Getting started with Patient-Centered Medical Home and NCQA PCMH Recognition

A Resource for Primary Care Practices

July 2013

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Acknowledgements

In 2010, the Delta States Innovative Project Grant, which is funded through the Delta States Rural Development Network Grant Program and administered by the Office of Rural Health Policy, was awarded to assist two southern Illinois primary care clinics in becoming a Patient-Centered Medical Home (PCMH). PCMH is a health care setting and a model of care that facilitates a partnership between patients, their physicians and their health care team to provide accessible, coordinated, comprehensive, and continuous quality healthcare. Based on the experiences at the two clinics, the Center for Rural Health and Social Service Development developed a PCMH template to disseminate to primary care practices throughout the 16 county Illinois Delta Region. This resource template is the compilation of information gleaned while working on the Patient-Centered Medical Home Innovative Project.

The steering committee for this project included Southern Illinois Healthcare, Shawnee Health Service, SIU HealthCare and the SIU School of Medicine Center for Rural Health and Social Service Development (CRHSSD). The CRHSSD wants to thank steering committee members for their collaboration and commitment to this project. We want to thank staff at the Center for Medical Arts and Shawnee Health Care-Carbondale for the time and effort put forth for PCMH transformation. We also want to thank the project consultants from TransforMED.

July 2013

Published by:
Southern Illinois University School of Medicine
Center for Rural Health and Social Service Development
1745 Innovation Drive, Suite C
Carbondale, IL 62901

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# Table of Contents

Getting started with Patient-Centered Medical Home................................................................. 1

**Part One: Overview of the Patient-Centered Medical Home**

Access and Continuity of Care........................................................................................................ 3
Care Coordination and Team-Based Care....................................................................................... 4
Population Health Management...................................................................................................... 6
Care Management............................................................................................................................ 7
Patient Self-Care Support and Community Resources................................................................. 8
Continuous Quality Improvement.................................................................................................. 9
NCQA Patient-Centered Medical Home Recognition....................................................................10

**Part Two: Implementing the Patient-Centered Medical Home**

Step One: Project Teams..................................................................................................................13
Step Two: The Initial Steering Committee Meeting.......................................................................15
Step Three: Patient-Centered Medical Home Readiness Assessment...........................................16
Step Four: Health Information Technology....................................................................................18
Step Five: Patient-Centered Medical Home Project Implementation Plan....................................19
Step Six: Preparing for PCMH Clinic Implementation...................................................................20
Step Seven: Rolling-out PCMH in the Clinic..................................................................................21
Step Eight: Making PCMH Happen............................................................................................... 22

**Part Three: Sample Resources**

Sample 1: Agenda for initial PCMH meeting.................................................................................. 25
Sample 2: Meeting content for initial PCMH meeting....................................................................26
Sample 3: PCMH project charter.................................................................................................29
Sample 4: PCMH logic model......................................................................................................30
Sample 5: Practice assessment form..........................................................................................32
Sample 6: Practice PCMH readiness assessment........................................................................33
Sample 7: Project manager initial work plan...............................................................................39
Sample 8: Agenda for initial meeting with the project manager and practice team..............42
Sample 9: Care coordination agreement....................................................................................43
Sample 10: Transition and coordination of care procedure.........................................................44
Sample 11: Guidelines for coordinating care transitions............................................................46
Sample 12: PCMH elements for diabetes care management program.........................................48
Sample 13: Diabetes action plan................................................................................................49
Sample 14: Flow diagram of referral process for diabetes care management program............50
Sample 15: Diabetes care management program staff duties......................................................51
Sample 16: Flow diagram of the process for lab testing results..................................................52
Sample 17: Standard work for huddle........................................................................................56
Sample 18: Message to patients for PCMH................................................................................58
Sample 19: PCMH patient poster...............................................................................................60
Sample 20: PCMH patient handout.............................................................................................61
Sample 21: Introduction to PCMH slides....................................................................................62
Sample 22: PCMH training for clinic employee slides.................................................................76
Sample 23: NCQA PCMH 2011 standards monitoring tool....................................................91

Bibliography..........................................................................................................................112
The Patient-Centered Medical Home (PCMH) is a model of primary care delivery that emphasizes the relationship between a patient and their health care provider for accessible, coordinated, comprehensive, and continuous quality health care. The health care provider ensures that each patient’s preventive, acute, and chronic health care needs are met by using the healthcare team to plan, coordinate and manage aspects of their care. The provider and the healthcare team support patients by teaching self-management skills, leading them through the health care delivery system, and showing them how to obtain needed resources and services in their community. Providers demonstrate their commitment to this model of care by implementing a quality program such as The National Committee for Quality Assurance (NCQA) PCMH recognition program. This program employs an evidence-based, systematic approach for health care delivery that improves quality and reduces cost.

Medical homes are expected to reduce healthcare cost by avoiding redundant and unnecessary services, especially duplication of lab and imaging services and reducing nonemergency use of hospital emergency departments. PCMH principles have reduced total spending 15-20% in pilot projects. PCMH Demonstration Projects have shown success in increasing quality of care. McGlynn et al. (2003) found that patients received recommended primary care services only one-half the time due to the focus of care being on a new symptom or injury and not chronic health problems. Both State and Federal initiatives are moving not only toward PCMH but bidirectional integration of behavioral health and primary care and treatment. It is anticipated that payment will appropriately recognize the added value provided to patients with a PCMH and reimbursement will move beyond the traditional fee-for-service payment model. This is already happening in the CMS Comprehensive Primary Care initiative whereby participants receive monthly care management fees and the opportunity to share in a portion of the total Medicare saving in their market area.

There are also costs associated with a PCMH. A practice must commit administrative and staff time for a period of approximately eight to eighteen months to transition to a PCMH and achieve NCQA PCMH recognition. Health Information Technology adds quality and safety to the practice; but this technology is expensive to purchase, to maintain, and requires on-going staff training.

This template is intended to guide you in getting started on becoming a PCMH and offer resources to assist you in this endeavor. Part one provides an overview of the PCMH, part two suggests steps to getting started with your PCMH project and part three includes sample resources that provide ideas for project implementation. The bibliography includes useful articles and web sites. The 2011 NCQA PCMH recognition standards are referenced throughout this document; however, this is not an all inclusive NCQA PCMH recognition resource.
Part One

Overview of the Patient-Centered Medical Home
Patient-Centered Medical Home

The key components of the PCMH are access and continuity, care coordination and team-based care, care management, patient self-care support and community resources, population health management and continuous quality improvement.

Access and Continuity of Care

In the PCMH model access is characterized by access during office hours, after-hours access and electronic access. Access during office hours is a must pass element for NCQA PCMH recognition and providing same-day appointments is a critical must pass factor. The practice must have a written policy for scheduling same day appointments that includes a defined standard (e.g. X% of appointments will be available for same day routine and urgent care) and a process for staff to follow when scheduling same day appointments. The practice must be able to demonstrate they have monitored performance against the standards and show they reserve time for same-day appointments by producing reports or screenshots of each provider’s daily schedule. A report showing third next appointment is available within 24 hours for routine or urgent care meets the goal of same-day access. Adding unscheduled appointments to a full day of scheduled appointments does not meet the requirement. Tracking the number of requests for appointments and for same day appointments, and comparing the number or appointment requests to the number of available appointments on a daily basis helps practices determine how many same day appointment slots are needed. After-hours appointment access is provided when a patient receives care outside of regular business hours. Providers can offer early morning, evening or weekend appointments or they can arrange for other clinicians or (non ER) facilities to provide services after-hours. After-hours access is not instructing patients to go to the Emergency Department for routine after-hours care and treatment.

In a PCMH clinicians provide patients timely communication during regular business hours and after-hours either telephonically or electronically. Providing timely clinical advice by telephone when the office is not open is also a critical must pass factor for NCQA PCMH recognition. Once again the practice must have a written policy and a standard defining a time frame for a response to a clinical issue, be able to demonstrate they have monitored performance against the standard, and produce a report summarizing actual response times for at least 5 days of calls. Standards may vary depending on the urgency and nature of the patient request, for example emergent calls are returned within 15 minutes and urgent calls are returned within 1 hour. Clinical advice is to be documented in the patient record whether it is delivered during regular business hours or after-hours. Lastly, another after-hours care PCMH factor is that on call providers must have access to the patient’s clinical information. This is accomplished by arranging for access their electronic health record, by telephonic communication with their primary clinician, or by reviewing the patient provided copy of their pertinent clinical information.

A PCMH uses a team to provide patient care and treatment and having a structured communication processes or regular team meetings is a critical factor for NCQA PCMH recognition. A healthcare team “huddle” is an example of a useful structured communication process. During a team huddle staff members review the day’s workload and make plans for
how to best deliver the day’s patient care. Huddles should be brief, regularly scheduled and attended by physicians, providers and their respective staff, including administrative or support staff as needed. During huddles the daily patient schedule is reviewed. Ideally this list will include a patient diagnosis, the type visit and whether or not a procedure is planned. Staff can identify patients who are known to require additional appointment time or assistance. Advance planning can ward off potential bottlenecks in patient flow. Staff duties can be reassigned to meet the day’s challenges. Huddles are a good time to reflect on yesterday’s work and evaluate what went well or plan for improvement strategies. Time allowing, huddles are also a good time for clinic communication and staff education. Having regular team meetings or a structured communication process is a critical must pass element for NCQA PCMH recognition. The practice demonstrates this by providing a description of their team communication processes and having samples of huddle notes, memos, meeting agendas or meeting summaries.

A PCMH provides patients continuity of care. This is accomplished by having patients choose a primary care provider and schedule all of their visits with this provider. The practice is expected to communicate the PCMH vision to their patients and provide resources that explain, in a way they understand, how the clinic provides care and treatment consistent with PCMH principles. A patient brochure or a practice website is a useful communication tool.

**Care Coordination and Team-Based Care**

A PCMH emphasizes a team-based approach to care delivery. A provider directs the health care team comprised of nurses, medical assistants, ancillary support staff and administrative staff to deliver care in a planned, efficient and organized manner.

- The team uses evidence-based practices and a coordinated delivery process, with defined policies, protocols and procedures, staff roles and responsibilities, and structured communication processes.
- The team’s role includes care coordination, care management and patient self-management support.
- The team tracks and follows-up with lab and imaging tests and referrals.
- The team coordinates with facilities to manage care transitions.
- Team members are trained in methods to promote patient self-management, self-efficacy and behavior change.
- Team members contribute to the quality of patient care delivered, and take an active role in evaluating and improving care.

Patient-centered care is meeting the patient’s needs and preferences for quality health care. This is accomplished by delivering proactive, planned, and coordinated evidenced-based care. The team plans for a patient visit by reviewing the record and making sure all pre-visit lab and imaging results are in the chart. The team follows-up on referrals; making sure appointments are kept, that specialists have patient information prior to the appointment, and that the patient’s provider receives the specialist’s recommendations. The team makes sure outpatient testing is completed, results are obtained, and patients are notified of results in a timely manner. When patients are admitted to the hospital, the team makes sure the hospitalist has patient health information. Likewise, when a patient is discharged the team reviews the hospital stay and makes sure a follow-up appointment is scheduled, and that patients know how to call if they have
questions about their treatments or medications.

During the patient visit the team ensures that routine clinic processes are completed for every patient every time. For example, during the rooming process the medical assistant collects patient vital measurements, updates the patient’s medical history, ensures immunization and preventive services are up-to-date, and reconciles medications. The medical assistant also reviews patient goals for the visit, makes referrals to ancillary staff, such as dieticians and social workers, assists patients with chronic disease self-management and provides information about resources and programs available in their community.

A practice may centralize all test and referral tracking activities to a staff care coordinator or each care team can manage these activities for their patients. Care coordination is enhanced when staff has the ability to access the local hospital and specialty clinic’s patient medical record.

The patient visit
A clinic can evaluate its efficiency by studying how care is delivered during a visit. “Front office” bottlenecks can be caused by scheduling too many patients for the same time slot or inefficient registration procedures. “Back office” bottlenecks occur when the patient record is incomplete, the provider must wait for staff to call for testing results, the room is not set up for a procedure, or the patient’s needs cannot be met in the amount of time allotted for the appointment. Practices can map out a patient visit flow to identify whether or not processes are in the correct order, if there are duplicative tasks, if tasks can be streamlined and if the appropriate staff member is assigned to a task. A cycle time study can be performed to identify the point in the visit causing the “bottleneck” such as time from check-in to rooming, rooming to being seen by the provider, time with the provider, and time from provider finish to check out. Practices may also want to examine how other clinic processes flow as well such as patient phone calls for triage, lab results, general information or medication refills. They may want to map the processes for notifying patients of scheduled appointments, testing results and needed preventive care. Practices may want to look at clinic staffing to make sure staff is assigned duties commensurate with the level of their licensure and ability. Once a practice has reliable information on how care is being delivered, efficient care delivery processes can be designed.

