation* measure in HEDIS.

Overall, the current core set includes 22 measures addressing cardiovascular care, diabetes, care

coordination and patient safety, preventative care, utilization and overuse, patient experience, behavioral health, pulmonary health, and readmissions. The Workgroup also identified patient-reported measures, stratification of existing measures to identify health disparities, overuse, comprehensive primary care, misdiagnosis and delayed diagnoses, continuity of care, and integration across settings, specialties, and populations as the highest-priority gap areas for the core set.

Measures for Maintenance

NQF staff shared that the CQMC measure selection principles ensure that measures in the core sets remain person-centered and holistic; relevant, meaningful, and actionable; parsimonious, promoting alignment and efficiency; scientifically sound; balanced between burden and innovation; and unlikely to promote unintended adverse consequences. The measure selection principles were updated in 2022 to ensure they remain relevant, focus on outcome measures and digital measures, and address priority topic areas such as care coordination and health equity. NQF staff noted that the CQMC will not consider cost measures in the future, as cost is captured as part of the payment models in which the core set measures may be used.

NQF staff noted that the original intent of the CQMC core sets was to focus on ambulatory care measures that have been tested and specified at the clinician level of analysis. The core set measures are intended to focus on measures that can be influenced by outpatient providers, and can be used for accountability by both public and private payers. While Workgroups may choose to discuss and include measures outside the clinician/group level of analysis, there should be clear rationale for discussing these measures (e.g., important topics in a specialty where care typically occurs at the hospital level, or high-priority topics that are not addressed by existing clinician-level measures). NQF staff also emphasized that measures at different levels of analysis will be clearly delineated in the final core set presentations, and that Workgroups can add core set notes to indicate considerations for measure use or note important topics or measures that are not yet ready for inclusion in the set.

NQF staff then reminded the Workgroup that annual maintenance helps the core sets remain aligned with the measure selection principles. As part of the process, NQF will bring forward major updates for the Workgroup's consideration (i.e., changes to endorsement and program use; recently endorsed or fully developed measures in the topic area; measures recommended for use in federal programs), as well as measures identified for discussion by Workgroup members prior to the meeting. No formal voting will be conducted during the Workgroup meetings. Proposed changes to the core set will proceed to voting after the conclusion of all measure discussions, and any changes to the core set must achieve a 60% affirmative vote including support from at least one provider and one payer stakeholder.

Potential Removals from the Core Set

NQF staff shared the process used to identify potential removals from the ACO/PCMH/Primary Care core set. The process includes reviewing the current core set and assessing measures based on changes in endorsement status, changes in program use (e.g., removal from Merit-Based Incentive Payment System [MIPS], HEDIS, or the Medicaid Core Set) and suggestions from Workgroup members.

NQF staff did not identify any measures for potential removal based on changes in endorsement status or program use. However, a Workgroup member suggested via email that the group consider #0421/0421e *Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up* for potential removal. The member noted that the BMI ranges are not necessarily appropriate for patients 65 and older. NQF shared that this measure will be discussed during a second ACO/PCMH/Primary Care Workgroup meeting later this year.

Potential Additions to the Core Set

NQF staff shared that measures proposed for potential addition to the ACO/PCMH/Primary Care core set are reviewed based on factors such as new NQF endorsement, recommendation for use in programs through the Measure Applications Partnership (MAP), and Workgroup member recommendations. NQF staff shared that four measures were identified for potential addition to the core set, and reviewed the process for discussion. NQF will provide background information on each measure before co-chairs open discussion; both voting members and non-voting members are welcome to share comments, although voting members will be recognized first.

3568: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)

NQF staff provided an overview of #3568, including a review of specifications. #3568 was discussed in detail during last year's ad hoc maintenance cycle, but due to requests for additional discussion and consideration, the discussion has been extended into this year. #3568 received conditional support for rulemaking (contingent on endorsement) as part of the MAP December 2020 cycle, and was endorsed by the Primary Care and Chronic Illness standing committee as part of the Fall 2020 cycle. During last year's discussion, members who supported addition of #3568 noted that this fills a gap area (patient-reported outcomes), measures a meaningful area, has been tested and implemented in many areas already, and could be particularly helpful to understand care for older adults and patients with complex needs. However, other members expressed concerns that the measure was relatively new, risk adjustment was insufficient, and there was insufficient evidence linking the measure to improved outcomes.

