PCMH/PCMH-N BINDER TABLE OF CONTENTS

**basic starting points for discussion/demonstration in prep for site visit, in no way do the following promise validation of the associated capability*

CAPABILITY DESCRIPTION/CHECKLIST		
1.1	**Patient Provider Partnership Agreement**	
		ANNUAL REQUIREMENT: Staff Trained on Process (log signed & dated) inclusion of new hires
		Communication Tool
		Flag for completed (able to calculate aggregate % completed)
		Process Documented; cannot just hand out at front desk, discussion must take place
1.2	**Systematic Outreach for PPP**	
		Communication Tool
		Including patients who are not engaged
1.3-1.8	**% of Completed PPPs on Active Patients (10%-90%)**	
		Recent report detailing numerator/denominator
1.10	**Process for Repeating the PPP**	
		Process Documented, detail on difficult to engage patients
		Date stamped to allow tracking for every 2-3 years
1.11	**New Patient Orientation**	
		Agenda, Handouts, Schedule, *Scheduled in advance as a group visit
		Can be led by mid-level provider or care team member (MSW, NP, PA, Rx, Nurse), not MA
1.12	**Patient and Family Advisory Council**	
		Agenda, Schedule, Attendee List
		Patient feedback example showing enacted change based on feedback
Domain 2	**All Payer Registry Tool - manage patients at population level and point of care**	
Domain 3	**Performance Reporting - benchmarking**	
4.1	**Practice staff trained on PCMH, Chronic Care Model, Practice Transformation Concepts**	
		ANNUAL REQUIREMENT: Staff trained on concepts (log signed & dated) inclusion of new hires
		Training documentation required
		Inclusion of new hires in training process
4.2	**Integrated, Multidisciplinary team approach for Coordinated Care Management**	
		Regular team meetings
		Examples of structured communication between team members on planned intervals
4.3	**Evidence Based Guidelines at Point of Care**	
		Process for ID-ing and flagging gaps in care
		Guidance for appointment type/length booking
4.4	**Patient Satisfaction/office efficiency measures**	
		Survey tool
		Survey results: quantified, aggregated, tracked performance over time
4.5/4.11	**Action Plan and Goal Setting in EMR**	
		Examples of action plan/goal setting and follow-up at subsequent visits
4.8/4.14	**Planned Visits**	
		Documented Chart Prep Process; proactive team approach with identified roles
		Recent Example
4.9/4.15	**Group Visits**	
		2 hr requirement, no more than 20 pts, must include 1:1 component with physician
		Patient selection process, overview of visit structure
4.10	**Medication Review and Management**	
		Demo that Med Recs performed at every encounter

		Demo that complete list of meds is addressed with updates
		Demo that concerns regarding meds (side effects, interactions) are addressed/resolved
4.12	**Systematic Appointment Tracking & Reminders**	
		Documented Process
		Point to evidence based guidelines prompting reminders
		Recent Examples of outreach (telephone, mail)
4.13	**Systematic Follow-Up for Needed Services**	
		Documented Process
		Point to evidence based guidelines prompting recalls for patients not seen
		Recent Examples of outreach (telephone, mail)
4.16/4.22	**Systematic Approach for Tracking Advanced Care Plans/Advance Directives**	
		Documented template or tool; how you initiate process with patients
		Demo follow-up for patients who were provided materials but not returned paperwork
		Process for Communicating lead responsibility/ACP status with co-managed provider(s)
4.17	**Survivorship Plans**	
		Systematic process for identifying who has lead responsibility for individualized plan
		Plan includes guidelines for monitoring
		Process for Communicating lead responsibility/SP status with co-managed provider(s)
4.18	**Palliative Care**	
		Documented Process for assessing need/trigger for Palliative referral (PHO has one)
		Process for Communicating lead responsibility/status with co-managed provider(s)
4.19	**Identifying Patients for Care Management based on conditions and/or utilization**	
		Documented qualifiers (conditions, utilization triggers, etc.)
		Process for Communicating CM status with other healthcare provider(s)
4.20	**Informing Patients about availability of Care Management services**	
		Process for informing patients and caregivers about CM services
		Demo conversation and documented response
4.21	**Case Reviews for Medically Complex Patients**	
		Process for conducting and documenting case reviews
		Note required elements in implementation guide
		Patient Example
4.23	**Process Improvement techniques to improve patient experience: LEAN, Journey Mapping,**	
		Document entire process - workgroup formation to end result
4.24	**Care Management Process and Workflows**	
		PHO CM policies and workflow examples
4.25	**Care Management Training, Onboarding and Integration**	
		Onboarding checklist
4.26	**Care Management Billing Processes**	
		Billing Process, reference materials or job aids, example
4.27	**Care Management Data**	
		PDCM member lists, reports, high risk targeting list
4.28	**Medication Assisted Therapy**	
		Proof of waiver and patient example
5.1	**24 Hour Access to Clinical Decision Maker and feedback loop to PCMH**	
		Urgent After Hours: response no later than 60 minute response time from inquiry
		Non Urgent Business Hours: response by end of business day
		Process for notifying PCP of interaction
		Patient Example of After Hours Inquiry