The clinic can standardize procedures to increase efficiency and ensure tasks are completed during a visit. Examples of standardized office procedures:

- Registration procedures that list information to obtain/verify/update on new and returning patients and forms the patient must sign during registration.
- Patient assessment procedures that provide instructions for completing a medical form, performing medication reconciliation and updating a health maintenance record.
- Standing order protocols for lab testing, preventive services, and medication refills: Standing lab orders specify lab testing that can be obtained for an identified condition. Preventive services orders may list vaccinations staff can administer based on a child’s age. Medication refill protocols identify medications that can be refilled and provide instructions for refilling them.
• Rooming procedures identify rooming tasks such as obtaining vital signs, performing medication reconciliation, updating health maintenance record, obtaining a patient history, reviewing a patient self-management log, and providing patient self-management education.

• Disease management procedures that identify when health care team members can refer a patient to a dietician, social worker or patient educator for additional education and training.

Lab, imaging and referral tracking
NCQA PCMH recognition standards require that practices have a documented process for tracking lab and imaging tests using an electronic system or paper log. This includes tracking tests until results are available and flagging and following up on overdue results, flagging abnormal testing results and bringing them to the provider’s attention and proactively notifying patients of normal and abnormal testing results. Tracking lab and imaging tests are critical must pass factors for NCQA PCMH recognition.

Similarly, the practice coordinates referrals using a log or electronic reporting system to document referral status. This includes tracking the referral’s status and the expected date for receiving the report, following-up on overdue referral reports, establishing and documenting agreements for co-management of patient care if needed and asking patients about self-referrals and requesting reports from other practitioners. A referral request should indicate the referral reason and its urgency, relevant clinical information and the level of involvement of the specialist. Referrals may range from a one-time request for evaluation of a chronic condition, where the specialist’s treatment recommendations will be carried out by the primary care provider, to a condition that the specialist will now manage entirely such as treatment for skin cancer. Often, primary care and specialty providers co-manage patient chronic conditions and clear communication is essential so that a treatment is not duplicated or overlooked. In PCMH primary care clinicians and specialists establish agreements to clarify practice expectations. Tracking and following-up on referrals is a must pass element for NCQA PCMH recognition.

Coordination with Hospitals
The care team coordinates with hospital clinicians and case managers to ensure they have important clinical information for admitted patients or patients seen in Emergency Departments, and that these patients are followed after discharge. This involves designing processes for information exchange. Hospitals and primary care practices can allow each other access to their patient medical records or create shared admission and discharge reports. Patients must understand the importance of identifying their primary care physician/practitioner, and to contact the primary caregiver, not a specialty provider, when they are seen at a hospital. Many primary care physicians allow hospitalists to manage their admitted patients; a good hospitalist/physician relationship reassures patients that their primary care physician is available if needed.

Population Health Management
Health Information Technology (HIT) provides practices a tool for implementing population health management. Population health management activities may include point of care
reminders such as letters or calls to parents of children in need of immunizations. A patient with diabetes can be reminded of an overdue annual retinal screening or a patient on high risk medications can be tracked to ensure they are following prescribed regimens for ongoing laboratory testing.

Using data for population health management is a must pass element for NCQA PCMH recognition. The practice must generate lists of patients and proactively remind patients/families and clinicians of needed services for at least two of the following categories to pass this standard:

- at least three different preventive care services
- at least three different chronic care services
- patients not recently seen by the practice
- specific medications

The practice may use mail, telephone or e-mail to remind patients when services are due. This is demonstrated by providing reports or lists of patients in need of services and materials showing how patients are notified such as a copy of a letter sent to a patient, a script or description of a phone reminder, or a screen shot of an electronic notice.

Rapid access to patient health data allows physicians to access, measure, quantify, qualify and benchmark how well the practice delivers health care to all patients. Practices can study their population demographics and service utilization, and plan programs to address patient disparities. For example, if the practice has a high rate of patient “no show,” is there a possibility these patients may live in a rural area without public transportation? If a high number of uninsured patients with serious chronic diseases have no visits in the past year are these patients only seeking urgent/emergent care in emergency departments?

**Care Management**

Care management is intensive clinical management that supports the patient’s efforts for self-management through education, counseling, specialized services, evidence-based practices and decision support. NCQA PCMH standards require that patients selected for care management include patients with chronic conditions and also patients with high-risk medical conditions. The practice analyzes its population to select three important conditions, two medical and one behavioral, for care management of chronic conditions. Selection of conditions is based on prevalent diagnoses, diagnoses where care management can help reduce complications and conditions with available evidence-based guidelines. High-risk patients for care management are selected from patients with high resource use and risk such as patients with frequent hospitalizations or visits to the emergency department, or patients noncompliant with prescribed treatment.

Care management services provided include pre-visit planning, creating and monitoring an individual’s care plan, medication management, and self-management support. The goal of pre-visit planning is to have complete patient information prior to a scheduled follow-up visit for the care managed condition. For example, the care manager will contact a patient scheduled for a routine visit for diabetes follow-up one or two weeks prior to the scheduled visit to have lab testing performed using standing orders. The care manager will follow-up on this testing and
make sure results are available to the provider at the time of the scheduled visit. Completing routine testing prior to the visit allows the provider to diagnose and treat during the visit, instead of contacting the patient after the visit if treatment changes are necessary. Each patient will work with the care manager and care team to design, implement and monitor their individual care plan. Treatment goals will be assessed each visit and the team will assist the patient in addressing barriers to progress. Patients are given a written clinical summary following each visit.

Medication management improves patient safety and is a priority for patients in care management programs. Medication review and reconciliation should occur at planned care management visits, care transitions, and following visits to specialists, emergency departments or hospitalization. Practices must document all prescription medications and over-the-counter medications, herbal therapies and supplements. Reviewing and reconciling medication with patients for more than fifty percent of care transitions is a critical must pass factor for NCQA PCMH recognition. Other components of medication management include providing patients information about new prescriptions and assessing patients understanding of medications, response to medications and barriers to adherence.

Care management is resource-intensive and practices decide what percentage of their patients they can effectively manage. Programs may be designed to deliver a range of activities based on a patient’s level of risk. For example, a diabetic patient with A1C in good control may not require the same number of face-to-face visits, or referrals to dieticians and counselors that a poorly controlled patient needs. Practices also decide how to use available resources for care management.

A dedicated care manager can be responsible for all aspects of the care management program or a care manager can provide program oversight and support the provider and care team’s care management activities. Practices can use a care management data base, such as an electronic registry or a spreadsheet program, to identify patients, proactively remind patients about needed services and monitor their program’s results. When implementing PCMH it may work best if the care team is comfortable with care coordination and team-based care before implementing care management.

**Patient Self-Care Support and Community Resources**

Self-management is a person’s ability to manage aspects of their health such as symptoms and treatment for a chronic condition. A must pass NCQA PCMH element is that the practice conducts activities for care managed patients that support the self-care process. Practices begin by assessing the patient’s understanding of their illness, their readiness to change, and self-care abilities. A critical must pass factor for this element is that the practice has documentation they provide at least fifty percent of patients in the care management program a written self-care plan that addresses the patient’s condition, and includes goals and an action plan for monitoring self-care. Clinicians provide appropriate educational resources and tools for collecting health information at home based on the patient’s health literacy level. Practices provide evidence-based counseling, coaching or motivational interviewing, to patients for adopting healthy
behaviors associated with their disease. Patients may be referred to community programs for ongoing education and support.

In a PCMH practices support all patients needing access to community resources. Practices demonstrate this by:

- maintaining a current resource list on five topics or key community service areas of importance to their entire population
- tracking patient referrals to community programs over time for monitoring program relevance and appropriateness
- providing treatment or assisting patients in obtaining care for mental health and substance abuse problems
- offering opportunities for health education programs

**Continuous Quality Improvement**

A PCMH reviews its performance on a variety of measures to understand the strengths and opportunities for health care delivery. NCQA PCMH recognition requires implementing and demonstrating continuous quality improvement, and reporting performance within the practice and externally to the public. Implementing continuous quality improvement is a must pass NCQA PCMH element.

The practice demonstrates ongoing monitoring of the effectiveness of its improvement program using improvement processes such as PDSA (plan, do, study, act). Examples of required PCMH activities are:

- setting goals and acting to improve performance
- measuring performance on three preventive/chronic/acute care clinical measures
- tracking utilization of two measures affecting health care costs such as rates of hospitalization or emergency department visits
- assessing for disparities in care delivery

A PCMH also implements a patient experience survey to assess the patient/family experience related to access to care and services, communication within the practice and care coordination. Feedback from patients can also be obtained through qualitative means such as focus groups, patient interviews or patient suggestion boxes.
**National Committee for Quality Assurance (NCQA)**

**Patient-Centered Medical Home (PCMH) Recognition**

There are six PCMH NCQA standards:
- Standard 1 – Enhance Access/Continuity
- Standard 2 – Identify/Manage Patient Populations
- Standard 3 – Plan and Manage Care
- Standard 4 – Provide Self-Care and Community Support
- Standard 5 – Track and Coordinate Care
- Standard 6 – Measure and Improve Performance

There are six MUST PASS elements:
- Standard 1A – Access during office hours
- Standard 2D – Using data for population management
- Standard 3C – Manage care
- Standard 4A – Self-care process
- Standard 5B – Referral tracking and follow-up
- Standard 6C – Implements continuous quality improvement

There are nine critical factors that must be met for practices to score any points for the element:
- Standard 1A1 – Access during office hours – providing same-day appointments
- Standard 1B3 – After-hours access – providing timely clinical advice by telephone when the office is not open
- Standard 1G2 – The practice team – having regular team meetings or a structured communication process
- Standard 3A3 – Implements evidence-based guidelines – related to unhealthy behaviors or mental health or substance abuse
- Standard 3D1 – Medication management – reviews and reconciles medications with patients/families for more than 50% of care transitions
- Standard 3E2 – Use electronic prescribing – generates at least 75% of prescriptions electronically
- Standard 4A3 – Support Self-care process – develops and documents self-management plans and goals in collaboration with at least 50% of patients/families
- Standard 5A1 – Test tracking and follow-up – tracks lab tests until results are available, flagging and following up on overdue results
- Standard 5A2 – Test tracking and follow-up – tracks imaging tests until results are available, flagging and following up on overdue results

Each NCQA PCMH standard includes multiple elements, and factors related to each element. There are 6 standards, 27 elements and 149 factors in total. Each standard includes a must pass element that must be met to obtain NCQA PCMH recognition. Each element is awarded a predetermined number of points and the number of points awarded depends on how many factors are met for each element. A must pass element requires a score of fifty percent to pass and, in addition, several must pass elements have critical factors that must also be met to score any points. The three levels of PCMH recognition are based on the total number of points received: level 1 with 35-59 points, level 2 with 60-84 points, and level 3 with 85-100 points. The NCQA
PCMH standards weigh heavily on the functionality of health information technology (HIT) and it is difficult for a practice to obtain PCMH level 3 recognition without HIT.

Many NCQA PCMH standards require a practice to have written policies, protocols and procedures supporting the standard. Practices can use documented processes, reports, patient files or prepared materials to demonstrate performance:

- **Documented processes** - Written policies, procedures, protocols, or forms the practice uses in workflow such as referral forms, checklists and flow sheets. The documented process must include a date of implementation or revision and must be in place for at least three months prior to submitting the PCMH 2011 survey tool. Examples of required policies include access to care, evidenced-based care management, and processes for care coordination and continuous quality improvement.

- **Reports** - Data including manual and computerized reports produced by the practice such as a list of patients who are due for a visit. Some factors allow using HIT screenshots to document compliance.

- **Records or files** - Actual patient files or registry entries documenting an activity. Performance can be measured by a query of electronic files yielding a count or using the NCQA PCMH record review workbook for manual review.

- **Materials** - Prepared materials the practice provides to patients, such as self-management and educational brochures and pamphlets.

Written policies should include a defined standard (e.g. X% of appointments will be available for same day routine and urgent care) and a process for staff to follow. The practice must be able to demonstrate they have monitored performance against the standards by producing reports or screen shots. Some factors set a benchmark rate that the practice must meet to receive points for the factor, and other factors only require the practice to demonstrate the ability to compute a rate. NCQA provides practices free educational materials and webinars to assist practices with their application for NCQA PCMH recognition[^4].
Part Two

Implementing the Patient-Centered Medical Home
Patient-Centered Medical Home (PCMH) Step One

Project Teams

The first step in the PCMH journey is organizing the project teams, identifying a project physician champion and selecting a project manager. Strong, committed leadership is critical to PCMH success. Leaders provide the vision for change, set the direction: mission, vision and strategy, instill confidence and enthusiasm for the PCMH, provide motivation for continuous improvement and innovation, identify changes to test, support staff as practice teams redesign themselves and their processes and sustain the will within the practice for transformation. It is crucial that the physician selected as the project “physician champion” supports PCMH transformation. A physician champion who does not support the project can quickly demoralize the teams and undermine the project. A successful project manager has experience in a primary care clinic, is skilled in managing complex projects, and has experience with building teams and facilitating change. Clearly defined project goals and objectives and leadership’s unwavering support will ensure the project manager’s success.