NQF staff shared that since last year's discussion, the measure has been approved for use in MIPS in 2022, including use in the Family and Internal Medicine measure sets and the Optimizing Chronic Disease Management MIPS Value Pathway for 2023. The developer has also shared that current users of the measure include the PRIME Registry, State of Connecticut Department of Social Services, University of Missouri School of Medicine, Anthem and University of Colorado, St. Michael's Hospital Family Health Teams, and other independent practices. NQF staff also shared that a patient representative group member was unable to join the meeting, but expressed their strong support of this measure.

A co-chair invited the measure developers to share any additional comments to inform the Workgroup's discussion. A representative from the American Board of Family Medicine (ABFM) shared that the developers and statisticians were unable to attend, but ABFM can answer additional

questions on the measure as the stewards and can follow up with the developers with any additional questions from the Workgroup.

A Workgroup member shared that during discussion last year, members had raised concerns over risk adjustment; however, this is a measure of the overall perception of primary care which would change based on age needs, chronic disease status, etc. and they are unclear how this would be adjusted as with other outcome measures. The member also noted that this measure is separate from clinical outcomes, and a patient could have a poor clinical outcome but could still have a good relationship with their primary care physician if their physician had tried to give them the expected care. Finally, the member noted that this measure addresses an important gap, patient-reported measures.

A Workgroup member asked whether there is additional information available to address the concerns with risk adjustment raised last year. For example, the measure includes any active patient in the practice, so a patient being seen for an acute injury (e.g., sprained ankle) would be answering items that might be irrelevant to the visit (e.g., "The care I get takes into account knowledge of my family"). The member noted that their organization has received feedback from providers that these questions are not valid for them and should not be used in a value-based contract. Another member commented that these measures may not be relevant to every patient encounter, but is still relevant to other established conditions (e.g., diabetes) and is helpful for understanding a long-term primary care provider relationship.

A Workgroup member asked for clarification on the denominator. An ABFM representative shared that the denominator includes all active patients, defined as patients who have been in the practice in the twelve months prior to their birth month. The representative emphasized that the instrument is not administered in connection with an encounter. A Workgroup member noted that the instrument could be administered to a patient that just had one visit; another member added that this was their concern during discussion last year and asked if there was any new information showing this is valid or if there is data available on how many patients have multiple visits in one year. The ABFM representative shared that they can follow up with additional information on the percentage of patients in the testing who only had one visit with their provider. The representative also emphasized that the measure assesses aspects of care (e.g., advocacy, goal-oriented care) that providers can score high on, even with a limited number of visits. A Workgroup member shared that asynchronous care may also help build the patient-provider relationship over time, even if a patient has only had one visit; they shared that as a provider, they might see a patient once a year but may message back and forth over the year in the online patient portal. The ABFM representative shared that over 2,200 physicians and patients were surveyed on whether the measure was meaningful and valuable, and estimated that 85% of respondents agreed that the measure was valuable and would add to their knowledge and understanding as a provider or a patient.

A Workgroup member noted that many practices are responsible for measuring the Consumer Assessment of Healthcare Providers & Systems (CAHPS) Clinician and Group Survey (CG-CAHPS), which is already in the core set. The member shared that CG-CAHPS has some similar questions as the PCPCM PRO-PM and there have been efforts in CG-CAHPS to focus on more objective measurements from patients. The member asked for additional information on the distinction between the CG-

