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PCMH 1A – Patient Centered Access

The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on:

- Providing same day appointments for routine and urgent care (critical factor)
- Providing routine and urgent care appointments outside regular business hours
- Providing alternative types of clinical encounters
- Availability of appointments
- Monitoring “no show” rates
- Acting on identified opportunities to improve access

The practice has a written policy for making appointments available for both urgent and routine issues. The policy states the time requirements and defines “routine” and “urgent”.

The practice triages patients to determine the urgency of a request for a same day appointment; triage considers patient care need and preference. Adding ad hoc or unscheduled appointments to a full day of scheduled appointments does not meet the requirement. A practice can provide walk-in hours in addition to same day appointments; however, providing walk in hours alone does not meet the requirement for providing same day appointments.

The practice schedules appointments outside its typical daytime schedule. For example, a practice may open for appointments at 7 am, or remain open until 8 pm on certain days or it may be open on Saturday mornings.

An alternative type of clinical encounter is a scheduled meeting, such as a billable visit, between patient and clinician using a mode of real time communication in lieu of a traditional one-on-one in-person office visit. Examples: scheduled telephone, video chat and secure instant messaging, home visits, group visits or shared medical appointments. Unscheduled encounters do not meet the requirement (such as ad hoc phone calls or emails). An appointment with an alternative type of clinician (such as a diabetes educator) does not meet the requirement.

The practice has standards for appointment availability, for a variety of appointment types including urgent care, new patient physicals, routine exams and return visit exams. One common approach to measuring appointment availability against standards is to determine the “third next

available” appointment for each appointment type, with an open access goal of zero days (same day availability).

To provide consistent access and help understand true demand, practice monitor “no show” rates. “No show” rates are calculated by taking the number of patients who did not keep their pre-scheduled appointments during a specific period of time divided by the number of patient who were pre-scheduled to come to the center for appointments during the same time period.

To expand access and capacity, the practice uses information gathered from reports in factors 1-5 to identify opportunities to improve access. The practice may implement an improvement process, such as Plan-Do-Study-Act (PDSA) that represents a commitment to ongoing quality improvement.

Documentation

- All factors require a documented process for staff (including date of implementation or date of revision, and has been in place for at least three months prior to submitting the PCMH 2014 survey tool)
- Factor 1 – report with five days of data showing availability and use of same day appointments for both routine and urgent care
- Factor 2 – report showing extended hour availability or materials provided to patients demonstrating extended hours – and – a report with five days of data showing availability and use of appointments outside normal hours of operation
- Factor 3 – report showing encounter types and frequency of scheduled alternative encounter types in a recent 30-calendar day period
- Factor 4 - report with at least five days of data showing appointment wait times compared with defined standards
- Factor 5 – report from a recent 30-calendar day period showing the number of scheduled visits, number of patients actually seen, number of no shows and a calculated “no show” rate
- Factor 6 – a report showing the practice has evaluated data on access, selected at least one opportunity to improve access and took at least one action to create greater access



PCMH 2D – The Practice Team

The practice uses a team to provide a range of patient care services by:

- Defining roles for clinical and nonclinical team members
- Identifying the team structure and the staff who lead and sustain team based care
- Holding scheduled patient care team meetings or a structured communication process focused on individual patient care (critical factor)
- Using standard orders for services
- Training and assigning members of the care team to coordinate care for individual patients
- Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change
- Training and assigning members of the care team to manage the patient population
- Holding scheduled team meetings to address practice functioning
- Involving care team staff in the practice's performance evaluation and quality improvement activities
- Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council

Managing patient care is a team effort that involves clinical and nonclinical staff interacting with patients and working as a team to achieve stated objectives.

The emphasis is on ongoing interactions of team members to discuss roles, responsibilities, communication and patient hand-off, working together to provide and enhance the care provided to patients.

Involvement of the patient/family/caregiver with care team members if critically important to patient-centeredness.