The size and complexity of the practice determines the number of teams. A single provider clinic will obviously have only one team; however, a large system with multiple primary care practices will have numerous teams. Suggested teams include a steering committee, practice team(s) and healthcare team(s).

Steering Committee
The steering committee provides project leadership and its members must be engaged in PCMH transformation and committed to the project’s success. This committee may include the practice directors for clinic operations, clinic managers, information technology and quality staff, the physician champion and project manager. In a large multispecialty practice executive leadership’s involvement may be project oversight or they may take an active roll on the steering committee. The steering committee communicates the vision and develops a project management plan with clearly defined project goals, implementation timelines, and allocated staff and resources. The plan must embed PCMH into daily operations and define how it integrates or competes with other projects. Depending on the practice’s organizational structure, the steering committee may delegate PCMH functions to existing practice committees such as having the quality committee approve all standing orders and evidenced-based protocols.

Practice Team
Each site in a multiclinic practice will have a practice team. The practice team includes the clinic manager, clinical and administrative supervisors, project manager and the physician champion for that clinic.

Health Care Team
Each clinic provider has a healthcare team. This team includes the provider, his medical assistants and support staff. Support staff may include a dietician, social worker, care coordinator, care manager, health educator, and front office staff. Each provider will lead his team to provide team-based patient-centered care. Depending on the size and number of providers in the practice, health care team members may support multiple providers.
The health care team’s duties include administrative and care delivery tasks. Administrative tasks may include obtaining pre-authorization for needed services, triaging patient phone calls, responding to patient inquiries such as requests for medication refills, and health advice. Examples of care delivery tasks are rooming patients, assisting with procedures, administering immunizations, scheduling return appointments and referrals to specialists, and patient education and self-management support.

Excellent communication within and among teams is essential. The clinic’s executive leadership provides oversight to ensure the project is meeting its goals and timelines, and has adequate resources. The steering committee makes sure administrative and clinical policy aligns with the PCMH model of care and that policy changes are approved by appropriate committees. The practice team implements the elements of patient-centered care at each clinic site. Implementation may differ among clinic sites; however, each site will follow the policy and procedures of the practice and steering committee guidelines and recommendations. Providers and their healthcare teams implement PCMH principles in a way that best meets the needs of their patients. Quality improvement and information technology staff support the steering committee, the project manager and practice teams.

The practice manager at each clinic site is responsible for PCMH implementation and the project manager and physician champion provide support. First steps for the project manager are educating clinic employees on the PCMH model, NCQA PCMH recognition standards and the project implementation plan. The practice team will then decide “who” and “how” to implement care coordination and team-based care, care management, population health management and quality improvement. Administrative staff can work on issues of appointment scheduling, patient registration and “front office” duties. Clinical staff can focus on team-based care, care management, care coordination, population health management and “back office” duties.

In a multi-clinic practice, it may be easiest to begin PCMH implementation at one clinic site initially. This allows for “tweaking” the implementation plan and obtaining additional resources if needed. Once the PCMH project is underway at the initial site, remaining clinics can follow. In a multi-clinic practice all sites follow the same policies, protocols and procedures; however, implementation may differ.

Project Consultant
Practices may hire a consultant to provide technical assistance and facilitate and coach all project teams. Ideally the consultant will be an expert in PCMH practice transformation and NCQA PCMH Recognition requirements. An experienced consultant’s expertise is invaluable; however, drawbacks are that the practice may view the consultant as an implementer instead of as a facilitator and consultants are costly. Even when a practice has a consultant, they still need strong and committed project teams. Exceptional resources are available for practices that forego a consultant. For example, government agencies (AHRQ, CMMI), Robert Wood Johnson Foundation, and Quallis Health have extensive publications and webinars on practice PCMH transformation. NCQA provides training on their PCMH standards and the NCQA PCMH recognition process.
Patient-Centered Medical Home Step Two
Initial steering committee meeting

Step two of the PCMH journey is the initial steering committee meeting. During this meeting the project manager (or consultant) introduces the PCMH model and NCQA PCMH recognition standards and facilitates meeting discussion. The group can create a project charter and a logic model addressing the long term goals of PCMH: education and implementation of the PCMH model, health information technology training and implementation, and NCQA PCMH Recognition. The meeting concludes with a discussion of project next steps: the practice readiness assessment and policy review. Turn to sample resources 1 - 4 for ideas for meeting agendas, a project charter and logic model.

Wise et al. (2011) looked at primary care practices’ readiness for PCMH implementation in sixteen practices in Michigan. Their findings suggested that employees of practices that are successful with implementing a PCMH saw the PCMH as intrinsically valuable to their patients, they took an active role in learning PCMH concepts and functions, and most employees were invested in the change process. When employees viewed the PCMH as an externally imposed program, saw financial incentives as insufficient and desired external teaching and direction for the PCMH, the transformation to PCMH was difficult. Successful practices viewed the difficulty with PCMH implementation as a challenge to overcome and practices that struggled viewed the PCMH objectives as obstacles that should be removed. Successful practices agree internally about goals and share responsibility for meeting those goals with team members. Struggling practices organize around individual physician’s idiosyncratic preferences or practices. Suggestions offered for improving motivation and capability included identifying and engaging practice champions, training motivated employees to become PCMH experts, and creating a project transformation plan that integrates seamlessly into clinic operations and addresses PCMH transformation incrementally. 6
Patient-Centered Medical Home (PCMH) Step Three
PCMH Readiness Assessment and Policy Assessment

In step three the project manager meets with the steering committee to assess the readiness of the practice for PCMH transformation and alignment of practice policies and procedures with PCMH standards. Results can be used to identify the practice’s strengths and opportunities for improvement.

**Practice Readiness Assessment**

A simple checklist developed by the American Academy of Family Physicians is a useful guide for assessing the “patient-centered” components of the practice. The guide evaluates your practice on four domains: practice organization, health information technology, quality and patient experience.

**Practice organization: does the practice**
- use a rigorous financial management process
- use data to drive decisions
- provide employees development opportunities

**Health information technology: does the practice**
- use an electronic health record
- use e-prescribing and medication alerts, clinical decision support, evidence-based medicine support, patient registries
- meet meaningful use requirements
- connect to patients, hospitals or specialty practices

**Continuous quality improvement: does the practice**
- track lab tests and referrals
- provide patients with testing results
- have care management programs in place
- use performance measures and benchmarks/best practice for prevention, chronic care and patient self-management support

**Patient experience: does the practice**
- provide patients’ access to care when they want and need it
- deliver respectful and meaningful patient care
- coordinate care and deliver care efficiently
- communicate clearly with patients and include patients in the decision-making process
- teach patients and care givers how to self-manage their care
- coordinate with community programs and services for additional patient support

A change readiness survey is another useful self-assessment tool; it examines the practice’s motivation and capability to change. Questions assessing motivation to change are structured around the level of understanding of PCMH domains and requirements, the perceived value of the PCMH model of care, and overall commitment to PCMH transformation. The practice’s capability to change is assessed by examining perceptions about the time demands for PCMH
implementation, the difficulties of changing patient’s behavior, and the complexity of implementing an electronic health record. NCQA provides a free practice readiness assessment tool for primary care practices. Turn to sample resources 5 and 6 for ideas for a practice assessment.

**Practice Policy Assessment**

A second component of a practice assessment is reviewing all policies, protocols and procedures for alignment with NCQA PCMH recognition standards. During this review the practice identifies policies that are needed and policies to revise or expand. Written policies should include a policy statement that summarizes the intent, a process for carrying out the policy, standards of performance and methods for monitoring process toward meeting the standard. Some NCQA PCMH recognition factors require the practice to meet a predetermined benchmark and other factors only require the practice to show progress toward meeting their own standard. Turn to sample resource 23 for an example of a NCQA standards monitoring tool.
Patient-Centered Medical Home (PCMH) Step Four
Health Information Technology

The PCMH model relies heavily on Health Information Technology (HIT) and step four focuses on selecting an appropriate system for the practice. Ideally the practice already has a HIT system; if not, selecting a system should be a priority. Suggested technologies are: a practice management system for day-to-day scheduling and billing operations, a patient electronic health record (EHR), an electronic system for e-prescribing, a clinical database (patient registry) and health information exchange technology. HIT systems can be used to monitor capacity and demand by trending patient panel size and visits per day. Patient registries can be used for population health management by identifying patients with specific disease processes or those patients requiring preventive care. Patient safety is improved when e-prescribing systems are used by reducing medication errors and adverse drug events.

IT systems whose vendors are certified for meaningful use have system reports that align with the NCQA PCMH reporting requirements. Some vendors also receive product PCMH prevalidation. This allows for automatic credit for certain PCMH elements demonstrating electronic capabilities saving the practice time and administrative burden. Clinics without these system capabilities may need to build additional templates and reports for the PCMH project.

Practices should ensure sufficient time is allocated for development and implementation of the EHR. This requires a dedicated information technology (IT) team of approximately 4-5 persons (depending on practice size) with knowledge of the operating system, building templates and writing reports, and experience in employee training. Having a team member with a clinical background is very helpful. The electronic health record must be comprehensive; yet “user friendly”. Initial staff EHR training should be in a “train” environment to allow employees the opportunity to practice prior to “go-live.” All staff should be trained at the “highly proficient” level and the importance of documenting “correctly and every time” in the EHR should be emphasized. Administration can anticipate that the first few weeks of “go-live” will slow down operations and the practice may want to reduce the number of patient appointments during this period. It is a good idea to tell patients that clinic operations may be impacted during this time. Ideally, all staff are available during the “go live” period and there are “expert users” available as a resource. The EHR is dynamic, and may require frequent upgrades and modifications. All staff will require ongoing training on the EHR system. The practice should routinely monitor EHR documentation compliance to ensure data integrity. Clinics without an EHR already in place should plan an additional 4-6 months for implementation in the PCMH work plan. PCMH recognition standards require the EHR to be operational 90 days on average to meet specified reporting time frames.
Patient-Centered Medical Home (PCMH) Step Five
PCMH Project Implementation Plan

Step five focuses on developing the project implementation plan. At this point steering committee members understand the PCMH model of care and are committed to implementing it. The practice’s readiness for PCMH has been assessed and strengths and barriers to successful implementation identified. Practice policies, protocols and procedures have been reviewed for alignment with NCQA PCMH recognition standards. The practice has a HIT system or is finalizing plans for a system.

A strategic planning session is a great way to “kick off” PCMH implementation. The session should include the clinic’s executive leadership, the steering committee and all providers. It may be difficult to schedule all providers for this session but they are essential to this project’s success! The strategic planning session can be devoted to PCMH education, team building, and drafting the project implementation plan. Turn to sample resource 21 to view PCMH slides.

The project manager can facilitate discussion during this planning session and provide guidance for adoption of the initial project management plan. The committee can also discuss the important conditions and complex patients for care management and select evidenced-based guidelines. They can also identify preventive and chronic care services for population health management.

Project implementation begins with a clearly defined project management plan. The plan should map out the timeline, actions and accountability for each NCQA PCMH factor; including required policies, activities and measurements. The plan should also include a timeline for implementing team-based care, care coordination, care management, patient self-care support, population health management and quality improvement at the clinic(s).

Based on clinic resources the process for PCMH clinic transformation may take from eight months to two years for completion. Clinics that have an electronic health record (EHR) and meet CMS meaningful use stage 1 requirement are poised to complete the process in eight months. Practices that are not currently using an EHR will have to plan additional time for EHR implementation (4-6 months). Clinics can begin the PCMH journey prior to implementing a EHR by concentrating efforts on PCMH administrative and clinical processes and shifting focus to EHR training and implementation when ready.

Successful PCMH projects have clear goals and deliverables, with a realistic timeline for implementation. The momentum for PCMH transformation is compromised when the project has an inconsistent implementation schedule. Once the practice has defined the scope of the project, identified and trained the project teams, and mapped out the implementation plan, it is ready for PCMH transformation.
Patient-Centered Medical Home (PCMH) Step Six
Preparing for PCMH Clinic Implementation

Step six involves laying the groundwork for PCMH implementation in the clinic. Following the steering committee strategic planning session the project manager now has the direction needed to begin clinic implementation. The project manager should meet with the practice manager and key clinic staff such as the administrative supervisor, nursing supervisor and practice physician champion. The goal for this meeting is that key staff understands the PCMH model and the potential for improving care delivery and patient outcomes. During this meeting clinic leadership identify roles for clinic staff and make staff assignments such as mapping patient flow through a visit, mapping process for notifying patients of testing results, writing procedures for the daily huddle or providing patients’ educational materials. The project manager learns how patient care is delivered in the clinic and what written materials are available to support the practices. Turn to sample resource 7 and 8 for ideas for a meeting agenda and an initial work plan.