CAHPS and PCPCM PRO-PM and whether recommending both of these measures poses a risk for over-surveying patients. Two Workgroup members agreed with the concern of over-surveying; one added that the intent and use of the survey may be helpful, but among their patients, response rates for surveys are already starting to fall below the threshold required for valid measurements. The ABFM representative shared that while CAHPS measures a specific healthcare experience (encounter), PCPCM evaluates person-centered care (overall relationship) and is meant to address aspects of primary care delivery known to be important (integrating, prioritizing, personalizing functions) but not captured as part of typical clinical processes or outcomes. While both CAHPS and PCPCM address access, the PCPCM asks unique questions related to advocacy, community awareness, comprehensiveness, coordinated care, family context, goal-oriented care, prioritization, and trust, which are not measured in the CAHPS surveys. CAHPS focuses on communication, follow-up, helpfulness of staff, and overall practice satisfaction. The PCPCM also has a unique focus on primary care and is not administered for specialty care.

A Workgroup member asked whether other members had concerns with the focus of the measure (i.e., not directly tied to patient outcomes). An ABFM representative reiterated that the measure is intended to focus on the core relationship between the patient and provider, which is why it incorporates aspects such as advocacy, awareness of context and community, prioritizing in line with patient concerns, and level of trust. Another member agreed that the measure feels more like a measure of patient experience with the provider than a patient-reported outcome. A member shared that the measure is well intended and they would favor this as a payer; however, as a provider they still have concerns with the potential for subjectivity and with the connection to overall health outcomes. Another member expressed that they would prefer more emphasis on patients reporting their own outcomes, rather than patients assessing the practice.

A Workgroup member noted that during last year's discussion, the measure developer indicated plans to provide a free service to help clinicians implement the measure. A free platform will be available for groups with six or fewer clinicians, but there will be a nominal fee for groups with more clinicians. An ABFM representative confirmed that the developers have created the free EASY (Effective, Affordable, Secure, Yours) platform for practices with six or fewer clinicians to implement the measure; larger practices can use the platform with a minor fee. The EASY platform is already available for use. The representative also shared that ABFM is also developing a tool to assist with implementation which would also have functionality to submit the measure; this platform will be ready for use in 2023.

A Workgroup member asked whether the ACO/PCMH/Primary Care group is able to provide advice on the use of the survey. The member shared that they would like entities to have the option to administer the PCPCM PRO-PM instead of CAHPS, as it seems more relevant for ACOs and PCMHs; however, they are concerned patients would be required to fill out both survey as well as entity-specific surveys. Another member agreed with this comment. A member commented that plans will still be responsible for assessing CAHPS giving existing programs and the practical need to adapt to what measures are used in CMS programs. An ABFM representative noted that CMS has called this measure out as unique to primary care and pushed to add this measure to the Family and Internal Medicine measure sets and the Optimizing Chronic Disease Management MIPS Value Pathway for

2023. A Workgroup member acknowledged that this measure may be difficult for large multi-specialty groups to implement, but it addresses the unique primary care physician relationship. A Workgroup member reminded the group that the CQMC can recommend measures that are not in complete alignment with CMS, along with notes that the group suggests this measure over CG-CAHPS or recommends additional testing.

A Workgroup member shared that when they score poorly on CG-CAHPS, there are resources available with notes on objective changes that can help improve CAHPS performance. The member asked if there is a similar crosswalk of recommendations for improving performance on each item in the PCPCM PRO-PM. An ABFM representative shared that the developer has created a crosswalk with recommended actions related to accessibility, comprehensiveness, coordination, relationship continuity, and advocacy (see Appendix A for detailed recommendations).

A Workgroup member shared that their organization has closely reviewed this measure and they strongly agree that this measure fills a gap related to understanding the breadth and depth of the primary care relationship between a patient and their practice. Their organization has researched the measure and published implementation guidance for their members, and members who implemented the measure reported that it is helpful for building out their practice-level capabilities and identifying gap areas for future improvement.

A Workgroup member asked how many practices have started to implement this measure. An ABFM representative shared that they do not have access to all practices who use the measure (as it has been included in the CMS final rule for MY2022), but users include the State of Connecticut Department of Social Services, University of Missouri School of Medicine, Anthem and University of Colorado, St. Michael's Hospital Family Health Teams, and dozens of other independent practices in different states. The measure has also been implemented on the PRIME Registry since 2020.