5.2	**Clinical Decision Maker updates EMR during call**	
		Proof that on-call provider has access to EMR and can update
		Patient Example required of after hours inquiry (date/time stamp)
5.3/5.5	**Non-ED after hours access for urgent care needs 8/12 hrs. per week in <u>different</u> location as PCMH Office**	
		Outside normal business hours (before 9a, after 5p, or weekend - lunch does not count)
		Review Office Hours, ways patients understand when the office is open
		Review how patients know how to access non-ED provider when office is closed
5.4	**Approach to ensure all patients are fully informed of after hours care availability and location**	
		Evidence of Communication Tool (where patients can find info on posted hours)
		Relationship with HH Urgent Care (alerts go back form UC to PCPs next day)
5.6	**Non-ED after hours provider updates patient's EMR during visit**	
		Demo examples
5.7/5.8	**30% / 50% Same Day Appointment availability**	
		Written Policy
		Communication Tool (how patients understand they can call for same-day care)
		Demo with screenshot of actual schedule blocks a week or two in advance
5.9	**Telephonic Access to Interpreter**	
		Only applies if >5% of patients primary language is not English (don't have to demo %)
		Description of tools available (vendor, multilingual staff, etc.)
5.10	**Patient Education form available in languages other than English**	
		Only applies if >5% of patients primary language is not English (don't have to demo %)
		Provide examples
5.11	**Access to non-ED after-hours for urgent needs, at least 8 hours per week, WITHIN provider's office**	
		Office hours, schedule example; standard BCBS hours are 9am-5pm
5.12	**Access to non-ED after-hours for urgent needs, at least 12 hours per week, WITHIN provider's office**	
		Office hours, schedule example; standard BCBS hours are 9am-5pm
Domain 6	**Test Tracking Policy**	
		ANNUAL REQUIREMENT: Staff Trained on Tracking Policy (log signed, dated) inclusion of new hires
		Demonstrate "the life of a test order" start to finish with patient examples
		Documented Procedure must include:
6.1		~tracking and follow-up for normal and abnormal results, within specified timeframes
6.2		~process for following up on patients for uncompleted tests
6.4		~mechanism for patients to obtain info on normal results
6.5		~approach to inform patients about abnormal results
6.6		~process for ensuring recommended follow-up care for patients with abnormal results
6.7		~all steps documented in EMR (ordered, resulted, reviewed, patient outreach)
		CPOE: Computerized Order Entry with integrated electronic test tracking system
8.7	**E-prescribing system in place and used by all providers for non-controlled substances**	
8.8	**E-prescribing system in place and used by all providers for CONTROLLED SUBSTANCES**	
		75% of controlled substances prescribing should be electronic
8.10	**Controlled Substance Agreements in place for patients on long-term prescriptions**	
		Long term defined as >60-90 days
		Defined process for completing CSA
		Example form
9.1	**Primary Prevention Program - identify/educate about personal health behaviors to reduce risk**	
		May be on patient intake form, questionnaire, etc.
		Describe process for identifying patients in need of preventive services
		Must be comprehensive primary prevention, not isolated elements