This meeting is an opportunity for the group to share their perspectives on the PCMH model and identify the clinic’s strengths and barriers for a successful implementation. The project manager can offer reassurance that the clinic will have adequate time and resources for project completion. Lastly, the group can make plans for PCMH roll-out in the clinic. This strategic planning session will set the tone for the project, so it needs to be motivating and fun!
Patient-Centered Medical Home (PCMH) Step Seven
Implementing PCMH in the Clinic

Step seven of the project is implementing PCMH in the clinic. Again a strategic planning session is a great way to “kick off” PCMH implementation. The strategic planning session can be devoted to PCMH education, reviewing the project implementation plan, defining team member’s roles and responsibilities, establishing channels for communication and team building. It is important that providers and clinic managers have a vision for the PCMH, are engaged with the project and supportive of their staff. Suggestions for the session include:

Training on the PCMH model:
- Access and continuity of care
- Team-based care and care coordination
- Care management using evidence-based practice
- Patient self-care support and community resources
- Population health management
- Continuous quality improvement

Training on NCQA PCMH recognition

Review clinic PCMH implementation plan
- review first steps – implementing team-based care, clinic processes review
- review staff assignments
- review processes for project communication – staff meetings, steering committee meeting, etc.
- review plans for staff development

Team building exercise

Turn to sample resources 21 and 22 to view PCMH training slides.
Patient-Centered Medical Home (PCMH) Step Eight
Making PCMH Happen

Step eight is the most difficult since it is doing the work for PCMH. Even after a great “kick-off” staff may not really understand what comes next. The following suggestions may help get things moving.

Practice manager
1. Develop program and train staff on team building, communication skills, organizational and change management, health coaching, program management and personnel supervision.
2. Continue staff training on PCMH model and NCQA PCMH recognition.
3. Sign up for free webinars offered by NCQA on PCMH standards.
4. Define roles and responsibilities for clinical and nonclinical team members.
5. Discuss an aspect of PCMH at every staff meeting to sustain momentum.
6. Concentrate on must pass PCMH elements and critical factors.
7. Make easy changes first.
8. Implement team-based care and care coordination prior to care management.

Front office staff
1. Is there a policy for scheduling same day appointments? If not, write one using PCMH guidelines.
2. Review patient scheduling guidelines and update if needed.
3. Is there a written patient registration procedure? Review and update as needed for PCMH.
4. Is the clinic brochure patient-centered? Are there written instructions on how to obtain care and treatment both during and after-hours? If not, develop or revise brochure.
5. Assign staff members to review patient materials for patient-centeredness.
6. Assign staff members to develop a patient resource list of community programs in the area.

Back office staff
1. Ask each provider to start daily huddles with his healthcare team.
2. Review patient records prior to the clinic visit and make sure all testing results, referral reports and other correspondence are in the record prior to the patient visit.
3. Are patient health maintenance forms up-to-date in patient medical record? If not, develop and implement a corrective action plan.
4. Does the patient schedule identify patients being seen for procedures, planned follow-up, physicals, or acute care? Is a patient diagnosis included on the daily schedule? If not, develop a process for including this information.
5. Review the lab, imaging and referral tracking logs to ensure compliance with PCMH requirements.
6. Map out how telephone calls are routed and answered. Review this during a staff meeting and have staff share ideas for making the process more coordinated and efficient.
7. Is there a report identifying calls for clinical advice? If not create a listing of patient calls by type, e.g. medication refill, clinical testing results, clinical advice, etc.
8. Are there standing orders for medication refills or important medical conditions such as hypertension and diabetes, or high risk medications such as coumadin? If not develop.
9. Is staff using approved standard orders? If not, develop and implement a corrective action plan.
10. Is there a policy on providers’ after hour patient communication? If not develop and implement a corrective action plan.
11. Is there a list identifying patients referred to providers for clinical advice after hours? If so, is there written documentation of the time the provider returned the call. Are providers documenting after hours clinical advice in the patient medical record? If not develop a procedure for this.
12. Work with local hospitals to receive a daily listing of all clinic patients seen in the ED and admitted to inpatient or placed in observation.

Quality Manager
1. Implement continuous quality improvement if not already in place.
2. Develop a quality practice dashboard if not already in place.
4. Implement a patient experience of care survey.
5. Identify and monitor quality metrics.

Information Technology
1. Review NCQA PCMH requirements and compile a listing of required electronic capabilities.
2. Review NCQA PCMH reporting requirements and compile a listing of needed reports.
3. Create a disease registry in MS Excel if the HIT system does not include one.
4. Develop and implement ongoing staff HIT training.

After these initial team-based care and care coordination tasks are underway, the clinic can then begin implementing population health management and care management. Once the clinic has health information technology capabilities, efforts can be directed toward meeting NCQA PCMH factors addressing electronic systems. Turn to sample resources 9 – 17 for ideas for getting started with team care, care coordination and care management. Sample resources 18 – 20 provide ideas for patient communication materials.

This completes the introduction to PCMH and getting started with PCMH implementation in your clinic. Although steps to achieving NCQA PCMH recognition can be overwhelming, keep in mind that over 5,700 practices have already received medical home recognition!
Part Three

Sample Resources
Sample 1: Agenda Initial PCMH Meeting

Agenda

Patient-Centered Medical Home Project (PCMH)

1. Introductions

2. Overview of PCMH Model
   a. Characteristics of PCMH
   b. Access and continuity of care
   c. Team-based care and care coordination
   d. Population health management
   e. Care management
   f. Patient self-management support
   g. Quality

3. Health Information Technology - electronic health record, disease registry, decision support

4. Project Scope
   a. Key staff for teams – physician champion, steering committee, practice team, provider health care teams, project manager
   b. PCMH readiness
   c. Implementation strategy
   d. Timelines and reporting

5. Wrap-Up and Next Steps
   a. Define PCMH vision for the practice
   b. Define project teams and roles
   c. Develop project logic model and charter
   d. Inventory practice written policies and procedures, including standing orders, work flows, job descriptions, staff education, quality improvement program
   e. Assess practice metrics – patient and employee satisfaction
   f. Observe clinic workflow for front desk/clerical, clinic staff/rooming, providers
   g. Interview clinic staff – role and responsibility, job satisfaction
   h. Assess staff education and training program
   i. Prepare clinic assessment report
   j. Review clinic assessment report with leadership team
   k. Develop project PCMH work plan with actions, responsible person(s), timeline
Sample 2: Detailed meeting content Patient-Centered Medical Home

1. Meeting detail
   1. Overview of Patient-Centered Medical Home (PCMH) model
      a. Characteristics of PCMH
      b. Access and continuity of care
         1. Same day access - 3rd next available appointment
         2. After hours care – availability and timely clinical advice
         3. Documentation of clinical advice
         4. Access is not: double booking appointments, sending patients to ED for after hours care
      c. Team-based care and care coordination
         1. Policy/Procedure
            a. patient communication – returning calls, clinical advice, triage
               i. call triage procedure for clinical and nonclinical advice
            b. medication reconciliation
            c. huddles
            d. standing orders
               i. medication refills
               ii. lab testing for selected chronic conditions
               iii. high risk medication
            e. patient reminders – appointment, preventive care
            f. common procedures – pap testing, physicals
         2. Team care – planned, proactive, efficient – pre-visit planning
         3. Patient flow – front to back
         4. Staff roles – job descriptions, work at highest level of licensure
         5. Lab and referral tracking – notification of lab/dx testing results
         6. Care coordination – hospital transitions, ED usage, specialty referrals
      d. Population health management
         1. Patient demographic and clinical information documentation
         2. Patient comprehensive health assessment
         3. Using patient data to create patient listings for needed services and proactively reminding patients of needed services
         4. Preventive care tracking and point-of-care reminders
      e. Care management
         1. Selecting 2 chronic and 1 behavioral condition
         2. Selecting vulnerable condition
         3. Defining care management program – program components, evidence-based guidelines, standing orders, program registry, treatment plan
      f. Patient self-management support
         1. Goal setting
a. patient self assessment
b. patient self management plan and treatment goals
c. self management tools
d. evidence-based counseling – coaching, motivational interviewing

2. Community resources
   a. listing of community resources
   b. tracks referrals to community programs
   c. health education – group visits
   d. arranges/provides mental health and substance abuse treatment

g. Quality
   1. Measures performance
      a. 3 preventive, 3 chronic or acute, and 2 utilization measures
      b. develops reports stratified by “vulnerabilities”
   2. Measure patient experience
      a. patient experience of care survey representative of all patients in practice
      b. practice has qualitative patient feedback – suggestion boxes, focus groups, patient interviews
   3. Continuous Quality Improvement (CQI) Program
      a. set goals and improves performance – 3 performance measures, 1 patient experience measure, 1 disparity measure
      b. involves patients in quality improvement teams
   4. Demonstrates CQI
      a. tracks results and assess effectiveness of actions
      b. demonstrate improved performance over time on 2 measures
   5. Practice share performance reports
      a. within the practice by clinician
      b. across the practice
      c. outside the practice – public
   6. External reporting of clinical quality measures

2. Health Information Technology - Electronic Record, Disease Registry, Decision Support

2. Next Steps
   1. Define PCMH vision for the practice
   2. Define leadership team and roles
   3. Develop project logic model and charter
   4. Inventory practice written policies and procedures, including standing orders, work flows, job descriptions, staff education, quality improvement program
   5. Assess practice metrics – patient and employee satisfaction
   6. Observe clinic workflow for front desk/clerical, clinic staff/rooming, providers
7. Interview clinic staff – role and responsibility, job satisfaction
8. Assess staff education and training program
9. Prepare clinic assessment report
10. Review clinic assessment report with leadership team
11. Develop project PCMH work plan with actions, responsible person(s), timeline
Sample 3: PCMH Project Charter

Project Scope

Project will focus on the CLINIC NAME obtaining Level III PCMH NCQA recognition by INSERT DATE. Policy changes/improvements to support PCMH recognition will be adapted/implemented system-wide. Workflow improvements and best practices will be implemented at the CLINIC NAME and later rolled out to other clinics.

Intended Outcome

Clinic to implement PCMH model of care, including team-based care and care coordination, care management, population health management
Clinic to implement same day access to care and after-hours availability
Clinic to be patient-centered with every patient selecting a personal clinician
Clinic to achieve NCQA PCMH Level III recognition by DATE
Clinic to implement health information technology - electronic health record, patient registry, e-prescribing and health information exchange capabilities

Critical Success Factors

Leadership and physician support for PCMH project
Physician/provider and clinic staff support for team-based care and care coordination, population health management and care management
Physicians/providers and clinic staff support for evidence-based care and patient self-care management
Leadership support for continuous quality improvement
Adherence to the PCMH project implementation plan and target dates
Accountability of PCMH team members for completion of assigned tasks
Ongoing PCMH regularly scheduled team meetings
Information technology resources/support for PCMH reporting requirements
Electronic Health Record

Initial Assumptions

Project Manager will complete practice assessment and assist with development of implementation plan
Multiple stakeholder groups will be involved in process change for their areas
Clinic staff will be allotted time for education on the PCMH model of care and attending PCMH meetings
Sample 4: PCMH Project Logic Model

Logic Model for Patient-Centered Medical Home Implementation

Goals:

Long Term
Patient-Centered care is achieved through an ongoing partnership between the patient and their provider and care team. The team provides and coordinates high quality evidenced-based patient care and supports each patient in learning to self manage aspects of their care using the PCMH model. NCQA PCMH level 3 recognition demonstrates the practice’s commitment to the PCMH model.

Intermediate Term
The practice has implemented the PCMH model of care. The practice has adopted health information technology (HIT). The practice has received NCQA PCMH level 3 recognition.

Short Term
The provider and care team have developed a work plan for staff education and implementation of the PCMH model of care The provider and care team have developed a work plan for installation, staff training and ongoing maintenance of the health information technology system. The provider and care team have developed a work plan for meeting NCQA PCMH standards and applying for NCQA PCMH recognition.

Goal #1
The provider and care team have developed a work plan for staff education and implementation of the PCMH model of care.

Activities
1. The practice has defined the PCMH team(s) and the project coordinator.
2. The practice has performed a baseline clinic assessment of policy, operations and personnel.
3. The practice has performed a gap analysis to determine the steps that need to be taken to ensure policy and operations meet PCMH recognition requirements.
4. The practice creates a work plan with activities displayed against time for meeting PCMH standards.
5. The practice implements the work plan.
6. Staff education provided on PCMH model of care.
7. The practice performs ongoing continuous quality improvement to ensure compliance with PCMH recognition requirements.