Documentation

- All factors require a documented process for staff (including date of implementation or date of revision, and has been in place for at least three months prior to submitting the PCMH 2014 survey tool)

- Factors 1, 5-7 – dated descriptions of staff positions or policies and procedures describing staff roles and functions (the practice may provide an organization chart)
- Factor 2 – overview of the staffing structure for team based care
- Factor 3 – description of structured communication process including frequency of communication and at least three samples of meeting summaries, checklists, appointment notes or chart notes for evidence the practice follows its process
- Factor 4 – at least one example of a standing order
- Factors 5-7 – description of training and training schedule/materials showing how staff have been trained
- Factor 8 – description of team meetings, including the frequency of these meetings and at least one example of meeting minutes, agendas or staff memos
- Factor 9 – process for quality improvement showing how staff/team members are involved
- Factor 10 – process for involving patients/families/caregivers in QI teams or on an advisory council



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PCMH 3D: Population Health Management

At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence based guidelines, including:

- At least two different preventive care services
- At least two different immunizations
- At least three different chronic or acute care services
- Patients not recently seen by the practice
- Medication monitoring or alert

This element ensures the practice uses registries and proactive reminders to address a variety of health care needs.

The practice may use mail, telephone or email, directly or through external providers (vendors) to remind patients when services are due.

Renewing practice: the practice should by identifying patients and conducting outreach for needed services at least annually

Examples:

- Preventive – well child visits, mammograms, pap smears, colonoscopy, fasting blood sugar. Preventive services consider the practice's entire population and are not limited to a population with chronic conditions. Immunizations do NOT meet the requirement of this factor.
- Immunizations – at least two different immunizations appropriate to patient age or gender. Practices may not use the same immunization for two different age groups.
- Chronic/Acute Care – diabetes care, coronary artery disease care, lab values outside norm range, post hospitalization follow up appointments, follow up related to asthma, ADD, obesity or depression, repeated sinusitis or flu symptoms, repeated pharyngitis or otitis media ear infections (** the practice may focus on three chronic care services related to one condition – example: for diabetes, the A1c, micro albumin and diabetic retinopathy exam)
- Patient Not Seen – patients overdue for an office visit (care management follow up visit or overdue periodic physical exam)
- Medication – manage patients prescribed medication with potentially harmful side effects; identify patients prescribed a brand name drug instead of a generic; notify patients about a

medication recall; remind patients about necessary monitoring because of specific medications (warfarin, liver function test, growth hormone); inform patients about drug-drug or dosage concerns

Documentation

- Identified services for each factor,
- Reports used by the practice in the previous 12 months to remind patients of needed services specified in the factors,
- Materials showing how patients were notified of each service with specific de-identified patient examples



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PCMH 4B: Care Planning and Self Care Support

The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for patient identified in PCMH 4A (ie, patients identified as likely to benefit from care management):

- Incorporates patient preferences and functional/lifestyle goals
- Identifies treatment goals
- Assesses and addresses potential barriers to meeting goals
- Includes a self-management plan
- Is provided in writing to the patient/family/caregiver

The care team and patient/family/caregiver collaborate on developing and updating a care plan that addresses whole person care. The care plan specifies the services offered by and responsibilities of the primary care practice and, if appropriate, integrates with a care plan created for the patient by a specialist, to avoid potential overlap or gap in services and care.

A care plan considered and/or specifies various areas related to a patient's care which could include;

- Patient preferences and functional/lifestyle goals
- Treatment goals
- Assessment of potential barriers to meeting goals
- Strategies for addressing potential barriers to meeting goals
- Care team members, including the primary care provider or record and team members beyond the referring provider and the receiving provider
- Current problems (may include historical problems, at the practice's discretion)
- Medication allergies
- A self-care plan

CMS defines a care plan as, "The structure used to define the management actions for the various conditions, problems or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has

given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome)."

The care plan must be updated at relevant visits. A relevant visit addresses an aspect of care that will affect program toward meeting existing goals or that require modification of an existing goal. The care plan must be reviewed/updated no less than once a year.

Documentation

- At least 30 patients are sampled from PCMH 4A, and a medical record review is conducted
- Use the instructions in the Record Review Workbook to choose a sample of relevant patients and check for the relevant items.