9.2	**Approach to providing primary preventive services**	
		Evidence of Guidelines followed (HEDIS, MQIC, PHO, etc.)
		Process for tracking to ensure follow-up
9.3	**Outreach regarding well care visits and screenings**	
		Evidence of Guidelines followed for age/gender (HEDIS, MQIC, PHO, etc.)
		Process for identifying patients in need of services - provide example
9.4	**Inquiring about Outside Health Encounters**	
		Describe how patients are asked about outside encounters
		Notation in EMR estimated date of services (ex: VA, health fair) for relevant preventive services
9.5	**Tobacco Assessment Tool and Advice Regarding Cessation**	
		Demonstrate How/When is tobacco use discussed, how frequently assessed
		Describe options offered to assist patients in quitting
9.6	**Written Standing Order Protocols**	
		Written signed, dated orders - reviewed annually (provide types of orders authorized)
9.7	**Secondary Prevention Program for asymptomatic patients with risk factors**	
		Guideline-based assessment tools (ex: depression, family history)
		Process for follow-up on positive screening results
		Specialist: only applicable secondary preventive guideline & testing recommendations
9.8	**Staff Training or Education on health promotion/disease prevention**	
		Provide proof of training/education documents
		Discuss who is lead for receiving updates, how info is shared with staff
9.9	**Structured Health Management Visits (see Planned Visits 4.8)**	
		Documented process required
		Walk through steps of planned preventive visit: info to patients prior, during, post
9.10/9.11	**Screening adult/pediatric behavioral health disorders for all patients**	
		Demo of screening tool, how it's utilized
		Example in HER of positive and negative result, follow up process, who and how
10.1-10.2	**PHO maintains a repository/relationship with community resources**	
		Good Samaritan Ministries KNOW Books are distributed every 3 years (now electronic)
		Ottawa County Pathways Community Health Worker program to address needs
		PHO shares info on resources via semiannual Resource Fair, manager meetings, email
10.3	**Practice has an Active Role in Community Resource Relationships**	
		Able to provide list of organizations providing services relative to patient population
10.4	**Staff Training on Availability of Community Resources**	
		ANNUAL REQUIREMENT: Staff Trained (log signed, dated) inclusion of new hires
		Evidence of staff training/education materials
		Describe impact on process for connecting patients with community resources
10.5	**Systematic Approach for Educating All Patients about Availability of Resources, Need for Referral**	
		Assessment requires screening tool related to Social Determinants AND proactive process
10.6	**Systematic Approach for Referring Patients to Community Resources**	
		Clinical-Community Linkages Procedure that walks through steps from assessment to referral
		Who initiates referrals and via what method(s)?
10.7	**Systematic Approach for Tracking Referrals to Community Resources for High Risk Patients**	
		Describe who might constitute a "high risk patient" and how they are identified
		Demonstrate how referrals are tracked
10.8	**Systematic Approach for Follow-up on Community Referrals for High Risk Patients**	
		Describe steps for following-up on high risk patient referrals, "Closing the Loop"
		Process for noncompliant patients - tracking those who decline and why