Goal #2
The provider and care team have developed a work plan for installation, staff training and ongoing maintenance of health information technology (HIT) - electronic health record, disease registry, health information exchange.
Activities

1. The practice has defined the HIT team(s) and the HIT project coordinator.
2. The practice has performed a baseline clinic assessment of patient medical record policy and procedures, process and personnel.
3. The practice has performed a gap analysis to determine steps needed to transition from a paper to electronic record system that meets PCMH recognition requirements.
4. The practice creates a work plan with activities displayed against time for EHR implementation and meeting PCMH standards.
5. The practice implements the work plan.
6. Staff education on the EHR system and how to document in the EHR system to meet PCMH standards.
7. Staff education on the disease registry.
8. The practice performs ongoing continuous quality improvement to ensure EHR documentation compliance with PCMH standards.

Goal #3
The provider and care team have developed a work plan for meeting NCQA PCMH recognition standards and applying for NCQA PCMH level 3 recognition.

Activities

1. The practice creates a work plan with activities displayed against time for ongoing measurement of compliance with PCMH standards.
2. The practice implements the work plan.
3. The practice initiates process improvement (PDSA) as needed.
4. Staff education on NCQA PCMH standards and requirements for meeting standards.
5. The practice creates a work plan for submitting the NCQA PCMH application with activities displayed against time for collecting data and uploading required documentation (policy, procedures, screenshots, record workbook) into the NCQA PCMH software tool.
Sample 5: Practice Assessment Form

ORGANIZATION

1. Practice clear goals tied to a vision, strategic plan?
2. What type of leadership – who, style?
3. Business strategies, policies and procedures are up to date?
4. Practice operates as a coordinated system/team?
5. Communication well managed – top down or down up?
6. Physician, staff and patient satisfaction measured?
7. Continuous quality improvement program?
8. Practice has Health Information Technology system?

STAFF

1. Staff roles and responsibilities clearly defined?
2. Staff works to highest level of licensure and ability?
3. Team members have the skills to get the job done?
4. Staff is cross trained?
5. Ongoing staff performance reviews?
6. Excessive staff turnover/absences?
7. Frequent overtime to get the job done?

PCMH

1. A plan for physician/provider and staff participation and education?
2. Practice has a plan for managing change?
3. Leadership committed to adhering to PCMH project scope and implementation plan?
4. Clear project outcome measures?
5. The practice has a plan for project communication?
6. Resources available for HIT?
# Sample 6: Initial PCMH practice readiness assessment

## ASSESSMENT

<table>
<thead>
<tr>
<th>PCMH TEAM MEMBERS</th>
<th>NOT STARTED</th>
<th>WORKING ON</th>
<th>COMPLETE</th>
<th>COMMENTS</th>
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<tr>
<td>Physician Champion</td>
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<td>Quality Improvement</td>
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<td>Project Manager</td>
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## PCMH IMPLEMENTATION PLAN

- Steering committee retreat
- Gant Chart and timeline
- Establish process and outcome metrics to monitor for process improvement
- Map practice workflow
- Re-allocate staff duties
- Educate staff on new processes
- Plan, do, study, act and reassess

## STAFF DEVELOPMENT

- Project Manager Training
- Staff Training
  - Overview of PCMH
  - NCQA standards
  - Team based care
  - Change Management
  - Staff cross training
  - Staff communication

## MEDICAL RECORD COMPONENTS

- Single patient record
- Demographics
- Clinical and family history
- Treatment plan
- Health maintenance history
<table>
<thead>
<tr>
<th>ASSESSMENT</th>
<th>NOT STARTED</th>
<th>WORKING ON</th>
<th>COMPLETE</th>
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<td><strong>ELECTRONIC CAPABILITIES</strong></td>
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<td>Hospital Interface</td>
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<td>Lab and diagnostic testing interface</td>
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<td><strong>QUALITY</strong></td>
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<td>Continuous quality improvement program</td>
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<td>Evidenced-based CARE MANAGEMENT programs</td>
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<td>Quality metrics – preventive, chronic</td>
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<td>Scheduling identifies an appointment as a follow-up and chronic condition</td>
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<td>Clinical advice timely and documented – office hours and after hours</td>
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<td>Availability of patient health information after hours</td>
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<td>FRONT OFFICE - Administrative Tasks</td>
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<td>BACK OFFICE - Care Delivery tasks</td>
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<td>Patient phone triage</td>
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<td>Scheduling return appointments and referrals</td>
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<td>TEAM BASED CARE Tasks</td>
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<td>Huddles</td>
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<td>Tracking lab and diagnostic tests and notifying patients of results</td>
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<td>Tracking referrals</td>
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<td>Motivational interviewing</td>
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<td>CARE COORDINATOR Tasks</td>
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<td>Previsit planning</td>
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<tr>
<td>Care transitions – ED and hospital</td>
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</table>

**CARE MANAGEMENT tasks**
- Assessing patient goals
- Initiating patient self management support
- Referrals to dietician, social services, community programs
- Medication management

**POPULATION MANAGEMENT tasks**
- Manage chronic and preventive care services—point of care reminders
- Monitor resource utilization
- Risk stratify patients
- Monitor patients lost to follow-up

**REMINDER SYSTEMS**
- Point of care reminder
- Appointment reminder

**REFERRALS**
- Intra-agency agreements for care transitions and referrals

**WRITTEN PRACTICE WORKFLOWS**
- **Front Office**
  - Appointment scheduling
  - Registration
- **Back Office**
  - Triage and documenting clinical advice
  - Pre-visit preparation
  - Clinical Processes
  - Standing orders
<table>
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<tr>
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<td>Tracking lab and diagnostic testing</td>
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<td>Assisting with Procedures</td>
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<td>Returning phone calls</td>
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<td>Patient notification of normal and abnormal lab results</td>
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<td>EHR documentation</td>
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<td>Return appointment scheduling</td>
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<td>Referral scheduling</td>
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<td>Preventive care – immunizations and physicals</td>
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<td>Chronic disease routine labs</td>
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<td>Office procedures</td>
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<td>Medication refill protocol</td>
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<td>Preventive immunization ordering policy</td>
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<td>Laboratory and health screen ordering policy</td>
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<td>High risk medication</td>
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<thead>
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<th>JOB DESCRIPTIONS</th>
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<td>Clinical and administrative staff - job duties by type position</td>
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<td>Registration</td>
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<td>ASSESSMENT</td>
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<td>Patient care associate</td>
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<tr>
<td>RN nurse manager</td>
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<td>Clinic manager</td>
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<td>MARKETING PCMH</td>
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<td>Patient materials</td>
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<td>Corporate materials</td>
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### Sample 7: Project manager PCMH initial work plan

<table>
<thead>
<tr>
<th>Activity/Task</th>
<th>Start Date</th>
<th>End Date</th>
<th>Goal</th>
<th>Actions/Documentation</th>
<th>Responsible Person(s)</th>
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<tbody>
<tr>
<td><strong>Teams</strong></td>
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<tr>
<td>1. Identify teams</td>
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<td>1. Define teams</td>
<td>Project Manager</td>
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<tr>
<td>2. Identify responsibilities</td>
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<td>2. Define team roles/responsibilities</td>
<td>Administration</td>
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<td>Develop project charter and logic model</td>
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<td>Develop Project Work plan</td>
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<td>Steering Committee</td>
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<tr>
<td><strong>Communication</strong></td>
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<tr>
<td>1. Clinic and Corporate</td>
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<td>Project Manager</td>
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<tr>
<td>2. Within clinic</td>
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<td>Clinic Manager</td>
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<tr>
<td>1. Educate Steering Committee</td>
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<td>2. Educate Practice Teams</td>
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<td>3. Continuing PCMH education</td>
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<td><strong>Team based Care</strong></td>
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<td>1. Previsit planning chart review: Lab Results Imaging Results Referrals</td>
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<td>Clinic Manager/Practice Team</td>
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</table>

- **PCMH Team Listing**
- **Team Roles/Responsibilities**
- **PCMH PowerPoint**
- **Project Manager**
- **Administration**
- **Steering Committee**
- **Clinic Manager**
- **Clinical team**
- **Previsit planning**
<table>
<thead>
<tr>
<th>Activity/Task</th>
<th>Start Date</th>
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<tbody>
<tr>
<td>2. Daily Huddles</td>
<td>2.</td>
<td>3.</td>
<td>2. Daily huddles occur 100% of time</td>
<td>2. Clinical team to develop format for daily huddles</td>
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<td>3. Other identified processes</td>
<td></td>
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<td>3. Clinic manager will meet with practitioners to discuss areas for review/improvement</td>
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<tr>
<td>Clinic Workflow</td>
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<tr>
<td>1. Map workflow</td>
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<td>2.</td>
<td>Identified tasks have processes and workflow that are monitored and evaluated</td>
<td>1. Clinical Team</td>
<td>1. Example patient visit flow</td>
<td>Practice Team</td>
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<td>Front Office</td>
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<td>Back Office</td>
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<td>b. Referral tracking</td>
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<td>c. Map process for updating health maintenance form</td>
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<td>c. Tasks</td>
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<td>d. Identify areas for improvement – “working task list”</td>
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<td>3. Health Maintenance Form</td>
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<tr>
<td>Care Management</td>
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<td>1. Important conditions identified</td>
<td>1. Defined process for care management</td>
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<td>1. Documenting patient education</td>
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<td>1. Clinical Team will review current process for improvement</td>
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<tr>
<td>2. Documenting preventive care</td>
<td></td>
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<td>2. Same</td>
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</table>
### Sample 7: Project manager PCMH initial work plan

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<tr>
<td>3. Care management evidenced based care</td>
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<td>3. Care Management process and workflow designed</td>
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<tr>
<td>Professional Development 1. Identify educational needs of staff for a. PCMH project management b. PCMH clinical management</td>
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<td>The organization encompasses all dimensions of the PCMH model. Patients recognize the organization as a PCMH.</td>
<td>1. Facilitate a session on process redesign 2. Facilitate a session on change management 3. Facilitate session on team-based care</td>
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<tr>
<td>Patient Education</td>
<td></td>
<td></td>
<td>Clinical staff competent in techniques for patient self care management</td>
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<td>Staff education in motivational interviewing, goal setting, etc.</td>
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Sample 8: Agenda for initial meeting - project manager and practice team

Practice team meeting agenda

1. Meet with practice manager, clinic supervisor for administration and nursing supervisor to review and answer additional questions about the PCMH
2. Identify administrative and clinical team members
3. Discuss and map out current front and back office procedures
   a. Identify and collect written policies/procedures/standing orders
4. Identify processes that work well, need improvement and do not exist
   a. Specific areas to discuss/evaluate
      i. Telephone triage/Patient call backs
      ii. Team Care
         1. Team communication i.e. daily huddles
         2. Pre-visit planning
         3. Tracking lab and diagnostic testing results
         4. Tracking referrals
         5. Medication refill procedure
         6. Standard patient procedures for routine visit, physical exam, GYN procedures
         7. Patient Flow
            a. Front office
            b. Back office
5. Patient self-care
   a. Health coaching
   b. Motivational interviewing
   c. Self management tools
6. Patient community support
   a. Educational resources
   b. Program resource listing
7. Medical record documentation
8. Continuous quality improvement program
9. Organize information and make plans for bringing findings to entire staff
Sample 9: Care Coordination Agreement

Care Coordination and Care Collaboration Agreement

Guidelines between [Insert Name of practice] and [Insert Hospitalist/ER Physicians]

This understanding is designed to coordinate the team roles between primary care and hospital/ER care to ensure high quality efficient care for patients. We agree on the following guidelines:

For ER visits by our primary care patients

- We as the primary care physician (PCP) will do the following:
  
  Provide pertinent information about the patient’s medications and medical history whenever possible *(define process)*
  
  Provide appropriate PCP follow-up as recommended

- Our expectations of you as the ER physicians include:
  
  Communication to PCP of ER visit within 24 hours of visit

For Hospitalization of our primary care patients

- We as the primary care physician will do the following:

  Provide a list of PCP’s providing hospital care or preferred hospitalists
  Provide pertinent information about the patient’s medications and medical history whenever possible *(define process)*
  
  Assist with chronic disease management as needed
  Assist with coordination of any post care as needed
  Phone follow-up in 3 days for high risk patients or as requested

- Our expectations of you as the hospitalist physician include:

  Admission notification to PCP or practice on-call physician
  Notification of any significant change in patient status
  PCP care collaboration for patients with high acuity, patient with high risk medications and patients who are non-compliant
  
  If the patient has a chronic condition, request/order PCP follow-up visit within 7 days of discharge
  
  Hospital discharge notification to PCP
Sample 10: Transition and Coordination of Care Procedure

Transition and Coordination of Care

Purpose:

To outline the process and steps for coordination of care from ED visit, inpatient/observation discharge to primary care provider (PCP) that will ensure timely and appropriate post hospitalization follow-up care.