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PCMH 5B: Referral Tracking and Follow Up

The practice:

- Considers available performance information on consultants/specialists when making referral recommendations
- Maintains formal and informal agreements with a subset of specialists based on established criteria
- Maintains agreements with behavioral healthcare providers
- Integrates behavioral healthcare providers within the practice site
- Gives the consultant or specialists the clinical question, the required timing and the type of referral
- Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan
- Has the capacity for electronic exchange of key clinical information and provides an electronic summary of care record when patients are referred out
- Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports (critical factor)
- Documents co-management arrangements in the patient's medical record
- Asks patients/families about self-referrals and requesting reports from clinicians

Referrals tracked by the practice using a log or electronic system are determined by the clinician to be important to a patient's treatment, or as indicated by practice guidelines (eg, referral to a surgeon for examination of a potentially malignant tumor, referral to a mental health specialist for a patient having depression, referral to a pediatric cardiologist for an infant with ventricular septal defect). This factor includes referrals to medical specialists, mental health and substance abuse specialists and other services.

Source of data on the performance of clinicians the practice refers patients to:

- www.medicare.gov/physiciancompare
- Health plan physician directors with quality rating information
- State physician report cards

Agreements between primary care and specialists may be formal or informal and may describe the expectations or embed them in a tool such as a referral request form. The agreement is an articulation of the exchange of information.

Integration of behavioral health may be partial (co-location with some systems in common) or fully (co-location with all systems shared)

The referring clinician provides a succinct reason for the referral (“the clinical question”), the urgency of the referral and type of referral (consult only, co-management, assume treatment).

Referrals include relevant clinical information such as: current medications, diagnoses including mental health, allergies, medical and family history, substance abuse and behaviors affective health, clinical findings and current treatment, follow up communication and information.

Patient demographic information includes: communication needs, primary language, relevant cultural or ethnic information, date of birth, sex, contact information, health insurance information.

Including the PCPs treatment plan in the referral, in addition to test results/procedures can reduce duplication of services, tests or treatments.

The practice should have a means to track referrals and ensure a report is received back from the specialist.

For patients regularly treatment by a specific specialist, the PCP and the specialist should enter into a co-management agreement for the patient’s care that includes timely sharing of changes in patient status and treatment plan.

Patients might see specialists without a referral from the PCP (example, ob/gyn or ophthalmology). Clinicians should routine ask patients if they have seen a specialist and if so, request a report from the specialist to be documented in the medical record.

Documentation

- All factors require a documented process for staff (including date of implementation or date of revision, and has been in place for at least three months prior to submitting the PCMH 2014 survey tool)
- Factor 1 – examples of the type of information the practice team has available on specialist performance
- Factor 2 & 3 – at least one example of each type of agreement
- Factor 4 – materials explaining how behavioral health is integrated with physical health
- Factors 5,6, 8, 10 – a report, log or other means of demonstrating the referral process is being followed (the report may be system generated or based on at least one week – five days – of referrals with de-identified patient data)
- Factor 7 – a screen shot demonstrating capability – and – a report from at least three months of data showing the number of referrals for which a summary of care record was provided electronically divided by the total number of referrals
- Factor 9 – three examples of asking patients about self-referrals and obtaining the report from the specialist with de-identified patient information



PCMH 6D: Implement Continuous Quality Improvement

The practice uses an ongoing quality improvement process to:

- Set goals and analyze at least three clinical quality measures from PCMH 6A
- Act to improve at least three clinical quality measures from PCMH 6A
- Set goals and analyze at least one resource use/care coordination measure from PCMH 6B
- Act to improve at least one resource use/care coordination measure from PCMH 6B
- Set goals and analyze at one patient experience measure from PCMH 6C
- Act to improve at least one patient experience measure from PCMH 6C
- Set goals and address at least one identified disparity in care/service for identified vulnerable populations

The practice has an ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks.

Review and evaluation offer an opportunity to identify and prioritize areas for improvement, analyze potential barriers to meeting goals and plan methods for addressing the barriers.

The practice may implement a rapid-cycle improvement process such as Plan-Do-Study-Act (PDSA) the represents a commitment to ongoing quality improvement.

Documentation

- Report showing how the practice meets each factor and/or completion of the PCMH Quality Measurement and Improvement Worksheet