A Workgroup member shared that for improvement on similar measures within behavioral health, they are typically resourced with more time and need to engage in more interdisciplinary teamwork with therapists and other providers. The member asked if any primary care providers can share any practical experience with implementing the measure. A member shared that since the measure is not encounter-based, it is implemented similar to their other patient satisfaction measures that are administered by text message, paper surveys, and paper portals separate from encounters.

NQF staff reiterated a Workgroup member's comment that the CQMC is able to make decisions that do not align with CMS, and that the group can add notes and recommendations to the core set presentations (e.g., support use of PCPCM PRO-PM over CG-CAHPS, or recommendations for additional testing or considerations for use). A Workgroup member asked whether CMS considers the CQMC's suggestions, or if addition of the measure would pose administrative burden. NQF staff shared that CMS has indicated that they consider the CQMC recommendations, but there is a separate process for reviewing policy considerations and making final decisions on use of measures in CMS programs.

NQF staff thanked the group for their robust discussion and summarized that there is interest in

moving this measure forward to another vote; #3568 will be included in the voting survey, which will be shared once all measure discussion has concluded for the year.

3541: Annual Monitoring for Persons on Long-Term Opioid Therapy

NQF staff provided an overview of #3541, including a review of specifications. #3541 was originally endorsed as part of the Fall 2019 review cycle and was discussed for potential addition by the ACO/PCMH/Primary Care Workgroup last year. Members previously commented that this is an important patient safety measure, but expressed concerns about attribution when opioids are prescribed by multiple providers, health plan level of analysis, and unintended consequences. Members also shared that the measure might be less applicable to primary care settings. Overall, the group requested to revisit the measure after the Behavioral Health Workgroup discussed the measure. The Behavioral Health group discussed the measure but ultimately chose not to include the measure in the set due to similar concerns (level of analysis, attribution, potential unintended consequences such as stigmatization); however, the group did note the measure may be better suited for primary care providers than behavioral health specialists due to the link to ongoing pain management. NQF staff shared that this measure is currently used as part of the Marketplace Quality Ratings System.

A co-chair opened discussion by asking whether Workgroup members had concerns with the health plan level of analysis for the measure. A Workgroup member noted that the core sets are intended to include measures at the clinician level; another member noted that many of the core set measures are specified at the health plan level. Another member asked if the group could review the goal of the measure, and how health plans would be able to use that information. The group discussed that the goal of the measure is related to patient safety and avoidance of unnecessary long-term opioid use; the measure developer also shared that annual monitoring of individuals on long-term opioid therapy is supported by clinical guidelines and can help clinicians identify at-risk patients; drug testing can be used to inform referrals for substance use disorder, prompt education, or alert the team to any needed treatment changes.

A member commented that even though the measure is specified at a health plan level, the work and improvements need to occur at a clinician level; the member agreed that opioid use is an important topic that should be represented, but proposed that more upstream measures (e.g., screening for opioid use risk) might be more appropriate for the set. Another member commented that from their organization's perspective, health plan level and provider level measurement are equivalent. The member shared that their organization tried to identify individual outlier providers and found that more challenging patients tend to self-select towards providers with enhanced skills in pain management; their organization found that it was difficult trying to monitor individual clinicians and that it was more helpful to monitor and collect information at the system level, as well as providing support services for primary care providers (e.g., consultation support, access to relevant specialists, availability of non-opioid alternatives). The member also shared that a recent journal article discussed a link between physician burnout and clinician-level performance comparisons (vs. aggregate tracking). Another Workgroup member shared appreciation for the comment recognizing physician burnout.