Identification of patients requiring post discharge follow-up following ED visit and/or hospitalization

- Patients will be identified from hospital site specific discharge lists daily during office hours.
- Patient follow-up care timelines determined by the hospital provider discharge instructions and/or primary care provider (PCP) clinical judgment.

Proactive follow-up for High Risk Patients with ED visit and/or hospitalization

- The care coordinator will review the hospital site specific discharge lists and patient ED/out/inpatient discharge instructions to identify high risk patients (if access to hospital EHR).
- Phone call at 3 days post ED visit, inpatient/observation discharge for high risk patients to assess patient status and medication management.
- All high risk patients will be scheduled a follow-up visit within 7 days of ED visit/hospital discharge (if not already scheduled).
- All high risk patients who cannot be reached by phone will be sent a letter with follow-up recommendations (if follow-up appointment not scheduled).
- The care coordinator will notify the PCP and document in the medical record when a letter is sent to a patient who cannot be reached by phone, and when a patient declines to schedule a follow-up appointment.

High risk patients will include:

- Pediatric Patient (birth to age 13)
- High risk diagnosis
  - DVT/coagulation disorder
  - Asthma
  - Diabetes
  - Depression
  - Serious mental illness
- High risk for readmission
  - COPD
  - CHF
- Pneumonia
- Asthma
- CAD

- Other as determined by PCP’s nurse/care coordinator

Proactive follow-up for Patients with ED visit and/or hospitalization not identified as High Risk

- All patients will be contacted within 7 days to schedule a follow-up appointment if a recommended follow-up visit has not been scheduled as noted on the hospital discharge instructions (if access to hospital EHR).

- All patients who cannot be reached by phone will be sent a letter with follow-up recommendations (if follow-up appointment not scheduled).

- The care coordinator will notify the PCP and document in the medical record when a letter is sent to a patient who cannot be reached by phone, and when a patient declines to schedule a follow-up appointment.
Sample 11: Guideline for coordinating care transitions

ED visit, inpatient/observation hospital discharge care coordination guidelines

Purpose:

To outline the process and steps for coordination of care from ED visit, inpatient/observation discharge to primary care provider (PCP) that will ensure timely and appropriate follow-up care.

Identification of patients requiring post discharge follow-up following ED visit and/or hospitalization

- Patients will be identified from hospital site specific discharge lists daily during office hours.
- The care coordinator will review the hospital site specific discharge lists within 5 days of patient discharge.
- The care coordinator will use the discharge lists as a log and document the follow-up appointment date, and/or date of phone contact/message, and/or case review or provider case referral.
- The care coordinator will flag and follow-up all phone messages.

Proactive follow-up for all patients with inpatient hospitalization discharge and ED patients in care management program

- The care coordinator will contact identified patients by phone within 5 days of ED visit or patient discharge.
- A follow-up appointment will be scheduled for all patients who do not have a follow-up appointment scheduled within 14 days of ED visit/hospital discharge.
- Care coordinator will reconcile the patient’s most recent medication list to post-hospital discharge medication list.
- The care coordinator will confer with the patient’s provider on medication discrepancies and clinical concerns, and communicate provider instructions to the patient.
- The care coordinator will document medication reconciliation and clinical advice/instructions in the patient EHR.

Phone messaging procedure

- The care coordinator will leave a phone message for the patient to contact the office when a call is unanswered. The care coordinator will document in the patient EHR instructions to refer the patient to the care coordinator.
- The care coordinator will track phone messages and re-attempt to contact the patient within 3 days if the patient has not responded to the message.
- All patients who cannot be reached by phone after 2 attempts will be referred to their primary care provider. A patient may be sent a letter with follow-up recommendations based on the provider clinical judgment. The care coordinator will document actions in the EHR.

- The care coordinator will notify the PCP and document in the medical record when a patient declines to schedule a follow-up appointment.

Proactive follow-up for an ED visit

- Patients who have a follow-up appointment scheduled within 14 days of ED visit/hospital discharge will have no further action.

- Patients who do not have a follow-up appointment scheduled will be contacted by phone to schedule a follow-up appointment within 14 days of ED visit/hospital discharge.

- During phone contact, the care coordinator will follow the patient triage protocol when responding to patient concerns and document clinical advice in the patient EHR.

Phone messaging procedure post ED visit

- The care coordinator will leave a phone message for the patient to contact the office for an appointment when a call is unanswered. The care coordinator will document in the patient EHR instructions to schedule the patient a follow-up appointment.

- The care coordinator will track phone messages and re-attempt to contact the patient within 3 days if a follow-up appointment remains unscheduled.

- All patients who cannot be reached by phone after 2 attempts will be referred to their primary care provider. A patient may be sent a letter with follow-up recommendations based on the provider clinical judgment. The care coordinator will document actions in the EHR.

- The care coordinator will notify the PCP and document in the medical record when a patient declines to schedule a follow-up appointment.
Sample 12: PCMH elements for a diabetes care management program

Diabetes Care Management Program (PCMH 3A1)

Elements of Care Management:

Patients in the diabetes care management program will collaborative with the care team for

- Pre-visit preparations (PCMH 3C1)
- Developing an individual plan of care with treatment goals that are reviewed and updated at every routine diabetes visit (PCMH3C2)
- Assessment of barriers when treatment goals are unmet (PCMH 3C4)

Patient/family in the diabetes care management program will:

- Receive a written plan of care (PCMH 3C3)
- Receive a clinical summary at each routine diabetes visit (PCMH 3C5)
- Receive clinic follow-up for missed routine diabetes care appointments (PCMH 3C7)
- Collaborate with the care team and receive a diabetes self-management plan with goals (PCMH 4A3)
- Receive tools to measure progress towards goals (PCMH4A5)
- Receive documentation of patient self-management abilities (PCMH 4A4)
- Receive evidence-based counseling to adopt healthy behaviors associated with diabetes (PCMH 4A6)
- Receive diabetes self-management education and training (PCMH4A1)
- Receive medication management that includes: maintaining a complete listing of patient medications including over the counter and herbal therapy/supplements, patient medication reconciliation following care transitions, patient medication education that includes assessment of medication understanding, response to medication and barriers to adherence. (PCMH 3D 1-6)

Continuous Quality Improvement (CQI):

- The practice will select to measure at least: one clinical process/outcome measure (PCMH 6A2).
- The practice will collect and analyze the clinical process/outcome measure(s) at least annually (PCMH 6A2).
- The practice will conduct continuous quality improvement (CQI) for selected clinical process/outcome measure(s) that includes: regular review and evaluation of performance against goals, and establishment of a CQI plan to improve performance. (PCMH 6C1)
- The practice will report selected clinical process/outcome measure(s) at least annually. Individual provides will be notified of their performance, and the practice performance at least annually. Practice staff will be notified of practice performance at least annually (PCMH 6E1 and 2).
Sample 13: Diabetes Action Plan

**DIABETES ACTION PLAN**

**Green Zone** Things to do everyday

- I will eat meals and snacks at designated times
- Use carbohydrate counting to plan my meals
- Read labels for carbohydrate and fat content
- Control my portion sizes
- Build my activity into my day (by walking, parking further away, taking the stairs)
- Wash, dry and examine my feet daily
- Check my blood sugar ____ times per day

**Yellow Zone** I will call my medical provider if:

- If my blood sugar is double the range set by my medical provider
- If my blood sugar is lower than _____ and does not improve after eating a meal
- Fever of 101 degrees or more
- Nausea or vomiting, especially if no food or fluid for more than 5 hours
- Symptoms of shakiness, lightheadedness, sweating, rapid heart rate that does not improve after eating a meal or snack.
- Any problems with my feet (burns, blisters, bruising or discoloration, bleeding or oozing fluid)

**Red Zone** I will call 911 if:

- I have chest pressure with or without shortness of breath, a cold sweat or nausea

**Blue Zone** **My Goals - My Plan**

HgbA1C _____________ LDL _____________ Blood Pressure _____________

________________________________________________________________________

________________________________________________________________________

1. Date _____________ nurse ____________________________________________
Sample 14: Flow diagram of referral process for diabetes care management program
<table>
<thead>
<tr>
<th>Sample 15: Diabetes care management program staff duties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Care Management Program: Diabetes Program Staff Duties</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Rooming Nurse</th>
<th>Care Manager</th>
<th>Provider</th>
<th>Diabetes Educator</th>
<th>Counselor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-visit planning</strong></td>
<td>Run patient schedule every 2 weeks</td>
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<tr>
<td></td>
<td>Contact patients scheduled for routine diabetic follow-up to have pre-visit lab drawn if not completed</td>
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<tr>
<td><strong>Patient Visit Assessment</strong></td>
<td>Complete Vital Signs</td>
<td>Medication Reconciliation</td>
<td>H&amp;P and physical exam</td>
<td>Clinical assessment of DM: knowledge of diabetes/ skills/literacy/ barriers</td>
<td>Reviews and updates patient plan of care and behavioral goals for healthy eating, being active, monitoring blood glucose at every routine follow-up visit for diabetes</td>
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<tr>
<td></td>
<td>Document most recent A1C</td>
<td>Assess smoking status and advise to quit</td>
<td></td>
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<tr>
<td></td>
<td>Assess goals for healthy eating, being active, monitoring blood glucose</td>
<td>Assess social needs - healthy coping, community support, medication assistance</td>
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<tr>
<td></td>
<td>Update Health Maintenance Annual - Foot exam, comprehensive eye exam, fasting lipid profile, serum creatinine, urine microalbumin, EKG, flu vaccine, Pneumococcal vaccine (per protocol)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Administer flu and pneumococcal vaccine per protocol</td>
<td></td>
<td></td>
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<tr>
<td>Rooming Nurse</td>
<td>Care Manager</td>
<td>Provider</td>
<td>Diabetes Educator</td>
<td>Counselor</td>
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<tr>
<td><strong>Patient Visit - Goal Setting</strong></td>
<td>Reviews patient goals: healthy eating, being active, monitoring blood glucose every visit</td>
<td>Develops patient plan of care and sets behavioral goals for healthy eating, being active, monitoring blood glucose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Visit Education</strong></td>
<td>Ensure patients understand their plan of care and medications</td>
<td>Diabetic medication management - action, prescribed dosage, appropriate timing and frequency of administration, missed or delayed doses, side effects, efficacy, toxicity,</td>
<td>Provides “patient plan” at every routine follow-up diabetes visit</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Teach self-monitoring of blood glucose</td>
<td></td>
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<tr>
<td></td>
<td>Provide information/tools/resources for diabetes self-management and community support</td>
<td></td>
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</tr>
<tr>
<td><strong>Care Coordination</strong></td>
<td>Coordinates referrals to care manager for care managed patients</td>
<td>Refers care managed patients to care manager</td>
<td></td>
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<tr>
<td></td>
<td>Coordinates referrals to diabetic educator for new and annual care patients</td>
<td>Refers new and annual care patients to diabetes educator</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Coordinates referrals to community programs for usual care patients</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Visit Referrals</strong></td>
<td>Coordinates referrals to diabetic educator for care managed patients</td>
<td>Refers care managed patients to care manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coordinates referrals to community programs for care managed patients</td>
<td>Refers usual care patients to community programs</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Refers patients to counselor as needed</td>
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<td></td>
<td></td>
<td>Refers patients to diabetes educator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up missed Visit</td>
<td>Rooming Nurse</td>
<td>Care Manager</td>
<td>Provider</td>
<td>Diabetes Educator</td>
<td>Counselor</td>
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<td>-----------</td>
</tr>
<tr>
<td>Follow-up on missed routine diabetic follow-up appoint-</td>
<td>Reviews patient goals: healthy eating, being active, monitoring blood glucose</td>
<td>Diabetic medication management - action, prescribed dosage, appropriate timing and frequency of administration, missed or delayed doses, side effects, efficacy, toxicity,</td>
<td>Assessment of DM: knowledge of Diabetes/ skills/ literacy</td>
<td>Assessment of barriers to behavior change</td>
<td></td>
</tr>
<tr>
<td>Referral visit education</td>
<td>Provides insulin administration - education and training</td>
<td>Functions as cultural bridge, point of access, and support for their patients</td>
<td>Provides nutrition education -carbohydrate counting</td>
<td>Provides insulin administration - education and training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provides education and training in self-management support</td>
<td></td>
<td></td>
<td>Provides education and training in self-management support</td>
<td>Utilizes evidenced-based counseling to promote patient self-management support</td>
</tr>
<tr>
<td>Role Responsibility</td>
<td>Rooming Nurse</td>
<td>Care Manager</td>
<td>Provider</td>
<td>Diabetes Educator</td>
<td>Counselor</td>
</tr>
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<tr>
<td></td>
<td></td>
<td>Clinic Diabetes Champion</td>
<td>Manages care management diabetes program</td>
<td>Responsible for diabetes care and treatment for their patient population</td>
<td>Agency-wide SHS certified diabetes educator responsible for diabetes self-management education, training and support</td>
</tr>
</tbody>
</table>
Sample 16: Flow diagram of the process for lab testing results
Sample 17: Standard Work for Huddle