11.1	**Trained staff on self-management support techniques (may be informal)**	
		Trained staff promotes self management techniques to all staff at least annually
		Examples: motivational interviewing, health literacy, teach-back, barrier analysis, follow-up
		Describe how training has supported interactions with patients
11.2	**Structured Self Management Support Systematically Offered**	
		May be in context of planned visits, telephone or face to face encounters, action plans
		Describe targeted population and how patients are engaged
		Describe tools to promote self management
11.3/11.6	**Systematic Follow-Up for Patients Engaged in Self Management**	
		Process for follow-up with patients on progress towards goals
		Examples of outreach between visits required
11.4	**Patient Satisfaction Surveys for Patients Engaged in Self Management**	
		Survey tool (might be included with capability 4.4 survey)
		Survey results: quantified, aggregated, tracked performance over time
		Follow-up on areas of improvement (documented examples) and outcome of steps taken
11.5	**Self Management Support Offered to Multiple Populations Based on Need, Suitability, Interest**	
		Method or mechanism for engaging patients in self management
		Describe tools and conditions selected for self management
11.7	**Self Management support offered to ALL patients (including well patients), "Establishing Goals"**	
		Method or mechanism for engaging patients in self management
		Describe tools, how patients are tracked, outreach between visits
11.8	**Formally Trained Staff in Self Management Techniques**	
		Certified individual to provide training for other staff (log signed, dated)
		Describe how training has supported interactions with patients
Domain 12	**Patient Portal Capabilities:**	
12.3		Request appointments electronically and practice notifies patient of slot
12.4		Log self administered tests (i.e.: blood pressure, weight) & what staff do with it
12.5		Provider alerted to SR data that indicates potential health issue/how they respond
12.6		Patients can participate in Virtual Visits
12.7		Send automated care reminders and health education materials
12.9		Patients can view test results electronically
12.10		Patients can request prescription renewals electronically
12.11		Graph/analyze self reported tests for self management and use at point of care
12.12		Patients can view electronic health record data released by provider
12.13		Patients can schedule appointments through interactive calendar
12.14		Prepare for planned visits i.e.: alert to needed tests, questionnaire to gather info
13.1	**Notification of Admission, Discharge, Transfer**	
		Practices receive Holland Hospital Daily IP, SP, and ED Discharge List (+ other ADT notifications)
		Describe how providers receive ADT notification and review pertinent info
13.2	**Process in Place for Exchanging Necessary Records, Discussing Continued Care Arrangements**	
		Describe info exchange process - transfer of care
13.3	**Approach to Systematically Track Patients Through ADT Process**	
		See interpretive guidelines for detail on required elements
		Demonstrate examples of patients being tracked (acute, intermediate, and/or home care)
13.4	**Process in Place for Systematically Flagging Patient Issue for Immediate Attention**	
		Examples of high risk triage patient situations (i.e.: patient reports high glucose, weight gain)
13.5	**Process in Place for Written Transition Plans for Patients Leaving the Practice**	
		Plan includes summary of diagnoses, procedures, current meds, gaps, prescription refills

		Copy of plan provided to patients
		Walk through steps from the time the office is notified patient will be leaving to active transfer
13.6	**Process in Place to Coordinate with Payer Care Management**	
		BCN: 800-392-2512, BCBSM: 800-845-5982, Priority Health: 616-355-3247 (Susan)
		Describe how/when you may refer or coordinate with payor care managers
13.7	**Care Coordination Procedure**	
		Written guideline for each phase of care coordination process with clearly defined roles
		ANNUAL REQUIREMENT: Staff trained (log signed, dated)
13.10	**Hospital Discharge Follow-Up Transition of Care Process**	
		Written tracking process, including PCP/SCP coordination when appropriate
		Phone call or visit within 24-48 hours
13.11	**Participation in Michigan ADT initiative**	
13.12	**Participation in Michigan ADT Medication Reconciliation Use Case initiative**	
14.1	**Specialist Referral Procedure**	
		Written procedure to guide referral process, including timeframes, scheduling outreach process
		See interpretive guidelines for detail on required elements
14.4	**Specialist Referral Materials**	
		Communication regarding expectations (provider to provider)
		Written Visit Summary for Patients as appropriate
14.6	**Bi-directional Electronic Referral Process**	
		Examples: P2P, GLHC
		Demonstrate the process
14.7	**Process for Follow-up Regarding Incomplete Specialist Referral**	
		System in place to determine if patient was seen, outcome of visit, and associated follow-up
		Patient EMR updated to reflect outcome of referral
		SCPs: process to inform PCPs of outcome, associated follow-up
14.8	**Staff Trained on Specialist Referral Process (see 14.1)**	
		ANNUAL REQUIREMENT: Staff Trained on Procedure (log signed, dated) inclusion of new hires
14.9	**Patient Satisfaction/office efficiency measures for COMMONLY REFERRED SPECIALISTS**	
		Survey tool conducted at least annually
		Survey results: quantified, aggregated, tracked performance over time
		Appropriate follow-up for SCPs identified as not meeting standards for patient-centered care
		SCPs: see 4.4 - sharing results with PCPs will constitute meeting 14.9
14.11	**Self-Referral to Specialists: Follow-up With PCP**	
		SCP routinely notifies PCP when patients self refer (ex: prove with PCP field on intake form)
		PCP conducts follow-up with patients who have self-referred (demo examples required)