A Workgroup member shared that their organization is concerned with using measures that have been tested at the health plan level for use with clinicians and group practices; the denominator at the clinician level may be quite small and not sufficiently reliable. The member shared that it would be inappropriate to apply at the clinician level unless there is additional information available to help evaluate reliability. A Workgroup member agreed with this concern and asked whether the Workgroup is able to put forth guidance on recommended use of the measures (e.g., appropriate level of use). Another Workgroup member agreed that this would be helpful guidance. NQF staff shared that the Workgroup can emphasize that this measure is recommended for use at the health plan level, not the clinician level, if it is included in the core set. NQF staff also noted that the CQMC would need to establish a consistent and appropriate process for putting forth guidance on recommended measure use across all the Workgroups, but this is a helpful idea for future.

A member asked for additional clarification on the exclusions of the measure; Workgroup members discussed that the exclusions include cancer patients and hospice care patients. A member noted that there are no exclusions based on major injury or complex musculoskeletal surgery. The developer shared that the measure is intended to include long-term opioid therapy (90 or more days within the year based on prescription claims data) as opposed to acute opioid therapy. The Workgroup member shared that the 90-day limitation may not adjust for a variety of complex injuries or procedures. The member also noted that sickle cell patients would be an appropriate exclusion, as well as other chronic or subacute injuries or illnesses. A member shared that a drug screening would still be useful for patients with chronic or subacute injuries. The developer also shared that a sickle cell disease exclusion was considered during development but was ultimately not recommended, as annual monitoring is still useful among this population.

NQF staff shared that based on support for the topic area and concerns about the level of analysis for the measure, #3541 will be included in the voting survey for potential inclusion. NQF staff will provide draft wording on a potential note in the core set presentation regarding the appropriate level of use for the measure.

3597: Clinician-Group Risk-Standardized Acute Hospital Admission Rate for Patients with Multiple Chronic Conditions under the Merit-based Incentive Payment System

NQF staff provided an overview of #3597's specifications. This measure was recently endorsed as part of the Fall 2020 endorsement cycle and is an outcome measure that uses claims and enrollment data. The measure is intended to be used in MIPS and uses a statistical risk model for risk adjustment. The developer also shared that this measure is intended to address patients with multiple chronic conditions, and that the measure will not pose burden for clinicians as CMS will automatically calculate this measure for reporting.

A Workgroup member asked for additional clarification on the attribution process for the measure. The developer shared that the measure uses a visit-based attribution approach, an algorithm developed in conjunction with a technical expert panel. This measure would be attributed to two different types of clinicians, primary care providers or relevant specialists. If a patient can be attributed to a primary care provider, this would be the first level of attribution; if there is a "dominant specialist" over the care period, the patient can be attributed to that specialist. For the

measure calculation, the patient would be scored as part the clinician's Tax Identification Number (TIN) group. The algorithm is based on the number of visits to each provider – e.g., if a patient only visited their primary care provider once during the year but they visited their cardiologist four times during the year, their care would be assigned to the cardiologist. The developer offered to share a written or visual description of the attribution process if it would be helpful.

A Workgroup member asked how "unplanned hospital admissions" are defined in the measure. The developer shared that the measure uses an adjusted version of a planned readmissions algorithm used for adjustments in other programs and care settings; the algorithm excludes certain admissions such as procedures or principal diagnoses that are typically pre-planned. The algorithm also excludes admissions directly from skilled nursing facilities or acute rehabilitation facilities, as well as allowing a ten-day buffer period after discharge from these facilities to allow patients to be seen after discharge in alignment with guidelines for transitions of care. A Workgroup member asked how the admissions rate for ambulatory care sensitive conditions is differentiated from the admissions rate for multiple chronic conditions; the developer shared that they do not have this information readily available but can provide additional information later if helpful.