**Purpose of Huddles:** To improve clinic flow by planning ahead and to improve communication amongst the care team.

**Time**
Less than 10 minutes for OVERALL huddle time.

<table>
<thead>
<tr>
<th>IMPORTANT STEPS</th>
<th>KEY POINTS</th>
<th>REASONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Front Staff prints care plans for patients scheduled next day and gives to nurse/MA</td>
<td>Print in afternoon, no sooner</td>
<td>Ensures most recent labs done will appear on the care plan</td>
</tr>
<tr>
<td></td>
<td>Print to double sided printer</td>
<td>Reduces paper usage</td>
</tr>
<tr>
<td></td>
<td>Take back to provider’s Nurse/MA</td>
<td>For review day prior; to give to provider next day during huddle. Reduces overall time of huddle the next day</td>
</tr>
<tr>
<td>Nurse/MA reviews and highlights overdue chronic disease labs and Health Maintenance items from care plan</td>
<td>Nurse/MA highlights overdue chronic disease labs and Health Maintenance items</td>
<td>1. Brings attention to provider when reviewing plan for office visit that day during huddle. 2. Brings attention when patient reviewing care plan while waiting to be roomed. 3. Brings attention to rooming MA/Nurse to address while rooming patient. 4. Brings attention to provider when reviewing care plan with patient; reminds provider to address</td>
</tr>
<tr>
<td>Schedules are posted in supervisor’s area</td>
<td>Supervisor will post daily patient schedules upon arrival to clinic in the morning (AM clinic) or at the end of morning huddle (for PM clinic)</td>
<td>1. Centralizes huddles and improves overall clinic communication 2. Allows for patient discussion to occur in a secure area</td>
</tr>
<tr>
<td>Huddles announced at 8:40 (8:15 on Wednesdays)</td>
<td>Supervisor announces overhead that huddle is occurring</td>
<td>A reminder for those that are in the office to gather to discuss schedules</td>
</tr>
<tr>
<td></td>
<td>2. &quot;Huddles are beginning, _______ is the huddle leader</td>
<td>Communicates who is leading the huddle</td>
</tr>
<tr>
<td>Huddle leader</td>
<td>Listed on the master schedule</td>
<td></td>
</tr>
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<td>---------------</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>If the designated leader is not present, the huddle can still occur, first back-up leader will lead huddle</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Huddle leader will guide the process for those providers that are present (providers will do their own schedule). If provider is not present, the Leader will huddle for that provider’s schedule</td>
<td></td>
</tr>
<tr>
<td></td>
<td>One person to guide the process and ensure standard work is followed</td>
<td></td>
</tr>
<tr>
<td>Attendance at huddles: Nurses, MA’s, one front staff rep, providers and huddle leader</td>
<td>Improves team communication</td>
<td></td>
</tr>
</tbody>
</table>

| Huddle - Review Schedule | To improve flow, plan ahead, reduce surprises/frustration, improve care of our patients |
| Review overall schedule and open slots | Improve flow, reduce patient, provider and staff frustration |
| Record meeting discussion on electronic huddle database | Huddle leader is recorder |
|               | Documentation for NCQA PCMH standard 1G2 |
Sample 18: Message to Patients for PCMH

A Message to Our Patients,

Over the next year we will be making changes at our community health centers to improve how we care for your health care needs. We will be transforming your clinic into a Patient-Centered Medical Home.

A Patient-Centered Medical Home (PCMH) is a new way of delivering healthcare

- promotes a partnership between you, your physician and care team
- provides accessible, coordinated, comprehensive, and continuous quality health care
- ensures all of your preventive, acute, and chronic care needs are met
- emphasis on efficient and timely service delivery

Your physician

- will provide medical care that is right for you
- will direct the care team (clinic staff) to coordinate your care

The team

- plan for your appointment by reviewing your record and making sure all required documents are in your chart
- make sure testing is completed, results are obtained, and you are notified of your results in a timely manner
- follow-up on referrals; making sure appointments are kept, that specialists have information about you before your appointment, and that your physician receives the specialist’s recommendations

If you are in the hospital your care team

- will make sure the physician seeing you in the hospital has your health information
- will make sure you understand how to call if you have questions about your treatments or medications after discharge
- will make sure you return for follow-up after discharge

In return, we ask that you

- are an active participant in your health care
- take charge of your health by assuming responsibility for aspects of your care
- be prepared for your appointment by bringing a list of your medications and questions
- follow the Care Plan your team has developed for you, and let your team know when you can’t
• call the clinic for advice before going to the Emergency Room in a non-emergent situation
• work with the care team to learn how to self-manage your care

Our PCMH is committed to enhancing access to care by providing

• same day appointments, and offering expanded hours
COMING SOON!

PATIENT—CENTERED MEDICAL HOME

it's all about YOU!

Do You want to:
• Be in Charge of Your Health Care
• Participate in Your Care
• Communicate with YOUR physician and care team

If so,

A Patient-Centered Medical Home is for YOU!

The Patient-Centered Medical Home will provide you with:
• Better, more personalized care
• Guide you through the complex health care system
• Offer you better access to care
• Teach you skill building and problem solving strategies for managing your health care

Over the next year we will be making changes at the clinic to improve how we care for you. Pick-up a Patient-Centered Medical Home (PCMH) Brochure and ask at the front desk for more information.

In a PCMH YOU are the most important member of your health care team!
Sample 20: PCMH Patient Handout

Your personal physician
The relationship between you, your physician, and care team is the driving force behind a Patient-Centered Medical Home (PCMH). Your physician will provide medical care that is right for you based on what has been shown to improve health.

Your Care Team
Your physician will direct the care team (clinic staff) to coordinate your care based on your wants and needs. To improve efficiency, the team will plan for your appointment by reviewing your record and making sure all required documents are in your chart. The team will make sure testing is completed, results are obtained, and you are notified of your results in a timely manner. The team will follow-up on your referrals; making sure your appointment is timely, that your specialists have your care summary before your appointment, and that your physician receives your specialist’s recommendations. If you are admitted to the hospital, your physician will make sure the physician seeing you in the hospital has your health information. Likewise, when you are discharged your care team will review your hospital stay, make sure you return for follow-up, and that you understand how to call if you have questions about your treatments or medications.

Your Care Management
Managing your care will be challenging, but your physician and care team is here to assist you. Your physician will direct the care team to provide care management designed so that you and/or your family can learn how to self-manage your care. If you have diabetes the care manager will work with you to develop a treatment plan with clear goals and steps to reach them; whether that may be learning how to monitor your blood sugar and administer insulin, or learning how diet and exercise can help you control your blood pressure. You will learn skill building and problem solving strategies that will help you identify and overcome even the most difficult challenges to managing your health care and medications.

Your Health
In return, we ask that you continue to be an active participant in your health care. We ask you to take charge of your health by assuming responsibility for aspects of your care. Ways to start are by being prepared for your appointment and bringing a list of your medications and questions, following the care plan your physician has developed for you, and letting your physician know when you can’t. You can call the clinic for advice before going to the Emergency Room in a non-emergent situation.

Quality for You
Our PCMH is committed to providing same day appointments, and offering expanded hours to meet your needs. We will use the electronic medical record to support the best care, quality, and safety. This electronic system will help us identify and provide for the needs of all our clinic patients such as sending you reminders about needed preventive and chronic care, and medication management.
Sample 21: Introduction to PCMH slides

Slide 1

PATIENT – CENTERED MEDICAL HOME

Slide 2

What is A Patient - Centered Medical Home?

- A vision of health care as it should be
- A framework for organizing systems of care at both the micro (practice) and macro (society) level
- A model to test, improve, and validate
- A part of the health care reform agenda

Definition by The American College of Physicians

The PCMH not only looks at the acute needs of patients; it takes an organized, proactive approach to improving the health of a population of patients.
The Patient-Center Medical Home (PCMH) is a health care setting that facilitates a partnership between patients, their physicians and health care team, and when appropriate, the patient’s family.

The PCMH model is a synthesis of primary care and chronic care models of care. In 2007 the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA), representing approximately 333,000 physicians have developed the following joint principles to describe the characteristics of the PCMH.

**Characteristics of the PCMH**

- **Personal Physician** – each patient has an ongoing relationship with a personal physician.
- **Physician directed medical practice** – the personal physician leads a team of individuals who collectively take responsibility for the ongoing care of patients.
- **Whole person orientation** – the personal physician is responsible for providing for all the patient's health care needs, or arranging care with other qualified providers, practitioners or professionals. This includes care for all stages of life.
Characteristics of the PCMH

- Enhanced Access to care - is available through systems such as open scheduling, expanded hours, and new options for communication between the patient and his care team.

- Care is coordinated and integrated – across all elements of the health care system. This may include hospitals, nursing homes, home health agencies, or community based support services.

- Care is structured so patients can receive it when and where they need and want it in a culturally and linguistically appropriate manner.

Characteristics of the PCMH

- Quality and Safety – Optimal patient-centered outcomes are achieved through a partnership between patients, physicians, and patient's family.
  - Decisions are made based on evidenced-based standards and clinical decision-support tools.
  - Information technology is used to support optimal patient care.
  - Patients and families participate in quality improvement activities.
  - Practices go through a voluntary recognition process.

- Payment – appropriately recognizes the added value provided to patients with a PCMH beyond the traditional fee-for-service payment model.
Why is it important for a practice to adopt the PCMH model?

- PCMH Demonstration Projects show success in increasing the quality of care.
- Currently patients receive recommended services only one-half the time due to the focus of care being on the new symptom or injury.
- PCMH principles have reduced total spending 15-20% in pilot projects.
- Medical homes are expected to reduce health care costs by avoiding redundant and unnecessary services and reducing emergency room visits and hospitalizations.

How is this achieved?

- PCMH transformation requires visible and sustained engagement and tangible support of leaders within the practice.

Leaders must provide:
- The vision for change
- Set the Direction: Mission, Vision and Strategy
- Instill confidence and enthusiasm for the PCMH
- Provide motivation for continuous improvement and innovation
- Identify changes to test
- Support staff as practice teams redesign themselves and their processes
- Build and sustain the will within the practice for transformation
What are we REALLY DOING?
The MACRO picture – POPULATION MANAGEMENT

Population Management is maintaining the overall health of all patients in the practice

Adapted from Care Coordination Ring

What are we REALLY DOING?
The Micro picture – patient care management

Patient-Centered care is providing for the overall needs for each patient

Adapted from Care Coordination Ring?
**Slide 11**

**PCMH will meet the patient’s health care needs**

Effective and efficient care is delivered when the physician practice is able to meet the patient needs. This can be achieved through Practice Based Team Care, Care Management, and Decision Support capabilities.

**Practice Based Team Care**

- The care team includes physicians, practitioners, nurses, and staff.
- Effective practices empower everyone to function at the highest level of their ability and licensure.
- The practice must find the appropriate mix of staff and task to maximize each employee’s contribution.
- Team communication is positive, timely and effective.
- Standardization and cross training facilitate the group’s flexibility.
- Patients receive care from a variety of practice members.

**Slide 12**

**An important function of the care team is:**

**Planned care** – care that is deliberately designed to assure that patient needs are met.

**Planned preventive or chronic illness care can be delivered either in REACTIVE, patient initiated visits or PROACTIVE, practice initiated chronic illness or preventive visits**

- Proactive visits are practice-initiated and they are anticipated allowing for pre-visit planning, i.e. ordering needed diagnostic testing, ensuring specialized staff is available.
- Reactive visits are patient-initiated and the practice is unable to anticipate the patient needs; important labs are unavailable and patient complaints are unforeseen.
Efficient practices develop processes to manage patient care

“Practice Huddles” are an example of team care and are used to plan a workday. Efficiency is improved by planning for any changes in the daily work flow and anticipating crises.

Activities may include:
- Reviewing the patient schedule to identify potential back logs and patients that may require more time
- Reviewing patient records to ensure all relevant testing results are available and that all services can be delivered
- Review staffing for the day and adjusting workflow as needed

• Individual patient needs are met by:
  - Reviewing patient data prior to the encounter to identify needed services
  - Identifying the key clinical tasks to accomplish based on evidenced-based care
  - Deciding who on the team should perform the task
  - Structure the encounter so that the relevant members of the care team can deliver all needed services.