A co-chair asked Workgroup members whether this measure adheres to the measure selection principles (e.g., relevant, meaningful, actionable, balanced between burden and innovation). The measure developer commented that this measure does not require clinicians to perform calculations, so it does not pose a burden; it also addresses gap areas in CMS' programs related to chronic conditions and is supported by scientific evidence. A Workgroup member commented that implementing this measure would be similar to looking at psychiatric deinstitutionalization without a corresponding accountability measure on community mental health center availability. While their organization has used the similar ambulatory care sensitive conditions hospitalization rate to assess adequacy of resources, these measures are difficult to use for accountability purposes because the effects of action are often delayed. The member shared that admissions and readmissions measures can also invite manipulation, and that accountability measures that cannot be met in real-time can be demoralizing for clinicians. Another Workgroup member agreed and shared that their organization has concerns with this measure including lack of evidence at the individual clinician level and limited actionability due to delays in seeing the measure data. Members also discussed concern around the accuracy of the attribution model, especially if the measure were to be used in value-based payment programs.

A Workgroup member commented that hospitalization is not always a bad outcome, and that using brick-and-mortar resources appropriately is the ultimate goal. The member also shared that community supports, caregiver support, and other social factors continue to pose challenges that contribute to hospitalizations.

NQF staff shared that since no members supported including #3597 in the ACO/PCMH/Primary Care core set, the measure will not be considered further for addition. Multiple Workgroup members agreed that it was appropriate to remove this measure from consideration.

Next Steps

NQF staff shared that the Workgroup will continue discussion on measures for addition and removal from the ACO/PCMH/Primary Care core set during a later meeting (likely in September). NQF staff will not share a voting survey for the measures discussed to date until after the second Workgroup meeting has been held, after which members can place votes for all measures in one survey. NQF will also summarize the discussion and will post the summary on the CQMC SharePoint page. NQF and the co-chairs thanked Workgroup members for their participation in the meeting.

Appendix A: PCPCM PRO-PM Action Items

Examples related to each of the PCPCM items include:

1. PCPCM Item: The practice makes it easy for me to get care
    a. Example Actions: Altering scheduling options, availability, or who does the scheduling; Providing options for asynchronous communication or telehealth visits
2. PCPCM Item: This practice is able to provide most of my care
    a. Example Actions: Schedule longer visits for more complicated problems or patients so that you provide more of the care rather than referring out; Refer in-house to staff or clinicians with specialized expertise or interests
3. PCPCM Item: In caring for me, my doctor considers all of the factors that affect my health
    a. Example Actions: Consider starting visits by asking patients what matters to them for this visit; Ask patients, "What one thing would you like someone taking care of you to know?" and add this to the medical record in a consistent and easy-to-see place
4. PCPCM Item: My practice coordinates the care I get from multiple places
    a. Example Actions: The medical assistant asks and documents any care received elsewhere since my last visit; When doing medication reconciliation, ask about care received elsewhere.
5. PCPCM Item: My doctor or practice knows me as a person.
    a. Example Actions: Try to talk about at least one non-medical item during each visit; Ask the patients what matters to them; Link recommended treatments to what gives meaning in the patient's life
6. PCPCM Item: My doctor and I have been through a lot together.
    a. Example Actions: Do phone follow up after hospital discharges; Consider other ways you might connect with patients' important health and life events.
7. PCPCM Item: My doctor or practice stands up for me.
    a. Example Actions: Let patients know when you spend time doing prior authorizations; Discuss options regarding medications with patients to show them you are aware of patient costs and taking that into account.
8. PCPCM Item: The care I get takes into account knowledge of my family.
    a. Example Actions: Do a quick and dirty family tree and update it periodically – try to find a consistent place in the EHR to keep this information; More routinely ask about the family as a resource or the impact of the patient's illness on the family.
9. PCPCM Item: The care I get in this practice is informed by knowledge of my community.
    a. Example Actions: Participate in community events and include that in posters or on the practice website; Ask about the patient's neighborhood.
10. PCPCM Item: Over time, this practice helps me to meet my goals.
    a. Example Actions: Frame care plans around patients' goals or what matters to them; Do HOPE notes: https://drwaynejonas.com/wpcontent/uploads/2018/01/HOPENoteQuestions_WEB.pdf.
11. PCPCM Item: Over time, my practice helps me to stay healthy.
    a. Example Actions: Look for teachable moments when the patient is open to a health behavior change; Standing orders for immunizations