CARE MANAGEMENT

As a care team member, the Care Manager collaborates to develop a treatment plan for patients that are determined to be at higher risk of morbidity and mortality. Services may include:

• Patient care coordination – manage care transitions from other providers, institutions or agencies
• Patient self-management support – providing information, counseling, and self-management training and education
• Patient emotional support – monitoring and recommending treatment if needed
• Patient medication management – performing medication reconciliation, monitoring compliance and medication effectiveness
• Patient follow-up monitoring
To effectively use the Care Manager:
• Practices need to determine which small percentage of their patients will benefit from care management using a standardized approach
• Set clear patient goals and specific plans for achieving the goals
• Discharge patients from care management once maximum benefit is obtained
• Train other care team members to assist with care management tasks, such as, monitoring patient follow-up and care coordination.

Decision support systems

Decision Support refers to interventions that assist healthcare providers make appropriate clinical decisions, usually based on computer technology.
Examples
• Evidence-based guidelines
• Point of Care reminders
Meaningful use criteria includes emphasis on decision support
• Computerized physician order entry with drug-drug or drug-allergy checks
How do Practices show that they are a Patient Centered Medical Home?

The National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) Recognition Program

- Recognition Program initiated in 2008
- 7600 Clinicians and 1500 Practices across the country have achieved PCMH recognition as of December 2010
- The program reflects elements that make primary care successful
- The NCQA framework provides goals and guidelines to becoming a PCMH based on evidence
- The NCQA 2011 PCMH standards align closely with using health information technology to improve quality and meaningful use requirements
The Case for (NCQA) Patient-Centered Medical Home (PCMH) Recognition

- Gives physicians a roadmap to improve quality with a systematic approach to preventive and chronic care delivery
- Focuses on evidence-based requirements to improve quality and reduce costs
- Considers capabilities of small and large practices, without sacrificing quality
- Program is built on what is shown to improve care and can be copied or replicated

Standard 1 – Enhance Access/Continuity

- Provide continuity of care with the same provider
- Provide information to patients about the medical home
- Provide access to care during and after office hours – appointment and clinical advice
- Provide materials and services to patients that meet their language needs
- Provide electronic access to patients
- Provide team-based care with trained staff
Standard 2 – Identify/Manage Patient Populations

- The practice uses an electronic system to collect demographic and clinical data
- The practice conducts and documents a comprehensive health assessment; including health risks and information needs
- The practice uses an electronic system to search data and produce lists of patients and proactively remind them about needed preventive and chronic care services, medication management, and visits/periodic physical exams

Standard 3 – Plan and Manage Care

- Through patient profiles, the practice identifies patients with specific high-risk or chronic care needs, and conditions related to health behaviors, mental health or substance abuse problems
- Care management is initiated for three conditions (2 high-risk or chronic care and 1 mental or behavioral health condition)
  - Care management components include:
    - Pre-visit planning
    - Assessing patient progress towards goals
    - Barriers to treatment goals
    - Reconciling medications
    - Electronic prescribing for medications
Standard 4 – Provide Self-Care and Community Support

- The practice assesses patient self-management abilities
- Works with the patient/family to develop a self-care plan and provides tools and resources
- Counsels patients on healthy behaviors
- Assesses/provides/arranges for mental health/substance abuse treatment
- Provides community resources

Standard 5 – Track and Coordinate Care

- The practice tracks lab and imaging results; notifies patients of normal and abnormal results
- Integrates results into the medical record
- Tracks referrals
- Coordinates with facilities and manages care transitions
- Identifies patients hospitalized or emergency department visit
- Establishes an process for information exchange with facilities
- Follows-up with discharged patients within an appropriate period
- Establishes agreements with specialists for patient co-management or transition
**Standard 6 – Measure and Improve Performance**

- The practice measures performance (preventive/chronic/acute care clinical measures)
- Tracks utilization measures, such as rates of hospitalization or emergency department visits
- Implements a patient experience survey, and identifies vulnerable patient populations
- Implements continuous quality improvement
- Demonstrates continuous quality improvement
- Reports performance internally and externally

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**Scoring Methodology for NCQA Recognition**

- 6 Standards with 27 elements and 149 factors
- 6 Must pass elements
  - Access during office hours
  - Using data for population management
  - Manage care for 3 conditions and complex patients
  - Support the patient self-care process
  - Track and follow-up on all referrals
  - Implement continuous quality improvement
- Certain elements contain “must pass” factors to receive points
Scoring Methodology for NCQA Recognition

Recognition requires achieving all 6 must pass elements with a score of 50% or greater. There are 100 points possible:

- Level 1 Recognition - a score of 35 or more points and all 6 must pass elements
- Level 2 Recognition - a score of 60 or more points and all 6 must pass elements
- Level 3 Recognition - a score of 85 or more points and all 6 must pass elements

How is compliance with a standard Documented?

- Written process and defined standards, and demonstration that we monitor performance against the standards:
  - Report showing availability of same-day appointments over time
  - Report showing the percentage of patients having clinical advice documented in the patient record
  - Report showing lists of patients needing services, and materials showing how patients are notified
  - Medical record review of a patient sample over the past 3 months
  - Paper log or electronic report showing referral tracking
Sample 22: PCMH training for clinic employees slides

Slide 1

Hello and welcome to our PCMH. Today we will be sharing information about what a PCMH means to us and how important you are to our success. We hope that you will embrace the PCMH and support our goal of providing the highest quality health care to all of our patients.
Today’s program will introduce you to the components of a PCMH. As we present these components, our hope is that you can identify the benefits of a PCMH for our patients. Each employee contributes to the success of our PCMH and has an important role.
A PCMH is organized around the patient and emphasizes the relationship between a patient and their provider. A PCMH improves health care quality and the efficiency of health care delivery by providing a framework for organizing the many components of patient care.

The PCMH is a model of primary care that is organized around the patient and emphasizes the relationship between a patient and their provider. Each patient is assigned to a provider and their health care team. This team assists the provider in making sure all of the patient’s needs are met. As patients, their provider and health care team work together, they develop a trusting relationship that leads to a better understanding of how to best help the patient achieve their health care goals.

A PCMH improves health care quality and the efficiency of health care delivery by providing a framework for organizing the many components of patient care. A PCMH implements practices that have been shown to improve health. An example of an “evidence-based practice” is a care management program for persons with diabetes. A PCMH uses tools that such as electronic medical records, electronic medication prescribing, electronic patient scheduling and appointment reminder systems, to make the job easier. Providers are always searching for new ways to help patients and the PCMH is a road map for health care improvement. The PCMH model of care is widely supported and utilized by medical practices throughout the United States.
In a PCMH each patient selects a personal provider and schedules all of their health care visits with them. This gives providers a chance to get to know their patients and have a better understanding of their health care needs.

Providers are the leaders of the health care team and ensure that patient needs are met for as long as they require care. The health care team makes sure patients are able to self-manage aspects of their health care and treatment. For example, patients with diabetes learn how to monitor their blood sugar, and manage their diet and medication.

Providers look at the “whole-person” and address the immediate and also the long term health care needs of their patients for preventive, acute and chronic illness care. For example, providers make sure children receive their immunizations and adults receive recommended testing for cancer prevention.
In a PCMH providers make sure their patients are cared for when they are admitted to a hospital or a nursing home, or if they are referred to a specialist, or in need of behavioral health services.

Each provider prescribes health care and treatment based on what research has shown to improve health. Providers partner with their patients and their families to decide how to best provide the care they need and want.

A PCMH is committed to being accessible to their patients by providing same day appointments when patients have an urgent need to be seen; such as, having a high fever or serious pain. The PCMH offers expanded hours making it easier for working patients and a provider is always “On Call” when the clinic is closed.
A PCMH emphasizes “Team-Based Care”. A provider directs the health care team to provide patient care in a proactive, planned and efficient manner. The team uses a coordinated delivery process, with defined policies, protocols and procedures, staff roles and responsibilities, and structured communication processes. Each team member contributes to the quality of patient care by taking an active role in evaluating and improving patient care, and working at their highest level of education and ability.

The care team’s role also includes care coordination, care management and patient self-management support.
The health care team coordinates patient care by ensuring that testing is completed, results are obtained, and patients are notified of results in a timely manner. The team follows-up on patient referrals; making sure appointments are timely, that specialists have needed patient information prior to an appointment, and that providers receive reports back from specialists.

When patients are admitted to the hospital, providers make sure their physician has their health information. Likewise, when patients are discharged the team reviews the hospital stay, makes sure patients return for follow-up, and that they understand how to call when they have questions about treatments or medications. Care coordination allows the team to manage the “big picture” of what is going on with their patients.
Care management is intensive clinical management provided to select patients with complex chronic diseases. Care management programs are designed around “evidence-based” best practices and include planned and coordinated appointments, and regular planned follow-up care. Providers or their care managers work with patients to develop a treatment plan with clear goals and steps to reach them. Care management programs may be designed to deliver a range of activities based on a patient’s needs; whether that is a one-time referral to a dietician or ongoing follow-up with a care manager.
In a PCMH there is a shared responsibility across the health care team to empower patients and provide them with skills for self-management and healthy living; whether that is learning how to monitor their blood sugar and administer insulin, learning how diet and exercise helps control blood pressure, or learning how to cope with depression. Patients learn skill building and problem solving strategies that will help them identify and overcome even the most difficult challenges to managing their health care and medications.

The PCMH also ensures that patients are “connected” to resources available in their communities such as diabetic education or parenting classes, or behavioral health services.
In a PCMH each patient selects a primary care provider. Patient visits and other communication are arranged with the primary provider whenever possible. Providers value communication with their patients and they show this by making sure patient phone calls are returned in a timely manner and ensuring that after-hours “On Call” providers have access to their clinical information.

In a PCMH patients have access to routine and urgent team-based care that meet their needs thru flexible scheduling; such as, same day appointments, or being open before or after regular business hours.
Population health management is maintaining the health of all patients in the practice and is an important function for a PCMH. A practice collects demographic and clinical data for each patient and uses this information to identify patients in need of services, such as, preventive screenings or follow-up visits.
An electronic health record is a tool for systematically documenting patient information and is utilized for population health management. Lists of patients requiring preventive or chronic illness care can be produced using the capabilities of an electronic system. An example is generating a report to identify children overdue for immunizations and sending their parents an immunization reminder letter.

Other forms of electronic communication used in a PCMH are E-prescribing - sending medication prescriptions electronically to pharmacies, and communicating with patients using e-mail or a patient portal.
A PCMH uses an ongoing quality improvement process and monitors the effectiveness of this process over time. Using data a PCMH measures the quality of care, the efficiency of care delivery, and patient satisfaction with their care.

An example of a quality measure is identifying the percentage of patients in the practice who smoke. By tracking this percentage over time practices can evaluate the effectiveness of their smoking cessation interventions. If smoking rates are increasing programs are in need of redesign.
By implementing programs, evidence-based practices, policies and procedures we know that our PCMH has a strong foundation. By following our roadmap we will make sure our patients obtain needed preventative, acute and chronic care services. We will track how well our patients manage their chronic diseases, such as diabetes and hypertension, and make changes when necessary to their plan of care. Through team delivered care coordination, care management and patient self-management support we will achieve high rates for patient health care quality and satisfaction.
Now that we have talked about PCMH, you may ask, “What does this mean for me?”

As an employee we ask that you understand our vision for our PCMH, and that you convey it to our patients and their families. All employees are members of the PCMH team, working together and supporting each other to provide the best care possible to our patients. Staff roles and responsibilities in our PCMH are outlined in your job description.

As a member of the PCMH team you are encouraged to share your ideas about what is or is not working in how we deliver patient care and what changes are needed to improve care.

The PCMH model of care empowers you to become an advocate for patients and challenges you to work to the highest level of your education and ability. The possibilities are endless when you strive to do your personal best.
### Sample 23: NCQA PCMH standards monitoring tool:
#### NCQA PCMH 2011 RECOGNITION standards

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93
Sample 23: NCQA PCMH standards monitoring tool:
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94
## NCQA PCMH standards monitoring tool:
### NCQA PCMH 2011 RECOGNITION standards

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NCQA PCMH 2011 RECOGNITION standards

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NCQA PCMH 2011 RECOGNITION standards

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105
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NCQA PCMH 2011 RECOGNITION standards

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Notes


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http://www.pcpcc.net/guide/transforming-patient-engagement#sthash.5Gl5fSxQ.dpuf


http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3214716/

Web Sites

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http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/pcmh_home_v2

American Academy of Family Physicians


American College of Physicians

Community Care of North Carolina

HealthTeamWorks
http://www.healthteamworks.org/medical-home

National Committee for Quality Assurance (NCQA)
http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH/PCMH2.aspx

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http://www.safetynetmedicalhome.org/resources-tools/all-resources


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http://www.jointcommission.org/accreditation/pchi.aspx

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http://www.transformed.com/index.cfm

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https://www.urac.org/pchch/